Value-Based Purchasing Versus Consumerism: Navigating the Riptide

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A riptide occurs when seawater beneath the ocean's surface surges in the opposite direction of the waves. This can cause violent disturbances, sinking ships and drowning inexperienced swimmers. A swimmer's instinct when encountering a riptide is to swim against the undercurrent and head for the more visible waves, but that instinct is deadly; the best strategy is to swim with the undercurrent. A riptide is cutting through the US healthcare system today, and the hazards for policy makers, purchasers, providers, and consumers are just as real as for swimmers caught in the undertow. We must proceed carefully as instincts are sure to fail here as well.

Underneath the waves of the Affordable Care Act (ACA) is a less visible current, but it is every bit as powerful: the expanding surge of consumerism. In some key respects, the ACA and consumerism flow with enormous strength in opposite directions. The ACA aims to incentivize providers to better manage care; meanwhile, consumerism calls for patients to better manage their own care. Neither movement is perfect, but we would be wise to learn to navigate both.

Managed Care and the ACA

One breakthrough of the ACA is its realignment of Medicare payment systems.[1] Provisions in the law move the US healthcare system away from fee-for-service payments that reimburse volume of services toward payment structures that recognize value. Medicare is the largest single purchaser of health services,[2] so even incremental shifts in its payment policy reverberate dramatically in the larger healthcare economy—and the changes in the ACA are hardly incremental. The law changes Medicare payment with 2 primary strategies: 1) tying hospital Medicare reimbursement to performance on key quality and safety metrics; and 2) establishing accountable care organizations (ACOs)—coordinated groups of hospitals, physicians, and other providers such as nursing homes that agree to hold themselves collectively accountable for how well their patients fare.[3]

Penalties and incentives for hospitals began in 2012 when CMS began linking a small percentage of Medicare payment rates to hospitals' rates of readmission. In 2014, additional incentives were added for patient safety performance. These have had some impact on hospitals, with readmission rates declining slightly and some evidence of progress on patient safety.[4]

Over 600 ACOs are now in existence—most with the opportunity to earn bonuses from Medicare for achieving better outcomes for patients. Medicare rates are adjusted according to a provider's overall record of achieving quality and safety goals for all their patients. Setting such standards is a highly politicized process overseen by the nonprofit National Quality Forum (NQF).[5] NQF's talented and diplomatic staff convenes stakeholder meetings to hash out which measures should be recommended for use in Medicare's incentives programs. Debates are frequently contentious, but the goal is to build consensus among purchasers, consumers, and providers on which measures ought to determine eligibility for incentives or penalties.

All of this points to a rapid acceleration of value-based purchasing. Just last month, HHS Secretary Burwell made a major announcement[6] on the administration's goal to tie 50% of payments to value by 2018.

With this shift, the dynamics of the marketplace have changed, and many private sector purchasers are quickly moving to align their own benefits programs with value as well. National and regional health plans have expanded payment incentives and pay-for-performance clauses in provider contracts, and purchasers are increasingly demanding use of narrow networks, centers of excellence, and other initiatives that reward providers for delivering high-value care. A study by Catalyst for Payment Reform[7] found that the percentage of payments tied to value increased from 11% in 2013 to 40% in 2014. Most of the payments reward higher-quality performance, and only rarely do they penalize poor performance, but the rapid movement signifies at least some shift away from fee-for-service and its perverse incentives.

Consumerism

Value-based payment policies, whether made by the public or private sector, usually pay providers a rate based on the value they deliver overall to a designated population. They typically do not customize payment for each patient or each encounter; one patient may have a bad experience, but the provider gets paid the same rate anyway.

By contrast, the consumerism movement personalizes healthcare decision making and payment determinations. Theoretically, the patient picks the provider, pays, and then judges the quality of the encounter. If he or she decides a provider delivered substandard care, they don't go back. The quality of the encounter is not determined by stakeholder consensus.

The movement for consumerism is the undercurrent of our riptide—less prominent than the ACA, but powerful nonetheless. Employers and other purchasers are quietly but rapidly moving to offer employees high-deductible health plans (HDHPs)—also called consumer-driven health plans. One in 5 American workers is now covered by an HDHP coupled with a tax-protected savings account, and many more Americans are covered by high-deductible plans without the savings.[8] These plans differ from PPOs and other traditional plans in that virtually every dime of expense before the deductible is met is covered by the consumer. When people pay the full bill, the theory goes, they become savvy consumers, intent on finding the right care at the right price.

When the subject of HDHPs comes up, furious debate often ensues about the merits of consumerism. Some point to research showing that these plans cause certain consumers to forgo needed care,[9] and others argue that consumer demand drives innovation in healthcare delivery. Harvard's Regina Herzlinger, one of the founders of the HDHP model, believes that consumer engagement motivates providers to innovate in setting prices and delivering care that appeals to consumers.[10] Either way, the point is essentially moot because HDHPs are here to stay and are growing rapidly in prevalence.

Already, the healthcare industry[11] has responded dramatically to the influence of HDHPs. More and more employers and policy makers are calling for price transparency—a term literally unheard of before 2011 or so. Massachusetts enacted legislation last year requiring disclosure of pricing to patients within 24 to 48 hours of the visit.[12] As patients pay their bills, providers see them in a new light: as customers. Many hospitals and systems are increasingly focused on improving patient experience and delivering care through a more patient-centered approach. Even a new job category has been created—the "chief experience officer"—reflecting hospitals' growing recognition that patient experience is a business imperative.

Former CMS administrator Don Berwick, by no means a proponent of HDHPs but one of the country's most eloquent advocates for patient empowerment, says: "I have come to believe that we—patients, families, clinicians, and the healthcare system as a whole—would all be far better off if we professionals recalibrated our work such that we behaved with patients and families not as hosts in the care system, but as guests in their lives. I suggest that we should without equivocation make patient-centeredness a primary quality dimension all its own, even when it does not contribute to the technical safety and effectiveness of care."[13]

As Berwick puts it, patient-centeredness is a goal in and of itself. Whereas value-based purchasing relies on the judgment of policy makers, consumerism lets each patient judge whether they received value or not.

Pros and Cons of Both Movements

Letting patients decide for themselves when care is high quality and putting the wishes of the patient at the center of care both sound appealing, but the advantages are not universal. Sometimes consumers are wrong about good care—as highlighted most recently by this country's measles outbreak. Despite overwhelming scientific evidence that vaccines are safe and effective, many parents declined to vaccinate their children. Ironically, outbreaks of measles and other vaccine-preventable diseases have occurred most seriously in geographic pockets of the country with a higher proportion of well-educated, active healthcare consumers.[14]

On the other hand, value-based payment is far from perfect either. In many respects, ACOs are the offspring of health maintenance organizations (HMOs) and other managed care models that were popular—and then shunned—in the 1990s. HMOs often shifted risk to providers, who were expected to manage patient care and get paid for outcomes, not volume of services delivered. In some

managed care programs, utilization managers oversaw care and on occasion overruled physicians. The backlash against 1990s-style managed care was severe.[15] Newspapers were filled with accounts of women discharged from the hospital within hours of giving birth ("drive-by deliveries") and bureaucrats denying what was purported to be lifesaving treatment. In many cases, these media accounts were overblown or inaccurate, but it didn't matter. Employers fled from HMOs, not wanting to alienate employees or appear to be cutting their costs by rationing employee care.

Yet, despite sharing many principles with HMOs, proponents suggest ACOs will avoid a similar backlash because things are different in the 21st century. Zeke Emmanuel, one of the ACA's leading voices, explained that unlike in the 1990s, we now have more data, more experience with integrated care, more guidelines to draw from, and more quality metrics. We also have access to electronic medical records, which improve coordination of care for the benefit of patients.[16]

While there is no doubt that we have advanced significantly in our ability to measure and track quality, we are not even close to where we should be. Despite hundreds of millions of taxpayer dollars invested to help hospitals to advance in electronic records, less than 60% are wired to date.[17] Measurement and quality improvement have evolved, but public reporting remains in its infancy and actual performance continues to lag.

Even if performance data could be readily accessible, there remains a fundamental philosophical question: who gets to decide what constitutes good quality? In traditional value-based purchasing, excellence is decided by the health plan, the doctor, the federal government, or some kind of political consensus. Patient experience may have a vote, but individual patients do not decide for themselves. Ultimately, from a patient's point of view, the idea that anyone except you decides what defines acceptable care is disconcerting.

How to Navigate the Riptide

The goal of managed care is for providers to manage patients better. The goal of consumerism is for patients to manage their own health better. The idea that consumers should be pure "shoppers"—deciding for themselves what is appropriate and how much to pay—is problematic because they can be wrong. Moreover, there are legitimate concerns about whether consumers will forgo urgently needed care when they pay the price out of their own pocket. Finally, the transition to consumerism puts enormous pressure on vulnerable patients to navigate an opaque health system and somehow assert their demands. It is tragically unfair that the least powerful player in healthcare—the patient—is expected to singlehandedly transform the entire system.

Despite the drawbacks of consumerism, all of managed care's vulnerabilities are accentuated by the consumerism undertow. When a consumer pays thousands of dollars out of their pocket, they are less willing than in the past to stomach interventions by care managers deciding what is right for them, and if they experience safety and quality problems, they are not interested in the opinion of Washington stakeholders on whether or not that problem was important.

In this environment, consumer engagement is not a sideline PR tactic, but rather critical to business survival no matter where you stand in the policy debate. Instead of ignoring the consumerism undertow, or worse, fighting against it, policy makers, providers, and purchasers are wise to swim in its wake. The time has come for healthcare to apply the techniques other industries use to appeal to their customers. That means the transition to value-based care must pivot on building consumer trust. Providers must demonstrate that they achieve value standards as defined not only by the value-based payers, but also by what their own patients individually demand. To get there, providers must incorporate patient feedback into every aspect of their operations so they can understand consumer perspectives in real time.

Most of all, the answer is transparency. In our market research at The Leapfrog Group, consumers react with alarm when they are told that certain hospital performance information is not publicly reported; they do not trust institutions that hide data. Indeed, the transparency imperative is so compelling that many new stakeholders are coming to the table, as evidenced by a recent white paper by the multi-stakeholder National Patient Safety Foundation, boldly calling for transparency in every aspect of healthcare.[18] As patients transform into shoppers and face the daunting task of navigating an opaque and intimidating healthcare system, health leaders that impede or ignore them will incur their wrath, which will have real market consequences. On the other hand, those that light the path of consumerism with transparency and trust will thrive. That is how to survive the riptide.

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