Payment Pilots as an Alternative to Fee for Service

Like every other state, Wisconsin faces a problem that cuts two ways—healthcare costs are rising at several times the rate of inflation or wages, while growth in costs considerably outpaces growth in healthcare quality. Although Wisconsin has an advantage over some states in that it has earned a reputation for relatively high-quality, low-cost healthcare, those knowledgeable about healthcare and costs have come to agree that because the current rate of cost growth is unsustainable, something must be done to rein it in.

A logical place to start: fee-for-service reimbursement. This payment model is widely considered a major contributor to the problem at hand. To come up with an alternative, the Wisconsin Health Information Organization (a voluntary, all-payer health claims data organization) and the Wisconsin Collaborative for Healthcare Quality (WCHQ, the grantee organization for AF4Q in Wisconsin and a founding member of WHIO), along with leading healthcare providers, payers, and purchasers, formed a group to explore a new model design and then test that model.

Aligning Forces for Quality
Improving Health & Health Care in Communities Across America
www.forces4quality.org

Robert Wood Johnson Foundation

Contact

Karen Timberlake
Director
Patnership for Healthcare
Payment Reform
ktimberlake1@gmail.com

The project, known as the Partnership for Healthcare Payment Reform (PHPR), began by committing to multi-payer reform on the premise that providers can respond more easily to aligned reimbursement signals from multiple payers.

The PHPR created and launched two pilots: a bundled payment for total knee replacement (TKR) and a shared savings project, transitioning to an episode-based payment, for adults with diabetes.

Both pilots began with patients between the ages of 18 and 64 who are commercially insured. Two hospitals and one ambulatory surgery center have embarked on the TKR pilot, with two more facilities expected to launch by the end of 2012. A large, clinically integrated collaboration of two major hospital and health systems is participating in the diabetes pilot.

Bumps in the road have included competition for resources within the participant—and nonparticipant—organizations, arriving at a common and trusted cost baseline for the episode or bundle definition in question, and identifying and developing appropriate incentives for participation.

To address these challenges, PHPR adopted a tried-but-true method: communication. "We are continuing to build an open dialogue among our participants and a strong commitment to shared learning," said PHPR Director Karen Timberlake.

The fastest progress, Timberlake said, has been achieved by groups that made their participation in the pilot a priority, devoting necessary staff and resources and adopting an attitude of answering the question "how?" with "yes."

So far, feedback from participants has been positive. They have stated that the pilots have catalyzed new conversations with all points in the healthcare stream including providers, payers, patients, employers, and suppliers.

Several sites are using the pilot to redesign care processes and expect to improve patient safety while reducing costs. Some report the existence of the pilots has increased openness to payment reform, even among organizations not participating.

"We have been pleasantly surprised at the potential to realize faster progress when participants come to the conversation with a history of trust and an expectation of moving forward together," Timberlake said.

Lessons Learned

- Participants must decide at the outset if they are prepared to commit the resources necessary to drive a pilot.
- Designing a bundle and episode definition can be very time consuming. Try looking for publicly available definitions and a local validation process.
- The more a payment reform pilot can be incorporated into ongoing processes such as care redesign, payment negotiations, and benefit design, the faster it will proceed and the more impact it is likely to have.