Are We Really Moving to Value?

Or, are we just paying for health care differently?

BY LARRY SOBAL, MBA, MHA, CMPE

Discussions surrounding shifting reimbursement models from fee-for-service (FFS) to value-based care have been ongoing for decades. Hospitals, physicians, politicians, and others have long recognized the need to align payment methods to patient interests and recognize that paying for health care simply by the number of services provided has neither improved care nor reduced costs to anyone's satisfaction. For the past 40 years, United States' spending on health care has been growing substantially faster than the economy, and it is estimated to reach nearly $5 trillion, or 20% of the gross domestic product, by 2021.[1]

With the advent of accountable care to reduce costs and improve quality, the health care delivery system in the United States is described as undergoing a fundamental shift from volume to value. The passage of the Affordable Care Act (ACA), along with various cost-controlling measures, continues to challenge health care providers to better manage and treat patients at a lower cost. One by-product of the ACA has been the recent activity by the Centers for Medicare and Medicaid Services (CMS), which includes a series of initiatives to achieve their stated goal of tying 30% of traditional, or FFS, Medicare payments to quality or value through alternative payment models (APMs), such as Accountable Care Organizations (ACOs) or bundled payment arrangements, by the end of 2016, and tying 50% of payments to these models by the end of 2018 (Figure 1).[2]

And now more change is potentially on the way with the Republican-backed Better Care Reconciliation Act (BCRA).[3] At the time of this writing it is unclear if this legislation will eventually be passed in its current state, or modified significantly, or fail to be voted on in the Senate. Therefore, it is impossible to say how the BCRA might have an impact on the trajectory toward moving reimbursements from FFS to value.

In this period of extreme uncertainty, the degree of value-centric thinking and reengineering the delivery of care varies widely; for every program trying to focus on tighter attainment of clinical standards or improved patient experience, or lowering costs, there are just as many (if not more) focused on volume growth.

This begs the question: is there going to be a significant movement toward value or is the United States just beginning to pay for health care differently?

DEFINING VALUE

To make the argument that we are moving to greater value in health care, we first must accept that the meaning of "value," at least as it pertains to health care, is ambiguous. There is no clear definition of what constitutes value among providers, let alone purchasers, nor is there a clear consensus around what represents a value outcome for a patient.

Michael Porter, a distinguished Harvard professor and author, attempted to define value in his 2010 *New England Journal of Medicine* article[4] as "health outcomes achieved per dollar spent." Dartmouth defines value as "quality over cost over time."[5] The Agency for Health

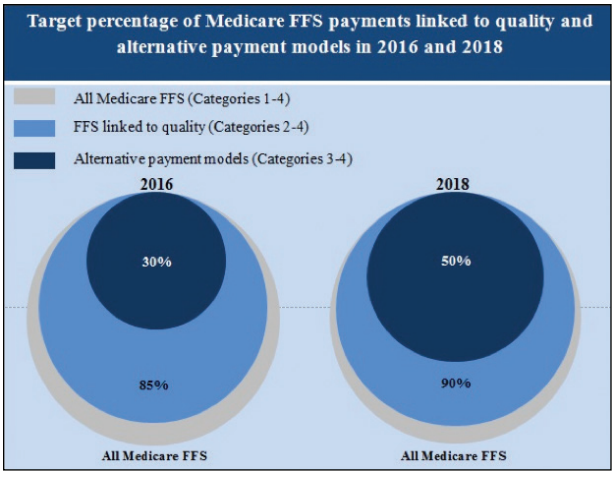

Figure 1. Changes in Medicare FFS payments from 2016 to 2018.

Care Policy and Research[6] speaks of bringing together information on the quality of health care, including patient outcomes and health status with data on the dollar outlays going toward health, and focusing on managing the use of the health care system to reduce inappropriate care and to identify and reward the best-performing providers.

My personal definition is "care is of high value if it enhances outcomes, safety, and patient satisfaction at a reasonable cost." Keeping in mind the differences in value definitions, is there evidence that we are seeing greater value in health care?

Unfortunately, demonstrating evidence-based, high-value health care remains one of the foremost challenges in health care today. Despite increasing scrutiny of the real-world effectiveness, safety, and costs of medical care, we have not conclusively deepened our understanding of high-quality and high-value care, nor can we quantify it. The reality is that avoiding over-treatment and overdiagnosis is often easier said than done, and the hundreds of health care performance metrics being collected and reported on today do not point toward a clear and consistent record of continuous improvement, at least not across the United States health industry.

United States population health measures, such as life expectancy and preterm birth, lag behind those of almost every other developed nation.[7] Patients are still harmed by medical errors. Recent assessments indicate that, 10 years after the Institute of Medicine report "To Err Is Human" estimated that medical errors cause up to 98,000 deaths in hospitals each year,[8] roughly 15% of hospital patients are still being harmed during their stays.[9] Poor care coordination places further strain on patients and the system, with about 20% of discharged elderly patients returning to the hospital within 30 days.[10]

Are there pockets of increasing value? Yes. But the overwhelming evidence is that our health care system is not innovating or improving enough on a widespread basis to say that we are moving to better health care value.

REACHING THE VALUE TIPPING POINT?

Payers have been touting that the volume-to-value movement is imminent for some time now. In a recent *Forbes* article,[11] the following data were shared:

- UnitedHealth Group spends $52 billion of its $115 billion "in total medical spend" through value-based care
- Over 45% of Aetna's medical spend is currently running through some form of a value-based care model
- Anthem, which operates Blue Cross & Blue Shield plans in 14 states, says it has 43% of payments tied to shared savings programs

As stated, in 2015 CMS announced a goal of tying 50% of all Medicare reimbursements to quality or value through APMs by the end of 2018.[12] Those CMS APMs include ACOs, the Medicare shared savings program (MSSP), the next-generation ACO model and the comprehensive end-stage renal disease care model (CEC), and the comprehensive primary care plus (CPC+) model. The MSSP added 99 new participants in 2017, bringing its total to 480 participants. The next-generation ACO model more than doubled in 2017 (28 new participants) bringing the total number to 45. In total, CMS reports[13] there are:

- More than 359,000 clinicians participating in the four APMs
- More than 12.3 million Medicare and/or Medicaid beneficiaries served
- 572 ACOs across the MSSP, next-generation ACO, and CEC models
- 131 ACOs in a risk-bearing track, including in the MSSP, next-generation ACO, and CEC models
- 2,893 primary care practices participating in the CPC+ program

It seems we are at least nearing a tipping point, where volume is truly being dethroned as organizations move down a continuum toward value-based reimbursement.

Many heart programs and health systems continue to express a curious apprehension about reimbursement moving away from FFS, but claim it has not become much of a reality. This is also reflected in a study published in Health Affairs,[14] which noted that 95% of all provider visits used FFS payment methods (in 2013). The article also shared that the percentage of payments in capitated reimbursement arrangements decreased from 6.6% in 2007 to 5.3% in 2013.

Understanding that value-based payments may have surged dramatically since 2013, many of the physicians profess little awareness that their respective markets have implemented what might be considered "value"-based reimbursement.

A key factor in this is that many payers, including Medicare, are still predominantly based on a FFS reimbursement model with contractual incentives layered on top. Plus, despite many statements to the contrary, there is not a strong consensus on when the payer market will become more aggressive in introducing payments that are significantly different from volume-based models. Despite the payer rhetoric and some truly alternative reimbursement models, the reality is that most health care is still volume-centric.

If there is disagreement on what value is, and the majority of payment mechanisms are still using FFS as their foundation, how is a shift measured? And, when do programs know when they should begin to move toward a value strategy?

THE CURRENT REALITY

There are four things to pay attention to. First, whether you are an independent physician who is in an ACO or an employed physician whose health system is in one of the Medicare APMs, the odds are you are still being paid on some derivative of FFS, with a high likelihood that work relative value units still drive most (if not all) of your individual compensation; this is because many organizations have not yet determined how to successfully align physician compensation with organizational reimbursement.

Second, despite their claims of having nearly 50% of their reimbursements in value-based models, commercial payers have been slow to move beyond FFS and are currently more prone to offer upside-only bonus incentive models versus more aggressive models, such as bundled payments or full or partial capitation that expose providers to real risk.[15]

Third, the variety of APMs themselves are not thus far delivering financial rewards.[16] Some providers are investing in value-based care delivery models, but the large payoffs on any significant scale haven't come yet. Achieving real value under value-based models remains elusive for many who struggle to manage chronic patient populations and transitions into, and from, postacute environments. New technologies to improve care and patient access, such as telemedicine, cost money. Providers are also buying primary care and specialty medical groups, and refocusing their processes and protocols to create narrow networks that serve defined populations. These are huge expenses that will continue to drain health system resources.

Fourth, a recent survey[17] found that > 70% of physicians prefer a fee-for-service model, even though they recognize that it is more expensive. Physicians are not yet convinced value-based reimbursement models improve clinical outcomes.

Reimbursement shifts are taking longer than expected and the initial investment in value-based infrastructure, combined with a reduction in revenues from removing unnecessary procedures and images, are having a detrimental impact on profits. With that in mind, it's possible that value-based reimbursement models are not yet proving to be an attractive replacement for FFS, at least when it comes to the bottom line. If that's the case, it's easy to see why some organizations may not be shifting quickly away from their historical FFS environment.

SUMMARY

Health care is moving in small ways in both directions, toward value and just paying differently. What does this mean? It becomes imperative that heart programs reach their own consensus on the definition of value, where the market is heading, what position their heart program wants/needs to be in that market, and the most critical goals and strategies needed to fulfill the definition of a high-value performer. Focusing on these will work to move one farther along on the volume-to-value continuum. ■

1. Robert Wood Johnson Foundation. What is driving U.S. health care spending? http://www.rwjf.org/en/library/research/2012/09/what-is-driving-u-s--health-care-spending.html. Accessed April 1, 2017.
2. Better care. Smarter spending. Healthier people: improving quality and paying for what works. https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-03-03-2.html. Accessed June 19, 2017.
3. American Health Care Act of 2017, HR 1628, 115th Congress. https://www.congress.gov/bill/115th-congress/house-bill/1628. Accessed June 19, 2017.
4. Porter ME. What is value in health care? N Engl J Med. 2010;363:2477-2481.
5. Dartmouth-Hitchcock. What is value-based care? http://www.dartmouth-hitchcock.org/about_dh/what_is_value_based_care.html. Accessed April 1, 2017.
6. Conrad DA. The theory of value-based payment incentives and their application to health care. Health Services Res. 2015;50:2057-2089.
7. Squires D, Anderson C. The Commonwealth Fund Publications. U.S. health care from a global perspective. 2015. http://www.commonwealthfund.org/publications/issue-briefs/2015/oct/us-health-care-from-a-global-perspective. Accessed April 1, 2017.
8. Institute of Medicine. To err is human: building a safer health system. National Academy Press. Washington, DC; 1999.
9. Landrigan CP, Parry GJ, Bones CB, et al. Temporal trends in rates of patient harm resulting from medical care. N Engl J Med. 2010;363:2124-2134.
10. Jencks SF, Williams MV, Coleman EA. Rehospitalizations among patients in the medicare fee for-service program. N Engl J Med. 2009;360:1418-1428.
11. Japsen B. UnitedHealth, Aetna, Anthem near 50% value-based care spending. Forbes. February 2, 2017. https://www.forbes.com/sites/brucejapsen/2017/02/02/unitedhealth-aetna-anthem-near-50-value-based-care-spending/#78f165331d4e. Accessed April 1, 2017.
12. Centers for Medicare & Medicaid Services. Better care. Smarter spending. Healthier people: paying providers for value, not volume, January 1, 2015. https://www.cms.gov/newsroom/mediareleasedatabase/fact-sheets/2015-fact-sheets-items/2015-01-26-3.html. Accessed April 1, 2017.
13. Centers for Medicare & Medicaid Services. New participants join several CMS alternative payment models. https://www.cms.gov/newsroom/mediareleasedatabase/press-releases/2017-press-releases-items/2017-01-18.html. Accessed April 1, 2017.
14. Zuvekas S, Cohen J. Fee-for-service, while much maligned, remains the dominant payment method for physician visits. Health Affairs. 2016;35:3411-3414.
15. Gruessner V. Payers slow to adopt value-based care payment arrangements. HealthPayer Intel. October 18, 2016. https://healthpayerintelligence.com/news/payers-slow-to-adopt-value-based-care-payment-arrangements. Accessed June 19, 2017.
16. Numerof R, Nash D. For truly affordable health care, we need to pay for outcomes, not services. STAT. March 29, 2017. https://www.statnews.com/2017/03/29/health-care-value-based. Accessed June 19, 2017.
17. Van Biesen T, Weisbrod, J, Brookshire M, et al. Front line of healthcare report 2017: why involving doctors can help improve US healthcare. Bain Report. May 11, 2017. http://www.bain.com/publications/articles/front-line-of-healthcare-report-2017.aspx. Accessed July 4, 2017.

Larry Sobal, MBA, MHA, CMPE
Executive Vice President
MedAxiom Consulting
Neptune Beach, Florida
Disclosures: None.