REDESIGNING HEALTH CARE FROM THE BOTTOM UP INSTEAD OF FROM THE TOP DOWN
Better Care at Lower Costs Through Patient-Centered Payment

Harold D. Miller
President and CEO
Center for Healthcare Quality and Payment Reform

www.CHQPR.org
There is one thing (and maybe only one thing) we have in common in America today…

…We’re all spending too much on healthcare
Healthcare Spending is the Biggest Driver of Federal Deficits

Source: CBO
Increasing Share of State Budgets Goes to Medicaid Spending

1/6 of All State Funds Are Now Used for Medicaid

State Medicaid Spending as % of All State Funds in State Budgets

Source: NASBO
U.S. Premiums Increased 73% More Than Inflation Since 2002

Average Family Premiums, Employer-Sponsored Insurance

Family Premiums $6,164 Higher Than Inflation

Source: Medical Expenditure Panel Survey & Bureau of Labor Statistics
Why Are Jobs Growing But Wages Stagnant?

THE WALL STREET JOURNAL.

U.S. Jobs Growth Picks Up, but Wage Gains Lag Behind

By Jeffrey Sparshott
Updated July 7, 2017 6:57 p.m. ET

U.S. employers are churning out jobs unabated as the economic expansion enters its ninth year, but the inability to generate more robust wage growth represents a missing piece in a largely complete labor recovery.
Spending on Higher Premiums Reduces $ for Take-Home Pay

Source: Medical Expenditure Panel Survey & Bureau of Labor Statistics
Family Premiums Now Equal to One-Third of Worker Pay

Source: Medical Expenditure Panel Survey & Bureau of Labor Statistics
What’s Causing the Increase in U.S. Insurance Premiums?

Private Health Insurance Spending 2009-2015

- **29% Increase in Spending**
- **$240 Billion**

Source: CMS National Health Expenditures
Biggest Causes are Hospitals & Insurance Administration/Profit

Private Health Insurance Spending 2009-2015

- Hospitals +41%
- Physician & Clinical +19%
- Drugs +20%
- Other +24%
- Insurance +30%

Source: CMS National Health Expenditures
Half of Growth in Private Spending Has Been for Hospital Services

Sources of Private Insurance Spending Increase, 2009-2015

- **Hospital Svcs**
  - 41% Increase
  - 49% of Total

- **Physician & Clinical Services**
  - 19% Increase
  - 18% of Total

- **Drugs**
  - 20% Increase
  - 10% of Total

- **Other Svcs**
  - 24% Increase
  - 11% of Total

- **Insurance Admin**
  - 30% Increase
  - 12% of Total

Source: CMS National Health Expenditures
Similar Pattern for Total Spending; >1/3 of Growth Due to Hospitals

Sources of Total Healthcare Spending Increase, 2009-2015

- **Insurance Admin**
  - 51% Increase
  - 12% of Total

- **Other Svcs**
  - 22% Increase
  - 10% of Total

- **Drugs**
  - 28% Increase
  - 10% of Total

- **Physician & Clinical Services**
  - 27% Increase
  - 20% of Total

- **Hospital Svcs**
  - 33% Increase
  - 37% of Total

Source: CMS National Health Expenditures
Hospitals Are Biggest Contributor to Growth for Two Decades

Source: CMS National Health Expenditures

Growth in U.S. Private Health Insurance Spending, 2001-2015

- Hospitals: +163%
- Physicians/Clinical: +83%
- Prescription Drugs: +96%
- Insurance Administration: +123%

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Insurance Administration is #2

Growth in U.S. Private Health Insurance Spending, 2001-2015

- Hospitals: +163%
- Physicians/Clinical: +83%
- Prescription Drugs: +96%
- Insurance Administration: +123%

Source: CMS National Health Expenditures
As Much Private Insurance $ Goes to Insurer Admin as to Drugs

Source: CMS National Health Expenditures
Spending is Increasing Rapidly in “Single Payer” Countries, Too

Growth in Per Capita Health Care Spending, 2008-2016

- Canada
- France
- United States
- Germany
- Australia
- United Kingdom
- Switzerland
How Do You Control the Growth in Healthcare Spending?

TOTAL HEALTH CARE SPENDING

TOTAL HEALTH CARE SPENDING

TOTAL HEALTH CARE SPENDING

TOTAL HEALTH CARE SPENDING

$  

TIME

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Payer Strategy #1: Cut Provider Fees for Services
Payer Strategy #2: Shift Costs to Patients

Higher Cost-Share & Deductibles

TOTAL HEALTHCARE SPENDING
TOTAL HEALTHCARE SPENDING
TOTAL HEALTHCARE SPENDING
TOTAL HEALTHCARE SPENDING BY PAYERS

SAVINGS

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Payer Strategy #3: Delay or Deny Care to Patients

- Lack of Needed Care

Total Health Care Spending by Payers

Savings
Results of Typical Strategies

• Patients don’t get the care they need and costs increase in the future

• Small physician practices and hospitals are forced out of business

• Health insurance premiums continue to rise and access to insurance coverage decreases
Results of Typical Strategies

• Patients don’t get the care they need and costs increase in the future
• Small physician practices and hospitals are forced out of business
• Health insurance premiums continue to rise and access to insurance coverage decreases

IS THERE A BETTER WAY?
The Right Focus: Spending That is *Unnecessary* or *Avoidable*
Avoidable Spending Occurs In All Aspects of Healthcare

AVOIDABLE SPENDING

NECESSARY SPENDING

SURGERY
- Unnecessary surgery
- Use of unnecessarily-expensive implants
- Infections and complications of surgery
- Overuse of inpatient rehabilitation

CANCER TREATMENT
- Use of unnecessarily-expensive drugs
- ER visits/hospital stays for dehydration and avoidable complications
- Fruitless treatment at end of life

CHRONIC DISEASE
- ER visits for exacerbations
- Hospital admissions and readmissions
- Amputations, blindness

MATERNITY CARE
- Unnecessary C-Sections
- Early elective deliveries
- Underuse of birth centers
- Complications of delivery
Most of the Avoidable Spending is in Hospitals

### NECESSARY SPENDING

- **Surgery**
  - Unnecessary surgery
  - Use of unnecessarily-expensive implants
  - Infections and complications of surgery
  - Overuse of inpatient rehabilitation

- **Cancer Treatment**
  - Use of unnecessarily-expensive drugs
  - ER visits/hospital stays for dehydration and avoidable complications
  - Fruitless treatment at end of life

- **Chronic Disease**
  - ER visits for exacerbations
  - Hospital admissions and readmissions
  - Amputations, blindness

- **Maternity Care**
  - Unnecessary C-Sections
  - Early elective deliveries
  - Underuse of birth centers
  - Complications of delivery

### AVOIDABLE SPENDING

- **Cancer Treatment**
  - Use of unnecessarily-expensive drugs
  - ER visits/hospital stays for dehydration and avoidable complications
  - Fruitless treatment at end of life

- **Surgery**
  - Unnecessary surgery
  - Use of unnecessarily-expensive implants
  - Infections and complications of surgery
  - Overuse of inpatient rehabilitation

- **Chronic Disease**
  - ER visits for exacerbations
  - Hospital admissions and readmissions
  - Amputations, blindness

- **Maternity Care**
  - Unnecessary C-Sections
  - Early elective deliveries
  - Underuse of birth centers
  - Complications of delivery
Institute of Medicine Estimate: 30% of Spending is Avoidable
25% of Avoidable Spending is Excess Administrative Costs

Excess Cost Domain Estimates:
Lower bound totals from workshop discussions*

UNNECESSARY SERVICES
- Total excess = $210 B*
  - Overuse: services beyond evidence-established levels
  - Discretionary use beyond benchmarks
  - Defensive medicine
  - Unnecessary choice of higher cost services

INEFFICIENTLY DELIVERED SERVICES
- Total excess = $130 B*
  - Mistakes—medical errors, preventable complications
  - Care fragmentation
  - Unnecessary use of higher cost providers
  - Operational inefficiencies at care delivery sites
  - Physician offices

EXCESS ADMINISTRATIVE COSTS
- Total excess = $190 B*
  - Insurance-related administrative costs beyond benchmarks
    - Insurers
    - Physician offices
    - Hospitals
    - Other providers
  - Insurer administrative inefficiencies
  - Care documentation requirement inefficiencies

- Product prices beyond competitive benchmarks
  - Pharmaceuticals
  - Medical devices
  - Durable medical equipment

MISSED PREVENTION OPPORTUNITIES
- Total excess = $55 B*
  - Primary prevention
  - Secondary prevention
  - Tertiary prevention

FRAUD
- Total excess = $75 B*
  - All sources—payer, clinician, patient

*Lower bound totals of various estimates, adjusted to 2009 total expenditure level.
The Right Goal: Less Avoidable $,
The Right Goal: Less Avoidable $, More Necessary $
Win-Win for Patients & Payers

- NECESSARY SPENDING
- AVOIDABLE SPENDING
- SAVINGS
- TIME

Lower Spending for Payers
Better Care for Patients
Barriers in the Payment System Create a Win-Lose for Providers

Necessary Spending
Avoidable Spending

BARRIERS IN THE CURRENT PAYMENT SYSTEM

Savings
Avoidable Spending

Necessary Spending
Barrier #1: No $ or Inadequate $ for High-Value Services

No Payment or Inadequate Payment for:

• Services delivered outside of face-to-face visits with clinicians, e.g., phone calls, e-mails, etc.
• Services delivered by non-clinicians, e.g., nurses, community health workers, etc.
• Communication between physicians to ensure accurate diagnosis & coordinate care
• Non-medical services, e.g., transportation
• Palliative care for patients at end of life
Barrier #2: Avoidable Spending Is Revenue for Providers…

- NECESSARY SPENDING
- AVOIDABLE SPENDING
- PROVIDER REVENUE
- COST OF SERVICE DELIVERY
- MARGIN

$
...And When Avoidable Services Aren’t Delivered...
…Providers’ Revenue Will Decrease…
…But Fixed Costs Don’t Vanish

Many Fixed Costs of Services Remain When Volume Decreases
  • Leases & staff in physician practice
  • Costs of hospital emergency room and other standby services
…But Fixed Costs Don’t Vanish and New Costs May Be Added…

Many Fixed Costs of Services Remain When Volume Decreases And New Costs May Be Incurred
• Costs of nurse care managers
• Costs of unpaid physician services
• Costs of collecting quality data
…Leaving Providers With Losses (or Bigger Losses Than Today)

Many Fixed Costs of Services Remain When Volume Decreases And New Costs May Be Incurred, Potentially Causing Financial Losses
A Payment Change isn’t Reform Unless It Removes the Barriers

BARRIER #1

No Payment or Inadequate Payment for:
- Services delivered outside of face-to-face visits with clinicians, e.g., phone calls, e-mails, etc.
- Services delivered by non-clinicians, e.g., nurses, community health workers, etc.
- Communication between physicians to ensure accurate diagnosis & coordinate care
- Non-medical services, e.g., transportation
- Palliative care for patients at end of life

BARRIER #2

Many Fixed Costs of Services Remain When Volume Decreases And New Costs May Be Incurred, Potentially Causing Financial Losses
Most Common “Value-Based” Payment: Pay for Performance

PAYER SOLUTION:

Hospitals & Physicians Have to Justify a Portion of What They Would Have Otherwise Received Based on Performance on Quality/Cost Measures
“Incentives” for Providers
Don’t Overcome the FFS Barriers

PAYER SOLUTION:

- Small P4P bonuses may not be enough to pay for the added costs of improving quality
- P4P $ may not be enough to pay the costs of collecting and reporting the data
- Small P4P bonuses are less than the loss of fee-for-service revenue from lower utilization
Despite Years of P4P, Quality Has NOT Improved

Source: NCQA: The State of Health Care Quality 2015
Despite Years of P4P, Quality Has NOT Improved

Over One-Third of Diabetic Patients Aren’t Receiving Adequate Care

Source:
NCQA:
The State of Health Care Quality 2015
Over-Emphasis on Narrow Quality Measures Can Harm Patients

Figure 2. Rates of Estimated Hospital Admissions for Hyperglycemia and Hypoglycemia Among Medicare Beneficiaries With Diabetes Mellitus, 1999 to 2010

Hypoglycemia
1 Yr Mortality: 19.9%
30 Day Readmits: 16.3%

Hyperglycemia
1 Yr Mortality: 17.1%
30 Day Readmits: 15.3%

Source: National Trends in US Hospital Admissions for Hyperglycemia and Hypoglycemia Among Medicare Beneficiaries, 1999 to 2011  JAMA Internal Medicine May 17, 2014
It’s Not Just Diabetics, It’s Everybody

Over One-Third of All Patients With High Blood Pressure Aren’t Receiving Adequate Care

Source: NCQA: The State of Health Care Quality 2015
It’s Costing Everybody a Lot of Money With No Apparent Benefit

PHYSICIANS


DOWTATCH

US Physician Practices Spend More Than $15.4 Billion Annually To Report Quality Measures

Each year US physician practices in four common specialties spend, on average, 785 hours per physician and more than $15.4 billion dealing with the reporting of quality measures. While much is to be gained from quality measurement, the current system is unnecessarily costly, and greater effort is needed to standardize measures and make them easier to report.
P4P Has Been Studied to Death &…

**Annals of Internal Medicine**

**Review**

**The Effects of Pay-for-Performance Programs on Health, Health Care Use, and Processes of Care**

**A Systematic Review**

Aaron Mendelson, BA; Karli Kondo, PhD; Cheryl Damberg, PhD; Allison Low, BA; Makalapua Motuapuaka, BA; Michele Freeman, MPH; Maya O’Neil, PhD; Rose Relevo, MLIS, MS; and Devan Kansagara, MD, MCR

**Background:** The benefits of pay-for-performance (P4P) programs are uncertain.

**Purpose:** To update and expand a prior review examining the effects of P4P programs targeted at the physician, group, managerial, or institutional level on process-of-care and patient outcomes in ambulatory and inpatient settings.

**Data Sources:** PubMed from June 2007 to October 2016; MEDLINE, PsycINFO, CINAHL, Business Economics and Theory, Business Source Elite, Scopus, Faculty of 1000, and Gartner Research from June 2007 to February 2016.

**Study Selection:** Trials and observational studies in ambulatory and inpatient settings reporting process-of-care, health, or utilization outcomes.

**Data Extraction:** Two investigators extracted data, assessed study quality, and graded the strength of the evidence.

**Data Synthesis:** Among 69 studies, 58 were in ambulatory settings, 52 reported process-of-care outcomes, and 38 reported patient outcomes. Low-strength evidence suggested that P4P programs in ambulatory settings may improve process-of-care outcomes over the short term (2 to 3 years), whereas data on longer-term effects were limited. Many of the positive studies were conducted in the United Kingdom, where incentives were larger than in the United States. The largest improvements were seen in areas where baseline performance was poor. There was no consistent effect of P4P on intermediate health outcomes (low-strength evidence) and insufficient evidence to characterize any effect on patient health outcomes. In the hospital setting, there was low-strength evidence that P4P had little or no effect on patient health outcomes and a positive effect on reducing hospital readmissions.

**Limitation:** Few methodologically rigorous studies; heterogeneous population and program characteristics and incentive targets.

**Conclusion:** Pay-for-performance programs may be associated with improved processes of care in ambulatory settings, but consistently positive associations with improved health outcomes have not been demonstrated in any setting.

**Primary Funding Source:** U.S. Department of Veterans Affairs.

*Annals.org*  
For author affiliations, see end of text.  
This article was published at Annals.org on 10 January 2017.
**Annals of Internal Medicine**

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**Primary Funding Source:** U.S. Department of Veterans Affairs.


This article was published at Annals.org on 10 January 2017.
P4P Has Been Studied to Death & It Doesn’t Work (But Isn’t Dead)

Annals of Internal Medicine

The Effects of Pay-for-Performance Programs on Health, Health Care Use, and Processes of Care

Review

How Does MIPS Work?

You earn a payment adjustment based on evidence-based and practice-specific quality data. You show you provided high quality, efficient care supported by technology by sending in information in the following categories:

- Quality
- Improvement Activities
- Advancing Care Information
- Cost

Data Extraction: The investigators extracted data, assessed study quality, and graded the strength of the evidence.

Data Synthesis: Among 69 studies, 58 were in ambulatory settings, 52 reported process-of-care outcomes, and 38 reported patient outcomes. Low-strength evidence suggested that P4P programs in ambulatory settings may improve process-of-care outcomes over the short term (2 to 3 years), whereas data on persistently positive associations with improved health outcomes have not been demonstrated in any setting.

Primary Funding Source: U.S. Department of Veterans Affairs.


For author affiliations, see end of text.

This article was published at Annals.org on 10 January 2017.
VBP Approach #2: Save Us $$…

PAYER SOLUTION:

YEAR 1

$AVOIDABLE SPENDING
$NECESSARY SPENDING

$UNPAID SERVICES

$SAVINGS

$LOSS OF REVENUE

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VBP Approach #2: Save Us $$ & (Maybe) We’ll Pay More Next Year

PAYER SOLUTION:

YEAR 1

YEAR 2

$
Provider Concern: Shared Savings is Too Little, Too Late

PAYER SOLUTION:

YEAR 1

AVOIDABLE SPENDING

NECESSARY SPENDING

UNPAID SERVICES

SAVINGS

YEAR 2

AVOIDABLE SPENDING

NECESSARY SPENDING

UNPAID SERVICES

SAVINGS

How does hospital or physician cover upfront costs of additional services and loss of revenue?

Shared savings, if received, may not cover costs & losses

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Medicare’s Shared Savings ACO Program Isn’t Succeeding

2013 Results for Medicare Shared Savings ACOs
- 46% of ACOs (102/220) *increased* Medicare spending
- Only 24% (52/220) received shared savings payments
- After making shared savings payments, Medicare spent more than it saved
- Net loss to Medicare: $78 million

2014 Results for Medicare Shared Savings ACOs
- 45% of ACOs (152/333) *increased* Medicare spending
- Only 26% (86/333) received shared savings payments
- After making shared savings payments, Medicare spent more than it saved
- Net loss to Medicare: $50 million

2015 Results for Medicare Shared Savings ACOs
- 48% of ACOs (189/392) *increased* Medicare spending
- Only 30% (119/392) received shared savings payments
- After making shared savings payments, Medicare spent more than it saved
- Net loss to Medicare: $216 million
Many private-payer ACOs fail to yield lower costs, better quality

By Bob Herman | October 15, 2015

CHICAGO—Medicare’s investment in accountable care organizations has inspired hospitals and doctors to create their own versions of ACOs with private insurers. But as with Medicare, not all private ACOs are achieving lower costs and higher quality.

Providers and insurers need to do a better job of reaching patients and employers, according to physician executives at four large health insurance companies. They gave their take on the private ACO movement at an event held by America’s Health Insurance Plans, the industry’s trade group.

Their experiences reflect that ACOs are still a new structure, and building a new payment and care model as complex as an ACO is not easy to roll out.

“Our alternative payment models are succeeding at a much lower rate than they should be,” said Dr. Stephen Ondra, chief medical officer at Health Care Service Corp., the Blue Cross and Blue Shield insurer for five states. “In the ACO, the consumer engagement is very, very low.”
Why Aren’t ACOs Succeeding?

ACO

PATIENTS
- Heart Disease
- Cancer
- Back Pain
- Pregnancy

Primary Care | Cardiology | Oncology | Neurosurgery | OB/GYN
No Change in the Way Physicians or Hospitals Are Paid

MEDICARE/HEALTH PLAN

PATIENTS
- Heart Disease
- Cancer
- Back Pain
- Pregnancy

Fee-for-Service Payment

ACO

Primary Care
Cardiology
Oncology
Neurosurgery
OB/GYN

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Providers Still Face All the Barriers in the Current Payment System…

MEDICARE/HEALTH PLAN

ACO

- No payment for high-value services
- Inadequate revenues to cover costs when fewer services are delivered

PATIENTS

Heart Disease
Cancer
Back Pain
Pregnancy

Primary Care  Cardiology  Oncology  Neurosurgery  OB/GYN
…With Only the Potential for Receiving Future “Shared Savings”

MEDICARE/HEALTH PLAN

Shared Savings Payment Next Year???

ACO

Fee-for-Service Payment

- No payment for high-value services
- Inadequate revenues to cover costs when fewer services are delivered

PATIENTS

- Heart Disease
- Cancer
- Back Pain
- Pregnancy

Primary Care  Cardiology  Oncology  Neurosurgery  OB/GYN

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ACOs Try to “Coordinate Care” Without Fixing Payment Barriers

MEDICARE/HEALTH PLAN

Shared Savings Payment Next Year??

ACO

Expensive IT Systems
Care Coordinators

Fee-for-Service Payment

- No payment for high-value services
- Inadequate revenues to cover costs when fewer services are delivered

PATIENTS

Heart Disease
Cancer
Back Pain
Pregnancy

Primary Care
Cardiology
Oncology
Neurosurgery
OB/GYN
Possibility of Future Bonuses Doesn’t Overcome Current Barriers

MEDICARE/HEALTH PLAN

Shared Savings Payment??

ACO

Fee-for-Service Payment

Expensive IT Systems
Care Coordinators

Part of Shared Savings??

• No payment for high-value services
• Inadequate revenues to cover costs when fewer services are delivered

PATIENTS
Heart Disease
Cancer
Back Pain
Pregnancy

Primary Care
Cardiology
Oncology
Neurosurgery
OB/GYN
What Do Medicare, Health Plans, and Big Systems Recommend?
#1: Keep Doing the Bad Value-Based Payment Models…
…Or #2: Implement “Population-Based Payment”
Capitation Has Not Transformed Care Where It’s Being Used

Over One-Third of Diabetics in California Aren’t Getting Adequate Care

Health Insurance Premiums in California Are Higher Than The U.S. Average

HbA1C Control <8.0%

Employer-Sponsored Family Insurance Premiums, 2015

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Is a 50/50 Chance of Good Care the Best A Big System Can Do???

### Optimal Diabetes Care (Medical Group Level Results)

#### MN Community Measurement 2016 Health Care Quality Report

<table>
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<tr>
<th>Medical Group Name</th>
<th>Rate (Actual)</th>
<th>Rating</th>
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<tr>
<td>STATEWIDE AVERAGE</td>
<td>46.3%</td>
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<tr>
<td>Meeker Memorial Clinic</td>
<td>83.8%</td>
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<td>Catalyst Medical Clinic</td>
<td>68.3%</td>
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<td>Park Nicollet Health Services</td>
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<tr>
<td>AALFA Family Clinic</td>
<td>56.2%</td>
<td>Average</td>
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<tr>
<td>Richfield Medical Group</td>
<td>55.6%</td>
<td>Average</td>
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<td>Apple Valley Medical Clinic</td>
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<tr>
<td>Family Practice Medical Center of Willmar</td>
<td>55.0%</td>
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<tr>
<td>Allina Health Clinics</td>
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<tr>
<td>Entira Family Clinics (formerly Family Health Services MN)</td>
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<td>Mayo Clinic Health System</td>
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<tr>
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After the ACO/IDN Gets Capitation, How It Will Pay Docs & Hospitals??

“DOWNSIDE RISK”
“Population-Based Payment” AKA Capitation

ACO/Integrated Delivery System

Expensive IT Systems
Care Coordinators

PATIENTS
Heart Disease
Cancer
Back Pain
Pregnancy

MEDICARE/HEALTH PLAN

Primary Care
Cardiology
Oncology
Neurosurgery
OB/GYN

PMPM
FFS
FFS
FFS
FFS
FFS

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What About The Downsides of Integrated Delivery Systems?

**Vertical Integration: Hospital Ownership Of Physician Practices Is Associated With Higher Prices And Spending**

ABSTRACT: We examined the consequences of contractual or ownership relationships between hospitals and physician practices, often described as vertical integration. Such integration can reduce health spending and increase the quality of care by improving communication across care settings, but it can also increase providers' market power and facilitate the payment of what are effectively kickbacks for inappropriate referrals. We investigated the impact of vertical integration on hospital prices, volumes (admissions), and spending for privately insured patients. Using hospital claims from Truven Analytics MarketScan for the nonelderly privately insured in the period 2001–07, we constructed county-level indices of prices, volumes, and spending and adjusted them for enrollees' age and sex. We measured hospital-physician integration using information from the American Hospital Association on the types of relationships hospitals have with physicians. We found that an increase in the market share of hospitals with the tightest vertically integrated relationships with physicians—ownership of physician practices—was associated with higher hospital prices and spending. We found that an increase in contractual integration reduced the frequency of hospital admissions, but this effect was relatively small. Taken together, our results provide a mixed, although somewhat negative, picture of vertical integration from the perspective of the privately insured.
And What About the Advantages of Small, Independent Practices?

Small Primary Care Physician Practices Have Low Rates Of Preventable Hospital Admissions

**ABSTRACT** Nearly two-thirds of US office-based physicians work in practices of fewer than seven physicians. It is often assumed that larger practices provide better care, although there is little evidence for or against this assumption. What is the relationship between practice size—and other practice characteristics, such as ownership or use of medical home processes—and the quality of care? We conducted a national survey of 1,045 primary care–based practices with nineteen or fewer physicians to determine practice characteristics. We used Medicare data to calculate practices’ rate of potentially preventable hospital admissions (ambulatory care–sensitive admissions). Compared to practices with 10–19 physicians, practices with 1–2 physicians had 33 percent fewer preventable admissions, and practices with 3–9 physicians had 27 percent fewer. Physician-owned practices had fewer preventable admissions than hospital-owned practices. In an era when health care reform appears to be driving physicians into larger organizations, it is important to measure the comparative performance of practices of all sizes, to learn more about how small practices provide patient care, and to learn more about the types of organizational structures—such as independent practice associations—that may make it possible for small practices to share resources that are useful for improving the quality of care.
Patients Don’t See the Benefits of Big Systems and Capitation…

Medical Group Structural Integration May Not Ensure That Care Is Integrated, From The Patient’s Perspective

ABSTRACT Structural integration is increasing among medical groups, but whether these changes yield care that is more integrated remains unclear. We explored the relationships between structural integration characteristics of 144 medical groups and perceptions of integrated care among their patients. Patients’ perceptions were measured by a validated national survey of 3,067 Medicare beneficiaries with multiple chronic conditions across six domains that reflect knowledge and support of, and communication with, the patient. Medical groups’ structural characteristics were taken from the National Study of Physician Organizations and included practice size, specialty mix, technological capabilities, and care management processes. Patients’ survey responses were most favorable for the domain of test result communication and least favorable for the domain of provider support for medication and home health management. Medical groups’ characteristics were not consistently associated with patients’ perceptions of integrated care. However, compared to patients of primary care groups, patients of multispecialty groups had strong favorable perceptions of medical group staff knowledge of patients’ medical histories. Opportunities exist to improve patient care, but structural integration of medical groups might not be sufficient for delivering care that patients perceive as integrated.
...And They’re Voting (With Their Feet) For Other Options

![Enrollment in Capitated Organizations in California, 2004-2014](chart)

- 38% Loss of Enrollment in Capitated Organizations
This is NOT a Good “Framework” for Fixing Healthcare Payment…

Alternative Payment Models
THE APM FRAMEWORK

CATEGORY 1
NO LINK TO QUALITY & VALUE
FFS

CATEGORY 2
LINK TO QUALITY & VALUE
FFS

CATEGORY 3
FEES-FOR-SERVICE ARCHITECTURE
“Risk”

CATEGORY 4
POPULATION-BASED PAYMENT
Capitation/Insurance Risk for Integrated Delivery Systems

© Center for Healthcare Quality and Payment Reform www.CHQPR.org
...And Following It Will Likely Make Things Worse, Not Better
Value-Based Payment Is Being Designed the Wrong Way Today
Value-Based Payment Is Being Designed the *Wrong* Way Today

**TOP-DOWN PAYMENT REFORM**

Medicare and Health Plans Define Payment Systems
Value-Based Payment Is Being Designed the *Wrong* Way Today

**TOP-DOWN PAYMENT REFORM**

Medicare and Health Plans Define Payment Systems

Physicians and Hospitals Have To Change Care to Align With Payment Systems
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**TOP-DOWN PAYMENT REFORM**

Medicare and Health Plans Define Payment Systems

Physicians and Hospitals Have To Change Care to Align With Payment Systems

Patients Get Worse Care and Providers Close/Consolidate
Is There a Better Way?

TOP-DOWN PAYMENT REFORM

Medicare and Health Plans Define Payment Systems

Physicians and Hospitals Have To Change Care to Align With Payment Systems

Patients Get Worse Care and Providers Close/Consolidate
Start By Identifying Ways to Improve Care & Reduce Costs…

**TOP-DOWN PAYMENT REFORM**

- Medicare and Health Plans Define Payment Systems

**BOTTOM-UP PAYMENT REFORM**

- Physicians and Hospitals Have To Change Care to Align With Payment Systems

- Ask Physicians and Hospitals to Identify Ways to Improve Care for Patients and Eliminate Avoidable Costs

- Patients Get Worse Care and Providers Close/Consolidate
…Pay Adequately & Expect Accountability for Outcomes…

**TOP-DOWN PAYMENT REFORM**

- Medicare and Health Plans Define Payment Systems
- Physicians and Hospitals Have To Change Care to Align With Payment Systems
- Patients Get Worse Care and Providers Close/Consolidate

**BOTTOM-UP PAYMENT REFORM**

- Payers Provide Adequate Payment for Quality Care & Providers Take Accountability for Quality & Efficiency
- Ask Physicians and Hospitals to Identify Ways to Improve Care for Patients and Eliminate Avoidable Costs
TOP-DOWN PAYMENT REFORM

Medicare and Health Plans Define Payment Systems

Physicians and Hospitals Have To Change Care to Align With Payment Systems

Patients Get Worse Care and Providers Close/Consolidate

BOTTOM-UP PAYMENT REFORM

Patients Get Good Care at an Affordable Cost and Independent Providers Remain Financially Viable

Payers Provide Adequate Payment for Quality Care & Providers Take Accountability for Quality & Efficiency

Ask Physicians and Hospitals to Identify Ways to Improve Care for Patients and Eliminate Avoidable Costs

...So the Result is Better, More Affordable Patient Care
What Happens When You Design Care Delivery and Payment From the Bottom Up Instead of From the Top Down?
Better Care at Lower Cost for Crohn’s Disease

PHYSICIAN LEADER: Lawrence R. Kosinski, MD
Managing Partner, Illinois Gastroenterology Group
Better Care at Lower Cost for Crohn’s Disease

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Managing Partner, Illinois Gastroenterology Group

OPPORTUNITIES TO IMPROVE CARE AND LOWER COSTS

- Health plan spends $11,000/year/patient on patients with Crohn’s
- >50% of expenses are for hospital care, most due to complications
- <33% of patients seen by physician in 30 days prior to hospitalization
- 10% of expenses for biologics, many administered in hospitals
- 3.5% of spending goes to gastroenterologists
## Better Care at Lower Cost for Crohn’s Disease

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➢ No payment for nurse care manager  
➢ No payment for clinical decision support tools to ensure evidence-based care  
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➤ No payment for proactive telephone contact with patients | • Hospitalization rate cut by more than 50%  
• Total spending reduced by 10% even with higher payments to the physician practice  
• Improved patient satisfaction due to fewer complications and lower out-of-pocket costs |
| • >50% of expenses are for hospital care, most due to complications |  |  |
| • <33% of patients seen by physician in 30 days prior to hospitalization |  |  |
| • 10% of expenses for biologics, many administered in hospitals |  |  |
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Better Care at Lower Cost for Total Joint Replacement

PHYSICIAN LEADER: Stephen J. Zabinski, MD
Director, Division of Orthopaedic Surgery, Shore Medical Ctr
Better Care at Lower Cost for Total Joint Replacement

PHYSICIAN LEADER: Stephen J. Zabinski, MD
Director, Division of Orthopaedic Surgery, Shore Medical Ctr

OPPORTUNITIES TO IMPROVE CARE AND LOWER COSTS

• Reduce surgical complications by reducing patient risk factors prior to surgery
• Obtain lower prices for implants from vendors
• Match implants to patient needs
• Return patients home as quickly as possible
• Use lower cost settings for surgery and rehabilitation
Better Care at Lower Cost for Total Joint Replacement

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Director, Division of Orthopaedic Surgery, Shore Medical Ctr

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| • Reduce surgical complications by reducing patient risk factors prior to surgery | • No payment for pre-operative patient risk reduction programs | • Average length of stay  
  TKR: 3.3 → 1.8 days  
  THR: 2.9 → 1.6 days |
| • Obtain lower prices for implants from vendors | • No payment for care coordination throughout surgical episode | • Average device cost  
  $6,301 → $4,242 |
| • Match implants to patient needs | • Separate payments to hospital and physician | • Discharges to home  
  34% → 78% |
| • Return patients home as quickly as possible | • No data on costs of facilities | • Readmission rate  
  3.2% → 2.7% |
| • Use lower cost settings for surgery and rehabilitation | | • Total Episode Spending  
  TKR: $25,365 → $19,597  
  THR: $26,580 → $20,636 |

- Average length of stay:
  - TKR: 3.3 → 1.8 days
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- Average device cost:
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Better Care at Lower Cost for Cancer

PHYSICIAN LEADER: Barbara McAneny, MD
CEO, New Mexico Cancer Center
Better Care at Lower Cost for Cancer

PHYSICIAN LEADER: Barbara McAneny, MD
CEO, New Mexico Cancer Center

OPPORTUNITIES TO IMPROVE CARE AND LOWER COSTS

• 40-50% of patients receiving chemotherapy are hospitalized for complications of treatment
## Better Care at Lower Cost for Cancer

**PHYSICIAN LEADER:** Barbara McAneny, MD  
CEO, New Mexico Cancer Center

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• No payment for patient and family education about complications and how to respond  
• Inadequate payment to reserve capacity for IV hydration of patients experiencing problems | • 36% fewer ED visits  
• 43% fewer admissions  
• 22% reduction in total cost of care ($4,784 over six months) |
Better Care at Lower Cost for Emergency Room Patients

PHYSICIAN LEADER: Jennifer L. Wiler, MD
Assoc. Prof. of Emergency Medicine, University of Colorado
Better Care at Lower Cost for Emergency Room Patients

PHYSICIAN LEADER: Jennifer L. Wiler, MD
Assoc. Prof. of Emergency Medicine, University of Colorado

OPPORTUNITIES TO IMPROVE CARE AND LOWER COSTS

• Many individuals have 3+ Emergency Department visits per year
• Many frequent ED users have no insurance or inability to afford copays, behavioral health problems, and no PCP
## Better Care at Lower Cost for Emergency Room Patients

**PHYSICIAN LEADER:** Jennifer L. Wiler, MD  
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Better Care at Lower Cost for Emergency Room Patients

**OPPORTUNITIES TO IMPROVE CARE AND LOWER COSTS**

- Many individuals have 3+ Emergency Department visits per year
- Many frequent ED users have no insurance or inability to afford copays, behavioral health problems, and no PCP

**BARRIERS IN THE CURRENT PAYMENT SYSTEM**

- No payment for patient education and care coordination in the ED
- No payment for home visits to help patients after discharge
- No funding to address non-medical needs such as lack of transportation

**RESULTS WITH ADEQUATE PAYMENT FOR BETTER CARE**

- 41% fewer ED visits
- 49% fewer admissions
- 80% now have a primary care provider
- 50% lower total spending including cost of program

**PHYSICIAN LEADER:** Jennifer L. Wiler, MD
Assoc. Prof. of Emergency Medicine, University of Colorado
What Does a Patient-Centered Payment & Delivery System Look Like?
Patient-Centered Care: Provide Preventive Services

PATIENT

Preventive Services

Preventive Services Management
Patient-Centered Payment: Pay for Good Preventive Care

PATIENT

Preventive Services

Bundled Pmt for Preventive Service

Preventive Services Management

Monthly Preventive Services Mgt Pmt
Patient-Centered Care: Accurately Diagnose Problems

PATIENT

Preventive Services

Preventive Services Management

Symptoms

Diagnosis & Treatment Planning
Patient-Centered Payment: Pay to Support Good Diagnosis

PATIENT

Preventive Services

Preventive Services Management

Symptoms

Diagnosis & Treatment Planning

Diagnosis Coordination Payment + FFS

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Patient-Centered Care: Treat Acute Conditions Effectively
Patient-Centered Payment: Support Essential Hospital Svcs…

- Preventive Services

PATIENT

Symptoms → Diagnosis & Treatment Planning

Standby Capacity Payment

→ Acute Condition Treatment
Patient-Centered Payment: Pay for Full Bundles of Treatment

PATIENT -> Symptoms -> Diagnosis & Treatment Planning -> Acute Condition Treatment

- Preventive Services
- Preventive Services Management

- Standby Capacity Payment
- Acute Condition Episode Payment
- Acute Condition Coord. Treatment Payment + FFS
Patient-Centered Care: Effective Care of Chronic Disease

PATIENT

Preventive Services

Preventive Services Management

Symptoms

Diagnosis & Treatment Planning

Acute Condition Treatment

Initial Treatment of Chronic Condition

Continued Management of Chronic Condition
Patient-Centered Payment: Monthly Pmts for Condition Mgt

PATIENT

Preventive Services

Preventive Services Management

Symptoms

Diagnosis & Treatment Planning

Acute Condition Treatment

Initial Treatment of Chronic Condition

Continued Management of Chronic Condition

Bundled Pmt for Initial Treatment of Chronic Cond.

Monthly Pmt for Mgt of Chronic Condition

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Patient-Centered Payment to Support Patient-Centered Care

PATIENT

Symptoms

Diagnosis & Treatment Planning

Preventive Services

Bundled Pmt for Preventive Service

Monthly Preventive Services Mgt Pmt

Diagnosis & Treatment Planning Episode Payment

Acute Condition Treatment

Initial Treatment of Chronic Condition

Continued Management of Chronic Condition

Bundled Pmt for Initial Treatment of Chronic Cond.

Monthly Pmt for Mgt of Chronic Condition

Acute Condition Coord. Treatment Payment + FFS

Standby Capacity Payment

Episode Payment

Support Patient-Centered Care
Instead of “Value-Based” Payment That Assures Nothing

CURRENT VALUE-BASED PMT

• The patient (and payer) can only find out the total price of treating a health problem after all of the services have been delivered;

• The patient may be able to find out the percentage of other patients who were treated by (some of) the providers two years ago received care that met quality standards;

• The patient (and payer) has to pay even if the quality of care they received was poor or if the treatment didn’t succeed, and if errors were made, the patient/payer has to pay extra to have them corrected; and

• The amount the patient (and payer) ultimately pays bears no relationship to the costs of the services provided.
Patient-Centered Payments With Predictable Costs and Outcomes

**CURRENT VALUE-BASED PMT**

- The patient (and payer) can only find out the total price of treating a health problem *after* all of the services have been delivered;
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- The amount the patient (and payer) ultimately pays bears *no relationship to the costs* of the services provided

**PATIENT-CENTERED PAYMENT**

- The patient (and payer) are told *in advance* what the total price of treating the health problem will be;
- The patient is told what standards of quality *their* care *will* meet and the specific results *they* should expect to see from the care they will receive;
- The patient (and payer) *will not pay extra* for services to correct errors made by the providers, and they *will not pay at all* unless the care they received met quality standards and achieved the expected results; and
- The amount the patient (and payer) pays *is based on the cost* of delivering high-quality care with a warranty
Which Physician Would YOU Want to Care for You?

• Physician A is paid Fee for Service
  She makes less money if she keeps you healthy

• Physician B gets “Pay for Performance”
  She makes more money if she keeps her EHR up to date

• Physician C gets Shared Savings
  She makes more money if you get less treatment than needed

• Physician D gets a Population-Based Payment
  She gets paid whether she does anything for you or not

• Physician E is paid through Patient-Centered Payment
  She’s paid adequately to address your needs, and she makes more money if your health condition(s) improve
How Do You Control the Price of Care? (Under Any Payment Model)
Traveling from Boston to Cleveland
Airfare Choices from Boston to Cleveland

<table>
<thead>
<tr>
<th></th>
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Airfares for July 6-7, 2011 as of 6/26/11
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# Flat Copayments: First Class Fare Wins

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High Deductible: First Class Fare Wins

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# Price Difference: Lowest Coach Fare Wins

![Boston](image1.png) ![Cleveland](image2.png)

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Knee Joint Replacement

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Will Transparency About Prices Result in Better Choices?

Estimated Treatment Cost Results

Knee Replacement, 25 miles from Raleigh - Modify Your Search

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be health plan design, deductibles/co-insurance and out-of-pocket limits.

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<th>Blue Options, Blue Advantage</th>
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<td>$20,300</td>
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<td></td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>Chapel Hill, NC 27514</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Virginia Hospital Pricing

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Number of Discharges</th>
<th>LOS (Average)</th>
<th>Charge (Average)</th>
<th>Charge per Day (Average)</th>
<th>Median Charge</th>
<th>Median Age</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Augusta Health (Fishersville)</td>
<td>543</td>
<td>2.9 Day(s)</td>
<td>$69,221</td>
<td>$23,684</td>
<td>$63,315</td>
<td>67</td>
<td>36.6%</td>
<td>63.4%</td>
</tr>
<tr>
<td>Bon Secours DePaul Medical Center (Norfolk)</td>
<td>53</td>
<td>3.4 Day(s)</td>
<td>$79,232</td>
<td>$23,592</td>
<td>$76,973</td>
<td>68</td>
<td>41.5%</td>
<td>58.5%</td>
</tr>
<tr>
<td>Sentara Virginia Beach General Hospital (Virginia Beach)</td>
<td>305</td>
<td>2.9 Day(s)</td>
<td>$43,019</td>
<td>$14,961</td>
<td>$40,760</td>
<td>65</td>
<td>43.3%</td>
<td>56.7%</td>
</tr>
<tr>
<td>Centra Health (Lynchburg)</td>
<td>617</td>
<td>2.4 Day(s)</td>
<td>$31,655</td>
<td>$13,143</td>
<td>$30,218</td>
<td>68</td>
<td>35%</td>
<td>65%</td>
</tr>
</tbody>
</table>
Current Transparency Efforts Are Focused on Procedure Price

<table>
<thead>
<tr>
<th>Payment for Procedure</th>
<th>Provider 1: $25,000</th>
<th>Provider 2: $23,000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>-8%</td>
</tr>
</tbody>
</table>
# What Hidden Costs Accompany the Lower Price?

<table>
<thead>
<tr>
<th>Payment for Procedure</th>
<th>Payment and Rate of Complications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider 1:</td>
<td></td>
</tr>
<tr>
<td>$25,000</td>
<td>$30,000</td>
</tr>
<tr>
<td>Provider 2:</td>
<td></td>
</tr>
<tr>
<td>$23,000</td>
<td>$30,000</td>
</tr>
<tr>
<td>-8%</td>
<td></td>
</tr>
</tbody>
</table>
Total Spending May Be Higher With the “Lower Price” Provider

<table>
<thead>
<tr>
<th>Provider</th>
<th>Payment for Procedure</th>
<th>Payment and Rate of Complications</th>
<th>Average Total Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider 1:</td>
<td>$25,000</td>
<td>$30,000</td>
<td>2%</td>
</tr>
<tr>
<td>Provider 2:</td>
<td>$23,000</td>
<td>$30,000</td>
<td>10%</td>
</tr>
</tbody>
</table>

-8%  +2%

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

<table>
<thead>
<tr>
<th>Payment for Procedure</th>
<th>Payment and Rate of Complications</th>
<th>Bundled/Episode Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider 1:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$25,600</td>
</tr>
<tr>
<td>Provider 2:</td>
<td></td>
<td>10%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$26,000 +2%</td>
</tr>
</tbody>
</table>

Bundled prices show that Provider 1 is the higher-value provider.
Flying to Pittsburgh vs. Cleveland
Why Is It So Much Cheaper to Fly to Pittsburgh Than Cleveland?

One-Stop Coach Fare: $662
Non-Stop Coach Fare: $1,107

Non-Stop Coach Fare: $188

Airfares for July 6-7, 2011 as of 6/26/11
Is It The Shorter Distance?

551 Air Miles

One-Stop Coach Fare: $662
Non-Stop Coach Fare: $1,107

483 Air Miles

Non-Stop Coach Fare: $188

Airfares for July 6-7, 2011 as of 6/26/11
Or Greater Competition?

**NON-COMPETITIVE MARKET**

- Choice: United Non-Stop: $1,107
  *(No other non-stop choice)*

**COMPETITIVE MARKET**

- Choice #1: Delta Non-Stop: $188
- Choice #2: JetBlue Non-Stop: $188
- Choice #3: USAirways Non-Stop: $238

Airfares for July 6-7, 2011 as of 6/26/11
Choice & Competition Encourages Efficiency

Knee Joint Replacement

<table>
<thead>
<tr>
<th>Consumer Share of Surgery Cost</th>
<th>Price #1</th>
<th>Price #2</th>
<th>Price #3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$20,000</td>
<td>$5,000</td>
<td>$10,000</td>
</tr>
<tr>
<td>Highest-Value:</td>
<td>$0</td>
<td>$5,000</td>
<td>$10,000</td>
</tr>
</tbody>
</table>
Loss of Choice & Competition Will Lead to Higher Costs

Knee Joint Replacement

<table>
<thead>
<tr>
<th>Consumer Share of Surgery Cost</th>
<th>Price #1</th>
<th>Price #2</th>
<th>Price #3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highest-Value: $0</td>
<td>$5,000</td>
<td>$10,000</td>
<td></td>
</tr>
</tbody>
</table>

Price #1 $20,000

Price #2 $25,000

Price #3 $30,000
How Can We Successfully Transition from a Fragmented Fee-for-Service System to Patient-Centered Delivery & Payment?
It Starts With Engaging the Frontline Healthcare Providers

Transitioning to a Patient-Centered System

Primary Care
Specialists
Hospitals
Rehab & Home Care
They Need Actionable Data to Redesign Both Care & Payment

Transitioning to a Patient-Centered System

- Claims Data
- Clinical Data
- Outcomes Data
- Cost Data

- Primary Care
- Specialists
- Hospitals
- Rehab & Home Care
“Total Cost of Care” Doesn’t Provide Actionable Information

Spending Per Patient

TODAY

Total Spending for a Group of Patients

Reduce Avoidable Costs

FUTURE

Lower Spending Without Rationing

Payer Savings

Where are avoidable costs occurring today? And how would they be reduced?

NOTE: Graph is not drawn to scale
Traditional Actuarial Breakdowns Aren’t Very Actionable

NOTE: Graph is not drawn to scale

**Today**
- Total Spending for a Group of Patients
  - Other
  - Labs
  - Physicians
  - Outpatient
  - Inpatient

**Future**
- Lower Spending Without Rationing
- *Payer Savings*
- *Which categories can be reduced?*
- *And how would that be done?*
More Detailed Breakdowns By Type of Service Don’t Help Much

**TODAY**

- Other
- DME
- Drugs
- Home Health
- SNF
- Procedures
- Tests
- Surgeries
- Medical Admissions
- ER Visits
- Tests
- E&M

**FUTURE**

- Lower Spending
- Without Rationing

**NOTE:**

Graph is not drawn to scale

Which categories can be reduced?
And how would that be done?
Data Needs to Be Analyzed for Patient *Conditions*, Not Service Silos

**Graph**

- Total Spending for a Group of Patients
  - Other
  - Maternity
  - Cancer
  - Chest Pain
  - Chronic Diseases

**NOTE:**

*Graph is not drawn to scale*
Data/Analysis Needs to Identify Actionable Opportunities

NOTE: Graph is not drawn to scale

Spending Per Patient

Total Spending for a Group of Patients

- Avoidable $
  - Other
  - Avoidable $
  - Maternity
  - Avoidable $
  - Cancer
  - Avoidable $
  - Chest Pain
  - Avoidable $
  - Chronic Diseases

- Unnecessary/avoidable services
- Overuse of C-Sections
- Early elective deliveries
- Low birthweight due to poor prenatal care
- Use of hospitals instead of birth centers
- Use of unnecessarily-expensive drugs
- ER visits/hospital stays for dehydration and avoidable complications
- Fruitless treatment at end of life
- Late-stage cancers due to poor screening
- Overuse of high-tech stress tests/imaging
- Overuse of cardiac catheterization
- Overuse of PCIs, high-priced stents
- ER visits for exacerbations
- Hospital admissions and readmissions
- Amputations, blindness

Spending

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Purchasers and Payers Need to Support Implementation

Transitioning to a Patient-Centered System

Claims Data
Clinical Data
Outcomes Data
Cost Data

Primary Care
Specialists
Hospitals
Rehab & Home Care

Engagement of All Purchasers
Alignment of All Payers
Patients Need to Be Engaged and See Better Results

Transitioning to a Patient-Centered System

- Claims Data
- Clinical Data
- Outcomes Data
- Cost Data

- Engagement of All Purchasers
- Alignment of All Payers

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

- Primary Care
- Specialists
- Hospitals
- Rehab & Home Care
This is Only Feasible at the Regional Level, with a Facilitator

REGIONAL HEALTH IMPROVEMENT COLLABORATIVE

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

- Claims Data
- Clinical Data
- Outcomes Data
- Cost Data

- Engagement of All Purchasers
- Alignment of All Payers

- Primary Care
- Specialists
- Hospitals
- Rehab & Home Care

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Which Path Will Your Community Choose?

**TODAY**
- High Prices
- Mediocre Quality
- Unhealthy People

**FUTURE**
- Higher Prices
- Mediocre Quality
- Limited Patient Choice
- Loss of Good Physicians
- Loss of Rural Hospitals
Which Path Will Your Community Choose?

TODAY
• High Prices
• Mediocre Quality
• Unhealthy People

FUTURE
• Higher Prices
• Mediocre Quality
• Limited Patient Choice
• Loss of Good Physicians
• Loss of Rural Hospitals

TOP-DOWN PAYMENT REFORM
- Medicare and Health Plans Define Payment Systems
- Physicians and Hospitals Have To Change Care to Align With Payment Systems
- Patients Get Worse Care and Providers Close/Consolidate

BOTTOM-UP PAYMENT REFORM
- Patients Get Good Care at an Affordable Cost and Independent Providers Remain Financially Viable
- Payers Provide Adequate Payment for Quality Care and Providers Take Accountability for Quality & Efficiency
- Ask Physicians and Hospitals to Identify Ways to Improve Care for Patients and Eliminate Avoidable Costs

Patient-Centered Care
- Affordable Prices
- Good Outcomes
- Choice of Providers
- Care Customized to Patient and Community Needs

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www.CHQPR.org
www.PaymentReform.org