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calling into question the nation's commitment to value-based health care

Both the healthcare establishment and the American public have readily embraced the importance of moving from a volume to a value focus in health care. But it is unclear to what extent this shift has actually occurred.

Before Tom Price abruptly resigned from his post as secretary of the U.S. Department of Health & Human Services (HHS) in late September, some pundits had questioned his commitment to moving health care to value-based care because of a proposed rule HHS had issued changing or eliminating mandatory bundling payment demonstrations. However, this conclusion confused Price's and other Republican objections to large-scale, mandatory demonstrations with an opposition to value-based care. When Price was in Congress as a Representative for Georgia, he and Rep. Michael C. Burgess (R-Texas) had been driving forces behind the passage of the Medicare Access and CHIP Reauthorization Act (MACRA), legislation encouraging the adoption of alternative payment models (APMs) and calling for the use of metrics to reward physicians who remain in fee-for-service but who can demonstrate improved quality and efficiency.

What the Data Suggest

The question remains, however, whether the value-based mantra has produced actual change in physician or hospital behavior or whether it has been mostly rhetorical. So far, there seems to have been more rhetoric than action. Most physicians continue to be paid on a fee-for-service basis, which clearly rewards volume rather than value. As late as 2016, reports showed that 95 percent of physician payments were coming come from fee for service, and although current data are difficult to find, there has been little indication that things have changed significantly since then.[a]

Under the Obama administration, HHS claimed that it was on track to reach its commitment of increasing shares of value-based payments but without ever specifying what share of a payment must be value-based to change behavior—especially physician behavior. Past changes have shown hospitals are likely to be prompted to change their behavior with only a 1 or 2 percent increase in their update, as occurred with the voluntary reporting of quality data once it became incentivized. Physicians, however, have seemed to require much larger increases in payment to be willing to change their behavior, in part because of the varying numbers of patients affected by payment changes, depending on each physician's specialty and type of practice.

In most of the value-based payments programs to date, only a small percentage of the total payment is related to any measure of value—substantially less than is likely to be required to motivate a change in behavior, especially among physicians. Even some incentive programs that have been regarded as successful, such as the Medicare Hospital Readmission Reduction program, allow hospitals that incur readmission penalties to reap

a. Haelle, T., "Fee-for-Service Still Dominates in United States," Medscape, March 8, 2016.

more financial rewards from the readmission revenue than hospitals that change their admissions behavior gain from being rewarded for avoiding readmissions—although penalized hospitals risk loss of repuation if identified as having been penalized under the program.

Aggressive Action Needed (If Value is What We Really Want)

If the nation is serious about moving to a value-based system, it must move away from fee-for-service payment much more aggressively than in the past. The inherent inefficiencies and problematic financial incentives embedded in the stand-alone fee-for-service payment model, where a physician is paid separately for each single unit of care, have been frequently noted.[b]

Value-based payments require a payment system that gives physicians an incentive to improve value—that is, deliver high-quality care efficiently in the lowest-cost medically appropriate setting with the goal of keeping people healthy—rather than simply to perform as many procedures as possible on people, where the payment increases as the procedures become more complex.

Controversies and Differing Perspectives

Despite widespread recognition of the changes that would be required to move completely to a value-based system, controversy remains about how much effort should be devoted to improving and refining the existing Medicare fee schedule, which is a classic example of a micro-level payment schedule for fees paid to individual physicians on the basis of 8,000 different CPT codes. This controversy arose most recently in a Sept. 27 event sponsored by the USC-Brookings Schaeffer Initiative for Health Policy and the Urban Institute, on the Medicare physician fee schedule and alternative payment models.[c]

I think most people agree that, in principle, it would be better to have a fee schedule that accurately reflects the fee-schedule components, including work effort and practice expense, rather than one that contains a substantial number of overvalued or undervalued fees. However, because such refinements inherently involve redistributions from some fees to other fees, the question is how much of what is always a limited amount of political capital—in this case, the political capital available for changing physician behavior—should be used to refine the existing Medicare fee schedule, given that the fee schedule exemplifies a micro level unit of payment based on inputs rather than outcomes.

Those who argue in favor of improving the existing Medicare fee schedule note the continuing extensive use of fee-for-service payments, particularly as a basis for many—or even most—other types of payments currently used in APMs. Those who argue against this approach (including me) focus on the incompatibility between fee schedules that base payments on the work activities provided by an individual physician with a payment system that rewards physicians who work effectively in teams, produce care efficiently, and can keep patients healthy.

Basing payments on individual inputs—rather than outcomes—is fundamentally inconsistent with moving to value-based payments. Exploring payment systems that blend elements of capitation payments with components that vary with productivity, patient satisfaction, research, or whatever other behaviors are deemed appropriate seems much more likely to move health care in the direction we claim we want to move. Even a perfectly defined fee schedule still pays physicians for performing increasingly complex procedures on their patients rather than for achieving the best possible outcomes. ■

b. See for example, the recommendations in 2012 of the Society of General Internal Medicine's National Commission on Physician Payment Reform, as outlined in Schroeder, S.A., and Frist, W., "Phasing Out Fee-for-Service Payment," *The New England Journal of Medicine*, May 23, 3013.

c. For more information about this event, go to brookings.edu/events/improving-medicare-physician-payment.

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