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INSIGHT: The Healthcare Industry's Shift from Fee-for-Service to Value-Based Reimbursement

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Historically, U.S. health care providers have been reimbursed on a fee-for-service ("FFS") basis. But the health care payment system has slowly evolved over the past few decades and at an accelerated pace since the passage of health care reform legislation in 2010. This legislation, the Affordable Care Act, which incorporated a number of initiatives promoting more value-based care, recognized that the traditional FFS model is inherently inefficient because providers are paid every time they provide a service, so the incentive is to provide more services.

The goal behind this legislation and other health care reform measures introduced by Congress, government agencies, and private providers, is to move toward value-based payment approaches in which providers are incentivized to provide high-quality service in the lowest cost setting. Although the shift to a new value-based system will not occur overnight, health care companies should be equipped to manage care under evolving payment models.

The current health care reimbursement system in the U.S. reflects challenges with the FFS model in light of rising industry costs, the shift to value-based care, and the new reimbursement models that healthcare companies are increasingly implementing under the value-based care framework.

The Current Healthcare Reimbursement System

The conventional payment model of the American healthcare system—the FFS model—has been in place for centuries. Under this model, primary health care professionals are paid per person, per visit with a separate fee charged for each service provided to the patient. As a result, each time a patient has a doctor's appointment, a hospital stay, or a surgical consultation, the patient or third-party payers (insurance companies and government agencies) are billed for each visit, procedure, test, treatment, or other health-care service provided. Providers are paid for seeing patients regardless of clinical outcome. Despite this system's historical longevity, there are signs that it is unsustainable in the current market environment.

Problems With the Current System

Critics have pointed to the FFS model as the culprit for ballooning health-care costs and for contributing to the decline in the primary-care workforce and it ability to meet patients' health maintenance needs. Criticisms of the FFS model focus on five primary categories of concern:

1. Increased Health Care Costs

While it is difficult to isolate the influence of the FFS model on the level and the rate of growth of health care spending, industry experts have identified the FFS business model as one of the reasons for the high spending levels and growth rates. According to the Kaiser Family Foundation, health care spending totaled $74.6 billion in 1970. In 2000, healthcare costs increased four-fold to $1.9 trillion, and by 2015, health care expenditures had increased to $3.2 trillion. As discussed below, the FFS system rewards quantity over quality, which encourages high-cost services and products. While insurers bear the brunt of these costs, healthcare consumers also share these costs in the form of increased premiums and deductibles.

2. Lack of Focus on Quality of Care

Critics of the FFS model frequently point to the failure

to focus on quality of performance as the key problem with the FFS model. While critics do not claim that health care providers intentionally underperform, they assert that the main focus of physicians is on what happens immediately, with little attention paid to the longer term clinical outcomes for the patient. Without the time, resources, or financial incentives to track patients after they leave their clinical doors, physicians have little incentive to focus on long-term outcomes. These gaps in care may dramatically reduce the overall quality of care for patients. The lack of focus on quality has been one of the primary areas of concern for the Centers for Medicare and Medicaid Services (''CMS''), which has advocated for pay for quality of care.

3. Focus on Service Volume

Under the FFS model, physicians and other providers are paid more if they provide more services. As a result, providers are incentivized to provide the highest number of health-care services and run more tests and perform more expensive procedures than may be necessary. Providers may believe that running more tests will increase their confidence in a diagnosis and decrease the likelihood of malpractice claims. But this, however, may increase costs and may not serve the shared goal of all constituencies: better patient outcomes.

4. Barrier to Shift to Low-Cost Setting

With the focus on quantity rather than quality of care in the FFS model, many physician practices have purchased medical technology equipment such as MRIs and other imaging equipment in an effort to increase profits. As a result, providers have an incentive to use their machine, even if a freestanding imaging center might be a lower cost option. In the end, the patient may end up receiving suboptimal care, paying a higher price, or both.

5. Little Focus on Preventive Care

The FFS model is based on treating people after they get sick, with few incentives to keep people healthy. This system does nothing to encourage low-cost, high-value services, such as preventive care or patient education—even if such services could significantly improve patients' health and lower health care costs. For example, many patients with poorly controlled diabetes or heart failure enter hospitals needing acute care when their conditions could have been managed with better preventive measures, which would eliminate the need for costly hospital stays.

Shift to Value-Based Model

In response to these concerns, there has been a shift away from fee for service toward fee for value. CMS has taken the lead in driving this movement. As the largest single payer for healthcare, CMS has made significant changes to the healthcare reimbursement landscape by tying Medicare and some commercial rates to quality, and has also set goals for continued movement to the value-based model.

However, CMS is not acting alone in the shift to value-based care. Congress and providers are also proponents of this shift. Congress' focus has been on controlling utilization and changing the way that money is spent in the system by attempting to save money through value-based arrangements (e.g., instead of cutting nursing home rates, assigning a penalty for readmissions to the hospital). Further, providers are increasingly embracing value-based care, focusing on being the highest quality providers possible, because new payment models require that they do so.

For example, pay-for-performance structures such as Medicare Accountable Care Organizations (''ACOs''), which allow providers to share in savings if they can reduce costs below a benchmark, often require that the provider achieve certain quality targets in addition to control costs if they want a bonus payment. Because a shift to value-based care is occurring, companies need to develop a strategy to adapt and should be well versed in the different types of value-based payment models.

Types of Value-Based Payment Models

There are many different value-based reimbursement models that can be implemented to link financial rewards with clinical performance and cost control. These models range from a FFS base with extra payments for providers who meet quality goals, to a shared-risk framework, to full capitation. The common thread is that the models incentivize providers to deliver not only top quality care, but also low-cost care. The primary new payment models include the following:

1. Pay-for-Performance Model

Under pay-for-performance types of arrangements, providers continue to be paid through the FFS model. However, in addition to the base rate, providers would be paid an additional amount for meeting certain quality benchmarks or would be penalized for not achieving certain thresholds. Under this model, the provider receives performance-based adjustments to its FFS rates in the form of bonuses for exceeding certain standards or clawbacks for falling short.

2. Bundled Payment/Episode-of-Care Model

With a bundled payments model, providers are reimbursed on a ''pay for episode of care'' basis. An episode is defined to include all necessary inpatient and outpatient services required to treat a specific injury or illness from the time of diagnosis through recovery. The single fixed fee covers the costs of the physicians and other clinicians, drugs, devices, facilities, and any other resources dedicated to the episode of care. This approach incentivizes providers to collaborate across the continuum of care to deliver high-quality, low-cost health care. There is no incentive to focus on preventive care because the payment begins at the time that the episode starts (after there is already a health care issue). However, there is a significant incentive to ensure that there are no gaps in care when a patient moves from one care setting to the next during recovery. The bundled payment rate is based on the average cost of an episode, so providers will profit by keeping spending below the bundled rate.

3. Accountable Care Organization Model

ACOs are physician-led groups (physician practices or integrated health systems) that collaborate to deliver quality care at a low cost. The goal of coordinated care is to ensure that patients receive appropriate and timely care, while avoiding unnecessary duplication of services. The financial incentives are similar to capitation (described below) in that providers are assigned a number of enrollees and there is a benchmark spending target for that pool of members. Unlike capitation, where providers are paid the full rate each month, ACOs are usually paid on a fee for service basis during a given time period. However, at the end of the period, actual spending is compared against the benchmark level of

spending and if there are savings, the providers share a percentage of the upside. ACOs can be structured as ''one-way risk'' models (where there is upside if costs are below the benchmark, but no penalties if costs are above the benchmark) or ''two-way risk'' models (where providers share in the upside if costs are below the benchmark and the downside if costs come in above the benchmark). Two-way risk models usually share a greater percentage of the upside with providers in return for providers taking risk to the downside.

4. Patient-Centered Medical Homes Model

In a patient-centered medical home, each individual has a personal primary care physician (''medical home''). The physician coordinates all aspects of patient care both inside and outside the clinic. The goal of this model is to provide higher quality and better care coordination, especially for those with chronic conditions, and to prevent hospital readmissions and emergency department visits. To cover the costs of infrastructure and staff for care coordination, providers often negotiate a FFS rate increase or a per-member-per-month payment in addition to standard FFS payments.

5. Capitation Model

Under the capitation model, providers are paid a set amount per each enrollee per month, regardless of the services that the enrollee needs. This population-based approach incentivizes a long-term commitment to (and associated investment in) patient health and wellness with a focus on preventative care and ensuring that when services are provided that they are provided in the lowest cost setting appropriate. If the provider can keep the costs below the capitated rate, then it makes money, while if costs go above the capitated rate, it loses money. Essentially, the managed care organization is fully assigning risk to the provider. Capitation can be ''Global'' or ''Full Capitation'' (covering all health care spending of the population) and ''Partial'' or ''Blended Capitation'' (only covering part of spending, such as physician services and laboratory services, but not hospital-based care, pharmacy, and mental health benefits). Regardless of the type of capitation, the provider is at full risk for the services that are covered. Often, the capitated amount will be risk adjusted to ensure that providers are not disincentivized to care for high risk patients.

When determining which value-based care program to implement, private and public healthcare payers should carefully consider the financial incentives of each payment model, the risk of fraud, abuse, or waste related to varying reimbursement structures, and the reliability of medical and claims data, as recommended by the Office of the Inspector General (''OIG'') (*see*). By following the OIG's tips for designing value-based care reimbursement programs, providers may boost their revenues while patients receive better quality of care.

Key Takeaways on the Shift From Volume to Value

In response to the need to reduce rising healthcare spending and to strive for better patient care, the healthcare industry is shifting toward value-based care models. This shift has put providers at the forefront of managing population health. Companies and nonprofits are embracing the movement toward value-based care at various speeds, but most are developing strategies for adapting to the new system. Managed care companies and CMS appear willing to steer payments in the direction of a value-based model by paying in part based on quality with incentives to control costs.

Major healthcare payers have already seen significant cost savings due to implementing value-based care reimbursement. For example, according to Humana's 2016 value-based care report, Humana's value-based care platform reduced total healthcare costs by 15% compared with traditional fee-for-service Medicare costs. Humana also reported a 26% percent higher Healthcare Effectiveness Data and Information Set (''HEDIS'') quality score in its value-based care program when compared to its fee-for-service payment system.

Similarly, according to UnitedHealthcare's 2018 value-based care report, UnitedHealthcare also decreased costs through its value-based care platform and has reported better outcomes on 87% of quality measures among its accountable care organizations when compared to non-ACOs. As these examples illustrate, key players in the healthcare industry are already significantly invested in the shift to new payment models and have experienced positive results as a result of the transition to value-based care.

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