Are APMs Better Than FFS?

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

www.CHQPR.org
PLEASE NOTE:
Although I am one of the 11 members of the Physician-Focused Payment Model Technical Advisory Committee (PTAC), my comments today reflect my personal opinions; my comments do not represent official positions of the PTAC, and other PTAC members may or may not agree with them.
The Biggest Barrier to *Coverage* is the High *Cost* of Health Care

![Bar graph showing increasing healthcare costs over time.](image)
Is Fee for Service (FFS) Payment to Blame for High Cost Care?
Will “Getting Rid” of FFS Solve the Problem?

“…a lot of what I do in my role running CMMI … is to blow up fee for service. That's one of our prime goals— is to get rid of fee for service.”

Adam Boehler
What Exactly is Wrong With Fee for Service?
People Seem to Believe FFS is an Addiction Physicians Can’t Control

“I wish I could stop ordering more services, but I can’t control myself”
The Four (Real) Problems with (Current) FFS Payment Systems
The Four (Real) Problems with (Current) FFS Payment Systems

1. No fee for many high value services that could help patients and reduce overall healthcare spending
Diagnosing a New Symptom: Call to Doctor Might Be Enough

$27

Phone Call
Medicare Doesn’t Pay for Phone Calls

$27
Medicare Only Pays for Face-to-Face Visits with Physician
What if the Patient is Too Sick to Drive or Has No Transportation?

$27  Phone Call

$150  Transport to Office

$150  Physician Office Visit
Medicare Doesn’t Pay for Transportation to Doctor’s Office

- Physicians’ Office Visit: $150
- Transport to Office: $27
- Phone Call: $27
Medicare WILL Pay for an ED Visit

-$27$ - Phone Call

-$150$ - Transport to Office

-$480+$ - Emergency Department Visit

-$150$ - Physician Office Visit
Medicare WILL Pay for an ED Visit AND the Ambulance to Get There

- Phone Call: $27
- Physician Office Visit: $150
- Emergency Department Visit: $700+
- Ambulance to Hospital: $700+
A Phone Call That Prevented an ED Visit Would Save a Lot of $
The Four (Real) Problems with (Current) FFS Payment Systems

1. No fee for many high value services that could help patients and reduce overall healthcare spending

2. Fees don’t match the cost of delivering high-quality care
Medicare Payment for Office Visit With Physician

Established Patient Office Visit

15 Min.
Level 3
Estab Pt E/M $75
$75 for 15 min = $300/Hour, Which Sounds Like a Lot…
...But Most of That Doesn’t Go to the Physician

Established Patient Office Visit

- Office rent
- Office equipment
- Utilities
- Receptionist
- Medical Assistant
- Nurse (if any)
- Billing staff/company
- EHR

- Patient no-shows
- Pre-visit & post-visit time

- Physician take-home compensation
What If The Physician Spends More Time With the Patient?

Established Patient Office Visit

- Level 3 Estab Pt E/M $75
- 15 Min. Visit
- $0 to $300 per Hour?
- More $ Per Visit?
- 20 Min. Visit
- Same $/Hr?
Large Penalty for Spending More Time With Patients

Established Patient Office Visit

- 25% lower earnings/hour
- 33% more time with patient
- 0% higher fee for physician
Established Patient Office Visit

- 15 Min. Level 3 Estab Pt E/M $75
- 20 Min. Level 3 Estab Pt E/M $75
- 25 Min. Level 4 Estab Pt E/M $110

- 12% lower earnings/hour
- 67% more time with patient
- 47% higher fee for physician
Financial Penalty for Level 5 vs Level 4 Visit

Established Patient Office Visit

- 15 Min. Level 3 Estab Pt E/M $75
  - 25% lower earnings/hour
  - 25% lower earnings/hour

- 20 Min. Level 3 Estab Pt E/M $75
  - 12% lower earnings/hour

- 25 Min. Level 4 Estab Pt E/M $110
  - 26% lower earnings/hour

- 40 Min. Level 5 Estab Pt. E/M $148
  - 167% more time with patient
  - 97% higher fee for physician
Penalty for Seeing New Patients vs. More Visits w/ Current Patients

Established Patient Office Visit

- Level 3 Estab Pt E/M $75
- Level 4 Estab Pt E/M $110
- Level 5 Estab Pt E/M $148

New Patient Office Visit

- Level 3 New Pt E/M $110
- Level 4 New Pt E/M $167
- Level 5 New Pt E/M $210

$300 → -25% → $225
$250 → -12% → $225
$200 → -26% → $148
$150 → -27% → $110
$100 → -26% → $75
$50 → -30% → $35
$0
What Happens if the Patient Needs 30 Minutes Instead of 15?

- 15 Min. visit with PCP: $75
- 30 min visit with PCP: [Diagram showing the higher expense]
Medicare Doesn’t Pay Twice as Much

$110
30 min visit with PCP

$150+
30 min visit with PCP

Savings of $40??

15 Min. with PCP
$75

30 min visit with PCP
$150+

Savings of $40??

30 min visit with PCP
$110
The Result:
(1) Shorter PCP Visit Than Needed

30 min visit with PCP: $110
15 Min. with PCP: $75

Savings: $40
The Result:
(2) Unnecessary Specialist Visit

- 30 min visit with PCP: $150+

Savings of $40??

15 Min. visit with PCP
$75

15 Min. with PCP
$75

15 Min. w/specialist
$110
The Result:
(3) Return for Second Visit to PCP

-$30 \text{ min visit with PCP} = \$110$

$15 \text{ Min. with PCP} = \$75$

$15 \text{ Min. w/specialist} = \$110$

Savings of $40$??

$30 \text{ min visit with PCP} = \$150+$

$15 \text{ Min. with PCP} = \$75$

$15 \text{ Min. with PCP} = \$75$

$15 \text{ Min. w/specialist} = \$110$
The Result: Three Visits Instead of One

<table>
<thead>
<tr>
<th>Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 min. visit with PCP</td>
<td>$30</td>
</tr>
<tr>
<td>15 min. with PCP</td>
<td>$110</td>
</tr>
<tr>
<td>15 min. with specialist</td>
<td>$110</td>
</tr>
<tr>
<td><strong>Total Payments for 3 visits</strong></td>
<td><strong>$260</strong></td>
</tr>
</tbody>
</table>

Savings of $40??
The Result: Higher Spending, Not Savings

$110 Higher Cost

30 min visit with PCP $150+

30 min visit with PCP $110

Savings of $40??

15 Min. with PCP $75

15 Min. with PCP $75

15 Min. w/specialist $110

Total Payments for 3 visits = $260

$30 min visit with PCP

$110

$75

Savings of $40??

$150+

$75

$110

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The PCP Isn’t Getting *Paid* More
But Medicare *Spends* More

$300 Per Hour

15 Min. w/specialist $110

15 Min. with PCP $75

$75

15 Min. with PCP

$75

20 min. w/PCP

$300 Per Hour
Many Cases Where Low/$0 Fees Cause Higher Spending Elsewhere

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<thead>
<tr>
<th>WE DON’T PAY (ENOUGH) FOR</th>
<th>SO WE END UP PAYING (MORE) FOR</th>
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</thead>
<tbody>
<tr>
<td>Phone calls to assess symptoms</td>
<td>Emergency Department visits</td>
</tr>
<tr>
<td>Extended physician visits to accurately diagnose new symptoms</td>
<td>Multiple referrals to specialists, unnecessary tests, and repeat visits</td>
</tr>
<tr>
<td>Patient education on self-management</td>
<td>ED visits and hospital admissions</td>
</tr>
<tr>
<td>Physical therapy</td>
<td>Spine and joint surgeries</td>
</tr>
<tr>
<td>Vaginal delivery</td>
<td>Cesarean sections</td>
</tr>
<tr>
<td>Palliative care</td>
<td>Hospitalizations at end of life</td>
</tr>
<tr>
<td>Home rehabilitation</td>
<td>Skilled nursing facility stays</td>
</tr>
<tr>
<td>IV hydration at home or a physician office for complications of cancer treatment</td>
<td>ED visits and hospital admissions</td>
</tr>
</tbody>
</table>
The Four (Real) Problems with (Current) FFS Payment Systems

1. No fee for many high value services that could help patients and reduce overall healthcare spending

2. Fees don’t match the cost of delivering high-quality care
   - Underpayment for diagnosis, preventive care, & low-cost treatment
   - Overpayment for services delivered in hospitals
It Doesn’t Cost Twice as Much to Do Surgery in a Hospital

ASC Payment for Cataract Surgery: $977

HOPD Payment For Cataract Surgery: $1917
The Four (Real) Problems with (Current) FFS Payment Systems

1. No fee for many high value services that could help patients and reduce overall healthcare spending

2. Fees don’t match the cost of delivering high-quality care
   - Underpayment for diagnosis, preventive care, & low-cost treatment
   - Overpayment for services delivered in hospitals

3. Impossible for patients or payers to know how much they will have to spend for treatment of a health problem
How Much Will a Procedure or Treatment Cost, *In Total*?

Total Payments for Cataract Surgery

- ASC Fee
- Surgeon Fee
How Much Will a Procedure or Treatment Cost, *In Total*?

Total Payments for Cataract Surgery

- Surgeon Fee
- ASC Fee
- Anesthesia Fee
- Post-Op Drugs

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How Much Will a Procedure or Treatment Cost, *In Total*?

Total Payments for Cataract Surgery

- ASC Fee
- Anesthesia Fee
- Surgeon Fee
- Post-Op Drugs
- Anesthesia Fee
- HOPD Payment
- Surgeon Fee
How Much Will a Procedure or Treatment Cost, *In Total*?

Total Payments for Cataract Surgery

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- HOPD Payment
- Payments to Treat Complications
The Four (Real) Problems with (Current) FFS Payment Systems

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2. Fees don’t match the cost of delivering high-quality care
   – Underpayment for diagnosis, preventive care, & low-cost treatment
   – Overpayment for services delivered in hospitals

3. Impossible for patients or payers to know how much they will have to spend for treatment of a health problem

4. No assurance that a patient will receive high quality care
Payment When the Treatment is Successful

Knee Surgery That Allows Patient to Walk Without Pain

Payments to Surgeon, Anesthesiologist, Hospital, and Post-Acute Care Providers for Surgery and Rehab
Payment When the Treatment is Unsuccessful

Knee Surgery That Allows Patient to Walk Without Pain

Payments to Surgeon, Anesthesiologist, Hospital, and Post-Acute Care Providers for Surgery and Rehab

Knee Surgery That Fails to Allow Patient to Walk Without Pain

Payments to Surgeon, Anesthesiologist, Hospital, and Post-Acute Care Providers for Surgery and Rehab
Payment When the Treatment Makes Things Worse

Knee Surgery That Allows Patient to Walk Without Pain
- Payments to Surgeon, Anesthesiologist, Hospital, and Post-Acute Care Providers for Surgery and Rehab

Knee Surgery That Fails to Allow Patient to Walk Without Pain
- Payments to Surgeon, Anesthesiologist, Hospital, and Post-Acute Care Providers for Surgery and Rehab

Knee Surgery That Results in Infection or Complications
- Payments for Treatment of Infection or for Repeat Surgery
  - Payments to Surgeon, Anesthesiologist, Hospital, and Post-Acute Care Providers for Surgery and Rehab
## Current FFS Systems

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<tr>
<th>Weaknesses of Fee for Service</th>
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We Don’t Pay for Other Products & Services This Way
We Don’t Pay for Other Products & Services This Way

What if We Paid for *Cars* the Way We Paid for *Care*?
The Government Would Set Fees for Each Car Part

HCPCS Codes (Hierarchical Car Parts Compensation System)
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
We Won’t Get “High-Value Care” Unless We Fix These Problems

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Do “Value-Based” Payments Solve the Problems With FFS?

Unpaid & Underpaid Services

FFS

“VALUE-BASED” PAYMENT
The Most Common “Value-Based” Payment is P4P (MIPS)
MIPS/P4P Doesn’t Add New Fees or Change Relative Fee Amounts
MIPS/P4P Bonuses/Penalties Don’t Enable or Ensure Quality

There is no bonus unless other physicians get a penalty.

FFS

Unpaid & Underpaid Services

FFS

All Current FFS Payments

MIPS/P4P

Bonus Penalty

No New Payments
MIPS/P4P Bonuses/Penalties Don’t Enable or Ensure Quality

There is no bonus unless other physicians get a penalty.

Bonuses may not be sufficient to support the costs of services needed to achieve better results or even the administrative costs of collecting the measures.

FFS

Unpaid & Underpaid Services

All Current FFS Payments

No New Payments

FFS

Bonus Penalty

FFS

MIPS/P4P

$
MIPS/P4P Bonuses/Penalties Don’t Enable or Ensure Quality

There is no bonus unless other physicians get a penalty.

Bonuses may not be sufficient to support the costs of services needed to achieve better results or even the administrative costs of collecting the measures.

Patients/payers still have to pay for services to a patient who failed to achieve the desired outcome or experienced complications as a result of the services.
Value-Based Payment Option #2: Alternative Payment Models (APMs)
In MACRA, Congress *Encouraged* Use of APMs Instead of MIPS

Physicians who participate in approved Alternative Payment Models (APMs) at more than a minimum level:

- are exempt from MIPS
- receive a 5% lump sum bonus
- receive a higher annual update in their FFS revenues
- receive the benefits of participating in the APM
CMS Has Only Implemented a Small Number of APMs

ALTERNATIVE PAYMENT MODELS

MIPS/P4P  | CPC+/OCM  | CJR/BPCI  | MSSP

Unpaid & Underpaid Services

FFS

Bonus Penalty

Comp. Primary Care Initiative (CPC+)
&
Oncology Care Model (OCM)

Comp. Care for Joint Rep. (CJR)
&
Bundled Pmts for Care Imp. (BPCI)

Medicare Shared Savings Program ACOs

All Current FFS Payments

No New Payments
Only 2 CMS APMs Pay for Things Standard FFS Doesn’t Cover

**ALTERNATIVE PAYMENT MODELS**

- **MIPS/P4P**
  - Unpaid & Underpaid Services
  - No New Payments

- **CPC+/OCM**
  - Bonus New Per-Patient Payment

- **CJR/BPCI**
  - Comp. Care for Joint Rep. (CJR) & Bundled Pmts for Care Imp. (BPCI)

- **MSSP**
  - Medicare Shared Savings Program ACOs
“Bundles” Pay Standard FFS + Bonus/Penalty for Total Spending

ALTERNATIVE PAYMENT MODELS

- MIPS/P4P
- CPC+/OCM
- CJR/BPCI
- MSSP

FFS

MSSP

Medicare Shared Savings Program ACOs

Unpaid & Underpaid Services

No New Payments

Bonus Per-Patient Payment

No New Payments

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ACOs Get Standard FFS w/ "Shared Savings" Payments

ALTERNATIVE PAYMENT MODELS
MIPS/P4P  CJR/BPCI  CPC+/OCM  MSSP

FFS  FFS  FFS  FFS  FFS

All Current FFS Payments  All Current FFS Payments  All Current FFS Payments  All Current FFS Payments  All Current FFS Payments

Unpaid & Underpaid Services  No New Payments  No New Payments  No New Payments  No New Payments

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Most CMS “APMs” Are Just FFS + P4P Based on Spending
If CMS APMs Don’t *Change* FFS, They Can’t *Solve* Its Problems

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**Little Change in Payment Means Small Savings from CMS APMs**

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<th>CMS APM</th>
<th>GROSS SAVINGS PER PATIENT</th>
<th>NET SAVINGS PER PATIENT AFTER PAYMENTS TO PROVIDERS</th>
<th>TOTAL ANNUAL NET SAVINGS TO CMS</th>
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# ACOs Savings is < Half the Cost of One Office Visit Per Pt Per Year

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Little Savings Overall From ACOs, But Some Are Saving a Lot

Source: Centers for Medicare and Medicaid Services ACO Public Use Files

% Change in Spending Net of Shared Savings Bonuses/Penalties 2017

- Savings > 3%
- 433 Upside Risk ACOs
- 39 Downside Risk ACOs

Higher Spend

Lower Spend
How Did the ACOs That Saved Money Achieve the Savings?
Did They Reduce Spending on Undesirable/Unnecessary Svcs?

- PRE-ACO BASELINE SPENDING
- AVOIDABLE SPENDING
- NECESSARY SPENDING
- AVOIDABLE SPENDING
- NECESSARY SPENDING
- ACO ACTUAL SPENDING
- SAVINGS

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

- PRE-ACO BASELINE SPENDING
- NECESSARY SPENDING
- AVOIDABLE SPENDING
- NECESSARY SPENDING
- AVOIDABLE SPENDING
- ACO ACTUAL SPENDING
- SAVINGS

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ACOs Don’t Have to Tell Us and CMS Doesn’t Ask

The ACO Black Box

PRE-ACO BASELINE SPENDING

ACO ACTUAL SPENDING

SAVINGS
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:**
- Delivery of high-quality cataract & retinal surgery
- 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
- Access to and quality of care for many other conditions

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Small Savings In Bundles Because The Opportunity is Relatively Small

SAVINGS OPPORTUNITIES IN HOSPITAL EPISODE PAYMENTS

- Reduce use of inpatient post-acute rehabilitation
- Reduce hospital readmissions due to complications
No New/Different Payments for Redesign of Post-Acute Care

SAVINGS OPPORTUNITIES IN HOSPITAL EPISODE PAYMENTS

- Reduce use of inpatient post-acute rehabilitation
- Reduce hospital readmissions due to complications

In BPCI/CJR, only standard hospital and post-acute care services are paid for directly, so there is no easy way to develop new types of in-home rehabilitation services or to improve physician follow-up and care management after discharge.
SAVINGS OPPORTUNITIES IN HOSPITAL EPISODE PAYMENTS

- Reduce use of inpatient post-acute rehabilitation
- Reduce hospital readmissions due to complications

In BPCI/CJR, the trigger is the inpatient surgery or hospital admission, so if outpatient surgery is used, or if the hospital admission can be avoided altogether, there is no “savings” credited to the program and many providers lose revenue
Potential Reward for Avoiding Higher-Risk Patients

SAVINGS OPPORTUNITIES IN HOSPITAL EPISODE PAYMENTS

- Reduce use of inpatient post-acute rehabilitation
- Reduce hospital readmissions due to complications

In BPCI/CJR, there is only limited risk-adjustment, so avoiding patients who would need significant post-acute care or be at high risk of readmissions would result in “savings” and associated bonus payments.
Growing Concerns About Negative Impacts of Current VBP

The Hospital Readmissions Reduction Program — Time for a Reboot
N ENGL J MED 380;24 NEJM.ORG JUNE 13, 2019

Health Policy & Economics

Are Medicare's “Comprehensive Care for Joint Replacement” Bundled Payments Stratifying Risk Adequately?

Mark A. Cairns, MD, MS", Peter T. Moskal, MD, Scott M. Eskildsen, MD, MS, Robert F. Ostrum, MD, R. Carter Clement, MD, MBA
Department of Orthopaedics, University of North Carolina Health Care, Durham, North Carolina

Risk Adjustment In Medicare ACO Program Deters Coding Increases But May Lead ACOs To Drop High-Risk Beneficiaries

Modern Healthcare

Oncologists set to lose big under CMS payment model
STEVEN ROSS JOHNSON
Since Current APMs Aren’t Reducing Spending…

ALTERNATIVE PAYMENT MODELS
MIPS/P4P  CPC+/OCM  CJR/BPCI  MSSP

FFS  FFS  FFS  FFS  FFS

All Current FFS Payments  All Current FFS Payments  All Current FFS Payments  All Current FFS Payments  All Current FFS Payments

Bonus  New  Bonus  Bonus  Bonus
Penalty  Per-Patient Payment  Penalty  Penalty  Penalty

Unpaid & Underpaid Services

Medicare Spending Under APMs

© Center for Healthcare Quality and Payment Reform www.CHQPR.org
…CMS Wants to Put Physicians at Risk for Reducing Spending

FFS

Bonus Penalty

Bonus New Per-Patient Payment

Bonus Penalty

“Population Based Payment”

“Direct Contracting”

Unpaid & Underpaid Services

© Center for Healthcare Quality and Payment Reform www.CHQPR.org
Downside Risk ACOs Saved Less in 2017 Than Upside-Only ACOs

<table>
<thead>
<tr>
<th></th>
<th>Upside Risk</th>
<th>Downside Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Track 1 MSSP ACOs</td>
<td>Two-Sided Risk MSSP ACOs</td>
</tr>
<tr>
<td>Net Savings Per Patient</td>
<td>$37</td>
<td>$27</td>
</tr>
<tr>
<td>% Savings</td>
<td>0.34%</td>
<td>0.24%</td>
</tr>
</tbody>
</table>
CMS-Funded “LAN” Says Best APM is “Population-Based Pmt”

Alternative Payment Models
THE APM FRAMEWORK

CATEGORY 1
NO LINK TO QUALITY & VALUE
FFS

CATEGORY 2
LINK TO QUALITY & VALUE
MIPS

CATEGORY 3
FEE-FOR-SERVICE ARCHITECTURE
Current CMS APMs

CATEGORY 4
POPULATION-BASED PAYMENT
Population Based Payment and “Direct Contracting”

CMS-Funded “LAN” Says Best APM is “Population-Based Pmt”

© Center for Healthcare Quality and Payment Reform www.CHQPR.org
Is
“Population-Based Payment”
Better Than
Fee for Service?
A Strength of FFS: No $ Unless Patient Gets Care

FEE FOR SERVICE PAYMENT

Patient Receives Care $FFS$

Sick Patient #1

Patient Receives No Care $0$

Sick Patient #2

© Center for Healthcare Quality and Payment Reform www.CHQPR.org
In Population-Based Pmt (PBP): $ Paid if Patient is Denied Care

**FEE FOR SERVICE PAYMENT**

- Patient Receives Care: $FFS$
- Patient Receives No Care: $0$

<table>
<thead>
<tr>
<th>Sick Patient #1</th>
<th>Sick Patient #2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FFS $</strong></td>
<td>$0</td>
</tr>
</tbody>
</table>

**POPULATION-BASED PAYMENT**

- Patient Receives Care: $PBP$
- Patient Receives No Care: $PBP$

<table>
<thead>
<tr>
<th>Sick Patient #1</th>
<th>Sick Patient #2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PBP $</strong></td>
<td><strong>PBP $</strong></td>
</tr>
</tbody>
</table>
A Strength of FFS: High-Need Patients Get More Care

FEE FOR SERVICE PAYMENT

Lower-Need Patient

Higher-Need Patient
In Population-Based Pmt (PBP): $ < Cost of High-Need Patients

FEE FOR SERVICE PAYMENT

Higher-Need Patient

Lower-Need Patient

Service $ FFS$

Service $ FFS$

Service $ FFS$

Service $ FFS$

POPULATION-BASED PAYMENT

Higher-Need Patient

Lower-Need Patient

Service $ PBP$

Service $ PBP$

Service $ PBP$

Service $ PBP$

Loss
A Strength of FFS: Fixed Fees Force Efficient Svcs

**FEE FOR SERVICE PAYMENT**

<table>
<thead>
<tr>
<th>Low-Cost Provider</th>
<th>High-Cost Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Profit Low Service Cost</td>
<td>FFS $</td>
</tr>
<tr>
<td>High Service Cost</td>
<td>Loss</td>
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<tr>
<td>FFS $</td>
<td>FFS $</td>
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</tbody>
</table>

© Center for Healthcare Quality and Payment Reform www.CHQPR.org
A Strength of FFS: No Risk for *Uncontrollable* Cost

**FEE FOR SERVICE PAYMENT**

<table>
<thead>
<tr>
<th>Current Drug Cost</th>
<th>New Drug or Price Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug Cost</td>
<td>FFS $</td>
</tr>
<tr>
<td>Profit</td>
<td>FFS $</td>
</tr>
<tr>
<td>Low Service Cost</td>
<td>FFS $</td>
</tr>
<tr>
<td>New Drug or Higher Price</td>
<td>FFS $</td>
</tr>
<tr>
<td>Profit</td>
<td>FFS $</td>
</tr>
<tr>
<td>Low Service Cost</td>
<td>FFS $</td>
</tr>
</tbody>
</table>
In Population-Based Pmt (PBP): Risk for Uncontrollable Cost

**FEE FOR SERVICE PAYMENT**

- **Drug Cost**: $FFS$
- **Profit**: $FFS$
- **Low Service Cost**: $FFS$

**New Drug or Price Increase**

- **Current Drug Cost**: $FFS$
- **New Drug or Price Increase**: $FFS$

**POPULATION-BASED PAYMENT**

- **Drug Cost**: $PBP$
- **Profit**: $PBP$
- **Low Service Cost**: $PBP$

**Current Drug Cost**

- **New Drug or Price Increase**: $PBP$

**New Drug or Price Increase**

- **Loss**: $PBP$

© Center for Healthcare Quality and Payment Reform www.CHQPR.org
A Strength of FFS: Fee is Known Before Care is Given

FEE FOR SERVICE PAYMENT

Fee Schedule

Service FFS $  Service FFS $
In Population-Based Pmt (PBP): How Much Will Be Paid for Care?

FEE FOR SERVICE PAYMENT

POPULATION-BASED PAYMENT

Fee Schedule

Service $FFS$

Patient

Service $FFS$

Patient

Service

Patient

Service

Patient
In Population-Based Pmt (PBP): How Much Will Be Paid for Care?

**FEE FOR SERVICE PAYMENT**
- Fee Schedule
  - Service \( \text{FFS} \) $Patient
  - Service \( \text{FFS} \) $Patient

**POPULATION-BASED PAYMENT**
- CMS/Payer “Benchmark”
  - Service $Patient
  - Service $Patient
In Population-Based Pmt (PBP): How Much Will Be Paid for Care?

**FEE FOR SERVICE PAYMENT**

- **Fee Schedule**
  - Service $FFS$
    - Patient

**POPULATION-BASED PAYMENT**

- CMS/Payer “Benchmark”
  - Penalties for Quality Measures

- ?
  - Service
    - Patient
  - ?
    - Service
      - Patient
In Population-Based Pmt (PBP): How Much Will Be Paid for Care?

**FEE FOR SERVICE PAYMENT**

- **Fee Schedule**
  - Patient Service: FFS $
  - Patient Service: FFS $

**POPULATION-BASED PAYMENT**

- CMS/Payer “Benchmark”
- Penalties for Quality Measures
- Fees to Non-ACO Providers

![](diagram.png)
In Population-Based Pmt (PBP): How Much Will Be Paid for Care?

**FEE FOR SERVICE PAYMENT**

- Fee Schedule

  - Service
    - FFS $
      - Patient

**POPULATION-BASED PAYMENT**

- CMS/Payer “Benchmark”
- Penalties for Quality Measures
- Fees to Non-ACO Providers
- Premiums to Re-Insurer

  - Service
    - FFS $
      - Patient

  - Service
    - FFS $
      - Patient

  - Service
    - Patient

  - Service
    - Patient
In Population-Based Pmt (PBP): How Much Will Be Paid for Care?

FEE FOR SERVICE PAYMENT

- Fee Schedule
  - Service: FFS $
    - Patient
  - Service: FFS $
    - Patient

POPULATION-BASED PAYMENT

- CMS/Payer “Benchmark”
  - Penalties for Quality Measures
  - Fees to Non-ACO Providers
  - Premiums to Re-Insurer
  - ACO Admin. Costs

? Service Patient

? Service Patient
In Population-Based Pmt (PBP): Will Any $ Be Left for Patient Care?

**FEE FOR SERVICE PAYMENT**

- Fee Schedule
  - Service $FFS$
  - Patient

**POPULATION-BASED PAYMENT**

- CMS/Payer “Benchmark”
- Penalties for Quality Measures
- Fees to Non-ACO Providers
- Premiums to Re-Insurer
- ACO Admin. Costs
  - $ for Physicians
  - $ for Hospitals
    - ?
      - Service
      - Patient
    - ?
      - Service
      - Patient

© Center for Healthcare Quality and Payment Reform www.CHQPR.org
 Ontario health care needs major surgery
Toronto Sun, January 31, 2019

Thursday’s report by Dr. Rueben Devlin, chair of Premier Doug Ford’s council on improving health care and ending hallway medicine, succinctly describes a major and long-standing problem with Ontario’s health care system. It starts with a lack of long-term care facilities for patients who can no longer live at home. Because there aren’t enough long-term care beds, many patients who require them occupy acute care beds in hospitals across the province, because there’s no where else for them to go. The average wait time for being transferred to a long-term care facility is 146 days….Due to the backlog of these patients in acute care hospitals, the hospitals don’t have enough beds to treat patients admitted through their emergency wards. As a result, at least 1,000 patients a day across Ontario are being treated in hospital hallways.
## Pop.-Based Pmt Doesn’t Fix FFS Problems and Makes Things Worse

<table>
<thead>
<tr>
<th>Weaknesses of Fee for Service</th>
<th>FFS</th>
<th>CMS APMs</th>
<th>Pop. Pmt</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment for all high-value services?</td>
<td>NO</td>
<td>NO*</td>
<td>NO</td>
</tr>
<tr>
<td>Payment adequate to cover cost of services?</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td>Ability to predict total payment for treatment?</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td>Assurance of high-quality for each patient?</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
</tr>
</tbody>
</table>

## Strengths of Fee for Service

| No payment unless care delivered? | YES | YES | NO |
| Higher amount for higher-need patients? | YES | YES | NO** |
| Payment based on what provider can control? | YES | NO | NO |
| Amount known before services delivered? | YES | NO | NO |

* CPC+ and OCM provide monthly payments that cover some additional services
** HCC risk adjustment identifies some but not all differences in patient needs
This is NOT a Good “Framework” for Fixing Healthcare Payment…

### Alternative Payment Models

**THE APM FRAMEWORK**

<table>
<thead>
<tr>
<th>CATEGORY 1</th>
<th>CATEGORY 2</th>
<th>CATEGORY 3</th>
<th>CATEGORY 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>FFS - FEE FOR SERVICE – NO LINK TO QUALITY &amp; VALUE</td>
<td>P4P - FEE FOR SERVICE – LINK TO QUALITY &amp; VALUE</td>
<td>“Risk” - APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE</td>
<td>Population Based Payment and “Direct Contracting”</td>
</tr>
</tbody>
</table>

**FFS**

**MIPS**

**Current CMS APMs**

© Center for Healthcare Quality and Payment Reform www.CHQPR.org
...And Following It Will Likely Make Things Worse, Not Better
## What Would a Good APM Look Like?

<table>
<thead>
<tr>
<th>Weaknesses of Fee for Service</th>
<th>FFS</th>
<th>CMS APMs</th>
<th>Pop. Pmt</th>
<th>Good APM</th>
</tr>
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<tbody>
<tr>
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## Strengths of Fee for Service

| No payment unless care delivered?                  | YES | YES | NO | ?        |
| Higher amount for higher-need patients?            | YES | YES | NO** | ?        |
| Payment based on what provider can control?        | YES | NO  | NO | ?        |
| Amount known before services delivered?            | YES | NO  | NO | ?        |

* CPC+ and OCM provide monthly payments that cover some additional services
** HCC risk adjustment identifies some but not all differences in patient needs
## A Good APM Would Correct the Weaknesses of FFS

<table>
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<tr>
<th>Weaknesses of Fee for Service</th>
<th>FFS</th>
<th>Good APM</th>
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### Strengths of Fee for Service

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<td>YES</td>
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</tbody>
</table>

* CPC+ and OCM provide monthly payments that cover some additional services
** HCC risk adjustment identifies some but not all differences in patient needs
Payment for High Value Services That Reduce Avoidable Services

$700+
Ambulance to Hospital

Emergency Department Visit

$150
Transport to Office
Physician Office Visit

$27
Phone Call

HIGH VALUE SERVICES

$
True Bundled Payment to a Team for Treatment of the Condition

Payment for Cataract Surgery

- Bundled/Warrantied Payment to Cataract Surgery Team for Treatment of Cataracts
- Post-Op Drugs
- Anesthesia Fee
- ASC Fee
- Surgeon Fee
- HOPD Payment
- Post-Op Drugs
- Anesthesia Fee
- Surgeon Fee
- HOPD Payment
- Payments to Treat Complications

$
No Payment for Poor Quality Care and Penalties for Poor Outcomes

Knee Surgery That Allows Patient to Walk Without Pain

Knee Surgery That Fails to Allow Patient to Walk Without Pain

Knee Surgery That Results in Infection or Complications

Bundled Payment to Surgery Team for Treatment of Knee Osteoarthritis

Surgery Team Pays for Treatment of Infection or for Repeat Surgery

$0

$0

$0
## A Good APM Would Also Preserve the Strengths of FFS

<table>
<thead>
<tr>
<th>Weaknesses of Fee for Service</th>
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<th>Good APM</th>
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## Strengths of Fee for Service

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<td>YES</td>
</tr>
<tr>
<td>Amount known before services delivered?</td>
<td>YES</td>
<td>YES</td>
</tr>
</tbody>
</table>

* CPC+ and OCM provide monthly payments that cover some additional services
** HCC risk adjustment identifies some but not all differences in patient needs
No Payment Unless Patient Actually Receives Needed Care

PATIENT-CENTERED PAYMENT

Patient Receives Care

Patient Receives No Care

Sick Patient #1

Sick Patient #2

APM $0
Higher Payment for Patients With Greater Needs

PATIENT-CENTERED PAYMENT

Lower-Need Patient

Needed Services

APM $

Higher-Need Patient

Needed Services

APM $
Accountability for Costs Providers CAN Control

PATIENT-CENTERED PAYMENT

Profit $Low Service Cost $APM$

Low-Cost Provider

High-Service Cost

APM$

High-Cost Provider

Loss
No Risk for Costs
Providers CANNOT Control

PATIENT-CENTERED PAYMENT

Drug Cost
Profit
Low Service Cost

Current Drug Cost

APM $

New Drug or Higher Price
Profit
Low Service Cost

New Drug or Price Increase

APM $
Amount of Payment Known Before Care is Delivered

<table>
<thead>
<tr>
<th>Condition-Based Pmts</th>
<th>APM $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services Needed to Treat Condition</td>
<td>Patient</td>
</tr>
<tr>
<td></td>
<td>Services Needed to Treat Condition</td>
</tr>
<tr>
<td></td>
<td>APM $</td>
</tr>
</tbody>
</table>
Patient-Centered APMs Solve FFS Problems & Preserve Its Strengths

<table>
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<th>Weaknesses of Fee for Service</th>
<th>Patient-Centered Payment</th>
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<tbody>
<tr>
<td>Payment for all high-value services?</td>
<td>Flexible, <em>condition</em>-based fee</td>
</tr>
<tr>
<td>Payment adequate to cover cost of services?</td>
<td>$ based on cost of best treatment</td>
</tr>
<tr>
<td>Ability to predict total payment for treatment?</td>
<td>Bundled payment to provider team</td>
</tr>
<tr>
<td>Assurance of high-quality for each patient?</td>
<td>$0 unless quality standards are met, $0 extra to treat avoidable problems</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Strengths of Fee for Service</th>
<th></th>
</tr>
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<td>No payment unless care delivered?</td>
<td>$0 unless care is provided</td>
</tr>
<tr>
<td>Higher amount for higher-need patients?</td>
<td>More $ for higher-need patient</td>
</tr>
<tr>
<td>Payment based on what provider can control?</td>
<td>Separate fees for costs and prices provider team cannot control</td>
</tr>
<tr>
<td>Amount known before services delivered?</td>
<td>$ for care defined in advance</td>
</tr>
</tbody>
</table>
Details on Patient-Centered Pmt and How to Create a Good APM

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

How to Create an Alternative Payment Model

Designing Value-Based Payments That Support Affordable, High-Quality Healthcare Services

Harold D. Miller
Detailed Examples of Good APMs

Website: PaymentReform.org

An Alternative Payment Model for CHRONIC CARE MANAGEMENT

OVERVIEW OF THE APM

Under this APM, an individual who has been diagnosed with a chronic disease or has been admitted to the hospital one or more times as a patient because of the condition will receive care under a Chronic Care Management team. The team will consist of a nurse care manager, pharmacist, dietitian, and other health professionals. The team will provide ongoing care and support to help the patient manage their condition and improve their quality of life.

Examples of how a Chronic Care Management team might work:

1. Education: The nurse care manager will educate the patient about their condition and how to manage it.
2. Medication Management: The pharmacist will review the patient's medications to ensure they are effective and not causing any adverse effects.
3. Nutrition: The dietitian will work with the patient to develop a healthy eating plan.

Chronic Care Management teams can help patients save money by:

1. Reducing hospitalizations: By providing ongoing care and support, patients are less likely to be readmitted to the hospital.
2. Improving medication adherence: Patients are more likely to take their medications correctly when they have a team supporting them.
3. Increasing patient satisfaction: Patients feel more comfortable and supported when they have a Chronic Care Management team.

An Alternative Payment Model for CHRONIC CONDITIONS

Every chronic disease is different. Different treatments and medications will be needed. The goals of treatment are to relieve symptoms, prevent complications, and improve quality of life.

For example, a patient with diabetes might need to take medication, monitor their blood sugar, and make dietary changes. A patient with heart disease might need to take medication, manage their blood pressure, and avoid smoking.

Chronic Care Management teams can help patients save money by:

1. Reducing hospitalizations: By providing ongoing care and support, patients are less likely to be readmitted to the hospital.
2. Improving medication adherence: Patients are more likely to take their medications correctly when they have a team supporting them.
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An Alternative Payment Model for MATERNITY CARE

An Alternative Payment Model for MATERNITY CARE

OVERVIEW OF THE APM

Under this APM, a pregnant woman who is covered by a health plan that offers the APM will be eligible for maternity care. The health plan will pay for the cost of maternity care, including the cost of prenatal care, delivery, and postpartum care.

Examples of how a maternity care team might work:

1. Prenatal Care: The obstetrician will provide care for the woman during pregnancy.
2. Delivery: The obstetrician will provide care during the delivery.
3. Postpartum Care: The obstetrician will provide care for the woman after delivery.

Maternity care teams can help patients save money by:

1. Reducing hospitalizations: By providing ongoing care and support, patients are less likely to be readmitted to the hospital.
2. Improving medication adherence: Patients are more likely to take their medications correctly when they have a team supporting them.
3. Increasing patient satisfaction: Patients feel more comfortable and supported when they have a maternity care team.

Details of the APM

1. Opportunities for Savings and Quality Improvement

Maternity care is one of the largest components of spending for commercial health plans and Medicaid programs. There are a number of important opportunities for reducing unnecessary and avoidable spending and improving the quality of care for women during pregnancy and the postpartum period.

a. Reduced hospitalizations:
   - Maternity care teams can help patients save money by reducing hospitalizations.

b. Improved medication adherence:
   - Maternity care teams can help patients save money by improving medication adherence.

2. Changes in Care Delivery Needed and Associated Costs

a. New and Different Services to Be Delivered

In most large cities, birth centers are rare but the maternal mortality rate is higher in those areas. In addition, the patient may develop additional health problems during their hospital stay, e.g., a hospital-acquired infection, and the patient is anesthetized, the patient will need more care for some days. Reducing the likelihood and frequency of these hospital admissions could generate significant savings for payers and improve patient outcomes.

Details of the APM

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a. Reduced hospitalizations:
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b. Improved medication adherence:
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2. Changes in Care Delivery Needed and Associated Costs

a. New and Different Services to Be Delivered

In most large cities, birth centers are rare but the maternal mortality rate is higher in those areas. In addition, the patient may develop additional health problems during their hospital stay, e.g., a hospital-acquired infection, and the patient is anesthetized, the patient will need more care for some days. Reducing the likelihood and frequency of these hospital admissions could generate significant savings for payers and improve patient outcomes.
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 a (Procedural) Episode Payment**  
  She makes more money by efficiently delivering procedures you don’t need

- **Physician D gets Shared Savings / Pop. Based Payment**  
  She makes more money if you get less treatment than needed

- **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
Is This the Health System You Really Want?

PATIENT

Primary Care ➔ Avoiding Hospital Admissions

Hospital ➔ Avoiding SNF Stays & Readmits

Everything Else from an ACO ➔ Avoiding Expensive Services

GOAL

Preventive Care
Accurate Diagnosis
Minor Acute Care
Appropriate Care
Good Outcomes
Appropriate Care
Choice of Teams
Good Outcomes

Home Care
Ambulatory Specialty Care
Creating a Truly Patient-Centered Health Delivery System

GOALS

- Good Preventive Care
- Accurate Diagnosis
- Minor Acute Care

PAYMENT

Accountable Medical Home Payment

HEALTHY PATIENTS → Primary Care Medical Home
Creating a Truly Patient-Centered Health Delivery System

GOALS
- Good Preventive Care
- Accurate Diagnosis
- Minor Acute Care

PAYMENT
- Accountable Medical Home Payment
- Condition-Based Payment

HEALTHY PATIENTS
- Primary Care Medical Home

PATIENTS WITH A CHRONIC OR ACUTE CONDITION
- Specialty Team
- Specialty Team
- Specialty Team

Primary Care Medical Home
- Appropriate Ambulatory Care, Inpatient Care, & Home Care
- Best Outcomes
- Affordable Cost

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Creating a Truly Patient-Centered Health Delivery System

GOALS

- Good Preventive Care
- Accurate Diagnosis
- Minor Acute Care

PAYMENT

- Accountable Medical Home Payment
- Condition-Based Payment
- Coordinated Care Payment

HEALTHY PATIENTS

- Primary Care Medical Home

PATIENTS WITH A CHRONIC OR ACUTE CONDITION

- Specialty Team
- Specialty Team
- Specialty Team

PATIENTS WITH MULTIPLE HEALTH PROBLEMS

- PCP + Multi-Specialty Team (“ACO”)

- Appropriate Ambulatory Care, Inpatient Care, & Home Care
- Best Outcomes
- Affordable Cost

- Appropriate Ambulatory, Inpatient & Home Care
- Best Outcomes at Affordable Cost
For More Information:

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