Healthcare Innovation NEWS

Making a Case for Healthcare Innovation

A Selected Case Study in Healthcare Innovation and Transformation…

Looking Beyond Fee for Service

by Rachel Regan

Program Objectives:

- Find a better way to pay for healthcare than the prevalent fee-for-service model. Due to the changes in Medicare reimbursements (Hospital Readmission Reduction Act), the Affordable Care Act and recent targets set by the Obama Administration to increase alternative payment methods in Medicare, this objective is more urgent than ever.
- Start the discussion on a model for payment reform that results in better value—higher quality and lower cost, resulting in better health. In other words, the right care, at the right time, in the right setting at the right price.
- Listen to the viewpoints of multiple stakeholders across the healthcare industry in Wisconsin, acknowledge those views and address them.
- Develop ideas for a new payment model that would reward value, not volume, benefit local and regional members and ideally serve as a model for the nation.

Program Description: Until now, experiments using alternative payment methods to meet similar objectives have shown mixed results. Wisconsin's Statewide Value Committee (SVC), a multi-stakeholder group working to accelerate the improvement of the healthcare system, began new discussions to engage key industry players on the topic of payment reform.

In early 2014, the Alliance, a business coalition of self-insured employers and member of the SVC, raised its hand to be part of a payment experiment. SVC leadership and the ThedaCare Center for Healthcare Value, an education institute focused on creating value in healthcare through delivery and payment reform and data transparency, gathered thoughtful, action-oriented leaders across stakeholder groups in order to understand payment from all angles. It was important to include stakeholders who would challenge each other in lively discussion so that the best ideas would be generated. A critical element to the success of the project was that multiple viewpoints and perspectives would be heard, acknowledged and addressed. The process of convening stakeholders with these unique qualities culminated in the first statewide Payment Reform Retreat in December 2014.

The individuals at the conference spent a day and a half in search of a better payment model. The group included company executives, hospital finance directors, physicians and public sector leaders, plus external (out-of-state) guests who shared their expertise, experiences, questions and suggestions. While seemingly on different sides of the healthcare equation table, all shared a vested interest in improving the healthcare payment system.

In preparation for the retreat, leaders developed a list of questions elicit each member's background and gauge how he or she viewed the problem of payment reform and his or her experiences with payment initiatives. The answers were compiled so that when the group convened face-to-face, time could be more effectively used to learn, discuss and make proposals.

The group used A3 Thinking to facilitate its conversations and devise a strategy for payment reform. A3 thinking started with grasping a deep understanding of the problem to be solved and then asked, "Where do we want to go? What is our target? How will we define success?"

A3 Thinking is a lean model deployed by Toyota and other companies/organizations to structure thinking, generate discussion and feedback and solve problems.

Next, the group determined the gaps between healthcare payment's current state and what it hoped to achieve: What's causing the gaps? What experiments can be run to prove or disprove theories of causes and solutions?

Finally, the A3 thinking format asked, "What's the most effective countermeasure that meets time and budget parameters? What plan should we implement? What metrics should we measure to ensure success? What are the next steps?"

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The retreat featured reports from organizations, which already have implemented alternative payment methods, including:

- Blue Cross Blue Shield of Massachusetts and its Alternative Quality Contract (HMO contracts with payment linked to quality outcomes).
- Integrated Healthcare Association in California, which rewards and publicly recognizes physician organizations who are accountable for the total cost, cost trend and resources used for all care provided to their commercial HMO/POS members, as well as for the quality of this care.
- State of Minnesota and how it tiers providers to encourage consumer behavior.
- Challenges Bellin-ThedaCare Healthcare Partners, the highest in quality and lowest in cost of all Pioneer ACOs, still faces with its new payment model.

Discussion topics centered on the concept of physician compensation and the impact a productivity-focused model could have on the ability to achieve the target, as well as questions about relative vs. absolute targets, timing and how to achieve sustainment after the target is reached. In the end, the group agreed that total cost of care would be measured by employer + employee share, with a reduction in trend for the first three years from the current 3% trend down to 2% for year two, 1% for year three and then holding flat for years four to six.

Results: The group split into work groups and simultaneously developed two different high-level models to test. Coincidentally, both had a strong primary care focus, along with goals of preventing illness and maintaining or improving health as parts of the value equation for all.

One payment model—"capitation acting"—focuses on health outcomes rather than on overburdening providers with additional measuring and reporting. It is essentially accountable primary care with incentives to refer to the highest value specialists. The model requires a designated primary care provider (PCP) and an agreement with providers to accept a flat unit price for services. Providers can earn a portion of that back based on total cost of care and "win" by early participation and a chance to influence design. If providers beat the trend, they receive a share of a withhold pool.

The other model could be described as accountable primary care with incentives and emphasizes longer term, better health and cost outcomes by incenting more primary care and getting ahead of potential and existing conditions. Key elements include measures for health outcomes, total cost of care and patient experience, including access. The model requires a health risk assessment review with a PCP; establishes centers of excellence for PCP referrals to specialists; and relies on shared risk to ensure employer engagement.

These two models create additional accountability for providers, both financially and clinically, but offer more autonomy in care management. There also was a theme of increased trust and collaboration among providers and employers, including the sharing of data so that providers could have a complete picture of what is occurring in their patients' medical lives.

Lessons Learned:

- There is general agreement that fee for service must step aside for a more progressive payment system that rewards value.
- A payment model cannot be designed without thinking about the effects on the entire system of healthcare delivery processes. The group had to incorporate aspects, such as how a primary care physician is selected, how consumers choose where they have elective surgeries and what kinds of copayments are designed into a plan. Although the initial intent was to focus strictly on payment design, in the end, the group recognized that it couldn't—and shouldn't—be a detached objective.
- Some employers were comfortable with the concept of "pay for what you use"; therefore, the value proposition must be clear.
- Data is king. Without it, a facts-based conversation is nearly impossible, and the discussion becomes opinion based.
- It is currently financially unsustainable for providers to move to a value-focused, delivery model unless a meaningful percentage of commercial payers in their market transition to value-based payments.
- In order to truly have an impact and influence the market, additional stakeholders must be part of the experiment—or somehow aligned.

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