WIN-WIN-WIN APPROACHES TO ACCOUNTABLE CARE
How Patients, Payers, Physicians, & Hospitals Can All Benefit from Better Ways to Pay for and Deliver Healthcare Services

Harold D. Miller
President and CEO
Center for Healthcare Quality and Payment Reform
www.CHQPR.org
How Do You Reduce/Control Total Spending on Healthcare?

**Spending Per Patient**

**TODAY**
- Total Spending for Care of Patients

**FUTURE**
- Lower Spending without Rationing

**Payer Savings**

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**NOTE:**
Graph is not drawn to scale.
Hundreds of Quality Measures & “Meaningful Use” Hasn’t Worked

NOTE: Graph is not drawn to scale

PAST

Total Spending for Care of Patients

• Mammograms
• Colon Cancer Screening
• Flu Vaccine
• BMI Screens
• Tobacco Counseling
• Fall Risk Assessment
• Hypertension Control
• HbA1c Control
• LDL
• Eye Exams
• Aspirin Use
• Beta Blockers for CHF

EHRs

TODAY

Total Spending

Payer Spending

Payer Spending
The Right Way: Look at the Health Conditions Affecting Patients…

**Total Spending for Care of Patients**

- Other
- Maternity
- Cancer
- Back/Joint Pain
- Chronic Diseases (Diabetes, Heart Failure, COPD)

**NOTE:** Graph is not drawn to scale.
...and Identify the **Avoidable** Spending Within Each Condition

NOTE: Graph is not drawn to scale.
Example: Avoidable Costs for Chronic Disease Patients

- **Total Spending for Care of Patients**
  - **Avoidable $**
    - Other
  - **Avoidable $**
    - Maternity
  - **Avoidable $**
    - Cancer
  - **Avoidable $**
    - Back/Joint Pain
  - **Avoidable $**
    - Chronic Diseases

**NOTE:** Graph is not drawn to scale

- ER visits for exacerbations
- Hospital admissions and readmissions
- Amputations, blindness

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

- Unnecessary surgery
- Use of unnecessarily-expensive implants
- Infections and complications of surgery
- ER visits for exacerbations
- Hospital admissions and readmissions
- Amputations, blindness

NOTE: Graph is not drawn to scale
Example: Avoidable Costs in Cancer Care

- Use of unnecessarily-expensively expensive drugs
- ER visits/hospital stays for dehydration and avoidable complications
- Fruitless treatment at end of life
- Late-stage cancers due to poor screening
- Unnecessary surgery
- Use of unnecessarily-expensively expensive implants
- Infections and complications of surgery
- ER visits for exacerbations
- Hospital admissions and readmissions
- Amputations, blindness

NOTE: Graph is not drawn to scale
Example: Avoidable Costs for Maternity Care

- Overuse of C-Sections
- Early elective deliveries
- Low birthweight due to poor prenatal care
- Use of hospitals instead of birth centers
- Use of unnecessarily-expensive drugs
- ER visits/hospital stays for dehydration and avoidable complications
- Fruitless treatment at end of life
- Late-stage cancers due to poor screening
- Unnecessary surgery
- Use of unnecessarily-expensive implants
- Infections and complications of surgery
- ER visits for exacerbations
- Hospital admissions and readmissions
- Amputations, blindness
And Many Other Opportunities

- Unnecessary/avoidable services
- Overuse of C-Sections
- Early elective deliveries
- Low birthweight due to poor prenatal care
- Use of hospitals instead of birth centers
- Use of unnecessarily-expensive drugs
- ER visits/hospital stays for dehydration and avoidable complications
- Fruitless treatment at end of life
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- Infections and complications of surgery
- ER visits for exacerbations
- Hospital admissions and readmissions
- Amputations, blindness

NOTE: Graph is not drawn to scale
Institute of Medicine Estimate: 30% of Spending is Avoidable
How Do You Reduce Avoidable Spending?

NOTE: Graph is not drawn to scale

TODAY

Payer Spending

Spending Per Patient

Total Spending for Care of Patients

Avoidable $
- Other
- Maternity
- Cancer
- Back/Joint Pain
- Chronic Diseases

FUTURE

Payer Savings

Avoidable $
- Other
- Maternity
- Cancer
- Back/Joint Pain
- Chronic Diseases
Information Technology Does Not Change Care Delivery

**NOTE:**
Graph is not drawn to scale

<table>
<thead>
<tr>
<th>TODAY</th>
<th>FUTURE</th>
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<tbody>
<tr>
<td><strong>Payer Spending</strong></td>
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<tr>
<td>Total Spending for Care of Patients</td>
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<tr>
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Only **Physicians** Know How to Change Care to Reduce Costs

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**NOTE:** Graph is not drawn to scale.
Strong Primary Care is Essential, But PCPs Can’t Do It Alone

NOTE: Graph is not drawn to scale

Total Spending for Care of Patients

Spending Per Patient

TODAY

FUTURE

Payer Savings

Payer Spending

Payer Spending

 Avoidable $
 Other

 Avoidable $
 Maternity

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 Chronic Diseases

 Primary Care?

 Primary Care?

 Primary Care?

 Primary Care?

 Primary Care?

 Primary Care?

 Avoidable $
 Other

 Avoidable $
 Maternity

 Avoidable $
 Cancer

 Avoidable $
 Back/Joint Pain

 Avoidable $
 Chronic Diseases

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Specialists Must Also Be Included

NOTE: Graph is not drawn to scale

### TODAY

- **Avoidable $**
  - Other
  - Maternity
  - Cancer
  - Back/Joint Pain
  - Chronic Diseases

### FUTURE

- **Payer Savings**
  - Other
  - Maternity
  - Cancer
  - Back/Joint Pain
  - Chronic Diseases

**Spending Per Patient**

- **Payer Spending**
  - Total Spending for Care of Patients

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What’s the Barrier?
The Current Payment System

TODAY

Payer Spending

Total Spending for Care of Patients
- Chronic Diseases
- Back/Joint Pain
- Cancer
- Maternity
- Other

FUTURE

Payer Savings

FEE FOR SERVICE PAYMENT
- Chronic Diseases
- Back/Joint Pain
- Cancer
- Maternity
- Other

NOTE: Graph is not drawn to scale.
Barrier #1: No $ or Inadequate $ for High-Value Services

No Payment or Inadequate Payment for:

- Services delivered outside of face-to-face visits with clinicians, e.g., phone calls, e-mails, etc.
- Services delivered by non-clinicians, e.g., nurses, community health workers, etc.
- Non-medical services, e.g., transportation
- Additional time or cost for patients with higher intensity needs
- Services not covered by benefit restrictions
Barrier #2: Avoidable Spending Is Usually *Revenue* for Providers…
...And When Avoidable Services Aren’t Delivered…
...Providers’ Revenue May Decrease...
…But Providers’ Fixed Costs Don’t Disappear…

Many Fixed Costs of Services Remain When Volume Decreases
...Leaving Providers Unable to Sustain the Necessary Services

Many Fixed Costs of Services Remain When Volume Decreases Potentially Causing Financial Losses
A Payment Change isn’t Reform Unless It Removes the Barriers

BARRIER #1

No Payment or Inadequate Payment for:
- Services delivered outside of face-to-face visits with clinicians, e.g., phone calls, e-mails, etc.
- Services delivered by non-clinicians, e.g., nurses, community health workers, etc.
- Non-medical services, e.g., transportation
- Additional time or cost for patients with higher intensity needs
- Services not covered by benefit restrictions

BARRIER #2

Many Fixed Costs of Services Remain When Volume Decreases Potentially Causing Financial Losses
Most “Payment Reforms” Today Don’t Remove the Barriers

“Value-Based Purchasing”

- No payment for services that will benefit patients
- Lower revenues from reducing avoidable costs

“APMs Built on FFS Architecture”

- No payment for services that will benefit patients
- Lower revenues from reducing avoidable costs

FFS
- No payment for services that will benefit patients
- Lower revenues from reducing avoidable costs

P4P

Shared Savings:

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

**FFS**
- No payment for services that will benefit patients
- Lower revenues from reducing avoidable costs

**“Value-Based Purchasing”**
- P4P
- No payment for services that will benefit patients
- Lower revenues from reducing avoidable costs

**“APMs Built on FFS Architecture”**
- Shared Savings
- PMPM
- No payment for services that will benefit patients
- Lower revenues from reducing avoidable costs

**Alternative Payment Models**

- **Condition-Based Payment**
  - No loss in margins for fewer tests, procedures, hospital admits

- **Bundles/Warranties**
  - Paying for teams of providers
  - Paying more for quality care, not for complications

- **Accountable Medical Home**
  - Flexible payments to PCPs not tied to office visits
Win-Win-Wins Possible Through True Payment Reforms

Alternative Payment Models

- **Condition-Based Payment**
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**BETTER CARE FOR PATIENTS**

**SAVINGS FOR PURCHASERS**

**HIGHER MARGINS FOR PROVIDERS**
True Payment Reforms Remove the Barriers to Improvement

TODAY

UNPAID SERVICES

NECESSARY SPENDING

PROVIDER REVENUE

COST OF SERVICE DELIVERY

PROFIT

AVOIDABLE SPENDING

WITH PAYMENT REFORM

SAVINGS

IMPROVED PAYMENT FOR NECESSARY SERVICES

PROVIDER REVENUE

COST OF SERVICE DELIVERY

PROFIT

AVOIDABLE SPENDING

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Many Specialties Developing Better Payment Models

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

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<tr>
<td>Psychiatry</td>
<td>- Reduce ER visits and admissions for patients with depression and chronic disease</td>
<td>- No payment for phone consults with PCPs</td>
<td>- Joint condition-based payment to PCP and psychiatrist</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>- Reduce unnecessary colonoscopies and colon cancer.</td>
<td>- No flexibility to focus extra resources on highest-risk patients</td>
<td>- Population-based payment for colon cancer screening</td>
</tr>
<tr>
<td></td>
<td>- Reduce ER/admits for inflammatory bowel disease.</td>
<td>- No flexibility to spend more on care mgmt</td>
<td>- Condition-based pmt for IBD</td>
</tr>
<tr>
<td>Oncology</td>
<td>- Reduce ER visits and admissions for dehydration.</td>
<td>- No payment for care management services</td>
<td>- Payment for care management svcs</td>
</tr>
<tr>
<td></td>
<td>- Reduce overuse of tests and drugs</td>
<td>- Inadequate payment for diagnosis and treatment planning</td>
<td>- Accountability for hospital admissions &amp; use of guidelines</td>
</tr>
<tr>
<td>Primary Care</td>
<td>- Reduce avoidable hospitalizations for chronic disease pts</td>
<td>- No payment for nurses to work with chronic disease patients</td>
<td>- Monthly payments for chronic care management</td>
</tr>
<tr>
<td></td>
<td>- Reduce unnecessary tests and referrals</td>
<td>- No payment for phone consults w/ specialists</td>
<td>- Payments to support PCP-specialist partnerships</td>
</tr>
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</table>
Other Examples of Specialty-Specific Payment Models

MEDICARE AND MOST HEALTH PLANS REFUSE TO MAKE THE FUNDAMENTAL CHANGES IN THEIR PAYMENT SYSTEMS NEEDED TO OVERCOME THE BARRIERS TO BETTER CARE
How Does This All Fit Into ACOs?
Starting With a Patient Population With Multiple Health Problems…

PATIENTS

- Heart Disease
- Diabetes
- Back Pain
- Pregnancy
Each Patient Should Choose & Use a Primary Care Practice…

<table>
<thead>
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Primary Care Practice
...Which Takes Accountability for What PCPs Can Control/Influence

MEDICARE, MEDICAID HEALTH PLAN

PATIENTS

Heart Disease
Diabetes
Back Pain
Pregnancy

Accountable Medical Home

Primary Care Practice

Accountability for:
• Avoidable ER Visits
• Avoidable Hospitalizations
• Unnecessary Tests
• Unnecessary Referrals
…With a Medical Neighborhood to Consult With on Complex Cases

MEDICARE, MEDICAID HEALTH PLAN

PATIENTS
- Heart Disease
- Diabetes
- Back Pain
- Pregnancy

Primary Care Practice

Endocrinology, Cardiology, Physiatry

Accountable Medical Home

Accountability for:
- Unnecessary Tests
- Unnecessary Referrals
- Co-Managed Outcomes
..And Specialists Accountable for the Conditions They Manage

Accountability for:
- Unnecessary Tests
- Unnecessary Procedures
- Infections, Complications

<table>
<thead>
<tr>
<th>PATIENTS</th>
<th>Heart Disease</th>
<th>Diabetes</th>
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<th>Pregnancy</th>
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- Primary Care Practice
- Cardiovasc. Group
- Neurosurg. Group
- OB/GYN Group

Accountable Medical Neighborhood

Endocrinology, Cardiology, Physiatry

Heart Episode/Condition Pmt
Back Episode/Condition Pmt
Pregnancy Condition Pmt

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That’s Building the ACO from the Bottom Up

MEDICARE, MEDICAID HEALTH PLAN

Accountable Payment Models

PATIENTS
- Heart Disease
- Diabetes
- Back Pain
- Pregnancy

Accountable Medical Home

Primary Care Practice

Endocrinology, Cardiology, Physiatry

Accountable Medical Neighborhood

ACO
- Cardiovasc. Group
- Neurosurg. Group
- OB/GYN Group

Heart Episode/Condition Pmt
- Back Episode/Condition Pmt
- Pregnancy Condition Pmt
Most ACOs Today Aren’t Truly Reinventing Care

MEDICARE, MEDICAID HEALTH PLAN

Fee-for-Service Payment

ACO

PATIENTS
- Heart Disease
- Diabetes
- Back Pain
- Pregnancy

Primary Care
Endocrin. Physiatry
Cardiology
Neurosurg.
OB/GYN
Most ACOs Today Aren’t Truly Reinventing Care

MEDICARE, MEDICAID HEALTH PLAN

Fee-for-Service Payment

Shared Savings Payment

ACO

Expensive IT Systems

Nurse Care Managers

Share of Shared Savings Payment??

PATIENTS
Heart Disease
Diabetes
Back Pain
Pregnancy

Primary Care
Endocrin. Physiatry
Cardiology
Neurosurge. OB/GYN
Most ACOs Aren’t Succeeding Due to Flaws in Payment Model

2013 Results for Medicare Shared Savings ACOs
• 46% of ACOs (102/220) increased Medicare spending
• Only one-fourth (52/220) received shared savings payments
• After making shared savings payments, Medicare spent more than it saved

2014 Results for Medicare Shared Savings ACOs
• 45% of ACOs (152/333) increased Medicare spending
• Only one-fourth (86/333) received shared savings payments
• After making shared savings payments, Medicare spent more than it saved
A True ACO Can Take a Global Payment And Make It Work

MEDICARE, MEDICAID HEALTH PLAN

Risk-Adjusted Global Payment

ACO

Heart Episode/Condition Pmt
Back Episode/Condition Pmt
Pregnancy Condition Pmt

Accountable Medical Home

Primary Care Practice

Endocrinology, Cardiology, Physiatry

Cardiovasc. Group
Neurosurv. Group
OB/GYN Group

Heart Disease
Diabetes
Back Pain
Pregnancy

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

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

- Joint Contracting by MDs & Hospitals for Global Payments
  - The Mount Auburn Cambridge IPA (MACIPA) and Mount Auburn Hospital jointly contract with three major Boston-area health plans for full-risk capitation. The IPA is independent of the hospital; they coordinate care with each other without any formal legal structure.  [www.macipa.com](http://www.macipa.com)
Which Is More Likely to Generate True Price Competition?

ONE BIG ACO

Hospital ACO

IPA ACO

Physician Group ACO

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What Most Communities Are Doing Will Ultimately Harm Patients…

- CMS
  - Cost-Shifting Through Underpayment

- Drug & Device Firms
  - Slowing of Innovation

- Hospitals
  - Inadequate Payment for High-Quality Care
  - Hospitals Acquiring MDs
  - Consolidations and Closures

- Specialists
  - Battle Over RVUs

- PCPs
  - Inadequate # of PCPs

- Employers
  - Inability to Provide Coverage

- Patients
  - Fragmented, Expensive Poor Quality Care

WIN-LOSE

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…But New Jersey Could Forge Win-Win Solutions If It Wants To
What New Jersey Could Do

• Focus on the major patient conditions that are driving most healthcare spending – chronic disease, maternity care, cancer care, orthopedics

• Work with physicians to identify the avoidable spending and the barriers that exist in the current payment system

• Create a neutral forum where all of the key stakeholders – patients, purchasers, PCPs, specialists, hospitals, and payers – can work together to develop win-win-win approaches

• Use the state’s purchasing power – for its employees and Medicaid – to implement the solutions and encourage other purchasers to join
Learn More About Win-Win-Win Payment and Delivery Reform

www.PaymentReform.org