Will "Value" Help Consumers Choose?

written by Theresa Hush | September 5, 2019

In the emerging days of Value-Based Health Care (VBHC), "value" was defined by quality, cost, and experience of health care for patients—the "Triple Aim." The movement's initial defining goal: patients should be able to access high value health care services that improved outcomes, to get value for their dollars. Likewise, employers and other purchasers deserved similar value for their share of investment in health care benefit plans.

Because incentives inherent in insurance and Fee-for-Service (FFS) payment systems reward volume over value, however, VBHC has also had a subagenda to make value pay for providers. But to reward better value instead, we must first measure it and then provide incentives that will either replace or overcome the disincentives under FFS.

Quality measures—first under PQRS and then converted into MIPS—developed into a complex performance measurement and reporting system. Patients' Consumer Assessment of Healthcare Providers and Systems (CAPHS) survey responses measured satisfaction and patient experience. Cost measures—the most difficult because prices, actual costs, and drivers (such as patient risk) don't easily lead to a cost "standard"—emerged, including monthly/annual cost-per-person and episodic costs of care.

As Value-Based Health Care goes full throttle, it's time to examine whether these intended goals are intact and how providers should set the correct path. Why now? Because evolving VBHC initiatives have the potential to redefine value and create unintended effects. Let's examine the key trends.

Quality Initiatives Are Simplifying and Scaling Back

Quality measurement expanded to more measures and complexity, but never progressed to a much broader focus on health outcomes. Quality performance under VBHC has been more concerned with the inputs and processes that may lead to better health results, but the outcome itself is neither measured nor trended to see if improvement results. So we can't answer whether the product of health care is improved outcomes.

That very unanswered question is the issue behind the outrage over our health care spending nationally, and what we are getting for it—declining life expectancy, high maternal death rates, and health inequities.

In its most recent rule, CMS is proposing scaling back quality measures and easing the reporting burden for providers. There is little argument that the current quality measurement is more complicated and less meaningful than necessary—and doesn't help consumers choose (once a key reason for Physician Compare and quality reporting in general). But we also need to answer the basic question: How do we know that our VBHC will produce a better system for patients, if we are not measuring that in any meaningful way?

Transition to Provider Risk in ACOs and Primary Care Models

The objective to eliminate or modify FFS has become a stronger part of the VBHC agenda for Medicare. The ACO Rule in December 2018 now requires ACOs to adopt downside risk for expenses over targets. Provider Direct Contracting with CMS, introduced this year, will pilot partial or global capitation payment systems, and will expand to include a population-based capitation.

The goal of these programs is to cap costs and ensure that providers are more conscious of the cost of services they are providing.

Cost Transparency Is a Bigger Part of Initiatives

Under Medicare's Quality Payment Program (QPP), including MIPS, Cost was always intended to

grow in importance for achievement of incentives. But concurrent with revision of quality initiatives and more models with downside risk, Cost is taking on an added importance.

Besides pressuring providers to keep costs down, VBHC has placed price transparency as a high priority. But price transparency is not equivalent to enabling consumers to choose among options based on cost, because health care pricing is extremely complex and opaque.

Cost should, in fact, be a front-and-center issue. It's why the VBHC efforts were invented, and we must address the driving issues behind cost that make health care unaffordable.

As we usher in an era of new provider risk and cost disincentives, however, we should also ensure that we protect consumers and patients from the denials of legitimate care, as well as from the bureaucracy that once plagued previous risk-based models of health care. And, we should freshly examine how we should structure cost to help consumers make wise choices.

Asking Essential Questions to Ensure VBHC Will Help

Over the next few posts, we will analyze the direction of current VBHC efforts, and whether those programs can be expected to lead to better value. We will suggest methods for providers to navigate a path to value when regulations seem to be shifting the focus.

> Will consumers be able to identify and access high-value health care services?
> Do quality, cost, and patient experience reflect the current criteria for value?
> Are measures adequate to reflect the criteria, and to see performance?
> What should ACOs and providers do to meet consumer needs for value?
> What are the critical tools providers need to enhance value?

Stay tuned!

Founded as ICLOPS in 2002, Roji Health Intelligence guides health care systems, providers and patients on the path to better health through Solutions that help providers improve their value and succeed in Risk. Roji Health Intelligence is a CMS Qualified Clinical Data Registry.

Image: Dominik Lange