CREATING A PROVIDER-LED HEALTHCARE FUTURE
Designing Alternative Payment Models for Better Care, Lower Spending, and Financially Viable Healthcare Providers

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

www.CHQPR.org
How Do You Control Growing Healthcare Spending?

TOTAL HEALTHCARE SPENDING

TOTAL HEALTHCARE SPENDING

TOTAL HEALTHCARE SPENDING

TOTAL HEALTHCARE SPENDING

TIME

$
Typical Strategy #1: 
Cut Provider Fees for Services
Typical Strategy #2: Shift Costs to Patients

TOTAL HEALTH CARE SPENDING

TOTAL HEALTH CARE SPENDING

TOTAL HEALTH CARE SPENDING

TOTAL HEALTH CARE SPENDING BY PAYERS

Higher Cost-Share & Deductibles

SAVINGS
Typical Strategy #3: Delay or Deny Care to Patients

- Lack of Needed Care

Graph showing total health care spending by payers, with savings indicated.
Results of Win-Lose Strategies

• Patients don’t get the care they need and costs increase in the future

• Small providers are forced out of business

• Health insurance premiums continue to rise and access to insurance coverage decreases
Results of Win-Lose Strategies

- Patients don’t get the care they need and costs increase in the future
- Small providers are forced out of business
- Health insurance premiums continue to rise and access to insurance coverage decreases

IS THERE A BETTER WAY?
The Right Focus: Spending That is *Unnecessary* or *Avoidable*

![Graph showing the comparison between necessary and avoidable spending over time.](#)
Avoidable Spending Occurs In All Aspects of Healthcare

**SURGERY**
- Unnecessary surgery
- Use of unnecessarily-expensive implants
- Infections and complications of surgery
- Overuse of inpatient rehabilitation

**CANCER TREATMENT**
- Use of unnecessarily-expensive drugs
- ER visits/hospital stays for dehydration and avoidable complications
- Fruitless treatment at end of life
- Late-stage cancers due to poor screening

**CHEST PAIN DIAGNOSIS/TREATMENT**
- Overuse of high-tech stress tests/imaging
- Overuse of cardiac catheterization
- Overuse of PCIs, high-priced stents

**CHRONIC DISEASE**
- ER visits for exacerbations
- Hospital admissions and readmissions
- Amputations, blindness
Institute of Medicine Estimate:
30% of Spending is Avoidable

Excess Cost Domain Estimates:
Lower bound totals from workshop discussions*

- **UNNECESSARY SERVICES**
  - Total excess = $210 B*
    - Overuse: services beyond evidence-established levels
    - Discretionary use beyond benchmarks
      - Defensive medicine
    - Unnecessary choice of higher cost services

- **INEFFICIENTLY DELIVERED SERVICES**
  - Total excess = $130 B*
    - Mistakes—medical errors, preventable complications
    - Care fragmentation
    - Unnecessary use of higher cost providers
    - Operational inefficiencies at care delivery sites
      - Physician offices
      - Hospitals

- **EXCESS ADMINISTRATIVE COSTS**
  - Total excess = $190 B*
    - Insurance-related administrative costs beyond benchmarks
      - Insurers
      - Physician offices
      - Hospitals
      - Other providers
    - Insurer administrative inefficiencies
    - Care documentation requirement inefficiencies

- **PRICES THAT ARE TOO HIGH**
  - Total excess = $105 B*
    - Service prices beyond competitive benchmarks
      - Physician services
        - Specialists
        - Generalists
      - Hospital services
    - Product prices beyond competitive benchmarks
      - Pharmaceuticals
      - Medical devices
      - Durable medical equipment

- **MISSED PREVENTION OPPORTUNITIES**
  - Total excess = $55 B*
    - Primary prevention
    - Secondary prevention
    - Tertiary prevention

- **FRAUD**
  - Total excess = $75 B*
    - All sources—payer, clinician, patient

*Lower bound totals of various estimates, adjusted to 2009 total expenditure level.
The Right Goal: Less Avoidable $,

- **NECESSARY SPENDING**
- **AVOIDABLE SPENDING**

$ vs. TIME
The Right Goal: Less Avoidable $, More Necessary $
Win-Win for Patients & Payers

NECESSARY SPENDING

AVOIDABLE SPENDING

SAVINGS

TIME

$ Lower Spending for Payers

Better Care for Patients

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Barriers in the Payment System Create a Win-Lose for Providers

- Necessary Spending
- Avoidable Spending

BARRIERS IN THE CURRENT PAYMENT SYSTEM

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Barrier #1: No $ or Inadequate $ for High-Value Services

No Payment or Inadequate Payment for:

- Services delivered outside of face-to-face visits with clinicians, e.g., phone calls, e-mails, etc.
- Services delivered by non-clinicians, e.g., nurses, community health workers, etc.
- Communication between providers to better manage patient needs
- Non-medical services, e.g., transportation
- Palliative care for patients at end of life
Barrier #2: Avoidable Spending May Be Revenue for Providers...

NECESSARY SPENDING

PROVIDER REVENUE

COST OF SERVICE DELIVERY

AVOIDABLE SPENDING

MARGIN

$
...And When Avoidable Services Aren’t Delivered...
…Providers’ Revenue May Decrease…
...But Fixed Costs Don’t Vanish

Many Fixed Costs of Services Remain When Volume Decreases
- Leases & staff in provider practice
- Costs of hospital emergency room and other standby services
...But Fixed Costs Don’t Vanish and New Costs May Be Added...

Many Fixed Costs of Services Remain When Volume Decreases And New Costs May Be Incurred
- Costs of non-clinical staff
- Costs of unpaid provider services
- Costs of collecting quality data
...Leaving Providers With Losses (or Bigger Losses Than Today)

Many Fixed Costs of Services Remain When Volume Decreases And New Costs May Be Incurred, Potentially Causing Financial Losses
Small P4P/VBP Bonuses Usually Won’t Offset the Losses

Many Fixed Costs of Services Remain When Volume Decreases And New Costs May Be Incurred, Potentially Causing Financial Losses That Aren’t Offset by Small Bonuses

$
A Payment Change isn't Reform Unless It Removes the Barriers

### BARRIER #1

No Payment or Inadequate Payment for:

- Services delivered outside of face-to-face visits with clinicians, e.g., phone calls, e-mails, etc.
- Services delivered by non-clinicians, e.g., nurses, community health workers, etc.
- Communication between providers to better manage patient needs
- Non-medical services, e.g., transportation
- Palliative care for patients at end of life

### BARRIER #2

Many Fixed Costs of Services Remain When Volume Decreases And New Costs May Be Incurred, Potentially Causing Financial Losses That Aren’t Offset by Small Bonuses
So Why Haven’t We Fixed This??
John Gray, Ph.D.

#1 New York Times Bestseller

MEN ARE FROM MARS, WOMEN ARE FROM VENUS

The Classic Guide to Understanding the Opposite Sex
In Healthcare, Payers Are From Mars, Providers Are From Venus
Provider Approach: Pay Us More…

Proper Solution:

- Necessary Spending
- Newly Paid Services
- Avoidable Spending

$
Provider Approach: Pay Us More…
…and “Trust Us” on Savings

PROVIDER SOLUTION:

Provider to Payer: “Paying for the services saved money in a demonstration project, so you can safely assume that you will also save money if you pay all providers to deliver the services for all patients”
Payer Concern: No Accountability to Reduce Avoidable Spending

NECESSARY SPENDING

AVOIDABLE SPENDING

UNPAID SERVICES

NEWLY PAID SERVICES

SAVINGS

PROVIDER SOLUTION:

PAYER FEAR:

AVOIDABLE SPENDING

NECESSARY SPENDING

NECESSARY SPENDING

$
Example: Accreditation Programs

- Providers want to be paid more if they are certified as delivering care the “right way” by an accrediting agency
Does Accreditation Assure High-Value Care?

• Thanks to Joint Commission hospital accreditation, there are no longer any infections or patient safety problems in hospitals

• Thanks to the Certification Commission for Health Information Technology (CCHIT), every EHR works effectively to support good patient care

• Thanks to college accreditation organizations, every parent who sends their child to college knows they will get a good education and a good job after graduation

“NOT”
In Healthcare, Payers Are From Mars, Providers Are From Venus
Payer Approach: Save Us Money and…

PAYER SOLUTION:

YEAR 1

NECESSARY SPENDING

AVOIDABLE SPENDING

NECESSARY SPENDING

UNPAID SERVICES

UNPAID SERVICES

SAVINGS

LOSS OF REVENUE

$
Payer Approach: Save Us Money and We’ll Pay You More Next Year

PAYER SOLUTION:

YEAR 1

NECESSARY SPENDING

SAVINGS

YEAR 2

NECESSARY SPENDING

SAVINGS

AVOIDABLE SPENDING

P4P/ShrdSvgs

UNPAID SERVICES

LOSS OF REVENUE

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Provider Concern: P4P & Shared Savings is Too Little, Too Late

PAYER SOLUTION:

YEAR 1
- Necessary Spending
- Avoidable Spending
- Savings
- Unpaid Services
- Loss of Revenue

YEAR 2
- Necessary Spending
- Avoidable Spending
- Savings
- P4P/SharedSvgs
- Unpaid Services
- Loss of Revenue

How does provider cover upfront costs of additional services and loss of revenue?

P4P or shared savings may be too little too late to cover costs & losses.
Medicare’s Shared Savings ACO Program Isn’t Succeeding

2013 Results for Medicare Shared Savings ACOs
- 46% of ACOs (102/220) increased Medicare spending
- Only 24% (52/220) received shared savings payments
- After making shared savings payments, Medicare spent more than it saved
- Net loss to Medicare: $78 million

2014 Results for Medicare Shared Savings ACOs
- 45% of ACOs (152/333) increased Medicare spending
- Only 26% (86/333) received shared savings payments
- After making shared savings payments, Medicare spent more than it saved
- Net loss to Medicare: $50 million

2015 Results for Medicare Shared Savings ACOs
- 48% of ACOs (189/392) increased Medicare spending
- Only 30% (119/392) received shared savings payments
- After making shared savings payments, Medicare spent more than it saved
- Net loss to Medicare: $216 million
Why Aren’t ACOs Succeeding?

ACO

PATIENTS
- Heart Disease
- Diabetes
- Back Pain
- Pregnancy

Primary Care  Cardiology  Physical Therapy  Neurosurgery  OB/GYN
No Change in the Way Providers Are Paid

MEDICARE

PATIENTS
- Heart Disease
- Diabetes
- Back Pain
- Pregnancy

Fee-for-Service Payment

ACO

Primary Care
Cardiology
Physical Therapy
Neurosurgery
OB/GYN
Providers Still Face All the Barriers in the Current Payment System…

MEDICARE

PATIENTS
- Heart Disease
- Diabetes
- Back Pain
- Pregnancy

ACO

Fee-for-Service Payment

- No payment for high-value services
- Inadequate revenues to cover costs when fewer services are delivered

Primary Care
Cardiology
Physical Therapy
Neurosurgery
OB/GYN

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ACOs Try to “Coordinate Care” Without Fixing Payment Barriers

- No payment for high-value services
- Inadequate revenues to cover costs when fewer services are delivered

PATIENTS
- Heart Disease
- Diabetes
- Back Pain
- Pregnancy

ACO
- Expensive IT Systems
- Care Coordinators

Fee-for-Service Payment

MEDICARE

Primary Care, Cardiology, Physical Therapy, Neurosurgery, OB/GYN
Possibility of Future Bonuses Doesn’t Overcome Current Barriers

MEDICARE

Shared Savings Payment??

ACO

Expensive IT Systems

Care Coordinators

Part of Shared Savings??

• No payment for high-value services
• Inadequate revenues to cover costs when fewer services are delivered

PATIENTS
Heart Disease
Diabetes
Back Pain
Pregnancy

Fee-for-Service Payment

Primary Care
Cardiology
Physical Therapy
Neurosurgery
OB/GYN
Creating More “Risk” Won’t Solve the Problems with Payment Either

PATIENTS
- Heart Disease
- Diabetes
- Back Pain
- Pregnancy

Fee-for-Service Payment

MEDICARE

More Downside Risk

ACO

Expensive IT Systems
Care Coordinators

• No payment for high-value services
• Inadequate revenues to cover costs when fewer services are delivered

Primary Care
Cardiology
Physical Therapy
Neurosurgery
OB/GYN
Problems With “Shared Savings” and “Two-Sided Risk”

- Providers receive no upfront resources to improve care management for patients
- Providers could be paid more for denying needed care
- Physicians are placed at risk for costs they cannot control
- Shared savings bonuses are temporary and “rebasing” leaves providers with inadequate payment to deliver necessary services
This is NOT a Good “Framework” for Alternative Payment Models

Alternative Payment Models (APM) Framework

Category 1
Fee for Service – No Link to Quality & Value
- Fee-for-Service
- A: Foundational Payments for Infrastructure & Operations

Category 2
Fee for Service – Link to Quality & Value
- Pay for Reporting
- B: Rewards for Performance

Category 3
APMs Built on Fee-for-Service Architecture
- Rewards and Penalties for Performance
- A: APMs with Upside Gainsharing
- B: APMs with Upside Gainsharing/Downside Risk

Category 4
Population-Based Payment
- Condition-Specific Population-Based Payment
- A: Comprehensive Population-Based Payment
It’s All Just FFS + P4P with Fancy Names
Value-Based Payment Is Being Designed the *Wrong* Way Today
Value-Based Payment Is Being Designed the *Wrong* Way Today

**TOP-DOWN PAYMENT REFORM**

Medicare and Health Plans Define Payment Systems

Providers Have To Change Care to Align With Payment Systems
Value-Based Payment Is Being Designed the *Wrong* Way Today

**TOP-DOWN PAYMENT REFORM**

Medicare and Health Plans Define Payment Systems

Providers Have To Change Care to Align With Payment Systems

Both Patients and Providers May Lose
Providers Need to Design Payments to Support Good Care

TOP-DOWN PAYMENT REFORM

Medicare and Health Plans Define Payment Systems

Providers Have To Change Care to Align With Payment Systems

Both Patients and Providers May Lose

BOTTOM-UP PAYMENT REFORM

Providers Redesign Care and Identify Payment Barriers
Providers Need to Design Payments to Support Good Care

**TOP-DOWN PAYMENT REFORM**
- Medicare and Health Plans Define Payment Systems
- Providers Have To Change Care to Align With Payment Systems
- Both Patients and Providers May Lose

**BOTTOM-UP PAYMENT REFORM**
- Payers Change Payment to Support Redesigned Care
- Providers Redesign Care and Identify Payment Barriers
Providers Need to Design Payments to Support Good Care

**TOP-DOWN PAYMENT REFORM**

- Medicare and Health Plans Define Payment Systems
- Providers Have To Change Care to Align With Payment Systems
- Both Patients and Providers May Lose

**BOTTOM-UP PAYMENT REFORM**

- Payers Change Payment to Support Redesigned Care
- Providers Redesign Care and Identify Payment Barriers
- Patients Get Better Care and Providers Stay Financially Viable
How Do You Design a *Good* Alternative Payment Model?
Step #1: Identify Avoidable Spending in FFS

**Avoidable Spending**

- Avoidable Hospital Admissions/Readmissions
- Unnecessary Tests and Procedures
- Use of Lower-Cost Settings
- Use of Lower-Cost Treatments
- Preventable Complications of Treatment
- Prevention & Early Identification of Disease

**Necessary Spending**

**Opportunities to Reduce Total Spending**
Most Specialties Have Identified Areas of Avoidable Spending
Step #2: Identify Barriers in FFS

BARRIERS IN CURRENT FFS SYSTEM

- No payment for high-value services
  - Phone calls, e-mails with clinicians
  - Services delivered by non-clinician staff
  - Communication/coordination among providers
  - Non-medical services, e.g., transportation
  - Palliative care for patients at end of life

- Inadequate payment for patients who need more time or resources

- Inadequate revenue to cover fixed costs when utilization of services is reduced
You Can’t Reduce Spending if You Don’t Remove the Barriers

- Avoidable Spending
- Necessary Spending
- Unpaid Services
- Loss of Revenue
Step #3: Remove the FFS Barriers

- Unpaid services: loss of revenue
- Necessary spending: avoidable spending
- Upfront payment to support improved delivery of care

Fee for Service vs. Alternative Payment Model

$
Step 4: Build in Accountability for Results

- **Fee for Service**
  - Avoidable Spending
  - Necessary Spending

- **Alternative Payment Model**
  - Lower Avoidable Spending
  - Adequate, Flexible Payment for High-Value Services

Accountability for reducing avoidable spending
Upfront payment to support improved delivery of care
True Alternative Payment Models Can Be Win-Win-Wins

Win for Payer: Lower Total Spending (and Lower Premiums)

Win for Patient: Better Care Without Unnecessary Services

Win for Providers: Adequate Payment for High-Value Services
Providers Can Win Since They Only Get 15% of Total Medicare $
But Individual Providers Can’t Control All Avoidable Spending

<table>
<thead>
<tr>
<th>FEE FOR SERVICE</th>
<th>FEE FOR SERVICE</th>
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<tbody>
<tr>
<td>AVOIDABLE SPENDING</td>
<td>Necessary Spending the Provider Can Control</td>
</tr>
<tr>
<td>Provider Payment</td>
<td>Necessary Spending the Provider Can Control or Influence</td>
</tr>
</tbody>
</table>

- PCPs can’t reduce surgical site infections
- Surgeons can’t prevent diabetic foot ulcers
- Physical therapists can’t prevent injuries due to workplace conditions

- PCPs can help diabetics avoid amputations
- Surgeons can reduce surgical site infections
- Physical therapists can help injured patients recover more quickly and safely
APM Design Must Focus on What Provider *Can* Control

**CURRENT FFS**
- Spending the Provider *Cannot* Control
  - Necessary Spending
  - Provider Payment
  - Unpaid Service Revenue Loss
- Avoidable Spending Provider *Can Control*

**ALTERNATIVE PAYMENT MODEL**
- Savings Spending the Provider *Cannot* Control
- Avoidable Spending
- Adequate, Flexible Payment for High-Value Services
What If There Isn’t Much Avoidable Healthcare Spending??

CURRENT FFS

$ Avoidable Spending

Necessary Spending

Provider Payment

Unpaid Service Revenue Loss

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An APM That Reduces Avoidable Costs Might Increase Spending

**CURRENT FFS**

**ALTERNATIVE PAYMENT MODEL**

- **Necessary Spending**
- **Provider Payment**
- **Avoidable Spending**
- **Unpaid Service Revenue Loss**

- **Payer Loss**

**ADEQUATE, FLEXIBLE PAYMENT FOR HIGH-VALUE SERVICES**
“Value” Derives from More Than Lower Healthcare Spending

CURRENT FFS

$

Avoidable Spending

Quality of Life & Worker Productivity

Necessary Spending

Provider Payment

Unpaid Service Revenue Loss

ALTERNATIVE PAYMENT MODEL

Avoidable

Adequate, Flexible Payment for High-Value Services

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Returning Patients to Work or Functionality Also Has Value

**CURRENT FFS**

- Quality of Life & Worker Productivity
- Necessary Spending
- Provider Payment
- Unpaid Service Revenue Loss

**ALTERNATIVE PAYMENT MODEL**

- Quicker Recovery & Improved Outcomes
- Avoidable

**ADEQUATE, FLEXIBLE PAYMENT FOR HIGH-VALUE SERVICES**

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APMs Could Be Designed to Monetize Better Outcomes

CURRENT FFS
- Quality of Life & Worker Productivity
- Necessary Spending
- Provider Payment
- Unpaid Service Revenue Loss

ALTERNATIVE PAYMENT MODEL
- Benefit to Employer/ee
- Quicker Recovery & Improved Outcomes
- ADEQUATE, FLEXIBLE PAYMENT FOR HIGH-VALUE SERVICES

$
Multiple APMs Needed for Different Opportunities & Barriers

APM #1: Payment for a High-Value Service
APM #2: Condition-Based Payment for a Physician’s Services
APM #3: Multi-Physician Bundled Payment
APM #4: Physician-Facility Procedure Bundle
APM #5: Warrantied Payment for Physician Services
APM #6: Episode Payment for a Procedure
APM #7: Condition-Based Payment
Option 1: Add New Payment(s) to Overcome Current Barriers

CURRENT FFS

$

Avoidable Spending Provider Can Control

Necessary Spending

Provider Payment

Unpaid Service Revenue Loss

New Payment

Current Payment

APM #1
Option 1, Part 2: Add in an Accountability Component

<table>
<thead>
<tr>
<th>CURRENT FFS</th>
<th>APM #1</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

- **Avoidable Spending Provider Can Control**
- **Necessary Spending**
- **Provider Payment**
- **Unpaid Service Revenue Loss**
- **Necessary Spending**
- **Necessary Spending**
- **New Payment**
- **Current Payment**

**SAVINGS**

Adjustment to New Payment Based on Control of Avoidable Spending
Accountability Component Could Utilize a P4P Approach

CURRENT

FFS

$=

Avoidable
Spending

Provider
Can Control

Necessary
Spending

Necessary
Spending

Provider
Payment

Unpaid Service
Revenue Loss

New Payment

Current Payment

Savings

Adjustment to New Payment Based on Control of Avoidable Spending

P4P Adjustments To Amount(s)
Option 2: Bundle New Payment with Existing Payments

- **CURRENT FFS**: Necessary Spending - Provider Payment - Unpaid Service - Revenue Loss
- **APM #1**: Necessary Spending - New Payment - Current Payment - SAVINGS - Avoidable Spending - Provider Can Control
- **APMs #2-3**: Bundled Payment for Provider Services - Avoidable Spending - Provider Can Control
Option 2, Part 2: Add an Accountability Component

- **CURRENT FFS**
  - Necessary Spending
  - Provider Payment
  - Unpaid Service Revenue Loss

- **APM #1**
  - Avoidable Spending
  - Savings
  - Necessary Spending
  - New Payment
  - Current Payment

- **APMs #2-3**
  - Avoidable Spending
  - Savings
  - Necessary Spending
  - Adjustment to New Payment Based on Control of Avoidable Spending
  - Bundled Payment for Provider Services
Option 3: Full Bundle Covering Necessary & Avoidable Costs

- **CURRENT FFS**
  - Avoidable Spending Provider Can Control
  - Necessary Spending
  - Provider Payment
  - Unpaid Service Revenue Loss

- **APM #1**
  - SAVINGS
  - Avoidable Spending
  - Necessary Spending
  - New Payment
  - Current Payment

- **APMs #2-3**
  - SAVINGS
  - Avoidable Spending
  - Necessary Spending
  - Bundled Payment for Provider Services

- **APMs #4-7**
  - SAVINGS
  - Costs of Other Related Services
  - Costs of Provider Services

| BUNDLED PAYMENT |
If Patients Differ in the Services They Need…

<table>
<thead>
<tr>
<th>Lower Need Patients</th>
<th>Medium Need Patients</th>
<th>Higher Need Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prov. Svcs</td>
<td>Provider Services</td>
<td>Provider Services</td>
</tr>
<tr>
<td>Unpaid Svc</td>
<td>Unpaid Svc</td>
<td>$ Loss</td>
</tr>
<tr>
<td>$ Loss</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
…Or if Patients Differ in Risks & Opportunities for Better Care
APM $ Will Have to Be Adjusted for Differences in Need

- Lower Need Patients
- Medium Need Patients
- Higher Need Patients
- Level 1
- Level 2
- Level 3

Avoidable Spending
Necessary Spending
Provider Services
Unpaid Svc
$ Loss

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Accountability Targets Need to Be Adjusted for Patient Differences

Lower Need Patients

Lower Need Patients

Medium Need Patients

Medium Need Patients

Higher Need Patients

Higher Need Patients

Avoidable Spending

Avoidable Spending

Necessary Spending

Necessary Spending

Necessary Spending

Necessary Spending

Level 1 APM $

Level 1 APM $

Provider Services

Provider Services

Unpaid Svc

Unpaid Svc

Unpaid Svc

$ Loss

$ Loss

$ Loss

$ Loss

Lower Need Patients

Medium Need Patients

Higher Need Patients

Provider Services

Unpaid Svc

Level 3 APM $

$ Loss

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# APMs Being Developed By Other Specialties

<table>
<thead>
<tr>
<th>AAN Headache APM</th>
<th>ACAAI Asthma APM</th>
<th>ACR Rheum. Arth. APM</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnosis &amp; Initial Treatment</strong>&lt;br&gt;(Monthly up to 3 months)&lt;br&gt;xxx11 1-2 headache day/mo.&lt;br&gt;xxx12 3-14 headache/mo. or 1+ severe/disabling&lt;br&gt;xxx13 Frequent+comorb. or complex disorders</td>
<td><strong>Diagnosis &amp; Initial Treatment</strong>&lt;br&gt;(Monthly up to 6 months)&lt;br&gt;xxx11 Mild symp/not asthma&lt;br&gt;xxx12 Mod symp/not asthma&lt;br&gt;xxx13 Mild symp/asthma&lt;br&gt;xxx14 Mod-sev symptoms&lt;br&gt;xxx15 Mod-sev+comorbid</td>
<td><strong>Diagnosis &amp; Tx Planning</strong>&lt;br&gt;(One Time)&lt;br&gt;xxx11 Swelling/pain not RA&lt;br&gt;xxx12 Confirmed RA&lt;br&gt;xxx20 RA Screening Consult</td>
</tr>
<tr>
<td><strong>Continued Care for Difficult-to-Control Headache</strong>&lt;br&gt;(Monthly)&lt;br&gt;xxx21 10+ headache/mo&lt;br&gt;xxx22 Poor response or comorbidities&lt;br&gt;xxx23 Freq. + poor response&lt;br&gt;xxx24 Migraine requiring intravenous therapy&lt;br&gt;xxx25 Complex migraine</td>
<td><strong>Continued Care for Difficult-to-Control Asthma</strong>&lt;br&gt;(Monthly)&lt;br&gt;xxx21 Well-controlled but comorbid/high-risk Rx&lt;br&gt;xxx22 Not well-controlled&lt;br&gt;xxx23 Very poorly controlled&lt;br&gt;xxx24 Very poor + comorbid</td>
<td><strong>Initial Treatment for RA</strong>&lt;br&gt;(Monthly up to 6 months)&lt;br&gt;xxx31 Low disease activity&lt;br&gt;xxx32 Mod. disease activity&lt;br&gt;xxx33 High disease activity&lt;br&gt;xxx34 High + comorbid</td>
</tr>
<tr>
<td><strong>Continued Care for Well-Controlled Headache</strong>&lt;br&gt;(Additional Service Fees)&lt;br&gt;xxx31 Call/email w/patient&lt;br&gt;xxx32 Call/email w/physician</td>
<td><strong>Continued Care for Difficult-to-Control Asthma</strong>&lt;br&gt;(Additional service fees)&lt;br&gt;xxx31 Call/email w/patient&lt;br&gt;xxx32 Call/email w/physician</td>
<td><strong>Continued Care for Difficult-to-Control RA</strong>&lt;br&gt;xxx41 Low disease activity&lt;br&gt;xxx42 Mod. disease activity&lt;br&gt;xxx43 High disease activity&lt;br&gt;xxx44 High + comorbid</td>
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<tr>
<td><strong>Continued Care for Well-Controlled Asthma</strong>&lt;br&gt;(Additional service fees)&lt;br&gt;xxx31 Call/email w/patient&lt;br&gt;xxx32 Call/email w/physician</td>
<td></td>
<td><strong>Continued Care for Low-Activity RA</strong>&lt;br&gt;(Additional service fees)&lt;br&gt;xxx51 Call/email w/patient&lt;br&gt;xxx52 Call/email w/physician</td>
</tr>
</tbody>
</table>
What Would a (Good) Alternative Payment Model Look Like for Physical Therapy?
Example: Patients Who Need Physical Therapy

<table>
<thead>
<tr>
<th>CURRENT FEE FOR SERVICE SYSTEM</th>
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</thead>
<tbody>
<tr>
<td>Payment Per 15 min Service</td>
</tr>
<tr>
<td>$33</td>
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Assumption: Patients currently receive eight 45 minute visits to achieve a good outcome
Today: Greater Efficiency Penalizes Therapist Financially

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Today: Therapist is Rewarded for Less Efficiency

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Win-Lose: Therapist Only Wins When Patient & Payer Lose

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Could an APM Create a Win-Win-Win-Win?

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ALTERNATIVE PAYMENT MODEL
Payment *Per Patient* Rather Than Per Minute or Per Visit

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Give the Payer a Discount Over Current Average Spending

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Loss of Revenue for Therapist?

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Now Therapist Is *Rewarded* for Higher Efficiency

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And the Therapist is Penalized for *Inefficiency*

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Win-Win-Win: More Pay for PT By Saving Patient Time & Payer $

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Impact of Higher Productivity on Total Revenue?
Under FFS, Higher Productivity Reduces Revenue/Patient...

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…Able to Serve More Patients, But No Net Change in Revenue

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*Payment based on time/visits means physical therapists are paid as much for serving fewer patients inefficiently as they are for serving more patients efficiently*
Under APM, Payment Isn’t Based on Visits…

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Under APM, Higher Productivity + Greater Volume = Higher Revenue

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Under FFS, Provider is Penalized for Undertreating Patients

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<td>4</td>
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Under APM, Provider Could Be Rewarded for Undertreatment

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Need Measures of *Outcomes* to Prevent Undertreatment

- Walking distance
- Functional independence
- Return to work
- Balance
- Strength
- Pain
# Adjusting Payment Rates Based on Quality/Outcomes

## Alternative Payment Model

<table>
<thead>
<tr>
<th>Quality/Outcomes</th>
<th>Payment Per Patient</th>
<th>Difference from Default Payment Rate</th>
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<tr>
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What Outcomes Would Justify 8% Higher Payment?

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Example: Time to Recovery

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<tr>
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<td>$752</td>
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</table>
Total Cost is Not Just PT, But Lost Wages During Recovery

**ALTERNATIVE PAYMENT MODEL**

<table>
<thead>
<tr>
<th>Quality/Outcomes</th>
<th>Payment Per Patient</th>
<th>Days to Recovery</th>
<th>Wages Lost at Min. Wage</th>
<th>Total Cost</th>
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<tbody>
<tr>
<td>Expected Levels</td>
<td>$752</td>
<td>16</td>
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<td>$1,680</td>
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# Better Pay for Better Outcomes Can Reduce Total Cost

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<th>Days to Recovery</th>
<th>Wages Lost at Min. Wage</th>
<th>Total Cost</th>
</tr>
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<tbody>
<tr>
<td>Expected Levels</td>
<td>$752</td>
<td>16</td>
<td>$928</td>
<td>$1,680</td>
</tr>
<tr>
<td>Significantly Higher Than Expected</td>
<td>$812</td>
<td>14</td>
<td>$812</td>
<td>$1,624</td>
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</table>
# Better Pay for Better Outcomes Can Reduce Total Cost

## ALTERNATIVE PAYMENT MODEL

<table>
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<th>Quality/Outcomes</th>
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<tr>
<td>Change</td>
<td>+$60</td>
<td>-2</td>
<td>-$116</td>
<td>-$56</td>
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Penalties Offset Loss of Wages from Longer Recovery Time

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<th>Wages Lost at Min. Wage</th>
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### ALTERNATIVE PAYMENT MODEL

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## Higher-Need Patients Need More Services

### LOWER-NEED PATIENTS UNDER FFS

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<th>Payment Per 15 min Service</th>
<th>Services Per Visit</th>
<th>Visits Per Patient</th>
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<tr>
<td>$33</td>
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<td>8</td>
<td>$792</td>
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### HIGHER-NEED PATIENTS UNDER FFS

<table>
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<tr>
<th>Payment Per 15 min Service</th>
<th>Services Per Visit</th>
<th>Visits Per Patient</th>
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</thead>
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<tr>
<td>$33</td>
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APM Needs to Adjust Payments Based on Differences in Need

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<tr>
<td>Payment Per Patient</td>
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<td>$752 (-5%)</td>
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<table>
<thead>
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<tbody>
<tr>
<td>Payment Per Patient</td>
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<td>$1,129 (-5%)</td>
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Base Price Assures the Payer Receives Savings…

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<tbody>
<tr>
<td></td>
<td>$752 (-5%)</td>
<td>3</td>
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<td>$31</td>
<td>-5%</td>
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</table>

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Then Efficiency is Rewarded While Assuring Adequate Payment

<table>
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<td>8</td>
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<td>-5%</td>
<td></td>
</tr>
<tr>
<td>$752 (-5%)</td>
<td>3</td>
<td>7</td>
<td>$36</td>
<td>+9%</td>
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</table>

<table>
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<tr>
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<td></td>
</tr>
<tr>
<td>$1,129 (-5%)</td>
<td>3</td>
<td>11</td>
<td>$34</td>
<td>+4%</td>
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</table>
APM #2: Condition-Based Payment for a Provider’s Services

- Payment based on the patient’s health condition rather than specific services delivered
- Payment replaces some or all current FFS payments
- Payment amounts stratified based on patient needs
- Measurement of appropriateness and/or outcomes
- Adjustment of payments based on performance
- Updating payment amounts over time
Under Fee for Service: Instead of Efficient Care...

Efficient Approach to Therapy

PT Evaluation

15 Min. Therapy
15 Min. Therapy
15 Min. Therapy
15 Min. Therapy
15 Min. Therapy
15 Min. Therapy
15 Min. Therapy
Under Fee for Service:
...Inefficient Care is Rewarded

Inefficient Approach to Therapy

Efficiency & Outcomes

Provider Margin

Efficiency
Low Margin

Inefficiency
High Margin

$
Under a Risk-Stratified APM…

- High-Need Therapy Episode with Limited Warranty
- Medium Need Therapy Episode with Limited Warranty
- Low-Need Therapy Episode with Limited Warranty

PT Evaluation
Under a Risk-Stratified APM… Efficiency is Rewarded

High-Need Therapy Episode with Limited Warranty

Medium Need Therapy Episode with Limited Warranty

Low-Need Therapy Episode with Limited Warranty

Efficiency & Outcomes

Provider Margin

High Margin

Inefficiency
Low Margin

Efficiency

Margin from Efficiency

Margin from Efficiency

Margin from Efficiency

$
High-Need Therapy Episode with Limited Warranty

Medium Need Therapy Episode with Limited Warranty

Low-Need Therapy Episode with Limited Warranty

Better Outcomes = Higher Margins

$
APM #5: Warrantied Payment

- Measurement of outcomes
- Higher payment when outcome is achieved
- No payment when outcome is not achieved
- Payment amounts stratified based on patient needs
- Updating payment amounts over time
Example 2: Reducing Avoidable Surgeries for Knee Osteoarthritis
CMS “Comprehensive Care for Joint Replacement”

EPISODE PAYMENT FOR SURGERIES

PATIENT

Hospital Costs for Surgery  Readmits  Post-Acute Care (IRF, SNF, HH)
Principal Goal of CMS Proposal Is Reducing Post-Acute Care Cost

EPISODE PAYMENT FOR SURGERIES

Hospital Costs for Surgery  Readmits  Post-Acute Care (IRF, SNF, HH)

Hospital Costs for Surgery  Readmits  Post-Acute Care  SAVINGS
Many Problems With How the Payments Are Defined for Surgery

EPISODE PAYMENT FOR SURGERIES

- Hospital Costs for Surgery
- Readmits
- Post-Acute Care (IRF, SNF, HH)

- Hospital is at risk for choices made by the patient

• No risk adjustment – target spending amount is the same for high-risk, poor functional status patients as low-risk patients

• No change in current payment systems, so physicians, physical therapists, and post-acute care providers must depend on the hospital “sharing savings” with them to cover any costs not paid for under fee-for-service

© Center for Healthcare Quality and Payment Reform www.CHQPR.org
But If There Are Fewer Surgeries, CMS Keeps ALL of the Savings

EPISODE PAYMENT FOR SURGERIES

PATIENT

Hospital Costs for Surgery

Readmits

Post-Acute Care (IRF, SNF, HH)

Hospital Costs for Surgery

Readmits

Post-Acute Care

SAVINGS

CMS

Physical Therapy

SAVINGS

Providers and Post-Acute Care

Hospital
But If There Are Fewer Surgeries, CMS Keeps ALL of the Savings

IS THERE A BETTER WAY?
Example 2: Reducing Avoidable Surgeries for Knee Osteoarthritis

<table>
<thead>
<tr>
<th>Treatment of Knee Osteoarthritis</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 100 patients with knee pain visit PCP for evaluation</td>
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</tbody>
</table>

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<tr>
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<tbody>
<tr>
<td>$/Patient</td>
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<tr>
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<td></td>
</tr>
<tr>
<td>Evaluations</td>
<td>$100</td>
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**Example 2: Reducing Avoidable Surgeries for Knee Osteoarthritis**

<table>
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<tr>
<th>CURRENT</th>
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<tr>
<td><strong>Non-Surg.Tx</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Management</td>
<td>$200</td>
<td>20</td>
<td>$4,000</td>
</tr>
<tr>
<td>Phys. Therapy</td>
<td>$500</td>
<td>20</td>
<td>$10,000</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td></td>
<td></td>
<td>$14,000</td>
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**Treatment of Knee Osteoarthritis**

- 100 patients with knee pain visit PCP for evaluation
- Physical therapy used by 20% of patients
### Example 2: Reducing Avoidable Surgeries for Knee Osteoarthritis

#### Treatment of Knee Osteoarthritis

- 100 patients with knee pain visit PCP for evaluation
- Physical therapy used by 20% of patients
- Surgery performed procedure on 80% of evaluated patients

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<tr>
<td><strong>Surgeon</strong></td>
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<tr>
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Example 2: Reducing Avoidable Surgeries for Knee Osteoarthritis

### CURRENT

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**Treatment of Knee Osteoarthritis**

- 100 patients with knee pain visit PCP for evaluation
- Physical therapy used by 20% of patients
- Surgery performed procedure on 80% of evaluated patients
## Example 2: Reducing Avoidable Surgeries for Knee Osteoarthritis

### Treatment of Knee Osteoarthritis

- 100 patients with knee pain visit PCP for evaluation
- Physical therapy used by 20% of patients
- Surgery performed procedure on 80% of evaluated patients
- 25% of surgeries avoidable with better physical therapy and outpatient management

### Current Costs

<table>
<thead>
<tr>
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<tr>
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## Under FFS, Low Payment for Diagnosis & Treatment Planning

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Under FFS, Low Payment for Non-Surgical Options

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Under FFS, High Payment for Surgery...

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</table>
Under FFS, Fewer Surgeries = Losses for Surgeons & Hospitals

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<th>FUTURE</th>
<th>Chg</th>
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### Is There a Better Way?

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### A Better Way: Pay PCPs for Good Diagnosis & Treatment Planning

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**Better Payment for Condition Management**
- PCP paid adequately to help patient decide on treatment options
A Better Way: Pay Adequately for Non-Surgical Management

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Better Payment for Condition Management
- PCP paid adequately to help patient decide on treatment options
- Physical therapists paid to deliver effective non-surgical care
A Better Way: Pay Adequately For the **Necessary** Surgeries

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**Better Payment for Condition Management**
- PCP paid adequately to help patient decide on treatment options
- Physical therapists paid to deliver effective non-surgical care
- Surgeon paid more per surgery for patients who need surgery
If That Results in 25% Fewer Surgeries…

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Providers Could Be Paid More…

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Providers Could Be Paid More… ….While Still Reducing Total $

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|                        |                  |                 |     |
| $/Patient # Pts        | Total $          | Chg             |     |
|                        |                  |                 |     |
| Primary Care           |                  |                 |     |
| Evaluations            | $200 100         | $20,000         | 100%|
| Non-Surg.Tx            |                  |                 |     |
| Management             | $500 40          | $20,000         | 400%|
| Phys. Therapy          | $750 40          | $30,000         | 200%|
| Subtotal               | $50,000          |                 | 257%|
| Surgeon                | $2,100 60        | $126,000        | +13%|
| Hospital Pmt           |                  |                 |     |
| Surgeries              | $12,000 60       | $720,000        | -25%|
| Total Pmt/Cost         | 100 $916,000     |                 | -16%|
## Win-Win-Win for Providers, Payers, & Patients

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- **Providers Win**
- **Patients Win**
- **Payer Wins**
## What About the Hospital?

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**Hospital Loses**
Do Hospitals Have to Lose In Order for Providers & Payers To Win?

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What Should Matter to Hospitals is *Margin*, Not Revenues (Volume)
Hospital Costs Are Not Proportional to Utilization

Cost & Revenue Changes With Fewer Patients

- 20% reduction in volume
- 7% reduction in cost
Reductions in Utilization Reduce Revenues More Than Costs

Cost & Revenue Changes With Fewer Patients

- 20% reduction in volume
- 7% reduction in cost
- 20% reduction in revenue
Causing Negative Margins for Hospitals

Cost & Revenue Changes With Fewer Patients

Payers Will Be Underpaying For Care If Surgeries, Readmissions, Etc. Are Reduced

#Patients

$000

$1,000
$980
$960
$940
$920
$900
$880
$860
$840
$820
$800

Revenues
Costs
But Spending Can Be Reduced Without Bankrupting Hospitals

Cost & Revenue Changes With Fewer Patients

Payers Can Still Save $ Without Causing Negative Margins for Hospital

$0 $20 $40 $60 $80 $100
$000 $800 $820 $840 $860 $880 $900

#Patients
We Need to Understand the Hospital’s Cost Structure

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Adequacy of Payment Depends On Fixed/Variable Costs & Margins

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Now, if the Number of Procedures is Reduced…

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...Fixed Costs Will Remain the Same (in the Short Run)...

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…Variable Costs Will Go Down in Proportion to Procedures…

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...And Even With a Higher Margin for the Hospital...

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The Hospital Gets Less Total Revenue But Higher Margin

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...And The Payer Still Saves Money

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### Win-Win-Win-Win for Patients, Providers, Hospital, and Payer

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*Providers Win* $126,000, +13%

*Hospital Wins* $480,000, 0%

*Payer Wins* $52,800, +10%
What Payment Model Supports This Win-Win-Win Approach?

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Renegotiating Every Individual Fee is Impractical...

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...What Assures The Payer That There Will Be Fewer Procedures?

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Solution: Pay Based on the Patient’s Condition, Not on the Procedures

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Plan to Offer Care of the Condition at a Lower Cost Per Patient

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Use the Payment as a Budget to Redesign Care…

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...And Let Providers & Hospitals Decide How They Should Be Paid

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### Condition-Based Payment Allows True Win-Win-Win Solutions

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</tr>
<tr>
<td>Variable Costs</td>
<td>$5,400</td>
<td>45%</td>
<td>$432,000</td>
</tr>
<tr>
<td>Margin</td>
<td>$600</td>
<td>5%</td>
<td>$48,000</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td>$12,000</td>
<td>80</td>
<td>$960,000</td>
</tr>
<tr>
<td><strong>Condition Pmt.</strong></td>
<td>$10,960</td>
<td>100</td>
<td>$1,096,000</td>
</tr>
<tr>
<td></td>
<td>$200</td>
<td>100</td>
<td>$20,000</td>
</tr>
<tr>
<td></td>
<td>$500</td>
<td>40</td>
<td>$20,000</td>
</tr>
<tr>
<td></td>
<td>$750</td>
<td>40</td>
<td>$30,000</td>
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<tr>
<td></td>
<td>$50,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$126,000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Providers Win  
Hospital Wins  
Payer Wins
APM #7: (Full) Condition-Based Payment

*Payment based on the patient’s health condition*
*Payment covers multiple treatment options*
*Measurement of appropriateness, quality, and/or outcomes*
*Adjustment of payments based on performance*
## Condition-Based Payment Requires a Team Approach to Care Delivery

<table>
<thead>
<tr>
<th>Condition Mgt Team</th>
<th>CURRENT</th>
<th>FUTURE</th>
<th>Chg</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>$/Patient</strong></td>
<td><strong># Pts</strong></td>
<td><strong>Total $</strong></td>
<td><strong>$/Patient</strong></td>
</tr>
<tr>
<td>Primary Care</td>
<td>$100</td>
<td>100</td>
<td>$10,000</td>
</tr>
<tr>
<td></td>
<td>$200</td>
<td>20</td>
<td>$4,000</td>
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<tr>
<td></td>
<td>$500</td>
<td>20</td>
<td>$10,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$14,000</td>
</tr>
<tr>
<td>Phys. Therapy</td>
<td>$1,400</td>
<td>80</td>
<td>$112,000</td>
</tr>
<tr>
<td>Surgeon</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$6,000</td>
<td>50%</td>
<td>$480,000</td>
</tr>
<tr>
<td></td>
<td>$5,400</td>
<td>45%</td>
<td>$432,000</td>
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<tr>
<td></td>
<td>$12,000</td>
<td>80</td>
<td>$960,000</td>
</tr>
<tr>
<td><strong>Condition Pmt.</strong></td>
<td>$10,960</td>
<td>100</td>
<td>$1,096,000</td>
</tr>
</tbody>
</table>

*Note: Chg represents the percentage change from current to future values.*
To Prevent Undertreatment, Tie Payment to *Outcomes*

- Patient return to functionality
- Lack of pain
- Avoiding infections for surgery
Patients Differ in Their Need for Surgery vs. Physical Therapy

<table>
<thead>
<tr>
<th></th>
<th>LOWER-RISK PATIENTS</th>
<th></th>
<th>HIGHER-RISK PATIENTS</th>
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</thead>
<tbody>
<tr>
<td></td>
<td># Pts</td>
<td></td>
<td># Pts</td>
<td></td>
</tr>
<tr>
<td>Primary Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evaluations</td>
<td>50</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Surg.Tx</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Management</td>
<td>30</td>
<td></td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Phys. Therapy</td>
<td>30</td>
<td></td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Surgery</td>
<td>20</td>
<td></td>
<td>40</td>
<td></td>
</tr>
</tbody>
</table>

40% Need Surgery  
80% Need Surgery
# Condition-Based Payment Amount Must Be Stratified on Patient Needs

## Table: Condition-Based Payment Amounts

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Lower-Risk Patients</th>
<th>Higher-Risk Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$/Patient</td>
<td># Pts</td>
</tr>
<tr>
<td>Primary Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evaluations</td>
<td>$200</td>
<td>50</td>
</tr>
<tr>
<td>Non-Surg. Tx</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Management</td>
<td>$500</td>
<td>30</td>
</tr>
<tr>
<td>Phys. Therapy</td>
<td>$750</td>
<td>30</td>
</tr>
<tr>
<td>Subtotal</td>
<td>$37,500</td>
<td></td>
</tr>
<tr>
<td>Surgeon</td>
<td>$2,100</td>
<td>20</td>
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<tr>
<td>Hospital Pmt</td>
<td></td>
<td></td>
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<tr>
<td>Fixed Costs</td>
<td>$192,000</td>
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<tr>
<td>Variable Costs</td>
<td>$5,400</td>
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<tr>
<td>Margin</td>
<td>$21,120</td>
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<tr>
<td>Subtotal</td>
<td>$321,120</td>
<td></td>
</tr>
<tr>
<td>Total Pmt/Cost</td>
<td>$8,212</td>
<td>50</td>
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</table>
More Than Comorbidities Affect Patient Need and Outcomes

• Most “risk adjustment” systems are based on comorbidities measured by ICD diagnosis codes

• But current diagnosis codes don’t measure many factors used to determine appropriateness and risk of poor outcomes:
  – Radiologic measure of joint space narrowing and bone attrition
  – Knee joint mobility and stability
  – Severity of pain
  – Patient functional status
  – Nature of patient activities
  – Trial of and response to physical therapy and medications

• Risk adjustment systems such as CMS Hierarchical Condition Categories (HCC) won’t support APMs
MACRA Requires Development of New Codes for These Reasons

- **Patient Condition Groups** (and associated codes)
  - take into account the patient’s clinical history at the time of a medical visit, such as the patient’s combination of chronic conditions, current health status, and recent significant history (such as hospitalization and major surgery during a previous period, such as 3 months); and other factors determined appropriate by the Secretary

- **Care Episode Groups** (and associated codes)
  - take into account the patient’s clinical problems at the time items and services are furnished during an episode of care, such as the clinical conditions or diagnoses, whether or not inpatient hospitalization occurs, and the principal procedures or services furnished; and other factors determined appropriate by the Secretary

- **Patient Relationship Categories** (and associated codes)
  - define and distinguish the relationship and responsibility of a physician or applicable practitioner with a patient at the time of furnishing an item or service
# Timetable for CMS Adoption and Use of New Codes Under MACRA

<table>
<thead>
<tr>
<th>Date</th>
<th>Care Episode Groups and Codes</th>
<th>Patient Condition Groups and Codes</th>
<th>Patient Relationship Categories &amp; Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 16, 2016</td>
<td></td>
<td></td>
<td>Draft issued for comment</td>
</tr>
<tr>
<td>December 2, 2016</td>
<td></td>
<td></td>
<td>Revised draft issued for comment</td>
</tr>
<tr>
<td>December 23, 2016</td>
<td>Draft list of care episode codes</td>
<td>Draft list of patient condition codes</td>
<td></td>
</tr>
<tr>
<td>April 20, 2017</td>
<td></td>
<td></td>
<td>Operational list of patient relationship categories and codes</td>
</tr>
<tr>
<td>April 24, 2017</td>
<td>Comments due on care episode codes</td>
<td>Comments due on patient condition codes</td>
<td></td>
</tr>
<tr>
<td>December 20, 2017</td>
<td>Operational list of care episode codes</td>
<td>Operational list of patient condition codes</td>
<td></td>
</tr>
<tr>
<td>January 1, 2018</td>
<td>Include care episode codes on claim forms</td>
<td>Include patient condition codes on claim forms</td>
<td>Include patient relationship category codes on claim forms</td>
</tr>
</tbody>
</table>
Opportunities for Alternative Treatments for Many Conditions

• Joint Osteoarthritis
  – Physical therapy instead of surgery
  – Home-based rehab instead of facility-based rehab

• Back Pain
  – Physical therapy instead of surgery
  – Home-based rehab instead of facility-based rehab

• Peripheral Artery Disease
  – Supervised exercise instead of invasive procedure

• Heart Disease
  – Cardiac rehabilitation to avoid heart attacks and readmissions
Should Providers Fear the Risks of Alternative Payment Models?

Risks Under Payment Reform

- Will the condition-based payment be adequate to cover the services patients need?
- Will risk adjustment be adequate to control for differences in need?
- How many additional services will be needed for patients with poor outcomes?
- Will you have enough patients to cover the costs of managing the new payment?
It’s Not *More* Risk Than Today, It’s Just *Different* Risk

<table>
<thead>
<tr>
<th>Risks Under FFS</th>
<th>Risks Under Payment Reform</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Will fee levels from payers be adequate to cover the costs of delivering services?</td>
<td>• Will the condition-based payment be adequate to cover the services patients need?</td>
</tr>
<tr>
<td>• What utilization controls will payers impose on your services?</td>
<td>• Will risk adjustment be adequate to control for differences in need?</td>
</tr>
<tr>
<td>• What “value-based” reductions will be made in your payments based on “efficiency” and quality measures?</td>
<td>• How many additional services will be need for patients with poor outcomes?</td>
</tr>
<tr>
<td>• Will you have enough patients to cover your practice expenses?</td>
<td>• Will you have enough patients to cover the costs of managing the new payment?</td>
</tr>
</tbody>
</table>
Protections For Providers Against Taking Inappropriate Risk in APMs

- **Risk Adjustment/Stratification:** The payment rates to the provider would be adjusted based on objective characteristics of the patient and treatment that would be expected to result in the need for more services or increase the risk of complications.

- **Outlier Payment or Individual Stop Loss Insurance:** The payment to the provider from the payer would be increased if spending on an individual patient exceeds a pre-defined threshold. An alternative would be for the provider to purchase individual stop loss insurance (sometimes referred to as reinsurance) and include the cost of the insurance in the payment bundle.

- **Risk Corridors or Aggregate Stop Loss Insurance:** The payment to the provider would be increased if spending on all patients exceeds a pre-defined percentage above the payments. An alternative would be for the provider to purchase aggregate stop loss insurance and include the cost of the insurance in the payment bundle.

- **Adjustment for External Price Changes:** The payment to the provider would be adjusted for changes in the prices of drugs or services from other providers that are beyond the control of the provider accepting the payment.

- **Excluded Services:** Services the provider does not deliver, or order, or otherwise have the ability to influence would not be included as part of accountability measures in the payment system.
Implementing APMs in Medicare
Congress Encouraged Use of APMs Instead of MIPS

• “Eligible Professionals” are encouraged to participate in approved Alternative Payment Models (APMs) at a minimum level:
  – They are exempt from MIPS (if they are subject to MIPS)
  – They receive a 5% lump sum bonus
  – They receive a higher annual update (increase) in their FFS revenues
  – They receive the benefits of participating in the APM
MACRA Requirements Regarding Participation in APMs

- Requirements for Eligible Professional
  - 2019: 25% of Medicare payments from an “alternative payment entity”
  - 2021: [50% of Medicare payments] or [25% Medicare & 50% of total payments] from an alternative payment entity
  - 2023: 75% of Medicare or total payments from an alternative payment entity
  - Option to count % of patients instead of % of payments
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  – Participate in an Alternative Payment Model
  – Bear financial risk for monetary losses under the APM “in excess of a nominal amount”
    OR
  be designated as a medical home expanded by the Innovation Center
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  – Require participants to use certified EHR technology
  – Base payment on quality measures “comparable” to MIPS
What Exactly is an “APM?”

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  - 2019: 25% of Medicare payments from an “alternative payment entity”
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  - Require participants to use certified EHR technology
  - Base payment on quality measures “comparable” to MIPS
Principal Focus of APMs is Improving Care to Save Money

• Innovation Center
  – The Secretary shall select models to be tested where there is evidence that the model addresses a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures.
  – The Secretary shall focus on models expected to reduce program costs while preserving or enhancing the quality of care.
  – The Secretary shall terminate or modify the design and implementation of a model unless the Secretary determines that the model is expected to: (i) improve the quality of care without increasing spending; (ii) reduce spending without reducing the quality of care; or (iii) improve the quality of care and reduce spending.

• Shared Savings Program
  – Purpose is to “promote accountability for a patient population,” “coordinate items and services under parts A and B,” and “encourage investment in infrastructure and redesigned care processes for high quality and efficient service delivery.”
  – Payments to an ACO shall be established in a manner that does not result in spending more for such ACO for such beneficiaries than would otherwise be expended for such ACO for such beneficiaries for such year if the model were not implemented, as estimated by the Secretary.
Congress Authorized Many APMs That Haven’t Been Implemented

(i) Promoting broad payment and practice reform in primary care, including patient-centered medical home models for high-need applicable individuals, medical homes that address women’s unique health care needs, and models that transition primary care practices away from fee-for-service based reimbursement and toward comprehensive payment or salary-based payment.

(ii) Contracting directly with groups of providers of services and suppliers to promote innovative care delivery models, such as through risk-based comprehensive payment or salary-based payment.

(iii) Utilizing geriatric assessments and comprehensive care plans to coordinate the care (including through interdisciplinary teams) of applicable individuals with multiple chronic conditions and at least one of the following:

- An inability to perform 2 or more activities of daily living.
- Cognitive impairment, including dementia.

(iv) Promote care coordination between providers of services and suppliers that transition health care providers away from fee-for-service based reimbursement and toward salary-based payment.

(v) Supporting care coordination for chronically ill applicable individuals at high risk of hospitalization through a health information technology-enabled provider network that includes care coordinators, a chronic disease registry, and home tele-health technology.

(vi) Varying payment to physicians who order advanced diagnostic imaging services (as defined in section 1834(e)(1)(B)) according to the physician’s adherence to appropriateness criteria for the ordering of such services, as determined in consultation with physician specialty groups and other relevant stakeholders.

(vii) Utilizing medication therapy management services, such as those described in section 935 of the Public Health Service Act.

(viii) Establishing community-based health teams to support small-practice medical homes by assisting the primary care practitioner in chronic care management, including patient self-management activities.

(ix) Assisting applicable individuals in making informed health care choices by paying providers of services and suppliers for using patient decision-support tools, including tools that meet the standards developed and identified under section 936(c)(2)(A) of the Public Health Service Act, that improve applicable individual and caregiver understanding of medical treatment options.

(x) Allowing States to test and evaluate fully integrating care for dual eligible individuals in the State, including the management and oversight of all funds under the applicable titles with respect to such individuals.

(xi) Allowing States to test and evaluate systems of all-payer payment reform for the medical care of residents of the State, including dual eligible individuals.

(xii) Aligning nationally recognized, evidence based guidelines of cancer care with payment incentives under title XVIII in the areas of treatment planning and follow-up care planning for applicable individuals described in clause (i) or (ii) of subsection (a)(4)(A) with cancer, including the identification of gaps in applicable quality measures.

(xiii) Improving post-acute care through continuing care hospitals that offer inpatient rehabilitation, long-term care hospitals, and home health or skilled nursing care during an inpatient stay and the 30 days immediately following discharge.

(xiv) Funding home health providers who offer chronic care management services to applicable individuals in cooperation with interdisciplinary teams.

(xv) Promoting improved quality and reduced cost by developing a collaborative of high-quality, low-cost health care institutions that is responsible for—

- (I) developing, documenting, and disseminating best practices and proven care methods;
- (II) implementing such best practices and proven care methods within such institutions to demonstrate further improvements in quality and efficiency; and
- (III) providing assistance to other health care institutions on how best to employ such best practices and proven care methods to improve health care quality and lower costs.

(xvi) Facilitating patient care, including intensive care, of hospitalized applicable individuals at their local hospital through the use of electronic monitoring by specialists, including intensivists and critical care specialists, based at integrated health systems.

(xvii) Promoting greater efficiencies and timely access to outpatient services (such as outpatient physical therapy services) through models that do not require a physician or other health professional to refer the service or be involved in establishing the plan of care for the service, when such service is furnished by a health professional who has the authority to furnish the service under existing State law.

(xviii) Establishing comprehensive payments to Healthcare Innovation Zones, consisting of groups of providers that include a teaching hospital, physicians, and other clinical entities, that, through their structure, operations, and joint-activity deliver a full spectrum of integrated and comprehensive health care services to applicable individuals while also incorporating innovative methods for the clinical training of future health care professionals.

(xix) Utilizing, in particular in entities located in medically underserved areas and facilities of the Indian Health Service (whether operated by such Service or by an Indian tribe or tribal organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act)), telehealth services—

- (I) in treating behavioral health issues (such as post-traumatic stress disorder) and stroke; and
- (II) to improve the capacity of non-medical providers and non-specialized medical providers to provide health services for patients with chronic complex conditions.

(xx) Using a diverse network of providers of services and suppliers to improve care coordination for applicable individuals described in subsection (a)(4)(A)(ii) with 2 or more chronic conditions and a history of prior-year hospitalization through interventions developed under the Medicare Coordinated Care Demonstration Project under section 4016 of the Balanced Budget Act of 1997 (42 U.S.C. 1395b–1 note).

(xi) Focusing primarily on physicians’ services (as defined in section 1848(j)(3)) furnished by physicians who are not primary care practitioners.

(xii) Focusing on practices of 15 or fewer professionals.

(xiii) Focusing on risk-based models for small physician practices which may involve two-sided risk and prospective patient assignment, and which examine risk-adjusted decreases in mortality rates, hospital readmissions rates, and other relevant and appropriate clinical measures.

(xiv) Focusing primarily on title XIX, working in conjunction with the Center for Medicaid and CHIP Services;
Not Every APM Qualifies

• Requirements for Physician
  – 2019: 25% of Medicare payments from an “alternative payment entity”
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  – 2023: 75% of Medicare or total payments from an alternative payment entity
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## Requirements for EHRs and Quality in “Advanced APMs”

<table>
<thead>
<tr>
<th>What MACRA Says</th>
<th>What Final Regs Say</th>
</tr>
</thead>
<tbody>
<tr>
<td>APM “requires participants in such model to use certified EHR technology”</td>
<td>ACO participants automatically meet EHR requirements</td>
</tr>
<tr>
<td></td>
<td>Other APMs must require at least 50% of eligible clinicians in the APM entity to use Certified EHR Technology to document and communicate clinical care</td>
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<td>ACO participants automatically meet EHR requirements</td>
</tr>
<tr>
<td>APM “provides for payment for covered professional services based on quality measures comparable to measures under MIPS”</td>
<td>Other APMs must require at least 50% of eligible clinicians in the APM entity to use Certified EHR Technology to document and communicate clinical care</td>
</tr>
<tr>
<td></td>
<td>APM must base payment at least in part on performance on quality measures</td>
</tr>
<tr>
<td></td>
<td>At least one quality measure must be used that CMS approves as reliable, valid, and based on evidence</td>
</tr>
<tr>
<td></td>
<td>At least one outcome measure must be used if there is an appropriate outcome measure available</td>
</tr>
</tbody>
</table>
MACRA Requires “Financial Risk” for Providers in the APM

• Requirements for Physician
  – 2019: 25% of Medicare payments from an “alternative payment entity”
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## Requirements for Financial Risk for Medicare “Advanced APMs”

### What MACRA Says
- APM Entity must
  - “bear financial risk for monetary losses under such alternative payment model that are in excess of a nominal amount”

### What Final Regs Say
- The APM Entity is required to reduce payments to clinicians or to repay Medicare when spending on patients exceeds expected amounts. Options for the maximum repayment are:
  - 8% of the APM Entity’s total Part A & B revenue (in 2017 and 2018), or
  - 5% of the APM Entity’s total Part A&B revenue if the entity is a primary care medical home with fewer than 50 clinicians (2.5% in 2017, 3% in 2018, 4% in 2019), or
  - 3% of total Medicare spending for which the APM Entity is responsible under the APM
Final Rules Are Better Than Proposed Rules...

What MACRA Says

• APM Entity must
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What Final Regs Say

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  - 5% of the APM Entity’s total Part A&B revenue if the entity is a primary care medical home with fewer than 50 clinicians (2.5% in 2017, 3% in 2018, 4% in 2019), or
  - 3% of total Medicare spending for which the APM Entity is responsible under the APM
Manageability of Risk Depends on How the APM is Defined

What MACRA Says

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What Final Regs Say

- The APM Entity is required to reduce payments to clinicians or to repay Medicare when spending on patients exceeds expected amounts. Options for the maximum repayment are:
  - 8% of the APM Entity’s total Part A & B revenue (in 2017 and 2018), or
  - 5% of the APM Entity’s total Part A&B revenue if the entity is a primary care medical home with fewer than 50 clinicians (2.5% in 2017, 3% in 2018, 4% in 2019), or
  - 3% of total Medicare spending for which the APM Entity is responsible under the APM
CMS Defines Non-Advanced APMs as “MIPS APMs”

- **Requirements for Physician**
  - 2019: 25% of Medicare payments from an “alternative payment entity”
  - 2021: [50% of Medicare payments] or [25% Medicare & 50% of total payments] from an alternative payment entity
  - 2023: 75% of Medicare or total payments from an alternative payment entity
  - Option to count % of patients instead of % of payments

- **Requirements for Alternative Payment Entity**
  - Participate in an Alternative Payment Model
    - Bear financial risk for monetary losses under the APM “in excess of a nominal amount”
    - OR be designated as a medical home expanded by the Innovation Center

- **Requirements for an Alternative Payment Model**
  - Be a model defined in the Innovation Center language under ACA, be part of the shared savings (ACO) program, or be a Medicare demonstration
  - Require participants to use certified EHR technology
  - Base payment on quality measures “comparable” to MIPS
What Good is a MIPS APM?

• Advantage:
  – Eligible Professional is exempt from “regular” MIPS requirements; must follow the quality and resource use measures in the APM itself, and receive credit for APM as a clinical practice improvement activity

• Disadvantage:
  – Eligible Professional wouldn’t qualify for the 5% bonus under MACRA
  – Eligible Professional wouldn’t qualify for the higher payment update in future
MACRA Requires Development of “Physician-Focused APMs”

- Physician-Focused Payment Model Technical Advisory Committee (PTAC) created by Congress to solicit and review proposals from physician groups, medical specialty societies, and others for “physician-focused payment models” and to make recommendations to CMS as to which models to implement.

- CMS Regulations defined “physician-focused payment models” as models in which “eligible clinicians that are eligible professionals as defined in section 1848(k)(3)(B) of the Act are participants and play a core role in implementing the APM’s payment methodology”
  - Eligible professional” includes “a physical or occupational therapist or a qualified speech-language pathologist”

- Under MACRA, CMS must respond to PTAC recommendations, but is not required to implement them.
HHS/CMS Defines the Criteria PTAC Uses in Evaluating APMs

1. **Scope (PTAC High Priority):** Broadens or expands the CMS APM portfolio by addressing an issue in payment policy in a new way or including APM Entities whose opportunities to participate in APMs have been limited.

2. **Quality and Cost (PTAC High Priority):** Anticipated to improve health care quality at no additional cost, maintain health care quality while decreasing cost, or both improve health care quality and decrease cost.

3. **Payment Methodology (PTAC High Priority):** Pays APM Entities with a payment methodology designed to achieve the goals of the PFPM Criteria.

4. **Value over Volume:** Provide incentives to deliver high-quality health care.

5. **Flexibility:** Provide flexibility needed for practitioners to deliver high-quality care.

6. **Ability to be Evaluated:** Evaluable goals for quality of care and cost.

7. **Integration and Care Coordination:** Encourage greater integration and care coordination among practitioners and across settings where multiple practitioners or settings are relevant to delivering care to the population treated under the PFPM.

8. **Patient Choice:** Encourage greater attention to the health of the population served while also supporting the unique needs and preferences of individual patients.

9. **Patient Safety:** Aim to maintain or improve standards of patient safety.

10. **Health Information Technology:** Encourage use of HIT to inform care.
Types of PTAC Recommendations

- **Do Not Recommend**
  - Does not necessarily mean “this is a bad idea,” but can mean “more work is needed to refine the details”

- **Recommend for Limited Scale Testing**
  - In many cases, it is impossible to determine exactly how to set prices, define risk categories, etc. until some providers have actually implemented the proposed approach

- **Recommend for Implementation**
  - In general, most alternative payment models will need to be “tested” because of the wording of the statute

- **Recommend for Implementation as a High Priority**
  - Proposals that are rated as high priority on multiple criteria
Implementing APMs With Other Payers
MACRA Requirements Regarding Participation in APMs

• Requirements for Eligible Professional
  – 2019: 25% of Medicare payments from an “alternative payment entity”
  – 2021: [50% of Medicare payments] or [25% Medicare & 50% of total payments] from an alternative payment entity
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  – Base payment on quality measures “comparable” to MIPS
Will Private Payers Implement Provider-Defined APMs?

Health Plans

Alternative Payment Models

Providers

Higher Value Care:
• Better Quality
• Lower Spending
Most Health Plans Resist True Payment Reforms

“Value-Based Purchasing”
- FFS + P4P
- Shared Savings
- Narrow Network Discounts

Low Value Care:
- Poor Quality
- High Avoidable Spending

Health Plans

Providers
For Most Workers, Employers are the Insurer, Not a Health Plan


> 60% of Workers Are in Self-Insured Plans

Source: Employer Health Benefits 2016 Annual Survey. The Kaiser Family Foundation and Health Research and Educational Trust
For Self-Funded Employers, The Health Plan is Just a Pass Through

![Diagram showing flow between Self-Funded Purchasers, ASO Health Plan (No Risk), and Providers.]
Little Incentive for Health Plans to Support Payment Reforms

True Payment Reform Means:
• Health plan incurs the costs of implementing new payment models
• Purchaser gains all the savings from reduced utilization and spending (because all claims are passed through)
2nd Biggest Source of Spending Growth is Insurance Administration

Sources of Private Insurance Spending Increase, 2009-2015

- **Hospital Svcs**: 41% Increase
- **Physician & Clinical Services**: 19% Increase
- **Drugs**: 20% Increase
- **Other Svcs**: 24% Increase
- **Insurance Admin**: 30% Increase

12% of Total
25% of Avoidable Spending is Excess Administrative Costs

Excess Cost Domain Estimates:
Lower bound totals from workshop discussions*

UNNECESSARY SERVICES
- Total excess = $210 B*
  - Overuse: services beyond evidence-established levels
  - Discretionary use beyond benchmarks
  - Defensive medicine
  - Unnecessary choice of higher cost services

INEFFICIENTLY DELIVERED SERVICES
- Total excess = $130 B*
  - Mistakes—medical errors, preventable complications
  - Care fragmentation
  - Unnecessary use of higher cost providers
  - Operational inefficiencies at care delivery sites
  - Physician offices

EXCESS ADMINISTRATIVE COSTS
- Total excess = $190 B*
  - Insurance-related administrative costs beyond benchmarks
  - Insurers
  - Physician offices
  - Hospitals
  - Other providers
  - Insurer administrative inefficiencies
  - Care documentation requirement inefficiencies

MISSED PREVENTION OPPORTUNITIES
- Total excess = $55 B*
  - Primary prevention
  - Secondary prevention
  - Tertiary prevention

FRAUD
- Total excess = $75 B*
  - All sources—payer, clinician, patient

*Lower bound totals of various estimates, adjusted to 2009 total expenditure level.
A Better Approach: Purchaser/Provider Partnerships

Self-Funded Purchasers → Better Payment and Benefit Structure → Providers Willing to Manage Cost/Quality

Purchasers and Patients “win” if:
- Providers reduce purchasers’ costs
- Patients stay healthy and have lower cost-sharing

Provider “wins” if:
- Patients stay healthy and need less care
- Purchaser pays provider adequately to manage care effectively
Purchasers (Not Plans) Can Pay for Improved Worker Productivity

**WORKER PRODUCTIVITY**

Self-Funded Purchasers

**EFFICIENCY OF SERVICES**

Providers Willing to Manage Cost/Quality

Better Payment and Benefit Structure

Lower Cost, Higher Quality Care

**Purchasers and Patients “win” if:**
- Providers reduce purchasers’ costs
- Patients stay healthy and have lower cost-sharing
- Patients return to work faster

**Provider “wins” if:**
- Patients stay healthy and need less care
- Purchaser pays provider adequately to manage care effectively and deliver services efficiently
Purchasers and Providers Have Common Interests, But Don’t Know It

“We’ve started talking directly to physicians, and we’ve discovered that what they want to sell is what we want to buy…”

Cheryl DeMars
CEO, The Alliance
(Employer Coalition in Wisconsin)
Purchasers Have Total Risk Today

TOTAL COST OF HEALTH CARE

Self-Funded Purchasers, Medicare, Medicaid

Providers
The Goal Should Not Be to Shift Total Risk to Providers

TOTAL COST OF HEALTH CARE

Self-Funded Purchasers, Medicare, Medicaid

TOTAL COST OF HEALTH CARE

Providers
Providers Should be Accountable for *Costs They Can Control*

**INSURANCE RISK**  
(Risk of Illness)  
Self-Funded Purchasers, Medicare, Medicaid

---

**PERFORMANCE RISK**  
(Cost/Illness)  
Providers
Successful Risk-Sharing is Possible With Well-Designed APMs

**INSURANCE RISK** (Risk of Illness)

Self-Funded Purchasers, Medicare, Medicaid

**PERFORMANCE RISK** (Cost/Illness)

Providers
Efficient Providers Can Provide Additional Value to Employers

- **TIME AWAY FROM WORK**
- **INSURANCE RISK** (Risk of Illness)
- **Employers**
- **EFFICIENCY OF CARE**
- **PERFORMANCE RISK** (Cost/Illness)
- **Providers**
Health Plan Implements Changes Purchasers/Providers Agree On

- Health Plans
  - Implementation
  - Better Payment and Benefit Structure
  - Lower Cost, Higher Quality Care
- Purchasers
- Providers
A Facilitator is Helpful to Support Purchaser-Provider Partnerships

Better Payment and Benefit Structure
Lower Cost, Higher Quality Care

Health Plans

Purchasers

Providers

Neutral Community Facilitator

Technical Assistance

Data
This All Sounds Really Hard
This All Sounds Really Hard

Can’t We Just Keep Doing What We’re Doing Today Until We Retire?
Opportunities to Reduce Costs Are Widely Known

<table>
<thead>
<tr>
<th>Opportunity</th>
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<tbody>
<tr>
<td>Reducing Hospital Readmissions</td>
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<tr>
<td>Reducing Infections and Complications</td>
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<tr>
<td>Reducing Overutilization of Tests and Procedures</td>
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<tr>
<td>Using Lower-Cost Sites of Service</td>
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<tr>
<td>Reducing Use of Expensive Drugs</td>
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</table>
The Question is: *How Will Payers Get The Savings?*

**PAYER**

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The Payer-Driven Approach to Achieving Savings

Managed Fee-for-Service

PAYER

- Reducing Hospital Readmissions
- Reducing Infections and Complications
- Reducing Overutilization of Tests and Procedures
- Using Lower-Cost Sites of Service
- Reducing Use of Expensive Drugs

Readmission Penalty
Provider P4P
High Deductibles
Prior Authorization
Narrow Networks
Tiering on Cost
The Provider-Driven Approach to Achieving Savings

Reducing Hospital Readmissions

Reducing Infections and Complications

Reducing Overutilization of Tests and Procedures

Using Lower-Cost Sites of Service

Reducing Use of Expensive Drugs

Coordinated, Provider-Led Care

Accountable Payment
Very Different Models…

Managed Fee-for-Service

Readmission Penalty

Provider P4P

High Deductibles

Prior Authorization

Narrow Networks

Tiering on Cost

Accountable Payment

PAYER

Reducing Hospital Readmissions

Reducing Infections and Complications

Reducing Overutilization of Tests and Procedures

Using Lower-Cost Sites of Service

Reducing Use of Expensive Drugs

Coordinated, Provider-Led Care
…And Very Different Impacts on Healthcare Providers

**Managed Fee-for-Service**

1. Payer defines how care should be redesigned
2. Payer obtains savings from lower utilization, if any
3. Payer decides whether and how much savings to share with providers

**Accountable Payment**

1. Providers determine how care should be redesigned
2. Provider and Payer agree on adequate price for appropriate care that reduces/controls spending
3. Providers get to keep any additional savings they create and determine how to use it
A Different “Triple Aim”

• Better Care for Patients
  – Providers with adequate, flexible payment needed to design care that matches patient needs and to take accountability for outcomes

• Lower Spending for Payers
  – Providers able to use the best combination of services for patients without worrying about which service generates more profits

• Financially Viable Healthcare Providers
  – Providers paid adequately to deliver high-quality care
  – Providers able to remain independent if they want to
Learn More About Win-Win-Win Payment and Delivery Reform

www.PaymentReform.org
For More Information:

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

Miller.Harold@CHQPR.org
(412) 803-3650

www.CHQPR.org
www.PaymentReform.org
APPENDIX
Prospective vs. Retrospective Payments
“Prospective” vs. “Retrospective” (Bundled) Payments

- No such thing as a truly “prospective” payment, i.e., payment that is made before services are rendered; all payments are made after services are delivered or after an episode ends.
- “Prospective” and “retrospective” actually refer to (1) when the total amount of payment is determined, and (2) how the total payment is divided among participating providers.

**Prospective(ly defined) Payment**: Physician/provider group knows the total payment/budget for the bundle in advance.

**Retrospective(ly defined) Payment**: Providers only know the total payment/budget after the services are delivered.

**Retrospective Reconciliation**: Providers are paid for services using standard FFS, then their payments are adjusted later (reconciled) based on a comparison of their total payments relative to the payment/budget amount (which can be established prospectively or retrospectively).
Shared Savings Program: Problems from Not Changing FFS

- Retrospective Reconciliation:
  - No change in underlying FFS payments
  - Any payment adjustment is through an additional payment made after calculations of savings are made

- Retrospective(ly Determined) Payment Amount:
  - Benchmark price is determined based on the physician/provider’s historical spending, trended forward based on increases in spending by providers not participating in the shared savings program
  - If the spending by the physician/provider that is participating in the shared savings program is lower than the benchmark spending by more than a minimum savings amount (equivalent to a discount), the physician/provider receives a shared savings payment
  - Shared savings payment may or may not be enough to cover costs of extra services delivered
  - The benchmark is recalculated periodically based on FFS spending with no accounting for the unbillable services used to create savings
Example: Physician Who Cares For Patients At Risk of Admission

YEAR 0

$ Total Spending Relevant to the Physician’s Services

FFS Payment to Hospital for Admissions

E&M to Physician

Physician Practice Revenue

Chart Not Drawn to Scale

© Center for Healthcare Quality and Payment Reform www.CHQPR.org
Assume Many Admissions Are Potentially Avoidable

YEAR 0

Total Spending Relevant to the Physician’s Services

Avoidable Admissions

FFS Payment to Hospital for Admissions

E&M to Physician

Physician Practice Revenue

Chart Not Drawn to Scale
In Current APMs, Target Spending Is Set Below Current Spending

YEAR 0

$  

Total Spending Relevant to the Physician’s Services

Avoidable Admissions

FFS Payment to Hospital for Admissions

E&M to Physician

Current Spend

Target Spending

Chart Not Drawn to Scale
If Physician Delivers Services That Aren’t Currently Billable…

YEAR 0

Total Spending Relevant to the Physician’s Services

Avoidable Admissions

FFS Payment to Hospital for Admissions

E&M to Physician

YEAR 1

Current Spend

Target Spending

Physician Practice Revenue

E&M to Physician

Non-Billable Service

Chart Not Drawn to Scale
...And Thereby Reduces the Number of Admissions...

![Diagram showing the reduction in admissions and associated costs.](chart)

- **Avoidable Admissions**
  - FFS Payment to Hospital for Admissions
  - E&M to Physician

- **Non-Billable Service**

- **Total Spending Relevant to the Physician’s Services**

- **Current Spend**
- **Target Spending**

- **Physician Practice Revenue**

Chart Not Drawn to Scale
Savings Generated for Payer, But Physician Loses Money in Year 1

YEAR 0

Total Spending Relevant to the Physician's Services

$ Avoidable Admissions

FFS Payment to Hospital for Admissions

E&M to Physician

YEAR 1

Savings

FFS Payment to Hospital for Admissions

E&M to Physician

Non-Billable Service

Loss for Physician

Current Spend
Target Spending

Savings for Payer

Non-Billable Service

Loss for Physician

Chart Not Drawn to Scale
Loss is Greater if New Services Substitute for Current Services

YEAR 0

Avoidable Admissions

FFS Payment to Hospital for Admissions

E&M to Physician

YEAR 1

Savings

Savings for Payer

FFS Payment to Hospital for Admissions

E&M to Physician

Loss of Fees Non-Billable Service

Loss for Physician

Current Spend Target Spending

Total Spending Relevant to the Physician’s Services

E&M to Physician FFS Payment to Hospital for Admissions

Physician Practice Revenue

Chart Not Drawn to Scale

© Center for Healthcare Quality and Payment Reform www.CHQPR.org
Physician Receives a Share of Savings a Year After Expenses

YEAR 0

<table>
<thead>
<tr>
<th>Avoidable Admissions</th>
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<tbody>
<tr>
<td>FFS Payment to Hospital for Admissions</td>
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<tr>
<td>E&amp;M to Physician</td>
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</table>

YEAR 1

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<thead>
<tr>
<th>Payer Share of Savings</th>
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<table>
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<th>Provider Share of Savings</th>
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<tr>
<td>FFS Payment to Hospital for Admissions</td>
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<td>E&amp;M to Physician</td>
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</table>

YEAR 2

<table>
<thead>
<tr>
<th>Payment to Hospital for Admissions</th>
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<tbody>
<tr>
<td>Lower E&amp;M</td>
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</tbody>
</table>

Loss of Fees Non-Billable Service

Current Spending

Target Spending

Chart Not Drawn to Scale
Shared Savings Payment May Not Cover Costs & Losses

**YEAR 0**
- **Avoidable Admissions**
- FFS Payment to Hospital for Admissions
- E&M to Physician

**YEAR 1**
- **Payer Share of Savings**
- **Provider Share of Savings**
- FFS Payment to Hospital for Admissions
- E&M to Physician

**YEAR 2**
- Payment to Hospital for Admissions
- Lower E&M

- **Shared Savings $ May Not Cover Year 1**
- **Loss of Fees Non-Billable Service**

**Current Spend**
- **Target Spending**

**Chart Not Drawn to Scale**

© Center for Healthcare Quality and Payment Reform www.CHQPR.org
Shared Savings Payment May Not Cover Costs & Losses

NO ONE KNOWS HOW BIG THE LOSS IS BECAUSE THERE IS NO RECORD OF UNBILLABLE SERVICES
Physician Spending Includes Both Billable and Non-Billable Services

- **YEAR 0**
  - **Avoidable Admissions**
  - **FFS Payment to Hospital for Admissions**
  - **E&M to Physician**

- **PROVIDER SPENDING**
  - **Current Spend**
  - **Target Spending**

- **Physician Practice Revenue**
  - **Total Spending Relevant to the Physician’s Services**

**TOTAL Physician Spending on Services**
- **Loss of Fees Non-Billable Service**
- **Lower E&M**

*Chart Not Drawn to Scale*
Payer Only Sees the Services That Are *Billable Under FFS*…

**YEAR 0**

- **Total Spending Relevant to the Physician’s Services**
  - *Avoidable Admissions*
  - FFS Payment to Hospital for Admissions
  - E&M to Physician
  - *Loss of Fees Non-Billable Service*

**PROVIDER SPENDING**

- FFS Payment to Hospital for Admissions
  - Lower E&M

**PAYER SPENDING**

- FFS Payment to Hospital for Admissions
  - Lower E&M

- Current Spend
- Target Spending

Chart Not Drawn to Scale

Visible Spending Under FFS

Invisible to Payer

© Center for Healthcare Quality and Payment Reform www.CHQPR.org
…Payer Revises Target Spending Based Only on Spending It Sees…

YEAR 0

$ Total Spending Relevant to the Physician’s Services

Avoidable Admissions

FFS Payment to Hospital for Admissions

E&M to Physician

YEAR 4+

Current Spend Target Spending

New Target

FFS Payment to Hospital for Admissions

Lower E&M

Chart Not Drawn to Scale
...Leaving No Revenue for the Services That Created Savings

YEAR 0

- Total Spending Relevant to the Physician’s Services

- Avoidable Admissions
  - FFS Payment to Hospital for Admissions
  - E&M to Physician

YEAR 4+

- Current Spend Target Spending

- New Target

- Loss of Fees Non-Billable Service

Chart Not Drawn to Scale

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Payer Wins, Physician Loses

YEAR 0 → YEAR 1 → YEAR 2-3 → YEAR 4+

$ Total Spending Relevant to the Physician’s Services

Avoidable Admissions

FFS Payment to Hospital for Admissions

E&M to Physician

Savings

FFS Payment to Hospital for Admissions

E&M to Physician

Payer Share of Savings

FFS Payment to Hospital for Admissions

Lower E&M

PAYER SAVINGS

Lower E&M

Physician Practice Revenue

Loss of Fees Non-Billable Service

Smaller Losses

Physician Loss

Chart Not Drawn to Scale
Prospective Bundled Amounts (Can) Avoid This Problem

YEAR 0  TRUE APM

Total Actual Spending

Current Spend

Total Actual Spending

Bundle Price

Actual Physician Spending

Avoidable Admissions

FFS Payment to Hospital for Admissions

E&M to Physician

Payer Savings

Payment to Hospital for Admissions

Office Visits & Other Billable & Non-Billable Services

Physician Margin

Bundled Payment or Budget for Physician Services

Chart Not Drawn to Scale
APPENDIX
Protecting Providers From Inappropriate Risk
To Attract Payers, New Payment Must Be < Projected FFS Spend

Bundled or Condition-Based Payment Level

FFS $  FFS $  APM $

Actual  Actual  Proposed  Lower Spend
...If All Goes Well, Provider’s Costs Are Lower Than the Payment...

![Diagram showing cost and time comparison between FFS, APM, and bundled or condition-based payment levels.](image)

- **Cost**: Actual FFS, Actual FFS, Proposed APM, Actual Costs of Svcs
- **Time**: Actual, Actual, Proposed, Actual

**Lower Spend** and **Lower Costs** are indicated in the diagram.
...And Both the Payer and Provider Will “Win”

- Bundled or Condition-Based Payment Level
- Costs of Svcs

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th>Actual</th>
<th>Proposed</th>
<th>Actual</th>
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<tbody>
<tr>
<td>FFS</td>
<td>$</td>
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<td>$</td>
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<tr>
<td>APM</td>
<td>Lower Spend</td>
<td></td>
<td>Lower Costs</td>
<td></td>
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<tr>
<td>Savings For Payer</td>
<td></td>
<td></td>
<td>WIN-WIN</td>
<td></td>
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<tr>
<td>Profit for Provider</td>
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</table>

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The Risk Providers Fear: All Won’t Go Well (Costs Go Up)..
…Creating a Win-Lose Situation

COST

Bundled or Condition-Based Payment Level

FFS $  FFS $  APM $  Costs of Svcs

Actual  Actual  Proposed  Actual

Savings For Payer

WIN-LOSE

Lower Spend

Excess Cost

Loss for Provider

TIME
Many Different Reasons Costs May Increase Beyond Payment

<table>
<thead>
<tr>
<th>COST</th>
<th>TIME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bundled or Condition-Based Payment Level</td>
<td></td>
</tr>
<tr>
<td>Actual FFS $</td>
<td>Actual FFS $</td>
</tr>
</tbody>
</table>

- Many Aviodable Complications
- Failure to Follow Guidelines
- Overutilization of Services
- Large Random Variation
- New, High-Cost Treatment
- Unusually Costly Patient
- Higher-Severity Patients

Lower Spend

Excess Cost

Actual

Proposed

Actual
Providers CAN Control Many of the Factors Causing Higher Costs

What Providers CAN Control (Performance Risk)

- Many Avoidable Complications
- Failure to Follow Guidelines
- Overutilization of Services
- Large Random Variation
- New, High-Cost Treatment
- Unusually Costly Patient
- Higher-Severity Patients
But Other Causes of Higher Costs CANNOT Be Controlled by Doctors

- Many Avoidable Complications
- Failure to Follow Guidelines
- Overutilization of Services
- Large Random Variation
- New, High-Cost Treatment
- Unusually Costly Patient
- Higher-Severity Patients

What Providers CAN Control (Performance Risk)

What Providers CANNOT Control (Insurance Risk)

COST

Bundled or Condition-Based Payment Level

FFS $  FFS $  APM $  Costs of Svcs

Lower Spend  Excess Cost

TIME

Actual  Actual  Proposed  Actual
Physicians Should NOT Be Expected To Take *Insurance* Risk

---

**COST**

- **Bundled or Condition-Based Payment Level**

**TIME**

<table>
<thead>
<tr>
<th></th>
<th>FFS $</th>
<th>FFS $</th>
<th>APM $</th>
<th>Costs of Svcs</th>
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**What Providers CAN Control (Performance Risk):**
- Many Avoidable Complications
- Failure to Follow Guidelines
- Overutilization of Services
- Large Random Variation
- New, High-Cost Treatment
- Unusually Costly Patient
- Higher-Severity Patients

**What Providers CANNOT Control (Insurance Risk):**

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Four Mechanisms for Separating Insurance and Performance Risk

<table>
<thead>
<tr>
<th>Mechanism</th>
<th>Performance Risk (Provider’s Responsibility)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Many Avoidable Complications</td>
<td></td>
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<td>Risk Corridors</td>
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<tr>
<td>Higher-Severity Patients</td>
<td>Risk Adjustment</td>
</tr>
</tbody>
</table>

**COST**

- Bundled or Condition-Based Payment Level

**TIME**

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th>Actual</th>
<th>Proposed</th>
<th>Actual</th>
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<td>Lower</td>
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<tr>
<td>FFS</td>
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<tr>
<td>APM</td>
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<td>$</td>
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</tbody>
</table>

**Costs of Svcs**

- Lower Spend

**Excess Cost**

- Many Avoidable Complications
- Failure to Follow Guidelines
- Overutilization of Services
- Large Random Variation
- New, High-Cost Treatment
- Unusually Costly Patient
- Higher-Severity Patients

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Risk Exclusions

- Many Avoidable Complications
- Performance Risk (Provider’s Responsibility)
  - Failure to Follow Guidelines
  - Overutilization of Services
  - Large Random Variation
  - New, High-Cost Treatment
  - Unusually Costly Patient
  - Higher-Severiity Patients
  - Outlier Pmt/Stop-Loss
  - Risk Adjustments

COST

- Bundled or Condition-Based Payment Level

<table>
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<tr>
<th>Cost of Svcs</th>
<th>Excess Cost</th>
</tr>
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<tr>
<td>FFS $ Actual</td>
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</table>

Lower Spend

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Risk (Acuity/Severity) Adjustment

COST

Bundled or Condition-Based Payment Level

FFS $  FFS $  APM $  Costs of Svcs  Excess Cost

TIME

Actual  Actual  Proposed  Actual

Many Avoidable Complications  Performance Risk (Provider’s Responsibility)

Failure to Follow Guidelines
Overutilization of Services
Large Random Variation
New, High-Cost Treatment
Unusually Costly Patient
Higher-Severity Patients

Risk Corridors  Risk Exclusions  Outlier Pmt/Stop-Loss  Risk Adjustment

Lower Spend
Outlier Payments/Stop-Loss

COST

Bundled or Condition-Based Payment Level

FFS $ Actual  FFS $ Actual  APM $ Proposed  Excess Cost Actual

Many Avoidable Complications
- Failure to Follow Guidelines
- Overutilization of Services
- Large Random Variation
- New, High-Cost Treatment
- Unusually Costly Patient
- Higher Severity Patients

Performance Risk (Provider’s Responsibility)

Risk Corridors
Risk Exclusions
Outlier Pmt/Stop-Loss
Risk Adjustment

Lower Spend

Costs of Svcs

FFS
Proposed
Actual

Time

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Outlier Payment
(Individual Stop-Loss)

- Some patients are unusually expensive
  - Risk adjustment models/stratifications are designed to predict average costs of groups of patients, not the exact cost of an individual patient
  - Risk for even a small percentage of the costs of treating a very expensive patient can result in a large financial penalty for a provider

- Outlier payment: an additional payment from a payer to a provider to cover all or part of the higher cost of the patient’s care
  - A threshold is created to define when a patient is an “outlier.”
  - The payer pays the provider a percentage (e.g., 80% or 100%) of the difference between the actual cost and the threshold amount

- Individual stop-loss insurance
  - Similar to an outlier payment, except that the provider has to pay a premium to an insurer to be eligible to receive the stop-loss payment

- Excluding or “Winsorizing” patients in spending measures
  - When the provider is not directly responsible for paying for services, but is held accountable for a measure of spending, “Winsorizing” means capping the amount included for an individual patient at a maximum amount. (The alternative is to exclude the patient from the measure denominator altogether.)
Using Risk Corridors to Share Risks Not Captured by Risk Adjustment

<table>
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Many Avoidable Complications
- Performance Risk (Provider’s Responsibility)
  - Risk Corridors
  - Risk Exclusions
  - Outlier Pmt/Stop-Loss
  - Risk Adjustment

Failure to Follow Guidelines
- Overutilization of Services
- Large Random Variation
- New, High-Cost Treatment
- Unusually Costly Patient
- Higher-Severity Patients

### Costs of Svcs

- Unusually Costly Patient
- New, High-Cost Treatment
- Higher-Severity Patients
- Failure to Follow Guidelines
- Large Random Variation
- Overutilization of Services
- Unusually Costly Patient
- New, High-Cost Treatment
- Higher-Severity Patients

### Lower Spend

- Failure to Follow Guidelines
- Large Random Variation
- Overutilization of Services
- Unusually Costly Patient
- New, High-Cost Treatment
- Higher-Severity Patients

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No One Expects That the Payment Amount Will Be Exactly Right

\[
\text{Cost} = \text{Payment}
\]

Actual Cost of Services

Payment Amount
Some Random Variation Will Occur From Year to Year

\[
\text{Actual Cost of Services} = \text{Payment Amount}
\]
Physician Practice Can Handle Some Variation, As It Does Today

Actual Cost of Services

Cost = Payment

Provider Pays 100% of Extra Cost in this Range

Risk Corridor #1

Actual Cost of Services

Cost = Pmt + x%

Provider Retains 100% of Savings

Risk Corridor #1

Cost = Pmt - x%

Payment Amount

Provider Pays 100% of Extra Cost in this Range
Payers Should Remain Responsible for All or Part of Large Variation

Actual Cost of Services

Cost = Payment

Cost = Pmt + x%  
Provider Pays All or Part of Excess Cost in this Range

Risk Corridor #1

Risk Corridor #2

Cost = Pmt - x%  
Payer Receives All or Part of Savings

Risk Corridor #1

Risk Corridor #2

Payment Amount

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New APMs Can Start with Narrow Risk Corridors

- **Cost = Payment**
  - **Risk Corridor #1**
    - Provider Retains 100% of Savings
  - **Risk Corridor #2**
    - Provider Pays 100% of Extra Cost

- **Cost = Pmt + x%**
  - **Risk Corridor #1**
    - Provider Retains 100% of Savings
  - **Risk Corridor #2**
    - Payer Receives All of Savings

- **Cost = Pmt - x%**
  - **Risk Corridor #1**
    - Provider Pays 100% of Extra Cost
  - **Risk Corridor #2**
    - Payer Receives All of Savings
Expand Risk Corridors Over Time, As Medicare Did in Part D
Use Narrow Risk Corridors for Small Providers over Short Times

Annual Measures

Multi-Year Measures
Complex Risk Corridor Arrangements Possible

EXAMPLE OF ASYMOMETRIC TIERED RISK CORRIDORS

- **Actual Cost of Services**
  - **Cost = Payment**
  - **Cost = Base + 10%**
  - **Cost = Base + 5%**
  - **Cost = Base - 8%**
  - **Cost = Base - 15%**

**Base Payment Amount**

- **Provider Pays 20%**
- **Payer Pays 80% of Extra Cost**
- **Provider Pays 50% of Extra Cost**
- **Payer Pays 50% of Extra Cost**
- **Provider Pays 80% of Extra Cost in this Range**
- **Payer Pays 20%**
- **Provider Retains 100% of Savings in this Range**
- **Payer Pays 20%**
- **Payer Receives 40% of Savings**
- **Provider Retains 60% of Savings**
- **Payer Receives 40% of Savings**
- **Provider Retains 34% of Savings**
- **Payer Receives 66% of Savings**

**Examples**:
- **Actual Cost of Services**
  - **Cost = Base + 10%**
  - **Cost = Base + 5%**
  - **Cost = Base - 8%**
  - **Cost = Base - 15%**

**Cost Formulae**:
- **Cost = Base + 5%**
- **Cost = Base - 8%**
- **Cost = Base - 15%**
APPENDIX
Creating ACOs With True APMs
What Happens to ACOs with Provider-Focused APMs?
Each Patient Should Have a Good Primary Care Practice…

PATIENTS
- Heart Disease
- Back Pain
- Pregnancy

Primary Care Practice
…With Payment That Enables Delivery of Good Primary Care…

MEDICARE, MEDICAID HEALTH PLAN

PATIENTS
- Heart Disease
- Back Pain
- Pregnancy

Payment That Supports Good Primary Care

Primary Care Practice
And PCPs Take Accountability for Costs They Can Control/Influence

MEDICARE, MEDICAID HEALTH PLAN

PATIENTS
- Heart Disease
- Back Pain
- Pregnancy

Primary Care Practice

Accountability for:
- Avoidable ER Visits
- Avoidable Hospitalizations
- Unnecessary Tests
- Unnecessary Referrals
- Adequate Preventive Care

Payment That Supports Good Primary Care
Give PCPs a Medical Neighborhood to Consult With on Difficult Cases

MEDICARE, MEDICAID HEALTH PLAN

PATIENTS
- Heart Disease
- Back Pain
- Pregnancy

Primary Care Practice
- Cardiology
- Physical Therapy
- OB/GYN

Payment That Supports Good Primary Care
Pay the Medical Neighbors to Support the PCPs

MEDICARE, MEDICAID HEALTH PLAN

PATIENTS
- Heart Disease
- Back Pain
- Pregnancy

Primary Care Practice

Cardiology
Physical Therapy
OB/GYN

Payment That Supports Good Primary Care

Payment That Supports Diagnostic & Care Management Help From Specialists
…Ask the Medical Neighbors to Be Accountable for Costs They Control

MEDICARE, MEDICAID HEALTH PLAN

PATIENTS

- Heart Disease
- Back Pain
- Pregnancy

Primary Care Practice

Cardiology
Physical Therapy
OB/GYN

Accountability for:
- Appropriate Use of Testing and Interventions
- Improving Chronic Disease Management

Payment That Supports Diagnostic & Care Management Help From Specialists

Payment That Supports Good Primary Care
Have Good Specialists Ready to Manage Serious Conditions…

**MEDICARE, MEDICAID HEALTH PLAN**

**Patients**
- Heart Disease
- Back Pain
- Pregnancy

**Primary Care Practice**
- Payment That Supports Good Primary Care

**Cardiology**
- Physical Therapy
- OB/GYN

**Heart Care Team**
- Payment That Supports Diagnostic & Care Management Help From Specialists

**Neurosurg. + PT Team**

**Maternity Team**
Pay Them To Deliver Quality Care
at the Most Affordable Cost

MEDICARE, MEDICAID
HEALTH PLAN

PATIENTS
- Heart Disease
- Back Pain
- Pregnancy

Primary Care Practice
- Payment That Supports Good Primary Care

Heart Care Team
- Payment That Supports Good Management of Heart Disease

Neurosurg. + PT Team
- Payment That Supports Good Care for Back Pain

Maternity Team
- Payment That Supports Good Care for Pregnancy

Cardiology
- Payment That Supports Diagnostic & Care Management Help From Specialists

Physical Therapy

OB/GYN
Ask Specialists to Be Accountable for Costs They Can Control

MEDICARE, MEDICAID HEALTH

Accountability for:
• Using Appropriate Procedures
• Avoiding Complications of Procedures

PATIENTS
Heart Disease
Back Pain
Pregnancy

Primary Care Practice

Payment That Supports Good Primary Care

Heart Care Team

Neurosurg. + PT Team

Maternity Team

Cardiology Physical Therapy OB/GYN

Payment That Supports Diagnostic & Care Management Help From Specialists

Payment That Supports Good Management of Heart Disease

Payment That Supports Good Care for Back Pain

Payment That Supports Good Care for Pregnancy
That’s an “ACO,” But Built from the Bottom Up, Not the Top Down

MEDICARE, MEDICAID HEALTH PLAN

PATIENTS
Heart Disease
Back Pain
Pregnancy

Primary Care Practice

Cardiology Physical Therapy OB/GYN

Heart Care Team
Neurosurg. + PT Team
Maternity Team

Payment That Supports Good Primary Care
Payment That Supports Good Management of Heart Disease
Payment That Supports Good Care for Back Pain
Payment That Supports Good Care for Pregnancy
Payment That Supports Diagnostic & Care Management Help From Specialists

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

MEDICARE, MEDICAID
HEALTH PLAN, EMPLOYER

Risk-Adjusted Global Payment

ACO

Payment That Supports Good Primary Care

Primary Care Practice

Cardiology Physical Therapy
OB/GYN

Heart Care Team

Neurosurg. + PT Team

Maternity Team

Payment That Supports Good Management of Heart Disease

Payment That Supports Good Care for Back Pain

Payment That Supports Good Care for Pregnancy

Payment That Supports Diagnostic & Care Management Help From Specialists

PATIENTS
Heart Disease
Back Pain
Pregnancy