



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

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Center for Healthcare Quality and Payment Reform

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

# The Problem of Diabetes

**Patient  
with  
Diabetes**



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

# A Quarter-Trillion Dollar Impact on the Economy

Patient  
with  
Diabetes

**\$176 Billion in  
Healthcare Spending**

**\$69 Billion in  
Reduced Productivity**

---

**\$245 Billion  
Total Cost**

**Bad Outcomes &  
High Spending**

Amputations

Kidney Failure

Hospitalizations

ER Visits

Blindness

Premature Death

Inability to Work

Low Productivity

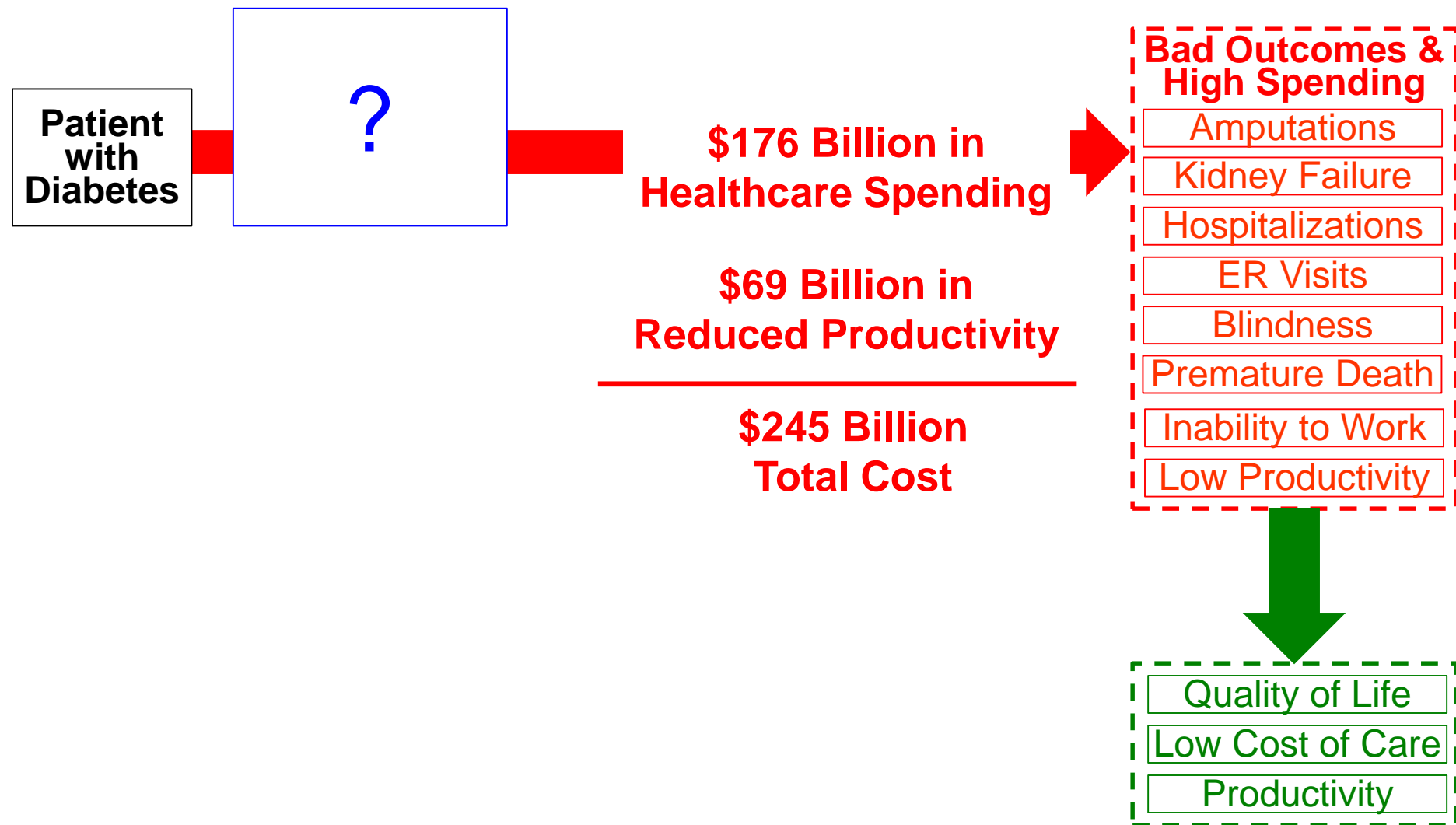
**Source:**

“Economic Costs of Diabetes  
in the U.S. in 2012,”

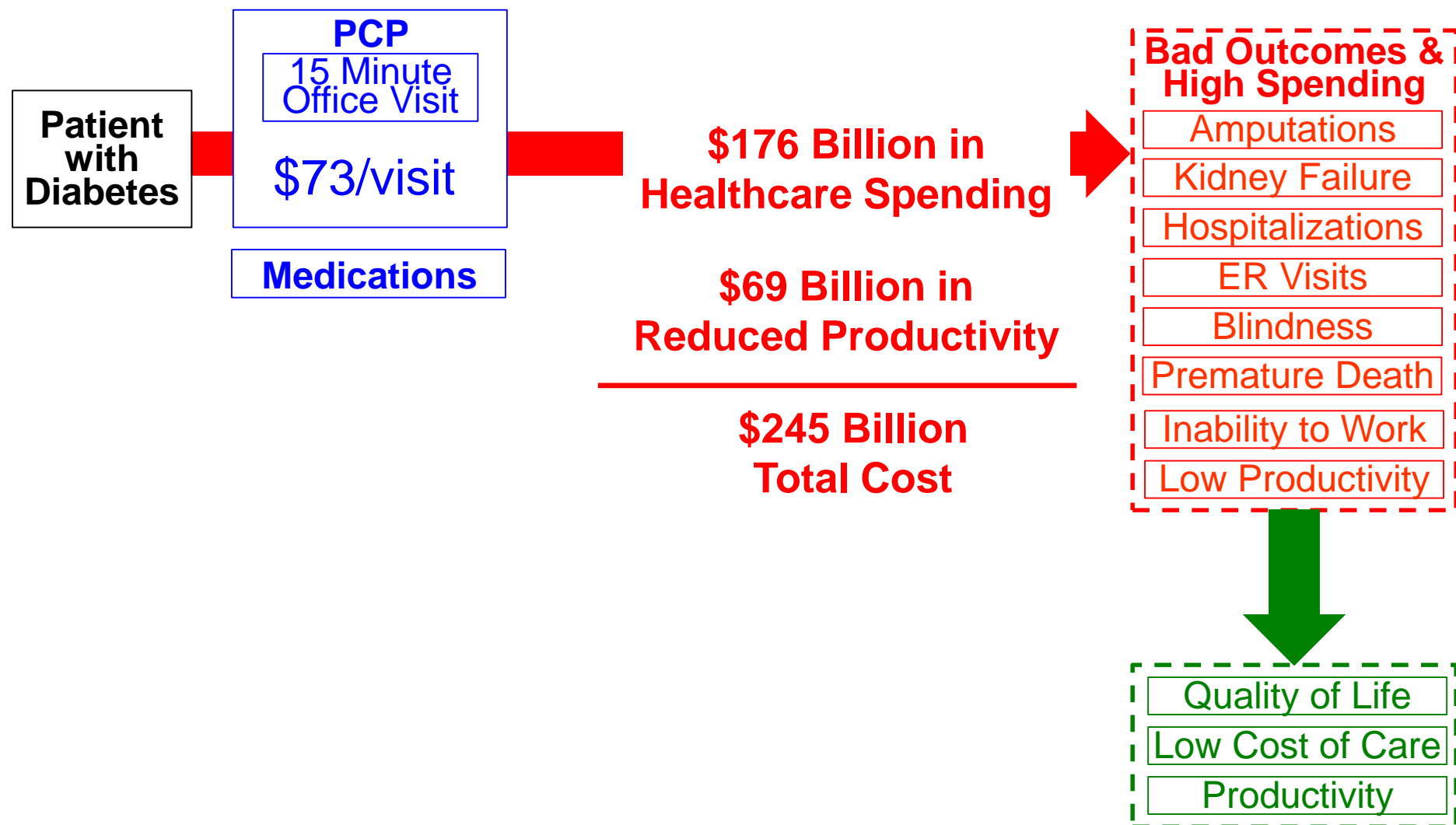
*Diabetes Care* (Volume 36)

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%**

**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**

Source: Average  
D5 Composite Measures in  
Cincinnati and Minnesota

# Why Don't PCPs Do a Better Job?

**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%**

**Bad Outcomes & High Spending**

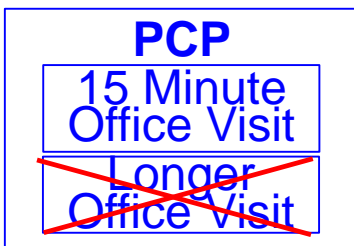
- Amputations
- Kidney Failure
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- ER Visits
- Blindness
- Premature Death
- Inability to Work
- Low Productivity

**Quality of Life**  
 Low Cost of Care  
 Productivity

Source: Average D5 Composite Measures in Cincinnati and Minnesota

# More Time With Patients Cuts Total Revenues to PCP Practice

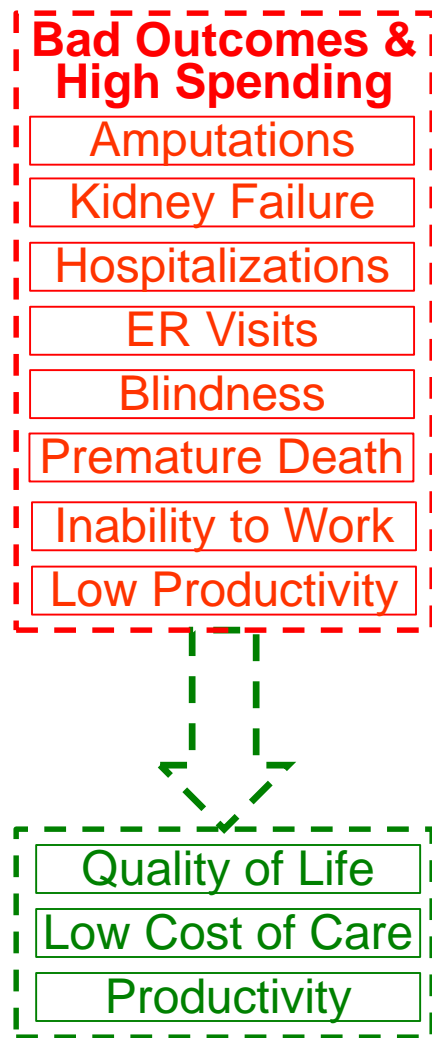
**Patient with Diabetes**



**Medications**

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

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



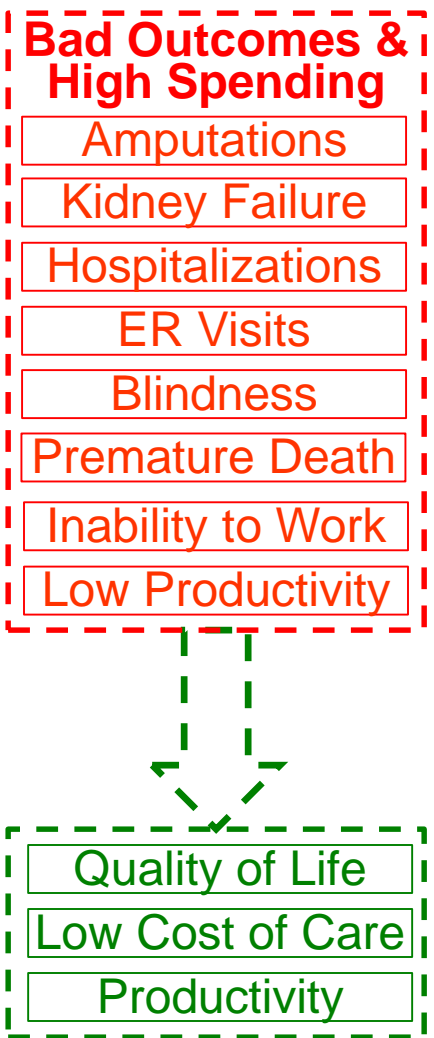


# Proactive Outreach to Patients to Improve Quality?

Patient with Diabetes

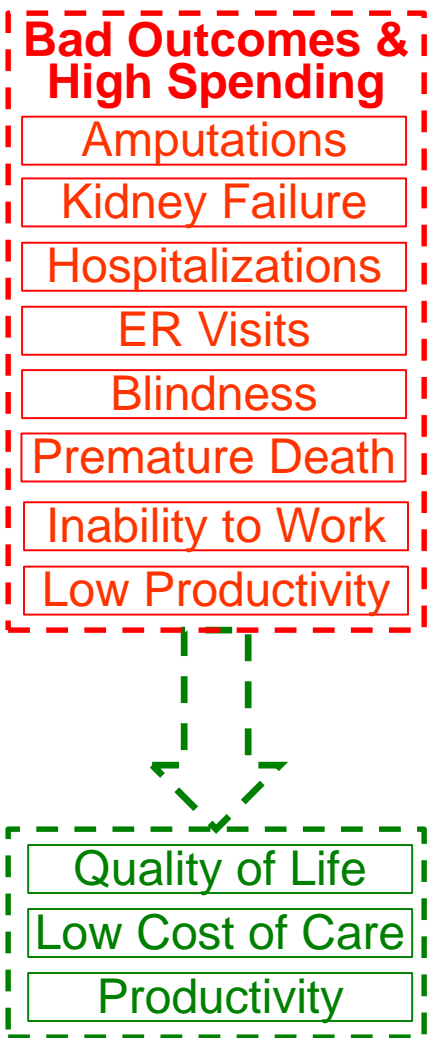
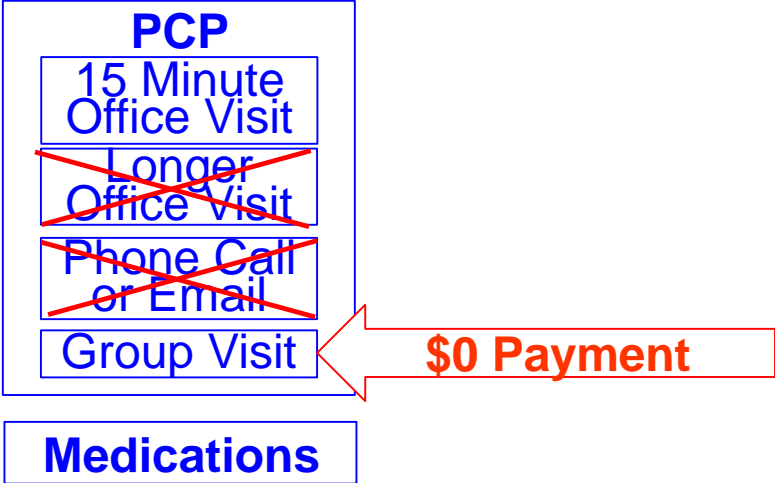


\$0 Payment



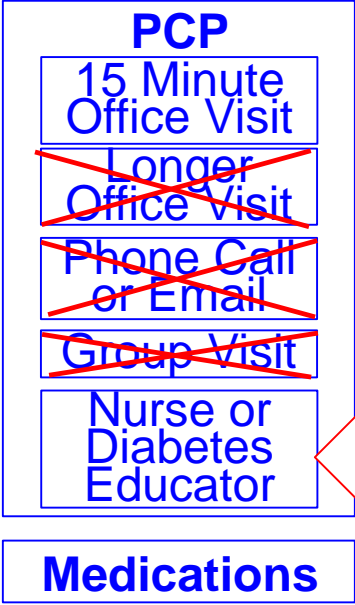
# Group Visits to Deliver Care at Lower Cost?

**Patient with Diabetes**

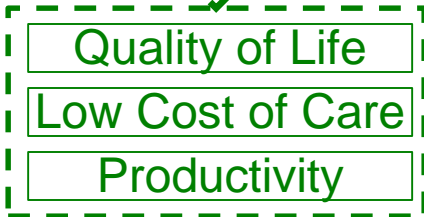
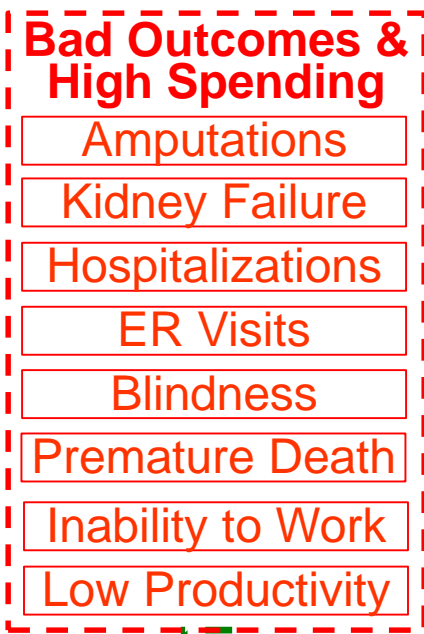


# Hire a Nurse/Diabetes Educator to Help Patients Manage Health?

**Patient with Diabetes**

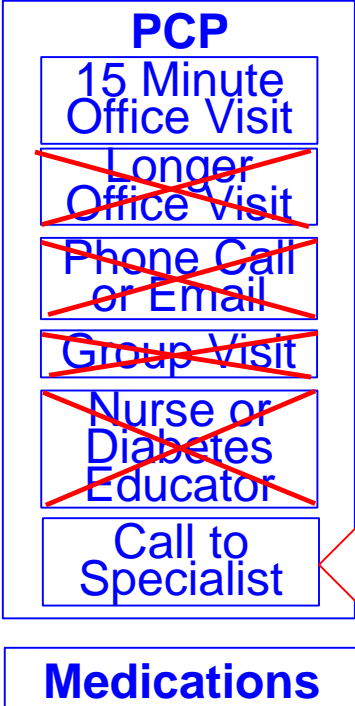


**\$0 Payment**

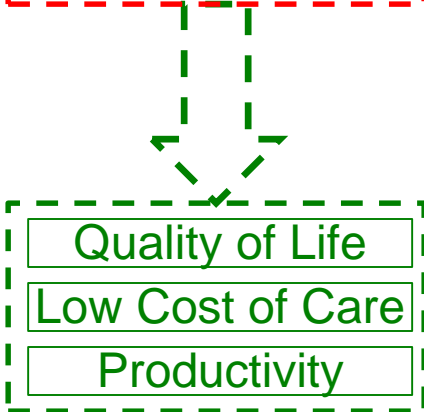


# Call an Endocrinologist to Help With Complex Patients?

**Patient with Diabetes**

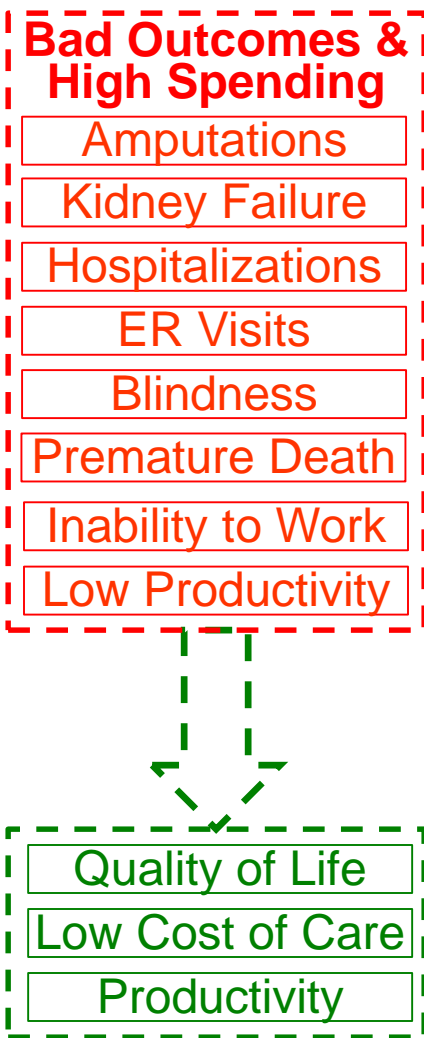
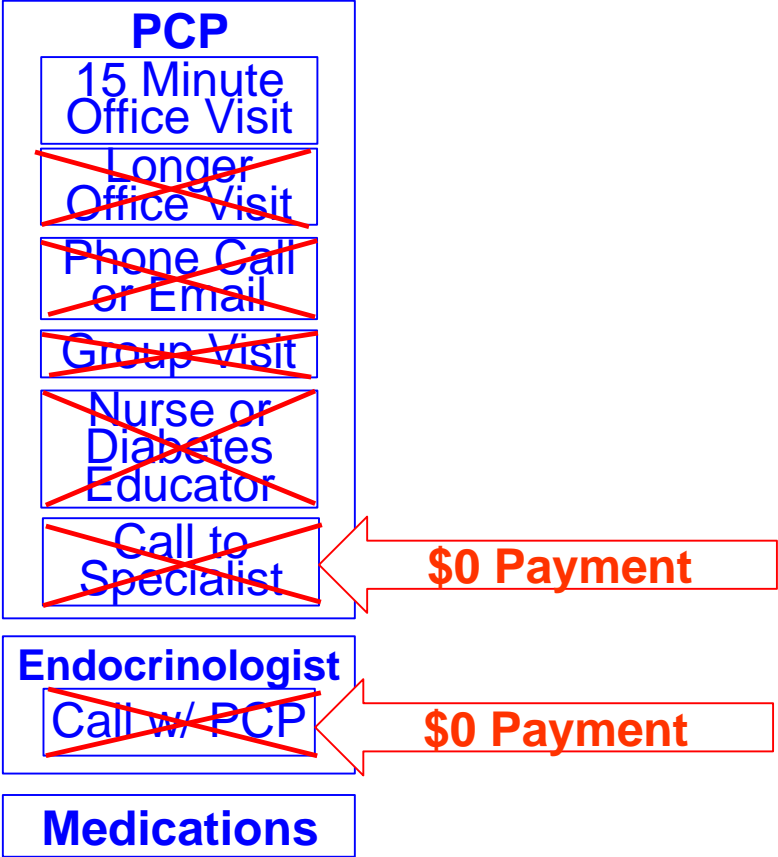


**\$0 Payment**



# No Payment for Coordination of PCPs and Specialists

Patient with Diabetes

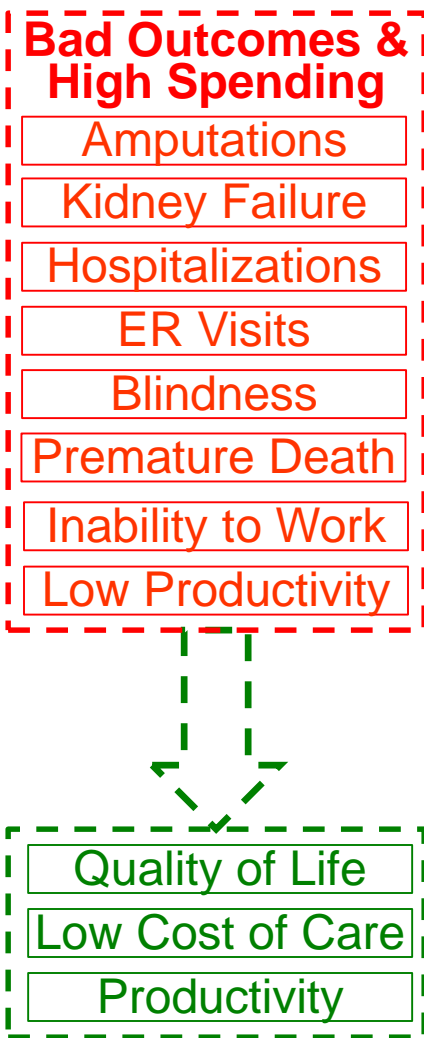


# Payers Do Pay for *Office Visits* with Endocrinologists....

**Patient with Diabetes**



**\$108-166**



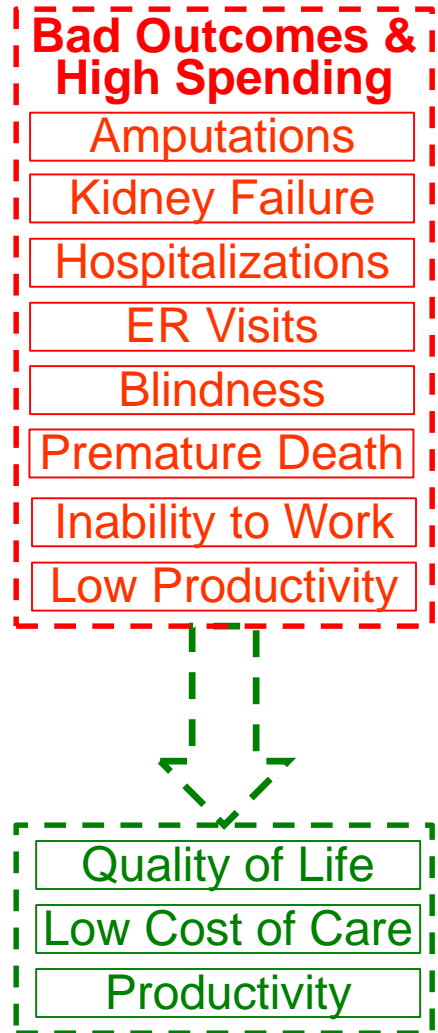
# Long Waits Due to Many Visits for Issues That Needed Only a Call...

**Patient with Diabetes**



**\$108-166**

**3-9 Month Wait for Visit**



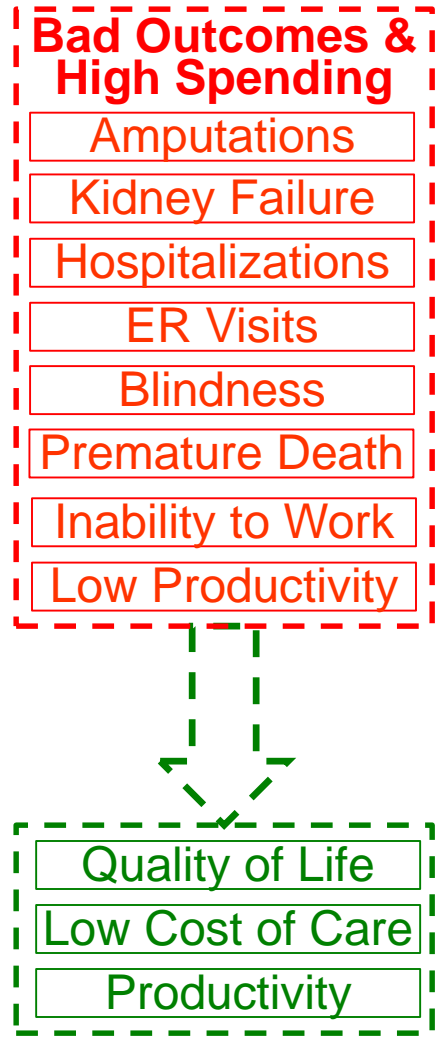
# ...And the Extra Copay May Deter the Patient From Making the Visit

**Patient with Diabetes**



**\$108-166**

**3-9 Month Wait for Visit**  
**Extra Patient Copay**





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

**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

- Medications**
- ~~Low Copay~~
  - High Copay

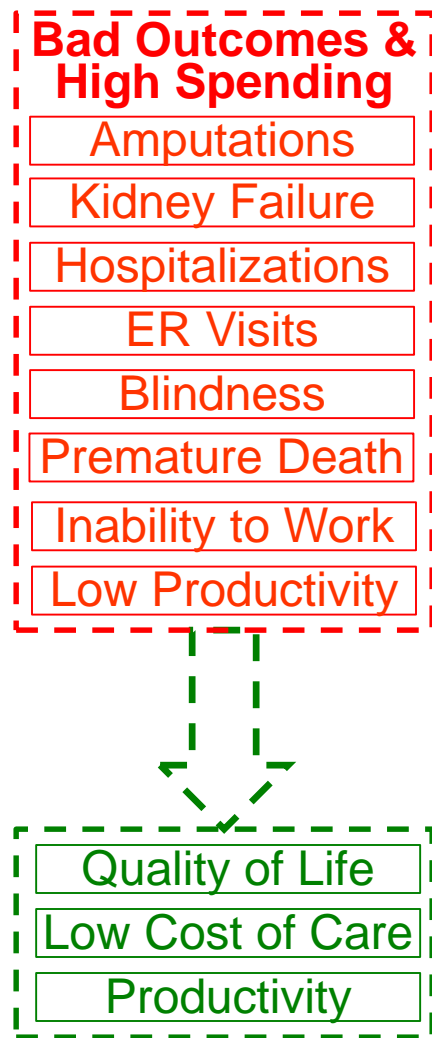
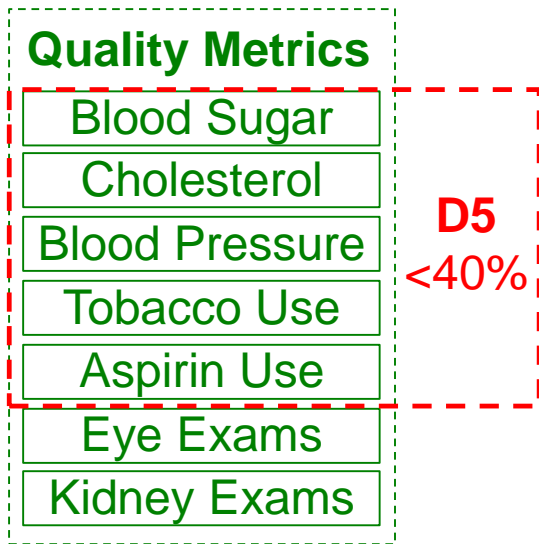
**High Cost-Share**

- 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

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

**Patient with Diabetes**



# What Are Medicare and Private Health Plans Doing to Fix This?

**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

**Medications**

- ~~Low Copay~~
- High Copay

**Bad Outcomes & High Spending**

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

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**Quality of Life**

- Low Cost of Care
- Productivity

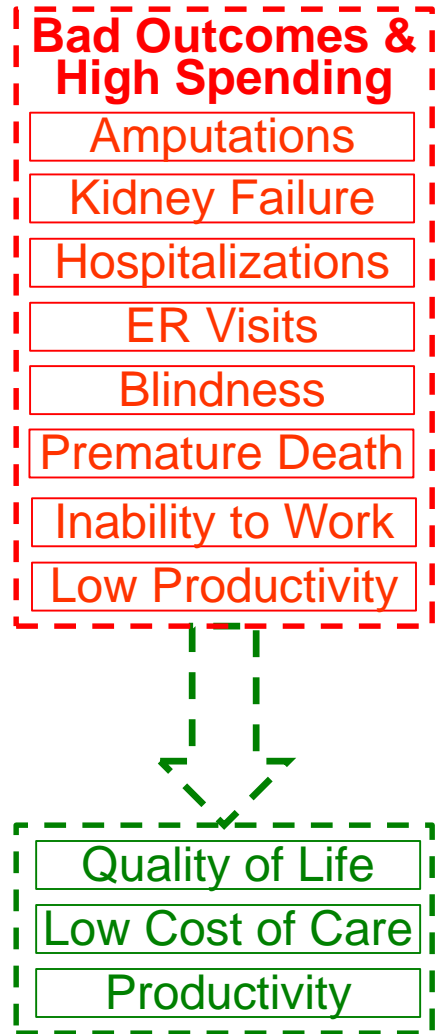
# Strategy 1: Force PCPs to Buy an EHR

**Patient  
with  
Diabetes**



## 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



# Strategy 2: Bonuses/Penalties for Quality

**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

**Medications**

- ~~Low Copay~~
- High Copay

**P4P/VBP**

**Quality Metrics**

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

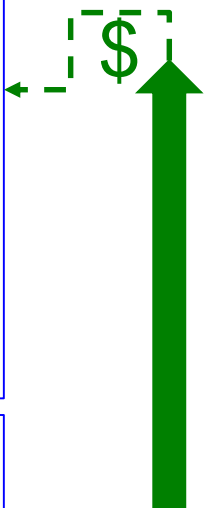
**Bad Outcomes & High Spending**

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

Hospitalizations & Death Due to Overtreatment

**Quality of Life**

- Low Cost of Care
- Productivity

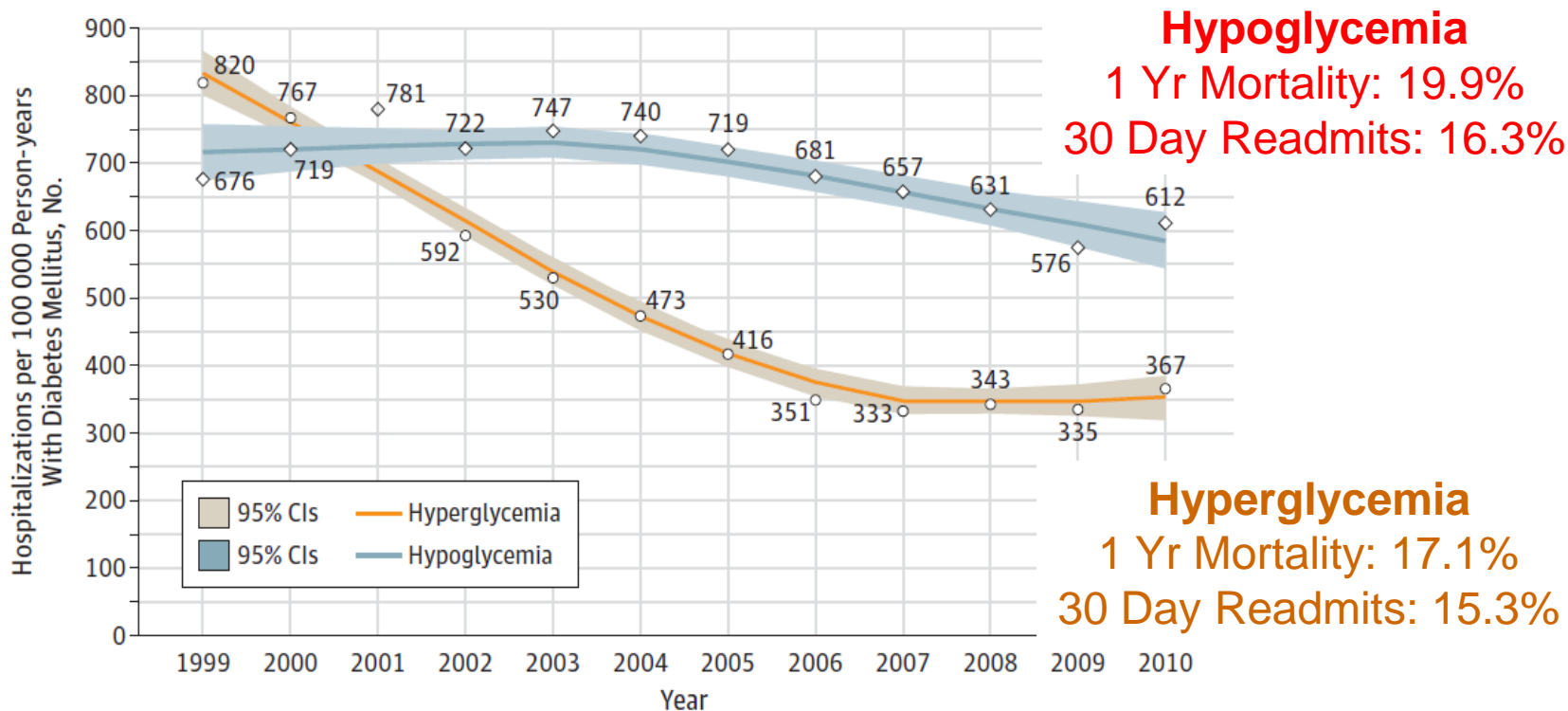


- No additional resources to address the barriers preventing higher quality
- Unintended consequences of over-focus on metrics



# 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



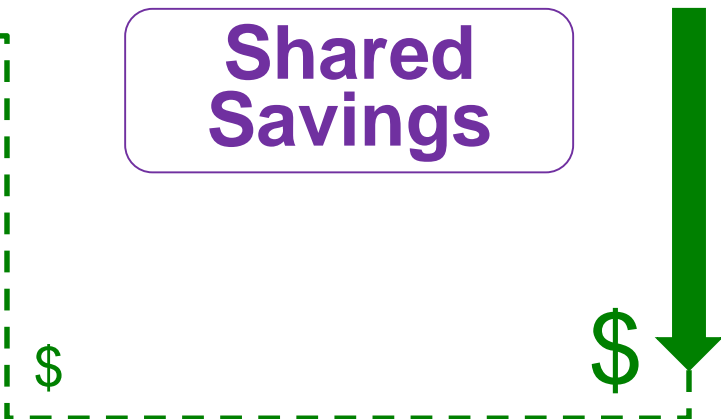
Source: National Trends in US Hospital Admissions for Hyperglycemia and Hypoglycemia Among Medicare Beneficiaries, 1999 to 2011 JAMA Internal Medicine May 17, 2014

# Strategy 3: “Shared Savings”

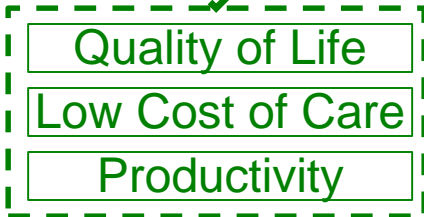
**Patient  
with  
Diabetes**



**Shared Savings**



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



# Strategy 4: Patient-Centered Medical Home

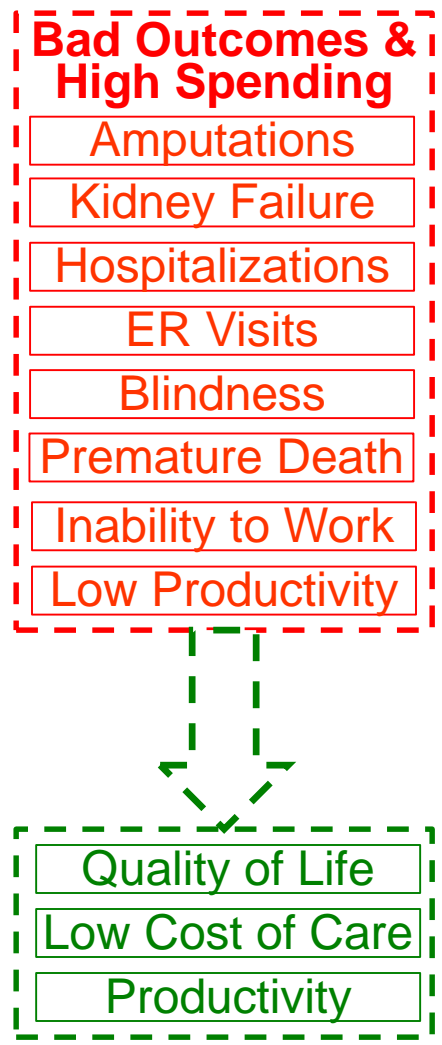
**Patient  
with  
Diabetes**



**PCMH/  
PMPM**

**(Small)  
Monthly  
Payment  
Per  
Patient**

- Monthly payment may be too 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





# A Better Way: Condition-Based Payment

**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

## Medications

- Low Copay

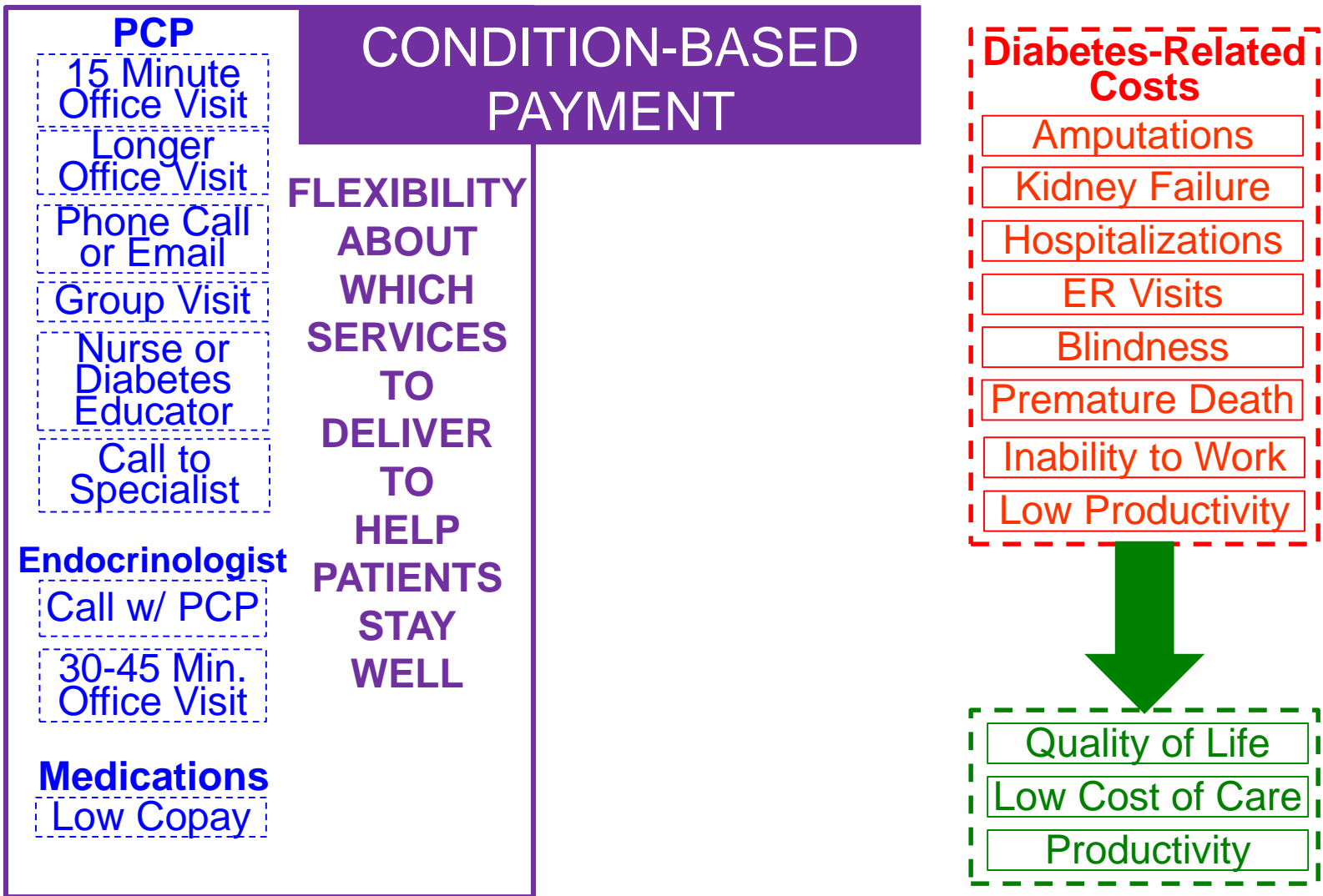
**CONDITION-BASED  
PAYMENT**

- 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

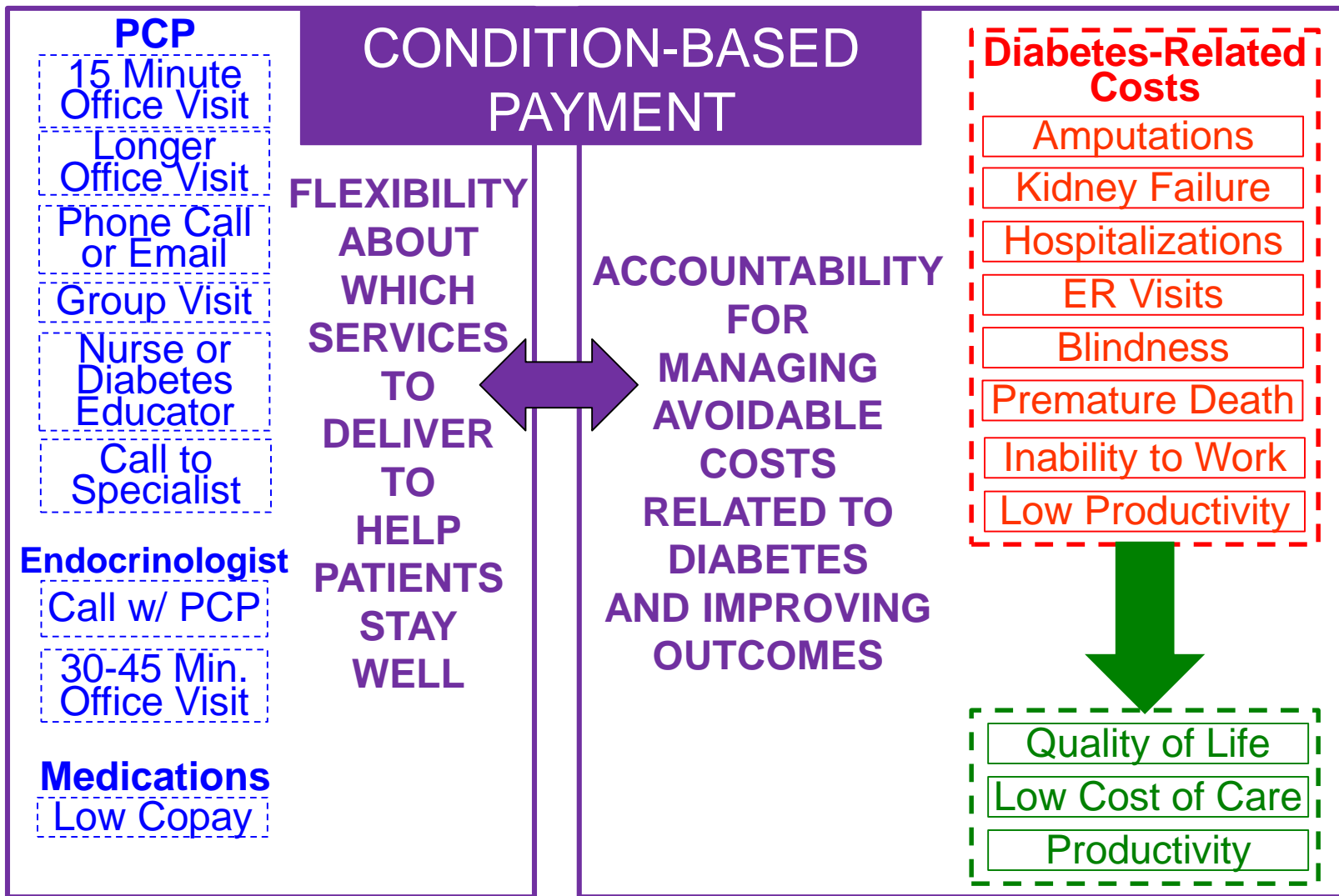
# Flexibility to Deliver Care Without Restrictions of FFS

**Patient with Diabetes**



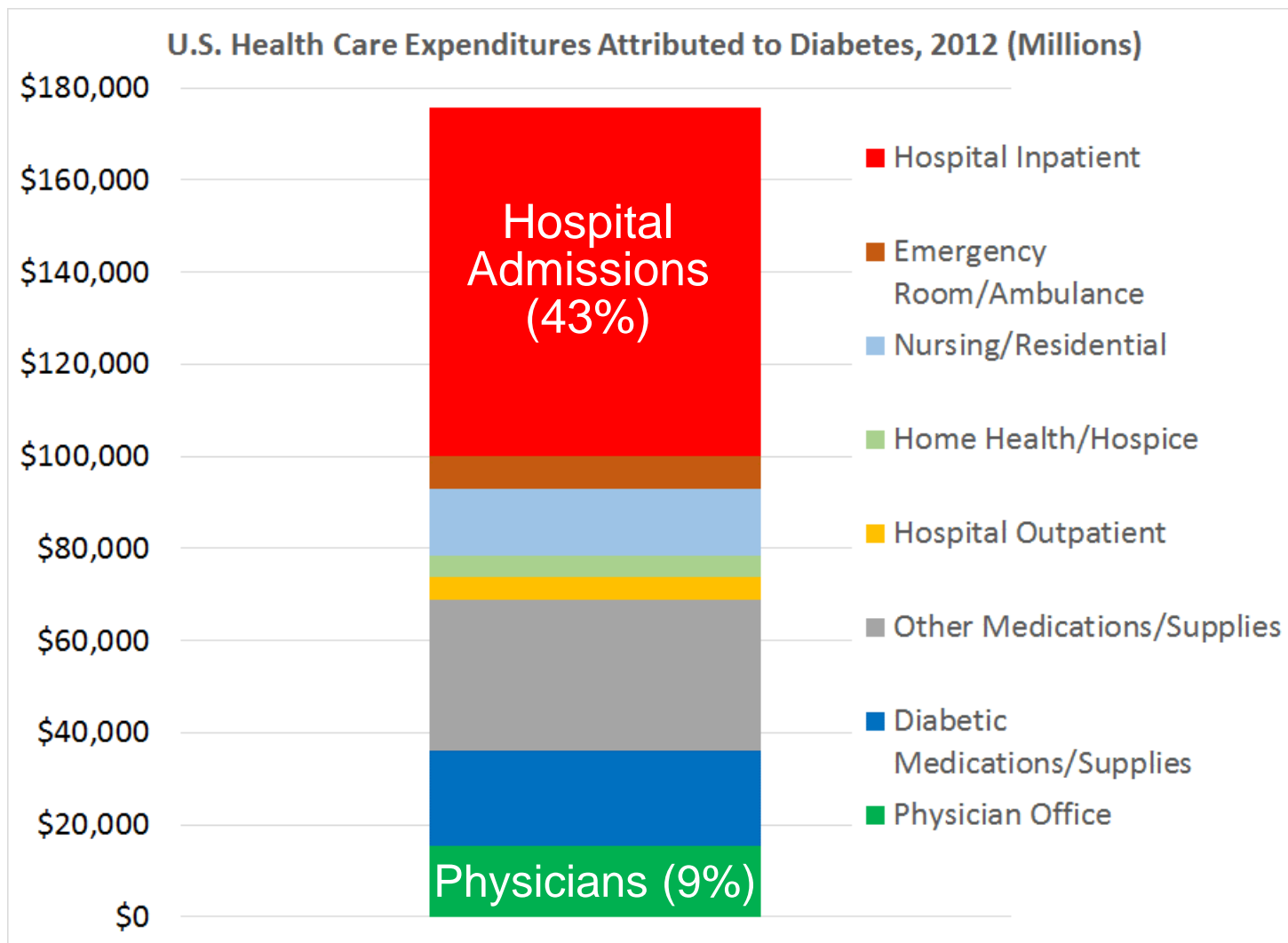
# Accountability to Ensure Outcomes and Costs Improve

**Patient with Diabetes**

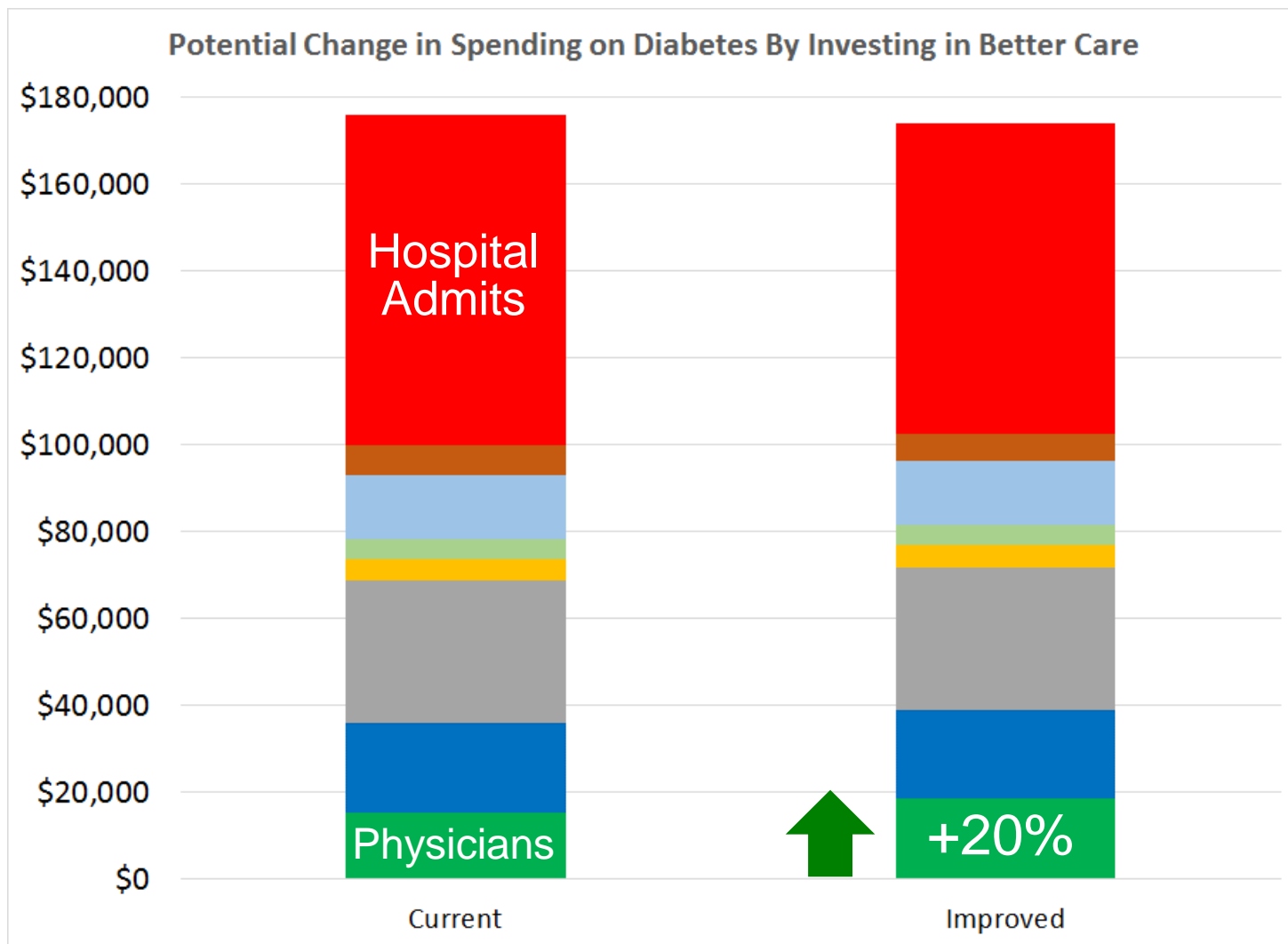


# Most of the Money Today is Going to Hospitals, Not Doctors

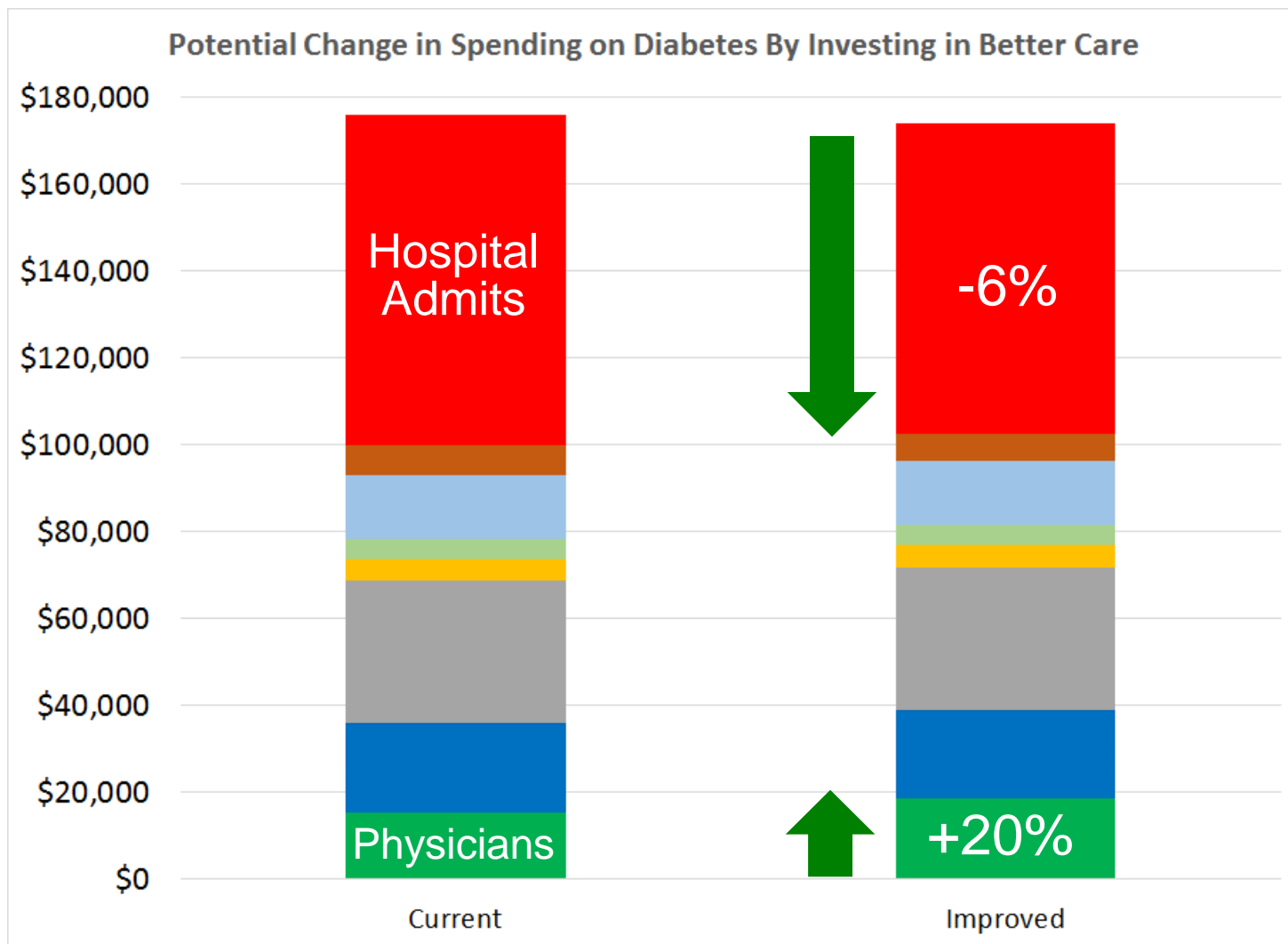
**Source:**  
 “Economic Costs of Diabetes in the U.S. in 2012,”  
*Diabetes Care*  
 (Volume 36)  
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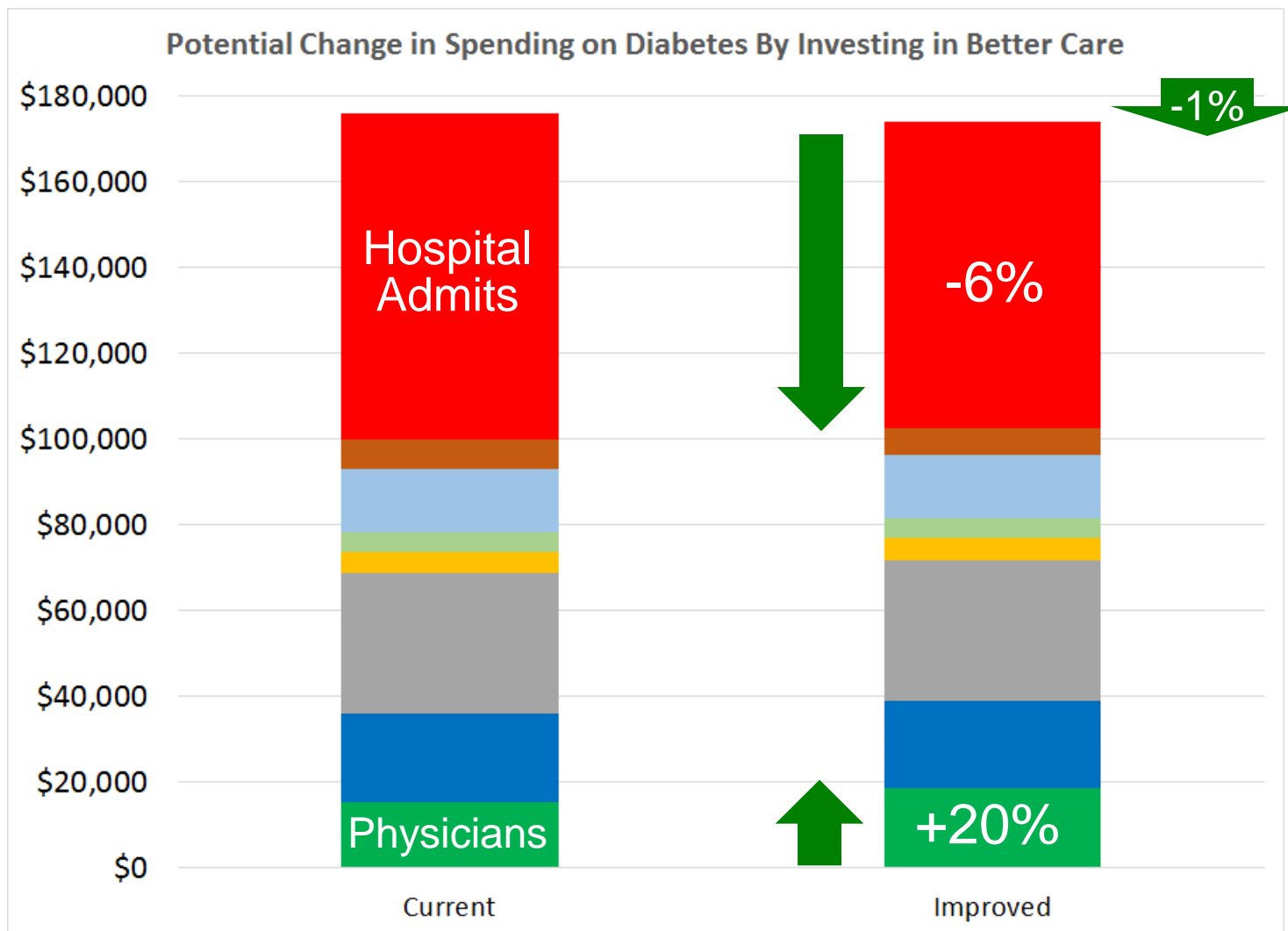
# Could We Afford to Spend 20% More on Better Care Management?



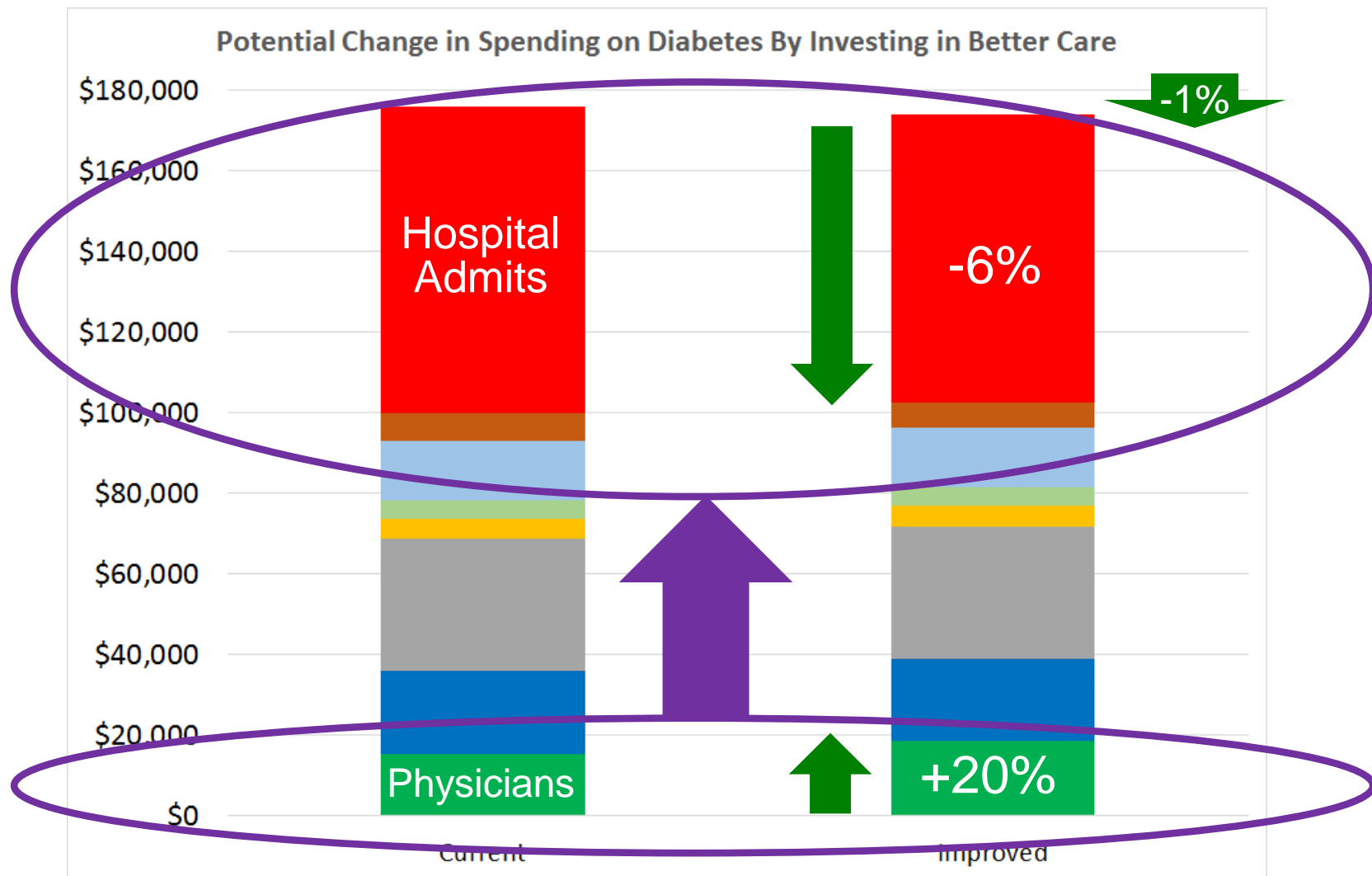
# A Small Reduction in Expensive Complications Saves A Lot of \$\$\$



# 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

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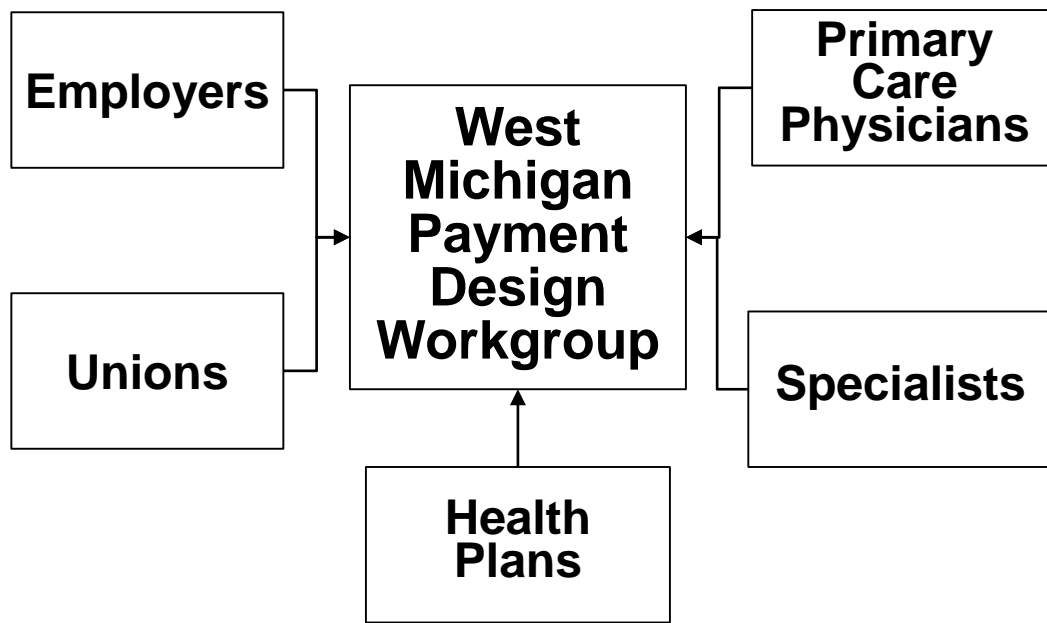
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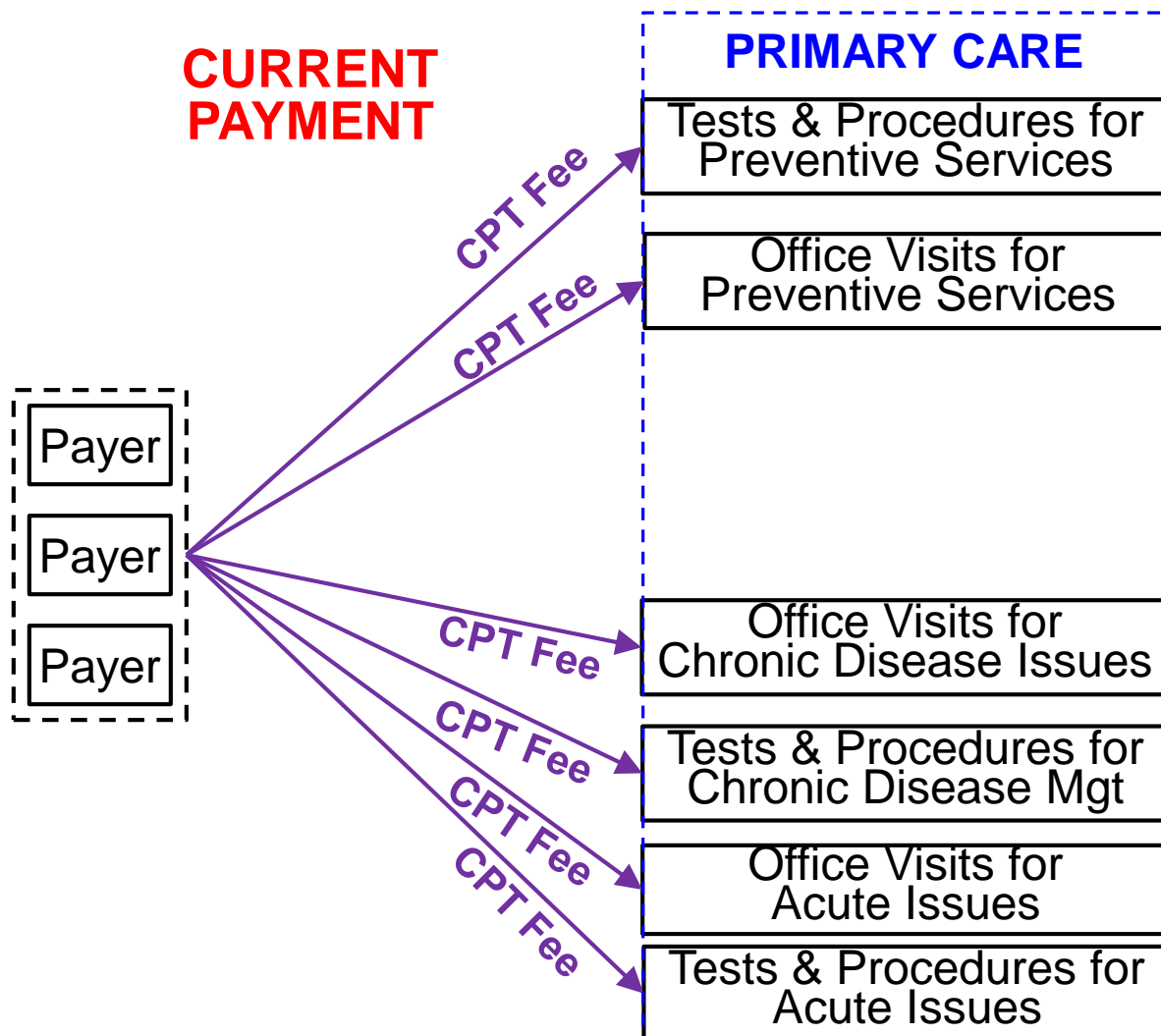
**X. FAQ: How a Patient-Centered Primary Care Payment and Delivery System Would Work in Specific Situations** ..... 26

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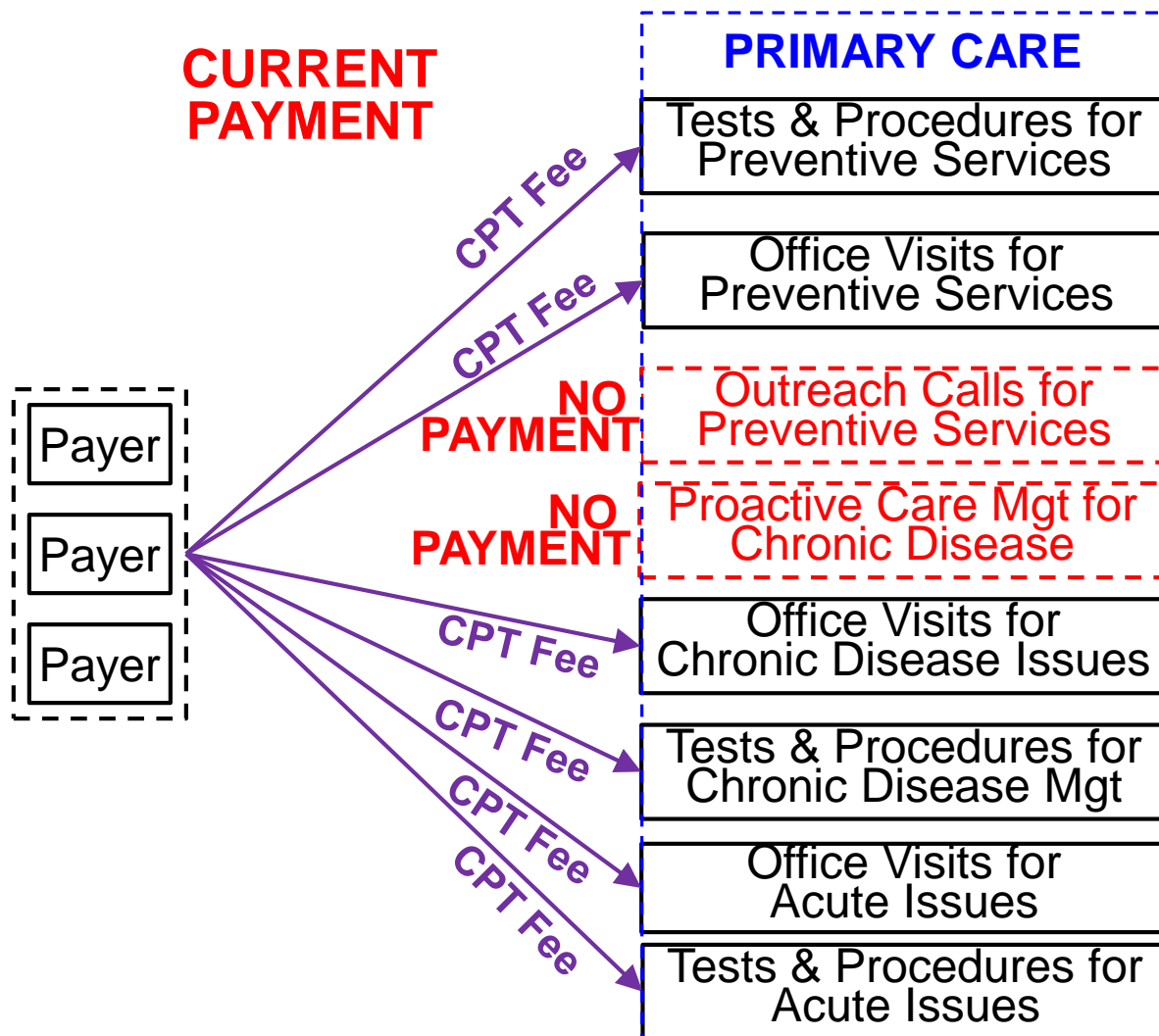


# Current Payment for Primary Care

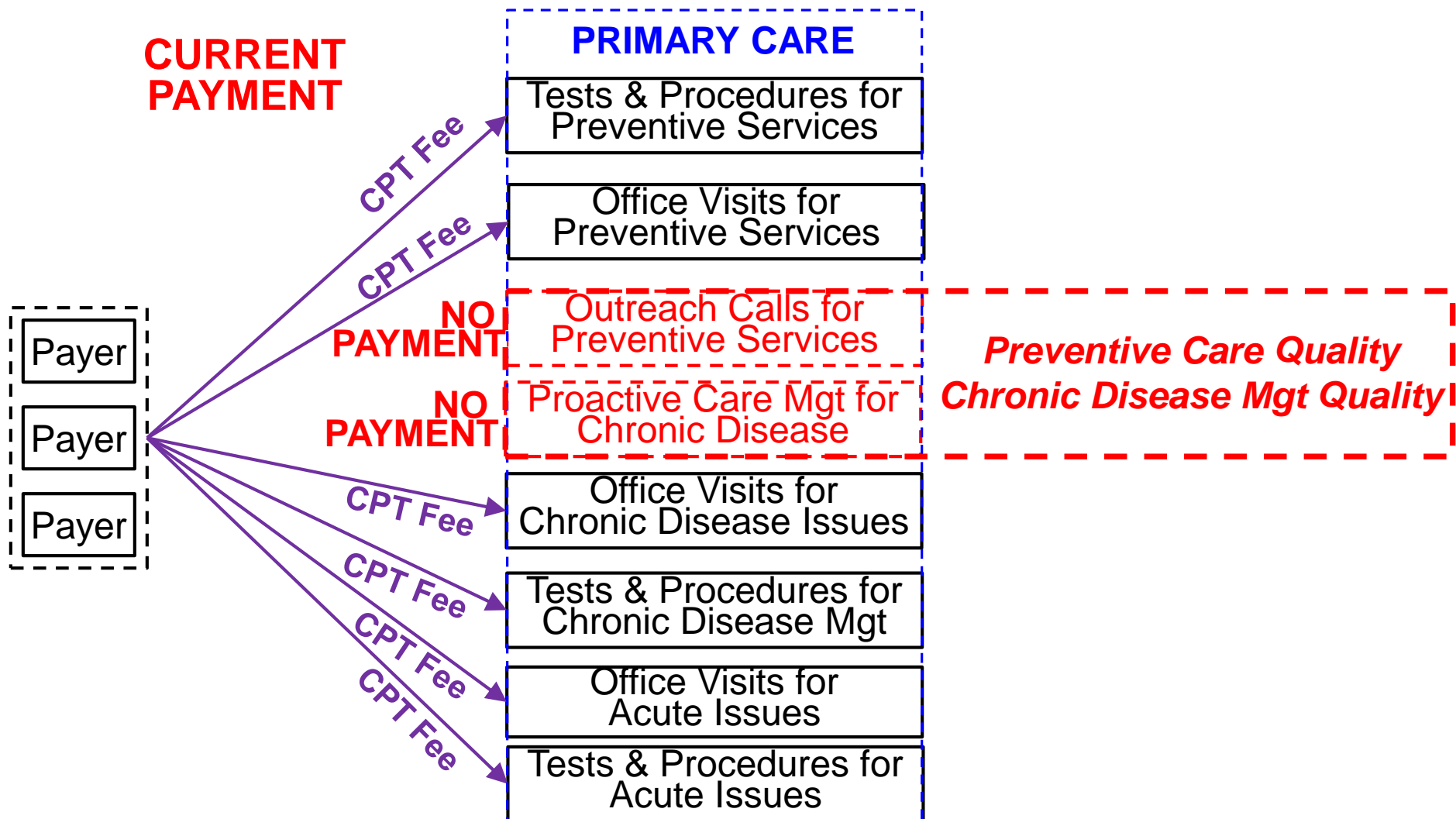
**CURRENT PAYMENT**



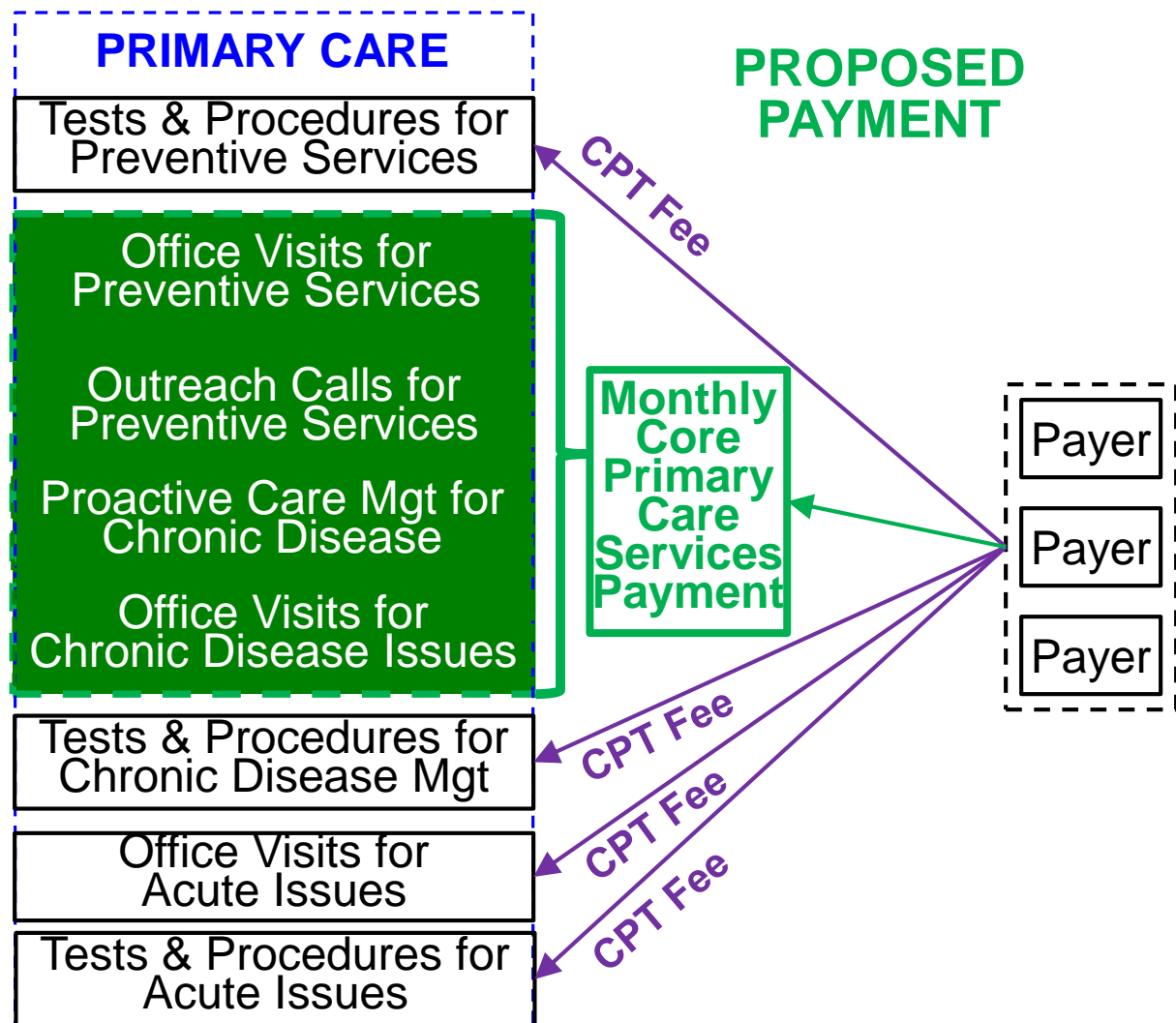
# Current *Non*-Payment for Primary Care



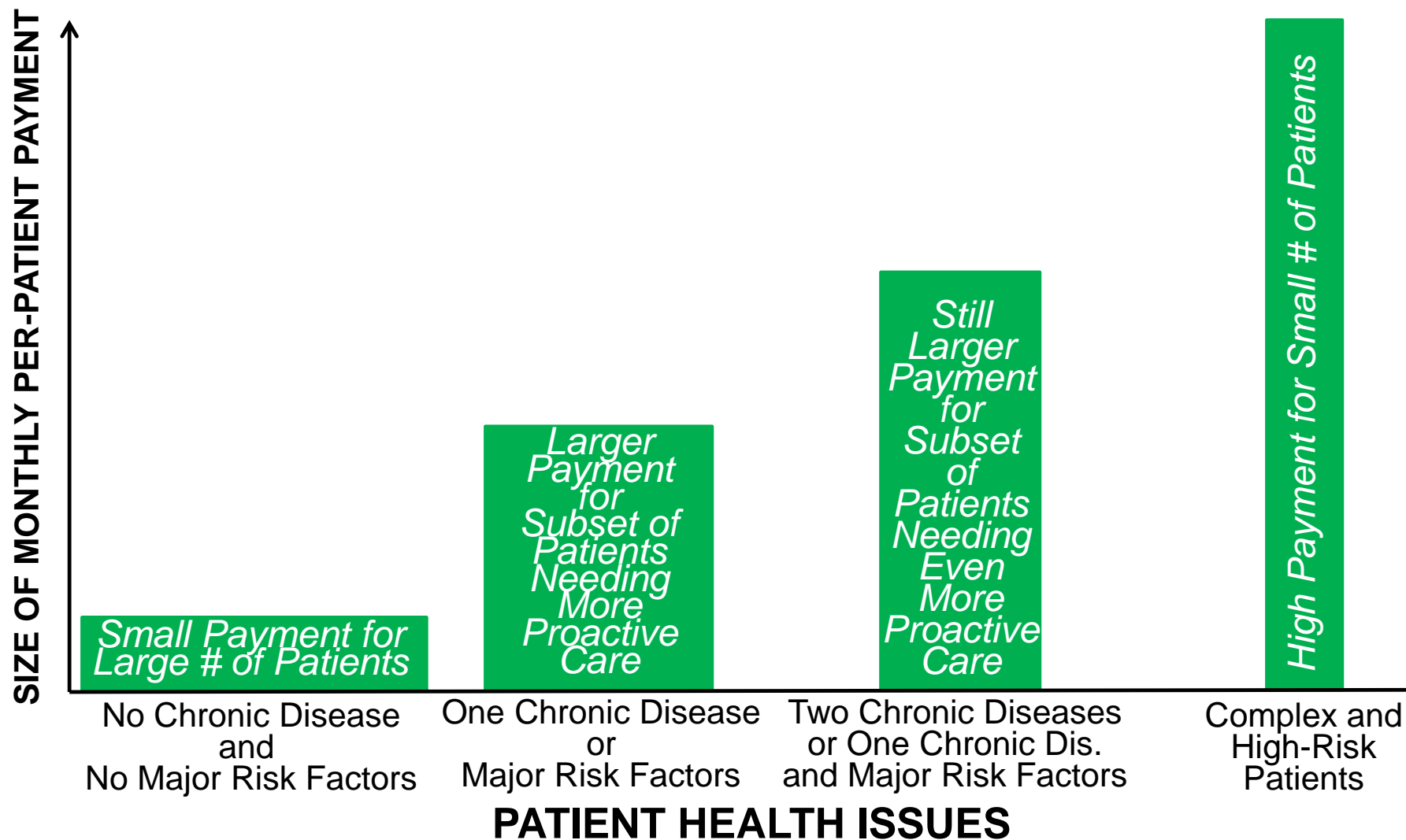
# What Is *Not Paid For* Is Exactly What's *Needed* to Improve *Quality*



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



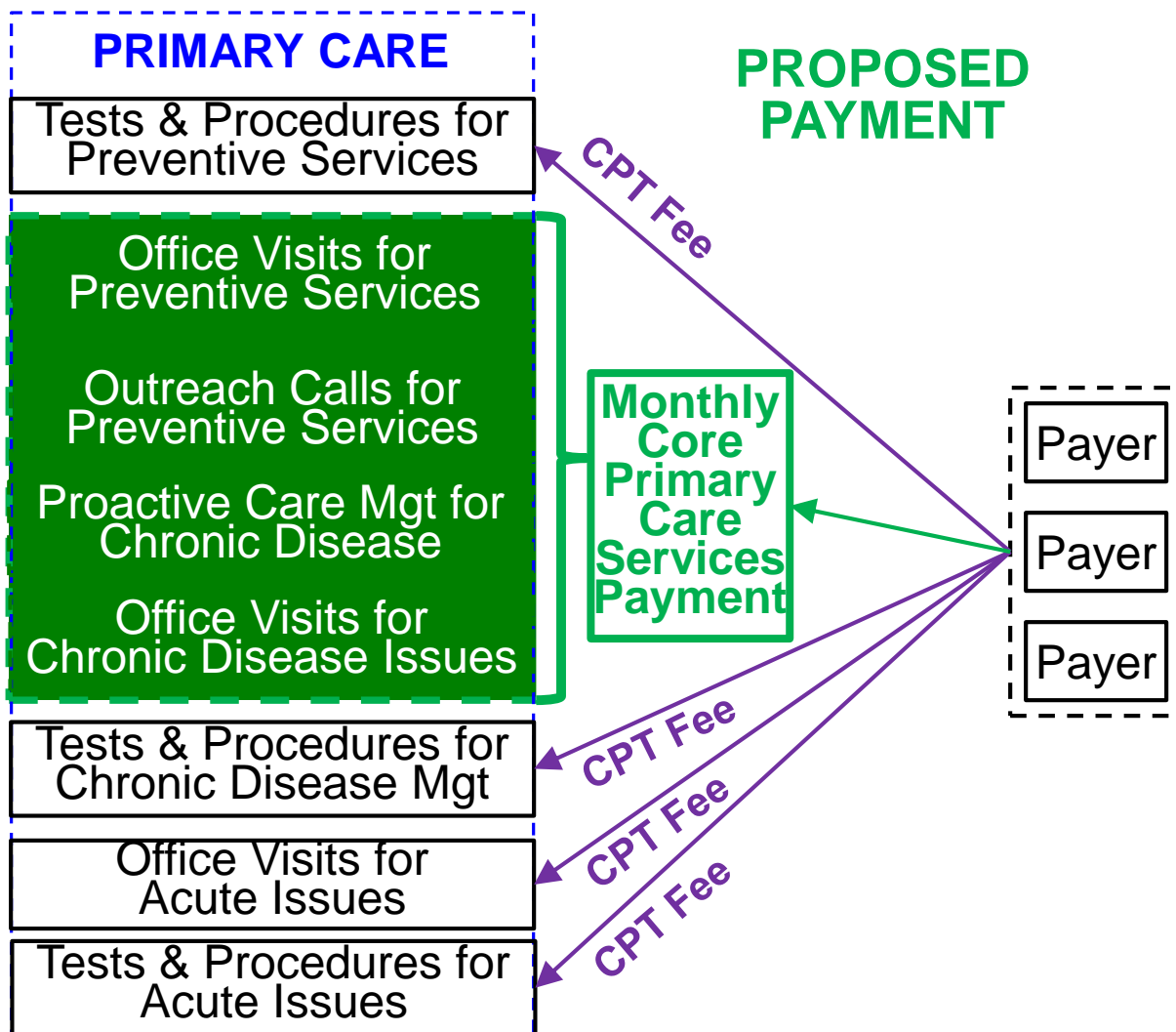
# Size of Monthly Payment Should Differ Based on Patient Health



# A Better Benefit Design For Patients

## BENEFIT DESIGN

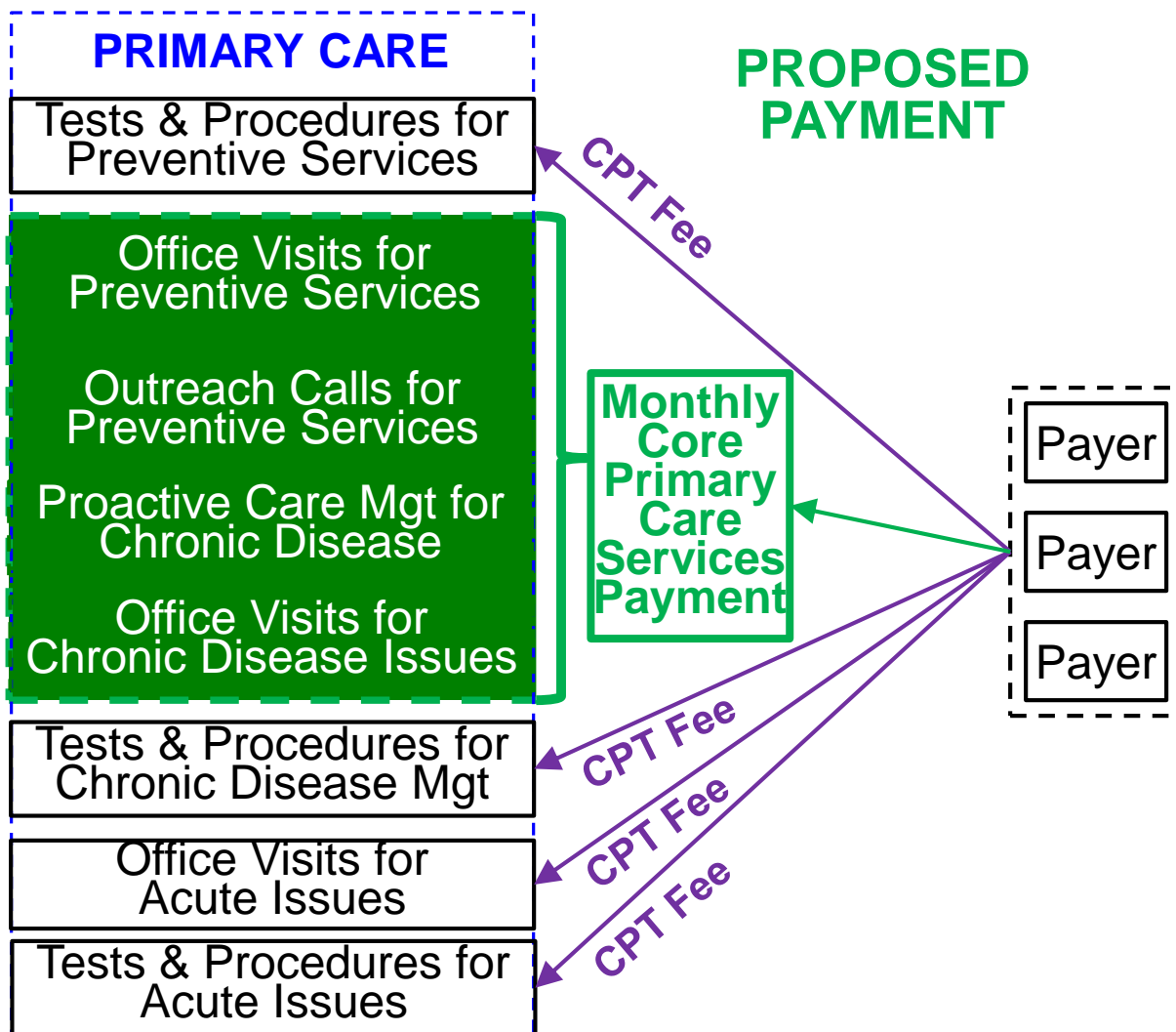
- Patient enrolls as a “member” of the primary care practice, but has no restrictions on other care
- Patient has no copays for visits related to either preventive care or chronic disease care from this practice
- Patient only pays cost-sharing for acute issues



# 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

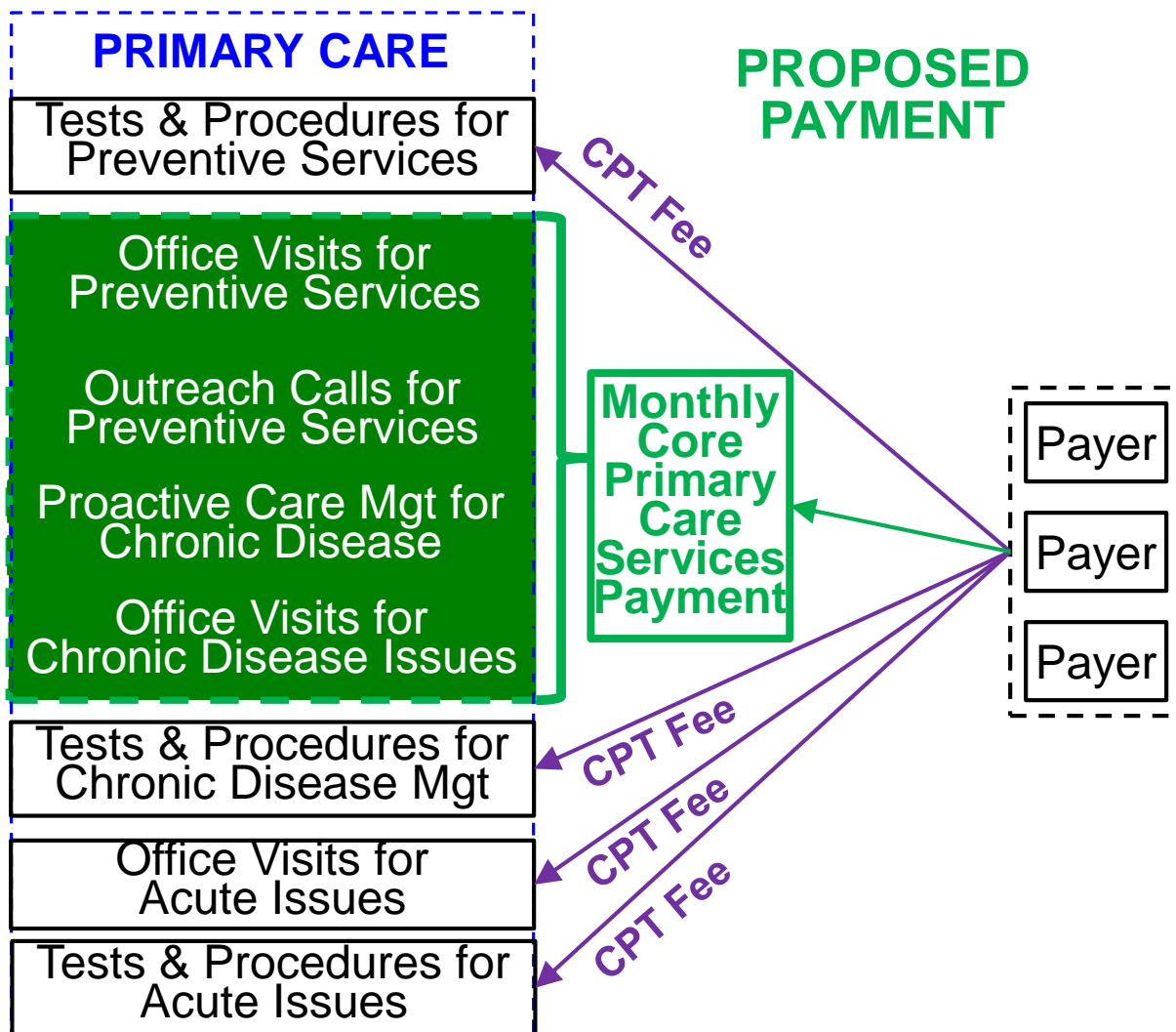




# Accountability for Spending and Quality That PCPs Can Control

## 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

P4P/Shared Savings
<b>PMPM for "Care Management"</b>
Tests & Procedures for Preventive Services
Office Visits for Preventive Services
Office Visits for Chronic Disease Issues
Tests & Procedures for Chronic Disease Mgt
Office Visits for Acute Issues
Tests & Procedures for Acute Issues

## NEW MODEL

Tests & Procedures for Acute Issues
Office Visits for Acute Issues
Tests & Procedures for Chronic Disease Mgt
Tests & Procedures for Preventive Services
Performance Adjustment
<b>Core Primary Care Services Payment</b>

# It's Also Different from Traditional PCP Capitation Programs

## Current PCMH Model

P4P/Shared Savings
<b>PMPM for "Care Management"</b>
Tests & Procedures for Preventive Services
Office Visits for Preventive Services
Office Visits for Chronic Disease Issues
Tests & Procedures for Chronic Disease Mgt
Office Visits for Acute Issues
Tests & Procedures for Acute Issues

## NEW MODEL

Tests & Procedures for Acute Issues
Office Visits for Acute Issues
Tests & Procedures for Chronic Disease Mgt
Tests & Procedures for Preventive Services
Performance Adjustment
<b>Core Primary Care Services Payment</b>

## PCP Capitation

P4P
<b>Primary Care Capitation</b>

# It's Better Than Current PCMH or Capitation

## Current PCMH Model

- 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

## NEW MODEL (PARTIAL CAPITATION)

- 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

## PCP Capitation

- 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?

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## **PATIENTS**

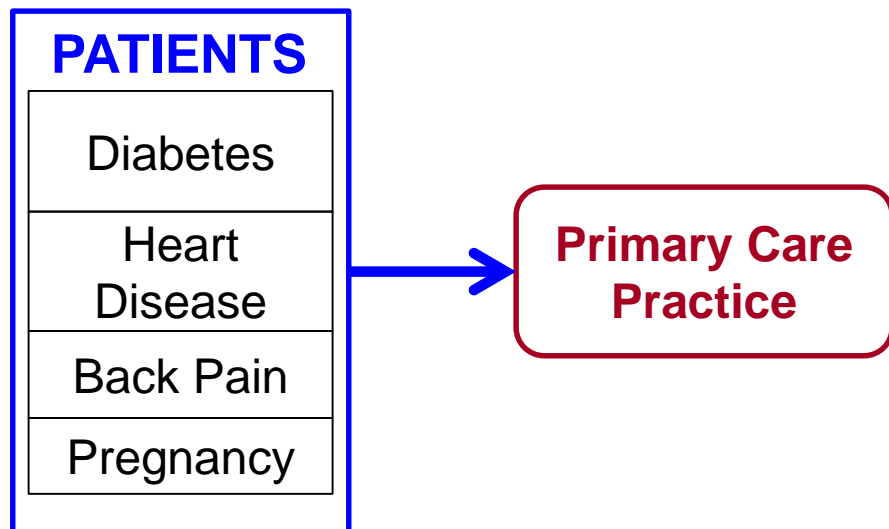
Diabetes

Heart  
Disease

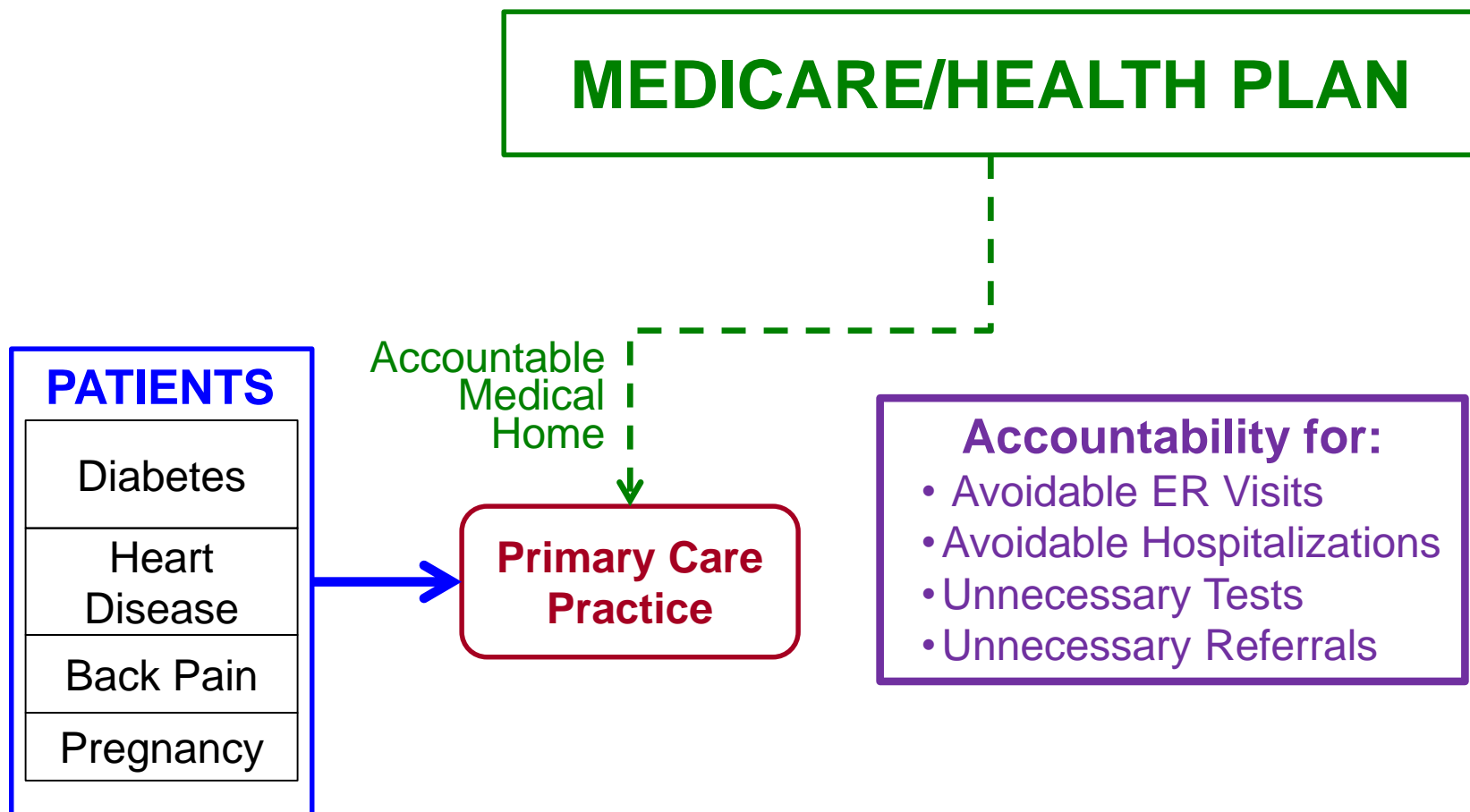
Back Pain

Pregnancy

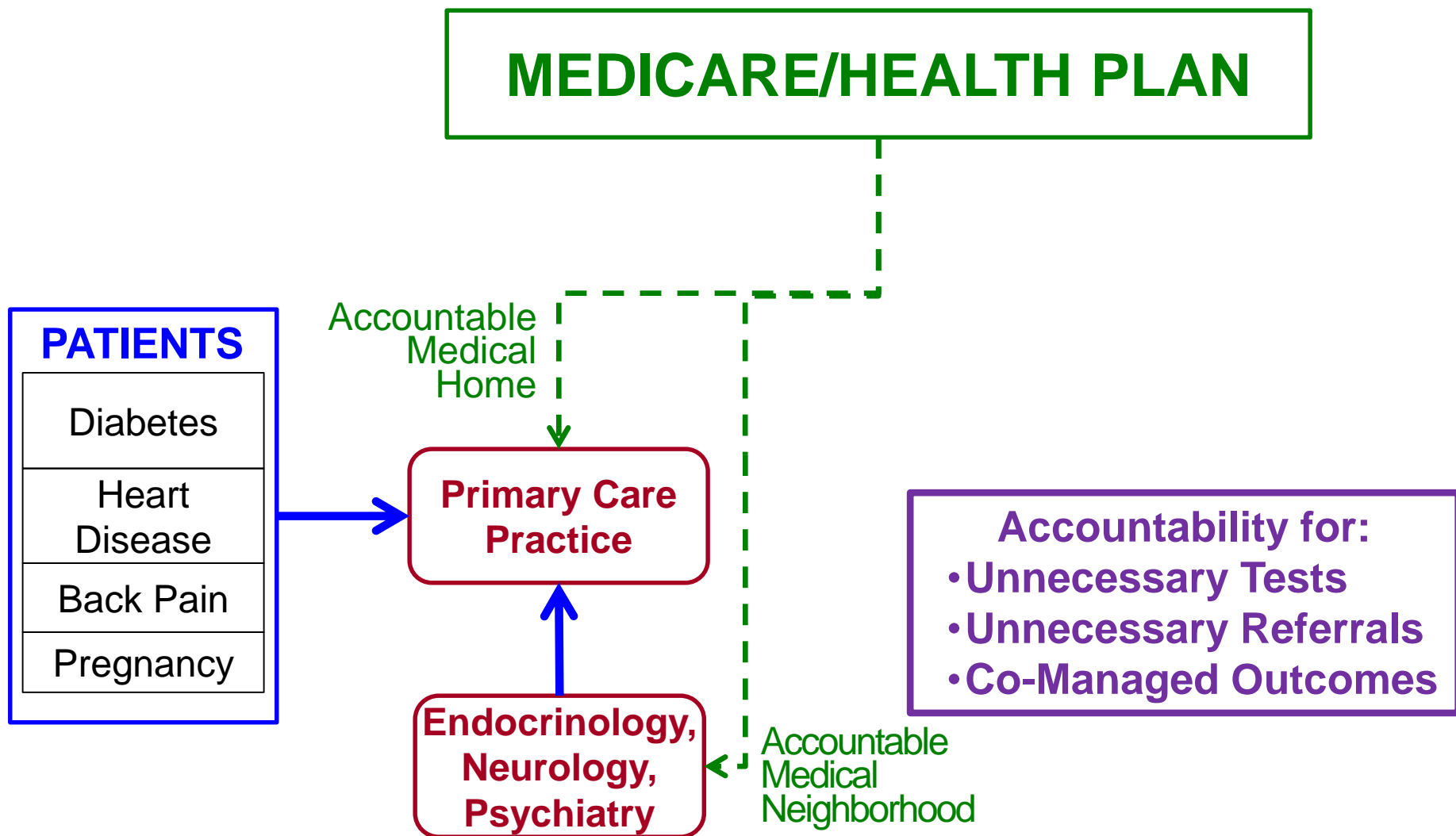
# Each Patient Should Choose & Use a Primary Care Practice...



# ...Which Takes Accountability for What PCPs Can Control/Influence

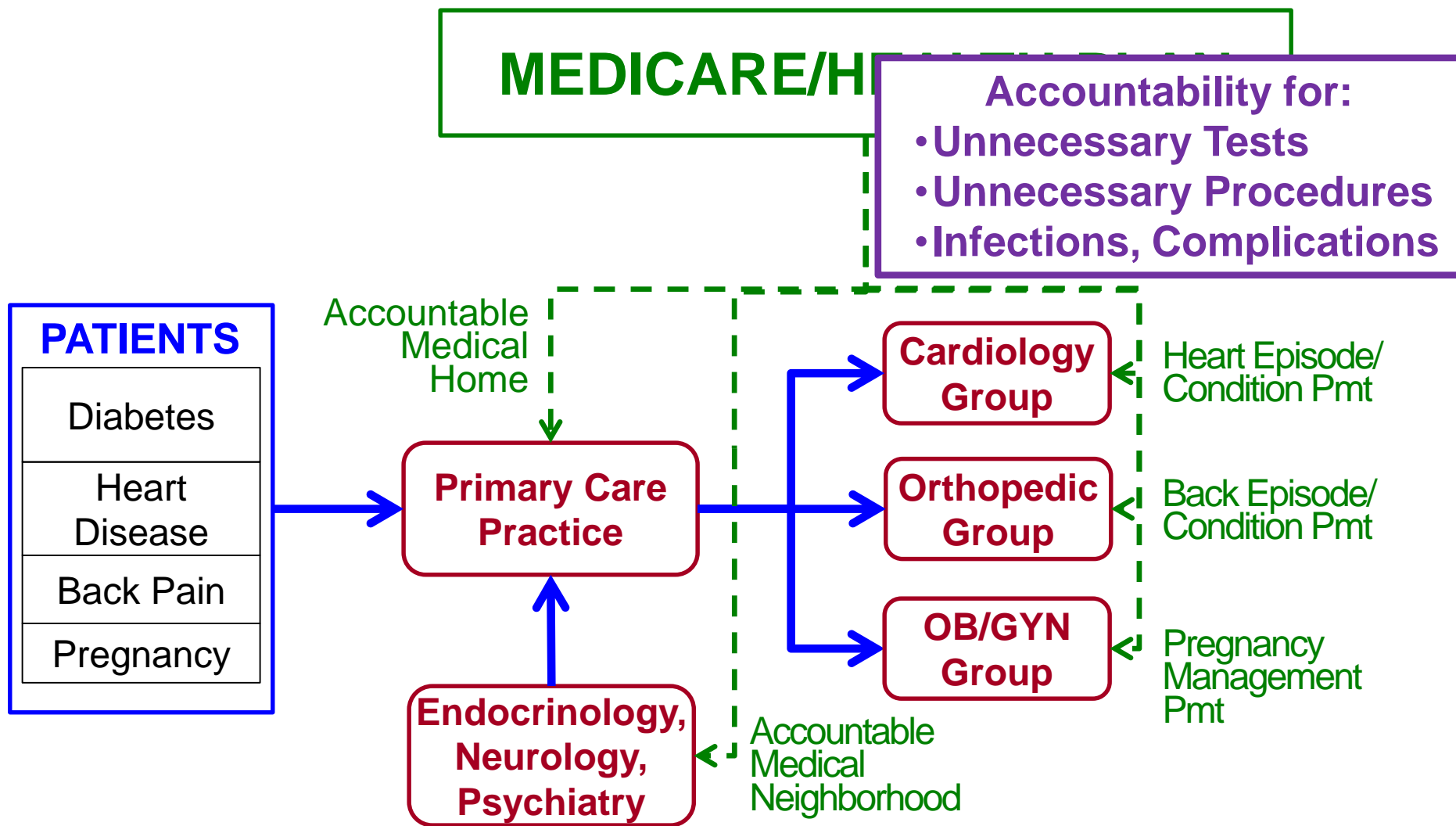


# ...With a Medical Neighborhood to Consult With on Complex Cases

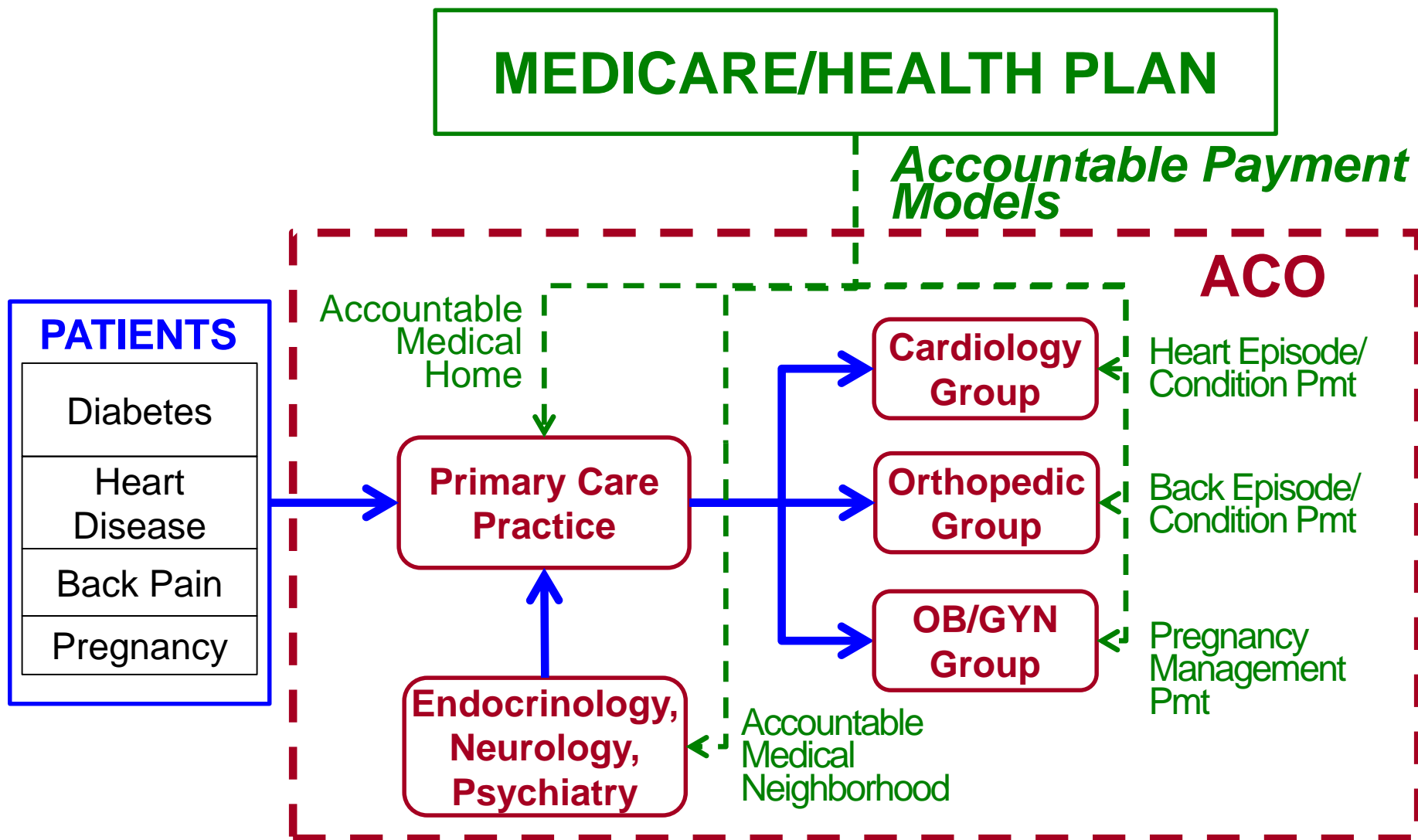




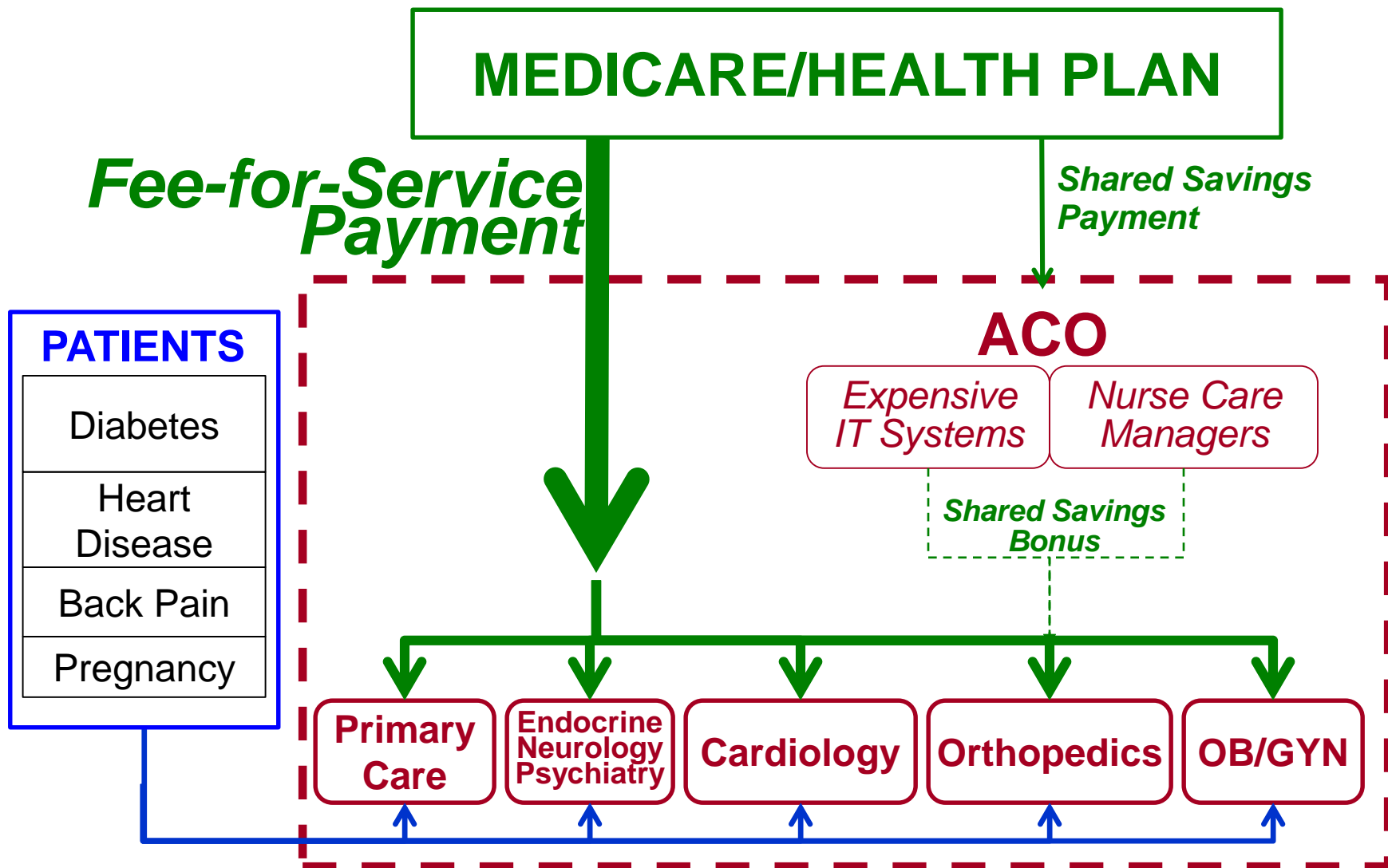
# ..And Specialists Accountable for the Conditions They Manage



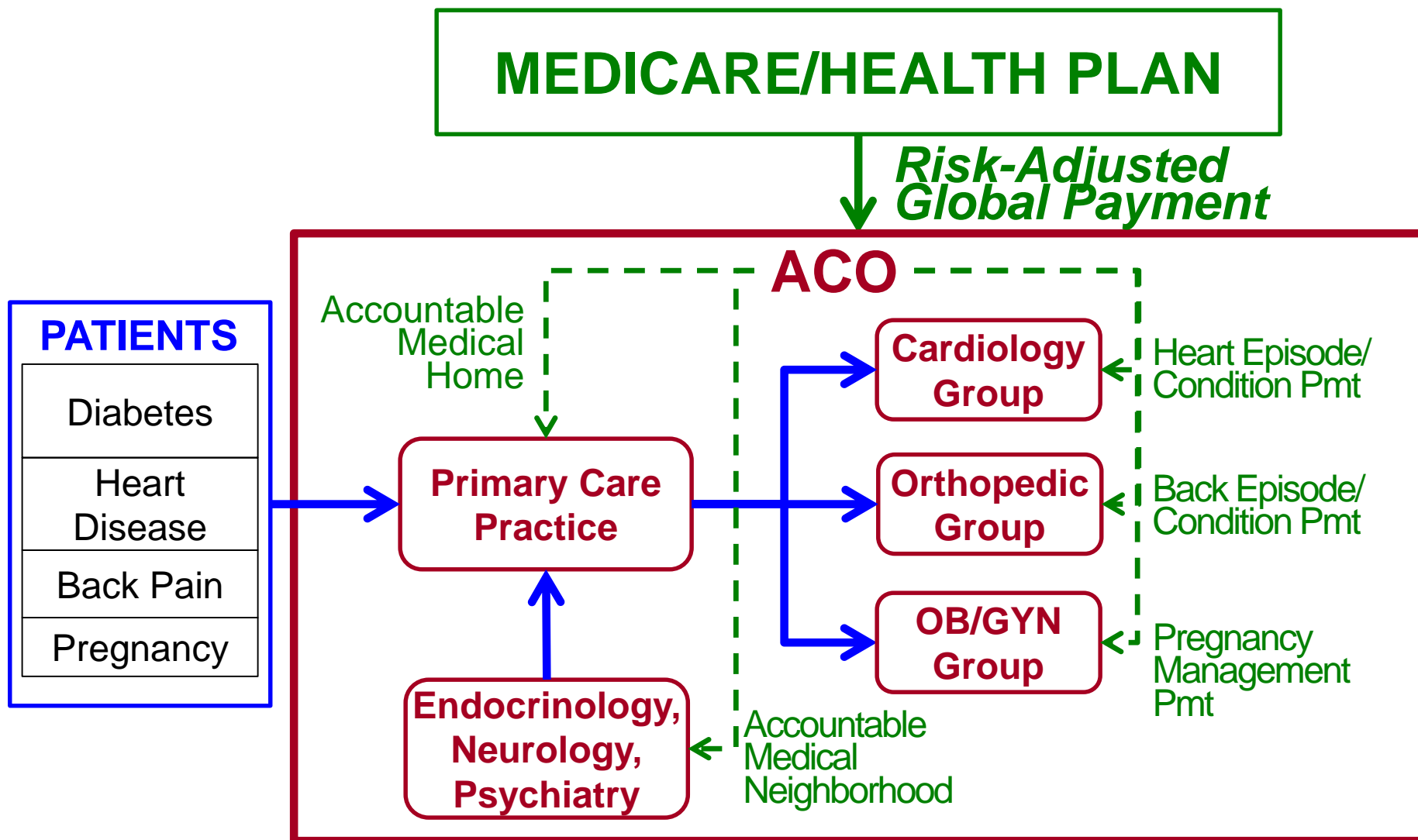
# That's Building the ACO from the Bottom Up



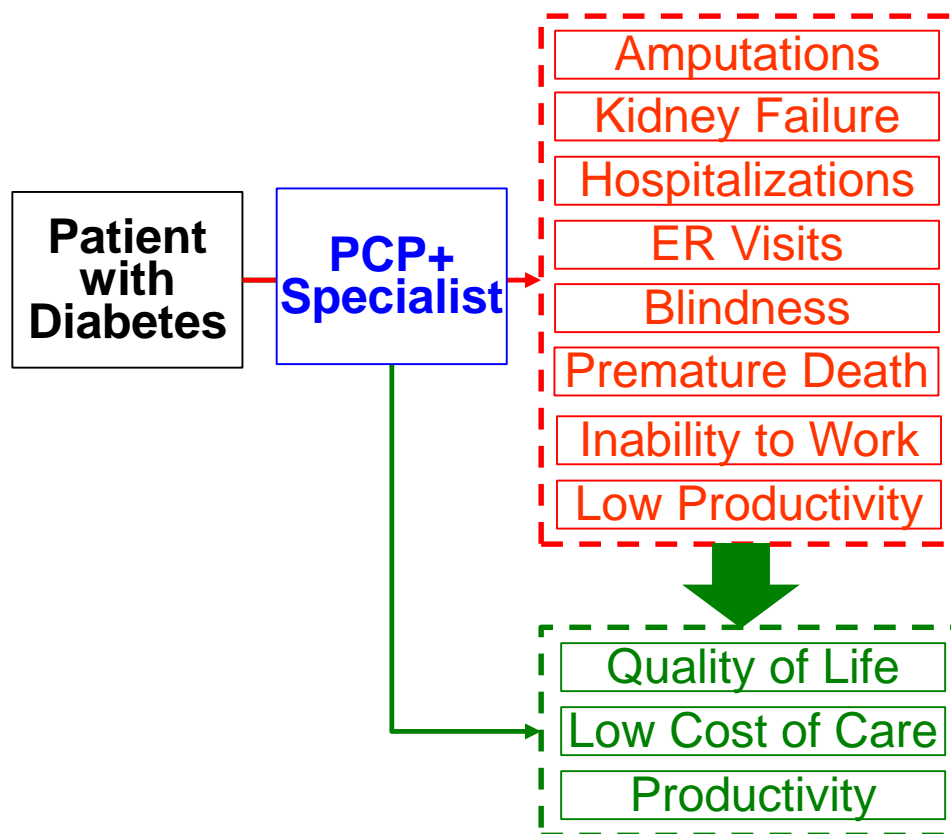
# Most ACOs Today Aren't Truly Reinventing Care or Payment



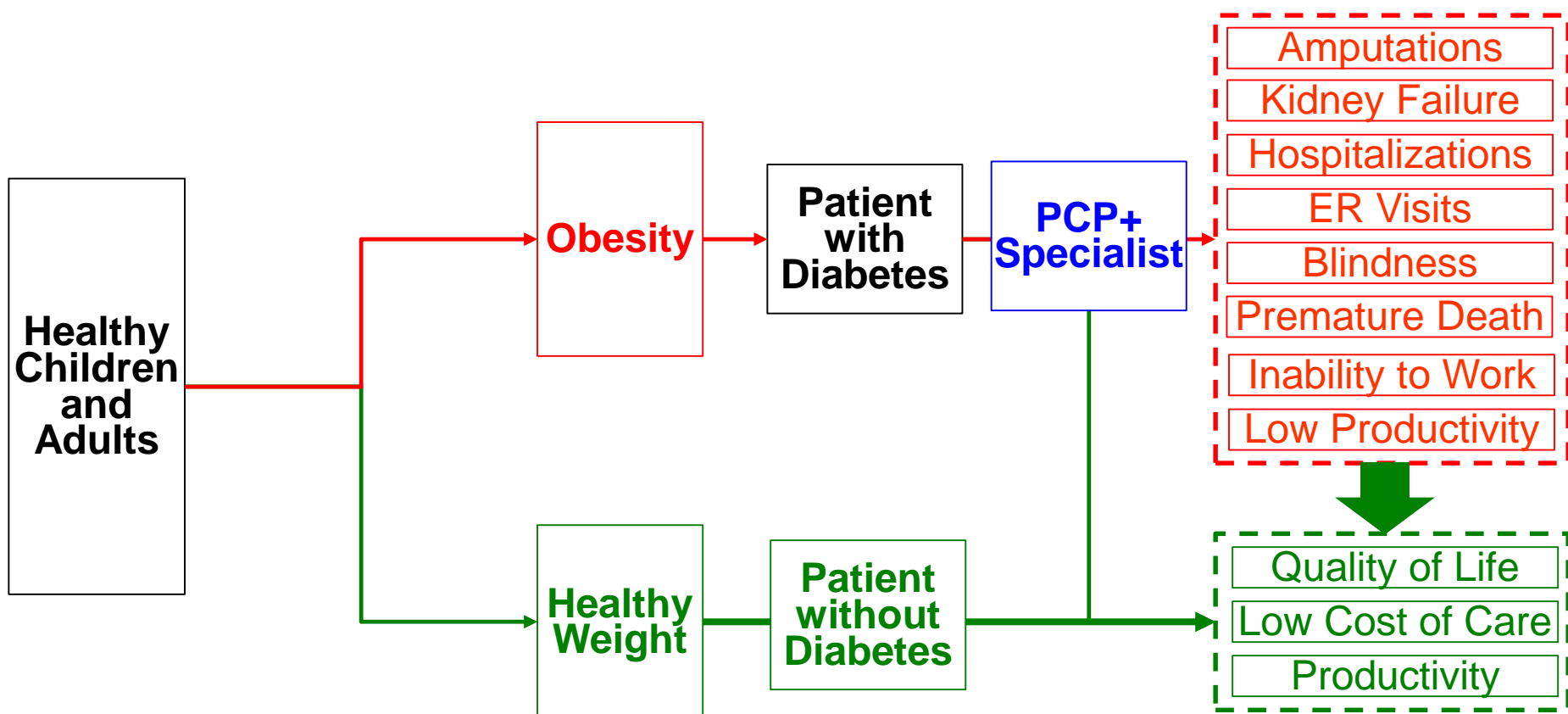
# A True ACO Can Take a Global Payment And Make It Work



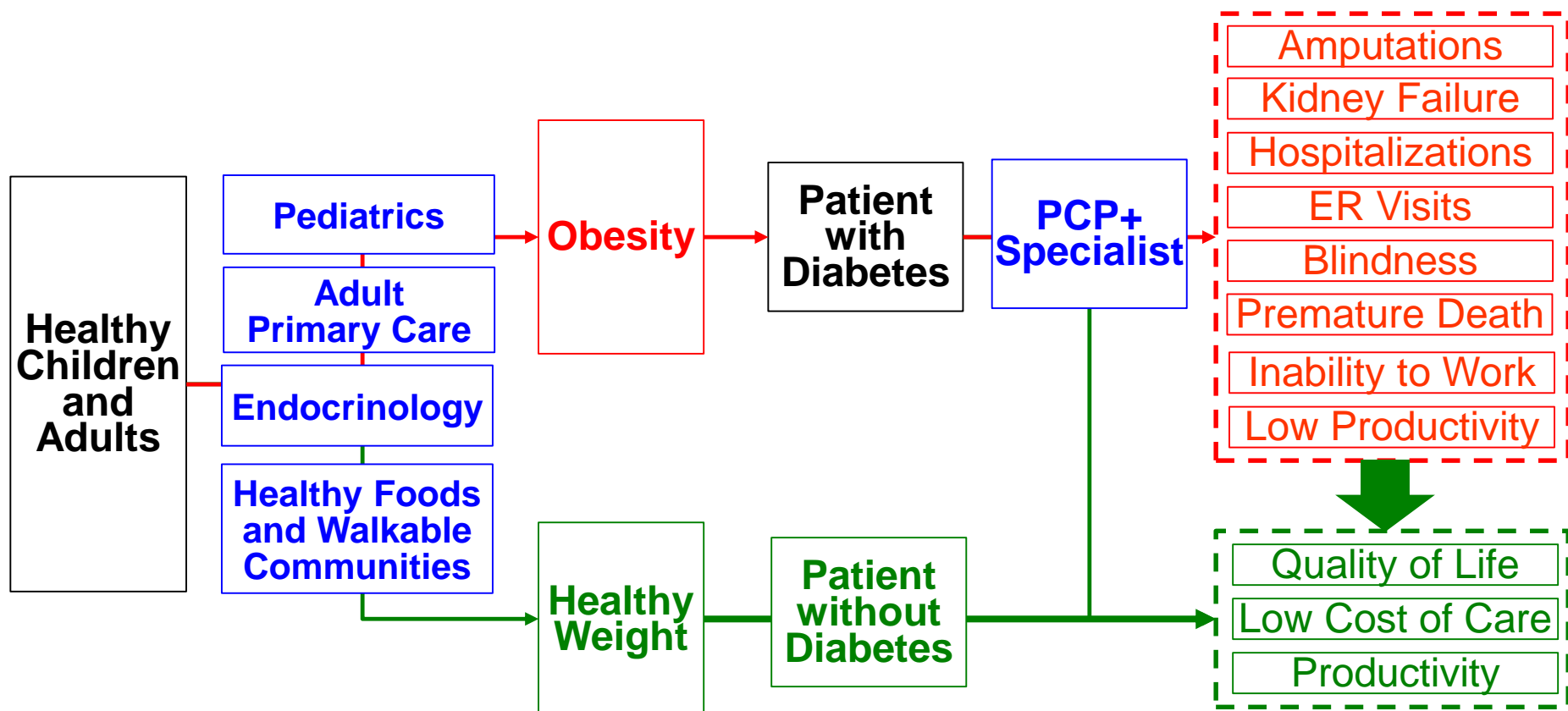
# Only So Much Can Be Done Once the Patient Has Diabetes



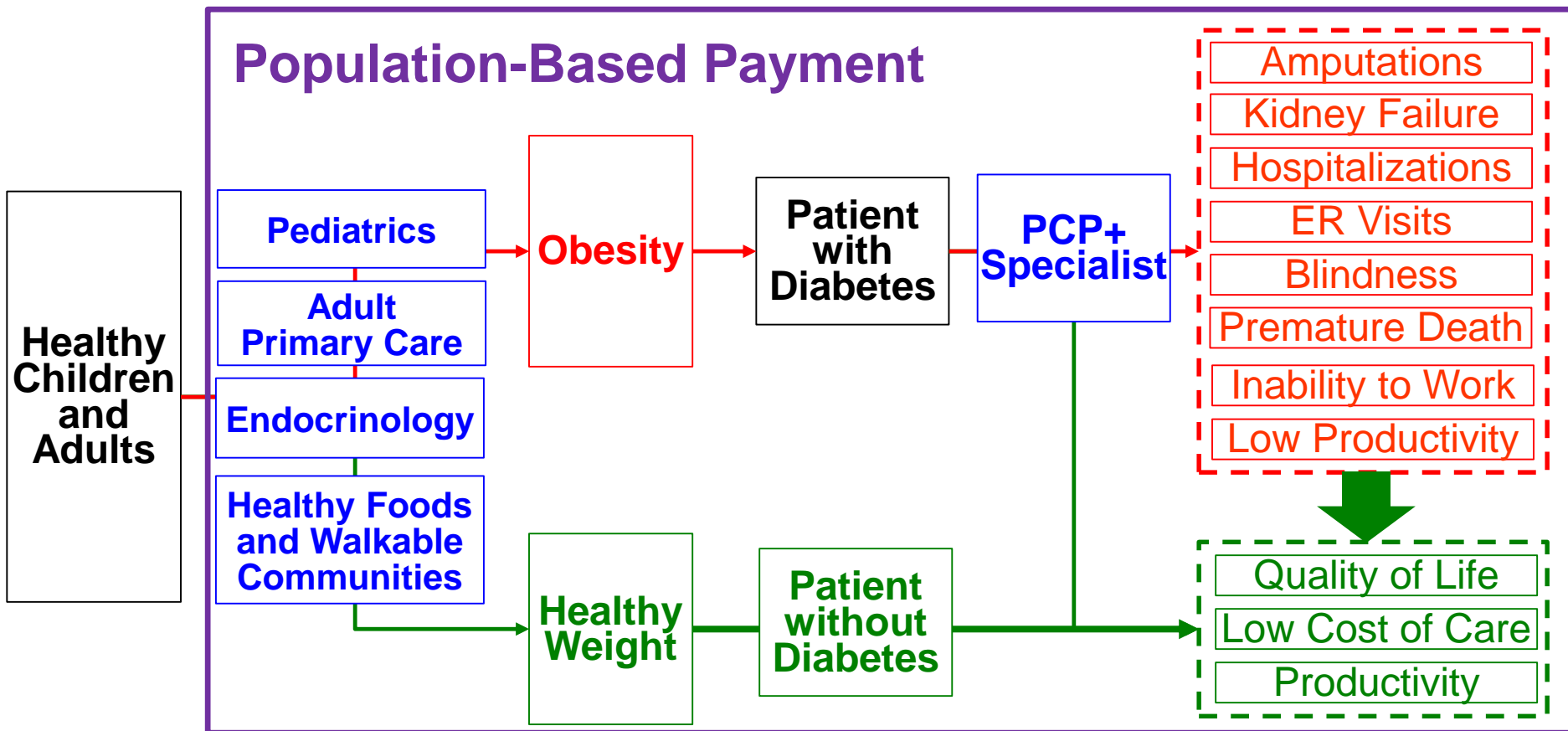
# We Need to Also Focus on *Preventing* Diabetes



# That Means Upstream Investment to Combat Obesity

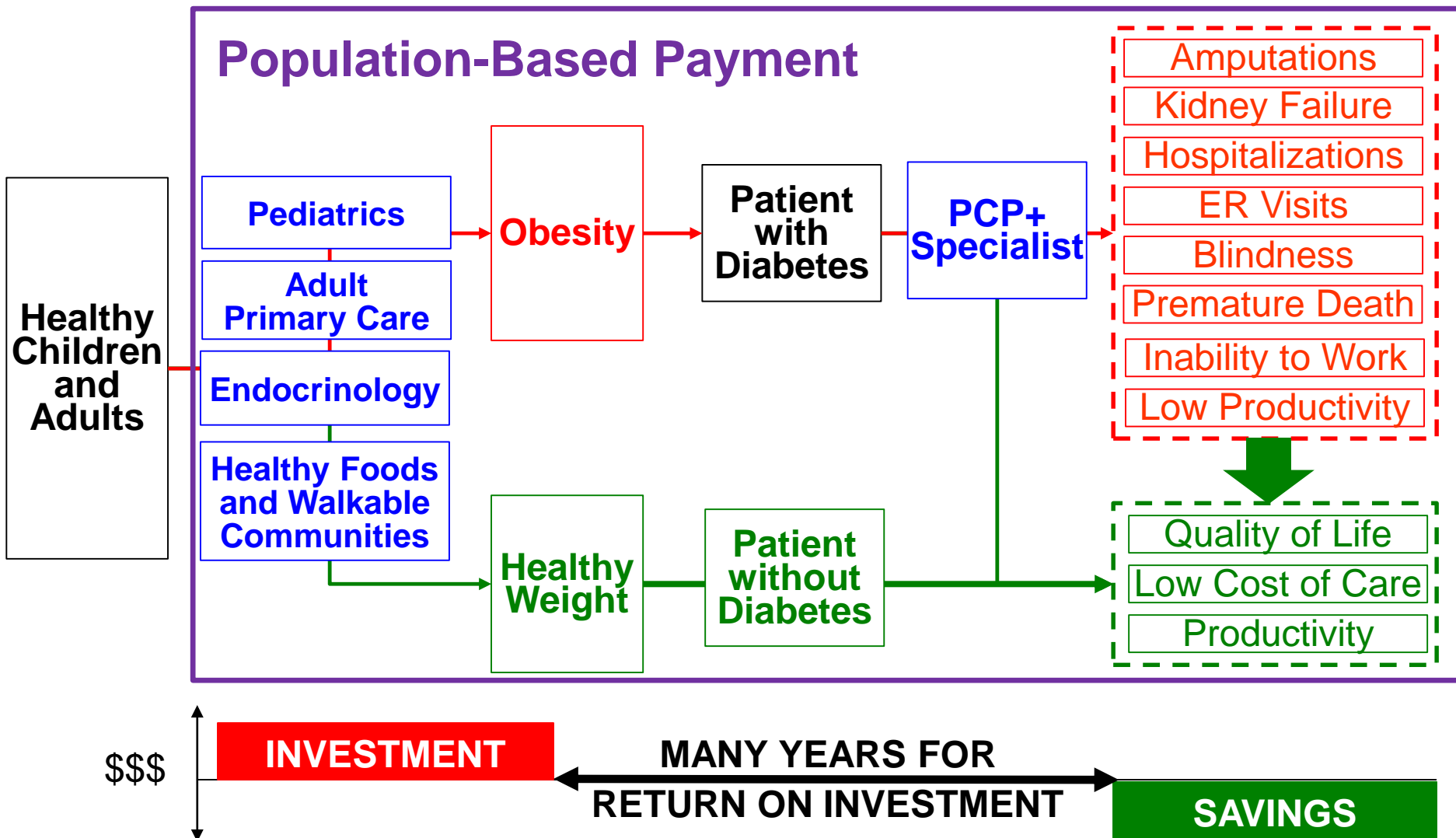


# True Population-Based Payment Has to Have a *Long-Term* Focus

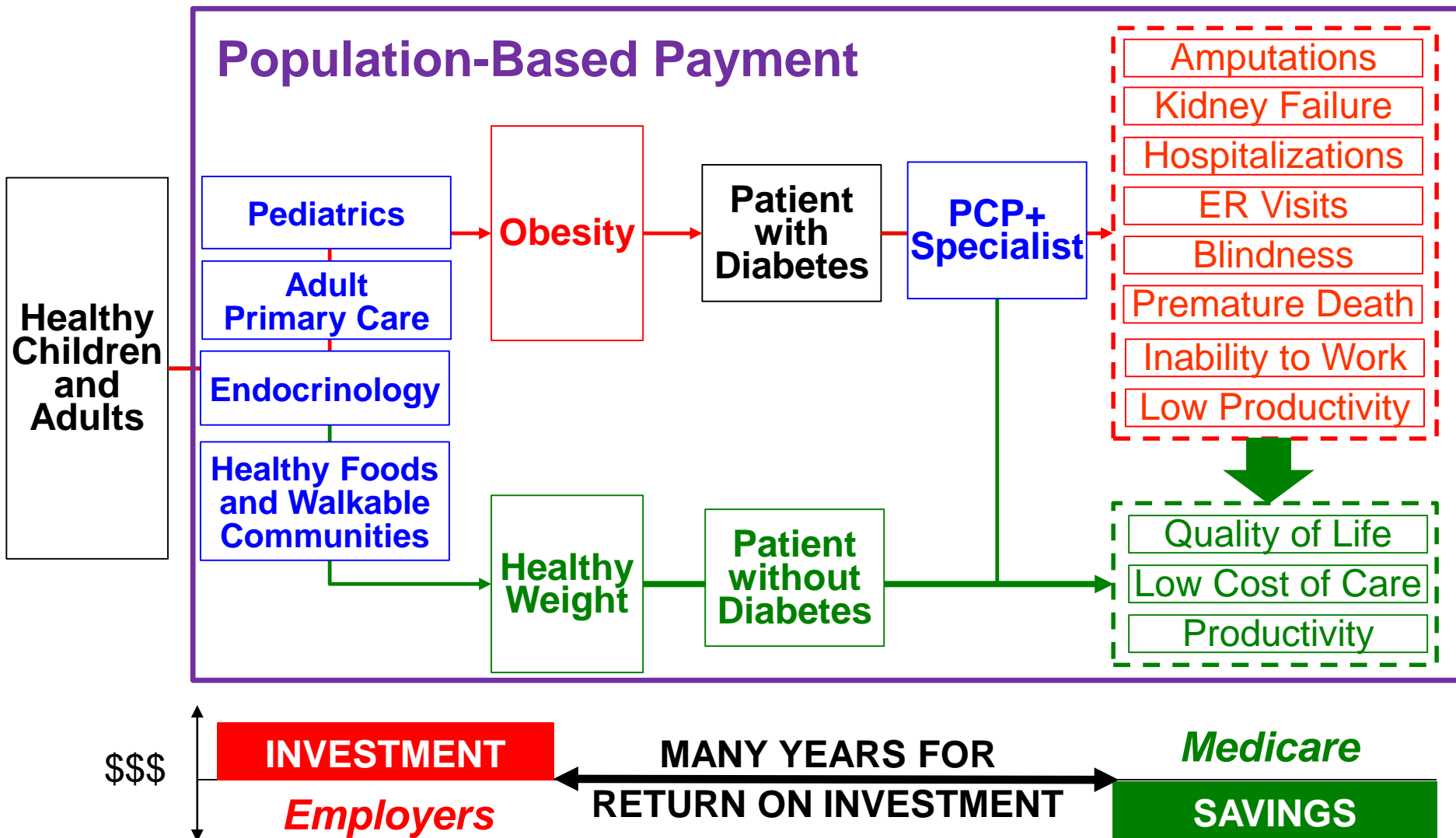




# Current “Shared Savings” Models Penalize Long-Term Prevention




# 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



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**Making the Business Case for Payment and Delivery Reform**

Robert Wood Johnson Foundation

Center for Healthcare Quality and Payment Reform

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Center for Healthcare Quality and Payment Reform

**Key findings:**

- To have an impact on quality, payment reform must be implemented in conjunction with other reforms, including changes in care models and organizational structures.
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**Key findings:**


1. Define the planned change in care and the results it is expected to achieve.
2. Assess the current state of care and delivery.
3. Determine the performance and delivery changes that are needed to achieve the planned change.
4. Calculate the change in operating margins for providers.
5. Identify the change in revenue needed to provide the planned change in care.
6. Define the change in care to improve the business case.
7. Analyze the impact of potential changes to payment, care and delivery models.
8. Change payment models that pay only for the desired services, prevent unwanted services and control costs and risk.

The report also identifies the five major types of data that will generally be needed to carry out all of the steps in a performance case analysis:

- Health care billing claims data.
- Clinical data from electronic health records or patient registries.
- Data on the costs of health care services and
- Data on patient utilization patterns.

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**Measuring and Assigning Accountability for Healthcare Spending**



Fair and Effective Ways to Analyze the Drivers of Healthcare Costs and Transition to Value-Based Payment

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