Federal Health Care Reform Agenda and Strategy for Success

This material was prepared by HealthInsight as part of our work as the Beacon Community, under Cooperative Agreement #90BC00006 from the Office of the National Coordinator, Department of Health and Human Services.

IC³
A Beacon Community

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ABOUT OUR MISSION AND ROLE

HEALTHINSIGHT OVERVIEW

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Who is *HealthInsight*?

- Non-profit, community based organization with local governance in New Mexico, Nevada and Utah
- A recognized leader in:
  - Transparency and public reporting
  - Health information technology initiatives
  - Payment reform efforts
  - Human factors science research and application
  - Quality assurance activities
- A Medicare Quality Improvement Organization (QIO); an ONC Regional Extension Center (or subcontractor); an ONC Beacon Community; an AHRQ Chartered Value Exchange; an ATOP care management provider; an AF4Q Community in New Mexico; an EQRO contractor

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Alignment of Ends with Federal Agenda

**Triple Aim**
- Better health for the population
- Better care for individuals
- Lower cost through improvement

**HealthInsight Ends Policies**
- 1. Engaged public & patient
- 2. Improved health
- 3. High quality processes and outcomes
- 4. Responsible use of resources
- 5. Transparent system

**NQS Six Priorities**
- Enable healthy living (5)
- Safe care delivery (1)
- More affordable (6)
- Patients, families engaged (2)
- Effective prevention (4)
- Communication & care coordination (3)

**Supports All Areas**
- Alignment of Ends with Federal Agenda

**Improving care • connectivity • collaboration**
Local Nexus

• We **connect people** together in the community
• We **build will** for change in our community
• We **bring programs together** to minimize confusion, accelerate pace, and maximize impact
• We **identify gaps**, and design strategies to fill those gaps

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Key HIT Projects Supporting Care Coordination at HealthInsight

• REC Support for HIT adoption and meaningful use by small primary care practices
• QIO Physician Office and Care Transitions Work
• Beacon Community Program efforts to show the impact of advance HIT implementation on care management
• HIE development, partnership and support
• ATOP, initiative to prevent unnecessary hospitalizations among nursing home residents
Improved System Performance Relationships

Better Outcomes & Health, and Lower Costs

Sharing Clinical Data Across Providers & Care Settings

Using HIT for Care Coordination

Transparency & Continuous Feedback Support

Work Flow & Care Process Redesign

Consumer Engagement

Payment Alignment

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Engaged Community

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OVERVIEW OF THE SYSTEM

WHY DO WE NEED TO CHANGE?
“Every system is perfectly designed to get the results it gets”

Paul Batalden, M.D.
Overall Health System Performance

Source: Commonwealth Fund Scorecard on Local Health System Performance, 2012.

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Health Care Costs are the Core of the National Budget Problem

“Our health-care problem is our deficit problem. Nothing else even comes close.”

President Obama
September 2010
Medicare+Medicaid is Largest Driver of Future Federal Spending

Projected Increases in Federal Spending, 2010-2021

- Medicare + Medicaid
- Net Interest
- Social Security
- Other Mandatory Spending
- Defense
- Nondefense Discretionary Spending

Federal Spending in Billions

$2,500
$2,250
$2,000
$1,750
$1,500
$1,250
$1,000
$750
$500
$250
$0

$250
$500
$750
$1,000
$1,250
$1,500
$1,750
$2,000
$2,250
$2,500

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Healthcare Cost-Shifting Makes U.S. Businesses Uncompetitive

Public and Private Health Expenditures as a Percentage of GDP, U.S. and Selected Countries, 2008

Source: Organisation for Economic Co-operation and Development (2010), "OECD Health Data", OECD Health Statistics (database)
Notes: Data from Australia and Japan are 2007 data. Figures for Canada, Norway and Switzerland are OECD estimates. Numbers are PPP adjusted.
Huge Increases in Costs for Both Employers & Workers

Average Annual Contributions to Health Insurance Premiums
1999-2010

Employer Contribution
Worker Contribution

Employer Contribution More Than Doubled
Employee Contribution Nearly Tripled

Single Coverage 1999 $1,878 Single Coverage 2010 $4,150
Family Coverage 1999 $1,543 Family Coverage 2010 $9,773

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Health Care Costs Have Wiped Out Real Income Gains

Monthly Income for Typical U.S. Family of Four

- $970 for inflation
- $945 for health care
- $95 for spending
- $1910 more income

Source: "A Decade of Health Care Cost Growth Has Wiped Out Real Income Gains For an Average US Family," Health Affairs, September 2001
How Health Care Stole Your Pay Raise

Figure 3: Projected Annual Total Compensation and Compensation Net of Health Insurance Premiums

Source: CEA calculations.

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Improving care • connectivity • collaboration
Figure 3. Prevalence of Diagnosed Diabetes in the United States

Diagnosed (1960-1998) and Projected Diagnosed (2000-2050) Cases

Source: Data for 1960-1998 from the National Health Interview Survey, NCHS, CDC
What the Focus Should Be: How to Reduce Costs By *Improving Care*

Patients \rightarrow \text{REDUCING COSTS WITHOUT RATIONING} \rightarrow \text{Lower Costs}
Reducing Costs Without Rationing: Can It Be Done??

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Reducing Costs Without Rationing: Prevention and Wellness

Healthy Consumer

Continued Health

Health Condition

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Reducing Costs Without Rationing: Avoiding Hospitalizations

Healthy Consumer ➔ Continued Health ➔ No Hospitalization

Health Condition ➔ Acute Care Episode
Reducing Costs Without Rationing: Efficient, Successful Treatment

Healthy Consumer → Continued Health → Health Condition → No Hospitalization → Acute Care Episode → Efficient Successful Outcome

High-Cost Successful Outcome → Complications, Infections, Readmissions

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Reducing Costs Without Rationing Is Also Quality Improvement!

Healthy Consumer → Continued Health → No Hospitalization → Efficient Successful Outcome

- Health Condition
- Acute Care Episode
- Complications, Infections, Readmissions

Better Outcomes/Higher Quality
WE HAVE LOTS OF ROOM FOR REDESIGN

HOW BIG ARE THE OPPORTUNITIES?

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5-17% of Hospital Admissions Are Potentially Preventable

Source: AHRQ HCUP
More than a *Million* Preventable Errors & Adverse Events Annually

<table>
<thead>
<tr>
<th>Medical Error</th>
<th># Errors (2008)</th>
<th>Cost Per Error</th>
<th>Total U.S. Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressure Ulcers</td>
<td>374,964</td>
<td>$10,288</td>
<td>$3,857,629,632</td>
</tr>
<tr>
<td>Postoperative Infection</td>
<td>252,695</td>
<td>$14,548</td>
<td>$3,676,000,000</td>
</tr>
<tr>
<td>Complications of Implanted Device</td>
<td>60,380</td>
<td>$18,771</td>
<td>$1,133,392,980</td>
</tr>
<tr>
<td>Infection Following Injection</td>
<td>8,855</td>
<td>$78,083</td>
<td>$691,424,965</td>
</tr>
<tr>
<td>Pneumothorax</td>
<td>25,559</td>
<td>$24,132</td>
<td>$616,789,788</td>
</tr>
<tr>
<td>Central Venous Catheter Infection</td>
<td>7,062</td>
<td>$83,365</td>
<td>$588,723,630</td>
</tr>
<tr>
<td>Others</td>
<td>773,808</td>
<td>$11,640</td>
<td>$9,007,039,005</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>1,503,323</strong></td>
<td><strong>$13,019</strong></td>
<td><strong>$19,571,000,000</strong></td>
</tr>
</tbody>
</table>

Source: *The Economic Measurement of Medical Errors*, Milliman and the Society of Actuaries, 2010
Many Procedures Could Be Done for 80-90% Less Than Today

Table 5: Observed Prices for Selected High-Volume Medical DRGs by Severity of Illness, 2009

<table>
<thead>
<tr>
<th>APR-DRG and severity</th>
<th>Minimum price</th>
<th>Median price</th>
<th>Average price</th>
<th>Maximum price</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knee joint replacement (302)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Severity 1</td>
<td>$5,202</td>
<td>$21,241</td>
<td>$21,040</td>
<td>$50,726</td>
</tr>
<tr>
<td>Severity 2</td>
<td>$7,999</td>
<td>$21,887</td>
<td>$22,743</td>
<td>$66,901</td>
</tr>
<tr>
<td>Severity 3</td>
<td>$16,069</td>
<td>$28,173</td>
<td>$30,376</td>
<td>$59,252</td>
</tr>
<tr>
<td>Cesarean delivery (540)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Severity 1</td>
<td>$3,244</td>
<td>$7,598</td>
<td>$7,859</td>
<td>$15,915</td>
</tr>
<tr>
<td>Severity 2</td>
<td>$2,628</td>
<td>$8,718</td>
<td>$9,338</td>
<td>$26,424</td>
</tr>
<tr>
<td>Severity 3</td>
<td>$3,621</td>
<td>$11,389</td>
<td>$13,266</td>
<td>$26,018</td>
</tr>
</tbody>
</table>

10-Fold Difference
5-Fold Difference
$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
Many Other Savings Opportunities

- 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
- Moving procedures to outpatient settings
- Etc., etc., etc.
A QUICK LOOK AT THE FEDERAL EFFORTS

UNDERSTANDING HEALTH REFORM
Healthcare Redesign Principles

All gears must be turned to achieve the goals of the ACA and other health reform initiatives.
One Problem: Insurance

- 50 million people uninsured
- Costs rising
- Fragmented coverage and care
- Insurance designs leave gaps
  - don’t cover “pre-existing conditions”
  - lifetime and annual limits
  - drop people when they get sick
Possible Solutions?

Left

Single Payer
• big government
• “non-starter” in this political environment

Right

Tax Credits
• free market
• doesn’t solve all the problems
The ACA Solution

• Build on current system
  – Create new marketplace exchanges
  – Use existing programs
  – Mix of public and private

• Attempt to fix the problems
  – Reform the marketplace
  – Goal is to increase access and affordability

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The New Insurance System Under ACA

- 3 major coverage changes:
  - Reformed insurance markets to increase coverage
  - Individual responsibility to get coverage (mandate)
  - Help those who can’t afford insurance

All 3 needed to make it work
1. Reformed Insurance Market

• Can’t refuse people with pre-existing conditions (kids now, adults in 2014)
• Can’t drop you if you get sick
• No lifetime limit on benefits
• No annual limit on benefits (2014)
• Government oversight of premium rates and how premium dollars are spent
2. Individual Responsibility

• Everyone must have insurance (2014)
• Most expected to still obtain it from their employers
• State “exchanges”
  – easier to find information about plans
  – plans must meet standards
  – choices
$1 Billion Dollar Federal Investment in Building Exchanges

Total Federal Grants for Health Insurance Exchanges

Note: Grant totals include Planning grants for up to $1 million, Level One and Two Establishment grants, and Early Innovator grants.

*To date, the state’s Legislature has not approved spending some or all of the state’s awarded grant money.

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3. Help for those who can’t afford insurance

- Medicaid expanded
- Federal tax credits
  - Small businesses
  - Families earning up to 400% of federal poverty level (2014)
One Problem: Payment

• The current FFS system encourages volume, not value
• Current providers and payers have a large legacy investments and incentives to maintain the FFS system
• Changing the payment system will redistribute resources and will harm some providers and payers
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

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We Should Focus First on How to *Improve* Patient Care

**Contributors to Healthcare Costs**

**How Do We Help:**
- Patients Stay Well
- Avoid Unnecessary Surgery and Other Hospitalizations
- Eliminate Potentially Life-Threatening Errors and Safety Problems
- Reduce Costs of Procedures

**How Do We Limit:**
- New Technologies
- Higher-Cost Drugs
- Potentially Life-Saving Treatment
Current Payment Systems Reward Bad Outcomes, Not Better Health

Healthy Consumer

- Continued Health
- Health Condition
- No Hospitalization
- Acute Care Episode

Efficient Successful Outcome

High-Cost Successful Outcome

Complications, Infections, Readmissions

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Are There Better Ways to Pay for Health Care?

Healthy Consumer → Continued Health → Health Condition → No Hospitalization → Acute Care Episode → Efficient Successful Outcome

High-Cost Successful Outcome → Complications, Infections, Readmissions

$ → ?

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“Episode Payments” to Reward Value Within Episodes

Healthy Consumer → Continued Health → Health Condition → No Hospitalization → Acute Care Episode → Efficient Successful Outcome

$ A Single Payment For All Care Needed From All Providers in the Episode, With a Warranty For Complications

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Yes, a Health Care Provider Can Offer a Warranty

Geisinger Health System ProvenCare SM

– A single payment for an ENTIRE 90 day period including:
  • ALL related pre-admission care
  • ALL inpatient physician and hospital services
  • ALL related post-acute care
  • ALL care for any related complications or readmissions

– Types of conditions/treatments currently offered:
  • Cardiac Bypass Surgery
  • Cardiac Stents
  • Cataract Surgery
  • Total Hip Replacement
  • Bariatric Surgery
  • Perinatal Care
  • Low Back Pain
  • Treatment of Chronic Kidney Disease
Payment + Process Improvement = Better Outcomes, Lower Costs

ProvenCare® CABG Quality Clinical Outcomes - (18. mos)

<table>
<thead>
<tr>
<th></th>
<th>Before ProvenCare (n=132)</th>
<th>With ProvenCare (n=181)</th>
<th>% Improvement/Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>In hospital mortality</td>
<td>1.5 %</td>
<td>0 %</td>
<td>21 %</td>
</tr>
<tr>
<td>Patients with any complication (STS)</td>
<td>38 %</td>
<td>30 %</td>
<td>28 %</td>
</tr>
<tr>
<td>Patients with &gt;1 complication</td>
<td>7.6 %</td>
<td>5.5 %</td>
<td>17 %</td>
</tr>
<tr>
<td>Atrial fibrillation</td>
<td>23 %</td>
<td>19 %</td>
<td>17 %</td>
</tr>
<tr>
<td>Neurologic complication</td>
<td>1.5 %</td>
<td>0.6 %</td>
<td>60 %</td>
</tr>
<tr>
<td>Any pulmonary complication</td>
<td>7 %</td>
<td>4 %</td>
<td>43 %</td>
</tr>
<tr>
<td>Blood products used</td>
<td>23 %</td>
<td>18 %</td>
<td>22 %</td>
</tr>
<tr>
<td>Re-operation for bleeding</td>
<td>3.8 %</td>
<td>1.7 %</td>
<td>55 %</td>
</tr>
<tr>
<td>Deep sternal wound infection</td>
<td>0.8 %</td>
<td>0.6 %</td>
<td>25 %</td>
</tr>
<tr>
<td>Readmission within 30 days</td>
<td>6.9 %</td>
<td>3.8 %</td>
<td>44 %</td>
</tr>
</tbody>
</table>
It Can Be Done By Physicians, Not Just Health Systems

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

The Weakness of Episode Payment

Healthy Consumer → Continued Health

Health Condition → No Hospitalization

Acute Care Episode

Efficient Successful Outcome
- High-Cost Successful Outcome
- Complications, Infections, Readmissions

How do you prevent unnecessary episodes of care? (e.g., preventable hospitalizations for chronic disease, overuse of cardiac surgery, back surgery, etc.)
Comprehensive Care Payments
To Avoid Episodes

Healthy Consumer

Continued Health

Health Condition

No Hospitalization

Acute Care Episode

Efficient Successful Outcome

High-Cost Successful Outcome

Complications, Infections, Readmissions

$ Comprehensiver Care Payment or "Global" Payment

A Single Payment For All Care Needed For A Condition

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Total Cost of Care Defined

The Total Cost of Care describes dollars spent by health care purchasers for health care services.

**Health Care Purchaser Universe**
- Government
  - Medicare
  - Medicaid
  - Children’s Health Insurance Program
  - Other
- Private Insurers
- Employers
- Other Purchasers
- Patient out-of-pocket

**Total Cost of Care**
Includes payment for the comprehensive basket of health care services utilized by a patient or population.

**Example Service Providers**
- Hospitals
- Community Health Centers
- Ancillary Service Providers
- Other Services
What is Included in Total Cost of Care?

**Total Cost of Care includes the complete range of health care services**
For Medicare patients, including beneficiary contribution, the average total cost of care is ~$1,182 Per Beneficiary Per Month (“PBPM”) for the following basket of services:

**How is ~$1,182 PBPM Spent?**

- Inpatient $364
- Professional Fees $251
- Prescript. Drugs $231
- Outpat. $138
- SNF $81
- HH $58
- DME $29
- Hospice $30
- ESRD $20
- LTACH $15
- Rehab Hosp. $18
- Surgical $159
- Medical $161

*Source: Data adjusted from 2010 Medicare Fee for Service Claims for illustrative purposes.*

**Definitions**
- **ESRD:** End Stage Renal Disease
- **SNF:** Skilled Nursing Facility
- **HH:** Home Health
- **DME:** Durable Medical Equipment
- **LTACH:** Long Term Acute Care Hospital

Figures include ~20% more PBPM to account for patient contribution.
How Do You Compute Total Cost of Care?

In 2010, Medicare Part A and B, excluding beneficiary contribution, paid approximately $760 PBPM.

<table>
<thead>
<tr>
<th>Common Nomenclature</th>
<th>Expenditure Per Service</th>
<th>Services per 1,000 Benes.</th>
<th>TOTAL COST OF CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>UNIT COST “Price”</td>
<td>TOTAL UNITS “Volume”</td>
<td>ANNUAL COST FOR 1,000 BENES</td>
</tr>
<tr>
<td>Evals</td>
<td>$65</td>
<td>12,563 events</td>
<td>$818,735</td>
</tr>
<tr>
<td>Acute Inpatient</td>
<td>$10,350</td>
<td>326 admissions</td>
<td>$3,369,983</td>
</tr>
<tr>
<td>Inpatient Rehab.</td>
<td>$16,673</td>
<td>10 visits</td>
<td>$165,320</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td>$4,765,963</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td><strong>$9,120,000</strong></td>
</tr>
</tbody>
</table>
Isn't This Capitation? No – It’s Different

**CAPITATION (WORST VERSIONS)**

- No Additional Revenue for Taking Sicker Patients
- Providers Lose Money On Unusually Expensive Cases
- Providers Are Paid Regardless of the Quality of Care
- Provider Makes More Money If Patients Stay Well
- Flexibility to Deliver Highest-Value Services

**COMPREHENSIVE CARE PAYMENT**

- Payment Levels Adjusted Based on Patient Conditions
- Limits on Total Risk Providers Accept for Unpredictable Events
- Bonuses/Penalties Based on Quality Measurement
- Provider Makes More Money If Patients Stay Well
- Flexibility to Deliver Highest-Value Services

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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


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

Healthy Consumer

Continued Health

Health Condition

No Hospitalization

Acute Care Episode

Efficient Successful Outcome

High-Cost Successful Outcome

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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
  

• 66% reduction in hospitalizations for CHF patients using home-based telemonitoring
  
  M.E. Cordisco, A. Benjainovitz, 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
  
We Don’t Pay for the Things That Will Prevent Overutilization

CURRENT PAYMENT SYSTEMS

Health Insurance Plan

- $ Office Visits
- $ ER Visits
  - Avoidable
  - Lab Work/Imaging
    - Avoidable
- $ Hospital Stay
  - Avoidable

No payment for services that can prevent utilization...

...No penalty or reward for high utilization elsewhere

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Global Payment Can Solve That

FULL COMP. CARE/GLOBAL PAYMENT

Health Insurance Plan

Condition-Adjusted Per Person Payment

$ Physican Practice/ ACO

Office Visits
Phone Calls
Nurse Care Mgr

ER Visits
Avoidable
Lab Work/ Imaging
Avoidable
Hospital Stay
Avoidable

Flexibility and accountability for a condition-adjusted budget covering all services

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Payment Reform Efforts Depend on Patient, Family & Consumer Engagement
Contribution to Premature Death

Determinants of Health and Their Contribution to Premature Death
Adapted from McGinnis, et al.

- Behavioral Patterns, 40%
- Genetic Predisposition, 30%
- Health Care, 10%
- Social Circumstances
- Environmental Exposure, 5%

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In the Clinic ➔ Outside the Clinic

• A ratio problem: 60 versus 525,540 minutes
• How can we leverage technology to help patients succeed beyond the physician office?
• How can individuals take control of their own healthcare, and ultimately their own health?
• What can providers and plans do to help?
The PAM® anchors our health activation model & programs

Activation Spectrum

- **Level 1**: Disengaged and overwhelmed
  Individuals are passive and lack confidence. Knowledge is low, goal-orientation is weak, and adherence is poor. Their perspective: “My doctor is in charge of my health.”

- **Level 2**: Becoming aware, but still struggling
  Individuals have some knowledge, but large gaps remain. They believe health is largely out of their control, but can set simple goals. Their perspective: “I could be doing more.”

- **Level 3**: Taking action
  Individuals have the key facts and are building self-management skills. They strive for best practice behaviors, and are goal-oriented. Their perspective: “I’m part of my health care team.”

- **Level 4**: Maintaining behaviors and pushing further
  Individuals have adopted new behaviors, but may struggle in times of stress or change. Maintaining a healthy lifestyle is a key focus. Their perspective: “I’m my own advocate.”

Increasing Level of Activation

- 10-20% of the population
- 20-35% of the population
- 20-30% of the population
- 20-30% of the population

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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

Payment System

Ability and Incentives to:

- Keep patients well
- Avoid unneeded services
- Deliver services efficiently
- Coordinate services with other providers

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Lack of Effective Incentives for Value-Based Choice by Patients

- Copays, Co-insurance, and High Deductibles can discourage patients from getting preventive treatments they need.
High Cost-Sharing on Drugs May *Increase* Total Spending

Single-minded focus on reducing costs here...

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

...could result in higher spending on hospitalizations

**Pharmacy Benefits**

- Drug Costs

**Medical Benefits**

- Hospital Costs
- Physician Costs
- Other Services

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

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Lack of Effective Incentives for Value-Based Choice by Patients

• Copays, Co-insurance, and High Deductibles can discourage patients from getting preventive treatments they need

• Copays, Co-insurance, and High Deductibles do little to encourage patients to be cost-conscious in choosing among high-cost providers and services
Where Will You Get Your Knee Replaced?

Knee Joint Replacement

<table>
<thead>
<tr>
<th>Consumer Share of Surgery Cost</th>
<th>Price #1</th>
<th>Price #2</th>
<th>Price #3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$23,000</td>
<td>$28,000</td>
<td>$33,000</td>
</tr>
</tbody>
</table>
## Copayment?
Use High Price Provider

### Knee Joint Replacement

<table>
<thead>
<tr>
<th>Consumer Share of Surgery Cost</th>
<th>Price #1 $23,000</th>
<th>Price #2 $28,000</th>
<th>Price #3 $33,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,000 Copayment:</td>
<td>$1,000</td>
<td>$1,000</td>
<td>$1,000</td>
</tr>
</tbody>
</table>

**$1,000 Copayment: $1,000 ✓**
Coinsurance?

Use High Price Provider

Knee Joint Replacement

<table>
<thead>
<tr>
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<td>$1,000</td>
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<td>$1,000</td>
</tr>
<tr>
<td>10% Coinsurance w/$2,000 OOP Max:</td>
<td>$2,000</td>
<td>$2,000</td>
<td>$2,000</td>
</tr>
</tbody>
</table>
# High Deductible?

Use High Price Provider

## Knee Joint Replacement

<table>
<thead>
<tr>
<th>Consumer Share of Surgery Cost</th>
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</tr>
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<td>10% Coinsurance w/$2,000 OOP Max:</td>
<td>$2,000</td>
<td>$2,000</td>
<td>$2,000</td>
</tr>
<tr>
<td>$5,000 High Deductible</td>
<td>$5,000</td>
<td>$5,000</td>
<td>$5,000</td>
</tr>
</tbody>
</table>
Pay the Difference in Price? Use the High-Value Provider

Knee Joint Replacement

<table>
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<tr>
<th>Consumer Share of Surgery Cost</th>
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<tr>
<td>10% Coinsurance w/$2,000 OOP Max</td>
<td>$2,000</td>
<td>$2,000</td>
<td>$2,000</td>
</tr>
<tr>
<td>$5,000 Deductible</td>
<td>$5,000</td>
<td>$5,000</td>
<td>$5,000</td>
</tr>
<tr>
<td>Highest-Value (Reference Pricing):</td>
<td><strong>$0</strong> ✓</td>
<td>$5,000</td>
<td>$10,000</td>
</tr>
</tbody>
</table>

*Improving care • connectivity • collaboration*
### Blue Cross/Blue Shield of MA Hospital Choice Cost-Share

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Low-Cost Hospitals</th>
<th>High-Cost Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP</td>
<td>$20</td>
<td>$20</td>
</tr>
<tr>
<td>SPC</td>
<td>$35</td>
<td>$35</td>
</tr>
<tr>
<td>Inpatient Hospital</td>
<td>$500</td>
<td>$1500*</td>
</tr>
<tr>
<td>Outpatient Hospital Day Surgery</td>
<td>$250</td>
<td>$1250</td>
</tr>
<tr>
<td>High Tech Radiology</td>
<td>$50</td>
<td>$500</td>
</tr>
<tr>
<td>Laboratory</td>
<td>$0</td>
<td>$35</td>
</tr>
<tr>
<td>X-Rays/Other Imaging Tests</td>
<td>$0</td>
<td>$100</td>
</tr>
<tr>
<td>PT/OT/ST</td>
<td>$35</td>
<td>$70</td>
</tr>
</tbody>
</table>

*LOWER INPATIENT COPAY APPLIES IF EMERGENCY ADMISSION*
Today: Care is Designed Around the Provider, Not the Patient

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Today: Many Barriers to Patient Adherence & Care Coordination

- Lack of Transportation
- Multiple Days Off Work
- Services Unavailable or Not Affordable

NON-MEDICAL SUPPORT (e.g., weight loss)

PCP OFFICE/MEDICAL HOME

SPECIALIST OFFICE

LAB FOR TESTING

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Is It Any Wonder The Patients Gravitate to More Convenience?

PATIENT

- EMERGENCY ROOM
- URGENT CARE CENTER
- PCP OFFICE/MEDICAL HOME
- SPECIALIST OFFICE
- LAB FOR TESTING
- NON-MEDICAL SUPPORT (e.g., weight loss)

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Or That Employers Are Trying to Create Their Own Systems?

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Flexible Payment Allows More Radical Care Redesign

Single, Flexible, Comprehensive Care Payment

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One Problem: Delivery Design

• The current system is designed around providers, not patients
• The current system is inefficient
• The current system is fragmented
• The current system focuses on recovery, not on prevention and management of disease
Quality can be measured and improved at multiple levels

Community
- Population-based denominator
- Multiple ways to define denominator, e.g., county, HRR
- Applicable to all providers

Practice setting
- Denominator based on practice setting, e.g., hospital, group practice

Individual physician
- Denominator bound by patients cared for
- Applies to all physicians
- Greatest component of a physician's total performance

- Three levels of measurement critical to achieving three aims of National Quality Strategy
- Measure concepts should "roll up" to align quality improvement objectives at all levels
- Patient-centric, outcomes oriented measures preferred at all three levels
- The "five domains" can be measured at each of the three levels

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How Will Change Actually Happen?

- There is no “silver bullet”
- We must apply many incentives
- We must show successful alternatives
- We must offer intensive supports
  - Help providers with the painstaking work of improvement
- We must learn how to scale and spread successful interventions

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The Innovation Center Mission
Accelerate Transformation

Identify, Test, Evaluate and Scale New Models

“The purpose of the Center is to test innovative payment and service delivery models to reduce program expenditures under Medicare, Medicaid, and CHIP...while preserving or enhancing the quality of care furnished.”

• **Opportunity to “scale up”:** The HHS Secretary has the authority to expand successful models to the national level

• **Resources:** $10 billion funding for FY2011 through 2019

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CMS CMMI: The Federal $10 Billion Investment in Payment & System Redesign

- Medicare Shared Savings Model ACO Initiative
- Medicare Advanced Payment Model ACO Initiative
- Medicare Pioneer ACO Initiative
- Bundled Payments for Care Improvement Initiative
- Comprehensive Primary Care Initiative
- FQHC Primary Practice Demonstration
- Independence at Home Demonstration
- Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents
- Medicaid Emergency Psychiatric Demonstration
- Medicaid Incentives for the Prevention of Chronic Disease
- State Demonstrations to Integrate Care for Dual Eligibles
- Community-based Care Transitions Program
- Partnership for Patients
- Innovation Advisors Program
- Innovation Awards Program

Where Medicare Is Going: Pioneer ACO Payment Models

<table>
<thead>
<tr>
<th>PAYMENT MODEL</th>
<th>YEAR 1</th>
<th>YEAR 2</th>
<th>YEAR 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core</td>
<td>Shared Savings/Loss</td>
<td>Shared Savings/Loss</td>
<td>•50% FFS/Shared Risk</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>•50% Capitation (Parts A&amp;B)</td>
</tr>
<tr>
<td>Option A</td>
<td>Shared Savings/Loss</td>
<td>Shared Savings/Loss</td>
<td>•50% FFS/Shared Risk</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>•50% Capitation (Parts A&amp;B)</td>
</tr>
<tr>
<td>Option B</td>
<td>Shared Savings/Loss</td>
<td>Shared Savings/Loss</td>
<td>•50% FFS/Shared Risk</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>•50% Capitation (Parts A&amp;B)</td>
</tr>
<tr>
<td>Alternative 1</td>
<td>Shared Savings</td>
<td>Shared Savings/Loss</td>
<td>•Shared Risk (Part A)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>•100% Capitation (Part B) with 3-6% Discount</td>
</tr>
<tr>
<td>Alternative 2</td>
<td>Shared Savings/Loss</td>
<td>Shared Savings/Loss</td>
<td>•100% Capitation (Part A&amp;B) with 3-6% Discount</td>
</tr>
</tbody>
</table>
## ACO Quality Measures

<table>
<thead>
<tr>
<th>ACO Quality Domain</th>
<th>ACO Quality Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient/Caregiver Experience</strong></td>
<td>• CAHPS Measures (7)</td>
</tr>
<tr>
<td><strong>Care Coordination/Patient Safety</strong></td>
<td>• Risk-Adjusted All-Cause Readmissions</td>
</tr>
<tr>
<td></td>
<td>• Ambulatory Care Sensitive Admits (2)</td>
</tr>
<tr>
<td></td>
<td>• PCPs Using EHRs</td>
</tr>
<tr>
<td></td>
<td>• Medication Reconciliation</td>
</tr>
<tr>
<td></td>
<td>• Screening for Fall Risk</td>
</tr>
<tr>
<td><strong>Preventive Health</strong></td>
<td>• Immunizations (2)</td>
</tr>
<tr>
<td></td>
<td>• Cancer Screening (2)</td>
</tr>
<tr>
<td></td>
<td>• Depression Screening</td>
</tr>
<tr>
<td></td>
<td>• Weight Screening</td>
</tr>
<tr>
<td></td>
<td>• Tobacco Cessation</td>
</tr>
<tr>
<td></td>
<td>• Blood Pressure Screening</td>
</tr>
<tr>
<td><strong>At Risk Population</strong></td>
<td>• Diabetes Control (6)</td>
</tr>
<tr>
<td></td>
<td>• Hypertension (1)</td>
</tr>
<tr>
<td></td>
<td>• Coronary Artery Disease (4)</td>
</tr>
<tr>
<td></td>
<td>• Heart Failure</td>
</tr>
<tr>
<td>YES (Maybe)</td>
<td>NO (Maybe)</td>
</tr>
<tr>
<td>-------------</td>
<td>------------</td>
</tr>
<tr>
<td>• Creates an (additional) financial incentive for providers, particularly physicians, to improve quality of care</td>
<td></td>
</tr>
<tr>
<td>• Creates a financial incentive to reduce overuse of care (at least in Medicare)</td>
<td></td>
</tr>
<tr>
<td>• Encourages PCPs, specialists, hospitals, post-acute care providers, and others to coordinate care</td>
<td></td>
</tr>
<tr>
<td>• Could lead to consolidation of small providers and increase commercial prices</td>
<td></td>
</tr>
<tr>
<td>• Could encourage cost-shifting to private payers</td>
<td></td>
</tr>
<tr>
<td>• Could divert attention from important cost reduction and quality improvement efforts already underway</td>
<td></td>
</tr>
<tr>
<td>• Could weaken support for locally-based quality measurement initiatives and other multi-stakeholder efforts</td>
<td></td>
</tr>
</tbody>
</table>

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Will Providers in Your Community Want to Be an ACO?

YES (Maybe)
- Opportunity to get bonuses for reducing utilization, with no risk of penalty if costs go up (under Track 1 model)
- Physician Groups, Independent Practice Associations, Physician-Hospital Organizations, and Integrated Systems are all eligible, so no mergers or consolidations are needed
- Formula favors regions that currently have below-average costs

NO (Maybe)
- Doesn’t change the underlying payment system
- Most savings will come from hospitals, and shared savings may not offset losses
- Patients will be assigned retrospectively based on statistical utilization, not based on patient choice
- Providers have no control over where patients get care
- Savings only shared for 3 years, then starting point is reset to zero
Design of a Triple Aim Enterprise

Define “Quality” from the perspective of an individual member of a defined population

The “Triple Aim”

Health care  Public health  Social services

System-Level Metrics

Individuals and families
Definition of primary care
Integration Social Capital Capability Building
Per capita cost reduction
Prevention and Health promotion

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Dr. Deming’s Profound Knowledge

Initial Steps of Leadership

1. Define the boundaries of the system
2. Define the aim of the system

The job of management is to optimize the system
The Boundaries of the System

Aim: Optimize the System

1. Nation
2. State
3. Community
4. Integrated Delivery System
5. Hospital-Medical Group
6. Service Line
7. Department

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The need for a comprehensive strategy to navigate the corridor.

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Where are we going?

- Care delivery system will need to accommodate more patients and sicker patients.
- New models of care and innovation needed to address cost/capacity/quality issues.
- Patient at the center and a new focus on care outside clinic walls.
- Payment models will continue to change; more accountability for outcomes, less focus on activities.
“Every system is perfectly designed to get the results it gets.”

Paul Batalden, M.D.