



NIHCM FOUNDATION

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August 2008

ESSAYS ON TRENDS, INNOVATIVE IDEAS AND CUTTING-EDGE RESEARCH IN HEALTH CARE

Getting to Value

By Dan Mendelson, President, Avalere Health
and Tanisha Carino, Ph.D., Vice President, Avalere Health

An Indisputable Goal

High health care expenditures and the chasm between what we know to be high quality care and what most Americans receive are motivating new efforts to recognize and reward value in our health care system. Here we review key challenges to achieving value in U.S. health care and offer a vision for the future and the additional steps needed to achieve change.

Where We Are

Four observations characterize where we are in achieving a redesign of our health care system to reward value. First, although there may be basic agreement at a conceptual level as to what constitutes value, there are competing visions on how to measure and encourage it. Second, we lack appropriate data and systems to be able to measure and monitor value. Third, the numerous attempts to pay for value at all levels in both the private and public sectors have been stand-alone with little learning of lessons across efforts. Finally, current efforts mostly focus on narrow and small components of health care rather than redesigning the overall system to reward value.

Stuck at Square One: Measuring Value

Everyone seems to agree that ideal value metrics should encompass both quality and cost. Groups such as the American Medical Association Physician Consortium for Performance Improvement, the National Quality Forum, the National Committee for Quality Assurance, and various physician specialty societies have led diverse efforts to develop, test and endorse performance measures. However, these efforts focus on capturing either cost or quality rather than defining metrics to promote value. A recent white paper jointly produced by Avalere

Health, the National Business Coalition on Health, the University of Michigan, and Pfizer examined employers' ability to assess value in their pharmacy benefits, looking for established metrics that consider both cost and quality. That analysis found that although many measures exist for employers to assess the cost or quality of pharmacy care, only 11 percent of nationally implemented measures capture both dimensions needed to assess value. Further, these measures focus predominantly on the structure of the delivery system and the processes used to deliver care rather than on the outcome that really counts – whether the patient received clinically appropriate services as needed (Figure 1).¹ This finding regarding the paucity of true measures of value is reinforced by a new study from RAND that found the quality dimension to be lacking in virtually all identified measures of efficiency.² Efficiency was almost always measured in terms of cost or expenditure without regard to the quality attained. In short, much developmental work remains to be done to marry quality and cost considerations in unified measures of value.

Limited Data

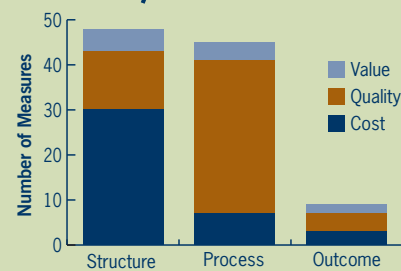
Even when we can define and agree on suitable measures of value, we often lack the data or information systems to be able to implement these metrics. The most meaningful value measures rely on data that reflect achievement of desired clinical outcomes. Such data are derived from medical records, not administrative data. Thus, development and use of electronic health records (EHRs) are vital early steps if we are ever to measure value on a widespread basis. Various efforts are underway in both the private and public sectors to encourage adoption of health information technology (IT) and improve data availability. For

example, the federal government is working to develop uniform standards and certify approved platforms in order to minimize investment risk. In addition, led by HHS Secretary Leavitt, the public and private sectors are experimenting with Value Exchanges, nationally chartered, local collaboratives that promote information sharing, quality and cost reporting, and rewards to providers for high performance. Despite all of these efforts, however, adoption of health IT remains quite low. A just-released survey of physicians found that only 13 percent are using a basic EHR in the office setting and only 4 percent have an advanced EHR that includes decision support and comprehensive order entry.³

Multiple Attempts, Slow Traction

Despite limitations in metrics and data, attempts to measure and pay for “performance” have occurred at state, regional and local levels in both the public and private sectors. At this time pay-for-performance (P4P) efforts typically target hospitals and physician groups and tie some portion of their reimbursement to public reporting of quality (and increasingly cost) information and/or performance based on qual-

Figure 1: Available National Measures to Assess Value in Pharmacy Benefits



Source: Heaton et al., 2007. Used with permission.

ity or other outcome measures. A recent survey identified more than 150 P4P programs nationwide in 2006 sponsored by a mix of government agencies, health plans and purchaser coalitions.⁴ Representing 40,000 physicians and seven health plans covering 12 million lives, the Integrated Healthcare Association in California leads the most significant private-sector effort in which participating physician groups can receive financial rewards based on their performance on quality measures, patient satisfaction and use of health IT.⁵ Medicare also has several program-wide initiatives aimed at rewarding quality measure reporting, such as the Reporting Hospital Quality Data for Annual Payment Update and the Physician Quality Reporting Initiative, and is now using pilot programs to test ways to align reimbursement with actual performance. For example, its new Electronic Health Records Demonstration project will eventually link physician payment to quality improvements achieved through IT use.

These P4P efforts have evolved with some effort to coordinate learning around quality measurement and the design of and experience with P4P programs. However, providers continue to be subjected to multiple variations of P4P programs sponsored by different payers. To address this confusion, groups such as Bridges to Excellence and Leapfrog Group have developed national P4P models that streamline quality measurement and data collection. Additionally, the Ambulatory Care Quality Alliance (AQA) and the Hospital Quality Alliance (HQA) are collaborating to further the development and reporting of quality and cost measures and to bring better national coordination to the diverse efforts currently underway. Because the AQA and HQA are very broad coalitions of affected stakeholders, this combined initiative holds promise for producing a more unified and comprehensive approach to value-based purchasing.

The proliferation of P4P programs has built a foundation and potential infrastructure for implementing value-based purchasing. Over time, these programs will transition to reward value as the payment paradigm shifts and the availability of meaningful value metrics increases. However, we still need to create a continuous learning platform to inform both public and private sector P4P sponsors and measure developers on the best ways to implement and streamline P4P nationwide.

Focusing on the Margins

Finally, many discussions of gaining more value in health care predominantly focus on

narrow components of the system – namely, new medical technologies. Researchers point to the rapid diffusion of technologies as a major driver of health care expenditures in the U.S. Recent proposals to boost federal investments in comparative effectiveness research are intended to address this technology growth by assessing the relative merits of different treatments for the same medical condition or within the same drug class. Similar efforts have been seen at the state level.⁶

In an attempt to improve the value of its spending, the Medicare program has also experimented with coverage with evidence development (CED). CED limits Medicare payment for potentially beneficial, but unproven, technologies to patients for whom they believe the intervention would be most valuable, while requiring the collection of additional information. Prime examples of CED are Medicare's previous coverage of lung volume reduction surgery for emphysema patients enrolled in a randomized clinical trial of the surgery and its policy to cover the off-label use of chemotherapy agents for colorectal cancer in clinical trials sponsored by the National Institutes of Health.⁷ Private payers have followed suit, such as the collaboration between General Electric and UnitedHealthcare to evaluate a novel therapeutic approach for uterine fibroids.

These efforts are an attempt to improve the value we get from medical technologies. However, they are early and largely unevaluated. Although CED is an important component of value-based thinking, policies narrowly focused on technologies can ignore the need to identify alternative approaches to organizing and delivering care – the area of focus most in need of attention if we are to achieve overall value in our health system.

Where We Need to Go

So, what can we do at this point to help create a value-based health care system? As with any challenge to change the current paradigm, progress will be incremental and will occur at many different levels.

First, there must be measures of value that are viewed by all stakeholders as fair, objective, patient-focused and relevant. Second, we must move toward more robust information collection methods and common approaches to measuring and reporting the performance of the health care system as a whole, as well as the value of specific technologies, providers and delivery systems. These data systems and measures must be treated as a public good and support-

ed by federal and state funds. Third, we must realign existing financial incentives to promote value to patients. Continued experimentation with methods to achieve value needs to continue in both the public and private sectors and should be supported and carefully evaluated. In many ways, private managed care plans are further along in achieving value in health care through their experience with various approaches to care coordination, disease management, pay for performance, and value-based insurance designs. Their learning should continue to inform other parts of the health care system.

Finally, the federal government must continue to provide strong leadership. As the largest payer of health care, the government can leverage its entitlement programs to bring together all stakeholders in defining and measuring value. It can also move forward in implementing and expanding current Medicare value-based purchasing initiatives, as well as providing leadership for the creation of Value Exchanges. In addition, the federal government is in a unique position to broker information sharing and continuous learning across all stakeholders interested and impacted by P4P programs. By taking careful stock of where we are and where we need to go, we can ensure that advancements toward value in health care will continue to be made at every level. ■

- 1 Heaton E, Fendrick M, Chernew M, White D, Peretto E. "Assessing Value in Pharmacy Benefits: Do Employers Have the Right Tools?" November 2007.
- 2 "Health Care Efficiency Measures: Identification, Categorization, and Evaluation." AHRQ Publication No. 08-0030, April 2008, Agency for Healthcare Research and Quality:Rockville, MD. <http://www.ahrq.gov/qual/efficiency/>. Accessed June 12, 2008.
- 3 DesRoches CM, Campbell EG, Rao SR, et al. "Electronic Health Records in Ambulatory Care – A National Survey of Physicians." *The New England Journal of Medicine* 359:1 (2008) 50-60.
- 4 Med-Vantage. "Provider Pay-for-Performance Incentive Programs: 2006-2007 National Study Results". December 2007. <http://www.medvantage.com/Pdf/National%20List%20of%2020062007P4PProgramswit hEnrollment123107.pdf>. Accessed May 12, 2008.
- 5 "Increased Use of Information Technology by California Physician Groups Supports Better Quality of Care." Integrated Healthcare Association. Press Release. July 23, 2007. http://www.iha.org/Year4_2006_P4PResults_vfinal.pdf. Accessed November 15, 2007.
- 6 Padrez R, Carino T, Blum J, Mendelson D. "The Use of Oregon's Evidence-Based Reviews for Medicaid Pharmacy Policies: Experiences in Four States." Kaiser Commission on Medicaid and the Uninsured. May 2005. Available at http://www.avalerehealth.net/research/docs/Oregons_Evidence_Based_Reviews.pdf.
- 7 Carino T, Sheingold S, Tunis S. "Using Clinical Trials as a Condition of Coverage: Lessons from the National Emphysema Treatment Trial." *Clinical Trials* 1:1 (2004) 108-21, and Carino T, Williams RD, Colbert AM, Bridger P. "Medicare's Coverage of Colorectal Cancer Drugs: A Case Study in Evidence Development and Policy." *Health Affairs* 25:5 (2006) 1231-39.