CENTER FOR HEALTHCARE QUALITY & PAYMENT REFORM

PITTSBURGH REGIONAL HEALTH INITIATIVE
Spreading Quality, Containing Costs.

Successfully Using Payment Reform To Help Reduce Hospital Readmissions

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The Need for Payment Reform

- We don’t pay for things that we know will reduce readmissions
  - E.g., care transitions coaches to assist patients returning home after a hospitalization
  - E.g., having a nurse care manager visit chronic disease patients to provide education and self-management support
  - E.g., using telemonitoring to identify patient problems before admissions are necessary
  - E.g., having a physician answer a phone call with a patient who is confused about their treatment plan or experiencing a potential problem

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  - E.g., having a physician answer a phone call with a patient who is confused about their treatment plan or experiencing a potential problem
- Hospitals and doctors lose money if they reduce readmissions
  - Hospitals are paid based on the number of times they admit patients
  - Physicians are paid based on the number of times they see patients and they see patients more often when patients are in the hospital

Five Basic Approaches to Payment Reform

1. Don’t pay providers (hospitals and/or docs) for readmissions
2. Pay a provider more to implement programs believed to reduce readmissions
3. Pay providers bonuses/penalties based on readmission rates
4. Pay for care with a limited warranty from the provider (i.e., provider does not charge for readmissions meeting specific criteria)
5. Make a comprehensive care (global) payment to a provider for all care a patient needs (regardless of how many hospitalizations or readmissions are needed)

A Blunt Approach: Don't Pay for Readmissions at All

1. Don't pay providers (hospitals and/or docs) for readmissions
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Refusing to Pay for Readmissions Has Undesirable Consequences

- The hospital and/or physicians could legitimately refuse to treat the patient needing readmission, if the payer won't pay for their services
- The patient may be readmitted to a hospital other than the one where the initial care was given, or the patient may be treated by physicians other than the ones which provided the care on the initial admission
- Hospitals/physicians may refuse to admit patients in the first place if they feel the patients are at high risk for readmission after discharge
- Not all readmissions may be preventable

A More Positive Approach: Paying for What Works

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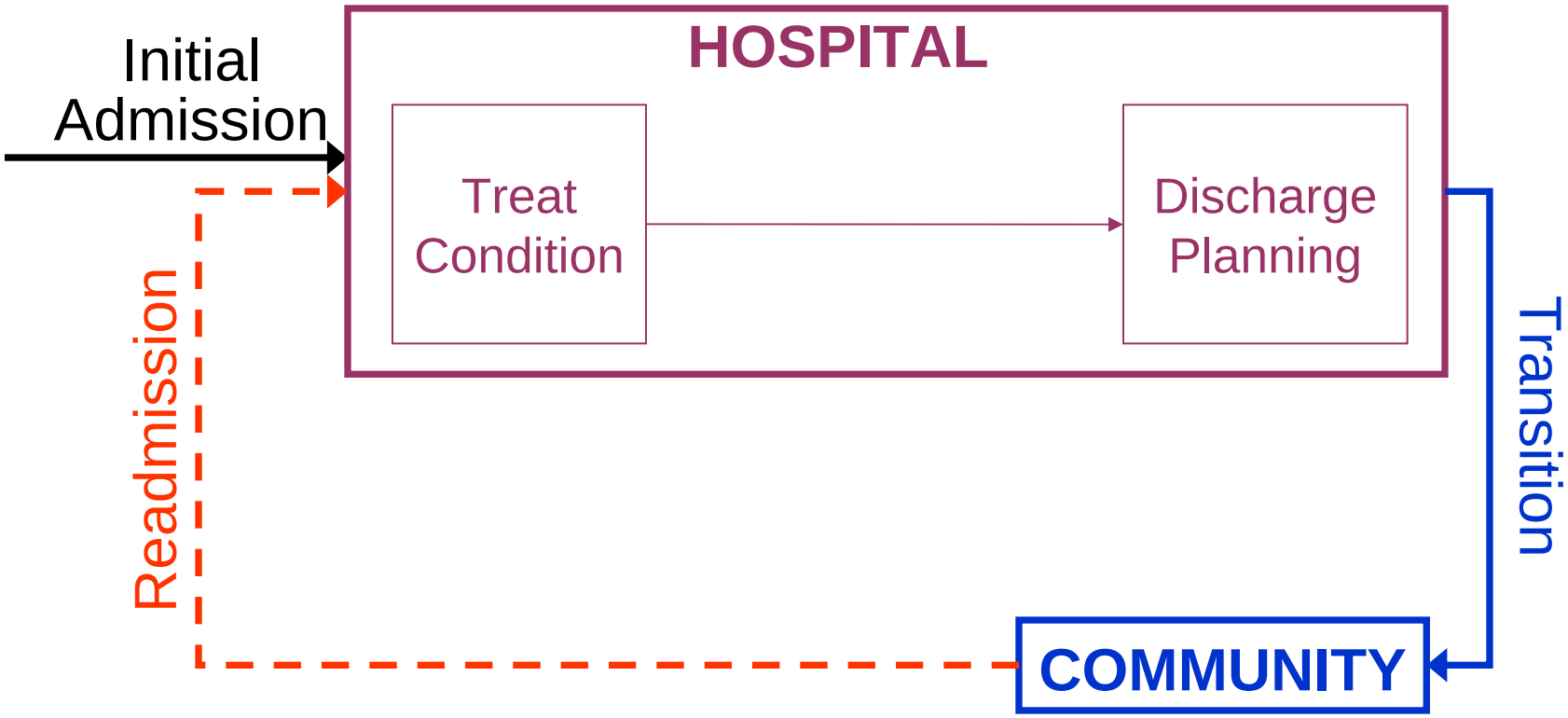
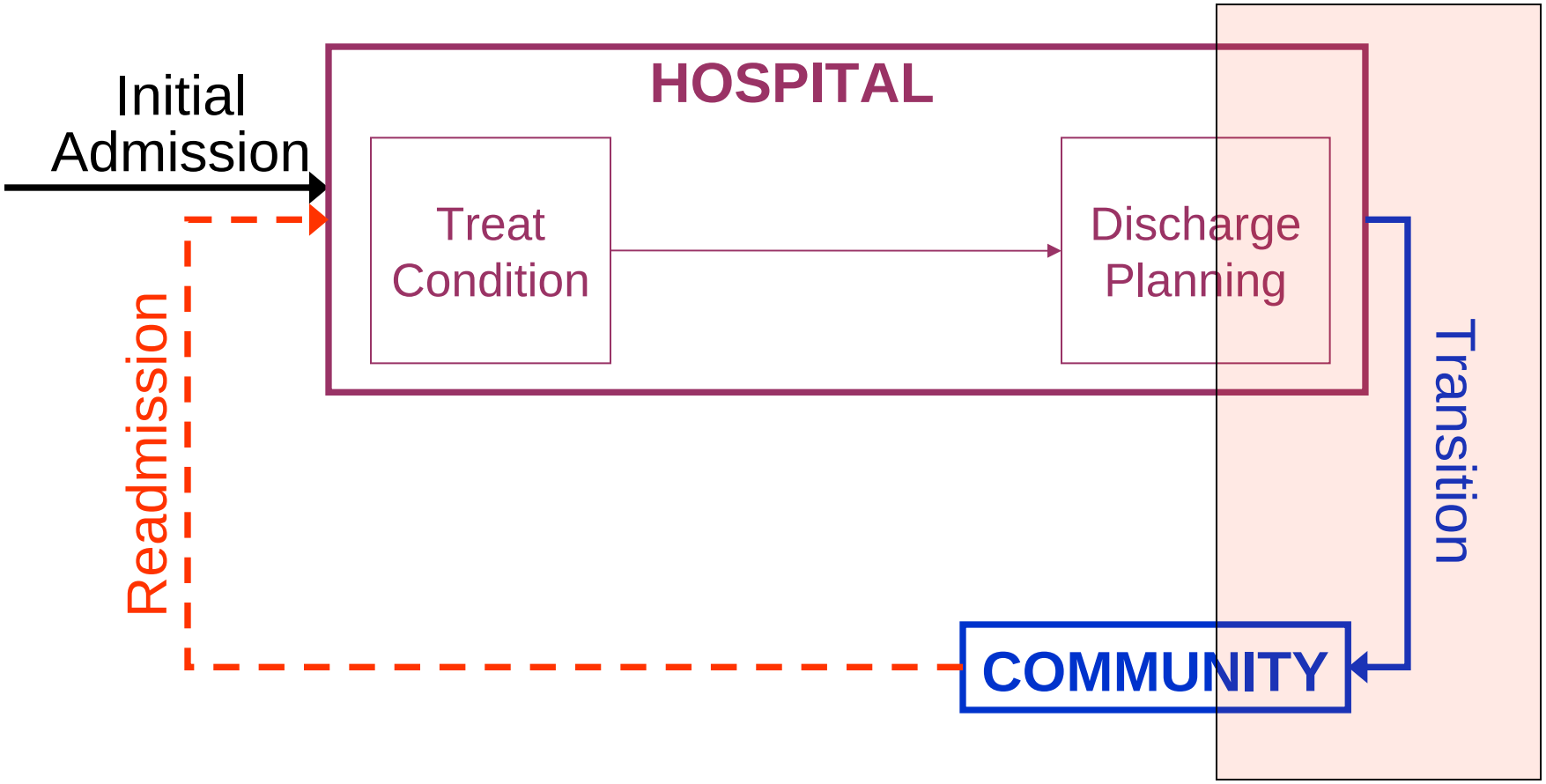
Dilemma #1:
What to Pay For & Whom to Pay

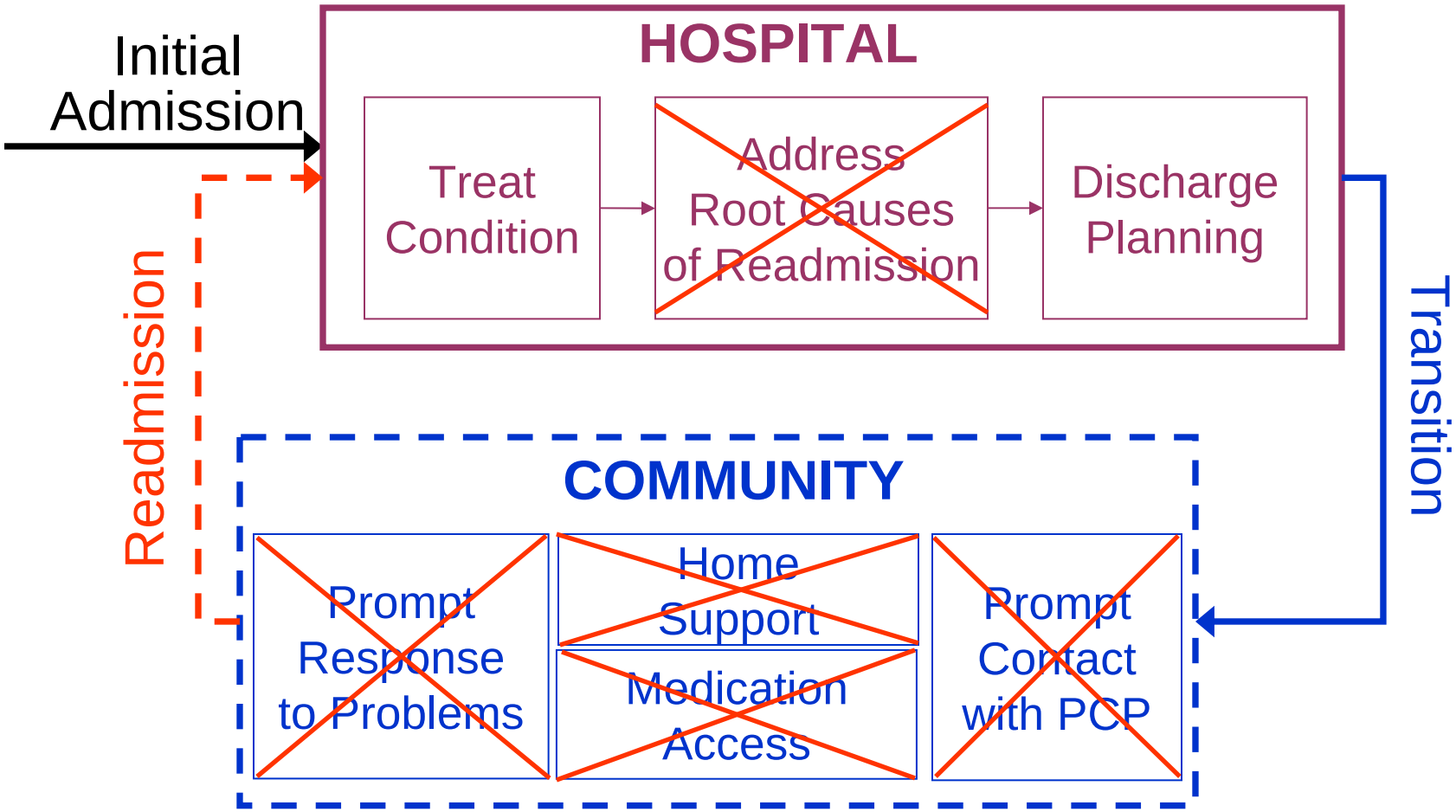
Most Discussions of Causes of Readmissions Are Too Simplistic



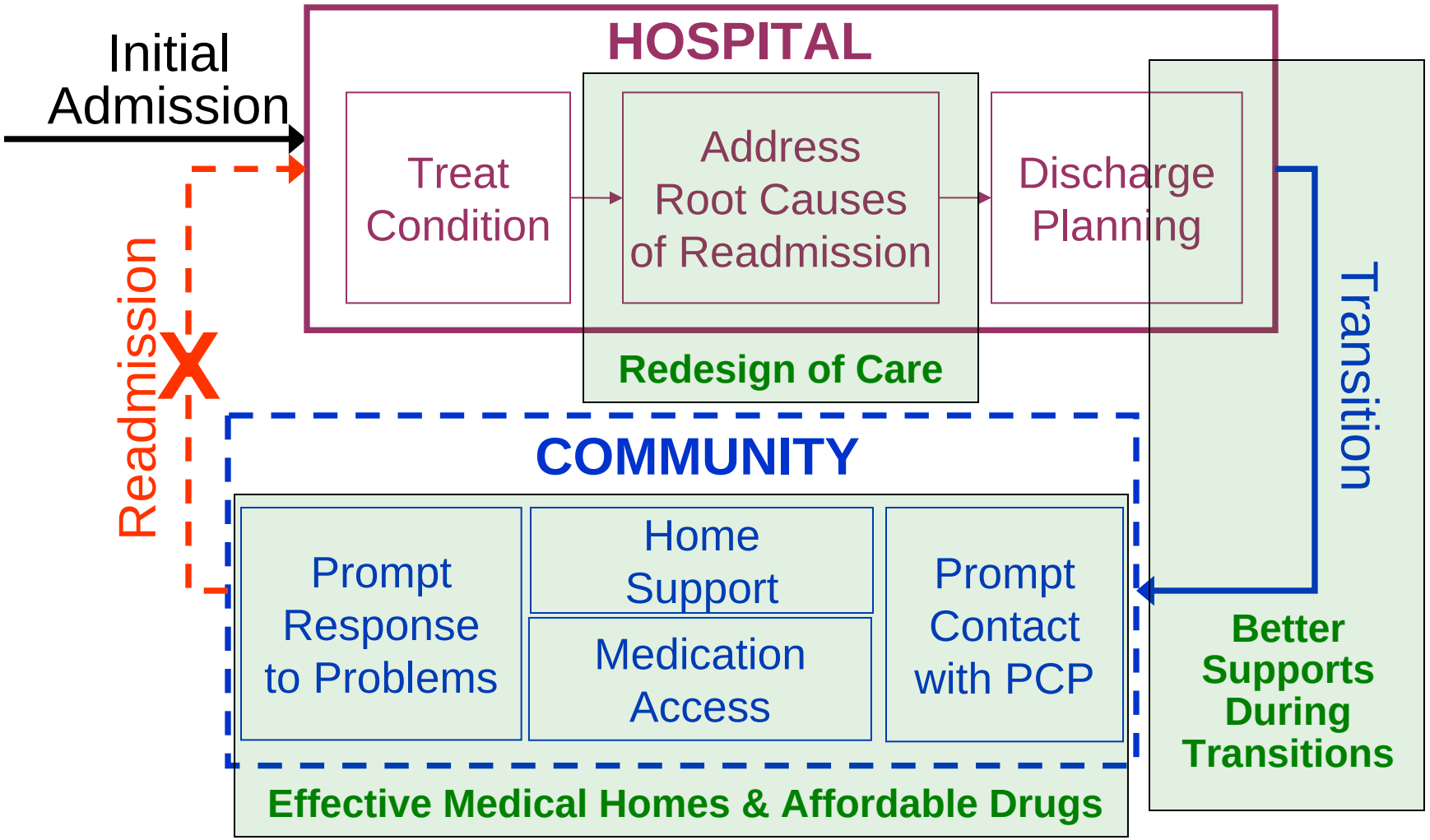
Focus on Transitions Presumes That's The (Sole) Cause



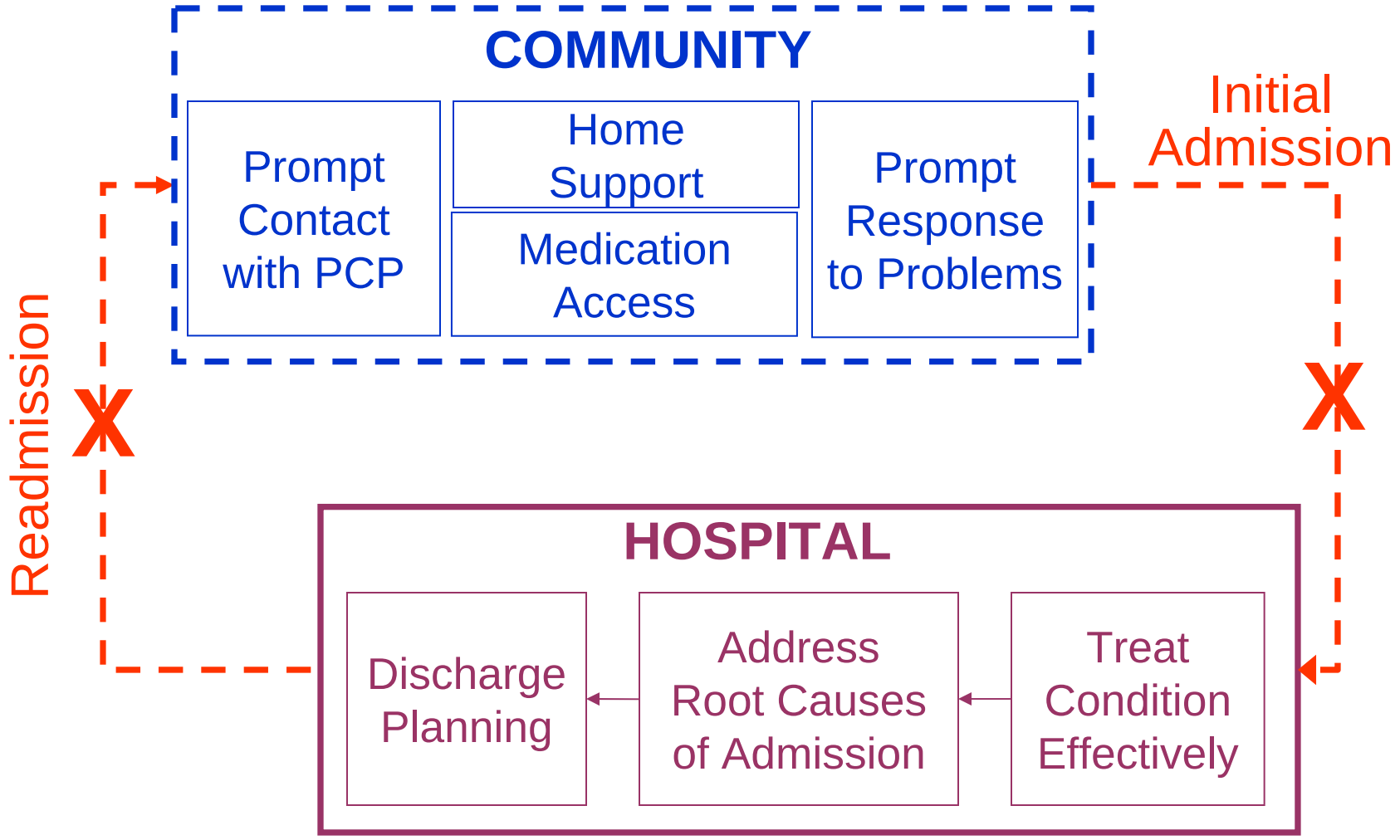
But the Problems Causing Readmissions Are More Complex



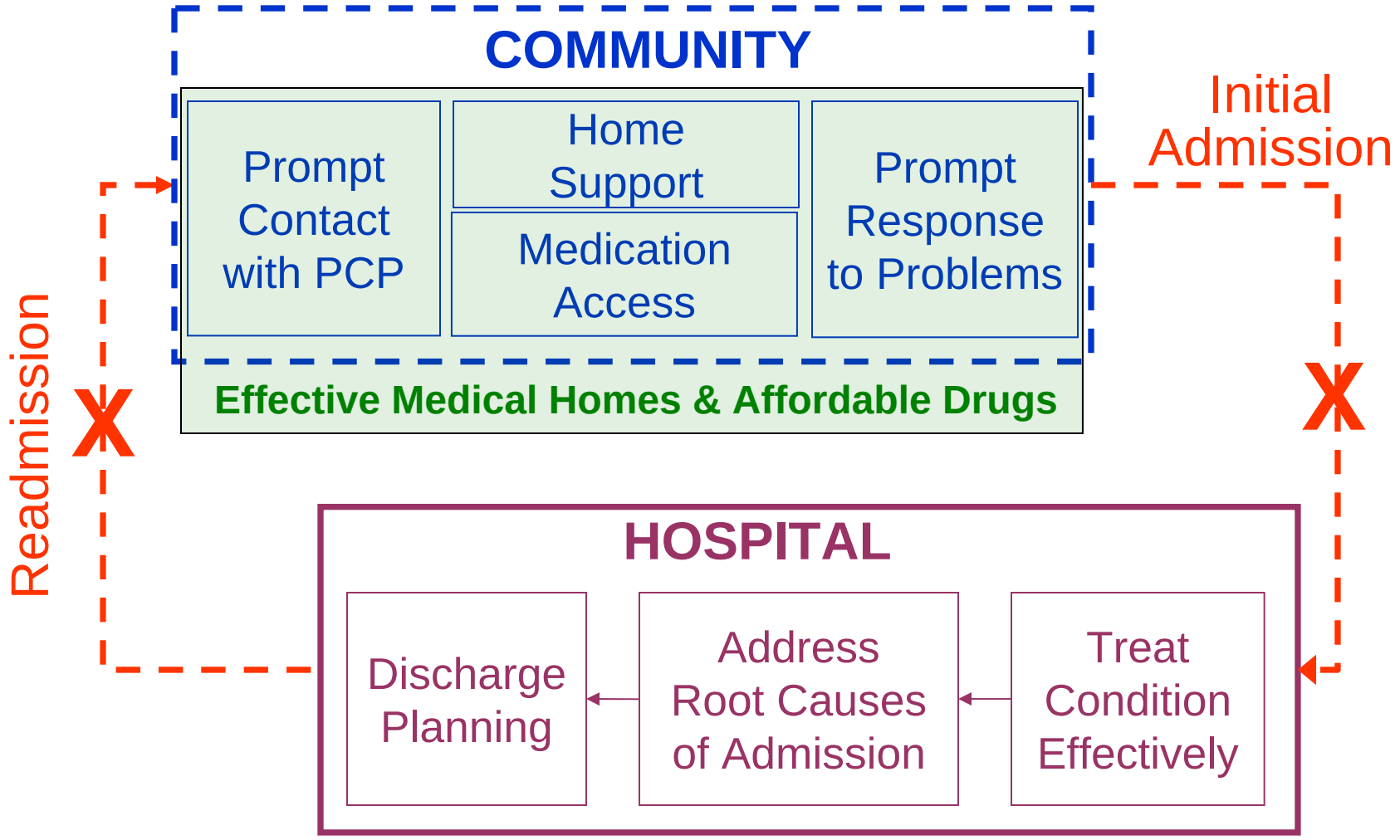
Better Inpatient & Outpatient Care Needed, As Well as Transitions



For Chronic Disease: Prevent *Initial* Admissions, Not Just Readmits



Highest Priority for Chronic Disease: Strengthen Primary Care



Dilemma #2: No *Guarantee* of Results

- Although it's been demonstrated that many different types of programs have been able to reduce readmissions, none of them are *guaranteed* to work, and those who want to replicate them aren't guaranteeing results
- So how does the payer (Medicare, Medicaid, or a commercial health plan) know that providing additional funding for a program will reduce readmissions by more than the cost of the program, or even reduce readmissions at all?
- Result: payers are reluctant to fund such programs on a broad scale

Creating Incentives for Performance

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P4P Programs Don’t Offset the Underlying FFS Incentives

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- **Example:** A pay-for-performance (P4P) program that reduces a hospital's payment rate by 5% if its readmission rate is higher than average
- **Scenario:** Hospital has 25% readmission rate for a particular condition; the average for all hospitals is 18%

Initial Admits	Readmit Rate	Total Admits	Payment Per Admit	Revenues
500	25%	625	$5,000	$3,125,000

P4P Hurts the Hospital If It Doesn't Reduce Readmissions

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Initial Admits	Readmit Rate	Total Admits	Payment Per Admit	Revenues	Change
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500	25%	625	$4,750 (-5%)	$2,968,750	($156,250)

But the Hospital May Be Hurt More If It Does Reduce Readmits

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500	25%	625	$4,750 (-5%)	$2,968,750	($156,250)
500	**18%**	590	$5,000	$2,950,000	($175,000)

The P4P penalty actually costs the hospital less than reducing readmissions, particularly if additional costs must be incurred for readmission reduction programs

The Problems With P4P Bonuses/Penalties Alone

- The P4P penalty has to be very large to overcome the very large underlying disincentive in the DRG/FFS payment system against reducing readmissions
- The P4P penalty has to be even larger if reducing readmissions means the hospital will need to incur extra costs for readmission reduction programs *in addition* to reducing its revenues
- The larger the P4P penalty, the closer it comes to looking like non-payment for readmissions, i.e., the hospital or physician may be deterred from admitting the patient in the first place if the patient is viewed as a high risk for readmission after discharge
- There is no incentive to do *better* than the performance standard which is set in the P4P program

Medicare's Complex Workaround

- Hospital Readmissions Reduction Program (§3025 of PPACA)
  - All DRG payments reduced up to 1% in 2013, 2% in 2014, 3% in 2015+
  - Actual reduction based on number of "excess" risk-adjusted readmissions for heart attack, heart failure, and pneumonia
  - Additional conditions to be added in 2015

It Will Provide Stronger Incentives Than Some P4P Programs…

- Hospital Readmissions Reduction Program (§3025 of PPACA)
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- Why this theoretically works "better" than other P4P programs:
  - Magnifies the penalty for high readmission rates for targeted conditions
  - Continues to pay (almost) the same for readmissions when they occur

…But That Doesn't Mean It's a Good Idea

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- Why this theoretically works "better" than other P4P programs:
  - Magnifies the penalty for high readmission rates for targeted conditions
  - Continues to pay (almost) the same for readmissions when they occur
- Why it's not good policy:
  - Reduces the hospital's payment for *all* admissions to the hospital, regardless of whether there is any problem with other admissions
  - Creates the largest penalties for hospitals that have relatively few patients with the target conditions (since the penalty is a percentage of revenues for *all* patients, not just the patients with those conditions)
  - Creates no incentive to reduce readmissions for any other conditions or to reduce rates below average
  - Only affects the hospital, not physicians & not community programs

A Better Idea: Paying for Care With a Warranty

1. Don't pay providers (hospitals and/or docs) for readmissions
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Yes, a Health Care Provider Can Offer a *Warranty*

Geisinger Health System ProvenCare℠

- 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

Readmission Reduction: 44%

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

	Before ProvenCare (n=132)	*With ProvenCare* (n=181)	% Improvement/ (Reduction)
In hospital mortality	1.5 %	0 %	
Patients with any complication (STS)	38 %	30 %	**21 %**
Patients with >1 complication	7.6 %	5.5 %	**28 %**
Atrial fibrillation	23 %	19 %	**17 %**
Neurologic complication	1.5 %	0.6 %	**60 %**
Any pulmonary complication	7 %	4 %	**43 %**
Blood products used	23 %	18 %	**22 %**
Re-operation for bleeding	3.8 %	1.7 %	**55 %**
Deep sternal wound infection	0.8 %	0.6 %	**25 %**
Readmission within 30 days	6.9 %	3.8 %	**44 %**

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What a Single Physician and Hospital Can Do

- 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:
  - Surgeon received over 80% more in payment than otherwise
  - Hospital received 13% more than otherwise, despite fewer rehospitalizations
  - Health insurer paid 40% less than otherwise
- Method:
  - Reducing unnecessary auxiliary services such as radiography and physical therapy
  - Reducing the length of stay in the hospital
  - Reducing complications and readmissions

Prices for Warrantied Care Will Likely Be *Higher*

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- 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: $5,000 Procedure, 20% Readmission Rate

Cost of Success	Added Cost of Readmit	Rate of Readmits
$5,000	$5,000	20%

Average Payment for Procedure is Higher than the Official "Price"

Cost of Success	Added Cost of Readmit	Rate of Readmits	Average Total Cost
$5,000	$5,000	20%	$6,000

Starting Point for Warranty Price: Actual Current Average Payment

Cost of Success	Added Cost of Readmit	Rate of Readmits	Average Total Cost	Price Charged	Net Margin
$5,000	$5,000	20%	$6,000	**$6,000**	$ 0

Limited Warranty Gives Financial Incentive to Improve Quality

Cost of Success	Added Cost of Readmit	Rate of Readmits	Average Total Cost	Price Charged	Net Margin
$5,000	$5,000	20%	$6,000	$6,000	$ 0
$5,000	$5,000	**15%**	**$5,750**	$6,000	$250

Reducing Adverse Events…

...Reduces Costs...

…Improves The Bottom Line

Higher-Quality Provider Can Charge Less, Attract Patients

Cost of Success	Added Cost of Readmit	Rate of Readmits	Average Total Cost	Price Charged	Net Margin
$5,000	$5,000	20%	$6,000	$6,000	$ 0
$5,000	$5,000	15%	$5,750	$6,000	$250
$5,000	$5,000	15%	$5,750	$5,900	$150

Enables Lower Prices

Still With Better Margin

A Virtuous Cycle of Quality Improvement & Cost Reduction

Cost of Success	Added Cost of Readmit	Rate of Readmits	Average Total Cost	Price Charged	Net Margin
$5,000	$5,000	20%	$6,000	$6,000	$ 0
$5,000	$5,000	15%	$5,750	$6,000	$250
$5,000	$5,000	15%	$5,750	$5,900	$150
$5,000	$5,000	10%	$5,500	$5,900	$400

Reducing Adverse Events…

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Win-Win-Win Through Appropriate Payment & Pricing

Cost of Success	Added Cost of Readmit	Rate of Readmits	Average Total Cost	Price Charged	Net Margin
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$5,000	$5,000	15%	$5,750	$6,000	$250
$5,000	$5,000	15%	$5,750	$5,900	$150
$5,000	$5,000	10%	$5,500	$5,900	$400
$5,000	$5,000	10%	$5,500	$5,700	$200
$5,000	$5,000	5%	$5,250	$5,700	$450

Quality is Better...

...Cost is Lower...

...Providers More Profitable

In Contrast, Non-Payment Alone Creates Financial Losses

Cost of Success	Added Cost of Readmit	Rate of Readmits	Average Total Cost	Payment	Net Margin
$5,000	$5,000	20%	$6,000	$6,000	$ 0
$5,000	$5,000	20%	$6,000	$5,000	-$1,000
$5,000	$5,000	10%	$5,500	$5,000	-$ 500
$5,000	$5,000	0%	$5,000	$5,000	$0

Non-Payment for Readmits

Causes Losses While Improving

Warranty Pricing Should Capture Costs of New Programs

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Cost of Success	Added Cost of Readmit	Rate of Readmits	Average Total Cost	Warranty Price	Net Margin
$5,000	$5,000	20%	$6,000	$5,900	-$100

Provider Offering Warranty Must Focus on Cost & Performance

Cost of Success	Added Cost of Readmit	Rate of Readmits	Average Total Cost	Warranty Price	Net Margin
$5,000	$5,000	20%	$6,000	$5,900	-$100
$5,200	$5,200	16%	$6,032	$5,900	-$132

High Cost to Reduce Readmits

Even If Somewhat Successful

Means Greater Losses

Option 1: Improve Performance Enough to Justify Higher Costs

Cost of Success	Added Cost of Readmit	Rate of Readmits	Average Total Cost	Warranty Price	Net Margin
$5,000	$5,000	20%	$6,000	$5,900	-$100
$5,200	$5,200	16%	$6,032	$5,900	-$132
$5,200	$5,200	10%	$5,720	$5,900	+$180

Better Results

Means Better Margins

Option 2: Reduce Costs of Interventions

Cost of Success	Added Cost of Readmit	Rate of Readmits	Average Total Cost	Warranty Price	Net Margin
$5,000	$5,000	20%	$6,000	$5,900	-$100
$5,200	$5,200	16%	$6,032	$5,900	-$132
$5,200	$5,200	10%	$5,720	$5,900	+$180
$5,050	$5,050	16%	$5,858	$5,900	+$ 42

Lower Program Costs

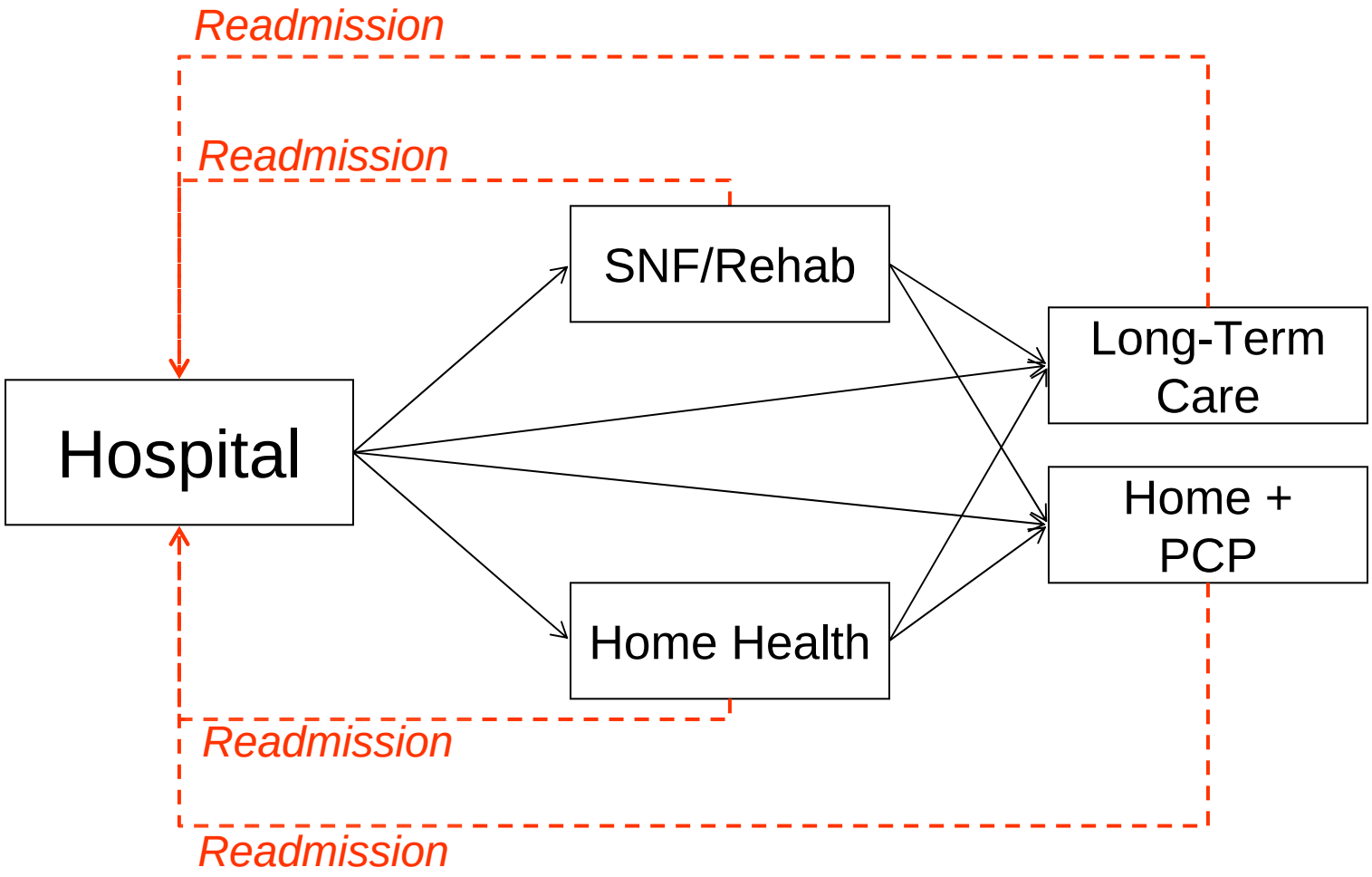
Means Better Margins

Warranty Enables the Right Balance of Cost & Performance

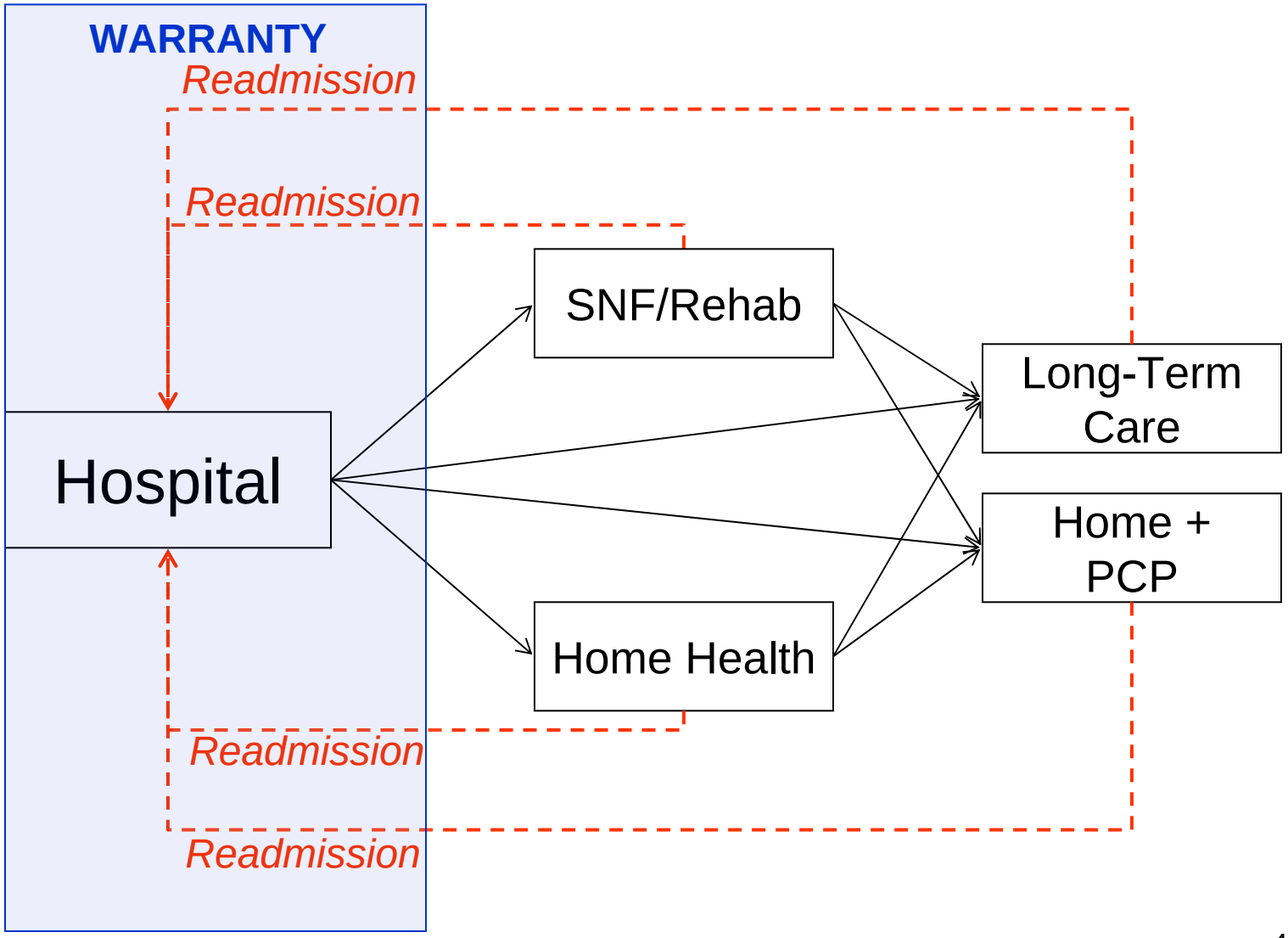
- Hospital & physicians have an incentive to reduce readmissions as much as possible
- Hospital & physicians have an incentive to find the lowest cost way to do that

Are Hospitals Responsible for Readmissions?

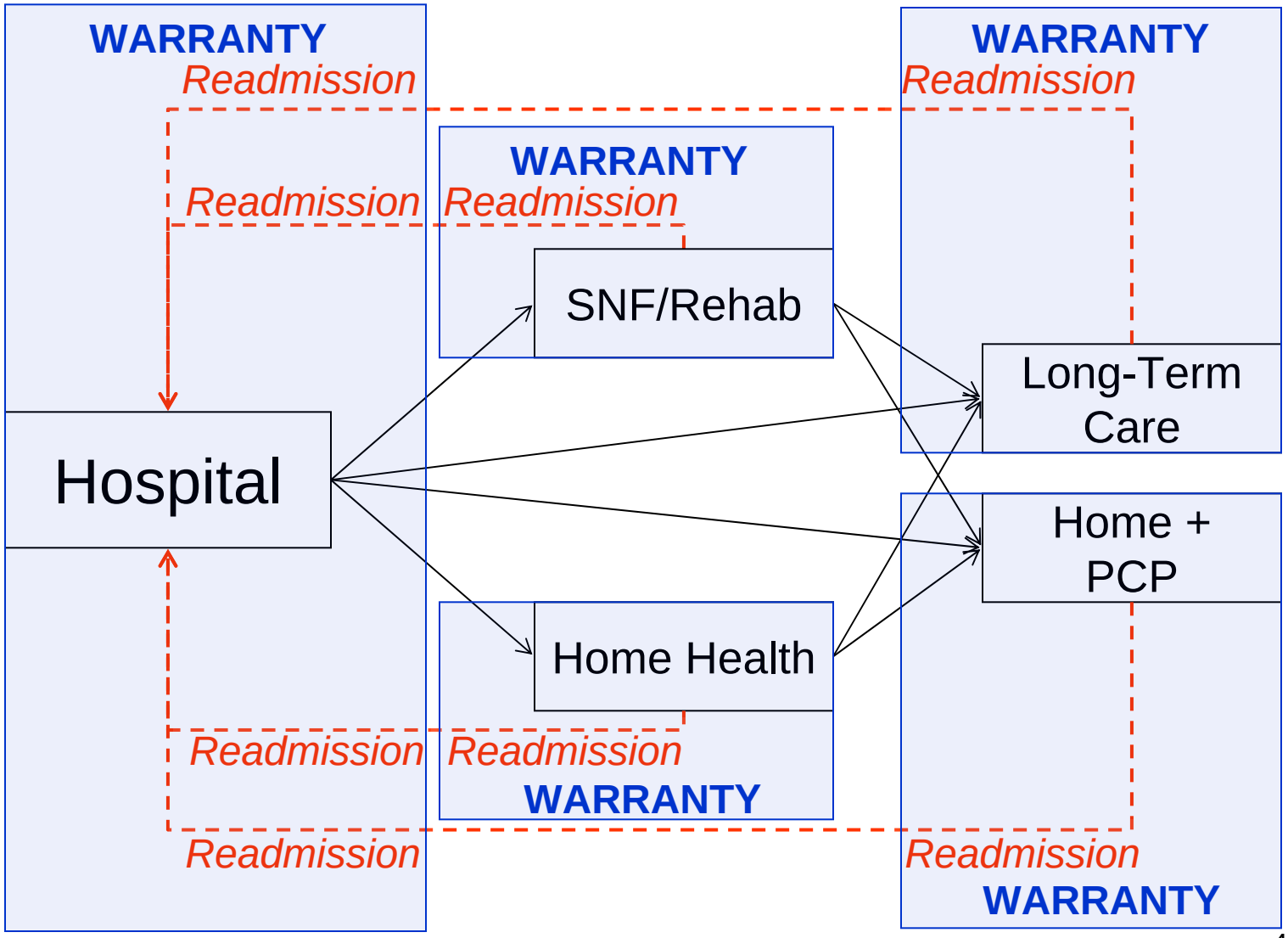
Many Post-Acute Care Providers May Contribute to Readmissions



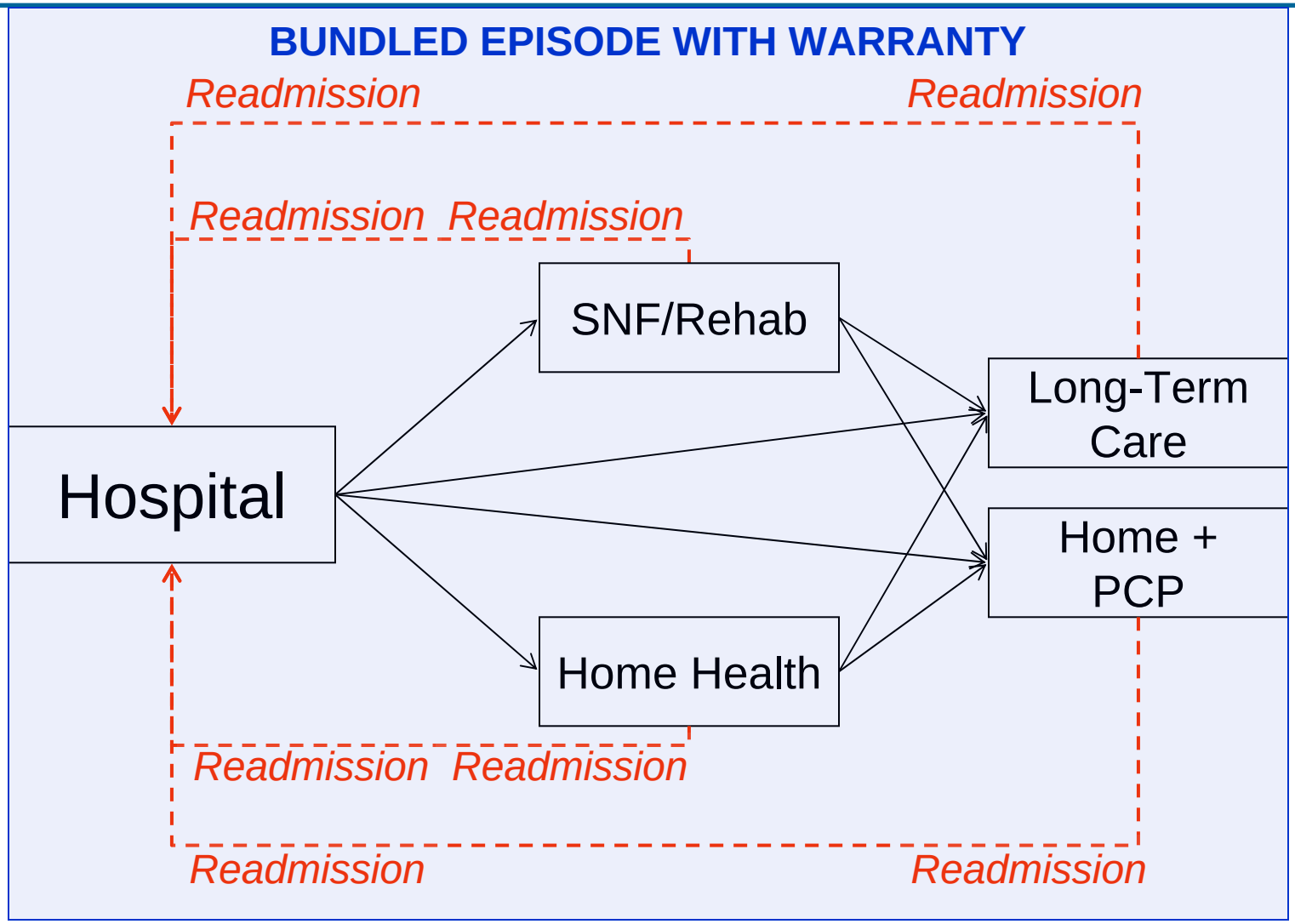
Should Hospitals Alone Be Responsible for Warranties?



But How Do You Attribute Responsibility for Readmissions?



Bundled Payment Encourages Joint Efforts to Reduce Readmits



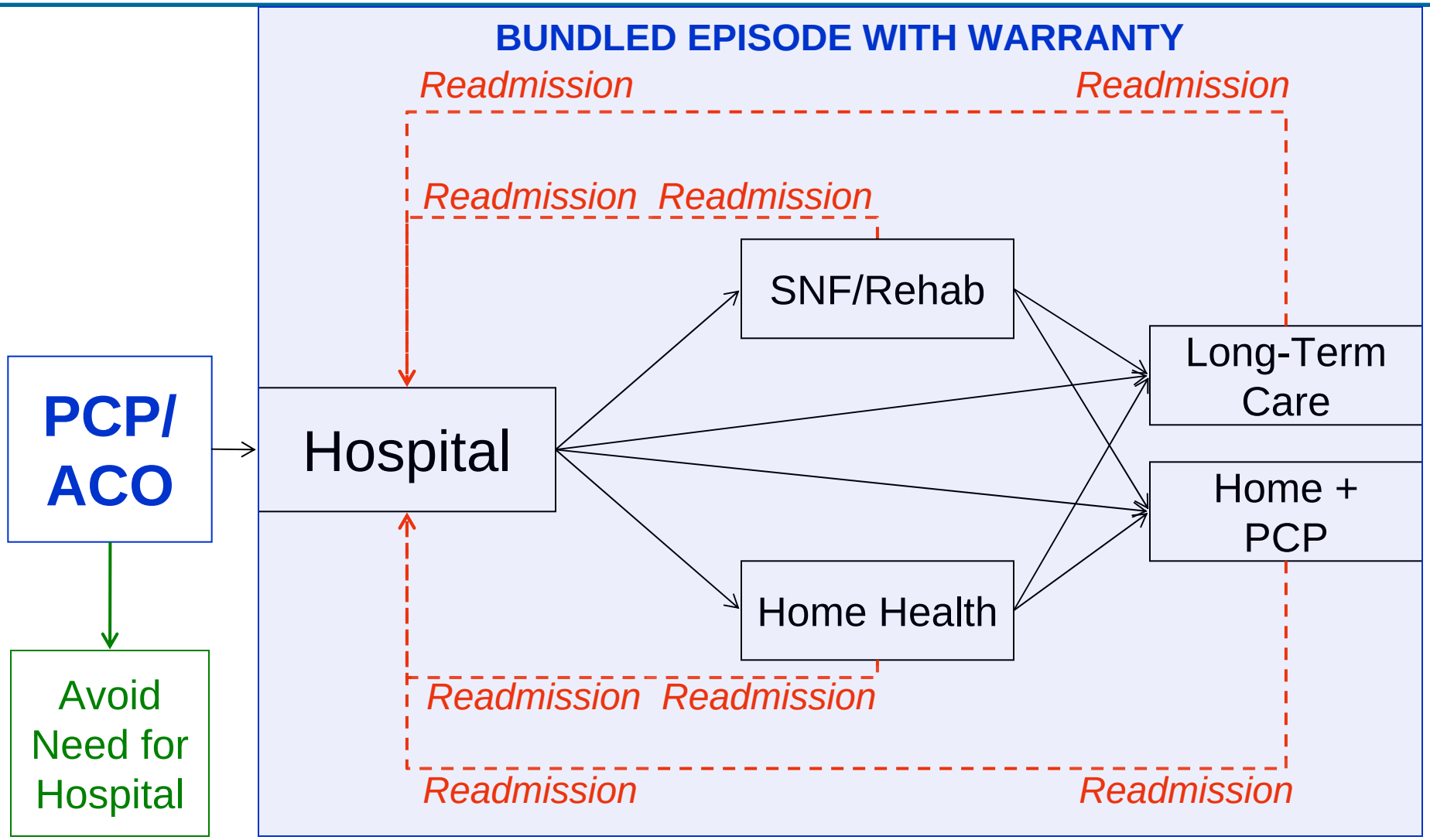
ACA Requires A Demonstration of Acute/Post-Acute Bundling

- Hospital Readmissions Reduction Program (§3025 of PPACA)
  - All DRG payments reduced up to 1% in 2013, 2% in 2014, 3% in 2015+
  - Actual reduction based on number of "excess" risk-adjusted readmissions for heart attack, heart failure, and pneumonia
  - Additional conditions to be added in 2015
- National Pilot Program on Payment Bundling (§3023 PPACA)
  - Creating a single payment for inpatient, outpatient, and post-acute care services for up to 10 high-volume conditions where there is variation in readmissions and high post-acute care expenditures

Challenges to Acute + Post-Acute Bundling

- Many hospitals and physicians have mechanisms for working together (e.g., Physician-Hospital Orgs)…
- …but most post-acute care providers (nursing homes, rehab facilities, home health agencies) are separate corporate entities without joint venture structures with the hospital
- Acute and post-acute care providers may be in different geographic regions
- Allowing patient choice of post-acute care provider can conflict with a bundled payment partnership
- Lack of good data on current utilization and lack of evidence on optimal combinations of care makes it difficult to define business case for improvement

Acute/Post-Acute Bundle Does Not Reduce *Initial* Admissions



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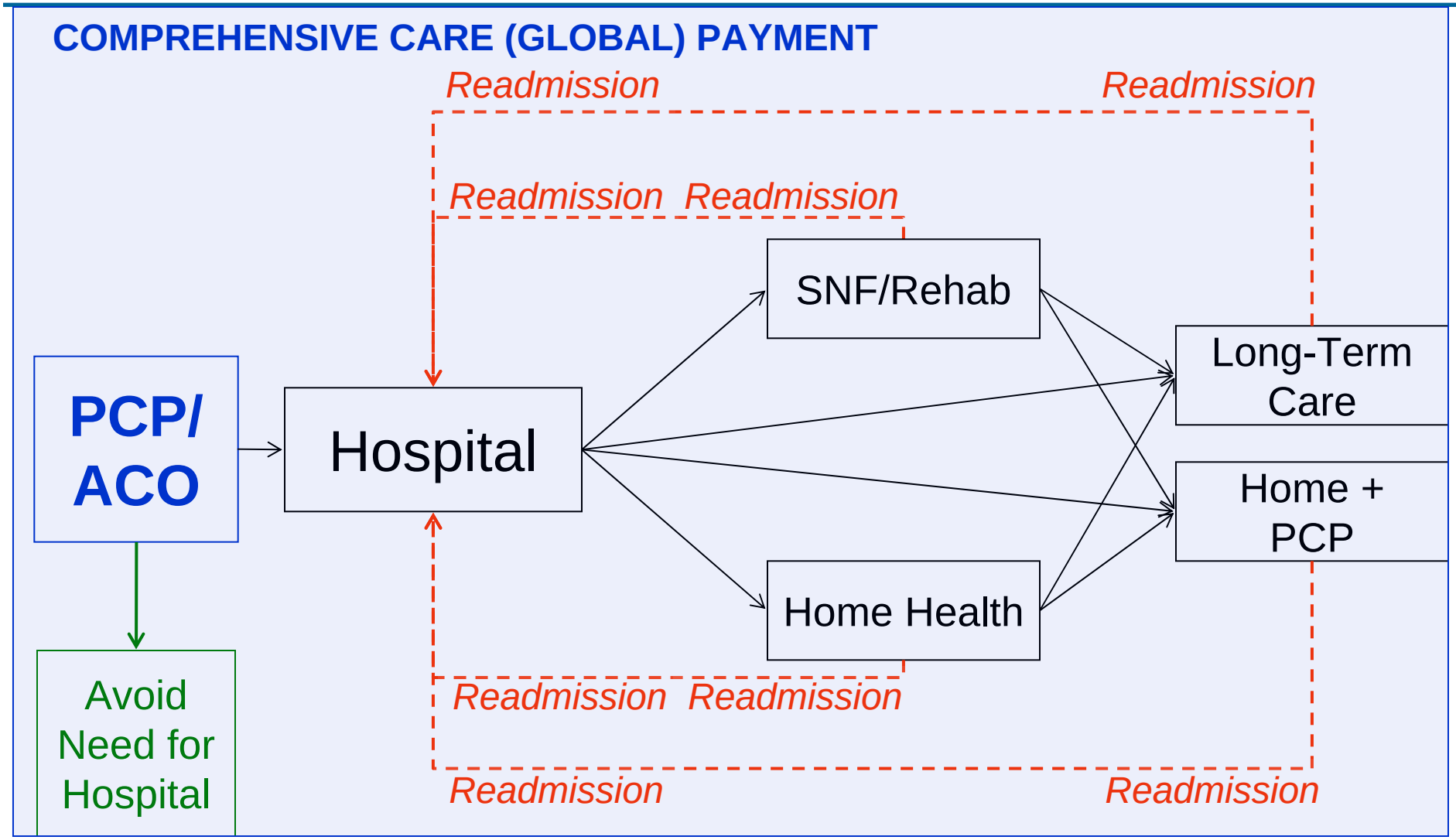
Comprehensive Care/Global Pmt to Prevent Initial Hospitalizations



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

Medicare Payment Reforms

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- **Shared Savings Program (§3022 PPACA)**

Weaknesses of the Shared Savings Model

- Provides no upfront money to pay for the changes in care needed to reduce readmissions
- Makes no changes in the current FFS/DRG payment structure for physicians and hospitals, so current incentives for volume remain
- Rules for attributing patients, defining whether savings have occurred, and allocating savings that are achieved may or may not cover providers' investments in better care or losses under FFS/DRG payments
- No reward for hospitals for reducing readmissions unless the patients' PCPs are part of the ACO
- Gives more rewards to the *poor* performers who improve than the providers who've done well all along
- I.e., it's not really *payment reform*

Medicare Payment Reform Options Beyond Shared Savings

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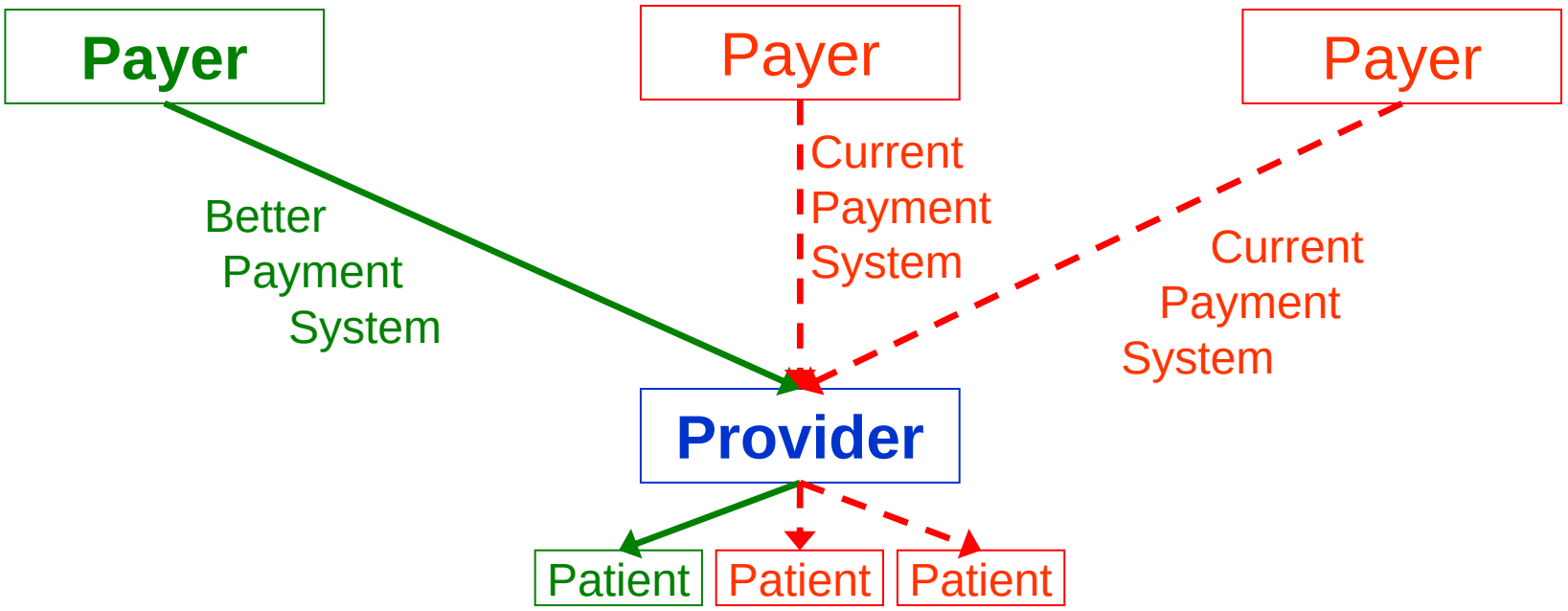
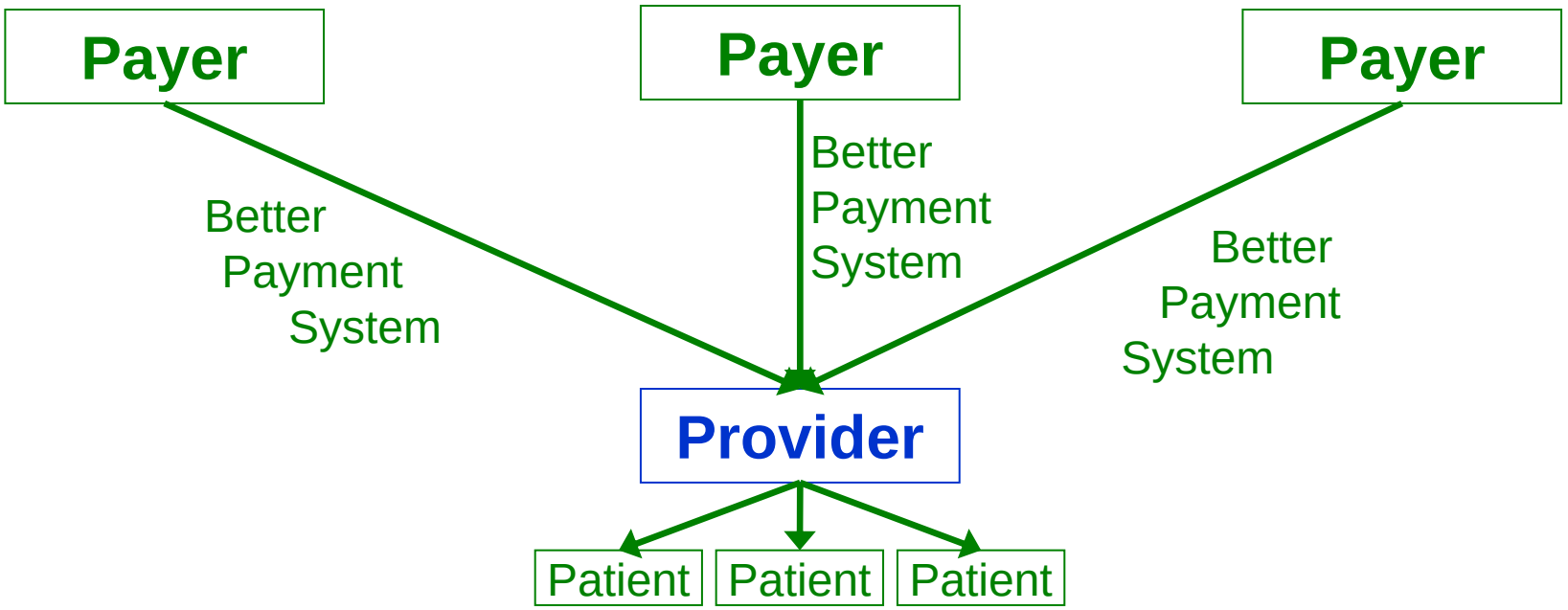
- Shared Savings Program (§3022 PPACA)
  - Shared savings
  - Partial capitation
  - "Other payment models"
- Center for Medicare and Medicaid Innovation (§3021 PPACA)
  - Other episode and global payment models

One Payer Changing Isn't Enough



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

Payers Need to Align to Enable Providers to Transform



Payer Coordination Is Beginning to Occur Around the Country

- Examples of Multi-Payer Payment Reforms:
  - Colorado, Maine, Michigan, Minnesota, New York, North Carolina, Oregon, Pennsylvania, Rhode Island ,Vermont, and Washington all have multi-payer medical home initiatives
- 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
  - Medicare is now participating in eight of the state-led multi-payer medical home initiatives

Effective Payment Reforms Are Challenging: Where to Start?

Existing Payment Reforms Are Proceeding in Silos

SILO #1

Implementing Medical Home/ Chronic Care Model

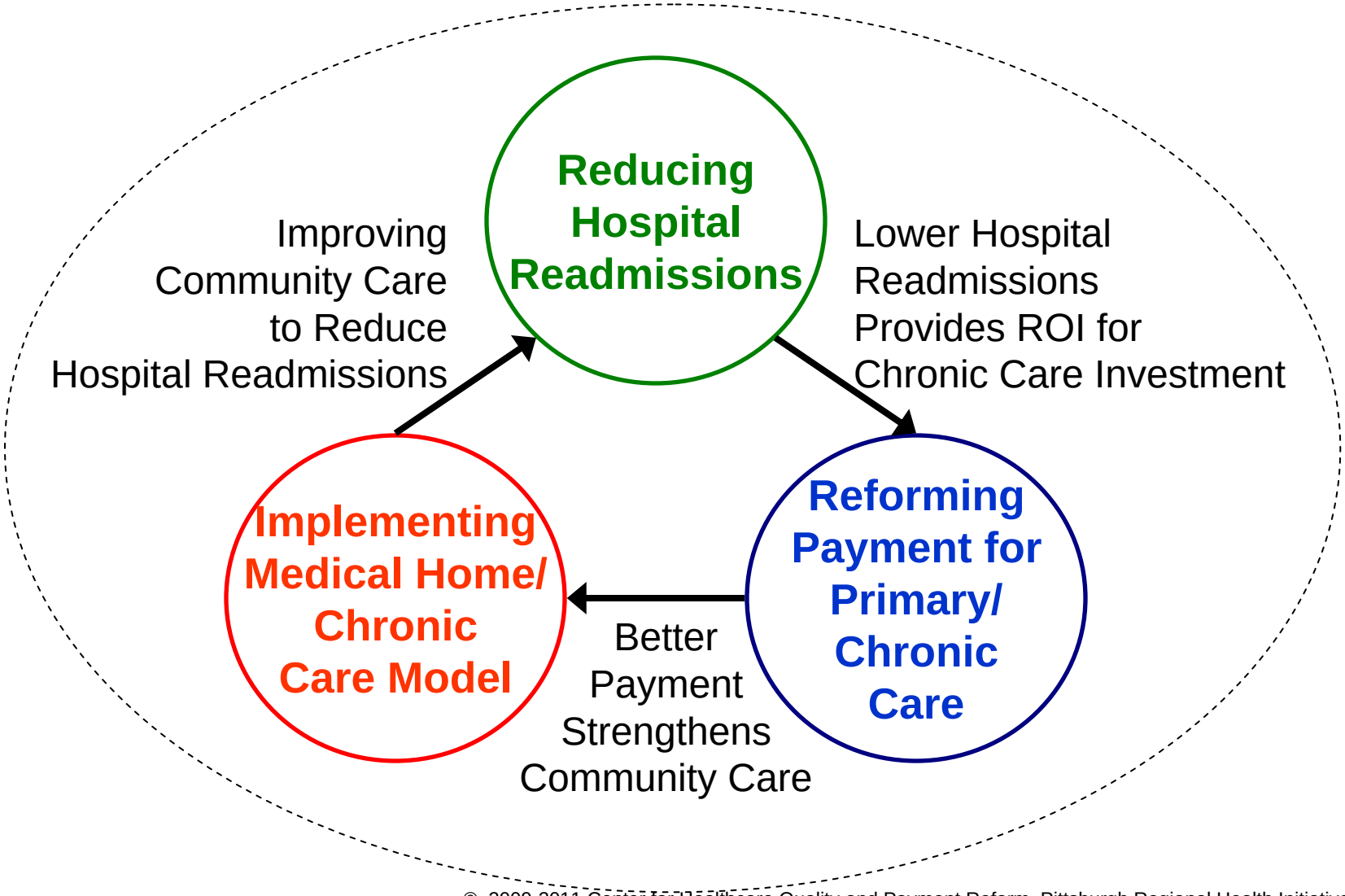
Pay More to Physicians For Being Certified As a Medical Home With No Focus on Readmissions

SILO #2

Reducing Hospital Readmissions

Penalize Hospitals for Readmissions Even If the Cause is Inadequate Primary Care

Marrying the Medical Home and Hospital Readmissions



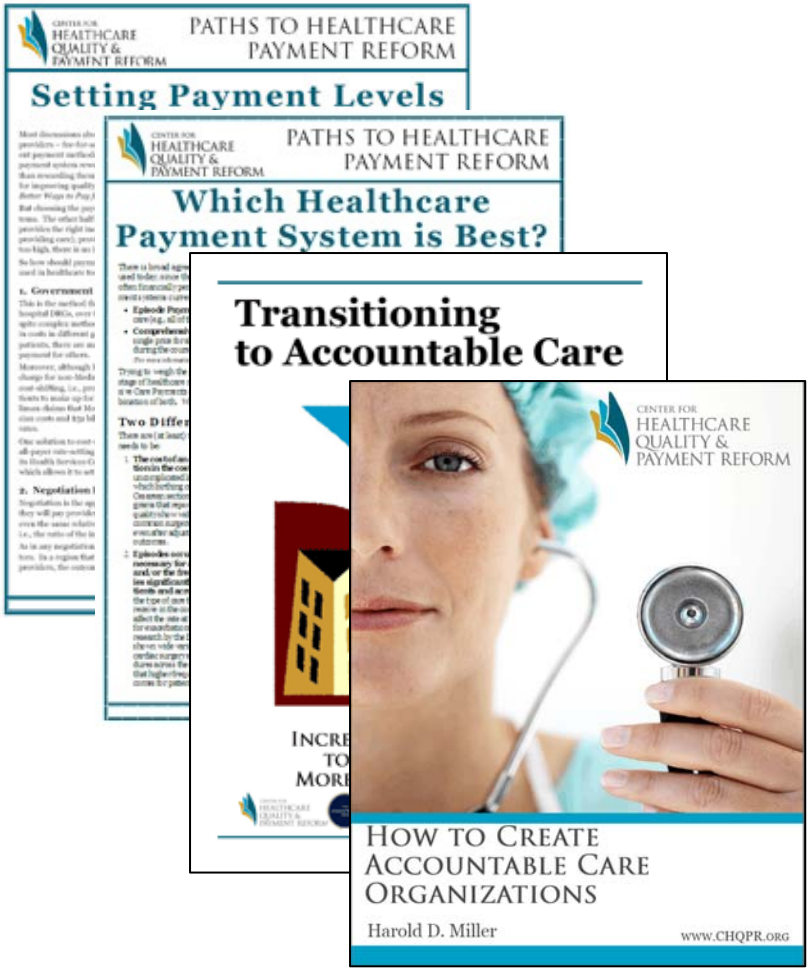
Example: Washington State "Accountable Medical Home" Pilot

- Health plans 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 repays up to 50% of Care Management Payment

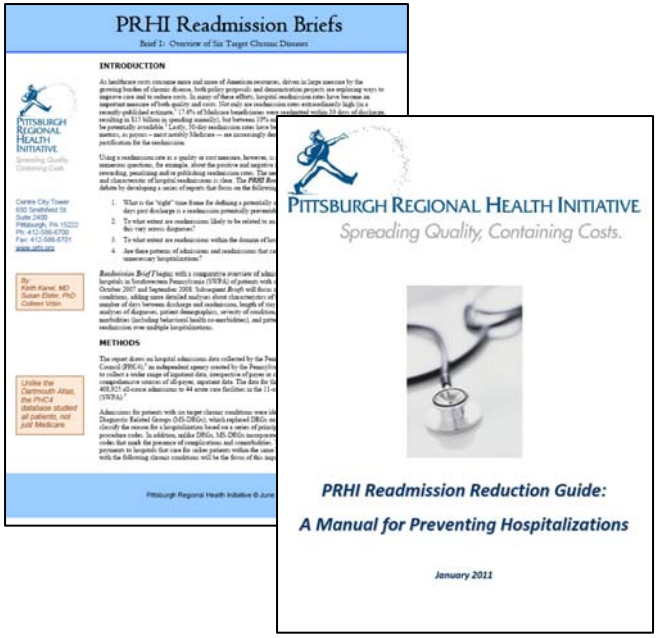
To Make It Work: Shared, Trusted Data for Pricing

- **Physicians and Hospitals** need to know what current readmission rates are and how many are preventable to know whether a warranty or global payment amount will cover the costs of better care
- **Medicare/Health Plan** needs to know what its current readmission rates and payments for readmissions are to know whether a warranty or global payment amount is a better deal than they have today
- **Both** sets of data have to match in order for both providers and payers to agree!

More on Payment Reform and Readmission Reduction



www.PaymentReform.org



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PITTSBURGH REGIONAL HEALTH INITIATIVE

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