MAKING HEALTH REFORM WORK
How Western New York Can Lead the Nation in Controlling Costs & Improving Quality

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

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

President Obama
September 2010
Medicare+Medicaid is largest driver of future federal spending.
Federal Cost Containment Policy Choices

MEDICARE SPENDING = SERVICES TO SENIORS × FEES TO PROVIDERS
If It’s A Choice of Rationing or Rate Cuts, Which is More Likely?

MEDICARE SPENDING = SERVICES TO SENIORS \times FEES TO PROVIDERS

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

Physician Practice Costs

Physician Payment Increases

If Sustainable Growth Rate Cut Is Made

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Past Solutions: Cost-Shifting Gov’t Cuts to Private Payers

Hospital Payment-to-Cost Ratios for Private Payers, Medicare, and Medicaid, 1988 – 2008

Source: Avalere Health analysis of American Hospital Association Annual Survey data, 2008, for community hospitals.
Huge Increases in Costs for Both Employers & Workers

Average Annual Contributions to Health Insurance Premiums
1999-2010

- Employer Contribution
- Worker Contribution

Employee Contribution
- More Than Doubled
- Nearly Tripled

Employer Contribution
- $318 to $899
- $1,878 to $4,150
- $3,997

Employee Contribution
- $899
- $4,150
- $1,543
- $3,997

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

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

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Health Care Costs Have Wiped Out Real Income Gains

Monthly Income for Typical U.S. Family of Four

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

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

It Can’t Be Done from Washington...

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

Healthy Consumer ➔ Continued Health ➔ Health Condition ➔ No Hospitalization ➔ Acute Care Episode
Reducing Costs Without Rationing: Efficient, Successful Treatment

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

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

Healthy Consumer → Continued Health → No Hospitalization → Efficient Successful Outcome

- Health Condition
- Acute Care Episode
- Complications, Infections, Readmissions

Better Outcomes/Higher Quality

Healthy Consumer

Continued Health

No Hospitalization

Efficient Successful Outcome

High-Cost Successful Outcome

Complications, Infections, Readmissions
Functions Needed for Regional Healthcare Reform

1 4

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Lack of Actionable Information About Utilization/Costs

• Barrier:
  – Most physician practices don’t know if they have high rates of preventable hospitalizations, complications, etc.
  – PCPs typically don’t even know if their patients go to the ER or are hospitalized
  – Prices of facilities and treatments are secret or impossible to compare
Turn Reams of Data Into Timely, Useable Information

• Barrier:
  – Most physician practices don’t know if they have high rates of preventable hospitalizations, complications, etc.
  – PCPs typically don’t even know if their patients go to the ER or are hospitalized
  – Prices of facilities and treatments are secret or impossible to compare

• Solution:
  – Analyze data to help physicians find opportunities for cost savings & quality improvement
  – Provide real-time performance measurement to support continuous quality improvement
How Is Western New York Doing?

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

Efficient Successful Outcome
- High-Cost Successful Outcome
- Complications, Infections, Readmissions
8th Highest Rate of ER Usage Among 40 Large Regions
5th Highest Rate of Surgeries Among 40 Large Regions

Surgeries Per 1,000 Population, 2008
Overuse of Hospitals?  
Or an Older/Sicker Population?
For Medicare Recipients, Spending Is Below Average

Total Medicare Reimbursements per Enrollee (Parts A and B) (2008)
Age, Sex, and Price Adjusted
Below-Average Rates of Surgery for Most Things

Rates of Surgery for Medicare Beneficiaries, Buffalo vs. U.S., 2007

- All Surgery
- PCI (Stent)
- Bypass Surgery
- Knee Replacement
- Hip Replacement
Above Average Rates of Hospitalization for Chronic Disease

Rates of Hospitalization for Medicare Beneficiaries
Buffalo vs. U.S., 2007

All Medical Discharges
Pneumonia
Asthma
COPD
Congestive Heart Failure
Diabetes

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Overuse of Hospitals?
Or an Older/Sicker Population?
Seniors in Buffalo Are Sicker Than in Other Regions

% Medicare Beneficiaries with Health Problems, Buffalo vs. U.S., 2008

- COPD
- Chronic Kidney Disease
- Heart Failure
- Diabetes
- Heart Disease

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Healthcare Spending Is Highly Correlated with Health of Residents

Lower Spending Per Patient

Healthier Patients

Average Medicare Spending vs. Average Beneficiary Health Status,
Hospital Referral Regions, 2008

McAllen, TX

Grand Junction

Average HCC Risk Score for Medicare Beneficiaries in Region

Standardized Total Cost Per Beneficiary

$16,000

$15,000

$14,000

$13,000

$12,000

$11,000

$10,000

$9,000

$8,000

$7,000

$6,000

$5,000

0.90

1.00

1.10

1.20

1.30

1.40

1.50

1.60
Spending is Low in Buffalo Relative to Illness Level of Residents

Lower Spending Per Patient

Healthier Patients
25% of Chronic Disease Patients Rehospitalized Within 30 Days

30-Day Readmission Rates for Congestive Heart Failure

- KALEIDA HEALTH
- NIAGARA FALLS MEMORIAL MEDICAL CENTER
- EASTERN NIAGARA HOSPITAL
- WESTERN NY VA HEALTHCARE SYSTEM
- ERIE COUNTY MEDICAL CENTER
- SISTERS OF CHARITY HOSPITAL
- BERTRAND CHAFFEE HOSPITAL
- MOUNT ST MARY’S HOSPITAL AND HEALTH CENTER
- KENMORE MERCY HOSPITAL
Higher Rates of Hospital Adverse Events in Buffalo

Rate of Adverse Events, Medicare Patients, Buffalo vs. U.S., 2008

- Bedsore, Age 65-74
- Post-Op PE/DVT, Age 65-74
- Post-Op Sepsis, Age 65-74
- Bedsore, Age 75+
- Post-Op PE/DVT, Age 75+
- Post-Op Sepsis, Age 75+

Red = Buffalo
Blue = U.S.
What About Younger Patients?
Over 1/3 of Births in NY State Are Now Delivered by C-Section
Some Western NY Counties Have Even Higher Rates
Significant Savings Opportunities For Younger Chronic Disease Pts

State Level Average Episode Cost --- Diabetes

- Potentially Avoidable Complications
- "Typical" Care

40%+ of diabetes care costs in every state are "Potentially Avoidable"

Source: Health Care Incentives Improvement Institute
Many Opportunities to Reduce Costs w/o Rationing in Western NY

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

High-Cost Successful Outcome

Complications, Infections, Readmissions
Functions Needed for Regional Healthcare Reform

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Analysis & Reporting is #1

Quality/Cost Analysis & Reporting

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2
Who Should Be Accountable For Achieving Higher Value Care?

• Health Plans?
• Hospitals?
Physicians are at the Core of “Accountable Care”

- **Healthy Consumer**
  - Continued Health
  - No Hospitalization
  - Efficient Successful Outcome
  - Acute Care Provider #1
    - High-Cost Successful Outcome
    - Complications, Infections, Readmissions
  - Acute Care Provider #2
  - Acute Care Provider #3

- **Health Condition**
  - PRIMARY CARE + SPECIALISTS
Accountability Requires New and Improved Skills & Relationships

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

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

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

Physician Practice

? 

Patient

Unneeded Testing

Inpatient Episodes
Resources/Capabilities Needed for Doctors 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
Capabilities Exist Today, But Don’t Coordinate w/ Physicians

- 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)
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- Physician w/ time for diagnosis, treatment planning, and followup

Health Plan or Disease Mgt Vendor

Physician Practice

Inpatient Episodes

Patient

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

Health Plan

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

Patient-Centered Medical Home

- Physician w/ time for diagnosis, treatment planning, and followup

Patient

- Inpatient Episodes
- Unneeded Testing

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Accountable Care Requires ROI Analysis & Targeting

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

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

• **Targeting Services/Patient Segmentation**
  – Focusing additional services on high-utilization patients
    vs.
  – Providing services to all patients as a general “benefit”
Goal: Give Physicians the Capacity to Deliver “Accountable Care”

Physician Practice + Partners = ACO

- Data and analytics to measure and monitor utilization and quality
- Capabilities for tracking patient care and ensuring followup (e.g., registry)
- Method for targeting high-risk patients (e.g., predictive modeling)
- Resources for patient education and self-management support (e.g., RN care manager)
- Physician with time for diagnosis, treatment planning, and followup

Patient

Unneeded Testing

Inpatient Episodes
#2 Is Redesigning Care for Better Outcomes & More Efficiency

Quality/Cost Analysis & Reporting

Value-Driven Delivery Systems

4

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

Quality/Cost Analysis & Reporting

Value-Driven Delivery Systems

4

3
Providers in Regions With Data Analysis Capacity Will Be Ahead

Welcome to My Quality Counts!

Through a pilot program granted to the Western New York Quality Measurement Collaborative and funded by the New York State Department of Health, primary care physicians in the region's eight counties now have access to their own aggregated quality measures reports.

This website provides a secure log-in site for internists, family practitioners, med/peds and pediatricians looking to access their My Quality Counts! quality measures report. This first My Quality Counts! report reflects months of work by stakeholders throughout the community who came together to develop a reporting process that is expected, over time, to provide data to empower providers to create sustainable, quality improvement initiatives within their practices.

But this report is only a first step on the journey to a healthy Western New York. We need your input today to ensure that the aggregated data posted in your password-protected report reflects, to a reasonable degree, the results of certain health care quality measures within your practice during calendar year 2008.

If you wish to receive patient-level data that supports your aggregated quality report, please print and fax back a fully-executed copy of the Business Associates Agreement available within the report portal to the My Quality Counts! Physician Services at (716) 218-1738. Please call My Quality Counts! at (716) 541-0299. If you would like to have any other questions answered about the report.

Have questions? Contact My Quality Counts! at (716) 541-0299.

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Current Payment Systems Reward Bad Outcomes, Not Better Health

Healthy Consumer

Continued Health

Health Condition

No Hospitalization

Acute Care Episode

Efficient Successful Outcome

High-Cost Successful Outcome

Complications, Infections, Readmissions
Better Payment Systems is #3

Quality/Cost Analysis & Reporting

Value-Driven Payment Systems

Value-Driven Delivery Systems
“Episode Payments” to Reward Value Within Episodes

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

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

Efficient Successful Outcome:
- High-Cost Successful Outcome
- Complications, Infections, Readmissions

$
Yes, a Health Care Provider Can Offer a Warranty

Geisinger Health System ProvenCare℠

– A single payment for an ENTIRE 90 day period including:
  • ALL related pre-admission care
  • ALL inpatient physician and hospital services
  • ALL related post-acute care
  • ALL care for any related complications or readmissions

– Types of conditions/treatments currently offered:
  • Cardiac Bypass Surgery
  • Cardiac Stents
  • Cataract Surgery
  • Total Hip Replacement
  • Bariatric Surgery
  • Perinatal Care
  • Low Back Pain
  • Treatment of Chronic Kidney Disease
# ProvenCare® CABG Quality Clinical Outcomes - (18. mos)

<table>
<thead>
<tr>
<th></th>
<th>Before ProvenCare (n=132)</th>
<th>With ProvenCare (n=181)</th>
<th>% Improvement/Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>In hospital mortality</td>
<td>1.5 %</td>
<td>0 %</td>
<td>21 %</td>
</tr>
<tr>
<td>Patients with any complication (STS)</td>
<td>38 %</td>
<td>30 %</td>
<td>28 %</td>
</tr>
<tr>
<td>Patients with &gt;1 complication</td>
<td>7.6 %</td>
<td>5.5 %</td>
<td>17 %</td>
</tr>
<tr>
<td>Atrial fibrillation</td>
<td>23 %</td>
<td>19 %</td>
<td>60 %</td>
</tr>
<tr>
<td>Neurologic complication</td>
<td>1.5 %</td>
<td>0.6 %</td>
<td>43 %</td>
</tr>
<tr>
<td>Any pulmonary complication</td>
<td>7 %</td>
<td>4 %</td>
<td>22 %</td>
</tr>
<tr>
<td>Blood products used</td>
<td>23 %</td>
<td>18 %</td>
<td>55 %</td>
</tr>
<tr>
<td>Re-operation for bleeding</td>
<td>3.8 %</td>
<td>1.7 %</td>
<td>25 %</td>
</tr>
<tr>
<td>Deep sternal wound infection</td>
<td>0.8 %</td>
<td>0.6 %</td>
<td></td>
</tr>
<tr>
<td>Readmission within 30 days</td>
<td>6.9 %</td>
<td>3.8 %</td>
<td>44 %</td>
</tr>
</tbody>
</table>
It Can Be Done By Physicians, Not Just Health Systems

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

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

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

A Warranty is Not an Outcome Guarantee

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

| Cost of Procedure | $10,000 |
Actual Average Payment for Procedure is Higher

<table>
<thead>
<tr>
<th>Cost of Procedure</th>
<th>Added Cost of Infection</th>
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<td>$20,000</td>
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## Starting Point for Warranty Price: Actual Current Average Payment

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Limited Warranty Gives Financial Incentive to Improve Quality

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<tr>
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<td>$20,000</td>
<td>4%</td>
<td>$10,800</td>
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Reducing Adverse Events…
...Reduces Costs...
…Improves The Bottom Line
Higher-Quality Provider Can Charge Less, Get More Patients

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

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Reducing Adverse Events...

...Reduces Costs...

...Improves The Bottom Line
### Win-Win-Win for Patients, Payers, and Providers

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

**...Cost is Lower...**

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

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

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

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

Healthy Consumer → Continued Health

Health Condition → No Hospitalization

Acute Care Episode → Efficient Successful Outcome

High-Cost Successful Outcome
Complications, Infections, Readmissions

$ A Single Payment For All Care Needed For A Condition

Comprehensive Care Payment or “Global” Payment
Significant Reduction in Rate of Hospitalizations Possible

Examples:

• 40% reduction in hospital admissions, 41% reduction in ER visits for exacerbations of COPD using in-home & phone patient education by nurses or respiratory therapists
  

• 66% reduction in hospitalizations for CHF patients using home-based telemonitoring
  
  M.E. Cordisco, A. Benjaminovitz, et al, “Use of Telemonitoring to Decrease the Rate of Hospitalization in Patients With Severe Congestive Heart Failure,” *American Journal of Cardiology* 84(7), 1999

• 27% reduction in hospital admissions, 21% reduction in ER visits through self-management education
  
We Don’t Pay for the Things That Will Prevent Overutilization

CURRENT PAYMENT SYSTEMS

Health Insurance Plan

Physician Practice

Office Visits
- Phone Calls
- Nurse Care Mgr

ER Visits
- Avoidable

Lab Work/Imaging
- Avoidable

Hospital Stay
- Avoidable

No payment for services that can prevent utilization...

...No penalty or reward for high utilization elsewhere
Comprehensive Care Payment Provides Flexibility + Accountability

FULL COMP. CARE/GLOBAL PAYMENT

Health Insurance Plan

Condition-Adjusted Per Person Payment

Physician Practice/ACO

Office Visits

Phone Calls

Nurse Care Mgr

ER Visits

Lab Work/Imaging

Hospital Stay

Avoidable

Avoidable

Avoidable

Flexibility and accountability for a condition-adjusted budget covering all services
Example: BCBS Massachusetts Alternative Quality Contract

• Single payment for all costs of care for a population of patients
  – Adjusted up/down annually based on severity of patient conditions
  – Initial payment set based on past expenditures, not arbitrary estimates
  – Provides flexibility to pay for new/different services
  – Bonus paid for high quality care

• Five-year contract
  – Savings for payer achieved by controlling increases in costs
  – Provider can reap returns on investment in prevention, infrastructure

• Analytic support to identify opportunities & monitor progress

• Broad participation
  – 14 physician groups/health systems participating with over 400,000 patients, including one primary care IPA with 72 physicians

• Positive first-year results
  – Higher ambulatory care quality than non-AQC practices, better patient outcomes, lower readmission rates and ER utilization

Comprehensive Care Payment Is Also A Big Change from FFS

FULL COMP. CARE/GLOBAL PAYMENT

Health Insurance Plan

Condition-Adjusted Per Person Payment

$  

Physician Practice/ACO

Office Visits
Phone Calls
Nurse Care Mgr

ER Visits
Lab Work/Imaging

Hospital Stay

Avoidable
Avoidable
Avoidable

Flexibility and accountability for a condition-adjusted budget covering all services
Transitional Approach: Some Flexibility + Some Accountability

CARE MGT PAYMENT + UTILIZATION P4P

Health Insurance Plan

Physician Practice

Office Visits

Monthly Care Mgt Payment

Phone Calls

RN Care Mgr

ER Visits

Lab Work/Imaging

Hospital Stay

Avoidable

Avoidable

Avoidable

Targets for Reduction In Utilization

P4P Bonus/Penalty Based on Utilization

More $ for PCP

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Example: Washington State Medical Home Pilot Program

• **4-Part Payment Model**
  – Current FFS payments for PCP services
  – Additional PMPM payment for “care management”
    • $2.50 per patient per month in Year 1 (part of year)
    • $2.00 per patient per month in Years 2 & 3
    • No restrictions on how money is used
  – **Targets for Reducing Preventable ER/Hospital Utilization**
    • Reduction targets large enough to repay health plans for upfront payments
    • Penalty for failure: Repayment of up to 50% of PMPM payment
  – **Bonus for success in reducing utilization beyond targets**
    • 50/50 split of payers’ savings from reductions in ER visits and/or hospitalizations net of PMPM payment
    • Quality of care must be maintained based on quality measures

• **Implementation Began May 2011**
  – 7 health plans (5 commercial, 2 Medicaid)
  – 12 primary care practice sites (8 provider orgs), ~ 25,000 patients
Better Payment Systems Require Good Quality Measurement

• Concern: Giving healthcare providers more accountability for costs reduces the incentives for overuse, but raises concerns about whether patients will get too little care
Better Payment Systems Require Good Quality Measurement

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

• Concern: Giving healthcare providers more accountability for costs reduces the incentives for overuse, but raises concerns about whether patients will get too little care

• Solution: Measure healthcare quality and include incentives for providers to maintain/improve quality as well as reduce costs

• Ideal: Develop quality measures with participation of physicians and hospitals, as a growing number of regions do

Massachusetts Health Quality Partners
Medical Groups Summary: Depression Care for Adults

Wisconsin Collaborative for Healthcare Quality
Diabetes: Blood Sugar (A1c) Control (HbA1c)
This measure assesses the care of 150,966 patients with Diabetes. More

W NY Quality Measurement Collaborative
Western New York
Quality Measurement Collaborative

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Measurement Supports Payment, As Well As Vice Versa

Quality/Cost Analysis & Reporting

4

Value-Driven Payment Systems

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

Quality/Cost Analysis & Reporting

Value-Driven Payment Systems

Value-Driven Delivery Systems
How Doctors Will Need to Change 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)
- Method for targeting high-risk patients (e.g., predictive modeling)
- Resources for patient educ. & self-mgt support (e.g., RN care mgr)
- MD w/ time for diagnosis, treatment planning, and followup

**Patient**

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

Healthy Consumer → Continued Health → No Hospitalization → Efficient Successful Outcome

Health Condition → Acute Care Episode → High-Cost Successful Outcome

Fewer Patients
Fewer Admissions
Less Revenue Per Admission
Reducing Healthcare Spending Requires Lower Hospital Spending

Hospitals are the largest component of healthcare spending and of increases in healthcare spending.
Hospital Costs Are Not Proportional to Utilization

Cost & Revenue Changes With Fewer Patients

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

#Patients

Costs

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

### Cost & Revenue Changes With Fewer Patients

<table>
<thead>
<tr>
<th>#Patients</th>
<th>Revenues</th>
<th>Costs</th>
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<tr>
<td>90</td>
<td>$800</td>
<td>$000</td>
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</tbody>
</table>

Payers Will Be Underpaying For Care If Adverse Events, Readmissions, Etc. Are Reduced
So Prices Need to Be Re-Set Under Payment Reform

Cost & Revenue Changes With Fewer Patients

Payers Can Still Save $ Without Causing Negative Margins for Hospital

#Patients

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Creating A Feasible Glide Path to the Future for Hospitals

- Different Hospitals Will Have Different Problems
  - For a hospital that’s constantly full and growing, a reduction in chronic disease admissions may be welcome, particularly since they may be less profitable than elective surgery cases
  - But for small community hospitals with empty beds, and hospitals with narrow operating margins, reductions in chronic disease admissions and readmissions could cause serious financial problems, particularly in the short run
Small Hospitals Will Lose More Patients If Chronic Care Improves

In some small and rural hospitals, 1 out of every 6 patients is admitted for CHF or COPD.
Creating A Feasible Glide Path to the Future for Hospitals

• Different Hospitals Will Have Different Problems
  – For a hospital that’s constantly full and growing, a reduction in chronic disease admissions may be welcome, particularly since they may be less profitable than elective surgery cases
  – But for small community hospitals with empty beds, and hospitals with narrow operating margins, reductions in chronic disease admissions and readmissions could cause serious financial problems, particularly in the short run

• Both Hospitals and Payers Will Need to Change
  – Hospitals will need to restructure to reduce fixed costs as much as possible (close units, share services, etc.)
  – Payers will need to renegotiate payment levels to enable hospitals to remain solvent, particularly during the lengthy transition process to reduce fixed costs
What Does All This Mean for the Health Care Workforce?
Buffalo Has High Hospital Capacity Per Capita Among Large Regions
High Concentration of Hospital Employment in Buffalo/Western NY

Hospital Personnel Per 1,000 Population, 2008

- San Francisco
- Detroit
- Austin
- Las Vegas
- Riverside
- San Diego
- Phoenix
- Seattle
- Virginia Beach
- Portland
- Denver
- San Jose
- Sacramento
- San Antonio
- Raleigh
- Louisville
- Minneapolis
- Oklahoma City
- Charlotte
- Jackson
- Richmond
- Tampa
- Providence
- Orlando
- Memphis
- Nashville
- Milwaukee
- Kansas City
- Hartford
- Salt Lake City
- Cincinnati
- St. Louis
- New Orleans
- Indianapolis
- Columbus
- Baltimore
- Birmingham
- Buffalo
- Rochester
- Cleveland
Hospital Spending Growth Is Not Due to More Employees

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

- U.S. Hospital Expenditures
- U.S. Hospital Employment

Expenditures in Millions

Employment in Thousands

- 1990
- 1991
- 1992
- 1993
- 1994
- 1995
- 1996
- 1997
- 1998
- 1999
- 2000
- 2001
- 2002
- 2003
- 2004
- 2005
- 2006
- 2007
- 2008
- 2009

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What Successful Reform Means for the Healthcare Workforce

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

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

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

4?

Quality/Cost Analysis & Reporting

Value-Driven Payment Systems

Value-Driven Delivery Systems
What About The Patient?
Benefit Design Changes Are Also Critical to Success

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

Ability and Incentives to:
- Keep patients well
- Avoid unneeded services
- Deliver services efficiently
- Coordinate services with other providers
Lack of Effective Incentives for Value-Based Choice by Patients

- Copays, Co-insurance, and High Deductibles can discourage patients from getting preventive treatments they need
Example: Coordinating Pharmacy & Medical Benefits

Single-minded focus on reducing costs here...

...could result in higher spending on hospitalizations

**Pharmacy Benefits**

- Drug Costs

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

**Medical Benefits**

- Hospital Costs
- Physician Costs
- Other Services

*Principal treatment for most chronic diseases involves regular use of maintenance medication*
Lack of Effective Incentives for Value-Based Choice by Patients

- Copays, Co-insurance, and High Deductibles can discourage patients from getting preventive treatments they need.
- Copays, Co-insurance, and High Deductibles do little to encourage patients to be cost-conscious in choosing among high-cost providers and services.
Where Will You Get Your Knee Replaced?

| Knee Joint Replacement | Price #1 $23,000 | Price #2 $28,000 | Price #3 $33,000 |
## Copayment?

Use High Price Provider

### Knee Joint Replacement

<table>
<thead>
<tr>
<th>Consumer Share of Surgery Cost</th>
<th>Price #1 $23,000</th>
<th>Price #2 $28,000</th>
<th>Price #3 $33,000</th>
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<tbody>
<tr>
<td>$1,000 Copayment:</td>
<td>$1,000</td>
<td>$1,000</td>
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</table>
## Coinsurance?
### Use High Price Provider

**Knee Joint Replacement**

<table>
<thead>
<tr>
<th>Consumer Share of Surgery Cost</th>
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<th>Price #2</th>
<th>Price #3</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,000 Copayment:</td>
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<td>10% Coinsurance w/$2,000 OOP Max:</td>
<td>$2,000</td>
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</table>
## High Deductible?

**Use High Price Provider**

### Knee Joint Replacement

<table>
<thead>
<tr>
<th>Consumer Share of Surgery Cost</th>
<th>Price #1 $23,000</th>
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<td>10% Coinsurance w/$2,000 OOP Max:</td>
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<tr>
<td>$5,000 Deductible:</td>
<td>$5,000</td>
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</tr>
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</table>
**Pay the Difference in Price? Use the High-Value Provider**

**Knee Joint Replacement**

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<th>Consumer Share of Surgery Cost</th>
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<tr>
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<td>$5,000 Deductible:</td>
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<tr>
<td>Highest-Value:</td>
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</table>
Blue Cross/Blue Shield of MA Hospital Choice Cost-Share

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Low-Cost Hospitals</th>
<th>High-Cost Hospitals</th>
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<tbody>
<tr>
<td>PCP</td>
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<td>Outpatient Hospital Day Surgery</td>
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<td>High Tech Radiology</td>
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<tr>
<td>Laboratory</td>
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<td>$35</td>
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<tr>
<td>X-Rays/Other Imaging Tests</td>
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<td>$100</td>
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<tr>
<td>PT/OT/ST</td>
<td>$35</td>
<td>$70</td>
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*LOWER INPATIENT COPAY APPLIES IF EMERGENCY ADMISSION*
Both Payment & Benefits Are Controlled by the Payer

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

Payment System

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

Provider

Benefit Design

Patient
But Purchaser Support is Needed Particularly for Benefit Changes

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

Ability and Incentives to:
• Keep patients well
• Avoid unneeded services
• Deliver services efficiently
• Coordinate services with other providers
And Consumer Support is Critical for Purchaser/Plan Support

Purchaser → PAYER → Patient → Provider

Purchaser → PAYER → Benefit Design

Purchaser → PAYER → Payment System
Consumer Support is #4, And Fundamental to All

Consumer Education & Engagement

Quality/Cost/Experience Analysis & Reporting

Value-Driven Payment Systems & Benefit Designs

Value-Driven Delivery w/ Patient Participation

Consumer Support is #4, And Fundamental to All
Functions Needed for Healthcare Payment & Delivery Reform

Quality/Cost Measure Design

Quality/Cost Reporting

Cost/Price Reporting

Consumer Education/Engagement

Education Materials

Consumer Education/Engagement

Value-Driven Payment Systems

Engagement of Purchasers

Alignment of Multiple Payers

Value-Driven Delivery Systems

Technical Assistance to Providers

Design & Delivery of Care

Provider Organization/Coordination

Benefit Design

Payment System Design

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Coordinated Support Needed

WHO CAN CONNECT AND COORDINATE ALL OF THIS?

- Quality/Cost Measure Design
- Education Materials
- Consumer Education/Engagement
- Technical Assistance to Providers
- Design & Delivery of Care
- Provider Organization/Coordination
- Benefit Design
- Payment System Design
- Engagement of Purchasers
- Alignment of Multiple Payers
With Active Involvement of All Stakeholders

- Physicians & Hospitals
- Payers
- Purchasers
- Consumers

Regional Health Improvement Collaborative
Leading Health Improvement Collaboratives in the U.S.

- Albuquerque Coalition for Healthcare Quality
- Aligning Forces for Quality – South Central PA
- Alliance for Health
- Better Health Greater Cleveland
- California Cooperative Healthcare Reporting Initiative
- California Quality Collaborative
- Center for Improving Value in Health Care (Colorado)
- Finger Lakes Health Systems Agency
- Greater Detroit Area Health Council
- The Health Collaborative (Greater Cincinnati)
- Healthy Memphis Common Table
- Institute for Clinical Systems Improvement
- Integrated Healthcare Association
- Iowa Healthcare Collaborative
- Kansas City Quality Improvement Consortium
- Louisiana Health Care Quality Forum
- Maine Health Management Coalition
- Massachusetts Health Quality Partners
- Midwest Health Initiative
- Minnesota Community Measurement
- Minnesota Healthcare Value Exchange
- Nevada Partnership for Value-Driven Healthcare (HealthInsight)
- New York Quality Alliance
- Oregon Health Care Quality Corporation

**P2 Collaborative of Western New York**

- Pittsburgh Regional Health Initiative
- Puget Sound Health Alliance
- Quality Counts (Maine)
- Quality Quest for Health of Illinois
- Utah Partnership for Value-Driven Healthcare (HealthInsight)
- Wisconsin Collaborative for Healthcare Quality
- Wisconsin Healthcare Value Exchange

www.NRHI.org
How Regional Collaboratives Are Working to Support Reform

• Help in Identifying Opportunities for Savings
  – Assembling multi-payer data on utilization and costs
  – Analyzing the data in ways that are actionable for docs

• Building Consensus on Payment Reforms
  – Reaching agreement among physicians, hospitals, employers, health plan, and consumers on payment reform
  – Encouraging and facilitating all health plans to use the same payment methods

• Providing Training & Technical Assistance
  – Tools physicians and hospitals can use in redesigning care to reduce costs and improve quality

• Neutral Facilitation to Achieve Win-Win Solutions
  – Providing the “table” where all stakeholders can come to resolve challenges in ways that are fair to everyone
Don’t Wait for Washington

• **There is no one-size-fits-all solution to reform**
  – Each region will need to make it happen in its own unique environment
  – The best federal policy will support regional innovation

• **Communities should educate their stakeholders and build consensus on the multi-payer payment & delivery reforms appropriate for their community**
  – Organize Payment Reform Summits, as Regional Health Improvement Collaboratives in Albuquerque, Colorado, Detroit, Maine, Nevada, Ohio, Oregon, Washington, West Michigan, and Wisconsin have done

• **All stakeholders need to work *together* to analyze data, find win-win opportunities, design transitional payment changes, & resolve inevitable implementation problems**
  – P2 Collaborative can serve as a neutral facilitator to help plan and coordinate community initiatives
For More Information on Payment and Delivery Reforms

www.PaymentReform.org
For More Information:

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

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(412) 803-3650

www.NRHI.org
www.CHQPR.org
www.PaymentReform.org