CREATING A PHYSICIAN-LED HEALTHCARE FUTURE
Better Care for Patients,
Lower Healthcare Spending,
& Financially Viable Physician Practices

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

www.CHQPR.org
There is one thing (and maybe only one thing) we have in common in America today...

...We’re all spending too much on healthcare
Healthcare Spending is the Biggest Driver of Federal Deficits

Source: CBO
Increasing Share of State Budgets Goes to Medicaid Spending

State Medicaid Spending as % of All State Funds in State Budgets

1/6 of All State Funds Are Now Used for Medicaid

Source: NASBO
U.S. Premiums Increased 73% More Than Inflation Since 2002

Average Family Premiums, Employer-Sponsored Insurance

Source: Medical Expenditure Panel Survey & Bureau of Labor Statistics

Family Premiums $6,164 Higher Than Inflation
Why Are Jobs Growing But Wages Stagnant?

THE WALL STREET JOURNAL.

U.S. Jobs Growth Picks Up, but Wage Gains Lag Behind

By Jeffrey Sparshott
Updated July 7, 2017 6:57 p.m. ET

U.S. employers are churning out jobs unabated as the economic expansion enters its ninth year, but the inability to generate more robust wage growth represents a missing piece in a largely complete labor recovery.
Spending on Higher Premiums Reduces $ for Take-Home Pay

Source: Medical Expenditure Panel Survey & Bureau of Labor Statistics
Spending is Increasing Rapidly in “Single Payer” Countries, Too

Growth in Per Capita Health Care Spending, 2008-2016

- Canada
- France
- United States
- Germany
- Australia
- United Kingdom
- Switzerland
How Do You Control the Growth in Healthcare Spending?

<table>
<thead>
<tr>
<th>TOTAL HEALTHCARE SPENDING</th>
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</table>

TIME
Payer Strategy #1: Cut Provider Fees for Services

TOTAL HEALTH CARE SPENDING

TOTAL HEALTH CARE SPENDING

TOTAL HEALTH CARE SPENDING

SAVINGS Cut Provider Fees

TOTAL HEALTH CARE SPENDING BY PAYERS
Payer Strategy #2: Shift Costs to Patients

$\quad$ SAVINGS

Higher Cost-Share & Deductibles

TOTAL HEALTH CARE SPENDING
TOTAL HEALTH CARE SPENDING
TOTAL HEALTH CARE SPENDING
TOTAL HEALTH CARE SPENDING BY PAYERS
Payer Strategy #3: Delay or Deny Care to Patients

TOTAL HEALTH CARE SPENDING

TOTAL HEALTH CARE SPENDING

TOTAL HEALTH CARE SPENDING

TOTAL HEALTH CARE SPENDING BY PAYERS

SAVINGS

Lack of Needed Care
Results of Standard Strategies

STANDARD STRATEGIES FOR REDUCING SPENDING

• Cutting amounts providers are paid for services
• Shifting costs to patients through high deductibles and high cost-sharing
• Delaying or denying care to patients through limits on benefits and prior authorization programs

RESULTS OF THE STANDARD STRATEGIES

• Patients don’t get the care they need and costs increase in the future
• Small physician practices and hospitals are forced out of business
• Health insurance premiums continue to rise and access to insurance coverage decreases
Results of Standard Strategies

STANDARD STRATEGIES FOR REDUCING SPENDING

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RESULTS OF THE STANDARD STRATEGIES

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• 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*
Avoidable Spending Occurs In All Aspects of Healthcare

**NECESSARY SPENDING**

- ER visits for exacerbations
- Hospital admissions and readmissions
- Preventable progression of disease
- Preventable chronic conditions

**SPENDING**

- Unnecessary C-Sections
- Early elective deliveries
- Underuse of birth centers

**CHRONIC DISEASE**

- ER visits for exacerbations
- Hospital admissions and readmissions
- Preventable progression of disease
- Preventable chronic conditions

**MATERNITY CARE**

- Use of unnecessarily-expensive drugs
- ER visits/hospital stays for dehydration and avoidable complications
- Fruitless treatment at end of life

**CANCER TREATMENT**

- Use of unnecessarily-expensive drugs
- ER visits/hospital stays for dehydration and avoidable complications
- Fruitless treatment at end of life

**SURGERY**

- Unnecessary surgery
- Use of unnecessarily-expensively implants
- Infections and complications of surgery
- Overuse of inpatient rehabilitation
Institute of Medicine Estimate: 30% of Spending is Avoidable

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

<table>
<thead>
<tr>
<th>Domain</th>
<th>Total Excess</th>
</tr>
</thead>
<tbody>
<tr>
<td>UNNECESSARY SERVICES</td>
<td>$210 B*</td>
</tr>
<tr>
<td>Overuse: services beyond evidence-established levels</td>
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<tr>
<td>Discretionary use beyond benchmarks</td>
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<tr>
<td>Defensive medicine</td>
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<td>Unnecessary choice of higher cost services</td>
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<tr>
<td>INEFFECTIVELY DELIVERED SERVICES</td>
<td>$130 B*</td>
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<tr>
<td>Mistakes — medical errors, preventable complications</td>
<td></td>
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<tr>
<td>Care fragmentation</td>
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<tr>
<td>Unnecessary use of higher cost providers</td>
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<tr>
<td>Operational inefficiencies at care delivery sites</td>
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<tr>
<td>- Physician offices</td>
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<td>- Hospitals</td>
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<tr>
<td>EXCESS ADMINISTRATIVE COSTS</td>
<td>$190 B*</td>
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<tr>
<td>Insurance-related administrative costs beyond benchmarks</td>
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<tr>
<td>- Insurers</td>
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<td>- Physician offices</td>
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<tr>
<td>- Hospitals</td>
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<tr>
<td>- Other providers</td>
<td></td>
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<tr>
<td>- Insurer administrative inefficiencies</td>
<td></td>
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<tr>
<td>- Care documentation requirement inefficiencies</td>
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<tr>
<td>PRICES THAT ARE TOO HIGH</td>
<td>$105 B*</td>
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<tr>
<td>Service prices beyond competitive benchmarks</td>
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<tr>
<td>- Physician services</td>
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<td>i. Specialists</td>
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<td>ii. Generalists</td>
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<td>- Pharmaceuticals</td>
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<tr>
<td>- Medical devices</td>
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<tr>
<td>- Durable medical equipment</td>
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</tr>
<tr>
<td>MISSED PREVENTION OPPORTUNITIES</td>
<td>$55 B*</td>
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<tr>
<td>Primary prevention</td>
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<tr>
<td>Secondary prevention</td>
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<tr>
<td>Tertiary prevention</td>
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<tr>
<td>FRAUD</td>
<td>$75 B*</td>
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<tr>
<td>All sources — payer, clinician, patient</td>
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</tbody>
</table>

*Lower bound totals of various estimates, adjusted to 2009 total expenditure level.
25% of Avoidable Spending is Excess Administrative Costs

EXCESS ADMINISTRATIVE COSTS

- Insurance-related administrative costs beyond benchmarks
  - Insurers
  - Physician offices
  - Hospitals
  - Other providers
- Insurer administrative inefficiencies
- Care documentation requirement inefficiencies

EXCESS COST DOMAIN ESTIMATES:

- **Lower bound totals from workshop discussions**
  - **UNNECESSARY SERVICES**
    - Overuse: services beyond evidence-established levels
    - Discretionary use beyond benchmarks
    - Defensive medicine
    - Unnecessary choice of higher cost services
    - Total excess = $210 B*
  - **INEFFICIENTLY DELIVERED SERVICES**
    - Mistakes—medical errors, preventable complications
    - Care fragmentation
    - Unnecessary use of higher cost providers
    - Operational inefficiencies at care delivery sites
    - Physician office
    - Total excess = $130 B*
  - **EXCESS ADMINISTRATIVE COSTS**
    - total excess = $190 B*
  - **MISSED PREVENTION OPPORTUNITIES**
    - Total excess = $55 B*
  - **FRAUD**
    - All sources—payer, clinician, patient
    - Total excess = $75 B*

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

![Diagram showing the decrease in avoidable spending over time, with necessary spending remaining constant.](chart.png)
The Right Goal: Less Avoidable $, More Necessary $
Win-Win for Patients & Payers

Lower Spending for Payers
Better Care for Patients

NECESSARY SPENDING
AVOIDABLE SPENDING

SAVINGS

TIME

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

$\quad$

\begin{align*}
&\text{NECESSARY SPENDING} & &\text{AVOIDABLE SPENDING} & &\text{SAVINGS} \\
&\text{BARRIERS IN THE CURRENT PAYMENT SYSTEM} & & & &
\end{align*}
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 physicians to ensure accurate diagnosis & coordinate care
- Non-medical services, e.g., transportation
- Palliative care for patients at end of life
Barrier #2: Healthier Patients = Financial Losses for Providers

Lower Revenue May Be Inadequate to Cover Fixed Costs and Costs of New, Unpaid Services

- Necessary Spending
- Avoidable Spending
- Payer Savings
- Provider Revenue
- Provider Loss
- Cost of New Services
- Variable Costs
- Fixed Cost of Service Delivery

Lower revenue may be inadequate to cover fixed costs and costs of new, unpaid services.
Significant Savings From Delaying Progression of Kidney Disease…

**Average Annual Medicare Spending Per Patient**

- **Stage 4-5 CKD**: $28,541
- **Dialysis**: $90,143

- **Source**: USRDS

- **Reduction**: 68%

**Comparison**

- **Stage 4-5 CKD**: $61,602 ($5,134/mo)
- **Dialysis**: $90,143

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... But Large Financial Penalties for Nephrologists

Average Annual Medicare Spending Per Patient

- **Stage 4-5 CKD**
  - $28,541
  - ($5,134/mo)
  - -68%

- **Dialysis**
  - $90,143

Annual Nephrologist Revenue Per Patient

- **Stage 4-5 CKD**
  - $652
  - Level 4 E/M ($108.74 x 6)

- **Dialysis**
  - $3,445
  - Monthly ESRD Capitation Payment to Nephrologist ($287.11 x 12)

Source: USRDS

**Stage 4-5 CKD**

- $28,541
- ($5,134/mo)
- -68%

**Dialysis**

- $90,143
- $652
- Level 4 E/M ($108.74 x 6)
- $2,793
- ($233/mo)
- -81%
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 physicians to ensure accurate diagnosis & coordinate care
  - Non-medical services, e.g., transportation
  - Palliative care for patients at end of life

**BARRIER #2**

Lower Revenue May Be Inadequate to Cover Fixed Costs and Costs of New, Unpaid Services
Three Paths to the Future:
Which Door Will Doctors Choose?

MACRA

Medicare & CHIP Reauthorization Act of 2015

FUTURE PAYMENT #1

FUTURE PAYMENT #2

FUTURE PAYMENT #3

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Door #1: Pay for Performance (P4P)

PAY FOR PERFORMANCE
Merit-Based Incentive Payment System

MACRA
Premise of MIPS/P4P is Physicians Need “Incentives” for Better Care

Fee for Service

MIPS and P4P Incentives Based on Quality and Cost Measures

Bonus

Penalty
The Problem Isn’t “Incentives” But *Barriers* in FFS Payment

- A small bonus may not be enough to pay for delivering a high-value service or for the added costs of improving quality
- A small bonus may not be enough to offset the costs of collecting and reporting the quality data
- A small penalty may be less than the loss of fee-for-service revenue from healthier patients or lower utilization
Time Lost to Quality Measures = Potential Bonus from MIPS

Study:
Physicians spend 2.6 hours per week on tasks related to quality measurement; equivalent to 5% of a 50 hour week.

MIPS:
4% penalty for not participating in 2017; possible 4% bonus for high performance.

NET RESULT
loss of 1% to 5% no matter what.
**Conclusion:** Pay-for-performance programs may be associated with improved processes of care in ambulatory settings, but consistently positive associations with improved health outcomes have not been demonstrated in any setting.

**Limitation:** Few methodologically rigorous studies; heterogeneous population and program characteristics and incentive targets.

**Conclusion:** Pay-for-performance programs may be associated with improved processes of care in ambulatory settings, but consistently positive associations with improved health outcomes have not been demonstrated in any setting.

**Primary Funding Source:** U.S. Department of Veterans Affairs.
Good Performance Only Results in Bonuses if Other Physicians Fail

- In MIPS, bonuses are *only* paid to physicians who have above average quality *if* penalties are assessed on other physicians with below average quality.
- To maintain budget neutrality, the size of bonuses depends on the size of penalties.
The End of Collaboration?

• In MIPS, bonuses are *only* paid to physicians who have above average quality if penalties are assessed on other physicians with below average quality.

• To maintain budget neutrality, the size of bonuses depends on the size of penalties.

• Under this system, why would high-performing physicians want to help under-performing physicians to improve?
Door #1: Accountability Without Resources or Flexibility

PAY FOR PERFORMANCE (MIPS)

- Accountability for:
  - Quality Measures
  - Spending on Patients
  - “Meaningful Use”
  - “Practice Improvement”

- No Change in the Services Physicians are Paid For or the Adequacy of Payment
Door #2: Alternative Payment Models

#1 PAY FOR PERFORMANCE (MIPS)

#2 ALTERNATIVE PAYMENT MODELS (APMs)
In MACRA, Congress *Encouraged* Use of APMs Instead of MIPS

- Physicians who participate in approved Alternative Payment Models (APMs) at more than a minimum level:
  - are exempt from MIPS
  - receive a 5% lump sum bonus
  - receive a higher annual update (increase) in their FFS revenues
  - receive the benefits of participating in the APM
CMS/Health Plan Approach to Alternative Payment Models

CMS/Health Plan APMs

YEAR 1

$  

AVOIDABLE SPENDING  
NECESSARY SPENDING

SAVINGS

UNPAID SERVICES  
LOSS OF REVENUE
“Shared Savings” = Save Us $$ & (Maybe) We’ll Pay More Next Year

**CMS/Health Plan APMs**

<table>
<thead>
<tr>
<th>YEAR 1</th>
<th>YEAR 2</th>
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<tr>
<td><strong>NECESSARY SPENDING</strong></td>
<td><strong>NECESSARY SPENDING</strong></td>
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<tr>
<td><strong>AVOIDABLE SPENDING</strong></td>
<td><strong>AVOIDABLE SPENDING</strong></td>
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</table>
| **SAVINGS** | **SAVINGS**

- **UNPAID SERVICES**
- **LOSS OF REVENUE**

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No $ for Unbillable Services, High Financial Risk for Providers

CMS/Health Plan APMs

How does hospital or physician cover upfront costs of additional services and loss of revenue?

Shared savings, if received, may not cover costs & losses.

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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

2016 Results for Medicare Shared Savings ACOs
• 44% of ACOs (191/432) increased Medicare spending
• Only 31% (134/432) received shared savings payments
• After making shared savings payments, Medicare spent more than it saved
• Net loss to Medicare: $39 million
Private Shared Savings ACOs Have Also Been Floundering

Many private-payer ACOs fail to yield lower costs, better quality

By Bob Herman | October 15, 2015

CHICAGO—Medicare’s investment in accountable care organizations has inspired hospitals and doctors to create their own versions of ACOs with private insurers. But as with Medicare, not all private ACOs are achieving lower costs and higher quality.

Providers and insurers need to do a better job of reaching patients and employers, according to physician executives at four large health insurance companies. They gave their take on the private ACO movement at an event held by America’s Health Insurance Plans, the industry’s trade group.

Their experiences reflect that ACOs are still a new structure, and building a new payment and care model as complex as an ACO is not easy to roll out.

“Our alternative payment models are succeeding at a much lower rate than they should be,” said Dr. Stephen Ondra, chief medical officer at Health Care Service Corp., the Blue Cross and Blue Shield insurer for five states. “In the ACO, the consumer engagement is very, very low.”
Why Aren’t ACOs Succeeding?

ACO

PATIENTS
- Heart Disease
- Cancer
- Kidney Disease
- Pregnancy

Primary Care  Cardiology  Oncology  Nephrology  OB/GYN
No Change in the Way Physicians or Hospitals Are Paid

MEDICARE/HEALTH PLAN

PATIENTS
- Heart Disease
- Cancer
- Kidney Disease
- Pregnancy

Fee-for-Service Payment

ACO

Primary Care, Cardiology, Oncology, Nephrology, OB/GYN
ACOs Try to “Coordinate Care” Without Fixing Payment Barriers

MEDICARE/HEALTH PLAN

ACO

Fee-for-Service Payment

Expensive IT Systems
Care Coordinators

PATIENTS
Heart Disease
Cancer
Kidney Disease
Pregnancy

Primary Care
Cardiology
Oncology
Nephrology
OB/GYN
Possibility of Future Bonuses Doesn’t Overcome Current Barriers

MEDICARE/HEALTH PLAN

Shared Savings Payment??

ACO

Expensive IT Systems

Care Coordinators

Part of Shared Savings??

PATIENTS

Heart Disease
Cancer
Kidney Disease
Pregnancy

Fee-for-Service Payment

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

Primary Care
Cardiology
Oncology
Nephrology
OB/GYN
Creating More “Risk” Doesn’t Remove the Barriers in FFS

MEDICARE

More Downside Risk

Fee-for-Service Payment

ACO

Expensive IT Systems

Care Coordinators

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

PATIENTS

Heart Disease
Cancer
Kidney Disease
Pregnancy

Primary Care
Cardiology
Oncology
Nephrology
OB/GYN

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Big ACOs = Higher Prices for Commercial Insurance

**Hospital Productivity**

**By Lawrence C. Baker, M. Kate Bundorf, and Daniel P. Kessler**

**Vertical Integration: Hospital Ownership Of Physician Practices Is Associated With Higher Prices And Spending**

**Abstract** We examined the consequences of contractual or ownership relationships between hospitals and physician practices, often described as vertical integration. Such integration can reduce health spending and increase the quality of care by improving communication across care settings, but it can also increase providers’ market power and facilitate the payment of what are effectively kickbacks for inappropriate referrals. We investigated the impact of vertical integration on hospital prices, volumes (admissions), and spending for privately insured patients. Using hospital claims from Truven Analytics MarketScan for the nonelderly privately insured in the period 2001–07, we constructed county-level indices of prices, volumes, and spending and adjusted them for enrollees’ age and sex. We measured hospital-physician integration using information from the American Hospital Association on the types of relationships hospitals have with physicians. We found that an increase in the market share of hospitals with the tightest vertically integrated relationship with physicians—ownership of physician practices—was associated with higher hospital prices and spending. We found that an increase in contractual integration reduced the frequency of hospital admissions, but this effect was relatively small. Taken together, our results provide a mixed, although somewhat negative, picture of vertical integration from the perspective of the privately insured.

**Conclusions and Relevance** Financial integration between physicians and hospitals has been associated with higher commercial prices and spending for outpatient care.

**Total Expenditures per Patient in Hospital-Owned and Physician-Owned Physician Organizations in California**

**By James C. Robinson, PhD, MPH; Kelly Miller, DA**

**Conclusions and Relevance** From the perspective of the insurers and patients, between 2009 and 2012, hospital-owned physician organizations in California incurred higher expenditures for commercial HMO enrollees for professional, hospital, laboratory, pharmaceutical, and ancillary services than physician-owned organizations. Although organizational consolidation may increase some forms of care coordination, it may be associated with higher total expenditures.
What’s Behind Door #3?

1. PAY FOR PERFORMANCE (MIPS)

2. ALTERNATIVE PAYMENT MODELS (APMs)

MACRA

DOOR #3
Value-Based Payment Is Being Designed the \textit{Wrong} Way Today
Value-Based Payment Is Being Designed the *Wrong* Way Today

**TOP-DOWN PAYMENT REFORM**

Medicare and Health Plans Define Payment Systems
Value-Based Payment Is Being Designed the *Wrong* Way Today

**TOP-DOWN PAYMENT REFORM**

- Medicare and Health Plans Define Payment Systems
- Physicians and Hospitals Have To Change Care to Align With Payment Systems
Value-Based Payment Is Being Designed the \textit{Wrong} Way Today

**TOP-DOWN PAYMENT REFORM**

Medicare and Health Plans Define Payment Systems

Physicians and Hospitals Have To Change Care to Align With Payment Systems

Patients Get Worse Care and Providers Close/Consolidate
Is There a Better Way?

TOP-DOWN PAYMENT REFORM

Medicare and Health Plans Define Payment Systems

Physicians and Hospitals Have To Change Care to Align With Payment Systems

Patients Get Worse Care and Providers Close/Consolidate
Start By Identifying Ways to Improve Care & Reduce Costs…

TOP-DOWN PAYMENT REFORM

Medicare and Health Plans Define Payment Systems

Physicians and Hospitals Have To Change Care to Align With Payment Systems

Patients Get Worse Care and Providers Close/Consolidate

BOTTOM-UP PAYMENT REFORM

Ask Physicians to Identify Ways to Improve Care for Patients and Eliminate Avoidable Costs
…Pay Adequately & Expect Accountability for Outcomes…

TOP-DOWN PAYMENT REFORM

Medicare and Health Plans Define Payment Systems

Physicians and Hospitals Have To Change Care to Align With Payment Systems

Patients Get Worse Care and Providers Close/Consolidate

BOTTOM-UP PAYMENT REFORM

Payers Provide Adequate Payment for Quality Care & Providers Take Accountability for Quality & Efficiency

Ask Physicians to Identify Ways to Improve Care for Patients and Eliminate Avoidable Costs
…So the Result is Better, More Affordable Patient Care

TOP-DOWN PAYMENT REFORM

Medicare and Health Plans Define Payment Systems

Physicians and Hospitals Have To Change Care to Align With Payment Systems

Patients Get Worse Care and Providers Close/Consolidate

BOTTOM-UP PAYMENT REFORM

Patients Get Good Care at an Affordable Cost and Independent Providers Remain Financially Viable

Payers Provide Adequate Payment for Quality Care & Providers Take Accountability for Quality & Efficiency

Ask Physicians to Identify Ways to Improve Care for Patients and Eliminate Avoidable Costs

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The Third Door Under MACRA

#1 PAY FOR PERFORMANCE (MIPS)

#2 PAYER-DESIGNED ALTERNATIVE PAYMENT MODELS

#3 PHYSICIAN-FOCUSED PAYMENT MODELS
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.
What Happens When *Physicians* Design Care Delivery and Payment?
Better Care at Lower Cost for Crohn’s Disease

PHYSICIAN LEADER: Lawrence R. Kosinski, MD
Managing Partner, Illinois Gastroenterology Group
**Better Care at Lower Cost for Crohn’s Disease**

**PHYSICIAN LEADER:** Lawrence R. Kosinski, MD  
Managing Partner, Illinois Gastroenterology Group

### OPPORTUNITIES TO IMPROVE CARE AND LOWER COSTS

- Health plan spends $11,000/year/patient on patients with Crohn’s
- >50% of expenses are for hospital care, most due to complications
- <33% of patients seen by physician in 30 days prior to hospitalization
- 10% of expenses for biologics, many administered in hospitals
- 3.5% of spending goes to gastroenterologists
**Better Care at Lower Cost for Crohn’s Disease**

**PHYSICIAN LEADER:** Lawrence R. Kosinski, MD  
Managing Partner, Illinois Gastroenterology Group

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<th>BARRIERS IN THE CURRENT PAYMENT SYSTEM</th>
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• 10% of expenses for biologics, many administered in hospitals  
• 3.5% of spending goes to gastroenterologists | • No payment to support “medical home” services in gastroenterology practice:  
➢ No payment for nurse care manager  
➢ No payment for clinical decision support tools to ensure evidence-based care  
➢ No payment for proactive telephone contact with patients |
## Better Care at Lower Cost for Crohn’s Disease

**PHYSICIAN LEADER:** Lawrence R. Kosinski, MD  
Managing Partner, Illinois Gastroenterology Group

<table>
<thead>
<tr>
<th>OPPORTUNITIES TO IMPROVE CARE AND LOWER COSTS</th>
<th>BARRIERS IN THE CURRENT PAYMENT SYSTEM</th>
<th>RESULTS WITH ADEQUATE PAYMENT FOR BETTER CARE</th>
</tr>
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| • Health plan spends $11,000/year/patient on patients with Crohn’s | • No payment to support “medical home” services in gastroenterology practice:  
  ➢ No payment for nurse care manager  
  ➢ No payment for clinical decision support tools to ensure evidence-based care  
  ➢ No payment for proactive telephone contact with patients | • Hospitalization rate cut by more than 50%  
• Total spending reduced by 10% even with higher payments to the physician practice  
• Improved patient satisfaction due to fewer complications and lower out-of-pocket costs |
| • >50% of expenses are for hospital care, most due to complications | | |
| • <33% of patients seen by physician in 30 days prior to hospitalization | | |
| • 10% of expenses for biologics, many administered in hospitals | | |
| • 3.5% of spending goes to gastroenterologists | | |

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Better Care at Lower Cost for Cancer

PHYSICIAN LEADER: Barbara McAneny, MD
CEO, New Mexico Cancer Center
Better Care at Lower Cost for Cancer

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CEO, New Mexico Cancer Center

OPPORTUNITIES TO IMPROVE CARE AND LOWER COSTS

• 40-50% of patients receiving chemotherapy are hospitalized for complications of treatment
Better Care at Lower Cost for Cancer

**PHYSICIAN LEADER:** Barbara McAneny, MD  
CEO, New Mexico Cancer Center

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<thead>
<tr>
<th>OPPORTUNITIES TO IMPROVE CARE AND LOWER COSTS</th>
<th>BARRIERS IN THE CURRENT PAYMENT SYSTEM</th>
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<td>• 40-50% of patients receiving chemotherapy are hospitalized for complications of treatment</td>
<td>• No payment for triage services to enable rapid response to patient complications</td>
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<td></td>
<td>• No payment for patient and family education about complications and how to respond</td>
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Better Care at Lower Cost for Cancer

**OPPORTUNITIES TO IMPROVE CARE AND LOWER COSTS**

- 40-50% of patients receiving chemotherapy are hospitalized for complications of treatment

**BARRIERS IN THE CURRENT PAYMENT SYSTEM**

- No payment for triage services to enable rapid response to patient complications
- No payment for patient and family education about complications and how to respond
- Inadequate payment to reserve capacity for IV hydration of patients experiencing problems

**RESULTS WITH ADEQUATE PAYMENT FOR BETTER CARE**

- 36% fewer ED visits
- 43% fewer admissions
- 22% reduction in total cost of care ($4,784 over six months)

**PHYSICIAN LEADER:** Barbara McAneny, MD  
CEO, New Mexico Cancer Center
How Do You Define a *Physician-Focused* Alternative Payment Model?
Step 1: Identify Opportunities to Reduce Related Spending

Fee-for-Service Payment (FFS)

Avoidable Spending

Payments to Other Providers for Related Services

FFS Payments to Physician Practice

OPPORTUNITIES TO REDUCE SPENDING THAT PHYSICIANS CAN CONTROL

- Reduce Avoidable Hospital Admissions
- Reduce Unnecessary Tests and Treatments
- Use Lower-Cost Tests and Treatments
- Deliver Services More Efficiently
- Use Lower-Cost Sites of Service
- Reduce Preventable Complications
- Prevent Serious Conditions From Occurring
Step 2: Identify Barriers in Current Payments That Need to Be Fixed

BARRIERS IN CURRENT FFS SYSTEM
- No Payment for Many High-Value Services
- Insufficient Revenue to Cover Costs When Using Fewer or Lower-Cost Services

OPPORTUNITIES TO REDUCE SPENDING THAT PHYSICIANS CAN CONTROL
- Reduce Avoidable Hospital Admissions
- Reduce Unnecessary Tests and Treatments
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- Prevent Serious Conditions From Occurring
Step 3: Design an APM That Removes the Payment Barriers

Fee-for-Service Payment (FFS)

- Payments to Other Providers for Related Services
- FFS Payments to Physician Practice
- Unpaid Services & Losses

Physician-Focused Alternative Payment Model

- Flexible, Adequate Payment for Physician’s Services

Avoidable Spending

Total Spending Relevant to the Physician’s Services

$
Step 3: Design an APM That Removes the Payment Barriers

Fee-for-Service Payment (FFS)

- **$\text{Avoidable Spending}$**
  - Payments to Other Providers for Related Services
  - FFS Payments to Physician Practice
  - Unpaid Services & Losses

Physician-Focused Alternative Payment Model

- Paying more for time needed for adequate diagnosis and treatment planning, particularly for complex patients
- Paying for time spent on phone calls & emails with patients & other physicians
- Paying for nurses to help patients with self-management
- Avoiding losses from delivering fewer procedures or lower-cost procedures

Flexible, Adequate Payment for Physician’s Services

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Step 4: Include Provisions to Assure Control of Cost & Quality

Fee-for-Service Payment (FFS)

| Payments to Other Providers for Related Services |

Physician-Focused Alternative Payment Model

| Payments to Other Providers for Related Services |

Avoidable Spending

Flexible, Adequate Payment for Physician’s Services

Savings

Unpaid Services & Losses

Total Spending Relevant to the Physician’s Services

Physician Practice Revenue

Accountability for Controlling Avoidable Spending

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Accountability Must Be Focused on What Each Physician Can Influence

- **Spending the Physician Cannot Control**
  - e.g., PCPs can’t reduce surgical site infections
  - e.g., surgeons can’t prevent diabetic foot ulcers
  - e.g., nephrologists can’t prevent kidney disease

- **Other Spending the Physician Can Control or Influence**
  - e.g., PCPs can help diabetics avoid amputations
  - e.g., surgeons can reduce surgical site infections
  - e.g., nephrologists can reduce the complications of kidney disease and its treatment

- **Payments to the Physician**
“Alternative Payment Models” Can Be Win-Win-Wins

- **Fee-for-Service Payment (FFS)**
  - Payments to Other Providers for Related Services
  - FFS Payments to Physician Practice
  - Unpaid Services & Losses

- **Physician-Focused Alternative Payment Model**
  - Avoidable Spending
  - Payments to Other Providers for Related Services
  - Flexible, Adequate Payment for Physician’s Services

**Win for Payer:** Lower Total Spending
**Win for Patient:** Better Care Without Unnecessary Services
**Win for Physician:** Adequate Payment for High-Value Services

Total Spending Relevant to the Physician’s Services

Physician Practice Revenue

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How Could This Work for Nephrologists?
CMS Focus Has Been on ESRD Because of High Spending/Patient

Medicare Spending Per Patient Per Year (2014)

- **Stage 3**: $20,000
- **Stages 4-5**: $30,000
- **ESRD-Dialysis**: $90,000

Source: USRDS
But There Are Far More *Patients* With Stages 3-5 CKD Than ESRD

Source: USRDS
Total Medicare Spending on CKD Is Higher Than on ESRD Patients

Source: USRDS
How Can Nephrologists Improve Care for All CKD/ESRD Patients?

Medicare Spending Per Patient Per Year

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<th>Spending Per Patient Per Year</th>
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</table>
#1: Improve Care/Reduce Costs for ESRD Patients

- Reduce catheter-related infections
- Increase use of home dialysis
- Avoid ED visits & admissions
- Increase use of transplants
- Transition end-of-life patients to hospice sooner

Medicare Spending Per Patient Per Year

- Stage 3
- Stages 4-5
- ESRD-Dialysis
#2: Improve Care/Reduce Costs for CKD Patients, Too

- Avoid ED visits & admissions
- Avoid overuse of ESAs
- Reduce unnecessary testing & medications

Medicare Spending Per Patient Per Year

- Stage 3
- Stages 4-5
- ESRD-Dialysis
#3: Improve Care/Reduce Costs By Avoiding Need for Dialysis

- Slow progression to ESRD
- Increase transplants before dialysis
- Avoid first dialysis in hospital

Medicare Spending Per Patient Per Year

- Stage 3
- Stages 4-5
- ESRD-Dialysis
Example: Slowing the Progression of Chronic Kidney Disease

Nephrologist Treating 50 Stage 4 CKD Patients + 50 ESRD Patients
Example: Slowing the Progression of Chronic Kidney Disease

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Nephrologist Treating 50 Stage 4 CKD Patients + 50 ESRD Patients

- Nephrologist paid only for periodic office visits with Stage 4 Patients (6 visits @ $109/visit =$650 per year)
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Nephrologist Treating 50 Stage 4 CKD Patients + 50 ESRD Patients

- Nephrologist paid only for periodic office visits with Stage 4 Patients (6 visits @ $109/visit = $650 per year)
- Nephrologist receives $287/month dialysis capitation = $3,445 per year
## Example: Slowing the Progression of Chronic Kidney Disease

A nephrologist is treating 50 Stage 4 CKD patients and 50 ESRD patients. Here is the breakdown of payments:

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### Other Spending

- **Stage 4 Patients**: $28,000, 50 patients = $1,400,000

### Nephrologist Treating 50 Stage 4 CKD Patients + 50 ESRD Patients

- **Nephrologist paid only for periodic office visits with Stage 4 Patients** (6 visits @ $109/visit = $650 per year)
- **Nephrologist receives $287/month dialysis capitation = $3,445 per year**
- **Average other spending on Stage 4 Patients = $28,000/pt**
Example: Slowing the Progression of Chronic Kidney Disease

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**Nephrologist Treating 50 Stage 4 CKD Patients + 50 ESRD Patients**

- Nephrologist paid only for periodic office visits with Stage 4 Patients (6 visits @ $109/visit = $650 per year)
- Nephrologist receives $287/month dialysis capitation = $3,445 per year
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| Total Spending | $58,548 | 100 | $5,854,750 |

Nephrologist Treating 50 Stage 4 CKD Patients + 50 ESRD Patients

- Nephrologist paid only for periodic office visits with Stage 4 Patients (6 visits @ $109/visit = $650 per year)
- Nephrologist receives $287/month dialysis capitation = $3,445 per year
- Average other spending on Stage 4 Patients = $28,000/pt
- Average other spending on ESRD Patients = $85,000/pt
- No payment for non-face-to-face services or case mgmt by nephrologist to improve CKD management
Most of the Money Isn’t Going to the Nephrologist

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| Other Spending          |      |       |         |
| Stage 4 Patients        | $28,000 | 50 | $1,400,000 |
| ESRD Patients           | $85,000 | 50 | $4,250,000 |
| Total Other             |      | 100   | $5,650,000 |

**Total Spending** $58,548 100 $5,854,750

Physician Payments = 3.2% of Total Spending
## What if the Nephrologist Could Slow Progression to ESRD?

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Today, Revenue for Stage 4 CKD Patients Would Increase…

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Total Spending        | $58,548 | 100  | $5,854,750 |   |     |
But Revenue for ESRD Patients Would Decrease…

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| Other Spending    |      |       |         |      |       |         |     |
| Stage 4 Patients  | $28,000 | 50 | $1,400,000 |      |       |         |     |
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| Total Other       |      | 100  | $5,650,000 |      |       |         |     |

| Total Spending    | $58,548 | 100 | $5,854,750 |      |       |         |     |
...So the Nephrology Practice Would Lose Money Overall...

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| Total Spending             | $58,548    | 100        | $5,854,750 |
…Even Though Medicare Would Save Money on Total Cost of Care

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Win for Patient, Win for Payer, Loss for Physician

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# APM Solution: Pay the Nephrologist to Support Improved Care…

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| Other Spending          |      |       |         |      |       |         |
| Stage 4 Patients        | $28,000| 50    | $1,400,000|      |       |         |      |
| ESRD Patients           | $85,000| 50    | $4,250,000|      |       |         |      |
| Total Other             |       | 100   | $5,650,000|      |       |         |      |

| Total Spending          | $58,548| 100   | $5,854,750|      |       |         |

Pay $50 per month to the Nephrologist for each Stage 4 CKD Patient in addition to E/M payments (or pay $100/month instead of E/M payment)
…the APM *Increases* Total Nephrologist Revenue…

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| Total Spending | $58,548 100 $5,854,750 |                           |     |
...The High Spending on ESRD Care is Reduced...

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| **Other Spending**   |      |      |         |      |      |         |     |
| Stage 4 Patients     | $28,000 | 50    | $1,400,000 | $28,000 | 55    | $1,540,000 | +10%|
| ESRD Patients        | $85,000 | 50    | $4,250,000 | $85,000 | 45    | $3,825,000 | -10%|
| Total Other          | $85,000 | 50    | $4,250,000 | $85,000 | 45    | $3,825,000 | -10%|

**Total Spending** | $58,548 | 100    | $5,854,750 |      |      |         |     |
…So Medicare Still Saves Money

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Win-Win-Win for Patients, Physician, and Payer

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Win for Patients
Win for Nephrologist
Win for Payer
## If Higher Payments & Nurse Support

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<tr>
<td>Nurse Care Mgr</td>
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| Other Spending                |                         |                           |     |
| Stage 4 Patients              | $28,000 50 $1,400,000   |                           |     |
| ESRD Patients                 | $85,000 50 $4,250,000    |                           |     |
| Total Other                   | 100 $5,650,000           |                           |     |

| Total Spending                | $58,548 100 $5,854,750   |                           |     |
If Higher Payments & Nurse Support Could Reduce Avoidable Admits…

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| **Other Spending**            |      |       |         |      |       |         |      |
| Stage 4 Patients             | $28,000 | 50   | $1,400,000| $26,600  | 55   | $1,463,000| +4%  |
| ESRD Patients                | $85,000 | 50   | $4,250,000| $80,750  | 45   | $3,633,750| -15% |
| Total Other                   | 100  |       | $5,650,000| -5%     | 100  | $5,096,750| -10% |

**Total Spending**            | $58,548 | 100 | $5,854,750 |
## Bigger Win-Win-Win for Patients, Physician, and Payer

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### Other Spending

|                      |      |      |         |      |      |         |      |
|----------------------|      |      |         |      |      |         |      |
| Stage 4 Patients     | $28,000 | 50 | $1,400,000 | $26,600 | 55 | $1,463,000 | +4%  |
| ESRD Patients        | $85,000 | 50 | $4,250,000 | $80,750 | 45 | $3,633,750 | -15% |
| Total Other          |      | 100   | $5,650,000 |      | 100   | $5,096,750 | -10% |

### Total Spending

|                      |      |      |         |      |      |         |      |
|----------------------|      |      |         |      |      |         |      |
| Total Spending       | $58,548 | 100 | $5,854,750 | $54,255 | 100 | $5,425,500 | -7%  |

© Center for Healthcare Quality and Payment Reform  www.CHQPR.org
Condition-Based Payment Instead of Procedure-Based FFS

APM #2: CONDITION-BASED PAYMENT FOR A PHYSICIAN’S SERVICES

Goal of the APM:
Give physicians the flexibility to use the most appropriate diagnostic or treatment option for a patient’s condition without excluding the operating margins of the physician’s practice, including diagnosis or treatment options not supported through the current payment system.

Components of the APM:
1. Payment Based on the Patient’s Health Condition Rather Than Services Delivered: The physician practice can bill and be paid for treating or managing the care of patients with a specific health condition (or combination of conditions), rather than having payment tied to the delivery of specific services or treatments. The physician practice has the flexibility to use the payment to support both services that are currently billable as well as new services that are not currently billable. The bundle could be defined to include services delivered on a single day or over a longer period of time, such as a month.

2. Condition-Based Payment Replaces Some Current Fee-for-Service Payments to the Physician Practice: For patients who have the relevant health condition, the physician practice would bill the payer for the condition-based payment. The physician practice would have the flexibility to use the payments for whatever combination of services were most effective for the patient, such as office visits, phone calls, lab tests, home visits, etc.

3. Monthly Payments would be higher for patients with more chronic conditions or severe chronic conditions, since the patients would be expected to need more contacts with physicians or practice staff.

4. Measurement of Appropriateness/Outcomes: In order to ensure that patients continue to receive the most appropriate services through the Condition-Based Payment, the physician practice would either agree to document the application of appropriate use criteria (if such criteria exist) or to measure quality or outcomes for treatment of the patient’s condition and compare the quality/outcome measures to benchmarks.

5. Adjustment of Payment Amounts Based on Performance: The payment amounts for the condition-based codes would be reduced if the physicians in the practice failed to apply appropriate use criteria or if the quality/outcome measures were significantly below benchmark levels.

6. Updating Payments Over Time: The Condition-Based Payment amounts would be updated each year based on inflation, and the payment amounts would be adjusted to meet the costs of delivering Medicare services in the United States. The condition-based payment in Medicare would be available to patients under 65, but would be available to patients who are enrolled in Medicare, including those who are eligible for Medicare due to disability or end-stage renal disease.

Benefits of the APM:
- The payer would benefit because the flexibility under the Condition-Based Payment would allow the physician practice to deliver different types of care to the patient, which may be more effective or less expensive.
- The payer would benefit because the new condition-based payments would pay for the appropriate care, rather than paying for the services that are not appropriate or necessary.
- The practice would benefit by offering the flexibility to deliver the most appropriate services to patients without concern about which service will generate more revenue for the practice.

Examples:
- **Monthly Payments for Chronic Disease Management:** Under this APM, a primary care practice or specialty practice that is managing a patient with a chronic disease such as asthma, COPD, diabetes, heart failure, or inflammatory bowel disease (or a combination of such conditions) would bill for a single payment amount each month. The practice would no longer bill for evaluation and management payments for these patients. The practice would continue to bill for E&M services for patients with chronic diseases and it could continue to bill for any individual procedures performed on all patients, including chronic disease patients.
- **Monthly Payments for Chemotherapy Treatment:** Under this APM, a medical oncology practice would bill for a single payment amount each month that a patient is undergoing chemotherapy. The monthly payment would include all services and payments for about 50 different CPT codes describing different types of radiographic and diagnostic tests.

Difference from Other Payment Models:
In contrast to typical pay-for-performance programs and shared savings programs, the physician practice would have the flexibility to deliver new types of services and different combinations of services rather than being limited to what is billed under the current fee-for-service payment system.

© American Medical Association and Center for Healthcare Quality and Payment Reform
Should Doctors Fear the Risks of Alternative Payment Models?

**Risks Under Payment Reform**

- Will the additional payment or bundled payment be adequate to cover the services patients need?
- Will the physician be able to reduce the avoidable spending?
- Will risk adjustment be adequate to control for differences in need?
- How will you ensure other providers involved in the care of patients perform their roles effectively?
- 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

### Risks Under FFS
- Will fee levels from payers be adequate to cover the costs of delivering services?
- What utilization controls will payers impose on your services?
- What “value-based” reductions will be made in your payments based on “efficiency” measures?
- What “value-based” reductions will be made in your fees based on quality measures?
- Will you have enough patients to cover your practice expenses?

### Risks Under Payment Reform
- Will the additional payment or bundled payment be adequate to cover the services patients need?
- Will the physician be able to reduce the avoidable spending?
- Will risk adjustment be adequate to control for differences in need?
- How will you ensure other providers involved in the care of patients perform their roles effectively?
- Will you have enough patients to cover the costs of managing the new payment?
Protections For Physicians Against Taking Inappropriate Risk

• **Risk Stratification:** The payment rates would vary 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 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 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 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.
Which Physician Would YOU Want to Care for You?

• Physician A is paid Fee for Service
  She makes less money if she keeps you healthy

• Physician B gets “Pay for Performance”
  She makes more money if she keeps her EHR up to date

• Physician C gets Shared Savings
  She makes more money if you get less treatment than needed

• Physician D gets a Population-Based Payment (Capitation)
  She gets paid whether she does anything for you or not

• Physician E is paid through Condition-Based Payment
  She’s paid adequately to address your needs, and
  she makes more money if your health condition(s) improve
A Tradition of Leadership from Nephrologists for Patient Care

Death From Chronic Kidney Disease 1960-2017

Life Through Long-Term Dialysis

Christopher R. Blagg
Continuing Nephrology Leadership Needed for Even Better Outcomes

Death From Chronic Kidney Disease

Life Through Long-Term Dialysis

Life With CKD But Without Dialysis

1960-2017

2018-Future

Christopher R. Blagg
Three Paths to the Future: Which Will Nephrologists Choose?

1. PAY FOR PERFORMANCE (MIPS)
2. PAYER-DESIGNED ALTERNATIVE PAYMENT MODELS
3. PHYSICIAN-FOCUSED, PATIENT-CENTERED PAYMENT MODELS
If You Don’t Like Doors 1 & 2, What Should You Do?
If You Don’t Like Doors 1 & 2, What Should You Do?

1. Listen to PowerPoint presentations at Kidney Week, go back home, continue business as usual, and hope somebody else figures this out
If You Don’t Like Doors 1 & 2, What Should You Do?

1. Listen to PowerPoint presentations at Kidney Week, go back home, continue business as usual, and hope somebody else figures this out

2. Plan to retire before 2019
If You Don’t Like Doors 1 & 2, What Should You Do?

1. Listen to PowerPoint presentations at Kidney Week, go back home, continue business as usual, and hope somebody else figures this out

2. Plan to retire before 2019

3. Design/implement physician-led APMs
   - Look at your own patient population and identify opportunities to improve care and reduce spending
   - Work with other nephrologists and physicians in other specialties to develop patient-centered alternative payment models with win-win-wins for patients, payers, & physicians
   - Demand that health plans and Medicare implement good alternative payment models to enable you to deliver more affordable, high-quality care for the patients you treat
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