WHAT PHYSICIANS WILL NEED TO DO TO SURVIVE AND THRIVE IN A HIGH(ER)-VALUE HEALTHCARE SYSTEM

Harold D. Miller
President and CEO
Center for Healthcare Quality and Payment Reform
Medicare Payments to Physicians Below Inflation for a Decade

- Physician Practice Costs
- If Sustainable Growth Rate Cut Is Made
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?

If Medicare spending = services to seniors * fees to providers, guess which one they’ll try to reduce?
What We Need: A Way to Reduce Costs Without Rationing or Fee Cuts
What We Need:
A Way to Reduce Costs
Without Rationing or Fee Cuts

It Can’t Be Done from Washington;
It Has to Happen at the Local Level,
Where Health Care is Delivered
What We Need:
A Way to Reduce Costs
Without Rationing or Fee Cuts

It Can’t Be Done from Washington;
It Has to Happen at the Local Level,
Where Health Care is Delivered

And It Cannot Succeed Without
Physician Knowledge & Leadership
Reducing Costs Without Rationing: 

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

Healthy Consumer → Continued Health

Health Condition

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Reducing Costs Without Rationing: Avoiding Hospitalizations

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

Health Condition
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

Complications, Infections, Readmissions
How Big Are the Opportunities?
5-17% of Hospital Admissions Are Potentially Preventable

% of Hospital Stays That Were Potentially Preventable, 2008

- Potentially Preventable Chronic Conditions
- Potentially Preventable Acute Conditions

Source: AHRQ HCUP
More than a *Million* Preventable Errors & Adverse Events Annually

<table>
<thead>
<tr>
<th>Medical Error</th>
<th># Errors (2008)</th>
<th>Cost Per Error</th>
<th>Total U.S. Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressure Ulcers</td>
<td>374,964</td>
<td>$10,288</td>
<td>$3,857,629,632</td>
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<tr>
<td>Postoperative Infection</td>
<td>252,695</td>
<td>$14,548</td>
<td>$3,676,000,000</td>
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<tr>
<td>Complications of Implanted Device</td>
<td>60,380</td>
<td>$18,771</td>
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<tr>
<td>Infection Following Injection</td>
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<td>$78,083</td>
<td>$691,424,965</td>
</tr>
<tr>
<td>Pneumothorax</td>
<td>25,559</td>
<td>$24,132</td>
<td>$616,789,788</td>
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<tr>
<td>Central Venous Catheter Infection</td>
<td>7,062</td>
<td>$83,365</td>
<td>$588,723,630</td>
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<tr>
<td>Others</td>
<td>773,808</td>
<td>$11,640</td>
<td>$9,007,039,005</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>1,503,323</strong></td>
<td><strong>$13,019</strong></td>
<td><strong>$19,571,000,000</strong></td>
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</tbody>
</table>

3 Adverse Events Every Minute

Source: *The Economic Measurement of Medical Errors*, Milliman and the Society of Actuaries, 2010
Many Ways to Reduce Tests & Services Without Harming Patients
Do Physicians Have to Lose in Order for Spending to Decrease?
Where is the Money Going Now?


- Prescription Drugs (Part D)
- Other Services
- Home Health Agencies
- Skilled Nursing Facilities
- Hospital Outpatient Services
- Hospital Inpatient Care
- Physician Fee Schedule
Only 16% of Medicare Spending Goes to Physicians…

**Medicare Part A, Part B, and Part D Spending in Billions, 2012**

- **$450**: Part D Benefits
- **$400**: Other Services
- **$350**: Home Health Agencies
- **$300**: Skilled Nursing Facilities
- **$250**: Hospital Outpatient Services
- **$200**: Hospital Inpatient Care
- **$150**: Physician Fee Schedule

**Physicians: 16%**
.. Most of The Rest Goes to Things That Physicians Can *Influence*

**Medicare Part A, Part B, and Part D Spending in Billions, 2012**

- **Physicians:** 16%
- **Things Physicians Prescribe, Control, or Influence:** 84%
- **Other Services**
- **Home Health Agencies**
- **Skilled Nursing Facilities**
- **Hospital Outpatient Services**
- **Hospital Inpatient Care**
- **Physician Fee Schedule**
Current Medicare Payment Silos Pit Physicians Against Each Other

Sustainable Growth Rate Cap on Total Medicare Spending on Physician Services
Physicians Should Benefit From Lowering *Other* Healthcare Costs
Reducing Costs Without Rationing Reduces Physician Revenues in FFS

Healthy Consumer

Continued Health

Health Condition

No Hospitalization

Acute Care Episode

Efficient Successful Outcome

High-Cost Successful Outcome

Complications, Infections, Readmissions

Fewer Patients

Fewer Procedures & Admissions

Less Revenue Per Patient
Most “Payment Reforms” Don’t Fix The Problems with FFS
The Goal Isn’t “Creating Incentives,”
The Goal is Removing Barriers

Lack of Flexibility in FFS

• No payment for phone calls or emails with patients
• No payment to coordinate care among providers
• No payment for non-physician support services to help patients with self-management
• No flexibility to shift resources across silos (hospital <-> physician, post-acute <-> hospital, SNF <-> home health, etc.)

Penalty for Quality/Efficiency

• Lower revenues if patients don’t make frequent office visits
• Lower revenues for performing fewer tests and procedures
• Lower revenues if infections and complications are prevented instead of treated
• No revenue at all if patients stay healthy
# Alternative Payment Models Allow Win-Win-Win Approaches

<table>
<thead>
<tr>
<th>BUILDING BLOCKS</th>
<th>HOW IT WORKS</th>
<th>HOW PHYSICIANS AND HOSPITALS CAN BENEFIT</th>
<th>HOW PAYERS CAN BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
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<td>Single payment to 2+ providers who are now paid separately (e.g., hospital+physician)</td>
<td>Higher payment for physicians if they reduce costs paid by hospitals</td>
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<td><strong>Condition-Based Payment</strong></td>
<td>Payment based on the patient’s condition, rather than on the procedure used</td>
<td>No loss of payment for physicians and hospitals using fewer tests and procedures</td>
<td>Medicare or health plan no longer pays more for unnecessary procedures</td>
</tr>
</tbody>
</table>
Who Says Congress and the President Can’t Agree?

Sustainable Growth Rate Repeal and Reform Proposal
“Providers can choose to participate in an Alternative Payment Model…We envision a system where providers have the flexibility to participate in the payment and delivery model that best fits their practice. The overarching goal is to reward providers for delivering high quality, efficient health care…”

House Energy & Commerce Committee and House Committee on Ways and Means

Request for Input from Stakeholders on Sustainable Growth Rate Reform
“Our ultimate goal is for Medicare to pay physicians…in a way that results in high quality, affordable care for seniors. We support identifying Alternative Models…”

Senate Finance Committee

President’s Budget Proposal to Encourage Adoption of New Physician Payment Models
“…The Administration supports … the continued development of scalable accountable payment models…[to] encourage care coordination, reward practitioners who provide high-quality efficient care, and hold practitioners accountable…”

President’s Budget for Fiscal Year 2014, p.37
Example: Reduce Avoidable Hospitalizations

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<th></th>
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<tbody>
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<td>$/Patient # Pts</td>
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<td><strong>Physician Svcs</strong></td>
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**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
Most Spending Is Not Going to the Physicians

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Physician Payment is 8% of Total Spending
## Better Pay for Care Mgt…

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Better Rx Adherence (Higher Rx Expenses)...

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#### Fewer Expensive Hospitalizations...

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Win-Win-Win: Better Care, Higher Physician Pay, Lower Spending

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## Pay to Manage The Condition

To Enable Win-Win-Win Solutions

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Four Things Needed
For Win-Win-Win Solutions
Four Things Needed For Win-Win-Win-Win Solutions

1. **Defining the Change in Care Delivery**
   - How can the physician, hospital, or other provider change the way care is delivered to reduce costs without harming patients?
Physicians Know How to Reduce Health Care Costs, But Can’t

“I have zero control over utilization or studies ordered. I don’t get paid for calling a referring doctor and telling him/her the imaging test is worthless.”
Radiologist in Maine

“I strongly suspect overutilization of abdominal CT scans in the ER and in the hospital; CT scans lead to further CT scans to follow up lung and adrenal nodules. The hospital focuses on length of stay, but never looks at appropriateness of radiologic studies.”
Internist at AMA HOD Meeting

“Patients often need to be in extended care to receive antibiotics because Medicare doesn’t pay for home IV therapy. Patient stays in the hospital for 3 days to justify a nursing home/rehab stay.”
Orthopedist at AMA HOD Meeting

“I do many unnecessary colonoscopies on young men. Give every PCP an anuscope to allow diagnosis of bleeding hemorrhoids in the office.”
Gastroenterologist in Maine
Four Things Needed For Win-Win-Win Solutions

1. **Defining the Change in Care Delivery**
   - How can the physician, hospital, or other provider change the way care is delivered to reduce costs without harming patients?

2. **Analyzing Expected Costs and Savings**
   - What will there be less of, and how much does that save?
   - What will there be more of, and how much does that cost?
   - Will the savings offset the costs on average?
   - How much variation in costs and savings is likely?
A Critical Element is Shared, Trusted Data

• **Physician** needs to know the current utilization and costs for his or her patients to know whether the condition-based or episode payment amount will cover the costs of delivering effective care to the patients

• **Purchaser/Payer** needs to know the current utilization and costs to know whether the condition-based or episode payment amount is a better deal than they have today

• **Both** sets of data have to match in order for physicians and payers to agree on the new approach!
Four Things Needed For Win-Win-Win-Win Solutions

1. **Defining the Change in Care Delivery**
   - How can the physician, hospital, or other provider change the way care is delivered to reduce costs without harming patients?

2. **Analyzing Expected Costs and Savings**
   - What will there be less of, and how much does that save?
   - What will there be more of, and how much does that cost?
   - Will the savings offset the costs on average?
   - How much variation in costs and savings is likely?

3. **Designing a Payment Model That Supports Change**
   - Flexibility to change the way care is delivered
   - Accountability for costs and quality/outcomes related to care
   - Adequate payment to cover lowest-achievable costs
   - Protection for the provider from insurance risk
# Opportunities and Solutions Vary By Specialty

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Opportunities to Improve Care and Reduce Cost</th>
<th>Barriers in Current Payment System</th>
<th>Solutions via Accountable Payment Models</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiology</td>
<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>Orthopedic</td>
<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>
<tr>
<td>Surgery</td>
<td>• Use less expensive post-acute care following surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatry</td>
<td>• Reduce ER visits and admissions for patients with depression and chronic disease</td>
<td>• No payment for phone consults with PCPs</td>
<td>• Joint condition-based payment to PCP and psychiatrist</td>
</tr>
<tr>
<td>OB/GYN</td>
<td>• Reduce use of elective C-sections</td>
<td>• No payment for RN care managers</td>
<td>• Condition-based payment for total cost of delivery in low-risk pregnancy</td>
</tr>
<tr>
<td></td>
<td>• Reduce early deliveries and use of NICU</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Examples from Other Specialties

<table>
<thead>
<tr>
<th>Primary Care</th>
<th>Opportunities to Improve Care and Reduce Cost</th>
<th>Barriers in Current Payment System</th>
<th>Solutions via Accountable Payment Models</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Help patients with chronic disease stay healthy and avoid ER visits and hospitalizations</td>
<td>• No payment for phone calls, nurse care managers</td>
<td>• Condition-based payment for chronic disease patients with flexibility for proactive care mgt</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>• Avoid hospital admission by spending more time planning discharge to community</td>
<td>• Only one E&amp;M code can be billed per day, even though patient Tx &amp; d/c each take time</td>
<td>• ER management fee with P4P for low admit rates</td>
</tr>
<tr>
<td>Oncology</td>
<td>• Reduce ER visits and admissions for dehydration</td>
<td>• No flexibility to spend more on preventive care</td>
<td>• Risk-adjusted global payment</td>
</tr>
<tr>
<td></td>
<td>• Reduce anti-emetic drug costs</td>
<td>• Payment based on office visits, not outcomes</td>
<td>• Condition-based payment including non-oncolytic Rx and ED/hospital utilization</td>
</tr>
<tr>
<td>Radiology</td>
<td>• Reduce use of high-cost imaging</td>
<td>• Low payment for reading images &amp; penalty for 2x</td>
<td>• Global payment for imaging costs</td>
</tr>
<tr>
<td></td>
<td>• Improve diagnostic speed &amp; accuracy</td>
<td>• Inability to change inapprop. orders</td>
<td>• Partnership in condition-based payments</td>
</tr>
</tbody>
</table>
You Can’t Control Total Costs Without Involving All Specialties

<table>
<thead>
<tr>
<th>Medical Condition</th>
<th>Savings for Medicare</th>
<th>TODAY</th>
<th>FUTURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart/Circulatory Conditions (23%)</td>
<td>Fewer Avoidable Hospitalizations</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fewer Complications</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fewer Infections, Complications, Reduce Cost of Treatments</td>
<td></td>
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<tr>
<td></td>
<td>Fewer Avoidable Hospitalizations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Illness (4%)</td>
<td>Due to Psychiatry, PCPs, Emergency Medicine, General Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trauma (6%)</td>
<td>Due to Neurology Neurosurgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brain and Nervous System (7%)</td>
<td>Due to Endocrinology, Primary Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes, Endocrine (8%)</td>
<td>Due to Endocrinology, Primary Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Joints, Back, Bones (8%)</td>
<td>Due to Orthopedics, Primary Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>COPD, Asthma, Pneumonia (9%)</td>
<td>Due to Pulmonology, Primary Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer (12%)</td>
<td>Due to Oncology, Radiology, Cardiology, Gastroenterology, Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Conditions (23%)</td>
<td>Due to Dermatology, Gastroenterology, Ophthalmology, Nephrology, Others</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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Four Things Needed For Win-Win-Win-Win Solutions

1. **Defining the Change in Care Delivery**
   - How can the physician, hospital, or other provider change the way care is delivered to reduce costs without harming patients?

2. **Analyzing Expected Costs and Savings**
   - What will there be less of, and how much does that save?
   - What will there be more of, and how much does that cost?
   - Will the savings offset the costs on average?
   - How much variation in costs and savings is likely?

3. **Designing a Payment Model That Supports Change**
   - Flexibility to change the way care is delivered
   - Accountability for costs and quality/outcomes related to care
   - Adequate payment to cover lowest-achievable costs
   - Protection for the provider from insurance risk

4. **Compensating Physicians Appropriately**
   - Changing payment to the provider *organization* (physician practice/group/IPA/health system) does not automatically change compensation to *physicians*
Should Physicians Fear the Risks of New Payment Models?

**Risks Under Payment Reform**

- How much will your practice expenses increase?
- How many patients will you have?
- Will your patients need more services than the available revenue?
- Will the episode or global payment amount be adequate to cover costs?
- Will risk adjustment be adequate to control for differences in need?
- What unexpected services will have to be provided to meet patient need?
- What portion of payments will be withheld based on quality?
- How will you control the costs of other providers involved in the care?
It’s Not *More* Risk, It’s Just *Different* Risk

<table>
<thead>
<tr>
<th>Risks Under FFS</th>
<th>Risks Under Payment Reform</th>
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<tr>
<td>• Will your patients need enough services to cover practice expense?</td>
<td>• Will your patients need more services than the available revenue?</td>
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<tr>
<td>• Will fee levels from payers be adequate to cover costs?</td>
<td>• Will the episode or global payment amount be adequate to cover costs?</td>
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<td>• What utilization controls will payers impose?</td>
<td>• Will risk adjustment be adequate to control for differences in need?</td>
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<tr>
<td>• Which services that patients need won’t be reimbursed by payers?</td>
<td>• What unexpected services will have to be provided to meet patient need?</td>
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<tr>
<td>• What P4P penalties will be imposed based on quality measures?</td>
<td>• What portion of payments will be withheld based on quality?</td>
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<td>• What P4P penalties will be imposed based on “efficiency” measures?</td>
<td>• How will you control the costs of other providers involved in the care?</td>
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Accountability Must Be Focused on What Each Specialty Can Influence

- Spending the Physician Cannot Control
  - e.g., PCPs can’t reduce surgical site infections
  - e.g., surgeons can’t prevent diabetic foot ulcers
  - e.g., cardiologists can’t prevent (all) heart problems

- Spending the Physician Can Control or Influence
  - e.g., PCPs can help patients manage diabetes and monitor blood pressure
  - e.g., surgeons can reduce surgical site infections
  - e.g., cardiologists can help patients choose the best care for their heart problems
Physicians Need Protections From Insurance Risk

• Two Major Types of Risk
  – Insurance Risk: Whether patients will have a health condition
  – Performance Risk: How much it costs to treat that health condition

• How Do You Separate Insurance & Performance Risk?
  – Risk/Severity adjustment of payment
  – Risk corridors in case costs were mis-estimated
  – Outlier payments for unusually expensive patients
  – Risk exclusions for some patient populations or situations where costs can’t reasonably be controlled by the physician
The Right Way and Wrong Way To Define Payment Reforms

THE WRONG WAY
(BUT THE DOMINANT MODE TODAY)

Medicare and Health Plans Define Payment Systems

Physicians Have To Change Care to Align With Payment Systems

Patients and Physicians May Not Come Out Ahead
The Right Way and Wrong Way To Define Payment Reforms

THE WRONG WAY
(BUT THE DOMINANT MODE TODAY)

Medicare and Health Plans Define Payment Systems → Physicians Have To Change Care to Align With Payment Systems → Patients and Physicians May Not Come Out Ahead

THE RIGHT WAY
(REQUIRES PHYSICIAN LEADERSHIP)

Physicians Redesign Care and Identify Payment Barriers → Payers Change Payment to Support Redesigned Care → Patients Get Better Care and Physicians Stay Financially Viable
What Skills Do Physicians Need to Take Accountability for Cost/Value?

Physician Practice

Hospital Admits
Patient
Unneeded Testing
Resources/Capabilities Needed for PCPs to Take Accountability

- 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

Physician Practice

Patient

Hospital Admits

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

- Data and analytics to measure and monitor utilization and quality
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- Physician Practice
- Hospital Admits
- Patient
- Unneeded Testing
Medical Home Initiatives Expand PCP Capacity, But Not Enough

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<tr>
<th>Patient-Centered Medical Home</th>
<th>Health Plan</th>
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- **Hospital Admits**
- **Patient**
- **Unneeded Testing**
Goal: Give Doctors the Capacity to Deliver “Accountable Care”

Physician Practice + Partners = ACO

- Data and analytics to measure and monitor utilization and quality
- Coordinated relationships with other specialists and hospitals
- Capability for tracking patient care and ensuring followup (e.g., registry)
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Hospital Admits

Patient

Unneeded Testing
Redesigning Care Delivery to Respond to Better Payment
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<td>Payment is made regardless of quality of care delivered by the practice</td>
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<td>Where is quality weakest, and how should services be redesigned to improve?</td>
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# Redesigning Care Delivery to Respond to Better Payment

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<td>Payment is made regardless of utilization of services outside the practice</td>
<td>Revenues will be higher if utilization/costs for services outside the practice are lower</td>
<td>Which extra services and which types of referrals will result in reductions in total cost of care?</td>
</tr>
</tbody>
</table>
Accountable Payment Requires
ROI Analysis & Targeting

• **Return on Investment (ROI; Cost-Effectiveness)**
  – Cost of intervention
    vs.
  – Savings from reduced utilization

• **Timeframe for Return**
  – Short-term: readmission, ER reduction, complex patients
  – Long-term: prevention, early-stage chronic disease patients

• **Targeting Services/Patient Segmentation**
  – Focusing additional services on high-utilization patients
    vs.
  – Providing services to all patients as a general “benefit”
Not Just PCPs, But The Medical Neighborhood, Too

Primary Care Medical Home

(Non-Primary Care) Specialists

PATIENT
Doctors Need to Communicate In Order to Coordinate

• Failures in care coordination are common and can create serious quality concerns. Bodenheimer NEJM 2008

• For referred patients:
  – 68% of specialists reported receiving no information from the primary care provider prior to referral visits:
  – 25% of primary care providers had received no information from specialists 4 weeks after referral visits:
  – 28% of primary care and 43% of specialists are dissatisfied with the information they receive from each other.

• 25%-50% of referring physicians did not know if patients had seen a specialist

Thanks to Carol Greenlee, MD for the references and her leadership in encouraging the Medical Neighborhood concept
Payment Reform Has to Support Communication/Coordination

Resources & Incentives for More Coordinated Care

Primary Care Medical Home

FFS Payment Based on Volume, Procedures, & Office Visits

(Non-Primary Care) Specialists

PATIENT
Pay Both PCPs & Specialists for Outcomes & Coordination

Resources & Incentives for More Coordinated Care

Primary Care Medical Home

Payment for Consultation w/ PCP; Outcomes-Based Payment

(Non-Primary Care) Specialists

PATIENT
Minnesota’s DIAMOND Initiative

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

http://www.icsi.org/health_care_redesign_/diamond_35953/
Can Small Physician Practices Manage Accountable Payments?

- **Inadequate Scale to Support Infrastructure/Services**
  - Small physician practices may not have enough patients to justify staff or other services to coordinate care, particularly for patients with complex illnesses (e.g., nurse care managers, patient registries, etc.)

- **Vulnerability to Variation in Patient Needs and Costs**
  - With small numbers of patients, a single outlier patient can cause costs to increase significantly

Better Patient Outcomes & Lower Cost
One Approach: Physicians Work for Hospitals/Health Systems

- **Economies of Scale in Infrastructure/Services**
  - In a larger health system, physicians can share staff and data systems to coordinate care, particularly for patients with complex illnesses (e.g., nurse care managers, patient registries, etc.)

- **Manageable Variation in Patient Needs and Costs**
  - With a larger number of patients in the health system, the costs of outlier patients can more easily be managed

Better Patient Outcomes & Lower Cost?
Independent Practice Associations Can Also Overcome the Barriers

• **Economies of Scale in Infrastructure/Services**
  – Through the IPA, small physician practices can share staff and data systems to coordinate care, particularly for patients with complex illnesses (e.g., nurse care managers, patient registries, etc.)

• **Manageable Variation in Patient Needs and Costs**
  – With a larger number of patients in the IPA, the costs of outlier patients can more easily be managed

Better Patient Outcomes & Lower Cost
Small, Independent Practices Work Together to Manage Global Pmt

• Small Primary Care Practices Managing Global Payments
  – Physician Health Partners (PHP) in Denver, CO is a management services organization that supports four separate IPAs (median size: 3 docs/practice). PHP accepts capitated risk-based contracts on behalf of the IPAs with both Medicare and commercial HMOs.  www.phpmcs.com

• Independent PCPs & Specialists Managing Global Payments
  – Northwest Physicians Network (NPN) in Tacoma, WA is an IPA with 109 PCPs and 345 specialists in 165 practices (average size: 2.4 physicians/practice). NPN accepts full or partial risk capitation contracts, operates its own Medicare Advantage plan, and does third party administration for self-insured businesses.  www.npnwa.net

• Joint Contracting by Physicians & Hospitals for Global Payments
  – The Mount Auburn Cambridge IPA (MACIPA) and Mount Auburn Hospital jointly contract with three major Boston-area health plans for full-risk capitation. The IPA is independent of the hospital; they coordinate care with each other without any formal legal structure.  www.macipa.com
How Many Patients Do You (Really) Need to (Successfully) Manage the Risk of Accountable Payments?
For Most Employees, the Employer is the Insurer, Not a Health Plan

60% of Workers with Employer-Sponsored Insurance are now in Self-Insured Plans

Source: Employer Health Benefits 2012 Annual Survey. The Kaiser Family Foundation and Health Research and Educational Trust
For Self-Funded Employers, The Health Plan is Just a Pass Through

Self-Funded Purchasers  \[\xrightarrow{\text{Purchaser Payment}}\]  ASO Health Plan (No Risk)  \[\xleftarrow{\text{Provider Claims}}\]  Providers
Even Small Employers Are Increasingly Self-Insured

Sources:
Most Businesses With 200-1,000 Employees Take Total Cost Risk

Percentage of Workers With Employer-Sponsored Insurance Who Are in Partially or Completely Self-Funded Plans, 2012

- **All Firms**
- **5,000 or More**
- **1,000-4,999**
- **200-999**
- **50-199**
- **0-49**

Sources:
- Employer Health Benefits 2012 Annual Survey, The Kaiser Family Foundation and Health Research and Educational Trust;
- State-Level Trends in Employer-Sponsored Health Insurance, April 2013, State Health Access Data Assistance Center and Robert Wood Johnson Foundation

Fewer employees than typical physician practice panel size
The Keys to Managing Risk

• How Do Small Employers Manage Self-Insurance Risk?
  – They know who their employees are and can estimate spending
  – They start with what they spent last year and try to control growth
  – They have reserves to cover year-to-year variation
  – They purchase stop-loss insurance to cover unusually expensive cases
The Keys to Managing Risk

• **How Do Small Employers Manage Self-Insurance Risk?**
  – They know who their employees are and can estimate spending
  – They start with what they spent last year and try to control growth
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• **How Would Small Physician Practices/IPAs Manage Risk?**
  – They need to know who their patients are in order to project spending
  – They need to start with last year’s payments and control growth
  – They need some reserves to cover year-to-year variation
  – They need to purchase stop-loss insurance to cover unusually expensive cases
# Building the Capabilities to Manage Accountable Payment Models

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<th>BARRIER</th>
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<td>1. Know who your patients are</td>
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<td></td>
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<tr>
<td>2. Start with last year’s spending and control growth</td>
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<td>3. Have reserves to cover year-to-year variation</td>
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<td>1. Know who your patients are</td>
<td>PPO health plans don’t require patients to designate PCPs or use a consistent set of physicians for care</td>
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The Limited Choices We Give Consumers/Patients Today

ROCK

CONSUMERS/PATIENTS CAN CHANGE OR USE MULTIPLE PROVIDERS AT WILL

HARD PLACE

CONSUMERS/PATIENTS ARE "LOCKED IN" TO A SINGLE GATEKEEPER PROVIDER
Creating a Middle Ground to Support the Medical Home/ACO

**ROCK**
- Consumers/Patients can change or use multiple providers at will

**MIDDLE GROUND**
- Consumers/Patients are encouraged to choose & use an ACO or Medical Home

**HARD PLACE**
- Consumers/Patients are “locked in” to a single gatekeeper provider

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Do Patients Need $ Incentives Or Better Care to Use an ACO/PCMH?

**ROCK**

CONSUMERS/PATIENTS CAN CHANGE OR USE MULTIPLE PROVIDERS AT WILL

**MIDDLE GROUND**

CONSUMERS/PATIENTS ARE ENCOURAGED TO CHOOSE & USE AN ACO OR MEDICAL HOME

**HARD PLACE**

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

**OPTION 1:** Charge patients more for using providers outside the ACO or medical home

**OPTION 2:** Give patients high quality, coordinated care so they will voluntarily choose to designate a medical home and use the ACO physicians
Will Patients Voluntarily Limit Their Choices?
Do You Have One of These?
Apps Can Only Be Purchased Through the Apple Store
Owners Will Live With a Battery They Can’t Replace
Patients Will Limit Choices if They Get Truly Well-Designed Service
Today: Care is Designed Around the Provider, Not the Patient

- PATIENT
- PCP OFFICE/MEDICAL HOME
- SPECIALIST OFFICE
- LAB FOR TESTING
Today: Many Barriers to Patient Adherence & Care Coordination

- Lack of Transportation
- Multiple Days Off Work
- Services Unavailable or Not Affordable

NON-MEDICAL SUPPORT (e.g., weight loss)

PCP OFFICE/ MEDICAL HOME

SPECIALIST OFFICE

LAB FOR TESTING
Is It Any Wonder The Patients Gravitate to More Convenience?

- PATIENT
  - EMERGENCY ROOM
  - URGENT CARE CENTER
  - PCP OFFICE/ MEDICAL HOME
  - SPECIALIST OFFICE
  - LAB FOR TESTING
  - NON-MEDICAL SUPPORT (e.g., weight loss)
Or That Employers Are Trying to Create Their Own Systems?
Flexible Payment Allows More Radical Redesign of Care Delivery

Flexible, Accountable Payment

PATIENT

PCP OFFICE

WORK-SITE CLINIC

SNF/ASSISTED LIVING CLINIC

URGENT CARE CENTER

LAB FOR TESTING

NON-MEDICAL SUPPORT

SPECIALIST SUPPORT

EMERGENCY ROOM

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For Businesses, It’s Not Just Healthcare Costs, But *Productivity*

- Economic Burden of Disease
- Total Healthcare Costs
- Physician Fees
  - Specialty Fees
  - PCP Fees
  - Hospital Costs
  - Drug Costs
  - Patient Time Off Work

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Employers May Pay More for Improved Employee Productivity

- Economic Burden of Disease
- Total Healthcare Costs
- Physician Fees

- Patient Time Off Work
- Hospital Costs
- Drug Costs
- Specialty Fees
- PCP Fees

- Increased employee productivity
- Increased physician revenue
# Building the Capabilities to Manage Accountable Payment Models

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<td>None – insurance companies offer this and many capitated IPAs and groups buy it</td>
<td>Factor the cost of stop-loss insurance into costs of managing care for patients</td>
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This All Sounds Really Hard
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Can’t We Just Keep Doing What We’re Doing Today Until We Retire?
The Opportunities to Reduce Costs Without Rationing Are Widely Known

- Reducing Hospital Readmissions
- Helping Patients with Chronic Disease Stay Out of Hospital
- Reducing Overutilization of Outpatient Services
- Shifting Preference-Sensitive Care to Lower-Cost Options
- Reducing the Cost of Expensive Inpatient Care
The Question is: How Will Payers Get The Savings?

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The Payer-Driven Approach to Achieving Savings

Managed Fee-for-Service

Readmission Penalty

PCP P4P

High Deductibles

Prior Authorization

Narrow Networks

Tiering on Cost

Reducing Hospital Readmissions

Helping Patients with Chronic Disease Stay Out of Hospital

Reducing Overutilization of Outpatient Services

Shifting Preference-Sensitive Care to Lower-Cost Options

Reducing the Cost of Expensive Inpatient Care

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The Provider-Driven Approach to Achieving Savings

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PAYER

Global Pmt/Budget

Coordinated Care/Accountable Care Organization
Very Different Models…

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PAYER

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Reducing the Cost of Expensive Inpatient Care

Coordinated Care/Accountable Care Organization
…And Very Different Impacts on Physicians and Hospitals

**Managed Fee-for-Service**

1. Payer defines how care should be redesigned
2. Payer obtains all savings from lower utilization
3. Payer decides how much savings to share with provider

**Global Pmt/Budget**

1. Provider determines how care should be redesigned
2. Provider and Purchaser or Payer agree on adequate price for provider care and amount of savings for payer
3. Provider gets to keep any additional savings and to determine how to divide it
Opportunities From Completely Redesigning Payment & Delivery

- **Better Payment for Physicians**
  - No threats of major fee cuts
  - No health plan/benefit manager utilization review
  - Physicians paid based on quality, not volume

- **Truly High Quality, Patient-Centric Care**
  - Coordinated care by multiple physicians
  - Care mgt from physician practices, not health plans or disease mgt co’s
  - Flexibility for telephone, internet, & home visits if patients need them

- **Greater Patient Engagement**
  - Zero or low copayments for essential medications and services
  - Higher cost-sharing for unnecessary tests and services
  - Incentives for patient wellness and adherence

- **Less Spending on Administrative Costs**
  - Less spending for health plan administrative costs and profits
  - Less spending by physicians on payer-imposed administrative costs

- **Lower Government Spending and Smaller Deficits**

- **Better Health for Citizens and More Affordable Insurance**
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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