Improving Access through Value-Based Care

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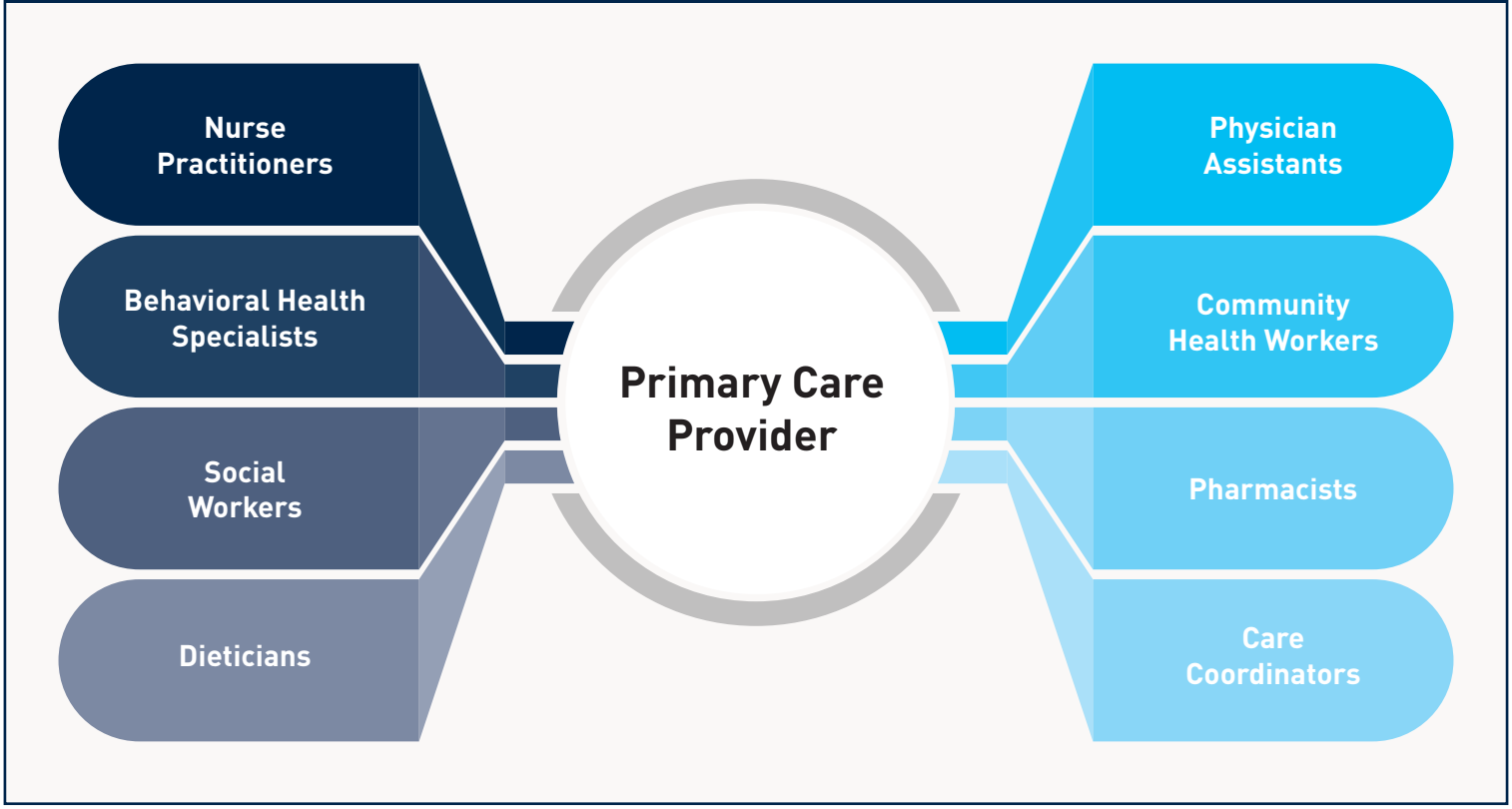
The Problem with Fee-for-Service: Paying for healthcare on a fee-for-service (FFS) basis encourages healthcare practitioners to perform more services (especially high-margin services) in their own practices but fails to encourage sharing information across practices or helping patients navigate the healthcare system. FFS leads to silos of care delivery, creating barriers for those who need timely access to care or support in finding their way into a care setting.

Improving Access through Value-Based Care: Paying for healthcare through a value-based care (VBC) arrangement creates incentives to break down silos to ensure patients can access the healthcare system on a timely basis. Examples from research show providers who participate in VBC arrangements—such as the Medicare Shared Savings Program and Center for Medicare and Medicaid Innovation models—create new care delivery models and adopt technologies to increase patient access.

Examples include:

- Forming care teams that combine clinicians, pairing providers of different backgrounds depending on the needs of the patient population (Figure 1)
- Increasing weekend and evening hours and proactively reaching out to patients who miss appointments
- Using data and analytics to identify gaps in care for clinicians to address at upcoming visits
- Developing relationships with unaffiliated providers who also care for their patients, while changing referral patterns to improve outcomes
- Establishing connections with community providers to improve handoffs and workflows between primary care, specialty, and acute care providers
- Adopting new technology to connect patients to community resources

Figure 1. VBC Leads to New Care-Delivery Models between Primary Care, Specialties, and Other Clinicians



Evidence Shows VBC Increases Access to Care

As providers develop new care delivery models under VBC arrangements, researchers have measured how those new models change access to care. Table 1 summarizes evidence that VBC increases access to care.

Table 1. Evidence from the Literature: Value-Based Care and Access

More Timely Access	– Patients of Medicare accountable care organizations (ACOs) reported obtaining more timely access to care than those in non-ACO control group.[1] – Pioneer ACO patients were more likely to report timely access to care and information.[2]
Easier Appointments	– Patients of employer ACOs reported finding it easier to make specialist appointments.[3] – Comprehensive ESRD Care Model patients received more frequent outpatient dialysis visits.[4]
Better Communication	– Patients scored Pioneer ACO clinicians as better communicators than FFS.[2] – Patients reported better communication from doctors and nurses at Pioneer ACO hospitals.[5]
Improved Coordination	– Patients of Medicare ACOs reported their primary care providers (PCPs) were more likely to be aware when they received care from specialists.[1] – ACO Investment Model patients received two times the number of chronic care management visits compared to FFS patients.[4]
More Primary Care Visits	– NY Medicaid VBC programs were associated with more behavioral health visits.[6] – Patients of one Medicare ACO had 34% higher PCP visits and 265% higher annual wellness visits compared to typical practices in one region.[7]
Fewer ER Visits	– Patients of Employer ACOs were less likely to report visiting the emergency room (ER) for care.[3] – NY Medicaid VBC programs were associated with fewer mental health ER visits.[6]

Lessons for Policymakers: Debate over VBC models often centers around whether those models lower spending, but focusing on costs alone may lead policymakers to overlook gains in patient access achieved by new care-delivery models that develop when providers switch from FFS to value-based payment arrangements. Continued investment in VBC can further these access gains as payment models are adjusted for long-term financial sustainability.

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