

Is the Move to Value-Based Care More Than Managed Care Redux?

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Medicare, Medicaid, and commercial insurers have committed to moving health care reimbursement from a fee-for-service system to a fee-for-value paradigm. Although this push for increased value is not new, the tools used to achieve this goal must change. This commentary will describe this evolution and will contrast prior quality and cost management approaches with those being implemented by health care systems today.

Those who cannot remember the past are condemned to repeat it.

George Santayana

There are many physicians, health care providers, and business professionals in North Carolina who can recall the early days of managed care. At the same time, some younger physicians may think that the health care system has always been the way it is now. I have had the unique opportunity to have been actively involved in improving quality and reducing health care costs through different eras: from participating in some of the first managed care plans while a resident at Duke; to working with Kaiser Permanente, where I spent my early career; to participating in Blue Cross and Blue Shield of North Carolina, when the pendulum began to swing away from the so-called “mother may I” version of managed care (eg, burdensome authorizations and coverage determinations); and now as senior medical director for Duke Health’s clinically integrated network and Medicare Shared Savings Program. I see many common threads from the early days to the present, but I believe we have also learned much about how we can do things better. Today’s move to value-based care and payment presents real opportunities for providers in the health care system.

Health insurance companies have existed in the United States since the mid-1800s. In their early days, they struggled with high costs of administration and opposition from organized medicine, labor unions, and employers; many companies went out of business by the early 1900s. Not-for-profit Blue Cross and, separately, Blue Shield grew during the second quarter of the 20th century and had more than 6 million subscribers by 1940; other for-profit commercial health insurance companies had another 3.7 million subscribers.

Kaiser Permanente rose out of the prepaid practice of

Dr. Sidney Garfield, who offered prepaid health care to 5,000 workers building Henry J. Kaiser’s Grand Coulee Dam. Kaiser Permanente expanded from there into a comprehensive prepaid health care system with a defined network of doctors and hospitals, and this system grew alongside traditional Blue Cross and Blue Shield indemnity offerings.

From 1950 to 1970, health expenditures grew from \$12.7 to \$71.6 billion per year (4.5% to 7.3% of gross national product) driven by improvements in technology and medical science, a shift from mortality due to infectious disease to death from chronic illness, and growth in the medical-industrial-research complex and academic medical centers. Medicare and Medicaid came later to address disparities in availability of insurance for retired elderly persons and low-income individuals [1].

In 1970, a health maintenance organization (HMO) modeled after Kaiser Permanente was proposed to help solve the issue of excessive costs in Medicare and Medicaid. President Nixon noted that, “the traditional system ... ‘operated episodically’ on an ‘illogical incentive’ encouraging doctors and hospitals to benefit from illness rather than health” [1]. The HMO Act of 1973 required businesses with 25 or more employees to offer at least one HMO as an alternative to conventional insurance; HMOs had to offer a long list of comprehensive services well beyond those of traditional indemnity plans [1].

Kaiser Permanente plans had clinical guidelines for physicians to use as they delivered care, but the list of services that required official authorization was quite a bit smaller than is typical for a commercial plan. However, other insurers entering the prepaid health care business resorted to various constraints to manage the rapidly growing costs of health care. Those constraints included utilization management, case management, pharmacy benefit management, and managed care-style contracting. Contracts included terms such as partial- or full-risk capitation for provider groups. Restricted provider networks were also prevalent; providers in such

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networks exchanged lower fees or capitation rates for in-network status and larger patient volume. The large dip in the rate of health insurance premium increases seen from the late 1980s through the mid-1990s (see Figure 1) demonstrates the impact of these techniques as well as significant competition between insurers in the marketplace.

Not unexpectedly, a backlash occurred in the late 1990s and lasted through at least the next decade, with both consumers and employers rejecting the stifling techniques of many managed care companies. Desire for broader networks and greater provider choice led to preferred provider organizations (PPOs) and point of service (POS) plans, and less price competition increased unit costs for services. Reduced utilization management requirements—no authorization requirement for specialty care referrals and reduced prior approvals for services—increased use of services. Together these led to a resumption of rapid increases in the cost of health insurance premiums; these increases were initially born by employers, but they then shifted to employees and their families in the form of higher premiums, increased copayments, higher deductibles, and higher out-of-pocket maximums.

In the late 1990s and early 2000s, employers and insurers tried some new tools. These included high-deductible health plans and health savings accounts which required the employee and family to take responsibility for a significant amount of their upfront health care costs, with the hope that they would become more cost-sensitive in their purchasing

decisions. Unfortunately, the tools that would allow them to shop responsibly were slow to develop. Although these plans reduced the costs to the employer by shifting some costs to the employee through the high deductible, they did not have much impact on total health care costs. Alarming, there is emerging evidence that they resulted in a reduction in the use of preventive services and chronic illness care [2].

Another strategy employers can use is to self insure their employees; in this case, employers are at risk for their employees' health care costs, and they use a third-party administrator to process claims. I refer to this as the "Lake Wobegon" option; each employer thinks his or her employees are healthier than average and believes that self-insuring will allow the company to avoid bearing the cost from other employers in the risk pool whose employees are less healthy. Although self-insurance may indeed work for employers whose employees are actually younger and healthier, it does nothing to abate the rising costs of health care across the whole marketplace.

All of this history brings us to where we are today: the era of the provider. Insurers have struggled to bend the cost curve, and they are now looking to providers to help them with this problem. Value-based contracts—where providers are rewarded based on maintaining or improving the quality of care while reducing the upward cost trend—are the next wave of change. Note that I did not suggest the goal of reducing the *absolute* costs of health care, as most believe this is unobtainable.



Many of the assumptions built into this new paradigm are true. First, fee-for-service (FFS) health care does have the potential to create perverse incentives in which providers are rewarded for delivering poor-quality care, resulting in readmissions and additional services. Second, providers need to invest in additional infrastructure to better manage patient care outside of routine office visits, for which they are not currently compensated via FFS payments. Third, providers are closer to patients and are better positioned to influence patient behavior, such as adherence to treatment recommendations and avoidance of unnecessary care. Fourth, health care providers, like those in any other service industry, should be held accountable for the quality, customer experience, and cost of the services they provide.

Unfortunately, there will be some trade-offs in this new era. As patients and providers are learning to better manage the health and health care of a population of patients, narrow insurance provider networks are becoming more prevalent. Narrow networks are smaller networks of physicians and hospitals in which subscribers' choice of providers is reduced in return for provider pricing concessions and improved coordination of care with resulting lower consumer premiums. On the positive side, this allows the provider organization to have a higher likelihood of managing the population of patients throughout the enrollment year. This also allows insurance companies to competitively bid between large provider organizations, leading to some downward pressure on prices. On the negative side, this has resulted in some patients having to change physicians if their personal primary care or specialist physician is no longer in their insurance company's network.

Another trade-off is the potential for this movement to generate additional consolidation within the provider sphere. In order to take accountability for the total cost of care of a population of patients, that population must be of a reasonable size to avoid large fluctuations in cost and use of services based on random variation. It is also reasonable to expect that providers who are given responsibility to manage cost and quality will want the components of their health care system to be under their influence or control. The move of large health systems to acquire home health companies, rehabilitation facilities, multispecialty practices, and primary care practices is thus expected. Consolidation of large health systems to include such components can facilitate the use of a single electronic medical record system and alignment of incentives with regard to shared savings or losses. However, that same consolidation has been shown to be part of the problem: the larger the size (market position) of the health system bidding for care in a given marketplace, the higher the prices. A report by the Massachusetts Attorney General states, "Price variations are correlated to market leverage as measured by the relative market position of the hospital or provider group compared with other hospitals or provider groups within a geographic region or within a group of academic medical centers" [3].

Provider organizations now have a historic opportunity to take a leadership role in the delivery of high-quality and higher value health care. At this fork in the road, we can decide to repeat the past—farm out to care management companies the traditional job of managing care through case management and utilization management—or we can take on the hard work of doing this ourselves. To be successful, providers will need better and different analytic capabilities and tools, different types of staff taking on new roles, and collaboration across the components of the health care system. For example, we will need to develop a better understanding of who our highest-risk patients are and how we can intervene to improve their care and avoid unnecessary emergency room and hospital visits. We will need to reorganize our clinics and hospitals to include resources such as clinical pharmacists, care coordinators, and case managers. We will need better communication between specialists and primary care physicians. We will need to use alternative modes of communicating with patients and each other.

We also need to work to understand the previously unexplained variation in how providers deliver care to patients. Better measurement of both outcomes and cost of care will provide better insights into improving the quality and efficiency of care. Beyond what insurance companies are doing to tier their networks based on relative cost and quality, provider organizations need to understand what disease states and types of services are driving variation and should adopt best practices for managing such variation. While each patient is unique and we must maintain the flexibility to treat each patient as an individual, we also need to be willing to scrutinize what we do more closely. Do the tests we order change the outcome of care? Are we unnecessarily duplicating services? Are we communicating with each other to better serve patients both during and outside the traditional office visit? If we address all these questions, I believe physicians stand a better chance of bending the cost curve than do health insurance companies. And, by doing this ourselves, we can avoid some of the administratively burdensome requirements of the early version of managed care. Whether or not the era of the provider will be managed care redux is entirely within our control. **NCMJ**

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