AHCCCS Payment Modernization
Blog # 7

Pay for Performance

March 18, 2015

The need to move to value based payment (VBP) models has become widely accepted. It is a central focus of AHCCCS Payment Modernization, Medicare targets set by CMS, and for many commercial payers. Much of the growth on the VBP model risk continuum has been with Pay for Performance (P4P) arrangements. However, some question whether P4P is effective in improving outcomes and/or reducing costs. Whether VBP goals are met depends on how value based payment is defined and measured.

Some research on the impact P4P has on outcomes shows mixed results, exemplified by a recent 30 day hospital mortality study. Other researchers state that the impact which a P4P arrangement has on outcomes varies by variables such as physician selection. Still others posit that the problem with many P4P arrangements is their design structure; they encompass all patients meeting a certain criteria such as a care setting, when in fact the focus should be on high risk patients in those settings.

In a 2013 Harvard Business Review [HBR] article, P4P arrangements are criticized because they do not address flaws in the fee for service system, and

> *Because nearly all of the evidence comes from programs that reward quality, we know almost nothing about whether pay-for-performance can improve efficiency or lower cost.*

Catalyst for Payment Reform (CPR) CEO Suzanne Delbanco concurs

> *While pay for performance has led to some positive movement on quality, the evidence shows it is not the most effective way to rein in costs.*

Ultimately, the question is does P4P drive value? How is “value” defined? What are providers really being incentivized to achieve? Since “quality/outcome” is 50% of the value equation, others question the impact of P4P without fully understanding what is being measured as the basis for incentive payment.

As Dr. Delbanco states

We need to measure our progress carefully and really understand if these value-oriented payments are aptly named.

What Is Value and How Is It Attained?

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The general consensus around the need to move to value based payment (VBP) structures does not mean there is consensus on how to measure value, let alone how to achieve it. As noted in the discussion of P4P, identifying how to identify the quality measures which lead to value is a work in progress. Even more basic, is the challenge of defining the two components of value-cost and outcome.
Michael Porter believes that "value"

> *is defined as the health outcomes achieved that matter to patients relative to the cost of achieving those outcomes. Improving value requires either improving one or more outcomes without raising costs or lowering costs without compromising outcomes, or both.*

He and others believe that the critical element to transforming to value-based health care must be on achieved patient outcomes, and this can only be achieved by providers re-orienting the structure of care delivery organized around the patient. For example, care would be systematized around medical conditions, not medical specialties; outcome measurement would be around metrics which are important to patients (e.g. foot amputation rate versus A1c measures for persons with diabetes). He acknowledges how difficult this transition is given

> *the prolonged period under which providers will work under multiple payment models.*
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> but
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> *If providers can improve patient outcomes, they can sustain or grow their market share. If they can improve the efficiency of providing excellent care, they will enter any contracting discussion from a position of strength. Those providers that increase value will be the most competitive.*

On the cost side of the value equation, Porter advocates time-driven activity-based costing, TDABC. He believes that cost

> *refers to the total costs involved in the full cycle of care for the patient's medical condition (or for his or her primary and preventive care), not just the costs involved in any one intervention or care episode.*
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> and
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> *Understanding true costs will finally allow clinicians to work with administrators to improve the value of care.*

Porter strongly promotes bundled payment. Key to this is the concentration of condition based care in fewer locations.

> *Less complex conditions and routine services should be moved out of teaching hospitals into lower-cost facilities, with charges set accordingly. There are huge value improvement opportunities in matching the complexity and skills needed with the*

resource intensity of the location, which will not only optimize cost but also increase staff utilization and productivity.

Others would drive the transformation to value differently. A panel of experts was assembled last year in a symposium titled Sustainable U.S. Health Spending: The Quest for Value. Some focused on the method of provider payment as the critical element to achieving a value based system, while others agree in theory with Porter but question the amount of time it would take to achieve his vision. Other experts place considerable focus on the need for actionable data and appropriate analysis of the data as the critical factor to improved outcomes at lower cost. Still another critical piece of the drive toward value is the patient experience and engagement. In a recently released CMS study

Hospitals with discharged inpatients reporting greater positive experiences as measured by HCAHPS scores had lower-than-expected costs associated with admissions and 30-day post-discharge care…

While there is disagreement about how to define and achieve value, perhaps no one has defined it succinctly as Warren Buffet:

Price is what you pay. Value is what you get.

If you would like to read **even more Michael Porter**, here's another article on Why Health Care Is Stuck

Why has it been so hard for health care organizations to improve outcomes and efficiency, despite their best intentions? With so many good, smart people working so hard? With patients' needs so obvious and so compelling? And with such deep societal concerns about health care spending? The answer is complex, but the result is clear: progress in health care has been all but paralyzed by self-reinforcing barriers to change.