

# Ensuring the Values in Value-Based Payments

By JAMES CORBETT, MDiv, JD

In “Something about Doctors,” a segment in *The Autobiography of Mark Twain*, Twain wrote: “Consider the wisdom and righteousness of that old time custom — the paying of the physician by the year. Consider what a safeguard it was, for both the physician’s livelihood and self-respect, and the family’s health. The physician had a regular and assured income, and that was an advantage to him; the family were safe from his invasions when nothing was the matter, and goodness knows that was an advantage to the family.”

More than a century after Twain wrote his comments, what we now label “fee-for-service” has, as Twain lamented, continued as the dominant payment model in health care. However, the march toward value-based payment has started to change the system, and far more dramatic changes are on the horizon.

The Affordable Care Act and payment reform are transforming the system back to Twain’s “old time custom” of paying the physician based on a budget. The shift has opened up vast potential for the health system to move toward a preventive ethos while at the same time establishing a new area of ethical scrutiny that impacts patient care.

Value-based payment creates new ethical challenges and requires new skill sets of ethicists and mission leaders to ensure we preserve our values as we move toward value-based payment models.

## NEW INCENTIVES AND CHALLENGES

Value-based payment models are those that align payment with health outcomes and encourage economic efficiency. These models differ from fee-for-service, in which payment is substantially based on the volume of services provided.

A range of value-based payment models have facilitated a shift from pure fee-for-service. The models exist on a continuum that allocates varying levels of risk to providers. For example, shared savings programs stand on a fee-for-service plat-

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form but allow the provider to obtain a bonus if cost and quality targets are met. Depending on the arrangement, the providers may be penalized if they fail to meet cost or quality targets.

The proliferation of Accountable Care Organizations demonstrates the substantial pivot toward value-based payment models. ACOs are a group of health care providers that agree to be responsible for the financial and quality outcomes for a defined population. According to the Leavitt Partners consultancy, the number of ACOs nationwide rose from 64 in the first quarter of 2012 to 744 in the first quarter of 2015. The ACO model



incentivizes collaborative care and transparency — operational strategies that stem from a more comprehensive approach to managing health costs of entire populations, regardless of where care is received. The ACO model also requires a higher level of cooperation among providers and a deeper insight into care administration, characteristics that align well with value-based models.

The Medicare and Medicaid programs are aggressively shifting toward value-based payment. For example, in 2015, CMS announced that approximately 8.9 million beneficiaries were receiving their care through ACOs.<sup>1</sup> Medicare ACO reimbursement models

are, in part, contingent upon meeting quality and budget goals. In pursuit of these goals, ACOs foster teamwork among clinicians, emphasize timely preventive services and focus on patients' transitions between clinical care settings and home.<sup>2</sup>

States are moving aggressively toward managed care through their Medicaid programs, as well. According to the Kaiser Family Foundation, there are 281 Medicaid managed care organizations in the United States, in 38 states and the District of Columbia. Providers have formed ACOs to accommodate this shift.<sup>3</sup>

Some large health systems, such as Michigan-based Trinity Health and Boston-based Partners Health Care, have committed to putting 75 percent of their business over the next five years into value-based payment arrangements.<sup>4</sup> These shifts signify a strong commitment to rethink and re-tool how health care systems deliver and manage services, for physicians and patients alike.

The overall cost of health care, including Medicare's long-term financial uncertainty and Medicaid's imposition on state budgets, puts much at stake. The trend toward value-based payment models will march ahead as Medicare and Medicaid put their massive buying power behind the shift toward such reimbursement models. Private payers also will continue to strengthen the effort. The collaborative team-based approach will help ensure more coordinated, effective health care, but it is necessary to ensure that the values of the organization — not the myopic interests of financial gain alone — help shape decision-making.

#### BROADENING THE SCOPE OF ETHICS

Since the mid-19th century, physicians primarily have used the biomedical model of medicine in diagnosing diseases.<sup>5</sup> During the “antibiotic revolution,” health care providers were able to bring under control a majority of the infectious diseases that previously had been endemic to large parts of the world.<sup>6</sup> The ability to target and treat disease

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led to what has been termed a shift from caring to curing.<sup>7</sup> Philosopher-historian Michel Foucault termed this phenomenon the “double system of observation,” whereby the treatment of an individual provides opportunity for understanding the disease itself, which emphasizes the focus on treatment rather than prevention or health promotion.<sup>8</sup>

As the development of bioethics moved from academic institutions into hospitals, there was great debate among academic philosophy departments, where most ethics programs were located at the time, and medical settings.<sup>9</sup>

While the problem-solving methodology for the day-to-day challenges of modern science was embraced by many bioethicists, the claim that ethical theory had a direct problem-solving capability was widely rejected within academic philosophy.<sup>10</sup> Yet the financial resources available to medical centers allowed them the leverage to establish bioethics programs, institutes and centers within medical centers and to establish journals that were underwritten in their facilities.<sup>11</sup>

The move to medical institutions also meant that ethics embraced the biomedical paradigm. The transition to value-based payment in hospital settings re-orientes the ethical framework for medical conduct. Therefore, decisions on how to enter the value-based payment arena are replete with ethical consequences impacting patient care. Yet these decisions are being made in the board rooms of senior management and far away from the purview of ethicists. In addition to the tradi-

tional and meaningful work that occurs in ethics committees, ethicists will need to more effectively influence C-suite decisions in the value-based arena.

The move toward value-based payments holds much promise and potential to transform the system, improve care and reduce costs, but it also holds potential peril. Ethical scrutiny around financial incentives is especially important as medicine becomes increasingly specialized. A recent study published in the *Journal of Health Economics*, analyzing how physician financial incentives affect surgery rates, indicated that financial incentives do, in fact, significantly influence patient surgery frequencies.<sup>12</sup> More specifically, the study indicated a 78 percent increase in surgery rates if a specialist is compensated via fee-for-service as opposed to capitation. Similarly, in an outpatient setting, fee-for-service increased surgery rates by 84 percent.<sup>13</sup>

Although the move to value-based payments will help prevent unnecessary utilization, there is a potential to swing toward underuse of vital testing and procedures. To be sure, quality metrics are in place in value-based contracts to ensure that

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cost alone doesn't drive care. However, more rigor is necessary to ensure that the protections put in place by the quality metrics sufficiently incentivize appropriate care and that those same metrics are the most important to health outcomes — not financial gain.

Elective testing and procedures such as colonoscopies or orthopedic surgeries can be articulated to patients in a way — deliberately or subliminally — that aligns with different payment models and financial incentives. A typical consumer may not know what types of underlying incentives drive the care they receive. Is there a financial incentive for more testing or medical procedures? Is there a budget-based incentive to skimp on services or procedures?

A consumer unaware of what motivations are driving the business of the health system is ill-

equipped to serve as a check against misaligned incentives. In an ethical health system, patients and providers would discuss care options and make shared decisions: the patient's preferences and values would be incorporated with the care provider's expertise and knowledge of the risks and benefits of each treatment option.

A related consequence of misaligned incentives is improvised decision-making, which can lead to makeshift practices, commonly known as “workarounds.” In clinical settings, “workarounds” occur when clinicians stray from standardized and routine practices designed to protect patients. Workarounds are difficult for health care professionals to discuss openly because they often involve departures from official rules, and their effects are frequently unclear, including the benefits and risks to patients. Health care professionals typically devise workarounds to compensate for misaligned financial incentives, which is not the best approach for the patient or the provider.<sup>14</sup>

### **FINANCIAL INCENTIVES**

While misaligned financial incentives are not new to health care, the proliferation of value-based payment will bring such incentives to light more clearly as health systems engage patients in different payment models. Patients will need to be more aware of fee-for-service plans. This incentivizes procedures, or value-based contracts, which are budget-based and inspire preventive efforts and the tendency to decrease health care utilization.

Dealing in both the fee-for-service payment model and the value-based payment model is an ethical and operational challenge. Treating patients differently based on the payment model, regrettably, is not new to health care; however, the increasing number of value-based contracts and associated care models will highlight a stark relationship between incentives and treatment. Health care providers and social workers will need support as they encounter the moral distress that treating patients differently will inevitably create. The function of ethicists and mission leaders can be crucial in this space, but only if there is a full understanding of the fast-changing nature of modern health care finance, delivery and operations.



**WORKFORCE AND INCENTIVES CHANGE**

In 2014, the turnover rate of hospital and health system CEOs was 18 percent, among the highest rates reported in the last 15 years, according to the American College of Healthcare Executives. There are many reasons for the high turnover, including industry consolidation, aging baby boomers moving into retirement, reorganization and centralization within multiple health systems and the push to get physicians in senior executive positions.<sup>15</sup> Yet it is the movement toward value-

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based payment that demands a new skill set for hospital CEOs. They may have spent their entire careers working with doctors and others to ensure appropriate volume in their entities under a model dominated by fee-for-service — now they need to be equipped to meet objectives on the value-payment population.

Additionally, health care professionals need to separate and manage the proliferation of value-based contracts and operations in a well-timed and methodical manner that does not embrace the value-based movement before the organization is ready to execute it, nor so late that competitors secure an advantage in the value-based space. High CEO turnover presents both an opportunity and challenge: as new health care leaders arrive on the job, mission leaders will need to be equipped to serve as their partners in the new surroundings. But will they be ready?

Several years ago, at a Catholic Health Association forum, a handful of hospital CEOs talked about each of the roles represented on their senior teams. Asked about the value of the mission leader role, the CEOs asked if the question meant political value.

This highlights a perception of the mission role that is a challenge to the profession: Does hospital leadership view mission leader as a role with political importance as it relates to sponsors and

dioceses alone? The very premise should be troubling to mission leaders and a cause for critical analysis. Are hiring decisions for the role of mission leader being made based on skill sets or on political value?

Perhaps it can be both. However, if political intent, rather than decision-making, is the guiding force behind the concept of the mission leader's role, more than likely candidates who are better qualified to serve in the value-based arena are being passed over.

To be sure, the role of mission leader has crucial importance beyond the value-based initiative. With the rise of value-based care, however, mission leaders will need to continuously broaden their knowledge base surrounding ethics of health care operations and finance in order to continue to assert their voice and advocate for health in an impactful way.

Mission leaders have been central to advocacy for health reform, particularly universal health care and the push toward a more preventive focus. Now that the ACA is in place, the same energy that was used to ensure its passage needs to be spent ensuring an ethical and value-driven approach to leveraging the structural solutions that the full promise of the ACA embodies.

As ACOs and other payment structures in the value-based space are given more flexibility in organizing care permitted by the most recent iteration of ACO practices, mission leaders will need to understand and address a myriad of potential ethical challenges. This includes the cherry picking of healthy patients for value-based care and the lemon dropping of unhealthy patients who may have a higher price tag under the budget-based care that exemplifies the value-based model.

Approximately 20 percent of today's health care workforce are millennials, born between 1980 and 1999, which means employers need to examine their approach to managing, leading, hiring, retaining and training the new talent pool.<sup>16</sup> Nowhere is this more important than in the role of the mission leader, which historically has a higher median age than the rest of the health care workforce. To effectively integrate millennials within health care systems and foster their success as future leaders, senior management must understand what makes this generation tick and estab-

## **Demand for more transparent, value-based, patient-centered care requires a refocusing of ethics and rethinking of skill sets of mission leaders.**

lish value alignment without being judgmental or paternalistic.

Among the many traits characterizing millennials and distinguishing them from the previous generation is their drive to do meaningful work and their willingness to sacrifice monetary value in the place of intrinsic value. This generational drive for value has great potential to shift the current health care delivery paradigm.

Globally minded millennials also are driven by a desire to make a meaningful difference in the world and to be part of something greater than themselves — a value set closely aligned with the role of the mission leader. However, they eschew the hierarchy that, unfortunately, is still dominant in health care. This represents a challenge for mission leaders to undergo critical self-analysis on the hierarchical nature of their thinking and how it has been shaped by their profession and relation to the church.

In the same vein, mission leaders might begin considering whether the turnover at the CEO level requires some of this generation of mission leaders to self-select out so that a new generation can help to groom the future generation of leaders. This era of health reform and the demand for more transparent, value-based, patient-centered care, requires a refocusing of ethics and rethinking of skill sets of mission leaders.

### **IN SUMMARY**

In their classic textbook, *Principles of Bioethics*, Tom Beauchamp and James Childress articulate the four basic principles: *autonomy, beneficence, non-maleficence, and justice*.<sup>17</sup> Although these principles remain critical guideposts, they alone will not allow us to account for the value-based ethical challenges ahead. A nuanced understanding of health finance will be crucial for ethicists

and mission leaders to support health systems in existing and emerging areas of ethical inquiry that impact health care delivery across multiple sectors and populations.

Value-based payment has the potential to result in more collaborative and less wasteful care and more of a preventive ethos. On the other hand, value-based reimbursement settings will not change conflict between payers and providers; rather they will change the conversation. There is an intentional move toward transparency, but actual transparency has yet to permeate the consumer market. Ensuring transparency in financial incentives will go a long way to ensuring that patient autonomy is respected and is driving decision-making.

As alternative payment systems continue to exist that encourage both higher quality and lower costs and offer providers greater responsibility for the factors driving health care costs, the moral distress of health professionals who are making decisions based on cost and quality will continue to rise.

The ethical complexities of value-based payments inherently present challenges. Price variation, transparency and physician incentives — particularly surrounding elective surgeries and procedures — provide new territory for ethicists and mission leaders. To effectively take on the new challenges ahead, it will be imperative for leaders to adapt and grow as the march toward value in health care reshapes the interaction between health care providers and patients.

**JAMES CORBETT** is senior vice president, community health and values integration, Centura Health, Englewood, Colorado.

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### **NOTES**

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