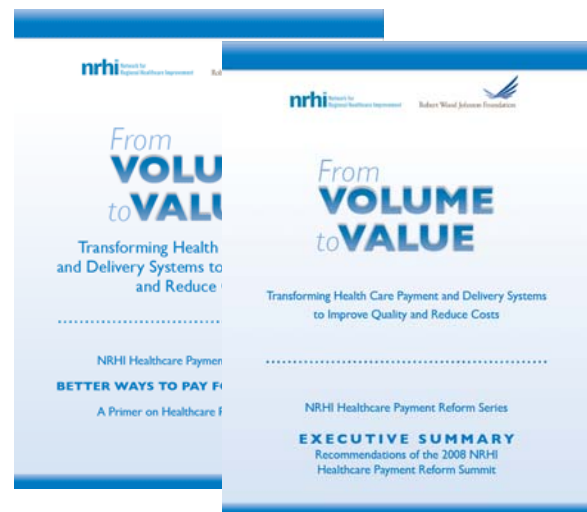
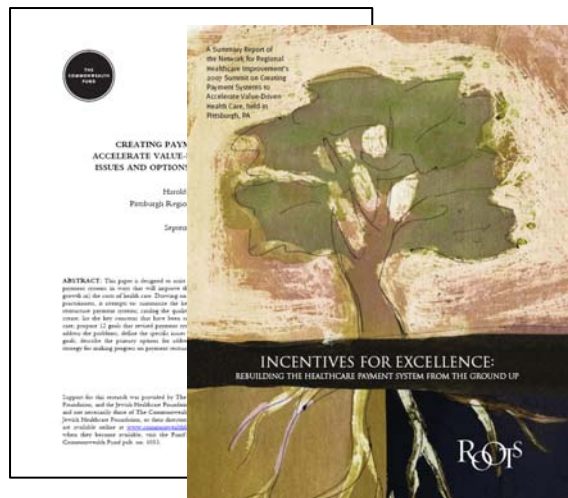


# FROM VOLUME TO VALUE:

Addressing the Key Challenges in Transforming  
Health Care Payment and Delivery Systems

**Mini-Summit IV: Payment Reform**  
Fourth National Pay for Performance Summit  
March 10, 2009

# Building Consensus Across Regions Toward Implementation

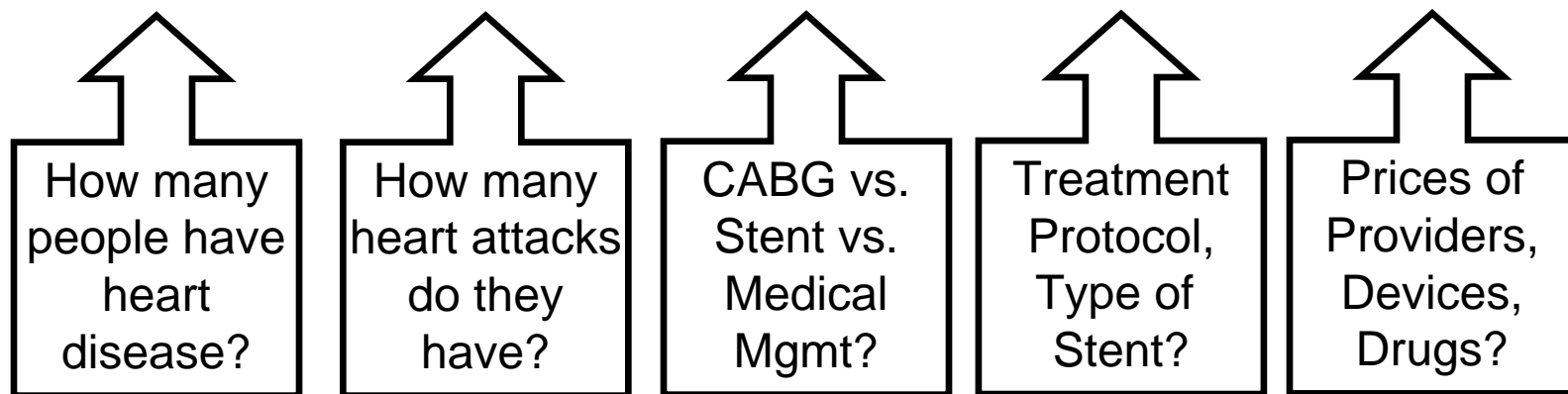


[www.nrhi.org/reports.html](http://www.nrhi.org/reports.html)

# The Health Care Cost Equation

## VARIABLES CONTRIBUTING TO THE COST OF CARE

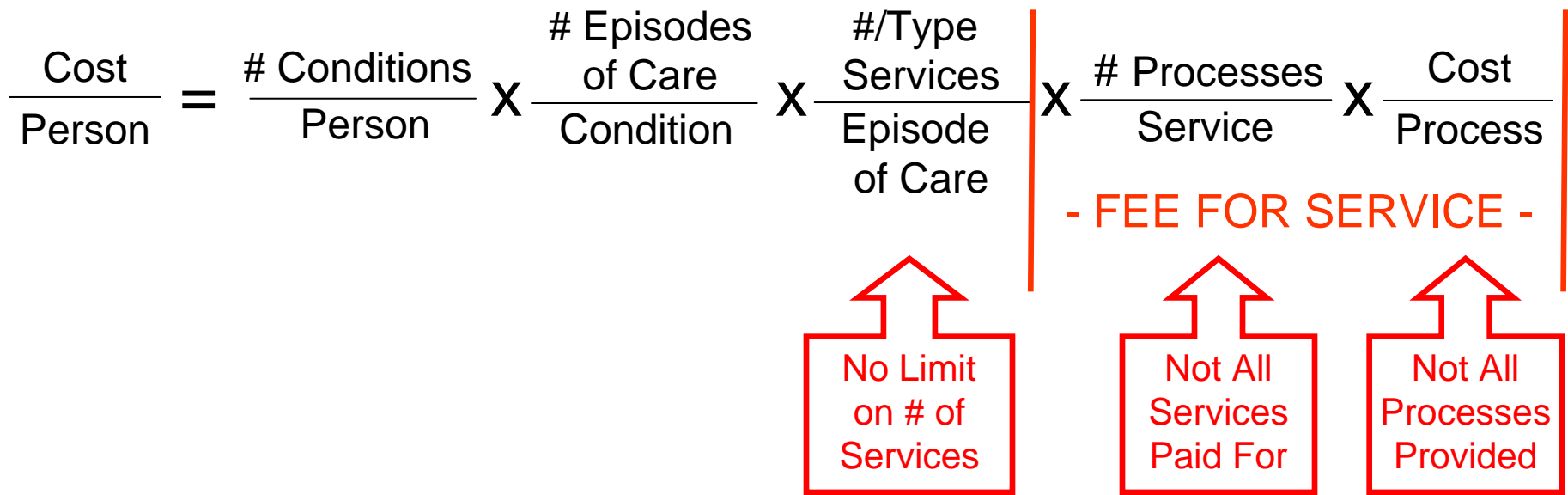
$$\frac{\text{Cost}}{\text{Person}} = \frac{\# \text{ Conditions}}{\text{Person}} \times \frac{\# \text{ Episodes of Care}}{\text{Condition}} \times \frac{\#/\text{Type Services}}{\text{Episode of Care}} \times \frac{\# \text{ Processes}}{\text{Service}} \times \frac{\text{Cost}}{\text{Process}}$$



Cost of Treating Heart Disease

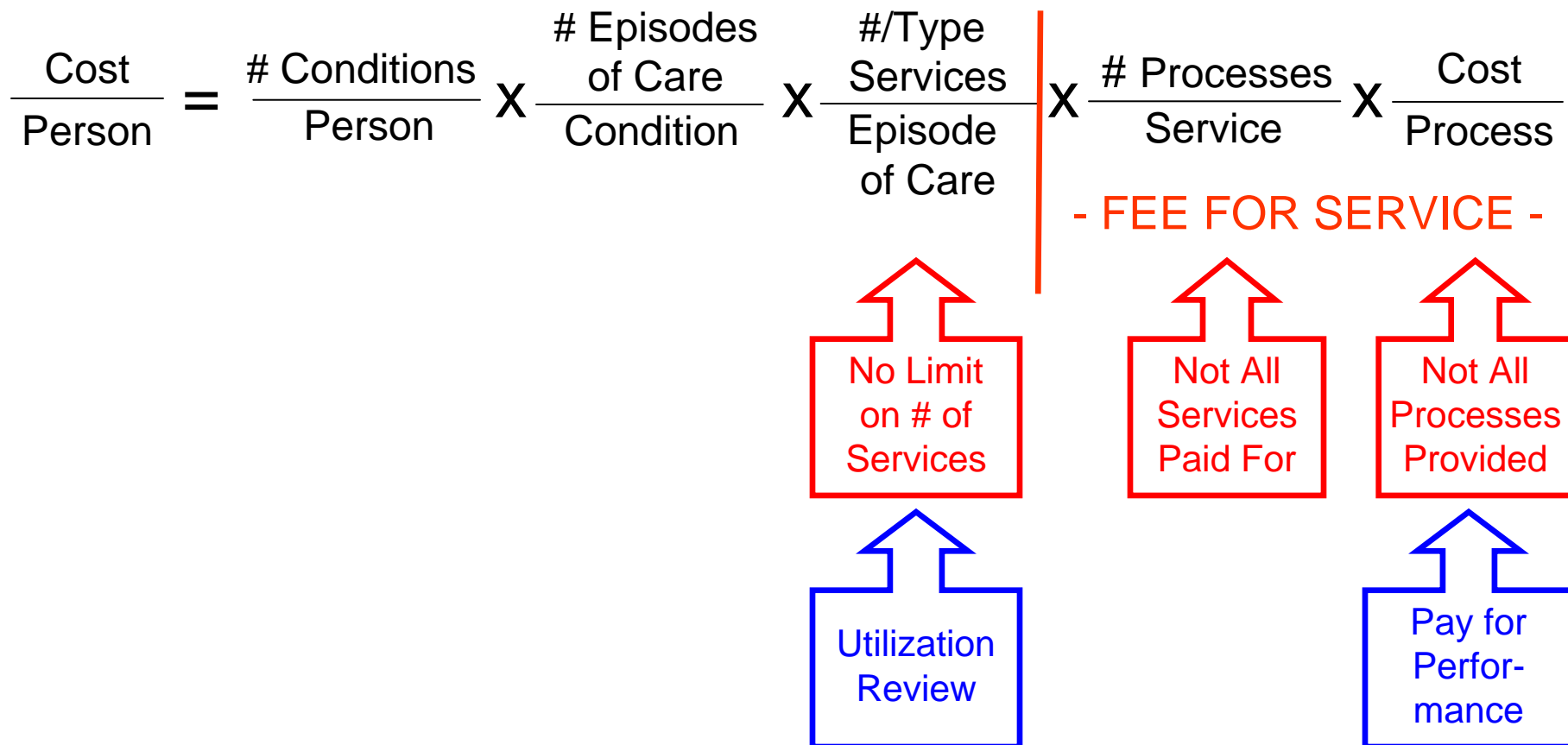
# Fee for Service System Result in Undesirable Effects...

## VARIABLES FOR WHICH THE PROVIDER IS AT RISK UNDER ALTERNATIVE PAYMENT SYSTEMS



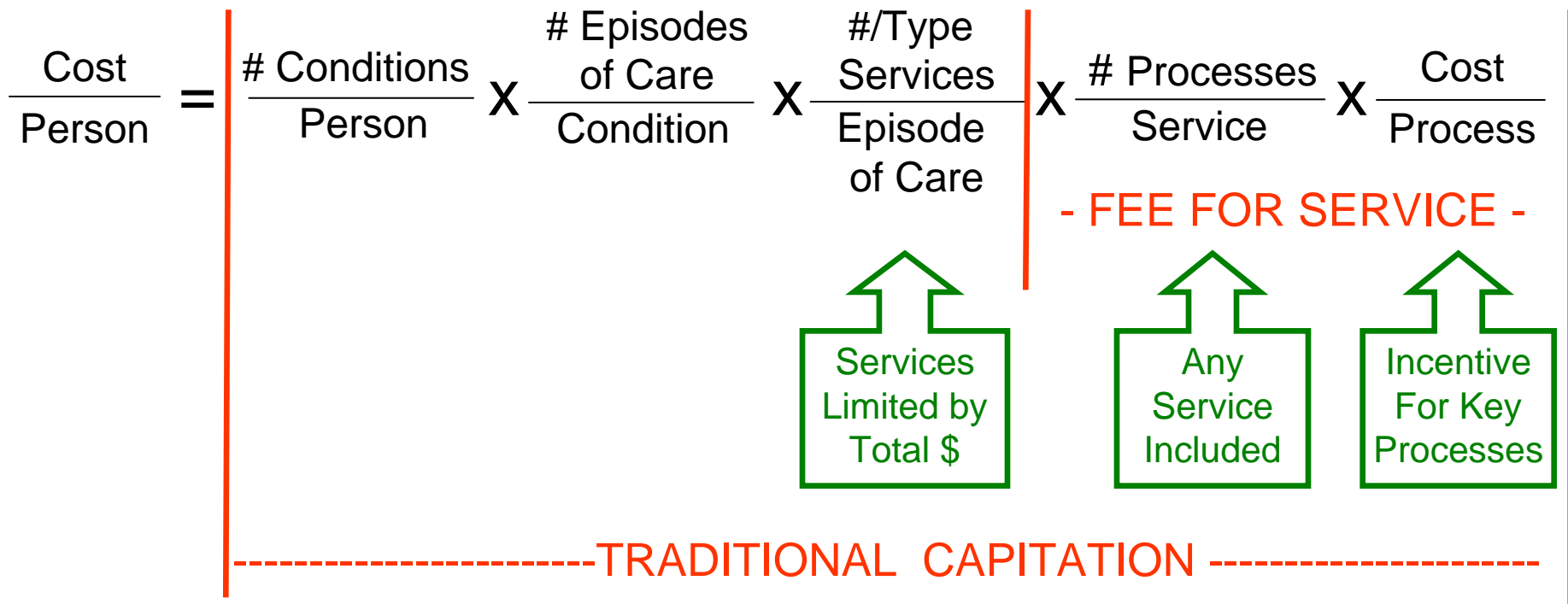
# ...Which Payers Try to Solve By Layering on Controls & Incentives

## VARIABLES FOR WHICH THE PROVIDER IS AT RISK UNDER ALTERNATIVE PAYMENT SYSTEMS



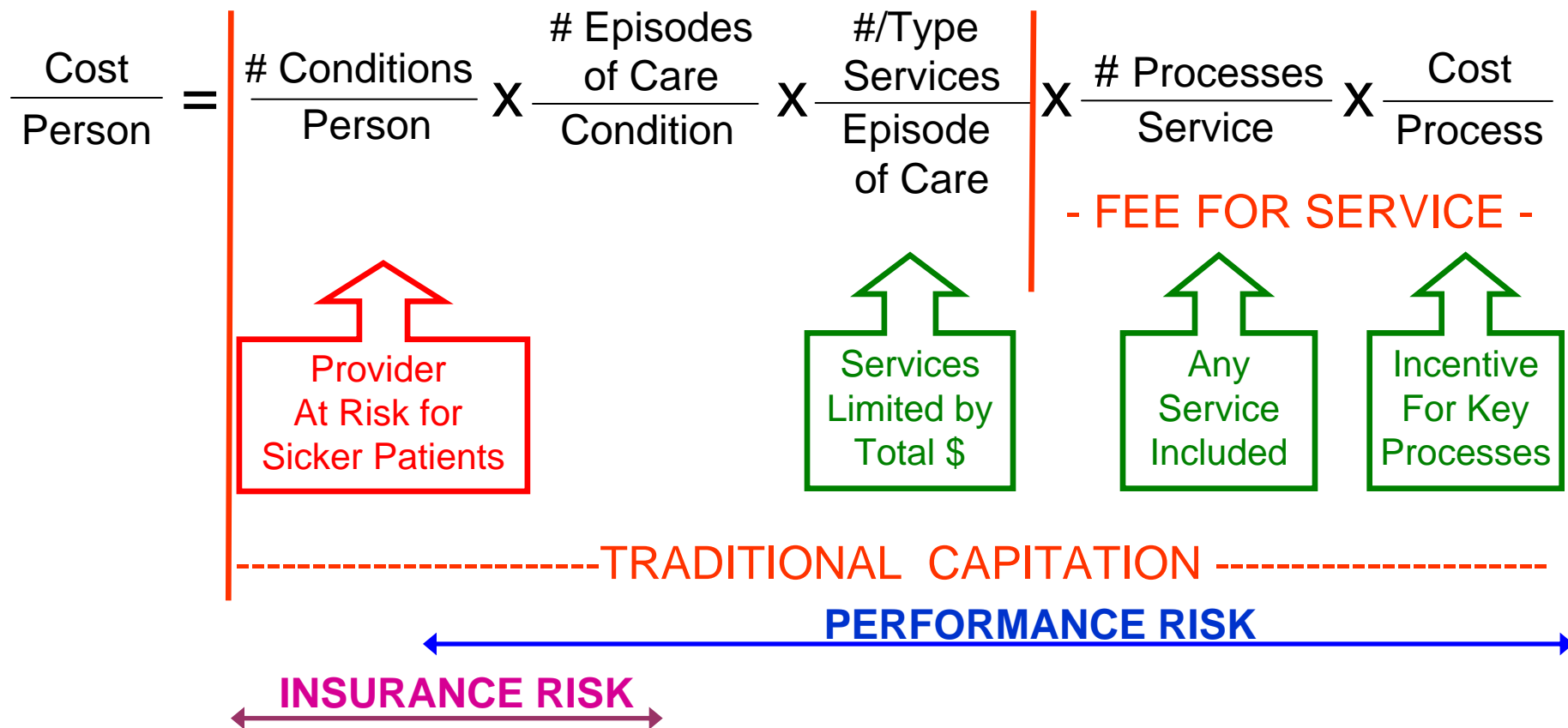
# Traditional Capitation “Solves” the Problems of Fee for Service...

## VARIABLES FOR WHICH THE PROVIDER IS AT RISK UNDER ALTERNATIVE PAYMENT SYSTEMS



# ...But Goes too Far in the Opposite Direction

## VARIABLES FOR WHICH THE PROVIDER IS AT RISK UNDER ALTERNATIVE PAYMENT SYSTEMS



# Middle Ground #1: Episode of Care Payment

## VARIABLES FOR WHICH THE PROVIDER IS AT RISK UNDER ALTERNATIVE PAYMENT SYSTEMS

$$\frac{\text{Cost}}{\text{Person}} = \frac{\# \text{ Conditions}}{\text{Person}} \times \frac{\# \text{ Episodes of Care}}{\text{Condition}} \times \frac{\#/\text{Type Services}}{\text{Episode of Care}} \times \frac{\# \text{ Processes}}{\text{Service}} \times \frac{\text{Cost}}{\text{Process}}$$

-- EPISODE OF CARE PAYMENT --
  
- FEE FOR SERVICE -

For Acute Conditions & Chronic Conditions:



# Middle Ground #2: Condition-Adjusted Capitation

## VARIABLES FOR WHICH THE PROVIDER IS AT RISK UNDER ALTERNATIVE PAYMENT SYSTEMS

$$\frac{\text{Cost}}{\text{Person}} = \frac{\# \text{ Conditions}}{\text{Person}} \times \frac{\# \text{ Episodes of Care}}{\text{Condition}} \times \frac{\#/\text{Type Services}}{\text{Episode of Care}} \times \frac{\# \text{ Processes}}{\text{Service}} \times \frac{\text{Cost}}{\text{Process}}$$

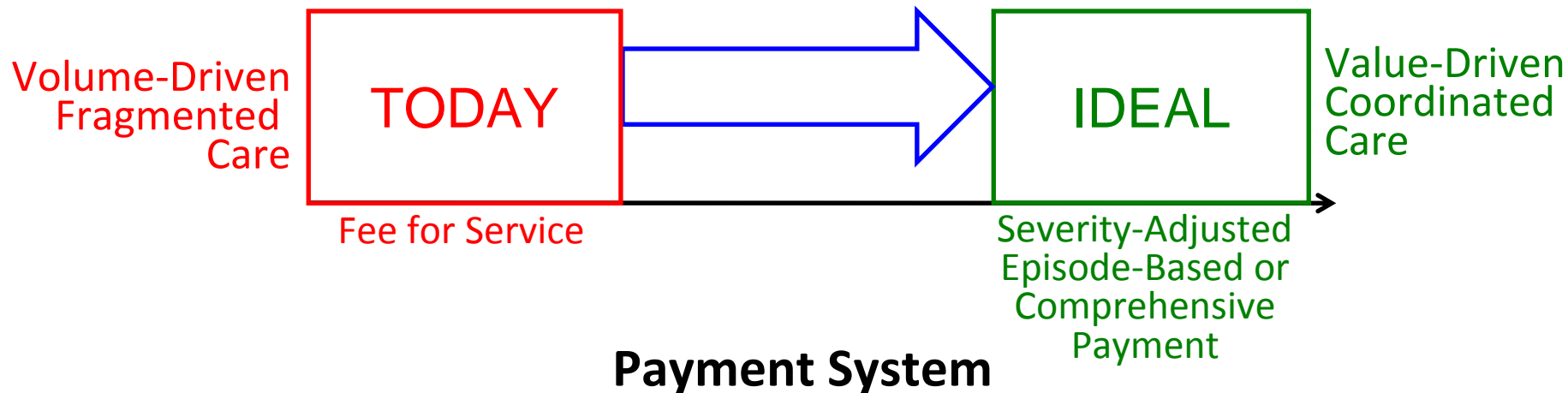
- FEE FOR SERVICE -  
-- EPISODE OF CARE PAYMENT --  
----- CONDITION-ADJUSTED CAPITATION -----  
OR RISK-ADJUSTED GLOBAL FEES

**For Acute Conditions  
& Chronic Conditions:**

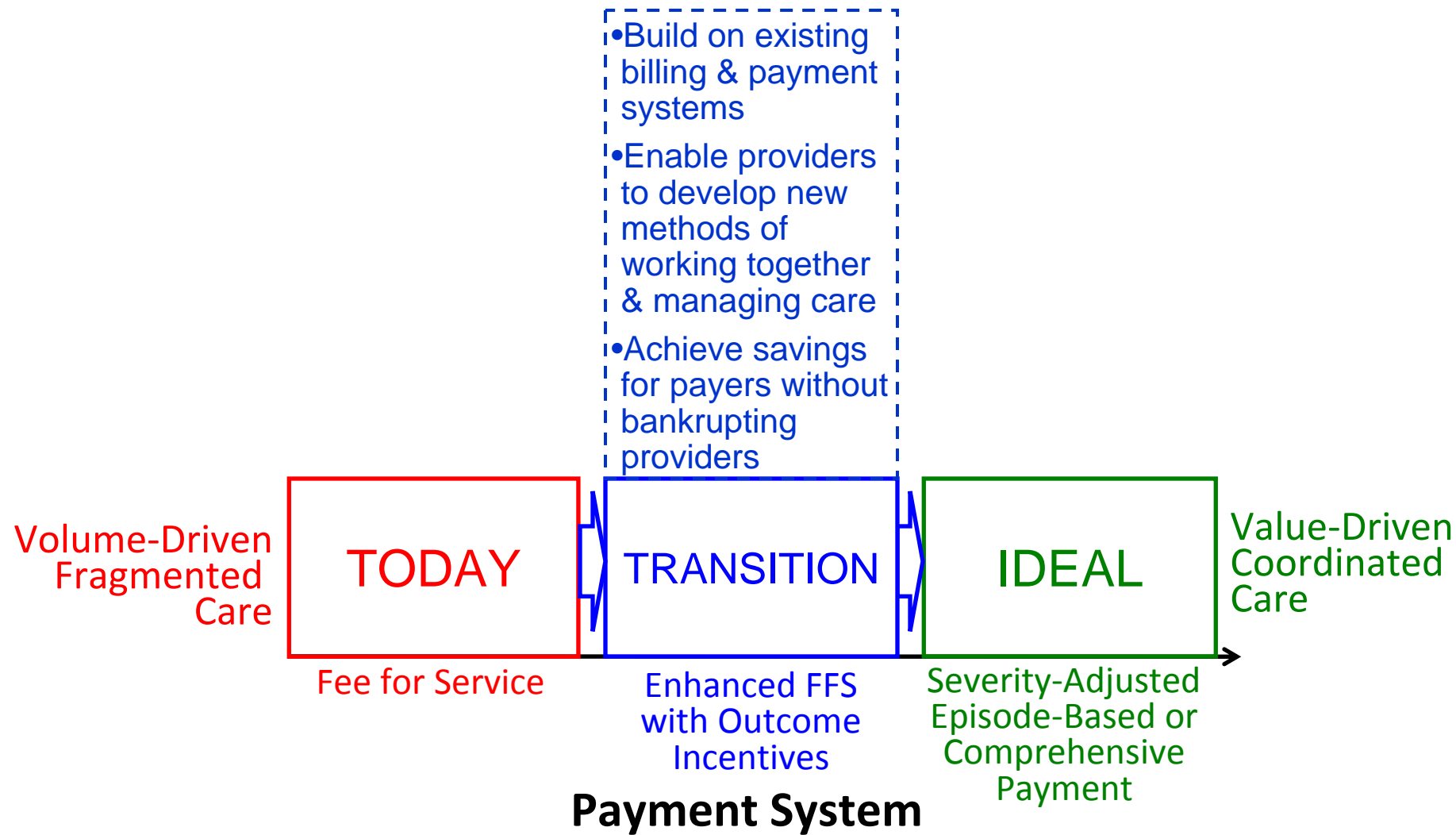
**For Comprehensive &  
& Preventive Care:**



# There Is Broad Agreement About What the Goal Should Be



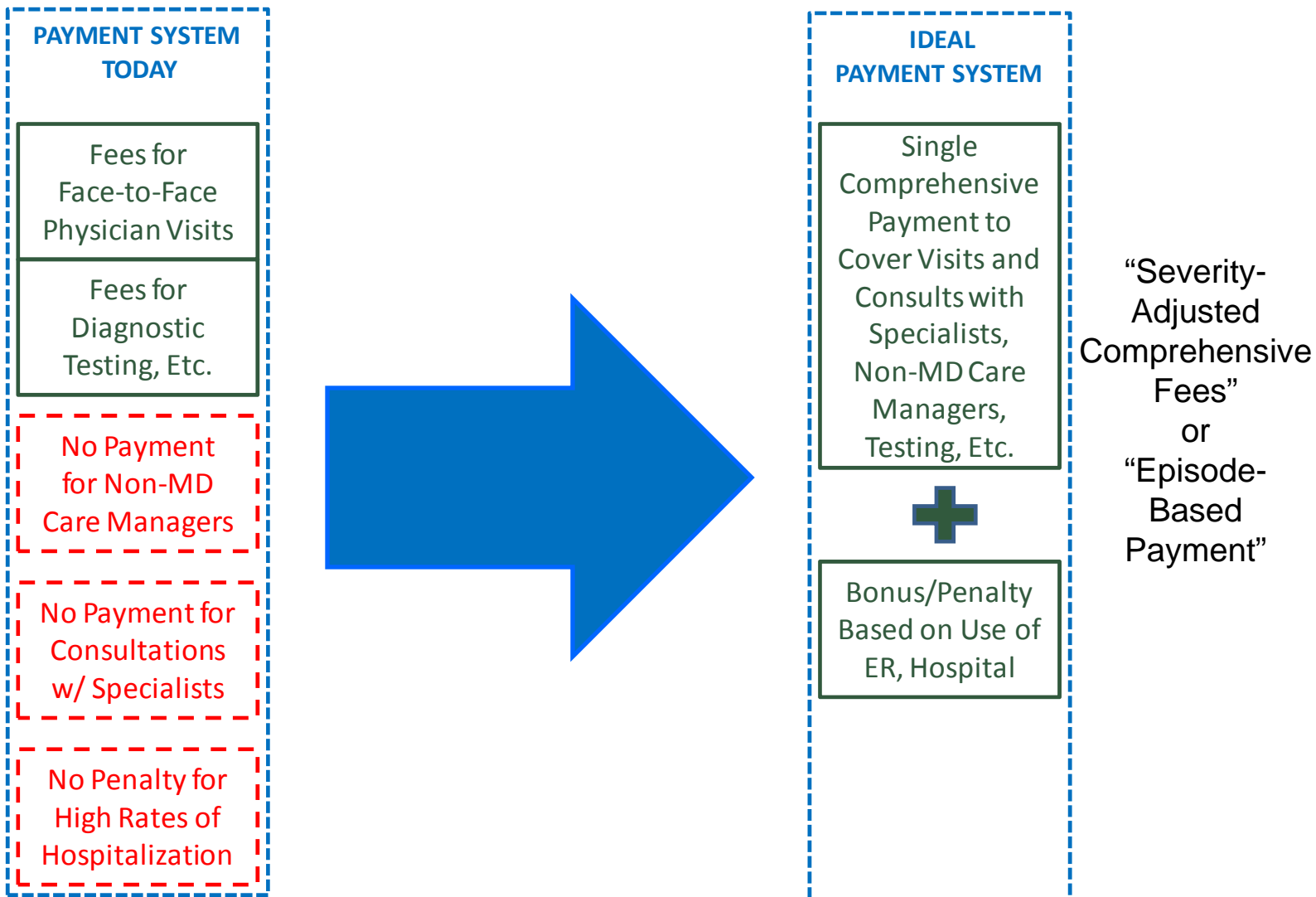
# We Can't Get There All At Once: Transitional Systems Needed



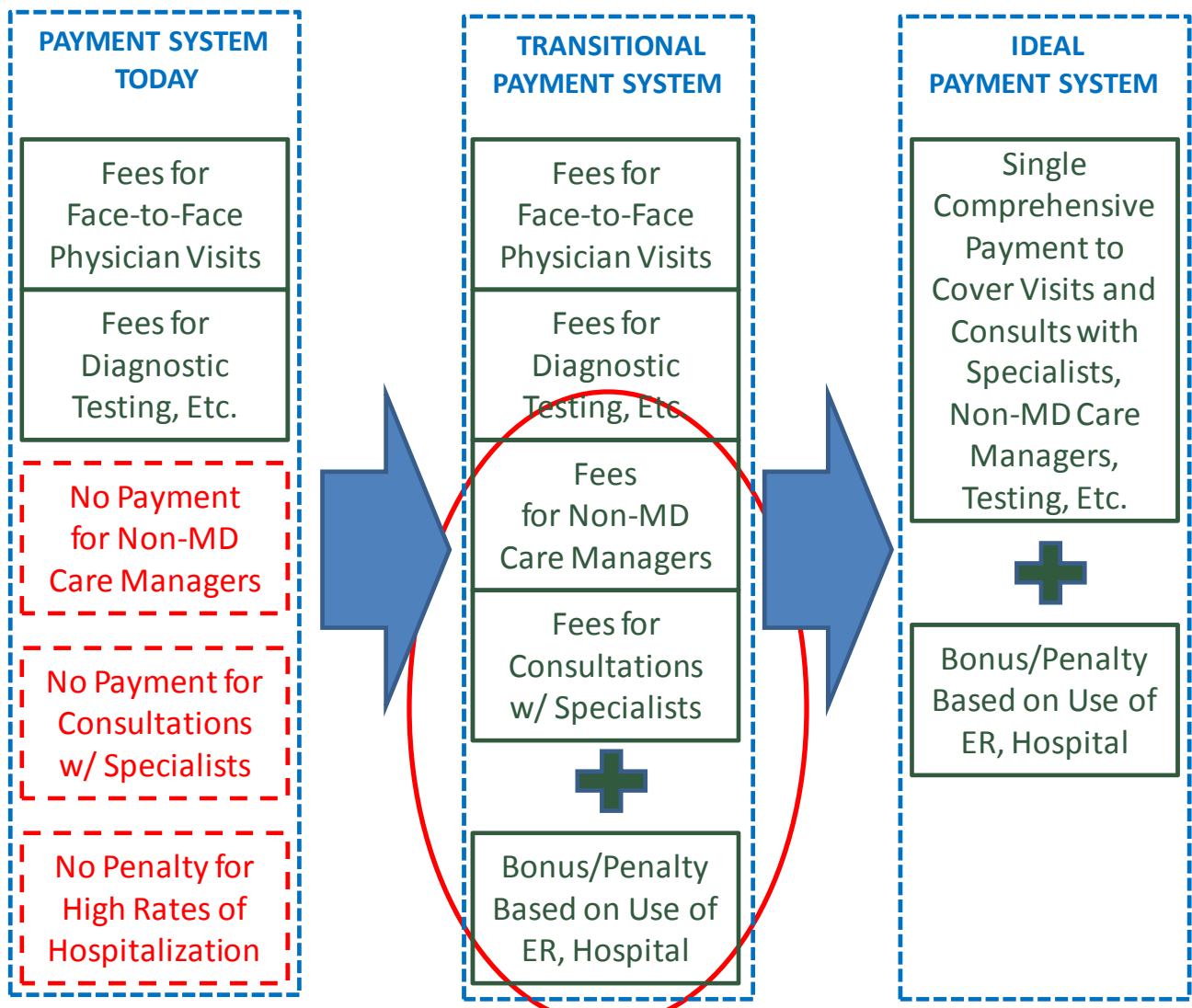
# Example: Changing the Payment Structure for Medical Homes



# Changing The Payment Structure: Long-Run Goal



# Changing the Payment Structure: Transitional Steps

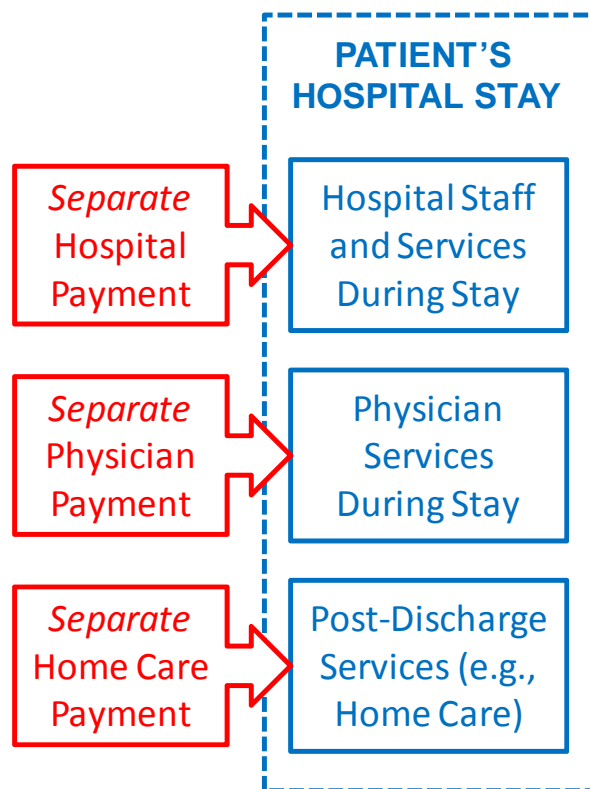


# Who Should Be Eligible for Medical Home Payments?

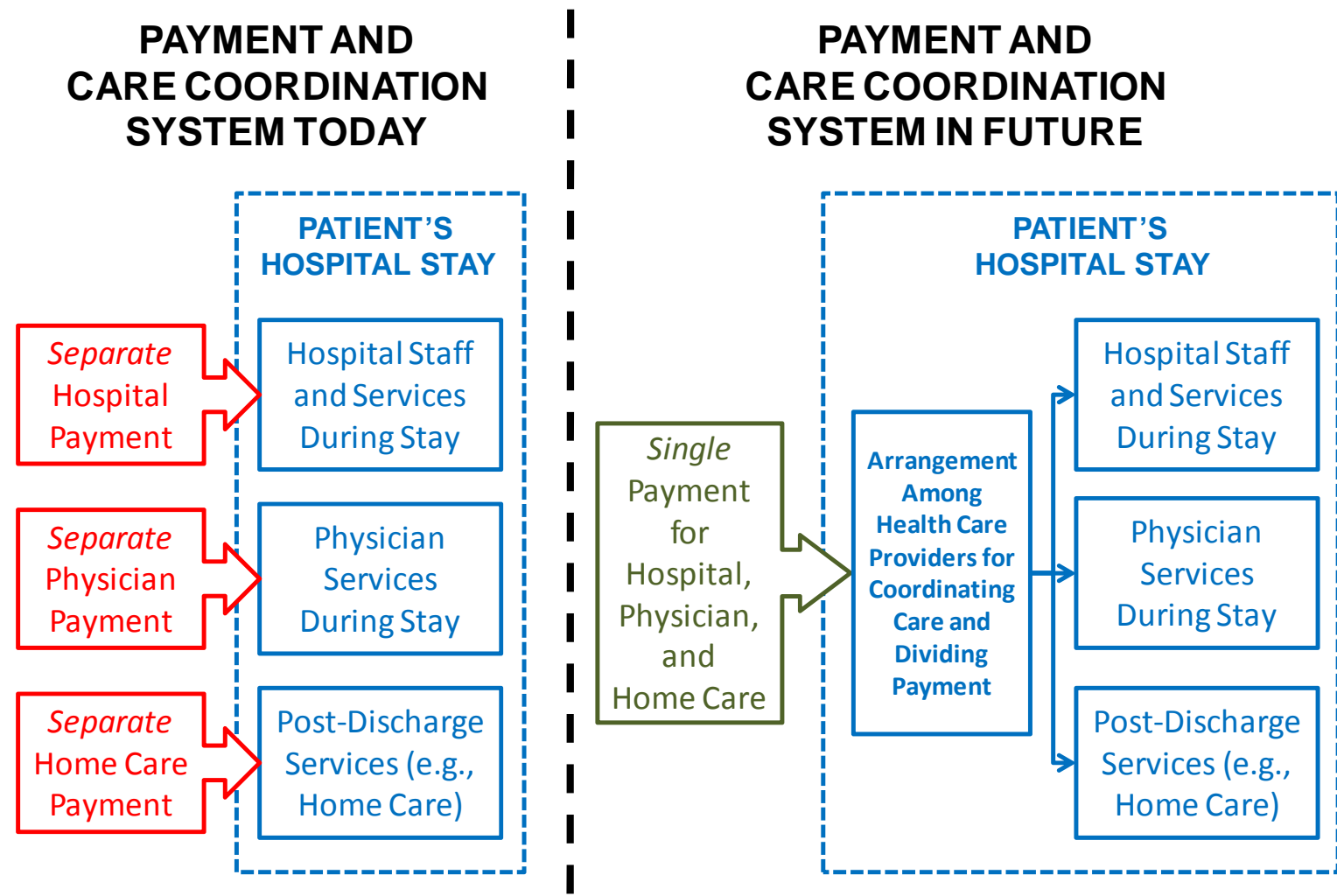
- **Current Approach: Require MD Practices to Meet NCQA Standards for Medical Homes**
  - Insufficient evidence to demonstrate that primary care practices meeting NCQA standards will deliver better value than those which do not
- **Recommended Approach: Focus Should Be on *Outcomes***
  - e.g., reducing preventable hospitalizations, improving patient satisfaction
  - Resist unnecessary barriers to entry, particular for smaller practices
  - Use NCQA standards as *guidance* to providers on how to organize
- **Research/Demonstrations Needed Before Standards Set**
  - Some pilot projects requiring NCQA standards would be desirable
  - But pilot projects with different standards and outcome-driven requirements are needed to determine what actually makes a difference

# Example: Payment For Major Acute Care

## PAYMENT AND CARE COORDINATION SYSTEM TODAY



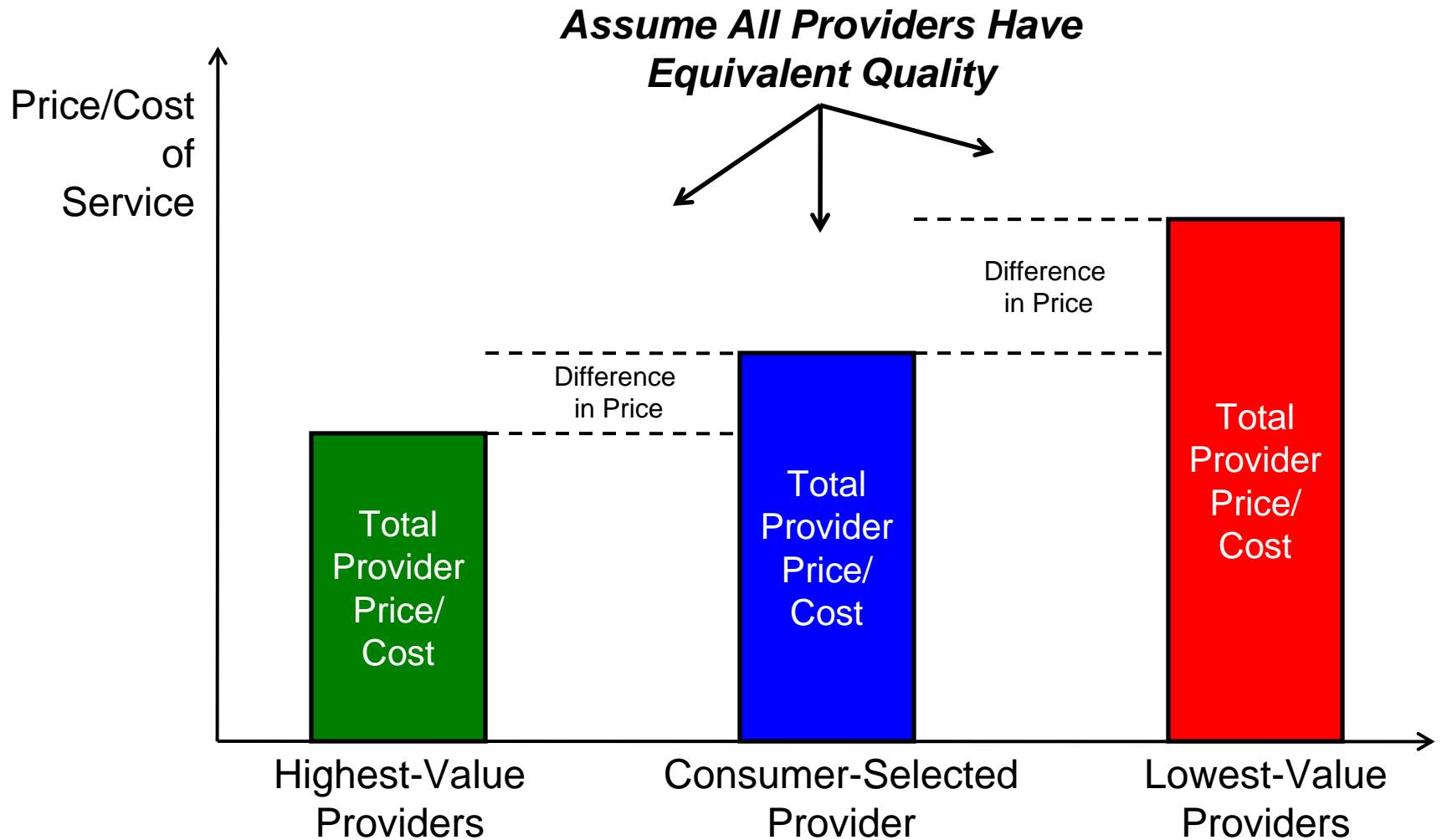
# Recommended System: Bundled Payment to All Providers



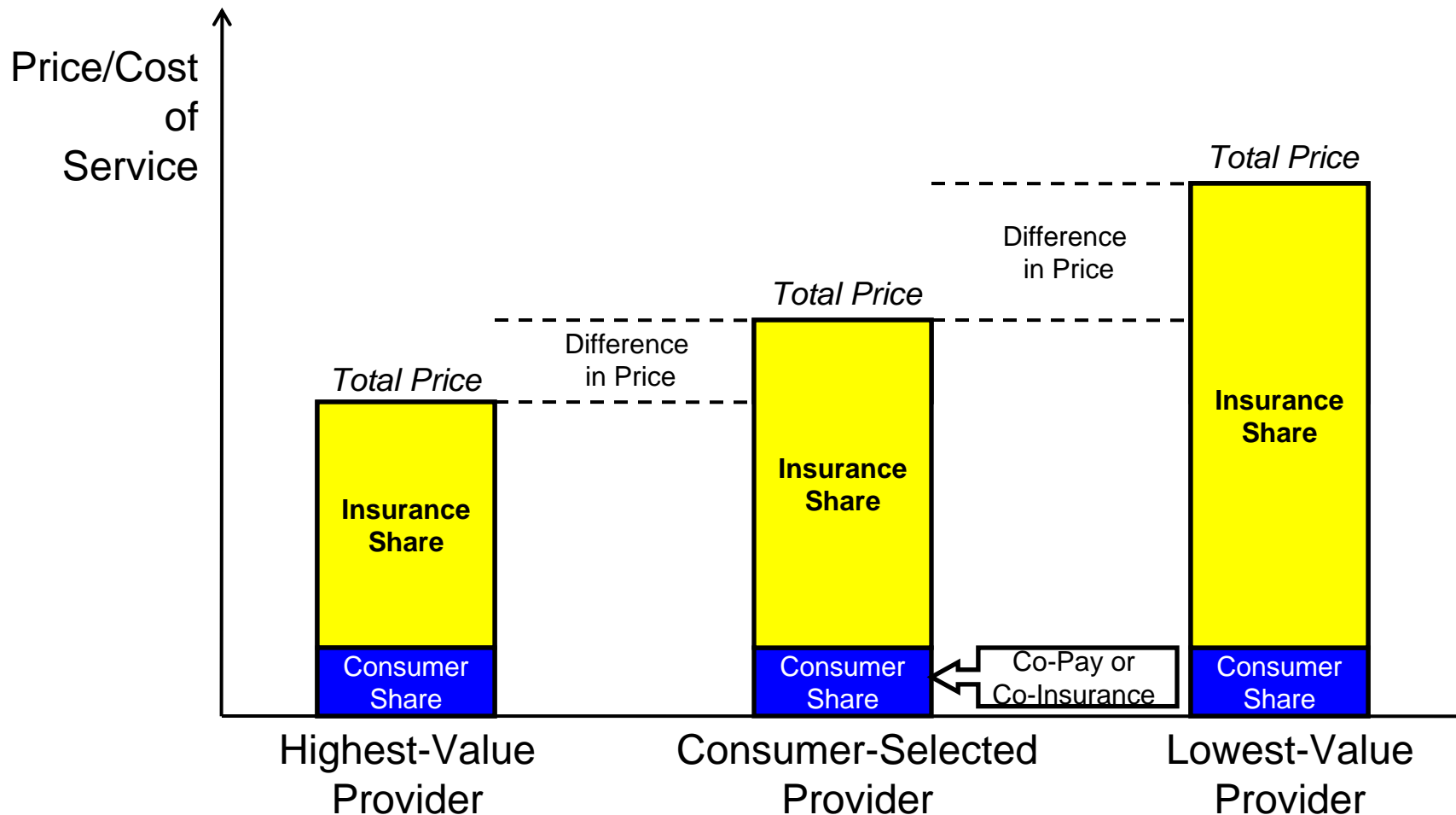
# Transitioning to Bundled Payment

- **Create Case Rates for All Providers:** Pay non-surgeon physicians in hospitals on a case rate basis for patients in major DRGs.
- **Expect Warranties from Each Provider:** Establish financial rewards for hospitals and physicians that reduce hospital readmissions (or penalties for those that do not). Give preference to providers that provide warranties on their care.
- **Increase Use of Gain-Sharing Between Providers:** Remove restrictions on gain-sharing between hospitals and physicians for efforts to improve efficiencies in hospital care.
- **Create “Virtual” Bundling Among Providers:** Provide rewards and/or penalties to all providers involved in an episode of care, based on the total cost of the episode relative to regional or national averages.
- **Bundle Case Rates for Providers into True Episode Payments:**
  - Bundle hospital and surgeon payments for surgical procedures
  - Bundle hospital and post-acute care payments for major DRGs

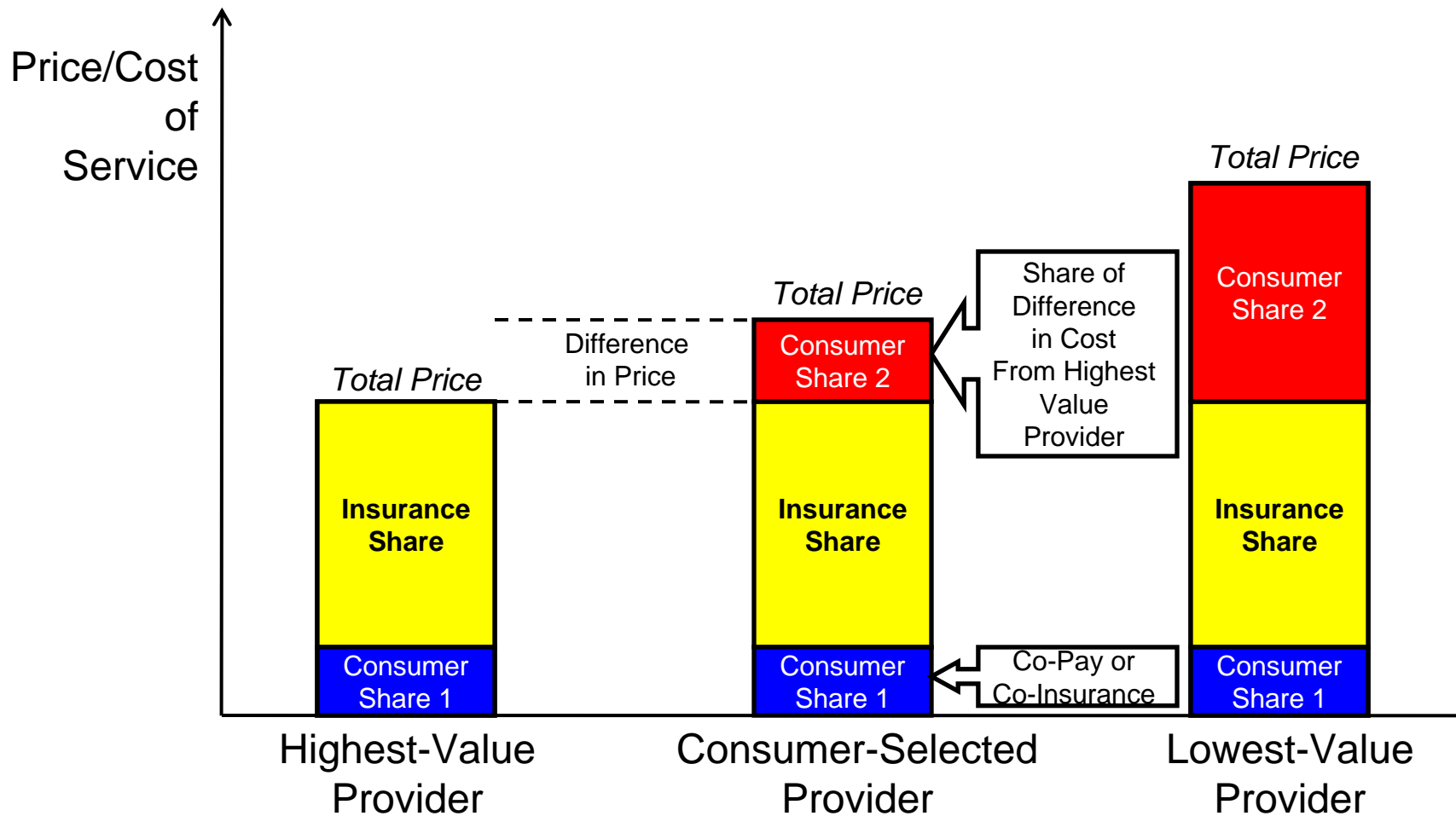
# nrhi Current Systems Don't Encourage Use of Lower Cost Providers



# Current Systems Insulate Consumers from Price Differences



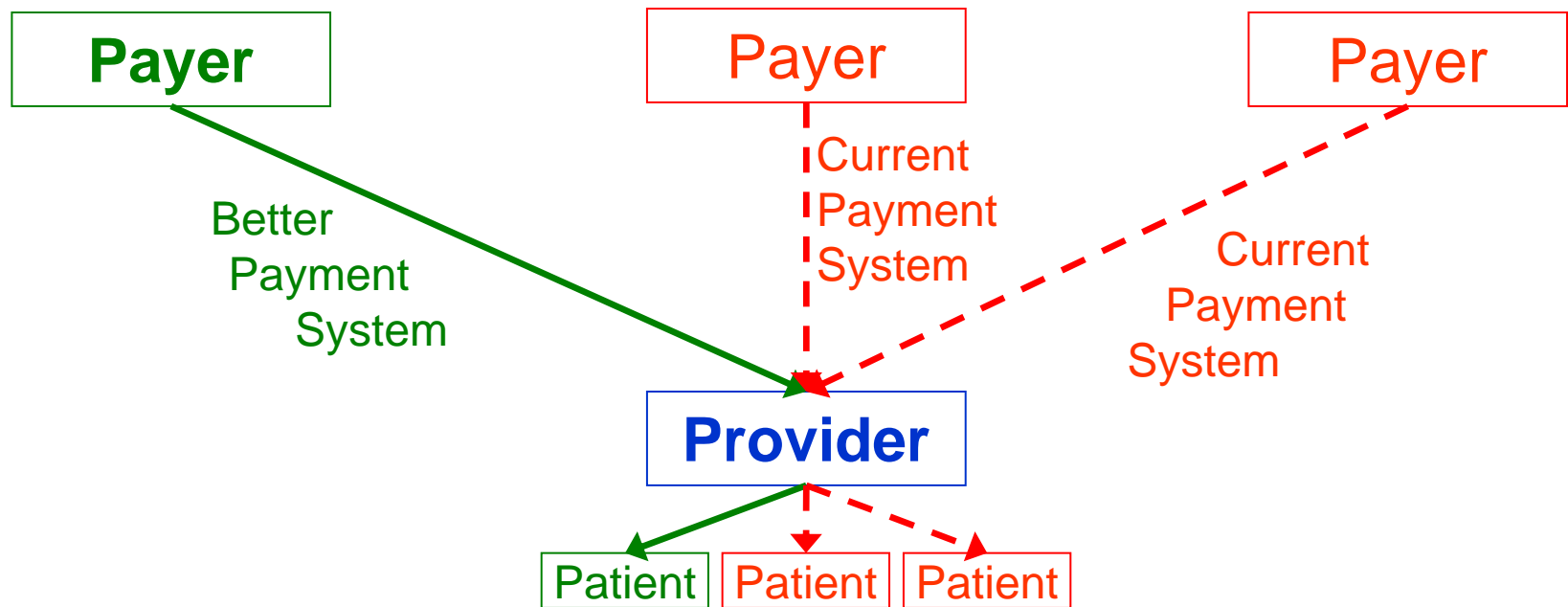
# Solution: Have Consumers Pay All or Part of the “Last Dollar”



# Encouraging Use of Higher-Value Providers and Services

- **Small Number of Tiers:** Tier providers into a small number of tiers based on cost and quality (for easier consumer choice)
- **Significant Consumer Share for Higher Cost:** Charge consumers a significant share of the difference in cost of providers in lower-value tiers; Charge consumers more for using lower-value services
- **Consumer Education:** Educate consumers how to use information

# A Key Challenge: Gaining Support from a Critical Mass of Payers

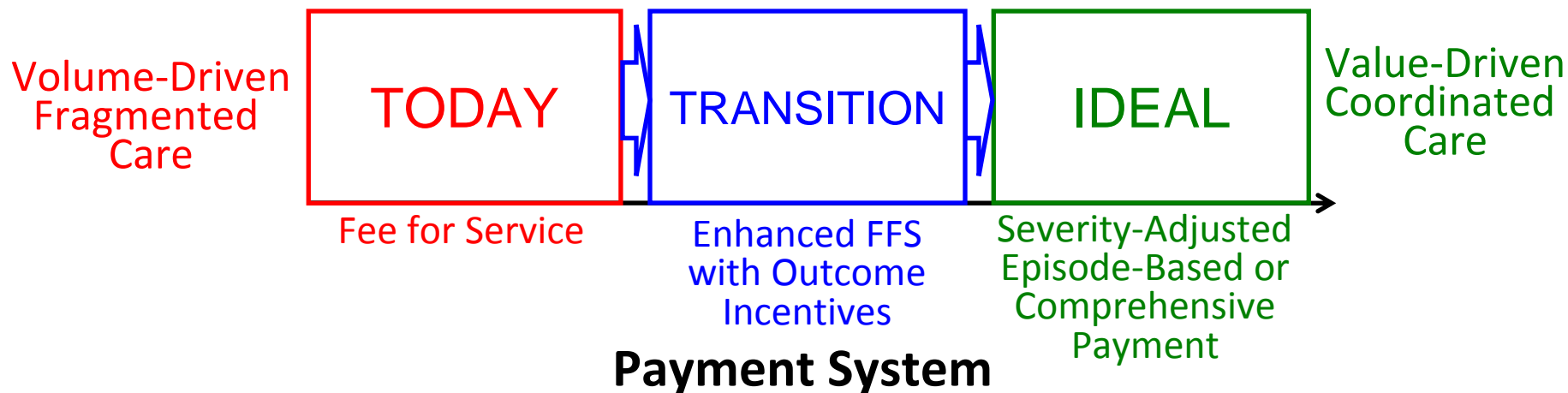


***Provider is only compensated for changed practices for the subset of patients covered by participating payers***

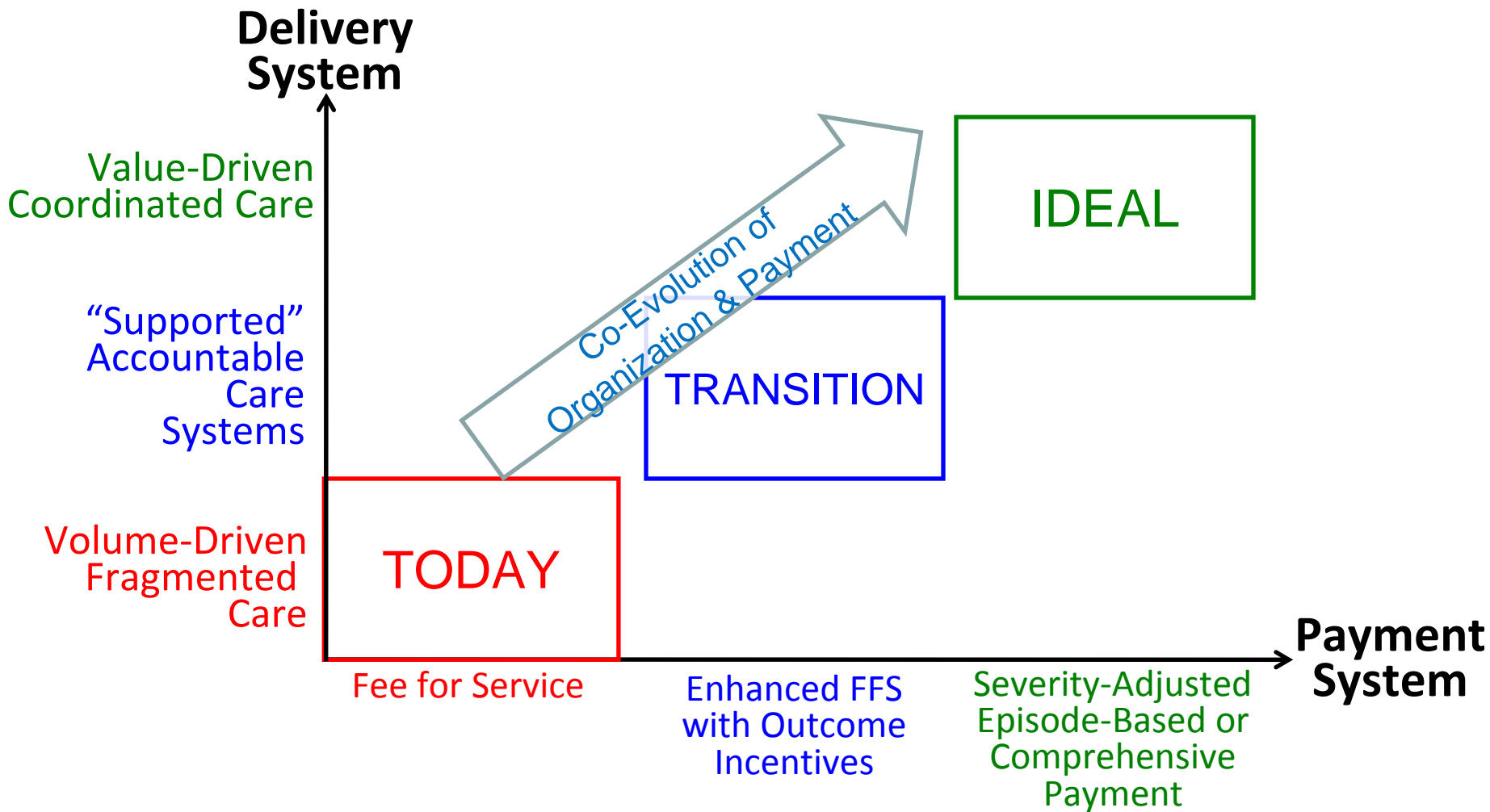
# Regional Collaboratives Needed to Support Payment Reform

- **Alignment of Payment Structures**
  - Due to anti-trust restrictions, there is a need for a neutral body to provide a mechanism for developing a payment structure acceptable to multiple payers
- **Quality and Cost Reporting**
  - Methodologies for quality measurement should be consistent across payers and ideally consistent across the country for national payers
- **Community/Patient Education**
  - Educate the community about the urgent need for change
  - Involve consumers in planning payment changes in meaningful ways

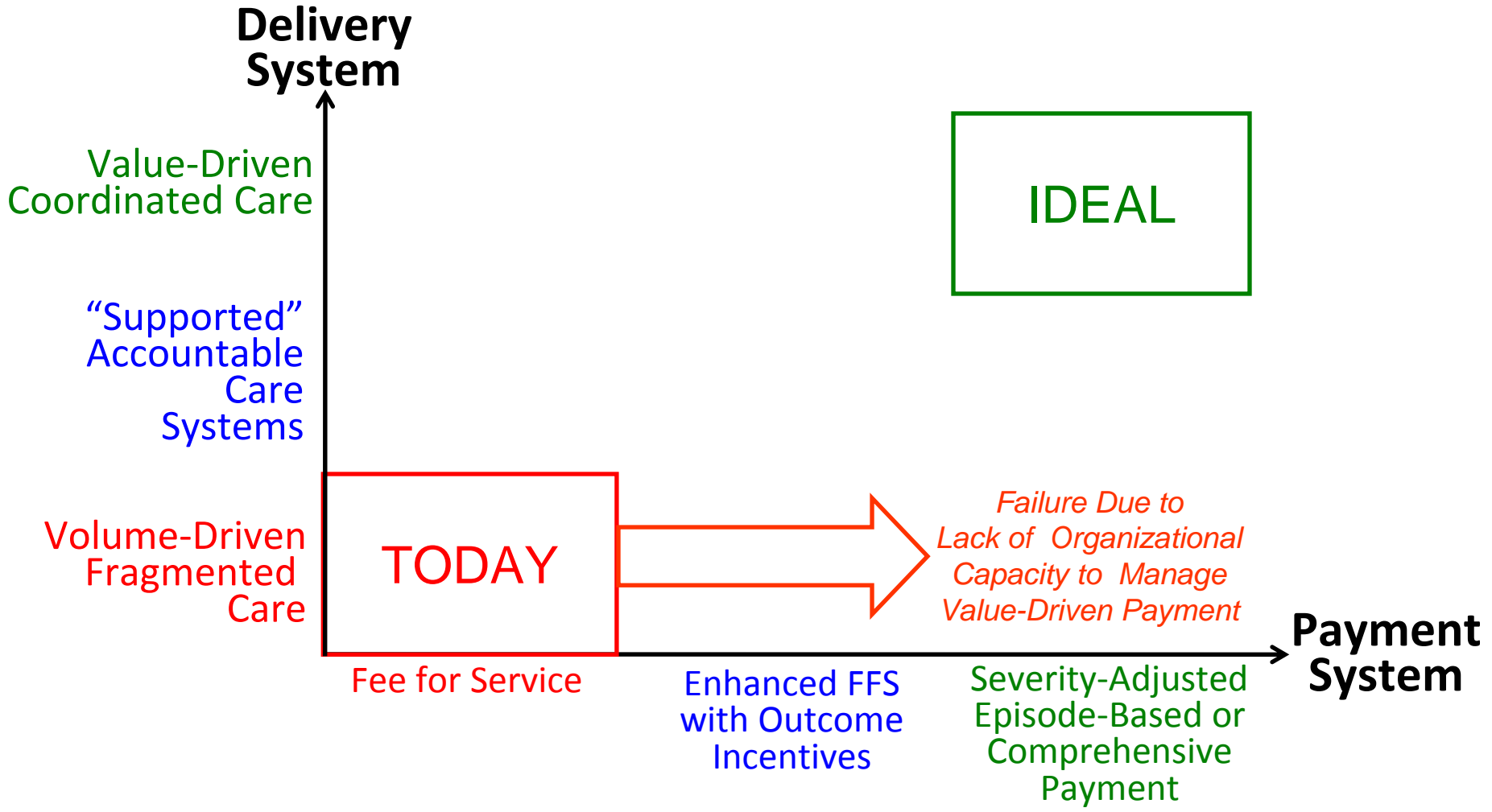
# Transitional Payment Systems Important and Feasible



# Transition for *Delivery System* As Well As Payment: Co-Evolution



# Payment Reform Without Delivery Reform May Not Be Successful

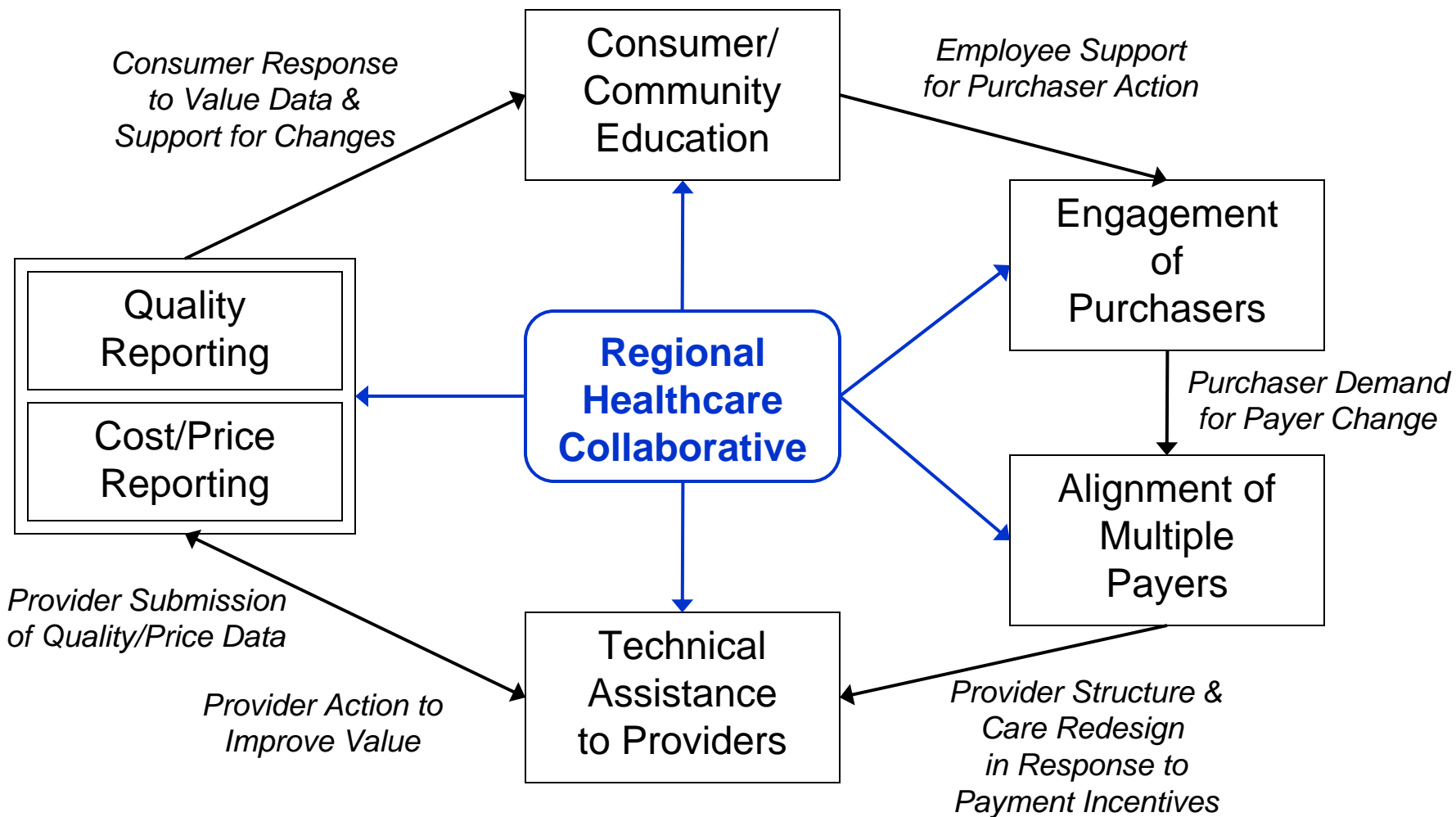


# nrhi Encouraging Providers to Support Changes



- **Hospitals and Specialty Providers**
  - Provide technical assistance in eliminating waste and increasing efficiency, to reduce costs as well as revenues
  - Payers should reduce administrative burdens on providers (e.g., inconsistent reporting requirements)
  - Payers and providers should collaboratively plan for the transition (make changes *with* providers, not *to* them)
- **Small Physician Practices**
  - Provide technical assistance in managing care and finances under new payment models
  - Provide help in forming organizational structures to facilitate quality improvement, share resources, and accept accountability for outcomes/costs

# Coordinated Regional Approach to Payment & Delivery Reform

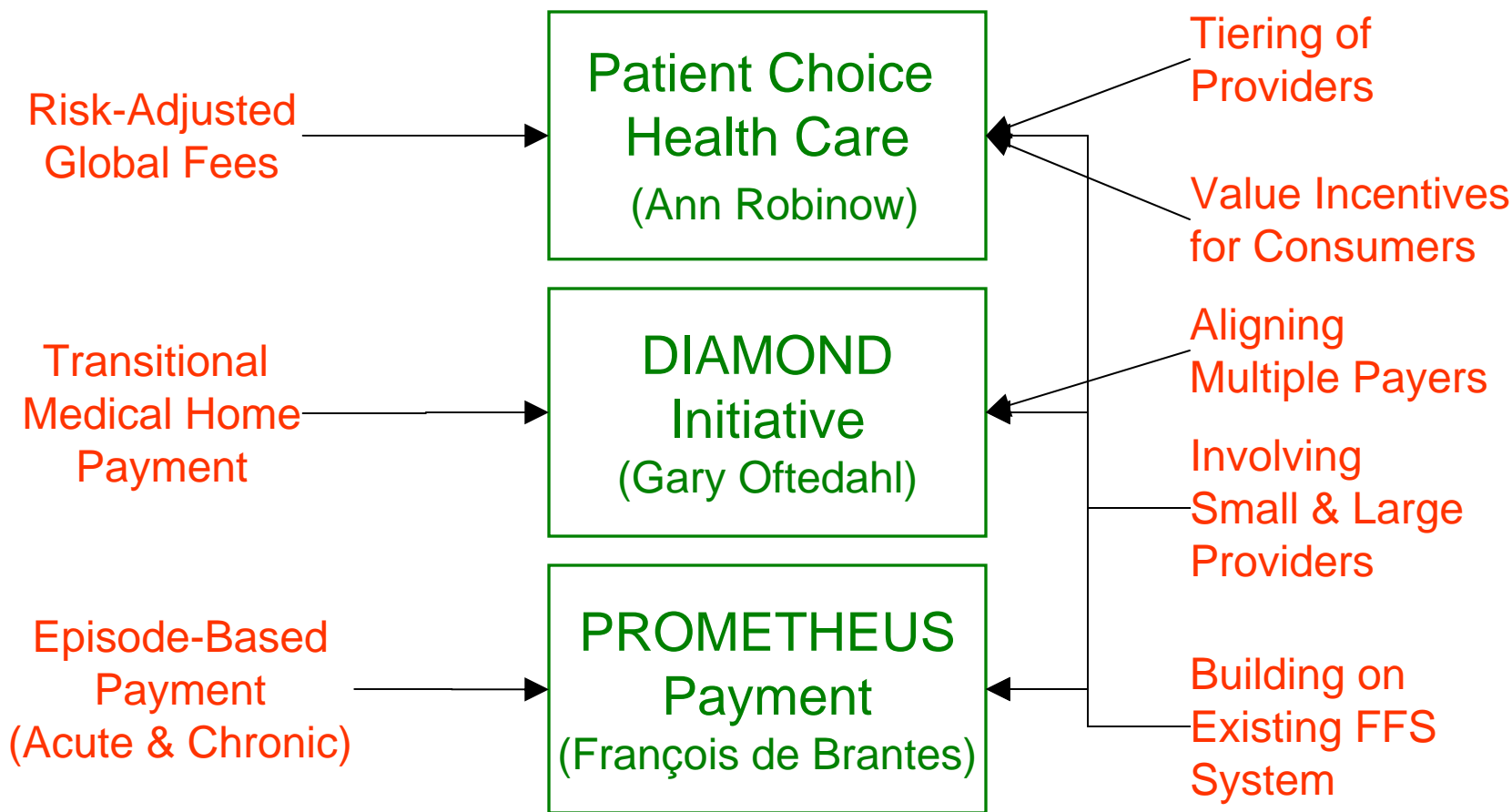


# It's Not Just a Theory – It's Being Done

## PAYMENT MODELS

## EXAMPLES

## CHALLENGES



# For More Information:

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and

Executive Director, Center for Healthcare Quality and Payment Reform

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