



No, value-based payments aren't doomed

By Bruce Hamory, M.D. | July 20, 2017

Value-based purchasing programs are designed to address the “perverse” incentives of the traditional fee-for-service payment model. They prioritize quality over volume, penalize practices with high costs and utilization – and reward physicians and hospitals for achieving the best possible outcomes at the lowest possible cost.

But are the rewards enough to make value-based care a success? In a recent essay, Paul Levy, the former CEO of Beth Israel Deaconess Medical Center, argued that value-based payment models are doomed to fail because they, themselves, are built on a perverse logic; the rewards are often too minor and delayed to effect substantive changes in behavior.

I disagree.

The major weakness of the value-based care approach is not in design but in execution. In most cases where we see slow uptake of value-based practice patterns and only a modest (or no) impact on cost and utilization, it's not the model that is to blame, but how it is implemented.

A tale of two PCMHs

The results of the Pennsylvania Chronic Care Initiative (CCI) illustrate the importance of execution. The CCI was a multi-payer collaborative initiative involving public and commercial payers. It was designed to train primary care practices in the primary care medical home (PCMH) model, and it provided support to 171 practices treating over 1 million patients. Its first phase ran from 2009-2011.

The program was divided into four regions, one of which was centered around the Philadelphia area. Under that region's pilot program, participating practices received a \$1.50 monthly payment per patient to be used for care manager salaries, and another \$1.50 payment per patient for other practice transformation costs.

Practices that lowered total annual spending and met certain performance measures also were eligible for bonus payments. At the conclusion of phase 1, participating primary care practices saw their performance on quality measures rise. But they did not see significant changes in utilization or cost of care.

In contrast, practices participating in the Northeastern Pennsylvania region had a similar payment structure, but statistically significant better performance on several quality measures. And, unlike their peers in the Philadelphia area, they also saw reductions in hospital, emergency department, and specialist use. By the third year, participating practices reported lower hospitalization rates (8.5 vs. 10.2 patients monthly per 1,000 patients) and fewer ER room visits (29.5 vs. 34.2 patients per 1,000).

What was the difference? A study examining the initiative noted that both programs had the right incentives in place.

But in the Northeast, primary care practices also were provided with on-site RN case managers to work with their most complex patients; near real-time data on specific patients and their needs for care; and monthly meetings with case management staff to review that month's activities and discuss what could have been done differently.

In other words, those practices invested in operations and data visibility, and made sure every participant had the tools and knowledge to succeed.

Preparing for change

Whatever happens with this next phase of health reform, value-based payment is here to stay. But the onus is on hospital and practice leaders to set up the conditions for the model to work. These programs require a grasp of the continuum of changes required for change; a commitment from leadership to stay the course, despite the occasional discomfort of those changes; and clinicians' active engagement in the process of change.

So Paul Levy is right: Simply putting a value-based purchasing program in place will not achieve results. Asking a physician to change practice behavior – performing fewer interventions, or recommending more lifestyle changes – will rarely achieve the results desired if the clinician does not have the motivation, knowledge, and appropriate tools (from information technology to a re-trained staff).

But when executed properly, redesign of the primary care practice can result in a markedly improved experience for the patient, more job satisfaction, and joy in practice for the physician and staff. The result is better practice economics – and better care.

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