Pursuit of value-based health care is now the aim of health policy in the United States. But caution is needed to avoid affirming Winston Churchill’s perspective that “you can always count on Americans to do the right thing—after they’ve tried everything else.”

The world’s largest insurance program, Medicare, has announced its move to pay for performance and its evolving value-based purchasing initiative. But key to its ultimate success is moving to reward outcomes—beyond the notion of simply rewarding providers who complete a predetermined set of process items, such as giving aspirin to heart attack patients.

According to Michael Porter, one of the world’s leading management thinkers, “Most pay for performance is really pay for compliance.” He elaborates in a recent *New England Journal of Medicine* article: “Since value depends on results, not inputs, value in health care is measured by the outcomes achieved, not the volume of services delivered, and shifting focus from volume to value is a central challenge.” These are important distinctions that Medicare, other insurers, and providers need to address.

Value can be defined as *patient outcomes divided by total cost per patient over time*. What we need are financial incentives and rewards for providers who actually deliver good value, yet we must be careful to guard against unintended consequences of Medicare’s present pay-for-performance and value-based purchasing schemes. For example, assume that medical centers receive a 5 percent financial bonus for completing a set of predefined processes. Then, take the actual experience of two teaching hospitals in urban California. The outcomes and costs of the two medical centers are quite different: Medical Center A’s Medicare case-mix-adjusted mortality rate is 43 percent better than expected, while Medical Center B’s is 12 percent worse than expected. Using cost data for Medicare patients in the last 6 months of life, Medical Center A’s cost is $37,000 per patient, while Medical Center B’s is $62,200 per patient. Thus, Medical Center A has better outcomes and significantly lower costs, thereby providing better value. Nevertheless, both will receive the 5 percent bonus for achieving process items. The lowest-value medical center will receive a $3,110 financial bonus vs. the $1,850 bonus for the higher-value medical center—a greater reward for the lower-value provider.

Why do we seem to have such a problem in truly moving to pay for value? A big part of the issue relates to how the United States has tried to control cost—through re-
restrictions on payment rates for individual process items (e.g., a physician office visit, a lab test). This approach is self-defeating, as reductions in payments for services consistently result in additional services being delivered. From 1997 to 2001, Medicare raised physician payment rates by an average of 3.4 percent per year. From 2001 to 2005, Medicare actually lowered physician payment rates by an average of 0.7 percent per year. However, the total physician cost per patient increased exactly the same amount in both time periods.\(^5\) We seem to have not yet come to grips with the reality that total health care costs evolve from a simple formula: Total costs = price per unit of service × use rate of services. Multiple studies have shown that the difference between high-cost and low-cost areas is related to the use rate of service, not the rate paid per service in the United States.\(^6,7,8\)

The key to higher-value care is getting good patient outcomes while using fewer health care resources. So, how can we start encouraging higher-value care? Common sense says that if we start paying for value we would be more likely to get it. In his book *Total Cure: The Antidote to the Health Care Crisis*, Hal Luft outlines a way to get there.\(^9\) Since we are concerned about overall health care costs, we should start with the most expensive cohort of patients, keeping in mind that approximately 80 percent of total costs come from 20 percent of patients. Most of the expensive patients in the cohort are patients who have been hospitalized. Luft suggests a modification for how providers are paid for hospitalized patients. The new payment scheme would be built on the existing diagnosis-related group (DRG) system in an approach he calls “Expanded DRGs” (EDRG). For each of the present Medicare DRGs, the lump-sum payment would be expanded in two ways: 1) It would include all physician services as well as hospital services; and 2) It would cover a longer time period than the initial hospitalization. For example, the EDRG for a hip replacement might be for all related services from hospital admission through the next 6 months. As stated by Ezekiel J. Emanuel, “The idea is to force all of a patient’s care providers to work together. They have a strong incentive to eliminate unnecessary tests and treatments and use less expensive implants, drugs and devices that don’t compromise quality, and to prevent infections and other complications that could land the patient back in the hospital.”\(^10\)

The most critical element is how to set the lump-sum payment amount. Rather than using the standard Medicare approach of complex formulas, Luft suggests a reality-based payment approach which would pay based on the cost of resources used by medical centers getting the best outcomes. In this approach, the medical centers presently using more resources than needed would have strong financial incentives to become more efficient, i.e., deliver better value.

The overriding implication for providers is clear: Get better patient outcomes using fewer resources. Many medical centers are well on their way toward this goal. For example, Banner Health, a nonprofit hospital system headquartered in Phoenix, AZ, implemented an electronically-assisted oversight of all intensive care unit (ICU) patients in its system. A remote team monitors ICU patient information for adverse trends, alerting the bedside team if a problem is detected. The timely responses have resulted in significantly improved patient outcomes (risk-adjusted ICU mortality is down 31 percent) and significantly reduced resource use (ICU days per patient are down 30 percent)—yielding higher value for patients.\(^11\)

It is possible to deliver better patient care at lower cost per patient than exists on average in the United States. Indeed, many medical centers are already doing this. Why not financially encourage other medical centers to do the same? After all, if we actually pay for value, we are more likely to receive it.
In this commentary, Denis Cortese, Natalie Landman, and Robert Smoldt’s discussion of value-based health care touches on several issues and lessons central to the delivery of care that is effective, efficient, and continuously improving, including the importance of:

- An increased focus on patient outcomes, rather than process items, to identify truly high-value care;
- Reassessment of current pay-for-performance systems to determine whether the right patient care behaviors are being incentivized;
- Encouragement of health care team collaboration to reduce risk of negative outcomes and patient readmissions; and
- Incentives that reduce costs and unnecessary resource utilization while improving patient outcomes.

Information on the IOM’s Learning Health System work may be found at www.iom.edu/learninghealthsystem.