CENTER FOR
HEALTHCARE
QUALITY &
PAYMENT REFORM

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

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

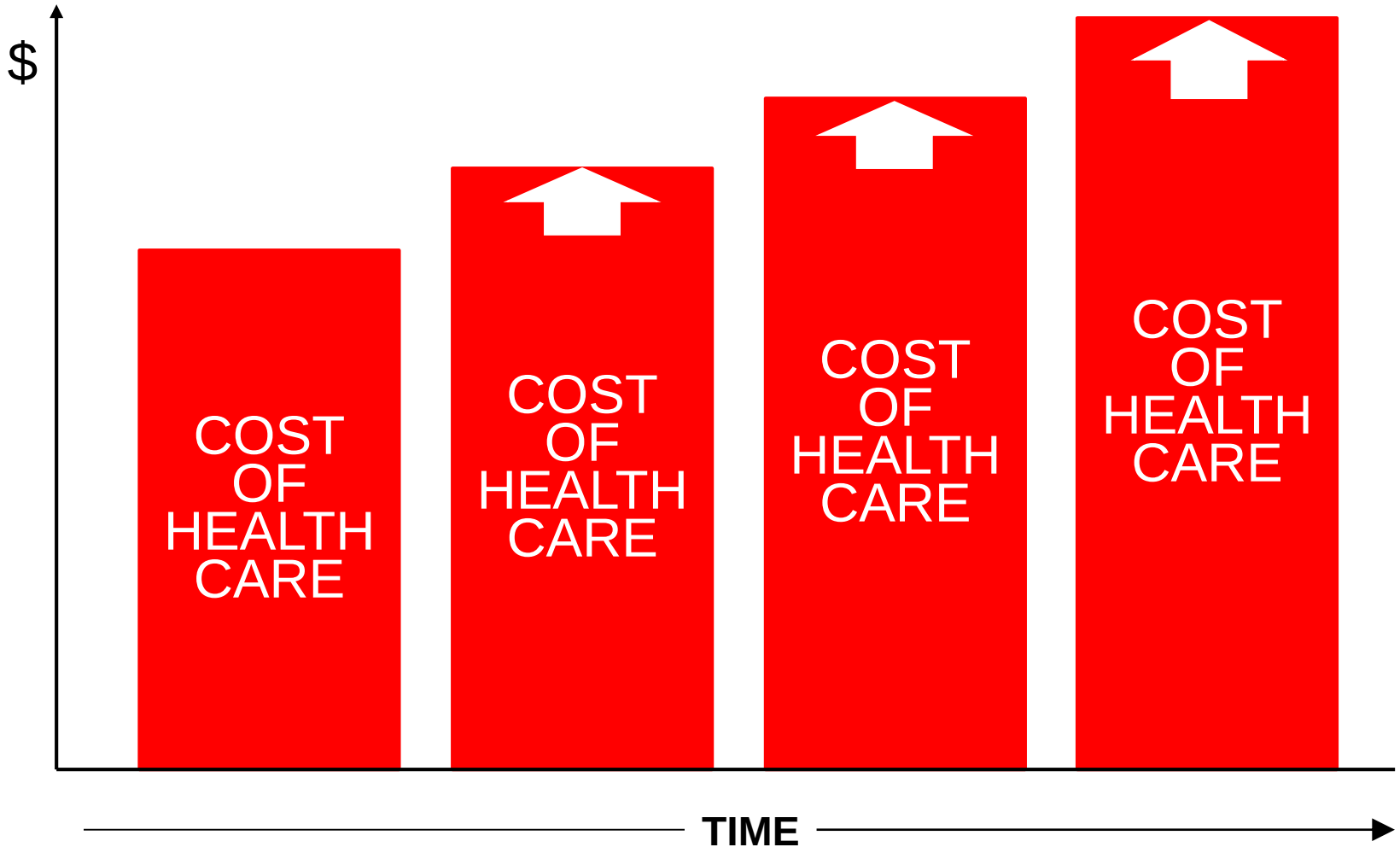
www.CHQPR.org

PLEASE NOTE:

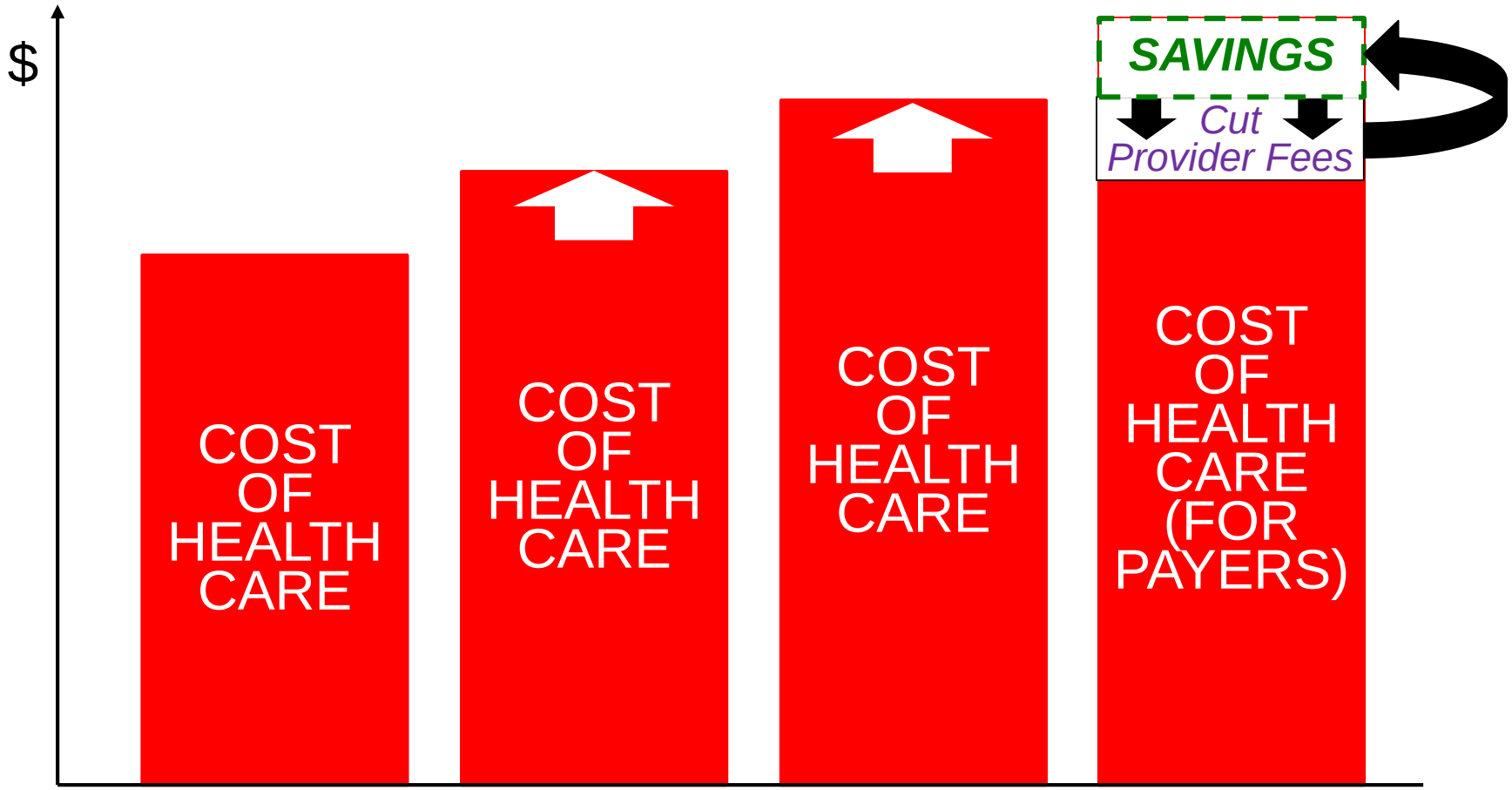
I am one of the 11 members of the Physician-Focused Payment Model Technical Advisory Committee (PTAC), but my comments today reflect my *personal* opinions.

My comments do not represent official positions of the PTAC, and other PTAC members may or may not agree with them.

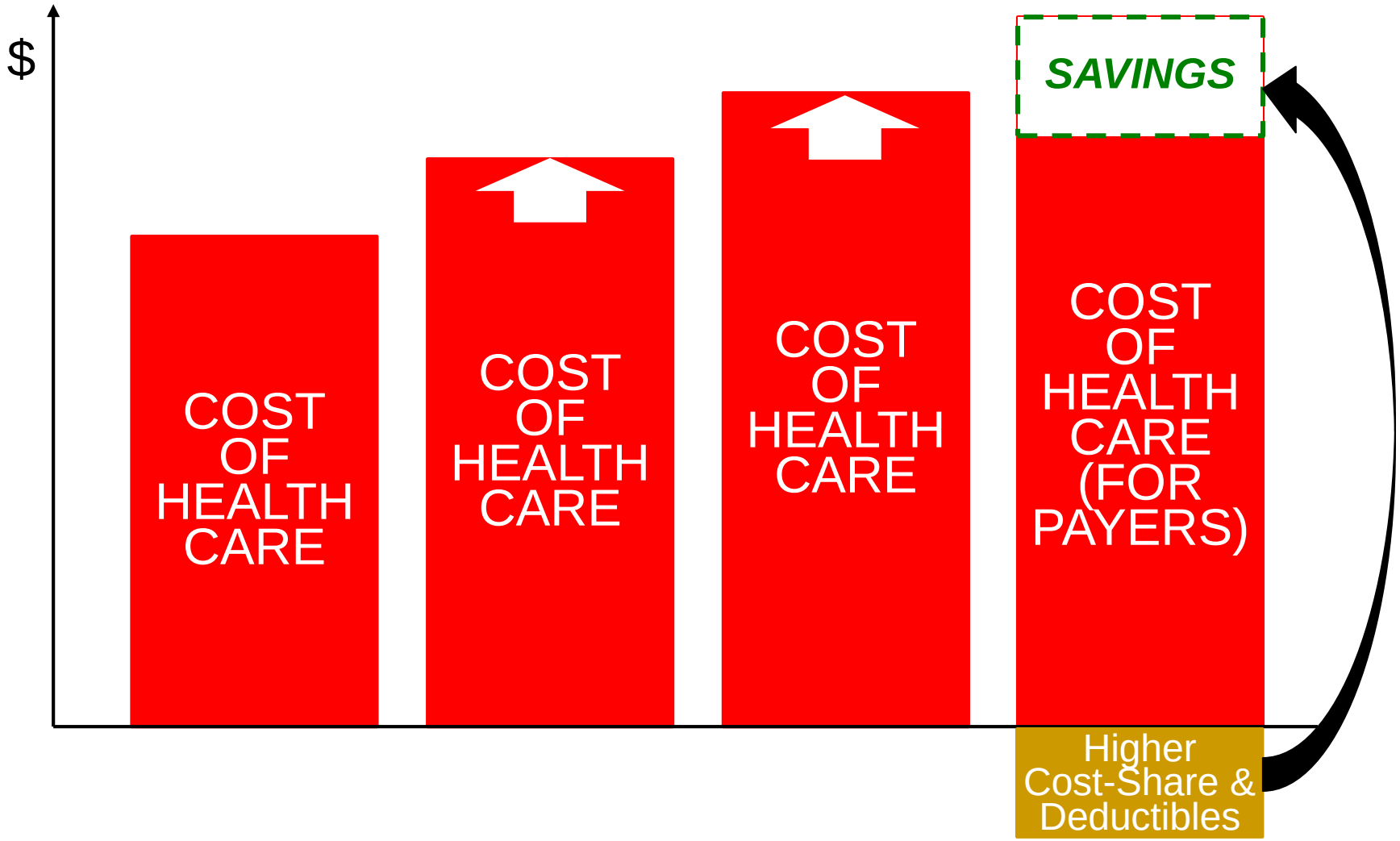
The Biggest Barrier to *Coverage* is the High *Cost* of Health Care



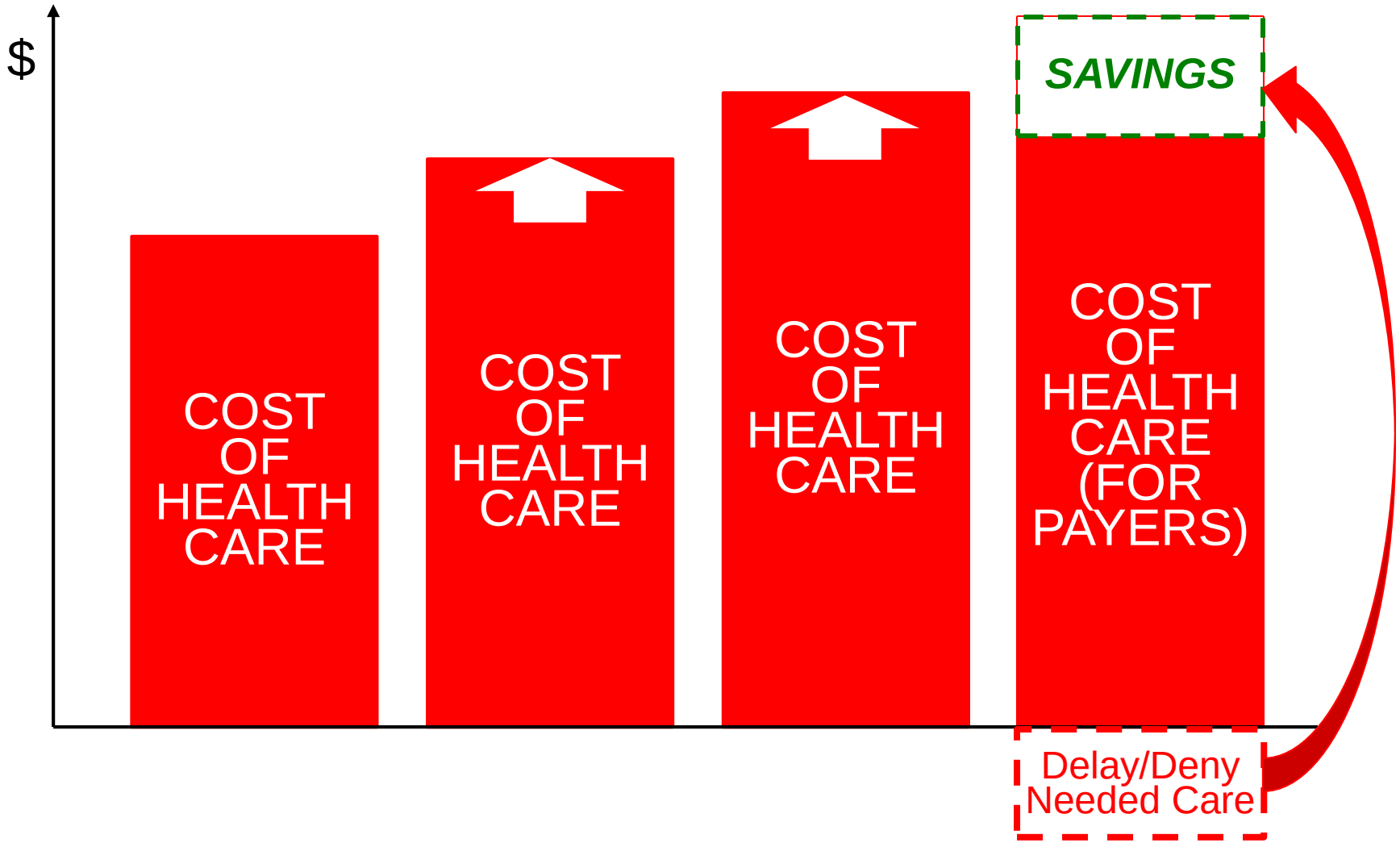
Typical Cost Control Strategy #1: Cut Provider Fees for Services



Typical Cost Control Strategy #2: Shift Costs to Patients



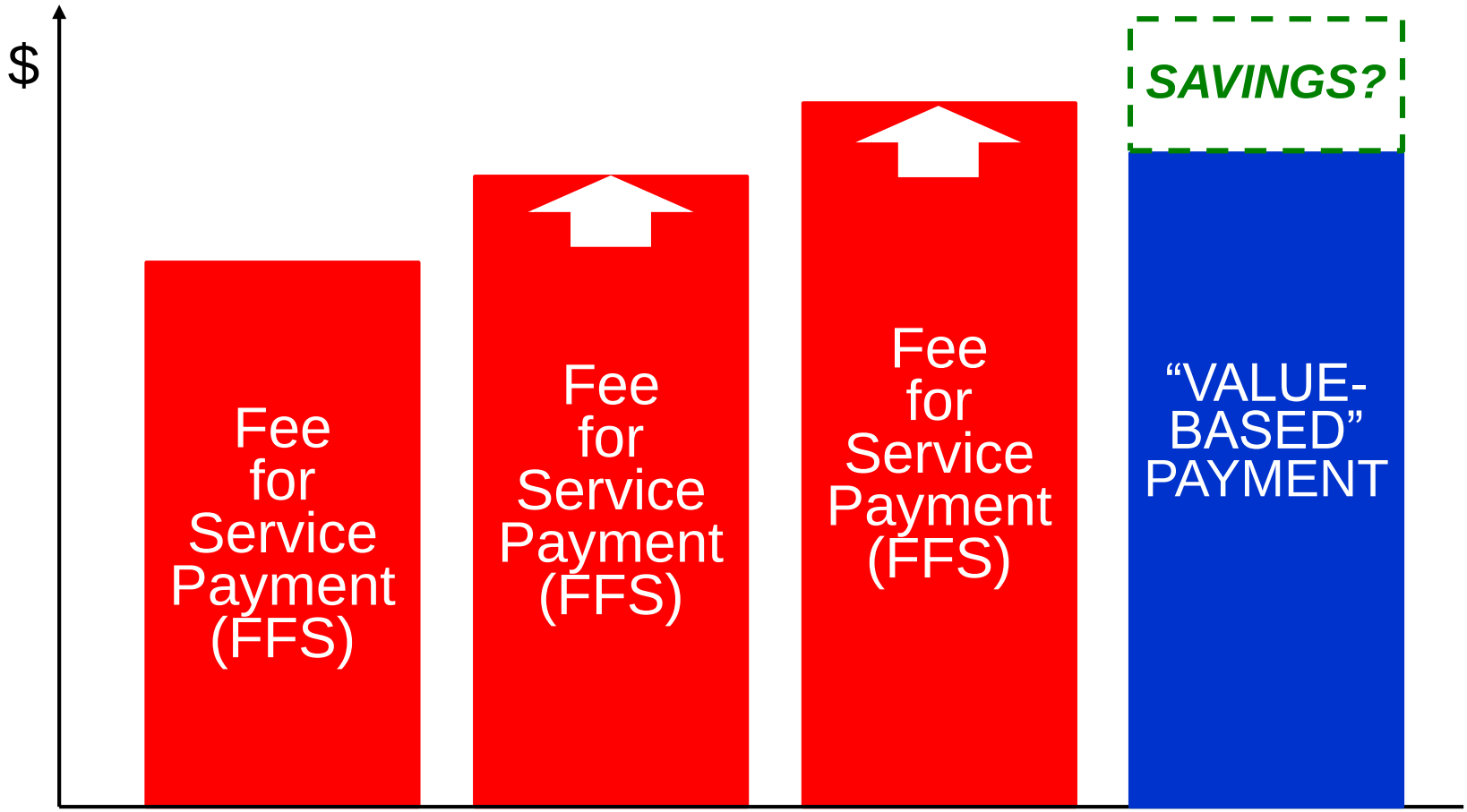
Typical Cost Control Strategy #3: Delay or Deny Care to Patients



Results of Typical Cost-Control Strategies

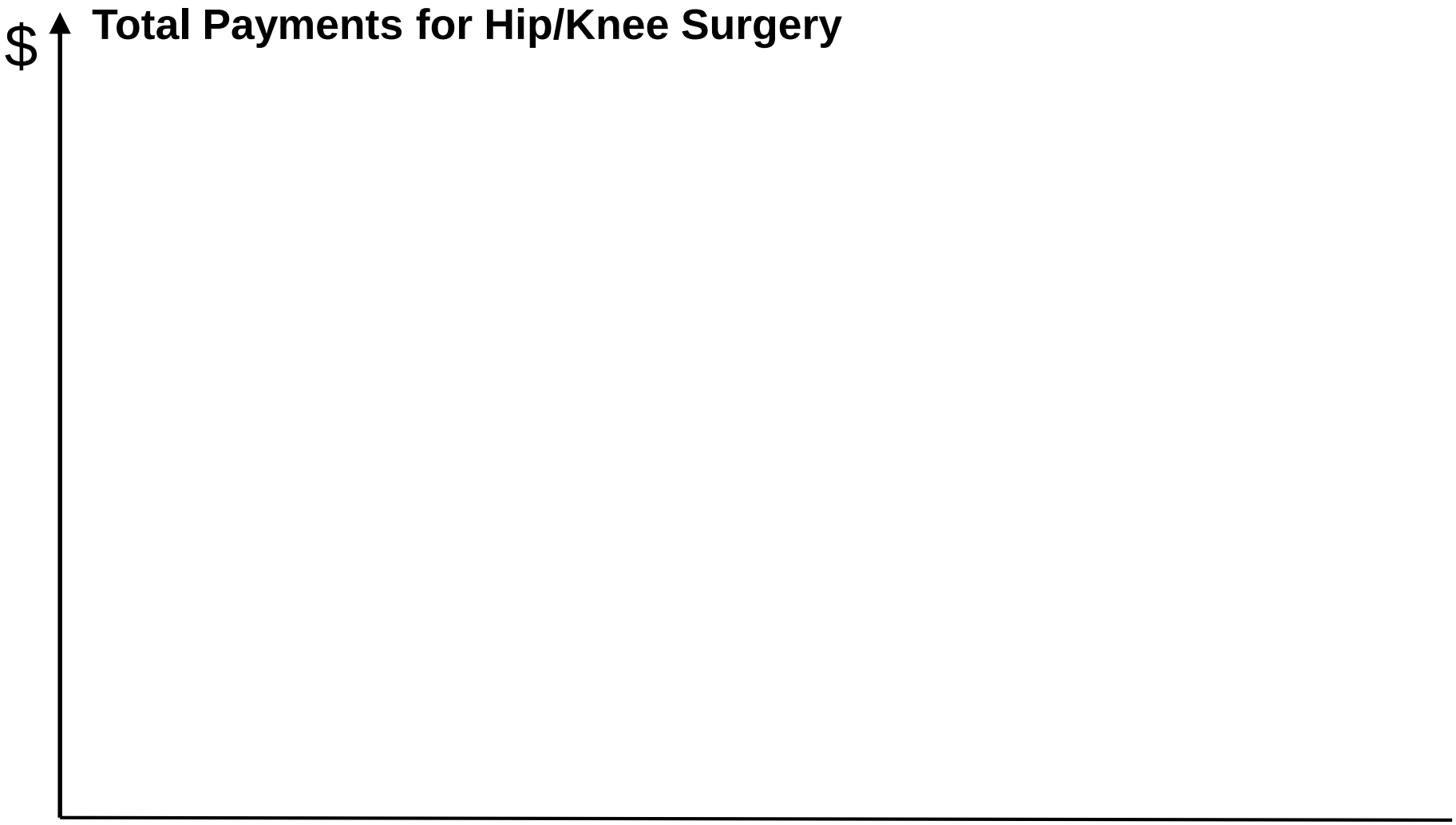
- Patients don’t get the care they need
- Small providers are forced out of business
- Health insurance premiums continue to rise and access to insurance coverage decreases

New Strategy: Create "Value-Based" Payments



What Exactly is Wrong With Fee for Service?

How Much Will Treatment Cost Under Fee for Service Payment?



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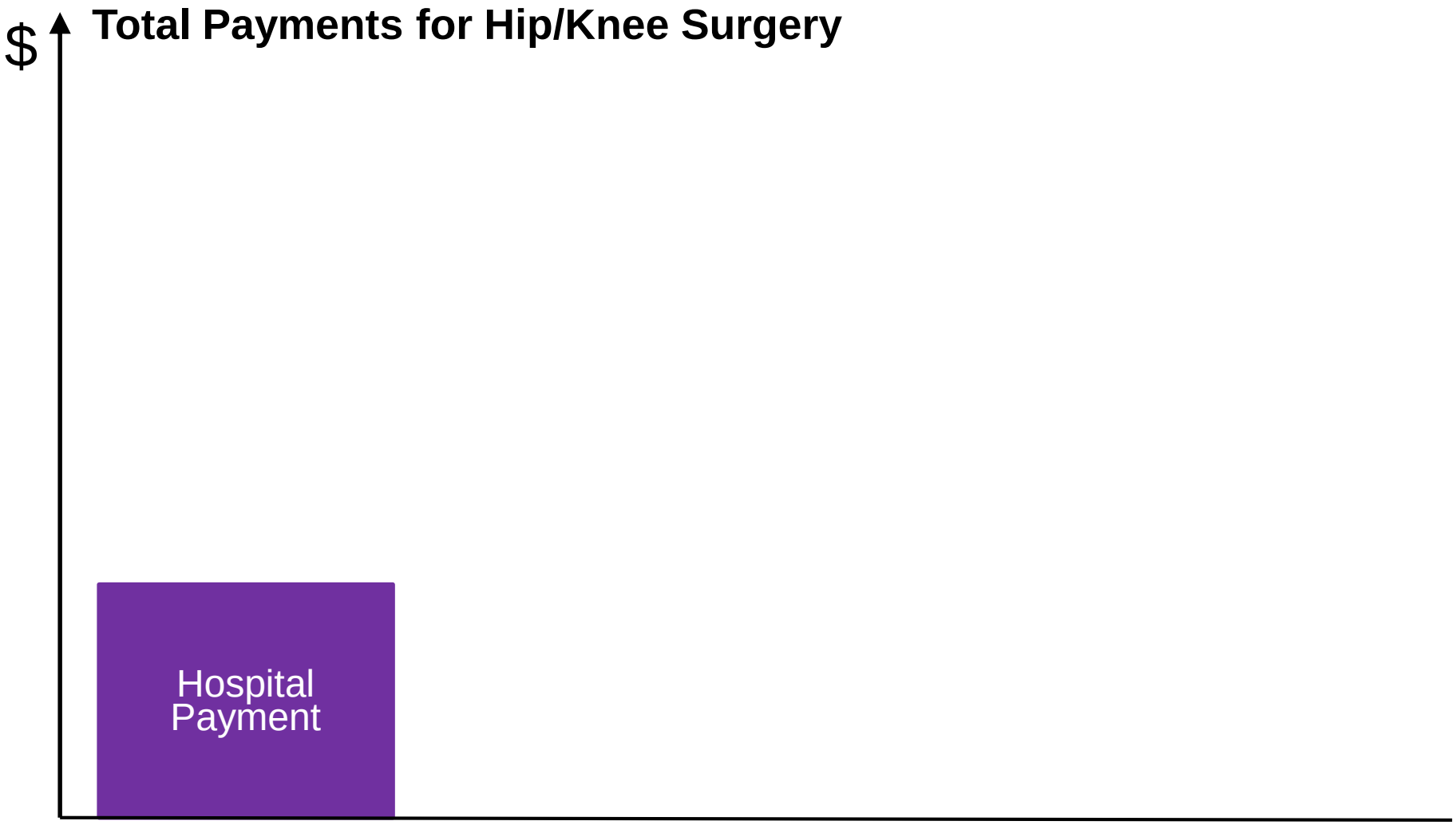

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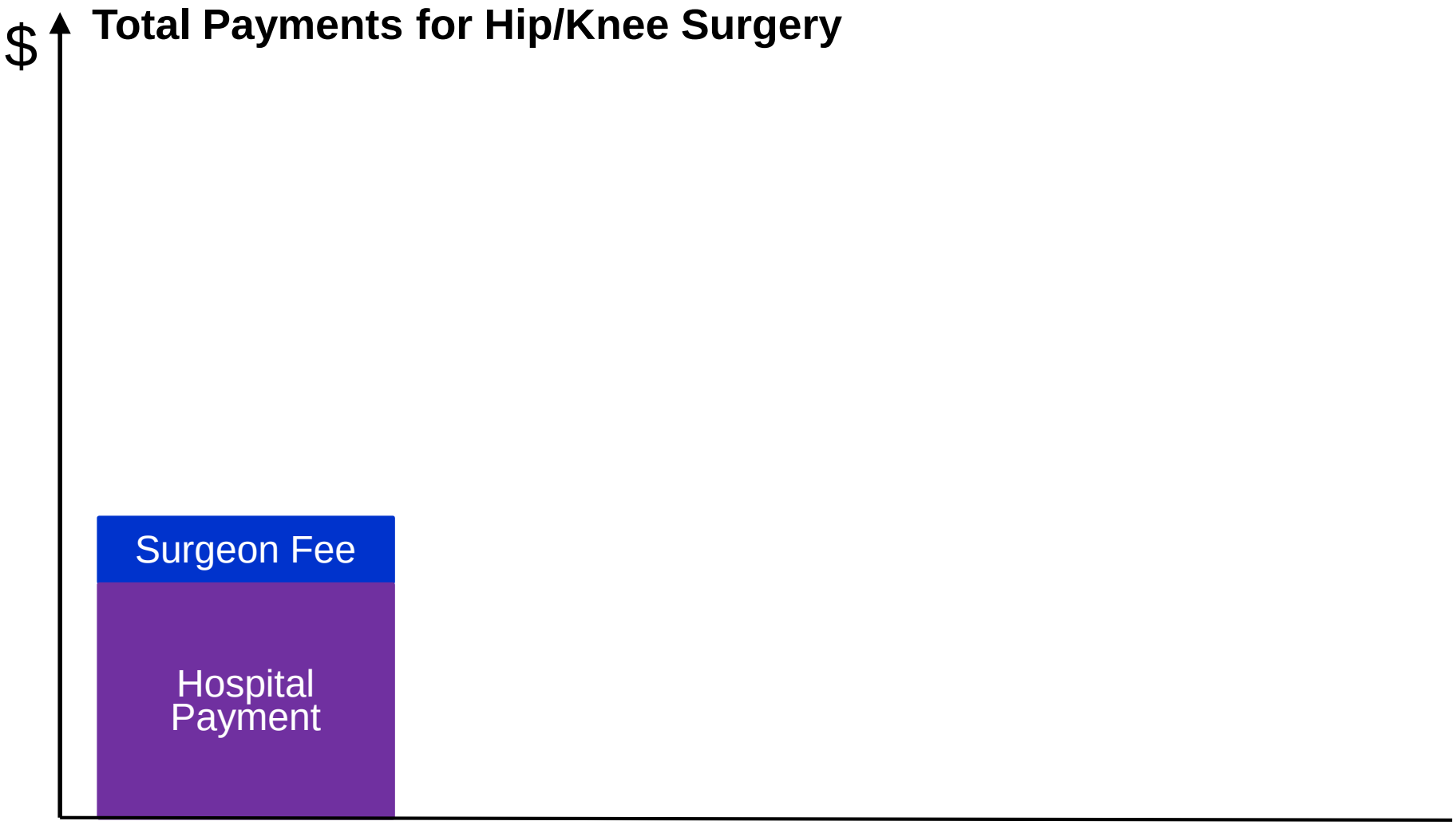

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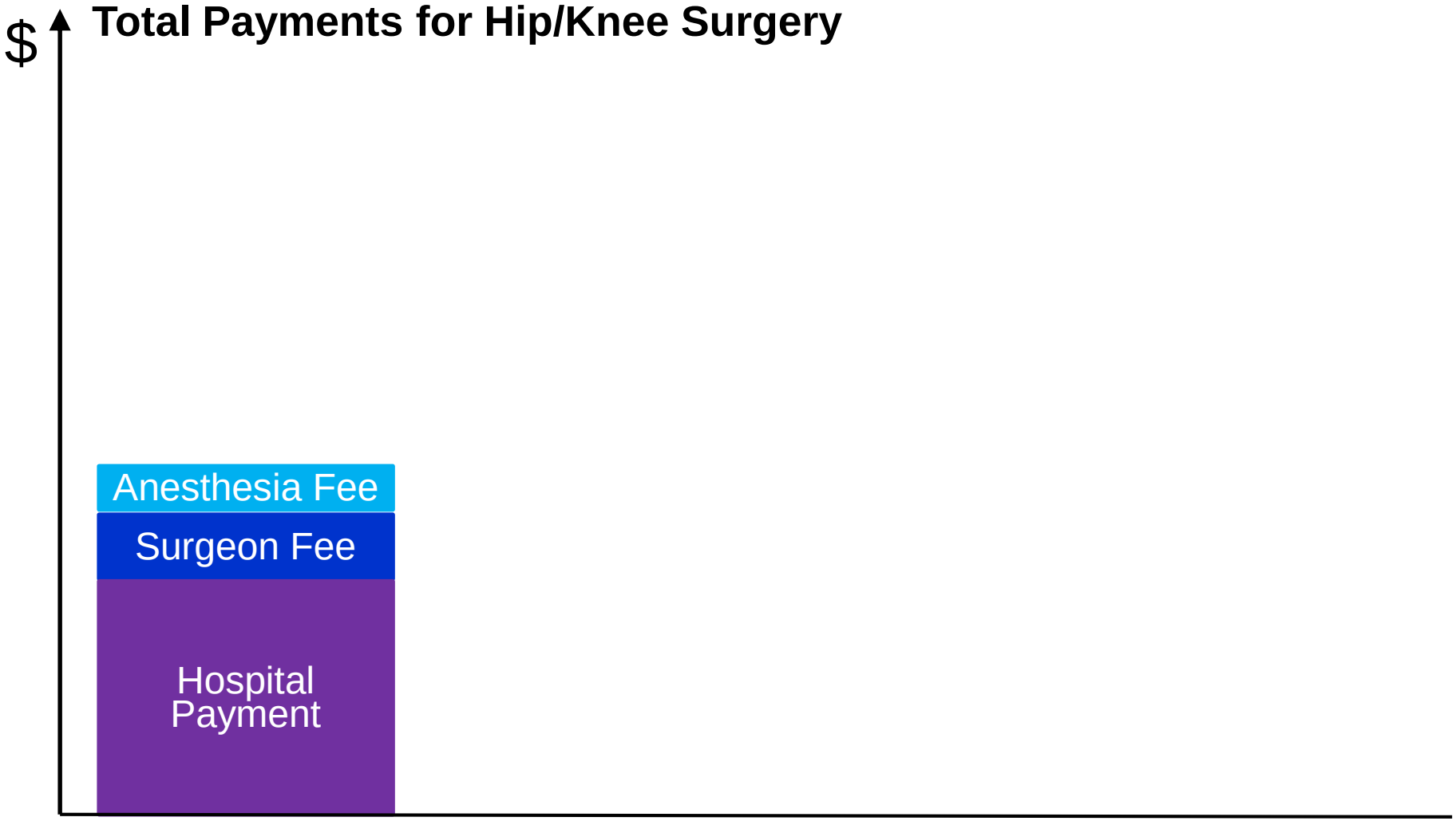

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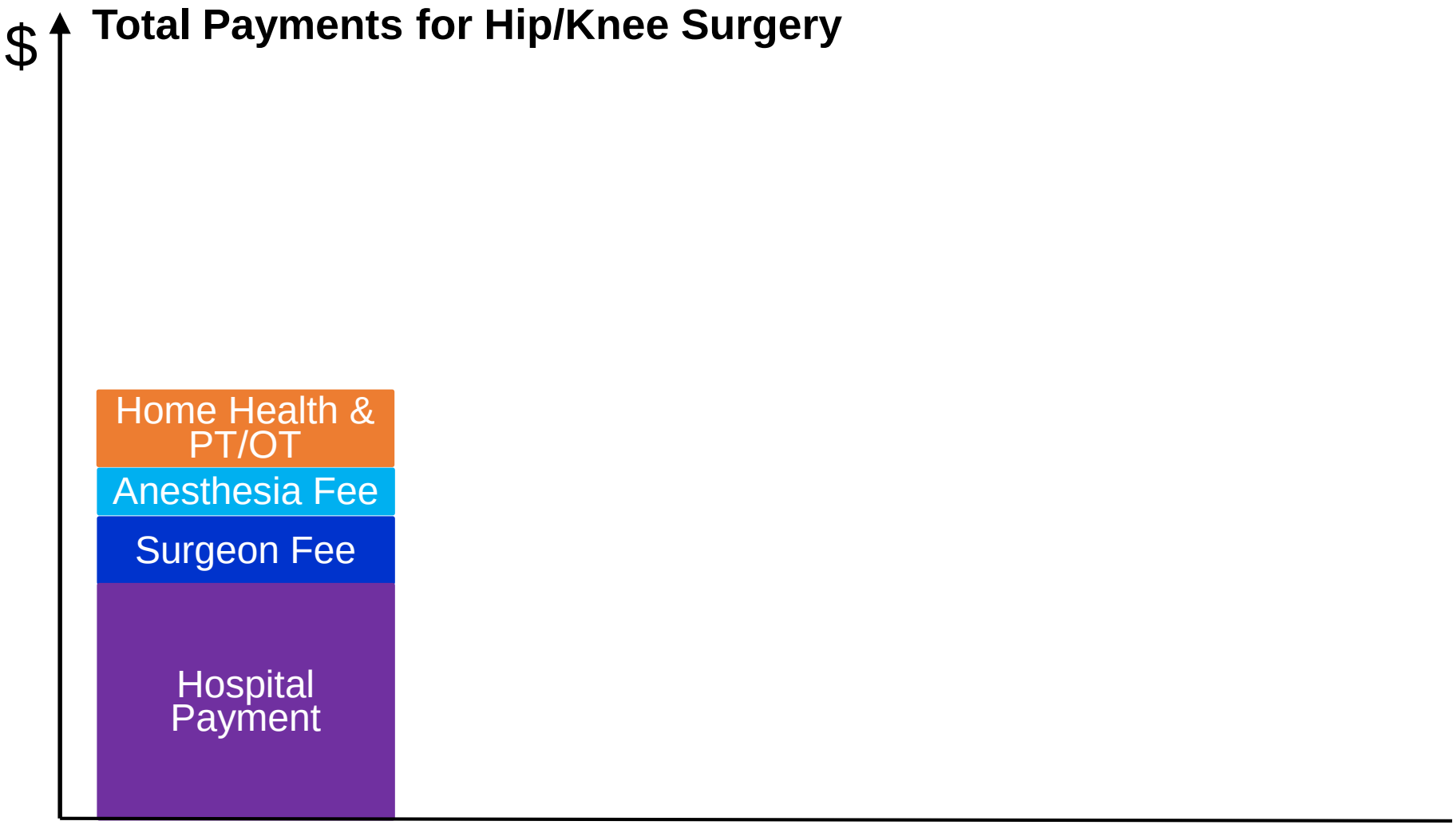

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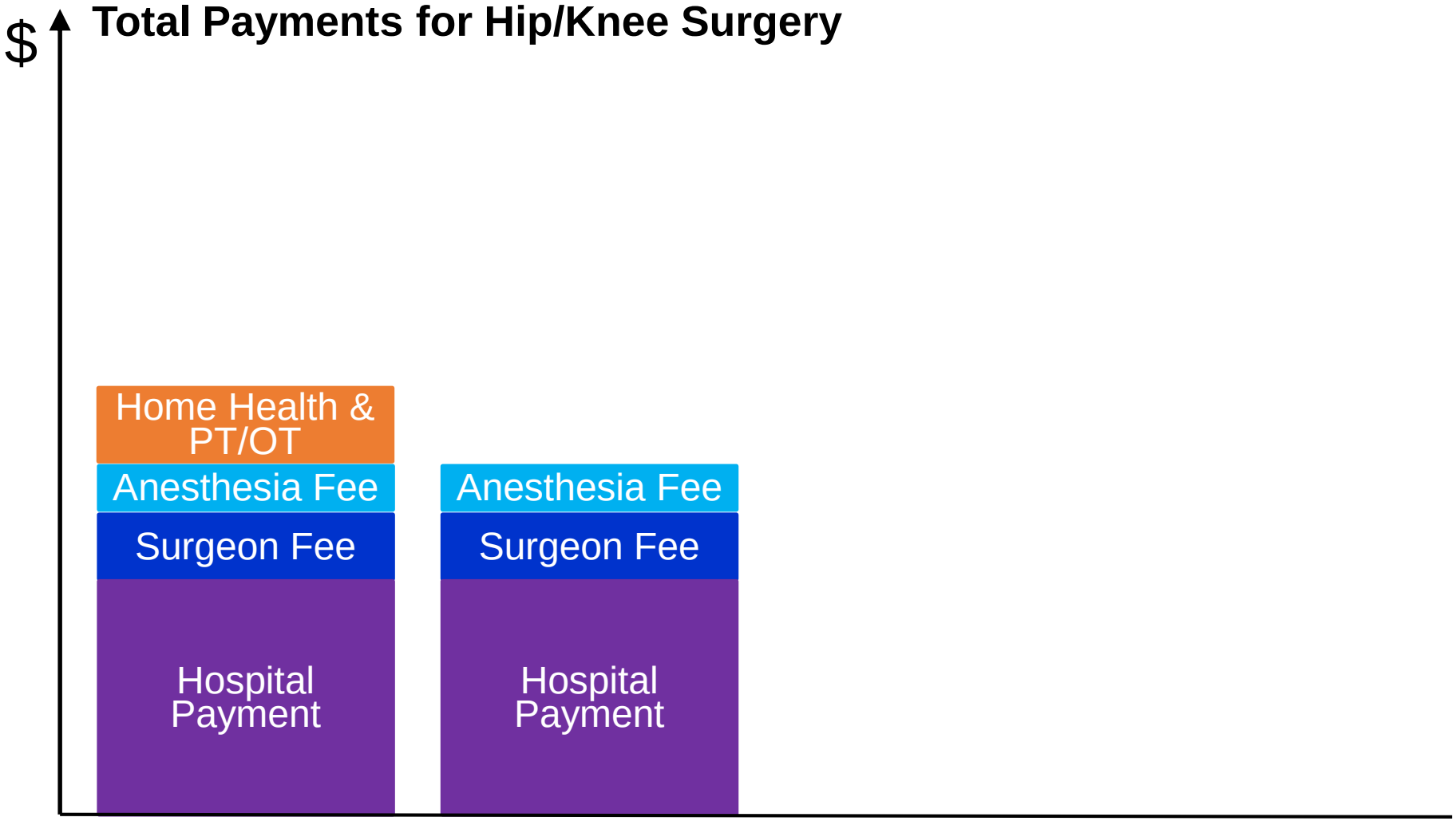

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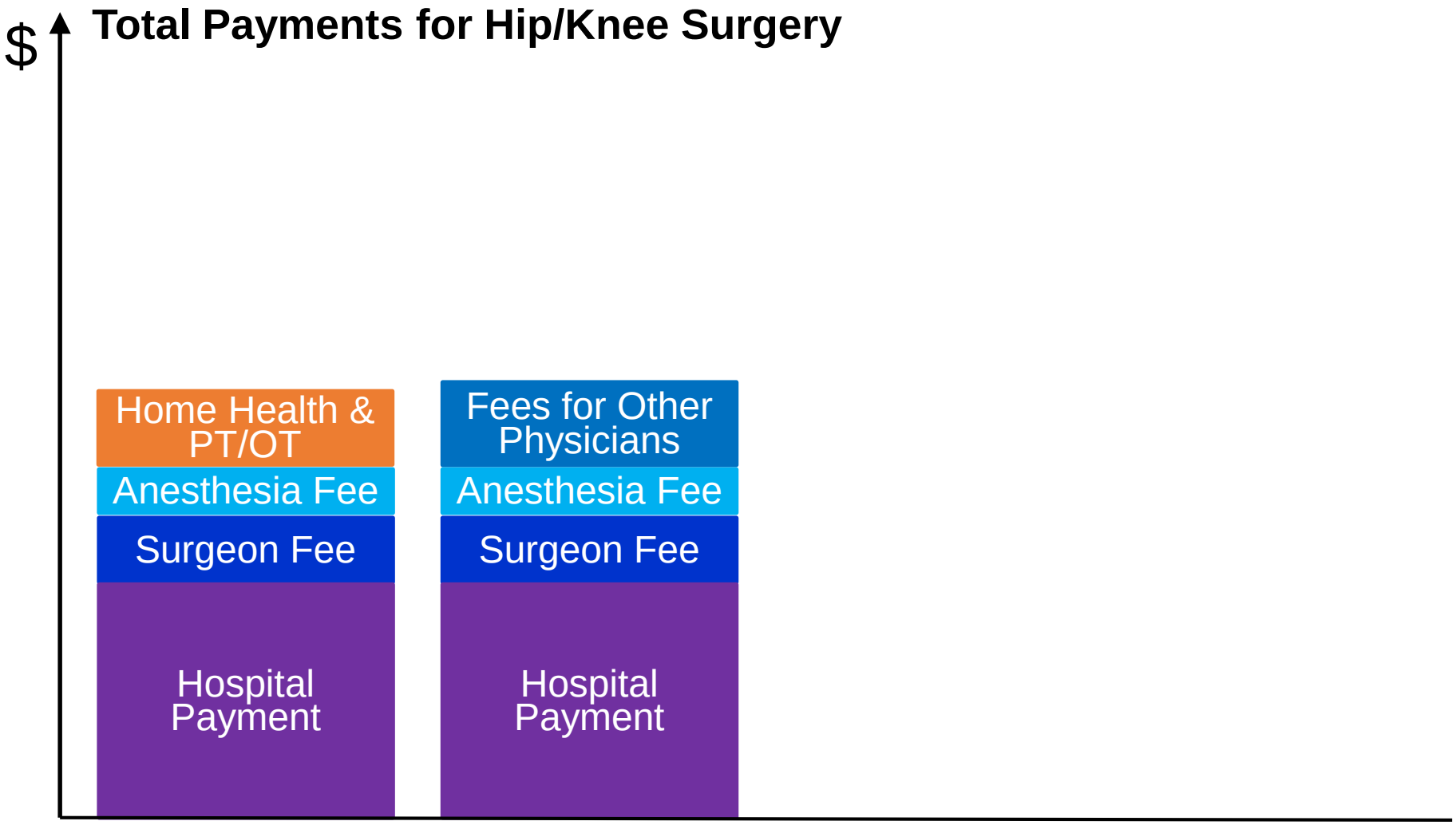

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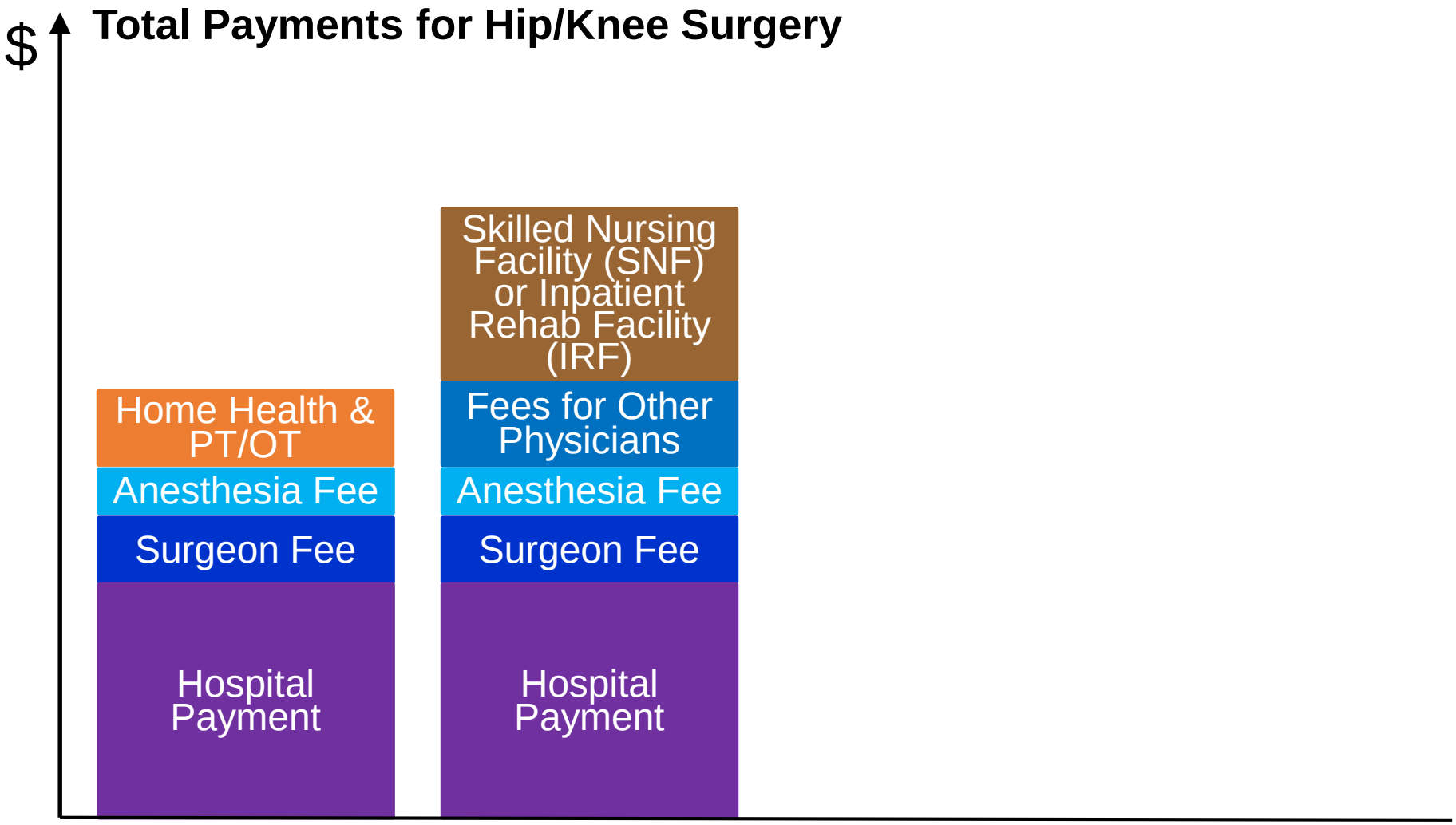
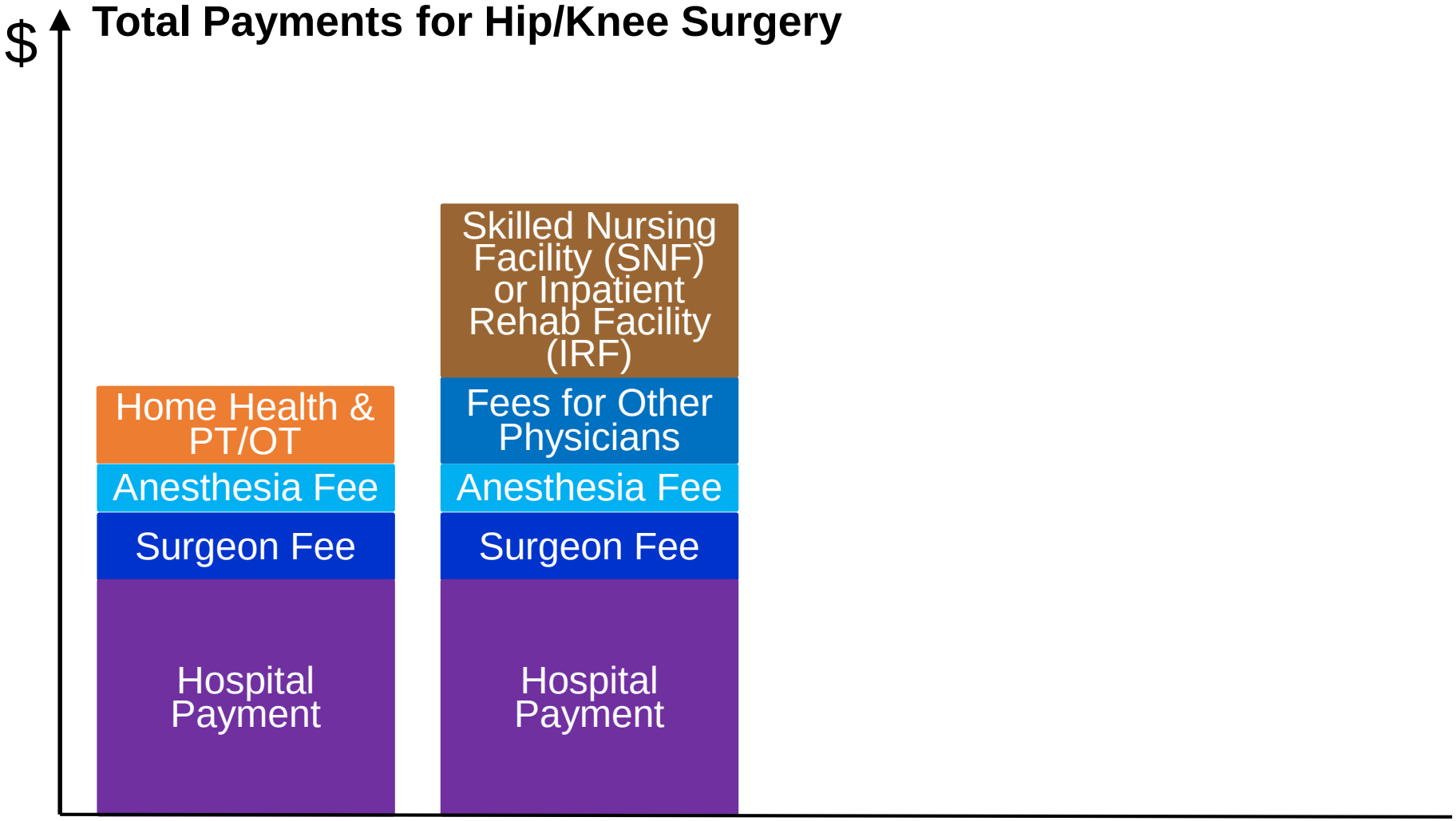
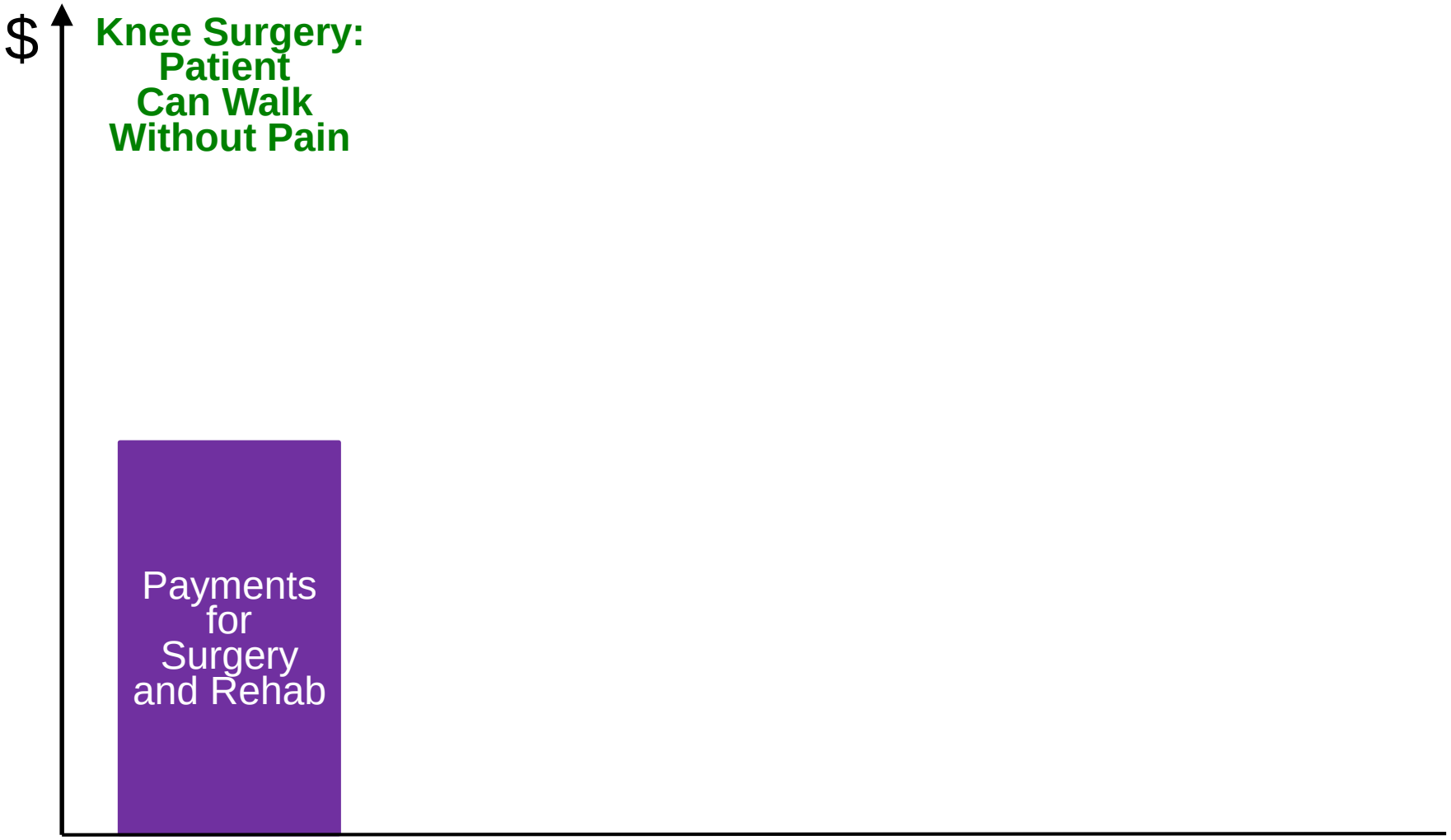


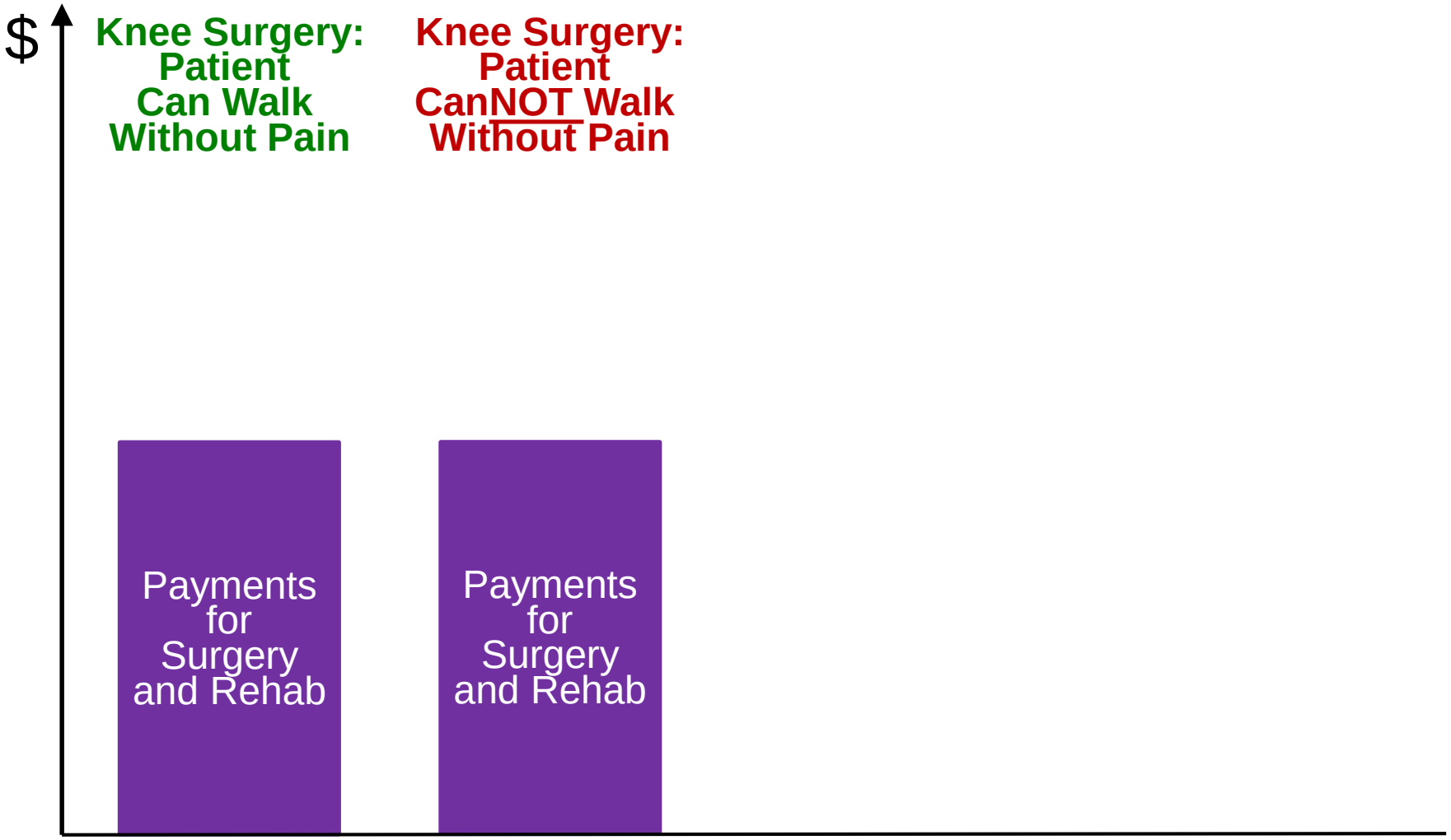
FFS Problem #1: Many Patients Get Services They Don't Need



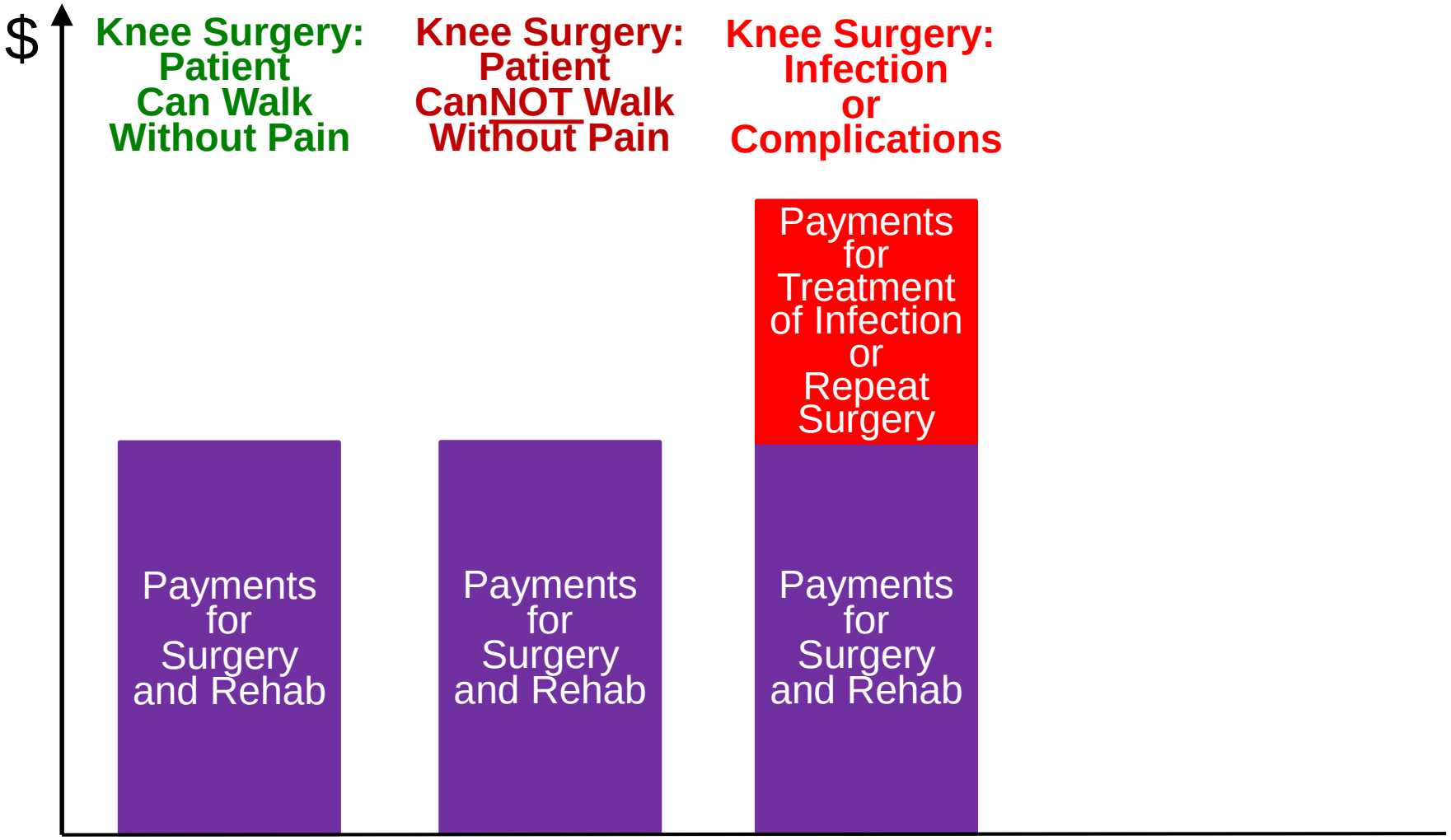
FFS Payment When the Treatment is Successful



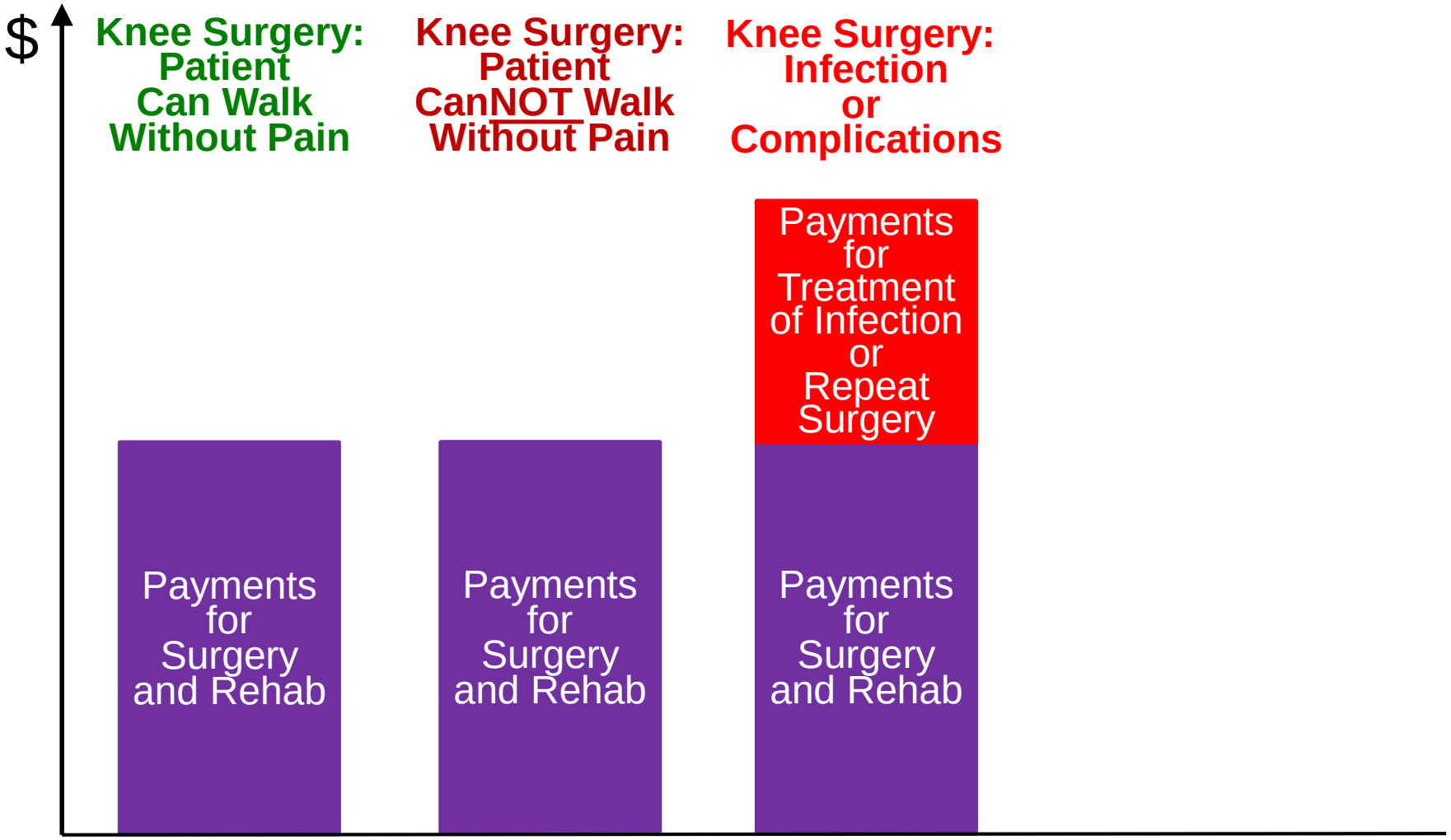
FFS Payment When the Treatment is Unsuccessful



FFS Payment When the Treatment Makes Things Worse



FFS Problem #2: No Penalty For Poor Outcomes

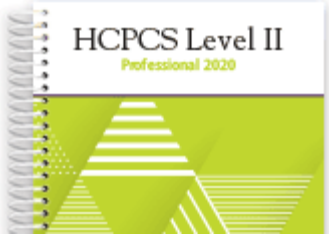


We Don’t Pay for Other Products & Services This Way

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)

08108-09159	Flange Weld on for Sid Blow Off Valve	£	9.74
11001-AN001	Turbine Kit SPL Single Z33 (VQ35DE) GT3037 RHD CARS ONLY!	£	4,603.50
11001-AN004	Twin Turbo Setup Kit VQ35 2 x GT2530 RHD (see notes)	£	4,313.65
11001-AS003	Turbo kit Swift ZC31S BOT+Fcon IS+ I/C (w/CAT)	£	3,502.95
11001-KS001	Turbo Kit Swift ZC31S BOT w/o Fcon IS w/o I/C (no CAT)	£	1,919.50
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11003-AM001ZZ	FTK (w/o Turbine) Evo 7/8/9 (inc intake system & f/pipe)	£	2,799.50
11003-AM002	Turbine Kit CZ4A GT3240 (6MT only!)	£	4,009.50
11003-AM003	Turbine Kit CZ4A GT3240 (5ST only!)	£	4,009.50
11003-AN001	T04Z Turbine Kit S14/15	£	4,944.50
11003-AN002	T04Z Turbine KitGTR32	£	5,219.50
11003-AN003	T04Z Turbine Kit GTR33	£	5,164.50
11003-AN004	T04Z Turbine Kit GTR34	£	5,164.50
11003-AN005	NLA! Turbine Kit GT3037 S14/15 SR20DET see 11003-AN010	£	2,950.00
11003-AN008	T51R KAI BB Turbine Kit GTR34	£	6,033.50
11003-AN010	Turbine Kit Nissan S14/15 GT3037S 56T A/R0.61 RHD only!	£	3,025.00
11003-AN011	GT800 FTK Nissan GTR35	£	8,195.00
11003-AT001	T04Z Special Full Turbine Kit JZA80	£	5,335.00
11003-AT001ZZ	T04Z Special Full Turbine Kit JZA80 (No Turbine)	£	3,096.50
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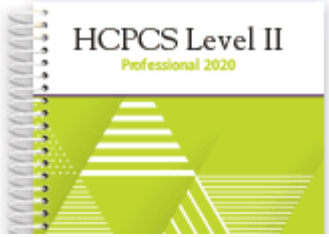
11003-KF001ZZ	Turbine Kit Subaru GRB (No Turbine) (Single Scroll Ext W/G)	£	2,194.50

And Pay Auto Workers Based On How Many Parts They Installed



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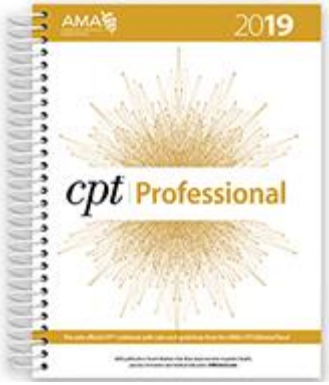
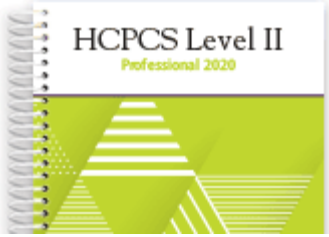
AMA
Automobile Manufacturing Association



CPT System (Car Parts Tokens)

With No Warranty for Defects



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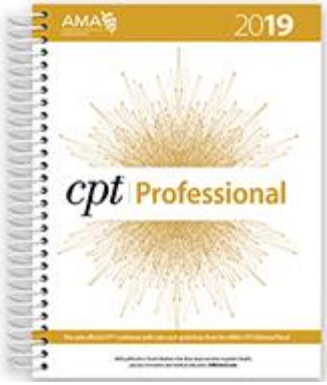


CPT System (Car Parts Tokens)

The Result for Drivers If We Paid That Way…

The Result for Drivers If We Paid That Way…

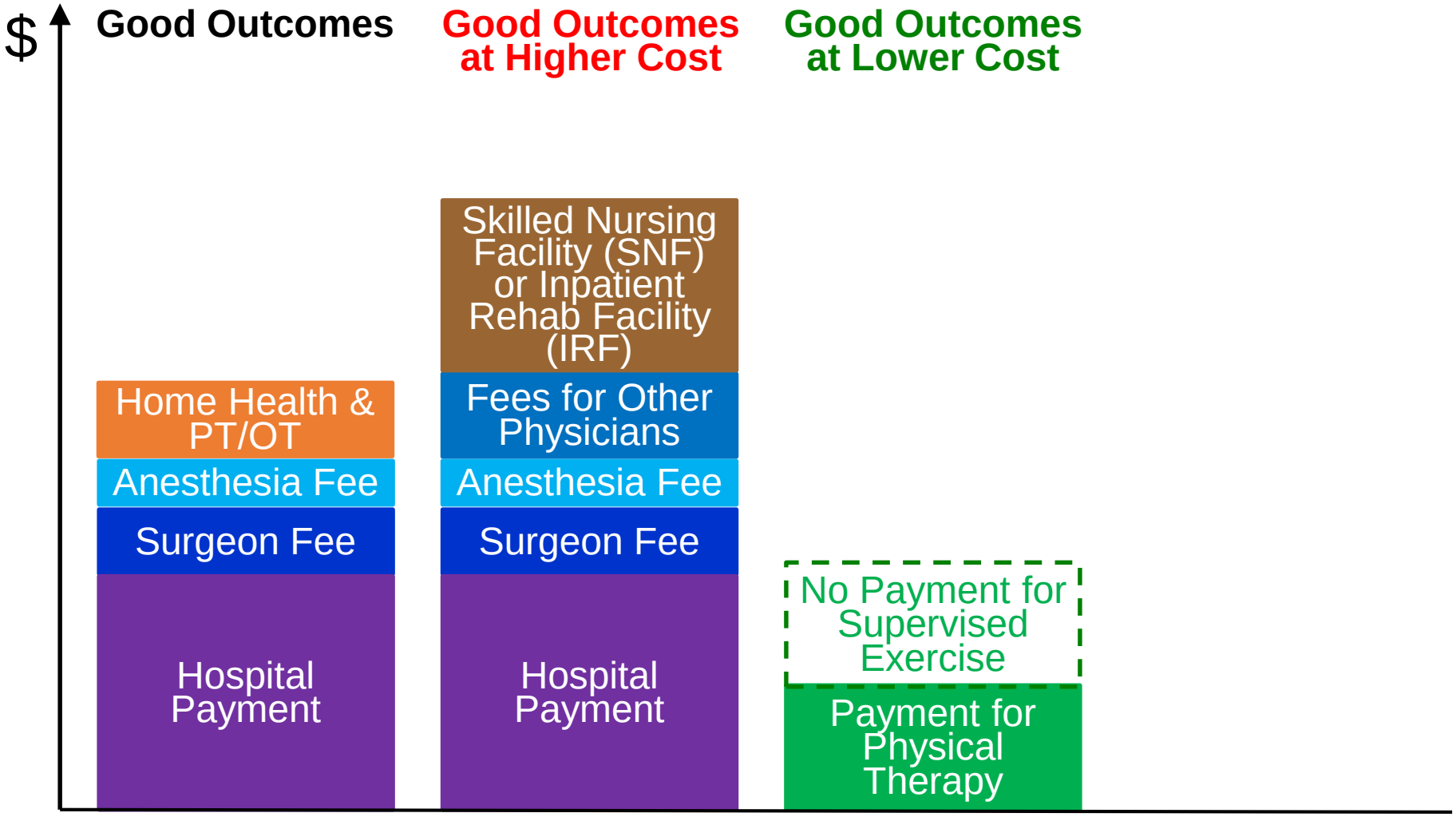
Cars would get many unnecessary parts

The Result for Drivers If We Paid That Way…

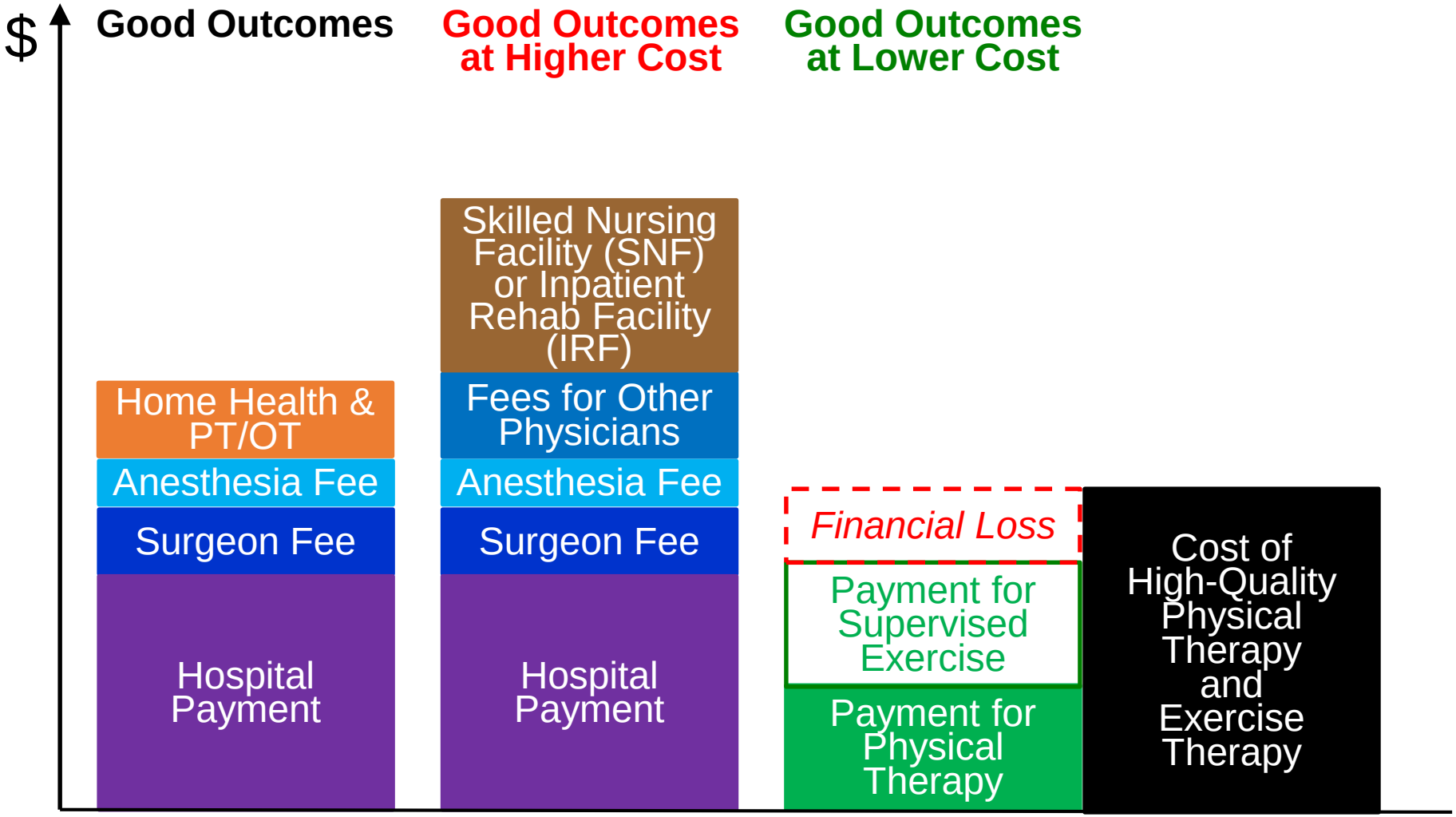
Cars would get many unnecessary parts

Cars would be readmitted to the factory frequently to correct malfunctions

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



FFS Problem #4: Fees Too Low for Some Services



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

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

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

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

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

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

Results: Among 1165 total participants, 213 (18.3%) were Medicare beneficiaries. Participating beneficiaries were 40.6% Hispanic, 31.6% non-Hispanic black, and 26.9% non-Hispanic white and 69.5% low-income. Overall beneficiary performance would result in an average reimbursement of $138.52 (interquartile range = 162.50). Program delivery costs were $800 per participant, leaving an average gap of $661 per beneficiary.

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

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

(*Med Care* 2018;56: 908–911)

The Centers for Medicare and Medicaid Services (CMS) recently issued the final rule for Medicare Diabetes Prevention Program (MDPP) coverage beginning April 2018,[1] offering an unprecedented opportunity to prevent diabetes among the estimated 48.3% of seniors with prediabetes.[2] The MDPP is a structured group class based on the National Diabetes Prevention Program (NDPP), a widely disseminated, evidence-based lifestyle intervention.[3] The NDPP aims to help participants prevent or delay onset of type 2 diabetes by achieving at least 5% weight loss.

The MDPP pay-for-performance methodology reimburses suppliers based on beneficiaries' attendance and weight loss outcomes.[1] Sustainable reimbursement rates are critical for policy impact, yet whether Medicare payments are sufficient to cover costs of service delivery is unknown, particularly for racial/ethnic minority and low-income individuals who experience disparately high prevalence of type 2 diabetes but lesser NDPP outcomes.[2,4–6] We compare projected payments based on performance data of a diverse, underserved sample of Medicare beneficiaries to service delivery costs and explore resulting implications for MDPP sustainability.

METHODS

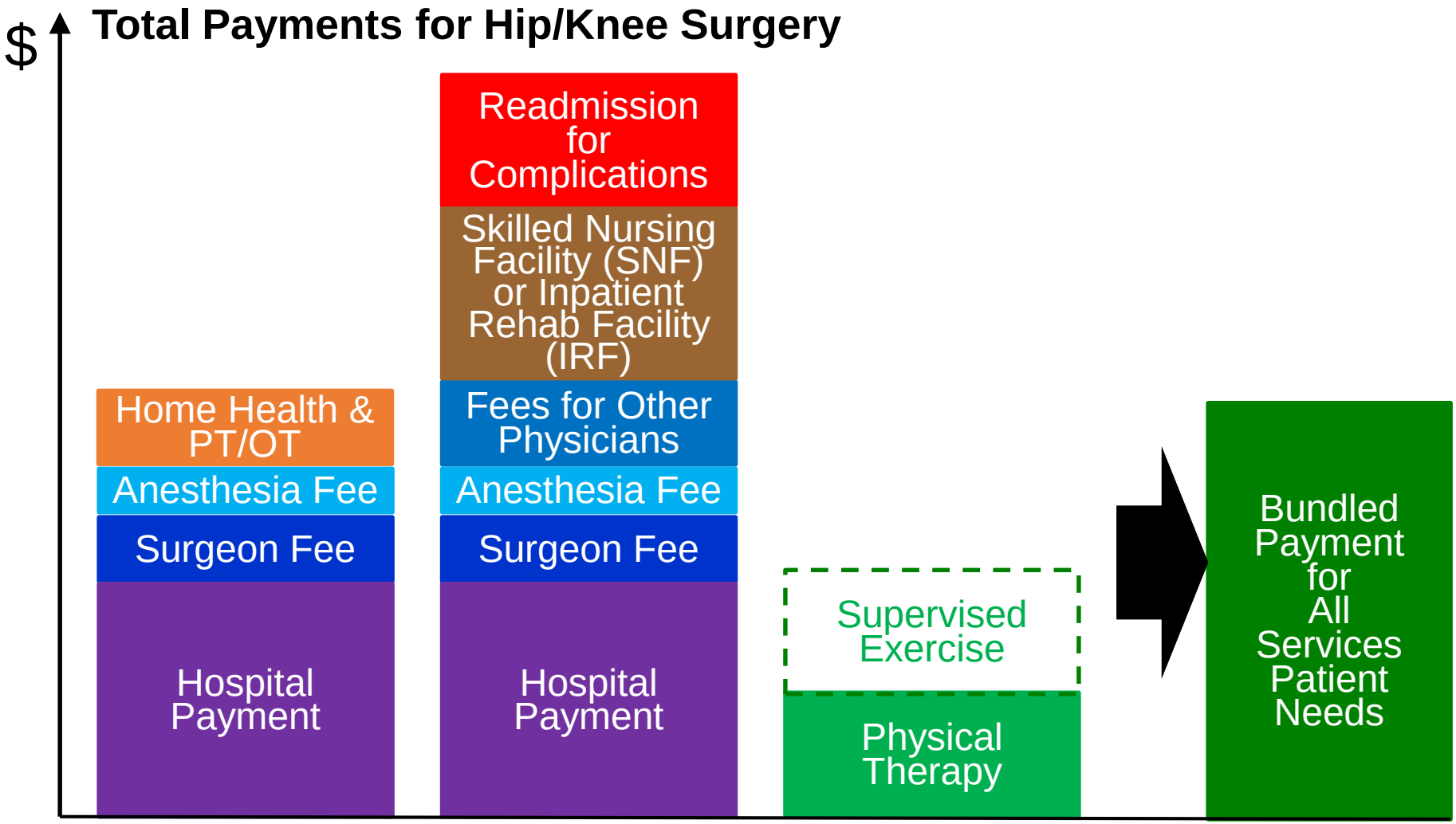
Denver Health and Hospital Authority is a safety-net health care system that has provided the NDPP following standards established by the Centers for Disease Control and Prevention (CDC),[7] and using the CDC's publicly available curriculum.[3] Sixteen weekly to biweekly sessions were held in months 1–6 and a minimum of 6 monthly sessions were held in months 7–12. NDPP participants were encouraged to attend as many sessions as possible and to lose at least 5% of their initial body weight. Sessions were conducted in neighborhood primary care clinics at a variety of days and times, including evenings and weekends, for convenience. Six yearlong NDPP classes were initially offered in March 2013. Thereafter, 2–4 new NDPP classes were launched approx-

Findings from delivering the NDPP to diverse and undeserved patients show a large gap between service costs and projected reimbursement… Health disparities may also widen as suppliers serving diverse and low-income populations will likely receive especially low payments, threatening access.

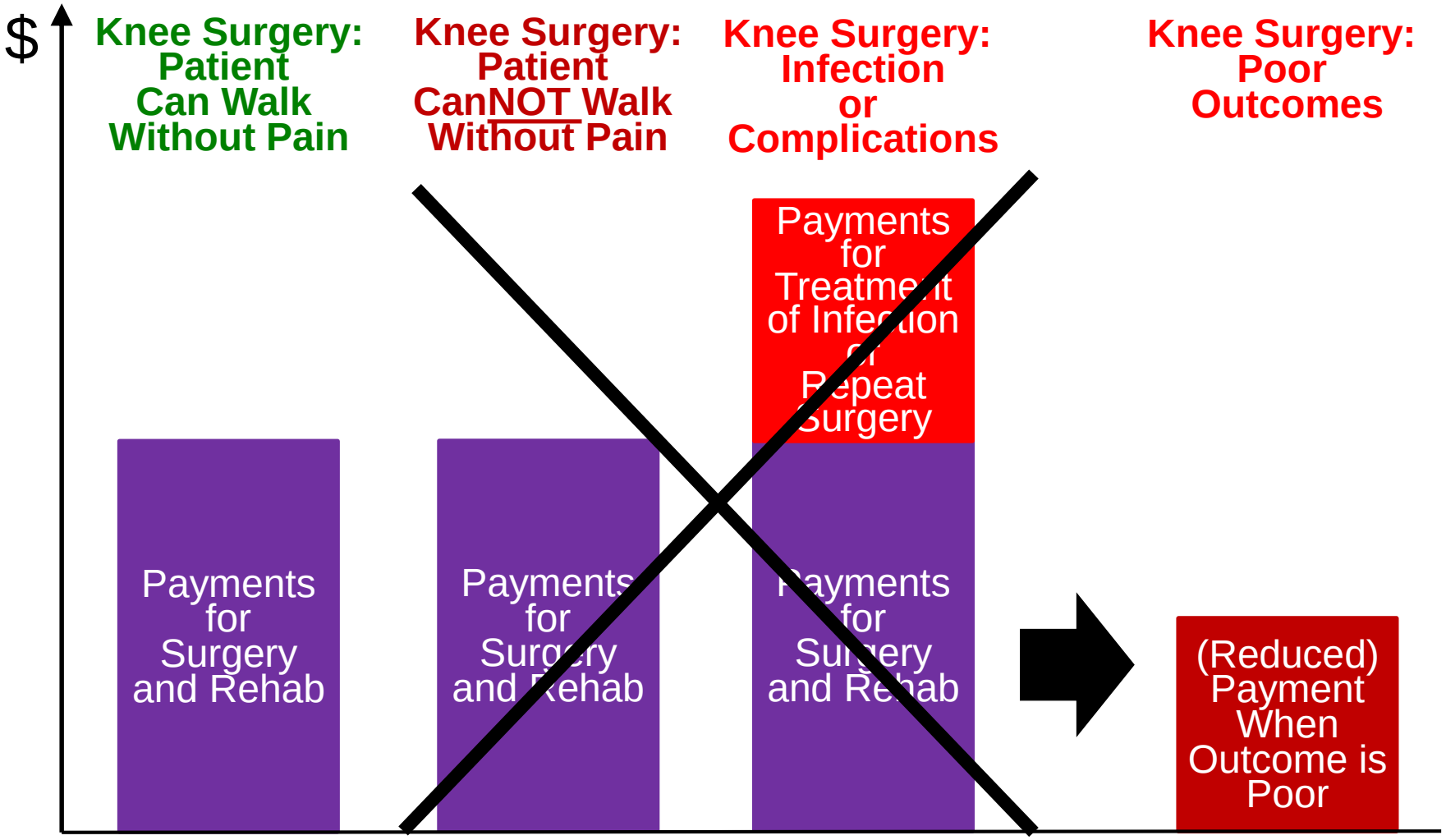
We Won't Get "High-Value Care" Unless We Fix These Problems

		FFS
Weaknesses of Fee for Service		
	Payment for unnecessary services?	YES
	Payment even if quality/outcome is bad?	YES
	Payment for all high-value services?	NO
	Payment sufficient to cover cost of services?	NO

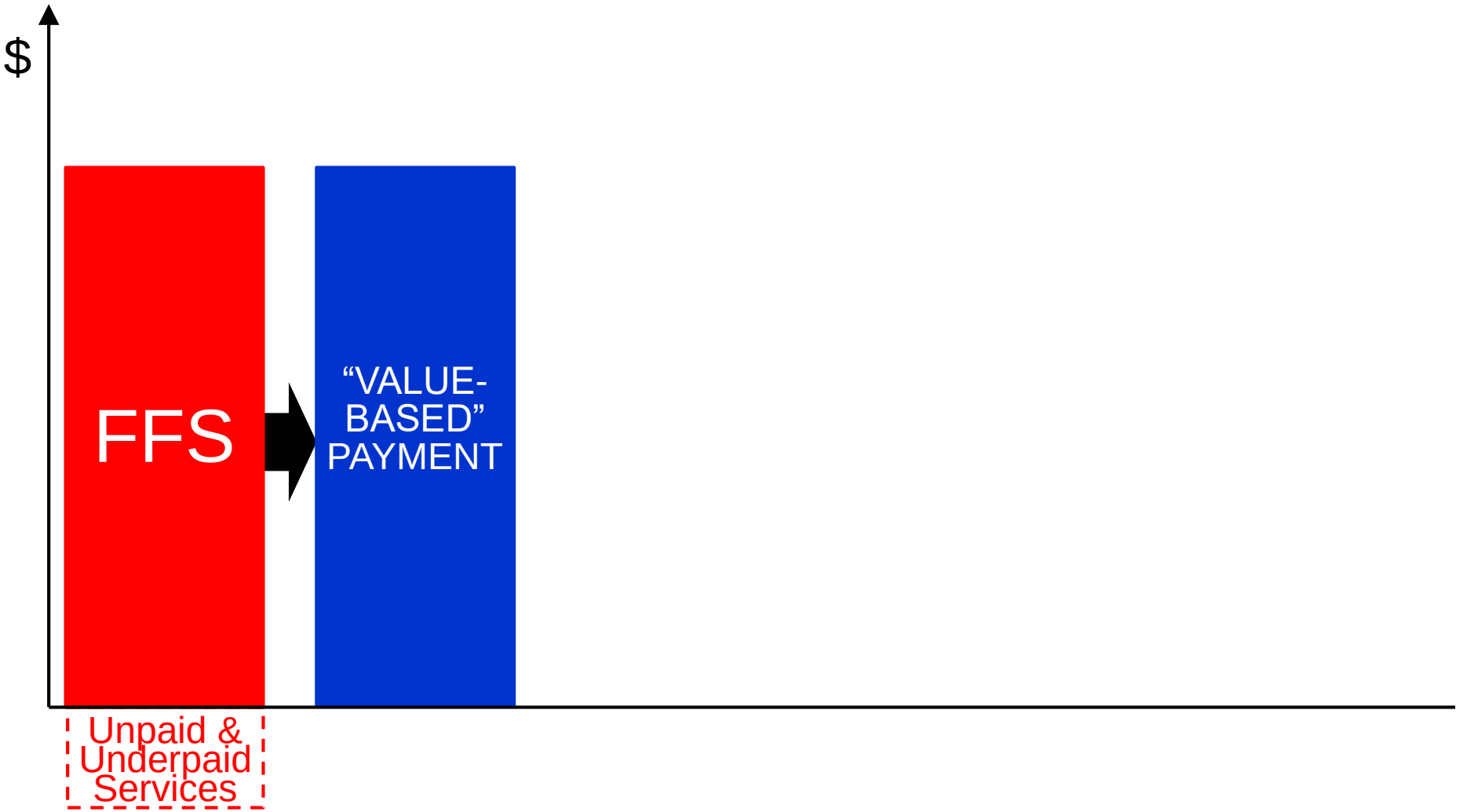
Solution: Single, Flexible Payment For All Services Patient Needs



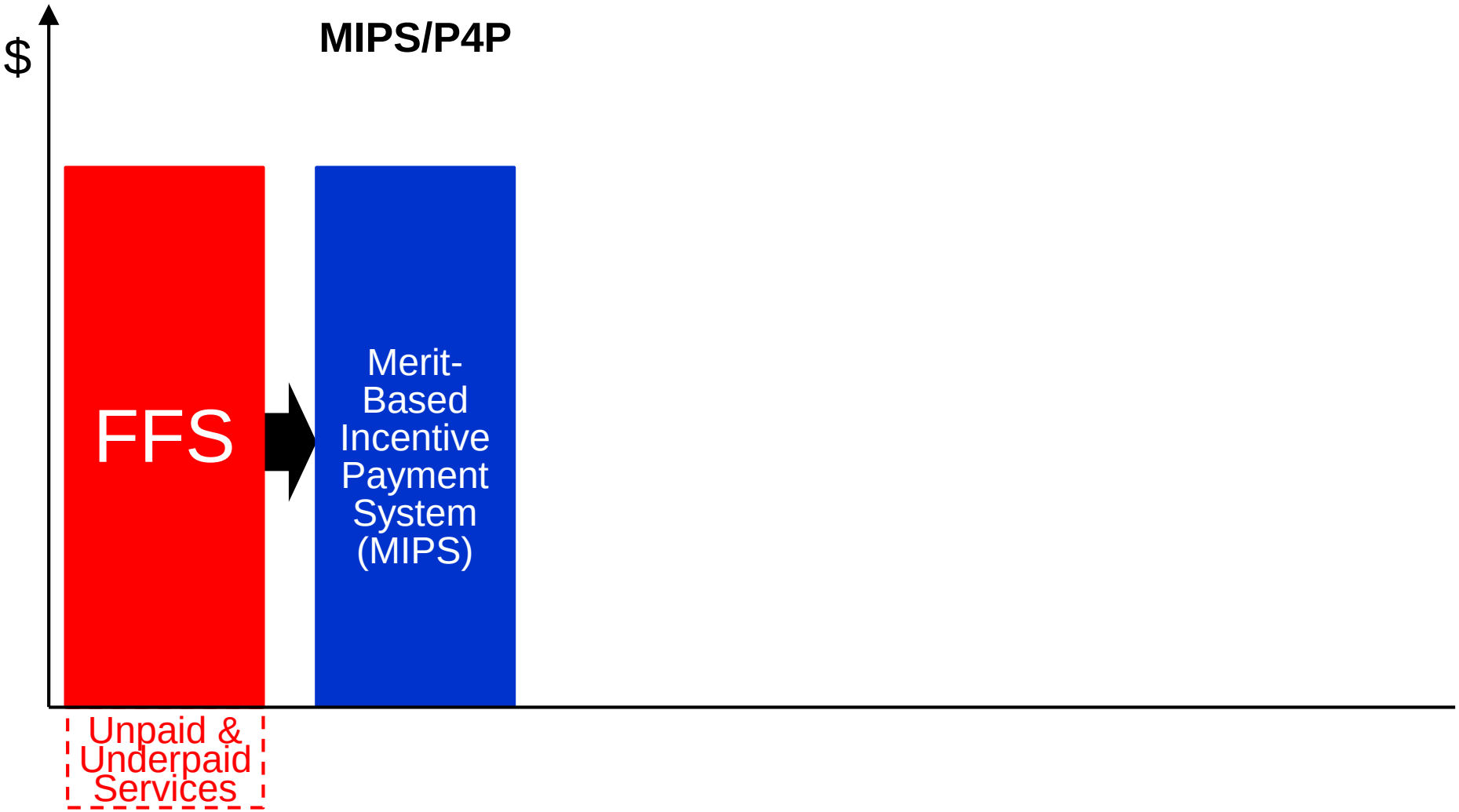
Solution: Pay Less (or Nothing) When Outcomes Aren't Achieved



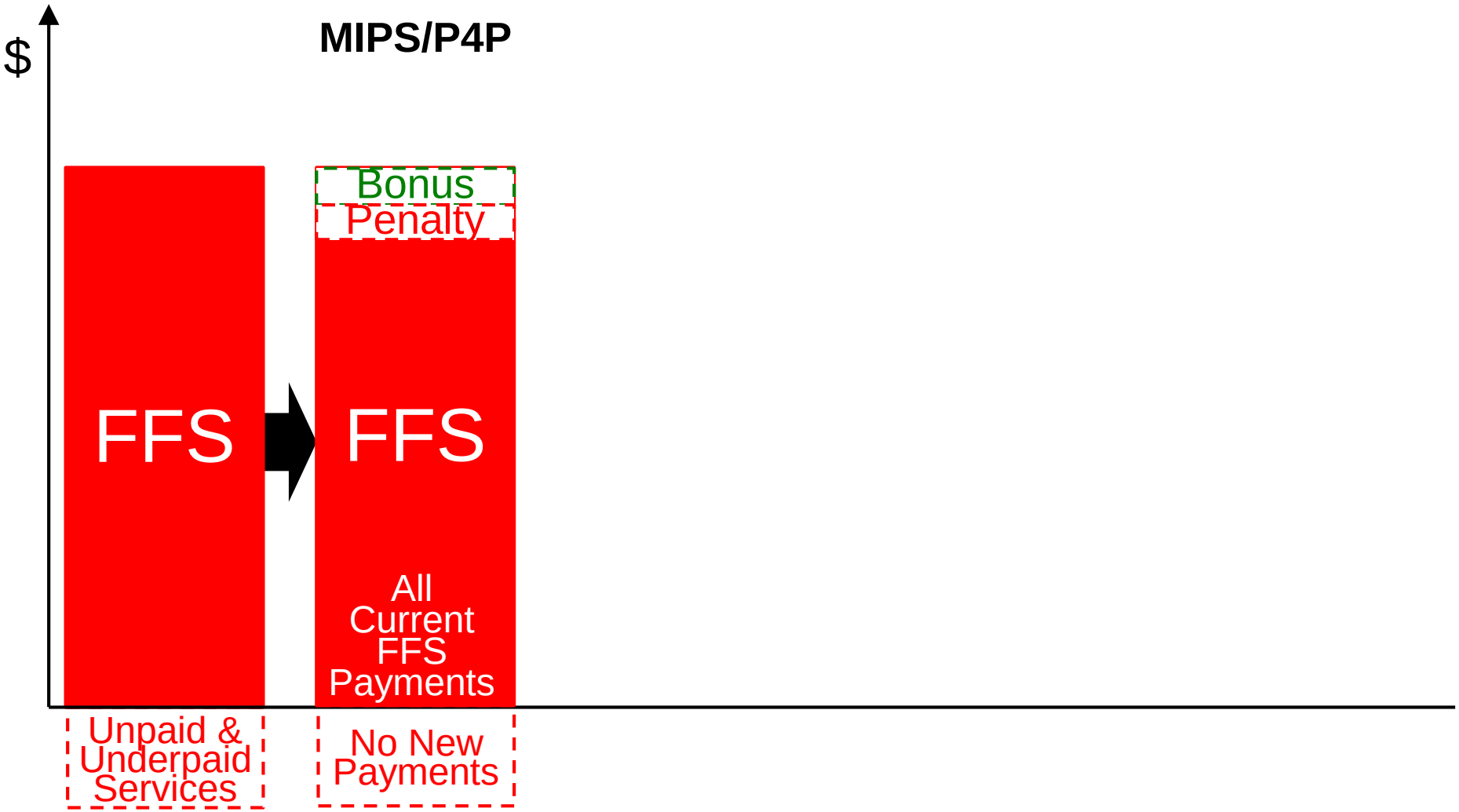
Do "Value-Based" Payments Solve the Problems With FFS?



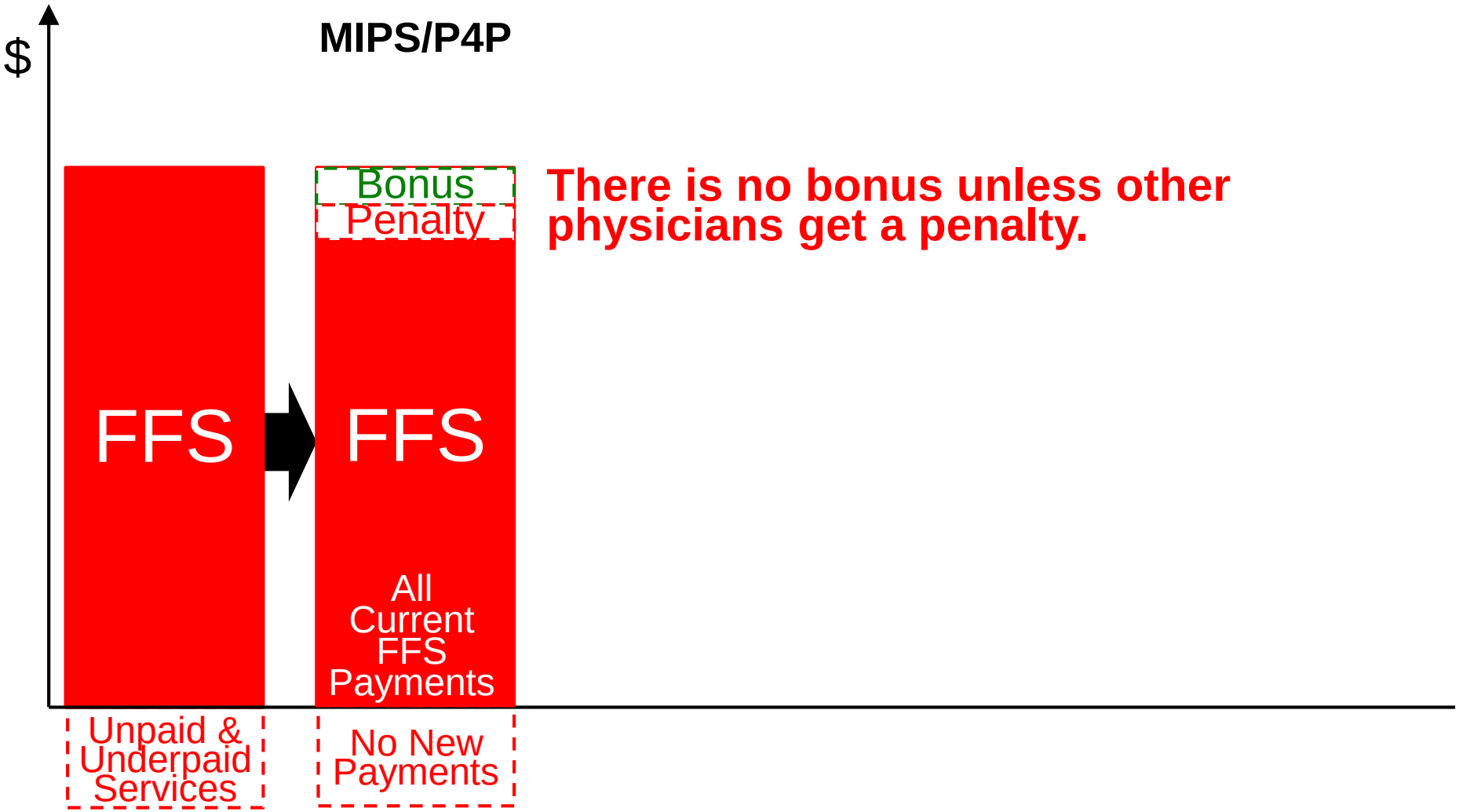
The Most Common "Value-Based" Payment is P4P (MIPS)



MIPS/P4P Doesn't Add New Fees or Change Relative Fee Amounts

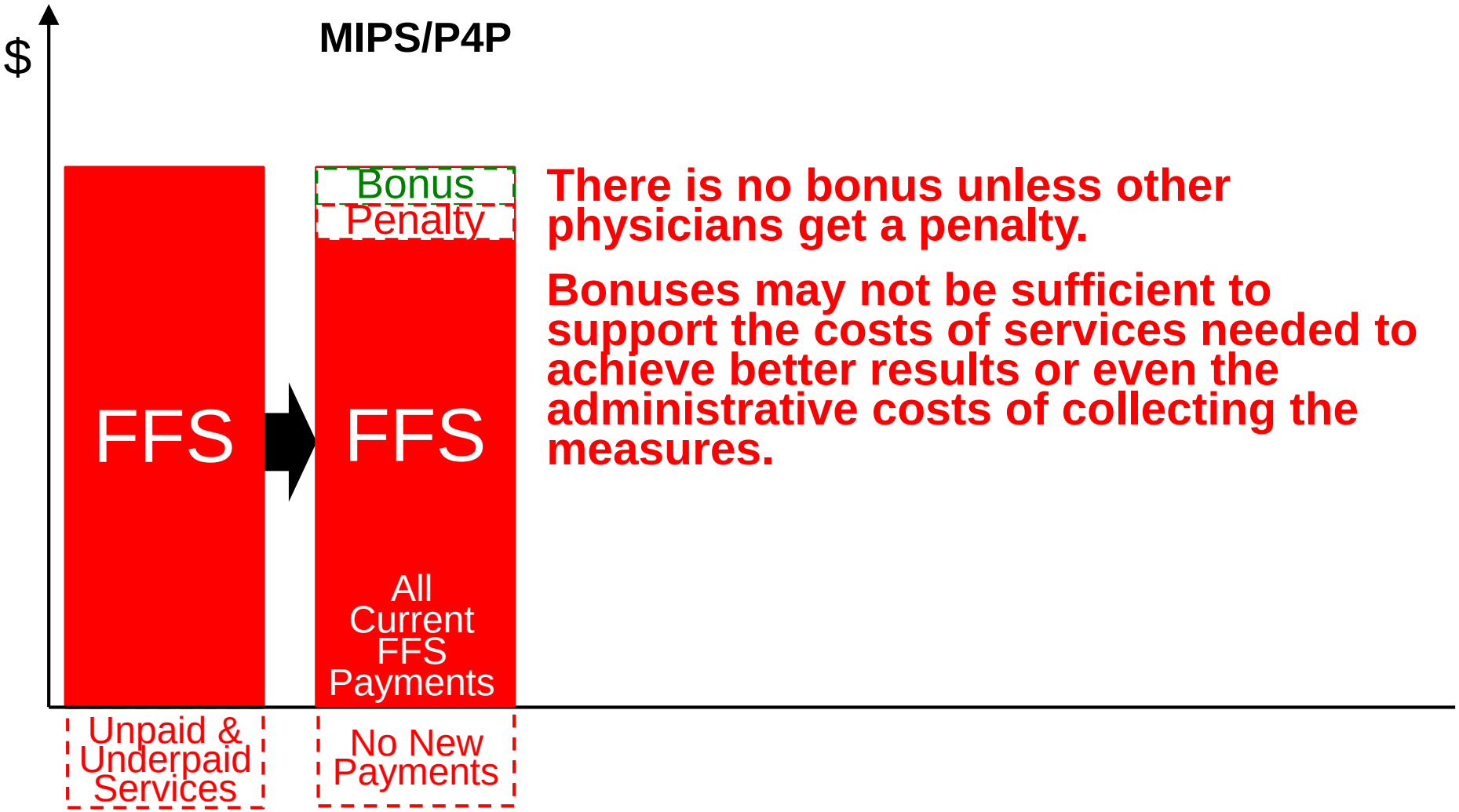


MIPS/P4P Bonuses/Penalties Don't Enable or Ensure Quality



There is no bonus unless other physicians get a penalty.

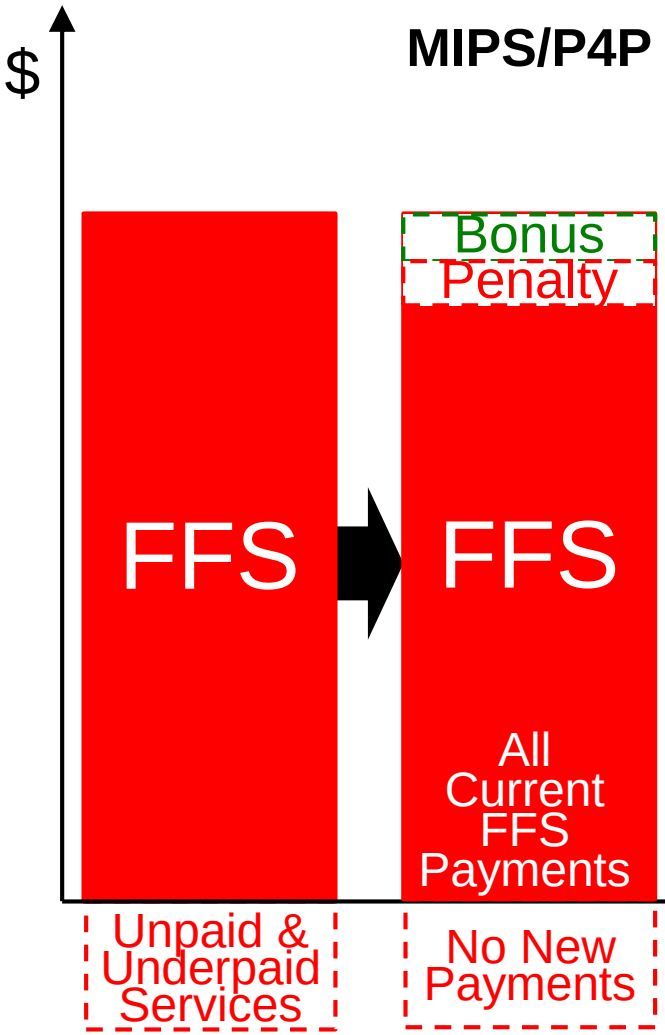
MIPS/P4P Bonuses/Penalties Don't Enable or Ensure Quality



There is no bonus unless other physicians get a penalty.

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

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

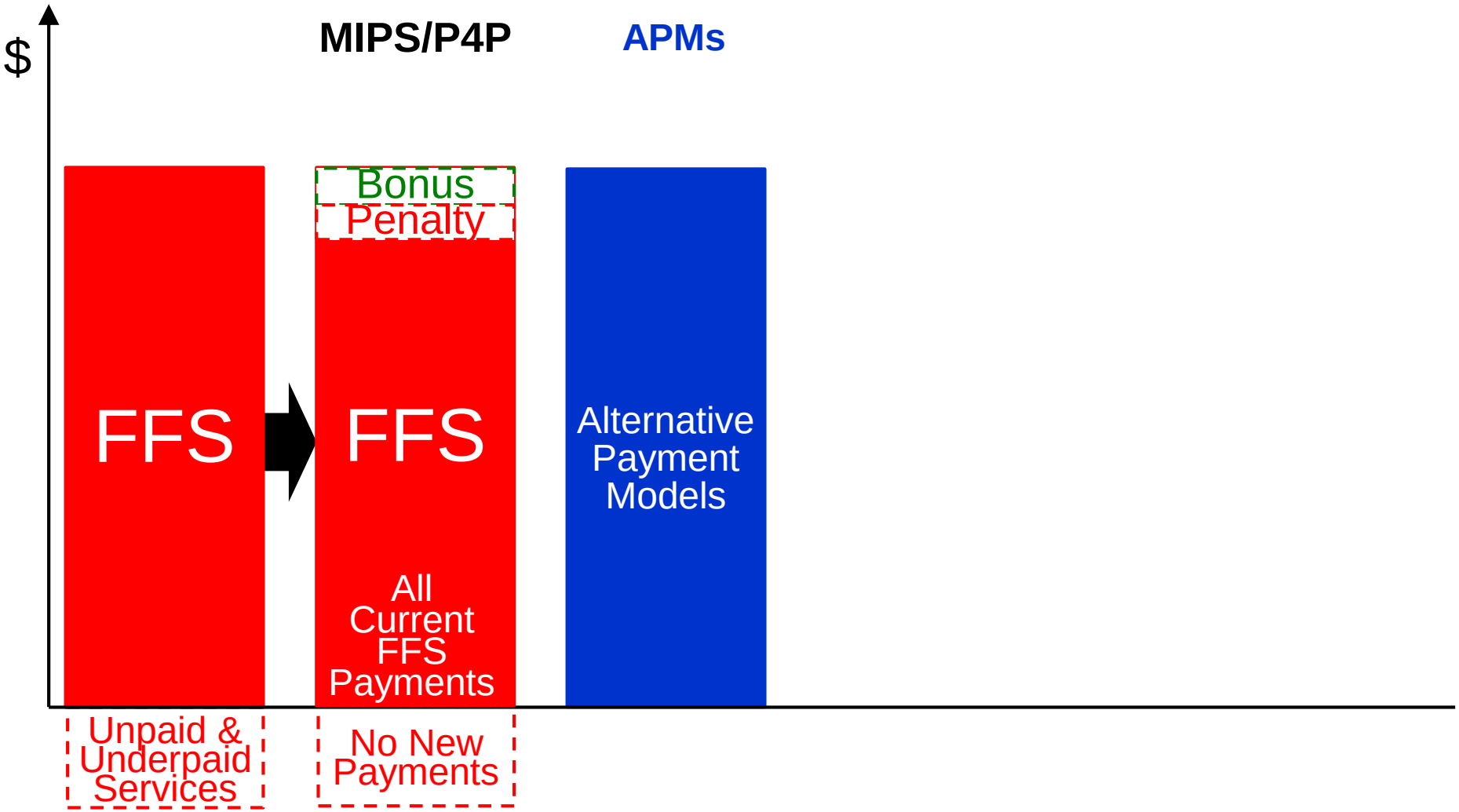


There is no bonus unless other physicians get a penalty.

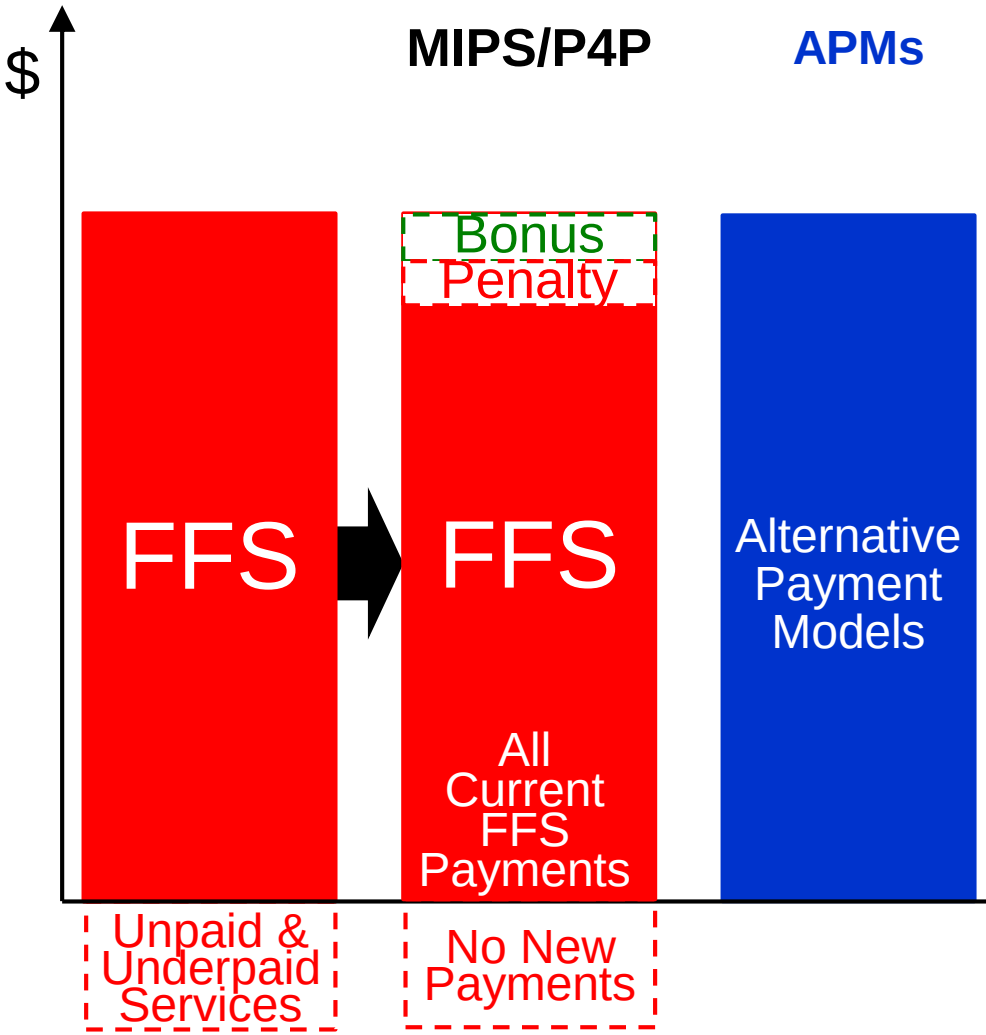
Bonuses may not be sufficient to support the costs of services needed to achieve better results or even the administrative costs of collecting the measures.

Patients/payers still have to pay for services to a patient who failed to achieve the desired outcome or experienced complications as a result of the services.

Value-Based Payment Option #2: Alternative Payment Models (APMs)



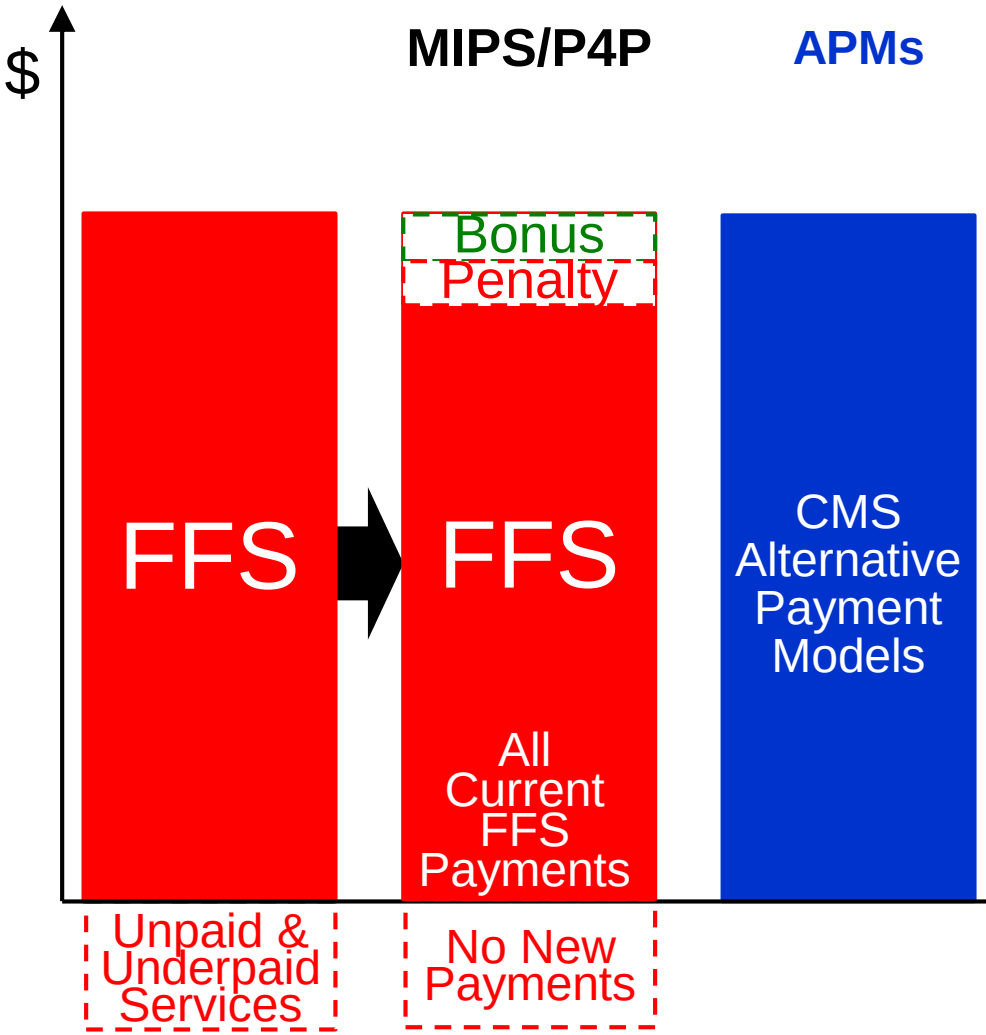
In MACRA, Congress *Encouraged* Use of APMs Instead of MIPS



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

- are exempt from MIPS
- receive a 5% lump sum bonus
- receive a higher annual update in their FFS revenues
- receive the benefits of participating in the APM

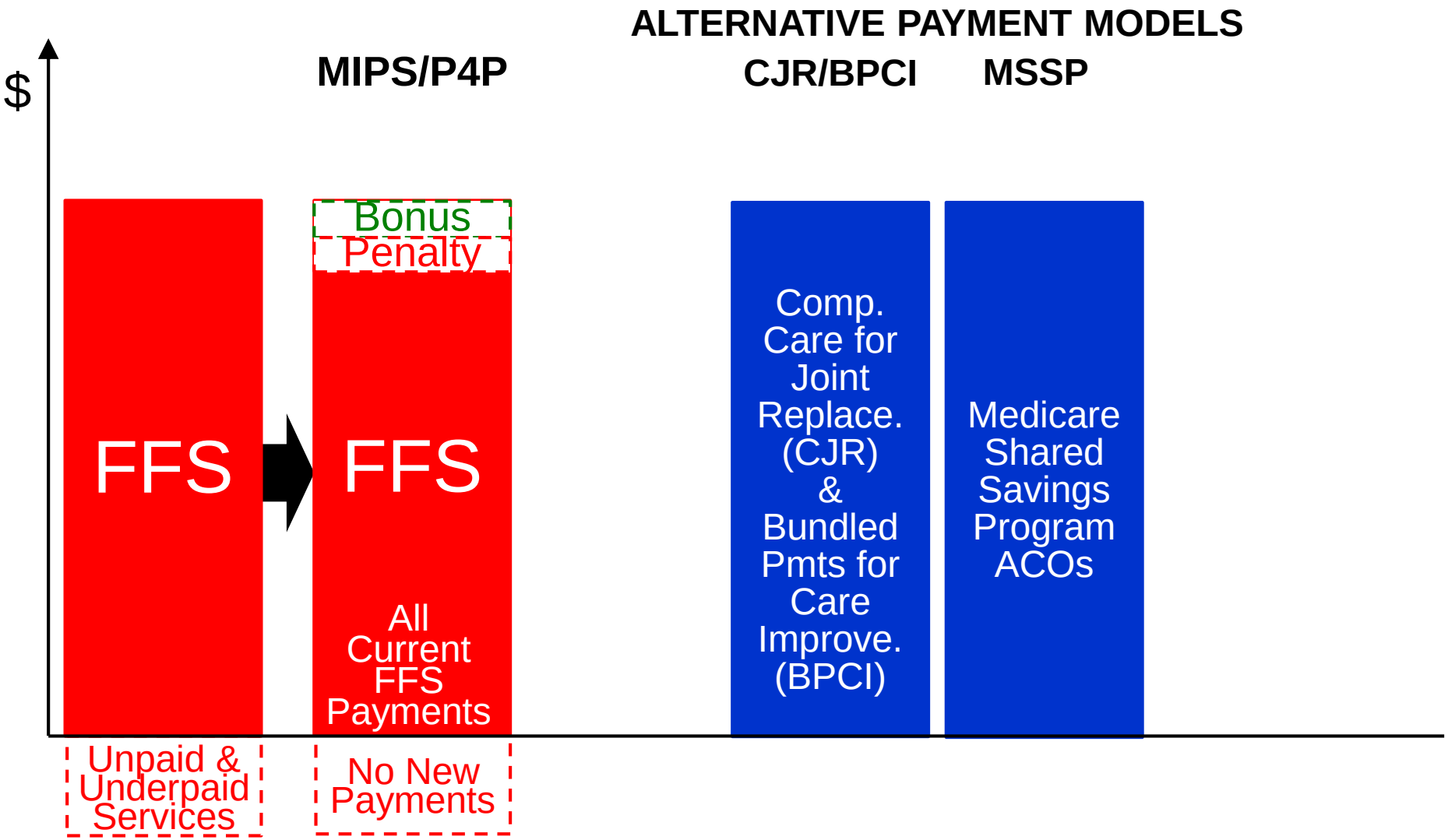
CMS Has Only Implemented a Small Number of APMs



Alternative Payment Models (APMs) implemented in Medicare:

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

Do Episode Payments and ACOs Create Higher-Value Care?

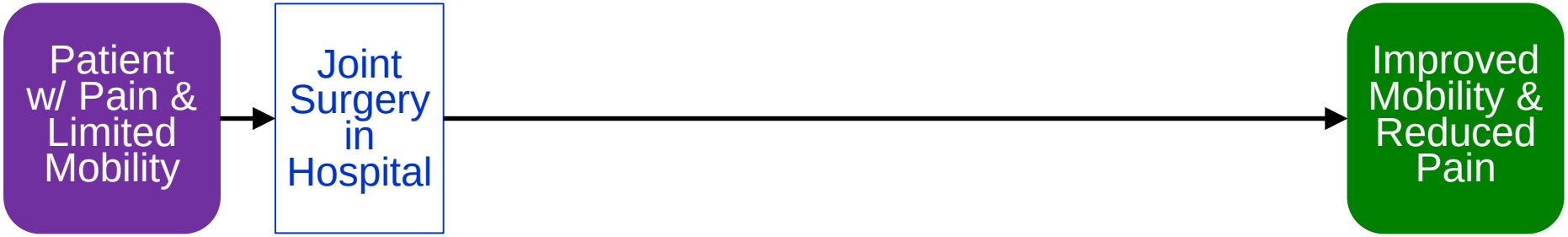


How the Comprehensive Care for Joint Replacement (CJR) Payment Model Works

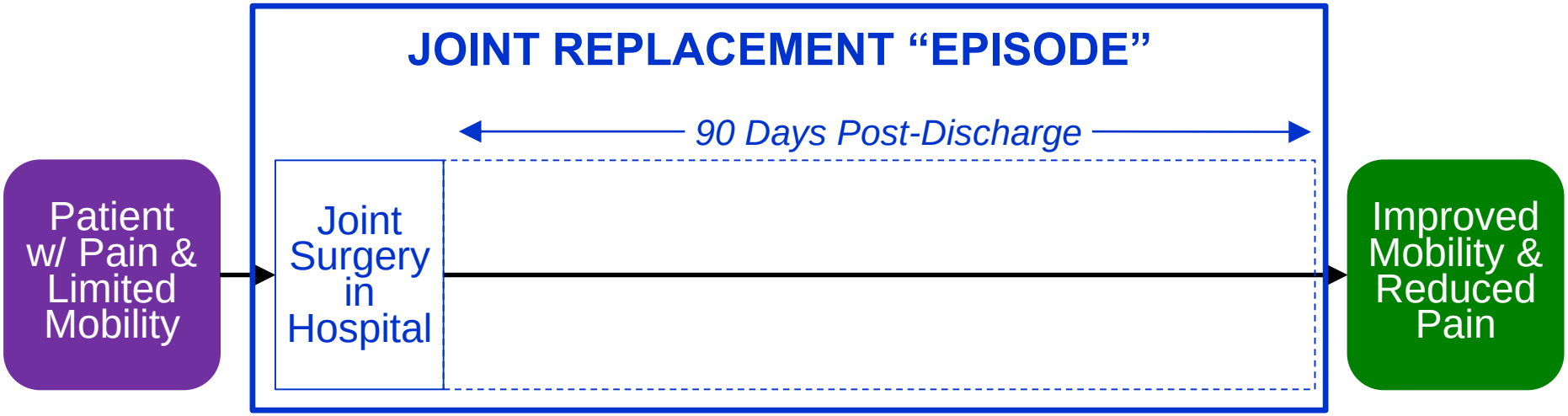
Starting with a Patient With Hip or Knee Problems…

Patient w/ Pain & Limited Mobility

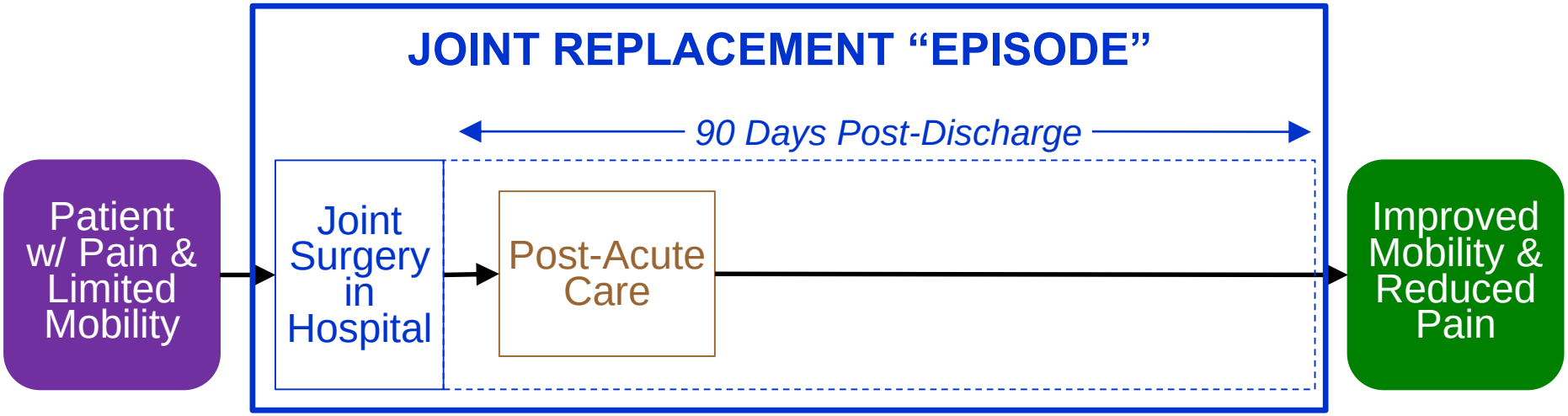
CJR Limited to Patients Receiving Hip or Knee Surgery in Hospital



CMS Defines the Hospital Stay + 90 Days as the "Episode"

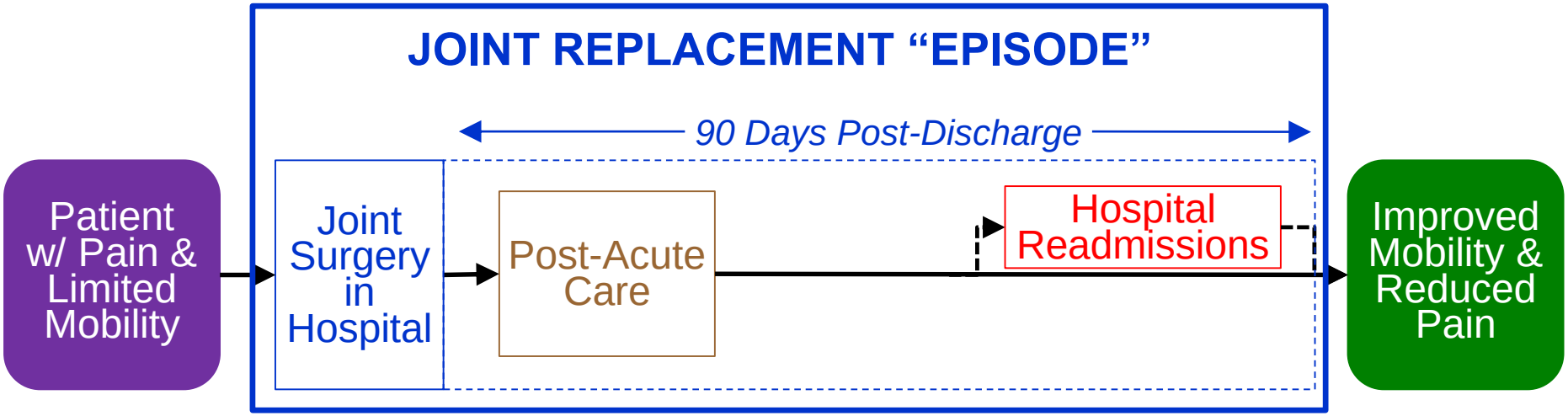


"Episode Spending" Includes Post-Acute Care Services



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

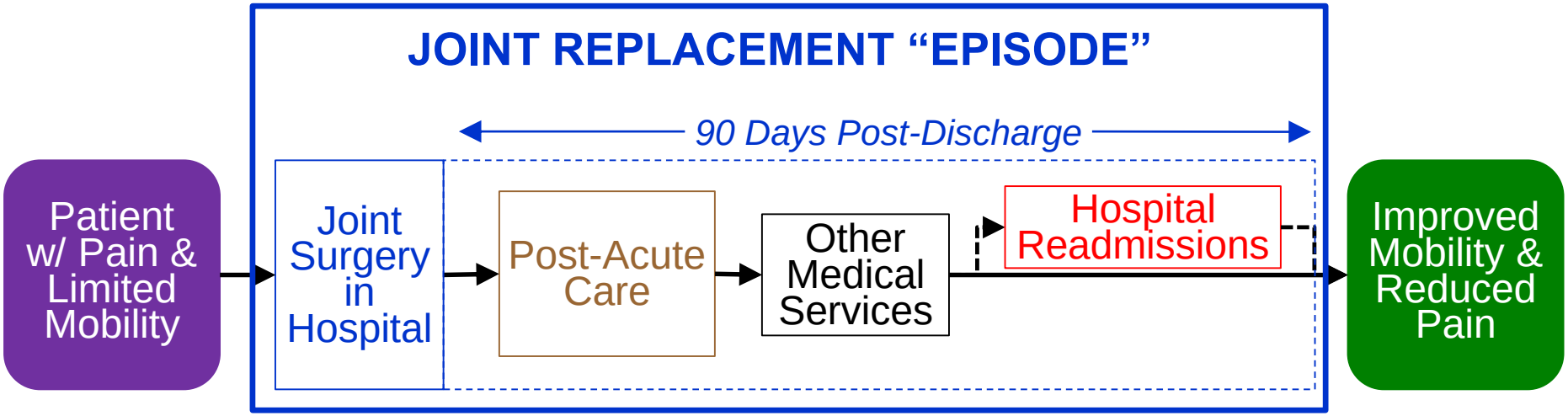
"Episode Spending" Includes Related + Unrelated Readmissions



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

- Surgical Complications
- Chronic Disease Exacerbations (COPD, CHF, Hypertension)
- Other Admissions (e.g., CABG)

"Episode Spending" Includes Other Related + Unrelated Services

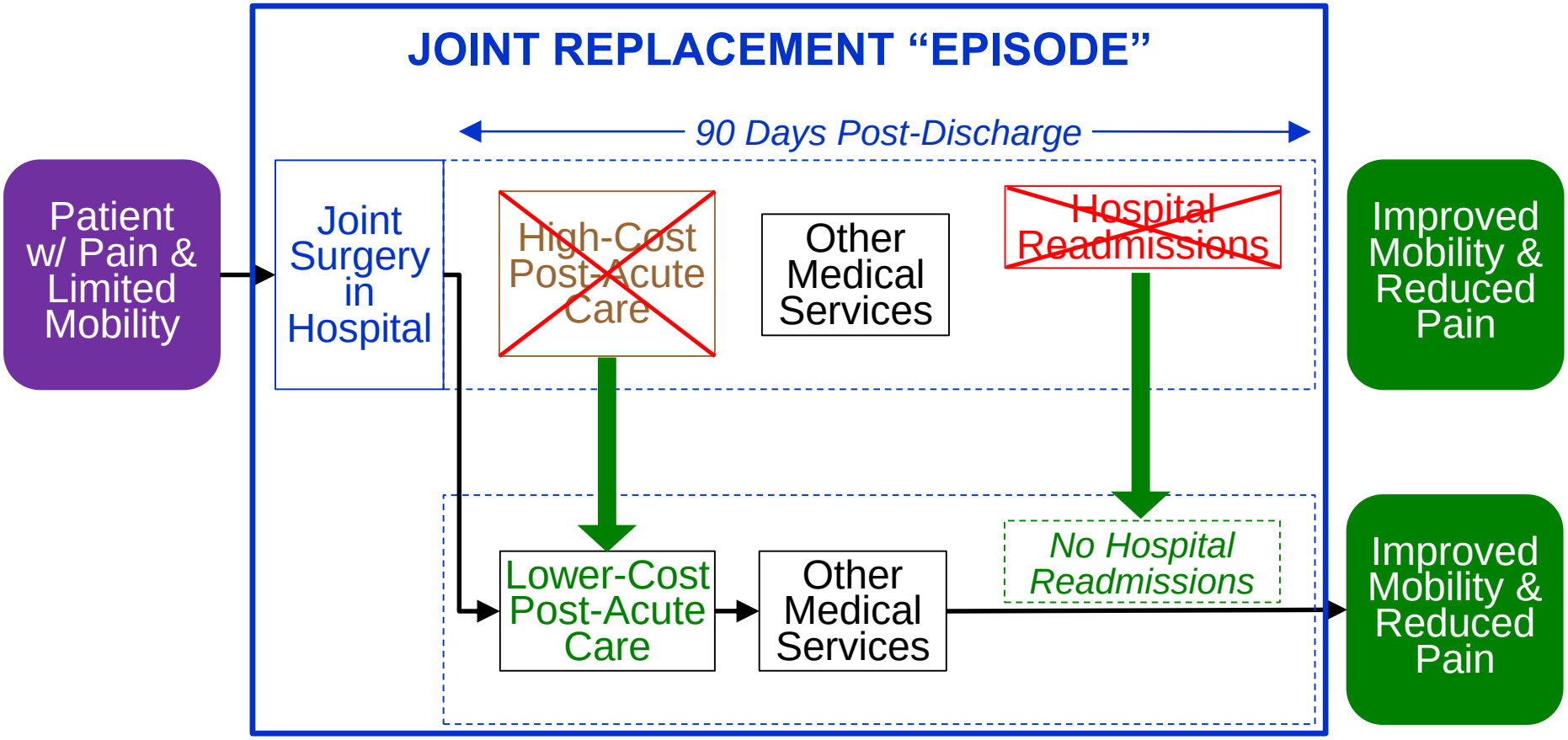


- Skilled Nursing Facility (SNF)
- Inpatient Rehab Facility (IRF)
- Home Health (HH)

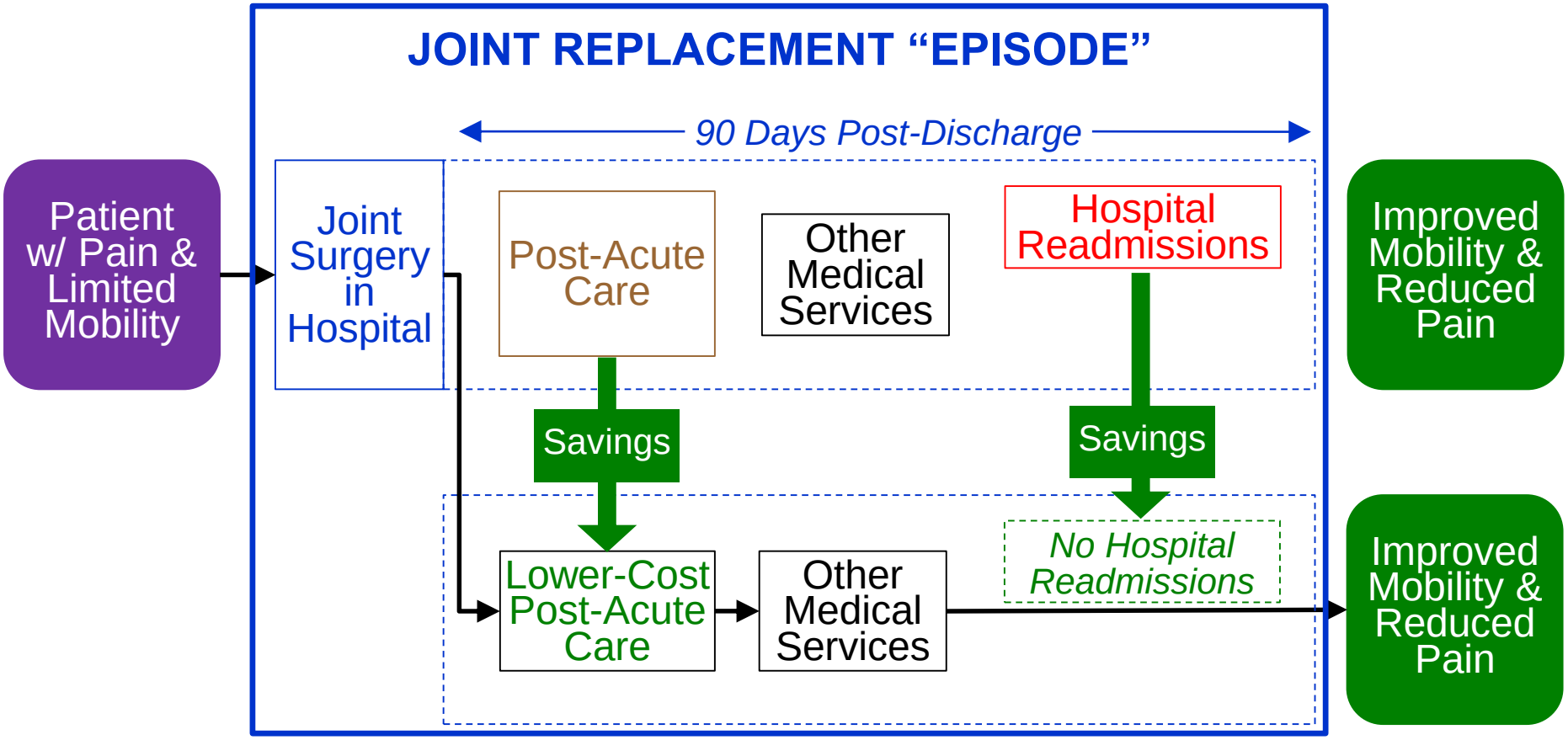
- Surgical Complications
- Chronic Disease Exacerbations (COPD, CHF, Hypertension)
- Other Admissions (e.g., CABG)

- PT/OT
- Visits to Physicians (for unrelated conditions)
- Tests & Other Services (for unrelated conditions)

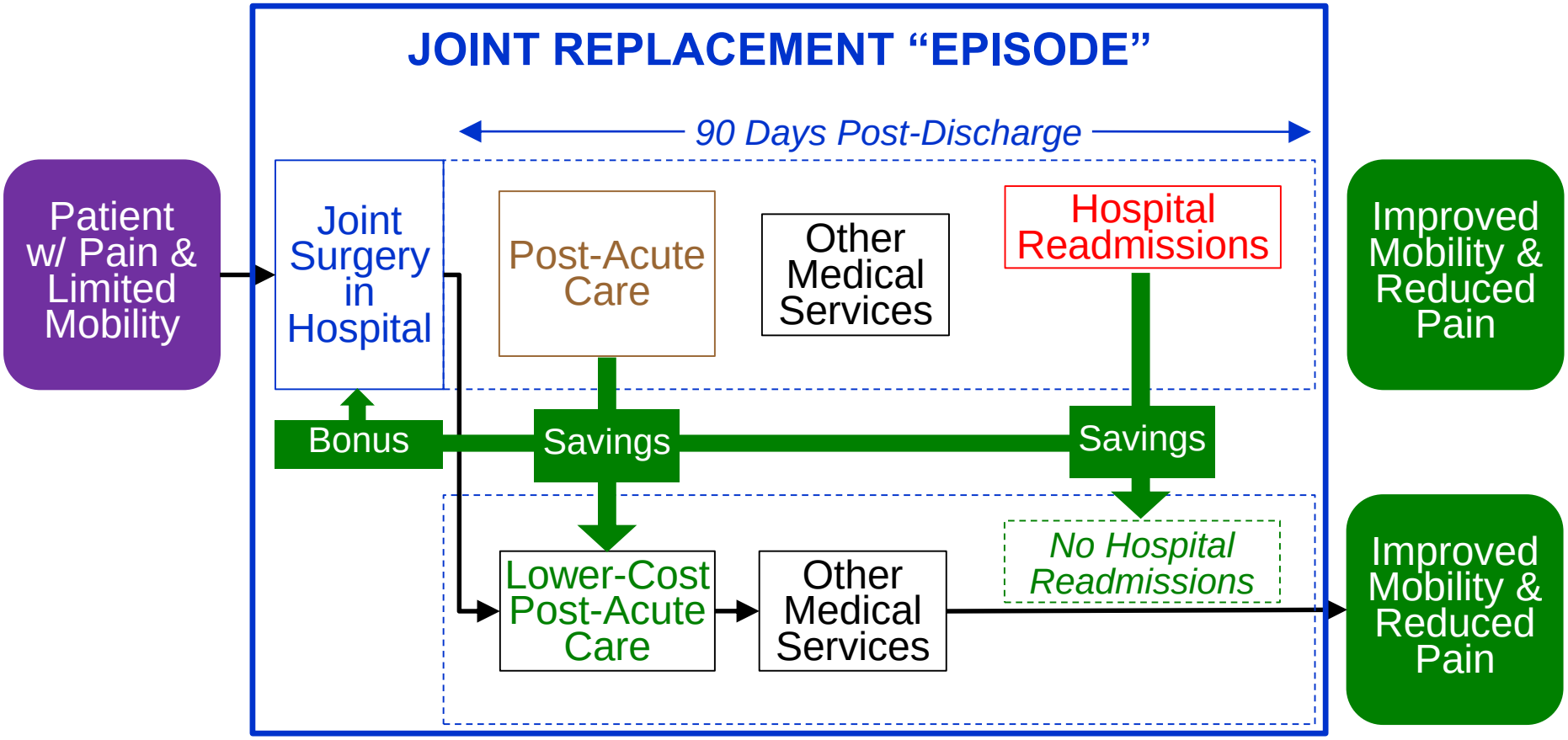
Goal: Reduce Post-Acute Care and Hospital Readmissions



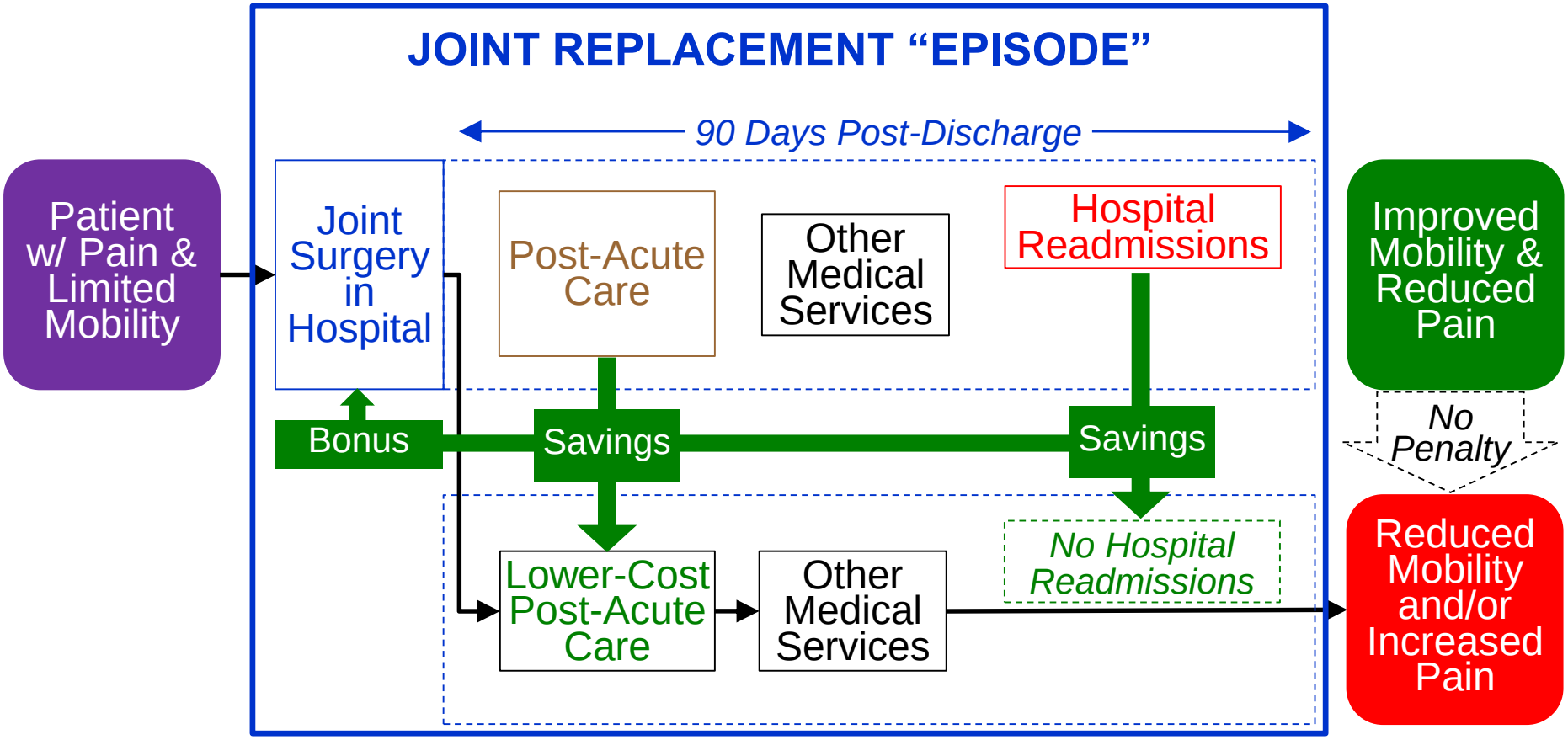
Lower Spending During the Episode = Savings for CMS



Hospital Gets a Bonus if Savings is Greater Than 3%



Problem #1: No Penalty for Worse Outcomes



Measures of Complications & Experience, Not Outcomes/Pain

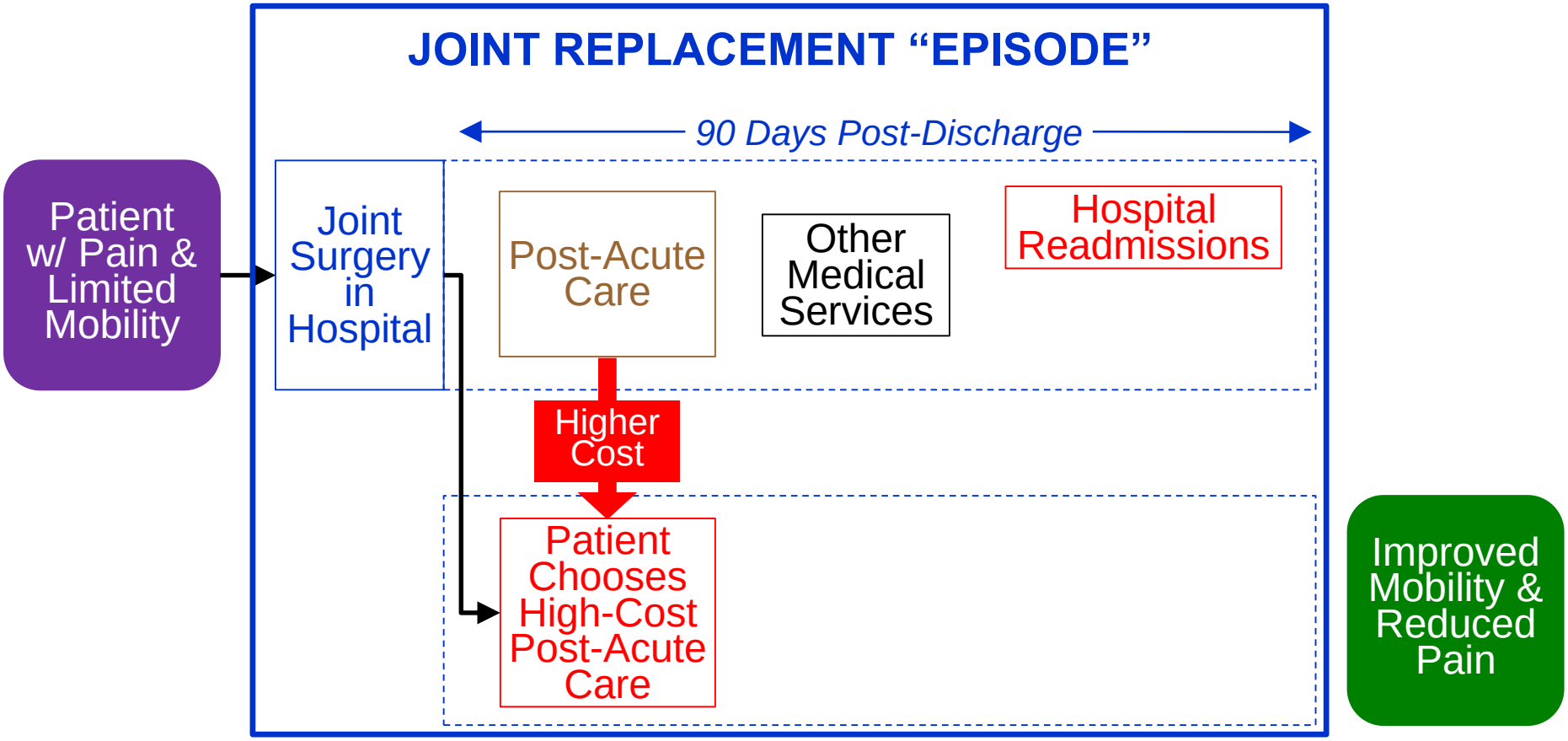
CJR Quality Measures

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

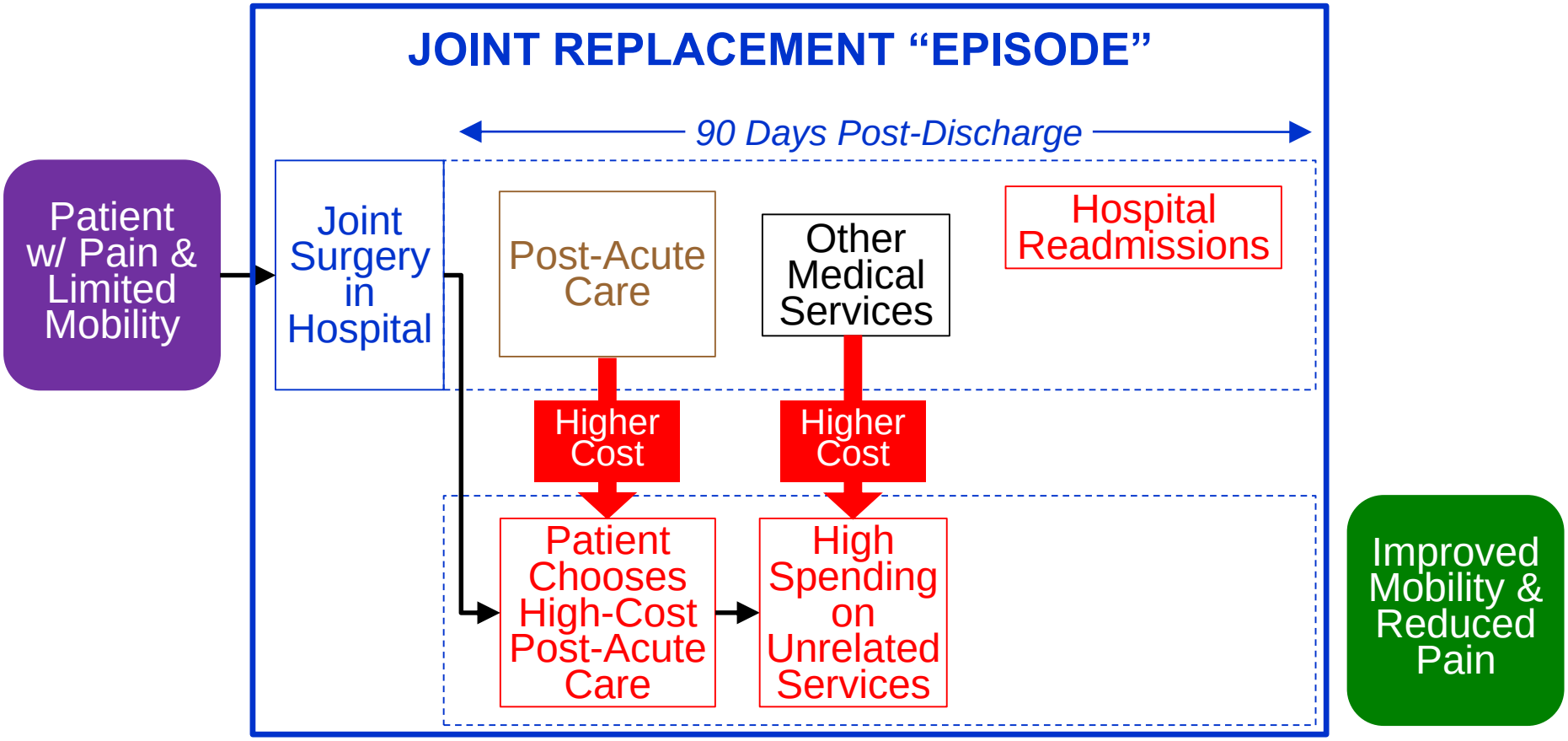
No Measures to Assure:

- Improved ability to walk
- Reduction in osteoarthritis pain
- Pain after

Problem #2: Penalty for Spending on Services Hospital Can't Control



Problem #2: Penalty for Spending on Services Hospital Can't Control



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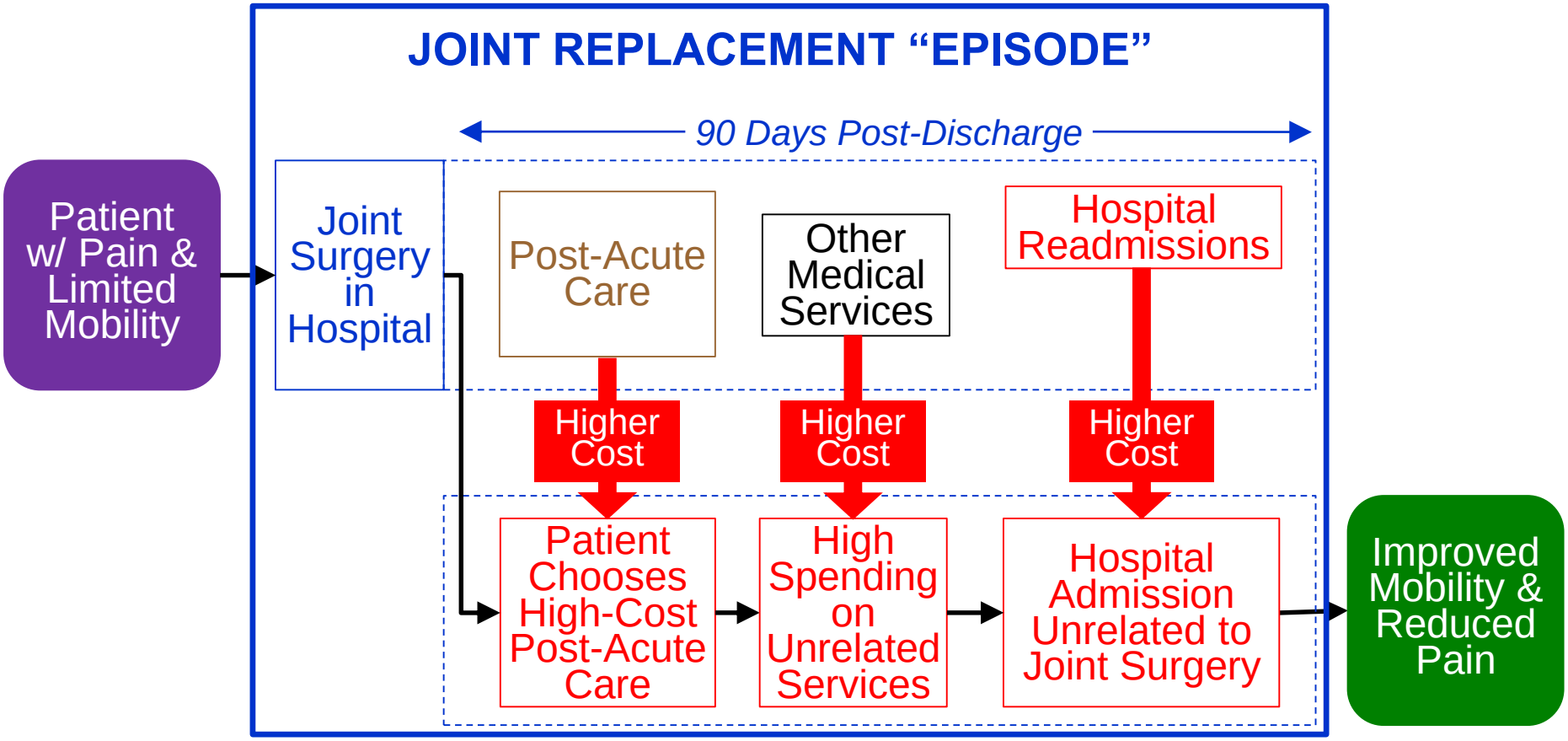
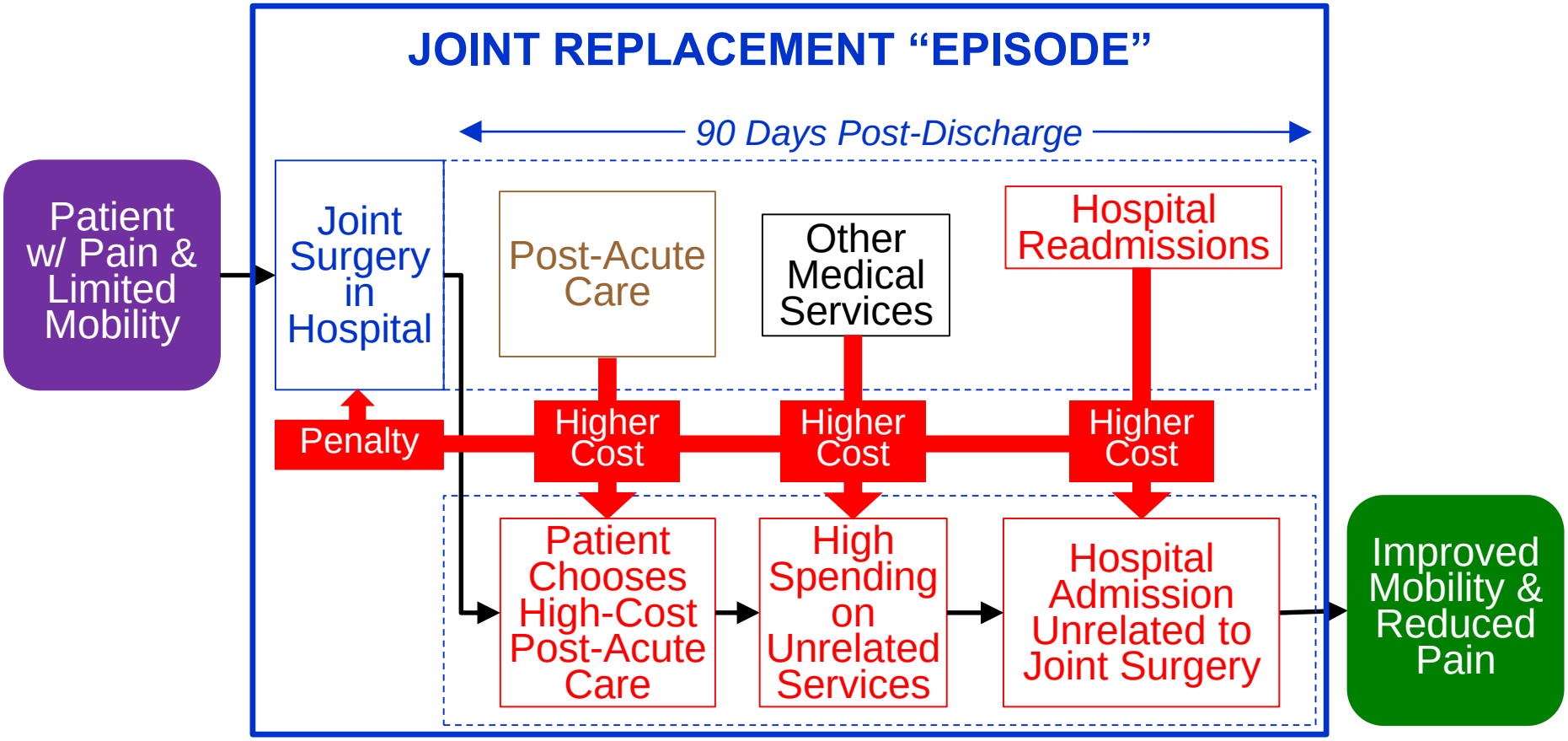
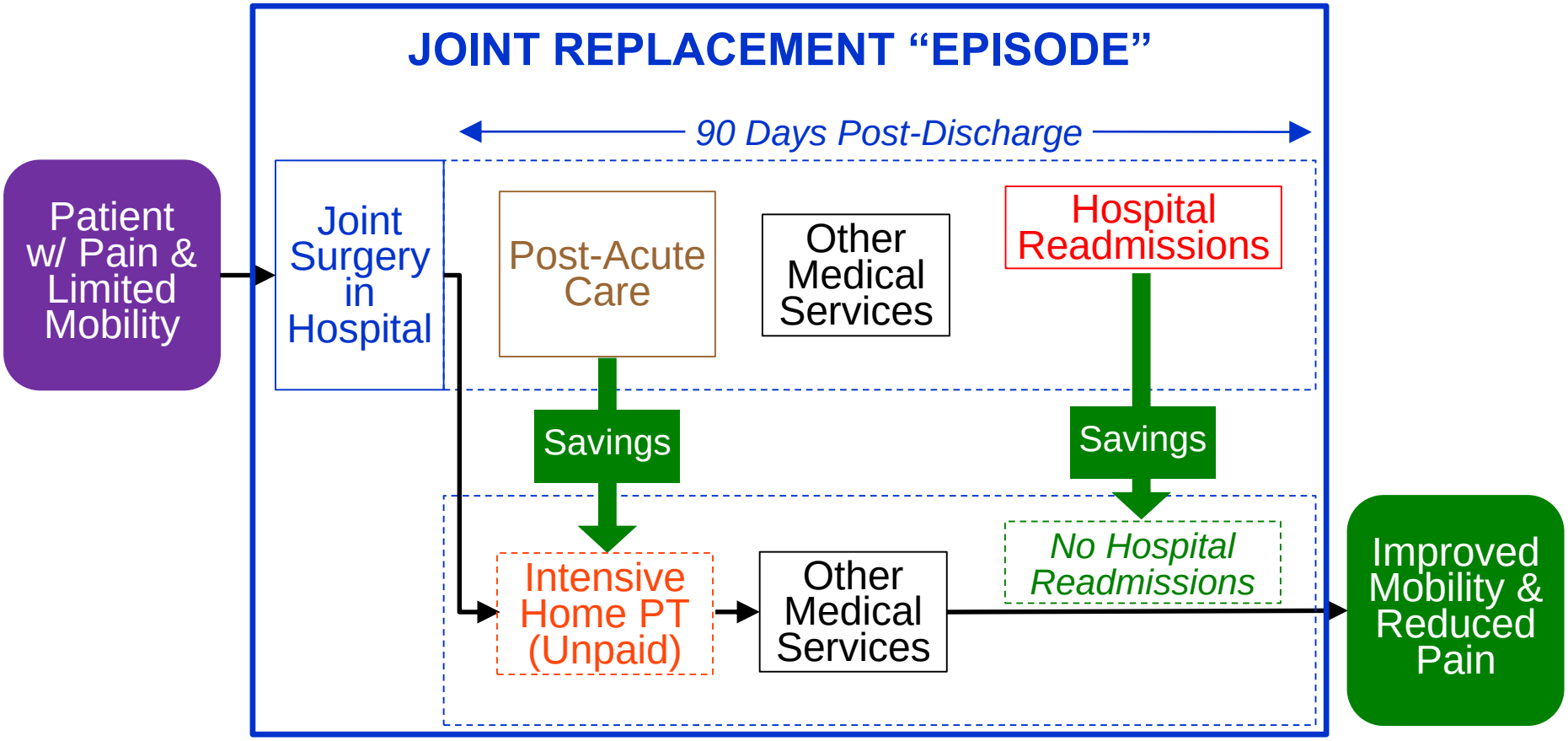


Problem #2: Penalty for Spending on Services Hospital Can't Control



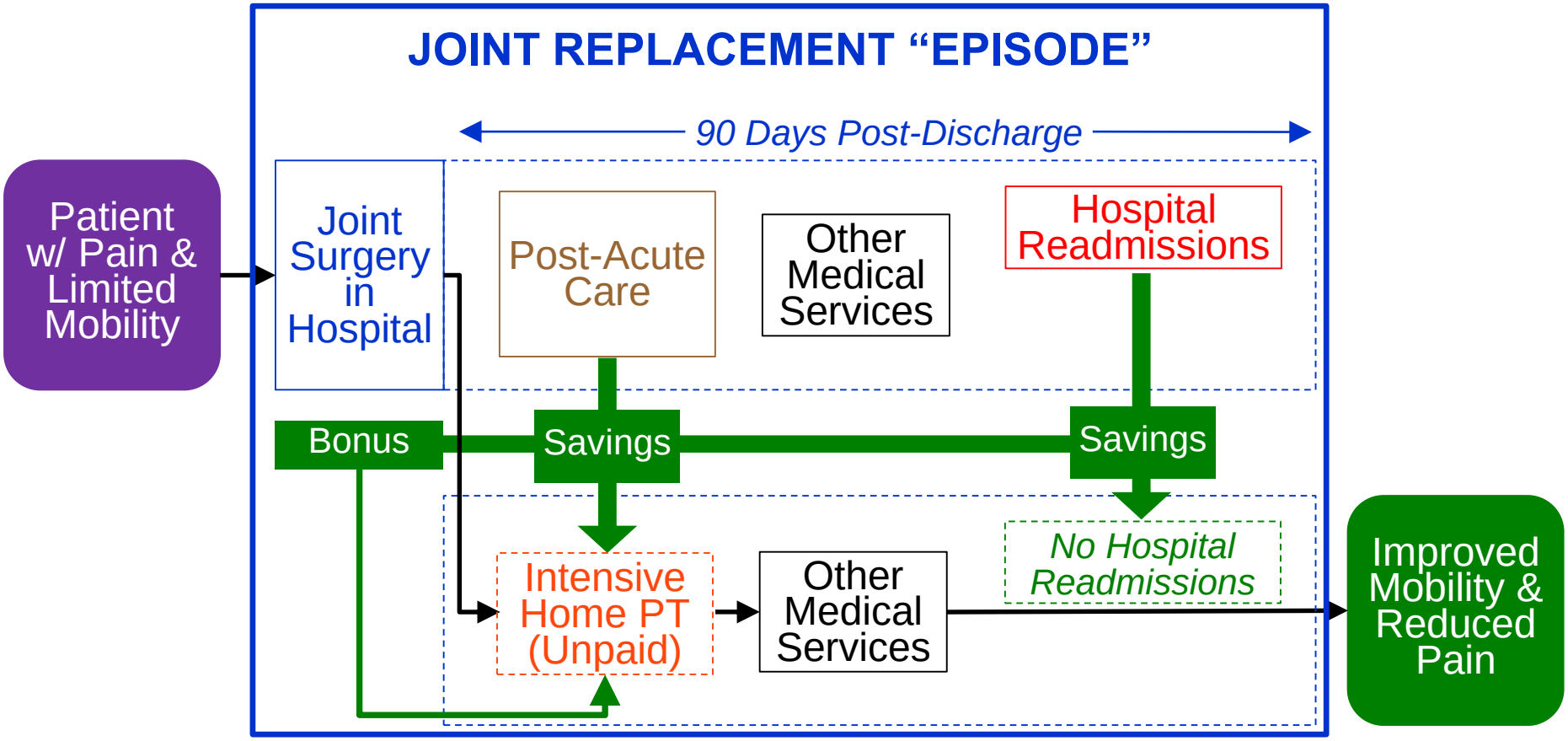
Problem #3: No Flexibility to Deliver Different Services

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



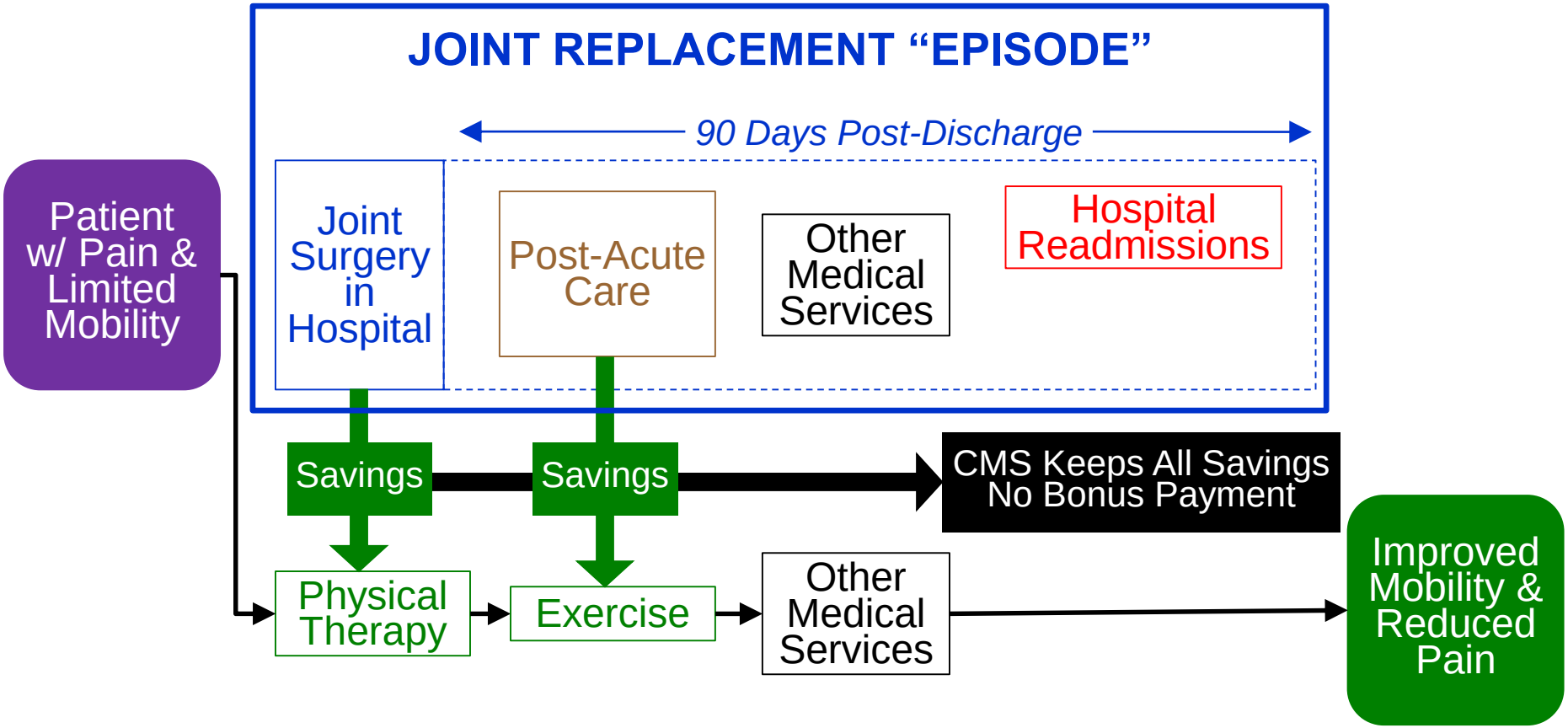
Providers Can Only Innovate if They Front the Money

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

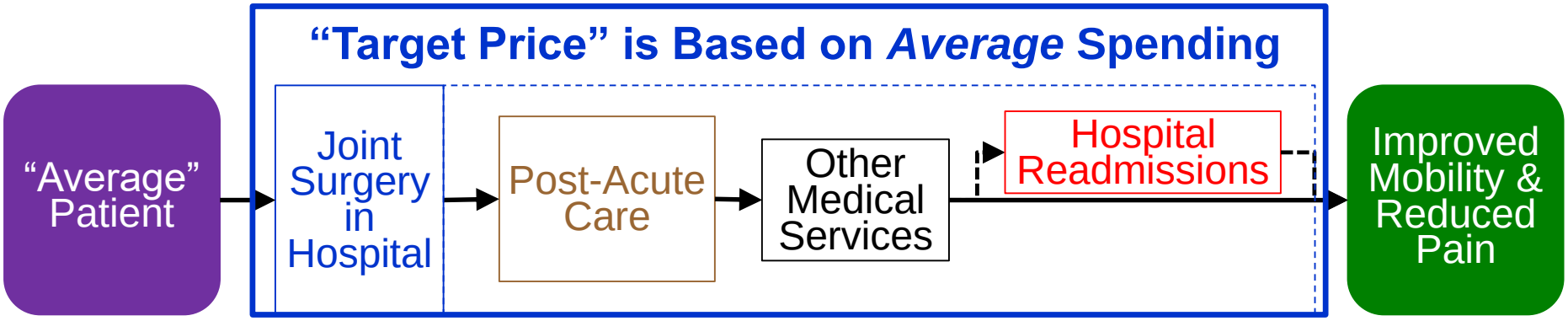


Problem #4: No Reward for Avoiding the Use of Surgery

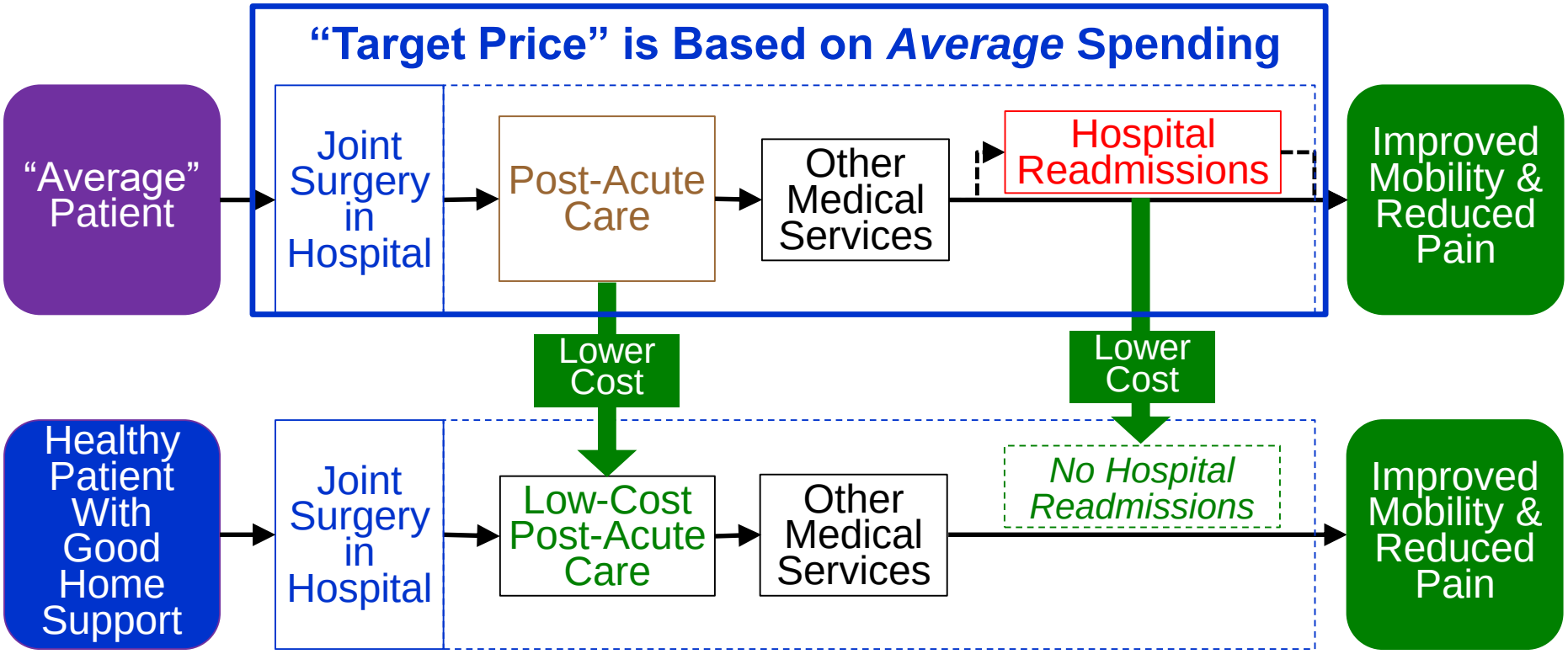
The episode is "triggered" by surgery in the hospital, so use of non-surgical treatments is not counted as savings



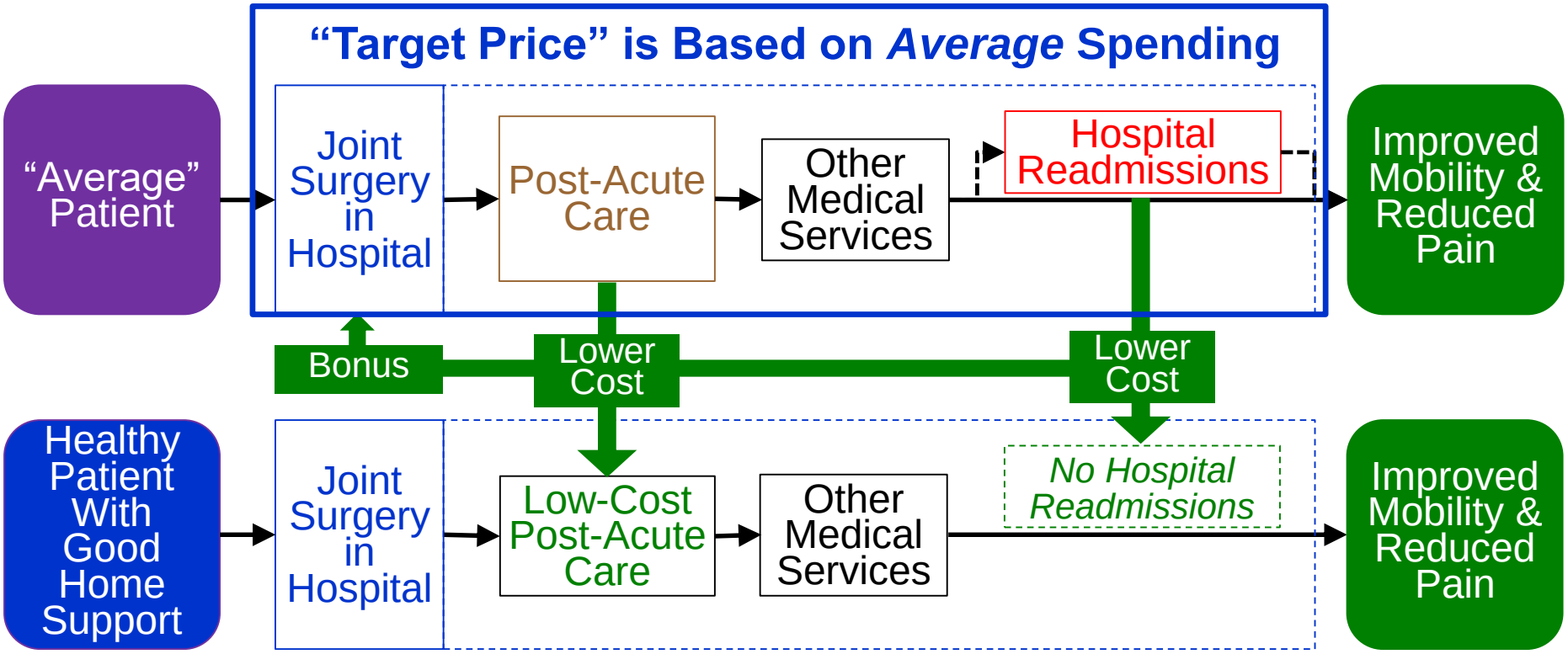
Problem #5: Spending Targets Are Based on *Average Spending*



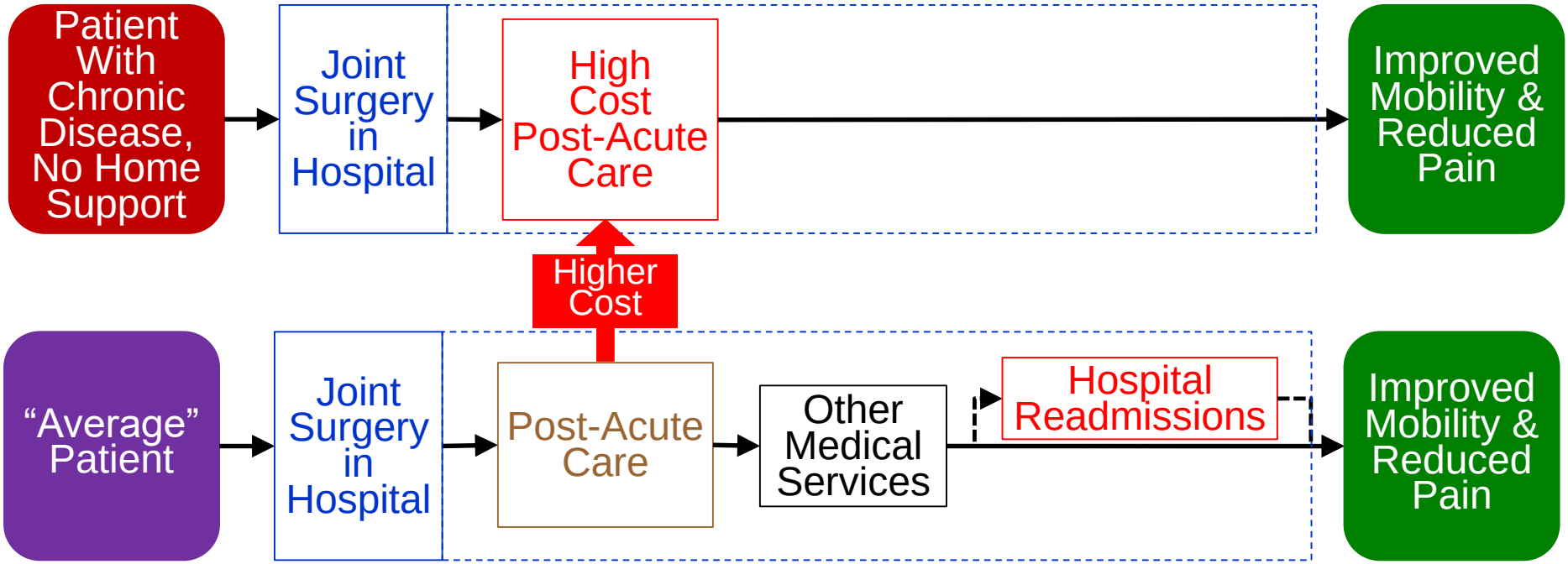
Hospitals With Lower-Need Patients Will Have Costs < Target



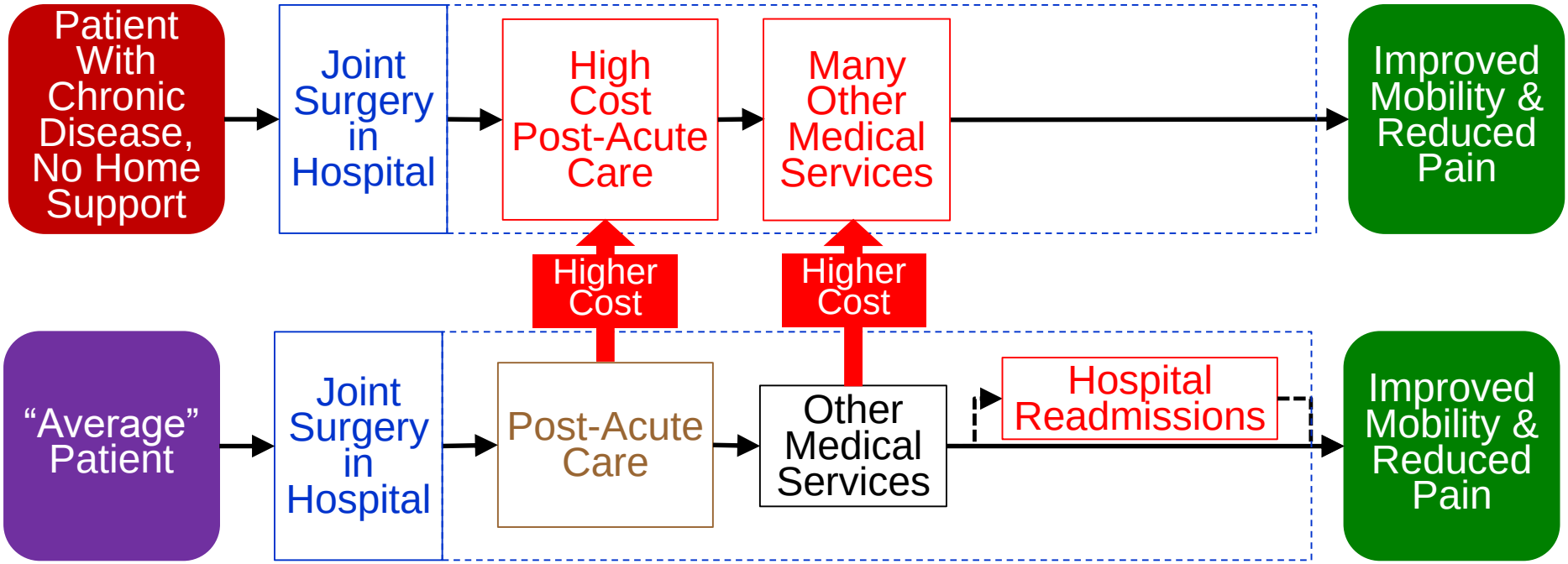
So Hospitals With Lower-Need Patients Will Likely Get Bonuses



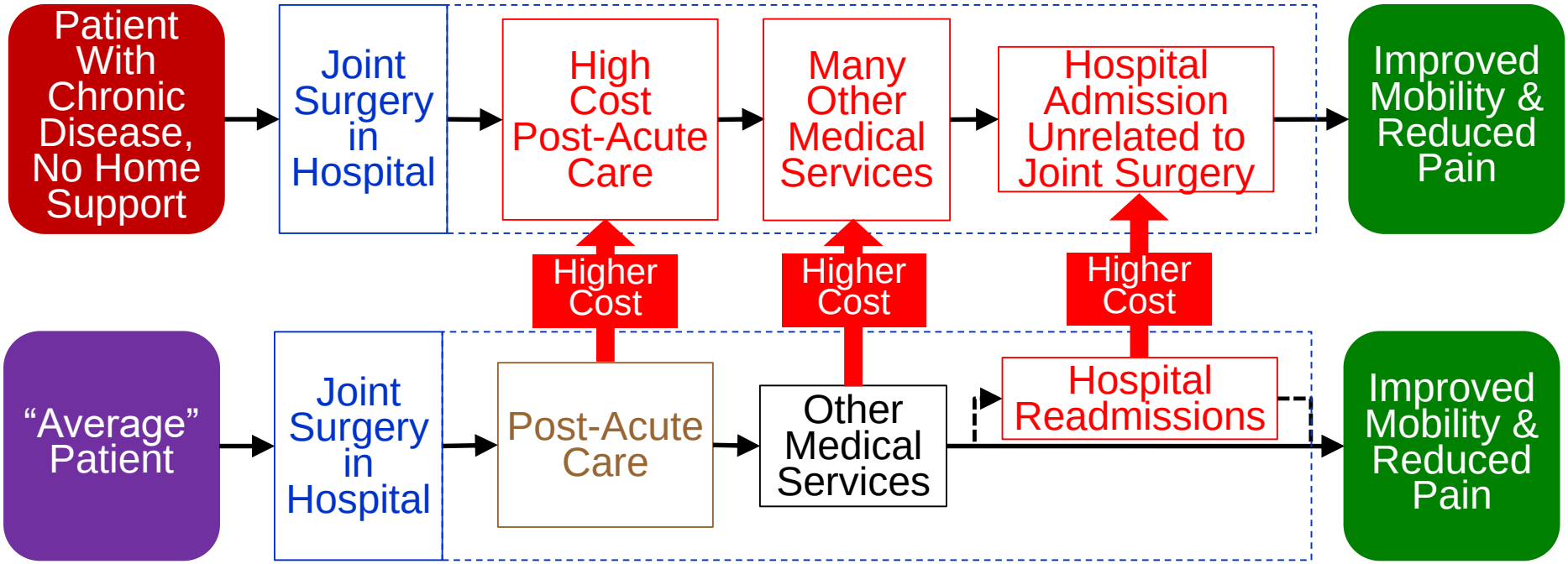
Hospitals With Higher-Need Patients Will Have Costs > Target



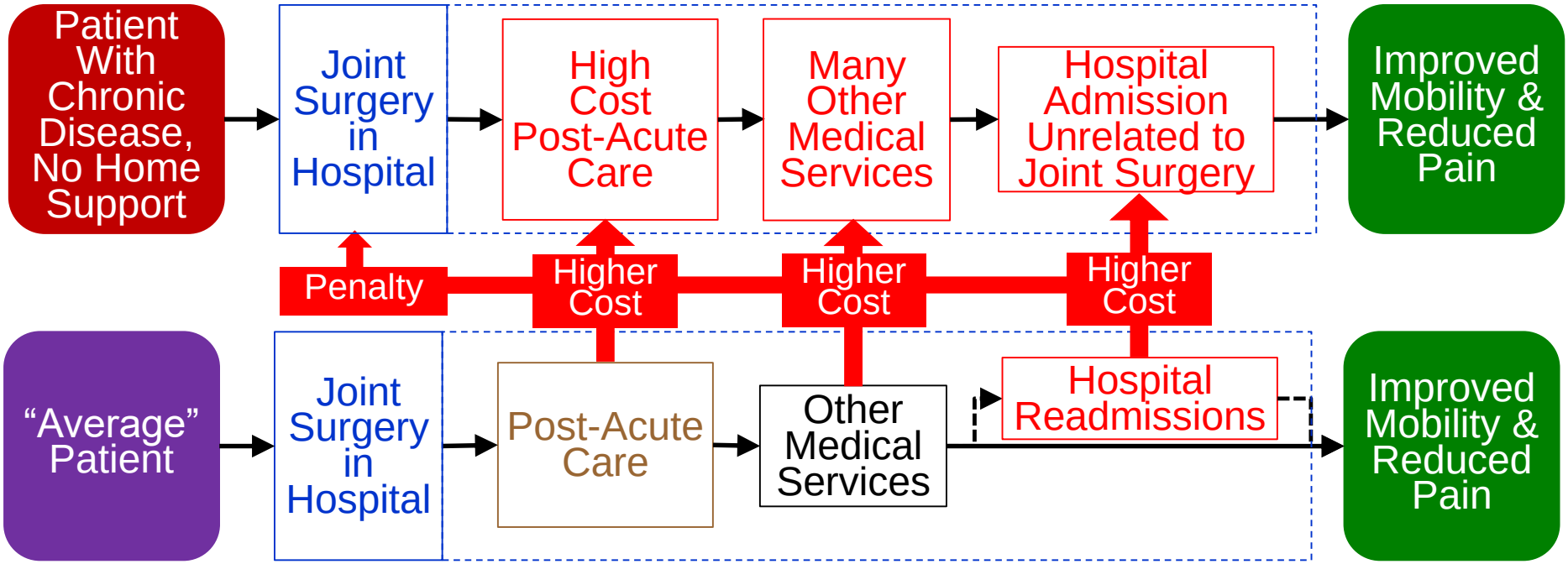
Hospitals With Higher-Need Patients Will Have Costs > Target



Hospitals With Higher-Need Patients Will Have Costs > Target



So Hospitals With Higher-Need Patients Will Receive Penalties



No Risk Adjustment for Factors Affecting Post-Discharge Services

CJR Risk Stratification

- DRG 469 vs DRG 470 with "Major Complications or Comorbidities"
- Fracture vs. Elective Surgery

No Adjustment for:

- Medical conditions not included as "major comorbidities" in the DRG grouper that could result in high use of medical services after discharge or risk of admission to hospital for conditions unrelated to joint surgery
- Patient characteristics that increase Medicare payments for SNF, home health, and other post-acute care services
  - Functional status
  - Depression
  - Cognitive status
- Lack of caregiver support at home
- Lack of access to transportation

CMS Didn't Risk Adjust Better Because They Didn't Know How

CJR Risk Stratification

- DRG 469 vs DRG 470 with "Major Complications or Comorbidities"
- Fracture vs. Elective Surgery

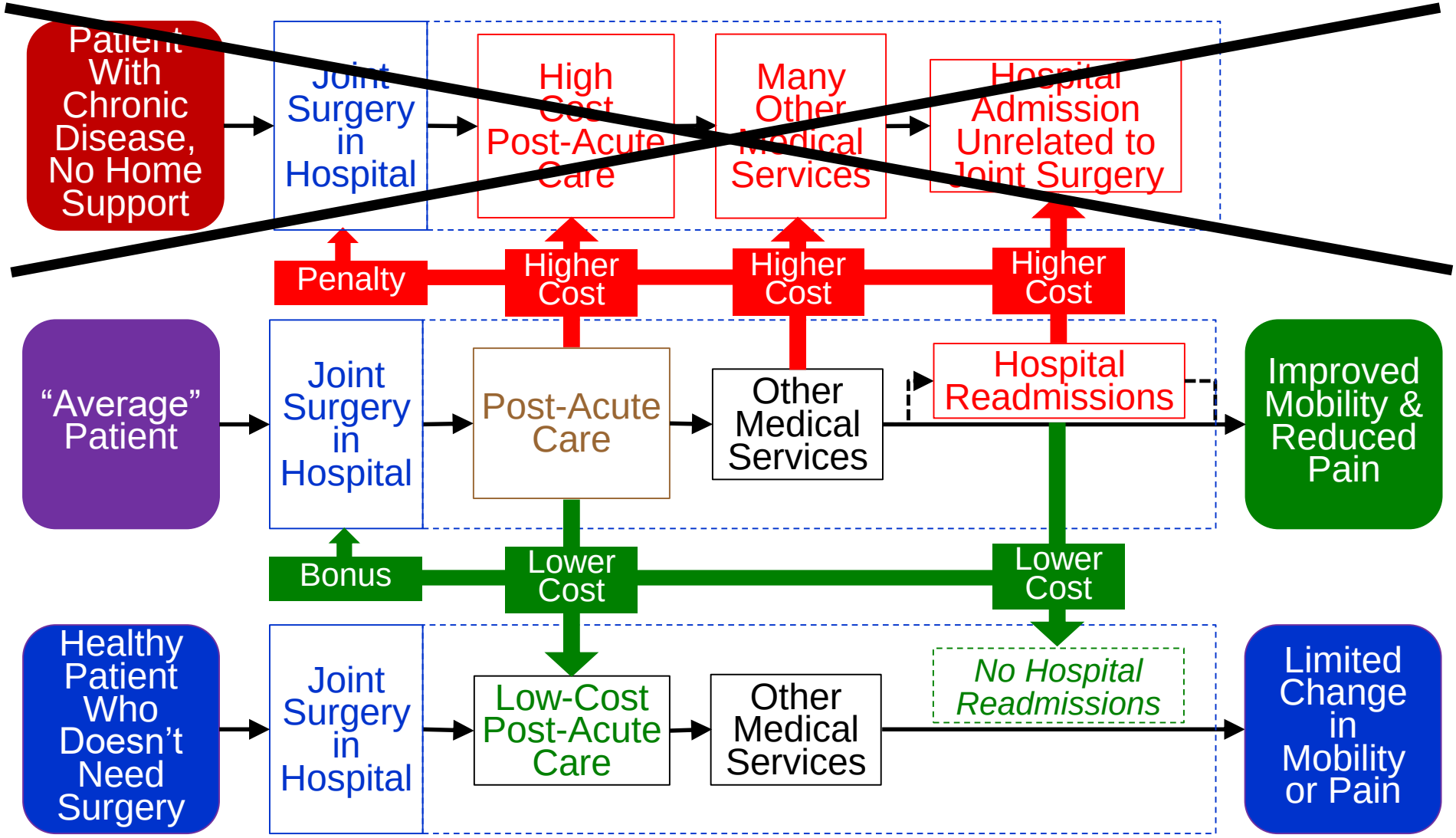
"We considered risk adjusting the episode target prices by making adjustments or setting different prices based on patient-specific clinical indicators (for example, comorbidities). However, we did not believe there is a sufficiently reliable approach that exists suitable for CJR episodes beyond MS–DRG-specific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

CMS (80 FR 73338)

No Adjustment for:

- Medical conditions not included as "major comorbidities" in the DRG grouper that could result in high use of medical services after discharge or risk of admission to hospital for conditions unrelated to joint surgery
- Patient characteristics that increase Medicare payments for SNF, home health, and other post-acute care services
  - Functional status
  - Depression
  - Cognitive status
- Lack of caregiver support at home
- Lack of access to transportation

Disincentive to Serve High-Need, Incentive for Unnecessary Surgery



Hypothetical Region With Two Hospitals

Hospital
#1

#2

25% of Patients at Hospital #1 Have High Post-Acute Care Needs

Hospital	Patient
#1	Low Need
	Low Need
	Low Need
	High Need

#2

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

Hospital	Patient	Surgery
#1	Low Need	$13,700
	Low Need	$13,700
	Low Need	$13,700
	High Need	$13,700

#2

High Need Patients Have Higher Post-Acute Care Costs

Hospital	Patient	Surgery	Post-Acute	Readmit	Other
#1	Low Need	$13,700	$3,000	$0	$1,000
	Low Need	$13,700	$3,000	$0	$1,000
	Low Need	$13,700	$12,000	$0	$1,000
	High Need	$13,700	$12,000	$12,000	$2,000

#2

So High-Need Patients Cost Twice as Much as Low-Need

Hospital	Patient	Surgery	Post-Acute	Readmit	Other	Total
#1	Low Need	$13,700	$3,000	$0	$1,000	$17,700
	Low Need	$13,700	$3,000	$0	$1,000	$17,700
	Low Need	$13,700	$12,000	$0	$1,000	$26,700
	High Need	$13,700	$12,000	$12,000	$2,000	$39,700

#2

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

Hospital	Patient	Surgery	Post-Acute	Readmit	Other	Total
#1	Low Need	$13,700	$3,000	$0	$1,000	$17,700
	Low Need	$13,700	$3,000	$0	$1,000	$17,700
	Low Need	$13,700	$12,000	$0	$1,000	$26,700
	High Need	$13,700	$12,000	$12,000	$2,000	$39,700
#2	Low Need	$13,700	$3,000	$0	$1,000	$17,700
	Low Need	$13,700	$12,000	$0	$1,000	$26,700
	High Need	$13,700	$12,000	$12,000	$2,000	$39,700
	High Need	$13,700	$12,000	$12,000	$2,000	$39,700

CMS Calculates the Average Cost of Episodes in the Region…

Hospital	Patient	Surgery	Post-Acute	Readmit	Other	Total
#1	Low Need	$13,700	$3,000	$0	$1,000	$17,700
	Low Need	$13,700	$3,000	$0	$1,000	$17,700
	Low Need	$13,700	$12,000	$0	$1,000	$26,700
	High Need	$13,700	$12,000	$12,000	$2,000	$39,700
#2	Low Need	$13,700	$3,000	$0	$1,000	$17,700
	Low Need	$13,700	$12,000	$0	$1,000	$26,700
	High Need	$13,700	$12,000	$12,000	$2,000	$39,700
	High Need	$13,700	$12,000	$12,000	$2,000	$39,700
					Average:	**$28,200**

…Then Discounts the Average to Calculate the "Target Price"

Hospital	Patient	Surgery	Post-Acute	Readmit	Other	Total
#1	Low Need	$13,700	$3,000	$0	$1,000	$17,700
	Low Need	$13,700	$3,000	$0	$1,000	$17,700
	Low Need	$13,700	$12,000	$0	$1,000	$26,700
	High Need	$13,700	$12,000	$12,000	$2,000	$39,700
#2	Low Need	$13,700	$3,000	$0	$1,000	$17,700
	Low Need	$13,700	$12,000	$0	$1,000	$26,700
	High Need	$13,700	$12,000	$12,000	$2,000	$39,700
	High Need	$13,700	$12,000	$12,000	$2,000	$39,700

Average:	**$28,200**
-3%	**($846)**
TARGET:	**$27,354**

Each Hospital Then Has to Meet the Target Price, *On Average*

Hospital	Patient	Surgery	Post-Acute	Readmit	Other	Total
#1	Low Need	$13,700	$3,000	$0	$1,000	$17,700
	Low Need	$13,700	$3,000	$0	$1,000	$17,700
	Low Need	$13,700	$12,000	$0	$1,000	$26,700
	High Need	$13,700	$12,000	$12,000	$2,000	$39,700
					TARGET:	**$27,354**
#2	Low Need	$13,700	$3,000	$0	$1,000	$17,700
	Low Need	$13,700	$12,000	$0	$1,000	$26,700
	High Need	$13,700	$12,000	$12,000	$2,000	$39,700
	High Need	$13,700	$12,000	$12,000	$2,000	$39,700
					TARGET:	**$27,354**
					TARGET:	**$27,354**

CMS Calculates Actual Average Spending at Each Hospital…

Hospital	Patient	Surgery	Post-Acute	Readmit	Other	Total
#1	Low Need	$13,700	$3,000	$0	$1,000	$17,700
	Low Need	$13,700	$3,000	$0	$1,000	$17,700
	Low Need	$13,700	$12,000	$0	$1,000	$26,700
	High Need	$13,700	$12,000	$12,000	$2,000	$39,700
					Average:	**$25,450**
					TARGET:	**$27,354**
#2	Low Need	$13,700	$3,000	$0	$1,000	$17,700
	Low Need	$13,700	$12,000	$0	$1,000	$26,700
	High Need	$13,700	$12,000	$12,000	$2,000	$39,700
	High Need	$13,700	$12,000	$12,000	$2,000	$39,700
					Average:	**$30,950**
					TARGET:	**$27,354**

…And Determines Whether the Hospital is Above or Below Target

Hospital	Patient	Surgery	Post-Acute	Readmit	Other	Total
#1	Low Need	$13,700	$3,000	$0	$1,000	$17,700
	Low Need	$13,700	$3,000	$0	$1,000	$17,700
	Low Need	$13,700	$12,000	$0	$1,000	$26,700
	High Need	$13,700	$12,000	$12,000	$2,000	$39,700
					Average:	**$25,450**
					TARGET:	**$27,354**
					Bonus:	**$1,904**
#2	Low Need	$13,700	$3,000	$0	$1,000	$17,700
	Low Need	$13,700	$12,000	$0	$1,000	$26,700
	High Need	$13,700	$12,000	$12,000	$2,000	$39,700
	High Need	$13,700	$12,000	$12,000	$2,000	$39,700
					Average:	**$30,950**
					TARGET:	**$27,354**
					Penalty:	**($3,596)**

Some Hospitals Start Out Ahead of the Curve

Hospital	Patient	Surgery	Post-Acute	Readmit	Other	Total
#1	Low Need	$13,700	$3,000	$0	$1,000	$17,700
	Low Need	$13,700	$3,000	$0	$1,000	$17,700
	Low Need	$13,700	$12,000	$0	$1,000	$26,700
	High Need	$13,700	$12,000	$12,000	$2,000	$39,700
					Average:	**$25,450**
					TARGET:	**$27,354**
					Bonus:	**$1,904**
#2	Low Need	$13,700	$3,000	$0	$1,000	$17,700
	Low Need	$13,700	$12,000	$0	$1,000	$26,700
	High Need	$13,700	$12,000	$12,000	$2,000	$39,700
	High Need	$13,700	$12,000	$12,000	$2,000	$39,700
					Average:	**$30,950**
					TARGET:	**$27,354**
					Penalty:	**($3,596)**

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

Other Hospitals Start Out Behind the Curve

Hospital	Patient	Surgery	Post-Acute	Readmit	Other	Total
#1	Low Need	$13,700	$3,000	$0	$1,000	$17,700
	Low Need	$13,700	$3,000	$0	$1,000	$17,700
	Low Need	$13,700	$12,000	$0	$1,000	$26,700
	High Need	$13,700	$12,000	$12,000	$2,000	$39,700
					Average:	**$25,450**
					TARGET:	**$27,354**
					Bonus:	**$1,904**

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

#2	Low Need	$13,700	$3,000	$0	$1,000	$17,700
	Low Need	$13,700	$12,000	$0	$1,000	$26,700
	High Need	$13,700	$12,000	$12,000	$2,000	$39,700
	High Need	$13,700	$12,000	$12,000	$2,000	$39,700
					Average:	**$30,950**
					TARGET:	**$27,354**
					Penalty:	**($3,596)**

Hospital #2 Is At Risk of a Penalty Because of the Higher-Need Patient Mix

Goal: Find Ways to Reduce Post-Acute Care Spending

Hospital	Patient	Surgery	Post-Acute	Readmit	Other	Total
#1	Low Need	$13,700	$3,000	$0	$1,000	$17,700
	Low Need	$13,700	$3,000	$0	$1,000	$17,700
	Low Need	$13,700	$12,000	$0	$1,000	$26,700
	High Need	$13,700	$12,000	$12,000	$2,000	$39,700
					Average:	**$25,450**
					TARGET:	**$27,354**
					Bonus:	**$1,904**
#2	Low Need	$13,700	$3,000	$0	$1,000	$17,700
	Low Need	$13,700	$12,000	$0	$1,000	$26,700
	High Need	$13,700	$12,000	$12,000	$2,000	$39,700
	High Need	$13,700	$12,000	$12,000	$2,000	$39,700
					Average:	**$30,950**
					TARGET:	**$27,354**
					Penalty:	**($3,596)**

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

Reducing Use of SNF/IRF or SNF LOS Reduces Spending

Hospital	Patient	Surgery	Post-Acute	Readmit	Other	Total
#1	Low Need	$13,700	$3,000	$0	$1,000	$17,700
	Low Need	$13,700	$3,000	$0	$1,000	$17,700
	Low Need	$13,700	$3,000	$0	$1,000	$17,700
	High Need	$13,700	$12,000	$12,000	$2,000	$39,700
					TARGET:	**$27,354**
#2	Low Need	$13,700	$3,000	$0	$1,000	$17,700
	Low Need	$13,700	$3,000	$0	$1,000	$17,700
	High Need	$13,700	$12,000	$12,000	$2,000	$39,700
	High Need	$13,700	$12,000	$12,000	$2,000	$39,700
					TARGET:	**$27,354**

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

Lower Post-Acute Spending Reduces Average Spending

Hospital	Patient	Surgery	Post-Acute	Readmit	Other	Total
#1	Low Need	$13,700	$3,000	$0	$1,000	$17,700
	Low Need	$13,700	$3,000	$0	$1,000	$17,700
	Low Need	$13,700	$3,000	$0	$1,000	$17,700
	High Need	$13,700	$12,000	$12,000	$2,000	$39,700
					Average:	**$23,200**
					TARGET:	**$27,354**
#2	Low Need	$13,700	$3,000	$0	$1,000	$17,700
	Low Need	$13,700	$3,000	$0	$1,000	$17,700
	High Need	$13,700	$12,000	$12,000	$2,000	$39,700
	High Need	$13,700	$12,000	$12,000	$2,000	$39,700
					Average:	**$28,700**
					TARGET:	**$27,354**

Hospital #1 Gets a Bigger Bonus, Hospital #2 Still Has a Penalty

Hospital	Patient	Surgery	Post-Acute	Readmit	Other	Total
#1	Low Need	$13,700	$3,000	$0	$1,000	$17,700
	Low Need	$13,700	$3,000	$0	$1,000	$17,700
	Low Need	$13,700	$3,000	$0	$1,000	$17,700
	High Need	$13,700	$12,000	$12,000	$2,000	$39,700
					Average:	**$23,200**
					TARGET:	**$27,354**
					Bonus:	**$4,154**
#2	Low Need	$13,700	$3,000	$0	$1,000	$17,700
	Low Need	$13,700	$3,000	$0	$1,000	$17,700
	High Need	$13,700	$12,000	$12,000	$2,000	$39,700
	High Need	$13,700	$12,000	$12,000	$2,000	$39,700
					Average:	**$28,700**
					TARGET:	**$27,354**
					Penalty:	**($1,346)**

Hospital #2 Can Get a Bonus By Avoiding High-Need Patients

Hospital	Patient	Surgery	Post-Acute	Readmit	Other	Total
#1	Low Need	$13,700	$3,000	$0	$1,000	$17,700
	Low Need	$13,700	$3,000	$0	$1,000	$17,700
	Low Need	$13,700	$3,000	$0	$1,000	$17,700
	High Need	$13,700	$12,000	$12,000	$2,000	$39,700
					Average:	**$23,200**
					TARGET:	**$27,354**
					Bonus:	**$4,154**
#2	Low Need	$13,700	$3,000	$0	$1,000	$17,700
	Low Need	$13,700	$3,000	$0	$1,000	$17,700
	High Need	$13,700	$12,000	$12,000	$2,000	$39,700
	~~High Need~~	~~$13,700~~	~~$12,000~~	~~$12,000~~	~~$2,000~~	~~$39,700~~
					Average:	**$25,033**
					TARGET:	**$27,354**
					Bonus:	**$2,321**

Bigger Bonuses From More Surgeries on Low-Need Patients

Hospital	Patient	Surgery	Post-Acute	Readmit	Other	Total
#1	Low Need	$13,700	$3,000	$0	$1,000	$17,700
	Low Need	$13,700	$3,000	$0	$1,000	$17,700
	Low Need	$13,700	$3,000	$0	$1,000	$17,700
	High Need	$13,700	$12,000	$12,000	$2,000	$39,700
					Average:	**$23,200**
					TARGET:	**$27,354**
					Bonus:	**$4,154**
#2	Low Need	$13,700	$3,000	$0	$1,000	$17,700
	Low Need	$13,700	$3,000	$0	$1,000	$17,700
	High Need	$13,700	$12,000	$12,000	$2,000	$39,700
	Low Need	$13,700	$3,000	$0	$1,000	$17,700
					Average:	**$23,200**
					TARGET:	**$27,354**
					Bonus:	**$4,154**

What Has Actually Happened Under CJR?

LEWIN GROUP®

CMS Comprehensive Care for Joint Replacement Model: Performance Year 2 Evaluation Report

Second Annual Report

HEALTH CARE AND HUMAN SERVICES POLICY, RESEARCH, AND ANALYTICS — WITH REAL-WORLD PERSPECTIVE.

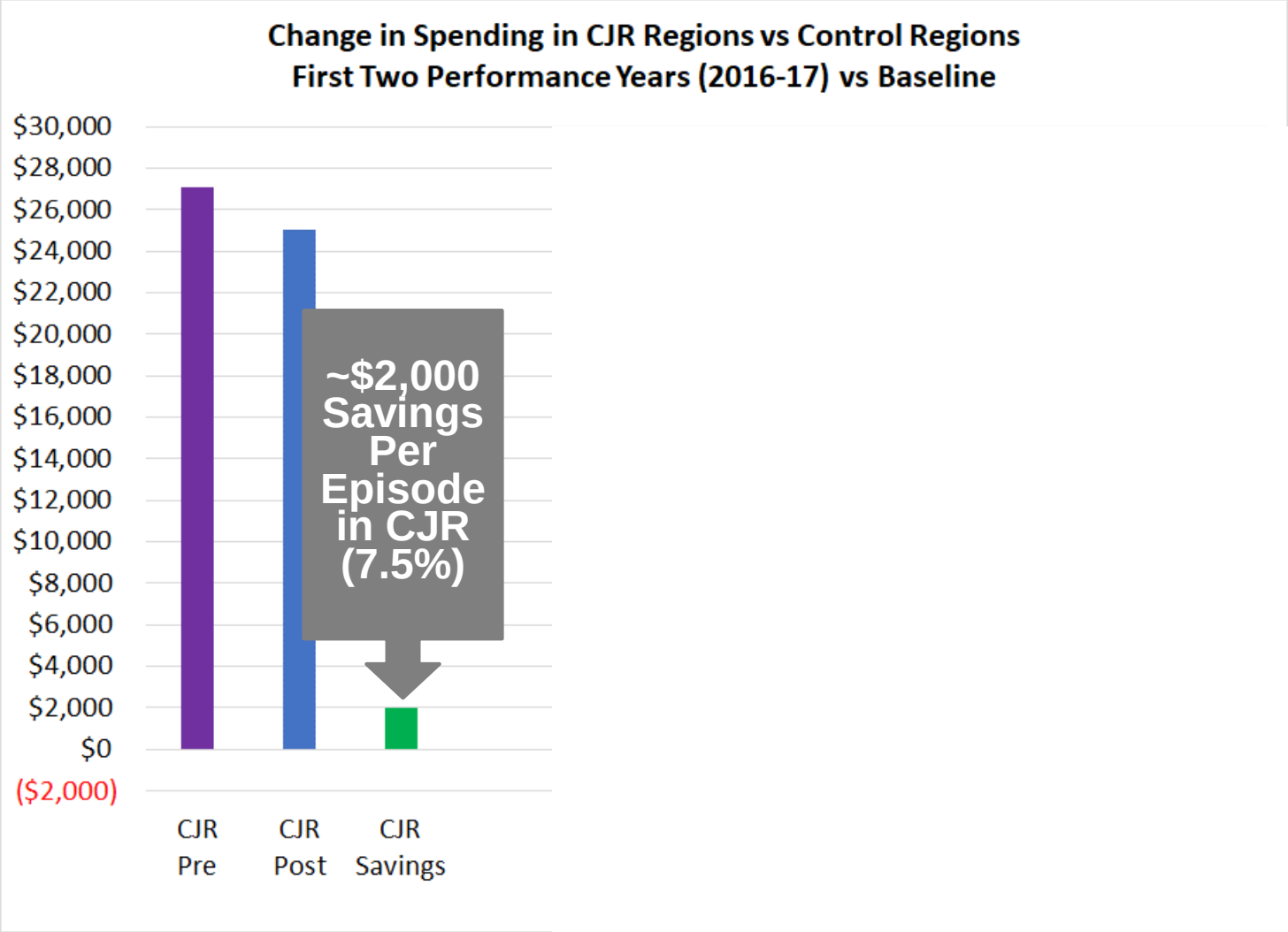
Prepared for: Centers for Medicare & Medicaid Services

Submitted by: The Lewin Group, Inc. with our partners: Abt Associates, GDIT, and Telligen

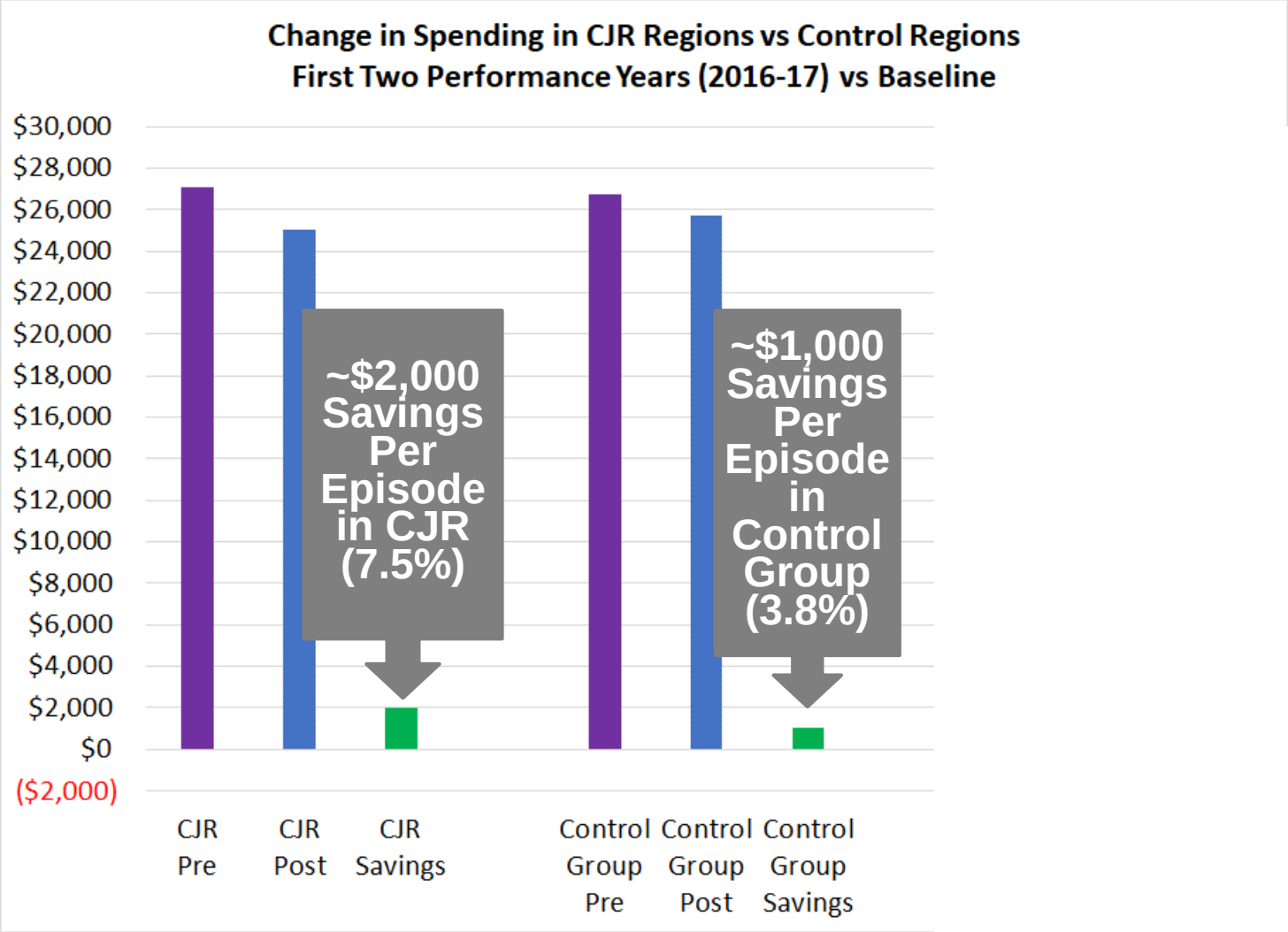
June 2019

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

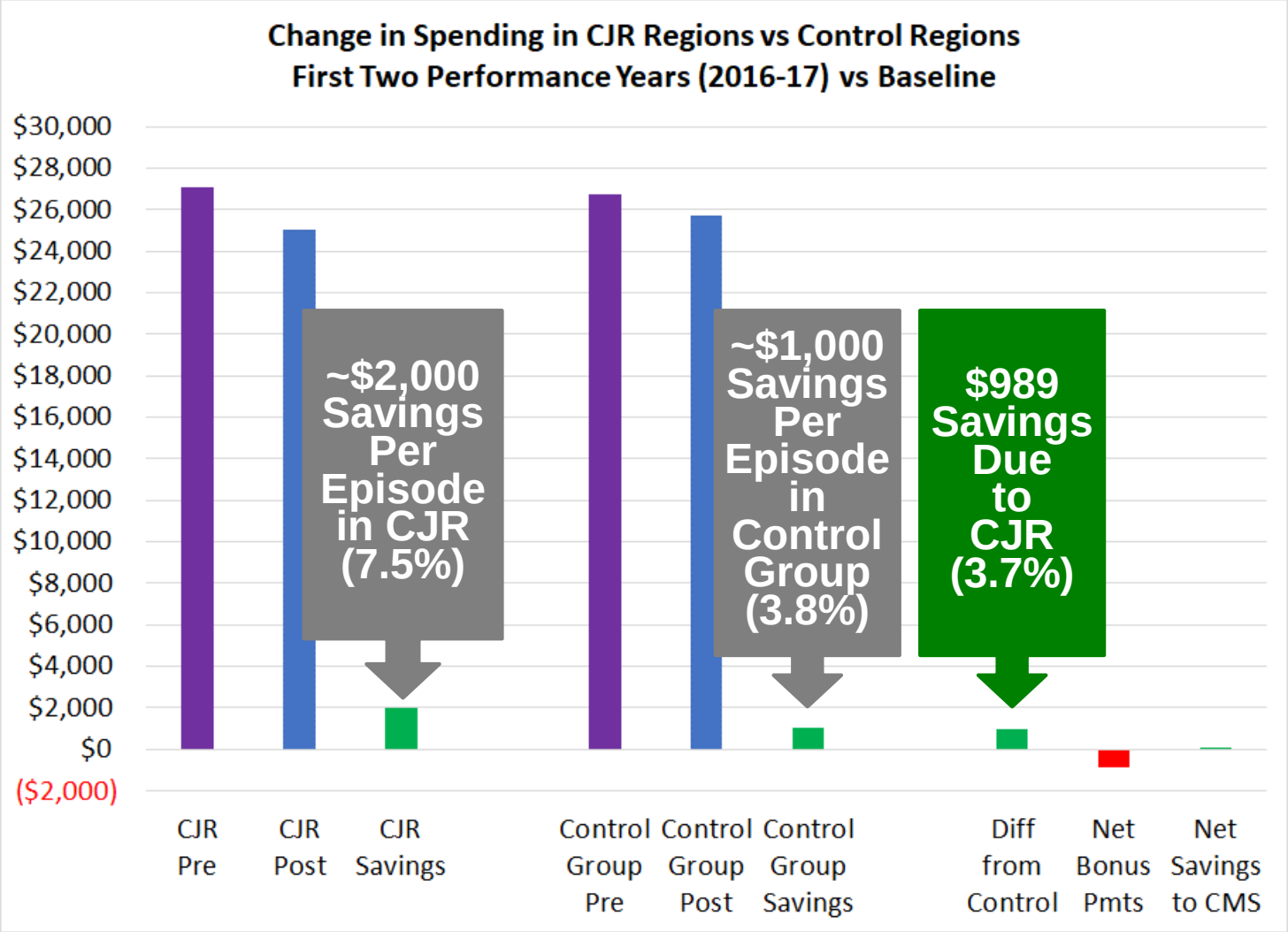
Spending Was Lower After CJR Was Implemented



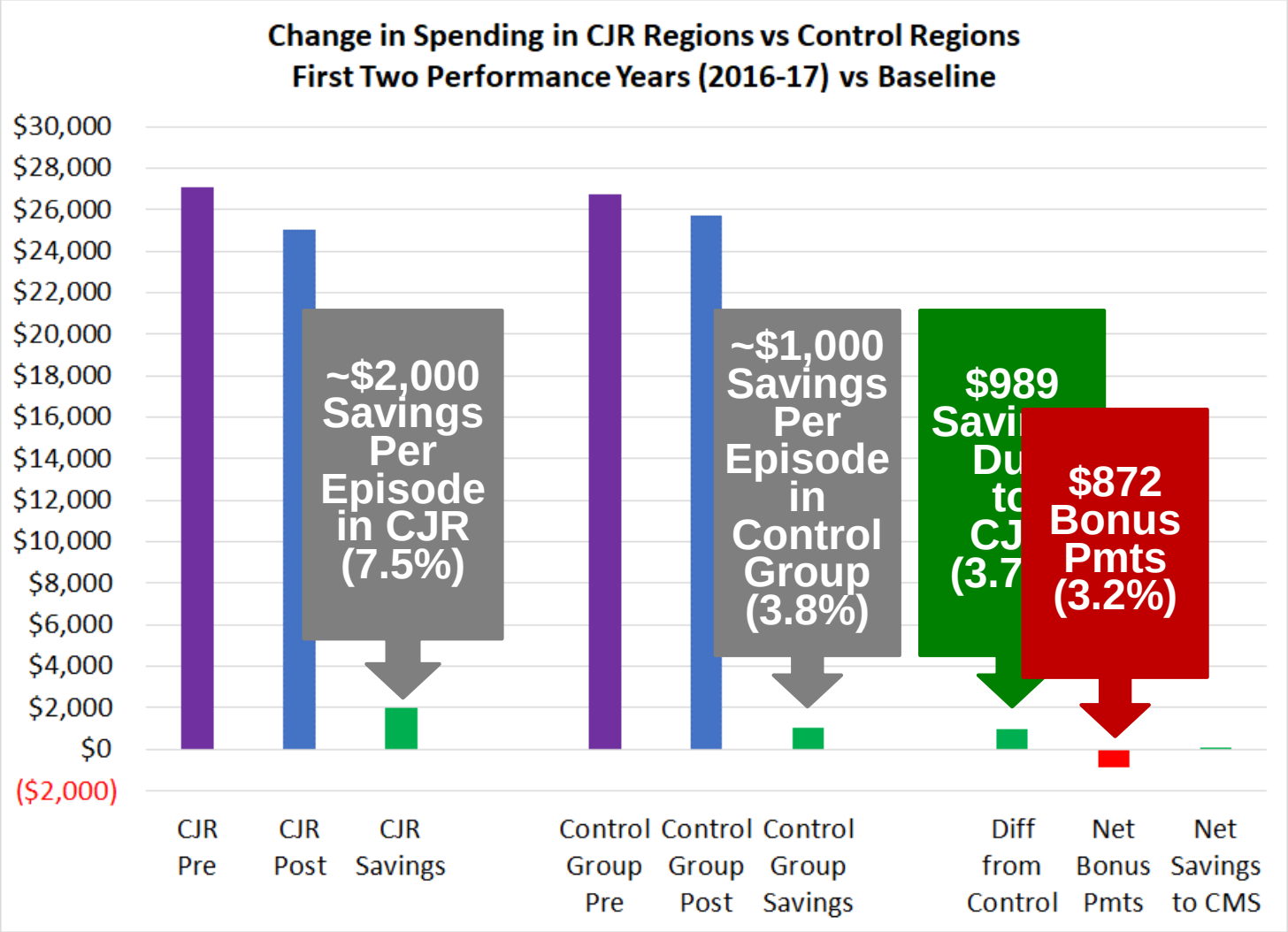
Spending on Joint Replacement Episodes Was Lower *Everywhere*



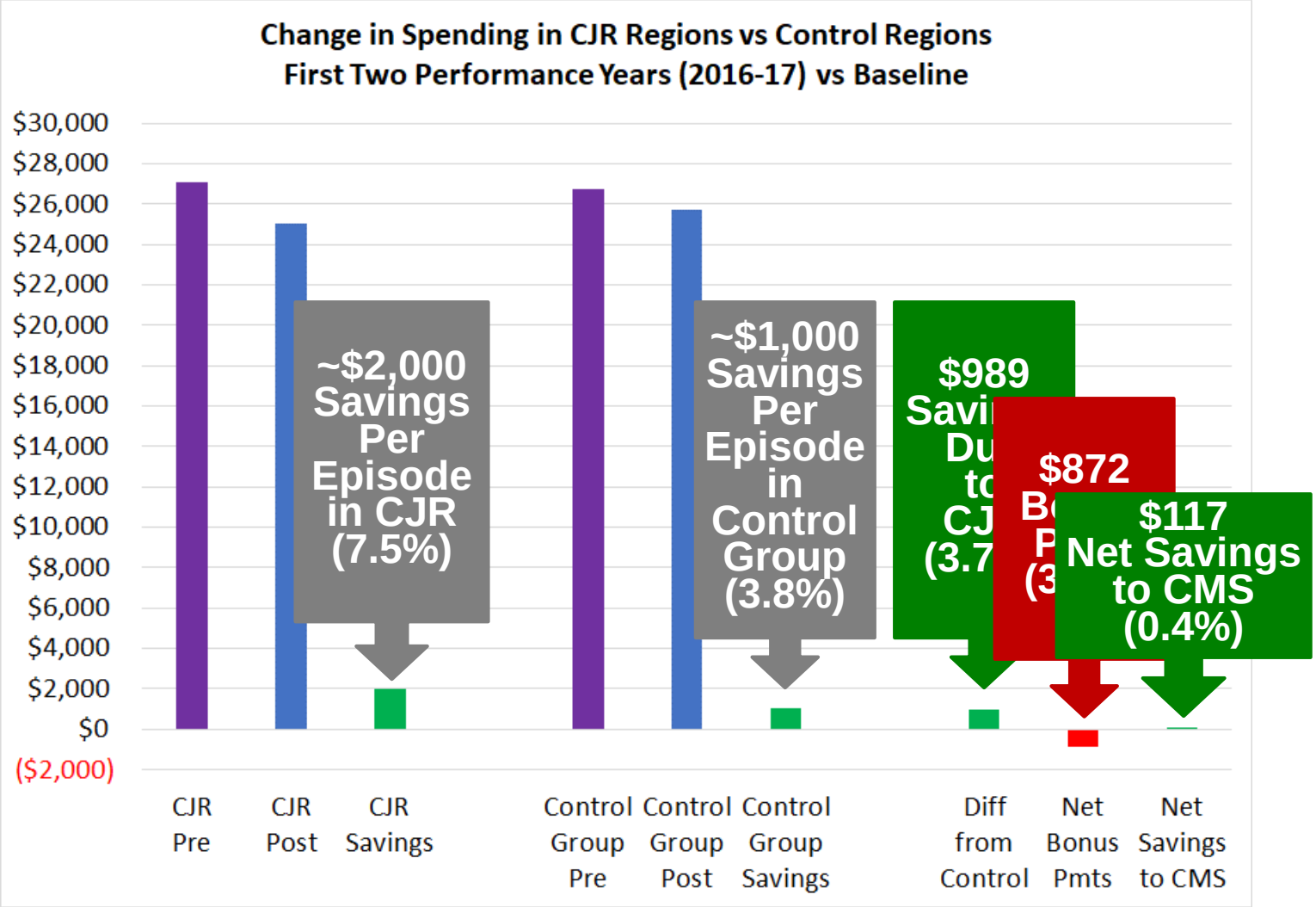
Spending Reductions Were Higher in CJR Hospitals



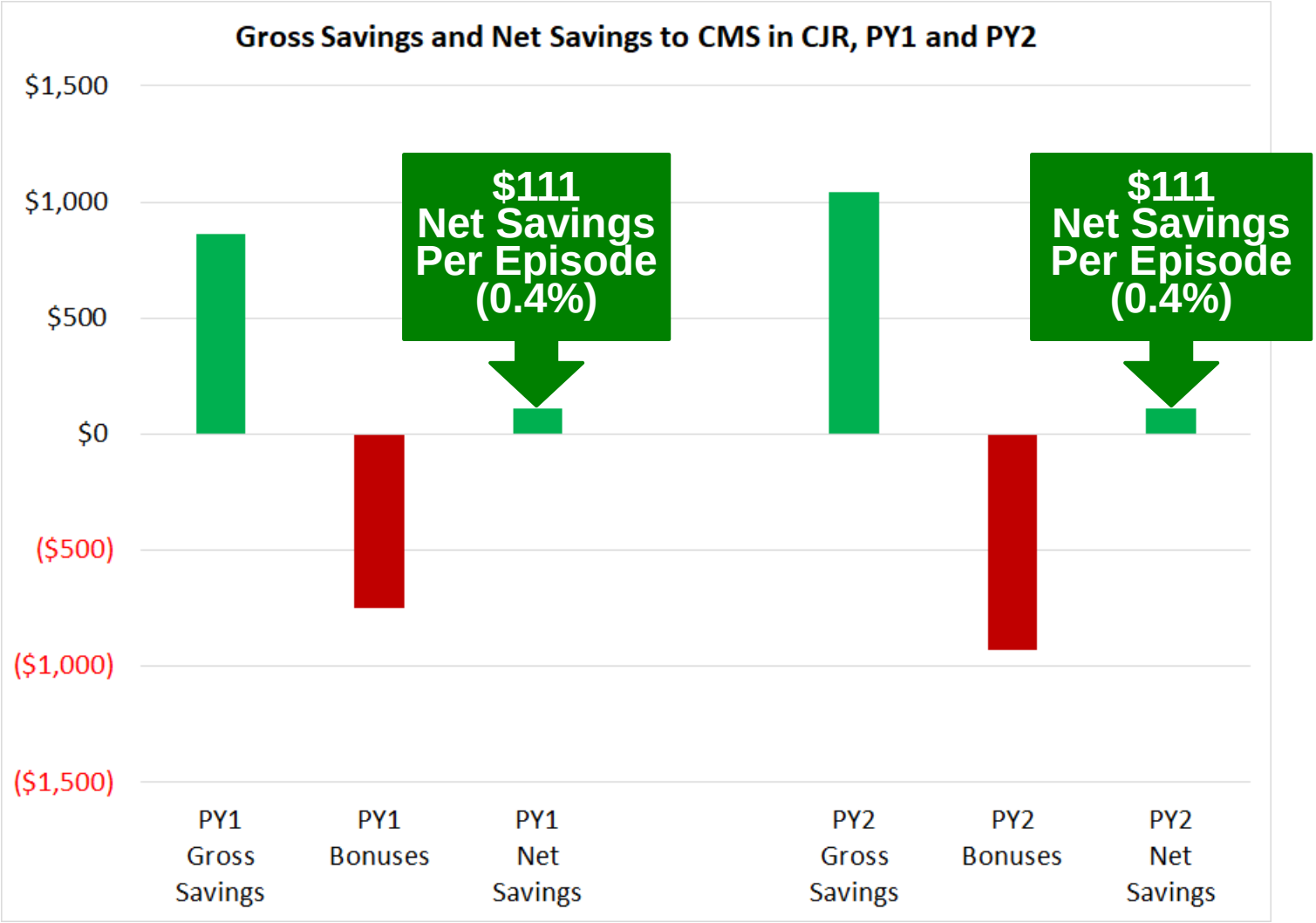
But Most of the Savings Went to Bonus Payments to Hospitals



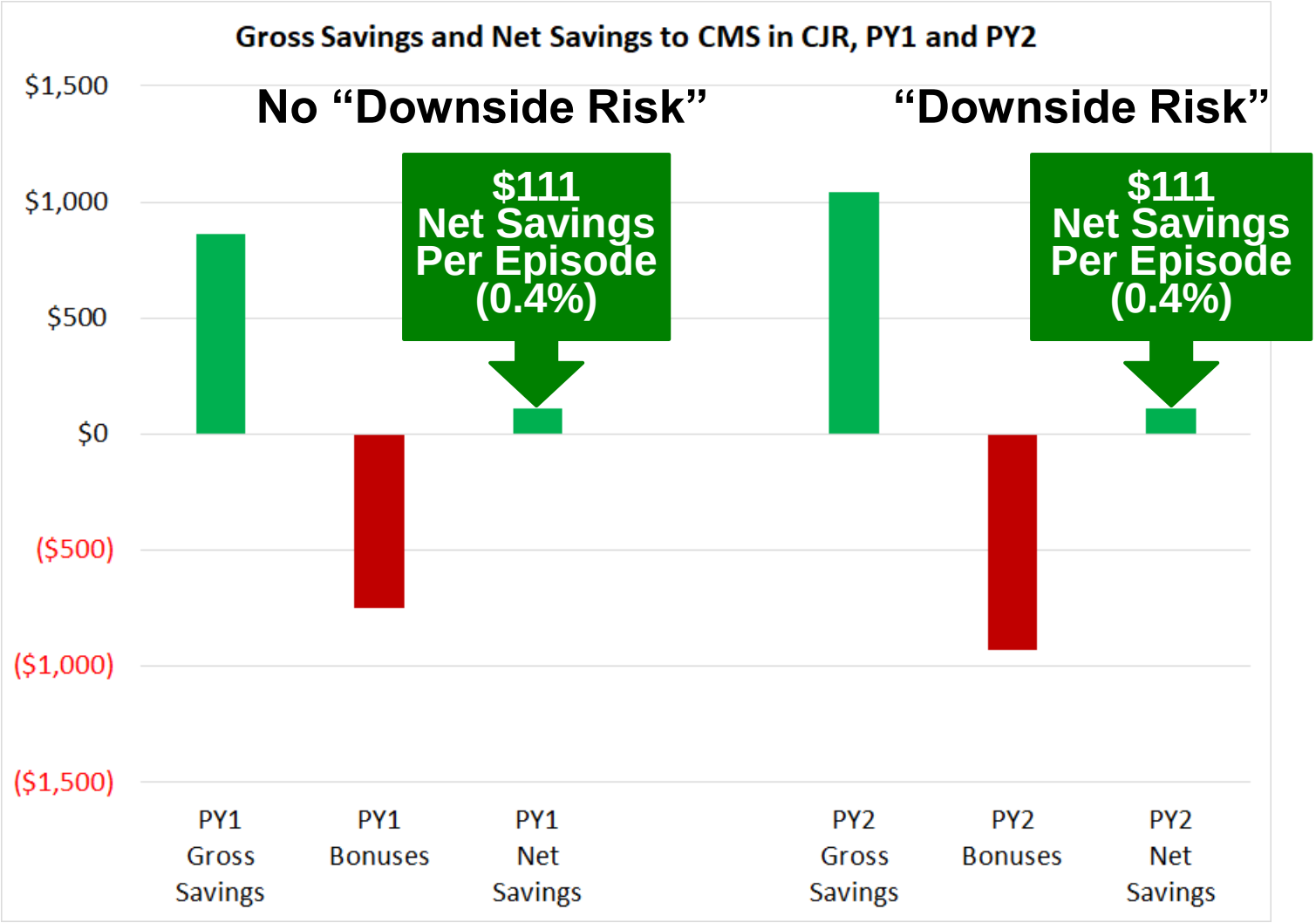
Net Savings to CMS Was Very Small



Net Savings Did Not Increase from Year 1 to Year 2

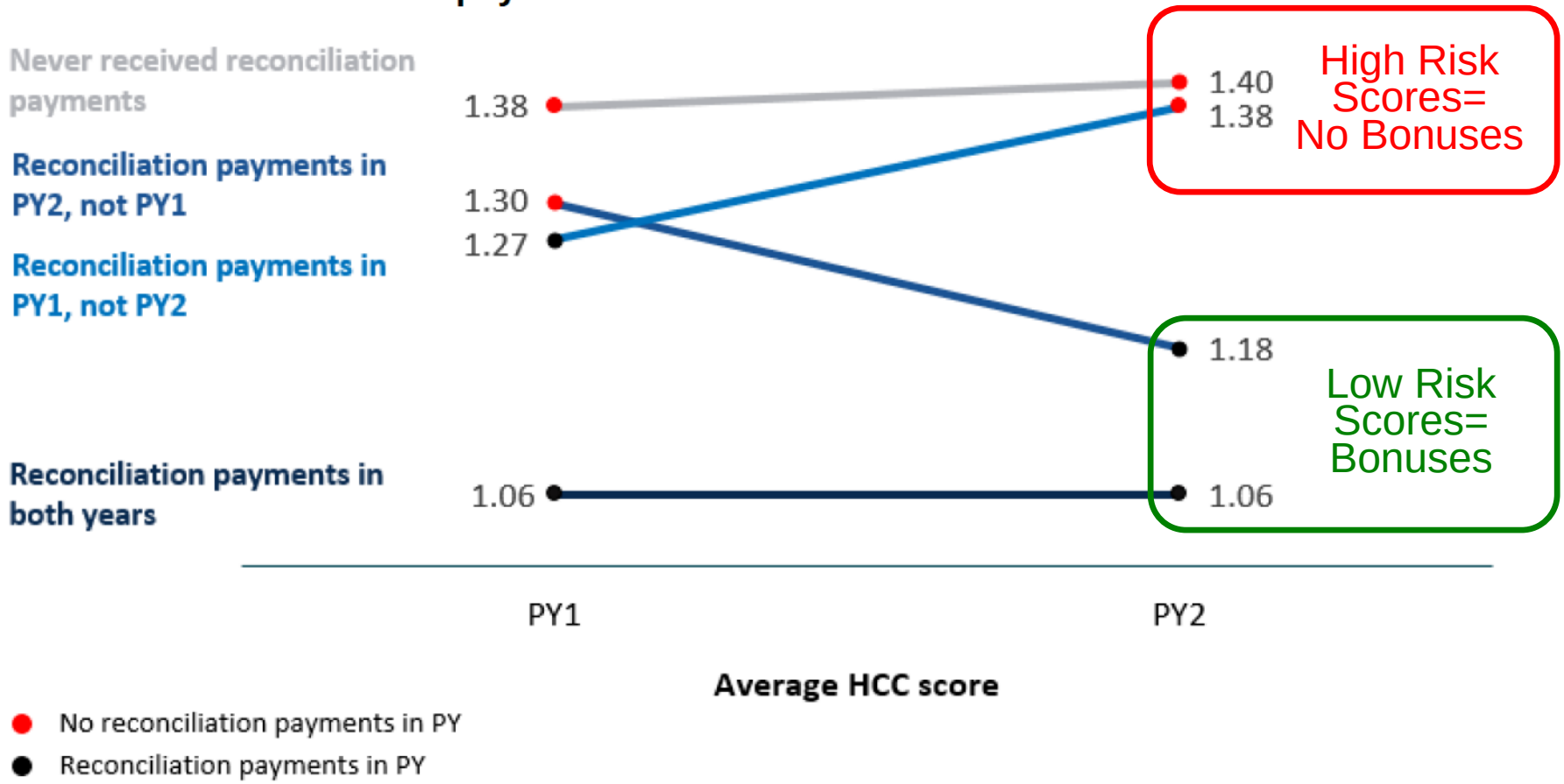


"Downside Risk" Did Not Increase Savings



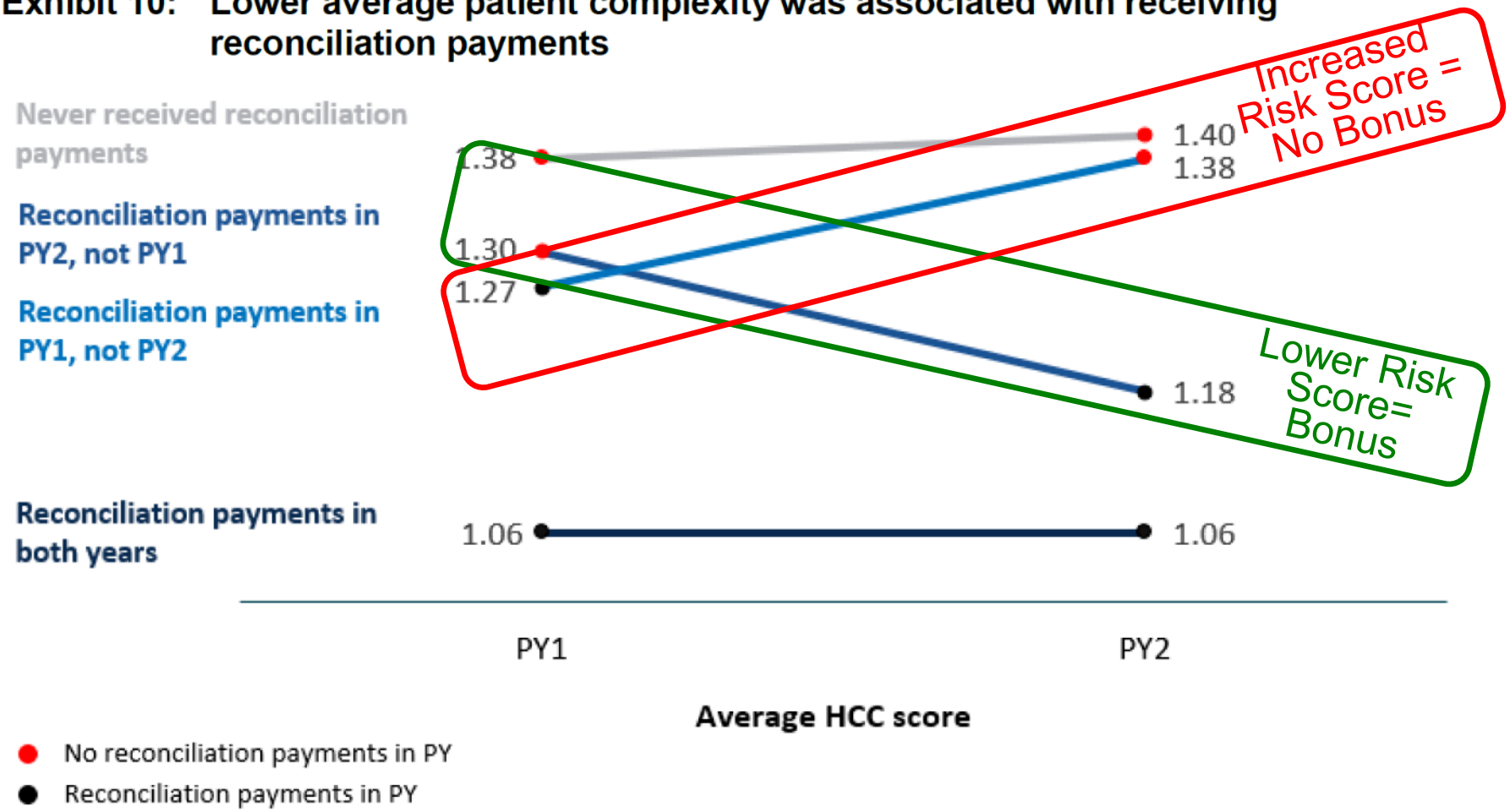
Bonuses Went to Hospitals With Lower-Complexity Patients

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



Change In Patient Complexity Changed The Bonus

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



Potential Financial Penalties for Serving Higher-Risk Patients

HOSPITALS

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

DOI: 10.1377/hlthaff.2018.05264
HEALTH AFFAIRS 38,
NO. 2 (2019): 190–196

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

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Laurent G. Glance is vice chair for research and a professor in the Department of Anesthesiology and Department of Public Health Sciences, University of Rochester.

Xueya Cai is a research associate professor in the Department of Biostatistics and Computational Biology, University of Rochester.

Rishi Balkissoon is an assistant professor in the Department of Orthopaedics, University of Rochester.

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

42% Fewer Safety-Net Hospitals Qualified for Bonuses, and Bonuses for Safety-Net Hospitals Were 39% Smaller Than for Non-Safety-Net Hospitals

Fee for Service Has *Strengths* as Well as Weaknesses

		FFS
Weaknesses of Fee for Service		
	Payment for unnecessary services?	YES
	Payment even if quality/outcome is bad?	YES
	Payment for all high-value services?	NO
	Payment sufficient to cover cost of services?	NO
Strengths of Fee for Service		
	Higher payment for higher-need patients?	YES
	Penalties for things provider cannot control?	NO

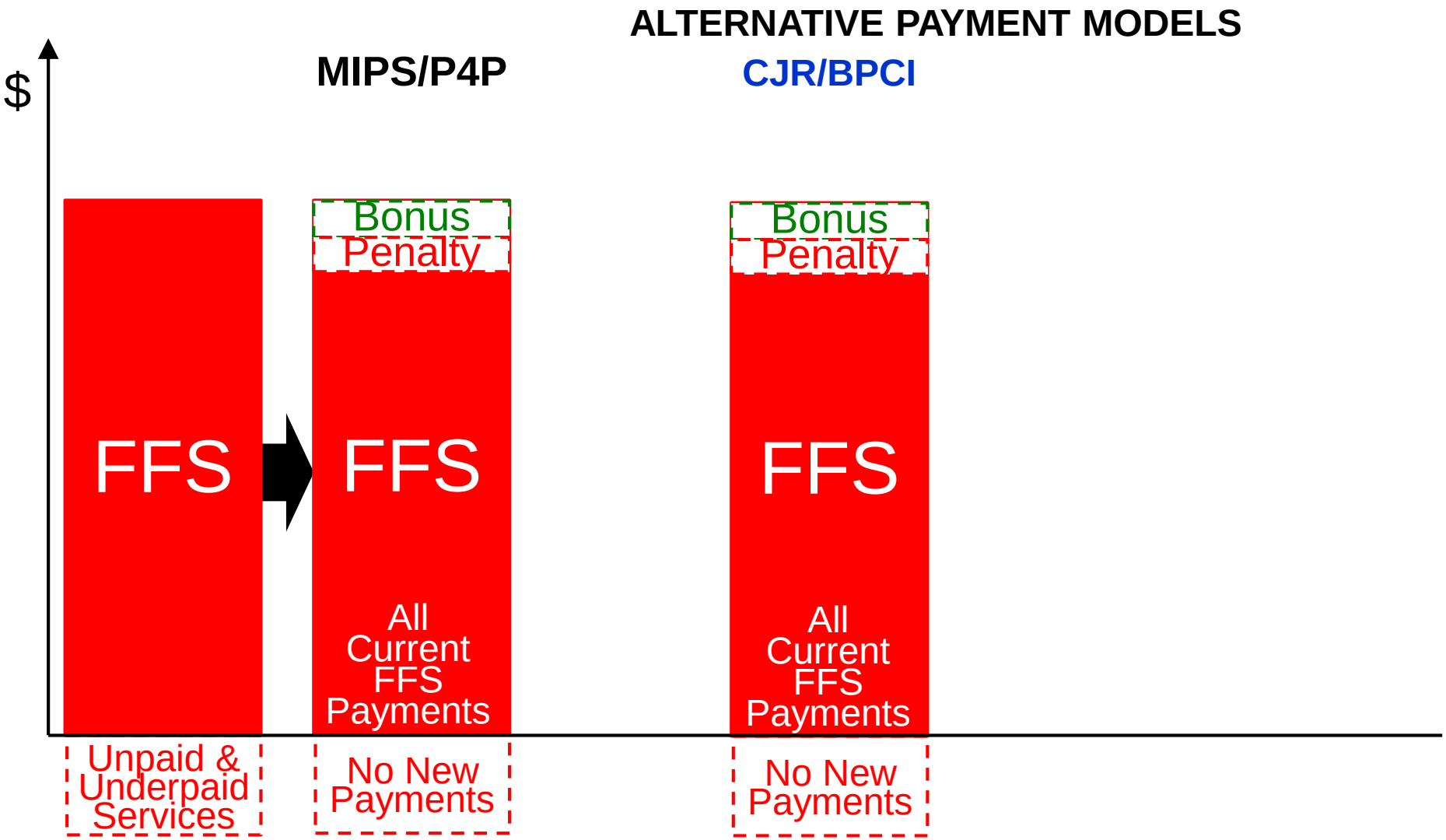
CJR Doesn't Fix FFS Problems & Doesn't Preserve FFS Strengths

		FFS	CJR
Weaknesses of Fee for Service			
	Payment for unnecessary services?	YES	Penalties for high spending regardless of necessity
	Payment even if quality/outcome is bad?	YES	YES (no outcome metric)
	Payment for all high-value services?	NO	NO (depends on savings)
	Payment sufficient to cover cost of services?	NO	NO (based on current fees)
Strengths of Fee for Service			
	Higher payment for higher-need patients?	YES	NO (limited risk adjust.)
	Penalties for things provider cannot control?	NO	YES (unrelated costs)

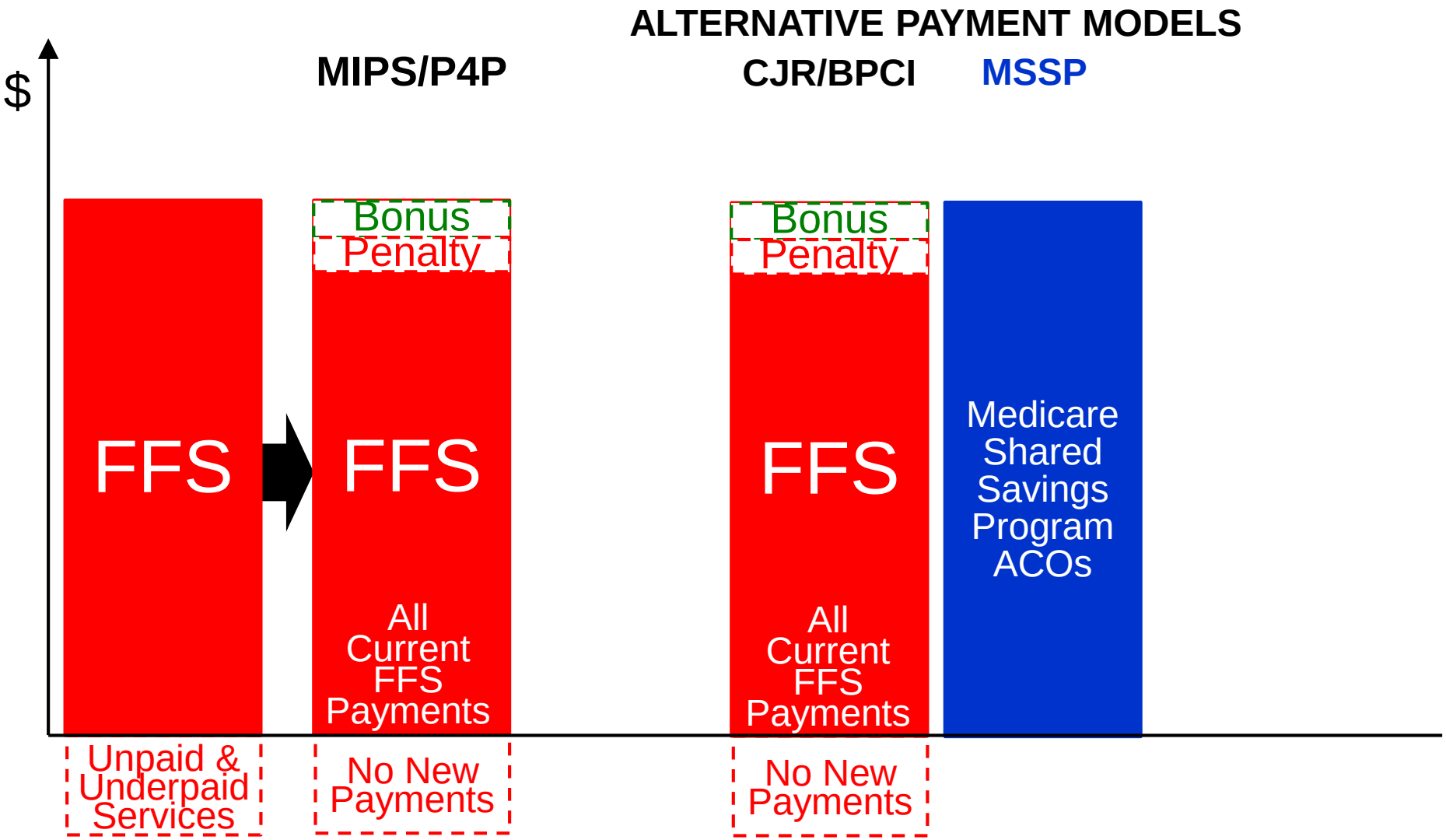
BPCI is Similar to CJR But for More Procedures/Admits

CJR (Comprehensive Care for Joint Replacement)	BPCI - Advanced (Bundled Payments for Care Improvement)
Hospitalization + All Services 90 Days After Discharge (Rehab, HH, readmits, physician svcs)	Hospitalization + All Services 90 Days After Discharge (Rehab, HH, readmits, physician svcs)
Mandatory Participation	Voluntary Participation
Hospitals Only	Hospitals Physician Groups
2 Types of Episodes: • Hip Replacement • Knee Replacement	35 Types of Episodes • Hip & Knee Replacement • Other Inpatient Surgical Procedures • Medical Admissions • Some Outpatient Procedures
• Hospitals share in savings if spending is below episode price • Hospitals at risk if spending exceeds episode price	• Providers share in savings if spending is below episode budget • Providers at risk if spending exceeds episode price

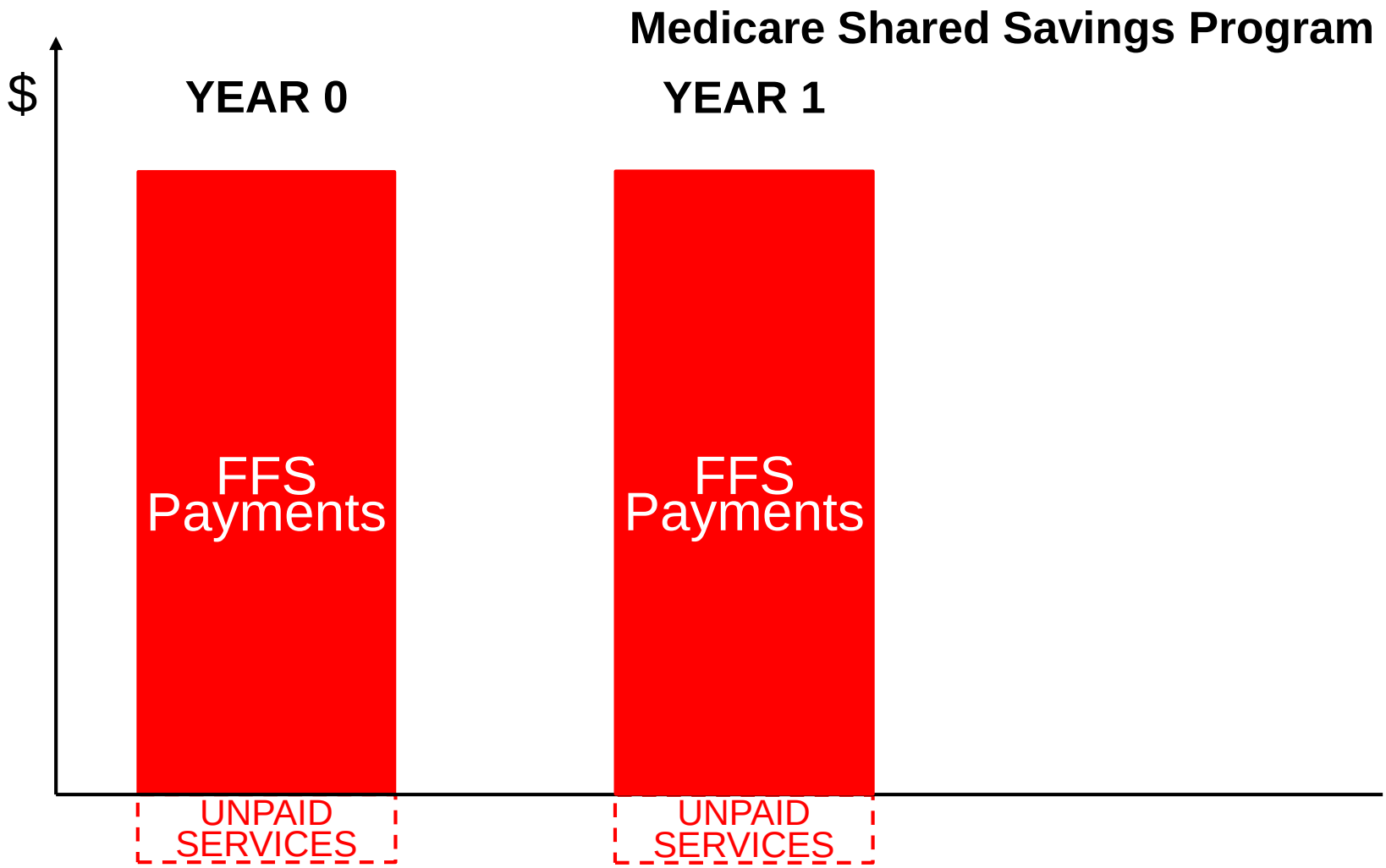
CJR/BPCI Are Really Just a Different Form of P4P



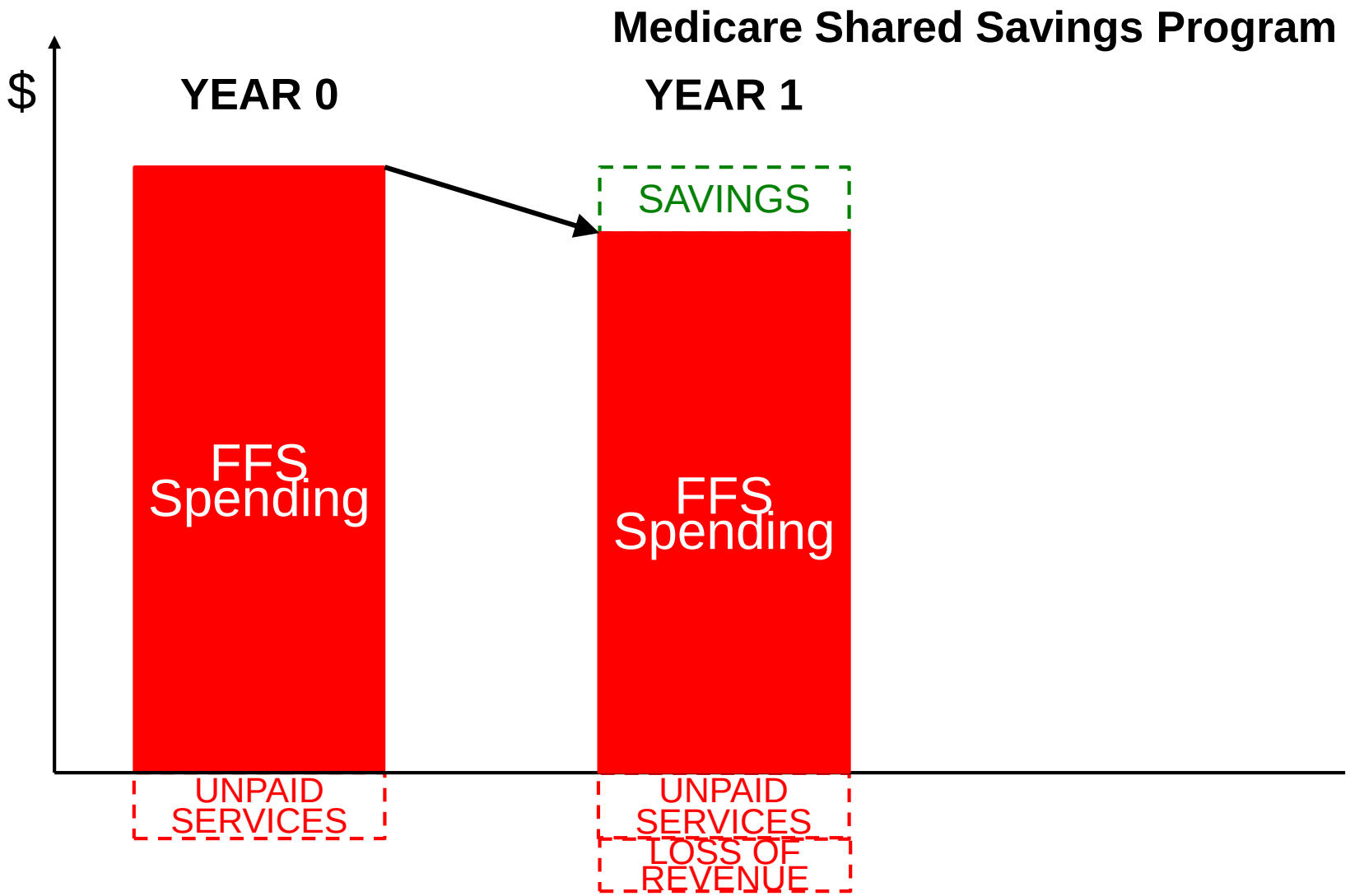
What About ACOs?



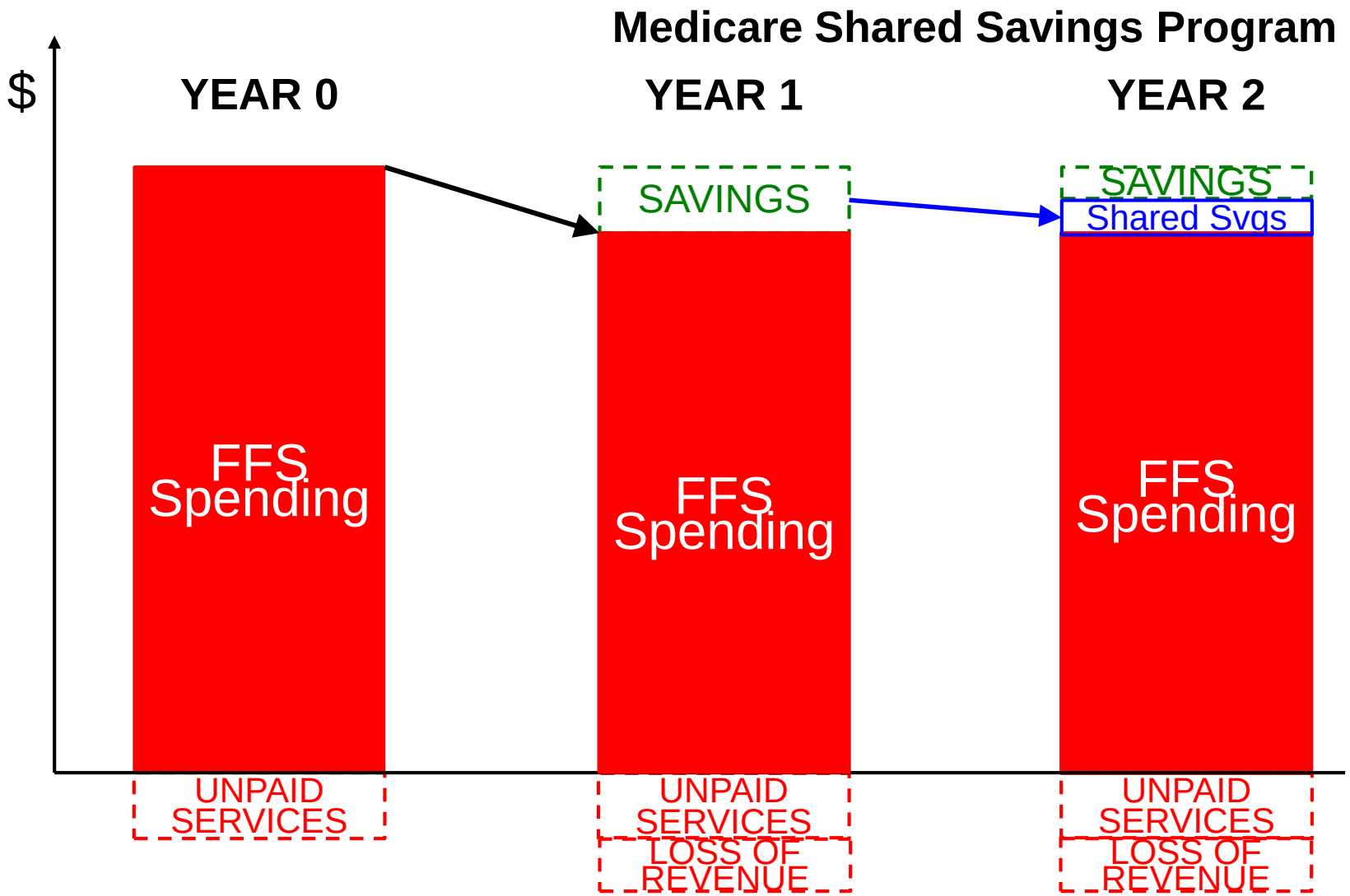
No Change in FFS Payments for Providers Under the ACO



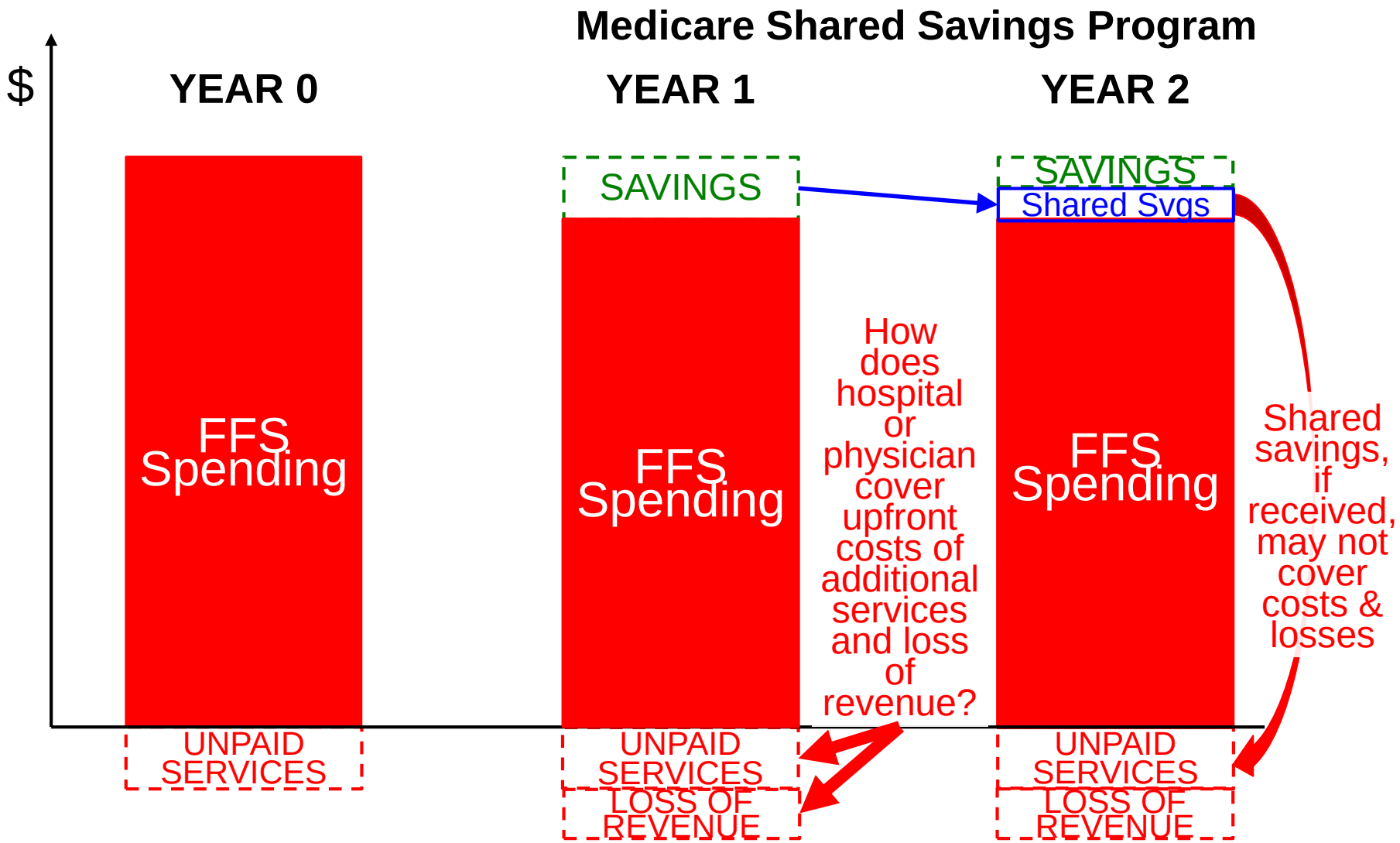
If Spending Decreases This Year,



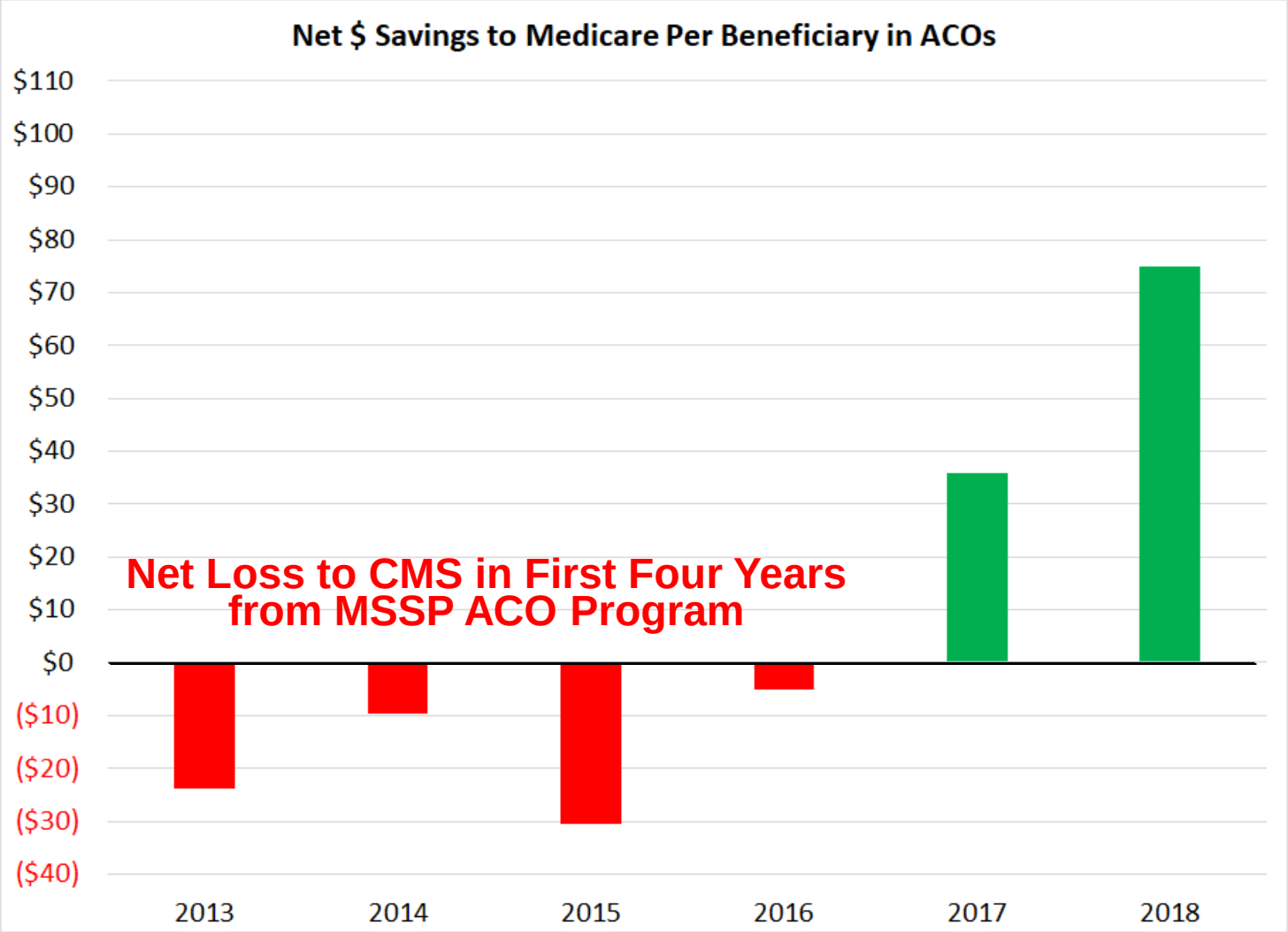
If Spending Decreases This Year, ACO (May) Get a Bonus Next Year



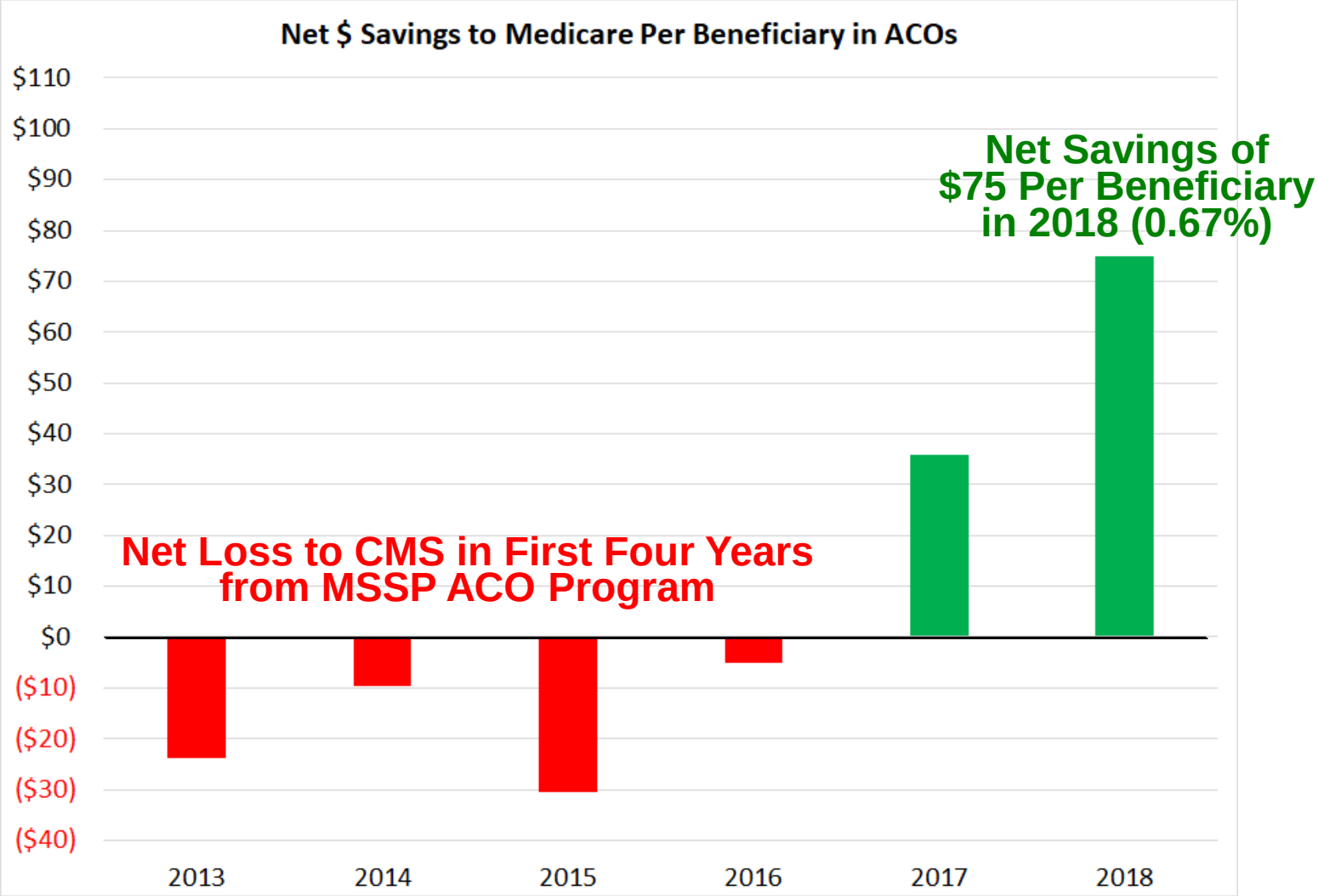
"Shared Savings" is Too Little, Too Late to Improve Care



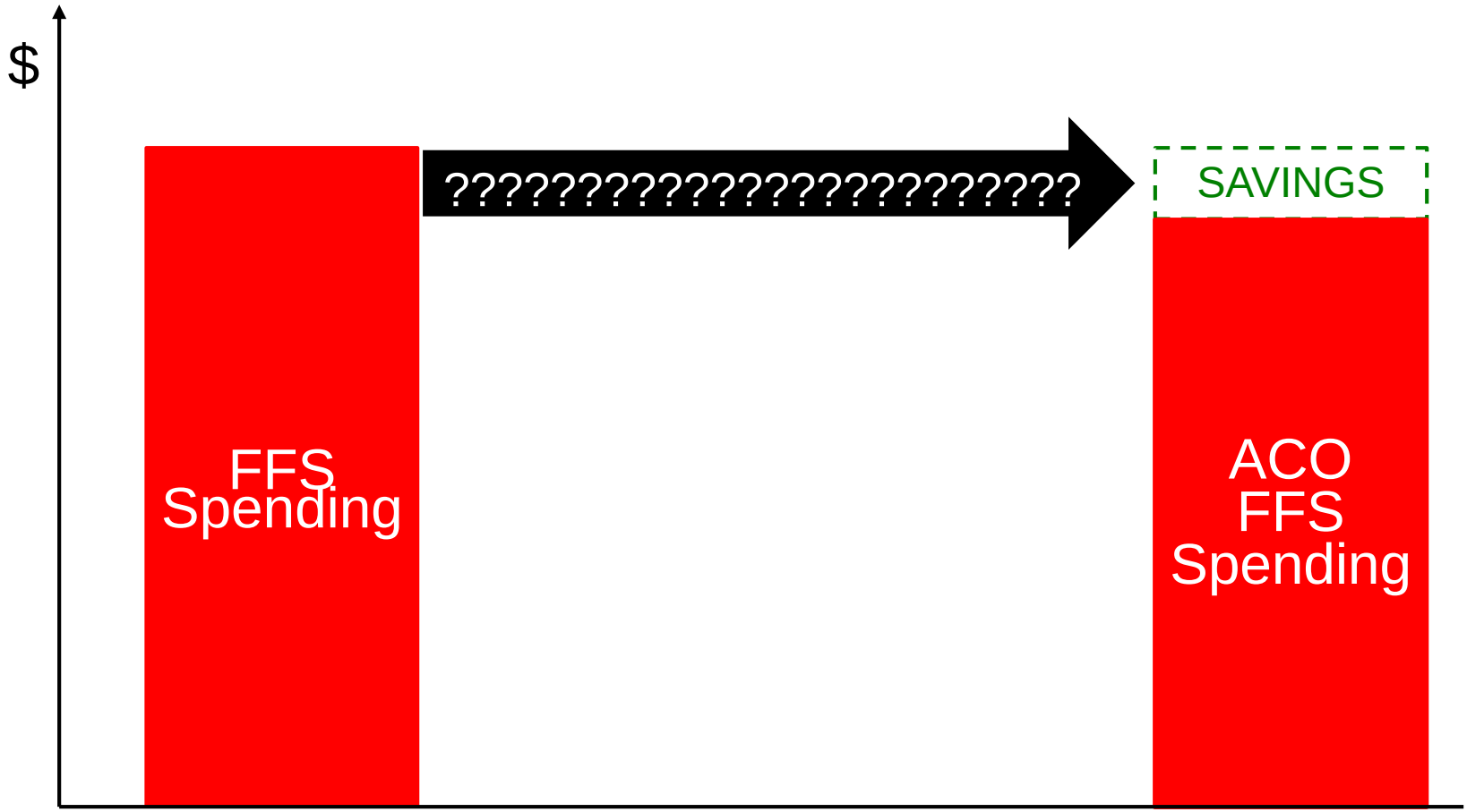
The "Shared Savings" Approach Hasn't Saved Very Much



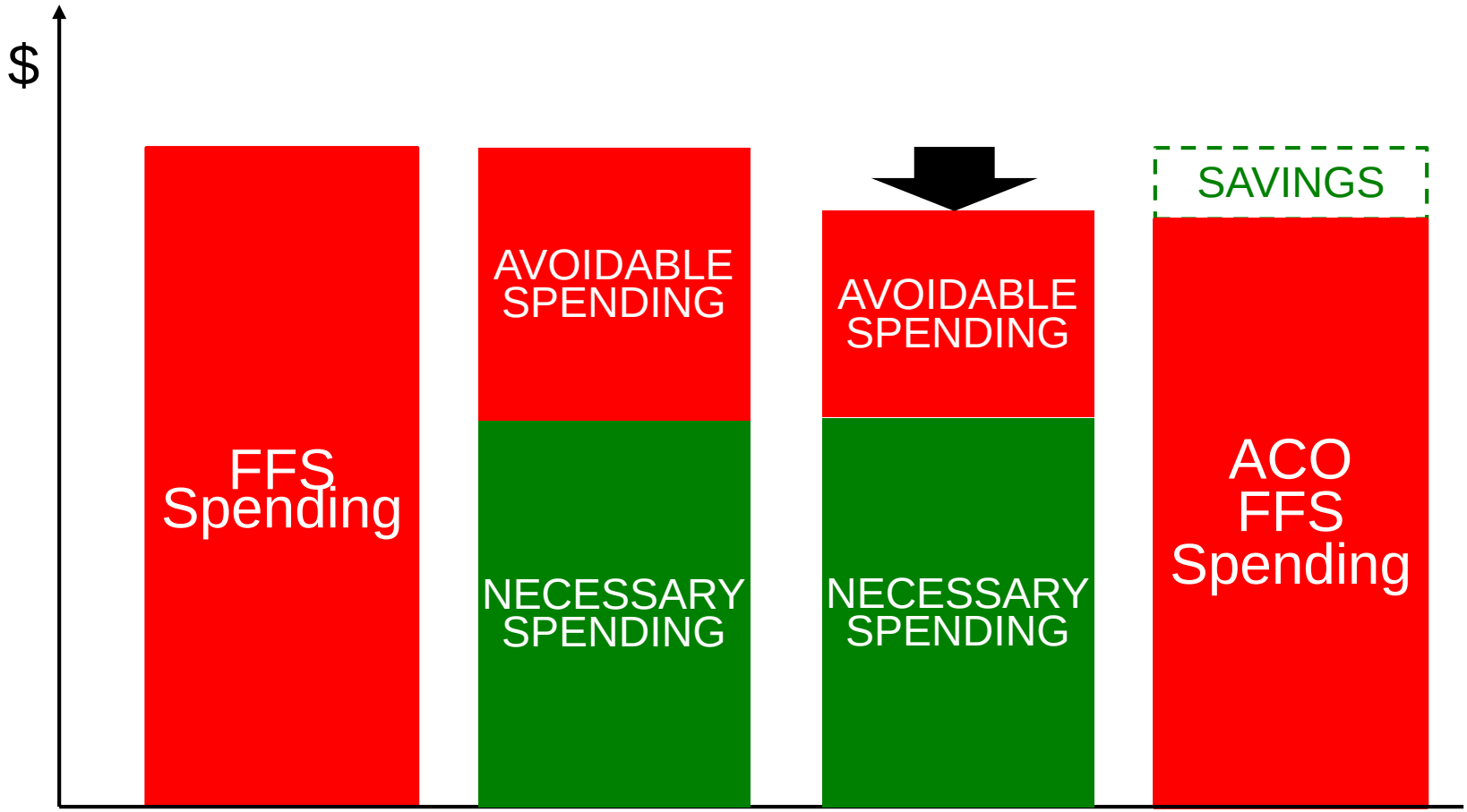
Extremely Small Amounts When Savings Are Achieved



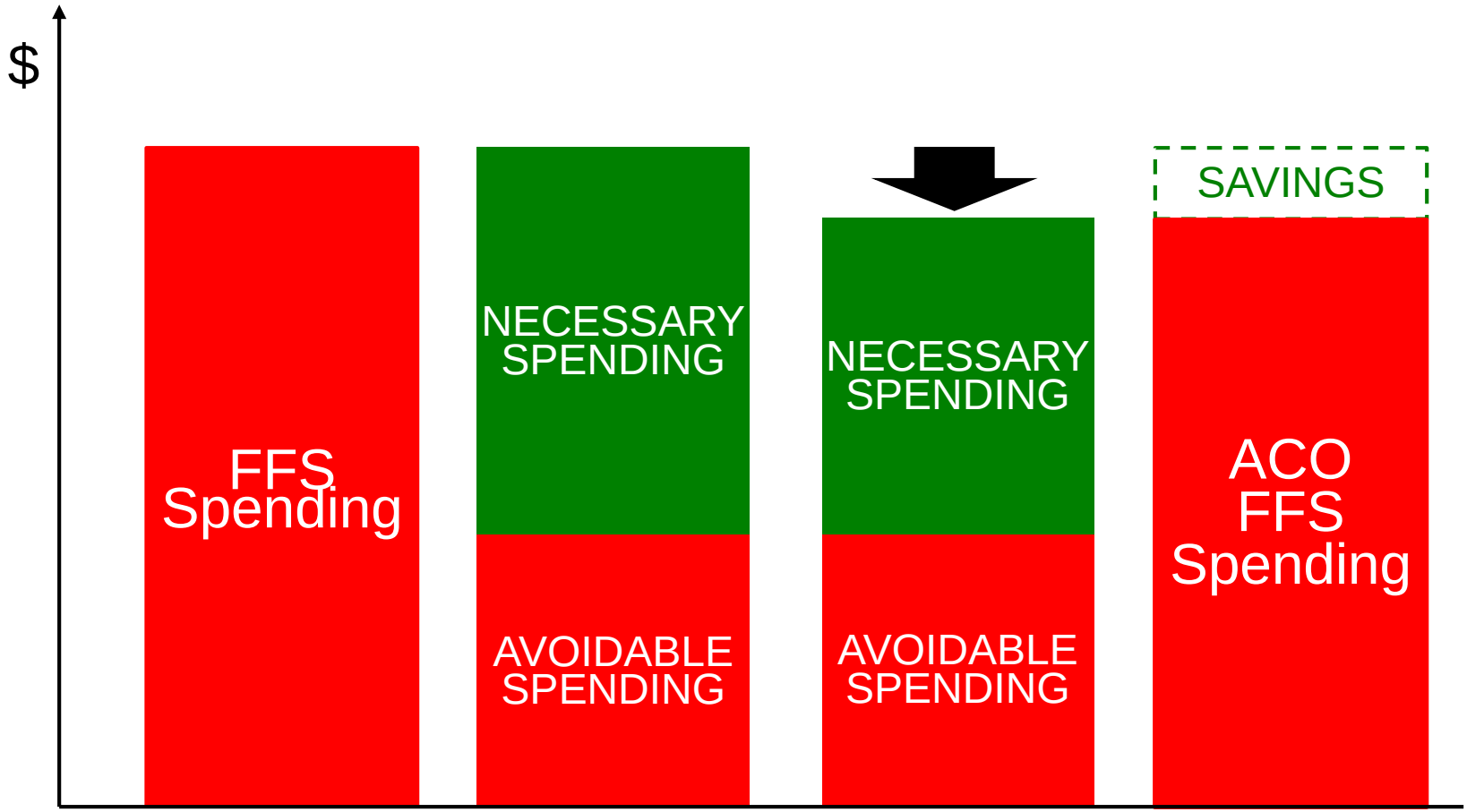
How Did the ACOs That Saved Money Achieve the Savings?



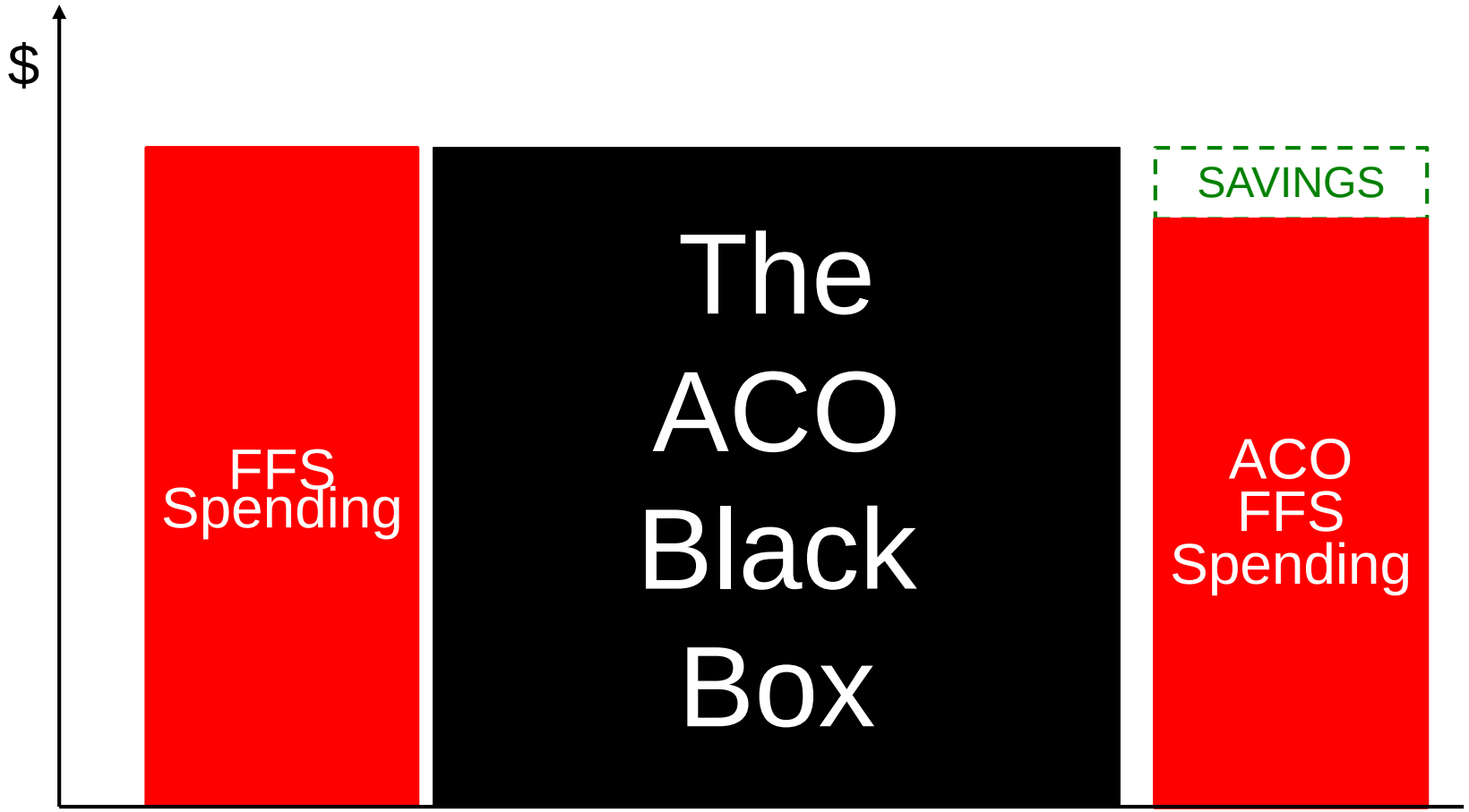
Did They Reduce Spending on Undesirable/Unnecessary Svcs?



Or Did They Stint on Necessary Care to Produce Savings?



ACOs Don't Have to Tell Us and CMS Doesn't Ask



Financial Risk for *Total Cost*, But Not for *Total Quality* of Care

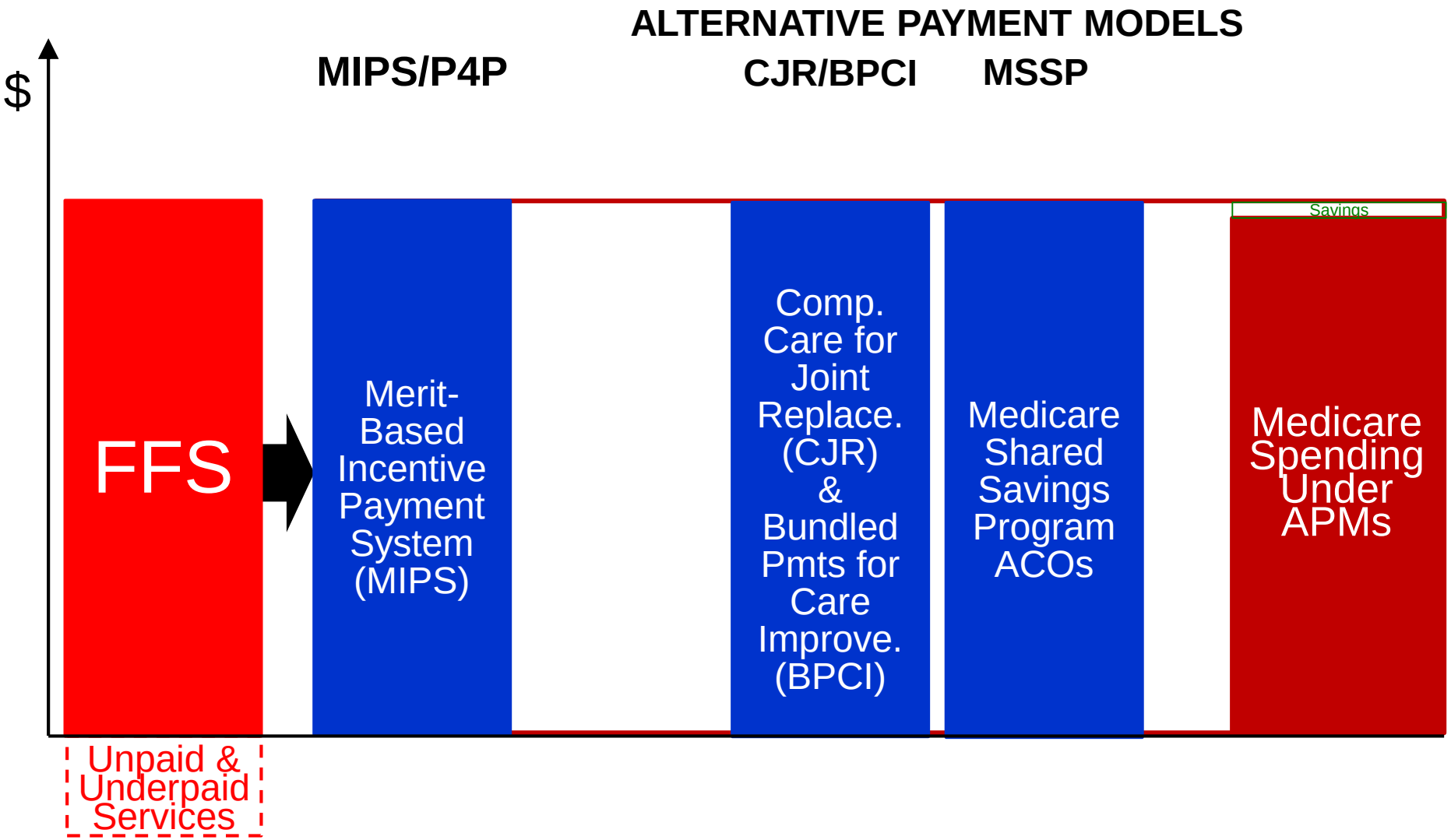
ACO Quality Measures

- Timely Care
- Provider Communication
- Rating of Provider
- Access to Specialists
- Health Promotion & Education
- Shared Decision-Making
- Health Status
- Readmissions
- COPD/Asthma Admissions
- Heart Failure Admissions
- Meaningful Use
- Fall Risk Screening
- Flu Vaccine
- Pneumonia Vaccine
- BMI Screening & Follow-Up
- Depression Screening
- Colon Cancer Screening
- Breast Cancer Screening
- Blood Pressure Screening
- HbA1c Poor Control
- Diabetic Eye Exam
- Blood Pressure Control
- Aspirin for Vascular Disease
- Beta Blockers for HF
- ACE/ARB Therapy
- SNF Readmissions
- Diabetes Admissions
- Multiple Condition Admissions
- Medication Documentation
- Depression Remission
- Statin Therapy

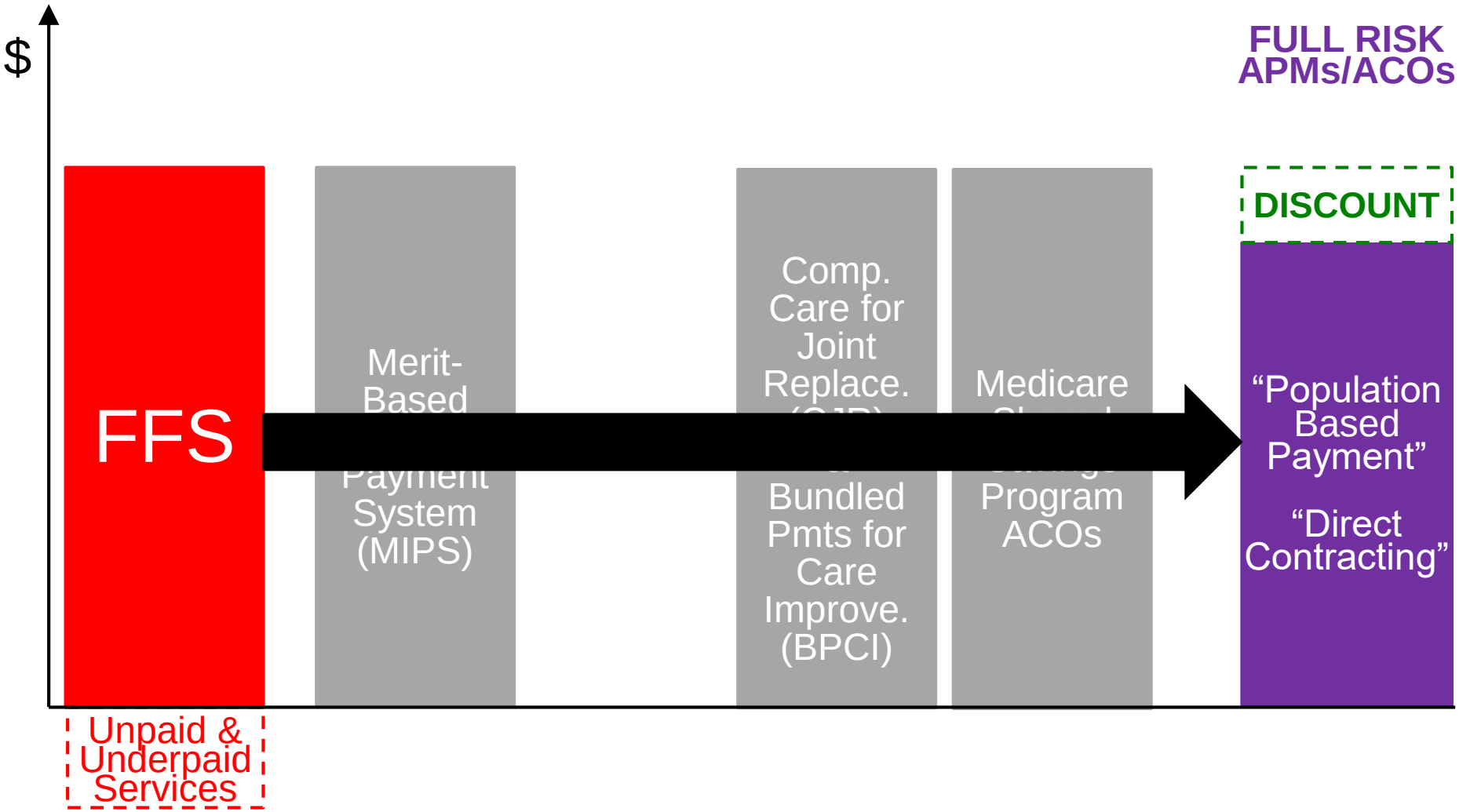
No Measures to Assure:

- Effective management for joint pain and mobility
- Effective management of back pain and mobility
- Evidence-based treatment for cancer
- Effective management of cancer treatment side effects
- Evidence-based treatment for rheumatoid arthritis
- Evidence-based treatment of inflammatory bowel disease
- Rapid treatment and rehabilitation for stroke
- Access to and quality of care for many other conditions

Since Current APMs Aren't Reducing Spending Very Much…



…CMS Wants to Put Physicians at Risk for Reducing Spending



Population-Based Payment & Full Risk Creates New Problems

		FFS	"Population-Based" (Full Risk) Payment
Weaknesses of Fee for Service			
	Payment for unnecessary services?	YES	Penalties for high spending regardless of necessity
	Payment even if quality/outcome is bad?	YES	YES (no outcome metric)
	Payment for all high-value services?	NO	YES (flexibility re: services)
	Payment sufficient to cover cost of services?	NO	NO (based on current fees)
Strengths of Fee for Service			
	Higher payment for higher-need patients?	YES	NO (limited risk adjust.)
	Penalties for things provider cannot control?	NO	YES (risk for uncontrollable costs, such as drug prices)
	Payment if patient does not receive care?	NO	YES (payment made even if no care is delivered)

Growing Concerns About Negative Impacts of Current VBP

The Hospital Readmissions Reduction Program — Time for a Reboot

Rishi K. Wadhera, M.D., M.P.P., Robert W. Yeh, M.D., and Karen E. Joynt Maddox, M.D., M.P.H.

N ENGL J MED 380;24 NEJM.ORG JUNE 13, 2019

Health Policy & Economics

The Journal of Arthroplasty 33 (2018) 2722–2727

Are Medicare's "Comprehensive Care for Joint Replacement" Bundled Payments Stratifying Risk Adequately?

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Risk Adjustment In Medicare ACO Program Deters Coding Increases But May Lead ACOs To Drop High-Risk Beneficiaries

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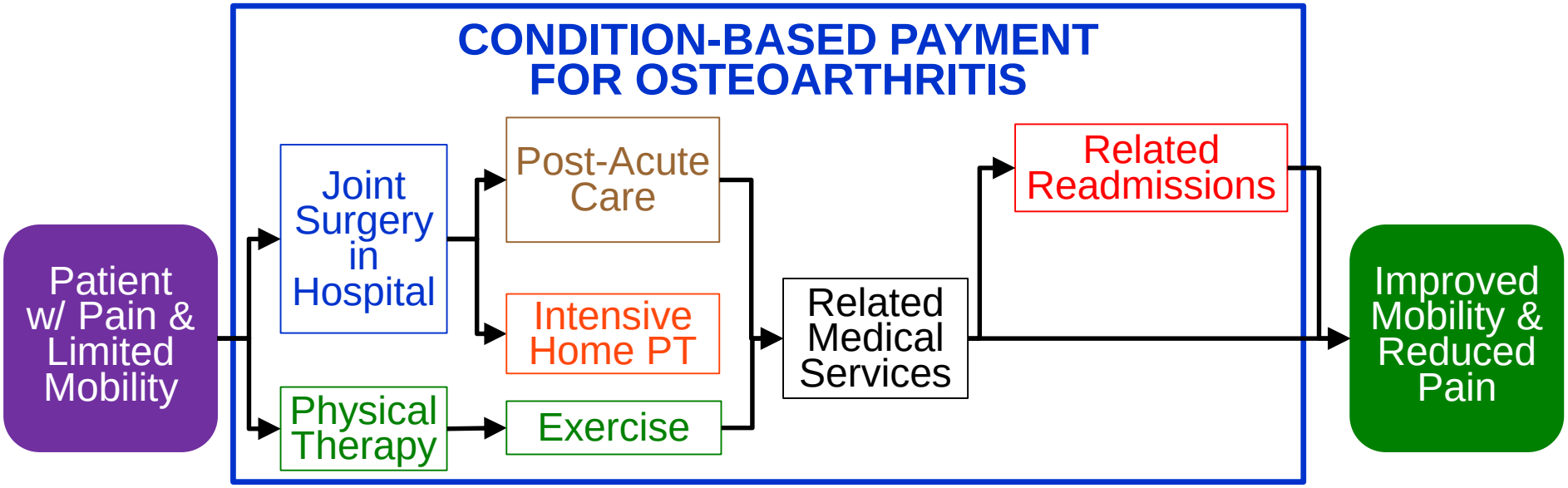
Oncologists set to lose big under CMS payment model

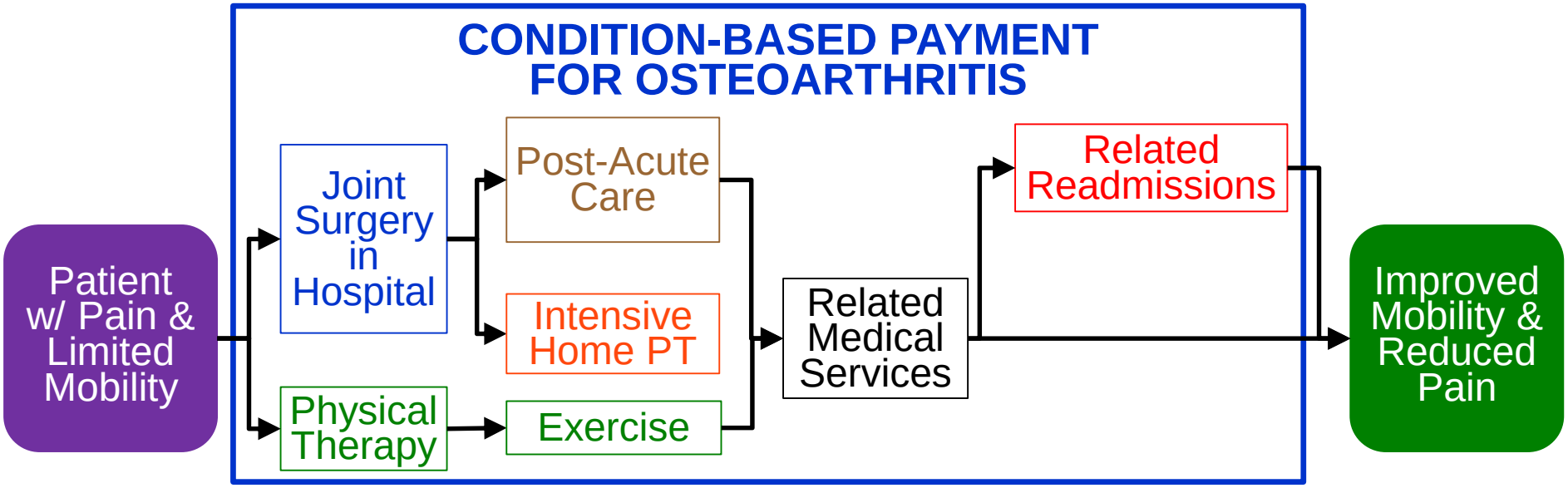
STEVEN ROSS JOHNSON

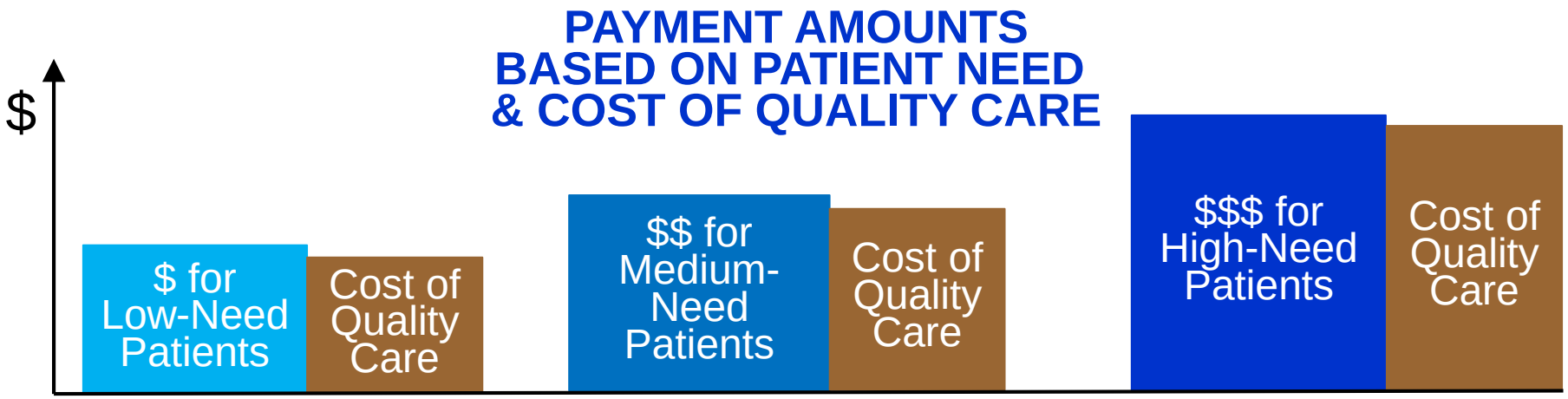
Is There Any Way to Create a *Good* Alternative Payment Model?

Bundling Better: *Condition*-Based Payment



Bundling Better: *Condition*-Based Payment





Condition-Based APM Solves FFS Problems & Preserves Its Strengths

	Condition-Based Payment
Weaknesses of Fee for Service	
Payment for unnecessary services?	Payment based on patient need, not the number or type of services
Payment even if quality/outcome is bad?	$0 unless quality standards are met $0 extra to treat avoidable problems
Payment for all high-value services?	Flexible, bundled payment to team
Payment sufficient to cover cost of services?	Payment based on cost of delivering high-quality services
Strengths of Fee for Service	
Higher payment for higher-need patients?	Payment amounts stratified based on patient needs
Penalties for things provider cannot control?	Accountability for services and outcomes providers can control
Payment if patient does not receive care?	No payment unless patient receives treatment for the condition

How Providers and Patients Can Help Create Better APMs

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- **Contribute information to help with better APM design**
  - Characteristics of patients who require more or different services
  - Characteristics of patients that can result in poorer outcomes
  - Actual cost of delivering services to low-need & high-need patients
  - Difference in cost to deliver services in small and rural communities

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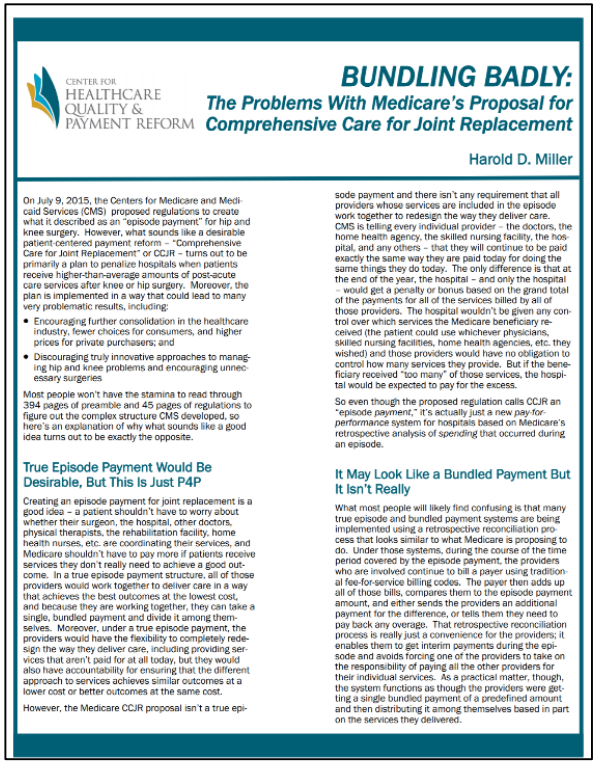
- **Support collection of data needed to implement APMs**
  - Data to measure patient needs, not just diagnosis codes
  - Data on patient outcomes, not just services delivered
- **Demand that Medicare and other payers use better APMs**
  - Condition-based payments rather than population-based payments
  - Adequate, flexible payments stratified by patient need
  - No untested mandatory payment models

More Details on Creating Better Payment Models

www.PaymentReform.org



CENTER FOR HEALTHCARE QUALITY & PAYMENT REFORM

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

Harold D. Miller

On July 9, 2015, the Centers for Medicare and Medicaid Services (CMS) proposed regulations to create what it described as an "episode payment" for hip and knee surgery. However, what sounds like a desirable patient-centered payment reform – "Comprehensive Care for Joint Replacement" or CCJR – turns out to be primarily a plan to penalize hospitals when patients receive higher-than-average amounts of post-acute care services after knee or hip surgery. Moreover, the plan is implemented in a way that could lead to many very problematic results, including:

- Encouraging further consolidation in the healthcare industry, fewer choices for consumers, and higher prices for private purchasers; and
- Discouraging truly innovative approaches to managing hip and knee problems and encouraging unnecessary surgeries

Most people won't have the stamina to read through 394 pages of preamble and 45 pages of regulations to figure out the complex structure CMS developed, so here's an explanation of why what sounds like a good idea turns out to be exactly the opposite.

True Episode Payment Would Be Desirable, But This Is Just P4P

Creating an episode payment for joint replacement is a good idea – a patient shouldn't have to worry about whether their surgeon, the hospital, other doctors, physical therapists, the rehabilitation facility, home health nurses, etc. are coordinating their services, and Medicare shouldn't have to pay more if patients receive services they don't really need to achieve a good outcome. In a true episode payment structure, all of those providers would work together to deliver care in a way that achieves the best outcomes at the lowest cost, and because they are working together, they can take a single, bundled payment and divide it among themselves. Moreover, under a true episode payment, the providers would have the flexibility to completely redesign the way they deliver care, including providing services that aren't paid for at all today, but they would also have accountability for ensuring that the different approach to services achieves similar outcomes at a lower cost or better outcomes at the same cost.

However, the Medicare CCJR proposal isn't a true episode payment and there isn't any requirement that all providers whose services are included in the episode work together to redesign the way they deliver care. CMS is telling every individual provider – the doctors, the home health agency, the skilled nursing facility, the hospital, and any others – that they will continue to be paid exactly the same way they are paid today for doing the same things they do today. The only difference is that at the end of the year, the hospital – and only the hospital – would get a penalty or bonus based on the grand total of the payments for all of the services billed by all of those providers. The hospital wouldn't be given any control over which services the Medicare beneficiary received (the patient could use whichever physicians, skilled nursing facilities, home health agencies, etc. they wished) and those providers would have no obligation to control how many services they provide. But if the beneficiary received "too many" of those services, the hospital would be expected to pay for the excess.

So even though the proposed regulation calls CCJR an "episode *payment*," it's actually just a new *pay-for-performance* system for hospitals based on Medicare's retrospective analysis of *spending* that occurred during an episode.

It May Look Like a Bundled Payment But It Isn't Really

What most people will likely find confusing is that many true episode and bundled payment systems are being implemented using a retrospective reconciliation process that looks similar to what Medicare is proposing to do. Under those systems, during the course of the time period covered by the episode payment, the providers who are involved continue to bill a payer using traditional fee-for-service billing codes. The payer then adds up all of those bills, compares them to the episode payment amount, and either sends the providers an additional payment for the difference, or tells them they need to pay back any overage. That retrospective reconciliation process is really just a convenience for the providers; it enables them to get interim payments during the episode and avoids forcing one of the providers to take on the responsibility of paying all the other providers for their individual services. As a practical matter, though, the system functions as though the providers were getting a single bundled payment of a predefined amount and then distributing it among themselves based in part on the services they delivered.

CENTER FOR HEALTHCARE QUALITY & PAYMENT REFORM

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

Harold D. Miller

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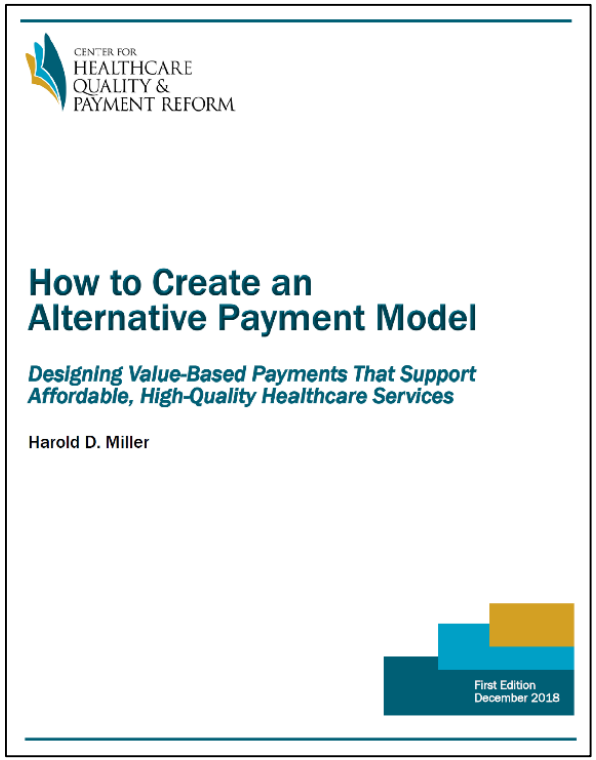
September 2015



CENTER FOR HEALTHCARE QUALITY & PAYMENT REFORM

How to Create an Alternative Payment Model

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

Harold D. Miller

First Edition
December 2018

Today's Slides Are Available Here

www.PaymentReform.org

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