CENTER FOR HEALTHCARE QUALITY & PAYMENT REFORM

nrhi Network for Regional Healthcare Improvement

Creating Win-Win-Win Strategies for Successful Payment and Delivery Reform

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

All Too Often, The Way We Approach Solutions in Healthcare…

Stakeholder 1

Government
Businesses
Health Plans
Physicians
Hospitals
Patients

Stakeholder 2

Government
Businesses
Health Plans
Physicians
Hospitals
Patients

…Is To Try to Get Big Wins For Ourselves…

Stakeholder 1

Government
Businesses
Health Plans
Physicians
Hospitals
Patients

Big Win

Lower Spending
Higher Profits
More Services

Stakeholder 2

Government
Businesses
Health Plans
Physicians
Hospitals
Patients

…At the Expense of Others

Federal Cost Containment Policy Choices

Reduce Federal $

Cut Services to Seniors?

Cut Fees to Providers?

MEDICARE SPENDING = SERVICES TO SENIORS X FEES TO PROVIDERS

If It's A Choice of Rationing or Rate Cuts, Which is More Likely?

Reduce Federal $

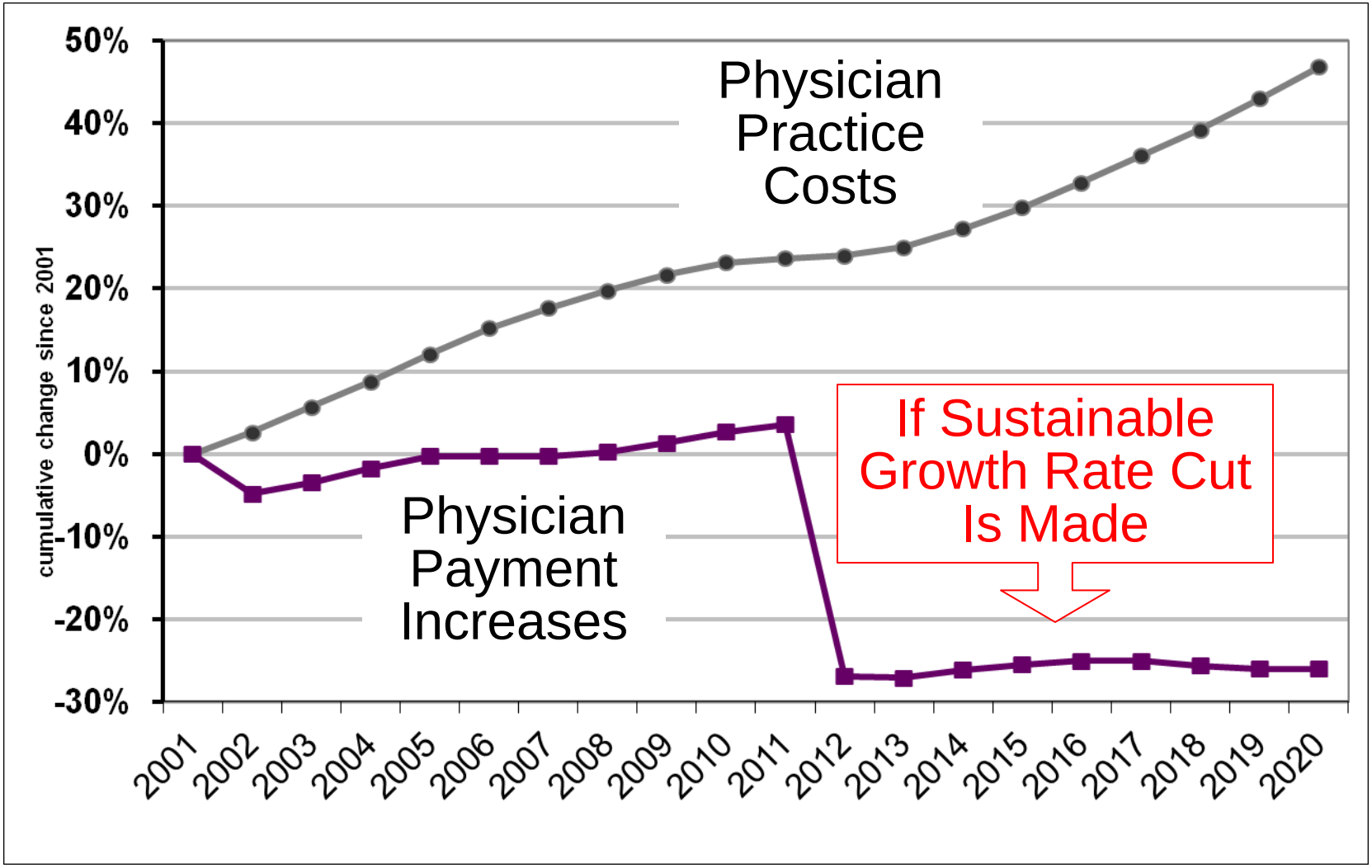
Cut Services to Seniors?

Cut Fees to Providers?

MEDICARE SPENDING = SERVICES TO SENIORS X FEES TO PROVIDERS

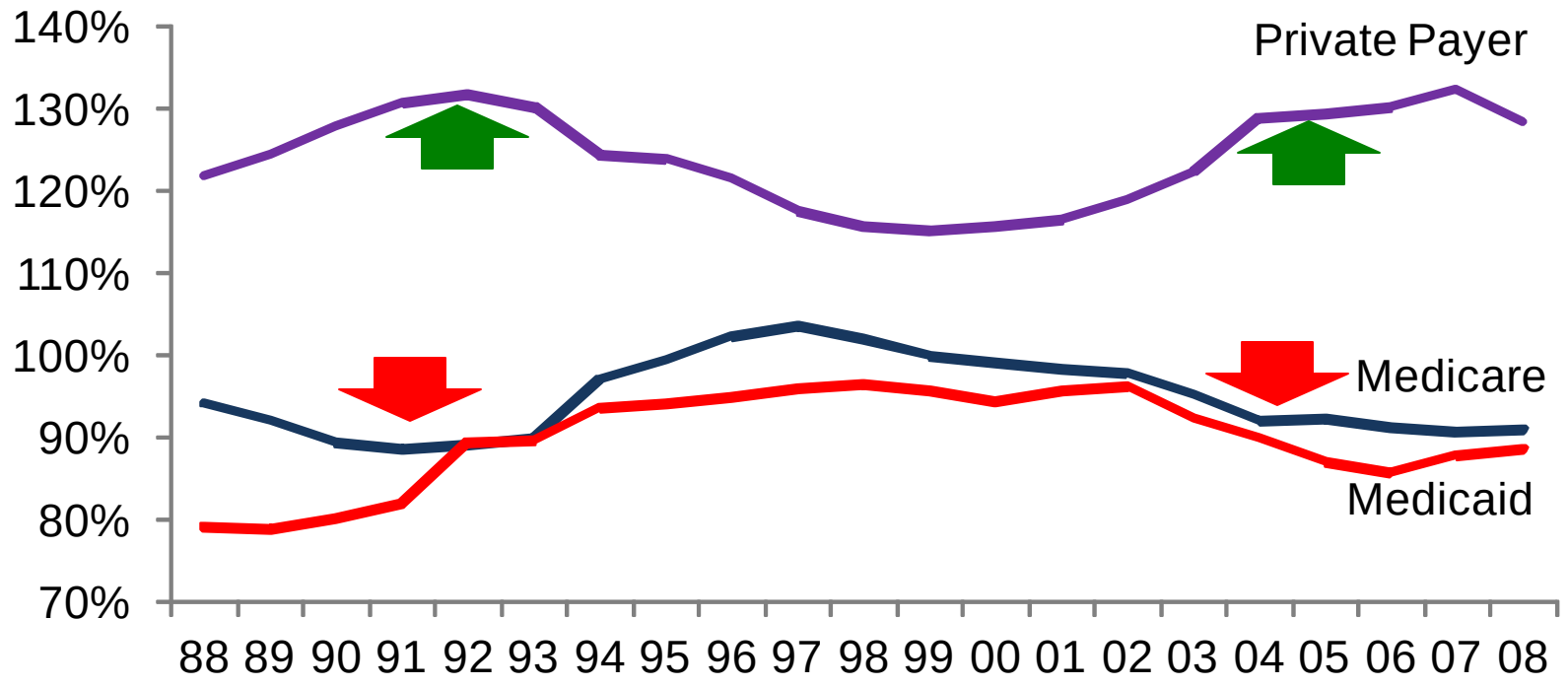
Guess which one they'll try to reduce?

Result: Medicare Fees to Doctors Below Inflation for a Decade



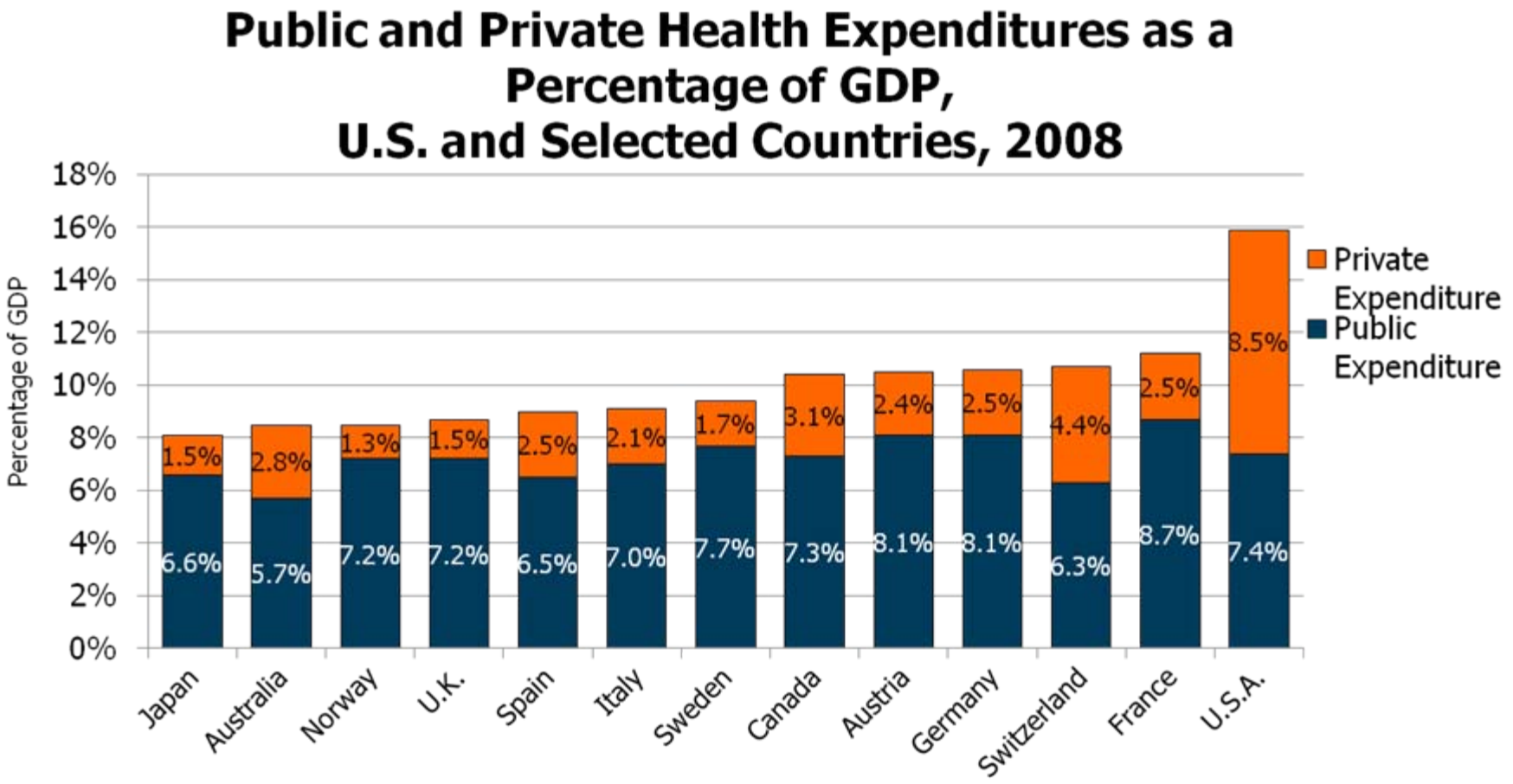
Past Solution: Businesses Pay More to Make Up For Gov't Cuts

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



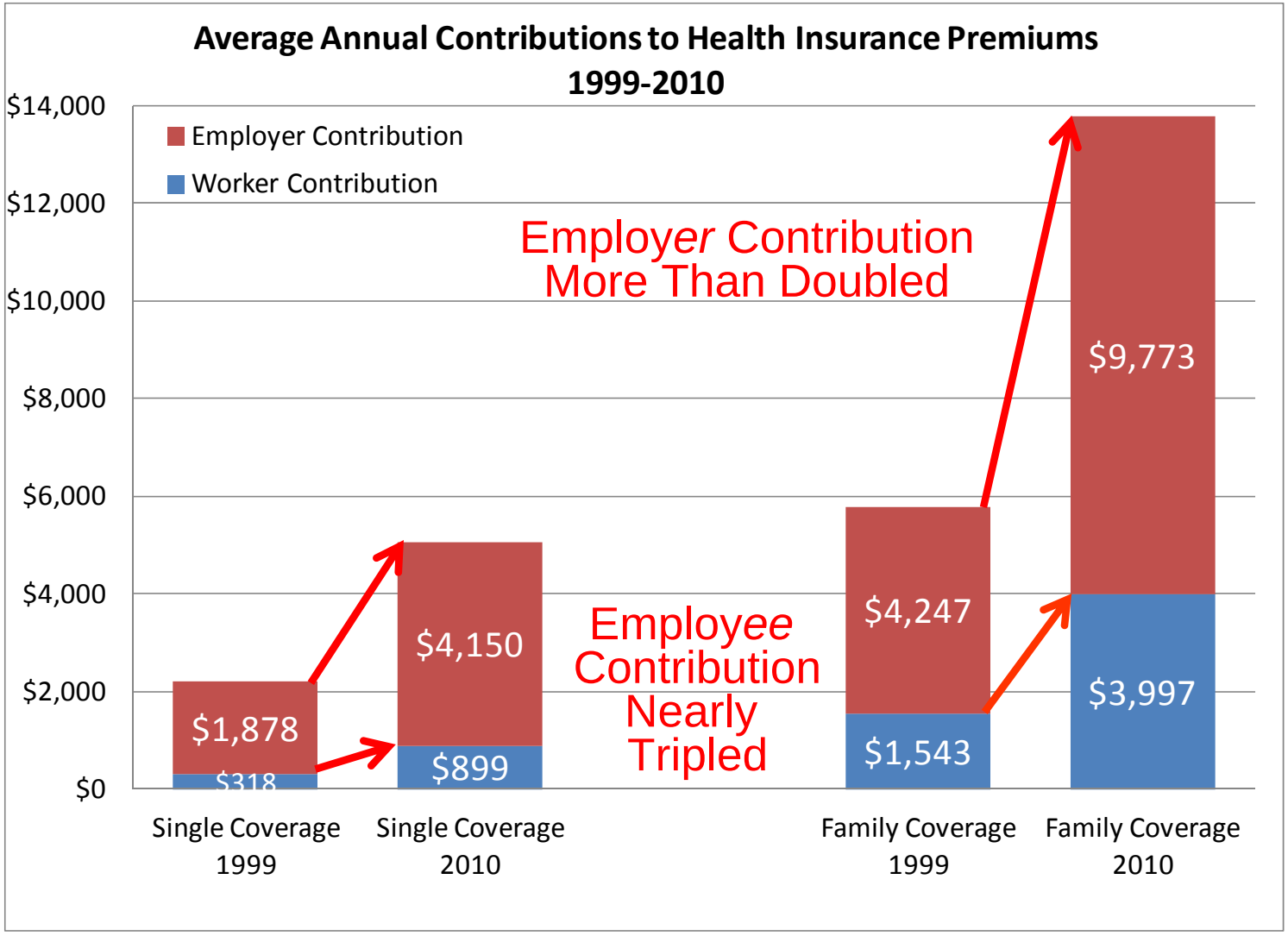
Source: Avalere Health analysis of American Hospital Association Annual Survey data, 2008, for community hospitals.

Healthcare Cost-Shifting Makes U.S. Businesses Uncompetitive

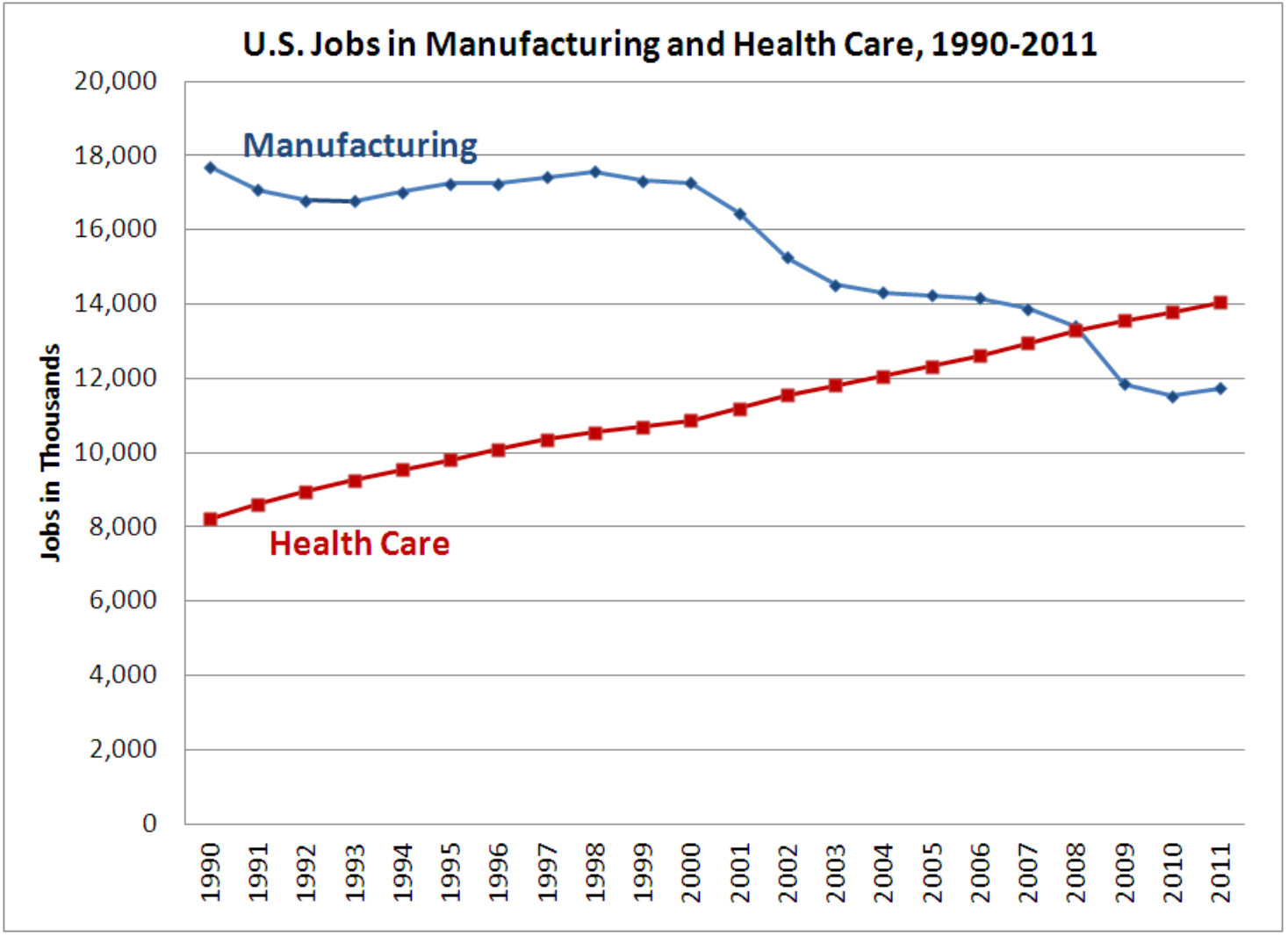


Source: Organisation for Economic Co-operation and Development (2010), "OECD Health Data", *OECD Health Statistics* (database)
Notes: Data from Australia and Japan are 2007 data. Figures for Canada, Norway and Switzerland, are OECD estimates. Numbers are PPP adjusted.

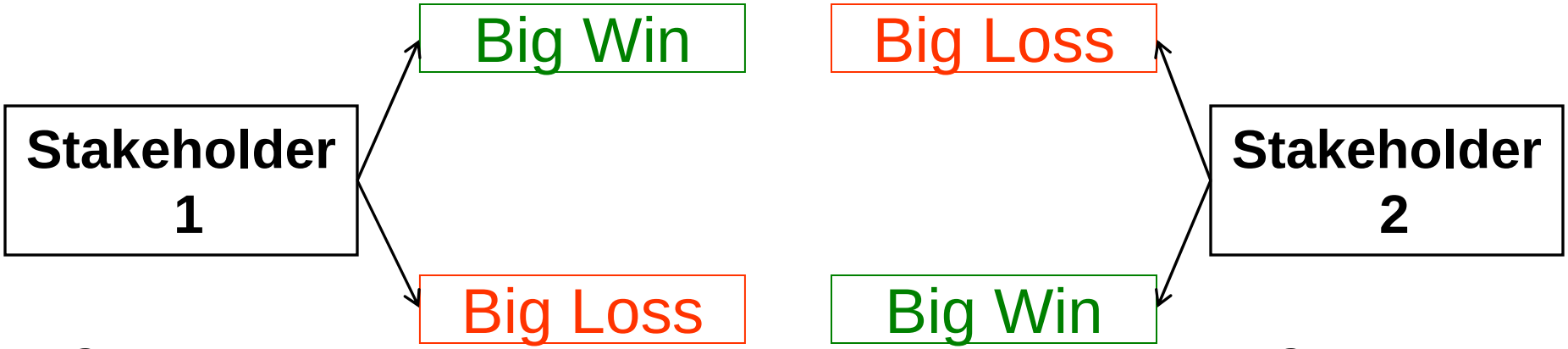
Employers Are Reducing Costs By Shifting Costs to Workers



We Worry Whether We Can Cut One of Our Only Growth Sectors



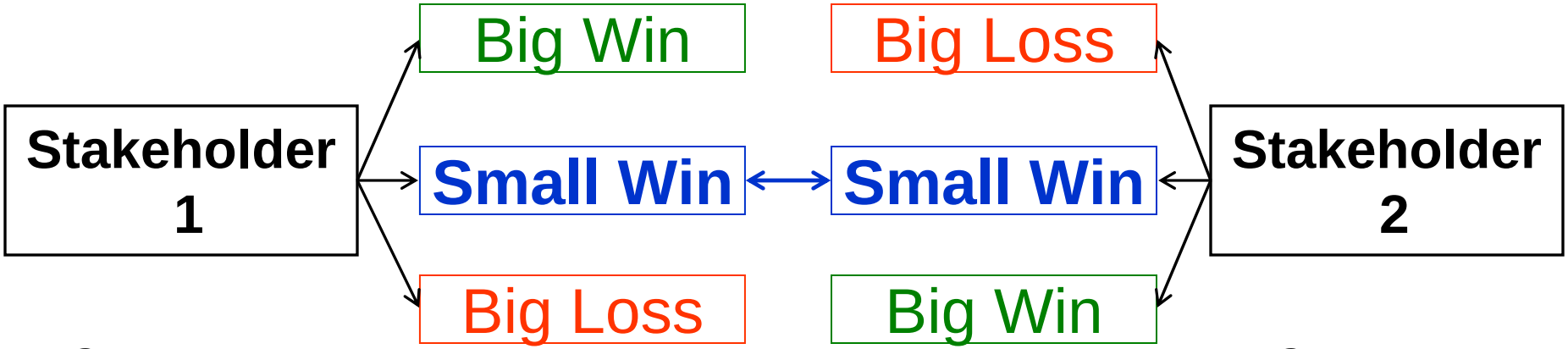
Instead of Pushing Solutions That Others Will Be Forced to Fight…



Government
Businesses
Health Plans
Physicians
Hospitals
Patients

Government
Businesses
Health Plans
Physicians
Hospitals
Patients

…We Should Be Seeking Win-Win Solutions



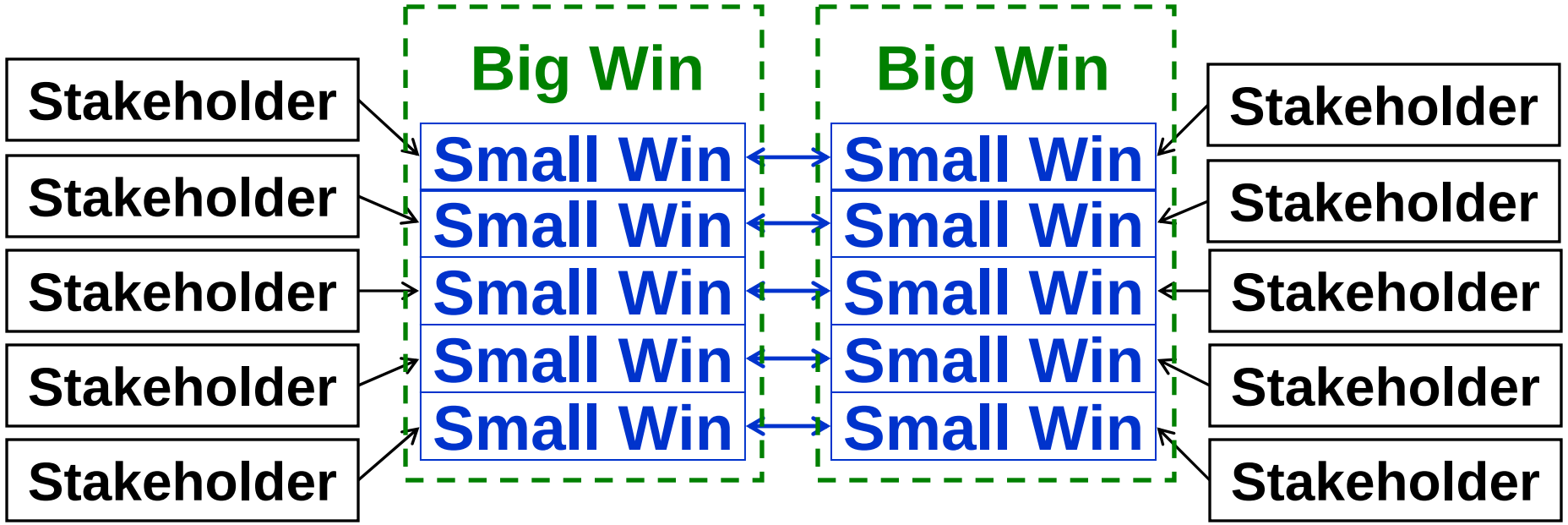
Government
Businesses
Health Plans
Physicians
Hospitals
Patients

Government
Businesses
Health Plans
Physicians
Hospitals
Patients

“Small Wins” Aren’t Big Enough?

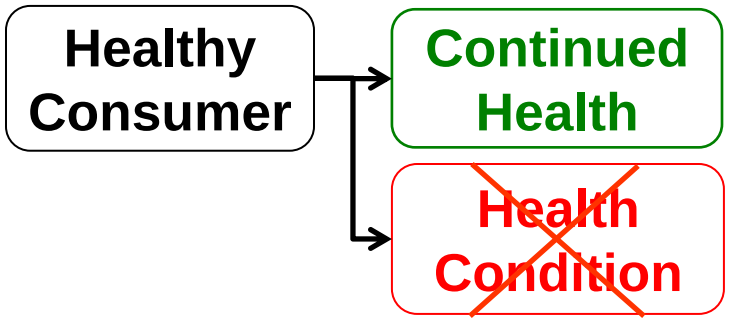
- Would you rather have a small win you can get?
- Or a “big win” that you can’t?

Many Small Win-Wins Can Add Up to Big Wins For Everyone

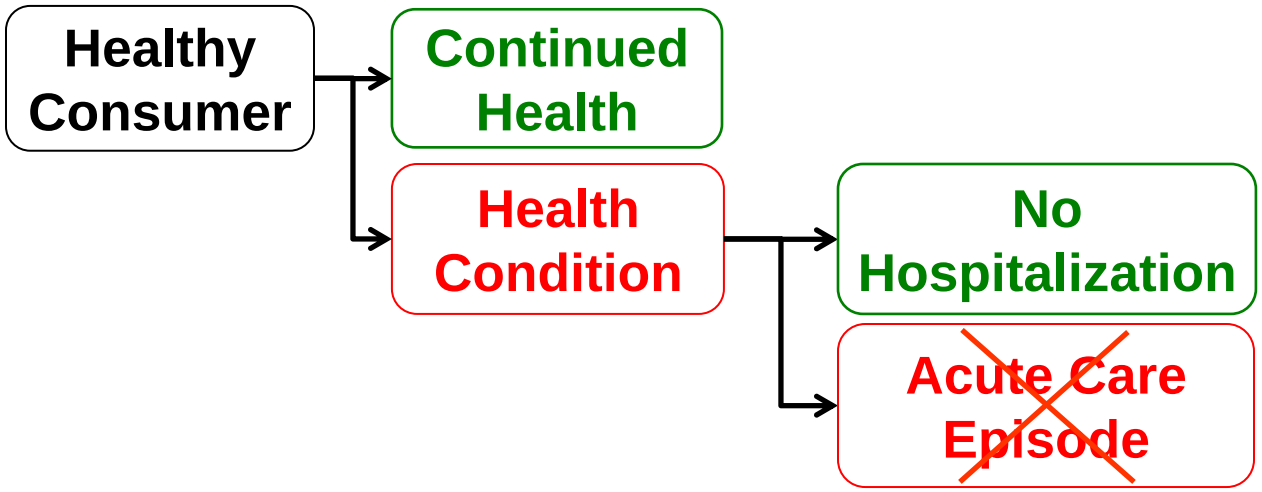


Starting with Patients: Can We Reduce Costs Without Rationing?

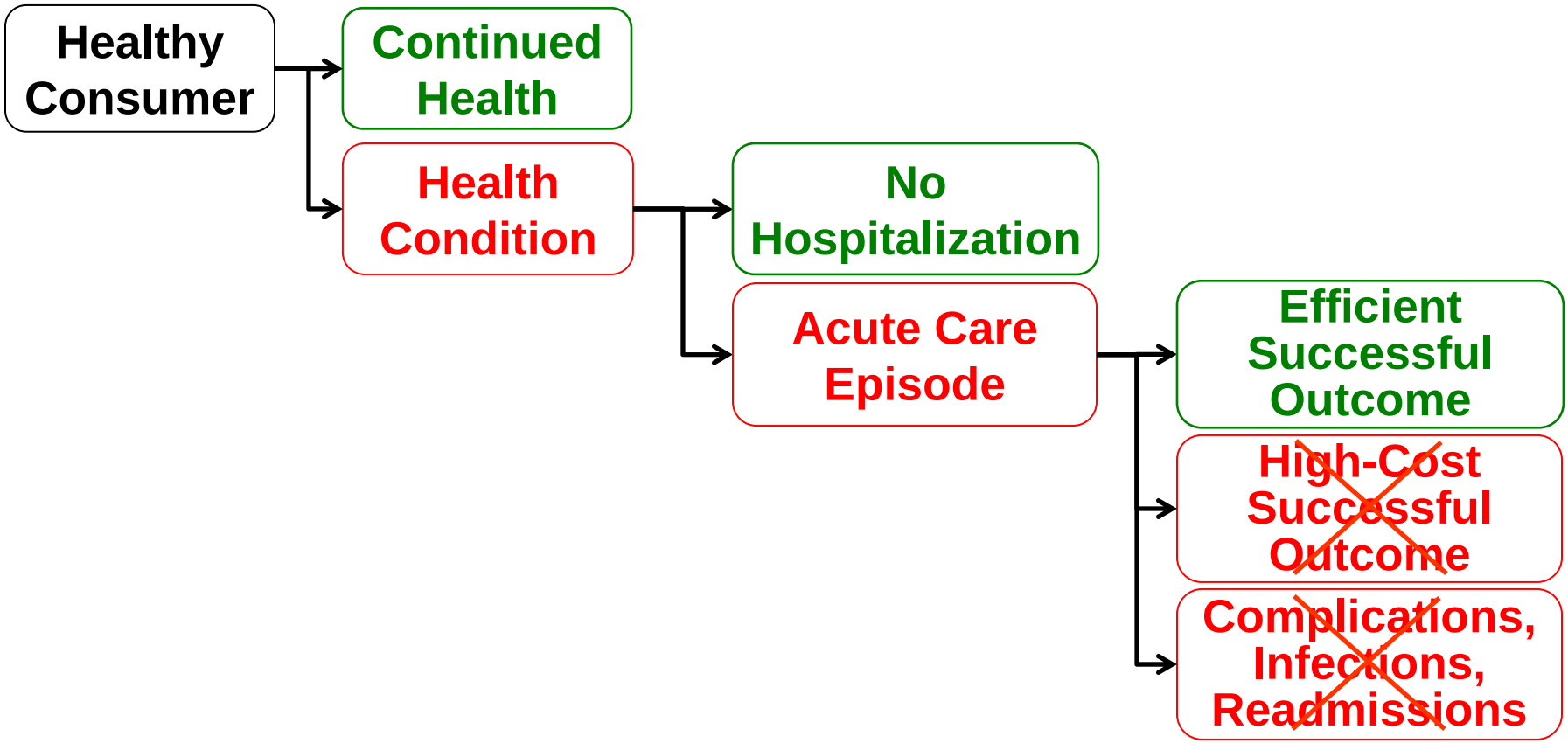
Reducing Costs Without Rationing:
Prevention and Wellness



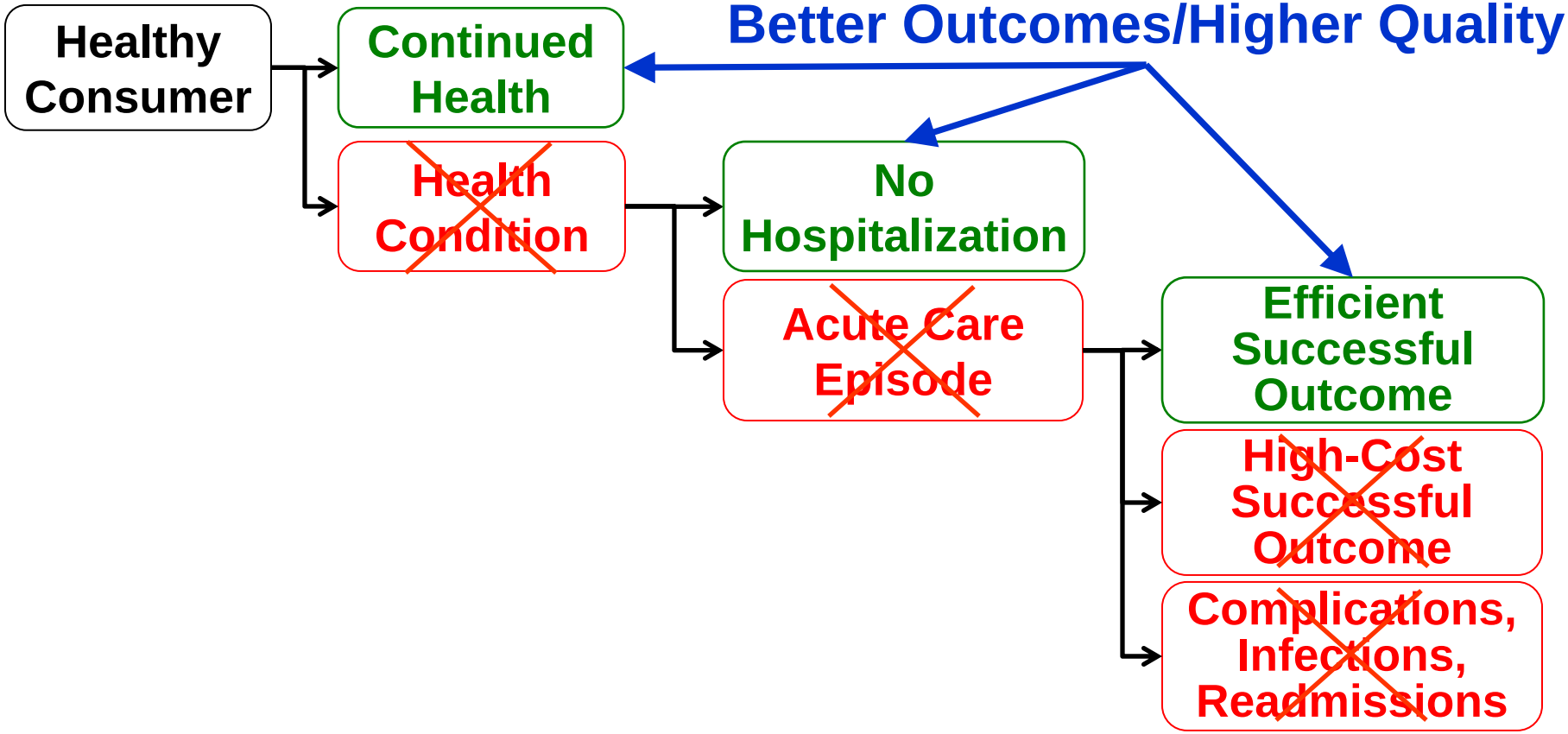
Reducing Costs Without Rationing: Avoiding Hospitalizations



Reducing Costs Without Rationing: Efficient, Successful Treatment

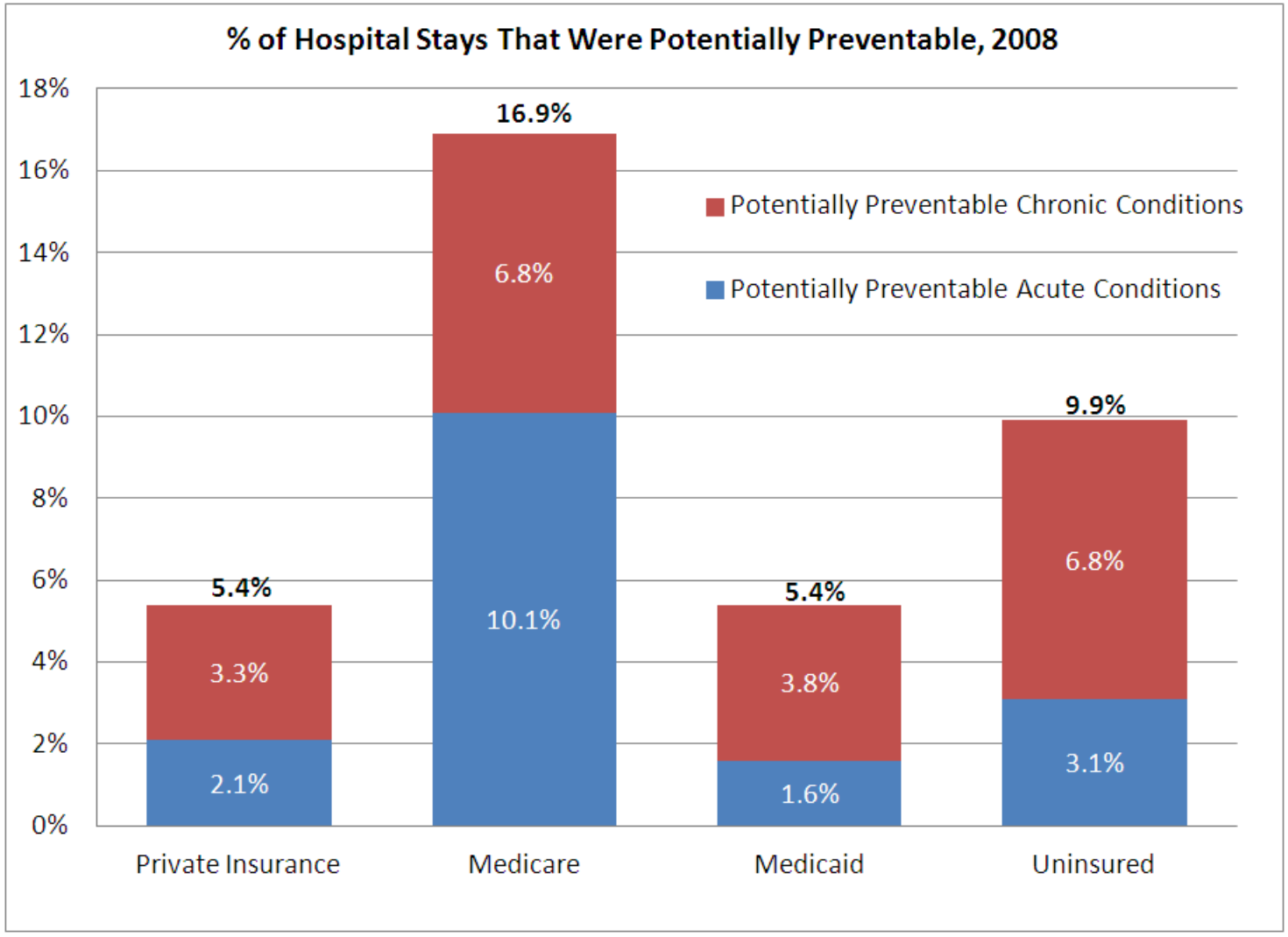


Reducing Costs Without Rationing Is Also Quality Improvement!



How Big Are the Opportunities?

5-17% of Hospital Admissions Are Potentially Preventable



Source: AHRQ HCUP

More than a *Million* Preventable Errors & Adverse Events Annually

Medical Error	# Errors (2008)	Cost Per Error	Total U.S. Cost
Pressure Ulcers	374,964	$10,288	$3,857,629,632
Postoperative Infection	252,695	$14,548	$3,676,000,000
Complications of Implanted Device	60,380	$18,771	$1,133,392,980
Infection Following Injection	8,855	$78,083	$691,424,965
Pneumothorax	25,559	$24,132	$616,789,788
Central Venous Catheter Infection	7,062	$83,365	$588,723,630
Others	773,808	$11,640	$9,007,039,005
TOTAL	1,503,323	$13,019	$19,571,000,000

Source: *The Economic Measurement of Medical Errors*, Milliman and the Society of Actuaries, 2010

Many Procedures Could Be Done for 80-90% Less Than Today

Massachusetts Health Care Cost Trends — *Price Variation in Massachusetts Health Care Services*

Table 5: Observed Prices for Selected High-Volume Medical DRGs by Severity of Illness, 2009

APR-DRG and severity	Minimum price	Median price	Average price	Maximum price
Knee joint replacement (302)				
Severity 1	$5,202	$21,241	$21,040	$50,726
Severity 2	$7,599	$21,887	$22,743	$68,901
Severity 3	$16,069	$28,173	$30,376	$59,252
Cesarean delivery (540)				
Severity 1	$3,244	$7,598	$7,859	$15,915
Severity 2	$2,828	$8,718	$9,338	$20,424
Severity 3	$3,621	$11,389	$13,266	$26,018

10-Fold Difference

5-Fold Difference

Instead of Starting With How to *Limit* Care for Patients…

Contributors to Healthcare Costs

How Do We Limit:

- New Technologies
- Higher-Cost Drugs
- Potentially Life-Saving Treatment

We Should Focus First on How to *Improve* Patient Care

Contributors to Healthcare Costs

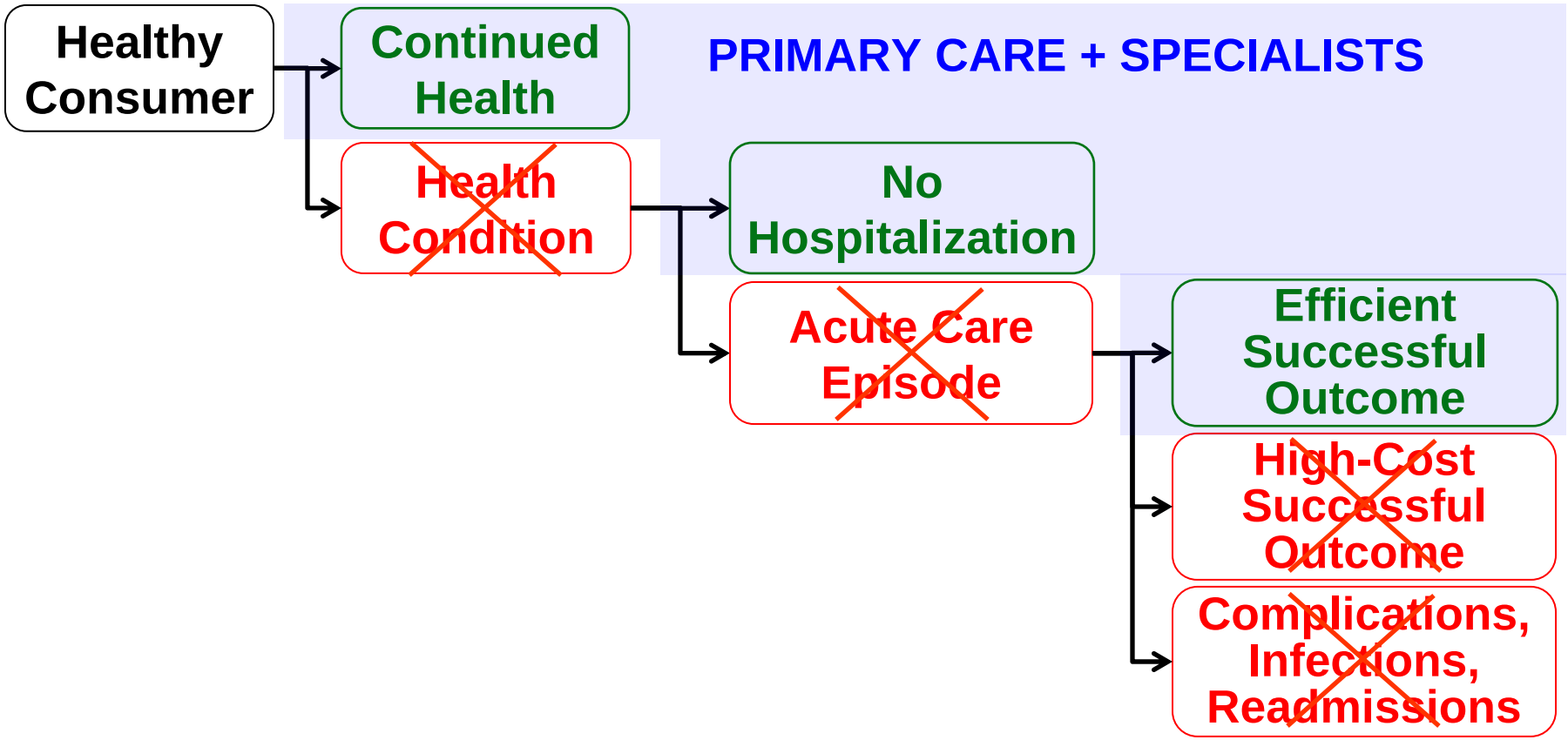
How Do We *Help*:

- Patients Stay Well
- Avoid Unnecessary Surgery and Other Hospitalizations
- Eliminate Potentially Life-Threatening Errors and Safety Problems
- Reduce Costs of Procedures

How Do We Limit:

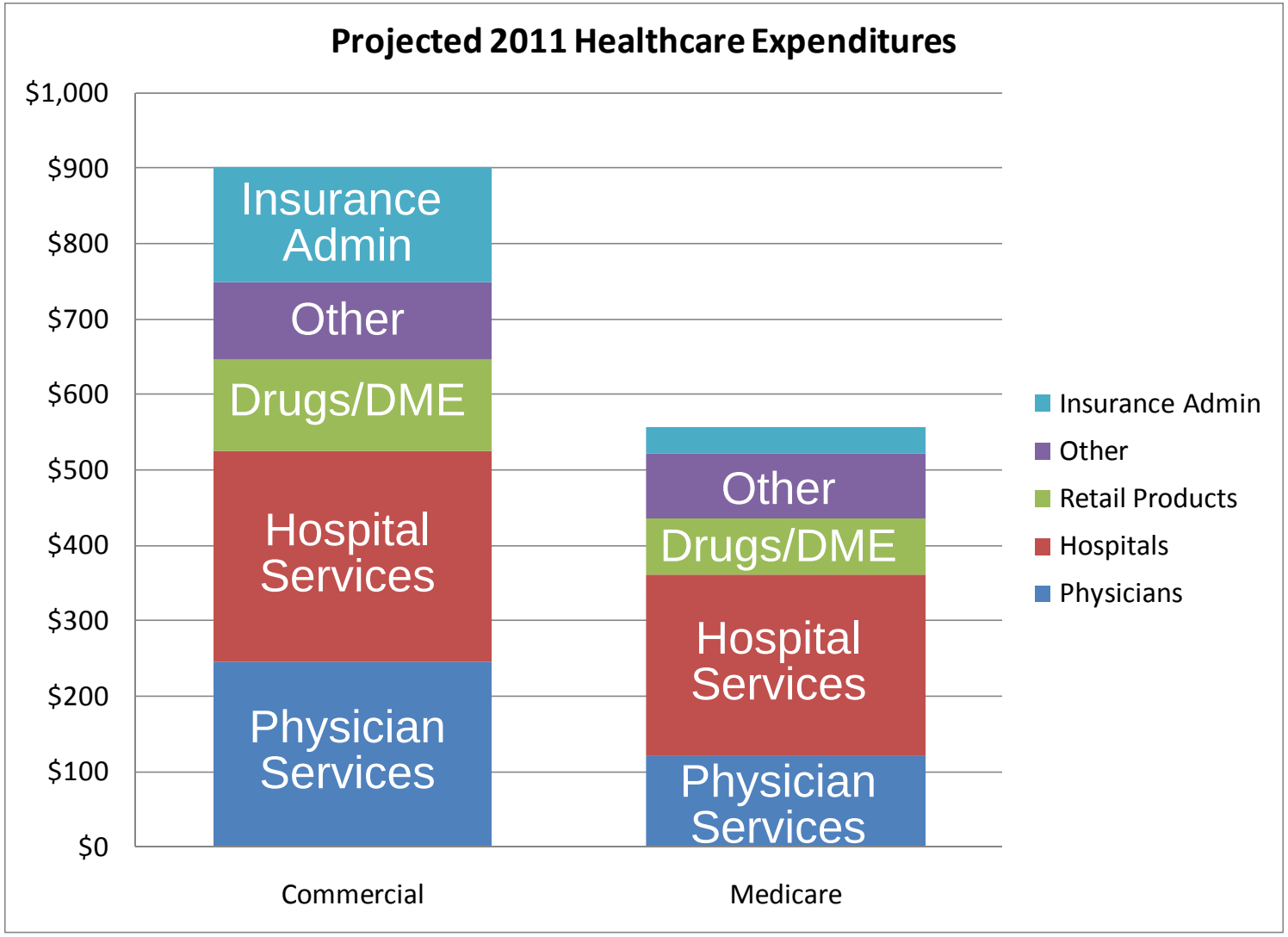
- New Technologies
- Higher-Cost Drugs
- Potentially Life-Saving Treatment

Physicians Are The Key to Higher Quality, Lower Cost Care

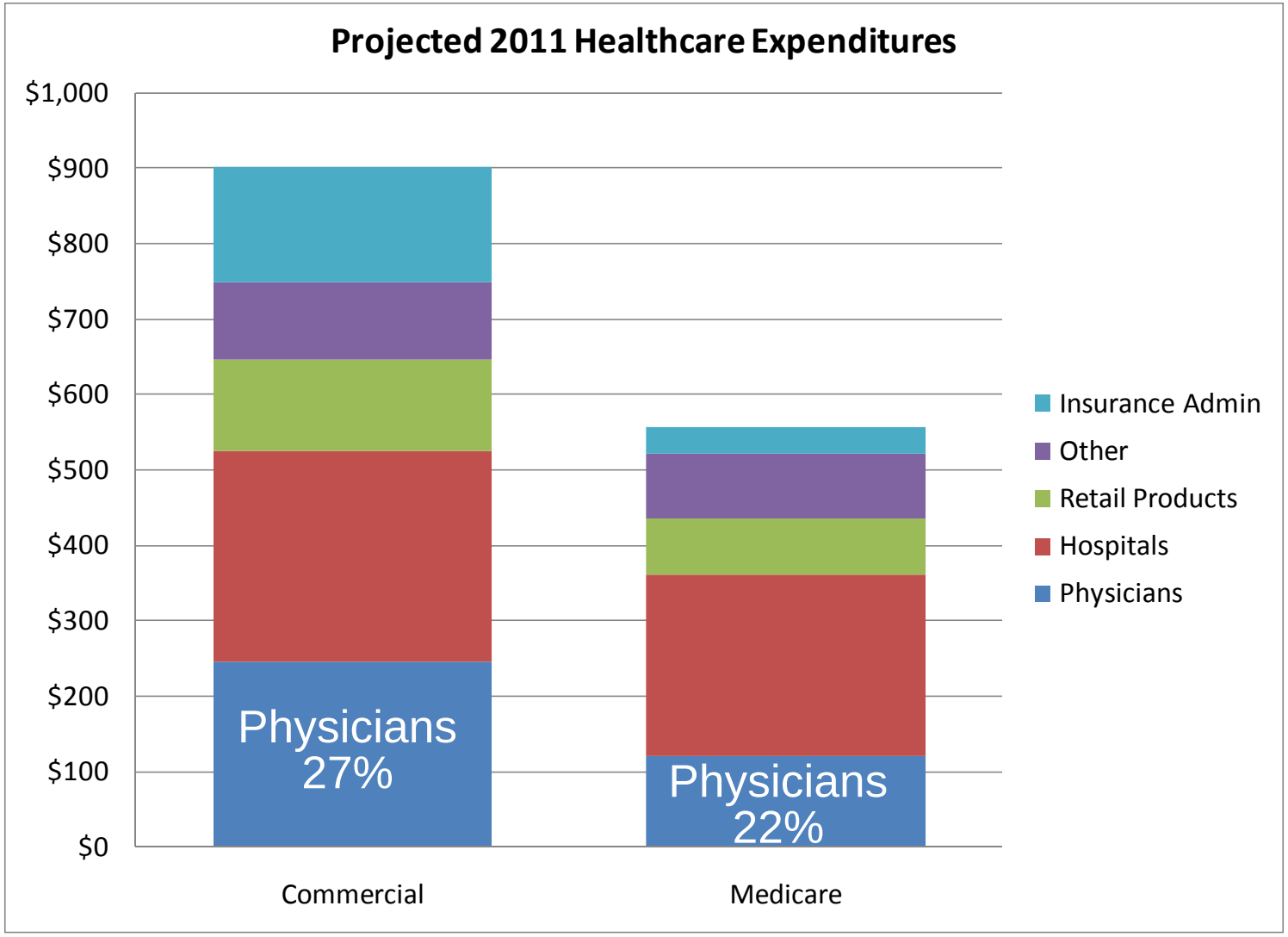


Will Physicians Win or Lose If Spending is Reduced?

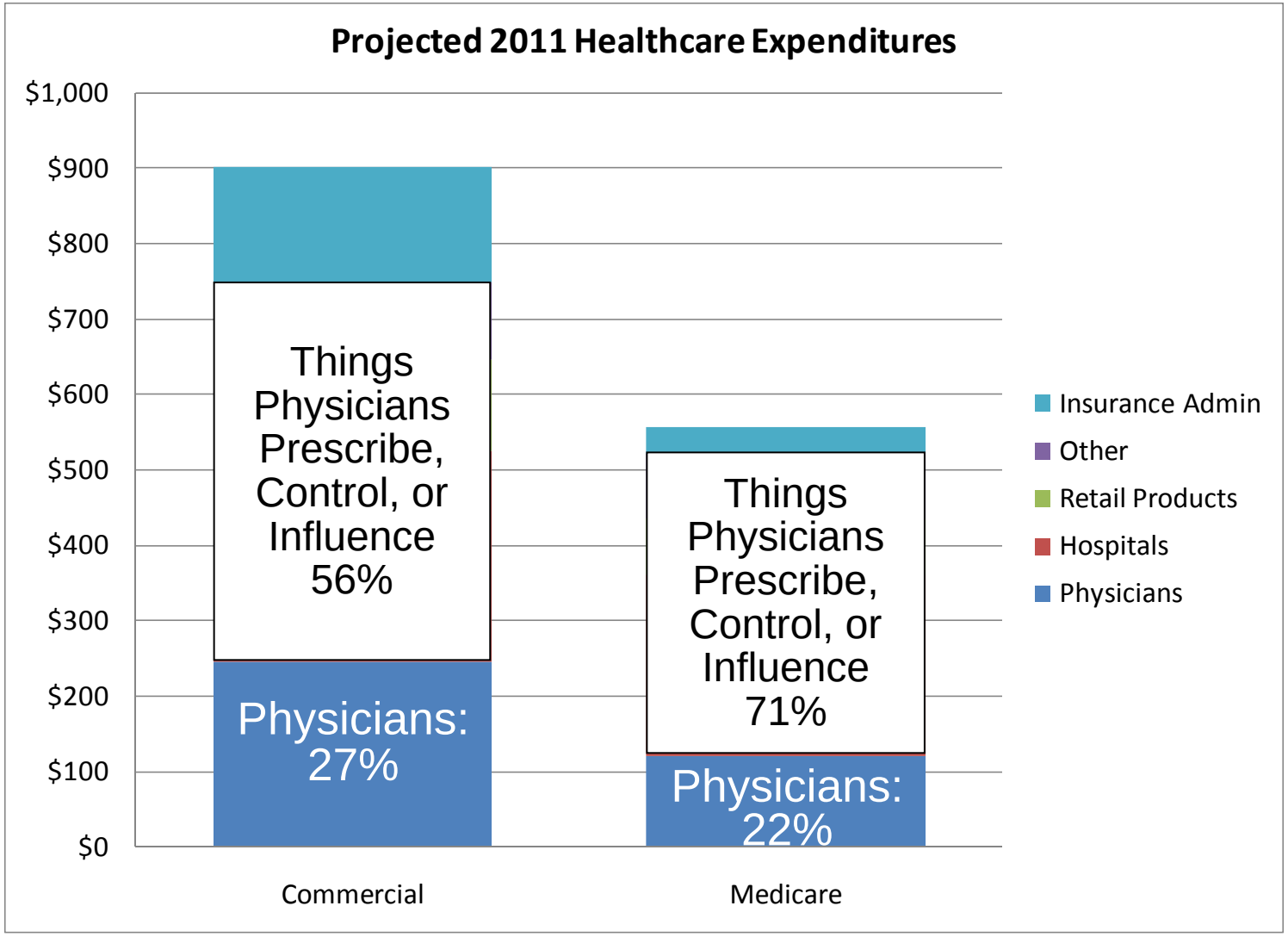
Where is the Money Going Now?



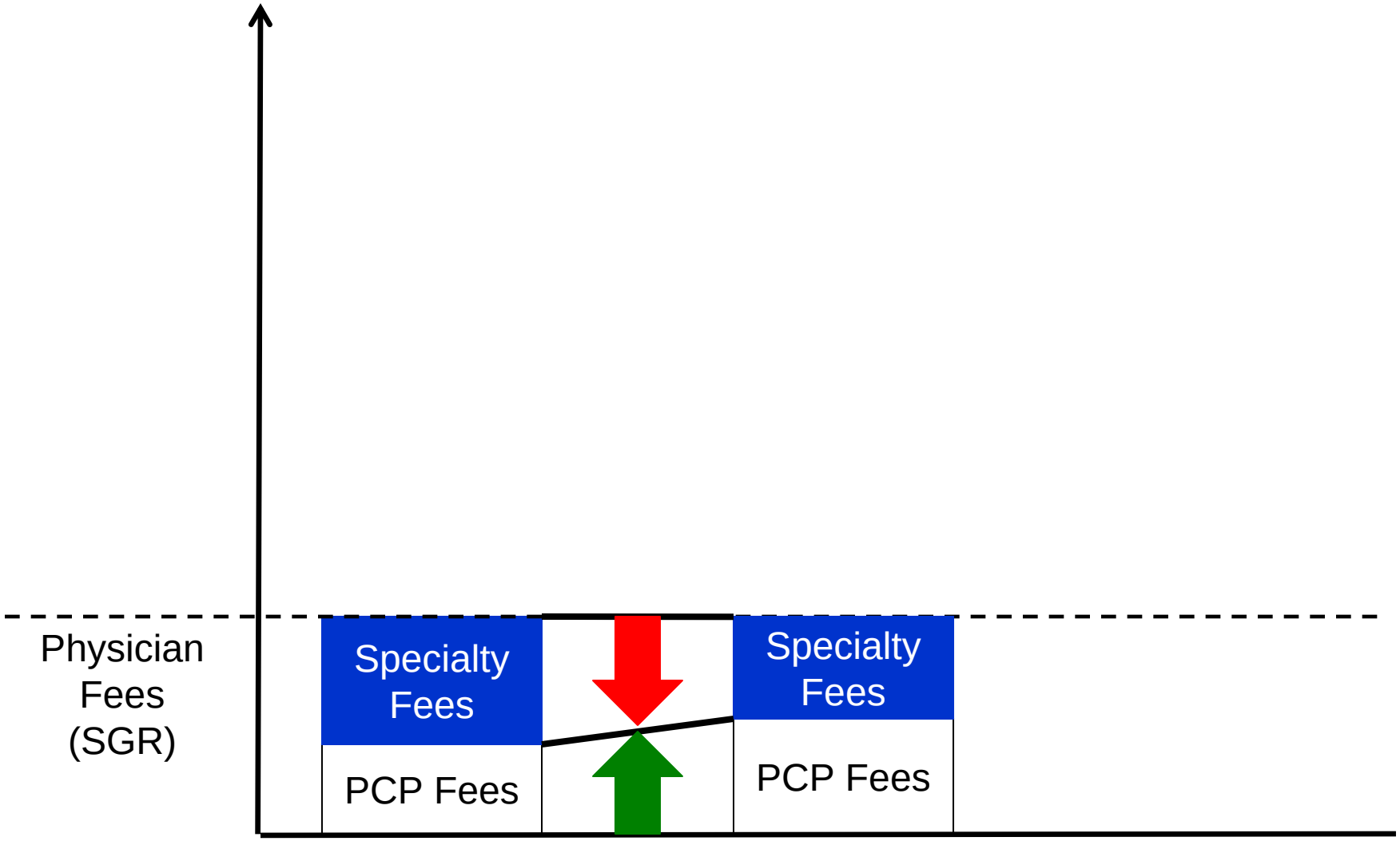
Only 1/4 of Healthcare Spending Goes to Physicians…



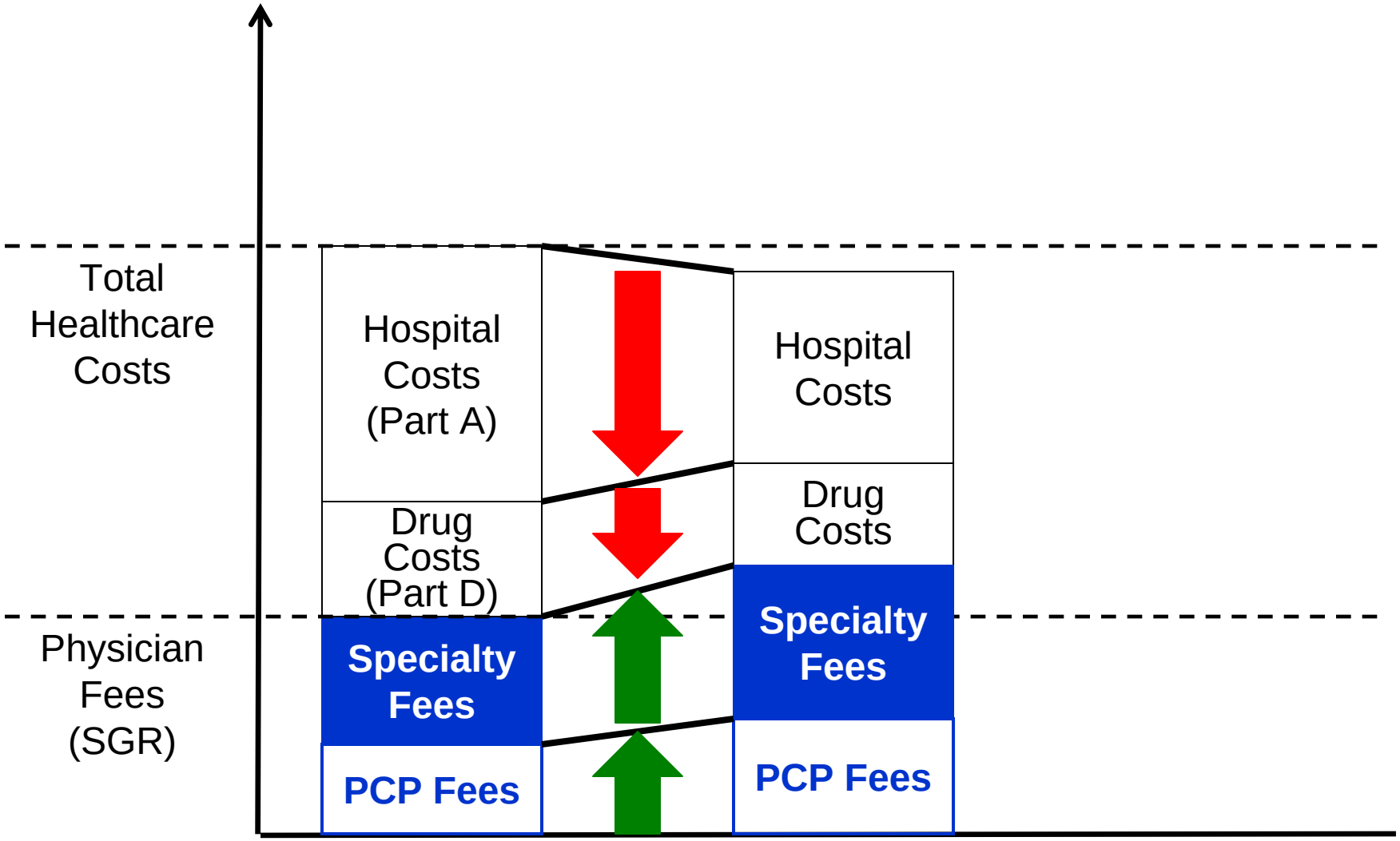
.. Most of The Rest Goes to Things That Physicians Can *Influence*



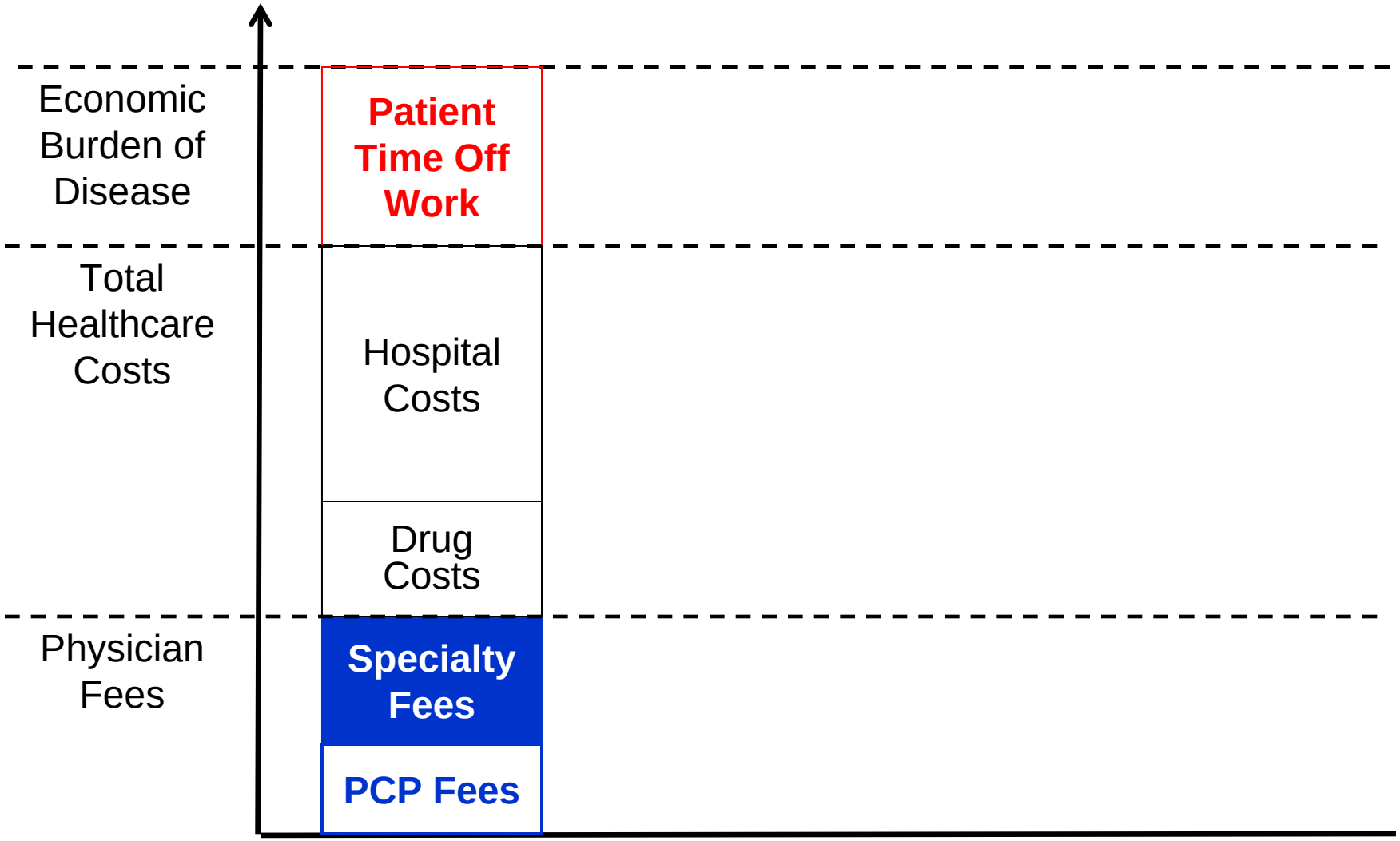
Sustainable Growth Rate Pits Physicians Against Each Other



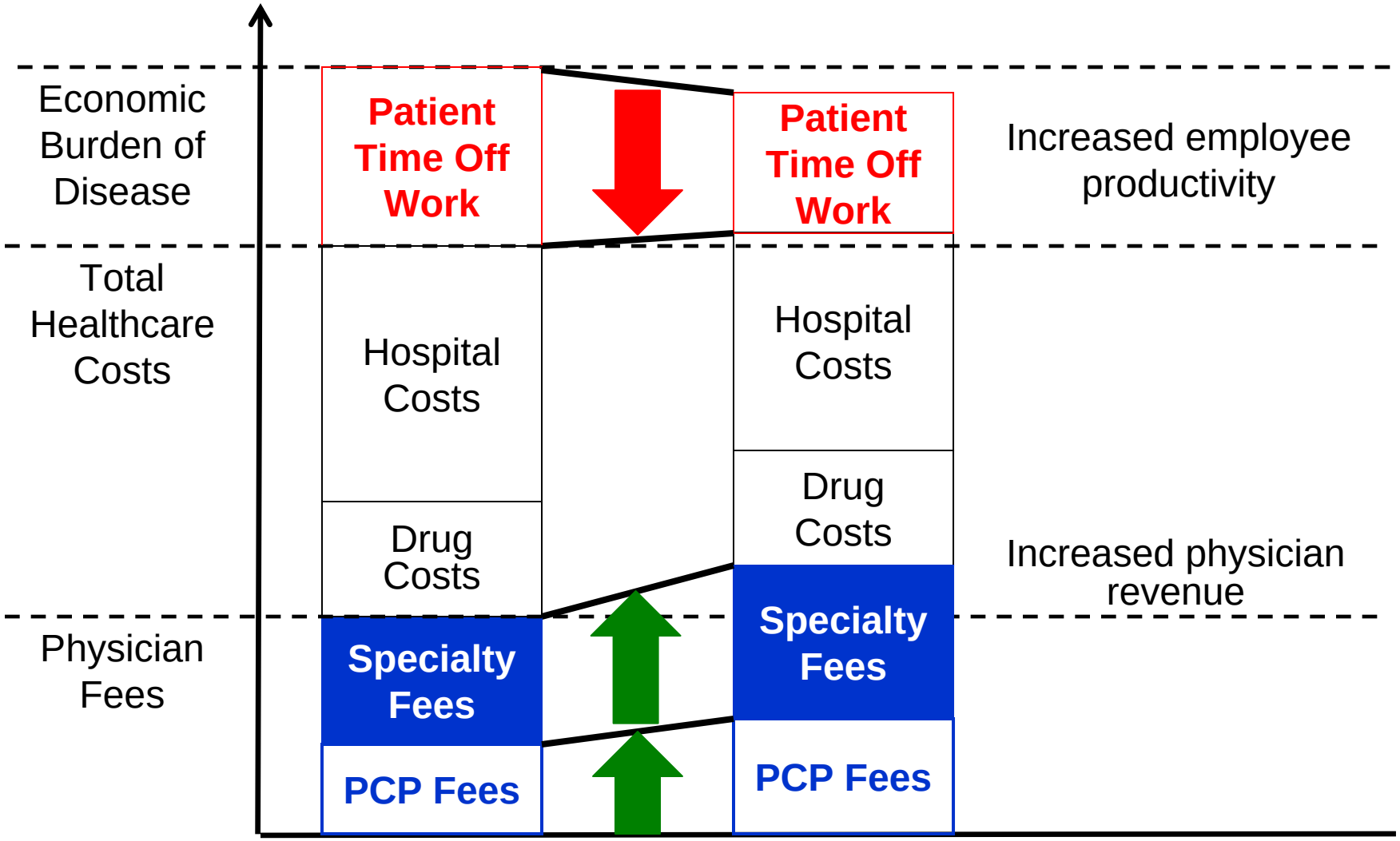
Physicians Should Benefit From Lowering Other Healthcare Costs



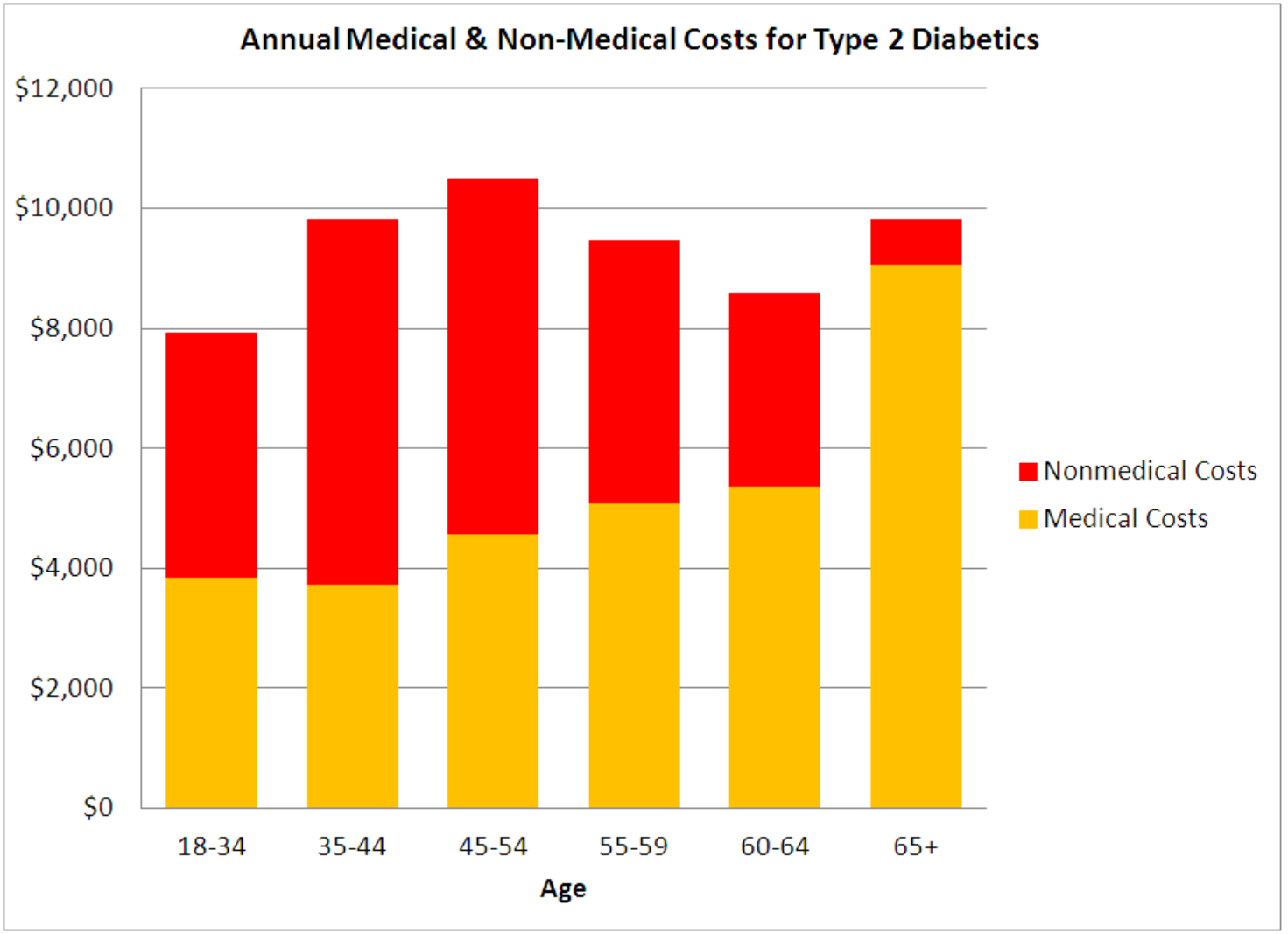
For Businesses, It's Not Just Healthcare Costs, But *Productivity*



Employers May Pay More for Improved Employee Productivity



Non-Medical Costs > Medical Costs For Working-Age Adults



Source: Timothy Dall et al,
"The Economic Burden of Diabetes,"
Health Affairs February 2010

Example: Reductions Possible in Chronic Disease Admissions

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

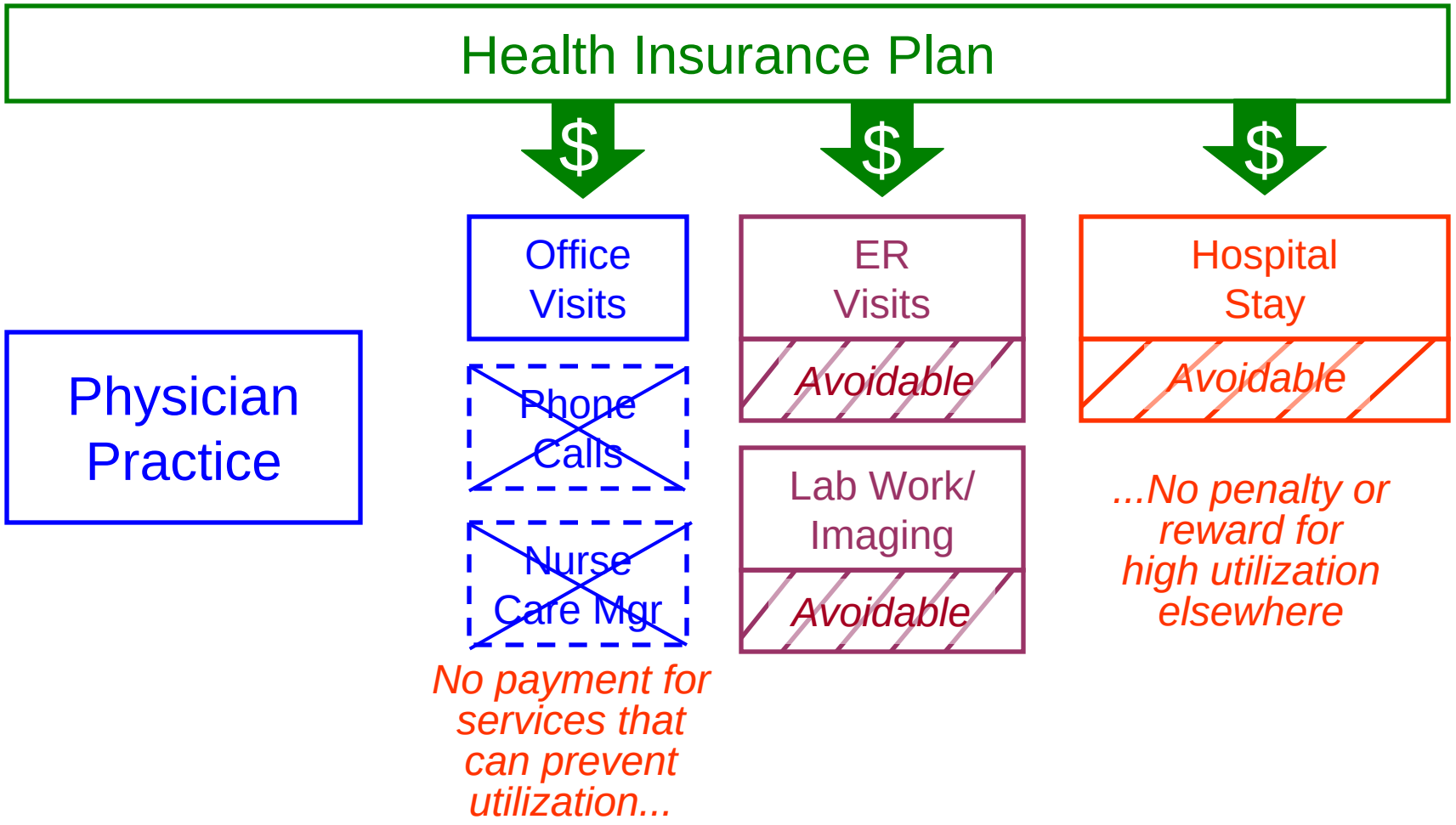
  M.E. Cordisco, A. Benjaminovitz, et al, “Use of Telemonitoring to Decrease the Rate of Hospitalization in Patients With Severe Congestive Heart Failure,” *American Journal of Cardiology* 84(7), 1999

- 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

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

CURRENT PAYMENT SYSTEMS



Example: PCP Practice Whose Patients Use the ER Unnecessarily

	Year 0
Primary Care Practice	
Extra Payments to PCPs	$0
Care Mgt Expense	$0
Change in Net Revenue	$0
Payer	
Preventable ER Visits	$500,000
Extra Payments to PCPs	$0
Combined Spending	$500,000

Simply Hiring A Nurse Care Mgr Could Avoid Many ER Visits…

CURRENT FEE-FOR-SERVICE STRUCTURE				
	Year 0	**Year 1**	**Change**	
Primary Care Practice				
Extra Payments to PCPs	$0			
Care Mgt Expense	$0	$75,000		Hire Nurse Care Manager
Change in Net Revenue	$0	($75,000)	**($75,000)**	
Payer				
Preventable ER Visits	$500,000	$350,000		Reduce Prev. ER Visits by 30%
Extra Payments to PCPs	$0	$0		
Combined Spending	$500,000	$350,000	**$150,000**	

But Today, the PCP Loses Money To Save $ for Payer

CURRENT FEE-FOR-SERVICE STRUCTURE				
	Year 0	**Year 1**	**Change**	
Primary Care Practice				
Extra Payments to PCPs	$0			
Care Mgt Expense	$0	$75,000		Hire Nurse Care Manager
Change in Net Revenue	$0	($75,000)	**($75,000)**	
Payer				
Preventable ER Visits	$500,000	$350,000		Reduce Prev. ER Visits by 30%
Extra Payments to PCPs	$0	$0		
Combined Spending	$500,000	$350,000	**$150,000**	

Primary Care Physicians Losing Money Even in PCMH Projects

THE WALL STREET JOURNAL.
WSJ.com

HEALTH INDUSTRY | Updated March 16, 2012, 1:06 p.m. ET

Why America's Doctors Are Struggling to Make Ends Meet

Some Upgrade Their Practices but Reimbursements Fall Short; Dr. Hammond Feels the Squeeze

By ANNA WILDE MATHEWS

Scott Hammond is trying to give his patients the kind of hands-on care that everyone from insurers to policy makers say they want. But the costs may outweigh his practice's ability to pay them. WSJ's Anna Mathews reports. (Photo: Nathan W. Ames)

Scott Hammond is doing everything modern doctors are supposed to be doing. But now Dr. Hammond is wondering: Is this any way to keep a practice going?

The lanky 59-year-old's Denver-area clinic has made significant upgrades over the past four years.

Inside a Medical Practice

Family practices like Westminster Medical Clinic are struggling with new ways of delivering and paying for primary care.

Item	Notes	Revenue	Expense
Insurer payments	Fees mostly for office visits	$1,541,743	
Nonprofit project	Payment for 'medical home' pilot project	243,089	
Practice Association	Medicare Advantage plan payment	222,763	
Grant	Award to add social worker	33,543	
Other income	Government incentives, etc.	44,103	

His family practice uses electronic health records, calls up patients at home to check on their progress, and coordinates with other specialists and hospitals—all the things that policy makers and insurers say should be done to improve patient care.

But many of these enhancements aren't reimbursed under traditional insurance contracts that pay mostly for face-to-face visits with patients. What's more, the practice gave up around $200,000 in revenue from patient visits that Dr. Hammond cut back as he worked to improve the practice.

Westminster Medical Clinic was able to fill the hole only with support from a nonprofit's program. Last year, the clinic took in $2,115,101 in total revenue and barely inched into the black. In 2010, the practice lost money.

The Win-Win Approach: Invest in PCP Care to Reduce Costs

SHARED INVESTMENT AND RETURN				
	Year 0	Year 1	Change	
Primary Care Practice				
Extra Payments to PCPs	$0	$85,000		Payment for Care Management
Care Mgt Expense	$0	$75,000		Hire Nurse Care Manager
Change in Net Revenue	$0	$10,000	**$10,000**	
Payer				
Preventable ER Visits	$500,000	$350,000		Reduce Prev. ER Visits by 30%
Extra Payments to PCPs	$0	$85,000		Pay PCP for Care Management
Spending	$500,000	$435,000	**$65,000**	

Example: Washington State Medical Home Pilot Program

- **Organized by Puget Sound Health Alliance and Washington State Health Care Authority**
- **4-Part Payment Model**
  - **Current FFS payments for PCP services**
  - **Additional PMPM payment for "care management"**
    - $2.50 per patient per month in Year 1 (part of year)
    - $2.00 per patient per month in Years 2 & 3
    - No restrictions on how money is used
  - **Targets for Reducing Preventable ER/Hospital Utilization**
    - Reduction targets large enough to repay health plans for upfront payments
    - Penalty for failure: Repayment of up to 50% of PMPM payment
  - **Bonus for success in reducing utilization beyond targets**
    - 50/50 split of payers' savings from reductions in ER visits and/or hospitalizations net of PMPM payment
    - Quality of care must be maintained based on quality measures
- **Implementation Began May 2011**
  - 7 health plans (5 commercial, 2 Medicaid)
  - 12 primary care practice sites (8 provider orgs), ~ 25,000 patients

Isn't That the Same As "Shared Savings?"

SHARED SAVINGS	
	Year 0
Primary Care Practice	
60% Shared Savings Pmt	$0
Care Mgt Expense	$0
Change in Net Revenue	$0
Payer	
Preventable ER Visits	$500,000
60% Shared Savings Pmt	$0
Combined Spending	$500,000
Projected Costs	

Year 1 of Shared Savings: PCP Loses, Payer Gains

SHARED SAVINGS		
	Year 0	Year 1
Primary Care Practice		
60% Shared Savings Pmt	$0	
Care Mgt Expense	$0	$75,000
Change in Net Revenue	$0	($75,000)
Payer		
Preventable ER Visits	$500,000	$350,000
60% Shared Savings Pmt	$0	$0
Combined Spending	$500,000	$350,000
Projected Costs		*$500,000*

Hiring Nurse Care Manager

Financial Loss for PCP in Year 1

30% Reduction in ER Visits

Year 2: PCP Gains, Payer Gains But Year 1 Losses Not Recovered

SHARED SAVINGS			
	Year 0	Year 1	Year 2
Primary Care Practice			
60% Shared Savings Pmt	$0		$90,000
Care Mgt Expense	$0	$75,000	$75,000
Change in Net Revenue	$0	($75,000)	$15,000
Payer			
Preventable ER Visits	$500,000	$350,000	$350,000
60% Shared Savings Pmt	$0	$0	$90,000
Combined Spending	$500,000	$350,000	$440,000
Projected Costs		*$500,000*	*$500,000*

Shared Savings Increases PCP Revenue

Shared Savings Doesn't Cover First Year Losses

After 3 Years of Shared Savings: Net Loss for PCP, Gain for Payer

SHARED SAVINGS						
	Year 0	Year 1	Year 2	Year 3	Yrs 1-3	3 Yr Net
Primary Care Practice						
60% Shared Savings Pmt	$0		$90,000	$90,000	$180,000	
Care Mgt Expense	$0	$75,000	$75,000	$75,000	$225,000	
Change in Net Revenue	$0	($75,000)	$15,000	$15,000	($45,000)	($45,000)
Payer						
Preventable ER Visits	$500,000	$350,000	$350,000	$350,000	$1,050,000	
60% Shared Savings Pmt	$0	$0	$90,000	$90,000	$180,000	
Combined Spending	$500,000	$350,000	$440,000	$440,000	$1,230,000	$270,000
Projected Costs		*$500,000*	*$500,000*	*$500,000*	*$1,500,000*	

3 Year Net Loss for PCP

3 Year Net Gain for Payer

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*

It's Not Just About Getting Money to Spend on EHRs & Infrastructure

- A physician practice loses money if the doctor comes to a meeting to plan a PCMH or ACO instead of seeing patients
- A physician practice loses money if the doctor takes time to redesign care processes, review data, apply for accreditation, etc. instead of seeing patients
- Physicians need upfront money to offset losses under fee-for-service as they transition to new modes of care; shared savings and other forms of P4P don't solve the problem

What About Specialists?

Episode Pmts Allow Specialists (and PCPs) to Create More Value

- **Bundling:** Making a single payment to two or more providers who are currently paid separately
  - e.g., services of both a hospital and a physician
  - e.g., both hospital and post-acute care services
- **Warranty:** Not charging/being paid more for costs of treating hospital-acquired infections, problems caused by errors, etc.

Example: Reducing Cost of Implanting Defibrillators

COST TYPE	TODAY
Physician Fee	$ 1,200
Device Cost	$20,000
Other Hospital Cost	$ 9,100
Hosp. Margin (3%)	$ 900
Total Hospital Pmt	$30,000
Total Cost to Payer	$31,200

Physicians Could Help Hospitals Reduce Cost of Medical Devices

COST TYPE	TODAY	CHANGE
Physician Fee	$ 1,200	
Device Cost	$20,000	-10% ($2,000)
Other Hospital Cost	$ 9,100	
Hosp. Margin	$ 900	
Total Hospital Pmt	$30,000	
Total Cost to Payer	$31,200	

Today: All Savings Goes to the Hospital, No Reward for Physician

COST TYPE	TODAY	CHANGE	SPLIT
Physician Fee	$ 1,200		+ 0%
Device Cost	$20,000	-10% ($2,000)	
Other Hospital Cost	$ 9,100		
Hosp. Margin	$ 900		+222% ($2000)
Total Hospital Pmt	$30,000		
Total Cost to Payer	$31,200		-0%

Bundling: Single Payment to Physicians and Hospital

COST TYPE	TODAY
Physician Fee	$ 1,200
Device Cost	$20,000
Other Hospital Cost	$ 9,100
Hosp. Margin	$ 900
Total Cost to Payer	$31,200

Bundling Allows Savings Split Among Docs, Hospital, Payers

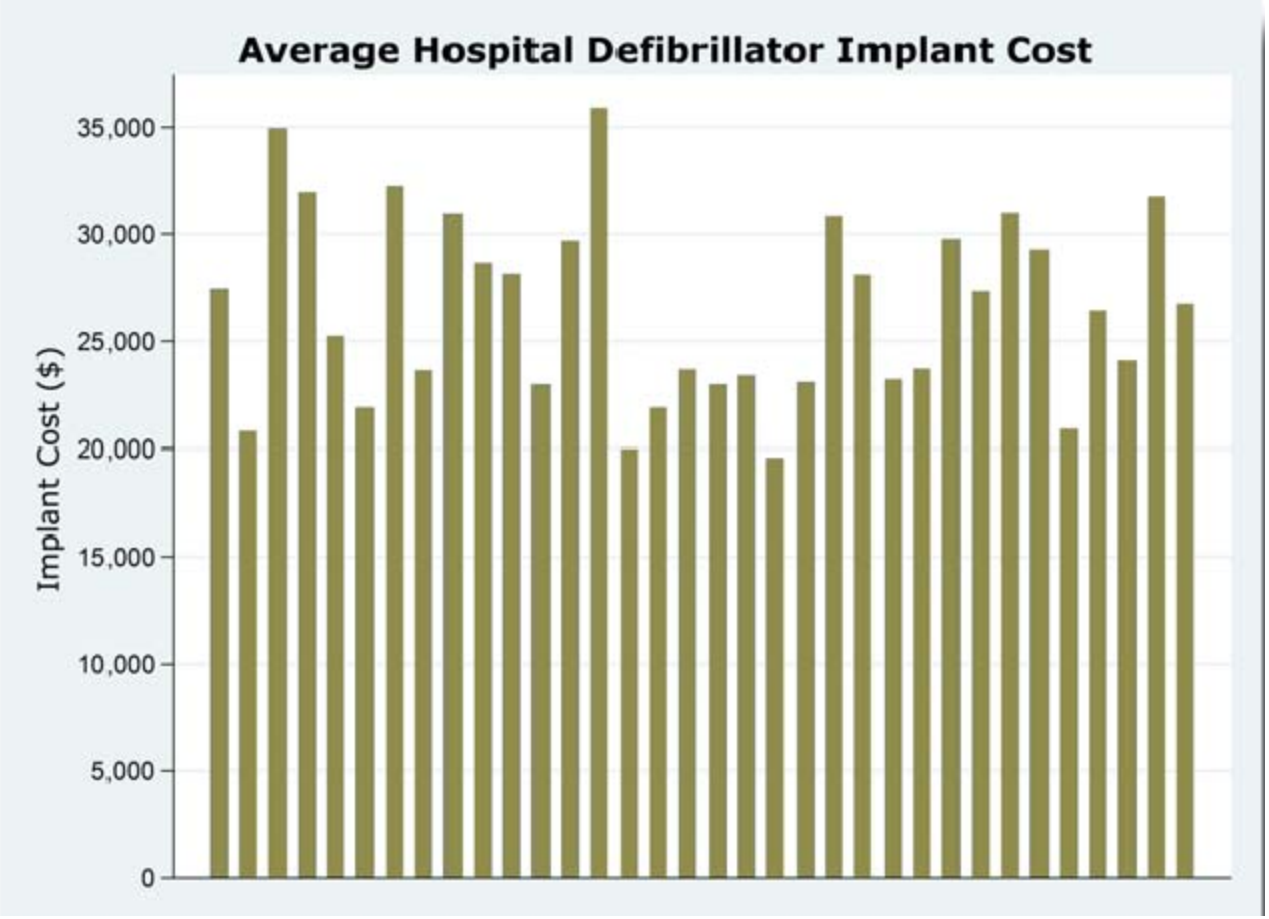
COST TYPE	TODAY	CHANGE	SPLIT
Physician Fee	$ 1,200		+ 50% ($600)
Device Cost	$20,000	-10% ($2,000)	
Other Hospital Cost	$ 9,100		
Hosp. Margin	$ 900		+50% ($450)
Total Cost to Payer	$31,200		- 2.3% ($950)

So Defibrillator Implantation is Cheaper, But More Profitable

COST TYPE	TODAY	CHANGE	SPLIT	NEW
Physician Fee	$ 1,200		+ 50% ($600)	$ 1,800
Device Cost	$20,000	-10% ($2,000)		$18,000
Other Hospital Cost	$ 9,100			$ 9,100
Hosp. Margin	$ 900		+50% ($450)	$ 1,350
Total Cost to Payer	$31,200		- 2.3% ($950)	$30,250

Win-Win-Win
for Physicians, Hospital, & Payer

$16,000 Variation in Avg Costs of Defibrillators Across CA Hospitals



Source: *Pacemaker and Implantable Cardioverter-Defibrillator Implant Procedures in California Hospitals*, James C. Robinson and Emma L. Dolan, Berkeley Center for Health Technology

What If There is Evidence of Overutilization?

COST TYPE	TODAY	200 Cases
Physician Fee	$ 1,200	$240,000
Device Cost	$20,000	
Other Hospital Cost	$ 9,100	
Hosp. Margin	$ 900	$180,000
Total Hospital Pmt	$30,000	
Total Cost to Payer	$31,200	$6,240,000

Assume a study finds that 20% of procedures are unnecessary or can be avoided through medical management

Simply Reducing Utilization Can Hurt Hospitals & Physicians

20% Reduction in Cases

COST TYPE	TODAY	200 Cases	TODAY	160 Cases	Chg
Physician Fee	$ 1,200	$240,000	$ 1,200	$192,000	-20%
Device Cost	$20,000		$20,000		
Other Hospital Cost	$ 9,100		$ 9,100		
Hosp. Margin	$ 900	$180,000	$ 900	$144,000	-20%
Total Hospital Pmt	$30,000		$30,000		
Total Cost to Payer	$31,200	$6,240,000	$31,200	$4,992,000	-20%

Reducing the Number of Procedures…

…Significantly Reduces Hospital/Physician Revenue

Bundling + Guidelines Can Avoid Harming Providers While Saving $

20% Reduction in Cases →

COST TYPE	TODAY	200 Cases	NEW	160 Cases	Chg
Physician Fee	$ 1,200	$240,000	$ 1,800	$288,000	+20%
Device Cost	$20,000		$18,000		
Other Hospital Cost	$ 9,100		$ 9,100		
Hosp. Margin	$ 900	$180,000	$ 1,350	$216,000	+20%
Total Cost to Payer	$31,200	$6,240,000	$30,250	$4,840,000	-22%

Reducing the Cost of the Procedure…

…Can Enable Higher Margins Even With Fewer Procedures

Not Just Implants: Many Other Savings Opportunities

- Better scheduling of scarce resources (e.g., surgery suites) to reduce both underutilization & overtime
- Standardization of equipment and supplies to facilitate bulk purchasing
- Less wastage of expensive supplies
- Reduced length of stay
- Moving procedures to lower-cost settings
- Etc.

Warranties Offer Win-Win-Wins, Even for Small Providers

- 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.

Johnson LL, Becker RL. An alternative health-care reimbursement system—application of arthroscopy and financial warranty: results of a two-year pilot study. Arthroscopy. 1994 Aug;10(4):462–70

Not Just Proceduralists: 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

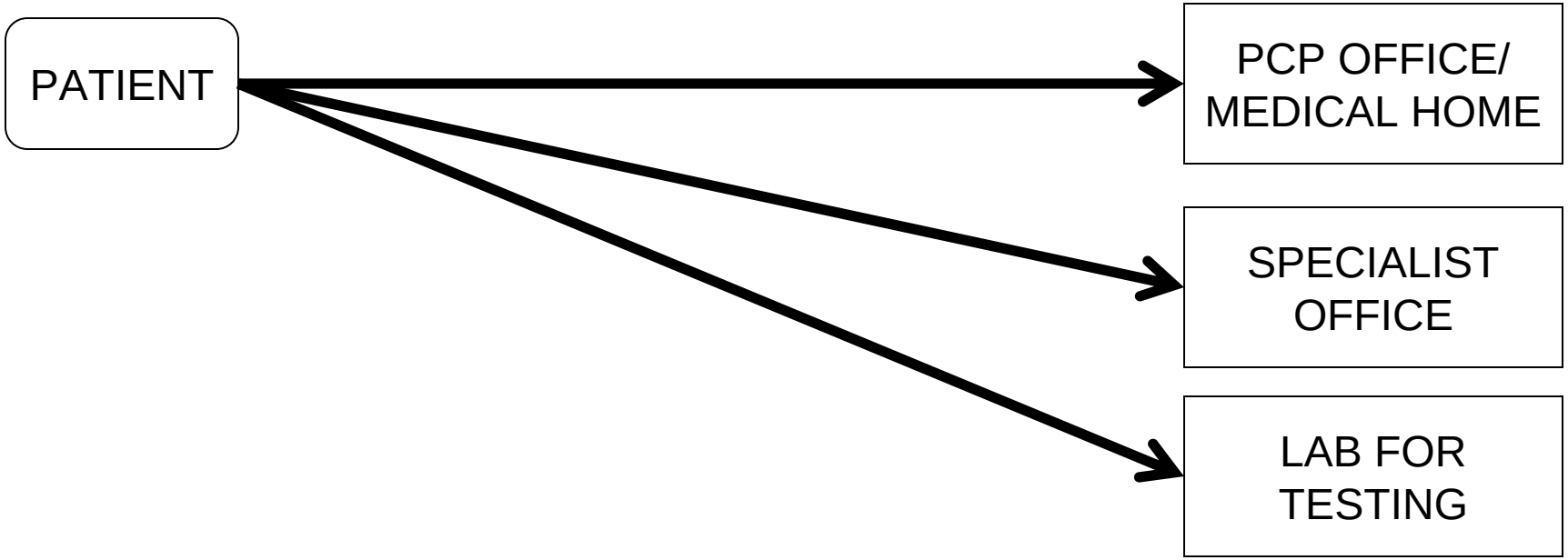
http://www.icsi.org/health_care_redesign_/diamond_35953/

Improving Employee Productivity Could Support Higher Pay for Docs

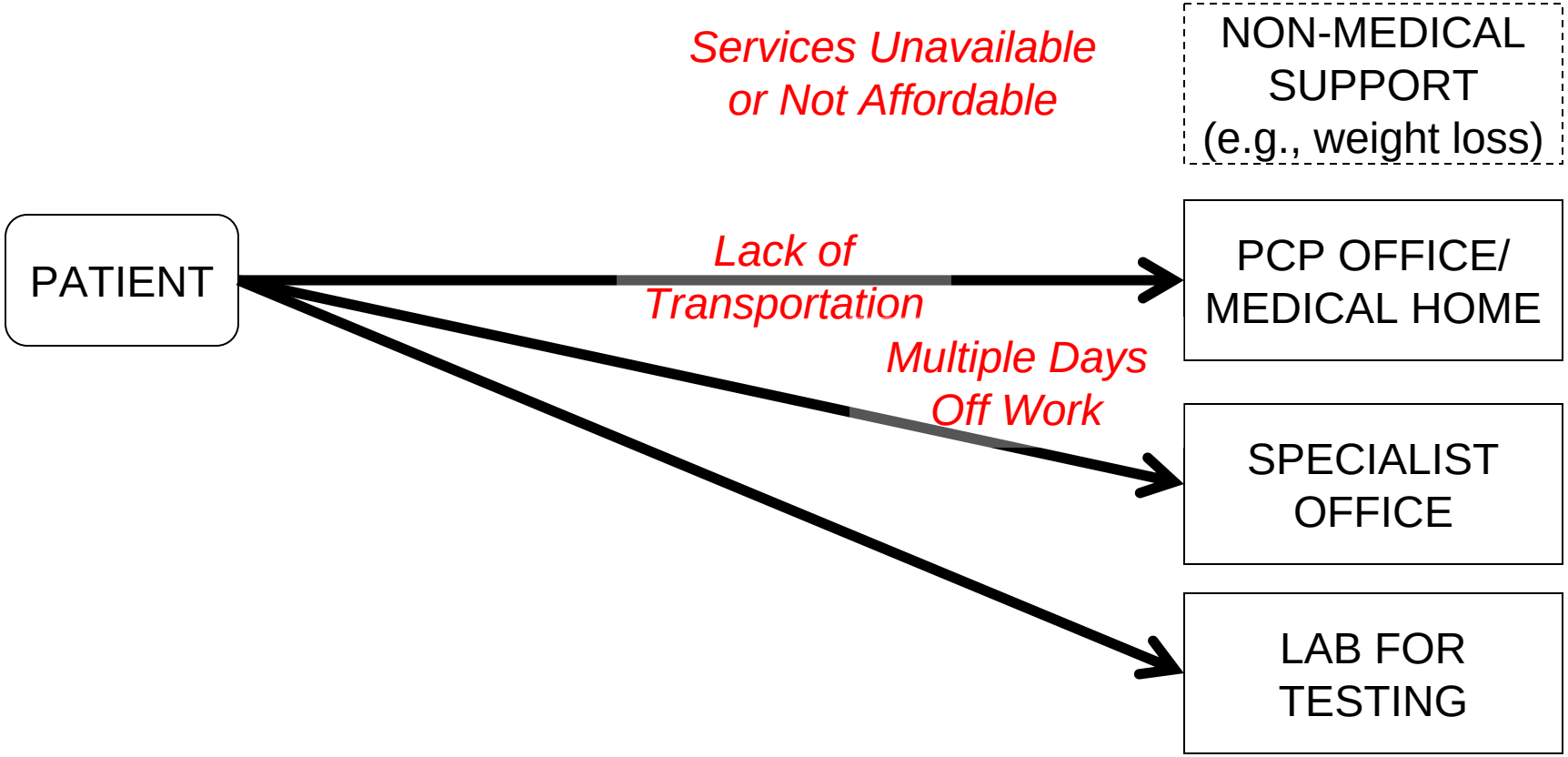
Skin Condition	Office Visits ($ millions)	Lost/Restricted Workdays ($ millions)
Acne	$398	$461
Atopic Dermatitis	$636	$371
Lupus	$67	$52
Psoriasis	$169	$83

Source: Bickers DR et al, “The Burden of Skin Diseases: 2004,”
Journal of the American Academy of Dermatology, Volume 55, No. 3, pp 490-500

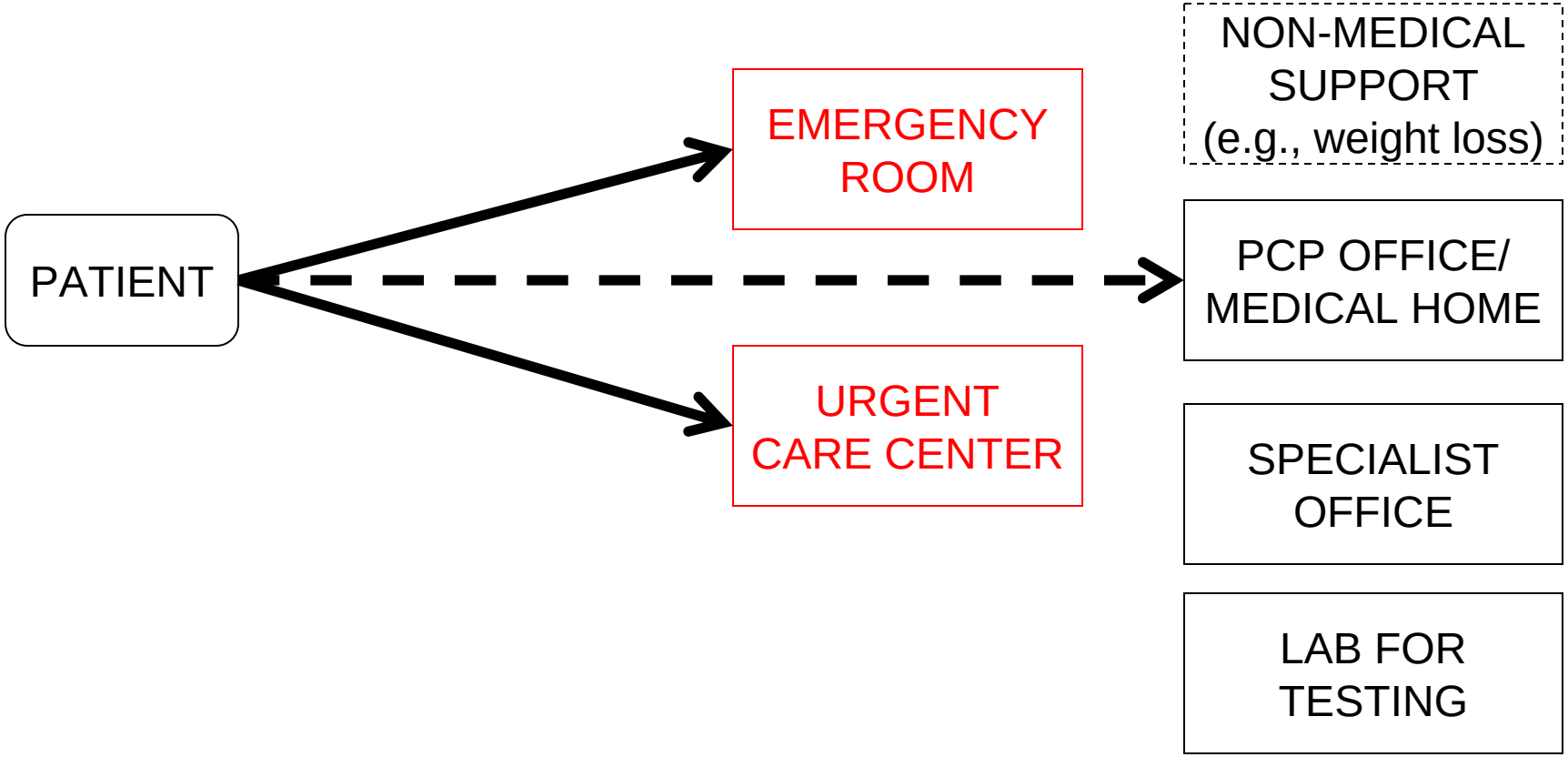
Today: Care is Designed Around the Provider, Not the Patient



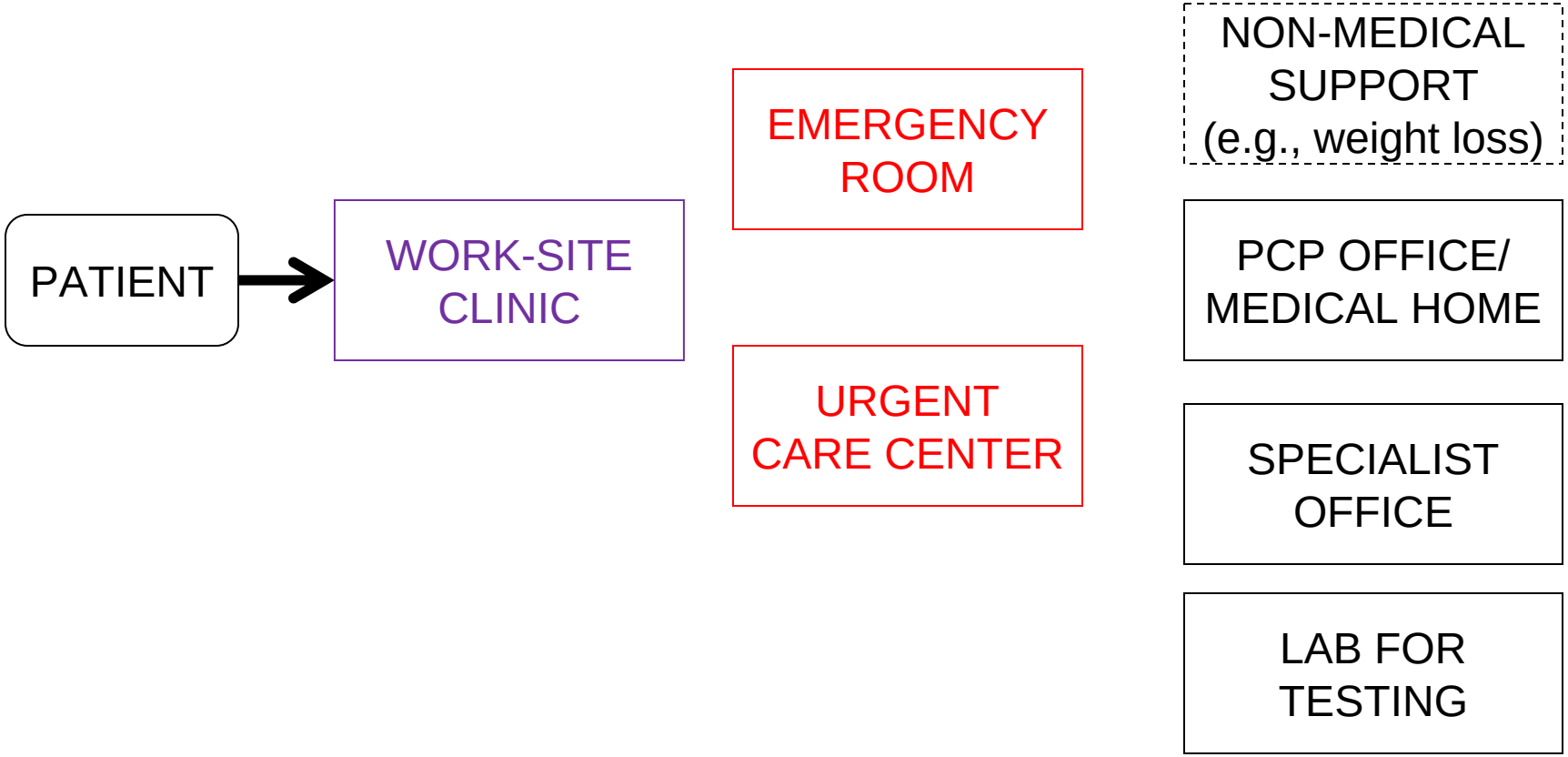
Today: Many Barriers to Patient Adherence & Care Coordination



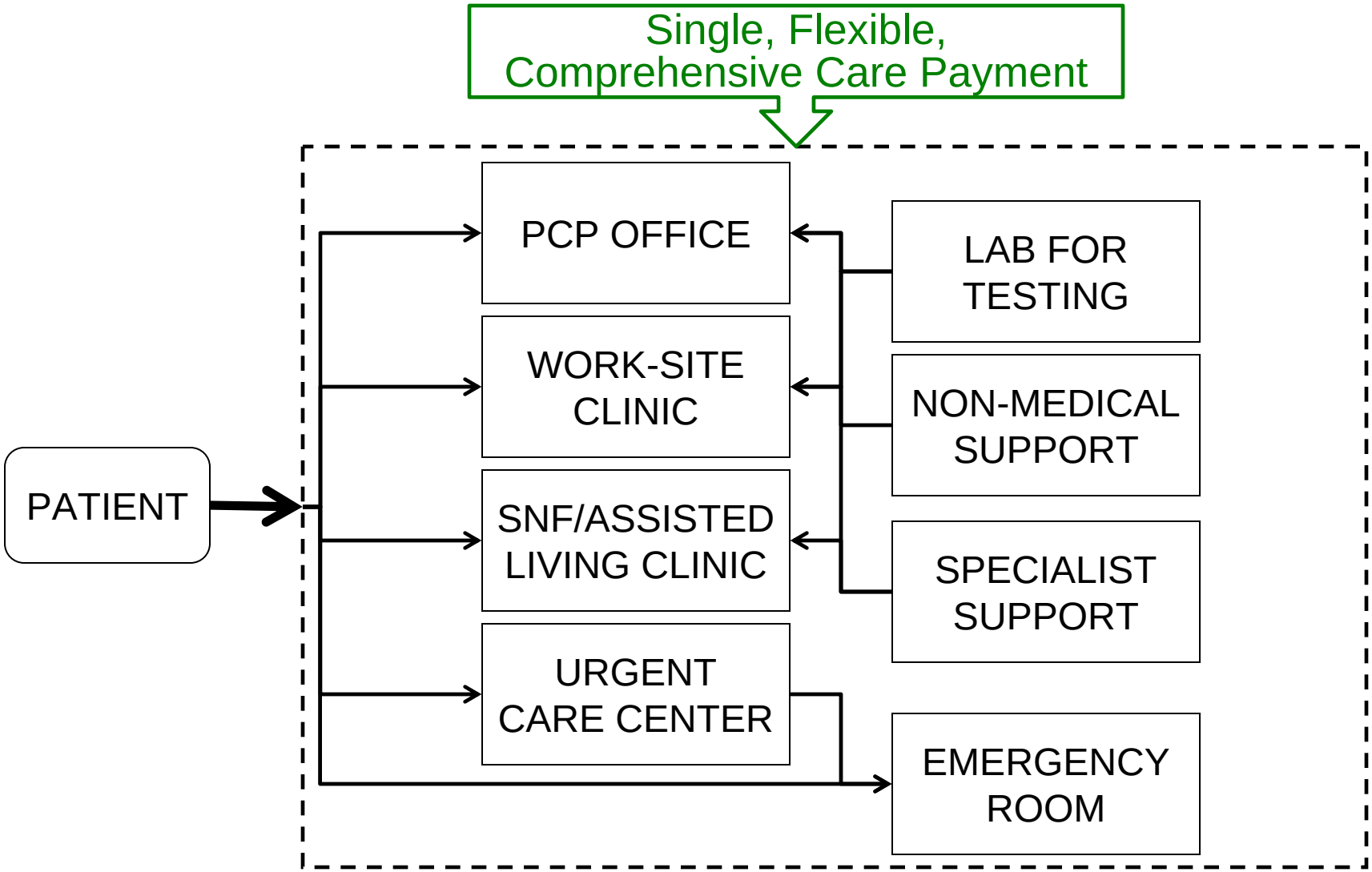
Is It Any Wonder The Patients Gravitate to More Convenience?



Or That Employers Are Trying to Create Their Own Systems?



Flexible Payment Allows More Radical Redesign of Care Delivery

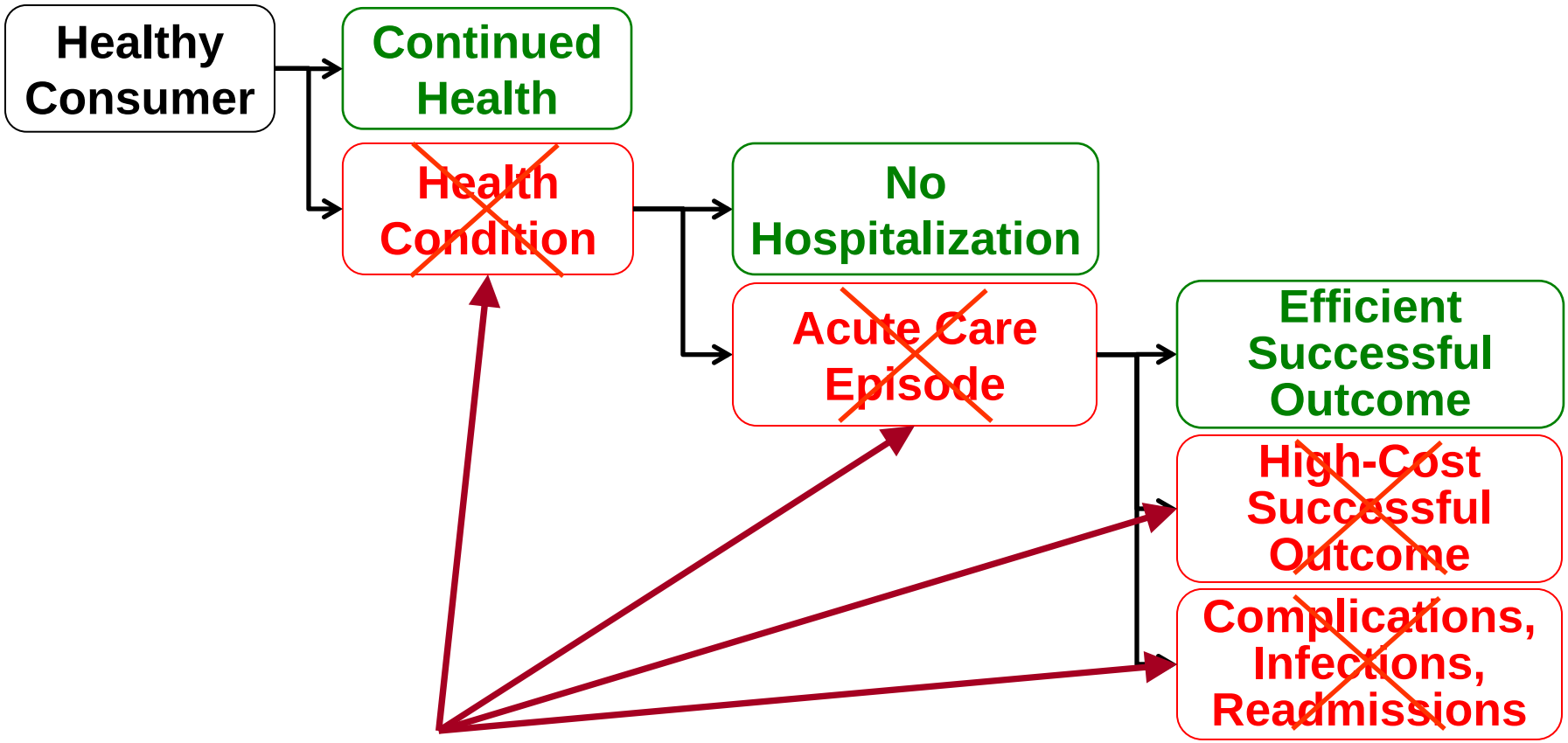


Things Needed to Make Payment Reform Work Well for Physicians

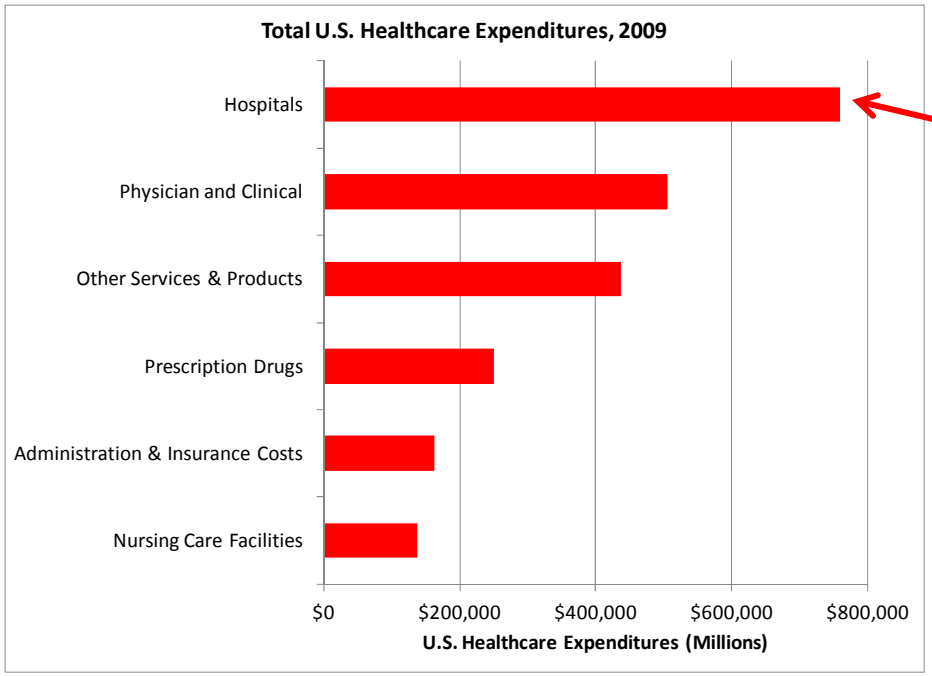
- **Trusted, Shared Data on Current Utilization, Cost**
  - Physician needs to know current rates of admissions, complications, etc. to set prices appropriately
  - Purchaser/payer needs to know that they're getting a better deal than they are today
- **Protections for Physicians from Insurance Risk**
  - Severity adjustment of payment
  - Risk corridors in case costs were mis-estimated
  - Outlier payments for unusually expensive patients
  - Risk exclusions for some patient populations
- **Good Measures of Outcomes**
  - Measures meaningful to patients using high-quality data

Can Hospitals "Win" Under Payment/Delivery Reform?

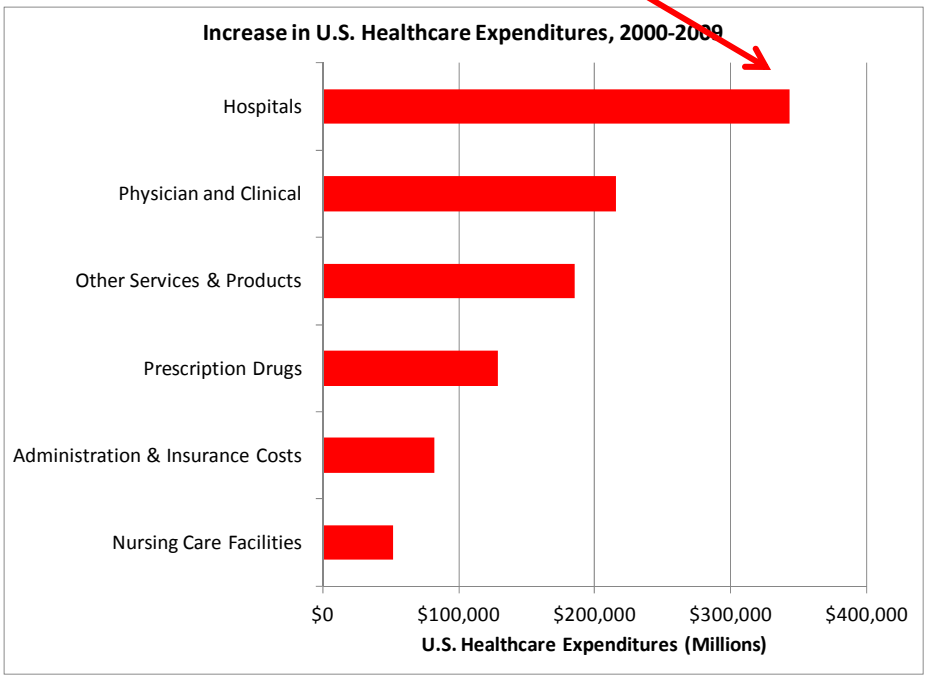
Reducing Costs Without Rationing Reduces Hospital Revenues



Reducing Healthcare Spending Requires Lower Hospital Spending



Hospitals are the largest component of healthcare spending and of increases in healthcare spending



QUIZ

If we could reduce U.S. hospitalization rates by:

- 15% for people ages 85+
- 10% for people ages 65-84
- 5% for people ages 45-64
- 0% for people ages <45

how many fewer hospital beds would we need in 2015?

- 15% fewer beds?
- 10% fewer beds?
- 5% fewer beds?
- 0% fewer beds?

QUIZ

If we could reduce U.S. hospitalization rates by:

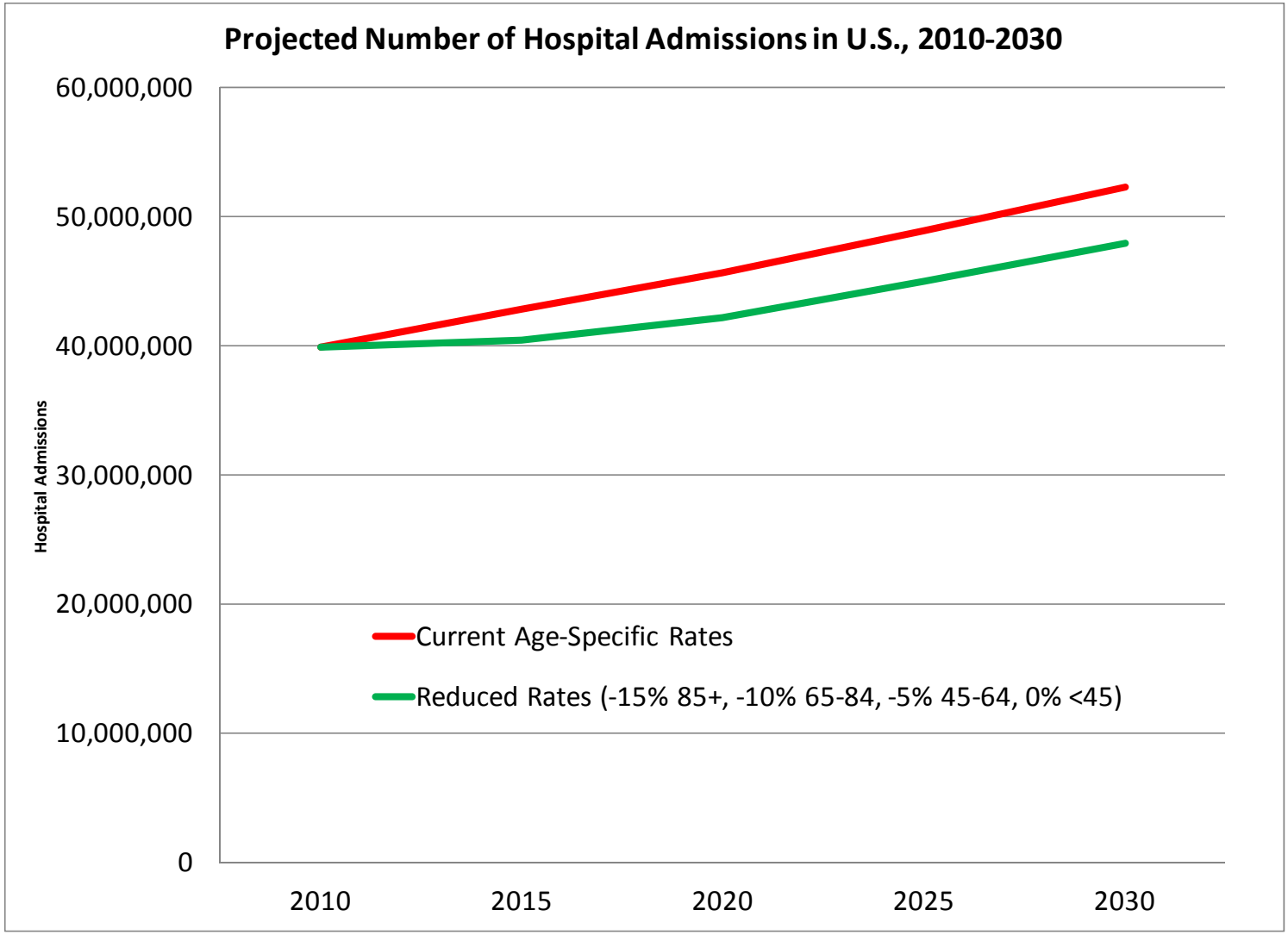
- 15% for people ages 85+
- 10% for people ages 65-84
- 5% for people ages 45-64
- 0% for people ages <45

how many fewer hospital beds would we need in 2015?

- ~~15% fewer beds~~
- ~~10% fewer beds~~
- ~~5% fewer beds~~
- **0% fewer beds**

We'd still have more hospital admissions than today

Population Growth & Aging Will Increase Hospital Admissions



Impact of Reduced Admissions on Hospital Capacity & Spending

If we could reduce U.S. hospitalization rates by:

- 15% for people ages 85+
- 10% for people ages 65-84
- 5% for people ages 45-64
- 0% for people ages <45

how many fewer hospital beds would we need in 2015?

- ~~15% fewer beds~~
- ~~10% fewer beds~~
- ~~5% fewer beds~~
- **0% fewer beds**

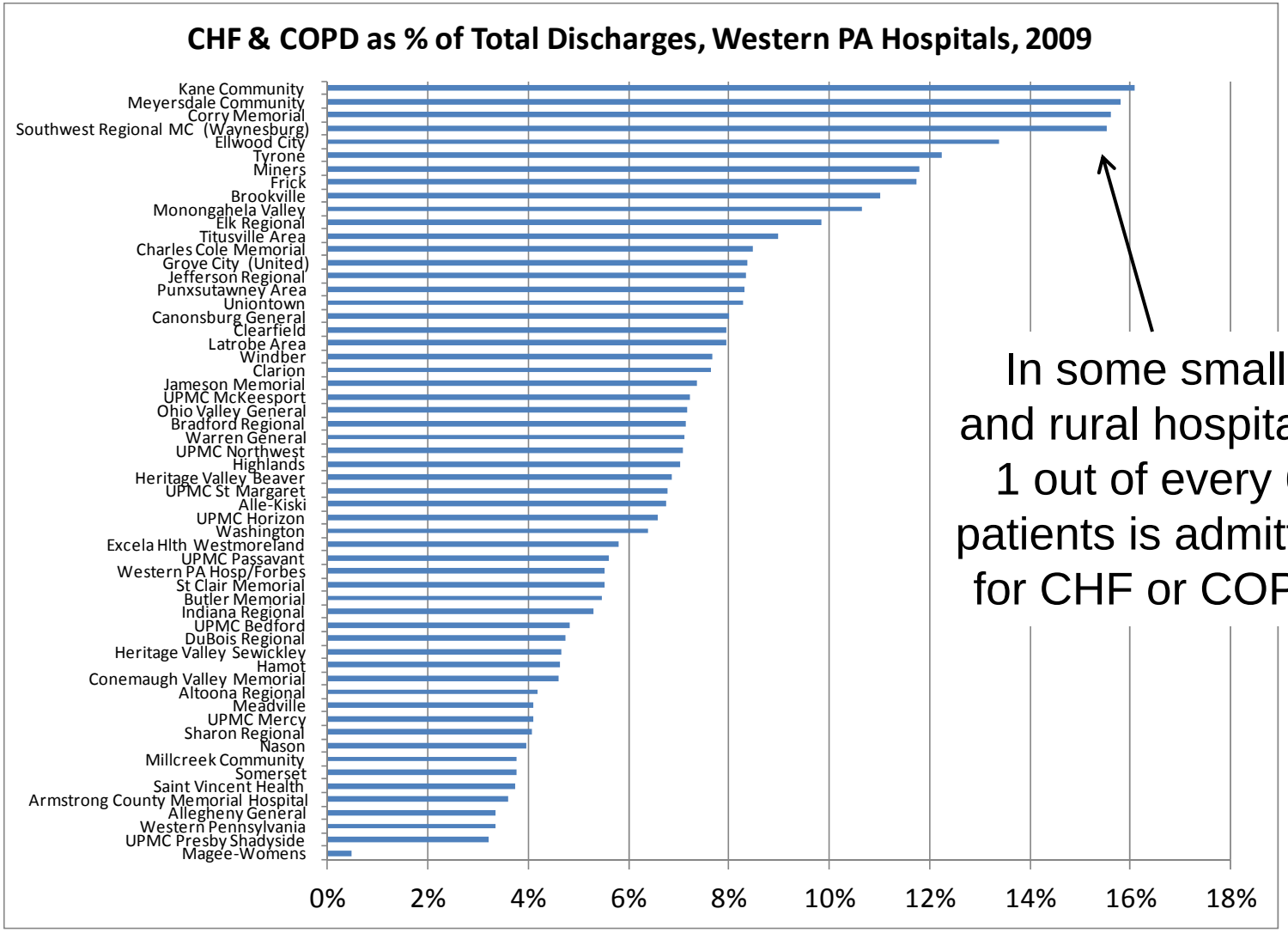
We'd still have more hospital admissions than today

But we'd spend 6.5% less on hospital care than we would have if current utilization rates continue

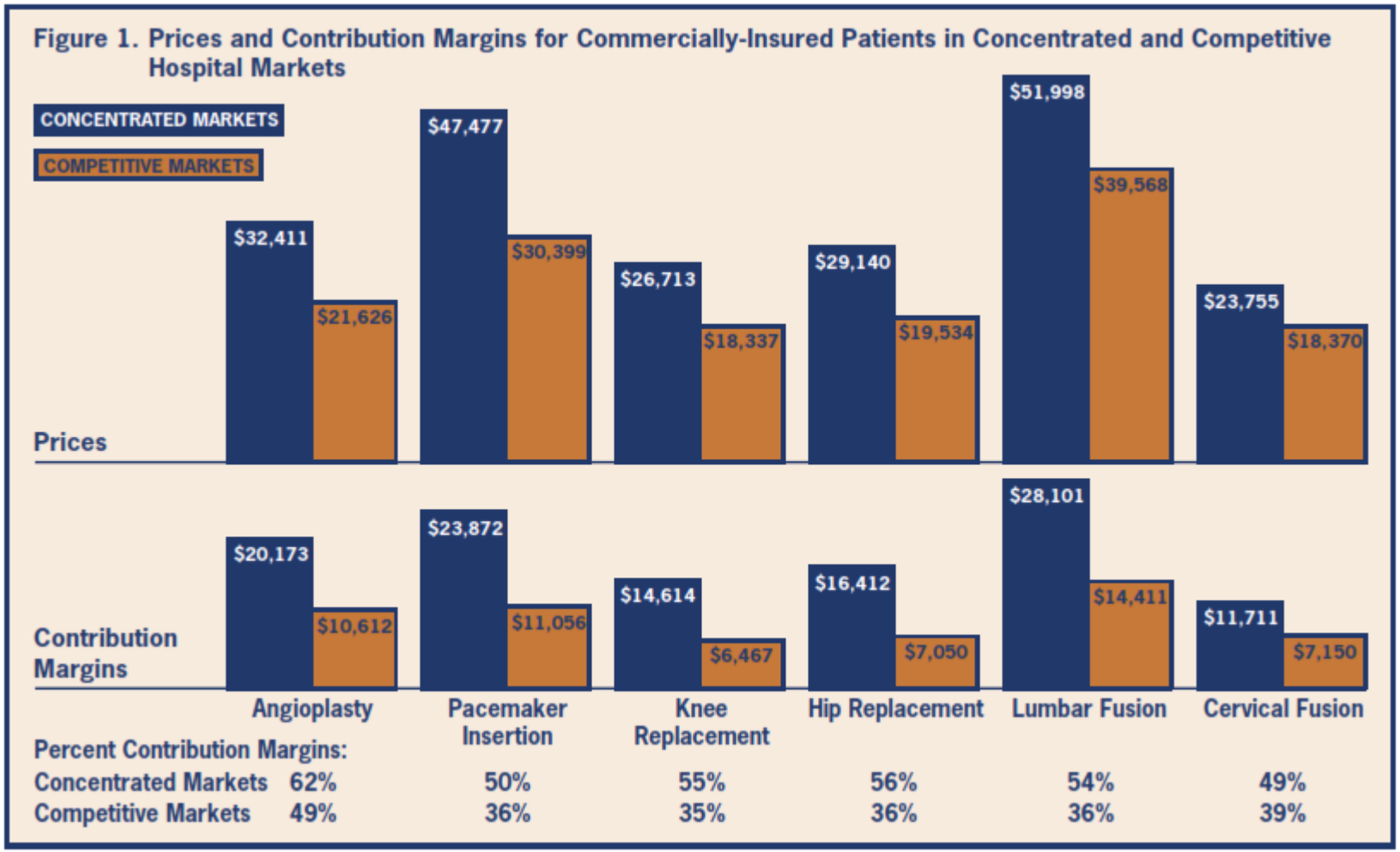
Impacts of Improved Care on Hospitals

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

Small Hospitals Will Lose More Patients If Chronic Care Improves



Hospital Consolidation May Increase Prices, Not Reduce Costs



Source: "More Evidence pf the Association Between Hospital Market Concentration and Higher Prices and Profits, James C. Robinson, National Institute for Healthcare Management, November 2011

Creating A Feasible Glide Path to the Future for Hospitals

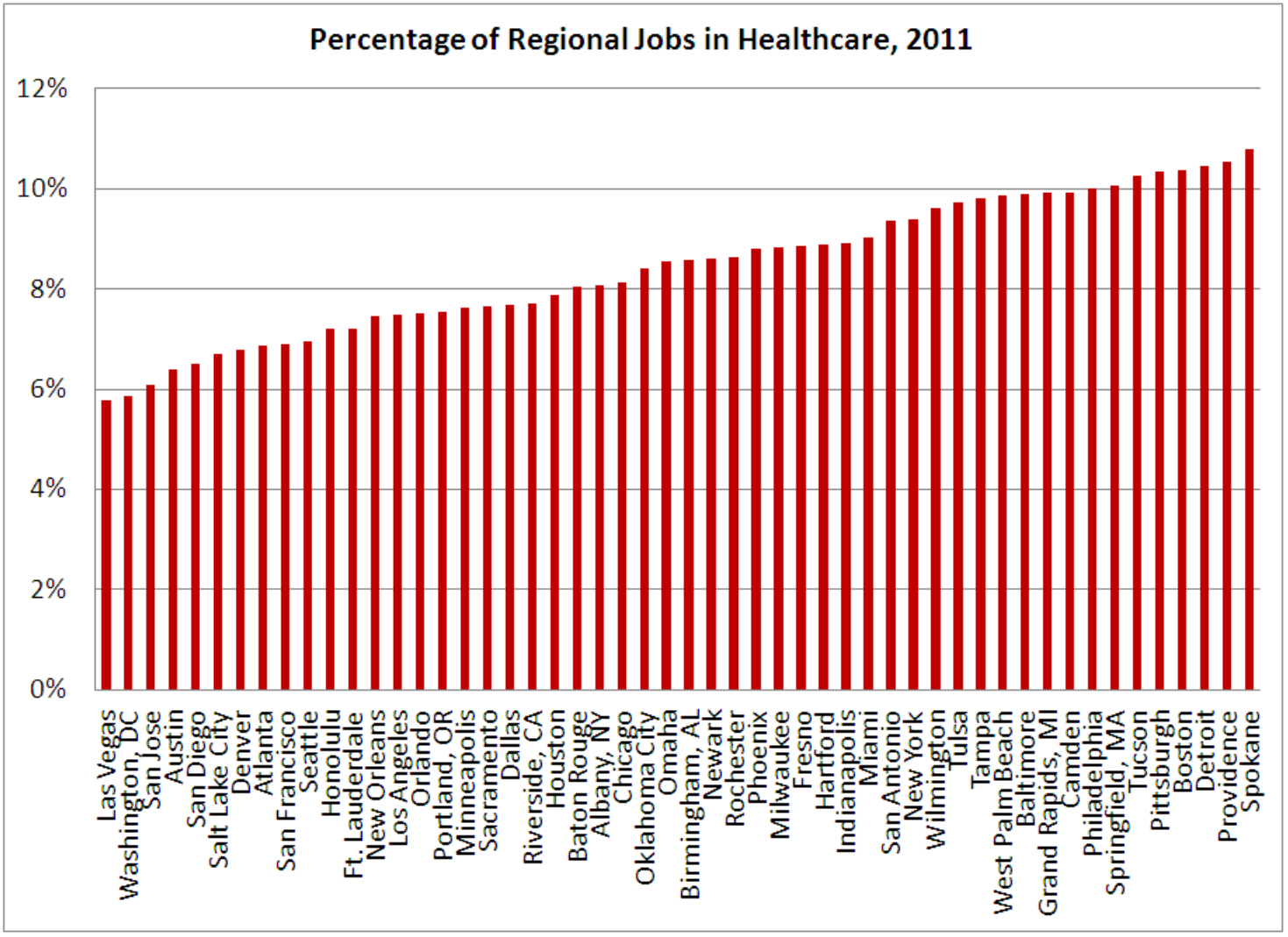
- Different Hospitals Will Have Different Problems
  - For a hospital that's constantly full and growing, a reduction in chronic disease admissions may be welcome, particularly since they may be less profitable than elective surgery cases
  - But for small community hospitals with empty beds, and hospitals with narrow operating margins, reductions in chronic disease admissions and readmissions could cause serious financial problems, particularly in the short run
- Both Hospitals and Payers Will Need to Change
  - Hospitals will need to restructure to reduce fixed costs as much as possible (close units, share services, etc.)
  - Payers will need to renegotiate payment levels to enable hospitals to remain solvent, particularly during the lengthy transition process to reduce fixed costs

“Shared Savings” Doesn’t Work for Hospitals Either

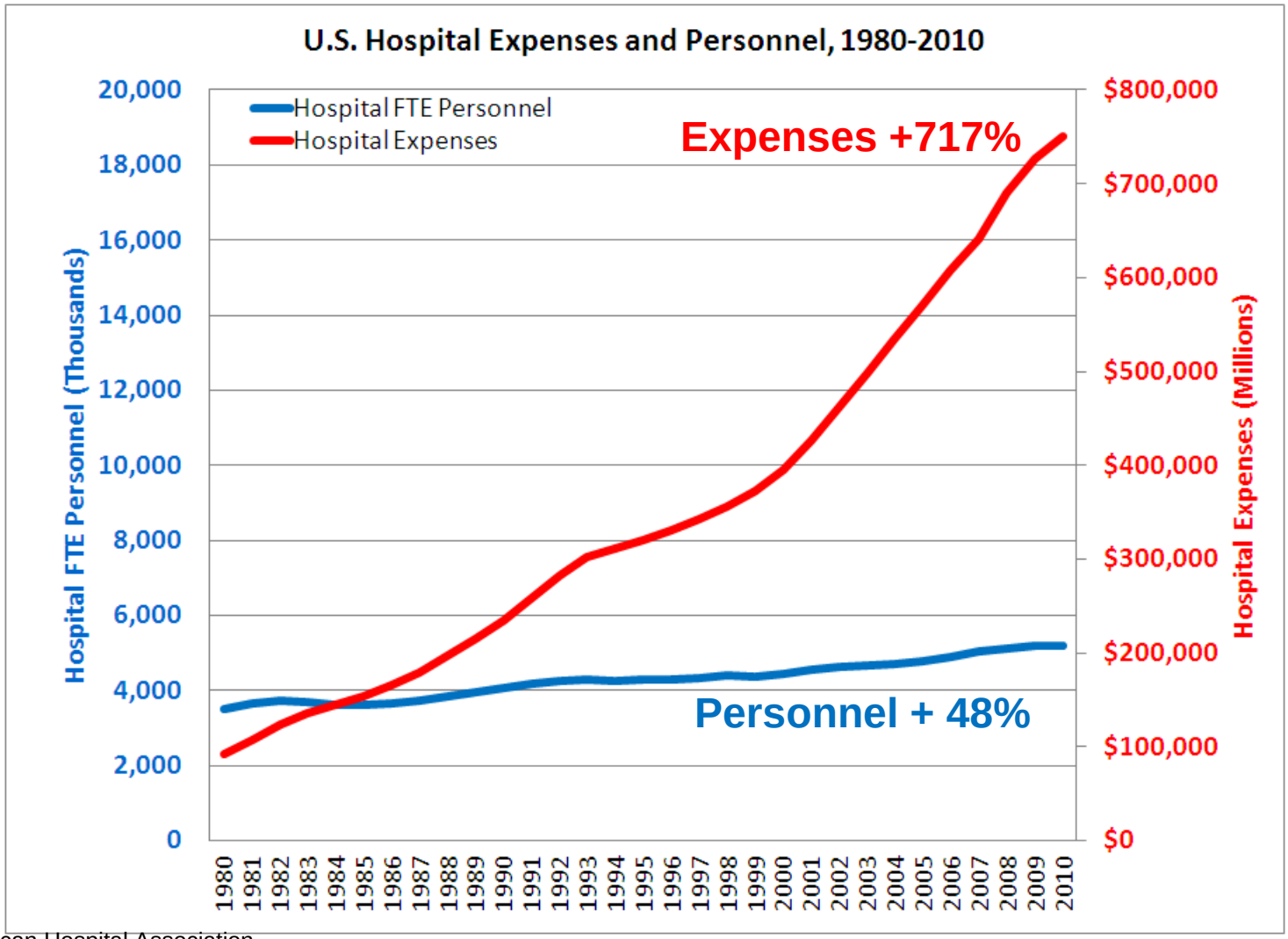
- Hospitals are not directly eligible for shared savings; all savings are attributed to primary care physicians
- Even if the hospital reduces readmissions, infections, complications, etc., it may receive no reward for doing so
- Reducing hospitalizations, ER visits, etc. will reduce the hospital’s revenues, 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!

What Does All This Mean for the Health Care Workforce?

In Most Regions, 7-10% of the Labor Force Works In Healthcare

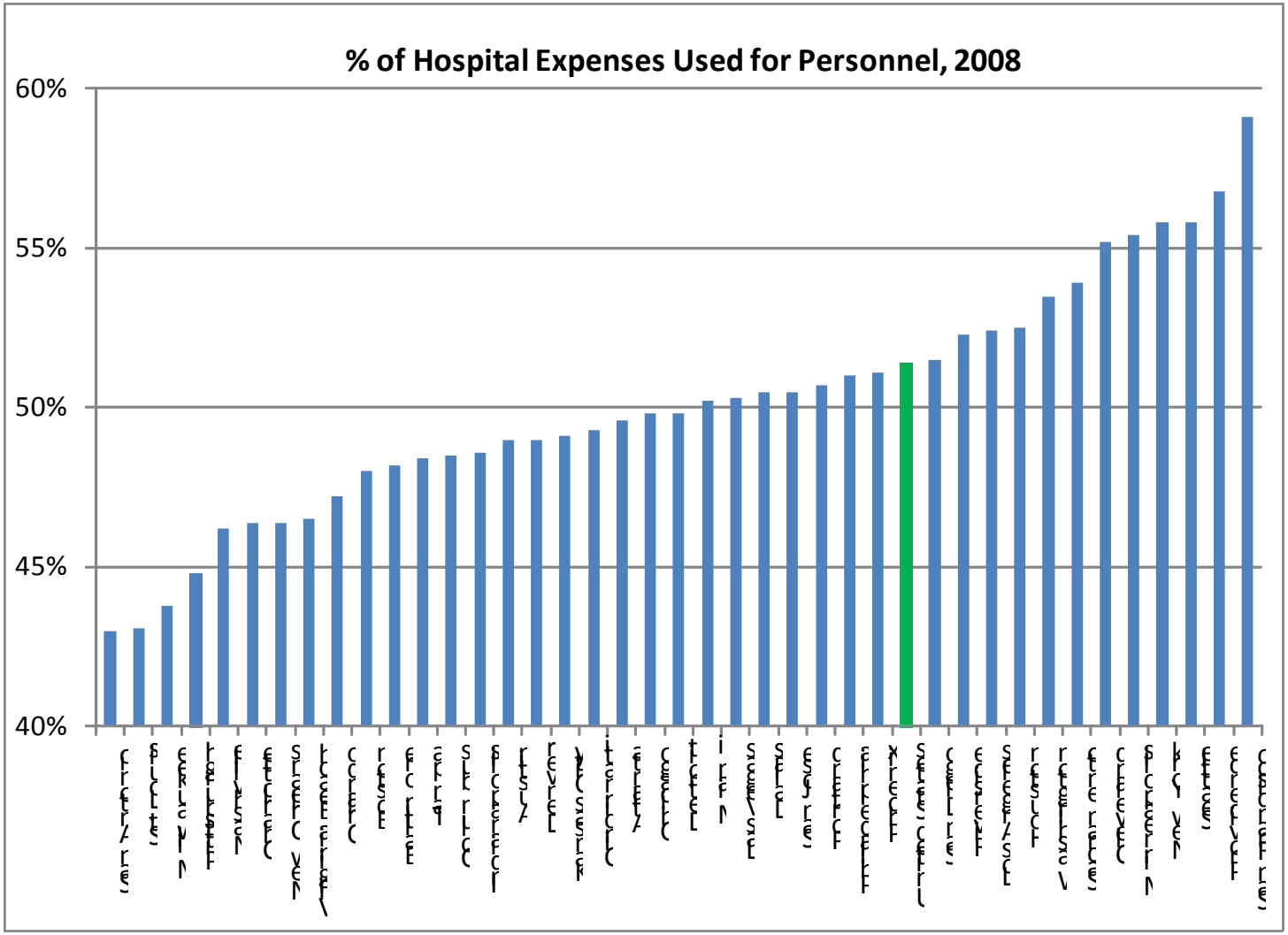


Growth in Hospital Expenses Is Not Due to More Hospital Staff



Source: American Hospital Association

More Than 50% of Hospital Cost in Many Regions is Not Personnel



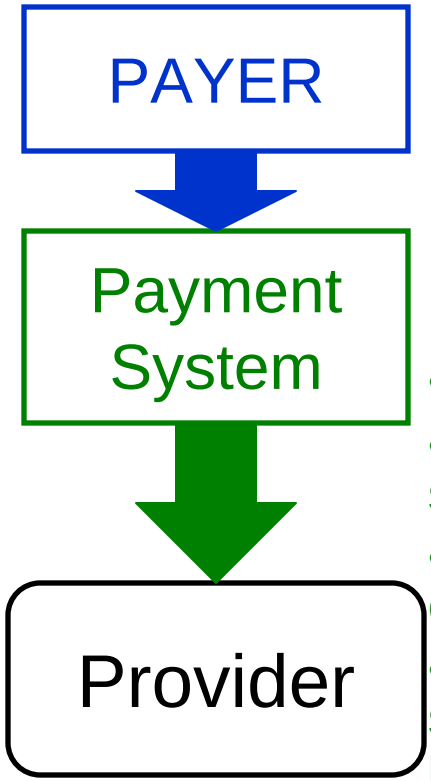
Source: American Hospital Association

What Successful Reform Means for the Healthcare Workforce

- **Reducing costs of supplies and equipment can preserve patient care jobs**
- **A greater % of healthcare jobs will be outside of hospitals**
  - Home health nurses vs. hospital nurses
  - Nurse care managers in PCP offices vs. hospitals
- **More jobs will be in primary care**
  - More primary care physicians vs. specialists
  - More nurse practitioners, nurse care managers

What Does All This Mean for Health Plans?

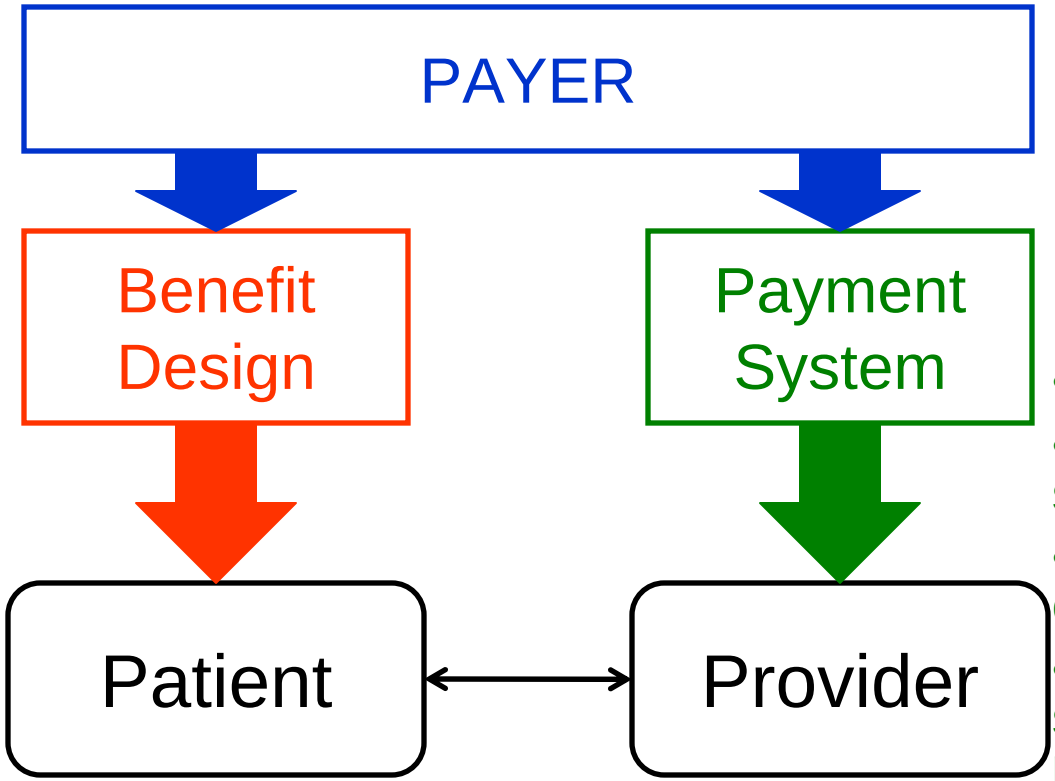
Providers Can't Change Unless Payers Pay Differently



Ability and Incentives to:

- Keep patients well
- Avoid unneeded services
- Deliver services efficiently
- Coordinate services with other providers

Benefit Design Changes Are Also Critical to Success



Ability and Incentives to:

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

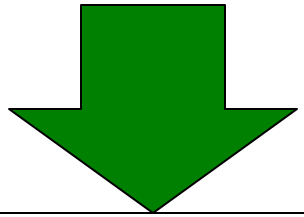
Ability and Incentives to:

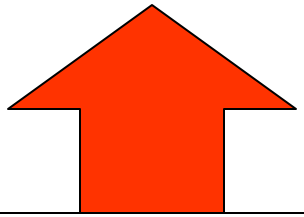
- Keep patients well
- Avoid unneeded services
- Deliver services efficiently
- Coordinate services with other providers

High Cost-Sharing on Drugs May *Increase* Total Spending

Single-minded focus on reducing costs here...

...could result in higher spending on hospitalizations





Pharmacy Benefits

Drug Costs

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

Medical Benefits

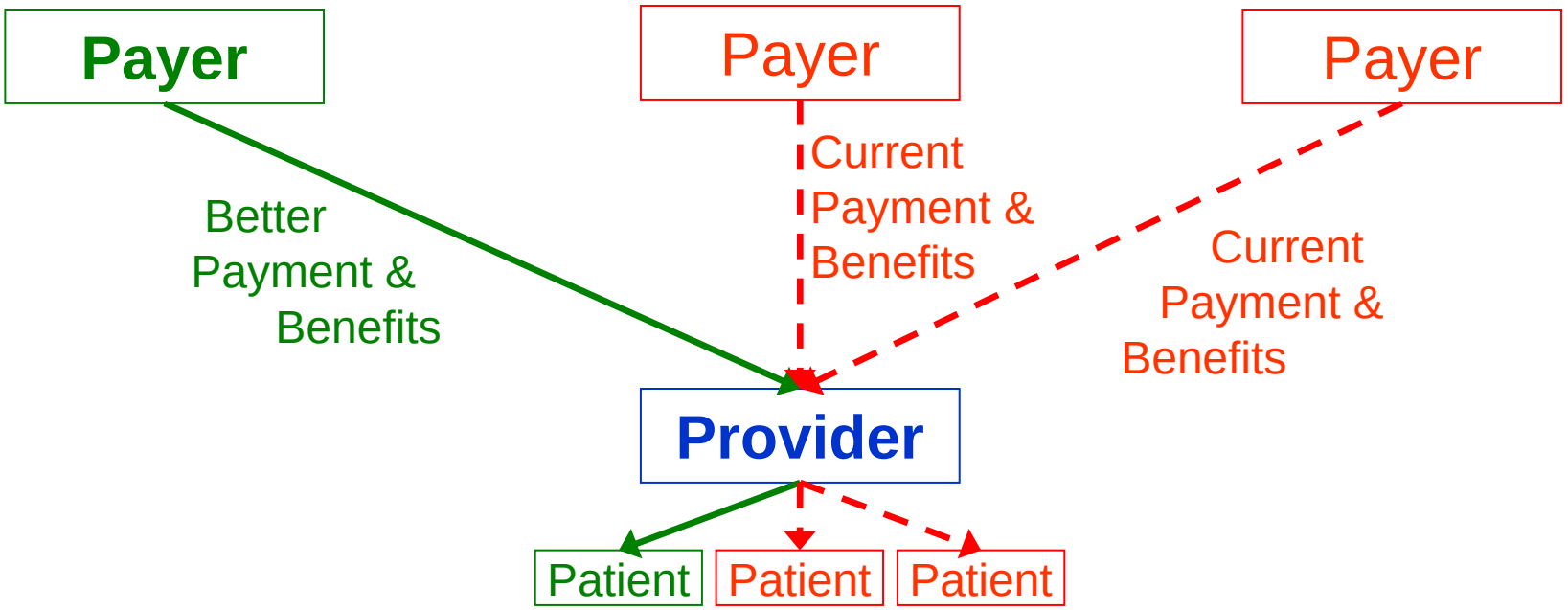
Hospital Costs

Physician Costs

Other Services

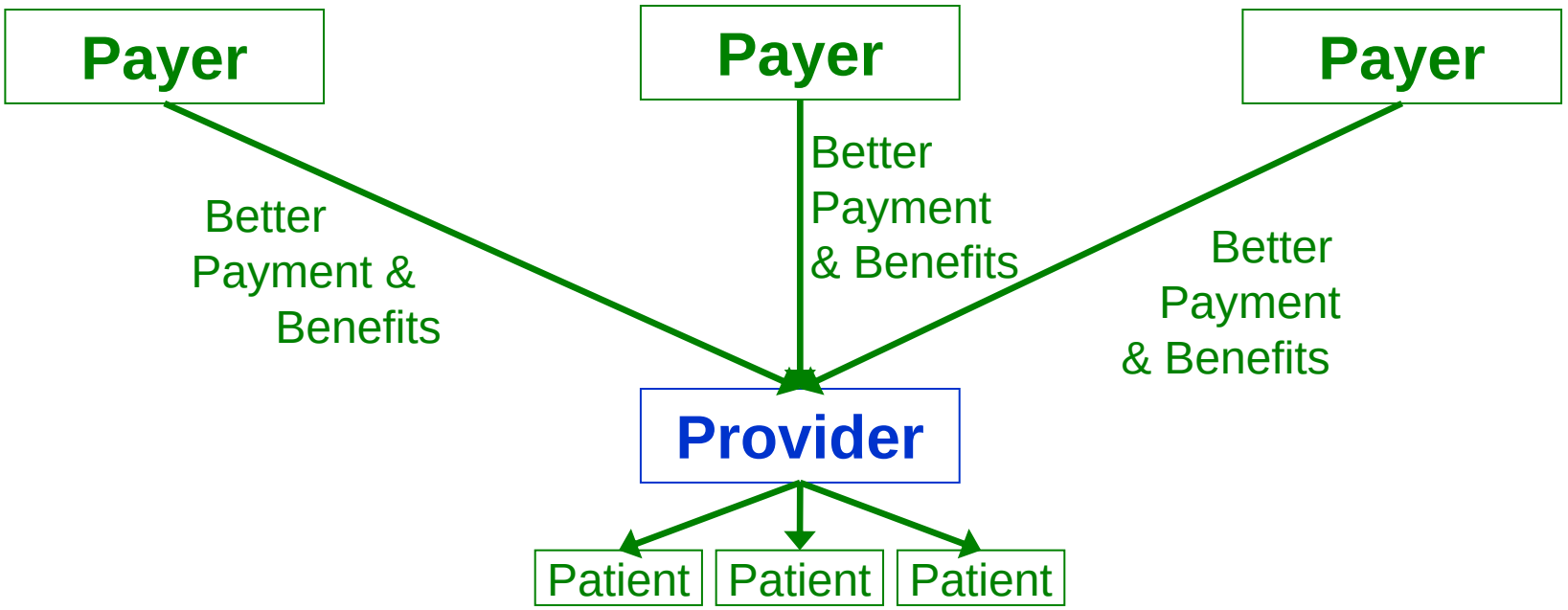
Principal treatment for most chronic diseases involves regular use of maintenance medication

One Payer Changing (Even Medicare) Is Not Enough

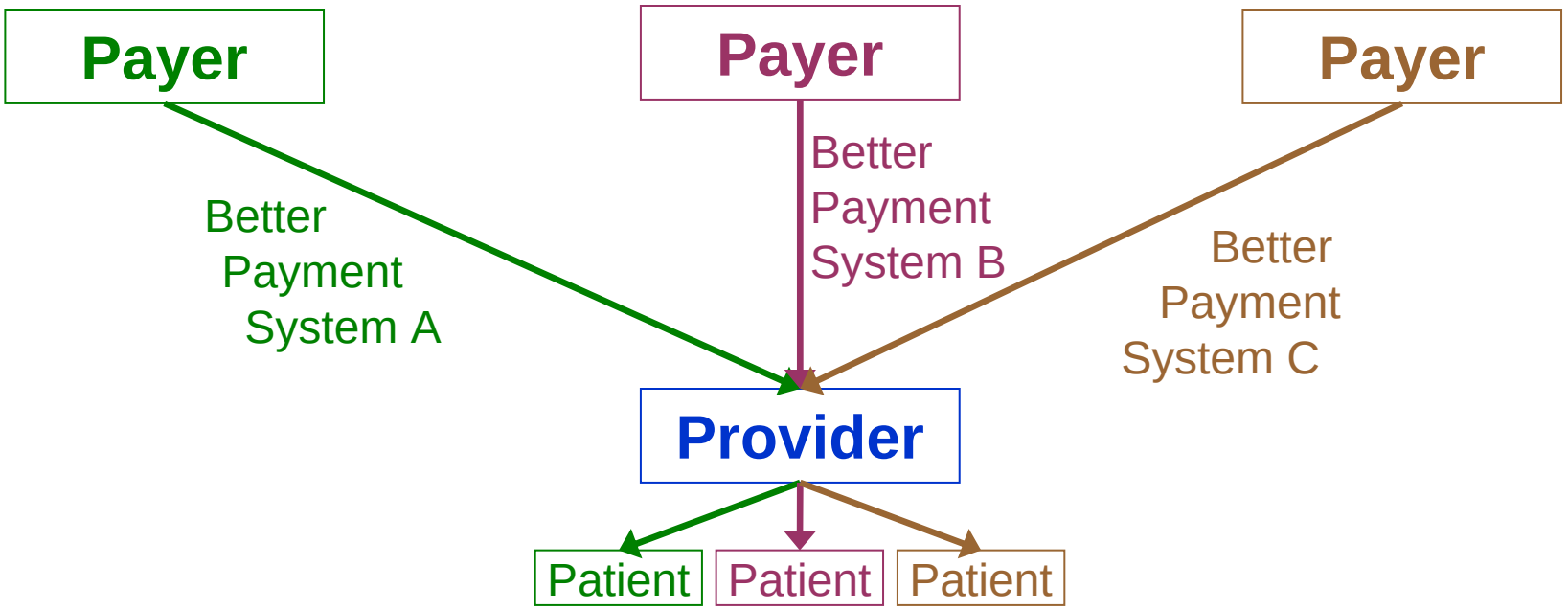


Provider is only compensated for changed practices for the subset of patients covered by participating payers

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

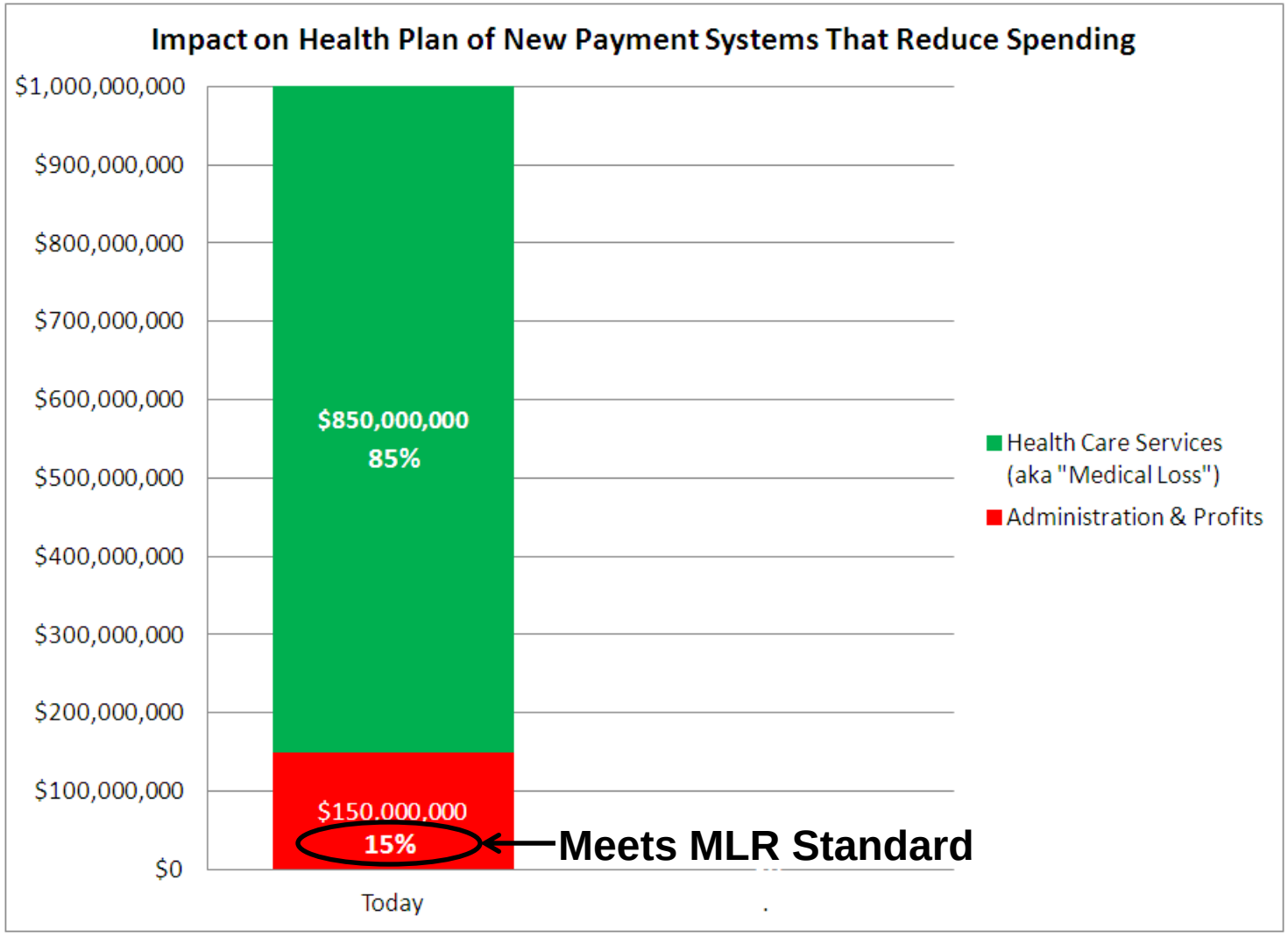
Payer Coordination Is Beginning to Occur Around the Country

- Examples of Multi-Payer Payment Reforms:
  - Colorado, Maine, Michigan, Minnesota, New York, North Carolina, Oregon, Pennsylvania, Rhode Island ,Vermont, and Washington all have multi-payer medical home initiatives
- A Facilitator of Coordination is Needed
  - State Government (provides anti-trust exemption)
  - Non-profit Regional Health Improvement Collaboratives
- Medicare Needs to Participate in Local Projects as Well as Define its Own Demonstrations
  - Center for Medicare and Medicaid Innovation (CMMI) provides the opportunity for this

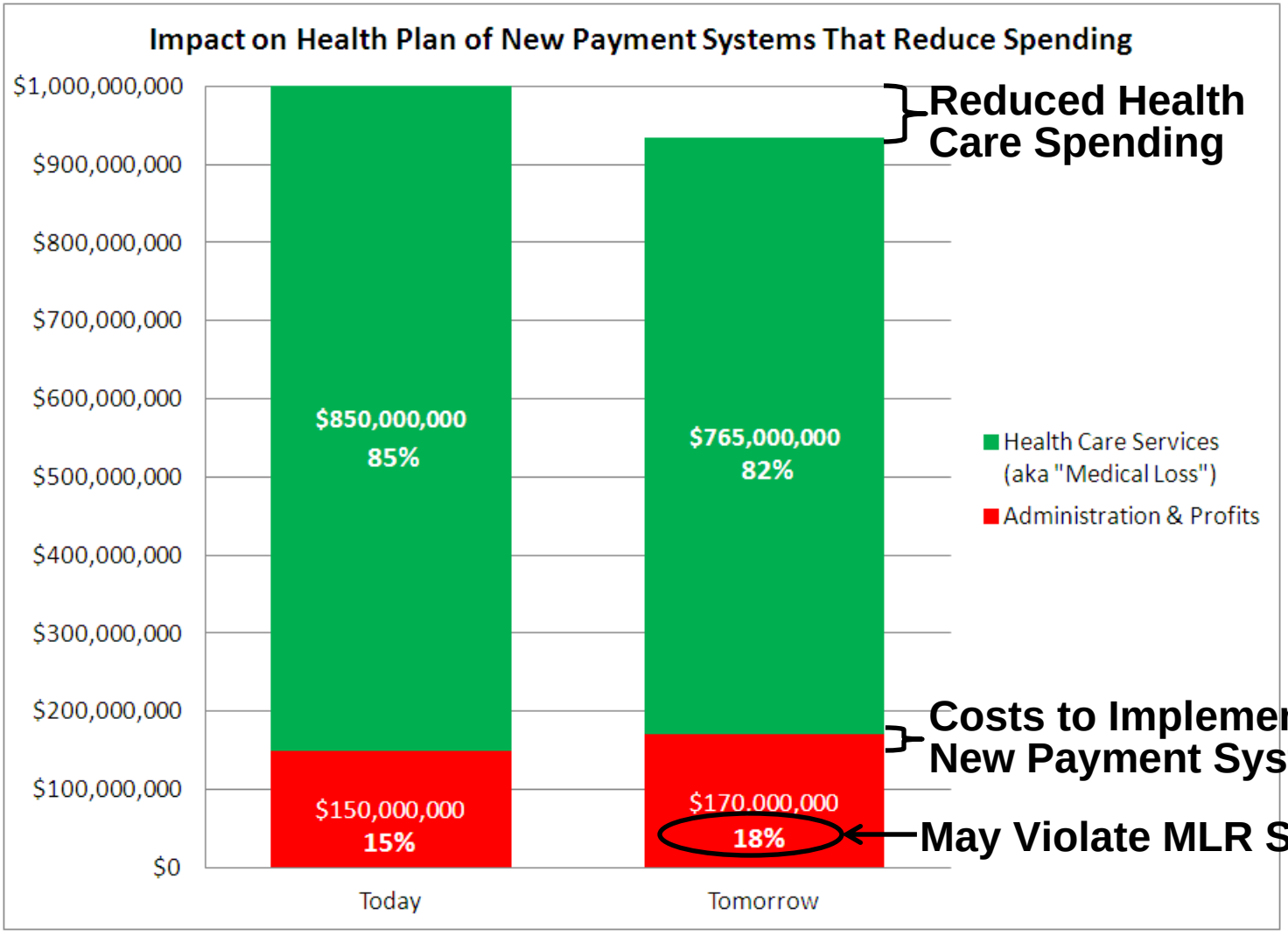
Challenges of Getting Aligned Payment Reform from Health Plans

- Improving payment systems will increase health plan administrative costs in the short-term
- Reducing health care spending will put pressure on health plan administrative costs and profits

Example: A Hypothetical $1 Billion Health Insurance Co.



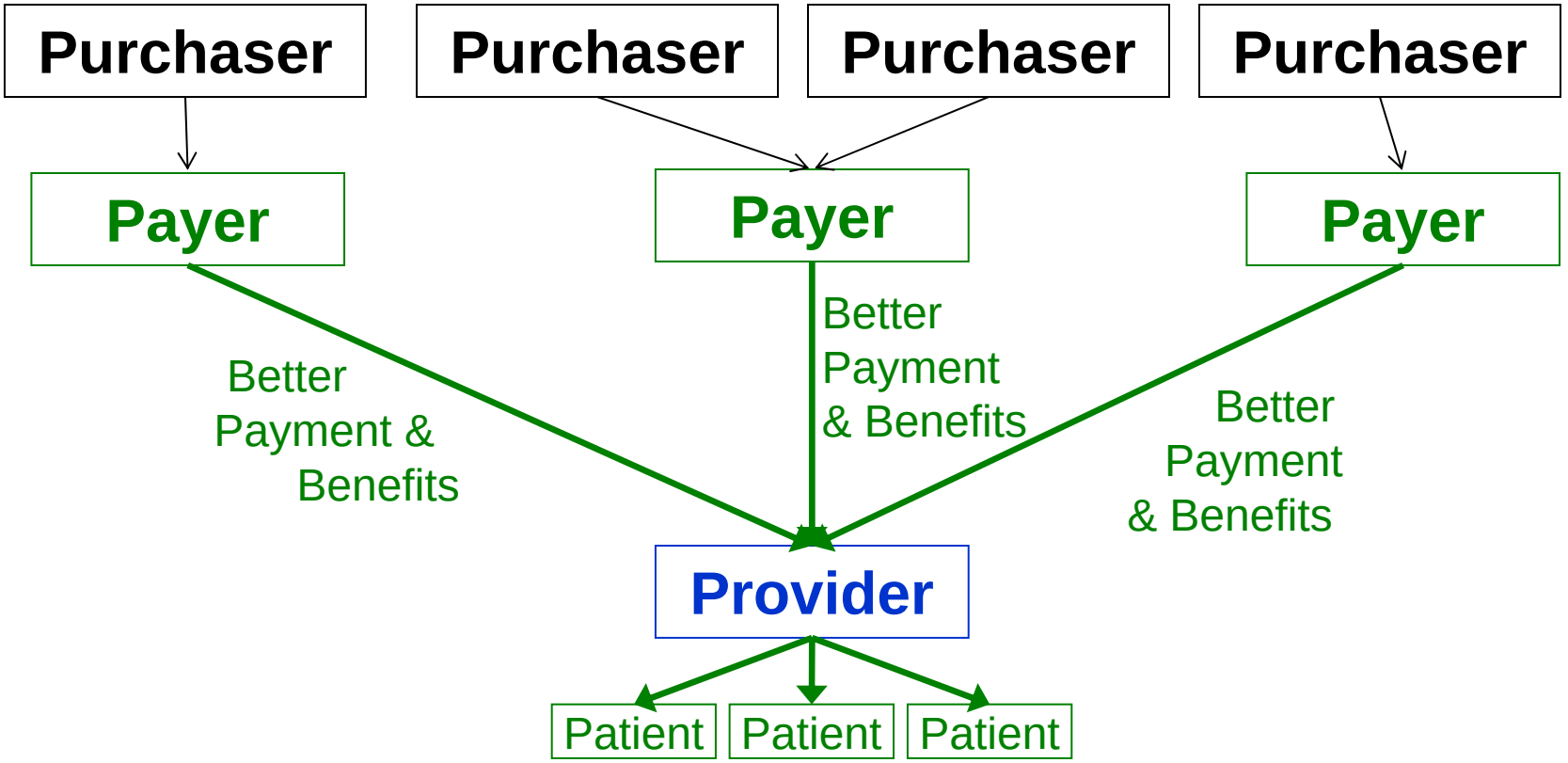
Administrative Costs + Reduced Spending = MLR Problems



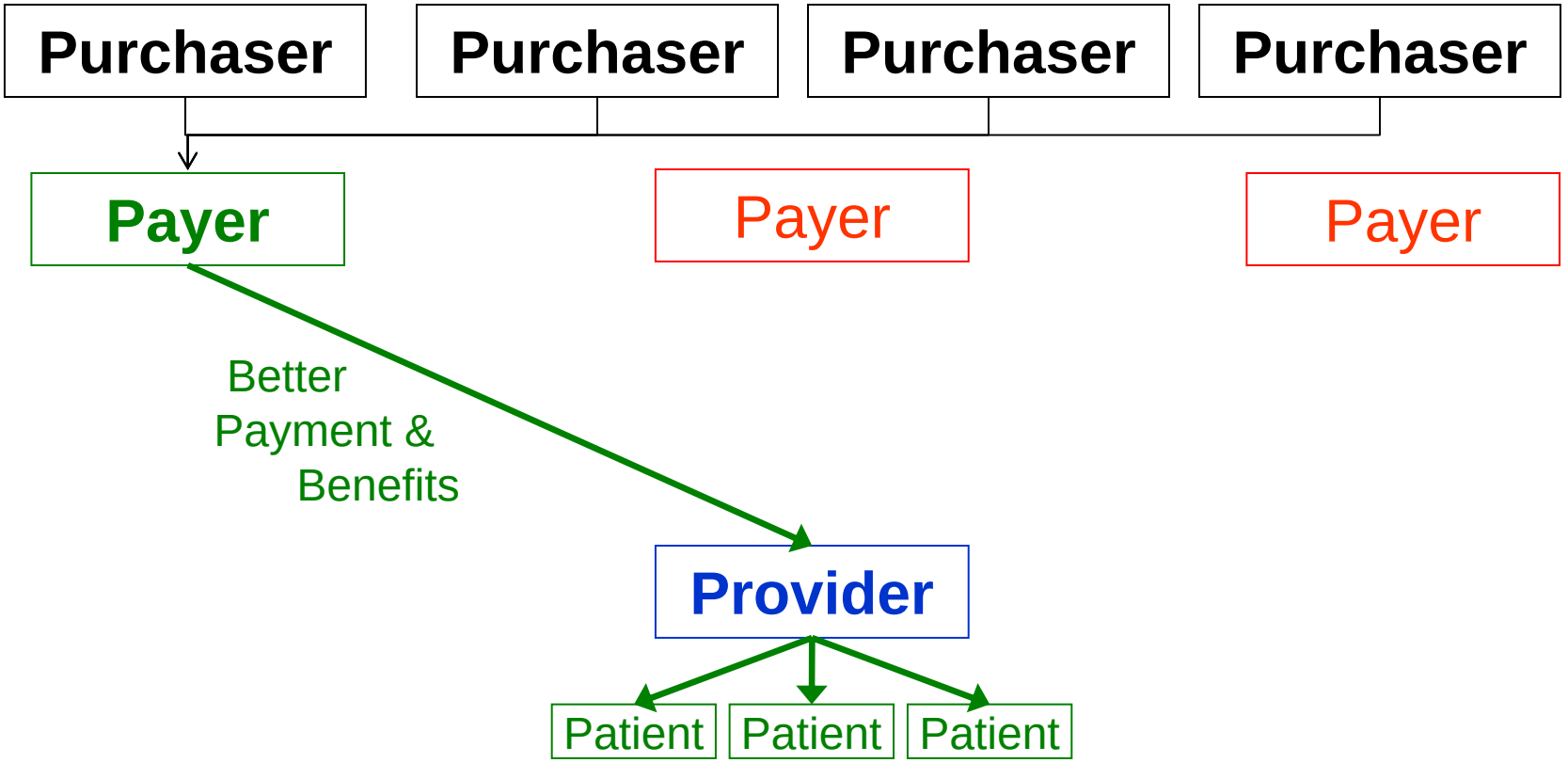
Challenges of Getting Aligned Payment Reform from Health Plans

- Improving payment systems will increase health plan administrative costs in the short-term
- Reducing health care spending will put pressure on health plan administrative costs and profits
- Individual health plans have an incentive to be free-riders on changes in care supported by other health plans to avoid costs, because employers focus on short-term premiums rather than multi-year solutions
- National health plans don't want to make different changes in different communities
- Employers encourage health plans to "compete" on payment systems rather than to collaborate on payment systems and compete on efficiency

Purchasers Must Encourage Multi-Payer Coordination

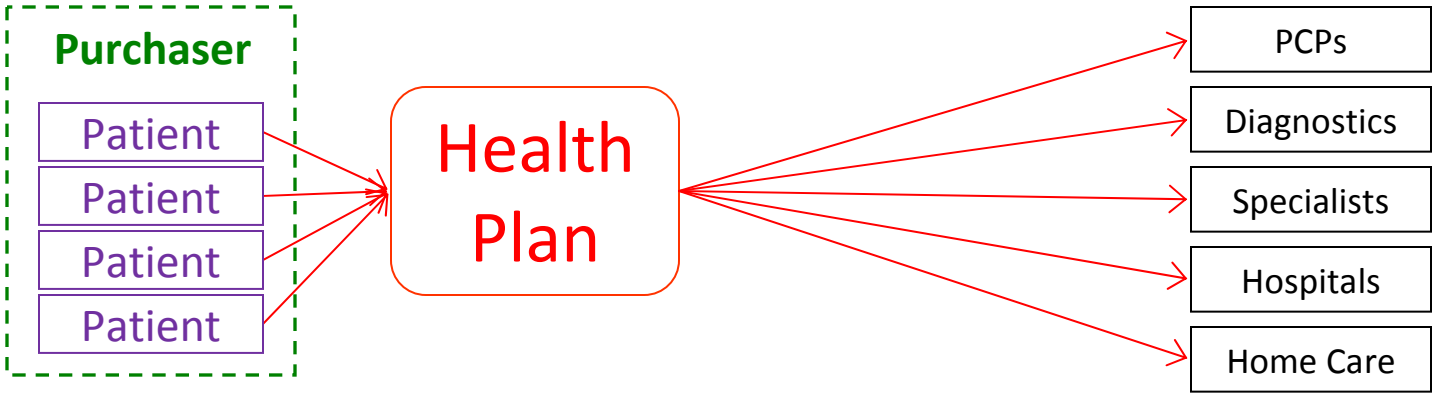


The Ultimate Tool: Purchasers Switching Payers to Get Changes



What We Need: New Roles for Health Plans and Providers

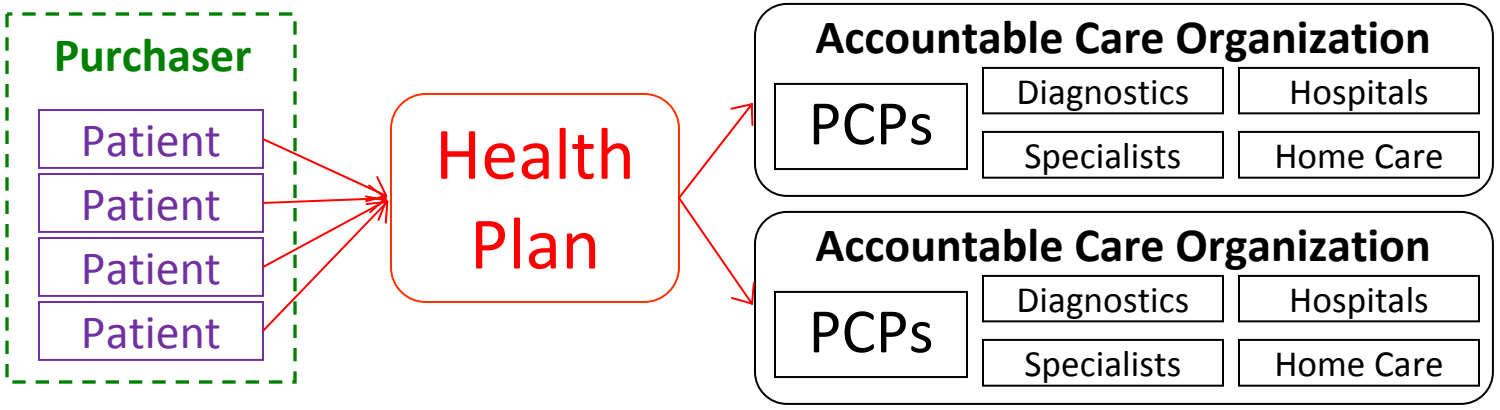
Today: Health Plans Can Be "In the Way" of Better Value



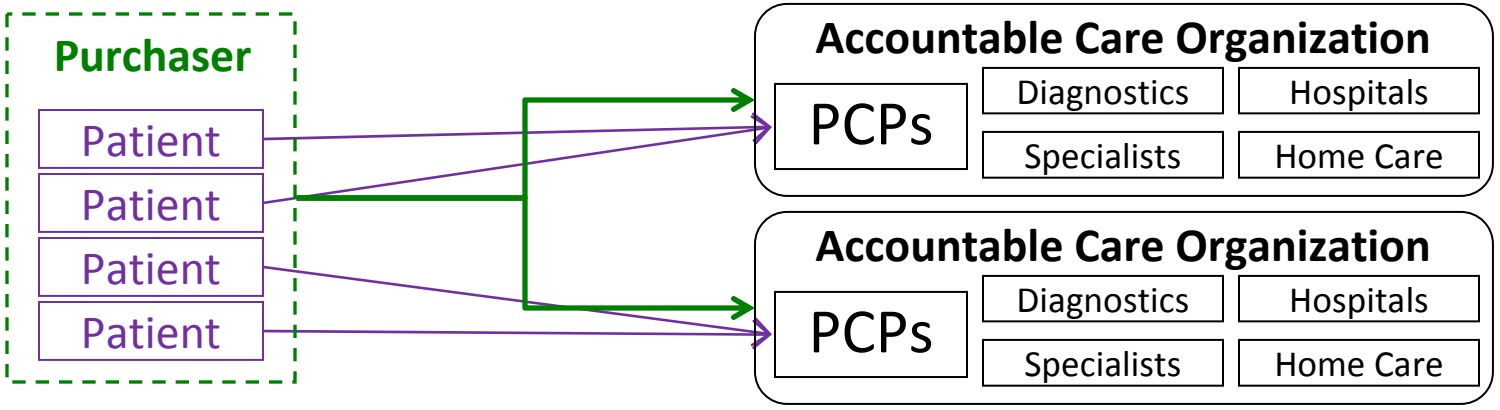
Health Plan "wins" if:

- patients lose (are denied needed care)
- providers lose (are paid less than costs)
- purchasers lose (pay higher premiums)

ACOs Shouldn't Just Be New Ways of Contracting With Health Plans…



ACOs: Entirely New Relationships for Patients, Purchasers, and Providers



Purchasers and Patients "win" if:

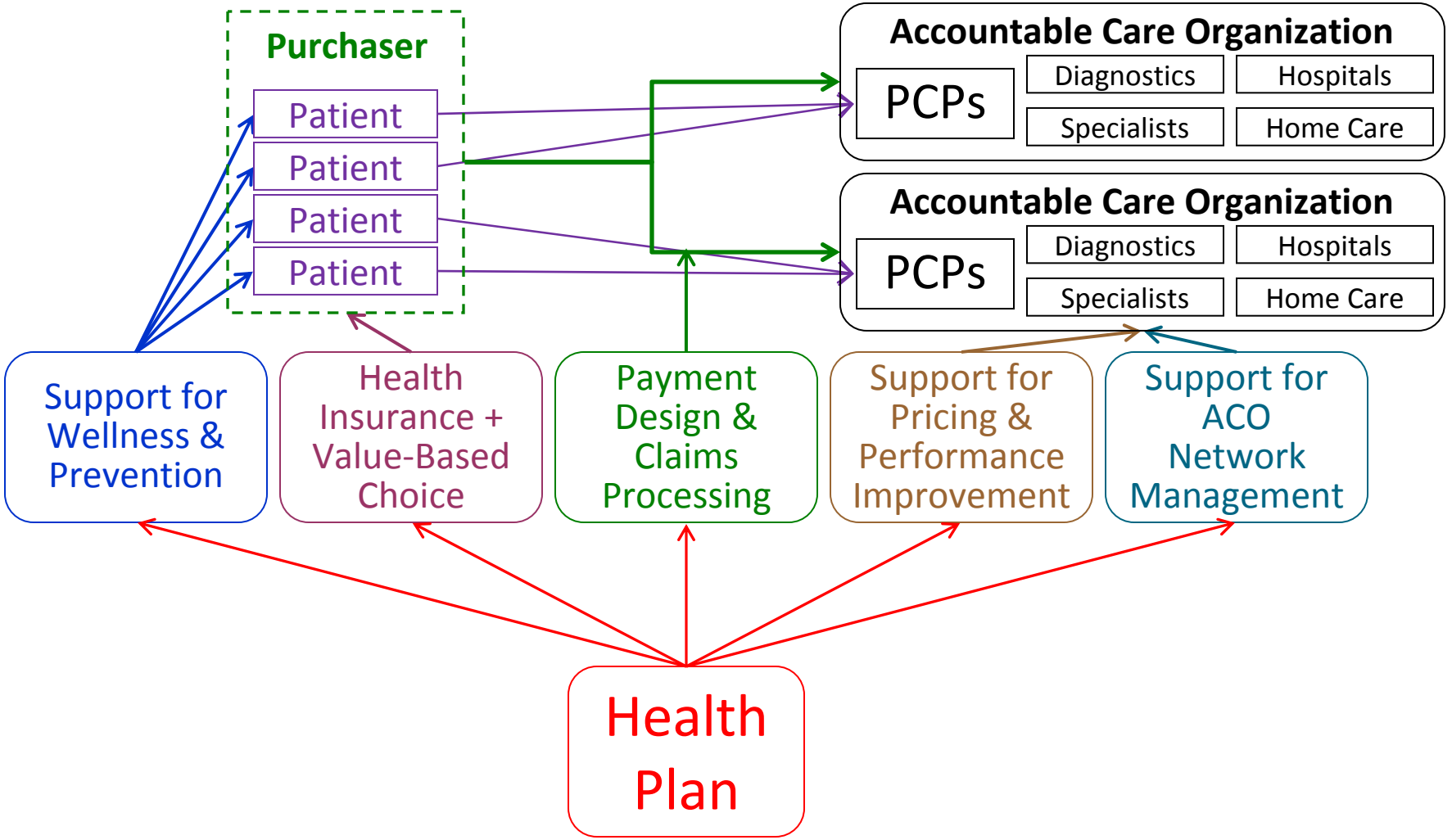
- ACOs compete to provide high-quality care at low prices

ACO "wins" if:

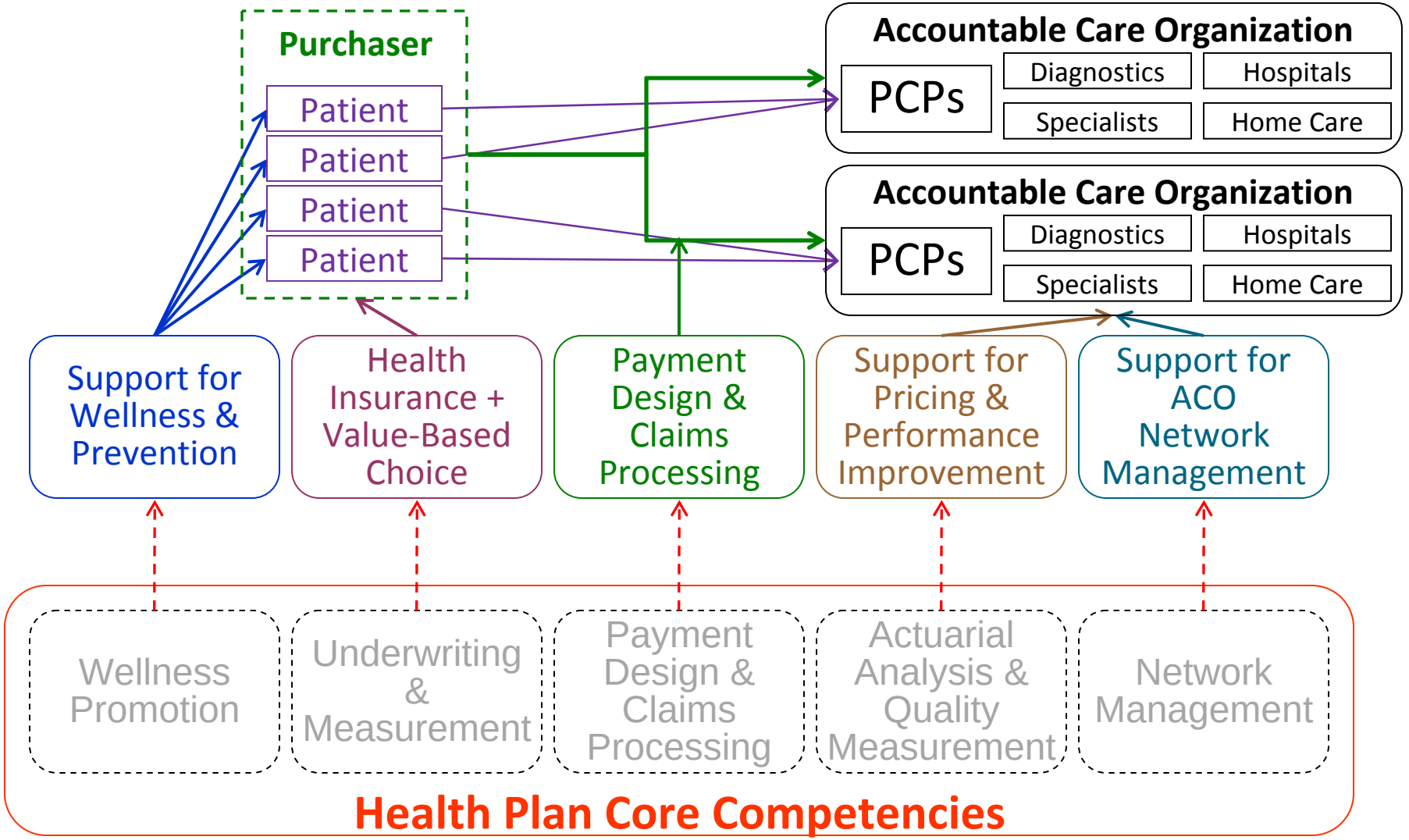
- Patients stay healthy and need less care
- Patients choose high-value ACOs

Health Plan?

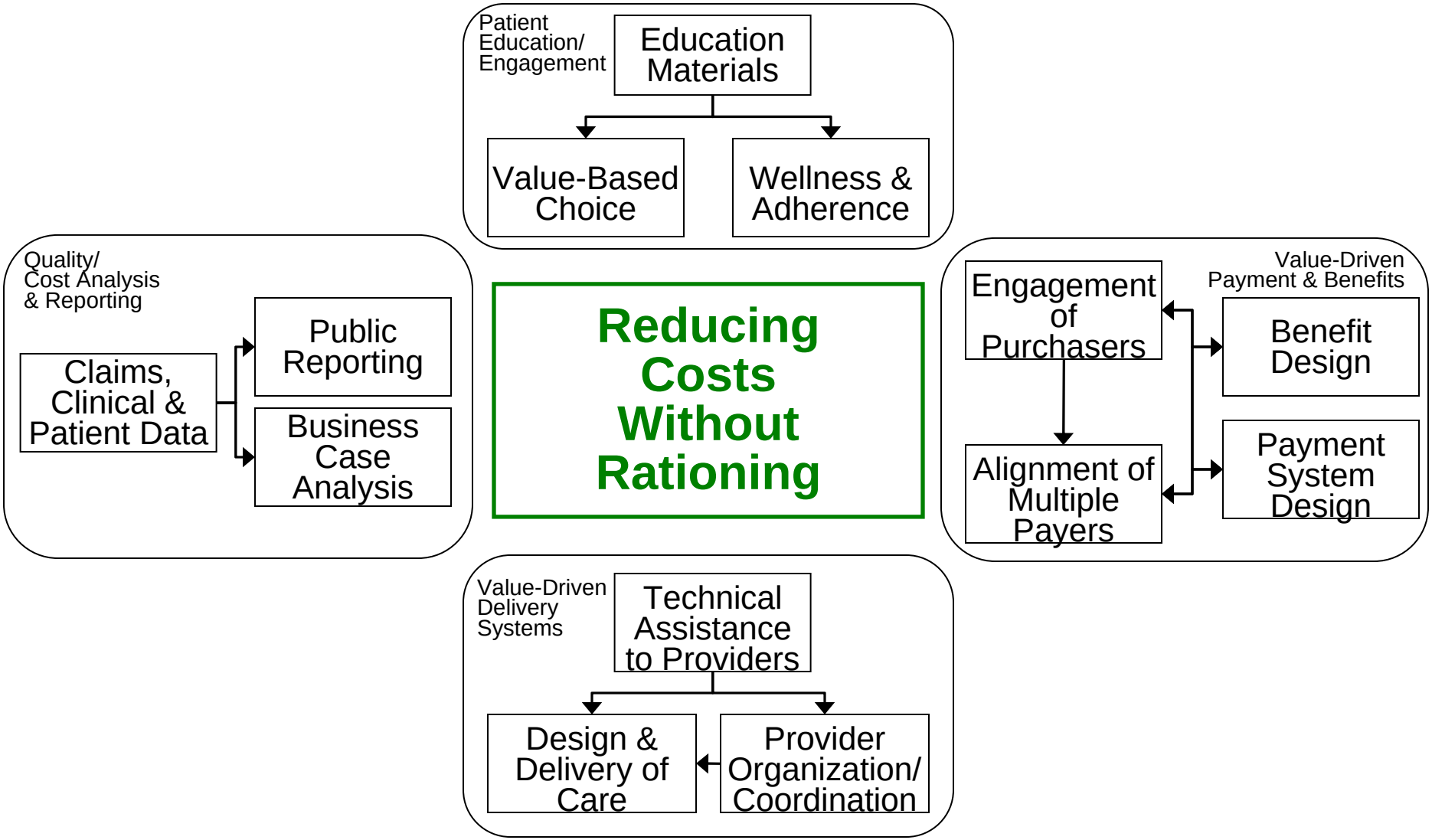
Putting Patients & Providers in the Driver's Seat, Supported by Plans



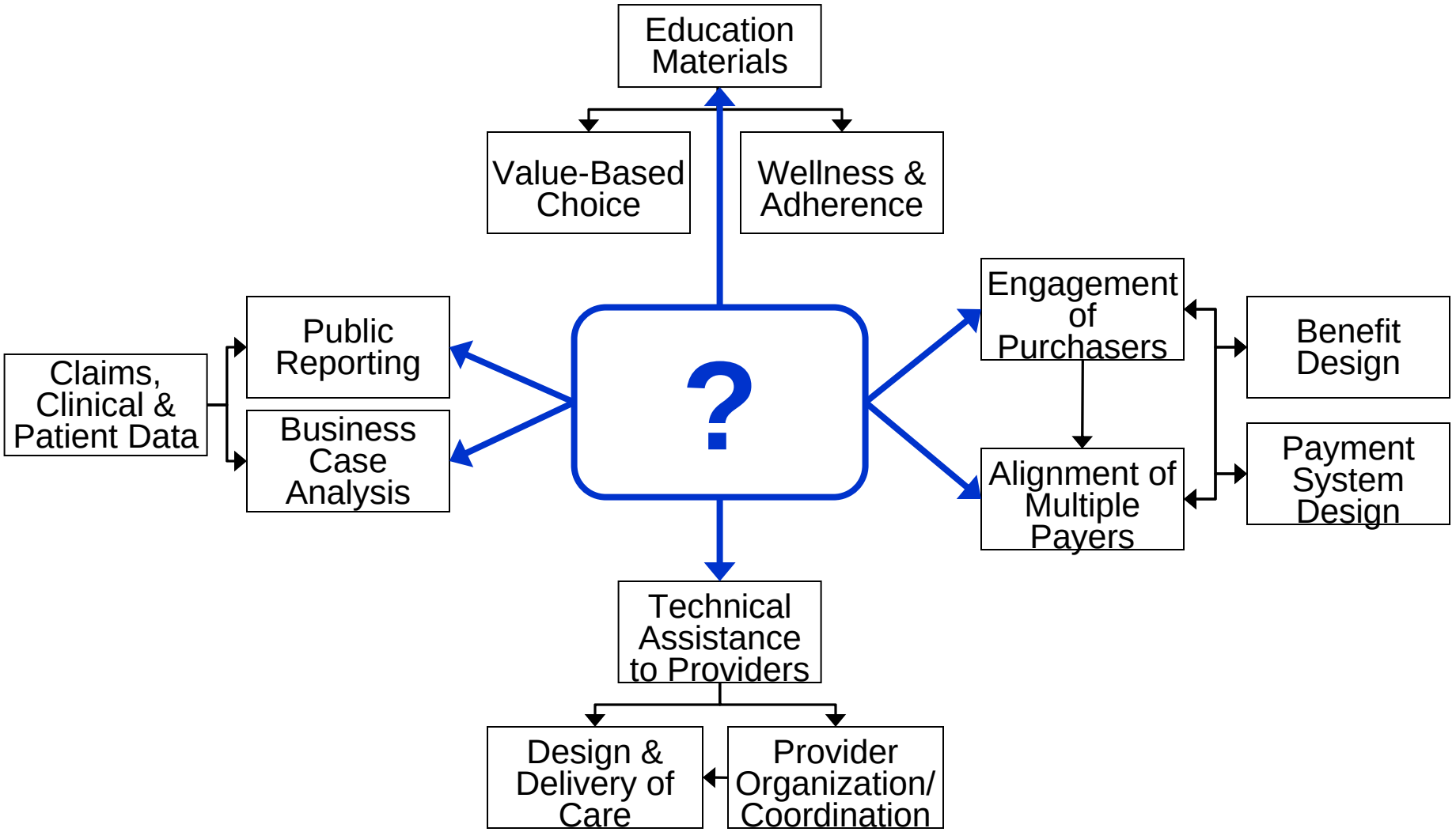
Health Plan Skills Can Help Patients, Purchasers, and ACOs Succeed



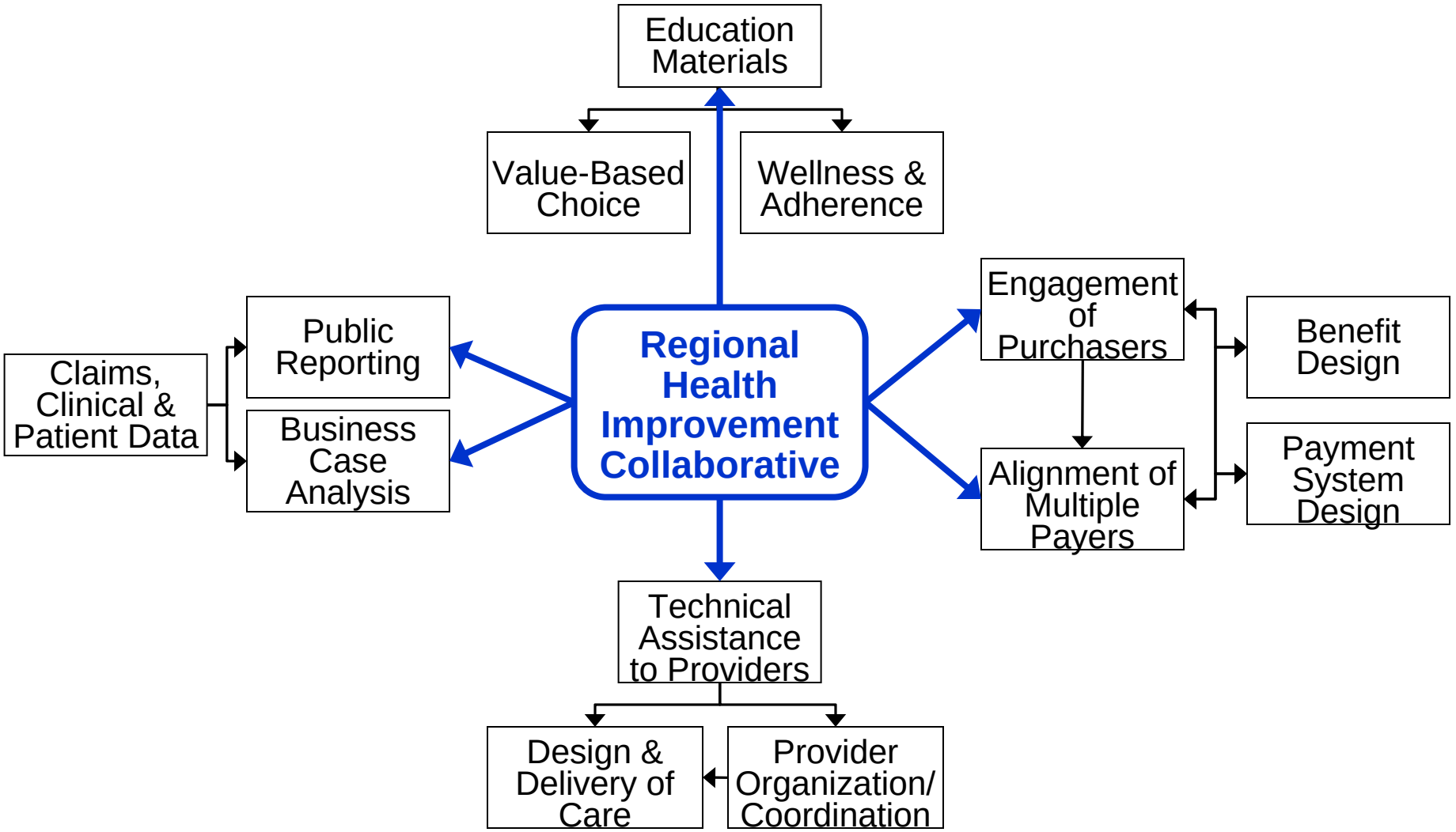
Many Things Necessary for Win-Win Solutions in Communities



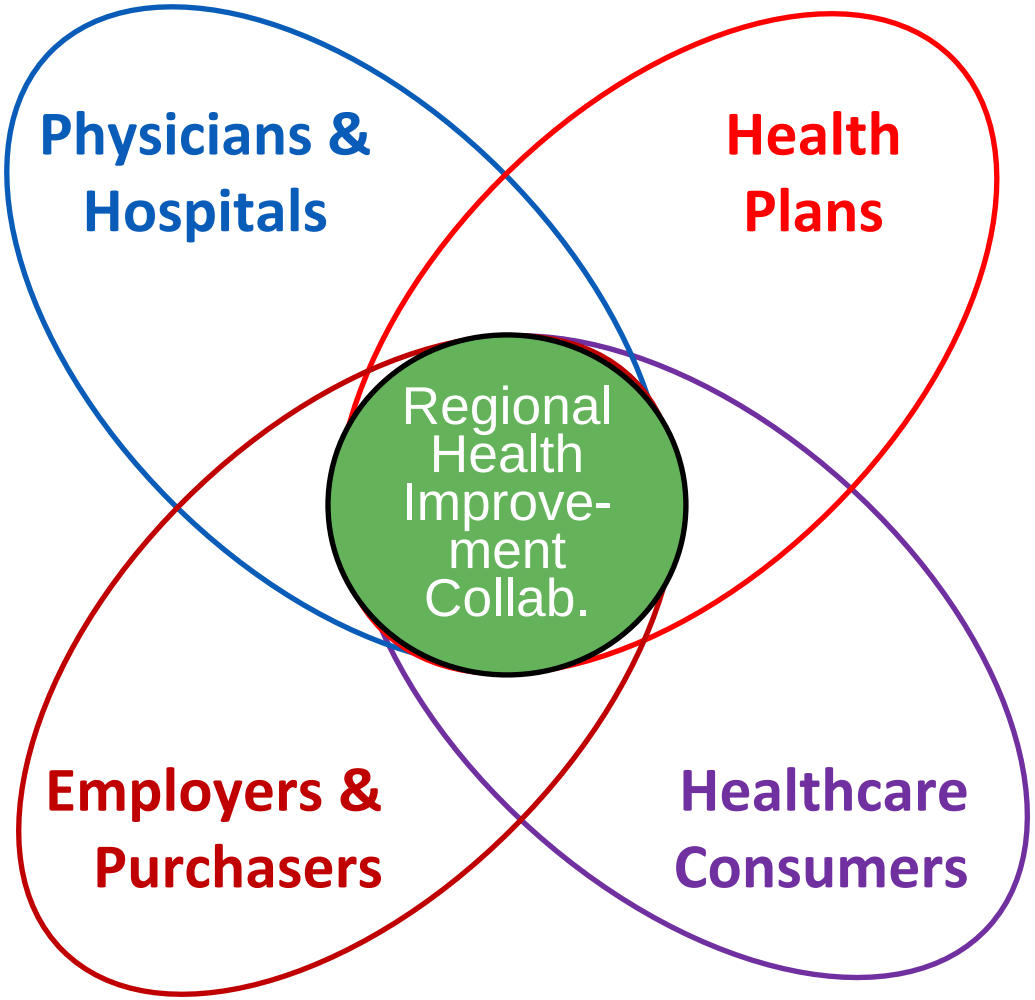
How Can You Ensure All This Is Happening in a Coordinated Way?



The Role of Regional Health Improvement Collaboratives



...With Active Involvement of All Healthcare Stakeholders



Leading Regional Health Improvement Collaboratives in U.S.

- Albuquerque Coalition for Healthcare Quality
- Aligning Forces for Quality – South Central PA
- Alliance for Health
- Better Health Greater Cleveland
- California Cooperative Healthcare Reporting Initiative
- California Quality Collaborative
- Center for Improving Value in Health Care (Colorado)
- Finger Lakes Health Systems Agency
- Greater Detroit Area Health Council
- 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

Network for Regional Healthcare Improvement
www.NRHI.org

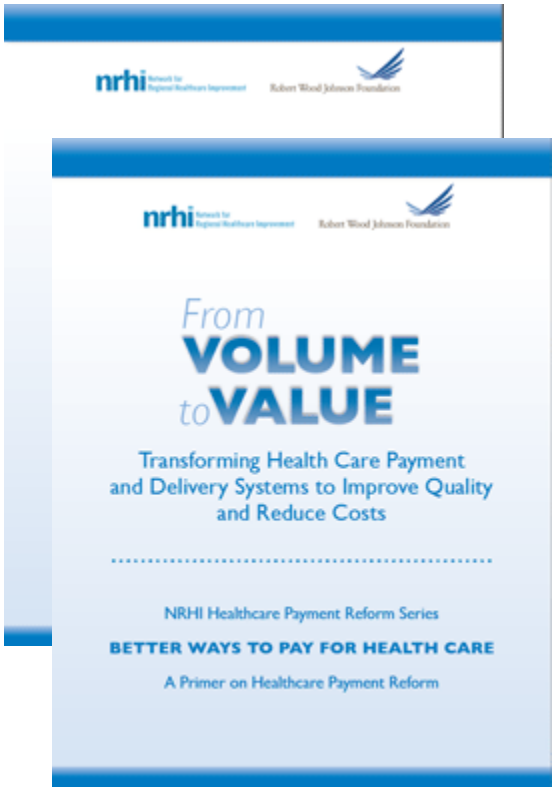
How Regional Collaboratives Are Working to Advance Reform

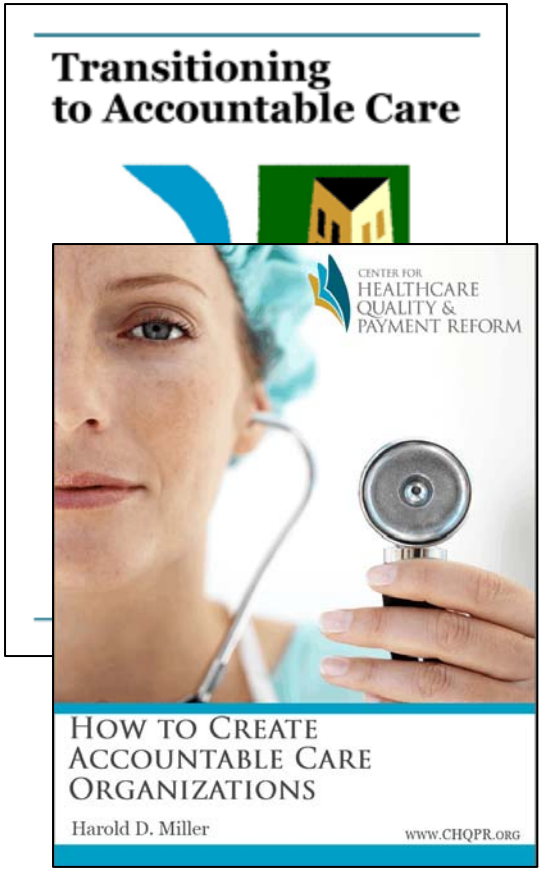
- **Help in Identifying Opportunities for Savings**
  - Assembling multi-payer data on utilization and costs
  - Analyzing the data in ways that are actionable for providers
- **Building Consensus on Payment/Benefit Reforms**
  - Reaching agreement among physicians, hospitals, employers, health plan, and consumers on payment reform
  - Encouraging and facilitating all purchasers/health plans to use the same payment methods and benefit designs
- **Providing Training & Technical Assistance**
  - Tools physicians and hospitals can use in redesigning care to reduce costs and improve quality
- **Neutral Facilitation to Achieve Win-Win Solutions**
  - Providing the "table" where all stakeholders can come to resolve challenges in ways that are fair to everyone

Where to Start: Data Analysis to Identify Win-Win Opportunities

- **Data needs to show the *total picture* of quality+cost**
  - High quality alone may be unaffordable
  - Low cost alone may be undesirable
  - Opportunities for improving quality/reducing costs will vary from community to community and provider to provider
- **Data needs to be *multi-payer***
  - Physicians and hospitals need to change care for *all* of their patients, not just for those from one health plan
  - Different report formats from different payers are confusing and inefficient
- **Health Plans, Medicare, and Medicaid need to make release of claims data to Regional Health Improvement Collaboratives, physicians, and hospitals a high priority**

For More Information on Win-Win Approaches to Reform





www.PaymentReform.org

CENTER FOR HEALTHCARE QUALITY & PAYMENT REFORM

nrhi Network for Regional Healthcare Improvement

For More Information:

Harold D. Miller

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

Miller.Harold@GMail.com

(412) 803-3650

www.CHQPR.org

www.NRHI.org

www.PaymentReform.org