CENTER FOR HEALTHCARE QUALITY & PAYMENT REFORM

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FROM VOLUME TO VALUE: Overcoming the Challenges to Meaningful Payment Reform and True Accountable Care

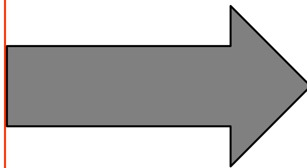
Harold D. Miller
Executive Director
Center for Healthcare Quality and Payment Reform
and
President and CEO
Network for Regional Healthcare Improvement

Just 3 Years Ago, Everyone Was Thinking Very Small...

TODAY

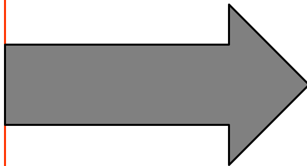
THE FUTURE

Fee
for
Service



Fee
for
Service
+
P4P

Fragmented
Care



Slightly
Better
Fragmented
Care

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...Today, We're Thinking Bigger, But The Future is a BIG Jump

TODAY		THE FUTURE
Fee for Service	→	Episode & Global Payment
Fragmented Care	→	Accountable Care Organizations

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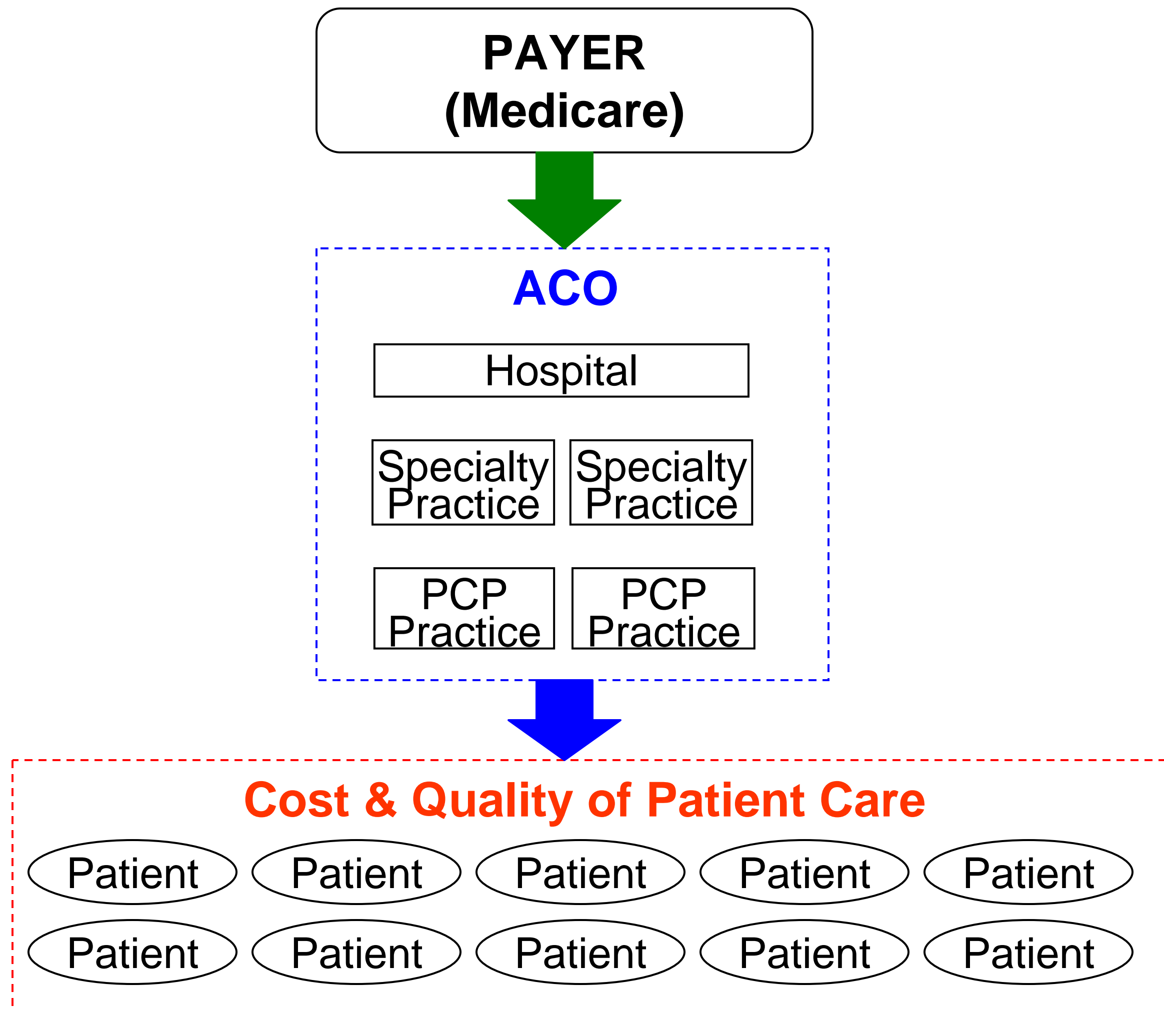
If You Only Think About Medicare, It Seems Easy to Create ACOs



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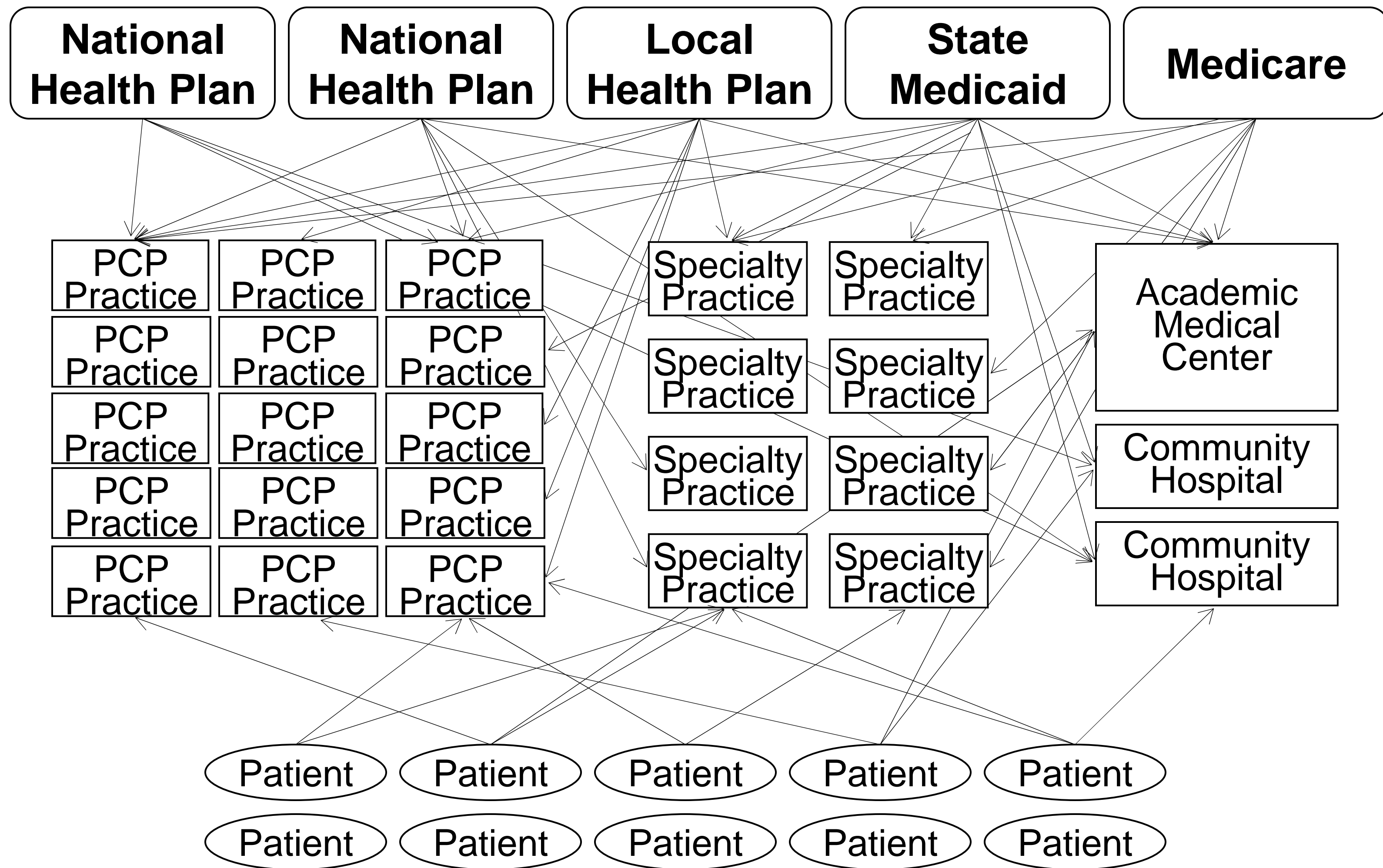
But Real Communities Are Much More Complex



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10 Strategies for Successfully Implementing Payment Reform and Accountable Care Organizations in the Real World

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Challenge: Where Will Savings Actually Come From?

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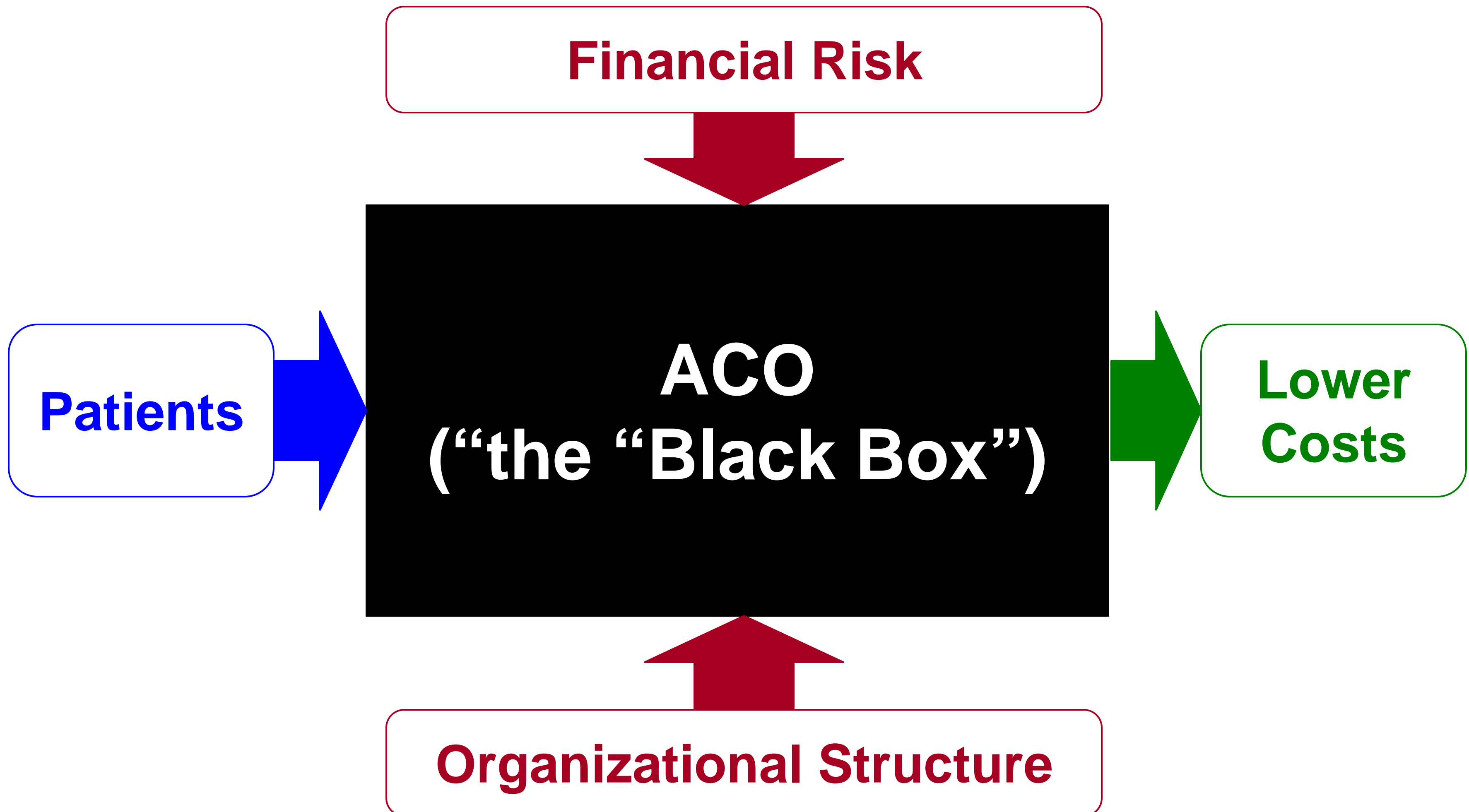
Most Discussions About ACOs Focus on “Risk” and “Structure”



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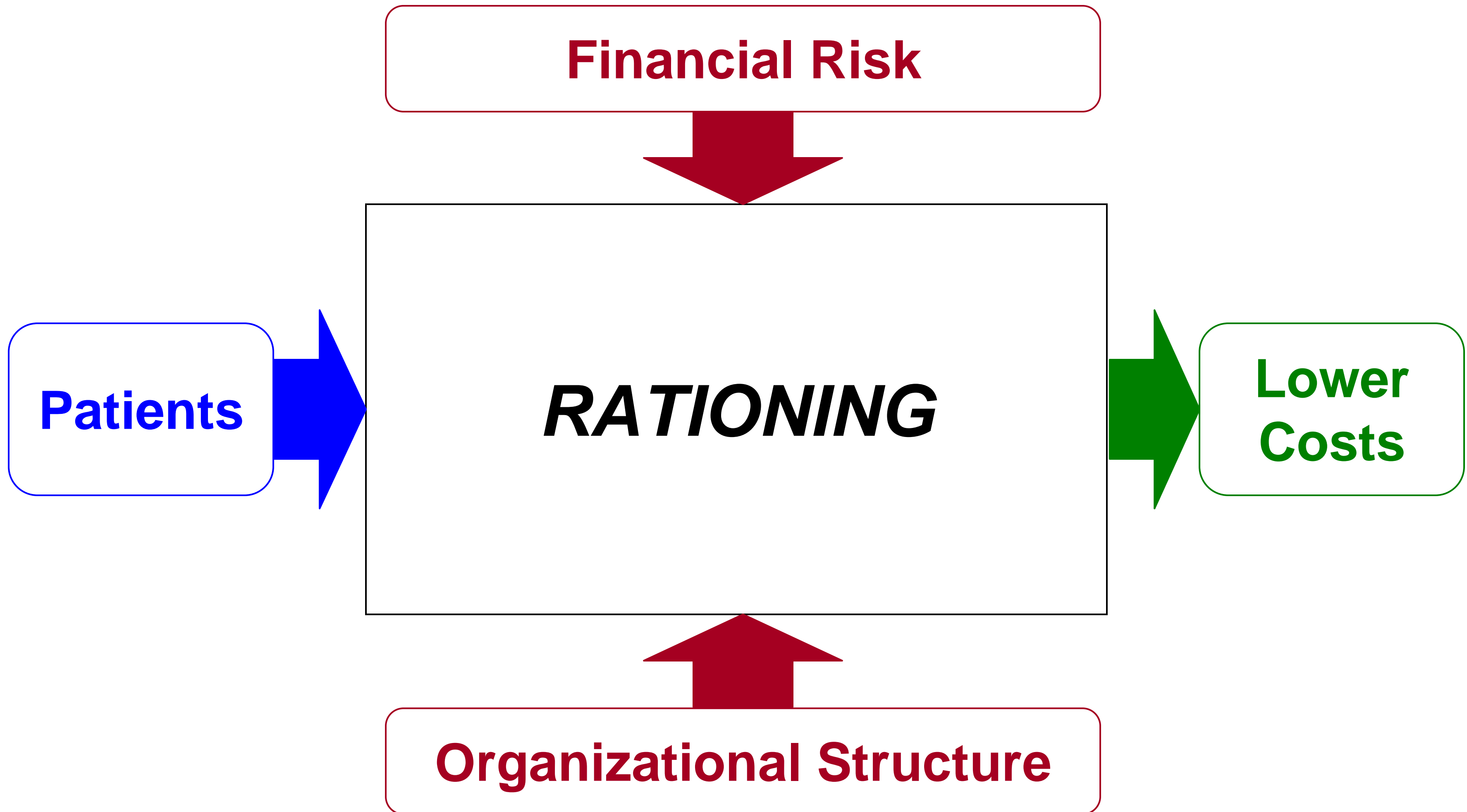
What's In That Black Box Can't Be Good For Consumers, Can It?



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Strategy #1: Focus on How Patient *Care* Will *Improve*

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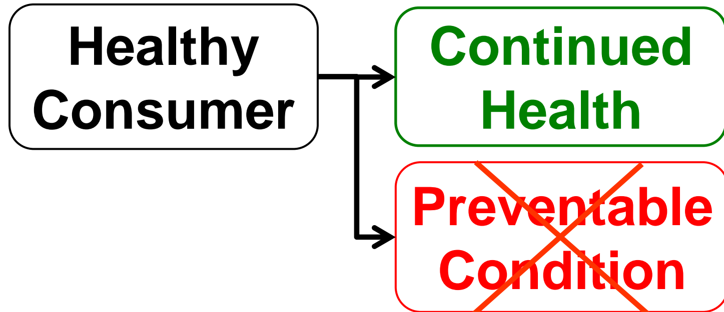
Reducing Costs Without Rationing: Prevention and Wellness



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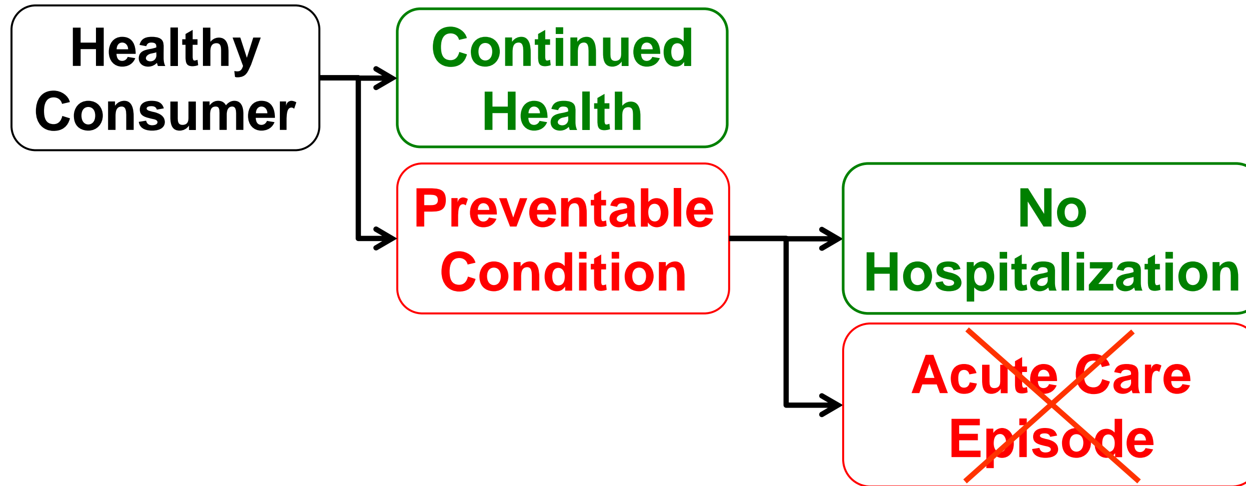
Reducing Costs Without Rationing: Avoiding Hospitalizations



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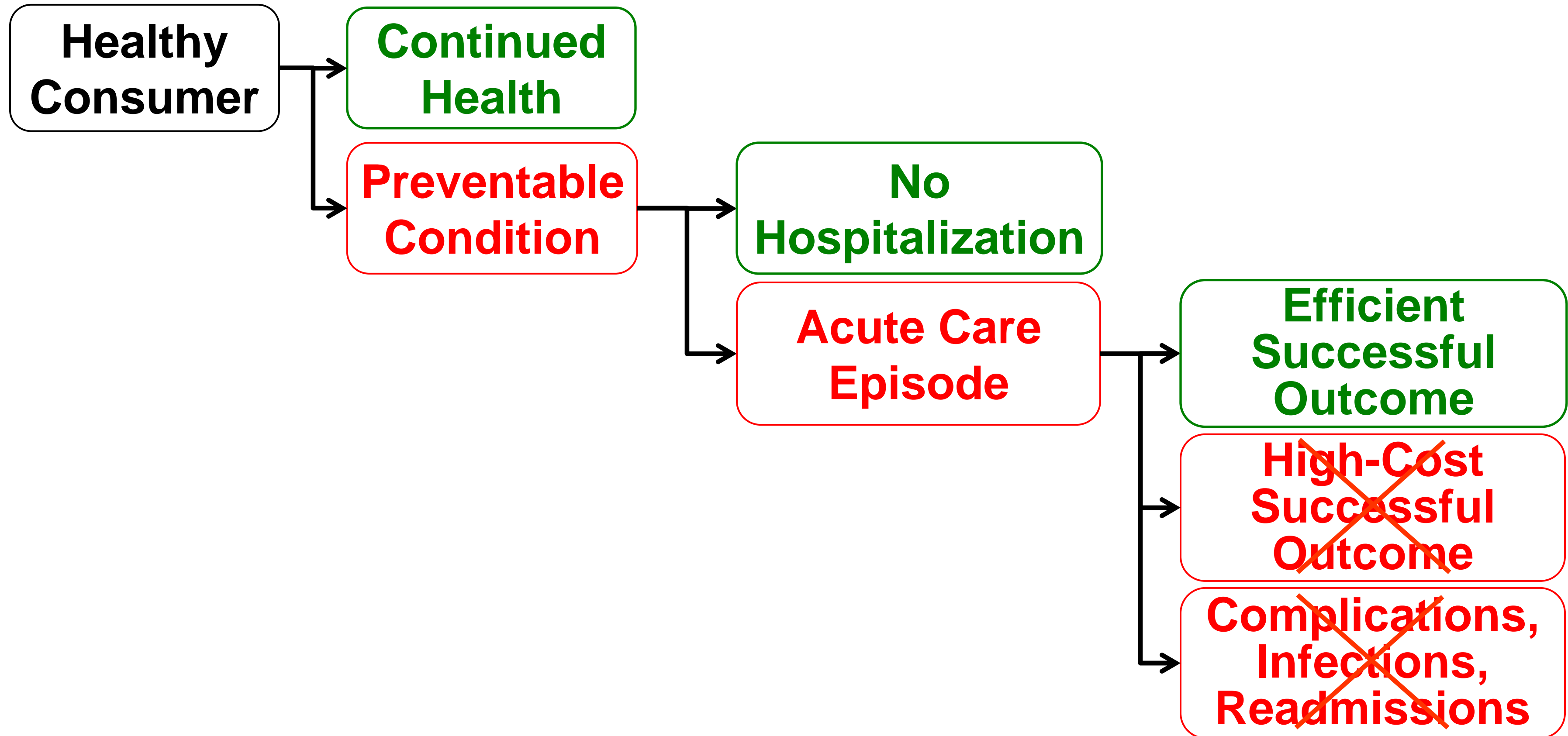
Reducing Costs Without Rationing: Efficient, Successful Treatment



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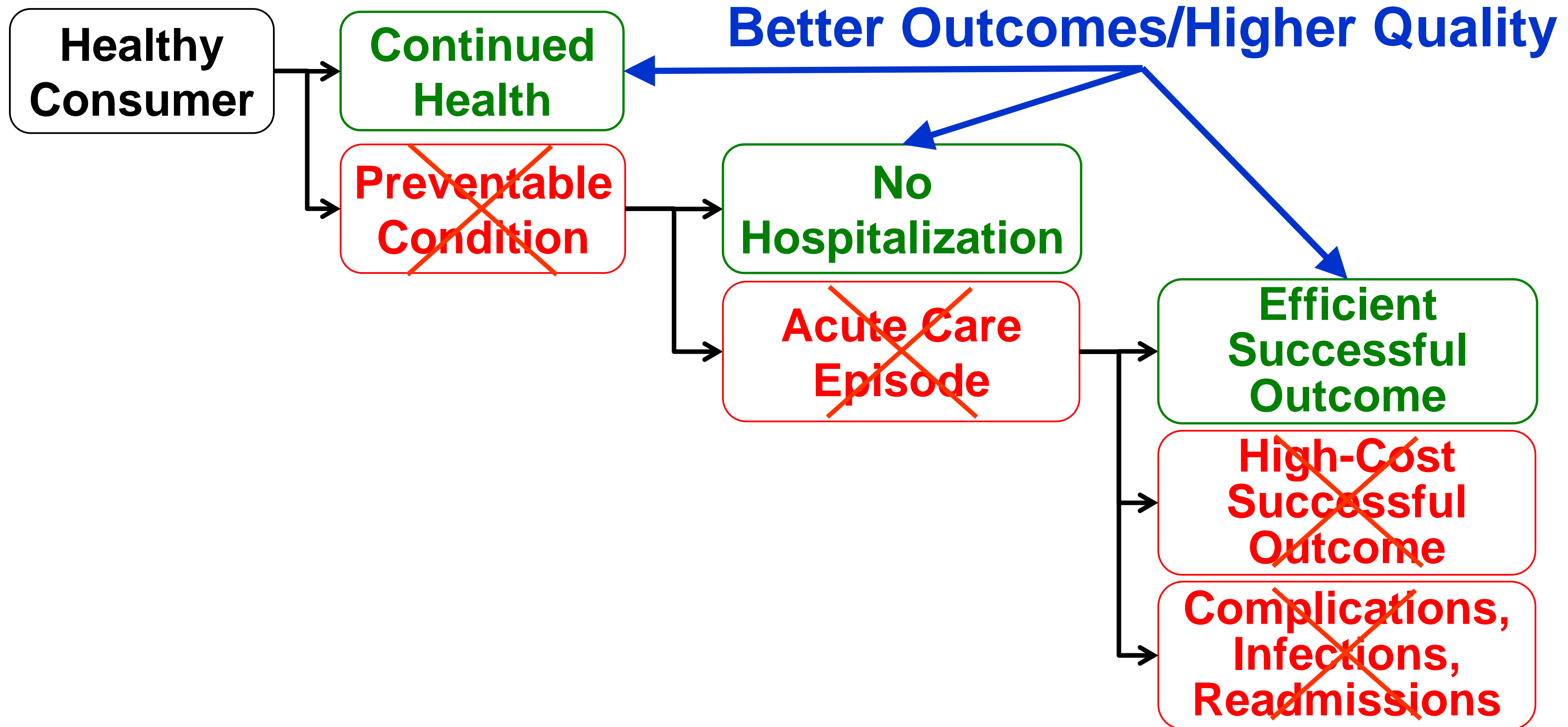
Reducing Costs Without Rationing Is Also Quality Improvement!



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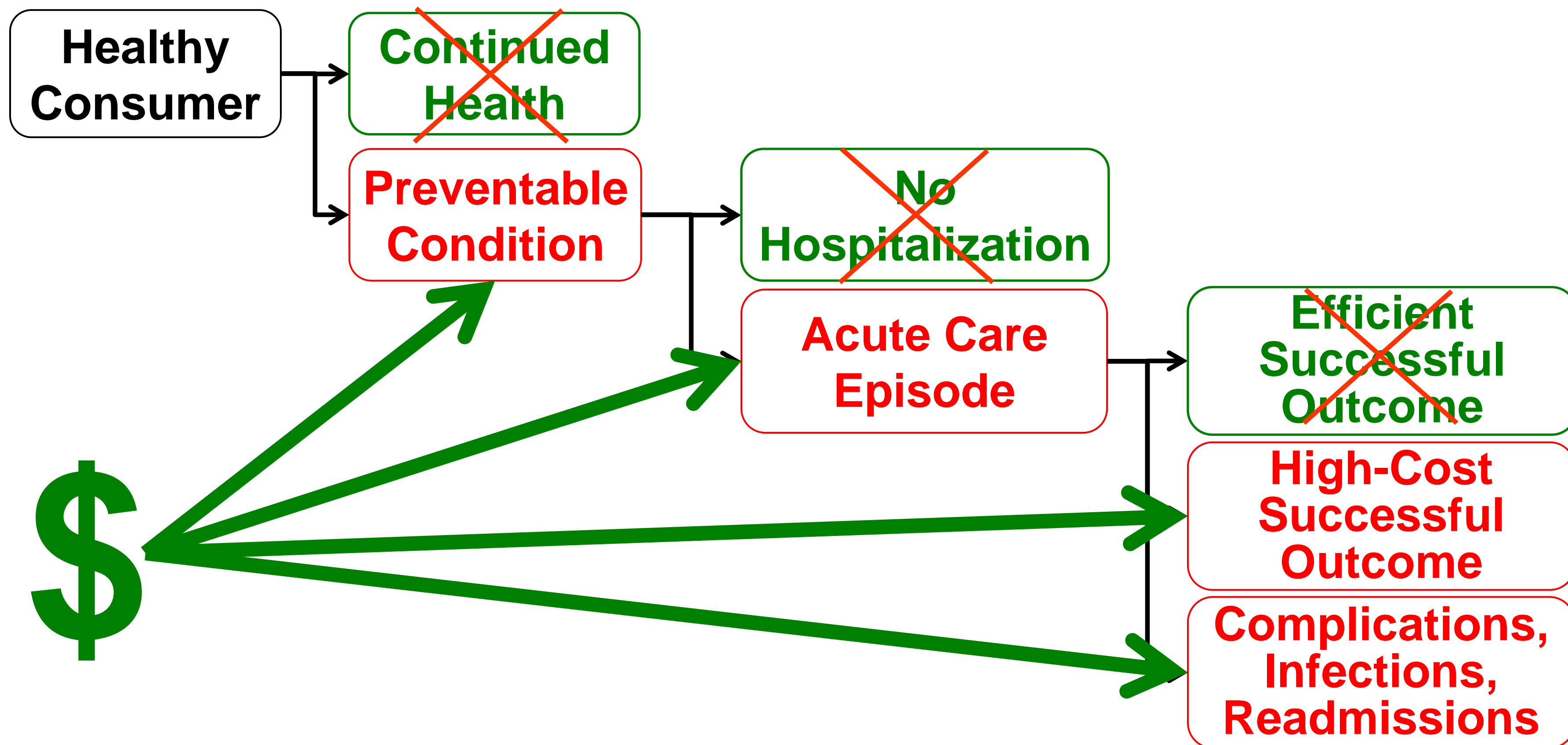
Current Payment Systems Reward Bad Outcomes, Not Better Health



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Strategy #2: Define Payment Reforms That Support Care Chgs

- It's not about "risk" or "incentives," it's about giving healthcare providers the *ability/flexibility* to improve outcomes and reduce costs in a way that is financially feasible
- Desired changes in care should drive payment reforms that support them, not the other way around
- Principal Tools:
  - Episode-of-Care Payment
  - Comprehensive Care Payment/Global Payment

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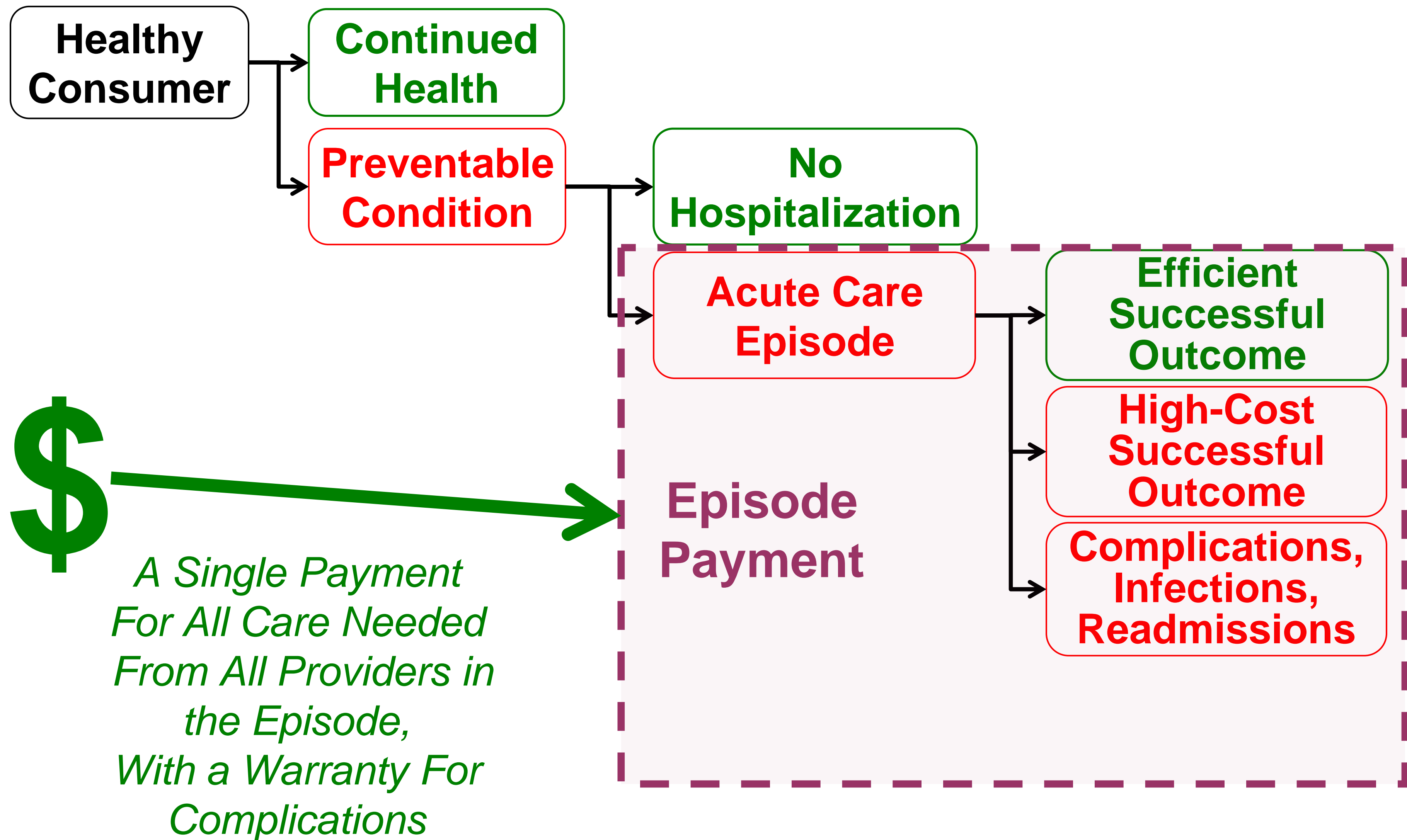
Episode Pmt: Preventing Adverse Events and Improving Coordination



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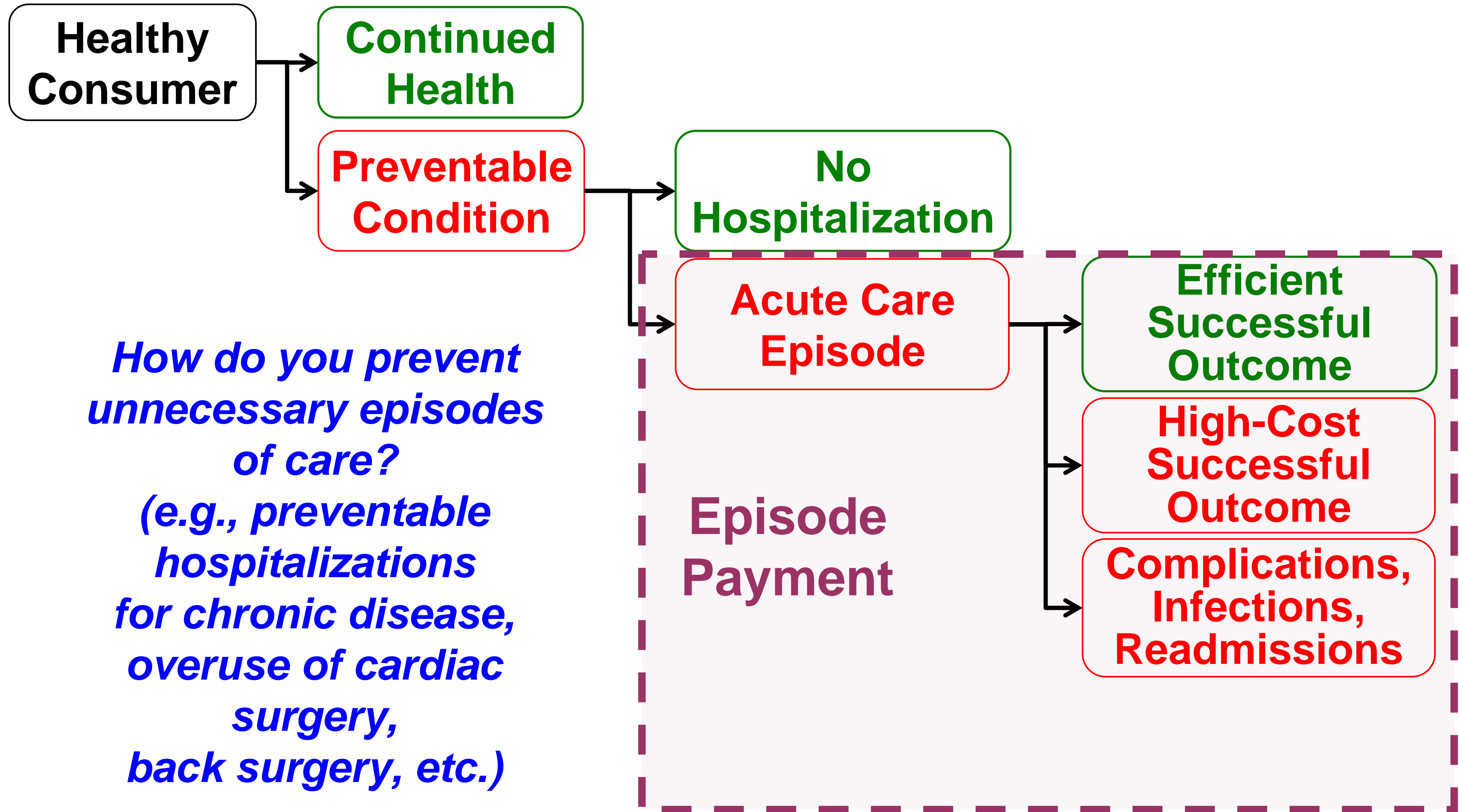
The Weakness of Episode Payment



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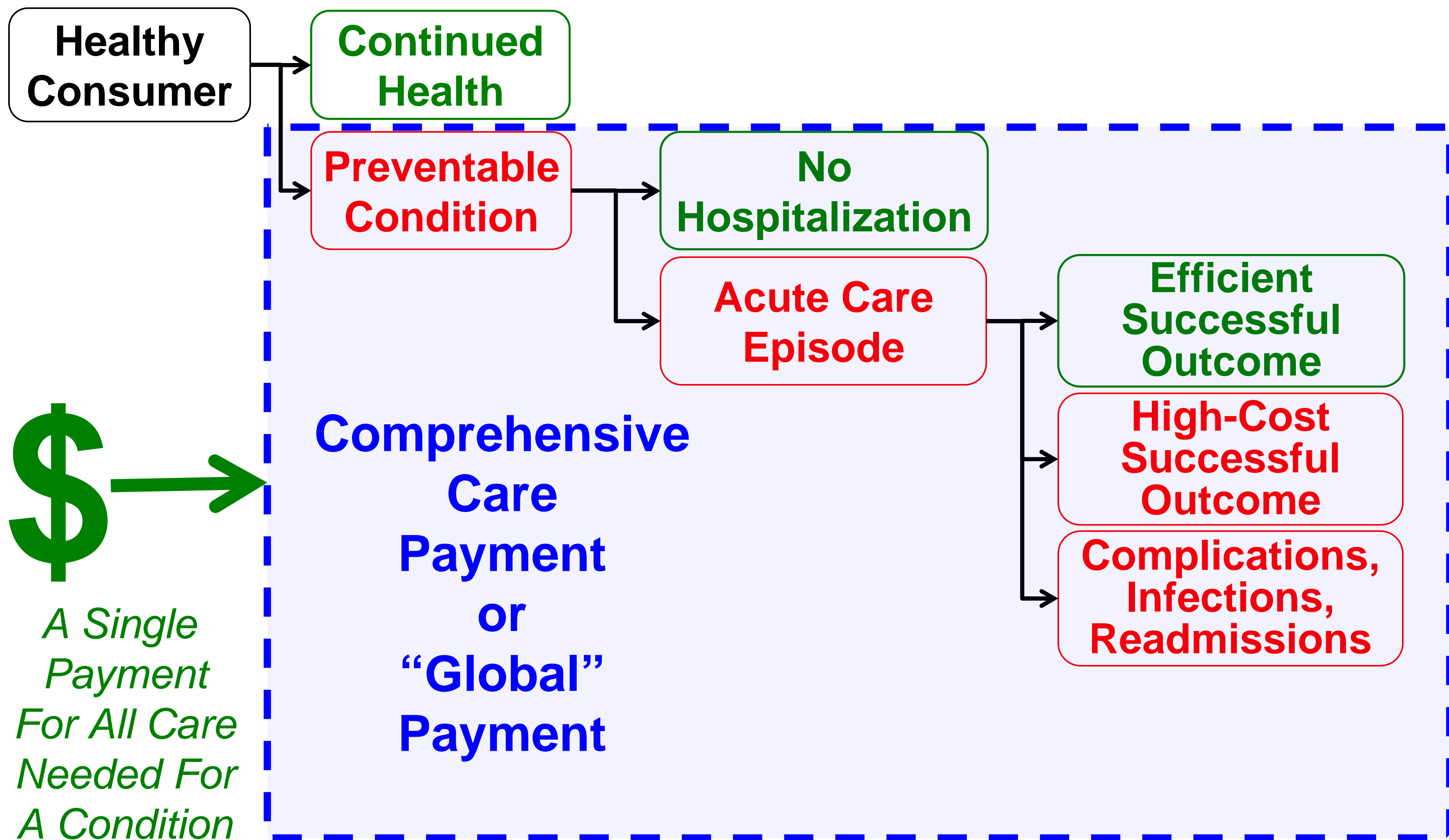
Comp. Care/Global Payments To *Avoid* Unnecessary Acute Care



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Isn't This Capitation (Ugh)? No – It's Different

CAPITATION (WORST VERSIONS)		COMPREHENSIVE CARE PAYMENT
No Additional Revenue for Taking Sicker Patients	→	Payment Levels Adjusted Based on Patient Conditions
Providers Lose Money On Unusually Expensive Cases	→	Limits on Total Risk Providers Accept for Unpredictable Events
Providers Are Paid Regardless of the Quality of Care	→	Bonuses/Penalties Based on Quality Measurement
Provider Makes More Money If Patients Stay Well	→	Provider Makes More Money If Patients Stay Well
Flexibility to Deliver Highest-Value Services	→	Flexibility to Deliver Highest-Value Services

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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
  - Allows provider to reap returns on investment in preventive care, infrastructure
- Broad participation, including small, non-integrated providers
  - 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

http://www.bluecrossma.com/visitor/about-us/making-quality-health-care-affordable.html

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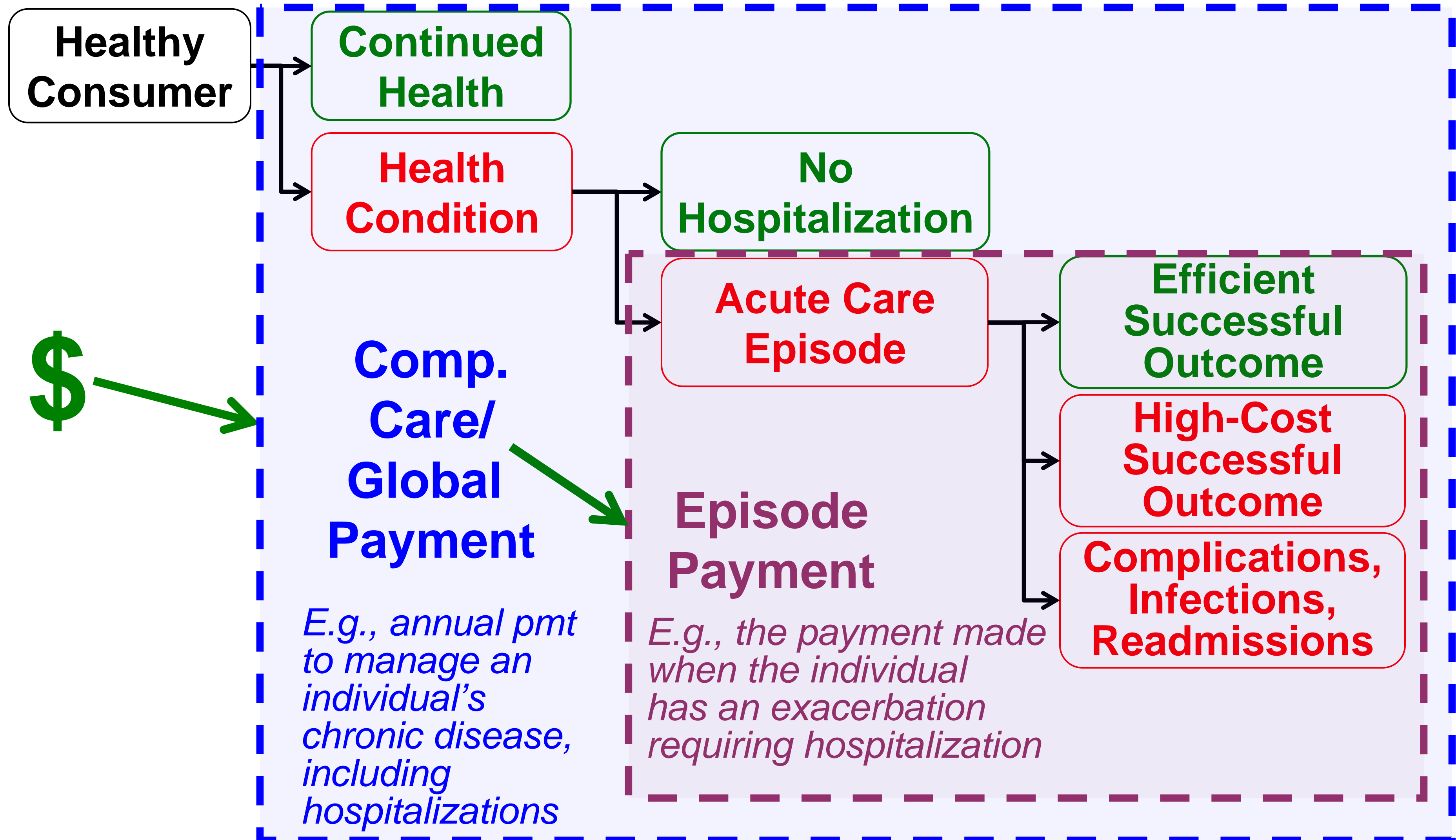
Comprehensive Care & Episode Payment Can Be Complementary



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Strategy #3: Use Data to Find Win-Win-Win Opportunities

- Better Care for Patients
- Lower Costs for Purchasers/Payers
- Equal or Better Margins for Providers

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Use Data for *Analysis* Not Just "Measurement"

- *Measurement* presumes we know what we're looking for, that we know what's desirable/achievable in all communities, and that we can legitimately rate/rank providers based on the measures
  - That's a high standard, and it's not surprising that we don't have adequate measures in many important areas, particularly outcome measures
- *Analysis*, particularly *exploratory* analysis, presumes only that we believe there are opportunities to improve value, and that more work will be needed to determine what is achievable and cost-effective

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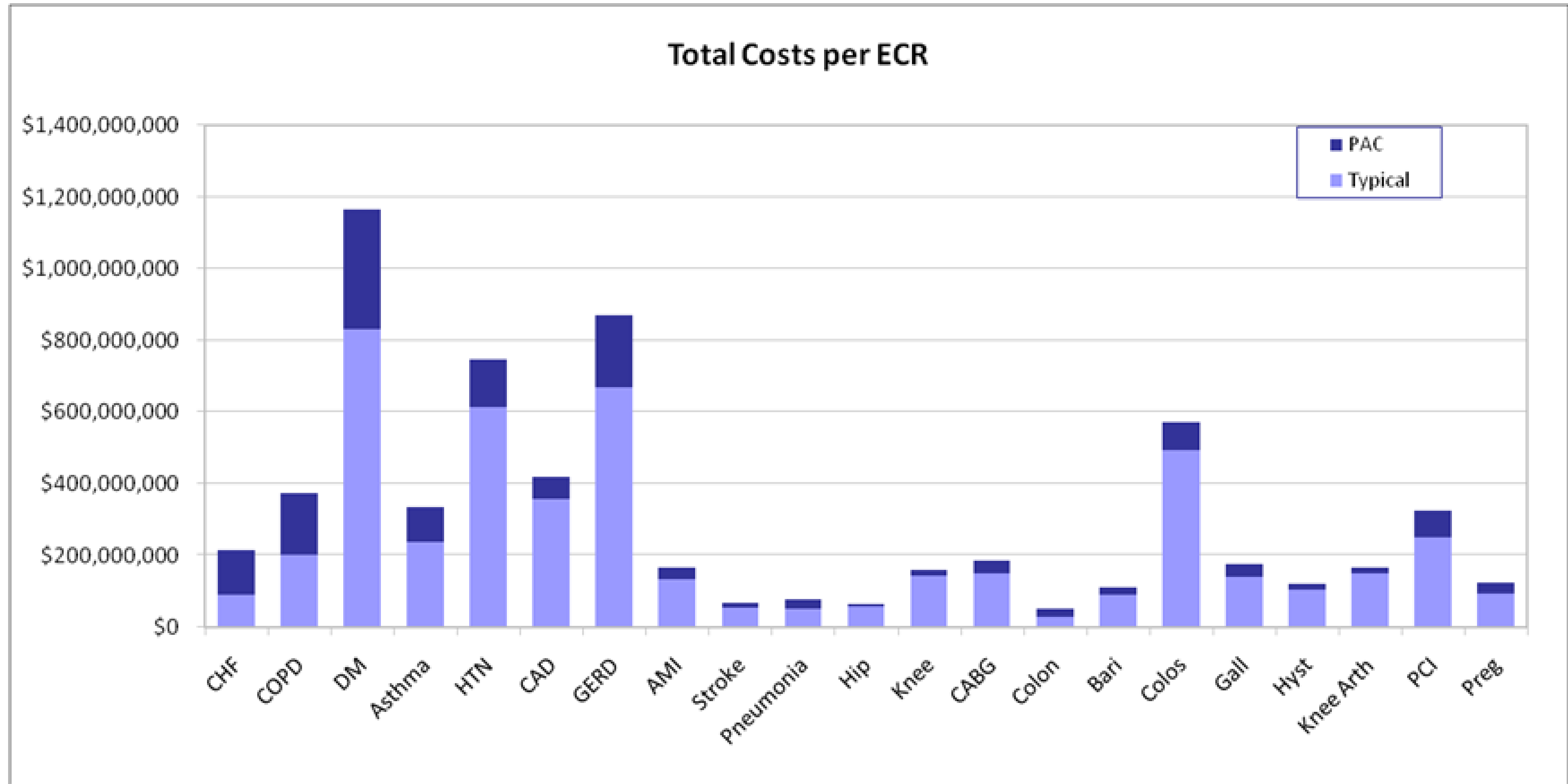
Example: Prometheus Analyses of Avoidable Complications



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It's Not Just Payment *Method*, But How Do You Set the *Price*?

- Improving the structure and incentives of payment systems is necessary but not sufficient
- If payment level is (too) high, there will be no savings and little incentive to transform care
- If payment level is too low, providers will be unable to deliver high-quality care and risk financial disaster

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Prices for Warrantied Care May Well Be *Higher*

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Prices for Warrantied Care May Well Be *Higher*

- Q: “Why should we pay more to get good-quality care??”
- A: In most industries, warrantied products cost more, but they’re desirable because TOTAL spending on the product (repairs & replacement) is lower than without the warranty

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Prices for Warrantied Care May Be Higher, But *Spending Lower*

- Q: "Why should we pay more to get good-quality care??"
- A: In most industries, warrantied products cost more, but they're desirable because TOTAL spending on the product (repairs & replacement) is lower than without the warranty
- In healthcare, a DRG with a warranty would need to have a higher payment rate than the equivalent non-warrantied DRG, but the higher price *should* be offset by fewer DRGs w/ complications, outlier payments, and readmissions

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Example: Procedure Where Provider is Paid $10,000 Today

Cost of Procedure
$10,000

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Actual Average Payment for Procedure is Higher

Cost of Procedure	Added Cost of Infection	Rate of Infections	Average Total Cost
$10,000	$20,000	5%	$11,000

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Starting Point for Warranty Price: Actual Current Average Payment

Cost of Procedure	Added Cost of Infection	Rate of Infections	Average Total Cost	Price Charged	Change in Net Revenue
$10,000	$20,000	5%	$11,000	$11,000	$0

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Limited Warranty Gives Financial Incentive to Improve Quality

Cost of Procedure	Added Cost of Infection	Rate of Infections	Average Total Cost	Price Charged	Change in Net Revenue
$10,000	$20,000	5%	$11,000	$11,000	$0
$10,000	$20,000	**4%**	$10,800	$11,000	**$200**

Reducing Adverse Events…

...Reduces Costs...

…Improves The Bottom Line

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Higher-Quality Provider Can Charge Less, Attract More Patients

Cost of Procedure	Added Cost of Infection	Rate of Infections	Average Total Cost	Price Charged	Change in Net Revenue
$10,000	$20,000	5%	$11,000	$11,000	$0
$10,000	$20,000	4%	$10,800	$11,000	$200
$10,000	$20,000	4%	$10,800	$10,800	$0

Enables Lower Prices

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A Virtuous Cycle of Quality Improvement & Cost Reduction

Cost of Procedure	Added Cost of Infection	Rate of Infections	Average Total Cost	Price Charged	Change in Net Revenue
$10,000	$20,000	5%	$11,000	$11,000	$0
$10,000	$20,000	4%	$10,800	$11,000	$200
$10,000	$20,000	4%	$10,800	$10,800	$0
$10,000	$20,000	**3%**	$10,600	$10,800	**$200**

Reducing Adverse Events…

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Win-Win-Win for Patients, Payers, and Providers

Cost of Procedure	Added Cost of Infection	Rate of Infections	Average Total Cost	Price Charged	Change in Net Revenue
$10,000	$20,000	5%	$11,000	$11,000	$0
$10,000	$20,000	4%	$10,800	$11,000	$200
$10,000	$20,000	4%	$10,800	$10,800	$0
$10,000	$20,000	3%	$10,600	$10,800	$200
$10,000	$20,000	3%	$10,600	$10,600	$0
$10,000	$20,000	0%	$10,000	$10,600	$600

Quality is Better...

...Cost is Lower...

...Providers More Profitable

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In Contrast, Non-Payment Alone Creates Financial Losses

Cost of Procedure	Added Cost of Infection	Rate of Infections	Average Total Cost	Amount Paid	Change in Net Revenue
$10,000	$20,000	5%	$11,000	$11,000	$0
$10,000	$20,000	5%	$11,000	$10,000	-$1,000
$10,000	$20,000	3%	$10,600	$10,000	-$600
$10,000	$20,000	0%	$10,000	$10,000	$0

Non-Payment for Infections

Causes Losses While Improving

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The Challenge Remains: How Do You Set a Warrantied Price?

- If the warrantied price is higher than (total) current costs, there are no savings and no incentive to transform care
- If the warrantied price is too low, providers will be unable to deliver high-quality care and risk financial disaster

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Shared, Trusted Data for Pricing Critical for Success

- **Provider** needs to know what its current utilization rates, preventable complication rates, etc. are to know whether an episode or global payment amount will cover its costs of delivering care
- **Purchaser** needs to know what its current utilization rates, preventable complication rates, etc. are to know whether an episode or global payment amount is a better deal than they have today
- **Both** sets of data have to match in order for both purchasers and payers to agree!

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Our Standard Methods of Controlling Prices Don't Work

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  - Even large insurers can't demand price concessions from large/monopoly providers

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- **Narrow Networks**
  - In theory, could steer patients to lower-cost providers and give providers greater volume to reduce prices
  - In practice, prohibits patients from using the providers they prefer and creates consumer backlash
  - Networks are based on providers, not services, so providers with some good services are either in or out for all services

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- **Copays, Co-insurance and High-Deductible Health Plans**
  - Create little incentive for consumers to choose lower-cost providers on the expensive items that make a difference
  - Create significant disincentive to pursue preventive care that may prevent the expensive items in the first place

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Strategy #4: Better Ways of Controlling Prices

- **Consumer Incentives for Value-Based Choice**
  - Understandable information on price and quality
  - Tier providers on price and quality
  - Require consumers to pay the “last dollar” of provider cost

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- **Ensuring There Are Competitors**
  - Avoiding anti-competitive consolidations
  - Avoiding creating unnecessarily high barriers to entry (e.g., requirements for EHRs, large numbers of patients, control of all services)
  - Provide technical and financial assistance to allow small physician practices to participate

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  - Provide technical and financial assistance to allow small physician practices to participate
- **Enabling Competitors to Compete**
  - Precluding all-or-nothing contracting
  - Precluding provider bans on tiered insurance products

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Strategy #5: Focus on Physicians, Not Hospitals

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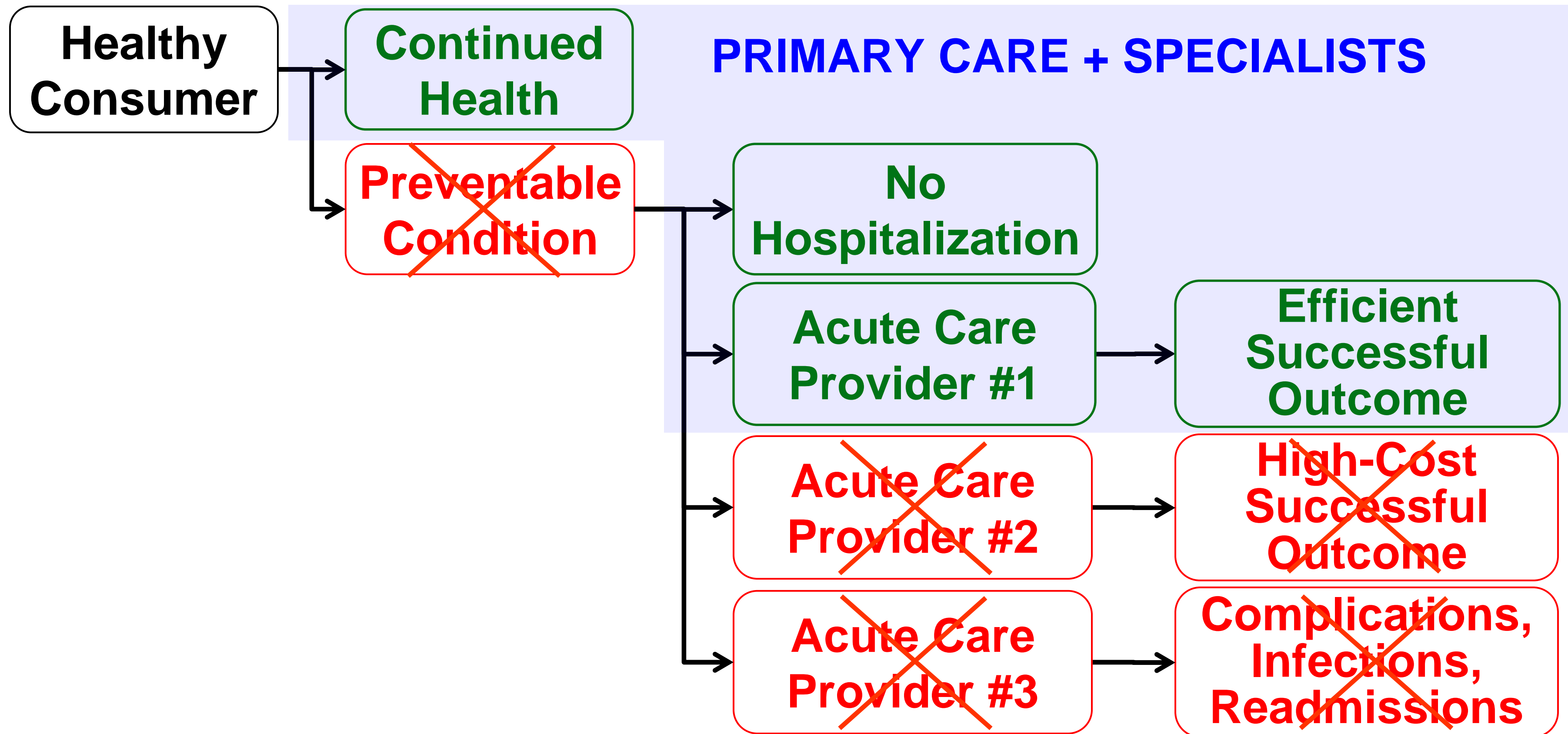
Strategy #5: Focus on Physicians, Not Hospitals



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What a Single Physician Can Do

- 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:
  - Surgeon received over 80% more in payment than otherwise
  - Hospital received 13% more than otherwise, despite fewer rehospitalizations
  - Health insurer paid 40% less than otherwise
- Method:
  - Reducing unnecessary auxiliary services such as radiography and physical therapy
  - Reducing the length of stay in the hospital
  - Reducing complications and readmissions.

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What Groups of Small, Independent Practices Can Do

- Small Primary Care Practices Managing Global Payments
  - Physician Health Partners (PHP) in Denver, CO is a management services organization that supports four separate IPAs (median size: 3 MDs/practice). PHP accepts capitated risk-based contracts on behalf of the IPAs with both Medicare and commercial HMOs. www.phpmcs.com
- Independent PCPs & Specialists Managing Global Payments
  - Northwest Physicians Network (NPN) in Tacoma, WA is an IPA with 109 PCPs and 345 specialists in 165 practices (average size: 2.4 MDs/practice). NPN accepts full or partial risk capitation contracts, operates its own Medicare Advantage plan, and does third party administration for self-insured businesses. www.npnwa.net
- Joint Contracting by MDs & Hospitals for Global Payments
  - The Mount Auburn Cambridge IPA (MACIPA) and Mount Auburn Hospital jointly contract with three major Boston-area health plans for full-risk capitation. The IPA is independent of the hospital; they coordinate care with each other without any formal legal structure. www.macipa.com

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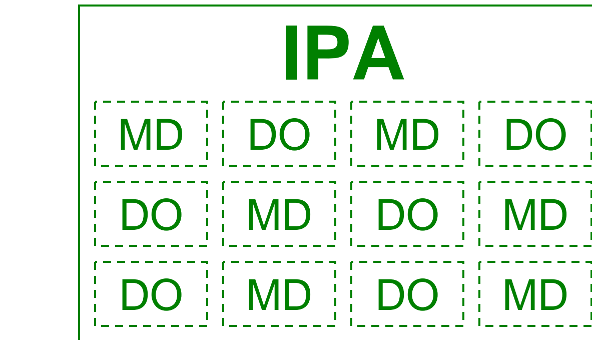
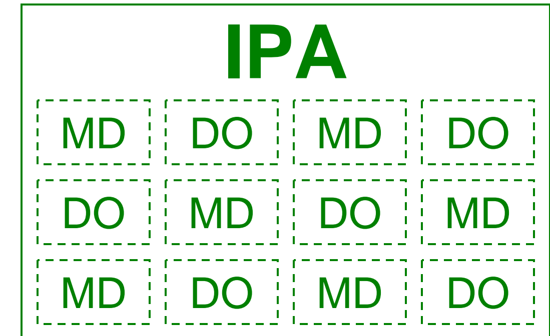
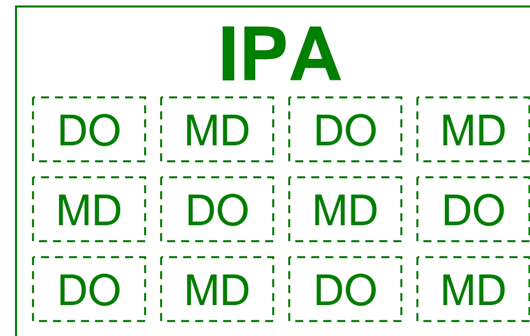
Which Is More Likely to Generate True Price Competition?

VS







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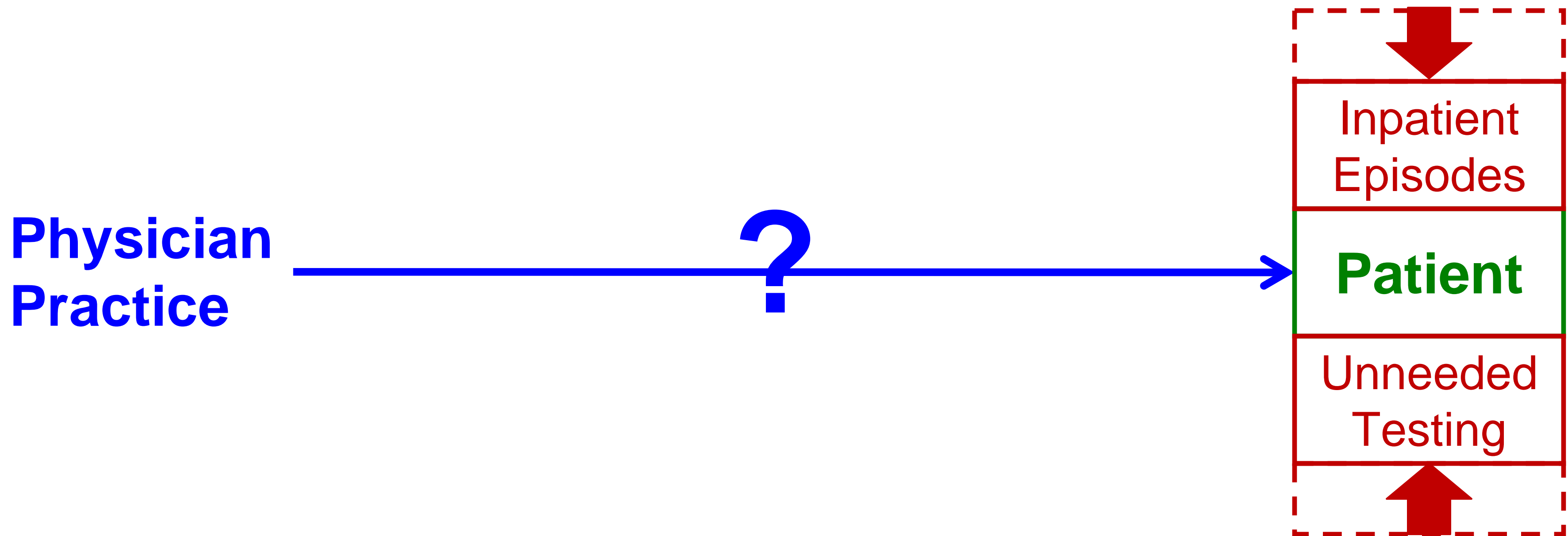
Physicians Need the Resources & Skills to Take Accountability



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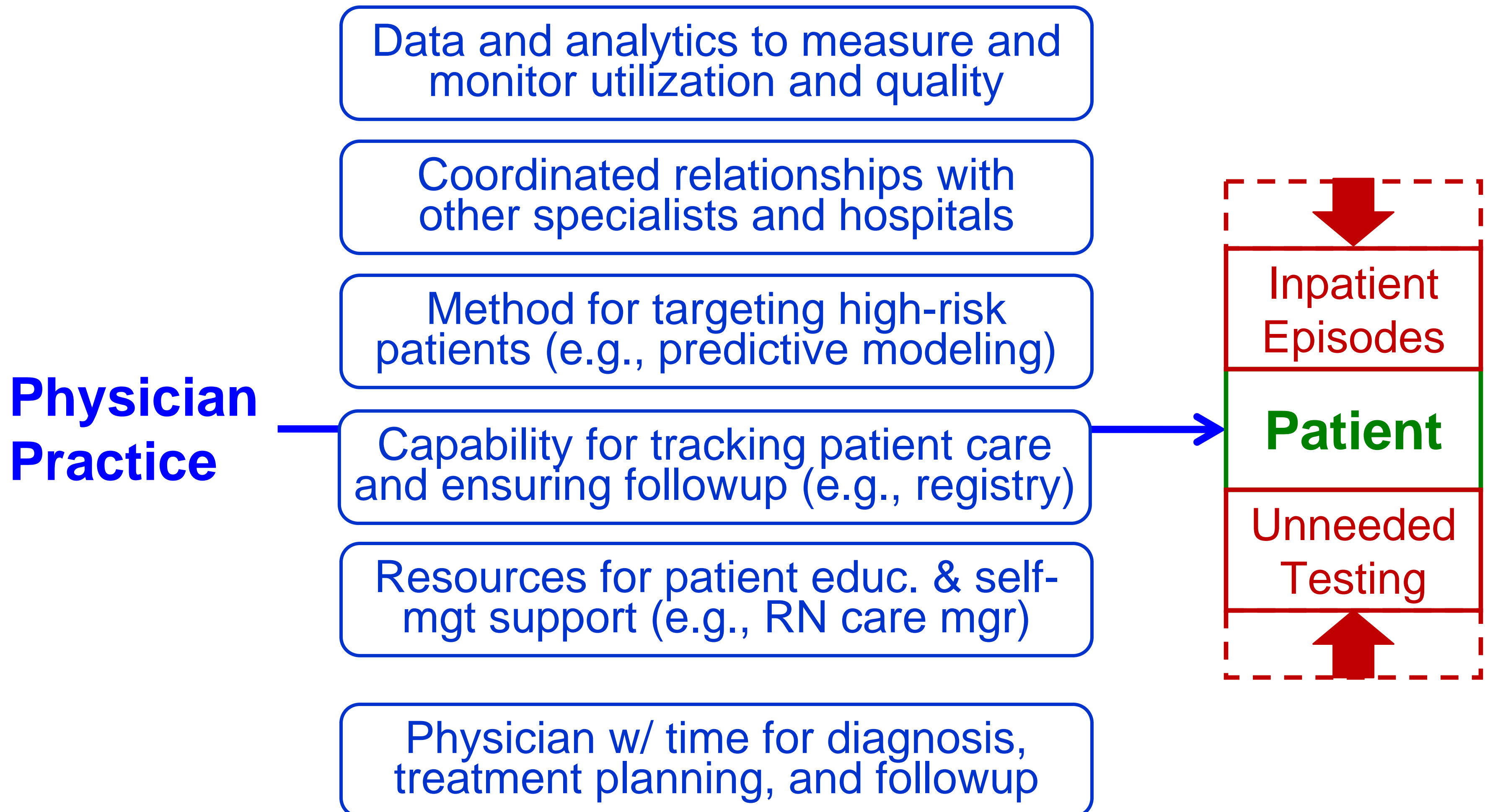
Resources/Capabilities Needed for Docs to Take Accountability



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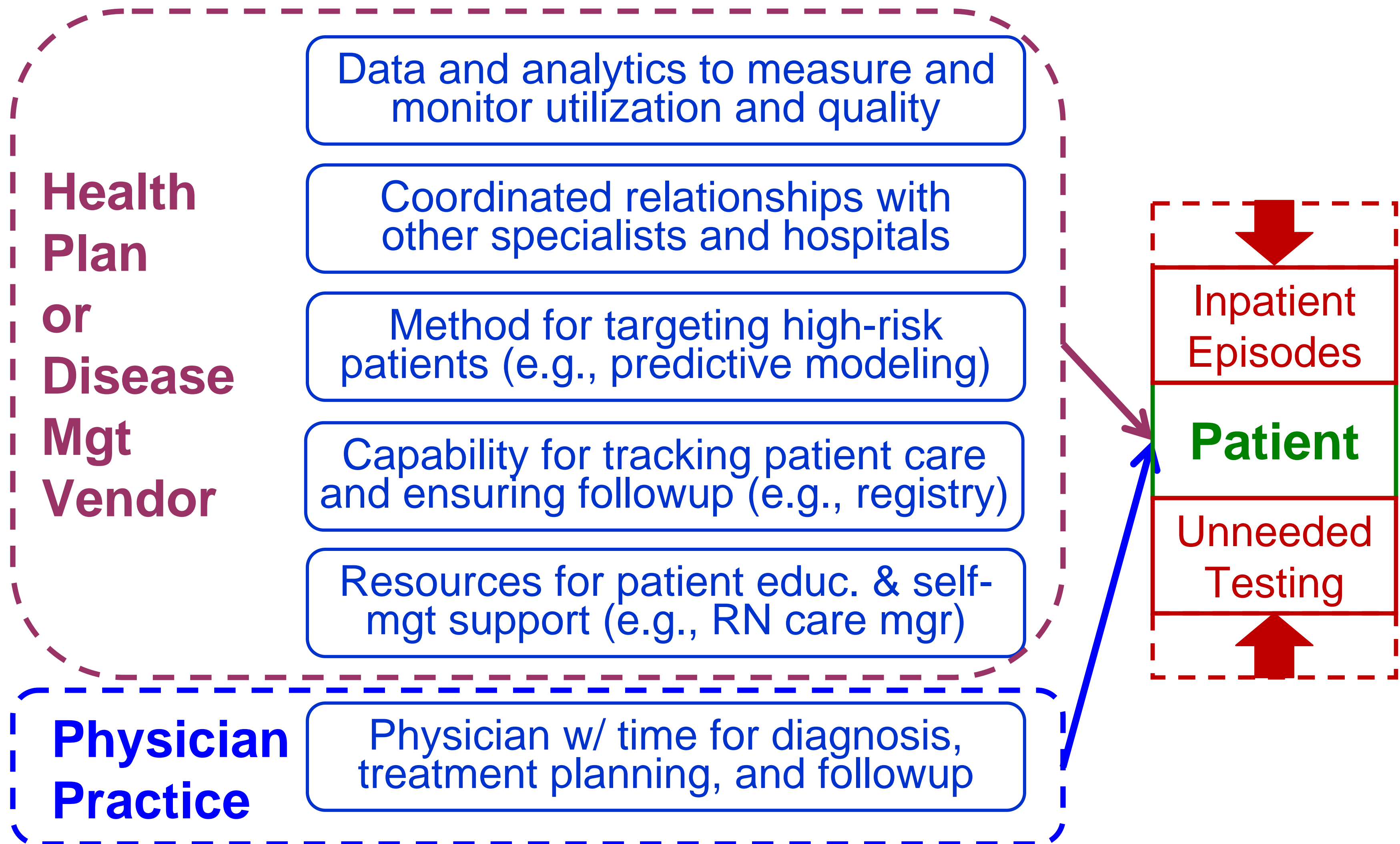
Capabilities Exist Today, But Don't Coordinate w/ Physicians



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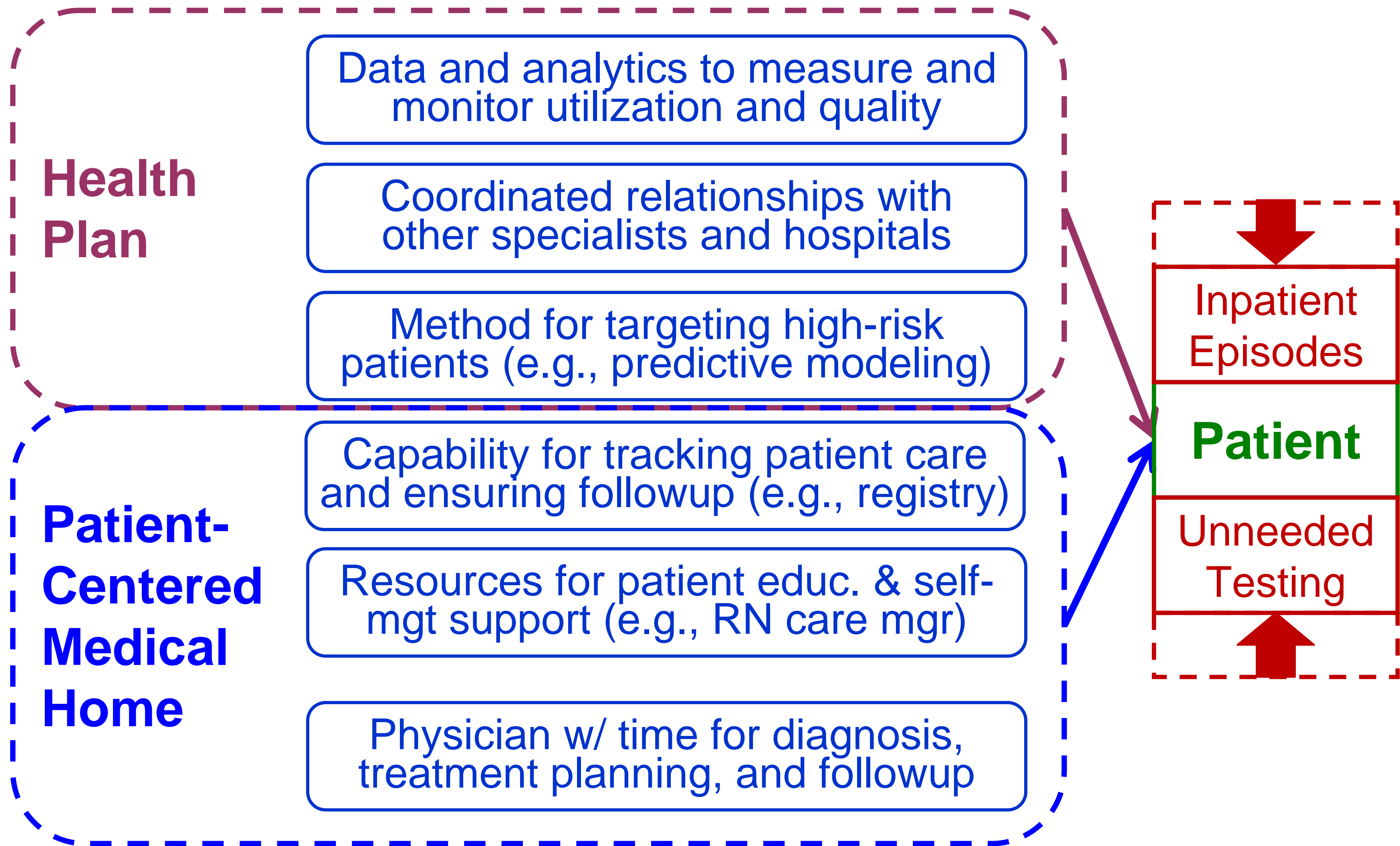
Medical Home Initiatives Expand Practice Capacity, But Not Enough



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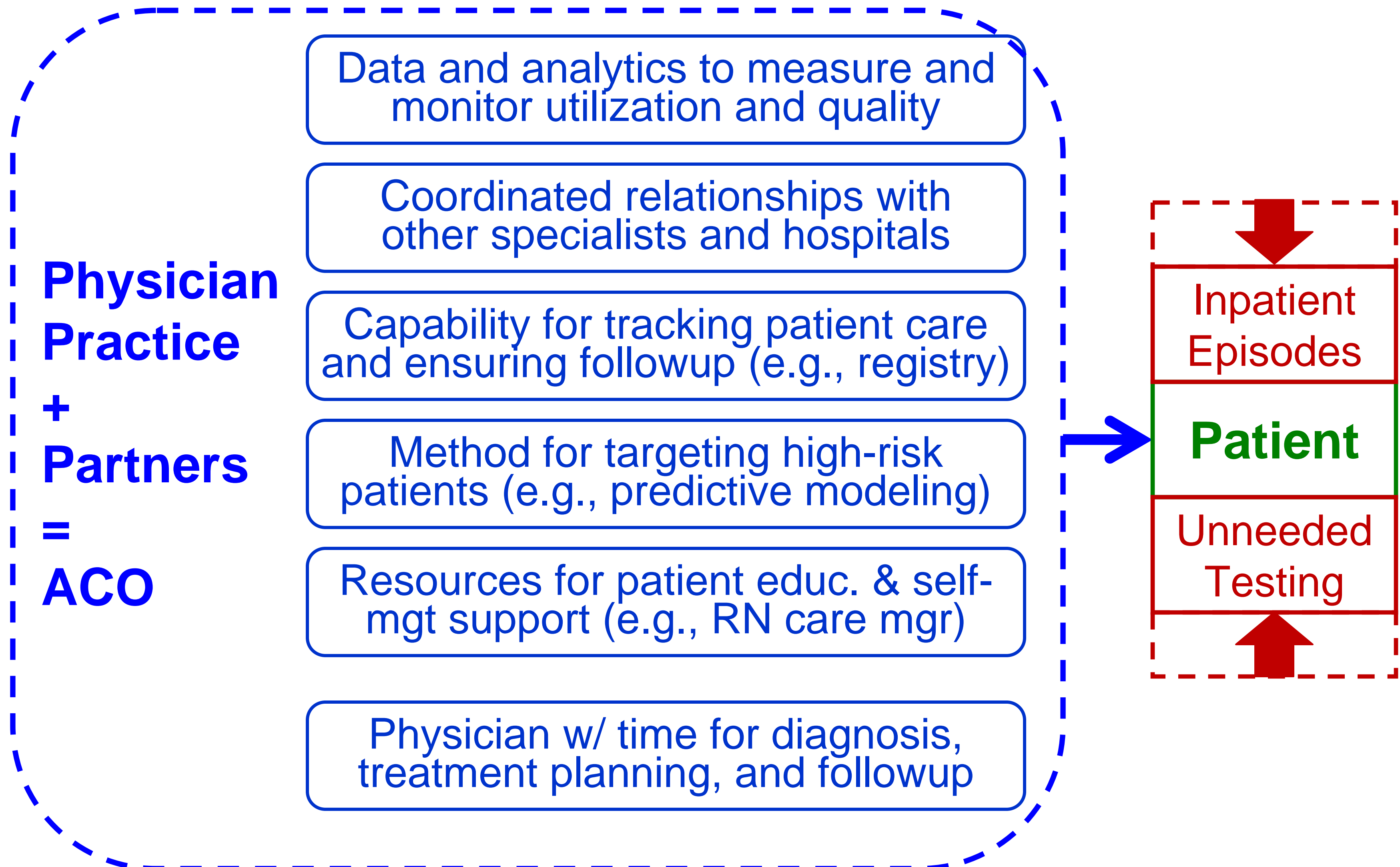
Goal: Give Docs the Capacity to Deliver "Accountable Care"



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Strategy 6: Creating Effective *Transitional* Payment Models

- Physicians and other healthcare providers need to take accountability *in stages*, beginning with things they can control, as they redesign care and build skills in managing new payment models
- This is different than varying the percentage of risk, or the direction of risk, a provider takes on *total* cost

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Significant Reduction in Rate of ER Visits, 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
  - J. Bourbeau, M. Julien, et al, "Reduction of Hospital Utilization in Patients with Chronic Obstructive Pulmonary Disease: A Disease-Specific Self-Management Intervention," *Archives of Internal Medicine* 163(5), 2003
- 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
  - M.A. Gadoury, K. Schwartzman, et al, "Self-Management Reduces Both Short- and Long-Term Hospitalisation in COPD," *European Respiratory Journal* 26(5), 2005

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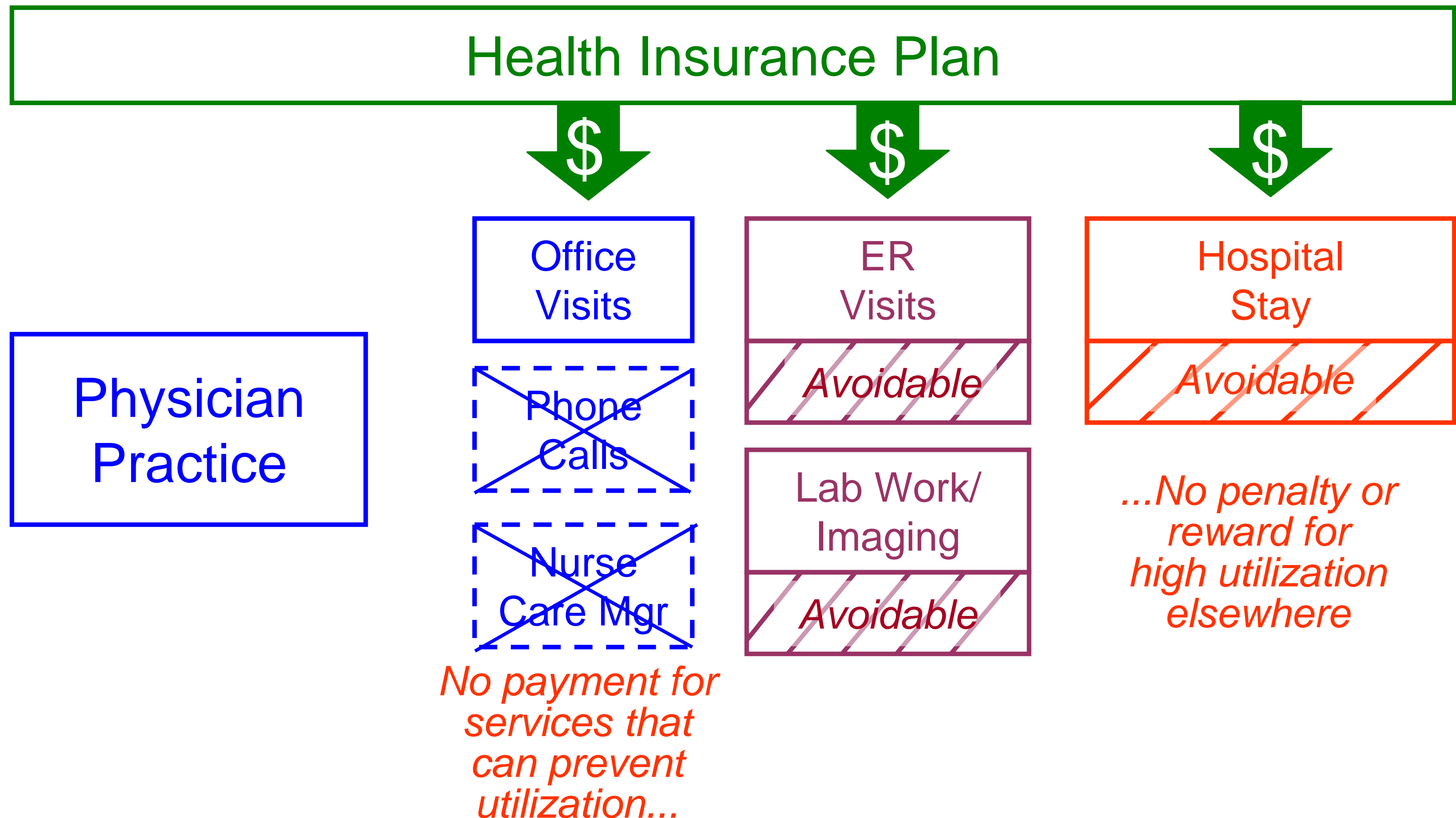
We Don't Pay for the Things That Will Prevent Overutilization

CURRENT PAYMENT SYSTEMS



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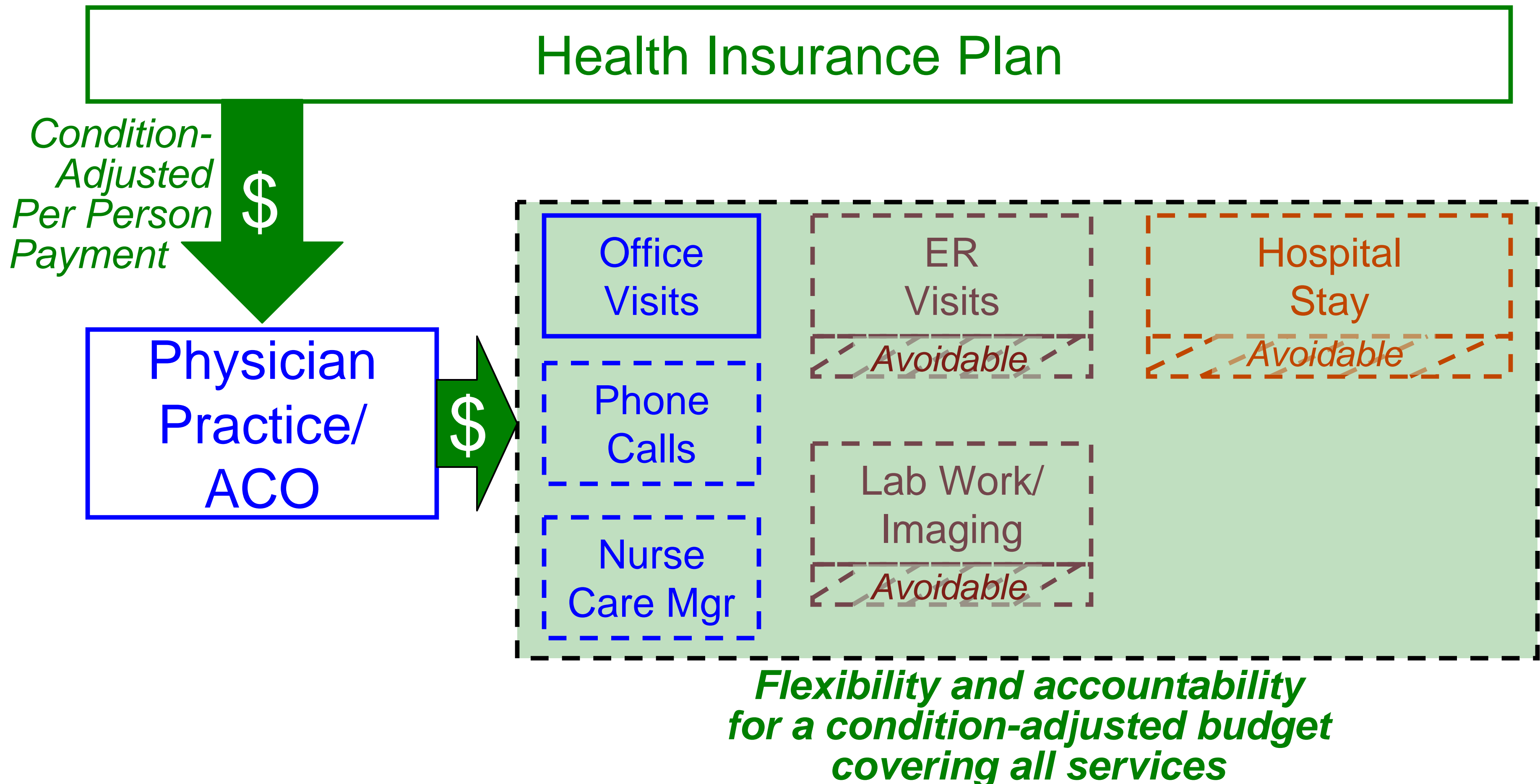
Episode/Global Pmt Solves That, But It's a Big Jump from FFS

FULL COMP. CARE/GLOBAL PAYMENT



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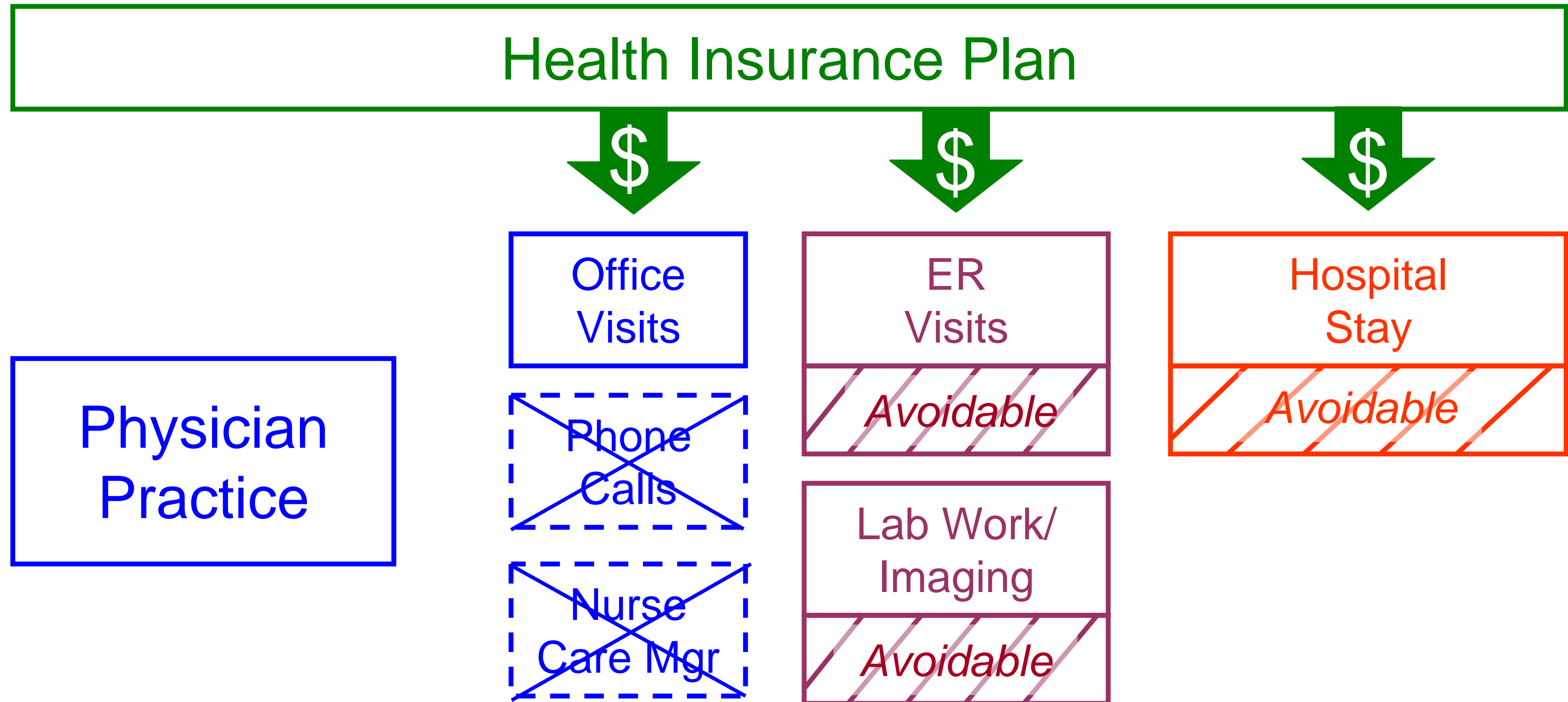
What Might a Transitional Payment System Look Like?



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Typical Medical Home "Solution": Pay More for Physician Services

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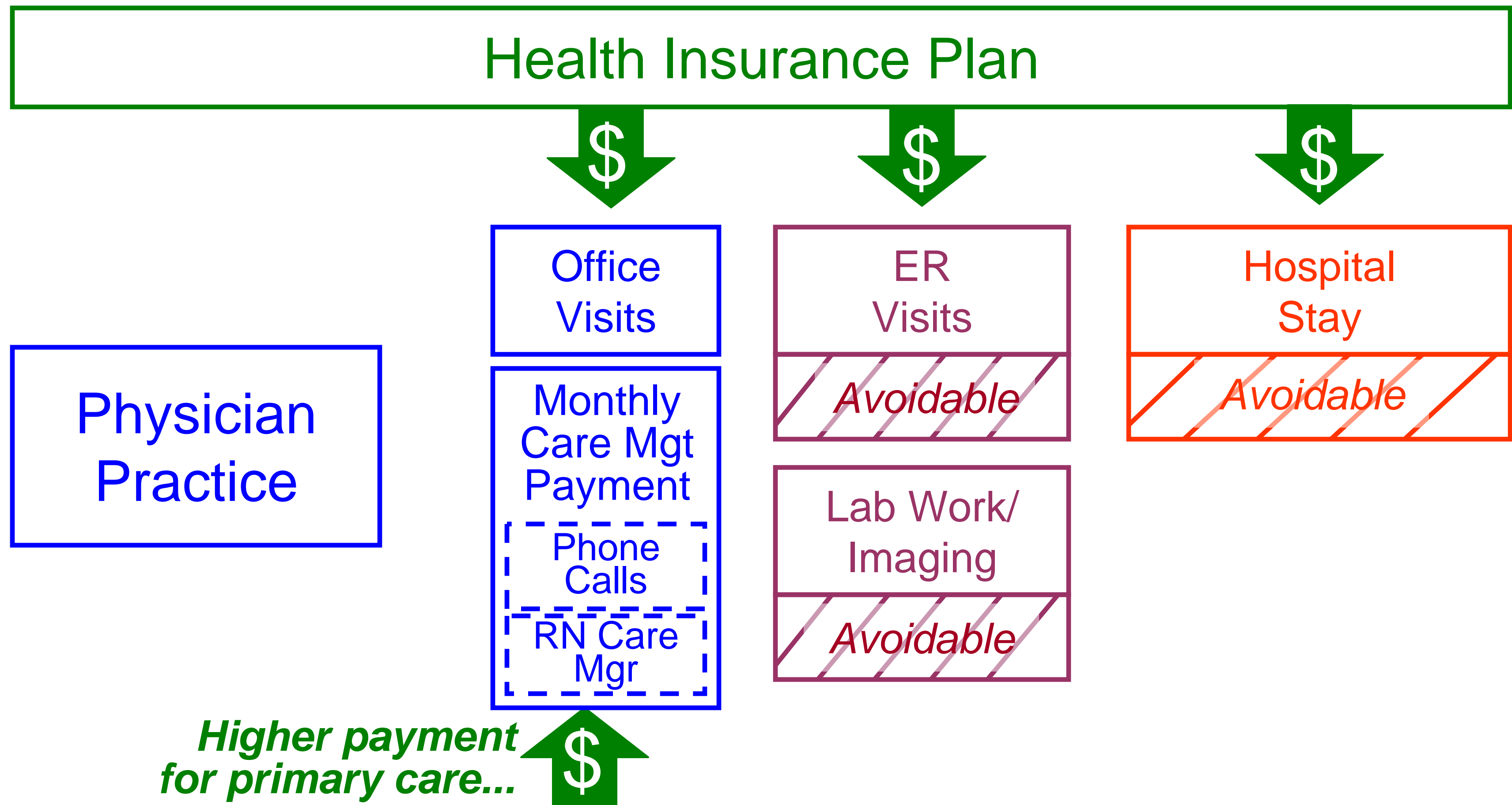

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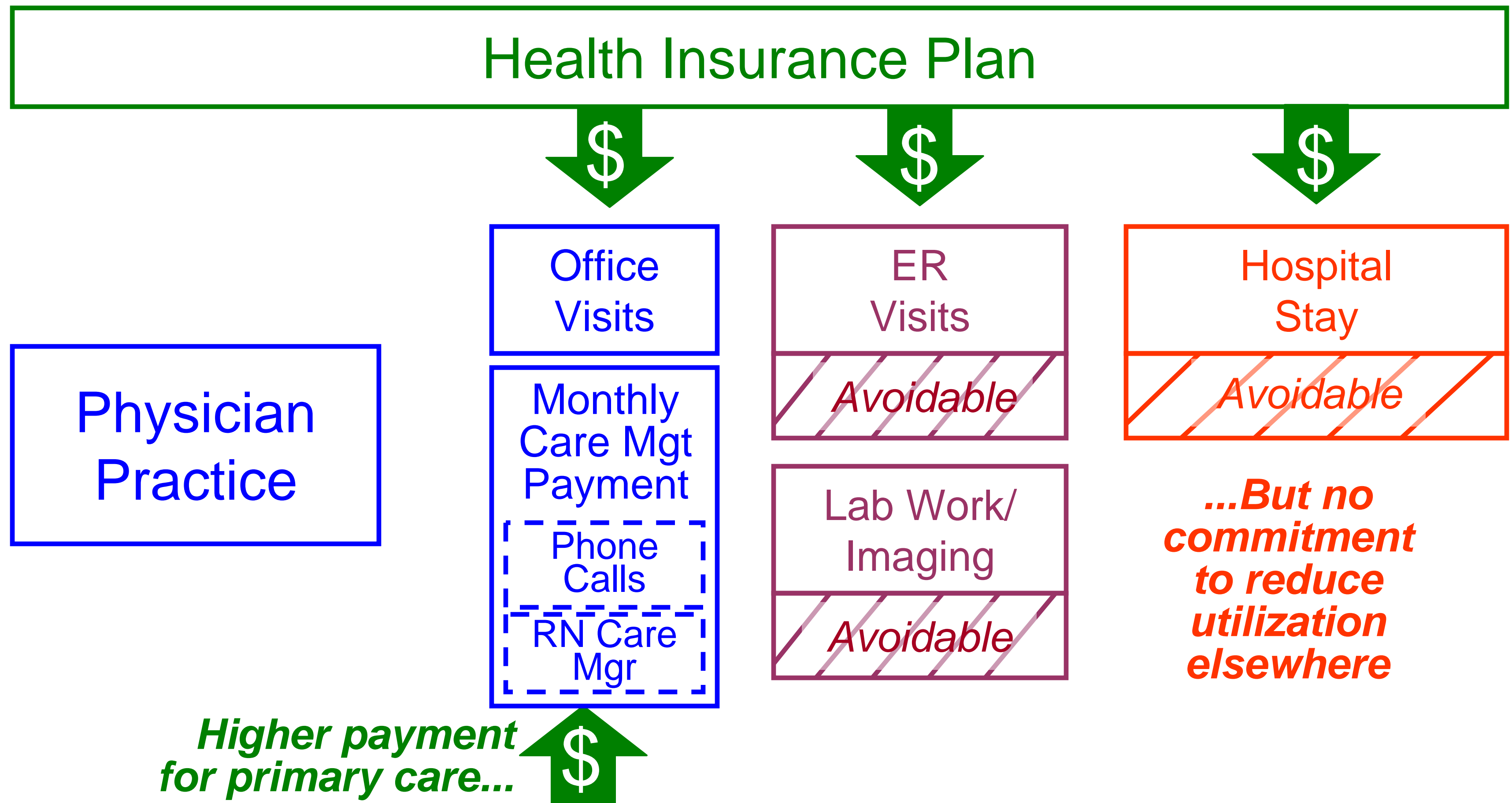
Weakness: More $ for Physicians, But Any Savings Elsewhere?

(TYPICAL) MEDICAL HOME PROGRAM



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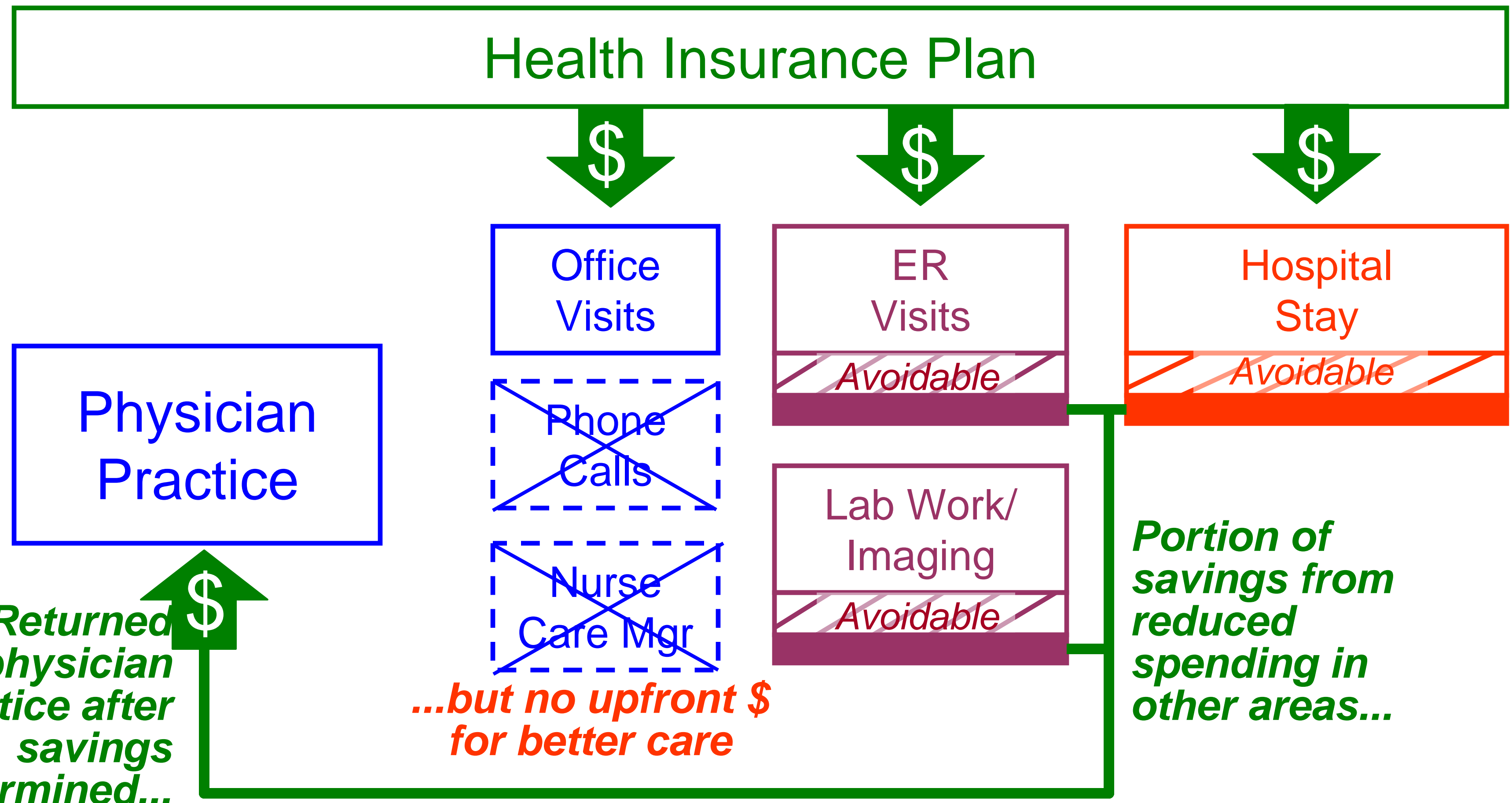
Is Shared Savings the Answer?



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Weaknesses of “Shared Savings”

- 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
- The underlying fee for service incentives continue; losing less (via shared savings) is still losing compared to FFS
- I.e., it’s not really true *payment reform*

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Better Approach: Simulate Flexibility/Incentives of Global Pmt

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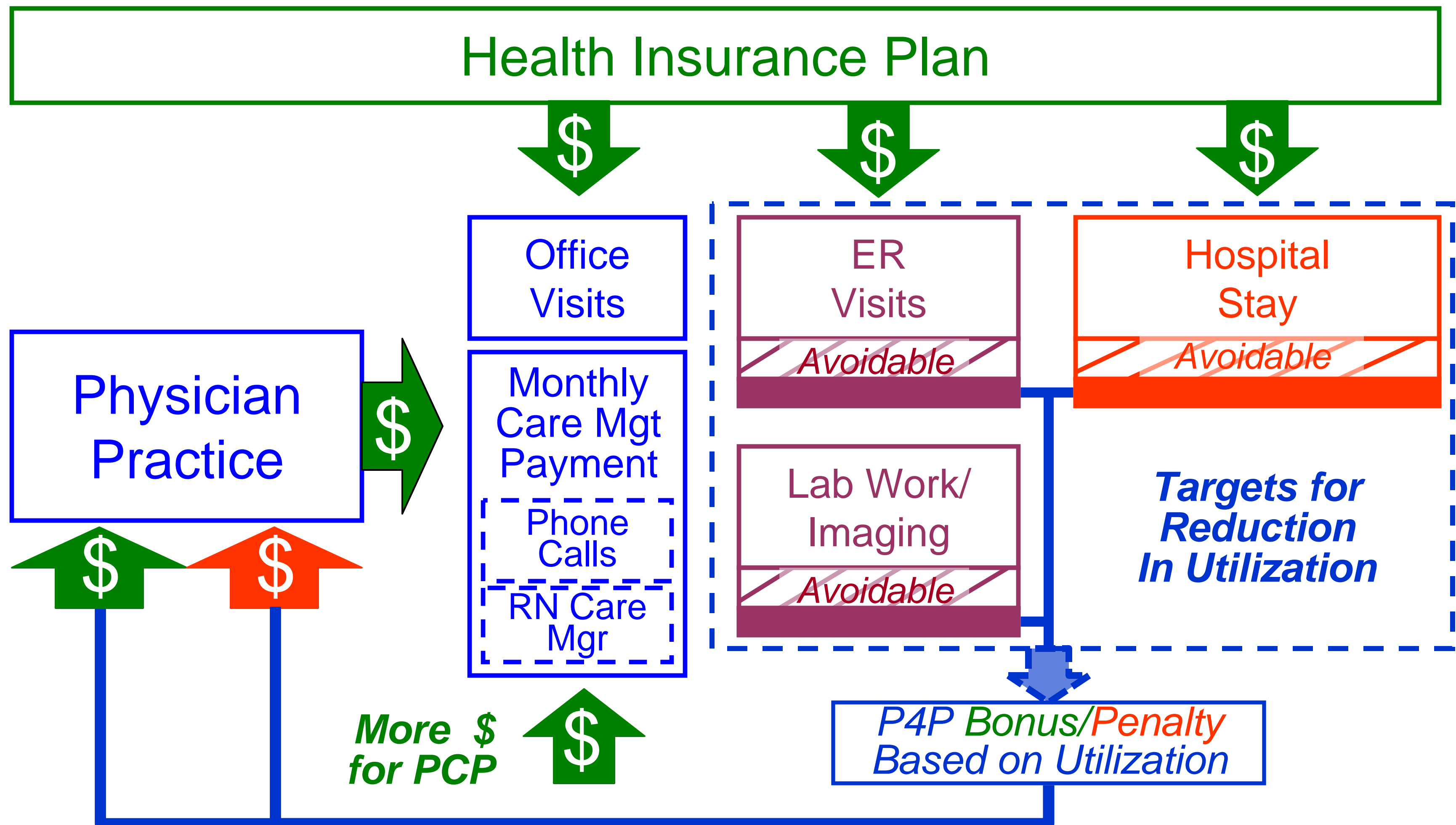
CARE MGT PAYMENT + UTILIZATION P4P



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Example: "Accountable Medical Home" Pilot Program in WA State

- 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

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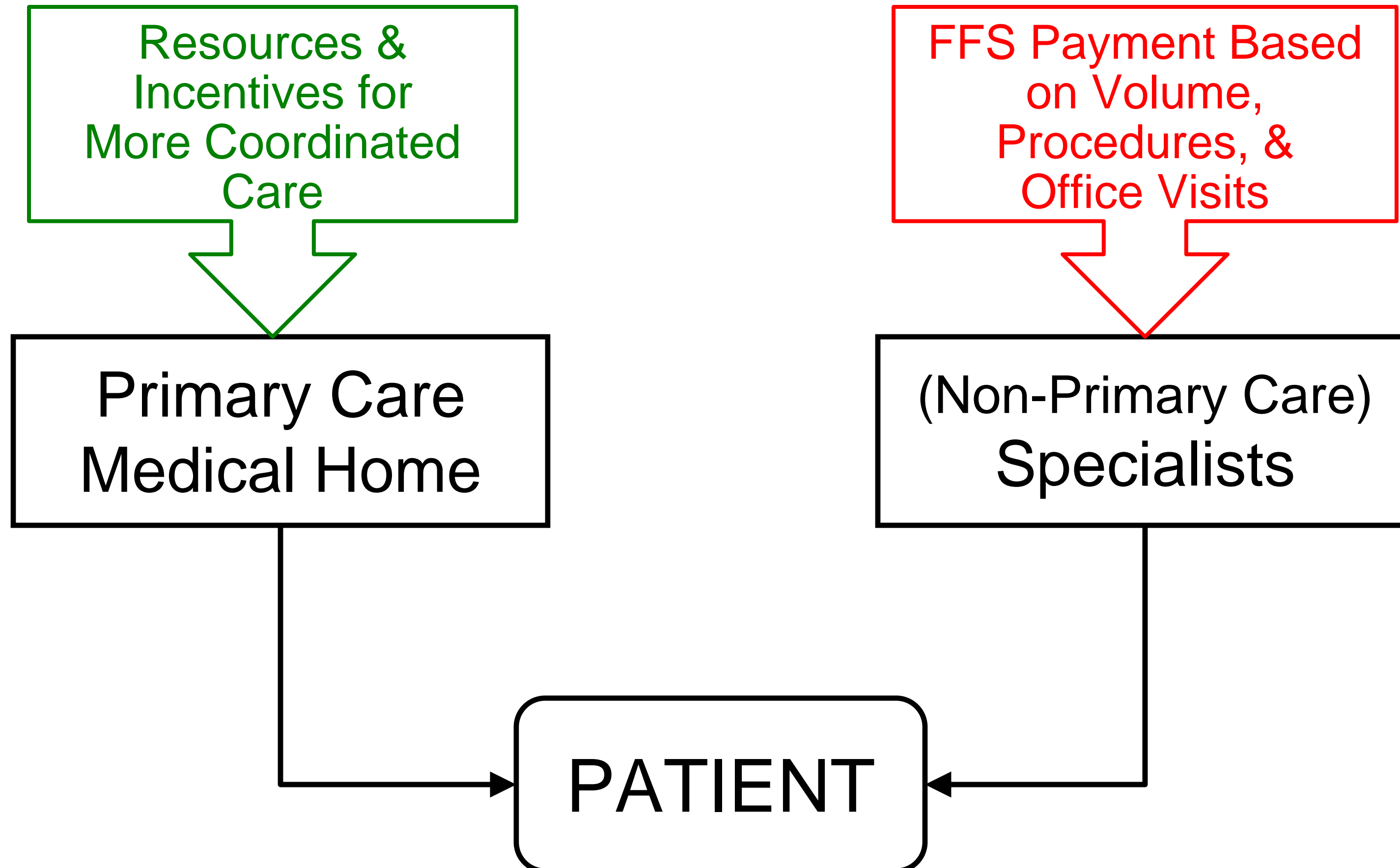
Not Just PCPs, But The Medical Neighborhood, Too



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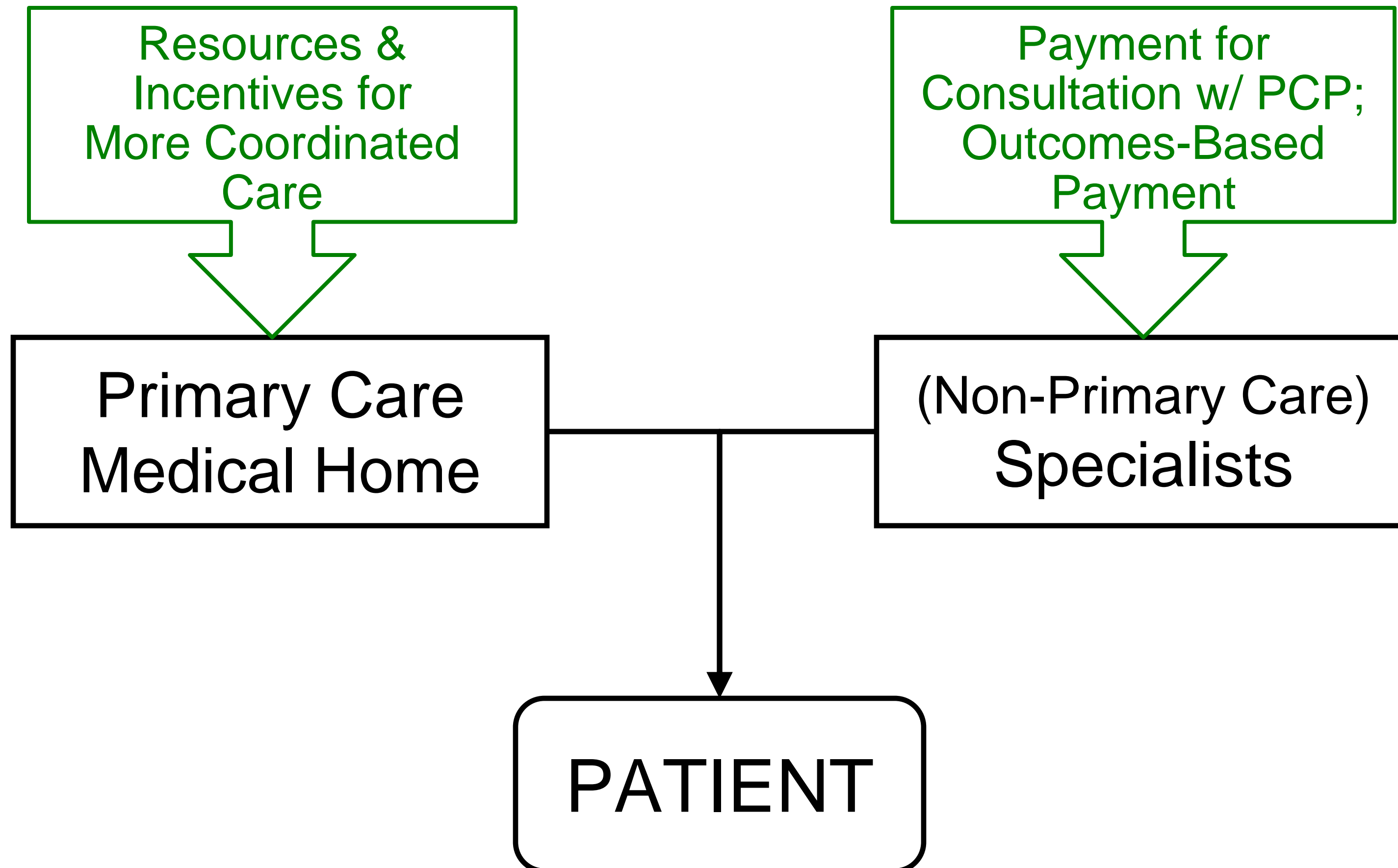
Pay Both PCPs & Specialists for Outcomes & Coordination



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Minnesota's DIAMOND Initiative

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

http://www.icsi.org/health_care_redesign_/diamond_35953/

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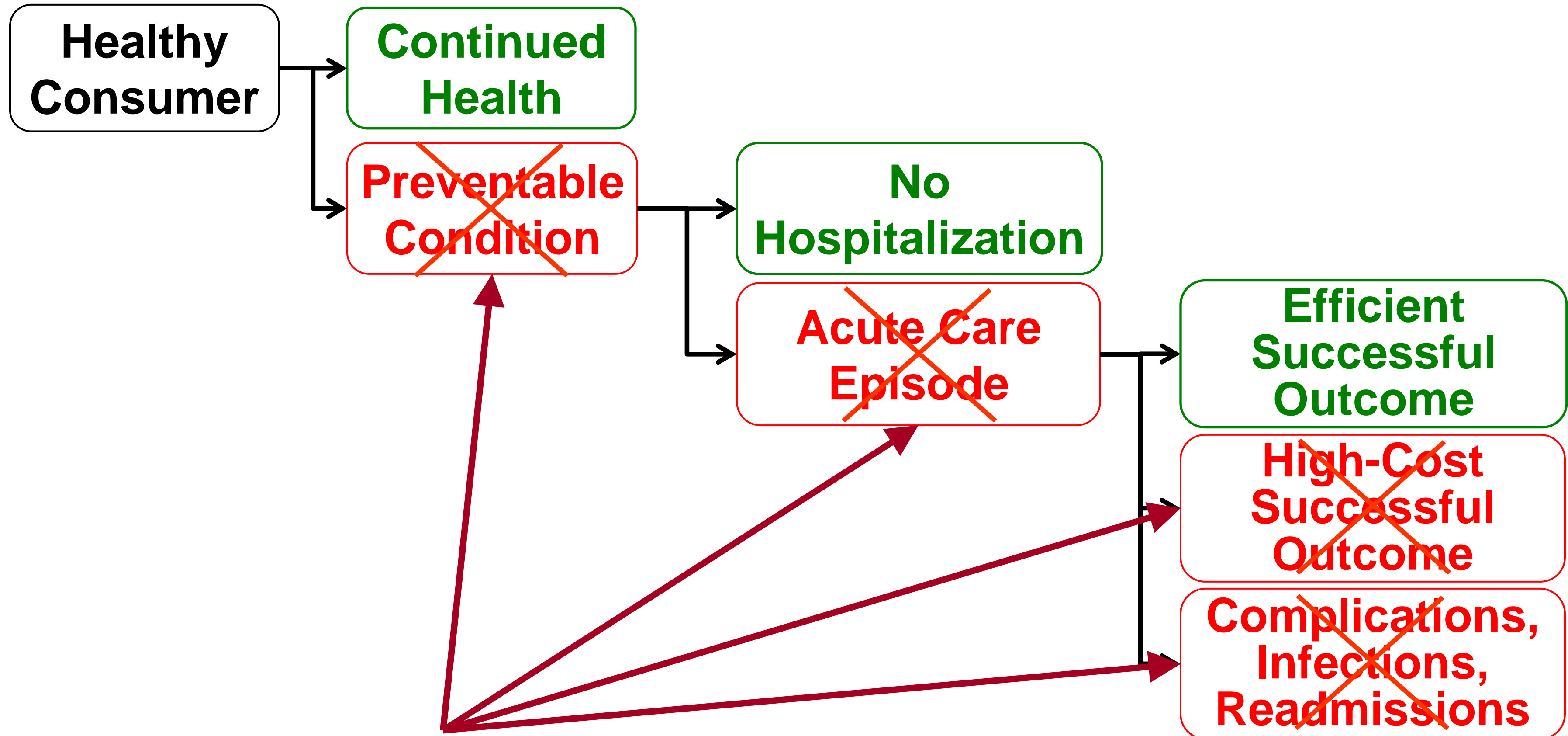
Reducing Costs Without Rationing Reduces Hospital Revenues



Fewer Patients
Fewer Admissions
Less Revenue Per Admission

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How Will Hospitals Have to Change?

- Answer: Smaller and higher-priced
- Huh???? Higher priced??
- In most industries, we want volume to go up, and when it does, prices go down.
  Why? Fixed costs are spread more broadly.
- In the health care industry, we don't want it to sell more products/services in total.
- In hospitals, most costs are fixed costs
- Implication: lower volume means *higher unit cost* (just like every other industry), although *total spending* <u>should</u> still be lower

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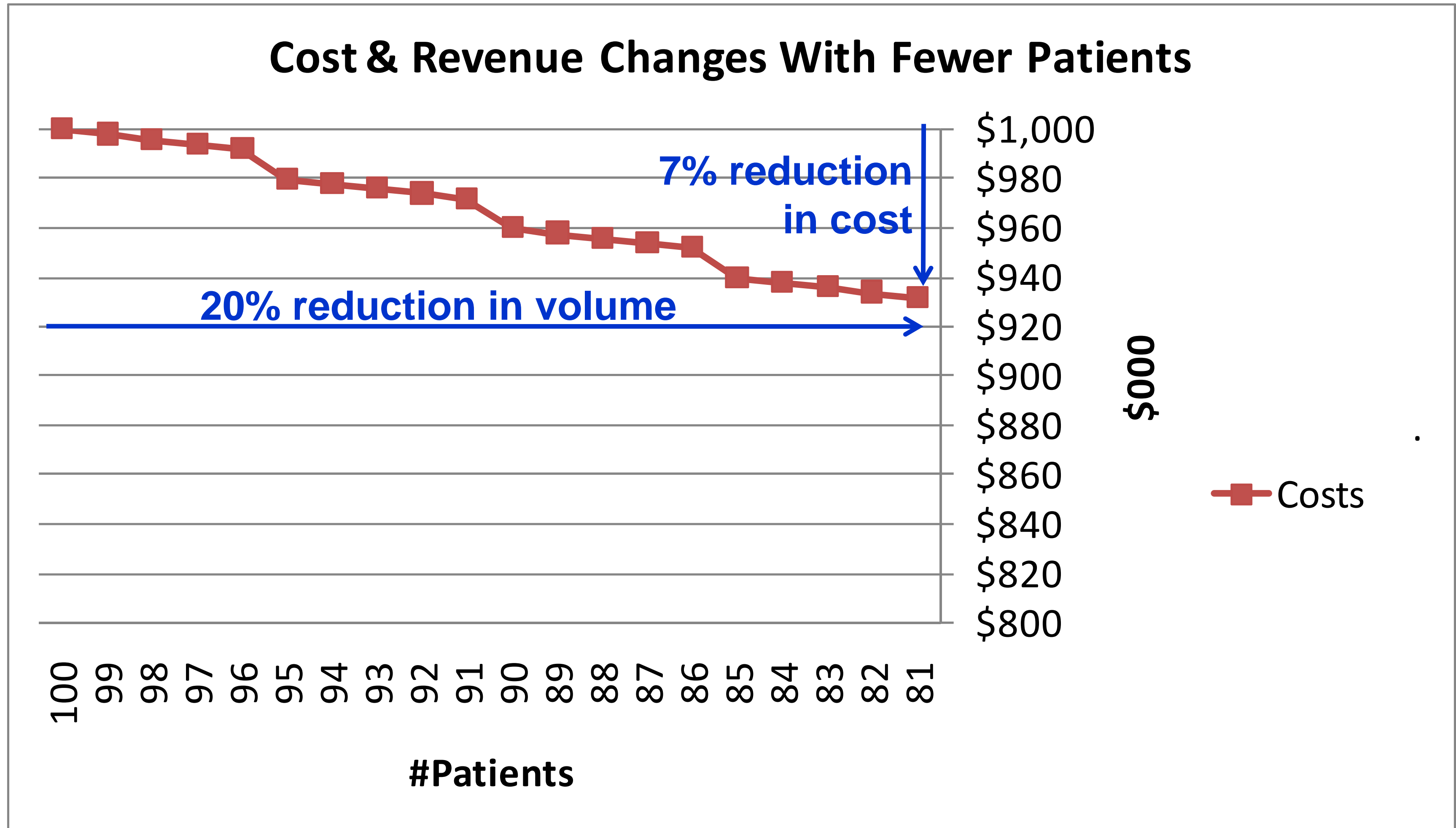
Hospital Costs Are Not Proportional to Utilization



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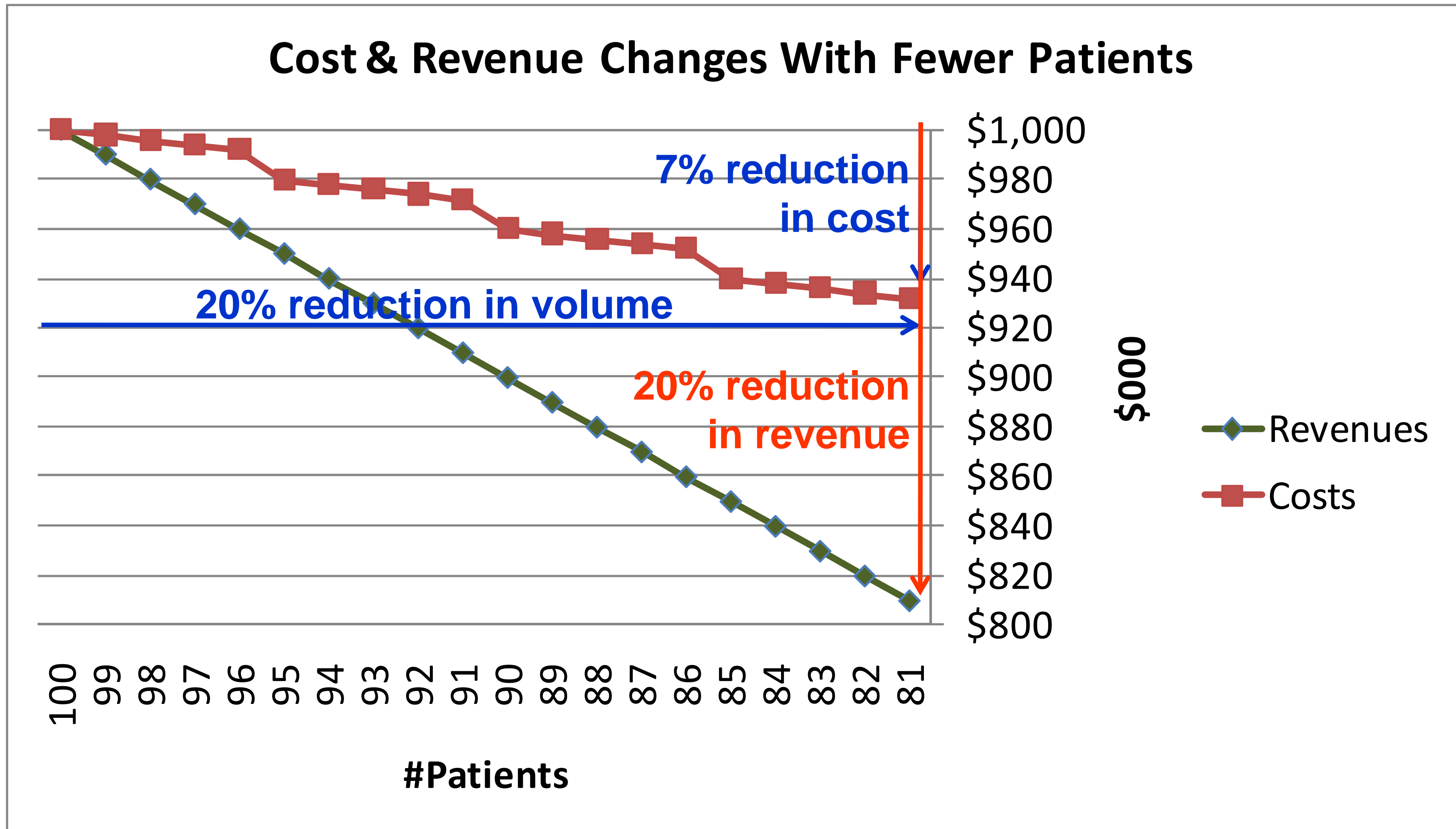
Reductions in Utilization Reduce Revenues More Than Costs



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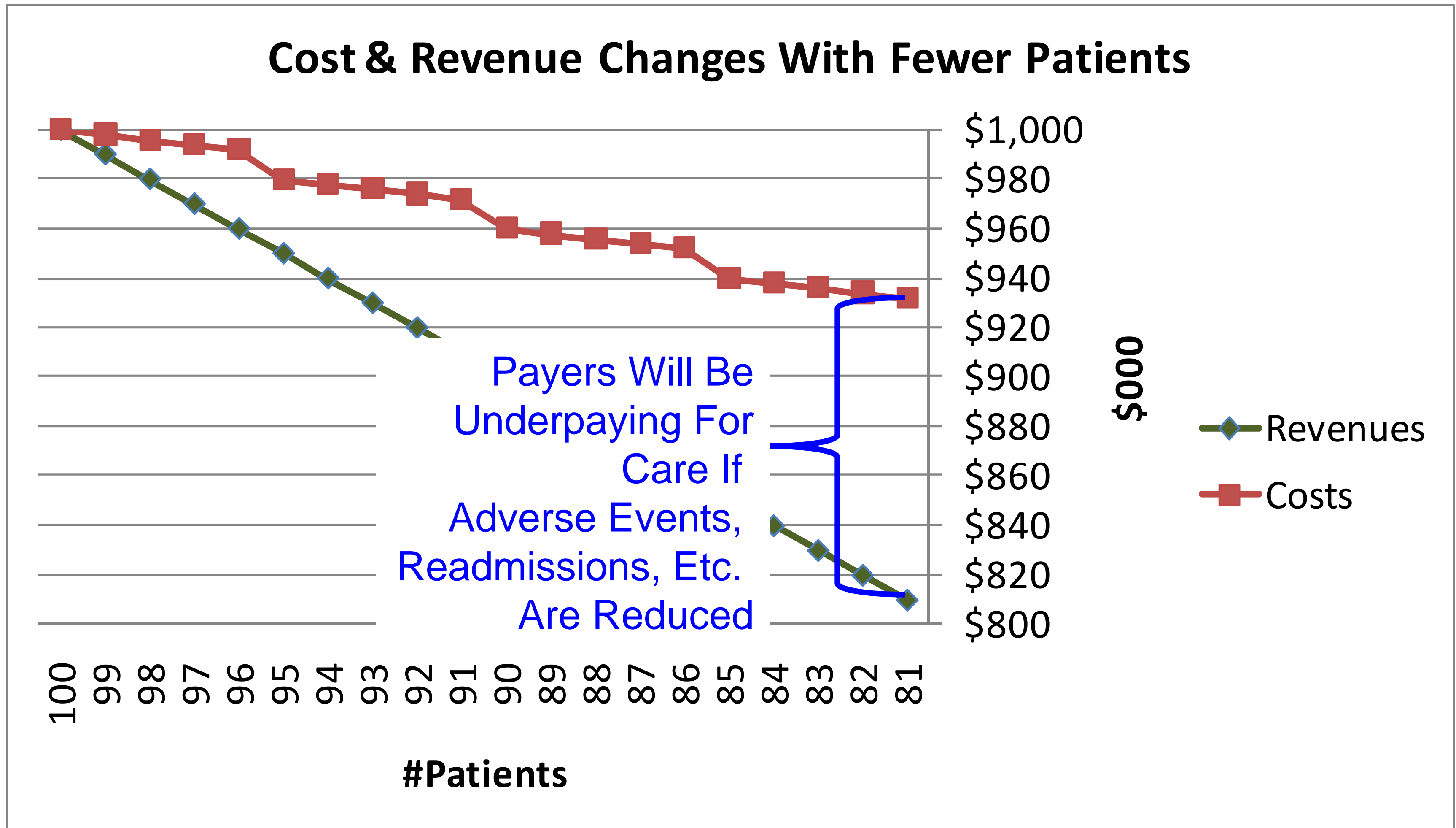
Causing Negative Margins for Hospitals



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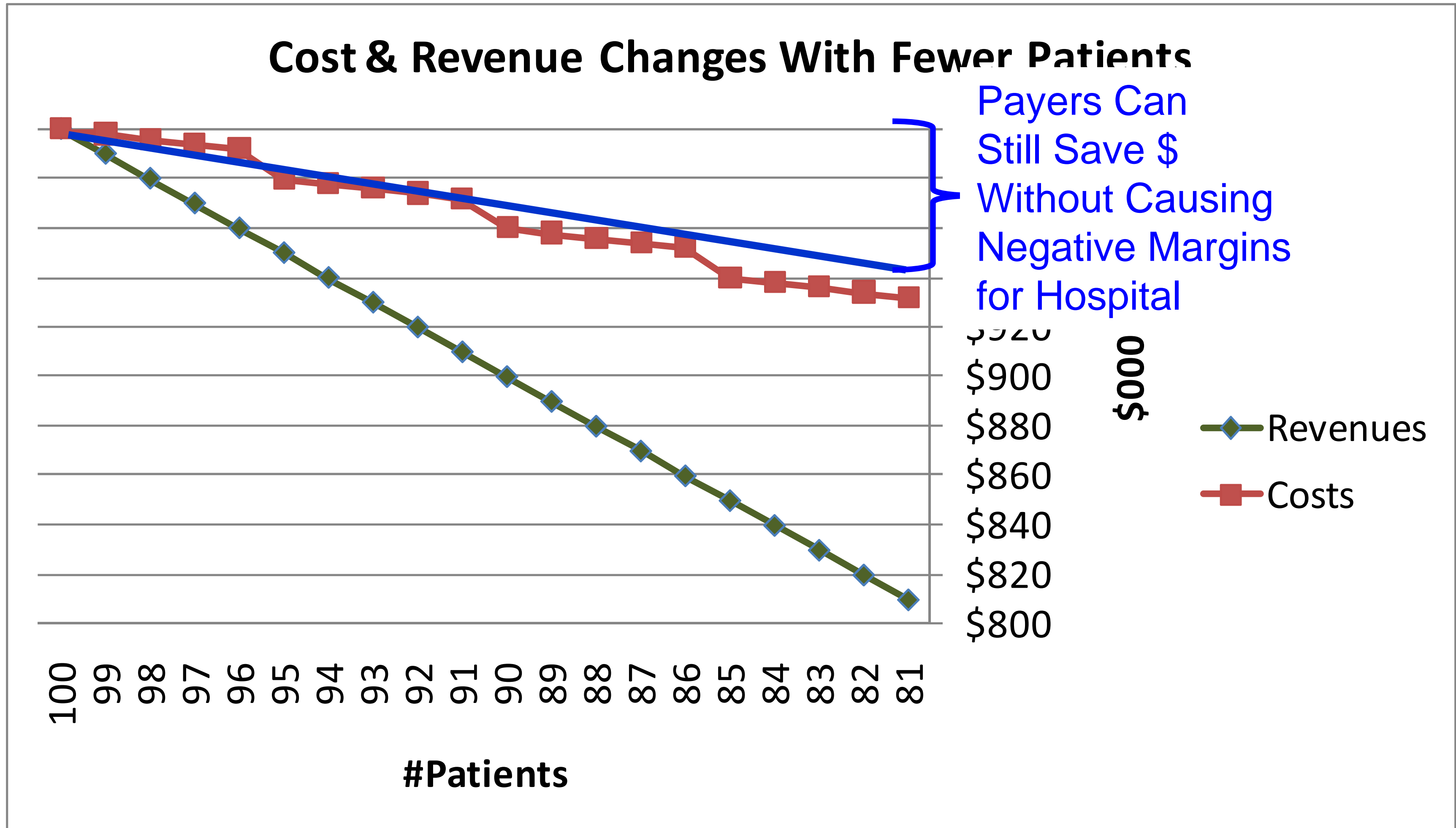
So Prices Need to Be Re-Set Under Payment Reform



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Strategy #7: Create a Feasible Glide Path for Hospitals

- 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
- In the long run, with sufficient reductions in admissions, a hospital could restructure to reduce its fixed costs (close units, etc.), but it will take time
- Consequently, payers and hospitals will need to renegotiate payment levels to enable hospitals to remain solvent
- Maryland's Total Patient Revenue (TPR) system may provide a model for helping small community hospitals transition

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Shared Savings Forces Hospitals To Consider Hiring Physicians

- Hospitals are not directly eligible for shared savings; all savings are attributed to primary care physicians
- Even if the hospital reduces readmissions, infections, complications, etc., it may receive no reward for doing so
- Reducing hospitalizations, ER visits, etc. will reduce the hospital's revenues, but the hospital may receive no share of the savings to help it cover its stranded fixed costs
- Consequently, hospitals may feel compelled to own physician practices, either to capture a portion of the shared savings revenue, or to prevent there from being any savings!

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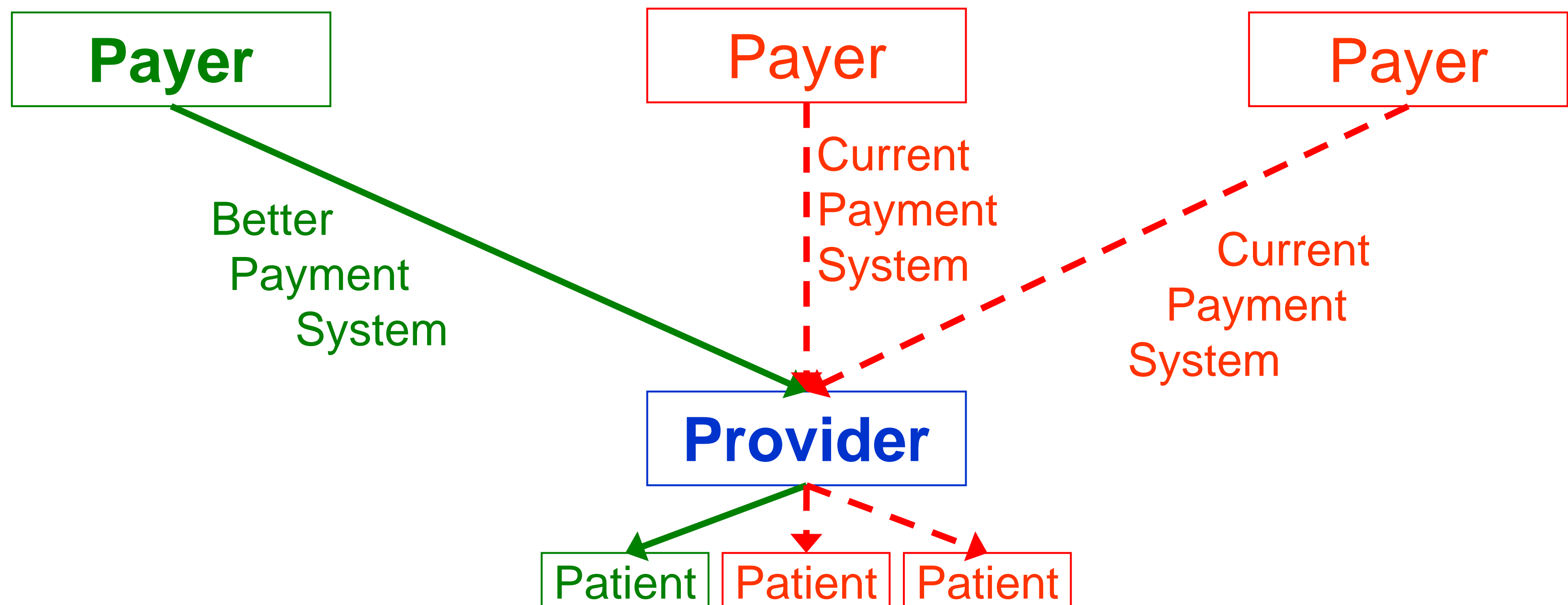
One Payer Changing (Even Medicare) Is Not Enough



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

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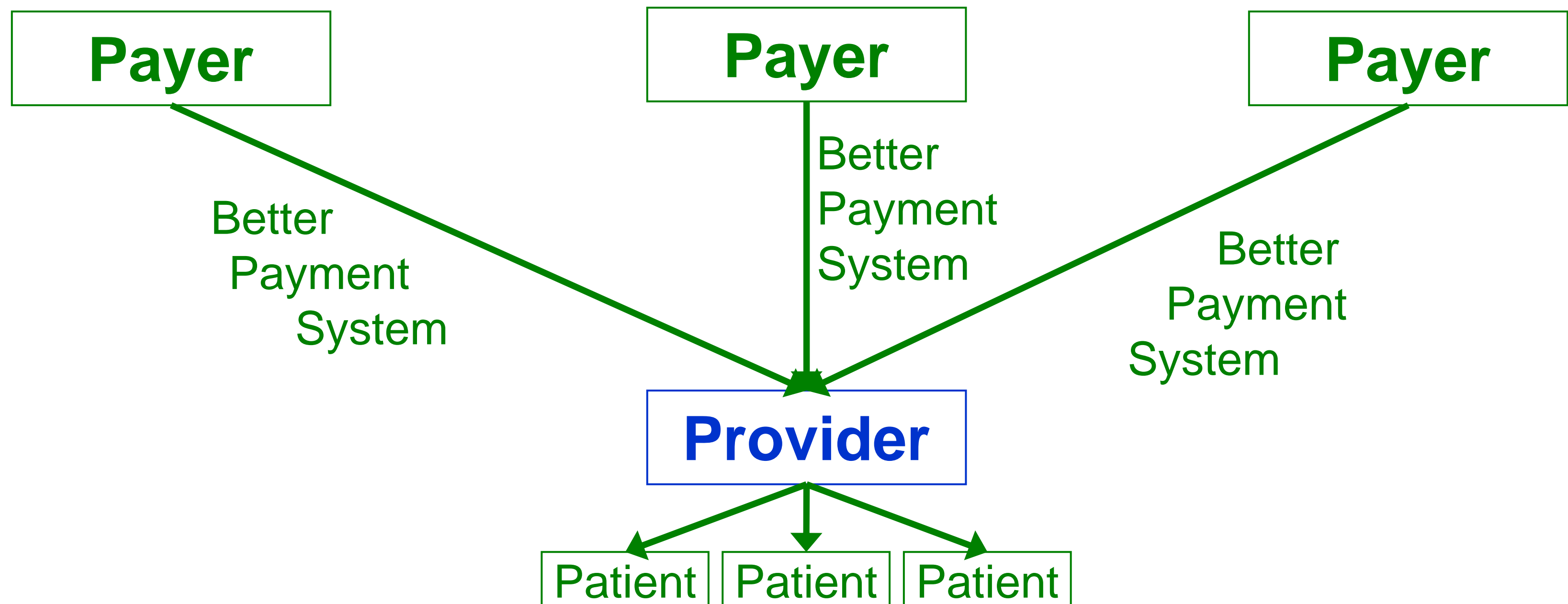
Strategy #8: Implementing Multi-Payer Payment Reforms



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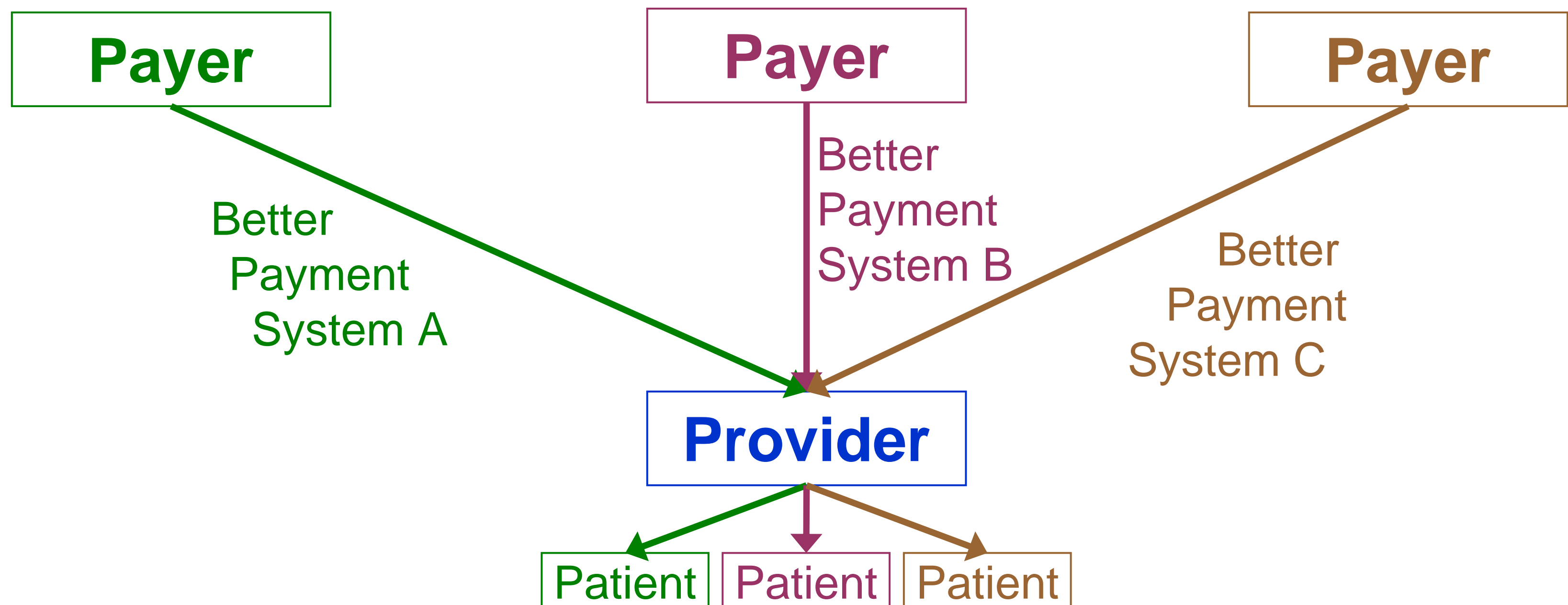
Payers Need to Truly *Align* to Allow Focus on Better Care



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

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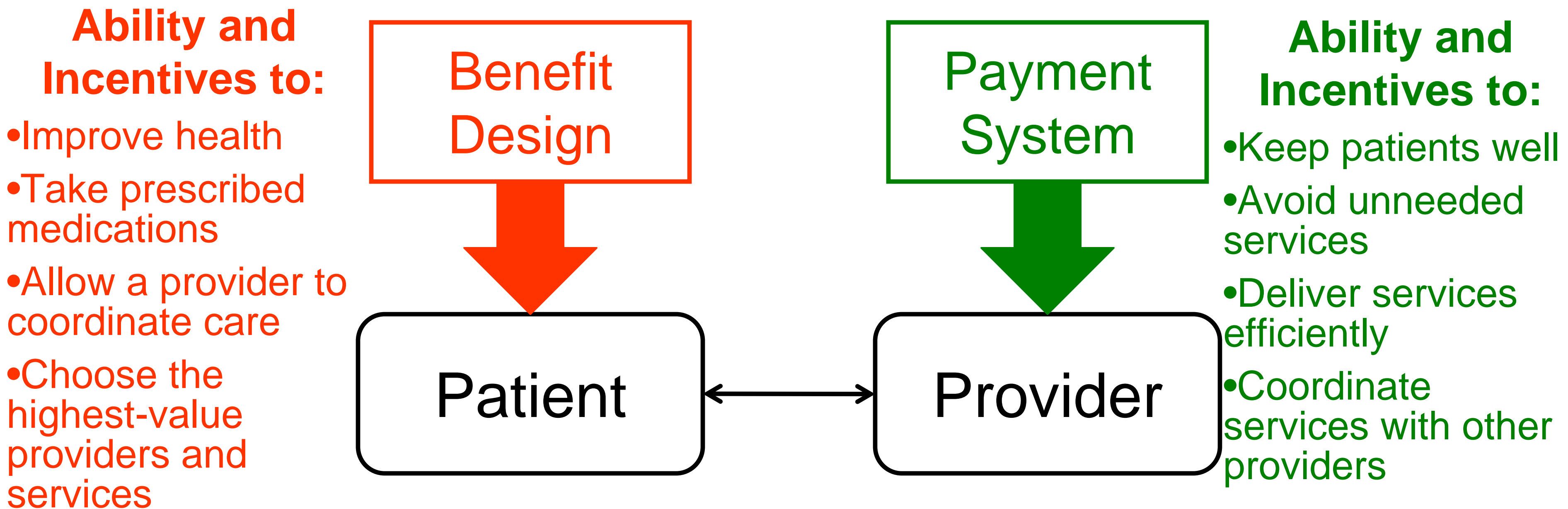
Strategy #9: Benefit Changes to Complement Payment Reforms



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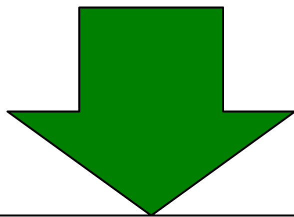
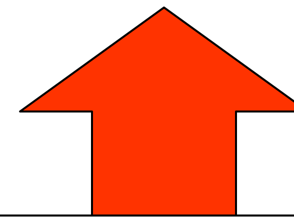
Example: Important to Coordinate Pharmacy & Medical Benefits

Single-minded focus on reducing costs here...



...could result in higher spending on hospitalizations



Pharmacy Benefits (Part D)

Drug Costs

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

Medical Benefits (Parts A/B)

Hospital Costs

Physician Costs

Other Services

Principal treatment for most chronic diseases involves regular use of maintenance medication

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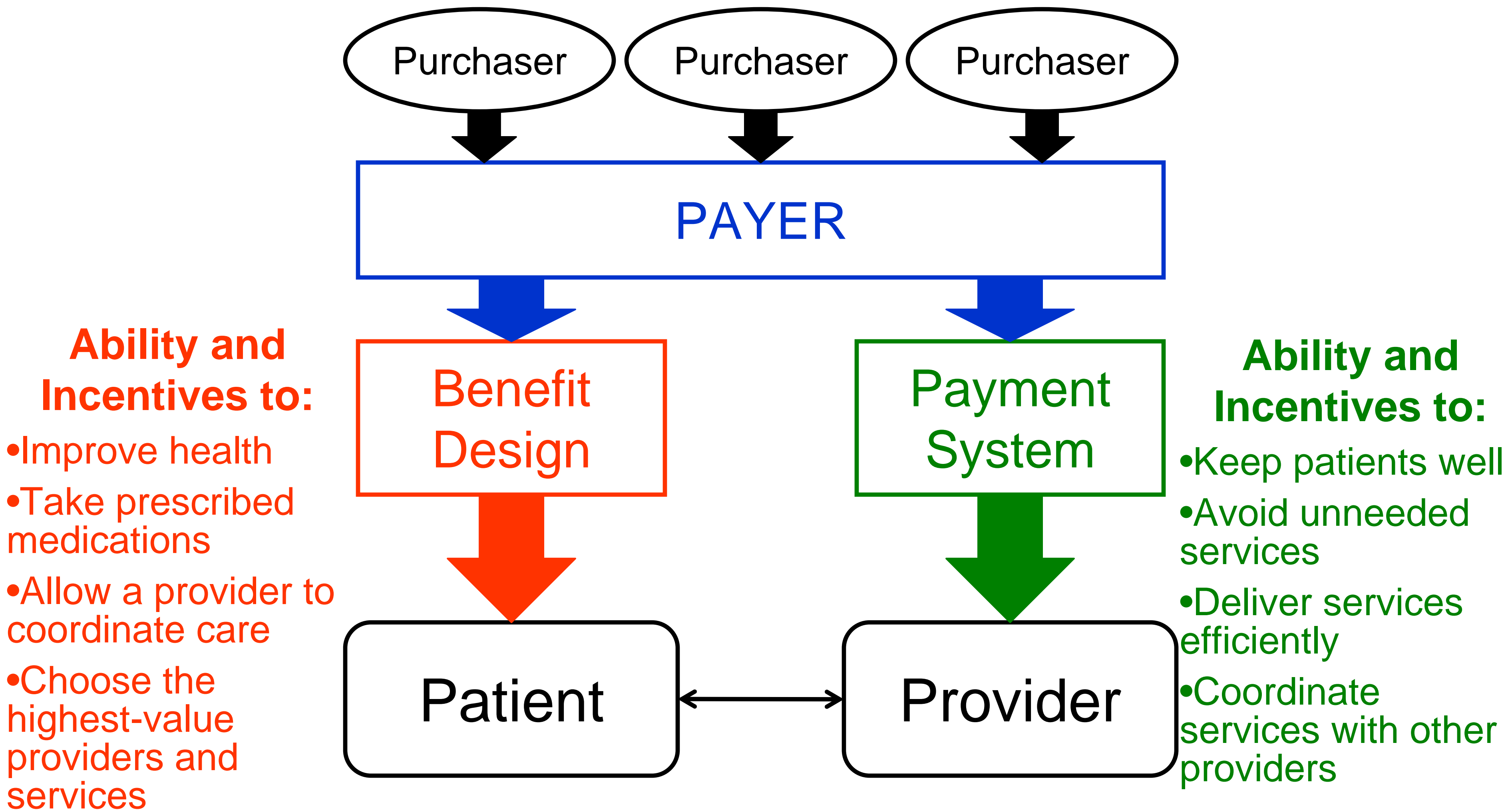
Purchaser Support is Needed Particularly for Benefit Changes



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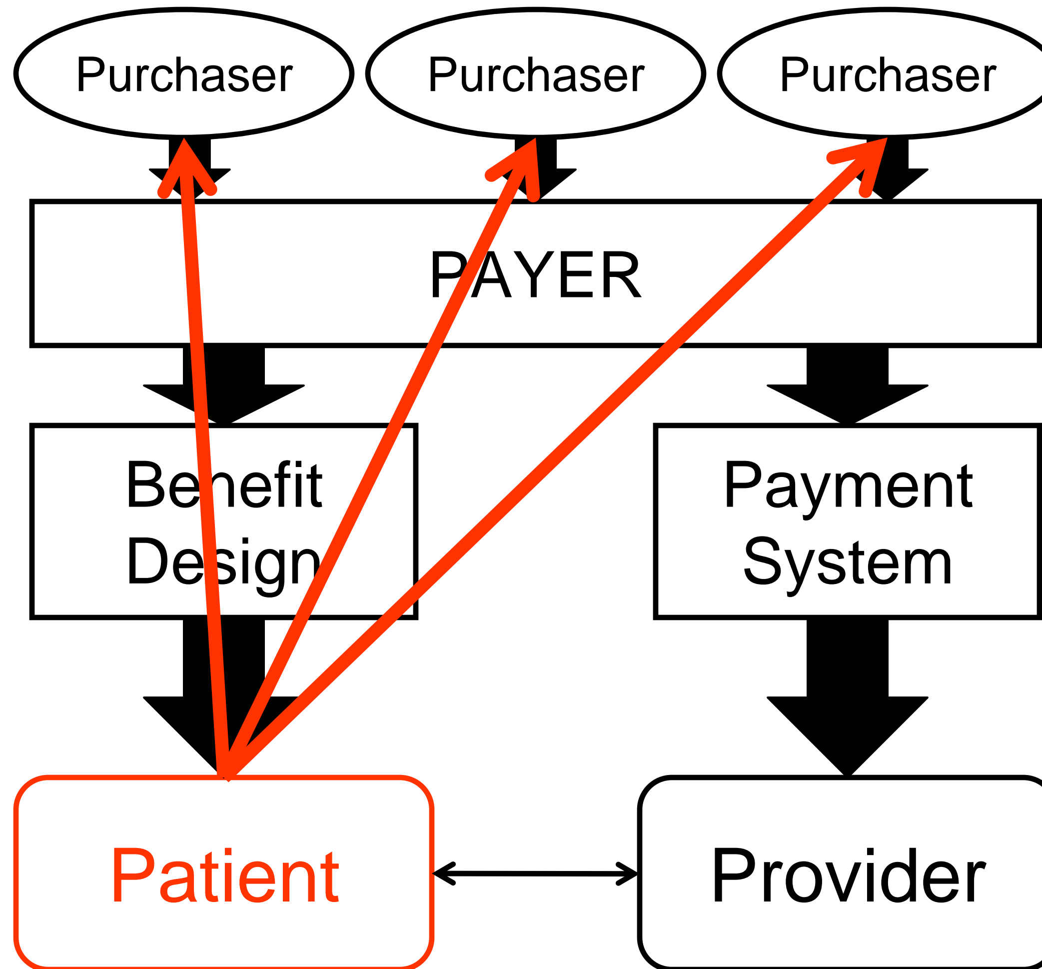
And Consumer Support is Critical for Purchaser/Plan Support



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Payment Reform Is Necessary, But Not Sufficient

Patient Education & Engagement

Quality/Cost Analysis & Reporting

Reducing Costs Without Rationing

Value-Driven Payment Systems & Benefit Designs

Value-Driven Delivery Systems

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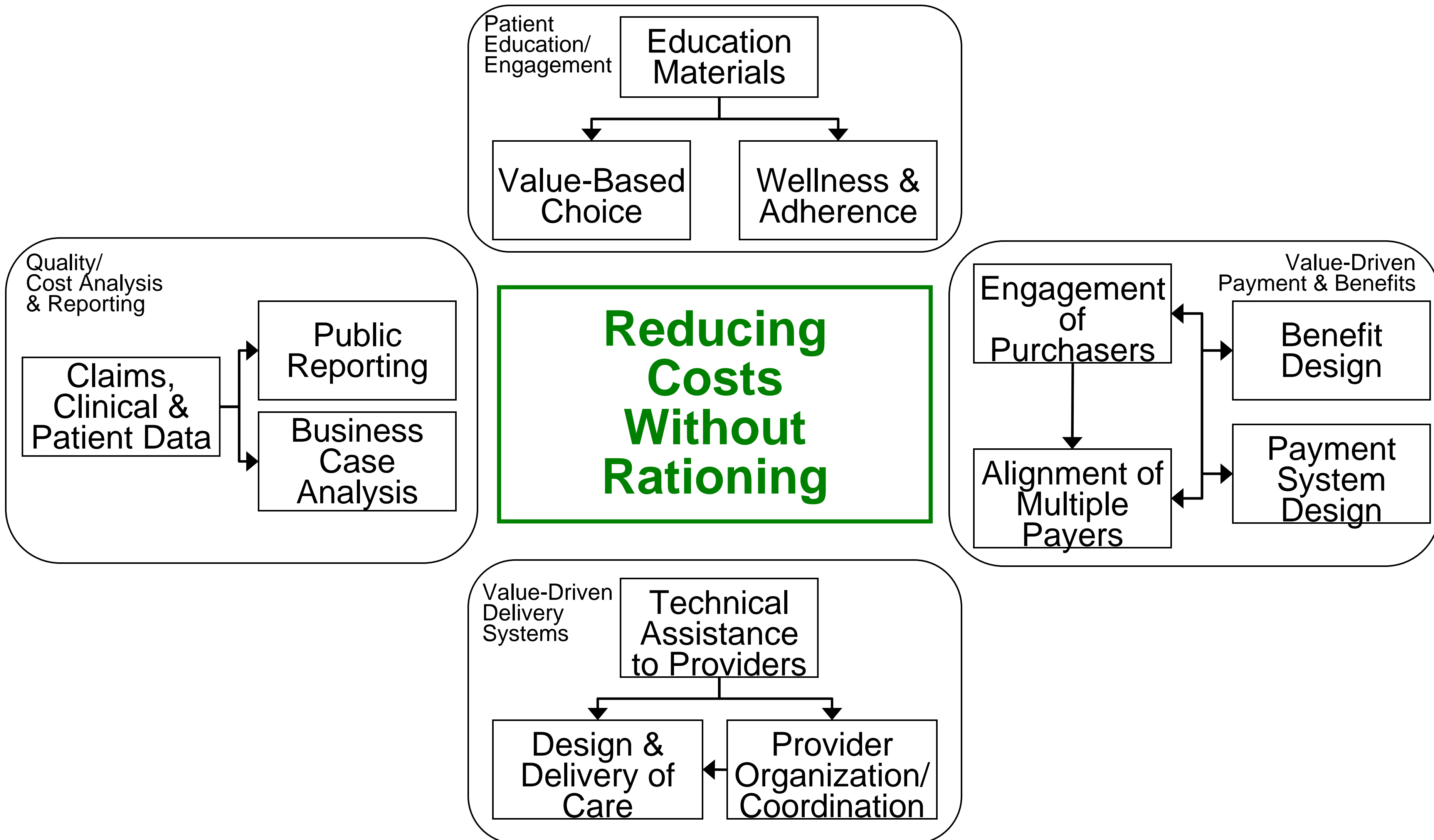
Many Specific Activities in Each Area...



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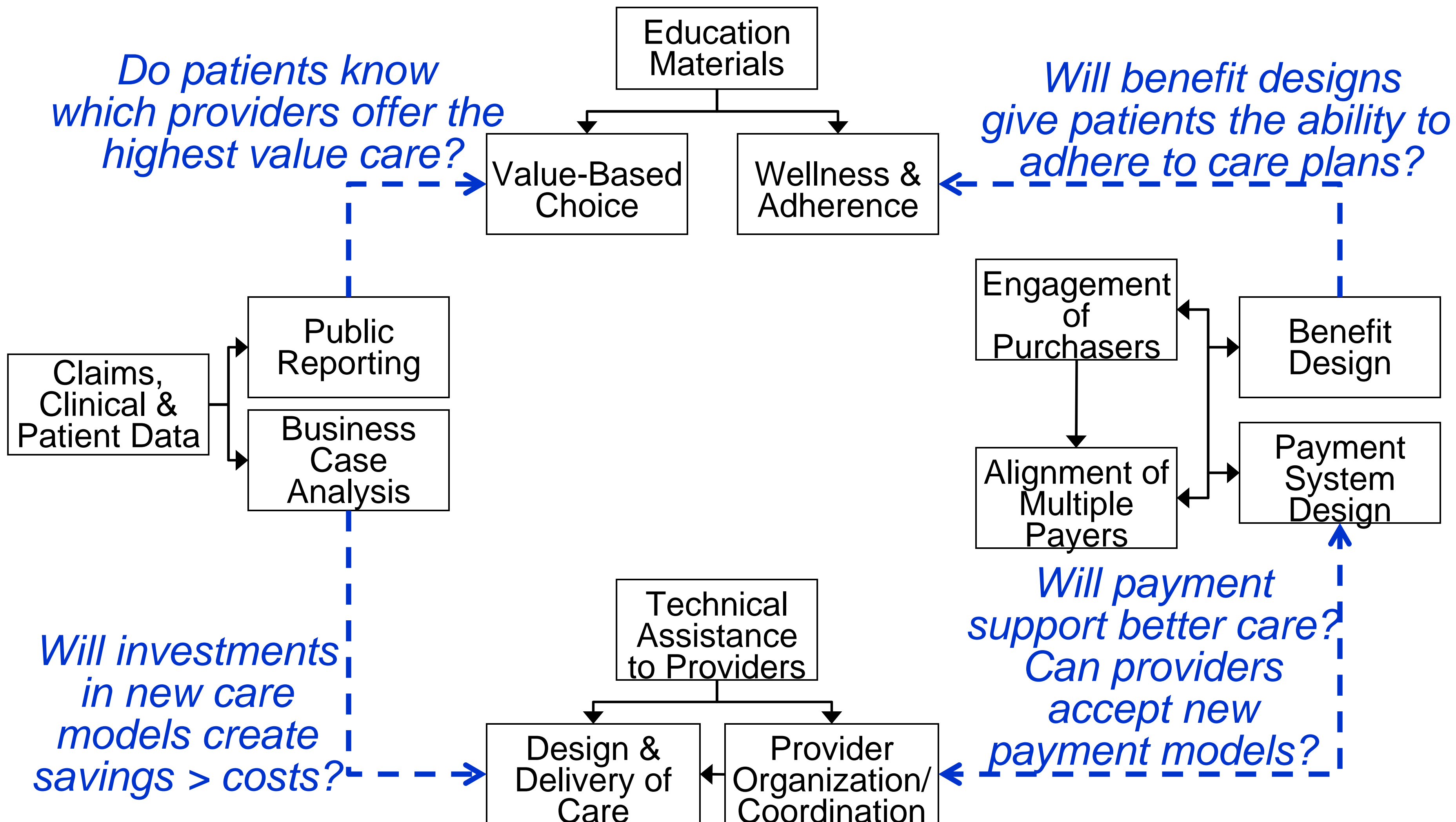
...All of Which Need to Be Coordinated to Be Successful



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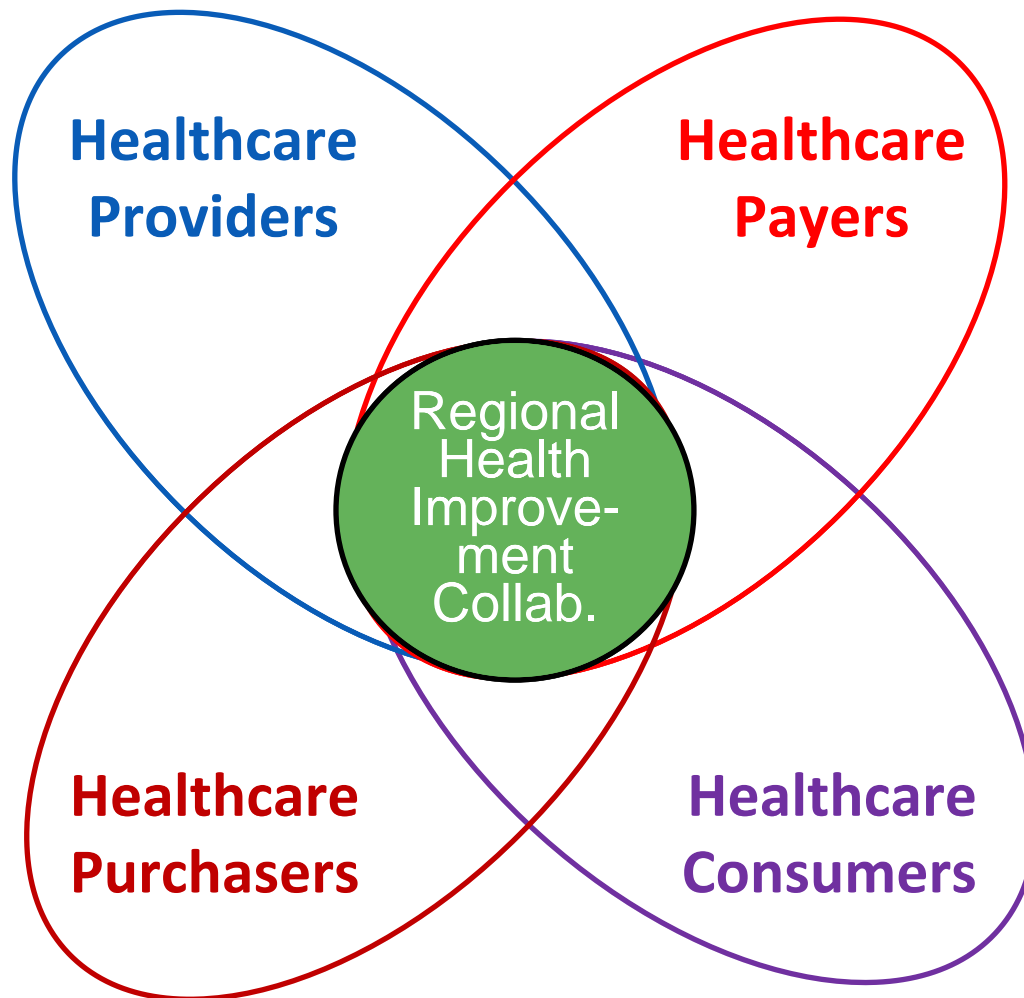
...With Active Involvement of All Healthcare Stakeholders



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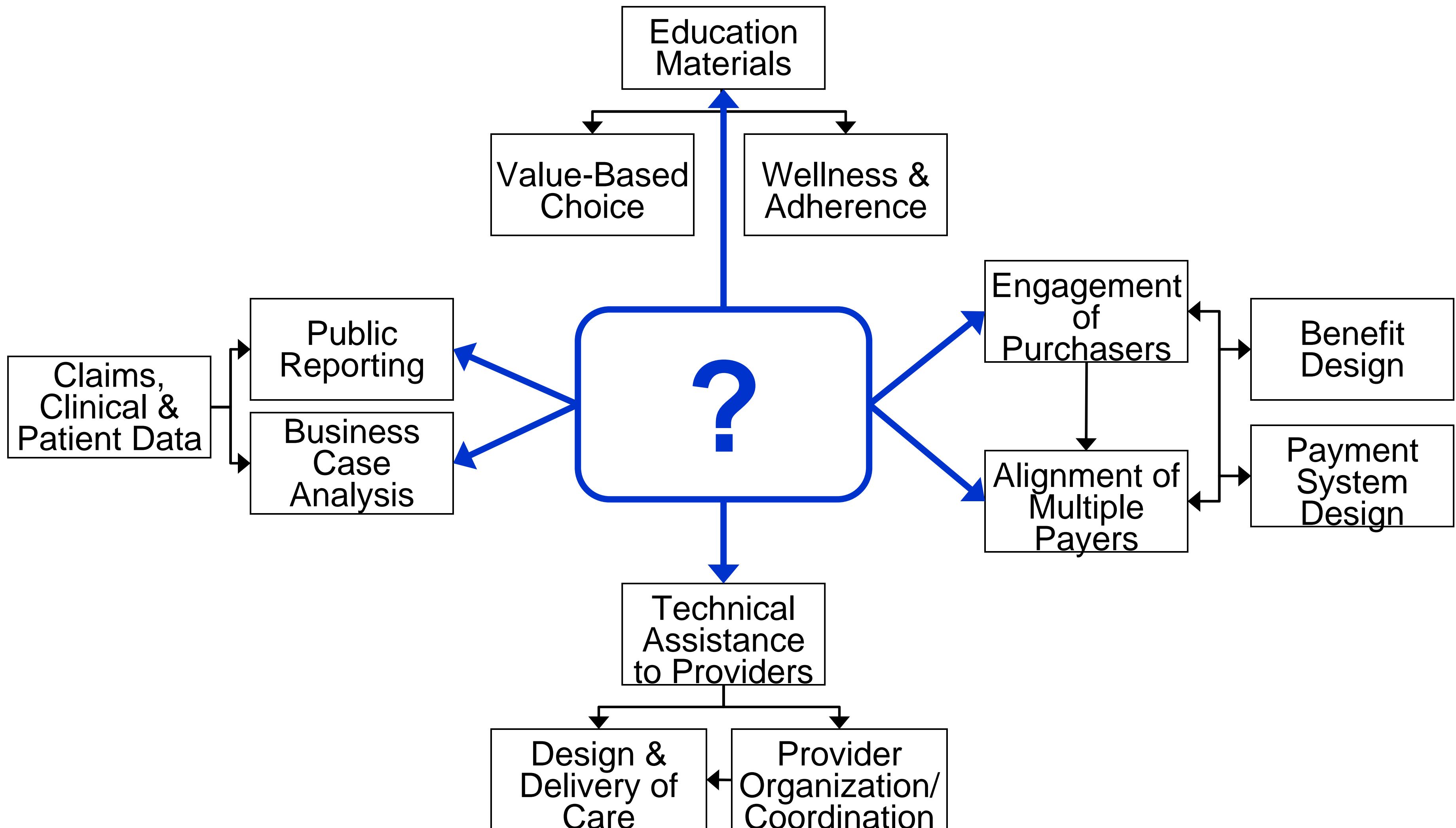
Who Can Deliver All of These Functions in a Coordinated Way?



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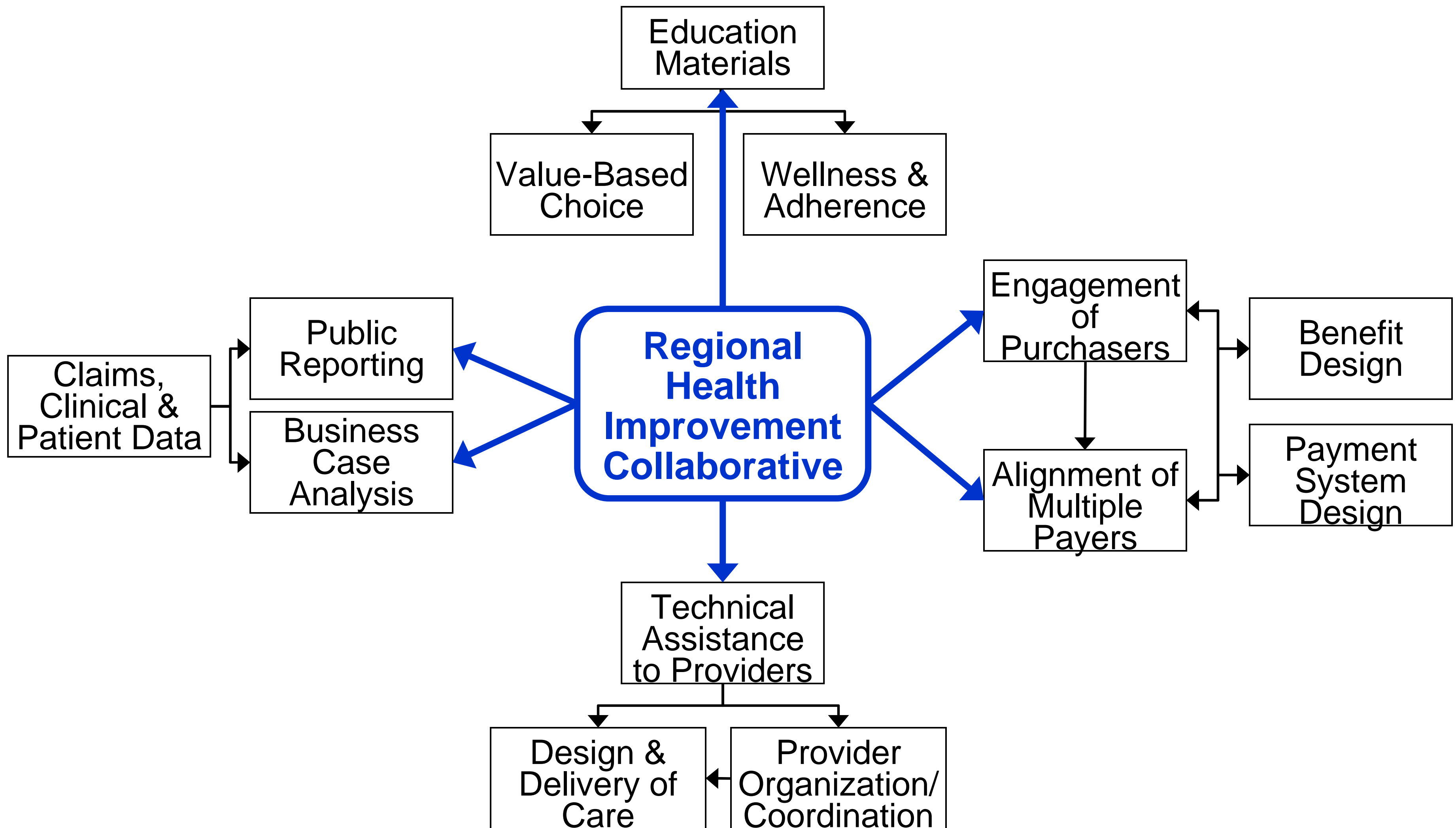
Strategy #10: Support Regional Health Improvement Collaboratives



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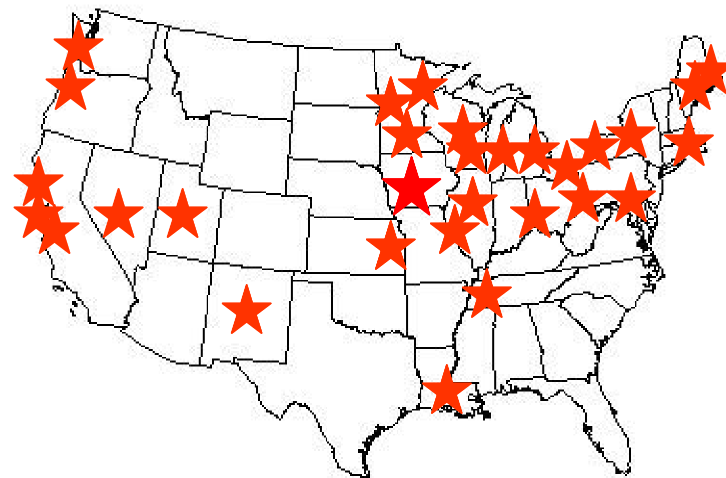
Growing Network of Regional Health Improvement Collaboratives

– 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



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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 Colorado, Maine, Nevada, Ohio, Oregon, Washington, Wisconsin have done
- **All stakeholders need to work *together* to analyze data, find win-win opportunities, design transitional payment changes, & resolve inevitable implementation problems**
  - Local multi-payer claims and clinical databases maintained by Regional Health Improvement Collaboratives provide a means to identify areas of poor quality care, overutilization, etc. and simulate the impacts of different payment models and prices through a neutral, trusted source

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For More Information on Payment and Delivery Reforms

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From VOLUME to VALUE

Transforming Health Care Payment and Delivery Systems to Improve Quality and Reduce Costs

NRHI Healthcare Payment Reform Series

BETTER WAYS TO PAY FOR HEALTH CARE

A Primer on Healthcare Payment Reform

Transitioning to Accountable Care

How to Create Accountable Care Organizations

Harold D. Miller

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PATHS TO HEALTHCARE PAYMENT REFORM: Setting Payment Levels

PATHS TO HEALTHCARE PAYMENT REFORM: Transitioning to Episode-Based Payment

PATHS TO HEALTHCARE PAYMENT REFORM: Which Healthcare Payment System is Best?

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