CREATING A PATIENT-CENTERED PAYMENT SYSTEM
Better Care for Patients, Lower Healthcare Spending, & Financially Viable Physician Practices & Hospitals

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

www.CHQPR.org
A Brief Quiz about Value-Based Payment
#1: What bonus will a Track 1 ACO receive if 100% of attributed beneficiaries receive ALL recommended preventive care?

- 5% of total spending
- 2% of total spending
- $100 per beneficiary
- $0
A Brief Quiz about Value-Based Payment

#1: What bonus will a Track 1 ACO receive if 100% of attributed beneficiaries receive ALL recommended preventive care?

- 5% of total spending
- 2% of total spending
- $100 per beneficiary
- $0

Answer: $0

There are no bonuses for ACOs based on quality. ACOs only receive bonus payments if they reduce Medicare spending.
A Brief Quiz about Value-Based Payment

#2: What **penalty** will be imposed on a two-sided risk ACO if 1/3 of its diabetic patients have blood sugar levels worse than the maximum recommended level (HbA1c >9%)?

- Loss of 10% of shared savings
- Loss of 2% of shared savings
- Repay CMS $95 per diabetic beneficiary
- $0
A Brief Quiz about Value-Based Payment

#2: What **penalty** will be imposed on a two-sided risk ACO if 1/3 of its diabetic patients have blood sugar levels worse than the maximum recommended level (HbA1c >9%)?

- Loss of 10% of shared savings
- Loss of 2% of shared savings
- Repay CMS $95 per diabetic beneficiary
- $0

**Answer:** $0

An ACO can receive a perfect score on quality and receive 100% of earned shared savings even if 40% of patients with diabetes have HbA1c levels >9%.
A Brief Quiz about Value-Based Payment

#3: If oncologists fail to deliver evidence-based treatment to patients who have lung cancer, which Alternative Payment Model would impose the biggest financial penalty?

- Track 1 (Upside-only) MSSP ACOs
- Track 2-3 (Two-sided risk) MSSP ACOs
- Next Generation ACO
- Oncology Care Model (OCM)
A Brief Quiz about Value-Based Payment

#3: If oncologists fail to deliver evidence-based treatment to patients who have lung cancer, which Alternative Payment Model would impose the biggest financial penalty?

- Track 1 (Upside-only) MSSP ACOs
- Track 2-3 (Two-sided risk) MSSP ACOs
- Next Generation ACO
- Oncology Care Model (OCM)

Answer: There are no penalties in OCM or in any of the ACO programs for failing to deliver recommended treatments to lung cancer patients.

In all of the programs, the ACO or oncologists could receive a financial bonus for using cheaper drugs to treat lung cancer, even if the drugs aren’t effective.
A Brief Quiz about Value-Based Payment

#4: Which of these would create more savings in private health insurance plans?

- 5% reduction in hospital prices
- 15% reduction in prescription drug prices
- 20% reduction in health plan administrative overhead
A Brief Quiz about Value-Based Payment

#4: Which of these would create more savings in private health insurance plans?

- 5% reduction in hospital prices
- 15% reduction in prescription drug prices
- 20% reduction in health plan administrative overhead

Answer: 20% reduction in health plan admin. costs/profits.

In 2016, private health insurance plans spent:

- $427 billion on hospital services
- $287 billion on physician & clinical services
- $143 billion on prescription drugs
- $130 billion on administration and profit

Private insurance plans spend almost as much on administration and profits as on prescription drugs.
Hospital Spending & Health Plan Admin/Profits Are Biggest $ Drivers
After Years of “Value-Based” P4P, Quality Has NOT Improved

25-50% of Diabetics Do Not Have Their Blood Sugar Controlled

Source:
NCQA: The State of Health Care Quality 2016

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It’s Costing Everybody a Lot of Money With No Apparent Benefit

PHYSICIANS


DATAWATCH

US Physician Practices Spend More Than $15.4 Billion Annually To Report Quality Measures

Each year US physician practices in four common specialties spend, on average, 785 hours per physician and more than $15.4 billion dealing with the reporting of quality measures. While much is to be gained from quality measurement, the current system is unnecessarily costly, and greater effort is needed to standardize measures and make them easier to report.
Costs Clearly Aren’t Being Controlled

Growth in Family Insurance Premiums, Annual Earnings, and Inflation

Source: Medical Expenditure Panel Survey & Bureau of Labor Statistics
P4P Has Been Studied to Death &…

**Annals of Internal Medicine**

The Effects of Pay-for-Performance Programs on Health, Health Care Use, and Processes of Care

A Systematic Review

Aaron Mendelson, BA; Karli Kondo, PhD; Cheryl Damberg, PhD; Allison Low, BA; Makalapua Motuapuaka, BA; Michele Freeman, MPH; Maya O’Neil, PhD; Rose Relevo, MLIS, MS; and Devan Kansagara, MD, MCR

**Background:** The benefits of pay-for-performance (P4P) programs are uncertain.

**Purpose:** To update and expand a prior review examining the effects of P4P programs targeted at the physician, group, managerial, or institutional level on process-of-care and patient outcomes in ambulatory and inpatient settings.

**Data Sources:** PubMed from June 2007 to October 2016; MEDLINE, PsycINFO, CINAHL, Business Economics and Theory, Business Source Elite, Scopus, Faculty of 1000, and Gartner Research from June 2007 to February 2016.

**Study Selection:** Trials and observational studies in ambulatory and inpatient settings reporting process-of-care, health, or utilization outcomes.

**Data Extraction:** Two investigators extracted data, assessed study quality, and graded the strength of the evidence.

**Data Synthesis:** Among 69 studies, 58 were in ambulatory settings, 52 reported process-of-care outcomes, and 38 reported patient outcomes. Low-strength evidence suggested that P4P programs in ambulatory settings may improve process-of-care outcomes over the short term (2 to 3 years), whereas data on longer-term effects were limited. Many of the positive studies were conducted in the United Kingdom, where incentives were larger than in the United States. The largest improvements were seen in areas where baseline performance was poor. There was no consistent effect of P4P on intermediate health outcomes (low-strength evidence) and insufficient evidence to characterize any effect on patient health outcomes. In the hospital setting, there was low-strength evidence that P4P had little or no effect on patient health outcomes and a positive effect on reducing hospital readmissions.

**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.

For author affiliations, see end of text.  
This article was published at Annals.org on 10 January 2017.
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But Like a Zombie, P4P Keeps Coming Back

How Does MIPS Work?
You earn a payment adjustment based on evidence-based and practice-specific quality data. You show you provided high quality, efficient care supported by technology by sending in information in the following categories.

- Quality
- Improvement Activities
- Advancing Care Information
- Cost
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
How Different Are CMS APMs From MIPS and P4P?
Track 1 MSSP ACOs: Regular FFS + Shared Svgs P4P

- **P4P/MIPS**
- **Upside-Only ACOs**

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**FFS STD PHYSICIAN FEES**

**Bonus Payments for All Services Patients Receive**
“Two-Sided Risk” ACOs: Regular FFS + P4P on Spending

<table>
<thead>
<tr>
<th>P4P/MIPS</th>
<th>Upside-Only ACOs</th>
<th>2-Sided Risk ACOs</th>
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Bundled Payment Programs: Regular FFS + P4P on Spending

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<td>FFS</td>
<td>Standard payments for all services patients receive</td>
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<td>Standard physician fees</td>
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Oncology Care Model:
FFS + PMPM + Spending P4P

- **P4P/MIPS**
- **Upside-Only ACOs**
- **2-Sided Risk ACOs**
- **BPCI & CJR**
- **Oncology Care Model**

### BPCI & CJR
- **FFS STANDARD PAYMENTS FOR ALL SERVICES PATIENTS RECEIVE**
- **FFS STANDARD PAYMENTS FOR ALL SERVICES IN A HOSPITAL EPISODE**
- **FFS STANDARD PAYMENTS FOR ALL SERVICES DURING CHEMO FOR CANCER**

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- **FFS STANDARD PAYMENTS FOR ALL SERVICES IN A HOSPITAL EPISODE**
- **FFS STANDARD PAYMENTS FOR ALL SERVICES DURING CHEMO FOR CANCER**

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Only Comp. Primary Care Plus is Significantly Different from FFS

- **P4P/MIPS**
- **Only-ACOs**
- **2-Sided Risk ACOs**
- **BPCI & CJR**
- **Oncology Care Model**
- **Comp. Primary Care +**

$\$ 

**Bonus**

**PMPM**

**Bonus**

**PMPM**

**Bonus**

**PMPM**

**Bonus**

**FFS STANDARD PAYMENTS FOR ALL SERVICES PATIENTS RECEIVE**

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**FFS STANDARD PAYMENTS FOR ALL SERVICES IN A HOSPITAL EPISODE**

**FFS STANDARD PAYMENTS FOR ALL SERVICES PATIENTS RECEIVE DURING CHEMO FOR CANCER**

**FFS STANDARD PHYSICIAN FEES FOR PRIMARY CARE SERVICES**
Medicare’s Shared Savings ACO Program Isn’t Succeeding
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
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2014 Results for Medicare Shared Savings ACOs
• 45% of ACOs (152/333) increased Medicare spending
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2015 Results for Medicare Shared Savings ACOs
• 48% of ACOs (189/392) increased Medicare spending
• Only 30% (119/392) received shared savings payments
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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
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WILL MORE FINANCIAL RISK FOR ACOs RESULT IN MORE SAVINGS?
Downside Risk ACOs Spend More Than Upside Only ACOs

Actual Spending Per Beneficiary in 2016

<table>
<thead>
<tr>
<th>Track 1: Shared Savings (119 ACOs)</th>
<th>Track 2-3 (22 ACOs)</th>
<th>NextGen (18 ACOs)</th>
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<tbody>
<tr>
<td>$11,500</td>
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<td>$9,750</td>
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</table>
“Savings” is Because They Were Even More Expensive to Start
ACOs That “Increased Spending” Spent Less Than 2-Sided ACOs

**Actual Spending Per Beneficiary Compared to Benchmark in 2016**

**UPSIDE-ONLY ACOs**

- Track 1: Spending > Benchmark (186 ACOs)

**DOWNSIDE RISK ACOs**

- Track 2-3 (22 ACOs)
- NextGen (18 ACOs)

- Benchmark Per Beneficiary
- Actual Spending
How Exactly Did Any of the ACOs Reduce Spending???

The ACO Black Box

<table>
<thead>
<tr>
<th>BENCHMARK SPENDING</th>
<th>ACTUAL SPENDING</th>
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<tbody>
<tr>
<td></td>
<td>SAVINGS</td>
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</table>
Did They Reduce Spending on Undesirable/Unnecessary Svcs?

- Benchmark Spending
- Necessary Spending
- Avoidable Spending
- Savings
- Actual Spending

$
Or Did They Stint on Necessary Care to Produce Savings?

- Benchmark Spending
- Avoidable Spending
- Necessary Spending
- Actual Spending
- Savings
ACOs Didn’t Save Money By Improving Quality

% of Diabetic Patients with HbA1c Scores >9% (Higher % is Worse)

Source: CMS:
How Much Could an ACO Save By Stinting on Care?
A Small Number of Lung Cancer Cases Involve a Lot of Spending

Lung Cancer Incidence in 65+ Population: 300/100,000

= 30 Cases in a 10,000 Member ACO

>$1.5 Million for Chemo Alone

11 Different Chemotherapy/Immunotherapy Regimens
Ranging from $2,500 to $105,000 Depending on Patient Characteristics
Using Cheaper Treatments for 15 Patients = 1.2% Savings

Lung Cancer Incidence in 65+ Population: 300/100,000
= 30 Cases in a 10,000 Member ACO
>$1.5 Million for Chemo Alone

Average Cost: $52,000

Average Cost: $13,000

Reduction in Total ACO Spending: 1.2%
Financial Risk for Total Cost, But Not for Total Quality of Care

ACO Quality Measures

• Timely Care
• Provider Communication
• Rating of Provider
• Access to Specialists
• Health Promotion & Education
• Shared Decision-Making
• Health Status
• Readmissions
• COPD/Asthma Admissions
• Heart Failure Admissions
• Meaningful Use
• Fall Risk Screening
• Flu Vaccine
• Pneumonia Vaccine
• BMI Screening & Follow-Up
• Depression Screening
• Colon Cancer Screening
• Breast Cancer Screening
• Blood Pressure Screening
• HbA1c Poor Control
• Diabetic Eye Exam
• Blood Pressure Control
• Aspirin for Vascular Disease
• Beta Blockers for HF
• ACE/ARB Therapy
• SNF Readmissions
• Diabetes Admissions
• Multiple Condition Admissions
• Medication Documentation
• Depression Remission
• Statin Therapy

No Measures to Assure:

• Evidence-based treatment for cancer
• Effective management of cancer treatment side effects
• Evidence-based treatment for rheumatoid arthritis
• Evidence-based treatment of inflammatory bowel disease
• Rapid treatment and rehabilitation for stroke
• Effective management for joint pain and mobility
• Effective management of back pain and mobility
What Do Medicare, Health Plans, and Big Systems Recommend?

Alternative Payment Models
THE APM FRAMEWORK

CATEGORY 1
FEE FOR SERVICE - NO LINK TO QUALITY & VALUE

CATEGORY 2
FEE FOR SERVICE - LINK TO QUALITY & VALUE

CATEGORY 3
APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE

CATEGORY 4
POPULATION - BASED PAYMENT
#1: Keep Doing the Bad P4P & Shared Risk Models…
…Or #2: Implement “Population-Based Payment”
Why Wouldn’t a Health Plan Want to Give Its Risk to Someone Else?
Health Plan Collects Premiums…

HEALTH INSURANCE PLAN

HEALTH PLAN PREMIUM REVENUE
Takes Its Cut Off the Top & Uses the Rest for “Population Payment”

HEALTH INSURANCE PLAN

$ HEALTH PLAN PREMIUM REVENUE

$ HEALTH PLAN ADMIN. & PROFITS

“POPULATION BASED PAYMENT” (CAPITATION)
The ACO Then Has to Incur Admin. Costs to Manage Risk.

HEALTH INSURANCE PLAN

$ HEALTH PLAN PREMIUM REVENUE

HEALTH PLAN ADMIN. & PROFITS

“POPULATION BASED PAYMENT” (CAPITATION)

ACO ADMIN. COST

Funds Available for Services to Patients

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…And if the Patients Need More Services Than Funds Available…

**HEALTH INSURANCE PLAN**

- **Health Plan Premium Revenue**
- **Health Plan Admin. & Profits**

**“ACO”**

- **ACO Admin. Cost**
- **Funds Available for Services to Patients**

**PATIENTS**

- **Cost of Services Patients Need**
...Physicians are Forced to Figure Out Which Services to Withhold

HEALTH INSURANCE PLAN

$ HEALTH PLAN PREMIUM REVENUE

HEALTH PLAN ADMIN. & PROFITS

“POPULATION BASED PAYMENT” (CAPITATION)

“ACO”

ACO ADMIN. COST

Funds Available for Services to Patients

PATIENTS

SERVICE CUTS

SERVICES DELIVERED TO PATIENTS

COST OF SERVICES PATIENTS NEED

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...Physicians are Forced to Figure Out Which Services to Withhold

HEALTH INSURANCE PLAN

Health

“ACO”

Funds Available for Services to Patients

Services Delivered to Patients

Patients

Why do you need a health plan at all if the providers are going to take full risk?

HEALTH PLAN

Premium Revenue

ACO

IN. COST

Cost of Services Patients Need

$
Individual Physicians Can’t Control *Total* Spending

- 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., PCPs can’t control the cost of cancer treatment

- 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., PCPs can deliver cancer prevention screening

- Payments to the Physician

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Only 16% of Medicare Spending Goes to **Physician Fees**

**Medicare Spending Per Beneficiary, 2016**

- **Physician Fees**: 16%
- **Hospital Inpatient & Outpatient Services**: 48%
- **SNF/Rehab**: 11%
- **HH/Hospice**: 11%
- **Tests**: 5%
- **Drugs**: 4%
- **Other**: 11%
4% of Total Spending = Huge Risk for Average Physician

Medicare Spending Per Beneficiary, 2016

- Hospital Inpatient & Outpatient Services: 48%
- Physician Fees: 16%
- Other: 11%
- Drugs: 4%
- Tests: 5%
- HH/Hospice: 11%
- SNF/Rehab: 11%

4% of Total Medicare Spending

25% of Physician Revenues
We have seen in the Original CPC Model that shared savings under that model has certain limitations in motivating practices to control total cost of care. For example: (1) individual practice control over the likelihood of a shared savings payment is attenuated because spending is aggregated at the regional level: (2) total cost of care may be challenging for small primary care practices to control and there are no independent incentives for improved quality; and (3) the amount of any shared savings payments is unknown in advance and the complexity of the regionally aggregated formula and paucity of actionable cost data leaves practices doubtful of achieving any return.

CMS FAQ on CPC+
<5% of Spending During Chemo Goes to Physician Fees

Medicare Spending on Colorectal Cancer Patients During 6 Months Following Initiation of Chemo, 2014

- Chemotherapy: 41%
- Hospital Inpatient Care: 27%
- Other: 12%
  - Lab/Imaging: 5%
  - SNF/HH: 7%
  - Radiation: 4%
- Oncologist Fees: 3%

FFS Payments
Risk for 4% of Total Spending > 100% of Oncologists’ Fees

Medicare Spending on Colorectal Cancer Patients During 6 Months Following Initiation of Chemo, 2014

- Chemotherapy: 41%
- Hospital Inpatient Care: 27%
- Other: 12%
- Lab/Imaging: 5%
- SNF/HH: 7%
- Radiation: 4%

Oncologist Fees 3%

4% of Total Medicare Spending

136% of Physician Revenues
Most Counties Aren’t Big Enough to Create a Medicare ACO

Number of Counties by Number of Medicare FFS Beneficiaries, 2015

Minimum of 5,000 Medicare FFS Beneficiaries Needed to Form an ACO
Capitation Has Not Transformed Care Where It’s Being Used

**Sources:**
- NCQA: *The State of Health Care Quality 2016*
- Integrated Healthcare Association
- California Regional Health Care Cost & Quality Atlas

**Health Care Quality is No Better In California Than Rest of U.S.**

**Health Insurance Premiums in California Are Higher Than The U.S. Average**

**% of Diabetic Patients with HbA1c Scores >9%**
(Higher % is Worse)

- U.S. Commercial HMO
- California Commercial HMO

**Employer-Sponsored Family Insurance Premiums, 2015**

- U.S. Average
- California
Small Primary Care Physician Practices Have Low Rates Of Preventable Hospital Admissions

ABSTRACT Nearly two-thirds of US office-based physicians work in practices of fewer than seven physicians. It is often assumed that larger practices provide better care, although there is little evidence for or against this assumption. What is the relationship between practice size—and other practice characteristics, such as ownership or use of medical home processes—and the quality of care? We conducted a national survey of 1,045 primary care–based practices with nineteen or fewer physicians to determine practice characteristics. We used Medicare data to calculate practices’ rate of potentially preventable hospital admissions (ambulatory care–sensitive admissions). Compared to practices with 10–19 physicians, practices with 1–2 physicians had 33 percent fewer preventable admissions, and practices with 3–9 physicians had 27 percent fewer. Physician-owned practices had fewer preventable admissions than hospital-owned practices. In an era when health care reform appears to be driving physicians into larger organizations, it is important to measure the comparative performance of practices of all sizes, to learn more about how small practices provide patient care, and to learn more about the types of organizational structures—such as independent practice associations—that may make it possible for small practices to share resources that are useful for improving the quality of care.
Big Delivery Systems Raise Prices

Research

Original Investigation
Association of Financial Integration Between Physicians and Hospitals With Commercial Health Care Prices

Hannah T. Negishi, BA, Michael S. Chernew, PhD, Andrew L. Mills, MD, Toria Gideon, PhD, J. Michael McWilliams, MD, PhD

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

Research

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

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.

Hospital Productivity

By Laurence 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.
Patients Don’t See the Benefits of Big Systems and Capitation…

Medical Group Structural Integration May Not Ensure That Care Is Integrated, From The Patient’s Perspective

ABSTRACT Structural integration is increasing among medical groups, but whether these changes yield care that is more integrated remains unclear. We explored the relationships between structural integration characteristics of 144 medical groups and perceptions of integrated care among their patients. Patients’ perceptions were measured by a validated national survey of 3,067 Medicare beneficiaries with multiple chronic conditions across six domains that reflect knowledge and support of, and communication with, the patient. Medical groups’ structural characteristics were taken from the National Study of Physician Organizations and included practice size, specialty mix, technological capabilities, and care management processes. Patients’ survey responses were most favorable for the domain of test result communication and least favorable for the domain of provider support for medication and home health management. Medical groups’ characteristics were not consistently associated with patients’ perceptions of integrated care. However, compared to patients of primary care groups, patients of multispecialty groups had strong favorable perceptions of medical group staff knowledge of patients’ medical histories. Opportunities exist to improve patient care, but structural integration of medical groups might not be sufficient for delivering care that patients perceive as integrated.
…And They’re Voting (With Their Feet) For Other Options

Enrollment in Capitated Organizations in California, 2004-2014

38% Loss of Enrollment in Capitated Organizations
This is NOT a Good “Framework” for Fixing Healthcare Payment…
…And Following It Will Likely Make Things Worse, Not Better
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 *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 and Hospitals 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 and Hospitals 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 and Hospitals to Identify Ways to Improve Care for Patients and Eliminate Avoidable Costs

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The Right Focus: Spending That is *Unnecessary* or *Avoidable*
Avoidable Spending Occurs In All Aspects of Healthcare

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

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

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-expensive implants
- Infections and complications of surgery
- Overuse of inpatient rehabilitation
Many Ways to Reduce Tests & Services Without Harming Patients

American Society of Nephrology
American Academy of Allergy, Asthma & Immunology
American Society of Clinical Oncology
American Academy of Family Physicians
Choosing Wisely

Five Things Physicians and Patients Should Question

1. Don't do imaging for low back pain within the first six weeks, unless red flags are present.
2. Don't routinely prescribe antibiotics for acute mild-to-moderate sinusitis unless symptoms last for seven or more days, or symptoms worsen after initial clinical improvement.
3. Don't use dual-energy x-ray absorptiometry (DEXA) screening for osteoporosis in women younger than 65 or men younger than 70 with no risk factors.
4. Don't order annual electrocardiograms (EKGs) or any other cardiac screening for low-risk patients without symptoms.
5. Don't perform Pap smears on women younger than 21 or who have had a hysterectomy for non-cancer disease.

American College of Cardiology
American Association of Physicists in Medicine

Five Things Physicians and Patients Should Question

1. Don't perform stress cardiac imaging or advanced non-invasive imaging in the initial evaluation of patients without cardiac symptoms unless high-risk markers are present.
2. Don't perform annual stress cardiac imaging or advanced non-invasive imaging as part of routine follow-up in asymptomatic patients.
3. Don't perform stress cardiac imaging or advanced non-invasive imaging as a pre-operative assessment in patients scheduled to undergo low-risk non-cardiac surgery.
4. Don't perform echocardiography as routine follow-up for mild, asymptomatic native valve disease in adult patients with no change in signs or symptoms.
5. Don't perform stenting of non-culprit lesions during percutaneous coronary intervention (PCI) for uncomplicated hemodynamically stable ST-segment elevation myocardial infarction (STEMI).

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Institute of Medicine Estimate: 30% of Spending is Avoidable

---

**Excess Cost Domain Estimates:**

<table>
<thead>
<tr>
<th>Category</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>
<td></td>
</tr>
<tr>
<td>- Discretionary use beyond benchmarks</td>
<td></td>
</tr>
<tr>
<td>- Defensive medicine</td>
<td></td>
</tr>
<tr>
<td>- Unnecessary choice of higher cost services</td>
<td></td>
</tr>
<tr>
<td>Inefficiently Delivered Services</td>
<td>$130 B*</td>
</tr>
<tr>
<td>- Mistakes—medical errors, preventable complications</td>
<td></td>
</tr>
<tr>
<td>- Care fragmentation</td>
<td></td>
</tr>
<tr>
<td>- Unnecessary use of higher cost providers</td>
<td></td>
</tr>
<tr>
<td>- Operational inefficiencies at care delivery sites</td>
<td></td>
</tr>
<tr>
<td>- Physician offices</td>
<td></td>
</tr>
<tr>
<td>- Hospitals</td>
<td></td>
</tr>
<tr>
<td>Excess Administrative Costs</td>
<td>$190 B*</td>
</tr>
<tr>
<td>- Insurance-related administrative costs beyond benchmarks</td>
<td></td>
</tr>
<tr>
<td>- Insurers</td>
<td></td>
</tr>
<tr>
<td>- Physician offices</td>
<td></td>
</tr>
<tr>
<td>- Hospitals</td>
<td></td>
</tr>
<tr>
<td>- Other providers</td>
<td></td>
</tr>
<tr>
<td>- Insurer administrative inefficiencies</td>
<td></td>
</tr>
<tr>
<td>- Care documentation requirement inefficiencies</td>
<td></td>
</tr>
<tr>
<td>Prices That Are Too High</td>
<td>$105 B*</td>
</tr>
<tr>
<td>- Service prices beyond competitive benchmarks</td>
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</tr>
<tr>
<td>- Physician services</td>
<td></td>
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<tr>
<td>- Specialists</td>
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<tr>
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<td></td>
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<td>- Hospital services</td>
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<tr>
<td>- Product prices beyond competitive benchmarks</td>
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<tr>
<td>- Pharmaceuticals</td>
<td></td>
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<tr>
<td>- Medical devices</td>
<td></td>
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<tr>
<td>- Durable medical equipment</td>
<td></td>
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<tr>
<td>Missed Prevention Opportunities</td>
<td>$55 B*</td>
</tr>
<tr>
<td>- Primary prevention</td>
<td></td>
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<tr>
<td>- Secondary prevention</td>
<td></td>
</tr>
<tr>
<td>- Tertiary prevention</td>
<td></td>
</tr>
<tr>
<td>Fraud</td>
<td>$75 B*</td>
</tr>
<tr>
<td>- All sources—payer, clinician, patient</td>
<td></td>
</tr>
</tbody>
</table>

*Lower bound totals of various estimates, adjusted to 2009 total expenditure level.
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 office

- **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**
  - 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 $,

$ 

TIME 

AVOIDABLE SPENDING 

NECESSARY SPENDING 

AVOIDABLE SPENDING 

AVOIDABLE SPENDING 

AVOIDABLE SPENDING
The Right Goal: Less Avoidable $, More Necessary $
Win-Win for Patients & Payers

Avoidable Spending

Necessary Spending

Savings

Time

Lower Spending for Payers

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

<table>
<thead>
<tr>
<th>NECESSARY SPENDING</th>
<th>BARRIERS IN THE CURRENT PAYMENT SYSTEM</th>
<th>AVOIDABLE SPENDING</th>
</tr>
</thead>
<tbody>
<tr>
<td>AVOIDABLE SPENDING</td>
<td></td>
<td>SAVINGS</td>
</tr>
</tbody>
</table>

$
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: Avoidable Spending Is Revenue for Providers…

Revenue from Necessary Services

Revenue from Avoidable Services

$
Revenue from Avoidable Services Helps Cover Cost of Services
...Many Costs Are Fixed, At Least in the Short Run

Hospitals:
- Cost of staffing the ED, surgery suite, cardiac cath lab, NICU, etc. whether there are patients or not

Physician Practices:
- Cost of office staff, rent, software, etc. whether there are visits/procedures or not
When Avoidable Services Are Reduced, Revenue Decreases…

<table>
<thead>
<tr>
<th>Revenue from Necessary Services</th>
<th>Revenue from Avoidable Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fixed cost of service delivery</td>
<td></td>
</tr>
<tr>
<td>Variable cost of services</td>
<td>MARGIN</td>
</tr>
</tbody>
</table>

Reduction in Revenue

Avoidable services
…Costs Decrease, But Not As Much as Revenue…

Fixed Costs of Services Remain When Volume Decreases
...Leaving Providers With Losses (or Bigger Losses Than Today)

Fixed Costs of Services Remaining When Volume Decreases Causes Financial Losses
Underpayment for High-Value Services Makes Losses Greater

Costs of Unreimbursed New Services Plus Fixed Costs of Services Remaining When Volume Decreases Causes Financial Losses

- **REVENUE FROM NECESSARY SERVICES**
- **REVENUE FROM AVOIDABLE SERVICES**
- **VARIABLE COST OF SERVICES**
- **FIXED COST OF SERVICE DELIVERY**
- **AVOIDABLE SERVICES**
- **REVENUE FROM NECESSARY SERVICES**
- **FIXED COST OF SERVICE DELIVERY**
- **AVOIDED COST**
- **NEW SVCS**
- **VARIABLE COST**
Many Rural Hospitals Are Closing Under Current Payment Systems

83 Rural Hospital Closures: January 2010 – Present
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.
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- Palliative care for patients at end of life

**BARRIER #2**

Costs of Unreimbursed New Services Plus Fixed Costs of Services Remaining When Volume Decreases Causes Financial Losses

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How Do You Define a Good Alternative Payment Model?
Step 1: Identify Opportunities to Reduce Avoidable Spending

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

**Fee-for-Service Payment (FFS)**

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

**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

**Barriers in Current FFS System**
- No Payment for Many High-Value Services
- Insufficient Revenue to Cover Costs When Using Fewer or Lower-Cost Services
Step 3: Pay Adequately for High-Value Services Patients Need

Fee-for-Service Payment (FFS)

<table>
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Good Alternative Payment Model

Flexible, Adequate Payment for High-Value Services

Unpaid Services & Losses

Total Spending Relevant to the Physician's Services

$
Step 3: Pay Adequately for High-Value Services Patients Need

Fee-for-Service Payment (FFS)

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

Good Alternative Payment Model

- Flexible, Adequate Payment for High-Value Services
  - 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

Total Spending Relevant to the Physician’s Services
Step 4: Hold Providers Accountable for Cost/Quality They Can Control

Fee-for-Service Payment (FFS)

- Avoidable Spending
  - Payments to Other Providers for Related Services
  - FFS Payments to Physician Practice

Good Alternative Payment Model

- Savings
  - Payments to Other Providers for Related Services

- Flexible, Adequate Payment for High-Value Services

Total Spending Relevant to the Physician’s Services

Unpaid Services & Losses

Accountability for Controlling Avoidable Spending

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Good Alternative Payment Models Can Be Win-Win-Wins

Fee-for-Service Payment (FFS)

- Total Spending Relevant to the Physician’s Services
  - Avoidable Spending
    - Payments to Other Providers for Related Services
      - FFS Payments to Physician Practice
      - Unpaid Services & Losses
    - 
  - Physician Practice Revenue

Good Alternative Payment Model

- Savings
  - Avoidable Spending
  - Payments to Other Providers for Related Services
    - Flexible, Adequate Payment for High-Value Services

Win for Payer: Lower Total Spending
Win for Patient: Better Care Without Unnecessary Services
Win for Physicians & Hospitals: Adequate Payment for High-Value Services

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What Happens When You Design Care Delivery and Payment From the Bottom Up Instead of From the Top Down?
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>OPPORTUNITIES TO IMPROVE CARE AND LOWER COSTS</th>
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- <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

**BARRIERS IN THE CURRENT PAYMENT SYSTEM**

- 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

**RESULTS WITH ADEQUATE PAYMENT FOR BETTER CARE**

- 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

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

SonarMD
www.SonarMD.com
Better Care at Lower Cost for Cancer

PHYSICIAN LEADER: Barbara McAneny, MD
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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<td>• No payment for triage services to enable rapid response to patient complications</td>
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<tr>
<td></td>
<td>• No payment for patient and family education about complications and how to respond</td>
</tr>
<tr>
<td></td>
<td>• Inadequate payment to reserve capacity for IV hydration of patients experiencing problems</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
A Step in the Right Direction: Bundled Payments in Medicare

**BENEFITS OF BUNDLED/WARRANTIEd PAYMENTS**

- Single price for all “parts” of care
- No reward for avoidable complications
- No reward for using expensive post-acute care

**Diagram**

- **Inpatient Episode Payment**
  - High Spending on Complications & Post-Acute Care
  - Low Complication & PAC Spending

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But BPCI Addresses Only a Fraction of Opportunities for Value

High Spending on Complications & Post-Acute Care

Low Complication & PAC Spending

Inpatient Hospital Care

Inpatient Episode Payment

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

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

- 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-expensive implants
  - Infections and complications of surgery
  - Overuse of inpatient rehabilitation
What If You Can Do The Procedure Outside the Hospital?

Inpatient Episode Payment

Inpatient Hospital Care

High Spending on Complications & Post-Acute Care

Low Complication & PAC Spending

Outpatient Hospital Procedure
What if You Could Save Even More With a Different Treatment?

- **Inpatient Episode Payment**
  - Inpatient Hospital Care
    - High Spending on Complications & Post-Acute Care
      - $\downarrow$
  - Low Complication & PAC Spending

- **Outpatient Hospital Procedure**
  - $\downarrow$

- **Alternative Procedure or Medical Management**
What if You Could Save Even More With a Different Treatment?

In BPCI, the trigger is the hospital procedure, so if a different procedure is used, or no procedure at all is used, care is paid through standard FFS and the payer keeps all the savings.

- High Spending on Complications & Post-Acute Care
- Low Complication & PAC Spending
- CMS or Health Plan
- Alternative Procedure or Medical Management
- Outpatient Hospital Procedure
- Inpatient Hospital Care
- Inpatient Episode Payment
Rewarding *Only* Inpatient Care Encourages *More* Inpatient Care

In BPCI, the trigger is the hospital procedure, so if a different procedure is used, or no procedure at all is used, care is paid through standard FFS and the payer keeps all the savings.
Use a *Condition*-Based Payment to Support Use of *Best* Treatment

**In a Condition-Based Payment Model, the trigger is the patient’s condition, so if a different procedure is used, or no procedure at all is used, the care is still paid for through the Condition-Based Payment.**

![Diagram](image-url)
**Condition-Based Payment Has More Benefits Than Episodes**

**BENEFITS OF CONDITION-BASED PAYMENTS**

- No reward for avoidable complications
- No reward for using expensive post-acute care
- No reward for using unnecessarily expensive facilities
- No reward for performing unnecessary procedures

**Condition-Based Payment**

- Inpatient Hospital Care
- Outpatient Hospital Procedure
- Alternative Procedure or Medical Management

**High Spending on Complications & Post-Acute Care**

$\downarrow$

**Low Complication & PAC Spending**

$\downarrow$

**BENEFITS OF CONDITION-BASED PAYMENTS**

- +

- No reward for avoidable complications
- No reward for using expensive post-acute care
- No reward for using unnecessarily expensive facilities
- No reward for performing unnecessary procedures
Condition-Based Payment Must Be Led by *Physicians*, Not *Hospitals*
Many Condition-Based Payments Won’t Involve Hospitals at All

For many types of conditions, hospitalization represents a *failure of treatment, not a method of treatment.*
Are We Making the Payment for the Correct Condition??

Condition-Based Payment

- Inpatient Episode Payment
  - Inpatient Hospital Care
    - High Spending on Complications & Post-Acute Care
  - Outpatient Hospital Procedure
- Alternative Procedure or Medical Management

Correct Condition

Correct Treatment

Patients

Wrong Condition

$
Diagnostic Error is a Fundamental Quality Issue Underlying All Others
We Need to Pay Adequately for Good Diagnosis, Too
We Need Multiple Types of “Bundled” Payments

- **Diagnostic Payment Bundle**
  - **Wrong Condition**
    - $\downarrow$ Correct Condition
      - **Diagnosis**
        - Lab Testing
        - Imaging

- **Condition-Based Payment**
  - **Inpatient Episode Payment**
    - **Inpatient Hospital Care**
    - $\downarrow$
      - **Outpatient Hospital Procedure**
      - $\downarrow$
        - **Alternative Procedure or Medical Management**

- **High Spending on Complications & Post-Acute Care**
  - $\downarrow$
    - **Low Complication & PAC Spending**
What Does a Patient-Centered Payment & Delivery System Look Like?
Patient-Centered Care: Provide Preventive Services

PATIENT

Preventive Services

Preventive Services Management
Patient-Centered Payment: Pay for Good Preventive Care

- Preventive Services
- Preventive Services Management
- Bundled Pmt for Preventive Service
- Monthly Preventive Services Mgt Pmt
Patient-Centered Care: Accurately Diagnose Problems

PATIENT

Preventive Services

Preventive Services Management

Symptoms

Diagnosis & Treatment Planning
Patient-Centered Payment: Pay to Support Good Diagnosis

PATIENT

Preventive Services

Preventive Services Management

Symptoms

Diagnosis & Treatment Planning

Diagnosis & Treatment Planning Episode Payment

Diagnosis Coordination Payment + FFS

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Patient-Centered Care: Treat Acute Conditions Effectively

PATIENT

Preventive Services

Preventive Services Management

Symptoms → Diagnosis & Treatment Planning → Acute Condition Treatment
Patient-Centered Payment: Support Essential Hospital Svcs…

PATIENT

Preventive Services

Preventive Services Management

Symptoms

Diagnosis & Treatment Planning

Standby Capacity Payment

Acute Condition Treatment
Patient-Centered Payment: Pay Teams for Full Tx Bundles

PATIENT

Preventive Services

Preventive Services Management

Symptoms

Diagnosis & Treatment Planning

Acute Condition Treatment

Standby Capacity Payment

Acute Condition Episode Payment

Acute Condition Coord. Treatment Payment +FFS
Patient-Centered Care: Effective Care of Chronic Disease

PATIENT

Preventive Services

Preventive Services Management

Symptoms

Diagnosis & Treatment Planning

Acute Condition Treatment

Initial Treatment of Chronic Condition

Continued Management of Chronic Condition
Patient-Centered Payment to Support Patient-Centered Care

PATIENT

Symptoms

Preventive Services

Preventive Services Management

Diagnosis & Treatment Planning Episode Payment

Diagnosis Coordination Payment + FFS

Standby Capacity Payment

Acute Condition Episode Payment

Acute Condition Coord. Treatment Payment + FFS

Initial Treatment of Chronic Condition

Continued Management of Chronic Condition

Bundled Pmt for Initial Treatment of Chronic Cond.

Monthly Pmt for Mgt of Chronic Condition

Bundled Pmt for Preventive Service

Monthly Preventive Services Mgt Pmt

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For More Details on Patient-Centered Payment:

www.PaymentReform.org

Why Value-Based Payment Isn’t Working, and How to Fix It

Creating a Patient-Centered Payment System to Support Higher-Quality, More Affordable Health Care

Harold D. Miller
Too Complex?
Too Complex?
Compared to What???
Too Complex? Compared to What???

**Physician Fee Schedule**
- 9,000+ CPT Codes
- 5,000+ HCPCS Codes
- MIPS Adjustments
Too Complex?
Compared to What???

**Physician Fee Schedule**
- 9,000+ CPT Codes
- 5,000+ HCPCS Codes
- MIPS Adjustments

**Inpatient Prospective Payment System**
- 700+ MS-DRGs
- Hospital VBP
- Readmission Penalties
- HAC Penalties
- DSH Payments
- Outlier Payments

**Outpatient Prospective Payment System**
- 700+ Ambulatory Patient Classifications (APCs)
Too Complex? Compared to What???

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**Home Health Care Prospective Payment System**
- 153 HHRGs

**Skilled Nursing Facility Prospective Payment System**
- 66 RUGs

**Critical Access Hospital Payments**
- 99% of eligible costs

**Inpatient Rehab Facility Payments**
- 92 Case Mix Groups
What Could Be More Complex Than the Current System?

**Physician Fee Schedule**
- 9,000+ CPT Codes
- 5,000+ HCPCS Codes
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**Ambulance Fee Schedule**

**DME Fee Schedule**

**Laboratory Fee Schedule**

**LTCH Payment System**

**Inpatient Psych. Payment System**

**Hospice Payment System**

**Amb. Surg Ctr. Payment System**

**Dialysis Payment System**

**Therapy Payment System**
The Most Complexity is Adding More Layers On Top of FFS

- Physician Fee Schedule
  - 9,000+ CPT Codes
  - 5,000+ HCPCS Codes
  - MIPS Adjustments

- Inpatient Prospective Payment System
  - 700+ MS-DRGs
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- Ambulance Fee Schedule

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- LTCH Payment System

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- Amb. Surg Ctr. Payment System

- Dialysis Payment System

- Therapy Payment System

- Track 1 ACO
- Track 1+ ACO
- Track 2 ACO
- Track 3 ACO
- NextGen ACO
- ESRD ACO
- OCM
- BPCI
- CJR
- CPC+
A Much Simpler, Predictable, Accountable System Than Today

CURRENT PAYMENTS
- Physician Fee Schedule
- Inpatient PPS
- Outpatient PPS
- Home Health PPS
- Hospice Per Diems
- SNF PPS
- IRF PPS
- LTCH PPS
- ASC PPS
- IPF PPS
- Dialysis PPS
- CAH Payment
- FQHC/RHC Payment
- Clinical Laboratory Fee Schedule
- DME Fee Schedule
- Ambulance Services Payment
- Track 1 ACO
- Track 1+ ACO
- Track 2 ACO
- Track 3 ACO
- Next Generation ACO
- ESRD ACO
- BPCI Advanced
- CJR
- Oncology Care Model
- Comp. Primary Care Plus

PATIENT-CENTERED PAYMENT
- Prevention/Wellness Mgt Pmt
- Preventive Service Bundled Pmts
- Diagnostic Bundled Payment
- Acute Condition Bundled Payment
- Standby Services Payment
- Chronic Condition Mgt Payment
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”**
  She gets paid whether she does anything for you or not

- **Physician E is paid through Patient-Centered Payment**
  She’s paid adequately to address your needs, and she makes more money if your health condition(s) improve
Which Path Will Your Community Choose?

TODAY
- High Prices
- Mediocre Quality
- Unhealthy People

FUTURE #1

FUTURE #2
Which Path Will Your Community Choose?

**TODAY**
- High Prices
- Mediocre Quality
- Unhealthy People

**FUTURE #1**
- Higher Prices
- Mediocre Quality
- Limited Patient Choice
- Loss of Good Physicians
- Loss of Rural Hospitals

**FUTURE #2**
Which Path Will Your Community Choose?

**TODAY**
- High Prices
- Mediocre Quality
- Unhealthy People

**FUTURE #1**
- Higher Prices
- Mediocre Quality
- Limited Patient Choice
- Loss of Good Physicians
- Loss of Rural Hospitals

**FUTURE #2**
- Affordable Prices
- Good Outcomes
- Choice of Providers
- Care Customized to Patient and Community Needs
Learn More in Mini-Summits 3, 8, & 13 This Afternoon

Mini-Summit 3: Hospital Global Budgets
- How Maryland is paying hospitals differently so they can reduce volume while paying adequately for essential fixed costs

Mini-Summit 8: APMs for Outpatient Specialty Care
- Ways to achieve significant savings and quality improvement by:
  - Finding opportunities for reducing truly avoidable spending
  - Providing individualized support to patients based on their needs
  - Providing hospital-level care in patient’s homes

Mini-Summit 13: APMs for Small/Rural Practices & Hospitals
- Making APMs work for small physician practices and hospitals
  - How well do CPC+ and other medical home payment systems support solo PCPs and small rural practices?
- Making ACOs work in rural communities
  - What support do critical access hospitals and small physician practices need to effectively manage spending and quality?
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

Comparison of Patient-Centered Payment to Current Alternative Payment Models
Current APMs Compared to Patient-Centered Payments

**CURRENT VALUE-BASED PMT**

- The patient (and payer) can only find out the total price of treating a health problem after all of the services have been delivered;
- The patient may be able to find out the percentage of other patients who were treated by (some of) the providers two years ago received care that met quality standards;
- The patient (and payer) has to pay even if the quality of care they received was poor or if the treatment didn’t succeed, and if errors were made, the patient/payer has to pay extra to have them corrected; and
- The amount the patient (and payer) ultimately pays bears no relationship to the costs of the services provided

**PATIENT-CENTERED PAYMENT**

- The patient (and payer) are told in advance what the total price of treating the health problem will be;
- The patient is told what standards of quality their care will meet and the specific results they should expect to see from the care they will receive;
- The patient (and payer) will not pay extra for services to correct errors made by the providers, and they will not pay at all unless the care they received met quality standards and achieved the expected results; and
- The amount the patient (and payer) pays is based on the cost of delivering high-quality care with a warranty
APPENDIX

Accountability for Quality & Outcomes in Patient-Centered Payment
If You’re No Longer Paying Based on the Services Delivered, How Does the Patient Know They’re Not Being Undertreated?
To Prevent Undertreatment, Tie Payment to Quality & Outcomes

- Precautions to avoiding post-surgical infections
- Use of high-quality medical devices
- Patient return to functionality
- Lack of pain
Can P4P Assure Quality of Bundles When It Doesn’t Work with FFS?

$\text{Fee for Service}$

$\text{P4P Incentives Based on Quality and Cost Measures}$

$\text{Bundled Payment}$

$\text{P4P Incentives Based on Quality and Cost Measures ?}$
## Hypothetical Procedure With a Bundled Payment

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<tr>
<td>Revenue to Provider</td>
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Assume 10% of Procedures Don’t Meet Quality Standard

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## Patients/Payers Pay the Same If the Standard is Met or Not

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### What Happens if Quality Improves Under FFS?

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<tr>
<td><strong>% Change</strong></td>
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## No Change in Provider Revenue; Patients Still Pay for the Bad Care

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# Table of Comparison

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<td><strong>% Change</strong></td>
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P4P = Small Rewards & Penalties, Patients Still Pay for Bad Care

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Revenue to Provider:
- $200K
- $210K
- $190K

% Change:
- +5%
- -5%

THIS IS NOT A PATIENT-CENTERED SYSTEM
What if Providers Charged *Nothing* When Standards Weren’t Met?

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They’d Need to Charge More for Good Quality Care

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Now, Provider is Rewarded for Better Quality…

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...and Penalized for Poor Quality

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<td>Payment When Standard Met</td>
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<td>$2,222</td>
<td>$2,100</td>
<td>$2,222</td>
<td>$1,900</td>
<td>$2,222</td>
</tr>
<tr>
<td>Payment When Standard Not Met</td>
<td>$2,000</td>
<td>$0</td>
<td>$2,100</td>
<td>$0</td>
<td>$1,900</td>
<td>$0</td>
</tr>
<tr>
<td>Revenue to Provider</td>
<td>$200K</td>
<td>$200K</td>
<td>$210K</td>
<td>$220K</td>
<td>$190K</td>
<td>$178K</td>
</tr>
<tr>
<td>% Change</td>
<td>+5%</td>
<td>+10%</td>
<td>-5%</td>
<td>-11%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
...and Penalized for Poor Quality & Patient Doesn’t Pay for Bad Care

<table>
<thead>
<tr>
<th></th>
<th>FFS</th>
<th>Pay for Quality</th>
<th>FFS+ P4P</th>
<th>Pay for Quality</th>
<th>FFS+ P4P</th>
<th>Pay for Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td># of Patients</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td># Cases Meeting Quality Standard</td>
<td>90</td>
<td>90</td>
<td>99</td>
<td>99</td>
<td>80</td>
<td>80</td>
</tr>
<tr>
<td># Not Meeting Quality Standard</td>
<td>10</td>
<td>10</td>
<td>1</td>
<td>1</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>Payment When Standard Met</td>
<td>$2,000</td>
<td>$2,222</td>
<td>$2,100</td>
<td>$2,222</td>
<td>$1,900</td>
<td>$2,222</td>
</tr>
<tr>
<td>Payment When Standard Not Met</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Revenue to Provider</td>
<td>$200K</td>
<td>$200K</td>
<td>$210K</td>
<td>$220K</td>
<td>$190K</td>
<td>$178K</td>
</tr>
<tr>
<td>% Change</td>
<td>+5%</td>
<td>+10%</td>
<td>-5%</td>
<td>-11%</td>
<td>-5%</td>
<td>-11%</td>
</tr>
</tbody>
</table>

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APPENDIX

How Do You Set/Control Prices Under Patient-Centered Payment?
## Where Will You Get Your Knee Replaced?

### Knee Joint Replacement

<table>
<thead>
<tr>
<th>Price #1</th>
<th>Price #2</th>
<th>Price #3</th>
</tr>
</thead>
<tbody>
<tr>
<td>$20,000</td>
<td>$25,000</td>
<td>$30,000</td>
</tr>
</tbody>
</table>
Current Cost-Sharing Encourages Use of Expensive Providers

Knee Joint Replacement

<table>
<thead>
<tr>
<th>Consumer Share of Surgery Cost</th>
<th>Price #1 $20,000</th>
<th>Price #2 $25,000</th>
<th>Price #3 $30,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,000 Copayment:</td>
<td>$1,000</td>
<td>$1,000</td>
<td>$1,000</td>
</tr>
<tr>
<td>10% Coinsurance w/$2,000 OOP Max:</td>
<td>$2,000</td>
<td>$2,000</td>
<td>$2,000</td>
</tr>
<tr>
<td>$5,000 Deductible:</td>
<td>$5,000</td>
<td>$5,000</td>
<td>$5,000</td>
</tr>
</tbody>
</table>
Patients Need to Pay the “Last Dollar” to Encourage Value

Knee Joint Replacement

<table>
<thead>
<tr>
<th>Consumer Share of Surgery Cost</th>
<th>Price #1 $20,000</th>
<th>Price #2 $25,000</th>
<th>Price #3 $30,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,000 Copayment:</td>
<td>$1,000</td>
<td>$1,000</td>
<td>$1,000</td>
</tr>
<tr>
<td>10% Coinsurance w/$2,000 OOP Max:</td>
<td>$2,000</td>
<td>$2,000</td>
<td>$2,000</td>
</tr>
<tr>
<td>$5,000 Deductible:</td>
<td>$5,000</td>
<td>$5,000</td>
<td>$5,000</td>
</tr>
<tr>
<td>Highest-Value:</td>
<td>$0 ✓</td>
<td>$5,000</td>
<td>$10,000</td>
</tr>
</tbody>
</table>
Will Transparency About Prices Result in Better Choices?

Estimated Treatment Cost Results

Knee Replacement: 25 miles from Raleigh - Modify Your Search

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be health plan design, deductibles/co-insurance and out-of-pocket limits.

North Carolina Specialty Hospital
3916 Ben Franklin Blvd
Durham, NC 27704

Blue Value $20,300
Blue Options, Blue Advantage $20,300

Blue Value $29,206
Blue Options, Blue Advantage $35,962

UNC Hospitals
101 Manning Dr
Chapel Hill, NC 27514

Virginia Hospital Pricing

Knee Replacement (APRDRG 302)
January 2014 - December 2014

<table>
<thead>
<tr>
<th>TIENT</th>
<th>CONSUMER INFORMATION</th>
<th>CONTACT</th>
<th>VHHA HOME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Augusta Health (Fishersville)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Discharges</td>
<td>543</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LOS (Average)</td>
<td>2.9 Day(s)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Charge (Average)</td>
<td>$69,221</td>
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<td></td>
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<tr>
<td>Charge per Day (Average)</td>
<td>$23,684</td>
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<td></td>
</tr>
<tr>
<td>Median Charge</td>
<td>$63,315</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median Age</td>
<td>67</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>36.6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>63.4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bon Secours DePaul Medical Center (Norfolk)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Discharges</td>
<td>53</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LOS (Average)</td>
<td>3.4 Day(s)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Charge (Average)</td>
<td>$79,232</td>
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<td></td>
</tr>
<tr>
<td>Charge per Day (Average)</td>
<td>$23,592</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median Charge</td>
<td>$76,973</td>
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<td></td>
</tr>
<tr>
<td>Median Age</td>
<td>68</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>41.5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>58.5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sentara Virginia Beach General Hospital (Virginia Beach)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Discharges</td>
<td>305</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LOS (Average)</td>
<td>2.9 Day(s)</td>
<td></td>
<td></td>
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<tr>
<td>Charge (Average)</td>
<td>$43,019</td>
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</tr>
<tr>
<td>Charge per Day (Average)</td>
<td>$14,961</td>
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</tr>
<tr>
<td>Median Charge</td>
<td>$40,760</td>
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<td></td>
</tr>
<tr>
<td>Median Age</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>43.3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>56.7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Centra Health (Lynchburg)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Discharges</td>
<td>617</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LOS (Average)</td>
<td>2.4 Day(s)</td>
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<td></td>
</tr>
<tr>
<td>Charge (Average)</td>
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<tr>
<td>Charge per Day (Average)</td>
<td>$13,143</td>
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</tr>
<tr>
<td>Median Charge</td>
<td>$30,218</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median Age</td>
<td>68</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>35%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>65%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Current Transparency Efforts Are Focused on Procedure Price

<table>
<thead>
<tr>
<th>Payment for Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Provider 1:</strong></td>
</tr>
<tr>
<td>$25,000</td>
</tr>
<tr>
<td><strong>Provider 2:</strong></td>
</tr>
<tr>
<td>$23,000 (-8%)</td>
</tr>
</tbody>
</table>
## What Hidden Costs Accompany the Lower Price?

<table>
<thead>
<tr>
<th>Payment for Procedure</th>
<th>Payment and Rate of Complications</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Provider 1:</strong></td>
<td></td>
</tr>
<tr>
<td>$25,000</td>
<td>$30,000</td>
</tr>
<tr>
<td><strong>Provider 2:</strong></td>
<td></td>
</tr>
<tr>
<td>$23,000</td>
<td>$30,000</td>
</tr>
<tr>
<td>-8%</td>
<td></td>
</tr>
</tbody>
</table>
Total Spending May Be Higher With the “Lower Price” Provider

<table>
<thead>
<tr>
<th>Payment for Procedure</th>
<th>Payment and Rate of Complications</th>
<th>Average Total Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider 1:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$25,000</td>
<td>$30,000</td>
<td>2%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$25,600</td>
</tr>
<tr>
<td>Provider 2:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$23,000</td>
<td>$30,000</td>
<td>10%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$26,000</td>
</tr>
<tr>
<td>-8%</td>
<td></td>
<td>+2%</td>
</tr>
</tbody>
</table>

Provider 2 has a lower starting price, but is more expensive when lower quality is factored in.
Bundled/Warrantied Pmts Allow Comparing Apples to Apples

<table>
<thead>
<tr>
<th>Payment for Procedure</th>
<th>Payment and Rate of Complications</th>
<th>Bundled/Episode Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider 1:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2%</td>
<td>$25,600</td>
</tr>
<tr>
<td>Provider 2:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>10%</td>
<td>$26,000 +2%</td>
</tr>
</tbody>
</table>

Bundled prices show that Provider 1 is the higher-value provider.
Choice & Competition Encourages Efficiency

Knee Joint Replacement

<table>
<thead>
<tr>
<th>Consumer Share of Surgery Cost</th>
<th>Price #1 $20,000</th>
<th>Price #2 $25,000</th>
<th>Price #3 $30,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highest-Value:</td>
<td>$0</td>
<td>$5,000</td>
<td>$10,000</td>
</tr>
</tbody>
</table>
Loss of Choice & Competition Will Lead to Higher Costs

Knee Joint Replacement

<table>
<thead>
<tr>
<th>Consumer Share of Surgery Cost</th>
<th>Price #1</th>
<th>Price #2</th>
<th>Price #3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highest-Value:</td>
<td>$0</td>
<td>$5,000</td>
<td>$10,000</td>
</tr>
</tbody>
</table>

Price #1: $20,000
Price #2: $25,000
Price #3: $30,000

Highest-Value: $0, $10,000