

Value-Based Purchasing

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The rise in healthcare spending is affecting business, government, and individuals. Too often the reaction is to shift large chunks of financial risk to beneficiaries, which lowers cost but can work against the agenda to address the underuse of needed services and better health. Also, the shift does nothing to send price and quality signals to the delivery system. With more use of reference pricing with quality built in, for example, providers who deliver care more efficiently would receive greater market share. This would make efficiency a “business issue” for providers. Although we do not underestimate the challenges of healthcare system reform, change to delivery systems, incentives, and expectations offers a better path to getting more value for healthcare spending.

So often, health plans, providers, and beneficiaries have no good reason to obtain better value. Health plans can have higher revenues if they do less to manage total spending; indeed, new rules limiting profits, administration, and utilization management may reward the plans that do the least to manage spending. As has been amply discussed elsewhere, fee-for-service payment systems to doctors, hospitals, and other providers reward volume over value. Current payment norms also reward specialty care over primary care and procedures over cognitive services, which heavily affects the mix of what is being delivered. Providers that are successful in commanding high fees through market power or cache also are rewarded with higher revenues. Due to the way insurance coverage—both the premiums and cost sharing—is generally structured, the consumer who seeks out more cost-effective care receives no financial reward for doing so. Moreover, there is usually little financial consequence for people who make unhealthy choices; eg, have a poor diet, lack exercise, do not take charge of chronic conditions.

Value-based purchasing offers a set of tools to achieve 2 important goals:

- It pays providers for what consumers want the healthcare system to do, ie, reward value and quality.
- It engage consumers to be sophisticated and knowledgeable users of healthcare and therefore encourages them to do more to improve their health.

We see purchasers—employers and government programs—as being the primary actors for pushing these changes; health plans can be partners. To the degree possible, purchasers

should send consistent signals to plans, providers, and consumers about what they want the healthcare system to achieve. Providers facing different incentives and measures from different payers often have no way to respond effectively. Ironically, if all pile on in a similar direction but in different ways, the signal to noise ratio goes down. Alignment among payers is very important. This does not necessarily mean that every initiative needs to use the same measures and payment methods—innovation is important in this area and we still need to learn more about what works best. But we have seen examples of multi-payer initiatives, eg, the patient-centered medical home, where collaboration among payers has sent a strong signal to primary care physicians, resulting in impressive outcomes.

Specific recommendations include the following:

- **Value-based insurance design.** Aligning cost sharing with value. Cost sharing would be lower for high-value services (eg, maintenance care for chronic conditions) and higher for low-value services.
- **Centers of excellence.** Another example of value-based purchasing is the use of “centers of excellence.” Health plans can use cost sharing to guide patients to high-value hospitals and providers. They can identify hospitals that are centers of excellence for treating high-cost or high-risk conditions, and make them preferred providers with the lowest cost sharing for patients. This approach could also reward hospitals or other providers that have strong patient safety records. The high-value plan of the future should rely heavily on value metrics to select its network. Ensuring that members have access to physicians with good credentials is an important part of consumer protection and of the National Committee for Quality Assurance (NCQA) health plan accreditation. But excellent health plans must also measure the performance of providers. They must use that information to build networks and report the information to consumers.
- **Payment and delivery system reform.** The last 3 years have seen an encouraging trend toward delivery system reform, and away from traditional fee-for-service payment methods that reward volume over value. The growth in the number of practices and providers involved in patient-centered

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medical home programs is a great example of this trend. This growth has been stimulated by the many purchasers—both public and private—that have embraced this effective model of care. Public purchasers include many state Medicaid programs and federal government agencies like the Health Resources and Services

Administration and the Department of Defense. Medicare is following the lead of these types of innovators and making payments for Medicare beneficiaries who see clinicians participating in existing multipayer pilots.

- **Reference pricing.** This strategy steers physicians and patients to the most cost-effective treatments by tying reimbursement for an item or service to the price of the most effective treatment. Less cost-effective treatments are still covered by the plan, but members pay more for them. Reference pricing needs to be done in a way that builds in quality, so there would need to be a quality threshold as well, except for items and services where quality is indistinguishable.

Now that there is a firm start toward delivery system reform made for primary care, the next challenge is building from this model and developing others that include specialists and hospitals. One way is through the accountable care organization (ACO), with Medicare leading development. Other purchasers, including private insurance companies and Medicaid programs, are beginning to experiment with the concept; however, employers are not driving forces in this area. To make it more worthwhile for providers to invest in the systems and other organizational changes needed to run successful ACOs, payers should work together to set the same requirements for ACOs. Based on our experience with the patient-centered medical home, we also recommend that payers go beyond the set of performance measures in these initiatives to include standards that articulate, in clear and unambiguous terms, what program elements are needed to lead to success and can be evaluated consistently. Too often these programs require lengthy descriptions that can be difficult to evaluate and thus not terribly useful.

Another approach for building from the patient-centered medical home is in the “patient-centered home neighborhood” idea, aspects of which the NCQA is building into its specialty practice recognition program. This program is designed to recognize the commitment specialists make to not only coordinate the care of their patients inside their practice

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Although we recognize that implementation is challenging, we recommend a value strategy including market based and regulatory activity rather than limiting coverage for individuals through high deductibles.

- Benefit design and coverage should reward the highest performing providers.
- Purchasing strategies fostering delivery system reform (eg, patient-centered medical home, accountable care organizations) should align into multipayer efforts to get the greatest impact; this does not mean that all the measures and payment methods need to be identical.
- Purchasers should reward the health plans that deliver on better quality and lower costs.

but also to coordinate with primary care providers. Although health reformers have developed more complex payment models with stronger incentives than the simpler versions of the pay-for-performance schemes of the 1990s, rigorous and meaningful measurement is still critical to help both plans and providers focus on what they need to do to be successful and to reassure consumers that any economies achieved will not be at the price of lower quality.

- **Pay for value health plans.** Employers should further the value agenda by awarding higher payments to plans that demonstrate high value. Many state Medicaid agencies have such programs; the Medicare Advantage program has one as well and we are beginning to see early signs of performance increases. Reference pricing can be used for choosing health plans also. This would make the patient pay the difference between the “benchmark plan” based on cost and quality and higher-priced options.
- **Exchanges.** While we support many of the policies regarding health plans in exchanges, we wish there were greater emphasis on using exchanges as a strategy to pursue a value agenda. Apart from a few states, the emphasis seems to be more on operational issues. While this emphasis is understandable, given the enormity of the task, we would like for the pace to pick up on articulating quality measures and encouraging health plans participating in exchanges to participate in statewide delivery reform initiatives. More investment should be made in developing useful measures of value—overuse, misuse, and waste. In an effort to keep subsidies relatively affordable, the benefit packages offered in the exchanges will likely have high deductibles. We encourage both federal and state policy makers to look for flexibility in the law to use elements of value-based insurance design to keep premiums down in place of high cost-sharing requirements. For example, consumers using exchanges could be allowed to reduce the deductible if they agree to get care in a patient-centered medical home, or participate in wellness or care management programs. Plans

and purchasers are developing benefit designs that waive cost sharing for effective services like those measured by the Healthcare Effectiveness Data and Information Set.

- **Medicare physician payment.** As the Congress contemplates permanent changes to the physician payment system in Medicare, now is the time to use the powerful payment incentives in payment systems to motivate better outcomes in quality and cost across all types of physicians. Medicare has taken some steps to rebalance payment in favor of primary care, but more should be done to reward the challenging work of primary care. Medicare should also adopt payment strategies that create incentives for physicians to provide care outside of face-to-face visits, including the work of coordinating care among different providers. Given the upcoming shortage of primary care providers and some specialists, capacity can only grow if the payment system creates innovative ways to deliver care through use of professional teams and through other methods of communication.
- **Price transparency.** We strongly support strategies to make healthcare costs, including prices, more visible to policy makers, purchasers, and consumers, and to create rewards to the consumers who act on this information. We recognize this is not a simple task given the wide variety of payment methods and accounting systems. But as health economists often find that higher prices underlie higher costs, it serves a very important public policy objective to make prices more visible as long as the information is presented in a fair yet meaningful way. Once these systems are built, we support using strategies like tiering and reference pricing to give consumers incentives to choose higher-value (lower-cost and higher-quality) alternatives.
- **Activating patients.** Health plans and the new delivery system entities taking responsibility for patients' care over time and across types of providers should incorporate strategies to improve health and consumer engagement. Examples of these strategies include:
 - Promoting wellness and health promotion through health appraisals and other strategies. Using financial incentives to encourage participation in programs designed to improve health; eg, smoking cessation and weight loss programs.
 - Publicly reporting provider performance and involvement in delivery system reforms.
 - Providing members with incentives like lower copays to use shared decision making to choose therapies.

- Covering palliative and end-of-life care and implementing strategies to ensure that providers know and follow patient preferences and decisions.
- Surveying enrollees about their experiences and how they rate providers. Then, use this information to provide feedback to physicians and construct networks.

None of these strategies alone can solve the problems of poor quality, poor health, and high healthcare costs. But synergies between them will reinforce key policy goals to improve efficiency and results.

All that we have enumerated above are pure “market-based strategies,” but we believe that a number of more classic regulatory strategies would help lower costs without diminishing the value of care. Ideas worth exploring are to simplify administrative systems, crack down on excessively high prices, work to reduce medical malpractice costs by creating safe harbors for high quality providers, and getting rid of barriers that prevent health professionals from practicing at the full scope of their training.

It has taken decades for American healthcare to become the expensive, complex, and often dysfunctional enterprise it is today. While there have been attempts to redesign policy and payment to address some of the major drivers of cost and complexity, they have often been relatively timid and narrow attempts to tweak the system, and have achieved very limited results. Too often, the different sectors that pay for healthcare have worked at cross purposes, sending confusing signals to providers, or allowing costs to be shifted onto other payers or patients. We are at a unique historical moment when the costs of care are a cause of widespread concern, when new and promising models of care delivery are beginning to emerge, and when technologies to engage the patient are affordable and widely available. A comprehensive strategy of value purchasing can align the interests of health plans, providers, and patients to achieve greater value for the healthcare dollar.

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