WHY “VALUE-BASED” PAYMENT ISN’T WORKING AND HOW PHYSICIANS CAN FIX IT

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

www.CHQPR.org
The Biggest Barrier to Coverage is the High Cost of Health Care
Typical Cost Control Strategy #1: Cut Provider Fees for Services

COST OF HEALTHCARE

COST OF HEALTHCARE

COST OF HEALTHCARE

COST OF HEALTHCARE (FOR PAYERS)

SAVINGS

Cut Provider Fees
Typical Cost Control Strategy #2: Shift Costs to Patients

- Higher Cost-Share & Deductibles

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Typical Cost Control Strategy #3: Delay or Deny Care to Patients

- Cost of Health Care (for payers)
- Delay/Deny Needed Care

Reached savings with delay/deny of needed care.
Results of Typical Cost-Control Strategies

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

Fee for Service Payment (FFS)

Fee for Service Payment (FFS)

Fee for Service Payment (FFS)

“VALUE-BASED” PAYMENT

SAVINGS?
Will “Getting Rid” of FFS Solve the Problem?

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

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

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

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

$27 Phone Call
Health Plans Don’t Pay for Phone Calls

$27
Health Plans Only Pay for Face-to-Face Visits with Physician

- $75 for Physician Office Visit
- $27 for Phone Call
What if the Patient is Too Sick to Drive or Has No Transportation?

- Phone Call: $27
- Physician Office Visit: $150
- Transport to Office: $27

Diagram showing costs associated with different options for patients who cannot drive.
Health Plans Don’t Pay for Transportation to Doctor’s Office

- Physician Office Visit: $150
- Transport to Office: $27
- Phone Call: $150

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Payers WILL Pay for an ED Visit

$480+

Emergency Department Visit

$150

Physician Office Visit

$27

Transport to Office

Phone Call
Payers WILL Pay for an ED Visit AND the Ambulance to Get There

- Phone Call: $27
- Physician Office Visit: $150
- Transport to Office: $150
- Ambulance to Hospital: $700+

$
A Phone Call That Prevented an ED Visit Would Save a Lot of $
There is No Fee for Many High-Value Services

- Services other than office visits, such as phone calls & e-mails
- Services delivered by non-clinicians, e.g., nurses, community health workers, etc.
- Communication between physicians to ensure accurate diagnosis & coordinate care
- Non-medical services, e.g., transportation
- Palliative care for patients at end of life
The Real Problems with (Current) FFS Payment Systems

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

2. No assurance that a patient will receive appropriate, high-quality care
Payment When the Treatment is Appropriate

$\uparrow$

APPROPRIATE TREATMENT

PAYMENT FOR TREATMENT OF HEALTH PROBLEM
Payment When the Treatment is Inappropriate

$\uparrow$

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<tr>
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Payment When the Treatment Makes Things Worse

- **Appropriate Treatment**
  - Payment for treatment of health problem

- **Inappropriate Treatment**
  - Payment for treatment of health problem

- **Poor Quality Treatment**
  - Payment for treatment of complications
We Don’t Pay for Other Products & Services This Way
We Don’t Pay for Other Products & Services This Way

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

HCPCS Codes (Hierarchical Car Parts Compensation System)
And Pay Auto Workers Based On How Many Parts They Installed

HCPCS Codes (Hierarchical Car Parts Compensation System)

AMA Automobile Manufacturing Association

CPT System (Car Parts Tokens)
The Result for Drivers
If We Paid That Way…
The Result for Drivers
If We Paid That Way…

Cars would get many unnecessary parts
The Result for Drivers
If We Paid That Way…

Cars would get many unnecessary parts

Cars would be “readmitted” to the factory frequently to correct malfunctions
Do “Value-Based” Payments Solve the Problems With FFS?

$FFS$

Unpaid & Underpaid Services

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

- FFS
- MIPS/P4P
- Unpaid & Underpaid Services
- Merit-Based Incentive Payment System (MIPS)
MIPS/P4P = FFS + Bonuses/Penalties

- Unpaid & Underpaid Services
- No New Payments
- All Current FFS Payments
- No Change in What Services Are Paid For

Bonuses & Penalties Based on Quality Measures
In MIPS/P4P, If Quality is Average, No Change in Payment at All

- FFS: Unpaid & Underpaid Services
- FFS: All Current FFS Payments
- MIPS/P4P: No New Payments
- Payment for Appropriate Treatment
- Payment for Inappropriate Treatment
- Treatment of Complications
If Quality is *Below* Average, Lower Payments for All Services

- **FFS**
  - Unpaid & Underpaid Services
  - All Current FFS Payments
  - No New Payments

- **MIPS/P4P**
  - Bonus
  - Penalty

- **Payment for Approp. Treatment**
  - Penalty

- **Payment for Inapprop. Treatment**
  - Penalty

- **Payment for Treatment of Complications**
  - Penalty

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If Quality is Above Average, Bonuses for Good & Bad Services

- **Unpaid & Underpaid Services**
  - FFS
  - All Current FFS Payments

- **No New Payments**
  - FFS

- **PAYMENT FOR APPROP. TREATMENT**
  - Bonus

- **PAYMENT FOR INAPPROP. TREATMENT**
  - Bonus

- **TREATMENT OF COMPLICATIONS**
  - Bonus

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

There is no bonus unless other physicians get a penalty.

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

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

- **FFS**: No New Payments
- **MIPS/P4P**: Bonus Penalty
- **APMs**: Alternative Payment Models

Unpaid & Underpaid Services

No New Payments
In MACRA, Congress *Encouraged* Use of APMs Instead of MIPS

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

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

ALTERNATIVE PAYMENT MODELS

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

- Comp. Primary Care Initiative (CPC+)
- Comp. Care for Joint Rep. (CJR)
- Medicare Shared Savings Program ACOs
- Oncology Care Model (OCM)
- Bundled Pmts for Care Imp. (BPCI)

FFS

Unpaid & Underpaid Services

All Current FFS Payments

No New Payments

Bonus Penalty

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Only 2 CMS APMs Pay for Things Standard FFS Doesn’t Cover

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<tr>
<th>Alternative Payment Models</th>
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<td>Medicare Shared Savings Program ACOs</td>
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<td>Bonus New Per-Patient Payment</td>
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“Bundles” Pay Standard FFS + Bonus/Penalty for Total Spending

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

Unpaid & Underpaid Services

No New Payments

Bonus New Per-Patient Payment

No New Payments

Medicare Shared Savings Program ACOs
ACOs Get Standard FFS w/ "Shared Savings" Payments

- Unpaid & Underpaid Services
- No New Payments
- Bonus New Per-Patient Payment
- Bonus Penalty
- No New Payments
- No New Payments
Most CMS “APMs” Are Just FFS + P4P Based on Spending

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## Little Change in Payment Means Little Savings from CMS APMs

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<th>Results</th>
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<tr>
<td>Comprehensive Primary Care Initiative (CPCI)</td>
<td>Increase in Medicare spending</td>
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<tr>
<td>Comprehensive Primary Care Plus (CPC+)</td>
<td>Increase in spending in first 2 years</td>
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<tr>
<td>Oncology Care Model (OCM)</td>
<td>Increase in spending in first 3 years</td>
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<tr>
<td>Comprehensive Care for Joint Replacement (CJR)</td>
<td>Savings of $117 (0.4%) per episode</td>
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<tr>
<td>Bundled Payments for Care Improvement (BPCI)</td>
<td>Increase in Medicare spending</td>
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<tr>
<td>Accountable Care Organizations (ACOs)</td>
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<tr>
<td>MSSP ACOs 2013-2016</td>
<td>Increase in Medicare spending</td>
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<tr>
<td>MSSP ACOs 2017</td>
<td>Savings of $36 (0.3%) per beneficiary</td>
</tr>
<tr>
<td>MSSP ACOs 2018</td>
<td>Savings of $75 (0.7%) per beneficiary</td>
</tr>
<tr>
<td>MSSP ACOs 2019</td>
<td>Savings of $118 (1.0%) per beneficiary</td>
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<td>NextGen ACOs</td>
<td>Increase in spending in first 2 years</td>
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Since Current APMs Aren’t Reducing Spending…

ALTERNATIVE PAYMENT MODELS

MIPS/P4P  
CPC+/OCM  
CJR/BPCI  
MSSP

Unpaid & Underpaid Services

FFS All Current FFS Payments

FFS No New Payments

FFS Bonus New Per-Patient Payment

FFS No New Payments

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FFS No New Payments

Medicare Spending Under APMs

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...CMS Wants to Put Physicians at Risk for Reducing Spending
CMS-Funded “LAN” Says Best APM is “Population-Based Pmt”
“Population-Based Payment” = Capitation

- Physician groups form or join Accountable Care Organizations and receive a monthly payment for each patient instead of fees for services
- All of the healthcare services the patients need must be paid for out of this monthly amount
- Monthly payments are reduced if quality measures are below average compared with other providers
Is “Population-Based Payment” Better Than Fee for Service?
Population-Based Payment: $ for Appropriate Treatment

APPROPRIATE TREATMENT

POPULATION-BASED PAYMENT FOR TREATMENT OF HEALTH PROBLEM
Population-Based Payment: $ for Inappropriate Treatment

- Population-Based Payment for Treatment of Health Problem
- Inappropriate Treatment
Population-Based Payment: No Extra $ for Complications

- **Appropriate Treatment**
  - Population-based payment for treatment of health problem

- **Inappropriate Treatment**
  - Population-based payment for treatment of health problem

- **Poor Quality Treatment**
  - Population-based payment for treatment of health problem
  - No extra payment for complications

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Population-Based Payment: $ When Problems Are Ignored

- **Appropriate Treatment**: Population-based payment for treatment of health problem.
- **Inappropriate Treatment**: Population-based payment for treatment of health problem.
- **Poor Quality Treatment**: Population-based payment for treatment of health problem.
- **Lack of Treatment**: Population-based payment if no treatment is provided for health problem.

No extra payment for complications.
Quality Measures Don’t Measure Many Key Aspects of Quality

ACO Quality Measures

• Patient Experience (10)
  • Timely Care
  • Provider Communication
  • Rating of Provider
  • Access to Specialists
  • Health Promotion & Education
  • Shared Decision-Making
  • Health Status
  • Stewardship of Patient Resources
  • Courteous and Helpful Office Staff
  • Care Coordination
• All-Cause Readmission Rate
• Admissions for Patients w/ Multiple Chronic Conditions
• Composite Prevention Quality Indicator
• Fall Risk Screening
• Influenza Immunization
• Tobacco Use Screening and Intervention
• Depression Screening and Plan
• Depression Remission
• Colon Cancer Screening
• Breast Cancer Screening
• Blood Pressure Control
• Statin Therapy for Cardiovascular Disease
• Diabetes HbA1c Control

No Measures to Assure:

• Evidence-based treatment of asthma or allergies
• Evidence-based treatment for cancer
• Evidence-based treatment for rheumatoid arthritis
• Evidence-based treatment of inflammatory bowel disease
• Delivery of high-quality cataract & retinal surgery
• Rapid treatment and rehabilitation for stroke
• Effective management for joint pain and mobility
• Effective management of back pain and mobility
• Access to and quality of care for many other conditions
Why Wouldn’t a Health Plan Want to Give Its Risk to Someone Else?
Health Plan Collects Premiums…
Takes Its Cut Off the Top & Uses the Rest for “Population Payment”
The ACO Then Has to Incur Admin. Costs to Manage Risk

The ACO then has to incur admin. costs to manage risk. This is typically done through a capitation model, where the ACO receives a fixed payment for each member of the population. The ACO must then manage the risk associated with providing healthcare services to these members. The funds available for services to patients are then determined by the health plan, after the admin. & profits and admin. cost have been accounted for.
…And if the Patients Need More Services Than Funds Available…

HEALTH INSURANCE PLAN

HEALTH PLAN ADMIN. & PROFITS

“POPULATION BASED PAYMENT” (CAPITATION)

“ACO”

ACO ADMIN. COST

Funds Available for Services to Patients

COST OF SERVICES PATIENTS NEED

PATIENTS
Physicians are Forced to Figure Out Which Services to Withhold

Healthcare Plan Administration & Profits

Healthcare Plan Premium Revenue

“Population Based Payment” (CAPITATION)

ACO Administration Cost

Funds Available for Services to Patients

Service Cuts

Services Delivered to Patients

Cost of Services Patients Need

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Physicians are Forced to Figure Out Which Services to Withhold

"POPULATION BASED PAYMENT" (CAPITATION)

HEALTH PLAN ADMIN. & PROFITS

FUNDS AVAILABLE FOR SERVICES TO PATIENTS

ACO ADMIN. COST

ACO IN. COST

SERVICES DELIVERED TO PATIENTS

COST OF SERVICES PATIENTS NEED

WHY DO YOU NEED A HEALTH PLAN AT ALL IF THE PHYSICIANS ARE GOING TO TAKE FULL RISK?
This is NOT a Good “Framework” for Fixing Healthcare Payment…
…And Following It Will Likely Make Things Worse, Not Better
Value-Based Payment Is Being Designed the Wrong Way Today
Value-Based Payment Is Being Designed the **Wrong** Way Today

**TOP-DOWN PAYMENT REFORM**

Medicare and Health Plans Define Payment Systems
Value-Based Payment Is Being Designed the *Wrong* Way Today

**TOP-DOWN PAYMENT REFORM**

Medicare and Health Plans Define Payment Systems

Physicians and Hospitals Have To Change Care to Align With Payment Systems
Value-Based Payment Is Being Designed the \textit{Wrong} Way Today

\textbf{TOP-DOWN PAYMENT REFORM}

- Medicare and Health Plans Define Payment Systems
- Physicians and Hospitals Have To Change Care to Align With Payment Systems
- Patients Get Worse Care and Providers Close/Consolidate
Is There a Better Way?

TOP-DOWN PAYMENT REFORM

Medicare and Health Plans Define Payment Systems

Physicians and Hospitals Have To Change Care to Align With Payment Systems

Patients Get Worse Care and Providers Close/Consolidate
Start By Identifying Ways to Improve Care & Reduce Costs…

TOP-DOWN PAYMENT REFORM

Medicare and Health Plans Define Payment Systems

Physicians and Hospitals Have To Change Care to Align With Payment Systems

Patients Get Worse Care and Providers Close/Consolidate

BOTTOM-UP PAYMENT REFORM

Ask Physicians to Identify Ways to Improve Care for Patients and Eliminate Avoidable Costs
…Pay Adequately & Expect Accountability for Outcomes…

**TOP-DOWN PAYMENT REFORM**

- Medicare and Health Plans Define Payment Systems
- Physicians and Hospitals Have To Change Care to Align With Payment Systems
- Patients Get Worse Care and Providers Close/Consolidate

**BOTTOM-UP PAYMENT REFORM**

- Payers Provide Adequate Payment for Quality Care & Physicians Take Accountability for Quality & Efficiency
- Ask Physicians to Identify Ways to Improve Care for Patients and Eliminate Avoidable Costs
…So the Result is Better, More Affordable Patient Care

**TOP-DOWN PAYMENT REFORM**

- Medicare and Health Plans Define Payment Systems
- Physicians and Hospitals Have To Change Care to Align With Payment Systems
- Patients Get Worse Care and Providers Close/Consolidate

**BOTTOM-UP PAYMENT REFORM**

- Patients Get Good Care at an Affordable Cost and Independent Physicians Remain Financially Viable
- Payers Provide Adequate Payment for Quality Care & Physicians Take Accountability for Quality & Efficiency
- Ask Physicians to Identify Ways to Improve Care for Patients and Eliminate Avoidable Costs
How Do We Control Healthcare Costs by *Improving* Patient Care?
Focus on Spending
That is *Unnecessary* or *Avoidable*

![Diagram showing spending categories over time](chart.png)
Avoidable Spending Occurs In All Aspects of Healthcare

**NECESSARY SERVICES**

**AVOIDABLE SPENDING**

**CHRONIC DISEASE**
- ED visits for exacerbations
- Hospital admissions and readmissions
- Preventable progression of disease
- Preventable chronic conditions

**MATERNITY CARE**
- Unnecessary C-Sections
- Early elective deliveries
- Underuse of birth centers

**CANCER TREATMENT**
- Use of unnecessarily-expensive drugs
- ED visits/hospital stays for dehydration and avoidable complications
- Fruitless treatment at end of life

**SURGERY**
- Unnecessary surgery
- Use of unnecessarily-expensively implants
- Infections and complications of surgery
- Overuse of inpatient rehabilitation
Many Low-Value Services Can Be Avoided Without Harming Patients
Institute of Medicine Estimate: 30% of Spending is Avoidable

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

**UNNECESSARY SERVICES**
- Overuse: services beyond evidence-established levels
- Discretionary use beyond benchmarks
  - Defensive medicine
- Unnecessary choice of higher cost services

**INEFFICIENTLY DELIVERED SERVICES**
- Mistakes—medical errors, preventable complications
- Care fragmentation
- Unnecessary use of higher cost providers
- Operational inefficiencies at care delivery sites
  - Physician offices
  - Hospitals

**EXCESS ADMINISTRATIVE COSTS**
- Insurance-related administrative costs beyond benchmarks
  - Insurers
  - Physician offices
  - Hospitals
  - Other providers
- Insurer administrative inefficiencies
- Care documentation requirement inefficiencies

**PRICES THAT ARE TOO HIGH**
- Service prices beyond competitive benchmarks
  - Physician services
    - Specialists
    - Generalists
  - Hospital services
- Product prices beyond competitive benchmarks
  - Pharmaceuticals
  - Medical devices
  - Durable medical equipment

**MISSED PREVENTION OPPORTUNITIES**
- Primary prevention
- Secondary prevention
- Tertiary prevention

**FRAUD**
- All sources—payer, clinician, patient

Total excess = $210 B*

Total excess = $130 B*

Total excess = $190 B*

Total excess = $105 B*

Total excess = $55 B*

Total excess = $75 B*

*Lower bound totals of various estimates, adjusted to 2009 total expenditure level.
The Goal: Less Avoidable $,
The Goal: Less Avoidable $, More Necessary Services
Value-Based Care Delivery is a Win-Win for Patients & Payers

Better Care for Patients

Lower Spending for Payers

$NECESSARY SERVICES

$AVOIDABLE SPENDING

$NECESSARY SERVICES

$SAVINGS

$AVOIDABLE SPENDING

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Barrier: Inadequate Payments for High-Value Services

Delivering these services improves value for payers and patients, but causes financial losses for healthcare providers.

Avoidable spending often occurs because payments are inadequate (or non-existent) for alternative, higher-value services.

LOW $ FOR HIGH-VALUE SERVICES
NECESSARY SERVICES
AVOIDABLE SPENDING

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Example: Value-Based Care for Inflammatory Bowel Disease (IBD)

Lawrence Kosinski, MD
Gastroenterologist
Chicago, USA

“Project Sonar”
www.SonarMD.com
Opportunity for Savings in IBD

AVOIDABLE SPENDING OPPORTUNITY:
- >50% of spending for patients with inflammatory bowel disease paid for hospital admissions of patients with exacerbations of their disease
- <33% of hospitalized patients saw their physician in the 30 days prior to hospital admission

Lawrence Kosinski, MD
Gastroenterologist
Chicago, USA

“Project Sonar”
www.SonarMD.com
Higher-Value Approach to Care for IBD Patients

AVOIDABLE SPENDING OPPORTUNITY:
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• <33% of hospitalized patients saw their physician in the 30 days prior to hospital admission

CARE REDESIGN:
• Proactive outreach to patients and monitoring of their symptoms using a smartphone app ("Sonar")
• Early intervention by nurse and physician when problematic symptoms are identified

Lawrence Kosinski, MD
Gastroenterologist
Chicago, USA

“Project Sonar”
www.SonarMD.com
Change to Overcome Barriers in Current Payments

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PAYMENT CHANGE:
• Additional payment to physician practice to hire nurse and use symptom monitoring technology

Lawrence Kosinski, MD
Gastroenterologist
Chicago, USA

“Project Sonar”
www.SonarMD.com
Result: Better Care at Lower Cost for IBD

AVOIDABLE SPENDING OPPORTUNITY:
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• Early intervention by nurse and physician when problematic symptoms are identified

PAYMENT CHANGE:
• Additional payment to physician practice to hire nurse and use symptom monitoring technology

RESULTS:
• 50% reduction in hospital admissions
• 10% reduction in total spending even with higher payments to physician practice for nurse
How Do You Create a Good Alternative Payment Model?

$\text{FFS} \rightarrow \text{GOOD ALTERNATIVE PAYMENT MODEL}$

UNPAID SERVICES → SAVINGS
Step 1: Identify *Specific* Areas of Potentially Avoidable Spending

- Avoidable Hospital Admissions
- Unnecessary Tests and Procedures
- Unnecessarily Expensive Treatments
- Preventable Complications of Treatment
- Treatment of Late-Stage Disease
Step 2: Design Services That Will Reduce The Avoidable Spending

Current Fee-for-Service

NECESSARY SERVICES

AVOIDABLE SPENDING

SERVICES THAT PREVENT AVOIDABLE SPENDING

SAVINGS

SERVICES NEEDED TO REDUCE THE IDENTIFIED AVOIDABLE SPENDING

- Care Management
- Care Coordination
- Lower-Cost Treatments
- Prevention & Screening
Step 3: Pay Adequately to Support Higher-Value Services

- Current Fee-for-Service

- Avoidable Spending
  - NECESSARY SERVICES
    - Unpaid Services
  - AVOIDABLE SPENDING
    - Services that prevent avoidable spending
    - Loss of revenue

- Savings
  - Avoidable Spending
  - Adequate payment for higher-value services

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Physicians Need to Determine the Cost to Deliver High-Value Care

**Current Fee-for-Service**

- **AVOIDABLE SPENDING**
  - NECESSARY SERVICES
  - UNPAID SERVICES
- **SAVINGS**
  - SERVICES THAT PREVENT AVOIDABLE SPENDING
  - LOSS OF REVENUE
- **COST OF HIGH-QUALITY SERVICE DELIVERY**
- **SAVINGS**
  - ADEQUATE PAYMENT FOR HIGHER-VALUE SERVICES
Step 4: Accountability for Quality and Appropriateness

Current Fee-for-Service

$\

AVOIDABLE SPENDING

NECESSARY SERVICES

UNPAID SERVICES

SAVINGS

AVOIDABLE SPENDING

SERVICES THAT PREVENT AVOIDABLE SPENDING

LOSS OF REVENUE

SAVINGS

AVOIDABLE SPENDING

ADEQUATE PAYMENT FOR HIGHER-VALUE SERVICES

Accountability for Reducing Avoidable Spending
Instead of *No Accountability* Under Fee-for-Service

---

**FEE FOR SERVICE PAYMENT**

- **APPROPRIATE TREATMENT**
  - Payment for treatment of health problem

- **INAPPROPRIATE TREATMENT**
  - Payment for treatment of health problem

- **POOR QUALITY TREATMENT**
  - Payment for treatment of complications

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Accountability for Quality and Appropriateness of Services

TRUE VALUE-BASED PAYMENT

$\uparrow$

- **APPROPRIATE TREATMENT**
  - HIGHER PAYMENT FOR APPROPRIATE HIGH-QUALITY TREATMENT

- **INAPPROPRIATE TREATMENT**
  - NO PAYMENT FOR INAPPROPRIATE TREATMENT

- **POOR QUALITY TREATMENT**
  - NO EXTRA PAYMENT FOR TREATMENT OF COMPLICATIONS
  - NET PAYMENT FOR TREATMENT AFTER ADDRESSING COMPLICATIONS
Physicians Can NOT Be Held Accountable for Total Spending

Total Spending Per Patient

$\$\$

Healthcare Spending

Payments to the Physician

Total Spending on All Services the Physician’s Patients Receive for All Conditions from All Providers

Accountability for Reducing Total Spending
Physicians *Can* Be Accountable For What They Can Control

- Spending the Physician *Cannot* Control
  - e.g., PCPs and allergists can’t prevent asthma
  - e.g., physicians can’t control the price of drugs

- Avoidable Spending the Physician *Can* Control or Influence
  - e.g., PCPs can consult with and refer to appropriate specialists to ensure accurate diagnosis
  - e.g., physicians can choose the most cost-effective drugs from among the drugs available at the prices charged by manufacturers

- Payments to the Physician

### Total Spending Per Patient

$
Needs & Opportunities for Savings Differ Among Patients

- Lower Need Patients
- Medium Need Patients
- Higher Need Patients

Avoidable Spending

Necessary Services

Unpaid Services

Lower Need Patients

Medium Need Patients

Higher Need Patients

$
Payers Can’t Pay the Same Amount for Every Patient

- Lower Need Patients
- Medium Need Patients
- Higher Need Patients

Avoidable Spending

- Same Payment for All Patients
- Necessary Services

Unpaid Services

Lower Need Patients:
- Avoidable Spending
- Necessary Services
- Unpaid Svc

Medium Need Patients:
- Avoidable Spending
- Necessary Services
- Unpaid Services

Higher Need Patients:
- Necessary Services
- Same Payment for All Patients
- Unpaid Services

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Payments Stratified Based on Differences in Patient Needs

- **Lower Need Patients**
  - Avoidable Spending
  - Necessary Services
  - Payments for Low-Need Patients
- **Medium Need Patients**
  - Avoidable Spending
  - Necessary Services
  - Payment for Medium-Need Patients
- **Higher Need Patients**
  - Avoidable Spending
  - Necessary Services
  - Payment for High-Need Patients

- Savings
Good Alternative Payment Models Can Be Win-Win-Wins

Current Fee-for-Service

- AVOIDABLE SPENDING
  - NECESSARY SERVICES
  - UNPAID SERVICES
  - LOSS OF REVENUE

SAVINGS

- SERVICES THAT PREVENT AVOIDABLE SPENDING

Alternative Payment Model

- AVOIDABLE SPENDING
  - ADEQUATE PAYMENT FOR HIGHER-VALUE SERVICES

SAVINGS

Win for Payers:
- Lower Total Spending

Win for Patients:
- Better Care Without Unnecessary Services

Win for Physicians:
- Adequate Payment for High-Value Services

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What Would a Good APM Look Like for Allergy & Asthma Specialists?
ACAAI Began Work on an APM Long Before Other Specialties

• ACAAI Alternative Payments Subcommittee began working to develop an APM for allergy and asthma specialists in 2015, shortly after MACRA was passed.
  – Co-Chairs: Steve Imbeau and Jim Tracy
  – Members: J. Allen Meadows, Travis Miller, Brian Smart, Steve Tilles, Kay Tyler, and Bill Finerfrock
  – Support from the American Medical Association

• Focused initially on improving payment for asthma care

• All-day working session held in April 2016

• Initial version of Asthma APM prepared during 2016 and 2017

• APM submitted to federal Physician-Focused Payment Model Technical Advisory Committee (PTAC) in May 2019

• ACAAI APM reviewed and voted on by PTAC in June 2020
AACAI Patient-Centered Asthma Care Payment (PCACP)

- **Payment for Diagnosis and Initial Treatment.** Monthly payments for up to 3 months to support diagnosis and initial treatment of patients with poorly controlled asthma-like symptoms. The monthly payments replace E/M payments.

- **Payment for Continued Care of Patients with Difficult-to-Control Asthma.** Monthly payments to an Asthma Care Team for management of patients whose symptoms are not being successfully controlled or who are being treated with higher-risk medications. The monthly payments replace E/M payments, and are stratified based on differences in patient needs.

- **Payments to Support Continued Care for Patients with Well-Controlled Asthma.** In addition to standard E/M payments for office visits, the allergist would receive:
  - Payments for telephone calls or emails with patients to address symptoms or medication issues
  - Payments for communications with the patient’s primary care physician to assist in managing the patient’s asthma.

- **Accountability for aspects of quality and spending allergists can control.**
ARLINGTON HEIGHTS, Ill. (September 16, 2020) – The Physician-Focused Payment Model Technical Advisory Committee (PTAC) unanimously voted to refer the American College of Allergy, Asthma & Immunology’s (ACAAI’s) Patient-Centered Asthma Care Payment model (PCACP) to the Department of Health and Human Services (HHS) for special attention and further consideration.

PTAC noted the PCACP model “offers a potentially promising approach for specialty-focused Physician Focused Payment Models.” PTAC’s letter also “commends the submitter’s efforts to improve care for patients with asthma by developing a specialty-based alternative payment model (APM) that would expand APM participation to multiple specialties involved in caring for asthma patients, particularly since asthma patients may be commonly misdiagnosed in primary care or not currently managed efficiently across specialties.”
Implementing Patient-Centered Payments in Medicare

• Congress created PTAC as part of MACRA so physicians could play a more direct role in designing APMs in Medicare.
Implementing Patient-Centered Payments in Medicare

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CMS has refused to implement any of them.
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<table>
<thead>
<tr>
<th>APM Proposals Submitted to PTAC during first 2 years</th>
<th>APMs Recommended by PTAC as of Sept 2019</th>
<th>Recommended APMs Implemented by CMS as of Sept 2020</th>
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</thead>
<tbody>
<tr>
<td>32</td>
<td>16</td>
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- Why? It’s easier for CMS to simply push financial risk onto physicians and hospitals than to make the specific changes in payments that physicians need to deliver the highest-quality care to patients.
- The solution? Physicians need to ask Congress to require CMS to implement the APMs that have been developed by physicians.
Implementing Patient-Centered Payments in Private Health Plans

- Private insurance plans should jump at the chance to implement an alternative payment model that would reduce healthcare spending and improve services to patients, right?
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Implementing Patient-Centered Payments in Private Health Plans

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  - **Fully Insured Plans:** Insurance plans that charge premiums to individuals and small employers are subject to federal Minimum Medical Loss Ratio requirements. If healthcare spending decreases, they must reduce premiums, which reduces their profits. If they have to incur additional administrative costs in order to implement new payment models, the insurance companies have to increase premiums or reduce their profits.
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  – **Self-Insured Plans:** Health insurance companies that administer benefits for larger, self-insured employers incur the administrative costs for implementing new payment models but must pass on any savings in healthcare spending to the employers, so implementing a successful APM could mean the insurance companies either have to raise their fees to employers or reduce their profits.
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• The solution? Physicians should start talking to the real purchasers of healthcare, not health insurance companies.
Employers & Individuals are the True Purchasers of Healthcare

**PURCHASERS**
- Community Employers & Residents

**PROVIDERS**
- Community Physicians
60%+ of Employed Workers Are in Self-Insured Plans

**PURCHASERS**

- **Self-Insured**
  - Community Employers & Residents

**MIDDLEMEN**

- Third Party Administrator (No Risk)
  - The TPA charges a fee to process claims and the employer pays the full cost of the claims

**PROVIDERS**

- FFS
  - Community Physicians
Small Employers & Individuals Purchase Insurance Plans

**PURCHASERS**
- Self-Insured
- Community Employers & Residents
- Premiums

**MIDDLEMEN**
- Third Party Administrator (No Risk)
- Insurance Plan (Full Risk)

**PROVIDERS**
- Community Physicians

Payment flows:
- PURCHASERS → MIDDLEMEN: $ (Premiums)
- MIDDLEMEN → PROVIDERS (Community Physicians): FFS
- MIDDLEMEN → PROVIDERS (Third Party Administrator): FFS

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The Middlemen Refuse to Implement Better Payments

PURCHASERS

- Self-Insured
  - Community Employers &Residents
  - Premiums

MIDDLEMEN

- Third Party Administrator (No Risk)
- STOP
- APM

PROVIDERS

- FFS
  - Community Physicians

FFS

APM

Insurance Plan (Full Risk)
A Better Approach: Purchaser/Provider Partnerships

PURCHASERS

Community Employers & Residents

MIDDLE MEN

Community Physicians

PROVIDERS
Physicians Offer a Better “Product” to Purchasers…

Community Employers & Residents

Lower Cost, Higher Quality Care

Community Physicians

PURCHASERS PROVIDERS
…Purchasers Agree to Pay Adequately for That Product

PURCHASERS

Community Employers & Residents

PROVIDERS

Community Physicians

Lower Cost, Higher Quality Care

Patient-Centered APM
Purchasers and Providers Have Common Interests, But Don’t Know It

“We’ve started talking directly to physicians, and we’ve discovered that what they want to sell is what we want to buy…”

Cheryl DeMars
CEO, The Alliance
(Employer Coalition in Wisconsin)
The Result is a Win-Win for Purchasers & Physicians

Community Employers & Residents

Employers and Patients “win” if:
• Patients receive the care they need
• Healthcare is more affordable

Lower Cost, Higher Quality Care

Patient-Centered APM

Community Physicians

Physicians “win” if:
• Physicians can deliver the care patients need
• Payment is adequate to cover the cost of services
Purchasers (Not Plans) Can Pay for Improved Worker Productivity

Purchasers

- Fewer Hours Away From Work
- Lower Cost, Higher Quality Care
- Patient-Centered APM

Providers

- Physicians can deliver the care patients need
- Payment is adequate to cover the cost of services
- Physicians have flexibility to redesign care delivery

Employers and Patients “win” if:
- Patients receive the care they need
- Healthcare is more affordable
- Employees return to work faster

Community Physicians

Community Employers & Residents

WORKER PRODUCTIVITY

ACCESS TO & COORDINATION OF CARE
Purchasers & Physicians Select Plans That Will Use the APM

**PURCHASERS**

- **Self-Insured**
  - Community Employers & Residents
  - Premiums

  $ \rightarrow \text{Willing TPA} \rightarrow \text{APM}

**PROVIDERS**

- Community Physicians
  - Unwilling TPA
  - FFS

- Health Plan
  - Willing Health Plan
  - APM

- Unwilling Health Plan
  - FFS
Physicians Need to Take the Lead, Not Wait for Payers

Community Employers & Residents

Lower Cost, Higher Quality Care

Patient-Centered APM

Community Physicians

PURCHASERS

PROVIDERS

TOP-DOWN PAYMENT REFORM

Medicare and Health Plans Define Payment Systems

Physicians and Hospitals Have To Change Care to Align with Payment Systems

Patients Get Worse Care and Providers Close/Consolidate

BOTTOM-UP PAYMENT REFORM

Patients Get Good Care at an Affordable Cost and Independent Physicians Remain Financially Viable

Payers Provide Adequate Payment for Quality Care & Physicians Take Accountability for Quality & Efficiency

Ask Physicians to Identify Ways to Improve Care for Patients and Eliminate Avoidable Costs

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What Physicians Need to Do
What Physicians Need to Do

• **Talk to the employers and patients in your community**
  – Demonstrate that you’re delivering high quality care now
  – Make them aware that you want to deliver even better care at lower cost
  – Find out what problems they want to solve and what constraints they face
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- **Develop the details of the services you want to deliver and the payment you need to support them**
  - How much will it cost you to deliver more proactive, cost-effective care?
  - Which unnecessary or avoidable services will you reduce?
  - What data and payments do you need to enable success?
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• Work in collaboration with employers to achieve a win-win
  – Agree on the results you want to achieve and the measures of success
  – Select and contract with the health plans that will support your efforts
  – Review progress frequently and make adjustments to ensure success
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• **Encourage other specialties in your community and other physicians in your specialty nationally to pursue a similar approach**
  – Employers want *all* of their employees to receive better care at lower cost, not just those with one type of health problem or those who receive care from a small number of physician practices
More Details on Creating Value-Based Payment Models

www.PaymentReform.org

Why Value-Based Payment Isn’t Working, and How to Fix It
Creating a Patient-Centered Payment System to Support Higher-Quality, More Affordable Health Care
Harold D. Miller

How to Create an Alternative Payment Model
Designing Value-Based Payments That Support Affordable, High-Quality Healthcare Services
Harold D. Miller

PATIENT-CENTERED ASTHMA CARE PAYMENT
AN ALTERNATIVE PAYMENT MODEL FOR PATIENT-CENTERED ASTHMA CARE
Executive Summary

Submitted by:
American College of Allergy, Asthma & Immunology
The Advocacy Council of ACAAI
85 W. Algonquin Rd.
Arlington Heights, IL 60005
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