MAKING HEALTH REFORM WORK
How Local Leadership Can Control Costs & Improve Quality

Harold D. Miller
President and CEO
Network for Regional Healthcare Improvement
and
Executive Director
Center for Healthcare Quality and Payment Reform
Are ACOs the Answer to Higher-Value Health Care?

Patients → ACO → Lower Costs
Everyone Is Focusing On “Risk” and Organizational Structure

- Financial Risk
- ACO
- Lower Costs
- Patients
- Organizational Structure
But How Will ACOs Generate All These Savings?

Financial Risk

ACO ("the "Black Box")

Organizational Structure

Patients

Lower Costs
What’s In That Black Box Can’t Be Good For Consumers, Can It?

RATIONING

Patients ➔ Financial Risk ➔ Lower Costs ➔ Organizational Structure
Our Focus Should Be On How to Reduce Costs Without Rationing

Patients

REDUCING COSTS WITHOUT RATIONING

Lower Costs
Reducing Costs Without Rationing: Can It Be Done??
Reducing Costs Without Rationing: Prevention and Wellness

Healthy Consumer → Continued Health

Preventable Condition

Healthy Consumer → Preventable Condition

Healthy Consumer → Continued Health

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Reducing Costs Without Rationing: Avoiding Hospitalizations

Healthy Consumer → Continued Health → Preventable Condition → No Hospitalization → Acute Care Episode
Reducing Costs Without Rationing: Efficient, Successful Treatment

Healthy Consumer → Continued Health

Preventable Condition → No Hospitalization

Acute Care Episode → Efficient Successful Outcome

High-Cost Successful Outcome

Complications, Infections, Readmissions
Reducing Costs Without Rationing
Is Also Quality Improvement!

Healthy Consumer → Continued Health → Preventable Condition → No Hospitalization → Acute Care Episode → Efficient Successful Outcome

Better Outcomes/Higher Quality

High-Cost Successful Outcome
Complications, Infections, Readmissions

Better Outcomes/Higher Quality
Reducing Costs Without Rationing Can’t Be Done from Washington...

...It Has to Happen at the Local Level, Where Health Care is Delivered.
Functions Needed for Regional Healthcare Reform

1. Reducing Costs Without Rationing

2. 

3. 

4. 

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Barrier: Lack of Actionable Information About Utilization/Costs

• Barrier:
  – Most physician practices don’t know if they have high rates of preventable hospitalizations, complications, etc.
  – PCPs typically don’t even know if their patients go to the ER or are hospitalized
  – Prices of facilities and treatments are secret or impossible to compare
Turn Reams of Data Into **Timely, Useable Information**

**Barrier:**
- Most physician practices don’t know if they have high rates of preventable hospitalizations, complications, etc.
- PCPs typically don’t even know if their patients go to the ER or are hospitalized
- Prices of facilities and treatments are secret or impossible to compare

**Solution:**
- Analyze data to help physicians find opportunities for cost savings & quality improvement
- Provide real-time performance measurement to support continuous quality improvement
“Measurement” vs. “Analysis”

- **Measurement** presumes we know what we’re looking for, that we know what’s desirable/achievable in all communities, and that we can legitimately rate/rank providers based on the measures
  - That’s a high standard, and it’s not surprising that we don’t have adequate measures in many important areas, particularly outcome measures
“Measurement” vs. “Analysis”

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- **Analysis**, particularly *exploratory* analysis, presumes only that we believe there are opportunities to improve value, and that more work will be needed to determine what is achievable and cost-effective
Functions Needed for Regional Healthcare Reform

1. Reducing Costs Without Rationing

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Analysis & Reporting is #1

1. Quality/Cost Analysis & Reporting
2. Reducing Costs Without Rationing
3. 
4.
Who Should Be Accountable For Achieving Higher Value Care?

- Health Plans?
- Hospitals?
Physicians are at the Core of “Accountable Care”

Healthy Consumer

Continued Health

Preventable Condition

PRIMARY CARE + SPECIALISTS

No Hospitalization

Efficient Successful Outcome

Acute Care Provider #1

High-Cost Successful Outcome

Complications, Infections, Readmissions

Acute Care Provider #2

Acute Care Provider #3
Accountability Requires New and Improved Skills & Relationships

1. Physicians will need to develop/expand skills in reducing preventable hospitalizations, unnecessary testing, etc.

2. Primary care physicians and (multiple) specialists will need to work together to better manage complex cases

3. Physicians and hospitals will need to work together to improve quality and lower costs for inpatient care
What Skills Do Physicians Need to Take Accountability?

Physician Practice

Patient

- Inpatient Episodes
- Unneeded Testing
Resources/Capabilities Needed for MDs to Take Accountability

- MD w/ time for diagnosis, treatment planning, and followup
- Resources for patient educ. & self-mgt support (e.g., RN care mgr)
- Capability for tracking patient care and ensuring followup (e.g., registry)
- Method for targeting high-risk patients (e.g., predictive modeling)
- Coordinated relationships with other specialists and hospitals
- Data and analytics to measure and monitor utilization and quality

Patient
- Unneeded Testing
- Inpatient Episodes

Physician Practice
Capabilities Exist Today, But Don’t Coordinate w/ Physicians

- Data and analytics to measure and monitor utilization and quality
- Coordinated relationships with other specialists and hospitals
- Method for targeting high-risk patients (e.g., predictive modeling)
- Capability for tracking patient care and ensuring followup (e.g., registry)
- Resources for patient educ. & self-mgt support (e.g., RN care mgr)
- Physician w/ time for diagnosis, treatment planning, and followup
- Physician Practice
- Health Plan or Disease Mgt Vendor
- Inpatient Episodes
- Patient
- Unneeded Testing
Medical Home Initiatives Expand MD Capacity, But Not Enough

<table>
<thead>
<tr>
<th>Patient-Centered Medical Home</th>
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<tbody>
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<td>Data and analytics to measure and monitor utilization and quality</td>
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<td>MD w/ time for diagnosis, treatment planning, and followup</td>
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- Inpatient Episodes
- Patient
- Unneeded Testing
Global/Episode Payment Requires ROI Analysis & Targeting

• Return on Investment (ROI; Cost-Effectiveness)
  – Cost of intervention
    vs.
  – Savings from reduced utilization

• Timeframe for Return
  – Short-term: readmission, ER reduction, complex patients
  – Long-term: prevention, early-stage chronic disease patients

• Targeting Services/Patient Segmentation
  – Focusing additional services on high-utilization patients
    vs.
  – Providing services to all patients as a general “benefit”
Goal: Give MDs the Capacity to Deliver “Accountable Care”

- MD w/ time for diagnosis, treatment planning, and followup
- Resources for patient educ. & self-mgt support (e.g., RN care mgr)
- Capability for tracking patient care and ensuring followup (e.g., registry)
- Method for targeting high-risk patients (e.g., predictive modeling)
- Coordinated relationships with other specialists and hospitals
- Data and analytics to measure and monitor utilization and quality

Physician Practice + Partners = ACO

Inpatient Episodes
Unneeded Testing

Patient
#2 Is Redesigning Care for Better Outcomes & More Efficiency

- Quality/Cost Analysis & Reporting
- Reducing Costs Without Rationing
- Value-Driven Delivery Systems

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3

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You Can’t Manage What You Can’t Measure

Quality/Cost Analysis & Reporting

Value-Driven Delivery Systems

3

4
Maine Physician Dashboards

ABOUT YOUR PATIENTS

Adult PCP Patients

<table>
<thead>
<tr>
<th>You</th>
<th>Peers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>345 275</td>
</tr>
<tr>
<td>Average Age</td>
<td>33 35</td>
</tr>
<tr>
<td>% Male</td>
<td>49 47</td>
</tr>
<tr>
<td>% Chronic</td>
<td>8.4 7.5</td>
</tr>
<tr>
<td>% Asthma</td>
<td>1.2 1.2</td>
</tr>
<tr>
<td>% CAD</td>
<td>1.6 1.3</td>
</tr>
<tr>
<td>% COPD</td>
<td>1.8 1.5</td>
</tr>
<tr>
<td>% Diabetes</td>
<td>1.8 2.0</td>
</tr>
<tr>
<td>% Heart Failure</td>
<td>2.0 1.5</td>
</tr>
<tr>
<td>Risk Index</td>
<td>1.05 1.0</td>
</tr>
</tbody>
</table>

PERFORMANCE SUMMARY

Your overall performance compared to your peers.

Effective Care (Quality)

Supply Sensitive Care (Efficiency) in Dollars

Preference Sensitive Care (Surgeries per 1000 patients)

QUALITY AND EFFICIENCY

Your composite quality and efficiency scores compared to your peers.

Adjusted Supply Sensitive Care (Efficiency) Score

PERFORMANCE IMPACT

The impact of your performance compared to your peers.

Effective Care (Quality)

Supply Sensitive Care (Efficiency)

Preference Sensitive Care (Surgeries per 1000 patients)

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Barrier: Current Payment Systems Reward Bad Outcomes

Healthy Consumer → Continued Health → Preventable Condition → No Hospitalization → Acute Care Episode → Efficient Successful Outcome

- High-Cost Successful Outcome
- Complications, Infections, Readmissions

$
Better Payment Systems is #3

Quality/Cost Analysis & Reporting

Reducing Costs Without Rationing

Value-Driven Payment Systems

Value-Driven Delivery Systems
Are There Better Ways to Pay for Health Care?

Healthy Consumer → Continued Health → Preventable Condition → No Hospitalization → Acute Care Episode → Efficient Successful Outcome:
- High-Cost Successful Outcome
- Complications, Infections, Readmissions

$ ?
“Episode Payments” to Reward Value *Within* Episodes

Healthy Consumer → Continued Health → Preventable Condition → No Hospitalization → Acute Care Episode → Efficient Successful Outcome → High-Cost Successful Outcome → Complications, Infections, Readmissions

A Single Payment For All Care Needed From All Providers in the Episode, With a Warranty For Complications
Yes, a Health Care Provider Can Offer a Warranty

Geisinger Health System ProvenCare™

– A single payment for an ENTIRE 90 day period including:
  • ALL related pre-admission care
  • ALL inpatient physician and hospital services
  • ALL related post-acute care
  • ALL care for any related complications or readmissions

– Types of conditions/treatments currently offered:
  • Cardiac Bypass Surgery
  • Cardiac Stents
  • Cataract Surgery
  • Total Hip Replacement
  • Bariatric Surgery
  • Perinatal Care
  • Low Back Pain
  • Treatment of Chronic Kidney Disease
ProvenCare® CABG Quality
Clinical Outcomes - (18. mos)

<table>
<thead>
<tr>
<th></th>
<th>Before ProvenCare (n=132)</th>
<th>With ProvenCare (n=181)</th>
<th>% Improvement/Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>In hospital mortality</td>
<td>1.5 %</td>
<td>0 %</td>
<td>21 %</td>
</tr>
<tr>
<td>Patients with any complication (STS)</td>
<td>38 %</td>
<td>30 %</td>
<td>28 %</td>
</tr>
<tr>
<td>Patients with &gt;1 complication</td>
<td>7.6 %</td>
<td>5.5 %</td>
<td>17 %</td>
</tr>
<tr>
<td>Atrial fibrillation</td>
<td>23 %</td>
<td>19 %</td>
<td>17 %</td>
</tr>
<tr>
<td>Neurologic complication</td>
<td>1.5 %</td>
<td>0.6 %</td>
<td>60 %</td>
</tr>
<tr>
<td>Any pulmonary complication</td>
<td>7 %</td>
<td>4 %</td>
<td>43 %</td>
</tr>
<tr>
<td>Blood products used</td>
<td>23 %</td>
<td>18 %</td>
<td>22 %</td>
</tr>
<tr>
<td>Re-operation for bleeding</td>
<td>3.8 %</td>
<td>1.7 %</td>
<td>55 %</td>
</tr>
<tr>
<td>Deep sternal wound infection</td>
<td>0.8 %</td>
<td>0.6 %</td>
<td>25 %</td>
</tr>
<tr>
<td>Readmission within 30 days</td>
<td>6.9 %</td>
<td>3.8 %</td>
<td>44 %</td>
</tr>
</tbody>
</table>
What a Single Physician and Hospital Can Do

• In 1987, an orthopedic surgeon in Lansing, MI and the local hospital, Ingham Medical Center, offered:
  – a fixed total price for surgical services for shoulder and knee problems
  – a warranty for any subsequent services needed for a two-year period, including repeat visits, imaging, rehospitalization and additional surgery.

• Results:
  – Surgeon received over 80% more in payment than otherwise
  – Hospital received 13% more than otherwise, despite fewer rehospitalizations
  – Health insurer paid 40% less than otherwise

• Method:
  – Reducing unnecessary auxiliary services such as radiography and physical therapy
  – Reducing the length of stay in the hospital
  – Reducing complications and readmissions.
The Weakness of Episode Payment

Healthy Consumer → Continued Health → Preventable Condition → No Hospitalization → Acute Care Episode → Efficient Successful Outcome

How do you prevent unnecessary episodes of care? (e.g., preventable hospitalizations for chronic disease, overuse of cardiac surgery, back surgery, etc.)
Comprehensive Care Payments
To Avoid Episodes

Healthy Consumer

Continued Health

Preventable Condition

No Hospitalization

Acute Care Episode

Efficient Successful Outcome

High-Cost Successful Outcome

Complications, Infections, Readmissions

Comprehensive Care Payment or “Global” Payment

A Single Payment For All Care Needed For A Condition

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Isn’t This Capitation (Ugh)?
No – It’s Different

**CAPITATION (WORST VERSIONS)**
- No Additional Revenue for Taking Sicker Patients
- Providers Lose Money On Unusually Expensive Cases
- Providers Are Paid Regardless of the Quality of Care
- Provider Makes More Money If Patients Stay Well
- Flexibility to Deliver Highest-Value Services

**COMPREHENSIVE CARE PAYMENT**
- Payment Levels Adjusted Based on Patient Conditions
- Limits on Total Risk Providers Accept for Unpredictable Events
- Bonuses/Penalties Based on Quality Measurement
- Provider Makes More Money If Patients Stay Well
- Flexibility to Deliver Highest-Value Services

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Example: BCBS Massachusetts Alternative Quality Contract

• Single payment for all costs of care for a population of patients
  – Adjusted up/down annually based on severity of patient conditions
  – Initial payment set based on past expenditures, not arbitrary estimates
  – Provides flexibility to pay for new/different services
  – Bonus paid for high quality care

• Five-year contract
  – Savings for payer achieved by controlling increases in costs
  – Provider can reap returns on investment in prevention, infrastructure

• Analytic support to identify opportunities & monitor progress

• Broad participation
  – 14 physician groups/health systems participating with over 400,000 patients, including one primary care IPA with 72 physicians

• Positive first-year results
  – Higher ambulatory care quality than non-AQC practices, better patient outcomes, lower readmission rates and ER utilization

## Wait for a Federal Solution? Look Who’s Actually Leading…

<table>
<thead>
<tr>
<th></th>
<th>STATES &amp; REGIONAL COLLABORATIVES</th>
<th>CONGRESS/ MEDICARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pay for Performance</td>
<td>Most regions and payers have some form of P4P for hospitals and/or MDs</td>
<td>Not yet</td>
</tr>
<tr>
<td>Medical Homes</td>
<td>Major initiatives underway in CO, MA, ME, MI, MN, NC, OR, PA, RI, VT, WA &amp; others</td>
<td>Started a demonstration project, then stopped, now supporting states</td>
</tr>
<tr>
<td>Episode/Bundled Payment</td>
<td>Initiatives beginning in Minnesota, Rockford (IL), Pennsylvania, others</td>
<td>Cardiac Demo in 1990s not expanded; ACE demo started in 2009</td>
</tr>
<tr>
<td>Total Cost Accountability</td>
<td>Initiatives in place or being developed in MA, ME, MN, Medicaid</td>
<td>Shared savings demos with large MD groups; proposed ACO regs</td>
</tr>
</tbody>
</table>
Measurement Supports Payment, As Well As Vice Versa

Quality/Cost Analysis & Reporting  

Value-Driven Payment Systems

Value-Driven Delivery Systems

4
Ensuring That Lower Cost ≠ Lower Quality

- Concern: Giving healthcare providers more accountability for costs reduces the incentives for overuse, but raises concerns about whether patients will get too little care
Effective Quality Measurement and Reporting Needed

- **Concern:** Giving healthcare providers more accountability for costs reduces the incentives for overuse, but raises concerns about whether patients will get too little care.

- **Solution:** Measure healthcare quality and include incentives for providers to maintain/improve quality as well as reduce costs.
Should We Have Federal Measurement of Quality?

• Concern: Giving healthcare providers more accountability for costs reduces the incentives for overuse, but raises concerns about whether patients will get too little care

• Solution: Measure healthcare quality and include incentives for providers to maintain/improve quality as well as reduce costs

• Undesirable: National data aggregation and reporting
  – E.g., PQRI/PQRS
A Better Approach: Community-Driven Quality Measurement

• **Concern:** Giving healthcare providers more accountability for costs reduces the incentives for overuse, but raises concerns about whether patients will get too little care

• **Solution:** Measure healthcare quality and include incentives for providers to maintain/improve quality as well as reduce costs

• **Ideal:** Develop quality measures with participation of physicians and hospitals, as a growing number of regions do
• Improving the structure and incentives of payment systems is necessary but not sufficient
• If payment level is (too) high, there will be no savings and little incentive to transform care
• If payment level is too low, providers will be unable to deliver high-quality care and risk financial disaster
Prices for Warrantied Care Will Likely Be Higher
Prices for Warrantied Care Will Likely Be Higher

• Q: “Why should we pay more to get good-quality care??”
• A: In most industries, warrantied products cost more, but they’re desirable because TOTAL spending on the product (repairs & replacement) is lower than without the warranty
Prices for Warrantied Care May Be Higher, But Spending Lower

- Q: “Why should we pay more to get good-quality care??”
- A: In most industries, warrantied products cost more, but they’re desirable because TOTAL spending on the product (repairs & replacement) is lower than without the warranty
- In healthcare, a DRG with a warranty would need to have a higher payment rate than the equivalent non-warrantied DRG, but the higher price would be offset by fewer DRGs w/ complications, outlier payments, and readmissions
Example: $10,000 Procedure

Cost of Procedure

$10,000
Actual Payment for Procedure is Higher than $10,000 on Average

<table>
<thead>
<tr>
<th>Cost of Procedure</th>
<th>Added Cost of Infection</th>
<th>Rate of Infections</th>
<th>Average Total Cost</th>
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<tbody>
<tr>
<td>$10,000</td>
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## Starting Point for Warranty Price:

**Actual Current Average Payment**

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## Limited Warranty Gives Financial Incentive to Improve Quality

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<tr>
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<td>4%</td>
<td>$10,800</td>
<td>$11,000</td>
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- Reducing Adverse Events...
- ...Reduces Costs...
- ...Improves The Bottom Line
Higher-Quality Provider Can Charge Less, Attract More Patients

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Enables Lower Prices
## A Virtuous Cycle of Quality Improvement & Cost Reduction

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<td>$10,000</td>
<td>$20,000</td>
<td>3%</td>
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- Reducing Adverse Events...
- ...Reduces Costs...
- ...Improves The Bottom Line
## Win-Win-Win for Patients, Payers, and Providers

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<tr>
<td>$10,000</td>
<td>$20,000</td>
<td>0%</td>
<td>$10,000</td>
<td>$10,600</td>
<td>$600</td>
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</table>

Quality is Better...

...Cost is Lower...

...Providers More Profitable
In Contrast, Non-Payment Alone Creates Financial Losses

<table>
<thead>
<tr>
<th>Cost of Procedure</th>
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<th>Average Total Cost</th>
<th>Amount Paid</th>
<th>Change in Net Revenue</th>
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<tbody>
<tr>
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<td>5%</td>
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<td>0%</td>
<td>$10,000</td>
<td>$10,000</td>
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</tr>
</tbody>
</table>

Non-Payment for Infections Causes Losses While Improving
Need for Shared, Trusted Data

- **Provider** needs to know what its current utilization rates, preventable complication rates, etc. are to know whether an episode or global payment amount will cover its costs of delivering care.

- **Purchaser** needs to know what its current utilization rates, preventable complication rates, etc. are to know whether an episode or global payment amount is a better deal than they have today.

- **Both** sets of data have to match in order for both purchasers and providers to agree!
Payment Systems & Delivery Systems Must Co-Evolve

Quality/Cost Analysis & Reporting

Value-Driven Payment Systems

Value-Driven Delivery Systems

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Example: Significant Reductions in ER, Hospitalizations Possible

Evidence:

• 40% reduction in hospital admissions, 41% reduction in ER visits for exacerbations of COPD using in-home & phone patient education by nurses or respiratory therapists

• 66% reduction in hospitalizations for CHF patients using home-based telemonitoring
  M.E. Cordisco, A. Benaminovitz, et al, “Use of Telemonitoring to Decrease the Rate of Hospitalization in Patients With Severe Congestive Heart Failure,” American Journal of Cardiology 84(7), 1999

• 27% reduction in hospital admissions, 21% reduction in ER visits through self-management education
We Don’t Pay for the Things That Will Prevent Overutilization

CURRENT PAYMENT SYSTEMS

Health Insurance Plan

<table>
<thead>
<tr>
<th>$</th>
<th>Office Visits</th>
<th>$</th>
<th>ER Visits</th>
<th>$</th>
<th>Hospital Stay</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Phone Calls</td>
<td>Avoidable</td>
<td>Lab Work/Imaging</td>
<td>Avoidable</td>
<td>Avoidable</td>
</tr>
<tr>
<td></td>
<td>Nurse Care Mgr</td>
<td></td>
<td></td>
<td></td>
<td>…No penalty or reward for high utilization elsewhere</td>
</tr>
</tbody>
</table>

No payment for services that can prevent utilization…
Global Payment Can Solve That, But It’s a Big Jump from FFS

FULL COMP. CARE/GLOBAL PAYMENT

Health Insurance Plan

Condition-Adjusted Per Person Payment

Physician Practice/ACO

Office Visits

Phone Calls

Nurse Care Mgr

ER Visits

Avoidable

Lab Work/Imaging

Avoidable

Hospital Stay

Avoidable

Flexibility and accountability for a condition-adjusted budget covering all services

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How Can MDs Transition to More Accountable Payment Systems?

CURRENT PAYMENT SYSTEMS

Health Insurance Plan

- Office Visits
- ER Visits
- Hospital Stay
  - Avoidable
- Phone Calls
- Lab Work/Imaging
  - Avoidable
- Nurse Care Mgr

Physician Practice
Option 1: Medical Home Payments

(TYPICAL) MEDICAL HOME PROGRAM

Health Insurance Plan

Physician Practice

- Office Visits
- Monthly Care Mgt Payment
  - Phone Calls
  - RN Care Mgr
- ER Visits Avoidable
- Lab Work/Imaging Avoidable
- Hospital Stay Avoidable

Higher payment for primary care...

...But no commitment to reduce utilization elsewhere
Option 2: Shared Savings

SHARED SAVINGS MODEL

Health Insurance Plan

- Physician Practice
  - Office Visits
    - Phone Calls
    - Nurse Care Mgr
  - Avoidable

- ER Visits
  - Avoidable

- Lab Work/Imaging
  - Avoidable

- Hospital Stay
  - Avoidable

Portion of savings from reduced spending in other areas...

...but no upfront $ for better care...

...Returned to physician practice after savings determined...
Weaknesses of “Shared Savings”

• Provides no upfront money to enable physician practices to hire nurse care managers, install IT, etc.; additional funds, if any, come years after the care changes are made
• Requires TOTAL costs to go down in order for the physician practice to receive ANY increase in payment, even if the practice can’t control all costs
• Gives more rewards to the poor performers who improve than the providers who’ve done well all along
• The underlying fee for service incentives continue; losing less (via shared savings) is still losing compared to FFS
• I.e., it’s not really true payment reform
Better Idea: Simulate Flexibility & Incentives of Global Payment

CARE MGT PAYMENT + UTILIZATION P4P

Health Insurance Plan

Physician Practice

Office Visits

Monthly Care Mgt Payment

Phone Calls

RN Care Mgr

Medical Practice

ER Visits

Avoidable

Lab Work/Imaging

Avoidable

Hospital Stay

Avoidable

Targets for Reduction In Utilization

More $ for PCP

P4P Bonus/Penalty Based on Utilization

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Example: Washington State Medical Home Pilot Program

• Payers will pay the Primary Care Practice an upfront PMPM Care Management Payment for all patients ($2.50 first year, $2.00 future years)
• Practice agrees to reduce rate of non-urgent ER visits and ambulatory care-sensitive hospital admissions by amounts which will generate savings for payers at least equal to the Care Management Payment (targets are practice specific)
• If a practice reduces ER visits and hospitalizations by more than the target amount, the payer shares 50% of the net savings (gross savings minus the PMPM) with the practice
• If a practice fails to meet its ER/hospitalization targets, the practice pays a penalty via a reduction in its FFS conversion factor equivalent to up to 50% of Care Management Payment
Example: A Hypothetical Underpaid PCP Practice

<table>
<thead>
<tr>
<th>PRIMARY CARE PRACTICE</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>PCPs</td>
<td>4</td>
</tr>
<tr>
<td>Patients/Physician</td>
<td>2,000</td>
</tr>
<tr>
<td>PMPY Primary Care Cost</td>
<td>$140</td>
</tr>
<tr>
<td>Annual Revenue</td>
<td>$1,120,000</td>
</tr>
<tr>
<td>Overhead Costs</td>
<td>$400,000</td>
</tr>
<tr>
<td>Physician Salary</td>
<td>$180,000</td>
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</tbody>
</table>
Many Patients Are Going to ER Due to Difficulty Seeing PCPs

<table>
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<tr>
<th>PRIMARY CARE PRACTICE</th>
<th>HEALTH PLAN ER EXPENSES</th>
</tr>
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<tbody>
<tr>
<td>PCPs</td>
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<td>40%</td>
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Many Patients Are Going to ER Due to Difficulty Seeing PCPs
PCPs Could Reduce ER Expenses With Right Resources

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<td>ER Visits/1000</td>
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Upfront Money Could *Enable* PCPs to Change, If Willing

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<td>Payment to Practice</td>
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<td>Net Savings to Payer</td>
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</table>

- PCPs: 4
- Patients/Physician: 2,000
- ER Visits/1000: 200
- % Preventable: 40%
- PMPY Primary Care Cost: $140
- Per ER Visit: $1,000
- Annual Revenue: $1,120,000
- ER Visit Cost to Payer: $640,000
- Overhead Costs: $400,000
- Physician Salary: $180,000
- Cost of Nurse Practitioner: $80,000
- Other Costs: $10,000
- Total Costs: $90,000
- Upfront Payment: $90,000
- Payment to Practice: $90,000
- Net Savings to Payer: $166,000

New Physician Salary: $200,750
Increase in Phys. Salary: 12%
Savings: $256,000
Share of Savings: $83,000
Share to Practice: 50%
## PRIMARY CARE PRACTICE

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<td>Total Costs</td>
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</tr>
</tbody>
</table>

## HEALTH PLAN ER EXPENSES

| ER Visits/1000 | 200 |
| % Preventable  | 40% |
| Per ER Visit   | $1,000 |
| ER Visit Cost to Payer | $640,000 |
| Reduction in Prev. ER Visits | 40% |
| Savings       | $256,000 |

### Upfront Payment
- Upfront Payment: $90,000
- Payment to Practice: $90,000
- Net Savings to Payer: $166,000

### Share of Savings
- Share of Savings: $83,000
- Share to Practice: 50%
- Net Savings to Payer: $83,000

### New Physician Salary
- New Physician Salary: $200,750
- Increase in Phys. Salary: 12%
- % Savings to Payer: 13%
Win-Win-Win for PCPs, Patients, & Premiums

<table>
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<tr>
<td></td>
<td>13%</td>
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</tbody>
</table>

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But *Upfront* Payment Reform is Needed So Care Can Be Changed

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<td>% Savings to Payer 13%</td>
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Would the Shared Savings Model Achieve the Same Goal?
## Same PCP Practice as Before...

<table>
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<tr>
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<tbody>
<tr>
<td><strong>PCP</strong></td>
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</tr>
<tr>
<td>Revenues</td>
<td>$1,120,000</td>
</tr>
<tr>
<td>Shared Savings</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>$1,120,000</td>
</tr>
<tr>
<td><strong>Expenses</strong></td>
<td></td>
</tr>
<tr>
<td>Care Mgt</td>
<td>$0</td>
</tr>
<tr>
<td>Total</td>
<td>$1,120,000</td>
</tr>
<tr>
<td><strong>Net Revenue</strong></td>
<td>$0</td>
</tr>
<tr>
<td><strong>Margin</strong></td>
<td>0.0%</td>
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Simple Model: Payer Spending Limited to PCPs & Prev. ER Visits

<table>
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<th></th>
<th></th>
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<tr>
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<td>$1,120,000</td>
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<tr>
<td></td>
<td>Margin</td>
<td>0.0%</td>
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<tr>
<td></td>
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<tr>
<td></td>
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<tr>
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<td>ER Costs</td>
<td>$640,000</td>
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<tr>
<td></td>
<td>50% Shared Savings</td>
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<td>Total</td>
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<td>Savings From Year 0</td>
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<tr>
<td></td>
<td>% Savings</td>
<td></td>
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### PCP Invests in Year 1, Payer Reaps Benefit, PCP Loses

<table>
<thead>
<tr>
<th></th>
<th>Year 0</th>
<th>Year 1</th>
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<tbody>
<tr>
<td><strong>PCP</strong></td>
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<tr>
<td>Total</td>
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<tr>
<td><strong>Expenses</strong></td>
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<tr>
<td>Care Mgt</td>
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<tr>
<td>Total</td>
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<td>$1,210,000</td>
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<tr>
<td><strong>Net Revenue</strong></td>
<td>$0</td>
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</tr>
<tr>
<td><strong>Margin</strong></td>
<td>0.0%</td>
<td>-7.4%</td>
</tr>
</tbody>
</table>

| **Payer**            |                 |                 |
| PCP Costs            | $1,120,000      | $1,120,000      |
| ER Costs             | $640,000        | $384,000        |
| 50% Shared Savings   |                 |                 |
| Total                | $1,760,000      | $1,504,000      |
| Savings From Year 0  | $0              | $256,000        |
| % Savings            |                 | 15%             |
PCP Invests in Year 1, Payer Reaps Benefit, PCP Loses

<table>
<thead>
<tr>
<th></th>
<th>Year 0</th>
<th>Year 1</th>
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<tr>
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<tr>
<td>Total</td>
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<td><strong>Expenses</strong></td>
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<tr>
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<tr>
<td><strong>Net Revenue</strong></td>
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<tr>
<td>ER Costs</td>
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<td>$256,000</td>
</tr>
<tr>
<td>% Savings</td>
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</table>

- No New Revenues for PCP in Year 1
- PCP Invests in Better Care Mgt
- Negative Margin for PCP in Year 1
- Payer Benefits if PCP is Successful
More PCP Revenue in Year 2, But Not Enough to Cover Year 1 Loss

<table>
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<tr>
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<th>Year 2</th>
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<td>PCP Costs</td>
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Shared Savings Paid in Year 2
Positive Margin But < Year 1 Loss
Payer Still Benefits
### PCP Still Worse Off After 3 Years, Payer Saves Significantly

<table>
<thead>
<tr>
<th></th>
<th>Year 0</th>
<th>Year 1</th>
<th>Year 2</th>
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<tr>
<td><strong>Payer</strong></td>
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<tr>
<td>PCP Costs</td>
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<td>ER Costs</td>
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<tr>
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<td>7%</td>
<td>7%</td>
<td>7%</td>
<td>10%</td>
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</tbody>
</table>

**Net Loser For PCP**: -$14,000, -0.4%

**Win for Payer**: $512,000, 10%
Not Just PCPs, But The Medical Neighborhood, Too

- Resources & Incentives for More Coordinated Care
- Primary Care Medical Home

- FFS Payment Based on Volume, Procedures, & Office Visits
- (Non-Primary Care) Specialists

PATIENT
Pay Both PCPs & Specialists for Outcomes & Coordination

Resources & Incentives for More Coordinated Care

Primary Care Medical Home

Payment for Consultation w/ PCP; Outcomes-Based Payment

(Non-Primary Care) Specialists

PATIENT
Minnesota’s DIAMOND Initiative

- Goal: improve outcomes for patients with depression
- Convened all payers in Minnesota (except for Medicare) to agree on common payment changes for PCPs & specialists
- Payment changes:
  - Support for a care manager in the primary care practice
  - Psychiatrists paid to consult with PCP on how to manage patient’s care comprehensively, rather than patient having to see psychiatrist separately
- Result: Dramatic improvement in remission rate

http://www.icsi.org/health_care_redesign_/diamond_35953/
How Will Hospitals Have to Change?

- Answer: Smaller and higher-priced
- Huh???? Higher priced??
- In most industries, we want volume to go up, and when it does, prices go down. Why? Fixed costs are spread more broadly.
- In the health care industry, we don’t want it to sell more products/services in total.
- In hospitals, most costs are fixed costs
- Implication: lower volume means higher unit cost (just like every other industry), although total spending should still be lower
Hospital Costs Are Not Proportional to Utilization

Cost & Revenue Changes With Fewer Patients

- 20% reduction in volume
- 7% reduction in cost

#Patients

$000

$1,000
$980
$960
$940
$920
$900
$880
$860
$840
$820
$800

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Reductions in Utilization Reduce Revenues More Than Costs

Cost & Revenue Changes With Fewer Patients

- 20% reduction in volume
- 7% reduction in cost
- 20% reduction in revenue

$000

100 99 98 97 96 95 94 93 92 91 90 89 88 87 86 85 84 83 82 81

#Patients

$1,000 $980 $960 $940 $920 $900 $880 $860 $840 $820 $800

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Causing Negative Margins for Hospitals

Cost & Revenue Changes With Fewer Patients

Payers Will Be Underpaying For Care If Adverse Events, Readmissions, Etc. Are Reduced
So Prices Need to Be Re-Set Under Payment Reform

Cost & Revenue Changes With Fewer Patients

Payers Can Still Save $ Without Causing Negative Margins for Hospital

#Patients

$000

$800
$820
$840
$860
$880
$900
$920
$940
$960
$980
$1,000

Revenues
Costs
Creating A Feasible Glide Path to the Future for Hospitals

• For a hospital that’s constantly full and growing, a reduction in chronic disease admissions may be welcome, particularly since they may be less profitable than elective surgery cases.

• But for small community hospitals with empty beds, and hospitals with narrow operating margins, reductions in chronic disease admissions and readmissions could cause serious financial problems, particularly in the short run.

• In the long run, with sufficient reductions in admissions, a hospital could restructure to reduce its fixed costs (close units, etc.), but it will take time.

• Consequently, payers and hospitals will need to renegotiate payment levels to enable hospitals to remain solvent.
Challenge: Gaining Support from a Critical Mass of Payers

**Provider**

Provider is only compensated for changed practices for the subset of patients covered by participating payers.
All Payers Need to Change to Enable Providers to Transform

Provider

Payer

Better Payment System

Payer

Better Payment System

Payer

Better Payment System

Patient  Patient  Patient
Payers Need to Truly **Align** to Allow Focus on Better Care

Even if every payer’s system is *better* than it was, if they’re all *different*, providers will spend too much time and money on administration rather than care improvement.
Payer Coordination Is Beginning to Occur Around the Country

• Examples of Multi-Payer Payment Reforms:
  – Maine, Michigan, Minnesota, New York, North Carolina, Pennsylvania, Vermont, and Rhode Island all have multi-payer medical home initiatives with Medicare participating
  – Oregon has 5 health plans and the state paying primary care practices to provide enhanced support for complex patients
  – Washington State has 8 health plans (commercial and Medicaid) paying practices to be “accountable medical homes”

• A Facilitator of Coordination is Needed
  – State Government (provides anti-trust exemption)
  – Non-profit Regional Health Improvement Collaboratives

• Medicare Needs to Participate in Local Projects as Well as Define its Own Demonstrations
  – Center for Medicare and Medicaid Innovation (CMMI) created under PPACA provides the opportunity for this
Benefit Design Changes Are Also Critical to Success

**Ability and Incentives to:**
- Improve health
- Take prescribed medications
- Allow a provider to coordinate care
- Choose the highest-value providers and services

**Benefit Design**

**Patient**

**Provider**

**Payment System**

**Ability and Incentives to:**
- Keep patients well
- Avoid unneeded services
- Deliver services efficiently
- Coordinate services with other providers
Example: Coordinating Pharmacy & Medical Benefits

Single-minded focus on reducing costs here...

Drug Costs

- High copays for brand-names when no generic exists
- Doughnut holes & deductibles

...could result in higher spending on hospitalizations

Medical Benefits

Hospital Costs

Physician Costs

Other Services

Principal treatment for most chronic diseases involves regular use of maintenance medication
Both Payment & Benefits Are Controlled by the Payer

PAYER

Ability and Incentives to:
• Improve health
• Take prescribed medications
• Allow a provider to coordinate care
• Choose the highest-value providers and services

Benefit Design

Payment System

Patient

Provider

Ability and Incentives to:
• Keep patients well
• Avoid unneeded services
• Deliver services efficiently
• Coordinate services with other providers
But Purchaser Support is Needed Particularly for Benefit Changes

Purchaser

Purchaser

Purchaser

PAYER

Benefit Design

Payment System

Patient

Provider

Ability and Incentives to:
• Improve health
• Take prescribed medications
• Allow a provider to coordinate care
• Choose the highest-value providers and services

Ability and Incentives to:
• Keep patients well
• Avoid unneeded services
• Deliver services efficiently
• Coordinate services with other providers
And Consumer Support is Critical for Purchaser/Plan Support

Purchaser → PAYER → Benefit Design → Patient

Purchaser → PAYER → Payment System → Provider
Consumer Support is #4, And Fundamental to All

Value-Driven Delivery w/ Patient Participation

Quality/Cost/Experience Analysis & Reporting

Consumer Education & Engagement

Value-Driven Payment Systems & Benefit Designs

Consumer Support is #4, and fundamental to all aspects of Value-Driven Delivery with Patient Participation. Quality/Cost/Experience Analysis & Reporting, Consumer Education & Engagement, and Value-Driven Payment Systems & Benefit Designs are all integral components of Value-Driven Delivery with Patient Participation.
Many Specific Activities
in Each Area...

- Value-Driven Payment & Benefits
- Quality/Cost Analysis & Reporting
- Patient Education/Engagement
- Public Reporting
- Business Case Analysis
- Claims, Clinical & Patient Data
- Education Materials
- Value-Based Choice
- Wellness & Adherence
- Engagement of Purchasers
- Alignment of Multiple Payers
- Benefit Design
- Payment System Design
- Technical Assistance to Providers
- Value-Driven Delivery Systems
- Design & Delivery of Care
- Provider Organization/Coordination

Reducing Costs Without Rationing
...All of Which Need to Be Coordinated to Be Successful

- Do patients know which providers offer the highest value care?
- Will investments in new care models create savings > costs?
- Will benefit designs give patients the ability to adhere to care plans?
- Will payment support better care?
- Can providers accept new payment models?

- Education Materials
  - Value-Based Choice
  - Wellness & Adherence

- Benefit Design
  - Engagement of Purchasers
    - Alignment of Multiple Payers

- Technical Assistance to Providers
  - Design & Delivery of Care
  - Provider Organization/Coordination
How Can These Functions Be Delivered in a Coordinated Way?

- Education Materials
- Value-Based Choice
- Wellness & Adherence
- Engagement of Purchasers
- Alignment of Multiple Payers
- Benefit Design
- Payment System Design
- Technical Assistance to Providers
- Design & Delivery of Care
- Provider Organization/Coordination

- Claims, Clinical & Patient Data
- Public Reporting
- Business Case Analysis

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Role of Regional Health Improvement Collaboratives

- Education Materials
- Value-Based Choice
- Wellness & Adherence
- Engagement of Purchasers
- Alignment of Multiple Payers
- Benefit Design
- Payment System Design
- Technical Assistance to Providers
- Design & Delivery of Care
- Provider Organization/Coordination
- Public Reporting
- Business Case Analysis
- Claims, Clinical & Patient Data
...With Active Involvement of All Healthcare Stakeholders

- Healthcare Providers
- Healthcare Payers
- Healthcare Purchasers
- Healthcare Consumers

Regional Health Improvement Collab.
Leading Regional Health Improvement Collaboratives

- Albuquerque Coalition for Healthcare Quality
- **Aligning Forces for Quality – South Central PA**
- Alliance for Health
- Better Health Greater Cleveland
- California Cooperative Healthcare Reporting Initiative
- California Quality Collaborative
- Finger Lakes Health Systems Agency
- Greater Detroit Area Health Council
- Health Improvement Collaborative of Greater Cincinnati
- Healthy Memphis Common Table
- Institute for Clinical Systems Improvement
- Integrated Healthcare Association
- Iowa Healthcare Collaborative
- Kansas City Quality Improvement Consortium
- Louisiana Health Care Quality Forum
- Maine Health Management Coalition
- Massachusetts Health Quality Partners
- Midwest Health Initiative
- Minnesota Community Measurement
- Minnesota Healthcare Value Exchange
- Nevada Partnership for Value-Driven Healthcare (HealthInsight)
- New York Quality Alliance
- Oregon Health Care Quality Corporation
- P2 Collaborative of Western New York
- Pittsburgh Regional Health Initiative
- Puget Sound Health Alliance
- Quality Counts (Maine)
- Quality Quest for Health of Illinois
- Utah Partnership for Value-Driven Healthcare (HealthInsight)
- Wisconsin Collaborative for Healthcare Quality
- Wisconsin Healthcare Value Exchange

www.NRHI.org
A Perfect Starting Point: Merging Two Payment Reform Silos

**SILO #1**
Implementing Medical Home/Chronic Care Model
Pay More to Physicians For Being Certified As a “Medical Home” And Hope That Outcomes Improve

**SILO #2**
Reducing Hospital Readmissions
Penalize Hospitals for Readmissions Even If the Cause is Poor Primary Care
Marrying the Medical Home and Hospital Readmissions

Reducing Hospital Readmissions

Reducing Hospital Readmissions Requires Improved Community Care

Implementing Medical Home/Chronic Care Model

Reforming Payment for Primary/Chronic Care

Reforming Payment for Primary/Chronic Care Requires Higher/Different Payment

Lower Hospital Readmissions Provides ROI for Chronic Care Investment

Chronic Care Requires Higher/Different Payment

Reducing Hospital Readmissions Provides ROI for Chronic Care Investment

Marrying the Medical Home and Hospital Readmissions
A Comprehensive Approach to Readmission Reduction

- Analyze data on readmissions to identify which types of patients are being readmitted at high volumes/rates
- Analyze and redesign current healthcare delivery system
  - Which physician practices are caring for the patients, both in the hospital and in the community?
  - How can care processes in the hospital and in physician practices be redesigned to prevent ER visits & hospitalizations?
  - What is the most cost-effective way to provide care management support for patients – hospital? PCP? Home health?
- Establish business case for improvement
  - What reductions in readmission rates are needed to justify higher expenditures on care management and other services?
- Change payment systems and benefit designs to support the alternative approach to care delivery
- Provide coaching to providers and to patients
- Analyze real-time data for continuous improvement
Don’t Wait for Washington

• There is no one-size-fits-all solution to reform
  – Each region will need to make it happen in its own unique environment
  – The best federal policy will support regional innovation

• Communities should educate their stakeholders and build consensus on the multi-payer payment & delivery reforms appropriate for their community
  – Organize Payment Reform Summits, as Regional Health Improvement Collaboratives in Colorado, Maine, Nevada, Ohio, Oregon, Washington, Wisconsin have done

• All stakeholders need to work together to analyze data, find win-win opportunities, design transitional payment changes, & resolve inevitable implementation problems
  – Local multi-payer claims and clinical databases maintained by Regional Health Improvement Collaboratives provide a means to identify areas of poor quality care, overutilization, etc. and simulate the impacts of different payment models and prices through a neutral, trusted source
For More Information on Payment and Delivery Reforms

www.PaymentReform.org
For More Information:

Harold D. Miller
President & CEO, Network for Regional Healthcare Improvement
and
Executive Director, Center for Healthcare Quality and Payment Reform

Miller.Harold@GMail.com
(412) 803-3650

www.CHQPR.org
www.NRHI.org
www.PaymentReform.org