Getting to better value in US healthcare: Perspectives from high-value providers

July 30, 2019

Executive summary:

All stakeholders in healthcare say they want higher value in healthcare, so on May 7, 2019 AMGA (American Medical Group Association) and the Healthcare Delivery & Policy Program (ASU-HCDPP) at Arizona State University engaged with high value healthcare (HVC) delivery organizations in a series of panel and group discussions to understand what it takes to provide high value care within the constraints of the current regulatory and reimbursement environment; to get their perspective on current public and private initiatives to promote high value care; and to gather their thoughts on barriers to high value care, and what can policy makers and regulators do to encourage high value care nationwide. The meeting consisted of three panel sessions:

- Panel 1: Providers delivering high-value care: What does it take and what are the barriers?
- Panel 2: Payer-provider strategies that promote high value care
- Panel 3: Patients as high-value care partners: Improving engagement within and beyond the clinic

While the details of each session and specific tactics are provided below, the following set of observations and recommendations may be of particular interest to policy makers and regulators as they try to move the country to high value care:

1. Payment for healthcare services remains a major barrier. This includes both payment models, as well as the level of reimbursement for healthcare services. Policy makers need to move the system away from fee-for-service (FFS) and toward payment models that give providers flexibility to deliver patient care in the most appropriate fashion and setting (e.g., IP/OP/virtual/in-the-home). In turn, payment levels should be based on real costs of delivering care by high-value organizations; focus on the level of attainment rather than the level of improvement (since the latter tends to penalize high-value providers, while rewarding low-value ones); and better reflect patient populations served through more robust patient attribution and risk adjustment.
2. Lack of timely and actionable data to design, implement, and evaluate new models of care, was cited as another major barrier to HVC adoption. Policy makers are in a unique position to mandate that all payers (including insurance companies, self-insured employers, government, etc.) provide healthcare delivery organizations with real-time, clinical and financial data, that are structured in ways that help these organizations in their efforts to positively impact patient care.
3. Lack of standardization and near-exponential growth in the number of quality and "value" measures across payers, has resulted in a heavy reporting burden on providers. Policy makers

and regulators should work with providers to establish a limited, yet robust set of value indicators and to mandate the consistent use of these measures across all payers.

4. Legal and regulatory constructs like scope of practice laws, HIPAA and Stark, tend to limit the hallmarks of high value care, i.e., teamwork and coordination of care around the patient. It may be time to review and revise these constructs in the context of the evolving high value healthcare system.

5. Finally, policy makers have a key role to play in improving patient health directly. To date, major improvements in health outcomes (e.g., reduction in smoking rates) have come as a result of policy, rather than provider-based patient engagement strategies. Moreover, in many instances, policy makers and government agencies are better positioned than healthcare providers to address the social determinants of health (e.g., education, income, environmental conditions). By better understanding their constituents and leveraging the lessons of behavioral economics, policy makers can influence health outcomes through levers like health benefit design, taxation, educational campaigns, etc.

In summary, high value care in the US is possible, as many integrated delivery organizations are able to deliver HVC despite the constraints of the current system. Despite the ongoing trend of consolidation, the majority of healthcare in the US is still delivered by independent providers (rather than integrated delivery systems or provider networks). We believe that by addressing the constraints described above, policy makers and regulators can create the necessary conditions to ensure that more providers are successful in their HVC efforts.

Meeting overview and summary of each panel session
Participating organizations
Atrium Health, Dartmouth Hitchcock Medical Center, Henry Ford Medical Center, HonorHealth, Inova Medical Group, Intermountain Healthcare, Johns Hopkins, Mayo Clinic, Medical College of Wisconsin, Mount Auburn IPA, Sutter Medical Foundation, University of Alabama Medical Center, University of Colorado, University of Vermont Medical Health Network, Virginia Mason Medical Center, Wake Forest Baptist Health, AMGA, ASU-HCDPP

Format
Three panel sessions, each followed by small group discussions and concluded with the prioritization of tactics to help healthcare organizations and policy makers move the country toward higher value healthcare. The following pages summarize the outcomes of these discussions and prioritization exercises.

Panel 1: Providers delivering high-value care: What does it take and what are the barriers?
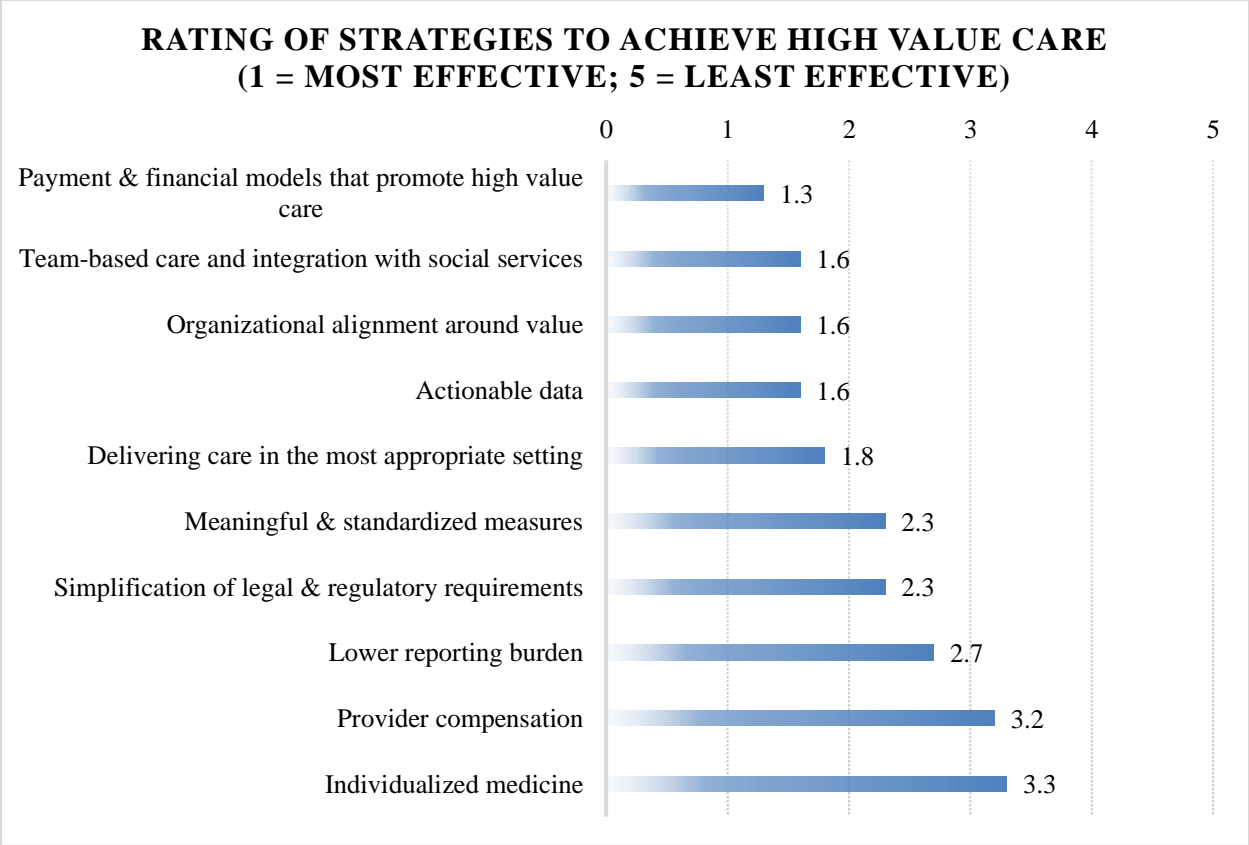Summary:
- High-value care (HVC) is a team sport, with clear understanding by various providers about their role in and impact on the value chain; roles and team composition may vary depending on patient type/need
- Growing recognition that to achieve measurable improvements in patient health, HVC requires addressing proximal social determinants of health and thus community engagement
- Getting to HVC requires (first and foremost) payment models that support teamwork across the care continuum and allow for the delivery of care in the most appropriate fashion/setting
- Smaller practices, in particular, will need additional assistance (through an aggregator or partnership with larger systems) to establish the infrastructure necessary to deliver HVC

Participants identified the following set of enablers as key to delivering high value care to the patient populations they serve:
- Organizational alignment around the notion of high value care (rather than around revenue generation in a FFS environment); requires strong leadership and clear communication across all layers of the organization, aligned financial incentives, and a commitment to delivering healthcare in new ways
- A continuum of care that includes inpatient and outpatient services, as well as collaborations and partnerships with community organizations that are best positioned to address the socio-economic determinants of patient health
- IT infrastructure that provides real decision support, i.e., collects and aggregates clinical and financial data across this care continuum, and provides meaningful and actionable information to provider practices
- Viable and flexible financial models that allow providers to deliver patient care in the most appropriate fashion and setting (IP/OP/virtual/in-the-home, etc)

Perhaps not surprisingly, key barriers to achieving high value care nationwide mirrored the above enablers:
- The predominance of the fee-for-service payment model that promotes volume over value and reimburses providers only when patients are sick and seek care
- Siloed nature of provider reimbursement and thus a lack of incentives to integrate care around the patient (e.g., behavioral health with primary care)
- Outdated legal and regulatory constructs, including scope of practice laws, HIPAA and Stark, that limit the level of teamwork and coordination of care around the patient
- Lack of timely and actionable data to design, implement and evaluate new models of care
- Lack of standardization and near-exponential growth in the number of quality and "value" measures across payers, resulting in a heavy reporting burden on providers

RATING OF STRATEGIES TO ACHIEVE HIGH VALUE CARE
(1 = MOST EFFECTIVE; 5 = LEAST EFFECTIVE)

Strategy	Rating
Payment & financial models that promote high value care	1.3
Team-based care and integration with social services	1.6
Organizational alignment around value	1.6
Actionable data	1.6
Delivering care in the most appropriate setting	1.8
Meaningful & standardized measures	2.3
Simplification of legal & regulatory requirements	2.3
Lower reporting burden	2.7
Provider compensation	3.2
Individualized medicine	3.3

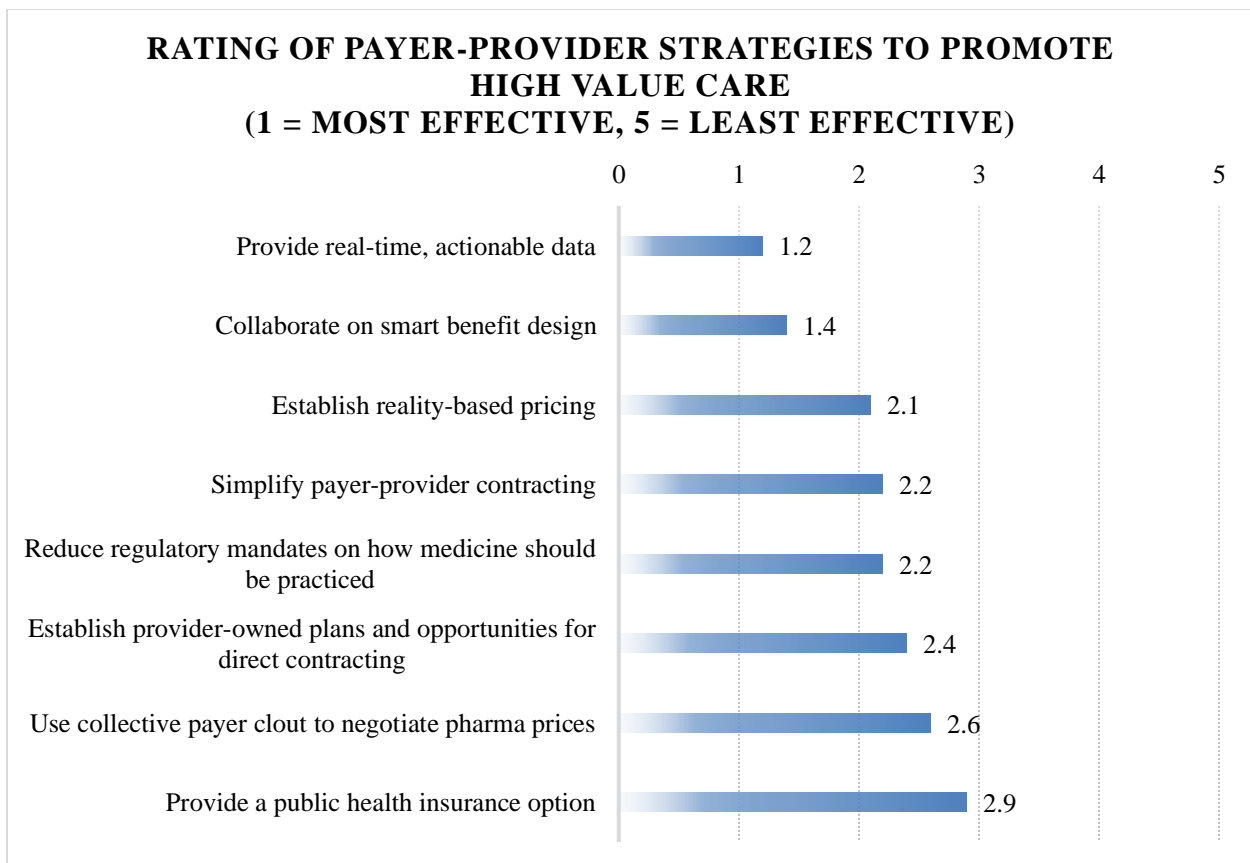**Panel 2:** Payer-provider strategies that promote high value care

Summary:

- Currently, most commercial payers have little incentive to change, since they are able to offset any increases in the cost of patient care by passing them on to employers and consumers
- There is a need for a clear and honest discussion around the fact that Medicare and Medicaid rates are unsustainable, and private insurance payments are subsidizing government programs
- The majority of innovation around HVC is happening in MAPs, with self-insured employers or providers that are developing own health plans

Participants felt that payers (insurance companies, self-insured employers, government, etc.) could help with moving the country toward HVC by focusing on:

- Providing real-time, clinical and financial data, that are structured in ways that help providers positively impact patient care
- Simplifying the payer-provider contracting process, e.g. by increasing transparency, eliminating majority of chargemaster items, reducing EOB complexity, as the impact of complicated negotiations is negative for both payers and providers

- Reality-based pricing that ensures that the best providers stay in business; focus on the level of attainment rather than the level of improvement which tends to penalize high-value providers, while rewarding low-value ones; improve patient attribution and risk adjustment to better reflect the patient populations served
- Revisiting health benefit design in collaboration with health systems, patients, community partners and employers to create appropriate incentives for all stakeholders (e.g., promote healthy behaviors in patients and the use of preventive services by providers) and increase transparency around pricing
- Using collective payer clout to negotiate the prices of pharmaceuticals
- Government, in particular, should focus on getting everyone insurance/access to healthcare, set reasonable payment rates, and avoid being overly prescriptive in how medicine should be practiced

Participants also brought up the possibility of providers competing directly with existing payers, either by starting their own health plans or direct contracting with other "risk-bearing" organizations, e.g., self-insured employers, unions, etc.

RATING OF PAYER-PROVIDER STRATEGIES TO PROMOTE HIGH VALUE CARE
(1 = MOST EFFECTIVE, 5 = LEAST EFFECTIVE)

Strategy	Rating
Provide real-time, actionable data	1.2
Collaborate on smart benefit design	1.4
Establish reality-based pricing	2.1
Simplify payer-provider contracting	2.2
Reduce regulatory mandates on how medicine should be practiced	2.2
Establish provider-owned plans and opportunities for direct contracting	2.4
Use collective payer clout to negotiate pharma prices	2.6
Provide a public health insurance option	2.9

Panel 3: Patients as high-value care partners: Improving engagement within and beyond the clinic

Summary:

- Patient engagement requires a multi-prong approach, especially once patients move beyond the immediate clinical setting
- Need to understand the full patient journey and design a system of care that meets the patients where they are vs. where we want them to be; this includes addressing access to healthcare services (e.g., by leveraging technology), affordability, as well as behavioral/mindset levers
- Increase transparency and openness in the delivery system across all dimensions of healthcare value (patient outcomes, safety, service and costs of care): "Nothing about me, without me"
- Scale remains an issue: to date, major improvements in health outcomes (e.g., tobacco) are the result of policy, rather than provider-based patient engagement strategies

Specific tactics to improve patient engagement cited by the participants included:

- Engage with the broader community around patient needs, e.g., community health workers, YMCAs, faith-based organizations, food banks, etc.
- Identify and utilize resources most likely to exercise a positive influence on patient health behaviors (e.g., employers through health benefit design, governments through policy decisions)
- Integrate patient-centered technologies, including "social" and community referral platforms (e.g., Prepared Health, NowPow), as well as remote monitoring tools and wearables that are cost-effective and accessible
- Promote more effective patient-provider communication through focused trainings (e.g., breaking bad news, bridges to poverty)
- Include patient advisors and a broad range of providers on committees that aim to improve value across the care continuum
- Remove productivity pressure from providers to establish strong/trusting patient-provider relationships
- Leverage existing patient data to better understand patient-provider interactions
- Include beneficiaries in the benefit design process; leverage learnings from behavior economics research

RATING OF PATIENT ENGAGEMENT STRATEGIES TO PROMOTE HIGH VALUE CARE
(1 = MOST EFFECTIVE; 5 = LEAST EFFECTIVE)

Strategy	Rating
Design system of care that meets patients where they are	1.4
Engage with broader community around patient	1.8
Promote more effective patient communication	1.8
Leverage patient-centered technologies	1.9
Include beneficiaries in benefit design process	2.2
Remove productivity pressure from providers	2.9