REDESIGNING HEALTHCARE PAYMENT AND DELIVERY FOR HIGHER QUALITY, LOWER COST CARE OF PATIENTS WITH DIABETES

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

www.CHQPR.org
DISCLOSURE:

I Have No Financial Relationships With Any Commercial Interests
Diabetes: A Quarter-Trillion Dollar Problem

Bad Outcomes & High Spending
- Amputations
- Kidney Failure
- Hospitalizations
- ER Visits
- Blindness
- Premature Death
- Inability to Work
- Low Productivity

Patient with Diabetes

$176 Billion in Healthcare Spending
$69 Billion in Reduced Productivity

$245 Billion Total Cost

Source:
“Economic Costs of Diabetes in the U.S. in 2012,”
*Diabetes Care* (Volume 36)
April 2013
What’s America’s Strategy for Reducing Cost, Improving Quality?

Patient with Diabetes

¿?

$176 Billion in Healthcare Spending

$69 Billion in Reduced Productivity

$245 Billion Total Cost

Bad Outcomes & High Spending
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- Hospitalizations
- ER Visits
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- Low Productivity

Quality of Life
Low Cost of Care
Productivity
Occasional 15 Minute Visits With Overworked PCPs

Patient with Diabetes

PCP 15 Minute Office Visit
$73/visit

Medications

$176 Billion in Healthcare Spending
$69 Billion in Reduced Productivity
$245 Billion Total Cost

Bad Outcomes & High Spending
- Amputations
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- Low Productivity

Quality of Life
Low Cost of Care
Productivity
With Limited Time & Resources, Is It Surprising Quality is Low?

Patient with Diabetes

PCP 15 Minute Office Visit
$73/visit

Medications

Quality Metrics
- Blood Sugar
- Cholesterol
- Blood Pressure
- Tobacco Use
- Aspirin Use
- Eye Exams
- Kidney Exams

Bad Outcomes & High Spending
- Amputations
- Kidney Failure
- Hospitalizations
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- Inability to Work
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Quality of Life
- Low Cost of Care
- Low Productivity

Source: Average D5 Composite Measures in Cincinnati and Minnesota

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Why Don’t PCPs Do a Better Job?

Patient with Diabetes

PCP
15 Minute Office Visit
$73/visit

Medications

Blood Sugar
Cholesterol
Blood Pressure
Tobacco Use
Aspirin Use
Eye Exams
Kidney Exams

Quality Metrics

Bad Outcomes & High Spending
Amputations
Kidney Failure
Hospitalizations
ER Visits
Blindness
Premature Death
Inability to Work
Low Productivity

Quality of Life
Low Cost of Care
Productivity

Source: Average D5 Composite Measures in Cincinnati and Minnesota
More Time With Patients = Lower Revenues to PCP Practice

Patient with Diabetes

PCP
15 Minute Office Visit
20 minutes per patient
@ $73 Level 3 E&M=
25% Less Revenue

Medications

25 minutes per patient
@ $108 Level 4 E&M=
11% Less Revenue

Bad Outcomes & High Spending
- Amputations
- Kidney Failure
- Hospitalizations
- ER Visits
- Blindness
- Premature Death
- Inability to Work
- Low Productivity

Quality of Life
Low Cost of Care
Productivity
Proactive Outreach to Patients to Improve Quality?

Patient with Diabetes

- PCP 15 Minute Office Visit
- Longer Office Visit
- Phone Call or Email
- Medications

$0 Payment

Bad Outcomes & High Spending
- Amputations
- Kidney Failure
- Hospitalizations
- ER Visits
- Blindness
- Premature Death
- Inability to Work
- Low Productivity

Quality of Life
- Low Cost of Care
- Productivity

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Group Visits to Deliver Care at Lower Cost?

Patient with Diabetes

PCP
15 Minute Office Visit

Longer Office Visit

Phone Call or Email

Group Visit

Medications

$0 Payment

Bad Outcomes & High Spending

Amputations
Kidney Failure
Hospitalizations
ER Visits
Blindness
Premature Death
Inability to Work
Low Productivity

Quality of Life
Low Cost of Care
Productivity
Hire a Nurse/Diabetes Educator to Help Patients Manage Health?

Patient with Diabetes

PCP
- 15 Minute Office Visit
- Longer Office Visit
- Phone Call or Email
- Group Visit

Nurse or Diabetes Educator

Medications

$0 Payment

Bad Outcomes & High Spending
- Amputations
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- Hospitalizations
- ER Visits
- Blindness
- Premature Death
- Inability to Work
- Low Productivity

Quality of Life
Low Cost of Care
Productivity
Call an Endocrinologist to Help With Complex Patients?

Patient with Diabetes

- PCP
  - 15 Minute Office Visit
  - Longer Office Visit
  - Phone Call or Email
  - Group Visit
  - Nurse or Diabetes Educator
  - Call to Specialist

Medications

$0 Payment

Bad Outcomes & High Spending
- Amputations
- Kidney Failure
- Hospitalizations
- ER Visits
- Blindness
- Premature Death
- Inability to Work
- Low Productivity

Quality of Life
Low Cost of Care
Productivity
No Payment for Endocrinologists to Advise PCPs

Patient with Diabetes

PCP
- 15 Minute Office Visit
- Longer Office Visit
- Phone Call or Email
- Group Visit
- Nurse or Diabetes Educator
- Call to Specialist

Endocrinologist
- Call w/ PCP

$0 Payment

Medications

Bad Outcomes & High Spending
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Quality of Life
- Low Cost of Care
- Productivity
Payers Do Pay for Office Visits with Endocrinologists….

**Patient with Diabetes**

- PCP
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  - Longer Office Visit
  - Phone Call or Email
  - Group Visit
  - Nurse or Diabetes Educator
  - Call to Specialist

- Endocrinologist
  - Call w/ PCP
  - 30-45 Min. Office Visit

- Medications

**Bad Outcomes & High Spending**

- Amputations
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**Quality of Life**

- Low Cost of Care
- Productivity
Long Waits Due to Many Visits for Issues That Needed Only a Call…

Patient with Diabetes

PCP
- 15 Minute Office Visit
- Longer Office Visit
- Phone Call or Email
- Group Visit
- Nurse or Diabetes Educator
- Call to Specialist

Endocrinologist
- Call w/ PCP
- 30-45 Min. Office Visit

3-9 Month Wait for Visit

308-166

Medications

Bad Outcomes & High Spending
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Quality of Life

Low Cost of Care

Productivity
...And the Extra Copay May Deter the Patient From Making the Visit

**Patient with Diabetes**

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- Nurse or Diabetes Educator
- Call to Specialist

- Endocrinologist Call w/ PCP
  - 30-45 Min. Office Visit

- Medications

**Bad Outcomes & High Spending**
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**Quality of Life**
- Low Cost of Care
- Productivity

**3-9 Month Wait for Visit**
**Extra Patient Copay**

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If Patients Can’t Afford Meds, All the Rest May Be in Vain

Patient with Diabetes

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- Endocrinologist
  - Call w/ PCP
  - 30-45 Min. Office Visit

- Medications
  - Low Copay
  - High Copay

High Cost-Share

Bad Outcomes & High Spending
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Quality of Life
Low Cost of Care
Low Productivity
Small $ for What Patients Need, Big $$$ for Resulting Problems

Patient with Diabetes

PCP
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- Longer Office Visit
- Phone Call or Email
- Group Visit
- Nurse or Diabetes Educator
- Call to Specialist

Endocrinologist
- Call w/ PCP
- 30-45 Min. Office Visit

Medications
- Low Copay
- High Copay

Lower Payment
$0 Payment
$0 Payment
$0 Payment
$0 Payment
$0 Payment

High Cost-Share

Bad Outcomes & High Spending
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- Blindness
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Quality of Life
Low Cost of Care
Productivity

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So Is It Any Surprise that Quality is Poor and Spending is High?

Patient with Diabetes

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  - Nurse or Diabetes Educator
  - Call to Specialist

- Endocrinologist
  - Call w/ PCP
  - 30-45 Min. Office Visit

- Medications
  - Low Copay
  - High Copay

Quality Metrics

- Blood Sugar
- Cholesterol
- Blood Pressure
- Tobacco Use
- Aspirin Use
- Eye Exams
- Kidney Exams

Bad Outcomes & High Spending

- Amputations
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- Premature Death
- Inability to Work
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Quality Metrics:

- D5 <40%

Medications

- Low Copay
- High Copay

Quality of Life

- Low Cost of Care
- Productivity
What Are Medicare and Private Health Plans Doing to Fix This?

Patient with Diabetes

- PCP
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Endocrinologist
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Medications
- Low Copay
- High Copay

Bad Outcomes & High Spending
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Quality of Life
- Low Cost of Care
- Productivity
Strategy 1: Force PCPs to Buy an EHR

Requiring EHRs

- Increases expenses for PCP practice
- Takes time away from office visits with patients
- PCP EHR and endocrinologist EHR may not be able to exchange data even if HIPAA barriers can be overcome

Patient with Diabetes

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- Call to Specialist

Endocrinologist
- Call w/ PCP
- 30-45 Min. Office Visit

Medications
- Low Copay
- High Copay

Bad Outcomes & High Spending
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Quality of Life
Low Cost of Care
Productivity
Strategy 2: Small Quality Bonuses/Penalties

- Small P4P bonuses insufficient to support delivery of needed services
- Unintended consequences of over-focus on metrics

**P4P/VBP**

- Quality Metrics
  - Blood Sugar
  - Cholesterol
  - Blood Pressure
  - Tobacco Use
  - Aspirin Use
  - Eye Exams
  - Kidney Exams

**Patient with Diabetes**

- PCP
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- Medications
  - Low Copay
  - High Copay

**Bad Outcomes & High Spending**

- Amputations
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**Hospitalizations & Death Due to Overtreatment**

- Quality of Life
- Low Cost of Care
- Productivity
Over-Emphasis on Narrow Quality Measures Can Have Bad Results

**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
Strategy 3: “Shared Savings”

- No additional upfront resources to address the barriers preventing higher quality care
- Puts physicians at risk for services and costs they cannot control

- Low Copay
- High Copay
- Endocrinologist Call w/ PCP
- 30-45 Min. Office Visit
- Nurse or Diabetes Educator
- Group Visit
- Phone Call or Email
- Longer Office Visit
- 15 Minute Office Visit

- Non-Diabetes Spending
  - Amputations
  - Kidney Failure
  - Hospitalizations
  - ER Visits
  - Blindness
  - Premature Death
  - Inability to Work
  - Low Productivity

- Quality of Life
- Low Cost of Care
- Productivity

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Strategy 4: Patient-Centered Medical Home

Patient with Diabetes

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  - Call to Specialist

- Endocrinologist
  - Call w/ PCP
  - 30-45 Min. Office Visit

- Medications
  - Low Copay
  - High Copay

PCMH/PMPM

(Small) Monthly Payment Per Patient

- Monthly payment may be too small to overcome service barriers
- Expectations for quality improvement or savings may be too high for resources invested
- No support for specialists

Bad Outcomes & High Spending
- Amputations
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Quality of Life
Low Cost of Care
Productivity
A Better Way: Condition-Based Payment

**Patient with Diabetes**

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  - Group Visit
  - Nurse or Diabetes Educator
  - Call to Specialist

- **Endocrinologist**
  - Call w/ PCP
  - 30-45 Min. Office Visit

**Diabetes-Related Costs**

- Amputations
- Kidney Failure
- Hospitalizations
- ER Visits
- Blindness
- Premature Death
- Inability to Work
- Low Productivity

- Quality of Life
- Low Cost of Care
- Productivity

**CONDITION-BASED PAYMENT**

- Medications
  - Low Copay
Flexibility to Deliver Care Without Restrictions of FFS

Patient with Diabetes

<table>
<thead>
<tr>
<th>PCP</th>
<th>CONDITION-BASED PAYMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 Minute Office Visit</td>
<td>FLEXIBLE RESOURCES FOR PCP &amp; SPECIALIST TO DELIVER SERVICES PATIENTS NEED TO STAY WELL</td>
</tr>
<tr>
<td>Longer Office Visit</td>
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<tr>
<td>Phone Call or Email</td>
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<td>Group Visit</td>
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<tr>
<td>Nurse or Diabetes Educator</td>
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<tr>
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<tr>
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<tr>
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<tr>
<td>Medications</td>
<td></td>
</tr>
<tr>
<td>Low Copay</td>
<td></td>
</tr>
</tbody>
</table>

Diabetes-Related Costs
- Amputations
- Kidney Failure
- Hospitalizations
- ER Visits
- Blindness
- Premature Death
- Inability to Work
- Low Productivity

Quality of Life
Low Cost of Care
Productivity
Accountability to Ensure Outcomes and Costs Improve

Patient with Diabetes

PCP
15 Minute Office Visit
Longer Office Visit
Phone Call or Email
Group Visit
Nurse or Diabetes Educator
Call to Specialist
Endocrinologist Call w/ PCP
30-45 Min. Office Visit
Medications Low Copay

CONDITION-BASED PAYMENT

FLEXIBLE RESOURCES FOR PCP & SPECIALIST TO DELIVER SERVICES PATIENTS NEED TO STAY WELL

ACCOUNTABILITY FOR MANAGING AVOIDABLE COSTS RELATED TO DIABETES AND IMPROVING OUTCOMES

Diabetes-Related Costs
- Amputations
- Kidney Failure
- Hospitalizations
- ER Visits
- Blindness
- Premature Death
- Inability to Work
- Low Productivity

Quality of Life
Low Cost of Care
Productivity
Can We Afford to *Spend More* for High-Quality, Coordinated Care When We’re Trying to *Reduce* Healthcare Spending?
Most of the $ for Diabetes Care is Going to Hospitals, Not Doctors

U.S. Health Care Expenditures Attributed to Diabetes, 2012 (Millions)

Could We Afford to Spend More on Better Diabetes Management?

Potential Change in Spending on Diabetes By Investing in Better Care

- Hospital Admits
- Physicians

Current vs. Improved Spending Comparison
Yes, If We Can Prevent Expensive Complications

Potential Change in Spending on Diabetes By Investing in Better Care

<table>
<thead>
<tr>
<th>Current</th>
<th>Improved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Admits</td>
<td>Physicians</td>
</tr>
<tr>
<td>$180,000</td>
<td>$0</td>
</tr>
<tr>
<td>$160,000</td>
<td>$20,000</td>
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<td>$140,000</td>
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<tr>
<td>$0</td>
<td>$180,000</td>
</tr>
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</table>

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Example: 20% More Care Mgt $ + 6% Fewer Admits = Lower Total $
Example: Reactive Care for Chronic Disease, Many Hospitalizations

<table>
<thead>
<tr>
<th>Physician Svcs</th>
<th>CURRENT</th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$/Patient</td>
<td># Pts</td>
<td>Total $</td>
</tr>
<tr>
<td>PCP</td>
<td>$600</td>
<td>500</td>
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<tr>
<td>Hospitalizations</td>
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<tr>
<td>Admissions</td>
<td>$10,000</td>
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<tr>
<td>Specialist</td>
<td>$400</td>
<td>250</td>
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<tr>
<td>Total Spending</td>
<td></td>
<td>500</td>
<td>$2,900,000</td>
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</table>

500 Moderately Severe Chronic Disease Patients

- PCP paid only for periodic office visits
- Patients do not take maintenance medications reliably
- 50% of patients are hospitalized each year for exacerbations
- Specialist only sees patient during hospital admissions
## Is There a Better Way?

<table>
<thead>
<tr>
<th></th>
<th>CURRENT</th>
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<th>FUTURE</th>
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<td>$/Patient</td>
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## Pay the PCP for Proactive Care Management

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### Pay the Specialist to Co-Manage The Patient’s Care

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Provide Nursing Support
For Patient Education & Care Mgt

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Can We Afford to Double Spending on Ambulatory Care?

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Yes, If It Succeeds In Reducing Hospitalizations

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© 2009-2014 Center for Healthcare Quality and Payment Reform  www.CHQPR.org
## Improved Chronic Disease Mgt Can Potentially Generate Large Savings

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But What About the Hospital?

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What Should Matter to Hospitals is *Margin*, Not Revenues (Volume)
Hospital Costs Are Not Proportional to Utilization

Cost & Revenue Changes With Fewer Patients

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

- Revenues
- Costs
Causing Negative Margins for Hospitals

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

Cost & Revenue Changes With Fewer Patients

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

$000

$000

#Patients
But Spending Can Be Reduced Without Bankrupting Hospitals

Cost & Revenue Changes With Fewer Patients

Payers Can Still Save $ Without Causing Negative Margins for Hospital
## How Can 40% Fewer Admissions Be a Win for the Hospital?

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# Analyze the Hospital’s Cost Structure

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### What Happens to Hospital Finances When Admissions Go Down?

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Continue to Cover the Fixed Costs

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$1,500,000 -0%
Save on Variable Costs With Fewer Patients

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Total Spending     | 500     |       | $2,900,000 |     |      |          |     |
# Increase the Hospital’s Contribution Margin

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<td>250</td>
<td>$2,500,000</td>
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</table>

| Specialist (Inpt) | $400 | 250 | $100,000 | $0 |       |

| Total Spending    | 500  |     | $2,900,000 |     |       |
Hospital Gets Less *Total Revenue*, But is Better Off *Financially*

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<tr>
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<td><strong>Total</strong></td>
<td>$10,000 250 $2,500,000</td>
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| Specialist (Inpt)      | $400 250 $100,000 |              |       |

| Total Spending         | 500 $2,900,000 |              |       |
And the Payer Still Spends Less

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| Specialist (Inpt)    | $400       | 250    | $100,000 |      |        | $0       |       |
| Total Spending       | $2,900,000 | 500    |          | 500  | $2,817,500 | -3%     |       |
### Win-Win-Win: Better Care, Higher Physician Pay, Lower Spending

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| Specialist (Inpt)  | $400 250 $100,000 | $0           |      |
| Total Spending     | 500 $2,900,000    | 500 $2,817,500 | -3% |
What Payment Model Supports This Win-Win-Win-Win Approach?

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You Don’t Want to Try and Renegotiate Individual Fees

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## Look at What is Being Spent Today in *Total* on the Patient’s *Condition*

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<td><strong>$2,900,000</strong></td>
<td>500</td>
<td><strong>$2,817,500</strong></td>
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Tell the Payer You’ll Do It For Less Than They’re Spending Today

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Use That Budget to Pay Doctors & Hospitals What They Really Need

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**Condition-Based Payment Puts the Providers in Charge of Care & Pmt**

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<td>$2,817,500</td>
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</tr>
</tbody>
</table>

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“Shared Savings” Doesn’t Solve the Problems with FFS

- No actual change in payment to the physicians
  - No funding for the nurse
  - No payment for phone calls instead of office visits
  - No flexibility to proactive outreach instead of reactive care

- Arbitrary “share” of savings may not be sufficient to cover higher costs of care or losses from FFS revenue
  - <50% of savings is not adequate if >50% of costs are fixed
We Need Win-Win Approaches Benefiting Providers and Payers

• It is unrealistic to expect physicians, hospitals, hospice programs, and other healthcare providers, no matter how motivated they are to provide higher value care, to improve quality or reduce spending if the payment system does not provide adequate financial support for their efforts.
We Need Win-Win Approaches Benefiting Providers and Payers

• It is unrealistic to expect physicians, hospitals, hospice programs, and other healthcare providers, no matter how motivated they are to provide higher value care, to improve quality or reduce spending if the payment system does not provide adequate financial support for their efforts.

• It is also unrealistic to expect that patients or payers will be willing to pay more or differently to overcome the barriers in the current payment system without assurances that the quality of care will be improved, spending will be lower, or both.
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- Payment systems must support the delivery of higher-quality care for patients at lower costs for payers in ways that are financially feasible for providers.
1. **Flexibility in Care Delivery.** The payment system should give providers freedom to deliver care in ways that will achieve high quality in the most efficient way and to adjust care delivery to the unique needs of individual patients.
The Four Key Elements of Accountable Payment Models

1. **Flexibility in Care Delivery.** The payment system should give providers freedom to deliver care in ways that will achieve high quality in the most efficient way and to adjust care delivery to the unique needs of individual patients.

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4. **Adequacy of Payment.** The size of the payments should be adequate to cover the providers’ costs of delivering high quality care for the types of patients they see and at the levels of cost or efficiency that are feasible for them to achieve.
Opportunities for Reducing Spending Exist in Every Specialty

### Opportunities to Improve Care and Reduce Cost

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Opportunities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiology</td>
<td>• Use less invasive and expensive procedures when appropriate</td>
</tr>
<tr>
<td>Orthopedic Surgery</td>
<td>• Reduce infections and complications</td>
</tr>
<tr>
<td></td>
<td>• Use less expensive post-acute care following surgery</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>• Reduce ER visits and admissions for patients with depression and chronic disease</td>
</tr>
<tr>
<td>OB/GYN</td>
<td>• Reduce use of elective C-sections</td>
</tr>
<tr>
<td></td>
<td>• Reduce early deliveries and use of NICU</td>
</tr>
</tbody>
</table>
Fee-for-Service Creates 
**Barriers** to Redesigning Care

<table>
<thead>
<tr>
<th>Opportunities to Improve Care and Reduce Cost</th>
<th>Barriers in Current Payment System</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cardiology</strong></td>
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</tr>
<tr>
<td>• Use less invasive and expensive procedures when appropriate</td>
<td>• Payment is based on which procedure is used, not the outcome for the patient</td>
</tr>
<tr>
<td><strong>Orthopedic Surgery</strong></td>
<td></td>
</tr>
<tr>
<td>• Reduce infections and complications</td>
<td>• No flexibility to increase inpatient services to reduce complications &amp; post-acute care</td>
</tr>
<tr>
<td>• Use less expensive post-acute care following surgery</td>
<td></td>
</tr>
<tr>
<td><strong>Psychiatry</strong></td>
<td></td>
</tr>
<tr>
<td>• Reduce ER visits and admissions for patients with depression and chronic disease</td>
<td>• No payment for phone consults with PCPs</td>
</tr>
<tr>
<td>• Reduce use of elective C-sections</td>
<td>• No payment for RN care managers</td>
</tr>
<tr>
<td>• Reduce early deliveries and use of NICU</td>
<td>• Similar/lower payment for vaginal deliveries</td>
</tr>
</tbody>
</table>

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There Are Win-Win-Win Solutions Through Better Payment Systems

<table>
<thead>
<tr>
<th>Opportunities to Improve Care and Reduce Cost</th>
<th>Barriers in Current Payment System</th>
<th>Solutions via Accountable Payment Models</th>
</tr>
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<tbody>
<tr>
<td><strong>Cardiology</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Use less invasive and expensive procedures when appropriate</td>
<td>• Payment is based on which procedure is used, not the outcome for the patient</td>
<td>• Condition-based payment covering CABG, PCI, or medication management</td>
</tr>
<tr>
<td><strong>Orthopedic Surgery</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Reduce infections and complications</td>
<td>• No flexibility to increase inpatient services to reduce complications &amp; post-acute care</td>
<td>• Episode payment for hospital and post-acute care costs with warranty</td>
</tr>
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<td>• Joint condition-based payment to PCP and psychiatrist</td>
</tr>
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<td><strong>OB/GYN</strong></td>
<td>• Similar/lower payment for vaginal deliveries</td>
<td>• Condition-based payment for total cost of delivery in low-risk pregnancy</td>
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</table>
Most Current “Payment Reforms” Don’t Fix The Problems with FFS

FFS
• No payment for services that will benefit patients
• Lower revenues from reducing avoidable costs
## Developing Patient-Centered Multi-Specialty Payment Models

<table>
<thead>
<tr>
<th>Specialties Involved</th>
<th>Opportunities to Improve Care and Reduce Cost</th>
<th>Solutions via Accountable Payment Models</th>
</tr>
</thead>
</table>
| CHF + COPD + Diabetes | • Preventing avoidable admissions and readmissions  
• Slowing progression of disease  
• Improving QOL | • Condition-Based Payment  
• Multi-Year Risk-Adjusted Global Payment |
| Cancer               | • Preventing avoidable complications  
• Reducing unnecessary testing & treatment | • Condition-Based Payment  
• Multi-Year Risk-Adjusted Global Payment |
| Pain & Mobility Limitations | • Avoiding unnecessary surgery  
• Reducing infections and complications | • Condition-Based Payment  
• Bundles/Warranties |
| Prevention/Screening | • Preventing chronic disease  
• Improving early detection/treatment  
• Avoiding unnecessary testing | • Multi-Year Risk-Adjusted Global Payment |

### Specialties Involved
- Primary Care
- Cardiology
- Pulmonology
- Endocrinology
- Emergency Medicine
- Medical Oncology
- Radiation Oncology
- Surgical Oncology
- Palliative Care
- Preventive Medicine
- Radiology
- Dermatology
- Primary Care

### Solutions via Accountable Payment Models
- Condition-Based Payment
- Multi-Year Risk-Adjusted Global Payment
Only So Much Can Be Done Once the Patient Has Diabetes

Patient with Diabetes → PCP+ Specialist →
- Amputations
- Kidney Failure
- Hospitalizations
- ER Visits
- Blindness
- Premature Death
- Inability to Work
- Low Productivity

↓
- Quality of Life
- Low Cost of Care
- Productivity
We Need to Also Focus on Preventing Diabetes

- Premature Death
- Amputations
- Kidney Failure
- Hospitalizations
- ER Visits
- Blindness
- Premature Death
- Inability to Work
- Low Productivity
- Quality of Life
- Low Cost of Care
- Productivity

Healthy Children and Adults

Obesity

Patient with Diabetes

PCP+ Specialist

Healthy Weight

Patient without Diabetes

- Healthy Children and Adults
- Obesity
- Patient with Diabetes
- PCP+ Specialist
- Healthy Weight
- Patient without Diabetes
- Amputations
- Kidney Failure
- Hospitalizations
- ER Visits
- Blindness
- Premature Death
- Inability to Work
- Low Productivity
- Quality of Life
- Low Cost of Care
- Productivity
That Means Upstream Investment to Combat Obesity

Healthy Children and Adults
- Pediatrics
  - Adult Primary Care
  - Endocrinology
- Healthy Foods and Walkable Communities

Obesity
- Healthy Weight
  - Patient without Diabetes
  - PCP+
  - Specialist
    - Patient with Diabetes
      - Amputations
      - Kidney Failure
      - Hospitalizations
      - ER Visits
      - Blindness
      - Premature Death
      - Inability to Work
      - Low Productivity

      Quality of Life
      - Low Cost of Care
      - Productivity
True Population-Based Payment Requires Multi-Year Payment

Population-Based Payment

Healthy Children and Adults

- Pediatrics
- Adult Primary Care
- Endocrinology
- Healthy Foods and Walkable Communities

Obesity

Patient with Diabetes

PCP+ Specialist

- Amputations
- Kidney Failure
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- Premature Death
- Inability to Work
- Low Productivity

Healthy Weight

Patient without Diabetes

Quality of Life

- Low Cost of Care
- Productivity

$\text{INVESTMENT}$

$\text{MANY YEARS FOR RETURN ON INVESTMENT}$

$\text{SAVINGS}$
A Public-Private Partnership Will Be Needed For Investment

Population-Based Payment

Healthy Children and Adults
- Pediatrics
- Adult Primary Care
- Endocrinology
- Healthy Foods and Walkable Communities

Healthy Weight
- Patient without Diabetes

Obesity
- Patient with Diabetes

PCP+ Specialist

- Amputations
- Kidney Failure
- Hospitalizations
- ER Visits
- Blindness
- Premature Death
- Inability to Work
- Low Productivity

Quality of Life
- Low Cost of Care
- Productivity

INVESTMENT

Employers

MANY YEARS FOR RETURN ON INVESTMENT

Medicare SAVINGS

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In Summary

• Most current “reforms” (pay for performance, value-based purchasing, and shared savings) don’t solve the real problems with care delivery and may make things worse

• Condition-based payment can be a win-win-win-win-win:
  – Better health and better care for patients
  – Lower spending for payers
  – Financially viable primary care and endocrinology practices that will attract new physicians
  – Financially viable community hospitals and medical centers

• Condition-based payment for diabetes can be an important building block for successful Accountable Care Organizations

• Multi-year contracts and public-private partnerships will be needed to adequately invest in prevention for long-term savings and better outcomes
Learn More About Win-Win-Win Payment and Delivery Reform

Center for Healthcare Quality and Payment Reform
www.PaymentReform.org
For More Information:

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

Miller.Harold@GMail.com
(412) 803-3650

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