VALUE-BASED PAYMENTS THAT SUPPORT VALUE-BASED CARE

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

www.CHQPR.org
A Significant Portion of Healthcare Spending is Avoidable

AVOIDABLE SPENDING

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

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

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

- SURGERY
  - Unnecessary surgery
  - Use of unnecessarily-expensive implants
  - Infections and complications of surgery
  - Overuse of inpatient rehabilitation

SPENDING ON NECESSARY SERVICES

© Center for Healthcare Quality and Payment Reform www.CHQPR.org
Value-Based Care Can Be a Win-Win for Payers & Patients

$\text{SPENDING ON NECESSARY SERVICES}$

$\text{AVOIDABLE SPENDING}$

$\text{SAVINGS}$

$\text{SPENDING ON NECESSARY SERVICES}$

Lower Spending for Payers

Better Care for 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

Avoidable Spending

Savings

Spending on Necessary Services

Lower Spending for Payers

Better Care for Patients

© Center for Healthcare Quality and Payment Reform www.CHQPR.org
Barrier #1: Inadequate Payments for Higher-Value Services

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.
- Technology that enables monitoring of patient health conditions to allow early intervention
- Non-medical services, e.g., transportation
- Home-based acute care & rehabilitation

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

- AVOIDABLE SPENDING
- SPENDING ON NECESSARY SERVICES
- COST OF SERVICE DELIVERY
- MARGIN

Payer

Provider

$
The Majority of Costs May Be Fixed (in the Short Term)

- **Avoidable Spending**
- **Spending on Necessary Services**
- **Variable Cost of Services**
- **Fixed Cost of Service Delivery**

<table>
<thead>
<tr>
<th>Payer</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Variable Cost of Services</td>
<td>Fixed Cost of Service Delivery</td>
</tr>
<tr>
<td>Marginal Revenue</td>
<td>Marginal Revenue</td>
</tr>
</tbody>
</table>
When Healthcare Providers Reduce Avoidable Services…

$\begin{align*}
\text{Avoidable Spending} & \rightarrow \text{Avoidable Spending} \\
\text{Spending on Necessary Services} & \rightarrow \text{Fixed Cost of Service Delivery} \\
\text{Payer} & \rightarrow \text{Provider}
\end{align*}$
…Variable Costs Decrease, But Fixed Costs Do Not
...Plus Added Costs of Delivering New High-Value Services

- AVOIDABLE SPENDING
- SPENDING ON NECESSARY SERVICES
- PROVIDER REVENUE
- MARGIN
- VARIABLE COST OF SERVICES
- FIXED COST OF SERVICE DELIVERY
- NEW SVCS VARIABLE COST
- FIXED COST OF SERVICE DELIVERY
Revenues Decrease in Direct Proportion to Service Volume…
…Resulting in Financial Loss for Healthcare Providers

$\text{AVOIDABLE SPENDING}$

$\text{SPENDING ON NECESSARY SERVICES}$

$\text{PROVIDER REVENUE}$

$\text{NEW SVCS}$

$\text{VARIABLE COST}$

$\text{FIXED COST OF SERVICE DELIVERY}$

$\text{Payer}$

$\text{Provider}$

$\text{Payer}$

$\text{Provider}$

© Center for Healthcare Quality and Payment Reform www.CHQPR.org 13
Win-Lose: Savings for Payers, Losses for Providers

- **SPENDING ON NECESSARY SERVICES**
- **AVOIDABLE SPENDING**

**PROVIDER REVENUE**
- **MARGIN**
- **VARIABLE COST OF SERVICES**
- **FIXED COST OF SERVICE DELIVERY**

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

**NEW SVCS**
- **PROVIDER REVENUE**
- **VARIABLE COST**
- **FIXED COST OF SERVICE DELIVERY**

© Center for Healthcare Quality and Payment Reform www.CHQPR.org
Value-Based Payment Must Remove the Barriers to Better Care

**BARRIER #1**

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.
- Technology that enables monitoring of patient health conditions to allow early intervention
- Non-medical services, e.g., transportation
- Home-based acute care & rehabilitation

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

**BARRIER #2**

<table>
<thead>
<tr>
<th>Payer</th>
<th>Provider</th>
<th>Payer</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>AVOIDABLE SPENDING</td>
<td>VARIABLE COST OF SERVICES</td>
<td>AVOIDABLE SPENDING</td>
<td>VARIABLE COST</td>
</tr>
<tr>
<td>SPENDING ON NECESSARY SERVICES</td>
<td>FIXED COST OF SERVICE DELIVERY</td>
<td>SPENDING ON NECESSARY SERVICES</td>
<td>FIXED COST OF SERVICE DELIVERY</td>
</tr>
</tbody>
</table>

© Center for Healthcare Quality and Payment Reform  www.CHQPR.org
Win-Win = Savings AND Adequate Payment for Services

- AVOIDABLE SPENDING
- SPENDING ON NECESSARY SERVICES
- LOW $ FOR HIGH-VALUE SERVICES
- ADJUSTED PAYMENT
- SPENDING ON NECESSARY SERVICES
- COST OF HIGH-VALUE SERVICES

Payer Provider

Savings Margin

WIN - WIN
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
Barriers in Current Payment System

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

BARRIER TO IMPLEMENTATION:
• No payments for nurse or monitoring technology
Change in Payment to Overcome Barriers

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

BARRIER TO IMPLEMENTATION:
- No payments for nurse or monitoring technology

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

BARRIER TO IMPLEMENTATION:
• No payments for nurse or monitoring technology

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

1. Step 1: AVOIDABLE SPENDING
2. Step 2: SPENDING ON NECESSARY SERVICES
3. Step 3: ADJUSTED PAYMENT
4. Step 4: SPENDING ON NECESSARY SERVICES

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

Payer
Provider

WIN - WIN
SAVINGS
MARGIN
COST OF HIGH-VALUE SERVICES

© Center for Healthcare Quality and Payment Reform www.CHQPR.org
Step 1: Identify Specific Areas of Potentially Avoidable Spending

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

$\text{NECESSARY SERVICES} \rightarrow \text{SERVICES THAT PREVENT AVOIDABLE SPENDING} \rightarrow \text{SAVINGS} \rightarrow \text{AVOIDABLE SPENDING}$

SERVICES NEEDED TO REDUCE THE IDENTIFIED AVOIDABLE SPENDING
- Care Management
- Home Care
- New Technology
- Prevention & Screening
Step 3: Pay Adequately to Support Higher-Value Services

- Avoidable Spending
- Necessary Services
- Unpaid Services
- Savings
- Services that Prevent Avoidable Spending
- Loss of Revenue
- Adequate Payment for Higher-Value Services

$
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
- Adequate Payment for Higher-Value Services
- Margin
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

<table>
<thead>
<tr>
<th>SERVICES THAT PREVENT AVOIDABLE SPENDING</th>
<th>COST OF SERVICES</th>
<th>ADEQUATE PAYMENT FOR HIGHER-VALUE SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>AVOIDABLE SPENDING</td>
<td>AVOIDABLE SPENDING</td>
<td>AVOIDABLE SPENDING</td>
</tr>
<tr>
<td>NECESSARY SERVICES</td>
<td>MARGIN</td>
<td>SAVINGS</td>
</tr>
<tr>
<td>UNPAID SERVICES</td>
<td>LOSS OF REVENUE</td>
<td>SAVINGS</td>
</tr>
</tbody>
</table>

© Center for Healthcare Quality and Payment Reform www.CHQPR.org
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
- MARGIN

- AVOIDABLE SPENDING
- ADEQUATE PAYMENT FOR HIGHER-VALUE SERVICES

Accountability for Reducing Avoidable Spending

© Center for Healthcare Quality and Payment Reform www.CHQPR.org
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

Services That Prevent Avoidable Spending

Cost of Services

Adequate Payment for Higher-Value Services

Avoidable Spending

Savings

Accountability for Reducing Avoidable Spending

© Center for Healthcare Quality and Payment Reform  www.CHQPR.org
No One “Right” Way to Structure Payment + Accountability

- Fees + P4P
- Bundled Payment
- Warrantied Payment
- Episode Payment
- Condition-Based Payment
- Outcome-Based Pmt

SAVINGS

AVOIDABLE SPENDING

Accountability for Reducing Avoidable Spending

$
Building Blocks of Value-Based Payment
Building Blocks of Value-Based Payment

<table>
<thead>
<tr>
<th>BUILDING BLOCKS</th>
<th>HOW IT WORKS</th>
<th>EXAMPLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>New/Increased Fee for Service</td>
<td>Adequate payment for a high-value service</td>
<td>Care management to prevent hospital admission/readmit</td>
</tr>
</tbody>
</table>
## Building Blocks of Value-Based Payment

<table>
<thead>
<tr>
<th>BUILDING BLOCKS</th>
<th>HOW IT WORKS</th>
<th>EXAMPLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>New/Increased Fee for Service</td>
<td>Adequate payment for a high-value service</td>
<td>Care management to prevent hospital admission/readmit</td>
</tr>
<tr>
<td>Bundled Payment (Single Provider)</td>
<td>One payment for 2+ services required for a <em>single procedure</em></td>
<td>- Hospital DRG (case rate)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Surgical global fee</td>
</tr>
</tbody>
</table>
# Building Blocks of Value-Based Payment

<table>
<thead>
<tr>
<th>Building Blocks</th>
<th>How It Works</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>New/Increased Fee for Service</td>
<td>Adequate payment for a high-value service</td>
<td>Care management to prevent hospital admission/readmit</td>
</tr>
<tr>
<td>Bundled Payment (Single Provider)</td>
<td>One payment for 2+ services required for a <em>single procedure</em></td>
<td>- Hospital DRG (case rate)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Surgical global fee</td>
</tr>
<tr>
<td>Bundled Payment (Multi-Provider)</td>
<td>One payment to 2+ providers involved in a <em>single procedure</em></td>
<td>- Inpatient: DRG + Surgeon</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Inpatient + Rehabilitation</td>
</tr>
</tbody>
</table>
# Building Blocks of Value-Based Payment

<table>
<thead>
<tr>
<th>BUILDING BLOCKS</th>
<th>HOW IT WORKS</th>
<th>EXAMPLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>New/Increased Fee for Service</td>
<td>Adequate payment for a high-value service</td>
<td>Care management to prevent hospital admission/readmit</td>
</tr>
<tr>
<td>Bundled Payment (Single Provider)</td>
<td>One payment for 2+ services required for a <em>single procedure</em></td>
<td>- Hospital DRG (case rate)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Surgical global fee</td>
</tr>
<tr>
<td>Bundled Payment (Multi-Provider)</td>
<td>One payment to 2+ providers involved in a <em>single procedure</em></td>
<td>- Inpatient: DRG + Surgeon</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Inpatient + Rehabilitation</td>
</tr>
<tr>
<td>Warrantied Payment</td>
<td>No extra payment for correcting preventable errors/complications</td>
<td>No payment for readmission or repeat surgery</td>
</tr>
</tbody>
</table>
Building Blocks of Value-Based Payment

<table>
<thead>
<tr>
<th>BUILDING BLOCKS</th>
<th>HOW IT WORKS</th>
<th>EXAMPLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>New/Increased Fee for Service</td>
<td>Adequate payment for a high-value service</td>
<td>Care management to prevent hospital admission/readmit</td>
</tr>
<tr>
<td>Bundled Payment (Single Provider)</td>
<td>One payment for 2+ services required for a single procedure</td>
<td>- Hospital DRG (case rate) - Surgical global fee</td>
</tr>
<tr>
<td>Bundled Payment (Multi-Provider)</td>
<td>One payment to 2+ providers involved in a single procedure</td>
<td>- Inpatient: DRG + Surgeon - Inpatient + Rehabilitation</td>
</tr>
<tr>
<td>Warrantied Payment</td>
<td>No extra payment for correcting preventable errors/complications</td>
<td>No payment for readmission or repeat surgery</td>
</tr>
<tr>
<td>Episode Payment</td>
<td>One payment for all providers, services, and complications</td>
<td>Payment for inpatient care + rehabilitation + readmissions</td>
</tr>
</tbody>
</table>
# Building Blocks of Value-Based Payment

<table>
<thead>
<tr>
<th>Building Blocks</th>
<th>How It Works</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>New/Increased Fee for Service</td>
<td>Adequate payment for a high-value service</td>
<td>Care management to prevent hospital admission/readmit</td>
</tr>
<tr>
<td>Bundled Payment (Single Provider)</td>
<td>One payment for 2+ services required for a single procedure</td>
<td>- Hospital DRG (case rate)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Surgical global fee</td>
</tr>
<tr>
<td>Bundled Payment (Multi-Provider)</td>
<td>One payment to 2+ providers involved in a single procedure</td>
<td>- Inpatient: DRG + Surgeon</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Inpatient + Rehabilitation</td>
</tr>
<tr>
<td>Warrantied Payment</td>
<td>No extra payment for correcting preventable errors/complications</td>
<td>No payment for readmission or repeat surgery</td>
</tr>
<tr>
<td>Episode Payment</td>
<td>One payment for all providers, services, and complications</td>
<td>Payment for inpatient care + rehabilitation + readmissions</td>
</tr>
<tr>
<td>Outcome-Based Payment</td>
<td>No payment unless desired outcome is achieved</td>
<td>Payment for surgery only if patient functionality achieved</td>
</tr>
</tbody>
</table>
## Building Blocks of Value-Based Payment

<table>
<thead>
<tr>
<th>Building Blocks</th>
<th>How It Works</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>New/Increased Fee for Service</td>
<td>Adequate payment for a high-value service</td>
<td>Care management to prevent hospital admission/readmission</td>
</tr>
<tr>
<td>Bundled Payment (Single Provider)</td>
<td>One payment for 2+ services required for a <em>single procedure</em></td>
<td>- Hospital DRG (case rate) - Surgical global fee</td>
</tr>
<tr>
<td>Bundled Payment (Multi-Provider)</td>
<td>One payment to 2+ providers involved in a <em>single procedure</em></td>
<td>- Inpatient: DRG + Surgeon - Inpatient + Rehabilitation</td>
</tr>
<tr>
<td>Warrantied Payment</td>
<td>No extra payment for correcting preventable errors/complications</td>
<td>No payment for readmission or repeat surgery</td>
</tr>
<tr>
<td>Episode Payment</td>
<td>One payment for <em>all providers, services, and complications</em></td>
<td>Payment for inpatient care + rehabilitation + readmissions</td>
</tr>
<tr>
<td>Outcome-Based Payment</td>
<td>No payment unless desired outcome is achieved</td>
<td>Payment for surgery only if patient functionality achieved</td>
</tr>
<tr>
<td>Condition-Based Payment</td>
<td>One payment for <em>all procedures used to treat a health condition</em></td>
<td>Payment for coronary artery disease regardless of whether inpatient surgery, outpatient procedure, or medical treatment is used</td>
</tr>
</tbody>
</table>
# Building Blocks of Value-Based Payment

<table>
<thead>
<tr>
<th>BUILDING BLOCKS</th>
<th>HOW IT WORKS</th>
<th>EXAMPLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>New/Increased Fee for Service</td>
<td>Adequate payment for a high-value service</td>
<td>Care management to prevent hospital admission/readmit</td>
</tr>
<tr>
<td>Bundled Payment (Single Provider)</td>
<td>One payment for 2+ services required for a single procedure</td>
<td>- Hospital DRG (case rate)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Surgical global fee</td>
</tr>
<tr>
<td>Bundled Payment (Multi-Provider)</td>
<td>One payment to 2+ providers involved in a single procedure</td>
<td>- Inpatient: DRG + Surgeon</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Inpatient + Rehabilitation</td>
</tr>
<tr>
<td>Warrantied Payment</td>
<td>No extra payment for correcting preventable errors/complications</td>
<td>No payment for readmission or repeat surgery</td>
</tr>
<tr>
<td>Episode Payment</td>
<td>One payment for all providers, services, and complications</td>
<td>Payment for inpatient care + rehabilitation + readmissions</td>
</tr>
<tr>
<td>Outcome-Based Payment</td>
<td>No payment unless desired outcome is achieved</td>
<td>Payment for surgery only if patient functionality achieved</td>
</tr>
<tr>
<td>Condition-Based Payment</td>
<td>One payment for all procedures used to treat a health condition</td>
<td>Payment for coronary artery disease regardless of whether inpatient surgery, outpatient procedure, or medical treatment is used</td>
</tr>
<tr>
<td>Symptom-Based Payment</td>
<td>One payment for all tests used to diagnose symptoms</td>
<td>Payment to determine cause of chest pain</td>
</tr>
</tbody>
</table>
The Right Payment Method Depends on Opportunities/Barriers

Episode Payment

- Hip Fractures
- Labor & Delivery

Additional Fees + P4P

- COPD
- Diabetes

Avoidable Services Used for a Specific Procedure/Treatment

Many

Few
The Right Payment Method Depends on Opportunities/Barriers

- **Episode Payment**
  - Hip Fractures
  - Labor & Delivery

- **Condition-Based Pmt + Episode Payment**
  - Joint Osteoarthritis
  - Ischemic Heart Disease

- **Additional Fees + P4P**
  - COPD
  - Diabetes

- **Condition-Based Payment**
  - Rheumatoid Arthritis
  - Diagnosis of Back Pain

Avoidable Services Used for a Specific Procedure/Treatment

- Many
- Few

Avoidable Use of a Procedure or Treatment

- Low
- High
A Patient-Centered Payment System
A Patient-Centered Payment System

PATIENT-CENTERED PAYMENT

PATIENT → PRIMARY CARE PAYMENT

Primary Care (Generalist)

Preventive Care
Diagnostic Services
A Patient-Centered Payment System

PATIENT-CENTERED PAYMENT

- PRIMARY CARE PAYMENT
  - Primary Care (Generalist)
  - Preventive Care
  - Diagnostic Services

- CONDITION-BASED PAYMENT
  - Condition #1 Specialist

- CONDITION-BASED PAYMENT
  - Condition #2 Specialist
A Patient-Centered Payment System

PATIENT-CENTERED PAYMENT

CONDITION-BASED PAYMENT

Primary Care (Generalist)
- Preventive Care
- Diagnostic Services

Condition #1 Specialist
- (Inpatient) Episode Payment
- (Outpatient) Episode Payment
- Monthly Medical Management Payment

Condition #2 Specialist
- (Inpatient) Episode Payment
- (Outpatient) Episode Payment
- Monthly Medical Management Payment

© Center for Healthcare Quality and Payment Reform  www.CHQPR.org
More Details on Creating Value-Based Payment Models

www.PaymentReform.org

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

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

Patient-Centered Payment for Primary Care
Harold D. Miller