

# **MOVING TO ACCOUNTABLE CARE: Better Ways to Pay For and Deliver Health Care**

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# What is an “Accountable Care Organization?”

# The Official Definition

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What is an  
“Accountable Care Organization?”

A group of providers who are  
“accountable for the quality,  
cost, and overall care” of patients

Section 3022, Patient Protection and Affordable Care Act

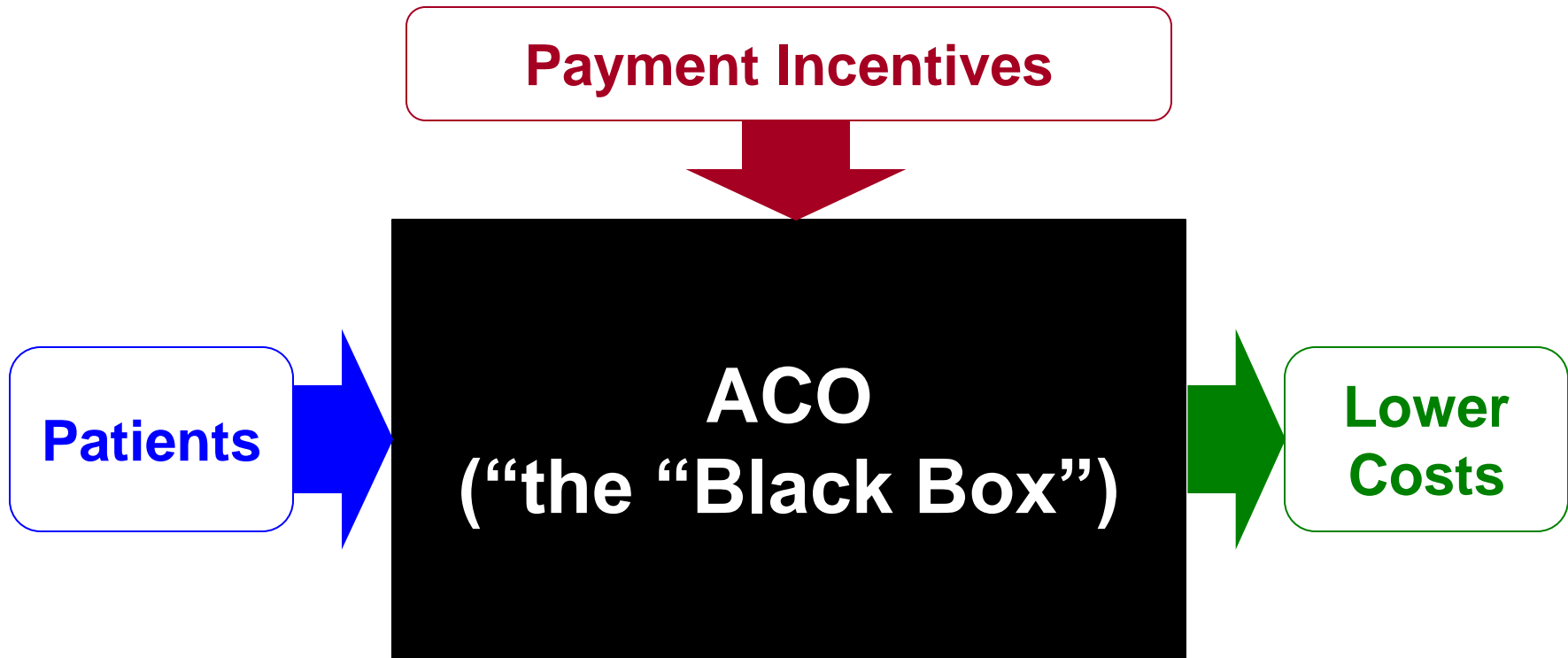
# The Real Definition

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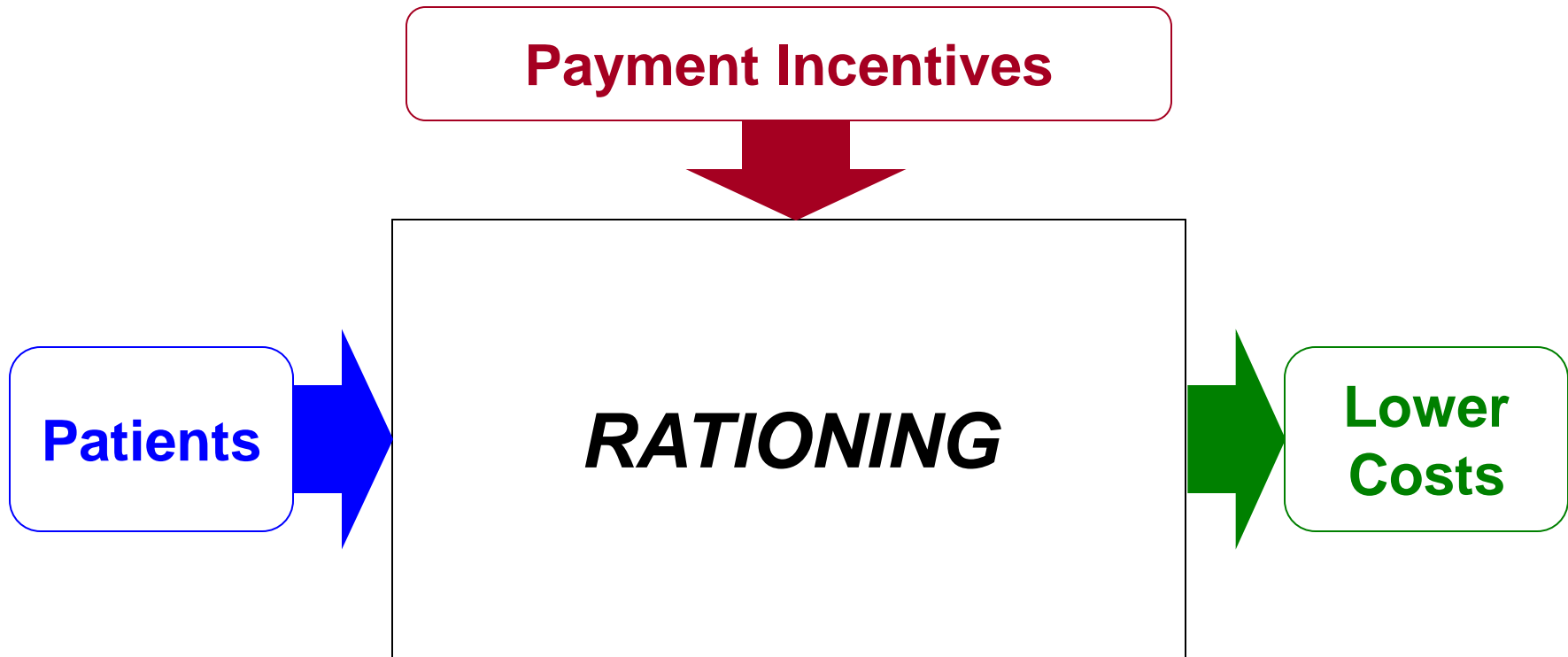
What is an  
“Accountable Care Organization?”

*A group of providers  
who can figure  
out how to save money  
in health care*

# How Will ACOs Generate All These Savings?



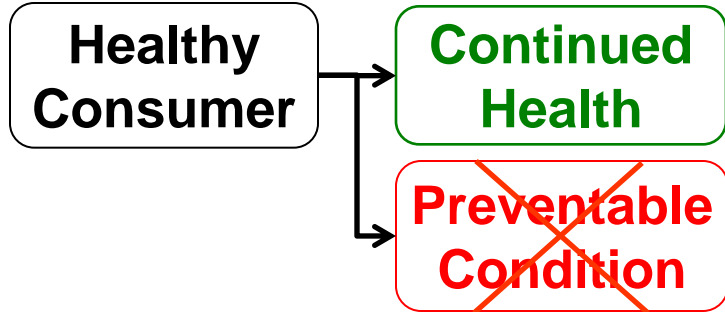
# What's In That Black Box Can't Be Good For Consumers, Can It?



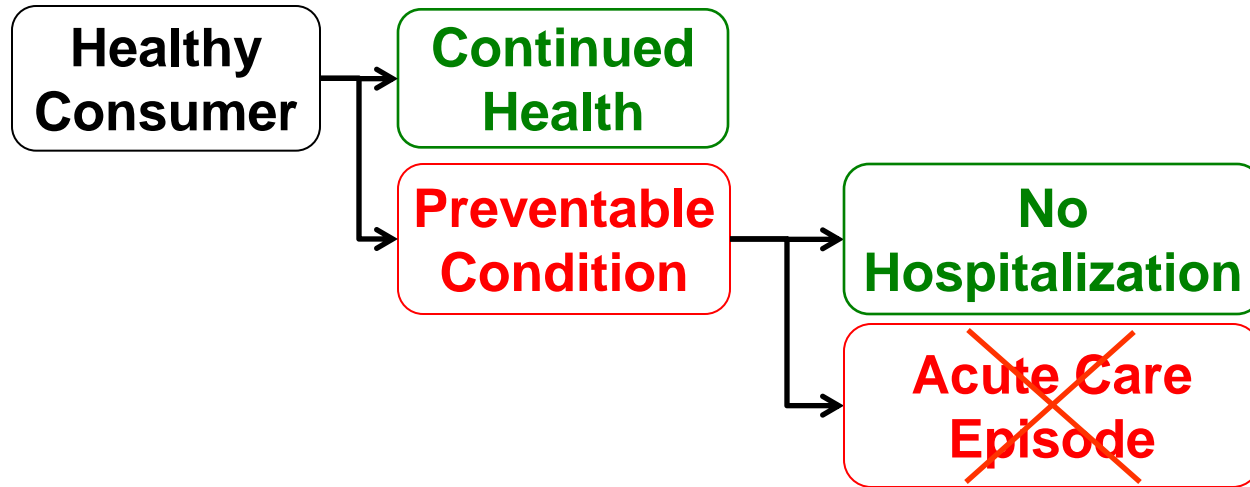
# Early Successes Need to Assure That Savings $\neq$ Rationing



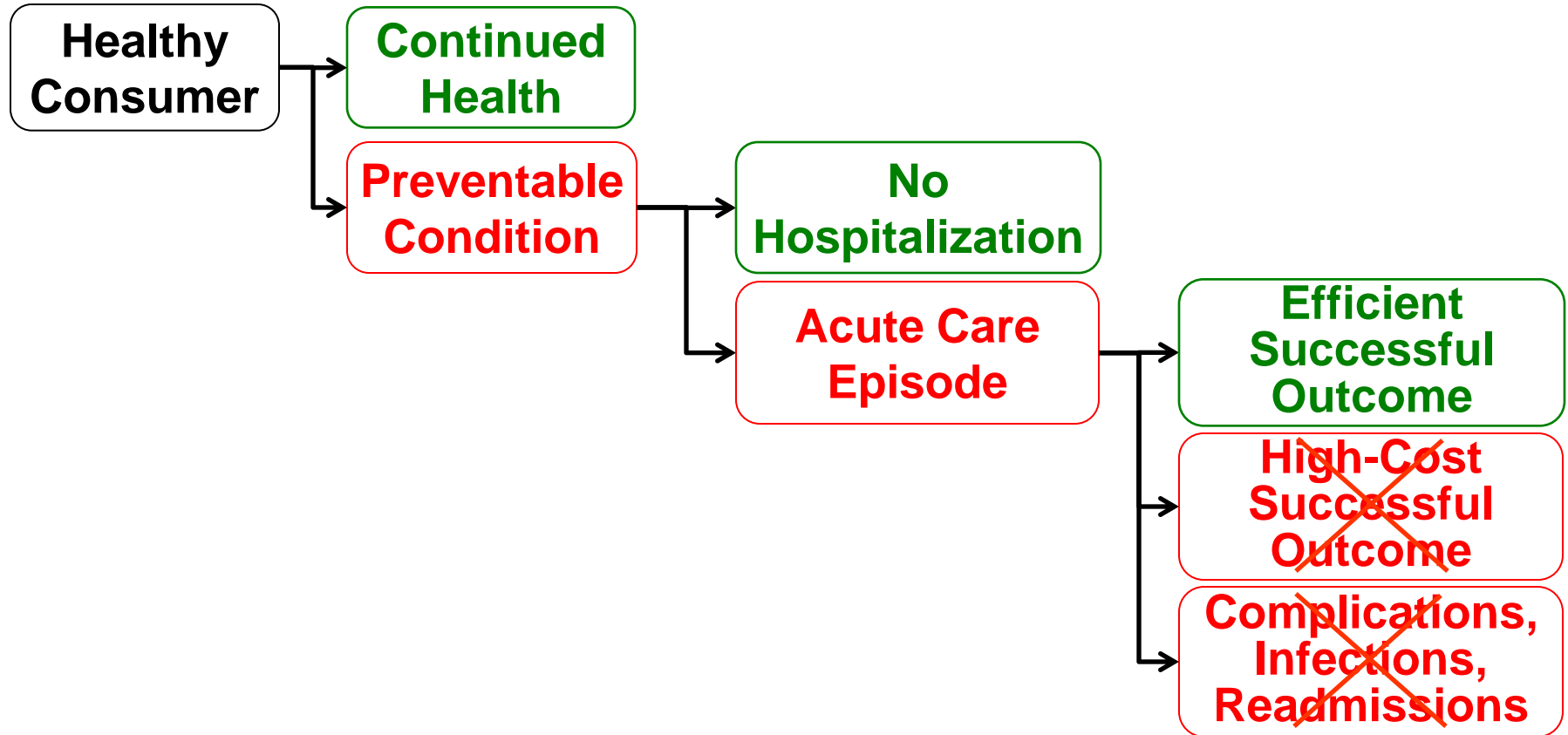
# Reducing Costs Without Rationing: Prevention and Wellness



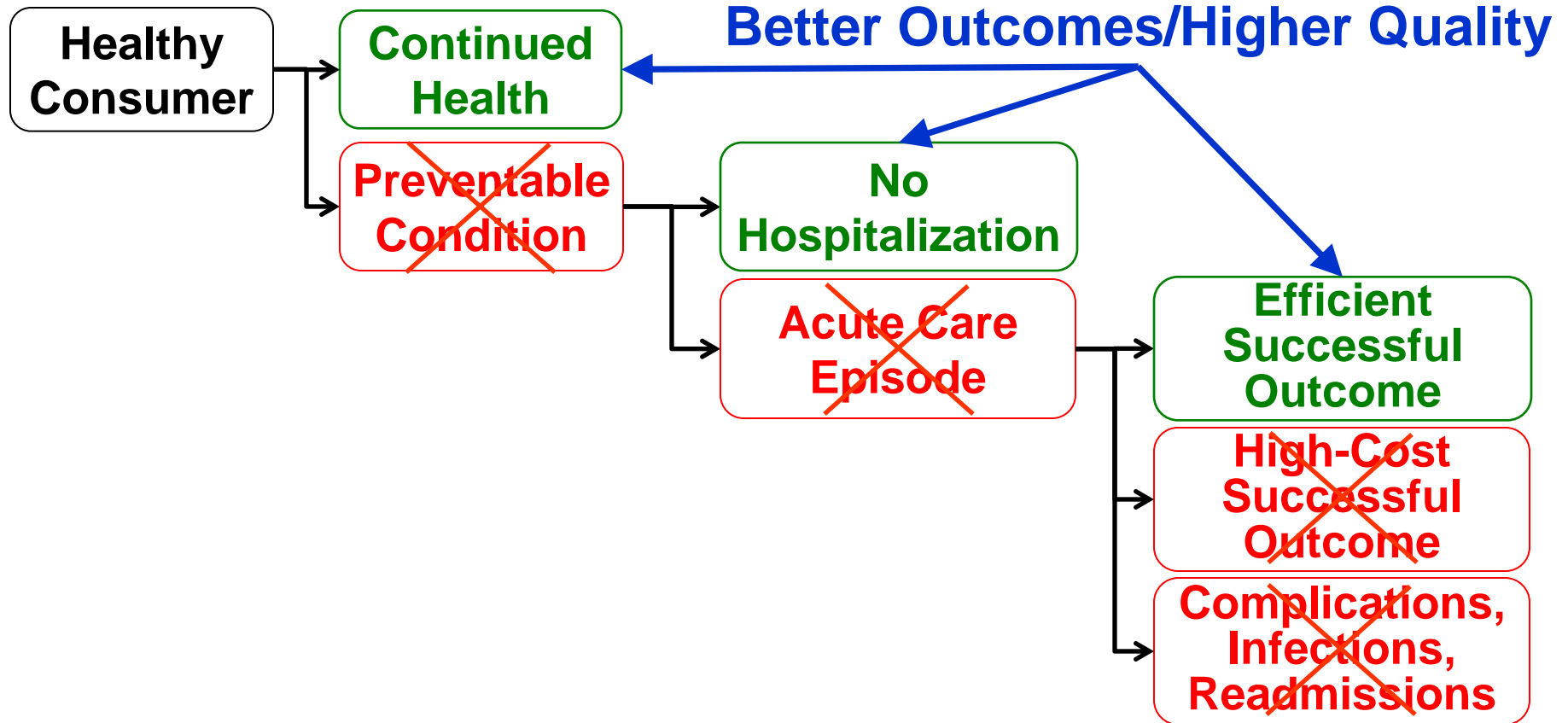
# Reducing Costs Without Rationing: Avoiding Hospitalizations



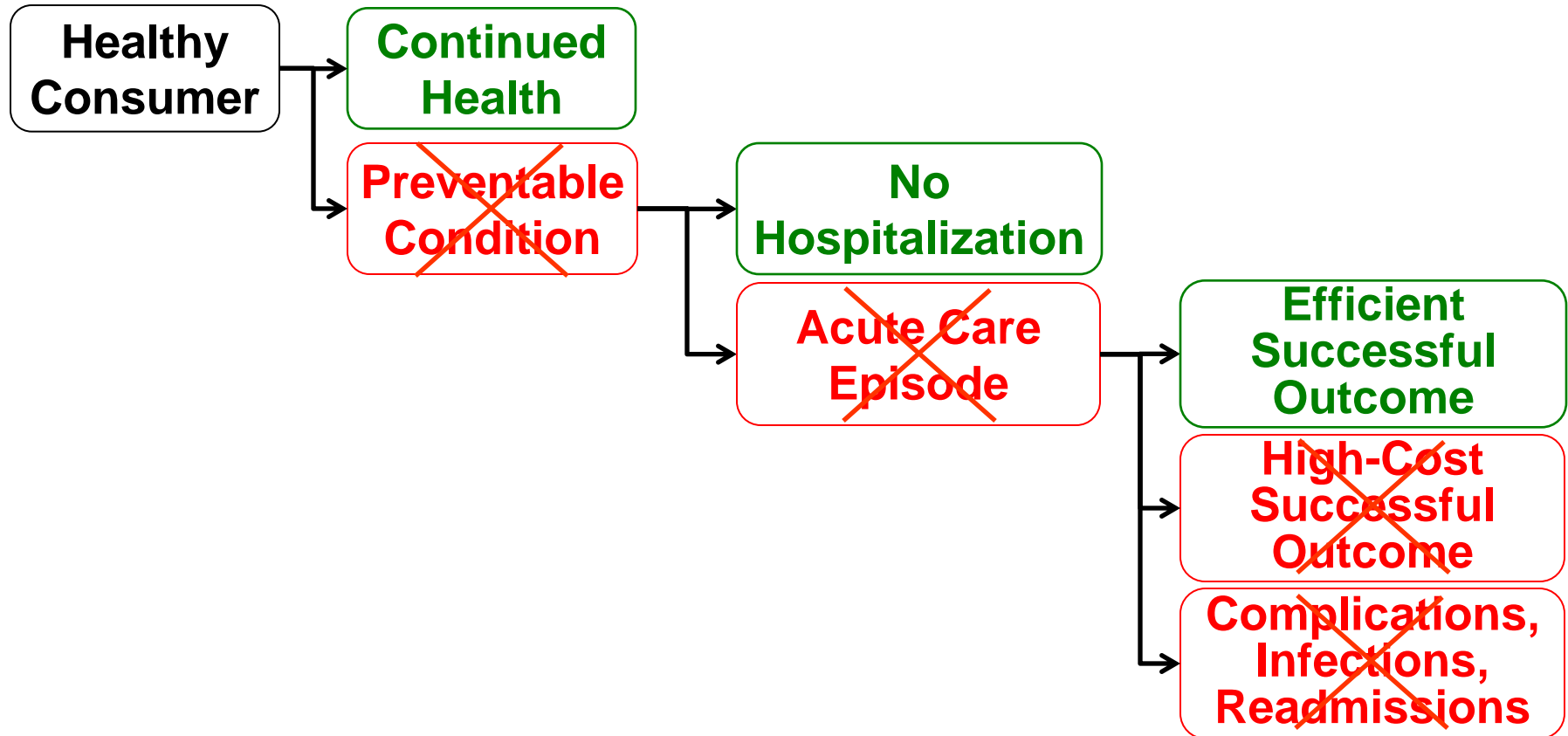
# Reducing Costs Without Rationing: Efficient, Successful Treatment



# Reducing Costs Without Rationing Is Also Quality Improvement!

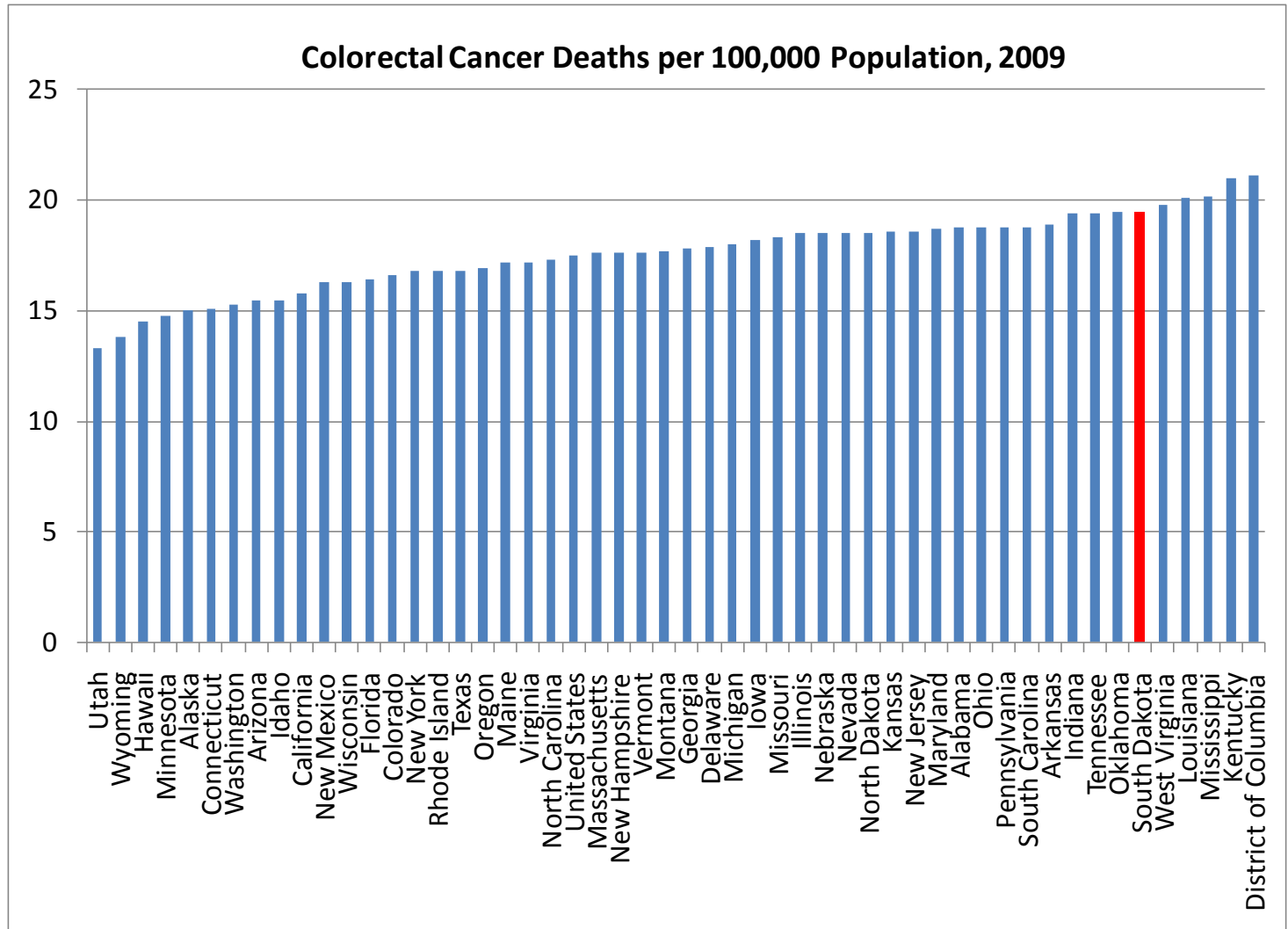


# Are There Opportunities in South Dakota?

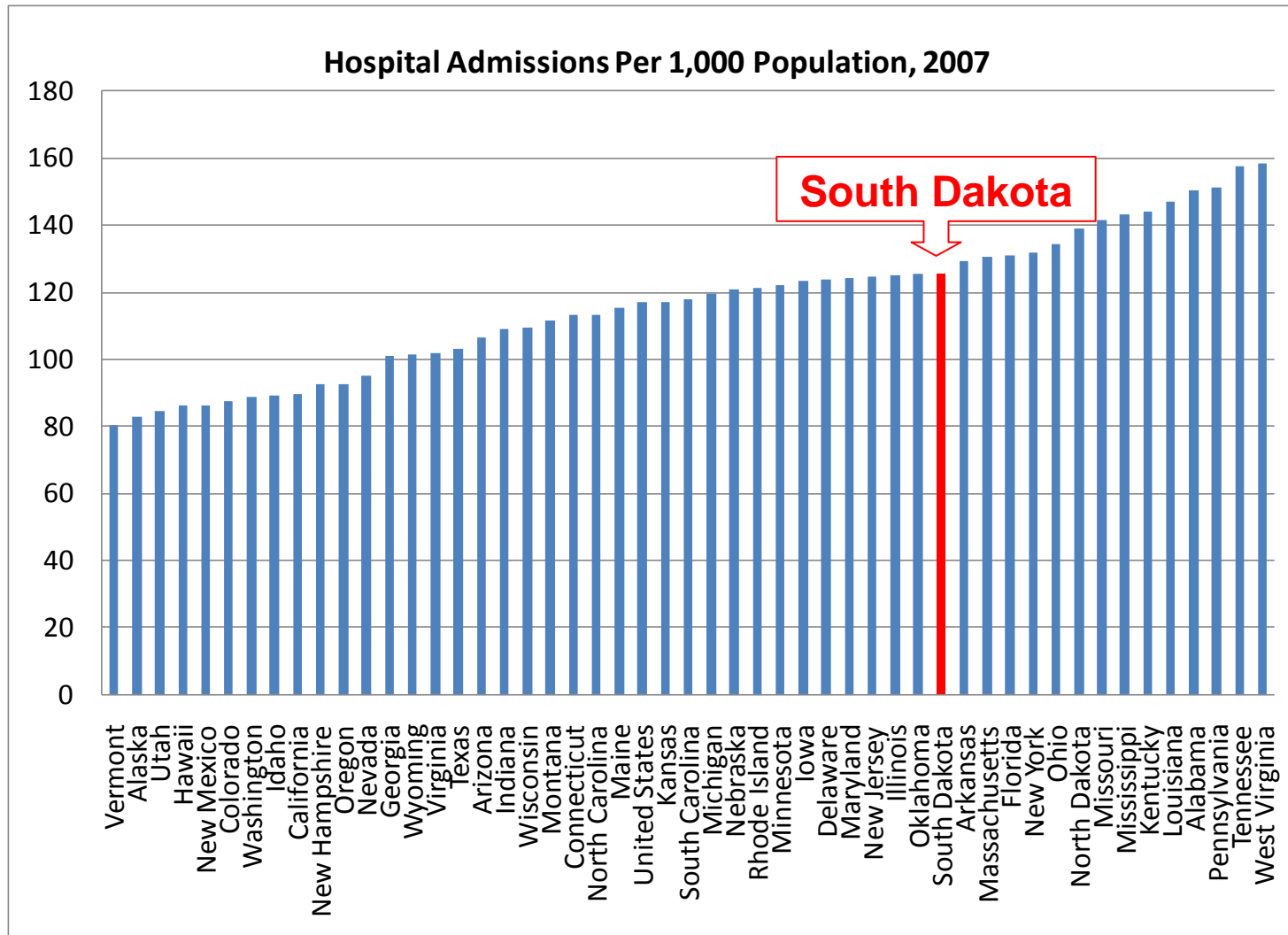


# Opportunities to Identify and Treat Conditions Earlier

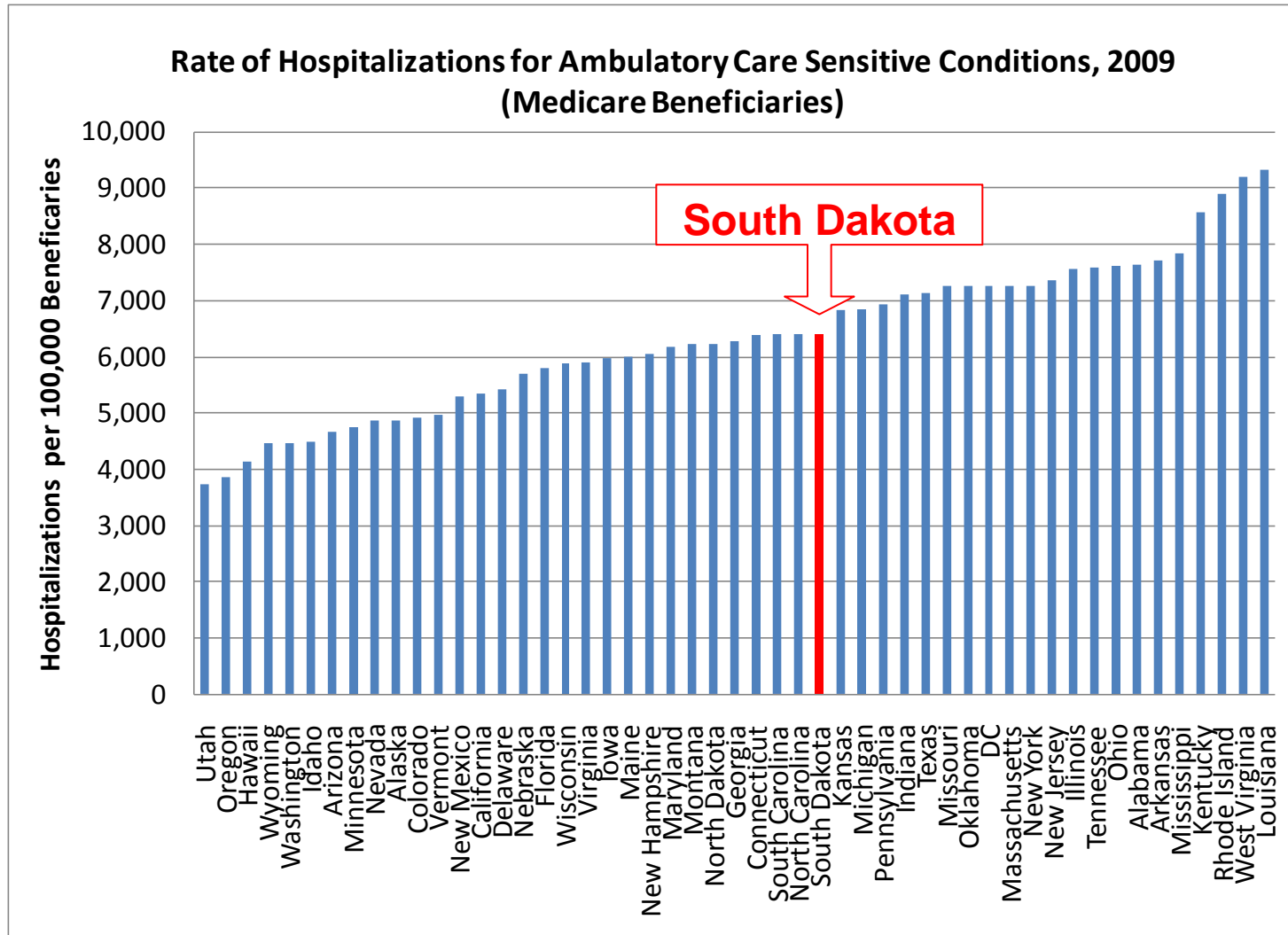
40-50% of Colorectal Cancer Identified at Late Stage in South Dakota



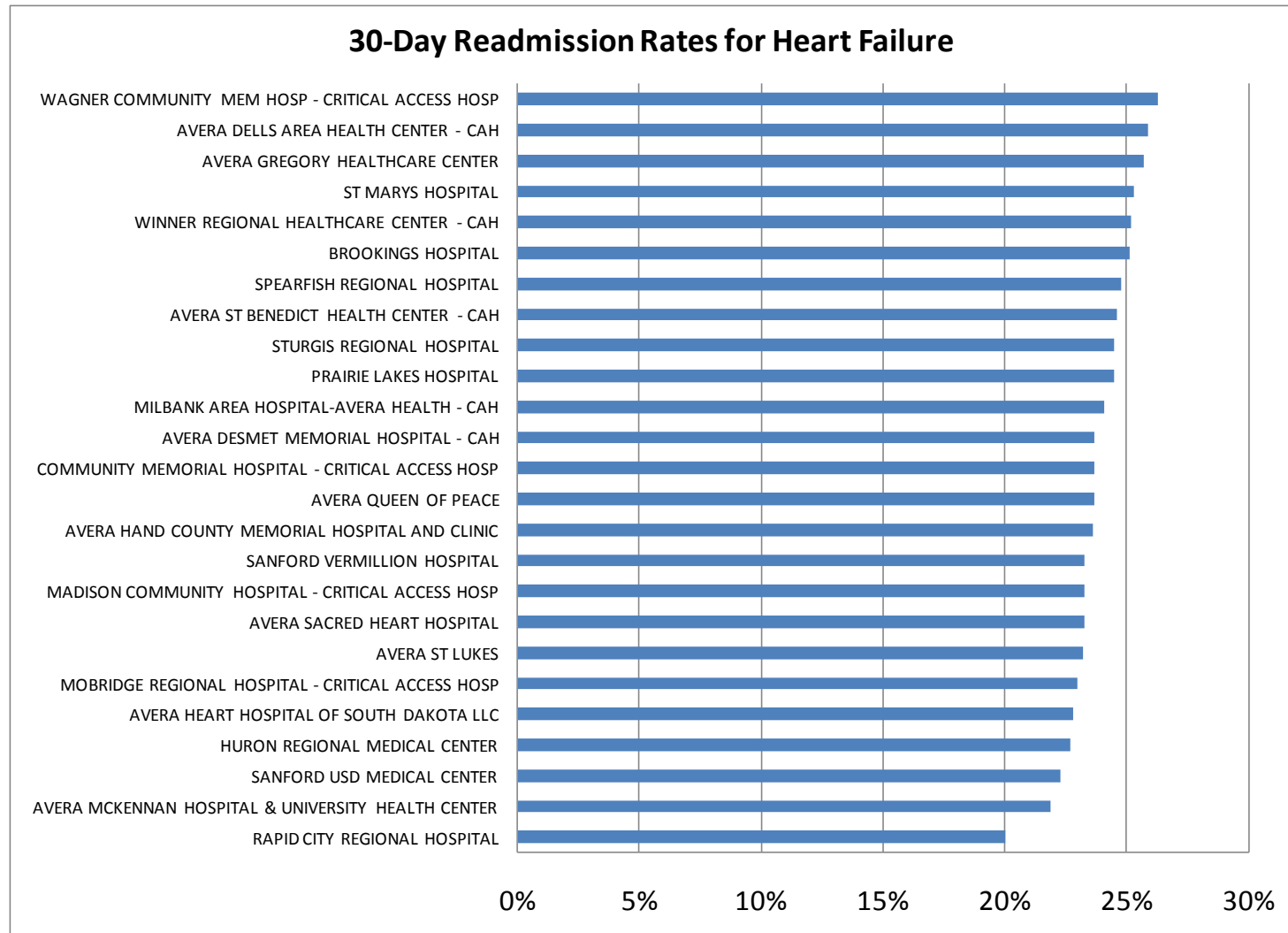
# S.D. Hospitalizes People at the 15<sup>th</sup> Highest Rate in the U.S.



# S.D. Above Average in Preventable Hospitalizations



# > 20% Heart Failure Patients Readmitted Within 30 Days

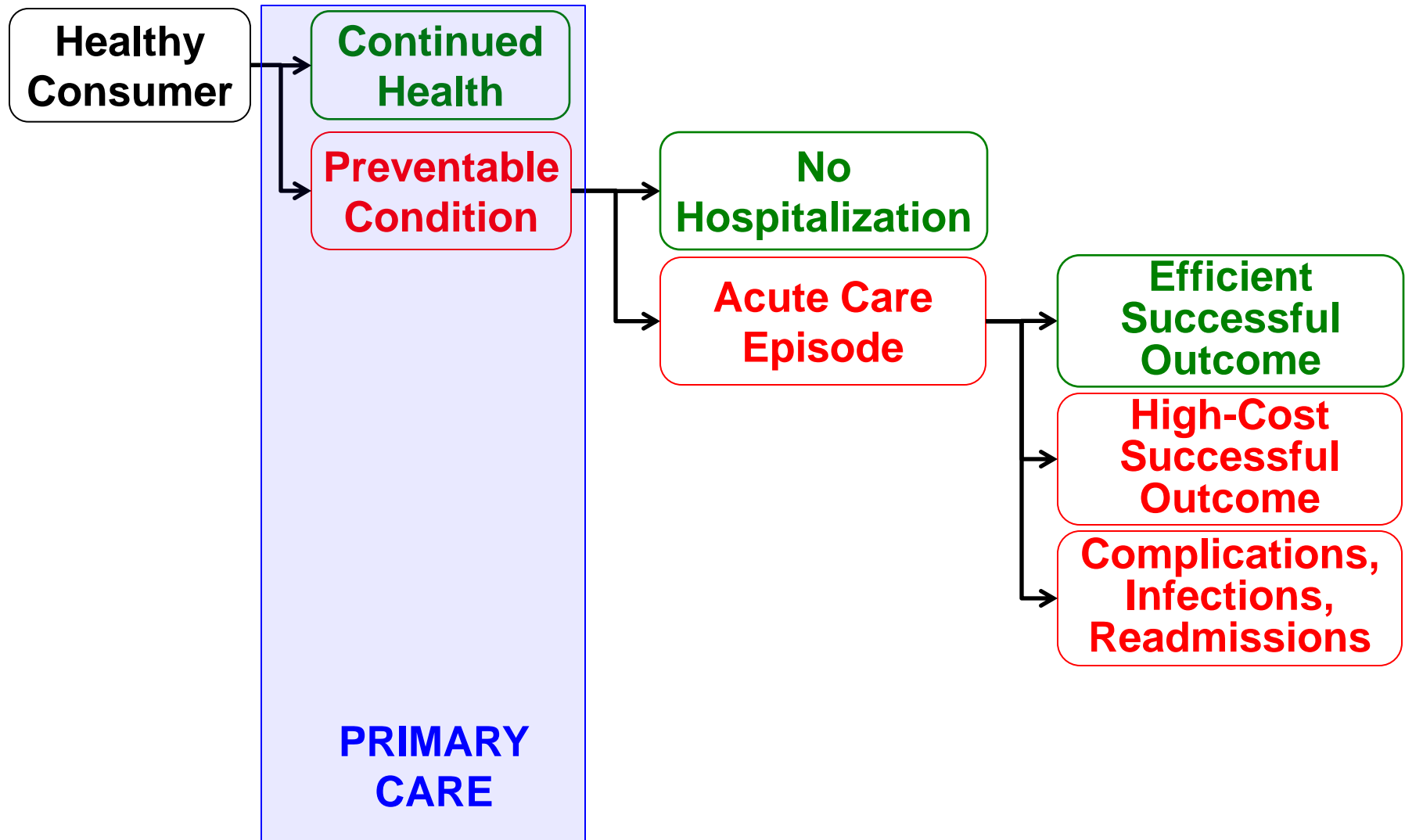


# nrhi For Achieving Higher Value Care?

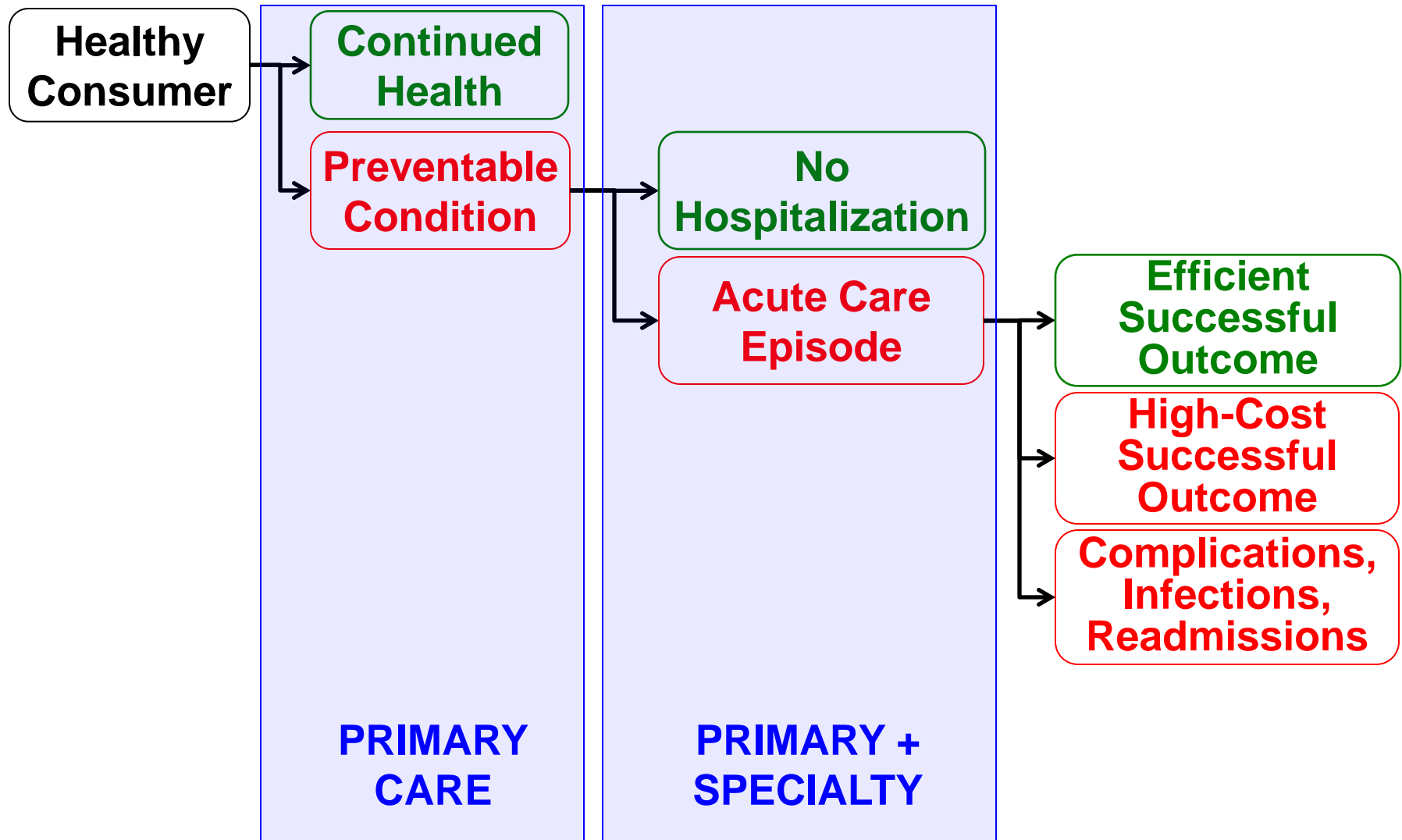
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- Hospitals?
- Integrated Delivery Systems?
- Health Plans?

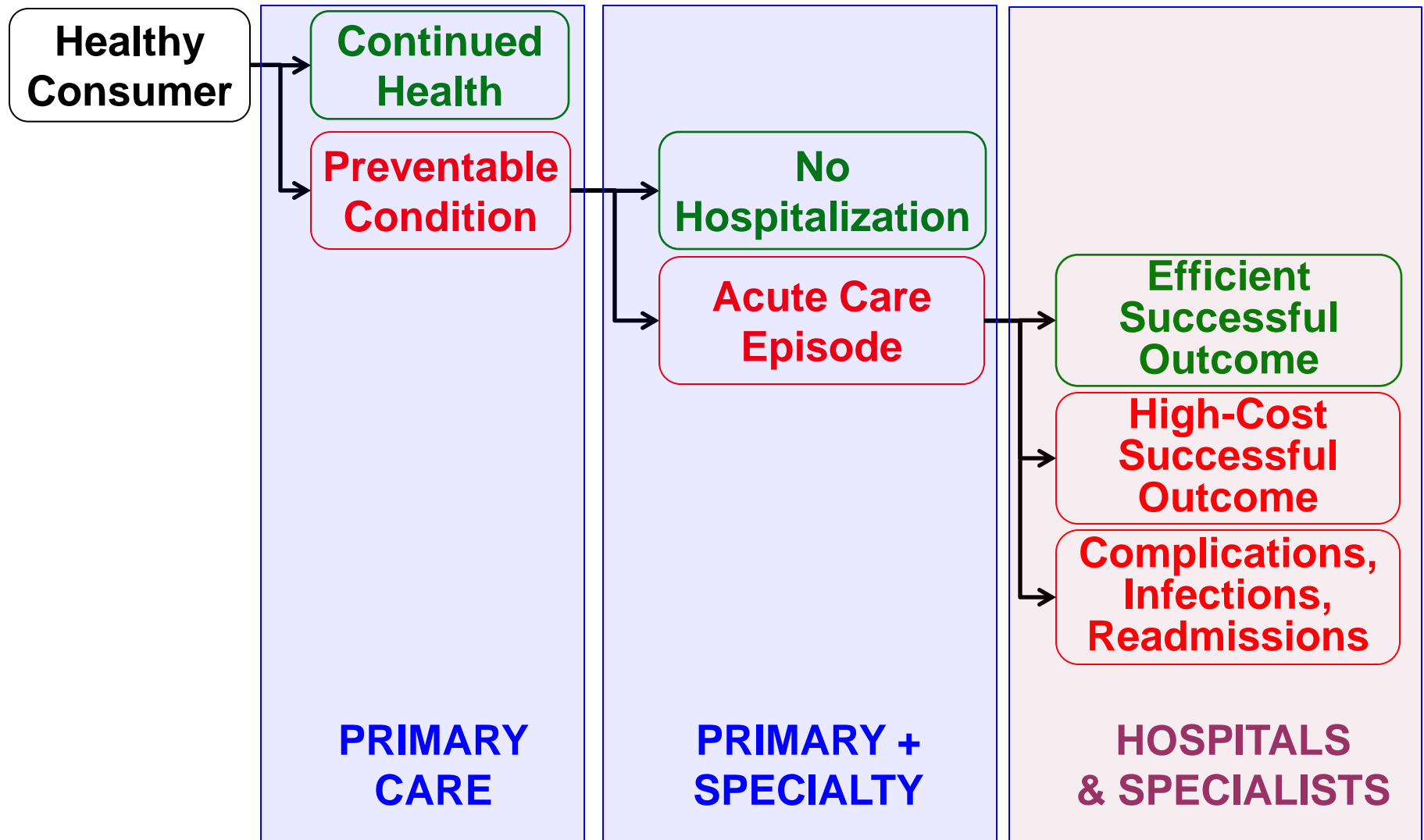
# Keeping People Well? Primary Care



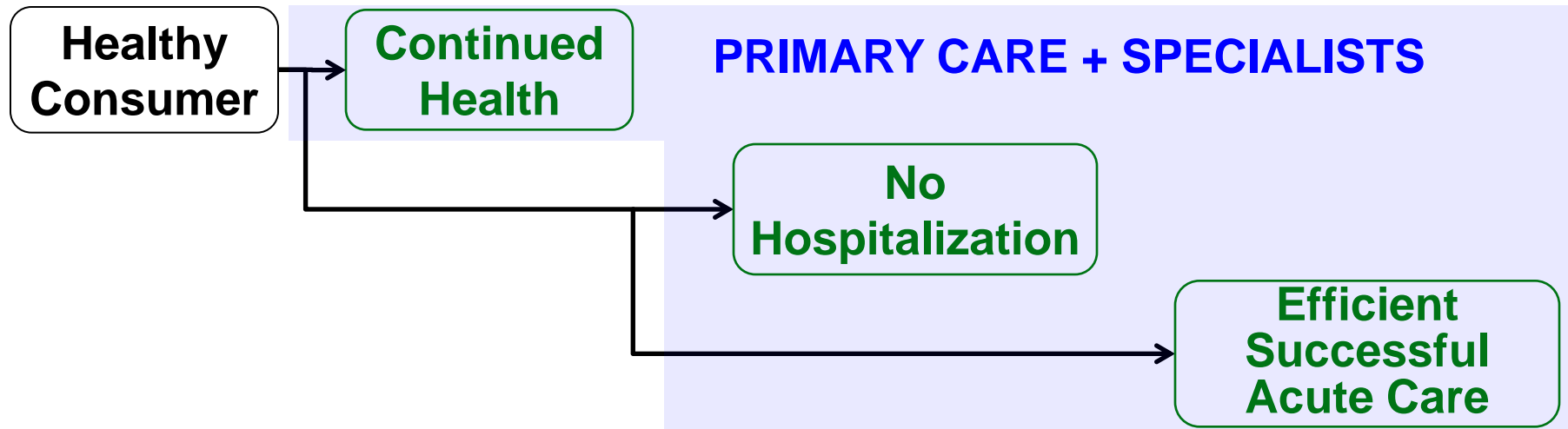
# Avoiding Hospitalizations? Primary + Specialty Care



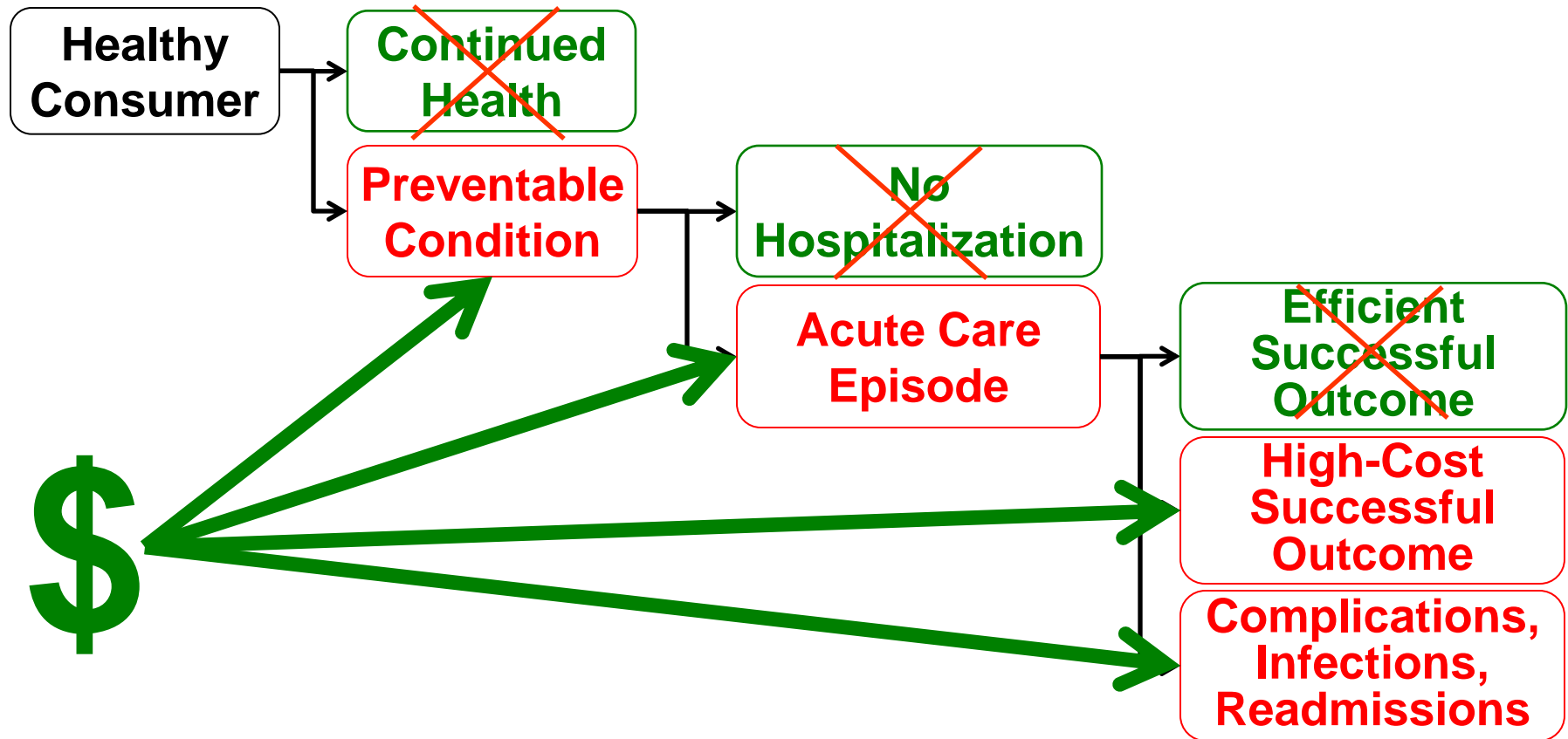
# Better Acute Care? Hospitals and Specialists



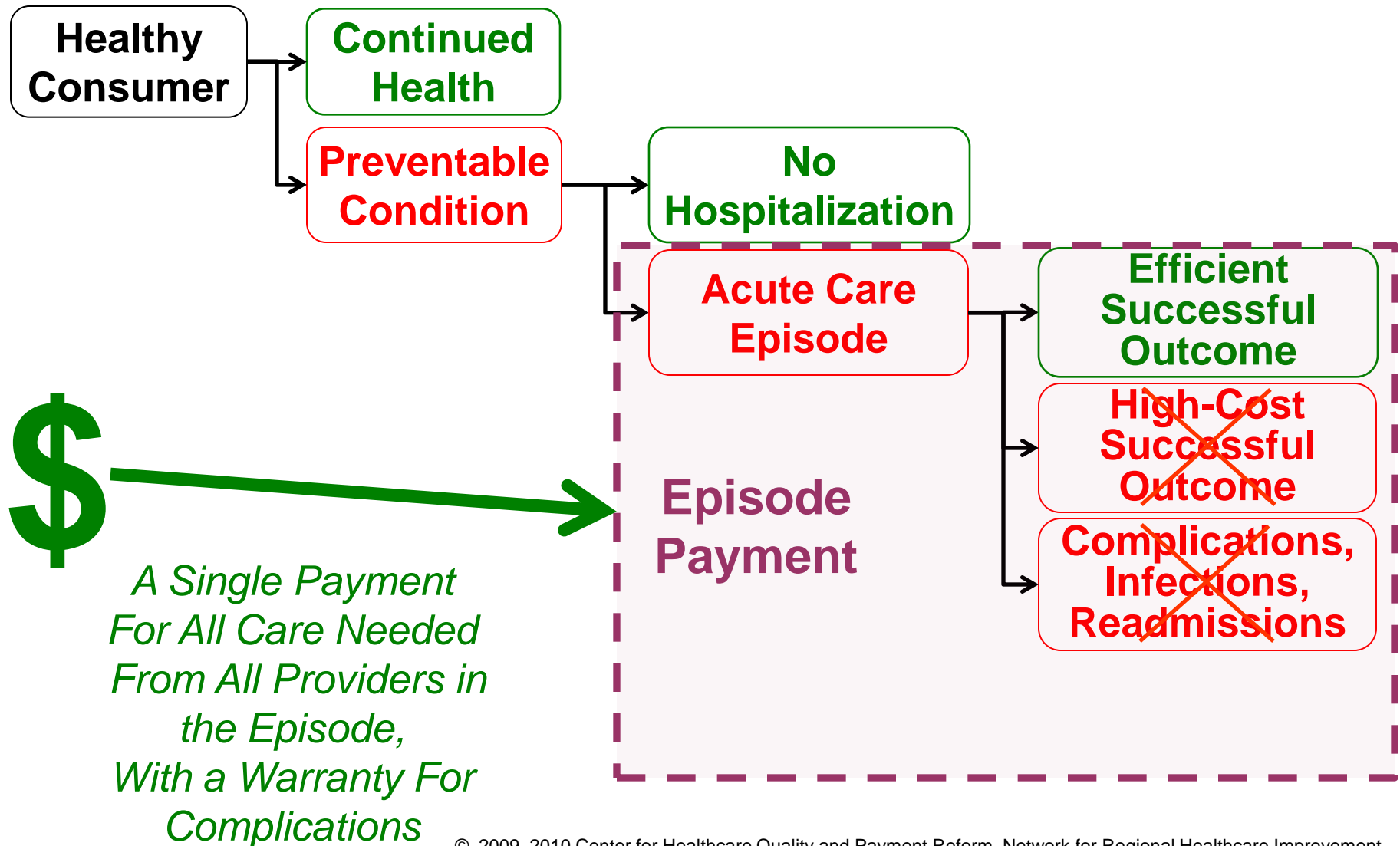
# So Physicians are at the Core of “Accountable Care”



# Current Payment Systems Reward Bad Outcomes, Not Better Health



# “Episode Payments” to Reward Value *Within* Episodes



# Yes, a Health Care Provider Can Offer a *Warranty*

## **Geisinger Health System ProvenCare<sup>SM</sup>**

- A single payment for an ENTIRE 90 day period including:
  - ALL related pre-admission care
  - ALL inpatient physician and hospital services
  - ALL related post-acute care
  - ALL care for any related complications or readmissions
- Types of conditions/treatments currently offered:
  - Cardiac Bypass Surgery
  - Cardiac Stents
  - Cataract Surgery
  - Total Hip Replacement
  - Bariatric Surgery
  - Perinatal Care
  - Low Back Pain
  - Treatment of Chronic Kidney Disease

# Payment + Process Improvement = Better Outcomes, Lower Costs

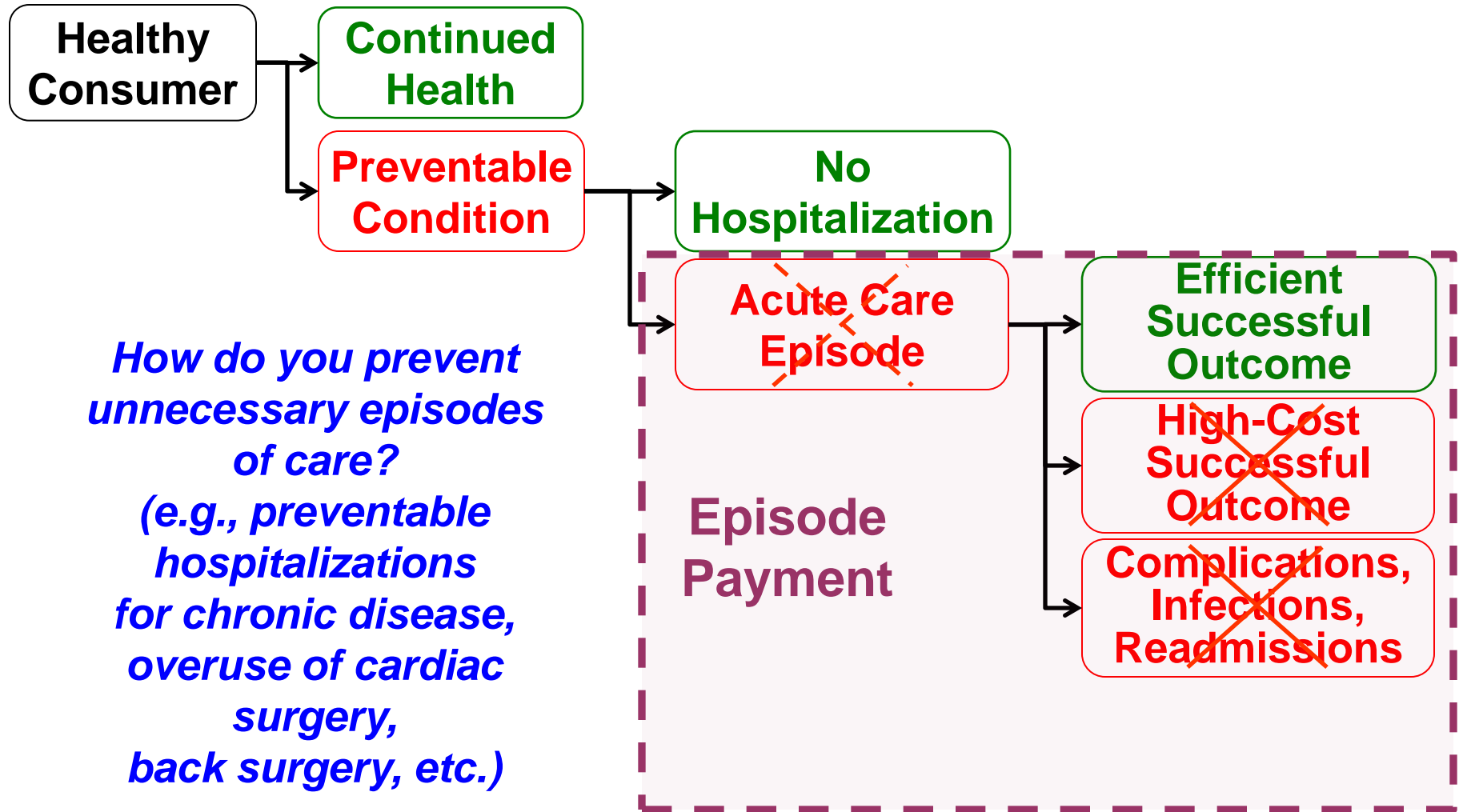
## ProvenCare<sup>®</sup> CABG Quality Clinical Outcomes - (18. mos)

	<i>Before ProvenCare (n=132)</i>	<i>With ProvenCare (n=181)</i>	<b>% Improvement/ (Reduction)</b>
In hospital mortality	1.5 %	0 %	
Patients with <u>any</u> complication (STS)	38 %	30 %	<b>21 %</b>
Patients with >1 complication	7.6 %	5.5 %	<b>28 %</b>
Atrial fibrillation	23 %	19 %	<b>17 %</b>
Neurologic complication	1.5 %	0.6 %	<b>60 %</b>
Any pulmonary complication	7 %	4 %	<b>43 %</b>
Blood products used	23 %	18 %	<b>22 %</b>
Re-operation for bleeding	3.8 %	1.7 %	<b>55 %</b>
Deep sternal wound infection	0.8 %	0.6 %	<b>25 %</b>
Readmission within 30 days	6.9 %	3.8 %	<b>44 %</b>

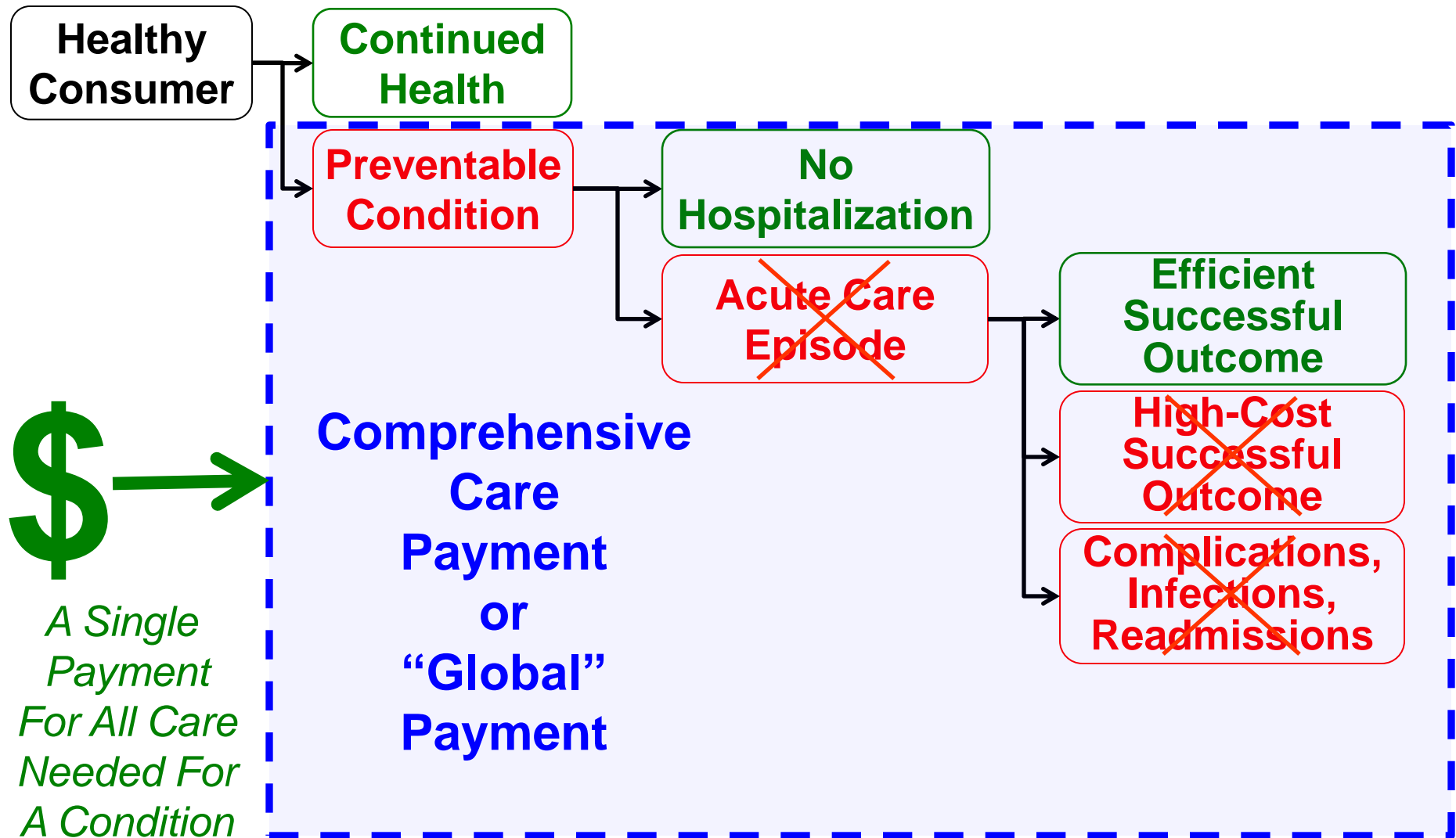
# It Can Be Done By Physicians, Not Just Health Systems

- 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.

# The Weakness of Episode Payment



# Comprehensive Care Payments To *Avoid* Episodes



# Isn't This Capitation (Ugh)?

## No – It's Different

### CAPITATION (WORST VERSIONS)

No Additional Revenue  
for Taking Sicker  
Patients

Providers Lose Money  
On Unusually  
Expensive Cases

Providers Are Paid  
Regardless of the  
Quality of Care

Provider Makes  
More Money If  
Patients Stay Well

Flexibility to Deliver  
Highest-Value  
Services

### COMPREHENSIVE CARE PAYMENT

Payment Levels  
Adjusted Based on  
Patient Conditions

Limits on Total Risk  
Providers Accept for  
Unpredictable Events

Bonuses/Penalties  
Based on Quality  
Measurement

Provider Makes  
More Money If  
Patients Stay Well

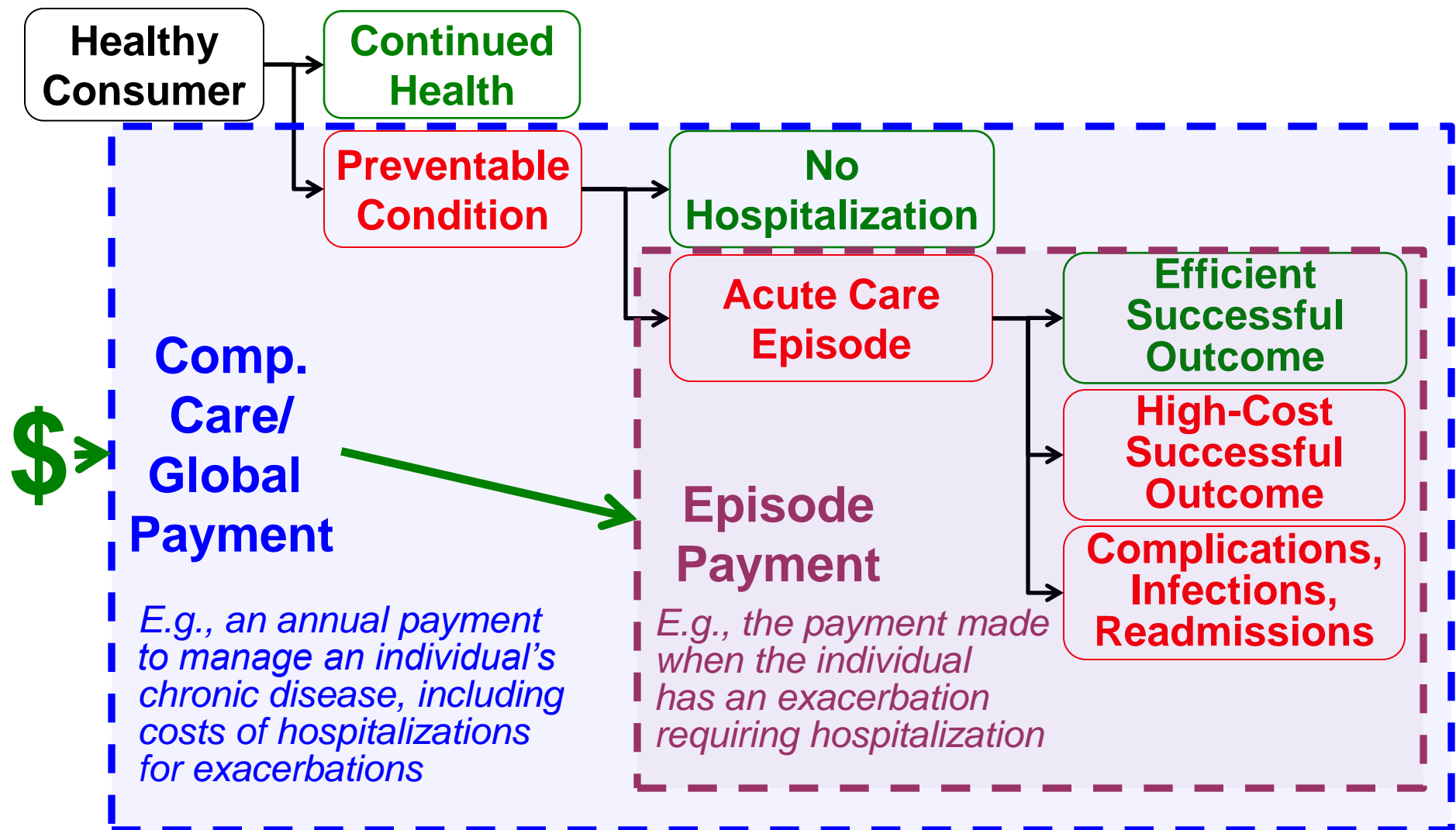
Flexibility to Deliver  
Highest-Value  
Services

# Example: BCBS Massachusetts Alternative Quality Contract

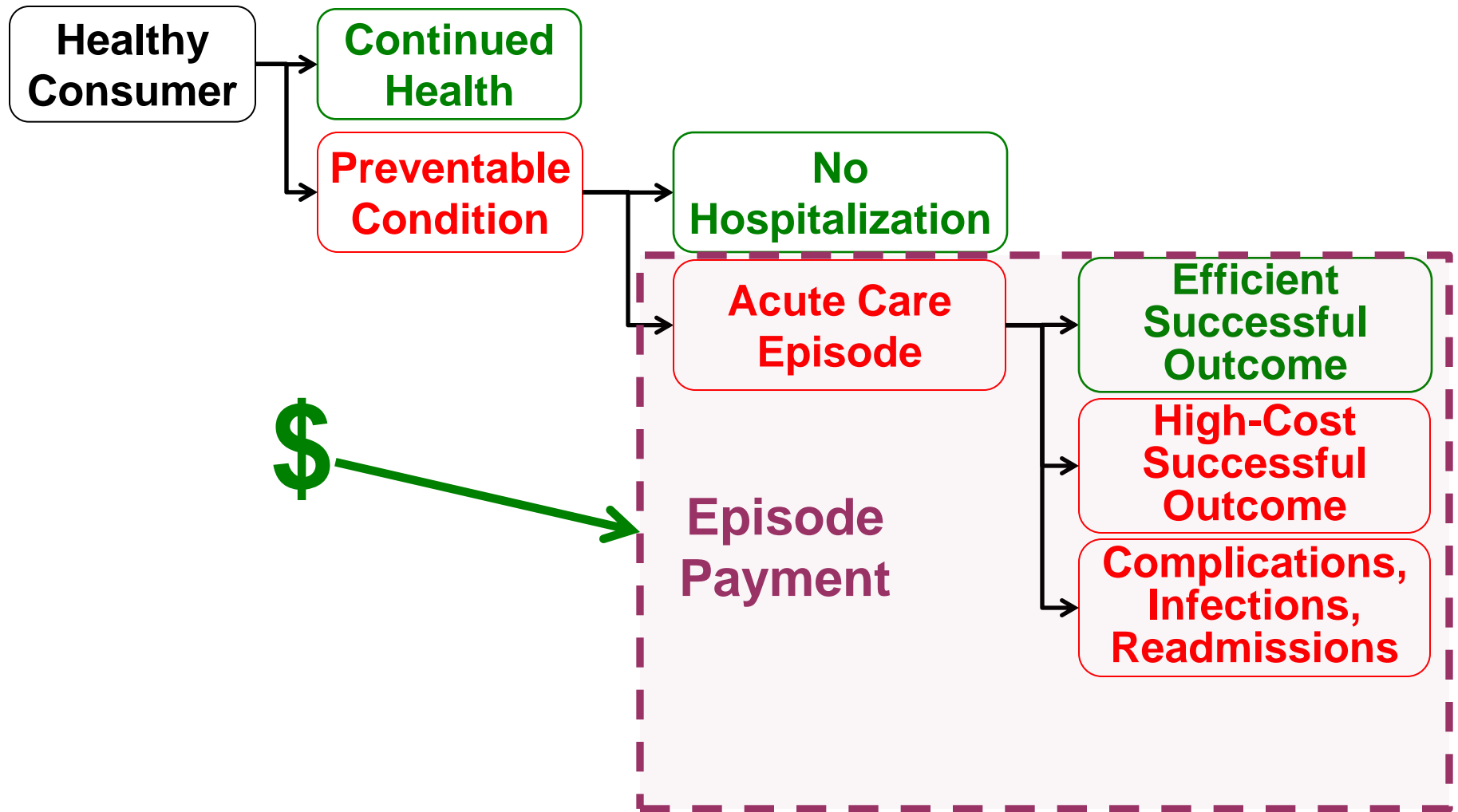
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- A single payment amount is established to cover all costs of care for a population of patients
- The payment amount is adjusted up or down based on the types and severity of conditions the patients have, so providers aren't taking insurance risk, only performance risk
- The initial payment is set based on past expenditures; the amount increases each year at an inflation rate based on CPI, not on medical inflation, so savings come from controlling increases over time
- Payments are increased by annual bonuses based on the quality of care delivered
- The provider doesn't need to pay claims; BCBS still pays individual providers fee-for-service, but fees are adjusted up or down to keep total costs within the budget (payment amount)

# Comprehensive Care & Episode Payment Can Be Complementary



# A Deeper Dive into Episode Payments and Implications



# Episode Payment = Bundling + Warranty

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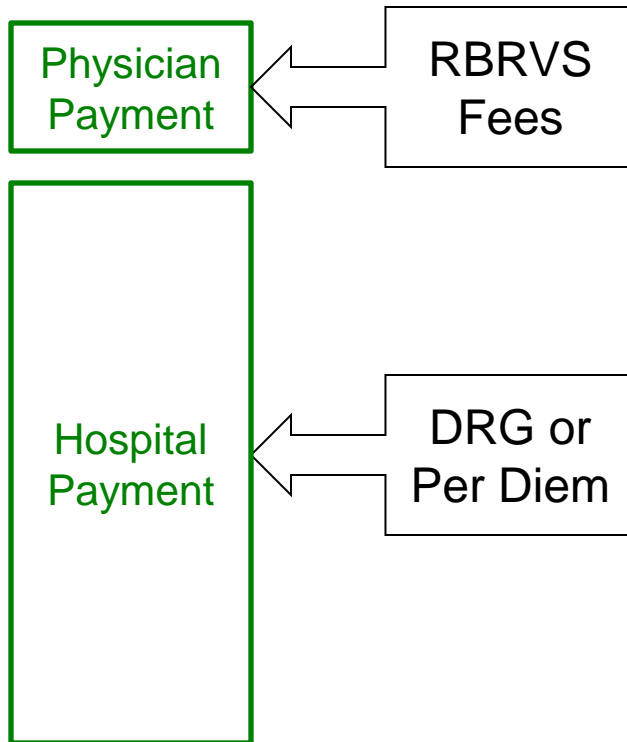
- **Bundling:** Making a single payment to two or more providers who are currently paid separately (e.g. a single payment to cover the services of both a hospital and a physician, or a single payment for both hospital and post-acute care services)
- **Warranty:** Not charging/being paid more for costs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

# How Can Providers & Payers Benefit from Bundling?

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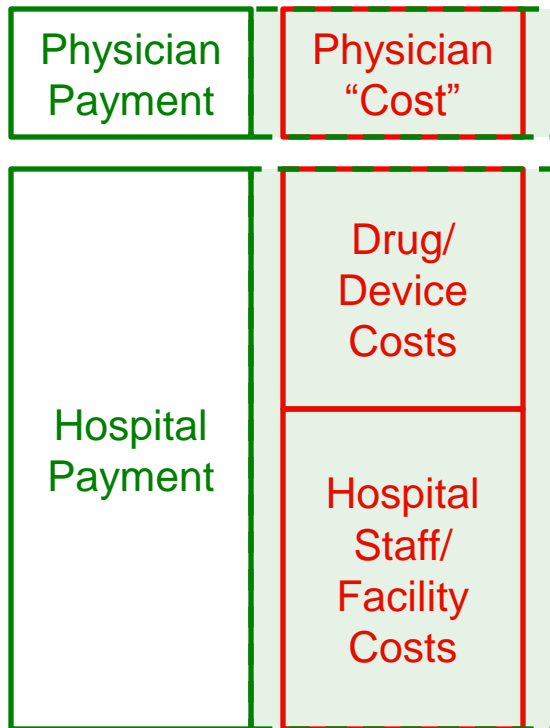
# Today: Hospitals & Doctors Paid Separately For Hospital Care...

## Costs and Payment Today

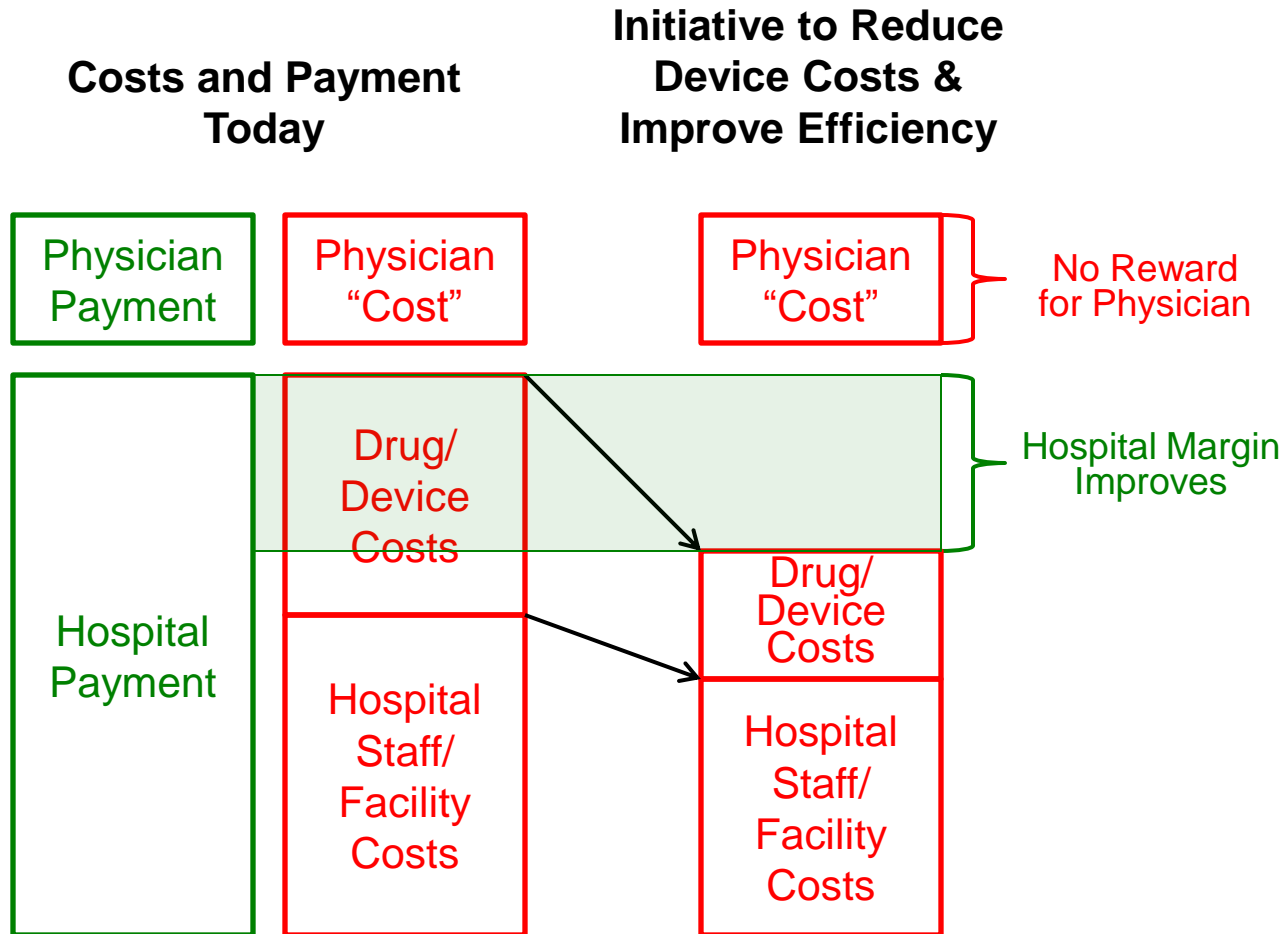


# ...Implies Doctors and Hospitals Should Cover Their “Own” Costs

## Costs and Payment Today

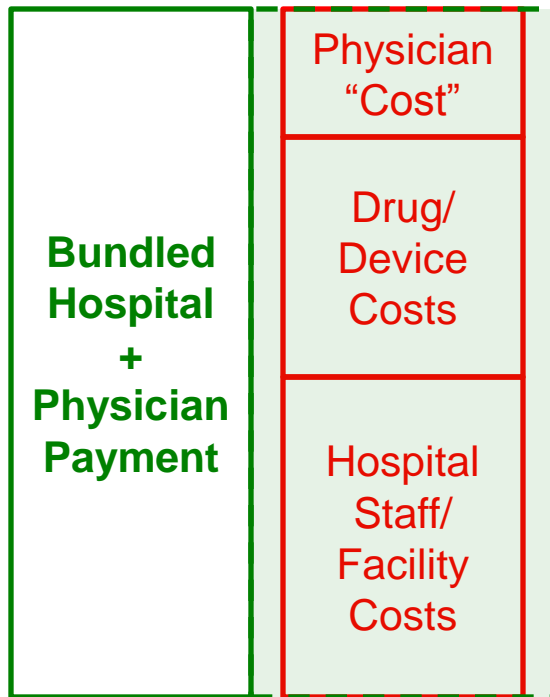


# So There's No Incentive for Docs to Help Hospitals Reduce Costs



# *Bundled* Payment Covers All Costs in a Single Payment...

**Bundled  
Episode  
Payment**

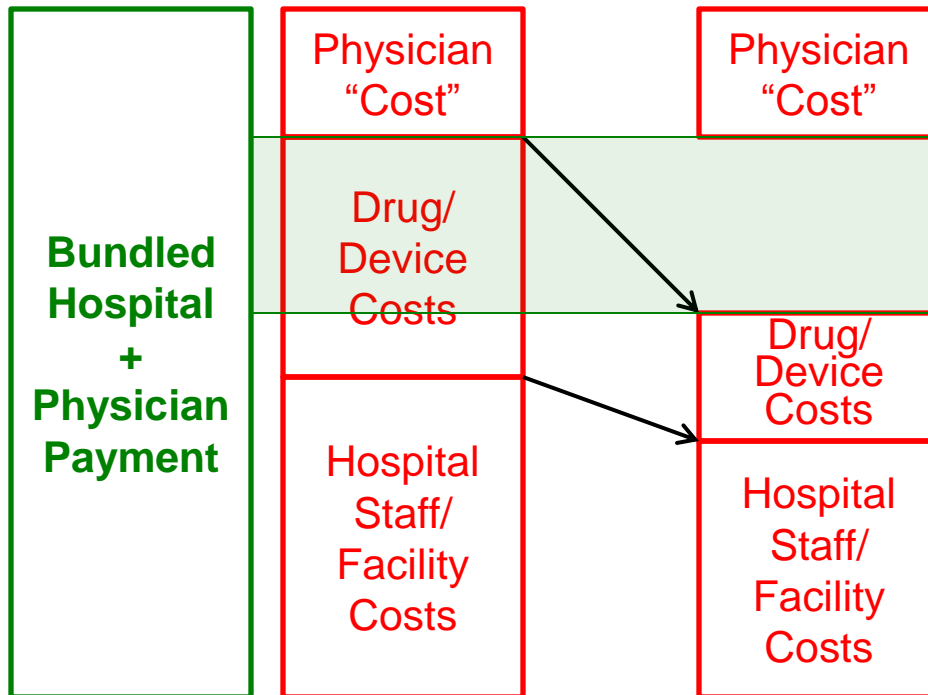


# ...So if MDs & Hospitals

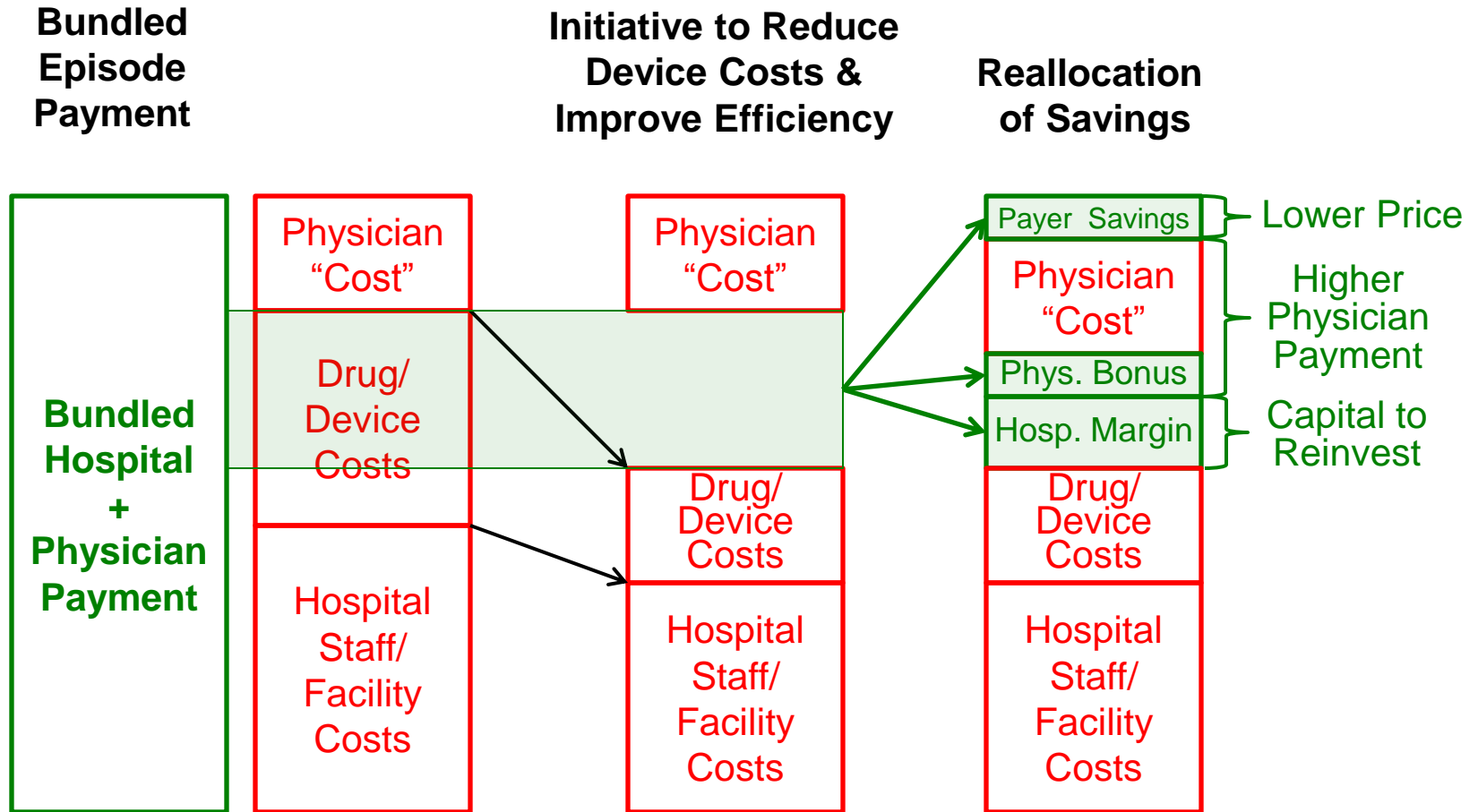
# Cooperate to Generate Savings...

**Bundled  
Episode  
Payment**

**Initiative to Reduce  
Device Costs &  
Improve Efficiency**

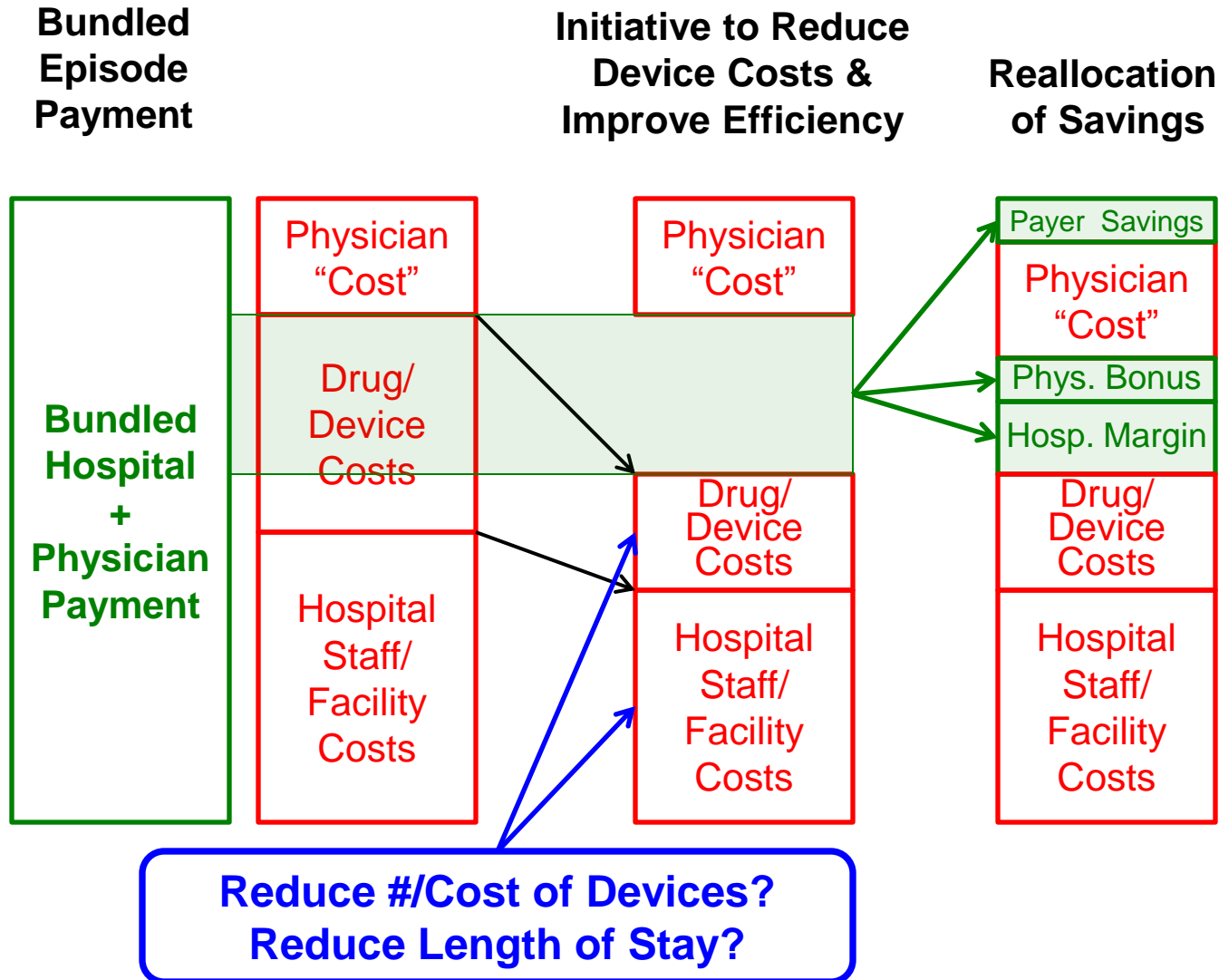


# ...MDs, Hospitals, and Payers Can All Benefit

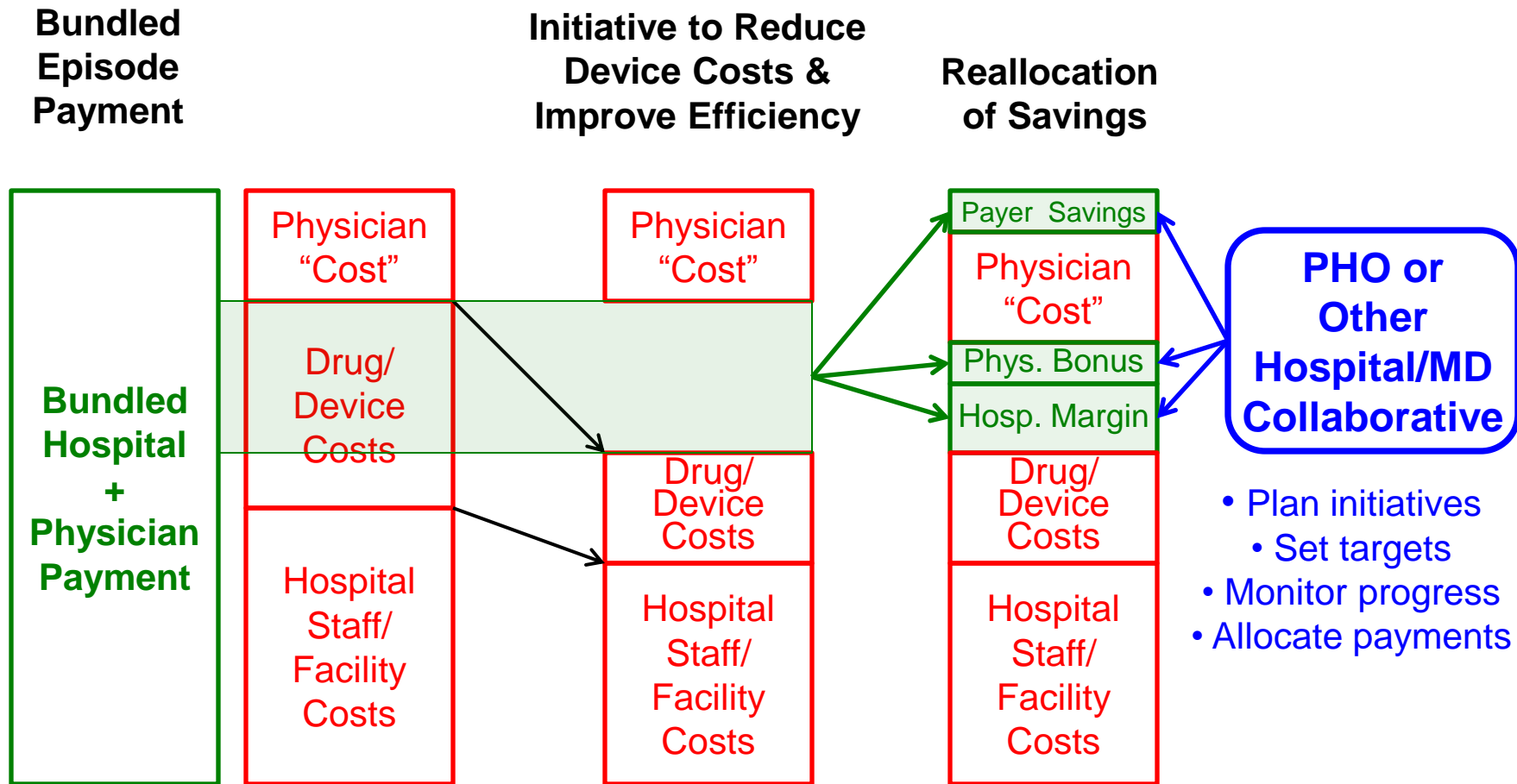


*Episode payment would give hospitals & MDs incentives to collaborate to reduce costs*

# A Strategy for Reducing Costs Is Needed...



# ... And a Mechanism to Allocate the Payments is Needed



# Example: Reducing Cost of Joint Replacement

<b>COST TYPE</b>	<b>TODAY</b>
Physician Fee	\$ 1,500
Device Cost	\$ 7,500
Other Hospital Cost	\$ 6,750
Hosp. Margin (5%)	\$ 750
<b>Total Hospital Pmt</b>	<b>\$15,000</b>
<b>Total Cost to Payer</b>	<b>\$16,500</b>

# Physicians Could Help Hospitals Reduce Cost of Medical Devices

<b>COST TYPE</b>	<b>TODAY</b>	<b>CHANGE</b>
Physician Fee	\$ 1,500	
Device Cost	\$ 7,500	-33% (\$2,500)
Other Hospital Cost	\$ 6,750	
Hosp. Margin (5%)	\$ 750	
<b>Total Hospital Pmt</b>	<b>\$15,000</b>	
<b>Total Cost to Payer</b>	<b>\$16,500</b>	

# Savings Could Be Split Among MDs, Hospitals, and Payers

<b>COST TYPE</b>	<b>TODAY</b>	<b>CHANGE</b>	<b>SPLIT</b>
Physician Fee	\$ 1,500		+ 50% (\$750)
Device Cost	\$ 7,500	-33% (\$2,500)	
Other Hospital Cost	\$ 6,750		
Hosp. Margin (5%)	\$ 750		+100% (\$750)
<b>Total Hospital Pmt</b>	<b>\$15,000</b>		
<b>Total Cost to Payer</b>	<b>\$16,500</b>		<b>- 6% (\$1000)</b>

# So Joint Replacement is Cheaper But More Profitable

<b>COST TYPE</b>	<b>TODAY</b>	<b>CHANGE</b>	<b>SPLIT</b>	<b>NEW</b>
Physician Fee	\$ 1,500		+ 50% (\$750)	\$ 2,250
Device Cost	\$ 7,500	-33% (\$2,500)		\$ 5,000
Other Hospital Cost	\$ 6,750			\$ 6,750
Hosp. Margin (5%)	\$ 750		+100% (\$750)	\$ 1,500
<b>Total Hospital Pmt</b>	<b>\$15,000</b>			<b>\$13,250</b>
<b>Total Cost to Payer</b>	<b>\$16,500</b>		<b>- 6% (\$1000)</b>	<b>\$15,500</b>

# How Can Providers & Payers Benefit from Offering Warranties?

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

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**Cost of  
Procedure**

**\$10,000**

# Actual Average Payment for Procedure is Higher

<b>Cost of Procedure</b>	<b>Added Cost of Infection</b>	<b>Rate of Infections</b>	<b>Average Total Cost</b>
\$10,000	\$20,000	5%	\$11,000

# Starting Point for Warranty Price: Actual Current Average Payment

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

# 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

# Higher-Quality Provider Can Charge Less, Attract 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



# 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	<b>3%</b>	\$10,600	\$10,800	<b>\$200</b>

Reducing Adverse Events...

...Reduces Costs...

...Improves The Bottom Line

# The Payment System Helps Improve Care for 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
\$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...**

# But the Price Per Service May Be Higher Than It Is Today

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

**“Why should we have to pay more for higher quality care??”**

# Prices May Be Higher, But *Spending* Would Be Lower

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

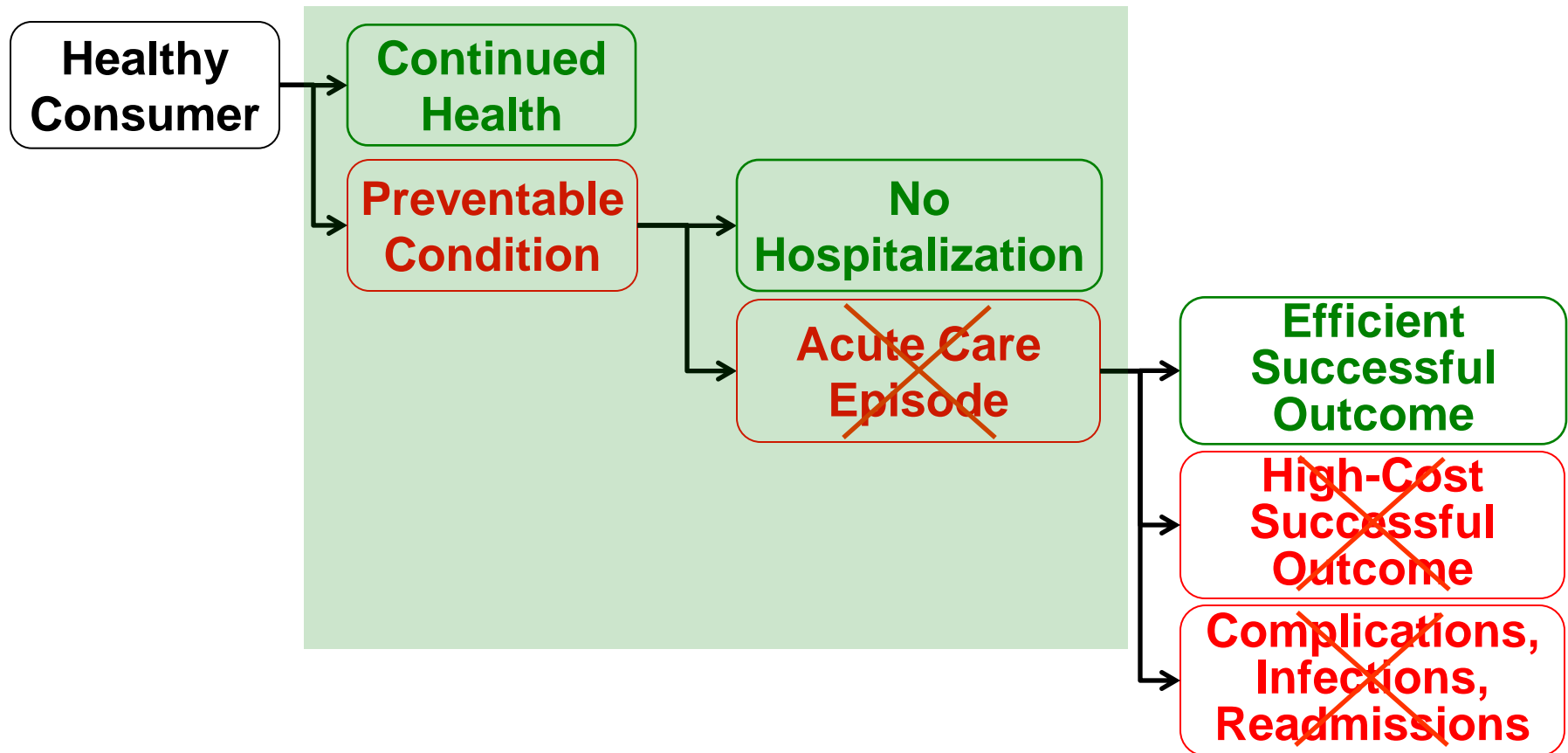
**Answer: You're not paying more!**

# And *Margins* for Hospitals and Physicians Would be *Higher*

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

**Higher Margins With Lower Revenues**

# Not Just Better Acute Care, But Less of It



# Dramatic Reductions in Rate of Hospitalizations Are Possible

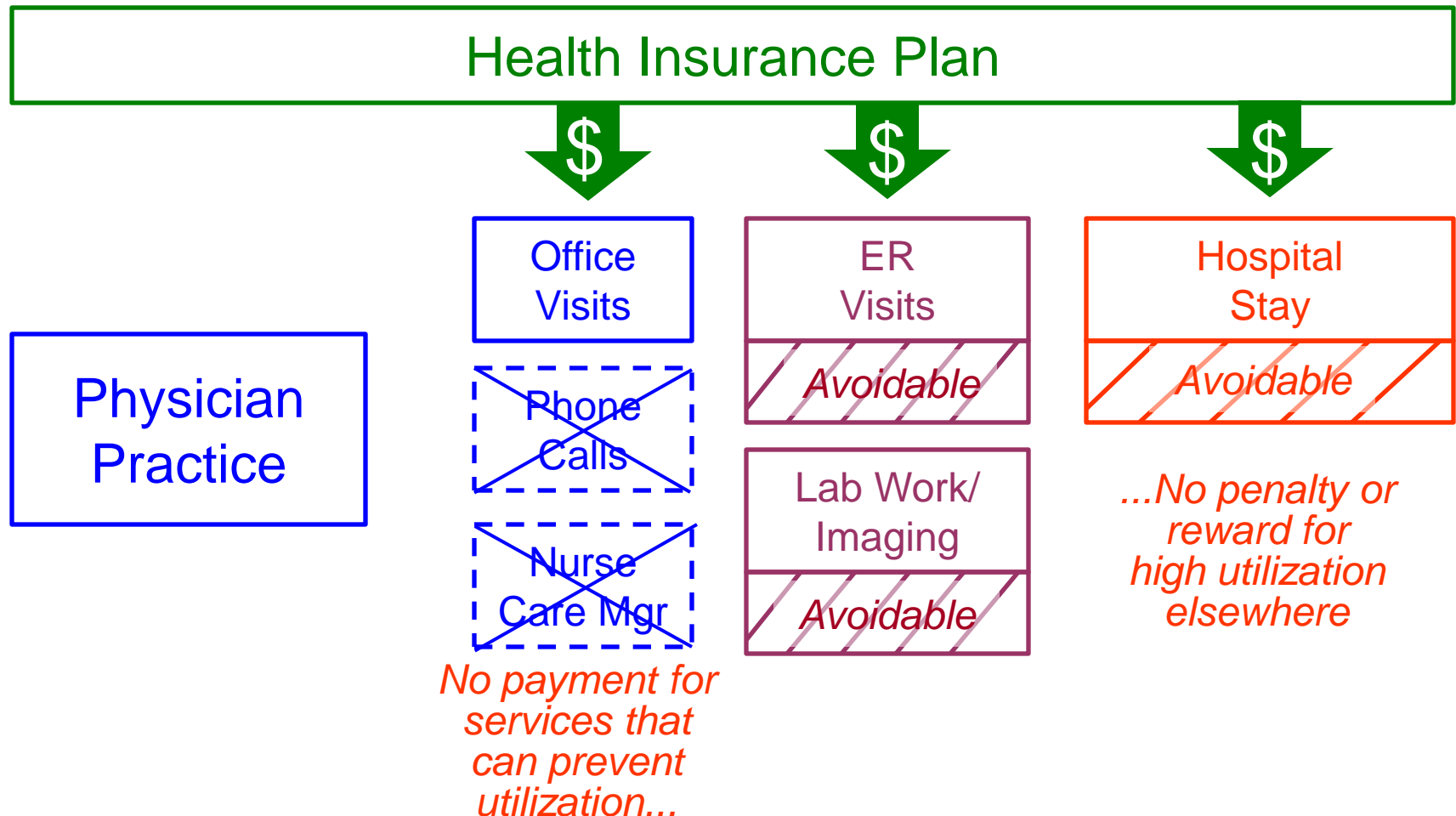
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## Examples:

- 40% reduction in hospital admissions, 41% reduction in ER visits for exacerbations of Chronic Obstructive Pulmonary Disease (COPD) using in-home & phone patient education by nurses or respiratory therapists
- 66% reduction in hospitalizations for Congestive Heart Failure patients using home-based telemonitoring
- 27% reduction in hospital admissions, 21% reduction in ER visits for Chronic Obstructive Pulmonary Disease (COPD) through self-management education

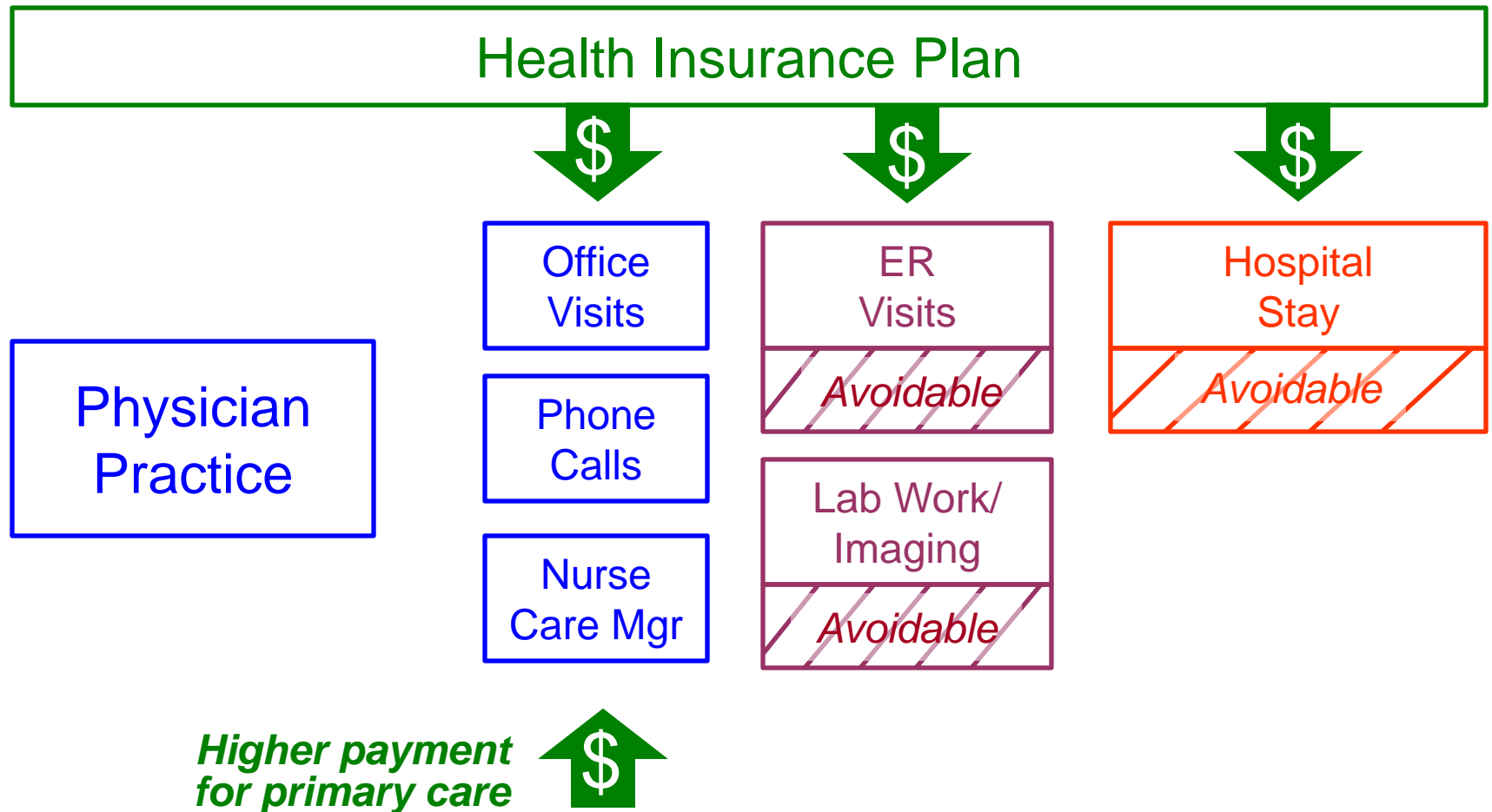
# We Don't Pay for the Things That Will Prevent Overutilization

## CURRENT PAYMENT SYSTEMS



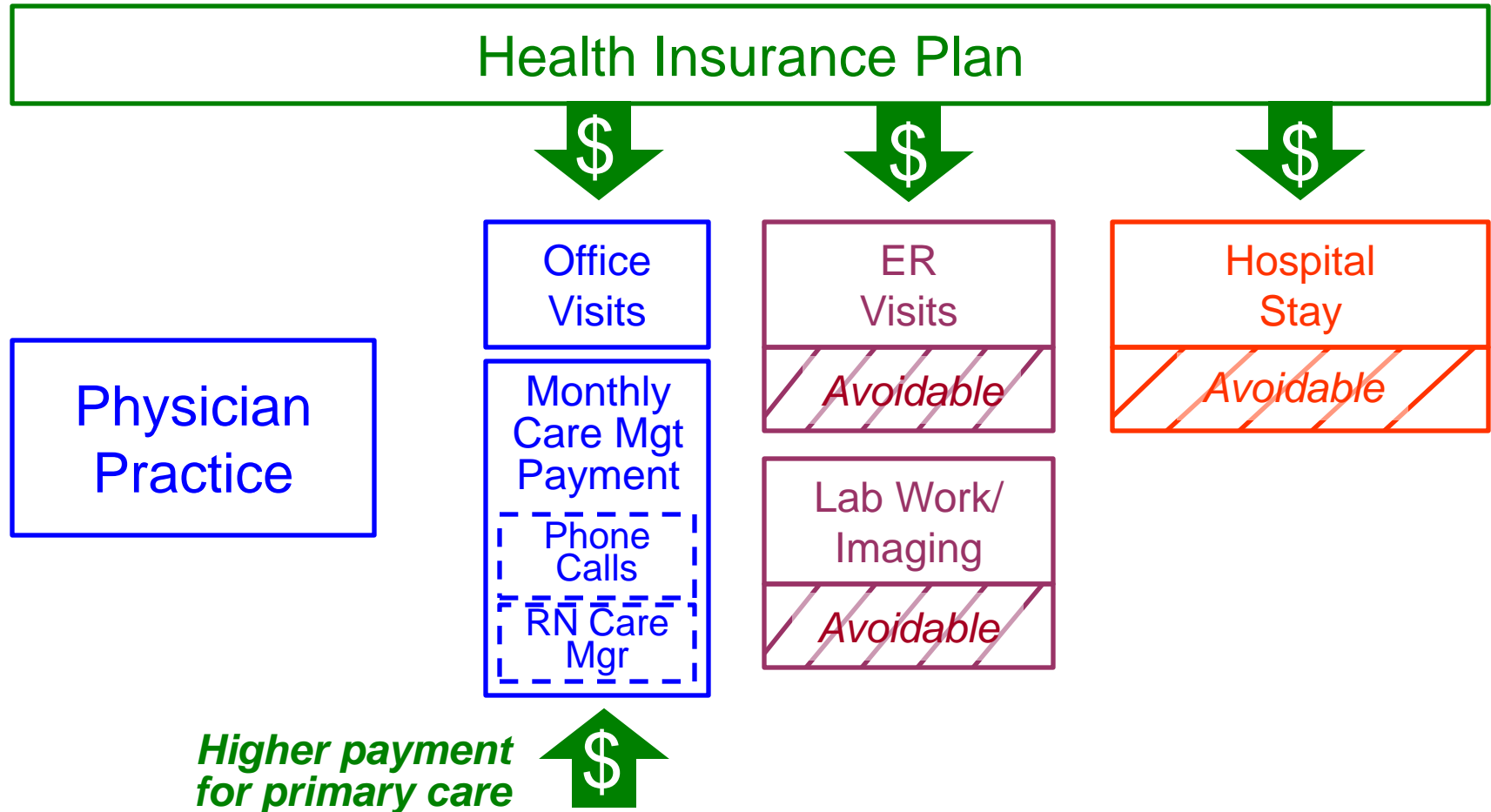
# Option 1: Add New Fee Codes for Unreimbursed PCP Services

## MEDICAL HOME PROGRAM



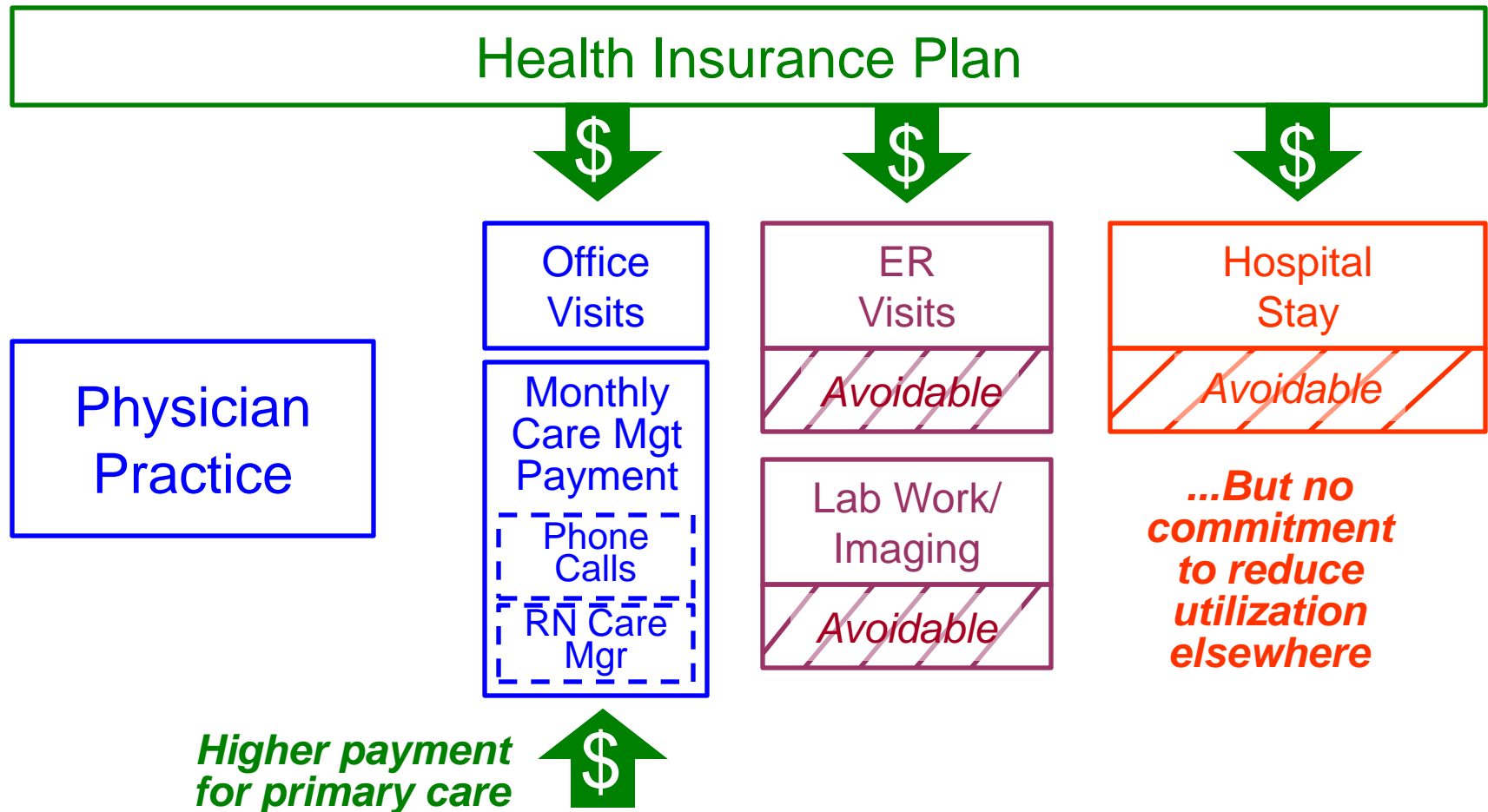
# Option 2: Pay for Monthly “Care Mgt” to Cover Missing Services

## MEDICAL HOME PROGRAM



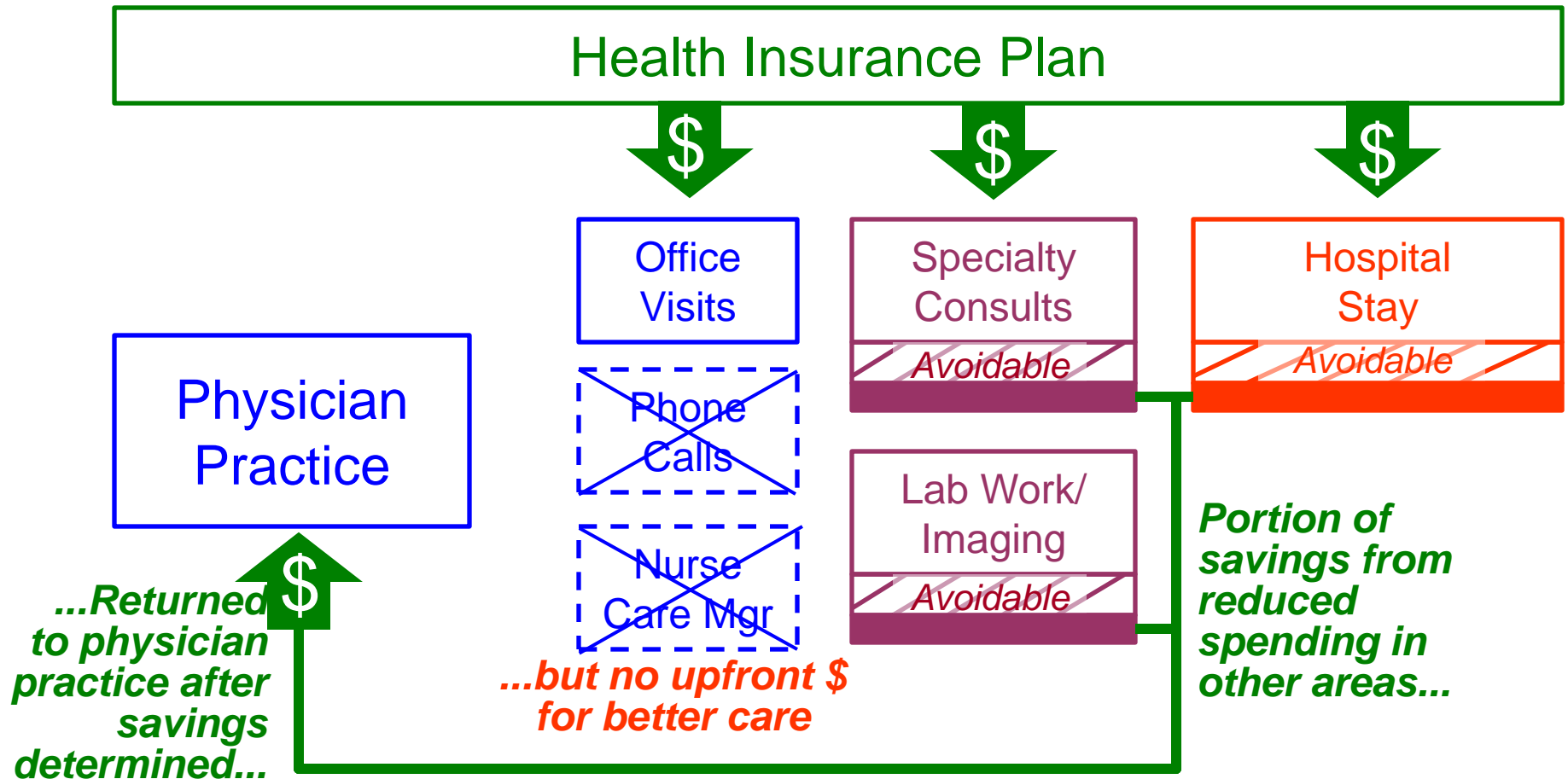
# More \$ for PCPs, But Any Savings Elsewhere?

## MEDICAL HOME PROGRAM



# Option 3: “Shared Savings” (More \$ Only If Total Costs Decrease)

## SHARED SAVINGS MODEL

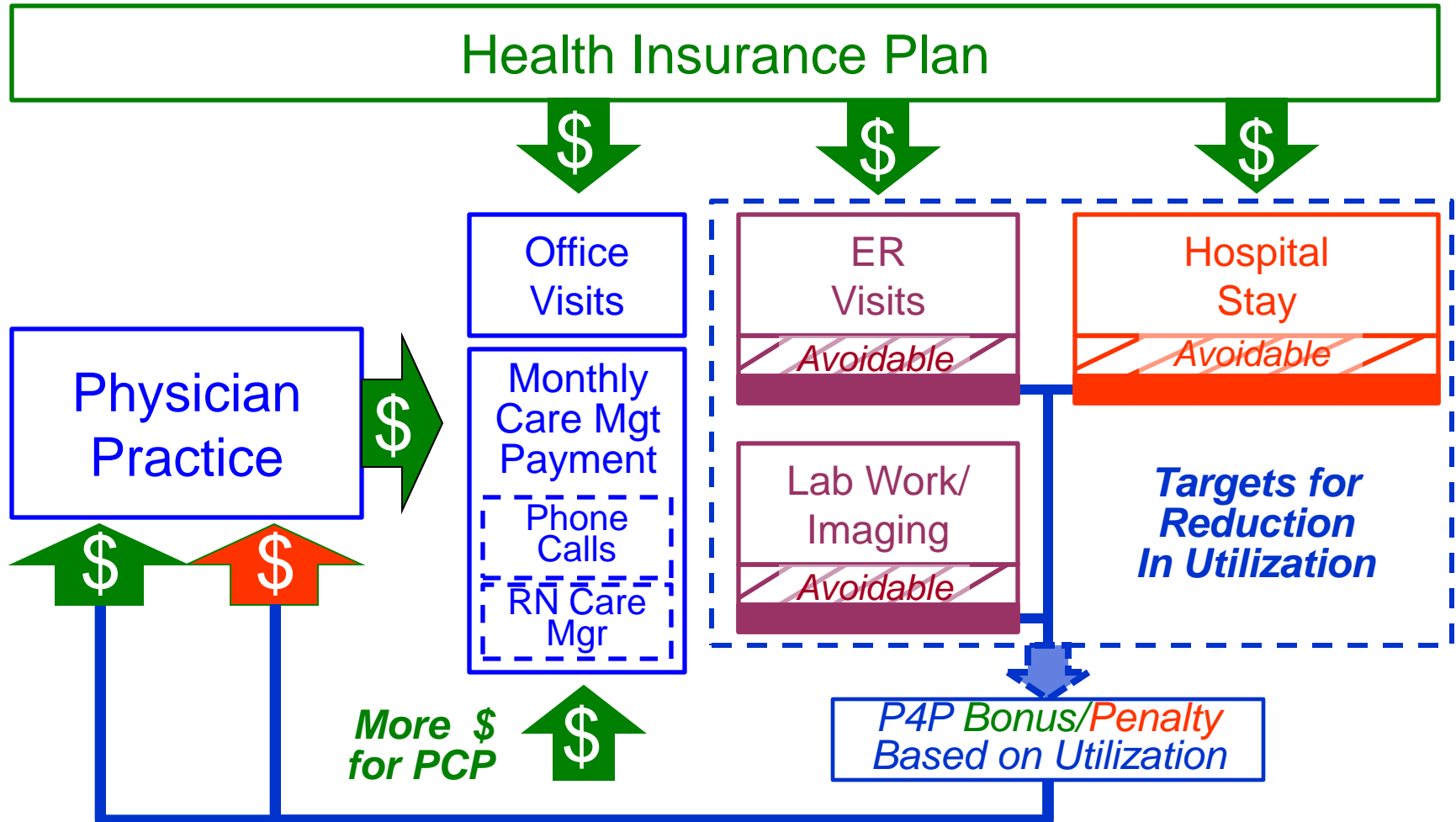


# Weaknesses of “Shared Savings”

- Provides no upfront money to enable providers 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 or health provider to receive ANY increase in payment, even if they can't control all costs
- Gives more rewards to the *poor* performers who improve than the providers who've done well all along
- I.e., it's not really *payment reform*

# Option 4: Resources + Accountability

## CARE MGT PAYMENT + UTILIZATION P4P



# Example: Washington State Medical Home Pilot Program

- 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

# Example: A Hypothetical Underpaid PCP Practice

## PRIMARY CARE PRACTICE

PCPs	4
Patients/Physician	2,000
PMPY Primary Care Cost	\$140
Annual Revenue	\$1,120,000
Overhead Costs	\$400,000
Physician Salary	\$180,000

# Many Patients Are Going to ER Due to Difficulty Seeing PCPs

## PRIMARY CARE PRACTICE

## HEALTH PLAN ER EXPENSES

PCPs	4	ER Visits/1000	200
Patients/Physician	2,000	% Preventable	40%
PMPY Primary Care Cost	\$140	Per ER Visit	\$1,000
Annual Revenue	\$1,120,000	ER Visit Cost to Payer	<b>\$640,000</b>
Overhead Costs	\$400,000		
Physician Salary	\$180,000		

# PCPs Could Reduce ER Expenses With Right Resources

## PRIMARY CARE PRACTICE

## HEALTH PLAN ER EXPENSES

PCPs	4	ER Visits/1000	200
Patients/Physician	2,000	% Preventable	40%
PMPY Primary Care Cost	\$140	Per ER Visit	\$1,000
Annual Revenue	\$1,120,000	ER Visit Cost to Payer	\$640,000
Overhead Costs	\$400,000		
Physician Salary	\$180,000		
Cost of Nurse Practitioner	\$80,000	Reduction in Prev. ER Visits	40%
Other Costs	\$10,000	Savings	\$256,000
Total Costs	\$90,000		

# Upfront Money Could *Enable* PCPs to Change, If Willing

## PRIMARY CARE PRACTICE

## HEALTH PLAN ER EXPENSES

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Total Costs	<b>\$90,000</b>		
Upfront Payment	<b>\$90,000</b>	Payment to Practice	<b>\$90,000</b>
		Net Savings to Payer	<b>\$166,000</b>

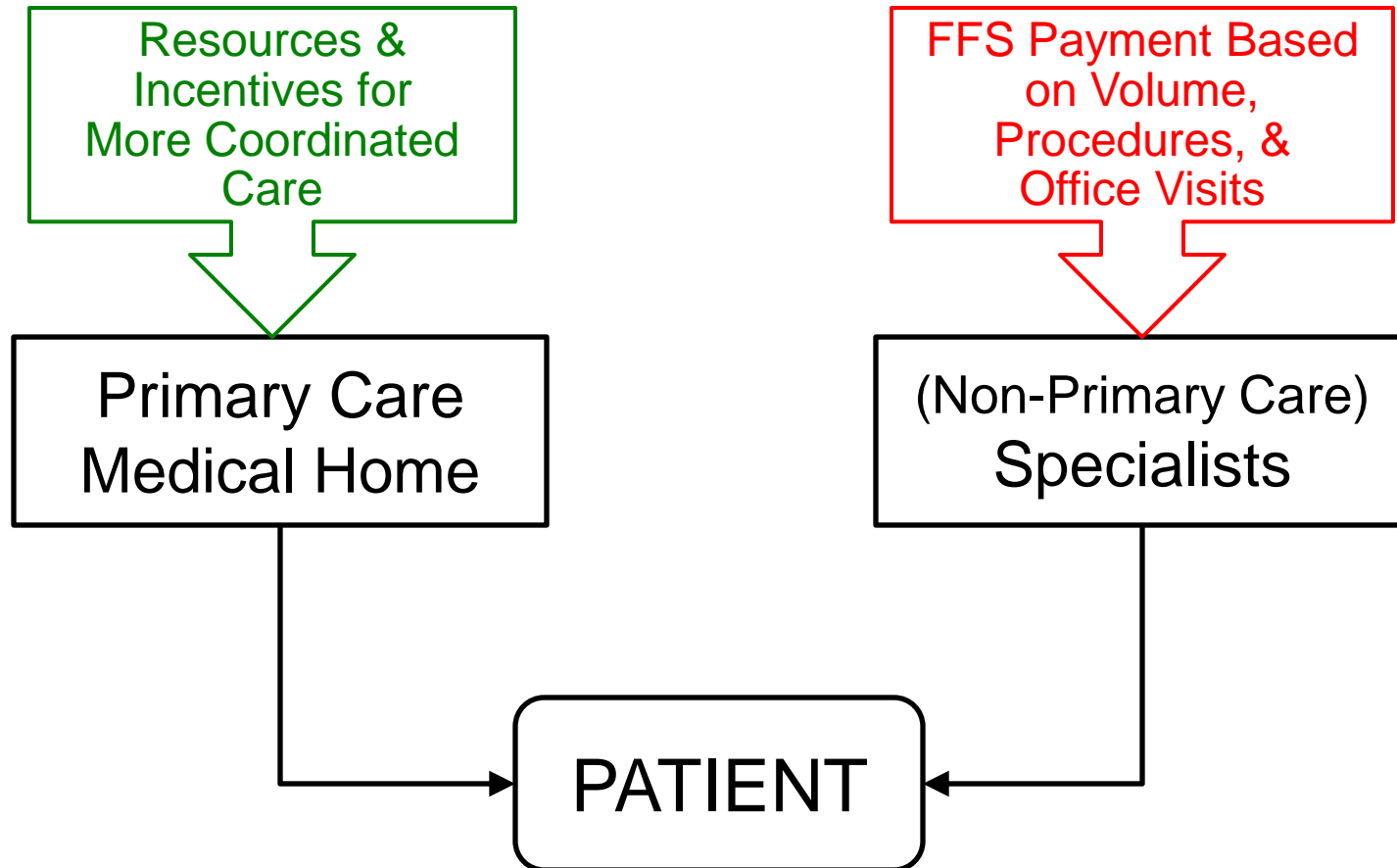
# Win-Win-Win for PCPs, Patients, & Premiums

## PRIMARY CARE PRACTICE

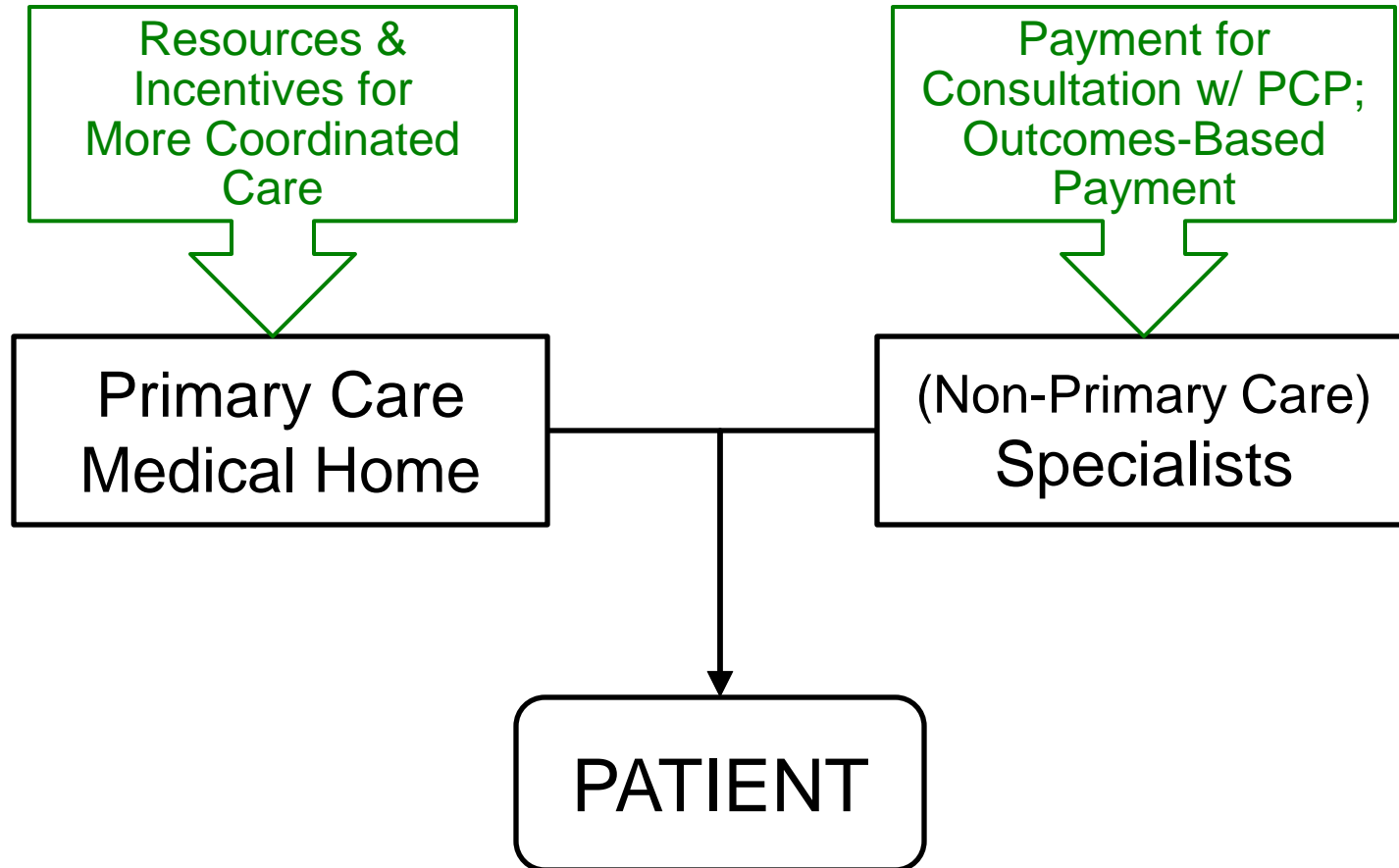
## HEALTH PLAN ER EXPENSES

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Total Costs	\$90,000		
Upfront Payment	\$90,000	Payment to Practice	\$90,000
		Net Savings to Payer	\$166,000
Share of Savings	\$83,000	Share to Practice	50%
New Physician Salary	\$200,750	Net Savings to Payer	\$83,000
Increase in Phys. Salary	12%	% Savings to Payer	13%

# Payment Reform Needed for the Medical Neighborhood, Too



# Pay Both PCPs & Specialists for Outcomes & Coordination



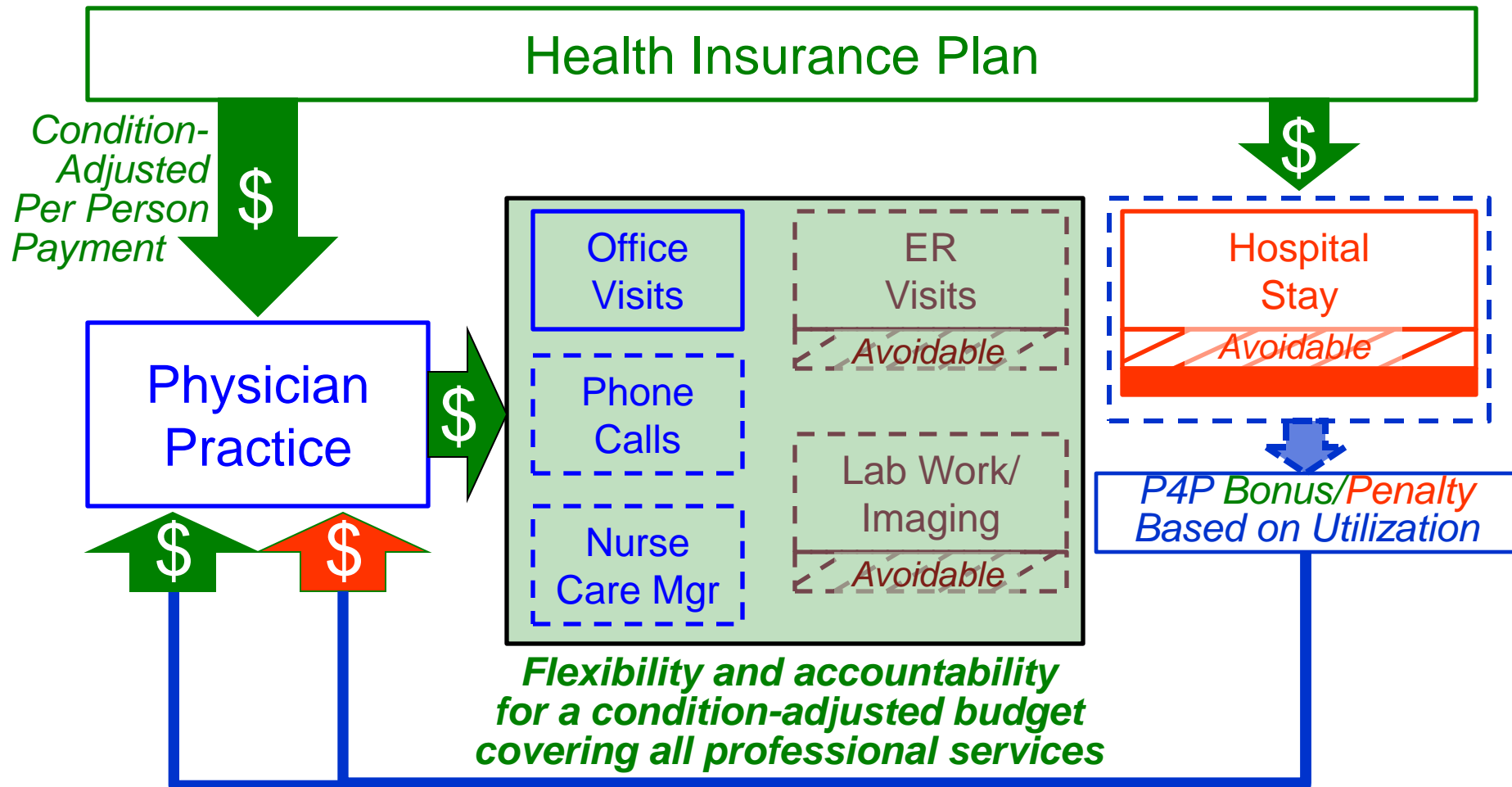
# Minnesota's DIAMOND Initiative

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- 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

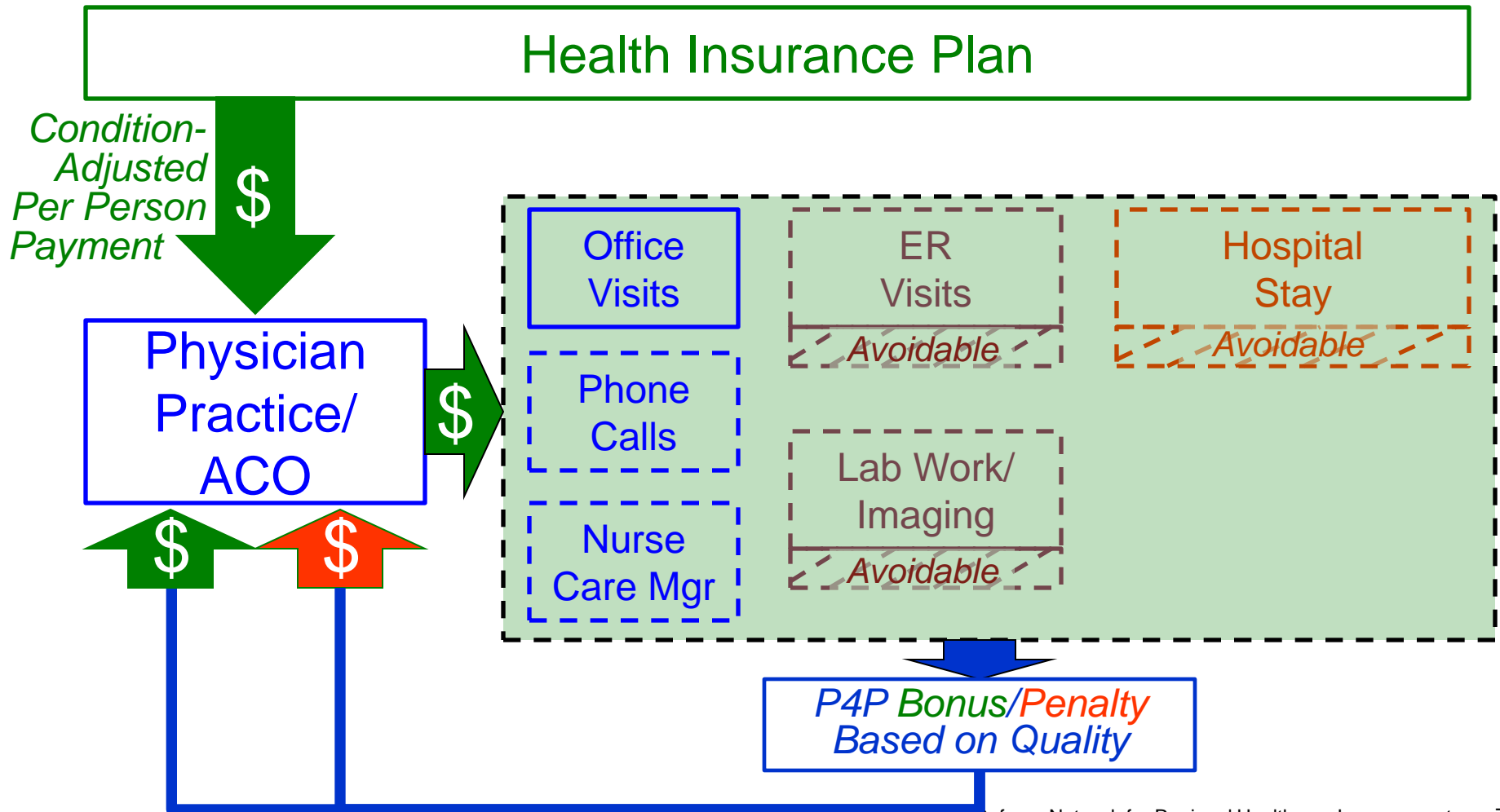
# Phase 2: More ACO-ness: Partial Global Payment

## PARTIAL GLOBAL PMT (Professional Svcs)

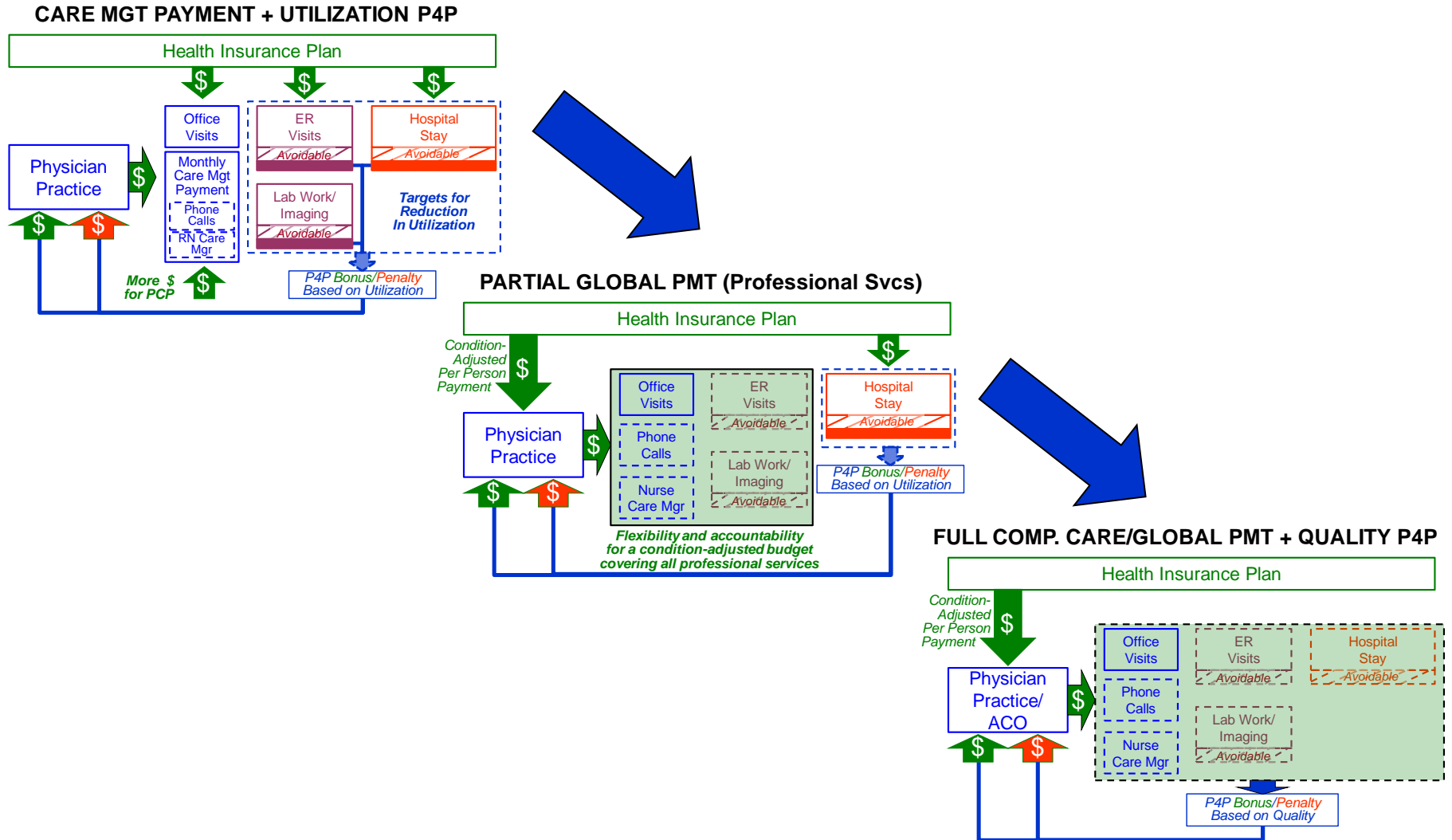


# And *Then* Transition to a Full Global Payment System

## FULL COMP. CARE/GLOBAL PAYMENT



# Transitioning to Accountable Care Payment



# How Will Medicare Pay for ACOs?

## Patient Protection and Affordable Care Act

Shared  
Savings  
Program  
(Section 1899 of SSA)

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### Shared Savings Program

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Shared Savings  
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“Partial Capitation”  
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“Other Payment  
Models” for ACOs

# How Will Medicare Pay for ACOs?

## Patient Protection and Affordable Care Act

### Shared Savings Program

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Shared Savings  
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“Other Payment  
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### Defined Demonstrations and Reforms

(Various Sections)

Medical Homes/  
Chronic Disease Mgt

Inpatient Bundling

“Value-Based  
Payment”

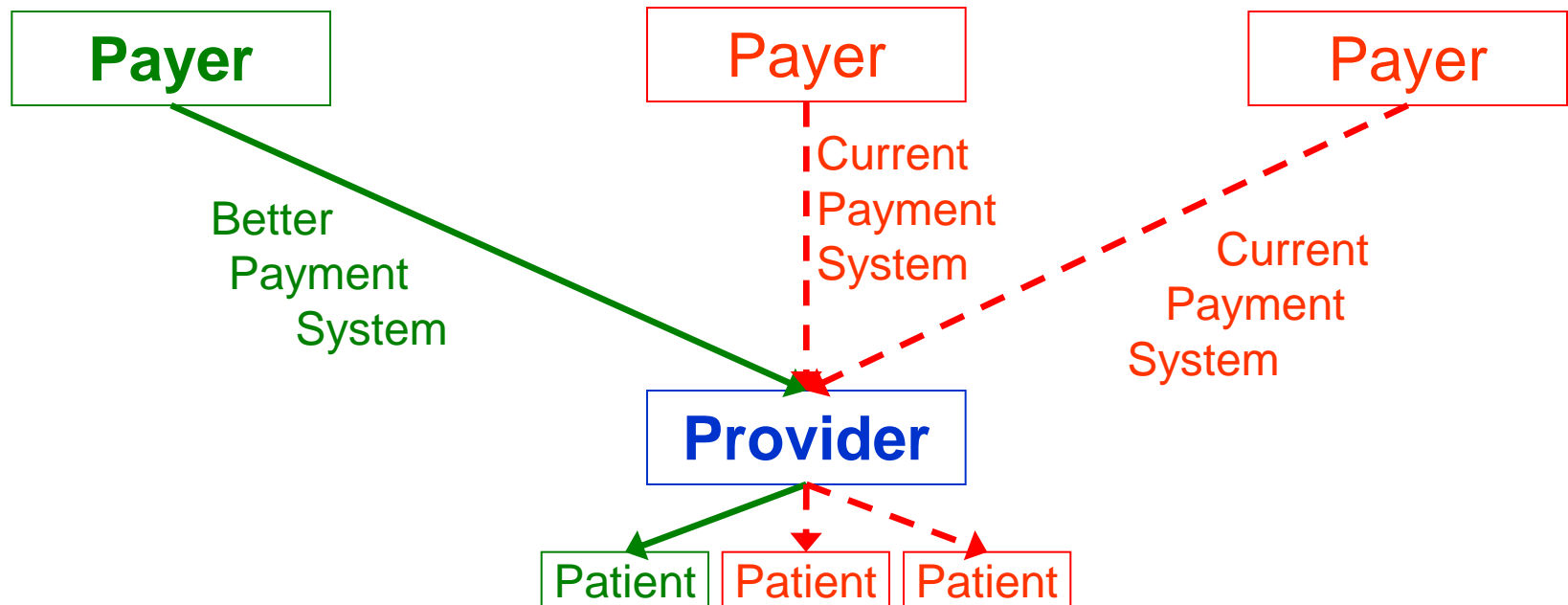
and others...

### Center for Medicare & Medicaid Innovation

(Section 1115A of SSA)

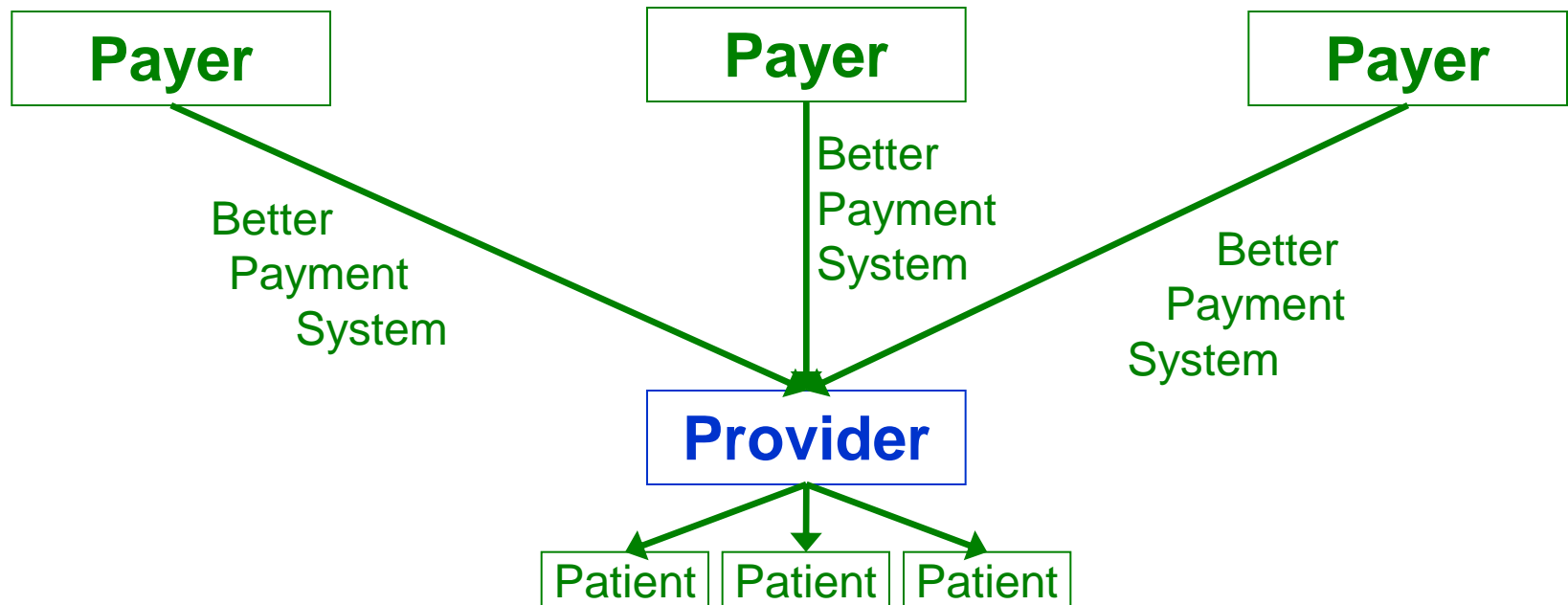
- Test models of care to improve quality & reduce costs
- Ultimately budget neutral, not initially
- Ability to use new payment models & waive legal barriers

# One Payer is Not Enough

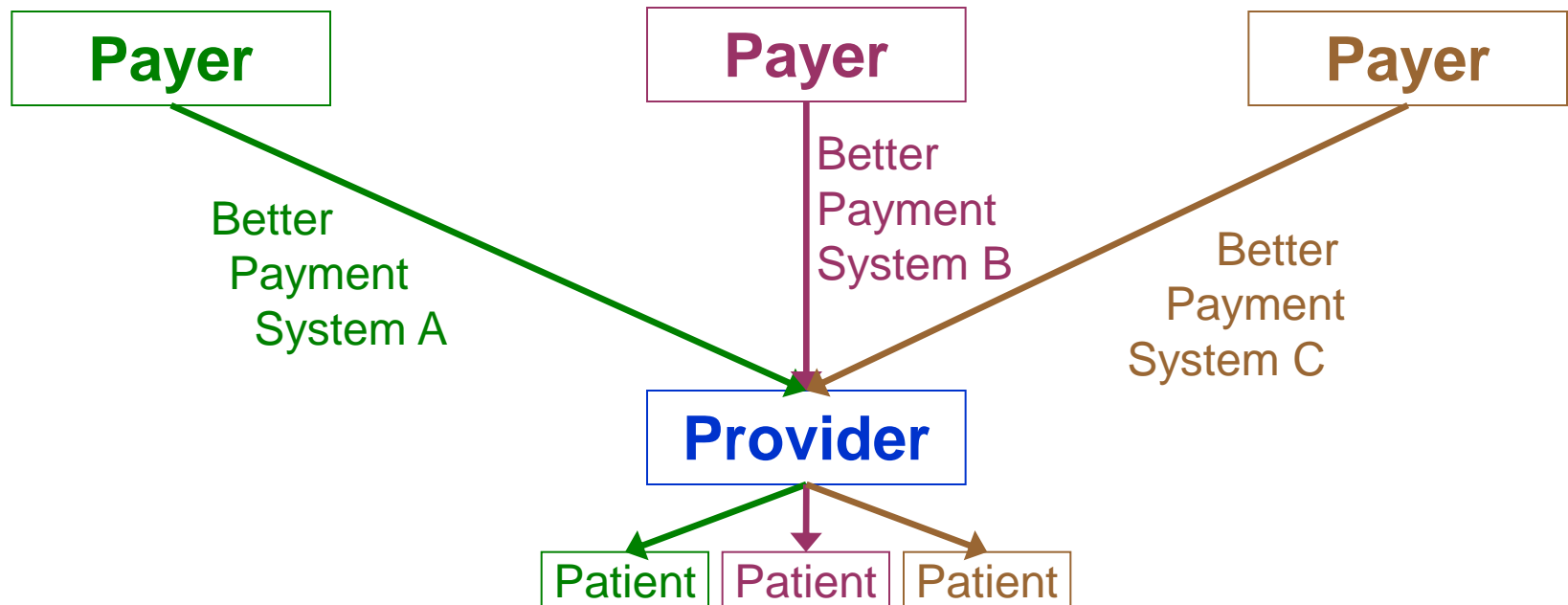


***Provider is only compensated for changed practices for the subset of patients covered by participating payers***

# 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

# Can Small Physician Practices Manage Accountable Payments?

- **Infrastructure/Services**

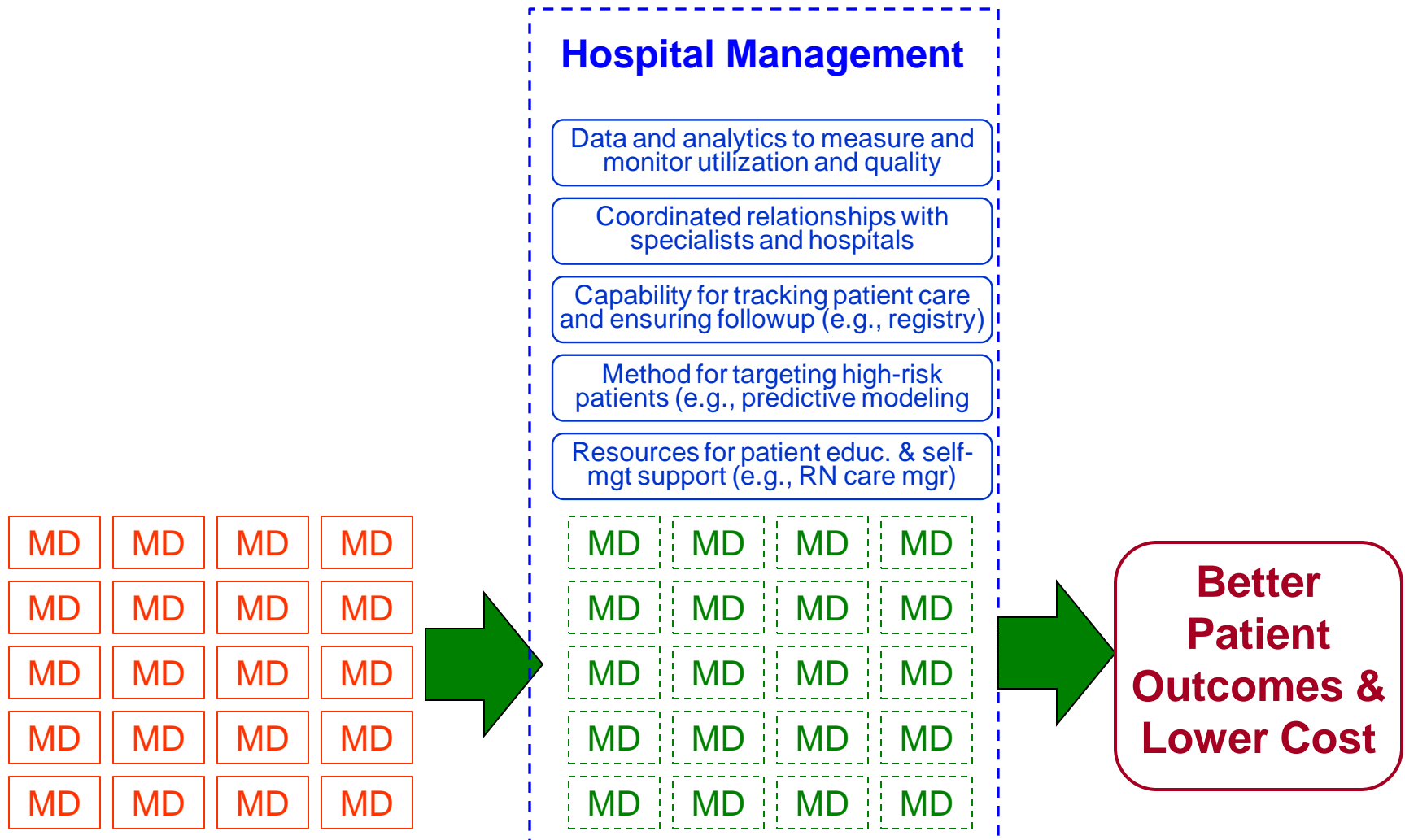
- Small physician practices may not have enough patients to justify staff or other services to coordinate care, particularly for patients with complex illnesses (e.g., nurse care managers, patient registries, etc.)

- **Quality/Cost Measurement**

- Small numbers of patients make measurement unreliable; physicians may be inappropriately labeled low quality, high cost, or vice versa



# Solution 1: Hospitals Acquire Physician Practices

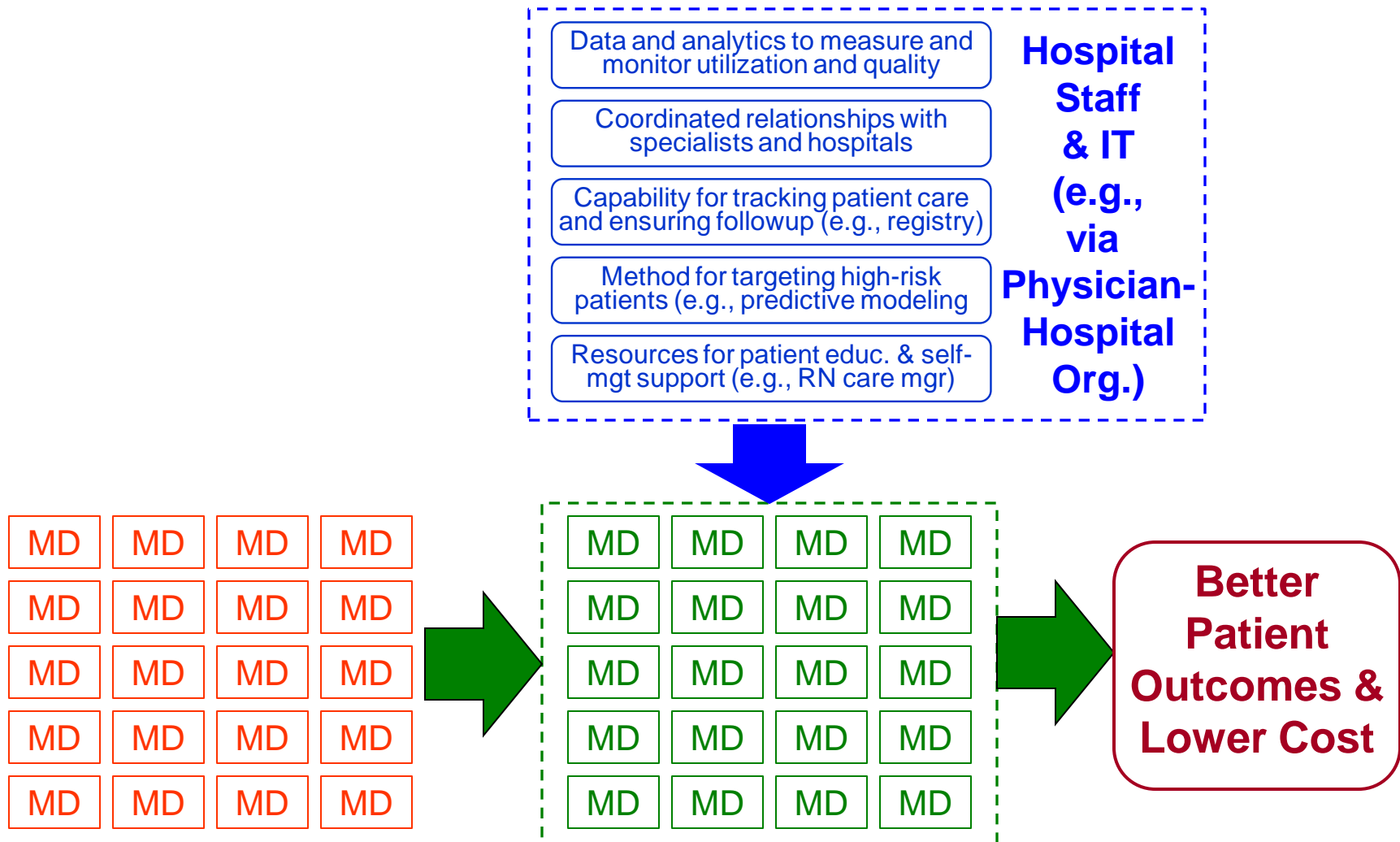


# Shared Savings Forces Hospitals To Consider Employing Docs

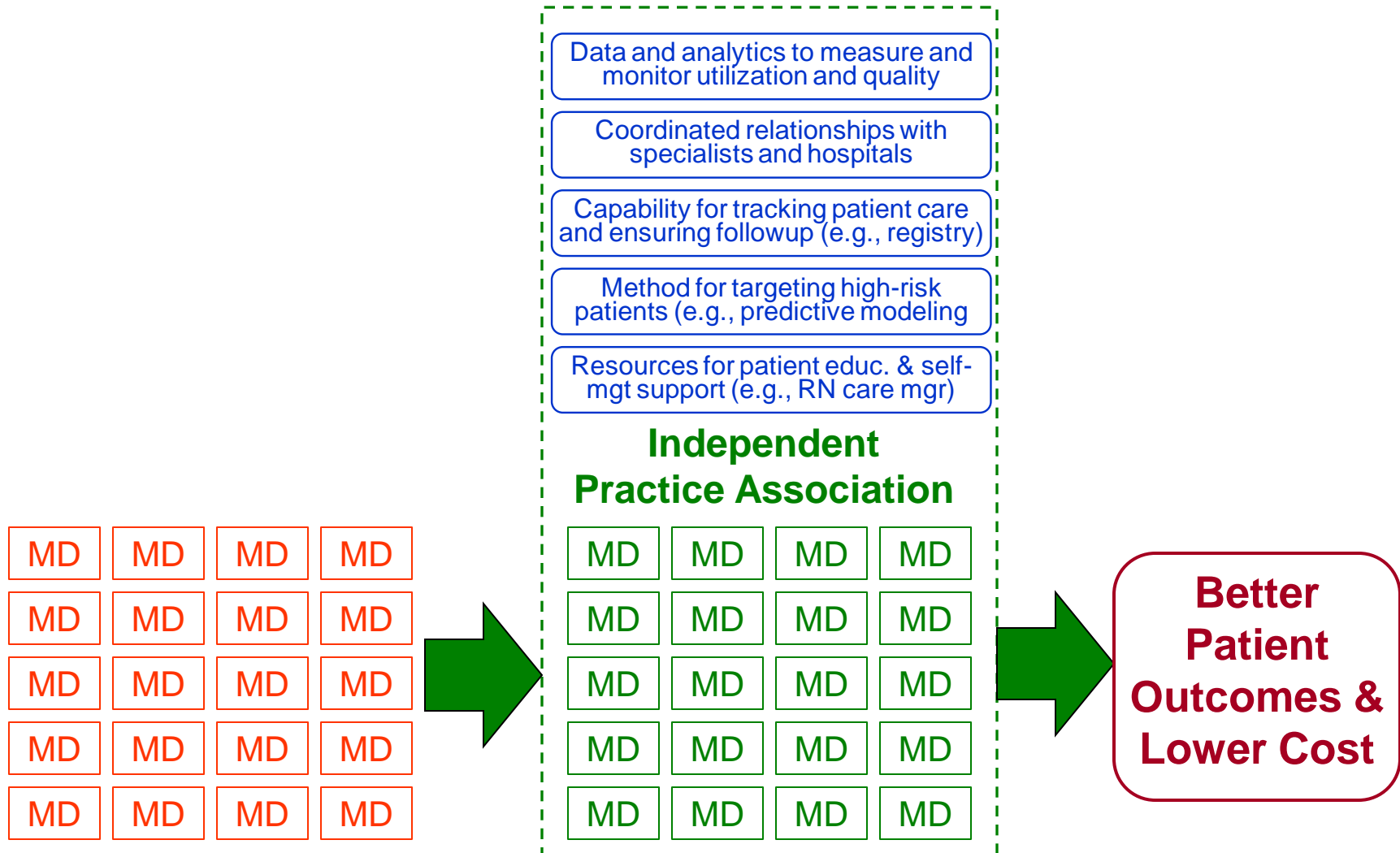
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- Hospitals are not directly eligible for shared savings : all savings are attributed to primary care physicians
- Even if the hospital reduces readmissions, infections, complications, etc., it may receive no reward for doing so
- Reducing hospitalizations, 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

# Solution 2: Hospital-Physician Partnerships



# Solution 3: Use IPAs for Critical Mass



# Examples of Small, Independent Phys. Practices With Global Pmt

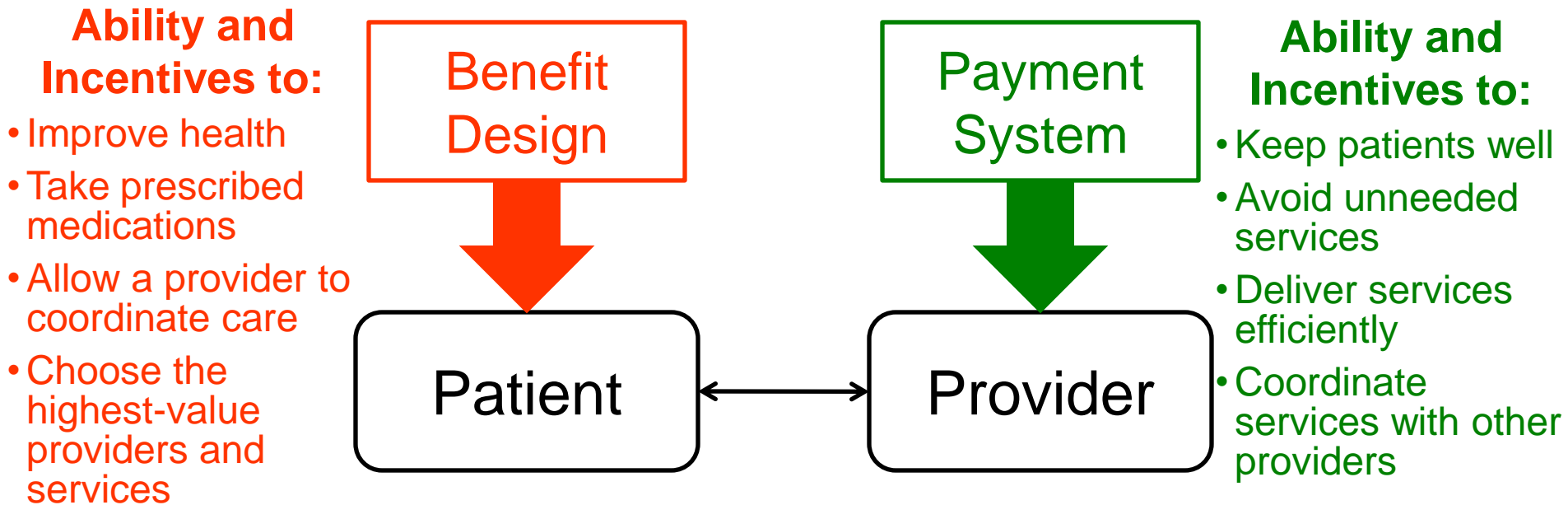
- **Small Primary Care Practices Managing Global Payments**
  - Physician Health Partners (PHP) in Denver, CO is a management services organization that supports four separate IPAs (median size: 3 docs/practice). PHP accepts capitated risk-based contracts on behalf of the IPAs with both Medicare and commercial HMOs. [www.phpmcs.com](http://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 physicians/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](http://www.npnwa.net)
- **Joint Contracting by Physicians & 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](http://www.macipa.com)

# PPACA/Medicare

## Definition of ACO

- “ACO professionals” (physicians, nurse practitioners, etc.) in group practice arrangements
  - Networks of individual practices of ACO professionals
  - Partnerships or joint venture arrangements between hospitals and ACO professionals
  - Hospitals employing ACO professionals
  - Other groups of providers as the Secretary of HHS determines appropriate
- Willing to become accountable for the quality, cost, and overall care of assigned Medicare FFS beneficiaries
  - Legal structure to receive and distribute payments for shared savings
  - Sufficient number of primary care “ACO professionals”
  - Leadership and management structure; clinical and administrative systems
  - Processes to use EBM, report on quality, coordinate care
  - Patient-centeredness

# Benefit Design Changes Are Also Critical to Success



# Creating Consumer Incentives for Value-Based Choice

## ROCK

CONSUMERS/  
PATIENTS RECEIVE  
INSURANCE  
COVERAGE FOR ALL  
SERVICES  
AND ALL  
PROVIDERS

## HARD PLACE

NARROW  
NETWORKS  
AND DENIAL OF  
BENEFITS  
FOR SERVICES  
VIEWED AS NOT  
COST-EFFECTIVE

# Creating Consumer Incentives for Value-Based Choice

## ROCK

CONSUMERS/  
PATIENTS RECEIVE  
INSURANCE  
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## MIDDLE GROUND

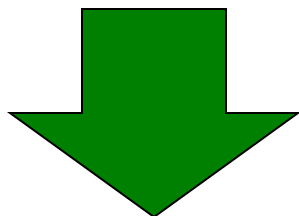
PATIENTS  
HAVE ACCESS TO  
ALL SERVICES AND  
PROVIDERS BUT  
PAY MORE TO USE  
LOWER-VALUE  
SERVICES AND  
PROVIDERS

## HARD PLACE

NARROW  
NETWORKS  
AND DENIAL OF  
BENEFITS  
FOR SERVICES  
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COST-EFFECTIVE

# Importance of Coordinating Pharmacy & Medical Benefits

Single-minded focus on reducing costs here...



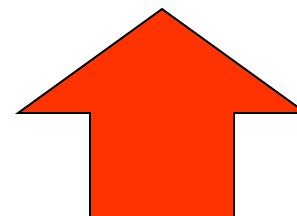
## Pharmacy Benefits

Drug Costs

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

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

...could result in higher spending on hospitalizations



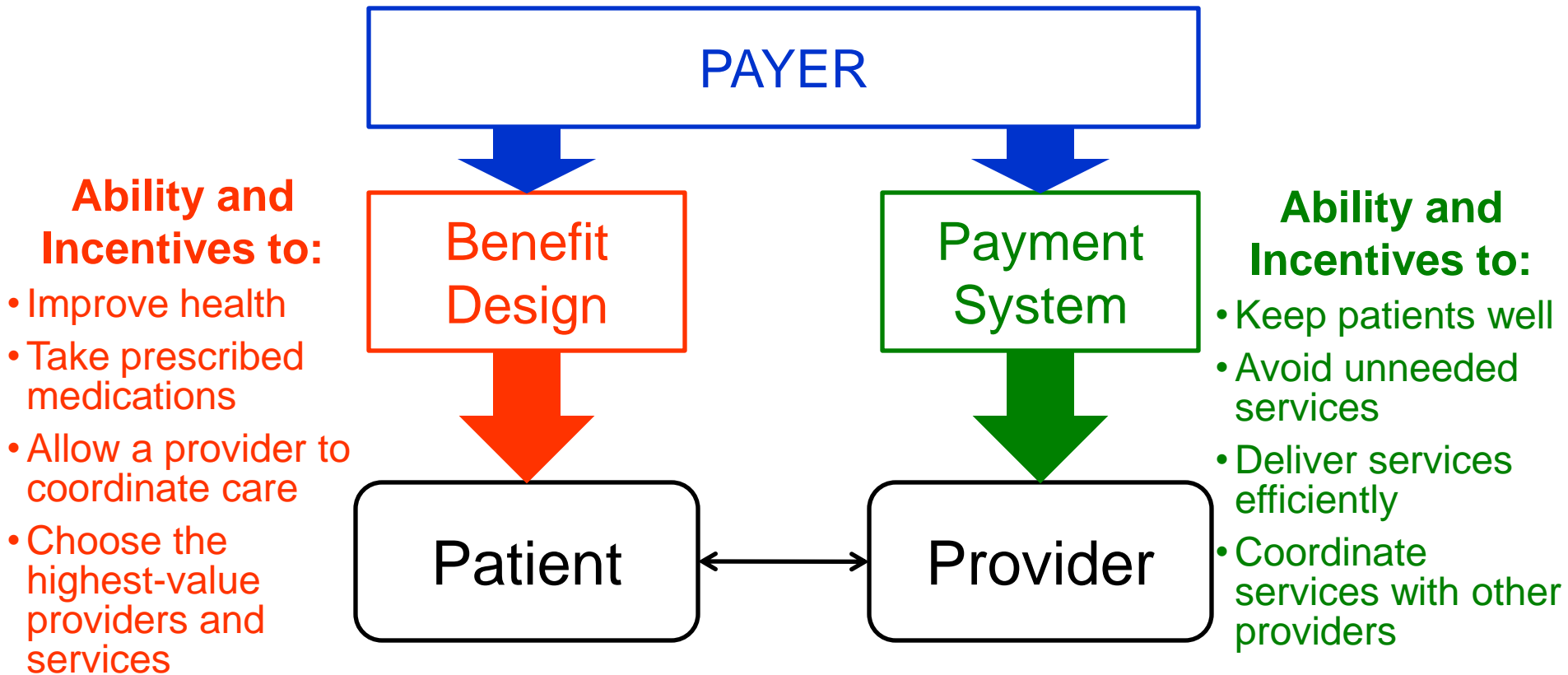
## Medical Benefits

Hospital Costs

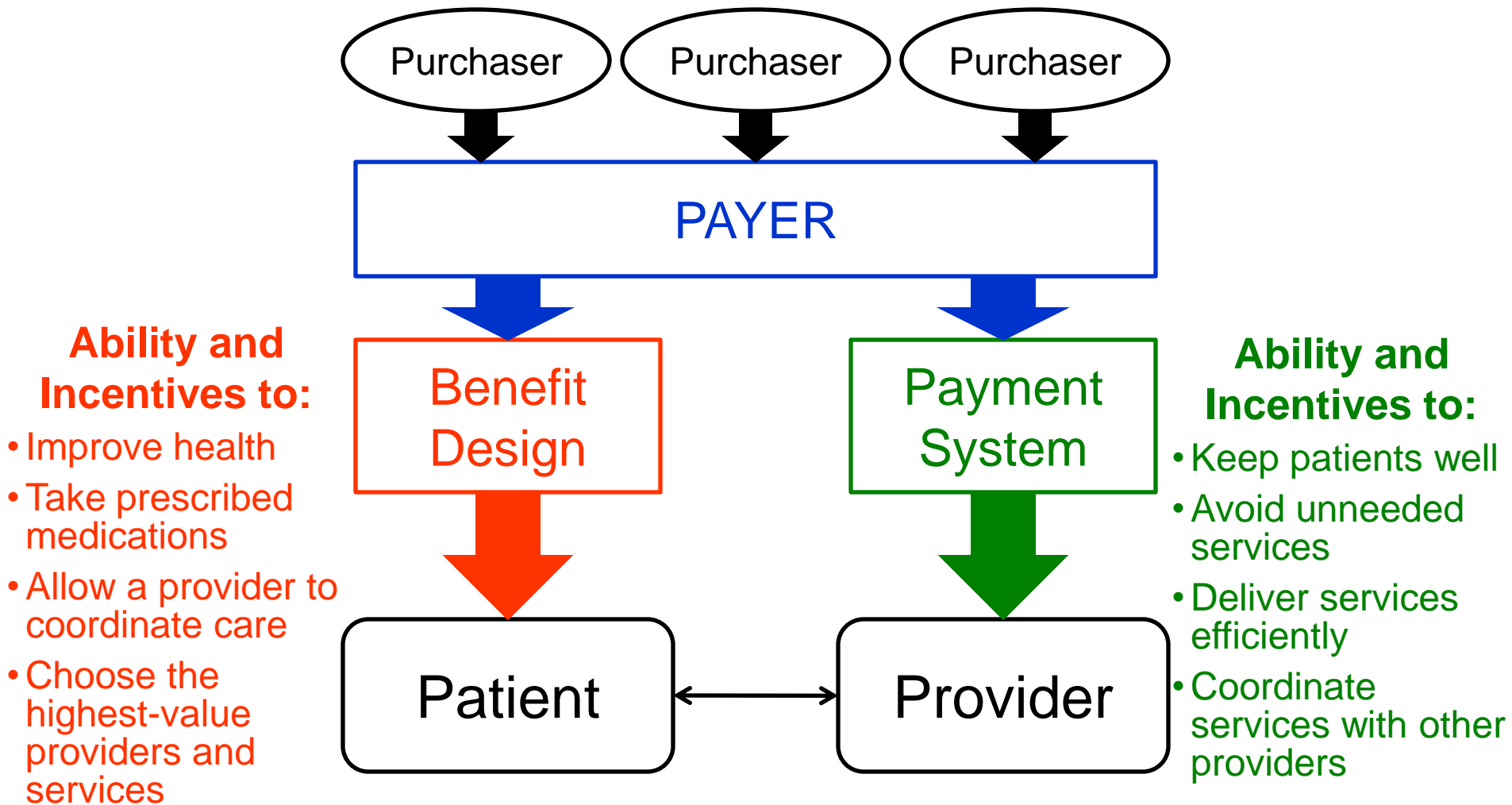
Physician Costs

Other Services

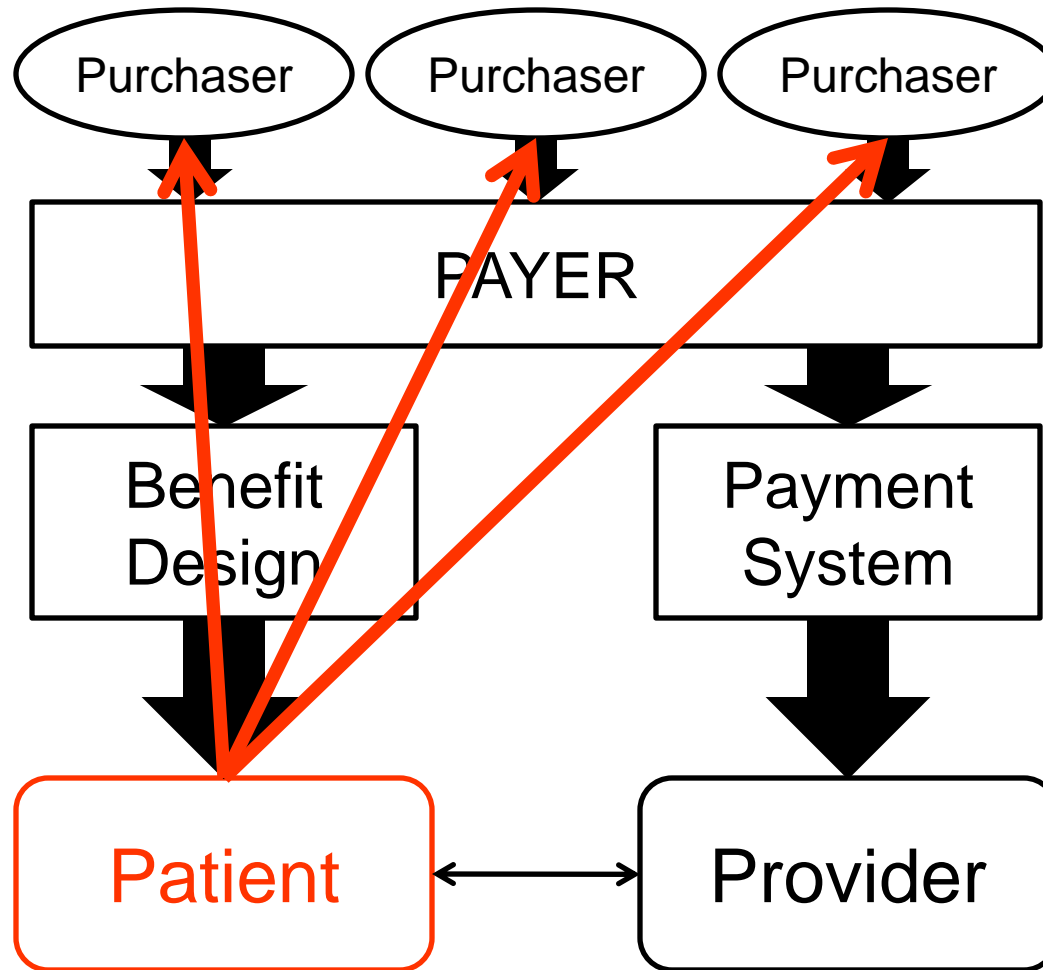
# Both Payment and Benefits are Controlled by the Payer



# But Purchaser Support is Needed Particularly for Benefit Changes



# And Consumer Support is Critical for Purchaser/Plan Support



# Better Quality Measurement Needed

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- Concern: Giving healthcare providers more accountability for costs reduces the incentives for overuse, but raises concerns about whether patients will get too little care

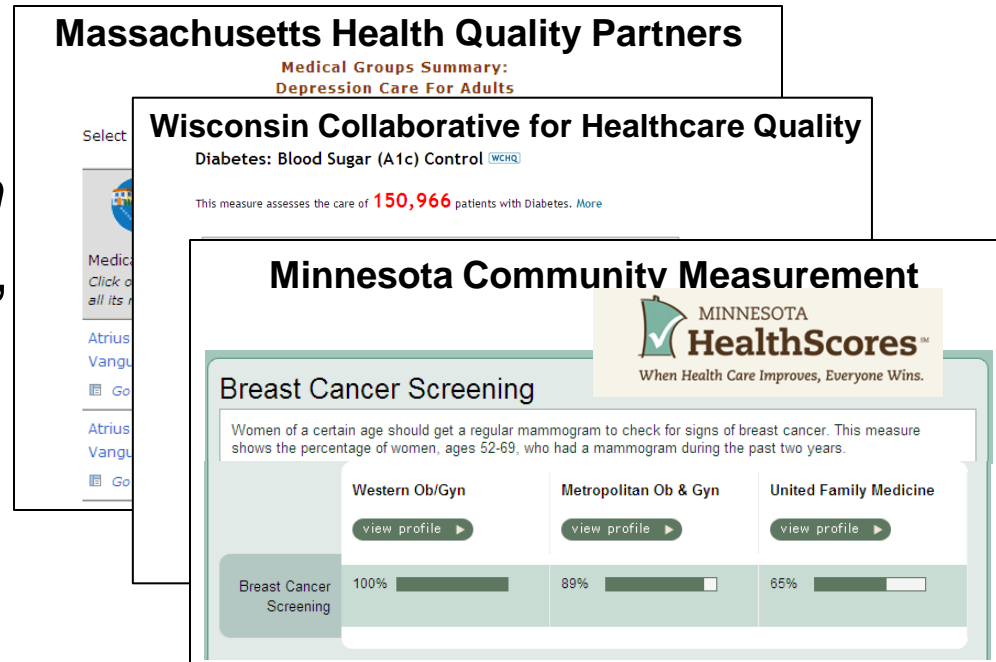
# Better Quality Measurement Needed

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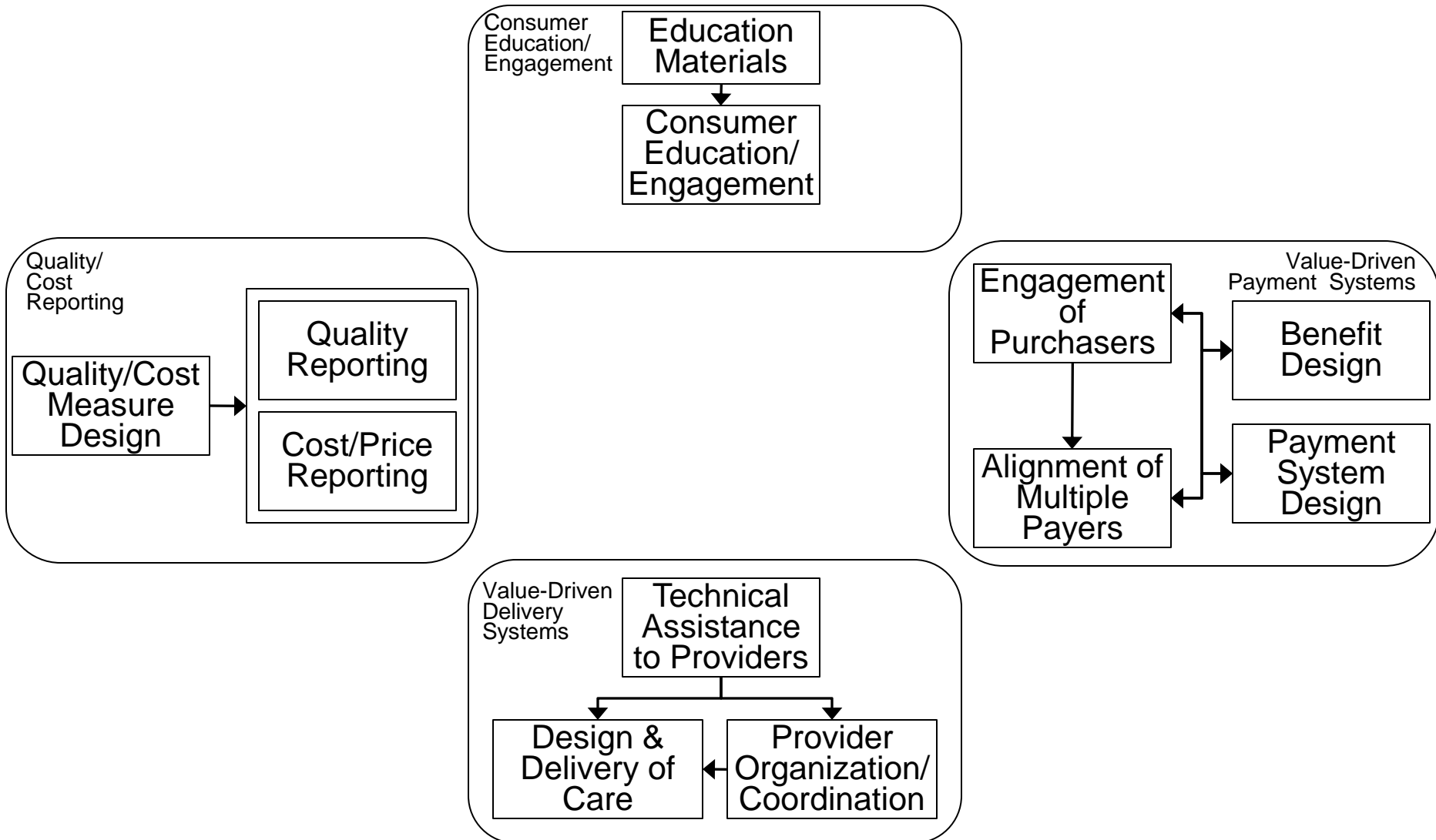
- **Concern:** Giving healthcare providers more accountability for costs reduces the incentives for overuse, but raises concerns about whether patients will get too little care
- **Solution:** Measure healthcare quality and include incentives for providers to maintain/improve quality as well as reduce costs

# Community-Driven Quality Measurement

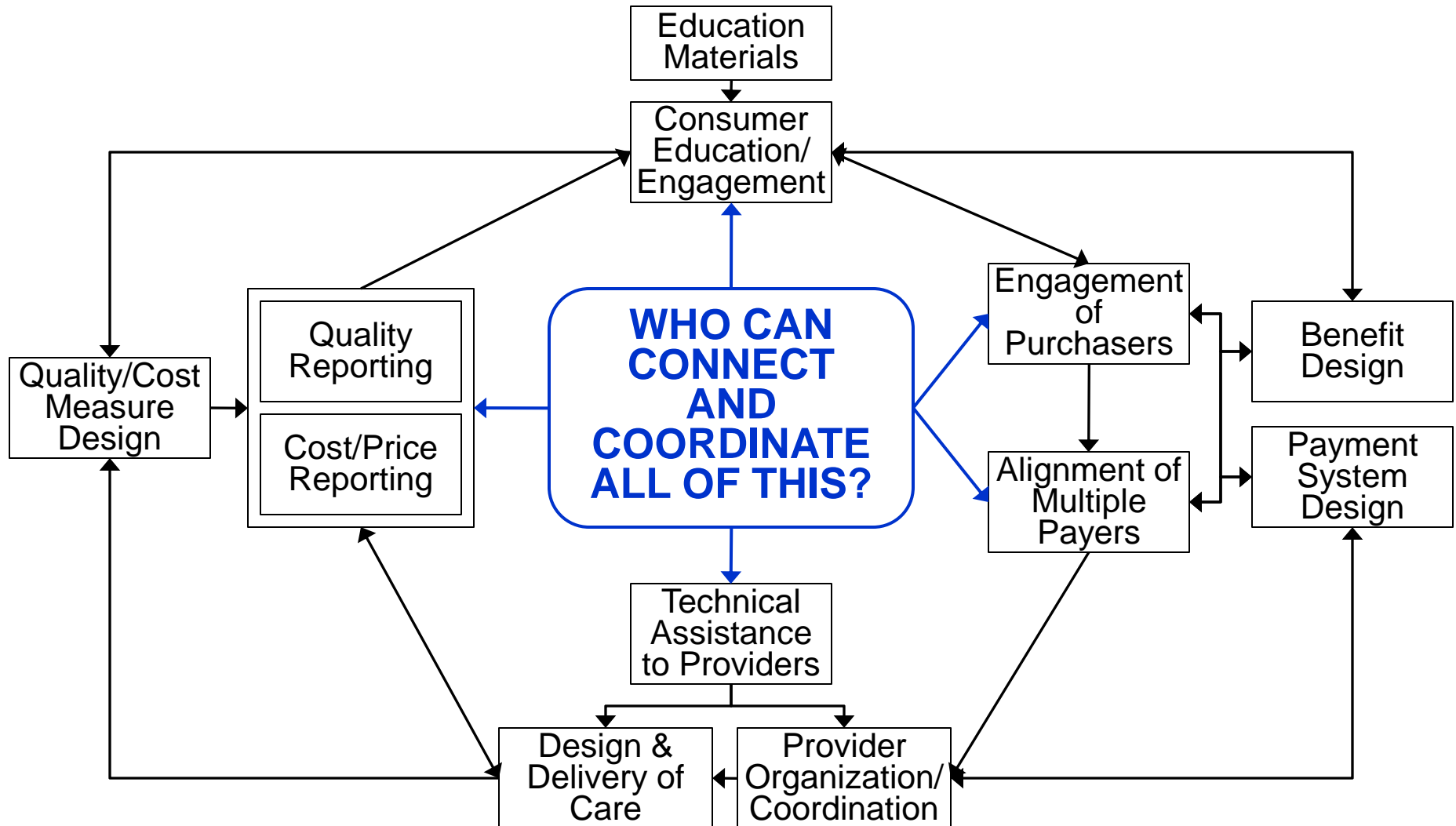
- **Concern:** Giving healthcare providers more accountability for costs reduces the incentives for overuse, but raises concerns about whether patients will get too little care
- **Solution:** Measure healthcare quality and include incentives for providers to maintain/improve quality as well as reduce costs
- **Ideal:** Develop quality measures *with participation of physicians and hospitals*, as Regional Health Improvement Collaboratives do



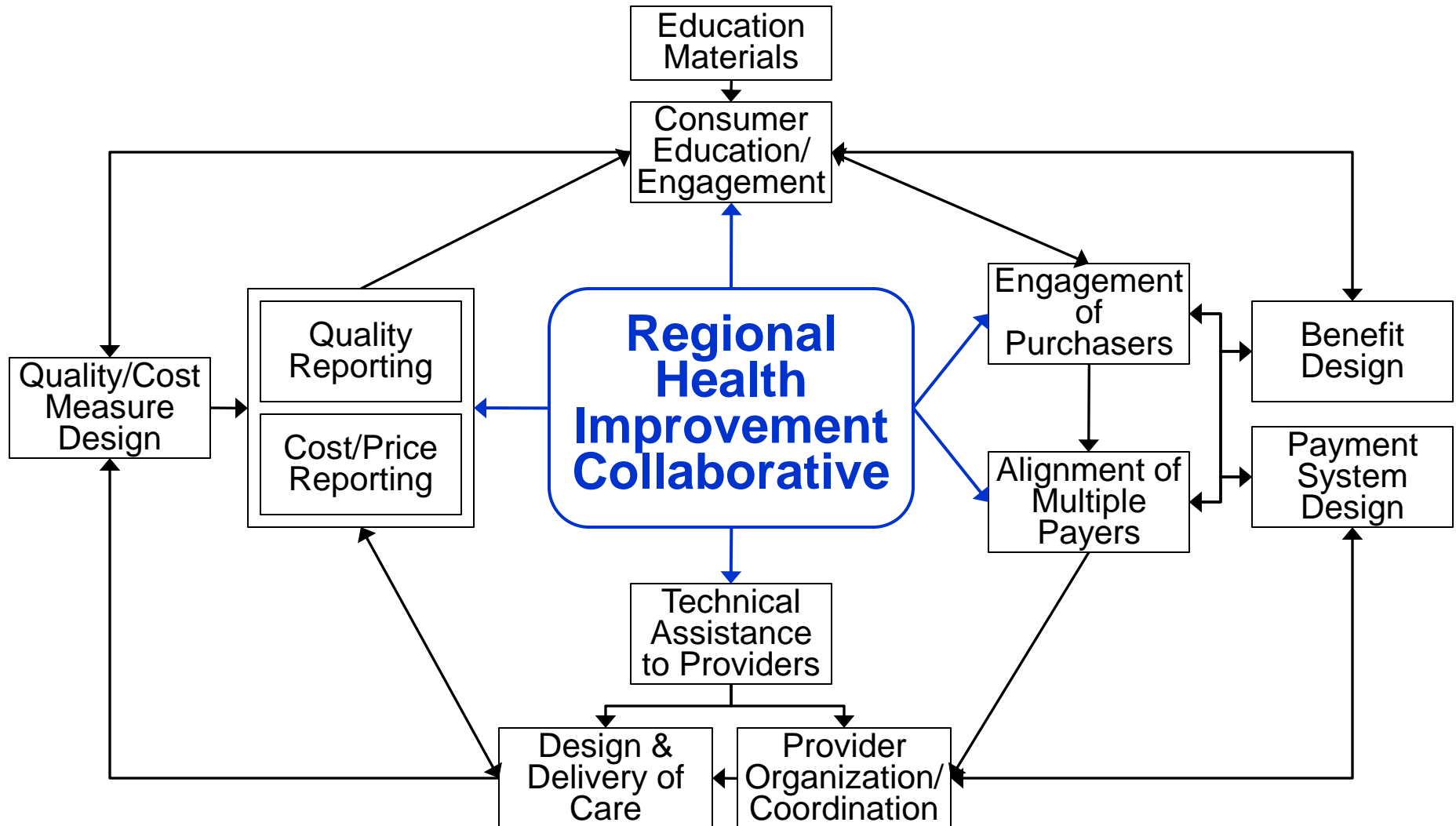
# Functions Needed for Healthcare Payment & Delivery Reform



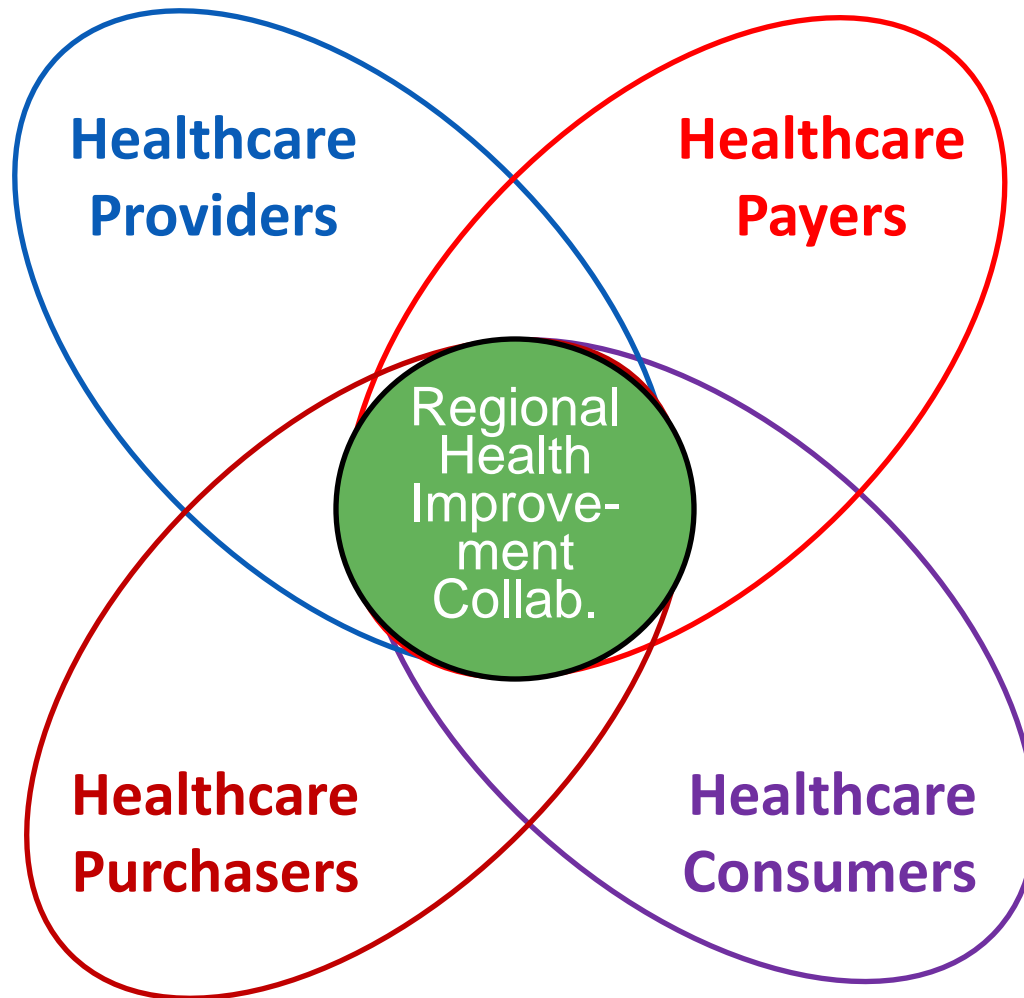
# Coordinated Support Needed



# The Role of Regional Health Improvement Collaboratives...



# ...With Active Involvement of All Healthcare Stakeholders



# Leading 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



# Getting Started on the Road to More Accountable Care

- Recognize that there is no one-size-fits-all solution or implementation path; the best thing the federal government can do is to support local strategies
- Get all stakeholders working together to design the kind of healthcare payment, delivery, and benefit structures the community wants to have in 5-7 years to reduce costs and improve quality
- Pilot test the payment and delivery reforms with willing providers while building consumer support
- Implement the payment and delivery reforms across the community
- Measure progress and resolve challenges through an ongoing collaborative, multi-stakeholder community process



# For More Information:

**Center for Healthcare Quality and Payment Reform**

[www.paymentreform.org](http://www.paymentreform.org)

**American Medical Association**  
*Payment Pathways*

[www.ama-assn.org/go/paymentpathways](http://www.ama-assn.org/go/paymentpathways)

*Health System Reform*

[www.hsreform.org](http://www.hsreform.org)

**Harold D. Miller**

**Executive Director, Center for Healthcare Quality and Payment Reform**

[Miller.Harold@CHQPR.org](mailto:Miller.Harold@CHQPR.org)

