Council of State Governments West
Fee for Service versus Value-Based Healthcare
September 15, 2018
i. Current State of Healthcare
ii. Fee for Service/Value-Based Healthcare
iii. Impact on Cost
iv. Impact on Care
v. Medicaid/Medicare
vi. Considerations
Healthcare costs are “a tapeworm eating at our economic body.”

-Warren Buffet
National Health Expenditures as a Share of Gross Domestic Product, 1987-2016

The share of GDP devoted to health was 17.9% in 2016

Calendar Years

Percent of GDP

CURRENT STATE OF HEALTHCARE

MEDICAL AND OVERALL INFLATION

Cumulative percent change since January 2000

Consumer Price Index: Medical care

Consumer Price Index: All items

SOURCE: Bureau of Labor Statistics via FRED

In 2017, respondents also rated affordability as most important aspect of healthcare (36%), followed by being seen by doctor in a timely manner (28%).

### Most Important Characteristics in Healthcare System (%)

**Five Most Common Responses**
- Being able to pay for the care I need: 35%
- Being seen by my doctor in a timely manner, not having long waits: 28%
- Doctors/providers having sufficient time to treat their patients: 20%
- Having access to specialists: 19%
- Focus on preventative care: 19%

Source: General Population Survey (2018), Transamerica Center for Health Studies

[www.transamericacenterforhealthstudies.org/](http://www.transamericacenterforhealthstudies.org/)
• Most medical treatment services are paid/reimbursed as a fee-for-service
• Every consultation visit, doctor appointment, surgical procedure, etc. is treated as a separate payment event
• Rate Card determines payment
• Has served medical specialties well
• Rewards physician industriousness/efforts
  • Provider only paid when patient receives service
• Wide network of providers
  • FFS familiar to patients and providers

FEE FOR SERVICE HEALTHCARE - DISADVANTAGES

• Lack of direct rewards for key primary care functions.
• Providers receive inadequate incentives for extra access and important, high-value services.
• Lack of provider incentives for high-value or to redesign practices to better serve patient needs.
  • High-quality services and appropriate care often cost provider more than compensated for.
• Lack of price transparency.


“It would be unwise for physicians to believe that the health care system would reverse its move away from fee for service...these systems are here to stay.”

-AMA
• Provides financial incentives to coordinate care and improve patient health
  • Focus on prevention and disease management programs
  • More sharing of data/information

• “Results in avoiding unnecessary use of high-cost healthcare services and improved health outcomes” (Avalare Report, 2018)
  • Reduces hospital stays

• Providers evaluated on quality performance
# Value-Based Healthcare – Payment Models

## Pay-for-Coordination

Coordinating between multiple providers and specialists, a primary care physician manages a unified care plan for patients and ensures efficiency and quality of care; e.g. Patient-centered Medical Homes (PCMH) model.

## Pay-for-Performance (P4P)

Physician reimbursements are directly related to achieving performance measures, an incentive to meet quality and efficiency benchmarks; e.g. Hospital Readmission Reduction (HRR) program and Skilled Nursing Facility Value-based Program (SNFVBP).

## Bundled Payment or Episode-of-Care Payment

Reimbursing healthcare providers with a set amount of money for a specific episode of care (i.e. a hip replacement and any potential complications), encourages quality and efficiency. Providers keeping any realized net savings. E.g. Bundled Payments for Care Improvement—Advanced (BPCI—Advanced) model and Comprehensive Care for Joint Replacement (CJR) model.

## Shared Savings Programs (Upside & Downside)

Coordinated team care through physician entity groups and managing population health achieve quality and efficiency, and providers retain any realized net savings; e.g. Accountable Care Organizations (ACOs).

VALUE-BASED HEALTHCARE - PUBLIC POLICY SHIFT

LEGISLATION
- ACA: Affordable Care Act
- MIPPA: Medicare Improvements for Patients & Providers Act
- PAMA: Protecting Access to Medicare Act

PROGRAM
- APMs: Alternative Payment Models
- ESRD-QIP: End-Stage Renal Disease Quality Incentive Program
- HACRP: Hospital-Acquired Condition Reduction Program
- HRRP: Hospital Readmissions Reduction Program
- HVBV: Hospital Value-Based Purchasing Program
- MIPS: Merit-Based Incentive Payment System
- VM: Value Modifier or Physician Value-Based Modifier (PVBM)
- SNFVBP: Skilled Nursing Facility Value-Based Purchasing Program

Source: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs.html
Accessed 17 August 2018
VALUE-BASED HEALTHCARE - BARRIERS

• Misaligned financial incentives
• Time pressure
• Imprecise measurements
• Lack of education
• Healthcare system fragmentation
• Local culture
• Fear of malpractice/diagnostic uncertainty
• Patient expectations of high-tech care/tests

• Physician practices may need significant investments in data and reporting tech
• Rationing care
• Stifling innovation in technology and pharmaceuticals
• Administrative burdens

VALUE-BASED HEALTHCARE

The Journey Towards
ALTERNATIVE HEALTHCARE
PAYMENT MODELS:
- A Progress Report

45% of organizations represented participate in some type of alternative payment model.

Those serving an exclusively urban market are more likely to participate in an alternate payment model than those exclusively serving a rural market.

48% urban market

69% serving both urban and rural markets

31% rural market

Only 3% believe their organization is highly prepared to make the transition from fee-for-service to a value-based payment system.

The top three needs in transitioning to a value-based payment system:

1. Tools to track and evaluate quality of care
2. Better communication between disparate providers
3. Consistent definition of quality by specific type of disease

• 93% of physicians agree they have “at least some responsibility in controlling health costs, even if they may be unsure how best to proceed” (Journal of American Medicine, 2013)

• Yale attending physicians involved in a cost awareness exercise had “significantly lower cost of care ($1,027 vs $4,264) and higher diagnostic accuracy than others.” (Journal of Teaching & Learning in Medicine, 2014)

• “Health spending potentially controlled by providing consumer-directed healthcare plans giving financial incentives for consumers to become involved in purchasing decisions about their healthcare.” (Health Affairs)

Medicare
• In 2017, spending totaled $707 billion (15% of total federal budget), up from $434 billion in 2007. (CMS)
• 20% of national healthcare expenditures.

Medicaid
• Largest insurance program in the US, covering 1 in 5 Americans.
• $595 billion spent in 2017, up from $332 billion in 2007, 17% of national healthcare expenditures. (CMS)

Accessed 17 August 2018
Healthcare Costs for Beneficiaries in Medicare Advantage and FFS Medicare

Source: Medicare Advantage Achieves Cost-Effective Care and Better Outcomes for Beneficiaries with Chronic Conditions Relative to Fee-for-Service Medicare, AVALARE HEALTH (July 2018), available at https://www.bettermedicarealliance.org/sites/default/files/2018-07/BMA_Avalere_MA_vs_FFS_Medicare_Report_0.pdf.
Value-Based Medicare Advantage outperformed FFS on all clinical quality measures across 17 regions. (Integrated Healthcare Association, 2018)

Medicare Advantage demonstrated more value than FFS (Integrated Healthcare Association, 2018)

Source: Atlas 2 Introduction and Example Results, Integrated Healthcare Association (2018), available at:
“McAllen, Texas, the most expensive town in the most expensive country for healthcare in the world…”

- Town had lower than average rates of common healthcare outcomes but still spent $15,000 per Medicare enrollee in 2006, twice the national average.
- Many of its hospitals performed worse than average in 23/25 Medicare quality metrics.
- Doctors in McAllen explained high costs resulted from concerns over malpractice.
- Investigation verified “doctors were performing extra tests, services, and procedures and the associated bills were racking up charges.”
MEDICARE REIMBURSEMENTS

• “Avoiding unnecessary medical tests, procedures, and treatments is the easiest way to simultaneously improve quality of care, safety, and patient experience, and decrease costs.” (Berwick, 2008)

• Providers should be trained and take time to explain benefits and drawbacks of expensive testing.
  - Engage patients who request unnecessary tests like MRIs and CT scans
  - Promising results of reduced wasteful lab utilization seen in teaching hospitals by giving residents targeted feedback

• Promote use of equivalent generic medications and follow conservative prescribing practices.

• Scale-up prevention activities by non-physician providers.

• Promote transparent health care costs and quality information.
• Understand and study ROI of new medical technology.
• Expert Panels from RAND and *Scientific Evaluation and Review of Claims in Health Care (SEaRCH)* provide evidence-based recommendations using IOM and NIH research to guide healthcare decision making.
• Establish analytics to capture quality and financial outcomes.

Expert panel source: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4704387/
Image source: https://www.mckesson.com/blog/optimizing-healthcare-analytics/
• Disruptive new payment models will not work unless physicians are on board and actively providing input. (AMA)
  • “Severity of chronic illnesses, such as diabetes and asthma, can vary widely. Treating all patients the same is one way to make a new payment model fail.”

• Doctors need appropriate financial reward for helping to generate savings.

• Alternate Payment Methods support more accurate diagnoses, treatment planning, care coordination, and outreach to high-risk patients to ensure they get preventive services. (AMA)

• Healthcare costs often cause patients to postpone or refuse needed care so do what is needed to reduce cost, and include cost in modern clinician risk/benefit calculation.
