The Tale of Two Healthcare Systems

A look at fee-for-service healthcare
vs. value-based healthcare

worldcare

Executive summary

Healthcare costs are out of control. Prescription prices are the highest they've ever been and are still on the rise. Despite the rising costs, many would agree that the quality of care is severely lacking. Every day, people undergo unnecessary and costly testing; patients are receiving treatments and surgeries they do not need while others do not receive the care that they should. This has become the typical state of affairs in the American healthcare system today. What can be done in the face of such systemic issues? This is a complex and multi-faceted situation that has no simple answers and more and more seems to require a complete restructuring of the present healthcare model.

Indeed, to create an effective system that addresses the quality gaps in care, the driving force should concentrate on desired outcomes and employ programs that address these gaps. Through outcome-based incentives, the goal and focus of care can finally shift to the overall health and wellness of the patient. By and large, America currently operates on a fee-for-service basis. But what if we could have a system based on value, one that could curtail the insurmountable rise in the cost of healthcare and concurrently improve the quality of care? ealthcare today increasingly relies on technology to provide patients with access to quality services. Despite rapid technological advances, however, healthcare costs remain high. Unnecessary tests and inaccurate procedures drive prices upwards and prescriptions now cost more than they ever have. Many patients do not receive the quality of care that they need and deserve, while others receive care that they do not require. Incorrect surgeries and treatments occur with alarming frequency and all of these factors continue to drive healthcare costs skyward.

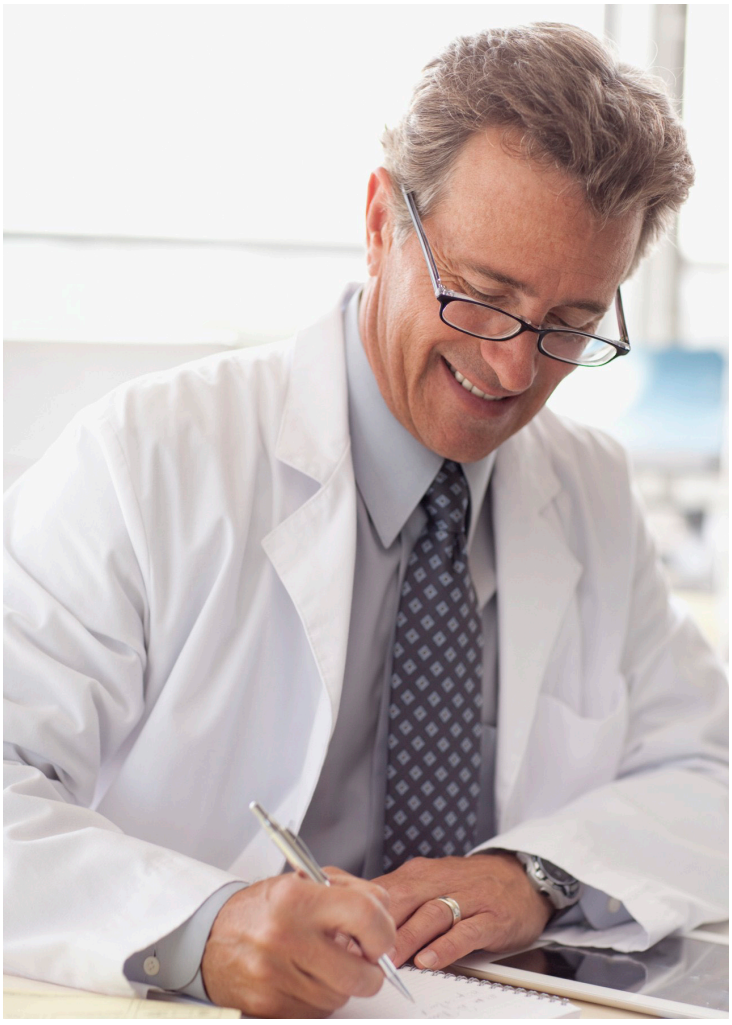
What is value-based healthcare?

Value-based healthcare is a system of healthcare based on the idea of paying more for care that benefits patients and less for care that does not.[1] It stresses a patient-centered system organized around patients' needs and achieving the best outcomes at the lowest cost.[2,3] Instead of the current prevailing U.S. system, which pays providers based on the number of visits and tests they order (fee-for-service), their payments would directly correlate to the value of care they deliver.[4]

To this end, improving value requires either improving outcomes without raising costs or lowering costs without compromising outcomes, or both.[2]

This form of healthcare would ideally involve a dedicated, multi-disciplinary team who takes responsibility for the totality of care for a condition, including outpatient, inpatient, rehabilitation and supportive services.[5] It has been suggested that value-based healthcare requires the complete restructuring of the current healthcare model and relies on a number of innovative components. These components are identified as:

1. Organizing into Integrated Practice Units or IPUs (multi-disciplinary teams);
2. Measuring outcomes and costs for every patient;
3. Transitioning to bundled payments;
4. Integrating care delivery across multiple facilities;
5. Geographically expanding services and;
6. Building an information technology platform suited to the demands of the new system.[2]



Shift in trend from quantity to quality

Value-based healthcare is on the rise in the U.S. Overall, 40 cents of every dollar spent on healthcare in 2014 was tied to value in some way compared to just 11 cents of every dollar the year before.[1]

Businesses are stepping into this newly-created space. Indeed, a new taskforce made up of providers, insurers and employers has committed to shift 75 percent of its members' business into contracts with incentives for health outcomes, quality and cost management by January 2020.[6]

Consulting companies are emerging to aid hospitals in the transition to value-based care.[1] Even Medicare is transitioning to a value-based system in an attempt to drive the current fee-for-service healthcare system to evolve.

Overall, the Department of Health and Human Services (HHS) seeks to have 85 percent of Medicare fee-for-service payments in value-based purchasing categories by 2016 and 90 percent by 2018.[7,8] When examined independently, shifts can be seen across several of the components listed above.

A physical, as well as electronic, restructuring of the healthcare system is underway. IPUs emerged initially in the care for particular medical conditions, such as breast cancer and joint replacement. Today, condition-based IPUs are proliferating rapidly across many areas of acute and chronic care.[2] Facing severe pressure to contain costs, payers are aggressively reducing reimbursements and finally moving away from fee-for-service and toward performance-based reimbursement. These pressures are leading more independent hospitals to join health systems and more physicians to move out of private practice and become salaried hospital employees.[2]

In 2011, 60 percent of all U.S. hospitals were part of such systems, up from 51 percent in 1999. Multi-site health organizations accounted for 69 percent of total admissions in 2011 and those proportions are even higher today.[2] Transitioning to a centralized electronic record system became imperative with this physical restructuring. The proportion of U.S. physicians using Electronic Health Records (EHRs) increased from 18 to 78 percent between 2001 and 2013 and 94 percent of hospitals now report use of certified EHRs.[8]

The bundled payment model is also becoming more pervasive. Indeed, Germany and Sweden implemented bundled payments back in 2009 and some U.S. employers have followed their lead.[2] Though organ transplant care, largely with bundled payments and IPUs, has mirrored value-based care for many years in the U.S., rising healthcare costs have necessitated that all players within the system, from insurers to providers to employers, reassess the fee-for-service model. In fact, sponsoring health insurance is the fastest increasing expenditure for many large companies today and employers resist absorbing these increases in healthcare costs.[9]

To promote amiable relationships with companies and remain competitive, payers are increasingly shying away from rate increases, which in turn translates to a shrinking profit margin for hospitals.[9] Coupled with healthcare reform, the burden of rising healthcare costs is shifting from payers to providers. Although their margin was about 2.2 percent in 2011, hospitals that continue to operate according to business as usual will have a -16.8 percent margin by 2021.[9,10]

Despite the many reasons and the growing trend for a value-based system, some resistance and questions remain. The key issue that emerges is identifying which specific payment strategies aimed at value are most effective.[3] Many question paying extra for new services like 'reward payments' for hospitals that excel, or for services they didn't pay for in the past, like care coordination services. The most common of the new value-based payment efforts make purchasers pay more for better care, but only a small minority of those initiatives penalizes providers for providing poor care.[1,3]

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Why the trend?

Many factors contribute to the increase in value-based care. Arguably, one such factor is the transition of individual components to models that encourage this form of care: namely IPUs, composed of multi-disciplinary teams who focus on specific conditions, IT improvements, such as more integrated electronic systems and bundled payments, where one rate applies to a particular condition regardless of the individual treatment and follow up services.[1,5]

The Affordable Care Act (ACA) has helped to further augment these improved components into the U.S. healthcare system. Payment strategies through the ACA are based on value.[3] These include, for example, Medicare payment reductions for hospitals with high readmission or infection rates. The ACA is also responsible for the proliferation of Accountable Care Organizations (ACOs), which are compensated based on the overall health of their patients.[1] Furthermore, through the Transforming Clinical Practice Initiative, HHS will invest up to $800 million in providing hands-on support to 150,000 physicians and other clinicians for developing the skills and tools needed to improve delivery and transition to alternative payment models.[8]

Beyond the trends of the value model components, out-of-control costs and current sub-standard quality of care are major driving factors. The percentage of the population in high-deductible health plans is now well into double digits and it is rising.[2] There are unwarranted price variations of tests and procedures and variable Medicare spending by region with negligible impact on value or quality of care.[11] Nearly 1 in 10 patients experience adverse events while hospitalized, and many people do not receive care that they should receive, while others receive care that does not benefit them.[8] U.S. demographics only exacerbate the problem. The rate of increase of Medicare and Medicaid expenditures due to an aging baby boomer population puts strain on the current state of affairs and demands a new sustainable system. Commercial payers decreased from 42 to 35 percent from 1990 to 2010, while Medicare increased from 35 to 39 percent and Medicaid from 10 to 16 percent in the same timeframe. In 2011, the average margin on Medicare patients was -5 percent.[4] Due to the many shortcomings of fee-for-service healthcare, employers and indeed the market are increasingly demanding value from private health insurers.[1]

Concluding summary

The right care at the right time in the right setting

Everyone benefits from a healthcare system that improves patient outcomes and decreases cost. The design of a value-based system, with IPUs integrating all aspects of care while EHR systems centralize all relevant medical information, could greatly reduce redundant and expensive tests. Moreover, transitioning away from a system where physicians and healthcare providers are paid per visit, scan, test, etc., de-incentivizes the 'kitchen sink' mentality of ordering every possible test related to a set of symptoms. Bundled payments also aid in discouraging unnecessary services as hospitals and physicians would need to absorb the extra costs associated with a particular illness.

The key driver of an effective value-based system is the ability to not only identify where there are financial and quality gaps in care, but also to systematically implement services that close those particular gaps. Integrated services like WorldCare ACCESS and WorldCare ONSITE focus clinical resources where they provide the most impact. These services target the most clinically-complex and expensive part of the population: the ~20 percent of patients who have catastrophic or chronic illnesses that drive about 80 percent of the cost.

Providing a second opinion using the same approach that care is delivered in a high-quality tertiary care setting ensures that the patient is diagnosed correctly and the most effective treatment plan is accessible for that patient.

WorldCare leverages top-ranked U.S. hospitals within the WorldCare Consortium® as the foundation behind their services. The WorldCare ONSIGHT case management service provides the ability to impact the level of care and to facilitate and coordinate care in the most appropriate setting, as well as the ability to negotiate costs for that care in a cost plus model. All of which ensures that patients are receiving the highest quality of care at the best price. Providing access to the clinically-rigorous multi-specialty, multi-institutional second opinions and coupling that with the clinical expertise of WorldCare's network of onsite case managers ensures that all mechanisms are in place to efficiently address the quality of care deficiencies including complications and readmissions that drive increased costs. This unique package improves patient outcomes and quality of care while reducing healthcare costs overall.

In a representative study of WorldCare's cases by The Center for HealthCare Informatics at Tennessee Tech University, 26 percent of second opinion reviews resulted in a change in diagnosis and 75 percent had a change in treatment. Notably, changes in treatment plans demonstrated healthcare cost savings from 10 percent to over 21 percent and cases that had a significant change in diagnosis and treatment could exceed a Return on Investment (ROI) of 6:1 or 600 percent for direct healthcare costs. Moreover, the study revealed that the WorldCare ACCESS service can reduce indirect costs (turnover, absenteeism and presenteeism) by nearly 18 percent, while providing an ROI of at least 123 percent for patients with any diagnostic or treatment change.

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