REDESIGNING HEALTH CARE FROM THE BOTTOM UP INSTEAD OF FROM THE TOP DOWN
Supporting Collaborative Regional Approaches to High-Value Healthcare

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

www.CHQPR.org
Are We Making Progress on the Road to Higher-Value Healthcare?

PAST

High Healthcare Costs
Mediocre Quality Care
Unhealthy People

FUTURE

Affordable Insurance Premiums
High Quality Care
Healthy People
Are We Making Progress on the Road to Higher-Value Healthcare?

PAST

High Healthcare Costs

Mediocre Quality Care

Unhealthy People

FUTURE

Affordable Insurance Premiums

High Quality Care

Healthy People

NO
Health Care is NOT More Affordable

Average Family Premium, Employer-Sponsored Insurance

Family Insurance Premiums Increased $3,000 (22%) More Than Inflation
Quality Has NOT Improved

Blood Pressure and HbA1c Control for Diabetics, Commercial PPOs & HMOs

Source: NCQA: The State of Health Care Quality 2015
Quality Has NOT Improved

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

Source: NCQA: The State of Health Care Quality 2015
It’s Not Just Diabetics, It’s Everybody

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

Source: NCQA: The State of Health Care Quality 2015
“Value” is *Lower* Today Than 6 Years Ago
California Isn’t Doing Any Better

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

Health Insurance Premiums in California Are Higher Than The U.S. Average
Spending is Growing Rapidly Regardless of Payer

- Commercial Insurance: 18% > CPI
- Medicare: 19% > CPI
- Medicaid: 35% > CPI
Quality Is Poor & Stagnant Regardless of Payer

Source: NCQA: The State of Health Care Quality 2015
Most “Value-Based Payment” is P4P for PCPs and Hospitals
P4P Has Been Studied to Death and…

Annals of Internal Medicine

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

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

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

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

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

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

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

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

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

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

Primary Funding Source: U.S. Department of Veterans Affairs.
P4P Has Been Studied to Death and It Doesn’t Work

**Annals of Internal Medicine**

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

**A Systematic Review**

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

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

**Purpose:** To update and expand a prior review examining the effects of P4P on mortality, rehospitalization, 30-day hospital readmission, and 30-day hospitalization costs.

**Data Source:** MEDLINE, Business Source Complete, Scopus, and other databases.

**Study:** A systematic review of 69 studies reporting process or outcome data in ambulatory and inpatient settings. Two investigators extracted data, assessed study quality, and graded the strength of the evidence. Among 69 studies, 58 were in ambulatory settings, 52 reported process-of-care outcomes, and 38 reported patient outcomes. Low-strength evidence suggested that P4P programs in ambulatory settings may improve process-of-care outcomes over the short term (2 to 3 years), whereas data on longer-term effects were limited. Many of the positive studies were conducted in the United Kingdom, where incentives were larger than in the United States. The largest improvements were seen in areas where baseline performance was poor. There was no evidence that P4P programs reduced 30-day hospital readmission or hospitalization costs.

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


For more information, see text and the original article.
“Value-Based Payment” Doesn’t Really Change FFS
P4P Increases Admin. Costs and Doesn’t Reduce Spending

- Endocrinologists
- Oncologists
- OB/GYNs
- Rheumatologists

Specialist Care

- Orthopedic Surgeons
- Gastroenterologists
- Nephrologists
- Cardiologists

PCP Care

Payer's Higher Admin Cost

FFS

Hospital Care

Rehab & Home Care

P4P Admin Cost

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The Result: Higher Premiums for Employers

<table>
<thead>
<tr>
<th>EMPLOYERS/PURCHASERS</th>
<th>PAYERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIGHER PREMIUM$</td>
<td>HIGHER ADMIN COST</td>
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</tbody>
</table>

**Specialist Care**
- Endocrinologists
- Oncologists
- OB/GYNs
- Rheumatologists
- Orthopedic Surgeons
- Gastroenterologists
- Nephrologists
- Cardiologists

**PCP Care**
**Hospital Care**
**Rehab & Home Care**
If P4P Doesn’t Work, Are ACOs the Answer?

ACO

PCP Care

Specialist Care
- Endocrinologists
- Oncologists
- OB/GYNs
- Rheumatologists

Hospital Care
- Orthopedic Surgeons
- Gastroenterologists
- Nephrologists
- Cardiologists

Rehab & Home Care

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Medicare’s Shared Savings ACO Program Isn’t Succeeding

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

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

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

By Bob Herman | October 15, 2015

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

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

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

"Our alternative payment models are succeeding at a much lower rate than they should be," said Dr. Stephen Ondra, chief medical officer at Health Care Service Corp., the Blue Cross and Blue Shield insurer for five states. "In the ACO, the consumer engagement is very, very low."
Why? Everybody is Still Paid FFS

PAYERS

ACO

FFS

FFS

FFS

FFS

PCP Care

Specialist Care
- Endocrinologists
- Oncologists
- OB/GYNs
- Rheumatologists

Hospital Care
- Orthopedic Surgeons
- Gastroenterologists
- Nephrologists
- Cardiologists

Rehab & Home Care

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Savings Used to Pay for IT Systems and “Care Coordination”

- FFS
- Savings

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<thead>
<tr>
<th>PAYERS</th>
<th>ACO Administration</th>
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<td>Care Coordinators</td>
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<td>FFS</td>
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<td>PCP Care</td>
<td>Specialist Care</td>
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<td>Specialist Care</td>
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<td>- Endocrinologists</td>
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<td>- Oncologists</td>
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<td>- OB/GYNs</td>
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<td>- Cardiologists</td>
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<td>Hospital Care</td>
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<tr>
<td>Rehab &amp; Home Care</td>
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</tbody>
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No Real Change in Care Delivery, No Reduction in Premiums

EMPLOYERS/PURCHASERS

| HIGHER PREMIUM$ |

Payers

| Shared Savings |

ACO Administration

| IT Systems | Care Coordinators |

PCP Care

Specialist Care
- Endocrinologists
- Oncologists
- OB/GYNs
- Rheumatologists

Orthopedic Surgeons
Gastroenterologists
Nephrologists
Cardiologists

Hospital Care

Rehab & Home Care
What About Capitated Groups in California and Other Areas?

HMOs

Capitation

Capitated Physician Group
- IT Systems
- Care Coordinators

PCP Care

Specialist Care
- Endocrinologists
- Oncologists
- OB/GYNs
- Rheumatologists

Hospita Care

Rehab & Home Care

- Orthopedic Surgeons
- Gastroenterologists
- Nephrologists
- Cardiologists
Most Providers Are Still Paid FFS, Now With Two Layers of Admin $
Result: Slightly Better Care and Slightly Lower Premiums

EMPLOYERS/PURCHASERS

HMOs

Capitation

Capitated Physician Group

<table>
<thead>
<tr>
<th>IT Systems</th>
<th>Care Coordinators</th>
</tr>
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</table>

Capitation

P4P

PMPM

FFS

PCP Care

Specialist Care

- Endocrinologists
- Oncologists
- OB/GYNs
- Rheumatologists

Orthopedic Surgeons
Gastroenterologists
Nephrologists
Cardiologists

Hospital Care

Rehab & Home Care

FFS

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Current VBP Doesn’t Address Drivers of Higher Spending

Private Health Insurance Spending 2009-2015

- $240 Billion
- 29% Increase in Spending
Biggest Increases are Hospitals & Insurance Administration/Profit

Private Health Insurance Spending 2009-2015

- Hospitals: +41%
- Insurance Administration: +30%
- Drugs: +20%
- Physician & Clinical Services: +19%
- Other Services: +24%
- Other: +15%
- Total: $1,100,000

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Half of the Growth in Spending Has Been for Hospital Services

- Hospital Svcs: 41% Increase, 49% of Total
- Physician & Clinical Services: 19% Increase, 18% of Total
- Drugs: 20% Increase, 10% of Total
- Other Svcs: 24% Increase, 11% of Total
- Insurance Admin: 30% Increase, 12% of Total

Change 2009-2015

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Isn’t It Time to Do Things DIFFERENTLY?
What Does a *True* Alternative Payment Model Look Like?
Step #1: Identify Avoidable Spending in FFS

- Avoidable Hospital Admissions/Readmissions
- Unnecessary Tests and Procedures
- Use of Lower-Cost Settings
- Use of Lower-Cost Treatments
- Preventable Complications of Treatment
- Prevention & Early Identification of Disease
Institute of Medicine Estimate:
30% of Spending is Avoidable

<table>
<thead>
<tr>
<th>Excess Cost Domain Estimates:</th>
<th>Lower bound totals from workshop discussions*</th>
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</thead>
<tbody>
<tr>
<td><strong>UNNECESSARY SERVICES</strong></td>
<td>Total excess = $210 B*</td>
</tr>
<tr>
<td>• Overtreatment services</td>
<td></td>
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<tr>
<td>• Discretionary use beyond</td>
<td></td>
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<tr>
<td>• Defensive medicine</td>
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<tr>
<td>• Unnecessary choice of</td>
<td></td>
</tr>
<tr>
<td>• Higher cost services</td>
<td></td>
</tr>
<tr>
<td><strong>INEFFICIENTLY DELIVERED SERVICES</strong></td>
<td>Total excess = $130 B*</td>
</tr>
<tr>
<td>• Medical errors, preventable</td>
<td></td>
</tr>
<tr>
<td>• Care fragmentation</td>
<td></td>
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<tr>
<td>• Unnecessary use of higher</td>
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<tr>
<td>• Operational inefficiencies</td>
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<tr>
<td>• Care delivery sites</td>
<td></td>
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<tr>
<td>• Physician offices</td>
<td></td>
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<tr>
<td>• Hospitals</td>
<td></td>
</tr>
<tr>
<td><strong>EXCESS ADMINISTRATIVE COSTS</strong></td>
<td>Total excess = $190 B*</td>
</tr>
<tr>
<td>• Insurance-related administrative</td>
<td></td>
</tr>
<tr>
<td>• Administrative costs</td>
<td></td>
</tr>
<tr>
<td>• Physician offices</td>
<td></td>
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<tr>
<td>• Hospitals</td>
<td></td>
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<tr>
<td>• Other providers</td>
<td></td>
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<tr>
<td>• Insurer administrative</td>
<td></td>
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<tr>
<td>• Insurer documentation</td>
<td></td>
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<tr>
<td>• Requirement efficiencies</td>
<td></td>
</tr>
<tr>
<td><strong>PRICES THAT ARE TOO HIGH</strong></td>
<td>Total excess = $105 B*</td>
</tr>
<tr>
<td>• Service prices beyond</td>
<td></td>
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<tr>
<td>• Competitive benchmarks</td>
<td></td>
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<tr>
<td>• Physician services</td>
<td></td>
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<tr>
<td>• Specialists</td>
<td></td>
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<tr>
<td>• Generalists</td>
<td></td>
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<tr>
<td>• Hospital services</td>
<td></td>
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<tr>
<td>• Product prices beyond</td>
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<tr>
<td>• Competitive benchmarks</td>
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<tr>
<td>• Pharmaceuticals</td>
<td></td>
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<tr>
<td>• Medical devices</td>
<td></td>
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<tr>
<td>• Durable medical equipment</td>
<td></td>
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<tr>
<td><strong>MISSED PREVENTION OPPORTUNITIES</strong></td>
<td>Total excess = $55 B*</td>
</tr>
<tr>
<td>• Primary prevention</td>
<td></td>
</tr>
<tr>
<td>• Secondary prevention</td>
<td></td>
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<tr>
<td>• Tertiary prevention</td>
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<tr>
<td><strong>FRAUD</strong></td>
<td>Total excess = $75 B*</td>
</tr>
<tr>
<td>• All sources—payer, physician, patient</td>
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</tr>
</tbody>
</table>

*Lower bound totals of various estimates, adjusted to 2009 total expenditure level.
25% of Avoidable Spending is Excess Administrative Costs

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

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

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

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

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

*Lower bound totals of various estimates, adjusted to 2009 total expenditure level.*
Physicians Have Identified Many Opportunities to Reduce Spending
Step #2: Identify Barriers in FFS

Barriers in Current FFS System:
- No payment for high-value services
- Phone calls, e-mails with physicians
- Services delivered by nurses, community workers
- Communication between PCPs and specialists
- Non-medical services, e.g., transportation
- Palliative care for patients at end of life
- Inadequate payment for patients who need more time or resources
- Inadequate revenue to cover fixed costs when utilization of services is reduced
You Can’t Reduce Spending if You Don’t Remove the Barriers

- **FEE FOR SERVICE**
  - Avoidable Spending
  - Necessary Spending
  - Unpaid Services
  - Loss of Revenue

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Step #3: Remove the FFS Barriers

Upfront payment to support improved delivery of care
Step 4: Build in Accountability for Results

- **Avoidable Spending**
  - 
  - 

- **Necessary Spending**
  - 
  - 

- **Unpaid Services Loss of Revenue**
  - 

**Fee for Service** vs. **Alternative Payment Model**

- Lower Avoidable Spending
- Adequate, Flexible Payment for High-Value Services

Accountability for reducing avoidable spending
Upfront payment to support improved delivery of care
True Alternative Payment Models Can Be Win-Win-Wins

Win for Purchaser: Lower Total Spending and Lower Premiums

Win for Patient: Better Care Without Unnecessary Services

Win for Provider: Adequate Payment for High-Value Services

FEE FOR SERVICE

ALTERNATIVE PAYMENT MODEL

SAVINGS

AVOIDABLE SPENDING

LOWER AVOIDABLE SPENDING

NECESSARY SPENDING

UNPAID SERVICES

LOSS OF REVENUE

ADEQUATE, FLEXIBLE PAYMENT FOR HIGH-VALUE SERVICES
No One Alternative Payment Model Will Meet All Needs

APM #1: Payment for a High-Value Service
APM #2: Condition-Based Payment for a Physician’s Services
APM #3: Multi-Physician Bundled Payment
APM #4: Physician-Facility Procedure Bundle
APM #5: Warrantied Payment for Physician Services
APM #6: Episode Payment for a Procedure
APM #7: Condition-Based Payment
This is NOT a Good “Framework” for Alternative Payment Models
It’s All Just FFS + P4P with Fancy Names
Which Physician Would YOU Want to Care for You?

• **Physician A is paid under FFS.**
  She makes less money if she keeps you healthy.

• **Physician B is paid under P4P.**
  She makes more money if she keeps her EHR up to date.

• **Physician C has “Downside Risk.”**
  She makes more money if she doesn't treat your problems.

• **Physician D is paid through a Condition-Based APM.**
  She’s paid adequately to address your needs, and she makes more money if your health condition(s) improve.
Redesigning Care & Payment from the Bottom Up Instead of the Top Down
Start by Identifying Patient Needs and Opportunities to Improve
Pay PCPs to Help Patients Stay Healthy

- Flexible monthly payments, not tied to office visits
- Higher payments for patients with more conditions
- Accountability for services that PCPs can control

PCP APM

PCP Care

Diabetes  Cancer  Pregnancy  PATIENTS  Arthritis  IBD  CKD  Heart Failure

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PCPs Can’t Treat Everything; Pay Specialists for Serious Conditions

- **Endocrinologists**
- **Oncologists**
- **OB/GYNs**
- **Rheumatologists**
- **Orthopedic Surgeons**
- **Gastroenterologists**
- **Nephrologists**
- **Cardiologists**

**PAYERS**

- Payment for e-consults to help PCPs screen & diagnose
- Flexible payments to treat or manage conditions, not tied to office visits or specific procedures
- Higher payments for patients with more complex conditions
- Accountability for services and complications that specialists can control

**PCP Care**

**Specialist Care**

- **Diabetes**
- **Cancer**
- **Pregnancy**
- **PATIENTS**
- **Arthritis**
- **IBD**
- **CKD**
- **Heart Failure**

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Pay Hospitals Adequately to Maintain *Essential* Services

- Adequate payment for fixed costs of standby services (ED, cath lab, trauma, stroke, etc.)
- Accountability for costs that hospitals can control

**Specialist Care**
- Endocrinologists
- Oncologists
- OB/GYNs
- Rheumatologists
- Orthopedic Surgeons
- Gastroenterologists
- Nephrologists
- Cardiologists

**PCP Care**
**Hospital Care**

**PAYERS**
- PCP APM
- Spec APM
- Spec APM
- Spec APM
- Hosp APM

**PATIENTS**
- Diabetes
- Cancer
- Pregnancy
- Arthritis
- IBD
- CKD
- Heart Failure
Pay for Services Designed to Help Patients Return to & Stay at Home

**PAYERS**

- PCP APM
- Spec APM
- Spec APM
- Spec APM
- Hosp APM
- Other APM

**PCP Care**

**Specialist Care**
- Endocrinologists
- Oncologists
- OB/GYNs
- Rheumatologists
- Orthopedic Surgeons
- Gastroenterologists
- Nephrologists
- Cardiologists

**Hospital Care**

**Rehab & Home Care**

**PATIENTS**
- Diabetes
- Cancer
- Pregnancy
- Arthritis
- IBD
- CKD
- Heart Failure
Result:
Better Outcomes for Patients
Result:
Lower Administrative Costs
Result:
More Affordable Health Insurance

EMPLOYERS/PURCHASERS
LOWER PREMIUMS

PAYERS
LOW ADMIN COST

PCP APM
Spec APM
Spec APM
Hosp APM
Other APM

PCP Care
Specialist Care
• Endocrinologists
• Oncologists
• OB/GYNs
• Rheumatologists
• Orthopedic Surgeons
• Gastroenterologists
• Nephrologists
• Cardiologists

BETTER PATIENT OUTCOMES FOR ALL CONDITIONS
Diabetes Cancer Pregnancy PATIENTS Arthritis IBD CKD Heart Failure
Healthcare Providers Can’t Change If Every Payer is Paying Differently

Specialist Care
- Endocrinologists
- Oncologists
- OB/GYNs
- Rheumatologists
- Orthopedic Surgeons
- Gastroenterologists
- Nephrologists
- Cardiologists

PCP Care

Rehab & Home Care

Diabetes Cancer Pregnancy PATIENTS Arthritis IBD CKD Heart Failure
All Payers Need to Participate in Common Payment Models

Specialist Care
- Endocrinologists
- Oncologists
- OB/GYNs
- Rheumatologists
- Orthopedic Surgeons
- Gastroenterologists
- Nephrologists
- Cardiologists

PCP Care

HospCare

OtherCare

Diabetes  Cancer  Pregnancy  PATIENTS  Arthritis  IBD  CKD  Heart Failure

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Many Things Necessary for Win-Win-Win Solutions

Implementing Alternative Payment Models Successfully
All Healthcare Providers Need to Be Involved

Implementing Alternative Payment Models Successfully

- Primary Care
- Specialists
- Hospitals
- Rehab & Home Care
Multiple Types of Data Needed to Design the Payment Model

Implementing Alternative Payment Models Successfully

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

- Primary Care
- Specialists
- Hospitals
- Rehab & Home Care
Purchasers and Payers Need to Support Implementation

Implementing Alternative Payment Models Successfully

Engagement of All Purchasers

Alignment of All Payers

Claims Data
Clinical Data
Outcomes Data
Cost Data

Primary Care
Specialists
Hospitals
Rehab & Home Care
Patients Need to Be Engaged and Supportive

Implementing Alternative Payment Models Successfully

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

Data and Alignments:
- Claims Data
- Clinical Data
- Outcomes Data
- Cost Data

- Engagement of All Purchasers
- Alignment of All Payers

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

REGIONAL HEALTH IMPROVEMENT COLLABORATIVE

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

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

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

- Engagement of All Purchasers
- Alignment of All Payers
# Learn More This Afternoon About Bottom-Up Reforms

<table>
<thead>
<tr>
<th>Regional Approaches to Collaboration and Analysis</th>
<th>Alternative Payment Models for Specialists</th>
<th>Better Ways to Pay Hospitals</th>
</tr>
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<tbody>
<tr>
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<td><strong>Mini-Summit 9</strong> 2:30</td>
<td><strong>Mini-Summit 13</strong> 4:15</td>
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<tr>
<td>• Oregon RHIC</td>
<td>• Heart Failure (Cardiology)</td>
<td>• Maryland Hospital Payment Reforms</td>
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<tr>
<td>• California RHICs</td>
<td>• Rheumatoid Arthritis (Rheumatology)</td>
<td>• Washington State Rural Hospital Payment Reforms</td>
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<tr>
<td>• St. Louis RHIC</td>
<td>• Chronic Kidney Disease (Nephrology)</td>
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For More Information:

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