REDESIGNING HEALTH CARE FROM THE BOTTOM UP INSTEAD OF FROM THE TOP DOWN
Supporting Collaborative Regional Approaches to Sustainable High-Value Healthcare

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

www.CHQPR.org
Are We Making Progress on the Road to Higher-Value Healthcare?

PAST

High Healthcare Costs

Mediocre Quality Care

Unhealthy People

FUTURE

Affordable Insurance Premiums

High Quality Care

Healthy People
Are We Making Progress on the Road to Higher-Value Healthcare?

PAST
- High Healthcare Costs
- Mediocre Quality Care
- Unhealthy People

FUTURE
- Affordable Insurance Premiums
- High Quality Care
- Healthy People

NO
Health Care is NOT More Affordable

Average Family Premium, Employer-Sponsored Insurance

- Family Insurance Premiums Increased $3,000 (22%) More Than Inflation
Quality Has NOT Improved

Blood Pressure and HbA1c Control for Diabetics, Commercial PPOs & HMOs

Source:
NCQA:
The State of Health Care Quality 2015
Quality Has NOT Improved

Over One-Third of Diabetic Patients Aren’t Receiving Adequate Care

Source: NCQA: The State of Health Care Quality 2015
It’s Not Just Diabetics, It’s Everybody

Over One-Third of All Patients With High Blood Pressure Aren’t Receiving Adequate Care

Source: NCQA: The State of Health Care Quality 2015
“Value” is *Lower Today Than 6 Years Ago*

- **Average Family Premium, Employer-Sponsored Insurance**
  - Higher Cost

- **Blood Pressure and HbA1c Control for Diabetics, Commercial PPOs & HMOs**
  - Poor Quality
California Isn’t Doing Any Better

Over One-Third of Diabetics in California Aren’t Getting Adequate Care

Health Insurance Premiums in California Are Higher Than The U.S. Average
Spending is Growing Rapidly Regardless of Payer

- Commercial Insurance: 18% > CPI
- Medicare: 19% > CPI
- Medicaid: 35% > CPI
Quality Is Poor & Stagnant Regardless of Payer

Blood Pressure and HbA1c Control for Diabetics
Commercial, Medicaid, & Medicare HMOs & PPOs

Source: NCQA: The State of Health Care Quality 2015
Most “Value-Based Payment” is P4P for PCPs and Hospitals
The Effects of Pay-for-Performance Programs on Health, Health Care Use, and Processes of Care

A Systematic Review

Aaron Mendelson, BA; Karli Kondo, PhD; Cheryl Damberg, PhD; Allison Low, BA; Makalapua Motuapuaka, BA; Michele Freeman, MPH; Maya O’Neil, PhD; Rose Relevo, MLIS, MS; and Devan Kansagara, MD, MCR

Background: The benefits of pay-for-performance (P4P) programs are uncertain.

Purpose: To update and expand a prior review examining the effects of P4P programs targeted at the physician, group, managerial, or institutional level on process-of-care and patient outcomes in ambulatory and inpatient settings.

Data Sources: PubMed from June 2007 to October 2016; MEDLINE, PsycINFO, CINAHL, Business Economics and Theory, Business Source Elite, Scopus, Faculty of 1000, and Gartner Research from June 2007 to February 2016.

Study Selection: Trials and observational studies in ambulatory and inpatient settings reporting process-of-care, health, or utilization outcomes.

Data Extraction: Two investigators extracted data, assessed study quality, and graded the strength of the evidence.

Data Synthesis: Among 69 studies, 58 were in ambulatory settings, 52 reported process-of-care outcomes, and 38 reported patient outcomes. Low-strength evidence suggested that P4P programs in ambulatory settings may improve process-of-care outcomes over the short term (2 to 3 years), whereas data on longer-term effects were limited. Many of the positive studies were conducted in the United Kingdom, where incentives were larger than in the United States. The largest improvements were seen in areas where baseline performance was poor. There was no consistent effect of P4P on intermediate health outcomes (low-strength evidence) and insufficient evidence to characterize any effect on patient health outcomes. In the hospital setting, there was low-strength evidence that P4P had little or no effect on patient health outcomes and a positive effect on reducing hospital readmissions.

Limitation: Few methodologically rigorous studies; heterogeneous population and program characteristics and incentive targets.

Conclusion: Pay-for-performance programs may be associated with improved processes of care in ambulatory settings, but consistently positive associations with improved health outcomes have not been demonstrated in any setting.

Primary Funding Source: U.S. Department of Veterans Affairs.


This article was published at Annals.org on 10 January 2017.
Conclusion: Pay-for-performance programs may be associated with improved processes of care in ambulatory settings, but consistently positive associations with improved health outcomes have not been demonstrated in any setting.
“Value-Based Payment” Doesn’t Really Change FFS

Payers

- P4P
- FFS

PCP Care

- Specialist Care
  - Endocrinologists
  - Oncologists
  - OB/GYNs
  - Rheumatologists

- FFS

- Hospital Care
  - Orthopedic Surgeons
  - Gastroenterologists
  - Nephrologists
  - Cardiologists

- FFS

- Rehab & Home Care

FFS
P4P Increases Admin. Costs and Doesn’t Reduce Spending

Payers

Higher Admin Cost

P4P

FFS

Admin Cost

PCP Care

Specialist Care
- Endocrinologists
- Oncologists
- OB/GYNs
- Rheumatologists
- Orthopedic Surgeons
- Gastroenterologists
- Nephrologists
- Cardiologists

Hospital Care

Rehab & Home Care

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The Result:
Higher Premiums for Employers

**EMPLOYERS/PURCHASERS**

- **HIGHER PREMIUM$**

**PAYERS**

- **HIGHER ADMIN COST**

**FFS**

- **P4P**

** ADMIN COST**

- **PCP Care**
- **Specialist Care**
  - Endocrinologists
  - Oncologists
  - OB/GYNs
  - Rheumatologists
- **Orthopedic Surgeons**
- **Gastroenterologists**
- **Nephrologists**
- **Cardiologists**

- **Hospital Care**

- **Rehab & Home Care**

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If P4P Doesn’t Work, Are ACOs the Answer?

ACO

PCP Care

Specialist Care
- Endocrinologists
- Oncologists
- OB/GYNs
- Rheumatologists
- Orthopedic Surgeons
- Gastroenterologists
- Nephrologists
- Cardiologists

Hospital Care

Rehab & Home Care
Medicare’s Shared Savings ACO Program Isn’t Succeeding

2013 Results for Medicare Shared Savings ACOs
• 46% of ACOs (102/220) increased Medicare spending
• Only 24% (52/220) received shared savings payments
• After making shared savings payments, Medicare spent more than it saved
• Net loss to Medicare: $78 million

2014 Results for Medicare Shared Savings ACOs
• 45% of ACOs (152/333) increased Medicare spending
• Only 26% (86/333) received shared savings payments
• After making shared savings payments, Medicare spent more than it saved
• Net loss to Medicare: $50 million

2015 Results for Medicare Shared Savings ACOs
• 48% of ACOs (189/392) increased Medicare spending
• Only 30% (119/392) received shared savings payments
• After making shared savings payments, Medicare spent more than it saved
• Net loss to Medicare: $216 million
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.”
Why? Everybody is Still Paid FFS

- PCP Care
- Specialist Care
  - Endocrinologists
  - Oncologists
  - OB/GYNs
  - Rheumatologists
- Hospital Care
  - Orthopedic Surgeons
  - Gastroenterologists
  - Nephrologists
  - Cardiologists
- Rehab & Home Care

PAYERS

ACO

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Savings Used to Pay for IT Systems and “Care Coordination”

**PAYERS**

| FFS | FFS | FFS |

**ACO Administration**

**IT Systems**
- Specialist Care
  - Endocrinologists
  - Oncologists
  - OB/GYNs
  - Rheumatologists
- Orthopedic Surgeons
- Gastroenterologists
- Nephrologists
- Cardiologists

**Care Coordinators**
- Hospital Care
- Rehab & Home Care

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No Real Change in Care Delivery, No Reduction in Premiums

Employers/Purchasers

Higher Premiums

Payers

ACO Administration

IT Systems

Care Coordinators

FFS

FFS

FFS

FFS

PCP Care

Specialist Care

- Endocrinologists
- Oncologists
- OB/GYNs
- Rheumatologists

- Orthopedic Surgeons
- Gastroenterologists
- Nephrologists
- Cardiologists

Hospital Care

Rehab & Home Care

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What About Capitated Groups in California and Other Areas?

HMOs

Capitation

Capitated Physician Group
- IT Systems
- Care Coordinators

Specialist Care
- Endocrinologists
- Oncologists
- OB/GYNs
- Rheumatologists
- Orthopedic Surgeons
- Gastroenterologists
- Nephrologists
- Cardiologists

PCP Care

Hospital Care

Rehab & Home Care
Most Providers Are Still Paid FFS, Now With Two Layers of Admin $
Result: Slightly Better Care and Slightly Lower Premiums

**EMPLOYERS/PURCHASERS**

SLIGHTLY LOWER PREMIUM$  

**HMOs**

**Capitation**

**Capitated Physician Group**

- IT Systems
- Care Coordinators

- **P4P**
- **PMPM**

**PCP Care**

**Specialist Care**

- Endocrinologists
- Oncologists
- OB/GYNs
- Rheumatologists

- Orthopedic Surgeons
- Gastroenterologists
- Nephrologists
- Cardiologists

**Hospital Care**

**Rehab & Home Care**

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Current VBP Doesn’t Address Drivers of Higher Spending

Private Health Insurance Spending 2009-2015

- 2009: $800,000
- 2015: $2,400,000

29% Increase in Spending

$240 Billion
Biggest Increases are Hospitals & Insurance Administration/Profit
Half of the Growth in Spending Has Been for Hospital Services

Sources of Private Insurance Spending Increase, 2009-2015

- **Hospital Svcs**: 41% Increase, 49% of Total
- **Physician & Clinical Services**: 19% Increase, 18% of Total
- **Drugs**: 20% Increase, 10% of Total
- **Other Svcs**: 24% Increase, 11% of Total
- **Insurance Admin**: 30% Increase, 12% of Total

Change 2009-2015
Isn’t It Time to Do Things DIFFERENTLY?

I’m as MAD as HELL...
...and I’m NOT going to take THIS anymore!
The Wrong Approach to Value-Based Payment

HOW PAYMENT REFORMS ARE DESIGNED TODAY

Medicare and Health Plans Define Payment Systems

Providers Have To Change Care to Align With Payment Systems

Patients and Providers May Not Come Out Ahead
Providers Need to Design Payments to Support Good Care

HOW PAYMENT REFORMS ARE DESIGNED TODAY

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

THE RIGHT WAY TO DESIGN PAYMENT REFORMS

Providers Redesign Care and Identify Payment Barriers → Payers Change Payment to Support Redesigned Care → Patients Get Better Care and Providers Stay Financially Viable
What Does a *True* Alternative Payment Model Look Like?
Step #1: Identify Avoidable Spending in FFS

Oppportunities to reduce total spending:
- Avoidable Hospital Admissions/Readmissions
- Unnecessary Tests and Procedures
- Use of Lower-Cost Settings
- Use of Lower-Cost Treatments
- Preventable Complications of Treatment
- Prevention & Early Identification of Disease
Institute of Medicine Estimate:
30% of Spending is Avoidable

Excess Cost Domain Estimates:
Lower bound totals from workshop discussions*

<table>
<thead>
<tr>
<th>Category</th>
<th>Total excess</th>
</tr>
</thead>
<tbody>
<tr>
<td>UNNECESSARY SERVICES</td>
<td>$210 B*</td>
</tr>
<tr>
<td>• Overuse: services beyond evidence-established levels</td>
<td></td>
</tr>
<tr>
<td>• Discretionary use beyond benchmarks</td>
<td></td>
</tr>
<tr>
<td>• Defensive medicine</td>
<td></td>
</tr>
<tr>
<td>• Unnecessary choice of higher cost services</td>
<td></td>
</tr>
<tr>
<td>INEFFICIENTLY DELIVERED SERVICES</td>
<td>$130 B*</td>
</tr>
<tr>
<td>• Mistakes—medical errors, preventable complications</td>
<td></td>
</tr>
<tr>
<td>• Care fragmentation</td>
<td></td>
</tr>
<tr>
<td>• Unnecessary use of higher cost providers</td>
<td></td>
</tr>
<tr>
<td>• Operational inefficiencies at care delivery sites</td>
<td></td>
</tr>
<tr>
<td>• Physician offices</td>
<td></td>
</tr>
<tr>
<td>• Hospitals</td>
<td></td>
</tr>
<tr>
<td>EXCESS ADMINISTRATIVE COSTS</td>
<td>$190 B*</td>
</tr>
<tr>
<td>• Insurance-related administrative costs beyond benchmarks</td>
<td></td>
</tr>
<tr>
<td>• Insurers</td>
<td></td>
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<tr>
<td>• Physician offices</td>
<td></td>
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<tr>
<td>• Hospitals</td>
<td></td>
</tr>
<tr>
<td>• Other providers</td>
<td></td>
</tr>
<tr>
<td>• Insurer administrative inefficiencies</td>
<td></td>
</tr>
<tr>
<td>• Care documentation requirement inefficiencies</td>
<td></td>
</tr>
<tr>
<td>PRICES THAT ARE TOO HIGH</td>
<td>$105 B*</td>
</tr>
<tr>
<td>• Service prices beyond competitive benchmarks</td>
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</tr>
<tr>
<td>• Physician services</td>
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<td></td>
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<td>• Pharmaceuticals</td>
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<tr>
<td>• Medical devices</td>
<td></td>
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<tr>
<td>• Durable medical equipment</td>
<td></td>
</tr>
<tr>
<td>MISSED PREVENTION OPPORTUNITIES</td>
<td>$55 B*</td>
</tr>
<tr>
<td>• Primary prevention</td>
<td></td>
</tr>
<tr>
<td>• Secondary prevention</td>
<td></td>
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<tr>
<td>• Tertiary prevention</td>
<td></td>
</tr>
<tr>
<td>FRAUD</td>
<td>$75 B*</td>
</tr>
<tr>
<td>• All sources—payer, clinician, patient</td>
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*Lower bound totals of various estimates, adjusted to 2009 total expenditure level.
25% of Avoidable Spending is Excess Administrative Costs

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<tr>
<td>• All sources—payer, clinician, patient</td>
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</tr>
</tbody>
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*Lower bound totals of various estimates, adjusted to 2009 total expenditure level.
Physicians Have Identified Many Opportunities to Reduce Spending
Creating Qualified Entities to Provide Multi-Payer Data
Step #2: Identify Barriers in FFS

BARRIERS IN CURRENT FFS SYSTEM

- No payment for high-value services
  - Phone calls, e-mails with physicians
  - Services delivered by nurses, community workers
  - Communication between PCPs and specialists
  - Non-medical services, e.g., transportation
  - Palliative care for patients at end of life

- Inadequate payment for patients who need more time or resources

- Inadequate revenue to cover fixed costs when utilization of services is reduced
You Can’t Reduce Spending if You Don’t Remove the Barriers

- Avoidable Spending
- Necessary Spending
- Unpaid Services
- Loss of Revenue

$
Step #3: Remove the FFS Barriers

FEE FOR SERVICE

ALTERNATIVE PAYMENT MODEL

NECESSARY SPENDING

AVOIDABLE SPENDING

Upfront payment to support improved delivery of care

$
Step 4: Build in Accountability for Results

- **Avoidable Spending**
  - Fee for Service
  - Alternative Payment Model

- **Necessary Spending**
  - Adequate, Flexible Payment for High-Value Services

Accountability for reducing avoidable spending

Upfront payment to support improved delivery of care
Accountability Must Be Focused on What Each Provider Can Influence

- **Spending the Physician Cannot Control**
  - e.g., PCPs can’t reduce surgical site infections
  - e.g., surgeons can’t prevent diabetic foot ulcers
  - e.g., rheumatologists can’t prevent autoimmune disorders

- **Other Spending the Physician Can Control or Influence**
  - e.g., PCPs can help diabetics avoid amputations
  - e.g., surgeons can reduce surgical site infections
  - e.g., rheumatologists can reduce complications of autoimmune diseases

- **Payments to the Physician**
True Alternative Payment Models Can Be Win-Win-Wins

Win for Purchaser: Lower Total Spending and Lower Premiums

Win for Patient: Better Care Without Unnecessary Services

Win for Provider: Adequate Payment for High-Value Services

- AVOIDABLE SPENDING
- NECESSARY SPENDING
- ADEQUATE, FLEXIBLE PAYMENT FOR HIGH-VALUE SERVICES
- SAVINGS
- LOWER AVOIDABLE SPENDING
- UNPAID SERVICES
- LOSS OF REVENUE
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>
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</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 |

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www.SonarMD.com

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Better Care at Lower Cost for Cancer

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

<table>
<thead>
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<th>RESULTS WITH ADEQUATE PAYMENT FOR BETTER CARE</th>
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</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) |
No One Alternative Payment Model Will Meet All Needs

www.PaymentReform.org

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
This is NOT a Good “Framework” for Alternative Payment Models
It’s All Just FFS + P4P with Fancy Names

Alternative Payment Models (APM) Framework

Category 1
Fee for Service – No Link to Quality & Value

Category 2
Fee for Service – Link to Quality & Value

Category 3
APMs Built on Fee-for-Service Architecture

Category 4
Population-Based Payment

Fee-for-Service
A: Foundational Payments for Infrastructure & Operations
B: Pay for Reporting
C: Rewards for Performance
D: Rewards and Penalties for Performance

APMs
A: APMs with Upside Gainsharing
B: APMs with Upside Gainsharing/Downside Risk

Condition-Specific Payment
A: Condition-Specific Population-Based Payment

Comprehensive Payment
B: Comprehensive Population-Based Payment

Pay for Performance
FFS

“Risk”
FFS

“More Risk”
FFS
Which Physician Would YOU Want to Care for You?

- **Physician A is paid under FFS.** She makes less money if she keeps you healthy.

- **Physician B is paid under P4P.** She makes more money if she keeps her EHR up to date.

- **Physician C has “Downside Risk.”** She makes more money if she doesn't treat your problems.

- **Physician D is paid through a Condition-Based APM.** She’s paid adequately to address your needs, and she makes more money if your health condition(s) improve.
Redesigning Care & Payment from the Bottom Up Instead of the Top Down
Start by Identifying Patient Needs and Opportunities to Improve
Pay PCPs to Help Patients Stay Healthy

PAYERS

- Flexible monthly payments, not tied to office visits
- Higher payments for patients with more conditions
- Accountability for services that PCPs can control

PCP Care

Diabetes  |  Cancer  |  Pregnancy  |  PATIENTS  |  Arthritis  |  IBD  |  CKD  |  Heart Failure
PCPs Can’t Treat Everything; Pay Specialists for Serious Conditions

PAYERS

PCP Care

Specialist Care
- Endocrinologists
- Oncologists
- OB/GYNs
- Rheumatologists

Spec APM
- Orthopedic Surgeons
- Gastroenterologists
- Nephrologists
- Cardiologists

• Payment for e-consults to help PCPs screen & diagnose
• Flexible payments to treat or manage conditions, not tied to office visits or specific procedures
• Higher payments for patients with more complex conditions
• Accountability for services and complications that specialists can control

Diabetes Cancer Pregnancy PATIENTS Arthritis IBD CKD Heart Failure
Pay Hospitals Adequately to Maintain *Essential* Services

**PAYERS**

- **PCP APM**
- **Spec APM (Specialist Care)**
  - Endocrinologists
  - Oncologists
  - OB/GYNs
  - Rheumatologists
  - Orthopedic Surgeons
  - Gastroenterologists
  - Nephrologists
  - Cardiologists
- **Hosp APM (Hospital Care)**

- Adequate payment for fixed costs of standby services (ED, cath lab, trauma, stroke, etc.)
- Accountability for costs that hospitals can control

**Diabetes | Cancer | Pregnancy | PATIENTS | Arthritis | IBD | CKD | Heart Failure**
Pay for Services Designed to Help Patients Return to & Stay at Home

**PAYERS**

- PCP APM
- Spec APM
- Spec APM
- Hosp APM
- Other APM

**PCP Care**

**Specialist Care**
- Endocrinologists
- Oncologists
- OB/GYNs
- Rheumatologists
- Orthopedic Surgeons
- Gastroenterologists
- Nephrologists
- Cardiologists

**Hospital Care**

**Rehab & Home Care**

**PATIENTS**
- Diabetes
- Cancer
- Pregnancy
- Arthritis
- IBD
- CKD
- Heart Failure
Result: Better Outcomes for Patients

**PAYERS**

- PCP APM
- Spec APM
- Spec APM
- Spec APM
- Hosp APM
- Other APM

**Specialist Care**
- Endocrinologists
- Oncologists
- OB/GYNs
- Rheumatologists
- Orthopedic Surgeons
- Gastroenterologists
- Nephrologists
- Cardiologists

**PCP Care**

**Hospital Care**

**Rehab & Home Care**

**Better Patient Outcomes for All Conditions**

- Diabetes
- Cancer
- Pregnancy
- **Patients**
- Arthritis
- IBD
- CKD
- Heart Failure

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Result: Lower Administrative Costs

PAYERS

PCP APM
Spec APM
Spec APM
Spec APM
Hosp APM
Other APM

PCP Care
Specialist Care
• Endocrinologists
• Oncologists
• OB/GYNs
• Rheumatologists

• Orthopedic Surgeons
• Gastroenterologists
• Nephrologists
• Cardiologists

Hospital Care
Rehab & Home Care

BETTER PATIENT OUTCOMES FOR ALL CONDITIONS
Diabetes | Cancer | Pregnancy | PATIENTS | Arthritis | IBD | CKD | Heart Failure
Result:
More Affordable Health Insurance

EMPLOYERS/PURCHASERS

LOW PREMIUMS

Payers

LOW ADMIN COST

PCP APM

Spec APM

Spec APM

Spec APM

Hosp APM

Other APM

PCP Care

Specialist Care

- Endocrinologists
- Oncologists
- OB/GYNs
- Rheumatologists

- Orthopedic Surgeons
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Hospital Care

Rehab & Home Care

BETTER PATIENT OUTCOMES FOR ALL CONDITIONS

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Healthcare Providers Can’t Change If Every Payer is Paying Differently

**Specialist Care**
- Endocrinologists
- Oncologists
- OB/GYNs
- Rheumatologists
- Orthopedic Surgeons
- Gastroenterologists
- Nephrologists
- Cardiologists

**PCP Care**

**Hospital Care**

**Rehab & Home Care**

**Healthcare Providers Can’t Change If Every Payer is Paying Differently**
All Payers Need to Participate in Common Payment Models

- **PCP APM**
  - PCP Care

- **Spec APM**
  - Specialist Care
    - Endocrinologists
    - Oncologists
    - OB/GYNs
    - Rheumatologists

- **Spec APM**
  - Orthopedic Surgeons
  - Gastroenterologists
  - Nephrologists
  - Cardiologists

- **Hosp APM**
  - Hospital Care

- **Other APM**
  - Rehab & Home Care

- **Diabetes**
- **Cancer**
- **Pregnancy**
- **PATIENTS**
- **Arthritis**
- **IBD**
- **CKD**
- **Heart Failure**

**Patients**

- Diabetes
- Cancer
- Pregnancy
- **PATIENTS**
- Arthritis
- IBD
- CKD
- Heart Failure

**Payment Models**

- EMPLOYERS
  - PREMIUM$
- HEALTH PLAN

- STATE GOV’T
  - $
- MEDICAID MCOs

- CMS
  - $
- MEDICARE ADV.

- MEDICARE
  - $

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Traditional Routes to Payment and Delivery Reform

Payment Model to Support High-Value Care Delivery

CMS

Medicare Beneficiaries

Health Plans

Commercially-Insured Patients

Medicaid MCOs

Medicaid Patients
Roadblocks to Reform

Payment Model to Support High-Value Care Delivery

CMS

Medicare Beneficiaries

Health Plans

Commercially-Insured Patients

Medicaid MCOs

Medicaid Patients
Routes Around the Roadblocks: PTAC

Payment Model to Support High-Value Care Delivery

- CMS
  - Medicare Beneficiaries
- PTAC
- Health Plans
  - Commercially-Insured Patients
- Medicaid MCOs
  - Medicaid Patients
Physician-Focused Payment Model Technical Advisory Committee

Routes Around the Roadblocks: Direct Contracts with Purchasers

Payment Model to Support High-Value Care Delivery

- CMS
- PTAC
- Health Plans
- Purchasers
- Medicaid MCOs

Medicare Beneficiaries
Commercially-Insured Patients
Medicaid Patients
Routes Around the Roadblocks: Exchanges as Active Purchasers

Payment Model to Support High-Value Care Delivery

CMS

Medicare Beneficiaries

PTAC

Commercially-Insured Patients

Health Plans

Purchasers

Medicaid MCOs

Medicaid Patients
Routes Around the Roadblocks: States as Active Purchasers

Payment Model to Support High-Value Care Delivery

CMS → Medicare Beneficiaries

PTAC → Commercially-Insured Patients

Health Plans → Purchasers

Purchasers → Exchanges

Exchanges → Medicaid MCOs

Medicaid MCOs → Medicaid Patients

State Gov’t
Purchasers/Payers Need A Better Product to Buy!

CMS APM “Framework”

Category 1: Fee for Service – No Link to Quality & Value
Category 2: Fee for Service – Link to Quality & Value
Category 3: APMs based on Fee-for-Service Architecture
Category 4: Population-Based Payment

FFS, FFS, P4P, More "Risk"
Providers Need to Design Better Payment/Delivery Models

CMS APM “Framework”

- Category 1: Fee for Service – No Link to Quality & Value
- Category 2: Fee for Service – Link to Quality & Value
- Category 3: APMs Based on Fee-for-Service Architecture
- Category 4: Population-Based Payment

TRUE ALTERNATIVE PAYMENT MODELS

SAVINGS

- LOWER AVOIDABLE SPENDING
- ADEQUATE, FLEXIBLE PAYMENT FOR HIGH-VALUE SERVICES

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: Warranted Payment for Physician Services
APM #6: Episode Payment for a Procedure
APM #7: Condition-Based Payment

www.PaymentReform.org

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Many Things Necessary for Win-Win-Win Solutions

Implementing Alternative Payment Models Successfully
All Healthcare Providers Need to Be Involved

Implementing Alternative Payment Models Successfully

Primary Care
Specialists
Hospitals
Rehab & Home Care
Multiple Types of Data Needed to Design the Payment Model

Implementing Alternative Payment Models Successfully

- Claims Data
- Clinical Data
- Outcomes Data
- Cost Data

- Primary Care
- Specialists
- Hospitals
- Rehab & Home Care
Purchasers and Payers Need to Support Implementation

Implementing Alternative Payment Models Successfully

- Claims Data
- Clinical Data
- Outcomes Data
- Cost Data

Engagement of All Purchasers

Alignment of All Payers

Primary Care
Specialists
Hospitals
Rehab & Home Care
Patients Need to Be Engaged and Supportive

Implementing Alternative Payment Models Successfully
This is Only Feasible at the Regional Level, with a Facilitator
Instead of Win-Lose Strategies That Ultimately Harm Patients...

- Hospitals
  - Acquiring MDs
  - Battle Over RVUs
  - Inadequate # of PCPs

- Specialists
  - Inadequate Payment for High-Quality Care

- Drug & Device Firms
  - Unaffordable Drugs & Devices

- CMS
  - Cost-Shifting Through Underpayment

- Employers
  - Inability to Provide Coverage

- Patients
  - Fragmented, Expensive Poor Quality Care
  - Inadequate Payment for High-Quality Care
Collaborating to Create
Sustainable High-Value Healthcare

CMS

Drug & Device Firms

Savings for Medicare

Innovation for High-Value Care

WIN-WIN-WIN

Hospitals

Savings for Employers

High Quality, Financially Viable PCPs, Specialists, & Hospitals

Specialists

Patients

Employers

High Quality, Affordable Care

Savings for Employers

CMS

Drug & Device Firms

Hospitals

Specialists

PCPs

Patients

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Learn More About Win-Win-Win Payment and Delivery Reform

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