FROM VOLUME TO VALUE: Better Ways to Pay for Health Care, and How to Get There

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

What is an “Accountable Care Organization?”

The Official Definition

What is an “Accountable Care Organization?”

A group of providers who are “accountable for the quality, cost, and overall care” of patients

Section 3022, Patient Protection and Affordable Care Act
The Real Definition

What is an “Accountable Care Organization?”

A group of providers who can figure out how to save money in health care

How Will ACOs Generate All These Savings?

Organizational Structure

ACO (“the “Black Box”)

Financial Risk

Patients

Lower Costs

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

Organizational Structure

Patients

RATIONING

Financial Risk

Lower Costs
Early Successes Need to Assure That Savings ≠ Rationing

Financial Risk

REDUCING COSTS WITHOUT RATIONING

Lower Costs

Organizational Structure

Supporting Value & Coordination, Not “Risk” and Consolidation

Value-Based Payment

REDUCING COSTS WITHOUT RATIONING

Lower Costs

Coordination of Care

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

Healthy Consumer

Preventable Condition

Continued Health

Reducing Costs Without Rationing:
Avoiding Hospitalizations

Healthy Consumer

Preventable Condition

No Hospitalization

Efficient, Successful Treatment

Healthy Consumer

Preventable Condition

No Hospitalization

Acute Care Episode

Efficient Successful Outcome

High-Cost Successful Outcomes
Complications, Infections, Rehospitalizations
Reducing Costs Without Rationing
Is Also Quality Improvement!

Current Payment Systems Reward
Bad Outcomes, Not Better Health

Are There Better Ways to
Pay for Health Care?
“Episode Payments” to Reward Value Within Episodes

Healthy Consumer → Continued Health → Preventable Condition → No Hospitalization → 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></th>
<th>Before ProvenCare (n=57)</th>
<th>Post ProvenCare (n=81)</th>
<th>% Improvement (Reduction)</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-hospital mortality</td>
<td>15.5%</td>
<td>0%</td>
<td>15.5%</td>
</tr>
<tr>
<td>Patients with any complications (M)</td>
<td>35.1%</td>
<td>16.5%</td>
<td>18.6%</td>
</tr>
<tr>
<td>Patients with T complications</td>
<td>7.6%</td>
<td>5.5%</td>
<td>21.1%</td>
</tr>
<tr>
<td>Amelioration</td>
<td>21.1%</td>
<td>19.1%</td>
<td>10.1%</td>
</tr>
<tr>
<td>Nonamelioration</td>
<td>11.1%</td>
<td>5.5%</td>
<td>50.0%</td>
</tr>
<tr>
<td>Any pulmonary complication</td>
<td>7.1%</td>
<td>4%</td>
<td>43.2%</td>
</tr>
<tr>
<td>Blood products used</td>
<td>21.1%</td>
<td>10.5%</td>
<td>42.4%</td>
</tr>
<tr>
<td>Re-operation for bleeding</td>
<td>5.5%</td>
<td>1.7%</td>
<td>68.2%</td>
</tr>
<tr>
<td>Deep venous thrombosis</td>
<td>9.1%</td>
<td>6.6%</td>
<td>28.2%</td>
</tr>
<tr>
<td>Readmissions within 30 days</td>
<td>6.6%</td>
<td>3.5%</td>
<td>46.9%</td>
</tr>
</tbody>
</table>
What a Single Physician and Hospital Can Do

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

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

- Method:
  - Reducing unnecessary auxiliary services such as radiography and physical therapy
  - Reducing the length of stay in the hospital
  - Reducing complications and readmissions.

The Weakness of Episode Payment

Preventable Condition

Healthy Consumer

Continued Health

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

Complications, Infections, Readmissions

High-Cost Successful Outcome

Successful Outcome

Episode Payment

Comprehensive Care Payments To Avoid Episodes

Comprehensive Care Payment or “Global” Payment

A Single Payment For All Care Needed For A Condition

$
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

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

Comprehensive Care & Episode Payment Can Be Complementary

- Healthy Consumer
- Continued Health
- Preventable Condition
- Comp. Care/Global Payment (E.g., an annual payment to manage an individual’s chronic disease, including costs of hospitalizations for exacerbations)
- No Hospitalization
- Efficient Outcome
- Complications, Infections, Readmissions
- Episode Payment (E.g., the payment made when the individual has an exacerbation requiring hospitalization)
- Acute Care Episode
- High-Cost Outcome
- Successful Outcome


© 2009-2011 Center for Healthcare Quality and Payment Reform, Network for Regional Healthcare Improvement
A Deeper Dive into Episode Payments and Implications

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

How Can Physicians, Hospitals, & Payers Benefit from Warranties?

Prices for Warrantied Care Will Likely Be Higher
Prices for Warrantied Care Will Likely Be Higher

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

Prices for Warrantied Care May Be Higher, But Spending Lower

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

Example: $10,000 Procedure

| Cost of Procedure | $10,000 |
### Actual 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>
</tbody>
</table>

### Starting Point for Warranty Price: Actual Current Average Payment

<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>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>
</tbody>
</table>

### Limited Warranty Gives Financial Incentive to Improve Quality

<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>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>
</tbody>
</table>

| $10,000           | $20,000                 | 4%                 | $10,800            | $11,000       | $200                 |

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

<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>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>
<tr>
<td>$10,000</td>
<td>$20,000</td>
<td>4%</td>
<td>$10,800</td>
<td>$10,800</td>
<td>$0</td>
</tr>
</tbody>
</table>

Enables Lower Prices

### A Virtuous Cycle of Quality Improvement & Cost Reduction

<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>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>
<tr>
<td>$10,000</td>
<td>$20,000</td>
<td>3%</td>
<td>$10,600</td>
<td>$10,800</td>
<td>$200</td>
</tr>
</tbody>
</table>

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

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

<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>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>$10,800</td>
<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>
<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>$10,000</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>
<td>$11,000</td>
<td>$0</td>
</tr>
<tr>
<td>$10,000</td>
<td>$20,000</td>
<td>5%</td>
<td>$11,000</td>
<td>$10,000</td>
<td>-$1,000</td>
</tr>
<tr>
<td>$10,000</td>
<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>

Not Just Better Acute Care, But Reducing the Need for It

Healthy Consumer

- Continued Health
- Preventable Condition
- No Hospitalization
- 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
  
  J. Bourbeau, M. Julien, et al., "Reduction of Hospital Utilization in Patients with Chronic Obstructive Pulmonary Disease: A Disease-Specific Self-Management Intervention," Archives of Internal Medicine 163(5), 2003

- 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
Lab Work/Imaging

Physician Practice

Health Insurance Plan

Office Visits
ER Visits
Hospital Stay
Lab Work/Imaging

Physician Practice

Health Insurance Plan

Office Visits
ER Visits
Hospital Stay
Lab Work/Imaging

Physician Practice

Global Payment Can Solve That, But It’s a Big Jump from FFS

FULL COMP. CARE/GLOBAL PAYMENT

Health Insurance Plan

Office Visits
ER Visits
Hospital Stay
Lab Work/Imaging

Physician Practice/ACO

Global Payment Can Solve That, But It’s a Big Jump from FFS

FULL COMP. CARE/GLOBAL PAYMENT

Health Insurance Plan

Office Visits
ER Visits
Hospital Stay
Lab Work/Imaging

Physician Practice/ACO

Global Payment Can Solve That, But It’s a Big Jump from FFS

FULL COMP. CARE/GLOBAL PAYMENT

Health Insurance Plan

Office Visits
ER Visits
Hospital Stay
Lab Work/Imaging

Physician Practice/ACO

What Might a Transitional Payment System Look Like?

CURRENT PAYMENT SYSTEMS

Health Insurance Plan

Office Visits
ER Visits
Hospital Stay
Lab Work/Imaging

Physician Practice

What Might a Transitional Payment System Look Like?

CURRENT PAYMENT SYSTEMS

Health Insurance Plan

Office Visits
ER Visits
Hospital Stay
Lab Work/Imaging

Physician Practice

What Might a Transitional Payment System Look Like?

CURRENT PAYMENT SYSTEMS

Health Insurance Plan

Office Visits
ER Visits
Hospital Stay
Lab Work/Imaging

Physician Practice

What Might a Transitional Payment System Look Like?

CURRENT PAYMENT SYSTEMS

Health Insurance Plan

Office Visits
ER Visits
Hospital Stay
Lab Work/Imaging

Physician Practice
Typical Medical Home “Solution”: Pay More for Physician Services

(TYPICAL) MEDICAL HOME PROGRAM

Health Insurance Plan

- Office Visits
- ER Visits
- Hospital Stay

Physician Practice

- Monthly Care Mgmt Payment
- "Phone" Calls
- Lab Work/Imaging

Higher payment for primary care...

Weakness: More $ for Physicians, But Any Savings Elsewhere?

(TYPICAL) MEDICAL HOME PROGRAM

Health Insurance Plan

- Office Visits
- ER Visits
- Hospital Stay

Physician Practice

- Monthly Care Mgmt Payment
- "Phone" Calls
- Lab Work/Imaging

...But no commitment to reduce utilization elsewhere

Is Shared Savings the Answer?

SHARED SAVINGS MODEL

Health Insurance Plan

- Office Visits
- ER Visits
- Hospital Stay

Physician Practice

- ...Returned to physician practice after savings determined...
- ...but no upfront $ for better care

Portion of savings from reduced spending in other areas...
Weaknesses of “Shared Savings”

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

Better Approach: Simulate Flexibility/Incentives of Global Pmt

Example: Washington State Medical Home Pilot Program

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

**Primary Care Practice**

<table>
<thead>
<tr>
<th>PCPs</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients/Physician</td>
<td>2,000</td>
</tr>
<tr>
<td>PMPY Primary Care Cost</td>
<td>$140</td>
</tr>
<tr>
<td>Annual Revenue</td>
<td>$1,120,000</td>
</tr>
<tr>
<td>Overhead Costs</td>
<td>$400,000</td>
</tr>
<tr>
<td>Physician Salary</td>
<td>$180,000</td>
</tr>
</tbody>
</table>

**Health Plan ER Expenses**

<table>
<thead>
<tr>
<th>ER Visits/1000</th>
<th>200</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Preventable</td>
<td>40%</td>
</tr>
<tr>
<td>Per ER Visit</td>
<td>$1,000</td>
</tr>
<tr>
<td>ER Visit Cost to Payer</td>
<td>$640,000</td>
</tr>
</tbody>
</table>

**Many Patients Are Going to ER Due to Difficulty Seeing PCPs**

**Primary Care Practice**

<table>
<thead>
<tr>
<th>PCPs</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients/Physician</td>
<td>2,000</td>
</tr>
<tr>
<td>PMPY Primary Care Cost</td>
<td>$140</td>
</tr>
<tr>
<td>Annual Revenue</td>
<td>$1,120,000</td>
</tr>
<tr>
<td>Overhead Costs</td>
<td>$400,000</td>
</tr>
<tr>
<td>Physician Salary</td>
<td>$180,000</td>
</tr>
</tbody>
</table>

**Health Plan ER Expenses**

<table>
<thead>
<tr>
<th>ER Visits/1000</th>
<th>200</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Preventable</td>
<td>40%</td>
</tr>
<tr>
<td>Per ER Visit</td>
<td>$1,000</td>
</tr>
<tr>
<td>ER Visit Cost to Payer</td>
<td>$640,000</td>
</tr>
</tbody>
</table>

**PCPs Could Reduce ER Expenses With Right Resources**

**Primary Care Practice**

<table>
<thead>
<tr>
<th>PCPs</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients/Physician</td>
<td>2,000</td>
</tr>
<tr>
<td>PMPY Primary Care Cost</td>
<td>$140</td>
</tr>
<tr>
<td>Annual Revenue</td>
<td>$1,120,000</td>
</tr>
<tr>
<td>Overhead Costs</td>
<td>$400,000</td>
</tr>
<tr>
<td>Physician Salary</td>
<td>$180,000</td>
</tr>
<tr>
<td>Cost of Nurse Practitioner</td>
<td>$80,000</td>
</tr>
<tr>
<td>Other Costs</td>
<td>$10,000</td>
</tr>
<tr>
<td>Total Costs</td>
<td>$90,000</td>
</tr>
</tbody>
</table>

**Health Plan ER Expenses**

<table>
<thead>
<tr>
<th>ER Visits/1000</th>
<th>200</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Preventable</td>
<td>40%</td>
</tr>
<tr>
<td>Per ER Visit</td>
<td>$1,000</td>
</tr>
<tr>
<td>ER Visit Cost to Payer</td>
<td>$640,000</td>
</tr>
<tr>
<td>Reduction in Prev. ER Visits</td>
<td>$256,000</td>
</tr>
<tr>
<td>Savings</td>
<td>$256,000</td>
</tr>
</tbody>
</table>
Upfront Money Could Enable PCPs to Change, If Willing

Pay Bonus to Physicians for Savings Beyond Upfront Costs

Win-Win-Win for PCPs, Patients, & Premiums
But **Upfront** Payment Reform is Needed So Care Can Be Changed

<table>
<thead>
<tr>
<th>PRIMARY CARE PRACTICE</th>
<th>HEALTH PLAN ER EXPENSES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PCPs</strong></td>
<td>4</td>
</tr>
<tr>
<td><strong>Patients/Physician</strong></td>
<td>2,000</td>
</tr>
<tr>
<td><strong>PMPY Primary Care Cost</strong></td>
<td>$140</td>
</tr>
<tr>
<td><strong>Annual Revenue</strong></td>
<td>$1,120,000</td>
</tr>
<tr>
<td><strong>Overhead Costs</strong></td>
<td>$400,000</td>
</tr>
<tr>
<td><strong>Physician Salary</strong></td>
<td>$180,000</td>
</tr>
<tr>
<td><strong>Total Costs</strong></td>
<td>$500,000</td>
</tr>
<tr>
<td><strong>Upfront Payment</strong></td>
<td>$500,000</td>
</tr>
<tr>
<td><strong>Share of Savings</strong></td>
<td>$83,000</td>
</tr>
<tr>
<td><strong>New Physician Salary</strong></td>
<td>$200,750</td>
</tr>
<tr>
<td><strong>Increase in Phys. Salary</strong></td>
<td>12%</td>
</tr>
</tbody>
</table>

And Savings Targets Need to Be Feasible for Practice to Achieve

<table>
<thead>
<tr>
<th>PRIMARY CARE PRACTICE</th>
<th>HEALTH PLAN ER EXPENSES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PCPs</strong></td>
<td>4</td>
</tr>
<tr>
<td><strong>Patients/Physician</strong></td>
<td>2,000</td>
</tr>
<tr>
<td><strong>PMPY Primary Care Cost</strong></td>
<td>$140</td>
</tr>
<tr>
<td><strong>Annual Revenue</strong></td>
<td>$1,120,000</td>
</tr>
<tr>
<td><strong>Overhead Costs</strong></td>
<td>$400,000</td>
</tr>
<tr>
<td><strong>Physician Salary</strong></td>
<td>$180,000</td>
</tr>
<tr>
<td><strong>Total Costs</strong></td>
<td>$500,000</td>
</tr>
<tr>
<td><strong>Upfront Payment</strong></td>
<td>$500,000</td>
</tr>
<tr>
<td><strong>Share of Savings</strong></td>
<td>$83,000</td>
</tr>
<tr>
<td><strong>New Physician Salary</strong></td>
<td>$200,750</td>
</tr>
<tr>
<td><strong>Increase in Phys. Salary</strong></td>
<td>12%</td>
</tr>
</tbody>
</table>

Would the Shared Savings Model Achieve the Same Goal?
### Simple Model: Payer Spending Limited to PCPs & Prev. ER Visits

#### Year 0

<table>
<thead>
<tr>
<th>Category</th>
<th>Revenues</th>
<th>Shared Savings</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP</td>
<td>$1,120,000</td>
<td>$1,120,000</td>
<td>$1,240,000</td>
</tr>
<tr>
<td>Expenses</td>
<td>$1,120,000</td>
<td>$1,120,000</td>
<td>$1,240,000</td>
</tr>
<tr>
<td>Care Mgt</td>
<td>$0</td>
<td>$640,000</td>
<td>$640,000</td>
</tr>
<tr>
<td>Total</td>
<td>$1,240,000</td>
<td>$1,760,000</td>
<td>$2,000,000</td>
</tr>
<tr>
<td>Net Revenue</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Margin</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

#### Payer

<table>
<thead>
<tr>
<th>Category</th>
<th>PCP Costs</th>
<th>ER Costs</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP</td>
<td>$1,120,000</td>
<td>$640,000</td>
<td>$1,760,000</td>
</tr>
<tr>
<td>ER</td>
<td>$640,000</td>
<td>$384,000</td>
<td>$1,024,000</td>
</tr>
<tr>
<td>Savings From Year 0</td>
<td>$256,000</td>
<td>$0</td>
<td>$256,000</td>
</tr>
<tr>
<td>% Savings</td>
<td>14.4%</td>
<td>0.0%</td>
<td>14.4%</td>
</tr>
</tbody>
</table>

### PCP Invests in Year 1, Payer Reaps Benefit, PCP Loses

#### Year 0

<table>
<thead>
<tr>
<th>Category</th>
<th>Revenues</th>
<th>Shared Savings</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP</td>
<td>$1,120,000</td>
<td>$1,120,000</td>
<td>$2,240,000</td>
</tr>
<tr>
<td>Expenses</td>
<td>$1,120,000</td>
<td>$1,120,000</td>
<td>$2,240,000</td>
</tr>
<tr>
<td>Care Mgt</td>
<td>$0</td>
<td>$90,000</td>
<td>$90,000</td>
</tr>
<tr>
<td>Total</td>
<td>$2,240,000</td>
<td>$3,310,000</td>
<td>$5,550,000</td>
</tr>
<tr>
<td>Net Revenue</td>
<td>$0</td>
<td>$-90,000</td>
<td>$-90,000</td>
</tr>
<tr>
<td>Margin</td>
<td>0.0%</td>
<td>-7.4%</td>
<td>-7.4%</td>
</tr>
</tbody>
</table>

#### Payer

<table>
<thead>
<tr>
<th>Category</th>
<th>PCP Costs</th>
<th>ER Costs</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP</td>
<td>$1,120,000</td>
<td>$640,000</td>
<td>$1,760,000</td>
</tr>
<tr>
<td>ER</td>
<td>$640,000</td>
<td>$384,000</td>
<td>$1,024,000</td>
</tr>
<tr>
<td>Savings From Year 0</td>
<td>$256,000</td>
<td>$0</td>
<td>$256,000</td>
</tr>
<tr>
<td>% Savings</td>
<td>14.4%</td>
<td>0.0%</td>
<td>14.4%</td>
</tr>
</tbody>
</table>
### PCP Invests in Year 1, Payer Reaps Benefit, PCP Loses

<table>
<thead>
<tr>
<th>Year 0</th>
<th>Year 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP</td>
<td>PCP</td>
</tr>
<tr>
<td>Revenues</td>
<td>$1,120,000</td>
</tr>
<tr>
<td>Shared Savings</td>
<td>$1,120,000</td>
</tr>
<tr>
<td>Expenses</td>
<td>$1,120,000</td>
</tr>
<tr>
<td>Care Mgt</td>
<td>$0</td>
</tr>
<tr>
<td>Total</td>
<td>$1,120,000</td>
</tr>
<tr>
<td>Net Revenue</td>
<td>$0</td>
</tr>
<tr>
<td>Margin</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Payer</th>
<th>Payer</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP Costs</td>
<td>$1,120,000</td>
</tr>
<tr>
<td>ER Costs</td>
<td>$640,000</td>
</tr>
<tr>
<td>50% Shared Savings</td>
<td>$1,120,000</td>
</tr>
<tr>
<td>Total</td>
<td>$1,120,000</td>
</tr>
<tr>
<td>Savings From Year 0</td>
<td>$0</td>
</tr>
<tr>
<td>% Savings</td>
<td>10.0%</td>
</tr>
</tbody>
</table>

No New Revenues for PCP in Year 1

PCP Invests in Better Care Mgt

Negative Margin for PCP in Year 1

### More PCP Revenue in Year 2, But Not Enough to Cover Year 1 Loss

<table>
<thead>
<tr>
<th>Year 0</th>
<th>Year 1</th>
<th>Year 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP</td>
<td>PCP</td>
<td>PCP</td>
</tr>
<tr>
<td>Revenues</td>
<td>$1,120,000</td>
<td>$1,120,000</td>
</tr>
<tr>
<td>Shared Savings</td>
<td>$1,120,000</td>
<td>$1,120,000</td>
</tr>
<tr>
<td>Expenses</td>
<td>$1,120,000</td>
<td>$1,120,000</td>
</tr>
<tr>
<td>Care Mgt</td>
<td>$0</td>
<td>$90,000</td>
</tr>
<tr>
<td>Total</td>
<td>$1,120,000</td>
<td>$1,210,000</td>
</tr>
<tr>
<td>Net Revenue</td>
<td>$0</td>
<td>$-90,000</td>
</tr>
<tr>
<td>Margin</td>
<td>0.0%</td>
<td>-7.4%</td>
</tr>
</tbody>
</table>

Positive Margin But < Year 1 Loss

<table>
<thead>
<tr>
<th>Payer</th>
<th>Payer</th>
<th>Payer</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP Costs</td>
<td>$1,120,000</td>
<td>$1,120,000</td>
</tr>
<tr>
<td>ER Costs</td>
<td>$640,000</td>
<td>$384,000</td>
</tr>
<tr>
<td>50% Shared Savings</td>
<td>$1,120,000</td>
<td>$1,120,000</td>
</tr>
<tr>
<td>Total</td>
<td>$1,120,000</td>
<td>$1,210,000</td>
</tr>
<tr>
<td>Savings From Year 0</td>
<td>$0</td>
<td>$256,000</td>
</tr>
<tr>
<td>% Savings</td>
<td>10.0%</td>
<td>3.1%</td>
</tr>
</tbody>
</table>

Payer Benefits if PCP is Successful

### PCP Still Worse Off After 3 Years, Payer Saves Significantly

<table>
<thead>
<tr>
<th>Year 0</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Total Yrs 1-3</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP</td>
<td>PCP</td>
<td>PCP</td>
<td>PCP</td>
<td>PCP</td>
</tr>
<tr>
<td>Revenues</td>
<td>$1,120,000</td>
<td>$1,120,000</td>
<td>$1,120,000</td>
<td>$1,120,000</td>
</tr>
<tr>
<td>Shared Savings</td>
<td>$1,120,000</td>
<td>$1,120,000</td>
<td>$1,120,000</td>
<td>$1,120,000</td>
</tr>
<tr>
<td>Expenses</td>
<td>$1,120,000</td>
<td>$1,120,000</td>
<td>$1,120,000</td>
<td>$1,120,000</td>
</tr>
<tr>
<td>Care Mgt</td>
<td>$0</td>
<td>$90,000</td>
<td>$90,000</td>
<td>$90,000</td>
</tr>
<tr>
<td>Total</td>
<td>$1,120,000</td>
<td>$1,210,000</td>
<td>$1,210,000</td>
<td>$1,210,000</td>
</tr>
<tr>
<td>Net Revenue</td>
<td>$0</td>
<td>$-90,000</td>
<td>$-38,000</td>
<td>$-38,000</td>
</tr>
<tr>
<td>Margin</td>
<td>0.0%</td>
<td>-7.4%</td>
<td>-3.1%</td>
<td>-3.1%</td>
</tr>
</tbody>
</table>

Net Loser For PCP

<table>
<thead>
<tr>
<th>Payer</th>
<th>Payer</th>
<th>Payer</th>
<th>Payer</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP Costs</td>
<td>$1,120,000</td>
<td>$1,120,000</td>
<td>$1,120,000</td>
</tr>
<tr>
<td>ER Costs</td>
<td>$640,000</td>
<td>$384,000</td>
<td>$384,000</td>
</tr>
<tr>
<td>50% Shared Savings</td>
<td>$1,120,000</td>
<td>$1,120,000</td>
<td>$1,120,000</td>
</tr>
<tr>
<td>Total</td>
<td>$1,120,000</td>
<td>$1,210,000</td>
<td>$1,210,000</td>
</tr>
<tr>
<td>Savings From Year 0</td>
<td>$0</td>
<td>$256,000</td>
<td>$256,000</td>
</tr>
<tr>
<td>% Savings</td>
<td>10.0%</td>
<td>7.1%</td>
<td>7.1%</td>
</tr>
</tbody>
</table>

Win For Payer

Payer Still Benefits

Net Loser For PCP
A Perfect Starting Point: Merging Two Payment Reform Silos

SILO #1
- Implementing Medical Home/Chronic Care Model
- Pay More to Physicians for Being Certified as a “Medical Home” and Hope That Outcomes Improve

SILO #2
- Reducing Hospital Readmissions
- Penalize Hospitals for Readmissions Even If the Cause is Poor Primary Care

Marrying the Medical Home and Hospital Readmissions

Reducing Hospital Readmissions Requires Improved Community Care

Reducing Hospital Readmissions Provides ROI for Chronic Care Investment

Implementing Medical Home/Chronic Care Model Requires Higher/Different Payment

Reforming Payment for Primary/Chronic Care

Not Just PCPs, But The Medical Neighborhood, Too

Resources & Incentives for More Coordinated Care

Primary Care Medical Home

FFS Payment Based on Volume, Procedures, & Office Visits

(Non-Primary Care) Specialists

PATIENT
Pay Both PCPs & Specialists for Outcomes & Coordination

Resources & Incentives for More Coordinated Care
Primary Care Medical Home

(Non-Primary Care) Specialists

Payment for Consultation w/ PCP; Outcomes-Based Payment

PATIENT

Today: Underpaid PCPs, Underused Specialists, High Costs

500 Moderate/Severe Chronic Disease Patients

Uncordinated Management Today

<table>
<thead>
<tr>
<th></th>
<th>Per Visit</th>
<th>Vists/yr</th>
<th>Per Ph</th>
<th>Phs/yr</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP</td>
<td>$100</td>
<td>6</td>
<td>$600</td>
<td>$300,000</td>
<td></td>
</tr>
<tr>
<td>Drugs</td>
<td>$400</td>
<td>10</td>
<td>$4,000</td>
<td>$200,000</td>
<td></td>
</tr>
<tr>
<td>Hospital</td>
<td>$10,000</td>
<td>1</td>
<td>$10,000</td>
<td>$5,000,000</td>
<td></td>
</tr>
<tr>
<td>Specialist</td>
<td>$100</td>
<td>4</td>
<td>$400</td>
<td>$200,000</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td><strong>$7,500,000</strong></td>
<td></td>
</tr>
</tbody>
</table>

Per Visit: 300 visits/yr, 50 patients/physician, 10 physicians

Today: Underpaid PCPs, Underused Specialists, High Costs

500 Moderate/Severe Chronic Disease Patients

Uncordinated Management Today

<table>
<thead>
<tr>
<th></th>
<th>Per Visit</th>
<th>Vists/yr</th>
<th>Per Ph</th>
<th>Phs/yr</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP</td>
<td>$100</td>
<td>6</td>
<td>$600</td>
<td>$300,000</td>
<td></td>
</tr>
<tr>
<td>Drugs</td>
<td>$400</td>
<td>10</td>
<td>$4,000</td>
<td>$200,000</td>
<td></td>
</tr>
<tr>
<td>Hospital</td>
<td>$10,000</td>
<td>1</td>
<td>$10,000</td>
<td>$5,000,000</td>
<td></td>
</tr>
<tr>
<td>Specialist</td>
<td>$100</td>
<td>4</td>
<td>$400</td>
<td>$200,000</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td><strong>$7,500,000</strong></td>
<td></td>
</tr>
</tbody>
</table>

Per Visit: 300 visits/yr, 50 patients/physician, 10 physicians

6.7% of the money goes to the physicians
Pay PCPs & Specialists to Provide More Coordinated, Proactive Care

### 500 Moderate/Severe Chronic Disease Patients

<table>
<thead>
<tr>
<th></th>
<th>Uncoordinated Management Today</th>
<th>Coordinated Management Tomorrow</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Per Visit</td>
<td>Per Month</td>
</tr>
<tr>
<td>PCP $300</td>
<td>6</td>
<td>60</td>
</tr>
<tr>
<td>Per Month</td>
<td>30</td>
<td>5,400</td>
</tr>
<tr>
<td>Drugs $400</td>
<td>40</td>
<td>10,400</td>
</tr>
<tr>
<td>Hospital $300</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Per Month</td>
<td>30</td>
<td>1,000</td>
</tr>
<tr>
<td>Specialist $300</td>
<td>4</td>
<td>40</td>
</tr>
<tr>
<td>Total</td>
<td>54</td>
<td>14,400</td>
</tr>
</tbody>
</table>

**Per Pt Total**

- PCP $600
- Specialist $400

**Total**

- PCP $2,150,000
- Specialist $1,600,000

- Medicare

### Higher Medication Expenses, But Lower Hospital Costs

<table>
<thead>
<tr>
<th></th>
<th>Uncoordinated Management Today</th>
<th>Coordinated Management Tomorrow</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Per Visit</td>
<td>Per Month</td>
</tr>
<tr>
<td>PCP $300</td>
<td>6</td>
<td>60</td>
</tr>
<tr>
<td>Per Month</td>
<td>30</td>
<td>5,400</td>
</tr>
<tr>
<td>Drugs $400</td>
<td>40</td>
<td>10,400</td>
</tr>
<tr>
<td>Hospital $300</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Per Month</td>
<td>30</td>
<td>1,000</td>
</tr>
<tr>
<td>Specialist $300</td>
<td>4</td>
<td>40</td>
</tr>
<tr>
<td>Total</td>
<td>54</td>
<td>14,400</td>
</tr>
</tbody>
</table>

**Per Pt Total**

- PCP $7,150,000
- Specialist $5,700,000

**Total**

- PCP $13,850,000
- Specialist $11,400,000

- Medicare

### Win-Win-Win Through PCP/Specialist Coordinated Mgt

<table>
<thead>
<tr>
<th></th>
<th>Uncoordinated Management Today</th>
<th>Coordinated Management Tomorrow</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Per Visit</td>
<td>Per Month</td>
</tr>
<tr>
<td>PCP $300</td>
<td>6</td>
<td>60</td>
</tr>
<tr>
<td>Per Month</td>
<td>30</td>
<td>5,400</td>
</tr>
<tr>
<td>Drugs $400</td>
<td>40</td>
<td>10,400</td>
</tr>
<tr>
<td>Hospital $300</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Per Month</td>
<td>30</td>
<td>1,000</td>
</tr>
<tr>
<td>Specialist $300</td>
<td>4</td>
<td>40</td>
</tr>
<tr>
<td>Total</td>
<td>54</td>
<td>14,400</td>
</tr>
</tbody>
</table>

**Per Pt Total**

- PCP $7,150,000
- Specialist $5,700,000

**Total**

- PCP $13,850,000
- Specialist $11,400,000

- Medicare

**Pay for Patient Care, Not Visits**

- Higher Medication Expenses
- Better Outcomes
- Better Medication Compliance
- Fewer Hospitalizations
- More Revenue for Docs
- Lower Total Costs
Minnesota’s DIAMOND Initiative

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

http://www.icsi.org/health_care_redesign/diamon_35953/

Phase 2: More ACO-ness:
Partial Global Payment

PARTIAL GLOBAL PMT (Professional Svcs)

<table>
<thead>
<tr>
<th>Health Insurance Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condition-Adjusted Per Person Payment</td>
</tr>
<tr>
<td>Physician Practice</td>
</tr>
<tr>
<td>ER Visits</td>
</tr>
<tr>
<td>Lab Work/Imaging</td>
</tr>
<tr>
<td>Avoidable Avoidable Avoidable</td>
</tr>
<tr>
<td>Hospital Stay</td>
</tr>
<tr>
<td>P4P Bonus/penalty Based on Utilization</td>
</tr>
<tr>
<td>Flexibility and accountability for a condition-adjusted budget covering all professional services</td>
</tr>
</tbody>
</table>

And Then Transition to a Full Global Payment System

FULL COMP. CARE/GLOBAL PAYMENT

<table>
<thead>
<tr>
<th>Health Insurance Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condition-Adjusted Per Person Payment</td>
</tr>
<tr>
<td>Physician Practice/ACO</td>
</tr>
<tr>
<td>ER Visits</td>
</tr>
<tr>
<td>Lab Work/Imaging</td>
</tr>
<tr>
<td>Avoidable Avoidable</td>
</tr>
<tr>
<td>Hospital Stay</td>
</tr>
<tr>
<td>P4P Bonus/penalty Based on Quality</td>
</tr>
</tbody>
</table>
Transitioning to Accountable Care Payment

Challenge: Giving Physicians the Skills to Take Accountability

Resources/Capabilities Needed for Docs to Take Accountability
Capabilities Exist Today, But Don’t Coordinate w/ Physicians

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

Medical Home Initiatives Expand Practice Capacity, But Not Enough

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

Global 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 Docs the Capacity to Deliver “Accountable Care”

Physician Practice + Partners = ACO

- Data and analytics to measure and monitor utilization and quality
- Coordinated relationships with other specialists and hospitals
- Capability for tracking patient care and ensuring follow-up (e.g., registry)
- Method for targeting high-risk patients (e.g., predictive modeling)
- Resources for patient education and self-management support (e.g., RN care managers)
- Physician with time for diagnosis, treatment planning, and follow-up

Can Small Physician Practices Manage Accountable Payments?

- Infrastructure/Services
  - Small physician practices may not have enough patients to justify staff or other services to coordinate care, particularly for patients with complex illnesses (e.g., nurse care managers, patient registries, etc.)
- Quality/Cost Measurement
  - Small numbers of patients make measurement unreliable; physicians may be inappropriately labeled low quality, high cost, or vice versa

Solution 1: Hospitals Acquire Physician Practices
Shared Savings Forces Hospitals To Consider Hiring Physicians

• Hospitals are not directly eligible for shared savings; all savings are attributed to primary care physicians
• Even if the hospital reduces readmissions, infections, complications, etc., it may receive no reward for doing so
• Reducing hospitalizations, ER visits, etc. will reduce the hospital’s revenues, but the hospital may receive no share of the savings to help it cover its stranded fixed costs
• Consequently, hospitals may feel compelled to own physician practices, either to capture a portion of the shared savings revenue, or to prevent there from being any savings!

Solution 2: Hospital-Physician Partnerships

Solution 3: Use IPAs for Critical Mass
Examples of Small, Independent MD Practices With Global Pmt

- 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 165 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 Does All This Fit Into Accountable Care Organizations??

If Physician Practices Want to Manage a Patient Population...

PATIENTS
- Heart Disease
- Back Pain
- Pregnancy

Primary Care Practice

Cardiology Group
Orthopedic Group
OB/GYN Group
...Should They Hope Payers Will Make the Right Payment Changes?

MEDICARE/HEALTH PLAN

PATIENTS
Heart Disease
Back Pain
Pregnancy

Primary Care Practice
Cardiology Group
Orthopedic Group
OB/GYN Group

Care Mgt Pmt +P4P
Heart Episode Pmt
Back Episode Pmt
Pregnancy Episode Pmt

Or Take a Single Payment & Work Out Internal Pmts Themselves?

MEDICARE/HEALTH PLAN

PATIENTS
Heart Disease
Back Pain
Pregnancy

Primary Care Practice
Cardiology Group
Orthopedic Group
OB/GYN Group

ACO
Condition-Adjusted Comprehensive Care (Global) Payment

Reducing Costs Without Rationing Reduces Hospital Revenues

Healthy Consumer
Continued Health
Preventable Condition
No Hospitalization
Ache 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

<table>
<thead>
<tr>
<th>#Patients</th>
<th>Cost &amp; Revenue Changes With Fewer Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

### Reductions in Utilization Reduce Revenues More Than Costs

<table>
<thead>
<tr>
<th>#Patients</th>
<th>Cost &amp; Revenue Changes With Fewer Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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.
Benefit Design Changes Are Also Critical to Success

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

Benefit Design → Patient → Provider

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

Payment System

Example: Important to Coordinate Pharmacy & Medical Benefits

Single-minded focus on reducing costs here...
...could result in higher spending on hospitalizations

Pharmacy Benefits (Part D)
- 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 (Parts A/B)
- Hospital Costs
- Physician Costs
- Other Services

Both Payment & Benefits Are Controlled by the Payer

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

PAYER

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

Benefit Design → Patient → Provider

Payment System → Provider

© 2009-2011 Center for Healthcare Quality and Payment Reform, Network for Regional Healthcare Improvement
But Purchaser Support is Needed Particularly for Benefit Changes

![Diagram showing Purchaser, Purchaser, Purchaser, PAYER, Benefit Design, Payment System, Ability and Incentives to: Improve health, Take proscribed medications, Allow a provider to coordinate care, Choose the highest-value providers and services, Patient, Provider.]

And Consumer Support is Critical for Purchaser/Plan Support

![Diagram showing Purchaser, Purchaser, Purchaser, FAYER, Benefit Design, Payment System, Patient, Provider.]

Ensuring That Lower Cost ≠ Lower Quality

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

- Concern: Giving healthcare providers more accountability for costs reduces the incentives for overuse, but raises concerns about whether patients will get too little care
- Solution: Measure healthcare quality and include incentives for providers to maintain/improve quality as well as reduce costs

Federal Measurement of Quality?

- Concern: Giving healthcare providers more accountability for costs reduces the incentives for overuse, but raises concerns about whether patients will get too little care
- Solution: Measure healthcare quality and include incentives for providers to maintain/improve quality as well as reduce costs
- Undesirable: National data aggregation and reporting
  - E.g., PQRI

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 Regional Health Improvement Collaboratives do

Minneso Community Measurement
Iowa Healthcare Collaborative
Wisconsin Collaborative for Healthcare Quality
“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.

(Many) Other Issues

- Malpractice/Defensive Medicine
  - Reforms in malpractice law
  - Collaborative changes in physician practice, so more conservative care is the standard of care across the entire community
    - e.g., HealthTeamWorks/Colorado Clinical Guidelines Collaborative
- Workforce Training/Retraining
  - More PCPs, more nurses willing to make home visits, fewer support staff for fewer procedures, etc.
- And Others

Payment Reform Is Necessary, But Not Sufficient

- Patient Education & Engagement
- Quality/Cost Analysis & Reporting
- Reducing Costs Without Rationing
- Value-Driven Payment Systems & Benefit Designs
- Value-Driven Delivery Systems
Many Specific Activities in Each Area...

Reducing Costs Without Rationing

Do patients know which providers offer the highest value care?

Will benefit designs give patients the ability to adhere to care plans?

Will investments in new care models create savings > costs?

Will payment support better care?

Can providers accept new payment models?

...All of Which Need to Be Coordinated to Be Successful

Regional Health Improvement Collab.
Healthcare Consumers
Healthcare Purchasers
Healthcare Providers

...With Active Involvement of All Healthcare Stakeholders
E.g., Comprehensive Approach to Readmission Reduction

- Analyze data on readmissions to identify which types of patients are being readmitted at high volumes/rates
- Analyze and redesign current healthcare delivery system
  - Which physician practices are caring for the patients, both in the hospital and in the community?
  - How can care processes in the hospital and in physician practices be redesigned to prevent ER visits & hospitalizations?
  - What is the most cost-effective way to provide care management support for patients – hospital? PCP? Home health?
- Establish business case for improvement
  - What reductions in readmission rates are needed to justify higher expenditures on care management and other services?
- Change payment systems and benefit designs
- Provide coaching to providers
- Provide education and support for patients
- Analyze real-time data for continuous improvement

How Can All These Functions Be Delivered in a Coordinated Way?

The Role of Regional Health Improvement Collaboratives
...With Active Involvement of All Healthcare Stakeholders

Leading Regional Health Improvement Collaboratives

- Albuquerque Coalition for Healthcare Quality
- Aligning Forces for Quality – South Central PA
- Alliance for Health
- Better Health Greater Cleveland
- California Cooperative Healthcare Reporting Initiative
- California Quality Collaborative
- Center for Healthcare Quality Improvement Agency
- Greater Detroit Area Health Council
- Health Improvement Collaborative of Greater Cincinnati
- Institute for Clinical Systems Improvement
- Institute for Clinical Systems Improvement
- Iowa Healthcare Collaborative
- Kansas City Quality Improvement Consortium
- 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
- Ohio Health Improvement Institute
- Ohio Quality Improvement Collaborative
- Ohio’s Regional Health Initiatives
- Oregon Health Care Quality Corporation
- P2 Collaborative of Western New York
- Philadelphia Regional Health Initiative
- Portugal Shared Health Alliance
- Quality Choice Québec
- Quality Health Care of Illinois
- Utah Partnership for Value-Driven Healthcare (HealthInsight)
- Oklahoma Collaborative for Healthcare Quality
- Wisconsin Healthcare Value Exchange

Moving to Accountable Care

- 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. The best federal policy will support regional innovation.
- Payment reform is necessary, but not sufficient. Delivery system reform, changes in benefit design, and effective quality measurement are also essential. Everything needs to focus on improving outcomes.
- Physicians need to take the lead by agreeing to take accountability for reducing costs without rationing, creating organizational structures that enable them to do so, and demanding the payment changes needed to support them.
For More Information on Payment and Delivery Reforms

www.PaymentReform.org

For More Information:

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

Miller.Harold@GMail.com
(412) 803-3650
www.CHQPR.org
www.NRHI.org
www.PaymentReform.org