

Choosing the Future

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Quality vs. “Value”

Let’s begin with two definitional clarifications. The discussion of “quality” in patient care has to do with the degree of excellence with which that care is provided. “Value” (as in “value-based care”) has to do with minimizing expense to Third Party Payers. The primary objective of every PPACA health care mandate is to reduce the amount of money that Third Parties must pay for care provided to patients in hospitals and physicians’ offices.

Given the arrogant and admittedly deliberate official falsehoods used to sell the PPACA to the public (see [Jonathan Gruber](#) on video), it shouldn’t be surprising that

additional misinformation, disinformation, and outright lies have been officially employed by the Act’s supporters and implementers every step of the way. What is surprising is the flaccid passivity with which physicians and hospitals have tolerated and continue to tolerate this behavior. Consider [this article](#) from CMS:

Prior to 2011, many Medicare payments to providers were tied only to volume, rewarding providers based on how many tests they ran, how many patients they saw, or how many procedures they did, for example, *regardless of whether these services helped (or harmed) the patient* [emphasis added].

Consider this description of “Value-Based Care”, taken verbatim from the [Dartmouth-Hitchcock web site](#).

In the current fee-for-service model of reimbursing providers for health care, physicians and organizations have incentives to 'do" more. *The more tests you order, patients you see, procedures you do, the more money you will make* [emphasis added].

The suggestion that physicians and hospitals would choose to harm patients for money is unfounded and gratuitous but all too typical of government officials and other PPACA fans, many of whom populate the rarified air of academic medical centers. In fact, these aspersions on the motives and character of America’s physicians and community hospitals are blatantly false. They are deliberately intended to defame physicians and hospitals and create public hostility toward them in the process. Here are the facts:

1. Patients, not providers, make the decision to present for care.
2. In community hospitals, the most expensive tests and procedures are not generally performed by the physicians who ordered them and, except for very minor office-based procedures, those physicians receive no payment for those tests.
3. The number of tests and procedures ordered has nothing to do with the DRG payment to hospitals for Medicare patients and generally doesn’t affect payment for care provided to Medicaid patients. In fact, both hospitals and physicians lose money on Medicaid patients.

Except in cases of gross negligence, patients aren’t typically capable of evaluating the clinical quality of care received. However, they can certainly evaluate the service quality that accompanied that care and they can be counted upon to do that with a vengeance. That is precisely why “value-based care” will fail.

“Value-based care” is a rebranded and repackaged HMO model that proposes to reward physicians and participating hospitals to the extent that they avoid treating patients. Limiting care will produce tremendous dissatisfaction among entitlement-minded patients who are paying for mandated insurance and have been conditioned to believe they will receive care.

Supporters of this method are going to encounter a backlash from the public as a result of the cognitive dissonance that their assumptions will produce. After all, if one truly believes that physicians and hospitals are motivated by money to provide unnecessary care, won’t those same physicians and hospitals be motivated by money to withhold necessary care? Perhaps this is a question that physicians and hospitals across the country should be asking their professional and institutional associations.

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