



WIN-WIN-WIN APPROACHES TO ACCOUNTABLE CARE

**How Patients, Payers, Physicians, & Hospitals
Can All Benefit from Better Ways
to Pay for and Deliver Healthcare Services**

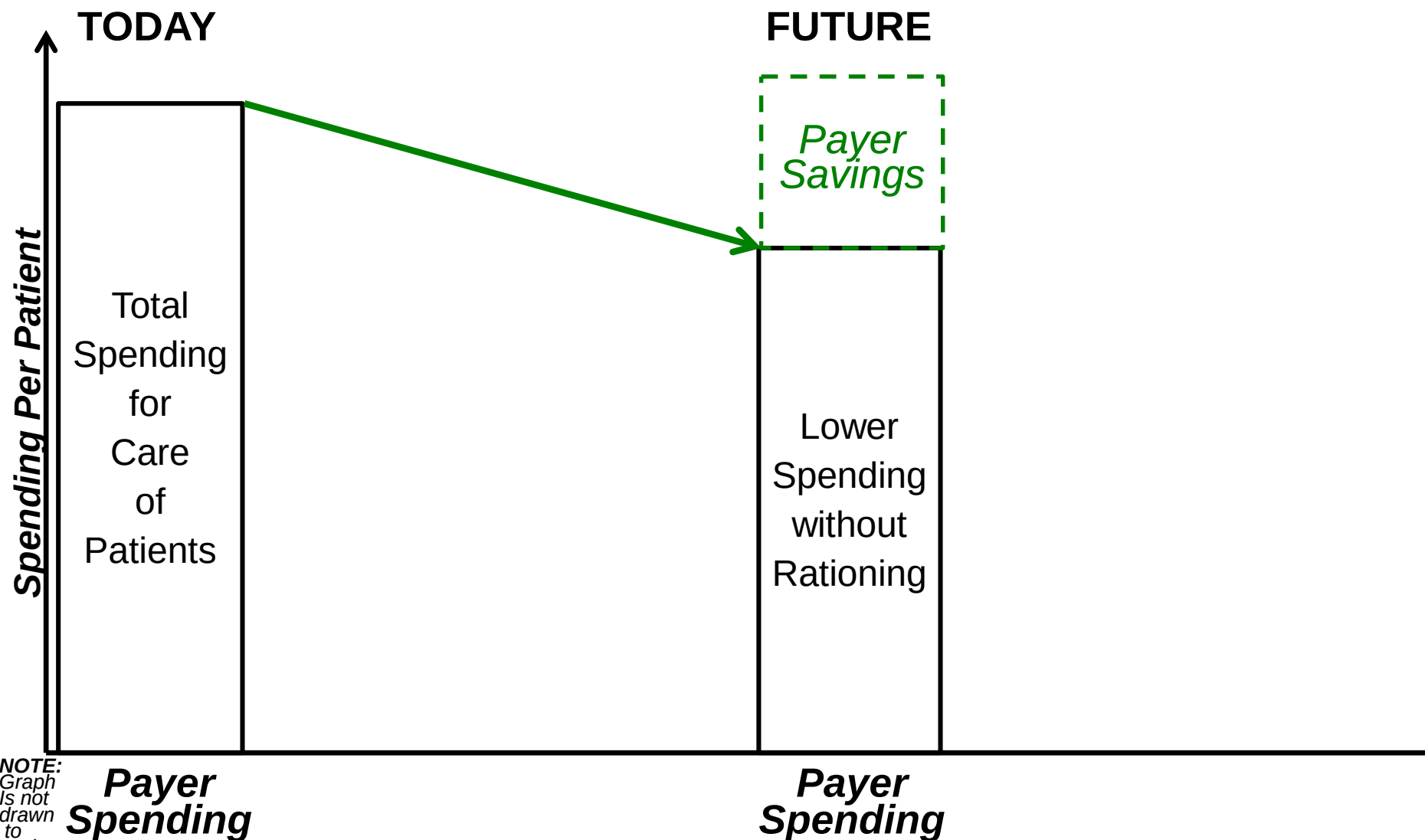
Harold D. Miller

President and CEO

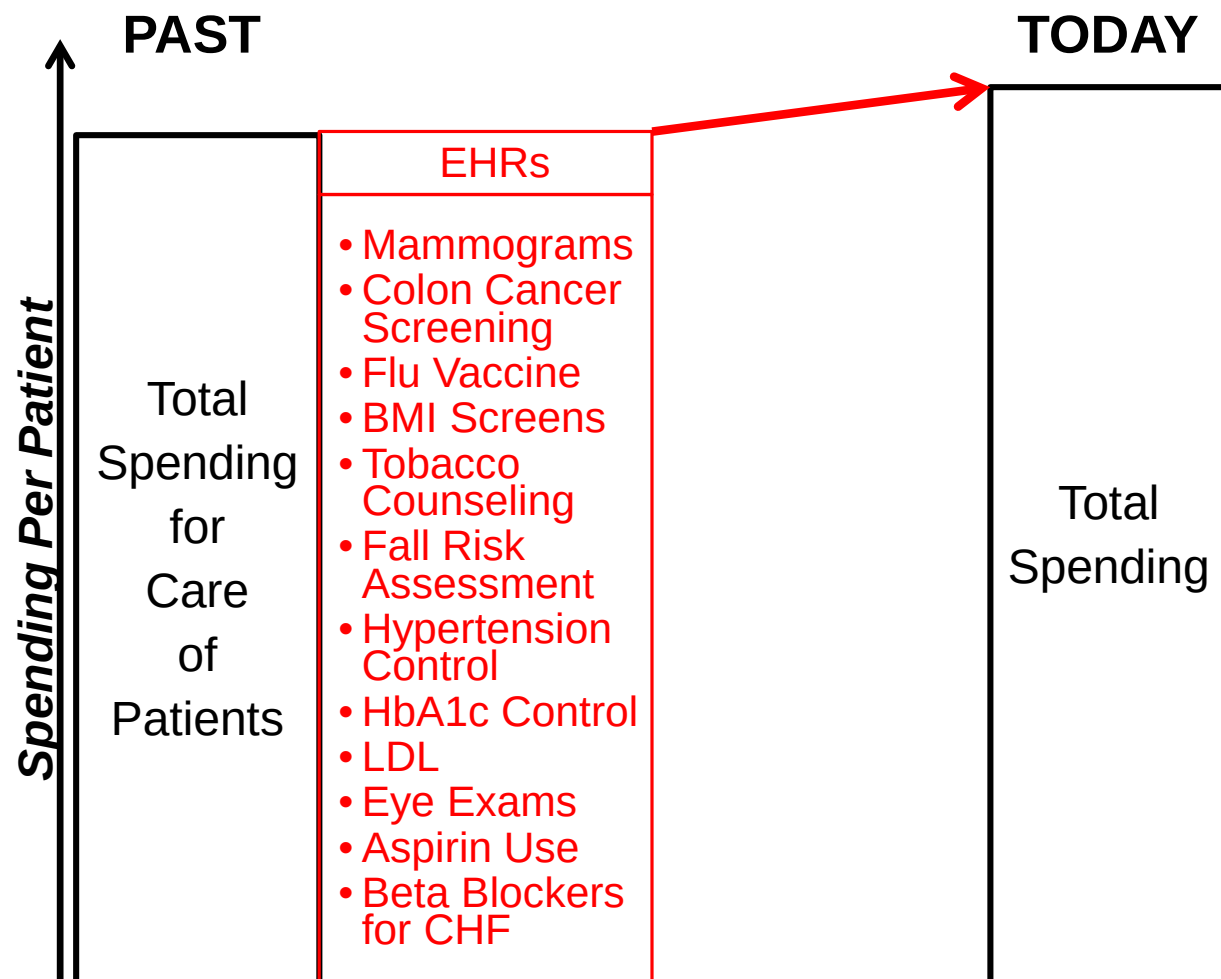
Center for Healthcare Quality and Payment Reform

www.CHQPR.org

How Do You Reduce/Control Total Spending on Healthcare?



Hundreds of Quality Measures & “Meaningful Use” Hasn’t Worked

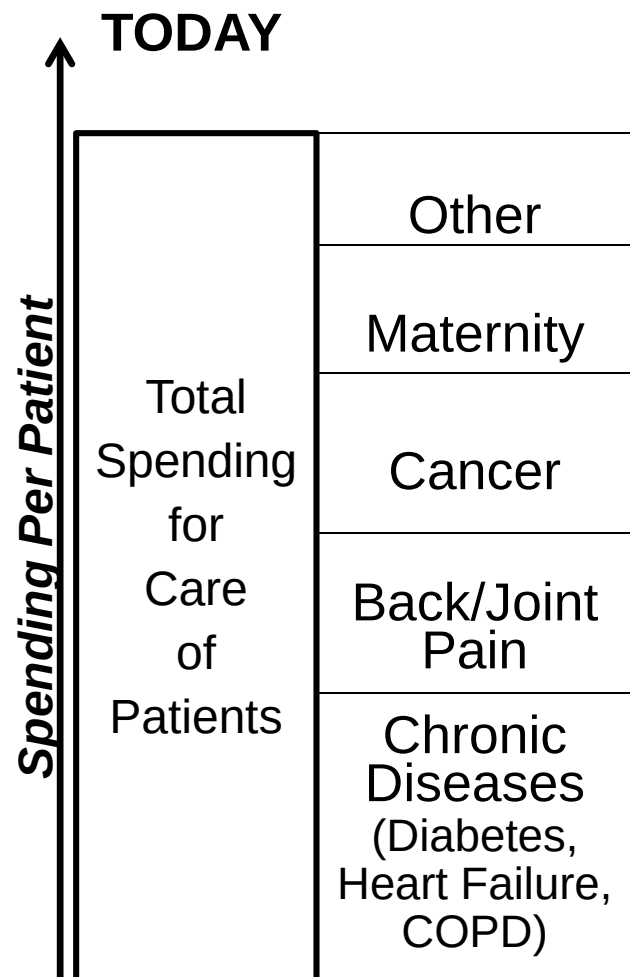


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**Payer
Spending**

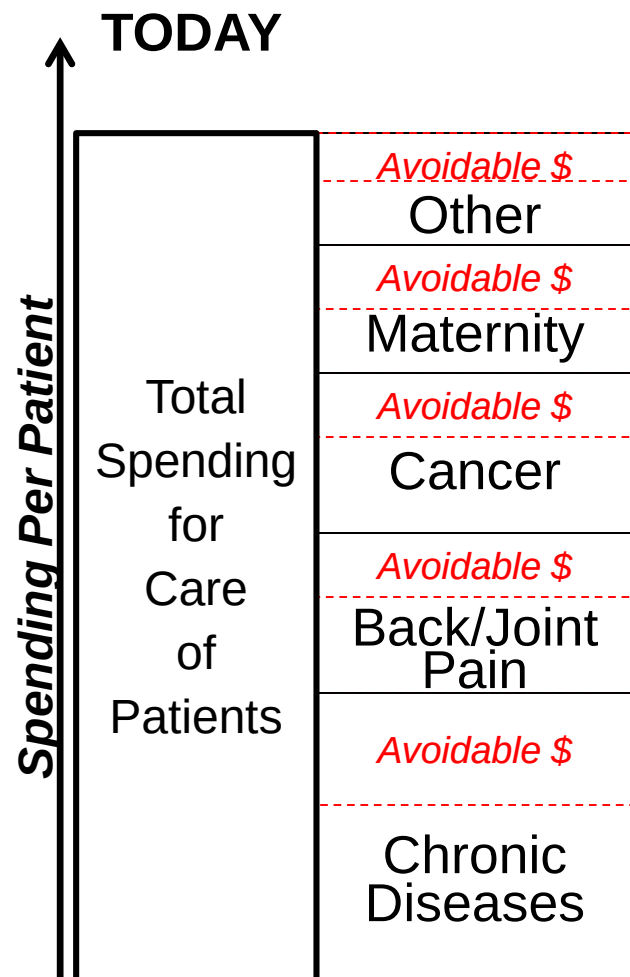
**Payer
Spending**

The Right Way: Look at the Health Conditions Affecting Patients...



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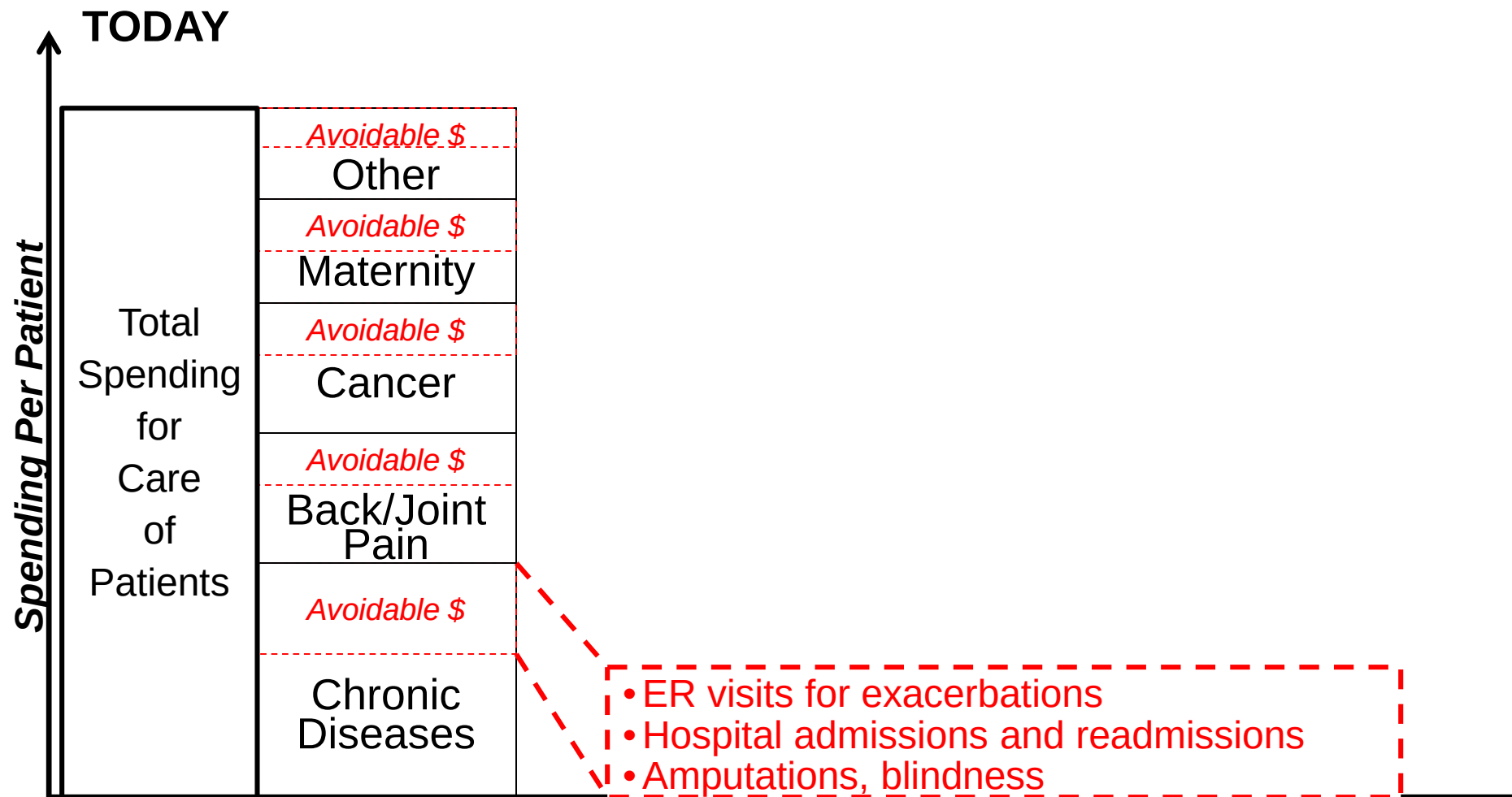
...and Identify the *Avoidable* Spending Within Each Condition



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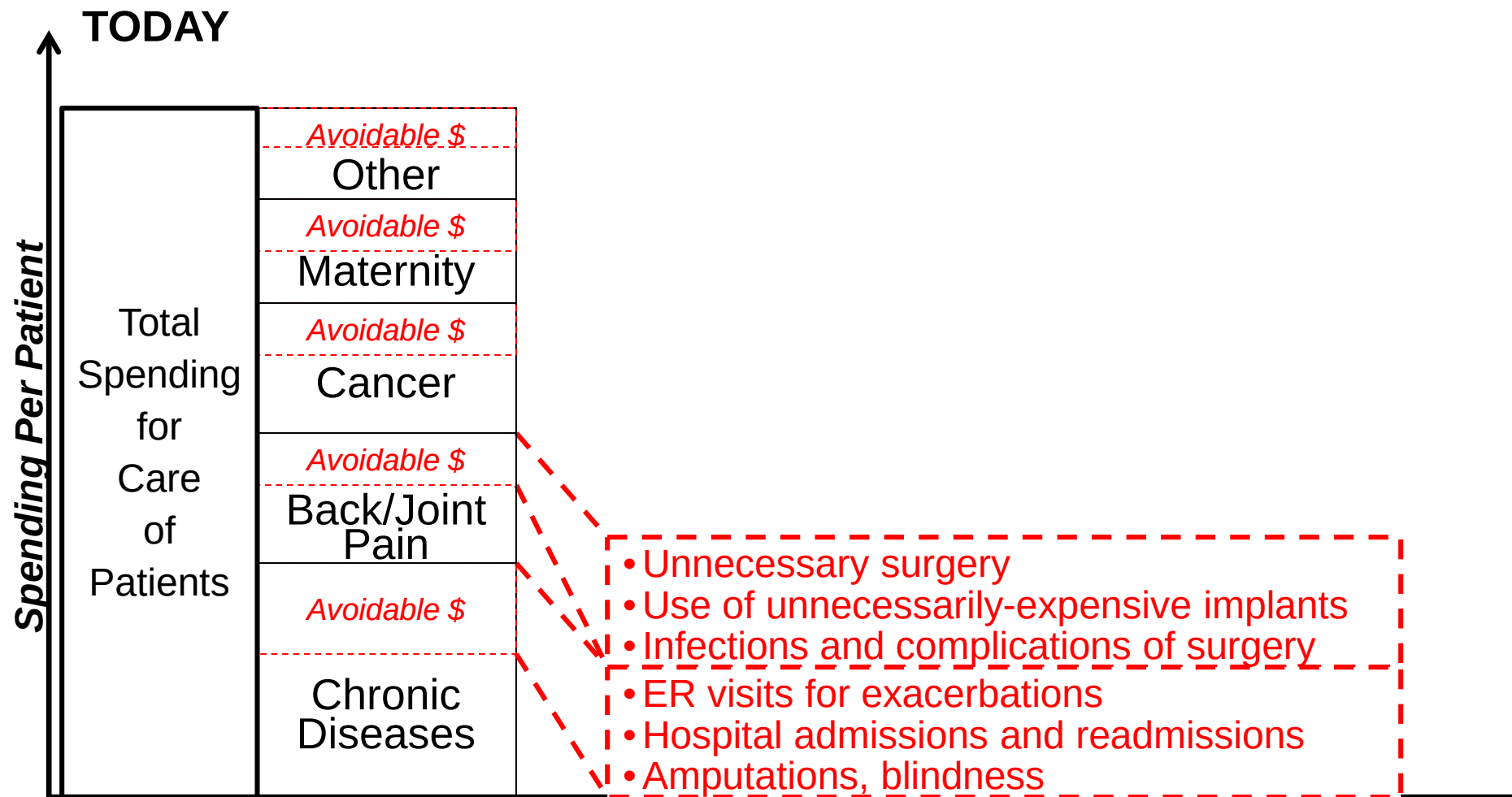
**Payer
Spending**

Example: Avoidable Costs for Chronic Disease Patients



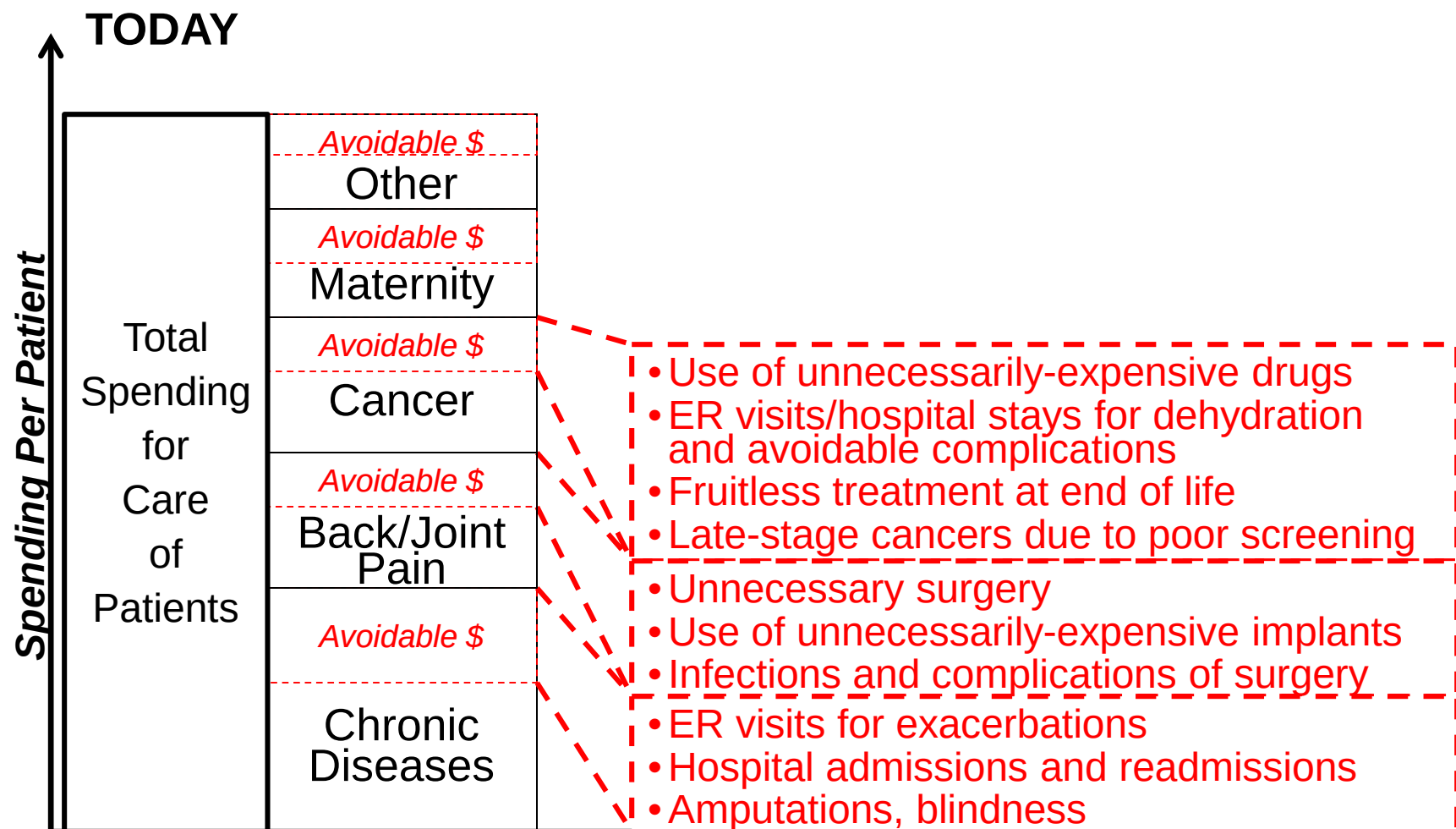
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Example: Avoidable Costs for Back, Knee, and Hip Pain



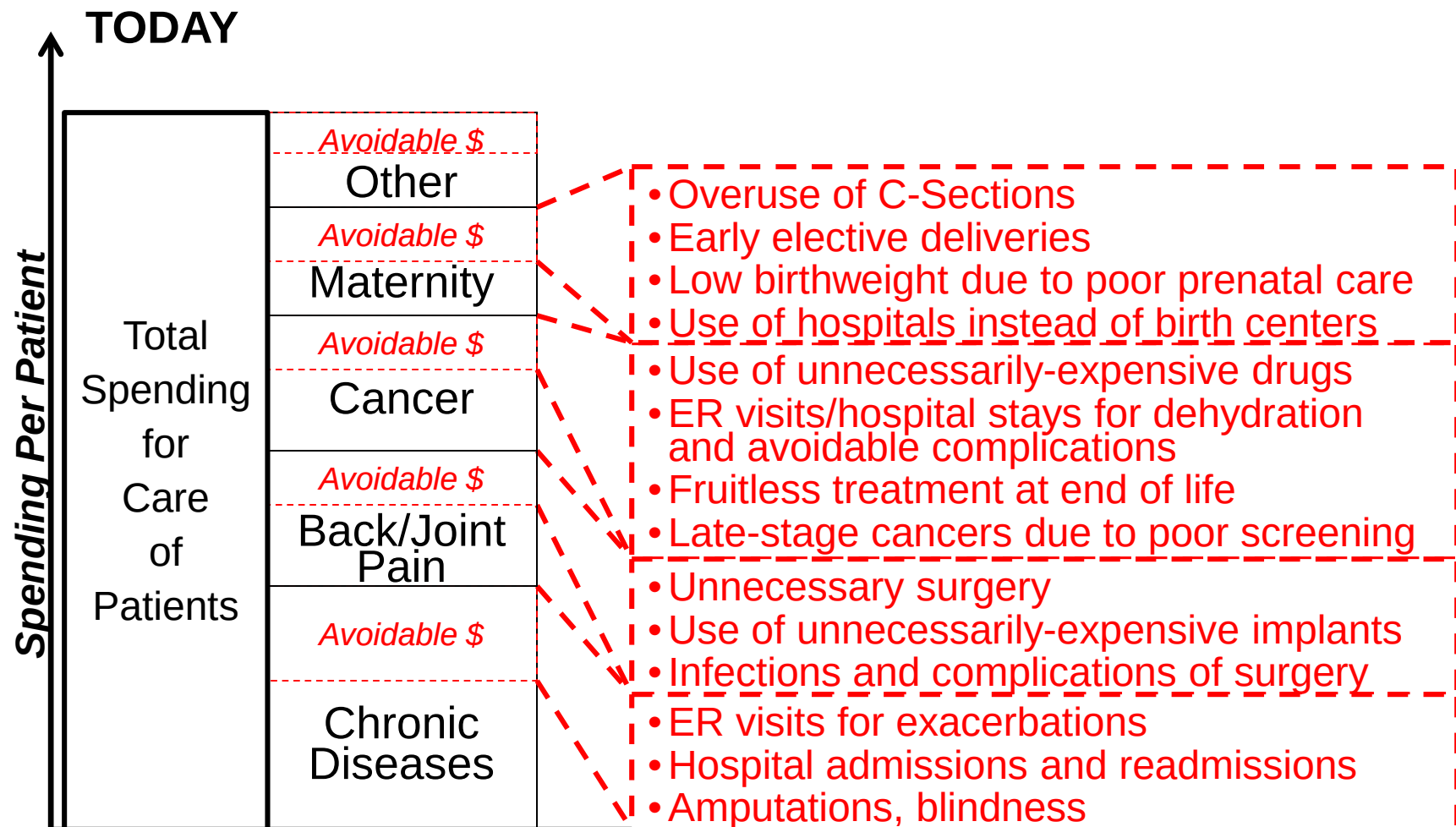
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Example: Avoidable Costs in Cancer Care



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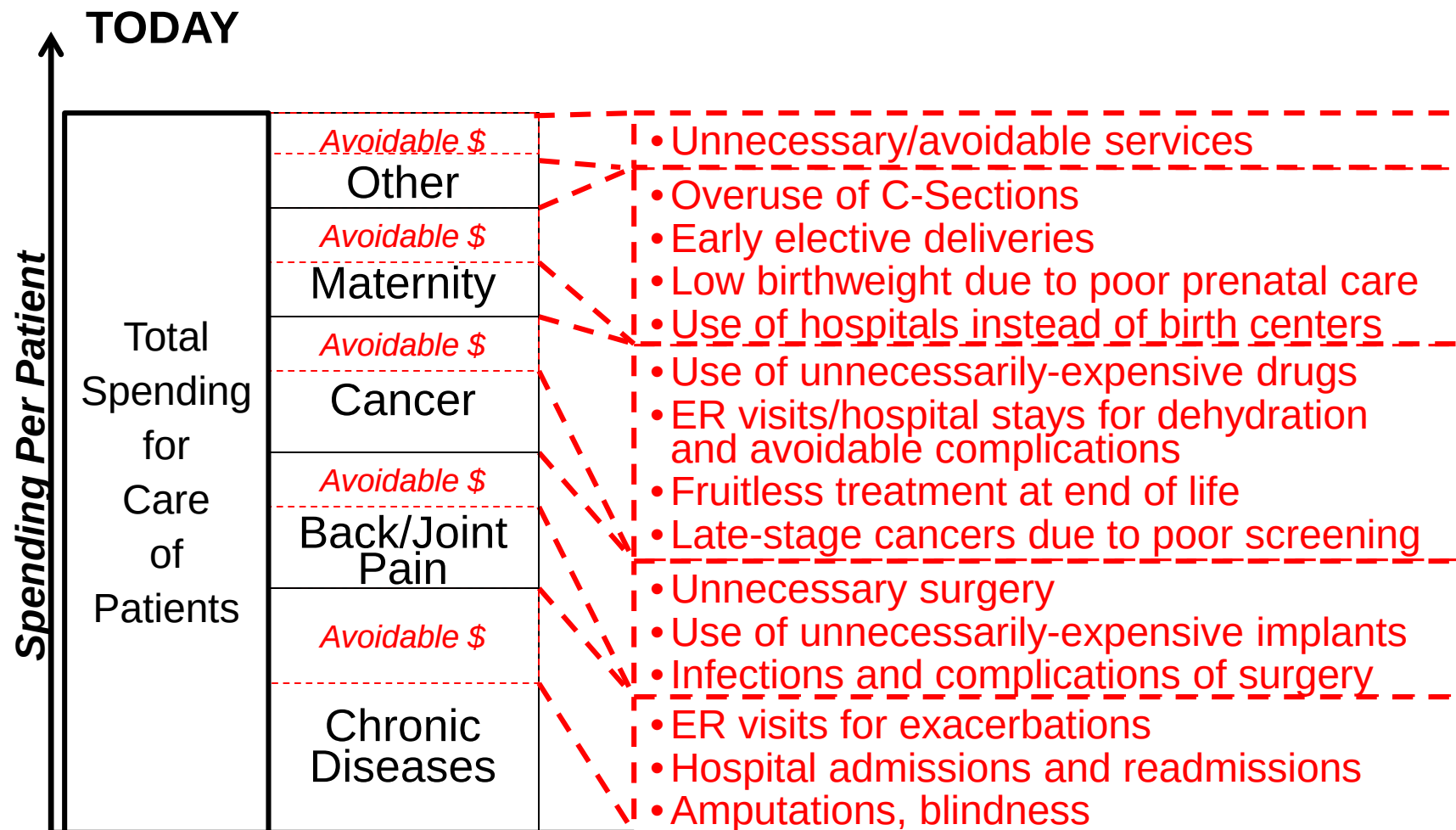
Example: Avoidable Costs for Maternity Care



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**Payer
Spending**

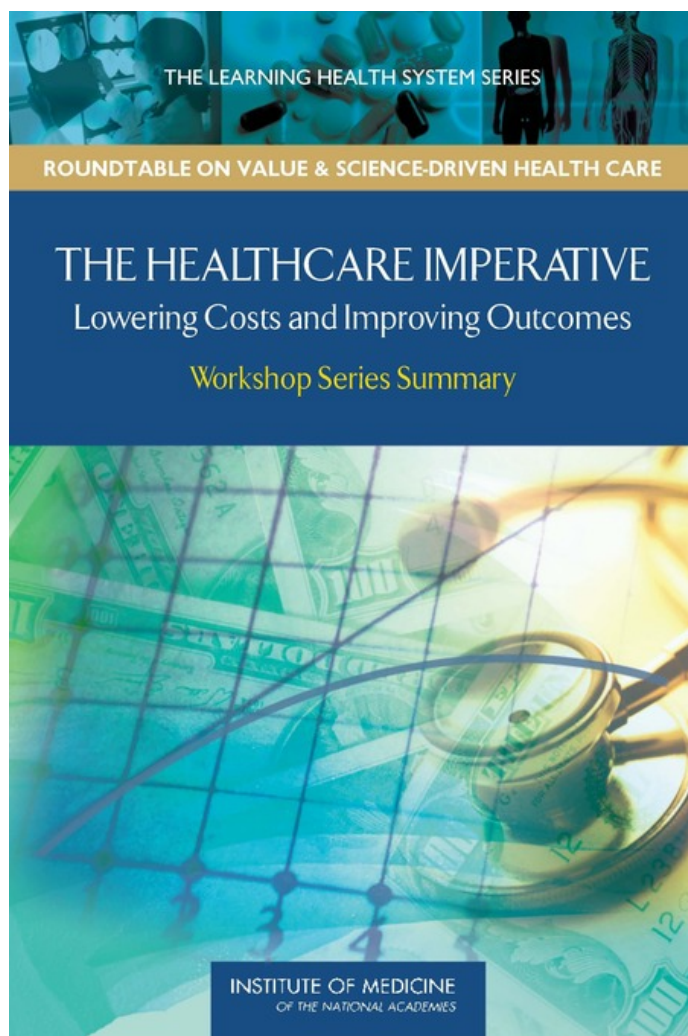
And Many Other Opportunities



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**Payer
Spending**

Institute of Medicine Estimate: 30% of Spending is Avoidable



Excess Cost Domain Estimates: *Lower bound totals from workshop discussions**

UNNECESSARY SERVICES Total excess = \$210 B*

- Overuse: services beyond evidence-established levels
- Discretionary use beyond benchmarks
 - Defensive medicine
- Unnecessary choice of higher cost services

INEFFICIENTLY DELIVERED SERVICES Total excess = \$130 B*

- Mistakes—medical errors, preventable complications
- Care fragmentation
- Unnecessary use of higher cost providers
- Operational inefficiencies at care delivery sites
 - Physician offices
 - Hospitals

EXCESS ADMINISTRATIVE COSTS Total excess = \$190 B*

- Insurance-related administrative costs beyond benchmarks
 - Insurers
 - Physician offices
 - Hospitals
 - Other providers
- Insurer administrative inefficiencies
- Care documentation requirement inefficiencies

PRICES THAT ARE TOO HIGH Total excess = \$105 B*

- Service prices beyond competitive benchmarks
 - Physician services
 - i. Specialists
 - ii. Generalists
 - Hospital services
- Product prices beyond competitive benchmarks
 - Pharmaceuticals
 - Medical devices
 - Durable medical equipment

MISSED PREVENTION OPPORTUNITIES Total excess = \$55 B*

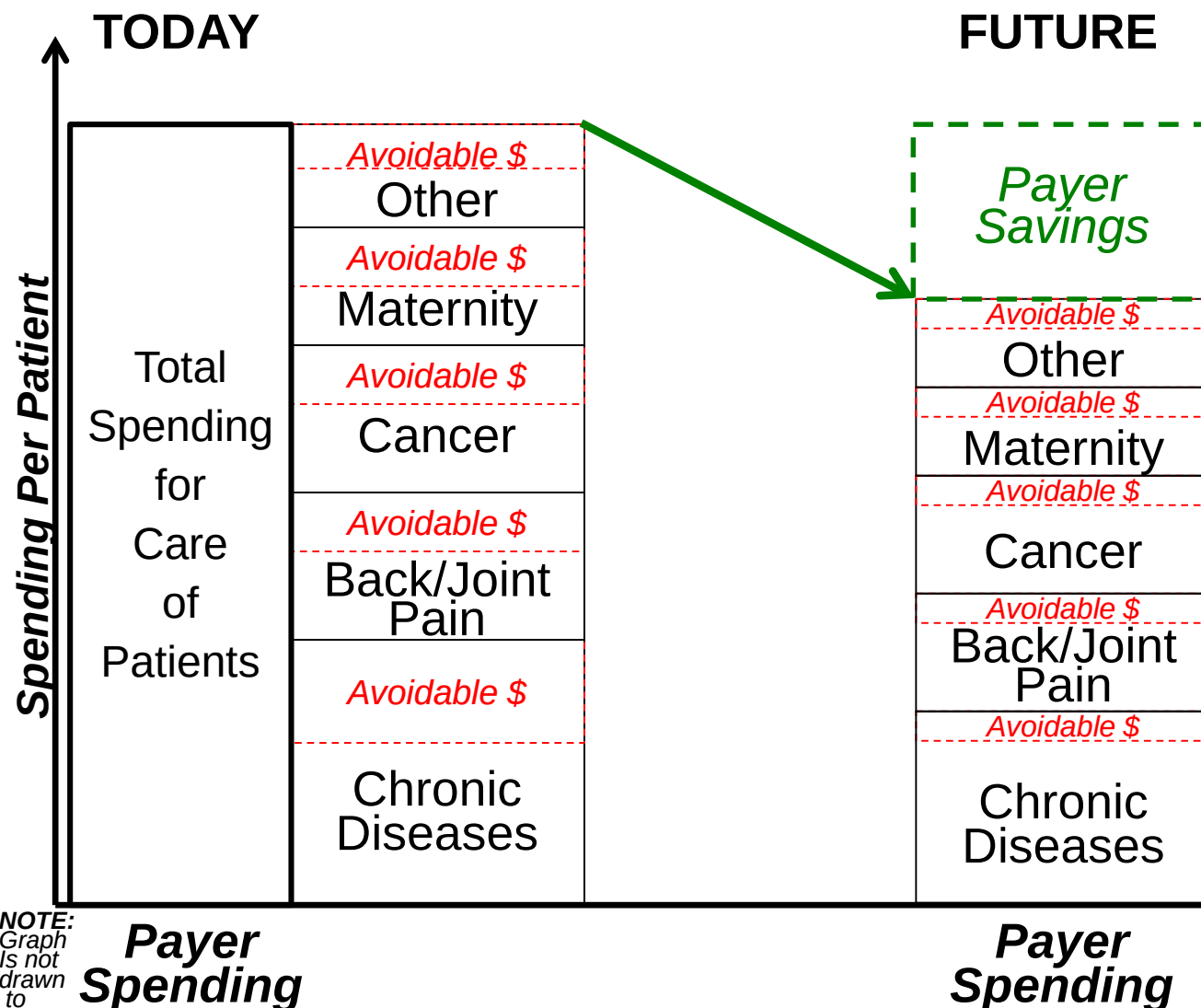
- Primary prevention
- Secondary prevention
- Tertiary prevention

FRAUD Total excess = \$75 B*

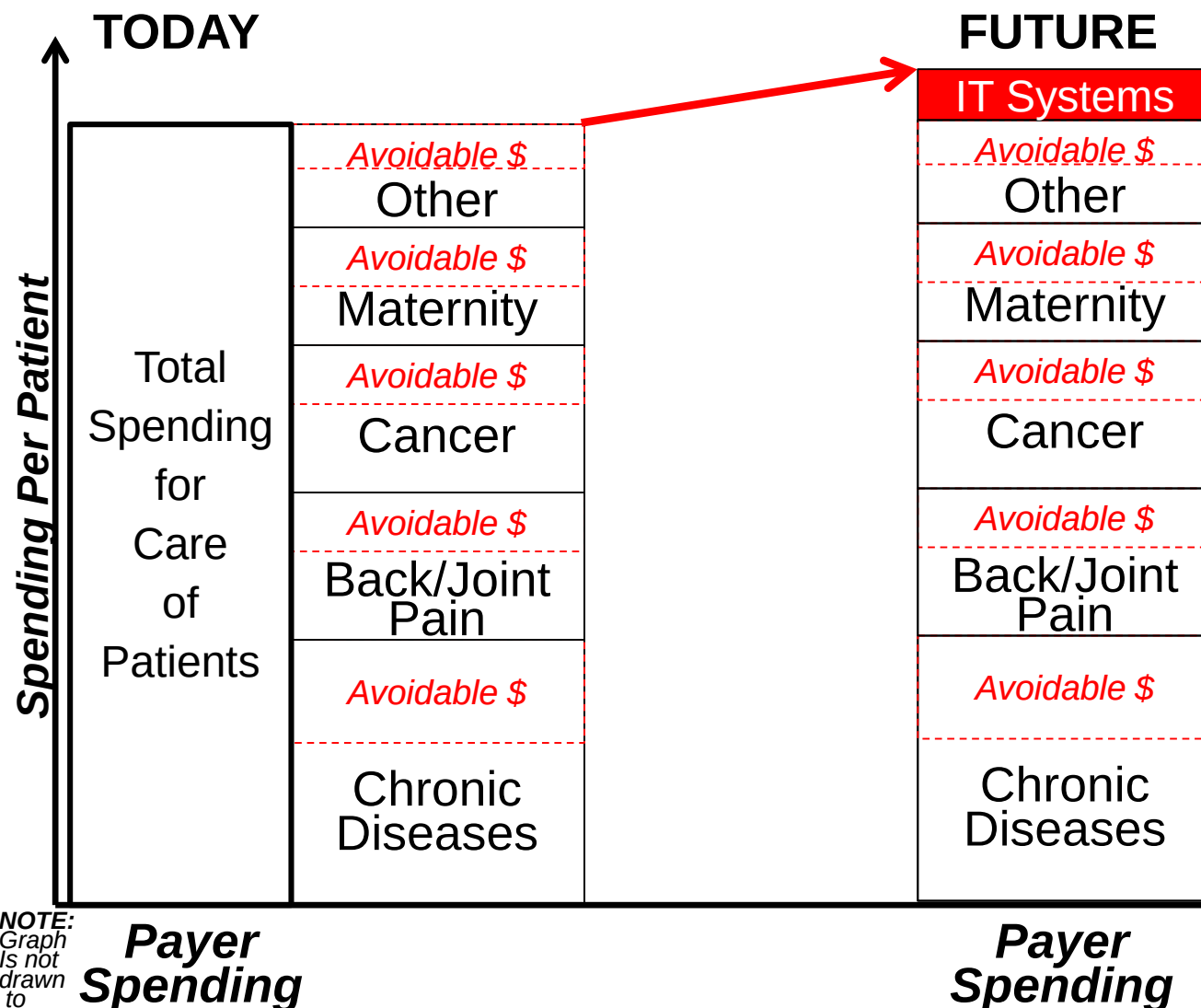
- All sources—payer, clinician, patient

*Lower bound totals of various estimates, adjusted to 2009 total expenditure level.

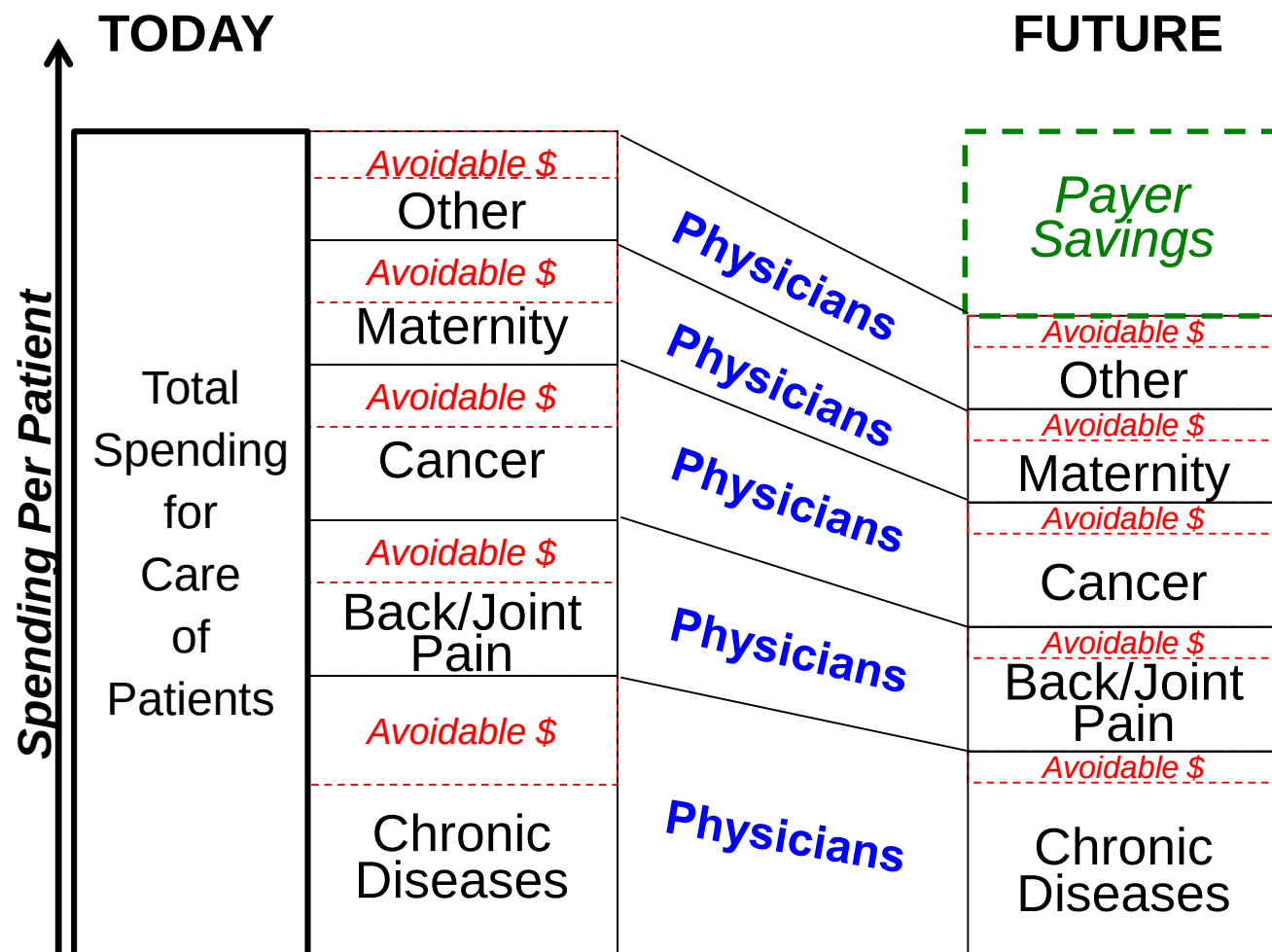
How Do You *Reduce* Avoidable Spending?



Information Technology Does Not Change Care Delivery



Only *Physicians* Know How to Change *Care* to Reduce Costs

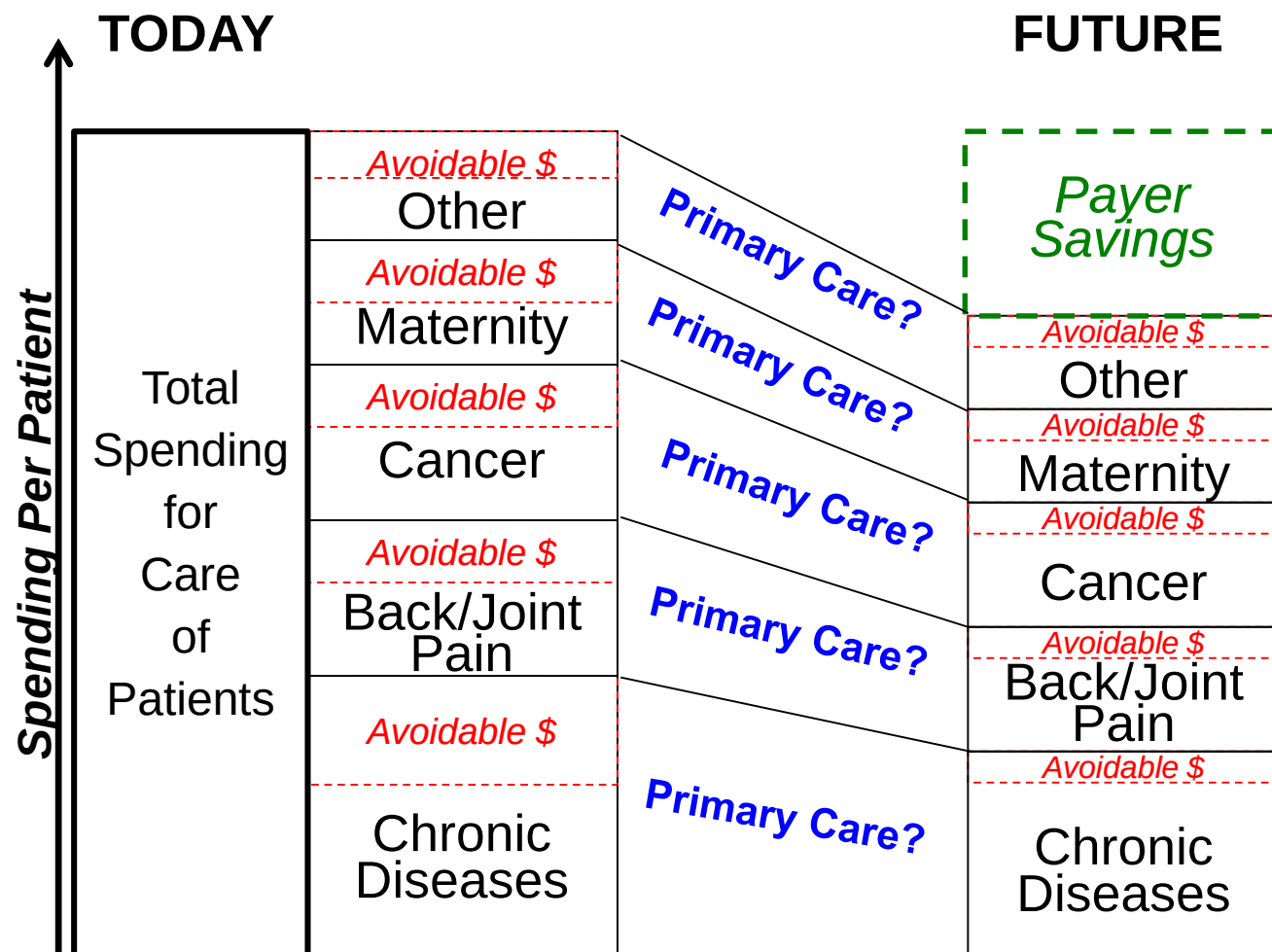


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**Payer
Spending**

**Payer
Spending**

Strong Primary Care is Essential, But PCPs Can't Do It Alone

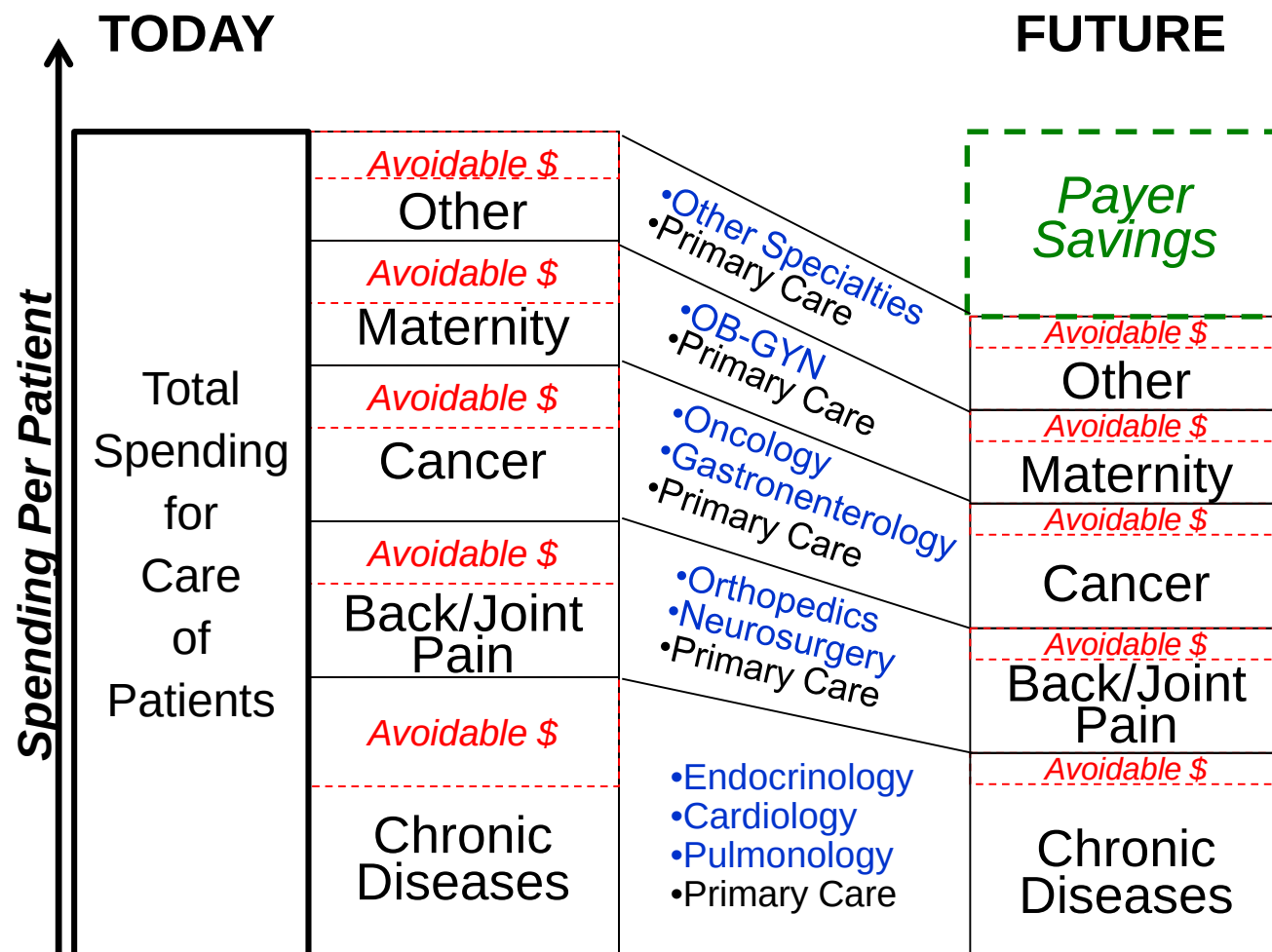


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**Payer
Spending**

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Spending**

Specialists Must Also Be Included



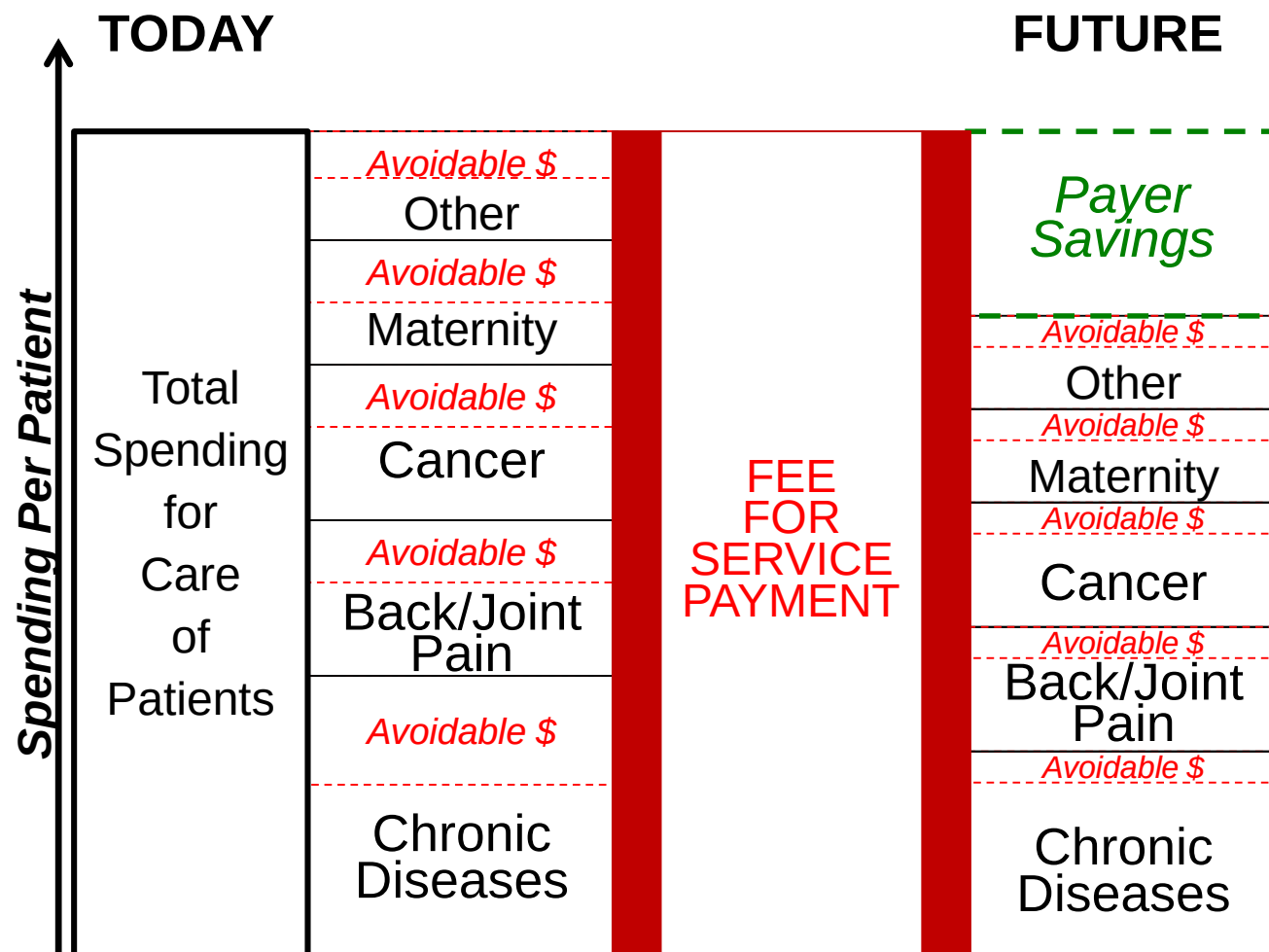
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**Payer
Spending**

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Spending**

What's the Barrier?

The Current Payment System

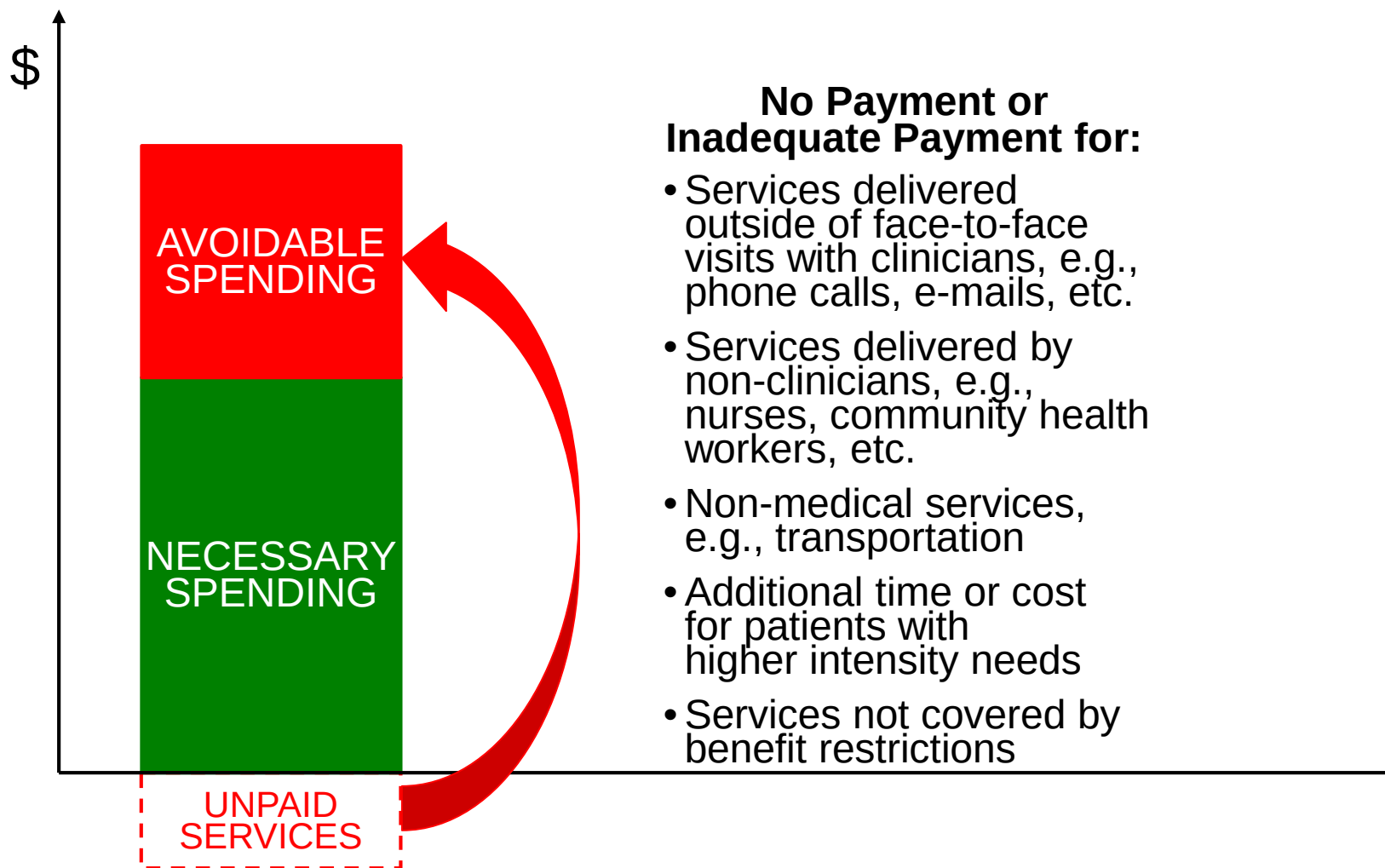


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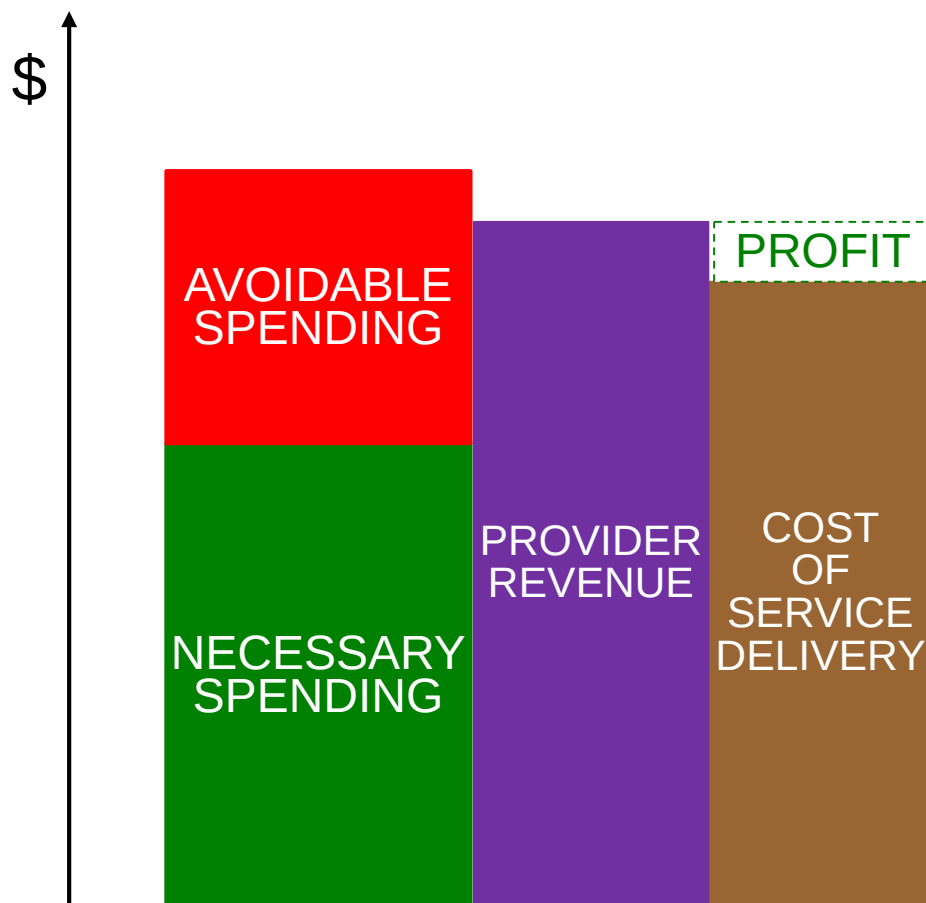
**Payer
Spending**

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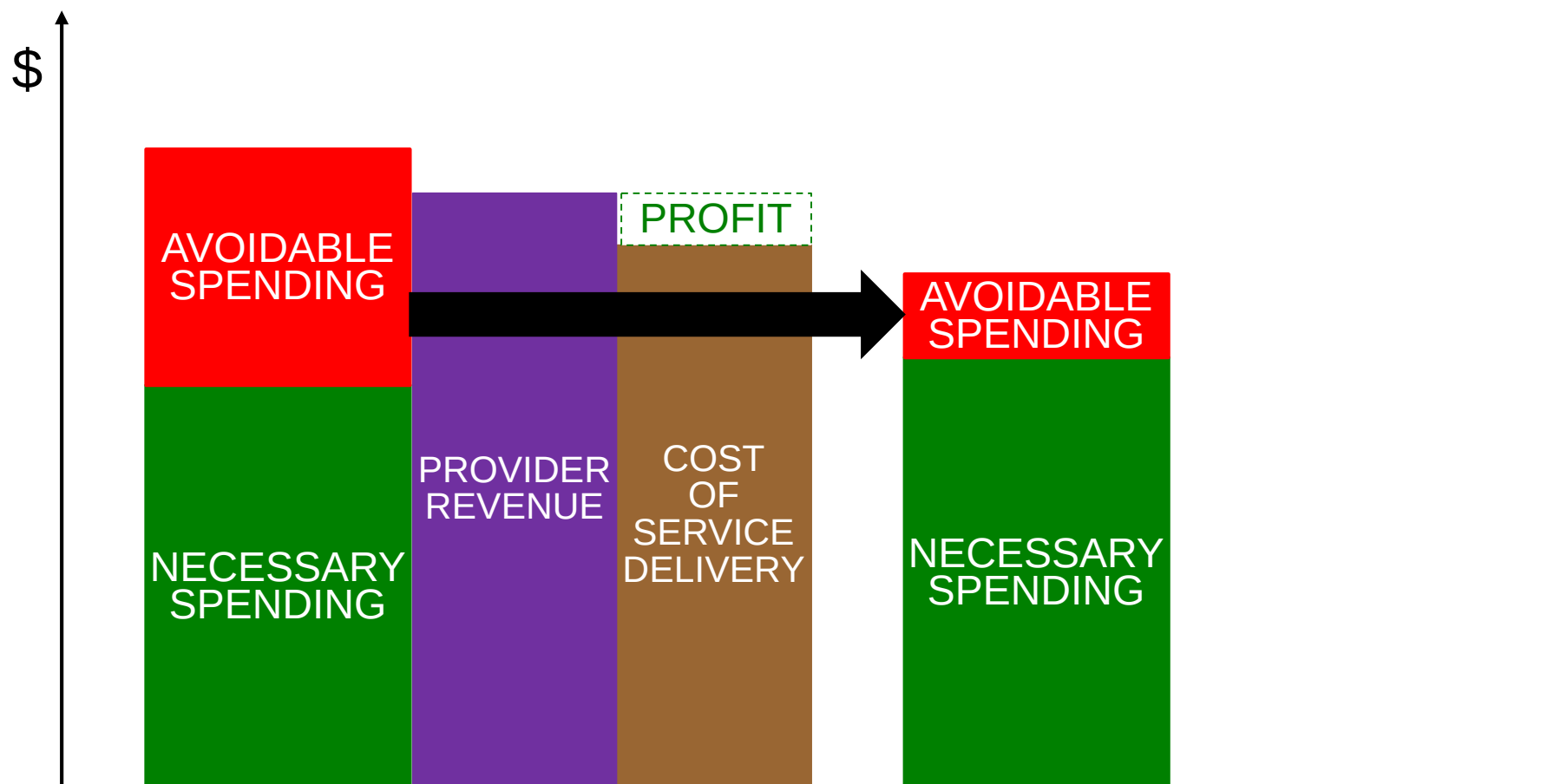
Barrier #1: No \$ or Inadequate \$ for High-Value Services



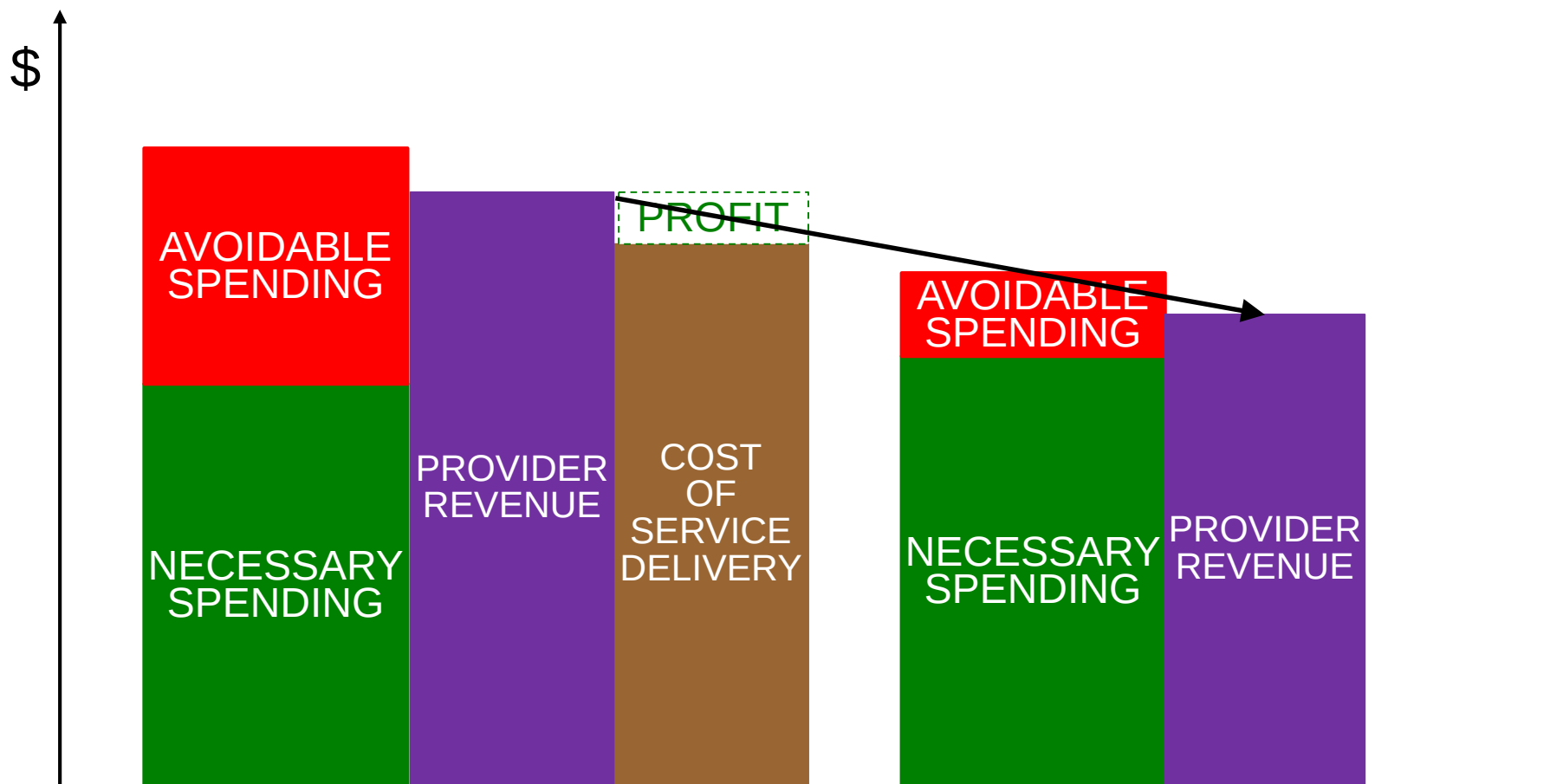
Barrier #2: Avoidable Spending Is Usually *Revenue* for Providers...



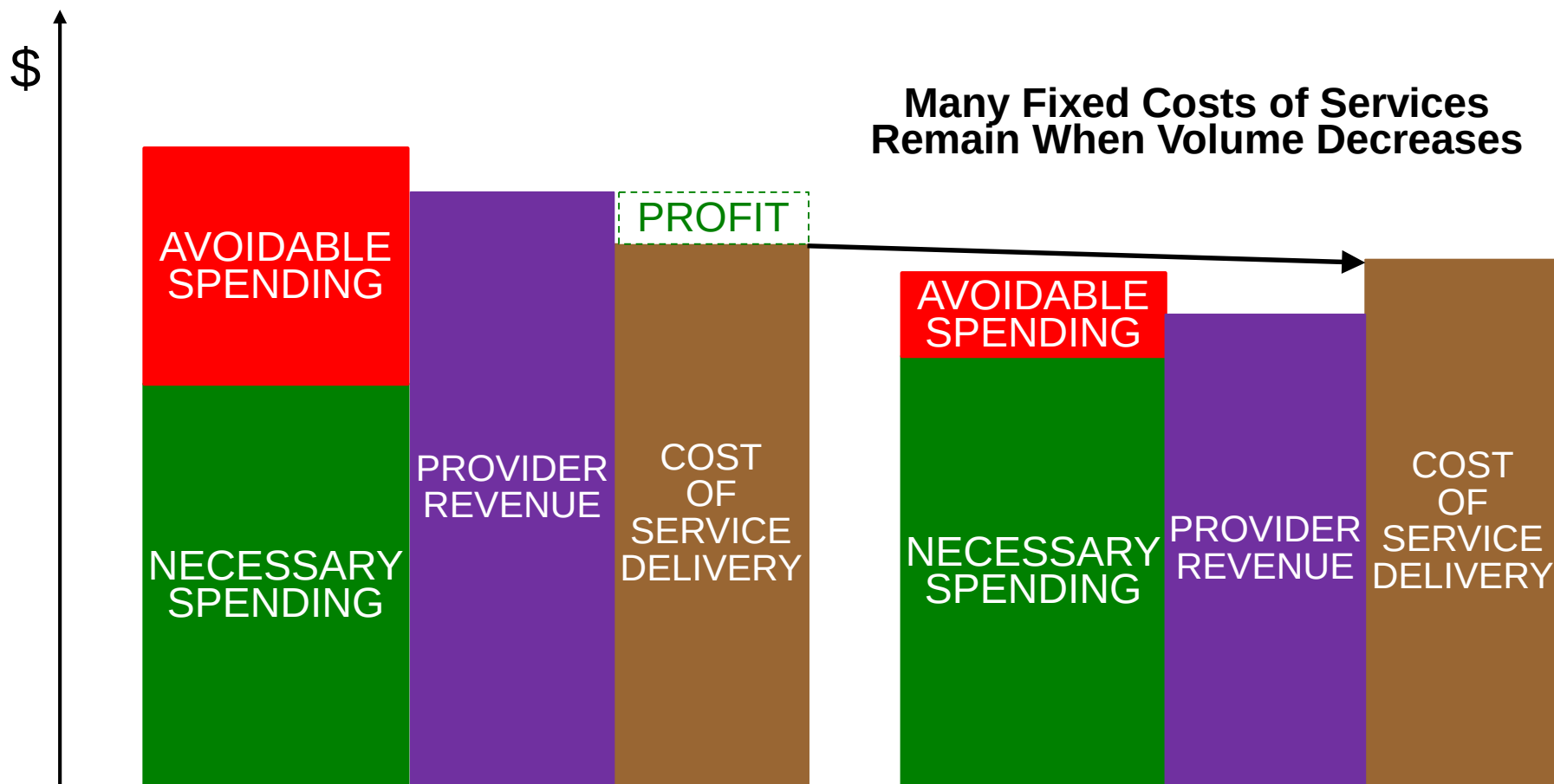
...And When Avoidable Services Aren't Delivered...



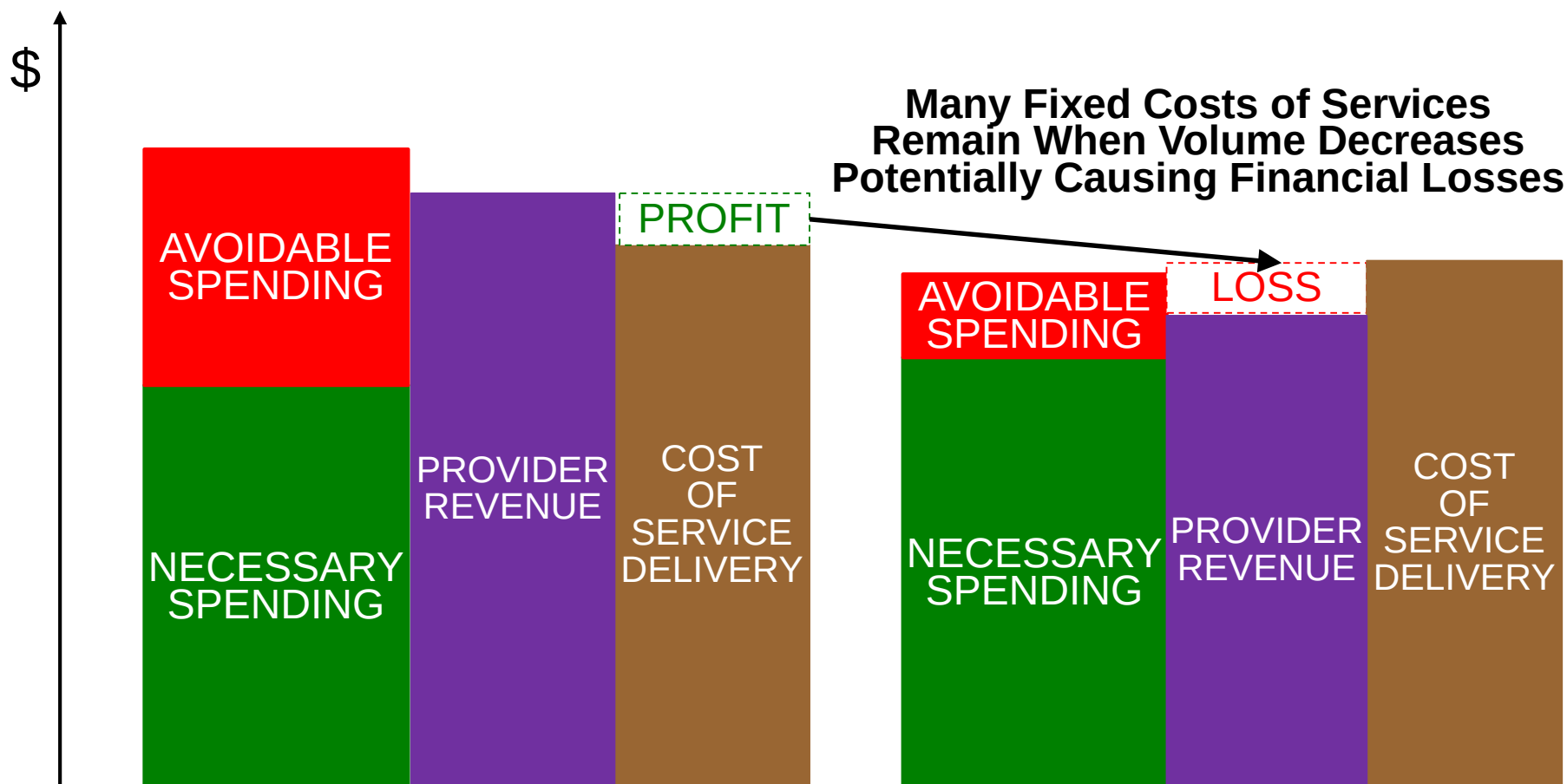
...Providers' Revenue May Decrease...



...But Providers' Fixed Costs Don't Disappear...

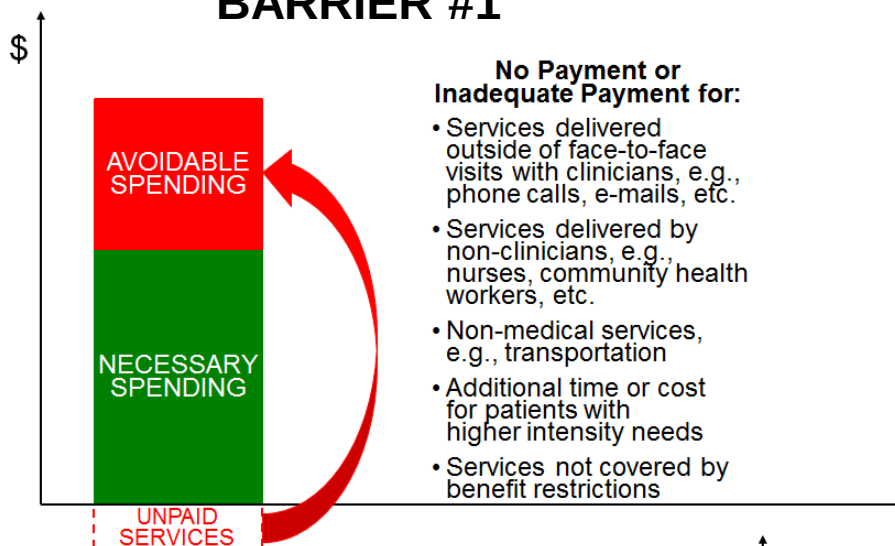


...Leaving Providers Unable to Sustain the *Necessary* Services

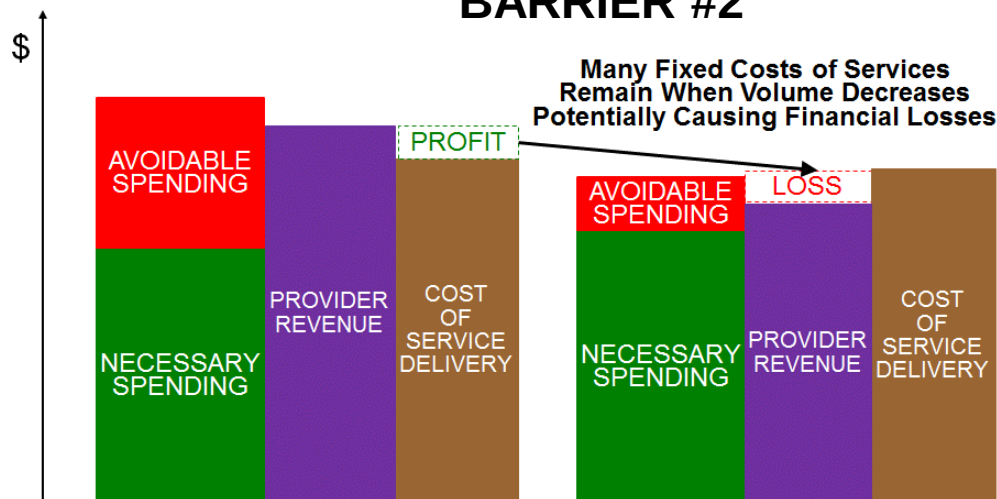


A Payment *Change* isn't *Reform* Unless It *Removes the Barriers*

BARRIER #1



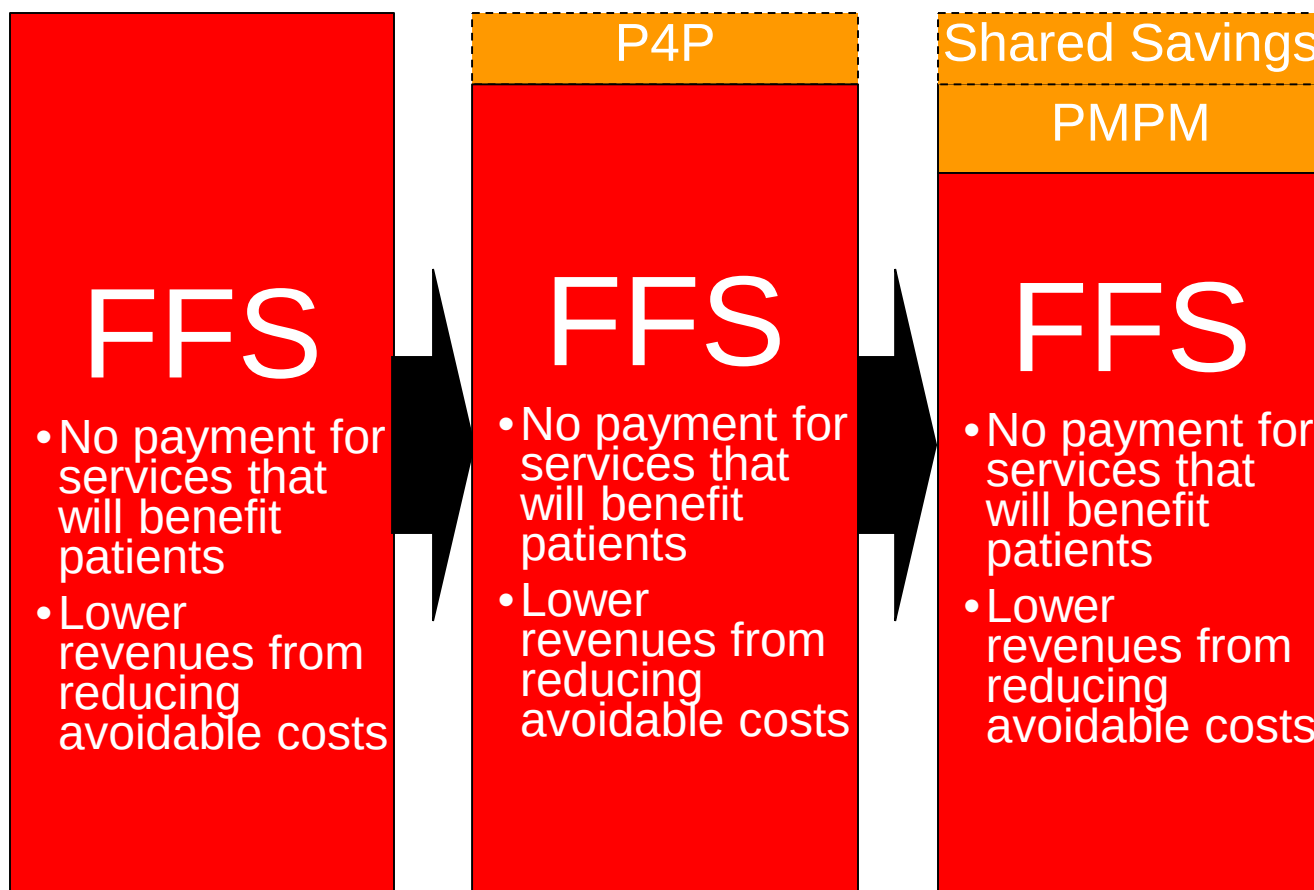
BARRIER #2



Most “Payment Reforms” Today Don’t Remove the Barriers

“Value-Based Purchasing”

“APMs Built on FFS Architecture”



Instead of Band-aids on a Broken System, We Need *True* Reforms

“Value-Based Purchasing”

“APMs Built on FFS Architecture”

Alternative Payment Models



Condition-Based Payment

- No loss in margins for fewer tests, procedures, hospital admits

Bundles/Warranties

- Paying for teams of providers
- Paying more for quality care, not for complications

Accountable Medical Home

- Flexible payments to PCPs not tied to office visits

Win-Win-Wins Possible Through True Payment Reforms

Alternative Payment Models

**BETTER CARE
FOR PATIENTS**

+

**SAVINGS
FOR
PURCHASERS**

+

**HIGHER MARGINS
FOR PROVIDERS**

Condition-Based Payment

- No loss in margins for fewer tests, procedures, hospital admits

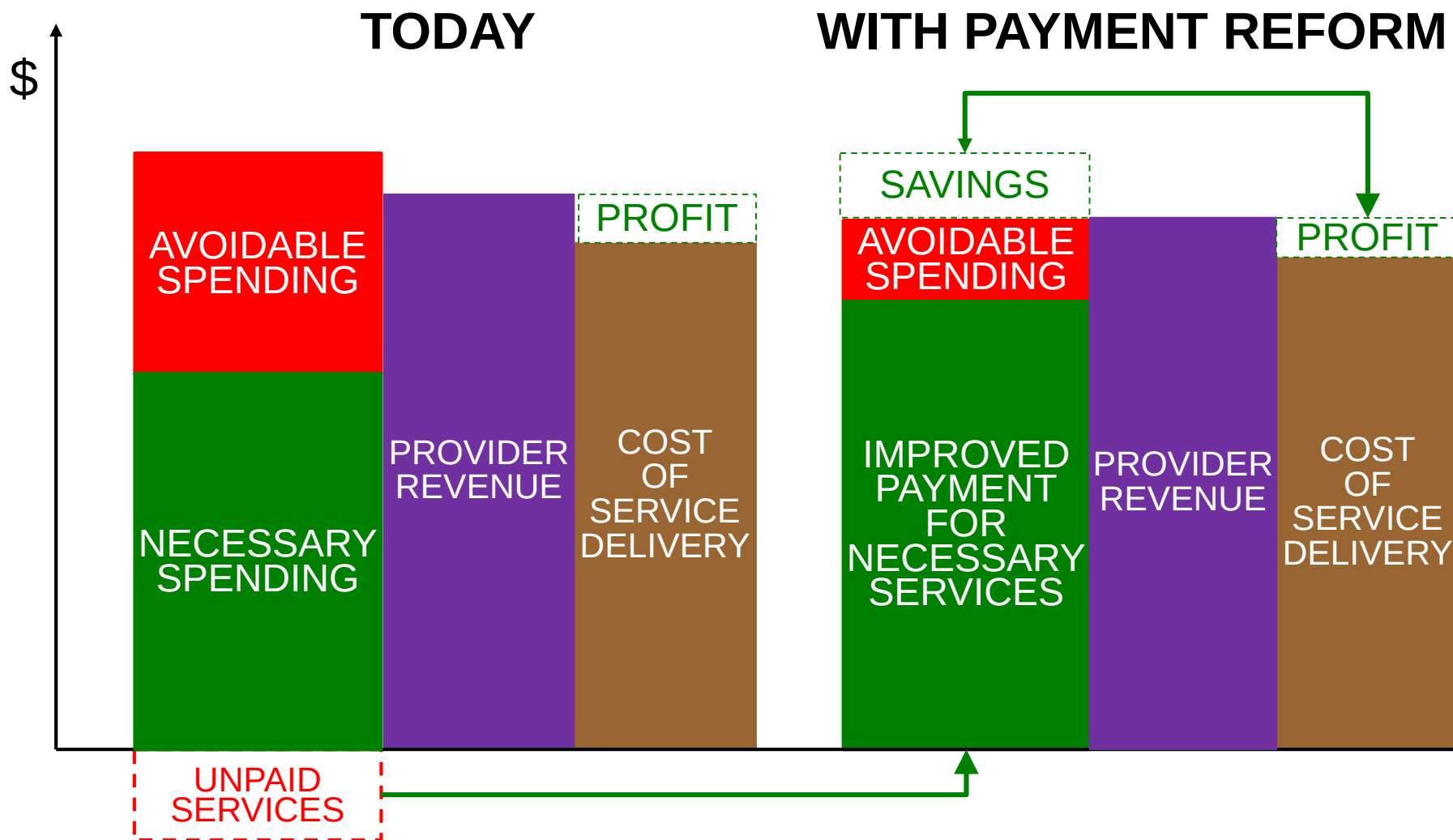
Bundles/ Warranties

- Paying for teams of providers
- Paying more for quality care, not for complications

Accountable Medical Home

- Flexible payments to PCPs not tied to office visits

True Payment Reforms Remove the Barriers to Improvement



Many Specialties Developing Better Payment Models

	<i>Opportunities to Improve Care and Reduce Cost</i>	<i>Barriers in Current Payment System</i>	<i>Solutions via Accountable Payment Models</i>
Cardiology	• Use less invasive procedures when appropriate • Reduce exacerbations of heart failure	• Payment is based on procedure is used, not the outcome • No payment for patient education & care mgt	• Condition-based payment for stable angina • Condition-based payment for HF
Orthopedic Surgery	• Reduce infections and complications of surgery • Use non-surgical care instead of surgery	• No support for shared decision-making • Lack of resources for good home-based care, patient education	• Bundled and warranted payment for surgery • Condition-based payment for arthritis
Neurology	• Avoid unnecessary hospitalizations for epilepsy patients • Reduce strokes and heart attacks after TIA	• No flexibility to spend more on preventive care • No payment for patient education & care mgt	• Condition-based payment for epilepsy • Episode or condition-based payment for TIA
OB/GYN	• Reduce use of elective C-sections • Reduce early deliveries and use of NICU	• Similar/lower payment for vaginal deliveries	• Condition-based payment for total cost of delivery in low-risk pregnancy

Other Examples of Specialty-Specific Payment Models

	<i>Opportunities to Improve Care and Reduce Cost</i>	<i>Barriers in Current Payment System</i>	<i>Solutions via Accountable Payment Models</i>
Psychiatry	• Reduce ER visits and admissions for patients with depression and chronic disease	• No payment for phone consults with PCPs • No payment for RN care managers	• Joint condition-based payment to PCP and psychiatrist
Gastroenterology	• Reduce unnecessary colonoscopies and colon cancer • Reduce ER/admits for inflammatory bowel d.	• No flexibility to focus extra resources on highest-risk patients • No flexibility to spend more on care mgt	• Population-based payment for colon cancer screening • Condition-based pmt for IBD
Oncology	• Reduce ER visits and admissions for dehydration • Reduce overuse of tests and drugs	• No payment for care management services • Inadequate payment for diagnosis and treatment planning	• Payment for care management svcs • Accountability for hospital admissions & use of guidelines
Primary Care	• Reduce avoidable hospitalizations for chronic disease pts • Reduce unnecessary tests and referrals	• No payment for nurses to work with chronic disease patients • No payment for phone consults w/ specialists	• Monthly payments for chronic care management • Payments to support PCP-specialist partnerships

Other Examples of Specialty-Specific Payment Models

**MEDICARE AND
MOST HEALTH PLANS
REFUSE TO
MAKE THE
FUNDAMENTAL
CHANGES IN THEIR
PAYMENT SYSTEMS
NEEDED TO OVERCOME
THE BARRIERS
TO BETTER CARE**



How Does This All Fit Into ACOs?

Starting With a Patient Population With Multiple Health Problems...

PATIENTS

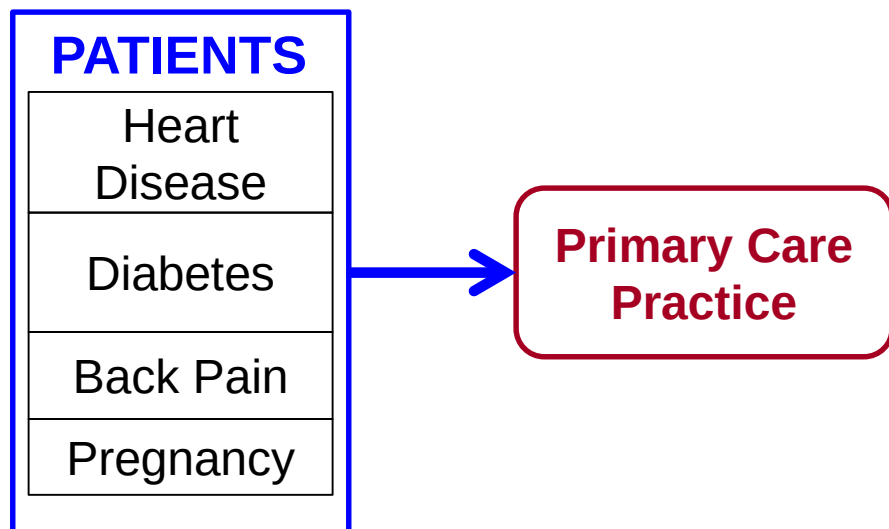
Heart
Disease

Diabetes

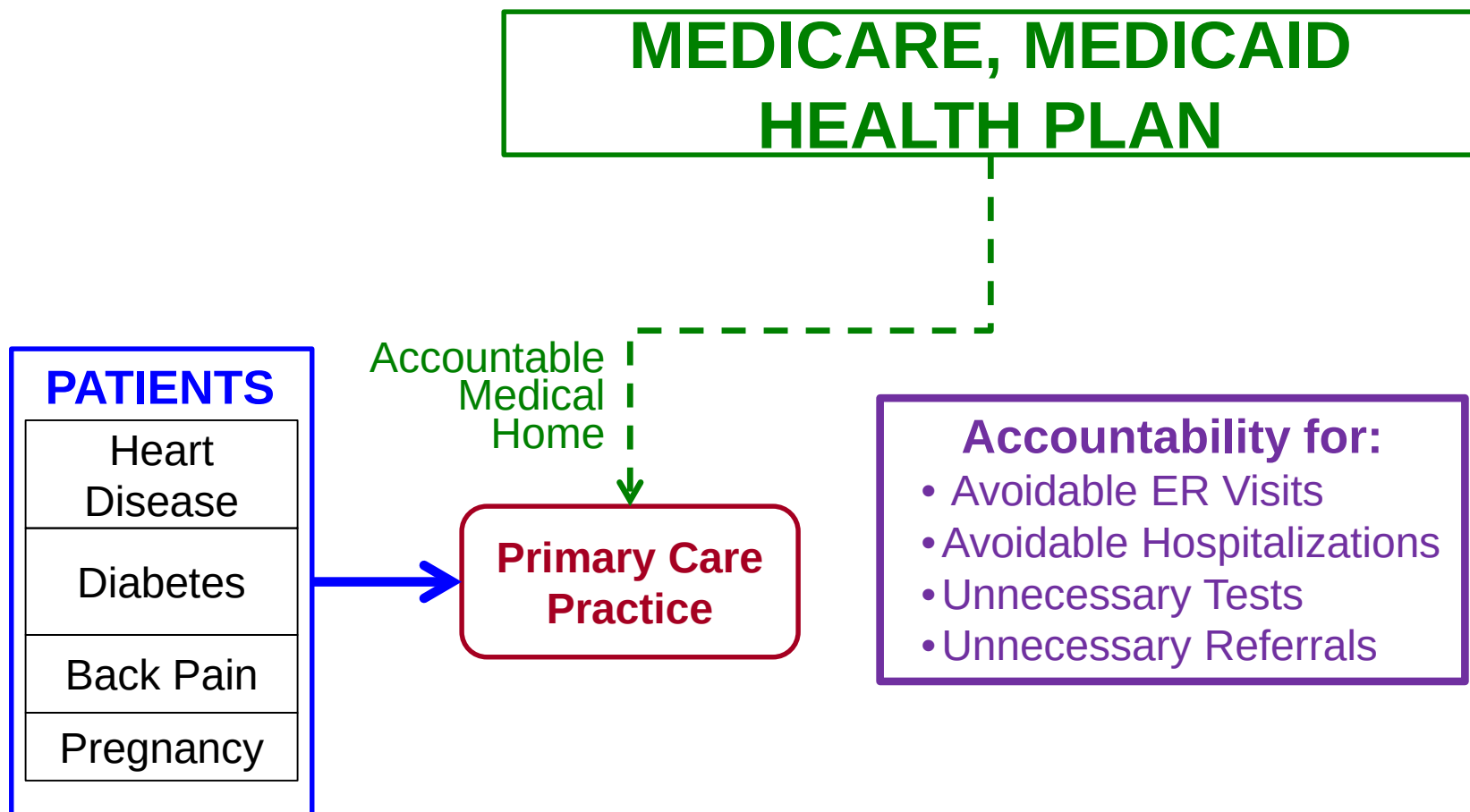
Back Pain

Pregnancy

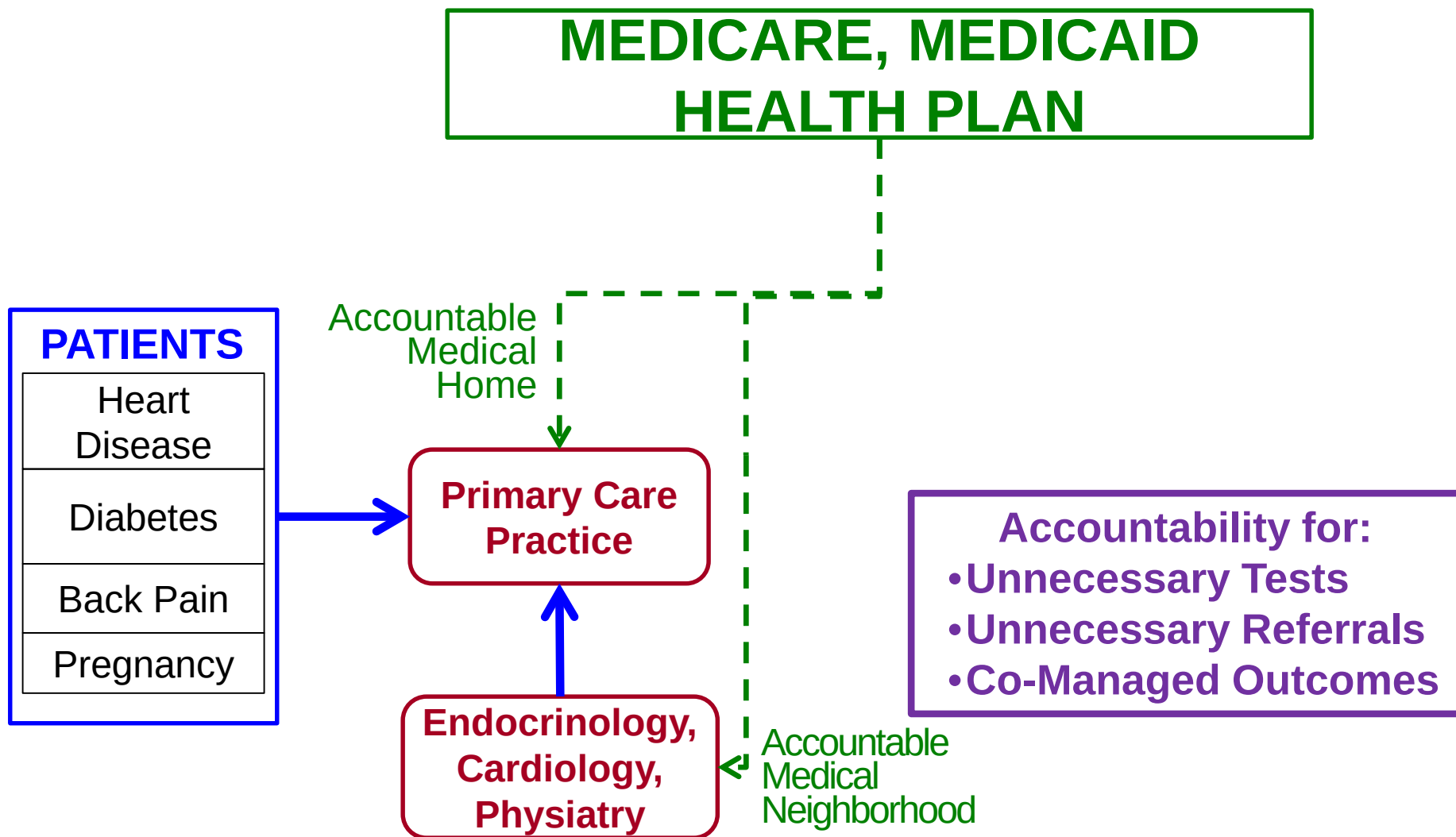
Each Patient Should Choose & Use a Primary Care Practice...



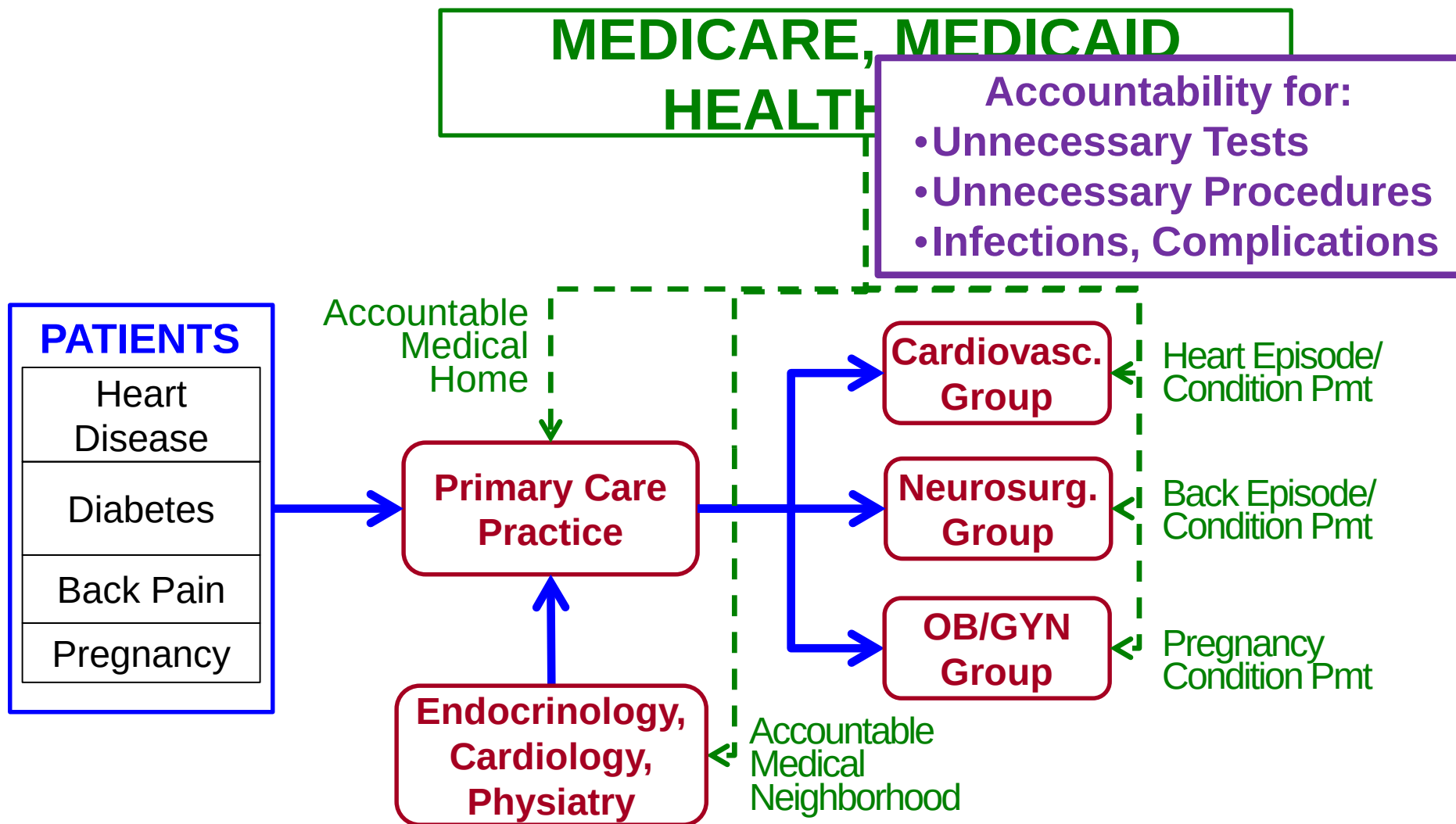
...Which Takes Accountability for What PCPs Can Control/Influence



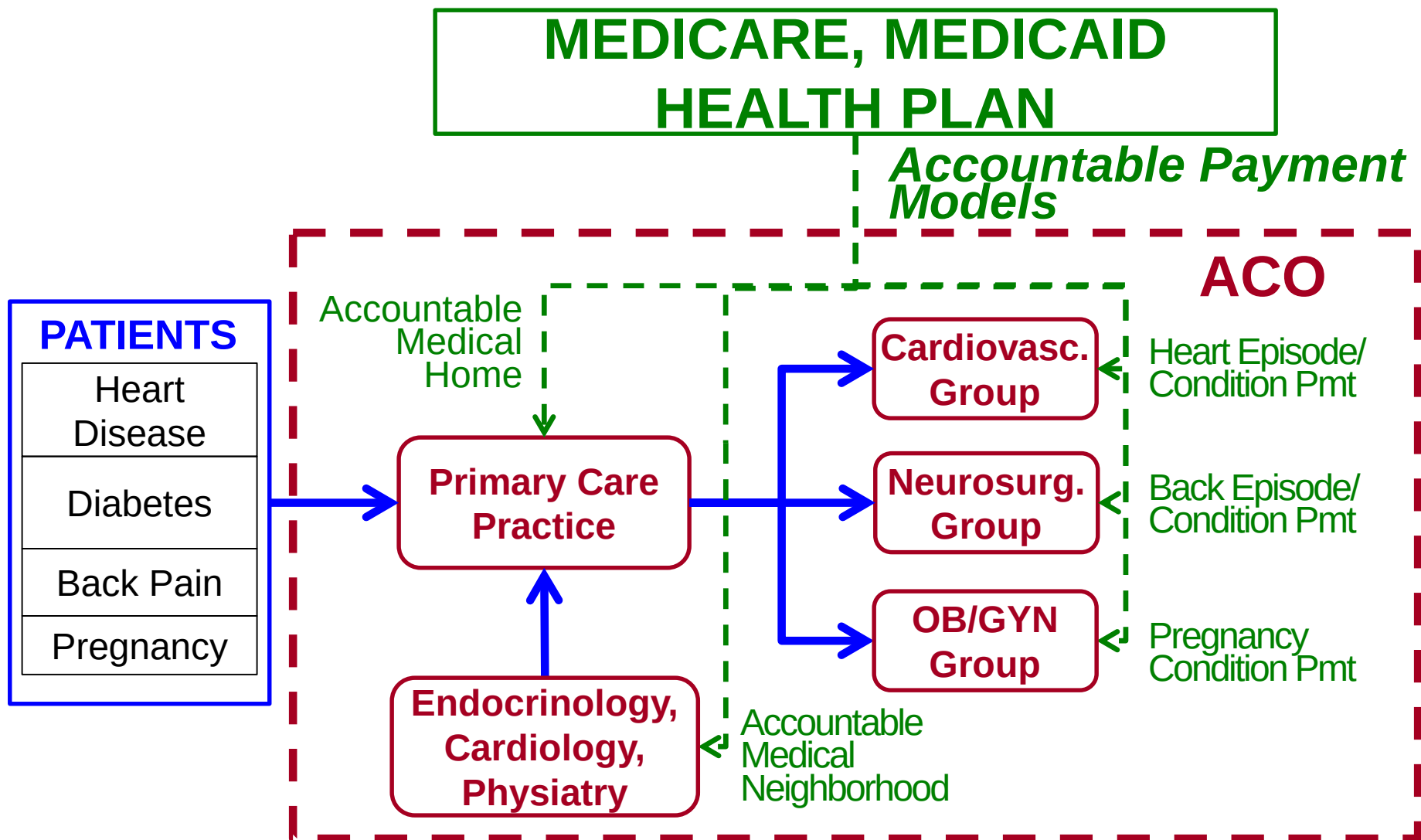
...With a Medical Neighborhood to Consult With on Complex Cases



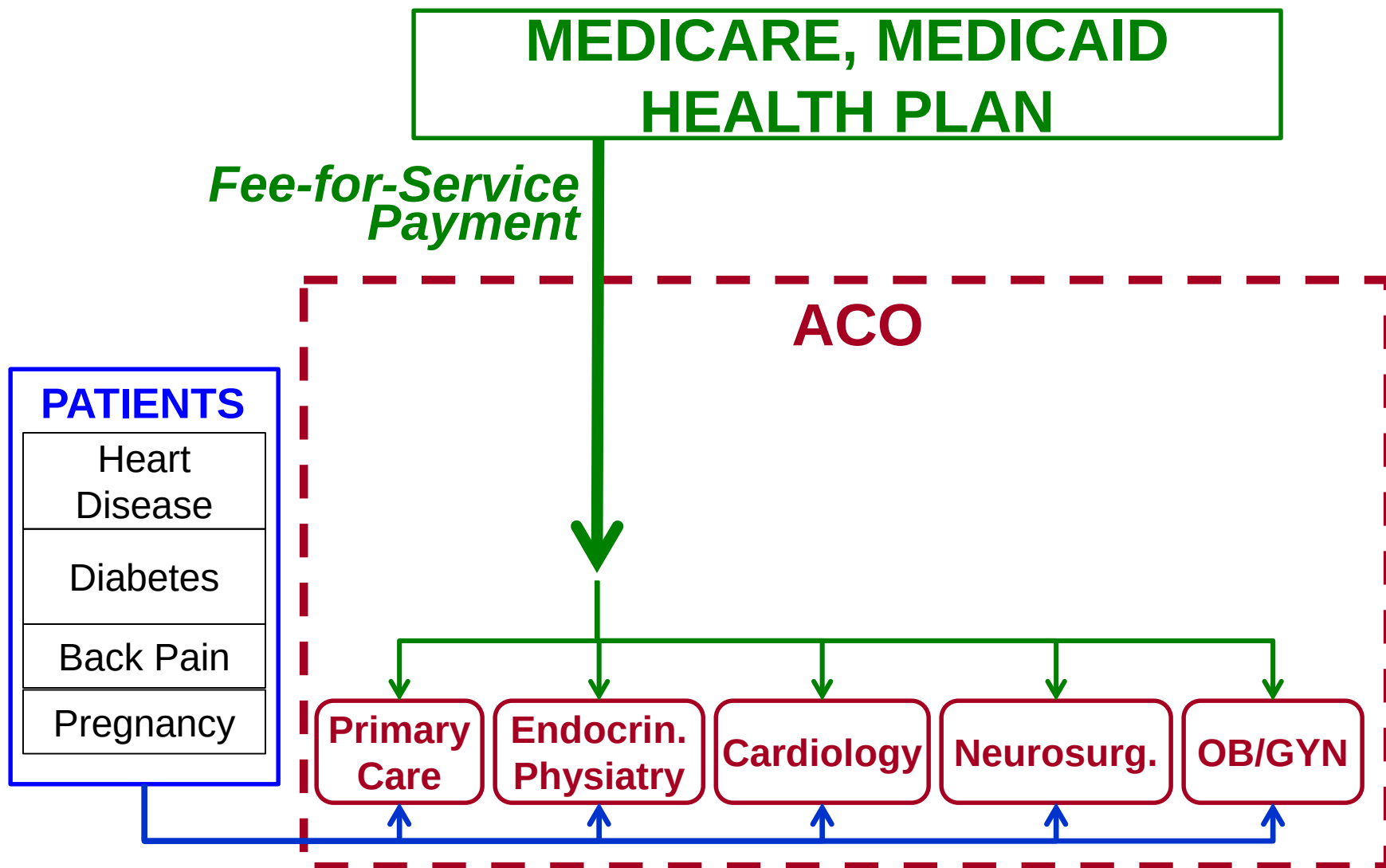
..And Specialists Accountable for the Conditions They Manage



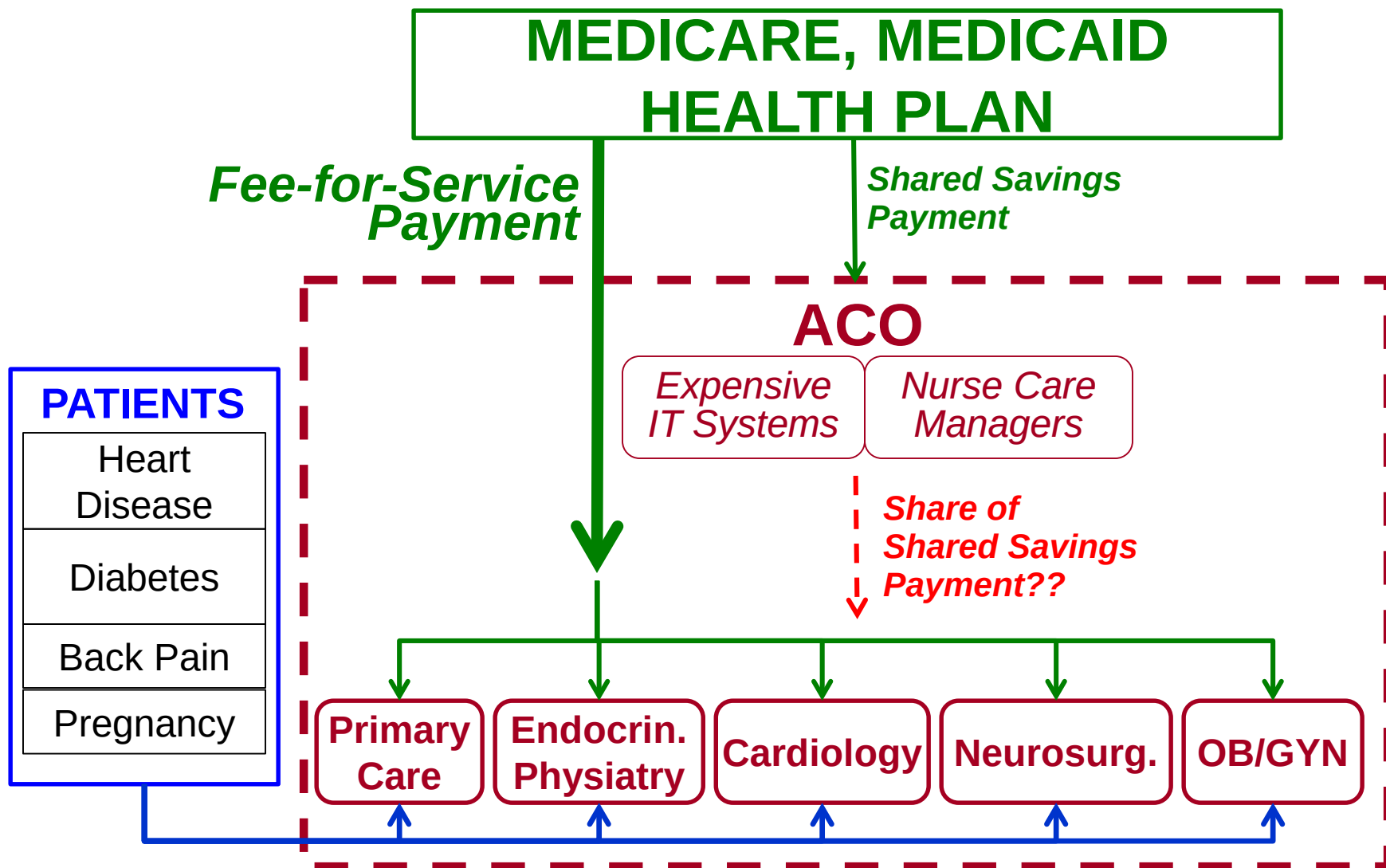
That's Building the ACO from the Bottom Up



Most ACOs Today Aren't Truly *Reinventing Care*



Most ACOs Today Aren't Truly *Reinventing Care*



Most ACOs Aren't Succeeding Due to Flaws in Payment Model

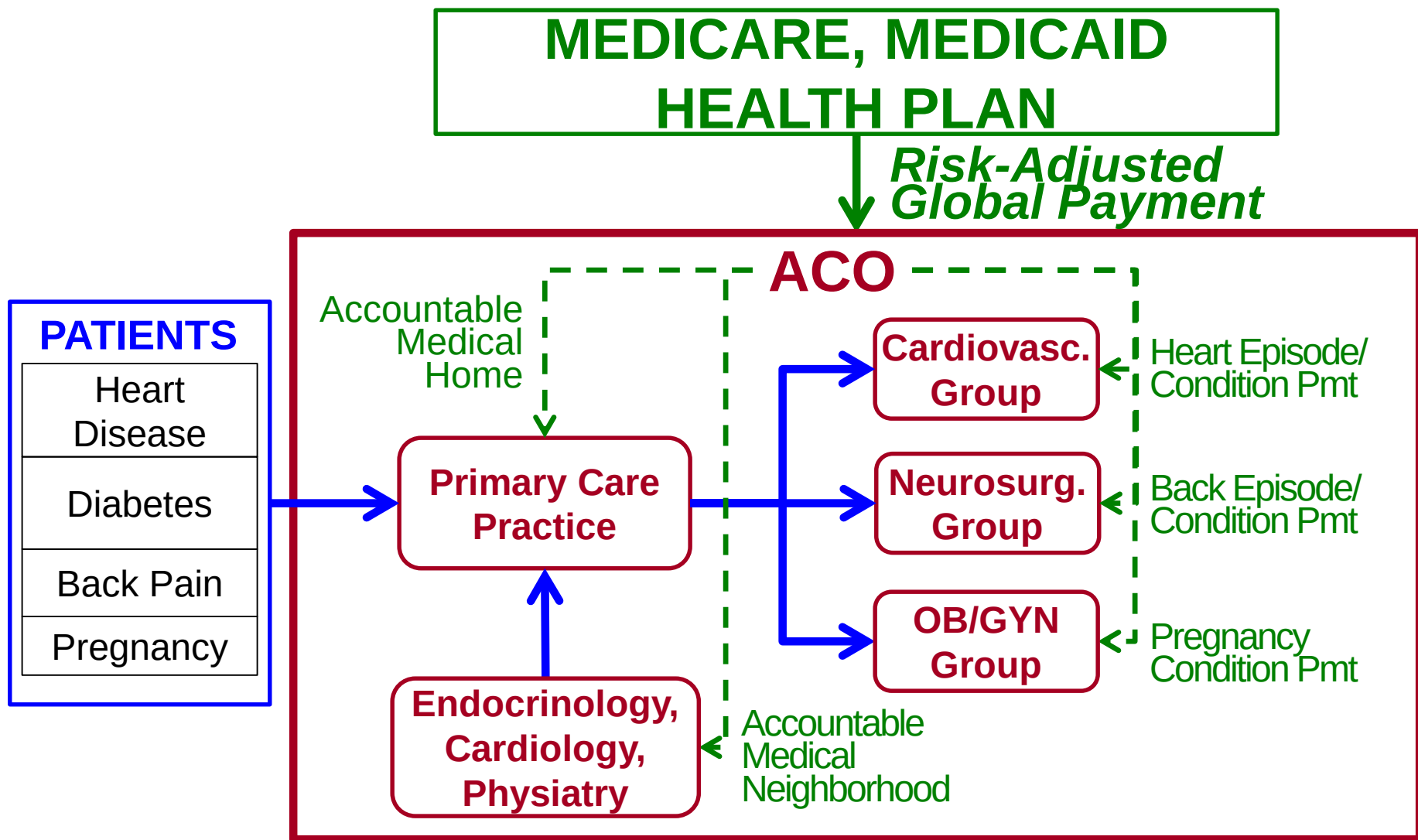
2013 Results for Medicare Shared Savings ACOs

- 46% of ACOs (102/220) *increased* Medicare spending
- Only one-fourth (52/220) received shared savings payments
- After making shared savings payments,
Medicare spent more than it saved

2014 Results for Medicare Shared Savings ACOs

- 45% of ACOs (152/333) *increased* Medicare spending
- Only one-fourth (86/333) received shared savings payments
- After making shared savings payments,
Medicare spent more than it saved

A True ACO Can Take a Global Payment And Make It Work



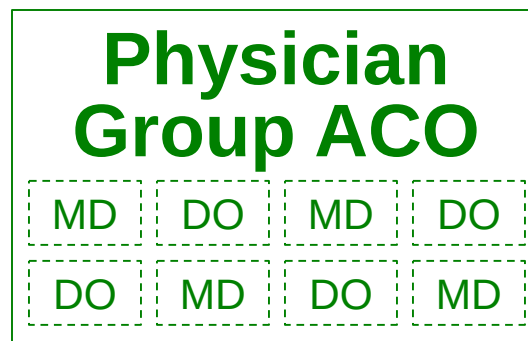
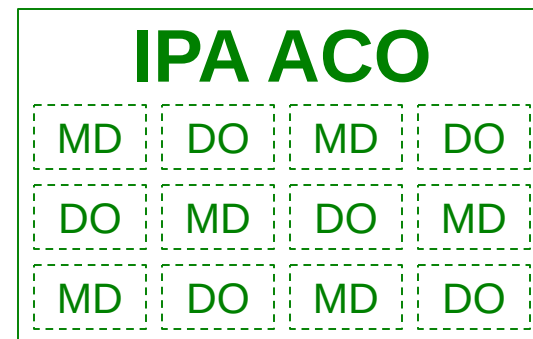
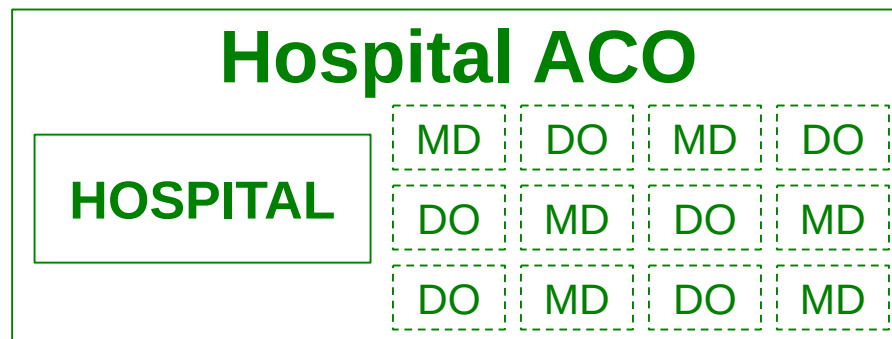
You Don't Need a Big Health System to Manage Global Payment

- Independent PCPs & Specialists Managing Global Payments
 - North Texas Specialty Physicians, a 600 physician multi-specialty IPA in Fort Worth, set up its own Medicare Advantage PPO plan and uses revenues from the health plan and capitation contracts to pay its PCPs 250% of Medicare rates and provides high quality, coordinated care to patients. www.ntspp.com
- 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

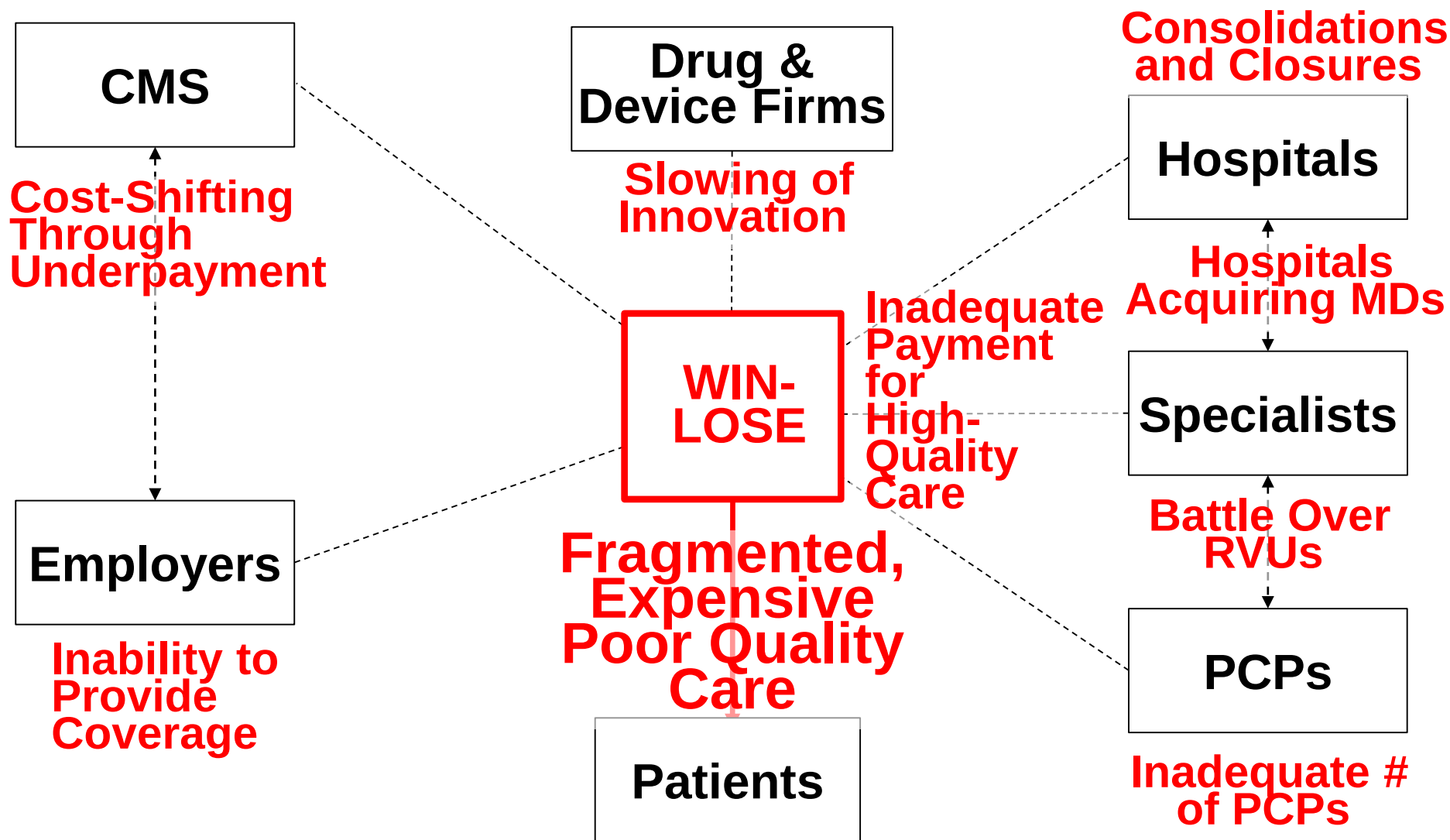
Which Is More Likely to Generate True Price Competition?



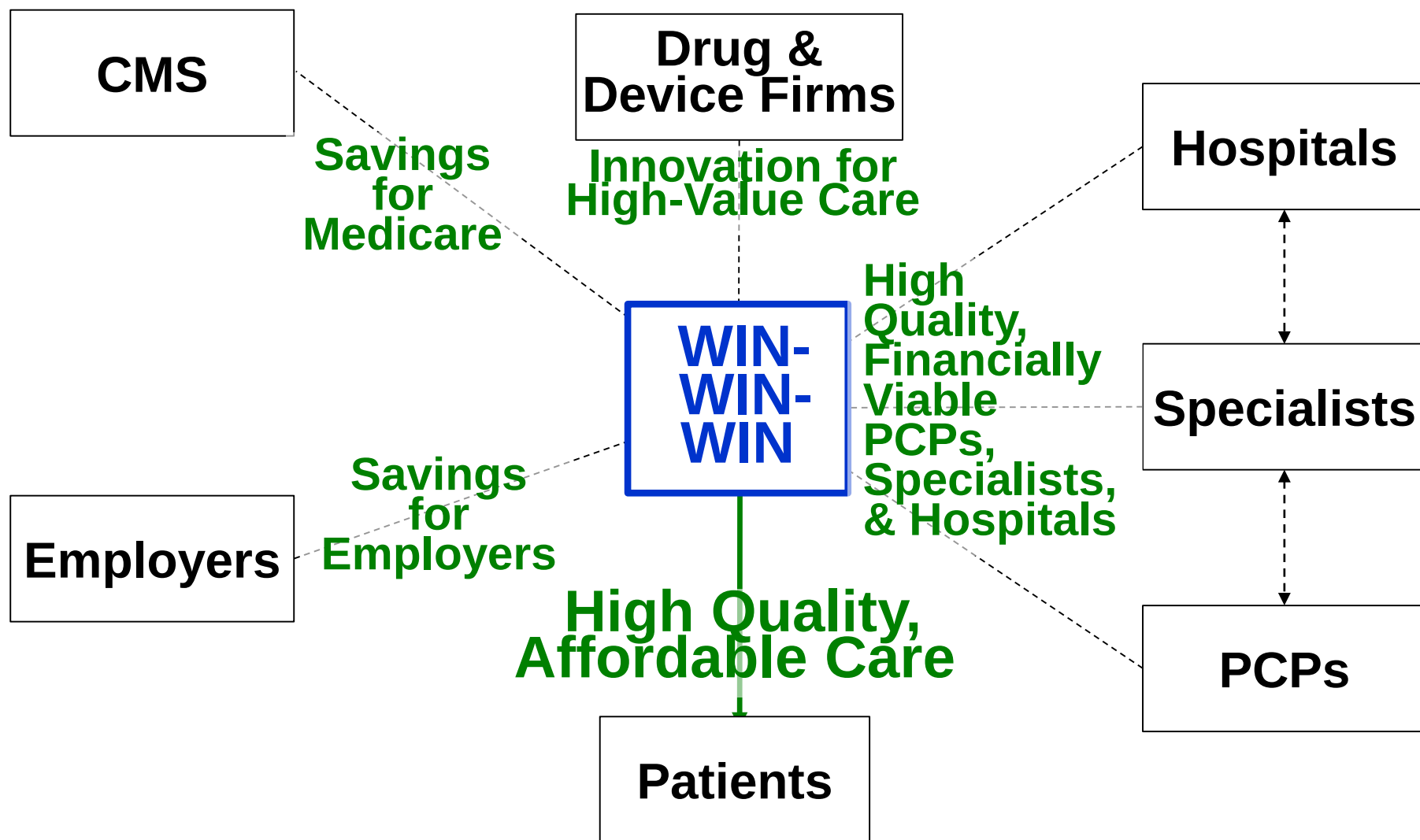
VS



What Most Communities Are Doing Will Ultimately Harm Patients...



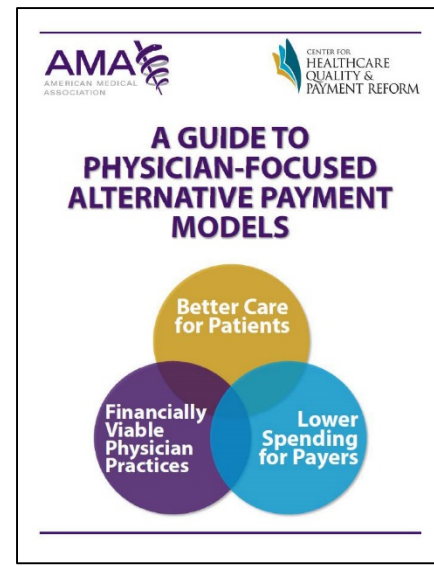
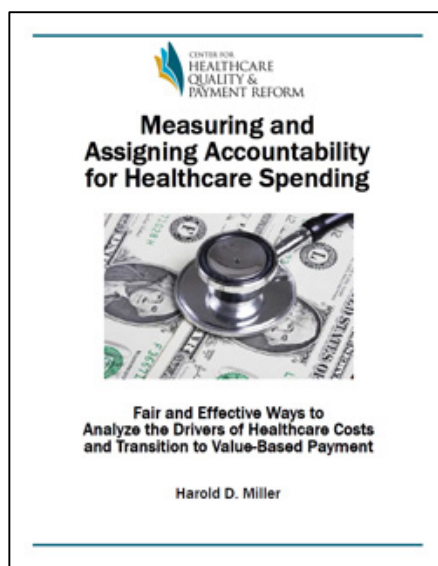
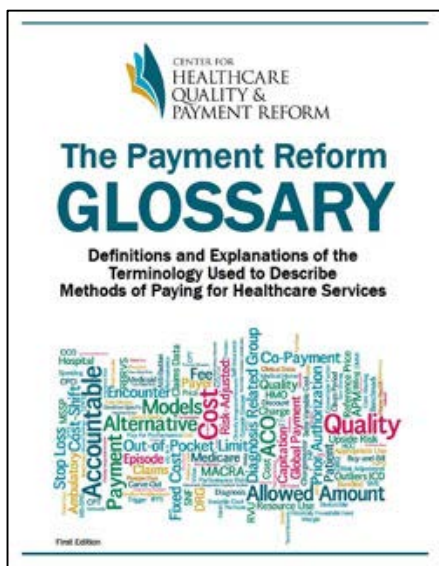
...But New Jersey Could Forge Win-Win Solutions If It Wants To



What New Jersey Could Do

- Focus on the major patient conditions that are driving most healthcare spending – chronic disease, maternity care, cancer care, orthopedics
- Work with physicians to identify the avoidable spending and the barriers that exist in the current payment system
- Create a neutral forum where all of the key stakeholders – patients, purchasers, PCPs, specialists, hospitals, and payers – can work together to develop win-win-win approaches
- Use the state's purchasing power – for its employees and Medicaid – to implement the solutions and encourage other purchasers to join

Learn More About Win-Win-Win Payment and Delivery Reform



www.PaymentReform.org



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