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

Harold D. Miller
Executive Director
Center for Healthcare Quality and Payment Reform
and
President and CEO
Network for Regional Healthcare Improvement
Health Care Costs are the Core of the National Budget Problem

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

President Obama
September 2010
Federal Cost Containment Policy Choices

MEDICARE SPENDING = SERVICES TO SENIORS × FEES TO PROVIDERS

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

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

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

Guess which one they’ll try to reduce?
Medicare Payments to Physicians Below Inflation for a Decade

Physician Practice Costs

Physician Payment Increases

If Sustainable Growth Rate Cut Is Made
Past Solutions: Cost-Shifting Gov’t Cuts to Private Payers

Hospital Payment-To-Cost Ratio, By Type Of Payer, 1980–2003

Source: Christopher Tompkins, Stuart Altman, and Efrat Eilat, “The Precarious Pricing System for Hospital Services,” Health Affairs, Jan/Feb 2006, pp. 45-56
What Makes Our % of GDP High is *Private* Expenditures on Health

Public and Private Health Expenditures as a Percentage of GDP, U.S. and Selected Countries, 2008


Notes: Data from Australia and Japan are 2007 data. Figures for Canada, Norway and Switzerland, are OECD estimates. Numbers are PPP adjusted.
Large Size and Growth in Costs for Both Employers & Workers

Average Annual Contributions to Health Insurance Premiums
1999-2010

11 Years

Employer Contribution
Worker Contribution

Single Coverage
1999: $1,878
2010: $4,150

Single Coverage
1999: $318
2010: $899

Family Coverage
1999: $1,543
2010: $4,247

Family Coverage
1999: $4,247
2010: $9,773

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Insurance Cost Growth Quadruple the Rate of Wages and Inflation

Cumulative Changes in Health Insurance Premiums, Inflation, and Workers’ Earnings, 1999-2010

Health Care Costs Have Wiped Out Real Income Gains

Monthly Income for Typical U.S. Family of Four

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

Source: "A Decade of Health Care Cost Growth Has Wiped Out Real Income Gains For an Average US Family," Health Affairs, September 20011
What We Need:
A Way to Reduce Costs Without Rationing
What We Need: A Way to Reduce Costs Without Rationing

It Can’t Be Done from Washington...

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

Healthy Consumer → Continued Health → 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 → Acute Care Episode → Efficient Successful Outcome → Better Outcomes/Higher Quality

- Health Condition
- High-Cost Successful Outcome
- Complications, Infections, Readmissions
Functions Needed for Regional Healthcare Reform

1

2

3

4
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 Missouri Doing?

Healthy Consumer → Continued Health → No Hospitalization → Acute Care Episode

Efficient Successful Outcome
- High-Cost Successful Outcome
- Complications, Infections, Readmissions
Missouri Residents Get More Surgeries Than 43 Other States

Surgeries per 1,000 Medicare Enrollees (2007)
Better Hips, But Worse Hearts, Backs, Knees, and Prostates

Surgical Procedures for Medicare Beneficiaries, Missouri vs. U.S., 2007

- All Surgical Discharges
- Coronary Angiography
- Percutaneous Coronary Interventions
- Coronary Artery Bypass Grafting (CABG)
- Valve Replacement
- Back Surgery
- Knee Replacement
- Hip Replacement
- Transurethral Prostatectomy for BPH

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Some Missouri Hips Are Worse Than Others

Hip Replacement per 1,000 Medicare Enrollees (2007)

- Columbia
- Kansas City
- United States
- Joplin
- St. Louis
- Springfield
- Cape Girardeau

50% More Hip Replacements
12th Highest Rate of Preventable Admissions In U.S.

Discharges for Ambulatory Care Sensitive Conditions per 1,000 Medicare Enrollees (2007)

Missouri
Chronic Disease Patients in MO Admitted More Often Than U.S.

Hospital Admissions for Medicare Beneficiaries, Missouri vs. U.S., 2007

- Ambulatory Care Sensitive Admissions
- Congestive Heart Failure
- Bacterial Pneumonia
- COPD
- Diabetes
- Asthma

Comparison of hospital admissions for various chronic diseases between Missouri and the U.S. for the year 2007, showing the percentage differences.
16th Highest Use of ER in U.S.

Emergency Room Visits Per 1,000 Population, 2007

Missouri
Functions Needed for Regional Healthcare Reform

1

2

3

4
Analysis & Reporting is #1

Quality/Cost Analysis & Reporting

4

3

2
“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

No Hospitalization

Efficient Successful Outcome

Acute Care Provider #1

High-Cost Successful Outcome

Acute Care Provider #2

Complications, Infections, Readmissions

Acute Care Provider #3

PRIMARY CARE + SPECIALISTS

Health Condition

Healthy Consumer

Consumer Health Condition

No Hospitalization

Efficient Successful Outcome

Acute Care Provider #1

High-Cost Successful Outcome

Acute Care Provider #2

Complications, Infections, Readmissions

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

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

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

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

<table>
<thead>
<tr>
<th>Physician Practice</th>
</tr>
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<tbody>
<tr>
<td>Physician w/ time for diagnosis, treatment planning, and followup</td>
</tr>
<tr>
<td>Resources for patient educ. &amp; self-mgt support (e.g., RN care mgr)</td>
</tr>
<tr>
<td>Capability for tracking patient care and ensuring followup (e.g., registry)</td>
</tr>
<tr>
<td>Method for targeting high-risk patients (e.g., predictive modeling)</td>
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<tr>
<td>Coordinated relationships with other specialists and hospitals</td>
</tr>
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<td>Data and analytics to measure and monitor utilization and quality</td>
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</table>

**Patient**

- Inpatient Episodes
- Unneeded Testing

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

- Physician 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 or Disease Mgt Vendor

Inpatient Episodes

Patient

Unneeded Testing
# Medical Home Initiatives Expand Doctors’ Capacity, But Not Enough

| Health Plan |
|---------------------|--------------------------------------------------|
| **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** |

<table>
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<th>Patient-Centered Medical Home</th>
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<tbody>
<tr>
<td><strong>Inpatient Episodes</strong></td>
</tr>
<tr>
<td><strong>Patient</strong></td>
</tr>
<tr>
<td><strong>Unneeded Testing</strong></td>
</tr>
</tbody>
</table>
Accountable Care 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 Physicians the Capacity to Deliver “Accountable Care”

Physician Practice + Partners = ACO

- Physician 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

Inpatient Episodes

Patient

Unneeded Testing
#2 Is Redesigning Care for Better Outcomes & More Efficiency

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

4

3
You Can’t Manage What You Can’t Measure, So Data Needed

Quality/Cost Analysis & Reporting

Value-Driven Delivery Systems

3

4
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
“Episode Payments” to Reward Value Within Episodes

Healthy Consumer → Continued Health → Health Condition

No Hospitalization → Acute Care Episode → Efficient Successful Outcome

$ A Single Payment For All Care Needed From All Providers in the Episode, With a Warranty For Complications

High-Cost Successful Outcome → Complications, Infections, Readmissions
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>17 %</td>
</tr>
<tr>
<td>Neurologic complication</td>
<td>1.5 %</td>
<td>0.6 %</td>
<td>60 %</td>
</tr>
<tr>
<td>Any pulmonary complication</td>
<td>7 %</td>
<td>4 %</td>
<td>43 %</td>
</tr>
<tr>
<td>Blood products used</td>
<td>23 %</td>
<td>18 %</td>
<td>22 %</td>
</tr>
<tr>
<td>Re-operation for bleeding</td>
<td>3.8 %</td>
<td>1.7 %</td>
<td>55 %</td>
</tr>
<tr>
<td>Deep sternal wound infection</td>
<td>0.8 %</td>
<td>0.6 %</td>
<td>25 %</td>
</tr>
<tr>
<td>Readmission within 30 days</td>
<td>6.9 %</td>
<td>3.8 %</td>
<td>44 %</td>
</tr>
</tbody>
</table>
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.
A Warranty is Not an Outcome Guarantee

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

Cost of Procedure

$10,000
Actual Average Payment for Procedure is Higher

<table>
<thead>
<tr>
<th>Cost of Procedure</th>
<th>Added Cost of Infection</th>
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<td>5%</td>
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Starting Point for Warranty Price: Actual Current Average Payment

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Limited Warranty Gives Financial Incentive to Improve Quality

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<tr>
<td>$10,000</td>
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<td>4%</td>
<td>$10,800</td>
<td>$11,000</td>
<td>$200</td>
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Reducing Adverse Events...  ...Reduces Costs...  ...Improves The Bottom Line
Higher-Quality Provider Can Charge Less, Get More Patients

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

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<td>3%</td>
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- Reducing Adverse Events...
- ...Reduces Costs...
- ...Improves The Bottom Line
### Cost of Procedure

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<td>3%</td>
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<tr>
<td>$10,000</td>
<td>$20,000</td>
<td>0%</td>
<td>$10,000</td>
<td>$10,600</td>
<td>$600</td>
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**Quality is Better...**

**Cost is Lower...**

**Providers More Profitable**
In Contrast, Non-Payment for Infections Creates Losses

<table>
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<tr>
<th>Cost of Procedure</th>
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<td>$11,000</td>
<td>$10,000</td>
<td>-$1,000</td>
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<td>$10,000</td>
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<td>$20,000</td>
<td>0%</td>
<td>$10,000</td>
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Non-Payment for Infections Causes Losses While Improving
The Weakness of Episode Payment

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

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

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. 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

$\rightarrow$

Office Visits

ER Visits

Hospital Stay

Physician Practice

Phone Calls

Nurse Care Mgr

Avoidable

Avoidable

Avoidable

No payment for services that can prevent utilization...

...No penalty or reward for high utilization elsewhere

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Comprehensive Care Payment Provides Flexibility + Accountability

FULL COMP. CARE/GLOBAL PAYMENT

Health Insurance Plan

Condition-Adjusted Per Person Payment

Physician Practice/ACO

Office Visits
Phone Calls
Nurse Care Mgr

ER Visits
Lab Work/Imaging

Hospital Stay

Avoidable
Avoidable
Avoidable

Flexibility and accountability for a condition-adjusted budget covering all 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

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

Massachusetts Health Quality Partners
Wisconsin Collaborative for Healthcare Quality
Kansas City Quality Improvement Consortium
Measurement Supports Payment, As Well As Vice Versa

Quality/Cost Analysis & Reporting

4

Value-Driven Payment Systems

Value-Driven Delivery Systems
Payment Systems & Delivery Systems Must Co-Evolve

Quality/Cost Analysis & Reporting

Value-Driven Delivery Systems

Value-Driven Payment Systems

4
How Doctors Will Need to Change to Deliver “Accountable Care”

**Physician Practice + Partners = ACO**

- MD w/ time for diagnosis, treatment planning, and followup
- Resources for patient educ. & self-mgt support (e.g., RN care mgr)
- Capabilities 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

**Inpatient Episodes**

**Patient**

**Unneeded Testing**
How Will Hospitals Have to Change?
Reducing Costs Without Rationing
Reduces Hospital Revenues

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

- Fewer Patients
- Fewer Admissions
- Less Revenue Per Admission

Complications, Infections, Readmissions → High-Cost Successful Outcome
Hospital Costs Are Not Proportional to Utilization

Cost & Revenue Changes With Fewer Patients

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

Revenues
Costs
Causing Negative Margins for Hospitals

Cost & Revenue Changes With Fewer Patients

Payers Will Be Underpaying For Care If Adverse Events, Readmissions, Etc. Are Reduced

#Patients

$000

$1,000

$980

$960

$940

$920

$900

$880

$860

$840

$820

$800

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So Prices Need to Be Re-Set Under Payment Reform

Cost & Revenue Changes With Fewer Patients

Payers Can Still Save $ Without Causing Negative Margins for Hospital

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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.
What Does All This Mean for the Health Care Workforce?
Missouri Has More Hospital Employees Than Average

FTE Hospital Employees per 100,000 Residents (2006)
But Missouri Has Fewer Physicians Than Average
Physicians Are A Small Fraction of Healthcare Employment

Healthcare Employment Per 100,000 Residents (2006)

- FTE Hospital Employees
- Total Physicians
Hospital Spending Growth Is Not Due to More Employees

U.S. Hospital Expenditures and Employment, 1990-2009

Expenditures in Millions

Employment in Thousands

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Most Hospital Spending in MO Is Non-Personnel, Unlike U.S.

% Hospital Expenses Used for Personnel, 2008

- Missouri: 42%
- Nebraska: 44%
- Iowa: 46%
- U.S.: 48%
- Kansas: 50%
- Minnesota: 52%

Most $ for Staff

Most $ Not for Staff
Could Missouri Hospitals Reduce Costs Without Cutting Staff?

Hospital Expenses in Minnesota and Missouri, 2008

- **Minnesota**
  - Personnel Costs, $6,856,753
  - Non-Personnel Costs, $5,544,654

- **Missouri**
  - Personnel Costs, $7,352,856
  - Non-Personnel Costs, $8,471,307

- **Comparison**
  - **$12.4 Million** in Non-Personnel Costs in Minnesota
  - **$15.8 Million** in Non-Personnel Costs in Missouri
  - **$3 Billion More (53%)** in Non-Personnel Costs (18% of Total) in Missouri
  - **$500 Million More (7%)** in Personnel Costs in Missouri

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What Successful Reform Means for the Healthcare Workforce

• Greater % of healthcare jobs outside of hospitals
  – Home health nurses vs. hospital nurses
  – Nurse care managers in PCP offices vs. hospitals

• More jobs in primary care
  – More primary care physicians vs. specialists
  – More nurse practitioners, nurse care managers

• Higher expectations for all healthcare workers to deliver higher quality/lower cost care
  – Helping patients stay well
  – Helping patients avoid needing the hospital
  – Eliminating infections & complications in the hospital
  – Reducing the cost and utilization of drugs & devices
What’s Left?

Quality/Cost Analysis & Reporting

4?

Value-Driven Delivery Systems

Value-Driven Payment Systems
What About The Patient?

Patient → Provider
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

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...

...could result in higher spending on hospitalizations

Pharmacy Benefits

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

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

Medical Benefits

- Hospital Costs
- Physician Costs
- Other Services

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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

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

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

Benefit Design

Payment System

Patient

Provider

PAYER
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 Delivery systems, involving Quality/Cost/Experience Analysis & Reporting, and linked to Value-Driven Payment Systems & Benefit Designs.
Many Specific, Complex Tasks Within Each Function

- **Value-Driven Payment Systems**
  - Engagement of Purchasers
  - Alignment of Multiple Payers
  - Benefit Design
  - Payment System Design

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

- **Quality/Cost Measure Design**
  - Quality Reporting
  - Cost/Price Reporting

- **Consumer Education/Engagement**
  - Education Materials
  - Consumer Education/Engagement
Functions and Support Activities Can’t Proceed In Silos

WHO CAN CONNECT AND COORDINATE ALL OF THIS?

- Education Materials
- Consumer Education/Engagement
- Engagement of Purchasers
- Alignment of Multiple Payers
- Benefit Design
- Payment System Design

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

- Quality/Cost Measure Design
- Cost/Price Reporting
- Quality Reporting

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That’s the Role of Regional Health Improvement Collaboratives...

Regional Health Improvement Collaborative

- Education Materials
- Consumer Education/Engagement
- Engagement of Purchasers
- Alignment of Multiple Payers
- Benefit Design
- Payment System Design

- Quality/Cost Measure Design
  - Quality Reporting
  - Cost/Price Reporting
- Technical Assistance to Providers
- Design & Delivery of Care
- Provider Organization/Coordination

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...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
- The Health Collaborative (Greater Cincinnati)
- Healthy Memphis Common Table
- Institute for Clinical Systems Improvement
- Integrated Healthcare Association
- Iowa Healthcare Collaborative
- **Kansas City Quality Improvement Consortium**
- Louisiana Health Care Quality Forum
- Maine Health Management Coalition
- Massachusetts Health Quality Partners
- **Midwest Health Initiative**
- Minnesota Community Measurement
- Minnesota Healthcare Value Exchange
- Nevada Partnership for Value-Driven Healthcare (HealthInsight)
- New York Quality Alliance
- Oregon Health Care Quality Corporation
- P2 Collaborative of Western New York
- Pittsburgh Regional Health Initiative
- Puget Sound Health Alliance
- Quality Counts (Maine)
- Quality Quest for Health of Illinois
- Utah Partnership for Value-Driven Healthcare (HealthInsight)
- Wisconsin Collaborative for Healthcare Quality
- Wisconsin Healthcare Value Exchange

www.NRHI.org
Don’t Wait for Washington

- 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 each community’s strategies.
- Measure progress and resolve challenges through an ongoing state/local, multi-stakeholder, collaborative process.
For More Information on Payment and Delivery Reforms

www.PaymentReform.org
For More Information:

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