Value-Based Healthcare in the United States

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Rising healthcare costs in the United States (U.S.) signify an urgent need for change. The Centers for Medicare & Medicaid Services (CMS) reported that in 2020, U.S. healthcare spending totaled $4.1 trillion or $12,530 per person and accounted for 19.7% of gross domestic product (GDP). CMS has projected that from 2019 to 2028, U.S. spending will grow at an average annual rate of 5.4%, reaching $6.2 trillion by 2028 [1]. Utilization of healthcare services and the associated costs per service are the main factors which drive national healthcare spending.

Fee-for-Service & Value-Based Healthcare Reimbursement Models

The U.S. provides healthcare reimbursements using a 'Fee for Service' (FFS) model in which reimbursements are based off the number of services or procedures ordered by providers [2]. Although FFS models allow providers to charge a reasonable amount for their services, there are significant disadvantages which have contributed to national spending. The FFS model has been criticized for incentivizing providers to order a greater number of tests and procedures per patient and discouraging holistic and preventive care. With the FFS model failing to incentivize hospitals and providers to focus on preventative care, more than 25% of U.S. adults report that they have been diagnosed with two or more chronic conditions at some point in their lifetime, compared to 22% or less in other countries [3]. In light of data showing that the U.S. spends double on healthcare costs compared to the global average while simultaneously having worse overall health outcomes, CMS has made it a priority to change current healthcare models [3].

Value-based healthcare (VBHC) reimburses providers based on the *quality* of care delivered to patients, not on the quantity of services ordered [4]. CMS defines value-based programs as a framework which "…reward(s) health care providers with incentive payments for the quality of care they give…" [5]. Quality of care is determined by collecting and measuring health outcomes and evaluating the impact of certain interventions on patient health metrics. Collection and sharing of patient data through interoperable systems is crucial to assess quality. Real-world data (RWD) is used in VBHC to track outcome metrics of interest which, in turn, allows for continuous advancements in treatment. Overall, VBHC aims to enhance patient health outcomes by providing care of value, reducing chronic disease burden, improving efficiencies, and lowering healthcare costs.

Status of Value-Based Healthcare in the United States

The U.S. has been working to transition away from the FFS model and towards VBHC. The first monumental step occurred in 2010 with the passing of the Affordable Care Act (ACA). Following CMS's passing of the ACA, additional value-based programs have been established such as the Hospital Value-Based Purchasing (VBP) Program and the Hospital Readmission Reduction Program (HRRP) [4]. Hospital VBP Programs incentivize acute care hospitals to improve quality of care by adjusting payments based on patient outcome metrics such as mortality and adverse event rates. The HRRP promotes quality of care by adjusting hospital payments based on reduced readmission rates for specific disease states such as heart failure and chronic obstructive pulmonary disease (COPD). The program reduces healthcare costs and promotes coordination and communication amongst providers.

CMS has designed patient-centered organizations in which a network of providers from different specialties delivers high-quality, coordinated care in a cost-effective manner, known as Accountable Care Organizations (ACOs) [6]. Similar to ACOs, patient-centered

medical homes (PCMH) connect primary, specialty, and acute care providers. PCMH allows patients to be treated by a coordinated team of primary providers rather than being unnecessarily referred to multiple specialists [7]. ACOs and PCMHs aim to avoid redundant care, reduce healthcare costs, utilize patient health metrics to improve efforts, and strengthen patient-provider relationships.

In 2016, the Department of Health & Human Services (DHHS) announced a goal of converting 30% of FFS Medicare payments to VBHC models and predicted that 50% of traditional payments will be value-based by 2018. However, by 2019 only 38.2% of healthcare payments were value-based [8].

By 2018, 48 states in the U.S. had implemented VBHC programs to varying degrees and all 50 states were at least beginning to engage stakeholders to assist with implementation. Six states had implemented well-developed VBHC programs for four years or longer. Twenty-two states had adopted or were considering the adoption of ACOs or similar programs to manage healthcare costs and deliver better care [9]. In 2020, Medicare's Shared Savings Program, which utilizes ACOs, served 10.6 million senior citizens and racked up $4.1 billion in savings, a tenfold increase in savings since 2015 [10]. CMS aims to have all Medicare payments be value-based by 2030 [8].

Value-Based Healthcare Implementation Principles

Michael Porter and Elizabeth Teisberg have studied VBHC for decades and discovered that current healthcare systems are built in a manner where hospitals and insurance companies compete against one another. This competition increases healthcare costs, is prone to error, and does not account for or benefit the patient. The authors go on to suggest that "value-based competition is needed" and propose eight principles that are applicable to providers, suppliers, consumers, employers, and governing bodies [11]:

1. The focus should be on value for patients, not just lowering costs.
2. There must be unrestricted competition based on results.
3. Competition should center on medical conditions and over the full cycle of care.
4. High-quality care should be less costly.
5. Value is driven by provider experience, scale, and learning at the medical condition level.
6. Competition should be regional and national, not just local.
7. Information on results and prices needed for value-based competition must be widely available.
8. Innovations that increase value must be strongly rewarded.

SUMMARY

VBHC is multi-factorial and requires effort and coordination amongst all stakeholders. In value-based care models, patients are just as influential over decisions regarding their overall health as their providers. The core principles of VBHC include a shift in focus from quantity to quality of services, collection and measurement of health outcomes, continuous quality improvement systems, and coordinated effort amongst teams of multi-disciplinary providers. The U.S. has made strides towards providing valuable care to patients through the establishment of CMS value-based programs and the development of technologies that allow for collection and sharing of patient data. Although VBHC is a relatively new healthcare model, it is recognized both nationally and globally as a means to improve societal health and reduce healthcare costs.

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Alyssa serves as a Project Lead II at CRS and is responsible for managing multiple trials involving medical devices and drug development research in critical care, GI surgery, abdominoplasty, oncology, infectious diseases, respiratory disorders, and digital therapeutics. Ms. Harris also has experience managing federally funded research programs in vulnerable populations, specifically in the neonatal intensive care unit.

Alyssa earned her master's degree from the University of Pittsburgh in Health, Physical Activity and Chronic Disease, focusing on the research track. Her undergraduate degree is in Exercise Physiology, where Ms. Harris gained extensive experience working in chronic disease research, specifically with metabolic disorders, and leading weight loss and physical activity interventions. Ms. Harris brings a unique range of expertise to CRS, and thrives in an environment that uses new methods and tools in research.

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Jennifer earned her doctorate of pharmacy from the University of Rhode Island, School of Pharmacy. She recently completed a 5-month long internship with CRS and landed her role by proving exceptional performance, know-how, and character.

Dr. Le currently serves as a Project Lead at CRS where she is involved in clinical trials for medical devices and drugs, regulatory submissions, and medical writing. She has experience managing clinical data, writing documents such as informed consent forms, preparing 510k submissions, and facilitating correspondences with the FDA. Dr. Le enjoys utilizing her pharmaceutical knowledge and critical thinking skills at CRS to provide exceptional clinical research services to our clients and continue fostering innovation.

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