HIGHER-VALUE HEALTHCARE
Who Will Win and Who Will Lose?

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

www.CHQPR.org
If You’re Under 65, You Should Be Worried

Oregon Family Insurance Premiums as % of Average Annual Pay

© Center for Healthcare Quality and Payment Reform  www.CHQPR.org
If You’re Under 65, You Should Be Worried

Health Insurance Premiums Are Equal to 35% of Average Annual Pay

Oregon Family Insurance Premiums as % of Average Annual Pay
Oregon Premiums $5,600 More Expensive Than 12-Year Inflation

Oregon Family Premiums

Inflation

© Center for Healthcare Quality and Payment Reform  www.CHQPR.org
Healthcare Creates Jobs But It Also Suppresses Job Growth

If insurance premiums in Oregon had increased at the same rate as wages from 2002 to 2014, Oregon employers could have increased wages by 10% or hired 10% more workers.
More Reasons to Worry

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

Source: CBO Budget Outlook August 2012

46% of Spending Growth is Healthcare
Is “Value-Based Purchasing” the Answer?
Step 1: Identify “High-Value Providers”

“High-Value” Providers

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

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

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

**ONCOLOGIST #1**

7 Year Survival
$5,000/patient

**ONCOLOGIST #2**

10 Year Survival
$10,000/patient
So Provider #1 Delivers Higher Value Care, Right?

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

**ONCOLOGIST #1**
- 7 Year Survival
- $5,000/patient
- 0.51 days of life per dollar

**ONCOLOGIST #2**
- 10 Year Survival
- $10,000/patient
- 0.37 days of life per dollar
Assessing Value is a Lot Harder Than This

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

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

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

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

“Low-Value” Providers
But Wait: Weren’t We Going to Stop Rewarding Volume???

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

"Low-Value" Providers → Volume → Value
Narrow Networks Are Not What “Volume to Value” Means!

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

“Low-Value” Providers

Volume → Value → Volume

From Volume To Value: Better Ways To Pay For Health Care

Changing Incentives

Health Affairs, Sept/Oct 2009
What if the Network is Already “Narrow?”

More? Patients → One Provider in the Community

(Rural Area, Consolidated System, Etc.)
National Narrow Networks: “Centers of Excellence”

More Patients → High-Value Providers in Other Cities

One Provider in the local Community
Will Every Cancer Patient Have to Go to Minnesota?
Will Every Cancer Patient Have to Go to Minnesota?

Are purchasers in the “sending” regions benefiting from the high prices that the “high value” providers are charging employers and patients in their own region?
We Know How to Improve Outcomes and Lower Costs

CARE DELIVERY IMPROVEMENTS

BETTER PATIENT OUTCOMES

LOWER PAYER COST
The Current Payment System Gets in the Way

- Failure to pay for high-value services
- Loss of revenue and negative margins when using fewer/lower-cost services
The Solution Isn’t “Incentives;”
More Fundamental Reforms Needed

- Adequate payment for high-value services
- Margins tied to outcomes, not volume of services
Three Major Types of Payment Reforms Today

CMS & Other Payers
Three Major Types of Payment Reforms Today

- CMS & Other Payers
- Medical Home Payments to Primary Care Practices
Three Major Types of Payment Reforms Today

- Medical Home Payments to Primary Care Practices
- Bundled Payments to Hospitals for Hip & Knee Replacement

CMS & Other Payers
Three Major Types of Payment Reforms Today

- Medical Home Payments to Primary Care Practices
- Shared Savings Payments to ACOs
- Bundled Payments to Hospitals for Hip & Knee Replacement

CMS & Other Payers
Three Major Types of Payment Reforms Today

CMS & Other Payers

- Medical Home Payments to Primary Care Practices
- Shared Savings Payments to ACOs
- Bundled Payments to Hospitals for Hip & Knee Replacement

CMS (6/6/16): “Medicare is moving away from paying for each service a physician provides towards a system that rewards physicians for coordinating with each other”
Is “Care Coordination” the Key to Value-Based Care?

- Is the biggest problem with health care lack of coordination?
- Can you get high quality, affordable care by coordinating poor quality, expensive services?
Is Fit & Finish of Assembly the Key to Safe Automobiles?
Is Fit & Finish of Assembly the Key to Safe Automobiles?

• When you buy a car, is your only concern whether the manufacturer assembled all the parts properly?
Is Fit & Finish of Assembly the Key to Safe Automobiles?

• When you buy a car, is your only concern whether the manufacturer assembled all the parts properly?

Millions More Cars With Takata Air Bags Recalled
Honda, Fiat Chrysler, Toyota, Nissan, Subaru, and more kick off latest U.S. recalls

Car makers recalled millions of additional vehicles world-wide with faulty Takata Corp. air bags, further escalating an automotive safety crisis linked to at least 11 deaths and more than 100 injuries. Auto makers in the U.S. on Friday recalled more than 12 million vehicles to replace the air bags, according to filings with U.S. regulators. The safety campaigns in the U.S. are part of a massive expansion disclosed earlier this month requiring auto makers to recall up to an additional 40 million air bags that risk rupturing and spraying shrapnel in vehicle cabins. All told, nearly 70 million air bags are being recalled in the U.S. alone.
Honda Motor Co., Fiat Chrysler Automobiles NV, Toyota Motor Corp, Nissan Motor Co., Fuji Heavy Industries Ltd.’s Subaru, Ferrari NV and Mitsubishi Motors Corp. kicked off the U.S. recalls on Friday. Honda, Takata’s largest customer, recalled roughly 4.5 million vehicles, including some that had already been recalled earlier. Fiat Chrysler recalled 4.3 million vehicles.
Healthcare Has Defective Parts, But We Continue to Use Them

<table>
<thead>
<tr>
<th>Medical Error</th>
<th># Errors (2008)</th>
<th>Cost Per Error</th>
<th>Total U.S. Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressure Ulcers</td>
<td>374,964</td>
<td>$10,288</td>
<td>$3,857,629,632</td>
</tr>
<tr>
<td>Postoperative Infection</td>
<td>252,695</td>
<td>$14,548</td>
<td>$3,676,000,000</td>
</tr>
<tr>
<td>Complications of Implanted Device</td>
<td>60,380</td>
<td>$18,771</td>
<td>$1,133,392,980</td>
</tr>
<tr>
<td>Infection Following Injection</td>
<td>8,855</td>
<td>$78,083</td>
<td>$691,424,965</td>
</tr>
<tr>
<td>Pneumothorax</td>
<td>25,559</td>
<td>$24,132</td>
<td>$616,789,788</td>
</tr>
<tr>
<td>Central Venous Catheter Infection</td>
<td>7,062</td>
<td>$83,365</td>
<td>$588,723,630</td>
</tr>
<tr>
<td>Others</td>
<td>773,808</td>
<td>$11,640</td>
<td>$9,007,039,005</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1,503,323</td>
<td>$13,019</td>
<td>$19,571,000,000</td>
</tr>
</tbody>
</table>

3 Adverse Events Every Minute

Source: The Economic Measurement of Medical Errors, Milliman and the Society of Actuaries, 2010
ACOs Are Supposed to Improve Care Through “Coordination”
In Most ACOs, Physicians Are Paid the Same As They Are Today

MEDICARE, MEDICAID HEALTH PLAN

Fee-for-Service Payment

PATIENTS
- Heart Disease
- Diabetes
- Back Pain
- Pregnancy

ACO

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

Fee-for-Service Payment

MEDICARE, MEDICAID HEALTH PLAN

ACO

Expensive IT Systems
Nurse Care Managers

PATIENTS

Heart Disease
Diabetes
Back Pain
Pregnancy

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

MEDICARE, MEDICAID HEALTH PLAN

Fee-for-Service Payment

Shared Savings Payment??

ACO

Expensive IT Systems

Nurse Care Managers

Share of Shared Savings Payment??

PATIENTS

Heart Disease
Diabetes
Back Pain
Pregnancy

Primary Care
Cardiology
Endocrinology
Neurosurgery
OB/GYN
Most ACOs Today Aren’t Truly Redesigning Care

MEDICARE, MEDICAID HEALTH PLAN

Fee-for-Service Payment

Shared Savings Payment??

ACO

Expensive IT Systems

Nurse Care Managers

Share of Shared Savings Payment??

PATIENTS

Heart Disease
Diabetes
Back Pain
Pregnancy

Primary Care
Cardiology
Endocrinology
Neurosurgery
OB/GYN

© Center for Healthcare Quality and Payment Reform  www.CHQPR.org
Medicare ACOs Aren’t Succeeding Due to Flaws in Payment Model

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

2014 Results for Medicare Shared Savings ACOs
• 45% of ACOs (152/333) increased Medicare spending
• Only one-fourth (86/333) received shared savings payments
• After making shared savings payments, Medicare spent more than it saved
Private Shared Savings ACOs Are Also Floundering

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

By Bob Herman | October 15, 2015

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

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

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

“Our alternative payment models are succeeding at a much lower rate than they should be,” said Dr. Stephen Ondra, chief medical officer at Health Care Service Corp., the Blue Cross and Blue Shield insurer for five states. “In the ACO, the consumer engagement is very, very low.”
How Would You Design a Good ACO?

PATIENTS

- Heart Disease
- Diabetes
- Back Pain
- Pregnancy
Connect Each Patient With a Good Primary Care Practice…

PATIENTS

- Heart Disease
- Diabetes
- Back Pain
- Pregnancy

Primary Care Practice
…With Payment That Enables Delivery of Good Primary Care…

MEDICARE, MEDICAID HEALTH PLAN

Primary Care Practice

Payment That Supports Good Primary Care

PATIENTS
- Heart Disease
- Diabetes
- Back Pain
- Pregnancy
...And PCPs Take Accountability for Costs They Can Control/Influence

MEDICARE, MEDICAID HEALTH PLAN

PATIENTS
- Heart Disease
- Diabetes
- Back Pain
- Pregnancy

Primary Care Practice

Payment That Supports Good Primary Care

Accountability for:
- Avoidable ER Visits
- Avoidable Hospitalizations
- Unnecessary Tests
- Unnecessary Referrals
- Adequate Preventive Care
Give PCPs a Medical Neighborhood to Consult With on Difficult Cases

MEDICARE, MEDICAID HEALTH PLAN

PATIENTS

Heart Disease
Diabetes
Back Pain
Pregnancy

Primary Care Practice

Endocrinology, Cardiology, Physiatry

Payment That Supports Good Primary Care
Pay the Medical Neighbors to Help Remotely Whenever Possible

MEDICARE, MEDICAID HEALTH PLAN

PATIENTS
- Heart Disease
- Diabetes
- Back Pain
- Pregnancy

Primary Care Practice

Payment That Supports Good Primary Care

Endocrinology, Cardiology, Physiatry

Payment That Supports Diagnostic & Care Management Help From Specialists
...Ask the Medical Neighbors to Be Accountable for Costs They Control

MEDICARE, MEDICAID HEALTH PLAN

PATIENTS
- Heart Disease
- Diabetes
- Back Pain
- Pregnancy

Primary Care Practice
- Payment That Supports Good Primary Care

Endocrinology, Cardiology, Physiatry
- Payment That Supports Diagnostic & Care Management Help From Specialists

Accountability for:
- Appropriate Use of Testing and Interventions
- Improving Chronic Disease Management

© Center for Healthcare Quality and Payment Reform  www.CHQPR.org
Have Good Specialists Ready to Manage Serious Conditions…

MEDICARE, MEDICAID HEALTH PLAN

PATIENTS

Heart Disease
Diabetes
Back Pain
Pregnancy

Primary Care Practice

Cardiology Group
Neurosurgeon Group
OB/GYN Group

Endocrinology, Cardiology, Physiatry

Payment That Supports Good Primary Care

Payment That Supports Diagnostic & Care Management Help From Specialists
Pay Them To Deliver Quality Care at the Most Affordable Cost

MEDICARE, MEDICAID HEALTH PLAN

PATIENTS
- Heart Disease
- Diabetes
- Back Pain
- Pregnancy

Payment That Supports Good Primary Care

Primary Care Practice

Payment That Supports Diagnostic & Care Management Help From Specialists

Endocrinology, Cardiology, Physiatry

Payment That Supports Good Management of Heart Disease

Cardiology Group

Payment That Supports Good Care for Back Pain

Neurosurg. Group

Payment That Supports Good Care for Pregnancy

OB/GYN Group
Ask Specialists to Be Accountable for Costs They Can Control

**MEDICARE, MEDICAID**

- Patients
  - Heart Disease
  - Diabetes
  - Back Pain
  - Pregnancy

Primary Care Practice

- Cardiology Group
- Neurosurg. Group
- OB/GYN Group

**Payment That Supports**
- Good Management of Heart Disease
- Good Care for Back Pain
- Good Care for Pregnancy

**Endocrinology, Cardiology, Physiatry**

**Accountability for:**
- Using Appropriate Procedures
- Avoiding Complications of Procedures

© Center for Healthcare Quality and Payment Reform  www.CHQPR.org
That’s an “ACO,” But Built from the Bottom Up, Not the Top Down

MEDICARE, MEDICAID HEALTH PLAN

Alternative Payment Models

PATIENTS
- Heart Disease
- Diabetes
- Back Pain
- Pregnancy

Payment That Supports Good Primary Care
Primary Care Practice

Cardiology Group
Neurosurgeon Group
OB/GYN Group

Payment That Supports Good Management of Heart Disease
Payment That Supports Good Care for Back Pain
Payment That Supports Good Care for Pregnancy

Endocrinology, Cardiology, Physiatry
Payment That Supports Diagnostic & Care Management Help From Specialists

“ACO”
A True ACO Can Take a Global Payment And Make It Work

MEDICARE, MEDICAID HEALTH PLAN, EMPLOYER

Risk-Adjusted Global Payment

PATIENTS
Heart Disease
Diabetes
Back Pain
Pregnancy

ACO

Cardiology Group
Neurosurg. Group
OB/GYN Group

Payment That Supports Good Management of Heart Disease
Payment That Supports Good Care for Back Pain
Payment That Supports Good Care for Pregnancy

Payment That Supports Diagnostic & Care Management Help From Specialists

Primary Care Practice

Endocrinology, Cardiology, Physiatry

Payment That Supports Good Primary Care
What Should These Other Payment Reforms Look Like?

MEDICARE, MEDICAID
HEALTH PLAN, EMPLOYER

Payment That Supports Good Primary Care

Payment That Supports Diagnostic & Care Management Help From Specialists

Primary Care Practice

Cardiology Group

Cardiology, Cardiology, Physiatry

Neurosurg. Group

Endocrinology, Cardiology, Physiatry

OB/GYN Group

Payment That Supports Good Management of Heart Disease

Payment That Supports Good Care for Back Pain

Payment That Supports Good Care for Pregnancy
CMS Medical Home Program Hasn’t Reduced Spending

Two-Year Costs and Quality in the Comprehensive Primary Care Initiative


CONCLUSIONS

Midway through this 4-year intervention, practices participating in the initiative have reported progress in transforming the delivery of primary care. However, at this point these practices have not yet shown savings in expenditures for Medicare Parts A and B after accounting for care-management fees, nor have they shown an appreciable improvement in the quality of care or patient experience. (Funded by the Department of Health and Human Services, Centers for Medicare and Medicaid Services; ClinicalTrials.gov number, NCT02320591.)
It Didn’t Reduce Spending in Oregon, Either

Table 7.1a. Summary table of percentage impacts on Medicare FFS expenditures and service utilization over the first two years of CPC: CPC-wide and by region (all attributed beneficiaries)

<table>
<thead>
<tr>
<th></th>
<th>CPC-wide</th>
<th>AR</th>
<th>CO</th>
<th>NJ</th>
<th>NY</th>
<th>OH/KY</th>
<th>OK</th>
<th>OR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Medicare expenditures ($ per beneficiary per month)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Without CPC care management fees</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 1</td>
<td>-2%**</td>
<td>0%</td>
<td>1%</td>
<td>-5%***</td>
<td>-2%</td>
<td>3%*</td>
<td>-6%***</td>
<td>-2%</td>
</tr>
<tr>
<td>Year 2</td>
<td>-1%</td>
<td>1%</td>
<td>-1%</td>
<td>-3%**</td>
<td>-3%</td>
<td>5%</td>
<td>-1%</td>
<td>-3%</td>
</tr>
<tr>
<td>Year 1 and Year 2 combined</td>
<td>-1%*</td>
<td>0%</td>
<td>0%</td>
<td>-4%***</td>
<td>-2%</td>
<td>4%*</td>
<td>-3%**</td>
<td>-3%</td>
</tr>
<tr>
<td>With CPC care management fees</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 1</td>
<td>0%</td>
<td>2%</td>
<td>3%</td>
<td>-3%*</td>
<td>0%</td>
<td>6%***</td>
<td>-4%***</td>
<td>1%</td>
</tr>
<tr>
<td>Year 2</td>
<td>1%</td>
<td>3%*</td>
<td>1%</td>
<td>-2%</td>
<td>0%</td>
<td>7%**</td>
<td>1%</td>
<td>-1%</td>
</tr>
<tr>
<td>Year 1 and year 2 combined</td>
<td>1%</td>
<td>3%</td>
<td>2%</td>
<td>-2%</td>
<td>0%</td>
<td>7%***</td>
<td>-1%</td>
<td>0%</td>
</tr>
</tbody>
</table>
We have seen in the Original CPC Model that shared savings under that model has certain limitations in motivating practices to control total cost of care. For example: (1) individual practice control over the likelihood of a shared savings payment is attenuated because spending is aggregated at the regional level; (2) total cost of care may be challenging for small primary care practices to control and there are no independent incentives for improved quality; and (3) the amount of any shared savings payments is unknown in advance and the complexity of the regionally aggregated formula and paucity of actionable cost data leaves practices doubtful of achieving any return.

CMS FAQ on CPC+
Most PCMH Programs Add $ On Top of Existing FFS

Current PCMH Model

<table>
<thead>
<tr>
<th>P4P/Shared Savings</th>
<th>PMPM for “Care Management”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tests &amp; Procedures for Preventive Services</td>
<td></td>
</tr>
<tr>
<td>Office Visits for Preventive Services</td>
<td></td>
</tr>
<tr>
<td>Office Visits for Chronic Disease Issues</td>
<td></td>
</tr>
<tr>
<td>Tests &amp; Procedures for Chronic Disease Mgt</td>
<td></td>
</tr>
<tr>
<td>Office Visits for Acute Issues</td>
<td></td>
</tr>
<tr>
<td>Tests &amp; Procedures for Acute Issues</td>
<td></td>
</tr>
</tbody>
</table>
Most Private Payers Aren’t Providing Significant New Funds

<table>
<thead>
<tr>
<th>Medicare PCMH Model</th>
<th>Private Payer Version</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>P4P/Shared Savings</strong></td>
<td><strong>P4P/Shared Savings</strong></td>
</tr>
<tr>
<td><strong>PMPM for “Care Management”</strong></td>
<td><strong>PMPM for “Care Management”</strong></td>
</tr>
<tr>
<td>Tests &amp; Procedures for Preventive Services</td>
<td>Tests &amp; Procedures for Preventive Services</td>
</tr>
<tr>
<td>Office Visits for Preventive Services</td>
<td>Office Visits for Preventive Services</td>
</tr>
<tr>
<td>Office Visits for Chronic Disease Issues</td>
<td>Office Visits for Chronic Disease Issues</td>
</tr>
<tr>
<td>Tests &amp; Procedures for Chronic Disease Mgt</td>
<td>Tests &amp; Procedures for Chronic Disease Mgt</td>
</tr>
<tr>
<td>Office Visits for Acute Issues</td>
<td>Office Visits for Acute Issues</td>
</tr>
<tr>
<td>Tests &amp; Procedures for Acute Issues</td>
<td>Tests &amp; Procedures for Acute Issues</td>
</tr>
</tbody>
</table>
The Other Major Approach: PCP Capitation

Current PCMH Model

<table>
<thead>
<tr>
<th>P4P/Shared Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PMPM for “Care Management”</strong></td>
</tr>
<tr>
<td>Tests &amp; Procedures for Preventive Services</td>
</tr>
<tr>
<td>Office Visits for Preventive Services</td>
</tr>
<tr>
<td>Office Visits for Chronic Disease Issues</td>
</tr>
<tr>
<td>Tests &amp; Procedures for Chronic Disease Mgt</td>
</tr>
<tr>
<td>Office Visits for Acute Issues</td>
</tr>
<tr>
<td>Tests &amp; Procedures for Acute Issues</td>
</tr>
</tbody>
</table>

PCP Capitation

| P4P |
| Primary Care Capitation |
Problems With Both Current PCMH Models and Capitation

Current PCMH Model

- Most practice revenue still comes from office visits
- Fewer office visits = lower revenue, even with PMPM
- Patient still discouraged from office visits by copays
- Patients must be attributed based on claims

PCP Capitation

- No incentive for PCP practice to see patient for acute needs
- Payment is the same for patients with high needs as low needs
- Employer is paying even if patient needs few services
- Patients must enroll for all services
How Would PCPs Like to Be Paid?
Current Payment for Primary Care

CURRENT PAYMENT

Payer

Payer

Payer

PRINCIPAL CARE

Tests & Procedures for Preventive Services

Office Visits for Preventive Services

Office Visits for Chronic Disease Issues

Tests & Procedures for Chronic Disease Management

Office Visits for Acute Issues

Tests & Procedures for Acute Issues

CPT Fee

CPT Fee

CPT Fee

CPT Fee

CPT Fee

CPT Fee
Current Non-Payment for Primary Care

CURRENT PAYMENT

Payer -> CPT Fee
Payer -> CPT Fee
Payer -> CPT Fee

NO PAYMENT

Tests & Procedures for Preventive Services
Office Visits for Preventive Services
Outreach Calls for Preventive Services
Proactive Care Mgt for Chronic Disease
Office Visits for Chronic Disease Issues
Tests & Procedures for Chronic Disease Mgt
Office Visits for Acute Issues
Tests & Procedures for Acute Issues
What Is Not Paid For Is Exactly What’s Needed to Improve Quality

CURRENT PAYMENT

<table>
<thead>
<tr>
<th>PRIMARY CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tests &amp; Procedures for Preventive Services</td>
</tr>
<tr>
<td>Office Visits for Preventive Services</td>
</tr>
<tr>
<td>Outreach Calls for Preventive Services</td>
</tr>
<tr>
<td>Proactive Care Mgt for Chronic Disease</td>
</tr>
<tr>
<td>Office Visits for Chronic Disease Issues</td>
</tr>
<tr>
<td>Tests &amp; Procedures for Chronic Disease Mgt</td>
</tr>
<tr>
<td>Office Visits for Acute Issues</td>
</tr>
<tr>
<td>Tests &amp; Procedures for Acute Issues</td>
</tr>
</tbody>
</table>

Preventive Care Quality
Chronic Disease Mgt Quality
A Better Approach: Flexible Payment Instead of E&M Payment

- Tests & Procedures for Preventive Services
- Office Visits for Preventive Services
- Outreach Calls for Preventive Services
- Proactive Care Mgt for Chronic Disease
- Office Visits for Chronic Disease Issues
- Tests & Procedures for Chronic Disease Mgt
- Office Visits for Acute Issues
- Tests & Procedures for Acute Issues

PROPOSED PAYMENT

- CPT Fee
- Payer
- Payer
- Payer

© Center for Healthcare Quality and Payment Reform www.CHQPR.org
Size of Monthly Payment Should Differ Based on Patient Health

<table>
<thead>
<tr>
<th>Patient Health Issues</th>
<th>Size of Monthly Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Chronic Disease and No Major Risk Factors</td>
<td>Small Payment for Large # of Patients</td>
</tr>
<tr>
<td>One Chronic Disease or Major Risk Factors</td>
<td>Larger Payment for Subset of Patients Needing More Proactive Care</td>
</tr>
<tr>
<td>Two Chronic Diseases or One Chronic Disease and One Major Risk Factor</td>
<td>Still Larger Payment for Subset of Patients Needing Even More Proactive Care</td>
</tr>
<tr>
<td>Complex and High-Risk Patients</td>
<td>High Payment for Small # of Patients</td>
</tr>
</tbody>
</table>
A Better Benefit Design For Patients

BENEFIT DESIGN

- Patient enrolls as a “member” of the primary care practice, but has no restrictions on other care.
- Patient has no copays for visits related to either preventive care or chronic disease care from this practice.
- Patient only pays cost-sharing for acute issues.

<table>
<thead>
<tr>
<th>PRIMARY CARE</th>
<th>PROPOSED PAYMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tests &amp; Procedures for Preventive Services</td>
<td>Monthly Core Primary Care Services Payment</td>
</tr>
<tr>
<td>Office Visits for Preventive Services</td>
<td>Payer</td>
</tr>
<tr>
<td>Outreach Calls for Preventive Services</td>
<td>Payer</td>
</tr>
<tr>
<td>Proactive Care Mgt for Chronic Disease</td>
<td>Payer</td>
</tr>
<tr>
<td>Office Visits for Chronic Disease Issues</td>
<td>Payer</td>
</tr>
<tr>
<td>Tests &amp; Procedures for Chronic Disease Mgt</td>
<td>Payer</td>
</tr>
<tr>
<td>Office Visits for Acute Issues</td>
<td>Payer</td>
</tr>
<tr>
<td>Tests &amp; Procedures for Acute Issues</td>
<td>CPT Fee</td>
</tr>
</tbody>
</table>

© Center for Healthcare Quality and Payment Reform  www.CHQPR.org
**SPECIALIST PMT**

- Payments for telephone calls & emails for PCP consults with specialists they work with
- Sharing of the monthly core payment if the specialist is co-managing the patient with the PCP
- Transfer of monthly payment to specialist for some patients

**PROPOSED PAYMENT**

- Tests & Procedures for Preventive Services
- Office Visits for Preventive Services
- Outreach Calls for Preventive Services
- Proactive Care Mgt for Chronic Disease
- Office Visits for Chronic Disease Issues
- Tests & Procedures for Chronic Disease Mgt
- Office Visits for Acute Issues
- Tests & Procedures for Acute Issues
Accountability for Spending and Quality That PCPs Can Control

ACCOUNTABILITY

- Monthly payment would be adjusted up or down based on quality and avoidable utilization
  - Quality of preventive care
  - Quality of chronic disease care
  - Avoidable ER utilization
  - High-tech imaging
  - Specialty referrals

PRINCIPAL CARE

Tests & Procedures for Preventive Services

Office Visits for Preventive Services

Outreach Calls for Preventive Services

Proactive Care Mgt for Chronic Disease

Office Visits for Chronic Disease Issues

Tests & Procedures for Chronic Disease Mgt

Office Visits for Acute Issues

Tests & Procedures for Acute Issues

PROPOSED PAYMENT

Payer

Payer

Payer

CPT Fee

CPT Fee

CPT Fee

CPT Fee
This is Different Than Current PCMH Programs

**Current PCMH Model**

- P4P/Shared Savings
- PMPM for “Care Management”
- Tests & Procedures for Preventive Services
- Office Visits for Preventive Services
- Office Visits for Chronic Disease Issues
- Tests & Procedures for Chronic Disease Mgt
- Office Visits for Acute Issues
- Tests & Procedures for Acute Issues

**NEW MODEL**

- Tests & Procedures for Acute Issues
- Office Visits for Acute Issues
- Tests & Procedures for Chronic Disease Mgt
- Tests & Procedures for Preventive Services

**Performance Adjustment**

**Core Primary Care Services Payment**
It’s Also Different from Traditional PCP Capitation Programs

<table>
<thead>
<tr>
<th>Current PCMH Model</th>
<th>NEW MODEL</th>
<th>PCP Capitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>P4P/Shared Savings</td>
<td>Tests &amp; Procedures for Acute Issues</td>
<td>P4P</td>
</tr>
<tr>
<td>PMPM for “Care Management”</td>
<td>Office Visits for Acute Issues</td>
<td>Primary Care Capitation</td>
</tr>
<tr>
<td>Tests &amp; Procedures for Preventive Services</td>
<td>Tests &amp; Procedures for Chronic Disease Mgt</td>
<td></td>
</tr>
<tr>
<td>Office Visits for Preventive Services</td>
<td>Tests &amp; Procedures for Preventive Services</td>
<td></td>
</tr>
<tr>
<td>Office Visits for Chronic Disease Issues</td>
<td>Performance Adjustment</td>
<td></td>
</tr>
<tr>
<td>Tests &amp; Procedures for Chronic Disease Mgt</td>
<td>Core Primary Care Services Payment</td>
<td></td>
</tr>
<tr>
<td>Office Visits for Acute Issues</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tests &amp; Procedures for Acute Issues</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tests &amp; Procedures for Acute Issues</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# It’s Better Than Current PCMH or Capitation

<table>
<thead>
<tr>
<th>Current PCMH Model</th>
<th>NEW MODEL (PARTIAL CAPITATION)</th>
<th>PCP Capitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Most practice revenue still comes from office visits</td>
<td>• PCP practice receives predictable, flexible payment for patient mgt</td>
<td>• No incentive for PCP practice to see patient for acute needs</td>
</tr>
<tr>
<td>• Fewer office visits = lower revenue, even with PMPM</td>
<td>• Higher payment for patients with greater needs</td>
<td>• Payment is the same for patients with high needs as low needs</td>
</tr>
<tr>
<td>• Patient still discouraged from office visits by copays</td>
<td>• Employer only pays more if patient needs or receives more services</td>
<td>• Employer is paying even if patient needs few services</td>
</tr>
<tr>
<td>• Patients must be attributed based on claims</td>
<td>• Patient enrolls only for prev. &amp; chronic care</td>
<td>• Patients must enroll for all services</td>
</tr>
</tbody>
</table>
All Stakeholders Worked Together To Develop a Win-Win Solution

NEW MODEL

<table>
<thead>
<tr>
<th>Tests &amp; Procedures for Acute Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Visits for Acute Issues</td>
</tr>
<tr>
<td>Tests &amp; Procedures for Chronic Disease Mgt</td>
</tr>
<tr>
<td>Tests &amp; Procedures for Preventive Services</td>
</tr>
<tr>
<td>Performance Adjustment</td>
</tr>
</tbody>
</table>

All Stakeholders Worked Together To Develop a Win-Win Solution

- Employers
- Unions
- West Michigan Payment Design Workgroup
- Health Plans
- Primary Care Physicians
- Specialists
- Core Primary Care Services Payment

All Stakeholders Worked Together To Develop a Win-Win Solution

- Alliance for Health
- Michigan Institute for Clinical Systems Improvement
Health Plans In Michigan Won’t Implement It

NEW MODEL

<table>
<thead>
<tr>
<th>Tests &amp; Procedures for Acute Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Visits for Acute Issues</td>
</tr>
<tr>
<td>Tests &amp; Procedures for Chronic Disease Mgt</td>
</tr>
<tr>
<td>Tests &amp; Procedures for Preventive Services</td>
</tr>
<tr>
<td>Performance Adjustment</td>
</tr>
</tbody>
</table>

Core Primary Care Services Payment

Alliance for Health

Michigan Institute for Clinical Systems Improvement

Employers

West Michigan Payment Design Workgroup

Unions

Primary Care Physicians

Specialists

Health Plans

© Center for Healthcare Quality and Payment Reform  www.CHQPR.org
Is the New CMS CPC+ Program the Answer?

• Better than current Comprehensive Primary Care Initiative
  – Provides significant, risk-adjusted care management payments without requiring PCPs to earn them through shared savings
  – Focuses accountability on things that primary care practices can control, such as ED visits and ambulatory care sensitive hospitalizations, not spending on cancer treatment, surgical site infections, etc.
  – Limits potential losses to a specific amount of payment paid in advance

• CPC+ is unnecessarily complex
  – Track 1: care management payments, no change to FFS
  – Track 2: care mgt pmts plus converting a portion of FFS to a monthly PMPM
    • Sub-track for practices wanting to manage dementia
    • Sub-tracks for different portions of FFS converted to PMPM
    • Requirements for use of special EHRs

• CPC+ is much too limited
  – Limited to 20 regions
  – Practices can’t participate unless private health plans participate
  – Limited to 5,000 practices
PCPs Can Improve Care and Reduce Spending Today

- Amputations
- Kidney Failure
- Hospitalizations
- ER Visits
- Blindness
- Premature Death
- Inability to Work
- Low Productivity

Patient with Diabetes → PCP → Quality of Life

- Low Cost of Care
- Productivity
But Many of the Things PCPs Do Will Achieve Savings in the Future

- Premature Death
- Amputations
- Blindness
- Kidney Failure
- Hospitalizations
- ER Visits
- Premature Death
- Inability to Work
- Low Productivity
- Low Cost of Care
- Quality of Life
- Productivity

Patient with Diabetes

Patient without Diabetes

Healthy Weight

Pre-Diabetes

PCP

PCP
Multi-Year Measures and Payment Models Needed

Multi-Year Alternative Payment Model

- Pre-Diabetes
- Patient with Diabetes
- PCP
- Patient without Diabetes
- Healthy Weight

Outcomes:
- Amputations
- Kidney Failure
- Hospitalizations
- ER Visits
- Blindness
- Premature Death
- Inability to Work
- Low Productivity
- Quality of Life
- Low Cost of Care
- Productivity
Savings Needed for All Conditions In Order to Truly Impact Costs

<table>
<thead>
<tr>
<th>Conditions</th>
<th>Percent</th>
<th>Savings for Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart/Circulatory Conditions (23%)</td>
<td></td>
<td>Fewer Avoidable Hospitalizations</td>
</tr>
<tr>
<td>Other Conditions (23%)</td>
<td></td>
<td>Fewer Complications</td>
</tr>
<tr>
<td>Mental Illness (4%)</td>
<td></td>
<td>Reduce Costs of Treatments</td>
</tr>
<tr>
<td>Trauma (6%)</td>
<td></td>
<td>Fewer Avoidable Hospitalizations</td>
</tr>
<tr>
<td>Brain and Nervous System (7%)</td>
<td></td>
<td>Fewer Complications</td>
</tr>
<tr>
<td>Diabetes, Endocrine (8%)</td>
<td></td>
<td>Fewer Complications</td>
</tr>
<tr>
<td>Joints, Back, Bones (8%)</td>
<td></td>
<td>Fewer Avoidable Hospitalizations</td>
</tr>
<tr>
<td>COPD, Asthma, Pneumonia (9%)</td>
<td></td>
<td>Fewer Infections, Complications</td>
</tr>
<tr>
<td>Cancer (12%)</td>
<td></td>
<td>Reduce Cost of Treatments</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fewer Avoidable Hospitalizations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fewer Avoidable Hospitalizations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fewer Avoidable Hospitalizations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fewer Avoidable Hospitalizations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Early Diagnosis and Treatment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reduce Cost of Treatments</td>
</tr>
</tbody>
</table>
Primary Care Can’t Do It Alone

Primary Care

SAVINGS FOR MEDICARE
Fewer Avoidable Hospitalizations
Fewer Complications
Reduce Costs of Treatments

Medicare Spending

<table>
<thead>
<tr>
<th>Condition</th>
<th>TODAY</th>
<th>FUTURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart/Circulatory Conditions</td>
<td>23%</td>
<td></td>
</tr>
<tr>
<td>Mental Illness</td>
<td>4%</td>
<td></td>
</tr>
<tr>
<td>Trauma</td>
<td>6%</td>
<td></td>
</tr>
<tr>
<td>Brain and Nervous System</td>
<td>7%</td>
<td></td>
</tr>
<tr>
<td>Diabetes, Endocrine</td>
<td>8%</td>
<td></td>
</tr>
<tr>
<td>Joints, Back, Bones</td>
<td>8%</td>
<td></td>
</tr>
<tr>
<td>COPD, Asthma, Pneumonia</td>
<td>9%</td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td>12%</td>
<td></td>
</tr>
</tbody>
</table>

Fewer Avoidable Hospitalizations
Fewer Complications
Reduce Costs of Treatments
Fewer Infections, Complications
Reduce Cost of Treatments
Fewer Avoidable Hospitalizations
Fewer Infections, Complications
Reduce Cost of Treatments
Fewer Avoidable Hospitalizations
Early Diagnosis and Treatment
Fewer Avoidable Hospitalizations
Reduce Cost of Treatments
All Specialties Need to Be Involved and Paid in Better Ways

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Medicare Spending</th>
<th>TODAY</th>
<th>FUTURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart/Circulatory Conditions (23%)</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Conditions (23%)</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Illness (4%)</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trauma (6%)</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brain and Nervous System (7%)</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes, Endocrine (8%)</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Joints, Back, Bones (8%)</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>COPD, Asthma, Pneumonia (9%)</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer (12%)</td>
<td>$</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SAVINGS FOR MEDICARE

- Fewer Avoidable Hospitalizations
- Fewer Complications
- Reduce Costs of Treatments
- Fewer Infections, Complications
- Reduce Cost of Treatments
- Fewer Avoidable Hospitalizations
- Early Diagnosis and Treatment
- Reduce Cost of Treatments
Many Patients Don’t Need an ACO, They Need Good Specialty Care

- **Patients** Heart Disease
  - Primary Care Practice
  - Cardiologists
  - Payment That Supports Good Management of Heart Disease

- **Patients** Diabetes
  - Primary Care Practice
  - Endocrinologists & Cardiologists
  - Payment That Supports Good Management of Diabetes

- **Patients** Back Pain
  - Primary Care Practice
  - Physiatrists & Neurosurgeons
  - Payment That Supports Good Care for Back Pain

- **Patients** Pregnancy
  - Primary Care Practice
  - OB/GYNs
  - Payment That Supports Good Care for Pregnancy
Do Current Bundled Payment Models Do What is Needed?

**PATIENTS**

**Heart Disease**

Primary Care Practice → Cardiologists

Payment That Supports Good Management of Heart Disease

**Diabetes**

Primary Care Practice → Endocrinologists & Cardiologists

Payment That Supports Good Management of Diabetes

**Back Pain**

Primary Care Practice → Physiatrists & Neurosurgeons

Payment That Supports Good Care for Back Pain

**Pregnancy**

Primary Care Practice → OB/GYNs

Payment That Supports Good Care for Pregnancy

© Center for Healthcare Quality and Payment Reform  www.CHQPR.org
Too Few Bundles Today; Current Ones Too Small or Too Big

• Too Few:
  – Focused mostly on hip and knee replacement surgery

• Too Small:
  – Most procedural bundles/episodes are limited to inpatient procedures
  – No protection against unnecessary procedures
  – No opportunity to move procedures to lower-cost, non-hospital settings
  – No opportunity to deliver care that would avoid the procedure
  – No real flexibility to change care – it’s just P4P on top of standard FFS

• Too Big:
  – Single payment amount for patients with very different needs
  – No protection against cherry-picking patients
  – Individual providers placed at risk for costs they can’t control
A Bundle or Episode is Not Always the Best Way to Fix FFS Problems

• Too Few:
  – Focused mostly on hip and knee replacement surgery

• Too Small:
  – Most procedural bundles/episodes are limited to inpatient procedures
  – No protection against unnecessary procedures
  – No opportunity to move procedures to lower-cost, non-hospital settings
  – No opportunity to deliver care that would avoid the procedure
  – No real flexibility to change care – it’s just P4P on top of standard FFS

• Too Big:
  – Single payment amount for patients with very different needs
  – No protection against cherry-picking patients
  – Individual providers placed at risk for costs they can’t control

• Too Much:
  – Creating a “bundle” may be unnecessary/unnecessarily complicated
  – Additional service codes + accountability measures may work better
Procedural Episode Payments Support Higher Quality/Lower Cost
What If You Can Do The Procedure Outside the Hospital?

$Proceduralist$

$Inpatient Hospital$

$High Spending on Complications & Post-Acute Care$

$Low Complication & PAC Spending$

$Outpatient Facility$
In most Episode Payment Models, the trigger is the hospitalization, so if the procedure is done elsewhere, it’s paid through standard FFS.
You Could Expand the Bundle to Include Outpatient Facilities…

[Diagram showing the relationship between proceduralists, inpatient hospital, and outpatient facility with high spending on complications and post-acute care vs. low complication and PAC spending.]
But What if You Could Save Even More With a Different Treatment?
But What if You Could Save Even More With a Different Treatment?

In most Episode Payment Models, the trigger is a procedure, so if a different procedure is used, or no procedure at all is used, care is paid through standard FFS.
**Condition-Based Payment**

Supports Use of *Best Treatment*

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

**BENEFITS OF CONDITION-BASED PAYMENTS**

- No reward for avoidable complications
- No reward for using expensive post-acute care

**Condition-Based Payment**

- **Proceduralist**
- **Inpatient Hospital**
- **Proceduralist**
- **Outpatient Facility**
- **Alternative Procedure or Medical Management**

**Procedural Episode Payment**

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

- **\$**

---

© Center for Healthcare Quality and Payment Reform  www.CHQPR.org
Condition-Based Payment Has More Benefits Than Episodes

BENEFITS OF CONDITION-BASED PAYMENTS

- No reward for avoidable complications
- No reward for using expensive post-acute care

+ No reward for using unnecessarily expensive facilities

- No reward for performing unnecessary procedures

Condition-Based Payment

Proceduralist

Inpatient Hospital

High Spending on Complications & Post-Acute Care

Low Complication & PAC Spending

Proceduralist

Outpatient Facility

Alternative Procedure or Medical Management

BENEFITS OF CONDITION-BASED PAYMENTS

- No reward for avoidable complications
- No reward for using expensive post-acute care

+ No reward for using unnecessarily expensive facilities

- No reward for performing unnecessary procedures

Procedural Episode Payment

High Spending on Complications & Post-Acute Care

Low Complication & PAC Spending

Alternative Procedure or Medical Management

• No reward for performing unnecessary procedures

© Center for Healthcare Quality and Payment Reform  www.CHQPR.org
Condition-Based Payment Must Be Led by *Physicians*, Not *Hospitals*

- **Condition-Based Payment**
  - Patients → Condition Specialist
  - Procedural Episode Payment
    - Proceduralist
      - Inpatient Hospital
    - Proceduralist
      - Outpatient Facility
  - Alternative Procedure or Medical Management

- **High Spending on Complications & Post-Acute Care**
  - $\downarrow$

- **Low Complication & PAC Spending**
  - $\downarrow$
Many Condition-Based Payments Won’t Involve Hospitals at All

For many types of conditions, hospitalization represents a *failure* of treatment, not a *method* of treatment.
Opportunities for Lower-Cost Care for Many Conditions

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

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

- **Chest Pain**
  - Non-invasive imaging instead of invasive imaging
  - Medical management instead of invasive treatment

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

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

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

- **Chest Pain**
  - Non-invasive imaging instead of invasive imaging
  - Medical management instead of invasive treatment

- **Chronic Disease Management**
  - Improved education and self-management support
  - Avoiding hospitalizations for exacerbations

TODAY

Savings for Payers = Lower Margins for Providers
Opportunities for Lower-Cost Care for Many Conditions

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

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

TODAY

Savings
for Payers
= Lower
Margins
for Providers

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

CONDITION-BASED PAYMENT

Savings
for Payers
= Higher
Margins
for Providers

• Chronic Disease Management
  – Improved education and self-management support
  – Avoiding hospitalizations for exacerbations

Savings
for Payers
= Higher
Margins
for Providers
Are We Making the Payment for the Correct Condition??

Condition-Based Payment

Procedural Episode Payment

Proceduralist

Inpatient Hospital

High Spending on Complications & Post-Acute Care

Proceduralist

Outpatient Facility

Low Complication & PAC Spending

Alternative Procedure or Medical Management

Correct Condition

Correct Treatment

Wrong Condition

? ? ? ?
Diagnostic Error is a Fundamental Quality Issue Underlying All Others
We Need a Diagnostician To Ensure the *Right Condition* is Being Treated

**Condition-Based Payment**

- **Diagnostic Payment**
  - **Diagnostician**
    - Lab Testing
    - Imaging
  - **Condition Specialist**
  - **Proceduralist**
    - Inpatient Hospital
    - **Proceduralist**
      - Outpatient Facility
    - **Procedural Episode Payment**
      - High Spending on Complications & Post-Acute Care
      - Low Complication & PAC Spending
      - Alternative Procedure or Medical Management
    - **Correct Condition**
    - **Correct Treatment**

**Procedural Payment**

- **Proceduralist**
  - **Alternative Procedure or Medical Management**
  - **Correct Treatment**
  - **Lab Testing**
  - **Imaging**
What Happens When *Physicians* Redesign Patient Care and Receive Adequate Payments to Support It?
Better Care at Lower Cost for Crohn’s Disease

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

**OPPORTUNITIES TO IMPROVE CARE AND LOWER COSTS**

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

**PHYSICIAN LEADER:** Lawrence R. Kosinski, MD
Managing Partner, Illinois Gastroenterology Group
### OPPORTUNITIES TO IMPROVE CARE AND LOWER COSTS

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

### BARRIERS IN THE CURRENT PAYMENT SYSTEM

- No payment to support “medical home” services in gastroenterology practice:
  - No payment for nurse care manager.
  - No payment for clinical decision support tools to ensure evidence-based care.
  - No payment for proactive telephone contact with patients.

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

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

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

---

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

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

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

OPPORTUNITIES TO IMPROVE CARE AND LOWER COSTS

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

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

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

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

<table>
<thead>
<tr>
<th>OPPORTUNITIES TO IMPROVE CARE AND LOWER COSTS</th>
<th>BARRIERS IN THE CURRENT PAYMENT SYSTEM</th>
<th>RESULTS WITH ADEQUATE PAYMENT FOR BETTER CARE</th>
</tr>
</thead>
</table>
| • 40-50% of patients receiving chemotherapy are hospitalized for complications of treatment | • No payment for triage services to enable rapid response to patient complications  
• No payment for patient and family education about complications and how to respond  
• Inadequate payment to reserve capacity for IV hydration of patients experiencing problems | • 36% fewer ED visits  
• 43% fewer admissions  
• 22% reduction in total cost of care ($4,784 over six months) |
Better Care at Lower Cost for Pregnancy

PHYSICIAN LEADER: Steve Calvin, MD
Medical Director, Minnesota Birth Center
Better Care at Lower Cost for Pregnancy

PHYSICIAN LEADER: Steve Calvin, MD  
Medical Director, Minnesota Birth Center

OPPORTUNITIES TO IMPROVE CARE AND LOWER COSTS

• 33% C-section rate, 2x recommended rate
• 25% of mothers want to deliver in a birth center, <2% actually do
• Significantly lower costs for delivery in birth centers than hospitals
## Better Care at Lower Cost for Pregnancy

**PHYSICIAN LEADER:** Steve Calvin, MD  
Medical Director, Minnesota Birth Center

<table>
<thead>
<tr>
<th><strong>OPPORTUNITIES TO IMPROVE CARE AND LOWER COSTS</strong></th>
<th><strong>BARRIERS IN THE CURRENT PAYMENT SYSTEM</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• 33% C-section rate, 2x recommended rate</td>
<td>• Inadequate payment or no payment at all for deliveries in birth centers</td>
</tr>
<tr>
<td>• 25% of mothers want to deliver in a birth center, &lt;2% actually do</td>
<td>• Higher payments to hospitals for C-sections, higher $/hour to physicians for C-sections</td>
</tr>
<tr>
<td>• Significantly lower costs for delivery in birth centers than hospitals</td>
<td>• Impossible to determine or compare total cost of delivery with separate payments for facility, OB/Gyn, pediatrician, and others and separate payments for mother and baby</td>
</tr>
</tbody>
</table>
# Better Care at Lower Cost for Pregnancy

**PHYSICIAN LEADER:** Steve Calvin, MD  
Medical Director, Minnesota Birth Center

## Opportunities to Improve Care and Lower Costs

- 33% C-section rate, 2x recommended rate  
- 25% of mothers want to deliver in a birth center, <2% actually do  
- Significantly lower costs for delivery in birth centers than hospitals

## Barriers in the Current Payment System

- Inadequate payment or no payment at all for deliveries in birth centers  
- Higher payments to hospitals for C-sections, higher $/hour to physicians for C-sections  
- Impossible to determine or compare total cost of delivery with separate payments for facility, OB/Gyn, pediatrician, and others and separate payments for mother and baby

## Results with Adequate Payment for Better Care

- 68% of deliveries in birth center  
- 9% C-section rate  
- 28% reduction in cost of maternity care
Better Care at Lower Cost for Emergency Room Patients

PHYSICIAN LEADER: Jennifer L. Wiler, MD
Assoc. Prof. of Emergency Medicine, University of Colorado
Better Care at Lower Cost for Emergency Room Patients

PHYSICIAN LEADER: Jennifer L. Wiler, MD
Assoc. Prof. of Emergency Medicine, University of Colorado

OPPORTUNITIES TO IMPROVE CARE AND LOWER COSTS

- Many individuals have 3+ Emergency Department visits per year
- Many frequent ED users have no insurance or inability to afford copays, behavioral health problems, and no PCP
Better Care at Lower Cost for Emergency Room Patients

**OPPORTUNITIES TO IMPROVE CARE AND LOWER COSTS**

- Many individuals have 3+ Emergency Department visits per year
- Many frequent ED users have no insurance or inability to afford copays, behavioral health problems, and no PCP

**BARRIERS IN THE CURRENT PAYMENT SYSTEM**

- No payment for patient education and care coordination in the ED
- No payment for home visits to help patients after discharge
- No funding to address non-medical needs such as lack of transportation

**PHYSICIAN LEADER:** Jennifer L. Wiler, MD  
Assoc. Prof. of Emergency Medicine, University of Colorado
## Better Care at Lower Cost for Emergency Room Patients

**PHYSICIAN LEADER:** Jennifer L. Wiler, MD  
Assoc. Prof. of Emergency Medicine, University of Colorado

<table>
<thead>
<tr>
<th>OPPORTUNITIES TO IMPROVE CARE AND LOWER COSTS</th>
<th>BARRIERS IN THE CURRENT PAYMENT SYSTEM</th>
<th>RESULTS WITH ADEQUATE PAYMENT FOR BETTER CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Many individuals have 3+ Emergency Department visits per year</td>
<td>• No payment for patient education and care coordination in the ED</td>
<td>• 41% fewer ED visits</td>
</tr>
<tr>
<td>• Many frequent ED users have no insurance or inability to afford copays, behavioral health problems, and no PCP</td>
<td>• No payment for home visits to help patients after discharge</td>
<td>• 49% fewer admissions</td>
</tr>
<tr>
<td></td>
<td>• No funding to address non-medical needs such as lack of transportation</td>
<td>• 80% now have a primary care provider</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 50% lower total spending including cost of program</td>
</tr>
</tbody>
</table>
Instead of Payer Designed Payment Systems…

HOW PAYMENT REFORMS ARE DESIGNED TODAY

Medicare and Health Plans Define Payment Systems → Physicians Have To Change Care to Align With Payment Systems → Patients and Physicians May Not Come Out Ahead
Physicians Should Design Payments to Support Good Care

HOW PAYMENT REFORMS ARE DESIGNED TODAY

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

THE RIGHT WAY TO DESIGN PAYMENT REFORMS

- Physicians Redesign Care and Identify Payment Barriers
- Payers Change Payment to Support Redesigned Care
- Patients Get Better Care and Physicians Stay Financially Viable
How Do You Define a *Good* Alternative Payment Model?
Step 1: Identify Opportunities to Reduce Related Spending

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

- **Total Spending Relevant to the Physician’s Services**
- **Payments to Other Providers for Related Services**
- **FFS Payments to Physician Practice**

### OPPORTUNITIES TO REDUCE SPENDING

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

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

<table>
<thead>
<tr>
<th>Total Spending Relevant to the Physician’s Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>$</td>
</tr>
</tbody>
</table>

**Avoidable Spending**

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

**OPPORTUNITIES TO REDUCE SPENDING**

- Reduce Avoidable Hospital Admissions
- Reduce Unnecessary Tests and Treatments
- Use Lower-Cost Tests and Treatments
- Deliver Services More Efficiently
- Use Lower-Cost Sites of Service
- Reduce Preventable Complications
- Prevent Serious Conditions From Occurring

**BARRIERS IN CURRENT FFS SYSTEM**

- No Payment for Many High-Value Services
- Insufficient Revenue to Cover Costs When Using Fewer or Lower-Cost Services
Step 3: Design an APM That Removes the Payment Barriers

Fee-for-Service Payment (FFS)

Physician-Focused Alternative Payment Model

Avoidable Spending

Payments to Other Providers for Related Services

FFS Payments to Physician Practice

Flexible, Adequate Payment for Physician’s Services

Unpaid Services

Total Spending Relevant to the Physician’s Services

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

Fee-for-Service Payment (FFS)

Physician-Focused Alternative Payment Model

$\uparrow$

Total Spending Relevant to the Physician’s Services

Avoidable Spending

Payments to Other Providers for Related Services

FFS Payments to Physician Practice

Unpaid Services

Flexible, Adequate Payment for Physician’s Services

Payments to Other Providers for Related Services

Avoidable Spending

Savings

Accountability for Controlling Avoidable Spending

© Center for Healthcare Quality and Payment Reform www.CHQPR.org
The CMS Models Are NOT the Only Way to Define APMs

<table>
<thead>
<tr>
<th>CMS APM Models</th>
<th>Focused Healthcare Models</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Medical Home</td>
<td>Episode Payment to Hospital</td>
</tr>
<tr>
<td>Upside-Only Shared Saviings</td>
<td>“Two-Sided Risk” Shared Savings</td>
</tr>
<tr>
<td>Full-Risk Capitation</td>
<td></td>
</tr>
</tbody>
</table>
There are More & Better Ways to Create **Physician-Focused APMs**

Primary Care Medical Home  
Episode Payment to Hospital  
Upside-Only Shared Savings  
“Two-Sided Risk” Shared Savings  
Full-Risk Capitation

APM #1: Payment for a High-Value Service  
APM #2: Condition-Based Payment for a Physician’s Services  
APM #3: Multi-Physician Bundled Payment  
APM #4: Physician-Facility Procedure Bundle  
APM #5: Warrantied Payment for Physician Services  
APM #6: Episode Payment for a Procedure  
APM #7: Condition-Based Payment
APM #1: Payment for a High-Value Service

Goal of the APM:
Pay physicians for delivering Evaluable and Usable services that are not currently reimbursed in order to promote the need for patients to receive other, more expensive services.

Components of the APM:
1. Continuation of existing FFS payments
2. Payment for additional services
3. Measurement of avoidable utilization and/or quality/outcomes
4. Adjustment of payment amounts based on performance
5. Updating payments over time

Difference from Other Payment Models:
- In contrast to typical pay-for-performance programs, the physician practice would be paid for the additional service it needs to deliver in order to improve or reduce total costs.
- In contrast to a typical shared savings program, an individual physician practice’s payments would not be explicitly tied to how much money that practice saved the payer. Instead, the physician practice would be paid for the additional service it needs to deliver in order to improve or reduce total costs.
APM #7: Condition-Based Payment

- Payment based on the patient’s health condition
- Payment covers multiple treatment options delivered by the physician(s) and other providers
- Payment amounts stratified based on patient needs
- Outlier payments and risk corridors to address random variation and unusually expensive patients
- Measurement of appropriateness, quality, and/or outcomes
- Adjustment of payments based on performance
- Updating payment amounts over time
Many Specialties Working on Alternative Payment Models

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Opportunities to Improve Care and Reduce Cost</th>
<th>Barriers in Current Payment System</th>
<th>Solutions via Accountable Payment Models</th>
</tr>
</thead>
</table>
| Cardiology    | • Use less invasive procedures when appropriate  
• Reduce exacerbations of heart failure                                                                         | • Payment is based on procedure is used, not the outcome                                        | • Condition-based payment for stable angina  
• Condition-based payment for HF                                                                            |
| Orthopedic Surgery | • Reduce infections and complications of surgery  
• Use non-surgical care instead of surgery                                                                   | • No support for shared decision-making  
• Lack of resources for good home-based care, patient education                                      | • Bundled and warrantied payment for surgery  
• Condition-based payment for arthritis                                                                    |
| Neurology     | • Avoid unnecessary hospitalizations for epilepsy patients  
• Reduce strokes and heart attacks after TIA                                                                  | • No flexibility to spend more on preventive care  
• No payment for patient education & care mgmt                                                          | • Condition-based payment for epilepsy  
• Episode or condition-based payment for TIA                                                                  |
| OB/GYN        | • Reduce use of elective C-sections  
• Reduce early deliveries and use of NICU                                                                     | • Similar/lower payment for vaginal deliveries                                                    | • Condition-based payment for total cost of delivery in low-risk pregnancy                              |
Other Examples of Specialty-Specific Payment Models

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Opportunities to Improve Care and Reduce Cost</th>
<th>Barriers in Current Payment System</th>
<th>Solutions via Accountable Payment Models</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatry</td>
<td>• Reduce ER visits and admissions for patients with depression and chronic disease</td>
<td>• No payment for phone consults with PCPs</td>
<td>• Joint condition-based payment to PCP and psychiatrist</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>• Reduce unnecessary colonoscopies and colon cancer • Reduce ER/admits for inflammatory bowel disease</td>
<td>• No extra resources on highest-risk patients • No flexibility to spend more on care mgmt</td>
<td>• Population-based payment for colon cancer screening • Condition-based pmt for IBD</td>
</tr>
<tr>
<td>Oncology</td>
<td>• Reduce ER visits and admissions for dehydration • Reduce overuse of tests and drugs</td>
<td>• No payment for care management services • Inadequate payment for diagnosis and treatment planning</td>
<td>• Payment for care management svcs • Accountability for hospital admissions &amp; use of guidelines</td>
</tr>
<tr>
<td>Primary Care</td>
<td>• Reduce avoidable hospitalizations for chronic disease pts • Reduce unnecessary tests and referrals</td>
<td>• No payment for nurses to work with chronic disease patients • No payment for phone consults w/ specialists</td>
<td>• Monthly payments for chronic care management • Payments to support PCP-specialist partnerships</td>
</tr>
</tbody>
</table>
Physicians in Oregon Working to Design Solutions

- **Heart Failure**
  - Inadequate payment for time needed for diagnosis and treatment planning
  - Inadequate payment for shared decision-making with patients about appropriate treatment
  - Inadequate payment for patient education and medical management of cardiac conditions
  - No payment for phone/email consultation with PCPs
  - Dependence on testing and procedures to subsidize other services

- **Musculoskeletal Pain/Arthritis**
  - Inadequate payment for time needed for diagnosis and treatment planning
  - Inadequate payment for shared decision-making with patients about appropriate treatment
  - Inadequate payment for non-surgical management of joint and back pain
  - Dependence on surgery to pay for practice costs
We Need Payment Reform for Hospitals, Not Just Physicians
Hospitals Are Critical for Economic Development

• Would you want to live or work in a community without an emergency room?

• We don’t pay hospitals to have an emergency room available when we need it

• We pay hospitals to treat people in the emergency room

• If there is no one to be treated, there is no revenue to keep the emergency room open
# A Simple Financial Model for an Emergency Department

<table>
<thead>
<tr>
<th>Revenues</th>
<th>$</th>
<th># Pts</th>
<th>Total $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per Visit</td>
<td>$900</td>
<td>20,000</td>
<td>$18,000,000</td>
</tr>
<tr>
<td>Total Revenues</td>
<td></td>
<td></td>
<td>$18,000,000</td>
</tr>
</tbody>
</table>

- 100,000 members of a health plan in the community
- 200/1000 of the members visit the ED annually (20,000)
Assume That Most Costs Are Fixed At Least in the Short Run

<table>
<thead>
<tr>
<th>Current</th>
<th>$</th>
<th># Pts</th>
<th>Total $</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenues</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per Visit</td>
<td>$900</td>
<td>20,000</td>
<td>$18,000,000</td>
</tr>
<tr>
<td>Total Revenues</td>
<td></td>
<td></td>
<td>$18,000,000</td>
</tr>
<tr>
<td><strong>Costs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed (75%)</td>
<td></td>
<td></td>
<td>$13,500,000</td>
</tr>
<tr>
<td>Variable (20%)</td>
<td>$180</td>
<td>20,000</td>
<td>$3,600,000</td>
</tr>
<tr>
<td>Total Costs</td>
<td></td>
<td></td>
<td>$17,100,000</td>
</tr>
</tbody>
</table>

- 100,000 members of a health plan in the community
- 200/1000 of the members visit the ED annually (20,000)
The Emergency Department Is Covering Its Costs Today

<table>
<thead>
<tr>
<th>CURRENT</th>
<th>$</th>
<th># Pts</th>
<th>Total $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenues</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per Visit</td>
<td>$900</td>
<td>20,000</td>
<td>$18,000,000</td>
</tr>
<tr>
<td>Total Revenues</td>
<td></td>
<td></td>
<td>$18,000,000</td>
</tr>
<tr>
<td>Costs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed (75%)</td>
<td></td>
<td></td>
<td>$13,500,000</td>
</tr>
<tr>
<td>Variable (20%)</td>
<td>$180</td>
<td>20,000</td>
<td>$3,600,000</td>
</tr>
<tr>
<td>Total Costs</td>
<td></td>
<td></td>
<td>$17,100,000</td>
</tr>
<tr>
<td>Margin (5%)</td>
<td></td>
<td></td>
<td>$900,000</td>
</tr>
</tbody>
</table>

- 100,000 members of a health plan in the community
- 200/1000 of the members visit the ED annually (20,000)
What Happens if PCPs Reduce ED Visits by 10%?

<table>
<thead>
<tr>
<th></th>
<th>CURRENT</th>
<th>CHANGE IN VISITS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$</td>
<td># Pts</td>
</tr>
<tr>
<td><strong>Revenues</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per Visit</td>
<td>$900</td>
<td>20,000</td>
</tr>
<tr>
<td>Total Revenues</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Costs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed (75%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Variable (20%)</td>
<td>$180</td>
<td>20,000</td>
</tr>
<tr>
<td>Total Costs</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Margin (5%)</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Costs Will Go Down But Not As Much as Revenues

<table>
<thead>
<tr>
<th></th>
<th>CURRENT</th>
<th></th>
<th></th>
<th>CHANGE IN VISITS</th>
<th></th>
<th></th>
<th>Chg</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$</td>
<td># Pts</td>
<td>Total $</td>
<td></td>
<td>$</td>
<td># Pts</td>
<td>Total $</td>
</tr>
<tr>
<td><strong>Revenues</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per Visit</td>
<td>$900</td>
<td>20,000</td>
<td>$18,000,000</td>
<td>$900</td>
<td>18,000</td>
<td>$16,200,000</td>
<td></td>
</tr>
<tr>
<td>Total Revenues</td>
<td></td>
<td></td>
<td>$18,000,000</td>
<td></td>
<td>$16,200,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Costs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed (75%)</td>
<td></td>
<td></td>
<td>$13,500,000</td>
<td></td>
<td>$13,500,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Variable (20%)</td>
<td></td>
<td></td>
<td>$3,600,000</td>
<td></td>
<td>$3,240,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Costs</td>
<td></td>
<td></td>
<td>$17,100,000</td>
<td></td>
<td>$16,740,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Margin (5%)</strong></td>
<td></td>
<td></td>
<td>$900,000</td>
<td></td>
<td>$900,000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The Emergency Department Now Has Significant Losses

<table>
<thead>
<tr>
<th></th>
<th>CURRENT</th>
<th></th>
<th>CHANGE IN VISITS</th>
<th></th>
<th>Chg</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$</td>
<td># Pts</td>
<td>Total $</td>
<td>$</td>
<td># Pts</td>
</tr>
<tr>
<td>Revenues</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per Visit</td>
<td>$900</td>
<td>20,000</td>
<td>$18,000,000</td>
<td>$900</td>
<td>18,000</td>
</tr>
<tr>
<td>Total Revenues</td>
<td>$18,000,000</td>
<td></td>
<td></td>
<td>$16,200,000</td>
<td></td>
</tr>
<tr>
<td>Costs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed (75%)</td>
<td>$13,500,000</td>
<td></td>
<td></td>
<td>$13,500,000</td>
<td></td>
</tr>
<tr>
<td>Variable (20%)</td>
<td>$180</td>
<td>20,000</td>
<td>$3,600,000</td>
<td>$180</td>
<td>18,000</td>
</tr>
<tr>
<td>Total Costs</td>
<td>$17,100,000</td>
<td></td>
<td></td>
<td>$16,740,000</td>
<td></td>
</tr>
<tr>
<td>Margin (5%)</td>
<td>$900,000</td>
<td></td>
<td></td>
<td>($540,000)</td>
<td></td>
</tr>
</tbody>
</table>
## What Happens If ED Visits Increase by 10%?

<table>
<thead>
<tr>
<th></th>
<th>CURRENT</th>
<th>CHANGE IN VISITS</th>
<th>Chg</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$</td>
<td># Pts</td>
<td>Total $</td>
</tr>
<tr>
<td><strong>Revenues</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per Visit</td>
<td>$900</td>
<td>20,000</td>
<td>$18,000,000</td>
</tr>
<tr>
<td>Total Revenues</td>
<td>$18,000,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Costs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed (75%)</td>
<td>$13,500,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Variable (20%)</td>
<td>$180</td>
<td>20,000</td>
<td>$3,600,000</td>
</tr>
<tr>
<td>Total Costs</td>
<td>$17,100,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Margin (5%)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$900,000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# Profits for the ED Soar

<table>
<thead>
<tr>
<th></th>
<th>CURRENT</th>
<th>CHANGE IN VISITS</th>
<th>Chg</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$</td>
<td># Pts</td>
<td>Total $</td>
</tr>
<tr>
<td><strong>Revenues</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per Visit</td>
<td>$900</td>
<td>20,000</td>
<td>$18,000,000</td>
</tr>
<tr>
<td>Total Revenues</td>
<td></td>
<td></td>
<td>$18,000,000</td>
</tr>
<tr>
<td><strong>Costs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed (75%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Variable (20%)</td>
<td>$180</td>
<td>20,000</td>
<td>$3,600,000</td>
</tr>
<tr>
<td>Total Costs</td>
<td></td>
<td></td>
<td>$17,100,000</td>
</tr>
<tr>
<td><strong>Margin (5%)</strong></td>
<td></td>
<td></td>
<td>$900,000</td>
</tr>
</tbody>
</table>
## Is It Any Wonder Hospitals Encourage Use of the ER?

<table>
<thead>
<tr>
<th></th>
<th>CURRENT</th>
<th></th>
<th>CHANGE IN VISITS</th>
<th></th>
<th>Chg</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$</td>
<td># Pts</td>
<td>Total $</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td><strong>Revenues</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per Visit</td>
<td>$900</td>
<td>20,000</td>
<td>$18,000,000</td>
<td>$900</td>
<td></td>
</tr>
<tr>
<td>Total Revenues</td>
<td></td>
<td></td>
<td>$18,000,000</td>
<td></td>
<td>+10%</td>
</tr>
<tr>
<td><strong>Costs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed (75%)</td>
<td></td>
<td></td>
<td>$13,500,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Variable (20%)</td>
<td>$180</td>
<td>20,000</td>
<td>$3,600,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Costs</td>
<td></td>
<td></td>
<td>$17,100,000</td>
<td></td>
<td>+2%</td>
</tr>
<tr>
<td><strong>Margin</strong></td>
<td></td>
<td></td>
<td>$900,000</td>
<td></td>
<td>+160%</td>
</tr>
</tbody>
</table>

© Center for Healthcare Quality and Payment Reform  www.CHQPR.org
Is There A Better Way?

<table>
<thead>
<tr>
<th>NEW PAYMENT MODEL</th>
<th>$</th>
<th># Pts</th>
<th>Total $</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenues</strong></td>
<td>?</td>
<td>?</td>
<td></td>
</tr>
<tr>
<td><strong>Costs</strong></td>
<td>?</td>
<td>?</td>
<td></td>
</tr>
<tr>
<td><strong>Total Revenues</strong></td>
<td>?</td>
<td>?</td>
<td></td>
</tr>
<tr>
<td>Fixed (75%)</td>
<td>$13,500,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Variable (20%)</td>
<td>$180</td>
<td>20,000</td>
<td>$3,600,000</td>
</tr>
<tr>
<td>Total Costs</td>
<td>$17,100,000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- 100,000 members of a health plan in the community
- 200/1000 of the members visit the ED annually (20,000)
Pay Less Per Visit, With Amount Tied To Variable Cost

<table>
<thead>
<tr>
<th>NEW PAYMENT MODEL</th>
<th>$</th>
<th># Pts</th>
<th>Total $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenues</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per Visit</td>
<td>$180</td>
<td>20,000</td>
<td>$3,600,000</td>
</tr>
<tr>
<td>Total Revenues</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Costs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed (75%)</td>
<td></td>
<td></td>
<td>$13,500,000</td>
</tr>
<tr>
<td>Variable (20%)</td>
<td>$180</td>
<td>20,000</td>
<td>$3,600,000</td>
</tr>
<tr>
<td>Total Costs</td>
<td></td>
<td></td>
<td>$17,100,000</td>
</tr>
</tbody>
</table>

- 100,000 members of a health plan in the community
- 200/1000 of the members visit the ED annually (20,000)
And Add a Payment By Member (Regardless of # of Visits)

<table>
<thead>
<tr>
<th>NEW PAYMENT MODEL</th>
<th>$</th>
<th># Pts</th>
<th>Total $</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenues</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per Visit</td>
<td>$180</td>
<td>20,000</td>
<td>$3,600,000</td>
</tr>
<tr>
<td>Per Member</td>
<td>$144</td>
<td>100,000</td>
<td>$14,400,000</td>
</tr>
<tr>
<td>Total Revenues</td>
<td></td>
<td></td>
<td>$18,000,000</td>
</tr>
<tr>
<td><strong>Costs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed (75%)</td>
<td></td>
<td></td>
<td>$13,500,000</td>
</tr>
<tr>
<td>Variable (20%)</td>
<td>$180</td>
<td>20,000</td>
<td>$3,600,000</td>
</tr>
<tr>
<td>Total Costs</td>
<td></td>
<td></td>
<td>$17,100,000</td>
</tr>
<tr>
<td><strong>Margin</strong></td>
<td></td>
<td></td>
<td>$900,000</td>
</tr>
</tbody>
</table>
And Add a Payment By Member (Regardless of # of Visits)

<table>
<thead>
<tr>
<th>NEW PAYMENT MODEL</th>
<th>$</th>
<th># Pts</th>
<th>Total $</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenues</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per Visit</td>
<td>$180</td>
<td>20,000</td>
<td>$3,600,000</td>
</tr>
<tr>
<td>Per Member</td>
<td>$144</td>
<td>100,000</td>
<td>$14,400,000</td>
</tr>
<tr>
<td>Total Revenues</td>
<td></td>
<td></td>
<td>$18,000,000</td>
</tr>
<tr>
<td><strong>Costs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed (75%)</td>
<td></td>
<td></td>
<td>$13,500,000</td>
</tr>
<tr>
<td>Variable (20%)</td>
<td>$180</td>
<td>20,000</td>
<td>$3,600,000</td>
</tr>
<tr>
<td>Total Costs</td>
<td></td>
<td></td>
<td>$17,100,000</td>
</tr>
<tr>
<td><strong>Margin</strong></td>
<td></td>
<td></td>
<td>$900,000</td>
</tr>
</tbody>
</table>

It’s How We Pay for Other Community Assets:
- Ambulance Services
- Fire Departments
- Libraries
Under This Payment System, If Visits Decrease…

<table>
<thead>
<tr>
<th>NEW PAYMENT MODEL</th>
<th>CHANGE IN VISITS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Revenues</td>
</tr>
<tr>
<td></td>
<td>Per Visit</td>
</tr>
<tr>
<td>$180</td>
<td>$13,500,000</td>
</tr>
<tr>
<td>20,000</td>
<td>$180</td>
</tr>
<tr>
<td>$3,600,000</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Per Member</td>
</tr>
<tr>
<td>$144</td>
<td></td>
</tr>
<tr>
<td>100,000</td>
<td></td>
</tr>
<tr>
<td>$14,400,000</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total Revenues</td>
</tr>
<tr>
<td></td>
<td>$18,000,000</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CHANGE IN VISITS</td>
</tr>
<tr>
<td>$180</td>
<td>$180</td>
</tr>
<tr>
<td>18,000</td>
<td>18,000</td>
</tr>
<tr>
<td>$3,240,000</td>
<td></td>
</tr>
<tr>
<td>-10%</td>
<td></td>
</tr>
</tbody>
</table>
### NEW PAYMENT MODEL

<table>
<thead>
<tr>
<th></th>
<th>NEW PAYMENT MODEL</th>
<th></th>
<th>CHANGE IN VISITS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenues</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per Visit</td>
<td>$180</td>
<td>20,000</td>
<td>$3,600,000</td>
<td>$180</td>
</tr>
<tr>
<td>Per Member</td>
<td>$144</td>
<td>100,000</td>
<td>$14,400,000</td>
<td>$144</td>
</tr>
<tr>
<td>Total Revenues</td>
<td>$18,000,000</td>
<td></td>
<td></td>
<td>$17,640,000</td>
</tr>
<tr>
<td><strong>Costs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed (75%)</td>
<td></td>
<td></td>
<td>$13,500,000</td>
<td></td>
</tr>
<tr>
<td>Variable (20%)</td>
<td>$180</td>
<td>20,000</td>
<td>$3,600,000</td>
<td></td>
</tr>
<tr>
<td>Total Costs</td>
<td>$17,100,000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Margin</strong></td>
<td></td>
<td></td>
<td>$900,000</td>
<td></td>
</tr>
</tbody>
</table>
So the ED Remains Afloat

<table>
<thead>
<tr>
<th>NEW PAYMENT MODEL</th>
<th>CHANGE IN VISITS</th>
<th>Chg</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenues</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per Visit</td>
<td>$180 20,000 $3,600,000</td>
<td>$180 18,000 $3,240,000</td>
</tr>
<tr>
<td>Per Member</td>
<td>$144 100,000 $14,400,000</td>
<td>$144 100,000 $14,400,000</td>
</tr>
<tr>
<td>Total Revenues</td>
<td>$18,000,000</td>
<td>$17,640,000</td>
</tr>
<tr>
<td>Costs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed (75%)</td>
<td>$13,500,000</td>
<td>$13,500,000</td>
</tr>
<tr>
<td>Variable (20%)</td>
<td>$180 20,000 $3,600,000</td>
<td>$180 18,000 $3,240,000</td>
</tr>
<tr>
<td>Total Costs</td>
<td>$17,100,000</td>
<td>$16,740,000</td>
</tr>
<tr>
<td>Margin</td>
<td>$900,000</td>
<td>$900,000</td>
</tr>
</tbody>
</table>
If ED Visits Increase…

<table>
<thead>
<tr>
<th>NEW PAYMENT MODEL</th>
<th>CHANGE IN VISITS</th>
<th>Chg</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenues</strong></td>
<td></td>
<td>+10%</td>
</tr>
<tr>
<td>Per Visit</td>
<td>$180</td>
<td>20,000</td>
</tr>
<tr>
<td>Per Member</td>
<td>$144</td>
<td>100,000</td>
</tr>
<tr>
<td>Total Revenues</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Costs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed (75%)</td>
<td></td>
<td>$13,500,000</td>
</tr>
<tr>
<td>Variable (20%)</td>
<td>$180</td>
<td>20,000</td>
</tr>
<tr>
<td>Total Costs</td>
<td></td>
<td>$17,100,000</td>
</tr>
<tr>
<td><strong>Margin</strong></td>
<td></td>
<td>$900,000</td>
</tr>
</tbody>
</table>
...Revenues Match Costs, and There is No Change in Profit

<table>
<thead>
<tr>
<th></th>
<th>NEW PAYMENT MODEL</th>
<th>CHANGE IN VISITS</th>
<th>Chg</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenues</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per Visit</td>
<td>$180</td>
<td>20,000</td>
<td>$3,600,000</td>
</tr>
<tr>
<td></td>
<td>$180</td>
<td>22,000</td>
<td>$3,960,000 +10%</td>
</tr>
<tr>
<td>Per Member</td>
<td>$144</td>
<td>100,000</td>
<td>$14,400,000</td>
</tr>
<tr>
<td></td>
<td>$144</td>
<td>100,000</td>
<td>$14,400,000</td>
</tr>
<tr>
<td>Total Revenues</td>
<td>$18,000,000</td>
<td></td>
<td>$18,360,000 +2%</td>
</tr>
<tr>
<td><strong>Costs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed (75%)</td>
<td>$13,500,000</td>
<td></td>
<td>$13,500,000</td>
</tr>
<tr>
<td>Variable (20%)</td>
<td>$180</td>
<td>20,000</td>
<td>$3,600,000</td>
</tr>
<tr>
<td></td>
<td>$180</td>
<td>22,000</td>
<td>$3,960,000 +2%</td>
</tr>
<tr>
<td>Total Costs</td>
<td>$17,100,000</td>
<td></td>
<td>$17,460,000</td>
</tr>
<tr>
<td><strong>Margin</strong></td>
<td>$900,000</td>
<td></td>
<td>$900,000</td>
</tr>
</tbody>
</table>
Are You Crazy?
Hospitals Doing Better Financially With Fewer Patients??
Maryland Has Been Moving to Global Budgets for Hospitals

• **All-Payer Payment Rates**
  – All payers pay the same, including Medicare
  – Costs of uncompensated care included in the all-payer rates
  – Adding incentives for quality, complications, readmissions
  – Problem: No control over volume; hospitals could always make more money by admitting more patients and doing more procedures

• **Total Patient Revenue (TPR)**
  – Global budget for hospital services, adjusted for population, not actual level of services
  – No incentive to admit more patients or do more procedures; incentive to reduce readmissions and avoidable admissions
  – Focused on isolated, rural hospitals, where one hospital serves the entire population

• **Global Budget Revenue (GBR)**
  – New CMS Waiver approved in January 2014
  – Being implemented now for urban hospitals
  – Designed to control increases in total hospital revenue per capita instead of revenue per case
Initial Results of Maryland Effort

- Reductions in Preventable Admissions
- Reductions in Readmissions
- No Financial Harm to Hospitals

Growth of Per Capita Hospital Costs, 2014.

Maryland’s Global Hospital Budgets — Preliminary Results from an All-Payer Model

On January 1, 2014, the Centers for Medicare and Medicaid Services (CMS) Innovation Center and the state of Maryland launched the Maryland All-Payer Model, under which CMS and Maryland agreed that all health care providers, including Medicare, would pay the same rates for inpatient and outpatient hospital services. This was set to reduce cost shifting among payers, equitably distribute the costs of uncompensated care and medical education, and limit the growth of per-admission costs. It also meant, however, that Medicare paid higher rates for hospital services in Maryland than under the national payment program.

As part of the agreement, Maryland pledged to achieve substantial cost savings and quality improvements by moving its hospital-reimbursement system away from traditional fee-for-service payments. The state established a new hospital global budget payment program in which all payers in aggregate pay hospitals a fixed annual amount for inpatient and outpatient services, adjusted for quality and irrespective of hospital utilization. The premise behind hospital global budgets is simple: providing fixed, predictable revenue allows hospitals to focus on value rather than volume and rewards them for improving population health improvement. The Maryland model requires the states to move almost all hospital revenue into value-based payment arrangements, such as global budgets, over a 5-year period.

The results from the first year are in, and several key findings have emerged. First, Maryland did shift away from fee-for-service hospital payments by all payers. By July 1, 2014 — earlier than required under the model — hospitals had agreed to move more than 99% of the state’s aggregate hospital revenue into global budgets. The speed of that transition demonstrates hospitals’ commitment to the new model and to value-based care.

Second, the initial cost results are promising. In 2014, Maryland committed to limiting annual growth of per capita hospital costs for all payers to 3.58%, the historical growth rate of the gross state product. According to hospital financial reports and claims, these costs grew by 1.4% in 2013 and 2014 for Maryland residents treated at Maryland hospitals—2.11 percentage points lower than the trend in growth rate (see graph). Costs were contained despite the expansion of health insurance under the Affordable Care Act (ACA), including growth of approximately 21% in Medicaid enrollment after implementation of the state’s Medicaid expansion. We believe Maryland’s cost growth was below the trend because of a combination of lower-than-anticipated growth in adjusted costs per admission and changes to the delivery in the global budget model.

Maryland also committed to saving Medicare $50 million by 2016. By 2014, Medicare’s per-capita hospital costs grew by 10% nationally and decreased by 10% in Maryland. Given these trends, Maryland has already saved Medicare $116 million. Although we are still evaluating the effects of changes in care delivery, hospital rate setting, and other factors, these preliminary results suggest that the state’s global budget program could provide a meaningful foundation for sustainable delivery reform in Maryland and a model for the rest of the country.

Third, Maryland improved the
More Detailed Condition-Based Payment Categories Needed

<table>
<thead>
<tr>
<th>PAYMENT MODEL 3</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$</td>
<td># Pts</td>
<td>Total $</td>
</tr>
<tr>
<td><strong>Revenues</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per Member</td>
<td>$50</td>
<td>100,000</td>
<td>$5,000,000</td>
</tr>
<tr>
<td>Per PC Visit</td>
<td>$140</td>
<td>10,000</td>
<td>$1,400,000</td>
</tr>
<tr>
<td>Per Dx Visit</td>
<td>$400</td>
<td>5,000</td>
<td>$2,000,000</td>
</tr>
<tr>
<td>Per Emerg. Visit</td>
<td>$1,920</td>
<td>5,000</td>
<td>$9,600,000</td>
</tr>
<tr>
<td>Total Revenues</td>
<td></td>
<td></td>
<td>$18,000,000</td>
</tr>
<tr>
<td><strong>Costs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Essential Fixed</td>
<td></td>
<td></td>
<td>$5,000,000</td>
</tr>
<tr>
<td>Variable – PC</td>
<td>$240</td>
<td>10,000</td>
<td>$2,400,000</td>
</tr>
<tr>
<td>Variable – Dx</td>
<td>$350</td>
<td>5,000</td>
<td>$1,750,000</td>
</tr>
<tr>
<td>Variable – Em.</td>
<td>$1,590</td>
<td>5,000</td>
<td>$7,950,000</td>
</tr>
<tr>
<td>Total Costs</td>
<td></td>
<td></td>
<td>$17,100,000</td>
</tr>
<tr>
<td><strong>Margin</strong></td>
<td></td>
<td></td>
<td>$900,000</td>
</tr>
</tbody>
</table>

Care Equivalent to a PCP Office
Efficient Diagnosis of Symptoms
Significant Emergencies
What’s the Patient’s Role and Accountability?

Ability and Incentives to:
- Keep patients well
- Avoid unneeded services
- Deliver services efficiently
- Coordinate services with other providers
Benefit Design Changes Are Also Critical to Success

Ability and Incentives to:
- Improve health
- Take prescribed medications
- Allow a provider to coordinate care
- Choose the highest-value providers and services

Payment System

Ability and Incentives to:
- Keep patients well
- Avoid unneeded services
- Deliver services efficiently
- Coordinate services with other providers
Barriers In Current Benefit Designs

- Co-pays, co-insurance, and high deductibles discourage or prevent patients from using primary care, preventive treatments, and chronic disease maintenance medications.
Example: No Coordination of Pharmacy & Medical Benefits

Single-minded focus on reducing costs here...

- High copays for brand-names when no generic exists
- Doughnut holes & deductibles

...often results in higher spending on hospitalizations

**Pharmacy Benefits**
- Drug Costs

**Medical Benefits**
- Hospital Costs
- Physician Costs
- Other Services

Principal treatment for most chronic diseases involves regular use of maintenance medication
Barriers In Current Benefit Designs

• Co-pays, co-insurance, and high deductibles discourage or prevent patients from using primary care, preventive treatments, and chronic disease maintenance medications

• Co-pays, co-insurance, and high deductibles provide little or no incentive for patients to choose the highest-value providers for expensive services
# Airfare Choices from Boston to Cleveland

<table>
<thead>
<tr>
<th>USAirways</th>
<th>United</th>
<th>United</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-Stop Coach</td>
<td>Non-Stop Coach</td>
<td>Non-Stop First Class</td>
</tr>
<tr>
<td>$622</td>
<td>$1,107</td>
<td>$1,355</td>
</tr>
</tbody>
</table>

Airfares for July 6-7, 2011 as of 6/26/11
What If We Paid for Travel the Way We Pay for Healthcare?

<table>
<thead>
<tr>
<th>Consumer Share of Travel Cost</th>
<th>USAirways 1-Stop Coach $622</th>
<th>United Non-Stop Coach $1,107</th>
<th>United Non-Stop First Class $1,355</th>
</tr>
</thead>
<tbody>
<tr>
<td>Airfares for July 6-7, 2011 as of 6/26/11</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Flat Copayments: First Class Fare Wins

**Consumer Share of Travel Cost**

<table>
<thead>
<tr>
<th></th>
<th>USAirways 1-Stop Coach</th>
<th>United Non-Stop Coach</th>
<th>United Non-Stop First Class</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>$100 Copayment:</strong></td>
<td>$622</td>
<td>$1,107</td>
<td>$1,355</td>
</tr>
</tbody>
</table>

**Airfares for July 6-7, 2011 as of 6/26/11**
# Coinsurance: First Class Fare Probably Wins

## Consumer Share of Travel Cost

<table>
<thead>
<tr>
<th></th>
<th>USAirways 1-Stop Coach</th>
<th>United Non-Stop Coach</th>
<th>United Non-Stop First Class</th>
</tr>
</thead>
<tbody>
<tr>
<td>$100 Copayment:</td>
<td>$100</td>
<td>$100</td>
<td>$100</td>
</tr>
<tr>
<td>10% Coinsurance:</td>
<td>$62</td>
<td>$111</td>
<td>$136</td>
</tr>
</tbody>
</table>

Airfares for July 6-7, 2011 as of 6/26/11
# High Deductible: First Class Fare Wins

<table>
<thead>
<tr>
<th>Consumer Share of Travel Cost</th>
<th>USAirways 1-Stop Coach $622</th>
<th>United Non-Stop Coach $1,107</th>
<th>United Non-Stop First Class $1,355</th>
</tr>
</thead>
<tbody>
<tr>
<td>$100 Copayment:</td>
<td>$100</td>
<td>$100</td>
<td>$100</td>
</tr>
<tr>
<td>10% Coinsurance:</td>
<td>$62</td>
<td>$111</td>
<td>$136</td>
</tr>
<tr>
<td>$500 Deductible:</td>
<td>$500</td>
<td>$500</td>
<td>$500</td>
</tr>
</tbody>
</table>

Airfares for July 6-7, 2011 as of 6/26/11
## Price Difference: Lowest Coach Fare Wins

### Airfares for July 6-7, 2011 as of 6/26/11

<table>
<thead>
<tr>
<th>Consumer Share of Travel Cost</th>
<th>USAirways 1-Stop Coach $622</th>
<th>United Non-Stop Coach $1,107</th>
<th>United Non-Stop First Class $1,355</th>
</tr>
</thead>
<tbody>
<tr>
<td>$100 Copayment:</td>
<td>$100</td>
<td>$100</td>
<td>$100</td>
</tr>
<tr>
<td>10% Coinsurance:</td>
<td>$62</td>
<td>$111</td>
<td>$136</td>
</tr>
<tr>
<td>$500 Deductible:</td>
<td>$500</td>
<td>$500</td>
<td>$500</td>
</tr>
<tr>
<td>Lowest Coach Fare:</td>
<td>$0</td>
<td>$485</td>
<td>$733</td>
</tr>
</tbody>
</table>

- $100 Copayment: $100
- 10% Coinsurance: $136
- $500 Deductible: $500
- Lowest Coach Fare: $0

© Center for Healthcare Quality and Payment Reform www.CHQPR.org
Where Will You Get Your Knee Replaced?

Knee Joint Replacement

<table>
<thead>
<tr>
<th>Price #1</th>
<th>Price #2</th>
<th>Price #3</th>
</tr>
</thead>
<tbody>
<tr>
<td>$20,000</td>
<td>$25,000</td>
<td>$30,000</td>
</tr>
<tr>
<td>Consumer Share of Surgery Cost</td>
<td>Price #1 $20,000</td>
<td>Price #2 $25,000</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-----------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>$1,000 Copayment:</td>
<td>$1,000</td>
<td>$1,000</td>
</tr>
<tr>
<td>10% Coinsurance w/$2,000 OOP Max:</td>
<td>$2,000</td>
<td>$2,000</td>
</tr>
<tr>
<td>$5,000 Deductible:</td>
<td>$5,000</td>
<td>$5,000</td>
</tr>
</tbody>
</table>
## Where Will You Get Your Knee Replaced?

<table>
<thead>
<tr>
<th>Consumer Share of Surgery Cost</th>
<th>Price #1 $20,000</th>
<th>Price #2 $25,000</th>
<th>Price #3 $30,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,000 Copayment</td>
<td>$1,000</td>
<td>$1,000</td>
<td>$1,000</td>
</tr>
<tr>
<td>10% Coinsurance w/$2,000 OOP Max</td>
<td>$2,000</td>
<td>$2,000</td>
<td>$2,000</td>
</tr>
<tr>
<td>$5,000 Deductible</td>
<td>$5,000</td>
<td>$5,000</td>
<td>$5,000</td>
</tr>
<tr>
<td>Highest-Value</td>
<td>$0</td>
<td>$5,000</td>
<td>$10,000</td>
</tr>
</tbody>
</table>
Current Transparency Efforts Are Focused on Procedure Price

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

<table>
<thead>
<tr>
<th>Provider 1:</th>
<th>Payment for Procedure</th>
<th>Payment and Rate of Complications</th>
</tr>
</thead>
<tbody>
<tr>
<td>$25,000</td>
<td>$30,000</td>
<td>2%</td>
</tr>
<tr>
<td>Provider 2:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$23,000</td>
<td>$30,000</td>
<td>10%</td>
</tr>
<tr>
<td>-8%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Total Spending May Be Higher With the “Lower Price” Provider

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

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

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

Bundled prices show that Provider 1 is the higher-value provider.
Why Is It So Much Cheaper to Fly to Pittsburgh Than Cleveland?

Non-Stop Coach Fare: $1,107

Non-Stop Coach Fare: $188

Airfares for July 6-7, 2011 as of 6/26/11
Is It The Shorter Distance?

551 Air Miles

Non-Stop Coach Fare: $1,107

483 Air Miles

Non-Stop Coach Fare: $188

Airfares for July 6-7, 2011 as of 6/26/11
Or Greater Competition?

NON-COMPETITIVE MARKET

Choice: United Non-Stop: $1,107
(No other non-stop choice)

COMPETITIVE MARKET

Choice #1: Delta Non-Stop: $188
Choice #2: JetBlue Non-Stop: $188
Choice #3: USAirways Non-Stop: $238

Airfares for July 6-7, 2011 as of 6/26/11
Which Is More Likely to Generate True Price Competition?

**ONE BIG ACO**

| MD | DO | MD | DO |
| MD | DO | MD | DO |
| MD | DO | MD | DO |
| MD | DO | MD | DO |
| MD | DO | MD | DO |
| MD | DO | MD | DO |
| MD | DO | MD | DO |

**Hospital ACO**

| MD | DO | MD | DO |
| DO | MD | DO | MD |
| DO | MD | DO | MD |
| DO | MD | DO | MD |

**IPA ACO**

| MD | DO | MD | DO |
| DO | MD | DO | MD |
| MD | DO | MD | DO |

**Physician Group ACO**

| MD | DO | MD | DO |
| DO | MD | DO | MD |
| DO | MD | DO | MD |
What’s the Biggest Barrier to True Payment Reform?
What’s the Biggest Barrier to True Payment Reform?

- CMS and health plans won’t implement true payment reforms
- Every payer has a different “value-based payment model”
For Most Workers, the Real Payer is the *Employer*, Not a Health Plan

**Percentage of Workers With Employer-Sponsored Insurance Who Are in Self-Funded Plans, 1999-2012**

Source: Employer Health Benefits 2012 Annual Survey. The Kaiser Family Foundation and Health Research and Educational Trust
For Self-Funded Employers, The Health Plan is Just a Pass Through

![Diagram showing the relationship between Self-Funded Purchasers, ASO Health Plan (No Risk), and Providers. The flow is from Self-Funded Purchasers to ASO Health Plan (No Risk) to Providers, with arrows indicating Purchaser Payment and Provider Claims.]
Little Incentive for Health Plans to Support Payment Reforms

True Payment Reform Means:
• Health plan incurs the costs of implementing new payment models
• Purchaser gains all the savings from reduced utilization and spending (because all claims are passed through)
A Better Approach: Purchaser/Provider Partnerships

Self-Funded Purchasers

Better Payment and Benefit Structure → Providers Willing to Manage Costs

Lower Cost, Higher Quality Care

Purchasers and Patients “win” if:
- Providers reduce purchasers’ costs
- Patients stay healthy and have lower cost-sharing

Provider “wins” if:
- Patients stay healthy and need less care
- Purchaser pays provider adequately to manage care efficiently
Health Plan Implements Changes
Purchasers/Providers Agree On

ASO Health Plan
(No Risk)

Better Payment and Benefit Structure
Lower Cost, Higher Quality Care

Self-Funded Purchasers

Providers Willing to Manage Costs

Implementation
Facilitator Needed to Provide Data and Technical Assistance

Better Payment and Benefit Structure

Lower Cost, Higher Quality Care

Health Plans

Purchasers

Providers

Neutral Community Facilitator

Technical Assistance

Data
Facilitator Needed to Provide Data and Technical Assistance

Better Payment and Benefit Structure

Lower Cost, Higher Quality Care

Technical Assistance

Oregon Health Care Quality Corporation

Data
State Government Cannot Be a “Neutral Facilitator”

• It’s a purchaser
• It’s a regulator
• It’s a political entity
• Leadership and priorities change
Partnerships Between State Govt and Regional Collaboratives

• **State Government Roles**
  – Statutory/regulatory requirements for data submission/analysis
  – Anti-trust safe harbors for payer coordination and provider coordination
  – Transitioning reserve requirements for payers and providers
  – Requiring supportive benefit designs in health plans
  – Serving as a lead purchaser and/or payer in collaborative efforts
  – Providing startup funding support

• **Regional Health Improvement Collaborative Roles**
  – Building community consensus on payment and delivery reforms
  – Assisting providers to analyze data and redesign care
  – Educating/engaging consumers
  – Creating a neutral forum to resolve problems
  – Providing a stable, politically-neutral mechanism for long-term change
Instead of a Vision That Won’t Work and Patients Don’t Want…

- Primary Care from a Medical Home
- Everything Else from an ACO
- Joint Replacement from a Hospital

“Coordinated” Low Quality High-Priced Health Care
Pursue a Vision That Will Benefit Patients, Providers & Payers
Pursue a Vision That Will Benefit Patients, Providers & Payers

A Better Vision

HEALTHY PATIENTS → Primary Care from a Medical Home → Accountable Medical Home Payment
Pursue a Vision That Will Benefit Patients, Providers & Payers

A Better Vision

HEALTHY PATIENTS

Primary Care from a Medical Home

Accountable Medical Home Payment

PATIENTS WITH A HEALTH PROBLEM

PCP

Specialist

Condition-Based Payment
Pursue a Vision That Will Benefit Patients, Providers & Payers

A Better Vision

HEALTHY PATIENTS → Primary Care from a Medical Home → Accountable Medical Home Payment

PATIENTS WITH A HEALTH PROBLEM → PCP → Condition-Based Payment

PATIENTS WITH MULTIPLE HEALTH PROBLEMS → Accountable Care Team
- PCP
- Specialist
- Specialist
- Specialist

Multi-Condition Payment or Risk-Adjusted Global Payment
Instead of Win-Lose Approaches That Ultimately Harm Patients…

- Hospitals
  - Hospitals Acquiring MDs
  - Battle Over RVUs
- Specialists
- PCPs
  - Inadequate # of PCPs
- Patients
  - Fragmented, Expensive, Poor Quality Care
- Employers
  - Inability to Provide Coverage
- CMS
  - Cost-Shifting Through Underpayment

**WIN-LOSE**

Consolidations and Closures
…We Need **Collaboration** That Benefits **All Stakeholders**

**Patients**
- Better Care for Patients
- High Quality, Financially Viable Primary Care Practices
- PCPs

**Employers**
- Savings for Employers
- Adequate Margins to Support Quality Care
- WIN-WIN-WIN

**CMS**
- Savings for Medicare
- Adequate Margins to Support Quality Care

**Hospitals**
- High Quality, Financially Viable Specialty Practices
- Specialists

**WIN-WIN-WIN**

© Center for Healthcare Quality and Payment Reform  www.CHQPR.org
...And You Need a Neutral Convener to Help You Get There

- **Patients**: Better Care for Patients
- **PCPs**: High Quality, Financially Viable Primary Care Practices
- **Specialists**: High Quality, Financially Viable Specialty Practices
- **Employers**: Savings for Employers
- **Q-Corp**: Adequate Margins to Support Quality Care
- **CMS**: Savings for Medicare
- **Hospitals**: Savings for Medicare

© Center for Healthcare Quality and Payment Reform  www.CHQPR.org
Learn More About Win-Win-Win Payment and Delivery Reform

www.PaymentReform.org

Transitioning to Accountable Care

Ten Barriers to Healthcare Payment Reform

Making the Business Case for Payment and Delivery Reform

Measuring and Assigning Accountability for Healthcare Spending

Bundling Better

A Guide to Physician-Focused Alternative Payment Models

Implementing Alternative Payment Models Under MACRA
For More Information:

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

Miller.Harold@CHQPR.org
(412) 803-3650

www.CHQPR.org
www.PaymentReform.org