WIN-WIN-WIN APPROACHES TO ACCOUNTABLE CARE
How Physicians, Hospitals, Patients, and Payers Can All Benefit From Healthcare Payment & Delivery Reform

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

www.CHQPR.org
Healthcare Spending Is the Biggest Driver of Federal Deficits

Source: CBO Budget Outlook August 2012

46% of Spending Growth is Healthcare
Federal Cost Containment Policy Choices

MEDICARE SPENDING = SERVICES TO SENIORS \times FEES TO PROVIDERS
If It’s A Choice of Rationing or Rate Cuts, Which is More Likely?

MEDICARE SPENDING = SERVICES TO SENIORS × FEES TO PROVIDERS

Cut Services to Seniors?  
Cut Fees to Providers?

Guess which one they’ll try to reduce?
Medicare Payments to Physicians Below Inflation for Over a Decade

Physician Practice Costs

Physician Payment Increases

23% Effective Reduction

If SGR Cut Is Made
What We Need:
A Way to Reduce Costs
Without Rationing or Fee Cuts
What We Need:  
A Way to Reduce Costs  
Without Rationing or Fee Cuts  

It Can’t Be Done from Washington;  
It Has to Happen at the Local Level,  
Where Health Care is Delivered
What We Need: A Way to Reduce Costs Without Rationing or Fee Cuts

It Can’t Be Done from Washington; It Has to Happen at the Local Level, Where Health Care is Delivered

And It Cannot Succeed Without Physician Knowledge & Leadership
What Physicians Can Do That Congress & CMS Can’t

\[
\text{MEDICARE SPENDING} = \text{SERVICES TO SENIORS} \times \text{FEES TO PROVIDERS}
\]

- Cut Services to Seniors?
- Cut Fees to Providers?

Redesign CARE to Improve Quality & Lower Costs

Redesign PAYMENT to Make Good Care Financially Viable
Reducing Costs Without Rationing:  
*Can It Be Done?*
Reducing Costs Without Rationing: Prevention and Wellness

Healthy Consumer → Continued Health

Health Condition
Reducing Costs Without Rationing: Avoiding Hospitalizations

Healthy Consumer ➔ Continued Health ➔ Health Condition ➔ No Hospitalization ➔ Acute Care Episode

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Reducing Costs Without Rationing: Efficient, Successful Treatment

Healthy Consumer → Continued Health → Health Condition → No Hospitalization → Acute Care Episode → Efficient Successful Outcome

- High-Cost Successful Outcome
- Complications, Infections, Readmissions
Reducing Costs Without Rationing Is Also Quality Improvement!

Healthy Consumer ➔ Continued Health ➔ No Hospitalization ➔ Efficient Successful Outcome

Health Condition ➔ Acute Care Episode ➔ High-Cost Successful Outcome ➔ Complications, Infections, Readmissions

Better Outcomes/Higher Quality

Healthy Consumer ➔ Continued Health ➔ No Hospitalization ➔ Efficient Successful Outcome

Health Condition ➔ Acute Care Episode ➔ High-Cost Successful Outcome ➔ Complications, Infections, Readmissions

Better Outcomes/Higher Quality
How Big Are the Opportunities?
5-17% of Hospital Admissions Are Potentially Preventable

% of Hospital Stays That Were Potentially Preventable, 2008

- Potentially Preventable Chronic Conditions
- Potentially Preventable Acute Conditions

Source: AHRQ HCUP

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# Millions of Preventable Events
Harm Patients and Increase Costs

<table>
<thead>
<tr>
<th>Medical Error</th>
<th># Errors (2008)</th>
<th>Cost Per Error</th>
<th>Total U.S. Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressure Ulcers</td>
<td>374,964</td>
<td>$10,288</td>
<td>$3,857,629,632</td>
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<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><strong>TOTAL</strong></td>
<td><strong>1,503,323</strong></td>
<td><strong>$13,019</strong></td>
<td><strong>$19,571,000,000</strong></td>
</tr>
</tbody>
</table>

**3 Adverse Events Every Minute**

Source: *The Economic Measurement of Medical Errors*, Milliman and the Society of Actuaries, 2010
Many Ways to Reduce Tests & Procedures w/o Harming Patients
Instead of Starting With How to \textit{Limit} Care for Patients…

\textbf{Contributors to Healthcare Costs}

\begin{itemize}
  \item New Technologies
  \item Higher-Cost Drugs
  \item Potentially Life-Saving Treatment
\end{itemize}
We Should Focus First on How to Improve Patient Care

Contributors to Healthcare Costs

How Do We Help:

- Patients Stay Well
- Avoid Preventable Emergencies and Hospitalizations
- Eliminate Errors and Safety Problems
- Reduce Costs of Treatment
- Reduce Complications and Readmissions

How Do We Limit:

- New Technologies
- Higher-Cost Drugs
- Potentially Life-Saving Treatment
Won’t Physicians Lose Revenues If Healthcare Spending is Reduced?
Where is the Money Going Now?


- Prescription Drugs (Part D)
- Other Services
- Home Health Agencies
- Skilled Nursing Facilities
- Hospital Outpatient Services
- Hospital Inpatient Care
- Physician Fee Schedule
Only 16% of Medicare Spending Goes to Physicians…


- Physicians: 16%
- Part D Benefits
- Other Services
- Home Health Agencies
- Skilled Nursing Facilities
- Hospital Outpatient Services
- Hospital Inpatient Care
- Physician Fee Schedule
.. Most of The Rest Goes to Things That Physicians Can Influence


- Physicians: 16%
- Things Physicians Prescribe, Control, or Influence: 84%
- Part D Benefits
- Other Services
- Home Health Agencies
- Skilled Nursing Facilities
- Hospital Outpatient Services
- Hospital Inpatient Care
- Physician Fee Schedule

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Medicare Payment Silos Pit Physicians Against Each Other
Physicians Should Benefit From Lowering Other Healthcare Costs

- Total Healthcare Costs (Parts A, B, and D)
- Physician Fees (Part B)

- Hospital & Post-Acute Care Costs (Part A)
- Drug Costs (Part D)
- Specialty Fees
- PCP Fees

- Hospital & Post-Acute Care Costs
- Drug Costs
- Specialty Fees
- PCP Fees
How Do You Repeal the SGR and Give Physicians Reasonable Payment Increases?
10 Year Federal Budget Projections for Medicare

Projected Medicare Spending, 2014-2023 (Billions)

- Physician Fee Schedule
- Part D Benefits
- Other Services
- Home Health Agencies
- Skilled Nursing Facilities
- Hospital Outpatient Services
- Hospital Inpatient Care

Physician Fees Only Represent 12% of Projected Medicare Spending

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SGR Repeal & MEI Update Increases Total Spending by 2.6%

Projected Medicare Spending, 2014-2023 (Billions)

- Part D Benefits
- Other Services
- Home Health Agencies
- Skilled Nursing Facilities
- Hospital Outpatient Services
- Hospital Inpatient Care
- MEI Update
- SGR Repeal
- Physician Fee Schedule

SGR Repeal & MEI Update: $160 Billion
3% Savings in Non-Physician Spending Would Pay for Repeal

$160 Billion = 3% of Non-Physician Spending

Projected Medicare Spending, 2014-2023 (Billions)
Look at Spending by *Condition*, Not By Type of Provider…

NOTE: Graph is not drawn to scale.
…Identify the Avoidable Spending in Each Condition…

NOTE:
Graph is not drawn to scale

Total Medicare Spending

Avoidable $
Other
Avoidable $
Surgery
Avoidable $
Cancer
Avoidable $
Heart
Avoidable $
Chronic Diseases
Large Savings Opportunities in Cancer Care and Surgery

NOTE: Graph is not drawn to scale

- Unnecessary surgery
- Use of unnecessarily-expensively devices
- Infections and complications of surgery
- Overuse of inpatient rehabilitation
- Use of unnecessarily-expensively drugs
- ER visits/hospital stays for dehydration and avoidable complications
- Fruitless treatment at end of life
- Late-stage cancers due to poor screening

Total Medicare Spending

Avoidable $
- Other

Avoidable $
- Surgery

Avoidable $
- Cancer

Avoidable $
- Heart

Avoidable $
- Chronic Diseases
…Savings Comes from Reducing Avoidable Costs, Not *Cutting Fees*

NOTE: Graph is not drawn to scale

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<tr>
<th>Total Medicare Spending</th>
<th>Savings</th>
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<td>Chronic Diseases</td>
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Payment Barriers for Physicians in Reducing Healthcare Spending

• What if Physicians Could Reduce Chemotherapy Costs?
  – Medicare would get all the savings
  – Revenues to physician practices would decline under “buy and bill”
  – Congress/CMS would still freeze or cut physicians’ payments
Payment Barriers for Physicians in Reducing Healthcare Spending

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• What if Physicians Could Reduce Avoidable Hospitalizations?
  – Medicare would get all the savings
  – Hospitals would lose revenues
  – Physicians would lose revenues
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  – Physicians would lose revenues
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• What if Physicians Reduced Fruitless End-of-Life Care?
  – Medicare would get all the savings
  – Physicians would get less revenue
  – Congress/CMS would still freeze or cut physicians’ payments
Most “Payment Reforms”
Don’t Fix The Problems with FFS

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

P4P

PMPM

Shared Savings

Shared Savings
Fortunately, There Are Good Alternatives to Fee for Service

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Who Says Congress and the President Can’t Agree?

Sustainable Growth Rate Repeal and Reform Proposal
“Providers can choose to participate in an Alternative Payment Model…We envision a system where providers have the flexibility to participate in the payment and delivery model that best fits their practice. The overarching goal is to reward providers for delivering high quality, efficient health care…”

House Energy & Commerce Committee and House Committee on Ways and Means

Request for Input from Stakeholders on Sustainable Growth Rate Reform
“Our ultimate goal is for Medicare to pay physicians…in a way that results in high quality, affordable care for seniors. We support identifying Alternative Models…

Senate Finance Committee

President’s Budget Proposal to Encourage Adoption of New Physician Payment Models
“…The Administration supports … the continued development of scalable accountable payment models…[to] encourage care coordination, reward practitioners who provide high-quality efficient care, and hold practitioners accountable…”

President’s Budget for Fiscal Year 2014, p.37
CBO expects that physicians would generally choose to participate in the payment options that offer the largest payments for the services they provide…

CBO expects that most of the alternative payment models that would be adopted under this legislation would increase Medicare spending. CBO’s review of numerous Medicare demonstration projects found that very few succeeded in reducing Medicare spending.

CBO expects that the greater influence of providers within the design process specified in H.R. 2810 would lead to smaller savings than would arise from the development and adoption of new approaches through the [current] CMMI process.

Congressional Budget Office Cost Estimate for H.R. 2810 (September 13, 2013)
### Alternative Payment Models Allow Win-Win-Win-Win Approaches

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## Example: Reducing Cost of Surgery

<table>
<thead>
<tr>
<th>COST TYPE</th>
<th>TODAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Fee</td>
<td>$1,500</td>
</tr>
<tr>
<td>Hospital Cost</td>
<td>$5,985</td>
</tr>
<tr>
<td>Hosp. Margin</td>
<td>$ 315</td>
</tr>
<tr>
<td>Total Hospital Pmt</td>
<td>$6,300</td>
</tr>
<tr>
<td>Total Cost to Payer</td>
<td>$7,800</td>
</tr>
</tbody>
</table>
What If You Could Reduce the Cost of the Surgery?

<table>
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<th>CHANGE</th>
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<tbody>
<tr>
<td>Physician Fee</td>
<td>$1,500</td>
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</tr>
<tr>
<td>Hospital Cost</td>
<td>$5,985</td>
<td>-$300 (5%)</td>
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<td>Hosp. Margin</td>
<td>$ 315</td>
<td></td>
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Today: All Savings Goes to the Hospital, No Reward for Physician

<table>
<thead>
<tr>
<th>COST TYPE</th>
<th>TODAY</th>
<th>CHANGE</th>
<th>SPLIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Fee</td>
<td>$1,500</td>
<td></td>
<td>+0%</td>
</tr>
<tr>
<td>Hospital Cost</td>
<td>$5,985</td>
<td>-$300 (5%)</td>
<td></td>
</tr>
<tr>
<td>Hosp. Margin</td>
<td>$315</td>
<td>$300 (+95%)</td>
<td></td>
</tr>
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<td>$6,300</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Cost to Payer</td>
<td>$7,800</td>
<td></td>
<td>-0%</td>
</tr>
</tbody>
</table>
Bundling Eliminates Boundary Between Hospital & Physician Pmt

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</tbody>
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*Single, “Bundled” Payment to Physician and Hospital For Procedure*
# Bundling Allows Savings Split Among Docs, Hospitals, Payers

<table>
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<th>TODAY</th>
<th>CHANGE</th>
<th>SPLIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Fee</td>
<td>$1,500</td>
<td>+ $75 (5%)</td>
<td>+ $75 (+5%)</td>
</tr>
<tr>
<td>Hospital Cost</td>
<td>$5,985</td>
<td>-$300 (5%)</td>
<td>+ $50 (+16%)</td>
</tr>
<tr>
<td>Hosp. Margin</td>
<td>$ 315</td>
<td>$ 50 (16%)</td>
<td>-$175 (-3%)</td>
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<td>Total Cost to Payer</td>
<td>$7,800</td>
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<td>-</td>
</tr>
</tbody>
</table>
Win-Win-Win By Making Surgery Cheaper But More Profitable

<table>
<thead>
<tr>
<th>COST TYPE</th>
<th>TODAY</th>
<th>CHANGE</th>
<th>SPLIT</th>
<th>NEW</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Fee</td>
<td>$1,500</td>
<td>$75 (+5%)</td>
<td>$1,575</td>
<td></td>
</tr>
<tr>
<td>Hospital Cost</td>
<td>$5,985</td>
<td>-$300 (5%)</td>
<td>$5,685</td>
<td></td>
</tr>
<tr>
<td>Hosp. Margin</td>
<td>$ 315</td>
<td>+$50 (+16%)</td>
<td>$ 365</td>
<td></td>
</tr>
<tr>
<td>Total Cost to Payer</td>
<td>$7,800</td>
<td>-$175 (-3%)</td>
<td>$7,625</td>
<td></td>
</tr>
</tbody>
</table>
Medicare Acute Care Episode (ACE) Demonstration

- Bundled Medicare Part A (hospital) and Part B (physician) payments together for cardiac and orthopedic (hips & knees) procedures
- Total Medicare payment was lower than what standard Medicare DRG + physician fee would have been
- Payment was made to a Physician-Hospital Organization, which then divided the payment between hospital and surgeon
- Surgeon could receive up to 25% above Medicare fee
- Patient cost-sharing reduced by up to 50% of Medicare’s savings
- CMS waived Stark rules for gainsharing
- Implemented in 2009/2010 in five hospital systems based on competitive bids:
  - Hillcrest Medical Center, Oklahoma (orthopedic procedures)
  - Baptist Health System, Texas (cardiac + orthopedic procedures)
  - Oklahoma Heart Hospital, Oklahoma (cardiac procedures)
  - Lovelace Health System, New Mexico (cardiac + orthopedic procedures)
  - Exempla Saint Joseph Hospital, Colorado (cardiac procedures)
- No formal evaluation results published, but participants have informally reported significant savings
$2,200 Variation in Average Cost of Drug-Eluting Stents in CA Hospitals

Source: Coronary Angioplasty with Drug Eluting Stents: Device Costs, Hospital Costs, and Insurance Payments, Emma L. Dolan and James C. Robinson
Berkeley Center for Health Technology, September 2010
$8,000 Variation in Avg Costs of Joint Implants Across CA Hospitals

Source: Implantable Medical Devices for Hip Replacement Surgery: Economic Implications for California Hospitals, Emma L. Dolan and James C. Robinson, Berkeley Center for Health Technology, May 2010
Not Just Devices: Other Savings Opportunities From Bundling

- Better scheduling of scarce resources (e.g., surgery suites) to reduce both underutilization & overtime
- Coordination among multiple physicians and departments to avoid duplication and conflicts in scheduling
- Standardization of equipment and supplies to facilitate bulk purchasing
- Less wastage of expensive supplies
- Reduced length of stay
- Etc.
Not Just Hospital-Physician Bundles, But Also Post-Acute Care
Medicare Payments for Inpatient Admissions

Inpatient Costs for Medicare Beneficiaries by Admission DRG, 2008

- Major Joint (470) - $25,000
- Pneumonia w/CC (194) - $10,000
- Heart Failure w/CC (292) - $5,000
- Renal Failure w/CC (683) - $5,000
- COPD w/MCC (190) - $5,000

Medicare Payments for Inpatient + Post-Discharge Svcs

Total Episode Costs for Medicare Beneficiaries by Admission DRG, 2008

- 30-90 Days Post-Discharge
- 30 Days Post-Discharge
- Index Admission

<table>
<thead>
<tr>
<th>Condition</th>
<th>Episodes</th>
<th>Cost (2008)</th>
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<tr>
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Post-Discharge Costs ≥100% of Inpatient Spending

Hospitals, Docs, & Payers Can Benefit From Lower Post-Acute $
## Alternative Payment Models Allow Win-Win-Win-Win Approaches

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<td>Higher payment for physicians and hospitals with low rates of infections and complications</td>
<td>Medicare or health plan no longer pays more for high rates of infections or complications</td>
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Yes, a Health Care Provider Can Offer a Warranty

Geisinger Health System ProvenCare℠

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

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

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

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

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Warranties Can Be Offered By Individual Docs & Small Hospitals

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

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

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

A Warranty is *Not* an Outcome Guarantee

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

- Q: “Why should we pay more to get good-quality care??”
- A: In most industries, warrantied products cost more, but they’re desirable because TOTAL spending on the product (repairs & replacement) is lower than without the warranty
Example: $7,800 Procedure, 15% Readmission Rate

<table>
<thead>
<tr>
<th>Cost of Success</th>
<th>Added Cost of Readmit</th>
<th>Rate of Readmits</th>
</tr>
</thead>
<tbody>
<tr>
<td>$7,800</td>
<td>$7,000</td>
<td>15%</td>
</tr>
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</table>
### Average Payment for Procedure is Higher than the Official “Price”

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</table>

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

<table>
<thead>
<tr>
<th>Cost of Success</th>
<th>Added Cost of Readmit</th>
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<th>Average Total Cost</th>
<th>Price Charged</th>
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</thead>
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</table>
Limited Warranty Gives Financial Incentive to Improve Quality

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<tr>
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<td>13%</td>
<td>$8,710</td>
<td>$8,850</td>
<td>$140</td>
</tr>
</tbody>
</table>

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

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

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<tr>
<td>$7,800</td>
<td>$7,000</td>
<td>10%</td>
<td>$8,500</td>
<td>$8,790</td>
<td>$290</td>
</tr>
</tbody>
</table>

Reducing Adverse Events... → ...Reduces Costs... → ...Improves The Bottom Line

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# Win-Win-Win Through Appropriate Payment & Pricing

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<td>$7,000</td>
<td>10%</td>
<td>$8,500</td>
<td>$8,700</td>
<td>$200</td>
</tr>
<tr>
<td>$7,800</td>
<td>$7,000</td>
<td>8%</td>
<td>$8,360</td>
<td><strong>$8,700</strong></td>
<td><strong>$340</strong></td>
</tr>
</tbody>
</table>

Quality is Better...

...Cost is Lower...

...Providers More Profitable
A Critical Element is Shared, Trusted Data

• **Physicians and Hospitals** need to know the current utilization and costs for their patients to determine whether a bundled/warrantied payment amount will cover the costs of delivering effective care to the patients.

• **Purchasers and Payers** need to know the current utilization and costs for their employees/members to determine whether the bundled/warrantied payment amount is a better deal than they have today.

• **Both** sets of data have to match in order for providers and payers to agree on the new approach!
## Different Warranty Prices for Cases With Different Risks

<table>
<thead>
<tr>
<th>Cost of Procedure</th>
<th>Cost and Rate of Readmits</th>
<th>Average Total Cost</th>
<th>Price Charged</th>
<th>Change in Net Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HIGH RISK CASES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>$7,800</td>
<td>$7,000</td>
<td>20%</td>
<td>$9,200</td>
<td>$9,200</td>
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<tr>
<td>$7,800</td>
<td>$7,000</td>
<td>10%</td>
<td>$8,500</td>
<td>$8,850</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Payer Savings:</td>
<td></td>
<td>$350</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>LOW RISK CASES</strong></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>$7,800</td>
<td>$7,000</td>
<td>10%</td>
<td>$8,500</td>
<td>$8,500</td>
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<tr>
<td>$7,800</td>
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<td>5%</td>
<td>$8,150</td>
<td>$8,325</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Payer Savings:</td>
<td></td>
<td>$175</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The Warranty Concept Can Be Applied to Many Costs/Outcomes

- Reducing Readmissions
- Reducing Surgical Site Infections
- Reducing Unnecessary Radiation Therapy
- Reducing Unnecessarily Expensive Chemotherapy
- Improving Survival
“Episode Payment” = Bundles + Warranties

• **Bundle Options**
  – Surgeon + Hospital
  – Surgeon + Anesthesiologist + Hospital
  – Surgeon + Anesthesiologist + Hospital + Post-Acute Care
  – Surgical Oncologist + Medical Oncologist + Radiation Oncologist
  – Primary Care + Specialist

• **Warranty Options**
  – Readmissions
    • 15 days
    • 30 days
    • 90 days
  – Complications
  – Preventable Admissions
Newest CMS “Bundling” Demo
Includes a Range of Opportunities

• **Model 1 (Inpatient Gainsharing, No Warranty)**
  – Hospitals can share savings with physicians
  – No actual change in the way Medicare payments are made

• **Model 2 (Virtual Full Episode Bundle + Warranty)**
  – Budget for Hospital+Physician+Post-Acute+Readmissions
  – Medicare pays bonus if actual cost < budget
  – Providers repay Medicare if actual cost > budget

• **Model 3 (Virtual Post-Acute Bundle + Warranty)**
  – Budget for Post-Acute Care+Physicians+Readmissions
  – Bonuses/penalties paid based on actual cost vs. budget

• **Model 4 (Prospective Inpatient Bundle + Warranty)**
  – Single Hospital + Physician payment for inpatient care & readmissions
CMS is planning to develop initiatives this year for oncology, cardiology, and gastroenterology.

CMS is seeking input on additional opportunities from other specialties – comments due April 10.
Payment Reform is Not Just About Lower Spending & Higher Doc Pay
The Current Payment System Creates Barriers to Better Care

Lack of Flexibility in FFS

- No payment for phone calls or emails with patients
- No payment to coordinate care among providers
- No payment for non-physician support services to help patients with self-management
- No flexibility to shift resources across silos (hospital <-> physician, post-acute <-> hospital, SNF <-> home health, etc.)
The Current Payment System Creates Barriers to Better Care

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- No payment for non-physician support services to help patients with self-management
- No flexibility to shift resources across silos (hospital <-> physician, post-acute <-> hospital, SNF <-> home health, etc.)

Penalty for Quality/Efficiency

- Lower revenues if patients don’t make frequent office visits
- Lower revenues for performing fewer tests and procedures
- Lower revenues if infections and complications are prevented instead of treated
- No revenue at all if patients stay healthy
## Alternative Payment Models Allow Win-Win-Win Approaches

<table>
<thead>
<tr>
<th>BUILDING BLOCKS</th>
<th>HOW IT WORKS</th>
<th>HOW PHYSICIANS AND HOSPITALS CAN BENEFIT</th>
<th>HOW PAYERS CAN BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bundled Payment</td>
<td>Single payment to 2+ providers who are now paid separately (e.g., hospital+physician)</td>
<td>Higher payment for physicians if they reduce costs paid by hospitals</td>
<td>Physician and hospital offer a lower total price to Medicare or health plan than today</td>
</tr>
<tr>
<td>Warrantied Payment</td>
<td>Higher payment for quality care, no extra payment for correcting preventable errors and complications</td>
<td>Higher payment for physicians and hospitals with low rates of infections and complications</td>
<td>Medicare or health plan no longer pays more for high rates of infections or complications</td>
</tr>
<tr>
<td>Condition-Based Payment</td>
<td>Payment based on the patient’s condition, rather than on the procedure used</td>
<td>No loss of payment for physicians doing fewer procedures &amp; keeping patients well</td>
<td>Medicare or health plan no longer pays more for unnecessary procedures &amp; services</td>
</tr>
</tbody>
</table>
The Payment Barriers to Primary Care Medical Homes

CURRENT PAYMENT SYSTEMS

Health Insurance Plan

Primary Care Practice

- Office Visits
- Phone Calls
- Nurse Care Mgr

No payment for services that can prevent utilization...

- Hospital Stay
  - Avoidable

...No penalty or reward for high utilization elsewhere

- ER Visits
  - Avoidable

- Lab Work/Imaging
  - Avoidable

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Similar Payment Barriers for Oncology Medical Homes

CURRENT PAYMENT SYSTEMS

Health Insurance Plan

- **Office Visits**
- **ER Visits**
- **Hospital Stay**

- **Phone Calls**
- **Lab Work/Imaging**

No payment for services that can prevent utilization...

Avoidable

...No penalty or reward for high utilization elsewhere
What Generates Revenues for an Oncology Practice?

Typical Medicare Payments for 6 Month Adjuvant Chemotherapy

- New Patient
- 6 Months of Treatment
- Post-Tx Follow-Up

Months Under Oncology Care

- E&M
- Infusion
- Drug Markup Low
- Drug Markup High
What Takes the Time/Expertise of an Oncology Practice?

![Graph showing physician and staff time for adjuvant chemotherapy over different months.]

- **New Patient**: 0 months
- **6 Months of Treatment**: Months 1 to 6
- **Post-Tx Follow-Up**: Months 7 to 11

The graph indicates that the highest demand for physician and staff time occurs in the initial month of treatment, with a gradual decrease in the following months.
Mismatch Between Revenues and Patient Care in Oncology

Typical Medicare Payments for 6 Month Adjuvant Chemotherapy

- E&M
- Infusion
- Drug Markup Low
- Drug Markup High

Physician and Staff Time for Adjuvant Chemotherapy

- New Patient
- 6 Months of Treatment
- Post-Tx Follow-Up
Shift to Oral Drugs Will Leave Oncology With Little Revenue

<table>
<thead>
<tr>
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<th>E&amp;M</th>
<th>Infusion</th>
<th>Drug Markup Low</th>
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</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>$1,600</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>$1,400</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
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<td>3</td>
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Typical Medicare Payments for 6 Month Adjuvant Chemotherapy

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Medicare Payments for 6 Month Adjuvant Chemotherapy w/Oral Drugs

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Oral Drugs Will Create Bigger Mismatch Between Pay & Cost
Condition-Based Payment Being Developed for Oncology by ASCO

New Patient Payment

<table>
<thead>
<tr>
<th>Tx Month Pmt</th>
<th>Tx Month Pmt</th>
<th>Tx Month Pmt</th>
<th>Tx Month Pmt</th>
<th>Tx Month Pmt</th>
<th>Tx Month Pmt</th>
<th>Non-Tx Mo. $</th>
<th>Non-Tx Mo. $</th>
<th>Non-Tx Mo. $</th>
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Higher Payments For More Complex Pts

Physician and Staff Time for Adjuvant Chemotherapy

- New Patient
- 6 Months of Treatment
- Post-Tx Follow-Up

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Steps to Successful Payment Reform

1. Defining the Change in Care Delivery
   – How can the physician, hospital, or other provider change the way care is delivered to reduce costs without harming patients?
Steps to Successful Payment Reform

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   – How can the physician, hospital, or other provider change the way care is delivered to reduce costs without harming patients?

2. Analyzing Expected Costs and Savings
   – What will there be less of, and how much does that save?
   – What will there be more of, and how much does that cost?
   – Will the savings offset the costs on average?
   – How much variation in costs and savings is likely?
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3. Designing a Payment Model That Supports Change
   - Flexibility to change the way care is delivered
   - Accountability for costs and quality/outcomes related to care
   - Adequate payment to cover lowest-achievable costs
   - Protection for the provider from insurance risk
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   - Adequate payment to cover lowest-achievable costs
   - Protection for the provider from insurance risk

4. Compensating Physicians Appropriately
   - Changing payment to the provider organization (physician practice/group/IPA/health system) does not automatically change compensation to physicians
## Many Opportunities to Increase Value in Gynecologic Oncology

<table>
<thead>
<tr>
<th>Patients Treated by Practice</th>
<th>Opportunities to Improve Care and Reduce Cost</th>
</tr>
</thead>
</table>
| Patients with Other Conditions | • Ensure cancer is properly staged  
• Avoid surgery complications  
• Use most appropriate radiotherapy and chemotherapy  
• Manage side effects of treatment  
• Improve end-of-life care  
• Improve screening for early detection |
| Cervical Cancer             |                                              |
| Ovarian Cancer              |                                              |
| Endometrial Cancer          |                                              |
Payment Barriers Must Be Overcome to Improve Care

<table>
<thead>
<tr>
<th>Patients Treated by Practice</th>
<th>Opportunities to Improve Care and Reduce Cost</th>
<th>Barriers in Current Payment System</th>
</tr>
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• Avoid surgery complications  
• Use most appropriate radiotherapy and chemotherapy  
• Manage side effects of treatment  
• Improve end-of-life care  
• Improve screening for early detection | • No incentive for payers or patients to see high-skill gynecologic oncologist  
• No reward for better outcomes and fewer complications  
• Revenue dependent on use of chemotherapy  
• No payment for care delivered by nurses, social workers, etc. |
| Cervical Cancer |  |  |
| Ovarian Cancer |  |  |
| Endometrial Cancer |  |  |
# Accountable Payment Models Provide the Solutions

## Patients Treated by Practice

<table>
<thead>
<tr>
<th>Patients with Other Conditions</th>
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<th>Barriers in Current Payment System</th>
<th>Solutions via Accountable Payment Models</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cervical Cancer</strong></td>
<td>• Ensure cancer is properly staged</td>
<td>• No incentive for payers or patients to see high-skill gynecologic oncologist</td>
<td>• Bundled payment for surgery</td>
</tr>
<tr>
<td></td>
<td>• Avoid surgery complications</td>
<td>• No reward for better outcomes and fewer complications</td>
<td>• Warranties for complications and outcomes</td>
</tr>
<tr>
<td></td>
<td>• Use most appropriate radiotherapy and chemotherapy</td>
<td>• Revenue dependent on use of chemotherapy</td>
<td>• Episode payment for specific treatments</td>
</tr>
<tr>
<td></td>
<td>• Manage side effects of treatment</td>
<td>• No payment for care delivered by nurses, social workers, etc.</td>
<td>• Condition-based payment for overall management of care</td>
</tr>
<tr>
<td><strong>Ovarian Cancer</strong></td>
<td>• Improve end-of-life care</td>
<td></td>
<td>• Global payment to improve screening</td>
</tr>
<tr>
<td><strong>Endometrial Cancer</strong></td>
<td>• Improve screening for early detection</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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SGO Is Ahead of Other Specialties in Working on This
# Other Specialties Working On Payment Reforms, Too

## Opportunities to Improve Care and Reduce Cost

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Opportunities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiology</td>
<td>• Use less invasive and expensive procedures when appropriate</td>
</tr>
<tr>
<td>Orthopedic Surgery</td>
<td>• Reduce infections and complications</td>
</tr>
<tr>
<td></td>
<td>• Use less expensive post-acute care following surgery</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>• Reduce ER visits and admissions for patients with depression and chronic disease</td>
</tr>
<tr>
<td>OB/GYN</td>
<td>• Reduce use of elective C-sections</td>
</tr>
<tr>
<td></td>
<td>• Reduce early deliveries and use of NICU</td>
</tr>
</tbody>
</table>

## Barriers in Current Payment System

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiology</td>
<td>• Payment is based on which procedure is used, not the outcome for the patient</td>
</tr>
<tr>
<td>Orthopedic Surgery</td>
<td>• No flexibility to increase inpatient services to reduce complications &amp; post-acute care</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>• No payment for phone consults with PCPs</td>
</tr>
<tr>
<td>OB/GYN</td>
<td>• Similar/lower payment for vaginal deliveries</td>
</tr>
</tbody>
</table>

## Solutions via Accountable Payment Models

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiology</td>
<td>• Condition-based payment covering CABG, PCI, or medication management</td>
</tr>
<tr>
<td>Orthopedic Surgery</td>
<td>• Episode payment for hospital and post-acute care costs with warranty</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>• Joint condition-based payment to PCP and psychiatrist</td>
</tr>
<tr>
<td>OB/GYN</td>
<td>• Condition-based payment for total cost of delivery in low-risk pregnancy</td>
</tr>
</tbody>
</table>
AMA is Working to Support and Coordinate Specialty Efforts

- **Advocacy for Physician-Driven Models**
  - What is easiest for payers may not best for physicians and patients
  - Physicians should not be expected to take on full “insurance risk”
  - Small, independent practices should be able to participate as well as large health systems
  - Physicians will need time, data, and technical assistance to transition to new payment models

- **Consistency of Payment Model Structures Across Payers and Specialties**
  - Enabling physicians to have a similar payment model for all payers
  - Simplifying administration for payers
  - Avoiding inconsistency/gaps across patient conditions & services
How Does This All Fit Into ACOs?

PATIENTS
- Heart Disease
- Diabetes
- Back Pain
- Cancer
Each Patient Should Choose & Use a Primary Care Practice…

PATIENTS

- Heart Disease
- Diabetes
- Back Pain
- Cancer

Primary Care Practice
…Which Takes Accountability for What PCPs Can Control/Influence

**Accountability for:**
- Avoidable ER Visits
- Avoidable Hospitalizations
- Unnecessary Tests
- Unnecessary Referrals

**Patients:**
- Heart Disease
- Diabetes
- Back Pain
- Cancer

**Primary Care Practice**

**Accountable Medical Home**

**Medicare/Health Plan**
...With a Medical Neighborhood to Consult With on Complex Cases

PATIENTS
- Heart Disease
- Diabetes
- Back Pain
- Cancer

Primary Care Practice
- Endocrinology, Oncology, Psychiatry

Accountability for:
- Unnecessary Tests
- Unnecessary Referrals
- Co-Managed Outcomes

Accountable Medical Home
..And Specialists Accountable for the Conditions They Manage

Accountability for:
- Unnecessary Tests
- Unnecessary Procedures
- Infections, Complications

PATIENTS
- Heart Disease
- Diabetes
- Back Pain
- Cancer

Heart Episode/Condition Pmt
Back Episode/Condition Pmt
Cancer Episode Management Pmt

MEDICARE/HEALTH PLAN

Accountable Medical Home

Primary Care Practice

Cardiology Group
Neurosurg. Group
Oncology Group

Endocrinology, Oncology, Psychiatry

Accountable Medical Neighborhood
That’s Building the ACO from the Bottom Up

**MEDITCARE/HEALTH PLAN**

**Accountable Payment Models**

**ACO**

Heart Episode/Condition Pmt

Back Episode/Condition Pmt

Cancer Episode Management Pmt

**PATIENTS**

- Heart Disease
- Diabetes
- Back Pain
- Cancer

**Primary Care Practice**

**Cardiology Group**

**Neurosurg. Group**

**Oncology Group**

Endocrinology, Oncology, Psychiatry

Accountable Medical Home

Accountable Medical Neighborhood
Most ACOs Today Aren’t Truly *Reinventing Care*

**MEDICARE/HEALTH PLAN**

- **Fee-for-Service Payment**
- **Shared Savings Payment**

**ACO**

- Expensive IT Systems
- Nurse Care Managers

**PATIENTS**
- Heart Disease
- Diabetes
- Back Pain
- Cancer

**Primary Care**
- Psych., Neuro
- Cardiology
- Neurosurg.
- Oncology
A True ACO Can Take a Global Payment And Make It Work

MEDICARE/HEALTH PLAN

Risk-Adjusted Global Payment

PATIENTS
Heart Disease
Diabetes
Back Pain
Cancer

ACO

Primary Care Practice
Endocrinology, Oncology, Psychiatry

Cardiology Group
Neurosurg. Group
Oncology Group

Accountable Medical Home
Accountable Medical Neighborhood

Heart Episode/Condition Pmt
Back Episode/Condition Pmt
Cancer Episode Management Pmt
Isn’t This Capitation? No – It’s Different

**CAPITATION (WORST VERSIONS)**

- No Additional Revenue for Taking Sicker Patients
- Providers Lose Money On Unusually Expensive Cases
- Providers Are Paid Regardless of the Quality of Care
- Provider Makes More Money If Patients Stay Well
- Flexibility to Deliver Highest-Value Services

**RISK-ADJUSTED GLOBAL PMT**

- Payment Levels Adjusted Based on Patient Conditions
- Limits on Total Risk Providers Accept for Unpredictable Events
- Bonuses/Penalties Based on Quality Measurement
- Provider Makes More Money If Patients Stay Well
- Flexibility to Deliver Highest-Value Services

**CAPITATION vs. RISK-ADJUSTED GLOBAL PMT**

- **CAPITATION** doesn’t address the challenges of unpredictable events or incentivizes quality measurement.
- **RISK-ADJUSTED GLOBAL PMT** adjusts payments based on patient conditions, limits risk, and ties bonuses/penalties to quality measurement.
Example: BCBS MA
Alternative Quality Contract

• Single payment for all costs of care for a population of patients
  – Adjusted up/down annually based on severity of patient conditions
  – Initial payment set based on past expenditures, not arbitrary estimates
  – Provides flexibility to pay for new/different services
  – Bonus paid for high quality care

• Five-year contract
  – Savings for payer achieved by controlling increases in costs
  – Allows provider to reap returns on investment in preventive care, infrastructure

• Broad participation
  – 14 physician groups/health systems participating with over 400,000 patients, including one primary care IPA with 72 physicians

• Positive two year results
  – Higher ambulatory care quality than non-AQC practices, better patient outcomes, lower readmission rates and ER utilization, lower costs

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

Benefit Design

Payment System

Patient

Provider

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: Coordinating Pharmacy & Medical Benefits

Single-minded focus on reducing costs here...

**Pharmacy Benefits**
- Drug Costs
  - High copays for brand-names when no generic exists
  - Doughnut holes & deductibles

...could result in higher spending on hospitalizations

**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
## Where Will You Get Your Cancer Care?

### Gynecologic Oncology Care

<table>
<thead>
<tr>
<th>Price #1</th>
<th>Price #2</th>
<th>Price #3</th>
</tr>
</thead>
<tbody>
<tr>
<td>$30,000</td>
<td>$40,000</td>
<td>$50,000</td>
</tr>
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</table>
Where Will You Get Your Cancer Care?

Gynecologic Oncology Care

<table>
<thead>
<tr>
<th>Consumer Share of Surgery Cost</th>
<th>Price #1 $30,000</th>
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</tr>
<tr>
<td>10% Coinsurance w/$2,000 OOP Max:</td>
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</tr>
<tr>
<td>Highest-Value:</td>
<td>$0</td>
<td>$10,000</td>
<td>$20,000</td>
</tr>
</tbody>
</table>

Gynecologic Oncology Care
Today: Hard to Know if Better Price Means Better Value

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

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

<table>
<thead>
<tr>
<th>Provider 1:</th>
<th>$25,000</th>
<th>$30,000</th>
<th>2%</th>
<th>$25,600</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider 2:</td>
<td>$23,000</td>
<td>$30,000</td>
<td>10%</td>
<td>$26,000</td>
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<tr>
<td>-8%</td>
<td>+2%</td>
<td></td>
<td></td>
<td></td>
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</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>
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<td>Provider 1:</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>+2%</td>
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Bundled prices show that Provider 1 is the higher-value provider.
This All Sounds Really Hard
This All Sounds Really Hard

Can’t We Just Keep Doing What We’re Doing Today Until We Retire?
The Opportunities to Reduce Costs w/o Rationing Are Widely Known

| Reducing Hospital Readmissions |
| Helping Patients with Chronic Disease Stay Out of Hospital |
| Reducing Overutilization of Drugs, Labs & Testing |
| Shifting Preference-Sensitive Care to Lower-Cost Options |
| Reducing the Cost of Expensive Procedures |
The Question is: *How Will Payers Get The Savings?*

<table>
<thead>
<tr>
<th>PURCHASER/PAYER</th>
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<tr>
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<tr>
<td>Reducing the Cost of Expensive Procedures</td>
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</table>
The Payer-Driven Approach to Achieving Savings

Managed Fee-for-Service

Purchaser/Payer

- Readmission Penalty
- Physician P4P
- High Deductibles
- Prior Authorization
- Narrow Networks
- Lower Fees

Reducing Hospital Readmissions
Helping Patients with Chronic Disease Stay Out of Hospital
Reducing Overutilization of Drugs, Labs & Testing
Shifting Preference-Sensitive Care to Lower-Cost Options
Reducing the Cost of Expensive Procedures

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The Provider-Driven Approach to Achieving Savings

Reducing Hospital Readmissions

Helping Patients with Chronic Disease Stay Out of Hospital

Reducing Overutilization of Drugs, Labs & Testing

Shifting Preference-Sensitive Care to Lower-Cost Options

Reducing the Cost of Expensive Procedures

Global Pmt/Budget

Coordinated Care/Accountable Care Organization
Very Different Models…

Managed Fee-for-Service

- Readmission Penalty
- Physician P4P
- High Deductibles
- Prior Authorization
- Narrow Networks
- Lower Fees

Purchaser/Payer

- Reducing Hospital Readmissions
- Helping Patients with Chronic Disease Stay Out of Hospital
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- Reducing the Cost of Expensive Procedures

Global Pmt/Budget

Coordinated Care/Accountable Care Organization

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…And Very Different Impacts on Physicians and Hospitals

Managed Fee-for-Service

1. Payer defines how care should be redesigned
2. Payer obtains all savings from lower utilization
3. Payer decides how much savings to share with provider

Global Pmt/Budget

1. Provider determines how care should be redesigned
2. Provider and Purchaser or Payer agree on adequate price for provider care and amount of savings for payer
3. Providers get to keep any additional savings and to determine how to divide it
Opportunities for Leadership from Academic Medical Centers

• Research
  – Look for ways to improve care with an explicit goal of reducing costs (i.e., not just better clinical outcomes, but greater cost-effectiveness)
  – Focus research on patient conditions and aspects of care where there are major opportunities for savings

*Research that helps save money in care delivery creates a natural business case for getting research support from payers*
Opportunities for Leadership from Academic Medical Centers

• Research
  – Look for ways to improve care with an explicit goal of reducing costs (i.e., not just better clinical outcomes, but greater cost-effectiveness)
  – Focus research on patient conditions and aspects of care where there are major opportunities for savings

  *Research that helps save money in care delivery creates a natural business case for getting research support from payers*

• Education
  – Develop more cost-effective ways of providing medical education
  – Teach physicians the skills they need to deliver better coordinated, more cost-effective care

  *Education that helps reduce costs and improve outcomes creates a natural business case for education support from providers & payers*
Opportunities for Leadership from Academic Medical Centers

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• Education
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  – Teach physicians the skills they need to deliver better coordinated, more cost-effective care

  Education that helps reduce costs and improve outcomes creates a natural business case for education support from providers & payers

• Care Delivery
  – Serve as models of accountable, physician-led care (e.g., using clinical guidelines, communicating with other specialties, controlling costs, working in teams, measuring and reporting on performance, etc.)
Opportunities From Completely Redesigning Payment & Delivery

• **Better Payment for Physicians and Hospitals**
  – No threats of major fee cuts
  – No health plan/benefit manager utilization review
  – Physicians and hospitals paid based on quality, not volume

• **Truly High Quality, Patient-Centric Care**
  – Coordinated care by multiple physicians
  – Care mgt from providers, not health plans or disease mgt co’s
  – Flexibility for telephone, internet, & home visits if patients need them

• **Greater Patient Engagement**
  – Zero or low copayments for essential medications and services
  – Higher cost-sharing for unnecessary tests and services
  – Incentives for patient wellness and adherence

• **Less Spending on Administrative Costs**
  – Less spending for health plan administrative costs and profits
  – Less spending by providers on payer-imposed administrative costs

• **Lower Government Spending and Smaller Deficits**

• **Better Health for Citizens and More Affordable Insurance**
Learn More About Win-Win-Win Payment and Delivery Reform

Center for Healthcare Quality and Payment Reform
www.PaymentReform.org
For More Information:

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President and CEO
Center for Healthcare Quality and Payment Reform

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

www.CHQPR.org
www.PaymentReform.org
APPENDIX
To Set A Fair Price, Start With Existing Costs…
…Set a Payment Level That Is $\leq$ Expected Costs…
...If All Goes Well, Costs Will Be Lower Than the Payment Level...

COST

Bundled or Episode Payment Level

Costs in FFS  Costs in FFS  Costs in FFS  Costs in New Pmt

TIME
...And Both the Purchaser and Provider Will “Win”

COST

Bundled or Episode Payment Level

 Costs in FFS
 Costs in FFS
 Costs in FFS
 Costs in New Pmt

Savings For Purchaser

Bonus for Provider

TIME
What Everybody Fears: All Won’t Go Well (Costs Go Up)

COST

TIME

Bundled or Episode Payment Level

<table>
<thead>
<tr>
<th>Costs in FFS</th>
<th>Costs in FFS</th>
<th>Costs in FFS</th>
<th>Costs in New Pmt</th>
</tr>
</thead>
</table>

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Many Different Reasons Costs May Increase Beyond Payment

- Many Avoidable Complications
- Failure to Follow Guidelines
- Overutilization of Services
- Large Random Variation
- New, High-Cost Treatment
- Unusually Costly Patient
- Higher-Severity Patients

Costs in FFS
Costs in FFS
Costs in FFS
Costs in New Pmt

Excess Cost

Bundled or Episode Payment Level

COST

TIME
Providers Should NOT Be Expected To Take *Insurance* Risk

<table>
<thead>
<tr>
<th>COST</th>
<th>Bundled or Episode Payment Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Costs in FFS</td>
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- Many Avoidable Complications
- Failure to Follow Guidelines
- Overutilization of Services
- Large Random Variation
- New, High-Cost Treatment
- Unusually Costly Patient
- Higher-Severity Patients

Provider Performance Risk

Insurance Risk

TIME
Four Mechanisms for Separating Insurance and Performance Risk

- Bundled or Episode Payment Level
- Costs in FFS
- Costs in FFS
- Costs in FFS
- Costs in New Pmt

Excess Cost

<table>
<thead>
<tr>
<th>Many Avoidable Complications</th>
<th>Performance Risk (Provider’s Responsibility)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failure to Follow Guidelines</td>
<td>Risk Corridors</td>
</tr>
<tr>
<td>Overutilization of Services</td>
<td>Risk Exclusions</td>
</tr>
<tr>
<td>Large Random Variation</td>
<td>New, High-Cost Treatment</td>
</tr>
<tr>
<td>Unusually Costly Patient</td>
<td>Unusually Costly Patient</td>
</tr>
<tr>
<td>Higher-Severity Patients</td>
<td>Outlier Pmt/Stop-Loss</td>
</tr>
<tr>
<td>Severity Adjustment</td>
<td></td>
</tr>
</tbody>
</table>