

## The Levers to Value and Why MACRA Is Not Enough

AN INTERVIEW WITH AMGA'S CHESTER A. SPEED, LL.M.



Chester A. “Chet” Speed, LL.M., serves as vice president, public policy at AMGA. As the leader of AMGA’s advocacy efforts, he is responsible for developing public policy that supports multispecialty medical groups and integrated delivery systems and represents AMGA members’ interests before Congress and federal agencies. He has over two decades of experience as an attorney and government affairs professional in the healthcare field. *Group Practice Journal* asked him about the role of government in the move to value-based care and the Medicare Access & CHIP Reauthorization Act of 2015 (MACRA).

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**GPJ:** Congress and the Department of Health and Human Services (HHS) count themselves as strong supporters of transitioning the healthcare system from volume to value. Is that right?

**Speed:** Yes. Congress looks at MACRA as its platform to value-based care and HHS is testing dozens of value-based concepts each year. So, they’re all in on value, so to speak.

**GPJ:** Given this level of federal commitment, is the transition a done deal?

**Speed:** I don’t think so. The problem with this approach is that federal policymakers are only pushing on the provider lever as they try to get to value. There are many other levers that need to be pulled if we’re all truly going to be successful in moving away from fee-for-service (FFS).

**GPJ:** You mention “levers” to value. What do you mean?

**Speed:** I mentioned MACRA and while that law is generally seen as a good first step to getting to value, it only addresses the physician side of the value equation, or the “provider lever.” While providers, especially AMGA members, have an outsized role in health care, there are other influencers in the system which play significant roles in getting to value. So, in my mind, MACRA only impacts one component of a complex system. And, to truly transition the healthcare system to value-based reimbursement, Congress needs to pull several other levers to create a new foundation that actually supports this change.

**GPJ:** What are the main levers other than the provider one?

**Speed:** What I call the “P” levers are the provider lever, the payer lever, the patient lever, and the policy-maker lever.

However, these aren’t the only steps necessary to change. There are other levers, such as employers and drug manufacturers, for example.

**GPJ:** Can you explain each P lever?

**Speed:** Let's start with the *Provider* lever.

Back to MACRA—Congress views this law as a seminal piece of legislation designed to transition Medicare physician payments from volume to value. MACRA does this by injecting a heavy dose of risk into doctor payments. By 2022, physician payments will vary plus-or-minus 9%, depending on whether they meet various cost and quality measures.

While MACRA is limited to the physician side of things, RAND Corporation anticipates its impact will spill over to hospital payments as doctors react to financial incentives to keep patients healthy and out of the inpatient setting.<sup>1</sup>

Despite this significant impact, however, MACRA only pushes the provider lever and leaves major players without an incentive to get to value.

The second P lever is the *Payer* lever.

As every AMGA member intimately knows, under a value-based system, providers are required to manage their patients' cost and care. To do this, they need to see the full picture of their patient's care, (i.e., what other services they are receiving and from what other providers). Seeing the patient's full picture reduces duplication of services and allows providers to appropriately design care plans for treating their patients.

*“Congress needs to pull the payer lever and require payers, federal and commercial, to share all administrative claims data with providers.”*

All this information is included in administrative claims data that is collected and maintained by the patients' payer. The problem is, most payers will not share this data with the provider, meaning the provider is blind to all of the healthcare services their patients receive outside of their four walls, including the cost of that care. Simply put, lack of data affects the success of our members' population health initiatives.

Another data-related issue is standardization. AMGA members are required to submit data, usually quality data, to each payer with which they have value-based contracts. For each different payer, there is a different format to submit and receive data, not to mention a wide array of measures. When providers contract with multiple payers and must submit data on literally hundreds of different measures, the IT burden becomes acute.

Congress needs to pull the payer lever and require payers, federal and commercial, to share all administrative claims data with providers. To ease the payer burden, access to this data could be limited to value-based arrangements. Moreover, Congress should require providers and payers to work together to standardize the data submission, reporting, and sharing process. These changes alone would significantly improve the chances of moving the healthcare system to value.

Now the *Patient* lever.

I think AMGA members would agree that in a value-based system, providers are appropriately held accountable for the care they deliver. However, patients need to be accountable too. In our current volume-based system, most patients are able to see any provider they want, as many times as they want, regardless of cost or quality. While this arrangement works in fee-for-service, it does not in a value-based system because a provider can be penalized if a patient chooses to get care from a high-cost and not necessarily high-quality provider. This is not fair to the provider and is a serious chink in the value armor.

To fully leverage a value-based system, Congress needs to allow providers in value-based arrangements to waive co-payments or deductibles for patients who agree to receive all their care from the provider and its network. Indeed, providers should be allowed to share savings from the value-based arrangements with their patients. This sharing of success better aligns the patient and the provider in a true value relationship.

Finally, the *Policymaker* lever.

Congress and HHS need to push the policymaker lever. Historically, Congress has legislated health care in a silo, typically focusing on one major function, (i.e., doctors, or hospitals, or insurance, or devices, etc). However, legislating in silos isn't optimal as health care is complex, and every part of the system is inherently linked. Said in a different way, legislating health care piecemeal is akin to building up the Army by only dealing with the artillery.

Another policymaker issue to consider—value is hard. This transition requires an almost complete remodeling of the industry's financial, administrative, and delivery systems, to say nothing of the needed cultural changes. As previously mentioned, our current payment system is based on FFS. This system has been around for 50 years, and it is not going away. Simply adding on value-based models like ACOs or bundled payments and claiming success does not mean we're closer to value.

As Congress and HHS continue to review their value agenda, they need to look at health care as a whole and develop system-wide policy solutions. They also need to recognize that the rules that existed under FFS—not sharing data and disincentivizing patient accountability to start—have to be fundamentally revamped or else the transition to value will not succeed. By creating policies that align the interests of patients, providers, and payers, Congress and HHS will make much greater strides to achieving their goal of creating a truly value-based healthcare system.

We developed a value agenda at AMGA that supports our members’ transition to value-based payment in MACRA and in the commercial setting. We’re happy to share our platform with any AMGA member. Please send me a note at [cspeed@amga.org](mailto:cspeed@amga.org).

## References

1. C. White, J.L. Liu, M. Zaydman, et al. 2016. *The RAND Health Care Payment and Delivery Simulation Model*. Rand Corporation. Accessed May 5, 2017 at [rand.org/content/dam/rand/pubs/research\\_reports/RR1400/RR1428/RAND\\_RR1428.pdf](http://rand.org/content/dam/rand/pubs/research_reports/RR1400/RR1428/RAND_RR1428.pdf).

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