ACHIEVING HIGHER VALUE HEALTH CARE IN ALASKA:
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

Patients

Lower Costs

Organizational Structure

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But How Will ACOs Generate All These Savings?

ACO ("the "Black Box")

Financial Risk

Patients

Organizational Structure

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

- Financial Risk
- RATIONING
- Organizational Structure
- Patients
- Lower Costs

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Our Focus Should Be On How to Reduce Costs Without Rationing
Reducing Costs Without Rationing: *Can It Be Done??*
Reducing Costs Without Rationing: Prevention and Wellness

Healthy Consumer → Continued Health

Health Condition
Reducing Costs Without Rationing: Avoiding Hospitalizations

Healthy Consumer ➔ Continued Health ➔ No Hospitalization

Healthy Consumer ➔ Health Condition ➔ No Hospitalization

Healthy Consumer ➔ Health Condition ➔ Acute Care Episode

Health Condition

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
- Acute Care Episode
- 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

2

4

3

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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
How Is Alaska Doing?

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

- High-Cost Successful Outcome
- Complications, Infections, Readmissions
Better Hearts and Worse Joints in Alaska Than Other States?

Rate of Surgeries for Medicare Beneficiaries in Alaska vs. U.S., 2007

- All Surgery
- Coronary Angiography
- Percutaneous Coronary Interventions
- Carotid Endarterectomy
- Coronary Artery Bypass Grafting (CABG)
- Valve Replacement
- Back Surgery
- Hospitalization for Hip Fracture
- Knee Replacement
- Hip Replacement
- Radical Prostatectomy

Cardiac Surgery
Orthopedic Surgery
Low Preventable Admission Rate in Alaska, But Room to Improve

Rate of Hospitalizations for Ambulatory Care Sensitive Conditions, 2009
(Medicare Beneficiaries)

Hospitilizations per 100,000 Beneficiaries

0
1,000
2,000
3,000
4,000
5,000
6,000
7,000
8,000
9,000
10,000

Alaska

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25% of CHF Patients Return to The Hospital Within One Month

Hospital 30-Day Readmission Rates for Heart Failure

- PROVIDENCE ALASKA MEDICAL CENTER
- ALASKA NATIVE MEDICAL CENTER
- YUKON KUSKOKWIM DELTA REG HOSPITAL
- BARTLETT REGIONAL HOSPITAL
- ALASKA REGIONAL HOSPITAL
- KETCHIKAN GENERAL HOSPITAL
- FAIRBANKS MEMORIAL HOSPITAL
- MAT-SU REGIONAL MEDICAL CENTER
- SOUTH PENINSULA HOSPITAL
- CENTRAL PENINSULA GENERAL HOSPITAL

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Example: Prometheus Analyses of Avoidable Complications

Total Costs per ECR

- CHF
- COPD
- DM
- Asthma
- HTN
- CAD
- GERD
- AMI
- Stroke
- Pneumonia
- Hip
- Knee
- CABG
- Colon
- Bari
- Colos
- Gall
- Hyst
- Knee Arth
- PCI
- Preg

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Functions Needed for Regional Healthcare Reform

1

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3

4
Analysis & Reporting is #1

Quality/Cost Analysis & Reporting

4

3

2

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“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”

• 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

• 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
Who Should Be Accountable For Achieving Higher Value Care?

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

Healthy Consumer ➔ Continued Health ➔ PRIMARY CARE + SPECIALISTS

Health Condition ➔ No Hospitalization ➔ Efficient Successful Outcome

Acute Care Provider #1 ➔ Acute Care Provider #2 ➔ Acute Care Provider #3

Complications, Infections, Readmissions

High-Cost Successful Outcome
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

Unneeded Testing

Inpatient Episodes

Patient
Resources/Capabilities Needed for MDs to Take Accountability

- 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)
- MD w/ time for diagnosis, treatment planning, and followup

Physician Practice

Inpatient Episodes

Patient

Unneeded Testing
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

Health Plan or Disease Mgt Vendor

Physician Practice

Inpatient Episodes
Patient
Unneeded Testing
Medical Home Initiatives Expand MD Capacity, But Not Enough

**Patient-Centered Medical Home**
- 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

**Health Plan**

**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
Patient
Unneeded Testing

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#2 Is Redesigning Care for Better Outcomes & More Efficiency

- Quality/Cost Analysis & Reporting
- Value-Driven Delivery Systems

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You Can’t Manage What You Can’t Measure

Quality/Cost Analysis & Reporting

Value-Driven Delivery Systems

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Maine Physician Dashboards

**About Your Patients**

### Adult PCP Patients

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

**Key Risk Adjusted Utilization Measures**

Your use of services compared to your peers.

- Admissions
- Hospital days
- Emergency Dept visits
- Prescriptions

**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)
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

$
Better Payment Systems is #3

- Quality/Cost Analysis & Reporting
- Value-Driven Payment Systems
- Value-Driven Delivery Systems

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“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

Episode Payment

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
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>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>60 %</td>
</tr>
<tr>
<td>Neurologic complication</td>
<td>1.5 %</td>
<td>0.6 %</td>
<td>43 %</td>
</tr>
<tr>
<td>Any pulmonary complication</td>
<td>7 %</td>
<td>4 %</td>
<td>22 %</td>
</tr>
<tr>
<td>Blood products used</td>
<td>23 %</td>
<td>18 %</td>
<td>55 %</td>
</tr>
<tr>
<td>Re-operation for bleeding</td>
<td>3.8 %</td>
<td>1.7 %</td>
<td>25 %</td>
</tr>
<tr>
<td>Deep sternal wound infection</td>
<td>0.8 %</td>
<td>0.6 %</td>
<td>44 %</td>
</tr>
<tr>
<td>Readmission within 30 days</td>
<td>6.9 %</td>
<td>3.8 %</td>
<td></td>
</tr>
</tbody>
</table>
It Can Be Done By Physicians, Not Just Health Systems

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

• Method:
  – Reducing unnecessary auxiliary services such as radiography and physical therapy
  – Reducing the length of stay in the hospital
  – Reducing complications and readmissions.
Can Providers, Payers, & Patients All Benefit from Warranties?
| Cost of Procedure | $10,000 |

Example: $10,000 Procedure
Actual Average Payment for Procedure is More 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>
</tbody>
</table>
## Starting Point for Warranty Price: Current Actual Average Payment

<table>
<thead>
<tr>
<th>Cost of Procedure</th>
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<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>
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</table>
## Limited Warranty Gives Financial Incentive to Improve Quality

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<tr>
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</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

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### 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>$0</td>
</tr>
<tr>
<td>$10,000</td>
<td>$20,000</td>
<td>3%</td>
<td>$10,600</td>
<td>$10,800</td>
<td>$200</td>
</tr>
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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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<td>$10,000</td>
<td>$20,000</td>
<td>3%</td>
<td>$10,600</td>
<td>$10,800</td>
<td>$200</td>
</tr>
<tr>
<td>$10,000</td>
<td>$20,000</td>
<td>3%</td>
<td>$10,600</td>
<td>$10,600</td>
<td>$0</td>
</tr>
<tr>
<td>$10,000</td>
<td>$20,000</td>
<td>0%</td>
<td>$10,000</td>
<td>$10,600</td>
<td>$600</td>
</tr>
</tbody>
</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>
<th>Added Cost of Infection</th>
<th>Rate of Infections</th>
<th>Average Total Cost</th>
<th>Amount Paid</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>
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<tr>
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<td>$20,000</td>
<td>3%</td>
<td>$10,600</td>
<td>$10,000</td>
<td>-$600</td>
</tr>
<tr>
<td>$10,000</td>
<td>$20,000</td>
<td>0%</td>
<td>$10,000</td>
<td>$10,000</td>
<td>$0</td>
</tr>
</tbody>
</table>
The Weakness of Episode Payment

Healthy Consumer → Continued Health → Health Condition → No Hospitalization

**How do you prevent unnecessary episodes of care?**
(e.g., preventable hospitalizations for chronic disease, overuse of cardiac surgery, back surgery, etc.)

Acute Care Episode → Efficient Successful Outcome

- High-Cost Successful Outcome
- Complications, Infections, Readmissions
Comprehensive Care Payments
To Avoid Episodes

Healthy Consumer

Continued Health

Health 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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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. Benjamanovitz, 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

Physician Practice

- Office Visits
- Phone Calls
- Nurse Care Mgr

No payment for services that can prevent utilization...

- ER Visits
  - Avoidable
- Lab Work/Imaging
  - Avoidable
- Hospital Stay
  - Avoidable

...No penalty or reward for high utilization elsewhere
Comprehensive Care Payment Provides Flexibility+Accountability

**COMPREHENSIVE CARE/GLOBAL PAYMENT**

Health Insurance Plan

Condition-Adjusted Per Person Payment

Physician Practice/ACO

- Office Visits
- Phone Calls
- Nurse Care Mgr

ER Visits
- Avoidable

Hospital Stay
- Avoidable

Lab Work/Imaging
- Avoidable

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

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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
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

Comprehensive Care Payment Is a Big Jump from FFS

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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Is Shared Savings a Good Transitional Model?

SHARED SAVINGS MODEL

Health Insurance Plan

- Physician Practice
  - Office Visits
  - ER Visits
  - Hospital Stay
    - Avoidable
    - 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
A Better Transition: Simulate Flexibility/Incentives of Global Pmt

CARE MGT PAYMENT + UTILIZATION P4P

Health Insurance Plan

Office Visits

ER Visits

Avoidable

Avoidable

Hospital Stay

Avoidable

Targets for Reduction In Utilization

Physician Practice

Monthly Care Mgt Payment

Phone Calls

RN Care Mgr

More $ for PCP

P4P Bonus/Penalty Based on Utilization

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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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PCPs Could Reduce ER Expenses With Right Resources

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## Upfront Money Could Enable PCPs to Change, If Willing

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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

### PRIMARY CARE PRACTICE

|                        | 
|------------------------|---|
| PCPs                   | 4 |
| Patients/Physician     | 2,000 |
| PMPY Primary Care Cost | $140 |
| Annual Revenue         | $1,120,000 |
| 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 |
| Share of Savings       | $83,000 |
| New Physician Salary   | $200,750 |
| Increase in Phys. Salary | 12% |

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## Upfront Payment Reform Needed
So Care Can Be Changed

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And Outcome Targets Need to Be Things Physicians Can Influence

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

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<th>CONGRESS/ MEDICARE</th>
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<tr>
<td>Pay for Performance</td>
<td>Most regions and payers have some form of P4P for hospitals and/or MDs</td>
<td>Just implementing hospital P4P in 2011</td>
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<tr>
<td>Medical Homes</td>
<td>Major initiatives underway in CO, LA, MA, ME, MI, MN, NC, OR, PA, RI, VT, WA, etc.</td>
<td>Advanced Primary Care Demo based on 8 state medical home programs</td>
</tr>
<tr>
<td>Episode/Bundled Payment</td>
<td>Bundling/warranty initiatives underway or starting in California, Pennsylvania, Wisconsin, others</td>
<td>ACE bundling demo implemented in 2009 in four states; just announced new prog.</td>
</tr>
<tr>
<td>Total Cost Accountability</td>
<td>Physician groups/IPAs in CA, CO, MA, TX, WA, etc. paid by capitation/global pmt</td>
<td>Shared savings demos with 10 large MD groups</td>
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Better Payment Systems Require Good 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
Better Payment Systems Require Good 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
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
Measurement Supports Payment, As Well As Vice Versa

Quality/Cost Analysis & Reporting

Value-Driven Payment Systems

Value-Driven Delivery Systems

4
It’s Not Just The Right Payment Method, But Also the Right Price

• Improving the structure and incentives of payment systems is necessary but not sufficient

• The payment level is as important as the method
  – 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

• Medicare dictates prices, but private payers negotiate them
Need for Shared, Trusted Data For Pricing Episode/Global Pmt

• **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
How Doctors Will Need to Change to Deliver “Accountable Care”

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

• Small Primary Care Practices Managing Global Payments
  – Physician Health Partners (PHP) in Denver, CO is a management services organization that supports four separate IPAs (median size: 3 MDs/practice). PHP accepts capitated risk-based contracts on behalf of the IPAs with both Medicare and commercial HMOs.  
    [www.phpmcs.com](http://www.phpmcs.com)

• Independent PCPs & Specialists Managing Global Payments
  – Northwest Physicians Network (NPN) in Tacoma, WA is an IPA with 109 PCPs and 345 specialists in 165 practices (average size: 2.4 MDs/practice). NPN accepts full or partial risk capitation contracts, operates its own Medicare Advantage plan, and does third party administration for self-insured businesses.  
    [www.npnwa.net](http://www.npnwa.net)

• Joint Contracting by MDs & Hospitals for Global Payments
  – The Mount Auburn Cambridge IPA (MACIPA) and Mount Auburn Hospital jointly contract with three major Boston-area health plans for full-risk capitation. The IPA is independent of the hospital; they coordinate care with each other without any formal legal structure.  
    [www.macipa.com](http://www.macipa.com)
How Will Hospitals Have to Change?
Reducing Costs Without Rationing
Reduces Hospital Revenues

Healthy Consumer

Continued Health

Health Condition

No Hospitalization

Acute Care Episode

Efficient Successful Outcome

High-Cost Successful Outcome

Complications, Infections, Readmissions

Fewer Patients
Fewer Admissions
Less Revenue Per Admission
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

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

#Patients

Costs

$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

#Patients

$000

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

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Causing Negative Margins for Hospitals

<table>
<thead>
<tr>
<th>#Patients</th>
<th>Revenues ($000)</th>
<th>Costs ($000)</th>
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</thead>
<tbody>
<tr>
<td>100</td>
<td>$1,000</td>
<td>$800</td>
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<tr>
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<td>$710</td>
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<tr>
<td>90</td>
<td>$800</td>
<td>$700</td>
</tr>
</tbody>
</table>

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

Payers Can Still Save $ Without Causing Negative Margins for Hospital

Cost & Revenue Changes With Fewer Patients

#Patients

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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.

• Both hospitals and payers will need a better understanding of hospital costs to determine what payment level is needed.
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

Payer

Better Payment System

Provider

Patient

Payer

Better Payment System

Payer

Better Payment System

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:
  – 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
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
Example: Coordinating Pharmacy & Medical Benefits

Single-minded focus on reducing costs here...

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

...could result in higher spending on hospitalizations

Pharmacy Benefits

- Drug Costs

Medical Benefits

- Hospital Costs
- Physician Costs
- Other Services

Principal treatment for most chronic diseases involves regular use of maintenance medication
Where Will You Get Your Knee Replaced?

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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<tbody>
<tr>
<td>$1,000 Copayment:</td>
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<tr>
<td>10% Coinsurance w/$2,000 OOP Max:</td>
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<td>$2,000</td>
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<tr>
<td>$5,000 Deductible:</td>
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<td>$5,000</td>
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<tr>
<td>Highest-Value:</td>
<td>$0 ✓</td>
<td>$5,000</td>
<td>$10,000</td>
</tr>
</tbody>
</table>
Both Payment & Benefits Are Controlled by the Payer

**PAYER**

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

**Payment System**
- Ability and Incentives to:
  - Keep patients well
  - Avoid unneeded services
  - Deliver services efficiently
  - Coordinate services with other providers

**Patient**

**Provider**
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

Payment System

Patient

Provider
Consumer Support is #4, And Fundamental to All

- Consumer Education & Engagement
- Quality/Cost/Experience Analysis & Reporting
- Value-Driven Payment Systems & Benefit Designs
- Value-Driven Delivery w/ Patient Participation

Consumer Support is #4, and fundamental to all Value-Driven Payment Systems & Benefit Designs.
Many Specific, Complex Tasks Within Each Function

Quality/Cost Reporting
- Quality Reporting
- Cost/Price Reporting

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

Consumer Education/Engagement
- Education Materials
  - Consumer Education/Engagement

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

Value-Driven Payment Systems
Functions and Support Activities Can’t Proceed In Silos

Who can connect and coordinate all of this?

- Education Materials
- Consumer Education/Engagement
- Quality Reporting
- Cost/Price Reporting
- Technical Assistance to Providers
- Design & Delivery of Care
- Provider Organization/Coordination
- Engagement of Purchasers
- Alignment of Multiple Payers
- Benefit Design
- Payment System Design

Quality/Cost Measure Design
That’s the Role of Regional Health Improvement Collaboratives...

Regional Health Improvement Collaborative

- Quality/Cost Measure Design
- Quality Reporting
- Cost/Price Reporting
- Education Materials
- Consumer Education/Engagement
- Technical Assistance to Providers
- Design & Delivery of Care
- Provider Organization/Coordination
- Engagement of Purchasers
- Alignment of Multiple Payers
- Benefit Design
- Payment System Design
...With Active Involvement of All Healthcare Stakeholders

Healthcare Providers

Healthcare Payers

Healthcare Purchasers

Healthcare Consumers

Regional Health Improvement Collab.
Leading Health Improvement Collaboratives in the U.S.

- 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

Regional Health Improvement Collaboratives in the Network for Regional Healthcare Improvement

www.NRHI.org
Don’t Wait for Washington

- Recognize that there is no one-size-fits-all solution or implementation path; every state and community is different, and the best thing the federal government can do is to support local strategies.
- Educate all stakeholders and build consensus on the need for changes in healthcare payment, delivery, and benefit structures to reduce costs and improve quality.
- Convene stakeholders to design win-win-win approaches for their community and a feasible transition strategy.
- Get federal and state support (e.g., Medicare, Medicaid, state employees, laws/regulations) for the community’s strategies.
- Measure progress and resolve challenges through an ongoing state/local, multi-stakeholder, collaborative process.
For More Information:

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and
Executive Director, Center for Healthcare Quality and Payment Reform

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