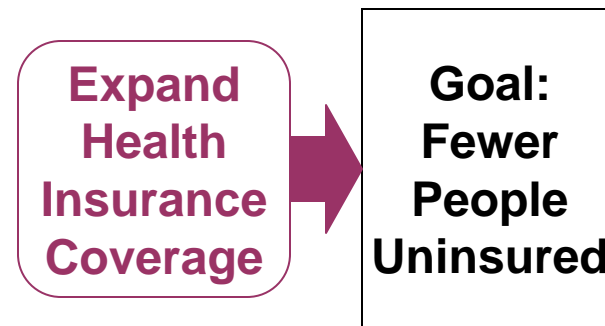


DON'T WAIT FOR WASHINGTON TO FIX HEALTHCARE: How Local Leadership Can Control Costs and Improve Quality

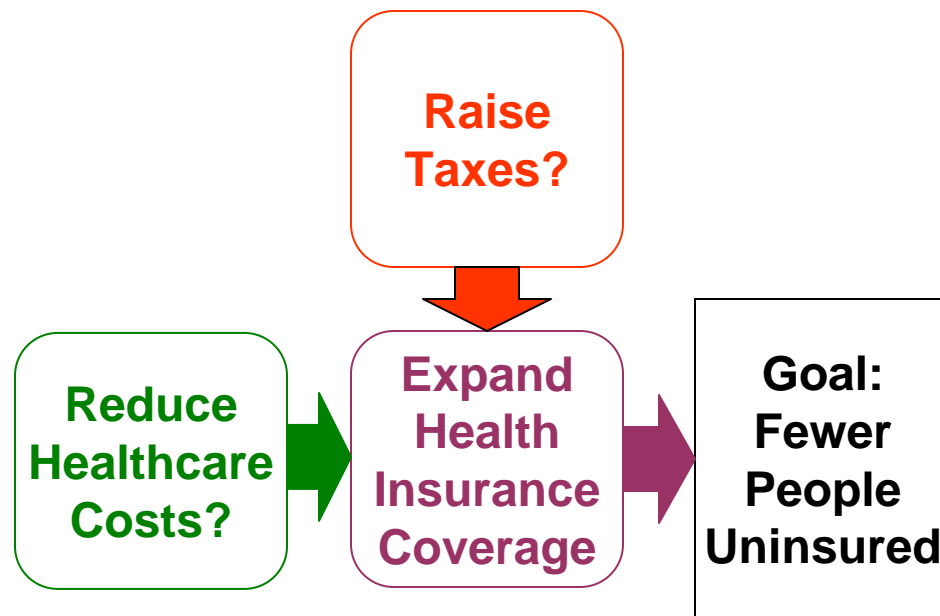
Harold D. Miller
President and CEO
Network for Regional Healthcare Improvement
and
Executive Director
Center for Healthcare Quality and Payment Reform

The Healthcare Problem Washington Is Trying to Solve

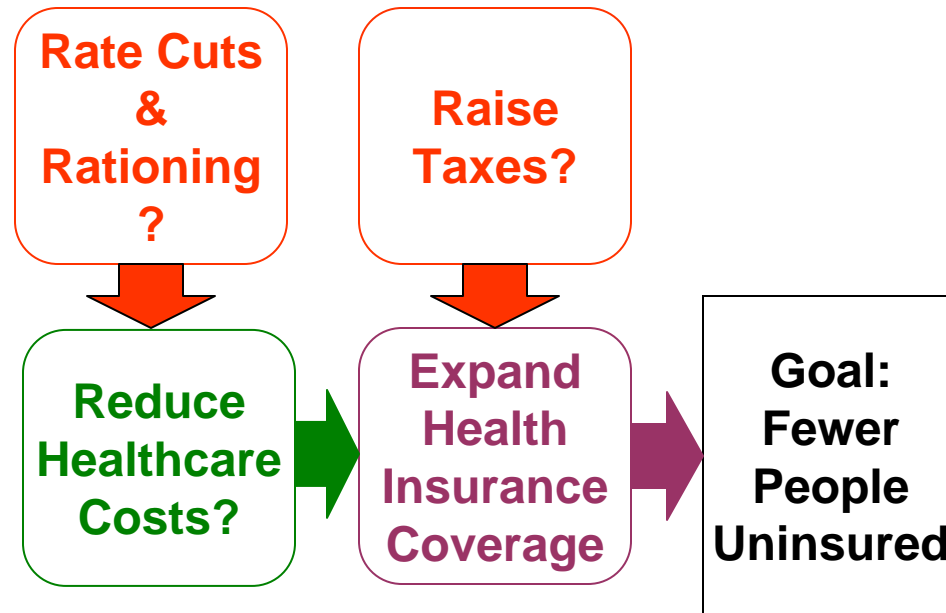


- Individual Mandate?
- Employer Mandate?
- Public Plan?
- Community Rating?

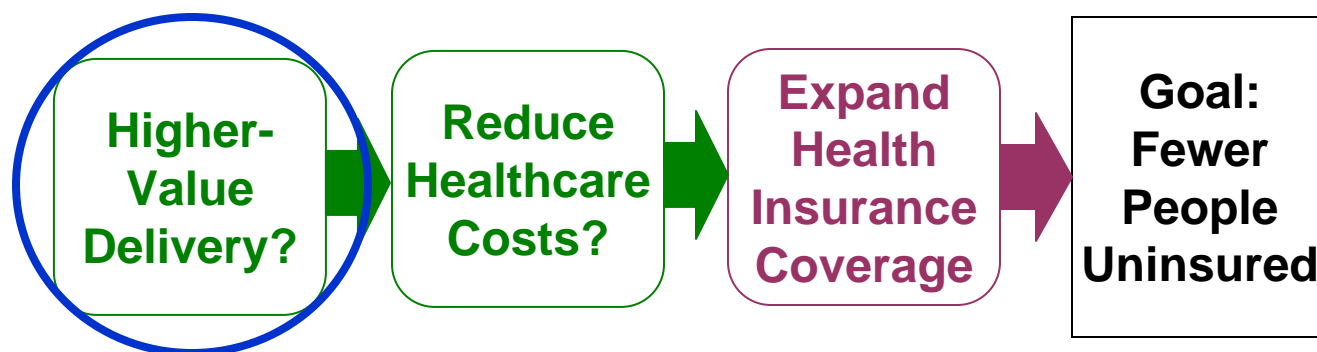
But How to Pay For It?



Reducing Costs Isn't Better If It Means Rate Cuts or Rationing

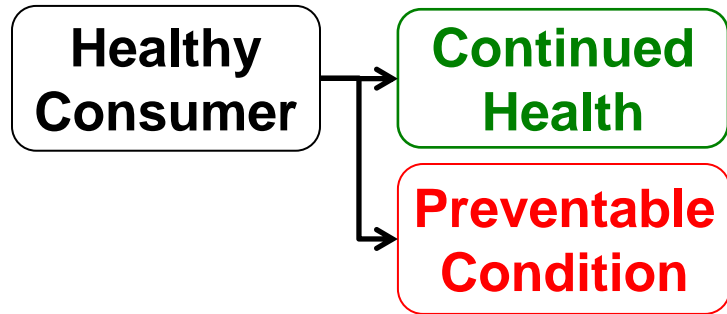


The Ideal Path – But Is It Possible?

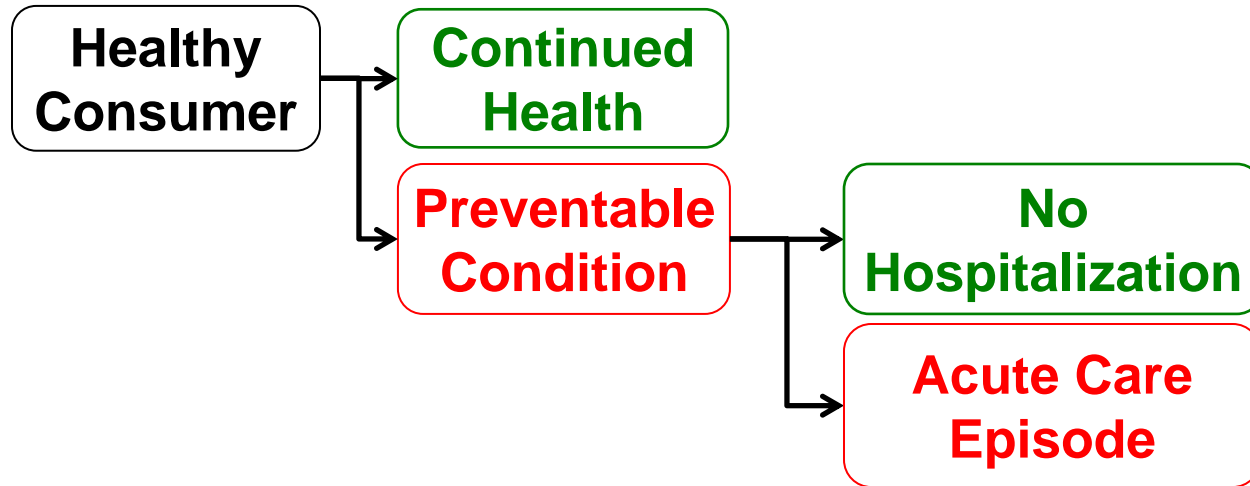


**THE “HOLY GRAIL”:
BETTER, MORE
AFFORDABLE
HEALTH CARE
WITHOUT RATIONING**

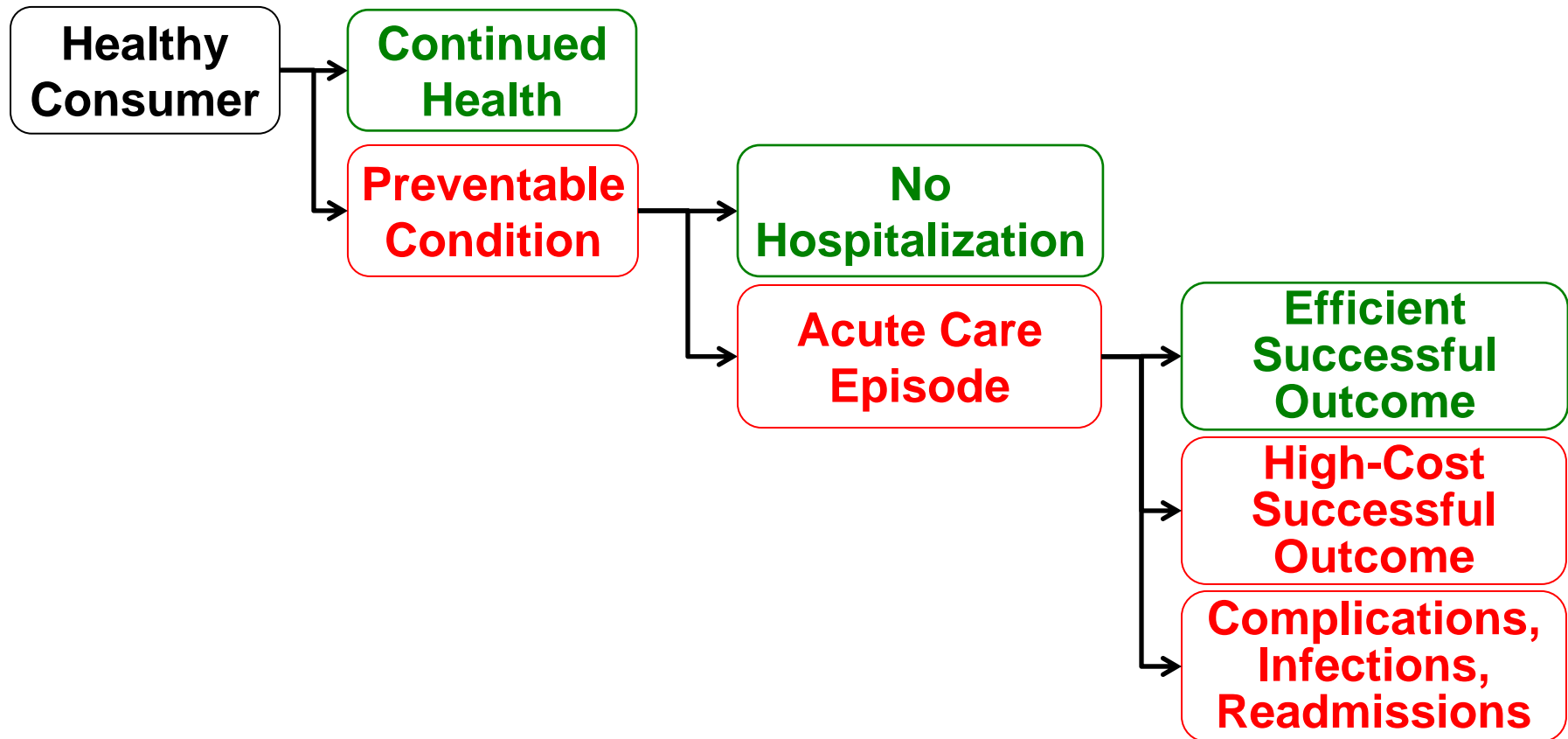
nrhi Reducing Costs Without Rationing: Prevention



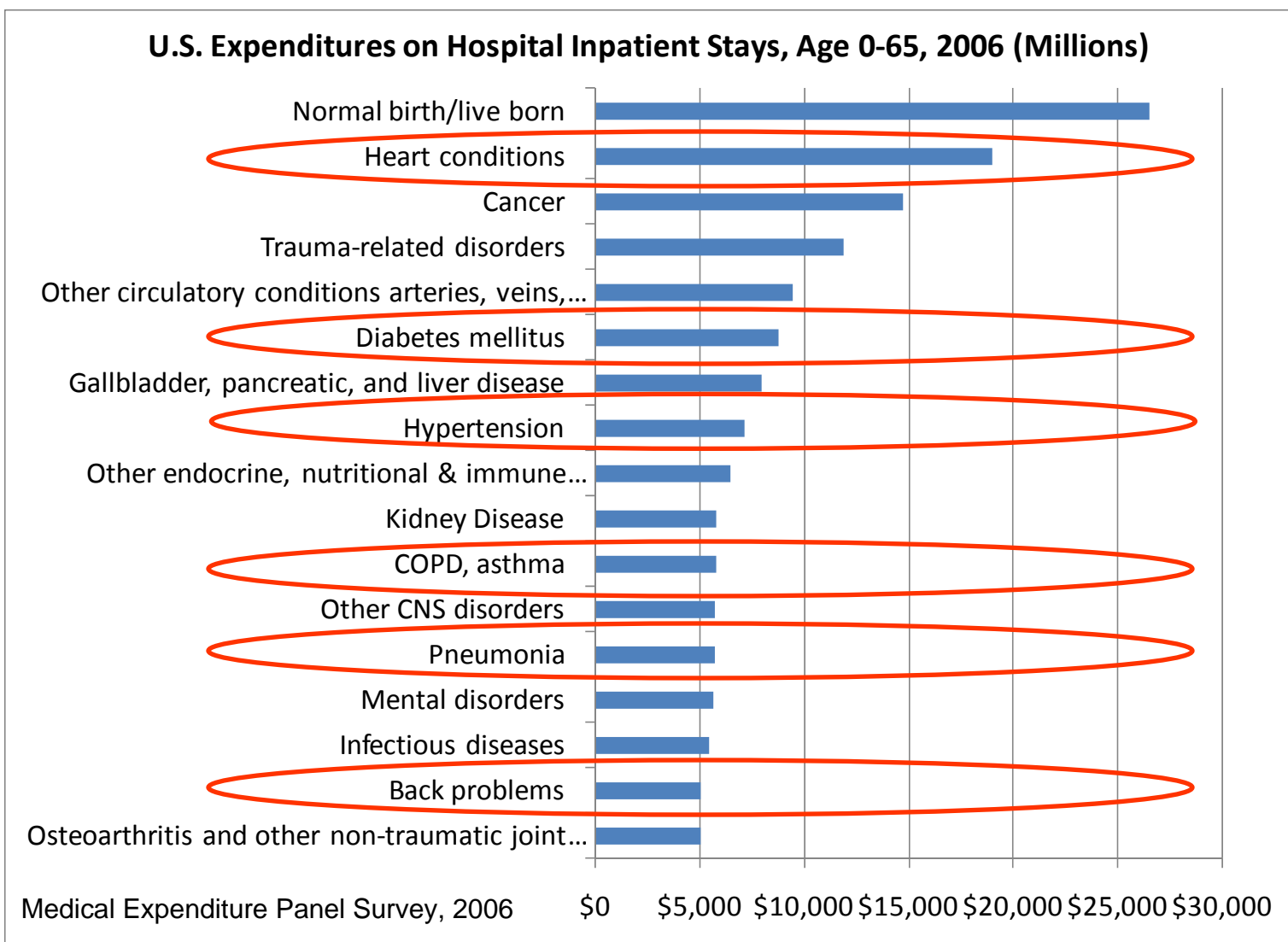
nrhi Reducing Costs Without Rationing: Avoiding Hospitalizations



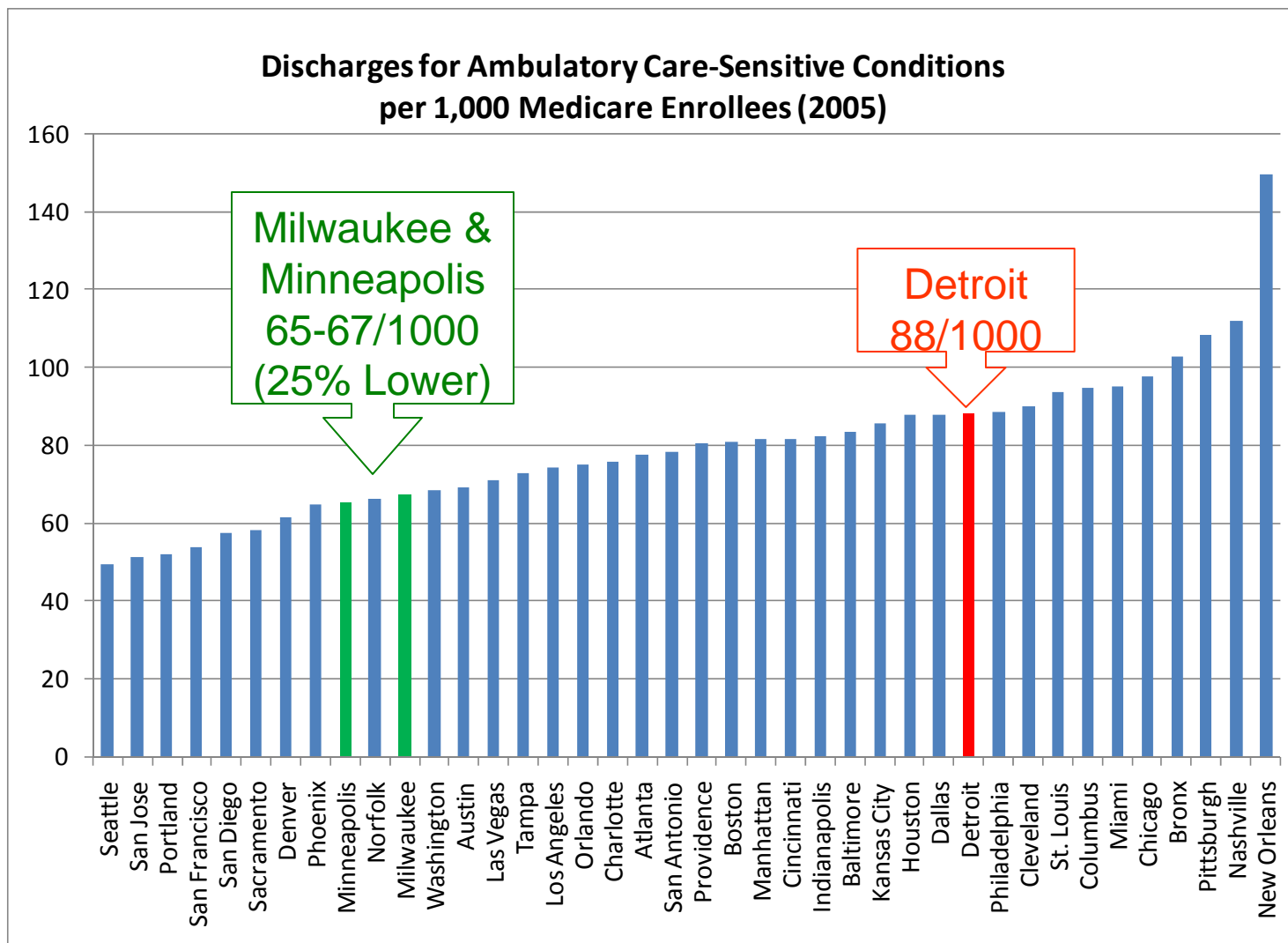
nrhi Reducing Costs Without Rationing: Efficient, Successful Treatment



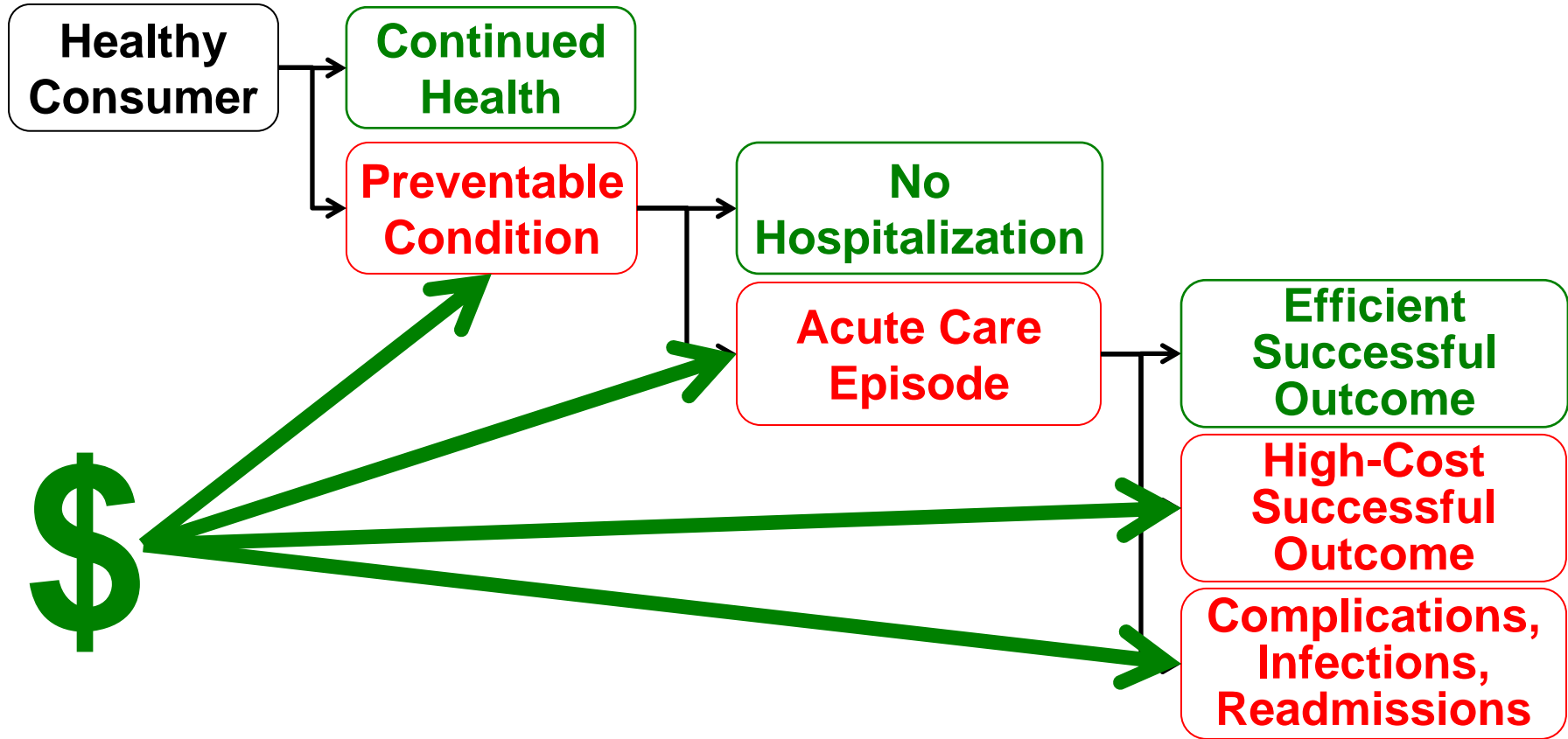
Opportunity: “Ambulatory-Care Sensitive Conditions”



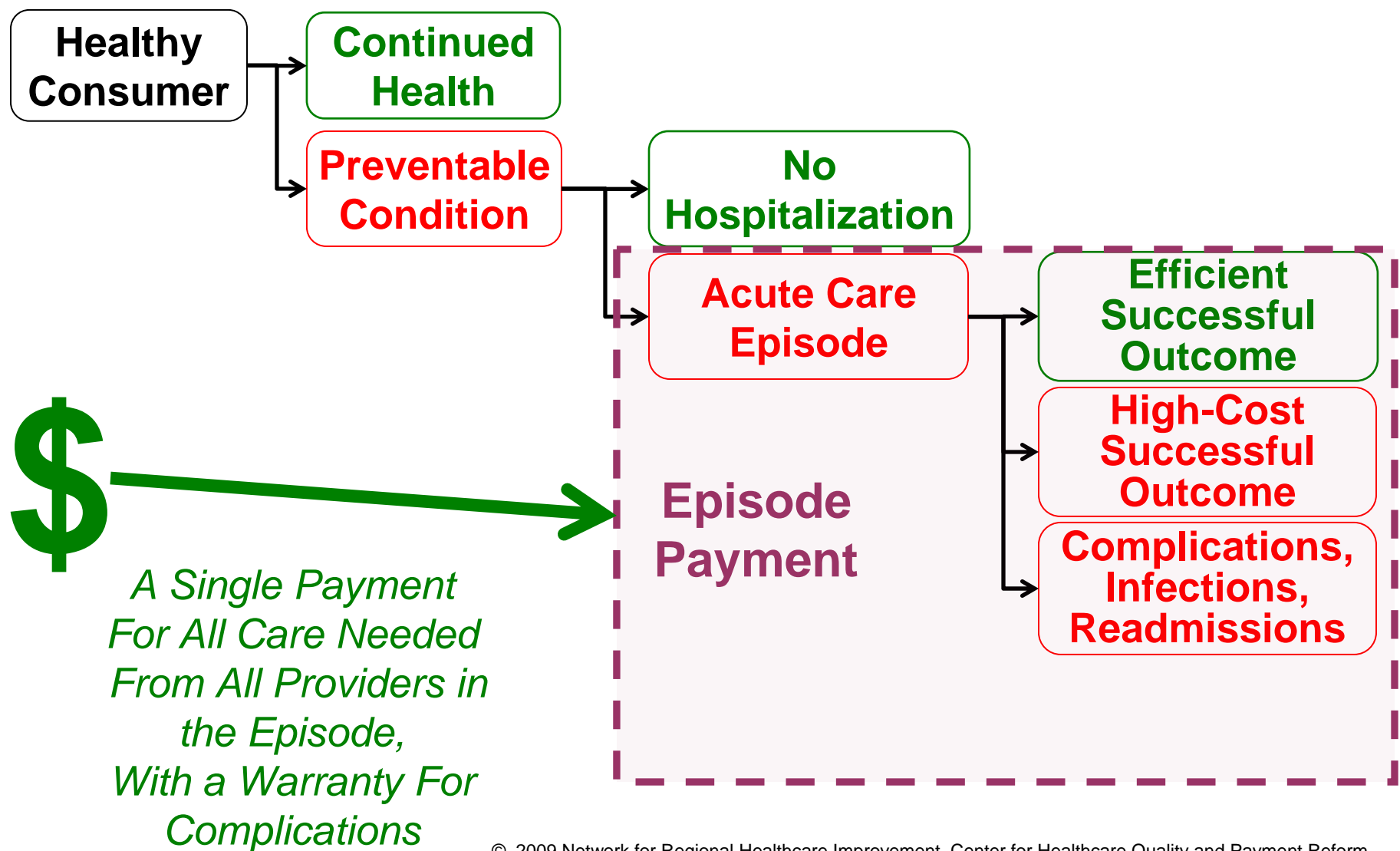
Detroit Region Is 11th Worst in Preventable Admissions



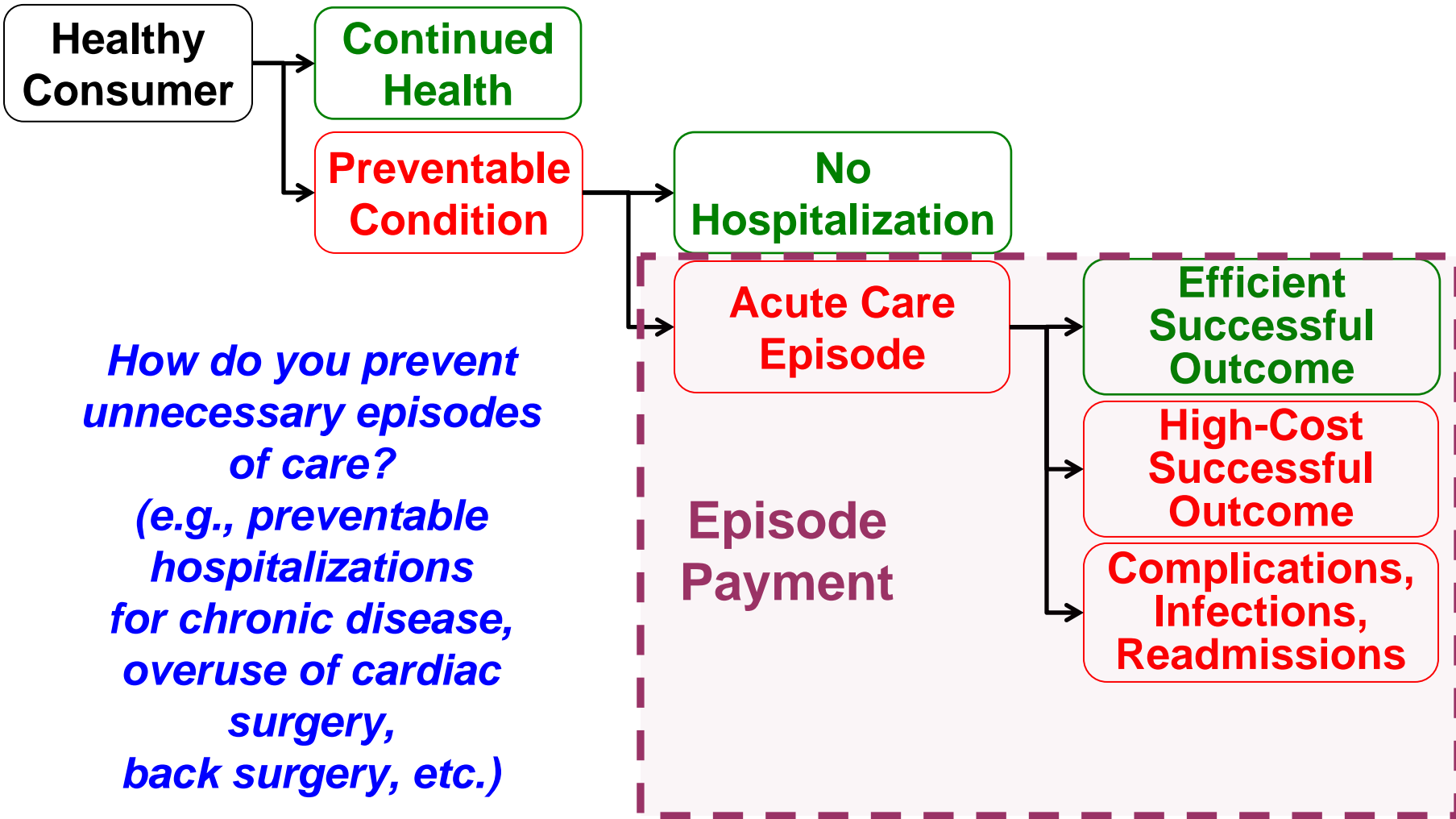
nrhi Current Payment Systems Reward Bad Outcomes, Not Better Health



“Episode Payments” to Reward Efficiency *Within* Episodes

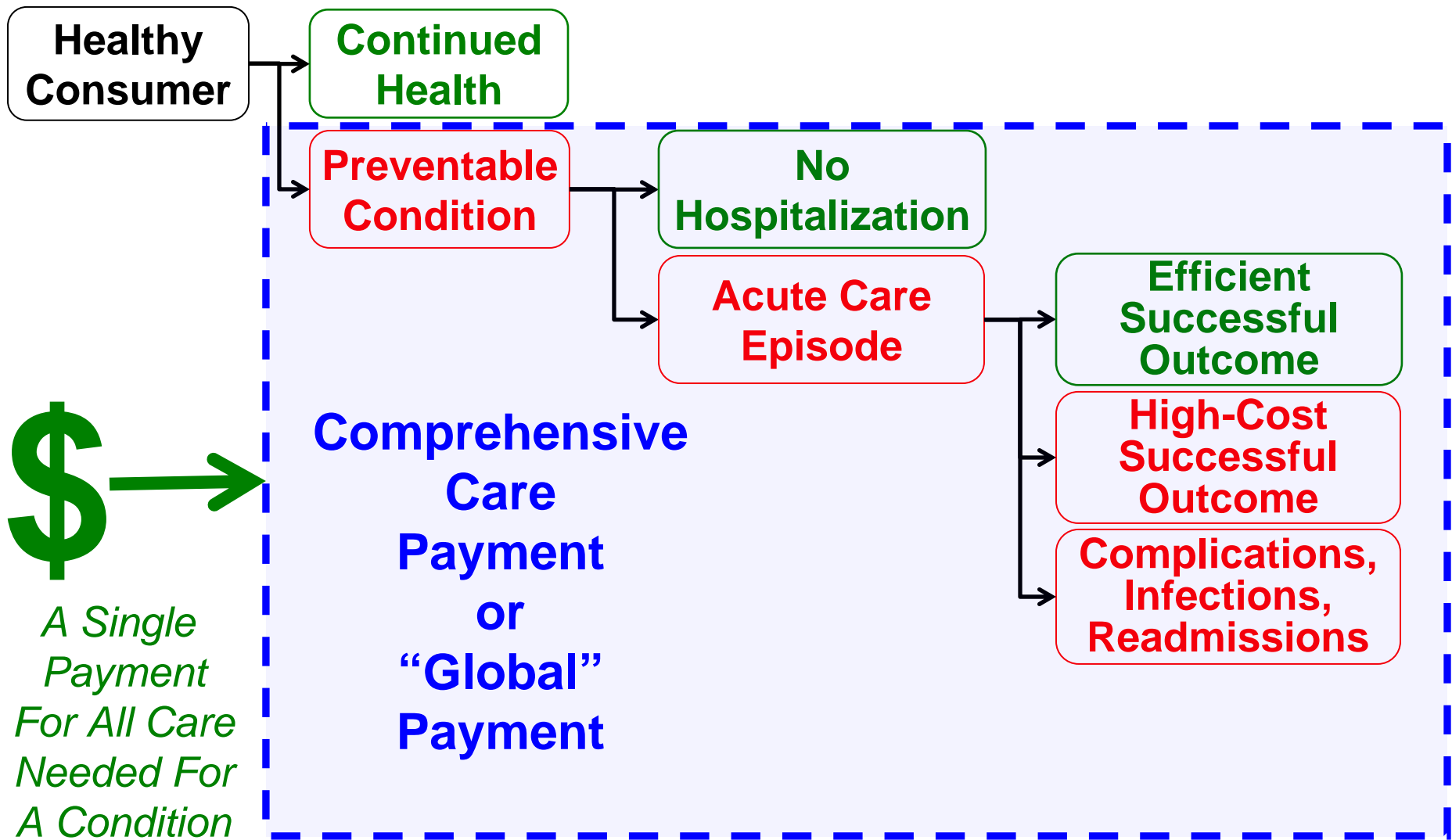


The Weakness of Episode Payment



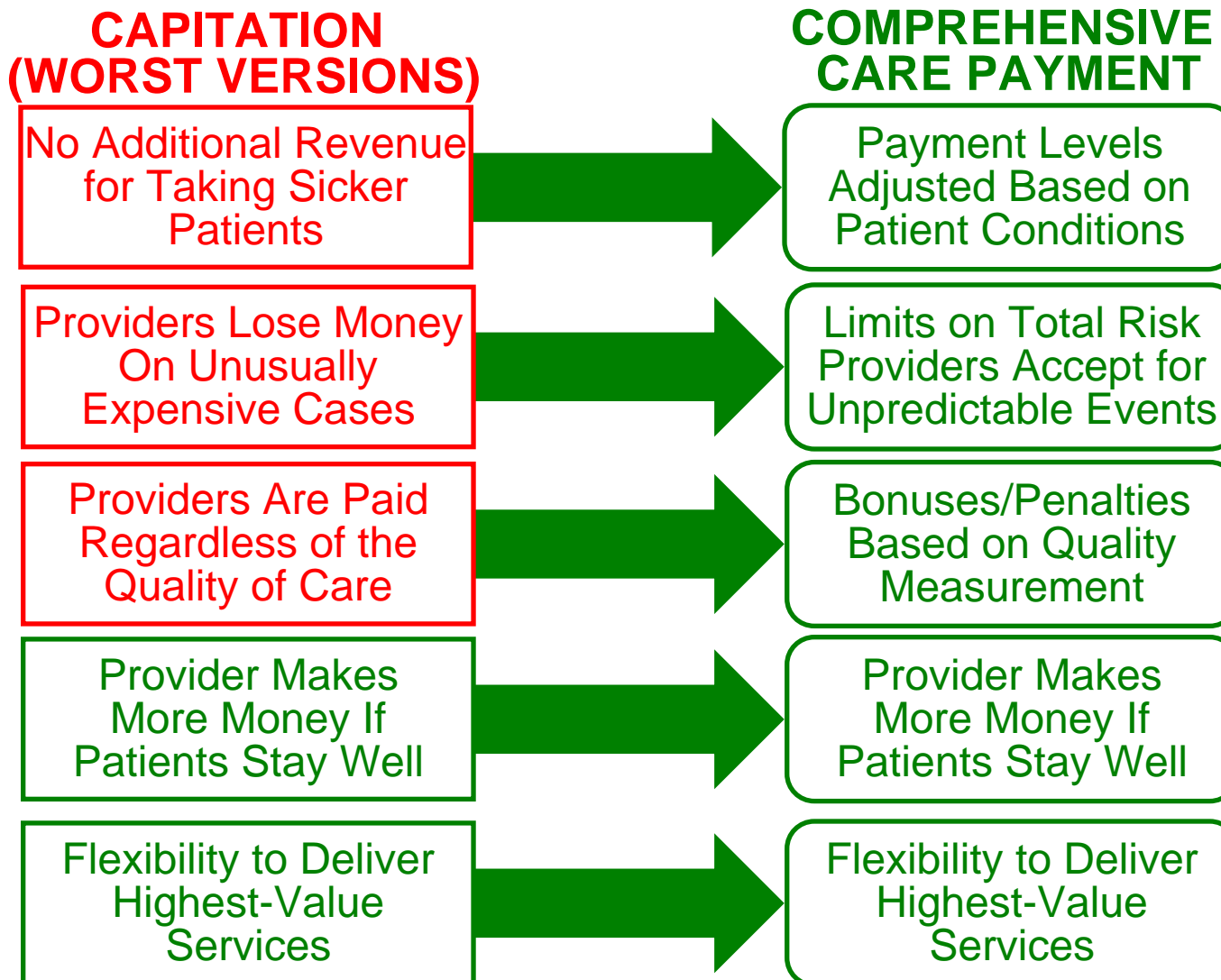
How do you prevent unnecessary episodes of care? (e.g., preventable hospitalizations for chronic disease, overuse of cardiac surgery, back surgery, etc.)

Comprehensive Care Payments To *Avoid* Episodes



Isn't This Capitation?

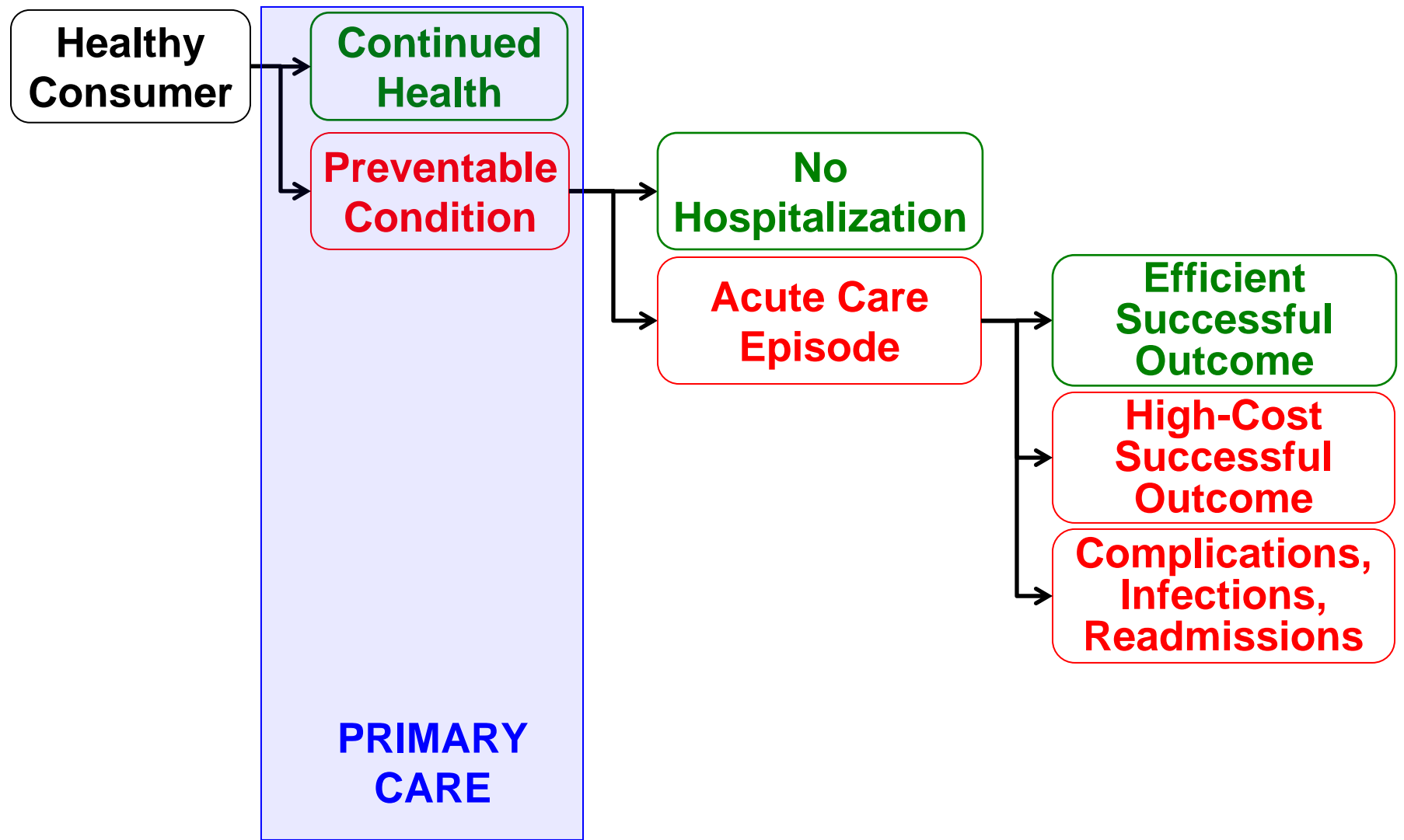
No – It's Different



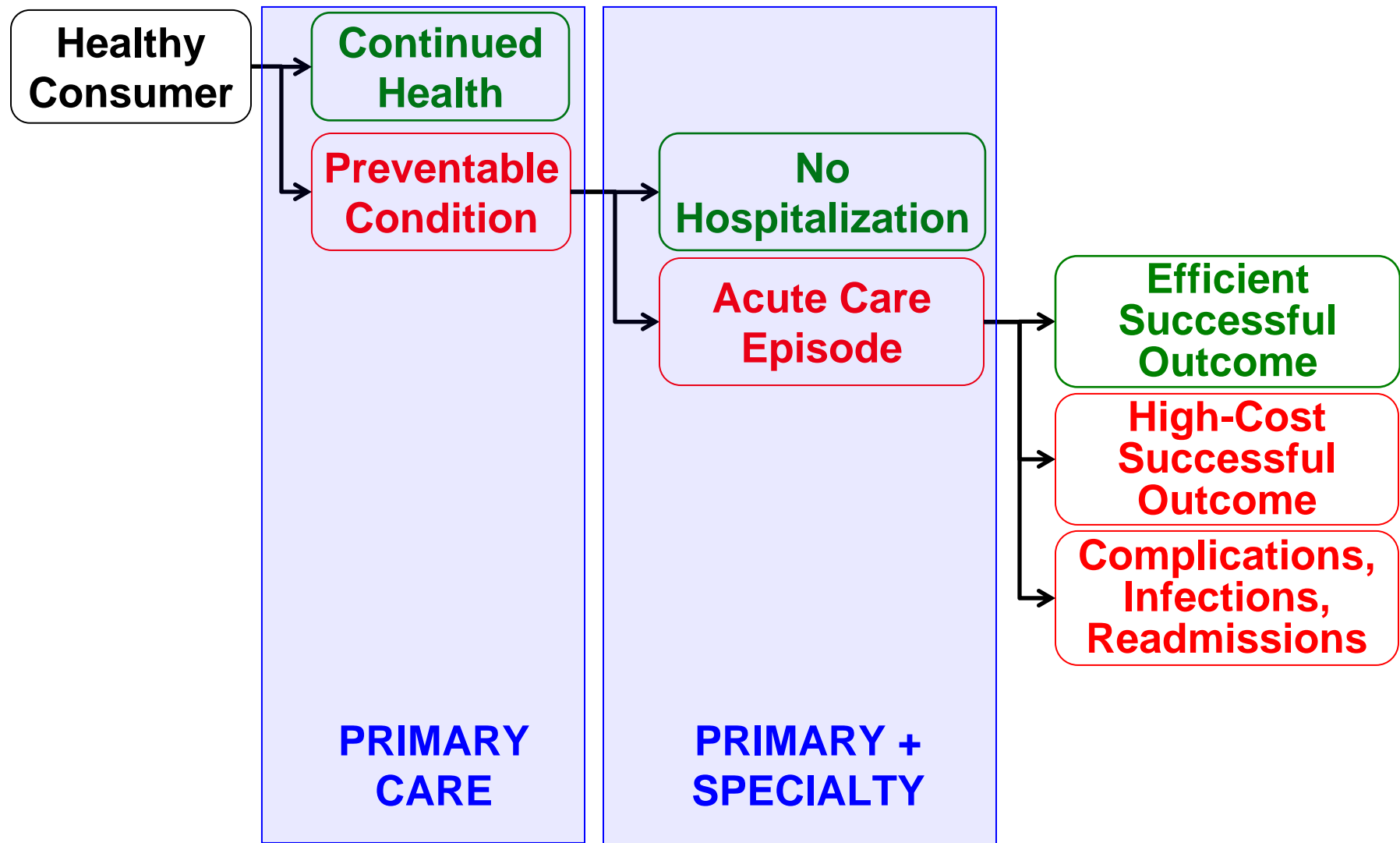
Who Should Be Accountable For Achieving Higher Value Care?

- Health Plans?
- Hospitals?
- Integrated Delivery Systems?
- Multi-Specialty Group Practices?

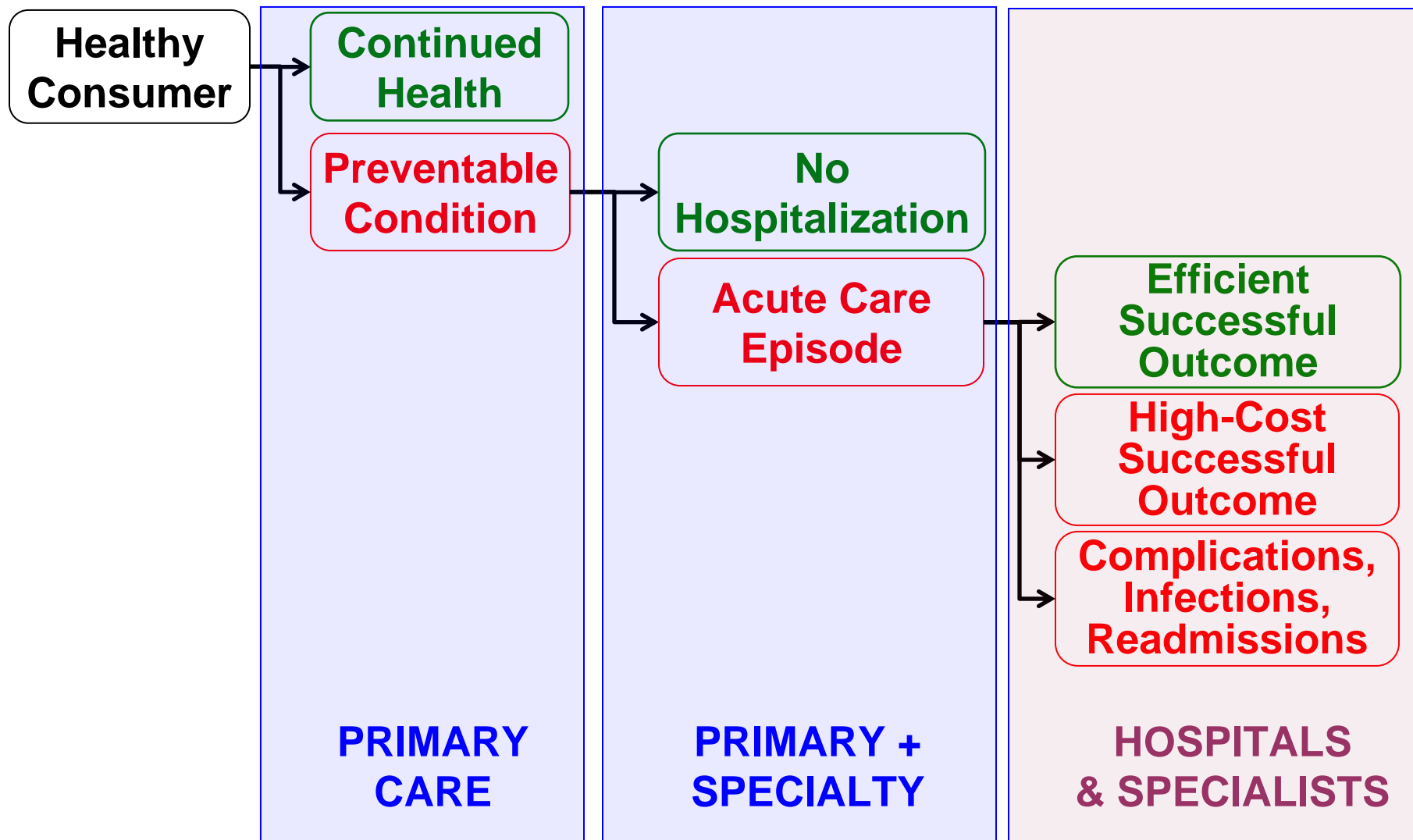
Keeping People Well? Primary Care



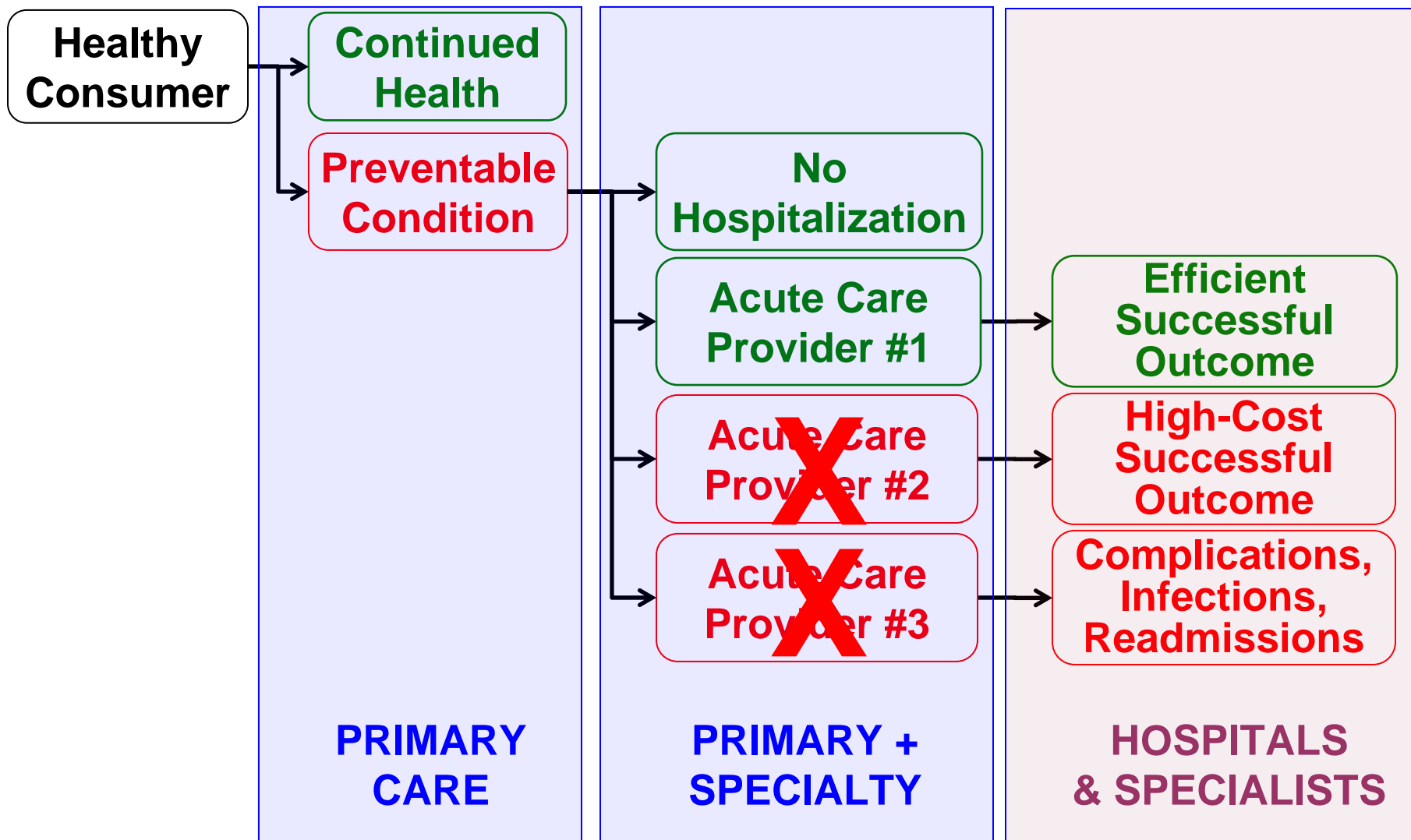
Avoiding Hospitalizations? Primary + Specialty Care



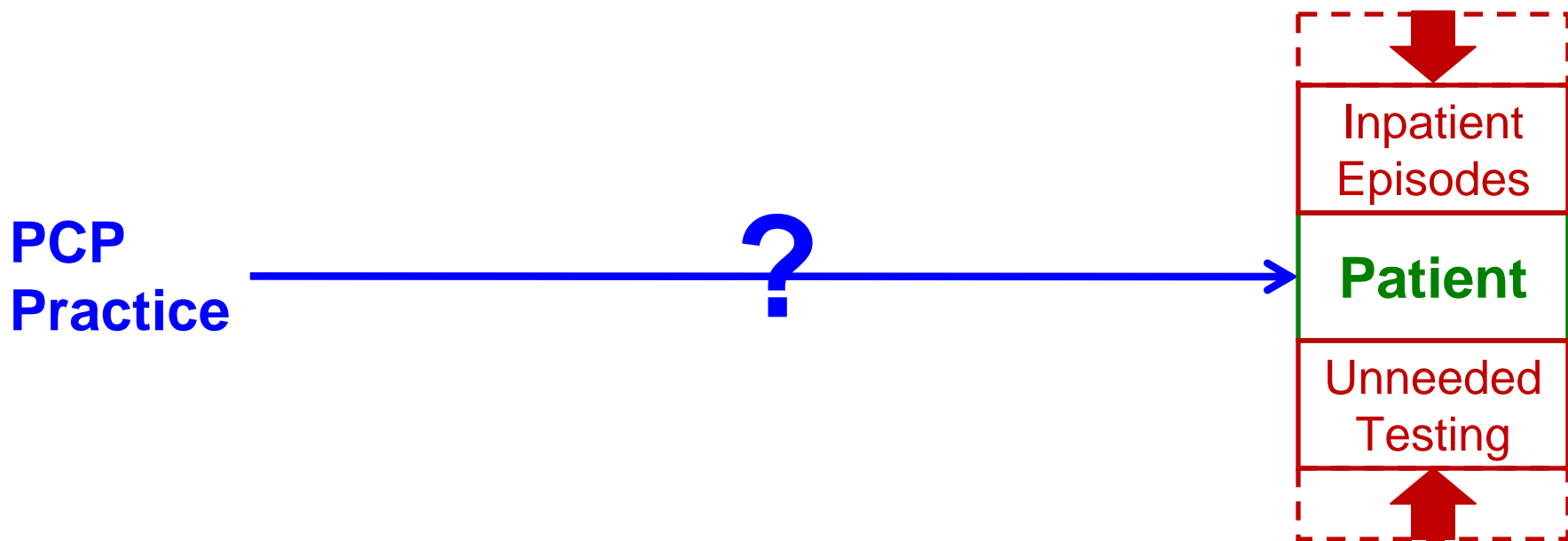
Better Acute Care? Hospitals and Specialists, But...



...MDs Choose Which Hospital (or Non-Hospital Setting) to Use



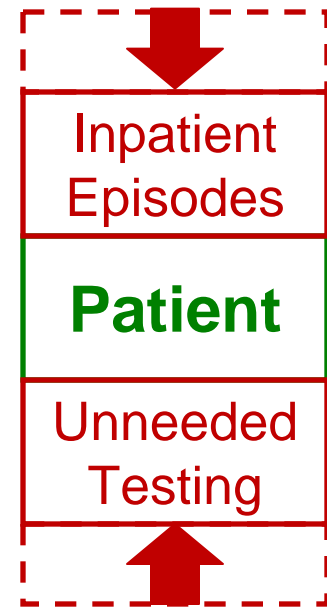
Resources/Capabilities Needed for PCPs to Manage Utilization



Resources/Capabilities Needed for PCPs to Manage Utilization

PCP Practice

- Data and analytics to measure and monitor utilization and quality
- Coordinated relationships with 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)
- PCP w/ time for diagnosis, treatment planning, and followup



Developing a Business Case Based on Quality & Cost

CURRENT

# Admissions/Year:	500
% Readmitted: (<30 Days)	25%
\$/Admission (Medicare/No Complic.):	\$5,400
Cost of Readmissions:	\$675,000
Cost of PCP Care Mgt:	\$150,000

Admissions for COPD/Pneumonia or CHF at large community hospitals

Developing a Business Case Based on Quality & Cost

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Cost of Readmissions:	\$675,000
Cost of PCP Care Mgt:	\$150,000

**WHAT IS THE
RETURN-ON-INVESTMENT
(ROI)
NEEDED TO REDUCE
TOTAL COSTS?**

Admissions for COPD/Pneumonia or CHF at large community hospitals

Success Needs to Be Sufficient to Justify the Cost of the Intervention

	CURRENT	20% REDUCTION
# Admissions/Year:	500	500
% Readmitted: (<30 Days)	25%	20%
\$/Admission (Medicare/No Complic.):	\$5,400	\$5,400
Cost of Readmissions:	\$675,000	\$540,000
Cost of PCP Care Mgt:	\$150,000	\$150,000
Savings:		\$135,000
Net Benefit/ROI:		(\$15,000)

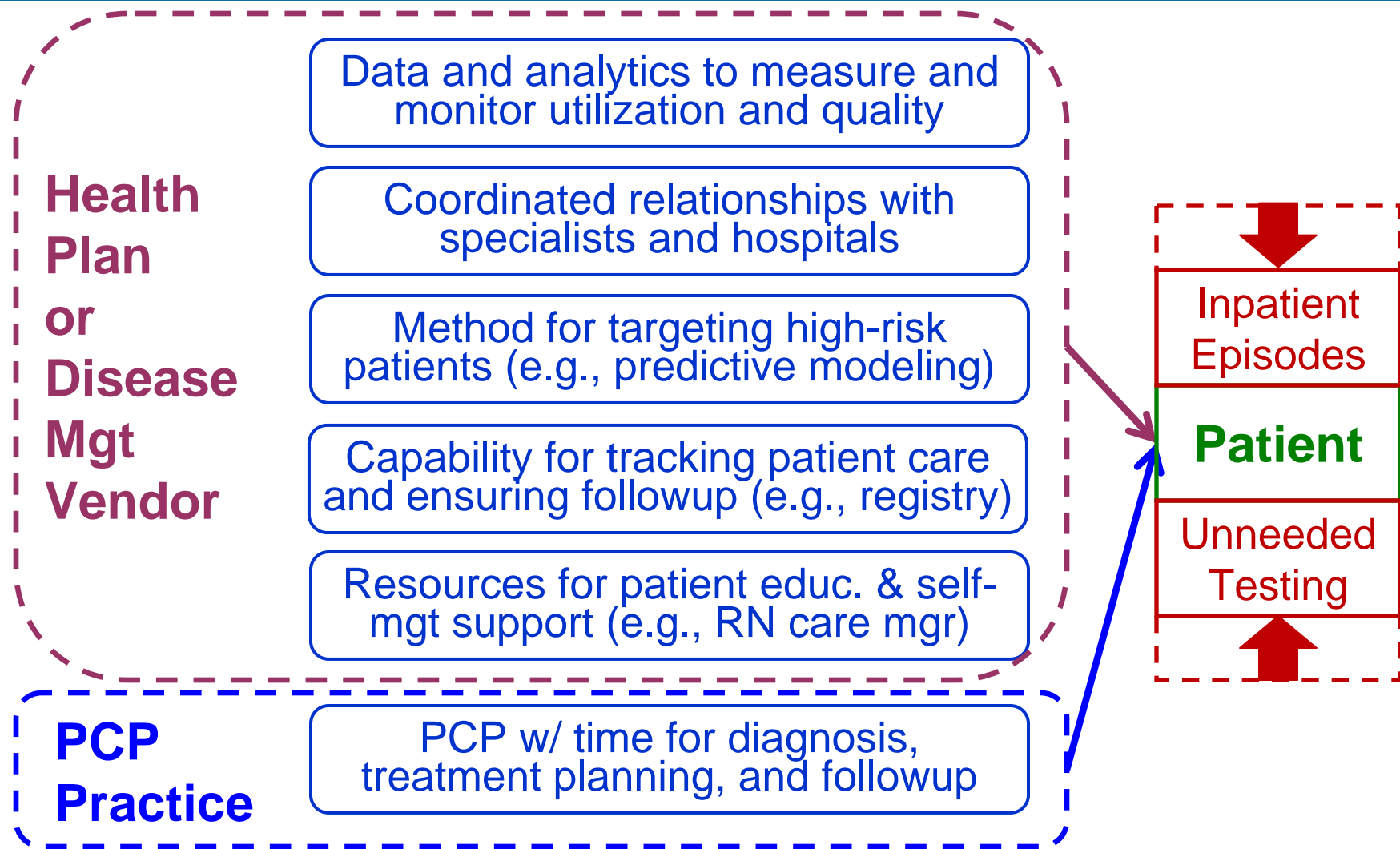
Cost and Outcomes Need to Be Jointly Defined for Success

	CURRENT	40% REDUCTION
# Admissions/Year:	500	500
% Readmitted: (<30 Days)	25%	15%
\$/Admission (Medicare/No Complic.):	\$5,400	\$5,400
Cost of Readmissions:	\$675,000	\$405,000
Cost of PCP Care Mgt:	\$150,000	\$150,000
Savings:		\$270,000
Net Benefit/ROI:		\$120,000 1.8:1

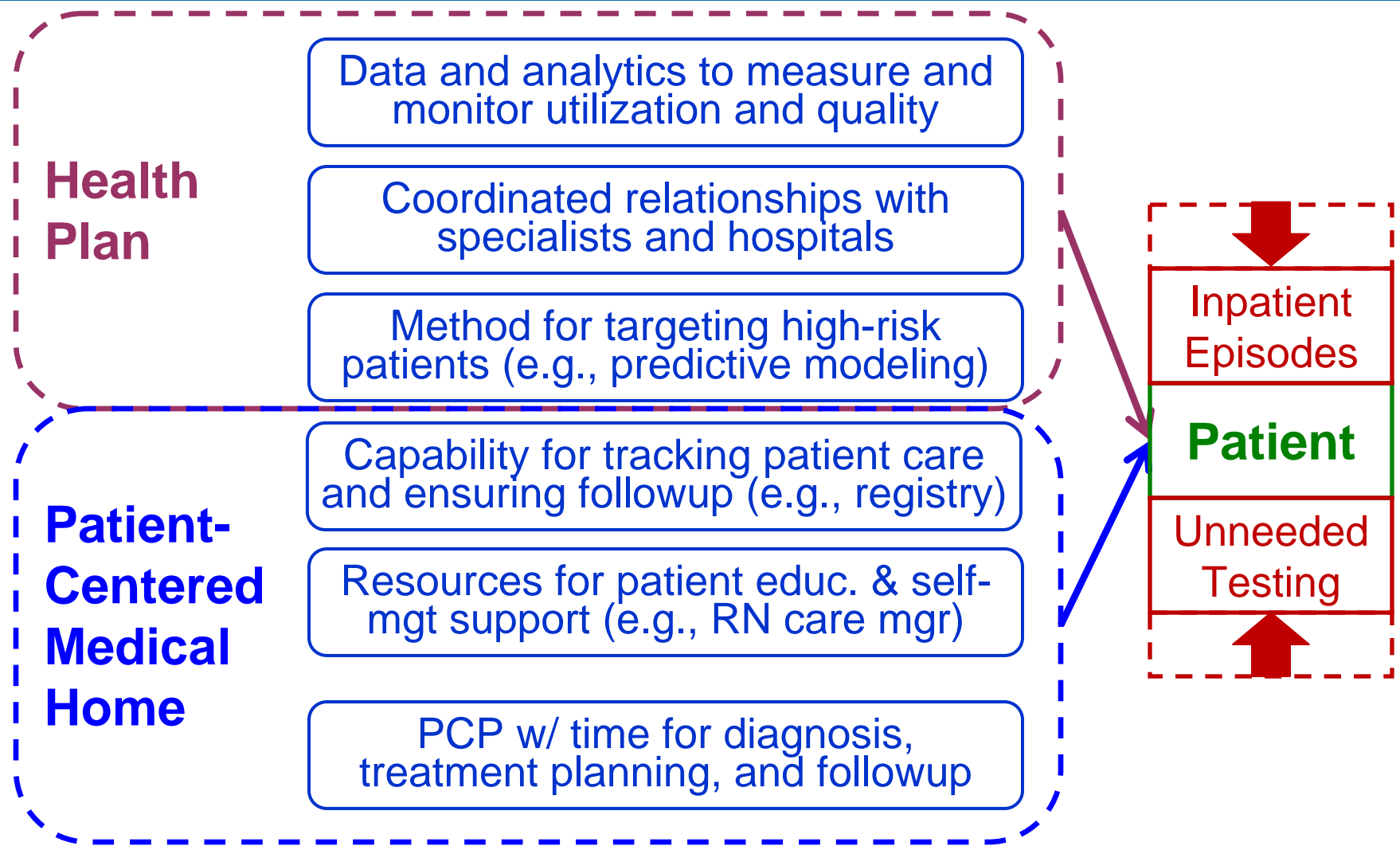
Comp. Care Payment Requires ROI Analysis & Targeting

- **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”

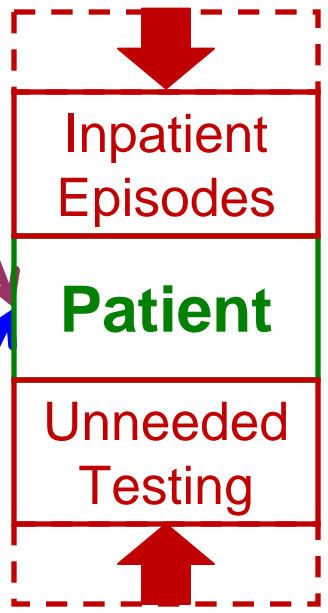
Capabilities Exist Today, But Function Independently of PCPs



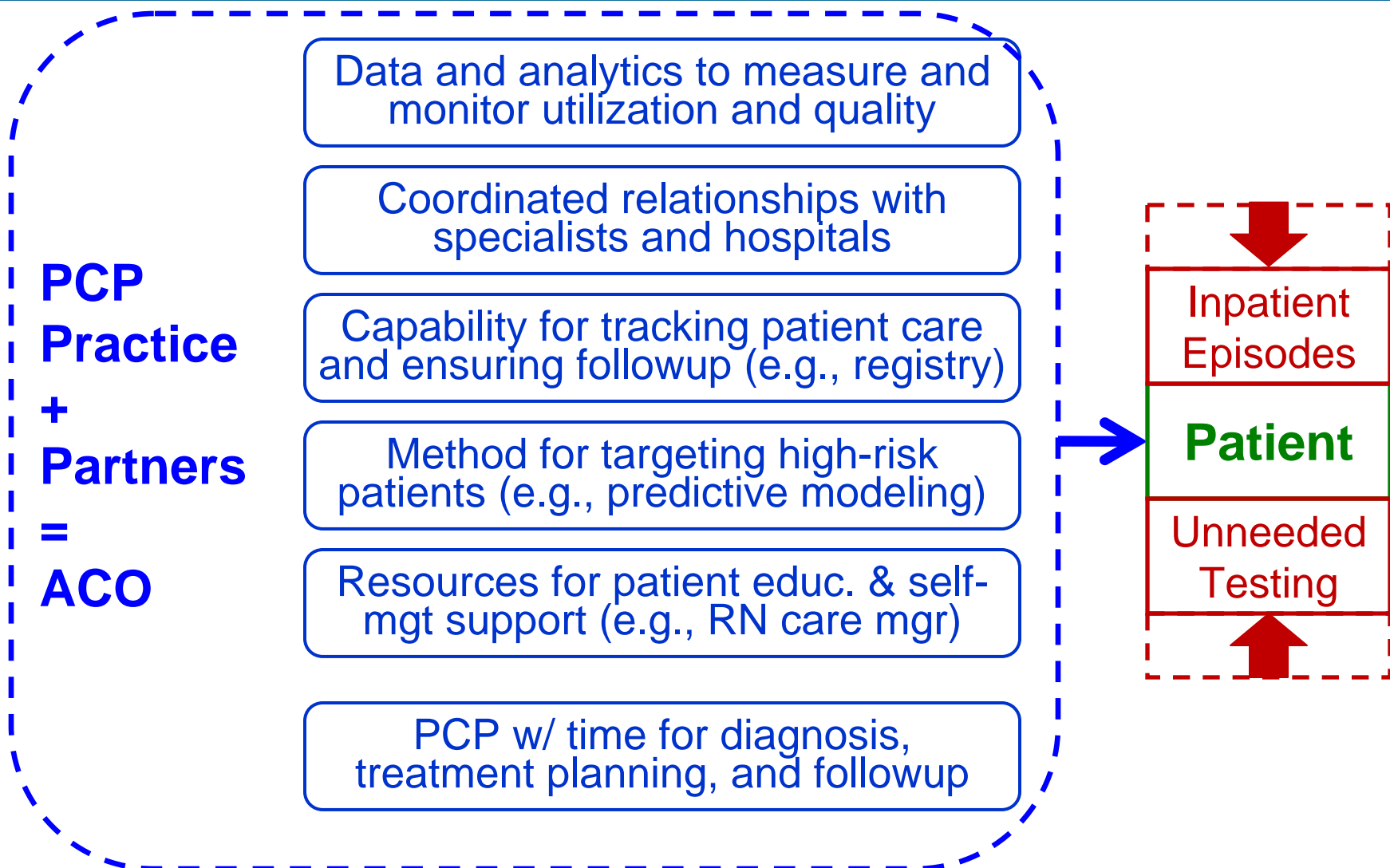
Medical Home Initiatives Expand PCP Capacity, But Not Enough



- Data and analytics to measure and monitor utilization and quality
- Coordinated relationships with 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)
- PCP w/ time for diagnosis, treatment planning, and followup



Goal: Give PCPs the Capacity to Deliver “Accountable Care”



Major Changes In *Both* Payment & Delivery Systems Are Needed...

TODAY

THE FUTURE

Fee
for
Service

PAYMENT SYSTEM REFORM

Episode &
Global
Payment

Fragmented
Care

DELIVERY SYSTEM REFORM

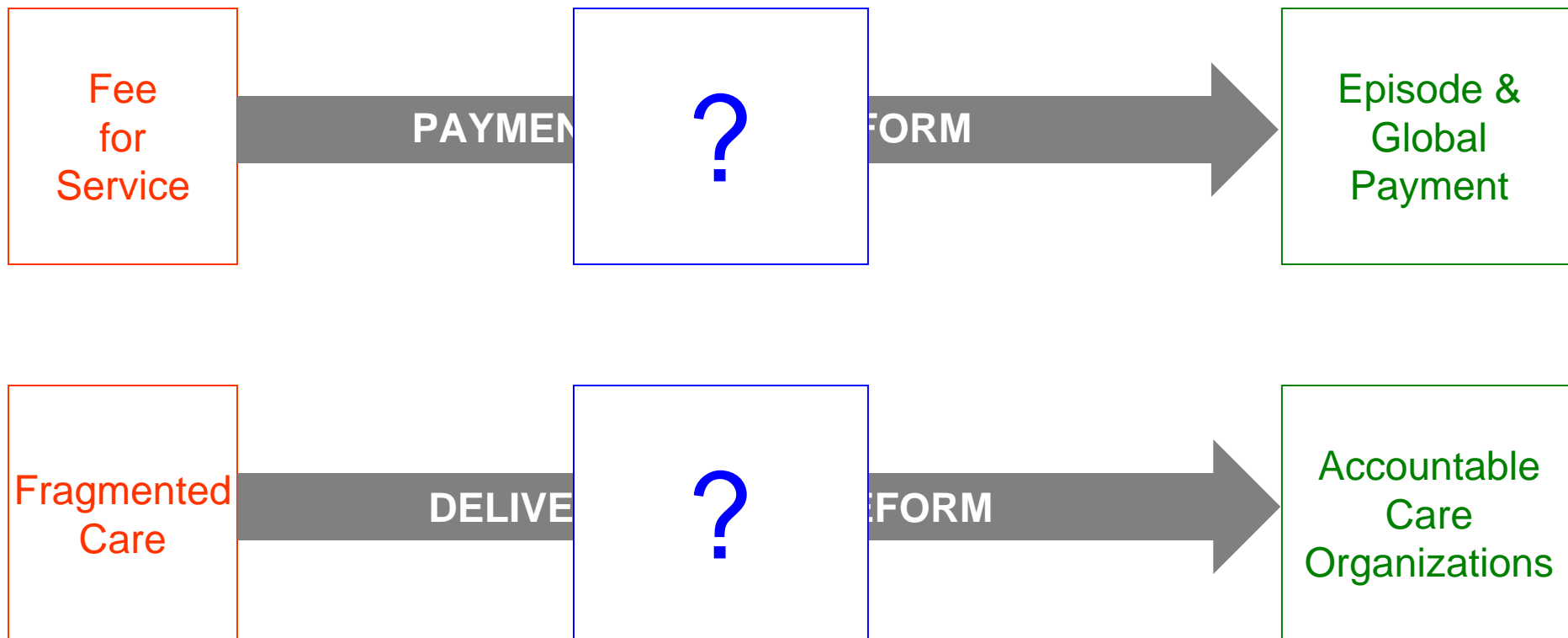
Accountable
Care
Organizations

...But Transitional Steps Will Be Needed

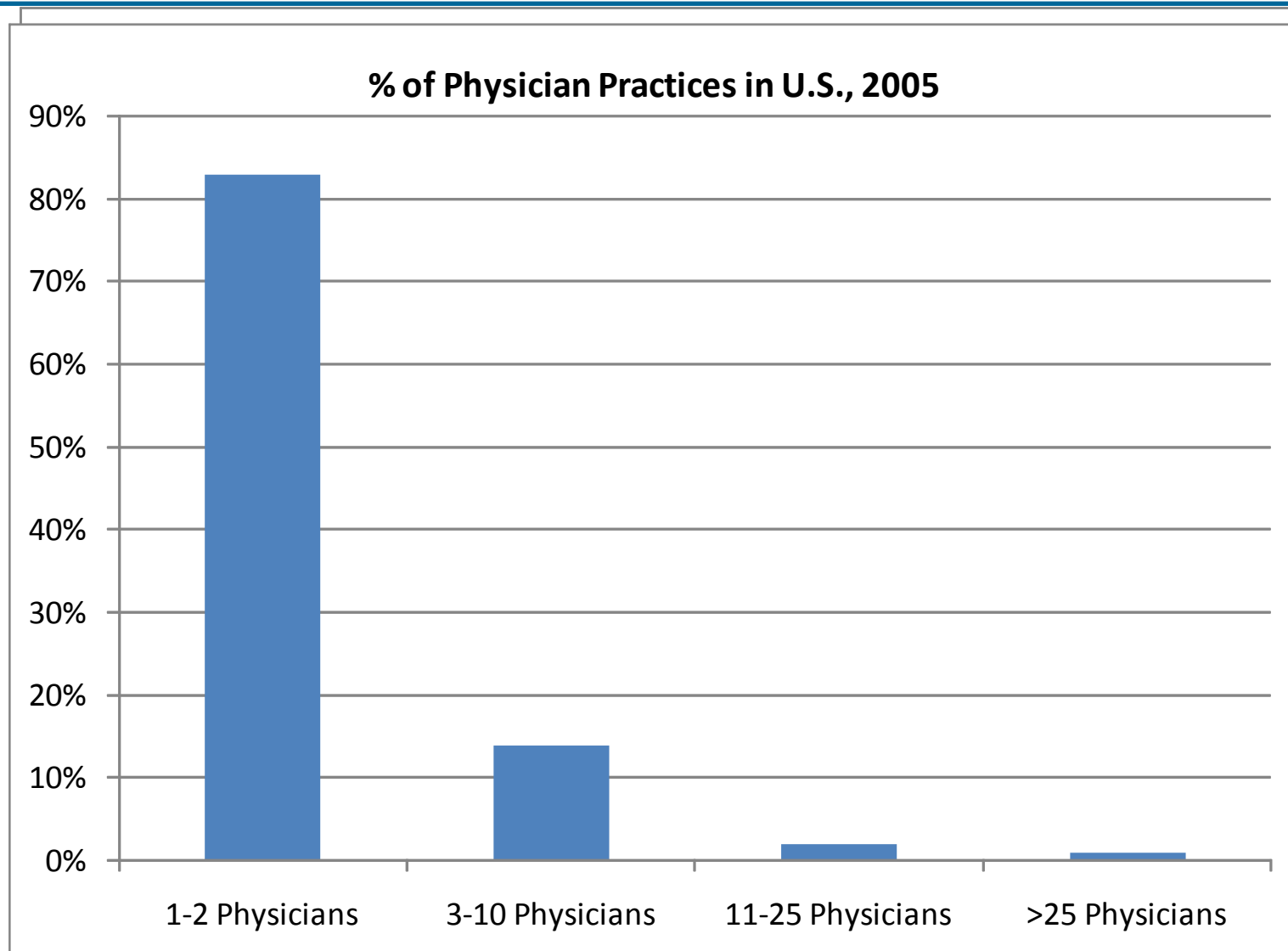
TODAY

TRANSITION

THE FUTURE



Challenge: Most Physicians Are In Very Small Practices



Potential Solutions

- All physicians join large groups
- Physician practices acquired by hospitals
- Small physician practices join together in IPAs or virtual Physician Organizations to share resources and manage patient populations

Michigan BC/BS Physician Group Incentive Program

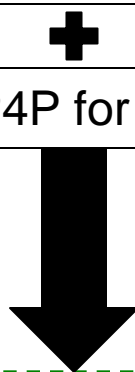
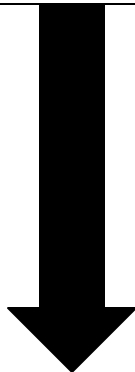
Phase I

Phase II

Fee-for-Service

Fee-for-Service

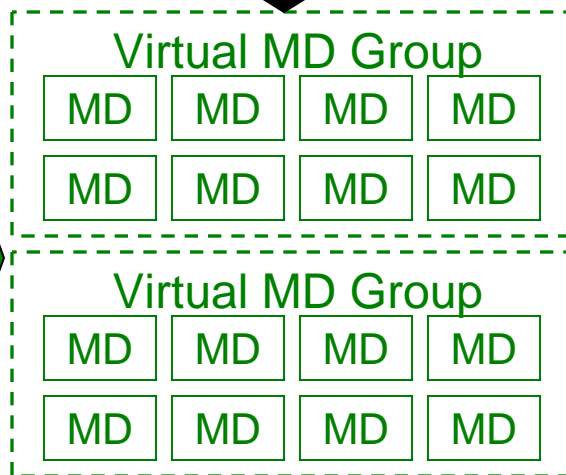
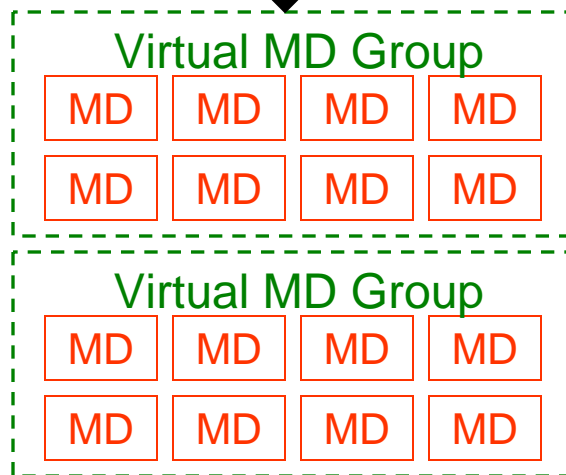
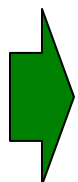
Fee-for-Service



P4P for QI

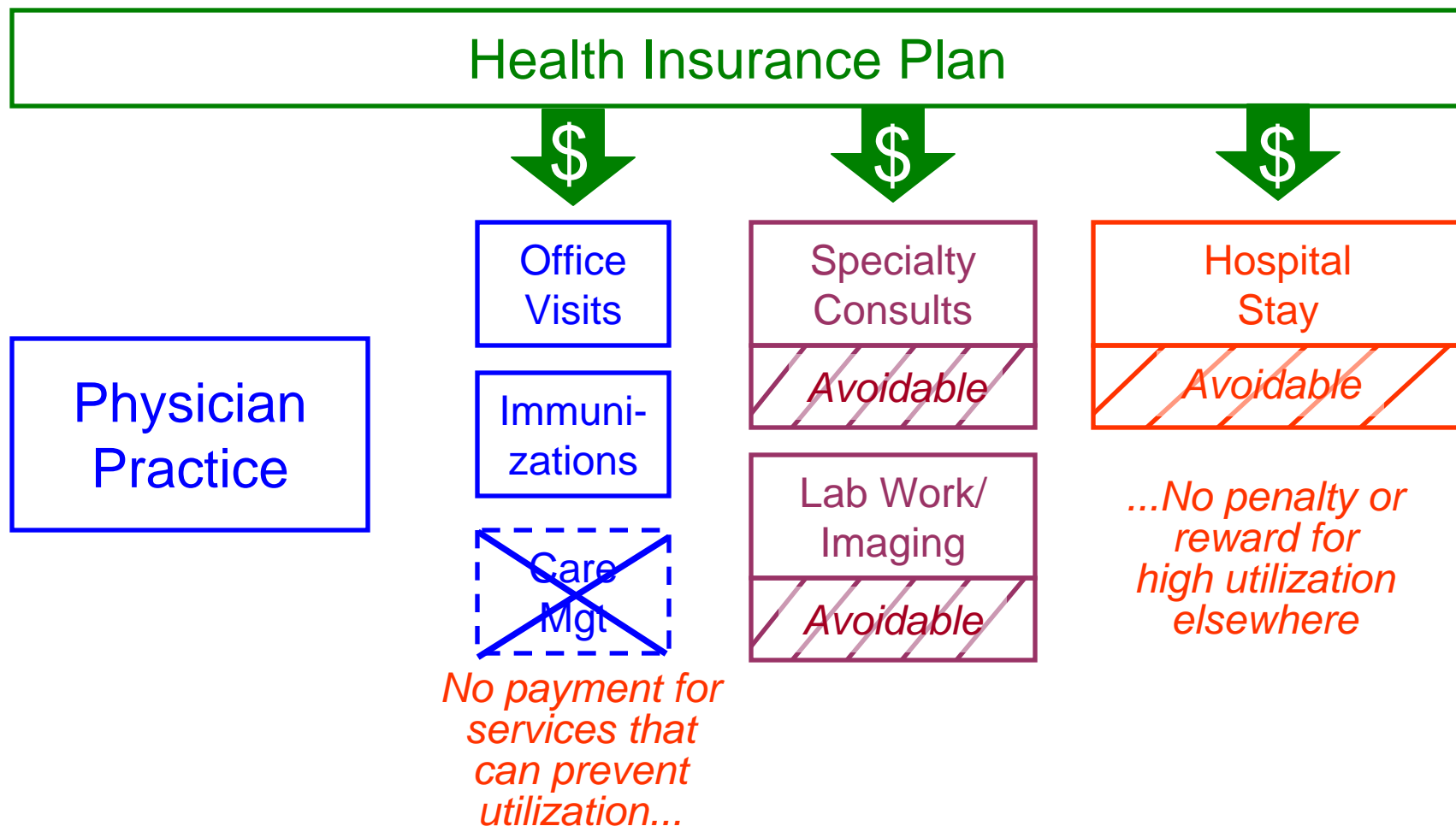
P4P for QI

Medical Home \$



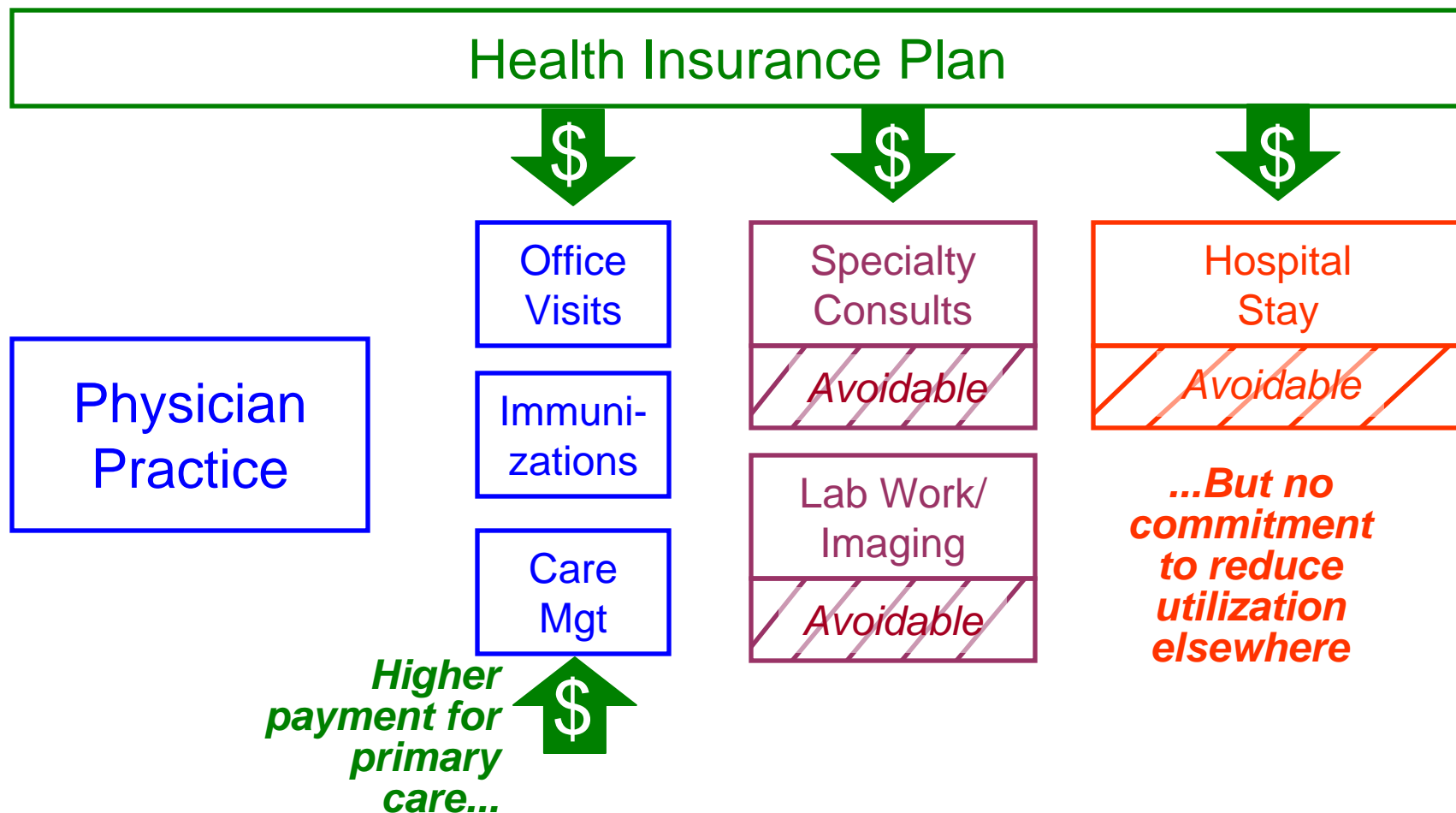
How Do You Transition to Better Payment Systems?

CURRENT PAYMENT SYSTEMS



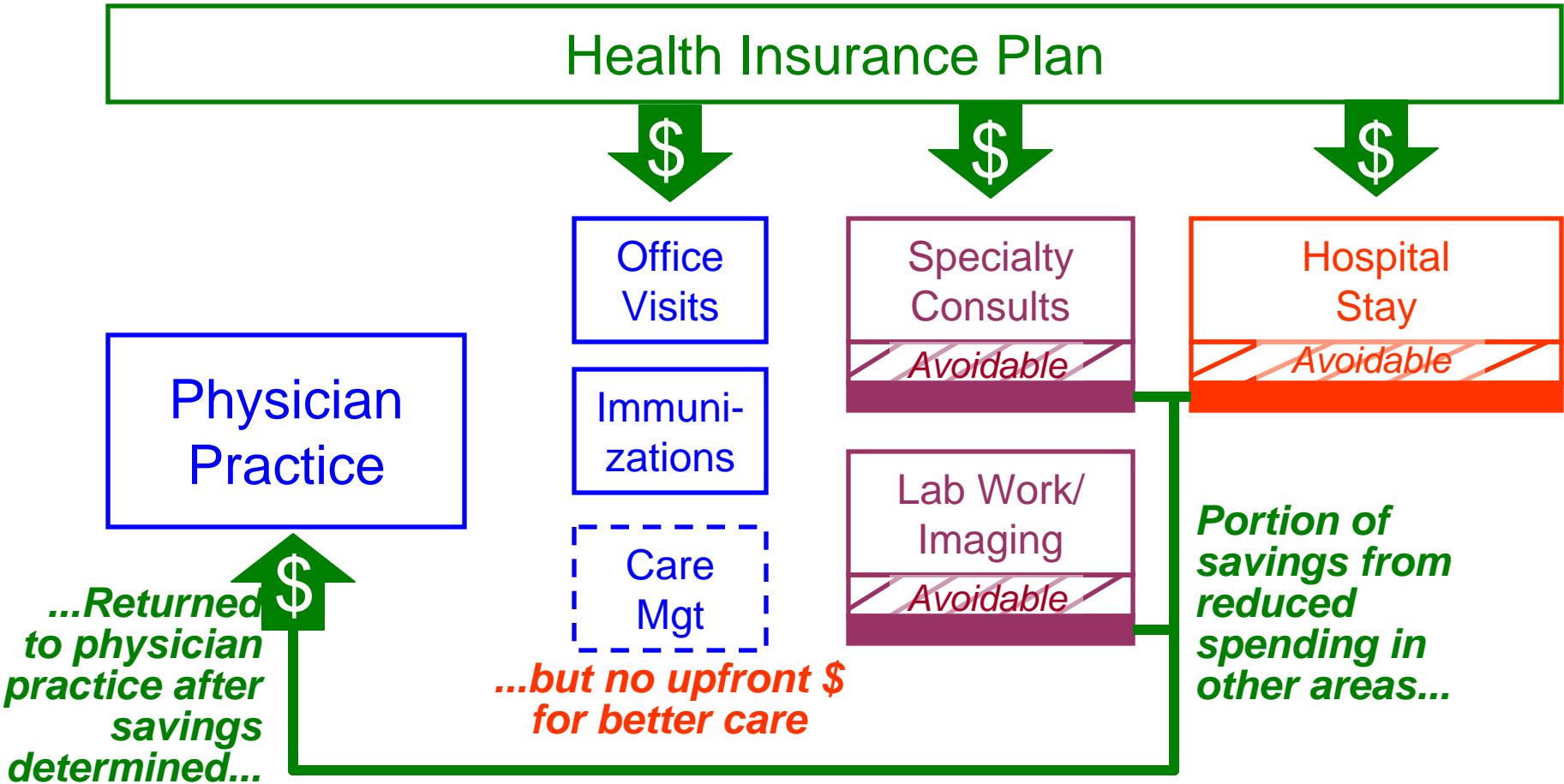
A Starting Point: Medical Home Payment

MEDICAL HOME PROGRAM



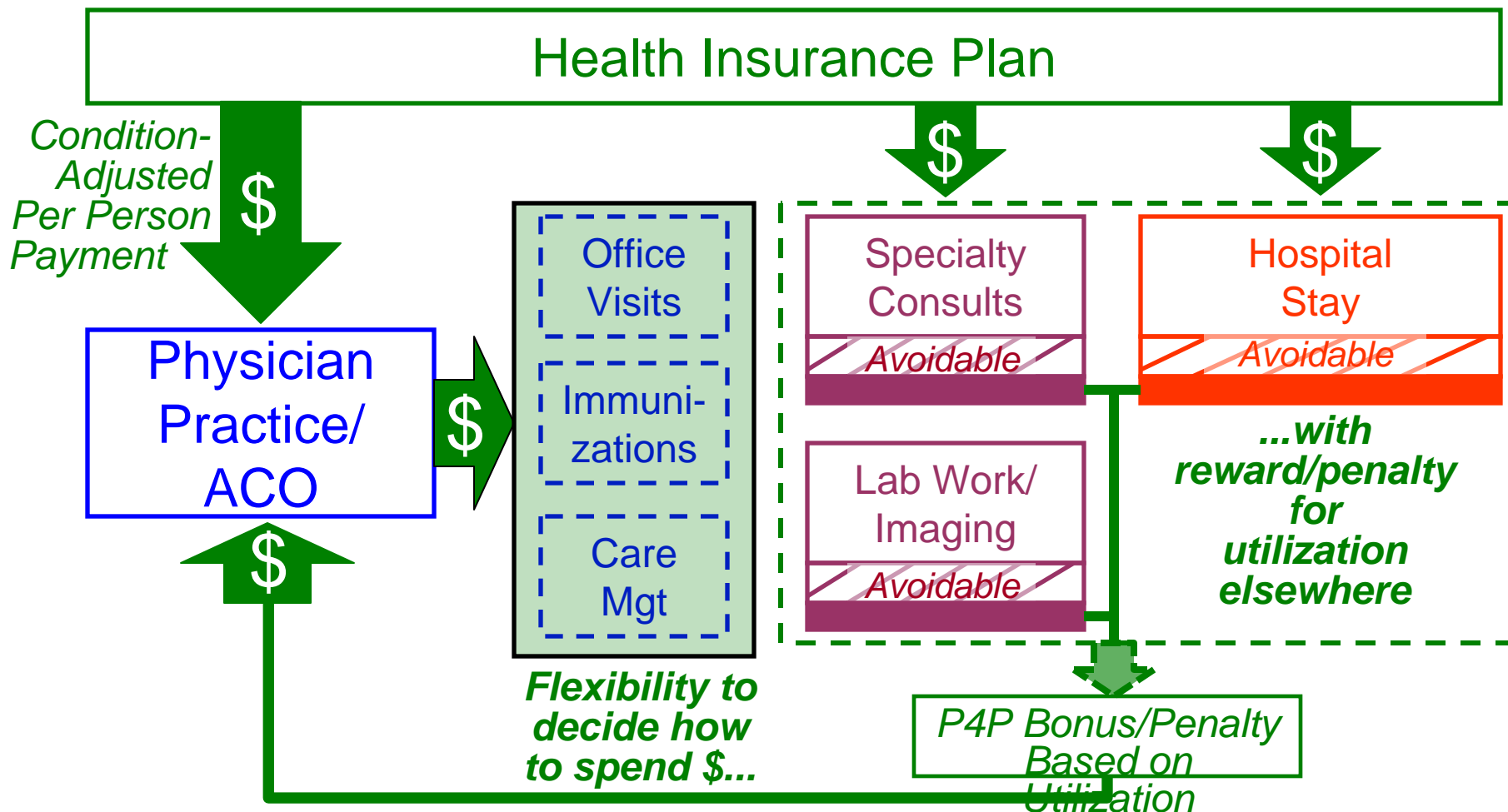
Shared Savings: Future Reward, But No Upfront Payment Reform

SHARED SAVINGS MODEL



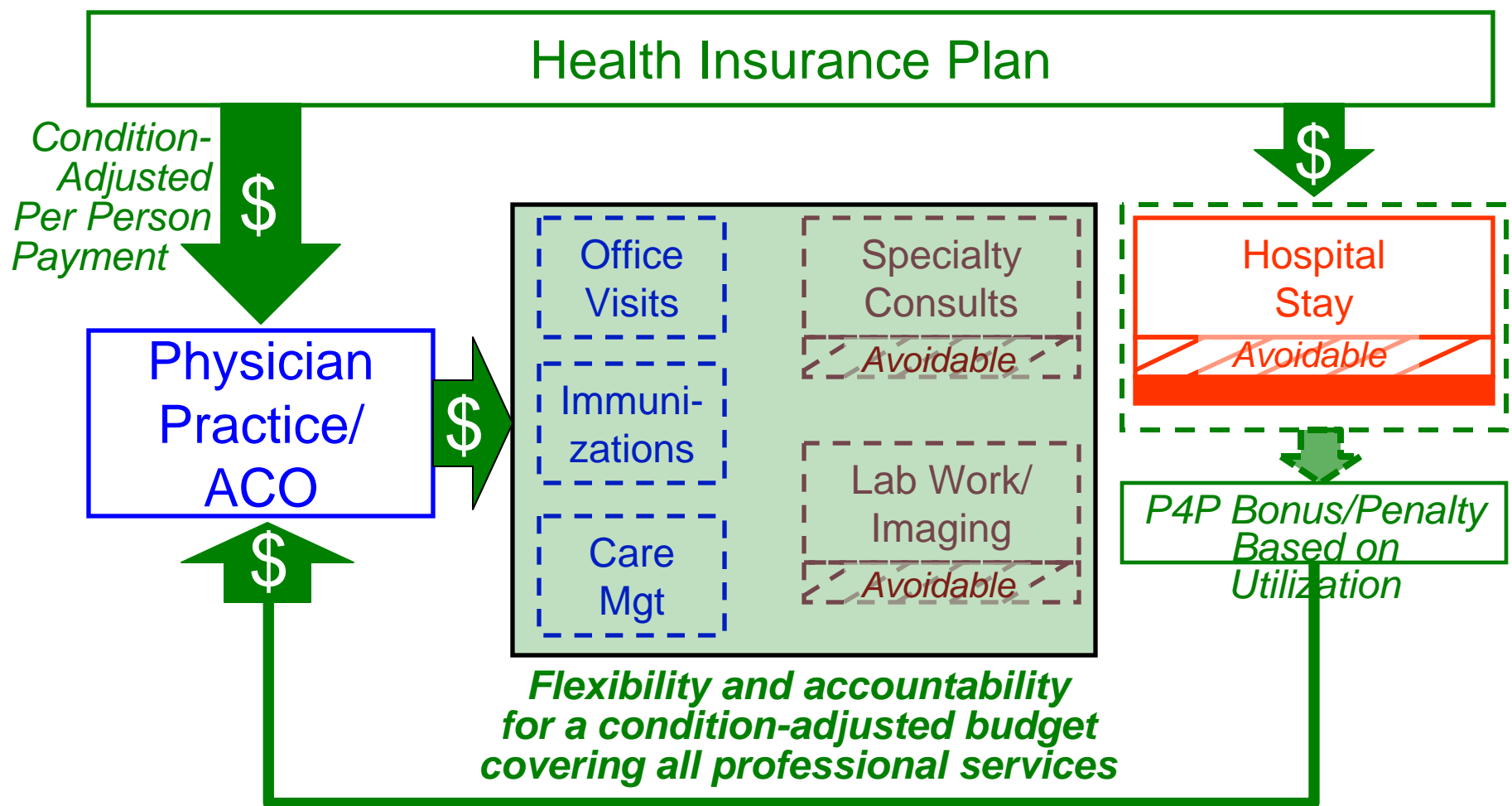
The Beginning of ACO-ness: Flexibility + Accountability

PARTIAL GLOBAL PMT + UTILIZATION P4P



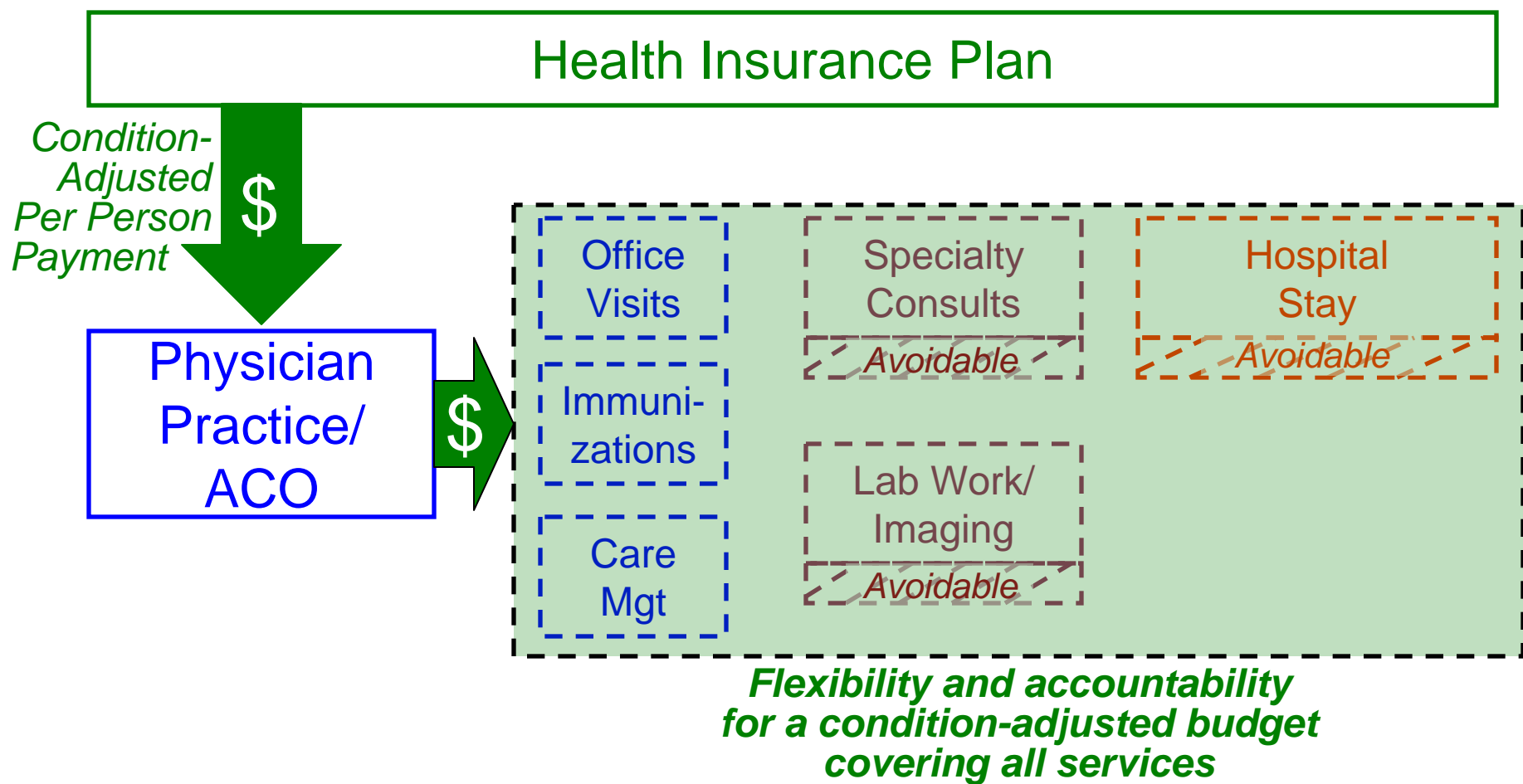
More ACO-ness: Partial Global Payment

PARTIAL GLOBAL PMT (Professional Svcs)



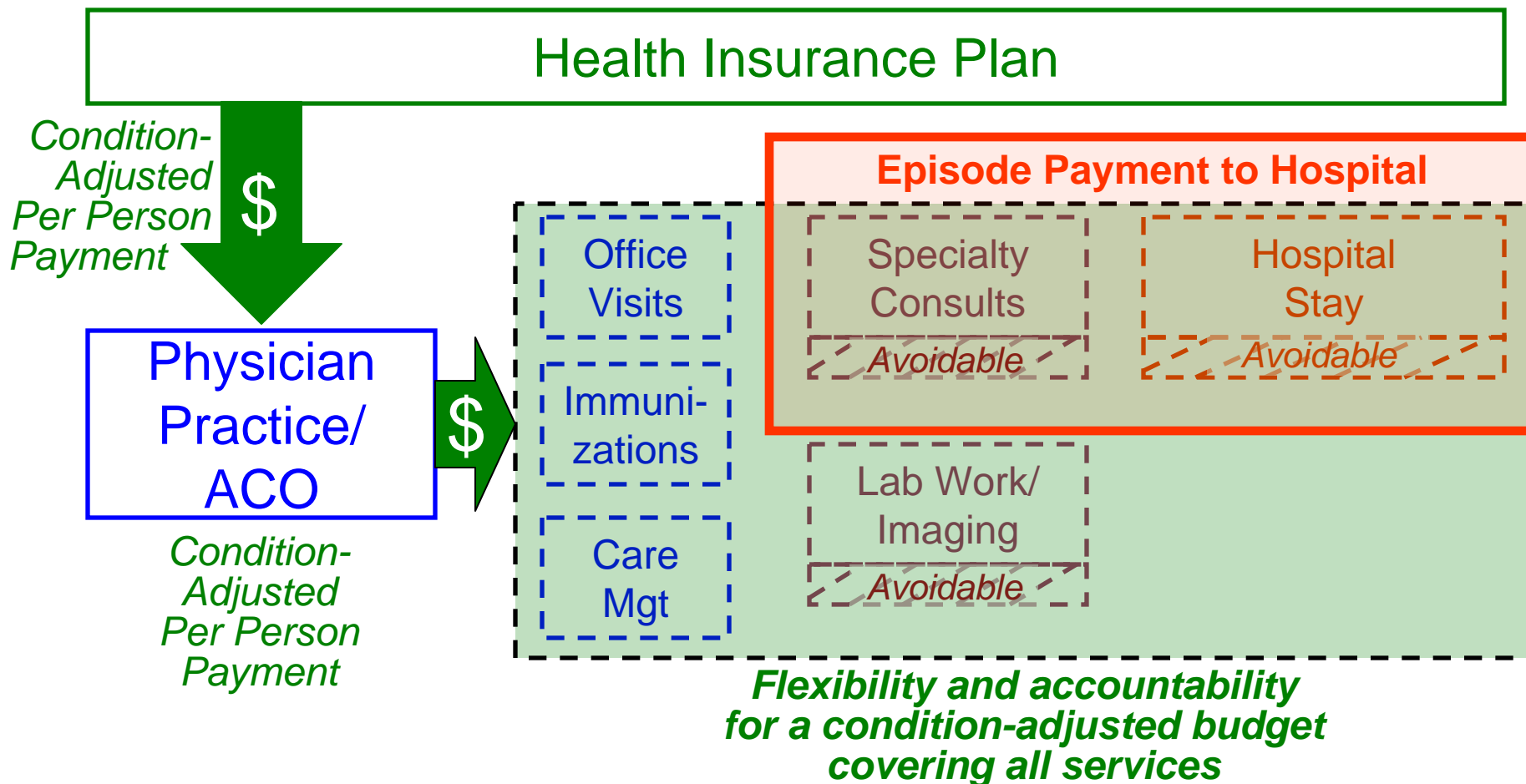
True ACO: Full Flexibility & Accountability w/o Insurance Risk

FULL GLOBAL PAYMENT



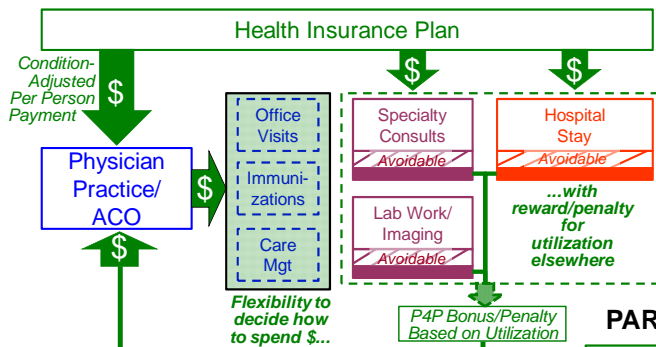
Episode Payments for Acute Care Help the ACO Manage Costs

FULL GLOBAL PAYMENT

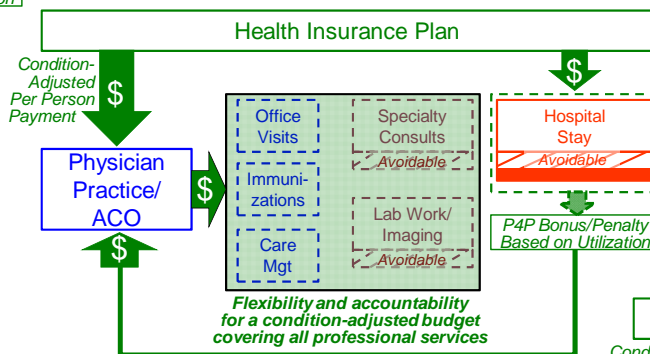


Transitioning to Global Payment

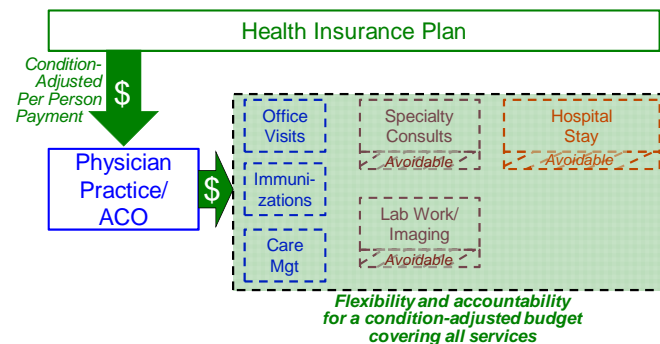
PARTIAL GLOBAL PMT + UTILIZATION P4P



PARTIAL GLOBAL PMT (Professional Svcs)

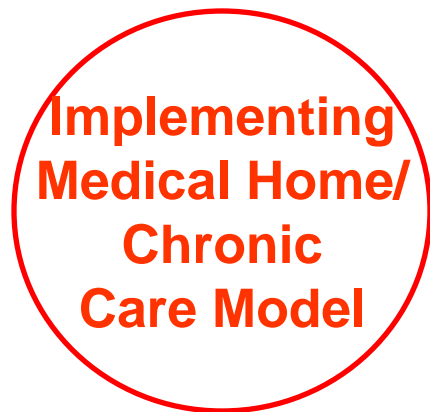


FULL GLOBAL PAYMENT



A Perfect Starting Point: Merging Two Payment Reform Silos

SILO #1



Pay More to Physicians
For Being Certified
As a “Medical Home”
And Hope That Outcomes
Improve

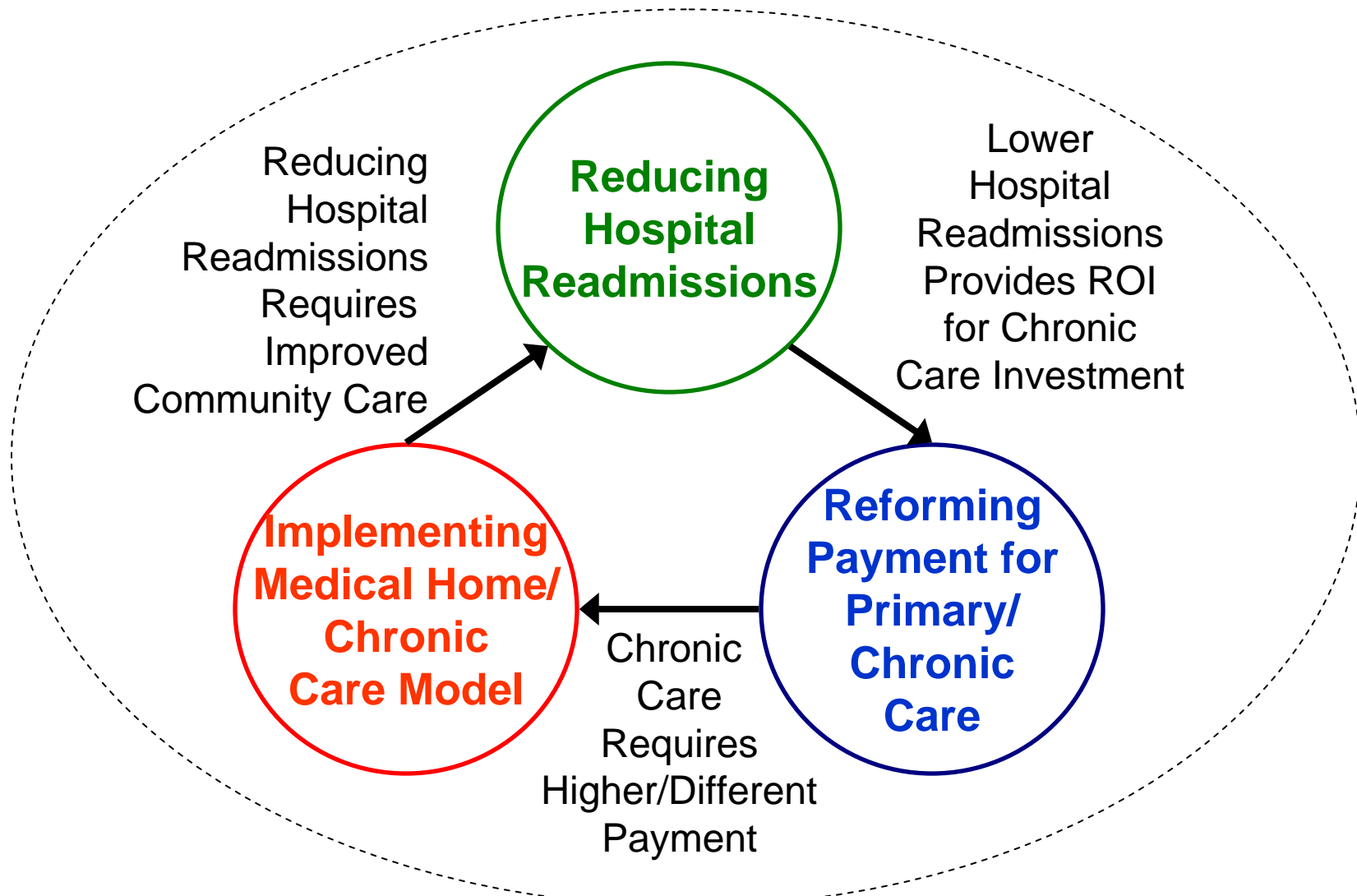


SILO #2

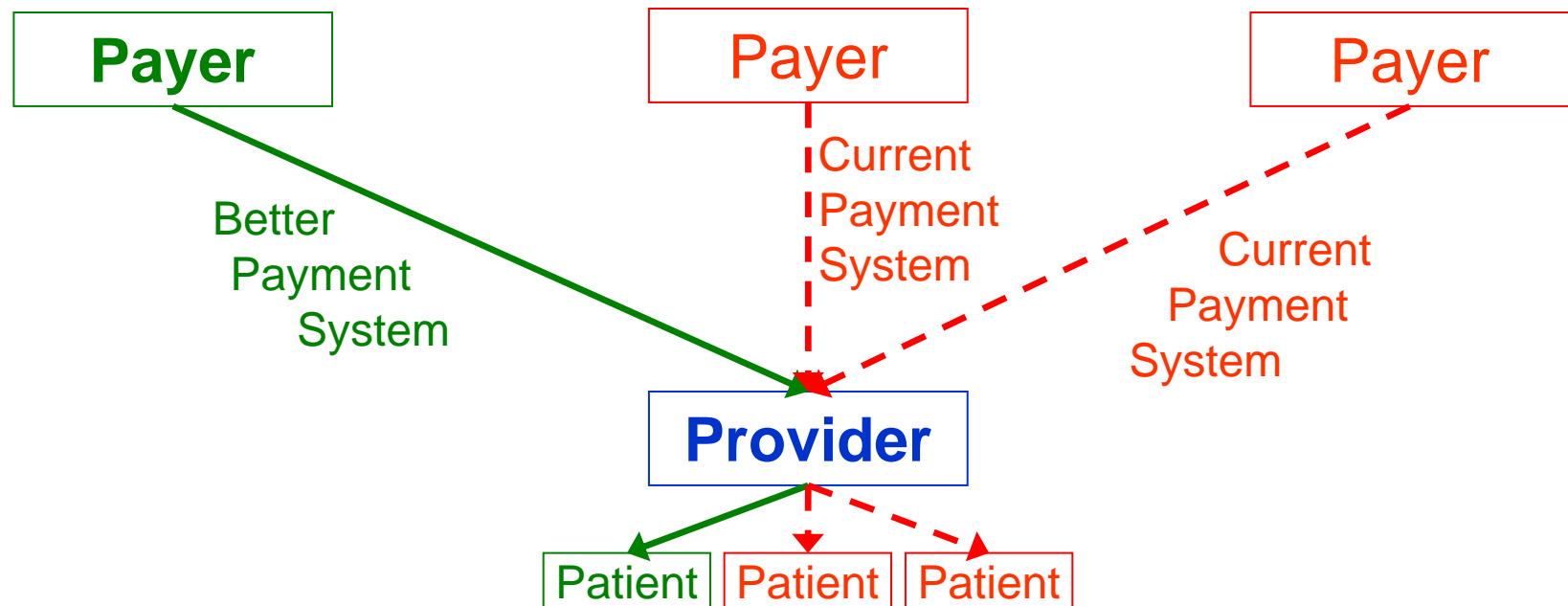


Penalize Hospitals for
Readmissions Even
If the Cause is Poor
Primary Care

Marrying the Medical Home and Hospital Readmissions

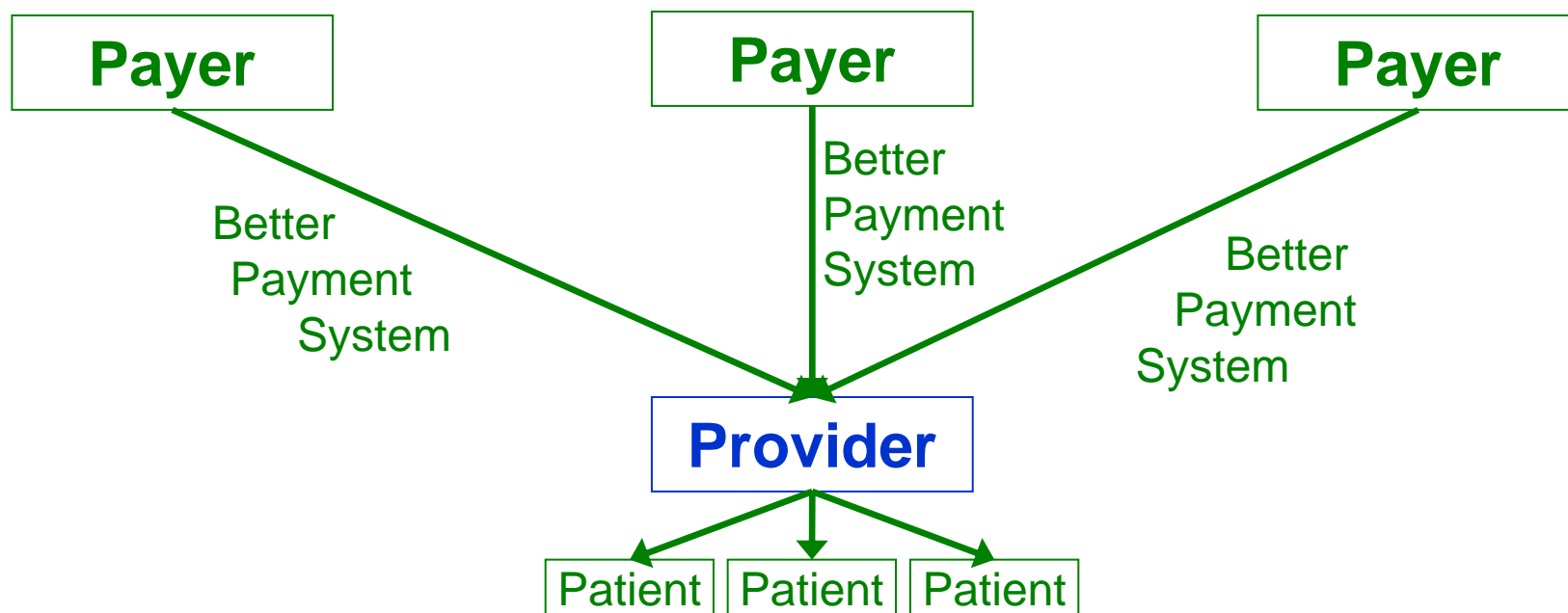


Difficult for Providers to Change If Only One Payer Changes



Provider is only compensated for changed practices for the subset of patients covered by participating payers

Payers Need to Align to Enable Providers to Transform



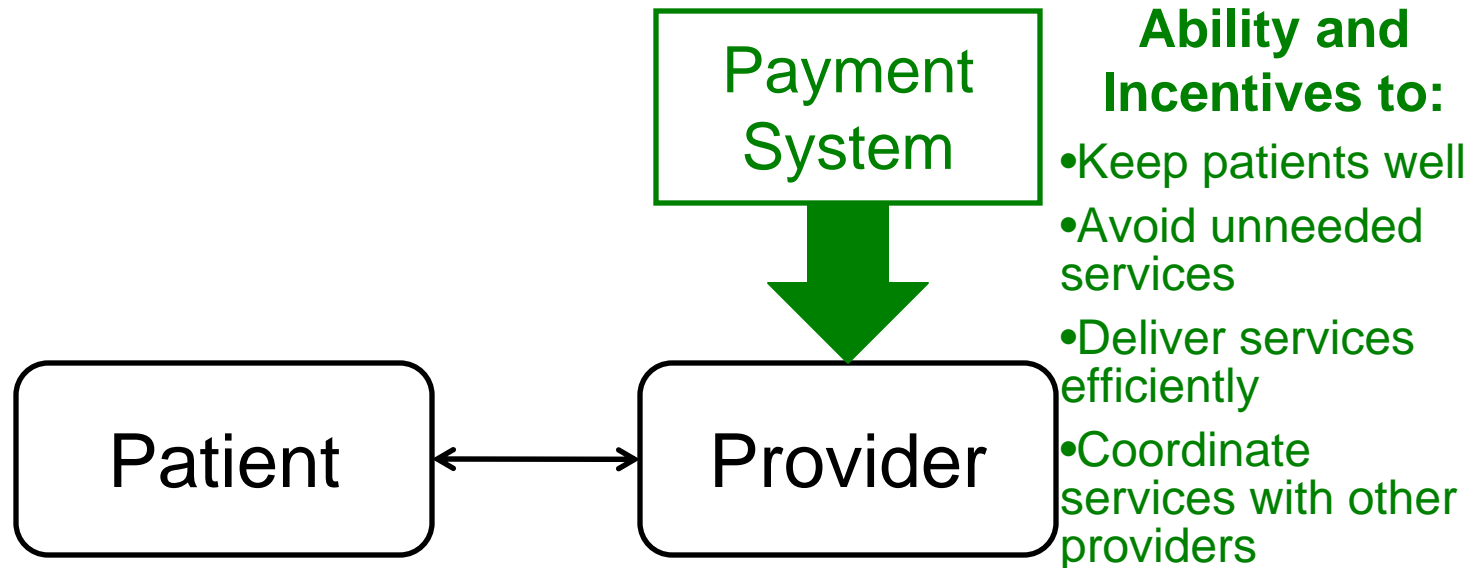
Payer Coordination Is Beginning to Occur Around the Country

- Examples of Payer Coordination:
 - Minnesota: All private payers have agreed to pay for care managers in primary care practices and consult fees to psychiatrists to help manage patients with depression
 - Pennsylvania: All commercial payers have agreed to pay for medical home/chronic care services in primary care practices
 - Rhode Island: All-payer medical home demonstration
- A Facilitator of Coordination is Needed
 - Minnesota: Institute for Clinical Systems Improvement
 - PA & RI: State Government
- Medicare Needs to Participate in Local Projects

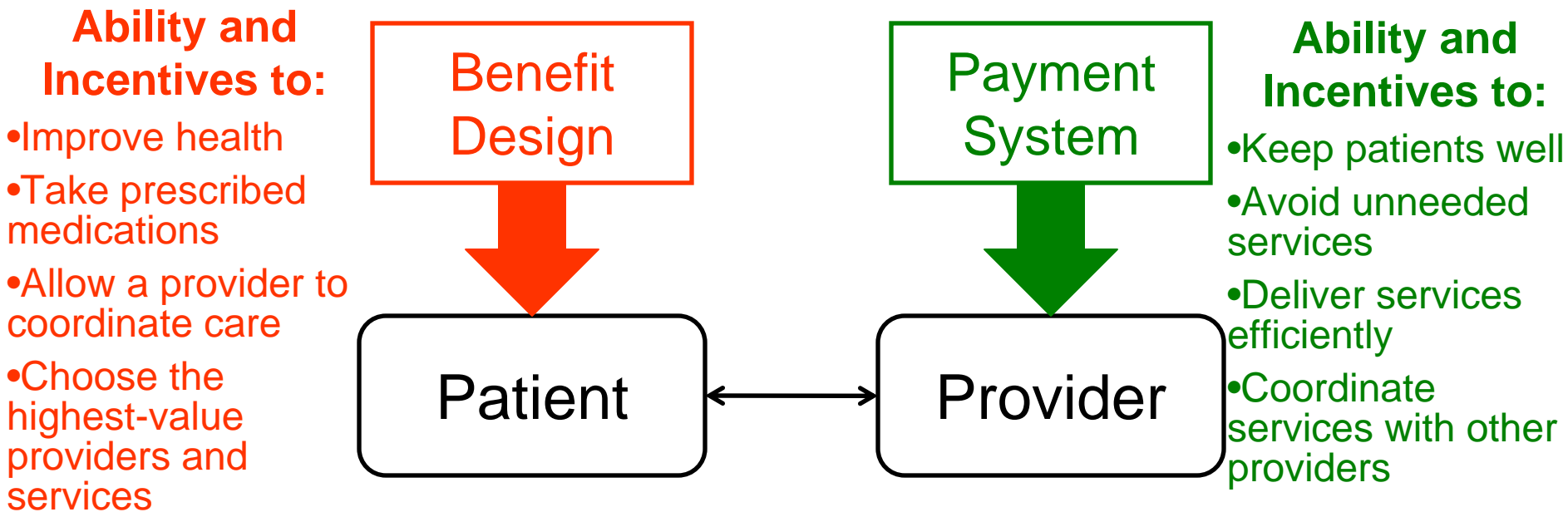
Impact of Federal Legislation on Payment/Delivery Reform

- If federal health reform passes:
 - Limited to pilot projects for Payment Reform/Accountable Care Organization; few significant broad-based changes
 - Applications for pilots will likely be primarily large providers/integrated systems unless communities help their smaller providers organize to apply
 - Communities with multi-payer initiatives will likely/hopefully receive preference from CMS for Medicare pilots
- If it doesn't pass:
 - Locally-organized projects with commercial payers will be the only way for payment and delivery reform to happen
 - Communities can still pursue case-by-case Medicare waivers

Payment Changes Only Affect One Side of the Relationship



Benefit Design Changes Are Also Critical to Success



Extreme Views of Patient Role in Use of Medical Home/ACO

ROCK

HARD PLACE

CONSUMERS/
PATIENTS CAN
CHANGE OR USE
MULTIPLE
PROVIDERS
AT WILL

CONSUMERS/
PATIENTS ARE
“LOCKED IN”
TO A SINGLE
GATEKEEPER
PROVIDER

Creating a Middle Ground to Support the Medical Home/ACO

ROCK

CONSUMERS/
PATIENTS CAN
CHANGE OR USE
MULTIPLE
PROVIDERS
AT WILL

MIDDLE GROUND

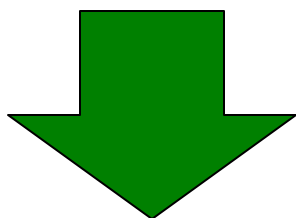
CONSUMERS/
PATIENTS HAVE
INCENTIVES
TO CHOOSE &
USE AN ACO OR
MEDICAL HOME

HARD PLACE

CONSUMERS/
PATIENTS ARE
“LOCKED IN”
TO A SINGLE
GATEKEEPER
PROVIDER

Lack of Coordination Between Pharmacy & Medical Benefits

Single-minded focus on reducing costs here...

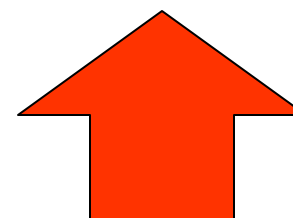


Pharmacy Benefits

Drug Costs

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

...could result in higher spending on hospitalizations



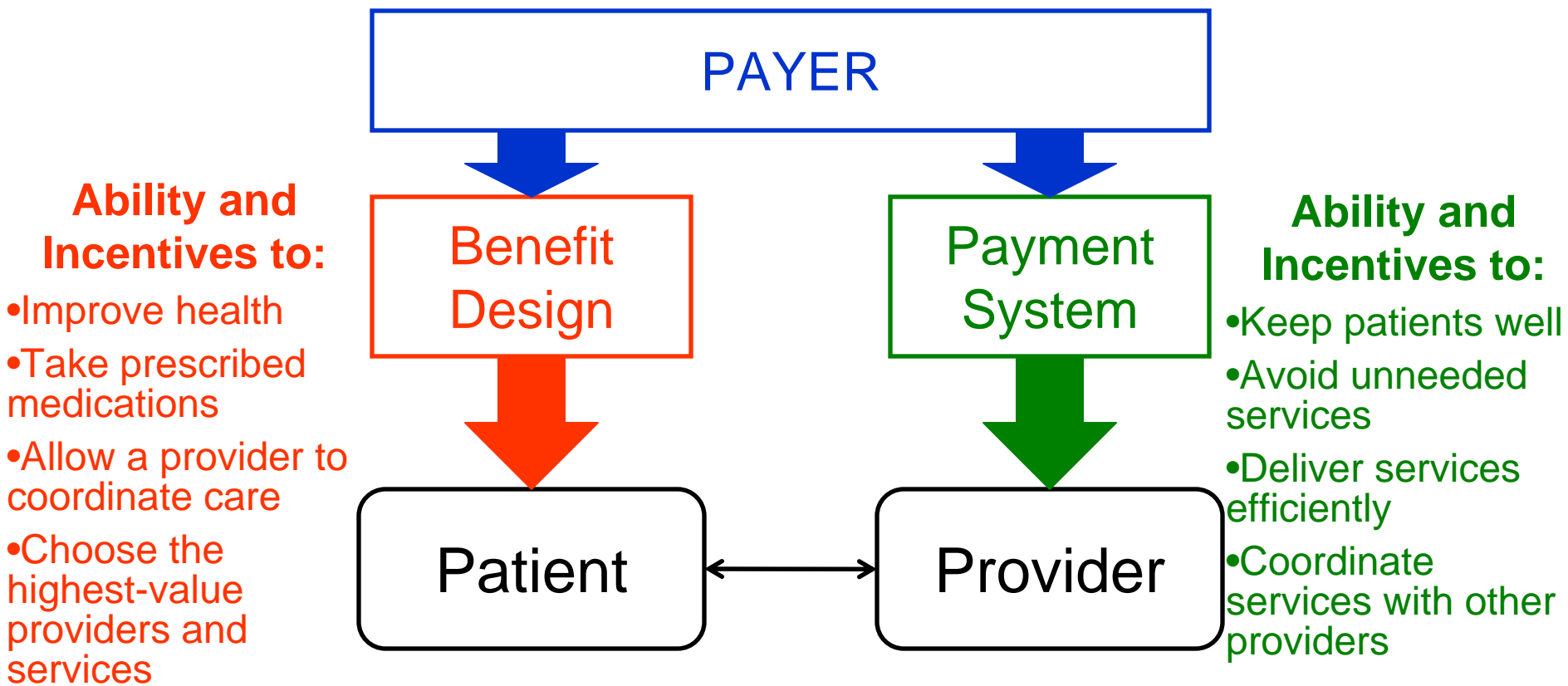
Health Insurance

Hospital Costs

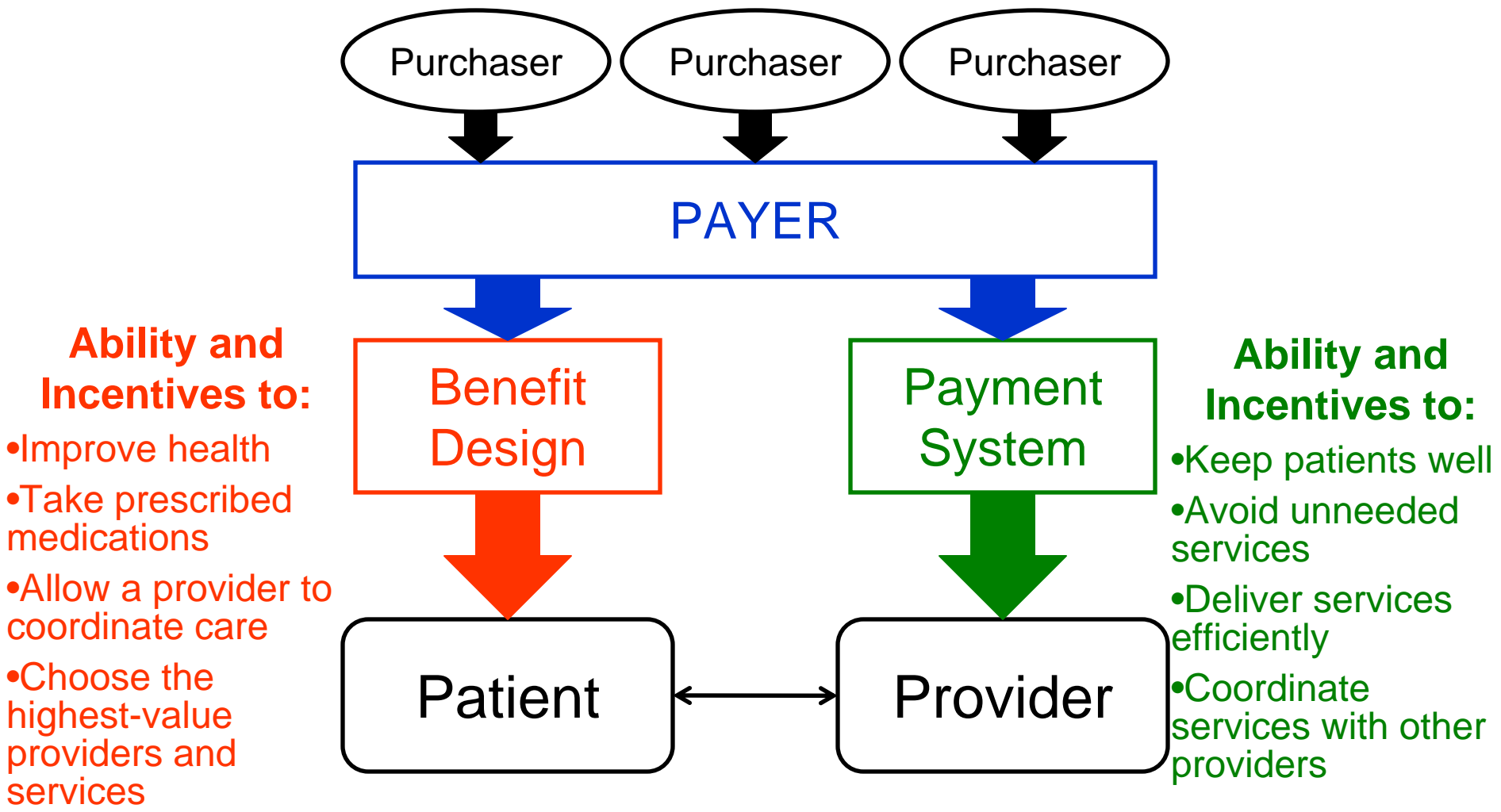
Physician Costs

Other Services

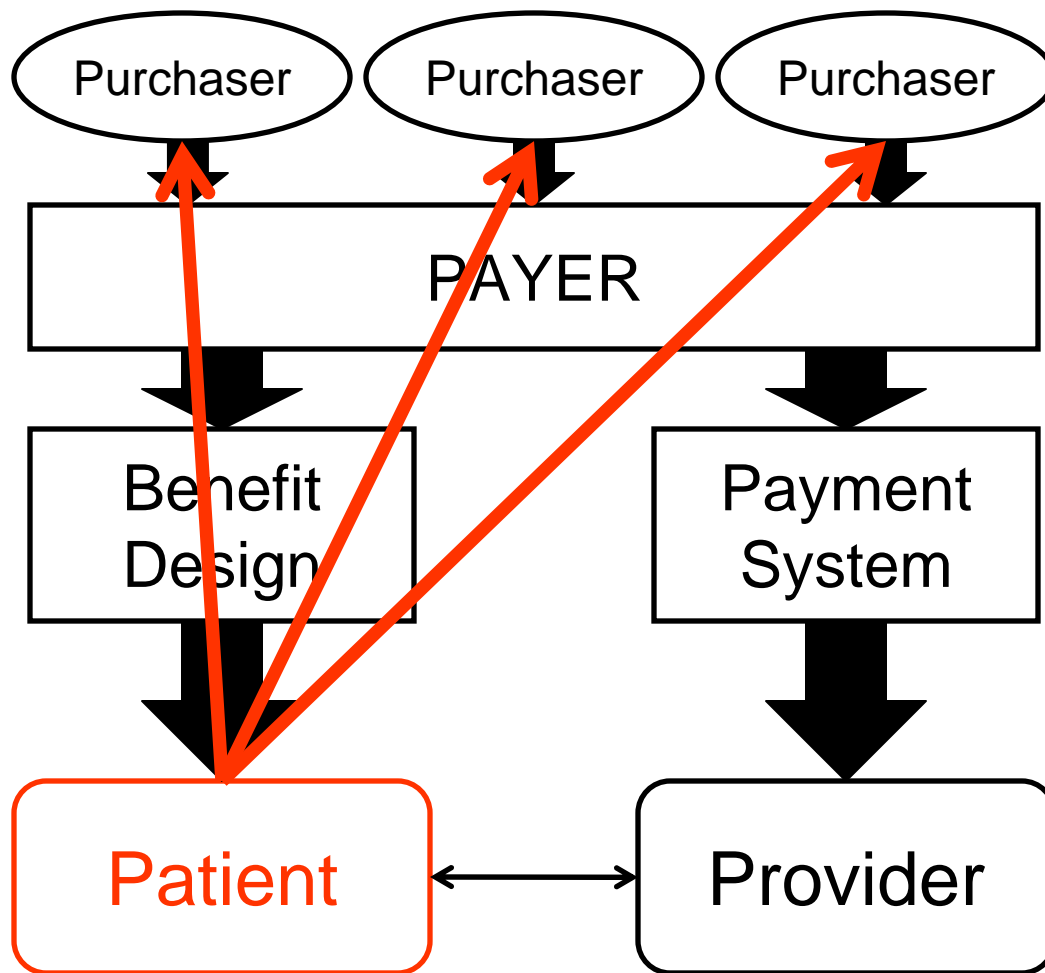
Both Payment & Benefit Design Are Controlled by the Payer



But Purchaser Support is Needed Particularly for Benefit Changes



And Consumer Support is Critical for Reform



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

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
- **Ideal:** Develop quality measures *with participation of physicians*, as Regional Health Improvement Collaboratives do

The screenshot shows a dashboard for the Wisconsin Collaborative for Healthcare Quality. The main heading is "Diabetes: Blood Sugar (A1c) Control" with a link to "WCHQ". Below this, it states "This measure assesses the care of 150,966 patients with Diabetes. More". On the left side, there are navigation buttons for "Legend", "Report", and "Sort". Below these are three data rows for "Affinity" (N=6627), "Aurora" (N=9245), and "Aurora" (N=2933), each with a "View" button. A large, empty rectangular box is overlaid on the right side of the dashboard, with the title "Greater Detroit Area Health Council" at the top. This box contains a small red 'x' icon in the top-left corner, suggesting a missing or broken image or report.

Don't Wait for a Federal "Answer"

- There is no one-size-fits-all solution to healthcare transformation; each region will need to actually make it happen in its own unique environment.
- Payment reform is necessary, but not sufficient. Delivery system reform, changes in benefit design, and effective quality measurement are also essential.
- The best federal policy will support regional action; Medicare should participate in regionally-defined payment reforms.

For More Information on Payment and Delivery Reforms

Robert Wood Johnson Foundation

From VOLUME to VALUE

Transforming Health Care Payment and Delivery Systems to Improve Quality and Reduce Costs

NRHI Healthcare Payment Reform Series

BETTER WAYS TO PAY FOR HEALTH CARE

A Primer on Healthcare Payment Reform

CENTER FOR HEALTHCARE QUALITY & PAYMENT REFORM

HOW TO CREATE ACCOUNTABLE CARE ORGANIZATIONS

Harold D. Miller

www.CHQPR.ORG

CENTER FOR HEALTHCARE QUALITY & PAYMENT REFORM

PATHS TO HEALTHCARE PAYMENT REFORM

Using Medical Homes To Reduce Readmissions

CENTER FOR HEALTHCARE QUALITY & PAYMENT REFORM

PATHS TO HEALTHCARE PAYMENT REFORM

Setting Payment Levels

CENTER FOR HEALTHCARE QUALITY & PAYMENT REFORM

PATHS TO HEALTHCARE PAYMENT REFORM

Transitioning to Episode-Based Payment

CENTER FOR HEALTHCARE QUALITY & PAYMENT REFORM

PATHS TO HEALTHCARE PAYMENT REFORM

Which Healthcare Payment System is Best?

There is broad agreement that episode-based payment is needed to drive down costs and improve quality, but there are many different ways to design these systems. This primer explores the pros and cons of different episode-based payment models and provides a framework for choosing the best approach for your organization.

Two Different Kinds of Cost/Quality Problems to be Solved

There are at least two different reasons why the cost of treating people with a particular condition may be higher than it needs to be:

- The cost of an episode of care for a particular condition is unreasonably high and/or there is high variability in the cost and quality of episodes across similar patients and across regions.** For example, the cost of coronary artery bypass graft surgery varies significantly across the country, depending on the site at which the surgery is performed and the quality of care provided. In such cases, the goal is to reduce the cost of care and/or improve the quality of care. This can be done by adjusting the payment to reflect the actual cost of care and/or by adjusting the payment to reflect the quality of care.
- Episodes of care occur frequently and/or the frequency of episodes varies significantly across similar patients and across regions.** For example, the frequency of heart failure hospitalizations varies significantly across the country. In such cases, the goal is to reduce the frequency of episodes and/or improve the quality of care. This can be done by adjusting the payment to reflect the frequency of episodes and/or by adjusting the payment to reflect the quality of care.

Different Payment Systems Solve Different Cost/Quality Problems

Amount Variation of Cost Per Episode	High	Low
Episode Payment	Example: Hip Fracture, Labor & Delivery	Example: Heart Disease, Back Pain
Free for Service	Example: Immunizations, Simple Injuries	Example: COPD, Complex Heart Failure

Size Variation in Frequency of Episodes Per Condition

(Continued on page 2)

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