BUNDLING BADLY: Why Current “Value-Based” Payments Can Harm High-Need Patients and How to Do Better

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

www.CHQPR.org
PLEASE NOTE:

I am one of the 11 members of the Physician-Focused Payment Model Technical Advisory Committee (PTAC), but 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
Typical Cost Control Strategy #1: Cut Provider Fees for Services
Typical Cost Control Strategy #2: Shift Costs to Patients

- Higher Cost-Share & Deductibles

Cost of Healthcare (For Payers)
Typical Cost Control Strategy #3: Delay or Deny Care to Patients

Cost of Health Care

- Delay/Deny Needed Care

Savings

COST OF HEALTH CARE

COST OF HEALTH CARE

COST OF HEALTH CARE (FOR PAYERS)

Delay/Deny Needed Care

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Results of Typical Cost-Control Strategies

- Patients don’t get the care they need
- Small providers are forced out of business
- Health insurance premiums continue to rise and access to insurance coverage decreases
New Strategy: Create “Value-Based” Payments

Fee for Service Payment (FFS)

Fee for Service Payment (FFS)

Fee for Service Payment (FFS)

“VALUE-BASED” PAYMENT

$
What Exactly is Wrong With Fee for Service?
How Much Will Treatment Cost Under Fee for Service Payment?

Total Payments for Hip/Knee Surgery

$
How Much Will Treatment Cost Under Fee for Service Payment?

Total Payments for Hip/Knee Surgery

$ Hospital Payment
How Much Will Treatment Cost Under Fee for Service Payment?

$ Total Payments for Hip/Knee Surgery

- Surgeon Fee
- Hospital Payment
How Much Will Treatment Cost Under Fee for Service Payment?

$\text{Total Payments for Hip/Knee Surgery}$

- Anesthesia Fee
- Surgeon Fee
- Hospital Payment
How Much Will Treatment Cost Under Fee for Service Payment?

Total Payments for Hip/Knee Surgery

- Hospital Payment
- Surgeon Fee
- Anesthesia Fee
- Home Health & PT/OT

$
How Much Will Treatment Cost Under Fee for Service Payment?

Total Payments for Hip/Knee Surgery

- Home Health & PT/OT
- Anesthesia Fee
- Surgeon Fee
- Hospital Payment

- Anesthesia Fee
- Surgeon Fee
- Hospital Payment
How Much Will Treatment Cost Under Fee for Service Payment?

Total Payments for Hip/Knee Surgery

- Hospital Payment
- Surgeon Fee
- Anesthesia Fee
- Home Health & PT/OT

- Hospital Payment
- Surgeon Fee
- Anesthesia Fee
- Fees for Other Physicians
How Much Will Treatment Cost Under Fee for Service Payment?

Total Payments for Hip/Knee Surgery

- Surgeon Fee
- Hospital Payment
- Anesthesia Fee
- Home Health & PT/OT
- Fees for Other Physicians
- Skilled Nursing Facility (SNF) or Inpatient Rehab Facility (IRF)
- Anesthesia Fee
- Surgeon Fee
- Hospital Payment
FFS Problem #1: Many Patients Get Services They Don’t Need

- Home Health & PT/OT
- Anesthesia Fee
- Surgeon Fee
- Hospital Payment

- Skilled Nursing Facility (SNF) or Inpatient Rehab Facility (IRF)
- Fees for Other Physicians
- Anesthesia Fee
- Surgeon Fee
- Hospital Payment
FFS Payment When the Treatment is Successful

Knee Surgery: Patient Can Walk Without Pain

Payments for Surgery and Rehab
FFS Payment When the Treatment is Unsuccessful

Knee Surgery: Patient Can Walk Without Pain

Knee Surgery: Patient CanNOT Walk Without Pain

Payments for Surgery and Rehab

Payments for Surgery and Rehab
FFS Payment When the Treatment Makes Things Worse

- **Knee Surgery:** Patient Can Walk Without Pain
- **Knee Surgery:** Patient Can NOT Walk Without Pain
- **Knee Surgery:** Infection or Complications

Payments for Surgery and Rehab

Payments for Treatment of Infection or Repeat Surgery
FFS Problem #2: No Penalty For Poor Outcomes

Knee Surgery: Patient Can Walk Without Pain
Payments for Surgery and Rehab

Knee Surgery: Patient Can NOT Walk Without Pain
Payments for Surgery and Rehab

Knee Surgery: Infection or Complications
Payments for Treatment of Infection or Repeat Surgery
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)
With No Warranty for Defects

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
FFS Problem #3: No Fee at All For Many High-Value Services

<table>
<thead>
<tr>
<th>Good Outcomes</th>
<th>Good Outcomes at Higher Cost</th>
<th>Good Outcomes at Lower Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health &amp; PT/OT</td>
<td>Fees for Other Physicians</td>
<td>No Payment for Supervised Exercise</td>
</tr>
<tr>
<td>Anesthesia Fee</td>
<td>Anesthesia Fee</td>
<td>Payment for Physical Therapy</td>
</tr>
<tr>
<td>Surgeon Fee</td>
<td>Surgeon Fee</td>
<td></td>
</tr>
<tr>
<td>Hospital Payment</td>
<td>Hospital Payment</td>
<td></td>
</tr>
<tr>
<td>Skilled Nursing Facility (SNF) or Inpatient Rehab Facility (IRF)</td>
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FFS Problem #4: Fees Too Low for Some Services

<table>
<thead>
<tr>
<th>Good Outcomes</th>
<th>Good Outcomes at Higher Cost</th>
<th>Good Outcomes at Lower Cost</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

- **Home Health & PT/OT**
- **Anesthesia Fee**
- **Surgeon Fee**
- **Hospital Payment**

- **Skilled Nursing Facility (SNF) or Inpatient Rehab Facility (IRF)**
- **Fees for Other Physicians**
- **Anesthesia Fee**
- **Surgeon Fee**
- **Hospital Payment**

- **Financial Loss**
  - Payment for Supervised Exercise
  - Payment for Physical Therapy
  - Cost of High-Quality Physical Therapy and Exercise Therapy

Good Outcomes at Higher Cost vs. Lower Cost

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Fees for Services Aren’t Much Good if They Don’t Cover Costs

New Medicare Diabetes Prevention Coverage May Limit Beneficiary Access and Widen Health Disparities

Natalie D. Ritchie, PhD*† and Robert M. Gritz, PhD‡

Background: The Centers for Medicare and Medicaid Services recently issued final rules for the Medicare Diabetes Prevention Program (MDPP), offering an unprecedented opportunity to provide lifestyle intervention to Medicare beneficiaries with prediabetes via a pay-for-performance model. The MDPP is based on the widely disseminated, yearlong National Diabetes Prevention Program (NDPP), which has lesser but still beneficial risk-reduction outcomes among minority and low-income participants.

Objectives: We compare projected payments based on outcomes of a diverse sample of Medicare beneficiaries to service delivery costs, and explore resulting implications for MDPP access and sustainability.

Methods: We delivered NDPP in a safety-net healthcare system from 2013 to 2017 and conducted an analysis of service cost, beneficiary performance, and projected MDPP reimbursement.

Results: Among 1165 total participants, 213 (18.5%) were Medicare beneficiaries. Participating beneficiaries were 40.6% Hispanic, 31.6% non-Hispanic white, and 26.9% non-Hispanic black, and 69.5% low-income. Overall beneficiary performance would result in an average reimbursement of $138.52 (interquartile range = 162.50). Program delivery costs were $800 per participant, leaving an average gap of $661 per beneficiary.

Conclusions: Findings from delivering the NDPP to diverse and underserved patients show a large gap between service costs and projected reimbursement. Although many MDPP suppliers are needed to reach all Medicare beneficiaries with prediabetes, insufficient reimbursement may be a deterrent. Health disparities may also widen as suppliers serving diverse and low-income populations will likely receive especially low payments, threatening access. Higher payments are supported by strong return-on-investment findings and seem needed to reduce diabetes prevalence and related disparities.

Key Words: disease prevention, diabetes, Medicare, health disparities, access to care

(The Med Care 2018;56: 908-911)

The Centers for Medicare and Medicaid Services (CMS) recently issued the final rule for Medicare Diabetes Prevention Program (MDPP) coverage beginning April 2018, offering an unprecedented opportunity to prevent diabetes among the estimated 48.3% of seniors with prediabetes. The MDPP is a structured group class based on the National Diabetes Prevention Program (NDPP), a widely disseminated, evidence-based lifestyle intervention. The NDPP aims to help participants prevent or delay onset of type 2 diabetes by achieving at least 5% weight loss.

The MDPP pay-for-performance methodology reimburses suppliers based on beneficiaries’ attendance and weight loss outcomes. Sustainable reimbursement rates are critical for policy impact, yet whether Medicare payments are sufficient to cover costs of service delivery is unknown, particularly for racial/ethnic minority and low-income individuals who experience disproportionately high prevalence of type 2 diabetes but lesser NDPP outcomes.

We compare projected payments based on performance data of a diverse, underserved sample of Medicare beneficiaries to service delivery costs and explore resulting implications for MDPP sustainability.

METHODS

Denver Health and Hospital Authority is a safety-net healthcare system that has provided the NDPP following standards established by the Centers for Disease Control and Prevention (CDC), and using the CDC’s publicly available curriculum. Sixteen weekly to biweekly sessions were held in months 1–6 and a minimum of 6 monthly sessions were held in months 7–12. NDPP participants were encouraged to attend as many sessions as possible and to lose at least 5% of their initial body weight. Sessions were conducted in neighborhood primary care clinics at a variety of days and times, including evenings and weekends, for convenience. Six yearlong NDPP classes were initially offered in March 2013. Thereafter, 5-4 new NDPP classes were launched approx.
We Won’t Get “High-Value Care” Unless We Fix These Problems

<table>
<thead>
<tr>
<th>Weaknesses of Fee for Service</th>
<th>FFS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment for unnecessary services?</td>
<td>YES</td>
</tr>
<tr>
<td>Payment even if quality/outcome is bad?</td>
<td>YES</td>
</tr>
<tr>
<td>Payment for all high-value services?</td>
<td>NO</td>
</tr>
<tr>
<td>Payment sufficient to cover cost of services?</td>
<td>NO</td>
</tr>
</tbody>
</table>
Solution: Single, Flexible Payment For All Services Patient Needs

Total Payments for Hip/Knee Surgery

- Home Health & PT/OT
- Anesthesia Fee
- Surgeon Fee
- Hospital Payment
- Fees for Other Physicians
- Anesthesia Fee
- Surgeon Fee
- Hospital Payment
- Skilled Nursing Facility (SNF) or Inpatient Rehab Facility (IRF)
- Readmission for Complications
- Physical Therapy
- Supervised Exercise

Bundled Payment for All Services Patient Needs
Solution: Pay Less (or Nothing) When Outcomes Aren’t Achieved

- **Knee Surgery:**
  - Patient Can Walk Without Pain
  - Payments for Surgery and Rehab

- **Knee Surgery:**
  - Patient Can NOT Walk Without Pain
  - Payments for Surgery and Rehab

- **Knee Surgery:**
  - Infection or Complications
  - Payments for Treatment of Infection or Repeat Surgery

- **Knee Surgery:**
  - Poor Outcomes
  - (Reduced) Payment When Outcome is Poor
Do “Value-Based” Payments Solve the Problems With FFS?

FFS

Unpaid & Underpaid Services

“VALUE-BASED” PAYMENT
The Most Common “Value-Based” Payment is P4P (MIPS)

$FFS \rightarrow \text{MIPS/P4P}$

Unpaid & Underpaid Services

Merit-Based Incentive Payment System (MIPS)
MIPS/P4P Doesn’t Add New Fees or Change Relative Fee Amounts

FFS

Unpaid & Underpaid Services

MIPS/P4P

FFS

No New Payments

All Current FFS Payments

Bonus

Penalty

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

There is no bonus unless other physicians get a penalty.
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.
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)

apms

FFS

Unpaid & Underpaid Services

MIPS/P4P

Bonus

Penalty

All Current FFS Payments

FFS

No New Payments

Alternative Payment Models
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 (APMs) implemented in Medicare:

- Medicare Shared Savings Program and NextGen ACOs
- Comprehensive Care for Joint Replacement (CJR)
- Bundled Payments for Care Improvement (BPCI)
- Comprehensive Primary Care Plus
- Oncology Care Model
- Comprehensive ESRD Care Model
Do Episode Payments and ACOs Create Higher-Value Care?

ALTERNATIVE PAYMENT MODELS

MIPS/P4P

CJR/BPCI

MSSP

FFS

Comp. Care for Joint Replace. (CJR) & Bundled Pmts for Care Improve. (BPCI)

Medicare Shared Savings Program ACOs

Unpaid & Underpaid Services

Bonus Penalty

All Current FFS Payments

No New Payments

$
How the Comprehensive Care for Joint Replacement (CJR) Payment Model Works
Starting with a Patient With Hip or Knee Problems...
CJR Limited to Patients Receiving Hip or Knee Surgery in Hospital

Patient w/ Pain & Limited Mobility → Joint Surgery in Hospital → Improved Mobility & Reduced Pain
CMS Defines the Hospital Stay + 90 Days as the “Episode”
“Episode Spending” Includes Post-Acute Care Services

JOINT REPLACEMENT “EPISODE”

- Skilled Nursing Facility (SNF)
- Inpatient Rehab Facility (IRF)
- Home Health (HH)

90 Days Post-Discharge
“Episode Spending” Includes Related + Unrelated Readmissions

JOINT REPLACEMENT “EPISODE”

90 Days Post-Discharge

Patient w/ Pain & Limited Mobility

Joint Surgery in Hospital

Post-Acute Care

Hospital Readmissions

Improved Mobility & Reduced Pain

• Skilled Nursing Facility (SNF)
• Inpatient Rehab Facility (IRF)
• Home Health (HH)

• Surgical Complications
• Chronic Disease Exacerbations (COPD, CHF, Hypertension)
• Other Admissions (e.g., CABG)
“Episode Spending” Includes Other Related + Unrelated Services

JOINT REPLACEMENT “EPISODE”

- Skilled Nursing Facility (SNF)
- Inpatient Rehab Facility (IRF)
- Home Health (HH)
- Surgical Complications
- Chronic Disease Exacerbations (COPD, CHF, Hypertension)
- Other Admissions (e.g., CABG)
- PT/OT
- Visits to Physicians (for unrelated conditions)
- Tests & Other Services (for unrelated conditions)

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Goal: Reduce Post-Acute Care and Hospital Readmissions

**JOINT REPLACEMENT “EPISODE”**

- Patient w/ Pain & Limited Mobility
  - Joint Surgery in Hospital
    - High-Cost Post-Acute Care
    - Other Medical Services
    - Hospital Readmissions
    - Lower-Cost Post-Acute Care
    - Other Medical Services
    - No Hospital Readmissions

- Improved Mobility & Reduced Pain
Lower Spending During the Episode = Savings for CMS

JOINT REPLACEMENT “EPISODE”

Patient w/ Pain & Limited Mobility

Joint Surgery in Hospital

Post-Acute Care

Savings

Lower-Cost Post-Acute Care

90 Days Post-Discharge

Other Medical Services

Hospital Readmissions

Savings

No Hospital Readmissions

Improved Mobility & Reduced Pain

Other Medical Services

Improved Mobility & Reduced Pain

Other Medical Services
Hospital Gets a Bonus if Savings is Greater Than 3%

JOINT REPLACEMENT “EPISODE”

90 Days Post-Discharge

- Joint Surgery in Hospital
- Post-Acute Care
- Other Medical Services
- Hospital Readmissions
- Bonus
- Savings
- Lower-Cost Post-Acute Care
- Other Medical Services
- No Hospital Readmissions

Patient w/ Pain & Limited Mobility

Improved Mobility & Reduced Pain

Other Medical Services

Improved Mobility & Reduced Pain
Problem #1: No Penalty for Worse Outcomes

JOINT REPLACEMENT “EPISODE”

90 Days Post-Discharge

Patient w/ Pain & Limited Mobility

Joint Surgery in Hospital

Post-Acute Care

Other Medical Services

Hospital Readmissions

Improved Mobility & Reduced Pain

No Penalty

Reduced Mobility and/or Increased Pain

Bonus

Savings

Savings

Lower-Cost Post-Acute Care

Other Medical Services

No Hospital Readmissions
Measures of Complications & Experience, Not Outcomes/Pain

CJR Quality Measures
• Post-surgical complications during 90 days after surgery
• HCAHPS patient experience survey, except for pain management questions

No Measures to Assure:
• Improved ability to walk
• Reduction in osteoarthritis pain
• Pain after
Problem #2: Penalty for Spending on Services Hospital Can’t Control

- Joint Surgery in Hospital
- Post-Acute Care
- Other Medical Services
- Hospital Readmissions
- Patient Chooses High-Cost Post-Acute Care
- Higher Cost

90 Days Post-Discharge

Patient w/ Pain & Limited Mobility

Improved Mobility & Reduced Pain
Problem #2: Penalty for Spending on Services Hospital Can’t Control

Joint Replacement “Episode”

90 Days Post-Discharge

- Joint Surgery in Hospital
- Post-Acute Care
- Other Medical Services
- Hospital Readmissions
- Patient chooses High-Cost Post-Acute Care
- High Spending on Unrelated Services

Improved Mobility & Reduced Pain
Problem #2: Penalty for Spending on Services Hospital Can’t Control

JOINT REPLACEMENT “EPISODE”

90 Days Post-Discharge

Patient w/ Pain & Limited Mobility

Joint Surgery in Hospital

Post-Acute Care

Other Medical Services

Hospital Readmissions

Higher Cost

Higher Cost

Higher Cost

Patient Chooses High-Cost Post-Acute Care

High Spending on Unrelated Services

Hospital Admission Unrelated to Joint Surgery

Improved Mobility & Reduced Pain
Problem #2: Penalty for Spending on Services Hospital Can’t Control

Patient w/ Pain & Limited Mobility

Joint Surgery in Hospital

Post-Acute Care

Other Medical Services

Hospital Readmissions

Penalty

Higher Cost

Higher Cost

Higher Cost

Patient Chooses High-Cost Post-Acute Care

High Spending on Unrelated Services

Hospital Admission Unrelated to Joint Surgery

Improved Mobility & Reduced Pain

90 Days Post-Discharge

JOINT REPLACEMENT “EPISODE”
Problem #3: No Flexibility to Deliver Different Services

There is no true “bundled” payment; providers can only be paid for services Medicare currently allows

JOINT REPLACEMENT “EPISODE”

90 Days Post-Discharge

Patient w/ Pain & Limited Mobility

Joint Surgery in Hospital

Post-Acute Care

Other Medical Services

Hospital Readmissions

Savings

Improved Mobility & Reduced Pain

Intensive Home PT (Unpaid)

Other Medical Services

No Hospital Readmissions

Savings
Providers Can Only Innovate if They Front the Money

There is no true “bundled” payment; providers can only be paid for services Medicare currently allows

JOINT REPLACEMENT “EPISODE”

90 Days Post-Discharge

Patient w/ Pain & Limited Mobility

Joint Surgery in Hospital

Post-Acute Care

Other Medical Services

Hospital Readmissions

Savings

Bonus

Intensive Home PT (Unpaid)

Other Medical Services

No Hospital Readmissions

Improved Mobility & Reduced Pain
Problem #4: No Reward for Avoiding the Use of Surgery

The episode is “triggered” by surgery in the hospital, so use of non-surgical treatments is not counted as savings.

JOINT REPLACEMENT “EPISODE”

90 Days Post-Discharge

Patient w/ Pain & Limited Mobility

Savings

Joint Surgery in Hospital

Post-Acute Care

Other Medical Services

Hospital Readmissions

CMS Keeps All Savings No Bonus Payment

Savings

Physical Therapy

Exercise

Other Medical Services

Improved Mobility & Reduced Pain

Savings

Exercise

Other Medical Services

Savings
Problem #5: Spending Targets Are Based on Average Spending

“Target Price” is Based on Average Spending

“Average” Patient → Joint Surgery in Hospital → Post-Acute Care → Other Medical Services → Hospital Readmissions → Improved Mobility & Reduced Pain
Hospitals With Lower-Need Patients Will Have Costs < Target

“Target Price” is Based on Average Spending

“Average” Patient

Joint Surgery in Hospital → Post-Acute Care → Other Medical Services → Hospital Readmissions

Improved Mobility & Reduced Pain

Healthy Patient With Good Home Support

Joint Surgery in Hospital → Low-Cost Post-Acute Care → Other Medical Services

No Hospital Readmissions

Improved Mobility & Reduced Pain
So Hospitals With Lower-Need Patients Will Likely Get Bonuses

“Target Price” is Based on Average Spending

- "Average" Patient
  - Joint Surgery in Hospital
  - Post-Acute Care
  - Other Medical Services
  - Hospital Readmissions
  - Improved Mobility & Reduced Pain
  - Bonus
  - Lower Cost

- Healthy Patient With Good Home Support
  - Joint Surgery in Hospital
  - Low-Cost Post-Acute Care
  - Other Medical Services
  - No Hospital Readmissions
  - Improved Mobility & Reduced Pain
Hospitals With Higher-Need Patients Will Have Costs > Target

- **Patient With Chronic Disease, No Home Support**
  - Joint Surgery in Hospital
  - High Cost Post-Acute Care
  - Improved Mobility & Reduced Pain

- **“Average” Patient**
  - Joint Surgery in Hospital
  - Post-Acute Care
  - Other Medical Services
  - Hospital Readmissions
  - Improved Mobility & Reduced Pain
Hospitals With Higher-Need Patients Will Have Costs > Target

- **Patient With Chronic Disease, No Home Support**
  - Joint Surgery in Hospital → High Cost Post-Acute Care → Many Other Medical Services → Improved Mobility & Reduced Pain

- **“Average” Patient**
  - Joint Surgery in Hospital → Post-Acute Care → Other Medical Services → Hospital Readmissions → Improved Mobility & Reduced Pain

- Higher Cost
  - Joint Surgery in Hospital → High Cost Post-Acute Care
  - Other Medical Services → Hospital Readmissions

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Hospitals With Higher-Need Patients Will Have Costs > Target

- **Patient With Chronic Disease, No Home Support**
  - Joint Surgery in Hospital → High Cost Post-Acute Care → Many Other Medical Services → Hospital Admission Unrelated to Joint Surgery → Improved Mobility & Reduced Pain
  - Higher Cost

- **“Average” Patient**
  - Joint Surgery in Hospital → Post-Acute Care → Other Medical Services → Hospital Readmissions → Improved Mobility & Reduced Pain
  - Higher Cost
So Hospitals With Higher-Need Patients Will Receive Penalties

Patient With Chronic Disease, No Home Support

Joint Surgery in Hospital → High Cost Post-Acute Care → Many Other Medical Services → Hospital Admission Unrelated to Joint Surgery → Improved Mobility & Reduced Pain

Penalty

Higher Cost

Higher Cost

Higher Cost

“Average” Patient

Joint Surgery in Hospital → Post-Acute Care → Other Medical Services → Hospital Readmissions → Improved Mobility & Reduced Pain

High Cost

Many Other Medical Services

Hospital Admission Unrelated to Joint Surgery

Improved Mobility & Reduced Pain

Higher Cost

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No Risk Adjustment for Factors Affecting Post-Discharge Services

**CJR Risk Stratification**
- DRG 469 vs DRG 470 with “Major Complications or Comorbidities”
- Fracture vs. Elective Surgery

**No Adjustment for:**
- Medical conditions not included as “major comorbidities” in the DRG grouper that could result in high use of medical services after discharge or risk of admission to hospital for conditions unrelated to joint surgery
- Patient characteristics that increase Medicare payments for SNF, home health, and other post-acute care services
  - Functional status
  - Depression
  - Cognitive status
- Lack of caregiver support at home
- Lack of access to transportation
CMS Didn’t Risk Adjust Better Because They Didn’t Know How

CJR Risk Stratification
• DRG 469 vs DRG 470 with “Major Complications or Comorbidities”
• Fracture vs. Elective Surgery

No Adjustment for:
• Medical conditions not included as “major comorbidities” in the DRG grouper that could result in high use of medical services after discharge or risk of admission to hospital for conditions unrelated to joint surgery
• Patient characteristics that increase Medicare payments for SNF, home health, and other post-acute care services
  • Functional status
  • Depression
  • Cognitive status
• Lack of caregiver support at home
• Lack of access to transportation

“We considered risk adjusting the episode target prices by making adjustments or setting different prices based on patient-specific clinical indicators (for example, comorbidities). However, we did not believe there is a sufficiently reliable approach that exists suitable for CJR episodes beyond MS–DRG-specific pricing, and there is no current standard on the best approach… Therefore, we did not propose to make risk adjustments based on patient-specific clinical indicators.”

CMS (80 FR 73338)
Disincentive to Serve High-Need, Incentive for Unnecessary Surgery

- **Patient With Chronic Disease, No Home Support**
  - Joint Surgery in Hospital
  - High Cost Post-Acute Care
  - Many Other Medical Services
  - Hospital Admission Unrelated to Joint Surgery
  - Penalty
  - Higher Cost
  - Other Medical Services
  - Hospital Readmissions

- **“Average” Patient**
  - Joint Surgery in Hospital
  - Post-Acute Care
  - Other Medical Services
  - Hospital Readmissions
  - Bonus
  - Lower Cost
  - Other Medical Services
  - No Hospital Readmissions

- **Healthy Patient Who Doesn’t Need Surgery**
  - Joint Surgery in Hospital
  - Low-Cost Post-Acute Care
  - Other Medical Services
  - No Hospital Readmissions
  - Limited Change in Mobility or Pain

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## Hypothetical Region With Two Hospitals

<table>
<thead>
<tr>
<th>Hospital</th>
<th>#1</th>
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<table>
<thead>
<tr>
<th>Hospital</th>
<th>#2</th>
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</table>
25% of Patients at Hospital #1 Have High Post-Acute Care Needs

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1</td>
<td>Low Need</td>
</tr>
<tr>
<td></td>
<td>Low Need</td>
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<tr>
<td></td>
<td>Low Need</td>
</tr>
<tr>
<td></td>
<td>High Need</td>
</tr>
</tbody>
</table>

#2
The Surgery Payment is the Same For Every Patient (in DRG 470)

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Patient</th>
<th>Surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1</td>
<td>Low Need</td>
<td>$13,700</td>
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<tr>
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<tr>
<td></td>
<td>High Need</td>
<td>$13,700</td>
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</tbody>
</table>
High Need Patients Have Higher Post-Acute Care Costs

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Patient</th>
<th>Surgery</th>
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#2
So High-Need Patients Cost Twice as Much as Low-Need

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50% of Patients at Hospital #2 Have High Post-Acute Care Needs

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CMS Calculates the Average Cost of Episodes in the Region…

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Average: $28,200
…Then Discounts the Average to Calculate the “Target Price”

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**Average:** $28,200  
**-3%:** ($846)  
**TARGET:** $27,354
Each Hospital Then Has to Meet the Target Price, *On Average*

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**TARGET:** $27,354

| #2       | Low Need   | $13,700  | $3,000     | $0      | $1,000 | $17,700|
|          | Low Need   | $13,700  | $12,000    | $0      | $1,000 | $26,700|
|          | High Need  | $13,700  | $12,000    | $12,000 | $2,000 | $39,700|
|          | High Need  | $13,700  | $12,000    | $12,000 | $2,000 | $39,700|

**TARGET:** $27,354

**TARGET:** $27,354
CMS Calculates Actual Average Spending at Each Hospital…

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Average: $25,450  
TARGET: $27,354

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Average: $30,950  
TARGET: $27,354
"...And Determines Whether the Hospital is Above or Below Target" 

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**Average:** $25,450

**TARGET:** $27,354

**Bonus:** $1,904

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**Average:** $30,950

**TARGET:** $27,354

**Penalty:** ($3,596)
Some Hospitals Start Out Ahead of the Curve

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Hospital #1 is Eligible for a Bonus Without Doing Anything at All

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Other Hospitals Start Out Behind the Curve

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<td>TARGET: $27,354</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Penalty: ($3,596)</td>
</tr>
</tbody>
</table>

Hospital #2 Is At Risk of a Penalty Because of the Higher-Need Patient Mix.
### Goal: Find Ways to Reduce Post-Acute Care Spending

Use lower-cost post-acute care services for lower-need patients, e.g., home health or shorter SNF stay

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Patient</th>
<th>Surgery</th>
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<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1</td>
<td>Low Need</td>
<td>$13,700</td>
<td>$3,000</td>
<td>$0</td>
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<tr>
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<td>$12,000</td>
<td>$12,000</td>
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<td>$39,700</td>
</tr>
</tbody>
</table>

**Average:** $25,450  
**TARGET:** $27,354  
**Bonus:** $1,904

| #2       | Low Need| $13,700 | $3,000     | $0      | $1,000| $17,700 |
|          | Low Need| $13,700 | $12,000    | $0      | $1,000| $26,700 |
|          | High Need| $13,700 | $12,000    | $12,000| $2,000| $39,700 |
|          | High Need| $13,700 | $12,000    | $12,000| $2,000| $39,700 |

**Average:** $30,950  
**TARGET:** $27,354  
**Penalty:** ($3,596)
Reducing Use of SNF/IRF or SNF LOS Reduces Spending

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Patient</th>
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<td>$2,000</td>
<td>$39,700</td>
</tr>
</tbody>
</table>

Use lower-cost post-acute care services for lower-need patients, e.g., home health or shorter SNF stay

|        | Low Need  | $13,700 | $3,000     | $0      | $1,000| $17,700 |
|        | Low Need  | $13,700 | $3,000     | $0      | $1,000| $17,700 |
|        | High Need | $13,700 | $12,000    | $12,000 | $2,000| $39,700 |
|        | High Need | $13,700 | $12,000    | $12,000 | $2,000| $39,700 |

TARGET: $27,354
## Lower Post-Acute Spending Reduces Average Spending

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Patient</th>
<th>Surgery</th>
<th>Post-Acute</th>
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<tr>
<td></td>
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<td>Average: $23,200</td>
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<tr>
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<td>TARGET: $27,354</td>
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<table>
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<tbody>
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<tr>
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<td></td>
<td></td>
<td></td>
<td></td>
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<td>TARGET: $27,354</td>
</tr>
</tbody>
</table>
## Hospital #1 Gets a Bigger Bonus, Hospital #2 Still Has a Penalty

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Patient</th>
<th>Surgery</th>
<th>Post-Acute</th>
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<tr>
<td></td>
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<td>$23,200 Average:</td>
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<td>$27,354 TARGET:</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>$4,154 Bonus:</td>
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</table>

<table>
<thead>
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<td></td>
<td>$28,700 Average:</td>
</tr>
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<td>$27,354 TARGET:</td>
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<td>($1,346) Penalty:</td>
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</table>
Hospital #2 Can Get a Bonus By Avoiding High-Need Patients

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Patient</th>
<th>Surgery</th>
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</table>

Average: $23,200
TARGET: $27,354
Bonus: $4,154

#2

<table>
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<tr>
<th>Hospital</th>
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<td>$39,700</td>
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</tbody>
</table>

Average: $25,033
TARGET: $27,354
Bonus: $2,321
Bigger Bonuses From More Surgeries on Low-Need Patients

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Patient</th>
<th>Surgery</th>
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</table>

Average: $23,200
Target: $27,354
Bonus: $4,154

<table>
<thead>
<tr>
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Average: $23,200
Target: $27,354
Bonus: $4,154

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What Has Actually Happened Under CJR?

CJR has been in effect for 3.5 years (since April 2016), but only results through the end of 2017 (the first 21 months) are currently available.
Spending Was Lower After CJR Was Implemented

Change in Spending in CJR Regions vs Control Regions
First Two Performance Years (2016-17) vs Baseline

- $2,000 Savings Per Episode in CJR (7.5%)
Spending on Joint Replacement Episodes Was Lower Everywhere

~$2,000 Savings Per Episode in CJR (7.5%)

~$1,000 Savings Per Episode in Control Group (3.8%)
Spending Reductions Were Higher in CJR Hospitals

~$2,000 Savings Per Episode in CJR (7.5%)

~$1,000 Savings Per Episode in Control Group (3.8%)

$989 Savings Due to CJR (3.7%)
But Most of the Savings Went to Bonus Payments to Hospitals

~$2,000 Savings Per Episode in CJR (7.5%)

~$1,000 Savings Per Episode in Control Group (3.8%)

$989 Savings Due to CJ (3.7%)

$872 Bonus Pmts (3.2%)
Net Savings to CMS Was Very Small

Change in Spending in CJR Regions vs Control Regions
First Two Performance Years (2016-17) vs Baseline

- ~$2,000 Savings Per Episode in CJR (7.5%)
- ~$1,000 Savings Per Episode in Control Group (3.8%)
- $989 Savings Due to CJ
- $872 Bonus Pmts
- $117 Net Savings to CMS (0.4%)
Net Savings Did Not Increase from Year 1 to Year 2

Gross Savings and Net Savings to CMS in CJR, PY1 and PY2

- **PY1 Gross Savings**
- **PY1 Bonuses**
- **PY1 Net Savings**
- **PY2 Gross Savings**
- **PY2 Bonuses**
- **PY2 Net Savings**

- $111 Net Savings Per Episode (0.4%)
“Downside Risk” Did Not Increase Savings

Gross Savings and Net Savings to CMS in CJR, PY1 and PY2

No “Downside Risk”

$111 Net Savings Per Episode (0.4%)

“Downside Risk”

$111 Net Savings Per Episode (0.4%)
Bonuses Went to Hospitals With Lower-Complexity Patients

Exhibit 10: Lower average patient complexity was associated with receiving reconciliation payments

- Never received reconciliation payments
  - High Risk Scores= No Bonuses
  - Low Risk Scores= Bonuses

- Reconciliation payments in PY2, not PY1
- Reconciliation payments in PY1, not PY2
- Reconciliation payments in both years

Average HCC score

- No reconciliation payments in PY
- Reconciliation payments in PY
Change In Patient Complexity Changed The Bonus

Exhibit 10: Lower average patient complexity was associated with receiving reconciliation payments

- Never received reconciliation payments
- Reconciliation payments in PY2, not PY1
- Reconciliation payments in PY1, not PY2
- Reconciliation payments in both years

Average HCC score

- No reconciliation payments in PY
- Reconciliation payments in PY

Increased Risk Score = No Bonus

Lower Risk Score = Bonus
Potential Financial Penalties for Serving Higher-Risk Patients

Performance Of Safety-Net Hospitals In Year 1 Of The Comprehensive Care For Joint Replacement Model

By Caroline P. Thirukumar, Laurent G. Glance, Xueya Cai, Rishi Balkissoon, Addisu Mesfin, and Yue Li

ABSTRACT The Comprehensive Care for Joint Replacement (CJR) model introduced in 2016 aims to improve the quality and costs of care for Medicare beneficiaries undergoing hip and knee replacements. However, there are concerns that the safety-net hospitals that care for the greatest number of vulnerable patients may perform poorly in CJR. In this study we used Medicare’s CJR data to evaluate the performance of 792 hospitals mandated to participate in the first year of CJR. We found that in comparison to non-safety-net hospitals, 42 percent fewer safety-net hospitals qualified for rewards based on their quality and spending performance (33 percent of safety-net hospitals qualified, compared to 57 percent of non-safety-net hospitals), and safety-net hospitals’ rewards per episode were 39 percent smaller ($456 compared to $743). Continuation of this performance trend could place safety-net hospitals at increased risk of penalties in future years. Medicare and hospital strategies such as those that reward high-quality care for vulnerable patients could enable safety-net hospitals to compete effectively in CJR.

42% Fewer Safety-Net Hospitals Qualified for Bonuses, and Bonuses for Safety-Net Hospitals Were 39% Smaller Than for Non-Safety-Net Hospitals
# Fee for Service Has *Strengths* as Well as Weaknesses

<table>
<thead>
<tr>
<th>Weaknesses of Fee for Service</th>
<th>FFS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment for unnecessary services?</td>
<td>YES</td>
</tr>
<tr>
<td>Payment even if quality/outcome is bad?</td>
<td>YES</td>
</tr>
<tr>
<td>Payment for all high-value services?</td>
<td>NO</td>
</tr>
<tr>
<td>Payment sufficient to cover cost of services?</td>
<td>NO</td>
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</table>

## Strengths of Fee for Service

<table>
<thead>
<tr>
<th>Higher payment for higher-need patients?</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Penalties for things provider cannot control?</td>
<td>NO</td>
</tr>
</tbody>
</table>
### CJR Doesn’t Fix FFS Problems & Doesn’t Preserve FFS Strengths

<table>
<thead>
<tr>
<th>Weaknesses of Fee for Service</th>
<th>FFS</th>
<th>CJR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment for unnecessary services?</td>
<td>YES</td>
<td>Penalties for high spending regardless of necessity</td>
</tr>
<tr>
<td>Payment even if quality/outcome is bad?</td>
<td>YES</td>
<td>YES (no outcome metric)</td>
</tr>
<tr>
<td>Payment for all high-value services?</td>
<td>NO</td>
<td>NO (depends on savings)</td>
</tr>
<tr>
<td>Payment sufficient to cover cost of services?</td>
<td>NO</td>
<td>NO (based on current fees)</td>
</tr>
</tbody>
</table>

### Strengths of Fee for Service

| Higher payment for higher-need patients? | YES | NO (limited risk adjust.) |
| Penalties for things provider cannot control? | NO | YES (unrelated costs) |
BPCI is Similar to CJR
But for More Procedures/Admits

<table>
<thead>
<tr>
<th>CJR</th>
<th>BPCI - Advanced</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Comprehensive Care for Joint Replacement)</td>
<td>(Bundled Payments for Care Improvement)</td>
</tr>
<tr>
<td>Hospitalization + All Services 90 Days After Discharge (Rehab, HH, readmits, physician svcs)</td>
<td>Hospitalization + All Services 90 Days After Discharge (Rehab, HH, readmits, physician svcs)</td>
</tr>
<tr>
<td>Mandatory Participation</td>
<td>Voluntary Participation</td>
</tr>
<tr>
<td>Hospitals Only</td>
<td>Hospitals Physician Groups</td>
</tr>
<tr>
<td>2 Types of Episodes:</td>
<td>35 Types of Episodes</td>
</tr>
<tr>
<td>• Hip Replacement</td>
<td>• Hip &amp; Knee Replacement</td>
</tr>
<tr>
<td>• Knee Replacement</td>
<td>• Other Inpatient Surgical Procedures</td>
</tr>
<tr>
<td>• Hospitals share in savings if spending is below episode price</td>
<td>• Providers share in savings if spending is below episode budget</td>
</tr>
<tr>
<td>• Hospitals at risk if spending exceeds episode price</td>
<td>• Providers at risk if spending exceeds episode price</td>
</tr>
</tbody>
</table>
CJR/BPCI Are Really Just a Different Form of P4P

ALTERNATIVE PAYMENT MODELS

MIPS/P4P

CJR/BPCI

Unpaid & Underpaid Services

No New Payments

No New Payments

All Current FFS Payments

All Current FFS Payments

Bonus

Penalty

Bonus

Penalty

FFS

FFS

FFS
What About ACOs?

ALTERNATIVE PAYMENT MODELS

MIPS/P4P

CJR/BPCI

MSSP

FFS

Unpaid & Underpaid Services

MIPS/P4P

Bonus Penalty

FFS

All Current FFS Payments

No New Payments

FFS

Medicare Shared Savings Program ACOs

No New Payments

FFS

All Current FFS Payments

No New Payments
No Change in FFS Payments for Providers Under the ACO

Medicare Shared Savings Program

YEAR 0

FFS Payments

YEAR 1

FFS Payments

UNPAID SERVICES

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If Spending Decreases This Year,

**Medicare Shared Savings Program**

YEAR 0

**FFS Spending**

YEAR 1

**FFS Spending**

UNPAID SERVICES

SAVINGS

LOSS OF REVENUE
If Spending Decreases This Year, ACO (May) Get a Bonus Next Year

Medicare Shared Savings Program

YEAR 0

YEAR 1

YEAR 2

$FFS Spending

$UNPAID SERVICES

$SAVINGS

$UNPAID SERVICES

$LOSS OF REVENUE

$FFS Spending

$UNPAID SERVICES

$LOSS OF REVENUE

$FFS Spending

$UNPAID SERVICES

$LOSS OF REVENUE
“Shared Savings” is Too Little, Too Late to Improve Care

Medicare Shared Savings Program

YEAR 0

FFS Spending

YEAR 1

FFS Spending

YEAR 2

FFS Spending

UNPAID SERVICES

UNPAID SERVICES

UNPAID SERVICES

SAVINGS

SAVINGS

SAVINGS

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

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

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The “Shared Savings” Approach Hasn’t Saved Very Much

Net Loss to CMS in First Four Years from MSSP ACO Program

Net $ Savings to Medicare Per Beneficiary in ACOs

- 2013: ($10)
- 2014: ($20)
- 2015: ($30)
- 2016: ($40)
- 2017: $0
- 2018: $110
Extremely Small Amounts When Savings Are Achieved

Net $ Savings to Medicare Per Beneficiary in ACOs

Net Savings of $75 Per Beneficiary in 2018 (0.67%)

Net Loss to CMS in First Four Years from MSSP ACO Program

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

<table>
<thead>
<tr>
<th></th>
<th>FFS Spending</th>
<th>AVOIDABLE SPENDING</th>
<th>NECESSARY SPENDING</th>
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<th>NECESSARY SPENDING</th>
<th>ACO FFS Spending</th>
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SAVINGS
Or Did They Stint on Necessary Care to Produce Savings?
ACOs Don’t Have to Tell Us and CMS Doesn’t Ask

The ACO Black Box

FFS Spending

ACO FFS 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:
- Effective management for joint pain and mobility
- Effective management of back pain and mobility
- 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
- Access to and quality of care for many other conditions
Since Current APMs Aren’t Reducing Spending Very Much…

- MIPS/P4P
- CJR/BPCI
- MSSP

- FFS
- Merit-Based Incentive Payment System (MIPS)
- Comp. Care for Joint Replace. (CJR) & Bundled Pmts for Care Improve. (BPCI)
- Medicare Shared Savings Program ACOs
- Medicare Spending Under APMs

Unpaid & Underpaid Services
...CMS Wants to Put Physicians at Risk for Reducing Spending
Population-Based Payment & Full Risk Creates New Problems

<table>
<thead>
<tr>
<th>Weaknesses of Fee for Service</th>
<th>FFS</th>
<th>“Population-Based” (Full Risk) Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment for unnecessary services?</td>
<td>YES</td>
<td>Penalties for high spending regardless of necessity</td>
</tr>
<tr>
<td>Payment even if quality/outcome is bad?</td>
<td>YES</td>
<td>YES (no outcome metric)</td>
</tr>
<tr>
<td>Payment for all high-value services?</td>
<td>NO</td>
<td>YES (flexibility re: services)</td>
</tr>
<tr>
<td>Payment sufficient to cover cost of services?</td>
<td>NO</td>
<td>NO (based on current fees)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Strengths of Fee for Service</th>
<th>FFS</th>
<th>“Population-Based” (Full Risk) Payment</th>
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</thead>
<tbody>
<tr>
<td>Higher payment for higher-need patients?</td>
<td>YES</td>
<td>NO (limited risk adjust.)</td>
</tr>
<tr>
<td>Penalties for things provider cannot control?</td>
<td>NO</td>
<td>YES (risk for uncontrollable costs, such as drug prices)</td>
</tr>
<tr>
<td>Payment if patient does not receive care?</td>
<td>NO</td>
<td>YES (payment made even if no care is delivered)</td>
</tr>
</tbody>
</table>
Growing Concerns About Negative Impacts of Current VBP

The Hospital Readmissions Reduction Program — Time for a Reboot

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
Is There Any Way to Create a *Good* Alternative Payment Model?
Bundling Better: *Condition*-Based Payment

**CONDITION-BASED PAYMENT FOR OSTEOARTHRITIS**

- **Joint Surgery in Hospital**
- **Post-Acute Care**
- **Intensive Home PT**
- **Related Medical Services**
- **Related Readmissions**

**Patient w/ Pain & Limited Mobility**
- **Physical Therapy**
- **Exercise**

**Improved Mobility & Reduced Pain**
Bundling Better: *Condition*-Based Payment

**CONDITION-BASED PAYMENT FOR OSTEOARTHRITIS**

- **Joint Surgery in Hospital**
- **Intensive Home PT**
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- **Related Medical Services**
- **Related Readmissions**

**PAYMENT AMOUNTS BASED ON PATIENT NEED & COST OF QUALITY CARE**

- $ for Low-Need Patients
- $ for Medium-Need Patients
- $$$ for High-Need Patients
- Cost of Quality Care

**Improved Mobility & Reduced Pain**

Patient w/ Pain & Limited Mobility

Physical Therapy → Exercise
## Condition-Based APM Solves FFS Problems & Preserves Its Strengths

<table>
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<th>Weaknesses of Fee for Service</th>
<th>Condition-Based Payment</th>
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<tbody>
<tr>
<td>Payment for unnecessary services?</td>
<td>Payment based on patient need, not the number or type of services</td>
</tr>
<tr>
<td>Payment even if quality/outcome is bad?</td>
<td>$0 unless quality standards are met $0 extra to treat avoidable problems</td>
</tr>
<tr>
<td>Payment for all high-value services?</td>
<td>Flexible, bundled payment to team</td>
</tr>
<tr>
<td>Payment sufficient to cover cost of services?</td>
<td>Payment based on cost of delivering high-quality services</td>
</tr>
</tbody>
</table>

## Strengths of Fee for Service

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</thead>
<tbody>
<tr>
<td>Higher payment for higher-need patients?</td>
<td>Payment amounts stratified based on patient needs</td>
</tr>
<tr>
<td>Penalties for things provider cannot control?</td>
<td>Accountability for services and outcomes providers can control</td>
</tr>
<tr>
<td>Payment if patient does not receive care?</td>
<td>No payment unless patient receives treatment for the condition</td>
</tr>
</tbody>
</table>
How Providers and Patients Can Help Create Better APMs
How Providers and Patients Can Help Create Better APMs

• **Contribute information to help with better APM design**
  – Characteristics of patients who require more or different services
  – Characteristics of patients that can result in poorer outcomes
  – Actual cost of delivering services to low-need & high-need patients
  – Difference in cost to deliver services in small and rural communities
How Providers and Patients Can Help Create Better APMs

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• **Support collection of data needed to implement APMs**
  – Data to measure patient needs, not just diagnosis codes
  – Data on patient outcomes, not just services delivered
How Providers and Patients Can Help Create Better APMs

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• Support collection of data needed to implement APMs
  – Data to measure patient needs, not just diagnosis codes
  – Data on patient outcomes, not just services delivered

• Demand that Medicare and other payers use better APMs
  – Condition-based payments rather than population-based payments
  – Adequate, flexible payments stratified by patient need
  – No untested mandatory payment models
More Details on Creating Better Payment Models

www.PaymentReform.org

BUNDLING BADLY:
The Problems With Medicare’s Proposal for Comprehensive Care for Joint Replacement

Harold D. Miller

On July 13, 2015, the Centers for Medicare and Medicaid Services (CMS) proposed regulations to implement what it described as an “episode payment” for hip and knee surgery. However, what it describes has demonstrated failure to improve quality and has severe unintended consequences.

The CMS proposal is based on the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which requires the agency to increase transparency and promote value for Medicare beneficiaries.

The CMS proposal is one of several initiatives designed to reduce the $1 trillion spent on health care in the United States. It is intended to improve quality of care while controlling costs.

However, the CMS proposal is flawed because it...

BUNDLING BETTER:
How Medicare Should Pay for Comprehensive Care (for Hip and Knee Surgery and Other Healthcare Needs)

Harold D. Miller

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How to Create an Alternative Payment Model

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

Harold D. Miller

September 2016
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