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IS A VALUE-BASED HEALTHCARE SYSTEM IN OUR FUTURE?

One of the central themes of the current healthcare reform debate is the need for a value-based system, one that rewards positive health outcomes achieved in a cost- and clinically-efficient manner. While the general consensus is that the current system is broken and a value-based model is part of the solution, such a model raises a number of concerns.

Any system that provides value for patients must focus on improving outcomes through cost- and clinically-effective devices, such as targeted disease-management programs and incentives to encourage medical compliance and preventative care. In the July 9, 2009, *New England Journal of Medicine* (*NEJM*), Michael E. Porter observed that "achieving and maintaining good health is inherently less costly than dealing with poor health." Implementing a value-based system involves many of the following key issues.

Episode-of-Care (EOC) Pricing

EOC is a reimbursement system designed to improve value for patients by aligning the interests of providers, physicians, labs, pharmacies and others. Specifically, under such a system, reimbursement is in the form of a bundled payment, covering all the providers and services related to an EOC. Chronic conditions may be treated as an extended EOC, and would include treatment for related complications. The EOC's collective, team-based approach to care delivery is a stark contrast to our current, nonintegrated, approach, which can lead to excess spending. According to François de Brantes, CEO of Bridges to Excellence, as quoted in *NEJM*, "across all types of episodes, chronic and acute, about 40 cents of every dollar goes toward potentially avoidable complications; and the key to successfully bundling reimbursements for EOCs, is creating the correct mix of incentives, binding together all of the players . . . one option being to have the various stakeholders agree upon a formula based upon the nature of the services each provides for a particular EOC; while another option is for an independent third party to decide how such payment should be allocated." Mr. de Brantes has observed that "payment reform is not sustainable unless we can get consumers to engage in value arbitrage the way they do in all other walks of life," and that we must "find a way to get consumers to shop." Health plans must be incentivized to compete on the basis of value, to measure and report their members' medical outcomes, to emphasize preventive care and to identify members at high risk of becoming sick in the future.

The Role of Employers

Some maintain that employers should be kept in the insurance system, as they have a vested interest in the health of their employees. Others contend that the financial burden on employers has become too great; and that employers may be better served in a system where their contributions to the cost of their employees' health insurance are more clearly defined—in the form of a monetary credit or otherwise—to employees who would then select their own benefit plans, thereby helping to cap the employers' health insurance costs. The issue of controlling costs is tied to improving quality and value for patients. Some have recommended that everyone be required to purchase health insurance, which would prevent certain classes of persons, such as the younger and healthier, from "opting out," thus increasing the amount of revenue flowing into the system and lowering premiums for everyone.

Health Information Technology (HIT)

The consensus appears to be that the primary value of HIT is its ability to measure clinical quality and financial performance and support coordinated care. An HIT must be integrated in order to attain these clinical and financial objectives, enabling providers to clearly understand the clinical and financial data that are a part of measuring the success of any value-based system.

Promoting Better Coordination Between Hospitals and Physicians

Various government and independent projects have emerged, including the Medicare Acute Care Episode project (ACE), a Medicaid children's health insurance program, plus independent pilot projects.

ACE provides global payment for acute care episodes within Medicare fee-for-service and covers all Part A and Part B services, including physician services, for inpatient stays for Medicare fee-for-service beneficiaries. ACE aims to improve quality of care for such beneficiaries and increase collaboration among providers. Under ACE, participating hospitals can reward those who make improvements in certain measurable clinical quality and efficiency standards.

The Medicaid children's health insurance program (CHIP) contains payment incentives based upon access, efficiency, quality or successful outcomes. Independent pilot projects include the program at INTEGRIS Health, the largest healthcare system in Oklahoma. This project, proposed by United Health Care, enabled United, INTEGRIS and certain of its physicians to share gains in the areas of quality, clinical documentation and efficiency of care. By encouraging collaboration in clinical care management, INTEGRIS significantly improved the accuracy of its medical records and verification of medical necessity concerning treatment. INTEGRIS has noted improved follow-up with patients, ensuring patients are complying with medication instructions. Home health representatives follow up with patients post-discharge in an effort to ensure compliance, and any generated surplus is shared among such professionals (*e.g.*, home health agencies or physical therapists).

Promoting Quality as a Means of Increasing Value

Ardent Health Services, a for-profit based in Nashville, Tennessee, has described the following as the underlying principles of its organizational commitment to quality: (i) establishing a link between financial and clinical operations under the theory—according to Ardent's Chief Medical Officer Steve Landgarten, M.D.—that "the highest quality care is probably the most efficient and therefore has a lower cost"; (ii) using evidence-based medical practice as the clinical standard and eliminating so-called "never events," while seeking to improve medication safety and fostering a culture of "attentive compassion"; (iii) collecting quality-related data and measuring it against internal and external criteria; (iv) recognizing clinical outcomes as driving financial results (*e.g.*, incurring costs associated with reducing hospital-acquired infections where the ultimate cost savings may be as much as one year away); and (v) participating in programs to create value-based health centers by ensuring that hospitals and physicians are aligned through global pricing and programs.

Although the healthcare reform debate continues, an inescapable conclusion is that any reform should include some type of value-based system. In light of rapidly rising costs and other factors, the benefits of the value-based system—especially the interrelated factors of quality and cost—are too compelling to ignore.

If you have a question on this material or would like to discuss legal services, please contact us at healthcare@duanemorris.com.

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