

Gambling on the Transition From Fee-for-Service to Value-Based Care

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Dedicating increasing amounts of income and personal time to lead and manage quality programs is not sustainable.

Mainstream media, and even medical journals, would lead one to believe that a new physician payment model based on quality, outcomes, and patient satisfaction is imminent. But most medical practices today must still operate as fee-for-service businesses, in which patient volume, visit coding, productivity, scheduling, payer mix, billing, collections, and expense control are preeminently important. This often leaves scarce resources available to participate in quality improvement programs.

In recent years, the Centers for Medicare & Medicaid Services (CMS) has implemented several programs that tie payment to performance, such as using a qualified e-prescribing system, reporting measures for the Physician Quality Reporting System (PQRS), and achieving meaningful use of certified electronic health record (EHR) technology. States, including our home state of Vermont, and private payers are offering their own quality-based payment incentives as well. Many medical practices believe the incentive payments associated with these programs are insufficient relative to the cost and complexity of their implementation but have pursued them anyway – as our practice has – recognizing their potential to help improve patient care. We are hoping that our efforts position us for success when the transition from fee-for-

service to value-based payment is complete. But we have some serious concerns about the financial sustainability of our work in the meantime.

An uncertain future

White River Family Practice resides in the shadow of a large academic medical center in a state where most family physicians are employed by hospitals. Our six-physician practice remains independent. Sunday mornings find our physicians studying quality data rather than reading the Sunday paper. Using reports available in our EHR, physicians track quality indicators in real time, such as the percentage of patients with diabetes who have had an

A1C test in the past three months; rates of alcohol or tobacco-use counseling provided

during office visits; and rates of preventive screening, such as colonoscopy and mammography. The practice changes care processes regularly to improve these and other measures. (To read about another group’s quality improvement journey, see page 23.)

As a level-III patient-centered medical home, our practice receives some support through the Vermont Blueprint for Health, calculated as a per-member, per-month management fee – but only for patients who are Vermont residents. Roughly half the patients seen at White River live in neighboring New Hampshire.

Our practice is also grateful to have received a grant from Vermont through the State Innovation Model program to advance population-based primary care initiatives. However, the grant provides only *short-term* support for the development of office staff and systems – all dedicated to the improvement of primary care for the *long term* – which does not promote confidence in the longevity of any innovations.

Our practice has also participated successfully in the EHR meaningful use program and PQRS, although one of our physicians describes the PQRS program as “clunky” and overly complex, noting that the measures,

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codes, and reporting options change every year and the PQRS feedback reports are far too slow to be effective in performance improvement. Although payments for participation in the CMS incentive programs have defrayed significant costs associated with the implementation of the systems and technology essential to good information management in the 21st century, the costs continue well after the systems have been installed. Information technology systems must be maintained and supported, upgraded, and periodically replaced, all at additional – currently unfunded – costs. The growing volume of information requires secure back-up, another growing expense. Furthermore, safe, high-quality patient care depends on secure regional (even national or global) connectivity – the ability to share clinical information when appropriate beyond a specific site of patient care – and

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Ultimately, improvements at our practice are financed primarily by physician salaries and investments of personal time. The revenue streams necessary to support ongoing investment in systems, staff, and care processes are variable and inconsistent, leaving the physicians in the position of funding these services themselves if they are to continue and even expand. So far, the physicians have trusted in the future, but that trust cannot last. The current fee-for-service payment model is at odds with investment in the evolution and development of programs providing high-quality, individualized primary care and population-based care that improves the health of communities. Physicians cannot keep trying to “do the right thing” hoping that a grant or some incentive money from widely differing programs with uncertain and changing rules will come through to support operations.

Our practice has bet that the time and money the providers have invested in care coordination and quality improvement will be economically rewarded. But leaders – be they from medicine, government, the insurance industry, or patient groups – should note that our physicians and others in independent practice regularly consider how large a bet they should make, and at what point the returns should be measured. The status quo is untenable. **FPM**

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