Value-Based Health Care: Cost Reduction AND Quality Improvement

Background

The United States' health care system, with its high costs and relatively poor outcomes, is in dire need of transformation. In 2017, U.S. health care spending reached $3.5 trillion, which amounts to 17.9% of Gross Domestic Product (GDP).[1] Despite spending nearly twice as much as other developed countries, our nation performs less well on many population health outcomes, and the trend continues in the wrong direction.[2] As just one example, between 1993 and 2013, the maternal mortality ratio in the U.S. more than doubled from 12 to 28 deaths per 100,000 births.[3]

Policymakers are understandably invested in lowering our nation's health care expenditures; however, conversations on cost reduction often overshadow the critical importance of addressing quality improvement. While bending the cost curve is crucial, cost containment cannot be the sole criterion of value transformation. It is paramount to ensure care delivery is of high-quality and puts consumers/patients at the center of their care by addressing their needs, goals, and preferences.

The Importance of Considering Quality When Managing Care

The proliferation of managed care in the 1980s and 1990s was intended to slow the growth of health care costs – including out of pocket costs for consumers – through improved utilization management and preferred provider networks. Yet the move was met with fierce criticism from consumers faced with perceived barriers such as prior authorization requirements

[1] https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountshistorical.html
[2] https://jamanetwork.com/journals/jama/article-abstract/2674671
[3] http://documents.worldbank.org/curated/en/937281468338969369/pdf/879050PUB0Tren00Box385214B00PUBLIC0.pdf

and limited choice of providers. Particularly among ill patients, those enrolled in managed care were dissatisfied with access to tests and specialists, as well as undesirable waiting times for care.[4]

The backlash against managed care in the 1990s demonstrated the need to pair cost reduction with quality improvement. Today, value-based payment offers a powerful mechanism to reduce cost and hold providers accountable for quality. The Health Care Transformation Task Force (HCTTF), a multi-sector health care industry organization committed to advancing value-based payment, defines successful value-based payment and care delivery systems as those that incentivize and hold payers and providers accountable for not just cost, but patient experience and outcomes as well. At the federal level, the Center for Medicare and Medicaid Innovation (CMMI) was created in 2010 with the mandate to test innovative payment delivery models that reduce expenditures while *also* preserving or enhancing the quality of care.

What Policymakers Can do to Push Cost Reduction and Quality Forward

Policymakers are actively investigating how best to drive cost reduction. In December, Sen. Lamar Alexander (R-TN), Chairman of the Senate HELP Committee, issued a request for information on specific recommendations to help lower America's health care costs. Specifically, the Committee sought information on concrete steps Congress can take to lower health care costs, incentivize care that improves the health and outcomes of patients, and increase the ability for patients to access information about their care decisions. While strategies to drive quality and improved health outcomes were specified in the RFI as an area of interest, the broader framing remained focused on cost reduction.

Policymakers are in a powerful position to help shape the national and industry dialogue on health care transformation in various ways. Disparate definitions of health care "value" and the asymmetric attention to cost reduction versus patient experience and outcomes highlight the need for alignment on both the definition of value-based payment and care delivery and the ultimate goals for transformation. It is critical that the public and private sectors, including consumer and patient advocates, align on the definition of value-based care to make sure all incentives for stakeholders are pointing in the same direction. The U.S. Department of Health and Human Services (HHS) is in position to lead a public discussion engaging industry and patient

[4] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.15.2.254

stakeholders to define value with a clear emphasis on quality improvement. Private sector thought leaders like HCTTF have significant experience in this space and can add value to this important conversation.

Policymakers can also drive improvements that matter to patients by devoting needed resources to support patient engagement in payment model design, and to developing better quality measures that track patient-reported outcomes and experience. HHS should provide easily accessible options for patients to share questions, concerns, or initiate appeals related to new value-based payment models and be responsive to those needs. Specifically, the Centers for Medicare & Medicaid Services (CMS) should follow through with plans to create an Ombudsman for value-based payment to give beneficiaries a clear and direct channel for providing feedback to CMS and ensure that these models are truly meeting the needs of patients. Additionally, patient-reported outcomes measures (PROs) are crucial to understanding whether health care interventions benefit patients in ways that are meaningful to them. CMS should pursue continued development and testing of these critical measures.

Conclusion

The United States' health care system is fraught with unsustainable rising costs, undesirable health outcomes, and health disparities, but a holistic definition of value-based health care can help by providing a powerful alternative to the current fee-for-service system that incentivizes volume of services over quality. Consumer priorities and engagement strategies should be front and center during all phases of health care transformation, including the design of payment models to ensure that cost-savings are only realized simultaneously with improvements in health and desirable patient outcomes.