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Behind the snail's pace adoption of value-based care

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The Buzz This Week

The concept of value-based care—delivering care in a way that optimizes outcomes while keeping costs low—was formalized in 2006 by Michael Porter and Elizabeth Olmstead Teisberg in their book *Redefining Healthcare*. The book posits that the U.S. healthcare system cannot be improved until providers are rewarded for and compete on value, as opposed to volume. Since then, value-based reimbursement models have been touted as the key to transforming healthcare. Various models have been launched by the Centers for Medicare and Medicaid Services (CMS) and commercial payers, and they span a wide spectrum of risk levels and maturity. Many rely on the historical fee-for-service reimbursement structure with a payment provided at the end of a specific timeframe, based on measured results (commonly referred to as a shared savings model, or upside-only model).

However, despite the attention these alternative payment models have received, market-wide adoption has been exceedingly slow. In a recent *NEJM Catalyst* survey of more than 1,000 clinicians, clinical leaders, and executives at care delivery organizations, over three-quarters of respondents said that payers and providers are either not very aligned or not aligned at all. Nearly half the respondents reported that less than 25% of their organization's revenue was from value-based reimbursement models. Still, respondents were positive about the potential benefits of these models. More than two-thirds reported that they expected their organization's value-based payment to increase "somewhat" or "greatly" in the next 2-3 years.

Brian Powers, Deputy Chief Medical Officer at Humana and Assistant Professor of Medicine at Tufts University School of Medicine, commented after analyzing the survey results, "...there's enough of a belief in the benefits of the approach that even those who don't feel like we have enough alignment today have acknowledged that we're heading in that direction. It's an interesting dynamic and suggests we're moving toward a tipping point, but that we need to improve alignment in order to reach that tipping point more quickly."

Why It Matters

If the general consensus is that value-based models would improve value in healthcare, then the shift should be encouraged from all directions. However, many hurdles remain, one of which is simply that fee-for-service reimbursement models are highly entrenched. Kenneth Soda, Chief Medical Officer for Dignity Health's Pacific Central Coast Health Centers, commented in a recent NEJM Catalyst piece that cited the aforementioned survey, "...comfort with fee-for-service models is so well entrenched that it is very difficult for health care businesses to consider something that might alter current revenue streams and operating margins.... Because of this, there's a lot of hesitancy about going to value-based payment, and we seem to be stuck in place. The question is, how do we get unstuck?"

To get the U.S. healthcare system "unstuck" and move more decisively toward value-based models of care delivery, several significant changes will need to take place:

- **Payers and providers** will need to be more aligned on how "value" is defined, what the cost and quality measures will be, and how they will be reported. Measuring outcomes is not straightforward in many specialties and has proved a tough hurdle to overcome in order to shift to value. On the cost side, "Most providers still do not understand their actual costs," as one U.S. healthcare leader stated in a recent NEJM Catalyst piece. "Until all sides of the equation are understood, and the means of allocating those costs can be developed, true value-based care will NEVER WORK. Until then, it is merely reallocated, reduced fee-for-service, and whittling around the margins and calling it value-based care."
- **Health systems and other provider entities** that employ providers need to align incentives and compensation models with value. Physicians cannot continue to be paid on volume. Instead, they should be compensated and rewarded for practicing high-value care.
- **Providers** will need to change how they deliver care. Without meaningful change, it will be difficult to produce improved outcomes at lower costs. Part of this, as Kenneth Soda explains, has to do with culture. "People have to be willing to do things differently and be flexible, and part of accomplishing this is creating a culture that supports change."
- **Providers** will need to be more open to accept upside and downside risk. While many upside models are present in the market, providers have been more reluctant to take on downside risk or take on more advanced models like bundled payments or capitation. This is likely because these models require truly managing target populations and medical spend, necessitating significant change in how care is provided and managed.
- **Patients** will need to demand higher-value care, basing healthcare provider selection on the value expected to be provided. This will require better transparency and a consistent source for how a provider performs in terms of "value." This gets back to agreeing on a definition—something that has posed a challenge in the past, particularly around quality measures.
- **Patients** will also need to be engaged and willing to participate in goal-oriented quality measures.

Improving the “value” of healthcare delivered in the U.S. is not the only potential outcome of more widespread adoption of value-based care models. There is also the potential to improve health equity, as the authors of a [*Health Affairs*](#) piece from January argue. They suggest that CMS introduce equity adjustments (e.g., financial benchmarks, infrastructure payments, and shared savings/loss percentages) for providers that serve disadvantaged populations, thereby encouraging those providers to deliver high-value care and help address the persistent health needs of the populations they serve. Finally, it was suggested that CMS examine its policies and design them with more pronounced intent to further the adoption of value-based models, influencing commercial payers (for example, by making CMS’s value-based payments more attractive than fee-for-service payments over time). “Although CMS action to influence non-Medicare markets is politically fraught, the alternative—disregarding the interplay between these different sectors—will lead VBP to continue falling short.”

One factor that appears to be accelerating the slow pace of adoption of value-based models is the impact that COVID-19 has had on providers. Many experienced serious financial damage at the height of the pandemic when patients did not seek care and/or providers were required to shut down certain services. A value-based/risk-based model (capitation in this case) would have smoothed a provider’s revenue stream. [Some believe](#) that this is truly accelerating the shift to value. But until the aforementioned hurdles are overcome, progress may continue at a slow pace.

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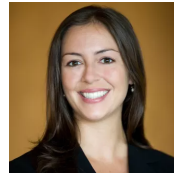
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