CENTER FOR HEALTHCARE QUALITY & PAYMENT REFORM

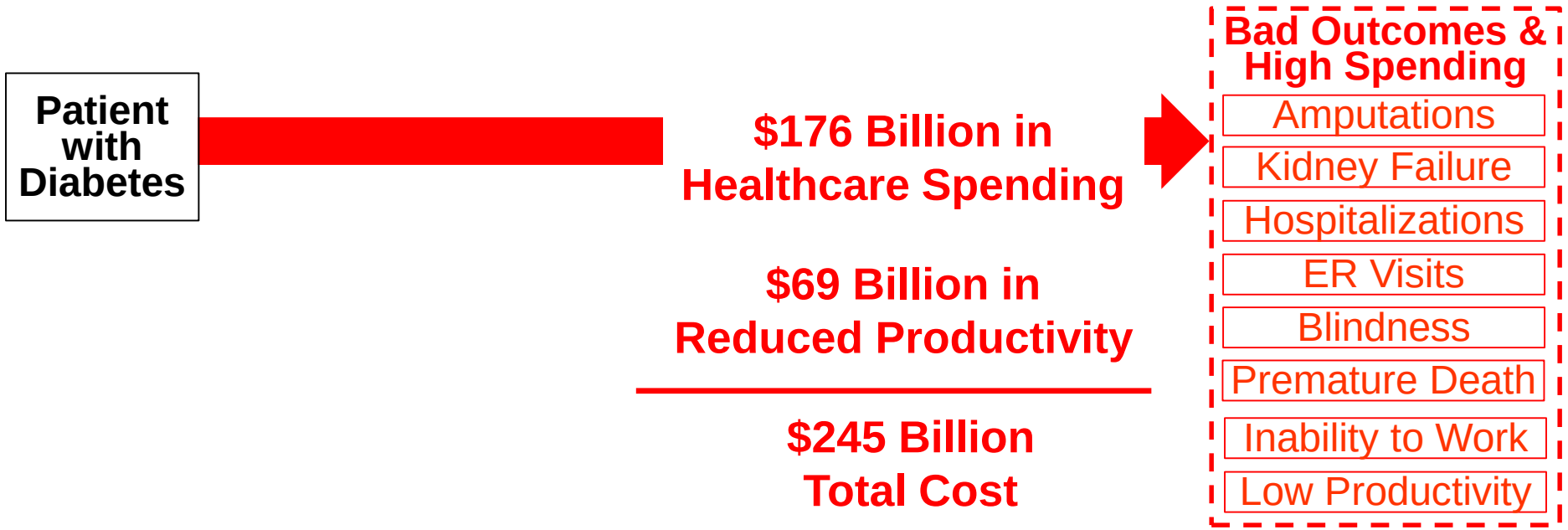
REDESIGNING HEALTHCARE PAYMENT AND DELIVERY FOR HIGHER QUALITY, LOWER COST CARE OF PATIENTS WITH DIABETES

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

www.CHQPR.org

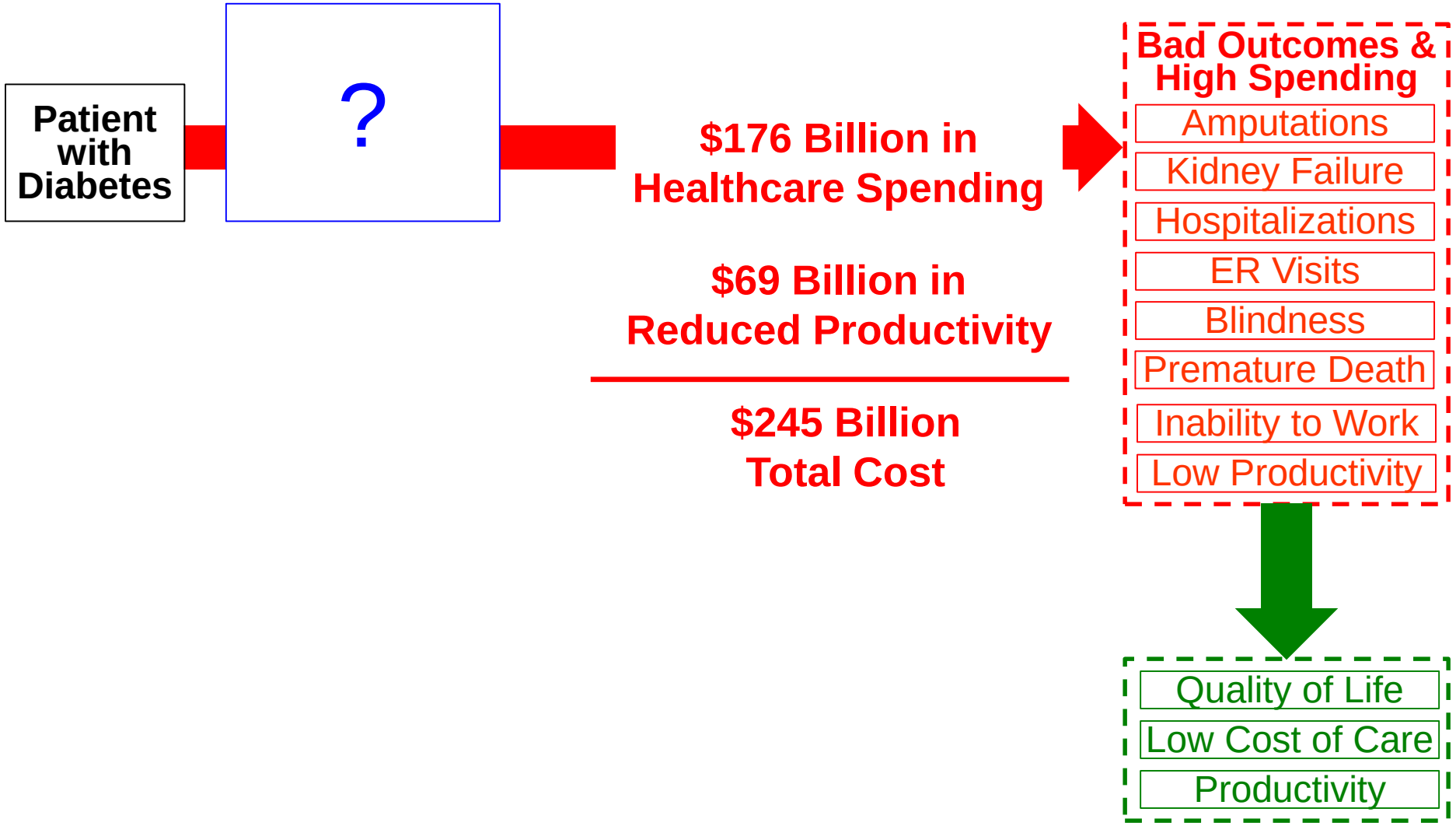
The Problem of Diabetes

A Quarter-Trillion Dollar Impact on the Economy

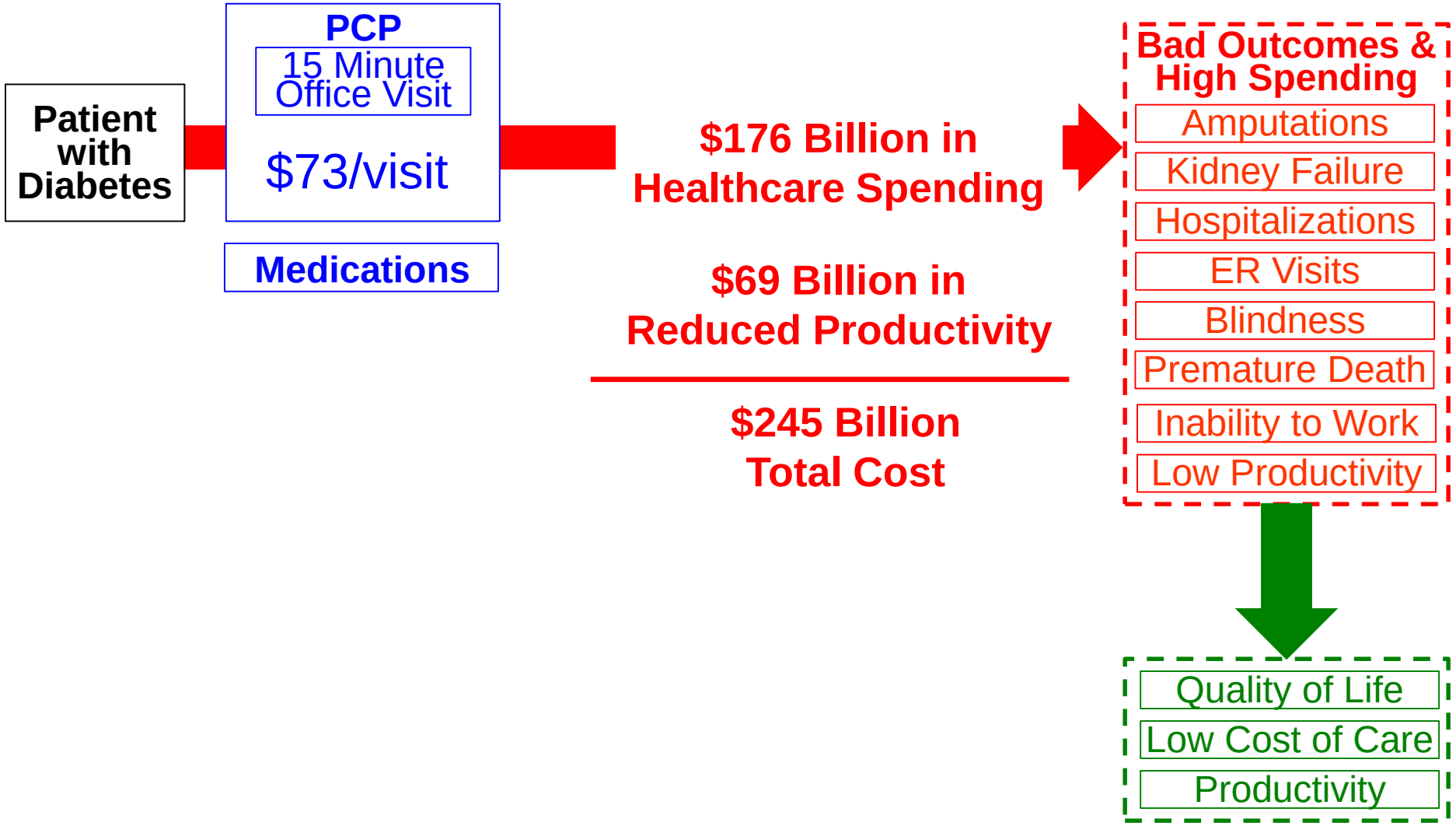


Source:
"Economic Costs of Diabetes in the U.S. in 2012,"
Diabetes Care (Volume 36)
April 2013

What's America's Strategy for Addressing This Problem?



Occasional 15 Minute Visits With Overworked PCPs



With Limited Time & Resources, Is It Surprising Quality is Low?

Patient with Diabetes

PCP

15 Minute Office Visit

$73/visit

Medications

Quality Metrics

- Blood Sugar
- Cholesterol
- Blood Pressure
- Tobacco Use
- Aspirin Use
- Eye Exams
- Kidney Exams

D5 <40%

Source: Average D5 Composite Measures in Cincinnati and Minnesota

Bad Outcomes & High Spending

- Amputations
- Kidney Failure
- Hospitalizations
- ER Visits
- Blindness
- Premature Death
- Inability to Work
- Low Productivity

- Quality of Life
- Low Cost of Care
- Productivity

Why Don't PCPs Do a Better Job?

Patient with Diabetes

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- Low Cost of Care
- Productivity

Source: Average D5 Composite Measures in Cincinnati and Minnesota

More Time With Patients Cuts Total Revenues to PCP Practice

Patient with Diabetes

PCP

15 Minute Office Visit

~~Longer Office Visit~~

20 minutes per patient
@ $73 Level 3 E&M=
25% Less Revenue

Medications

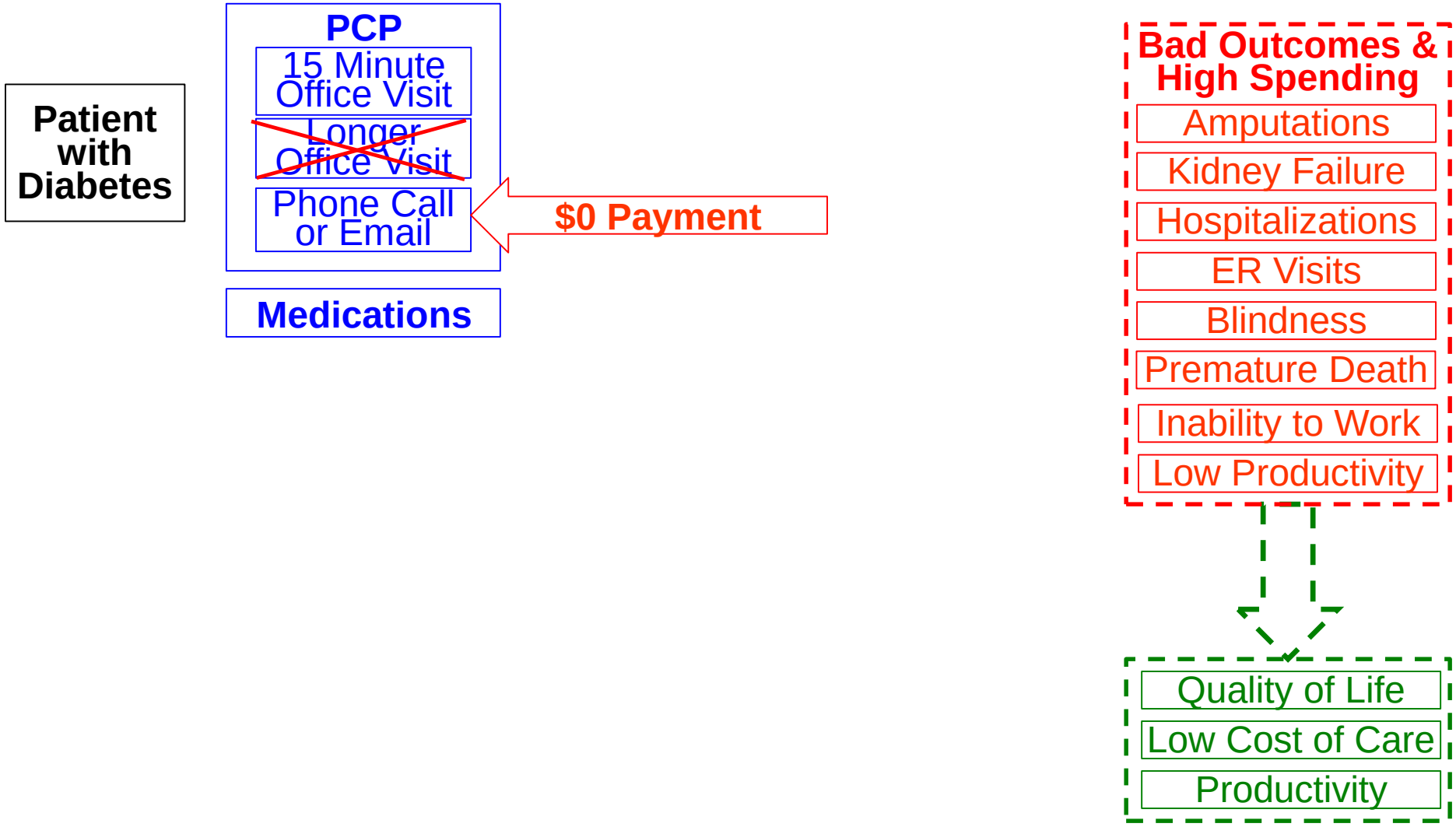
25 minutes per patient
@ $108 Level 4 E&M=
11% Less Revenue

Bad Outcomes & High Spending

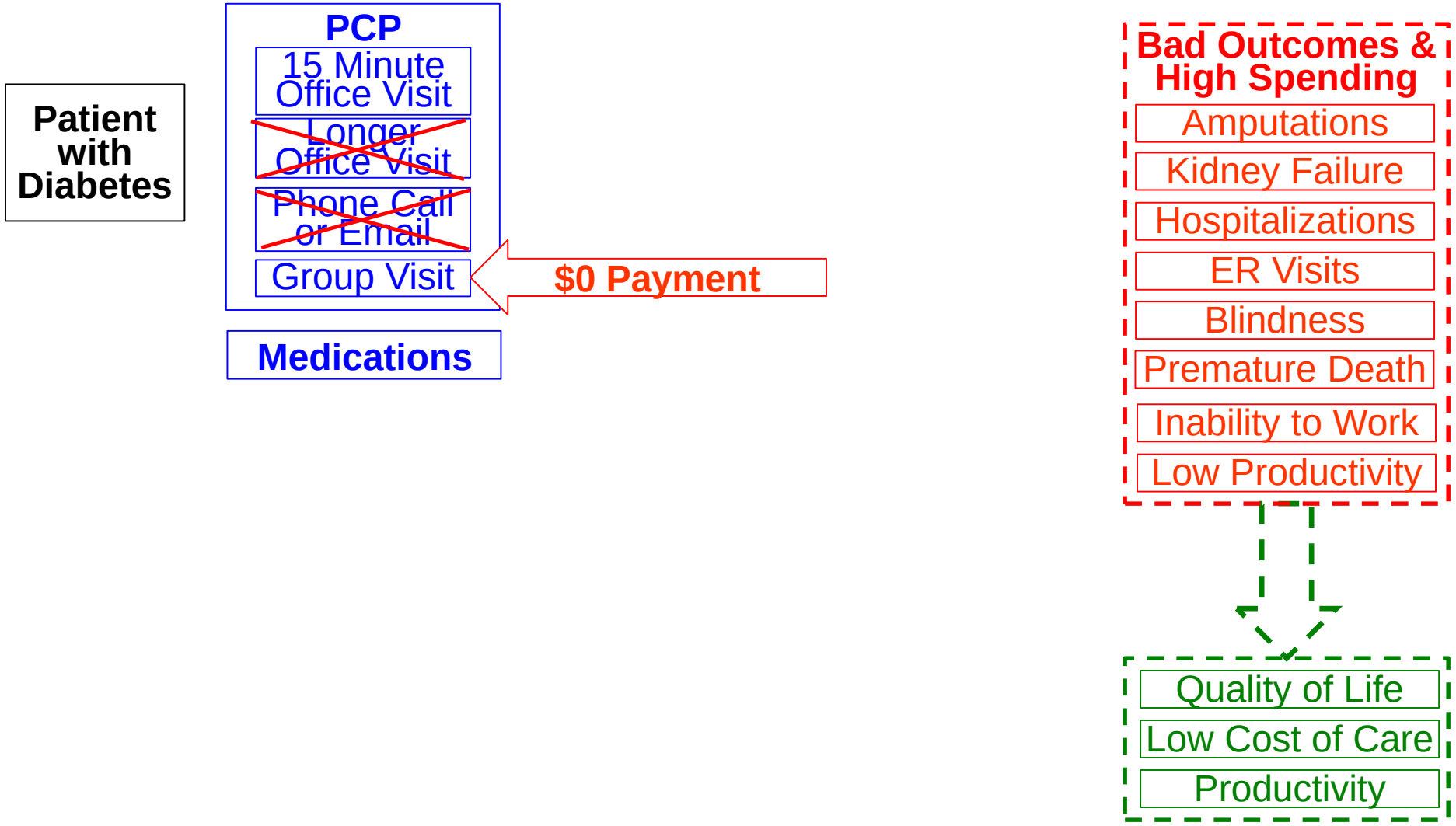
- Amputations
- Kidney Failure
- Hospitalizations
- ER Visits
- Blindness
- Premature Death
- Inability to Work
- Low Productivity

- Quality of Life
- Low Cost of Care
- Productivity

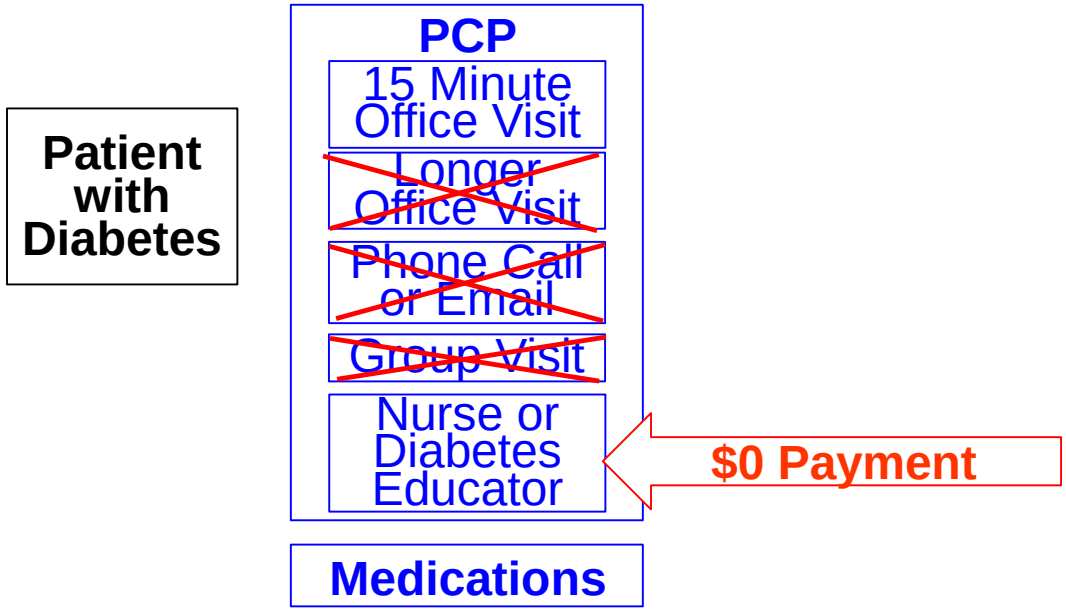
Proactive Outreach to Patients to Improve Quality?



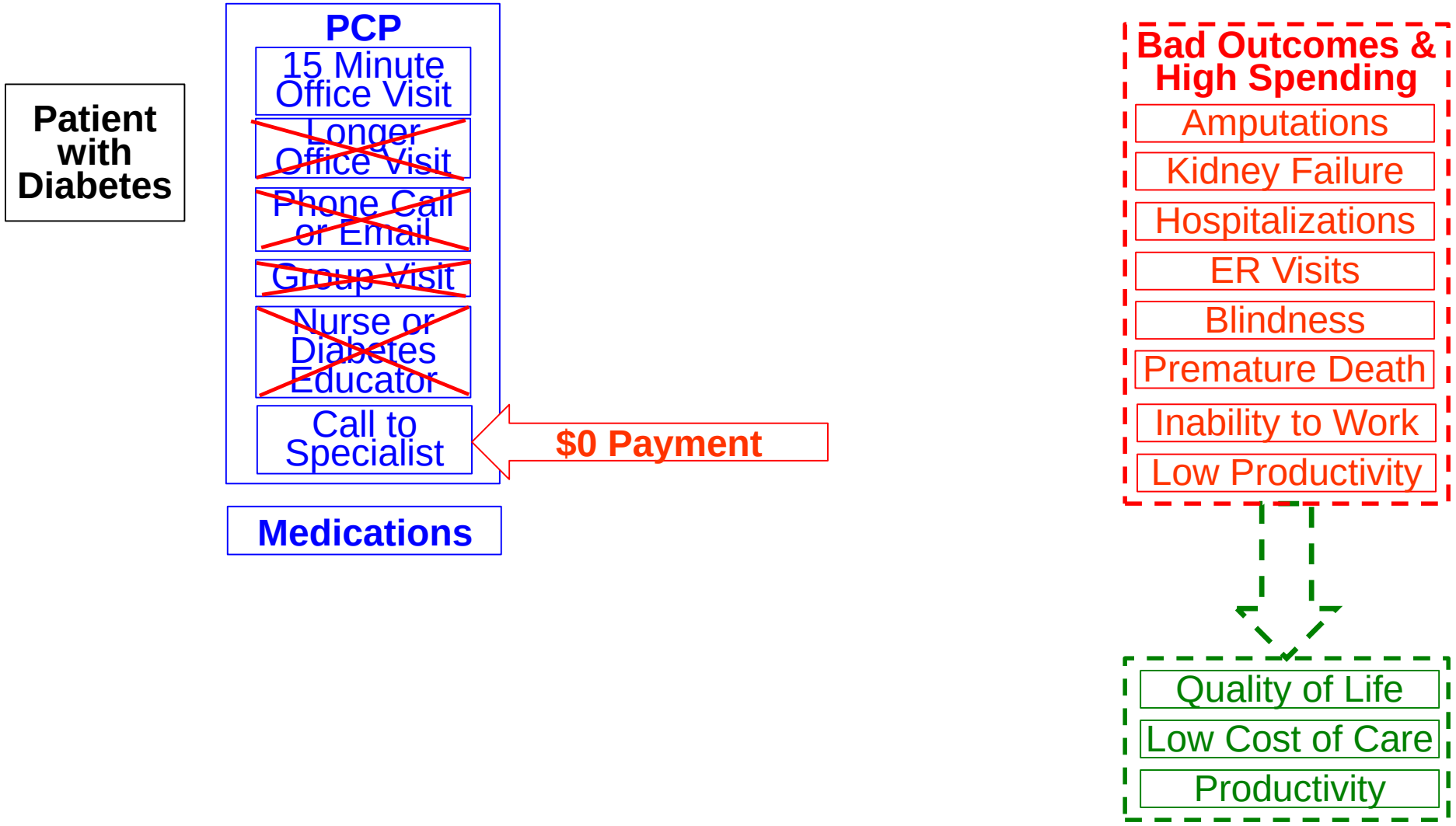
Group Visits to Deliver Care at Lower Cost?



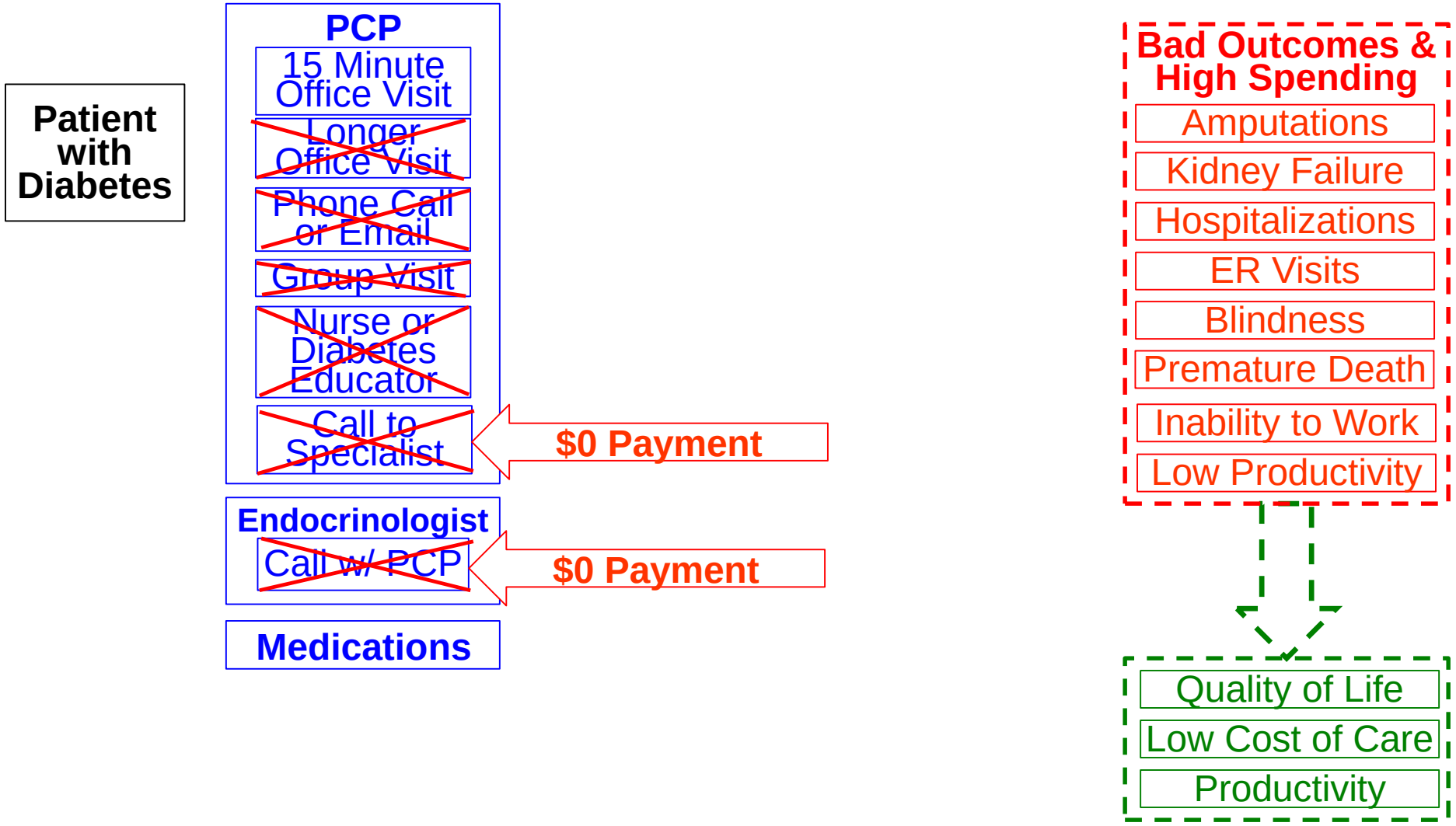
Hire a Nurse/Diabetes Educator to Help Patients Manage Health?



Call an Endocrinologist to Help With Complex Patients?



No Payment for Coordination of PCPs and Specialists



Payers Do Pay for *Office* Visits with Endocrinologists….

Patient with Diabetes

PCP

- 15 Minute Office Visit
- ~~Longer Office Visit~~
- ~~Phone Call or Email~~
- ~~Group Visit~~
- ~~Nurse or Diabetes Educator~~
- ~~Call to Specialist~~

Endocrinologist

- ~~Call w/ PCP~~
- 30-45 Min. Office Visit

$108-166

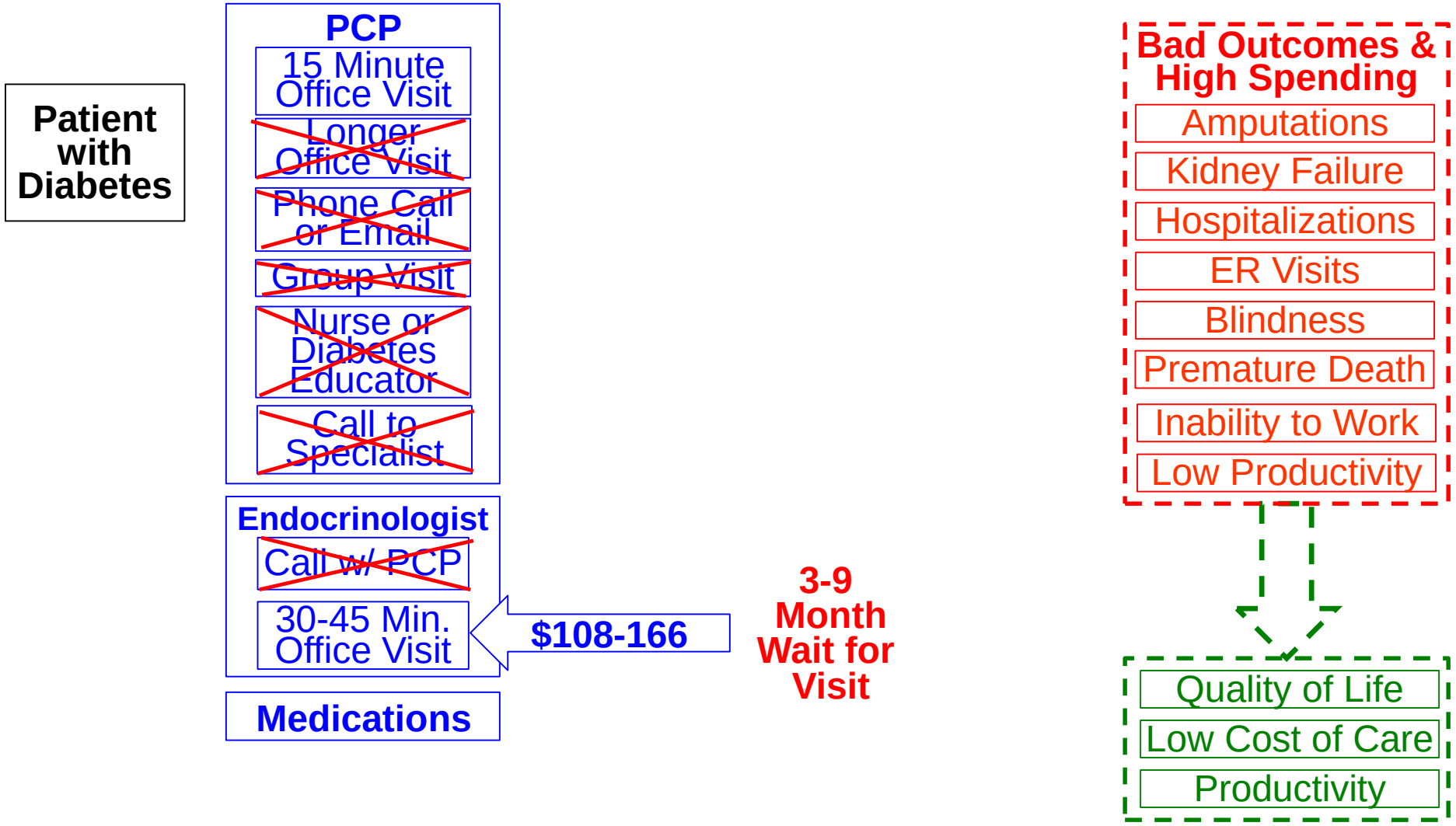
Medications

Bad Outcomes & High Spending

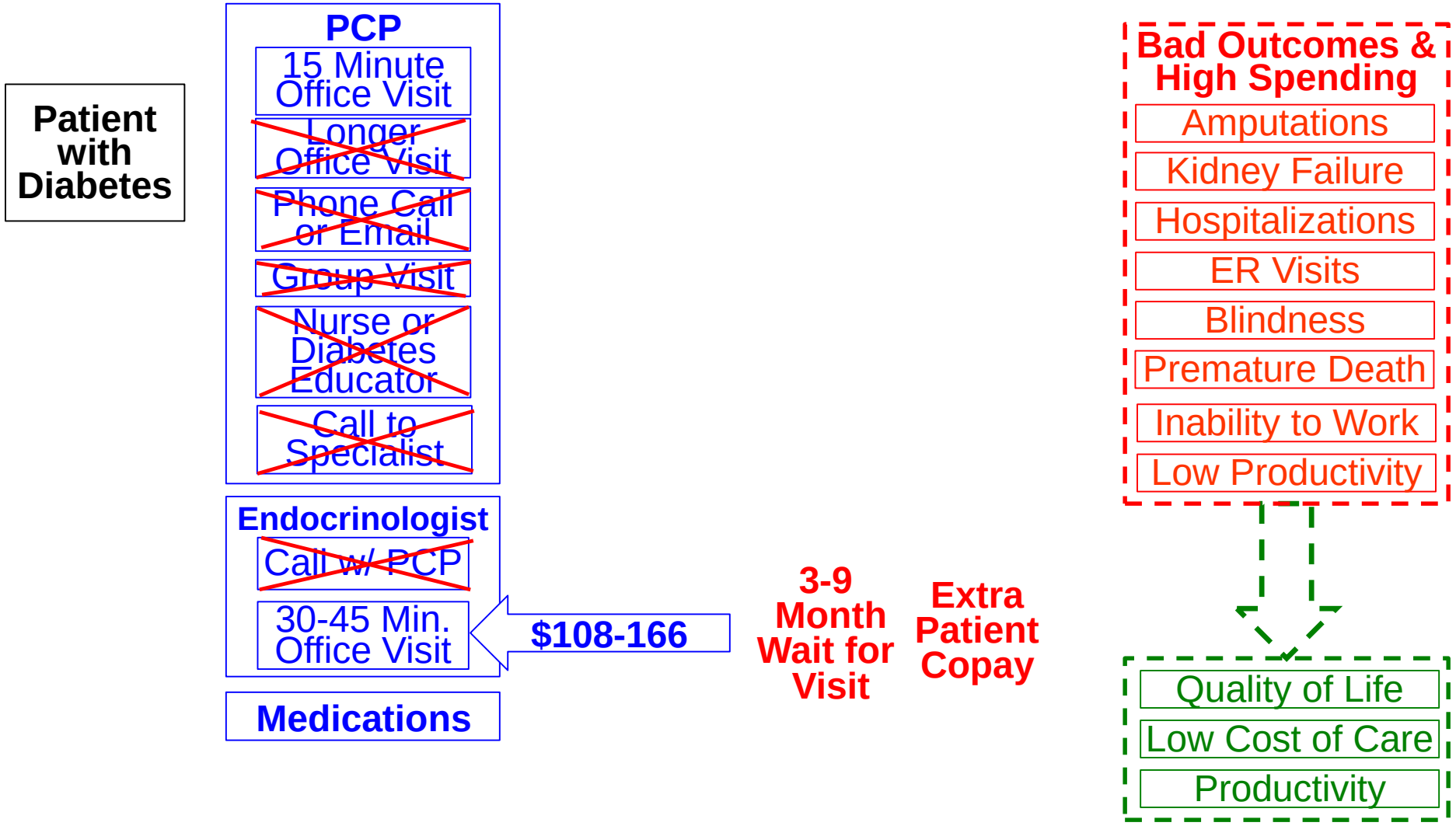
- Amputations
- Kidney Failure
- Hospitalizations
- ER Visits
- Blindness
- Premature Death
- Inability to Work
- Low Productivity

- Quality of Life
- Low Cost of Care
- Productivity

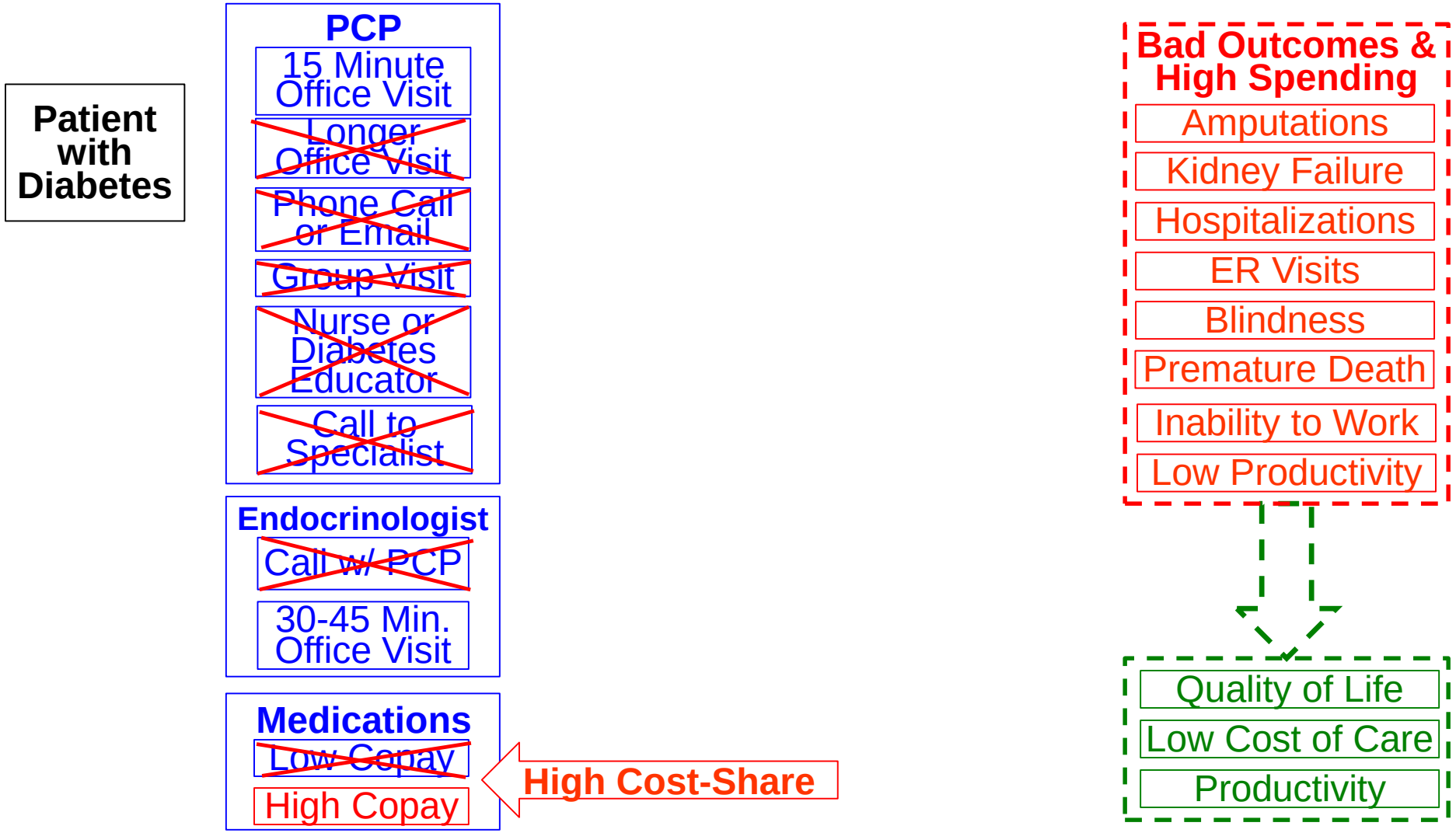
Long Waits Due to Many Visits for Issues That Needed Only a Call…



…And the Extra Copay May Deter the Patient From Making the Visit



If Patients Can't Afford Meds, All the Rest May Be in Vain



So Is It Any Surprise that Quality is Poor and Spending is High?

Patient with Diabetes

PCP
- 15 Minute Office Visit
- ~~Longer Office Visit~~
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- ~~Group Visit~~
- ~~Nurse or Diabetes Educator~~
- ~~Call to Specialist~~

Endocrinologist
- ~~Call w/ PCP~~
- 30-45 Min. Office Visit

Medications
- ~~Low Copay~~
- High Copay

Quality Metrics
- Blood Sugar
- Cholesterol
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- Kidney Exams

D5 <40%

Bad Outcomes & High Spending
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What Are Medicare and Private Health Plans Doing to Fix This?

Patient with Diabetes

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- 15 Minute Office Visit
- ~~Longer Office Visit~~
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- ~~Nurse or Diabetes Educator~~
- ~~Call to Specialist~~

Endocrinologist

- ~~Call w/ PCP~~
- 30-45 Min. Office Visit

Medications

- ~~Low Copay~~
- High Copay

Bad Outcomes & High Spending

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- Quality of Life
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Strategy 1: Force PCPs to Buy an EHR

Patient with Diabetes

PCP

- 15 Minute Office Visit
- ~~Longer Office Visit~~
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- ~~Group Visit~~
- ~~Nurse or Diabetes Educator~~
- ~~Call to Specialist~~

Endocrinologist

- ~~Call w/ PCP~~
- 30-45 Min. Office Visit

Medications

- ~~Low Copay~~
- High Copay

Requiring EHRs

- Increases expenses for PCP practice
- Takes time away from office visits with patients
- PCP EHR and endocrinologist EHR may not be able to exchange data even if HIPAA barriers can be overcome

Bad Outcomes & High Spending

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Quality of Life

- Low Cost of Care
- Productivity

Strategy 2: Bonuses/Penalties for Quality

Patient with Diabetes

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Endocrinologist
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- 30-45 Min. Office Visit

Medications
- ~~Low Copay~~
- High Copay

$

P4P/VBP

Quality Metrics
- Blood Sugar
- Cholesterol
- Blood Pressure
- Tobacco Use
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- Eye Exams
- Kidney Exams

Bad Outcomes & High Spending
- Amputations
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- ER Visits
- Blindness
- Premature Death
- Inability to Work
- Low Productivity

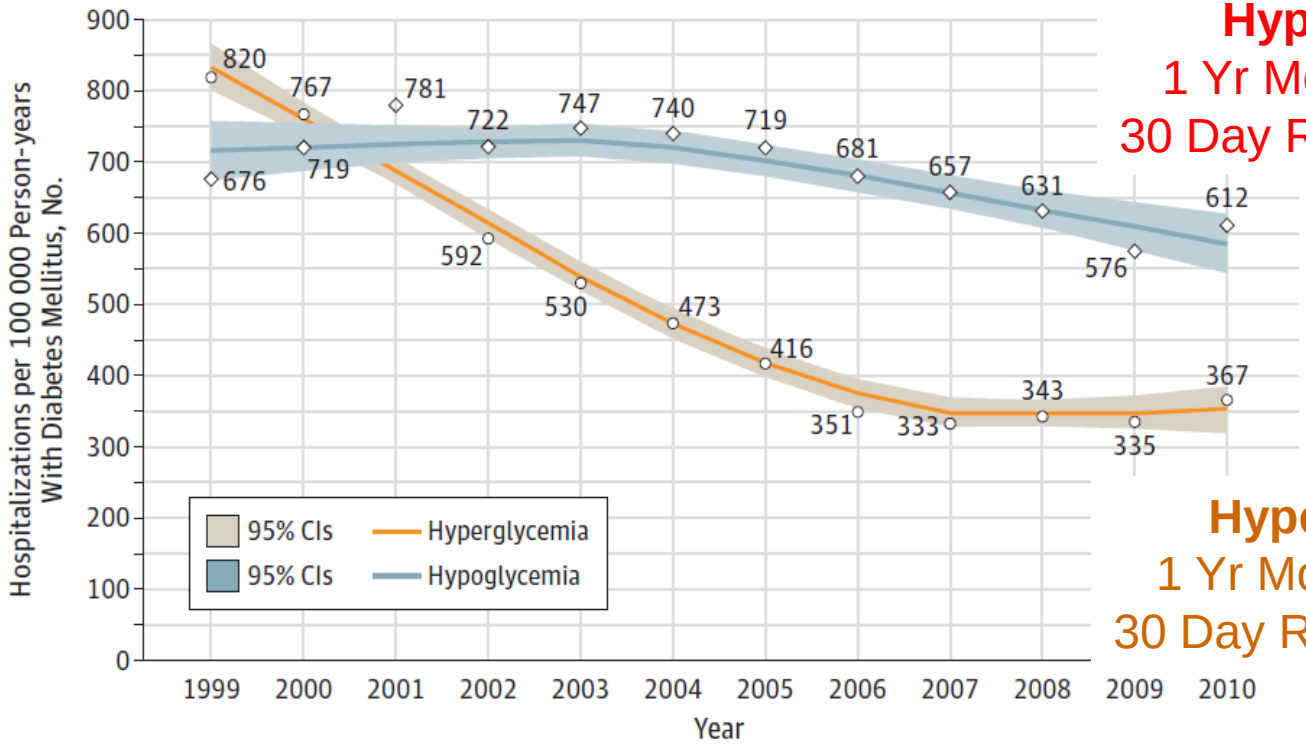
Hospitalizations & Death Due to Overtreatment

Quality of Life
- Low Cost of Care
- Productivity

- No additional resources to address the barriers preventing higher quality
- Unintended consequences of over-focus on metrics

More Admits/Deaths Today Due to *Low* Blood Sugar Than High

Figure 2. Rates of Estimated Hospital Admissions for Hyperglycemia and Hypoglycemia Among Medicare Beneficiaries With Diabetes Mellitus, 1999 to 2010



Hypoglycemia
1 Yr Mortality: 19.9%
30 Day Readmits: 16.3%

Hyperglycemia
1 Yr Mortality: 17.1%
30 Day Readmits: 15.3%

Source: National Trends in US Hospital Admissions for Hyperglycemia and Hypoglycemia Among Medicare Beneficiaries, 1999 to 2011 JAMA Internal Medicine May 17, 2014

Strategy 3: "Shared Savings"

Patient with Diabetes

PCP
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- ~~Group Visit~~
- ~~Nurse or Diabetes Educator~~
- ~~Call to Specialist~~

Endocrinologist
- ~~Call w/ PCP~~
- 30-45 Min. Office Visit

Medications
- ~~Low Copay~~
- High Copay

Shared Savings

$ → $

- Non-Diabetes Spending
- Amputations
- Kidney Failure
- Hospitalizations
- ER Visits
- Blindness
- Premature Death
- Inability to Work
- Low Productivity

- No additional upfront resources to address the barriers preventing higher quality care
- Puts physicians at risk for services and costs they cannot control

- Quality of Life
- Low Cost of Care
- Productivity

Strategy 4: Patient-Centered Medical Home

Patient with Diabetes

PCP
- 15 Minute Office Visit
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- ~~Group Visit~~
- ~~Nurse or Diabetes Educator~~
- ~~Call to Specialist~~

Endocrinologist
- ~~Call w/ PCP~~
- 30-45 Min. Office Visit

Medications
- ~~Low Copay~~
- High Copay

PCMH/ PMPM

(Small) Monthly Payment Per Patient

- Monthly payment may be to small or inflexible to overcome service barriers
- No support for specialists
- Quality improvement or shared savings requirements may be unreasonable given size of monthly payment

Bad Outcomes & High Spending
- Amputations
- Kidney Failure
- Hospitalizations
- ER Visits
- Blindness
- Premature Death
- Inability to Work
- Low Productivity

- Quality of Life
- Low Cost of Care
- Productivity

A Better Way: Condition-Based Payment

Patient with Diabetes

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- Call to Specialist

Endocrinologist
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- 30-45 Min. Office Visit

Medications
- Low Copay

CONDITION-BASED PAYMENT

Diabetes-Related Costs
- Amputations
- Kidney Failure
- Hospitalizations
- ER Visits
- Blindness
- Premature Death
- Inability to Work
- Low Productivity

- Quality of Life
- Low Cost of Care
- Productivity

Flexibility to Deliver Care Without Restrictions of FFS

Patient with Diabetes

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Endocrinologist
- Call w/ PCP
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Medications
- Low Copay

CONDITION-BASED PAYMENT

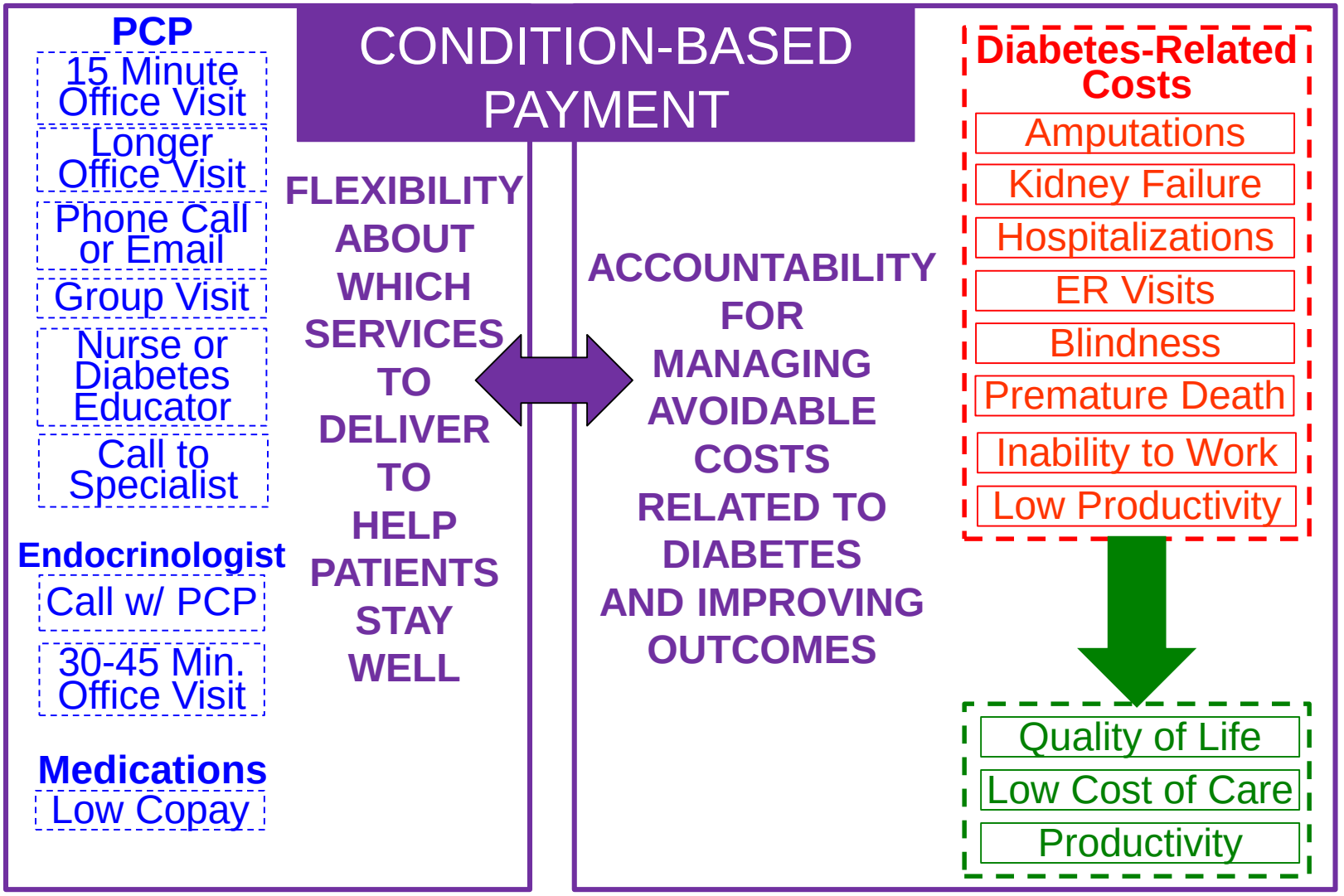
FLEXIBILITY ABOUT WHICH SERVICES TO DELIVER TO HELP PATIENTS STAY WELL

Diabetes-Related Costs
- Amputations
- Kidney Failure
- Hospitalizations
- ER Visits
- Blindness
- Premature Death
- Inability to Work
- Low Productivity

- Quality of Life
- Low Cost of Care
- Productivity

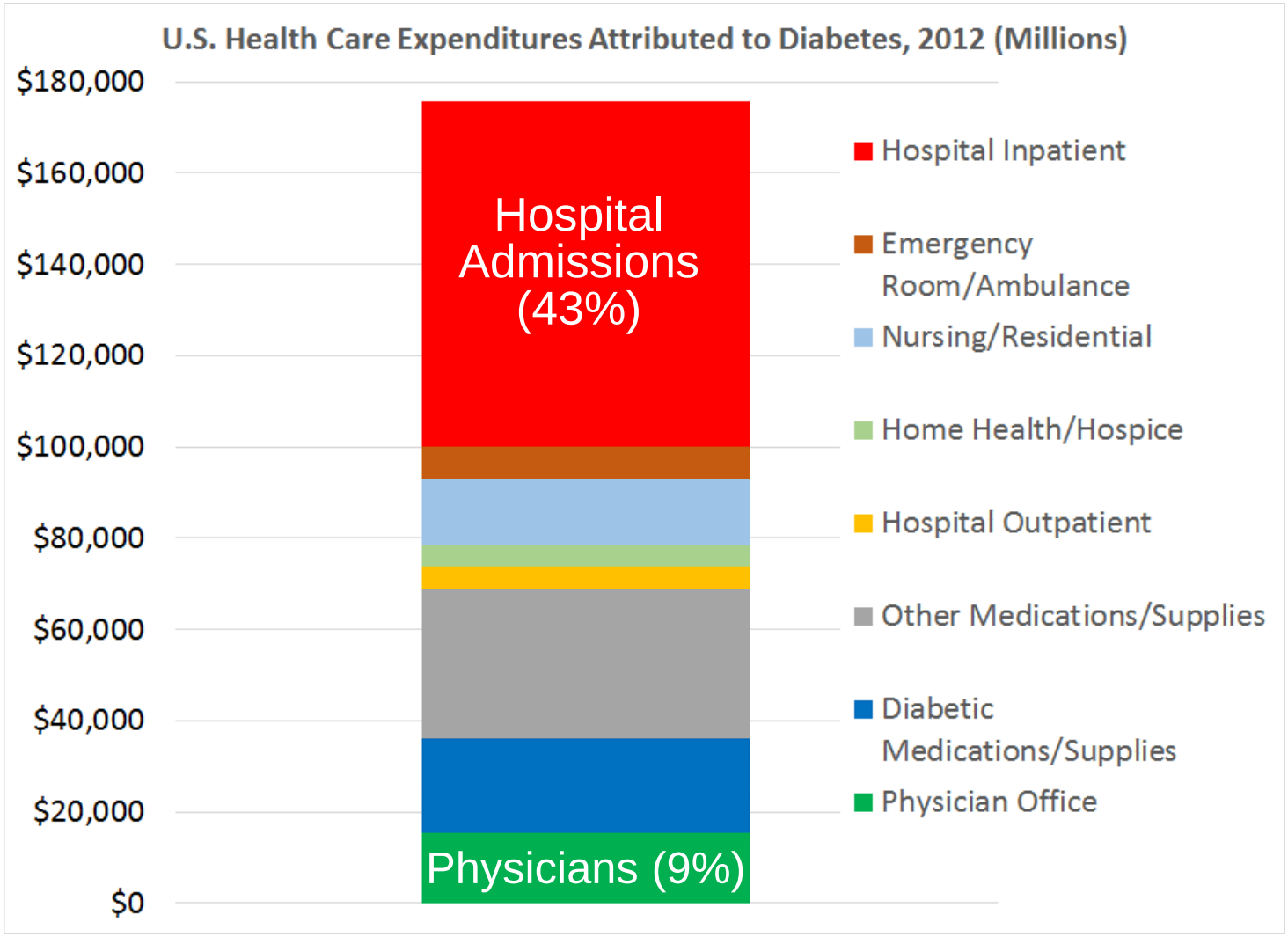
Accountability to Ensure Outcomes and Costs Improve

Patient with Diabetes

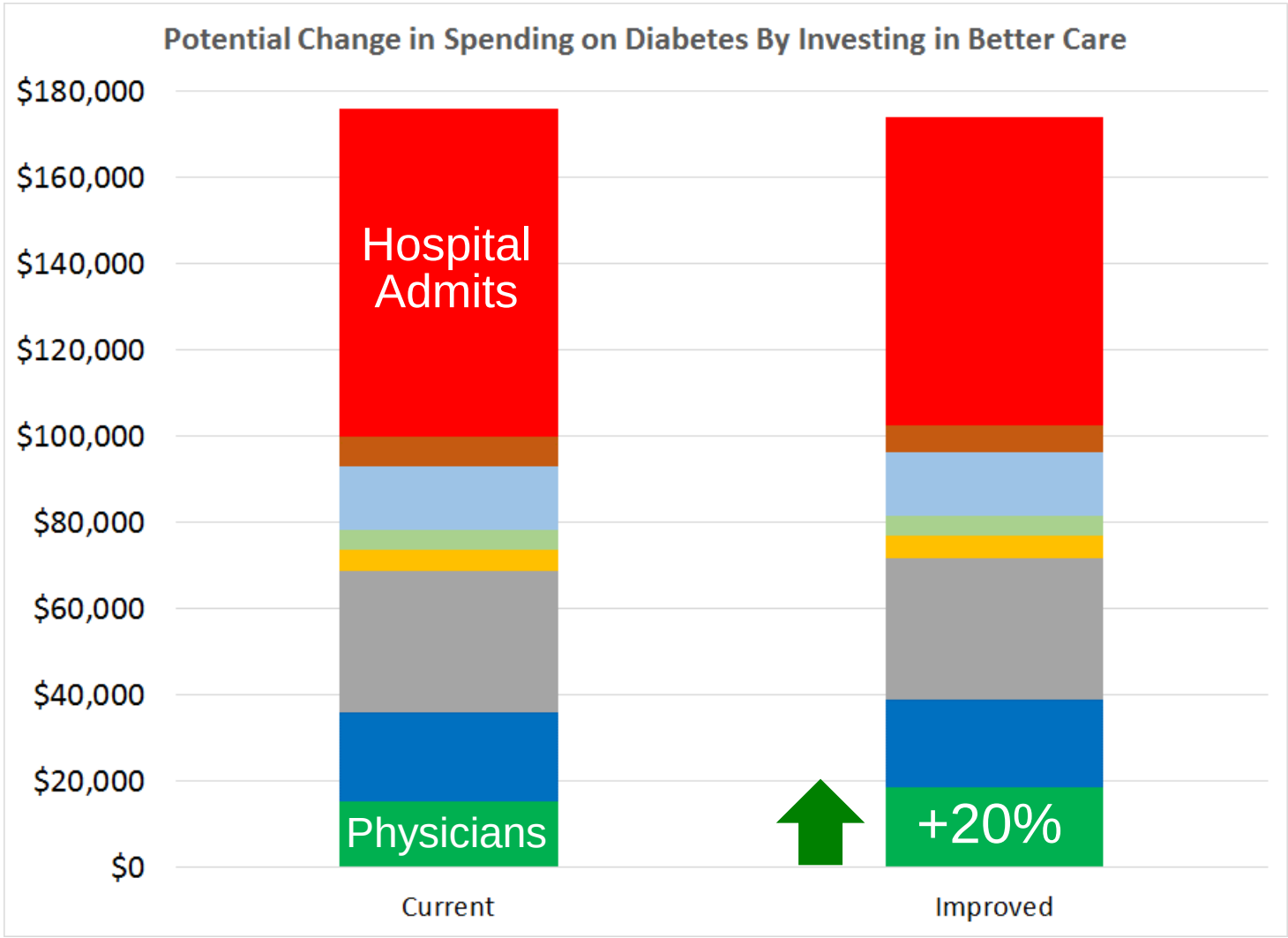


Most of the Money Today is Going to Hospitals, Not Doctors

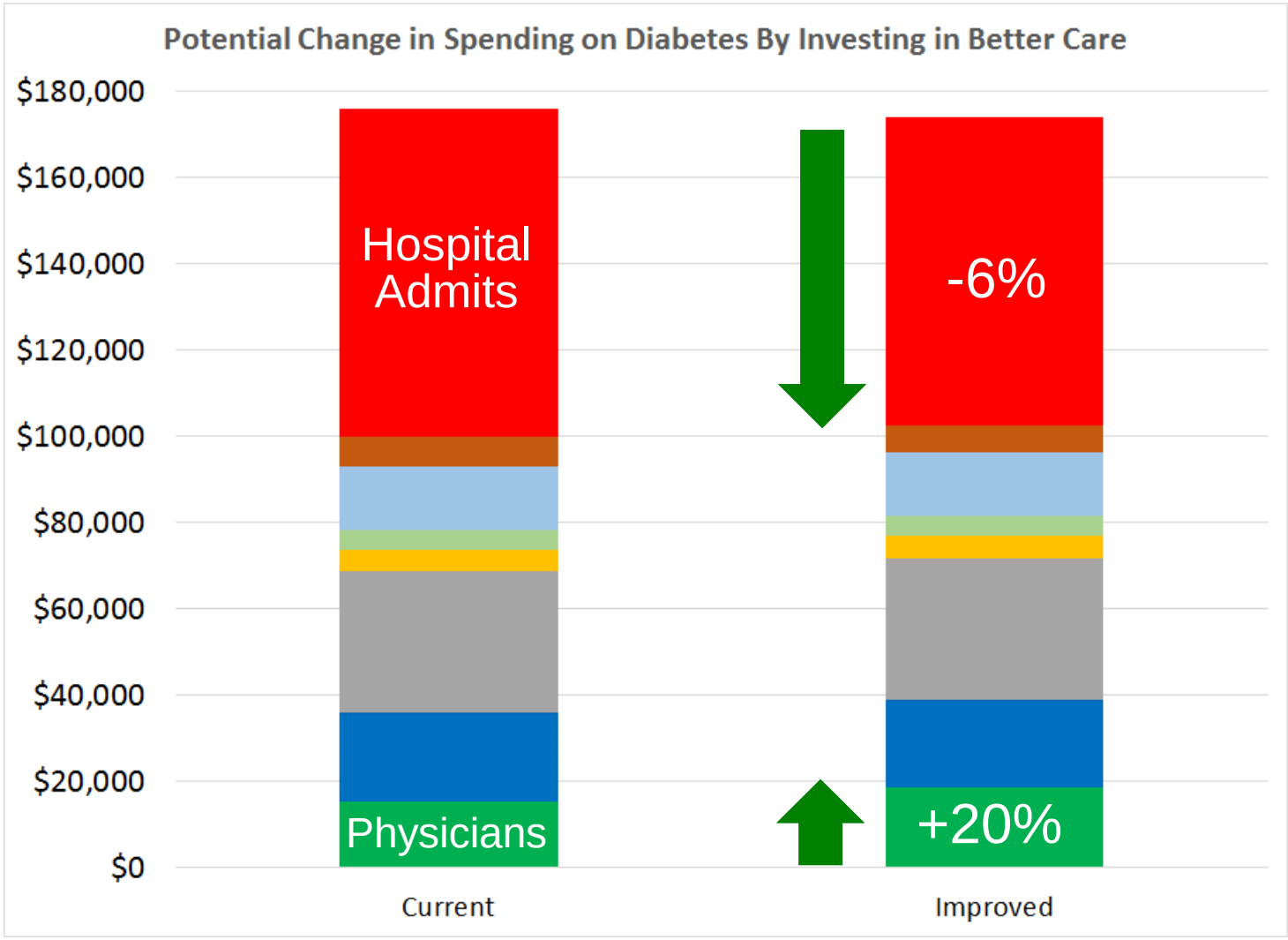
Source: "Economic Costs of Diabetes in the U.S. in 2012," *Diabetes Care* (Volume 36) April 2013



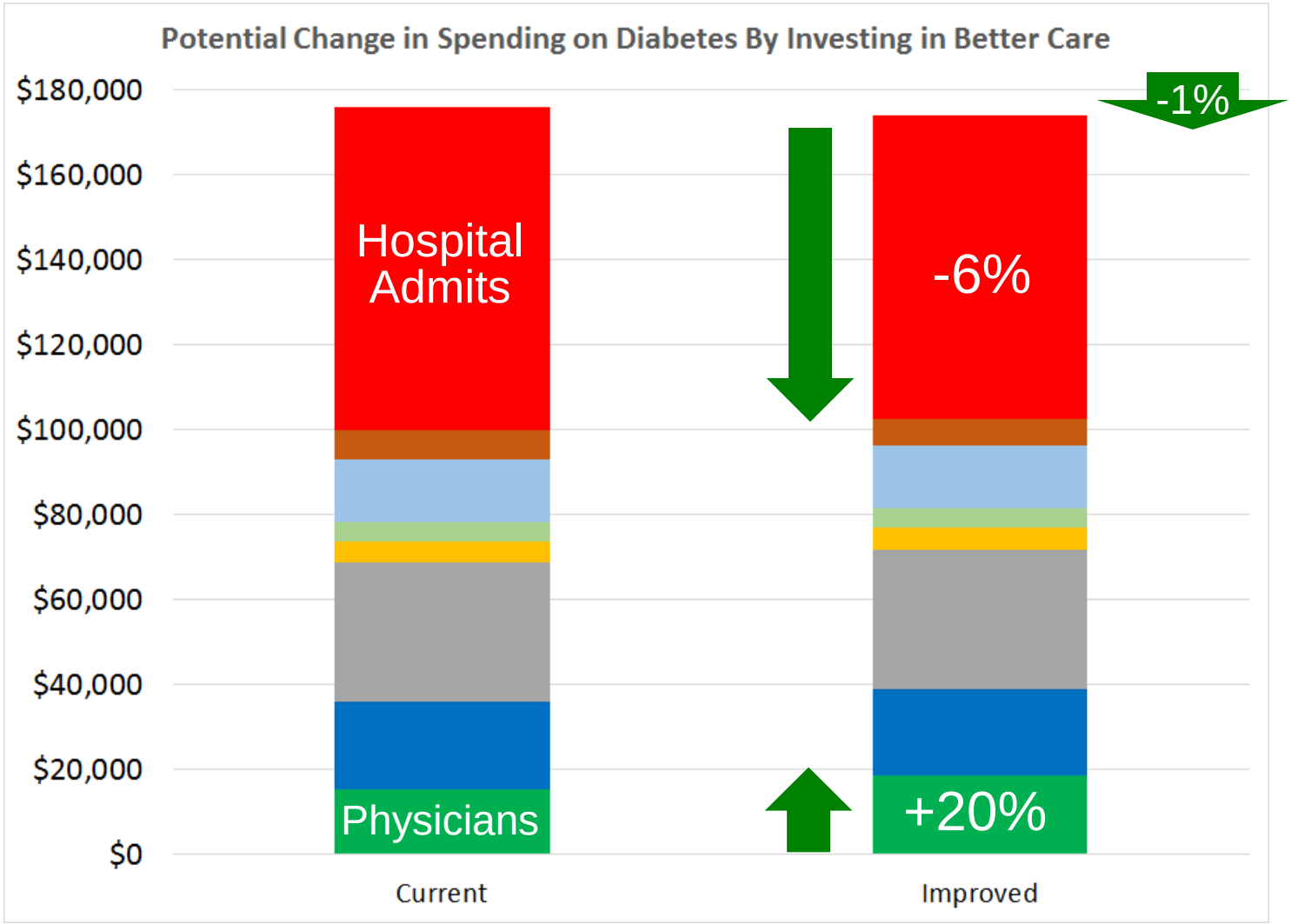
Could We Afford to Spend 20% More on Better Care Management?



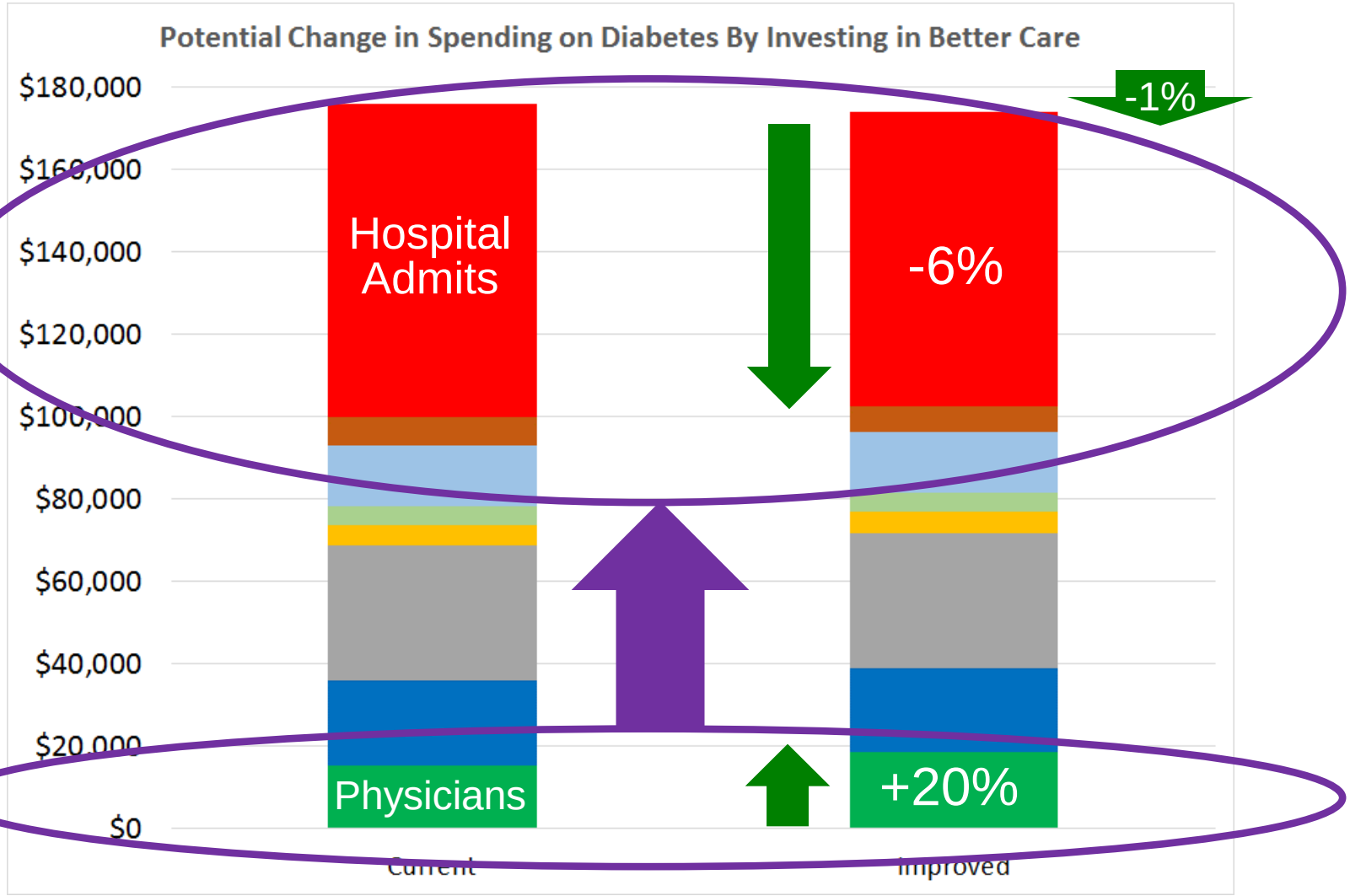
A Small Reduction in Expensive Complications Saves A Lot of $$$



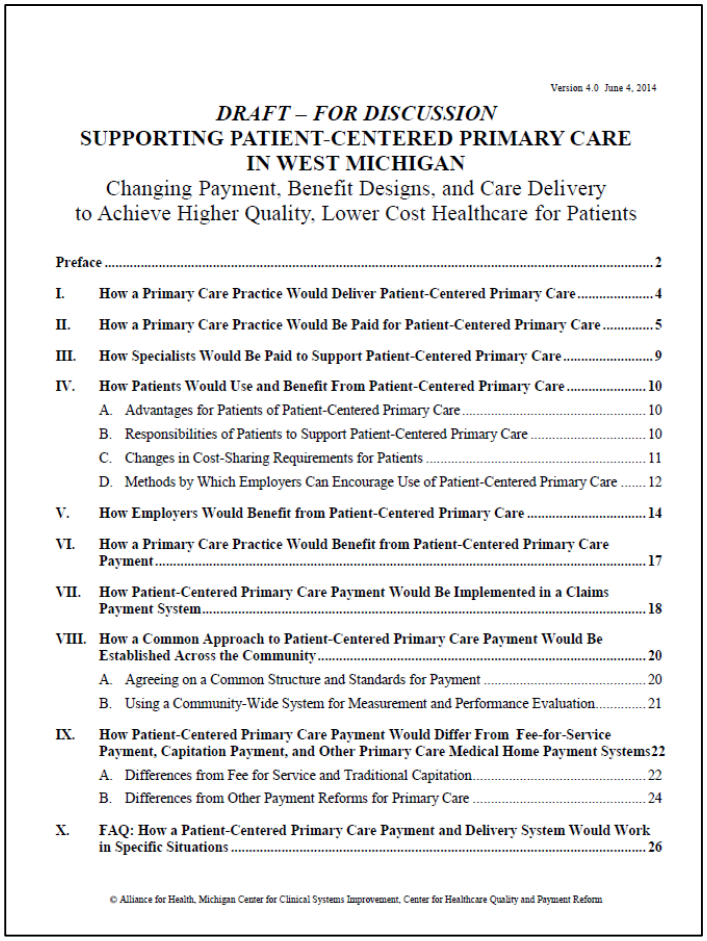
20% More $ on Care Mgt + 6% Fewer Admits = Lower Total $



Upfront Investment Is Needed, Targeted by Docs to Achieve Impact



Example of Condition-Based Payment

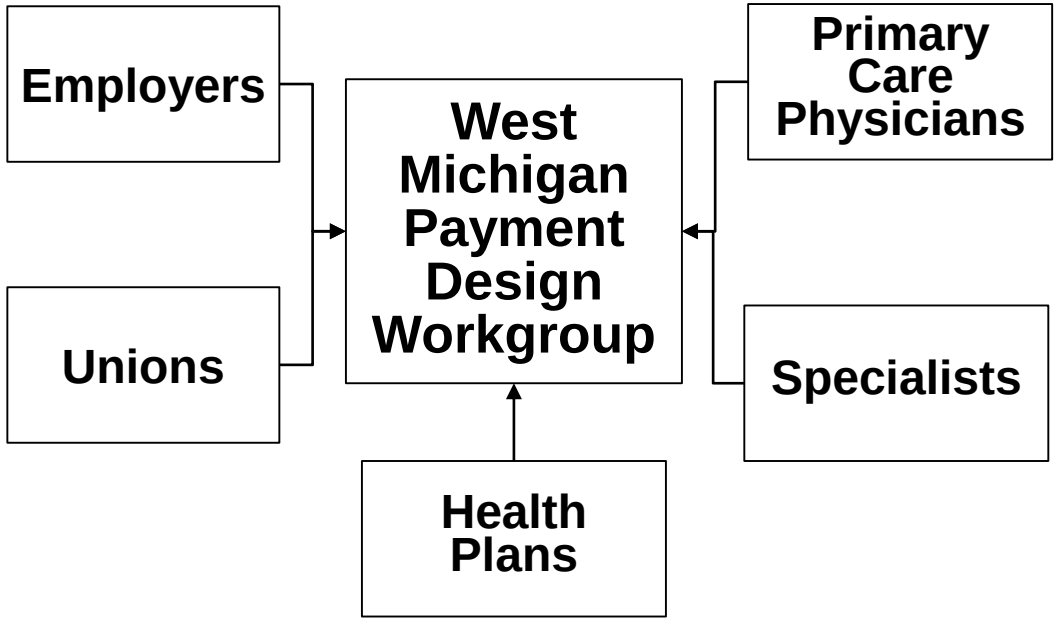


Version 4.0 June 4, 2014

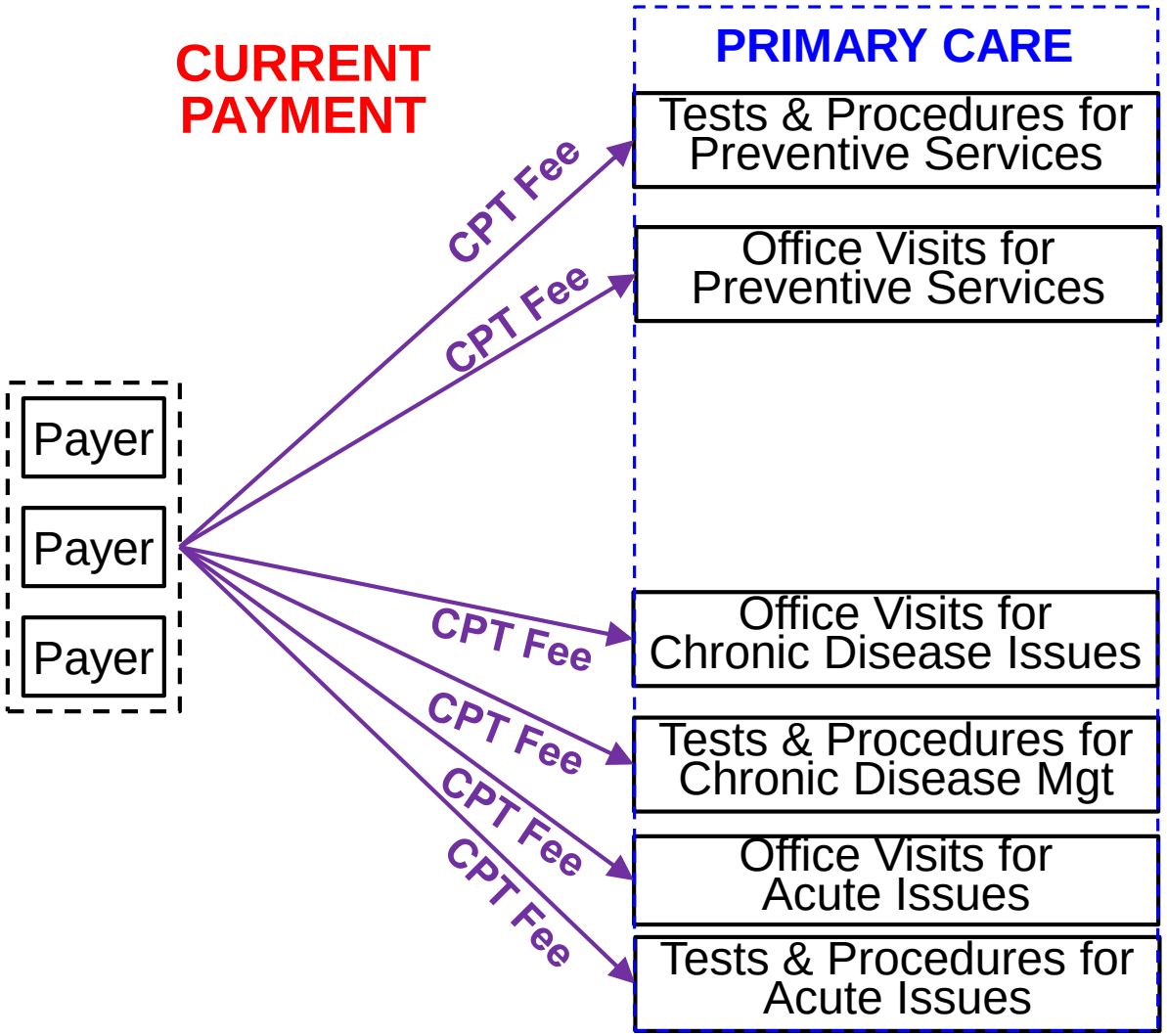
DRAFT – FOR DISCUSSION

SUPPORTING PATIENT-CENTERED PRIMARY CARE IN WEST MICHIGAN

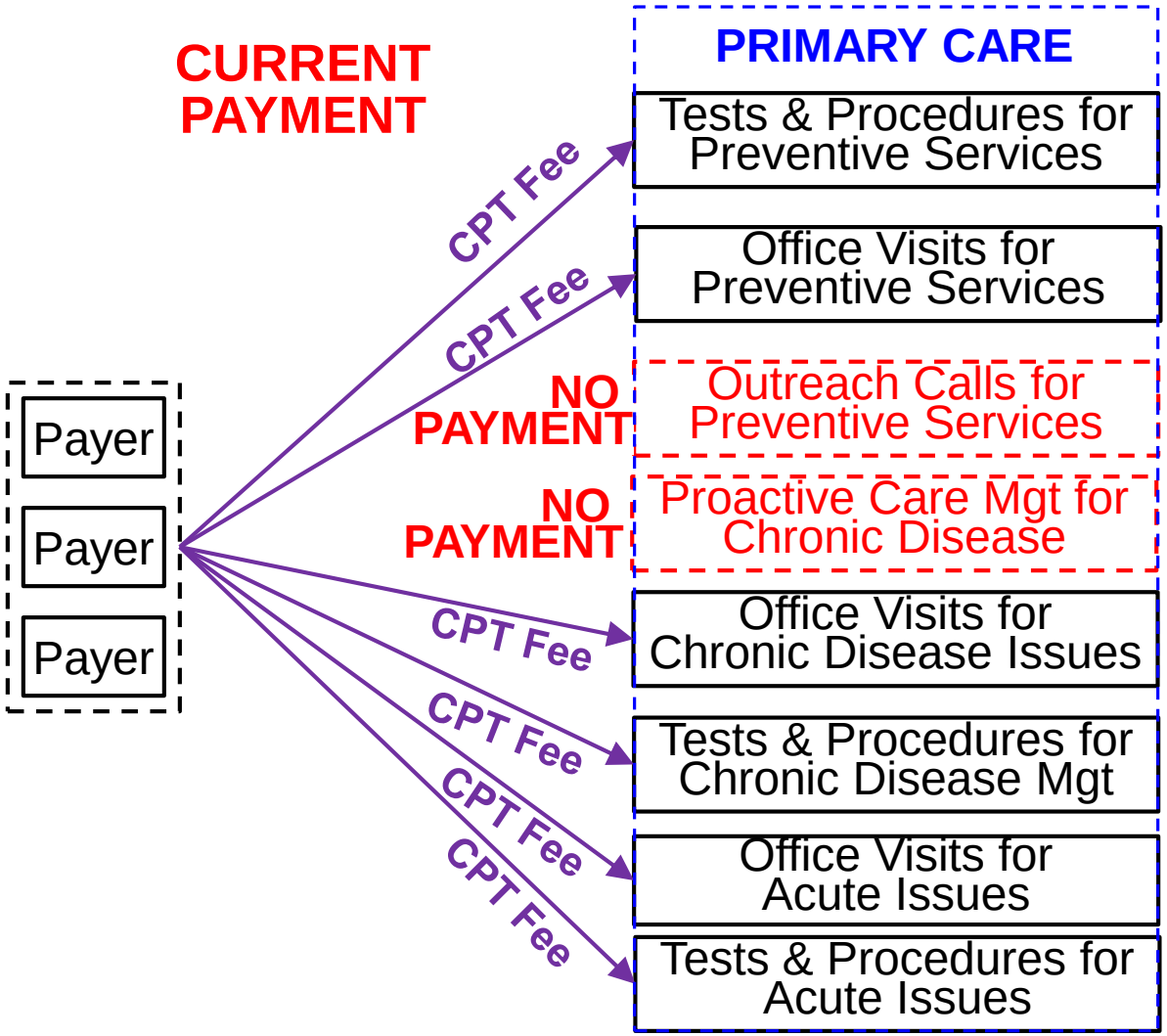
Changing Payment, Benefit Designs, and Care Delivery to Achieve Higher Quality, Lower Cost Healthcare for Patients



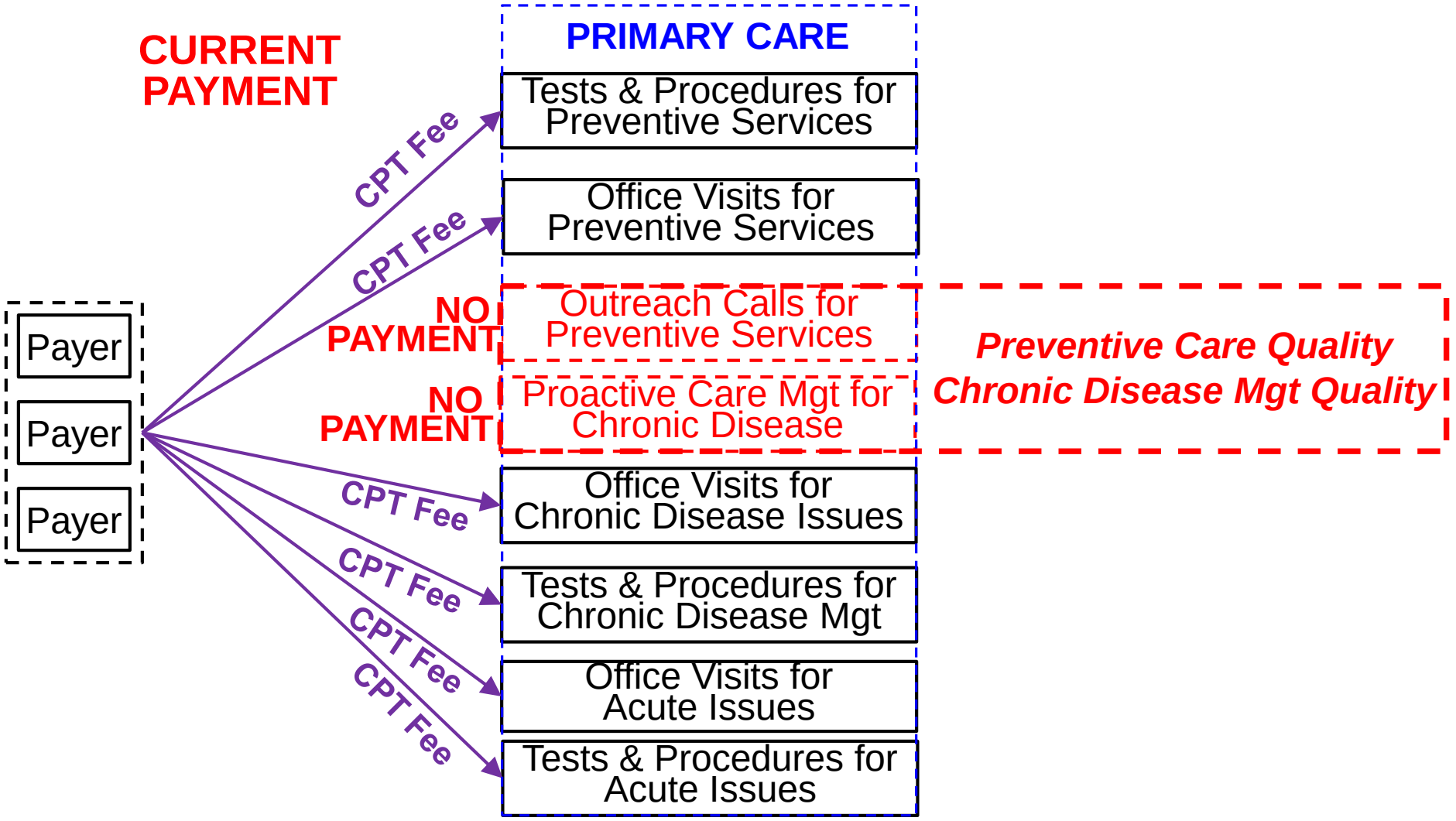
Current Payment for Primary Care



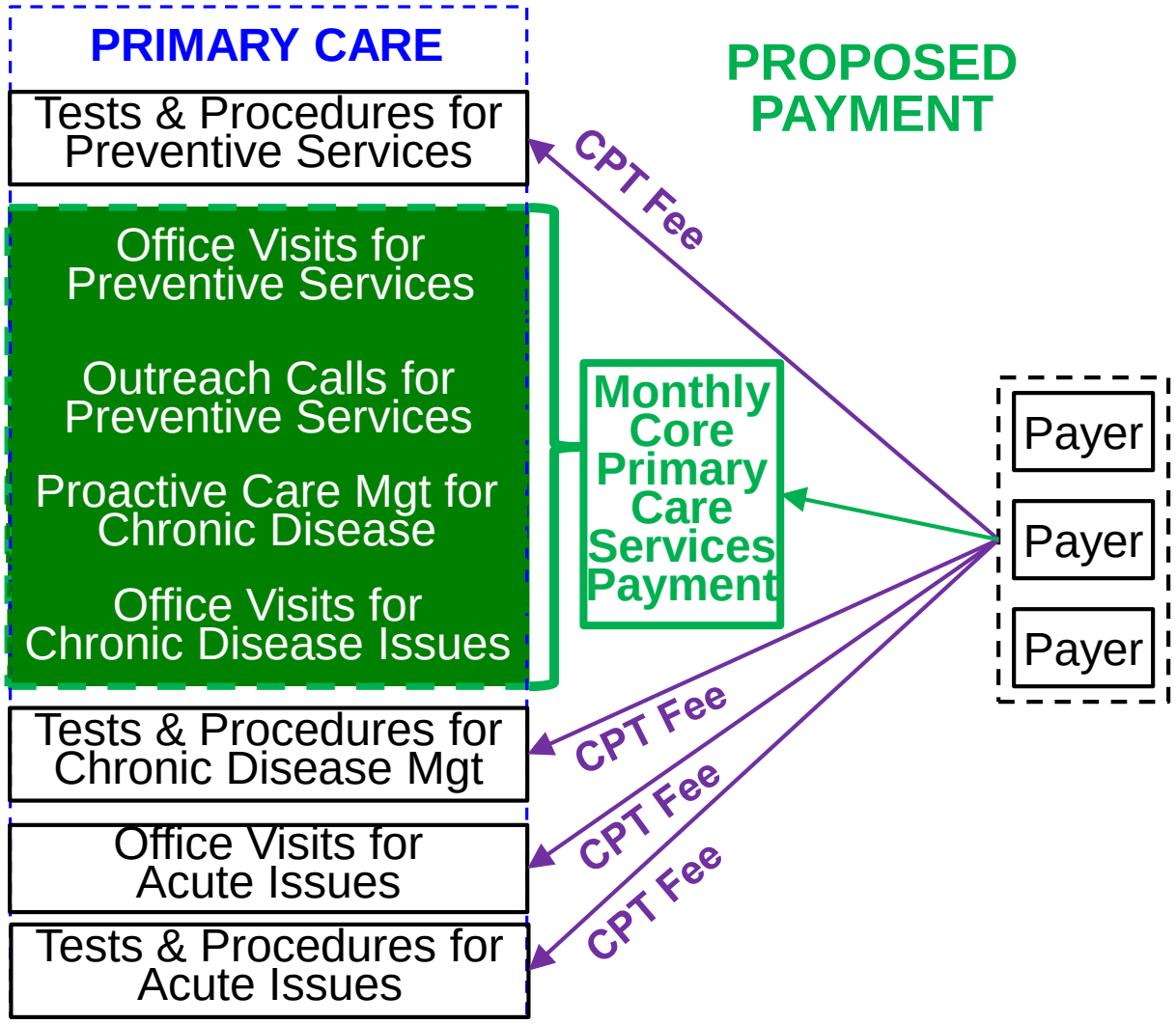
Current *Non*-Payment for Primary Care



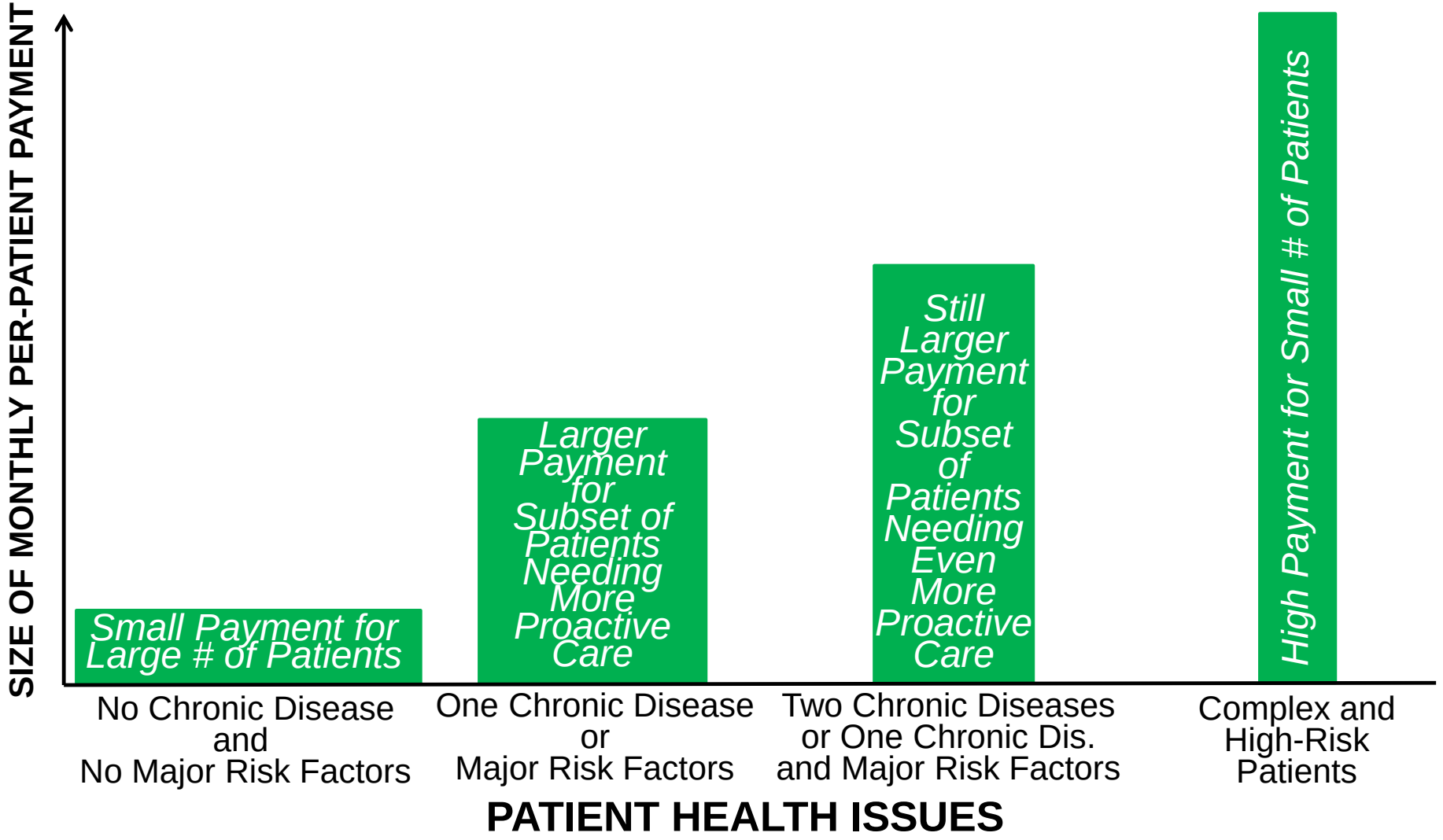
What Is *Not Paid For* Is Exactly What's *Needed* to Improve *Quality*



A Better Approach: Flexible Payment Instead of E&M Payment



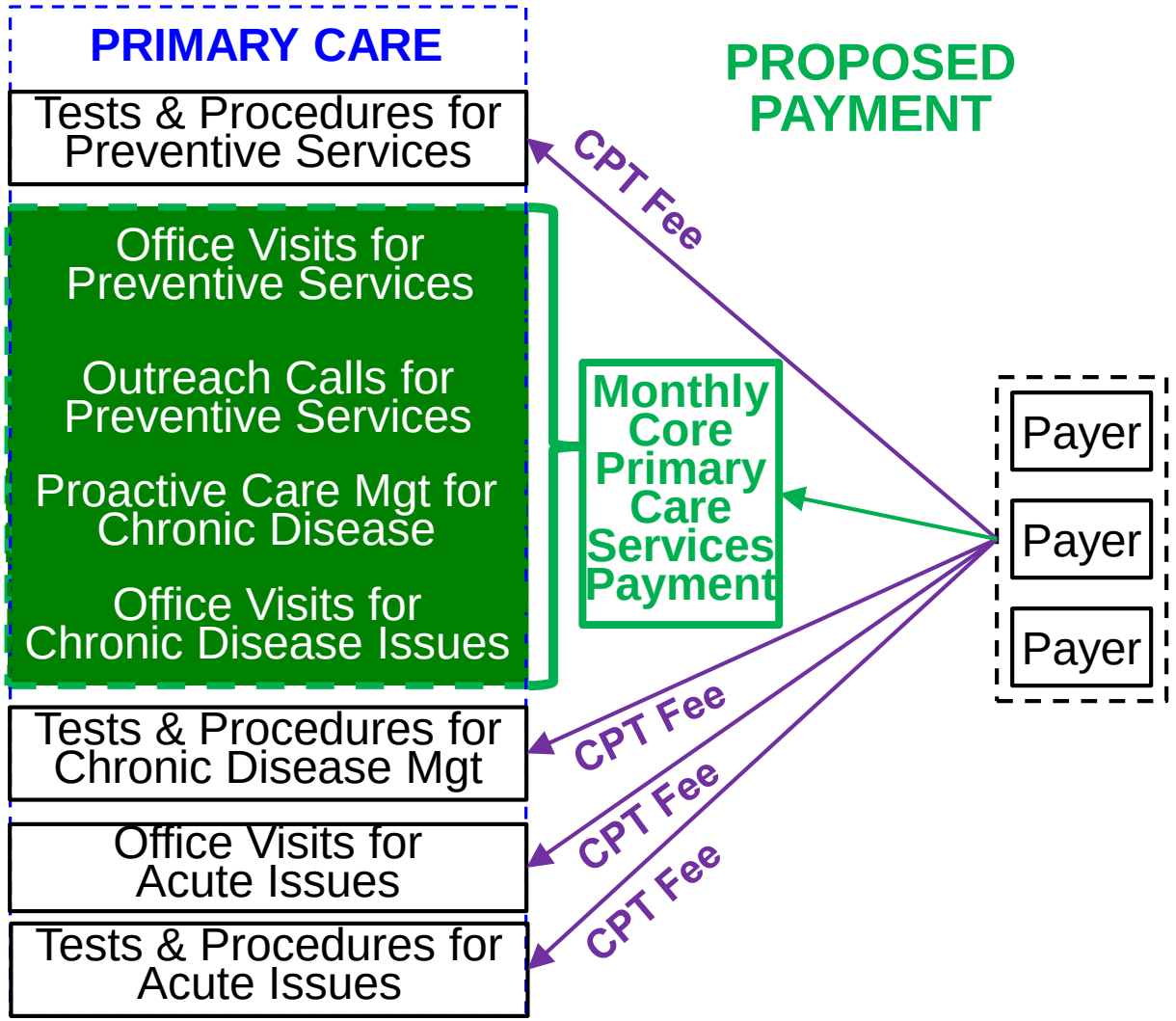
Size of Monthly Payment Should Differ Based on Patient Health



A Better Benefit Design For Patients

BENEFIT DESIGN

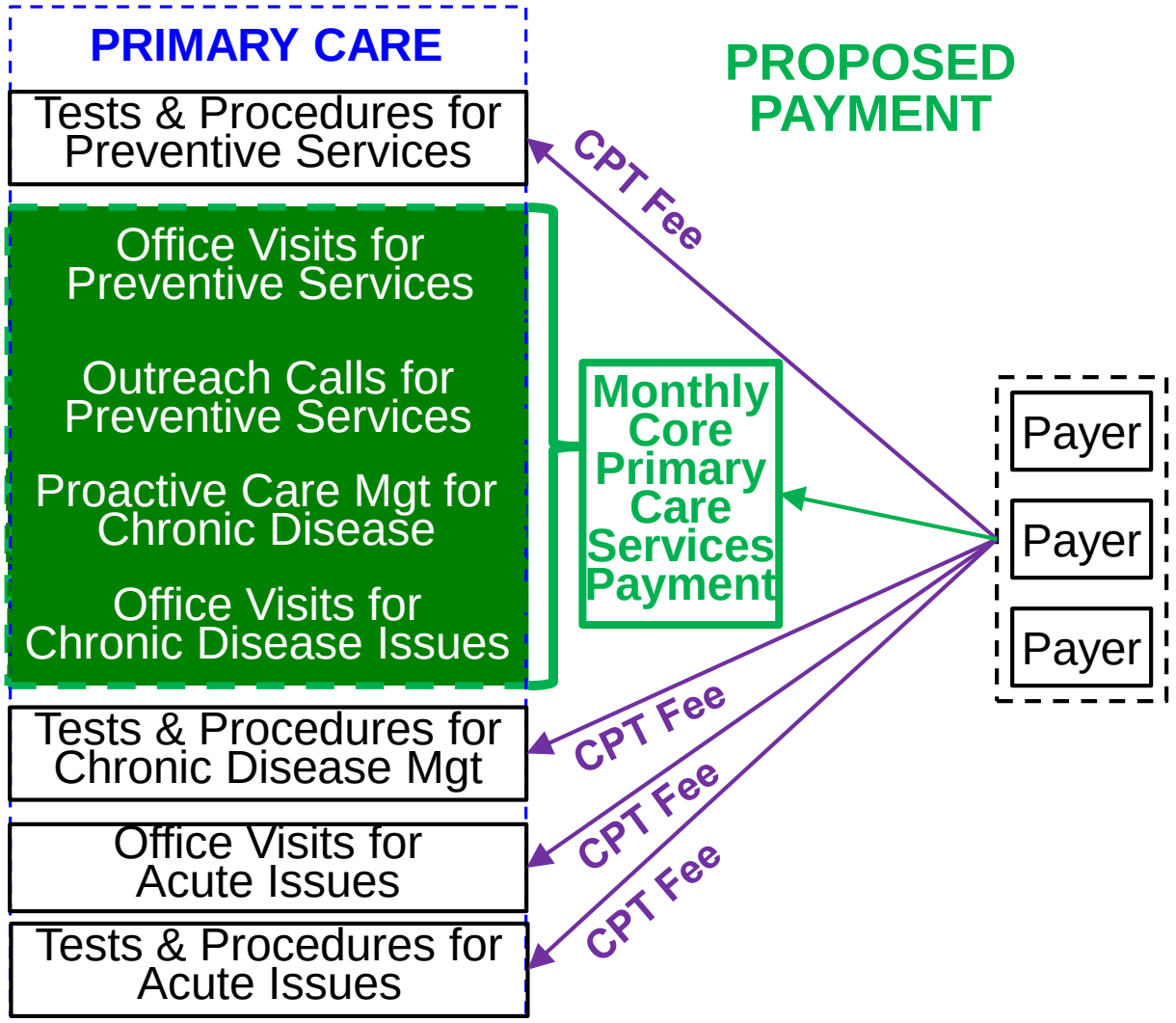
- Patient enrolls as a “member” of the primary care practice, but has no restrictions on other care
- Patient has no copays for visits related to either preventive care or chronic disease care from this practice
- Patient only pays cost-sharing for acute issues



Better Payment for the "Medical Neighborhood" (Specialists)

SPECIALIST PMT

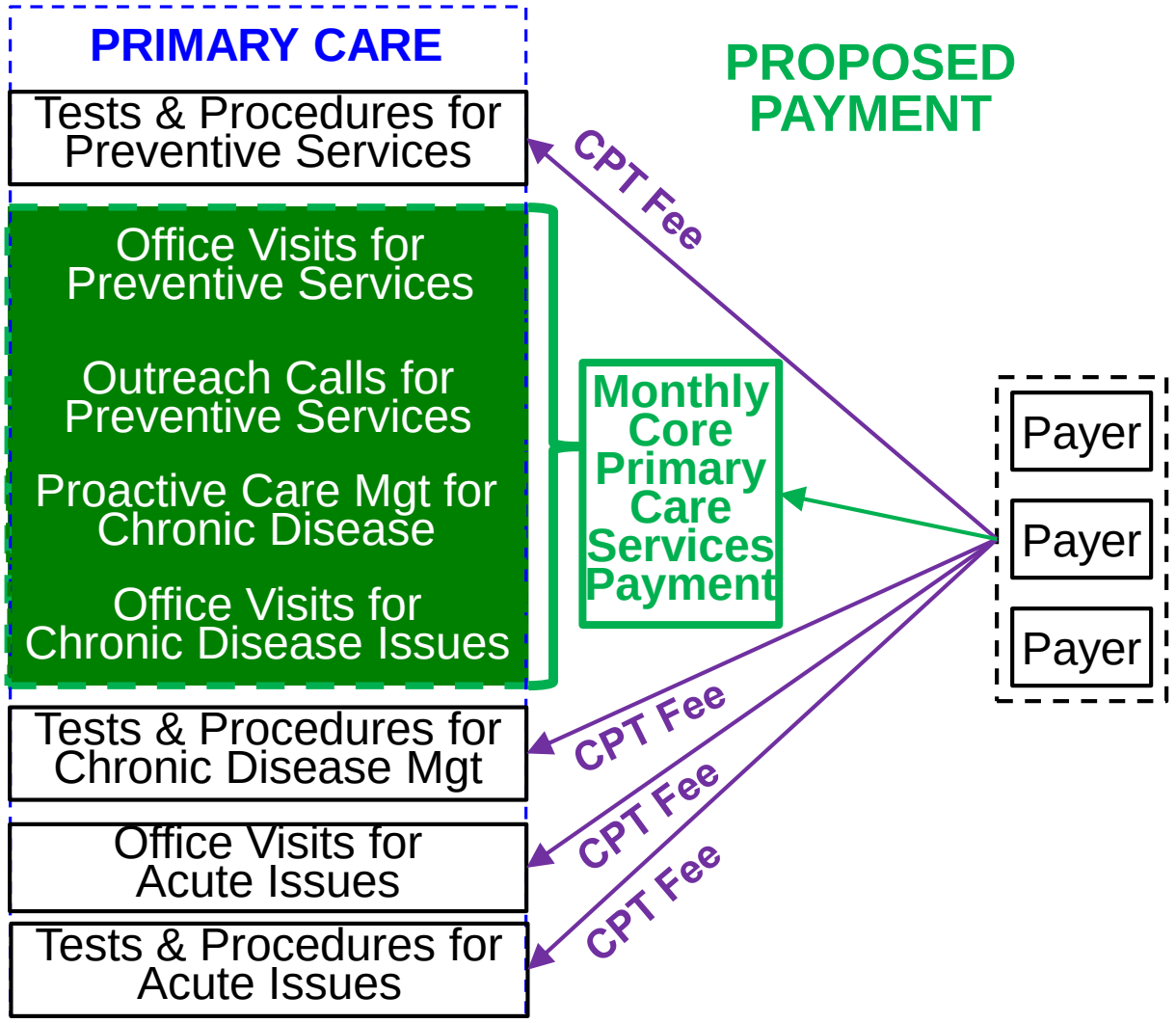
- Payments for telephone calls & emails for PCP consults with specialists they work with
- Sharing of the monthly core payment if the specialist is co-managing the patient with the PCP
- Transfer of monthly payment to specialist for some patients



Accountability for Spending and Quality That PCPs Can Control

ACCOUNTABILITY

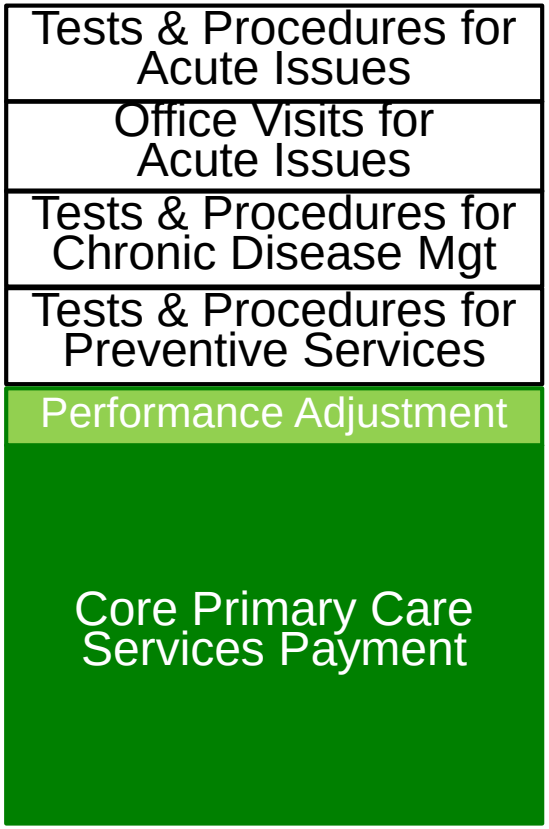
- Monthly payment would be adjusted up or down based on quality and avoidable utilization
  - Quality of preventive care
  - Quality of chronic disease care
  - Avoidable ER utilization
  - High-tech imaging
  - Specialty referrals



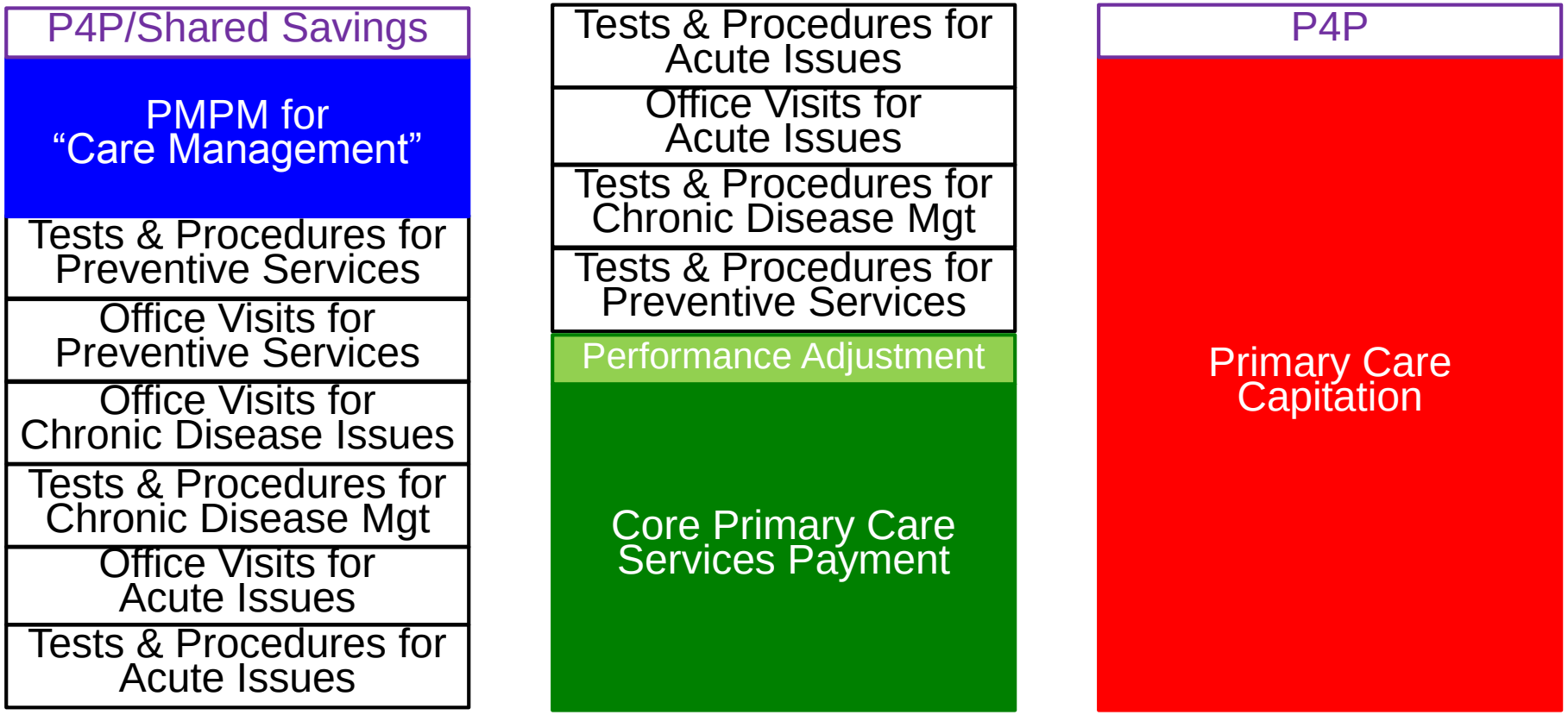
This is Different Than Current PCMH Programs

Current PCMH Model

NEW MODEL



It's Also Different from Traditional PCP Capitation Programs

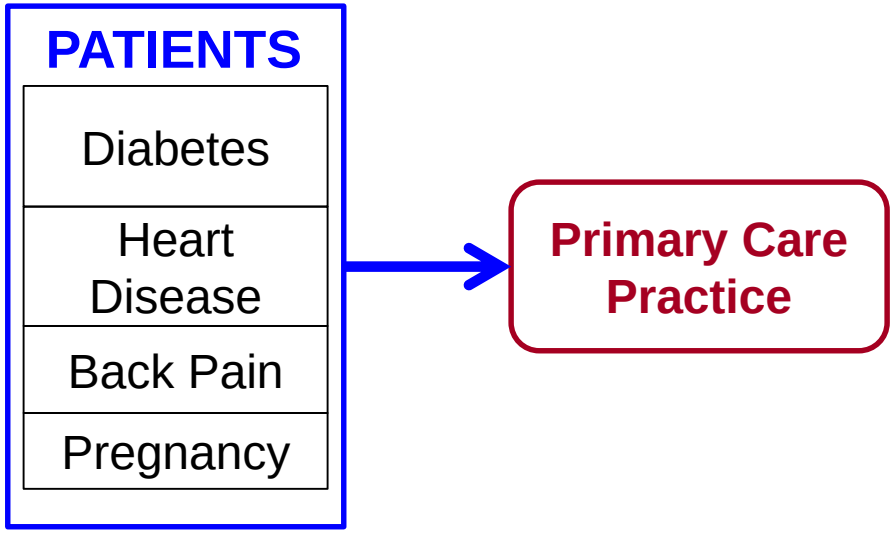


It's Better Than Current PCMH or Capitation

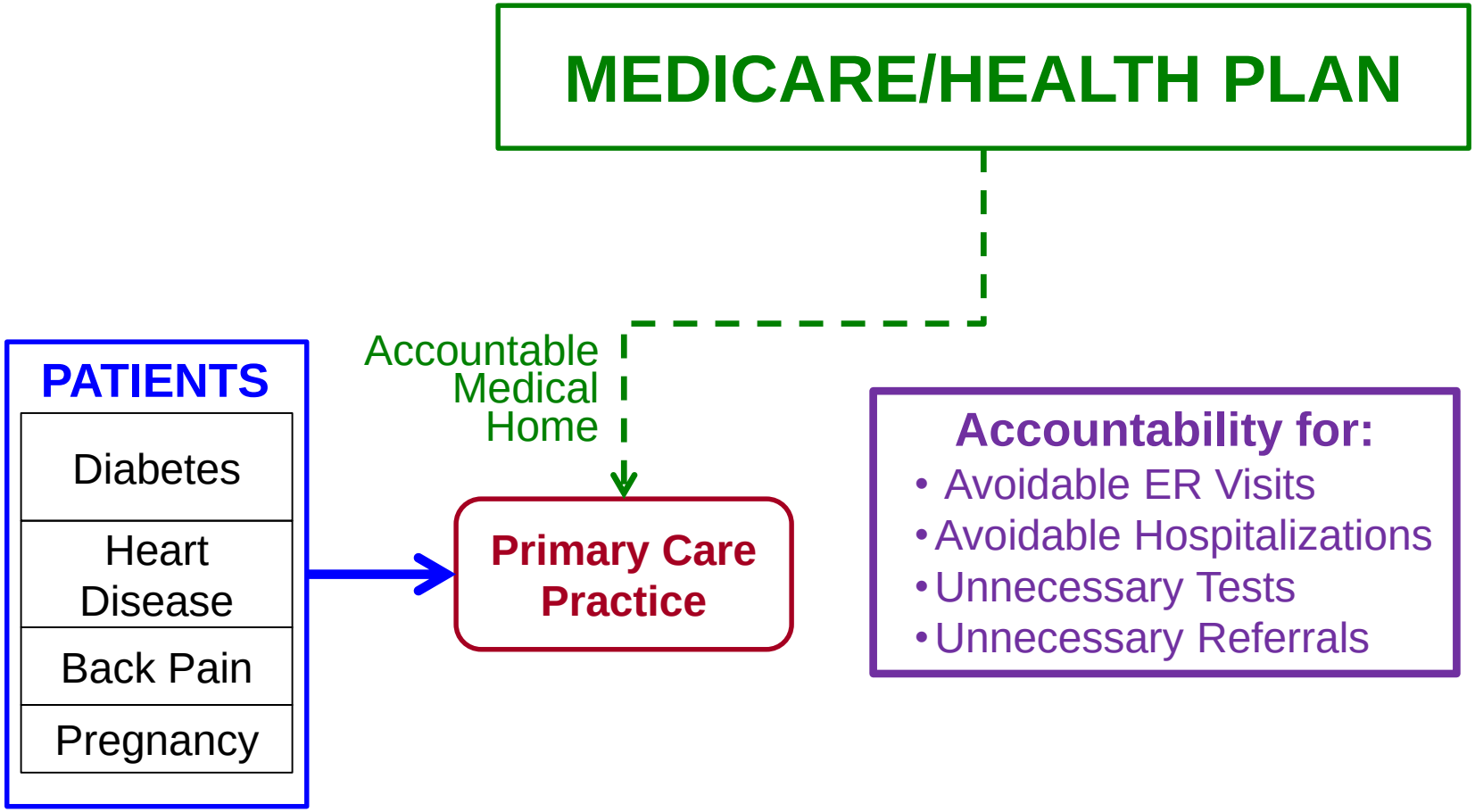
Current PCMH Model	NEW MODEL (PARTIAL CAPITATION)	PCP Capitation
• Most practice revenue still comes from office visits • Fewer office visits = lower revenue, even with PMPM • Patient still discouraged from office visits by copays • Patients must be attributed based on claims	• PCP practice receives predictable, flexible payment for patient mgt • Higher payment for patients with greater needs • Employer only pays more if patient needs or receives more services • Patient enrolls only for prev. & chronic care	• No incentive for PCP practice to see patient for acute needs • Payment is the same for patients with high needs as low needs • Employer is paying even if patient needs few services • Patients must enroll for all services

How Does This All Fit Into ACOs?

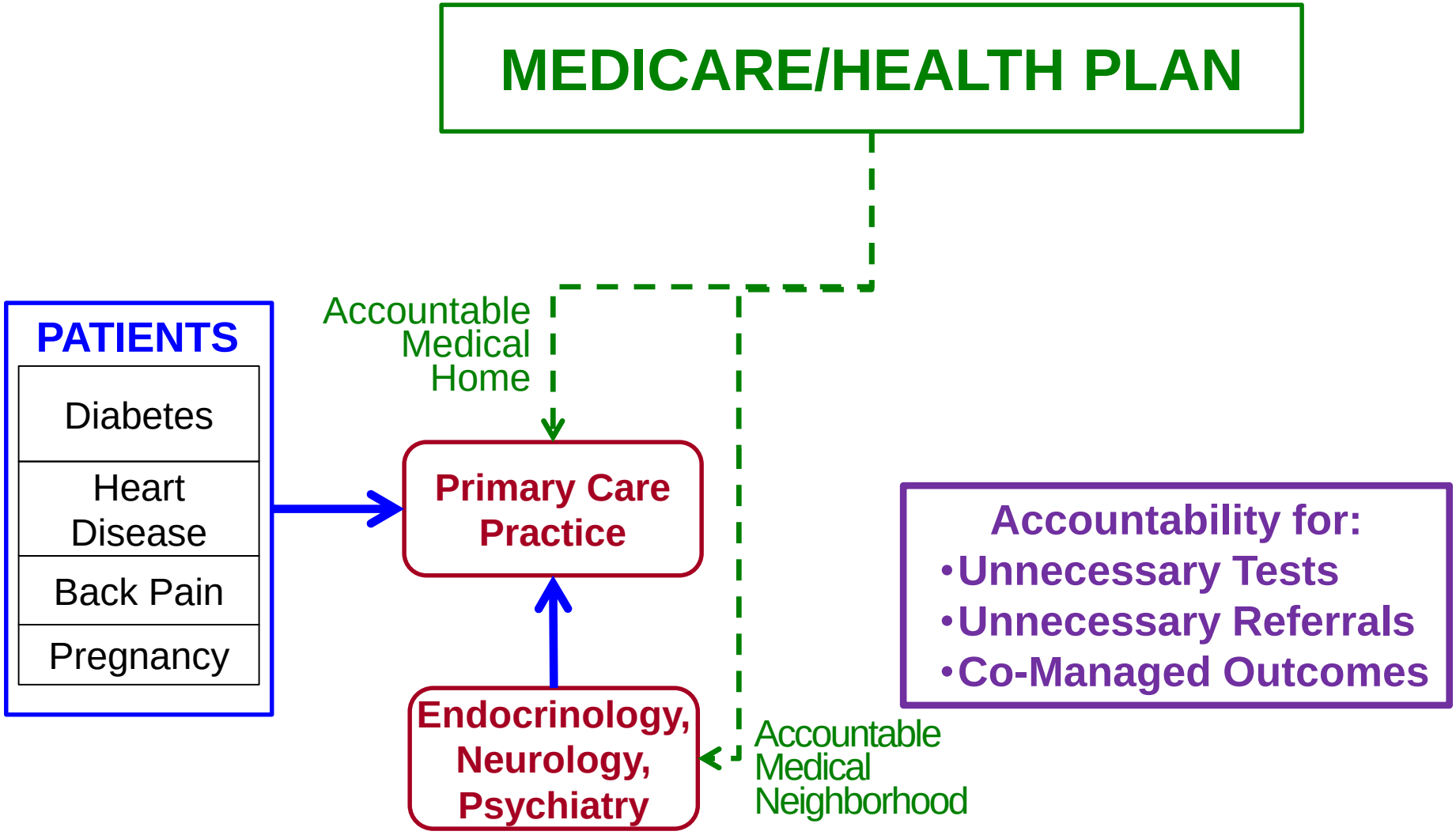
Each Patient Should Choose & Use a Primary Care Practice…



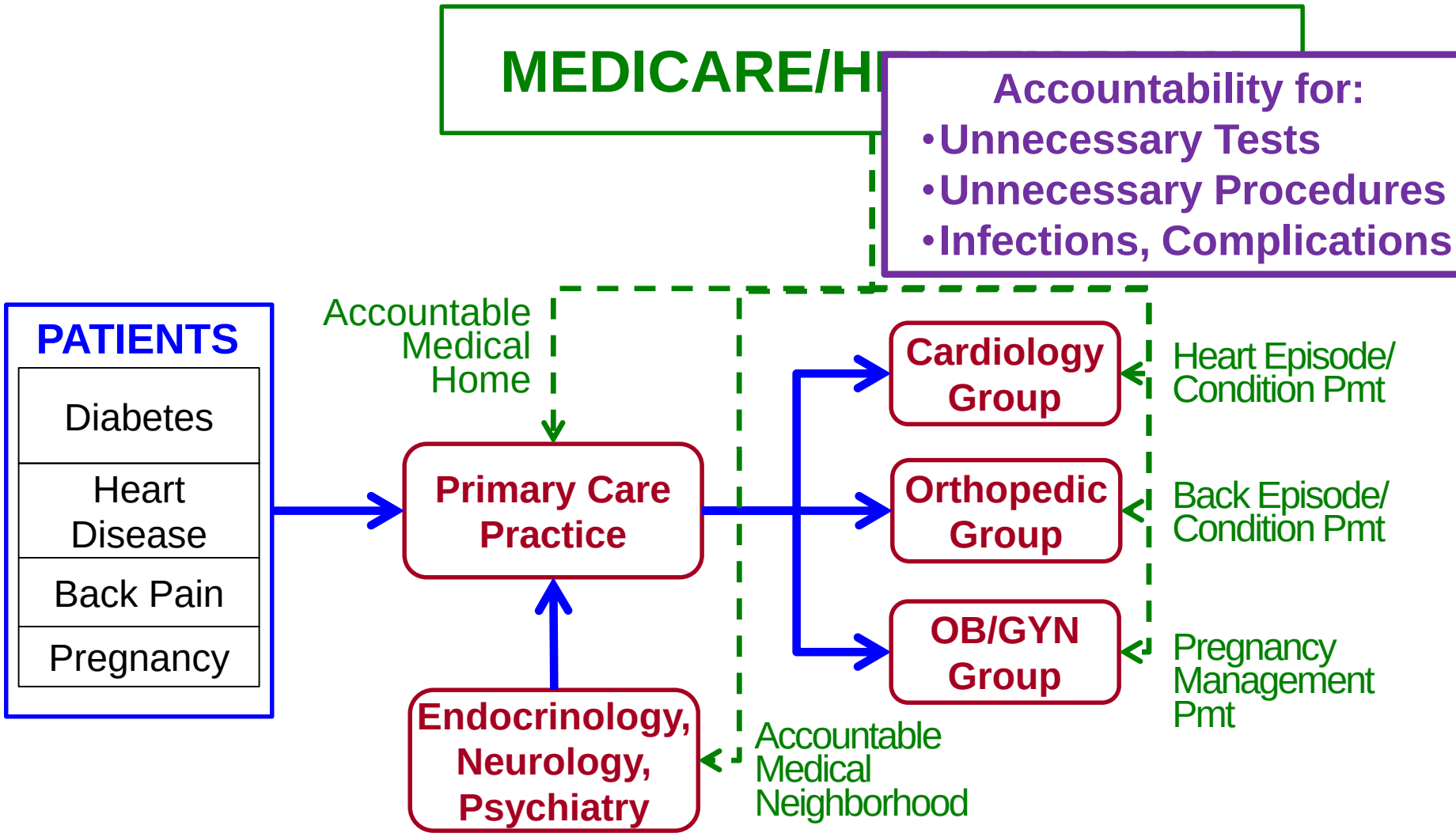
…Which Takes Accountability for What PCPs Can Control/Influence



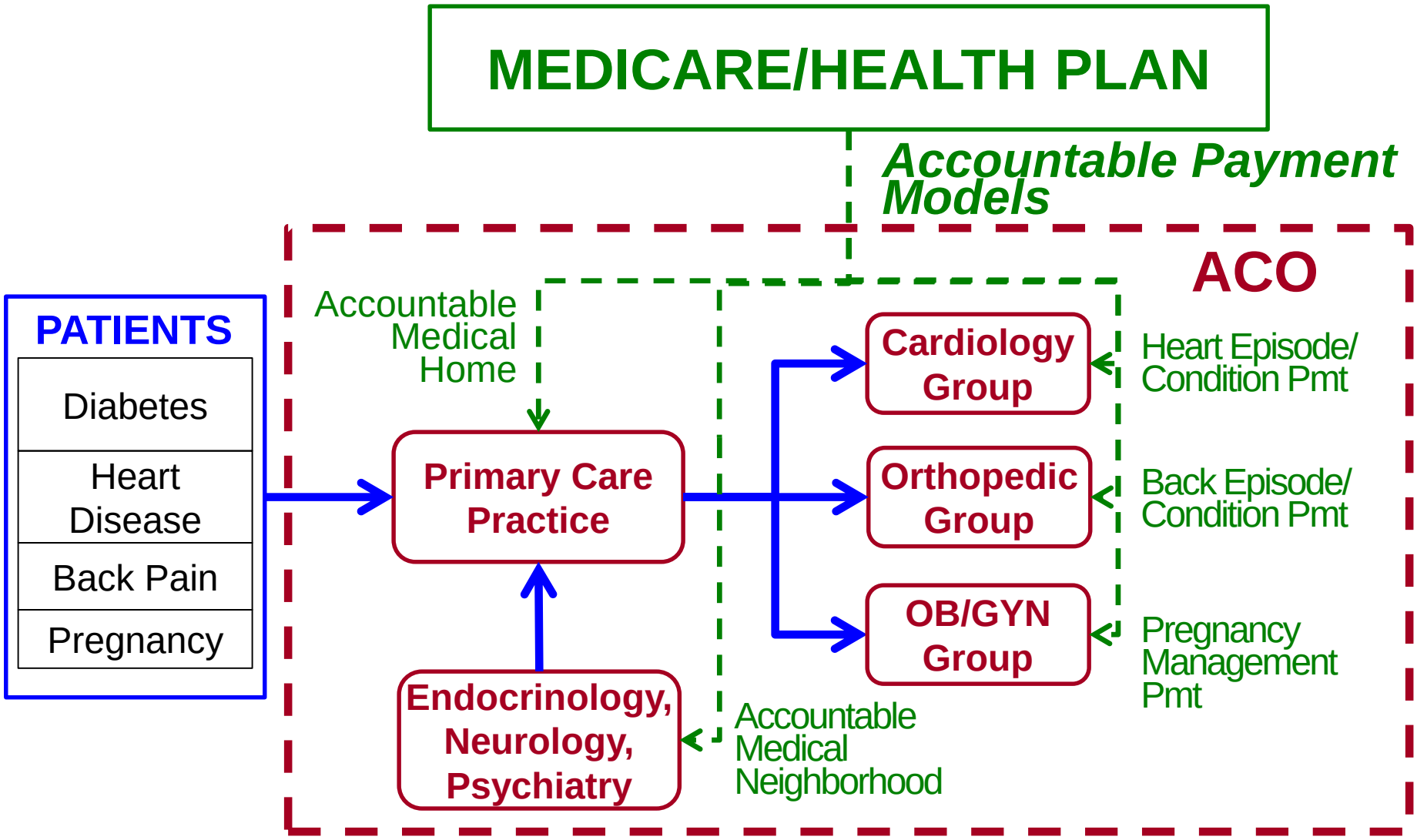
…With a Medical Neighborhood to Consult With on Complex Cases



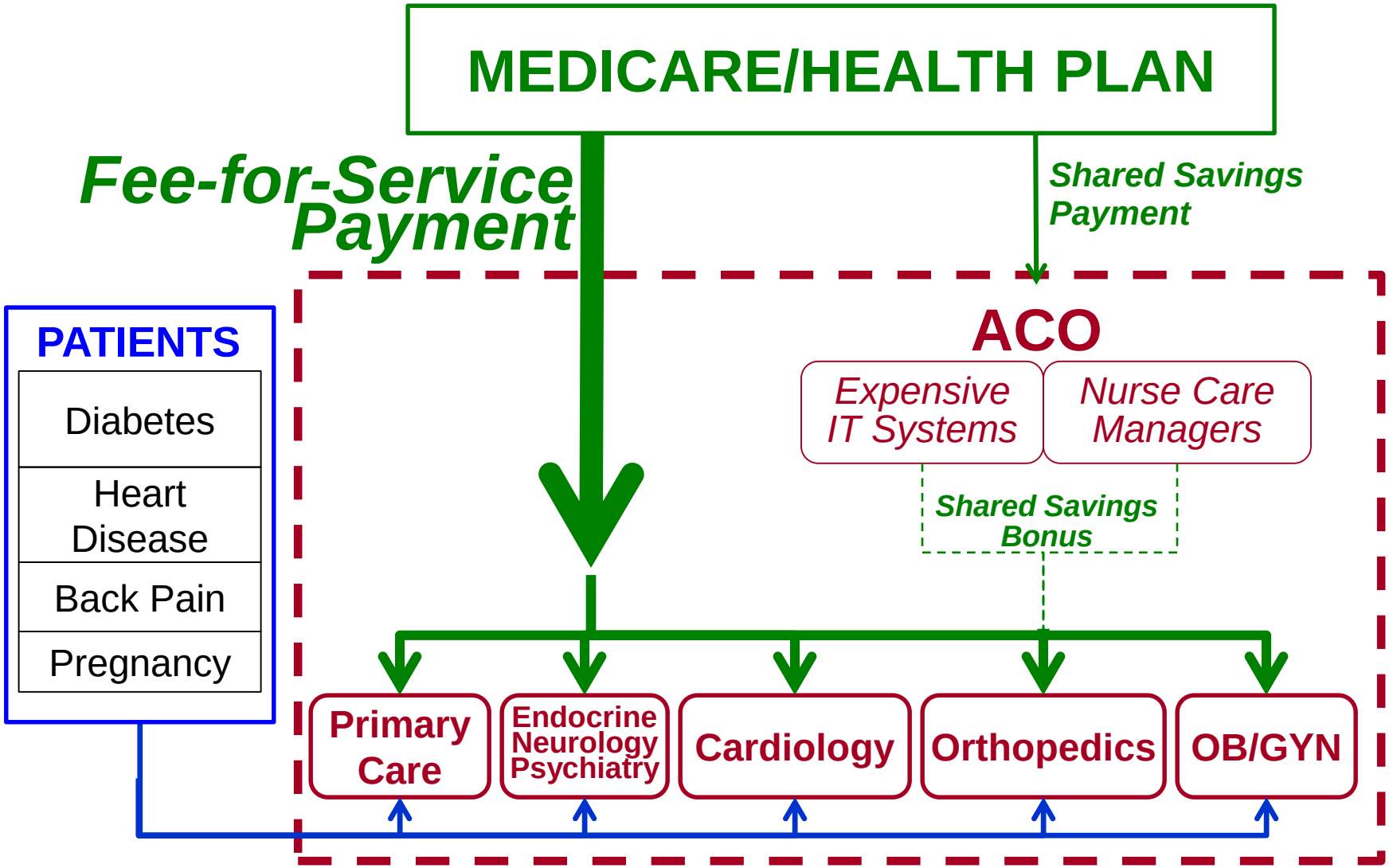
..And Specialists Accountable for the Conditions They Manage



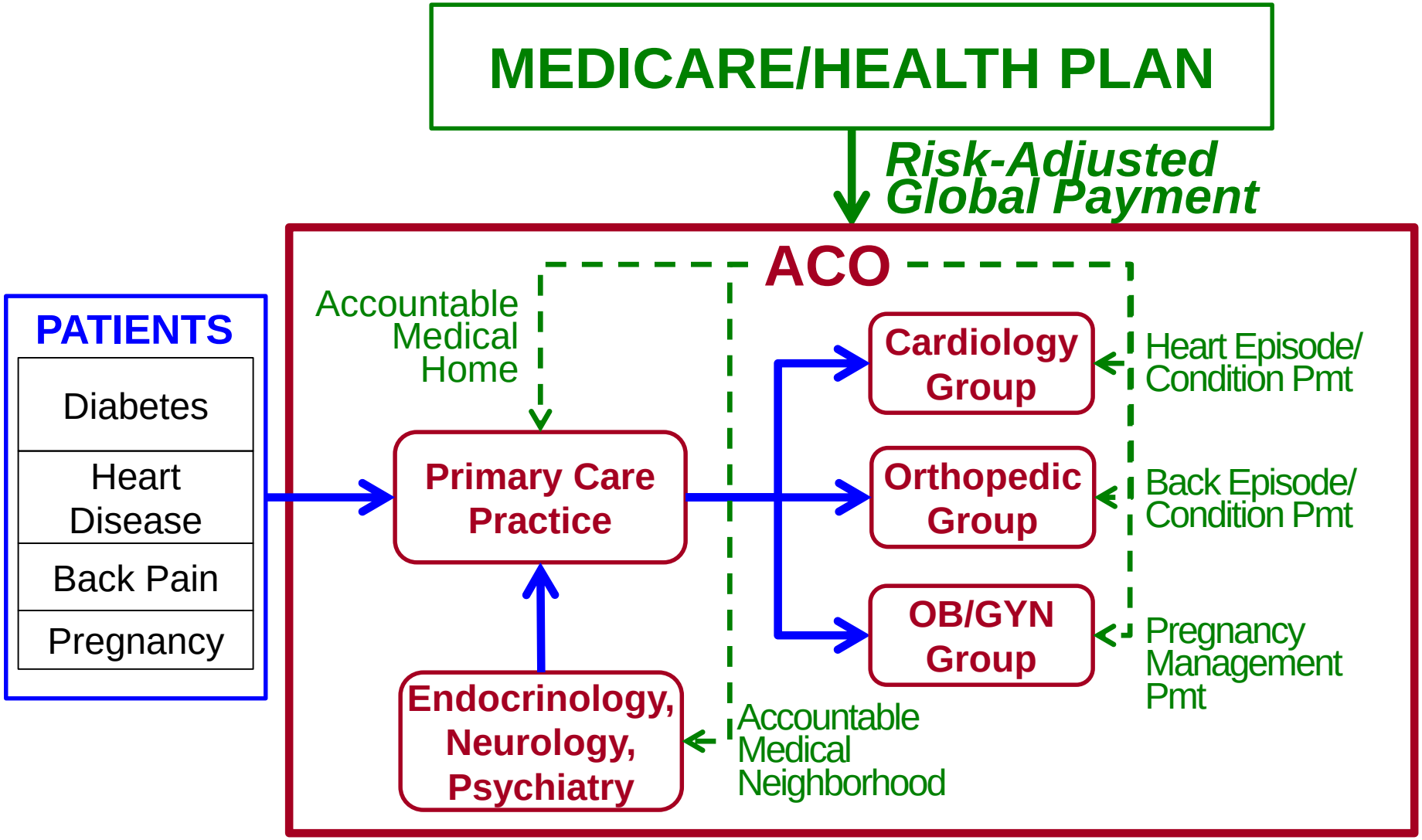
That's Building the ACO from the Bottom Up



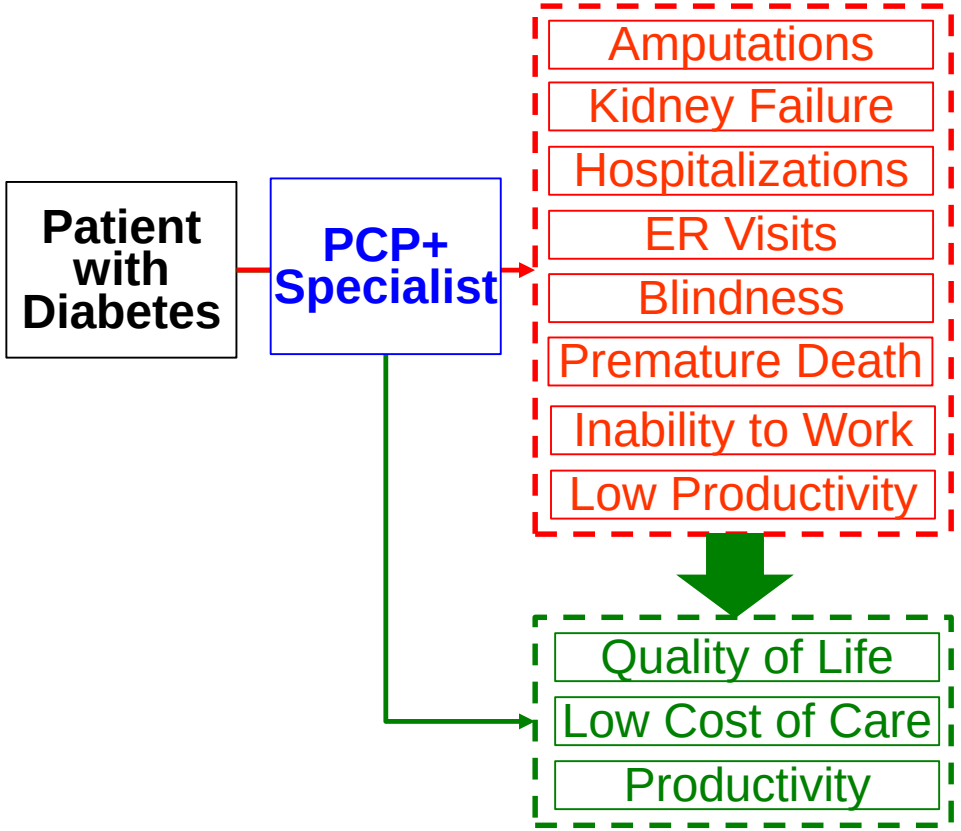
Most ACOs Today Aren't Truly *Reinventing Care or Payment*



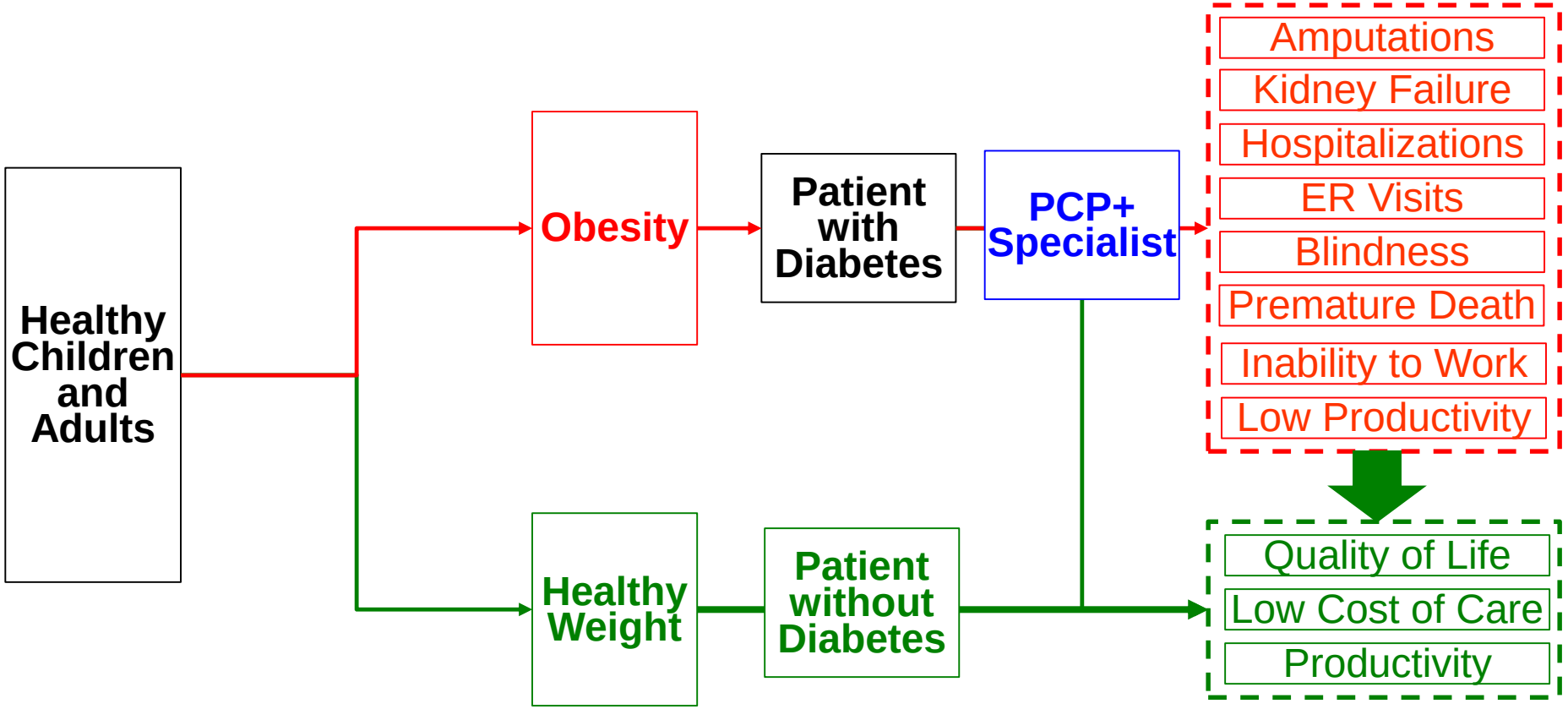
A True ACO Can Take a Global Payment And Make It Work



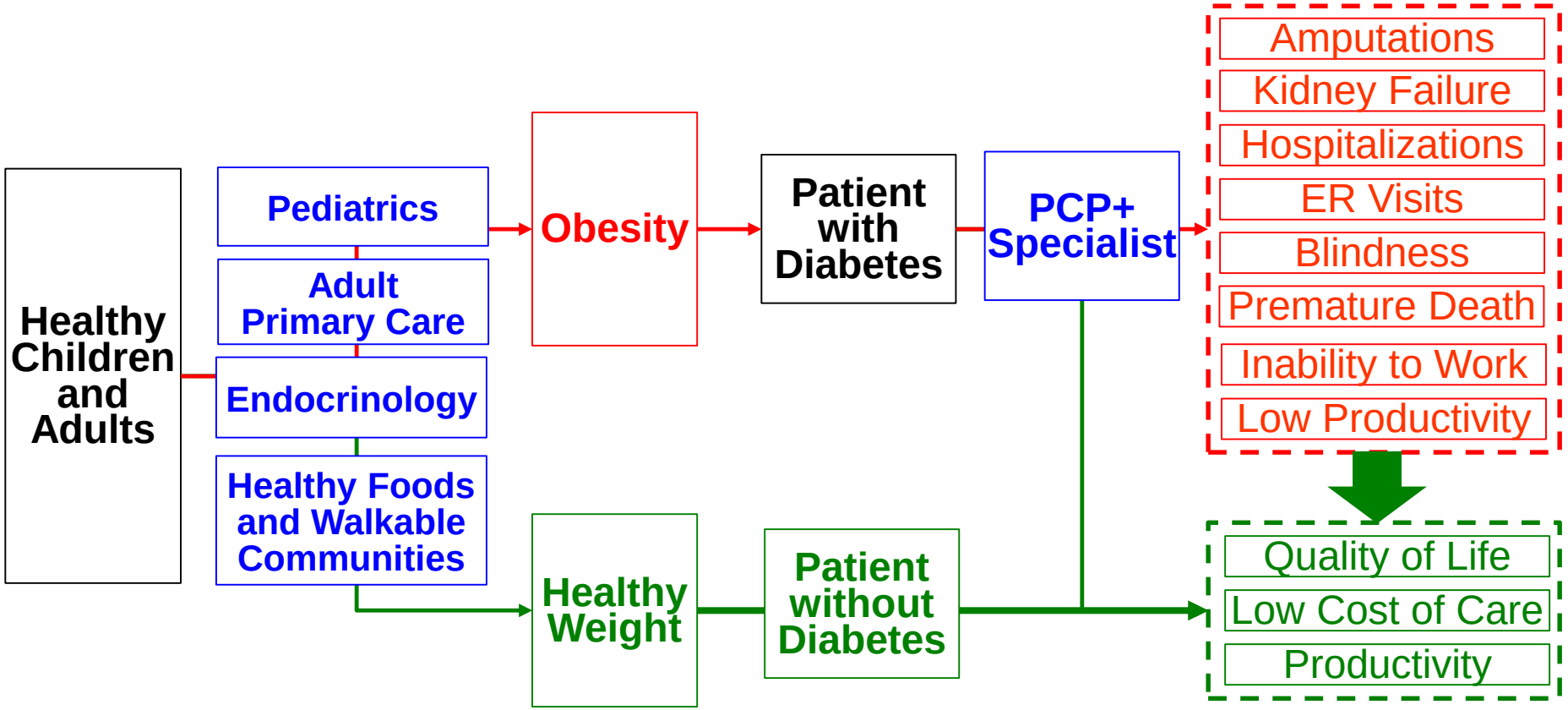
Only So Much Can Be Done Once the Patient Has Diabetes



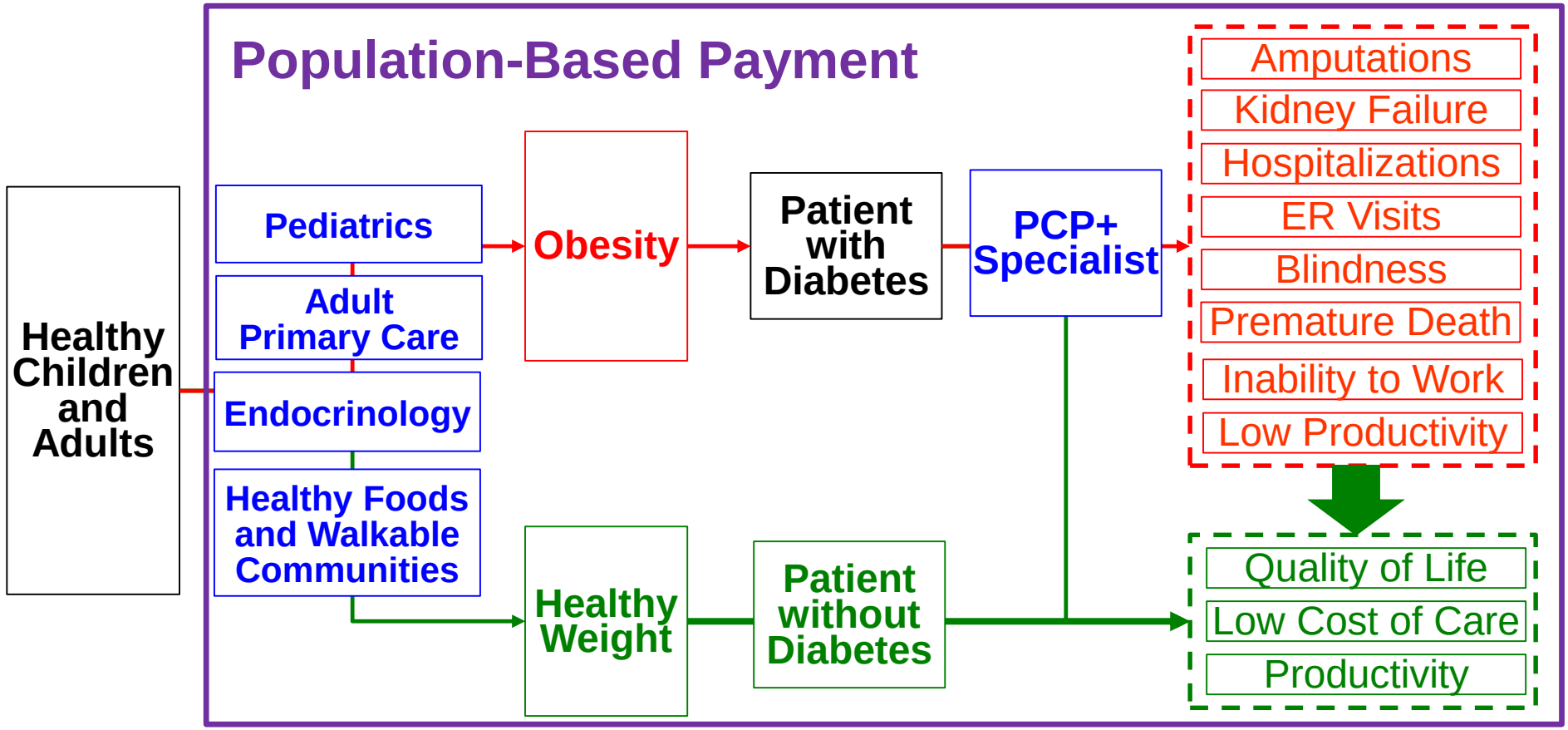
We Need to Also Focus on *Preventing* Diabetes



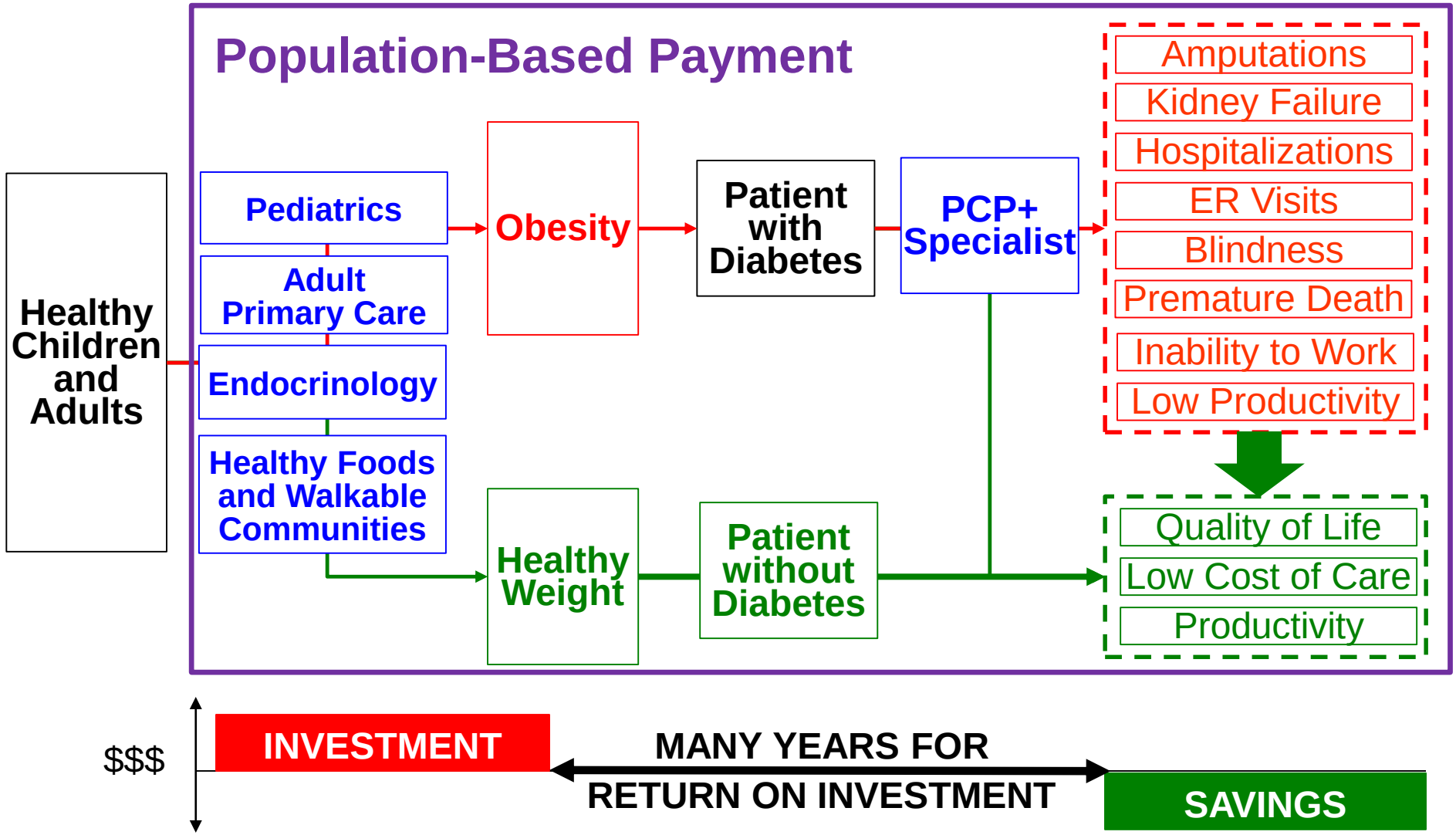
That Means Upstream Investment to Combat Obesity



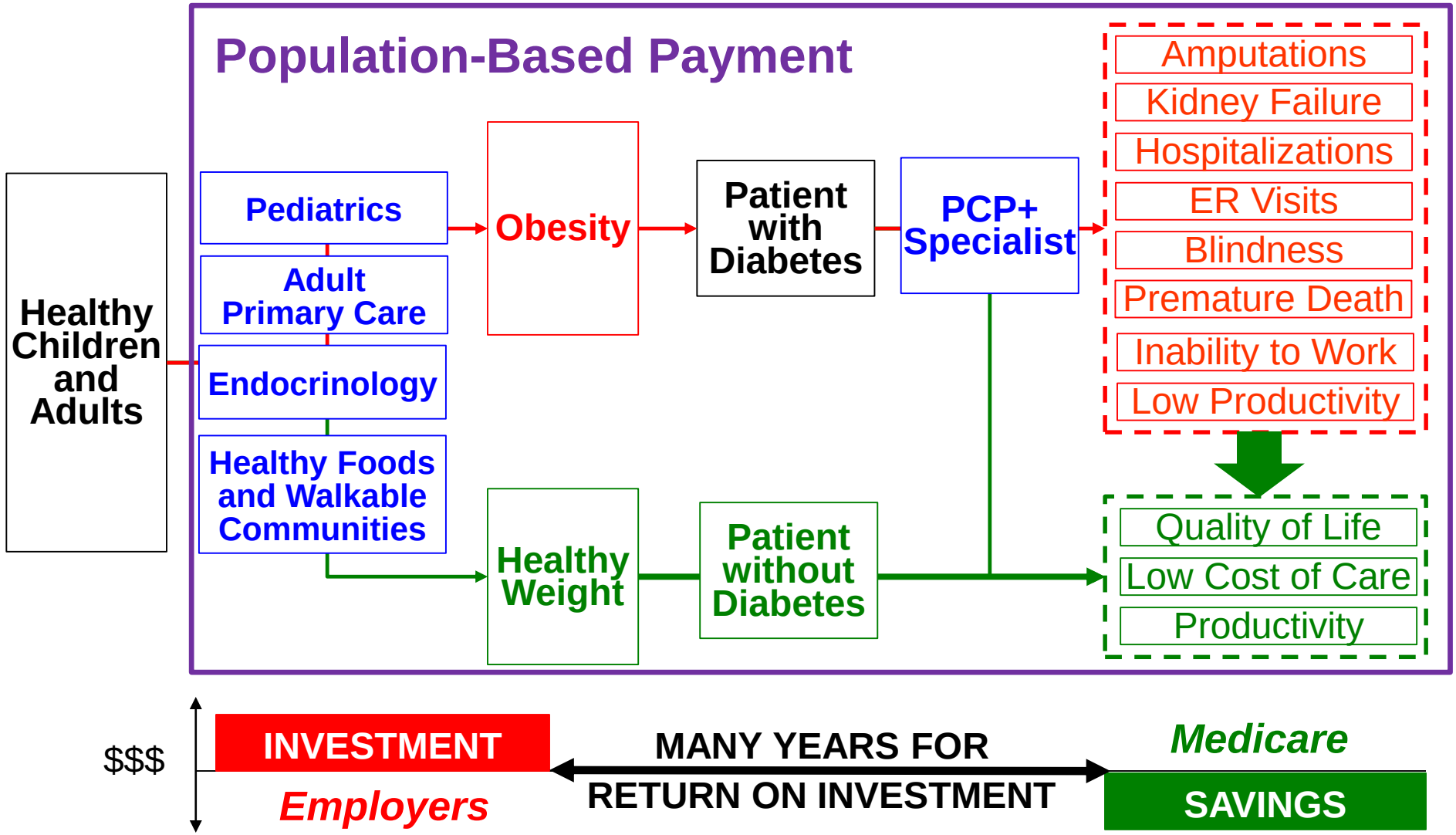
True Population-Based Payment Has to Have a *Long-Term* Focus



Current "Shared Savings" Models Penalize Long-Term Prevention



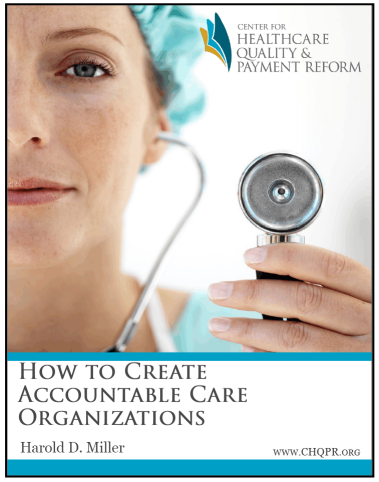
A Public-Private Partnership Will Be Needed For Investment

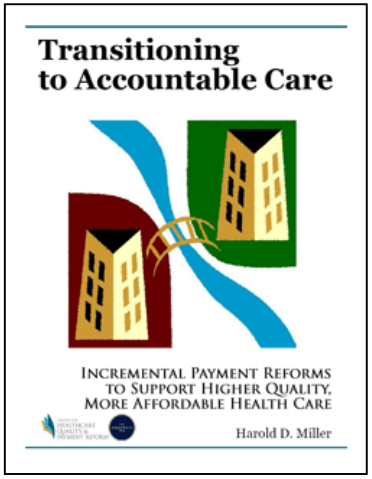


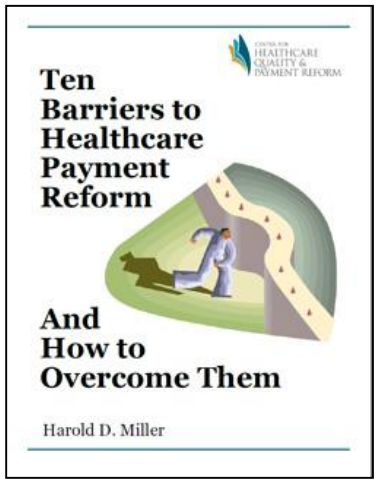
In Summary

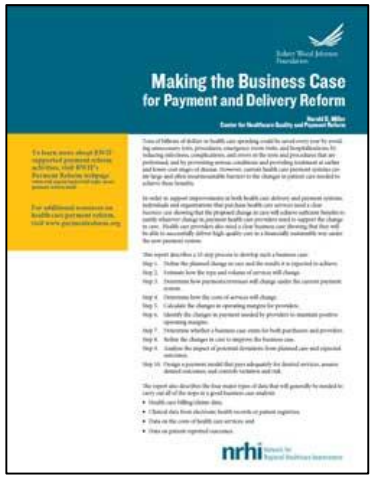
- Most current “reforms” (pay for performance, value-based purchasing, and shared savings) don’t solve the real problems with care delivery and may make things worse
- True payment reform can be a win-win-win:
  - Better care for patients
  - Lower spending for payers
  - Financially viable PCP and endocrinology practices that attract new physicians
- Condition-based payment for diabetes can be an important building block for successful ACOs
- Medicare and commercial health plans need to implement new payment models designed by physicians
- Multi-year contracts and public-private partnerships will be needed to adequately invest in prevention for long-term savings and better outcomes

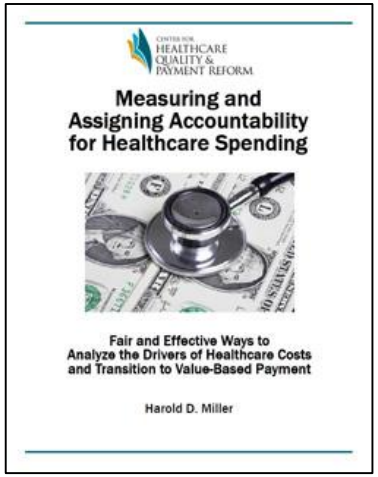
Learn More About Win-Win-Win Payment and Delivery Reform











Center for Healthcare Quality and Payment Reform
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