Better Ways to Pay for Health Care and How to Get From Here to There

Harold D. Miller
Executive Director
Center for Healthcare Quality and Payment Reform
and
President and CEO
Network for Regional Healthcare Improvement
What’s the Key to Success in Making Health Reform Affordable?
What’s the Key to Success in Making Health Reform Affordable?

Answer:
Reducing Healthcare Costs *Without* Rationing
Reducing Costs Without Rationing: Prevention and Wellness

Healthy Consumer → Continued Health

Healthy Consumer → Preventable Condition
Reducing Costs Without Rationing: Avoiding Hospitalizations

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

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

Acute Care Episode → High-Cost Successful Outcome

Complications, Infections, Readmissions
Reducing Costs Without Rationing Is Also Quality Improvement!

Healthy Consumer → Continued Health → Preventable Condition

No Hospitalization → Acute Care Episode → Efficient Successful Outcome

Better Outcomes/Higher Quality

Complications, Infections, Readmissions

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What Are the Key Challenges in Reducing Costs w/o Rationing?
Challenge #1: Lack of Actionable Information About Utilization/Costs

• Barrier:
  – Most providers don’t know if they have high rates of preventable hospitalizations, infections, 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 providers don’t know if they have high rates of preventable hospitalizations, infections, 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 and hospitals find opportunities for cost savings & quality improvement
  – Provide real-time performance measurement to support continuous quality improvement
State/Regional Leadership on All-Payer Quality Reporting

Greater Detroit Area Health Council

Wisconsin Collaborative for Healthcare Quality

Minneapolis Community Measurement

Maine Health Management Coalition
Growing Focus on Price Transparency

**Cost Report Info:**
Total healthcare costs are a product of the amount paid for a service and how many services are used. Here we show the payment amount for physician services, which includes how much a health plan pays for a procedure or office visit plus what the health plan tells the physician to collect as a copayment from the patient.

### Colonoscopy
Colonoscopy to look at the lower part of the digestive system

<table>
<thead>
<tr>
<th>Sort by Name</th>
<th>Sort by Cost</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Olmsted Medical Center</td>
<td>$1,154</td>
<td></td>
</tr>
<tr>
<td>Gunderson Lutheran</td>
<td>$1,132</td>
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<tr>
<td>Allina Health System</td>
<td>$570</td>
<td></td>
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<tr>
<td>MeritCare</td>
<td>$566</td>
<td></td>
</tr>
<tr>
<td>University of Minnesota Physicians</td>
<td>$487</td>
<td></td>
</tr>
<tr>
<td>HealthPartners Clinic</td>
<td>$485</td>
<td></td>
</tr>
<tr>
<td>Grand Itasca Clinic</td>
<td>$484</td>
<td></td>
</tr>
</tbody>
</table>
Challenge #2: Payment Systems
Reward Low-Value Care

Healthy Consumer

Continued Health

Preventable Condition

No Hospitalization

Acute Care Episode

Efficient Successful Outcome

High-Cost Successful Outcome

Complications, Infections, Readmissions

$
"Episode Payments" to Reward Value Within Episodes

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

High-Cost Successful Outcome → Complications, Infections, Readmissions

A Single Payment For All Care Needed From All Providers in the Episode, With a Warranty For Complications
Yes, a Health Care Provider Can Offer a Warranty

Geisinger Health System ProvenCare℠

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

– Types of conditions/treatments currently offered:
  • Cardiac Bypass Surgery
  • Cardiac Stents
  • Cataract Surgery
  • Total Hip Replacement
  • Bariatric Surgery
  • Perinatal Care
  • Low Back Pain
  • Treatment of Chronic Kidney Disease
Payment + Process Improvement = Better Outcomes, Lower Costs

ProvenCare® CABG Quality Clinical Outcomes - (18. mos)

<table>
<thead>
<tr>
<th>Condition</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></td>
</tr>
<tr>
<td>Patients with any complication (STS)</td>
<td>38 %</td>
<td>30 %</td>
<td>21 %</td>
</tr>
<tr>
<td>Patients with &gt;1 complication</td>
<td>7.6 %</td>
<td>5.5 %</td>
<td>28 %</td>
</tr>
<tr>
<td>Atrial fibrillation</td>
<td>23 %</td>
<td>19 %</td>
<td>17 %</td>
</tr>
<tr>
<td>Neurologic complication</td>
<td>1.5 %</td>
<td>0.6 %</td>
<td>60 %</td>
</tr>
<tr>
<td>Any pulmonary complication</td>
<td>7 %</td>
<td>4 %</td>
<td>43 %</td>
</tr>
<tr>
<td>Blood products used</td>
<td>23 %</td>
<td>18 %</td>
<td>22 %</td>
</tr>
<tr>
<td>Re-operation for bleeding</td>
<td>3.8 %</td>
<td>1.7 %</td>
<td>55 %</td>
</tr>
<tr>
<td>Deep sternal wound infection</td>
<td>0.8 %</td>
<td>0.6 %</td>
<td>25 %</td>
</tr>
<tr>
<td>Readmission within 30 days</td>
<td>6.9 %</td>
<td>3.8 %</td>
<td>44 %</td>
</tr>
</tbody>
</table>
Central teachers gain $7G average
Super: Health-care savings balance raises in contract

By GARY PANG
Press Enterprise Writer

SOUTH CENTRE TWP. — Central Columbia teachers will see their average salary of $53,417 jump up by $7,000 under a new three-year contract, newspaper calculations show.

School directors recently gave 4.54 percent raises to their teachers, the largest in the area for the coming year.

But Superintendent Harry Mathias said the district can afford the pay increases because the teachers agreed to changes that will slash health insurance costs.

Teachers also agreed to pay more toward their health insurance.

The changes will let Central keep the lowest insurance costs among area school districts, he said.

The new contract costs $8.3 million in the coming year, Mathias estimated. However, retirements would reduce expenses, he added.

Higher starting salary
Pay raises were set at 4.54 percent for the coming year; 3.62 percent in the contract’s second year, 2010-11, and 4.36 percent in

New insurance
Back in April, Central was predicting a big rise in insurance premiums. To lower costs, the district switched from Capital Blue Cross to Geisinger Health Plan for all employees.

The switch will reduce costs by $130,000 to $140,000, Mathias estimated.

The union accepted the change as part of the new contract, Mathias said.

While other school districts are facing 7 to 8 percent increases in insurance costs, Central is dealing with just a 2.5 percent increase, the superintendent said.

Central’s average health insurance cost is $8,400 per teacher, Mathias estimated. He said other school districts are paying thousands of dollars more.

That’s because many school districts get health insurance through the Northeast Pennsylvania School Health Trust, he said. Central, however, finds insurance and bargains on its own. That reduces district costs by $500,000.

Teachers’ concession
Teachers made another concession that

What they’ll pay
Teachers had been paying 10 percent of their insurance premiums. That will increase to 11 percent in the first year of the new contract, then 12 percent the second year and 13 percent the third year.

Mathias gave examples of what they might pay in the coming year. These figures do not include the "buy-up" option.

• The premium for a single employee is $4,500, with the employee paying $500.

• The premium for a family plan is $10,500, so the employee pays $1,150.

The rate is different for non-teacher employees, Mathias noted. Support staff members pay 5 percent of their premiums, while administrators pay 6 percent of their premiums, plus .6 percent of their salaries.

Expense breakdown
The contract’s cost of $8.3 million for the coming year includes insurance expenses: $1 million for teachers and $800,000 to $900,000 for everyone else, Mathias estimated.
Small Hospitals and Doctors Can Offer Warranties, Too

• 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.
The Weakness of Episode Payment

Healthy Consumer

- Continued Health
- Preventable Condition

No Hospitalization

Acute Care Episode

Efficient Successful Outcome

High-Cost Successful Outcome

Complications, Infections, Readmissions

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

Preventable Condition

No Hospitalization

Acute Care Episode

Efficient Successful Outcome

High-Cost Successful Outcome

Complications, Infections, Readmissions

Comprehensive Care Payment or “Global” Payment

A Single Payment For All Care Needed For A Condition
Isn’t This Capitation (Ugh)?
No – It’s Different

CAPITATION (WORST VERSIONS)
- No Additional Revenue for Taking Sicker Patients
- Providers Lose Money On Unusually Expensive Cases
- Providers Are Paid Regardless of the Quality of Care
- Provider Makes More Money If Patients Stay Well
- Flexibility to Deliver Highest-Value Services

COMPREHENSIVE CARE PAYMENT
- Payment Levels Adjusted Based on Patient Conditions
- Limits on Total Risk Providers Accept for Unpredictable Events
- Bonuses/Penalties Based on Quality Measurement
- Provider Makes More Money If Patients Stay Well
- Flexibility to Deliver Highest-Value Services
Example: BCBS Massachusetts
Alternative Quality Contract

- A single payment amount is established to cover all costs of care for a population of patients
- The payment amount is adjusted up or down based on the types and severity of conditions the patients have, so providers aren’t taking insurance risk, only performance risk
- The initial payment is set based on past expenditures; the amount increases each year at an inflation rate based on CPI, not on medical inflation, so savings come from controlling increases over time
- Payments are increased by annual bonuses based on the quality of care delivered
- The provider doesn’t need to pay claims; BCBS still pays individual providers fee-for-service, but fees are adjusted up or down to keep total costs within the budget (payment amount)
Comprehensive Care & Episode Payment Can Be Complementary

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

Comp. Care/Global Payment

Complications, Infections, Readmissions

$→ E.g., an annual payment to manage an individual’s chronic disease, including costs of hospitalizations for exacerbations

E.g., the payment made when the individual has an exacerbation requiring hospitalization
### Examples of Comprehensive Care + Episode Payment

<table>
<thead>
<tr>
<th>Condition</th>
<th>Comprehensive Care Payment</th>
<th>Episode Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnancy</td>
<td>Maternity Care (Prenatal Care + Childbirth + Postnatal Care)</td>
<td>Childbirth</td>
</tr>
<tr>
<td>Heart Disease</td>
<td>Heart Care (Weight/Cholesterol Reduction, Smoking Cessation, Medical Management, Surgery)</td>
<td>Bypass Surgery</td>
</tr>
<tr>
<td>COPD</td>
<td>Chronic Disease Management</td>
<td>Hospitalization for COPD Exacerbation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hospitalization for Pneumonia</td>
</tr>
</tbody>
</table>
Challenge #3: Is Payment Reform a Win-Lose Proposition?

- Since healthcare costs = provider revenues, won’t lowering costs for payers hurt providers?
- If revenues have to be reduced, won’t smaller providers lose the most?
## Example: Reducing Cost of Joint Replacement

<table>
<thead>
<tr>
<th>COST TYPE</th>
<th>TODAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Fee</td>
<td>$1,500</td>
</tr>
<tr>
<td>Device Cost</td>
<td>$7,500</td>
</tr>
<tr>
<td>Other Hospital Cost</td>
<td>$6,750</td>
</tr>
<tr>
<td>Hosp. Margin (5%)</td>
<td>$750</td>
</tr>
<tr>
<td>Total Hospital Pmt</td>
<td>$15,000</td>
</tr>
<tr>
<td>Total Cost to Payer</td>
<td>$16,500</td>
</tr>
</tbody>
</table>

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## Physicians Could Help Hospitals Reduce Cost of Medical Devices

<table>
<thead>
<tr>
<th>COST TYPE</th>
<th>TODAY</th>
<th>CHANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Fee</td>
<td>$1,500</td>
<td></td>
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<tr>
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<td>$7,500</td>
<td>-33% ($2,500)</td>
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Today: All Savings Goes to the Hospital, No Reward for Physician

<table>
<thead>
<tr>
<th>COST TYPE</th>
<th>TODAY</th>
<th>CHANGE</th>
<th>SPLIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Fee</td>
<td>$ 1,500</td>
<td>+ 0%</td>
<td></td>
</tr>
<tr>
<td>Device Cost</td>
<td>$ 7,500</td>
<td>-33% ($2,500)</td>
<td></td>
</tr>
<tr>
<td>Other Hospital Cost</td>
<td>$ 6,750</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hosp. Margin (5%)</td>
<td>$ 750</td>
<td>+333% ($2500)</td>
<td></td>
</tr>
<tr>
<td>Total Hospital Pmt</td>
<td>$15,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Cost to Payer</td>
<td>$16,500</td>
<td>-0%</td>
<td></td>
</tr>
</tbody>
</table>
Bundling Allows Savings Split Among MDs, Hospitals, Payers

<table>
<thead>
<tr>
<th>COST TYPE</th>
<th>TODAY</th>
<th>CHANGE</th>
<th>SPLIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Fee</td>
<td>$1,500</td>
<td>+ 50% ($750)</td>
<td></td>
</tr>
<tr>
<td>Device Cost</td>
<td>$7,500</td>
<td>-33% ($2,500)</td>
<td></td>
</tr>
<tr>
<td>Other Hospital Cost</td>
<td>$6,750</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hosp. Margin (5%)</td>
<td>$750</td>
<td>+100% ($750)</td>
<td></td>
</tr>
<tr>
<td>Total Hospital Pmt</td>
<td>$15,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Cost to Payer</td>
<td>$16,500</td>
<td>- 6% ($1000)</td>
<td></td>
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</tbody>
</table>
So Joint Replacement is Cheaper
But More Profitable

<table>
<thead>
<tr>
<th>COST TYPE</th>
<th>TODAY</th>
<th>CHANGE</th>
<th>SPLIT</th>
<th>NEW</th>
</tr>
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<tr>
<td>Physician Fee</td>
<td>$1,500</td>
<td>+ 50% ($750)</td>
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<tr>
<td>Device Cost</td>
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<td>$5,000</td>
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<td></td>
<td>$15,500</td>
</tr>
</tbody>
</table>
Creating Win-Win-Win Payment Reforms

• Payment reform can be win-win-win for providers, payers, and patients by targeting opportunities to prevent hospitalizations, infections, etc. and working to preserve providers’ margins rather than their revenues.

• However, data on current utilization/spending is needed to enable analysis/simulation to find the win-win-win solutions.
Challenge #4: Getting Payment Reform Started
<table>
<thead>
<tr>
<th>States &amp; Regional Collaboratives</th>
<th>Congress/Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pay for Performance</td>
<td></td>
</tr>
<tr>
<td>Most regions and payers have some form of P4P for hospitals and/or MDs</td>
<td>Just now proposing it for hospitals; no system for physicians</td>
</tr>
<tr>
<td>Medical Homes</td>
<td></td>
</tr>
<tr>
<td>Major initiatives underway in CO, MA, ME, MI, MN, NC, OR, PA, RI, VT, WA &amp; others</td>
<td>Started a demonstration project, then stopped, now starting again</td>
</tr>
<tr>
<td>Episode/Bundled Payment</td>
<td>Cardiac Demo in 1990s not expanded; ACE demo started in 2009</td>
</tr>
<tr>
<td>Initiatives in place or being developed in CA, MA, ME, MN, Medicaid</td>
<td>Shared savings demos with large MD groups; ACO program in 2012</td>
</tr>
</tbody>
</table>
Challenge #4: Getting Payment Reform Started

- Building community consensus on multi-payer payment reforms and getting a feasible transition plan underway
  - Organize Payment Reform Summits, as Colorado, Maine, Minnesota, Nevada, Ohio, Oregon, Washington, and Wisconsin have done
  - Facilitate direct communication between purchasers & providers
  - Develop a common approach among multiple payers, as Maine, Minnesota, Washington, Wisconsin, and others are working to do
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• Providing the data needed for planning and pricing
  – “Shared savings” only works if you know where savings opportunities are and how to achieve them
  – Multi-payer claims databases provide a means to simulate different payment models through a neutral, trusted source
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- Creating transitional payment systems to help providers evolve their organizational structures and skills
Is “Shared Savings” a Good Transitional Model?

• Provides no upfront money to enable physician practices to hire nurse care managers, install IT, etc.; additional funds, if any, come years after the care changes are made

• Requires TOTAL costs to go down in order for the physician practice to receive ANY increase in payment, even if the practice can’t control all costs

• Gives more rewards to the *poor* performers who improve than the providers who’ve done well all along

• Does not remove the underlying problems with fee-for-service payment; requires giving up the certainty of revenue for a possibility of a bonus

• I.e., it’s not really *payment reform*
Example of a Better Transition:
WA Medical Home Pilot Program

- Payers will pay the Primary Care Practice an upfront PMPM Care Management Payment for all patients ($2.50 first year, $2.00 future years)
- Practice agrees to reduce rate of non-urgent ER visits and ambulatory care-sensitive hospital admissions by amounts which will generate savings for payers at least equal to the Care Management Payment (targets are practice specific)
- If a practice reduces ER visits and hospitalizations by more than the target amount, the payer shares 50% of the net savings (gross savings minus the PMPM) with the practice
- If a practice fails to meet its ER/hospitalization targets, the practice pays a penalty via a reduction in its FFS conversion factor equivalent to up to 50% of Care Management Payment
Payment Reform Needed for the Medical Neighborhood, Too

- **Primary Care Medical Home**
  - Resources & Incentives for More Coordinated Care

- **(Non-Primary Care) Specialists**
  - FFS Payment Based on Volume, Procedures, & Office Visits

- **PATIENT**
Pay Both PCPs & Specialists for Outcomes & Coordination

- Resources & Incentives for More Coordinated Care
- Payment for Consultation w/ PCP; Outcomes-Based Payment

Primary Care Medical Home

(Non-Primary Care) Specialists

PATIENT
Challenge #5: One Payer
Changing is Not Enough

Provider is only compensated for changed practices for the subset of patients covered by participating payers.
All Payers Need to Change to Enable Providers to Transform
Payers Need to Truly Align to Allow Focus on Better Care

Even if every payer’s system is *better* than it was, if they’re all *different*, providers will spend too much time and money on administration rather than care improvement.
Some Purchasers Are Considering Switching Payers

A growing number of purchasers are looking for payers/TPAs who will implement innovative payment models; many of those purchasers are health systems, and some health systems have TPA capability!
Challenge #6: Delivery System Reform Also Needed

• Problem: Most providers are not trained or organized to reduce preventable utilization without assistance, even if payment incentives are aligned
Accountability Requires New and Improved Skills & Relationships

• Problem: Most providers are not trained or organized to reduce preventable utilization without assistance, even if payment incentives are aligned

• Solution #1: Quality improvement initiatives focused on utilization reduction
  – E.g., ICSI initiative to reduce overuse of diagnostic imaging
  – E.g., Pittsburgh Regional Health Initiative (PRHI) program to reduce hospital-acquired infections

• Solution #2: Helping small physician practices and specialists/hospitals to better coordinate care
  – E.g., ICSI initiative to improve care of people w/ depression
  – E.g., PRHI initiative to reduce readmissions
Challenge #6: Benefit Design
Changes 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

Benefit Design

Payment System

Patient

Provider

Ability and Incentives to:
- Keep patients well
- Avoid unneeded services
- Deliver services efficiently
- Coordinate services with other providers
**Example: Coordinating Pharmacy & Medical Benefits**

<table>
<thead>
<tr>
<th>Pharmacy Benefits</th>
<th>Medical Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug Costs</td>
<td>Physician Costs</td>
</tr>
<tr>
<td></td>
<td>Hospital Costs</td>
</tr>
<tr>
<td></td>
<td>Other Services</td>
</tr>
</tbody>
</table>

- **Single-minded focus on reducing costs here...**
- **...could result in higher spending on hospitalizations**

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

*Principal treatment for most chronic diseases involves regular use of maintenance medication*
Both are Controlled by the Payer

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

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

 Ability and Incentives to:

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

Ability and Incentives to:

- Keep patients well
- Avoid unneeded services
- Deliver services efficiently
- Coordinate services with other providers
And Consumer Support is Critical for Purchaser/Plan Support
Challenge #7: Will Payment Reform Hurt Quality?

• 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
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
- Ideal: Develop quality measures with participation of physicians and hospitals, as Regional Health Improvement Collaboratives do
Functions Needed for Healthcare Payment & Delivery Reform

- **Consumer Education/Engagement**
  - Education Materials
  - Consumer Education/Engagement

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

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

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

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Coordinated Support Needed

WHO CAN CONNECT AND COORDINATE ALL OF THIS?

Quality/Cost Measure Design

Quality Reporting

Consumer Education/Engagement

Cost/Price Reporting

Education Materials

Technical Assistance to Providers

Engagement of Purchasers

Design & Delivery of Care

Alignment of Multiple Payers

Provider Organization/Coordination

Benefit Design

Payment System Design

Consumer Education/Engagement
The Role of Regional Health Improvement Collaboratives...
...With Active Involvement of All Healthcare Stakeholders
Leading Regional Health Improvement Collaboratives

Albuquerque Coalition for Healthcare Quality
Aligning Forces for Quality – South Central PA
Alliance for Health
Better Health Greater Cleveland
California Cooperative Healthcare Reporting Initiative
California Quality Collaborative
Finger Lakes Health Systems Agency
Greater Detroit Area Health Council
Health Improvement Collaborative of 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
Today: Leading Examples of Local Payment Reform Initiatives

- Designing and Implementing Multi-Payer Payment Reforms in Minnesota
  John Sakowski, Institute for Clinical Systems Improvement

- Implementing Global Payments Through Purchaser-Provider Partnerships in Maine
  Elizabeth Mitchell, Maine Health Management Coalition

- Transitioning to Payment Reform in Wisconsin
  Julie Bartels, Wisconsin Health Information Organization
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www.CHQPR.org
www.NRHI.org
www.PaymentReform.org