UNITED STATES of CARE

People Demand Better from the Health Care System: How Innovation Drives A Patient-Centered Health Care Vision

Making Health Care Work For People: The Transition Away From Fee-For-Service

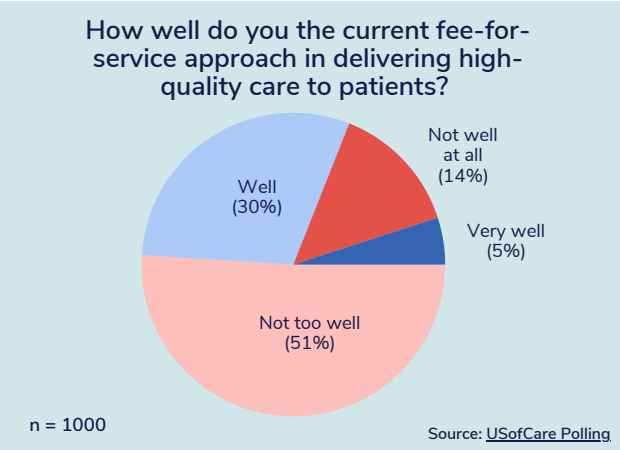
Health care affordability remains the top concern for people across the country, with families increasingly delaying or skipping needed care as costs continue to rise. Our nation's dependence on the costly fee-for-service system, in which providers are paid for the *volume* of services they deliver instead of the *quality* of care they provide, is partly to blame. Unless there's a meaningful change to how care is delivered nationwide, people will become increasingly frustrated with a system that fails to deliver on the basic promise of affordable, quality health care. Instead of doubling down on the failing fee-for-service system, policymakers must shift toward patient-first care, or "value-based care," to respond to people's real needs, improve health outcomes, and lower costs for all.

***Public Opinion Research** Shows Criticisms of the Fee-for-Service System:*

- Fee-for-service is fragmented, with little coordination between providers. Patients spend too much time waiting for appointments than with their doctors.
- Providers over-rely on prescription drugs as the easiest course of treatment.
- People have to repeat their latest health challenges to each provider they see, often leaving patients with conflicting medical advice.
- People with money are prioritized when getting appointments and care.
- People feel they spend more time in the system because they aren't able to address all their issues in one appointment & have to make another one.

By a 4:1 Margin, Patients Prefer a Patient-First Care System Over Fee-for-Service, Which Delivers:

- Greater coordination between providers.
- Increased quality of care.
- Quality over quantity.
- Patients being treated as a whole person.
- Providers being encouraged to offer more personalized care.
- Providers being held accountable for the care they deliver.



How Patient-First Care Can Lead to Long-Term Savings for Federal Programs

- During CMMI's second decade (2021-2030), the Congressional Budget Office (CBO) expects that the Innovation Center will generate net annual budgetary savings as the number of certified models that produce savings grows over time and **expects to reduce spending on benefits in the second decade (2021-2030) by $6.8 billion.**
- Medicare's Trustees estimate Medicare spending from 2021 to 2030 will be $13 trillion. CBO estimates CMMI's activities to increase net federal spending by $1.3 billion, or 0.01 percent of net spending on Medicare during that same period, and **CMMI spending is expected to break even over the next 5 years, by 2029.**
- The Medicare Shared Savings Program for Accountable Care Organizations saved money for Medicare while continuing to support high-quality care. Specifically, **it saved Medicare $1.8 billion in 2022** compared to spending targets–continuing a six-year trend of higher than expected savings.
- The Medicare Diabetes Prevention Program, which encourages healthier lifestyles among Medicare beneficiaries with a high risk of diabetes to prevent or delay onset, **produced cumulative net savings of $0.01 billion in the model's first three years.**

How Patient-First Care Models Improve Quality of Care

The existing fee-for-service model is broken and doesn't address what people say they need from the health care system. The Center for Medicare and Medicaid Services Innovation (CMMI, or the CMS Innovation Center) was established by Congress in 2010 to identify ways to improve the quality of health care and reduce costs in Medicare, Medicaid, and the Children's Health Insurance Program. CMMI does this by identifying, developing, testing, and evaluating new ways to pay for and deliver care under these programs, which was built upon the fee-for-service model. Patient-first centered or value-based care realigns financial incentives to support providers moving toward innovative and accountable care models which are linked to better health outcomes and quality of care for patients because it ties provider payment to patient care outcomes, instead of patient care volume. To continue supporting the shifting of the U.S. health care system away from fee-for-service, policymakers must look beyond just cost savings to also focus on patient care, satisfaction, and outcomes and continue supporting the use of innovative models that benefit both patients and the health care system by providing more coordinated and efficient care.

Case Studies: Federal-State Models Driving Innovation & Lowering Health Care Costs

States are a key component to efforts that transition the health care system to a patient-first care. Two recent examples of this include the Pennsylvania Rural Health Model and the Arkansas Health Care Payment Improvement Initiative.

Arkansas Health Care Payment Improvement Initiative

The Arkansas Health Care Payment Improvement Initiative (AHCPII) is designed to transition the state of Arkansas to a patient-centered health care system that:

- Improves the health of the population;
- Enhances the patient experience of care, including quality, access, and reliability; and
- Reduces or controls the cost of care.

Since 2012 AHCPII has integrated patient-centered medical homes with episode-based payments to bolster patient outcomes and manage costs. A large number of providers throughout Arkansas are participating in the Patient-Centered Medical Home (PCMH) program which has demonstrated both quality improvements and state Medicare system and provider savings. Private payers have reported quality improvements and cost avoidance in episodes of care.

As of 2019, most primary care providers adopted this model, contributing to a 75% improvement in preventive care metrics for Medicaid. Furthermore, Arkansas Blue Cross and Blue Shield fulfilled two-thirds of the PCMH quality metrics. Providers and patients are benefitting from improvements in quality of care and a better patient-provider relationship.

Pennsylvania Rural Health Model

The Pennsylvania Rural Health Model (PARHM) seeks to test whether a hospital care delivery transformation model focused on patient-centered care alongside the use of hospital global budgets can:

- Improve the health of the population and increase access to high-quality care for rural Pennsylvanians;
- Reduce health care costs for payers; and
- Improve the financial health of hospitals and providers in rural Pennsylvania.

Since it began in 2019, PARHM pays participating hospitals a fixed amount upfront, regardless of patient volume, allowing these hospitals to invest in high-quality primary and specialty care that addresses the specific needs of the communities they serve. PARHM encourages a focus on increased care and coordination for patients with chronic illnesses, such as congestive heart failure, chronic obstructive pulmonary disease, and diabetes.

Eighteen hospitals across Pennsylvania participate in this model and overall findings highlight that the hospital care delivery transformation planning process encouraged hospitals to focus their attention hiring staff to coordinate care and engage community partners. The model also reportedly helped some participating hospitals attain greater financial stability.

Transitioning the health care system to one that centers patients and puts quality over quantity takes coordination, planning, partnerships, programming, and time. CMMI is making progress on dozens of models, not only to assess whether they lower spending, but also to assess benefits for patient access, quality of care, patient experience, and other factors that future policy and models can adjust to ensure long-term financial sustainability.