THE ASPEN INSTITUTE
HEALTH INNOVATION PROJECT

Accelerating Innovation in Health Care: **Five Game-Changing Ideas to Clear the Way**

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INTRODUCTION

Discussions of health reform once again dominate the policy landscape in Washington and state capitols, yet most policy proposals center on insurance coverage—not improvements to the delivery or value of American health care. As debate over the Affordable Care Act (ACA) and the American Health Care Act (AHCA) continue, policymakers may be missing a significant opportunity to accelerate value-based care and improved health outcomes. Despite decades of experimentation, few innovations designed to improve the value and quality of health care have moved beyond the pilot phase. Fewer still have become self-sustaining, or successfully spread to other settings.

The Aspen Health Innovation Project draws together the collective insights of innovation experts and leading health care stakeholders—practitioners and policymakers—to consider what it will take to change that. This group of bipartisan thought leaders unanimously agrees on the need to foster bold and broad changes in how the health system delivers care. The constellation of Big Ideas they propose here are intended to clear a pathway for the scale and spread of transformative innovations that will produce a health care delivery system designed to work better for all.

APPROACH

In late 2016 and early 2017, the Aspen Health Innovation Project team interviewed and convened dozens of thought leaders across the health care field to seek their views on levers and strategies that could lead to widespread adoption of delivery system reforms. To guide these conversations, the project team conducted an environmental scan of existing research on health innovation and prepared materials incorporating the insights of both the literature and early interviewees.

What do we mean by "innovation"?

The Aspen Health Innovation Project focuses on delivery system reforms–innovations in the way care is organized and delivered to improve health outcomes, lower overall health care spending, and optimize the efficiency and value of health care. Examples of delivery system reforms, which can occur alone or in tandem, include: improved care coordination across settings; connections with community-based social services and public health resources; and strategies to engage patients in their own care.

In most cases, these kinds of innovations rely on some type of payment reform that shifts financial incentives away from rewarding volume and towards an emphasis on quality. However, the Aspen Health Innovation Project is not seeking to spread payment reform, per se, but rather to identify ideas or concepts that, if adopted, would promote the scale and spread of delivery system reforms that may be supported or inspired by new payment models.

These interviews and meetings were held off the record to elicit fresh thinking and bold ideas. Participants included current and former government officials, executives of provider organizations, insurance companies, Fortune 500 companies, and leading innovators, researchers, and academics. The guarantee of anonymity allowed these experts to set aside their usual talking points, engage in rich, challenging conversations, and put proposals on the table that had not necessarily been publicly endorsed by their institutions.

The interviewed thought leaders coalesced around a set of primary barriers to widespread scale and spread of health care innovations. These included the complexity of reforms to the delivery system; the difficulty of measuring pilots that are applicable across diverse settings; and the struggle of generating intrinsic and extrinsic motivation for change among providers and system leaders. Notably, these factors were considered far more influential than challenges associated with disseminating the results of pilot programs or findings from learning collaboratives.

The Aspen Health Innovation Project concluded that the most pressing task at this stage was not so much to disseminate promising concepts, but rather to create fertile ground in which the seeds of innovation could grow. Most crucial to this effort is stimulating the market demand for change—a demand generated by either financial opportunity for providers or the clearly expressed needs of empowered consumers.

The five "Big Ideas" presented here are designed to change how health care is financed, to empower consumers, and in some cases to do both. While these are valuable outcomes in and of themselves, their real power is the opportunity they foster to unleash innovation. Although the nature and magnitude of that innovation cannot yet be fully imagined, the Aspen Health Innovation Project is convinced that these Big Ideas will help create the conditions in which transformative new models for delivering health care can thrive.

Five Big Ideas to Accelerate the Spread of Delivery System Reforms

1. End Fee-For-Service Reimbursement by 2025

The existing payment system for health care allows almost any provided service to be paid for, creating a strong business case for developing new products, and new ways of selling them. Thus, the prolific innovation evident in the volume-based industries of pharmaceuticals and medical products is no surprise.

But what of innovations that seek to reduce volume? There is no comparable business case for preventing unnecessary hospitalizations, managing chronic conditions, or addressing the social determinants of health. If health care continues to be reimbursed based on how much service is provided, there is no sustainable incentive to apply innovation to diminish volume and lower health care costs.

Although new value-based payment models, such as accountable care organizations and bundled payments*, are being developed, volume remains an important cost driver for reimbursement. The pricing also undervalues cognitive specialties, such as primary care or geriatrics, and pays most for highly interventional practices, despite a consensus that the latter should be discouraged where possible. Moreover, even providers who are participating in the new models continue to receive the bulk of their revenue from traditional fee-for-service reimbursement.

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*Accountable care organizations (ACOs) and bundled payments are health care reimbursement models that allow health care providers, such as hospitals, doctors, and nursing homes, to share the savings they generate by improving quality. In an ACO, savings are measured against expected costs for a given population of patients over a specified period of time (e.g., a year). In a bundled payment, savings are measured against expected costs for an episode of care, such as a hip or knee replacement, for a specific patient. Medicare, Medicaid, and private insurers all offer somewhat different versions of these payment models.

A true end to fee-for-service payment would include a clear signal from major public and private payers that these arrangements are winding down and the implementation of strategies to support a transition process for providers. Its replacement—a new universal reimbursement model, designed collaboratively by payers and patient advocates—would pay for patient and community outcomes, not for services provided. Rather than carrying over existing fee schedules, the new model would fundamentally revalue primary care and other practices and procedures known to foster long-term well-being.

Ending fee-for-service reimbursement entirely, and instead paying for the patient and community outcomes we seek, would immediately create incentives for new innovations to keep patients healthy and remove waste from the health care system. The business case for all providers and stakeholders would at last become clear. Designing or implementing this would, of course, be no small task. Many health care providers would resist the call to fundamentally shift their business model away from volume, and even supporters of innovation would fiercely debate the nature of anything intended to replace the current model. Despite the complexity of the undertaking, however, the Aspen Health Innovation Project believes it is essential to create a climate that will allow value-based health care innovations to spread.

2. Cut Out the Middle Man: Direct-to-Consumer Insurance Products

In most industries, there is only one degree of separation between the provider of a product or service and the consumer who pays for it. When Toyota produces a lower quality car or adds features its customers don't want, it is likely to sell fewer cars – a direct feedback loop that affects the manufacturer's bottom line. That creates an incentive to course correct through innovation.

In health care, there is little feedback between hospitals and doctors and the satisfaction or outcomes of their patients. Instead, providers are contracted and paid by insurance companies, which see large employers as their primary clients.

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Those employers may or may not ask employees whether they are satisfied with their care. Providers have little incentive to innovate around a patient's stated values and goals because those views generally do not influence how they are evaluated or paid.

A direct provider-to-consumer insurance product would create a tight alignment between what patients value about their care and the financial goals of their providers. While some providers are already coming together to assume financial risk for the cost of their patients, their contracts remain largely with insurers and employers. A direct-to-consumer marketplace would allow patients to opt into a relationship with a particular provider group, pushing providers to respond to their needs or risk losing market share. Employers could still contribute to the cost of this insurance model for their employees, but they would no longer be able to influence its design as middlemen.

This model is already emerging in some areas of the country, with provider groups offering their own Medicare Advantage products, which are always selected by individual seniors, rather than by employers. These are usually co-branded with an insurance company, which continues to manage the regulatory requirements of the Medicare Advantage program, but responsibility for the plan design, network management, and customer service falls directly on providers. This model, or one with a more limited role for the insurance company, could be replicated in the small and large group markets.

Such an approach would rely on careful policy design, including multi-year contracts between patients and provider groups, market-wide risk adjustment, and stop-loss insurance to protect providers against catastrophic costs. If regulatory barriers were eased, these direct-to-consumer products could compete with traditional insurance, opening opportunities for innovative delivery system reforms to take hold. Debate over this idea would likely center on the possible disruption to the employer-based insurance model, which provides economies of scale, risk pooling, and tax advantages. Implementing this idea would be optional, allowing innovative employers to find ways to harness the power of direct patient-provider engagement without ceding the advantages of the current system.

3. Power to the People: Sharing Health Care Savings with Consumers and Communities

Lowering long-term health care costs cannot and should not be the sole responsibility of hospitals and clinicians. Social determinants of health, individual lifestyle choices, and local policies all contribute significantly to health status, and, in turn, to health care costs. As we shift to payment models that reward providers for good outcomes, we must also reward patients and communities for achieving those outcomes.

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While some health reform proposals advocate patients having "skin in the game," such that they consume fewer services or choose lower cost providers, this approach can place untenable financial burdens on those with little disposable income and generate strong disincentives to seek necessary care. A shared savings model lets patients earn money for keeping their medical or health conditions well-managed, which may involve their seeking more regular preventive care and/or making behavioral changes. Though some employers offer small wellness program incentives with the same goal, allowing patients to share in savings commensurate with the savings to the health care system would be a game-changer for fostering widespread, innovative health delivery reforms.

The same concept could be applied on a larger scale. The federal government could calculate how much Medicare, Medicaid, and other taxpayer-funded programs would save over the next 30 years if, for example, blood pressure readings were controlled to a certain level among the population in a particular city. To save that kind of money—running perhaps into the billions of dollars—the city would receive federal funds to promote blood-pressure-lowering goals through local policies and at all levels of the community, including schools, workplaces, and public spaces. Continued funding would be contingent on measurable progress. Such financing would orient social services, public health entities, patients, and clinicians towards common goals, and generate a marketplace of innovation.

Implementing this idea requires a long-term vision of health system transformation across an entire community. No one health care payer, public or private, will solely benefit from improvements made to the health of the entire community. It will be difficult, then, to convince any given payer to invest in patient or community health incentives that only yield results over a protracted period of time. Wrestling with this collective action conundrum, and with behavioral economics questions about how best to design the financial incentives or shared savings programs, will be required to advance this big idea.

4. Wired for Success: Empowering Consumers with Their Own Data

Despite an extraordinary amount of health data—including insurance claims, electronic medical records, clinical trials, public health surveys, and personal monitoring devices—most health care decisions are based on the advice of one physician. That advice is usually rooted in personal experience and the necessarily limited amount of research any one doctor can digest. Even the most sophisticated patients have few tools for becoming informed participants in charting their own care.

Aggregated data, supported by artificial intelligence and analytics, would allow patients and providers to draw connections to similarly situated patients and the treatments that proved effective for them. The concept of aggregated health databases is not new, but emphasizing consumers as the end users would be revolutionary. Existing law requires providers to give patients access to their own data, but it is of little use if not curated, analyzed, and contextualized in other data that allow for comparison and insight. Current efforts oriented towards providers or researchers (e.g., interoperable health records and disease registries) are necessary, of course, but they have high barriers to entry, which diminishes the opportunity for innovation.

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Patient-led internet forums, such as Patients Like Me and others, are already allowing patients to compare notes with peers and challenge their health providers to consider interventions tried elsewhere, but these forums are often ad hoc and unscientific. Supporting this patient-led effort with better data and stronger analytics would democratize solution-seeking for health problems and create a new demand for innovation.

Debates over implementing this idea will center on where the data is housed, how it is protected, and for what purposes it may be used. The scientific standards for artificial intelligence that identifies connections among patient experiences also need to be carefully navigated. Drawing conclusions from small samples may give patients false hope, while waiting for a full study design may delay possible remedies or experimentation. Efforts to aggregate and democratize data will bring new insights, but also new concerns about privacy violations. Patients will need to feel confident that they are in control of how much of their information is shared, and with whom; yet sharing must be easy enough for scientists, providers, and patient advocates to benefit from broad-scale information.

5. Sophisticated Spending: Return on Investment (ROI) Calculator

As we create new financial models that reward good outcomes, communities and health systems should understand how best to invest their resources to achieve those outcomes. Currently, each health system is on its own to read competing studies, listen to ad hoc pitches from new technology companies, and try to adapt the myriad approaches taken by other health systems to its own circumstances.

Innovations would be adopted and refined more quickly if a common ROI calculator provided a trusted source of information about likely outcomes and costs. Such a calculator should be as comprehensive as possible and include short-term savings, long-term impacts, and cross-sector benefits. New research and outcomes should feed into the ROI calculator

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on a regular basis so that it remains current and relevant. Although individual entities, such as the Innovation Center of the Centers for Medicare and Medicaid (CMS), have encouraged ROI calculations for specific payment reform proposals, an industry-wide approach would accelerate innovation exponentially.

Though creating an online tool may appear modest, a reliable, trusted, and ever-evolving calculator requires intense cross-industry effort and consensus. Its value is obvious and the downsides few, but debates over this idea would likely center on where the effort should be housed, what assumptions should be used to calculate value over time, and how to accommodate the competing interests of various stakeholders. The big idea here is to wrestle through these challenges collaboratively, and emerge with a broadly valuable tool that can support other innovative delivery system reforms.

NEXT STEPS

As Congress and local lawmakers once again debate significant changes in the American health care system, innovations in care delivery have emerged as bipartisan common ground. The Big Ideas considered here—bold, yet practical and non-partisan in nature—are ripe for further discussion, development, and refinement to clear the way to scale and spread innovations in the delivery of health care. The Aspen Health Innovation Project is prepared to continue convening thought leaders as a pathway towards achieving better health outcomes and a higher-value health system.