Improving Health Care Quality and Reducing Costs through Payment and Delivery System Reform

Harold D. Miller
President and CEO
Network for Regional Healthcare Improvement

and

Executive Director
Center for Healthcare Quality and Payment Reform
Health Care Costs are the Core of the National Budget Problem

“Our health-care problem is our deficit problem. Nothing else even comes close.”

President Obama
September 2010
Medicare+Medicaid is Largest Driver of Future Federal Spending

Projected Increases in Federal Spending, 2010-2021

- Medicare + Medicaid
- Social Security
- Net Interest
- Other Mandatory Spending
- Defense
- Nondefense Discretionary Spending

Federal Spending in Billions

$0 $250 $500 $750 $1,000 $1,250 $1,500 $1,750 $2,000 $2,250 $2,500

Projected Increases in Federal Spending, 2010-2021

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Federal Cost Containment
Policy Choices

MEDICARE SPENDING = SERVICES TO SENIORS \times FEES TO PROVIDERS

Cut Services to Seniors? 

Cut Fees to Providers?
If It’s A Choice of Rationing or Rate Cuts, Which is More Likely?

\[
\text{MEDICARE SPENDING} = \text{SERVICES TO SENIORS} \times \text{FEES TO PROVIDERS}
\]

- Cut Services to Seniors?
- Cut Fees to Providers?

Guess which one they’ll try to reduce?
Past Solutions: Cost-Shifting Gov’t Cuts to Private Payers

Hospital Payment-to-Cost Ratios for Private Payers, Medicare, and Medicaid, 1988 – 2008

Source: Avalere Health analysis of American Hospital Association Annual Survey data, 2008, for community hospitals.
Huge Increases in Costs for Both Employers & Workers

Average Annual Contributions to Health Insurance Premiums
1999-2010

- Employer Contribution
- Worker Contribution

- Employer Contribution
  - Single Coverage 1999: $1,878
  - Single Coverage 2010: $4,150
  - Family Coverage 1999: $1,543
  - Family Coverage 2010: $4,247

- Worker Contribution
  - Single Coverage 1999: $318
  - Single Coverage 2010: $899
  - Family Coverage 1999: $1,543
  - Family Coverage 2010: $3,997

- Employer Contribution More Than Doubled
- Employee Contribution Nearly Tripled
Health Care Costs Have Wiped Out Real Income Gains

Monthly Income for Typical U.S. Family of Four

- $870 for inflation
- $945 for health care
- $95 for spending
- $1910 more income

Source: “A Decade of Health Care Cost Growth Has Wiped Out Real Income Gains For an Average US Family,” Health Affairs, September 2011
What We Need:
A Way to Reduce Costs Without Rationing
What We Need:
A Way to Reduce Costs
Without Rationing

It Can’t Be Done from Washington…

...It Has to Happen at the Local Level, Where Health Care is Delivered.
Reducing Costs Without Rationing:  
*Can It Be Done??*
Reducing Costs Without Rationing: Prevention and Wellness

Healthy Consumer → Continued Health

Health Condition

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Reducing Costs Without Rationing: Avoiding Hospitalizations

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

Healthy Consumer → Continued Health → Health 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 → No Hospitalization → Efficient Successful Outcome

Health Condition → Acute Care Episode → High-Cost Successful Outcome

Complications, Infections, Readmissions → Better Outcomes/Higher Quality
How is Southeast Michigan Doing?

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

High-Cost Successful Outcome

Complications, Infections, Readmissions
Detroit Spends More Per Medicare Beneficiary Than Most Regions

Price, Age, Sex & Race-Adjusted Medicare Spending, 2008

Detroit Spends More Per Medicare Beneficiary Than Most Regions
Detroit Residents Get Surgeries More Than Any Major Region

All Surgical Discharges per 1,000 Medicare Enrollees (2007)

- Detroit
Bad Joints and Really Bad Hearts in Detroit Compared to U.S.?

Rate of Surgery for Medicare Beneficiaries in Detroit vs. U.S., 2007

- PCI
- CABG
- Knee Replacement
- Back Surgery
- Hip Replacement
- Hip Fracture
- All Surgeries

Fixing Bones & Joints

Fixing Hearts
Detroit Does More CABGs Than Any Other Region

Coronary Artery Bypass Grafting (CABG) per 1,000 Medicare Enrollees (2007)

- Detroit
Detroit Has 2nd Highest Rate of Chronic Disease Admissions

Discharges for Asthma, COPD, Congestive Heart Failure, and Diabetes per 1,000 Medicare Enrollees (2007)

Detroit Has 2nd Highest Rate of Chronic Disease Admissions

Discharges for Asthma, COPD, Congestive Heart Failure, and Diabetes per 1,000 Medicare Enrollees (2007)
Above-Average Hospital Readmission Rates in SE MI

30-Day Hospital Readmission Rates for Heart Failure Patients

- Detroit

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25% of Heart Failure Patients Return to Hospital in 30 Days

30-Day Readmission Rate for Heart Failure Patients, SE MI Hospitals

- SINAI-GRACE HOSPITAL
- HENRY FORD HOSPITAL
- ST MARY MERCY HOSPITAL
- DETROIT RECEIVING HOSPITAL & UNIV HEALTH CENTER
- ST JOHN HOSPITAL AND MEDICAL CENTER
- WILLIAM BEAUMONT HOSPITAL-TROY
- HARPER UNIVERSITY HOSPITAL
- HURON VALLEY-SINAI HOSPITAL
- ST JOHN RIVER DISTRICT HOSPITAL
- BOTSFORD HOSPITAL
- OAKWOOD HOSPITAL AND MEDICAL CENTER
- OAKWOOD HERITAGE HOSPITAL
- GARDEN CITY HOSPITAL
- OAKWOOD ANNAPOLIS HOSPITAL
- PROVIDENCE HOSPITAL AND MEDICAL CENTERS
- ST JOHN MACOMB-OAKLAND HOSPITAL-MACOMB...
- DOCTOR'S HOSPITAL OF MICHIGAN
- HENRY FORD MACOMB HOSPITAL
- LAPEER REGIONAL MEDICAL CENTER
- EDWARD W SPARROW HOSPITAL
- POH MEDICAL CENTER
- WILLIAM BEAUMONT HOSPITAL
- HENRY FORD WYANDOTTE HOSPITAL
- PORT HURON HOSPITAL
- BEAUMONT HOSPITAL, GROSSE POINTE
- CRITTENTON HOSPITAL MEDICAL CENTER
- MOUNT CLEMENS REGIONAL MEDICAL CENTER
- HENRY FORD WEST BLOOMFIELD HOSPITAL
- OAKWOOD SOUTHSHORE MEDICAL CENTER
- SAINT JOSEPH MERCY LIVINGSTON HOSPITAL
- ST JOSEPH MERCY OAKLAND
- ST JOSEPH MERCY PORT HURON
There Are Ways to Reduce Costs w/o Rationing in Southeast Mich.!
Current Payment Systems Reward Bad Outcomes, Not Better Health

Healthy Consumer

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

$
Are There Better Ways to Pay for Health Care?

Healthy Consumer → Continued Health → Health 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 ➔ Health 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
Episode Payment = Bundling + Warranty

- **Bundling**: Making a single payment to two or more providers who are currently paid separately
  - e.g., services of both a hospital and a physician
  - e.g., both hospital and post-acute care services

- **Warranty**: Not charging/being paid more for costs of treating hospital-acquired infections, problems caused by errors, etc.
Cardiac Care is the Single Largest Category of Hospital Expenditure
Example: Reducing Cost of Implanting Defibrillators

<table>
<thead>
<tr>
<th>COST TYPE</th>
<th>TODAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Fee</td>
<td>$1,200</td>
</tr>
<tr>
<td>Device Cost</td>
<td>$20,000</td>
</tr>
<tr>
<td>Other Hospital Cost</td>
<td>$9,100</td>
</tr>
<tr>
<td>Hosp. Margin (3%)</td>
<td>$900</td>
</tr>
<tr>
<td>Total Hospital Pmt</td>
<td>$30,000</td>
</tr>
<tr>
<td>Total Cost to Payer</td>
<td>$31,200</td>
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Physicians Could Help Hospitals Reduce Cost of Medical Devices

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Today: All Savings Goes to the Hospital, No Reward for Physician

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<th>SPLIT</th>
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<tr>
<td>Physician Fee</td>
<td>$ 1,200</td>
<td></td>
<td>+ 0%</td>
</tr>
<tr>
<td>Device Cost</td>
<td>$20,000</td>
<td>-10% ($2,000)</td>
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<td>Total Cost to Payer</td>
<td>$31,200</td>
<td></td>
<td>-0%</td>
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Bundling: Single Payment to Physicians and Hospital

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</table>
### Bundling Allows Savings Split Among Docs, Hospital, Payers

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<th>SPLIT</th>
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</thead>
<tbody>
<tr>
<td>Physician Fee</td>
<td>$ 1,200</td>
<td>+50% ($600)</td>
<td></td>
</tr>
<tr>
<td>Device Cost</td>
<td>$20,000</td>
<td>-10% ($2,000)</td>
<td></td>
</tr>
<tr>
<td>Other Hospital Cost</td>
<td>$ 9,100</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Hosp. Margin</td>
<td>$  900</td>
<td>+50% ($450)</td>
<td></td>
</tr>
<tr>
<td>Total Cost to Payer</td>
<td>$31,200</td>
<td>-2.3% ($950)</td>
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So Defibrillator Implantation is Cheaper, But More Profitable

<table>
<thead>
<tr>
<th>COST TYPE</th>
<th>TODAY</th>
<th>CHANGE</th>
<th>SPLIT</th>
<th>NEW</th>
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</thead>
<tbody>
<tr>
<td>Physician Fee</td>
<td>$1,200</td>
<td>+50% ($600)</td>
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<tr>
<td>Device Cost</td>
<td>$20,000</td>
<td>-10% ($2,000)</td>
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<tr>
<td>Other Hospital Cost</td>
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<td></td>
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<td></td>
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<td>$900</td>
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<td>$1,350</td>
<td></td>
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<tr>
<td>Total Cost to Payer</td>
<td>$31,200</td>
<td>-2.3% ($950)</td>
<td>$30,250</td>
<td></td>
</tr>
</tbody>
</table>

Win-Win-Win for Physicians, Hospital, & Payer
$16,000 Variation in Avg Costs of Defibrillators Across CA Hospitals

Source: Pacemaker and Implantable Cardioverter-Defibrillator Implant Procedures in California Hospitals, James C. Robinson and Emma L. Dolan, Berkeley Center for Health Technology
Many Other Savings Opportunities

- Better scheduling of scarce resources (e.g., surgery suites) to reduce both underutilization & overtime
- Standardization of equipment and supplies to facilitate bulk purchasing
- Less wastage of expensive supplies
- Reduced length of stay
- Moving procedures to lower-cost settings
- Etc.
What If There is Evidence of Overutilization?

Assume a study finds that 20% of procedures are unnecessary or can be avoided through medical management.

<table>
<thead>
<tr>
<th>COST TYPE</th>
<th>TODAY</th>
<th>200 Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Fee</td>
<td>$ 1,200</td>
<td>$240,000</td>
</tr>
<tr>
<td>Device Cost</td>
<td>$20,000</td>
<td></td>
</tr>
<tr>
<td>Other Hospital Cost</td>
<td>$ 9,100</td>
<td></td>
</tr>
<tr>
<td>Hosp. Margin</td>
<td>$ 900</td>
<td>$180,000</td>
</tr>
<tr>
<td>Total Hospital Pmt</td>
<td>$30,000</td>
<td></td>
</tr>
<tr>
<td>Total Cost to Payer</td>
<td>$31,200</td>
<td>$6,240,000</td>
</tr>
</tbody>
</table>
## Simply Reducing Utilization Can Hurt Hospitals & Physicians

Reducing the Number of Procedures…
…Significantly Reduces Hospital/Physician Revenue

<table>
<thead>
<tr>
<th>COST TYPE</th>
<th>TODAY</th>
<th>200 Cases</th>
<th>TODAY</th>
<th>160 Cases</th>
<th>Chg</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Fee</td>
<td>$1,200</td>
<td>$240,000</td>
<td>$1,200</td>
<td>$192,000</td>
<td>-20%</td>
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<tr>
<td>Device Cost</td>
<td>$20,000</td>
<td></td>
<td>$20,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Hospital Cost</td>
<td>$9,100</td>
<td></td>
<td>$9,100</td>
<td>$144,000</td>
<td>-20%</td>
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<tr>
<td>Hosp. Margin</td>
<td>$900</td>
<td>$180,000</td>
<td>$900</td>
<td>$144,000</td>
<td>-20%</td>
</tr>
<tr>
<td>Total Hospital Pmt</td>
<td>$30,000</td>
<td></td>
<td>$30,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Cost to Payer</td>
<td>$31,200</td>
<td>$6,240,000</td>
<td>$31,200</td>
<td>$4,992,000</td>
<td>-20%</td>
</tr>
</tbody>
</table>
Bundling + Guidelines Can Avoid Harming Providers While Saving $

Reducing the Cost of the Procedure…
...Can Enable Higher Margins Even With Fewer Procedures

<table>
<thead>
<tr>
<th>COST TYPE</th>
<th>TODAY</th>
<th>200 Cases</th>
<th></th>
<th>NEW</th>
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<th>Chg</th>
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<tbody>
<tr>
<td>Physician Fee</td>
<td>$ 1,200</td>
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<td></td>
<td>$ 1,800</td>
<td>$288,000</td>
<td>+20%</td>
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<td>Device Cost</td>
<td>$20,000</td>
<td></td>
<td></td>
<td>$18,000</td>
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<td></td>
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<tr>
<td>Hosp. Margin</td>
<td>$  900</td>
<td>$180,000</td>
<td></td>
<td>$ 1,350</td>
<td>$216,000</td>
<td>+20%</td>
</tr>
<tr>
<td>Total Cost to Payer</td>
<td>$31,200</td>
<td>$6,240,000</td>
<td></td>
<td>$30,250</td>
<td>$4,840,000</td>
<td>-22%</td>
</tr>
</tbody>
</table>

20% Reduction in Cases
Episode Payment = Bundling + Warranty

- **Bundling**: Making a single payment to two or more providers who are currently paid separately
  - e.g., services of both a hospital and a physician
  - e.g., both hospital and post-acute care services

- **Warranty**: Not charging/being paid more for costs of treating hospital-acquired infections, problems caused by errors, etc.
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
Payment + Process Improvement = Better Outcomes, Lower Costs

ProvenCare® CABG Quality Clinical Outcomes - (18. mos)

<table>
<thead>
<tr>
<th>Outcome</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></td>
</tr>
<tr>
<td>Patients with any complication (STS)</td>
<td>38 %</td>
<td>30 %</td>
<td>21 %</td>
</tr>
<tr>
<td>Patients with &gt;1 complication</td>
<td>7.6 %</td>
<td>5.5 %</td>
<td>28 %</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.
A Warranty is Not an Outcome Guarantee

• Offering a warranty on care does not imply that you are guaranteeing a cure or a good outcome
• It merely means that you are agreeing to correct problems at no (additional) charge
• Most warranties are “limited warranties,” in the sense that they agree to pay to correct some problems, but not all
Example: $10,000 Procedure

Cost of Procedure

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

<table>
<thead>
<tr>
<th>Cost of Procedure</th>
<th>Added Cost of Infection</th>
<th>Rate of Infections</th>
<th>Average Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>$10,000</td>
<td>$20,000</td>
<td>5%</td>
<td>$11,000</td>
</tr>
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<td>Rate of Infections</td>
<td>Average Total Cost</td>
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<td>-------------------</td>
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<td>$20,000</td>
<td>5%</td>
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Limited Warranty Gives Financial Incentive to Improve Quality

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<th>Cost of Procedure</th>
<th>Added Cost of Infection</th>
<th>Rate of Infections</th>
<th>Average Total Cost</th>
<th>Price Charged</th>
<th>Change in Net Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>$10,000</td>
<td>$20,000</td>
<td>5%</td>
<td>$11,000</td>
<td>$11,000</td>
<td>$0</td>
</tr>
<tr>
<td>$10,000</td>
<td>$20,000</td>
<td>4%</td>
<td>$10,800</td>
<td>$11,000</td>
<td>$200</td>
</tr>
</tbody>
</table>

Reducing Adverse Events...
...Reduces Costs...
...Improves The Bottom Line
Higher-Quality Provider Can Charge Less, Attract More Patients

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<tr>
<td>$10,000</td>
<td>$20,000</td>
<td>4%</td>
<td>$10,800</td>
<td>$11,000</td>
<td>$200</td>
</tr>
<tr>
<td>$10,000</td>
<td>$20,000</td>
<td>4%</td>
<td>$10,800</td>
<td>$10,800</td>
<td>$0</td>
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Enables Lower Prices
### A Virtuous Cycle of Quality Improvement & Cost Reduction

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<tr>
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<tr>
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<td>3%</td>
<td>$10,600</td>
<td>$10,800</td>
<td>$200</td>
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</tbody>
</table>

- Reducing Adverse Events...
- ...Reduces Costs...
- ...Improves The Bottom Line

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Win-Win-Win for Patients, Payers, and Providers

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<th>Cost of Procedure</th>
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<td>$10,000</td>
<td>$10,600</td>
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Quality is Better...

...Cost is Lower...

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

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Non-Payment for Infections Causes Losses While Improving
CMS “Bundling” Initiatives Provide Multiple Opportunities

- **Model 1 (Inpatient Gainsharing, No Warranty)**
  - Hospitals can share savings with physicians
  - No actual change in the way Medicare payments are made

- **Model 2 (Virtual Full Episode Bundle + Warranty)**
  - Budget for Hospital + Physician + Post-Acute + Readmissions
  - Medicare pays bonus if actual cost < budget
  - Providers repay Medicare if actual cost > budget

- **Model 3 (Virtual Post-Acute Bundle + Warranty)**
  - Budget for Post-Acute Care + Physicians + Readmissions
  - Bonuses/penalties paid based on actual cost vs. budget

- **Model 4 (Prospective Inpatient Bundle, No Warranty)**
  - Single Hospital + Physician payment for inpatient care
How do you prevent unnecessary episodes of care? (e.g., preventable hospitalizations for chronic disease, overuse of cardiac surgery, back surgery, etc.)
Not Just *Better* Acute Care, But *Reducing* the Need for It

Healthy Consumer -> Continued Health -> Health Condition -> No Hospitalization -> Acute Care Episode

Efficient Successful Outcome
- High-Cost Successful Outcome
- Complications, Infections, Readmissions
Significant Reduction in Rate of Hospitalizations Possible

Examples:

- 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. Benjaminovitz, 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

- Office Visits
- ER Visits
- Hospital Stay

Physician Practice

- Phone Calls
- Nurse Care Mgr

Avoidable
Avoidable
Avoidable

No payment for services that can prevent utilization...
...No penalty or reward for high utilization elsewhere
Option 1: Add New Fee Codes for Unreimbursed PCP Services

MEDICAL HOME PROGRAM

Health Insurance Plan

Physician Practice

- Office Visits
- Phone Calls
- Nurse Care Mgr

ER Visits
- Avoidable

Lab Work/Imaging
- Avoidable

Hospital Stay
- Avoidable

Higher payment for primary care

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Option 2: Pay for Monthly “Care Mgt” to Cover Missing Services

MEDICAL HOME PROGRAM

Health Insurance Plan

- Office Visits
- ER Visits
- Hospital Stay

Physician Practice

- Monthly Care Mgt Payment
  - Phone Calls
  - RN Care Mgr
- Avoidable
- Avoidable

Higher payment for primary care

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More $ for PCPs, But Any Savings Elsewhere?

MEDICAL HOME PROGRAM

Health Insurance Plan

- Office Visits
- ER Visits
- Hospital Stay

Physician Practice

- Monthly Care Mgt Payment
- Phone Calls
- RN Care Mgr

Avoidable

Avoidable

Avoidable

Higher payment for primary care

...But no commitment to reduce utilization elsewhere
Option 3: “Shared Savings” (More $ Only If Total Costs Decrease)

**SHARED SAVINGS MODEL**

- **Health Insurance Plan**
  - **Physician Practice**
    - Office Visits
    - Phone Calls
    - Nurse Care Mgr
  - Specialty Consults
  - Lab Work/Imaging
  - Hospital Stay

- **Portion of savings from reduced spending in other areas...**
- **...but no upfront $ for better care**

...Returned to physician practice after savings determined...
Option 4: Resources + Accountability

CARE MGT PAYMENT + UTILIZATION P4P

Health Insurance Plan

Physician Practice

Office Visits

Monthly Care Mgt Payment

Phone Calls

RN Care Mgr

ER Visits

Lab Work/Imaging

Hospital Stay

Avoidable

Avoidable

Avoidable

P4P Bonus/Penalty Based on Utilization

More $ for PCP

Targets for Reduction In Utilization

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Example: Washington State Medical Home Pilot Program

• 4-Part Payment Model
  – Current FFS payments for PCP services
  – Additional PMPM pmt for “care management”
    • $2.50 per patient per month in Year 1 (part of year)
    • $2.00 per patient per month in Years 2 & 3
    • No restrictions on how money is used
  – Penalty for failure to reduce ER/hospital utilization
    • Focus: Non-urgent ER visits and preventable admissions
    • Reduction targets large enough to repay health plans for upfront payments
    • Penalty for failure: Repayment of up to 50% of PMPM payment
  – Bonus for success in reducing utilization beyond targets
    • 50/50 split of payers’ savings from reductions in ER visits and/or hospitalizations net of PMPM payment
    • Quality of care must be maintained based on quality measures

• Implementation Began May 2011
  – 7 health plans (5 commercial, 2 Medicaid)
  – 12 primary care practice sites (8 provider orgs), ~ 25,000 patients
**Example: A Hypothetical Underpaid PCP Practice**

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Many Patients Are Going to ER Due to Difficulty Seeing PCPs

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### 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 |

PCPs Could Reduce ER Expenses With Right Resources

With the right resources, PCPs could reduce ER expenses by preventing 40% of visits, leading to a total cost savings of $256,000. This includes a reduction in Prev. ER Visits of 40%, leading to a savings of $256,000. The cost to the payer is reduced by 13%, from $640,000 to $512,000, while the PCPs receive an increase in salary of 12%, from $180,000 to $200,750. The net savings to the payer is $83,000. The upfront payment is $90,000, and the payment to the practice is also $90,000, resulting in a net savings to the payer of $166,000.
Upfront Money Could *Enable* PCPs to Change, If Willing

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- PCPs: 4
- Patients/Physician: 2,000
- PMPY Primary Care Cost: $140
- Annual Revenue: $1,120,000
- Overhead Costs: $400,000
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Savings:
- Reduction in Prev. ER Visits: 40%
- Savings: $256,000
- Net Savings to Payer: $166,000

Net Savings to Payer: $166,000

New Physician Salary: $200,750

Increase in Phys. Salary: 12%

% Savings to Payer: 13%
# Payer Can Reward PCP for Results and Still Save Money

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# Win-Win-Win for PCPs, Patients, & Premiums

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## Health Plan ER Expenses

- **Upfront Payment**: $90,000
- **Payment to Practice**: $90,000
- **Net Savings to Payer**: $166,000
- **Share of Savings**: $83,000
- **Share to Practice**: 50%
- **Net Savings to Payer**: $83,000
- **New Physician Salary**: $200,750
- **Increase in Phys. Salary**: 12%
- **% Savings to Payer**: 13%
But *Upfront* Payment Reform is Needed So Care Can Be Changed

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And Outcome Targets Need to Be Things Physicians Can Influence

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Not Just PCPs, But The Medical Neighborhood, Too

Primary Care Medical Home

Resources & Incentives for More Coordinated Care

FFS Payment Based on Volume, Procedures, & Office Visits

(Non-Primary Care) Specialists

PATIENT

FFS Payment Based on Volume, Procedures, & Office Visits

(Non-Primary Care) Specialists

PATIENT

Primary Care Medical Home

Resources & Incentives for More Coordinated Care
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
• All payers in Minnesota (except for Medicare) agreed 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/
Option 5: Partial Comprehensive Care Payment

PARTIAL GLOBAL PMT (Professional Svcs)

Health Insurance Plan

Condition-Adjusted Per Person Payment

PCPs + Specialists

Office Visits
Phone Calls
Nurse Care Mgr

ER Visits
Lab Work/Imaging

Hospital Stay
Avoidable

P4P Bonus/Penalty Based on Utilization

Flexibility and accountability for a condition-adjusted budget covering all professional services
Option 6: Risk-Adjusted Full Comprehensive Care Payment

COMPREHENSIVE CARE/YEAR-LONG EPISODE

Health Insurance Plan

Condition-Adjusted Per Person Payment

PCPs + Specialists

Office Visits
Phone Calls
Nurse Care Mgr

ER Visits
Lab Work/Imaging

Hospital Stay

Avoidable
Avoidable
Avoidable

P4P Bonus/Penalty Based on Quality

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Isn’t This Capitation? 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

Isn’t This Capitation?
No – It’s Different
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
  – Allows provider to reap returns on investment in preventive care, infrastructure

• 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

Things Needed to Make Comp. Care Payment a Win-Win-Win

• **Trusted, Shared Data on Current Utilization, Cost**
  – Physician needs to know current rates of admissions, complications, etc. to set prices appropriately
  – Purchaser/payer needs to know that they’re getting a better deal than they are today

• **Protections for Physicians from Insurance Risk**
  – Severity adjustment of payment
  – Risk corridors in case costs were mis-estimated
  – Outlier payments for unusually expensive patients
  – Risk exclusions for some patient populations

• **Good Measures of Outcomes**
  – Measures meaningful to patients using high-quality data
Quality Measures Needed to Ensure Low Cost ≠ Low 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

• Ideal: Develop quality measures with participation of physicians and hospitals, as a growing number of regions do
Transitioning to Accountable Care Payment

**CARE MGT PAYMENT + UTILIZATION P4P**

Health Insurance Plan

- Office Visits
- Monthly Care Mgt Payment
- ER Visits
- Phone Calls
- Lab Work/Imaging
- Nurse Care Mgr

**PARTIAL GLOBAL PMT (Professional Svcs)**

Health Insurance Plan

- Condition-Adjusted Per Person Payment
- Physician Practice
- ER Visits
- Lab Work/Imaging
- Nurse Care Mgr

**FULL COMP. CARE/GLOBAL PMT + QUALITY P4P**

Health Insurance Plan

- Condition-Adjusted Per Person Payment
- Physician Practice/ACO
- ER Visits
- Lab Work/Imaging
- Nurse Care Mgr

- P4P Bonus/Penalty Based on Utilization
- Targets for Reduction in Utilization
- More $ for PCP
- P4P Bonus/Penalty Based on Utilization
- Flexibility and accountability for a condition-adjusted budget covering all professional services

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Michigan BC/BS Physician Group Incentive Program

Phase I

Fee-for-Service

Virtual MD Group

Fee-for-Service + P4P for QI

Virtual MD Group

Phase II

Fee-for-Service + P4P for QI + Medical Home $

Virtual MD Group

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Payment Reform Helps Control Utilization But Not Prices

- Changing the payment *method* removes the incentives to increase volume and removes barriers to reducing costs

- But under any payment method, prices may be too high or too low
  - If the price is (too) high, there are no savings and no incentive to transform care
  - If the price is too low, providers will be unable to deliver high-quality care and risk financial disaster
Growing Concern That Price, Not Use, is Driving Spending

Figure 1. Components of Change in Spending for Privately Insured Hospital Inpatient Care

Wide Variation in Payments for Same Procedure

**Massachusetts Health Care Cost Trends**

**Price Variation in Massachusetts Health Care Services**

---

**Table 5: Observed Prices for Selected High-Volume Medical DRGs by Severity of Illness, 2009**

<table>
<thead>
<tr>
<th>APR-DRG and severity</th>
<th>Minimum price</th>
<th>Median price</th>
<th>Average price</th>
<th>Maximum price</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knee joint replacement (302)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Severity 1</td>
<td>$5,202</td>
<td>$21,241</td>
<td>$21,040</td>
<td>$50,726</td>
</tr>
<tr>
<td>Severity 2</td>
<td>$7,599</td>
<td>$21,887</td>
<td>$22,743</td>
<td>$66,901</td>
</tr>
<tr>
<td>Severity 3</td>
<td>$16,069</td>
<td>$28,173</td>
<td>$30,376</td>
<td>$59,252</td>
</tr>
<tr>
<td>Cesarean delivery (540)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Severity 1</td>
<td>$3,244</td>
<td>$7,598</td>
<td>$7,859</td>
<td>$15,915</td>
</tr>
<tr>
<td>Severity 2</td>
<td>$2,828</td>
<td>$8,718</td>
<td>$9,338</td>
<td>$20,424</td>
</tr>
<tr>
<td>Severity 3</td>
<td>$3,621</td>
<td>$11,389</td>
<td>$13,266</td>
<td>$26,018</td>
</tr>
<tr>
<td>Severity 4</td>
<td>$9,600</td>
<td>$17,134</td>
<td>$19,156</td>
<td>$30,660</td>
</tr>
</tbody>
</table>

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2:1 Price Range for MD Services Across/Within Regions in US

Source: Report to the Congress: Medicare and the Health Care Delivery System
Medicare Payment Advisory Commission, June 2011
How Do You Set the Price?

### APPROACHES TO SETTING PRICES

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<th>(All Payer) Regulation</th>
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## How Do You Set the Price?

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Ability to Negotiate
Depends on Market Power
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<td>Result varies depending on size of payer vs. provider</td>
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<tr>
<td>Competition</td>
<td>Providers set prices in order to attract more patients</td>
</tr>
</tbody>
</table>
Lack of Effective Incentives for Value-Based Choice by Patients

• Copays, Co-insurance, and High Deductibles do little to encourage patients to be cost-conscious in choosing among high-cost providers and services
### Where Will You Get Your Knee Replaced?

<table>
<thead>
<tr>
<th>Knee Joint Replacement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Price #1</strong></td>
</tr>
<tr>
<td>$23,000</td>
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</table>
Copayment?

Use High Price Provider

Knee Joint Replacement

<table>
<thead>
<tr>
<th>Consumer Share of Surgery Cost</th>
<th>Price #1 $23,000</th>
<th>Price #2 $28,000</th>
<th>Price #3 $33,000</th>
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<tr>
<td>$1,000 Copayment:</td>
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Coinsurance?  
Use High Price Provider

Knee Joint Replacement

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<td>$1,000 Copayment:</td>
<td>$1,000</td>
<td>$1,000</td>
<td>$1,000</td>
</tr>
<tr>
<td>10% Coinsurance w/$2,000 OOP Max:</td>
<td>$2,000</td>
<td>$2,000</td>
<td>$2,000</td>
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### Consumer Share of Surgery Cost

<table>
<thead>
<tr>
<th>Price #1</th>
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</tr>
</thead>
<tbody>
<tr>
<td>$23,000</td>
<td>$28,000</td>
<td>$33,000</td>
</tr>
</tbody>
</table>

#### $1,000 Copayment:
- $1,000 Copayment: $1,000, $1,000, $1,000
- $5,000 Deductible: $5,000, $5,000, $5,000

#### 10% Coinsurance w/$2,000 OOP Max:
- $2,000 Coinsurance: $2,000, $2,000, $2,000
# Pay the Difference in Price?

## Use the High-Value Provider

**Knee Joint Replacement**

<table>
<thead>
<tr>
<th>Consumer Share of Surgery Cost</th>
<th>Price #1 $23,000</th>
<th>Price #2 $28,000</th>
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<td>$2,000</td>
</tr>
<tr>
<td>$5,000 Deductible:</td>
<td>$5,000</td>
<td>$5,000</td>
<td>$5,000</td>
</tr>
<tr>
<td>Highest-Value:</td>
<td>$0 ✓</td>
<td>$5,000</td>
<td>$10,000</td>
</tr>
</tbody>
</table>
### Tiered, Open Network is Better for Patient Than a Narrow Network

#### Knee Joint Replacement

<table>
<thead>
<tr>
<th>Consumer Share of Surgery Cost</th>
<th>Price #1 $20,000</th>
<th>Price #2 $25,000</th>
<th>Price #3 $30,000</th>
</tr>
</thead>
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<tr>
<td>$1,000 Copayment:</td>
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<td>$5,000</td>
<td>$5,000</td>
<td>$5,000</td>
</tr>
<tr>
<td>Highest-Value:</td>
<td>$0</td>
<td>$5,000</td>
<td>$10,000</td>
</tr>
<tr>
<td>Narrow Network:</td>
<td>$1,000</td>
<td>$25,000</td>
<td>$30,000</td>
</tr>
</tbody>
</table>
# Blue Cross/Blue Shield of MA Hospital Choice Cost-Share

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Low-Cost Hospitals</th>
<th>High-Cost Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP</td>
<td>$20</td>
<td>$20</td>
</tr>
<tr>
<td>SPC</td>
<td>$35</td>
<td>$35</td>
</tr>
<tr>
<td>Inpatient Hospital</td>
<td>$500</td>
<td>$1500*</td>
</tr>
<tr>
<td>Outpatient Hospital Day Surgery</td>
<td>$250</td>
<td>$1250</td>
</tr>
<tr>
<td>High Tech Radiology</td>
<td>$50</td>
<td>$500</td>
</tr>
<tr>
<td>Laboratory</td>
<td>$0</td>
<td>$35</td>
</tr>
<tr>
<td>X-Rays/Other Imaging Tests</td>
<td>$0</td>
<td>$100</td>
</tr>
<tr>
<td>PT/OT/ST</td>
<td>$35</td>
<td>$70</td>
</tr>
</tbody>
</table>

*LOWER INPATIENT COPAY APPLIES IF EMERGENCY ADMISSION*
Today: Hard to Know if Better Price Means Better Value

<table>
<thead>
<tr>
<th>Payment for Procedure</th>
<th>Provider 1:</th>
<th>$10,000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Provider 2:</td>
<td>$9,500</td>
</tr>
<tr>
<td></td>
<td>-5%</td>
<td></td>
</tr>
</tbody>
</table>
What Hidden Costs Accompany the Lower Price?

<table>
<thead>
<tr>
<th>Payment for Procedure</th>
<th>Added Payment for Infection</th>
<th>Rate of Infections</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Provider 1:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$10,000</td>
<td>$20,000</td>
<td>5%</td>
</tr>
<tr>
<td><strong>Provider 2:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$9,500 (green)</td>
<td>$19,000</td>
<td>10%</td>
</tr>
<tr>
<td>-5%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Total Spending May Be Higher With the “Lower Price” Provider

<table>
<thead>
<tr>
<th>Payment for Procedure</th>
<th>Added Payment for Infection</th>
<th>Rate of Infections</th>
<th>Average Total Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Provider 1:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$10,000</td>
<td>$20,000</td>
<td>5%</td>
<td>$11,000</td>
</tr>
<tr>
<td><strong>Provider 2:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$9,500</td>
<td>$19,000</td>
<td>10%</td>
<td>$11,400</td>
</tr>
<tr>
<td>-5%</td>
<td></td>
<td></td>
<td>+4%</td>
</tr>
</tbody>
</table>

Provider 2 has a lower starting price, but is more expensive when lower quality is factored in.
## Bundled/Episode Payments Allow Comparing Apples to Apples

<table>
<thead>
<tr>
<th>Payment for Procedure</th>
<th>Added Payment for Infection</th>
<th>Rate of Infections</th>
<th>Bundled/Episode Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider 1:</td>
<td></td>
<td>5%</td>
<td>$11,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider 2:</td>
<td></td>
<td>10%</td>
<td>$11,400</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>+4%</td>
</tr>
</tbody>
</table>

Bundled prices show that Provider 1 is the higher-value provider.
Lack of Effective Incentives for Value-Based Choice by Patients

- Copays, Co-insurance, and High Deductibles do little to encourage patients to be cost-conscious in choosing among high-cost providers and services.

- Copays, Co-insurance, and High Deductibles can discourage patients from getting preventive treatments they need.
Example: Important to Coordinate Pharmacy & Medical Benefits

Single-minded focus on reducing costs here...

...could result in higher spending on hospitalizations

Pharmacy Benefits

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

Principal treatment for most chronic diseases involves regular use of maintenance medication

Medical Benefits

- Hospital Costs
- Physician Costs
- Other Services
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

Payment System

Patient

Provider

Ability and Incentives to:
• Keep patients well
• Avoid unneeded services
• Deliver services efficiently
• Coordinate services with other providers
Challenge: Gaining Support from a Critical Mass of Payers

Provider is only compensated for changed practices for the subset of patients covered by participating payers.
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.
Purchasers Must Support Multi-Payer Payment Reforms
Payer Coordination Is Beginning to Occur Around the Country

• Examples of Multi-Payer Payment Reforms:
  – Colorado, Maine, Michigan, Minnesota, New York, North Carolina, Oregon, Pennsylvania, Rhode Island, Vermont, and Washington all have multi-payer medical home initiatives

• 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
  – Medicare is now participating in eight of the state-led multi-payer medical home initiatives
Many Different Activities Needed for Success

Reducing Costs Without Rationing

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

- Public Reporting
- Business Case Analysis

- Claims, Clinical & Patient Data

- Technical Assistance to Providers
  - Design & Delivery of Care
  - Provider Organization/Coordination

- Value-Driven Delivery Systems

- Engagement of Purchasers
  - Alignment of Multiple Payers

- Value-Driven Payment & Benefits
  - Benefit Design
  - Payment System Design
How Can These Functions Be Delivered in a Coordinated Way?
Role of Regional Health Improvement Collaboratives

Regional Health Improvement Collaborative

- 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
...With Active Involvement of All Healthcare Stakeholders

Healthcare Providers

Healthcare Payers

Healthcare Purchasers

Healthcare Consumers

Regional Health Improvement Collab.
Growing Network of 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

Network for Regional Healthcare Improvement
www.NRHI.org
Getting Started on the Road to More Accountable Care

- Recognize that there is no one-size-fits-all solution or implementation path; the best thing the federal government can do is to support local strategies
- Get all stakeholders working together to design the kind of healthcare payment, delivery, and benefit structures the community wants to have in 5-7 years to reduce costs and improve quality
- Develop/implement a strategy for testing/implementing the payment and delivery reforms across the community
- Measure progress and resolve challenges through an ongoing collaborative, multi-stakeholder community process
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.NRHI.org
www.CHQPR.org
www.PaymentReform.org
Healthcare Redesign in SE MI: Today’s Work Session Topics

1. Improving Outcomes and Reducing Costs for Patients With Chronic Disease
   A. What should payment/delivery/benefits look like in Southeast Michigan in 5 years?
   B. How should Southeast Michigan transition to the desired structure?

2. Improving Outcomes and Reducing Costs for Patients Hospitalized With Cardiac Conditions
   A. What should payment/delivery/benefits look like in Southeast Michigan in 5 years?
   B. How should Southeast Michigan transition to the desired structure?
Guidelines for Work Sessions

• Goal A: Design payment systems for ~5 years in the future
  – It won’t be possible to make significant broad-based changes within a year or two
  – The need for change is too urgent to wait 10-20 years

• Goal B: How should the transition be made

• You’ll get a list of options as a starting point, but you’re free to modify them or add new ones
• There is no “right answer” -- a compromise that everyone supports is better than an ideal approach that nobody is willing to implement
• Don’t just rehash the problems or recommend more studies – work to forge agreement on solutions
• There are win-win solutions, but everyone will have to change to achieve them; preserving the status quo is impossible
• Be nice to your facilitator!