PAYING FOR VALUE
Implications for Rural Hospitals

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

www.CHQPR.org
Concern Continues to Grow About Rising Healthcare Costs
Typical Solution #1: Cut Provider Fees for Services

- Cut Provider Fees
- SAVINGS
- TOTAL HEALTH CARE SPENDING
- BY PAYERS
Typical Solution #2: Shift Costs to Patients

- Total Health Care Spending
- Total Health Care Spending
- Total Health Care Spending
- Higher Cost-Share & Deductibles

Extra Savings
Typical Solution #3: Delay or Deny Care to Patients

$LACK OF NEEDED CARE$
Results of These Win-Lose Strategies

• Small physician practices and hospitals forced out of business or forced to consolidate with large systems that can demand higher prices

• Hard-to-treat patients can’t get the care they need

• Deferral of needed services and delivery of unnecessary services results in more serious problems and more expensive care in the future

• Health insurance costs continue to rise and access to insurance coverage and healthcare services decreases
Health Insurance Premiums Continue to Grow

Employer-Sponsored Family Insurance Premiums, 2002-2014

- U.S. Family Premiums
- Inflation

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WA Premiums $6,000 More Expensive Than 12-Year Inflation

Washington Family Health Insurance Premiums

Washington State Family Premiums

$6,119

Inflation

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Health Insurance Premiums Are Equal to 35% of Avg. Annual Pay
Health Insurance Premiums Are Equal to 35% of Avg. Annual Pay

If insurance premiums in Washington State had increased at the same rate as inflation from 2002 to 2014, Washington employers could have increased wages by 11% or hired 11% more workers.

Washington Family Insurance Premiums as % of Average Annual Pay
Medicare Isn’t Doing Any Better

Medicare Will Be Insolvent by 2028
Medicare Spending Is the Biggest Driver of Federal Deficits

Source: CBO Budget Outlook August 2012

46% of Spending Growth is Healthcare

Projected Federal Spending, 2011-2022 (Billions)
Is There a Better Way?
Institute of Medicine Estimate: 30% of Spending is Avoidable

<table>
<thead>
<tr>
<th>Excess Cost Domain Estimates: Lower bound totals from workshop discussions*</th>
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<tbody>
<tr>
<td><strong>UNNECESSARY SERVICES</strong></td>
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<tr>
<td>• Overuse: services beyond evidence-established levels</td>
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<td>• Discretionary use beyond benchmarks</td>
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<td>• Defensive medicine</td>
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<td>• Unnecessary choice of higher cost services</td>
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<td>• Mistakes—medical errors, preventable complications</td>
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<td>• Care fragmentation</td>
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<td>• Unnecessary use of higher cost providers</td>
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<td>• Operational inefficiencies at care delivery sites</td>
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<td><strong>EXCESS ADMINISTRATIVE COSTS</strong></td>
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<td>• Insurance-related administrative costs beyond benchmarks</td>
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<td><strong>PRICES THAT ARE TOO HIGH</strong></td>
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<td><strong>MISSED PREVENTION OPPORTUNITIES</strong></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><strong>FRAUD</strong></td>
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<tr>
<td>• All sources—payer, clinician, patient</td>
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*Lower bound totals of various estimates, adjusted to 2009 total expenditure level.
5-17% of Hospital Admissions Are Potentially Preventable

% of Hospital Stays That Were Potentially Preventable, 2008

- Potentially Preventable Chronic Conditions
- Potentially Preventable Acute Conditions

Source: AHRQ HCUP
### Millions of Preventable Events
#### Harm Patients and Increase Costs

<table>
<thead>
<tr>
<th>Medical Error</th>
<th># Errors (2008)</th>
<th>Cost Per Error</th>
<th>Total U.S. Cost</th>
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<td>Pressure Ulcers</td>
<td>374,964</td>
<td>$10,288</td>
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<tr>
<td>Postoperative Infection</td>
<td>252,695</td>
<td>$14,548</td>
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<td>Pneumothorax</td>
<td>25,559</td>
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<td>Central Venous Catheter Infection</td>
<td>7,062</td>
<td>$83,365</td>
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<td>Others</td>
<td>773,808</td>
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<td><strong>TOTAL</strong></td>
<td><strong>1,503,323</strong></td>
<td><strong>$13,019</strong></td>
<td><strong>$19,571,000,000</strong></td>
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</tbody>
</table>

### 3 Adverse Events Every Minute

Source: *The Economic Measurement of Medical Errors*, Milliman and the Society of Actuaries, 2010
Many Tests & Services Are Unnecessary & May Be Harmful
20-50% Non-Adherence to Choosing Wisely Criteria
Significant Variation in Avoidable Spending in WA

Figure 1. The percentage of patients who had an uncomplicated headache and had a potentially unnecessary CT scan or MRI imaging test, compared to the state commercial average of 22%, 2011-2012.*

Figure 13. The percentage of female patients who had too frequent Pap tests, compared by the commercial average of 59%, 2011-2012.*
The Right Focus: Spending That is Unnecessary or Avoidable

$\text{AVOIDABLE SPENDING}$

$\text{NECESSARY SPENDING}$

$\text{AVOIDABLE SPENDING}$

$\text{NECESSARY SPENDING}$

$\text{AVOIDABLE SPENDING}$

$\text{NECESSARY SPENDING}$

$\text{AVOIDABLE SPENDING}$

$\text{NECESSARY SPENDING}$
The Right Goal: Less Avoidable $,
The Right Goal: Less Avoidable $, More Necessary $
The Hoped-For Result: Win-Win for Patients & Payers

- NECESSARY SPENDING
- AVOIDABLE SPENDING

SAVINGS

$ Lower Spending for Payers

Better Care for Patients

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Payer Efforts to Promote “Value” Rather Than Volume of Services

- Value-Based Purchasing
- Value-Based Payment
Private “Value-Based Purchasing”
= Using “High-Value” Providers

Patients → “High-Value” Providers

“Low-Value” Providers
How Do You Define “High Value?”

Patients ➔ “High-Value” Providers

“Low-Value” Providers

X
Is This How to Define Value?

\[
\text{VALUE} = \frac{\text{QUALITY}}{\text{COST}}
\]
Which Oncologist Would You Use to Treat Your Cancer?

\[
\text{VALUE} = \frac{\text{QUALITY}}{\text{COST}}
\]

**ONCOLOGIST #1**
7 Year Survival
$5,000/patient

**ONCOLOGIST #2**
10 Year Survival
$10,000/patient
Oncologist #2 Rates Worse on the Standard Measure of “Value”

\[
\text{VALUE} = \frac{\text{QUALITY}}{\text{COST}}
\]

**ONCOLOGIST #1**

- 7 Year Survival: \(\frac{\text{0.51 days of life}}{\text{\$5,000/patient}}\)

**ONCOLOGIST #2**

- 10 Year Survival: \(\frac{\text{0.37 days of life}}{\text{\$10,000/patient}}\)
Assessing Value is a Lot Harder Than This

\[ \text{VALUE} \neq \frac{\text{QUALITY}}{\text{COST}} \]
All Too Often, “High-Value” Means “Willing to Accept Discounted Fee”

“High-Value” Providers
(i.e., discounts)

“Low-Value” Providers
Step 2: Reward High-Value Providers With More Patients

More Patients

“High-Value” Providers (i.e., discounts)

“Low-Value” Providers

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But Wait: Weren’t We Going to Stop Rewarding Volume???

More Patients → “High-Value” Providers (i.e., discounts)

Volume → Value

“Low-Value” Providers
What if the Network is Already “Narrow?”

More? Patients → One Provider in the Community
(Rural Area, Consolidated System, Etc.)
National Narrow Networks: “Centers of Excellence”

More Patients → High-Value Providers in Other Cities → One Provider in the local Community

© Center for Healthcare Quality and Payment Reform  www.CHQPR.org
Walmart, Lowes, and Others Using “Centers of Excellence”
Will Every Cancer Patient Have to Go to Minnesota?
Critical Access Hospitals Could Be Harmed by Value-Based Purchasing

- CAHs don’t have published data on quality
- CAHs will not be able to underbid large hospitals
- Patients going to hospitals in other cities for treatment would reduce volumes in the CAH, making it more difficult to maintain high quality care in the CAH, creating a downward spiral
Paying Based on “Value” Rather Than Volume of Services

- Value-Based Purchasing
- **Value-Based Payment**
Value-Based Payment Provides “Incentives” for Higher Value Care

Pay for Performance (“P4P”) Based on Quality and Cost Measures

Fee for Service

Bonus
Penalty
Hospital Value-Based Payment

- Hospital Readmission Penalties
- Hospital-Acquired Condition Penalties
- Hospital Value-Based Purchasing
Hospital Readmission Penalties

Current Payment & High Readmit Rate

Revenue from High Readmit Rate

Reduce Readmissions

OR

Payments for All Admissions Will Be Cut

Revenue from Admissions

$
The Hope: Hospitals Will Reduce Readmissions to Avoid Penalties

Current Payment & High Readmit Rate

- Revenue from High Readmit Rate
- Revenue from Admissions

Lower Readmits & No Payment Cut

- Revenue from Average Readmit Rate
- Revenue from Admissions w/ no Change in Payment Rate

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The Myth: Hospitals Control All of the Reasons for Readmissions

Current Payment & High Readmit Rate vs. Lower Readmits & No Payment Cut

Revenue from High Readmit Rate:
- Poor Access to Primary Care
- Low Quality of Post-Acute Care
- Patients w/o Capacity for Self-Care or Inadequate Home Support

Revenue from Admissions:
- Revenue from Admissions w/ no Change in Payment Rate

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CONCLUSIONS AND RELEVANCE  Patient characteristics not included in Medicare’s current risk-adjustment methods explained much of the difference in readmission risk between patients admitted to hospitals with higher vs lower readmission rates. Hospitals with high readmission rates may be penalized to a large extent based on the patients they serve.
Under Current Pmt System, Fewer Readmissions = Lower Margins

Current Payment & High Readmit Rate

- Revenue from High Readmit Rate
- Hospital Costs
- Revenue from Admissions

Lower Readmits & No Payment Cut

- Revenue from Average Readmit Rate
- Hospital Costs
- (Don’t Decrease in Proportion to Revenues)

Margin

Losses
So Hospitals Are Hurt Financially One Way or the Other

Current Payment & High Readmit Rate

- Reduced Revenue from Admissions Due to Readmission Penalties
  - Losses

Hospital Costs

Lower Readmits & No Payment Cut

- Revenue from Admissions w/ no Change in Payment Rate
  - Losses

Hospital Costs

(Don’t Decrease in Proportion to Revenues)
Hospital Value-Based Payment

- Hospital Readmission Penalties
- Hospital-Acquired Condition Penalties
- Hospital Value-Based Purchasing
  - Payment levels are cut across the board
  - Hospitals have to earn back the cuts based on quality measures and “resource use” measures
    - Medicare Spending Per Beneficiary measure calculates cost of all services that occur up to 30 days after discharge
    - Hospital is penalized if costs are higher than other hospitals for similar patients
Impact of VBP on Critical Access Hospitals

• CAHs not subject directly to Value-Based Purchasing
  – Affordable Care Act required a demonstration project to do this but CMS has not implemented one

• Resource Use measures for IPPS hospitals could discourage use of CAHs
  – If CAH SNF cost per day is high or if patient is readmitted to the CAH, IPPS hospitals could avoid using the CAH for post-acute care services
Most Value-Based Payment for Docs Has Been Quality Bonuses

QUALITY MEASURES
• Mammograms
• Colon Cancer Screening
• HbA1c Control
• LDL

FFS

P4P+
P4P Hasn’t Worked Terribly Well

- A small bonus may not be enough to pay for the added costs of improving quality
- A small bonus may not be enough to offset loss of fee-for-service revenue from healthier patients or lower utilization
- A small bonus may not be enough to offset the costs of collecting and reporting the quality data
Over-Emphasis on Narrow Quality Measures Can Harm Patients

Hypoglycemia
1 Yr Mortality: 19.9%
30 Day Readmits: 16.3%

Hyperglycemia
1 Yr Mortality: 17.1%
30 Day Readmits: 15.3%

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

QUALITY MEASURES
- Mammograms
- Colon Cancer Screening
- HbA1c Control
- LDL

QUALITY MEASURES
- Mammograms
- Colon Cancer Screening
- Flu Vaccine
- Tobacco Counseling
- Hypertension Control
- HbA1c Control
- LDL
- Eye Exams
- Aspirin Use
When That Didn’t Work, Bonuses Were Converted Into Penalties

QUALITY MEASURES
- Mammograms
- Colon Cancer Screening
- Flu Vaccine
- Tobacco Counseling
- Hypertension Control
- HbA1c Control
- LDL
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P4P+
FFS
LOSSES/UNPAID SVCS

P4P+
QUALITY MEASURES
- Mammograms
- Colon Cancer Screening
- Flu Vaccine
- BMI Screens
- Tobacco Counseling
- Fall Risk Assessment
- Hypertension Control
- HbA1c Control
- LDL
- Eye Exams
- Aspirin Use

P4P-
FFS
LOSSES/UNPAID SVCS
The End of Collaboration?

• In the CMS Value-Based Payment Modifier, 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?
MACRA

- MACRA (Medicare Access and CHIP Reauthorization Act) repealed the Sustainable Growth Rate (SGR) formula that was threatening to cut physician payment every year
- MACRA created two optional replacements
  - MIPS (Merit-Based Incentive Payment System)
  - APMs (Alternative Payment Models)
MIPS is P4P on Steroids

MIPS
“Merit-Based Incentive Payment System”

<table>
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<tr>
<th>Year</th>
<th>FFS ± PQRS</th>
<th>FFS ± PQRS</th>
<th>FFS ± PQRS</th>
<th>FFS + MIPS</th>
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Quality

- 50% -> 30%
- 10% -> 30%
- 15%
- 25%

Resource Use
“Clinical Practice Improvement Activities”
EHR “Meaningful Use”

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Docs Will Be Rewarded for Using Fewer and Lower-Cost Services

Physicians’ Pay Will Be Based on Total Cost of Care For their Patients

<table>
<thead>
<tr>
<th>Year</th>
<th>FFS</th>
<th>PQRS</th>
<th>MU</th>
<th>VBM</th>
<th>MIPS</th>
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Quality

Resource Use

“Clinical Practice Improvement Activities”

EHR “Meaningful Use”

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Critical Access Hospitals Could Be Harmed by MIPS

• Quality Measures
  – Small volumes of patients and safety net services could make quality measures for physicians look poor compared to those at other hospitals

• Resource Use Measures
  – Surgeons will be penalized if their patients use higher-cost post-acute care services
  – Primary care physicians will be penalized if their patients are hospitalized at higher-cost hospitals
  – If CAH cost per day or cost per admission is higher than other hospitals, physicians could avoid using the CAH for admissions or post-acute care services
MACRA Encourages “APMs”

- MACRA (Medicare Access and CHIP Reauthorization Act) repealed the Sustainable Growth Rate (SGR) formula that was threatening to cut physician payment every year
- MACRA created two optional replacements
  - MIPS (Merit-Based Incentive Payment System)
  - APMs (Alternative Payment Models)
HHS Announced Goal to Move Away From VBP & FFS+P4P

“Value-Based Purchasing”

FFS
- No payment for services that will benefit patients
- Lower revenues from reducing avoidable costs

P4P

HHS Goal for 2018

“Alternative Payment Models Built on a FFS Architecture”

FFS
- No payment for services that will benefit patients
- Lower revenues from reducing avoidable costs

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FFS
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• Lower revenues from reducing avoidable costs

P4P

What the heck is an “Alternative Payment Model Built on FFS Architecture?”

And is that better than FFS+P4P?
## CMS “Alternative Payment Models” Announced To Date

<table>
<thead>
<tr>
<th>TYPE OF PROVIDER</th>
<th>CMS PROGRAM</th>
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<tbody>
<tr>
<td>Health Systems, Multi-Specialty Groups, PHOs, and IPAs</td>
<td>Accountable Care Organizations (MSSP &amp; Pioneer)</td>
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<tr>
<td>Primary Care</td>
<td>Comprehensive Primary Care Initiative</td>
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<tr>
<td>Specialty Care</td>
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### CMS “Alternative Payment Models”
Don’t Change Current Payments

<table>
<thead>
<tr>
<th>TYPE OF PROVIDER</th>
<th>CMS PROGRAM</th>
<th>PAYMENT STRUCTURE</th>
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<tbody>
<tr>
<td>Health Systems, Multi-Specialty Groups, PHOs, and IPAs</td>
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<td>FFS + Shared Savings on Attributed Total Spending</td>
</tr>
<tr>
<td>Primary Care</td>
<td>Comprehensive Primary Care Initiative</td>
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</tr>
<tr>
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Some Provide Additional Upfront Resources to Physicians…

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…Most Only Provide More $ After Other Spending is Reduced

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How “Shared Savings” Works

• Hospitals, physicians, skilled nursing facilities, etc. all get paid the same way they do today.
• CMS adds up all of your spending and compares it to what you spent the previous year to calculate the increase.
• CMS compares your increase to the increase in spending for other providers treating supposedly similar patients.
• If your increase is less than the other providers, CMS makes an additional payment to you next year based on a percentage of the difference between your increase and other providers’ increases (i.e., a share of the savings).

• “One-sided risk” means you can get an additional payment if your increase is lower than others, but no penalty if your increase is higher.
• “Two-sided risk” means you also have to pay money back to CMS if your increase is higher.
Problems With “Shared Savings”

- Providers receive no upfront resources to improve care management for patients
- Already efficient providers receive little or no additional revenue and may be forced out of business
- Providers who have been practicing inefficiently or inappropriately are paid more than others
- Providers could be rewarded for denying needed care as well as by reducing overuse
- Providers are placed at risk for costs they cannot control and random variation in spending
In Most ACOs, Physicians/Hospitals Are Paid the Same As Today

Fee-for-Service Payment

MEDICARE, MEDICAID HEALTH PLAN

ACO

Hospitals

PATIENTS

Heart Disease
Diabetes
Back Pain
Pregnancy

Primary Care
Cardiology
Endocrinology
Neurosurgery
OB/GYN
Most ACOs Spend a Lot on IT and Nurse Care Managers

MEDICARE, MEDICAID HEALTH PLAN

Fee-for-Service Payment

ACO
- Expensive IT Systems
- Nurse Care Managers

Hospitals

PATIENTS
- Heart Disease
- Diabetes
- Back Pain
- Pregnancy

Primary Care
Cardiology
Endocrinology
Neurosurgery
OB/GYN
Possible Future “Shared Savings” Doesn’t Support Better Care Today

MEDICARE, MEDICAID HEALTH PLAN

Fee-for-Service Payment

Shared Savings Payment??

ACO

Expensive IT Systems

Nurse Care Managers

Share of Shared Savings $ ??

Hospitals

PATIENTS

Heart Disease
 Diabetes
 Back Pain
 Pregnancy

Primary Care Cardiology Endocrinology Neurosurgery OB/GYN
Medicare ACOs Aren’t Succeeding Due to Flaws in Payment Model

2013 Results for Medicare Shared Savings ACOs
• 46% of ACOs (102/220) increased Medicare spending
• Only one-fourth (52/220) received shared savings payments
• After making shared savings payments, Medicare spent more than it saved

2014 Results for Medicare Shared Savings ACOs
• 45% of ACOs (152/333) increased Medicare spending
• Only one-fourth (86/333) received shared savings payments
• After making shared savings payments, Medicare spent more than it saved
Private Shared Savings ACOs Are Also 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.”
Most “Alternative Payment Models” Are Just FFS + P4P

“Value-Based Purchasing”

**FFS**
- No payment for services that will benefit patients
- Lower revenues from reducing avoidable costs

**P4P**
- No payment for services that will benefit patients
- Lower revenues from reducing avoidable costs

“APMs Built on FFS Architecture”

**Shared Savings**
- No payment for services that will benefit patients
- Lower revenues from reducing avoidable costs

**PMPM**
Is There a Better Way?

“Value-Based Purchasing”
- No payment for services that will benefit patients
- Lower revenues from reducing avoidable costs

“APMs Built on FFS Architecture”
- No payment for services that will benefit patients
- Lower revenues from reducing avoidable costs
What If We Paid for *Cars* the Way We Pay for *Care*?
What If We Paid for *Cars* the Way We Pay for *Care*?

ACA

Affordable Car Act
What If We Paid for *Cars* the Way We Pay for *Care*?

ACA
Affordable Car Act

**Goal:**
Every citizen should have affordable transportation
What If We Paid for *Cars* the Way We Pay for *Care*?

**ACA**

Affordable Car Act

**Goal:**
Every citizen should have affordable transportation

**Method for Achieving the Goal:**
Give all citizens insurance that would cover the cost of new automobiles and repairs when needed
How to Control Spending on Cars If Insurance Is Paying For Them?
Should the Government Set Fees for Each Car Part…
...And Pay Auto Workers Based On How Many Parts They Installed?

HCPCS Codes (Hierarchical Car Parts Compensation System)

AMA Automobile Manufacturing Association

CPT System (Car Parts Tokens)
The Result for Drivers If We Paid That Way…
The Result for Drivers If We Paid That Way…

Cars would get many unnecessary parts
The Result for Drivers If We Paid That Way…

Cars would get many unnecessary parts

Cars would be readmitted to the factory frequently to correct malfunctions
Spending on Cars Would Grow Rapidly

Car Manufacturing as % of GDP

0%  5%  10%  15%  20%
Spending on Cars Would Grow Rapidly

Car Manufacturing as % of GDP

Government Spending

- Car Subsidies
- Other Govt Spending

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What to Do?
What to Do?
Cut Fees for Parts & Assembly

Cut Fees for Parts & Assembly
What to Do?
Cut Fees for Parts & Assembly

Cut Fees for Parts & Assembly

More Parts Used
What to Do?
Cut Fees for Parts & Assembly

More Parts Used

Factories Merge to Resist Fee Cuts

Cut Fees for Parts & Assembly

$ $
What to Do?
“Managed Cars”
What to Do?
“Managed Cars”

Waiting for Prior Authorization to Buy a New Car
What to Do?
“Managed Cars”

Waiting for Prior Authorization to Buy a New Car

Requirements to Try Lower-Cost Services First
What to Do?
“Shared Savings” Program

STEP 1
Continue Paying Factories & Workers Based on Parts
What to Do?
“Shared Savings” Program

**STEP 1**
Continue Paying Factories & Workers Based on Parts

**STEP 2**
After Cars Are Built & Sold, Compare Total Cost of Parts and Award “Shared Savings”

\[
\# \text{ of Parts} \times \text{Cost of Parts} < \]

\[
\# \text{ of Parts} \times \text{Cost of Parts}
\]
What to Do?
“Shared Savings” Program

STEP 1
Continue Paying Factories & Workers Based on Parts

STEP 2
After Cars Are Built & Sold, Compare Total Cost of Parts and Award “Shared Savings”

\[
\text{Give Factory } \left(0-50\% \text{ of } \left| \sum \text{Cost of Parts} \right|_{\text{other cars}} \right) + \left(\sum \text{Cost of Parts} \right) \times \left(\sum \text{Number of Parts} \right) \times \left(0-50\% \text{ of } \left| \sum \text{Cost of Parts} \right|_{\text{other cars}} \right)
\]

\[
\left| \sum \text{Cost of Parts} \right|_{\text{other cars}} < \left(\sum \text{Number of Parts} \right) \times \left(\sum \text{Cost of Parts} \right) \times \left(0-50\% \text{ of } \left| \sum \text{Cost of Parts} \right|_{\text{other cars}} \right)
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“Shared Savings” Program

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After Cars Are Built & Sold, Compare Total Cost of Parts and Award “Shared Savings”

\[
\text{RESULT} = \text{# of Parts} \times \text{Cost of Parts} + \text{Give Factory 0-50% of Difference in Cost of Parts Compared to Other Cars If Minimum Savings Threshold and Quality Targets Were Met}
\]

\[
< \text{# of Parts} \times \text{Cost of Parts}
\]
What to Do?
“Shared Savings” Program

**STEP 1**
Continue Paying Factories & Workers Based on Parts

**STEP 2**
After Cars Are Built & Sold, Compare Total Cost of Parts and Award “Shared Savings”

- Give Factory 0-50% of Difference in Cost of Parts Compared to Other Cars If Minimum Savings Threshold and Quality Targets Were Met

**RESULT**
- Some factories would reduce parts, but not enough to get shared savings
What to Do?
“Shared Savings” Program

STEP 1
Continue Paying Factories & Workers Based on Parts

STEP 2
After Cars Are Built & Sold, Compare Total Cost of Parts and Award “Shared Savings”

RESULT
• Some factories would reduce parts, but not enough to get shared savings
• Some factories would spend more to meet quality targets than they receive in shared savings

# of Parts x Cost of Parts

+ 0-50% of Difference in Cost of Parts Compared to Other Cars

# of Parts x Cost of Parts

<

Give Factory Minimum Savings Threshold and Quality Targets Were Met
What to Do?
“Shared Savings” Program

**STEP 1**
Continue Paying Factories & Workers Based on Parts

**STEP 2**
After Cars Are Built & Sold, Compare Total Cost of Parts and Award “Shared Savings”

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\text{# of Parts} \times \text{Cost of Parts} + \text{Give Factory} \times 0-50\% \text{ of Difference in Cost of Parts Compared to Other Cars If Minimum Savings Threshold and Quality Targets Were Met}
\]

**RESULT**
- Some factories would reduce parts, but not enough to get shared savings
- Some factories would spend more to meet quality targets than they receive in shared savings
- Some factories would leave out parts where there were no quality measures
### What to Do?

**“Shared Savings” Program**

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#### STEP 2
After Cars Are Built & Sold, Compare Total Cost of Parts and Award “Shared Savings”

<table>
<thead>
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<th>Cost of Parts</th>
</tr>
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<td></td>
<td></td>
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</tbody>
</table>

Give Factory 0-50% of Difference in Cost of Parts Compared to Other Cars If Minimum Savings Threshold and Quality Targets Were Met

#### RESULT
- Some factories would reduce parts, but not enough to get shared savings
- Some factories would spend more to meet quality targets than they receive in shared savings
- Some factories would leave out parts where there were no quality measures
- Most factories and workers would lose money and go back to business as usual
The Way We Actually Pay for Cars Is Much Better
Pay for *Complete* Cars With *Warranties*, Not Parts & Repairs

For more than a decade, America’s Best Warranty hasn’t just changed how our customers feel about their cars, it’s changed how we build vehicles. To make sure we deliver automobiles worthy of a 10-year warranty, Hyundai initiated the Drive Defects to Zero plan. This program has a dedicated team of Hyundai engineers that are charged with catching, learning about and fixing any issue, no matter how small, before it gets to the customer.
True “Value-Based” APMs Pay for Comprehensive Services

“Value-Based Purchasing”

- No payment for services that will benefit patients
- Lower revenues from reducing avoidable costs

“APMs Built on FFS Architecture”

- P4P
- Shared Savings
- PMPM
- Condition-Based Payments
- Bundled/Warrantied Payments
- Primary Care Medical Home Payments
Examples of How Good APMs Can Work

- **FFS**
  - No payment for services that will benefit patients
  - Lower revenues from reducing avoidable costs

- **“Value-Based Purchasing”**
  - P4P
  - No payment for services that will benefit patients
  - Lower revenues from reducing avoidable costs

- **“APMs Built on FFS Architecture”**
  - Shared Savings
  - PMPM
  - No payment for services that will benefit patients
  - Lower revenues from reducing avoidable costs

- **Condition-Based Payments**
  - Bundled/Warrantied Payments
  - Primary Care Medical Home Payments
## A Hypothetical Case of Surgery

<table>
<thead>
<tr>
<th>COST TYPE</th>
<th>TODAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Fee</td>
<td>$2,000</td>
</tr>
<tr>
<td>Hospital Cost</td>
<td>$20,900</td>
</tr>
<tr>
<td>Hosp. Margin (5%)</td>
<td>$1,100</td>
</tr>
<tr>
<td>Total Hospital Pmt</td>
<td>$22,000</td>
</tr>
<tr>
<td>Total Cost to Payer</td>
<td>$24,000</td>
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</table>
Most of the Money Is Not Going to the Physician

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</table>

Physician receives 8% of total spending
What if the Surgeon Could Reduce The Hospital’s Costs?

<table>
<thead>
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<th>TODAY</th>
<th>CHANGE</th>
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</thead>
<tbody>
<tr>
<td>Physician Fee</td>
<td>$2,000</td>
<td></td>
</tr>
<tr>
<td>Hospital Cost</td>
<td>$20,900</td>
<td>-3% ($630)</td>
</tr>
<tr>
<td>Hosp. Margin (5%)</td>
<td>$1,100</td>
<td></td>
</tr>
<tr>
<td>Total Hospital Pmt</td>
<td>$22,000</td>
<td></td>
</tr>
<tr>
<td>Total Cost to Payer</td>
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<td></td>
</tr>
</tbody>
</table>
Today: All Savings Goes to the Hospital, No Reward for Physician

<table>
<thead>
<tr>
<th>COST TYPE</th>
<th>TODAY</th>
<th>CHANGE</th>
<th>SPLIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Fee</td>
<td>$2,000</td>
<td>+ 0%</td>
<td></td>
</tr>
<tr>
<td>Hospital Cost</td>
<td>$20,900</td>
<td>-3% ($630)</td>
<td></td>
</tr>
<tr>
<td>Hosp. Margin (5%)</td>
<td>$ 1,100</td>
<td>+57% ($630)</td>
<td></td>
</tr>
<tr>
<td>Total Hospital Pmt</td>
<td>$22,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Cost to Payer</td>
<td>$24,000</td>
<td>-0%</td>
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Bundling Eliminates Boundary Between Hospital & Physician Pmt

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Bundling Allows Savings Split Among Docs, Hospitals, Payers

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<th>SPLIT</th>
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<tbody>
<tr>
<td>Physician Fee</td>
<td>$ 2,000</td>
<td></td>
<td>+ 10% ($200)</td>
</tr>
<tr>
<td>Hospital Cost</td>
<td>$20,900</td>
<td>-3% ($630)</td>
<td></td>
</tr>
<tr>
<td>Hospital Margin</td>
<td>$ 1,100</td>
<td></td>
<td>+18% ($200)</td>
</tr>
<tr>
<td>Total Cost to Payer</td>
<td>$24,000</td>
<td></td>
<td>- 1% ($230)</td>
</tr>
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</table>
So Price of Surgery is Lower But More Profitable

<table>
<thead>
<tr>
<th>COST TYPE</th>
<th>TODAY</th>
<th>CHANGE</th>
<th>SPLIT</th>
<th>NEW</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Fee</td>
<td>$ 2,000</td>
<td>+ 10% ($200)</td>
<td>$ 2,200</td>
<td></td>
</tr>
<tr>
<td>Hospital Cost</td>
<td>$20,900</td>
<td>-3% ($630)</td>
<td>$20,270</td>
<td></td>
</tr>
<tr>
<td>Hospital Margin</td>
<td>$ 1,100</td>
<td>+18% ($200)</td>
<td>$ 1,300</td>
<td></td>
</tr>
<tr>
<td>Total Cost to Payer</td>
<td>$24,000</td>
<td>- 1% ($230)</td>
<td>$23,770</td>
<td></td>
</tr>
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</table>
Opportunities to Reduce Hospital Costs

• Use of lower-cost medical devices and equipment, or negotiating for better prices on devices
• Better scheduling of scarce resources (e.g., surgery suites) to reduce both underutilization & overtime
• Coordination among multiple physicians and departments to avoid duplication and conflicts in scheduling
• Standardization of equipment and supplies to facilitate bulk purchasing
• Less wastage of expensive supplies
• Reduced length of stay
• Etc.
Medicare Acute Care Episode (ACE) Demonstration

- Bundled Medicare Part A (hospital) and Part B (physician) payments together for cardiac and orthopedic (hips & knees) procedures
- Total Medicare payment was 1%-8% lower than what the standard Medicare DRG + physician fee would have been
- Payment was made to a Physician-Hospital Organization, which then divided the payment between hospital and surgeon
- Surgeon could receive up to 25% above Medicare fee
- Patient cost-sharing reduced by up to 50% of Medicare’s savings
- CMS waived Stark rules for gainsharing
- Implemented in 2009/2010 in five hospital systems based on competitive bids:
  - Hillcrest Medical Center, Oklahoma (cardiac + orthopedic procedures)
  - Baptist Health System, Texas (cardiac + orthopedic procedures)
  - Oklahoma Heart Hospital, Oklahoma (cardiac procedures)
  - Lovelace Health System, New Mexico (cardiac + orthopedic procedures)
  - Exempla Saint Joseph Hospital, Colorado (cardiac procedures)
- Most hospitals achieved significant savings, and physicians received increases in payment for procedures
Yes, a Health Care Provider Can Offer a Warranty

Geisinger Health System ProvenCare℠

- A single payment for an ENTIRE 90 day period including:
  - ALL related pre-admission care
  - ALL inpatient physician and hospital services
  - ALL related post-acute care
  - ALL care for any related complications or readmissions

- Types of conditions/treatments currently offered:
  - Cardiac Bypass Surgery
  - Cardiac Stents
  - Cataract Surgery
  - Total Hip Replacement
  - Bariatric Surgery
  - Perinatal Care
  - Low Back Pain
  - Treatment of Chronic Kidney Disease
Payment + Process Improvement = Better Outcomes, Lower Costs

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

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

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

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<td>Neurologic complication</td>
<td>1.5 %</td>
<td>0.6 %</td>
<td>60 %</td>
</tr>
<tr>
<td>Any pulmonary complication</td>
<td>7 %</td>
<td>4 %</td>
<td>43 %</td>
</tr>
<tr>
<td>Blood products used</td>
<td>23 %</td>
<td>18 %</td>
<td>22 %</td>
</tr>
<tr>
<td>Re-operation for bleeding</td>
<td>3.8 %</td>
<td>1.7 %</td>
<td>55 %</td>
</tr>
<tr>
<td>Deep sternal wound infection</td>
<td>0.8 %</td>
<td>0.6 %</td>
<td>25 %</td>
</tr>
<tr>
<td>Readmission within 30 days</td>
<td>6.9 %</td>
<td>3.8 %</td>
<td>44 %</td>
</tr>
</tbody>
</table>

Readmission within 30 days 6.9 % 3.8 % 44 %
Central teachers gain $7G average
Super: Health-care savings balance raises in contract

By GARY PANG
Press Enterprise Writer

SOUTH CENTRE TWP. — Central Columbia teachers will see their average salary of $55,417 jump up by $7,000 under a new three-year contract, newspaper calculations show.

School directors recently gave 4.54 percent raises to their teachers, the largest in the area for the coming year.

But Superintendent Harry Mathias said the district can afford the pay increases because the teachers agreed to changes that will slash health insurance costs.

Teachers also agreed to pay more toward their health insurance.

The changes will let Central keep the lowest insurance costs among area school districts, he said.

The new contract costs $8.3 million in the coming year, Mathias estimated. However, retirements would reduce expenses, he added.

Higher starting salary
Pay raises were set at 4.54 percent for the coming year; 3.62 percent in the contract's second year, 2010-11, and 4.36 percent in 2011-12.

These raises would push the average teacher salary up to $55,842 in the coming year, $57,864 in the second year and $60,387 in the third year, calculations show.

Central also raised the starting salary for teachers. The $33,638 figure would jump up in three years by $4,774, calculations show.

The starting salary will be $35,656 in the coming year, $37,054 in the second year and $38,412 in the final year, Mathias said.

But the contract isn't just about pay raises, he said.

New insurance
Back in April, Central was predicting a big rise in insurance premiums. To lower costs, the district switched from Capital Blue Cross to Geisinger Health Plan for all employees.

The switch will reduce costs by $130,000 to $140,000, Mathias estimated.

The union accepted the change as part of the new contract, Mathias said.

While other school districts are facing 7 to 8 percent increases in insurance costs, Central is dealing with just a 2.5 percent increase, the superintendent said.

Central's average health insurance cost is $8,400 per teacher, Mathias estimated. He said other school districts are paying thousands of dollars more.

That's because many school districts get health insurance through the Northeast Pennsylvania School Health Trust, he said. Central, however, finds insurance and bargains on its own. That reduces district costs by $500,000.

Teachers' concession
Teachers made another concession that might save Central an additional $20,000, Mathias said.

Before, teachers could choose between an ordinary plan and a more expensive one. If they chose the pricier plan, they paid more money toward the upgrade, but the district picked up some of the additional cost.

Now, if they choose a pricier insurance plan, they'll swallow all the extra expenses.

The pricier plan costs $250 more for single employees and $650 more for employees with families.

What they'll pay
Teachers had been paying 10 percent of their insurance premiums. That will increase to 11 percent in the first year of the new contract, then 12 percent the second year and 13 percent the third year.

Mathias gave examples of what they might pay in the coming year. These figures do not include the "premium" option.

• The premium for a single employee is $4,500, with the employee paying $500.

• The premium for a family plan is $10,500, so the employee pays $1,150.

The rate is different for non-teacher employees, Mathias noted. Support staff members pay 5 percent of their premiums, while administrators pay 6 percent of their premiums, plus .6 percent of their salaries.

Expense breakdown
The contract's cost of $8.3 million for the coming year includes insurance expenses: $1 million for teachers and $800,000 to $900,000 for everyone else, Mathias estimated.

In 2008-09, Central paid about $7.17 million in teacher salaries and $1 million in benefits, Mathias said.

Despite the recent raises, the Central board is not increasing taxes in the coming year under its recently passed budget.
It Can Be Done By Physicians, Not Just Large Health Systems

• In 1987, an orthopedic surgeon in Lansing, Michigan and the local hospital, Ingham Medical Center, offered:
  – a fixed total price for surgical services for shoulder and knee problems
  – a warranty for any subsequent services needed for a two-year period, including repeat visits, imaging, rehospitalization and additional surgery

• Results:
  – Health insurer paid 40% less than otherwise
  – Surgeon received over 80% more in payment than otherwise
  – Hospital received 13% more than otherwise, despite fewer rehospitalizations

• Method:
  – Reducing unnecessary auxiliary services such as radiography and physical therapy
  – Reducing the length of stay in the hospital
  – Reducing complications and readmissions.

A Warranty is Not an Outcome Guarantee

- Offering a warranty on care does not imply that you are guaranteeing a cure or a good outcome
- It merely means that you are agreeing to correct avoidable problems at no (additional) charge
- Most warranties are “limited warranties,” in the sense that they agree to pay to correct some problems, but not all
Prices for Warrantied Care Will Likely Be Higher
Prices for Warrantied Care Will Likely Be Higher

- Q: “Why should we pay more to get good-quality care??”
- A: In most industries, warrantied products cost more, but they’re desirable because TOTAL spending on the product (repairs & replacement) is lower than without the warranty.
Example: $5,000 Procedure, 20% Readmission Rate

<table>
<thead>
<tr>
<th>Cost of Success</th>
<th>Added Cost of Readmit</th>
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</tr>
</thead>
<tbody>
<tr>
<td>$5,000</td>
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<td>20%</td>
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Average Payment for Procedure is Higher than the Official “Price”

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So how much should you charge to offer this same procedure with a warranty?
### Starting Point for Warranty Price: Actual Current Average Payment

<table>
<thead>
<tr>
<th>Cost of Success</th>
<th>Added Cost of Readmit</th>
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<th>Average Total Cost</th>
<th>Price Charged</th>
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</tr>
</thead>
<tbody>
<tr>
<td>$5,000</td>
<td>$5,000</td>
<td>20%</td>
<td>$6,000</td>
<td>$6,000</td>
<td>$ 0</td>
</tr>
</tbody>
</table>
Limited Warranty Gives Financial Incentive to Improve Quality

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<tr>
<td>$5,000</td>
<td>$5,000</td>
<td>15%</td>
<td>$5,750</td>
<td>$6,000</td>
<td>$250</td>
</tr>
</tbody>
</table>

- Reducing Adverse Events...
- ...Reduces Costs...
- ...Improves The Bottom Line
### Higher-Quality Provider Can Charge Less, Attract Patients

<table>
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<tr>
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Enables Lower Prices  
Still With Better Margin
### A Virtuous Cycle of Quality Improvement & Cost Reduction

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- Reducing Adverse Events...
- ...Reduces Costs...
- ...Improves The Bottom Line
Win-Win-Win Through Appropriate Payment & Pricing

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<td>$5,700</td>
<td>$200</td>
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<tr>
<td>$5,000</td>
<td>$5,000</td>
<td>5%</td>
<td>$5,250</td>
<td>$5,700</td>
<td>$450</td>
</tr>
</tbody>
</table>

Quality is Better...

...Cost is Lower...

...Providers More Profitable
In Contrast, Non-Payment Alone Creates Financial Losses

<table>
<thead>
<tr>
<th>Cost of Success</th>
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<td>$  0</td>
</tr>
<tr>
<td>$5,000</td>
<td>$5,000</td>
<td>20%</td>
<td>$6,000</td>
<td>$5,000</td>
<td>-$1,000</td>
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<tr>
<td>$5,000</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$5,000</td>
<td>$5,000</td>
<td>0%</td>
<td>$5,000</td>
<td>$5,000</td>
<td>$   0</td>
</tr>
</tbody>
</table>

Non-Payment for Readmits Causes Losses While Improving
Many Variations Possible in Combining Bundles and Warranties
Starting with a Hospital Procedure…
Simplest Bundle, Already Working in CMS Demonstrations

SINGLE PMT

Procedure

Hospital DRG

Physician Fee

PATIENT
Bundling All Physicians Promotes More Care Coordination

**SINGLE PMT**

- **Procedure**
- Hospital DRG
- Lead Doc. Fee
- Consultant Fee
- Consultant Fee

**PATIENT**
Not All Care Providers Are Inside the Hospital Walls

<table>
<thead>
<tr>
<th>SINGLE PMT</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hospital DRG</td>
</tr>
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<tr>
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<td>Consultant Fee</td>
</tr>
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<td></td>
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</table>

<table>
<thead>
<tr>
<th>Post-Acute</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rehab</td>
</tr>
<tr>
<td>Home Health</td>
</tr>
<tr>
<td>PCP</td>
</tr>
<tr>
<td>Specialist</td>
</tr>
</tbody>
</table>

**PROBLEM:**
No incentive to reduce unnecessary use of expensive post-acute care
Bundling Inpatient and Post-Acute Care Promotes Coordination

**SINGLE PAYMENT**

**Procedure**
- Hospital DRG
- Lead Doc. Fee
- Consultant Fee
- Consultant Fee

**Post-Acute**
- Rehab
- Home Health
- PCP
- Specialist

PATIENT →
# Does the Bundle Stop When Things Go Bad in the Hospital?

## SINGLE PAYMENT

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Complication</th>
<th>Post-Acute</th>
</tr>
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## PATIENT

**PATIENT**

**PROBLEM:**
Hospital and physicians are paid more to treat expensive infections and complications.
Including a Warranty for Complications in the Bundle

PATIENT

SINGLE PAYMENT

Procedure
- Hospital DRG
- Lead Doc. Fee
- Consultant Fee
- Consultant Fee

Complication
- DRG/Outlier
- Lead Doc. Fee
- Consultant Fee
- Consultant Fee

Post-Acute
- Rehab
- Home Health
- PCP
- Specialist
Including a Warranty for Post-Discharge Problems

**SINGLE PAYMENT**

**Procedure**
- Hospital DRG
- Lead Doc. Fee
- Consultant Fee
- Consultant Fee

**Complication**
- DRG/Outlier
- Lead Doc. Fee
- Consultant Fee
- Consultant Fee

**Post-Acute**
- Rehab
- Home Health
- PCP
- Specialist

**Readmission**
- Hospital DRG
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- Consultant Fee
- Consultant Fee

**Days Post-Discharge**
- 15
- 30
- 90+
“Episode” Payments Are Bundles Over a Full Course of Treatment

<table>
<thead>
<tr>
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</tr>
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Days Post-Discharge: 15, 30, 90+
What If The Procedure Could Be Done Outside the Hospital?

**PROBLEM:**
No incentive to use lower-cost setting, since payer gains all savings from lower facility fees.
A Facility-Independent Episode

SINGLE PAYMENT

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SOLUTION: Providers keep some of the savings from moving procedures to lower-cost settings
What if An Alternative Procedure Would Be Better or Cheaper?

**PROBLEM:**
No incentive to use lower-cost procedures (or to use no procedure at all)
A **Condition-Based** (Not Procedure-Based) Payment

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**SOLUTION:**
Provider keeps some of the savings from using lower-cost procedures.
Opportunities for Lower-Cost Care for Many Conditions

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

• Maternity Care
  – Vaginal delivery instead of C-Section
  – Term delivery instead of early elective delivery
  – Delivery in birth center instead of hospital

• Chest Pain
  – Non-invasive imaging instead of invasive imaging
  – Medical management instead of invasive treatment

• Chronic Disease Management
  – Improved education and self-management support
  – Avoiding hospitalizations for exacerbations
Opportunities for Lower-Cost Care for Many Conditions

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TODAY
Savings for Payers = Lower Margins for Hospitals
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TODAY
Savings for Payers = Lower Margins for Hospitals

CONDITION-BASED PAYMENT
Savings for Payers = Higher Margins for Hospitals
What About “Transparency?”

Care Bundle

Knee Arthroscopy With ACL Surgery

A knee arthroscopy is a surgery that uses small medical instruments and a camera to look inside the knee joint to treat certain

read more

Detailed estimates for Uninsured Procedure

<table>
<thead>
<tr>
<th>Lead Provider</th>
<th>Estimated Charge Amount</th>
<th>Uninsured Discount Rate</th>
<th>Estimate of Amount Due</th>
<th>Typical Patient Complexity</th>
</tr>
</thead>
<tbody>
<tr>
<td>STRATHAM AMBULATORY SURGERY CENTER (PARADIGM LLC)</td>
<td>$7,850</td>
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<td>$7,850</td>
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<tr>
<td>SPEARE MEMORIAL HOSPITAL</td>
<td>$8,496</td>
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<td>ALICE PECK DRY MEMORIAL HOSPITAL</td>
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<td>CONCORD AMBULATORY SURGERY CENTER</td>
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<td>ELLIOT ONE-DAY SURGERY CENTER</td>
<td>$10,589</td>
<td>0%</td>
<td>$10,589</td>
<td>MEDIUM</td>
</tr>
<tr>
<td>LETTLETON REGIONAL HOSPITAL</td>
<td>$11,065</td>
<td>33%</td>
<td>$7,413</td>
<td>MEDIUM</td>
</tr>
</tbody>
</table>

National Average

$11,045

IN YOUR AREA:

California State Average

$18,234

San Francisco, California Average

$16,420

Click here to change location.
Current Transparency Efforts Are Focused on Procedure Price

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

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

Bundled prices show that Provider 1 is the higher-value provider.
True “Value-Based”
Alternative Payment Models…

“Value-Based Purchasing”

- No payment for services that will benefit patients
- Lower revenues from reducing avoidable costs

“APMs Built on FFS Architecture”

- No payment for services that will benefit patients
- Lower revenues from reducing avoidable costs

<table>
<thead>
<tr>
<th>Condition-Based Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bundled/Warrantied Payments</td>
</tr>
<tr>
<td>Primary Care Medical Home Payments</td>
</tr>
</tbody>
</table>
…Can Create Win-Win-Wins for Patients, Payers, & Hospitals

“Value-Based Purchasing”

“APMs Built on FFS Architecture”

FFS

• No payment for services that will benefit patients
• Lower revenues from reducing avoidable costs

P4P

• No payment for services that will benefit patients
• Lower revenues from reducing avoidable costs

Shared Savings PMPM

• No payment for services that will benefit patients
• Lower revenues from reducing avoidable costs

Better Care for Patients

Lower Spending for Payers

Financially Viable Physician Practices & Hospitals
...Can Create Win-Win-Wins for Patients, Payers, & Hospitals

**“Value-Based Purchasing”**
- P4P

**“APMs Built on FFS Architecture”**
- Shared Savings
- PMPM

**FFS**
- No payment for services that will benefit patients
- Lower revenues from reducing avoidable costs

**Better**
- BUT ONLY IF THEY’RE DESIGNED THE RIGHT WAY

**Hospitals**

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CMS “Comprehensive Care for Joint Replacement”

EPISODE PAYMENT FOR SURGERIES

PATIENT

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

**EPISODE PAYMENT FOR SURGERIES**

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

SAVINGS

PATIENT

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Proposed Structure Encourages Lower Spending, Not Better Care

EPISODE PAYMENT FOR SURGERIES

- No risk adjustment – target spending amount is the same for high-risk, poor functional status patients as low-risk patients
- No flexibility to deliver different types of post-acute care or to be paid differently – no change in current payment systems
Hospitals at Risk for Total Cost With Everyone Still Paid the Same

EPISODE PAYMENT FOR SURGERIES

- No risk adjustment – target spending amount is the same for high-risk, poor functional status patients as low-risk patients
- No flexibility to deliver different types of post-acute care or to be paid differently – no change in current payment systems
- Hospital is at risk for higher post-acute care spending
Over Time, CMS Keeps More of the Savings, If There Are Any

**EPISODE PAYMENT FOR SURGERIES**

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

- **Hospital Costs for Surgery**
  - Readmits
  - Post-Acute Care

**SAVINGS**

**CMS**

- **No risk adjustment** – target spending amount is the same for high-risk, poor functional status patients as low-risk patients
- **No flexibility** to deliver different types of post-acute care or to be paid differently – no change in current payment systems
- **Hospital** is at risk for higher post-acute care spending
- **Target spending** is reduced every year to match lower FFS spending

---

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

EPISODE PAYMENT FOR SURGERIES

PATIENT

Hospital Costs for Surgery

Readmits

Post-Acute Care (IRF, SNF, HH)

SAVINGS

Hospital

Physicians and Post-Acute Care

Non-Surg. Treatment

SAVINGS
Critical Access Hospitals Could Be Harmed by CJR

- Hospitals will be penalized if their patients use higher-cost post-acute care services.
- If CAH cost per SNF/swing day is higher than other hospitals, CJR hospitals could avoid using the CAH for post-acute care services.
Good Ways and Bad Ways to Define Alternative Payment Models

**HOW PAYMENT REFORMS ARE DESIGNED TODAY**

- Medicare and Health Plans Define Payment Systems
- Providers Have To Change Care to Align With Payment Systems
- Patients and Providers May Not Come Out Ahead

**THE RIGHT WAY TO DESIGN PAYMENT REFORMS**

- Providers Redesign Care and Identify Payment Barriers
- Payers Change Payment to Support Redesigned Care
- Patients Get Better Care and Providers Stay Financially Viable
Three Paths to the Future

CURRENT PAYMENT SYSTEMS

PAY FOR PERFORMANCE
(“Value-Based Payment/Purchasing”)
(“Merit-Based Incentive Payment System”)

PAYER-DESIGNED ALTERNATIVE PAYMENT MODELS (APMs)

PROVIDER-DESIGNED ALTERNATIVE PAYMENT MODELS (APMs)
Learn More About Win-Win-Win Payment and Delivery Reform

www.PaymentReform.org
For More Information:

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President and CEO  
Center for Healthcare Quality and Payment Reform

Miller.Harold@GMail.com  
(412) 803-3650

www.CHQPR.org  
www.PaymentReform.org