

LEAVING FEE FOR SERVICE BEHIND

BY BRUCE JAPSEN
PHOTOGRAPHY BY PAUL HOWELL

Physicians and hospitals in Wisconsin are all in on efforts to shift the health care payment system from volume-based payment to reimbursement based on the quality of patient care. Will other states follow their lead?

In contrast to some physicians, John Toussaint, MD, and his colleagues in northeast Wisconsin don't mind when the quality of care they provide is measured or even when they are compared to their peers.

More than most, Toussaint, previously an internist who now works full-time as CEO of ThedaCare Health System's Center for Healthcare Value in Appleton, Wis., embraces transparency, and even welcomes having his pay tied to performance, something studies and doctor surveys show remain a worry or even a foreign concept to most physicians across the country. Today, 55 percent of Wisconsin's

physicians report quality information and agree to have it publicly reported on a website for all to see.

But Toussaint and scores of doctors affiliated with ThedaCare and rival Bellin Health in nearby Green Bay have done more than just report whether they have done tests for diabetes and cholesterol. They have turned the results of their treatments into outcome measures that show how care for patients has improved. And now they are even willing to put their pay at risk in the name of quality—an agreement some providers have been leery of in the past.

"Across Wisconsin, we are not just measuring whether the test is done or not, we are reporting whether your blood sugar and cholesterol are under control," says Christopher Queram, president and CEO of the Wisconsin Collaborative for Healthcare Quality (WCHQ), which is leading the Robert Wood Johnson Foundation's Aligning Forces for Quality initiative in Wisconsin. "This is unique. We are alive and moving into 2014 with momentum and optimism."

As founding members of the WCHQ, Bellin and ThedaCare have gained national recognition for their efforts to measure, improve,

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and be paid differently than is predominant for the U.S. health care system across the country. They are helping lead WCHQ’s effort to reform payment across Wisconsin in a way that reduces costs for all consumers, but also expands access to higher quality care for poor patients insured by Medicaid and those with little to no health coverage.

This willingness to go against the grain of traditional health care reimbursement led Bellin and ThedaCare executives to apply, and be chosen, two years ago by the Centers for Medicare & Medicaid Services (CMS) as one

of the first 32 provider groups to test a new Affordable Care Act (ACA) pilot initiative that rewards doctors and hospitals if they improve quality and reduce costs through accountable care organizations (ACOs). But they can be penalized if costs rise.

ACCOUNTABLE CARE ‘PIONEERS’

Under the CMS Shared Savings program, Bellin, which operates a flagship hospital in Green Bay and a network of clinics and doctor practices, linked with the larger ThedaCare,

which operates a six-hospital system, under the same umbrella to form a “Pioneer ACO.” ACOs are intended to have doctors and hospitals take responsibility for managing the care of Medicare beneficiaries, and receive financial rewards for improving care and saving dollars. The ACOs agree to adhere to more than 30 outcome and quality measures and can also have “shared savings” arrangements with other insurers and employers.

“We look at the whole population and put them in segments: high-risk, rising risk, and low-risk,” says Pete Knox, executive vice president and chief learning and innovation officer at Bellin.

A high-risk patient typically has a number of chronic conditions, or poorly managed chronic conditions such as diabetes, high cholesterol, and hypertension, Bellin doctors say. The rising risk profile refers to a patient or patients who have fewer chronic conditions that may not be well-managed, while a person with low-risk has well-managed or no chronic conditions. Brad Wozney, MD, head of ambulatory quality and informatics at Bellin Health, said data helps assign risk to a patient in any number of ways.

“Depending on what type of data we are able to get for a population, we are assigning risk using either a proprietary prospective risk score, number of chronic diseases and/or dollars spent in the last year,” says Wozney. “The prospective risk scoring takes into account chronic disease burden, how well they are managed, and spend.”

This relentless focus last year kept both Bellin’s and ThedaCare’s readmission rates below 7 percent, which is less than half of the typical U.S. community hospital. Historically, about one in five, or nearly 20 percent of Medicare patients who enter U.S. hospitals for a surgical procedure, such as a heart bypass or another operation, are readmitted within 30 days due to a mistake, infection or other problem, according to the federal government.

Today, hospitals that readmit patients within 30 days can face penalties in the form of fines or reduced Medicare payments. The government levied more than \$220 million in penalties against hospitals across the U.S. last year due to readmissions, according to the U.S. Department of Health and Human Services.

“Bellin has positioned itself not to be alarmed by the Affordable Care Act,” says Dr. Edward Millermaier, chief medical officer at Bellin Health. “We understand that the rules are changing. We are very focused on primary health.”

During 2012, for example, the Bellin-ThedaCare Health Partners ACO reduced



Christopher Queram, president and CEO of the Wisconsin Collaborative for Healthcare Quality, talks to staff at the group’s headquarters.

the cost of care for about 20,000 Medicare beneficiaries in northeast Wisconsin by 4.6 percent. The Centers for Medicare & Medicaid Services, which runs the Medicare program, reported that the Bellin-ThedaCare Pioneer ACO was the best performer on per capita cost.

WILL AN EXPERIMENTAL MODEL CATCH ON?

The Bellin-ThedaCare example is part of the emerging move away from fee-for-service medicine, a volume-based approach that has led to overuse of medical care when providers are not accountable for ordering up tests and

procedures.

Still, among Medicare patients in the northeast Wisconsin market, dominated by Bellin and ThedaCare, more than 80 percent of the reimbursement for Medicare patients is still fee-for-service despite the more than 20,000 patients that are a part of their ACO. The percentage of payment on a fee-for-service basis is even larger among commercial insurance companies, executives say.

"We need to move off of the fee-for-service system," Toussaint says.

Still, the ACO's effort to run toward payments tied to provider performance is in sharp contrast to what is going on nationally. The Medical Group Management Association (MGMA), a large trade group that represents more than 33,000 medical practices, last year said primary care physicians reported that just 3 percent of their total compensation was based upon quality measures. Meanwhile, specialists reported that just 2 percent of their total compensation was based on quality metrics, according to MGMA's annual "Physician Compensation and Production Survey," which was based on 2012 data.

With regard to ACOs, a study conducted last year by consulting firm Oliver Wyman showed that between 37 million and 43 million patients, or about 14 percent of the U.S. population, is in ACOs or similar health care delivery systems. And most of those people who are receiving medical care from providers under the umbrella of an ACO are just beginning to be treated via such a system, because the ACOs are only in the early stages of being formed.

The slow uptake is triggering Wisconsin providers to put the value proposition into their own hands, in part to convince insurers and others who pay for care that quality can be improved and costs can be lowered through shared savings models like the ACOs and other efforts.

ROOTING OUT VARIATION

Shortly after Congress passed the ACA in the spring of 2010, Wisconsin's health care community began meeting to decide ways to tackle health care costs via payment reform. Insurers, providers, and employers had a seat at the table through an already-existing collaborative effort known as the Wisconsin Health Information Organization (WHIO), which was created by providers, insurers, employers, and state officials in charge of various health programs to find ways to reform payments for health care services.

Through an unprecedented database

managed by the WHIO that includes more than 300 million claims for medical care provided to more than 4 million of the state's 5.6 million people, those involved uncovered wide variation in health spending on total knee replacements.

The data uncovered "standardized costs based on billed charges" ranging from a high of \$55,000 to a low of around \$17,000. Though billed amounts to health plans and insurers don't mean that is the actual price that was paid for the procedure, the database revealed to the group that there was a need to come up with a better way.

"What we saw in the claims database is that three times as many resources were going into some total knee replacements compared to others," said Karen Timberlake, director of Wisconsin's Partnership for Healthcare Payment Reform, which was established by the WHIO to lead Wisconsin's payment reform initiatives.

The partnership began to hold meetings, gather data, and find new ways of doing things for total knee replacement, looking at the cost from the first day the patient is admitted for surgery out to 90 days after the patient is discharged.

"WHIO data allowed providers and payers to have a common view of variation, and drove us to explore payment reform as one solution," Timberlake said.

A single, or bundled, payment is negotiated between the payer and provider for all "relevant services," Timberlake said, including any complications or readmissions to the hospital. By making sure the payment included putting the providers at risk should there be complications, errors or other problems, it ensured that there would be a quality component and that the bundled payment wasn't just a way to reduce costs, she said.

Though the group is not ready to disclose specific savings and results of the first year, Timberlake sees successes in improving care and ways to reduce costs through bundled payment in part because it forces providers to think about a different way of doing something.

"The basic premise is that what gets measured gets focused on," Timberlake said. "When you start to shift the payments, there is some money at risk and it causes different questions to be asked and causes organizations to think differently."

ACCOUNTABLE CARE FOR ALL?

Beyond northeast Wisconsin, other WCHQ providers are also working to tackle the challenging questions that lie ahead in the move

THE PATIENT'S ROLE IN MORE ACCOUNTABLE CARE

Across the state, WCHQ has worked to educate patients on questions they should be asking their doctors. Providers are also getting their information out into the community with more than just brochures and fliers in a doctor's office.

"If we share information, we think that will influence patient behavior," said Cindy Schlough, director of strategic partnerships for WCHQ.

For example, the collaborative has partnered with the Wisconsin Lions Foundation, AARP, and other groups to get information like the fictional story of a woman named Helen, who doctors have a "more frank conversation with about her diabetes," Schlough said.

When Helen switches doctors, she doesn't really feel well and realizes not all doctors are "following the same playbook and using the same tests," according to the script, called "Helen's Story." "But when I started doing some research, I found out there are certain tests every diabetic should be getting."

Just like Helen, Schlough says, patients need to be managing their diabetes. "We are saying, if you have diabetes, here are things you need to look for when you interact with your health care team," she added.



Chris Decker, MD (right), director of clinical services for Froedtert Emergency Department at Medical College of Wisconsin in Milwaukee, confers with hospital social worker Jeffrey Martz in the ED.

“You need to get people the right care, at the right place, at the right time.”

Betty Ragalie

Project Manager, Milwaukee Health Care Partnership

to a more coordinated health care system. In Milwaukee County, an alliance of all five rival community hospital systems, the county, and the state of Wisconsin created the Milwaukee Health Care Partnership in part to find a way to decrease avoidable emergency department visits, particularly for Medicaid patients and those with little to no health insurance coverage.

The partnership, which also works with the WCHQ, uses health information technology and patient information through an effort known as the “Emergency Department Care Coordination Initiative.”

Once a patient shows up to the emergency room, doctors and nurses feed patient information into a computer, hooking them up to a network of primary clinics, such as

federally-qualified health centers. If the patients have never been to the facility, the process allows providers to create a medical record, which can help reduce unnecessary medications and visits down the road.

After the patients visit the outpatient site, the partners in the alliance follow up to make sure patients return and maintain a relationship with the clinic that serves as their centralized ‘medical home’ through a variety of means, from phone calls to text messages.

“You need to get people the right care, at the right place, at the right time,” said Betty Ragalie, project director for the Milwaukee Health Care Partnership. “Is the clinic near their home? Is it near a bus line? You want the patient to be comfortable and familiar with

where they are going.”

Of the more than 7,000 appointments that were scheduled, there was a show rate of 47 percent for those who kept their primary care appointments. “For patients who kept their scheduled appointment, there was a 44 percent reduction in the number of emergency department visits,” Ragalie said.

This translates into significant savings when an emergency room visit can cost, on average, between \$500 and \$1,000. Over a six-month period in 2012, the partnership estimates \$2.3 million in costs were avoided based on a 30 percent reduction in emergency department visits for uninsured and Medicaid patients who schedule primary care appointments at their medical home.

Eventually, the Milwaukee partnership wants to apply its care coordination initiative to Medicaid patients and others who are admitted to the hospital for surgeries and other illnesses, but aren’t discharged to a medical home for proper follow-up or to the patients that don’t follow through. If inpatients don’t get proper care after they leave a hospital, they might regress into poor care and be readmitted, costing the health care system more money.

As more and more medical care providers form ACOs, the partnership sees the emergency care coordination effort as a potentially broader initiative to share savings with state Medicaid programs and promote more cost-effective care.

“We want to apply accountable care principles to the uninsured,” said Joy Tapper, executive director of the Milwaukee Health Care Partnership. “There is a lot of potential.” □

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