WIN-WIN-WIN APPROACHES TO ACCOUNTABLE CARE
How Physicians, Hospitals, Patients, & Payers Can All Benefit from Healthcare Payment and Delivery Reform and How AMGA Members Can Lead the Way

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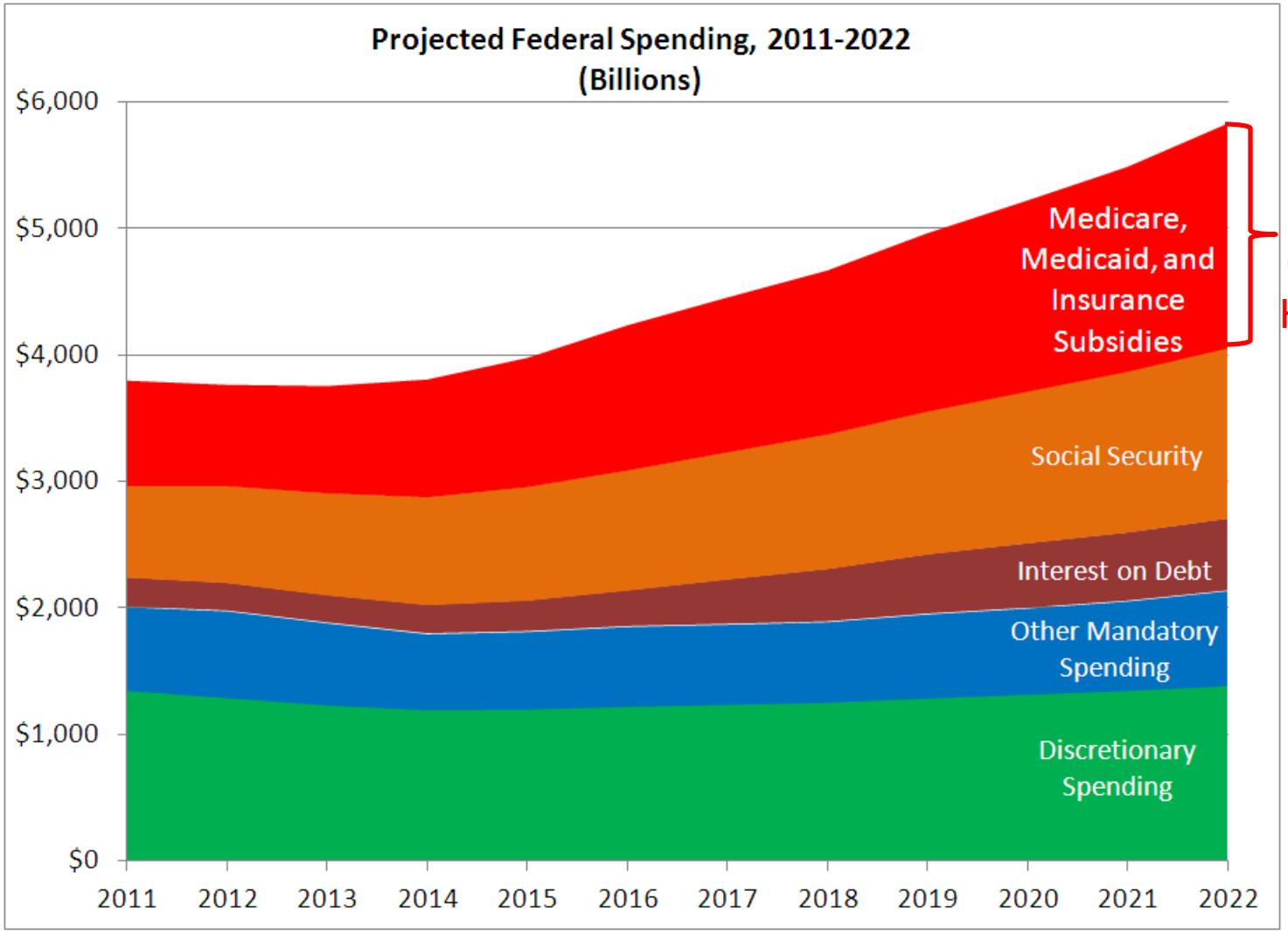
Center for Healthcare Quality and Payment Reform

www.CHQPR.org

Goals of Today's Presentation

- **How to Eliminate the Federal Deficit**
- **How to Double Physicians' Pay (While Reducing Healthcare Spending)**
- **How to Make Physicians *Want* to Create a (True) ACO *and* Make It Successful**
- **How to Help Americans Live Longer, Healthier Lives**

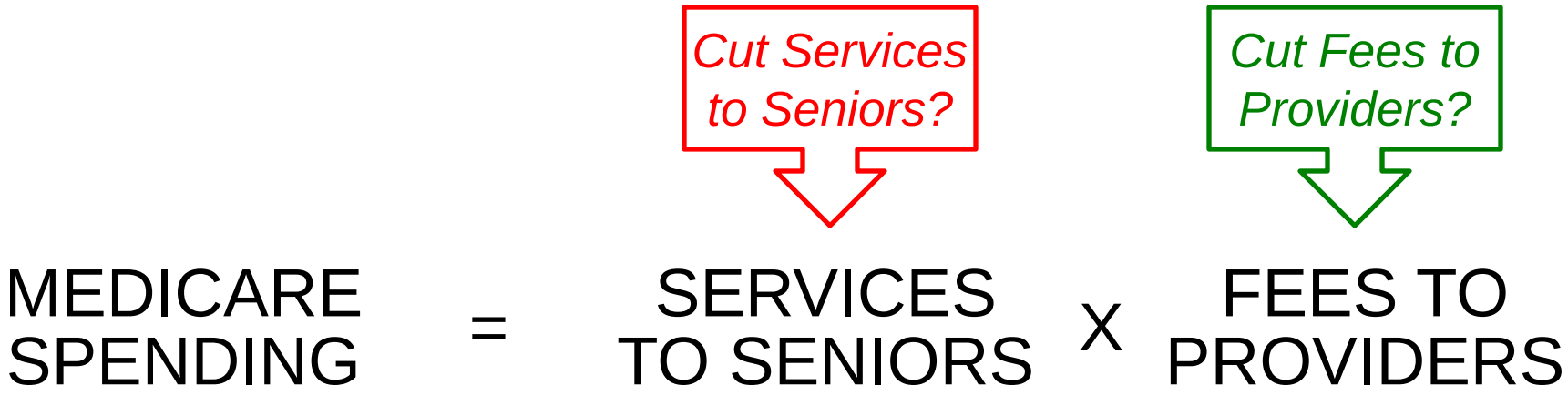
Healthcare Spending Is the Biggest Driver of Federal Deficits



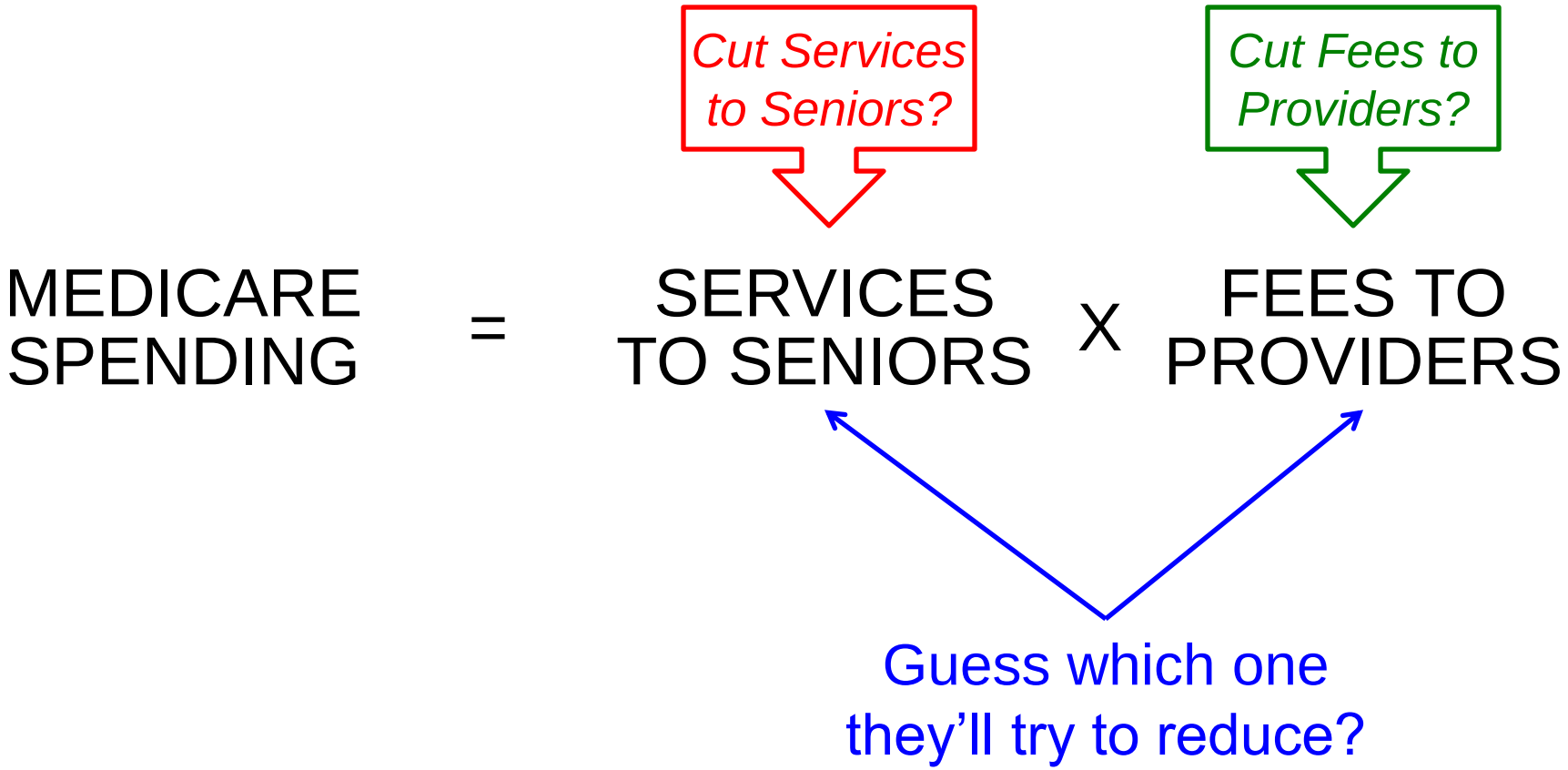
46% of Spending Growth is Healthcare

Source:
CBO
Budget Outlook
August 2012

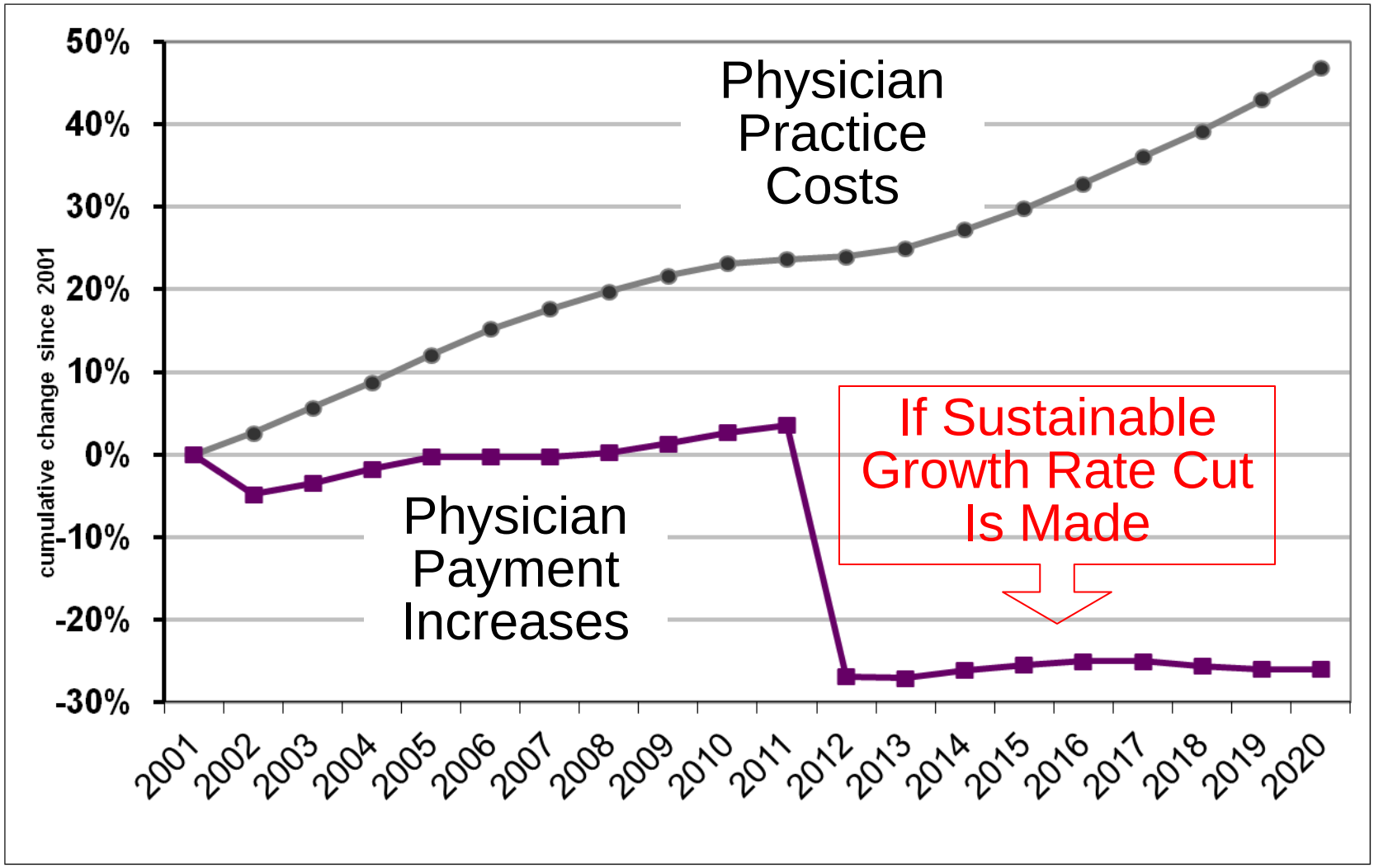
Federal Cost Containment Policy Choices



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



Medicare Payments to Physicians Below Inflation for a Decade



In the Commercial Insurance World…

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Payers try to get bigger
so they can demand bigger discounts
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Payers try to get bigger
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Providers try to get bigger
so they can demand higher fees
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Providers try to get bigger
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Getting bigger doesn't
mean better or lower cost care
for patients

What We Need:
A Way to Reduce Costs
Without Rationing or Fee Cuts

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It Can't Be Done from Washington;
It Has to Happen at the Local Level,
Where Health Care is Delivered

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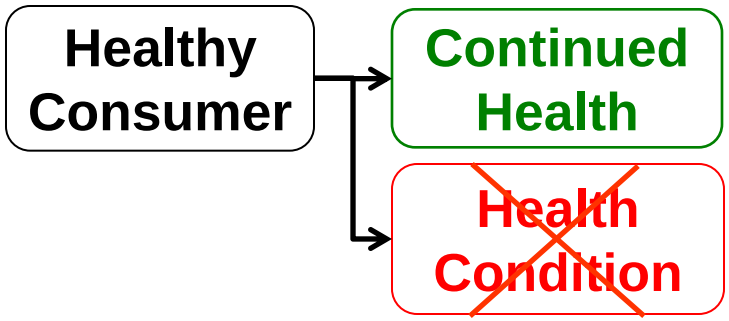
It Can't Be Done from Washington;
It Has to Happen at the Local Level,
Where Health Care is Delivered

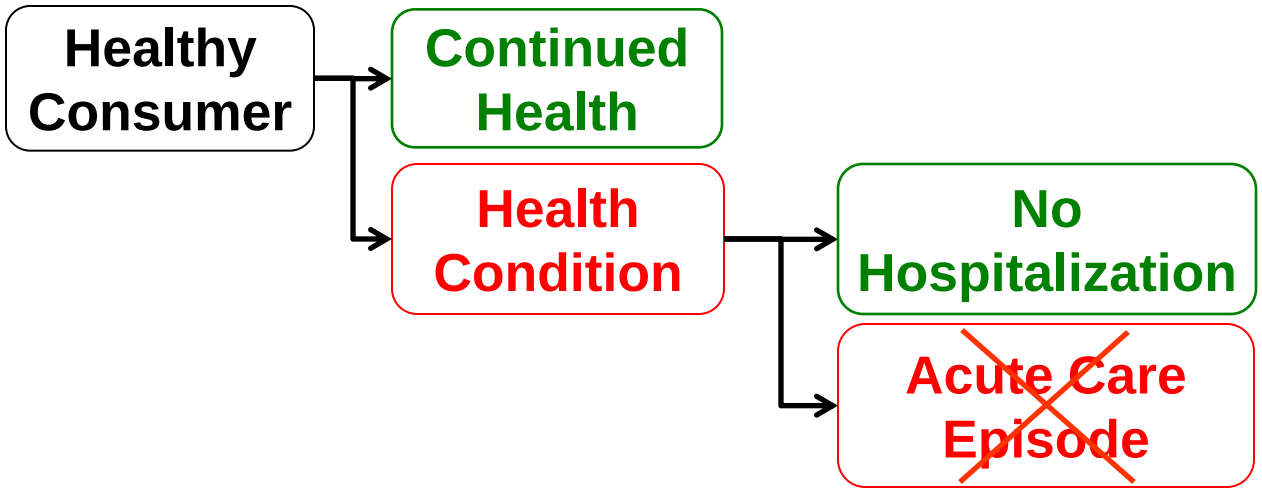
And It Cannot Succeed Without Physician Engagement & Leadership

Reducing Costs Without Rationing: ***Can It Be Done?***

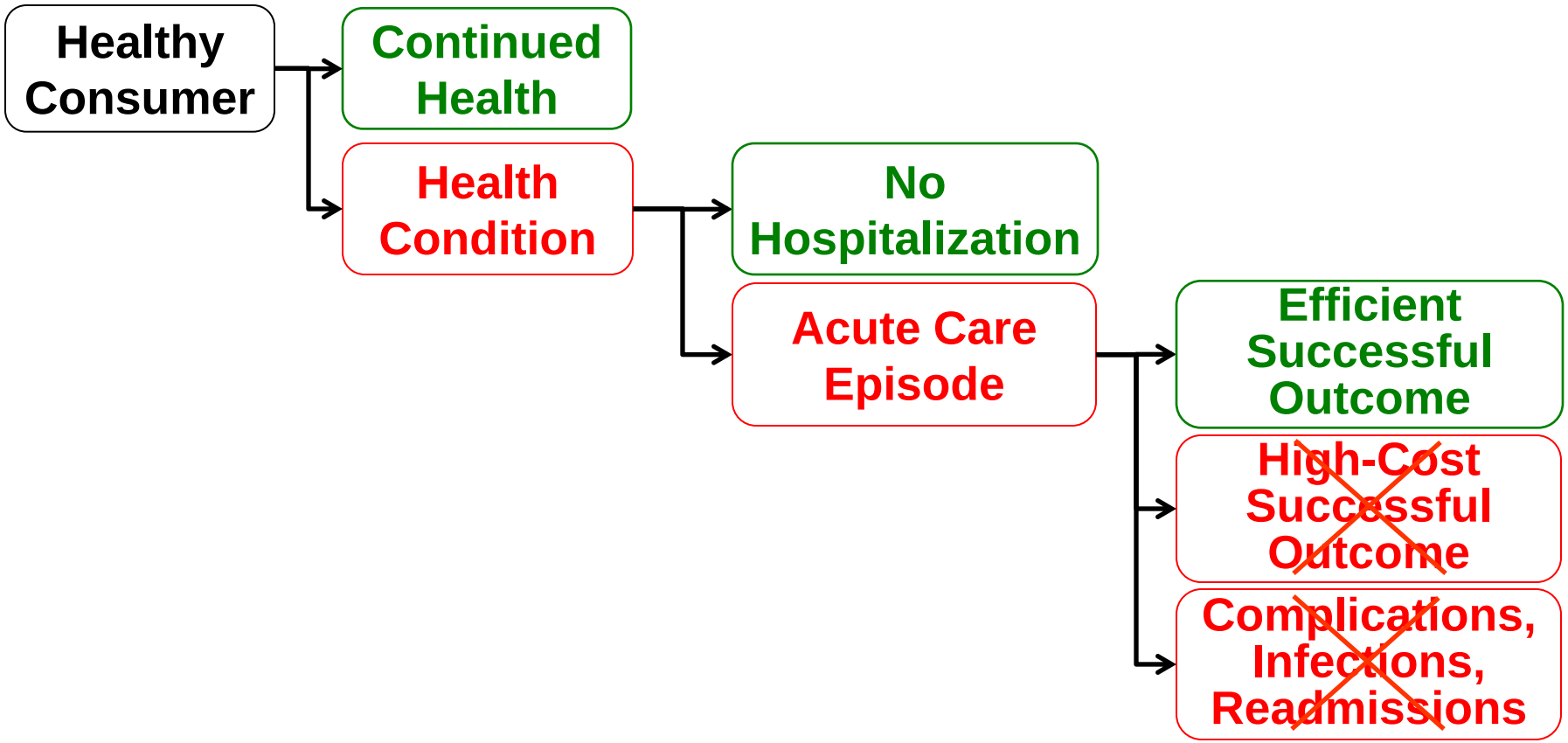
Reducing Costs Without Rationing:
Prevention and Wellness



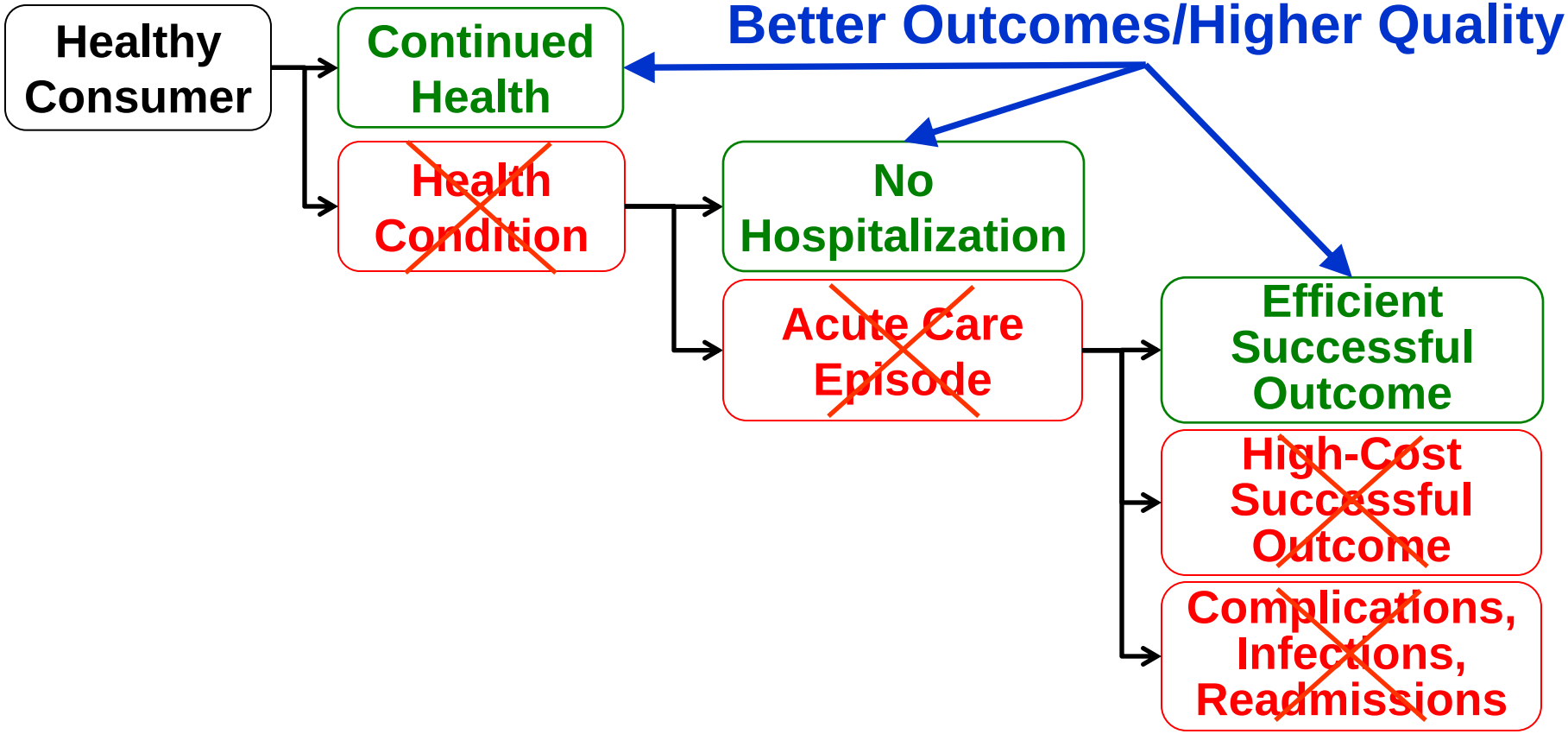
Reducing Costs Without Rationing: Avoiding Hospitalizations



Reducing Costs Without Rationing: Efficient, Successful Treatment

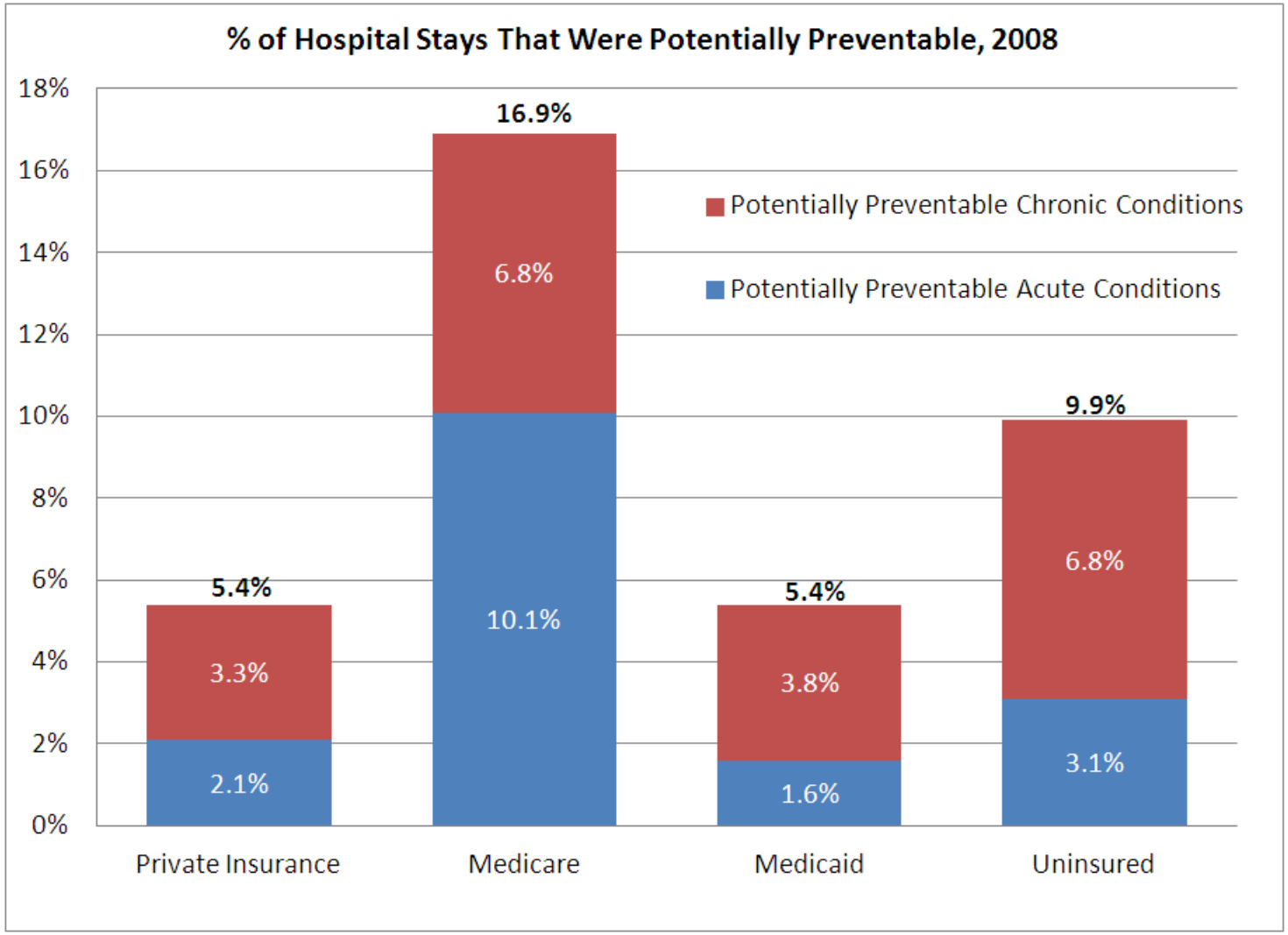


Reducing Costs Without Rationing Is Also Quality Improvement!



How Big Are the Opportunities?

5-17% of Hospital Admissions Are Potentially Preventable



Source: AHRQ HCUP

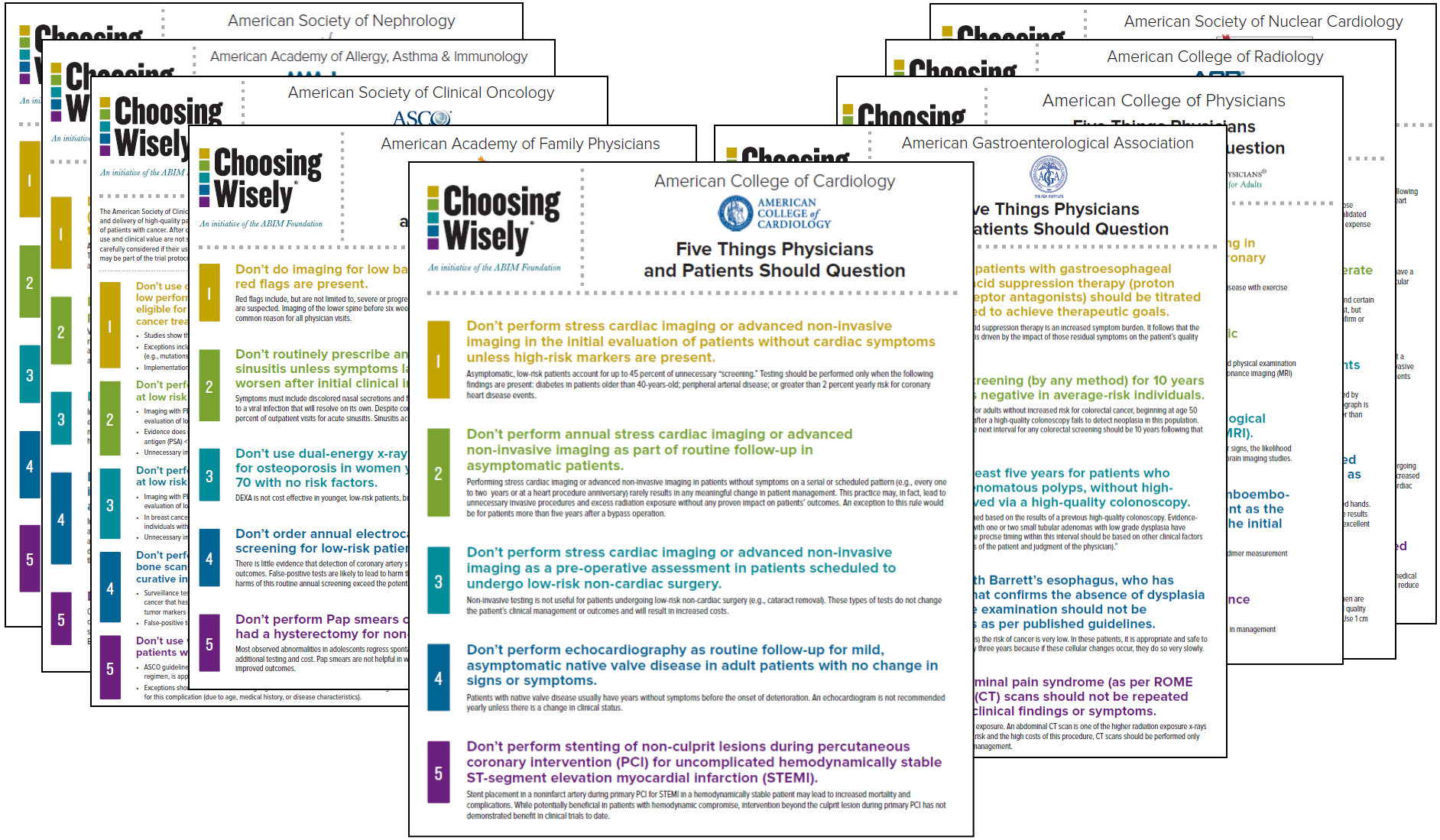
Millions of Preventable Events Harm Patients and Increase Costs

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

3 Adverse Events Every Minute

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

Many Ways to Reduce Tests & Services Without Harming Patients



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

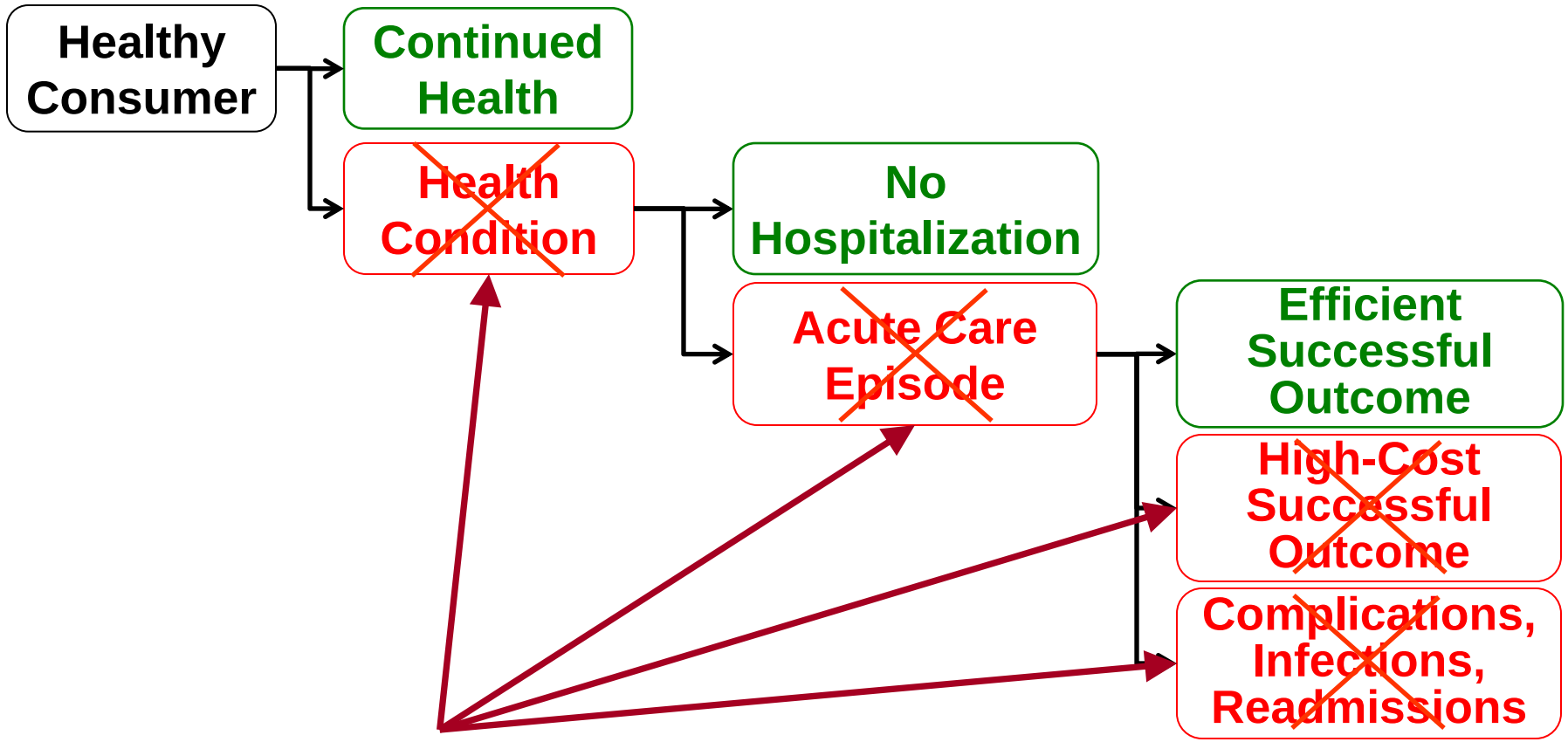
How Do We *Help*:

- Patients Stay Well
- Avoid Preventable Emergencies and Hospitalizations
- Eliminate Errors and Safety Problems
- Reduce Costs of Treatment
- Reduce Complications and Readmissions

How Do We Limit:

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

Reducing Costs Without Rationing Reduces Provider Revenues in FFS



Fewer Patients
Fewer Procedures & Admissions
Less Revenue Per Procedure

The Goal Isn't "Creating Incentives," The Goal is *Removing Barriers*

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Lack of Flexibility in FFS

- No payment for phone calls or emails with patients
- No payment to coordinate care among providers
- No payment for non-physician support services to help patients with self-management
- No flexibility to shift resources across silos (hospital <-> physician, post-acute <->hospital, SNF <-> home health, etc.)

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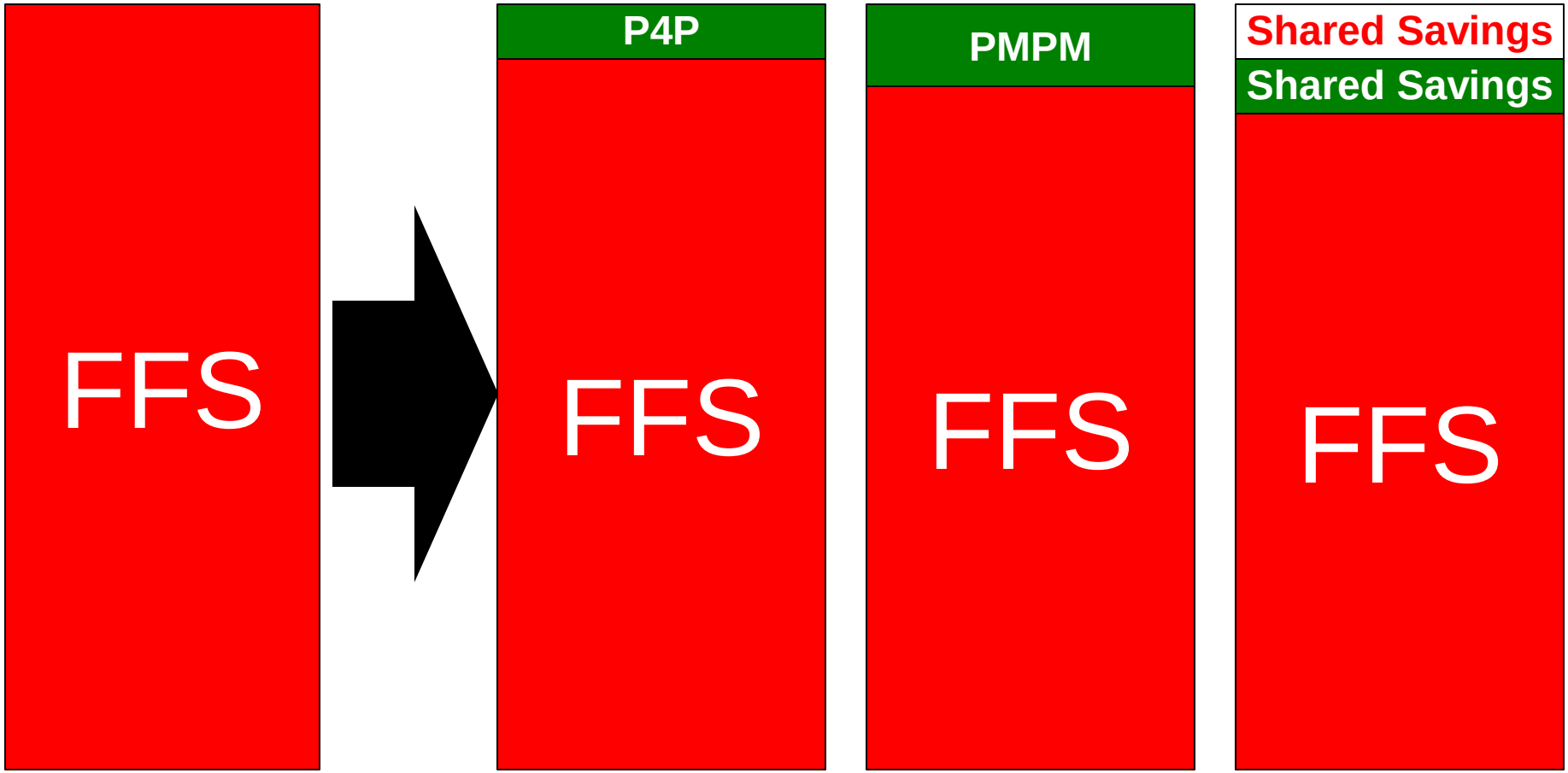
Penalty for Quality/Efficiency

- Lower revenues if patients don't make frequent office visits
- Lower revenues for performing fewer tests and procedures
- Lower revenues if infections and complications are prevented instead of treated
- No revenue at all if patients stay healthy

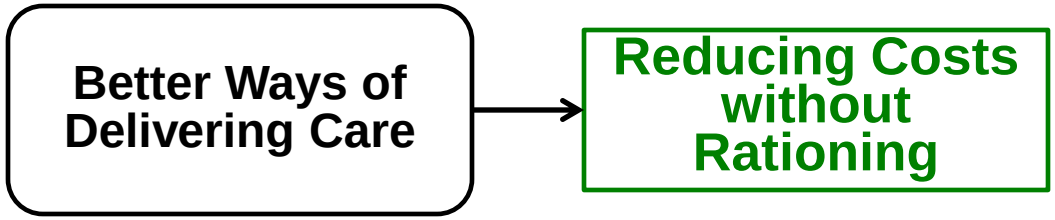
Most “Payment Reforms” Don’t Fix The Problems with FFS



If We Want to Reduce Costs Without Rationing…

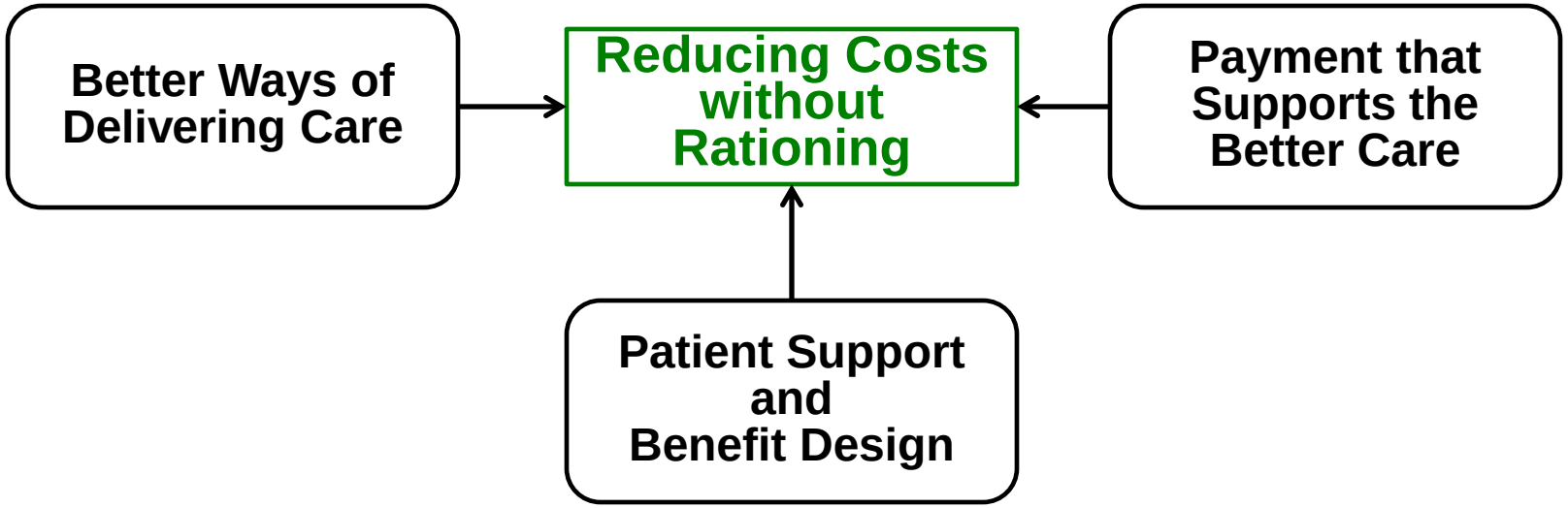
Reducing Costs without Rationing

1. We Need Different and *Better* Ways of Delivering Care

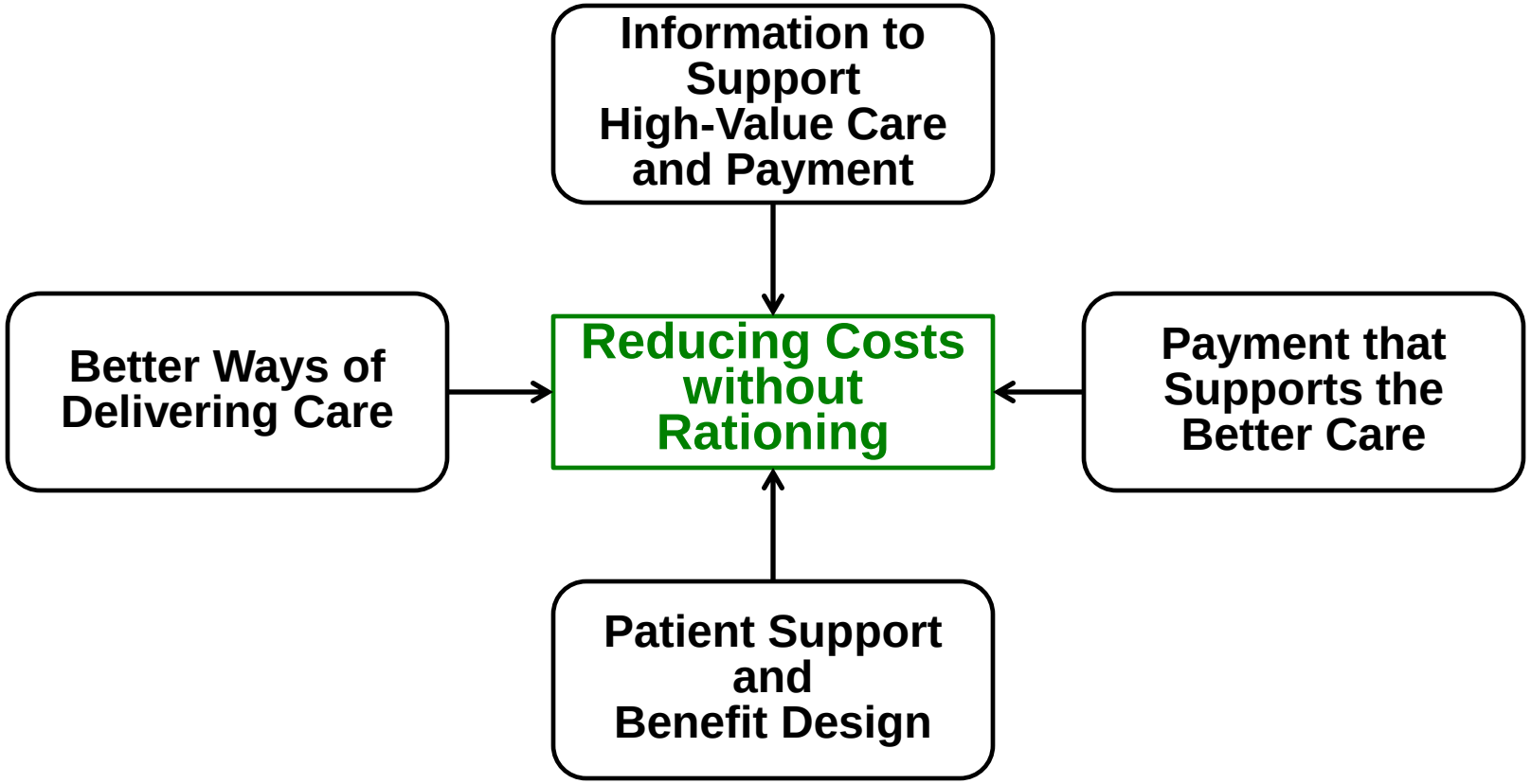


2. We Need New Payment Models That Support Better Care

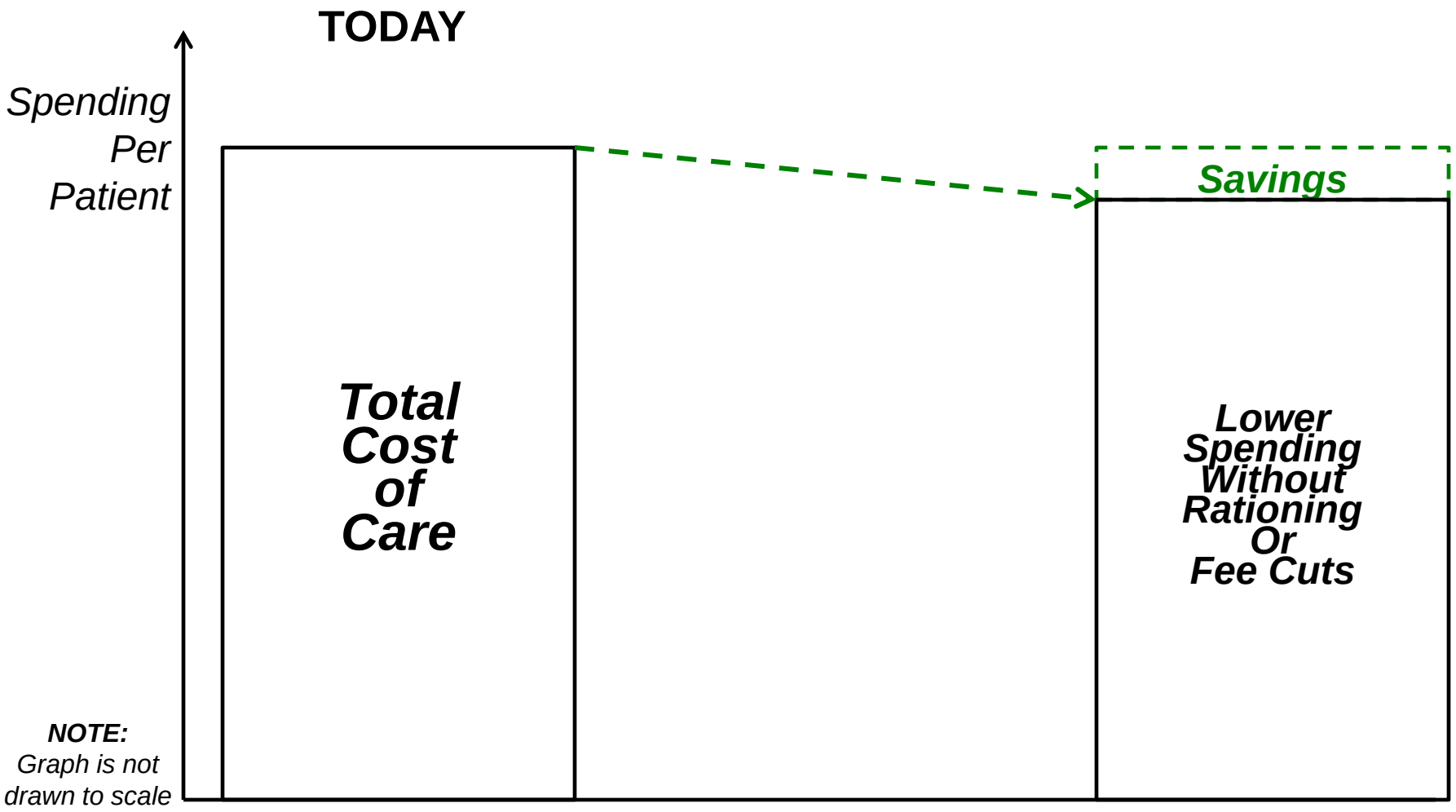
3. We Need Engaged Patients and a Supportive Benefit Design



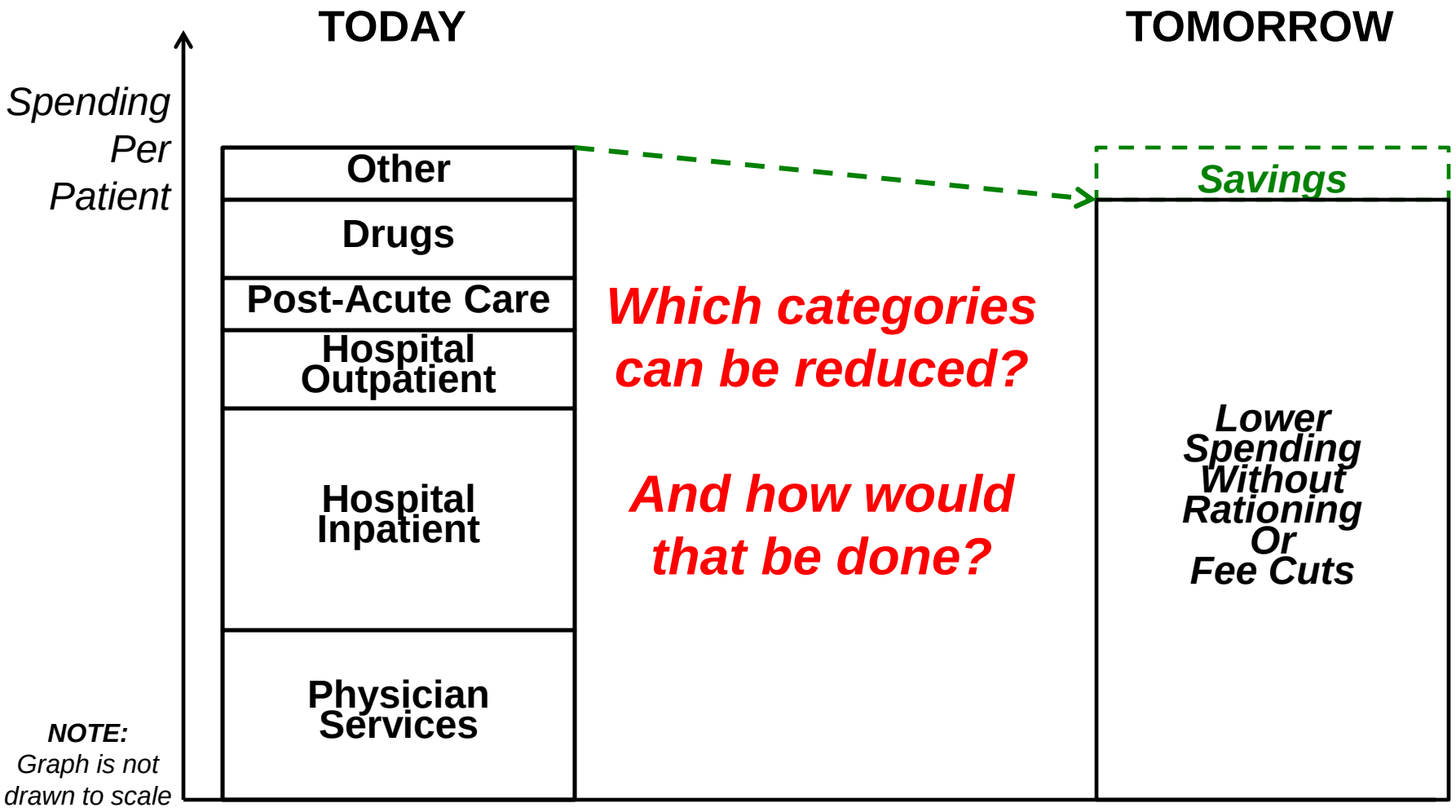
4. We Need Good Information to Design and Manage Everything



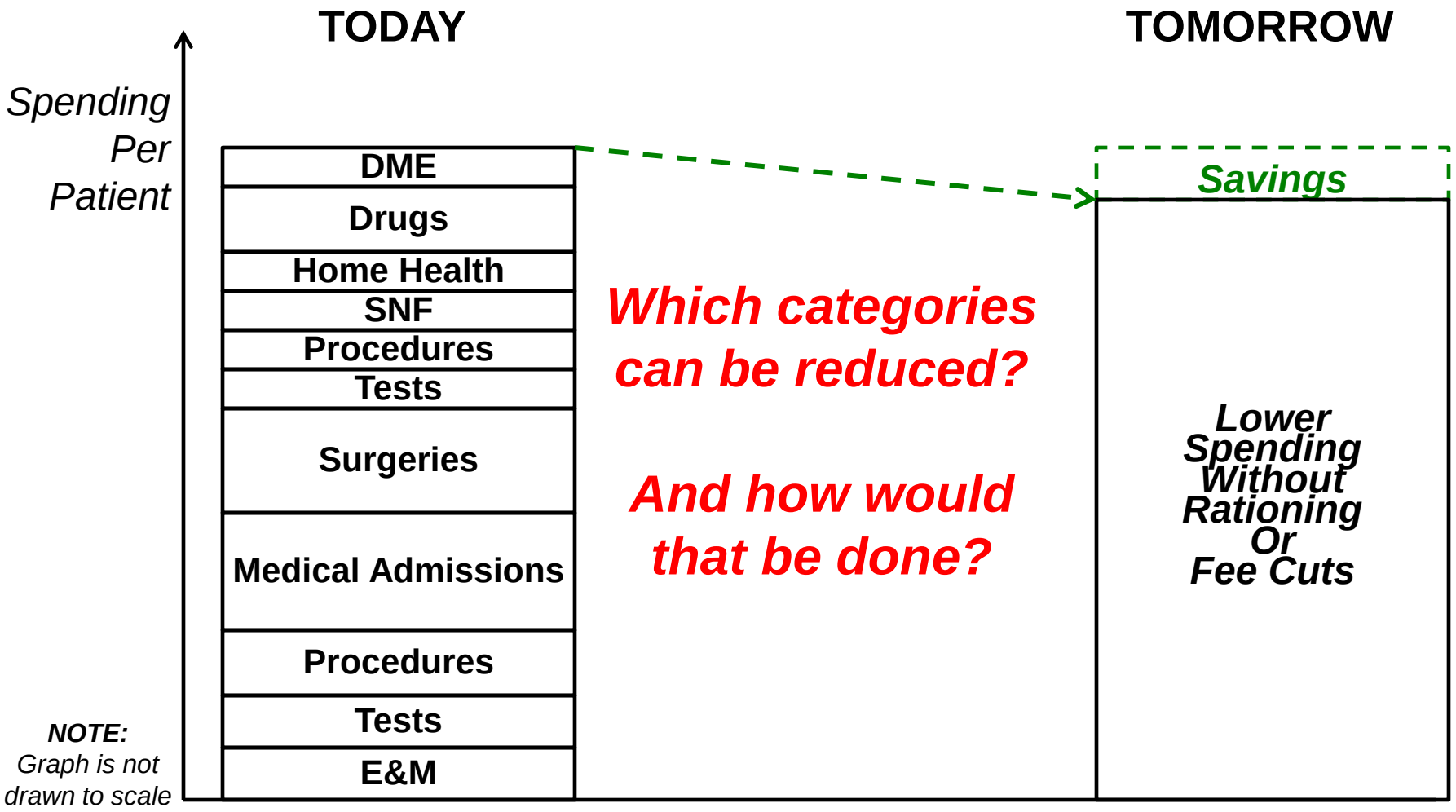
What Information Do You Need to Reduce Spending w/o Rationing?



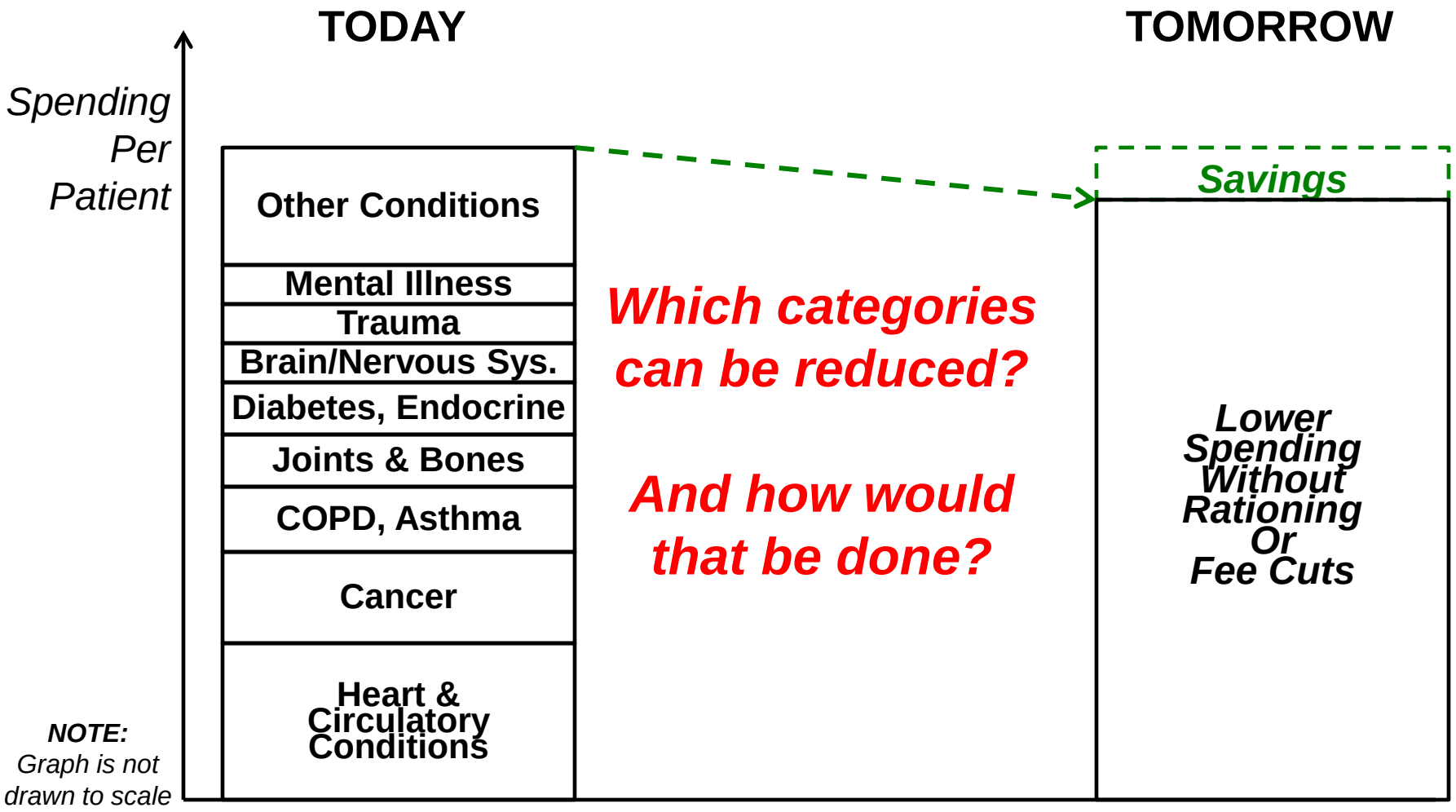
Most Breakdowns of Spending Aren't Terribly Useful



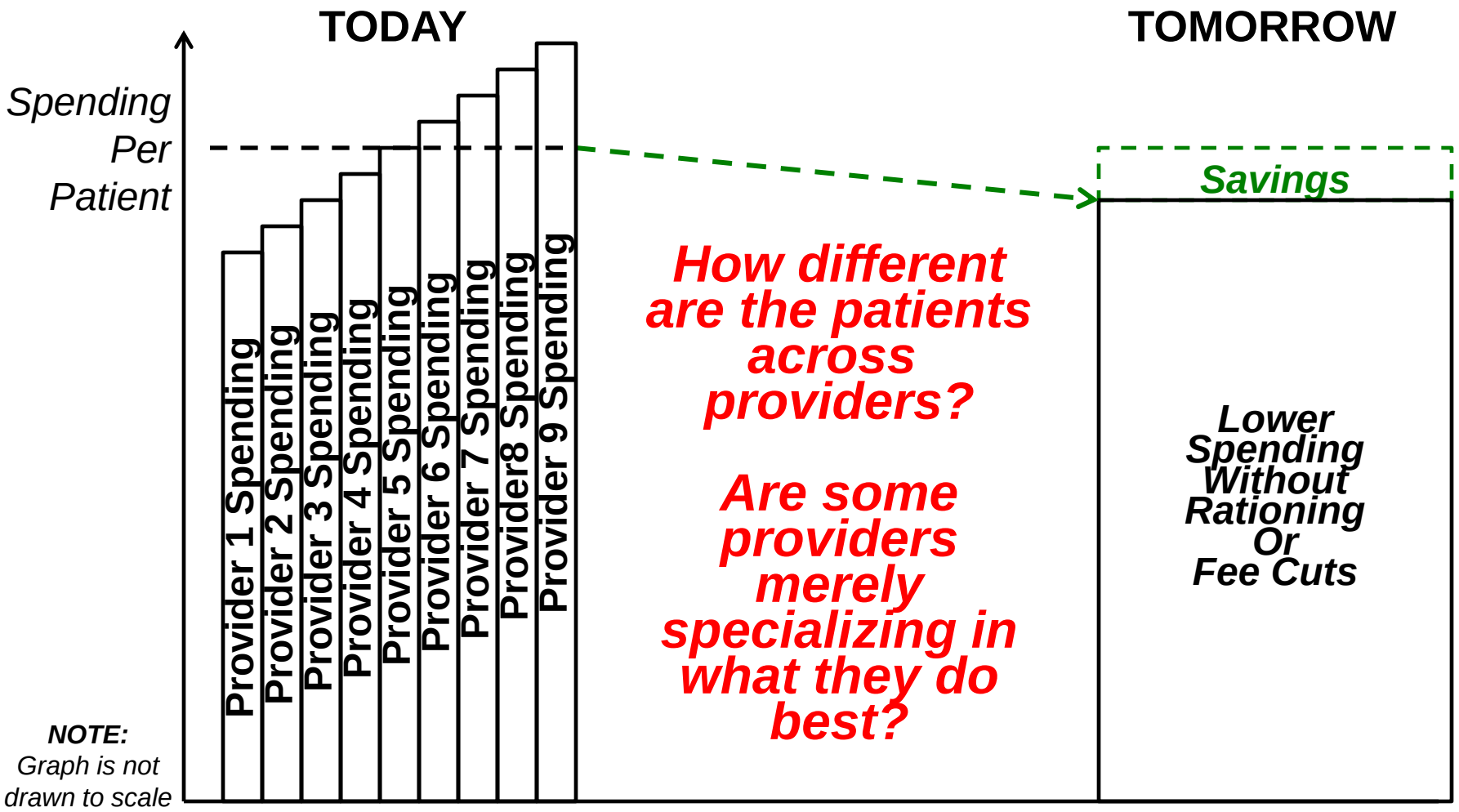
Finer Breakdowns Don't Help Much



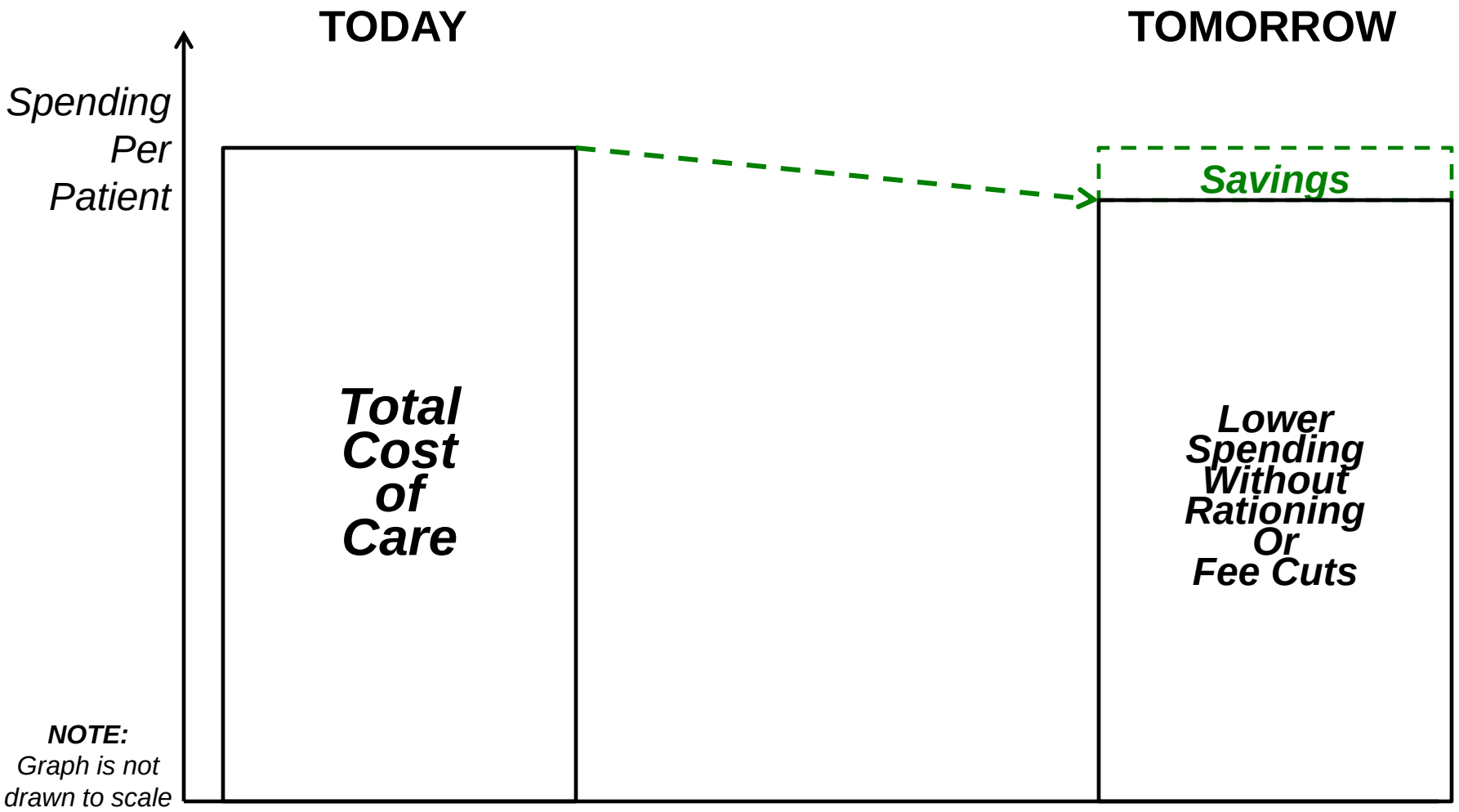
Even Diagnosis Breakdowns Aren't Terribly Useful



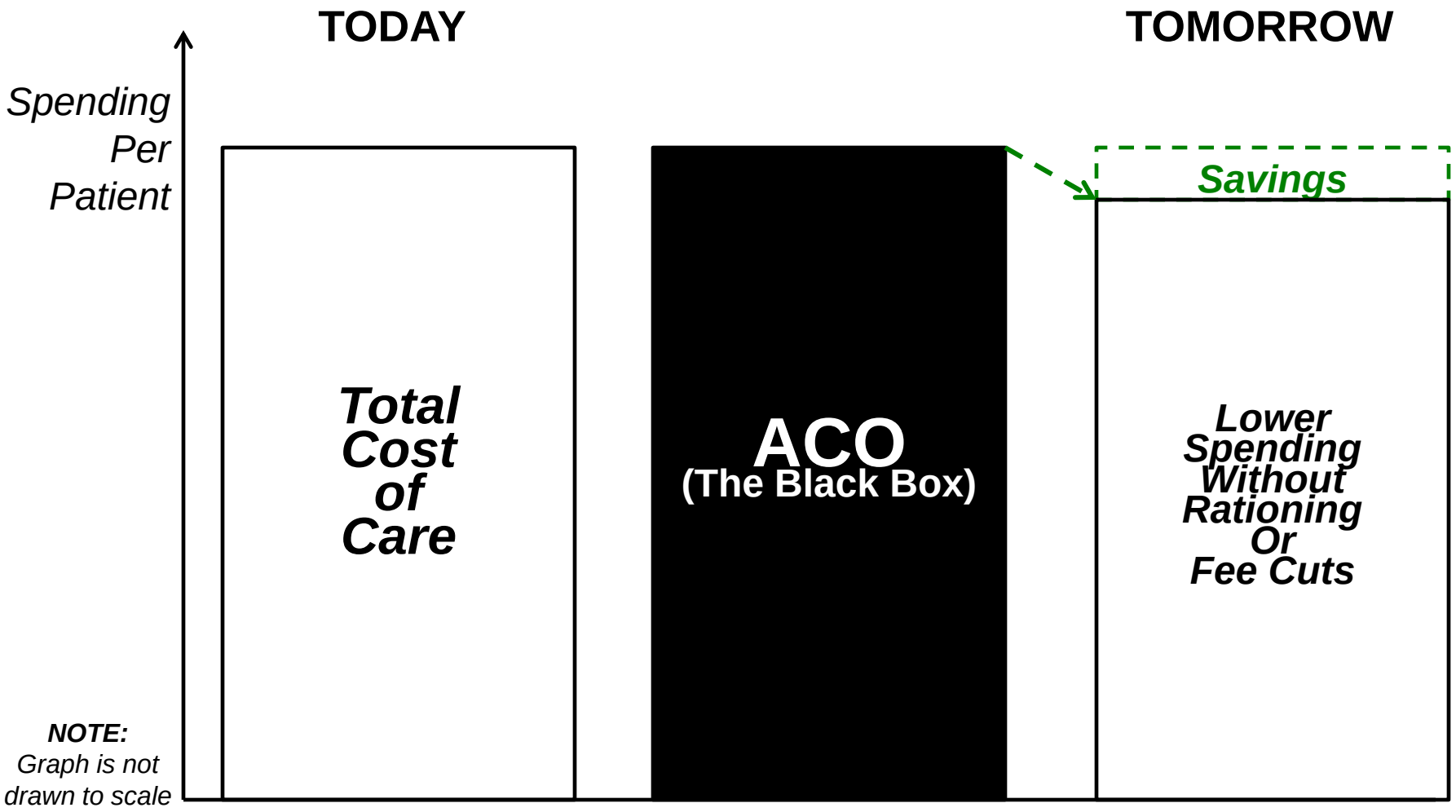
Variations Across Providers May or May Not Indicate Opportunities



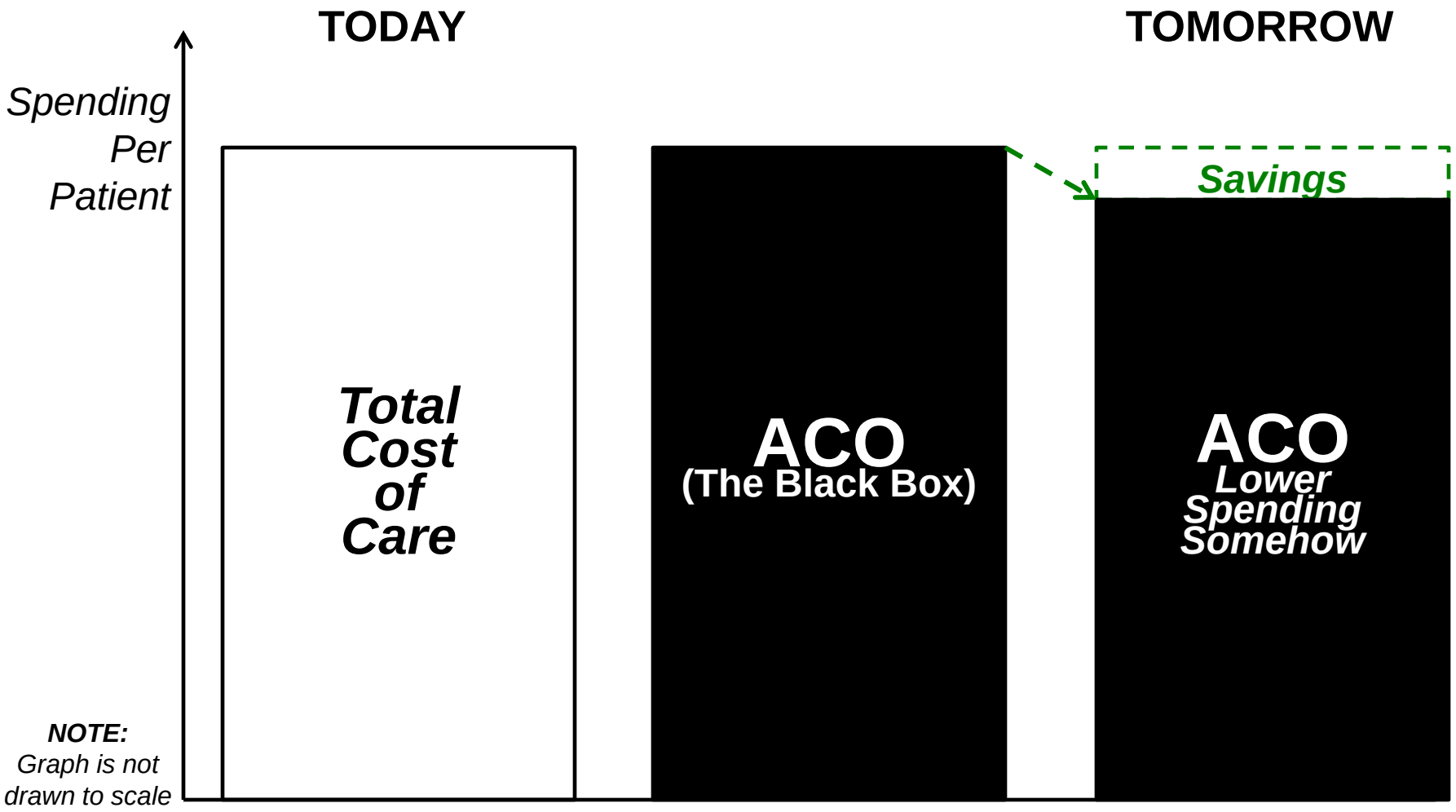
Fortunately, We Now Have the Answer



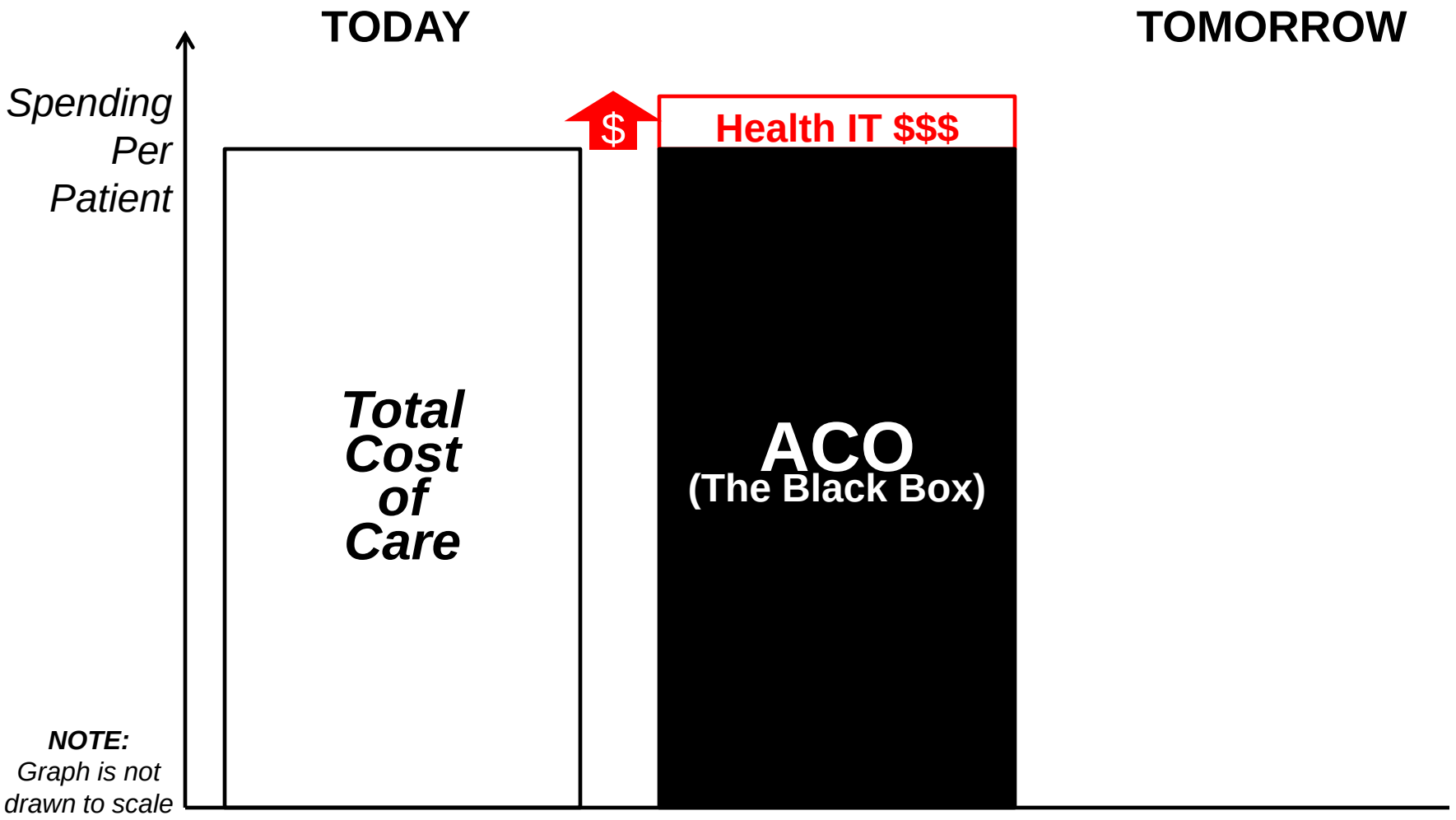
The ACO Will Figure It Out!



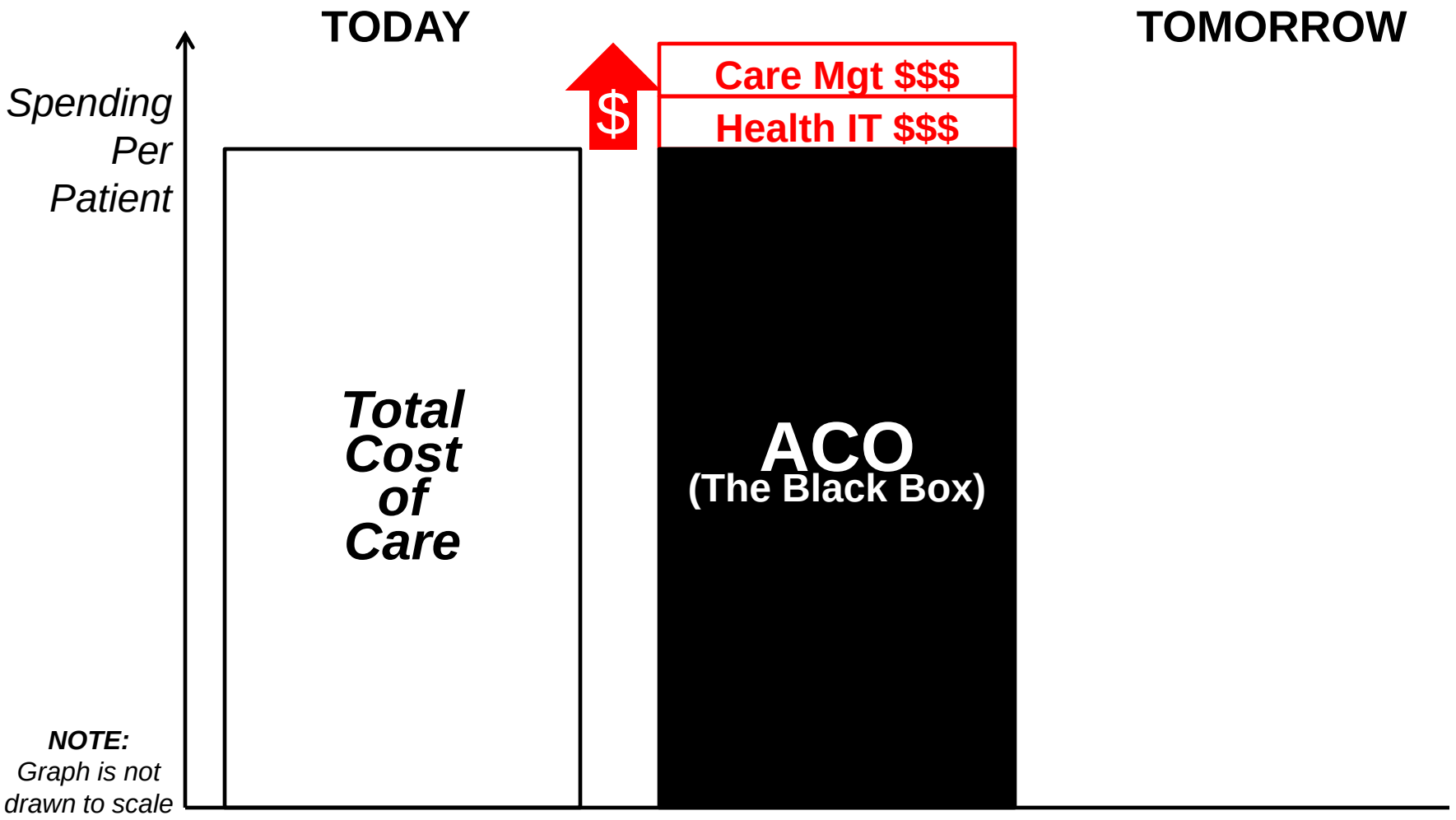
The ACO Will Figure It Out! (Somehow)



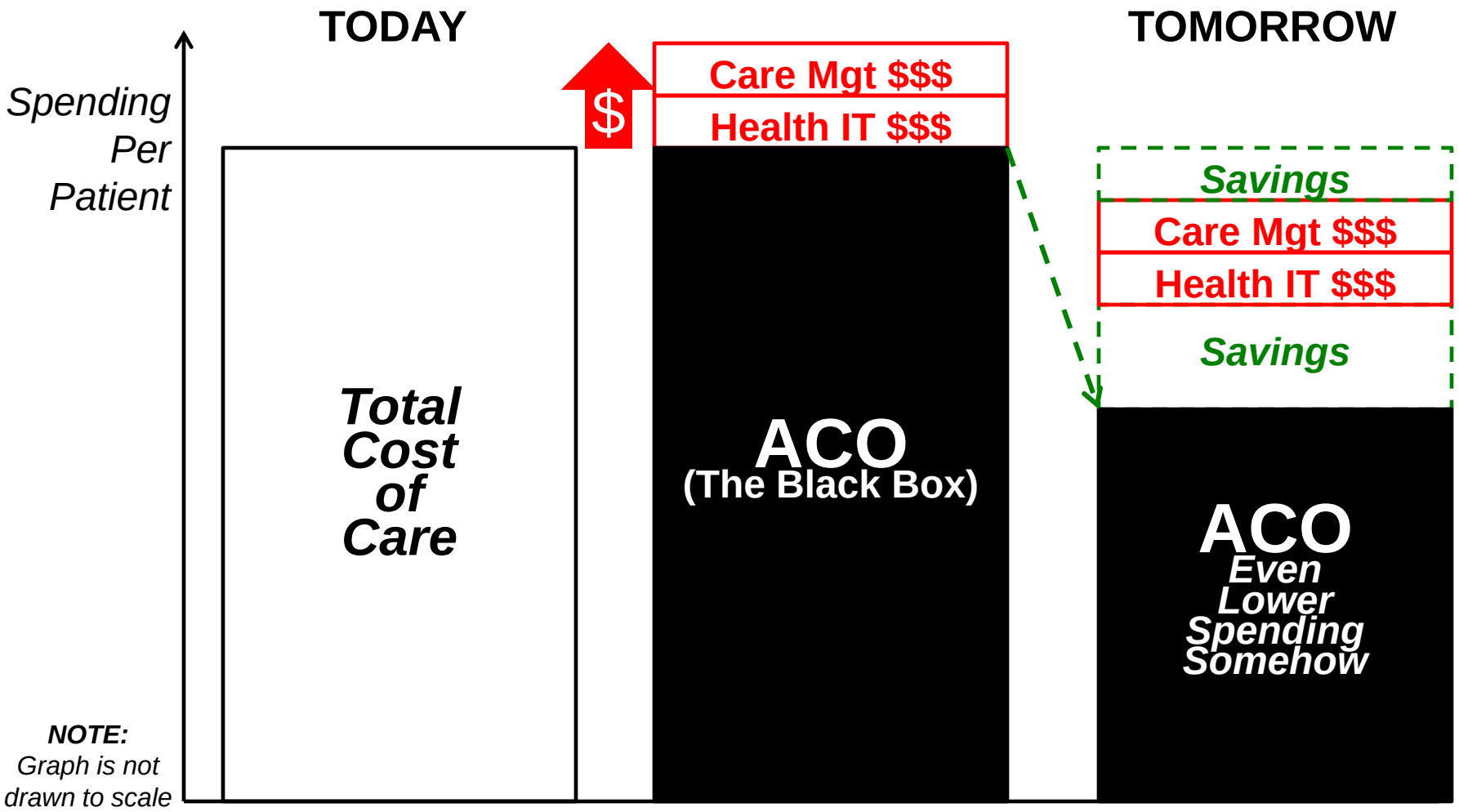
Most ACOs Assume They'll Need Heavy-Duty Health IT (Big $$$)



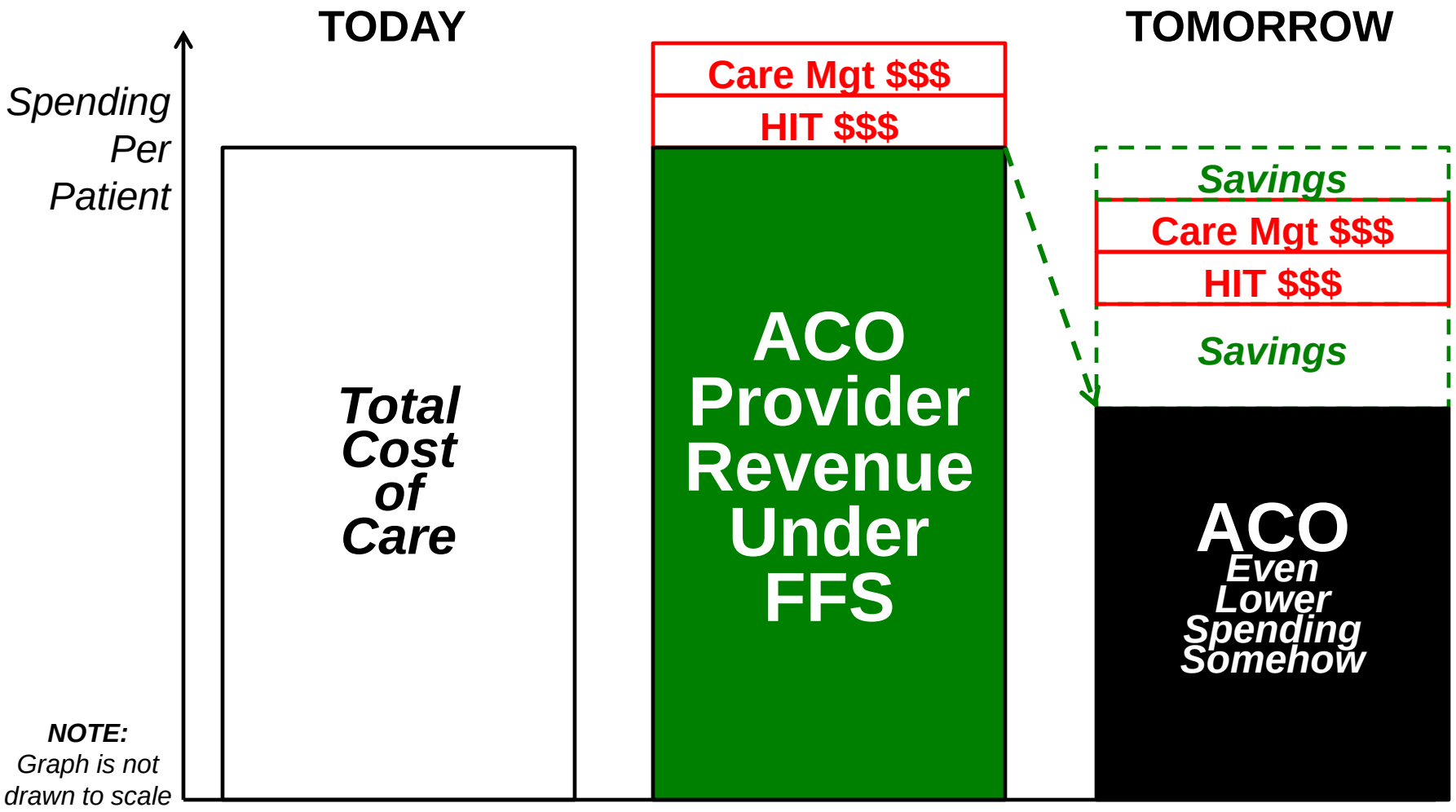
And a Lot of Care Coordinators and Utilization Managers ($$$)



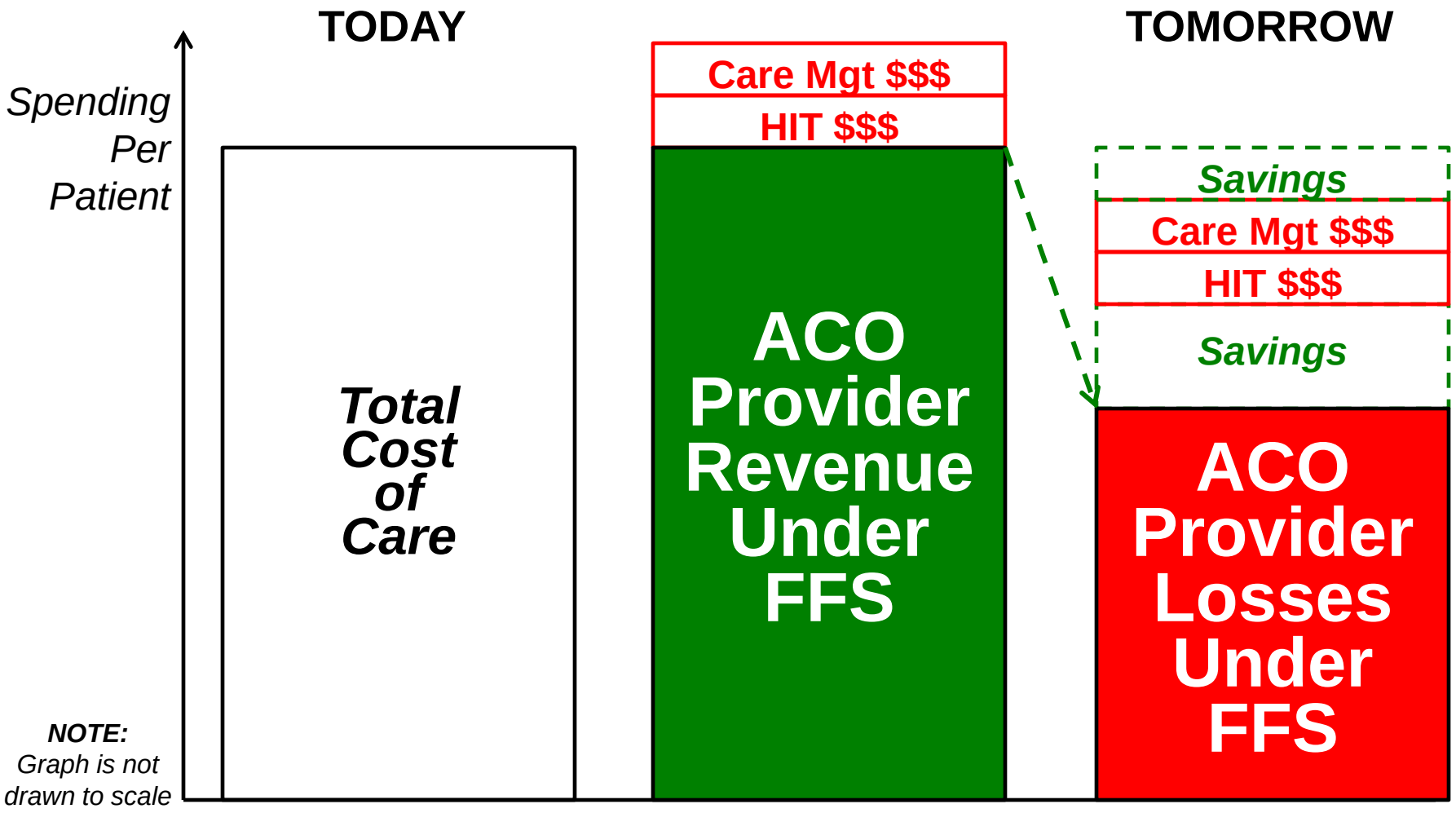
Problem #1: Even More Savings Needed to Pay For the New Costs



Problem #2: The *Spending* Is the ACO Members' *Revenue*



And the ACO Can't Succeed If Its Members Don't Succeed



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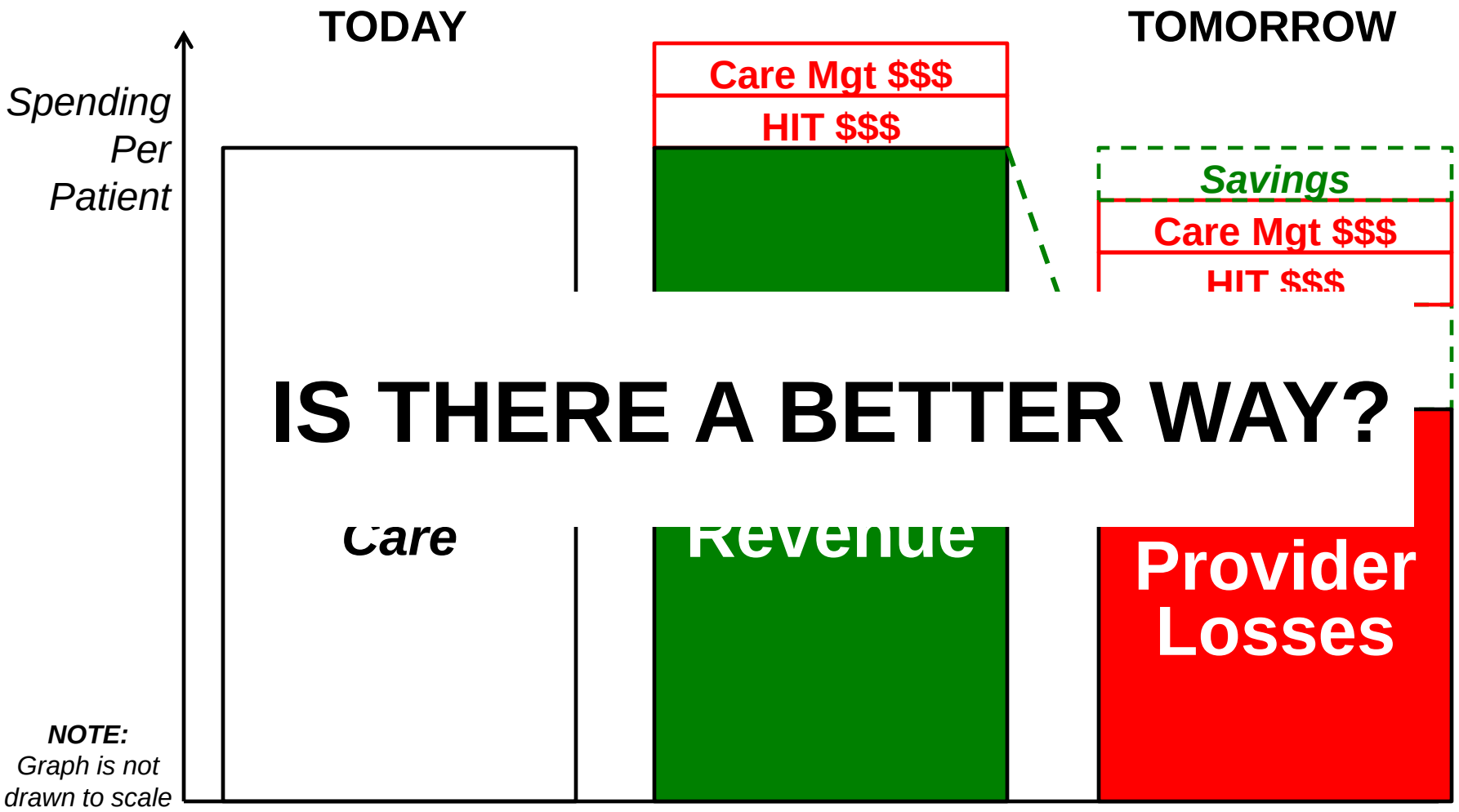
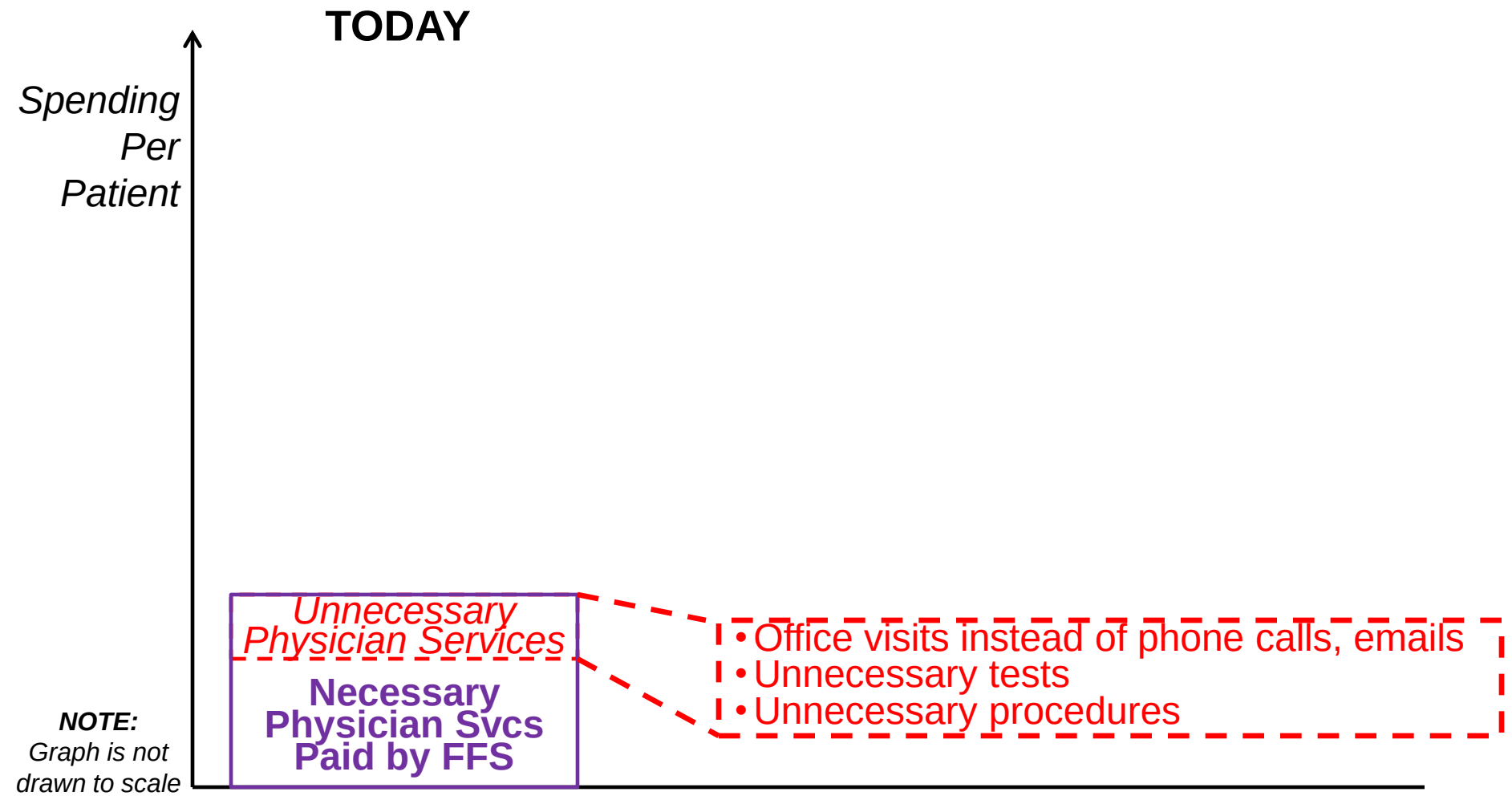
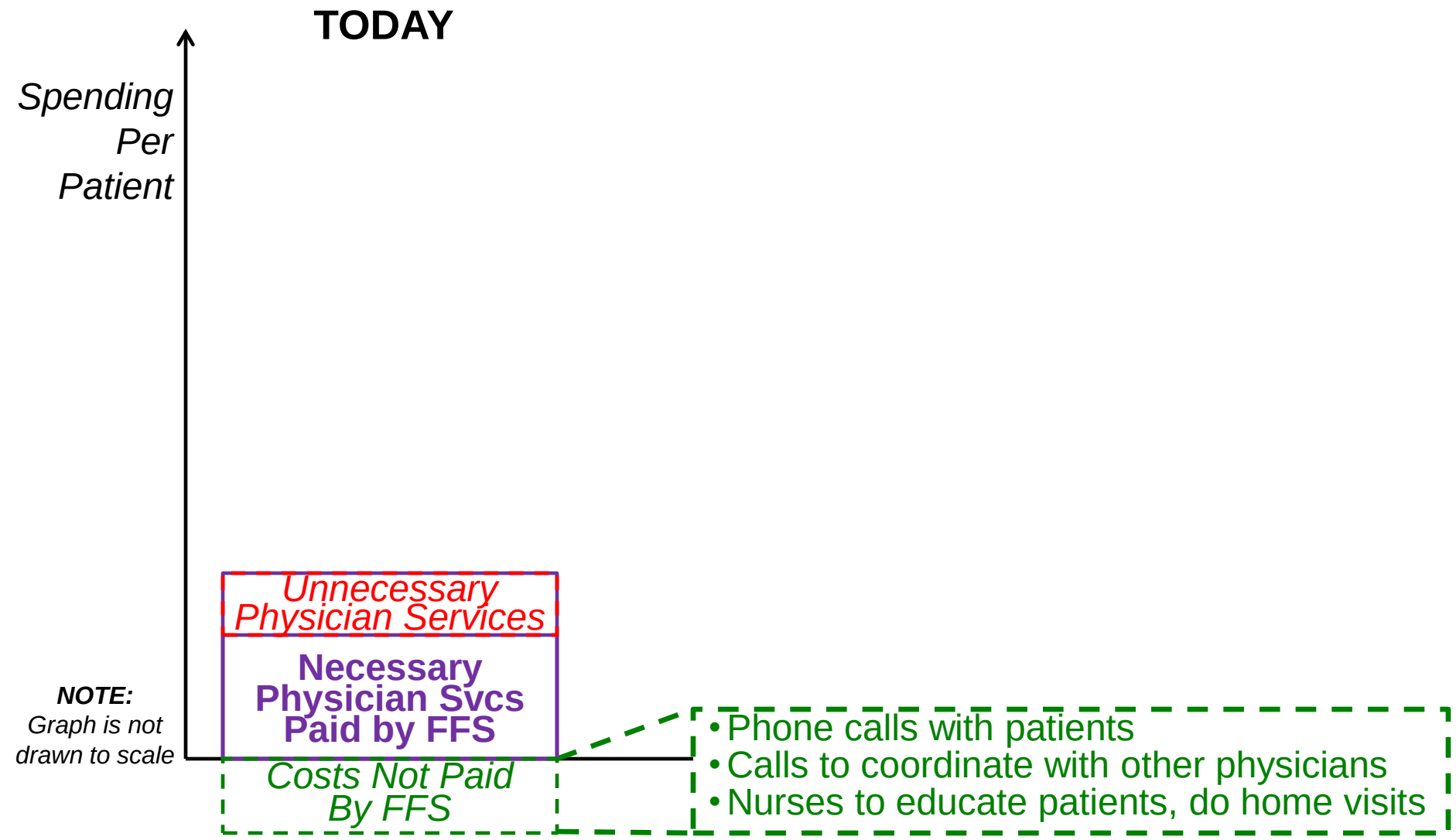


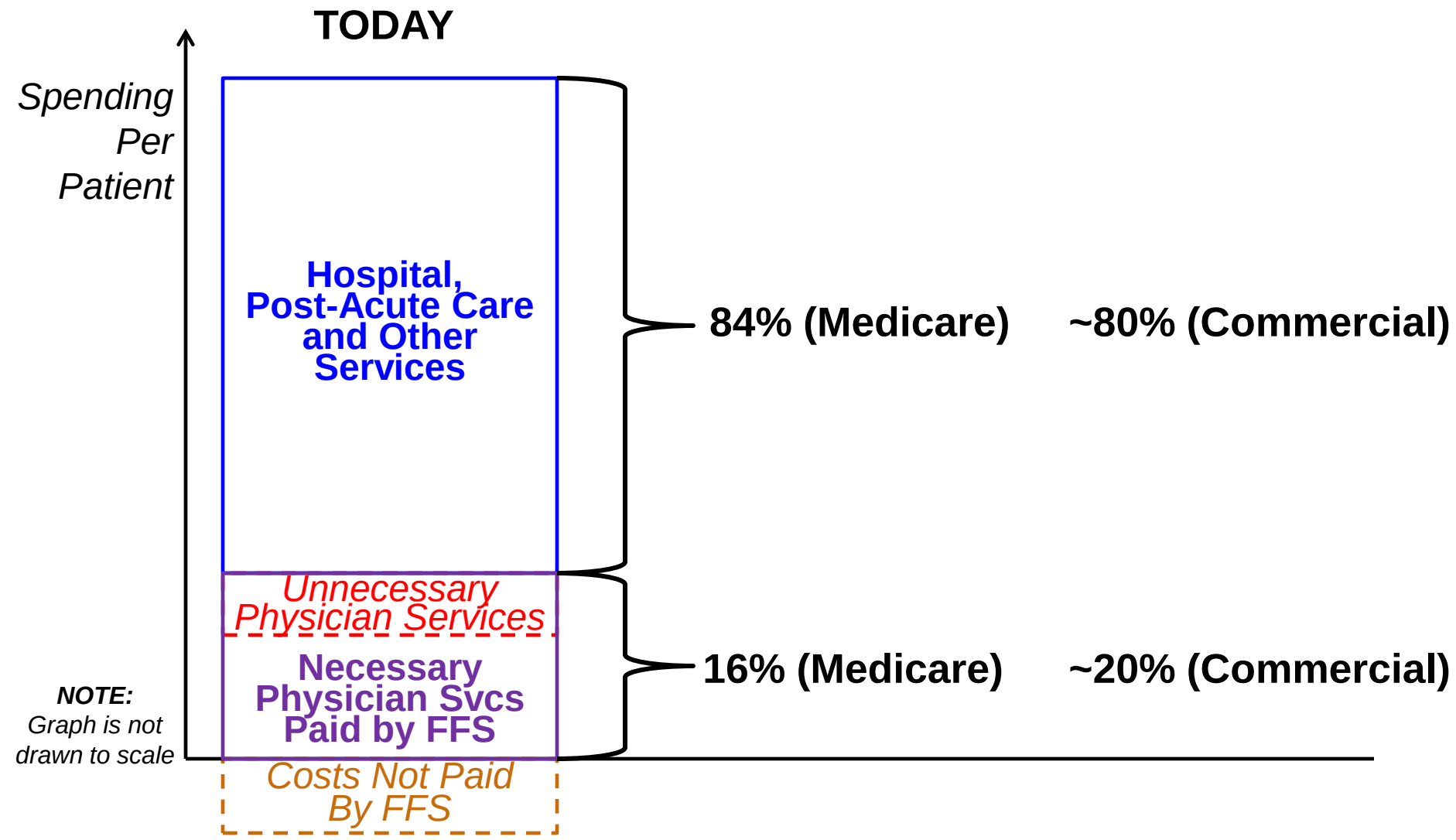
We Need to Identify the *Avoidable* Spending



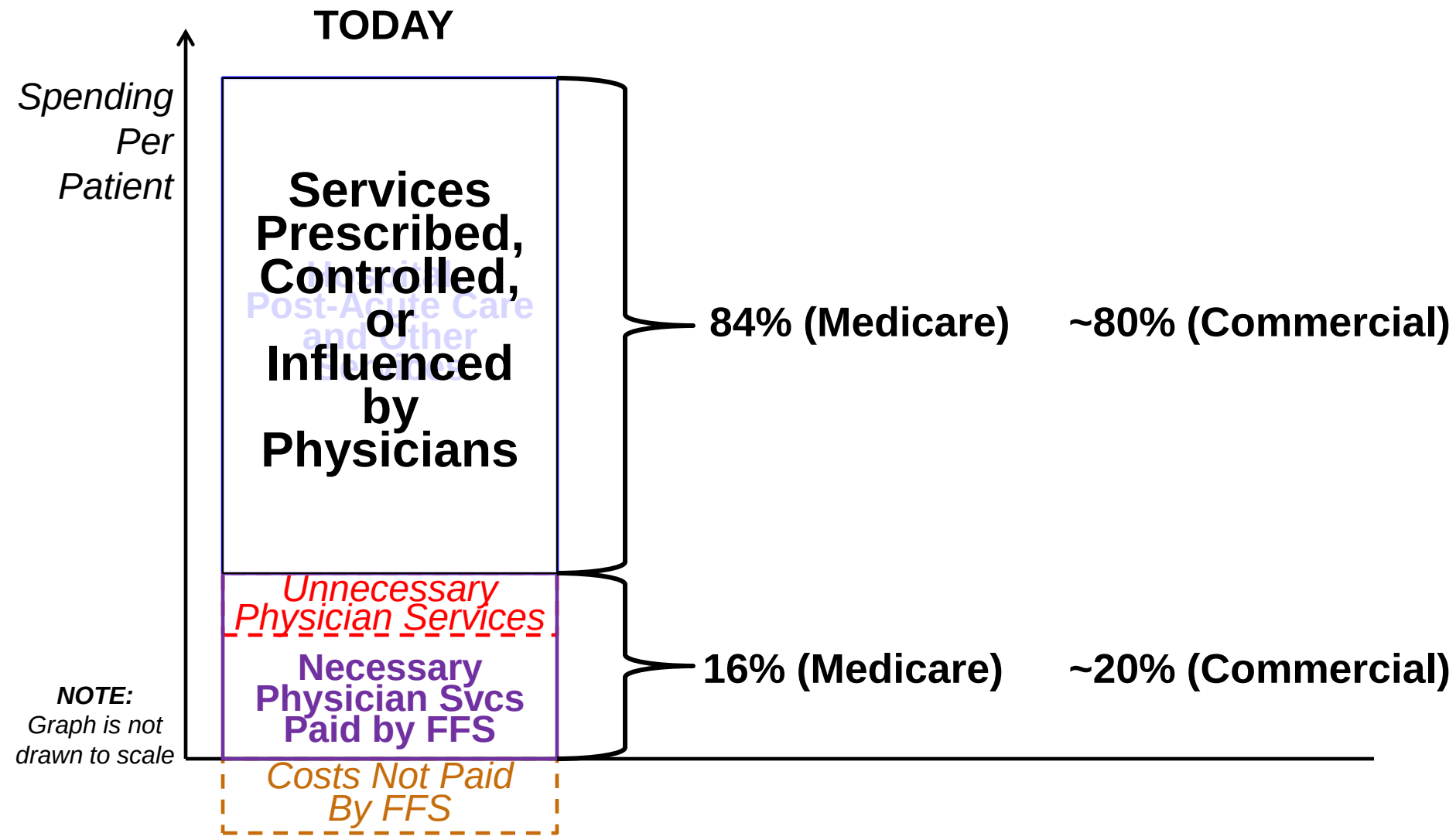
But We Also Have to Pay for What's Not Covered By FFS



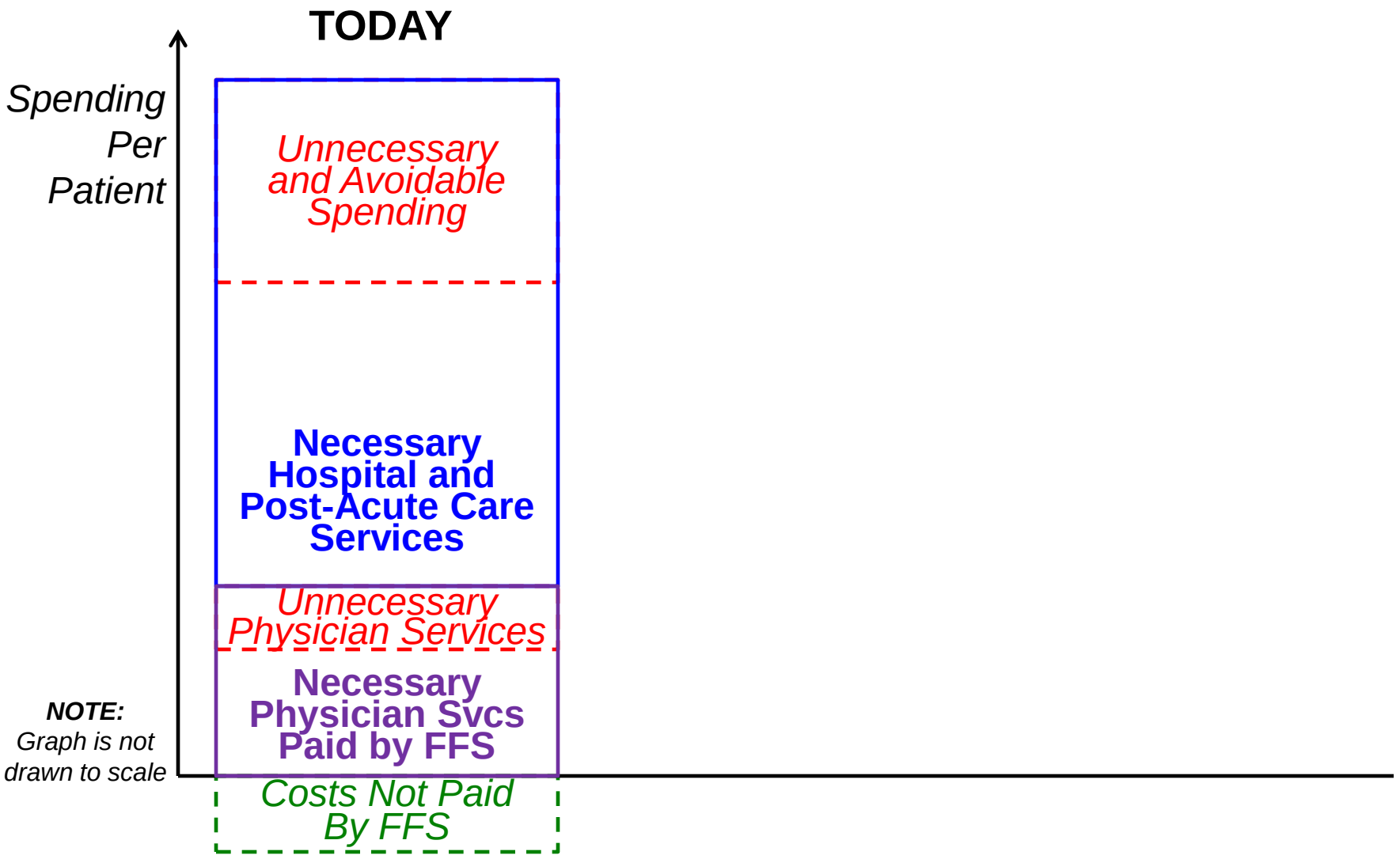
Most Healthcare Spending Doesn't Go to Physicians…



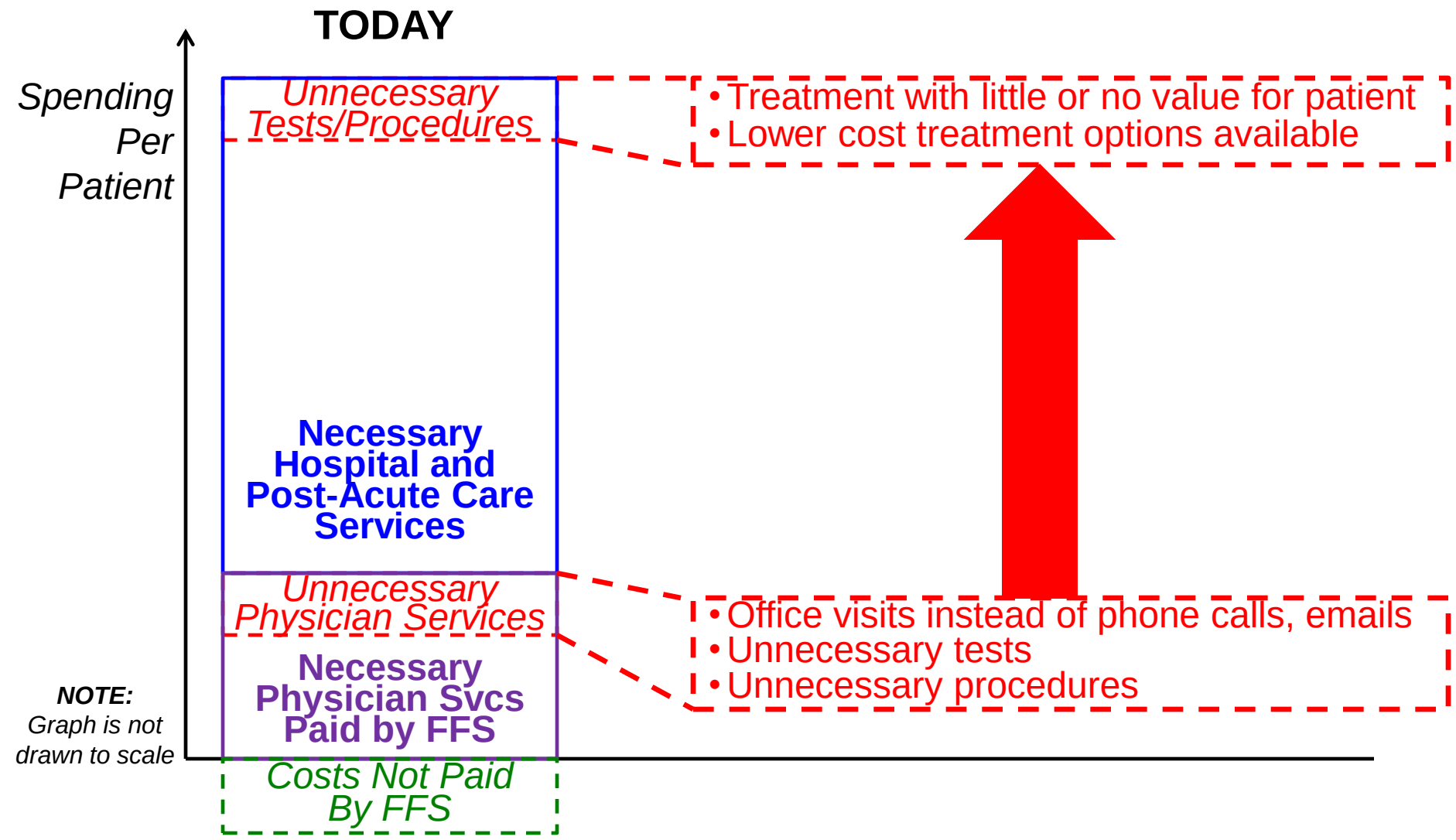
…But Physicians Have Significant Influence Over the Other 80%+…



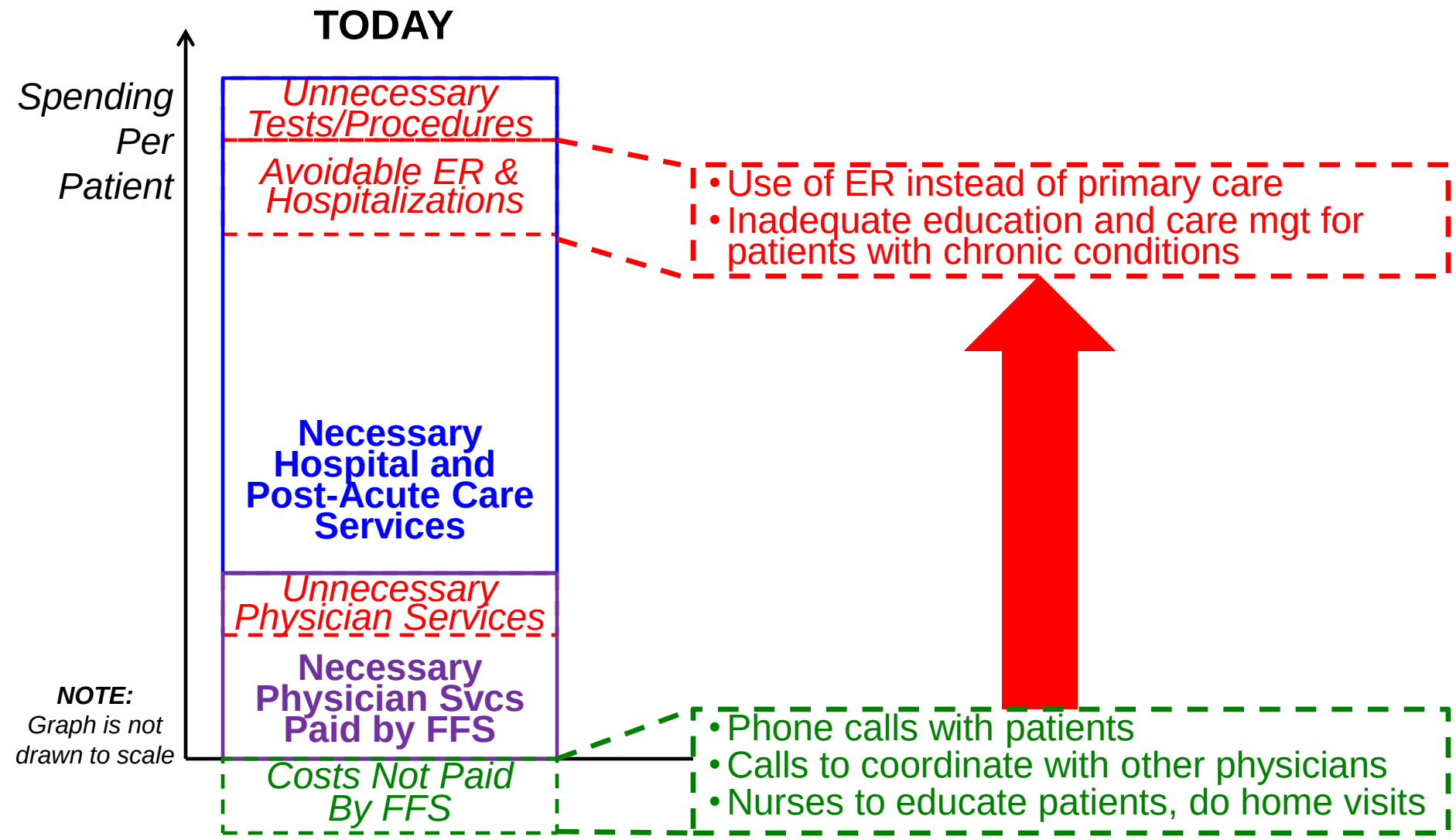
…And the Biggest Savings Are in the Non-Physician Categories



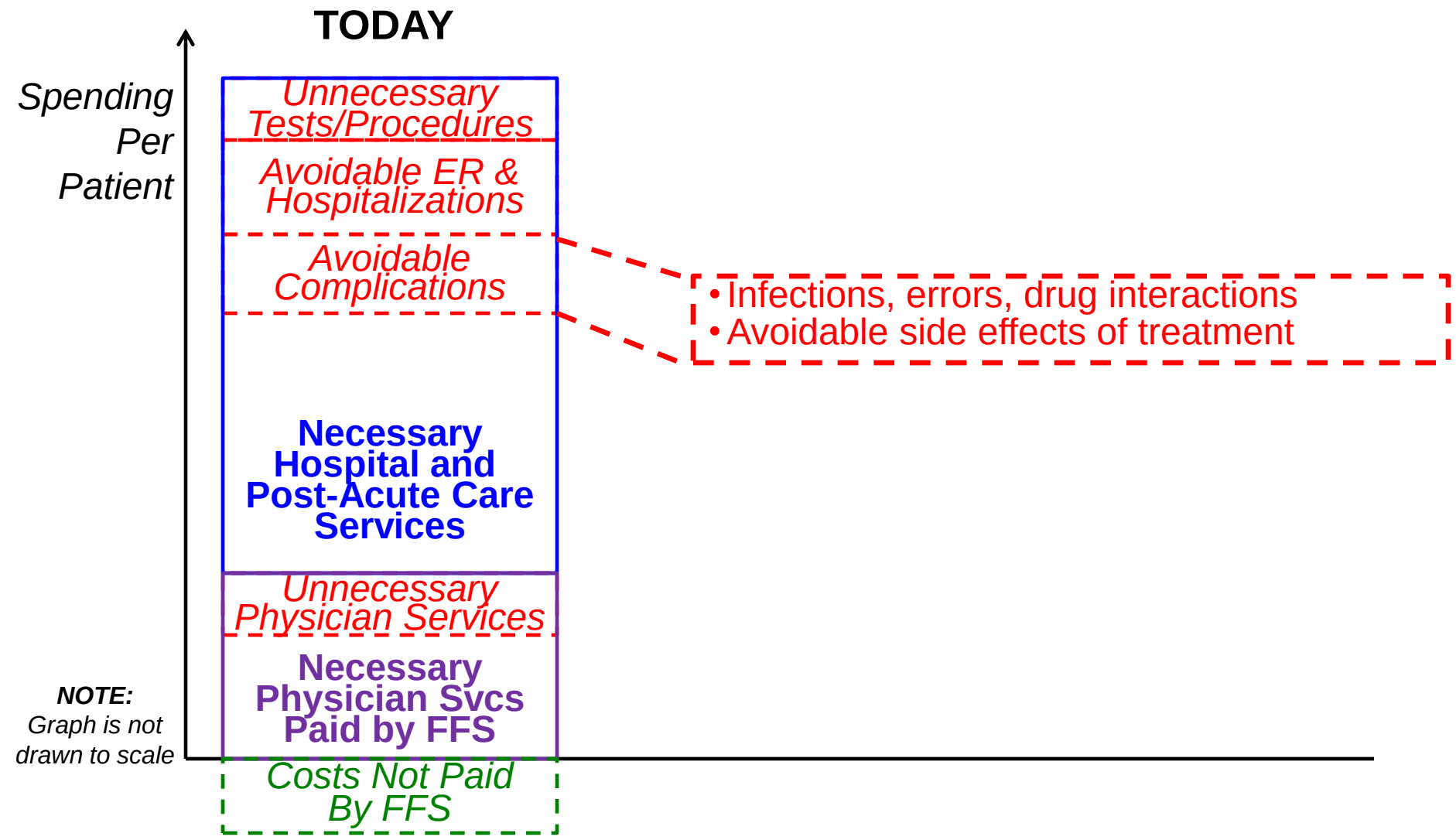
Unnecessary Tests and Procedures



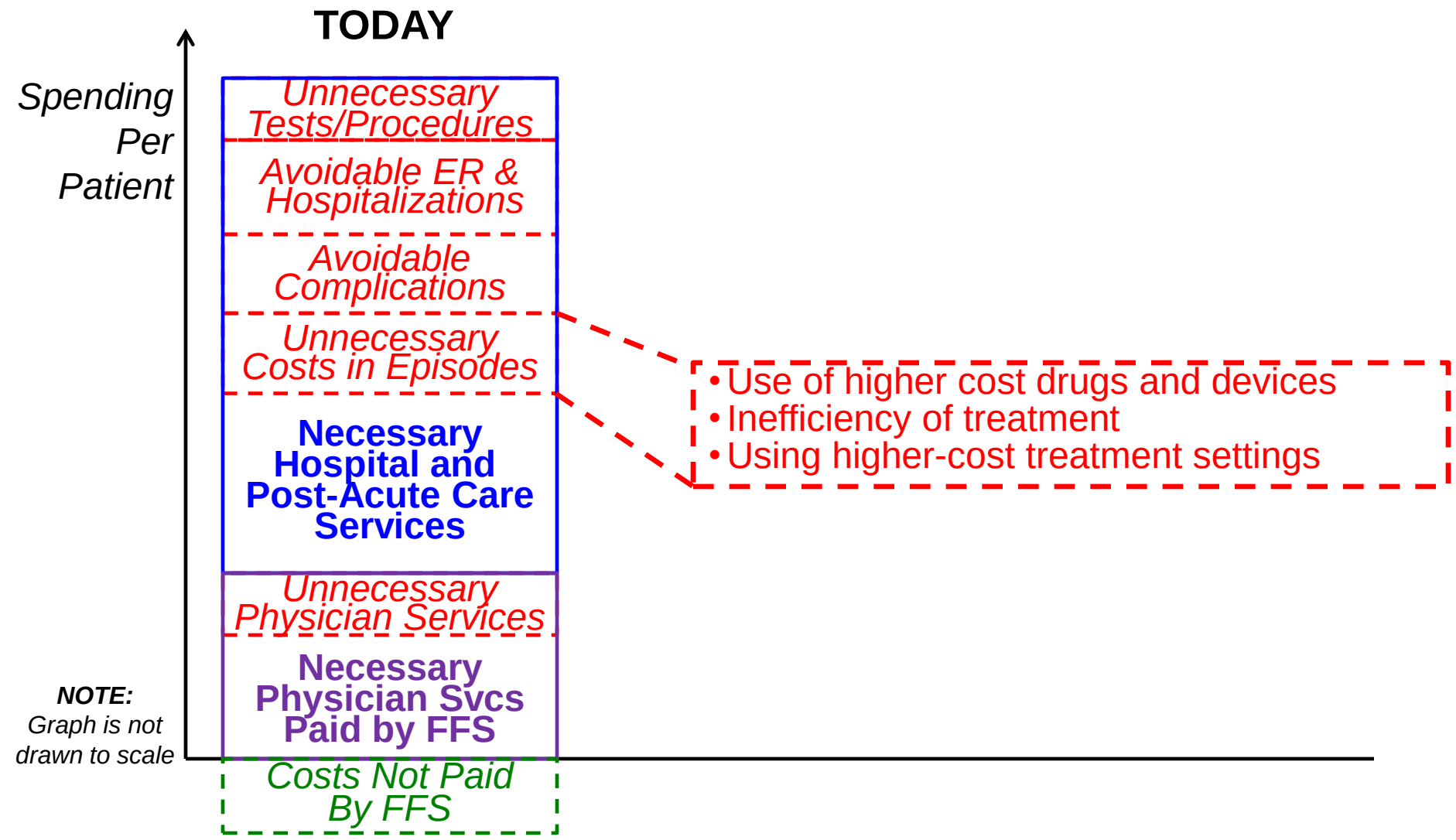
Avoidable ER Visits and Hospitalizations



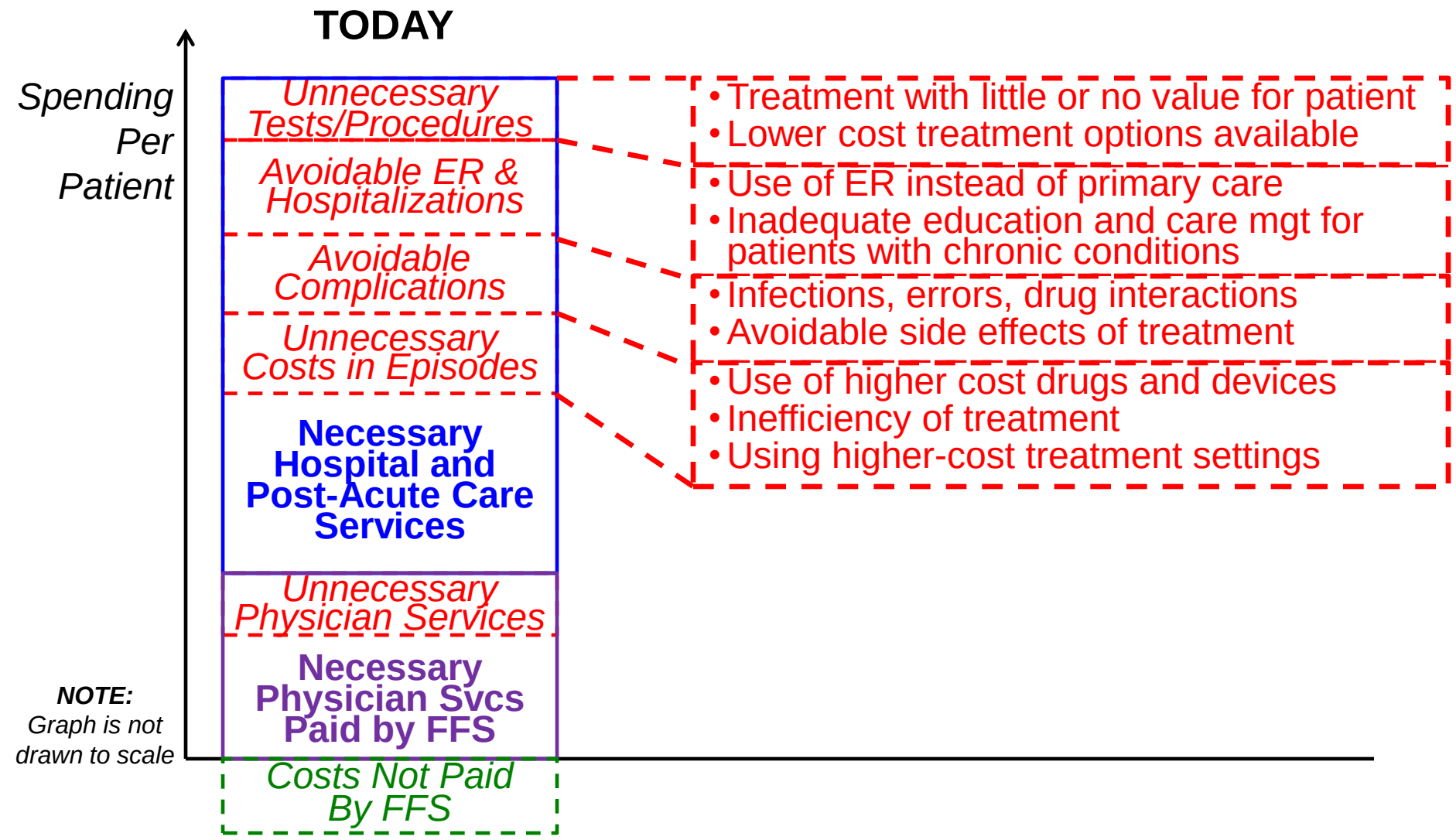
Avoidable Complications



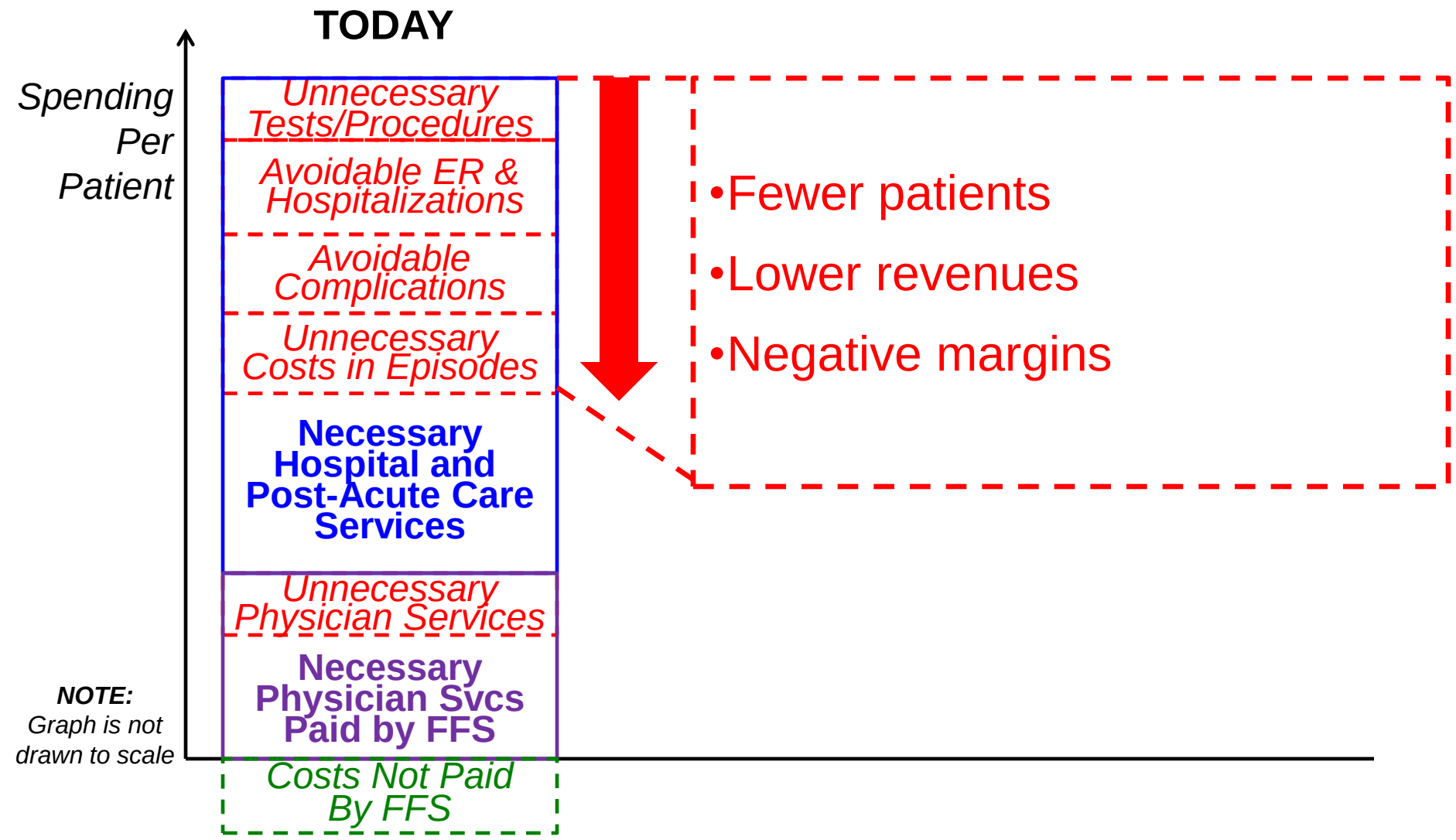
Inefficiencies in Care Delivery and Use of High-Cost Settings/Supplies



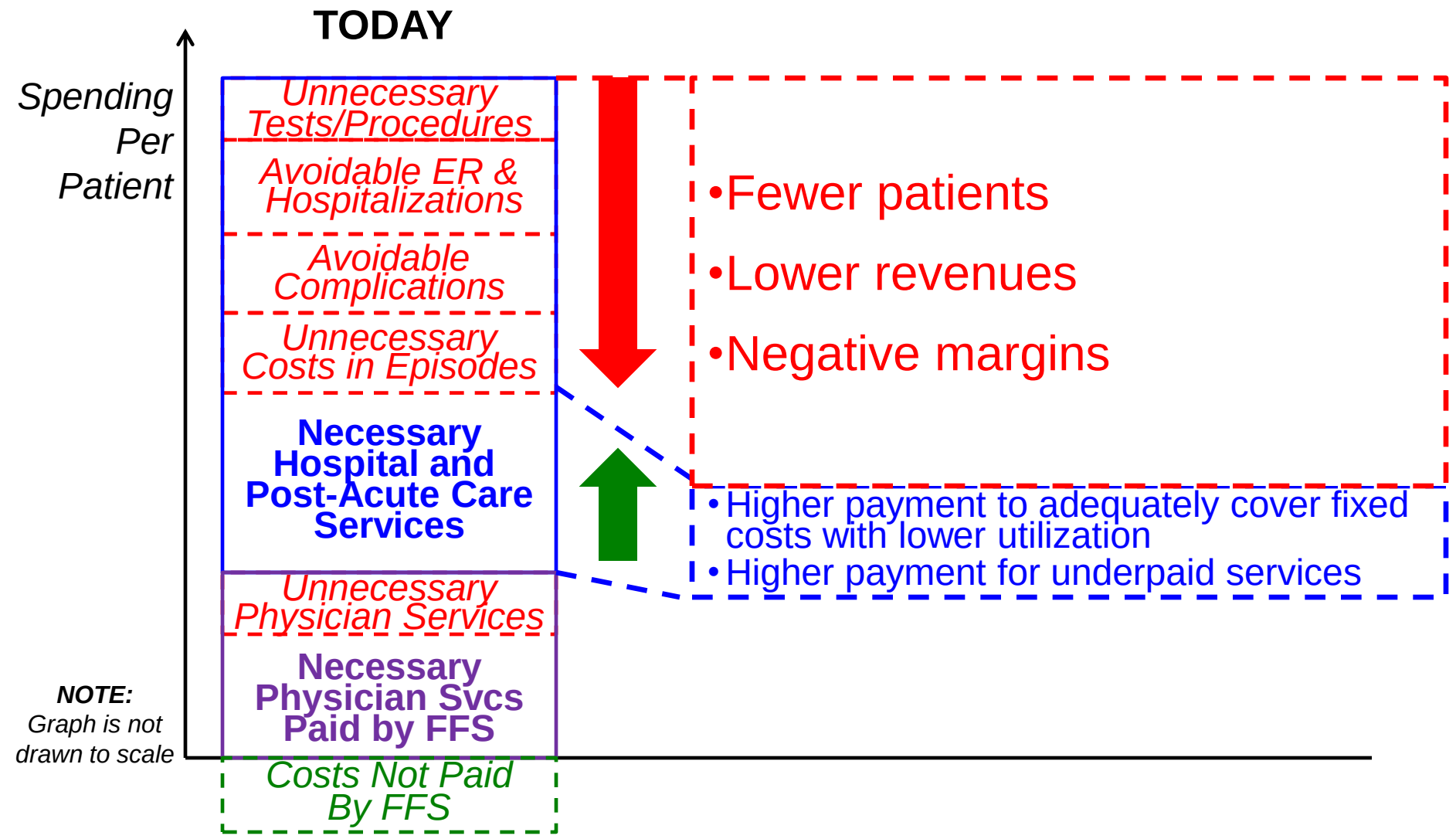
Many Different Opportunities to Reduce Non-Physician Spending



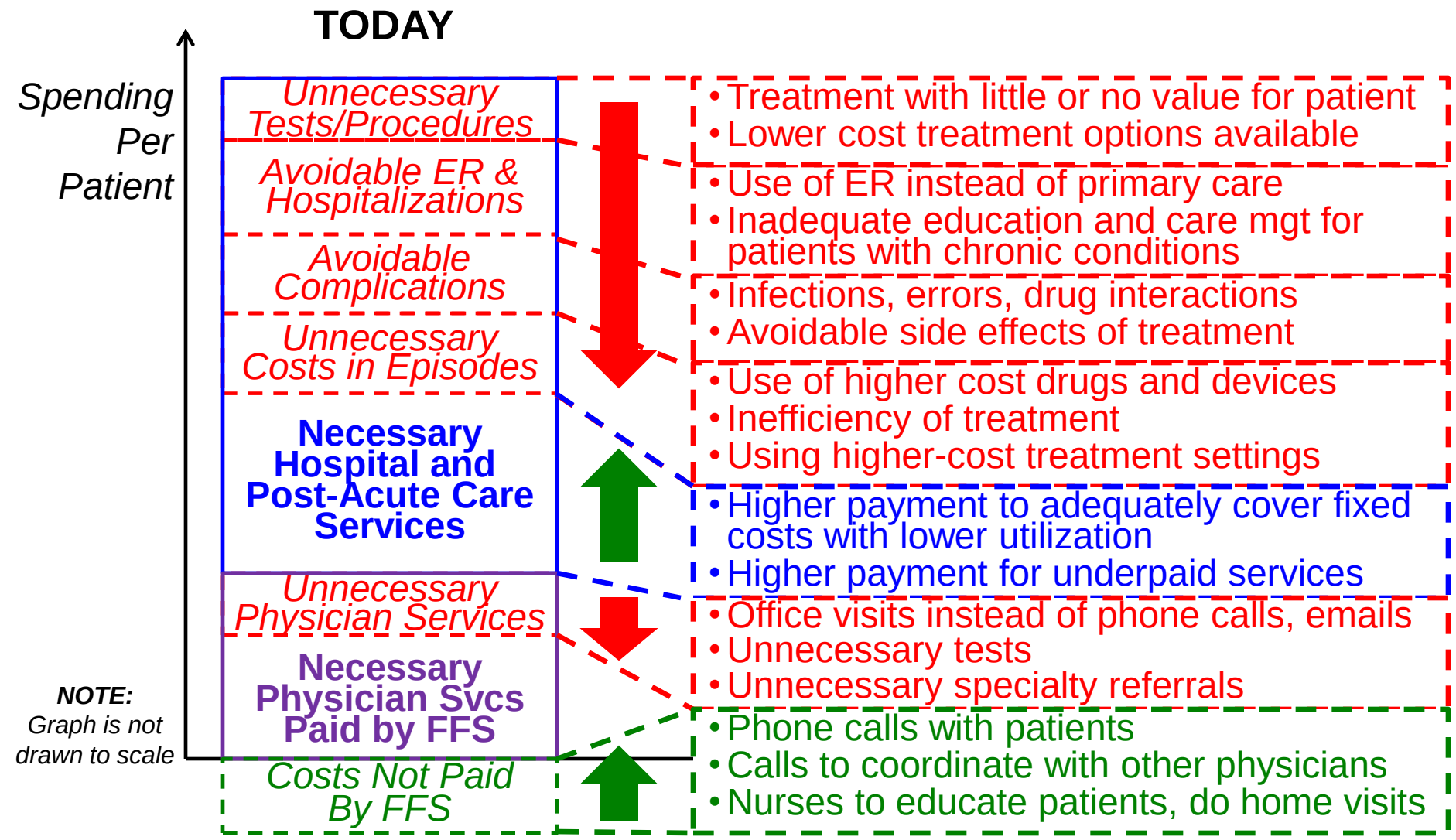
But Lower Spending Can Harm Hospitals and Other Providers



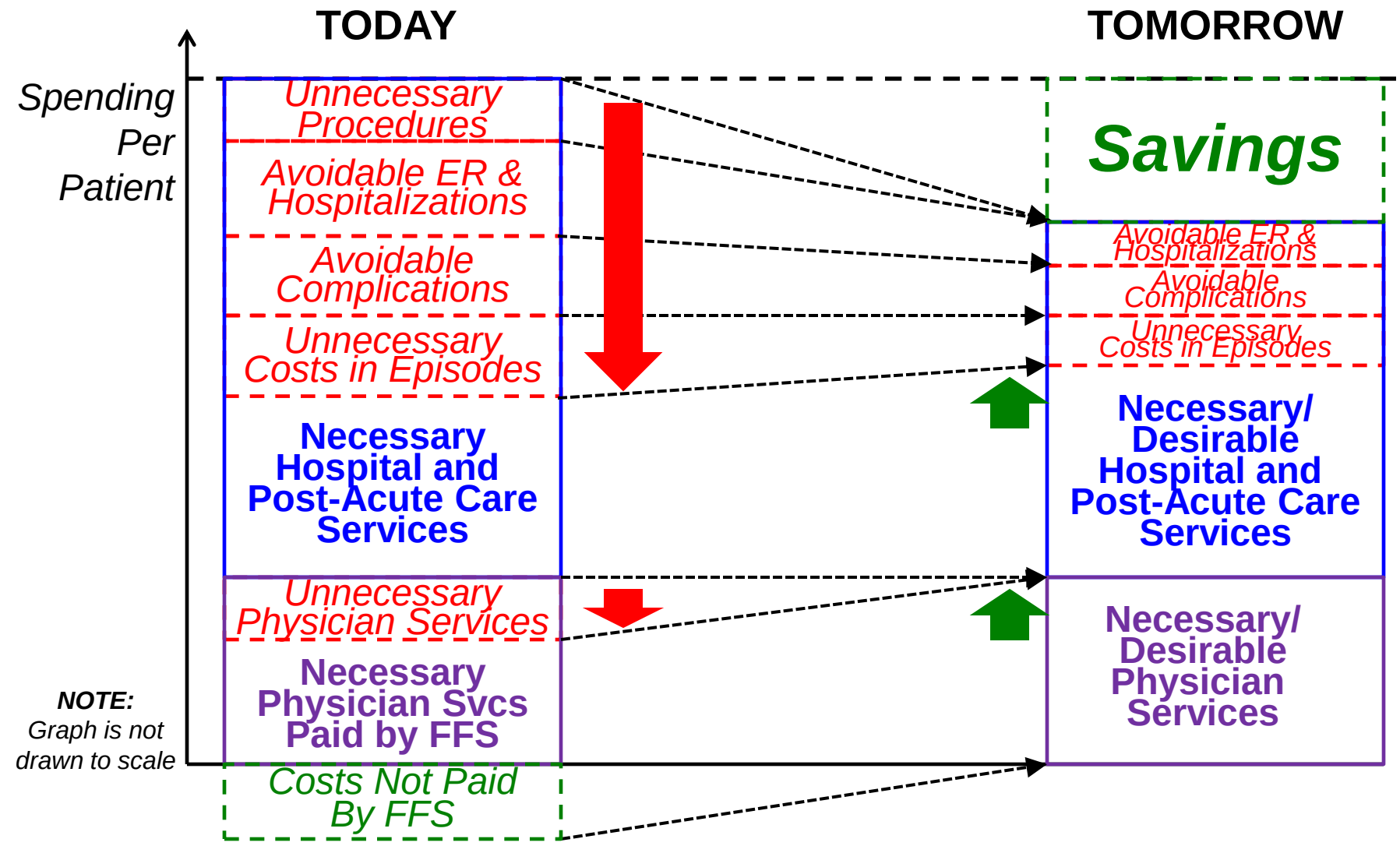
…Unless We Adjust Payments to Adequately Cover Costs



Many Opportunities for Savings, But Also Needs for More Payment



Win-Win: Lower Spending Offsets Higher Payments to Providers



Win-Win: Lower Spending Offsets Higher Payments to Providers

DOESN'T SOMEBODY HAVE TO LOSE?

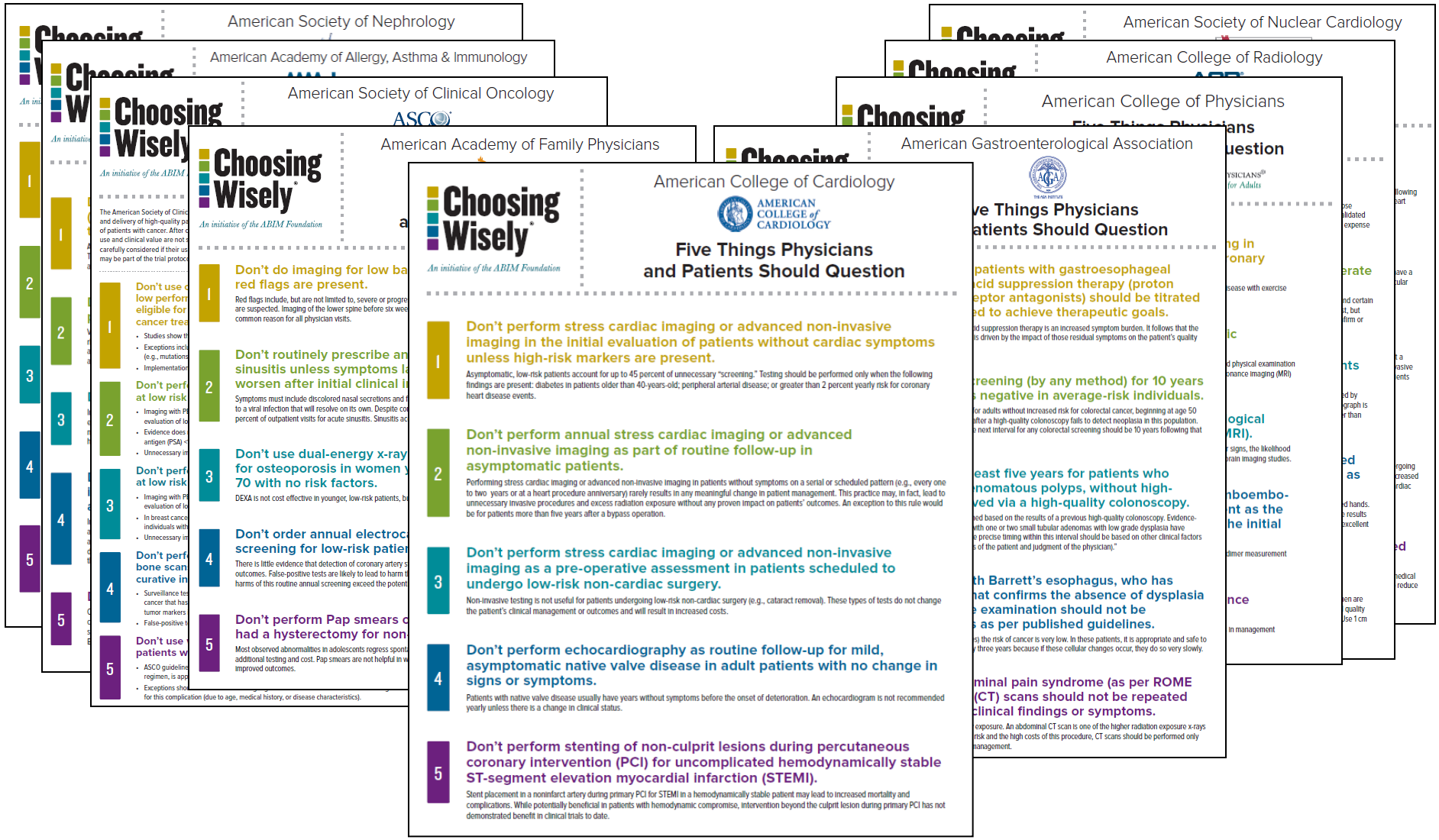
Win-Win: Lower Spending Offsets Higher Payments to Providers

DOESN'T SOMEBODY HAVE TO LOSE?

WHO IS THAT GOING TO BE?

(BETTER NOT BE ME…)

Example: Reducing Avoidable Procedures



Example: Reducing Avoidable Procedures

	TODAY		
	$/Patient	# Pts	Total $
Physician Svcs			
Evaluations	$150	300	$45,000
Procedures	$850	200	$170,000
Subtotal			$215,000
Hospital Pmt	$11,000	200	$2,200,000
Total Pmt/Cost			$2,415,000

Optional Procedure for a Condition

- Physician evaluates all patients
- Physician performs procedure on 2/3 of evaluated patients
- Up to 10% of procedures may be avoidable through patient choice or alternative treatment

Typical Health Plan Approach: Prior Auth/Utilization Controls

	TODAY			w/ UTILIZATION CTRL			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Physician Svcs							
Evaluations	$150	300	$45,000	$150	300	$45,000	
Procedures	$850	200	~~$170,000~~	~~$850~~	180	$153,000	
Subtotal			$215,000			$198,000	
Hospital Pmt	$11,000	200	~~$2,200,000~~	~~$11,000~~	180	$1,980,000	
Total Pmt/Cost			$2,415,000			$2,178,000	-10%

Under FFS, Payer Wins, Physicians and Hospitals Lose

	TODAY			w/ UTILIZATION CTRL			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Physician Svcs							
Evaluations	$150	300	$45,000	$150	300	$45,000	
Procedures	$850	200	~~$170,000~~	~~$850~~	180	$153,000	
Subtotal			$215,000			$198,000	-8%
Hospital Pmt	$11,000	200	$2,200,000	$11,000	180	$1,980,000	-10%
Total Pmt/Cost			$2,415,000			$2,178,000	-10%

Is There a Better Way?

	TODAY			TOMORROW			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Physician Svcs							
Evaluations	$150	300	$45,000	?	?	?	
Procedures	$850	200	$170,000	?	?	?	
Subtotal			$215,000			?	
				?	?	?	
Hospital Pmt	$11,000	200	$2,200,000	?	?	?	
Total Pmt/Cost			$2,415,000	?	?	?	

A Better Way: Pay Physicians *Differently*

	TODAY			TOMORROW			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Physician Svcs							
Evaluations	$150	300	$45,000	$200	300	$60,000	
Procedures	$850	200	$170,000	$900	180	$162,000	
Subtotal			$215,000			$222,000	
Hospital Pmt	$11,000	200	$2,200,000	$11,000	180	$1,980,000	
Total Pmt/Cost			$2,415,000			$2,202,000	

Better Payment for Condition Management

- Physician paid adequately to engage in shared decision making process with patients
- Physician paid adequately for procedures without needing to increase volume of procedures

Physicians Could Be Paid *More* While Still Reducing Total $

	TODAY			TOMORROW			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Physician Svcs							
Evaluations	$150	300	$45,000	$200	300	$60,000	
Procedures	$850	200	$170,000	$900	180	$162,000	
Subtotal			$215,000			$222,000	+3%
Hospital Pmt	$11,000	200	$2,200,000	$11,000	180	$1,980,000	-10%
Total Pmt/Cost			$2,415,000			$2,202,000	-9%

Do Hospitals Have to Lose In Order for Physicians To Win?

	TODAY			TOMORROW			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Physician Svcs							
Evaluations	$150	300	$45,000	$200	300	$60,000	
Procedures	$850	200	$170,000	$900	180	$162,000	
Subtotal			$215,000			$222,000	+3%
Hospital Pmt	$11,000	200	$2,200,000	$11,000	180	$1,980,000	-10%
Total Pmt/Cost			$2,415,000			$2,202,000	-9%

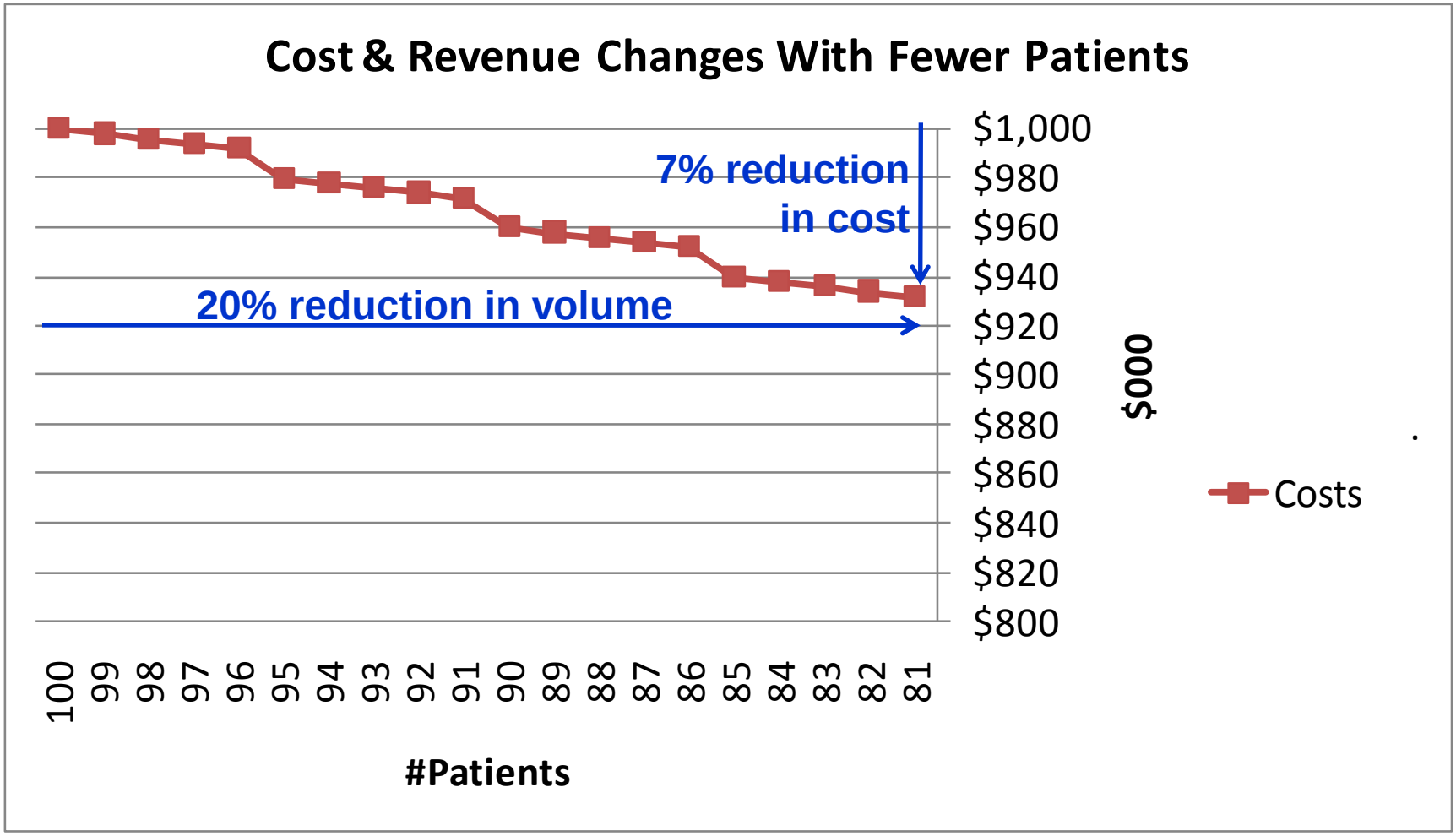
Physician Wins

Hospital Loses

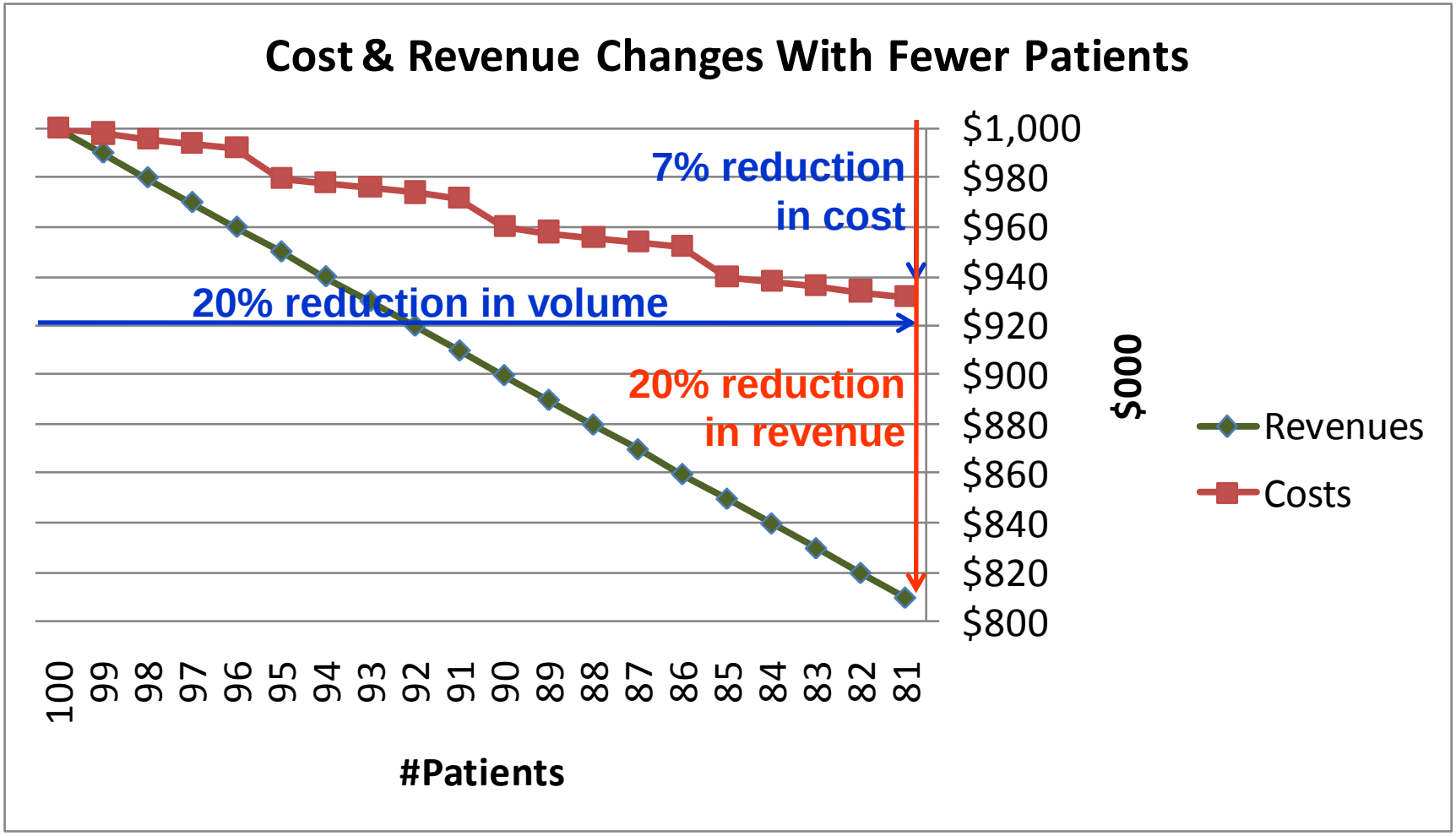
Payer Wins

What Should Matter to Hospitals is *Margin*, Not Revenues (Volume)

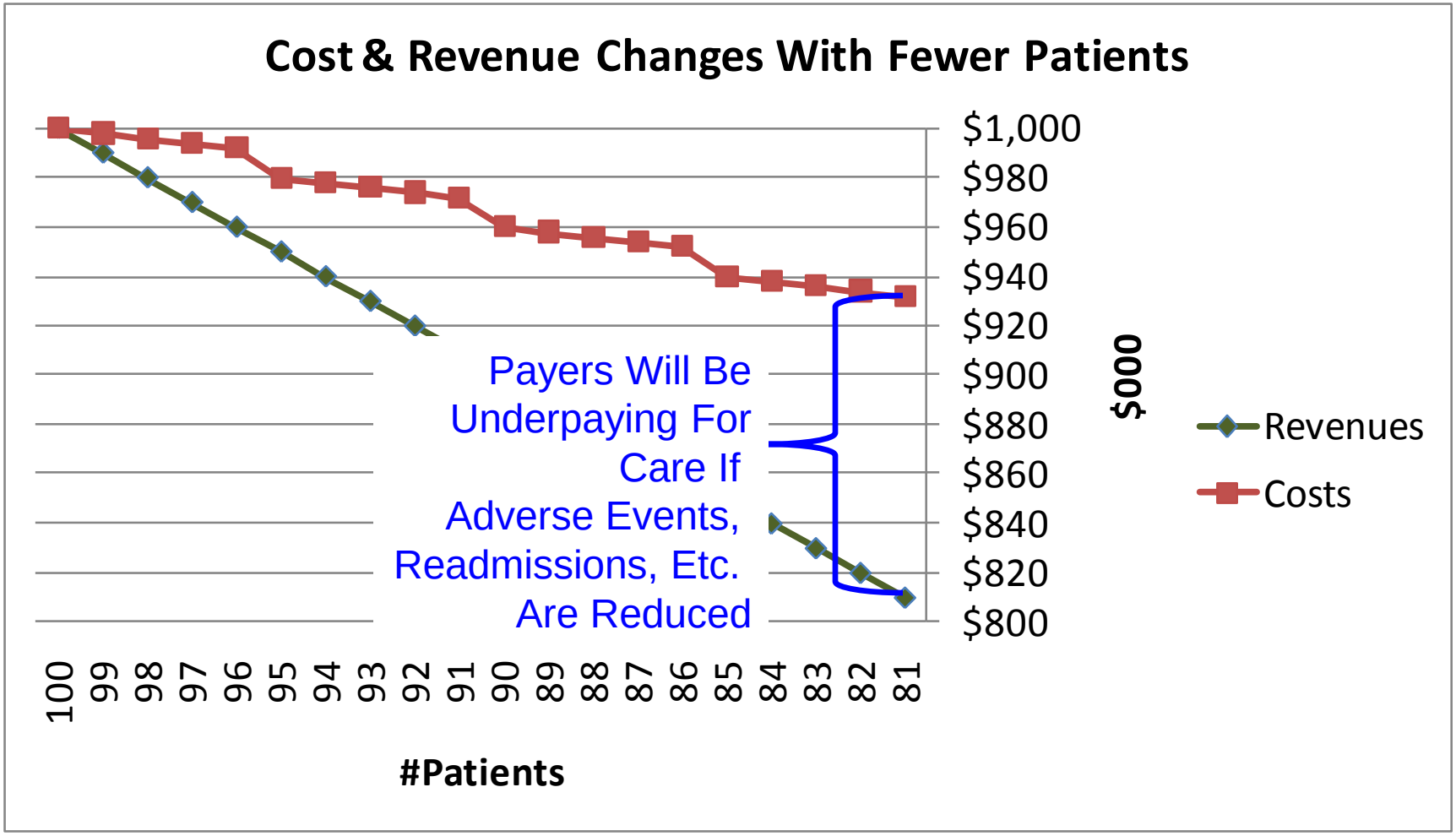
Hospital Costs Are Not Proportional to Utilization



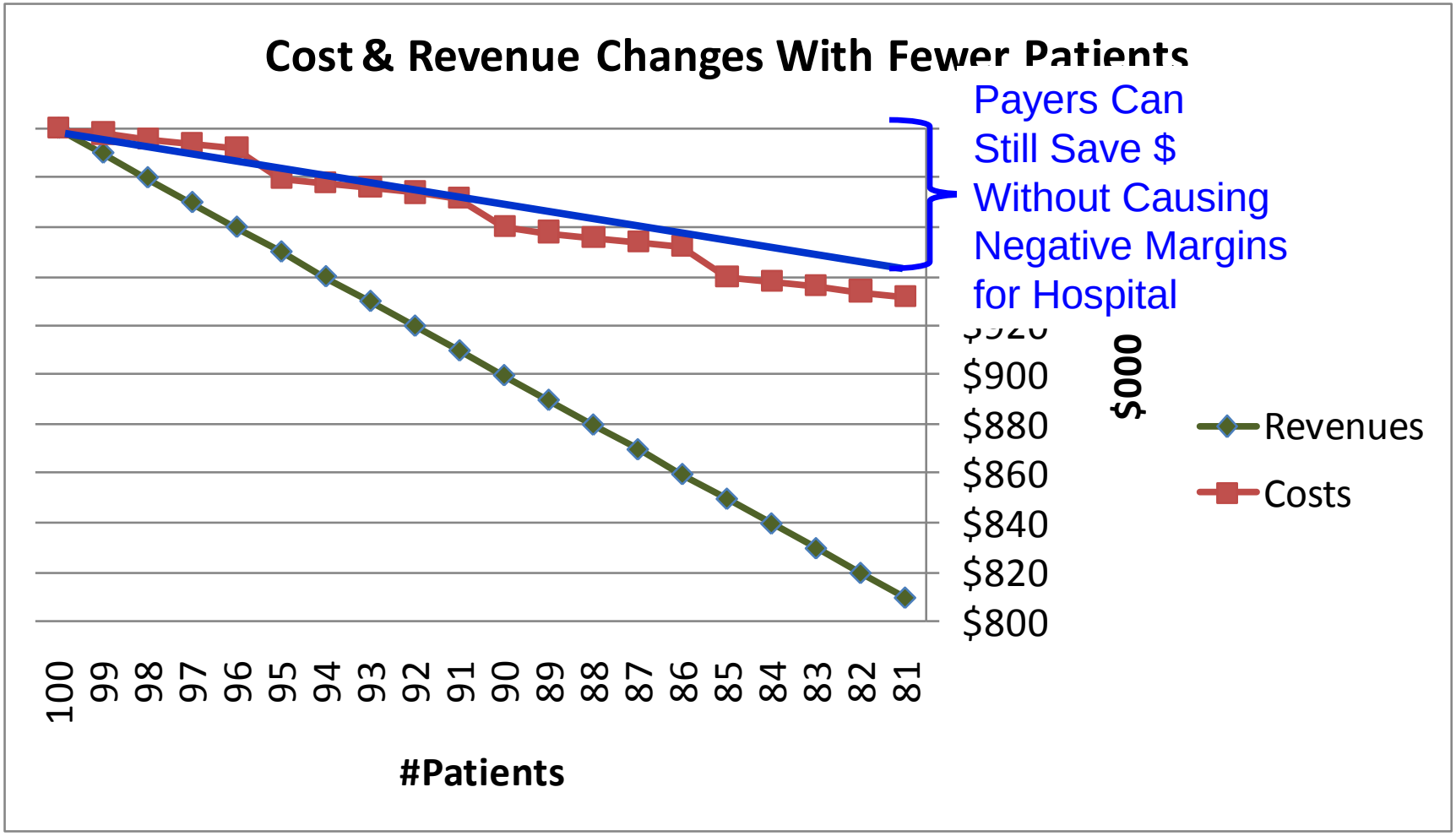
Reductions in Utilization Reduce Revenues More Than Costs



Causing Negative Margins for Hospitals



But Spending Can Be Reduced Without Bankrupting Hospitals



Adequacy of Payment Depends On Fixed/Variable Costs & Margins

	TODAY			TOMORROW			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Physician Svcs							
Evaluations	$150	300	$45,000	$200	300	$60,000	
Procedures	$850	200	$170,000	$900	180	$162,000	
Subtotal			$215,000			$222,000	+3%
Hospital Pmt							
Fixed Costs	$7,150	*65%*	$1,430,000				
Variable Costs	$3,300	*30%*	$660,000				
Margin	$550	*5%*	$110,000				
Subtotal	$11,000	200	$2,200,000				
Total Pmt/Cost			$2,415,000				

Now, if the Number of Procedures is Reduced…

	TODAY			TOMORROW			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Physician Svcs							
Evaluations	$150	300	$45,000	$200	300	$60,000	
Procedures	$850	200	$170,000	$900	180	$162,000	
Subtotal			$215,000			$222,000	+3%
Hospital Pmt							
Fixed Costs	$7,150	*65%*	$1,430,000				
Variable Costs	$3,300	*30%*	$660,000				
Margin	$550	*5%*	$110,000				
Subtotal	$11,000	200	~~$2,200,000~~		180		
Total Pmt/Cost			$2,415,000				

…Fixed Costs Will Remain the Same (in the Short Run)…

	TODAY			TOMORROW			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Physician Svcs							
Evaluations	$150	300	$45,000	$200	300	$60,000	
Procedures	$850	200	$170,000	$900	180	$162,000	
Subtotal			$215,000			$222,000	+3%
Hospital Pmt							
Fixed Costs	$7,150	*65%*	$1,430,000			$1,430,000	-0%
Variable Costs	$3,300	*30%*	$660,000				
Margin	$550	*5%*	$110,000				
Subtotal	$11,000	200	$2,200,000		180		
Total Pmt/Cost			$2,415,000				

…Variable Costs Will Go Down in Proportion to Procedures…

	TODAY			TOMORROW			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Physician Svcs							
Evaluations	$150	300	$45,000	$200	300	$60,000	
Procedures	$850	200	$170,000	$900	180	$162,000	
Subtotal			$215,000			$222,000	+3%
Hospital Pmt							
Fixed Costs	$7,150	*65%*	$1,430,000			$1,430,000	-0%
Variable Costs	$3,300	~~*30%*~~	~~$660,000~~	$3,300		$594,000	-10%
Margin	$550	*5%*	$110,000				
Subtotal	$11,000	200	$2,200,000		180		
Total Pmt/Cost			$2,415,000				

…And Even With a Higher Margin for the Hospital…

	TODAY			TOMORROW			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Physician Svcs							
Evaluations	$150	300	$45,000	$200	300	$60,000	
Procedures	$850	200	$170,000	$900	180	$162,000	
Subtotal			$215,000			$222,000	+3%
Hospital Pmt							
Fixed Costs	$7,150	*65%*	$1,430,000			$1,430,000	-0%
Variable Costs	$3,300	*30%*	$660,000			$594,000	-10%
Margin	$550	*5%*	$110,000			$113,000	+3%
Subtotal	$11,000	200	$2,200,000		180		
Total Pmt/Cost			$2,415,000				

…The Hospital Gets Less Total Revenue (But More Per Case)…

	TODAY			TOMORROW			Chg
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	
Physician Svcs							
Evaluations	$150	300	$45,000	$200	300	$60,000	
Procedures	$850	200	$170,000	$900	180	$162,000	
Subtotal			$215,000			$222,000	+3%
Hospital Pmt							
Fixed Costs	$7,150	*65%*	$1,430,000	$7,944		$1,430,000	-0%
Variable Costs	$3,300	*30%*	$660,000	$3,300		$594,000	-10%
Margin	$550	*5%*	$110,000	$628		$113,000	+3%
Subtotal	$11,000	200	$2,200,000	$11,872	180	$2,137,000	-3%
Total Pmt/Cost			$2,415,000				

…And The Payer Still Saves Money

	TODAY			TOMORROW			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Physician Svcs							
Evaluations	$150	300	$45,000	$200	300	$60,000	
Procedures	$850	200	$170,000	$900	180	$162,000	
Subtotal			$215,000			$222,000	+3%
Hospital Pmt							
Fixed Costs	$7,150	*65%*	$1,430,000	$7,944		$1,430,000	-0%
Variable Costs	$3,300	*30%*	$660,000	$3,300		$594,000	-10%
Margin	$550	*5%*	$110,000	$628		$113,000	+3%
Subtotal	$11,000	200	$2,200,000	$11,872	180	$2,137,000	-3%
Total Pmt/Cost			$2,415,000			$2,359,000	-2%

I.e., Win-Win-Win for Physician, Hospital, and Payer

	TODAY			TOMORROW			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Physician Svcs							
Evaluations	$150	300	$45,000	$200	300	$60,000	
Procedures	$850	200	$170,000	$900	180	$162,000	
Subtotal			$215,000			$222,000	+3%
Hospital Pmt							
Fixed Costs	$7,150	*65%*	$1,430,000			$1,430,000	-0%
Variable Costs	$3,300	*30%*	$660,000	$3,300		$594,000	-10%
Margin	$550	*5%*	$110,000	$628		$113,000	+3%
Subtotal	$11,000	200	$2,200,000	$11,872	180	$2,137,000	-3%
Total Pmt/Cost			$2,415,000			$2,359,000	-2%

Physician Wins
Hospital Wins
Payer Wins

I.e., Win-Win-Win for Physician, Hospital, and Payer

	TODAY			TOMORROW			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Physician Svcs							
Evaluations	$150	300	$45,000	$200	300	$60,000	
Procedures	$850	200	$170,000	$900	180	$162,000	
Subtotal			$215,000			$222,000	+3%
Hosp							
Fixe							-0%
Variable Costs	$3,300	*30%*	$660,000	$3,300		$594,000	-10%
Margin	$550	*5%*	$110,000	$628		$113,000	+3%
Subtotal	$11,000	200	$2,200,000	$11,872	180	$2,137,000	-3%
Total Pmt/Cost			$2,415,000			$2,359,000	-2%

I thought you said you were going to double the physicians' pay??

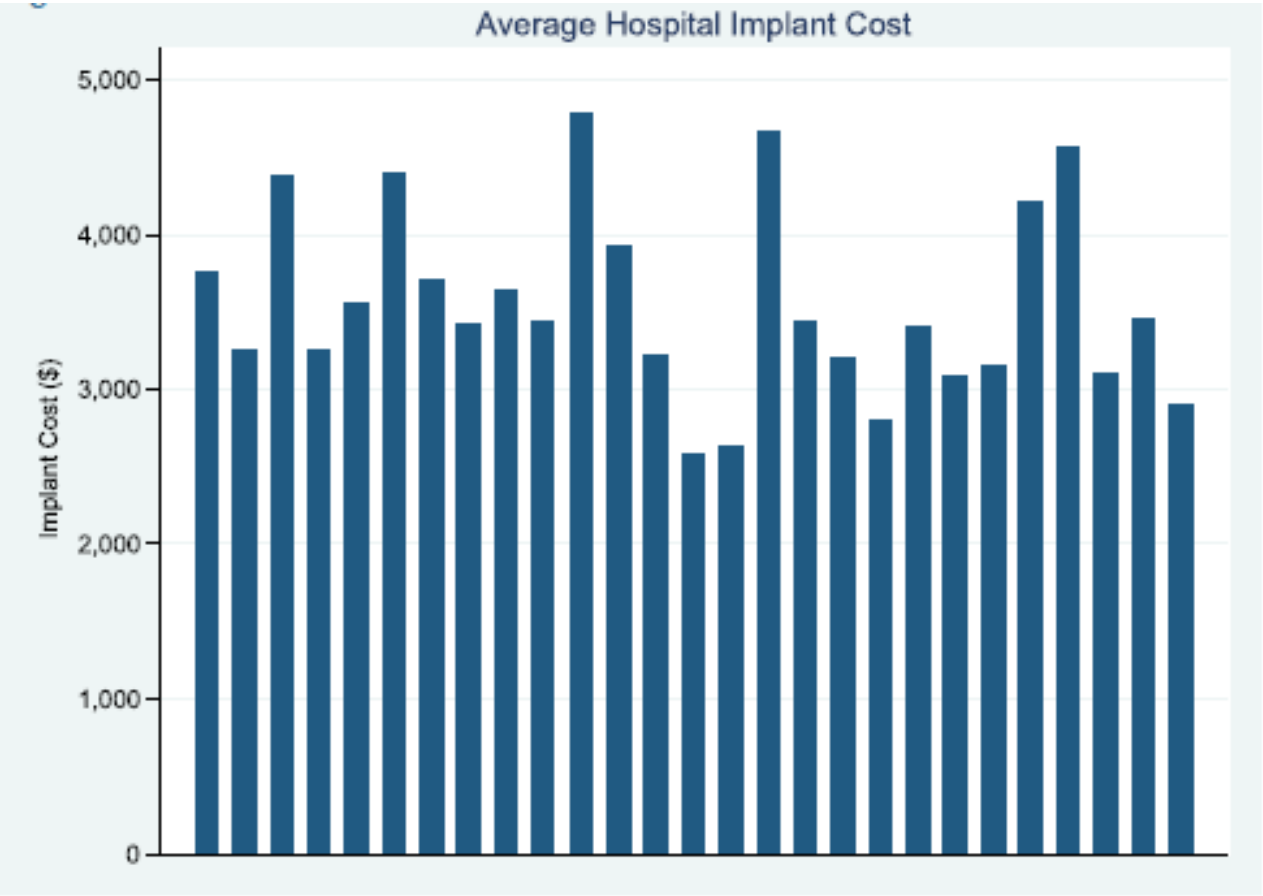
If The Physician Can Reduce the Hospital's Costs Per Procedure….

	TODAY			TOMORROW			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Physician Svcs							
Evaluations	$150	300	$45,000				
Procedures	$850	200	$170,000				
Subtotal			$215,000				
Hospital Pmt							
Fixed Costs	$7,150	*65%*	$1,430,000			$1,430,000	
Variable Costs	$3,300	*30%*	~~$660,000~~	**$2,000**		$360,000	-46%
Margin	$550	*5%*	$110,000				
Subtotal	$11,000	200	$2,200,000		180		
Total Pmt/Cost			$2,415,000				

Everyone Can Win Even More

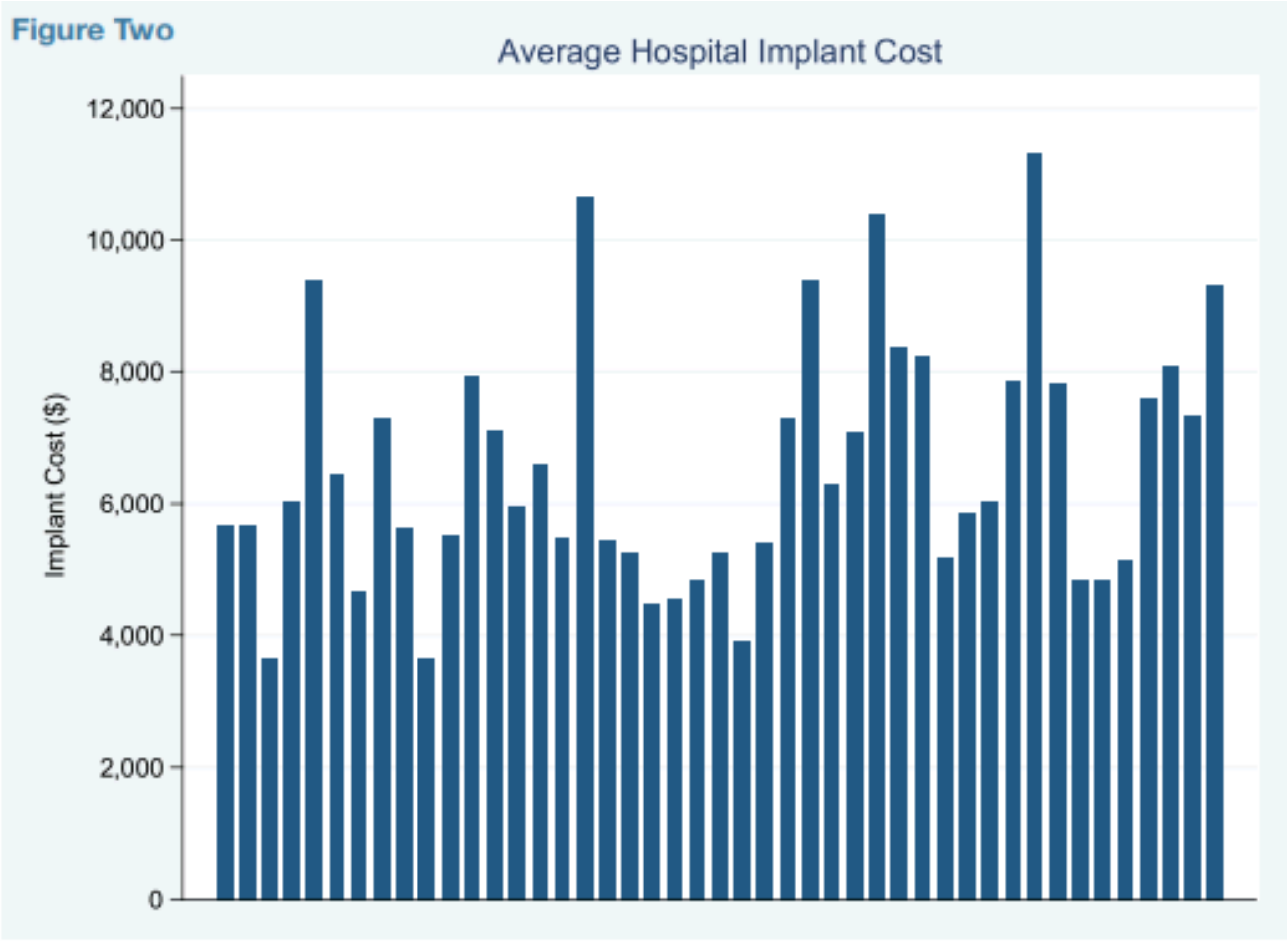
	TODAY			TOMORROW			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Physician Svcs							
Evaluations	$150	300	$45,000	**$830**	300	$249,000	
Procedures	$850	200	$170,000	**$1,000**	180	$180,000	
Subtotal			$215,000			$429,000	100%
Hospital Pmt							
Fixed Costs	$7,150	*65%*	$1,430,000			$1,430,000	
Variable Costs	$3,300	*30%*	$660,000	$2,000		$360,000	
Margin	$550	*5%*	$110,000	**$672**		$121,000	+10%
Subtotal	$11,000	200	$2,200,000		180	$1,911,000	-13%
Total Pmt/Cost			$2,415,000			$2,340,000	-3%

$2,200 Variation in Average Cost of Drug-Eluting Stents in CA Hospitals



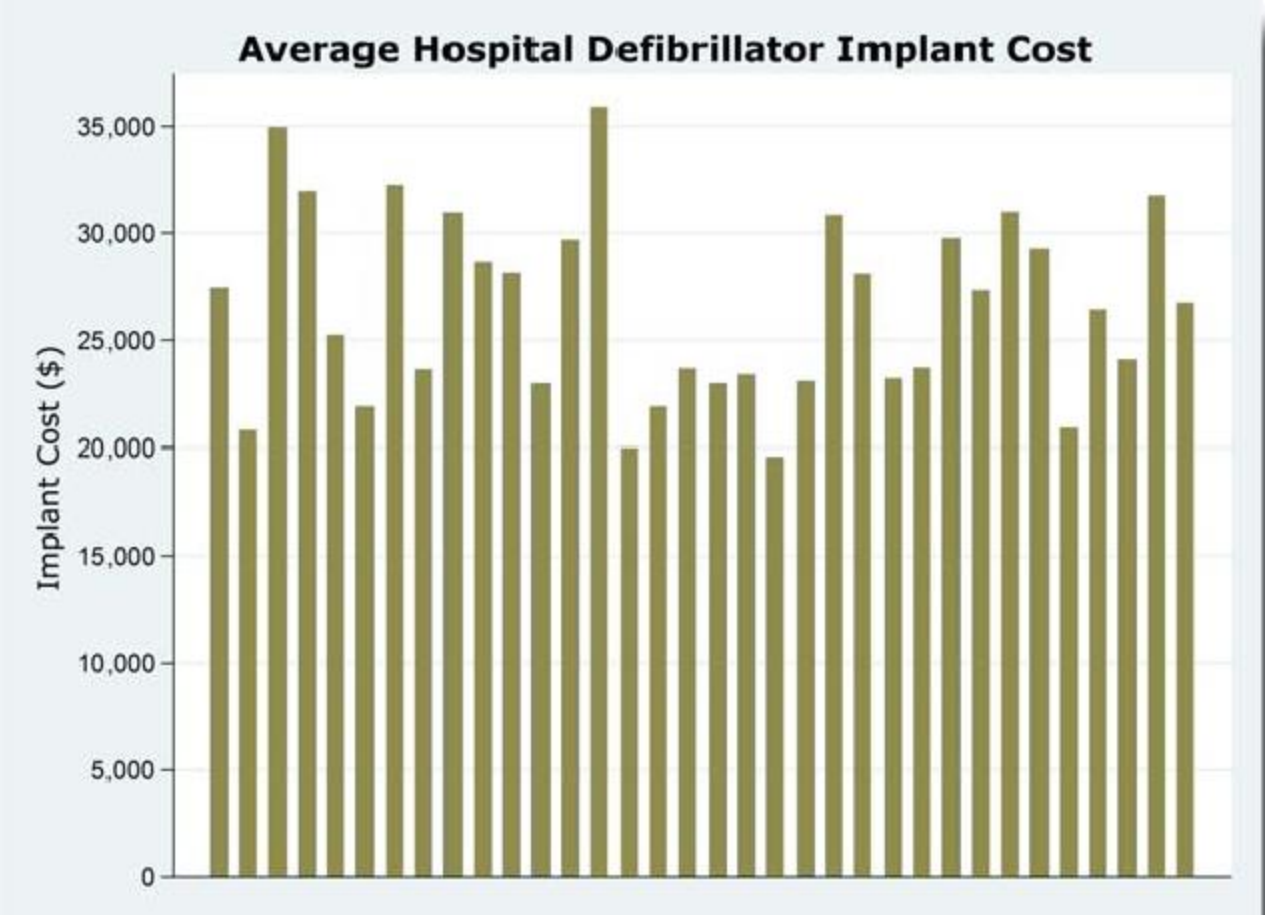
Source: *Coronary Angioplasty with Drug Eluting Stents: Device Costs, Hospital Costs, and Insurance Payments*, Emma L. Dolan and James C. Robinson Berkeley Center for Health Technology, September 2010

$8,000 Variation in Avg Costs of Joint Implants Across CA Hospitals



Source: Implantable Medical Devices for Hip Replacement Surgery: Economic Implications for California Hospitals, Emma L. Dolan and James C. Robinson , Berkeley Center for Health Technology, May 2010

$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, 2010

Not Just Devices: Other Savings Opportunities From Bundling

- Better scheduling of scarce resources (e.g., surgery suites) to reduce both underutilization & overtime
- Coordination among multiple physicians and departments to avoid duplication and conflicts in scheduling
- Standardization of equipment and supplies to facilitate bulk purchasing
- Less wastage of expensive supplies
- Reduced length of stay
- Etc.

A More Balanced Distribution

	TODAY			TOMORROW			Chg
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	
Physician Svcs							
Evaluations	$150	300	$45,000	**$350**	300	$105,000	
Procedures	$850	200	$170,000	**$950**	180	$171,000	
Subtotal			$215,000			$276,000	+28%
Hospital Pmt							
Fixed Costs	$7,150	*65%*	$1,430,000			$1,430,000	
Variable Costs	$3,300	*30%*	$660,000	$2,000		$360,000	
Margin	$550	*5%*	$110,000	**$672**		$121,000	+10%
Subtotal	$11,000	200	$2,200,000		180	$1,911,000	-13%
Total Pmt/Cost			$2,415,000			$2,187,000	-9%

What Payment Model Supports This Win-Win-Win Approach?

	TODAY			TOMORROW			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Physician Svcs							
Evaluations	$150	300	$45,000	$350	300	$105,000	
Procedures	$850	200	$170,000	$950	180	$171,000	
Subtotal			$215,000			$276,000	+28%
Hospital Pmt							
Fixed Costs	$7,150	*65%*	$1,430,000			$1,430,000	
Variable Costs	$3,300	*30%*	$660,000	$2,000		$360,000	
Margin	$550	*5%*	$110,000	$672		$121,000	+10%
Subtotal	$11,000	200	$2,200,000		180	$1,911,000	-13%
Total Pmt/Cost			$2,415,000			$2,187,000	-9%

Pay Based on the Patient's *Condition*, Not on the *Procedure*

	TODAY			TOMORROW			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Physician Svcs							
Evaluations	$150	300	$45,000	$350	300	$105,000	
Procedures	$850	200	$170,000	$950	180	$171,000	
Subtotal			$215,000			$276,000	+28%
Hospital Pmt							
Fixed Costs	$7,150	*65%*	$1,430,000			$1,430,000	
Variable Costs	$3,300	*30%*	$660,000	$2,000		$360,000	
Margin	$550	*5%*	$110,000	$672		$121,000	+10%
Subtotal	$11,000	200	$2,200,000		180	$1,911,000	-13%
Total Pmt/Cost	$8,050	300	$2,415,000			$2,187,000	-9%

Plan to Offer Care of the Condition at a Lower Cost Per Patient

	TODAY			TOMORROW			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Physician Svcs							
Evaluations	$150	300	$45,000	$350	300	$105,000	
Procedures	$850	200	$170,000	$950	180	$171,000	
Subtotal			$215,000			$276,000	+28%
Hospital Pmt							
Fixed Costs	$7,150	*65%*	$1,430,000			$1,430,000	
Variable Costs	$3,300	*30%*	$660,000	$2,000		$360,000	
Margin	$550	*5%*	$110,000	$672		$121,000	+10%
Subtotal	$11,000	200	$2,200,000		180	$1,911,000	-13%
Total Pmt/Cost	$8,050	300	~~$2,415,000~~	$7,290	300	$2,187,000	-9%

Use the Payment as a Budget to Redesign Care…

	TODAY			TOMORROW			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Physician Svcs							
Evaluations	$150	300	$45,000	$350	300	$105,000	
Procedures	$850	200	$170,000	$950	180	$171,000	
Subtotal			$215,000			$276,000	+28%
Hospital Pmt							
Fixed Costs	$7,150	*65%*	$1,430,000			$1,430,000	
Variable Costs	$3,300	*30%*	$660,000	$2,000		$360,000	
Margin	$550	*5%*	$110,000	$672		$121,000	+10%
Subtotal	$11,000	200	$2,200,000		180	$1,911,000	-13%
Total Pmt/Cost	$8,050	300	$2,415,000	$7,290	300	$2,187,000	-9%

…And Let the Providers Decide How They Should Be Paid

	TODAY			TOMORROW			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Physician Svcs							
Evaluations	$150	300	$45,000	$350	300	$105,000	
Procedures	$850	200	$170,000	$950	180	$171,000	
Subtotal			$215,000			$276,000	+28%
Hospital Pmt							
Fixed Costs	$7,150	*65%*	$1,430,000			$1,430,000	
Variable Costs	$3,300	*30%*	$660,000	$2,000		$360,000	
Margin	$550	*5%*	$110,000	$672		$121,000	+10%
Subtotal	$11,000	200	$2,200,000		180	$1,911,000	-13%
Total Pmt/Cost	$8,050	300	$2,415,000	$7,290	300	$2,187,000	-9%

Would “Shared Savings” Achieve the Same Thing?

Same Example As Before…

	Year 0	# Patients	$/Patient
Physician Svcs			
Evaluations	$45,000	300	$150
Procedures	$170,000	200	$850
Subtotal	$215,000		
Hospital Pmt			
Procedures	$2,200,000	200	$11,000
Subtotal	$2,200,000		
Total Pmt/Cost	$2,415,000		
Savings			

Optional Procedure for a Condition

- Physician evaluates all patients
- Physician performs procedure on 2/3 of evaluated patients
- Up to 10% of procedures may be avoidable through patient choice or alternative treatment

Year 1: Physicians & Hospitals Both Lose With Fewer Procedures

	Year 0	Year 1	Chg
Physician Svcs			
Evaluations	$45,000	$45,000	
Procedures ↓	$170,000	$153,000	
		$0	
Subtotal	$215,000	$198,000	-8%
Hospital Pmt			
Procedures ↓	$2,200,000	$1,980,000	
Subtotal	$2,200,000	$1,980,000	-10%
Total Pmt/Cost	$2,415,000	$2,178,000	-10%
Savings		$237,000	

Reduce Procs by 10%

Year 1: Lower Revenue for Docs & Hospital

Year 2: Losses Are Lower If Shared Savings Are Paid…

	Year 0	Year 1	Chg	Year 2	Chg
Physician Svcs					
Evaluations	$45,000	$45,000		$45,000	
Procedures	$170,000	$153,000		$153,000	
Shared Savings		$0		$17,000	
Subtotal	$215,000	$198,000	-8%	$215,000	-0%
Hospital Pmt					
Procedures	$2,200,000	$1,980,000		$1,980,000	
Shared Savings		$0		$101,500	
Subtotal	$2,200,000	$1,980,000	-10%	$2,081,500	-6%
Total Pmt/Cost	$2,415,000	$2,178,000	-10%	$2,296,500	-5%
Savings		$237,000		$118,500	

Reduce Procs by 10%

Year 1: Lower Revenue for Docs & Hospital

Year 2: Shared Savings Offsets Some Losses

…But Physicians and Hospitals Still Have Net 2-Year Losses

	Year 0	Year 1	Chg	Year 2	Chg	Cumulative
Physician Svcs						
Evaluations	$45,000	$45,000		$45,000		
Procedures	$170,000	$153,000		$153,000		
Shared Savings		$0		$17,000		
Subtotal	$215,000	$198,000	-8%	$215,000	-0%	-$17,000
						-4%
Hospital Pmt						
Procedures	$2,200,000	$1,980,000		$1,980,000		
Shared Savings		$0		$101,500		
Subtotal	$2,200,000	$1,980,000	-10%	$2,081,500	-5%	-$338,500
						-8%
Total Pmt/Cost	$2,415,000	$2,178,000	-10%	$2,296,500	-5%	$355,500
Savings		$237,000		$118,500		-7%

Physician Unlikely to Get Shared Savings If Hospital is First in Line

	Year 0	Year 1	Chg	Year 2	Chg	Cumulative
Physician Svcs						
Evaluations	$45,000	$45,000		$45,000		
Surgeries	$170,000	$153,000		$153,000		
Shared Savings		$0		$0		
Subtotal	$215,000	$198,000	-8%	$198,000	-8%	-$34,000
						-8%
Hospital Pmt						
Surgeries	$2,200,000	$1,980,000		$1,980,000		
Shared Savings		$0		$118,500		
Subtotal	$2,200,000	$1,980,000	-10%	$2,098,500	-5%	-$321,500
						-7%
Total Pmt/Cost	$2,415,000	$2,178,000	-10%	$2,296,500	-5%	$355,500
Savings		$237,000		$118,500		-7%

It's Even Worse Than That…

- **There is no shared savings payment at all if a minimum total savings level is not reached**
  - With 10,000 Medicare beneficiaries and ~$100 million annual spending, $237,000 is only 0.2% savings, not 3.0% required by Medicare, so no shared savings payment would be made
  - If spending increases elsewhere in the ACO, it may offset savings here, leaving nothing to be shared with physicians or hospital
- **If there is a shared savings payment, it's reduced if quality thresholds aren't met, even if the quality measures have nothing to do with where savings occurred**
- **The shared savings payment ends at the end of the 3-year contract period, even if utilization remains lower, and the payer keeps 100% of the savings in future years**

So Why Do Payers Like The Shared Savings Model So Much??

It's easy for them to implement:

- No changes in underlying fee for service payment and no costs to change claims payment system
- Additional payments only made if savings are achieved
- The payer sets the rules as to how "savings" are calculated
- Shared savings payments are made well after savings are achieved, helping the payers' cash flow
- All of the savings goes back to the payer after the end of the shared savings contract

Four Things Needed For Win-Win-Win Solutions

Four Things Needed For Win-Win-Win Solutions

1. Defining the Change in Care Delivery

- How can the physician, hospital, or other provider change the way care is delivered to reduce costs without harming patients?

Best Way to Find Savings Opportunities? Ask Physicians

"I have zero control over utilization or studies ordered. I don't get paid for calling a referring doctor and telling him/her the imaging test is worthless."
Radiologist in Maine

"Patients often need to be in extended care to receive antibiotics because Medicare doesn't pay for home IV therapy. Patient stays in the hospital for 3 days to justify a nursing home/rehab stay."
Orthopedist at AMA HOD Meeting

"I strongly suspect overutilization of abdominal CT scans in the ER and in the hospital; CT scans lead to further CT scans to follow up lung and adrenal nodules. The hospital focuses on length of stay, but never looks at appropriateness of radiologic studies."
Internist at AMA HOD Meeting

"I do many unnecessary colonoscopies on young men. Give every PCP an anuscope to allow diagnosis of bleeding hemorrhoids in the office."
Gastroenterologist in Maine

Four Things Needed For Win-Win-Win Solutions

1. **Defining the Change in Care Delivery**
   - How can the physician, hospital, or other provider change the way care is delivered to reduce costs without harming patients?

2. **Analyzing Expected Costs and Savings**
   - What will there be less of, and how much does that save?
   - What will there be more of, and how much does that cost?
   - Will the savings offset the costs on average?
   - How much variation in costs and savings is likely?

A Critical Element is Shared, Trusted Data

- **Physician/Hospital** need to know the current utilization and costs for their patients to know whether the condition-based or episode payment amount will cover the costs of delivering effective care to the patients

- **Purchaser/Payer** needs to know the current utilization and costs to know whether the condition-based or episode payment amount is a better deal than they have today

- **Both** sets of data have to match in order for providers and payers to agree on the new approach!

Four Things Needed For Win-Win-Win Solutions

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   - Will the savings offset the costs on average?
   - How much variation in costs and savings is likely?
3. **Designing a Payment Model That Supports Change**
   - Flexibility to change the way care is delivered
   - Accountability for costs and quality/outcomes related to care
   - Adequate payment to cover lowest-achievable costs
   - Protection for the provider from insurance risk

Accountable Payment Models Provide Flexibility + Accountability

BUILDING BLOCKS	HOW IT WORKS
Bundled Payment	Single payment to 2+ providers who are now paid separately (e.g., hospital+physician)
Warrantied Payment	Higher payment for quality care, no extra payment for correcting preventable errors and complications
Condition-Based Payment	Payment based on the patient's condition, rather than on the procedure used

Accountable Payment Models Allow Win-Win-Win Approaches

BUILDING BLOCKS	HOW IT WORKS	HOW PHYSICIANS AND HOSPITALS CAN BENEFIT	HOW PAYERS CAN BENEFIT
Bundled Payment	Single payment to 2+ providers who are now paid separately (e.g., hospital+physician)	Higher payment for physicians if they reduce costs paid by hospitals	Physician and hospital offer a lower total price to Medicare or health plan than today
Warrantied Payment	Higher payment for quality care, no extra payment for correcting preventable errors and complications	Higher payment for physicians and hospitals with low rates of infections and complications	Medicare or health plan no longer pays more for high rates of infections or complications
Condition-Based Payment	Payment based on the patient's condition, rather than on the procedure used	No loss of payment for physicians and hospitals using fewer tests and procedures	Medicare or health plan no longer pays more for unnecessary procedures

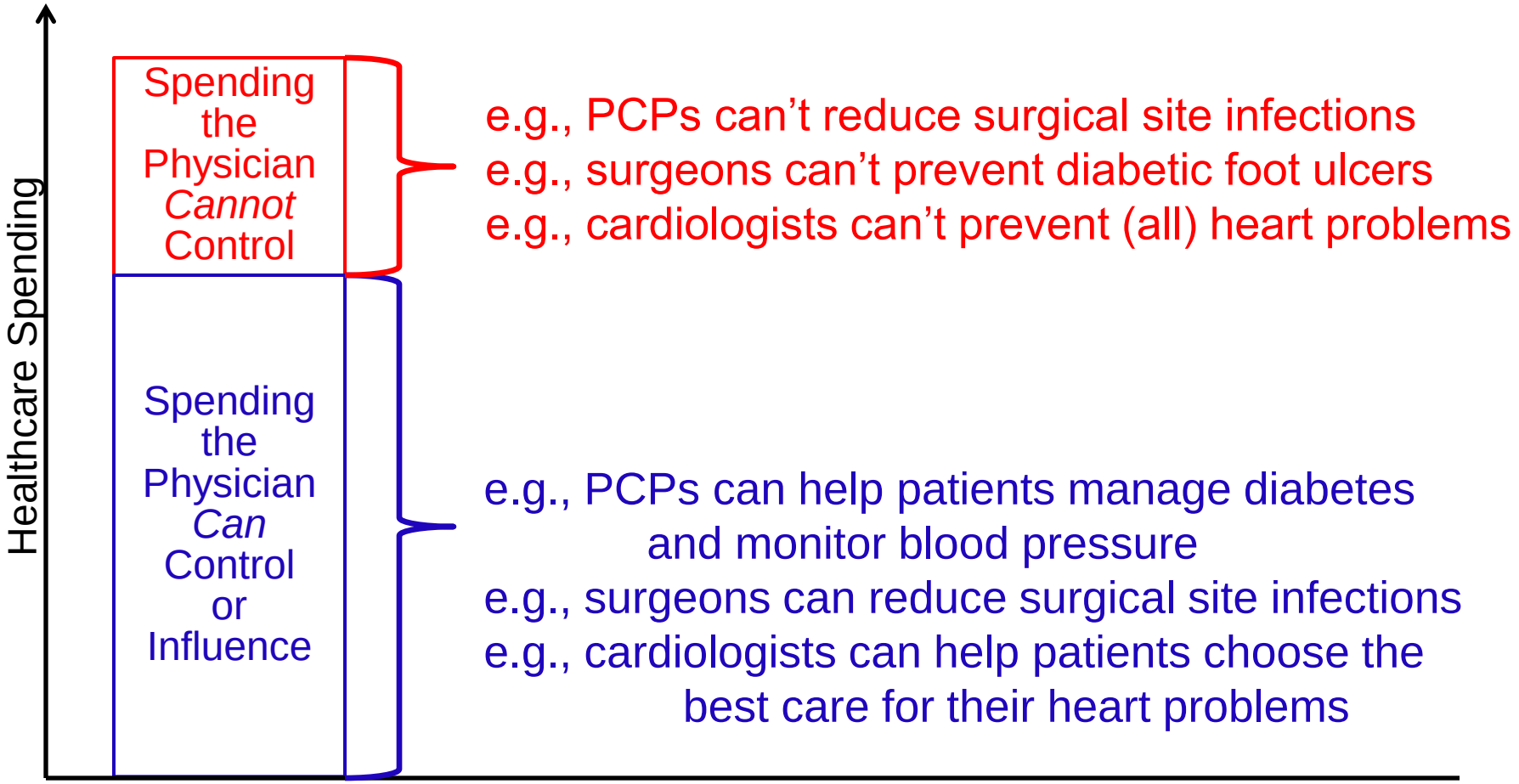
Opportunities and Solutions Vary By Specialty

	Opportunities to Improve Care and Reduce Cost	Barriers in Current Payment System	Solutions via Accountable Payment Models
Cardiology	• Use less invasive and expensive procedures when appropriate	• Payment is based on which procedure is used, not the outcome for the patient	• Condition-based payment covering CABG, PCI, or medication management
Orthopedic Surgery	• Reduce infections and complications • Use less expensive post-acute care following surgery	• No flexibility to increase inpatient services to reduce complications & post-acute care	• Episode payment for hospital and post-acute care costs with warranty
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
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

Examples from Other Specialties

	Opportunities to Improve Care and Reduce Cost	Barriers in Current Payment System	Solutions via Accountable Payment Models
Neurology	• Avoid unnecessary hospitalizations for epilepsy patients • Reduce strokes and heart attacks after TIA	• No flexibility to spend more on preventive care • No payment to coordinate w/ cardio	• Condition-based payment for epilepsy • Episode or condition-based payment for TIA
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 anti-emetic drug costs	• No flexibility to spend more on preventive care • Payment based on office visits, not outcomes	• Condition-based payment including non-oncolytic Rx and ED/hospital utilization
Radiology	• Reduce use of high-cost imaging • Improve diagnostic speed & accuracy	• Low payment for reading images & penalty for 2x • Inability to change inapprop. orders	• Global payment for imaging costs • Partnership in condition-based payments

Accountability Must Be Focused on What Each Specialty Can Influence



Physicians Need Protections From *Insurance* Risk

- Two Major Types of Risk
  - **Insurance Risk:** Whether patients will have a health condition
    - The payer/purchaser pays for this today, and should continue to do so
  - **Performance Risk:** How much it costs to treat that health condition
    - The payer/purchaser pays for this today, but the provider can control it
- How Do You Separate Insurance & Performance Risk?
  - 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 or situations where costs can't reasonably be controlled by the physician or hospital

Four Things Needed For Win-Win-Win Solutions

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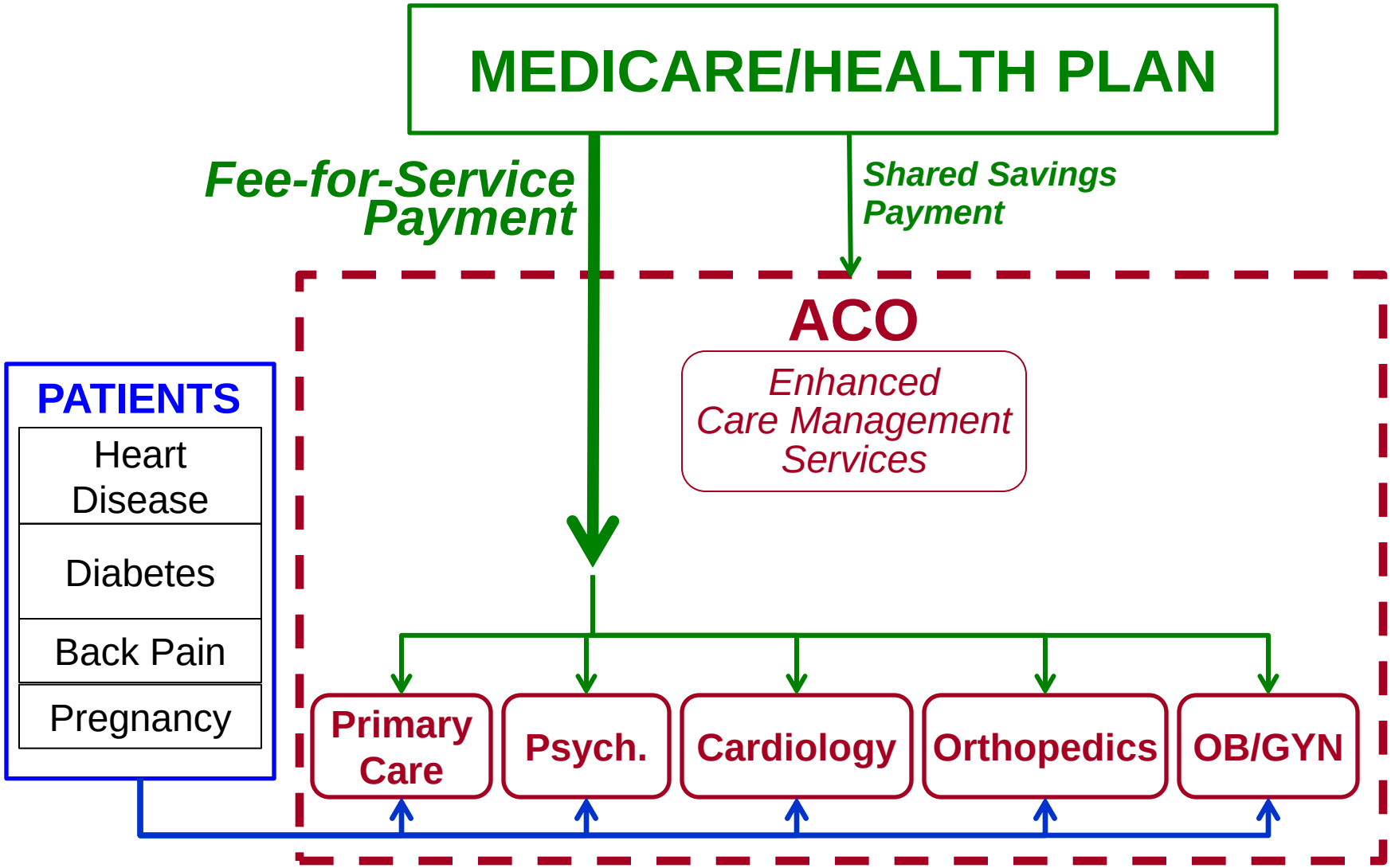
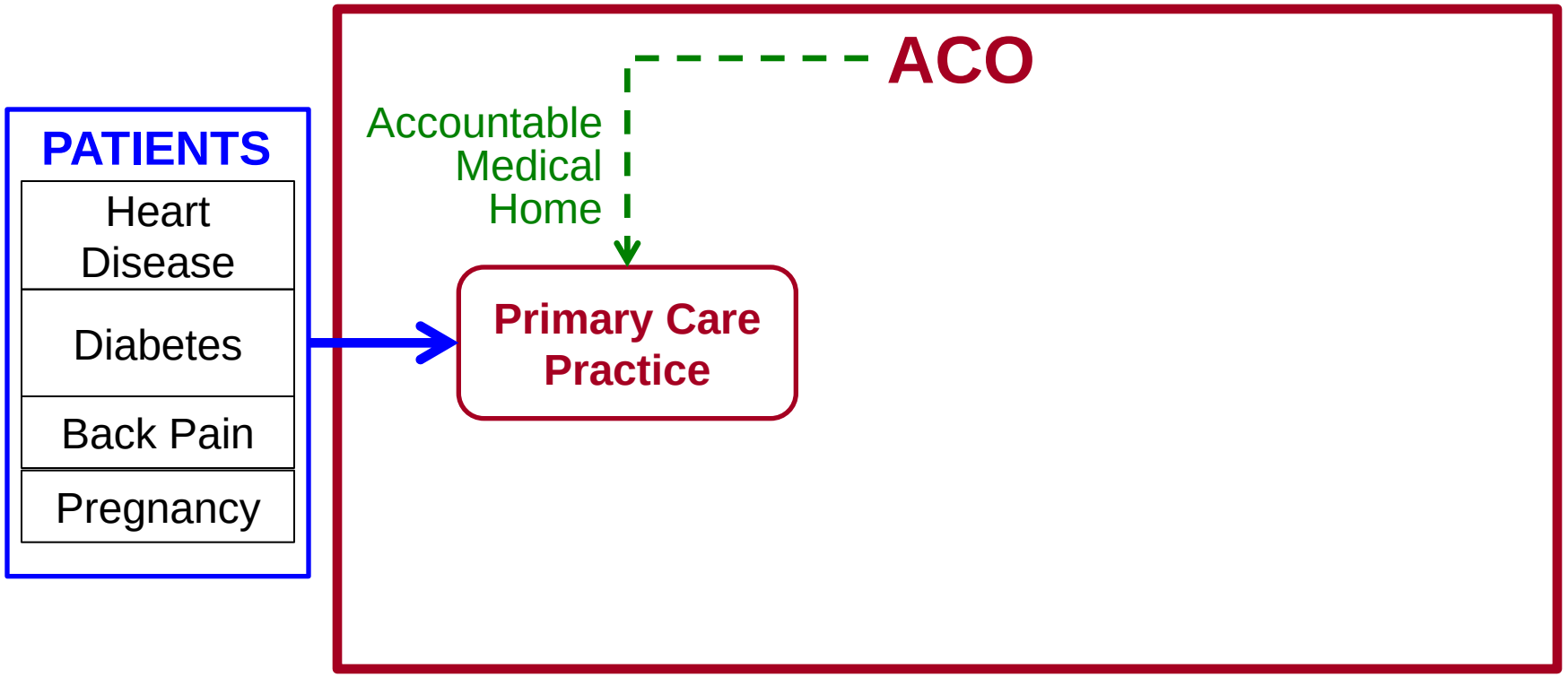
   - Protection for the provider from insurance risk
4. **Compensating Physicians Appropriately**
   - Changing payment to the provider *organization* (physician practice/group/IPA/health system) does not automatically change compensation to *physicians*

How You Do Create a Successful ACO?

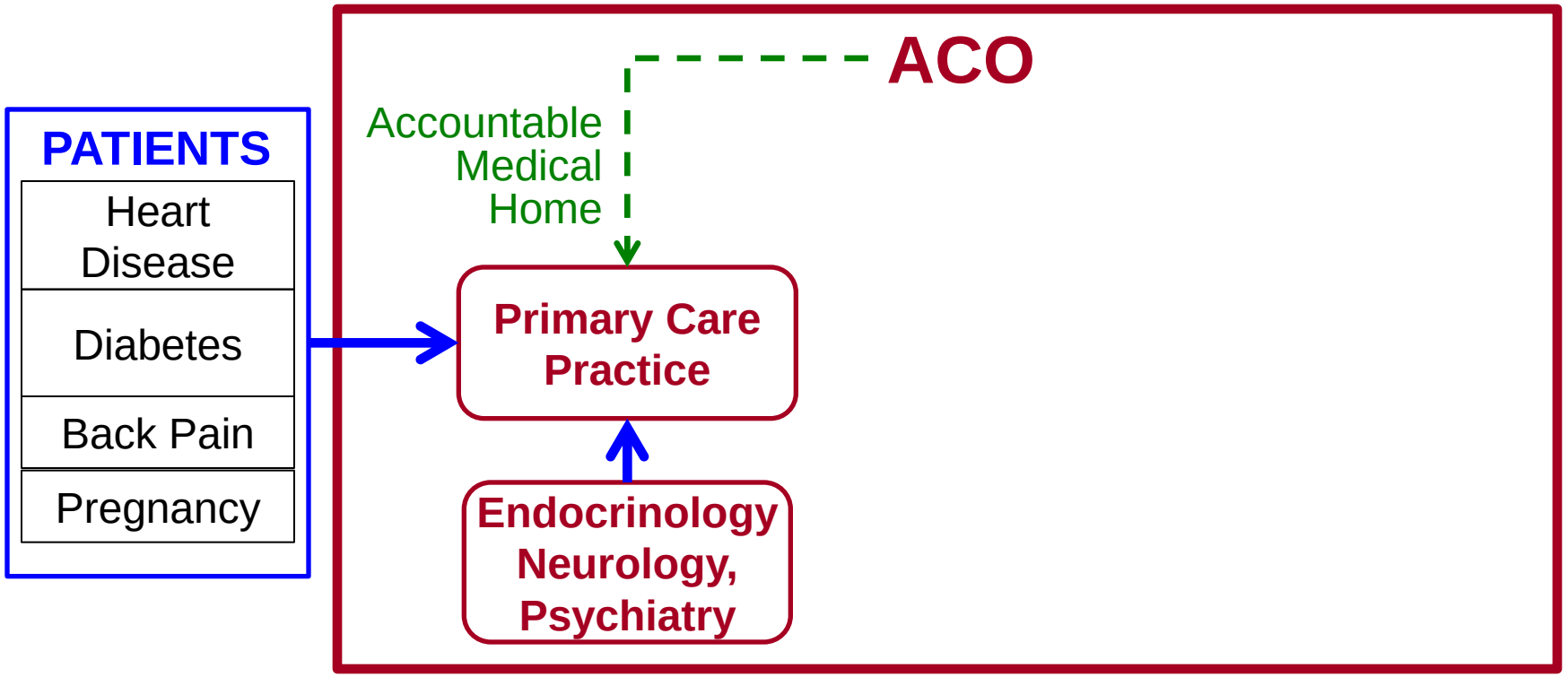
Most ACOs Today Aren't Truly *Reinventing Care*



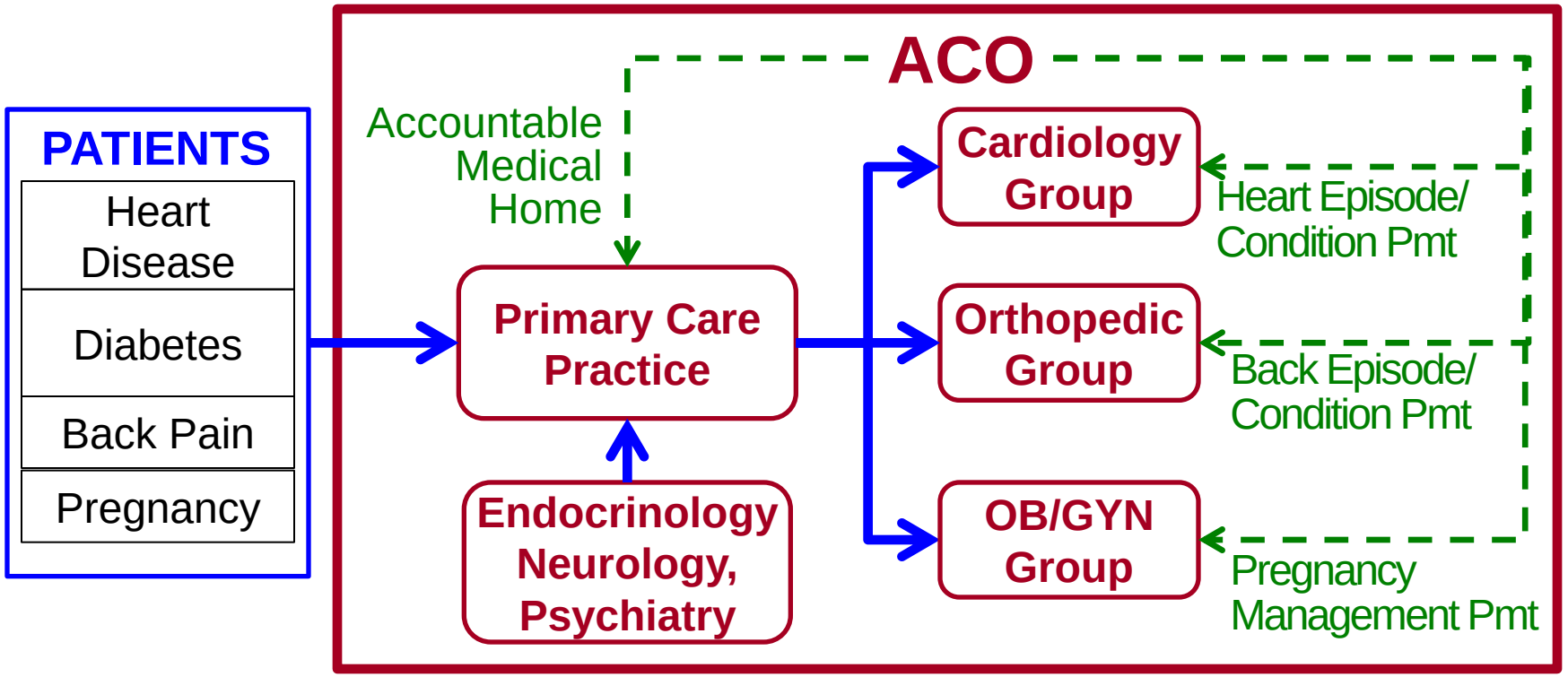
The Right Way: Give Each Patient an Accountable Medical Home…



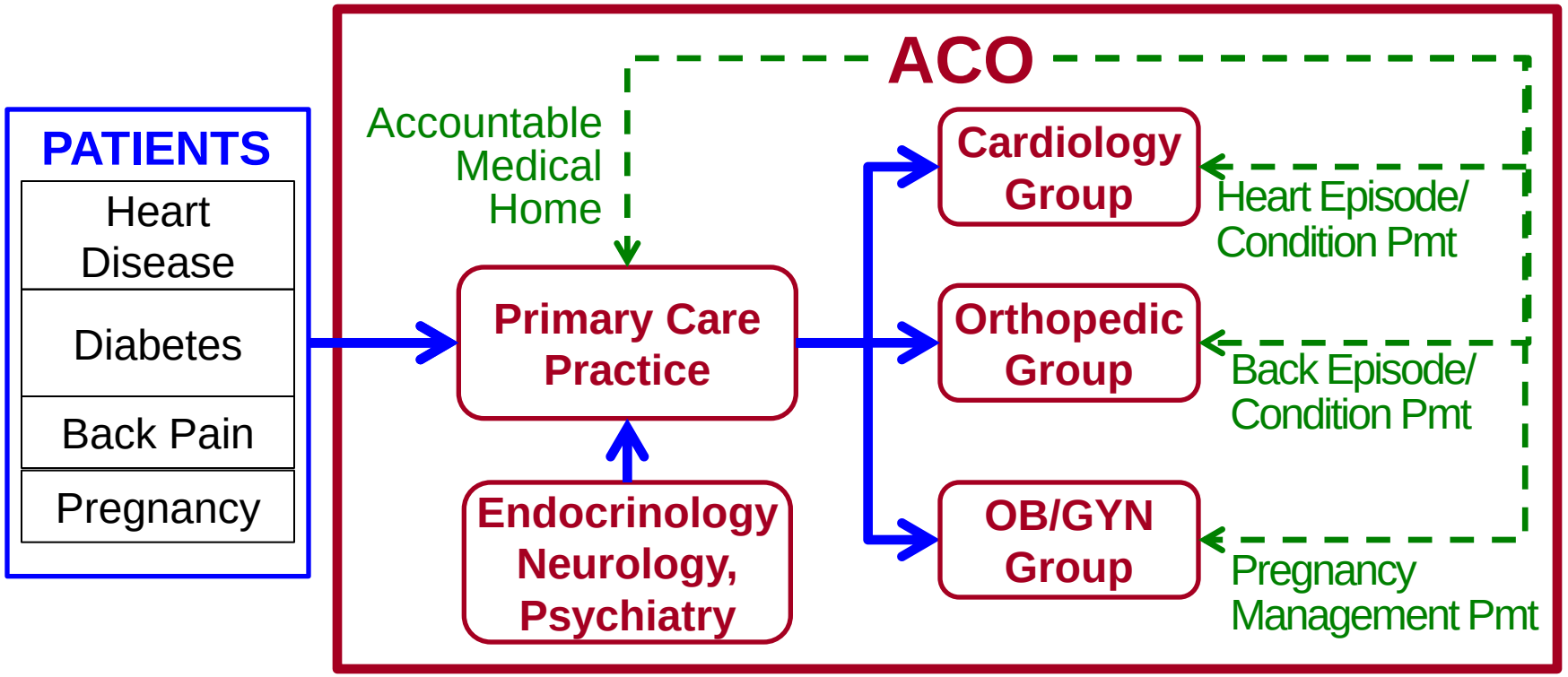
…With a Medical Neighborhood to Consult With on Complex Cases



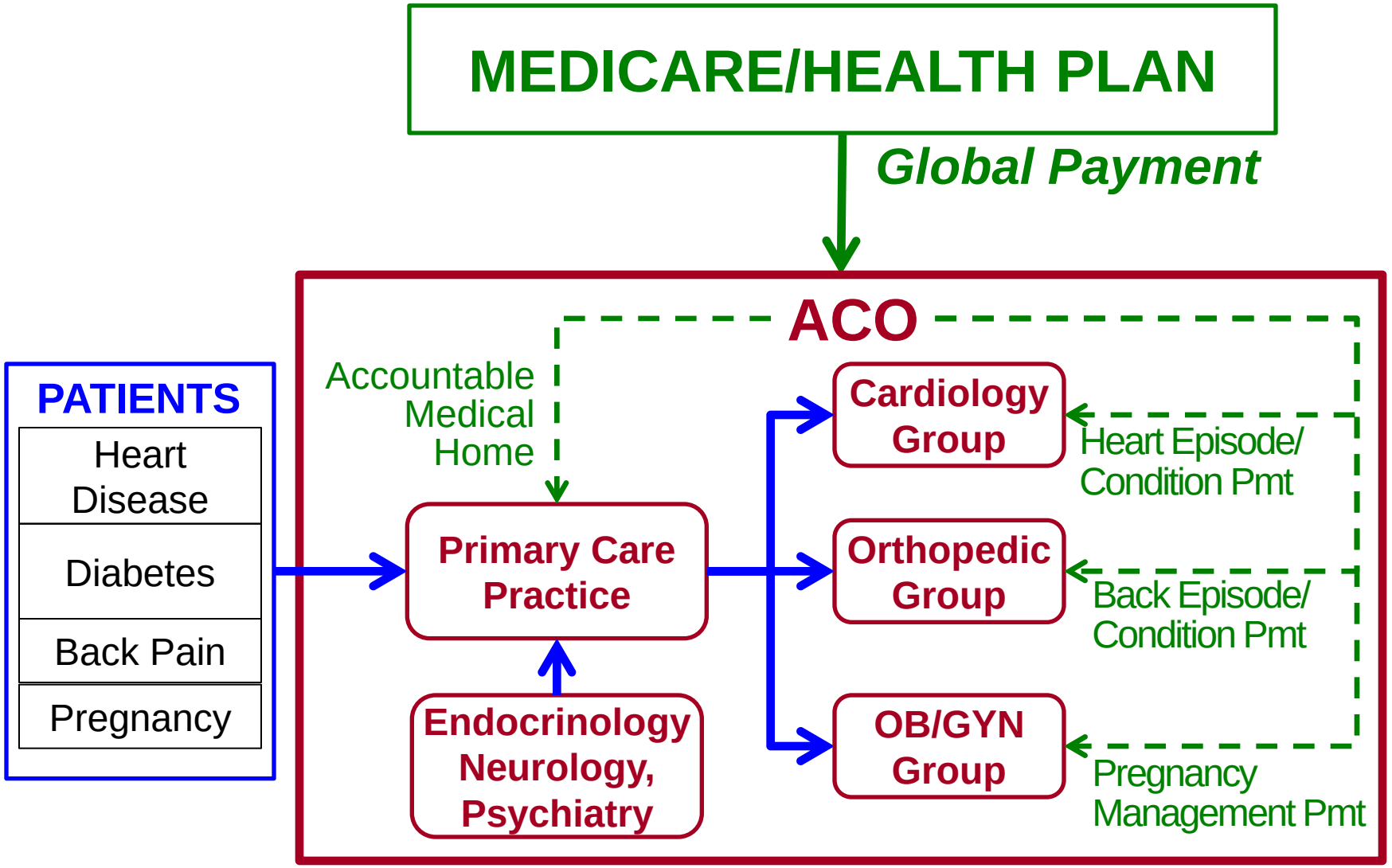
..Ask Specialists to Be Accountable for Conditions They Manage



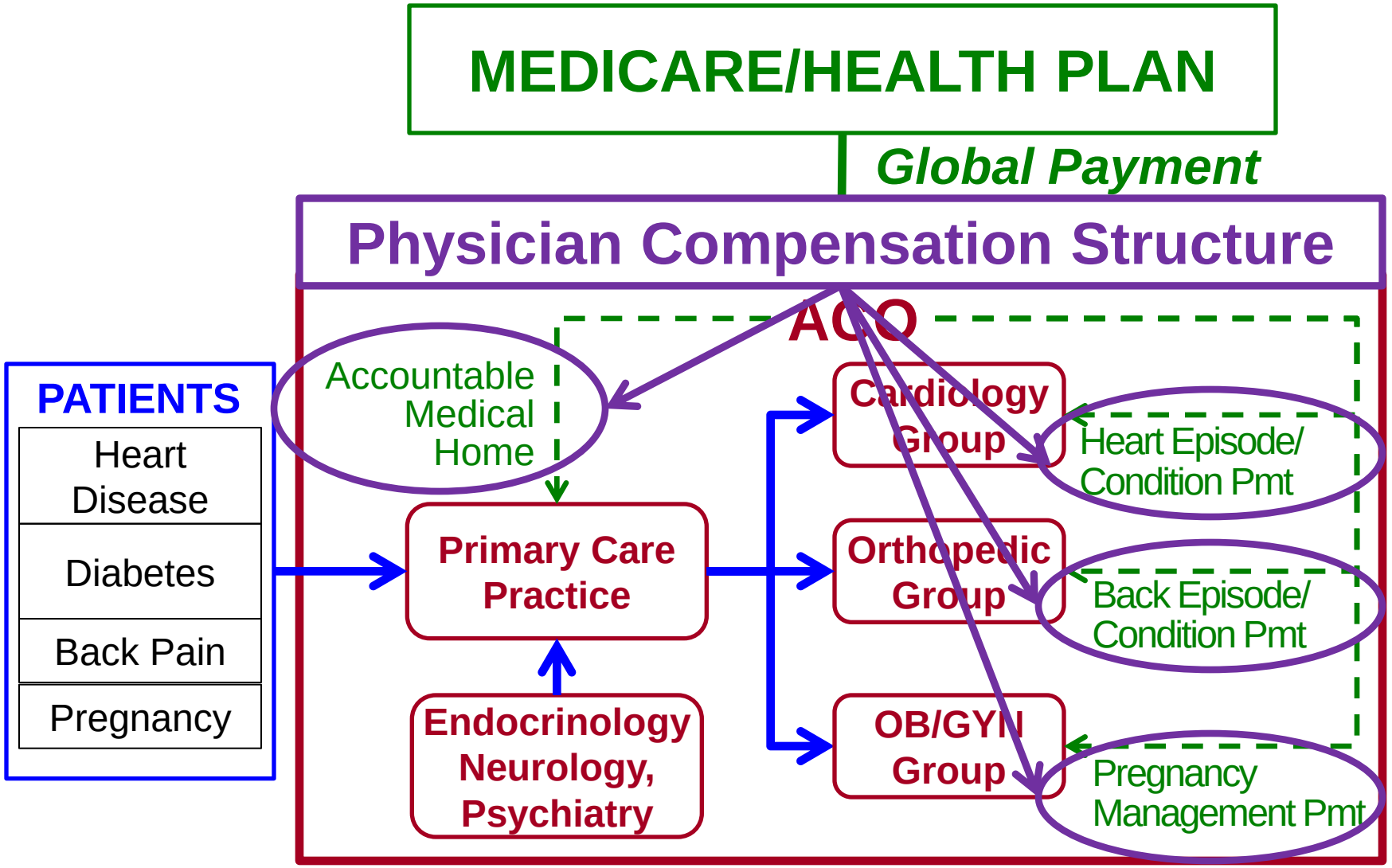
That's Building the ACO From the *Bottom Up*, Not the *Top Down*



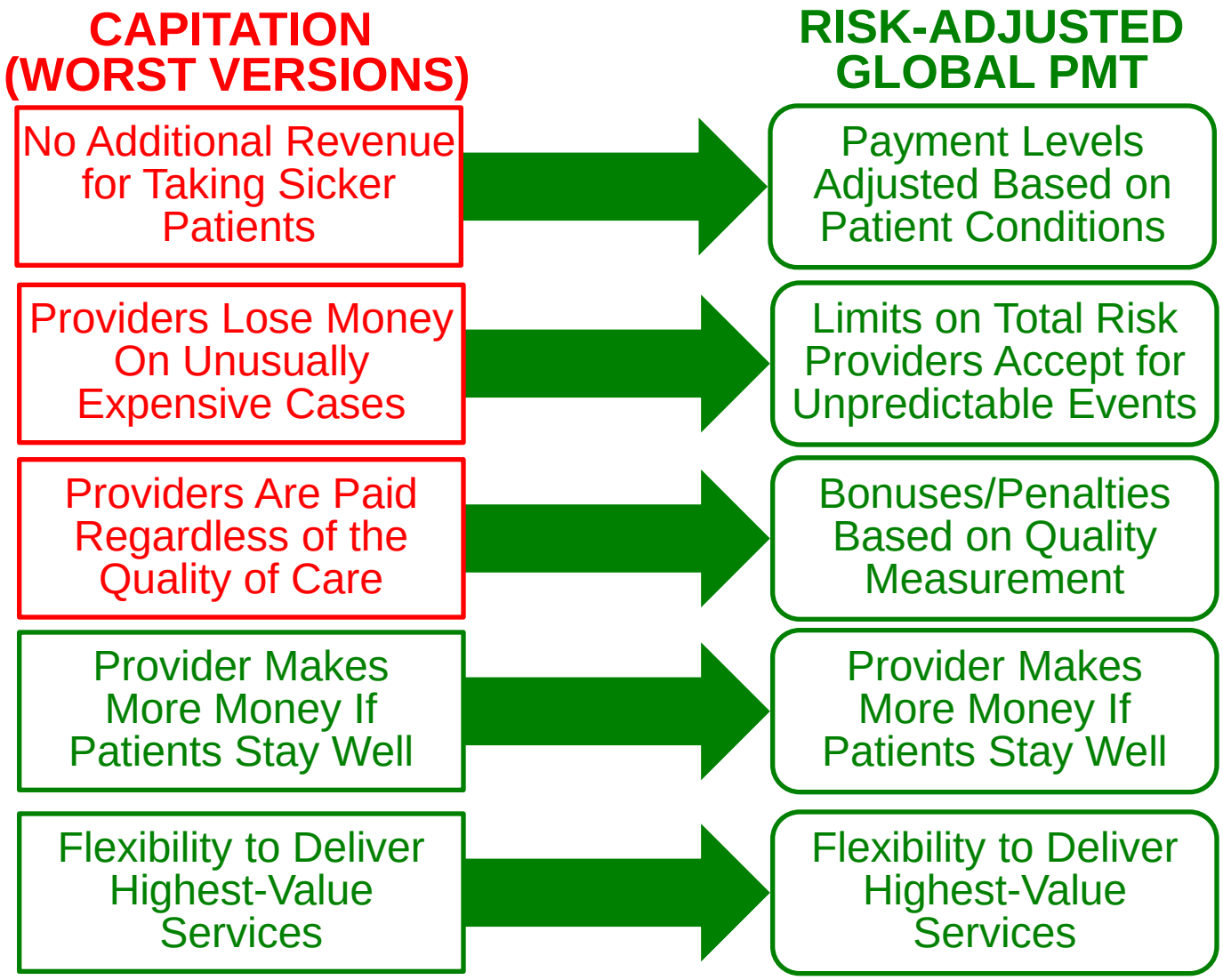
Now the ACO Can Take a Global Payment And Make It Work



And Accountable Pmt Models Can Be the Basis of Compensation



Isn't This Capitation? No – It's Different



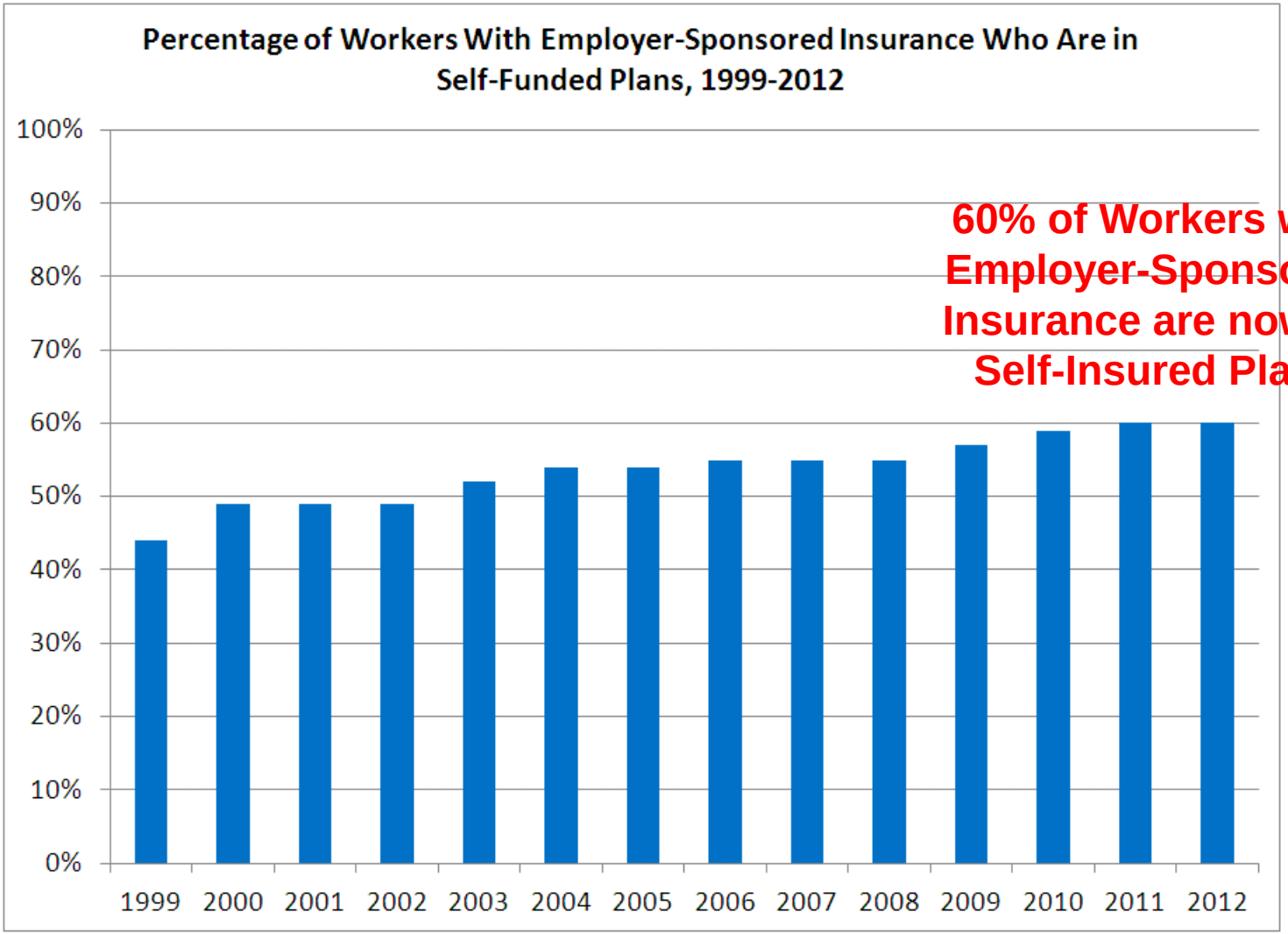
Example: BCBS MA Alternative Quality Contract

- Single payment for all costs of care for a population of patients
  - Adjusted up/down annually based on severity of patient conditions
  - Initial payment set based on past expenditures, not arbitrary estimates
  - Provides flexibility to pay for new/different services
  - Bonus paid for high quality care
- Five-year contract
  - Savings for payer achieved by controlling increases in costs
  - Allows provider to reap returns on investment in preventive care, infrastructure
- Broad participation
  - 14 physician groups/health systems participating with over 400,000 patients, including one primary care IPA with 72 physicians
- Positive two year results
  - Higher ambulatory care quality than non-AQC practices, better patient outcomes, lower readmission rates and ER utilization, lower costs

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

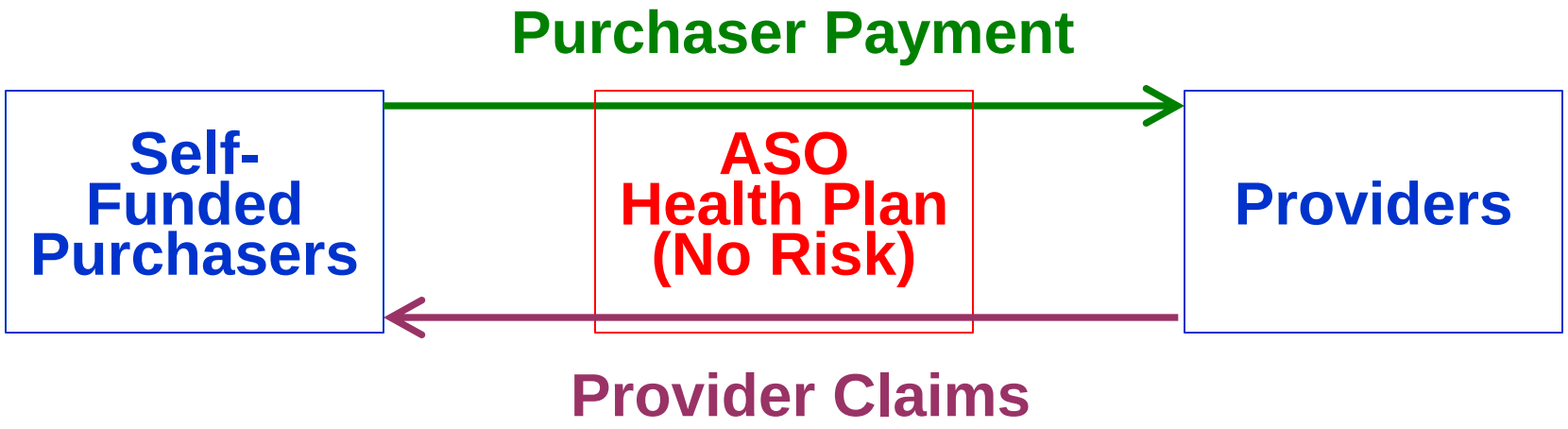
How Many Patients Do You (Really) Need to (Successfully) Manage the Risk of Accountable Payments?

For Most Employees, the Employer is the Insurer, Not a Health Plan

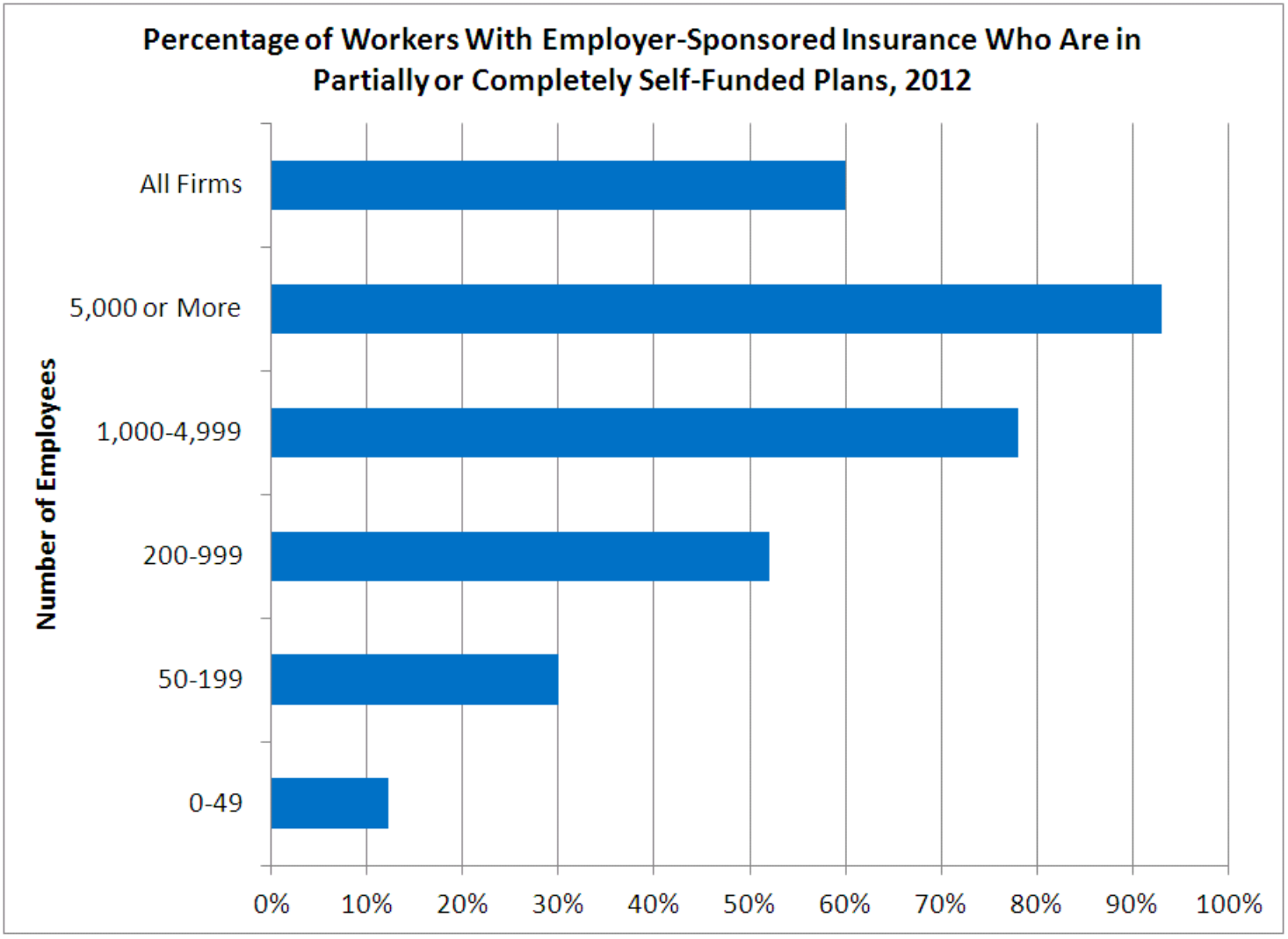


Source: Employer Health Benefits 2012 Annual Survey. The Kaiser Family Foundation and Health Research and Educational Trust

For Self-Funded Employers, The Health Plan is Just a Pass Through

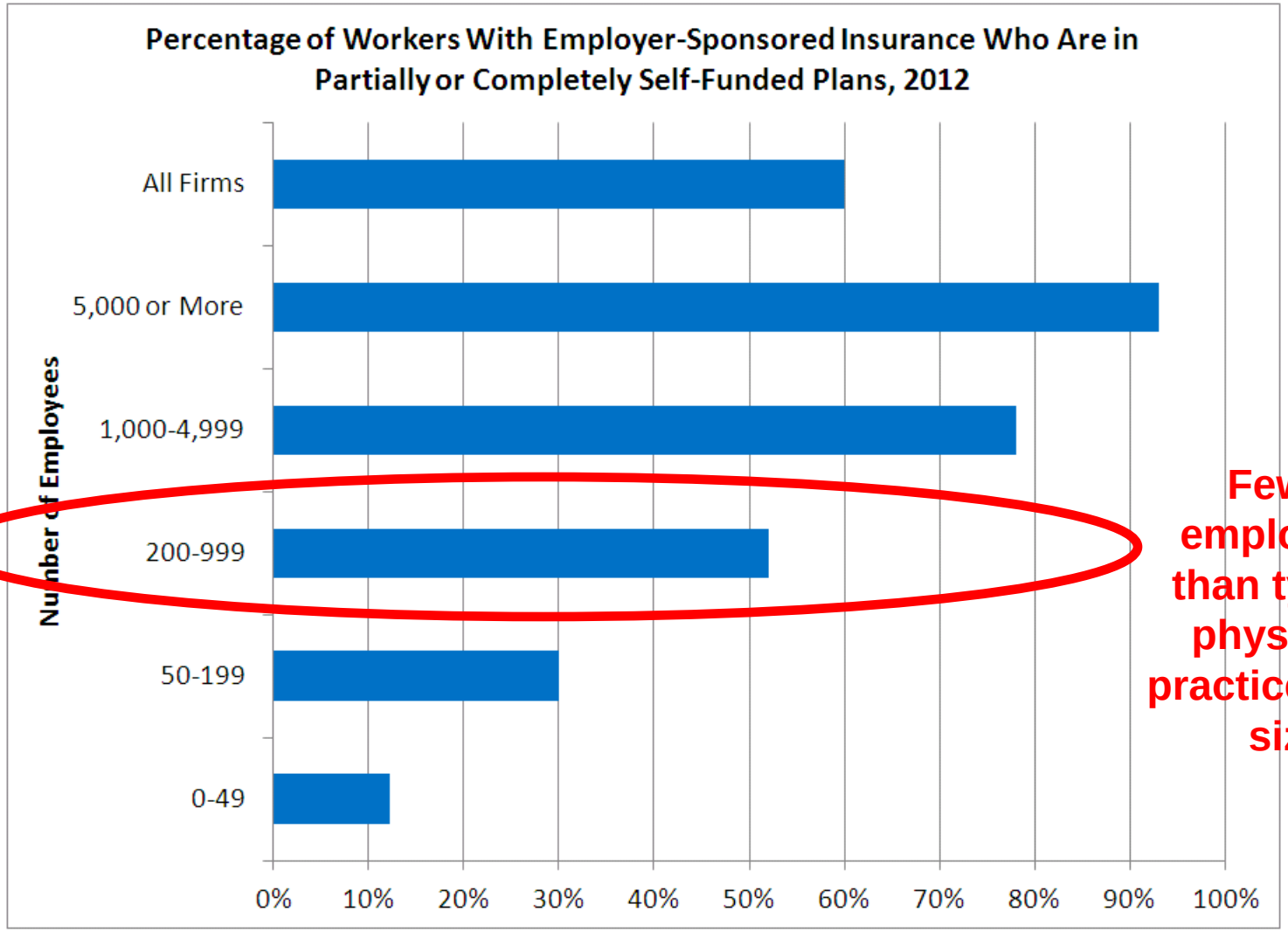


Even Small Employers Are Increasingly Self-Insured



Sources: Employer Health Benefits 2012 Annual Survey. The Kaiser Family Foundation and Health Research and Educational Trust; State-Level Trends in Employer-Sponsored Health Insurance, April 2013. State Health Access Data Assistance Center and Robert Wood Johnson Foundation

Most Businesses With 200-1,000 Employees Take Total Cost Risk



Sources: Employer Health Benefits 2012 Annual Survey. The Kaiser Family Foundation and Health Research and Educational Trust; State-Level Trends in Employer-Sponsored Health Insurance, April 2013. State Health Access Data Assistance Center and Robert Wood Johnson Foundation

Fewer employees than typical physician practice panel size

The Keys to Managing Risk

- **How Do Small Employers Manage Self-Insurance Risk?**
  - They know who their employees are and can estimate spending
  - They start with what they spent last year and try to control growth
  - They have reserves to cover year-to-year variation
  - They purchase stop-loss insurance to cover unusually expensive cases

The Keys to Managing Risk

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  - They start with what they spent last year and try to control growth
  - They have reserves to cover year-to-year variation
  - They purchase stop-loss insurance to cover unusually expensive cases
- **How Would Small Physician Practices/IPAs Manage Risk?**
  - They need to know who their patients are in order to project spending
  - They need to start with last year's payment s and control growth
  - They need some reserves to cover year-to-year variation
  - They need to purchase stop-loss insurance to cover unusually expensive cases

Building the Capabilities to Manage Accountable Payment Models

CAPABILITY	BARRIER	SOLUTIONS
1. Know who your patients are		
2. Start with last year's spending and control growth		
3. Have reserves to cover year-to-year variation		
4. Purchase stop-loss insurance to cover unusually expensive cases		

Building the Capabilities to Manage Accountable Payment Models

CAPABILITY	BARRIER	SOLUTIONS
1. Know who your patients are	PPO health plans don't require patients to designate PCPs or use a consistent set of physicians for care	
2. Start with last year's spending and control growth		
3. Have reserves to cover year-to-year variation		
4. Purchase stop-loss insurance to cover unusually expensive cases		

The Limited Choices We Give Consumers/Patients Today

ROCK

CONSUMERS/ PATIENTS CAN CHANGE OR USE MULTIPLE PROVIDERS AT WILL

HARD PLACE

CONSUMERS/ PATIENTS ARE "LOCKED IN" TO A SINGLE GATEKEEPER PROVIDER

Creating a Middle Ground to Support the Medical Home/ACO

ROCK	MIDDLE GROUND	HARD PLACE
CONSUMERS/ PATIENTS CAN CHANGE OR USE MULTIPLE PROVIDERS AT WILL	**CONSUMERS/ PATIENTS ARE ENCOURAGED TO CHOOSE & USE AN ACO OR MEDICAL HOME**	CONSUMERS/ PATIENTS ARE "LOCKED IN" TO A SINGLE GATEKEEPER PROVIDER

Do Patients Need $ Incentives Or Better Care to Use an ACO/PCMH?

ROCK	MIDDLE GROUND	HARD PLACE
CONSUMERS/ PATIENTS CAN CHANGE OR USE MULTIPLE PROVIDERS AT WILL	**CONSUMERS/ PATIENTS ARE ENCOURAGED TO CHOOSE & USE AN ACO OR MEDICAL HOME**	CONSUMERS/ PATIENTS ARE "LOCKED IN" TO A SINGLE GATEKEEPER PROVIDER

OPTION 1: Charge patients more for using providers outside the ACO or medical home

OPTION 2: Give patients high quality, coordinated care so they will voluntarily choose to designate a medical home and use the ACO physicians

Will Patients Voluntarily Limit Their Choices?

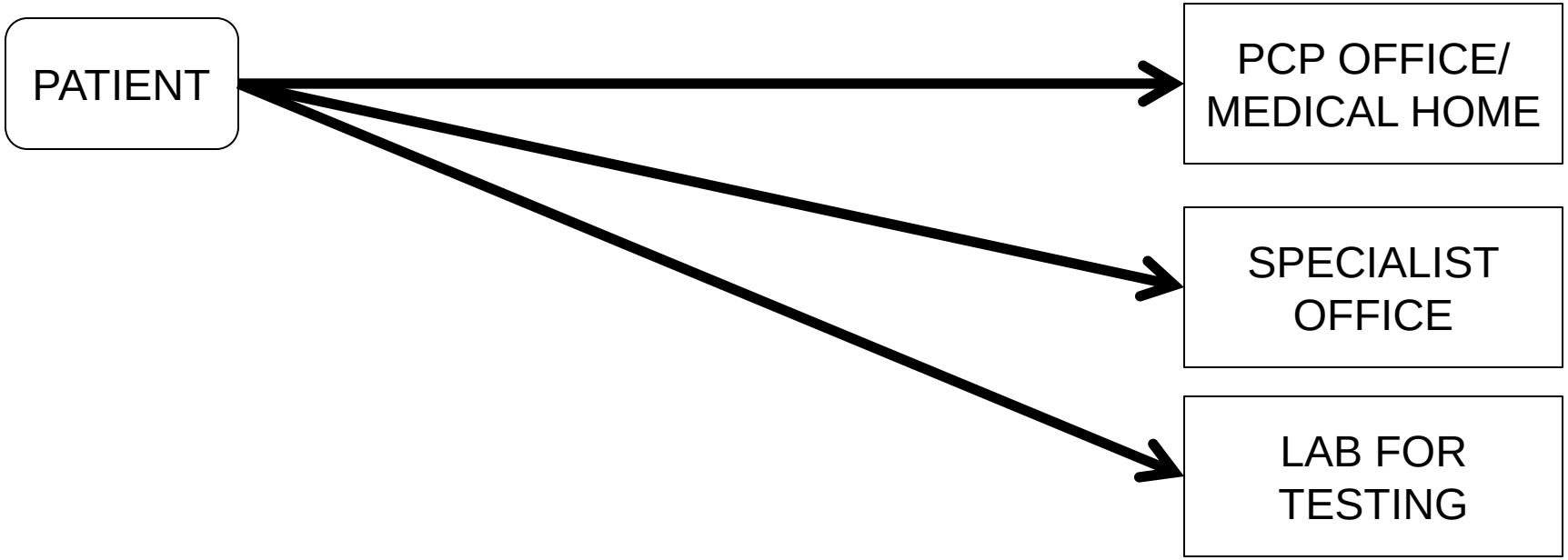
Do You Have One of These?

Apps Can Only Be Purchased Through the Apple Store

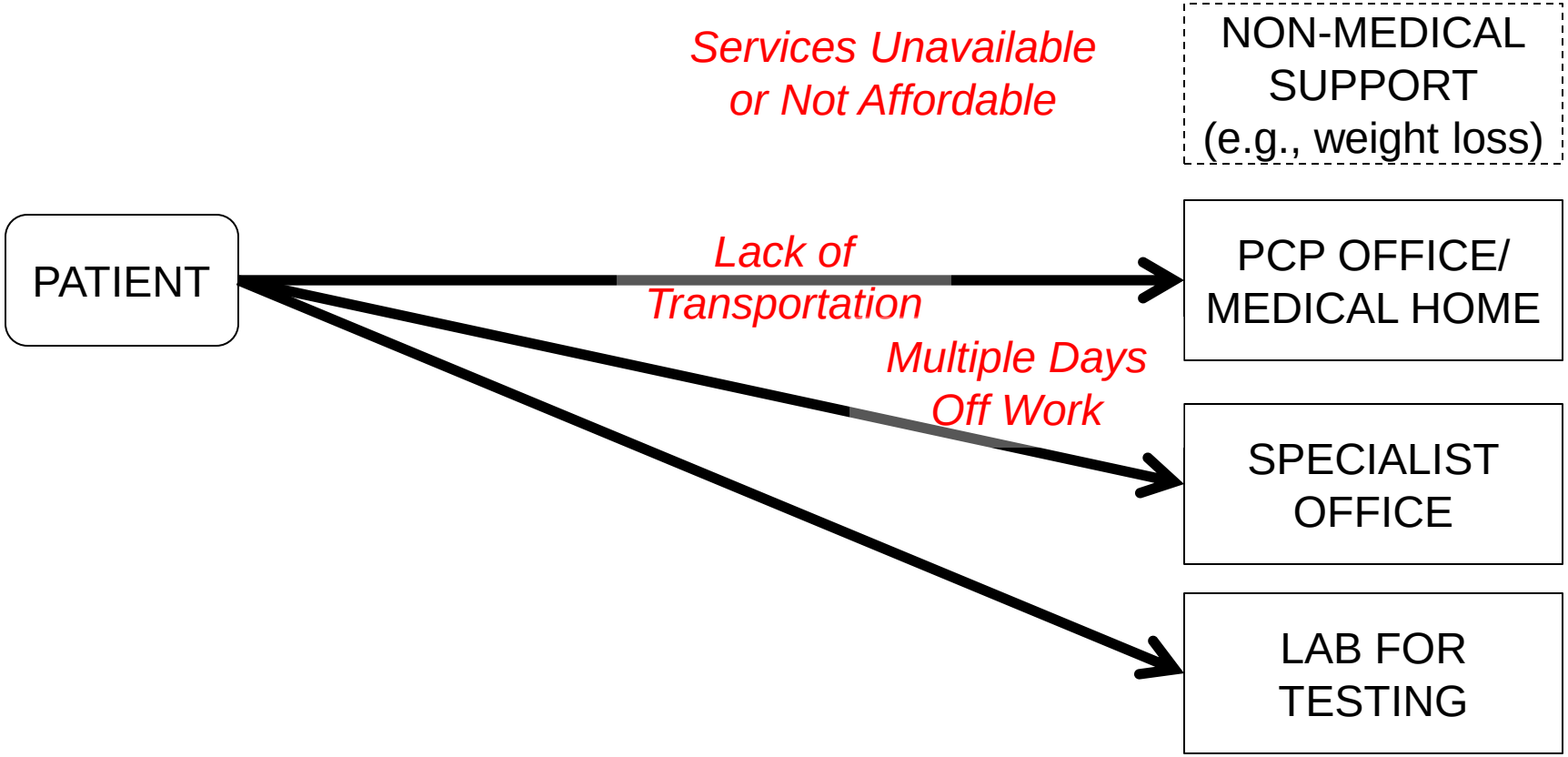
Owners Will Live With a Battery They Can't Replace

Patients Will Limit Choices if They Get Truly Well-Designed Service

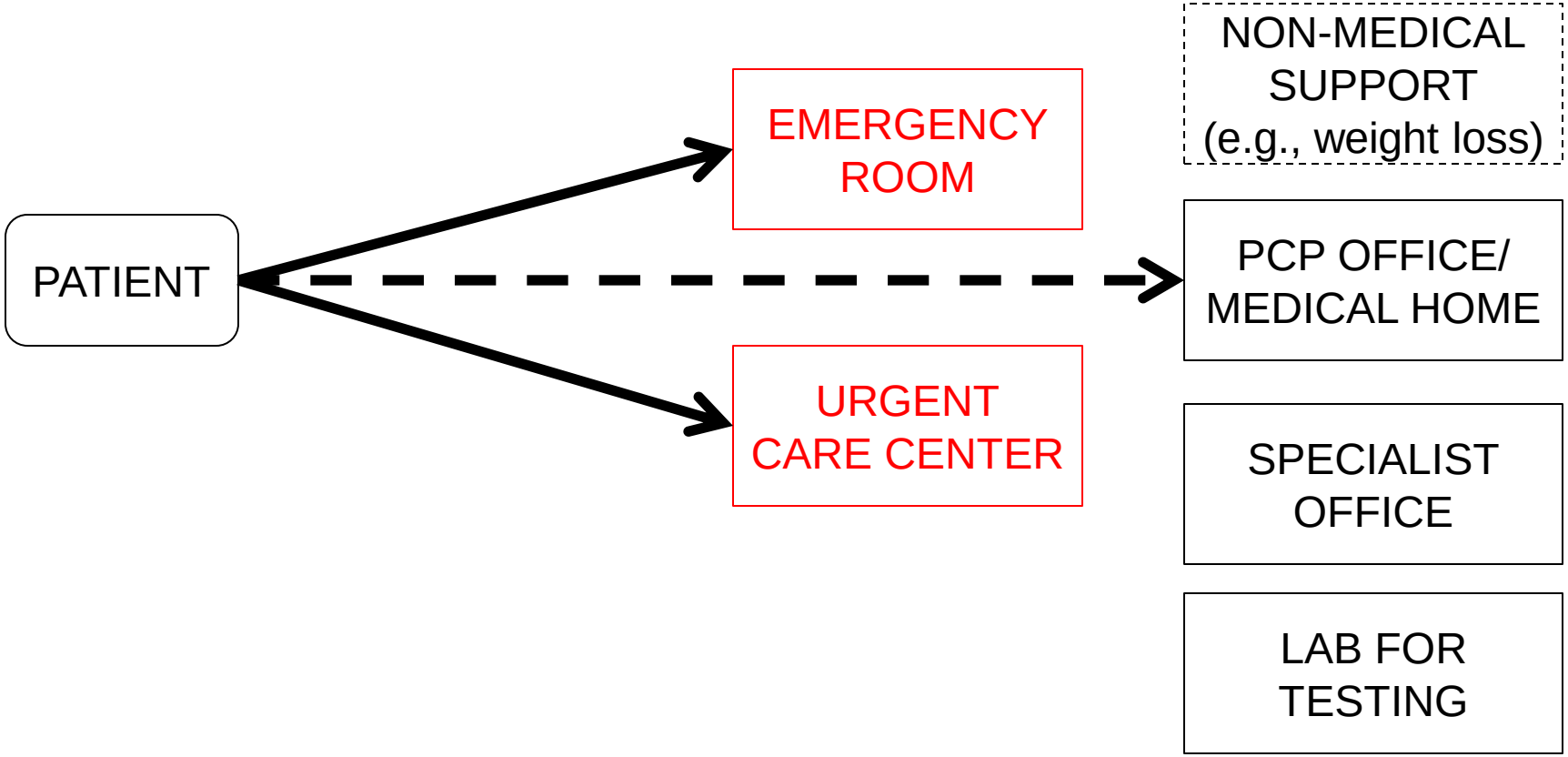
Today: Care is Designed Around the Provider, Not the Patient



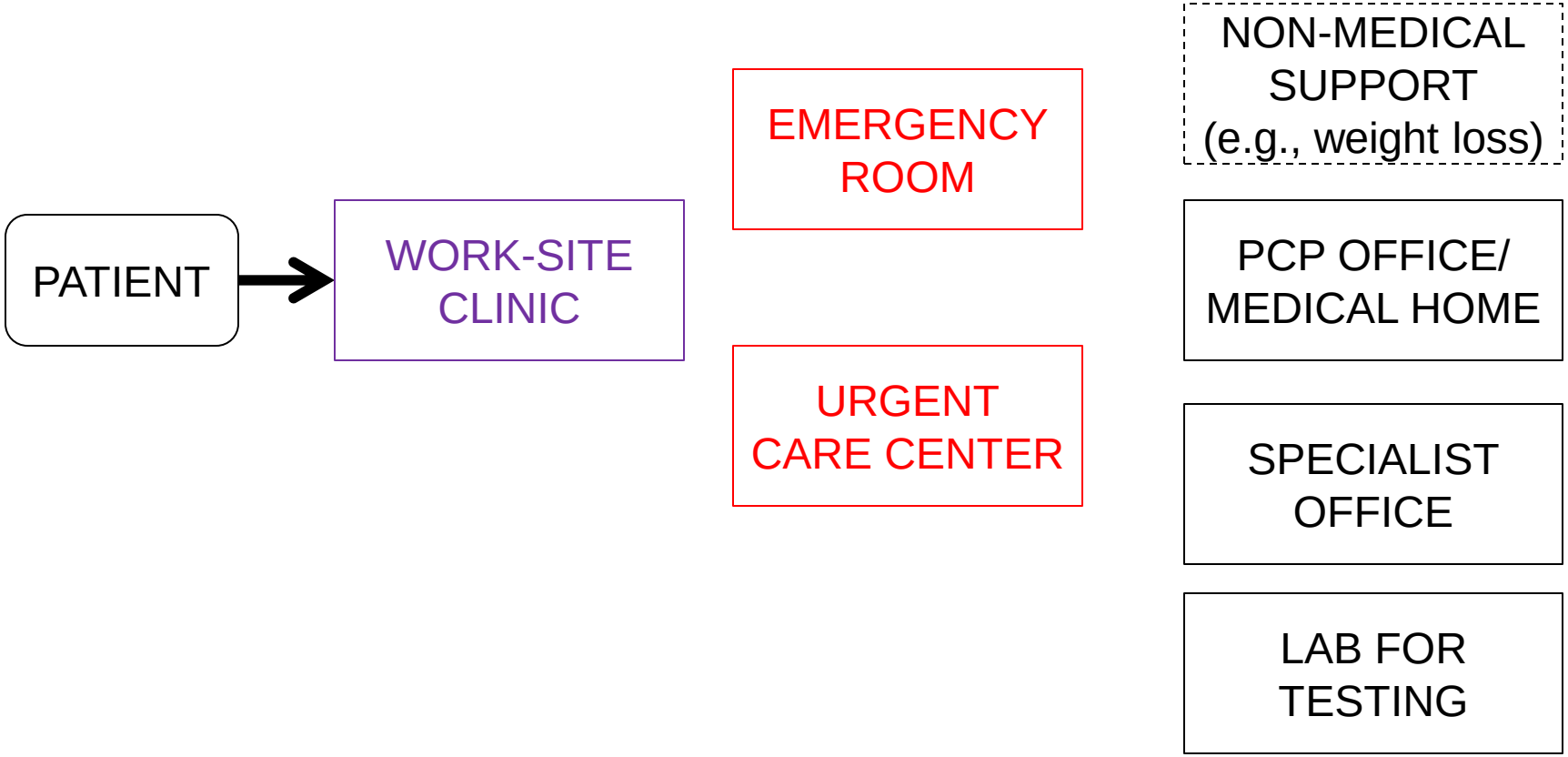
Today: Many Barriers to Patient Adherence & Care Coordination



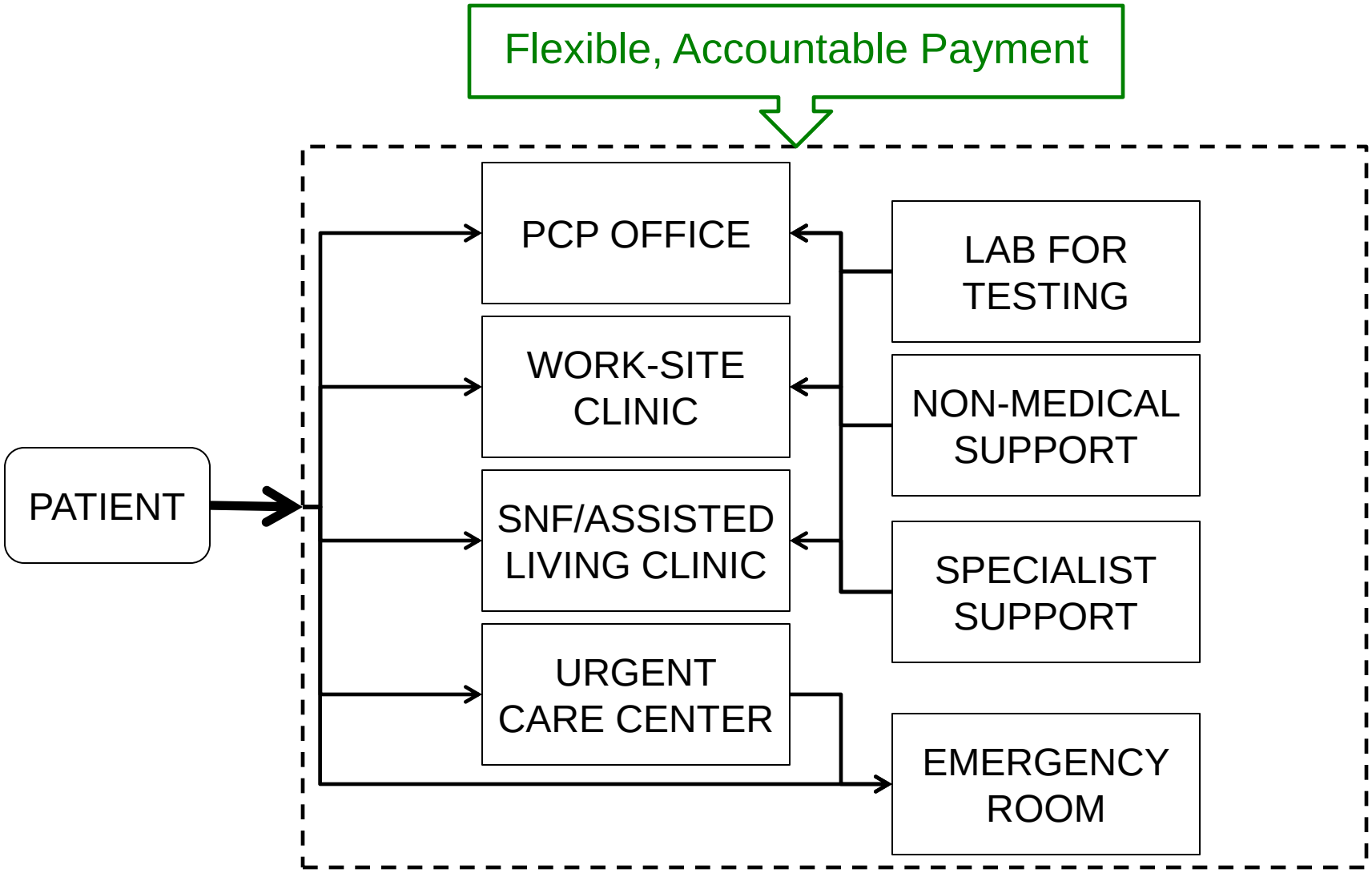
Is It Any Wonder The Patients Gravitate to More Convenience?



Or That Employers Are Trying to Create Their Own Systems?



Flexible Payment Allows More Radical Redesign of Care Delivery



Building the Capabilities to Manage Accountable Payment Models

CAPABILITY	BARRIER	SOLUTIONS
1. Know who your patients are	PPO health plans don't require patients to designate PCPs or use a consistent set of physicians for care	Redesign care to be sufficiently patient-friendly that patients will be willing to have physicians coordinate their care
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3. Have reserves to cover year-to-year variation	Physician practices don't have retained earnings	Begin setting aside revenues to build reserves Transition to higher levels of risk over time
4. Purchase stop-loss insurance to cover unusually expensive cases		

Building the Capabilities to Manage Accountable Payment Models

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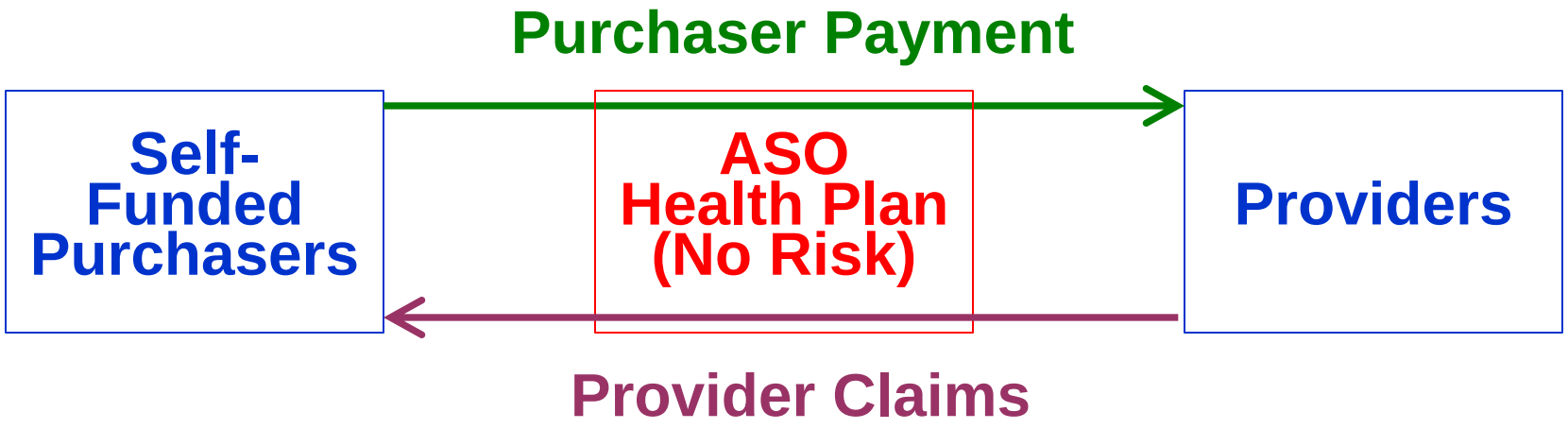
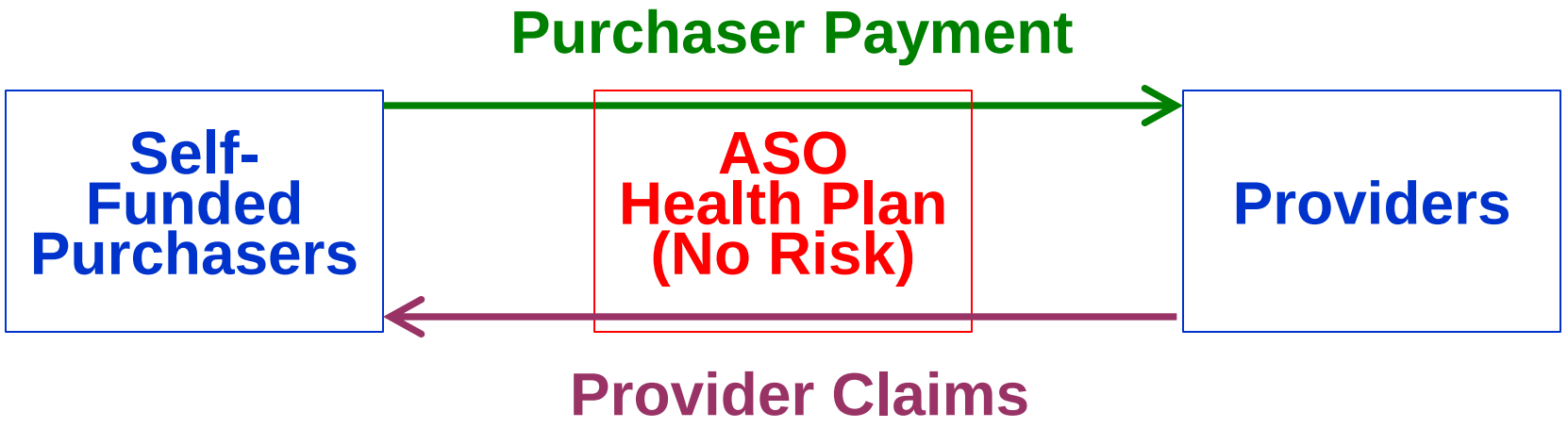
3. Have reserves to cover year-to-year variation	Physician practices don't have retained earnings	Begin setting aside revenues to build reserves Transition to higher levels of risk over time
4. Purchase stop-loss insurance to cover unusually expensive cases	None – insurance companies offer this and many capitated IPAs and groups buy it	Factor the cost of stop-loss insurance into costs of managing care for patients

Since Most Health Plan Business Is Just a Pass-Through…



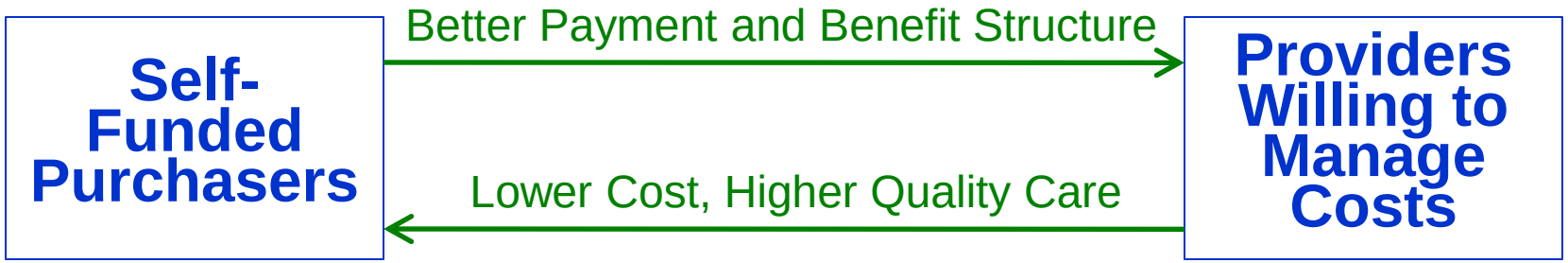
…Little Incentive for Health Plans to Support Payment Reforms



True Payment Reform Means:

- Health plan incurs the costs of implementing new payment models
- Purchaser gains all the savings from reduced utilization and spending (because all claims are passed through)

The Purchaser and Suppliers (Providers) Need to Talk



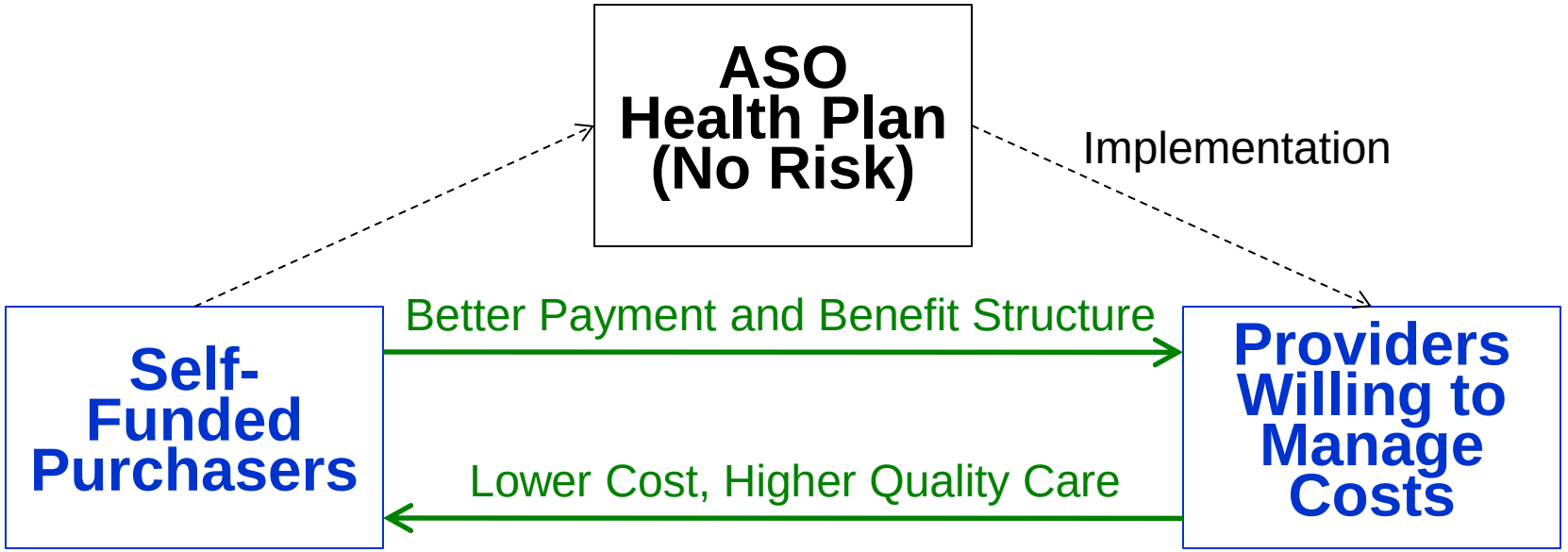
Purchasers and Patients "win" if:

- Providers reduce purchasers' costs
- Patients stay healthy and have lower cost-sharing

Provider "wins" if:

- Patients stay healthy and need less care
- Purchaser pays provider adequately to manage care efficiently

Health Plan Implements Changes Purchasers/Providers Agree On



This All Sounds Really Hard

This All Sounds Really Hard

Can’t We Just Keep Doing What We’re Doing Today Until We Retire?

The Opportunities to Reduce Costs Without Rationing Are Widely Known

- Reducing Hospital Readmissions
- Helping Patients with Chronic Disease Stay Out of Hospital
- Reducing Overutilization of Outpatient Services
- Shifting Preference-Sensitive Care to Lower-Cost Options
- Reducing the Cost of Expensive Inpatient Care

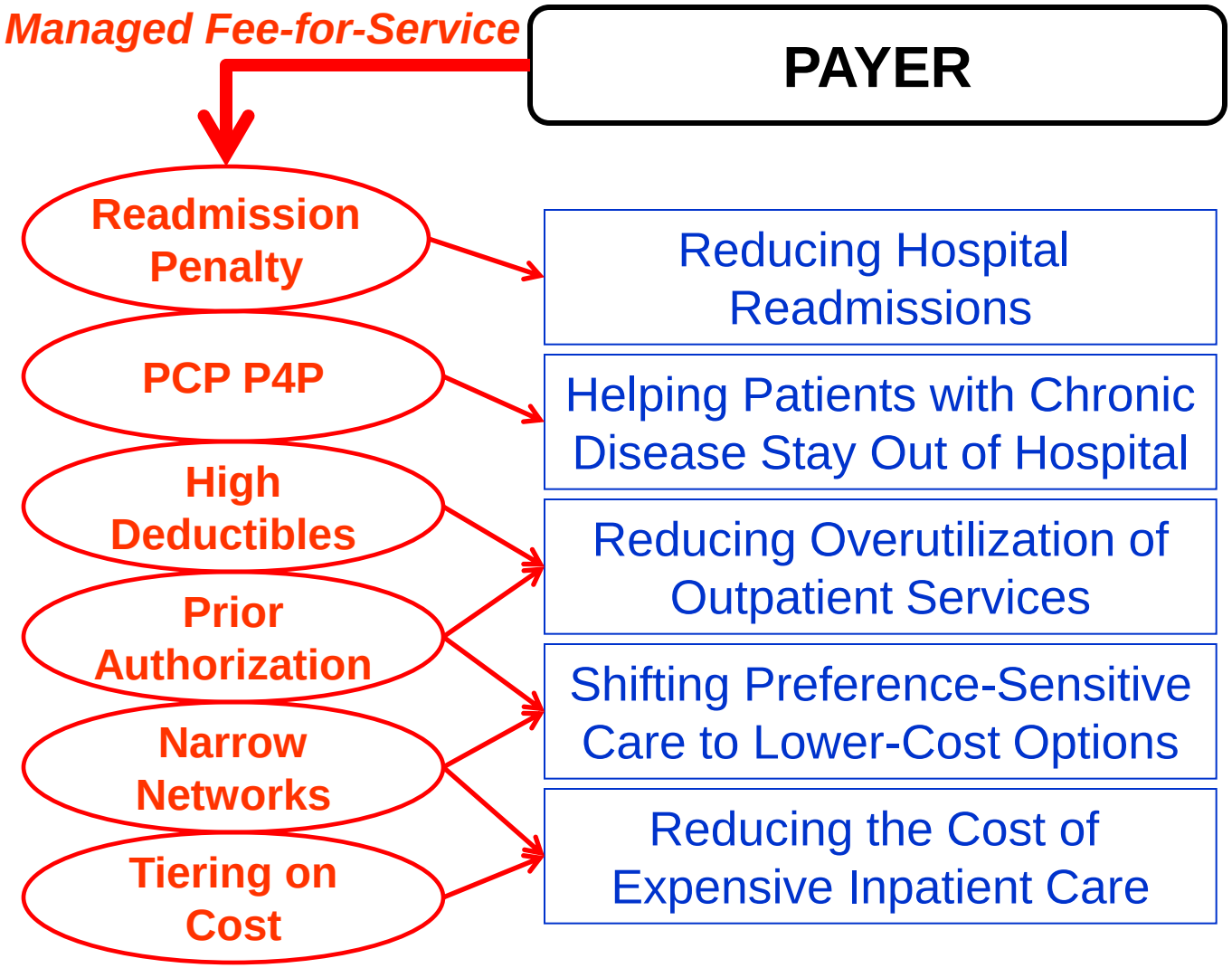
The Question is: *How* Will Payers Get The Savings?

PAYER

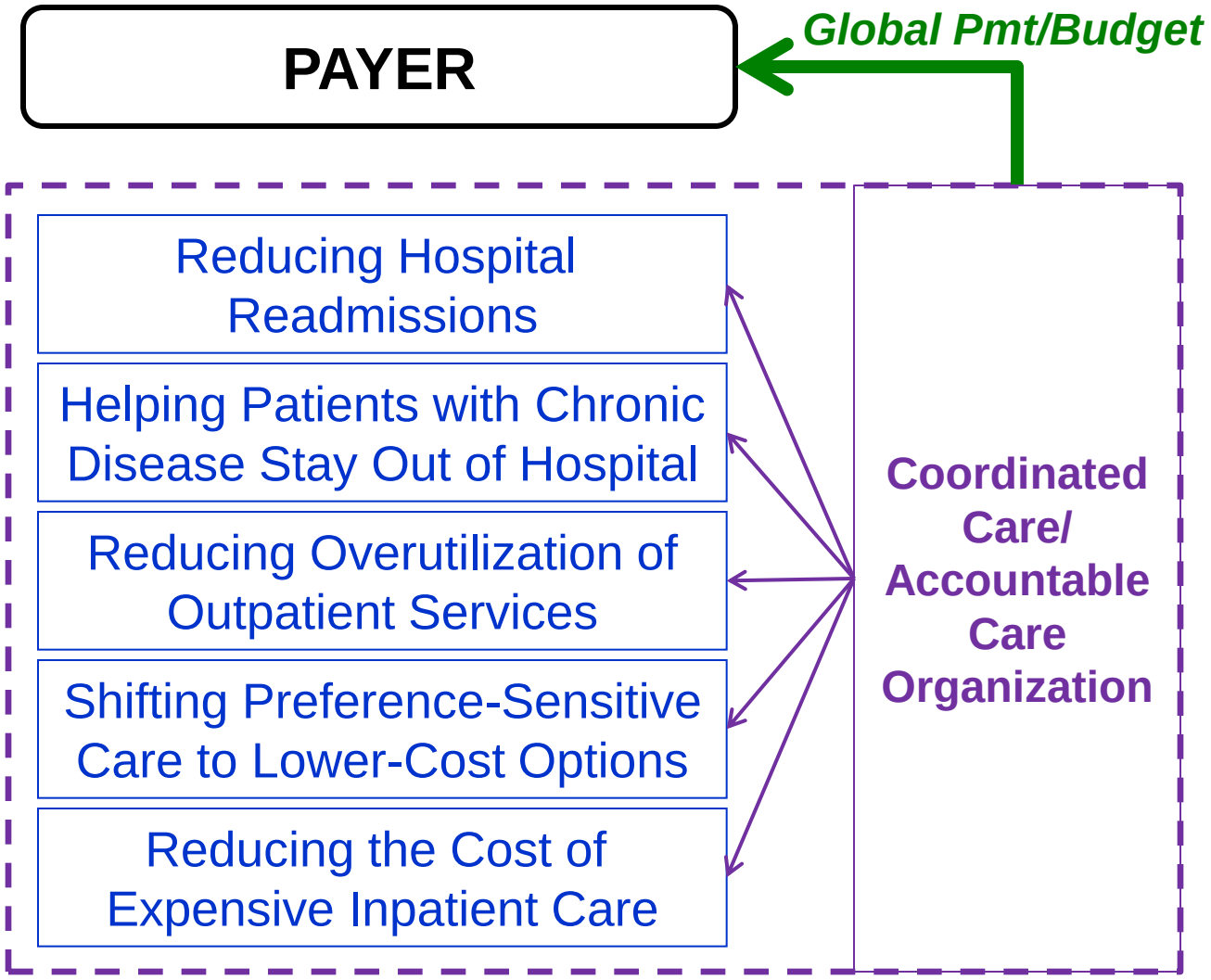
?

- Reducing Hospital Readmissions
- Helping Patients with Chronic Disease Stay Out of Hospital
- Reducing Overutilization of Outpatient Services
- Shifting Preference-Sensitive Care to Lower-Cost Options
- Reducing the Cost of Expensive Inpatient Care

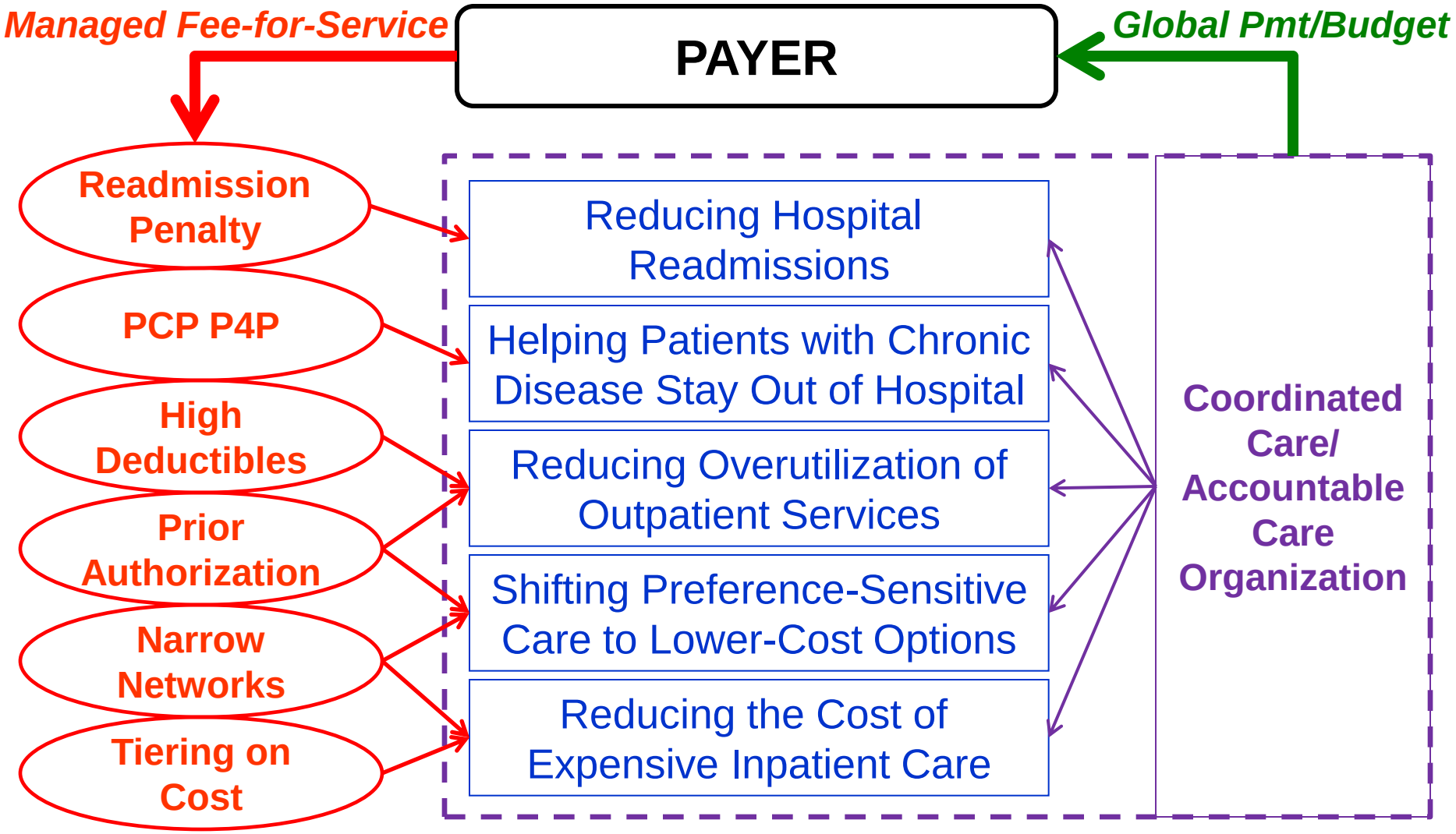
The Payer-Driven Approach to Achieving Savings



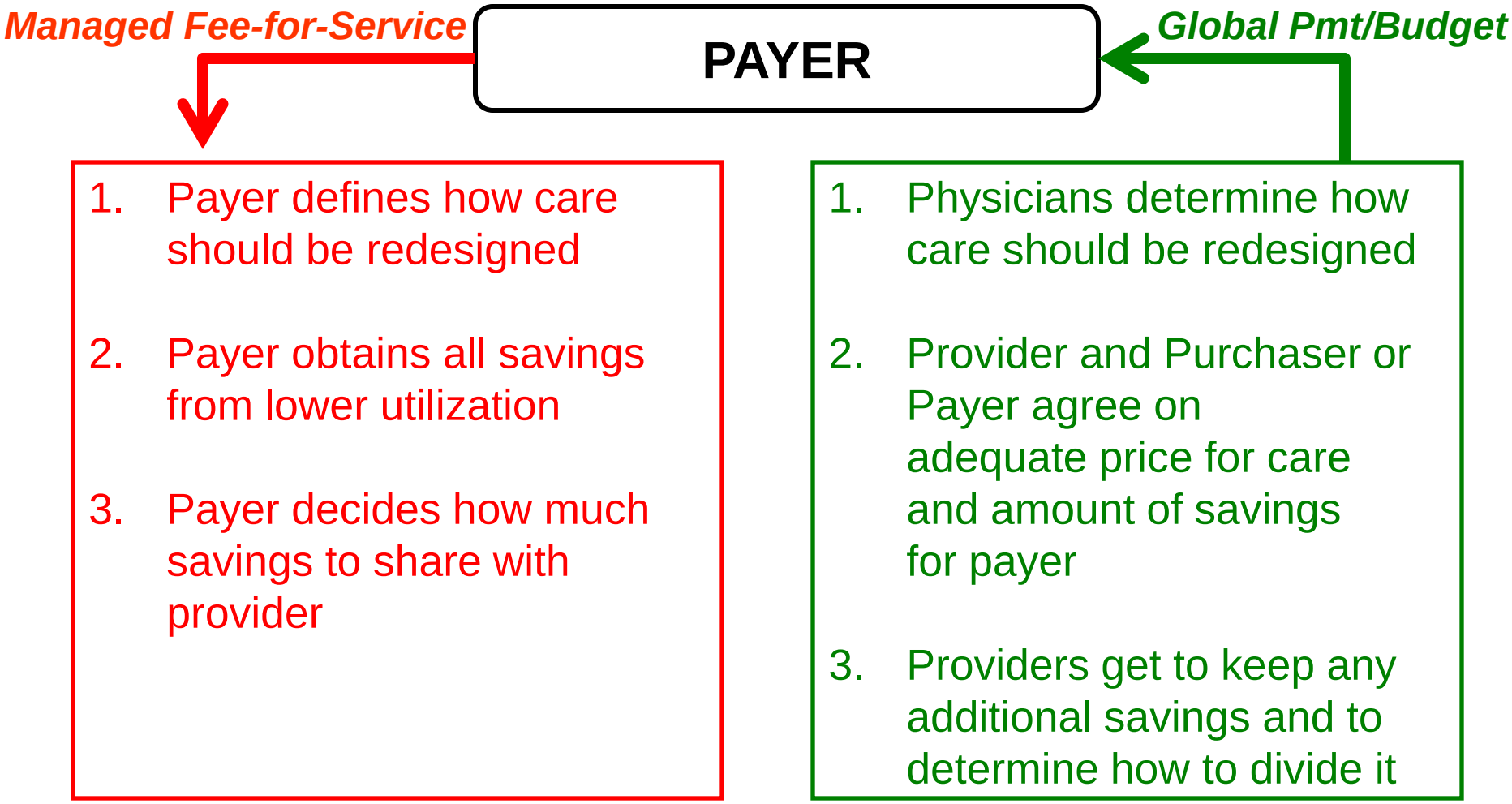
The Provider-Driven Approach to Achieving Savings



Very Different Models…



…And Very Different Impacts on Physicians



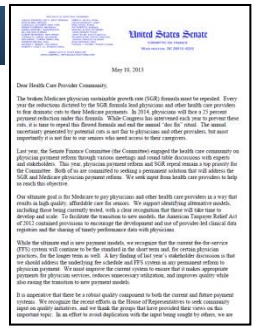
Fixing the Sustainable Growth Rate

Who Says Congress and the President Can't Agree?

Sustainable Growth Rate Repeal and Reform Proposal

"Providers can choose to participate in an **Alternative Payment Model**…We envision a system where providers have the flexibility to participate in the payment and delivery model that best fits their practice. The overarching goal is to reward providers for delivering high quality, efficient health care…"

House Energy & Commerce Committee and House Committee on Ways and Means



Request for Input from Stakeholders on Sustainable Growth Rate Reform

"Our utlimate goal is for Medicare to pay physicians…in a way that results in high quality, affordable care for seniors. We support identifying **Alternative Models**…

Senate Finance Committee

President's Budget Proposal to Encourage Adoption of New Physician Payment Models

"…The Administration supports … the continued development of scalable **accountable payment models**…[to] encourage care coordination, reward practitioners who provide high-quality efficient care, and hold practitioners accountable…"

President's Budget for Fiscal Year 2014, p.37

Fixing the Sustainable Growth Rate

- How much does it cost to repeal the SGR and give small updates to physicians?
  - $175 billion total for 2014-2023

Fixing the Sustainable Growth Rate

- How much does it cost to repeal the SGR and give small updates to physicians?
  - $175 billion total for 2014-2023

- How much of a reduction in Medicare spending would be needed to pay for the SGR repeal?
  - 18%
  - 13%
  - 10%
  - 7%
  - 5%
  - 3%
  - 1%

Relatively Small Savings Needed to Repeal the SGR

- How much does it cost to repeal the SGR and give small updates to physicians?
  - $175 billion total for 2014-2023

- How much of a reduction in Medicare spending would be needed to pay for the SGR repeal?
  - ~~18%~~
  - ~~13%~~
  - ~~10%~~
  - ~~7%~~
  - ~~5%~~
  - **3%**
  - ~~1%~~

But Nobody in DC Believes That Physicians Can/Will Do It

CBO expects that physicians would generally choose to participate in the payment options that offer the largest payments for the services they provide…

CBO expects that most of the alternative payment models that would be adopted under this legislation would increase Medicare spending. CBO's review of numerous Medicare demonstration projects found that very few succeeded in reducing Medicare spending.

CBO expects that the greater influence of providers within the design process specified in H.R. 2810 would lead to smaller savings than would arise from the development and adoption of new approaches through the [current] CMMI process.

Congressional Budget Office Cost Estimate for H.R. 2810 (September 13, 2013)

We Have to Stop *Testing* Models & Start Implementing/Evolving Them

The Slow Process the Government Thinks is Possible *Without* Physician Leadership to Develop Win-Win Approaches

During the 2019-2023 period, CBO anticipates that most spending through the APM mechanism would involve models being tested through demonstrations, because relatively few models would be likely to meet the criteria for operation without first being tested in demonstration programs.

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Congressional Budget Office Cost Estimate for H.R. 2810 (September 13, 2013)

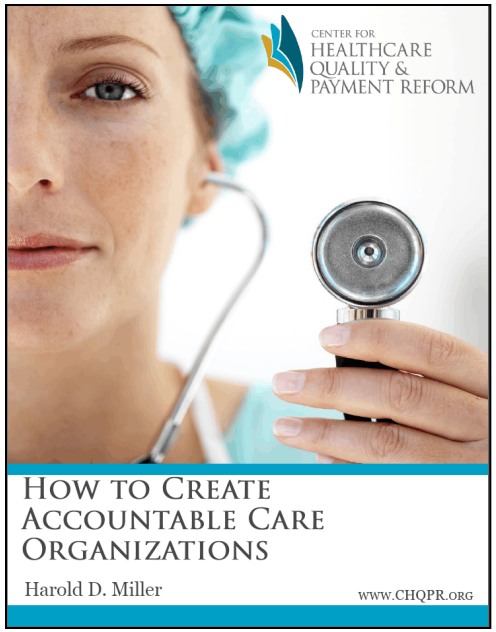
A Better Approach *With* Physician Group Leadership

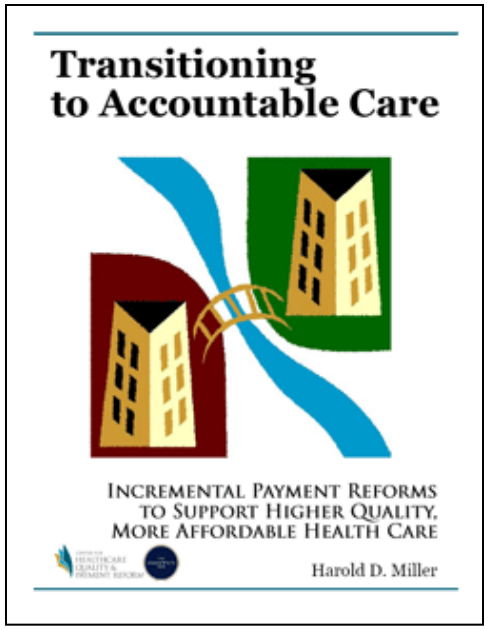
- Implement accountable models immediately, with narrow risk corridors
- Commit to small savings initially, then control the trend
- Expand the risk corridors over time and adjust the payment amounts to assure win-win-win approaches

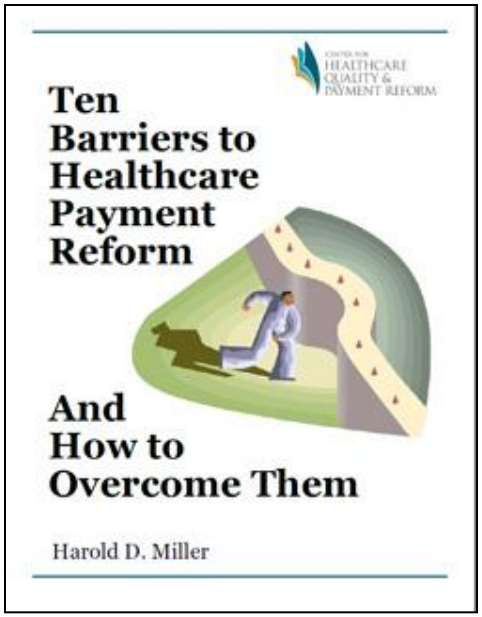
How AMGA Members Can Lead

- Tell Congress (and state Medicaid agencies and private purchasers) that you can and will take accountability for controlling healthcare spending – if you have the right payment model and enough time to implement it
- Show how care can be redesigned to improve care for patients without rationing while reducing spending – identify opportunities in *all* specialties
- Focus on ways to provide at least some savings (or slowing of growth) immediately in addition to longer-term savings
- Create coordinated care that patients will *voluntarily* use even in PPO structures
- Develop solutions to problems with current payment models
  - Better risk adjustment systems
  - Better ways of measuring accountability for individual specialties
  - Better quality measures
- Design new compensation models for physicians that match the flexibility/accountability of better payment

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







Center for Healthcare Quality and Payment Reform
www.PaymentReform.org

For More Information:

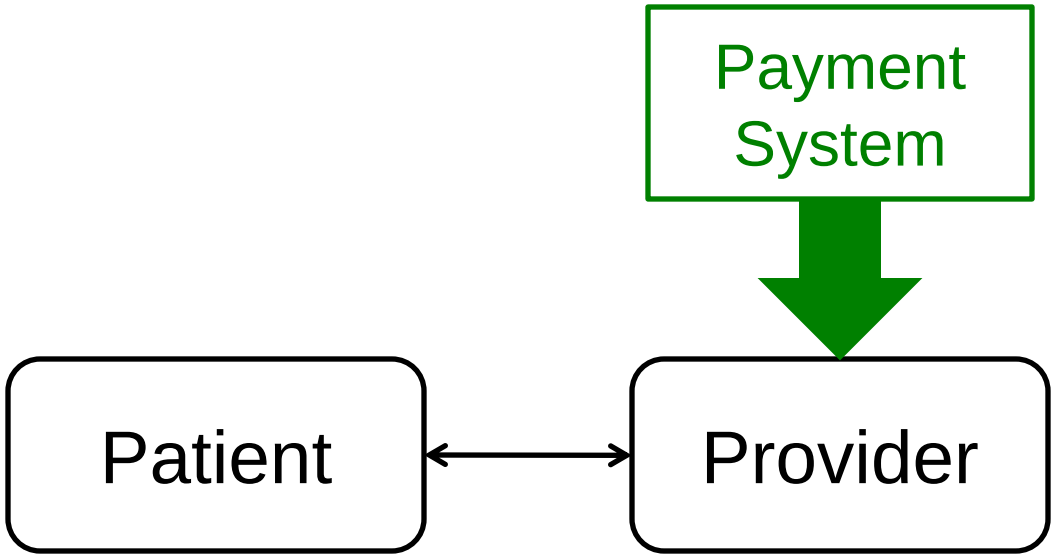
Harold D. Miller
President and CEO
Center for Healthcare Quality and Payment Reform

Miller.Harold@GMail.com
(412) 803-3650

www.CHQPR.org
www.PaymentReform.org

APPENDIX

What's the Patient's Role and Accountability?



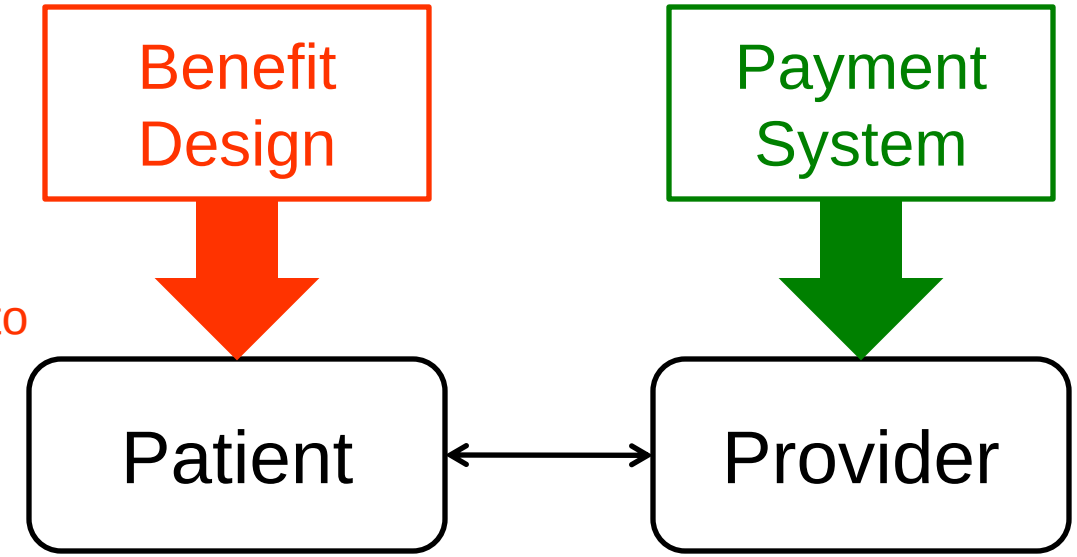
Ability and Incentives to:

- 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

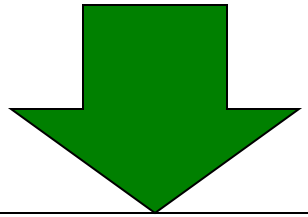
Changes Needed in Benefit Designs

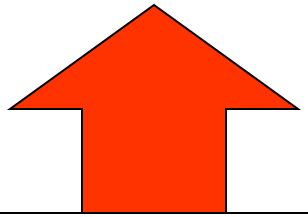
- Reduce or eliminate co-pays, co-insurance, and high deductibles for primary care, preventive treatments, and chronic disease maintenance medications

Example: Coordinating Pharmacy & Medical Benefits

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

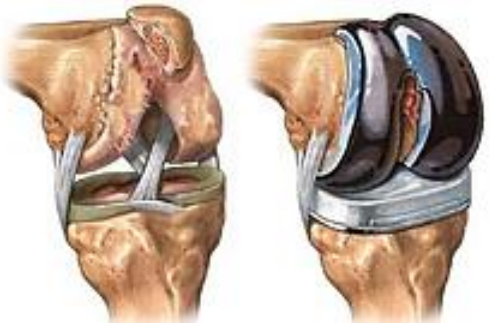
Principal treatment for most chronic diseases involves regular use of maintenance medication

Changes Needed in Benefit Designs

- Reduce or eliminate co-pays, co-insurance, and high deductibles for primary care, preventive treatments, and chronic disease maintenance medications
- Have patients share the LAST dollar of prices rather than the FIRST dollar to encourage price competition

Where Will You Get Your Knee Replaced?

Knee Joint Replacement



Consumer Share of Surgery Cost	Price #1 $20,000	Price #2 $25,000	Price #3 $30,000

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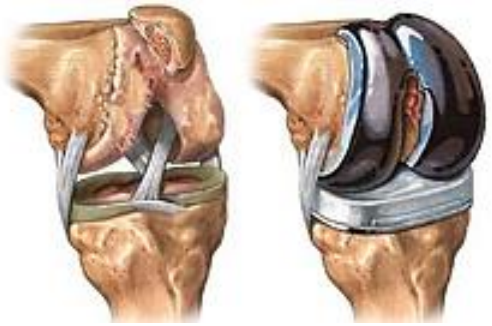

Consumer Share of Surgery Cost	Price #1 $20,000	Price #2 $25,000	Price #3 $30,000
$1,000 Copayment:	$1,000	$1,000	**$1,000** ✓
10% Coinsurance w/$2,000 OOP Max:	$2,000	$2,000	**$2,000** ✓
$5,000 Deductible:	$5,000	$5,000	**$5,000** ✓

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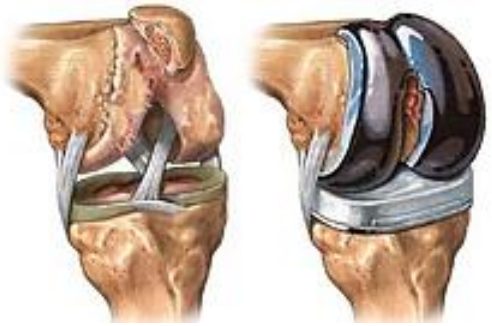

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$5,000 Deductible:	$5,000	$5,000	**$5,000** ✓
Highest-Value:	**$0** ✓	$5,000	$10,000

Which Health System or ACO Will You Choose?

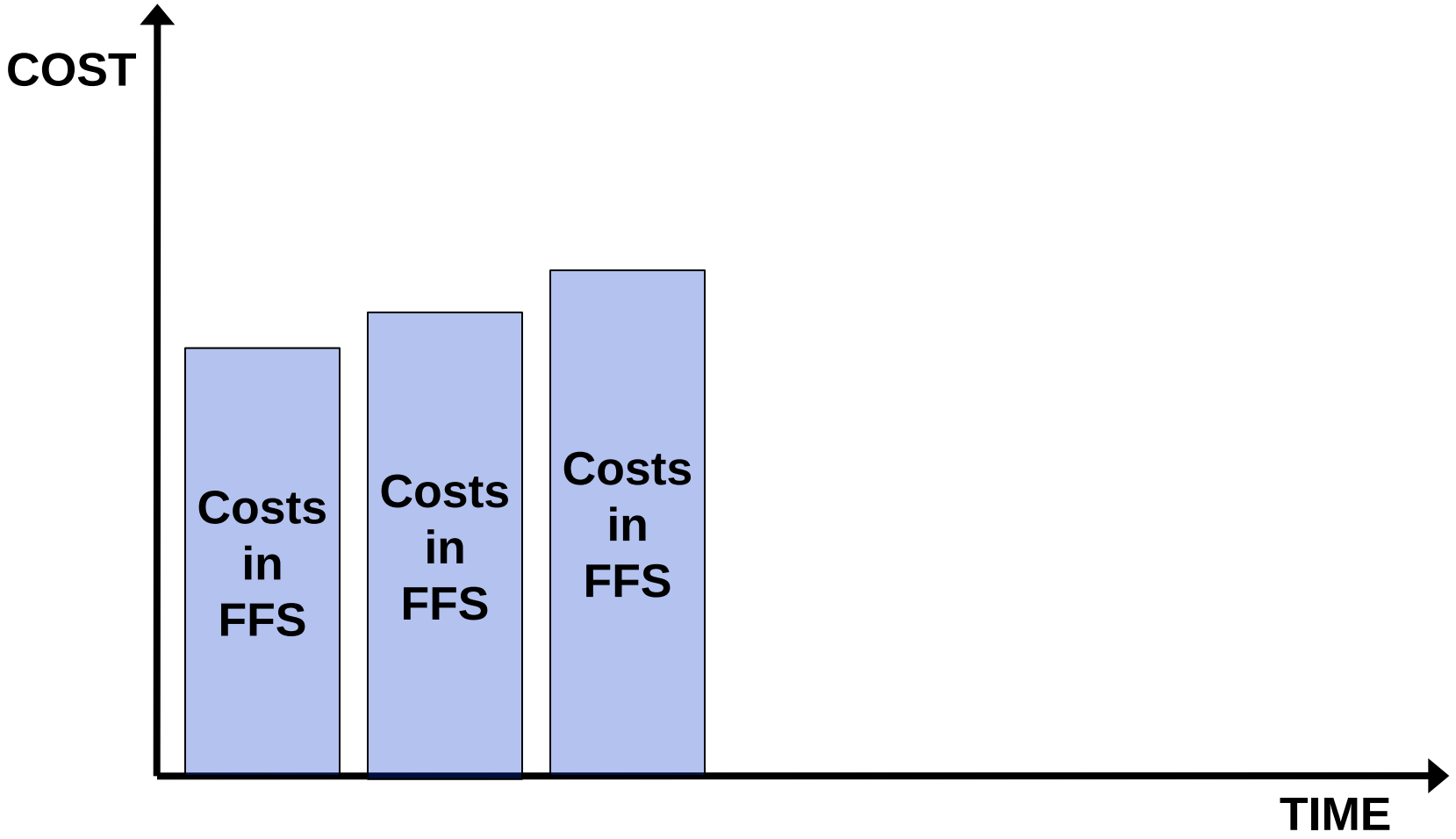
Total Annual Cost Per Patient/Member	Health System/ ACO #1 $6,000	Health System/ ACO #2 $8,000	Health System/ ACO #3 $10,000
Consumer Share	$0	$2,000	$4,000

APPENDIX

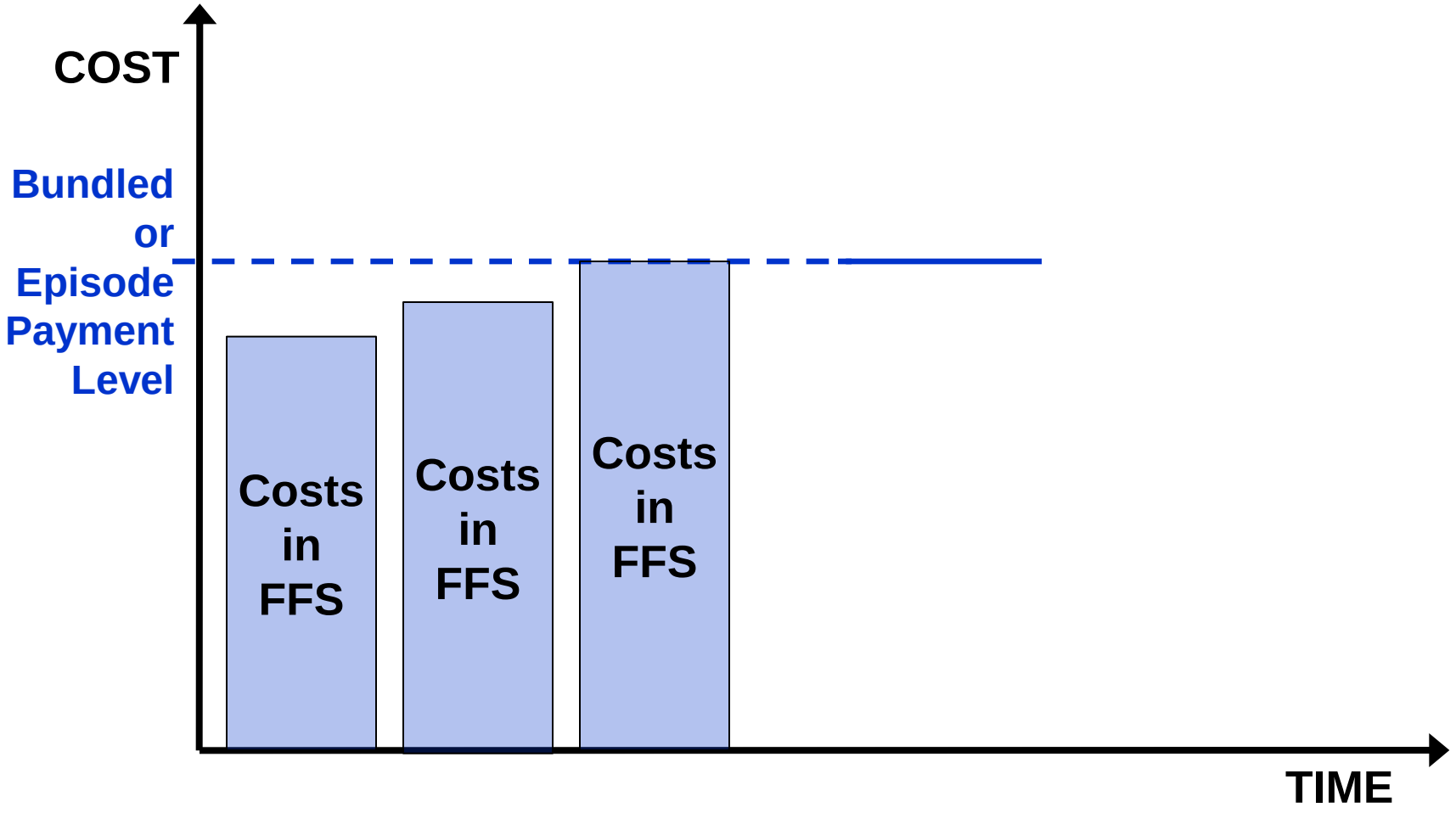
Not Just Payment *Method*, But Also *Price*

- Changing the payment *method* removes barriers to reducing costs and may reduce the incentives to increase volume
- But under any payment method, prices may be too high or too low
  - If the price is (too) high, there are no savings and no incentive to transform care
  - If the price is too low, providers will be unable to deliver high-quality care and risk financial disaster

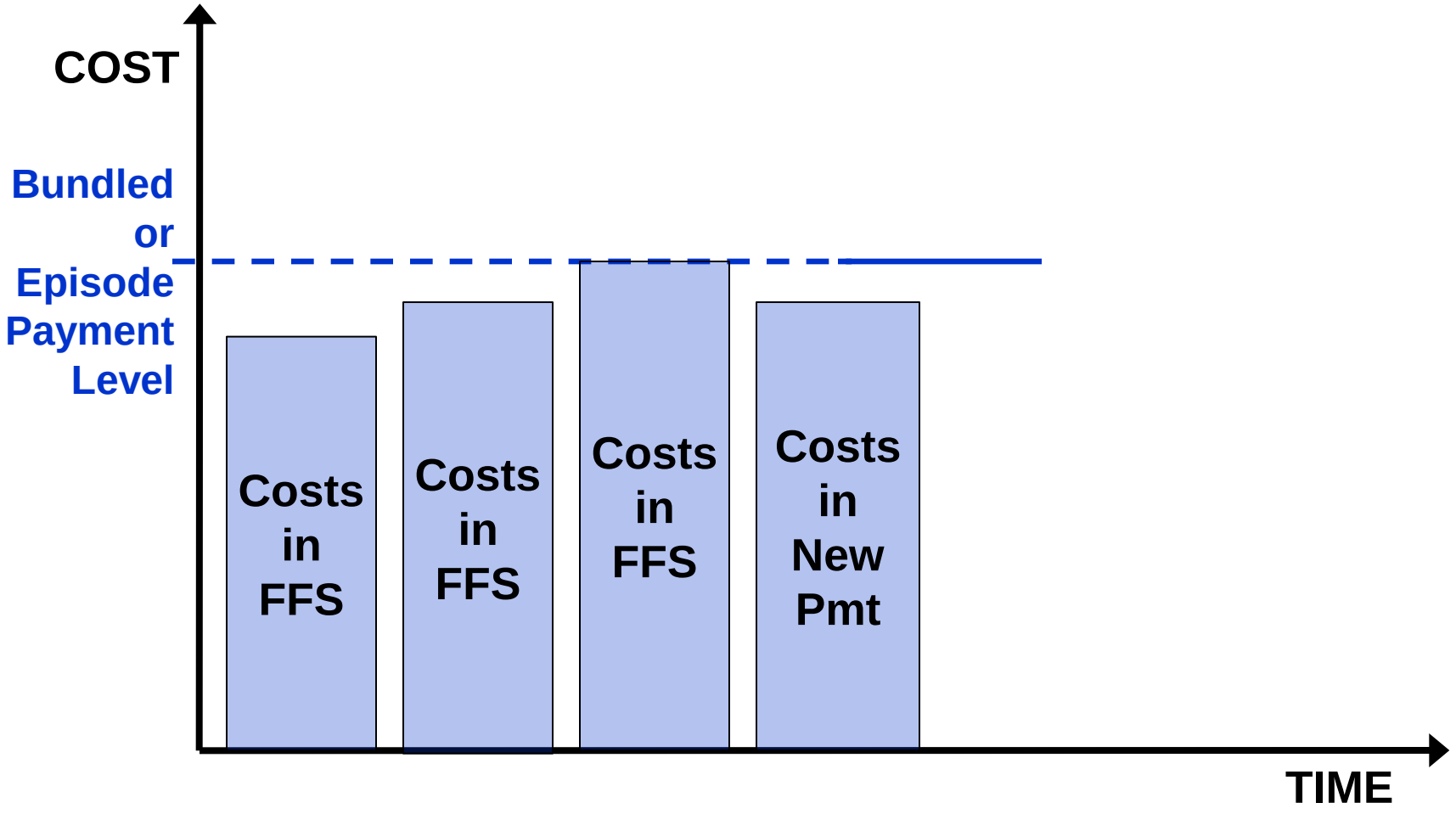
To Set A Fair Price, Start With Existing Costs…



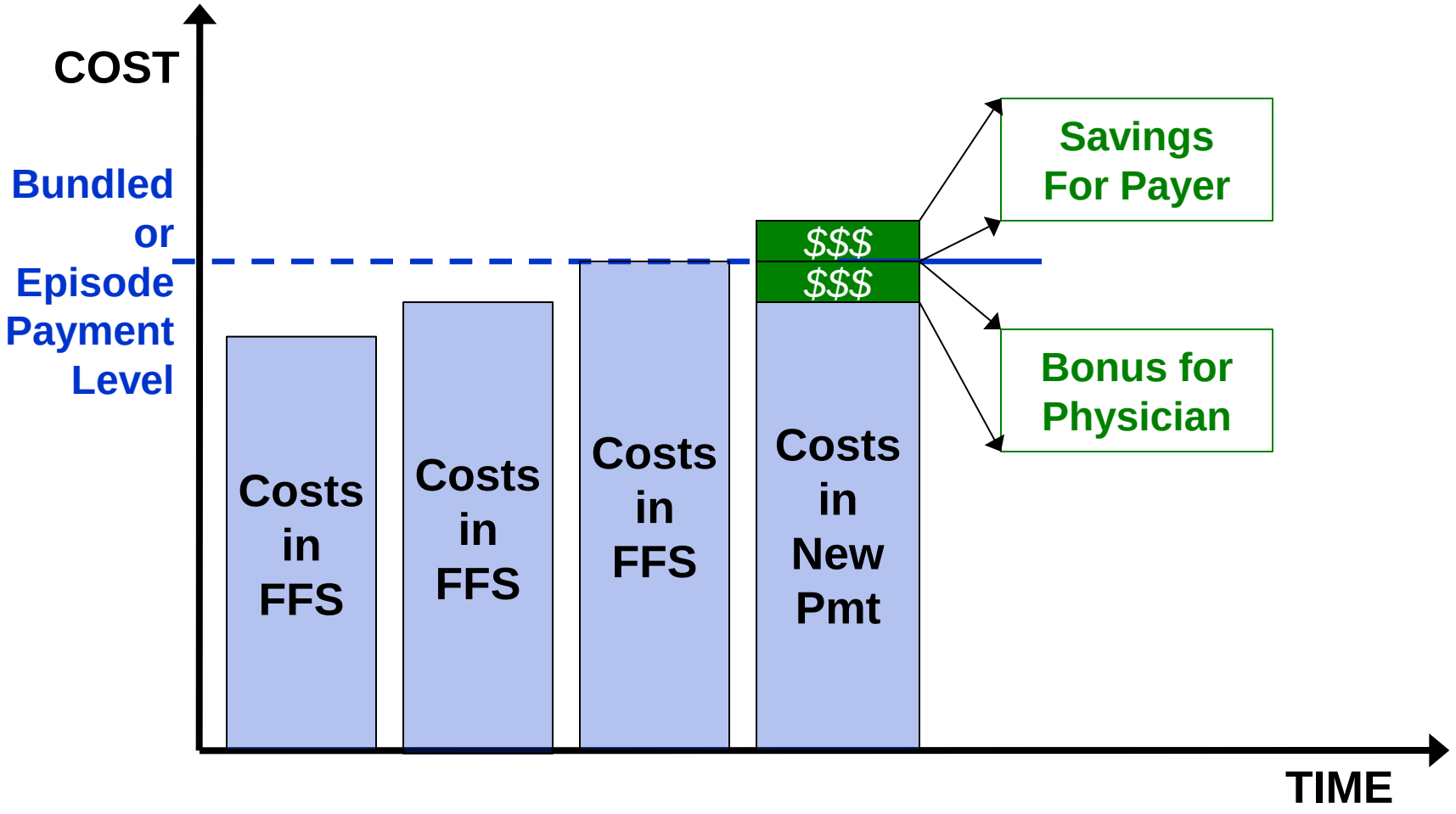
…Set a Payment Level That Is ≤ Expected Costs…



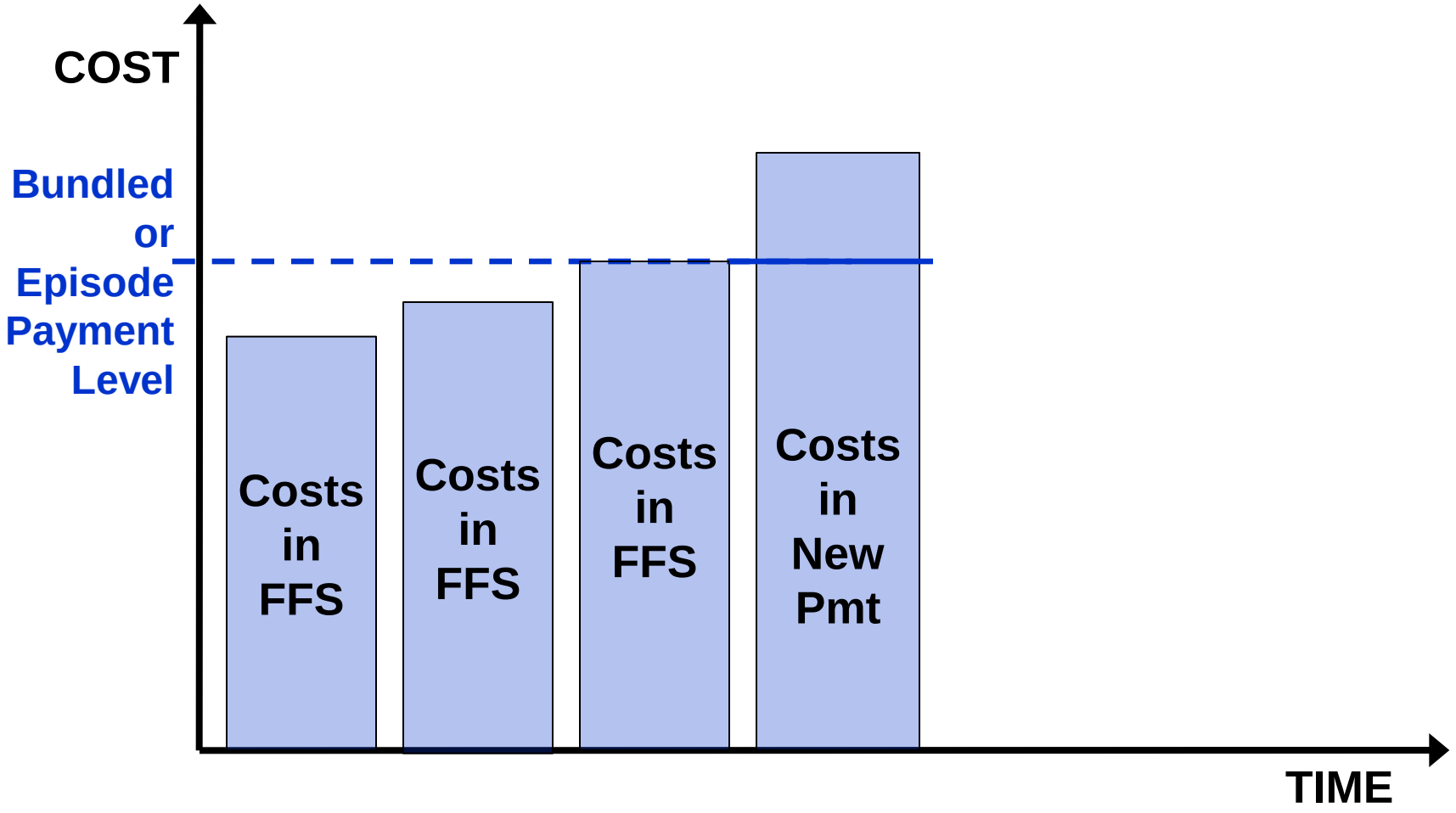
…If All Goes Well, Costs Will Be Lower Than the Payment Level…



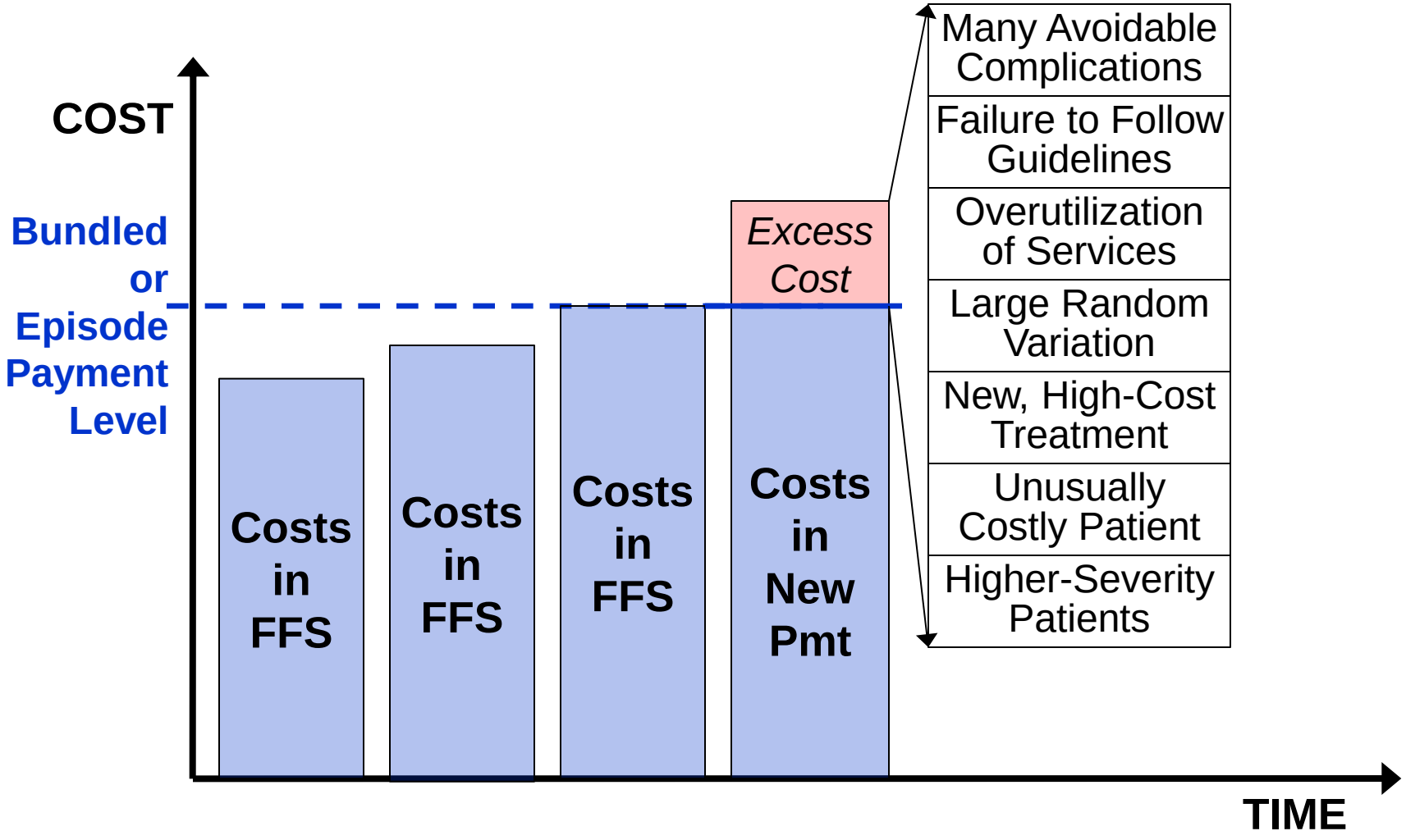
...And Both the Payer and Physician Will "Win"



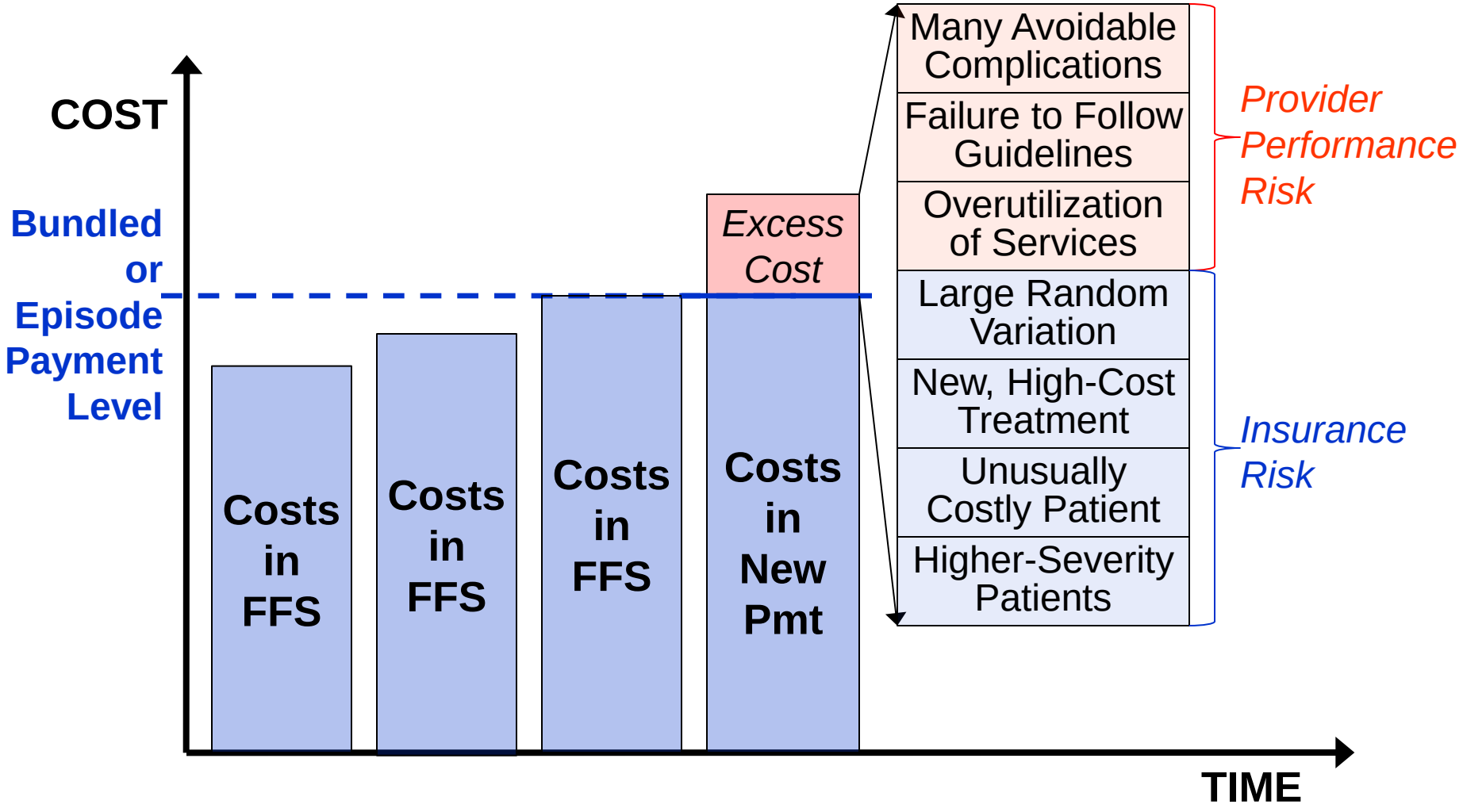
What Everybody Fears: All *Won't* Go Well (Costs Go Up)



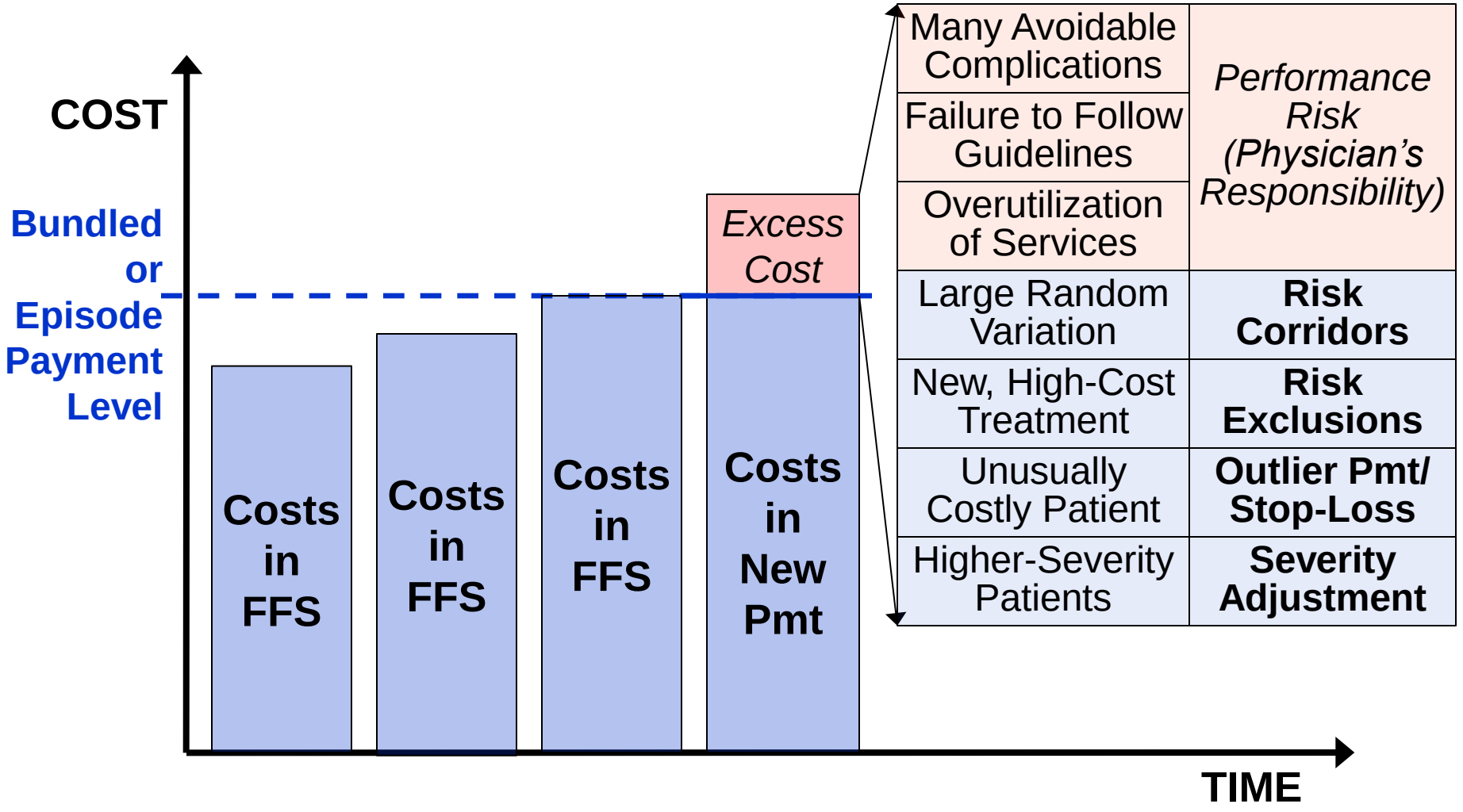
Many Different Reasons Costs May Increase Beyond Payment



Physicians Should NOT Be Expected To Take *Insurance* Risk



Four Mechanisms for Separating Insurance and Performance Risk



APPENDIX

What about Primary Care and Non-Proceduralists?

For the Non-Proceduralists: Reduce Avoidable Hospitalizations

	TODAY		
	$/Patient	# Pts	Total $
Physician Svcs			
PCP	$600	500	$300,000
Medication Pmts	$4,000	500	$2,000,000
Hospitalizations			
Hospital	$10,000	250	$2,500,000
Specialist	$400	250	$100,000
Total Pmt (Cost)			$4,900,000

500 Moderately Severe Chronic Disease Patients

- PCP paid only for periodic office visits
- Patients do not take maintenance medications reliably
- 50% of patients are hospitalized each year for exacerbations
- Specialist only sees patient during hospital admissions

Most Spending Is Not Going to the Physicians

	TODAY		
	$/Patient	# Pts	Total $
Physician Svcs			
PCP	$600	500	$300,000
Medication Pmts	$4,000	500	$2,000,000
Hospitalizations			
Hospital	$10,000	250	$2,500,000
Specialist	$400	250	$100,000
Total Pmt (Cost)			$4,900,000

Physician Payment is 8% of Total Spending

Better Pay for Care Mgt…

	TODAY			TOMORROW			
	$/Patient	# Pts	Total $	$/Pt	# Pts	Total $	Chg
Physician Svcs							
PCP	$600	500	$300,000	$1,200	500	$600,000	100%
Specialist				$400	500	$200,000	100%
Medication Pmts	$4,000	500	$2,000,000	$4,800	500	$2,400,000	20%
Hospitalizations							
Hospital	$10,000	250	$2,500,000	$10,000	150	$1,500,000	-40%
Specialist	$400	250	$100,000				
Total Pmt (Cost)			$4,900,000			$4,700,000	-4%

Better Rx Adherence (Higher Rx Expenses)…

	TODAY			TOMORROW			
	$/Patient	# Pts	Total $	$/Pt	# Pts	Total $	Chg
Physician Svcs							
PCP	$600	500	$300,000	$1,200	500	$600,000	100%
Specialist				$400	500	$200,000	100%
Medication Pmts	$4,000	500	$2,000,000	$4,800	500	$2,400,000	20%
Hospitalizations							
Hospital	$10,000	250	$2,500,000	$10,000	150	$1,500,000	-40%
Specialist	$400	250	$100,000				
Total Pmt (Cost)			$4,900,000			$4,700,000	-4%

Fewer Expensive Hospitalizations…

	TODAY			TOMORROW			
	$/Patient	# Pts	Total $	$/Pt	# Pts	Total $	Chg
Physician Svcs							
PCP	$600	500	$300,000	$1,200	500	$600,000	100%
Specialist				$400	500	$200,000	100%
Medication Pmts	$4,000	500	$2,000,000	$4,800	500	$2,400,000	20%
Hospitalizations							
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Specialist	$400	250	$100,000				
Total Pmt (Cost)			$4,900,000			$4,700,000	-4%

Win-Win-Win: Better Care, Higher Physician Pay, Lower Spending

	TODAY			TOMORROW			
	$/Patient	# Pts	Total $	$/Pt	# Pts	Total $	Chg
Physician Svcs							
PCP	$600	500	$300,000	$1,200	500	$600,000	100%
Specialist				$400	500	$200,000	100%
Medication Pmts	$4,000	500	$2,000,000	$4,800	500	$2,400,000	20%
Hospitalizations							
Hospital	$10,000	250	$2,500,000	$10,000	150	$1,500,000	-40%
Specialist	$400	250	$100,000				
Total Pmt (Cost)			$4,900,000			$4,700,000	-4%

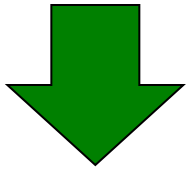
Pay to Manage The Condition To Enable Win-Win-Win Solutions

	TODAY			TOMORROW			
	$/Patient	# Pts	Total $	$/Pt	# Pts	Total $	Chg
Physician Svcs							
PCP	$600	500	$300,000	$1,200	500	$600,000	100%
Specialist				$400	500	$200,000	100%
Medication Pmts	$4,000	500	$2,000,000	$4,800	500	$2,400,000	20%
Hospitalizations							
Hospital	$10,000	250	$2,500,000	$10,000	150	$1,500,000	-40%
Specialist	$400	250	$100,000				
Total Pmt (Cost)	$9,800	500	$4,900,000	$9,400	500	$4,700,000	-4%

APPENDIX

We Want to Save Money By Reducing Overuse…

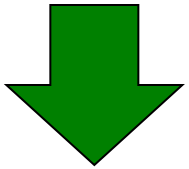
OVERUSE



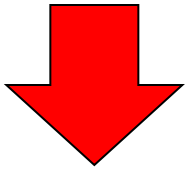
APPROPRIATE USE

…But Without Denying Needed Care

OVERUSE



APPROPRIATE USE



UNDERUSE

By Definition, Targets for Cost Savings Are Undesirable Services

SOURCE OF COST SAVINGS FROM CARE DELIVERY CHANGE
• Reducing unnecessary procedures • Reducing unnecessary tests • Reducing readmissions • Reducing avoidable ER visits • Reducing avoidable hospitalizations • Reducing avoidable complications • Reducing inefficiencies

But Quality Measures Must Ensure Reductions Don't Go Too *Far*

SOURCE OF COST SAVINGS FROM CARE DELIVERY CHANGE	UNDESIRABLE OUTCOME TO BE MEASURED
• Reducing unnecessary procedures • Reducing unnecessary tests • Reducing readmissions • Reducing avoidable ER visits • Reducing avoidable hospitalizations • Reducing avoidable complications • Reducing inefficiencies	• Mortality • Misdiagnosis • Delays in needed care • Increases in >30 day readmissions • Exacerbation of conditions • Delayed complications • Avoidance of high-risk patients

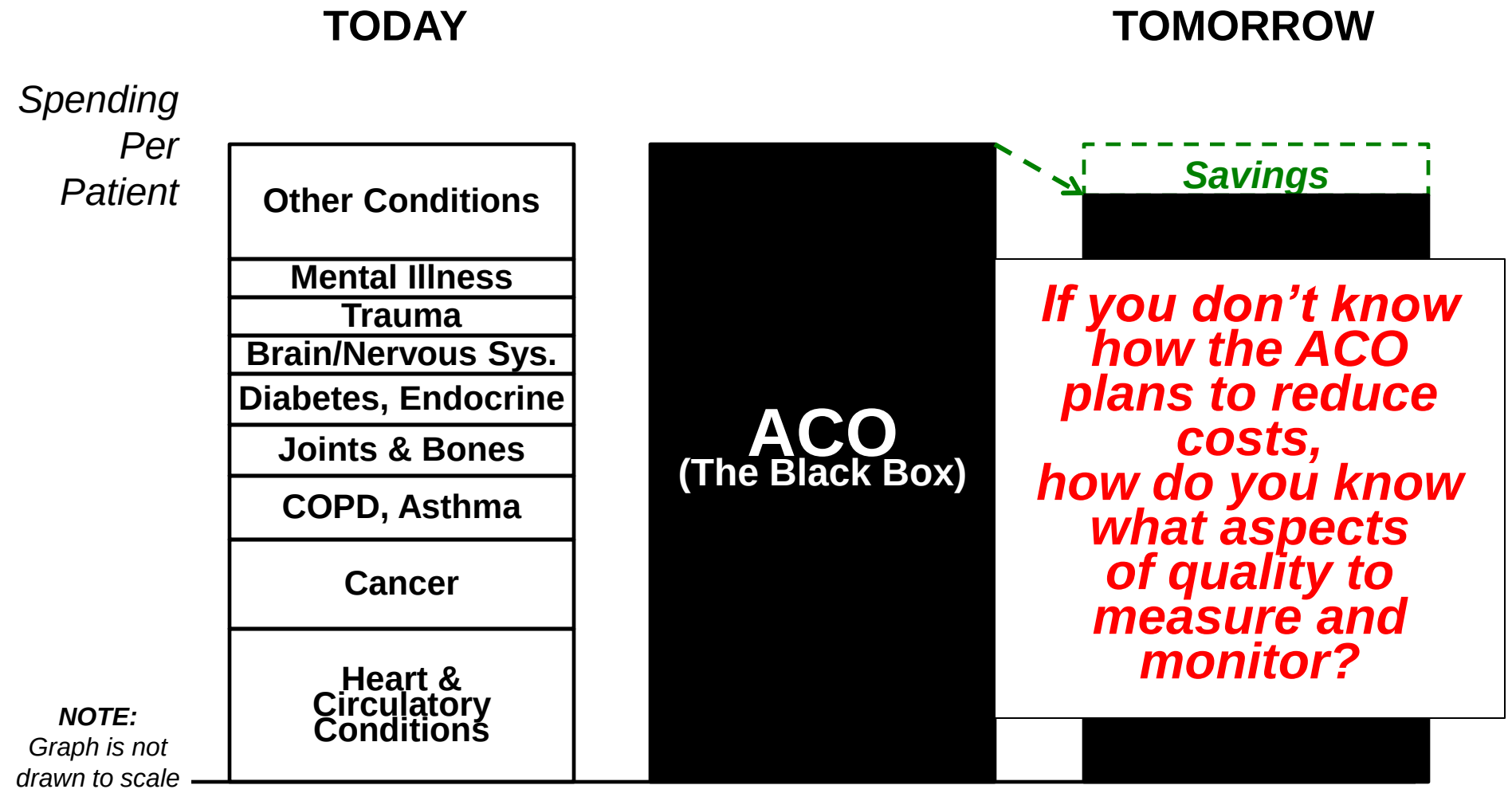
You Can't Just Use Whatever Quality Measures Are Available

SOURCE OF COST SAVINGS FROM CARE DELIVERY CHANGE	UNDESIRABLE OUTCOME TO BE MEASURED
• Reducing unnecessary procedures • Reducing unnecessary tests • Reducing readmissions • Reducing avoidable ER visits • Reducing avoidable hospitalizations • Reducing avoidable complications • Reducing inefficiencies	• Mortality • Misdiagnosis • Delays in needed care • Increases in >30 day readmissions • Exacerbation of conditions • Delayed complications • Avoidance of high-risk patients
	UNRELATED OR INAPPROPRIATE QUALITY MEASURES
	• Different conditions • Different settings • Different processes or procedures • Different time periods • Different outcomes • Different patients

Or You'll End Up Distracting Providers From The Primary Goal

SOURCE OF COST SAVINGS FROM CARE DELIVERY CHANGE	UNDESIRABLE OUTCOME TO BE MEASURED
• Reducing unnecessary procedures • Reducing unnecessary tests • Reducing readmissions • Reducing avoidable ER visits • Reducing avoidable hospitalizations • Reducing avoidable complications • Reducing inefficiencies	• Mortality • Misdiagnosis • Delays in needed care • Increases in >30 day readmissions • Exacerbation of conditions • Delayed complications • Avoidance of high-risk patients
UNDESIRABLE IMPACTS OF UNRELATED QUALITY MEASURES	**UNRELATED OR INAPPROPRIATE QUALITY MEASURES**
• Time and cost to collect data on unrelated/inappropriate measures • Time and cost to improve performance on unrelated measures • Inappropriate penalties for mis-measured performance	• Different conditions • Different settings • Different processes or procedures • Different time periods • Different outcomes • Different patients

It Matters What Exactly Is Happening Inside the Black Box



APPENDIX

Look at the Specific Conditions Managed by Each Specialty

Total Patients Treated by Specialty Practice	
Patients with Other Conditions	
Patients Screened for Health Problems	
Patients Receiving Acute Procedures	
Chronic Disease Patients	

Identify the Opportunities to Improve Care and Reduce Cost

Total Patients Treated by Specialty Practice	***Opportunities to Improve Care and Reduce Cost***
Patients with Other Conditions	
Patients Screened for Health Problems	• Identify and treat problems at earlier stages at lower cost
Patients Receiving Acute Procedures	• Reduce infections and complications • Reduce readmits • Reduce cost of procedure and/or post-treatment care
Chronic Disease Patients	• Prevent avoidable ER visits and hospitalizations • Reduce unneeded & duplicate testing

Identify the Barriers in the Current Payment System

Total Patients Treated by Specialty Practice	Opportunities to Improve Care and Reduce Cost	Barriers in Current Payment System
Patients with Other Conditions		
Patients Screened for Health Problems	• Identify and treat problems at earlier stages at lower cost	• No payment for proactive outreach to patients
Patients Receiving Acute Procedures	• Reduce infections and complications • Reduce readmits • Reduce cost of procedure and/or post-treatment care	• Higher pay to treat complications than to prevent them • All providers are paid separately
Chronic Disease Patients	• Prevent avoidable ER visits and hospitalizations • Reduce unneeded & duplicate testing	• No payment for care management svcs • No payment for phone calls with pts or other specialists

Using Better Payment Models to Support Redesigned Care

Total Patients Treated by Specialty Practice	Opportunities to Improve Care and Reduce Cost	Barriers in Current Payment System	Solutions via Accountable Payment Models
Patients with Other Conditions			
Patients Screened for Health Problems	• Identify and treat problems at earlier stages at lower cost	• No payment for proactive outreach to patients	• Condition-specific capitation • Risk-adjusted global payment
Patients Receiving Acute Procedures	• Reduce infections and complications • Reduce readmits • Reduce cost of procedure and/or post-treatment care	• Higher pay to treat complications than to prevent them • All providers are paid separately	• Bundled payment • Warrantied payment • Episode payment
Chronic Disease Patients	• Prevent avoidable ER visits and hospitalizations • Reduce unneeded & duplicate testing	• No payment for care management svcs • No payment for phone calls with pts or other specialists	• Condition-based payment • PCP medical home • Specialty medical home

Example: Gastroenterology

Total Patients Treated by Specialty Practice	Opportunities to Improve Care and Reduce Cost	Barriers in Current Payment System	Solutions via Accountable Payment Models
Patients with Other Conditions			
Hepatitis C Infection	• Identify and treat problems at earlier stages at lower cost	• No payment for proactive outreach to patients	• Condition-based payment
Colon Cancer Prevention	• Identify and treat problems at earlier stages at lower cost	• No payment for proactive outreach to patients	• Condition-specific capitation • Risk-adjusted global payment
Colonoscopy	• Reduce infections and complications • Reduce readmits • Reduce cost of procedure and/or post-treatment care	• Higher pay to treat complications than to prevent them • All providers are paid separately	• Bundled payment • Warrantied payment • Episode payment
Inflammatory Bowel Disease	• Prevent avoidable ER visits and hospitalizations • Reduce unneeded & duplicate testing	• No payment for care management svcs • No payment for phone calls with pts or other specialists	• Specialty medical home • Condition-based payment