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

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

www.CHQPR.org
How Do You Control the Growth in Healthcare Spending?
Wrong Ways: Cut Providers Fees or Delay/Deny Services to Patients

- Total Health Care Spending
- Cut Fees
- Delay/Deny Care

Lower Spending for Payers
Worse Care & Access for Patients

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The Right Way: Reducing *Avoidable* Spending

The graph illustrates the reduction of *avoidable* spending on necessary services, leading to savings.
Avoidable Spending Exists In All Areas of Health Care

- **SPENDING ON NECESSARY SERVICES**
  - Maternity Care
    - Unnecessary C-Sections
    - Early elective deliveries
    - Underuse of birth centers
  - Chronic Disease
    - ED visits for exacerbations
    - Hospital admissions and readmissions
    - Preventable progression of disease
    - Preventable chronic conditions
  - 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-expensive implants
    - Infections and complications of surgery
    - Overuse of inpatient rehabilitation

- **AVOIDABLE SPENDING**

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Reducing Avoidable Spending is a Win-Win for Payers & Patients
Barriers in the Payment System Create a Win-Lose for Providers

- Avoidable Spending
- Spending on Necessary Services
- Losses for Healthcare Providers
- BARRIERS TO VALUE IN THE CURRENT PAYMENT SYSTEM
- Savings
- Avoidable Spending
- Spending on Necessary Services

Lower Spending for Payers
Better Care for Patients
Avoidable spending often occurs because payments are inadequate (or non-existent) for alternative, higher-value services:

- Services other than office visits, such as phone calls, e-mails, etc.
- 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

Delivering these services improves value for payers and patients, but causes financial losses for healthcare providers.
Barrier #2: “Avoidable Spending” is Revenue for Providers

$\\begin{align*}
\text{Payer} & \quad \text{Provider} \\
\text{SPENDING ON NECESSARY SERVICES} & \quad \text{HOSPITAL AND PHYSICIAN REVENUE} \\
\text{AVOIDABLE SPENDING} & \quad \\
\end{align*}
Providers Use the Revenue to Pay for the Costs of Services

- Providers use the revenue to pay for the costs of services.
- Spending on necessary services versus avoidable spending.
- Margin between provider revenue and cost of service delivery.

Graph showing the relationship between payer and provider revenue, with spending categories.
The Majority of Costs May Be Fixed (in the Short Term)

$\text{AVOIDABLE SPENDING}$

$\text{SPENDING ON NECESSARY SERVICES}$

$\text{MARGIN}$

$\text{VARIABLE COST OF SERVICES}$

$\text{FIXED COST OF SERVICE DELIVERY}$

$\text{PROVIDER REVENUE}$

Payer

Provider
When Healthcare Providers Reduce Avoidable Services…

- **AVOIDABLE SPENDING**
- **SPENDING ON NECESSARY SERVICES**
- **FIXED COST OF SERVICE DELIVERY**
- **SPENDING ON NECESSARY SERVICES**

- **Payer**
- **Provider**

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…Variable Costs Decrease, But Fixed Costs Do Not
…Plus Added Costs of Delivering New High-Value Services
Revenues Decrease in Direct Proportion to Service Volume…

AVOIDABLE SPENDING

SPENDING ON NECESSARY SERVICES

PROVIDER REVENUE

REV MARGIN

NEW SVCS

VARIABLE COST

FIXED COST OF SERVICE DELIVERY

Payer

Provider

Payer

Provider
...Resulting in Financial Loss for Healthcare Providers
Win-Lose: Savings for Payers, Losses for Providers

- **SPENDING ON NECESSARY SERVICES**
  - Payer: Provider Revenue
  - Provider: Fixed Cost of Service Delivery
- **AVOIDABLE SPENDING**
  - Payer: Variable Cost of Services
  - Provider: Avoidable Spending
  - Payer: Provider Revenue
  - Provider: New SVCS / Variable Cost

**WIN - LOSE**
A Good Payment System Must Remove the Barriers to Better Care

**BARRIER #1**

Avoidable Spending Occurs Because Payments Are Inadequate (or Non-Existing) for Alternative, Higher-Value Services:

- Services other than office visits, such as phone calls, e-mails, etc.
- 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

**LOW $ FOR HIGH-VALUE SERVICES**

**BARRIER #2**

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<td>AVOIDABLE SPENDING</td>
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<td>CURRENT SPENDING ON NECESSARY SERVICES</td>
<td>FIXED COST OF SERVICE DELIVERY</td>
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<td>PROVIDER REVENUE</td>
<td>MARGIN</td>
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<td>MARGIN</td>
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Do Current Value-Based Payment Systems and Alternative Payment Models Remove the Barriers to Value-Based Care?
Most “Value-Based Payment” is Fee for Service + “Incentives”

Under typical P4P systems & alternative payment models, providers are still paid the same amounts for the same services as under standard fee-for-service payments, and they receive no new payments or higher payments for high-value services, only small bonuses or penalties received long after care is delivered.
Under Shared Savings APMs, If Payers Save $$ This Year...

Shared Savings Alternative Payment Model

YEAR 1

- AVOIDABLE SPENDING
- SPENDING ON NECESSARY SERVICES
- SAVINGS
- AVOIDABLE SPENDING
- SPENDING ON NECESSARY SERVICES

LOW $ FOR HIGH-VALUE SERVICES

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If Payers Save $$ This Year… Providers (May) Get $ Next Year

Shared Savings Alternative Payment Model

Under typical Shared Savings systems, the only change in payment is a bonus paid based on savings or quality/cost performance in a previous year.
No Additional Payments for New High-Value Services

Shared Savings Alternative Payment Model

YEAR 1

- AVOIDABLE SPENDING
  - SPENDING ON NECESSARY SERVICES
    - LOW $ FOR HIGH-VALUE SERVICES

- SAVINGS

- AVOIDABLE SPENDING
  - SPENDING ON NECESSARY SERVICES
    - LOW $ FOR HIGH-VALUE SERVICES

How does provider cover upfront costs of high-value care?
If Provider Qualifies for a Shared Savings Payment...

Shared Savings Alternative Payment Model

YEAR 1

AVOIDABLE SPENDING

SPENDING ON NECESSARY SERVICES

LOW $ FOR HIGH-VALUE SERVICES

SAVINGS

YEAR 2

AVOIDABLE SPENDING

P4P/Shared Svgs

SAVINGS

SPENDING ON NECESSARY SERVICES

LOW $ FOR HIGH-VALUE SERVICES

How does provider cover upfront costs of high-value care?
Payment is Generally Less Than Added Costs & Losses

Shared Savings Alternative Payment Model

How does provider cover upfront costs of high-value care?

Bonus may not be large enough to cover the costs incurred.
## Little Change in Payment Means Little Savings from CMS APMs

<table>
<thead>
<tr>
<th>CMS APM</th>
<th>Results</th>
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<tbody>
<tr>
<td>Accountable Care Organizations (ACOs)</td>
<td></td>
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<tr>
<td>MSSP ACOs 2013-2016</td>
<td>Increase in Medicare spending</td>
</tr>
<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>
</tr>
<tr>
<td>NextGen ACOs</td>
<td>Increase in spending in first 2 years</td>
</tr>
<tr>
<td>Comprehensive Care for Joint Replacement (CJR)</td>
<td>Savings of $117 (0.4%) per episode</td>
</tr>
<tr>
<td>Bundled Payments for Care Improvement (BPCI)</td>
<td>Increase in Medicare spending</td>
</tr>
<tr>
<td>Oncology Care Model (OCM)</td>
<td>Increase in spending in first 3 years</td>
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Win-Win Requires Savings AND Adequate Payment for Services

- Win-Win Requires Savings AND Adequate Payment for Services
- Avoidable Spending
- Spending on Necessary Services
- Low $ for High-Value Services
- Adjusted Payment
- Cost of High-Value Services
- Payer
- Provider

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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:
- >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

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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• <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

PAYMENT CHANGE:
• Additional payment to physician practice to hire nurse and use symptom monitoring technology
Result: Better Care at Lower Cost for 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

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

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
4 Steps for Creating Successful Value-Based Payments

- NECESSARY SERVICES
- AVOIDABLE SPENDING
- LOW $ FOR HIGH-VALUE SERVICES
- ADJUSTED PAYMENT
- SAVINGS
- WIN - WIN
- MARGIN
- COST OF HIGH-VALUE SERVICES

Step 1
Step 2
Step 3
Step 4

Payer
Provider
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

SERVICES NEEDED TO REDUCE THE IDENTIFIED AVOIDABLE SPENDING

- Care Management
- Home Visits
- New Technology
- Prevention & Screening

AVOIDABLE SPENDING

NECESSARY SERVICES

SERVICES THAT PREVENT AVOIDABLE SPENDING

SAVINGS
Step 3: Pay Adequately to Support Higher-Value Services

- AVOIDABLE SPENDING
- NECESSARY SERVICES
- UNPAID SERVICES
- LOSS OF REVENUE
- SAVINGS
- AVOIDABLE SPENDING
- SERVICES THAT PREVENT AVOIDABLE SPENDING
- ADEQUATE PAYMENT FOR HIGHER-VALUE SERVICES

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Adequacy Requires Knowing the Cost of Higher-Value Care

- **Avoidable Spending**
- **Necessary Services**
- **Unpaid Services**
- **Loss of Revenue**
- **Savings**
- **Services That Prevent Avoidable Spending**
- **Cost of Services**
- **Avoidable Payment for Higher-Value Services**

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Knowing Your *Current* Costs Is Not Enough

- Time-Driven Activity-Based Costing and other cost-accounting systems can tell you what it *currently* costs to deliver *non-value-based care*, but not what it *will* cost to deliver *value-based care*.

- A *Cost Model* is needed to determine how costs will *change* as value-based care is implemented:
  - What will it cost to deliver *new*, high-value services?
  - How much of the cost of *current* services is:
    - **Variable**, i.e., it will change with each unit change in services (e.g., drugs, disposable items)
    - **Semi-Variable**, i.e., it will change only with large changes in volume (e.g., personnel, equipment)
    - **Fixed**, i.e., it can only be changed over a longer time horizon
Step 3: Pay Adequately to Support Higher-Value Services

- AVOIDABLE SPENDING
- NECESSARY SERVICES
- UNPAID SERVICES
- LOSS OF REVENUE
- SAVINGS
- AVODIBLE SPENDING
- SERVICES THAT PREVENT AVOIDABLE SPENDING
- COST OF SERVICES
- MARGIN
- SAVINGS
- AVOIDABLE SPENDING
- ADEQUATE PAYMENT FOR HIGHER-VALUE SERVICES

$
Step 4: Hold Providers Accountable for Results

- **Avoidable Spending**
  - Necessary Services
  - Unpaid Services

- **Savings**
  - Services That Prevent Avoidable Spending
  - Loss of Revenue

- **Cost of Services**

- **Adequate Payment for Higher-Value Services**

Accountability for Reducing Avoidable Spending
Good Alternative Payment Models Can Be Win-Win-Wins

Win for Patients: Better Care Without Unnecessary Services
Win for Providers: Adequate Payment for High-Value Services
Win for Payers: Lower Spending

Avoidable Spending
Necessary Services
Unpaid Services
Loss of Revenue

Cost of Services
MARGIN

Services that Prevent Avoidable Spending

Savings
Accountability for Reducing Avoidable Spending

Adequate Payment for Higher-Value Services

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## Three Key Components of APMs Needed To Ensure Success

<table>
<thead>
<tr>
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<td>Accountability for Spending and Quality</td>
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Success Requires Using the Right Approach to Each Component

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<tr>
<td>Adequate Resources to Address Patient Needs</td>
<td>Same payment amount for each patient regardless of differences in health problems or other needs</td>
<td>Stratified payments with higher amounts for patients with greater needs</td>
</tr>
<tr>
<td>Adequate Resources to Support Costs of Services</td>
<td>Fixed fee per service or per patient regardless of number of patients treated</td>
<td>Standby Capacity Payment to support fixed costs of a service line (paid on a per member per month basis)</td>
</tr>
<tr>
<td>Accountability for Spending and Quality</td>
<td>Risk for total cost of care for outcomes beyond the control of the physician or hospital</td>
<td>Accountability for costs and aspects of quality the physician or hospital can control</td>
</tr>
</tbody>
</table>
## Component #1

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</table>
Necessary & Avoidable Services Differ Among Patients

Lower Need Patients

Medium Need Patients

Higher Need Patients

$ Loss

Avoidable Spending

Necessary Services

Unpaid Svc
A Wrong Way: Paying the Same Amount for Every Patient

Lower Need Patients
- Necessary Services
- Same Payment Amount for All Patients
- Avoidable Spending

Medium Need Patients
- Necessary Services
- Same Payment Amount for All Patients
- Avoidable Spending

Higher Need Patients
- Necessary Services
- Same Payment Amount for All Patients
- Avoidable Spending

$ Loss

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Condition-Based Payments Adjust for Differences in Patient Needs

Lower Need Patients

Avoidable Spending

Necessary Services

Unpaid Svc

Savings

Medium Need Patients

Avoidable Spending

Necessary Services

Unpaid Svc

Savings

Higher Need Patients

Avoidable Spending

Necessary Services

Condition-Based Payment

Unpaid Svc $ Loss

Savings

$ Loss

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Under Population-Based Payment: Will It All Average Out?

POPULATION-BASED PAYMENT (CAPITATION)

- High Need Patients: Same Payment for All Patients
- Medium Need Patients: Same Payment for All Patients
- Lower Need Patients: Same Payment for All Patients
Under Population-Based Payment: More High-Need Patients = Losses

POPULATION-BASED PAYMENT (CAPITATION)

- High Need Patients
  - Same Payment for All Patients
- Medium Need Patients
  - Same Payment for All Patients
- Lower Need Patients
  - Same Payment for All Patients

Loss

- High Need Patients
  - Same Payment for All Patients
- Lower Need Patients
  - Same Payment for All Patients
Under Population-Based Payment: Cherry-Picking Patients = Profits

- High Need Patients
  - Same Payment for All Patients
- Medium Need Patients
  - Same Payment for All Patients
- Lower Need Patients
  - Same Payment for All Patients

LOSS

PROFIT

Same Payment for All Patients

Same Payment for All Patients

Same Payment for All Patients

Same Payment for All Patients

Same Payment for All Patients

Same Payment for All Patients

Same Payment for All Patients

Same Payment for All Patients

Same Payment for All Patients

Same Payment for All Patients

 Same Payment for All Patients

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Under Condition-Based Payment: Payment Differs by Patient Need

CONDITION-BASED PAYMENT

$\uparrow$

High Need Patients

Medium Need Patients

Lower Need Patients

High Need Payment

Medium Need Payment

Low Need Payment
Under Condition-Based Payment: No Losses for Serving High Needs

CONDITION-BASED PAYMENT

$\

High Need Patients

Medium Need Patients

Lower Need Patients

High Need Payment

Medium Need Payment

Low Need Payment

High Need Payment

High Need Payment

Low Need Payment
Under Condition-Based Payment: No Profits from Cherry-Picking

CONDITION-BASED PAYMENT

High Need Patients

Medium Need Patients

Lower Need Patients

High Need Payment

Medium Need Payment

Low Need Payment

High Need Payment

Medium Need Payment

Low Need Payment

High Need Payment

Medium Need Payment

Low Need Payment

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High Need Payment

Medium Need Payment

Low Need Payment

High Need Payment

Medium Need Payment

Low Need Payment
# Population-Based Payment Can Worsen Health Disparities

<table>
<thead>
<tr>
<th></th>
<th>Fee-for-Service Payment (Fixed payment for each service, regardless of whether service is needed)</th>
<th>Condition-Based Payment (Fixed payment for all services that are related to a specific condition)</th>
<th>Population-Based Payment (Fixed payment for all services, regardless of patient’s needs)</th>
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<tbody>
<tr>
<td>Rewards over-treatment?</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
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<tr>
<td>Rewards under-treatment?</td>
<td>No</td>
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A Wrong Way: Paying the Same Fees Regardless of Volume

Fee Per Service

Much Lower Service Volume

Lower Service Volume

Baseline Service Volume

Higher Service Volume

Much Higher Service Volume

$
If Fees Are Adequate to Cover Costs at One Volume of Services...

- **Baseline Service Volume**: Adequate payment at baseline volume.
  - Profit
  - Variable Cost
  - Fixed Cost
  - Fee Per Service

- **Higher Service Volume**: Fee Per Service
- **Much Higher Service Volume**: Fee Per Service

- **Much Lower Service Volume**: Fee Per Service
- **Lower Service Volume**: Fee Per Service
…The Fees Will Be Too Low When Volume Decreases…

FEE FOR SERVICE PAYMENT

Revenue decreases more than costs decrease

Adequate payment at baseline volume

<table>
<thead>
<tr>
<th>Much Lower Service Volume</th>
<th>Lower Service Volume</th>
<th>Baseline Service Volume</th>
<th>Higher Service Volume</th>
<th>Much Higher Service Volume</th>
</tr>
</thead>
<tbody>
<tr>
<td>Variable Cost</td>
<td>Loss</td>
<td>Profit</td>
<td>Variable Cost</td>
<td>Fixed Cost</td>
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…Penalizing Efforts to Improve Patient Health and Outcomes

FEE FOR SERVICE PAYMENT

- **Variable Cost**: Fee Per Service
- **Fixed Cost**: Fee Per Service

**Revenue decreases more than costs decrease**

- **Loss**: Variable Cost
- **Adequate payment at baseline volume**
  - **Profit**: Fixed Cost
  - **Fee Per Service**: Variable Cost

**Large losses if patients need fewer services**

- **Variable Cost**: Fee Per Service
- **Fixed Cost**: Fee Per Service

**Large losses if patients need fewer services**

- **Variable Cost**: Fee Per Service
- **Fixed Cost**: Fee Per Service
Conversely, Fees Will Be Higher Than Needed If Volume Grows…

FEE FOR SERVICE PAYMENT

Revenue decreases more than costs decrease

Adequate payment at baseline volume

Revenue increases more than costs increase

Large losses if patients need fewer services

Variable Cost

Fee Per Service

Fixed Cost

Fee Per Service

Variable Cost

Fee Per Service

Fixed Cost

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...Retaining a Financial Incentive to Deliver More Services

FEE FOR SERVICE PAYMENT

- High profits when more services are delivered
- Revenue increases more than costs increase
- Adequate payment at baseline volume
- Revenue decreases more than costs decrease
- Large losses if patients need fewer services

Costs:
- Fixed Cost
- Variable Cost

Services:
- Fee Per Service

Volume:
- Much Lower Service Volume
- Lower Service Volume
- Baseline Service Volume
- Higher Service Volume
- Much Higher Service Volume

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- Standby Capacity Payment
- Separate payments to cover fixed and variable costs

Baseline Service Volume

- Fixed Cost
- Variable Cost
- Standby Capacity Payment
…With Service-Based Fees Tied to Variable Costs of Services

Separate payments to cover fixed and variable costs

- Fixed Cost
- Variable Cost
- Service-Based Fees
- Standby Capacity Payment
- Profit

Baseline Service Volume

$
When Volume Decreases, Payment Still Covers Costs

Adequate revenue is maintained if patients need fewer services

Separate payments to cover fixed and variable costs

Fixed Cost
Variable Cost
Service-Based Fees
Profit
Standby Capacity Payment

Lower Service Volume

Baseline Service Volume

Much Lower Service Volume

Fixed Cost
Variable Cost
Service-Based Fees
When Volume Increases, No Windfall Profits

Revenue grows in proportion to costs if more services are needed.

Adequate revenue is maintained if patients need fewer services.

Separate payments to cover fixed and variable costs.
Combination of Per Member & Per Service Pmt

PATIENT-CENTERED PAYMENT

$

Baseline Service Volume

Fixed Cost

Variable Cost

Profit

Fee

Fee

Fee

Fee

Fee

Fee

SERVICE-BASED FEES
• For variable cost of delivering an additional service
• Paid when an insured member receives the service

STANDBY CAPACITY PAYMENT
• For fixed cost of essential services for community
• Payment for each insured member living in community (regardless of whether service is delivered to that member)
This Approach to Payment is Essential for Rural Hospitals

A fee for a service based on the average cost per service at large hospitals will be below the average cost of the service at small hospitals.

Paying separately for fixed costs and variable costs better matches revenues to costs at hospitals of different sizes.

**FEE-FOR-SERVICE PAYMENT**

- Variable Cost
- Fixed Cost
- Fee Per Service
- Loss

**PATIENT-CENTERED PAYMENT**

- Variable Cost
- Fixed Cost
- Fee Per Service
- Service-Based Fees

A fee for a service based on the average cost per service at large hospitals will be below the average cost of the service at small hospitals.

Paying separately for fixed costs and variable costs better matches revenues to costs at hospitals of different sizes.
Success Requires Using the Right Approach to Each Component

<table>
<thead>
<tr>
<th>KEY COMPONENT</th>
<th>BAD APPROACHES</th>
<th>GOOD APPROACH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adequate Resources to Address Patient Needs</td>
<td>Same payment amount for each patient regardless of differences in health problems or other needs</td>
<td>Stratified payments with higher amounts for patients with greater needs</td>
</tr>
<tr>
<td>Adequate Resources to Support Costs of Services</td>
<td>Fixed fee per service or per patient regardless of number of patients treated</td>
<td>Standby Capacity Payment to support fixed costs of a service line (paid on a per member per month basis)</td>
</tr>
<tr>
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<td>Service-Based Fees and Patient-Based Payments based on semi-variable and variable costs</td>
</tr>
<tr>
<td>Accountability for Spending and Quality</td>
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</table>
## Component #3

<table>
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</table>
A Wrong Way: Holding Providers Accountable for Total Cost of Care

Many “value-based” payment systems put a provider at financial risk for total healthcare spending on patients, including spending on services for unrelated health problems and increases in spending due to higher prices of drugs and medical devices that the provider cannot control.
Accountability Must Be Focused on What Each Provider Can Influence

- Spending the Provider Cannot Control
  - e.g., PCPs can’t control the cost of cancer treatment
  - e.g., oncologists can’t prevent cancer
  - e.g., hospitals can’t prevent diabetic foot ulcers that require amputation
  - e.g., providers can’t control the price of drugs

- Avoidable Spending the Provider Can Control or Influence
  - e.g., PCPs can encourage patients to get mammograms and colonoscopies
  - e.g., oncologists can help patients avoid or minimize problems from chemotherapy toxicity
  - e.g., hospitals can reduce surgical site infections when amputations are needed
  - e.g., providers can choose the most cost-effective drugs from among the drugs available at the prices charged by manufacturers

- Payments to the Provider

Total Spending Per Patient

$
# Success Requires Using the Right Approach to Each Component

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<td>Accountability for Spending and Quality</td>
<td>Risk for total cost of care</td>
<td>Accountability for costs and aspects of quality the physician or hospital can control</td>
</tr>
<tr>
<td></td>
<td>Risk for outcomes beyond the control of the physician or hospital</td>
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</table>
Quantitative Example of a Condition-Based Payment for Knee Osteoarthritis
Focus of Example: 3 Key Services for Knee Osteoarthritis

- KNEE SURGERY
- PHYSICAL THERAPY
- PRIMARY CARE
Focus of Example: 3 Key Services for Knee Osteoarthritis

For simplicity, the example will ignore post-acute rehabilitation services after surgery, hospital readmissions & complications that occur during and after treatment services.

There are also important opportunities to reduce avoidable spending in post-acute care, and they should be included in any actual approach to delivering and paying for care for this condition.
Assumption: Some of the Surgeries Are Avoidable

- Avoidable Surgeries
- Knee Surgery
- Physical Therapy
- Primary Care
Premise: Better Primary Care + Therapy -> Less Need for Surgery

- **AVOIDABLE SURGERIES**
  - Knee Surgery
  - Physical Therapy
  - Primary Care

- **SAVINGS**

- **KNEE SURGERY**

- **PHYSICAL THERAPY**

- **PRIMARY CARE**

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Value Improves if Savings is Greater Than Increased Cost
How Could a Value-Based Payment Model Support This?

- Avoidable Surgeries
- Savings
- Knee Surgery
- Value-Based Payment for High-Value Care of Knee Arthritis
- Physical Therapy
- Primary Care
- Primary Care
Example: Reducing Avoidable Surgeries for Knee Osteoarthritis

<table>
<thead>
<tr>
<th>Primary Care</th>
<th>$/Patient</th>
<th># Pts</th>
<th>Total $</th>
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<tr>
<td>Evaluations</td>
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</table>

Treatment of Knee Osteoarthritis

- 100 patients with knee pain visit PCP/GP for evaluation
Example: Reducing Avoidable Surgeries for Knee Osteoarthritis

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<td>Management</td>
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<td>Phys. Therapy</td>
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<td>Subtotal</td>
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Treatment of Knee Osteoarthritis

- 100 patients with knee pain visit PCP/GP for evaluation
- Physical therapy used by 20% of patients
Example: Reducing Avoidable Surgeries for Knee Osteoarthritis

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<tr>
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Treatment of Knee Osteoarthritis

- 100 patients with knee pain visit PCP/GP for evaluation
- Physical therapy used by 20% of patients
- Surgery performed on 80% of evaluated patients
Example: Reducing Avoidable Surgeries for Knee Osteoarthritis

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**Treatment of Knee Osteoarthritis**

- 100 patients with knee pain visit PCP/GP for evaluation
- Physical therapy used by 20% of patients
- Surgery performed on 80% of evaluated patients
- Total current spending: $1.1 million/100 patients
Example: Reducing Avoidable Surgeries for Knee Osteoarthritis

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**Treatment of Knee Osteoarthritis**

- 100 patients with knee pain visit PCP/GP for evaluation
- Physical therapy used by 20% of patients
- Surgery performed on 80% of evaluated patients
- Total current spending: $1.1 million/100 patients
- 25% of surgeries avoidable with better outpatient management
Under FFS, Low Payment for Diagnosis & Treatment Planning

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## Under FFS, Low Payment for Non-Surgical Options

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Under FFS, High Payment for Surgery...

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Under FFS, Fewer Surgeries = Losses for Surgeons & Hospitals

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A Better Way: Pay PCPs for Good Diagnosis & Treatment Planning

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**Better Payment for Condition Management**

• PCP/GP paid adequately to help patient decide on treatment options
A Better Way: Pay Adequately for Non-Surgical Management

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Better Payment for Condition Management
- PCP/GP paid adequately to help patient decide on treatment options
- Physiatrists & physical therapists paid to deliver effective non-surgical care
# A Better Way: Pay Adequately For the Necessary Surgeries

## Better Payment for Condition Management
- PCP/GP paid adequately to help patient decide on treatment options
- Physiatrists & physical therapists paid to deliver effective non-surgical care
- Surgeon paid more per surgery for patients who need surgery

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If That Results in 25% Fewer Surgeries…

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Physicians Could Be Paid More…

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Physicians Could Be Paid More…
While Still Reducing Total Spending

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## Win-Win-Win for Physicians, Payers, & Patients

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- **Physicians Win**: 100%
- **Patients Win**: 200%
- **Payer Wins**: 257%

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## What About the Hospital?

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**Hospital Loses**
### Do Hospitals Have to Lose In Order for Physicians & Payers To Win?

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**Physicians Win**

**Hospital Loses**

**Payer Wins**
What Should Matter to Hospitals is *Margin*, Not Revenues (Volume)
Hospital Costs Are Not Proportional to Utilization

Cost & Revenue Changes With Fewer Patients

- 20% reduction in volume
- 7% reduction in cost

#Patients

Costs

$000

$1,000
$980
$960
$940
$920
$900
$880
$860
$840
$820
$800
Reductions in Utilization Reduce Revenues More Than Costs

Cost & Revenue Changes With Fewer Patients

- 20% reduction in volume
- 7% reduction in cost
- 20% reduction in revenue
Causing Negative Margins for Hospitals

Cost & Revenue Changes With Fewer Patients

Payers Will Be Underpaying For Care If Surgeries, Readmissions, Etc. Are Reduced
But Spending Can Be Reduced Without Bankrupting Hospitals

Cost & Revenue Changes With Fewer Patients

Payers Can Still Save $ Without Causing Negative Margins for Hospital

Revenues
Costs

#Patients
We Need to Understand the Hospital’s Cost Structure

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It isn’t sufficient to know the hospital’s current cost per procedure; we need to know how the costs will change when the number of procedures changes.
### Adequacy of Payment Depends On Fixed/Variable Costs & Margins

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The actual mix of fixed and variable costs will depend on the procedure, the hospital, and the time horizon.
If the Number of Procedures is Reduced…

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...Fixed Costs Will Remain the Same (in the Short Run)...
...But Variable Costs Will Go Down in Proportion to Procedures

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Let’s Allow the Hospital to Get a Higher Margin Than Before

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The Hospital Gets Less *Total Revenue* But a Higher *Margin*...

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…And The Payer Still Saves Money

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## Win-Win-Win-Win for Patients, Physicians, Hospital, and Payer

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|                  | $/Patient # Pts    | Total $           |       |
| Current          | $200 100           | $20,000           | 100%  |
| Non-Surg.Tx      | $500 40            | $20,000           | 400%  |
| Phys. Therapy    | $750 40            | $30,000           | 200%  |
| Subtotal         |                    | $50,000           | 257%  |
| Surgeon          | $2,100 60          | $126,000          | +13%  |
| Hospital Pmt     |                    |                   |       |
| Fixed Costs      |                    | $480,000          | 0%    |
| Variable Costs   | $5,400 45%         | $324,000          | -25%  |
| Margin           |                    | $52,800           | +10%  |
| Subtotal         | 100 $1,052,800     |                   | -11%  |

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Renegotiating Every Individual Fee is Impractical…

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…What Assures The Payer That There Will Be Fewer Procedures?

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Start With Team of Providers
Managing the Condition

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They Should Function as a Team to Manage the Patient’s Condition

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Their Decisions Also Determine the Hospital’s Variable Cost of Surgery

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The Full Cost the Condition Team is Responsible For

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## Use a Per-Patient Payment to Pay for Condition Management

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Use the Payment as Budget to Support the Work of the Team…

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...And Let the Team Members Decide How They Should Be Paid

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The Hospital Needs to Cover Its Fixed Costs No Matter What

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<td>$568,000</td>
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<td></td>
<td>$520,000</td>
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<tr>
<td>Per Patient</td>
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<table>
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<tr>
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<td><strong>Total Standby</strong></td>
<td></td>
<td>$528,000</td>
<td></td>
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Support Standby Costs Through a Payment for Each *Plan Member*

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<tr>
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<td>$700 20 $14,000</td>
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<td>$1,400 80 $112,000</td>
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<td>$5,400 80 $432,000</td>
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<tr>
<td>Total Condition</td>
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<td>$520,000</td>
<td>-8%</td>
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<tr>
<td>Per Patient</td>
<td>$5,280 100 $520,000</td>
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|                  | Members $ Total $        | Members $ Total $       |       |
| Hospital Pmt     |                         |                         |       |
| Fixed Costs      |                         |                         |       |
| Margin           | $480,000                 | $52,800                 |       |
| Total Standby    | $528,000                 | $532,800                |       |
| Per Member       | 1000 $533 $533,000       |                         |       |
The Combination of Payments is Still Less Than Previously Spent

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<td>$/Patient</td>
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<tr>
<td>Per Patient</td>
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Patients Differ in Their Need for Surgery vs. Alternative Treatment

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<th>HIGHER-NEED PATIENTS</th>
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<tr>
<td>Surgeon</td>
<td>20</td>
<td>40</td>
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</tbody>
</table>

- Assume 50% of Patients Are Low-Need
- Assume 40% of Low-Need Patients Need Surgery
- Assume 50% of Patients Are High-Need
- Assume 80% of High-Need Patients Need Surgery
Payment Amounts Must Be Stratified Based on Patient Needs

<table>
<thead>
<tr>
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<th>HIGHER-NEED PATIENTS</th>
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</table>

Lower Per-Patient Payment for Lower-Need Patients

Higher Per-Patient Payment for Higher-Need Patients
Protections For Providers Against Taking Inappropriate Risk

- **Risk Stratification:** The payment rates should vary based on objective characteristics of the patient and treatment that would be expected to result in the need for more services or increase the risk of complications.

- **Outlier Payment or Individual Stop Loss Insurance:** The payment should be increased if spending on an individual patient exceeds a pre-defined threshold. An alternative would be for the provider to purchase individual stop loss insurance (sometimes referred to as reinsurance) and include the cost of the insurance in the payment bundle.

- **Risk Corridors or Aggregate Stop Loss Insurance:** The payment should be increased if spending on all patients exceeds a pre-defined percentage above the payments. An alternative would be for the provider to purchase aggregate stop loss insurance and include the cost of the insurance in the payment bundle.

- **Adjustment for External Price Changes:** The payment should be adjusted for changes in the prices of drugs or services from other providers that are beyond the control of the provider accepting the payment.

- **Excluded Services:** Services the provider does not deliver, or order, or otherwise have the ability to influence should not be included as part of accountability measures in the payment system.
How Could a Value-Based Payment Model Support This?

- **AVOIDABLE SURGERIES**
- **SAVINGS**
- **KNEE SURGERY**
- **VALUE-BASED PAYMENT FOR HIGH-VALUE CARE OF KNEE ARTHRITIS**

- **PHYSICAL THERAPY**
- **PRIMARY CARE**

Primary care and physical therapy interventions can lead to savings, reducing the need for knee surgery and avoiding unnecessary surgeries.
Identify the Components of the Cost of Surgery

- AVOIDABLE SURGERIES
- KNEE SURGERY
- PHYSICAL THERAPY
- PRIMARY CARE
- PRIMARY CARE
- PHYSICAL THERAPY
- SURGEON
- HOSPITAL VARIABLE COST
- HOSPITAL FIXED COST
- SAVINGS
Define the Care Team That Will Manage the Patient’s Condition

AVOIDABLE SURGERIES
KNEE SURGERY
PHYSICAL THERAPY
PRIMARY CARE

SAVINGS
HOSPITAL FIXED COST
HOSPITAL VARIABLE COST
SURGEON
PHYSICAL THERAPY
PRIMARY CARE

Musculo-skeletal Care Team
Pay the Care Team to Manage the Patient’s Condition

- Avoidable Surgeries
- Savings
- Hospital Fixed Cost
- Hospital Variable Cost
- Surgeon
- Physical Therapy
- Primary Care

Condition-Based Payment to Manage Knee Arthritis

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The Care Team Pays for the Incremental Cost of More Surgery

- Avoidable Surgeries
- Knee Surgery
- Physical Therapy
- Primary Care
- Hospital Fixed Cost
- Hospital Variable Cost
- Surgeon
- Physical Therapy
- Primary Care

Savings

Condition-Based Payment to Manage Knee Arthritis

Musculoskeletal Care Team

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Hospital Receives Payment to Support Standby Capacity Cost

- AVOIDABLE SURGERIES
- KNEE SURGERY
- PHYSICAL THERAPY
- PRIMARY CARE

SAVINGS

- HOSPITAL FIXED COST
- HOSPITAL VARIABLE COST
- SURGEON
- PHYSICAL THERAPY
- PRIMARY CARE

Condition-Based Payment to Manage Knee Arthritis

Standby Capacity Payment for Surgery

Musculo-skeletal Care Team

$
Win-Win-Win Through Good Value-Based Care and Payment

Win for Payers: Lower Spending
Win for Patients: Better Care Without Unnecessary Services
Win for Providers: Adequate Payment for Services Regardless of Volume

Avoidable Surgeries
Knee Surgery
Primary Care
Physical Therapy
Musculoskeletal Care Team
Condition-Based Payment to Manage Knee Arthritis
Standby Capacity Payment for Surgery
Surgery Episode Payment
Hospital Fixed Cost
Hospital Variable Cost
Savings

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Implementing Good Alternative Payment Models
Implementing Patient-Centered Payments in Private Health Plans

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

- Private insurance plans should jump at the chance to implement an alternative payment model designed by providers that would reduce healthcare spending and improve services to patients, right?

- **Wrong.** Good APMs that improve quality and reduce healthcare spending cause insurance companies to lose money:
Implementing Patient-Centered Payments in Private Health Plans

- Private insurance plans should jump at the chance to implement an alternative payment model designed by providers that would reduce healthcare spending and improve services to patients, right?

- Wrong. Good APMs that improve quality and reduce healthcare spending cause insurance companies to lose money:
  - **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.
Implementing Patient-Centered Payments in Private Health Plans

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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?** Hospitals and 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**

- Hospitals & Physicians
60%+ of Employed Workers Are in Self-Insured Plans

The TPA charges a fee to process claims and the employer pays the full cost of the claims.
Small Employers & Individuals Purchase Insurance Plans

PURCHASERS

- Self-Insured
- Community Employers & Residents
- Premiums

$ $ $

MIDDLEMEN

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

PROVIDERS

- Hospitals & Physicians
  - 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)
- Insurance Plan (Full Risk)

**PROVIDERS**
- FFS
- APM
- Hospitals & Physicians
A Better Approach: Purchaser/Provider Partnerships

Community Employers & Residents

Hospitals & Physicians

PURCHASERS

MIDDLEMEN

PROVIDERS
Physicians Offer a Better “Product” to Purchasers…

PURCHASERS

Community Employers & Residents

Lower Cost, Higher Quality Care

Hospitals & Physicians

PROVIDERS
…Purchasers Agree to Pay Adequately for That Product

PURCHASERS

Community Employers & Residents

PROVIDERS

Hospitals & Physicians

Lower Cost, Higher Quality Care

Patient-Centered APM
The Result is a Win-Win for Purchasers & Providers

**Purchasers**

- Community
  - Employers
  - & Residents

**Providers**

- Hospitals & Physicians

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Employers and Patients “win” if:

- Patients receive the care they need
- Healthcare is more affordable

Providers “win” if:

- Providers can deliver the care patients need
- Payment is adequate to cover the cost of services

Lower Cost, Higher Quality Care

**Patient-Centered APM**
Purchasers (Not Plans) Can Pay for Improved Worker Productivity

**PURCHASERS**

**WORKER PRODUCTIVITY**

Community Employers & Residents

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

Fewer Hours Away From Work

**ACCESS TO & COORDINATION OF CARE**

Lower Cost, Higher Quality Care

Patient-Centered APM

**PROVIDERS**

Hospitals & Physicians

Providers “win” if:
- Providers can deliver the care patients need
- Payment is adequate to cover the cost of services
- Providers have flexibility to redesign care delivery

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Purchasers & Providers Select Plans That Will Use the APM

__PURCHASERS__

- **Self-Insured**
  - $ \rightarrow \text{Willing TPA} \rightarrow \text{APM}
- **Community Employers & Residents**
  - $ \rightarrow \text{Willing TPA} \rightarrow \text{APM}
- **Premiums**
  - $ \rightarrow \text{Willing Health Plan} \rightarrow \text{APM}

__PROVIDERS__

- **Unwilling TPA**
  - FFS
- **Unwilling Health Plan**
  - FFS

- **Hospitals & Physicians**
How to Create and Implement a Good Alternative Payment Model

• **Design the Payment Model to Support High-Value Care**
  1. Develop ways to deliver care that improve outcomes and reduce costs
     • Focus on opportunities to reduce healthcare spending or time away from work
     • Opportunities will differ for different patients and in different communities
  2. Estimate the costs and expected savings of value-based care
     • Costs will change when care is delivered in different ways
     • Improvements in outcomes need to be quantified and monetized
  3. Ensure there is a business case for both providers and payers
     • If not, revise the care delivery model to reduce costs or improve outcomes
  4. Design a payment model based on achievable costs and outcomes
     • Payments adequate but not excessive for costs at different levels of volume
     • Payments & outcome standards adjusted for differences in patient need/risk
     • Providers taking accountability for controllable spending and expected outcomes

• **Convince Purchasers to Implement the Payment Model**
  – Show the business case for purchasers and benefits for patients
  – Commit to ensuring a win-win approach for purchasers and providers
More Details on Creating Value-Based Payment Models

www.PaymentReform.org  www.RuralHospitals.org

Making the Business Case for Payment and Delivery Reform

How to Create an Alternative Payment Model

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

Saving Rural Hospitals and Sustaining Rural Healthcare

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