

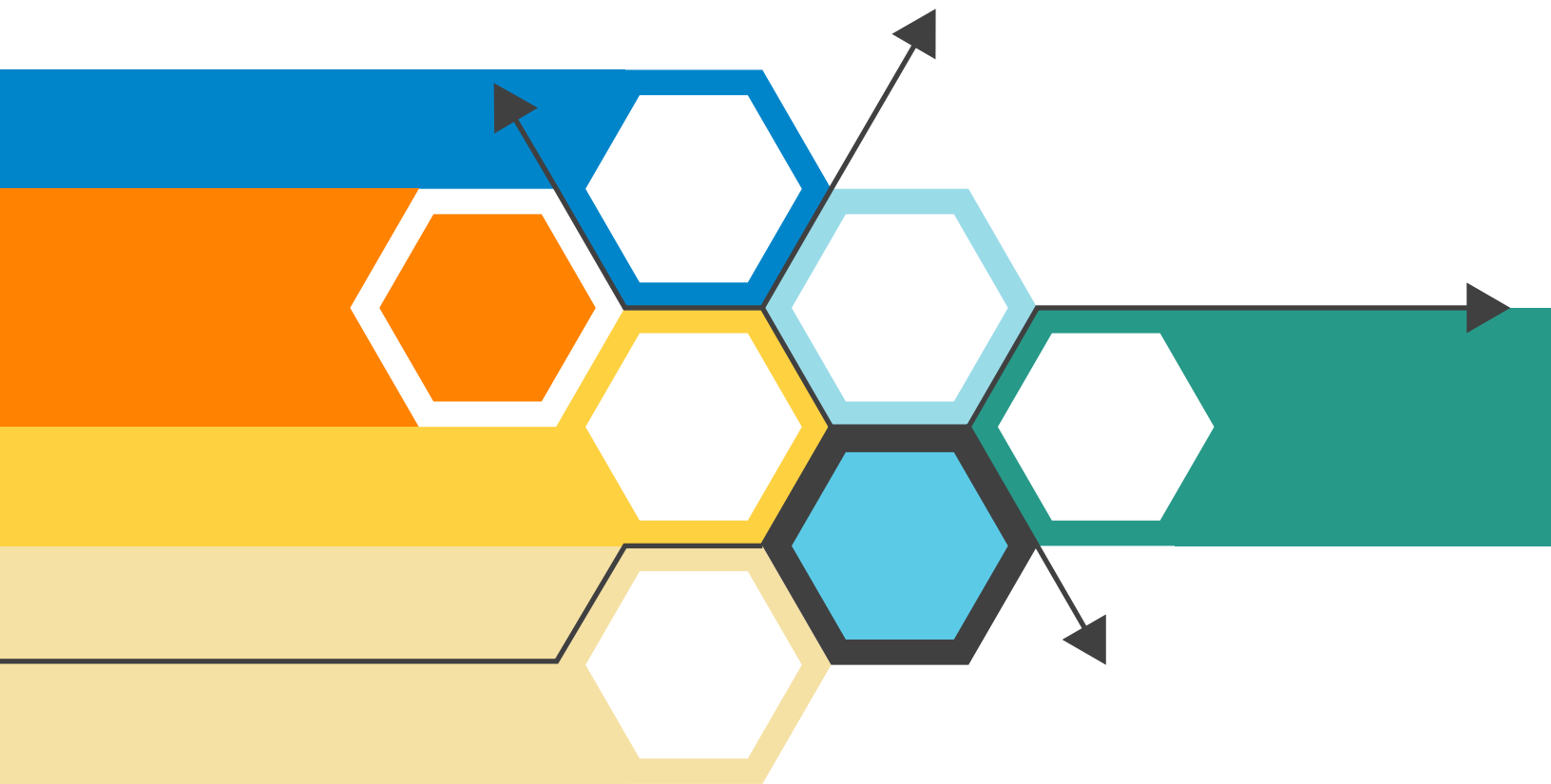
NEJM
Catalyst

New Marketplace Survey

Transitioning Payment Models: Fee-for-Service to Value-Based Care

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An independent NEJM Catalyst Insights Report sponsored by:



Transitioning Payment Models: Fee-for-Service to Value-Based Care



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Insights Report · November 2018

In a survey of the NEJM Catalyst Insights Council in July 2018, 42% of respondents say they think value-based reimbursement models will be the primary revenue model for U.S. health care. Indeed, this transition is already happening. Respondents report that a quarter of reimbursement at their organizations is based on value, on average. While three-quarters of their revenue remains fee-for-service, we see a remarkable change to a reimbursement system that was static for decades.

What percentage of your organization's revenue do you estimate comes from fee-for-service? From value-based reimbursement?



Base: 323 (Among those who did not answer "Don't know")
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In particular, survey respondents' organizations are pursuing two value-based strategies: accountable care organizations, which often use capitated payments; and bundled payments, which provide single payments for multiple services addressing a single condition.

Nearly half (46%) of respondents – who are clinical leaders, clinicians, and executives at U.S.-based organizations that deliver health care – say value-based contracts significantly improve the quality of care, and another 42% say value-based contracts significantly lower the cost of care. While this data suggests considerable support for value-based reimbursement, it is worth mentioning that a significant number

(36%) of respondents say they are uncertain that this will ever become the primary revenue model for U.S. health care, indicating that for many, the jury is still out.

This finding deserves some informed speculation. Some respondents may want to adhere to the fee-for-service system. Others may want to see more evidence that value-based reimbursement actually improves outcomes and controls costs. Others may be unfamiliar with what value-based reimbursement actually represents. All of these concerns we have heard repeatedly over the past several years, and they are reflected in verbatim comments from survey respondents.

Clinicians, in particular, have reservations about value-based reimbursement. Fewer clinicians (37%) and clinical leaders (39%) than executives (51%) say they think value-based reimbursement will be the primary revenue model of the future. Fewer clinicians (38%) than executives (55%) and clinical leaders (47%) believe that value-based contracts significantly improve the quality of care, and fewer clinicians (36%) than executives (50%) and clinical leaders (42%) think value-based contracts significantly lower the cost of care.

As with several other questions in this survey, a significant number of respondents are undecided. More than one-third (37%) say they neither agree nor disagree that value-based contracts significantly improve the quality of care, and 41% neither agree nor disagree that value-based contracts significantly lower the cost of care.

We find it interesting that 23% of respondents say they don't know their organizations' status with regard to value-based care, with more clinicians (34%) than clinical leaders (16%) and executives (12%) indicating that they don't know. This could suggest a need for greater transparency from leadership regarding value-based activities. It could also indicate something far more fundamental – a lack of consensus on what exactly constitutes value-based care.

While there is broad agreement that value in health care is represented by the balance between the patient-centered outcomes of care achieved with the costs to reach those outcomes, many individuals do not completely understand that concept. For example, in a written survey comment, a clinician suggests that one of the obstacles to developing value-based models is “Defining value and value to whom. I think

patient value is not yet fully integrated in the equation.” Another clinician comments: “Defining what [value] is exactly. Right now, it's a convenient term that means whatever the speaker wants it to mean.”

The survey identifies the leading barriers to implementing value-based reimbursement models. Infrastructure requirements, including information technology (indicated by 42% of respondents), and changing regulation/policy (34%) are the top two. Additional barriers include problems related to change management – administrative details (33%) and concerns about sustainability (28%).

There is strong consensus by Insights Council members on the broad metrics that are most important for measuring value-based care. All five metrics mentioned in our survey – outcomes, costs, safety indicators, patient experience indicators, and process measures – are rated as important by more than 85% of respondents. Outcome measures top the list, with 60% of respondents saying they are extremely important.

To us, this survey suggests that many in health care see value-based reimbursement as a real solution to the nation's current health care crisis. Until payers and providers become better aligned, however, there will be challenges in scaling and accelerating this approach. The survey participants say what is needed is a better understanding of value and better ways of assessing value. Collectively, we must measure outcomes that matter to patients seamlessly in the workflow, through advances in information technology, and then reward those outcomes in a value-based reimbursement system. ●



Darshak Sanghavi, MD, Chief Medical Officer and Senior Vice President of Translation, OptumLabs

Sanghavi is the former Director of Preventive and Population Health at the Center for Medicare and Medicaid Innovation within HHS, and a fellow and managing director of the Engelberg Center for Health Care Reform at the Brookings Institution. Also an award-winning medical educator, Sanghavi attended Harvard College and Johns Hopkins Medical School, completing his pediatrics residency and cardiology fellowship at Harvard Medical School and Boston Children's Hospital.

Most health care stakeholders realize health care costs are high and quality can be improved. And as these survey results from NEJM Catalyst show, many are embracing diverse value-based payment models as the way forward. However, the survey also points to some contradictions: On average, 75% of clinical revenue still comes from standard fee-for-service. And less than half of all respondents believe value-based contracts can improve care and lower costs. Still, the majority of respondents believe their organizations have achieved or will achieve broad value-based payment contracts within the next five years.

There may be a simple reason why respondents express enthusiasm for value-based care but have conflicting opinions about just how far along that path they should go now. Value-based care makes a bold promise: to reduce costs, improve care, and boost patient satisfaction all at once. But there may be trade-offs among these goals, and substantial short-term frustration.

For example, electronic health records once promised to make clinical care easier, cheaper, and more fulfilling; yet a number of respondents still see the electronic health record (EHR), and IT more broadly, as the biggest barrier to value-based care. It has also been cited elsewhere as a major contributor to provider burnout. Another example of short-term frustration around transformation efforts to value-based care: Survey respondents acknowledge the importance of good measures to illuminate the journey to better value, yet historically, there has been dissatisfaction with the administration and effectiveness of the modern measurement-industrial complex.

Ultimately, the survey results indicate a powerful desire for simplified, aligned multi-payer approaches to value-based care. Even here, some contradictions are present – the second-largest barrier to value-based care adoption listed in the survey is the uncertain regulatory landscape. This is likely a result of shifting government priorities and programs, such as the recent cancellation of a mandatory bundled program by the Centers for Medicare and Medicaid Services.

In the end, value-based care has achieved remarkable traction, given that almost no contracts incorporated value even 15 years ago. And as the survey respondents indicate, there's much to like about the potential to advance the Triple Aim vision. The principal obstacles don't appear to be philosophical resistance from providers and administrators, but operational and regulatory concerns. The challenge, moving forward, is to demonstrate how this vision can be realized – and how leaders and providers can trust the value-based payment approach enough to deliver it. Now the hard part begins in earnest.



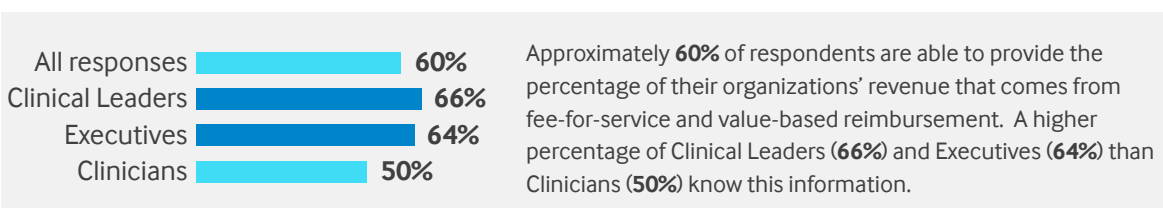
Transitioning Payment Models: Fee-for-Service to Value-Based Care

We surveyed members of the NEJM Catalyst Insights Council — who comprise health care executives, clinical leaders, and clinicians — about transitioning payment models from fee-for-service to value-based care. The survey explores value-based care models currently being pursued, the percentage of revenue from fee-for-service and value-based reimbursement, the status of organizations’ movement toward value-based care, agreement with value-based care statements, value-based reimbursement as the primary revenue model, barriers to implementing value-based reimbursement models, and the importance of various metrics in measuring value-based care. Completed surveys from 552 respondents are included in the analysis.

Insights Council members indicate that a quarter of their revenue comes from value-based reimbursement, on average, and three-quarters from fee-for-service. This modest level of value-based activity suggests that the health care industry is exercising an abundance of caution as it slowly transitions to value. Around two-thirds of executives and clinical leaders are able to provide the breakout of their organizations’ revenue, compared to half of clinicians.

Fee-for-Service Continues to Account for the Majority of Revenue

What percentage of your organization’s revenue do you estimate comes from fee-for-service? From value-based reimbursement?

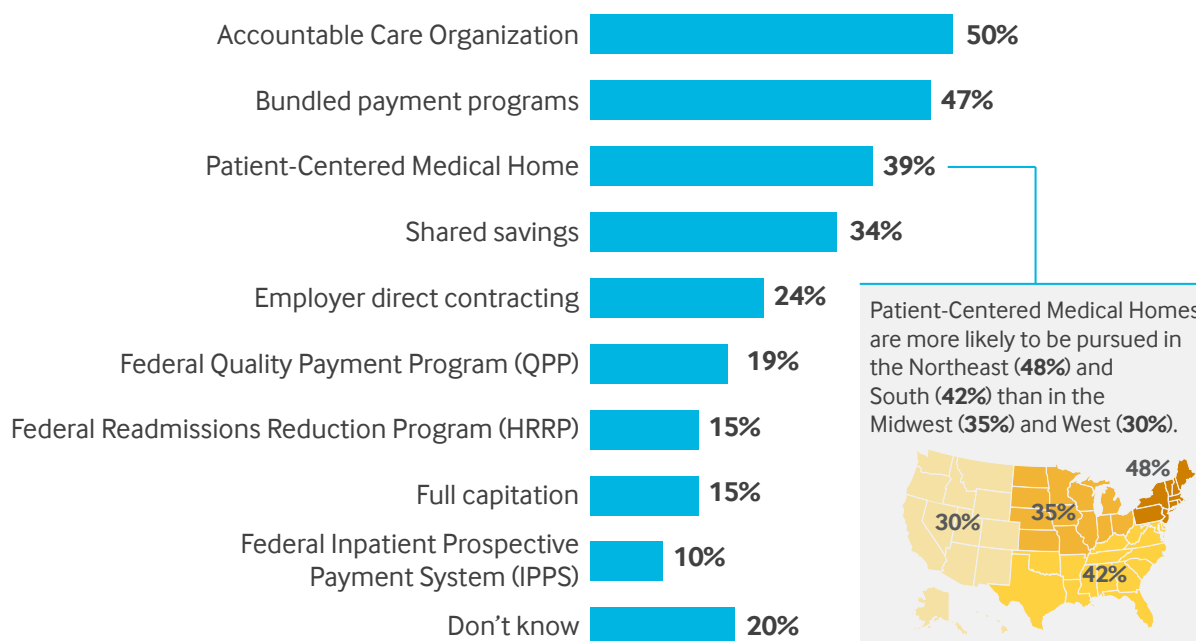


Base: 323 (Among those who did not answer “Don’t know”)
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Half of survey respondents say their organizations participate in Accountable Care Organizations (ACOs). Bundled payment programs follow closely among value-based care models that health care organizations are actively pursuing. Responses for Patient-Centered Medical Homes and shared savings approaches form a second tier. Shared savings models are more prevalent in the Midwest (39%), Northeast (37%), and South (36%) than the West (24%). A number of respondents cite Medicaid DSRIP (Delivery System Reform Incentive Payment programs) under the “Other” category.

Health Care Organizations Are Pursuing a Range of Value-Based Care Models

Which value-based care models is your organization actively pursuing?

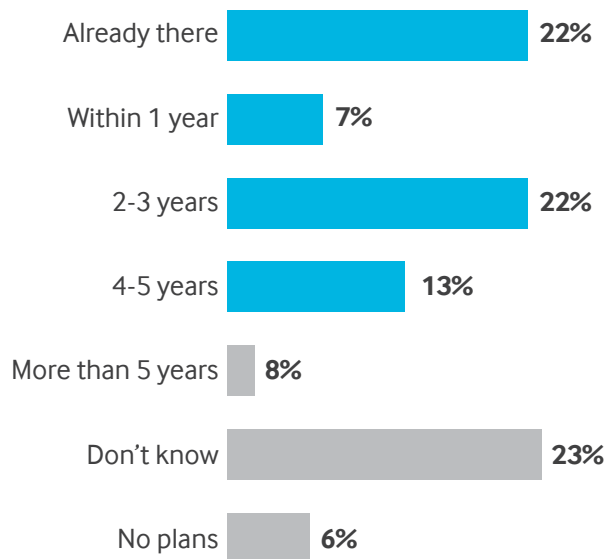


Base: 552 (multiple responses)
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Nearly one-quarter of respondents say that their organization has already achieved value-based care, and another 29% say they will get there within the next three years. A greater share of executives (27%) and clinical leaders (25%) than clinicians (17%) say their organizations have made the transition to providing value-based care. Aggregating the data reveals that just over half of respondents expect their organizations to be value-based in three years. In a written comment, a clinical leader in the South says the key to accelerating the adoption of value-based care is “Data agreed on by payers, researchers, and clinicians that actually save money – including hidden costs – and improve health of Americans and our health care system over the long haul.” But another clinical leader in the same region cautions, “We are a long way off from being able to track metrics as well, at least in my state.” Nearly a quarter of respondents don’t know their organizations’ status. This suggests there may be a need for greater transparency from leadership regarding value-based activities.

A Wide Range of Time Lines for Organizations to Move to Value-Based Care

What is the status of your organization moving toward value-based care?



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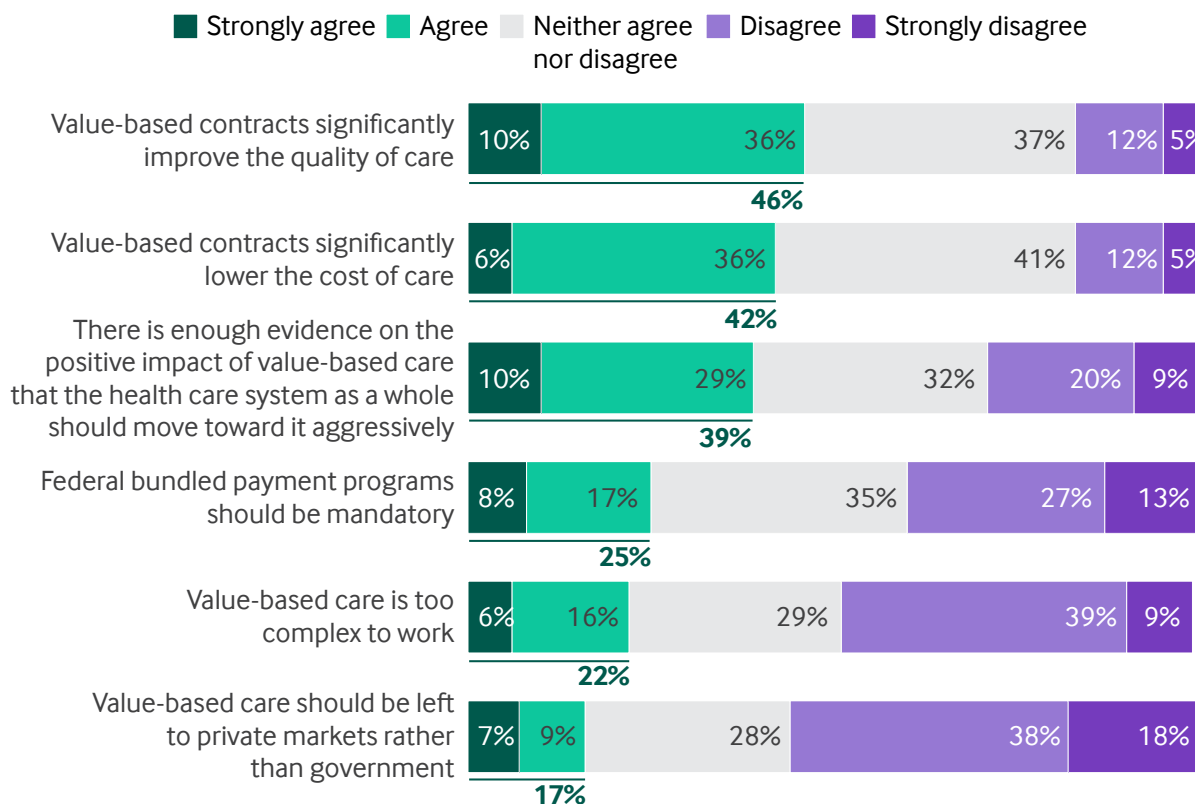
There is widespread agreement among Insights Council members about the benefits of value-based care. Nearly half say they either strongly agree or agree that value-based contracts significantly improve the quality of care, and 42% say they strongly agree or agree that value-based contracts significantly lower the cost of care. On the other hand, more than a third of respondents are undecided on the impact that value-based contracts have on the quality and cost of care. This suggests that, for many providers, the jury is still out on the benefits of value-based care.

Executives on the whole are more bullish than clinicians about value-based care: whether it significantly improves the quality of care (executives 55%, clinicians 38%) or lowers the cost of care (executives 50%, clinicians 36%); and whether there is enough evidence about the positive impact of value-based care that the health system as a whole should move toward it aggressively (executives 55%, clinicians 38%).

A plurality of respondents do not believe that value-based care should be left to private markets rather than the government (disagree 56%, agree 17%); or that value-based care is too complex to work (disagree 48%, agree 22%).

Opinions on Value-Based Contracts and Care

Please indicate to what extent you agree or disagree with each of the following statements.



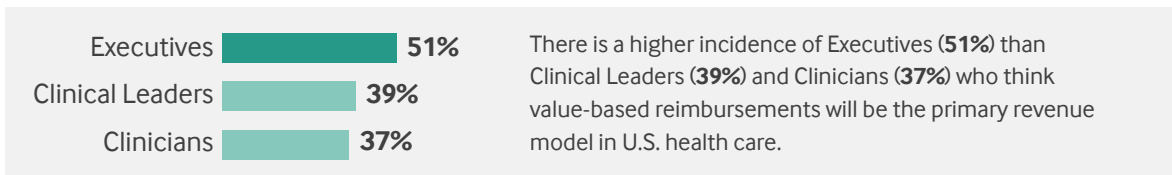
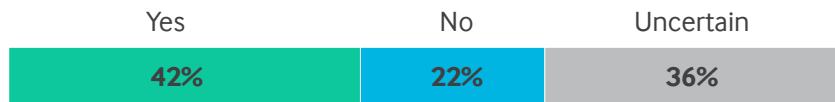
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More than 40% of Insights Council members think value-based reimbursement will become the primary revenue model in U.S. health care at some point. But more than a third of respondents indicate that they are uncertain, a finding that is consistent with several other questions in this survey. More executives (51%) than clinical leaders (39%) and clinicians (37%) think value-based reimbursements will be the primary revenue model in U.S. health care. In written comments, however, many respondents call for a single-payer system. “Some model of single payer/universal health care is the only way to control costs and maintain quality,” says one physician.

Cautious Optimism That Value-Based Reimbursement Will Become the Primary Revenue Model

Do you think value-based reimbursement will ever be the primary revenue model in U.S. health care?



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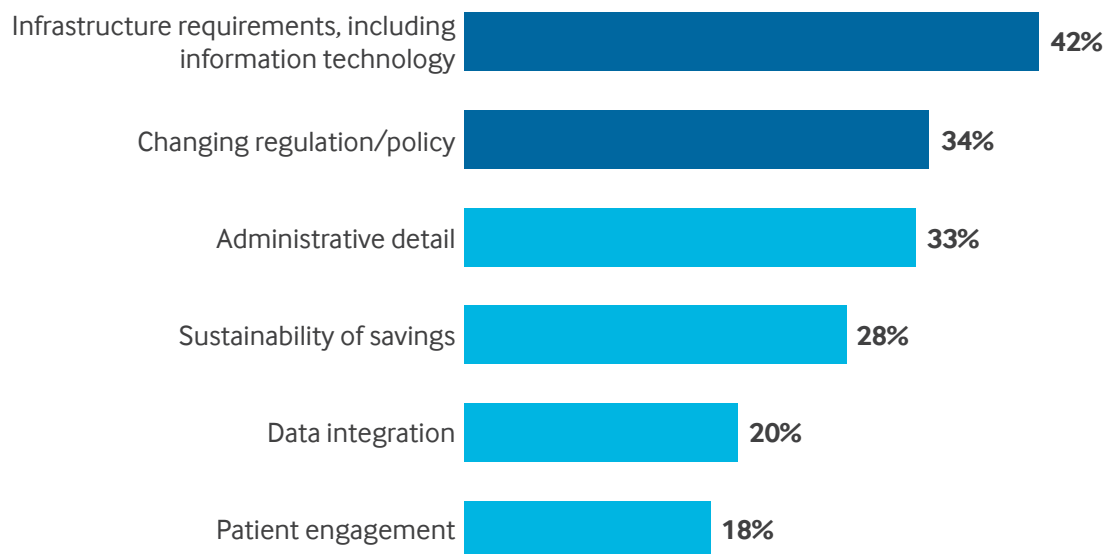
More than a third of respondents indicate that they are uncertain, a finding that is consistent with several other questions in this survey.

The top two barriers to implementing value-based reimbursement models are infrastructure requirements, including information technology and changing regulation/policy. A greater share of clinical leaders (34%) than executives (26%) and clinicians (24%) mention sustainability of savings, and a greater share of clinicians (38%) than clinical leaders (34%) and executives (25%) cite administrative detail.

Respondents identify a number of challenges under the “Other” category, including “defining value,” “consensus about what constitutes ‘value,’” and “defining quality in a meaningful way.” This indicates that, although value-based care was incorporated in the Affordable Care Act in 2010, the industry is still wrestling with the concept of what it means to provide value. Other barriers noted in written comments are “lack of hard evidence that the concept is sound,” “fragmented care delivery in most parts of the U.S.,” and “commercial insurers (United, Anthem, Aetna) who pull billions of dollars out of the system without putting in any value.”

Infrastructure and Changing Policy Are the Top Barriers to Implementing Value-Based Reimbursement Models

What are the top two biggest barriers to implementing value-based reimbursement models?



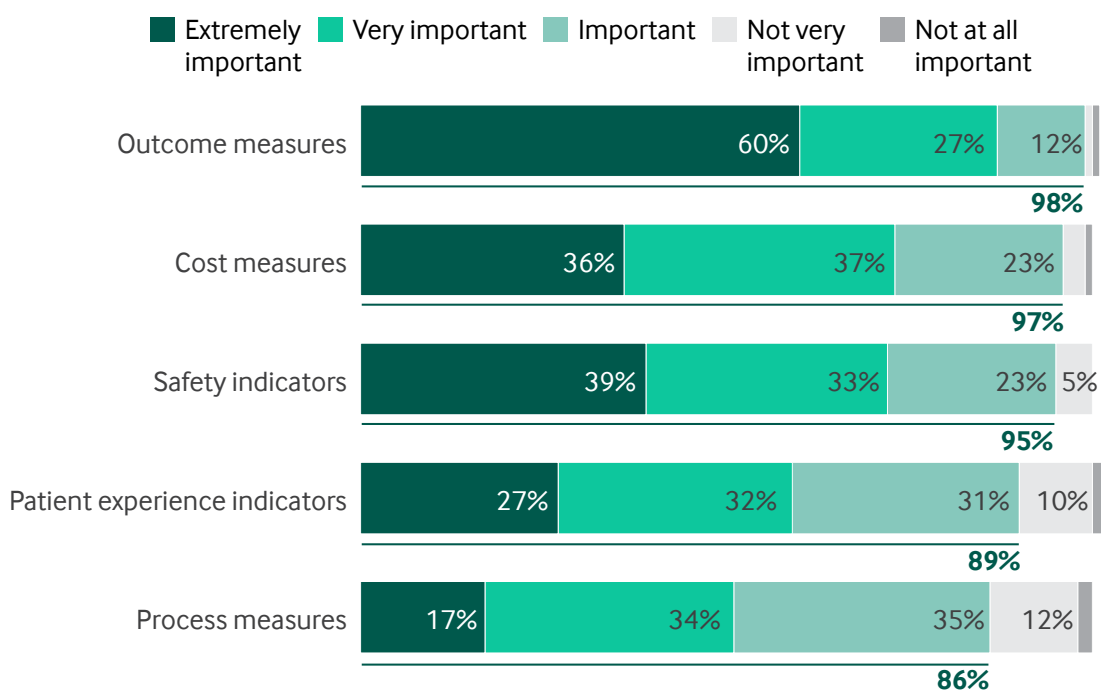
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More than 85% of survey respondents say a range of metrics for measuring value-based care are important, very important, or extremely important. Outcome measures are rated extremely important by nearly two-thirds. A greater share of executives (42%) and clinical leaders (38%) than clinicians (31%) say cost measures are extremely important.

Outcome Measures Are Most Important for Measuring Value-Based Care

How important is each of the following metrics in measuring value-based care?



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Verbatim Comments from Survey Respondents

What single change would accelerate the adoption of value-based care?

“Bring back the bedside medicine and shared decision. EHR is the biggest culprit in high cost and low satisfaction. If physicians motivated and got reimbursed for not doing things, we would save 50% of cost overnight. Prescribe Magic pill of “Talk to patient and listen” – well, guess what, we don’t have time for that. US health system is screwed up far beyond repair, it needs overhaul in biggest way possible.”

— Clinician from a large nonprofit teaching hospital in the South

“Patients should have skin in the game.”

— Department chair from a large for-profit community hospital in the South

“A move to a single payer system.”

— Director of a large nonprofit health system in the Northeast

“A clear representation of financials.”

— Clinician from a large nonprofit clinic in the West

“Federal mandate.”

— VP of medical affairs from a small nonprofit community hospital in the Northeast

“A way to incentivize physicians to take on high risk patients.”

— Director of a large for-profit health plan in the South

“Mandatory rule.”

— Clinician at a small nonprofit health system in the Midwest

“Pay MDs less.”

— Program director at a large medical school program in the South

“Include practicing physicians in the planning & implementation process. Make it experimental for 5 years to assess the complexities & outcomes before making it mandatory.”

— Clinician at a large nonprofit teaching hospital in the Northeast

“Single payer system. Or uniform values among multiple payers. Again think of professional sports. The leagues have a uniform set of rules to play the game. Otherwise there are moving targets and enormous uncertainty for administrators, docs, patients, and community stakeholders.”

— *Department chair at a midsized nonprofit health system in the Northeast*

“Successful models gaining market share. Possibly the likes of Oak Street Health.”

— *VP of a large nonprofit health system in the Midwest*

“Quit making us document a ton of stuff that isn’t applicable to our particular practice and that stops us from being able to work with our patients to achieve better outcomes. When we are having to document in the late hours of the night, or look at lab results in the late hours of the night because we have spent a good part of our day motivationally interviewing our patients to get them involved as partners in their own health care, it leads to physician burnout and lack of empathy for our patients.”

— *Clinician at a large nonprofit teaching hospital in the West*

“Requirement that the federal budget be balanced.”

— *Department chair at a midsized nonprofit community hospital in the Northeast*

“Physicians had been taught for decades that they were the final arbiter of everything that happens to their patient. When, and until, we change the culture to one of team-based care where the patient belongs to the team, we will continue to struggle with adopting value-based care. As an example, a physician with a length of stay that is 10 days longer than his peer average once told me that the hospital has a length of stay problem because the hospital gets paid a single fee for the entirety of care.”

— *Executive at a large nonprofit hospital in the South*

Methodology

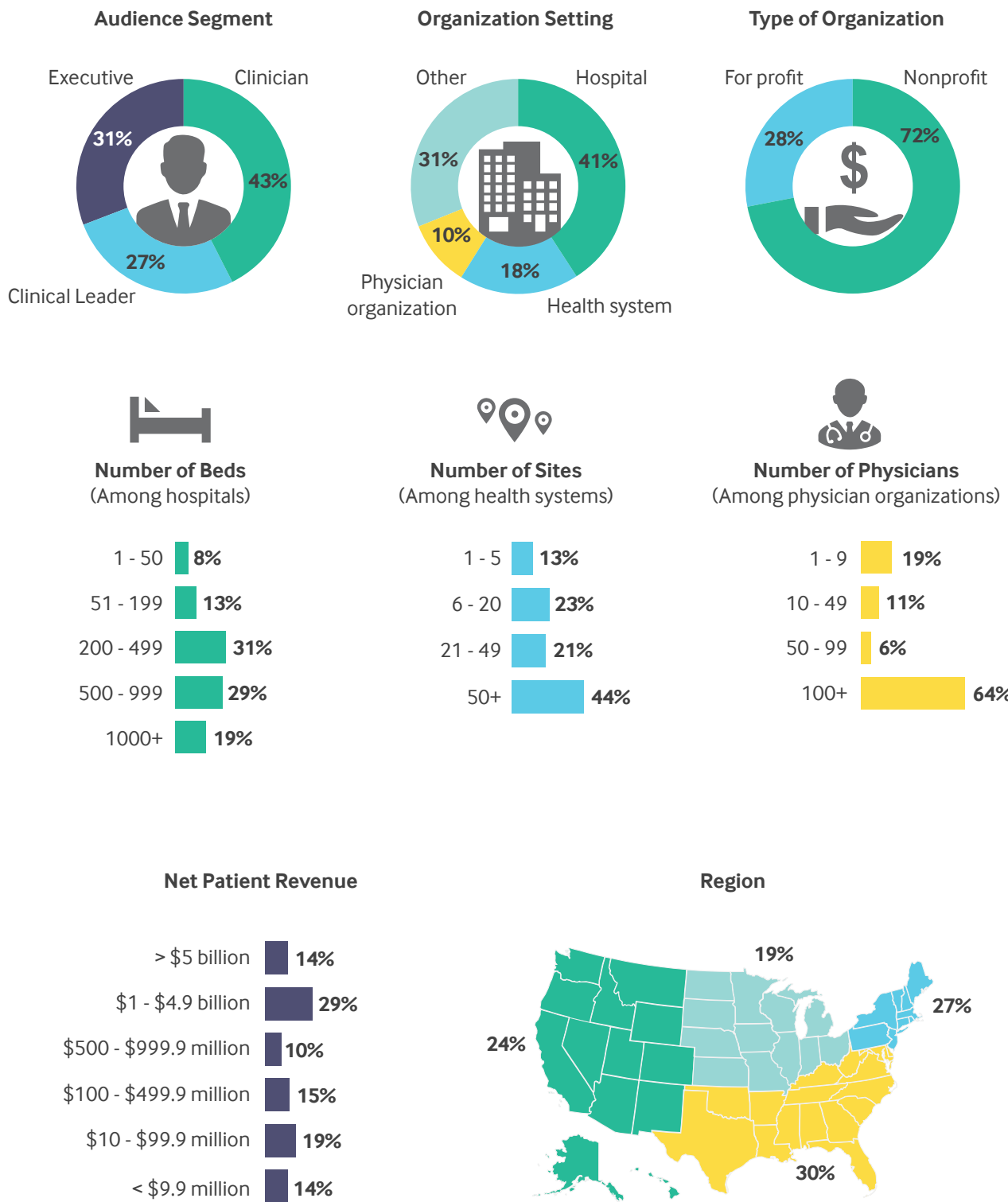
- The Transitioning Payment Models: Fee-for-Service to Value-Based Care survey was conducted by NEJM Catalyst, powered by the NEJM Catalyst Insights Council.
- The NEJM Catalyst Insights Council is a qualified group of U.S. executives, clinical leaders, and clinicians at organizations directly involved in health care delivery, who bring an expert perspective and set of experiences to the conversation about health care transformation. They are change agents who are both influential and knowledgeable.
- In July 2018, an online survey was sent to the NEJM Catalyst Insights Council.
- A total of 552 completed surveys are included in the analysis. The margin of error for a base of 552 is +/- 4.2% at the 95% confidence interval.

NEJM Catalyst Insights Council

We'd like to acknowledge the NEJM Catalyst Insights Council. Insights Council members participate in monthly surveys with specific topics on health care delivery. These results are published as NEJM Catalyst Insights Reports, such as this one, including summary findings, key takeaways from NEJM Catalyst leaders, expert analysis, and commentary.

It is through the Insights Council's participation and commitment to the transformation of health care delivery that we are able to provide actionable data that can help move the industry forward. To join your peers in the conversation, visit join.catalyst.nejm.org/insights-council.

Respondent Profile



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Optum is a leading health services and innovation company dedicated to helping make the health system work better for everyone. With more than 133,000 people worldwide, Optum combines technology, data, and expertise to improve the delivery, quality, and efficiency of health care. Optum uniquely collaborates with all participants in health care, connecting them with a shared focus on creating a healthier world. Hospitals, doctors, pharmacies, employers, health plans, government agencies, and life sciences companies rely on Optum services and solutions to solve their most complex challenges and meet the growing needs of the people and communities they serve. Learn more at optum.com/valueinhealthcare.