

# Pathways for Physician Success in Accountable Care Organizations and Healthcare Payment Reform

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Executive Director

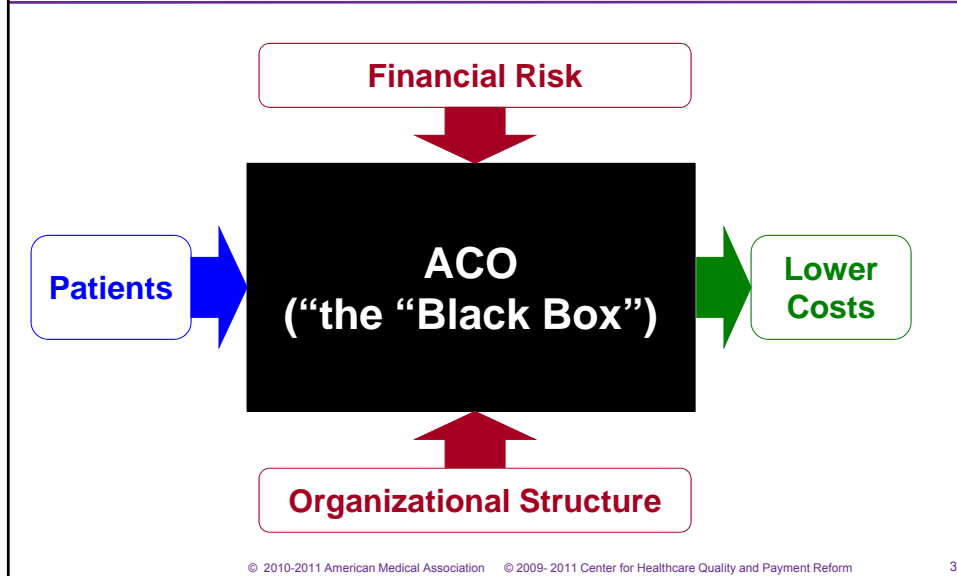
Center for Healthcare Quality and Payment Reform  
July 16, 2011



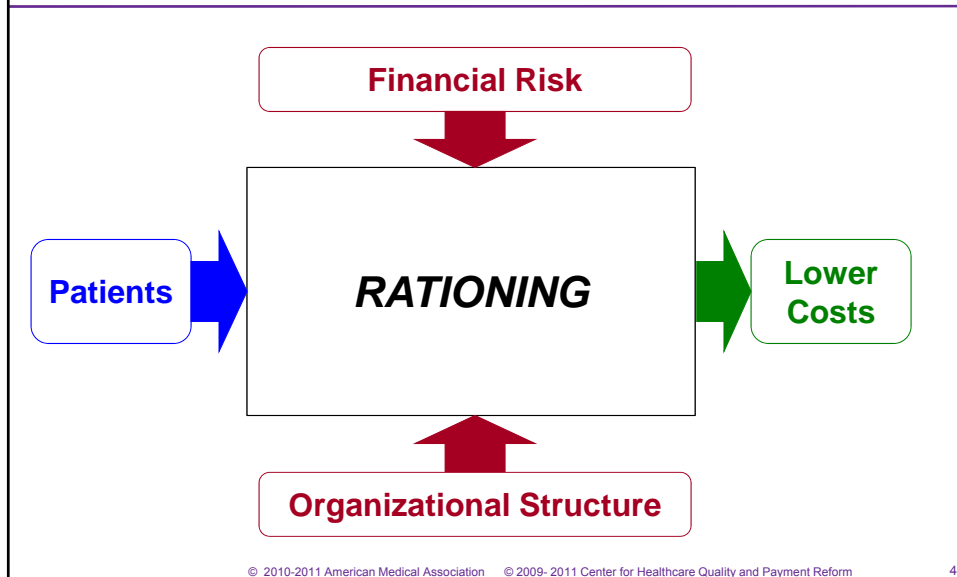
## Everybody's Talking About "ACOs"



## How Will ACOs Generate All These Savings?



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



## What the Focus Should Be: How to Reduce Costs By *Improving Care*



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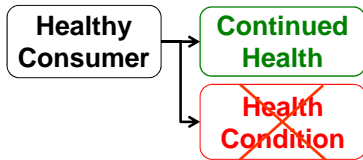
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## Reducing Costs Without Rationing: *Can It Be Done??*

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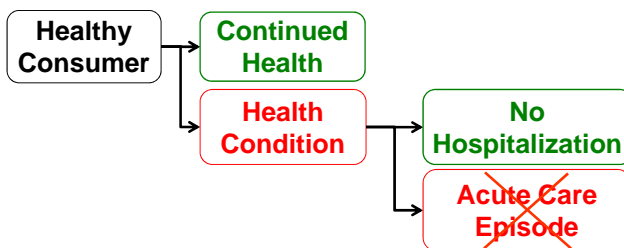
## Reducing Costs Without Rationing: Prevention and Wellness



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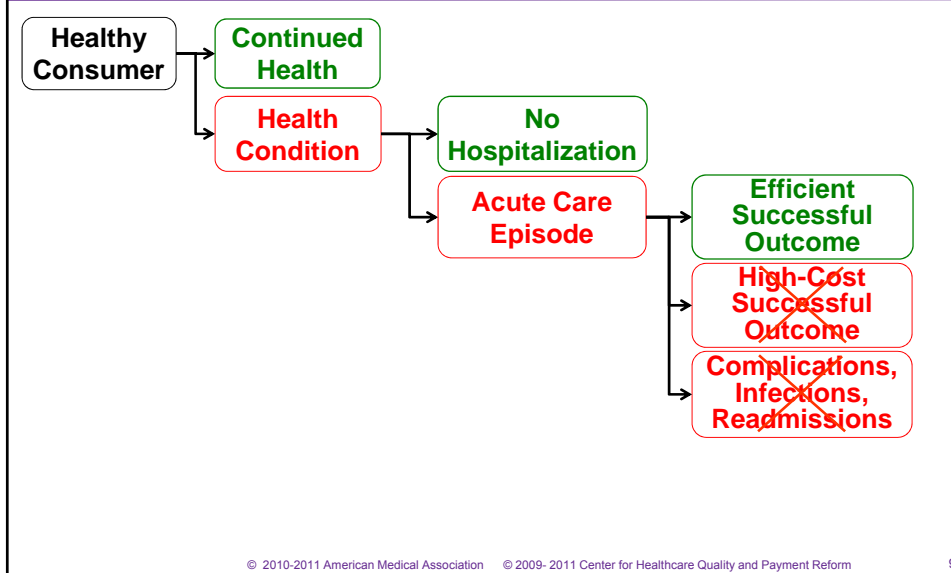
## Reducing Costs Without Rationing: Avoiding Hospitalizations



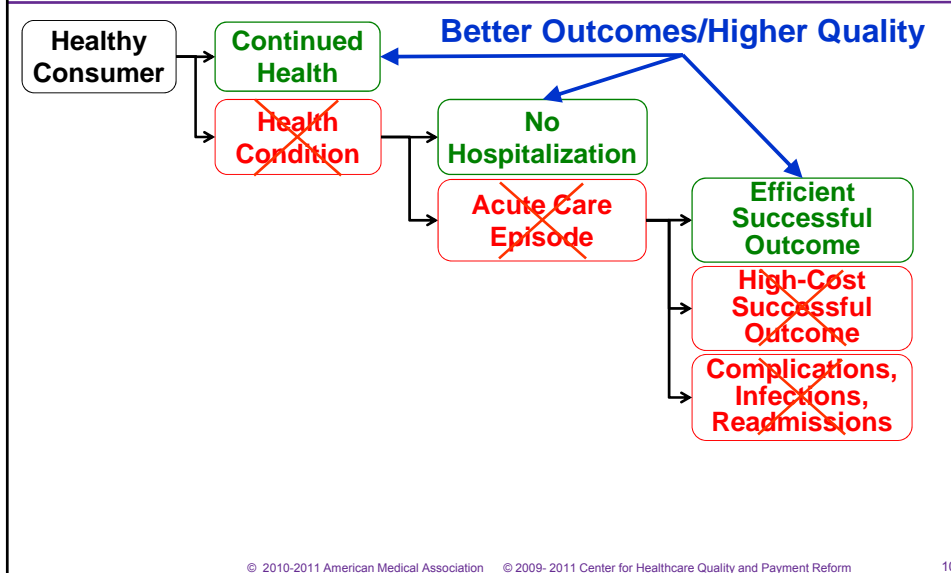
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## Reducing Costs Without Rationing: Efficient, Successful Treatment



## Reducing Costs Without Rationing Is Also Quality Improvement!



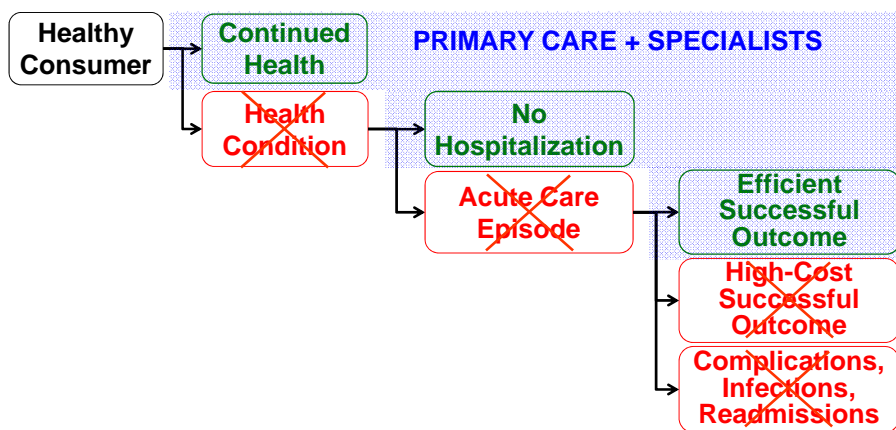
## Who Should Be Accountable For Achieving Higher Value Care?

- Health Plans?
- Hospitals?

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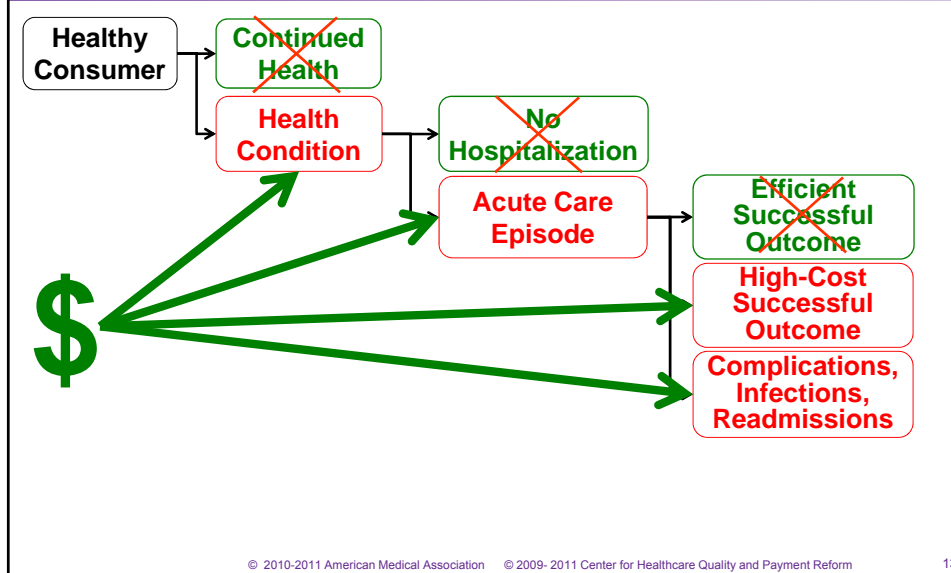
## Physicians are at the Core of “Accountable Care”



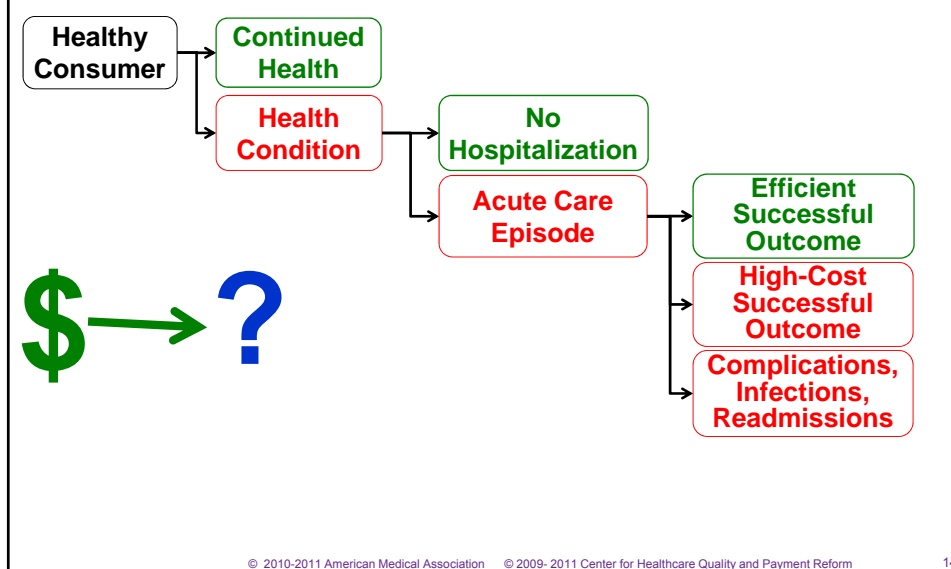
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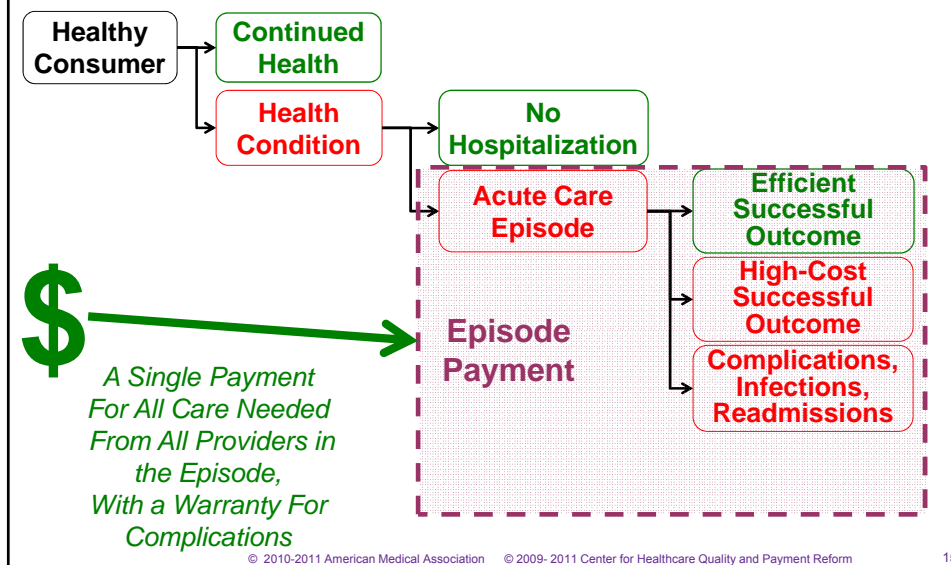
## Current Payment Systems Reward Bad Outcomes, Not Better Health



## Are There Better Ways to Pay for Health Care?



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



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

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

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

## Win-Win-Win at Geisinger from ProvenCare for CABG

### **Patient:**

- 21% reduction in complications
- 44% reduction in readmissions

### **Hospital:**

- 17.6% increase in contribution margin
- \$1,946 increase in total inpatient profit per case

### **Health Plan:**

- 4.8% lower payment per case than previously
- 28-36% less with Geisinger than with other providers

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

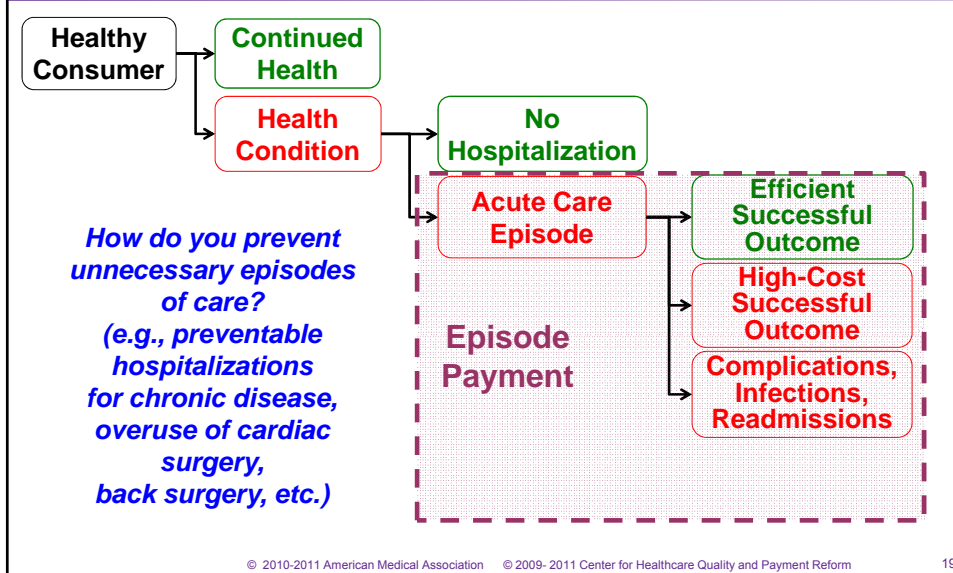
- In 1987, an orthopedic surgeon in Lansing, MI and the local hospital, Ingham Medical Center, offered:
  - a fixed total price for surgical services for shoulder and knee problems
  - a warranty for any subsequent services needed for a two-year period, including repeat visits, imaging, rehospitalization and additional surgery
- Results:
  - Health insurer paid 40% less than otherwise
  - Surgeon received over 80% more in payment than otherwise
  - Hospital received 13% more than otherwise, despite fewer rehospitalizations
- Method:
  - Reducing unnecessary auxiliary services such as radiography and physical therapy
  - Reducing the length of stay in the hospital
  - Reducing complications and readmissions.

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

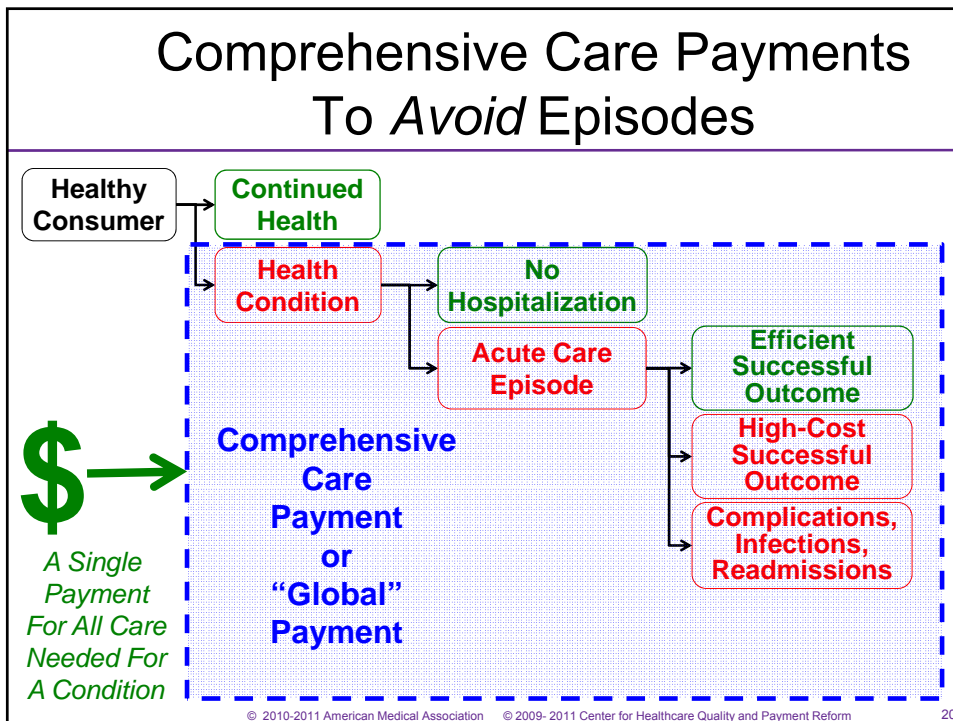
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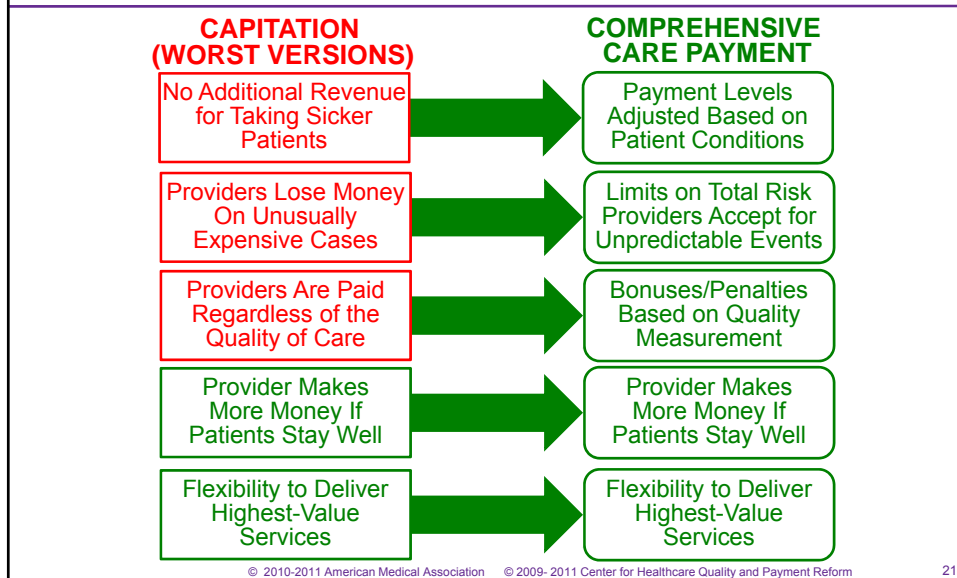
# The Weakness of Episode Payment



# Comprehensive Care Payments To Avoid Episodes



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



## Example: BCBS Massachusetts Alternative Quality Contract

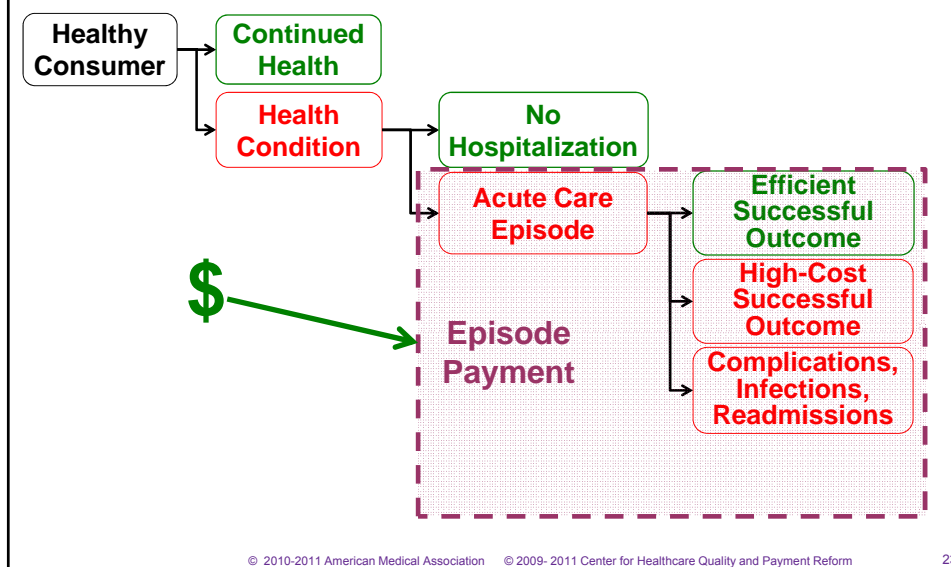
- Single payment for all costs of care for a population of patients
  - Adjusted up/down annually based on severity of patient conditions
  - Initial payment set based on past expenditures, not arbitrary estimates
  - Provides flexibility to pay for new/different services
  - Bonus paid for high quality 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 first-year results
  - Higher ambulatory care quality than non-AQC practices, better patient outcomes, lower readmission rates and ER utilization

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

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## A Deeper Dive into Episode Payments and Implications



## Episode Payment = Bundling + Warranty

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

## Example: Reducing Cost of Joint Replacement

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

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## Physicians Could Help Hospitals Reduce Cost of Medical Devices

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

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

COST TYPE	TODAY	CHANGE	SPLIT
Physician Fee	\$ 1,500		+ 0%
Device Cost	\$ 7,500	-33% (\$2,500)	
Other Hospital Cost	\$ 6,750		
Hosp. Margin	\$ 750		+333% (\$2500)
Total Hospital Pmt	\$15,000		
Total Cost to Payer	\$16,500		-0%

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## Bundling Eliminates Boundary Between Hospital & Physician Pmt

COST TYPE	TODAY	CHANGE	SPLIT
Physician Fee	\$ 1,500		
Device Cost	\$ 7,500		
Other Hospital Cost	\$ 6,750		
Hosp. Margin	\$ 750		
Total Cost to Payer	\$16,500		

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## Bundling Allows Savings Split Among Physicians, Hospitals, Payers

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

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## So Joint Replacement is Cheaper But More Profitable

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

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## Won't Bundling Encourage More Procedures?

- Medicare, health plans, employers, etc. want ways to reduce overutilization of expensive procedures, not to make procedures even more profitable

## The Same Procedure, But For a Full Population of Patients

COST TYPE	TODAY	200 Cases
Physician Fee	\$ 1,500	\$300,000
Device Cost	\$ 7,500	
Other Hospital Cost	\$ 6,750	
Hosp. Margin	\$ 750	\$150,000
Total Hospital Pmt	\$15,000	
Total Cost to Payer	\$16,500	\$3,300,000

## Assume There is Evidence of Overutilization

COST TYPE	TODAY	200 Cases
Physician Fee	\$ 1,500	\$300,000
Device Cost	\$ 7,500	
Other Hospital Cost	\$ 6,750	
Hosp. Margin	\$ 750	\$150,000
Total Hospital Pmt	\$15,000	
Total Cost to Payer	\$16,500	\$3,300,000

*Local study finds  
that 25% of procedures  
are unnecessary or  
can be avoided through  
medical management*

## Appropriateness Guidelines Alone Can Hurt Both Hospitals & Physicians

Fewer Cases =  
Lower Revenues

COST TYPE	TODAY	200 Cases	TODAY	150 Cases	Chg
Physician Fee	\$ 1,500	\$300,000	\$ 1,500	\$225,000	-25%
Device Cost	\$ 7,500		\$ 7,500		
Other Hospital Cost	\$ 6,750		\$ 6,750		
Hosp. Margin	\$ 750	\$150,000	\$ 750	\$112,500	-25%
Total Hospital Pmt	\$15,000		\$15,000		
Total Cost to Payer	\$16,500	\$3,300,000	\$16,500	\$2,475,000	-25%

## Bundling+Appropriateness Guidelines Can Reduce Costs w/o Financial Harm

COST TYPE	TODAY	200 Cases	NEW	150 Cases	Chg
Physician Fee	\$ 1,500	\$300,000	\$ 2,250	\$337,500	+13%
Device Cost	\$ 7,500		\$ 5,000		
Other Hospital Cost	\$ 6,750		\$ 6,750		
Hosp. Margin	\$ 750	\$150,000	\$ 1,500	\$225,000	+50%
Total Cost to Payer	\$16,500	\$3,300,000	\$15,500	\$2,325,000	-30%

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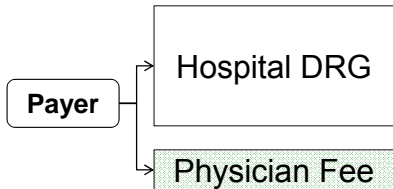
## Bundling Can Also Allow Physicians to Benefit From Changes in Settings

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## Under Today's Separate Facility and Physician Fees...

### ***INPATIENT***



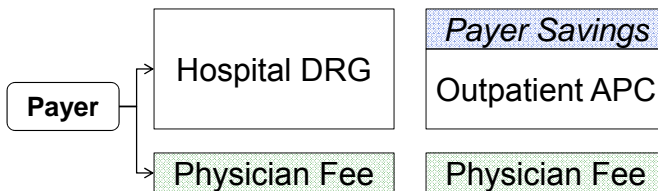
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## ...Savings From Shifts to Lower Cost Settings Will All Accrue to the Payer

### ***INPATIENT***

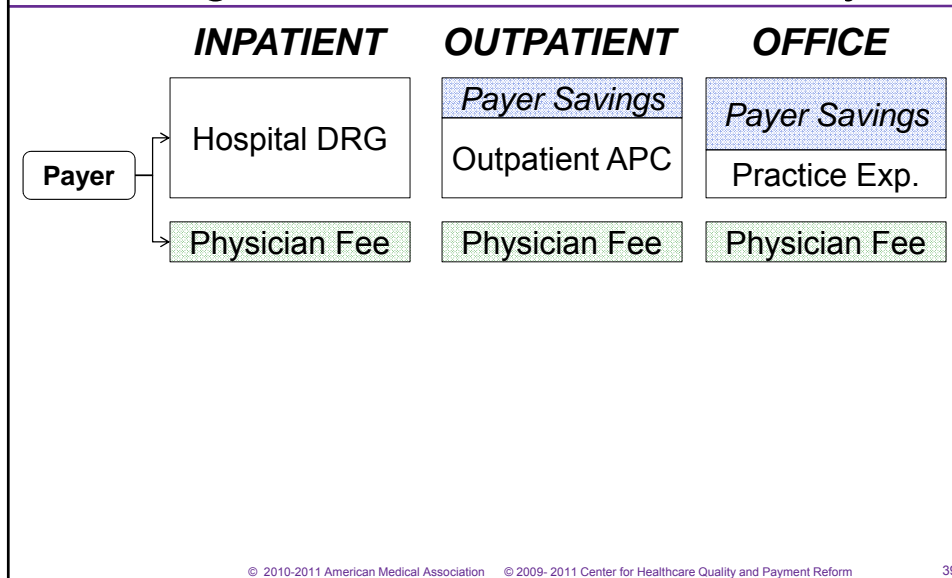
### ***OUTPATIENT***



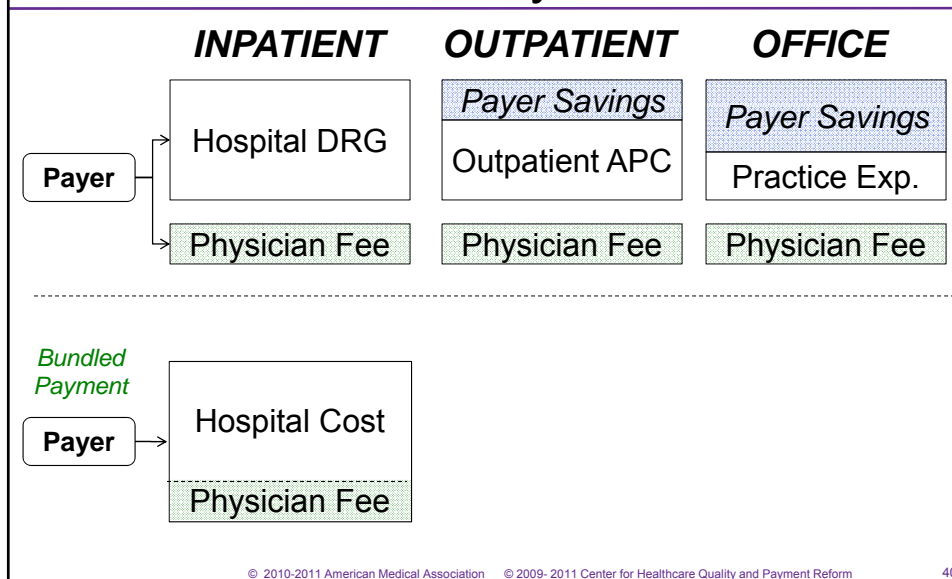
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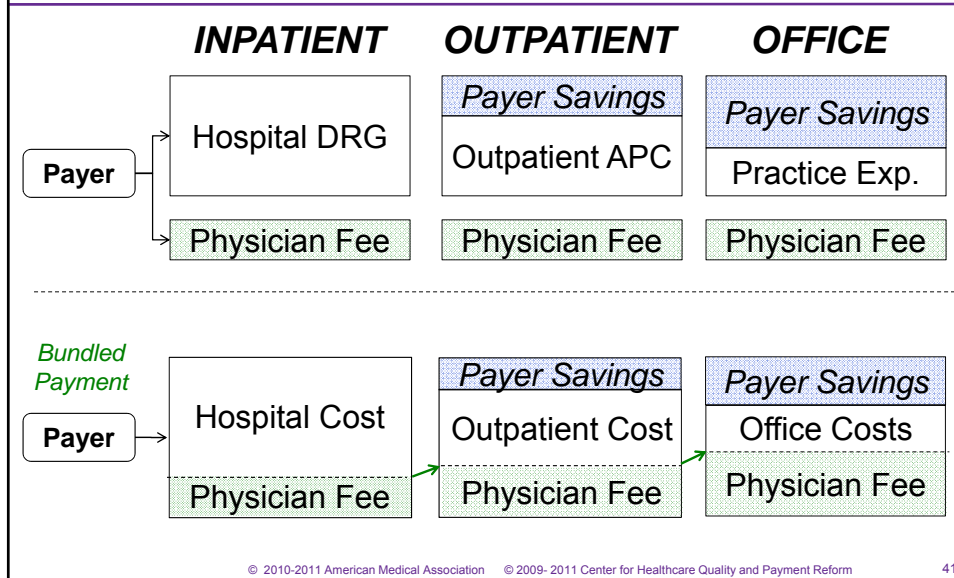
## ...Savings From Shifts to Lower Cost Settings Will All Accrue to the Payer



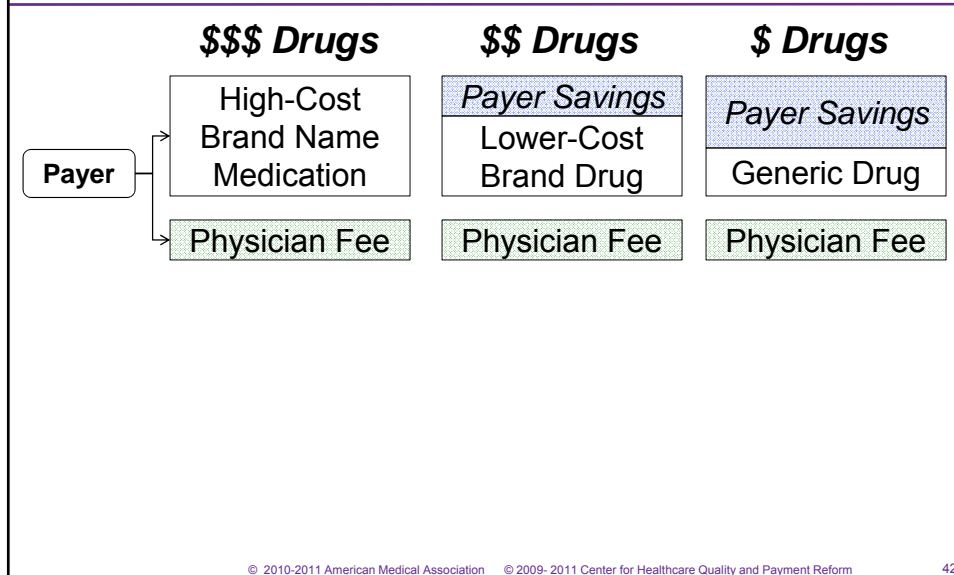
## But if the *Physician* Is Accepting a Bundled Payment...



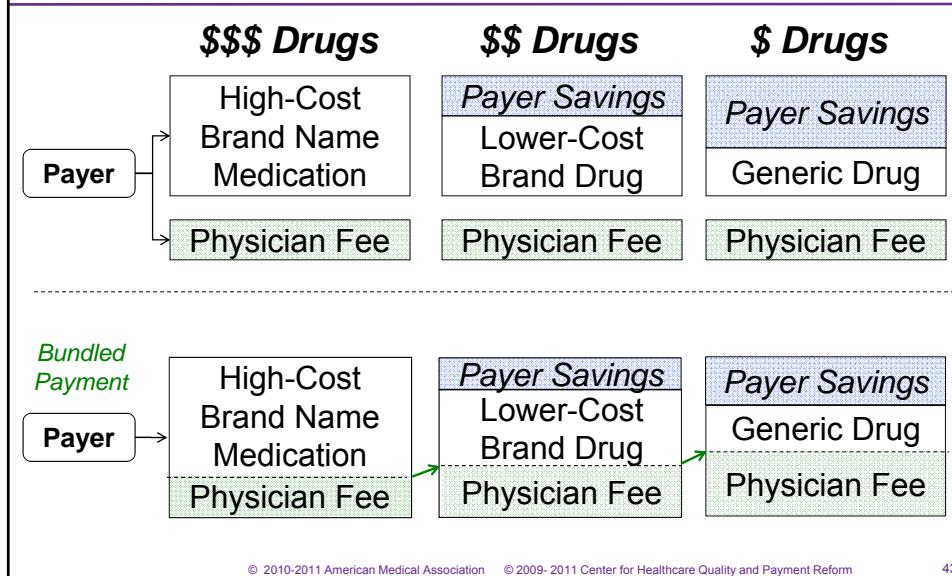
## ...The Physician Can Be Paid More But Still Charge Less to the Payer



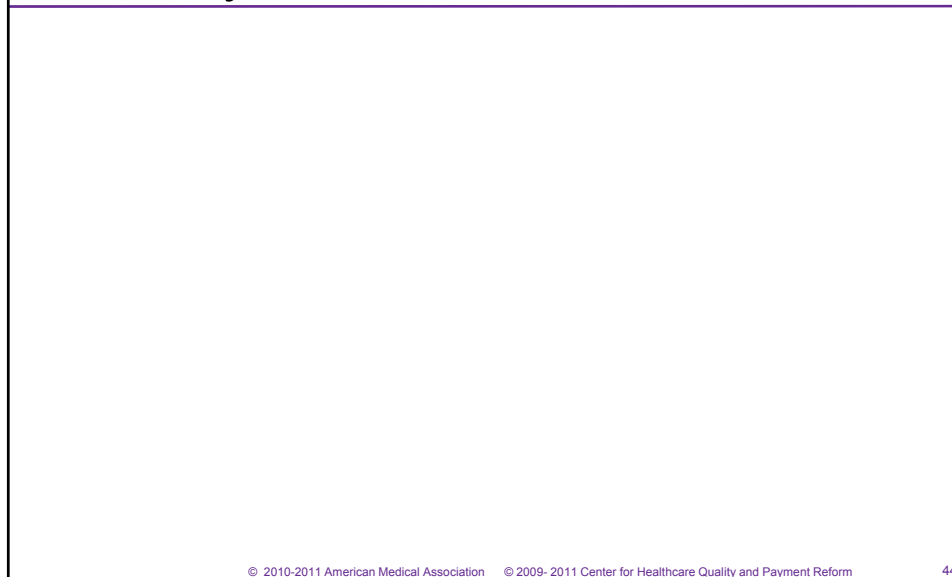
## Pharmaceutical Costs Can Also Be a Bundling Opportunity



## Bundling Drugs Into Payment Allows Docs To Share Savings



## How Can Physicians, Hospitals, and Payers Benefit from Warranties?



## A Warranty is Not an Outcome Guarantee

- Offering a warranty on care does not imply that you are guaranteeing a cure or a good outcome
- It merely means that you are agreeing to correct problems at no (additional) charge
- Most warranties are “limited warranties,” in the sense that they agree to pay to correct some problems, but not all

## *Prices for Warrantied Care Will Likely Be Higher*

## *Prices for Warrantied Care Will Likely Be Higher*

- Q: “Why should we pay more to get good-quality care??”
- A: In most industries, warrantied products cost more, but they’re desirable because TOTAL spending on the product (repairs & replacement) is lower than without the warranty

## *Prices for Warrantied Care May Be Higher, But Spending Lower*

- Q: “Why should we pay more to get good-quality care??”
- A: In most industries, warrantied products cost more, but they’re desirable because TOTAL spending on the product (repairs & replacement) is lower than without the warranty
- In healthcare, a DRG with a warranty would need to have a higher payment rate than the equivalent non-warrantied DRG, but the higher price would be offset by fewer DRGs w/ complications, outlier payments, and readmissions

## Example: Procedure Where Physician & Hospital are Paid \$10,000 Today

**Cost of Procedure**

\$10,000

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## Actual Average Payment for Procedure is Higher

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

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## Starting Point for Warranty Price: Actual Current Average Payment

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

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## Limited Warranty Gives Financial Incentive to Improve Quality

Cost of Procedure	Added Cost of Infection	Rate of Infections	Average Total Cost	Price Charged	Change in Net Revenue
\$10,000	\$20,000	5%	\$11,000	\$11,000	\$0
\$10,000	\$20,000	4%	\$10,800	\$11,000	\$200

Reducing  
Adverse  
Events...

...Reduces  
Costs...

...Improves  
The Bottom  
Line

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## Higher-Quality Provider Can Charge Less, Attract More Patients

Cost of Procedure	Added Cost of Infection	Rate of Infections	Average Total Cost	Price Charged	Change in Net Revenue
\$10,000	\$20,000	5%	\$11,000	\$11,000	\$0
\$10,000	\$20,000	4%	\$10,800	\$11,000	\$200
\$10,000	\$20,000	4%	\$10,800	\$10,800	\$0

↑  
 Enables  
 Lower  
 Prices

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## A Virtuous Cycle of Quality Improvement & Cost Reduction

Cost of Procedure	Added Cost of Infection	Rate of Infections	Average Total Cost	Price Charged	Change in Net Revenue
\$10,000	\$20,000	5%	\$11,000	\$11,000	\$0
\$10,000	\$20,000	4%	\$10,800	\$11,000	\$200
\$10,000	\$20,000	4%	\$10,800	\$10,800	\$0
\$10,000	\$20,000	3%	\$10,600	\$10,800	\$200

↑  
 Reducing  
 Adverse  
 Events...

↑  
 ...Reduces  
 Costs...

↑  
 ...Improves  
 The Bottom  
 Line

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## Win-Win-Win for Patients, Payers, and Providers

Cost of Procedure	Added Cost of Infection	Rate of Infections	Average Total Cost	Price Charged	Change in Net Revenue
\$10,000	\$20,000	5%	\$11,000	\$11,000	\$0
\$10,000	\$20,000	4%	\$10,800	\$11,000	\$200
\$10,000	\$20,000	4%	\$10,800	\$10,800	\$0
\$10,000	\$20,000	3%	\$10,600	\$10,800	\$200
\$10,000	\$20,000	3%	\$10,600	\$10,600	\$0
\$10,000	\$20,000	0%	\$10,000	\$10,600	\$600

Quality is Better...

...Cost is Lower...

...Providers More Profitable

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## In Contrast, Non-Payment for Infections Creates Financial Losses

Cost of Procedure	Added Cost of Infection	Rate of Infections	Average Total Cost	Amount Paid	Change in Net Revenue
\$10,000	\$20,000	5%	\$11,000	\$11,000	\$0
\$10,000	\$20,000	5%	\$11,000	\$10,000	-\$1,000
\$10,000	\$20,000	3%	\$10,600	\$10,000	-\$600
\$10,000	\$20,000	0%	\$10,000	\$10,000	\$0

Non-Payment for Infections

Causes Losses While Improving

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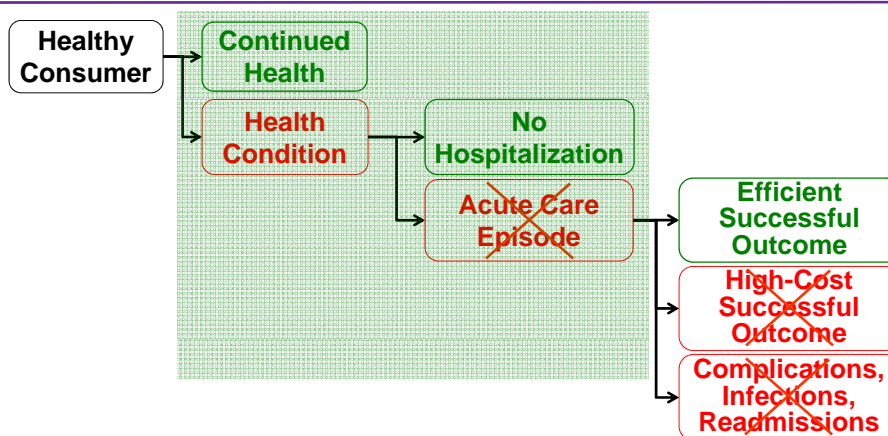
## Current Episode-of-Care Initiatives

- **Medicare Acute Care Episode (ACE) Demonstration**
  - single amount for hospital & physician services for cardiac, orthopedic DRGs
  - combined payment lower than current Medicare payments
  - bundled payment goes to a Physician-Hospital Organization which then divides the payment between the hospital and the physicians
  - CMS waives restrictions on gain-sharing, so hospitals can share internal savings with physicians
  - Physicians eligible to receive up to 25% more than current payment levels
- **Prometheus Payment™**
  - covers *full* episode of care and *all* providers
  - estimates the appropriate payment amount based on historical costs and any guidelines for evidence-based care
  - “virtual bundling”: no provider receives the money for another provider’s services; each provider receives a share of the total episode payment in proportion to the services they’ve billed
  - Pilot sites in Rockford, IL; Michigan; Minneapolis; Philadelphia; Utah

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## Not Just *Better* Acute Care, But *Reducing the Need for It*



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# Significant Reduction in Rate of Hospitalizations Possible

## Examples:

- 40% reduction in hospital admissions, 41% reduction in ER visits for exacerbations of COPD using in-home & phone patient education by nurses or respiratory therapists

J. Bourbeau, M. Julien, et al, "Reduction of Hospital Utilization in Patients with Chronic Obstructive Pulmonary Disease: A Disease-Specific Self-Management Intervention," *Archives of Internal Medicine* 163(5), 2003

- 66% reduction in hospitalizations for CHF patients using home-based telemonitoring

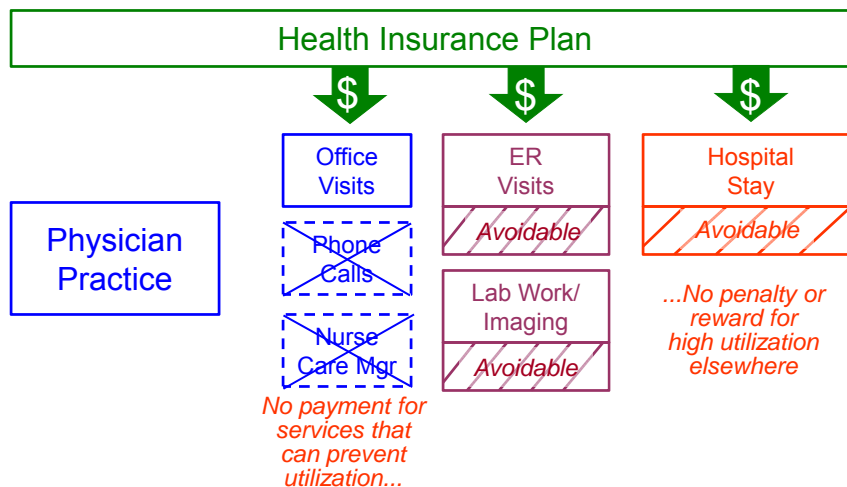
M.E. Cordisco, A. Benjaminovitz, et al, "Use of Telemonitoring to Decrease the Rate of Hospitalization in Patients With Severe Congestive Heart Failure," *American Journal of Cardiology* 84(7), 1999

- 27% reduction in hospital admissions, 21% reduction in ER visits through self-management education

M.A. Gadoury, K. Schwartzman, et al, "Self-Management Reduces Both Short- and Long-Term Hospitalisation in COPD," *European Respiratory Journal* 26(5), 2005

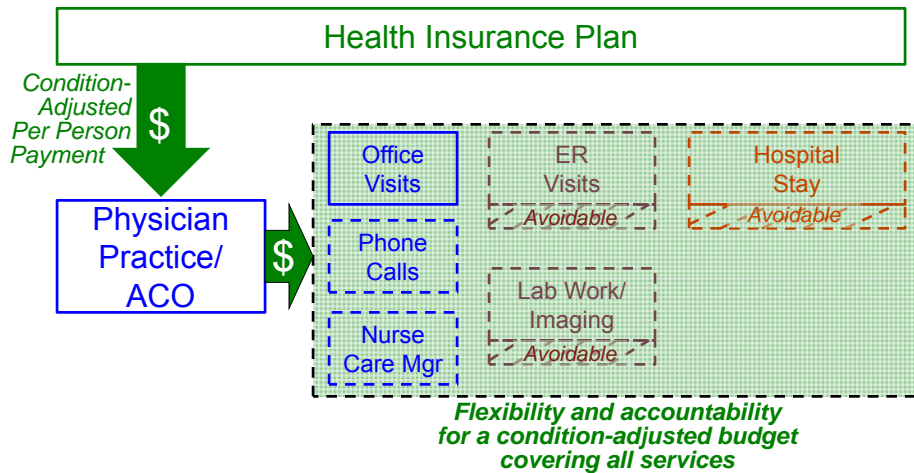
# We Don't Pay for the Things That Will Prevent Overutilization

## CURRENT PAYMENT SYSTEMS



# Global Payment Can Solve That, But It's a Big Jump from FFS

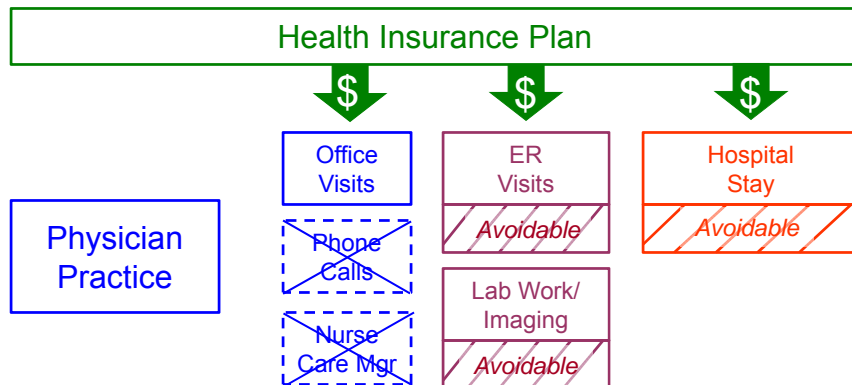
## FULL COMP. CARE/GLOBAL PAYMENT



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# What Might a Transitional Payment System Look Like?

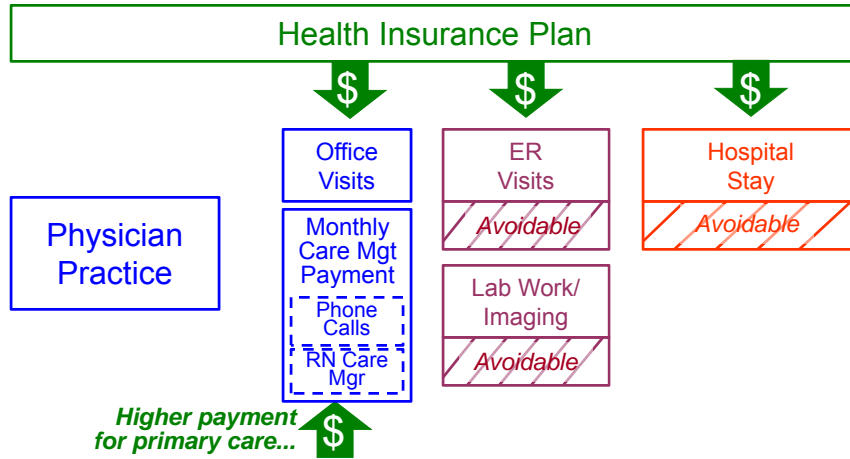
## CURRENT PAYMENT SYSTEMS



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# Typical Medical Home “Solution”: Pay More for Physician Services

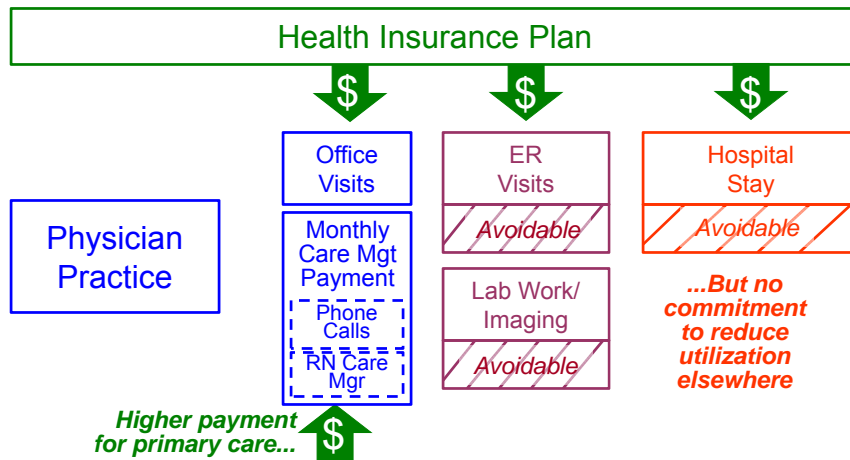
## (TYPICAL) MEDICAL HOME PROGRAM



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# Weakness: More \$ for Physicians, But Any Savings Elsewhere?

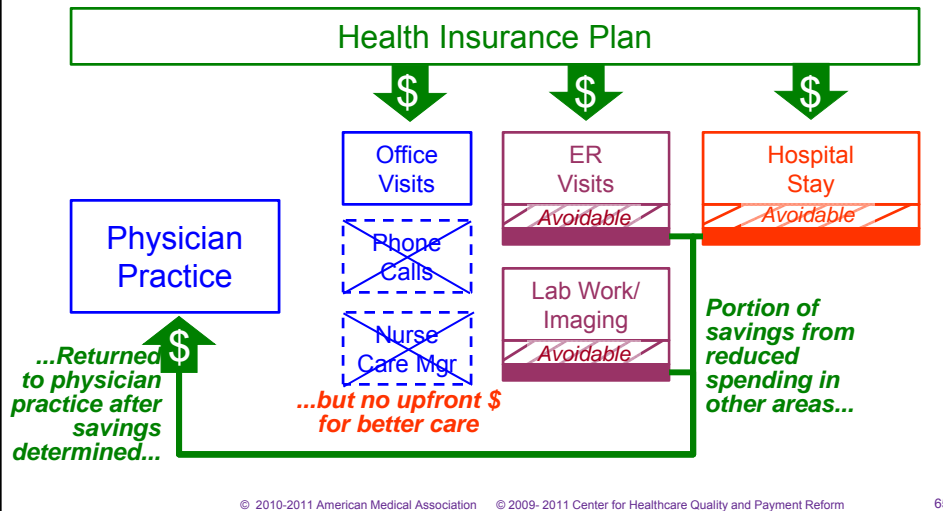
## (TYPICAL) MEDICAL HOME PROGRAM



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## Is Shared Savings the Answer?

### SHARED SAVINGS MODEL

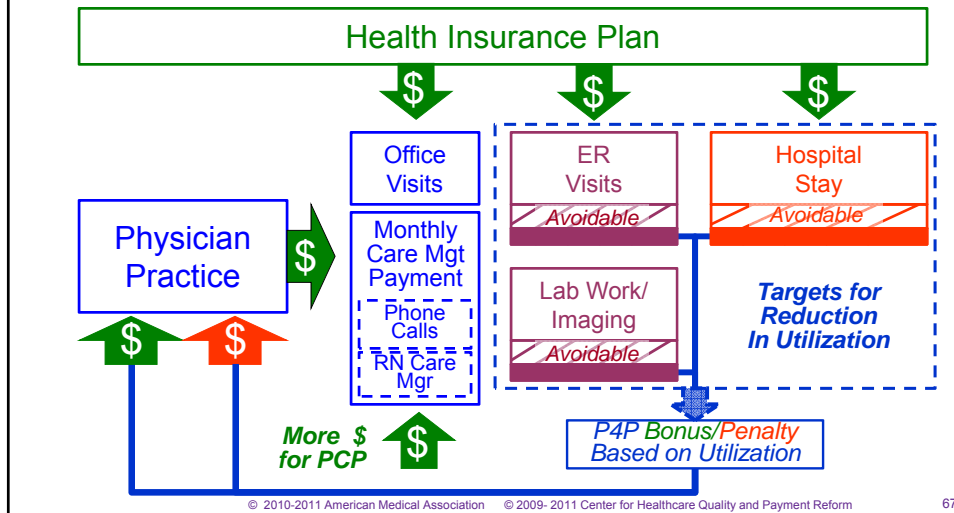


## Weaknesses of “Shared Savings”

- Provides no upfront money to enable physician practices to hire nurse care managers, install IT, etc.; additional funds, if any, come years after the care changes are made
- Requires TOTAL costs to go down in order for the physician practice to receive ANY increase in payment, even if the practice can't control all costs
- Gives more rewards to the *poor* performers who improve than the providers who've done well all along
- The underlying fee for service incentives continue; losing less (via shared savings) is still losing compared to FFS
- I.e., it's not really true *payment reform*

## Better Approach: Simulate Flexibility/Incentives of Global Pmt

### CARE MGT PAYMENT + UTILIZATION P4P



## Example: A Hypothetical Underpaid PCP Practice

### PRIMARY CARE PRACTICE

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

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

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

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## PCPs Could Reduce ER Expenses With Right Resources

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

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

PRIMARY CARE PRACTICE			HEALTH PLAN ER EXPENSES	
PCPs	4		ER Visits/1000	200
Patients/Physician	2,000		% Preventable	40%
PMPY Primary Care Cost	\$140		Per ER Visit	\$1,000
Annual Revenue	\$1,120,000		ER Visit Cost to Payer	\$640,000
Overhead Costs	\$400,000			
Physician Salary	\$180,000			
Cost of Nurse Practitioner	\$80,000		Reduction in Prev. ER Visits	40%
Other Costs	\$10,000		Savings	\$256,000
Total Costs	\$90,000			
Upfront Payment	\$90,000		Payment to Practice	\$90,000
			Net Savings to Payer	\$166,000

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## Payer Can Reward PCP for Results and Still Save Money

PRIMARY CARE PRACTICE			HEALTH PLAN ER EXPENSES	
PCPs	4		ER Visits/1000	200
Patients/Physician	2,000		% Preventable	40%
PMPY Primary Care Cost	\$140		Per ER Visit	\$1,000
Annual Revenue	\$1,120,000		ER Visit Cost to Payer	\$640,000
Overhead Costs	\$400,000			
Physician Salary	\$180,000			
Cost of Nurse Practitioner	\$80,000		Reduction in Prev. ER Visits	40%
Other Costs	\$10,000		Savings	\$256,000
Total Costs	\$90,000			
Upfront Payment	\$90,000		Payment to Practice	\$90,000
			Net Savings to Payer	\$166,000
Share of Savings	\$83,000		Share to Practice	50%
New Physician Salary	\$200,750		Net Savings to Payer	\$83,000
Increase in Phys. Salary	12%		% Savings to Payer	13%

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

PRIMARY CARE PRACTICE			HEALTH PLAN ER EXPENSES	
PCPs	4		ER Visits/1000	200
Patients/Physician	2,000		% Preventable	40%
PMPY Primary Care Cost	\$140		Per ER Visit	\$1,000
Annual Revenue	\$1,120,000		ER Visit Cost to Payer	\$640,000
Overhead Costs	\$400,000			
Physician Salary	\$180,000			
Cost of Nurse Practitioner	\$80,000		Reduction in Prev. ER Visits	40%
Other Costs	\$10,000		Savings	\$256,000
Total Costs	\$90,000			
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			Net Savings to Payer	\$166,000
Share of Savings	\$83,000		Share to Practice	50%
New Physician Salary	\$200,750		Net Savings to Payer	\$83,000
Increase in Phys. Salary	12%		% Savings to Payer	13%

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## But *Upfront* Payment Reform is Needed So Care Can Be Changed

PRIMARY CARE PRACTICE			HEALTH PLAN ER EXPENSES	
PCPs	4		ER Visits/1000	200
Patients/Physician	2,000		% Preventable	40%
PMPY Primary Care Cost	\$140		Per ER Visit	\$1,000
Annual Revenue	\$1,120,000		ER Visit Cost to Payer	\$640,000
Overhead Costs	\$400,000			
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Other Costs	\$10,000		Savings	\$256,000
Total Costs	\$90,000			
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New Physician Salary	\$200,750		Net Savings to Payer	\$83,000
Increase in Phys. Salary	12%		% Savings to Payer	13%

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## And Outcome Targets Need to Be Things Physicians Can Influence

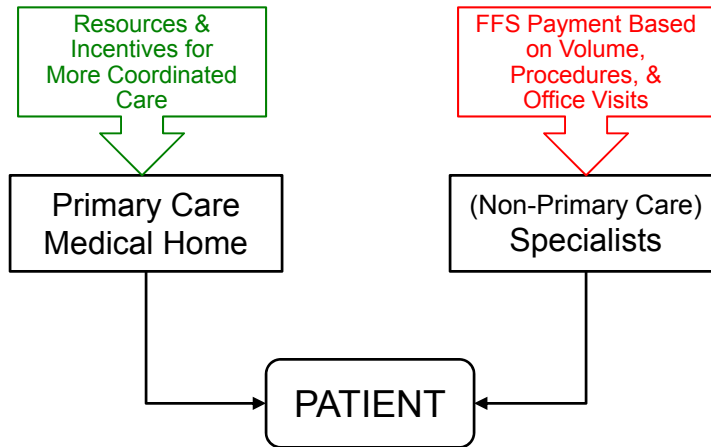
PRIMARY CARE PRACTICE			HEALTH PLAN ER EXPENSES	
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Patients/Physician	2,000		% Preventable	40%
PMPY Primary Care Cost	\$140		Per ER Visit	\$1,000
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Increase in Phys. Salary	12%		% Savings to Payer	13%

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## Example: Washington State Medical Home Pilot Program

- Payers will pay the Primary Care Practice an upfront PMPM Care Management Payment for all patients (\$2.50 first year, \$2.00 future years)
- Practice agrees to reduce rate of non-urgent ER visits and ambulatory care-sensitive hospital admissions by amounts which will generate savings for payers at least equal to the Care Management Payment (targets are practice specific)
- If a practice reduces ER visits and hospitalizations by more than the target amount, the payer shares 50% of the net savings (gross savings minus the PMPM) with the practice
- If a practice fails to meet its ER/hospitalization targets, the practice pays a penalty via a reduction in its FFS conversion factor equivalent to up to 50% of Care Management Payment

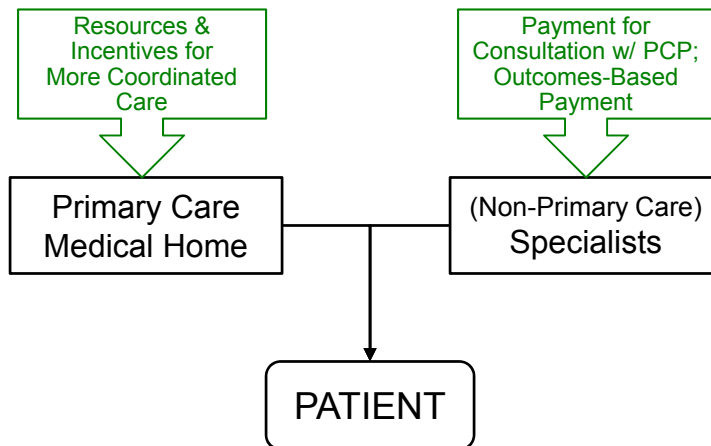
## Not Just PCPs, But The Medical Neighborhood, Too



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## Pay Both PCPs & Specialists for Outcomes & Coordination



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# Today: Underpaid PCPs, Underused Specialists, High Costs

## 500 Moderate/Severe Chronic Disease Patients

Uncoordinated Management Today				
	Per Visit	Visits/ Yr	Per Pt	Total
PCP	\$100	6	\$600	\$300,000
	Per Month	Mo/Yr	Per Pt	Total
Drugs	\$400	10	\$4,000	\$2,000,000
	Per Stay	Stays/ Yr	Per Pt	Total
Hospital	\$10,000	1	\$10,000	\$5,000,000
	Per Visit	Visits/ Yr	Per Pt	Total
Specialist	\$100	4	\$400	\$200,000
<b>Total</b>				<b>\$7,500,000</b>

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# Today: Underpaid PCPs, Underused Specialists, High Costs

## 500 Moderate/Severe Chronic Disease Patients

Uncoordinated Management Today				
	Per Visit	Visits/ Yr	Per Pt	Total
PCP	\$100	6	\$600	\$300,000
	Per Month	Mo/Yr	Per Pt	Total
Drugs	\$400	10	\$4,000	\$2,000,000
	Per Stay	Stays/ Yr	Per Pt	Total
Hospital	\$10,000	1	\$10,000	\$5,000,000
	Per Visit	Visits/ Yr	Per Pt	Total
Specialist	\$100	4	\$400	\$200,000
<b>Total</b>				<b>\$7,500,000</b>

**6.7% of the money goes to the physicians**

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# Pay PCPs & Specialists to Provide More Coordinated, Proactive Care

## 500 Moderate/Severe Chronic Disease Patients

Uncoordinated Management Today					Coordinated Management Tomorrow					
	Per Visit	Visits/ Yr	Per Pt	Total			Per Pt	Total	Change	
PCP	\$100	6	\$600	\$300,000	PCP		\$1,000	\$500,000	67%	
					Specialist		\$1,000	\$500,000	150%	
	Per Month	Mo/Yr	Per Pt	Total		Per Month	Mo Filled	Per Pt	Total	
Drugs	\$400	10	\$4,000	\$2,000,000	Drugs	400	12	\$4,800	\$2,400,000	20%
	Per Stay	Stays/ Yr	Per Pt	Total		Per Stay	Stays/ Yr	Per Case	Total	
Hospital	\$10,000	1	\$10,000	\$5,000,000	Hospital	\$10,000	0.75	\$7,500	\$3,750,000	-25%
	Per Visit	Visits/ Yr	Per Pt	Total						
Specialist	\$100	4	\$400	\$200,000						
<b>Total</b>				<b>\$7,500,000</b>	<b>Total</b>				<b>\$7,150,000</b>	<b>-5%</b>

Pay for Patient Care, Not Visits

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# Higher Medication Expenses, But Lower Hospital Costs

## 500 Moderate/Severe Chronic Disease Patients

Uncoordinated Management Today					Coordinated Management Tomorrow					
	Per Visit	Visits/ Yr	Per Pt	Total			Per Pt	Total	Change	
PCP	\$100	6	\$600	\$300,000	PCP		\$1,000	\$500,000	67%	
					Specialist		\$1,000	\$500,000	150%	
	Per Month	Mo/Yr	Per Pt	Total		Per Month	Mo Filled	Per Pt	Total	
Drugs	\$400	10	\$4,000	\$2,000,000	Drugs	400	12	\$4,800	\$2,400,000	20%
	Per Stay	Stays/ Yr	Per Pt	Total		Per Stay	Stays/ Yr	Per Case	Total	
Hospital	\$10,000	1	\$10,000	\$5,000,000	Hospital	\$10,000	0.75	\$7,500	\$3,750,000	-25%
	Per Visit	Visits/ Yr	Per Pt	Total						
Specialist	\$100	4	\$400	\$200,000						
<b>Total</b>				<b>\$7,500,000</b>	<b>Total</b>				<b>\$7,150,000</b>	<b>-5%</b>

Pay for Patient Care, Not Visits

Better Outcomes

Better Medication Compliance

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## Win-Win-Win Through PCP/Specialist Coordinated Mgt

### 500 Moderate/Severe Chronic Disease Patients

Uncoordinated Management Today					Coordinated Management Tomorrow					
	Per Visit	Visits/ Yr	Per Pt	Total			Per Pt	Total	Change	
PCP	\$100	6	\$600	\$300,000	PCP		\$1,000	\$500,000	67%	
					Specialist		\$1,000	\$500,000	150%	
	Per Month	Mo/Yr	Per Pt	Total		Per Month	Mo Filled	Per Pt	Total	
Drugs	\$400	10	\$4,000	\$2,000,000	Drugs	400	12	\$4,800	\$2,400,000	20%
	Per Stay	Stays/ Yr	Per Pt	Total		Per Stay	Stays/ Yr	Per Case	Total	
Hospital	\$10,000	1	\$10,000	\$5,000,000	Hospital	\$10,000	0.75	\$7,500	\$3,750,000	-25%
	Per Visit	Visits/ Yr	Per Pt	Total						
Specialist	\$100	4	\$400	\$200,000						
<b>Total</b>				<b>\$7,500,000</b>	<b>Total</b>				<b>\$7,150,000</b>	<b>-5%</b>

More Revenue for Docs Fewer Hospitalizations Lower Total Costs

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## Minnesota's DIAMOND Initiative

- Goal: improve outcomes for patients with depression
- Convened all payers in Minnesota (except for Medicare) to agree on common payment changes for PCPs & specialists
- Payment changes:
  - Support for a care manager in the primary care practice
  - Psychiatrists paid to consult with PCP on how to manage patient's care comprehensively, rather than patient having to see psychiatrist separately
- Result: Dramatic improvement in remission rate

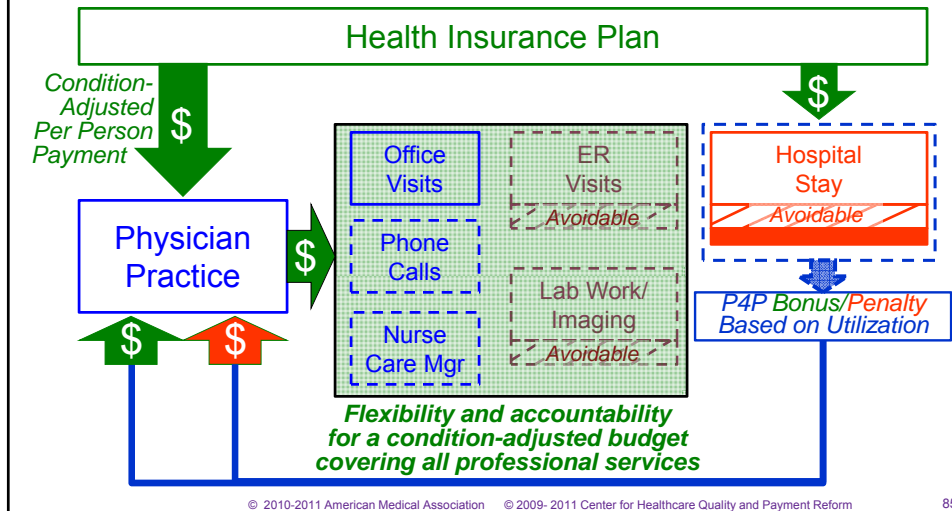
[http://www.icsi.org/health\\_care\\_redesign\\_/diamond\\_35953/](http://www.icsi.org/health_care_redesign_/diamond_35953/)

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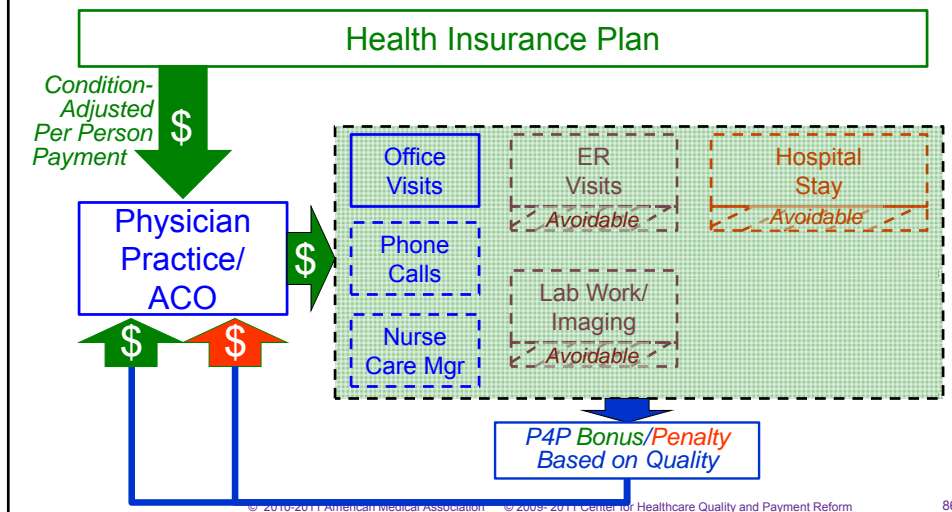
## Phase 2: More ACO-ness: Partial Global Payment

### PARTIAL GLOBAL PMT (Professional Svcs)

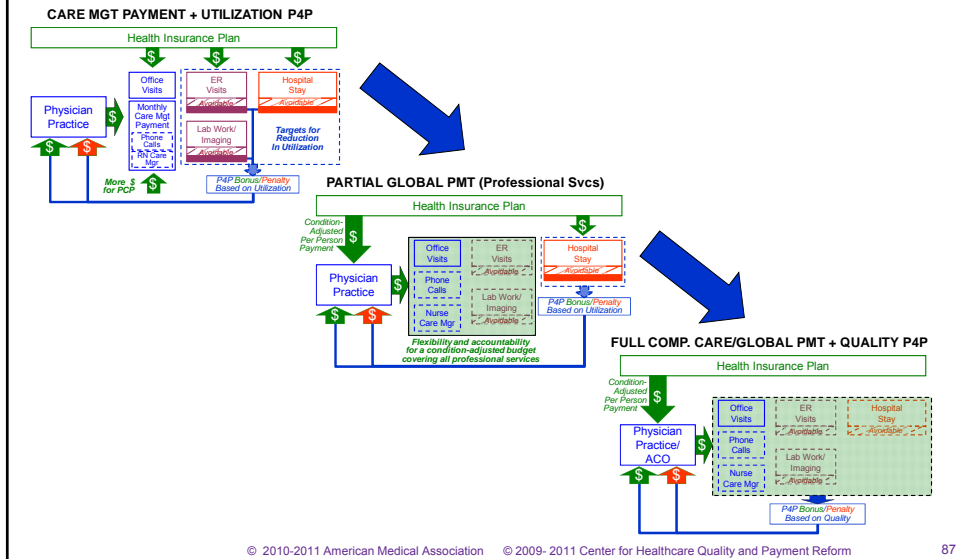


## And Then Transition to a Full Global Payment System

### FULL COMP. CARE/GLOBAL PAYMENT



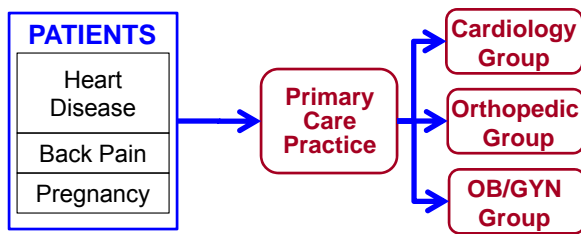
# Transitioning to Accountable Care Payment



# How Does All This Fit Into Accountable Care Organizations??

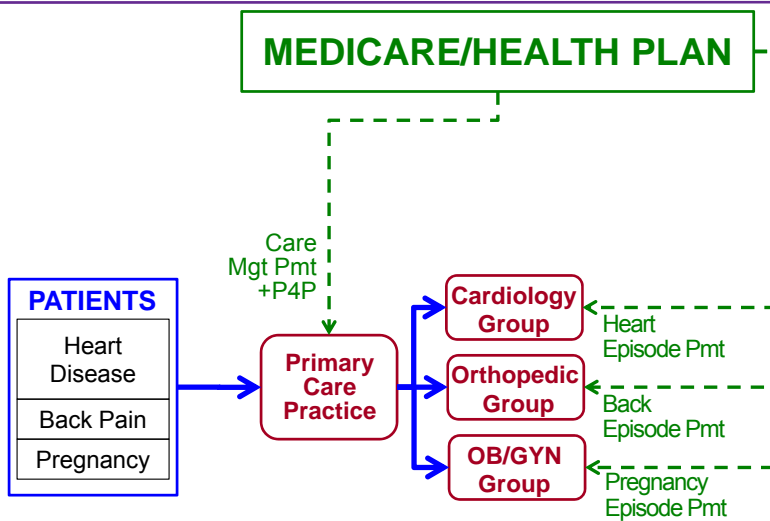


# If Physicians Wants to Better Manage A Patient Population...



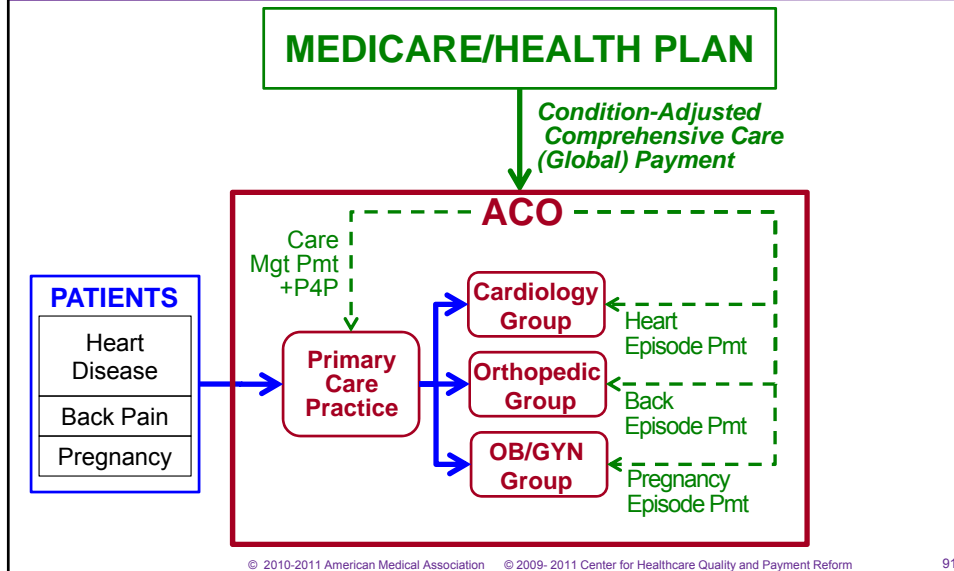
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# ...Should They Hope That Payers Will Make All the Right Payment Changes?



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## ...or Take a Single Payment & Work Out Internal Payments Themselves?



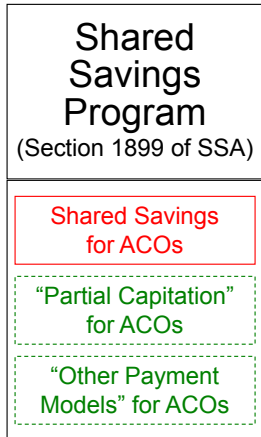
## How Will Medicare Pay for ACOs?

### Patient Protection and Affordable Care Act

Shared Savings Program  
(Section 1899 of SSA)

## Other Payment Options Authorized Under the ACO Section

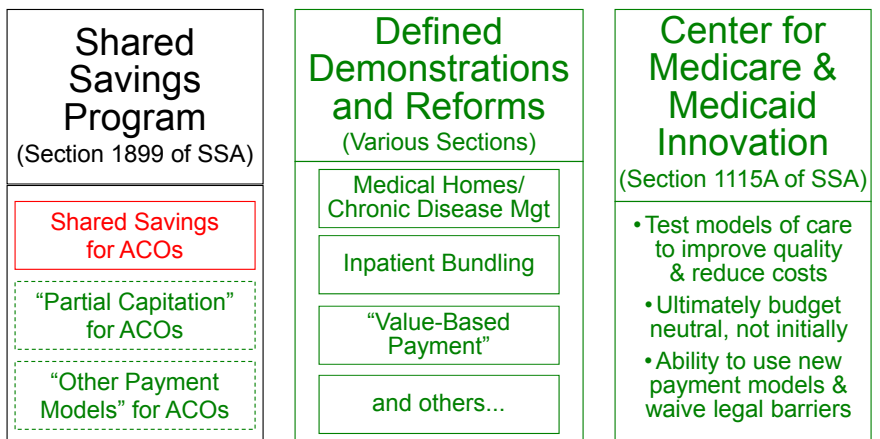
### Patient Protection and Affordable Care Act



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## Other Payment Reform Options Besides ACOs

### Patient Protection and Affordable Care Act



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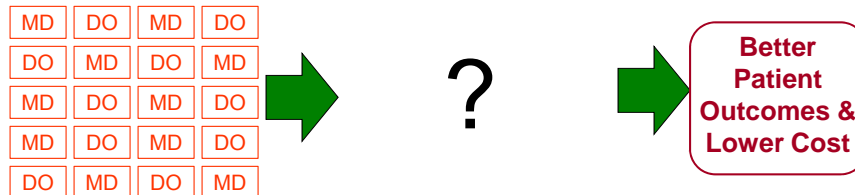
# Can Small Physician Practices Manage Accountable Payments?

- **Infrastructure/Services**

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

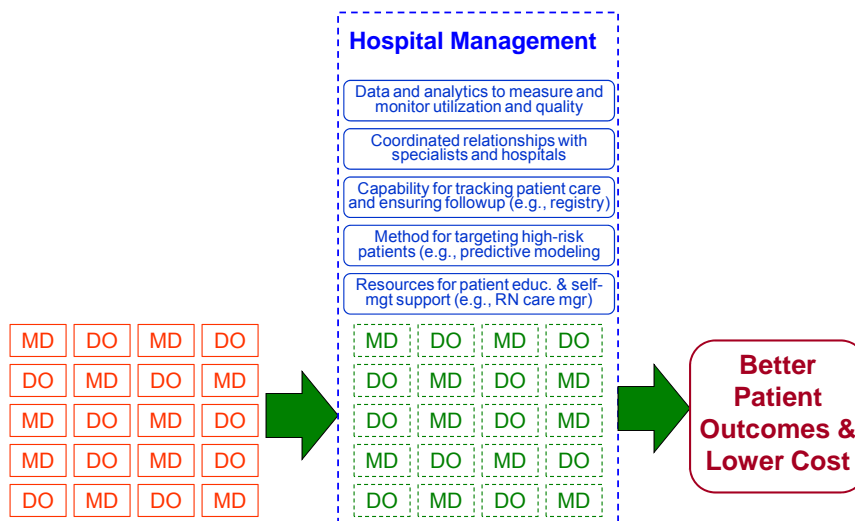
- **Quality/Cost Measurement**

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



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# One Solution: Hospitals Acquire Physician Practices



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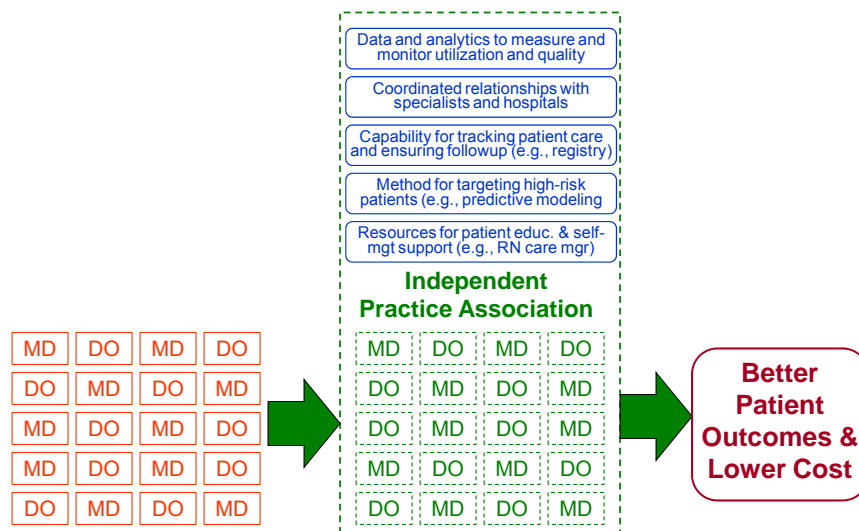
## Shared Savings Forces Hospitals To Consider Hiring Physicians

- Hospitals are not directly eligible for shared savings; all savings are attributed to primary care physicians
- Even if the hospital reduces readmissions, infections, complications, etc., it may receive no reward for doing so
- Reducing hospitalizations, ER visits, etc. will reduce the hospital's revenues, but the hospital may receive no share of the savings to help it cover its stranded fixed costs
- Consequently, hospitals may feel compelled to own physician practices, either to capture a portion of the shared savings revenue, or to prevent there from being any savings!

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## A Better Solution: Independent Physicians Working Together



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## Small, Independent Practices Can Work Together to Manage Global Pmt

- **Small Primary Care Practices Managing Global Payments**
  - Physician Health Partners (PHP) in Denver, CO is a management services organization that supports four separate IPAs (median size: 3 docs/practice). PHP accepts capitated risk-based contracts on behalf of the IPAs with both Medicare and commercial HMOs. [www.phpmcs.com](http://www.phpmcs.com)
- **Independent PCPs & Specialists Managing Global Payments**
  - Northwest Physicians Network (NPN) in Tacoma, WA is an IPA with 109 PCPs and 345 specialists in 165 practices (average size: 2.4 physicians/practice). NPN accepts full or partial risk capitation contracts, operates its own Medicare Advantage plan, and does third party administration for self-insured businesses. [www.npnwa.net](http://www.npnwa.net)
- **Joint Contracting by Physicians & Hospitals for Global Payments**
  - The Mount Auburn Cambridge IPA (MACIPA) and Mount Auburn Hospital jointly contract with three major Boston-area health plans for full-risk capitation. The IPA is independent of the hospital; they coordinate care with each other without any formal legal structure. [www.macipa.com](http://www.macipa.com)

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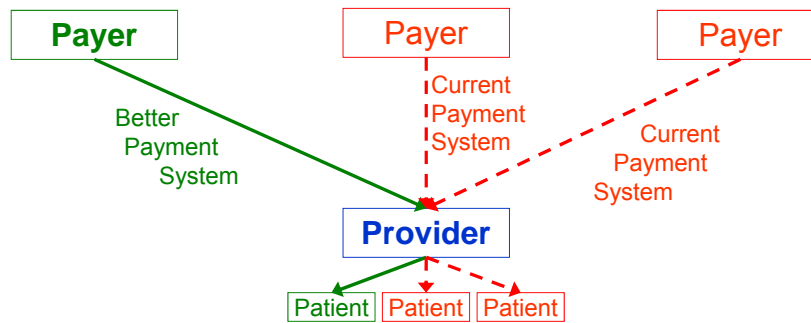
## PPACA/Medicare Definition of ACO Allows Physicians to Take the Lead

- |  |  |
|--|--|
| <ul style="list-style-type: none"> <li>• “ACO professionals” (physicians, nurse practitioners, etc.) in group practice arrangements</li> <li>• Networks of individual practices of ACO professionals</li> <li>• Partnerships or joint venture arrangements between hospitals and ACO professionals</li> <li>• Hospitals employing ACO professionals</li> <li>• Other groups of providers as the Secretary of HHS determines appropriate</li> </ul> | <ul style="list-style-type: none"> <li>• Willing to become accountable for the quality, cost, and overall care of assigned Medicare FFS beneficiaries</li> <li>• Legal structure to receive and distribute payments for shared savings</li> <li>• Sufficient number of primary care “ACO professionals”</li> <li>• Leadership and management structure; clinical and administrative systems</li> <li>• Processes to use EBM, report on quality, coordinate care</li> <li>• Patient-centeredness</li> </ul> |
|--|--|

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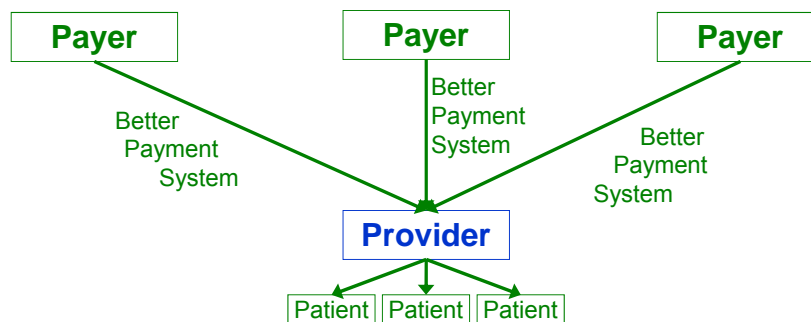
## Medicare is Not Enough -- Support Needed from a Private Payers, Too



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

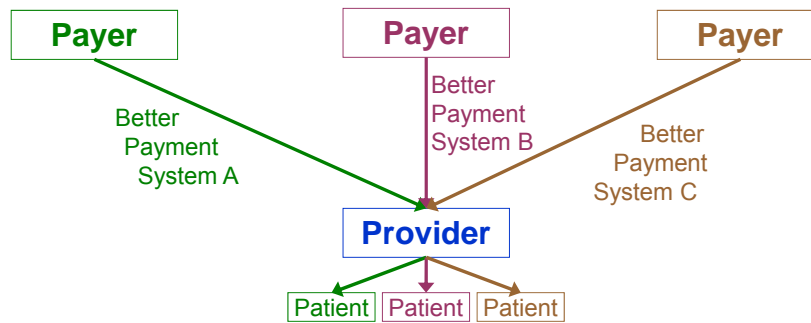
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## All Payers Need to Change to Enable Providers to Transform



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## Payers Need to Truly *Align* to Allow Focus on Better Care



Even if every payer's system is *better* than it was, if they're all *different*, providers will spend too much time and money on administration rather than care improvement

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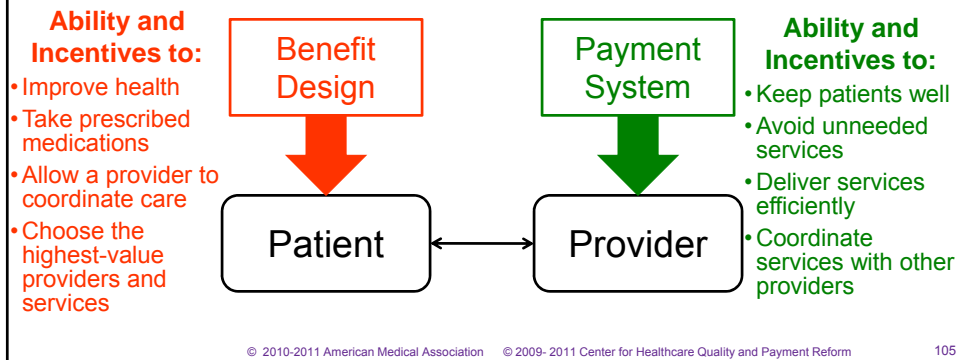
## Payer Coordination Is Beginning to Occur Around the Country

- Examples of Multi-Payer Payment Reforms:
  - Maine, Michigan, Minnesota, New York, North Carolina, Pennsylvania, Vermont, and Rhode Island all have multi-payer medical home initiatives with Medicare participating
  - Other states – Oregon, Washington – have multiple commercial health plans and Medicaid paying primary care practices to provide better support for patients to reduce hospitalizations, ER visits, etc.
- A Facilitator of Coordination is Needed
  - State Government (provides anti-trust exemption)
  - Non-profit Regional Health Improvement Collaboratives
- Medicare Needs to Participate in Local Projects as Well as Define its Own Demonstrations
  - Center for Medicare and Medicaid Innovation (CMMI) created under PPACA provides the opportunity for this

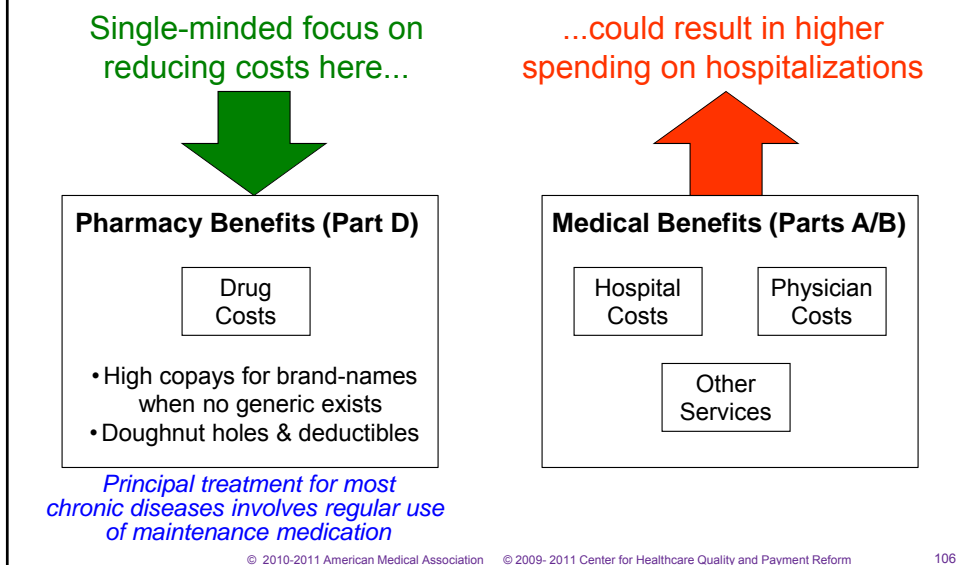
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## Benefit Design Changes Are Also Critical to Success



## Example: Importance of Coordinating Pharmacy & Medical Benefits



## Ensuring That Lower Cost ≠ Lower Quality

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

## Effective Quality Measurement and Reporting Needed

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

## Federal Measurement of Quality?

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

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## Community-Driven Quality Measurement

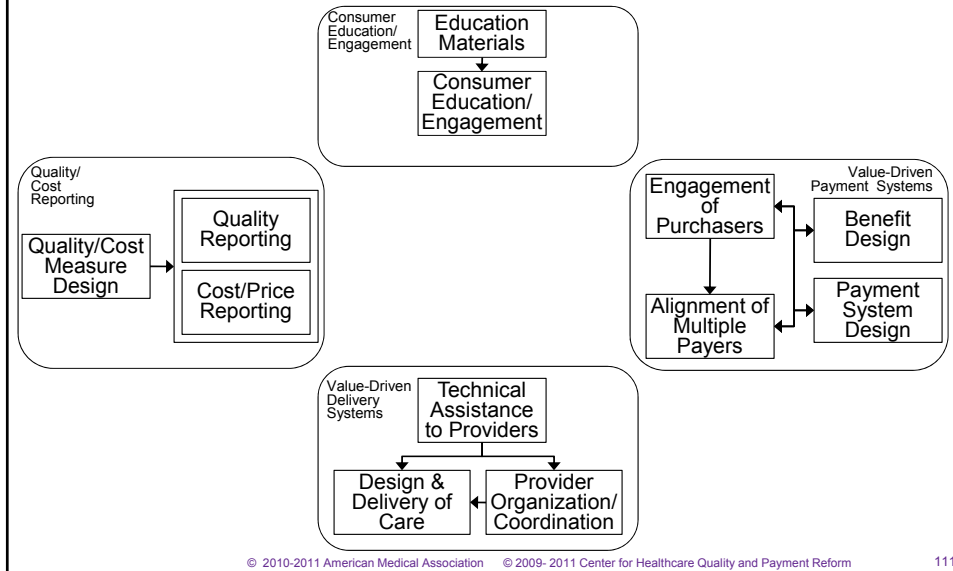
- **Concern:** Giving healthcare providers more accountability for costs reduces the incentives for overuse, but raises concerns about whether patients will get too little care
- **Solution:** Measure healthcare quality and include incentives for providers to maintain/improve quality as well as reduce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



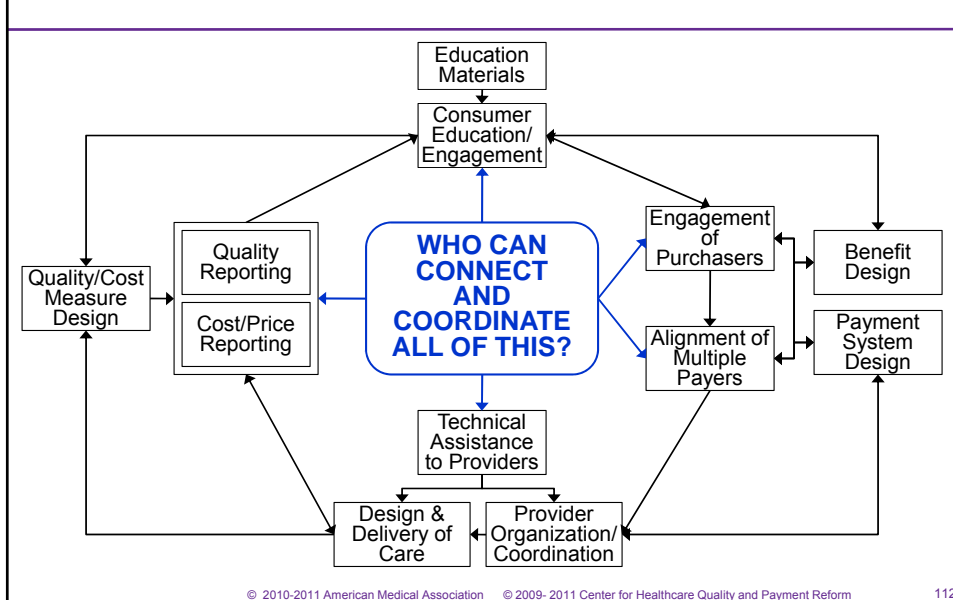
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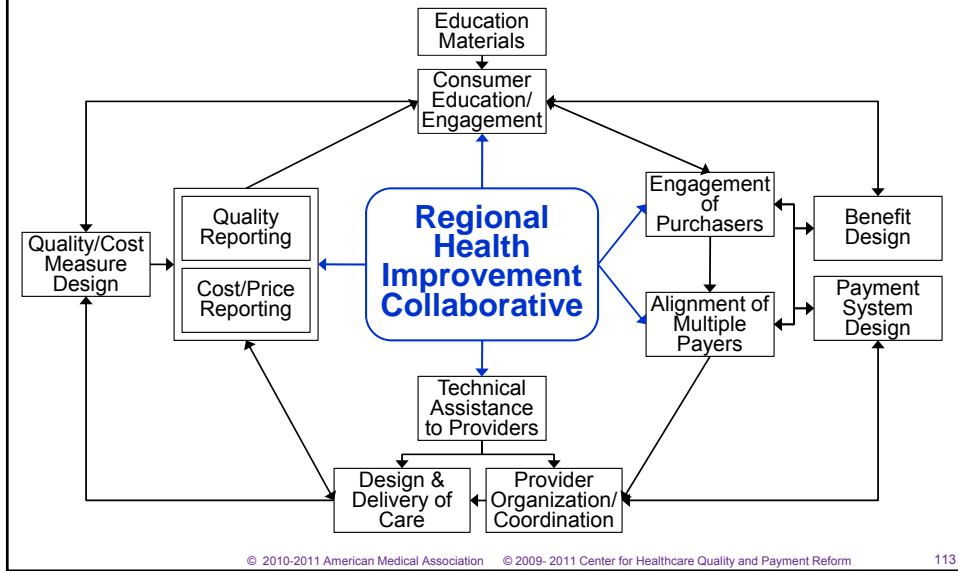
# Functions Needed for Healthcare Payment & Delivery Reform



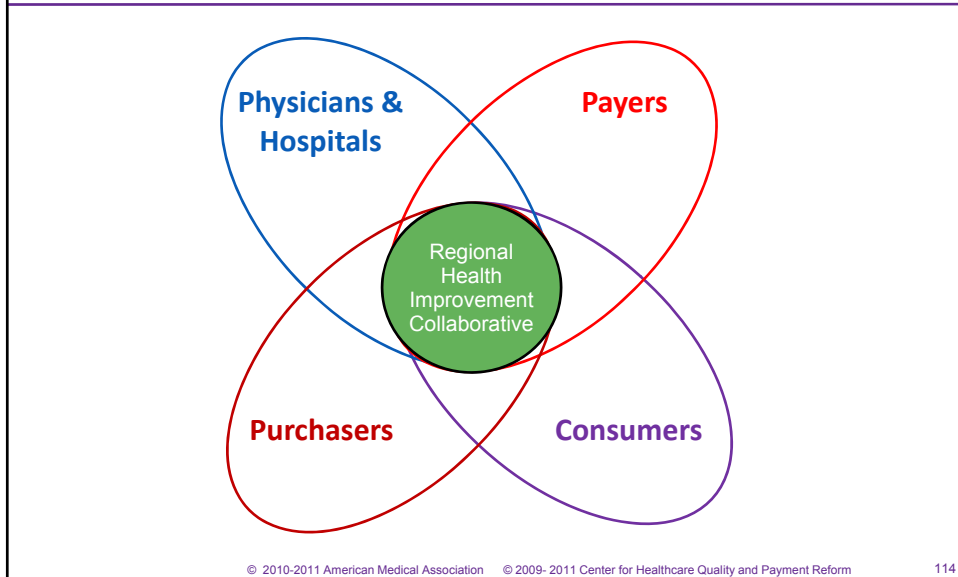
# Coordinated Support Needed



# The Role of Regional Health Improvement Collaboratives...



# ...With Active Involvement of Physicians and Other Stakeholders



## Growing Network of Regional Health Improvement Collaboratives

- Albuquerque Coalition for Healthcare Quality
- Aligning Forces for Quality – South Central PA
- Alliance for Health
- Better Health Greater Cleveland
- California Cooperative Healthcare Reporting Initiative
- California Quality Collaborative
- Finger Lakes Health Systems Agency
- Greater Detroit Area Health Council
- Health Improvement Collaborative of Greater Cincinnati
- Healthy Memphis Common Table
- Institute for Clinical Systems Improvement
- Integrated Healthcare Association
- Iowa Healthcare Collaborative
- Kansas City Quality Improvement Consortium
- Louisiana Health Care Quality Forum
- Maine Health Management Coalition
- Massachusetts Health Quality Partners
- Midwest Health Initiative
- Minnesota Community Measurement
- Minnesota Healthcare Value Exchange
- Nevada Partnership for Value-Driven Healthcare (HealthInsight)
- New York Quality Alliance
- Oregon Health Care Quality Corporation
- P2 Collaborative of Western New York
- Pittsburgh Regional Health Initiative
- Puget Sound Health Alliance
- Quality Counts (Maine)
- Quality Quest for Health of Illinois
- Utah Partnership for Value-Driven Healthcare (HealthInsight)
- Wisconsin Collaborative for Healthcare Quality
- Wisconsin Healthcare Value Exchange



**Network for Regional  
Healthcare Improvement**  
[www.NRHI.org](http://www.NRHI.org)

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## Moving to Accountable Care

- There is no one-size-fits-all solution to healthcare transformation; each region will need to actually make it happen in its own unique environment. The best federal policy will support regional innovation.
- Payment reform is necessary, but not sufficient. Delivery system reform, changes in benefit design, and effective quality measurement are also essential. Everything needs to focus on improving *outcomes*.
- Physicians need to take the lead by agreeing to take accountability for reducing costs without rationing, creating organizational structures that enable them to do so, and demanding the payment changes needed to support them.

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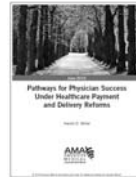
## For More Information:

**American Medical Association**  
*Payment Pathways*

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

*Health System Reform*

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



**Center for Healthcare Quality and Payment Reform**

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



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