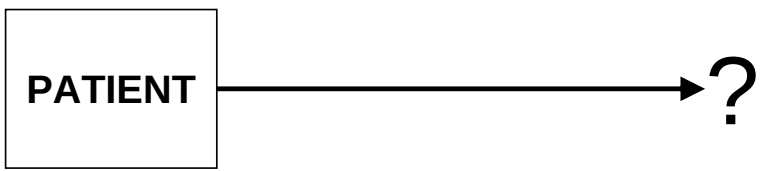
BUILDING BETTER BUNDLES AND BETTER ACOS USING CONDITION-BASED PAYMENT

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

www.CHQPR.org

How Will Patients Get Healthcare In the Future?

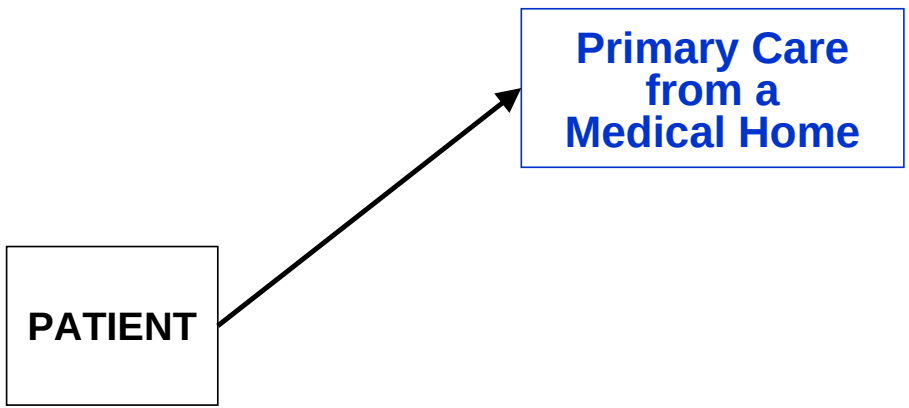


CMS Vision of the Future: Three Ways to Get Healthcare

PATIENT

CMS Vision of the Future: Three Ways to Get Healthcare

What CMS's Vision Appears to Be



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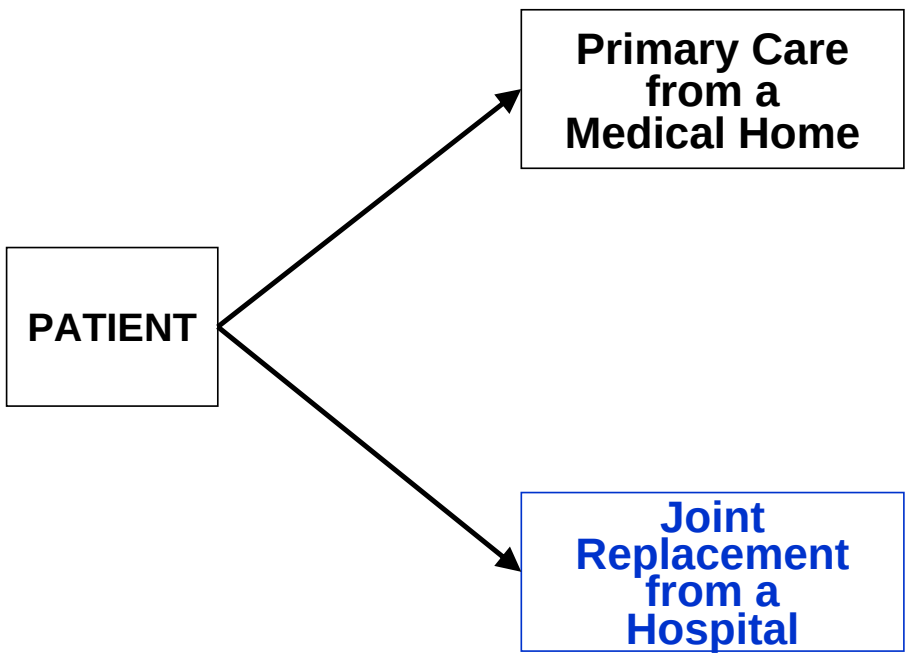

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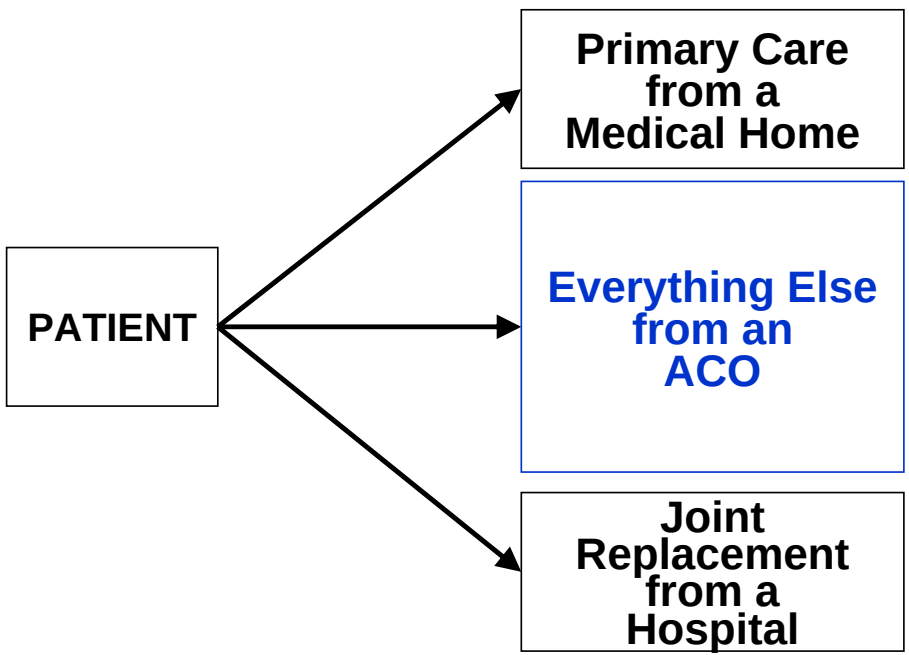

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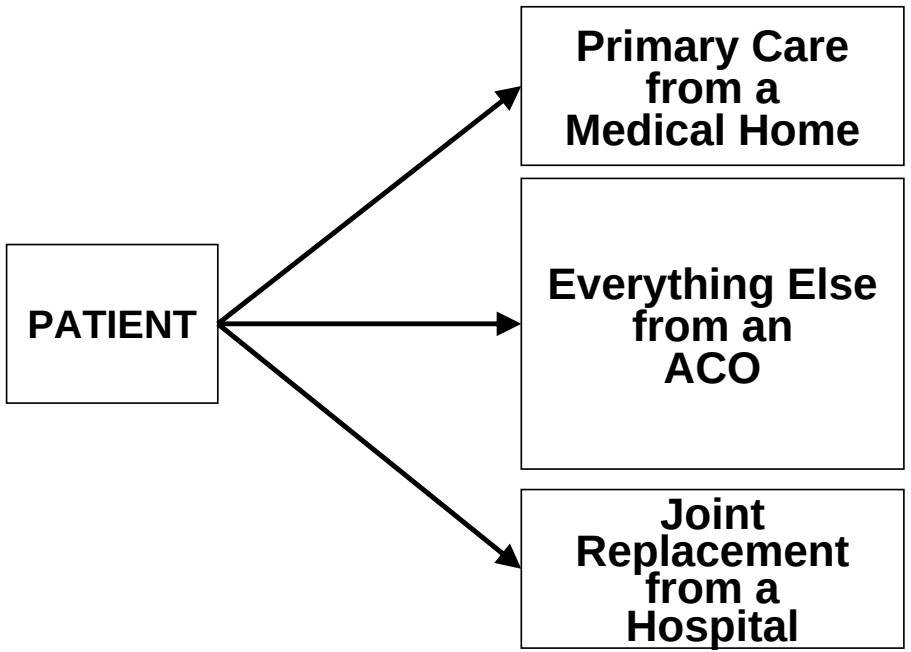

CMS (6/6/16): "Medicare is *moving away from paying for each service a physician provides* towards a system that rewards physicians for coordinating with each other"

Is “Care Coordination” the Key to Value-Based Care?

- Is the biggest problem with health care lack of coordination?
- Can you get high quality, affordable care by coordinating poor quality, expensive services?

Is Fit & Finish of Assembly the Key to Safe Automobiles?

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- When you buy a car, is your only concern whether the manufacturer assembled all the parts properly?

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Millions More Cars With Takata Air Bags Recalled

Honda, Fiat Chrysler, Toyota, Nissan, Subaru, and more kick off latest U.S. recalls

The Wall Street Journal, May 27, 2016

Car makers recalled millions of additional vehicles world-wide with faulty Takata Corp. air bags, further escalating an automotive safety crisis linked to at least 11 deaths and more than 100 injuries.

Auto makers in the U.S. on Friday recalled more than 12 million vehicles to replace the air bags, according to filings with U.S. regulators. The safety campaigns in the U.S. are part of a massive expansion disclosed earlier this month requiring auto makers to recall up to an additional 40 million air bags that risk rupturing and spraying shrapnel in vehicle cabins. All told, nearly 70 million air bags are being recalled in the U.S. alone.

Honda Motor Co., Fiat Chrysler Automobiles NV, Toyota Motor Corp, Nissan Motor Co., Fuji Heavy Industries Ltd.'s Subaru, Ferrari NV and Mitsubishi Motors Corp. kicked off the U.S. recalls on Friday. Honda, Takata's largest customer, recalled roughly 4.5 million vehicles, including some that had already been recalled earlier. Fiat Chrysler recalled 4.3 million vehicles.

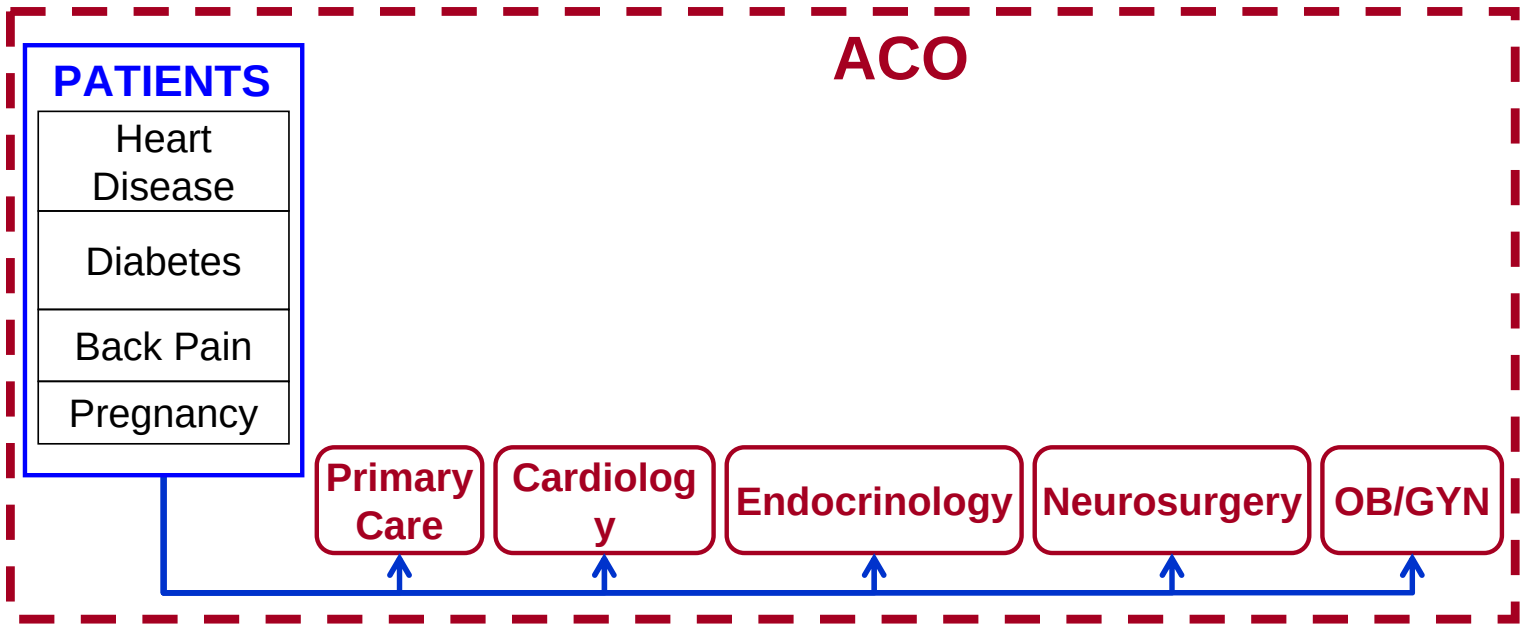
Healthcare Has Defective Parts, But We Continue to Use Them

Medical Error	# Errors (2008)	Cost Per Error	Total U.S. Cost
Pressure Ulcers	374,964	$10,288	$3,857,629,632
Postoperative Infection	252,695	$14,548	$3,676,000,000
Complications of Implanted Device	60,380	$18,771	$1,133,392,980
Infection Following Injection	8,855	$78,083	$691,424,965
Pneumothorax	25,559	$24,132	$616,789,788
Central Venous Catheter Infection	7,062	$83,365	$588,723,630
Others	773,808	$11,640	$9,007,039,005
TOTAL	1,503,323	$13,019	$19,571,000,000

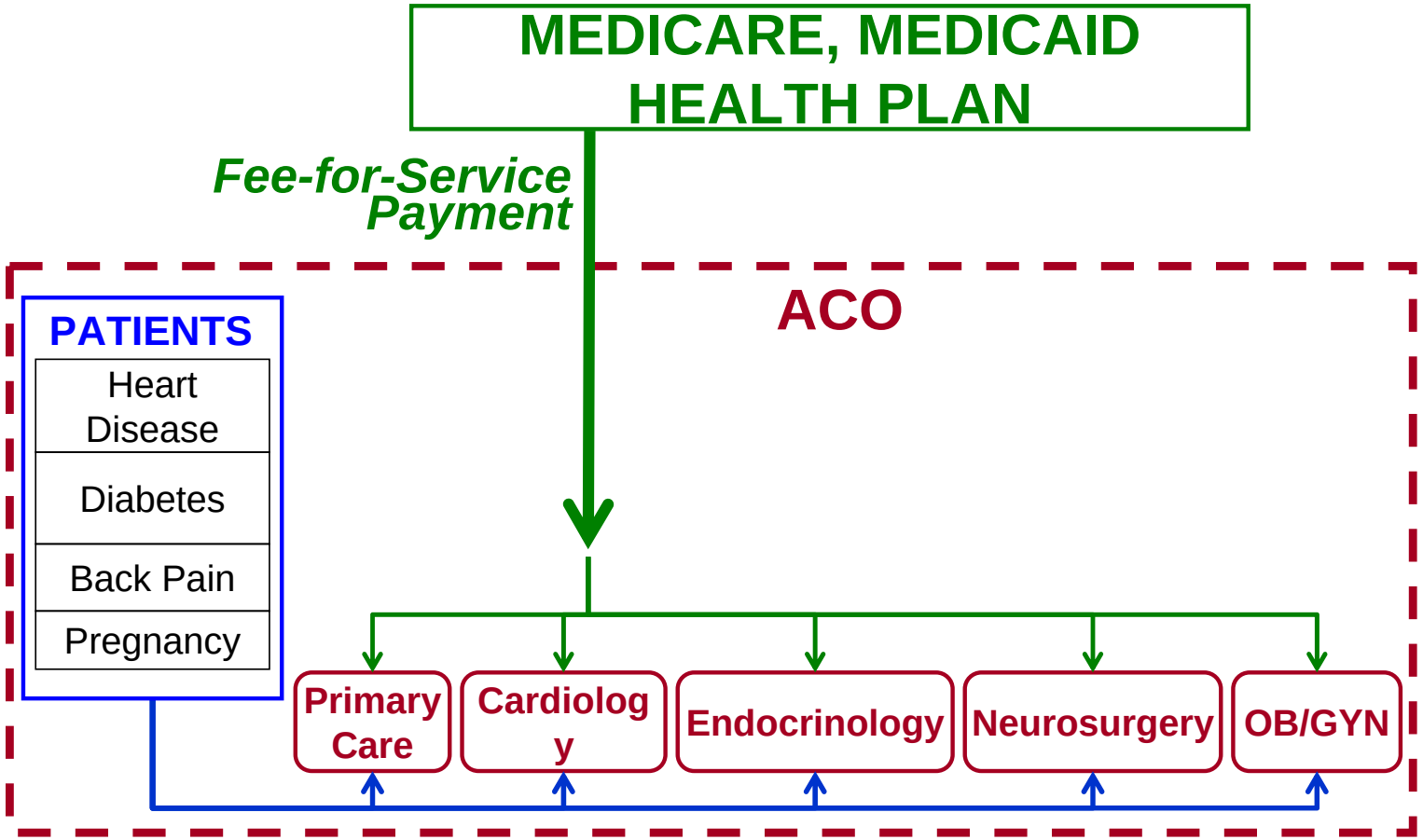
3 Adverse Events Every Minute

Source: *The Economic Measurement of Medical Errors*, Milliman and the Society of Actuaries, 2010

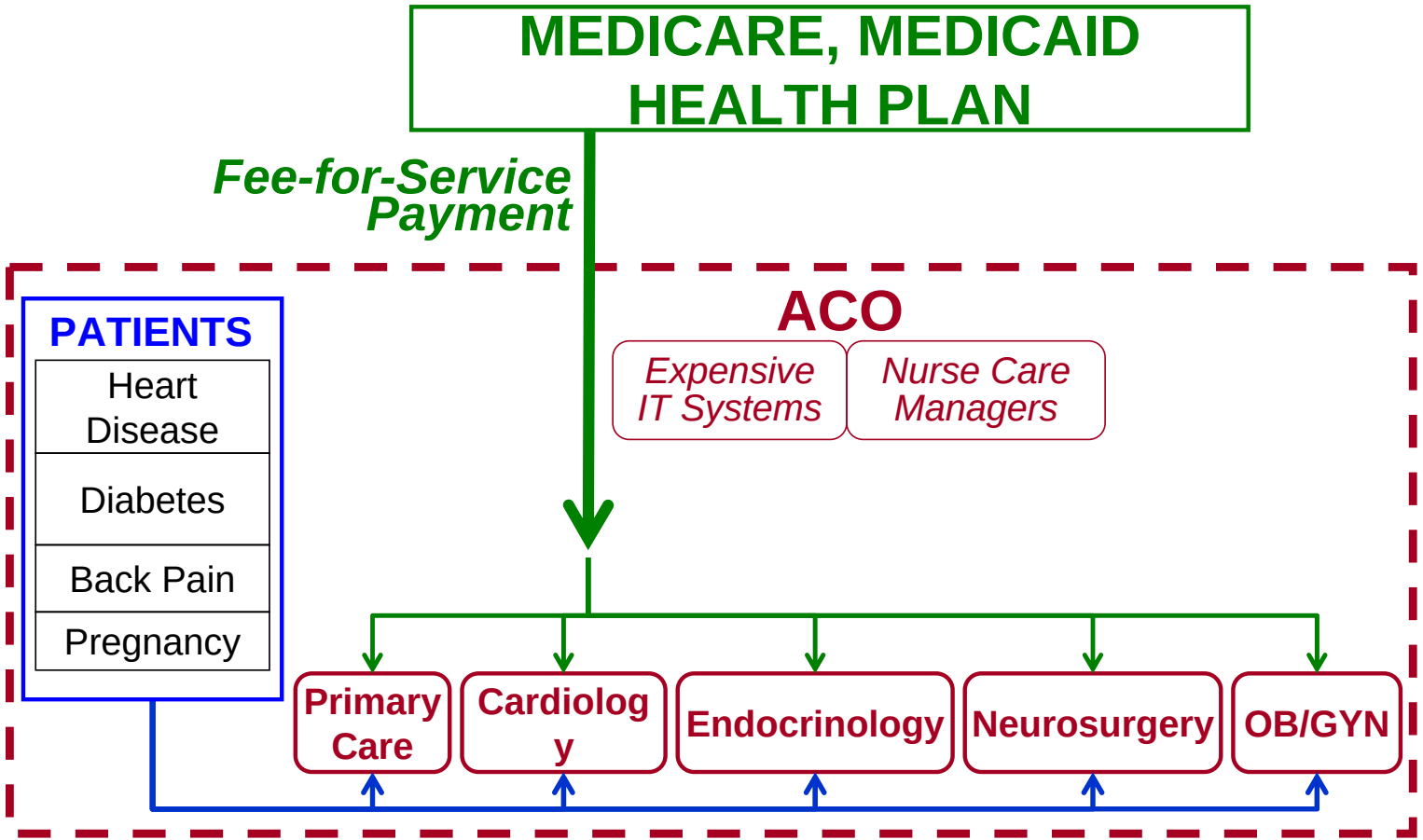
ACOs Are Supposed to Improve Care Through "Coordination"



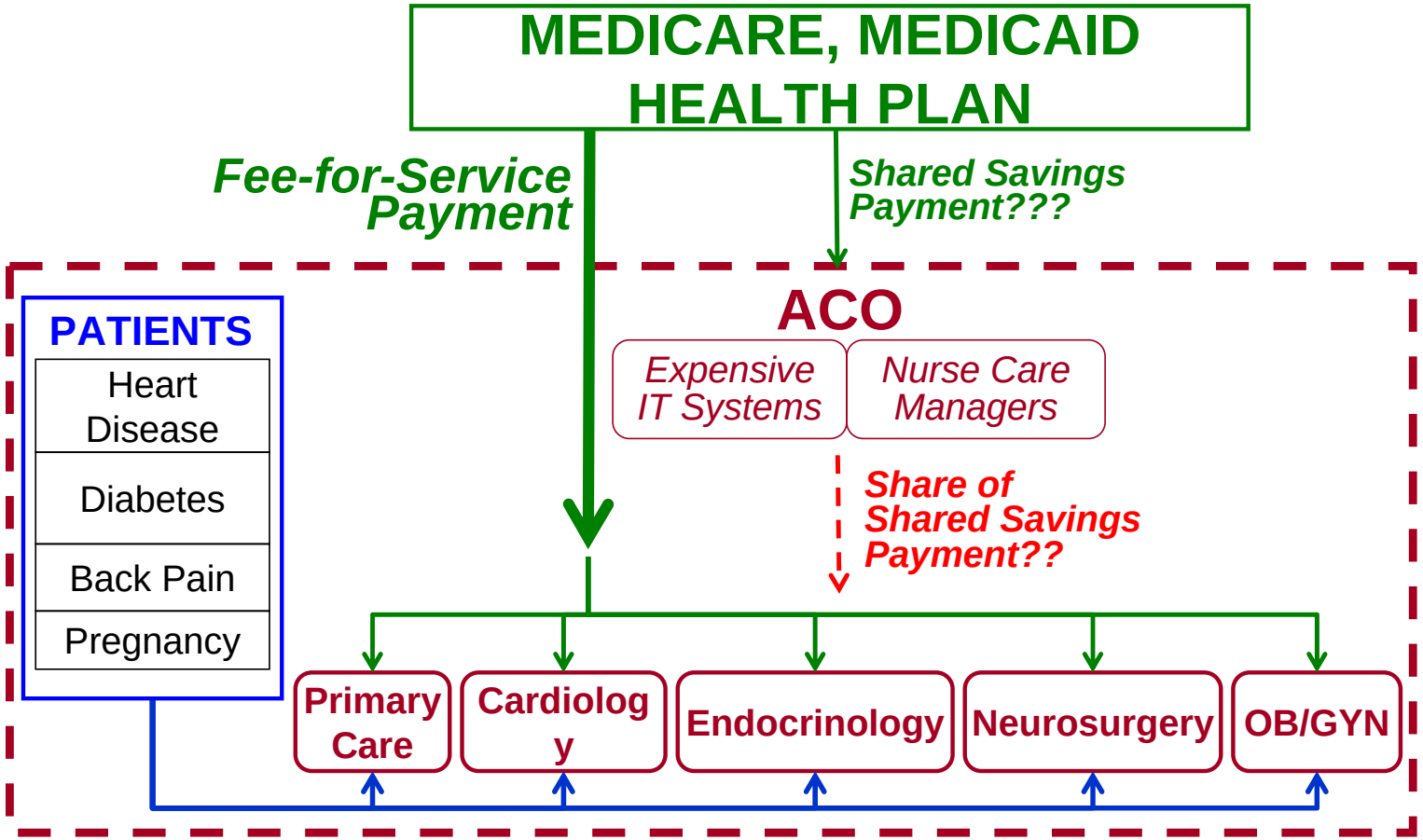
In Most ACOs, Physicians Are Paid the Same As They Are Today



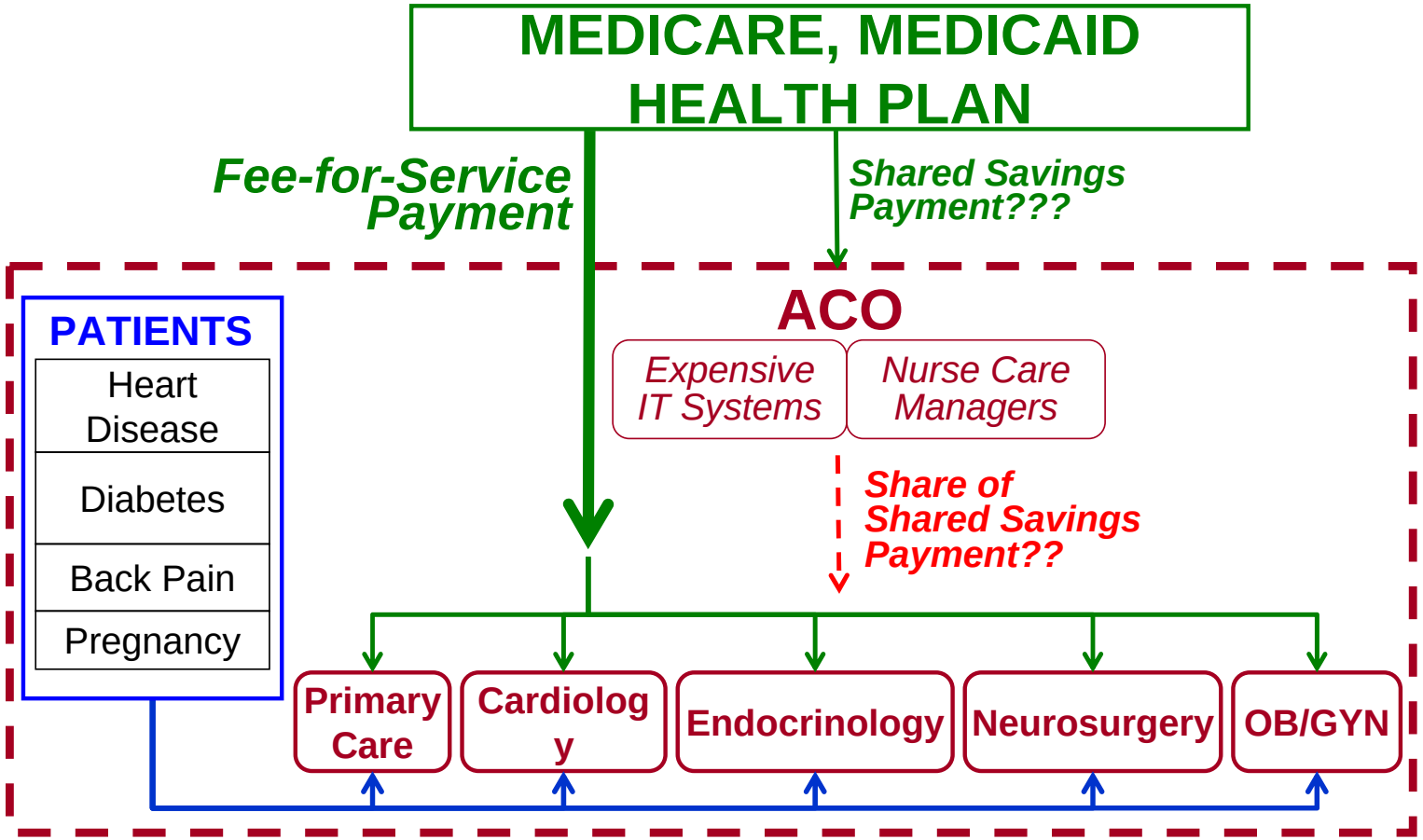
Most ACOs Spend a Lot on IT and Nurse Care Managers



Possible Future "Shared Savings" Doesn't Support Better Care *Today*



Most ACOs Today Aren't Truly *Redesigning Care*



Medicare ACOs Aren't Succeeding Due to Flaws in Payment Model

2013 Results for Medicare Shared Savings ACOs

- 46% of ACOs (102/220) *increased* Medicare spending
- Only one-fourth (52/220) received shared savings payments
- After making shared savings payments,

Medicare spent more than it saved

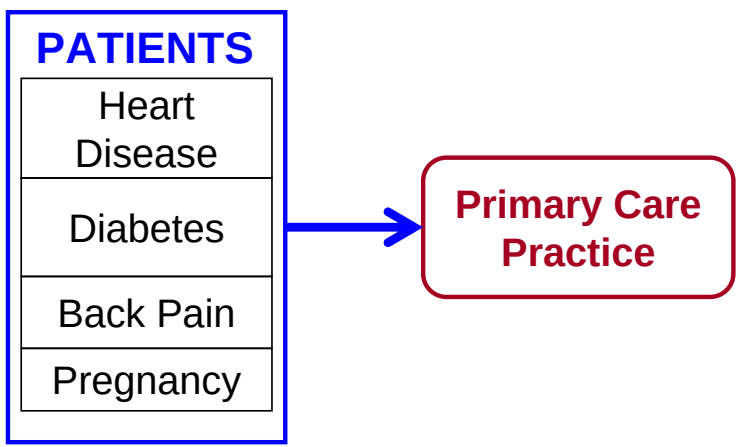
2014 Results for Medicare Shared Savings ACOs

- 45% of ACOs (152/333) *increased* Medicare spending
- Only one-fourth (86/333) received shared savings payments
- After making shared savings payments,

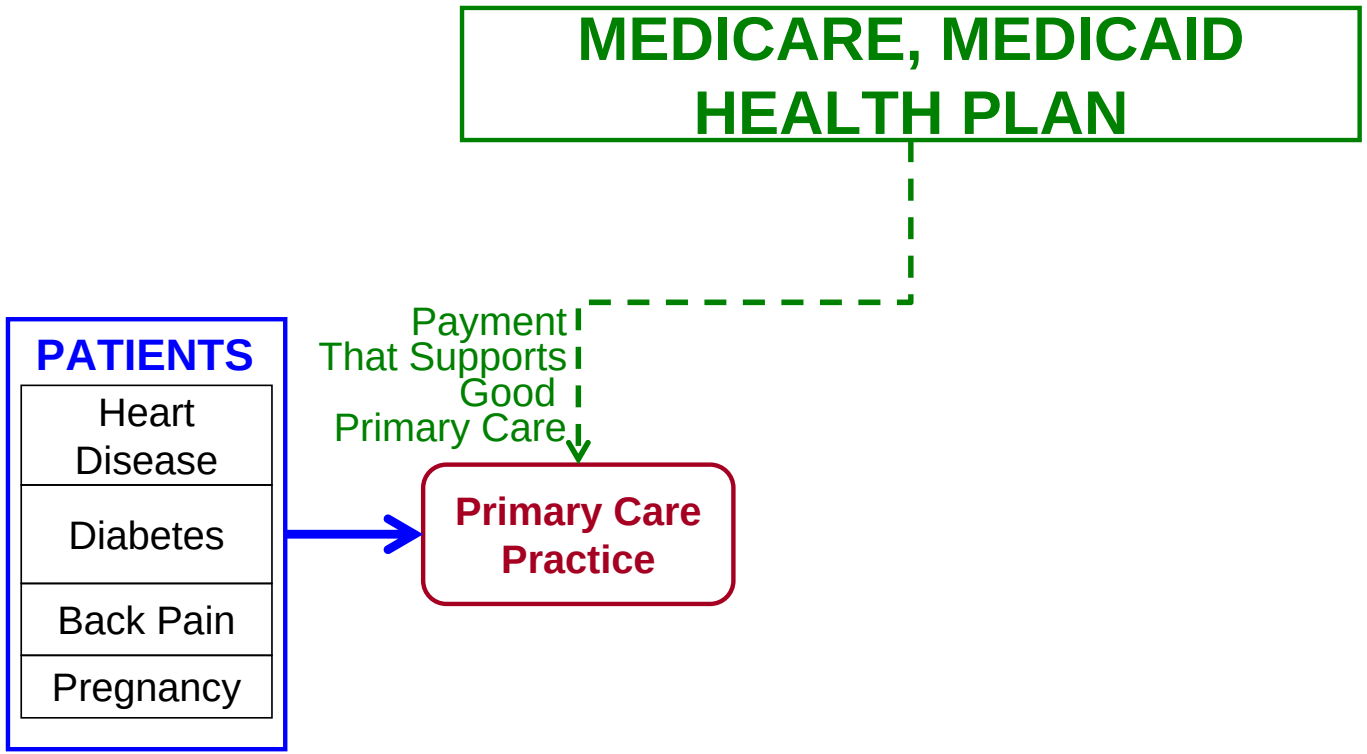
Medicare spent more than it saved

How Would You Design a Good ACO?

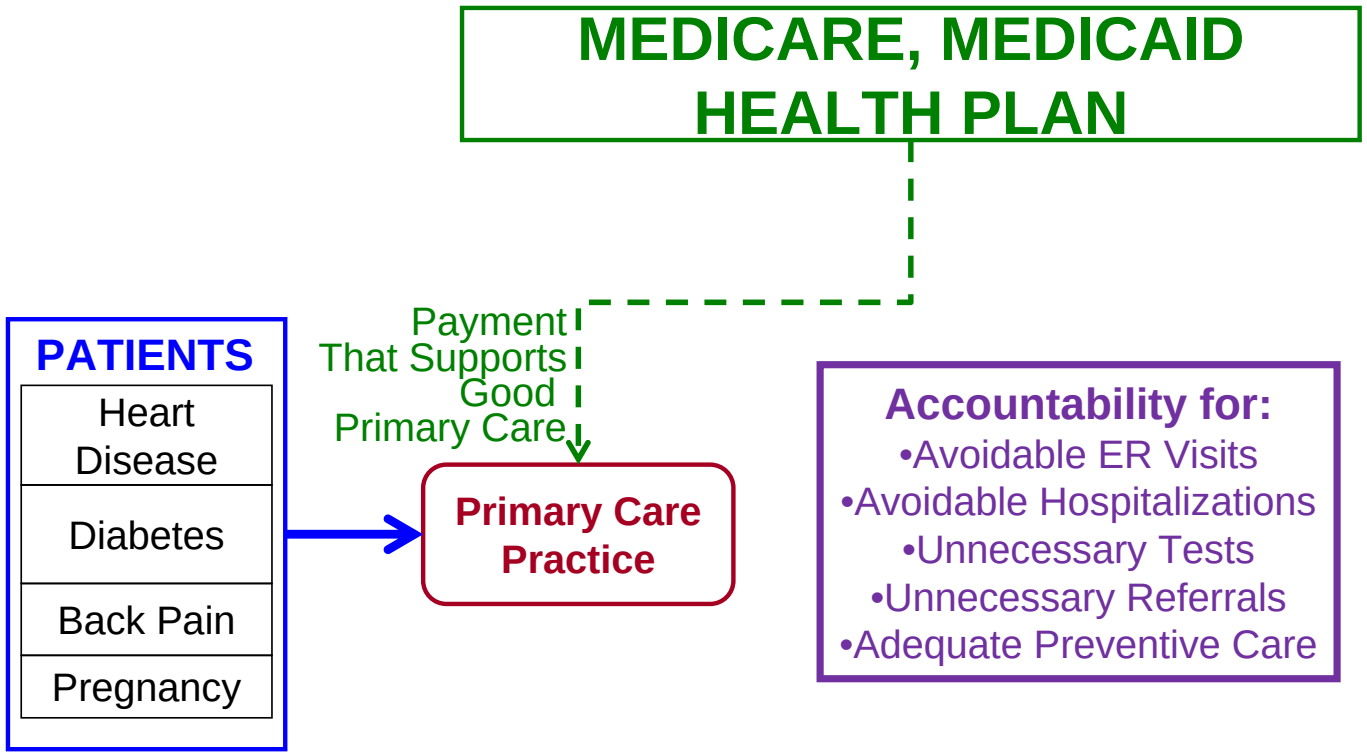
Connect Each Patient With a Good Primary Care Practice…



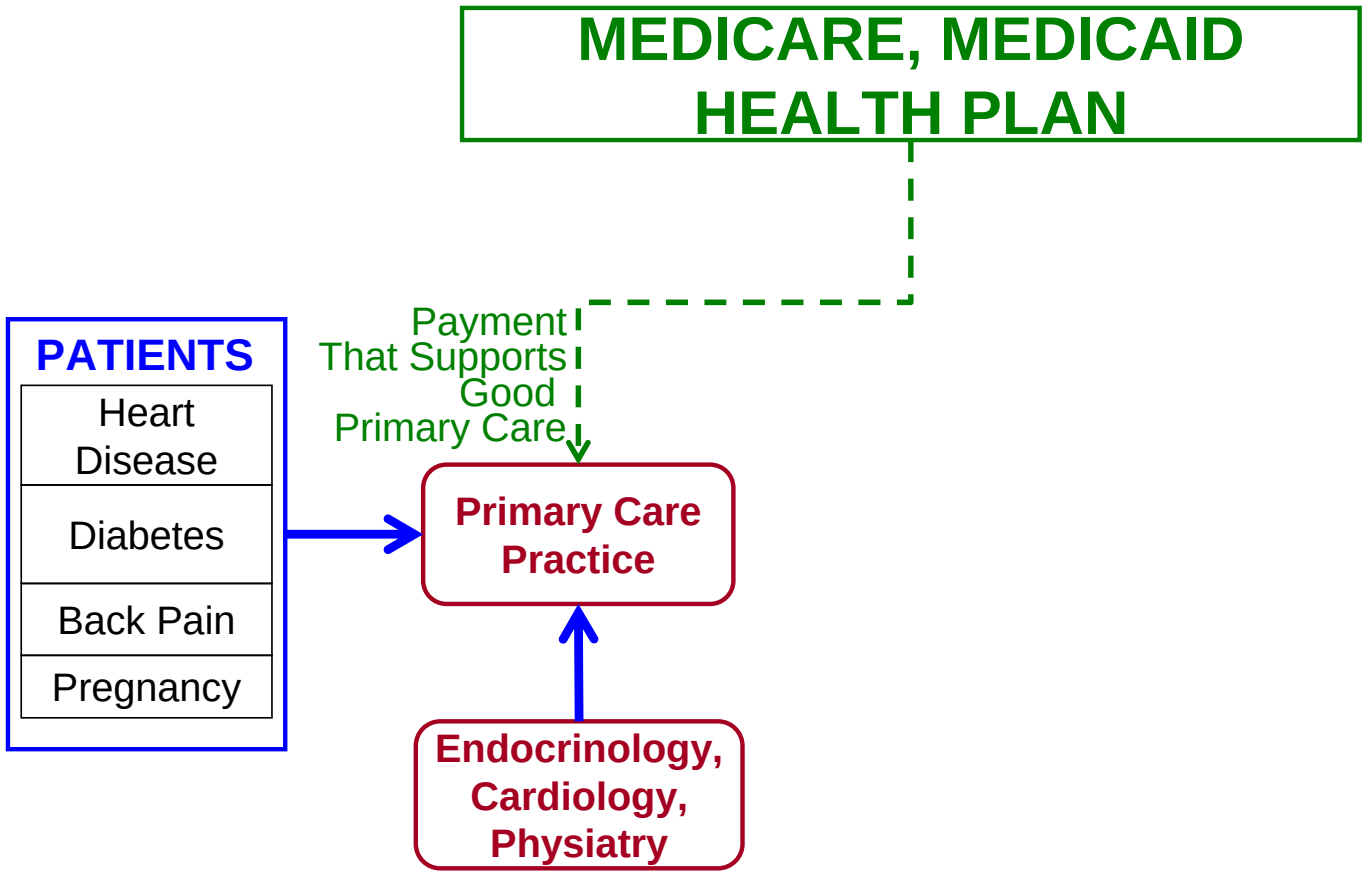
…With Payment That Enables Delivery of Good Primary Care…



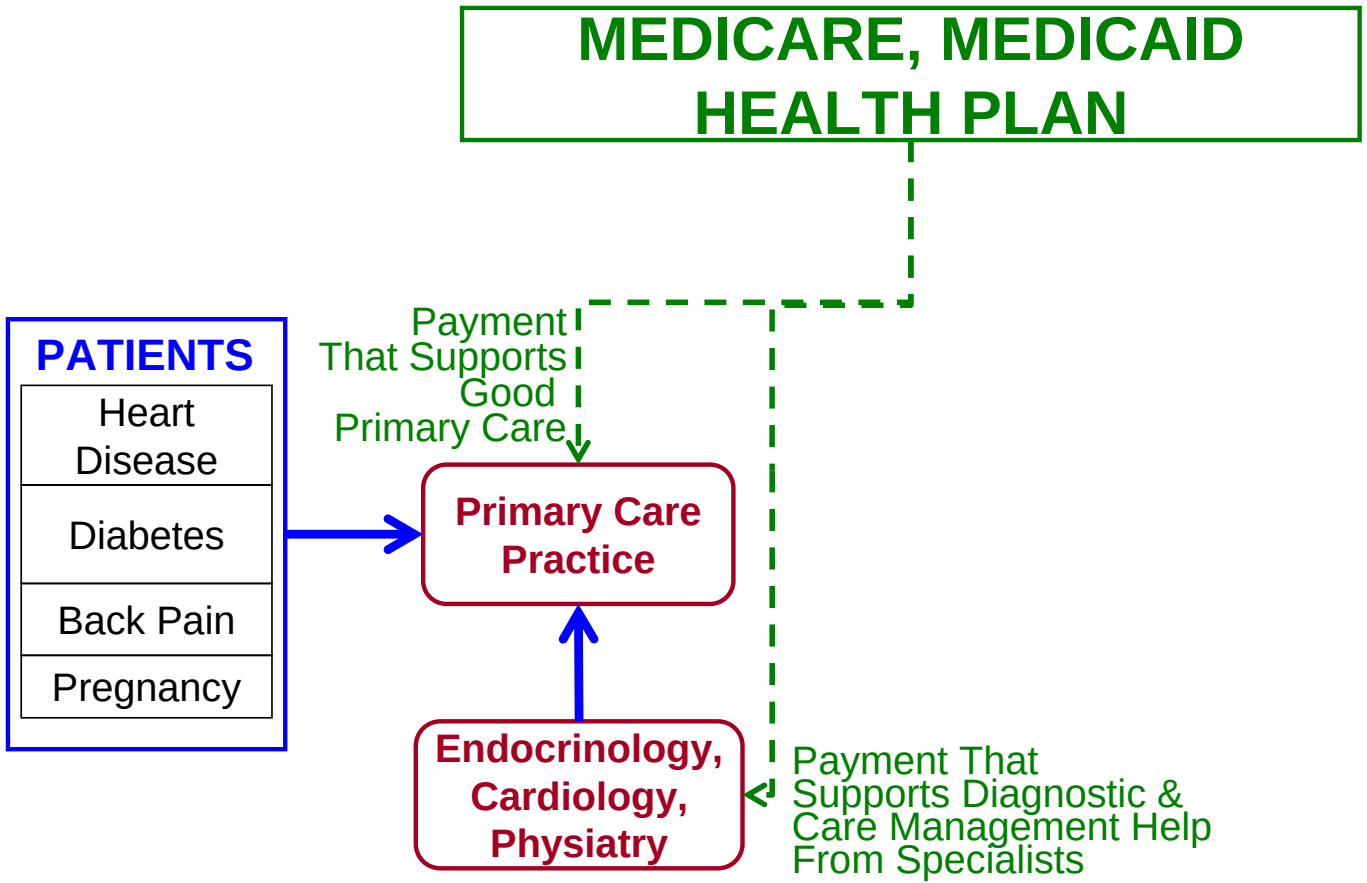
…And PCPs Take Accountability for Costs They Can Control/Influence



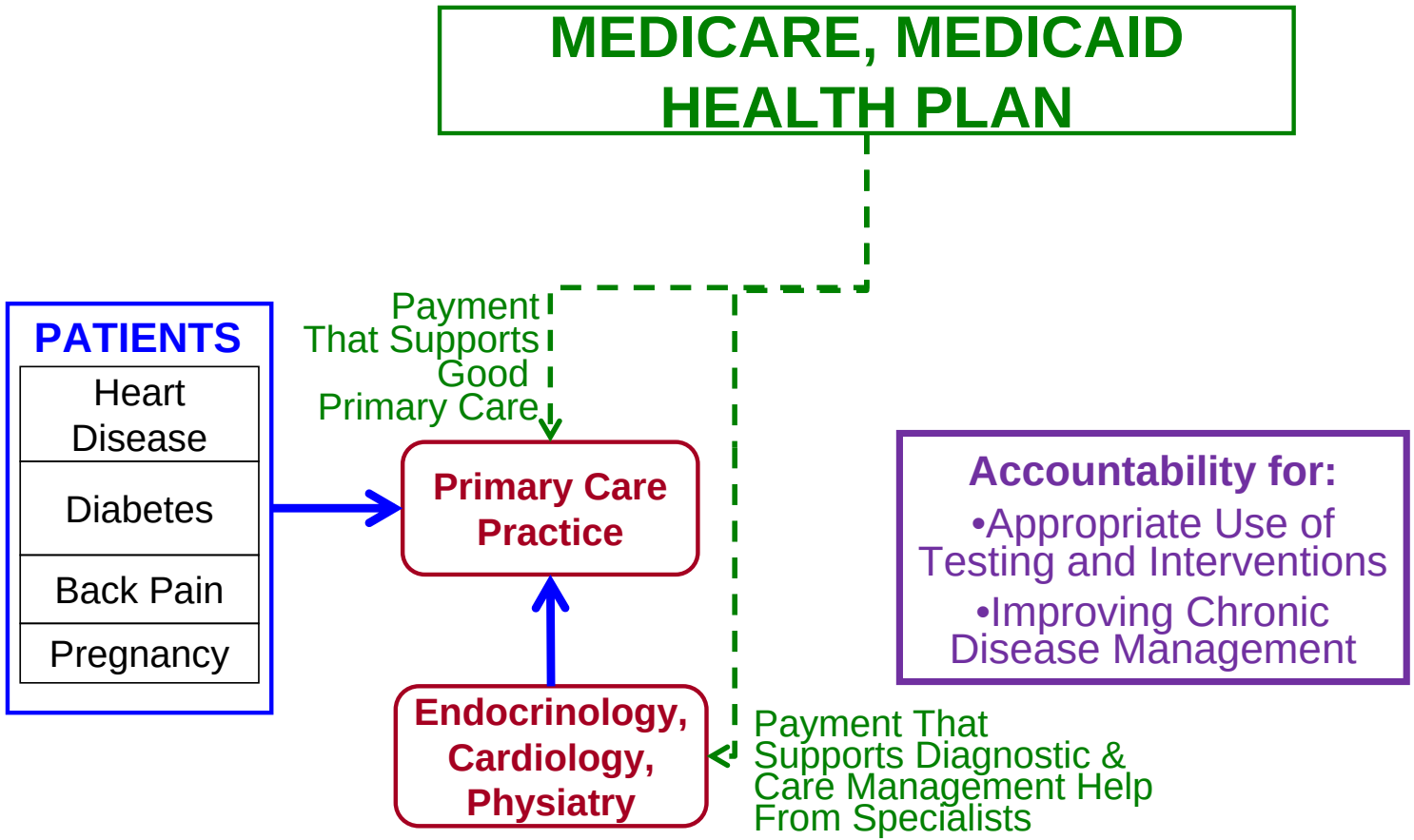
Give PCPs a Medical Neighborhood to Consult With on Difficult Cases



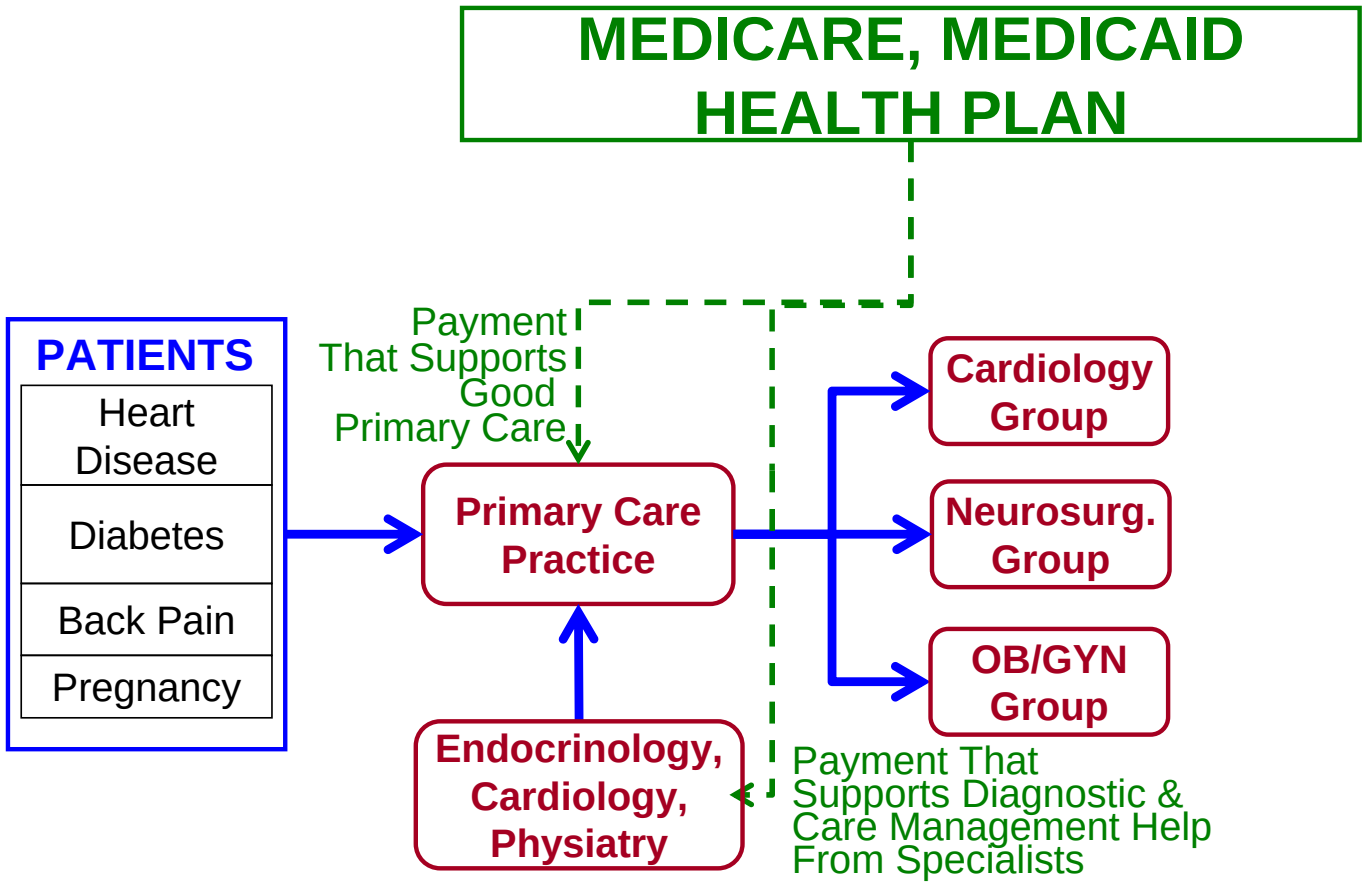
Pay the Medical Neighbors to Help Remotely Whenever Possible



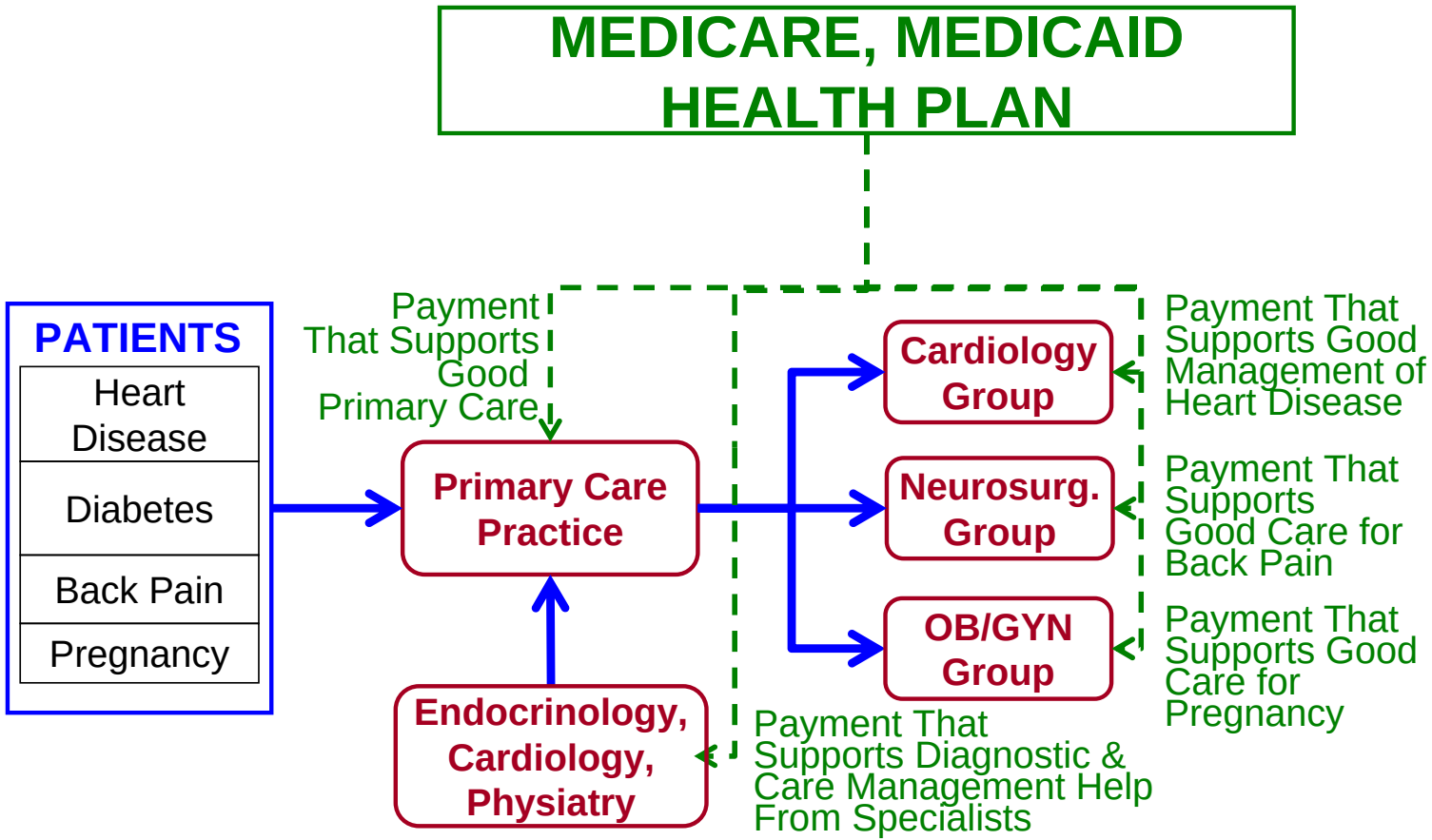
…Ask the Medical Neighbors to Be Accountable for Costs They Control



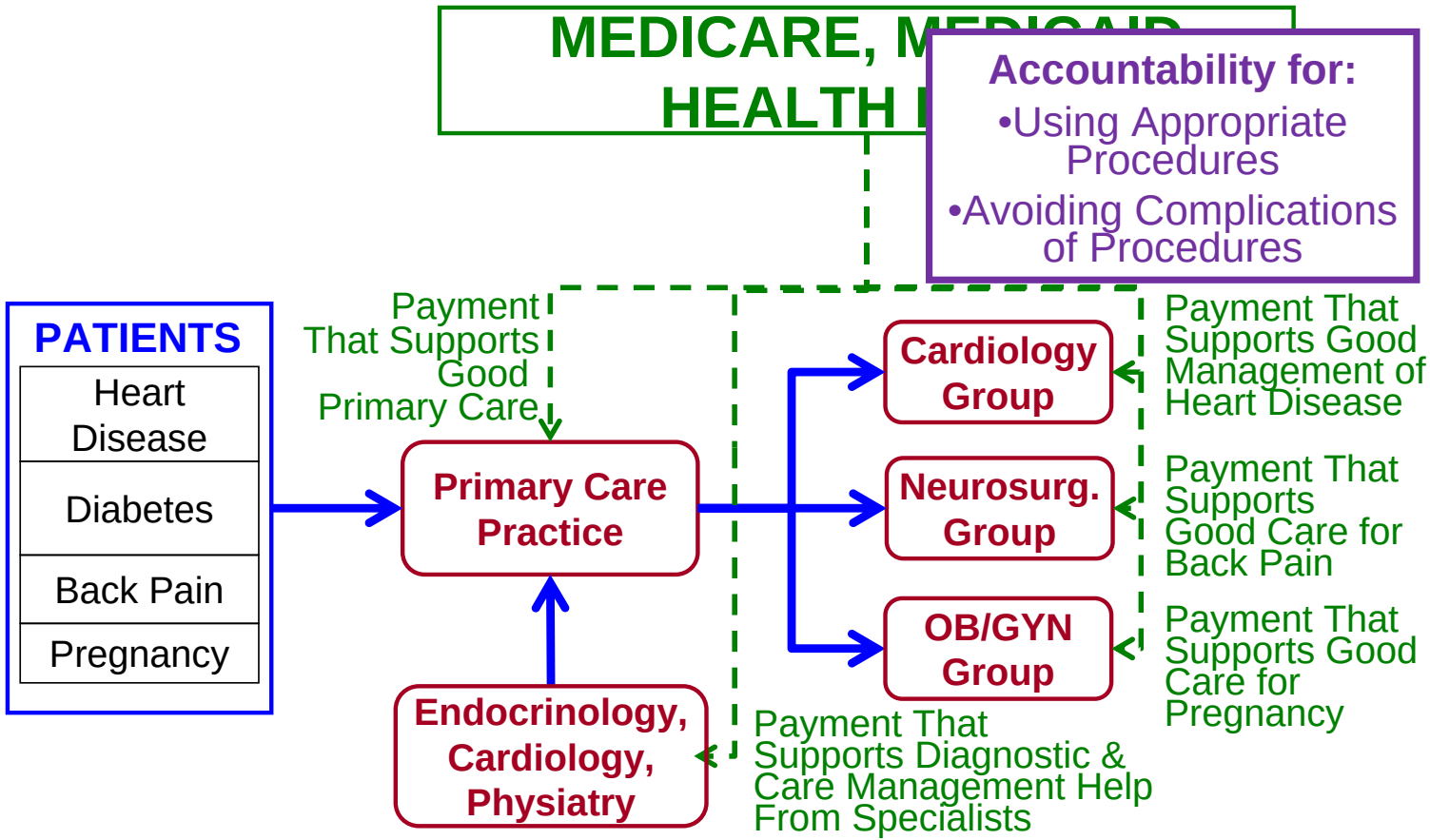
Have Good Specialists Ready to Manage Serious Conditions…



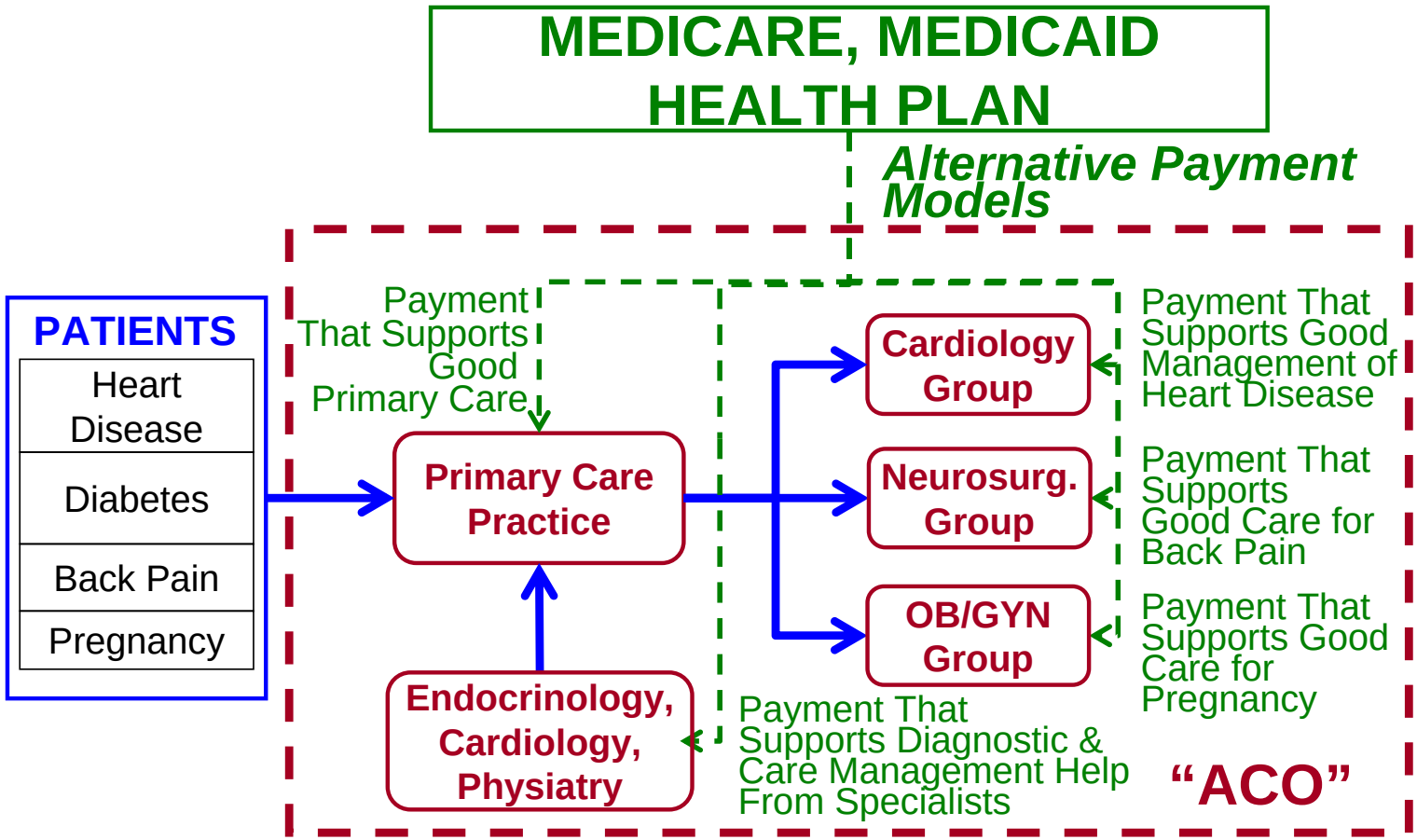
Pay Them To Deliver Quality Care at the Most Affordable Cost



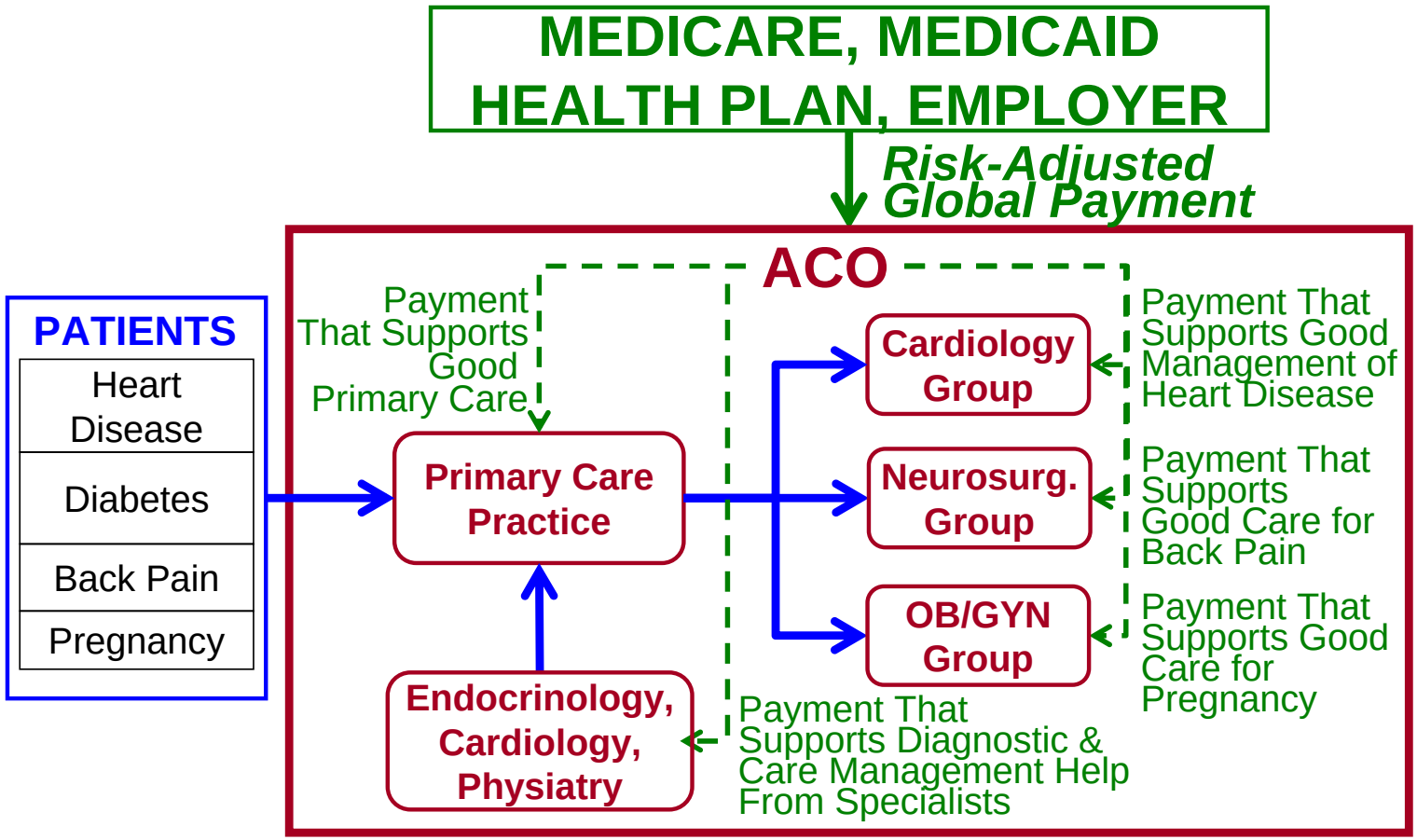
Ask Specialists to Be Accountable for Costs They Can Control



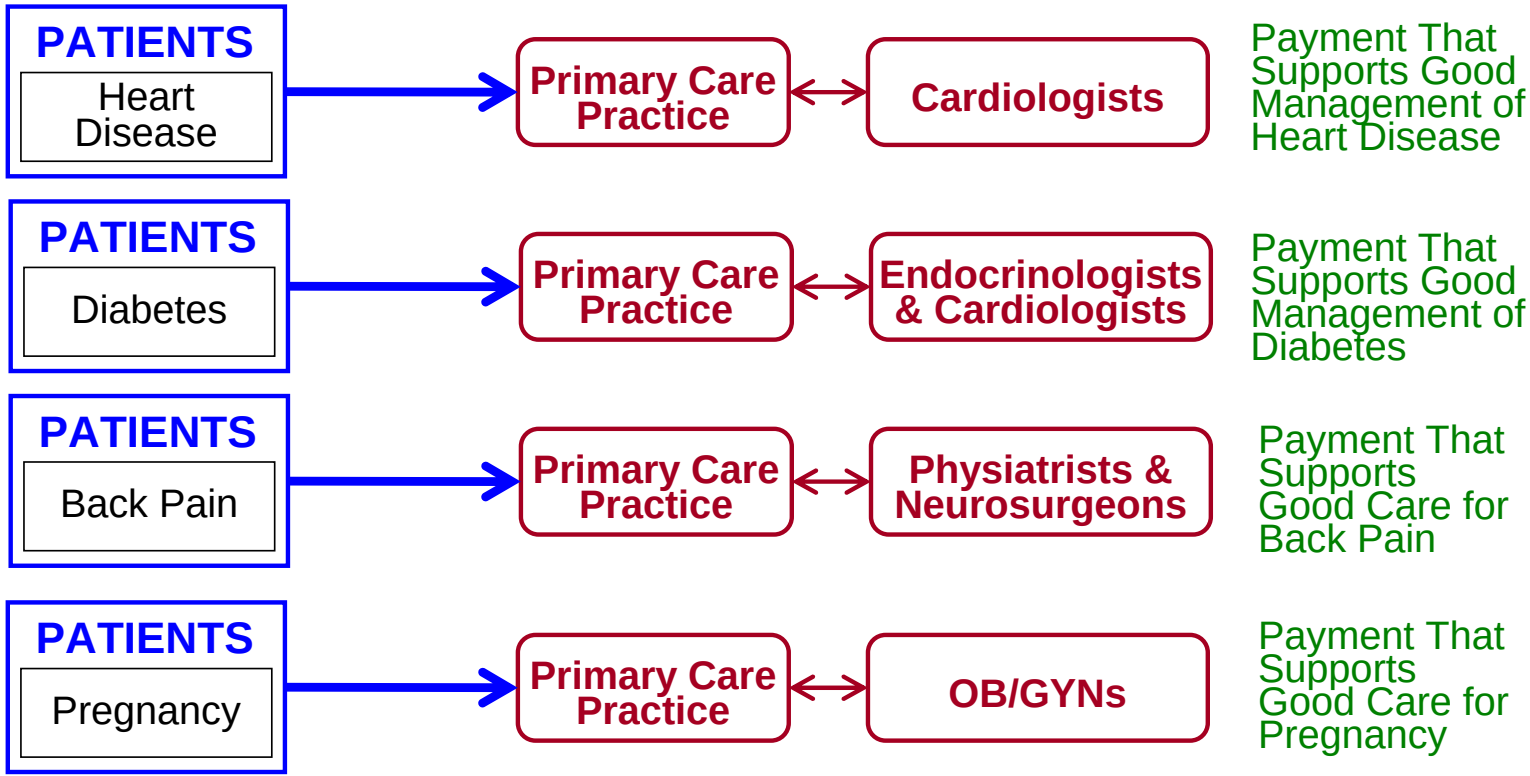
That's an "ACO," But Built from the *Bottom Up*, Not the *Top Down*



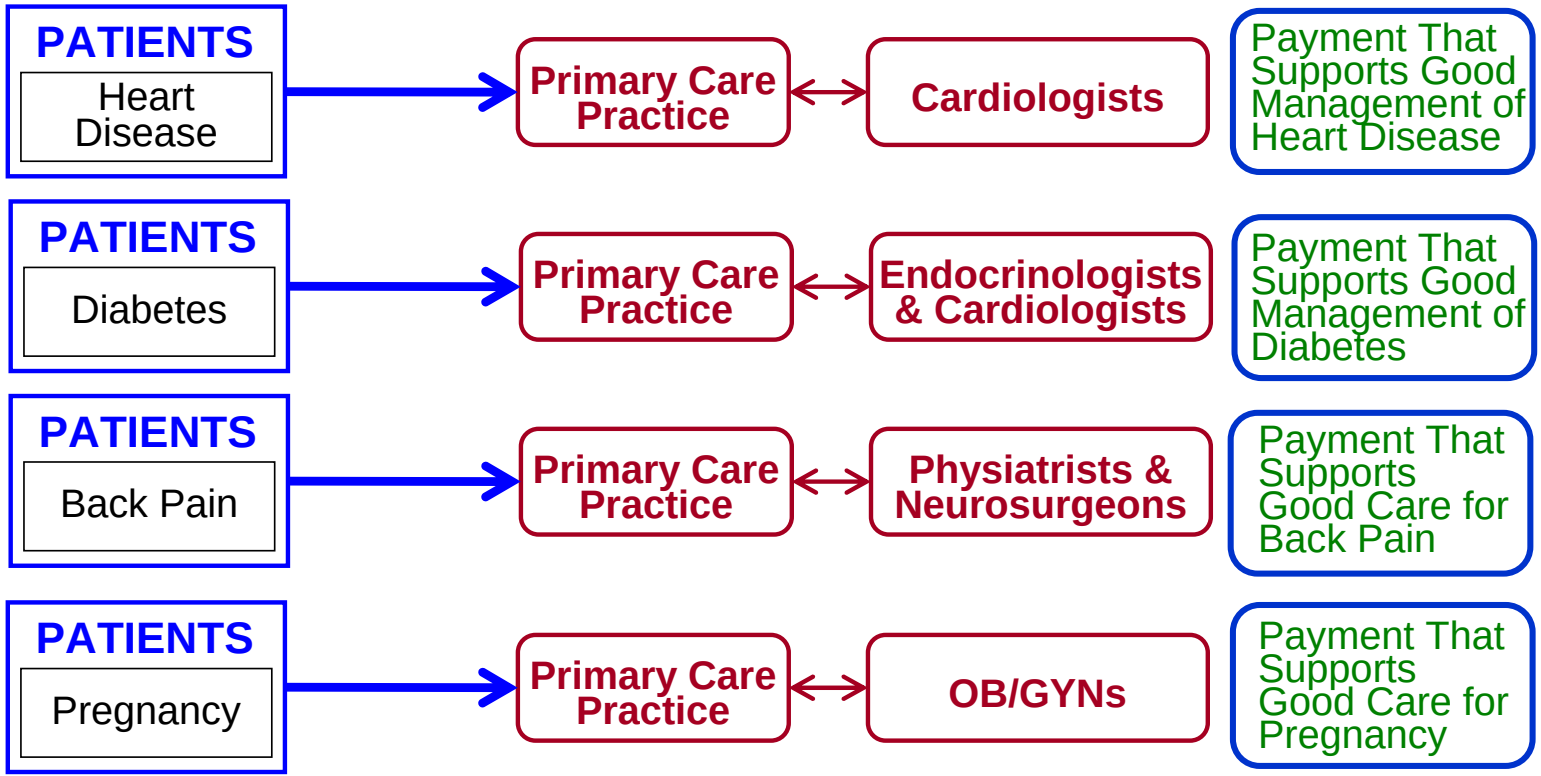
A True ACO Can Take a Global Payment And Make It Work



Many Patients Don't Need an *ACO*, They Need Good *Specialty Care*



Do Current Bundled Payment Models Do What is Needed?



Too Few Bundles Today; Current Ones Too Small or Too Big

- Too Few:
  - Focused mostly on hip and knee replacement surgery
- Too Small:
  - Most procedural bundles/episodes are limited to inpatient procedures
  - No protection against unnecessary procedures
  - No opportunity to move procedures to lower-cost, non-hospital settings
  - No opportunity to deliver care that would avoid the procedure
  - No real flexibility to change care – it's just P4P on top of standard FFS
- Too Big:
  - Single payment amount for patients with very different needs
  - No protection against cherry-picking patients
  - Individual providers placed at risk for costs they can't control

A *Bundle* or *Episode* is Not Always the Best Way to Fix FFS Problems

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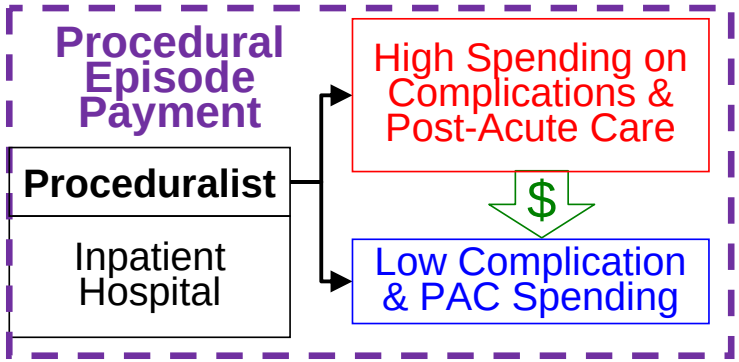
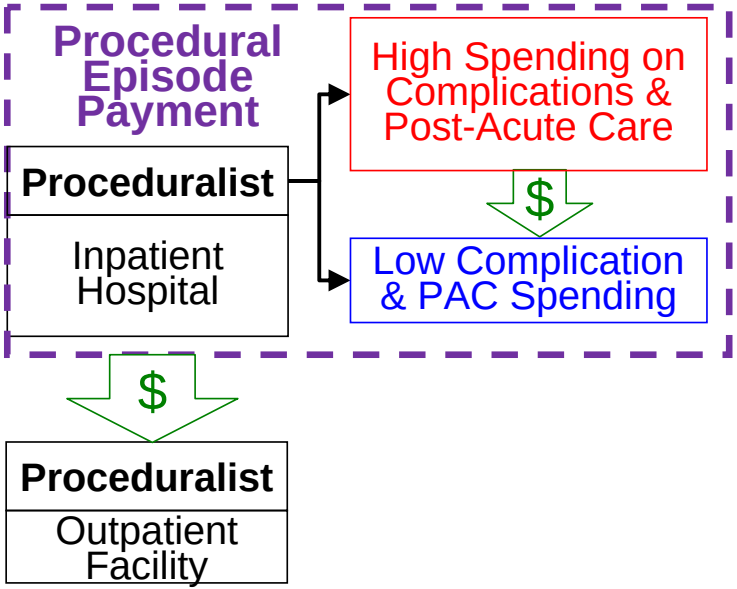
- Too Big:
  - Single payment amount for patients with very different needs
  - No protection against cherry-picking patients
  - Individual providers placed at risk for costs they can't control
- Too Much:
  - Creating a "bundle" may be unnecessary/unnecessarily complicated
  - Additional service codes + accountability measures may work better

Procedural Episode Payments Support Higher Quality/Lower Cost



What If You Can Do The Procedure Outside the Hospital?



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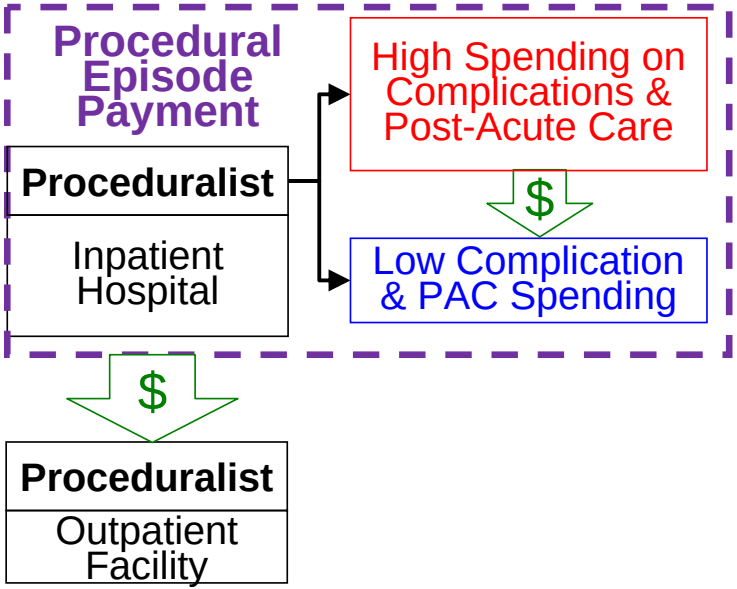
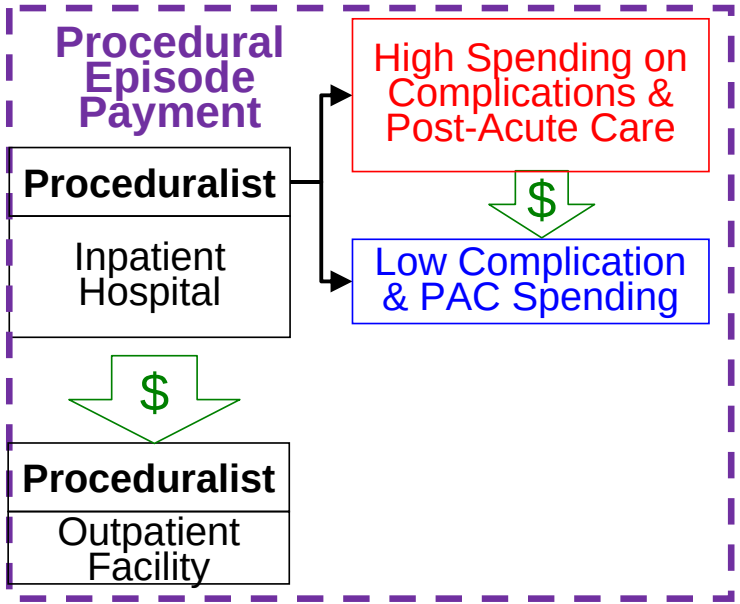
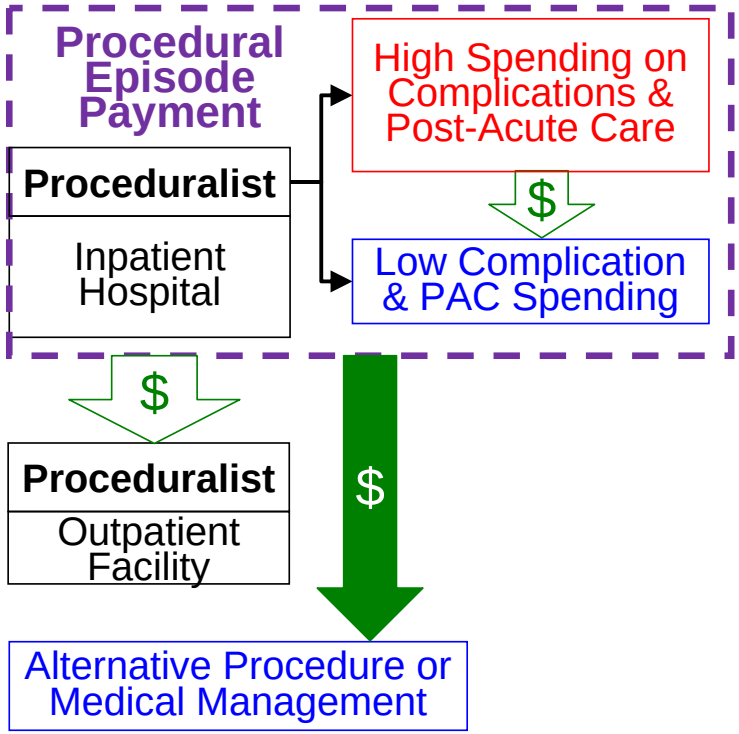


In most Episode Payment Models, the trigger is the hospitalization, so if the procedure is done elsewhere, it's paid through standard FFS

You Could Expand the Bundle to Include Outpatient Facilities…

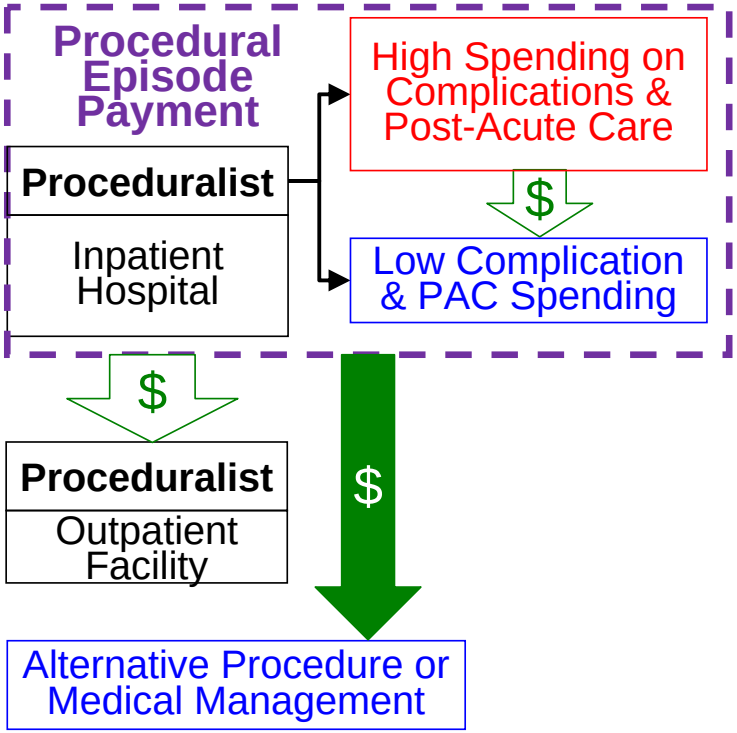


But What if You Could Save Even More With a Different Treatment?



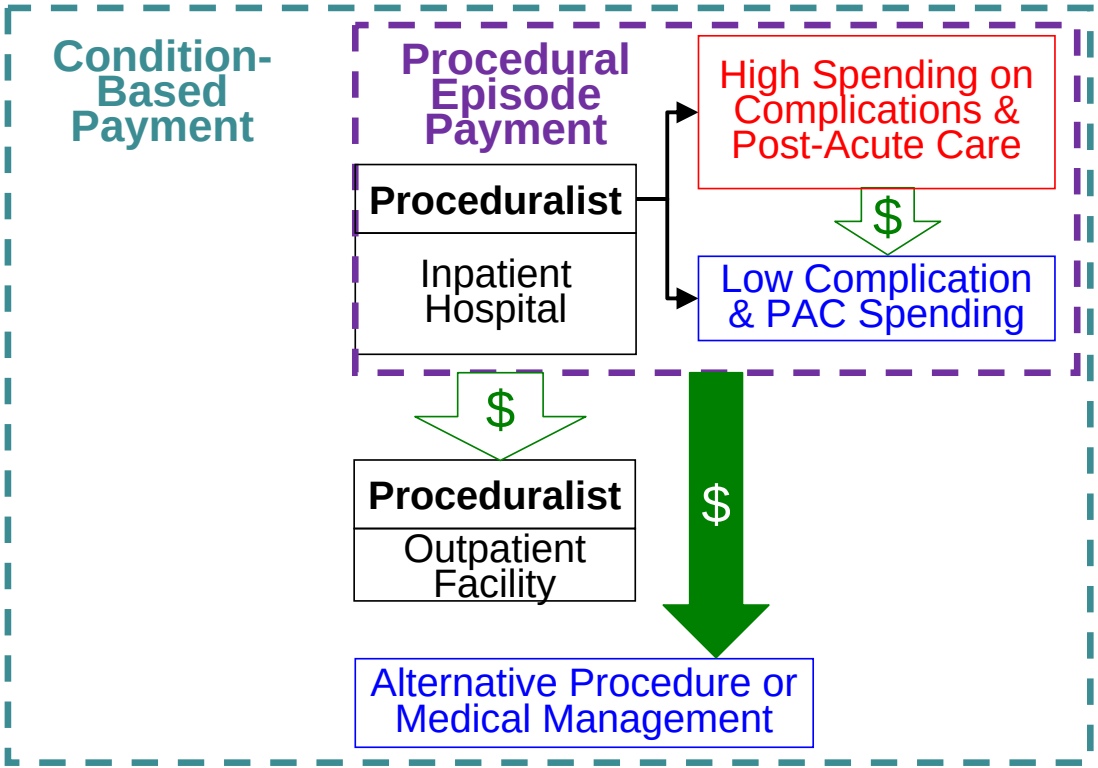
But What if You Could Save Even More With a Different Treatment?

In most Episode Payment Models, the trigger is a procedure, so if a different procedure is used, or no procedure at all is used, care is paid through standard FFS



Condition-Based Payment Supports Use of *Best Treatment*

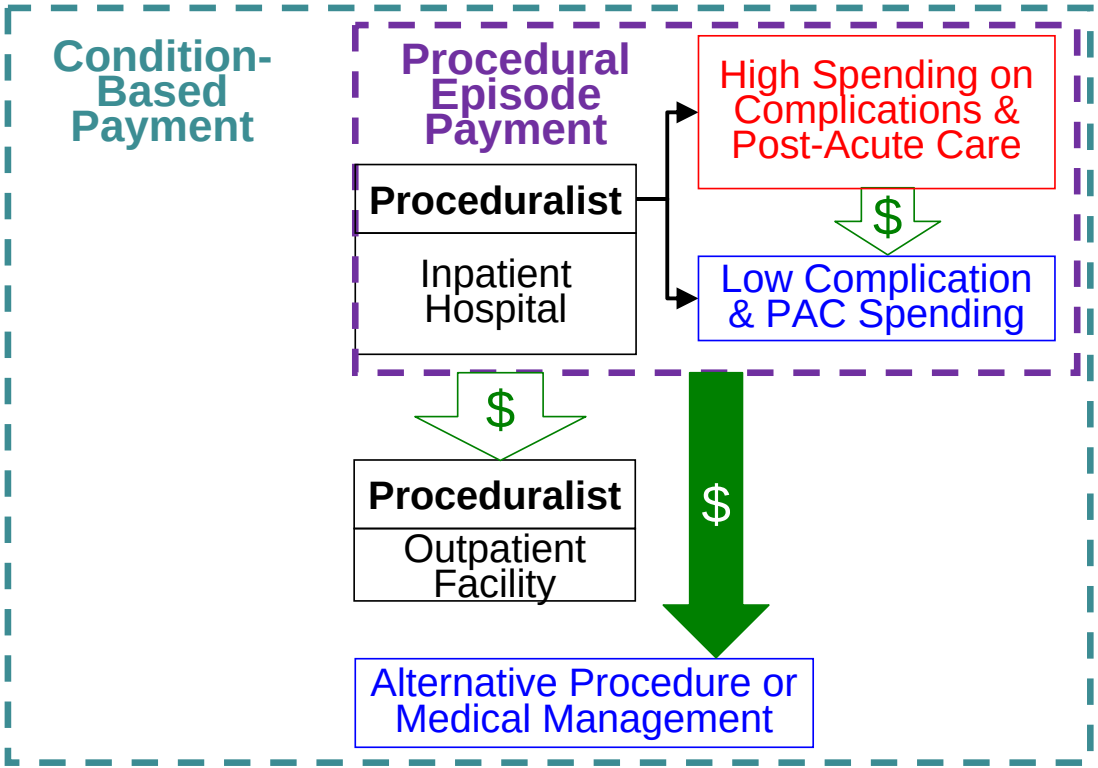
In a Condition-Based Payment Model, the trigger is the patient's condition, so if a different procedure is used, or no procedure at all is used, the care is still paid for through the Condition-Based Payment



Condition-Based Payment Has Same Benefits as Episodes

BENEFITS OF CONDITION-BASED PAYMENTS

- No reward for avoidable complications
- No reward for using expensive post-acute care



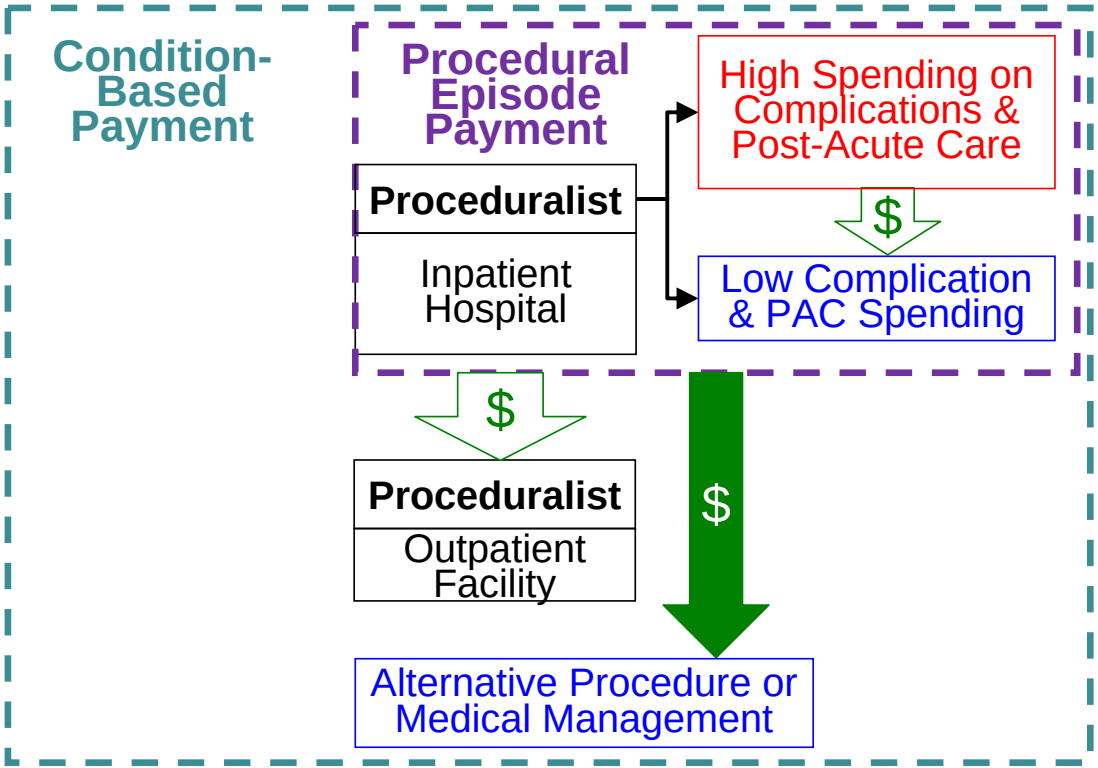
Condition-Based Payment Has More Benefits Than Episodes

BENEFITS OF CONDITION-BASED PAYMENTS

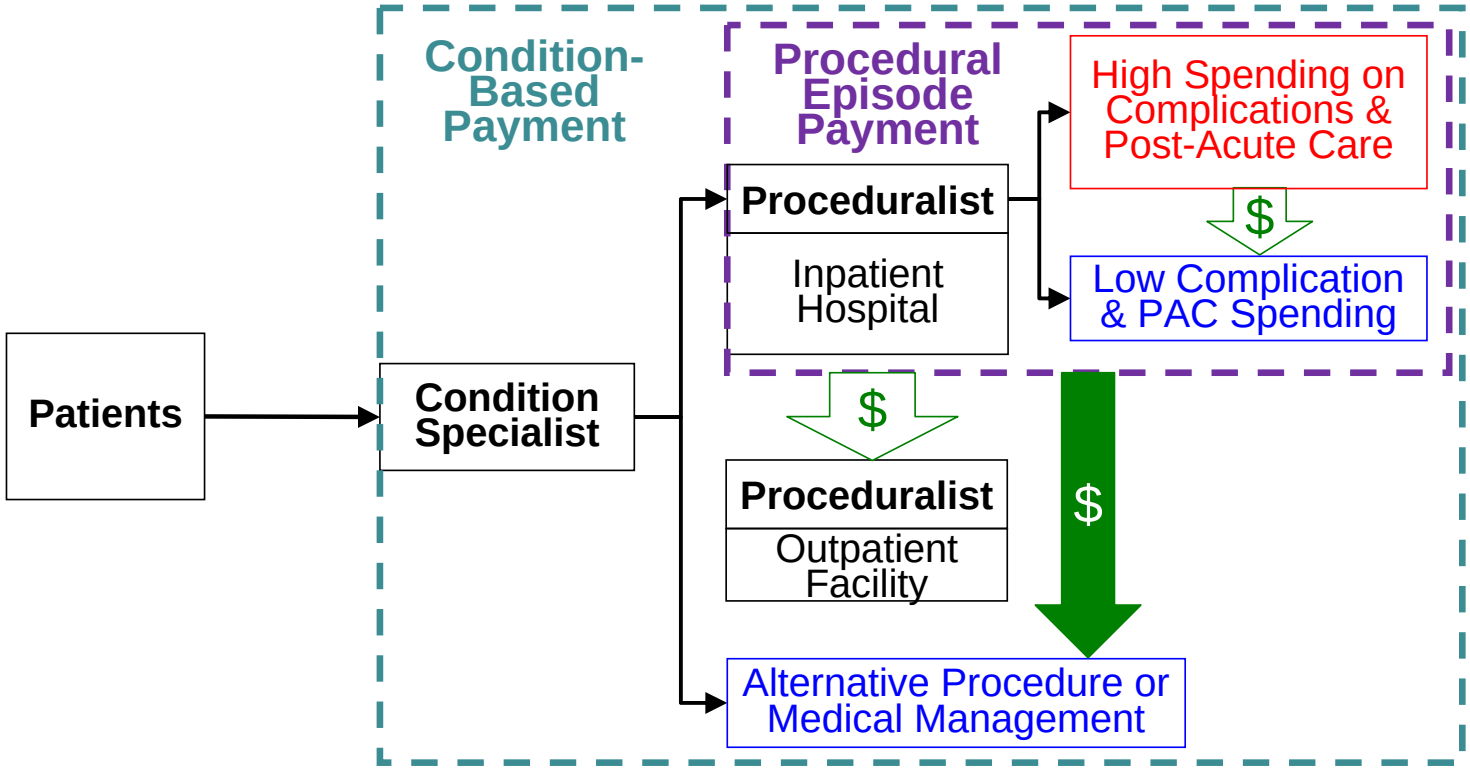
- No reward for avoidable complications
- No reward for using expensive post-acute care

+

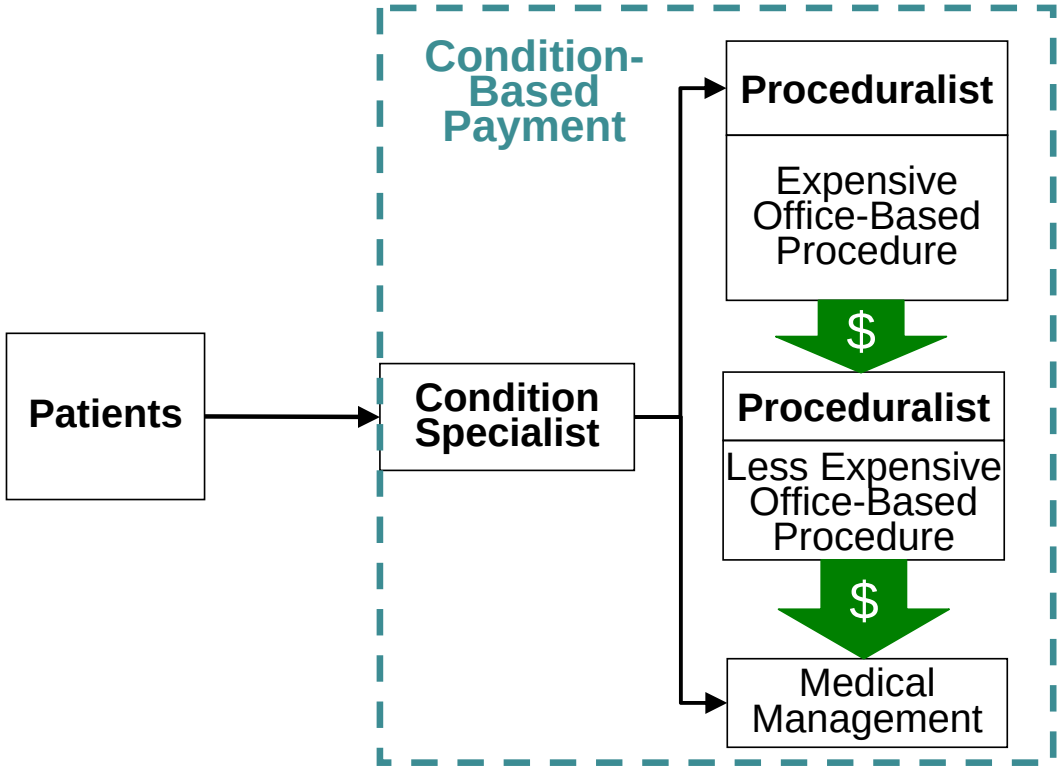
- No reward for using unnecessarily expensive facilities
- No reward for performing unnecessary procedures



Condition-Based Payment Must Be Led by *Physicians*, Not *Hospitals*

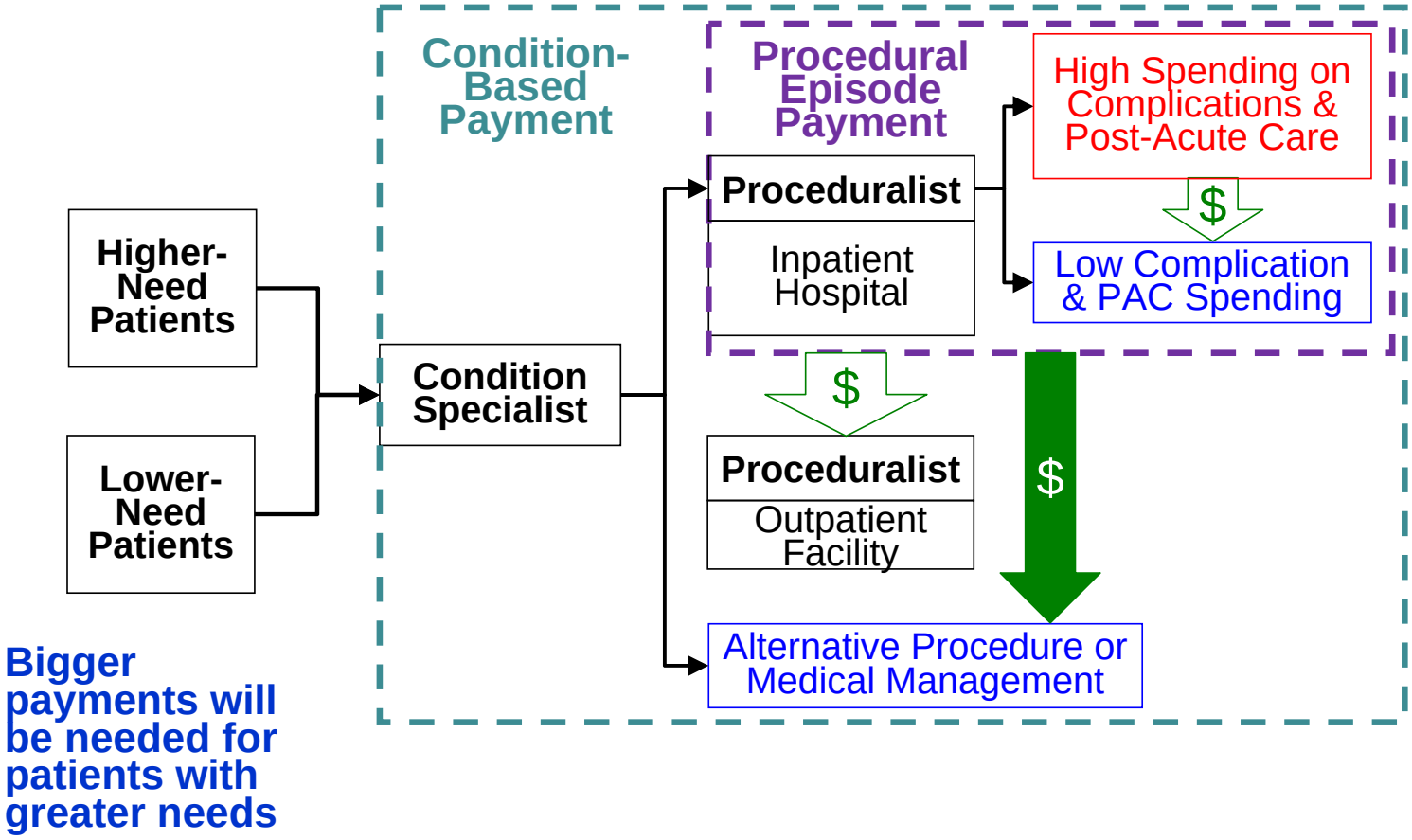


Many Condition-Based Payments Won't Involve Hospitals at All

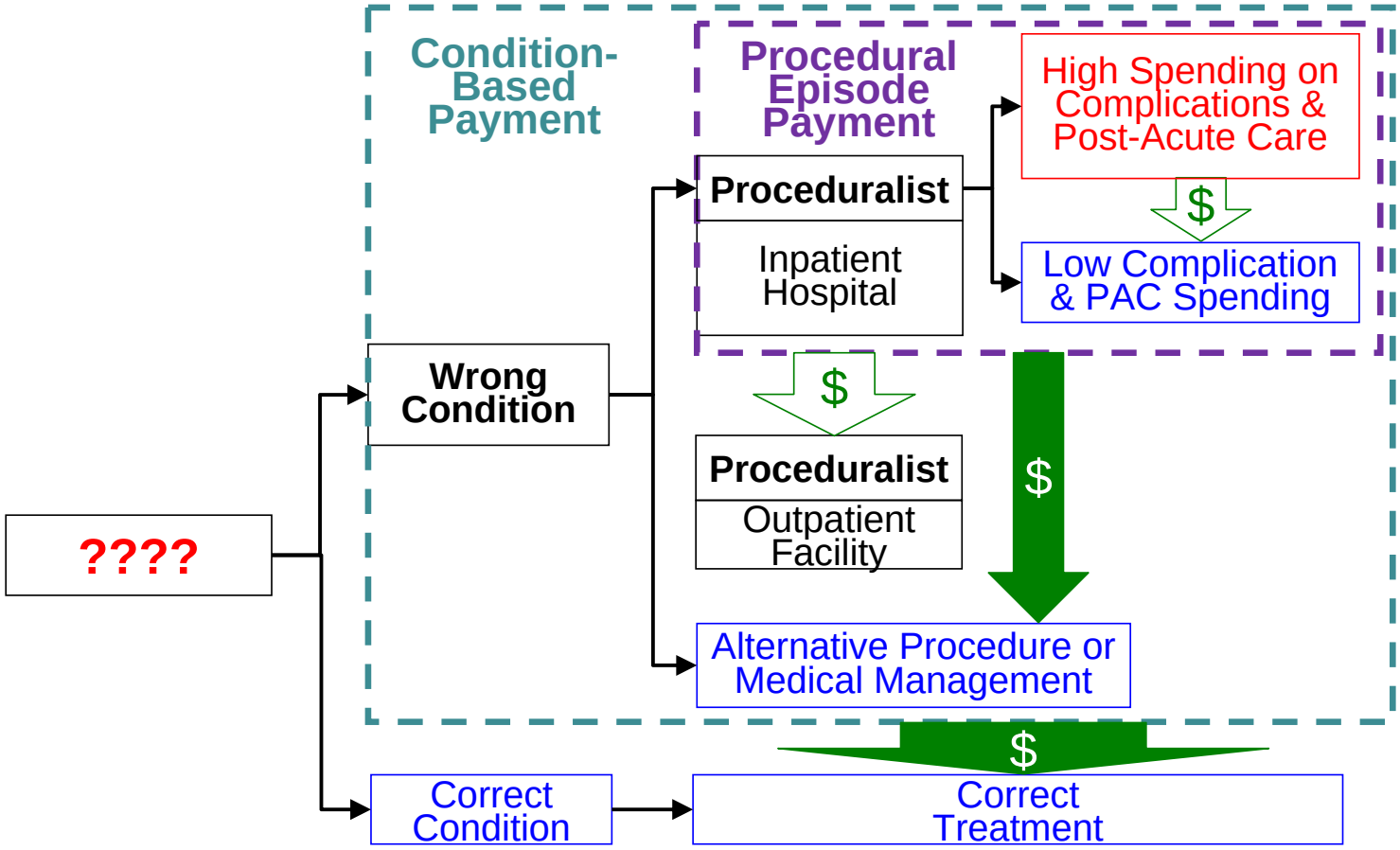


For many types of conditions, hospitalization represents a *failure* of treatment, not a *method* of treatment

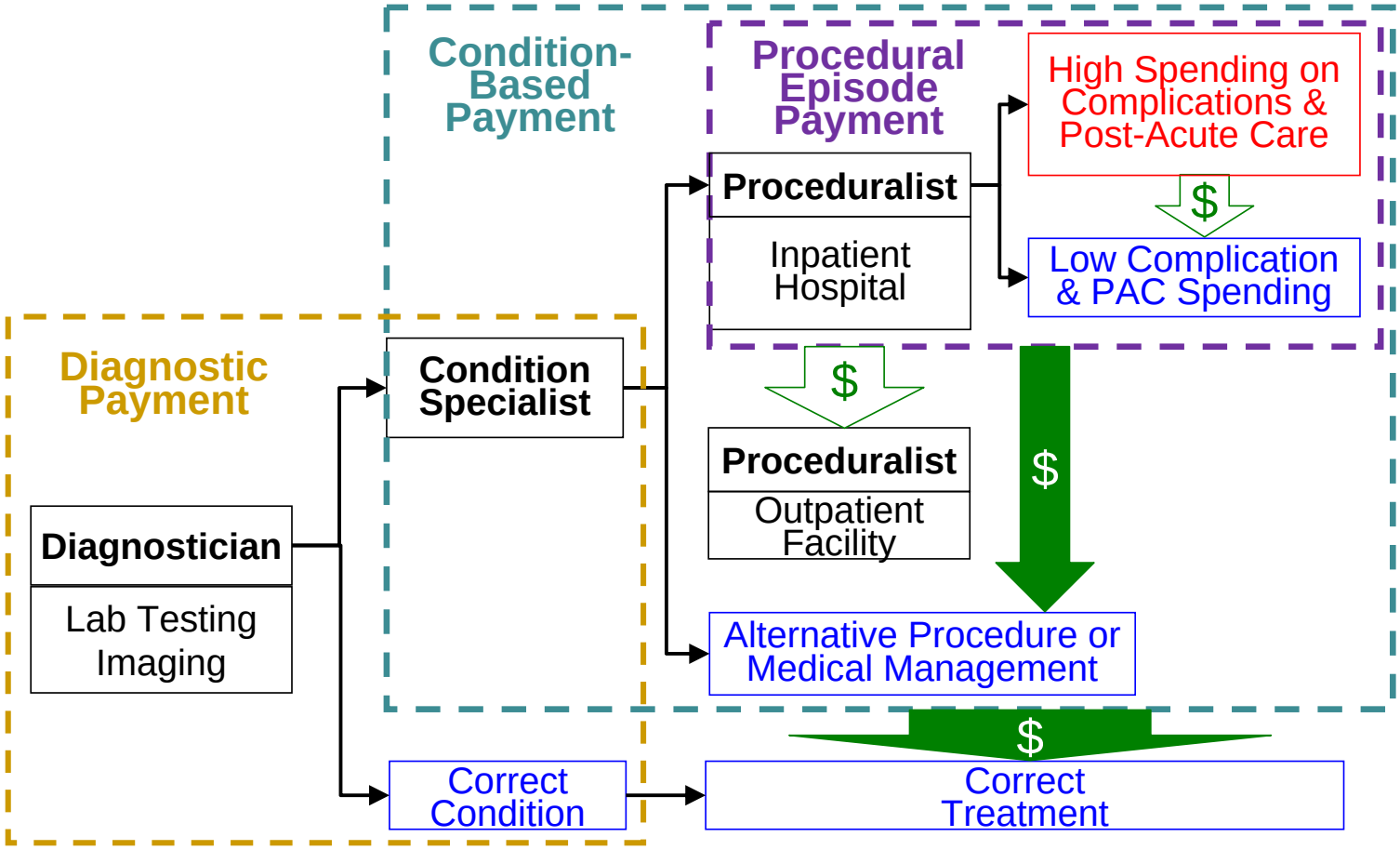
Condition-Based Payment Requires Stratifying Patients on Care Needs



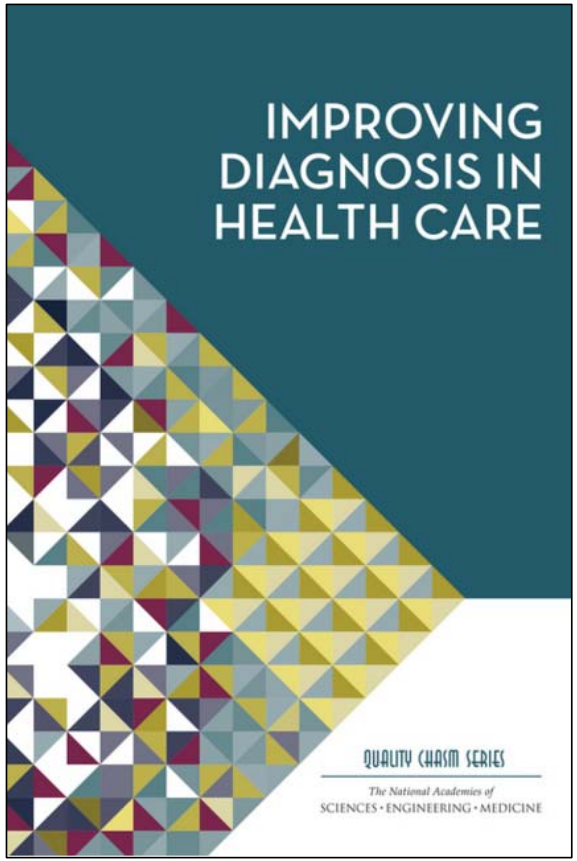
Are We Making the Payment for the Correct Condition??



We Need a Diagnostician To Ensure the *Right Condition* is Being Treated



Diagnostic Error is a Fundamental Quality Issue Underlying All Others



Opportunities for Lower-Cost Care for Many Conditions

- Knee Osteoarthritis
  - Home-based rehab instead of facility-based rehab
  - Physical therapy instead of surgery
- Maternity Care
  - Vaginal delivery instead of C-Section
  - Term delivery instead of early elective delivery
  - Delivery in birth center instead of hospital
- Chest Pain
  - Non-invasive imaging instead of invasive imaging
  - Medical management instead of invasive treatment
- Chronic Disease Management
  - Improved education and self-management support
  - Avoiding hospitalizations for exacerbations

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TODAY

Savings for Payers = Lower Margins for Providers

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CONDITION-BASED PAYMENT

Savings for Payers = Higher Margins for Providers

Example: Reducing Avoidable Surgeries for Knee Osteoarthritis

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WARNING TO THOSE
WITH MATH PHOBIA:

Lots of Numbers Coming Quickly;
Slides Available for
Detailed Review Afterwards

Example: Reducing Avoidable Surgeries for Knee Osteoarthritis

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Examples are all simplified for purposes of presentation
but the principles and conclusions are realistic

Example: Reducing Avoidable Surgeries for Knee Osteoarthritis

	CURRENT		
	$/Patient	# Pts	Total $
Primary Care			
Evaluations	$100	100	$10,000

Treatment of Knee Osteoarthritis

- 100 patients with knee pain visit PCP for evaluation

Example: Reducing Avoidable Surgeries for Knee Osteoarthritis

	CURRENT		
	$/Patient	# Pts	Total $
Primary Care			
Evaluations	$100	100	$10,000
Non-Surg.Tx			
Management	$200	20	$4,000
Phys. Therapy	$500	20	$10,000
Subtotal			$14,000

Treatment of Knee Osteoarthritis

- 100 patients with knee pain visit PCP for evaluation
- Physical therapy used by 20% of patients

Example: Reducing Avoidable Surgeries for Knee Osteoarthritis

	CURRENT		
	$/Patient	# Pts	Total $
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Non-Surg.Tx			
Management	$200	20	$4,000
Phys. Therapy	$500	20	$10,000
Subtotal			$14,000
Surgeon	$1,400	80	$112,000
Hospital Pmt			
Surgeries	$12,000	80	$960,000

Treatment of Knee Osteoarthritis

- 100 patients with knee pain visit PCP for evaluation
- Physical therapy used by 20% of patients
- Surgery performed procedure on 80% of evaluated patients

Example: Reducing Avoidable Surgeries for Knee Osteoarthritis

	CURRENT		
	$/Patient	# Pts	Total $
Primary Care			
Evaluations	$100	100	$10,000
Non-Surg.Tx			
Management	$200	20	$4,000
Phys. Therapy	$500	20	$10,000
Subtotal			$14,000
Surgeon	$1,400	80	$112,000
Hospital Pmt			
Surgeries	$12,000	80	$960,000
Total Pmt/Cost		100	$1,096,000

Treatment of Knee Osteoarthritis

- 100 patients with knee pain visit PCP for evaluation
- Physical therapy used by 20% of patients
- Surgery performed procedure on 80% of evaluated patients

Example: Reducing Avoidable Surgeries for Knee Osteoarthritis

	CURRENT		
	$/Patient	# Pts	Total $
Primary Care			
Evaluations	$100	100	$10,000
Non-Surg.Tx			
Management	$200	20	$4,000
Phys. Therapy	$500	20	$10,000
Subtotal			$14,000
Surgeon	$1,400	80	$112,000
Hospital Pmt			
Surgeries	$12,000	80	$960,000
Total Pmt/Cost		100	$1,096,000

Treatment of Knee Osteoarthritis

- 100 patients with knee pain visit PCP for evaluation
- Physical therapy used by 20% of patients
- Surgery performed procedure on 80% of evaluated patients
- 25% of surgeries avoidable with better outpatient management

Under FFS, Low Payment for Diagnosis & Treatment Planning

	CURRENT		
	$/Patient	# Pts	Total $
Primary Care			
Evaluations	$100	100	$10,000
Non-Surg.Tx			
Management	$200	20	$4,000
Phys. Therapy	$500	20	$10,000
Subtotal			$14,000
Surgeon	$1,400	80	$112,000
Hospital Pmt			
Surgeries	$12,000	80	$960,000
Total Pmt/Cost		100	$1,096,000

Under FFS, Low Payment for Non-Surgical Options

	CURRENT		
	$/Patient	# Pts	Total $
Primary Care			
Evaluations	$100	100	$10,000
Non-Surg.Tx			
Management	$200	20	$4,000
Phys. Therapy	$500	20	$10,000
Subtotal			$14,000
Surgeon	$1,400	80	$112,000
Hospital Pmt			
Surgeries	$12,000	80	$960,000
Total Pmt/Cost		100	$1,096,000

Under FFS, Fewer Surgeries = Losses for Physicians & Hospitals

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Primary Care							
Evaluations	$100	100	$10,000				
Non-Surg.Tx							
Management	$200	20	$4,000				
Phys. Therapy	$500	20	$10,000				
Subtotal			$14,000				
Surgeon	$1,400	80	~~$112,000~~	~~$1,400~~	60	$84,000	-25%
Hospital Pmt							
Surgeries	$12,000	80	~~$960,000~~	~~$12,000~~	60	$720,000	-25%
Total Pmt/Cost		100	$1,096,000				

A P4P/MIPS Bonus to the Surgeon Doesn't Offset Loss of Revenue

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Primary Care							
Evaluations	$100	100	$10,000				
Non-Surg.Tx							
Management	$200	20	$4,000				
Phys. Therapy	$500	20	$10,000				
Subtotal			$14,000				
Surgeon	$1,400	80	$112,000	$1,456	60	$87,360	-22%
Hospital Pmt				+4%			
Surgeries	$12,000	80	$960,000				
Total Pmt/Cost		100	$1,096,000				

Is There a Better Way?

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Primary Care							
Evaluations	$100	100	$10,000	?			
Non-Surg.Tx							
Management	$200	20	$4,000	?			
Phys. Therapy	$500	20	$10,000	?			
Subtotal			$14,000				
Surgeon	$1,400	80	$112,000	?			
Hospital Pmt							
Surgeries	$12,000	80	$960,000	?			
Total Pmt/Cost		100	$1,096,000				

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

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Primary Care							
Evaluations	$100	~~100~~	~~$10,000~~	$200			
Non-Surg.Tx							
Management	$200	20	$4,000				
Phys. Therapy	$500	20	$10,000				
Subtotal			$14,000				
Surgeon	$1,400	80	$112,000				
Hospital Pmt							
Surgeries	$12,000	80	$960,000				
Total Pmt/Cost		100	$1,096,000				

Better Payment for Condition Management

- PCP paid adequately to help patient decide on treatment options

A Better Way: Pay Adequately for Non-Surgical Management

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Primary Care							
Evaluations	$100	~~100~~	~~$10,000~~	$200			
Non-Surg.Tx							
Management	$200	~~20~~	~~$4,000~~	$500			
Phys. Therapy	$500	~~20~~	~~$10,000~~	$750			
Subtotal			$14,000				
Surgeon	$1,400	80	$112,000				
Hospital Pmt							
Surgeries	$12,000	80	$960,000				
Total Pmt/Cost		100	$1,096,000				

Better Payment for Condition Management

- PCP paid adequately to help patient decide on treatment options
- PCP, physiatrist, or surgeon paid to deliver effective non-surgical care

A Better Way: Pay Adequately For the *Necessary* Surgeries

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Primary Care							
Evaluations	$100	~~100~~	~~$10,000~~	$200			
Non-Surg.Tx							
Management	$200	~~20~~	~~$4,000~~	$500			
Phys. Therapy	$500	~~20~~	~~$10,000~~	$750			
Subtotal			$14,000				
Surgeon	$1,400	~~80~~	~~$112,000~~	$2,100			
Hospital Pmt							
Surgeries	$12,000	80	$960,000				
Total Pmt/Cost		100	$1,096,000				

Better Payment for Condition Management

- PCP paid adequately to help patient decide on treatment options
- PCP, physiatrist, or surgeon paid to deliver effective non-surgical care
- Surgeon paid more per surgery for patients who need surgery

If That Results in 25% Fewer Surgeries…

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Primary Care							
Evaluations	$100	100	$10,000	$200	100		
Non-Surg.Tx							
Management	$200	20	$4,000	$500	40		
Phys. Therapy	$500	20	$10,000	$750	40		
Subtotal			$14,000				
Surgeon	$1,400	80	~~$112,000~~	~~$2,100~~	60		
Hospital Pmt							
Surgeries	$12,000	80	$960,000	$12,000	60		
Total Pmt/Cost		100	$1,096,000				

Physicians Could Be Paid *More…*

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Primary Care							
Evaluations	$100	100	$10,000	$200	100	$20,000	100%
Non-Surg.Tx							
Management	$200	20	$4,000	$500	40	$20,000	400%
Phys. Therapy	$500	20	$10,000	$750	40	$30,000	200%
Subtotal			$14,000			$50,000	257%
Surgeon	$1,400	80	$112,000	$2,100	60	$126,000	+13%
Hospital Pmt							
Surgeries	$12,000	80	$960,000				
Total Pmt/Cost		100	$1,096,000				

Physicians Could Be Paid *More…*
….While Still Reducing Total $

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Primary Care							
Evaluations	$100	100	$10,000	$200	100	$20,000	100%
Non-Surg.Tx							
Management	$200	20	$4,000	$500	40	$20,000	400%
Phys. Therapy	$500	20	$10,000	$750	40	$30,000	200%
Subtotal			$14,000			$50,000	257%
Surgeon	$1,400	80	$112,000	$2,100	60	$126,000	+13%
Hospital Pmt							
Surgeries	$12,000	80	$960,000	$12,000	60	$720,000	-25%
Total Pmt/Cost		100	$1,096,000		100	$916,000	-16%

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

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Primary Care							
Evaluations	$100	100	$10,000	$200	100	$20,000	100%
Non-Surg.Tx							
Management	$200	20	$4,000	$500	40	$20,000	400%
Phys. Therapy	$500	20	$10,000	$750	40	$30,000	200%
Subtotal			$14,000			$50,000	257%
Surgeon	$1,400	80	$112,000	$2,100	60	$126,000	+13%
Hospital Pmt							
Surgeries	$12,000	80	$960,000	$12,000	60	$720,000	-25%
Total Pmt/Cost		100	$1,096,000		100	$916,000	-16%

Physicians Win

Payer Wins

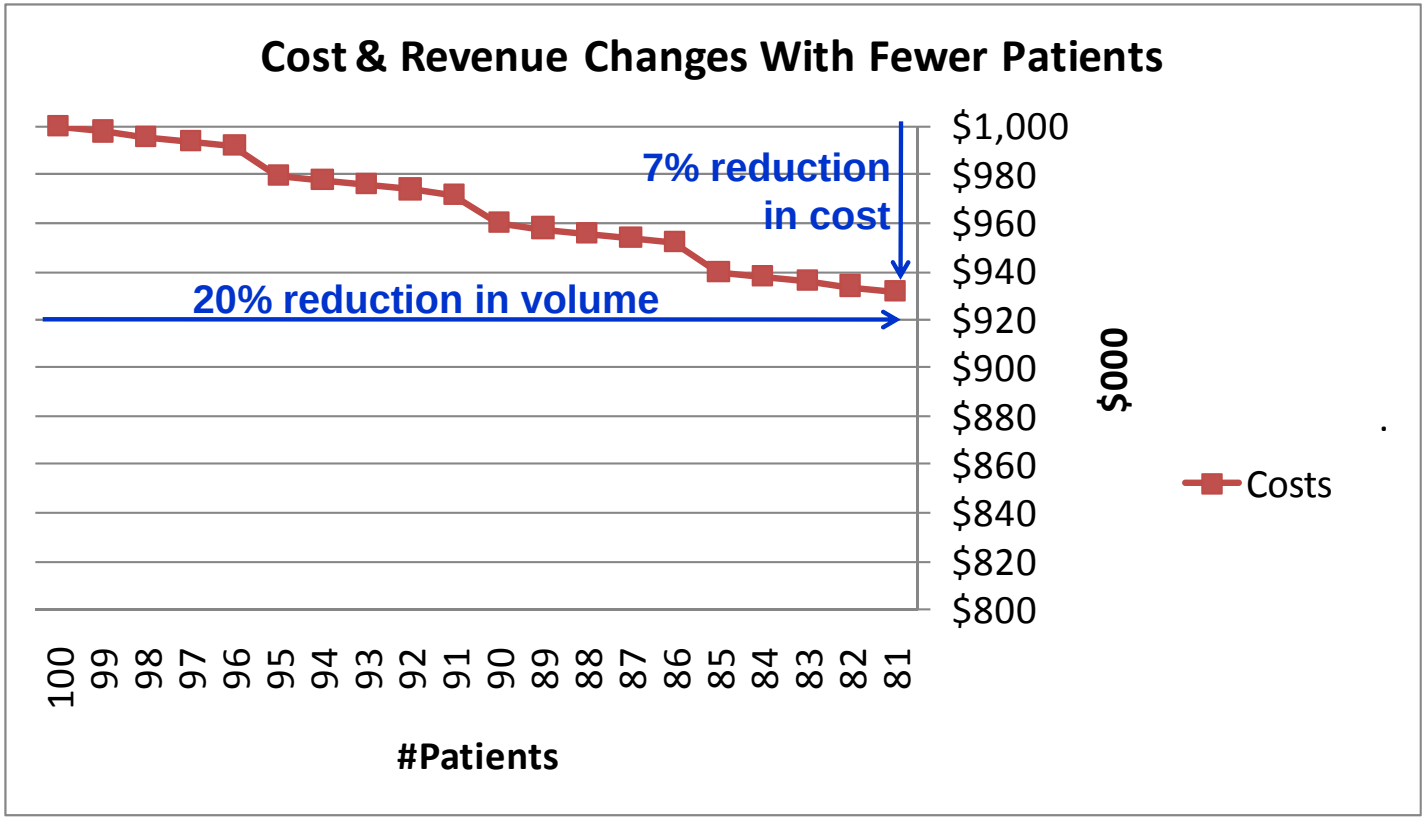
Do Hospitals Have to Lose In Order for Physicians & Payers To Win?

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Primary Care							
Evaluations	$100	100	$10,000	$200	100	$20,000	100%
Non-Surg.Tx							
Management	$200	20	$4,000	$500	40	$20,000	400%
Phys. Therapy	$500	20	$10,000	$750	40	$30,000	200%
Subtotal			$14,000			$50,000	257%
Surgeon	$1,400	80	$112,000	$2,100	60	$126,000	+13%
Hospital Pmt							
Surgeries	$12,000	80	$960,000	$12,000	60	$720,000	-25%
Total Pmt/Cost		100	$1,096,000		100	$916,000	-16%

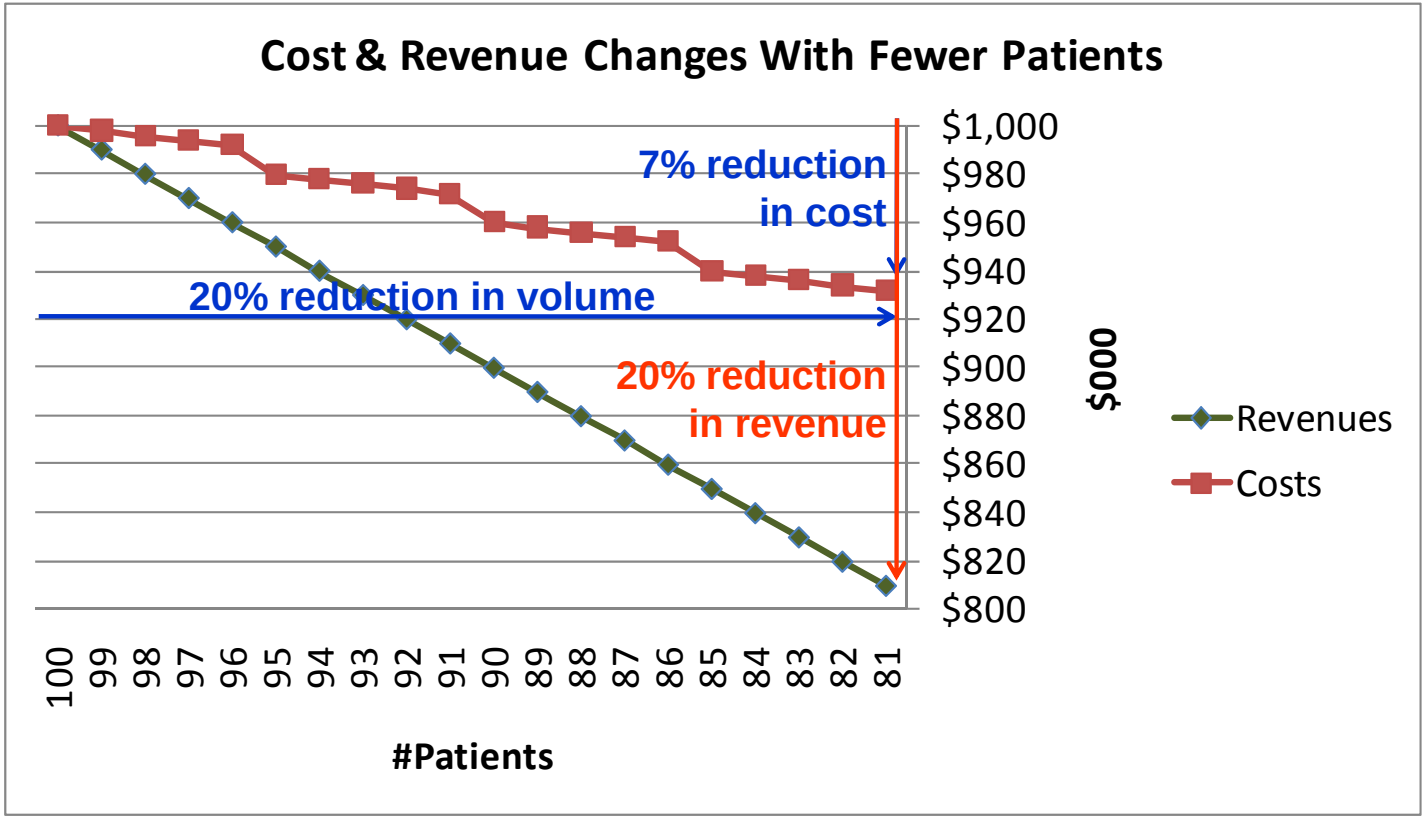
Physicians Win **Hospital Loses** **Payer Wins**

What Should Matter to Hospitals is *Margin*, Not Revenues (Volume)

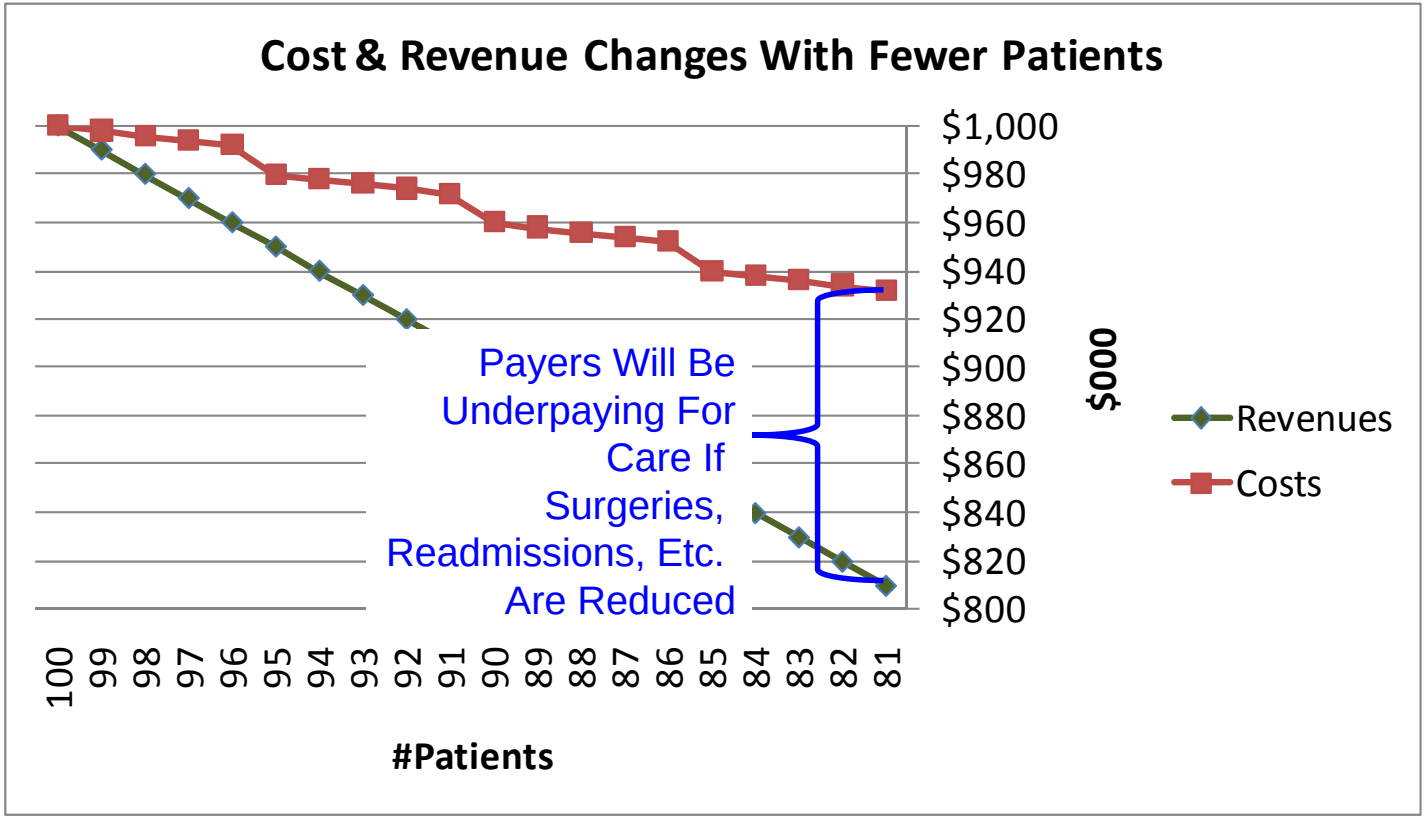
Hospital Costs Are Not Proportional to Utilization



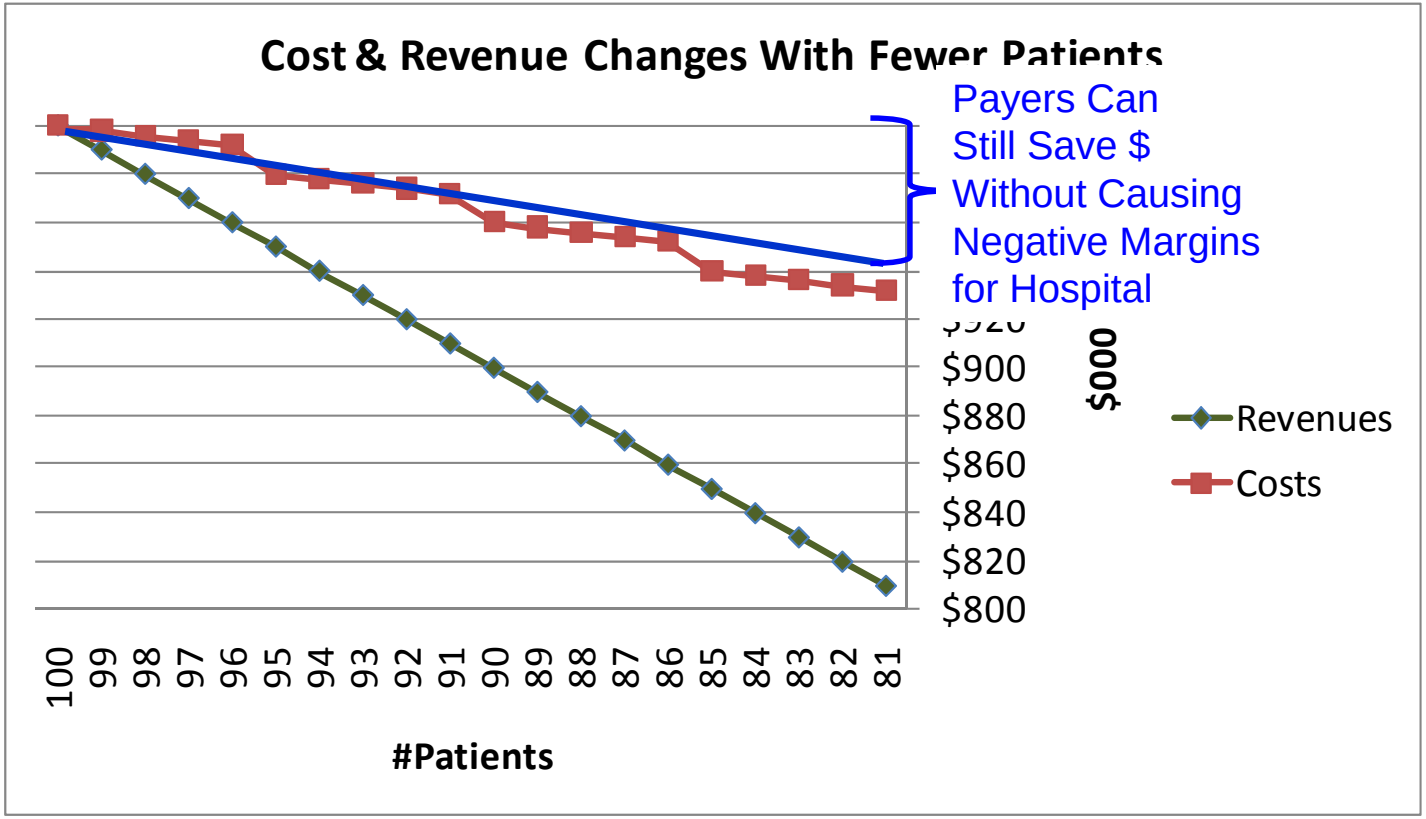
Reductions in Utilization Reduce Revenues More Than Costs



Causing Negative Margins for Hospitals



But Spending Can Be Reduced Without Bankrupting Hospitals



We Need to Understand the Hospital's Cost Structure

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Primary Care							
Evaluations	$100	100	$10,000	$200	100	$20,000	100%
Non-Surg.Tx							
Management	$200	20	$4,000	$500	40	$20,000	400%
Phys. Therapy	$500	20	$10,000	$750	40	$30,000	200%
Subtotal			$14,000			$50,000	257%
Surgeon	$1,400	80	$112,000	$2,100	60	$126,000	+13%
Hospital Pmt							
Surgeries	$12,000	80	$960,000	$12,000	60	$720,000	-25%
Total Pmt/Cost		100	$1,096,000		100	$916,000	-16%

Adequacy of Payment Depends On Fixed/Variable Costs & Margins

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Primary Care							
Evaluations	$100	100	$10,000	$200	100	$20,000	100%
Non-Surg.Tx							
Management	$200	20	$4,000	$500	40	$20,000	400%
Phys. Therapy	$500	20	$10,000	$750	40	$30,000	200%
Subtotal			$14,000			$50,000	257%
Surgeon	$1,400	80	$112,000	$2,100	60	$126,000	+13%
Hospital Pmt							
Fixed Costs	$6,000	*50%*	$480,000				
Variable Costs	$5,400	*45%*	$432,000				
Margin	$600	*5%*	$48,000				
Subtotal	$12,000	80	$960,000				
Total Pmt/Cost		100	$1,096,000				

Now, if the Number of Procedures is Reduced…

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Primary Care							
Evaluations	$100	100	$10,000	$200	100	$20,000	100%
Non-Surg.Tx							
Management	$200	20	$4,000	$500	40	$20,000	400%
Phys. Therapy	$500	20	$10,000	$750	40	$30,000	200%
Subtotal			$14,000			$50,000	257%
Surgeon	$1,400	80	$112,000	$2,100	60	$126,000	+13%
Hospital Pmt							
Fixed Costs	$6,000	*50%*	$480,000				
Variable Costs	$5,400	*45%*	$432,000				
Margin	$600	*5%*	$48,000				
Subtotal	$12,000	80	$960,000		60		
Total Pmt/Cost		100	$1,096,000				

…Fixed Costs Will Remain the Same (in the Short Run)…

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Primary Care							
Evaluations	$100	100	$10,000	$200	100	$20,000	100%
Non-Surg.Tx							
Management	$200	20	$4,000	$500	40	$20,000	400%
Phys. Therapy	$500	20	$10,000	$750	40	$30,000	200%
Subtotal			$14,000			$50,000	257%
Surgeon	$1,400	80	$112,000	$2,100	60	$126,000	+13%
Hospital Pmt							
Fixed Costs	$6,000	*50%*	$480,000			$480,000	0%
Variable Costs	$5,400	*45%*	$432,000				
Margin	$600	*5%*	$48,000				
Subtotal	$12,000	80	$960,000		60		
Total Pmt/Cost		100	$1,096,000				

…Variable Costs Will Go Down in Proportion to Procedures…

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Primary Care							
Evaluations	$100	100	$10,000	$200	100	$20,000	100%
Non-Surg.Tx							
Management	$200	20	$4,000	$500	40	$20,000	400%
Phys. Therapy	$500	20	$10,000	$750	40	$30,000	200%
Subtotal			$14,000			$50,000	257%
Surgeon	$1,400	80	$112,000	$2,100	60	$126,000	+13%
Hospital Pmt							
Fixed Costs	$6,000	*50%*	$480,000			$480,000	0%
Variable Costs	$5,400	*45%*	$432,000	$5,400		$324,000	-25%
Margin	$600	*5%*	$48,000				
Subtotal	$12,000	80	$960,000		60		
Total Pmt/Cost		100	$1,096,000				

…And Even With a Higher Margin for the Hospital…

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Primary Care							
Evaluations	$100	100	$10,000	$200	100	$20,000	100%
Non-Surg.Tx							
Management	$200	20	$4,000	$500	40	$20,000	400%
Phys. Therapy	$500	20	$10,000	$750	40	$30,000	200%
Subtotal			$14,000			$50,000	257%
Surgeon	$1,400	80	$112,000	$2,100	60	$126,000	+13%
Hospital Pmt							
Fixed Costs	$6,000	*50%*	$480,000			$480,000	0%
Variable Costs	$5,400	*45%*	$432,000	$5,400		$324,000	-25%
Margin	$600	*5%*	$48,000			$52,800	+10%
Subtotal	$12,000	80	$960,000		60		
Total Pmt/Cost		100	$1,096,000				

…The Hospital Gets Less *Total* Revenue But Higher *Margin*

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Primary Care							
Evaluations	$100	100	$10,000	$200	100	$20,000	100%
Non-Surg.Tx							
Management	$200	20	$4,000	$500	40	$20,000	400%
Phys. Therapy	$500	20	$10,000	$750	40	$30,000	200%
Subtotal			$14,000			$50,000	257%
Surgeon	$1,400	80	$112,000	$2,100	60	$126,000	+13%
Hospital Pmt							
Fixed Costs	$6,000	*50%*	$480,000			$480,000	0%
Variable Costs	$5,400	*45%*	$432,000	$5,400		$324,000	-25%
Margin	$600	*5%*	$48,000			$52,800	+10%
Subtotal	$12,000	80	$960,000		80	$856,800	-11%
Total Pmt/Cost		100	$1,096,000				

…And The Payer Still Saves Money

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Primary Care							
Evaluations	$100	100	$10,000	$200	100	$20,000	100%
Non-Surg.Tx							
Management	$200	20	$4,000	$500	40	$20,000	400%
Phys. Therapy	$500	20	$10,000	$750	40	$30,000	200%
Subtotal			$14,000			$50,000	257%
Surgeon	$1,400	80	$112,000	$2,100	60	$126,000	+13%
Hospital Pmt							
Fixed Costs	$6,000	*50%*	$480,000			$480,000	0%
Variable Costs	$5,400	*45%*	$432,000	$5,400		$324,000	-25%
Margin	$600	*5%*	$48,000			$52,800	+10%
Subtotal	$12,000	80	$960,000		60	$856,800	-11%
Total Pmt/Cost		100	$1,096,000		100	$1,052,800	-4%

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

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Primary Care							
Evaluations	$100	100	$10,000	$200	100	$20,000	100%
Non-Surg.Tx							
Management	$200	20	$4,000	$500	40	$20,000	400%
Phys. Therapy	$500	20	$10,000	$750	40	$30,000	200%
Subtotal			$14,000			$50,000	257%
Surgeon	$1,400	80	$112,000			$126,000	+13%
Hospital Pmt							
Fixed Costs	$6,000	*50%*	$480,000			$480,000	0%
Variable Costs	$5,400	*45%*	$432,000	$5,400		$324,000	-25%
Margin	$600	*5%*	$48,000			$52,800	+10%
Subtotal	$12,000	80	$960,000		60	$856,800	-11%
Total Pmt/Cost		100	$1,096,000		100	$1,052,800	-4%

Physicians Win

Hospital Wins

Payer Wins

What Payment Model Supports This Win-Win-Win Approach?

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Primary Care							
Evaluations	$100	100	$10,000	$200	100	$20,000	100%
Non-Surg.Tx							
Management	$200	20	$4,000	$500	40	$20,000	400%
Phys. Therapy	$500	20	$10,000	$750	40	$30,000	200%
Subtotal			$14,000			$50,000	257%
Surgeon	$1,400	80	$112,000	$2,100	60	$126,000	+13%
Hospital Pmt							
Fixed Costs	$6,000	*50%*	$480,000			$480,000	0%
Variable Costs	$5,400	*45%*	$432,000	$5,400		$324,000	-25%
Margin	$600	*5%*	$48,000			$52,800	+10%
Subtotal	$12,000	80	$960,000		60	$856,800	-11%
Total Pmt/Cost		100	$1,096,000		100	$1,052,800	-4%

Renegotiating Individual Fees is Impractical…

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Primary Care							
Evaluations	$100	100	$10,000	$200	100	$20,000	100%
Non-Surg.Tx							
Management	$200	20	$4,000	$500	40	$20,000	400%
Phys. Therapy	$500	20	$10,000	$750	40	$30,000	200%
Subtotal			$14,000			$50,000	257%
Surgeon	$1,400	80	$112,000	$2,100	60	$126,000	+13%
Hospital Pmt							
Fixed Costs	$6,000	*50%*	$480,000			$480,000	0%
Variable Costs	$5,400	*45%*	$432,000	$5,400		$324,000	-25%
Margin	$600	*5%*	$48,000			$52,800	+10%
Subtotal	$12,000	80	$960,000	$14,280	60	$856,800	-11%
Total Pmt/Cost		100	$1,096,000		100	$1,052,800	-4%

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

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Primary Care							
Evaluations	$100	100	$10,000	$200	100	$20,000	100%
Non-Surg.Tx							
Management	$200	20	$4,000	$500	40	$20,000	400%
Phys. Therapy	$500	20	$10,000	$750	40	$30,000	200%
Subtotal			$14,000			$50,000	257%
Surgeon	$1,400	80	$112,000	$2,100	60	$126,000	+13%
Hospital Pmt							
Fixed Costs	$6,000	*50%*	$480,000			$480,000	0%
Variable Costs	$5,400	*45%*	$432,000	$5,400		$324,000	-25%
Margin	$600	*5%*	$48,000			$52,800	+10%
Subtotal	$12,000	80	$960,000	$14,280	60	$856,800	-11%
Total Pmt/Cost		100	$1,096,000		100	$1,052,800	-4%

?

Solution: Pay Based on the Patient's *Condition*, Not on the *Procedures*

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Primary Care							
Evaluations	$100	100	$10,000				
Non-Surg.Tx							
Management	$200	20	$4,000				
Phys. Therapy	$500	20	$10,000				
Subtotal			$14,000				
Surgeon	$1,400	80	$112,000				
Hospital Pmt							
Fixed Costs	$6,000	*50%*	$480,000				
Variable Costs	$5,400	*45%*	$432,000				
Margin	$600	*5%*	$48,000				
Subtotal	$12,000	80	$960,000				
Total Pmt/Cost	$10,960	100	$1,096,000				

Plan to Offer Care of the Condition at a Lower Cost Per Patient

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Primary Care							
Evaluations	$100	100	$10,000				
Non-Surg.Tx							
Management	$200	20	$4,000				
Phys. Therapy	$500	20	$10,000				
Subtotal			$14,000				
Surgeon	$1,400	80	$112,000				
Hospital Pmt							
Fixed Costs	$6,000	*50%*	$480,000				
Variable Costs	$5,400	*45%*	$432,000				
Margin	$600	*5%*	$48,000				
Subtotal	$12,000	80	$960,000				
Total Pmt/Cost	$10,960	100	~~$1,096,000~~	$10,528	100		-4%

Use the Payment as a Budget to Redesign Care…

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Primary Care							
Evaluations	$100	100	$10,000		100	$20,000	100%
Non-Surg.Tx							
Management	$200	20	$4,000				
Phys. Therapy	$500	20	$10,000				
Subtotal			$14,000			$50,000	257%
Surgeon	$1,400	80	$112,000		60	$126,000	+13%
Hospital Pmt							
Fixed Costs	$6,000	*50%*	$480,000			$480,000	
Variable Costs	$5,400	*45%*	$432,000			$324,000	
Margin	$600	*5%*	$48,000			$52,800	
Subtotal	$12,000	80	$960,000		60	$856,800	
Total Pmt/Cost	$10,960	100	~~$1,096,000~~	$10,528	100	$1,052,800	-4%

…And Let Physicians & Hospitals Decide How They Should Be Paid

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Primary Care							
Evaluations	$100	100	$10,000	$200	~~100~~	$20,000	100%
Non-Surg.Tx							
Management	$200	20	$4,000	$500			
Phys. Therapy	$500	20	$10,000	$750			
Subtotal			$14,000			$50,000	257%
Surgeon	$1,400	80	$112,000	$2,100	~~60~~	$126,000	+13%
Hospital Pmt							
Fixed Costs	$6,000	*50%*	$480,000			$480,000	
Variable Costs	$5,400	*45%*	$432,000			$324,000	
Margin	$600	*5%*	$48,000			$52,800	
Subtotal	$12,000	80	$960,000		60	$856,800	
Total Pmt/Cost	$10,960	100	~~$1,096,000~~	$10,528	100	$1,052,800	-4%

Condition-Based Payment Allows True Win-Win-Win Solutions

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Primary Care							
Evaluations	$100	100	$10,000	$200	100	$20,000	100%
Non-Surg.Tx							
Management	$200	20	$4,000	$500	40	$20,000	400%
Phys. Therapy	$500	20	$10,000	$750	40	$30,000	200%
Subtotal			$14,000			$50,000	257%
Surgeon	$1,400	80	$112,000			$126,000	+13%
Hospital Pmt							
Fixed Costs	$6,000	*50%*	$480,000			$480,000	0%
Variable Costs	$5,400	*45%*	$432,000			$324,000	-25%
Margin	$600	*5%*	$48,000			$52,800	+10%
Subtotal	$12,000	80	$960,000		60	$856,800	-11%
Total Pmt/Cost	$10,960	100	$1,096,000	$10,528	100	$1,052,800	-4%

Physicians Win

Hospital Wins

Payer Wins

What Would Happen If You Reduce Surgeries Even More?

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Primary Care							
Evaluations	$100	100	$10,000		100		
Non-Surg.Tx							
Management	$200	20	$4,000		60		
Phys. Therapy	$500	20	$10,000		60		
Subtotal			$14,000				
Surgeon	$1,400	80	~~$112,000~~		40		-50%
Hospital Pmt							
Fixed Costs	$6,000	*50%*	$480,000				
Variable Costs	$5,400	*45%*	$432,000				
Margin	$600	*5%*	$48,000				
Subtotal	$12,000	80	~~$960,000~~		40		-50%
Total Pmt/Cost	$10,960	100	$1,096,000				

The Overall Condition-Based Budget is Already Set

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Primary Care							
Evaluations	$100	100	$10,000		100		
Non-Surg.Tx							
Management	$200	20	$4,000		60		
Phys. Therapy	$500	20	$10,000		60		
Subtotal			$14,000				
Surgeon	$1,400	80	$112,000		40		
Hospital Pmt							
Fixed Costs	$6,000	*50%*	$480,000				
Variable Costs	$5,400	*45%*	$432,000				
Margin	$600	*5%*	$48,000				
Subtotal	$12,000	80	$960,000		40		
Total Pmt/Cost	$10,960	100	$1,096,000	$10,528	100	$1,052,800	-4%

Spend Some More on Outpatient Care, A Lot Less on Inpatient Care

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Primary Care							
Evaluations	$100	100	$10,000		100		
Non-Surg.Tx							
Management	$200	20	$4,000		60	$30,000	650%
Phys. Therapy	$500	20	$10,000		60	$45,000	350%
Subtotal			$14,000			$75,000	435%
Surgeon	$1,400	80	$112,000		40		
Hospital Pmt							
Fixed Costs	$6,000	*50%*	$480,000			$480,000	0%
Variable Costs	$5,400	*45%*	$432,000			$216,000	-50%
Margin	$600	*5%*	$48,000				
Subtotal	$12,000	80	$960,000		40		
Total Pmt/Cost	$10,960	100	$1,096,000	$10,528	100	$1,052,800	-4%

Continue to Maintain Higher Revenues for PCP & Surgeon

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Primary Care							
Evaluations	$100	100	$10,000	$200	100	$25,000	150%
Non-Surg.Tx							
Management	$200	20	$4,000	$500	60	$30,000	650%
Phys. Therapy	$500	20	$10,000	$750	60	$45,000	350%
Subtotal			$14,000			$75,000	435%
Surgeon	$1,400	80	$112,000	$3,350	40	$134,000	+20%
Hospital Pmt							
Fixed Costs	$6,000	*50%*	$480,000			$480,000	0%
Variable Costs	$5,400	*45%*	$432,000			$216,000	-50%
Margin	$600	*5%*	$48,000				
Subtotal	$12,000	80	$960,000				
Total Pmt/Cost	$10,960	100	$1,096,000	$10,528			

Increase the Hospital's Margin Even More

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Primary Care							
Evaluations	$100	100	$10,000	$200	100	$25,000	150%
Non-Surg.Tx							
Management	$200	20	$4,000	$500	60	$30,000	650%
Phys. Therapy	$500	20	$10,000	$750	60	$45,000	350%
Subtotal			$14,000			$75,000	435%
Surgeon	$1,400	80	$112,000	$2,100	40	$134,000	+20%
Hospital Pmt							
Fixed Costs	$6,000	*50%*	$480,000			$480,000	0%
Variable Costs	$5,400	*45%*	$432,000			$216,000	-50%
Margin	$600	*5%*	$48,000			$70,000	+46%
Subtotal	$12,000	80	$960,000		40		
Total Pmt/Cost	$10,960	100	$1,096,000	$10,528	100	$1,052,800	-4%

And Offer Care at a Lower Cost

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Primary Care							
Evaluations	$100	100	$10,000	$200	100	$25,000	150%
Non-Surg.Tx							
Management	$200	20	$4,000	$500	60	$30,000	650%
Phys. Therapy	$500	20	$10,000	$750	60	$45,000	350%
Subtotal			$14,000			$75,000	435%
Surgeon	$1,400	80	$112,000	$2,100	40	$134,000	+20%
Hospital Pmt							
Fixed Costs	$6,000	*50%*	$480,000			$480,000	0%
Variable Costs	$5,400	*45%*	$432,000			$216,000	-50%
Margin	$600	*5%*	$48,000			$70,000	+46%
Subtotal	$12,000	80	$960,000		40	$766,000	-20%
Total Pmt/Cost	$10,960	100	$1,096,000	$10,000	100	$1,000,000	-9%

Everyone Could Win Even More

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Primary Care							
Evaluations	$100	100	$10,000	$200	100	$25,000	150%
Non-Surg.Tx							
Management	$200	20	$4,000	$500	60	$30,000	650%
Phys. Therapy	$500	20	$10,000	$750	60	$45,000	350%
Subtotal			$14,000			$75,000	435%
Surgeon	$1,400	80	$112,000			$134,000	+20%
Hospital Pmt							
Fixed Costs	$6,000	*50%*	$480,000			$480,000	0%
Variable Costs	$5,400	*45%*	$432,000			$216,000	-50%
Margin	$600	*5%*	$48,000			$70,000	+46%
Subtotal	$12,000	80	$960,000		40	$766,000	-20%
Total Pmt/Cost	$10,960	100	$1,096,000	$10,000	100	$1,000,000	-9%

Physicians Win

Hospital Wins

Payer Wins

Are You Crazy?

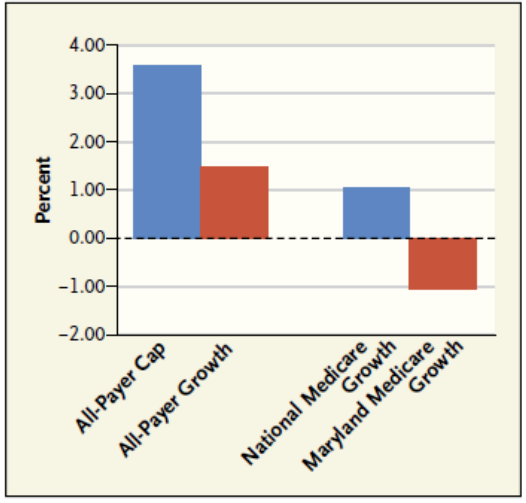
Hospitals Doing
Better Financially
With Fewer Patients??

Maryland Has Been Moving to Global Budgets for Hospitals

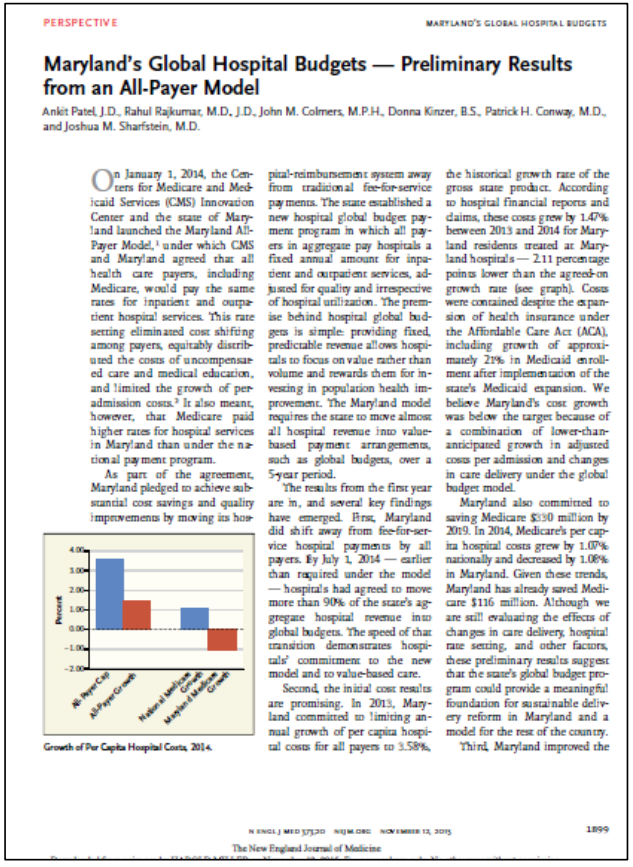
- **All-Payer Payment Rates**
  - All payers pay the same, including Medicare
  - Costs of uncompensated care included in the all-payer rates
  - Adding incentives for quality, complications, readmissions
  - Problem: No control over volume; hospitals could always make more money by admitting more patients and doing more procedures
- **Total Patient Revenue (TPR)**
  - Global budget for hospital services, adjusted for population, not actual level of services
  - No incentive to admit more patients or do more procedures; incentive to reduce readmissions and avoidable admissions
  - Focused on isolated, rural hospitals, where one hospital serves the entire population
- **Global Budget Revenue (GBR)**
  - New CMS Waiver approved in January 2014
  - Being implemented now for urban hospitals
  - Designed to control increases in total hospital revenue per capita instead of revenue per case

Initial Results of Maryland Effort

- Reductions in Preventable Admissions
- Reductions in Readmissions
- No Financial Harm to Hospitals



Growth of Per Capita Hospital Costs, 2014.



PERSPECTIVE

MARYLAND'S GLOBAL HOSPITAL BUDGETS

Maryland's Global Hospital Budgets — Preliminary Results from an All-Payer Model

Ankit Patel, J.D., Rahul Rajkumar, M.D., J.D., John M. Colmers, M.P.H., Donna Kinzer, B.S., Patrick H. Conway, M.D., and Joshua M. Sharfstein, M.D.

On January 1, 2014, the Centers for Medicare and Medicaid Services (CMS) Innovation Center and the state of Maryland launched the Maryland All-Payer Model,[1] under which CMS and Maryland agreed that all health care payers, including Medicare, would pay the same rates for inpatient and outpatient hospital services. This rate setting eliminated cost shifting among payers, equitably distributed the costs of uncompensated care and medical education, and limited the growth of per-admission costs.[2] It also meant, however, that Medicare paid higher rates for hospital services in Maryland than under the national payment program.

As part of the agreement, Maryland pledged to achieve substantial cost savings and quality improvements by moving its hospital-reimbursement system away from traditional fee-for-service payments. The state established a new hospital global budget payment program in which all payers in aggregate pay hospitals a fixed annual amount for inpatient and outpatient services, adjusted for quality and irrespective of hospital utilization. The premise behind hospital global budgets is simple: providing fixed, predictable revenue allows hospitals to focus on value rather than volume and rewards them for investing in population health improvement. The Maryland model requires the state to move almost all hospital revenue into value-based payment arrangements, such as global budgets, over a 5-year period.

The results from the first year are in, and several key findings have emerged. First, Maryland did shift away from fee-for-service hospital payments by all payers. By July 1, 2014 — earlier than required under the model — hospitals had agreed to move more than 90% of the state's aggregate hospital revenue into global budgets. The speed of that transition demonstrates hospitals' commitment to the new model and to value-based care.

Second, the initial cost results are promising. In 2013, Maryland committed to limiting annual growth of per capita hospital costs for all payers to 3.58%, the historical growth rate of the gross state product. According to hospital financial reports and claims, these costs grew by 1.49% between 2013 and 2014 for Maryland residents treated at Maryland hospitals — 2.11 percentage points lower than the agreed-on growth rate (see graph). Costs were contained despite the expansion of health insurance under the Affordable Care Act (ACA), including growth of approximately 21% in Medicaid enrollment after implementation of the state's Medicaid expansion. We believe Maryland's cost growth was below the target because of a combination of lower-than-anticipated growth in adjusted costs per admission and changes in care delivery under the global budget model.

Maryland also committed to saving Medicare $330 million by 2019. In 2014, Medicare's per capita hospital costs grew by 1.07% nationally and decreased by 1.08% in Maryland. Given these trends, Maryland has already saved Medicare $116 million. Although we are still evaluating the effects of changes in care delivery, hospital rate setting, and other factors, these preliminary results suggest that the state's global budget program could provide a meaningful foundation for sustainable delivery reform in Maryland and a model for the rest of the country.

Third, Maryland improved the

Growth of Per Capita Hospital Costs, 2014.

N ENGL J MED 373;20 NEJM.ORG NOVEMBER 12, 2015

1899

The New England Journal of Medicine

Need to Measure Outcomes to Prevent Undertreatment

- Avoiding infections
- Lack of pain
- Patient return to functionality

Patients Differ in Their Need for Surgery

	LOWER-RISK PATIENTS # Pts	HIGHER-RISK PATIENTS # Pts
Primary Care		
Evaluations	50	50
Non-Surg.Tx		
Management	30	10
Phys. Therapy	30	10
Surgery	20	40

40% Need Surgery

80% Need Surgery

Condition-Based Payment Amount Must Be Based on Patient Needs

	LOWER-RISK PATIENTS			HIGHER-RISK PATIENTS		
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $
Primary Care						
Evaluations	$200	50	$10,000	$200	50	$10,000
Non-Surg.Tx						
Management	$500	30	$15,000	$500	10	$5,000
Phys. Therapy	$750	30	$22,500	$750	10	$7,500
Subtotal			$37,500			$12,500
Surgeon	$2,100	20	$42,000	$2,100	40	$84,000
Hospital Pmt						
Fixed Costs			$192,000			$288,000
Variable Costs	$5,400		$108,000	$5,400		$216,000
Margin			$21,120			$31,680
Subtotal		20	$321,120		40	$535,680
Total Pmt/Cost	$8,212	50	$410,620	$12,844	50	$642,180

Fee for Service Has Built-In Risk Adjustment

Traditional FFS

- Higher payments made for patients who receive more services
- Physician receives higher payment based on bills submitted for services delivered
- No higher payment if individual services require more time or resources

Payer Risk Adjustment Models Are a Poor Substitute

Traditional FFS

- Higher payments made for patients who receive more services
- Physician receives higher payment based on bills submitted for services delivered
- No higher payment if individual services require more time or resources

Payer Risk Adjustment

- Higher payments made for patients who are assigned more diagnosis codes
- Physician receives higher payment based on number and type of diagnosis codes assigned on claims
- No higher payment for some diagnosis codes or for higher severity conditions without separate codes

Effective Risk Adjustment via Physician-Defined Classifications

Traditional FFS

- Higher payments made for patients who receive more services
- Physician receives higher payment based on bills submitted for services delivered
- No higher payment if individual services require more time or resources

Patient Classification

- Higher payments are made for patients who are classified as higher need for their condition
- Physician bills for a “condition-based payment” code from a family of codes stratified based on patient needs
- No higher payment based solely on number of services delivered

Payer Risk Adjustment

- Higher payments made for patients who are assigned more diagnosis codes
- Physician receives higher payment based on number and type of diagnosis codes assigned on claims
- No higher payment for some diagnosis codes or for higher severity conditions without separate codes

Development of Patient Condition Groups Under MACRA

SEC. 101. REPEALING THE SUSTAINABLE GROWTH RATE (SGR) AND IMPROVING MEDICARE PAYMENT FOR PHYSICIANS' SERVICES.

(f) COLLABORATING WITH THE PHYSICIAN, PRACTITIONER, AND OTHER STAKEHOLDER COMMUNITIES TO IMPROVE RESOURCE USE MEASUREMENT.

(2) DEVELOPMENT OF CARE EPISODE AND PATIENT CONDITION GROUPS AND CLASSIFICATION CODES.—

(D) DEVELOPMENT OF PROPOSED CLASSIFICATION CODES.—

(i) IN GENERAL.—Taking into account the information described in subparagraph (B) and the information received under subparagraph (C), the Secretary shall—

(I) establish care episode groups and patient condition groups, which account for a target of an estimated 1⁄2 of expenditures under parts A and B (with such target increasing over time as appropriate); and (II) assign codes to such groups.

(ii) CARE EPISODE GROUPS.—In establishing the care episode groups under clause (i), the Secretary shall take into account—(I) the patient's clinical problems at the time items and services are furnished during an episode of care, such as the clinical conditions or diagnoses, whether or not inpatient hospitalization occurs, and the principal procedures or services furnished; and (II) other factors determined appropriate by the Secretary.

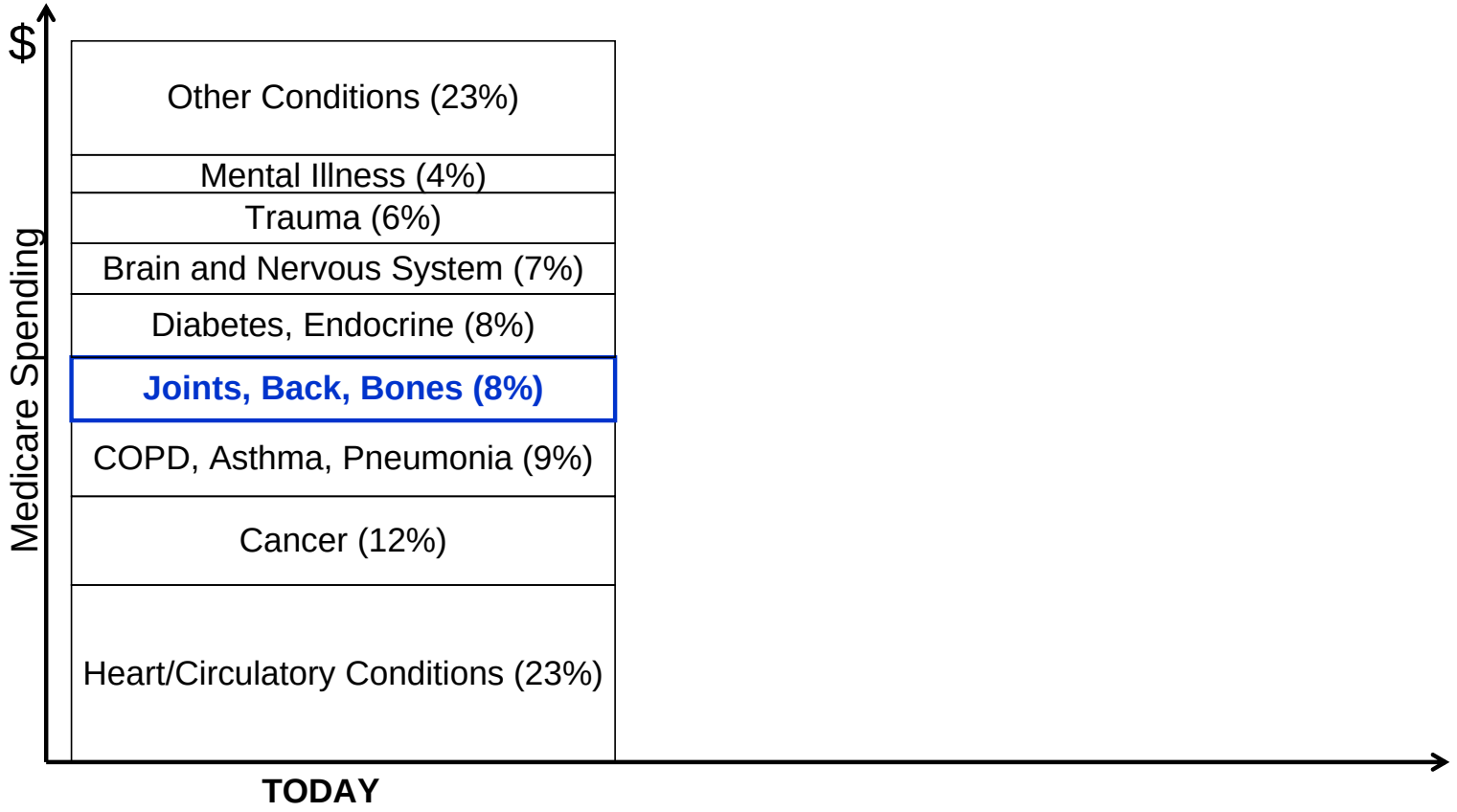
(iii) PATIENT CONDITION GROUPS.—In establishing the patient condition groups under clause (i), the Secretary shall take into account— (I) the patient's clinical history at the time of a medical visit, such as the patient's combination of chronic conditions, current health status, and recent significant history (such as hospitalization and major surgery during a previous period, such as 3 months); and (II) other factors determined appropriate by the Secretary,

Timetable for New Codes Under MACRA

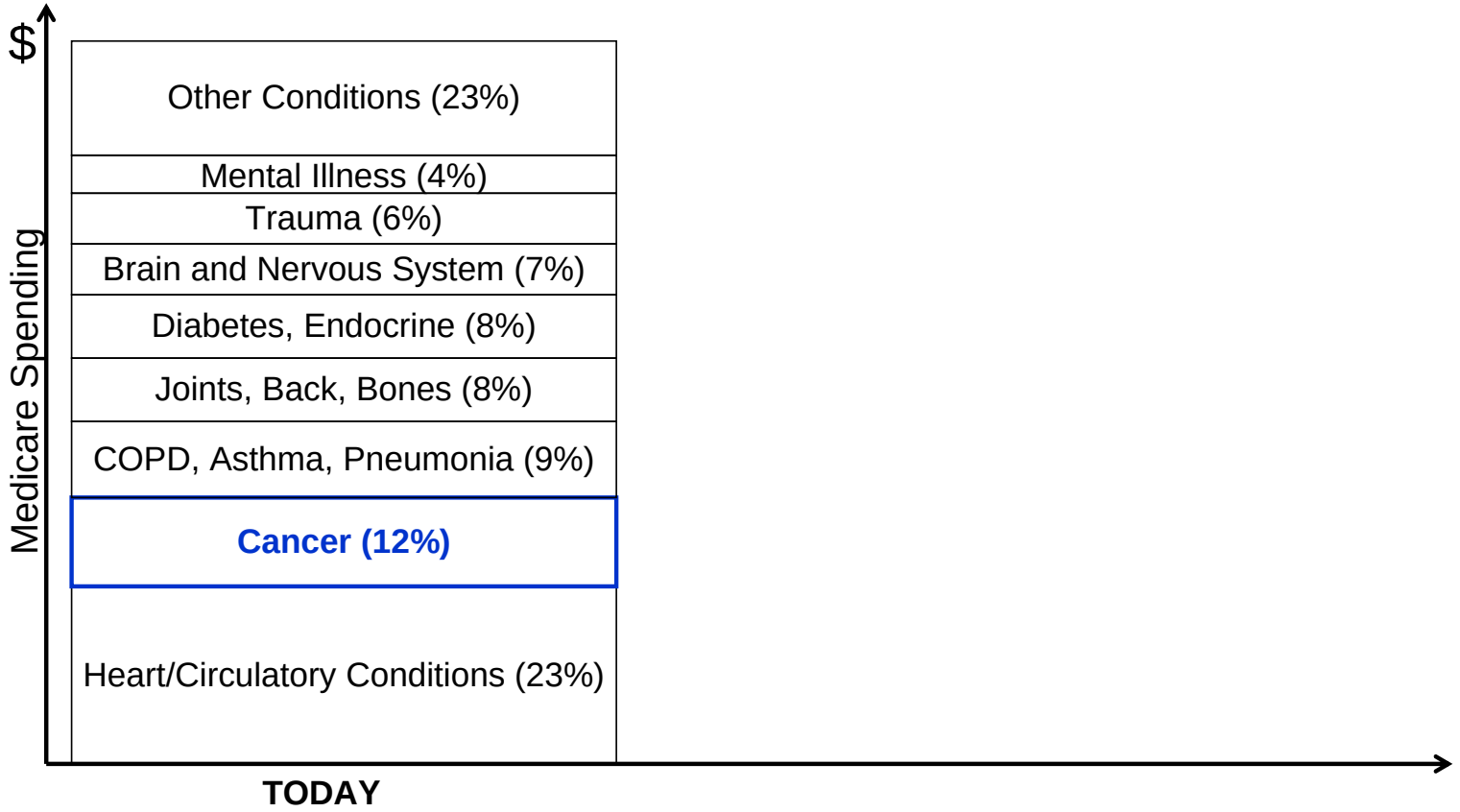
Estimated Date	Care Episode Groups and Codes	Patient Condition Groups and Codes	Patient Relationship Categories & Codes
April 16, 2016 (Completed)			Draft patient relationship categories and codes Comments due August 15, 2016
November 25, 2016	Draft list of care episode codes	Draft list of patient condition codes	
April 20, 2017			Operational list of patient relationship categories and codes
December 20, 2017	Operational list of care episode codes	Operational list of patient condition codes	
January 1, 2018	Include care episode codes on claim forms	Include patient condition codes on claim forms	Include patient relationship category codes on claim forms

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-Feedback.html

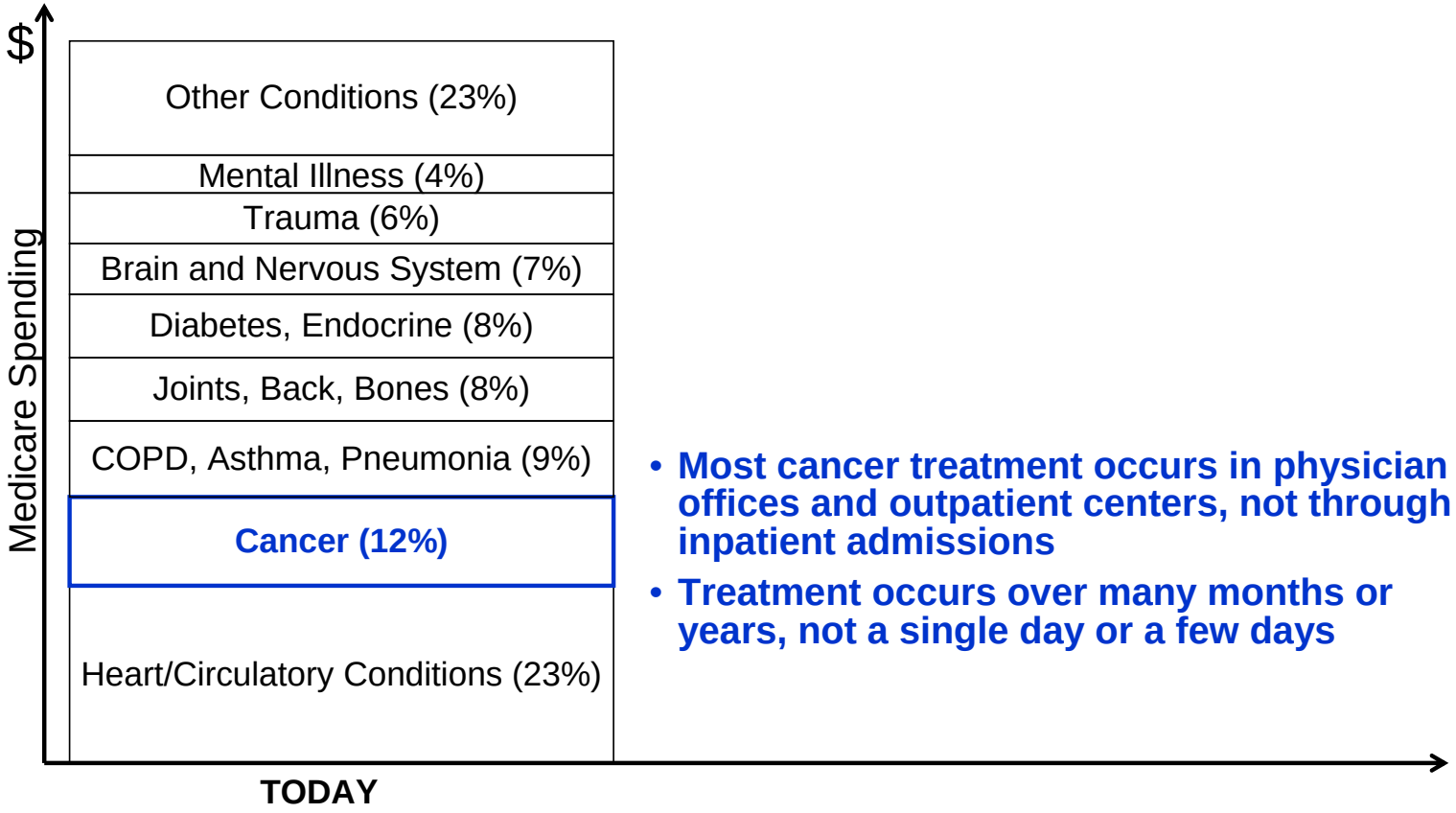
Musculoskeletal Care is Only a Small Part of Total Spending



What About Other Conditions Like Cancer?

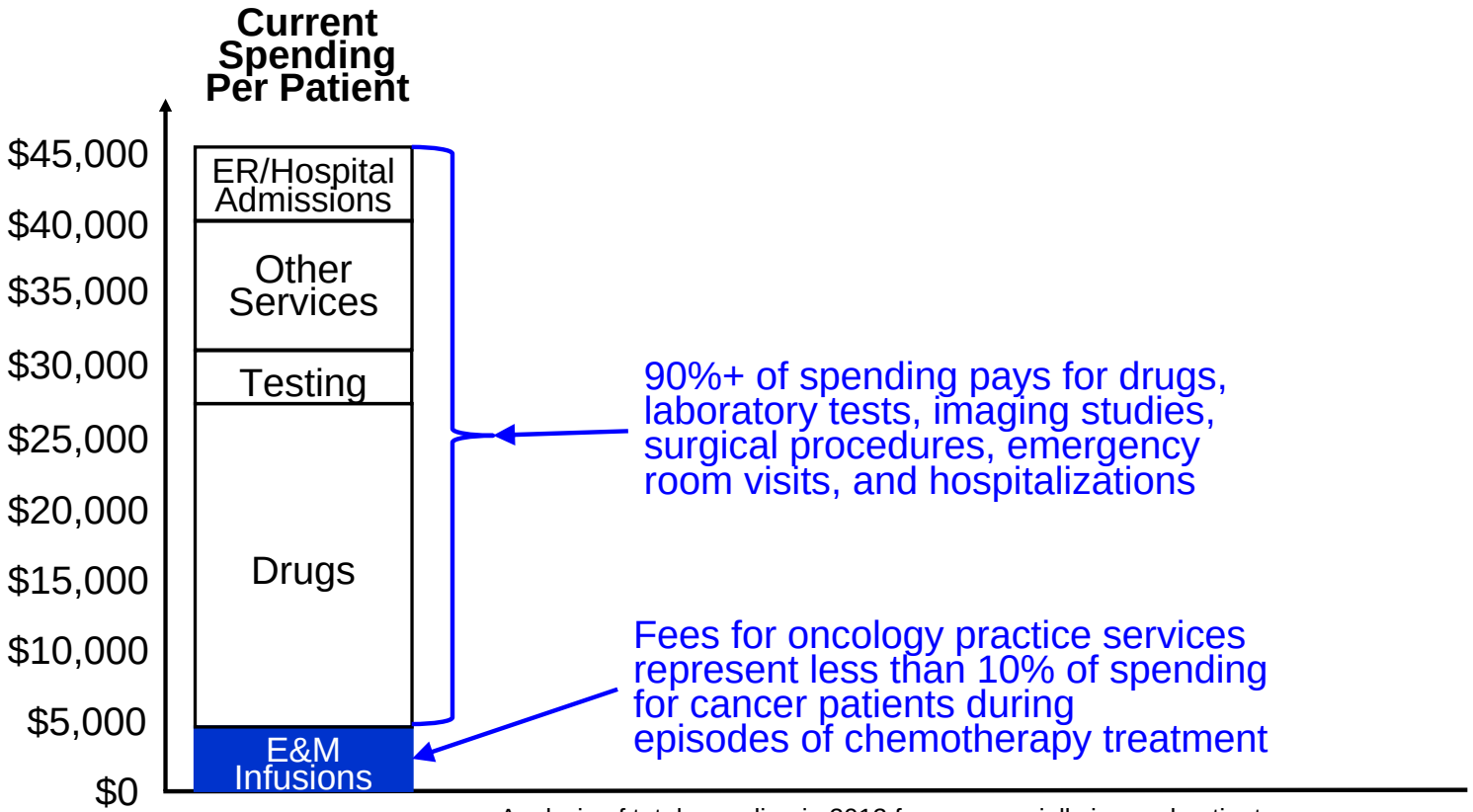


Current Procedural Episode Models Don't Work for These Conditions



- **Most cancer treatment occurs in physician offices and outpatient centers, not through inpatient admissions**
- **Treatment occurs over many months or years, not a single day or a few days**

Most $$ Go to Drugs, Tests, and Admissions, Not Oncology Practices



Analysis of total spending in 2012 for commercially insured patients during an "episode" of chemotherapy treatment (treatment months through the second month after treatment ends)

Large Reductions in Avoidable Hospitalizations Are Possible

Source: Sprandio JD. "Oncology patient-centered medical home and accountable cancer care." *Community Oncology*, December 2010

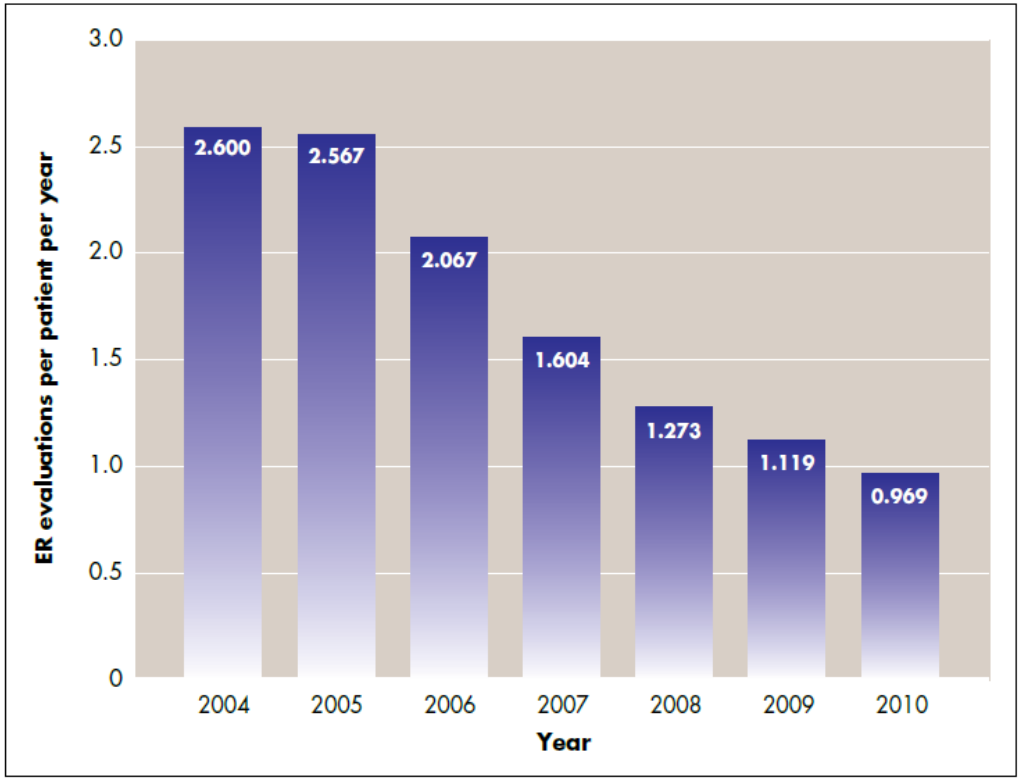
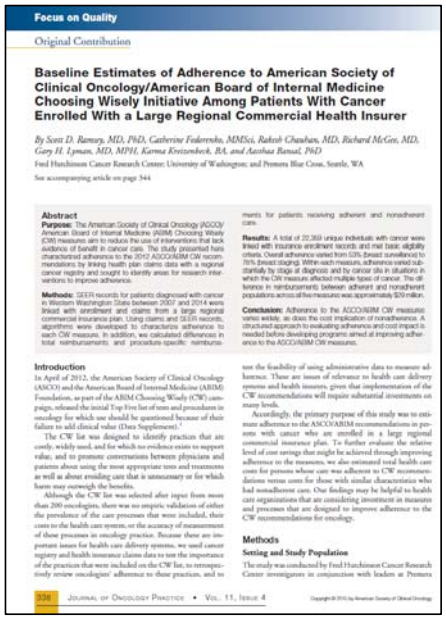


FIGURE 3 Average emergency room (ER) evaluations at Delaware County Memorial Hospital of the Drexel Hill office population per chemotherapy patient per year, 2004–2010 (YTD).

20-50% Non-Adherence to Choosing Wisely Criteria



Focus on Quality

Original Contribution

Baseline Estimates of Adherence to American Society of Clinical Oncology/American Board of Internal Medicine Choosing Wisely Initiative Among Patients With Cancer Enrolled With a Large Regional Commercial Health Insurer

By Scott D. Ramsey, MD, PhD, Catherine Fedorenko, MMSci, Rakesh Chauhan, MD, Richard McGee, MD, Gary H. Lyman, MD, MPH, Karma Kreizenbeck, BA, and Aasthaa Bansal, PhD

Fred Hutchinson Cancer Research Center; University of Washington; and Premera Blue Cross, Seattle, WA

See accompanying article on page 344

Abstract

Purpose: The American Society of Clinical Oncology (ASCO)/American Board of Internal Medicine (ABIM) Choosing Wisely (CW) measures aim to reduce the use of interventions that lack evidence of benefit in cancer care. The study presented here characterized adherence to the 2012 ASCO/ABIM CW recommendations by linking health plan claims data with a regional cancer registry and sought to identify areas for research interventions to improve adherence.

Methods: SEER records for patients diagnosed with cancer in Western Washington State between 2007 and 2014 were linked with enrollment and claims from a large regional commercial insurance plan. Using claims and SEER records, algorithms were developed to characterize adherence to each CW measure. In addition, we calculated differences in total reimbursements and procedure-specific reimbursements for patients receiving adherent and nonadherent care.

Results: A total of 22,359 unique individuals with cancer were linked with insurance enrollment records and met basic eligibility criteria. Overall adherence varied from 53% (breast surveillance) to 76% (breast staging). Within each measure, adherence varied substantially by stage at diagnosis and by cancer site in situations in which the CW measure affected multiple types of cancer. The difference in reimbursements between adherent and nonadherent populations across all five measures was approximately $29 million.

Conclusion: Adherence to the ASCO/ABIM CW measures varies widely, as does the cost implication of nonadherence. A structured approach to evaluating adherence and cost impact is needed before developing programs aimed at improving adherence to the ASCO/ABIM CW measures.

Introduction

In April of 2012, the American Society of Clinical Oncology (ASCO) and the American Board of Internal Medicine (ABIM) Foundation, as part of the ABIM Choosing Wisely (CW) campaign, released the initial Top Five list of tests and procedures in oncology for which use should be questioned because of their failure to add clinical value (Data Supplement).[1]

The CW list was designed to identify practices that are costly, widely used, and for which no evidence exists to support value, and to promote conversations between physicians and patients about using the most appropriate tests and treatments as well as about avoiding care that is unnecessary or for which harms may outweigh the benefits.

Although the CW list was selected after input from more than 200 oncologists, there was no empiric validation of either the prevalence of the care processes that were included, their costs to the health care system, or the accuracy of measurement of these processes in oncology practice. Because these are important issues for health care delivery systems, we used cancer registry and health insurance claims data to test the importance of the practices that were included on the CW list, to retrospectively review oncologists' adherence to these practices, and to test the feasibility of using administrative data to measure adherence. These are issues of relevance to health care delivery systems and health insurers, given that implementation of the CW recommendations will require substantial investments on many levels.

Accordingly, the primary purpose of this study was to estimate adherence to the ASCO/ABIM recommendations in persons with cancer who are enrolled in a large regional commercial insurance plan. To further evaluate the relative level of cost savings that might be achieved through improving adherence to the measures, we also estimated total health care costs for persons whose care was adherent to CW recommendations versus costs for those with similar characteristics who had nonadherent care. Our findings may be helpful to health care organizations that are considering investment in measures and processes that are designed to improve adherence to the CW recommendations for oncology.

Methods

Setting and Study Population

The study was conducted by Fred Hutchinson Cancer Research Center investigators in conjunction with leaders at Premera

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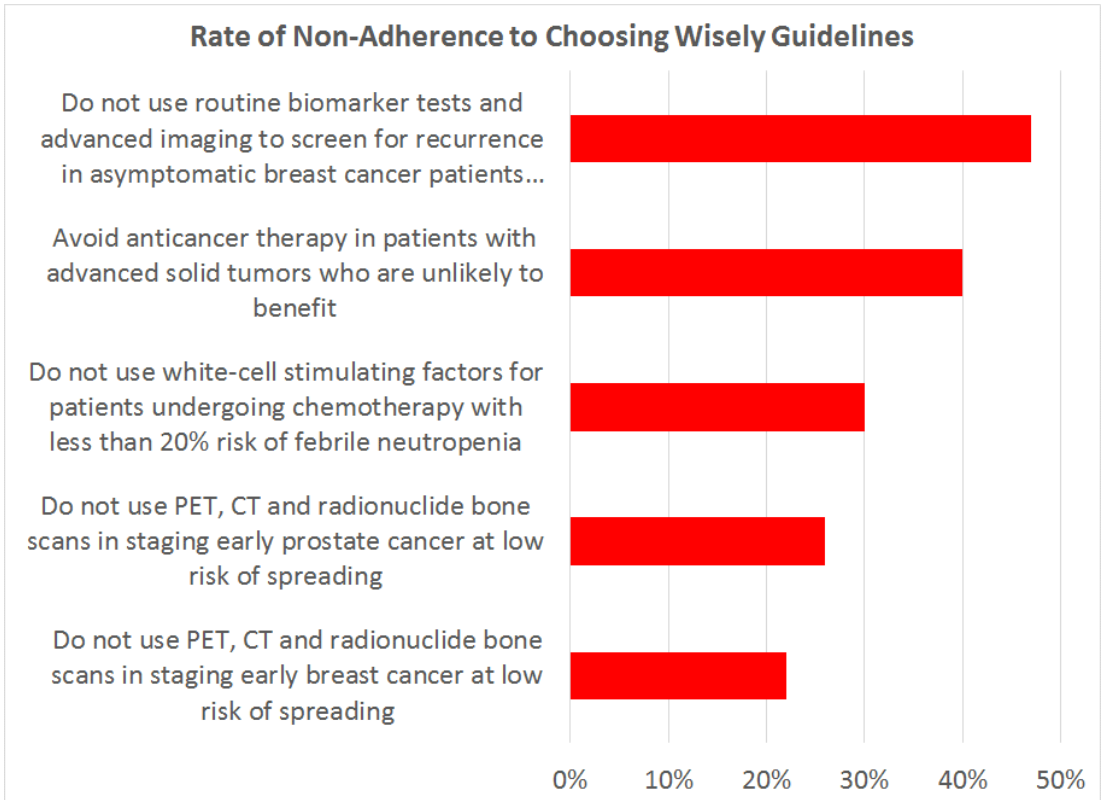
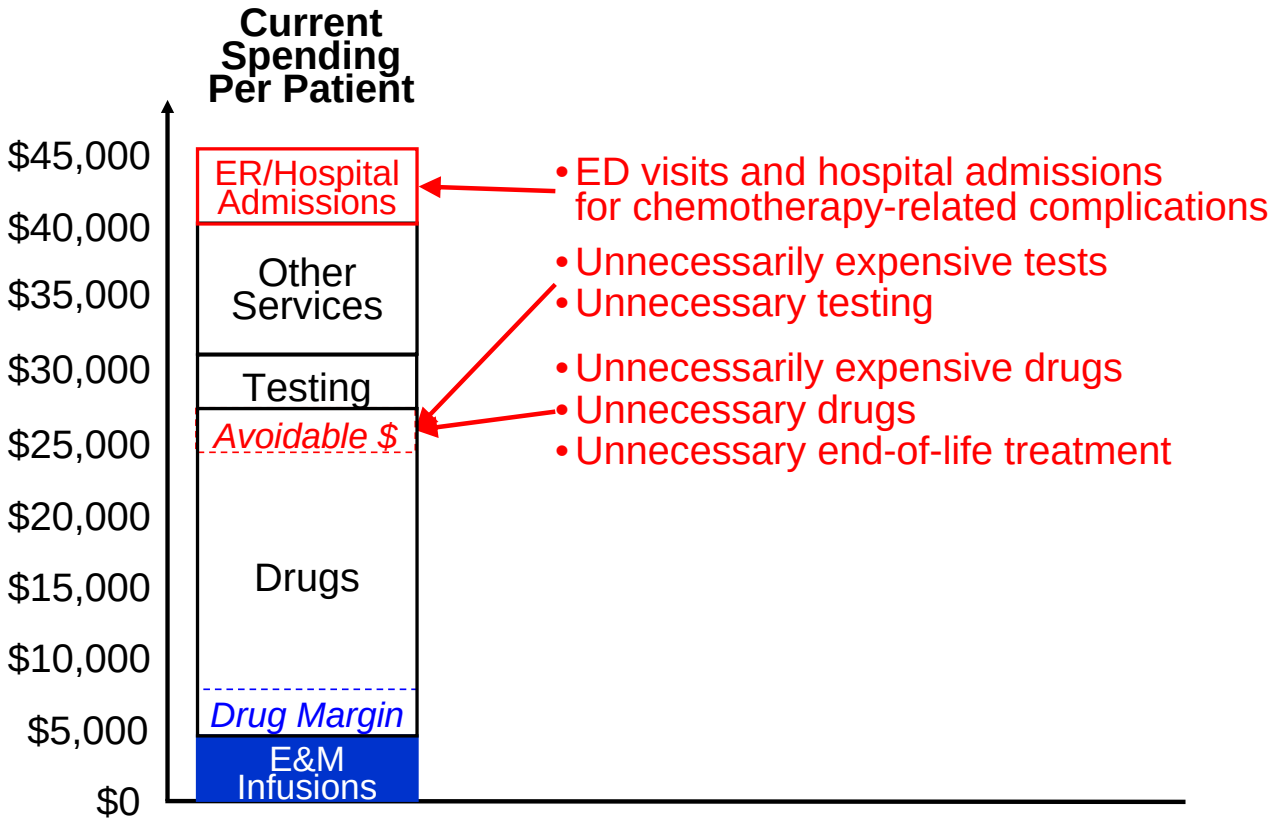
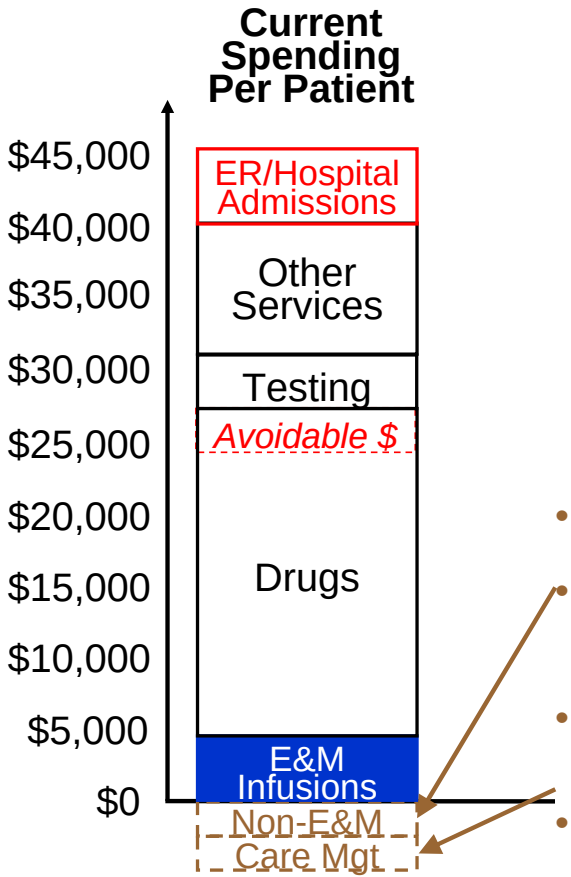


Many Opportunities to Improve Care & Reduce Spending

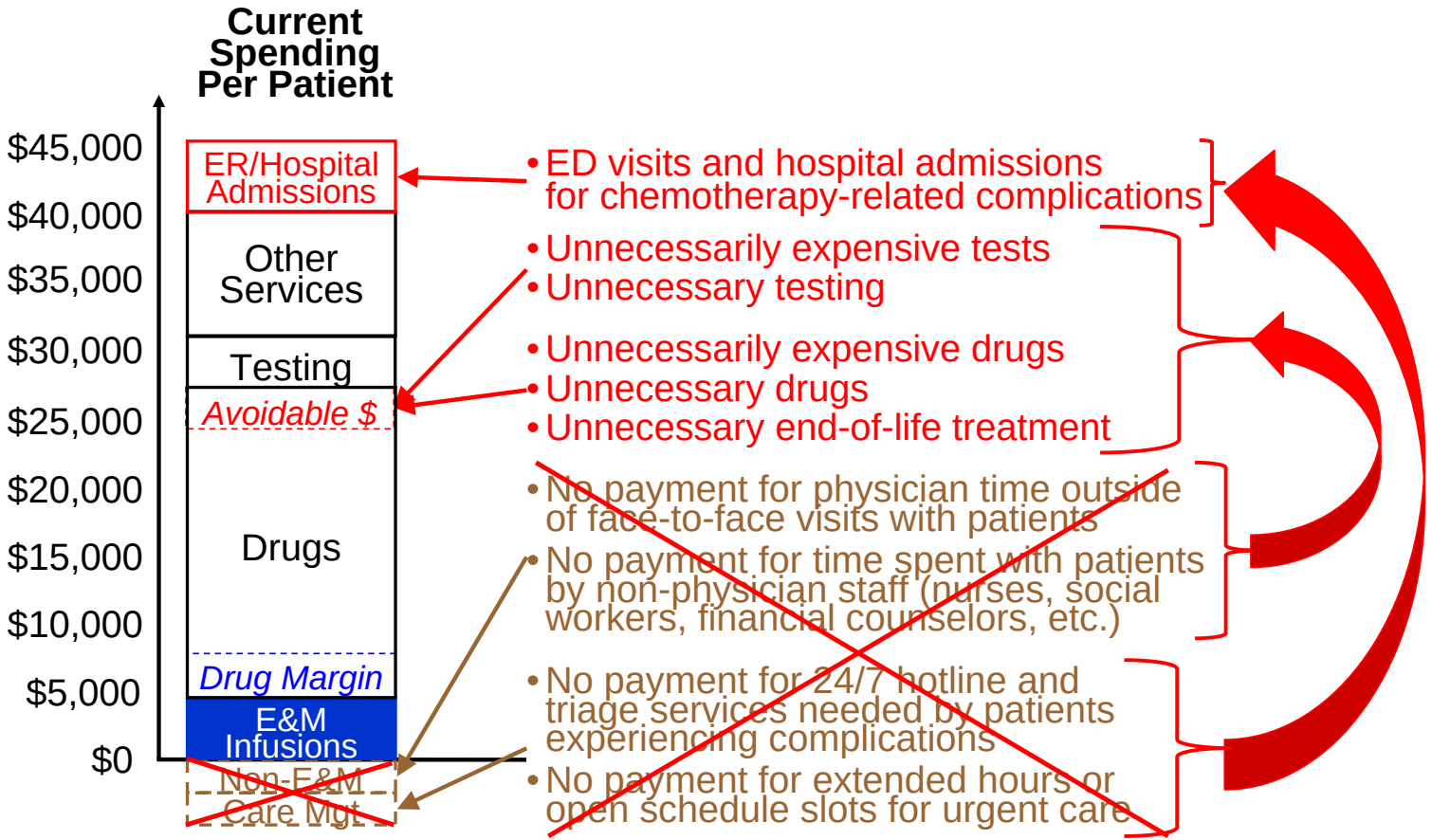


No Payment For Many Services Essential to Quality Cancer Care

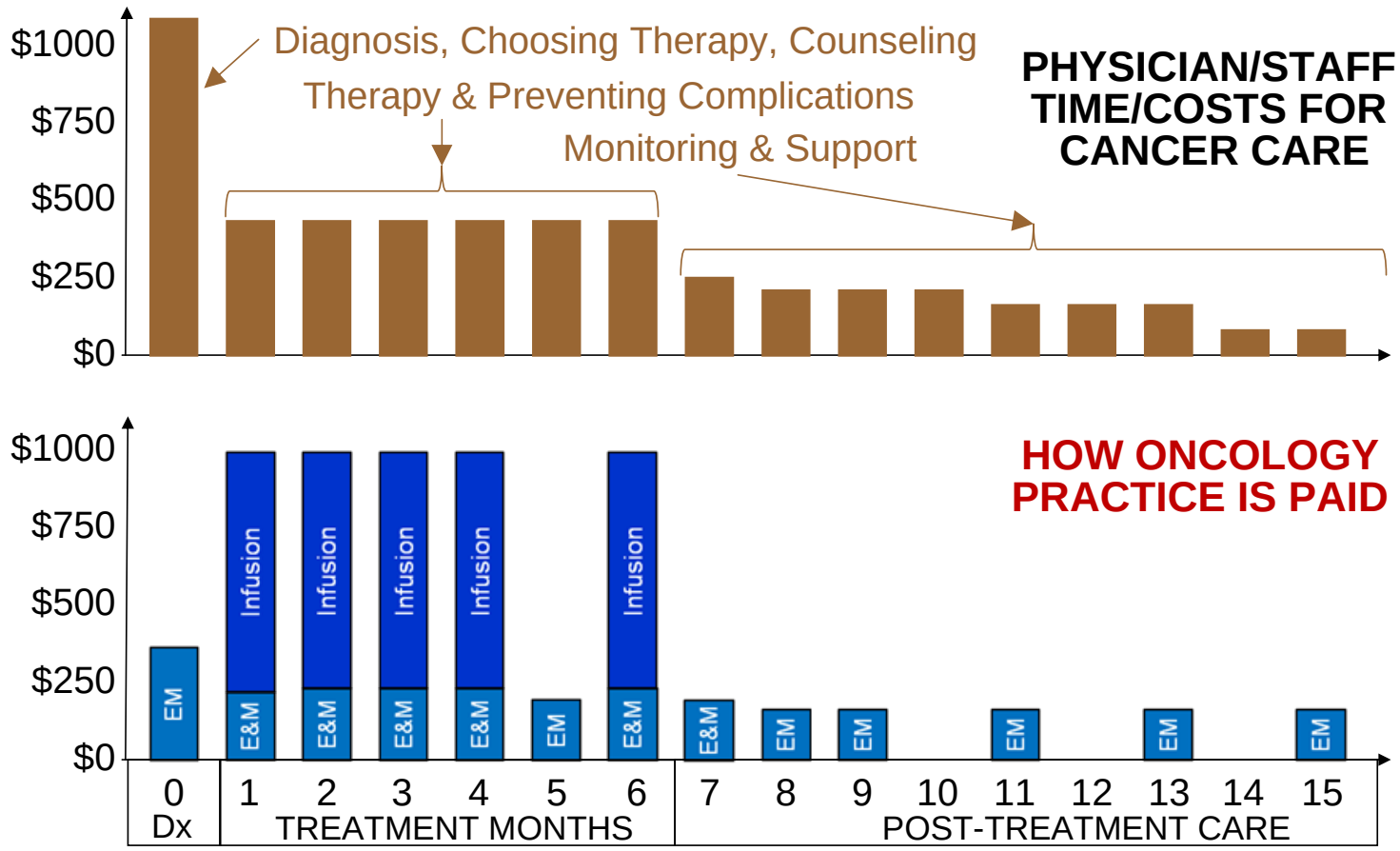


- No payment for physician time outside of face-to-face visits with patients
- No payment for time spent with patients by non-physician staff (nurses, social workers, financial counselors, etc.)
- No payment for 24/7 hotline and triage services needed by patients experiencing complications
- No payment for extended hours or open schedule slots for urgent care

Failure to Pay for Good Care… Leads to Costly, Low-Value Services

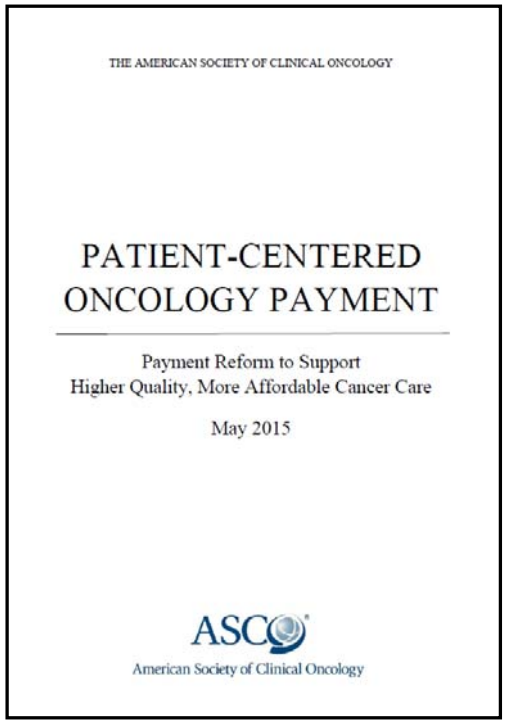


Mismatch Today
Between Payment and Services…



ASCO Payment Reform Developed by Oncologists & Practice Managers

- Christian Thomas, MD, New England Cancer Specialists
- Dan Zuckerman, MD, Mountain States Tumor Institute
- Tammy Chambers, Center for Cancer and Blood Disorders
- James Frame, MD, CAMC Cancer Center
- Bruce Gould, MD, Northwest Georgia Oncology Center
- Ann Kaley, Mountain States Tumor Institute
- Justin Klamerus, MD, Karmanos Cancer Institute
- Lauren Lawrence, Karmanos Cancer Institute
- Barbara McAneny, MD, New Mexico Cancer Center
- Roscoe Morton, MD, Cancer Center of Iowa
- Julie Moran, Seidman Cancer Center
- Ray Page, DO, PhD, Center for Cancer and Blood Disorders
- Scott Parker, Northwest Georgia Oncology Center
- Charles Penley, MD, Tennessee Oncology
- Gabrielle Rocque, MD, University of Alabama at Birmingham
- Barry Russo, Center for Cancer and Blood Disorders
- Joel Saltzman, MD, Seidman Cancer Center
- Laura Stevens, Innovative Oncology Business Solutions
- Jeffery Ward, MD, Swedish Cancer Institute
- Kim Woofter, Michiana Hematology Oncology
- Robin Zon, MD, Michiana Hematology Oncology

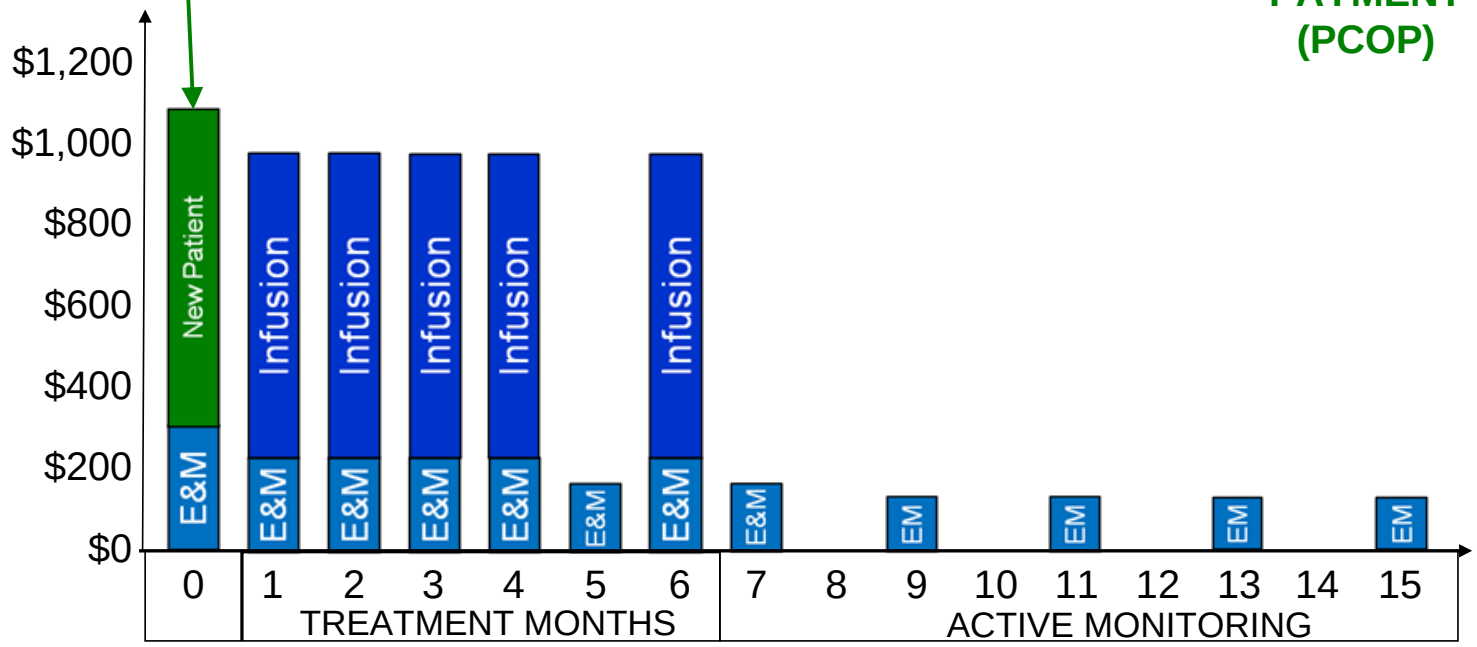


www.asco.org/paymentreform

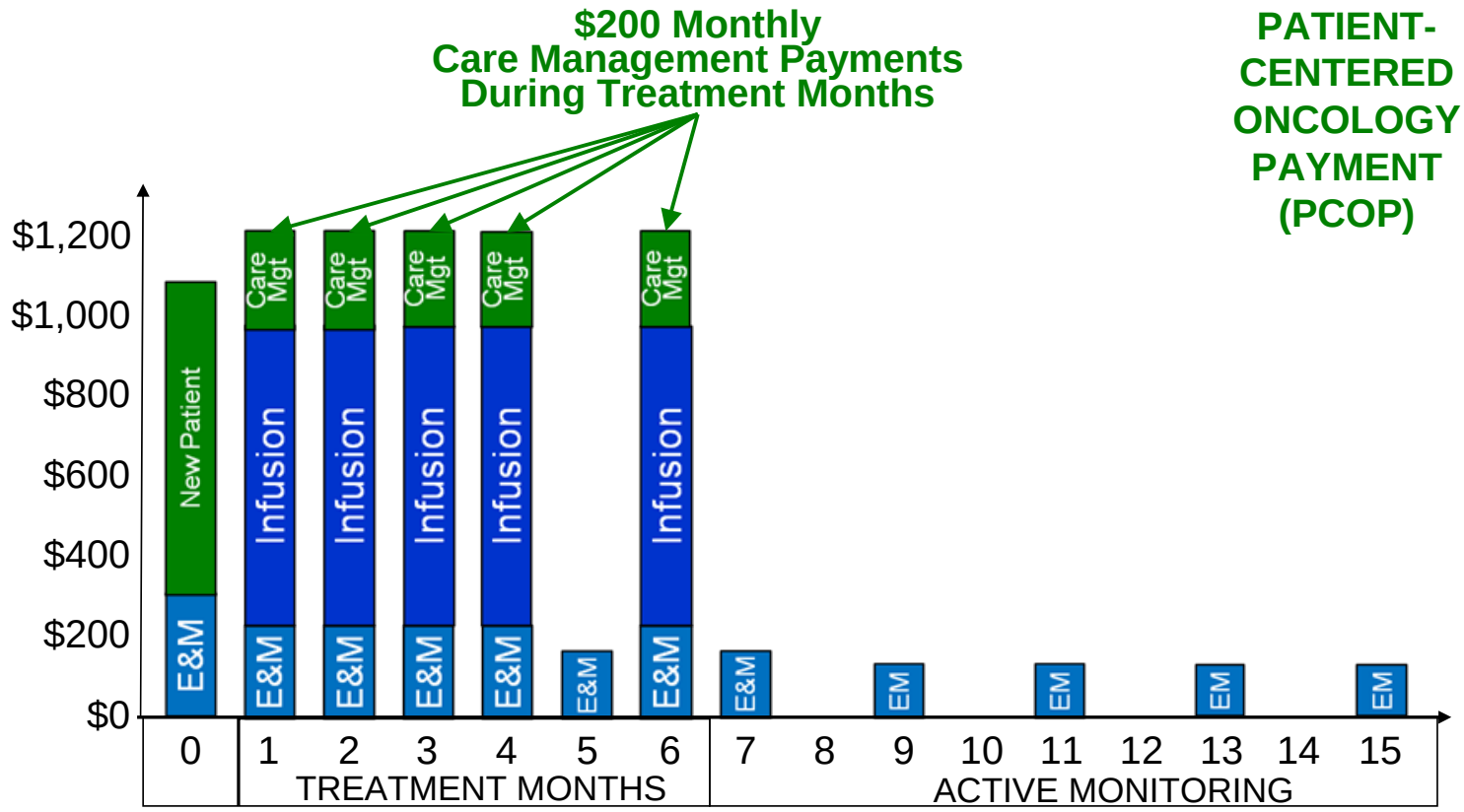
Part 1. Higher Payment During Crucial Diagnosis/Planning Stage

Additional $750 One-Time Payment for Each New Patient

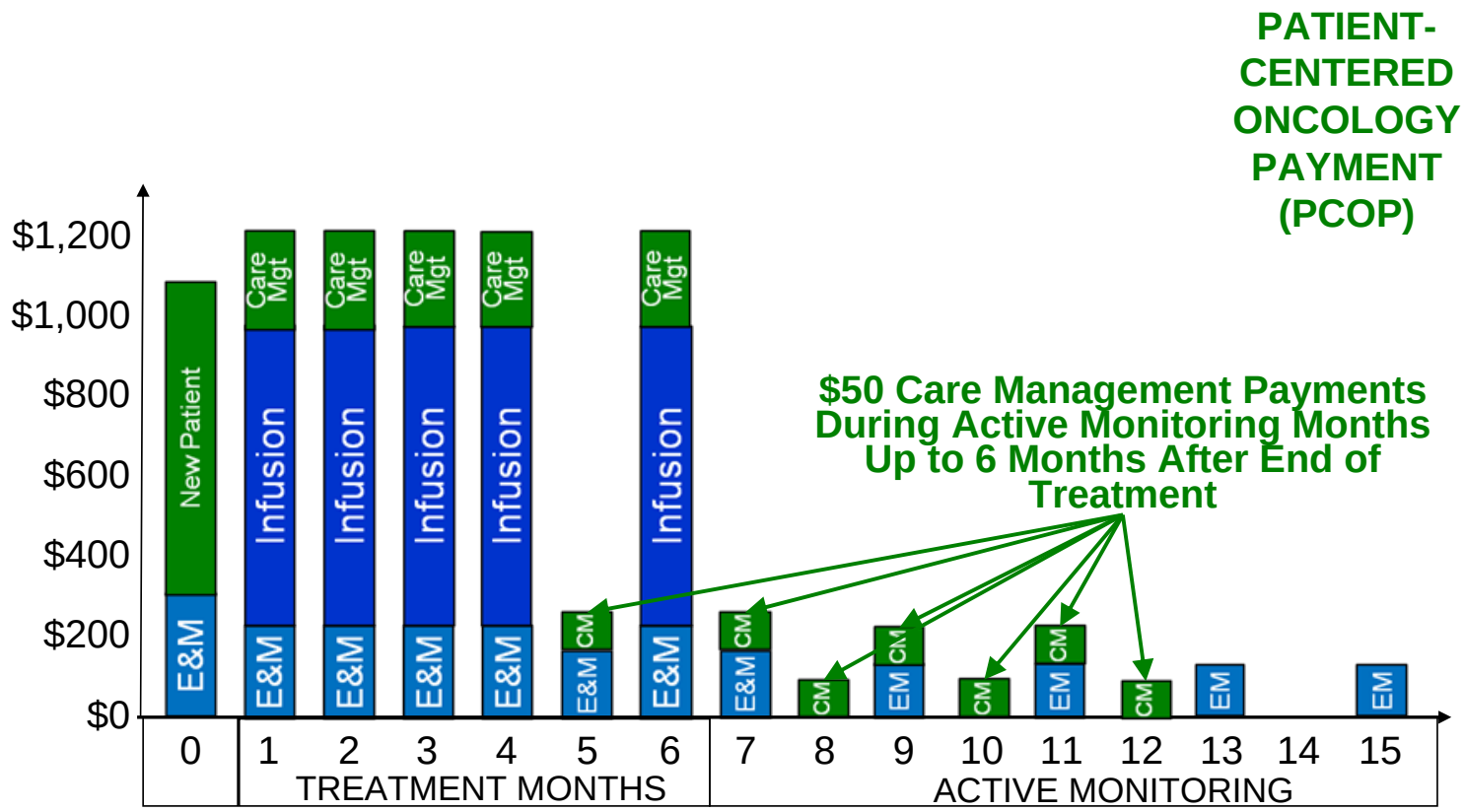
PATIENT-CENTERED ONCOLOGY PAYMENT (PCOP)



Part 2. Flexible Care Management Payments During Treatment



Part 3. Smaller Care Management Payments After Treatment Ends



New Billing Codes Will Be Easy for Payers & Practices to Implement

- **New Billing Code for New Patient Treatment Planning**

The oncology practice would bill the payer for a $750 payment for each new oncology patient who begins treatment or active management with the practice.

- **New Billing Code for Care Management During Treatment**

The oncology practice would bill the payer for a $200 payment for each month in which an oncology patient is receiving parenteral or oral anti-cancer treatment prescribed by the practice. This payment would also be made for patients who are in hospice if the oncologist is the hospice physician.

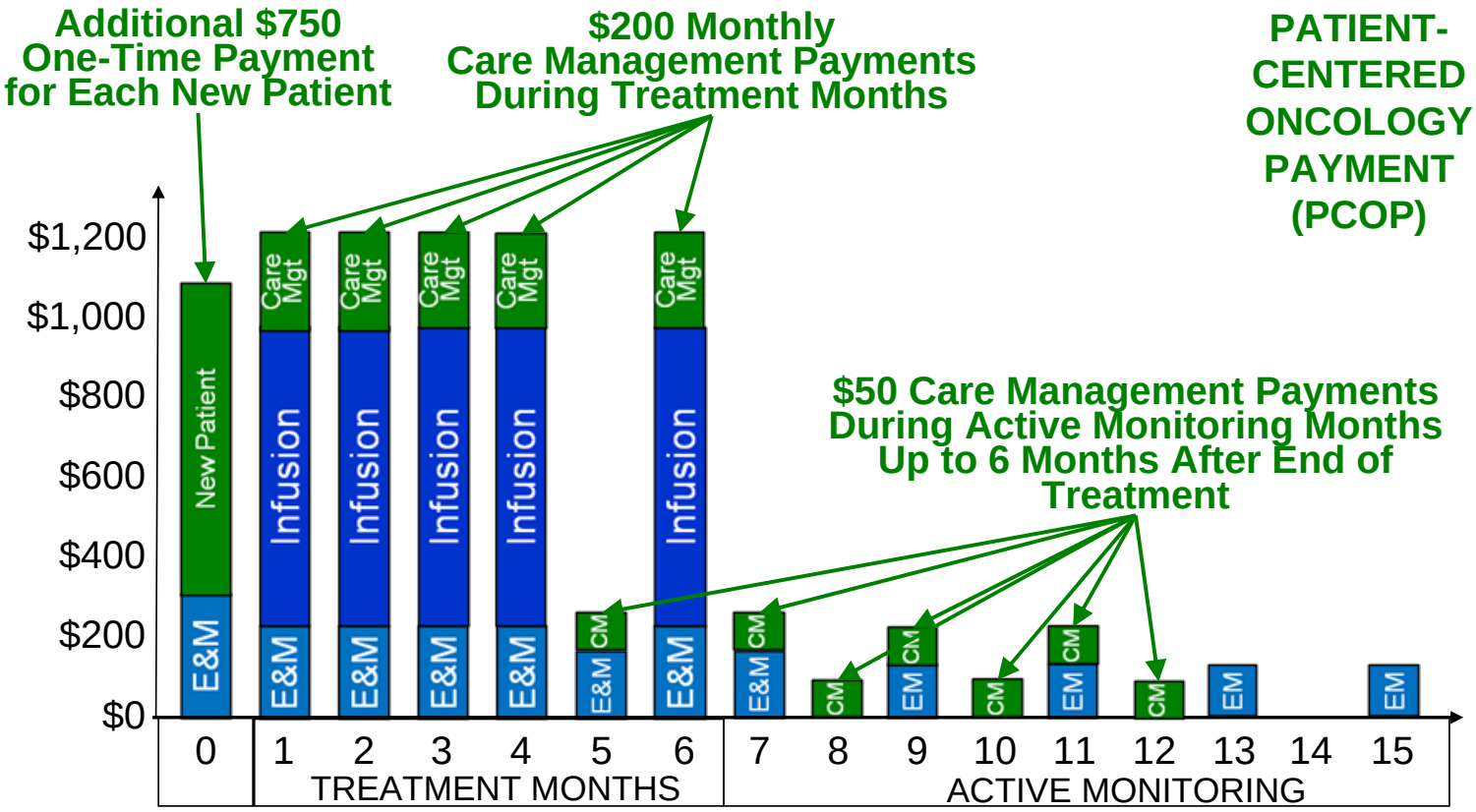
- **New Billing Code for Care Management During Active Monitoring**

The oncology practice would bill the payer for a $50 per month payment when an oncology patient was not receiving anti-cancer treatment but was being actively monitored by the practice. This would include any months in which treatment was not received before a treatment regimen was completed and up to six months after the completion of treatment.

- **Continuation of Current Billing Codes for Services**

The practice would continue to bill the payer for all existing CPT and HCPCS codes (e.g., E&M services, infusions, drugs administered in the practice, etc.)

~$2,100/patient more from PCOP; 50% Increase from FFS Today



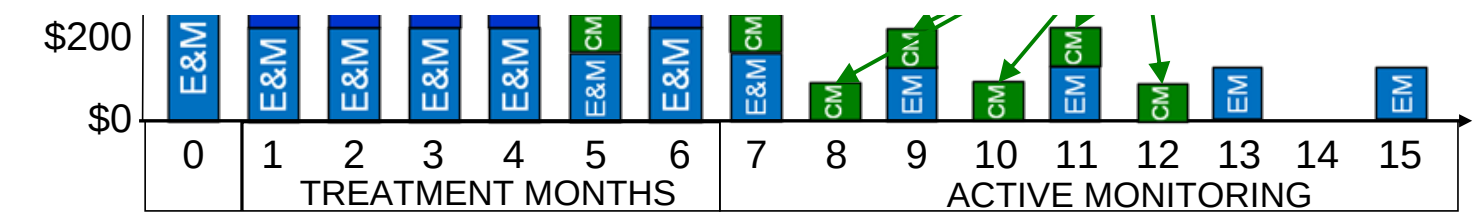
~$2,100/patient more from PCOP; 50% Increase from FFS Today

Additional $750 One-Time Payment for Each New Patient

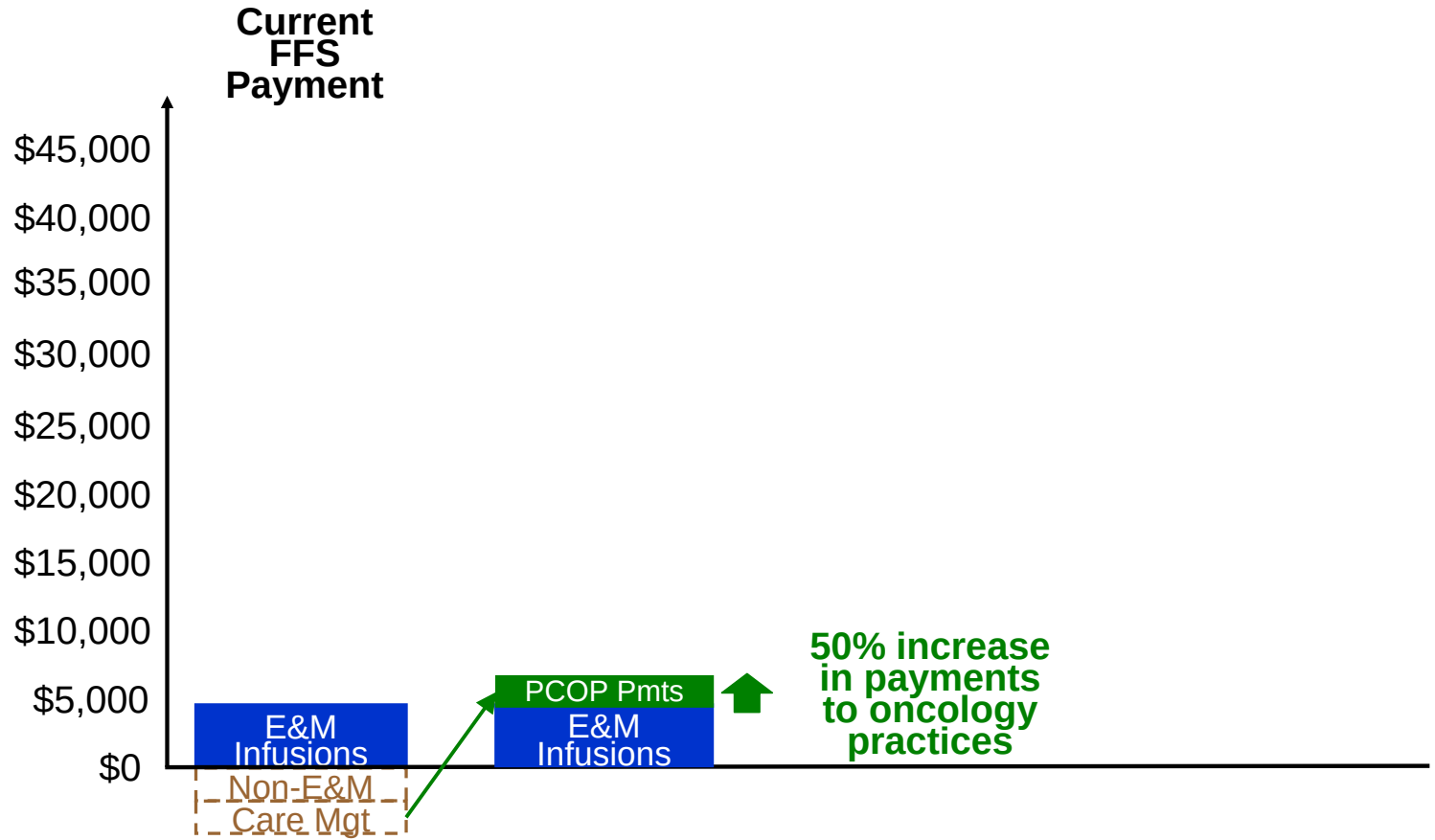
$200 Monthly Care Management Payments During Treatment Months

PATIENT-CENTERED ONCOLOGY T

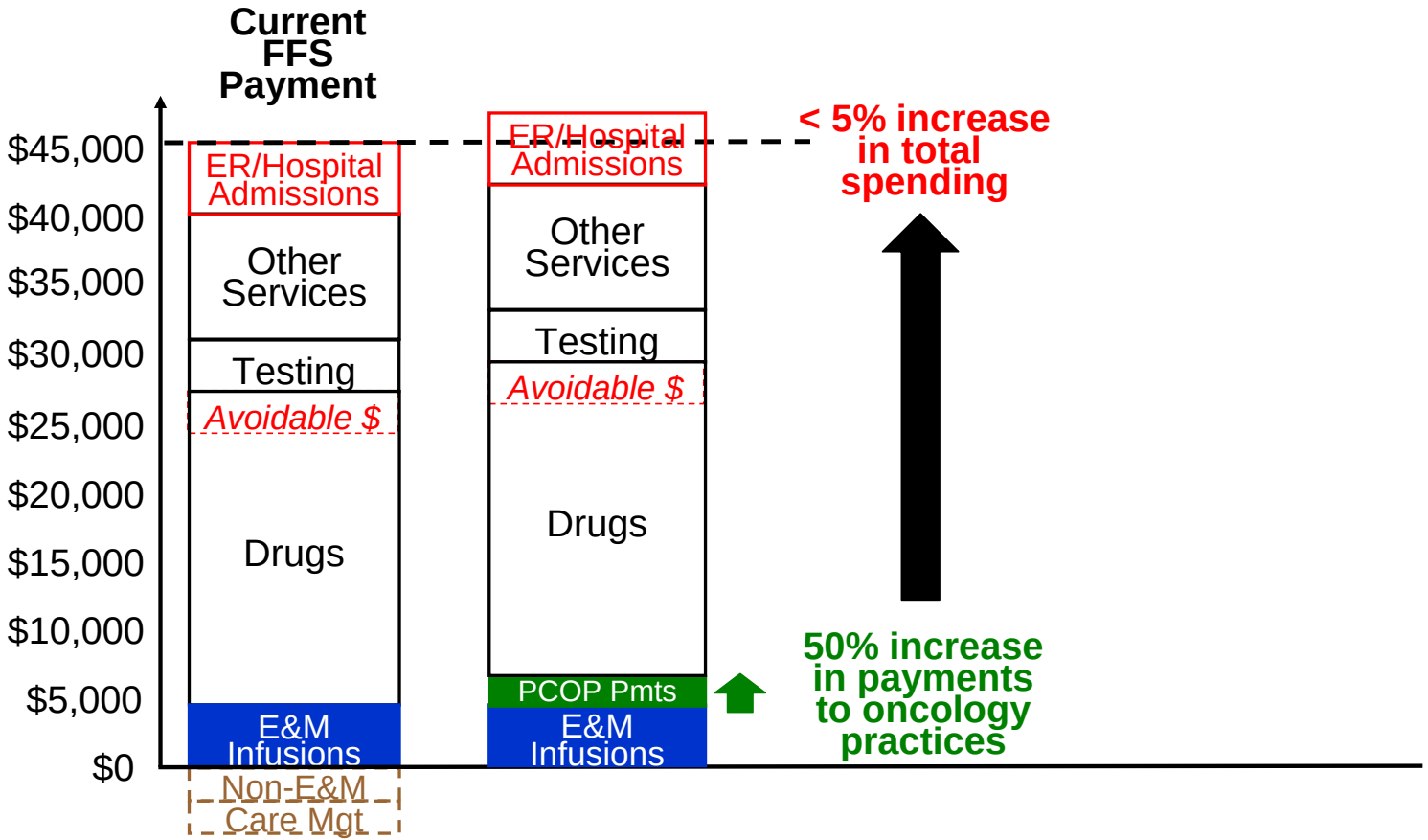
HOW CAN WE AFFORD TO INCREASE PAYMENTS TO ONCOLOGISTS BY 50%??



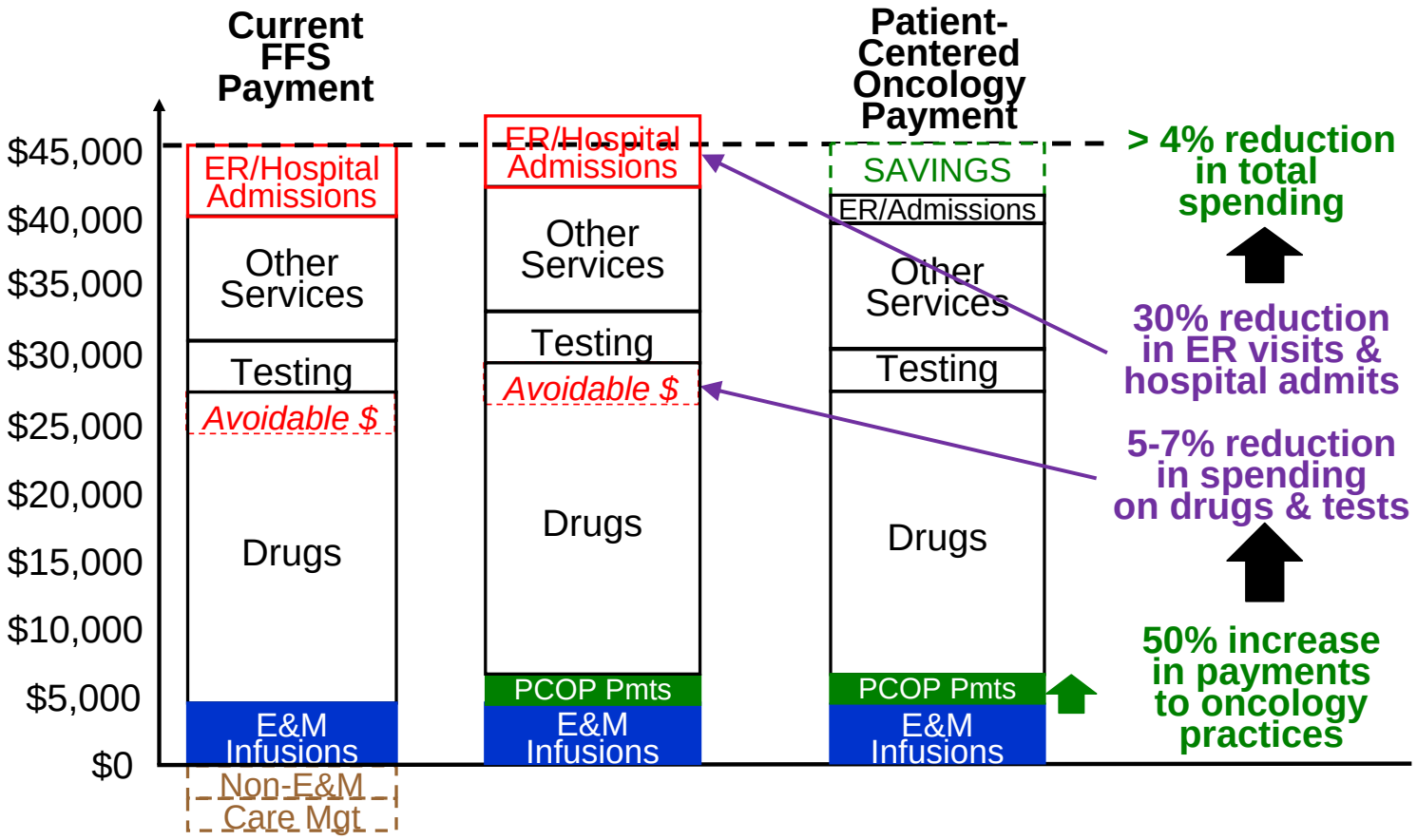
Large Increase for *Practices…*



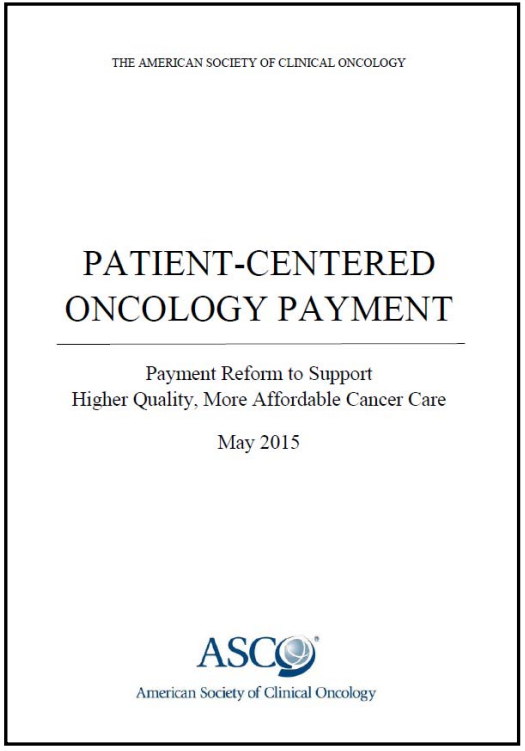
Large Increase for *Practices* is a Small Increase in *Total* Spending



Reductions in Avoidable Spending Will More Than Offset New Pmts



Analysis of PCOP Shows Large Net Savings from Better Payment



www.asco.org/paymentreform

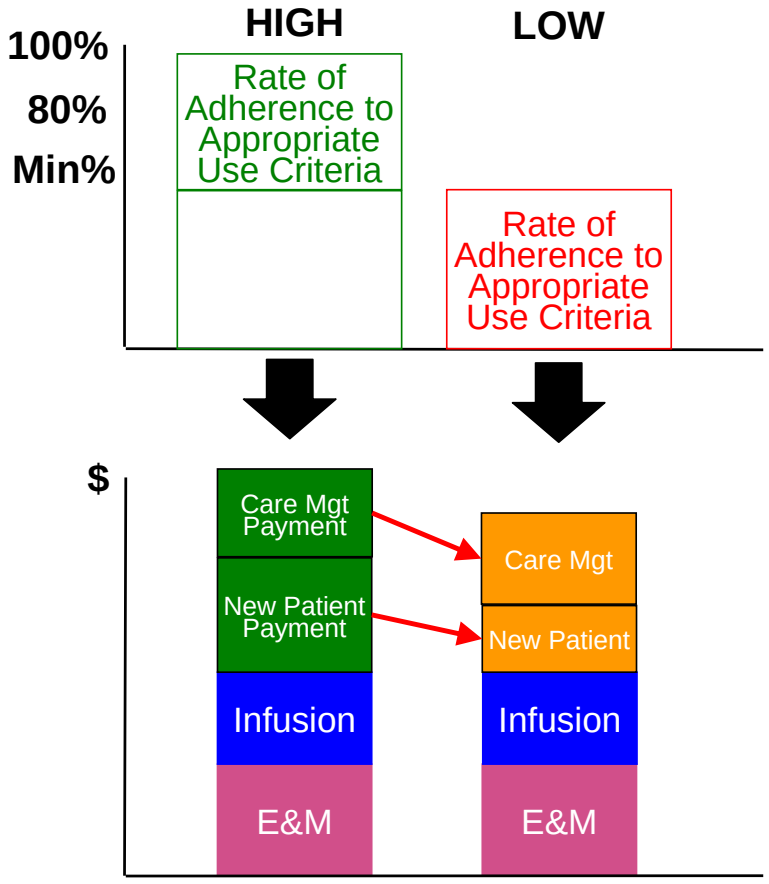
Costs and Savings from Patient-Centered Oncology Payment

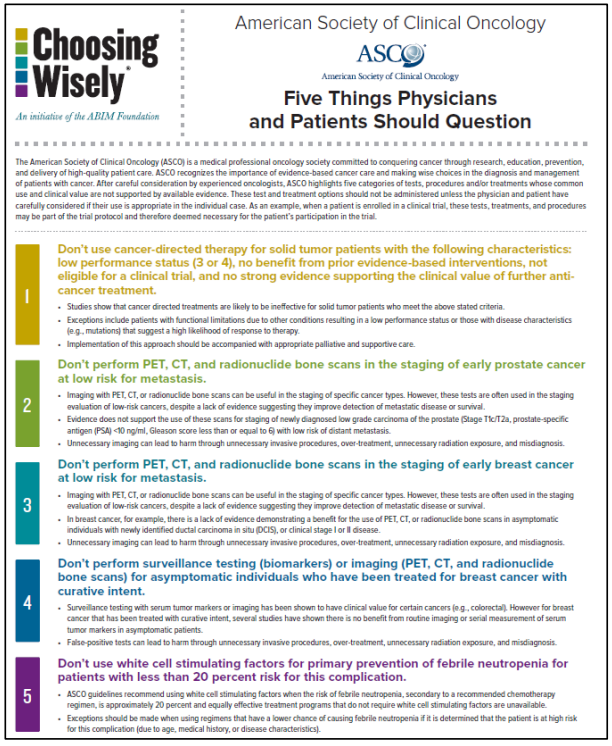
	Current Average Spending Per Beneficiary	With Proposed New Payments and Estimated Savings	% Change
Month Prior to Treatment			
E&M Services	$296	$296	
PCOP		$750	
During and 2 Months After Treatment			
E&M Services	$2,071	$2,071	
Infusion Services	$1,904	$1,904	
PCOP		$1,190	
Chemotherapy/Drugs	$25,131	$23,372	-7%
Lab Tests	$583	$553	-5%
Imaging	$1,503	$1,428	-5%
ED/Ambulance	$421	$295	-30%
Inpatient	$7,100	$4,970	-30%
Other	$10,920	$10,920	0%
Months 3-6 After Treatment			
E&M Services	$120	$120	
PCOP		$220	
Total	**$50,048**	**$48,089**	**-3.9%**

For 500 New Patients:	
Additional Practice Revenues	$1,080,000
Net Payer Savings	$979,802

How Does the Payer Know the Oncology Practice Will Reduce Avoidable Spending?

Low Adherence to Appropriate Use Criteria → Lower Payments





Choosing Wisely
An initiative of the ABIM Foundation

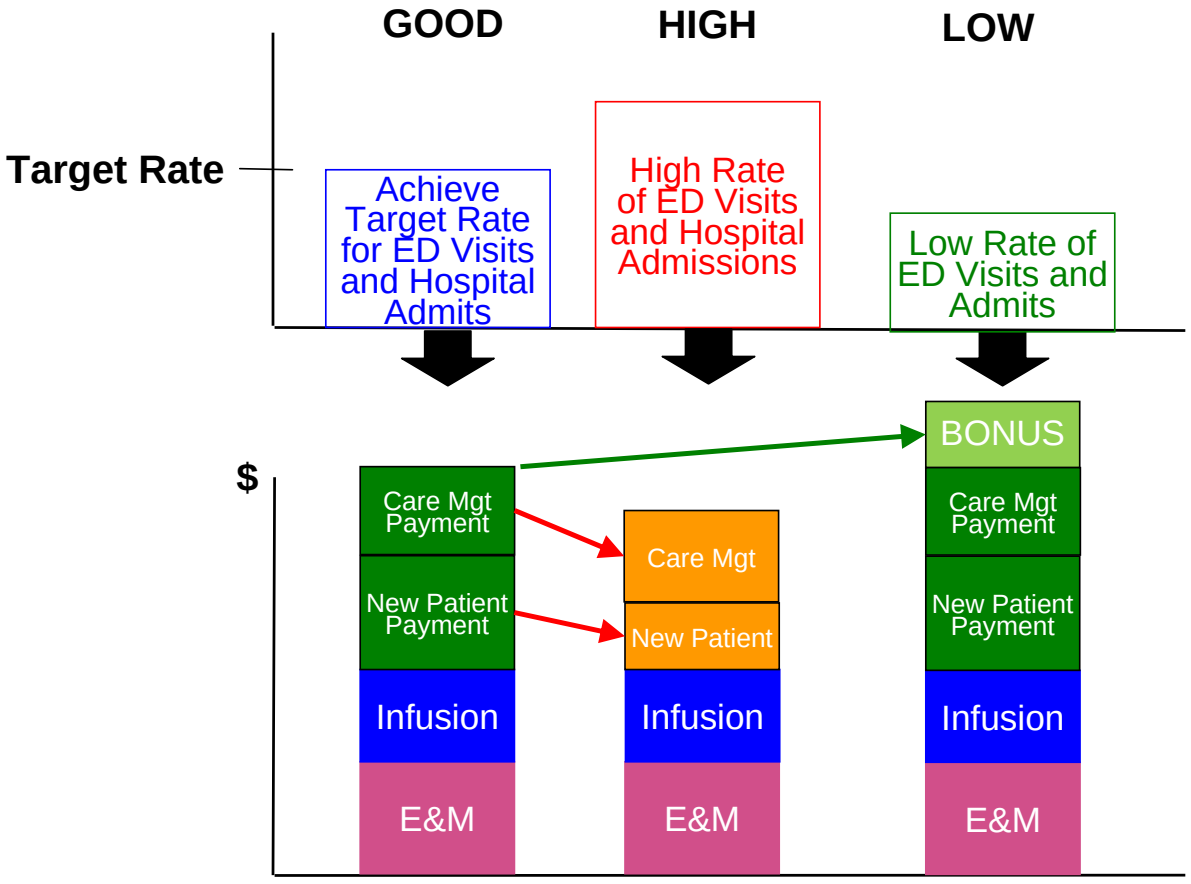
American Society of Clinical Oncology
ASCO
American Society of Clinical Oncology

Five Things Physicians and Patients Should Question

The American Society of Clinical Oncology (ASCO) is a medical professional oncology society committed to conquering cancer through research, education, prevention, and delivery of high-quality patient care. ASCO recognizes the importance of evidence-based cancer care and making wise choices in the diagnosis and management of patients with cancer. After careful consideration by experienced oncologists, ASCO highlights five categories of tests, procedures and/or treatments whose common use and clinical value are not supported by available evidence. These test and treatment options should not be administered unless the physician and patient have carefully considered if their use is appropriate in the individual case. As an example, when a patient is enrolled in a clinical trial, these tests, treatments, and procedures may be part of the trial protocol and therefore deemed necessary for the patient's participation in the trial.

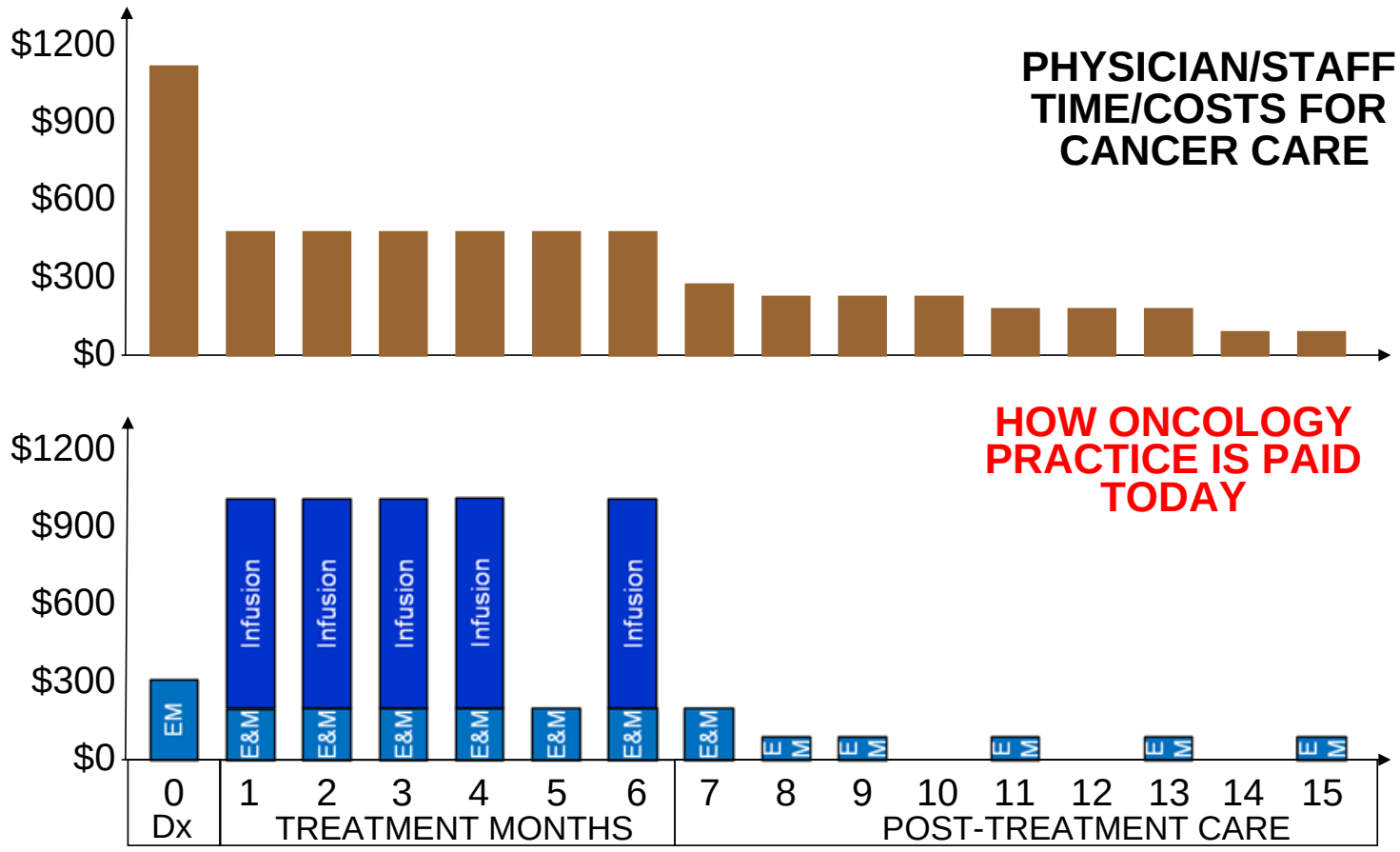
1. **Don't use cancer-directed therapy for solid tumor patients with the following characteristics: low performance status (3 or 4), no benefit from prior evidence-based interventions, not eligible for a clinical trial, and no strong evidence supporting the clinical value of further anti-cancer treatment.**
   - Studies show that cancer directed treatments are likely to be ineffective for solid tumor patients who meet the above stated criteria.
   - Exceptions include patients with functional limitations due to other conditions resulting in a low performance status or those with disease characteristics (e.g., mutations) that suggest a high likelihood of response to therapy.
   - Implementation of this approach should be accompanied with appropriate palliative and supportive care.
2. **Don't perform PET, CT, and radionuclide bone scans in the staging of early prostate cancer at low risk for metastasis.**
   - Imaging with PET, CT, or radionuclide bone scans can be useful in the staging of specific cancer types. However, these tests are often used in the staging evaluation of low-risk cancers, despite a lack of evidence suggesting they improve detection of metastatic disease or survival.
   - Evidence does not support the use of these scans for staging of newly diagnosed low grade carcinoma of the prostate (Stage T1c/T2a, prostate-specific antigen (PSA) <10 ng/ml, Gleason score less than or equal to 6) with low risk of distant metastasis.
   - Unnecessary imaging can lead to harm through unnecessary invasive procedures, over-treatment, unnecessary radiation exposure, and misdiagnosis.
3. **Don't perform PET, CT, and radionuclide bone scans in the staging of early breast cancer at low risk for metastasis.**
   - Imaging with PET, CT, or radionuclide bone scans can be useful in the staging of specific cancer types. However, these tests are often used in the staging evaluation of low-risk cancers, despite a lack of evidence suggesting they improve detection of metastatic disease or survival.
   - In breast cancer, for example, there is a lack of evidence demonstrating a benefit for the use of PET, CT, or radionuclide bone scans in asymptomatic individuals with newly identified ductal carcinoma in situ (DCIS), or clinical stage I or II disease.
   - Unnecessary imaging can lead to harm through unnecessary invasive procedures, over-treatment, unnecessary radiation exposure, and misdiagnosis.
4. **Don't perform surveillance testing (biomarkers) or imaging (PET, CT, and radionuclide bone scans) for asymptomatic individuals who have been treated for breast cancer with curative intent.**
   - Surveillance testing with serum tumor markers or imaging has been shown to have clinical value for certain cancers (e.g., colorectal). However for breast cancer that has been treated with curative intent, several studies have shown there is no benefit from routine imaging or serial measurement of serum tumor markers in asymptomatic patients.
   - False-positive tests can lead to harm through unnecessary invasive procedures, over-treatment, unnecessary radiation exposure, and misdiagnosis.
5. **Don't use white cell stimulating factors for primary prevention of febrile neutropenia for patients with less than 20 percent risk for this complication.**
   - ASCO guidelines recommend using white cell stimulating factors when the risk of febrile neutropenia, secondary to a recommended chemotherapy regimen, is approximately 20 percent and equally effective treatment programs that do not require white cell stimulating factors are unavailable.
   - Exceptions should be made when using regimens that have a lower chance of causing febrile neutropenia if it is determined that the patient is at high risk for this complication (due to age, medical history, or disease characteristics).

Adjustment to Payment Based on ED/Hospital Use

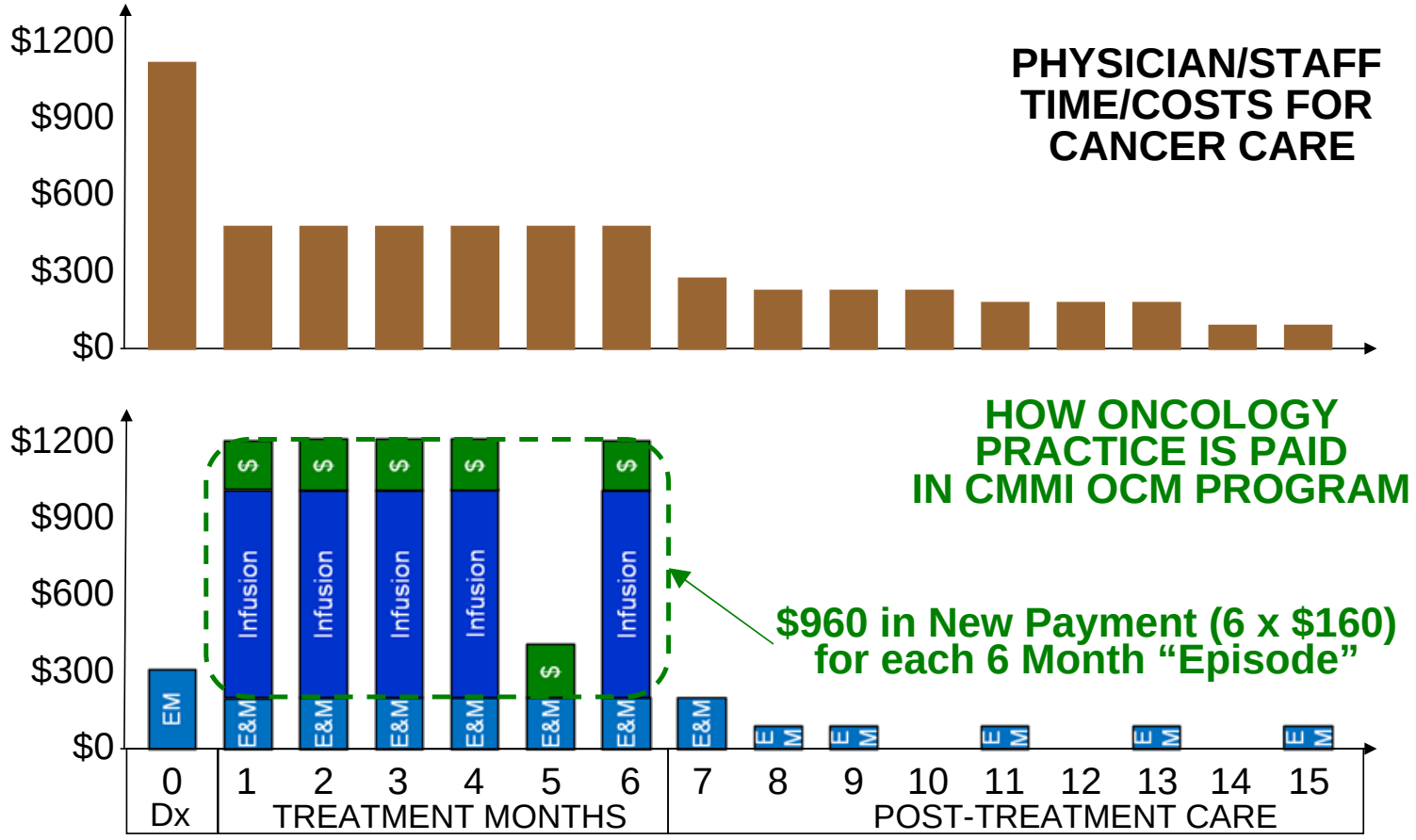


How Is Medicare Proposing to Improve Oncology Payment?

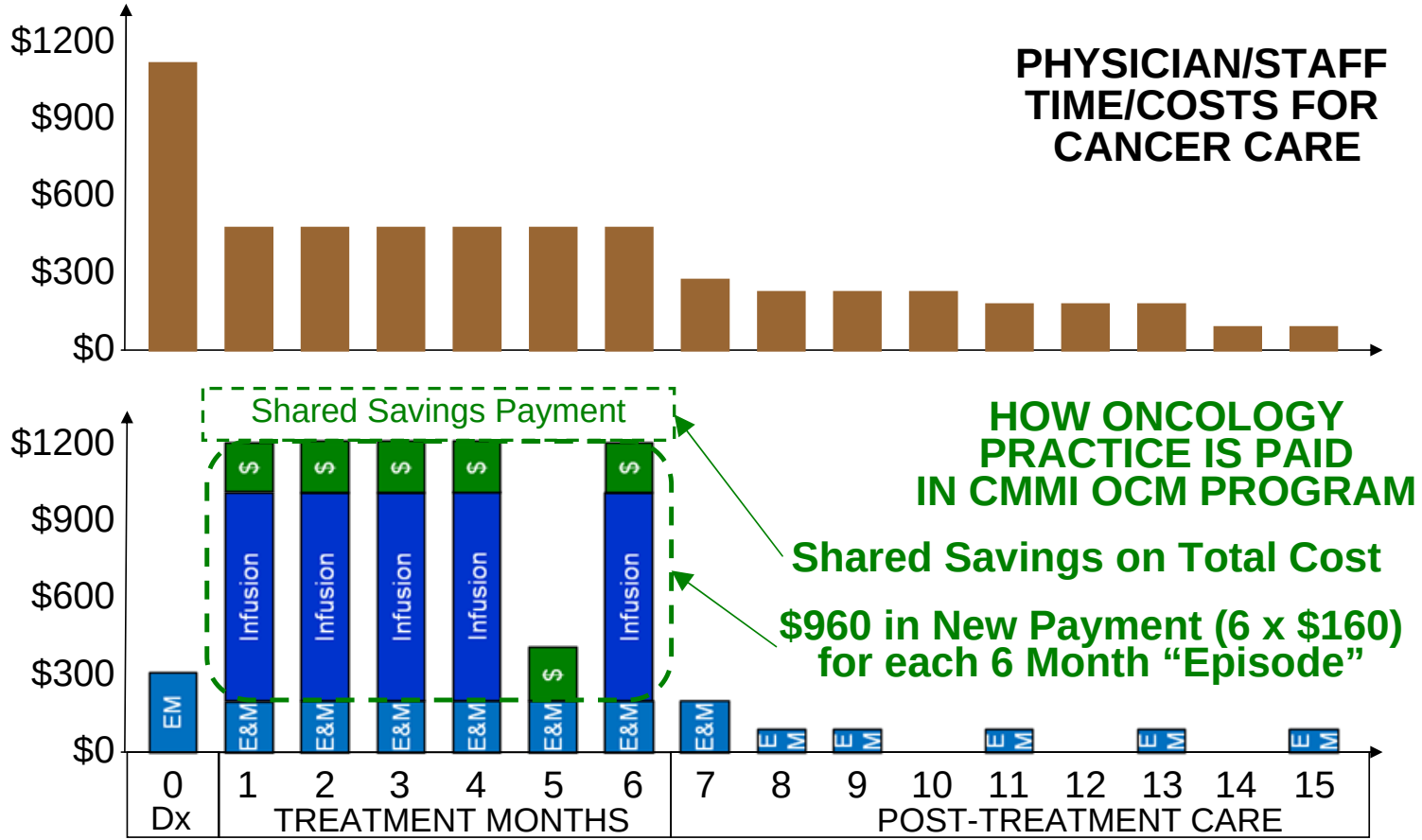
Starting with the Current Gap in Payments…



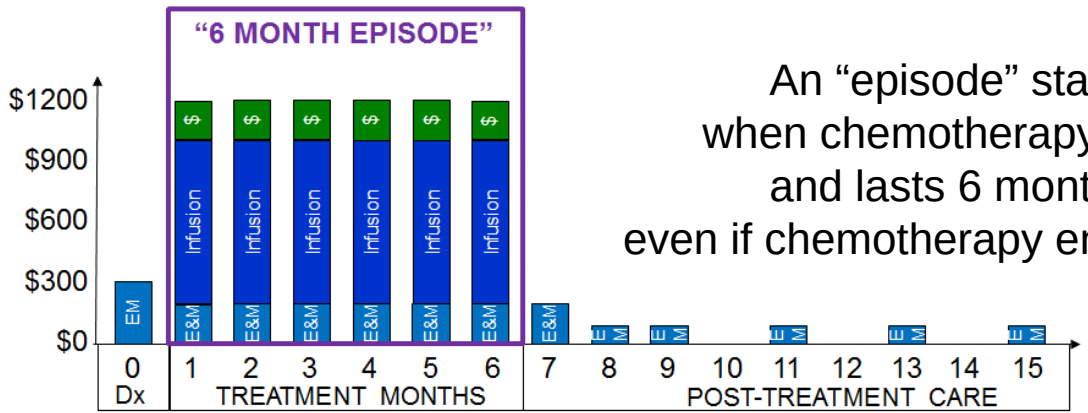
OCM: More $ During Treatment ..



OCM: More $ During Treatment + Shared Savings on Total Spending

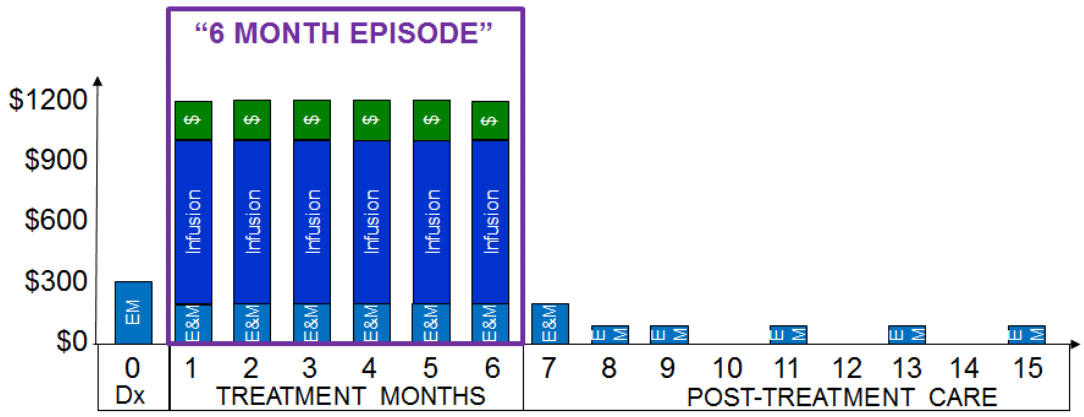


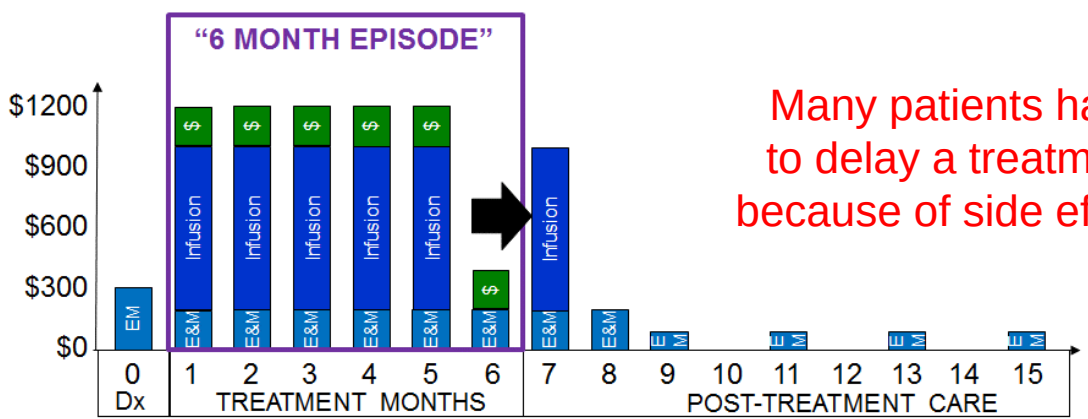
Extra Payments Are Made for *Fixed* 6 Month Episodes



An "episode" starts
when chemotherapy starts
and lasts 6 months
even if chemotherapy ends sooner

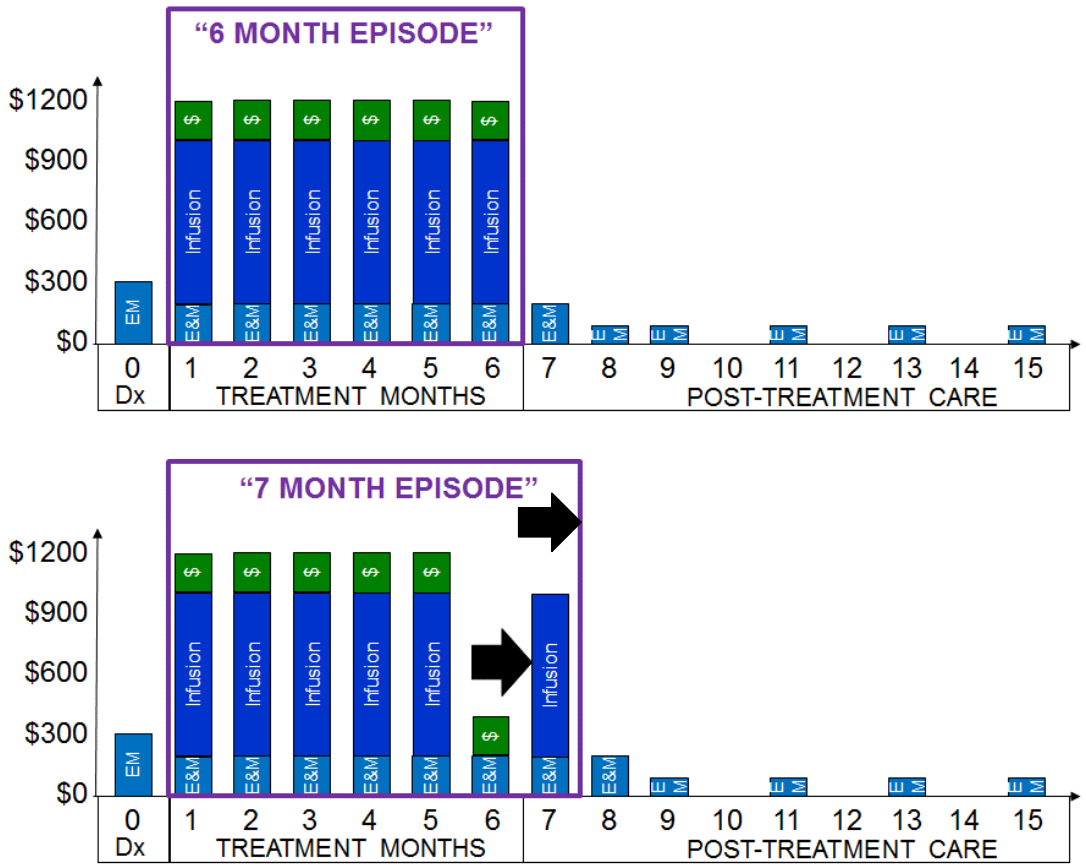
What Happens If One of the Patient's Treatments is Delayed?



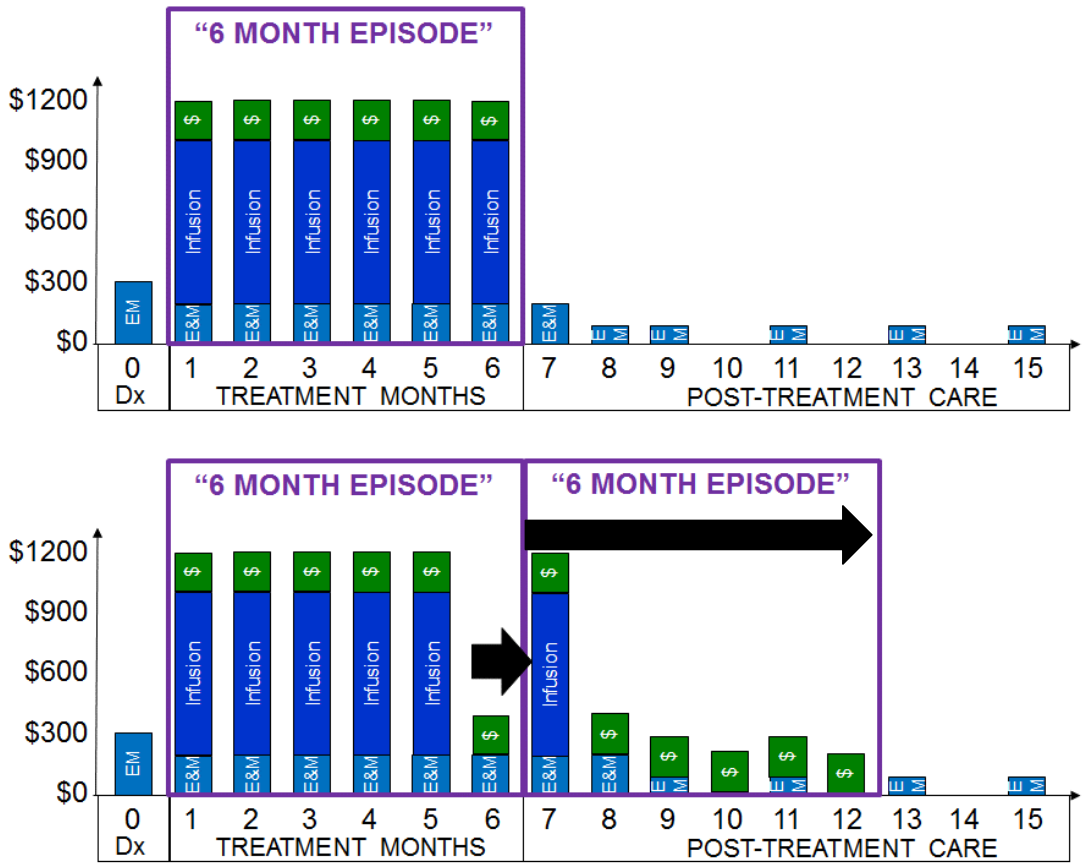


Many patients have to delay a treatment because of side effects

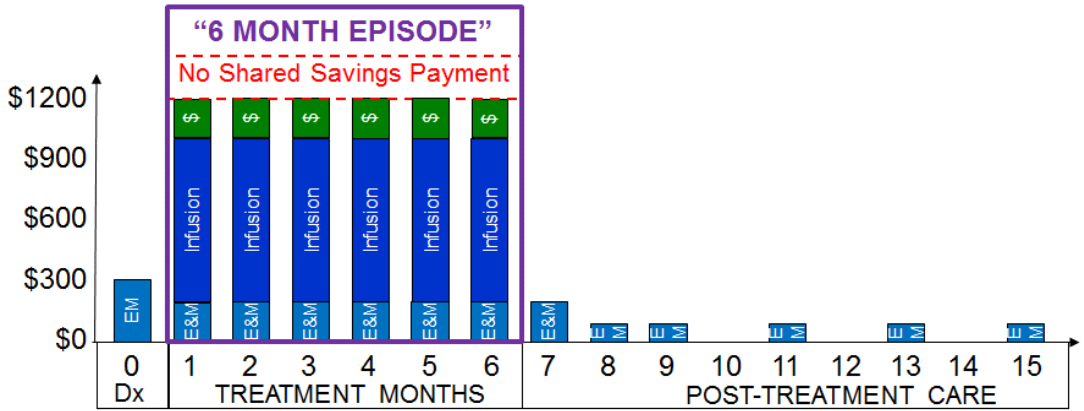
Logic Would Say That It's Now a Longer (7 Month) Episode

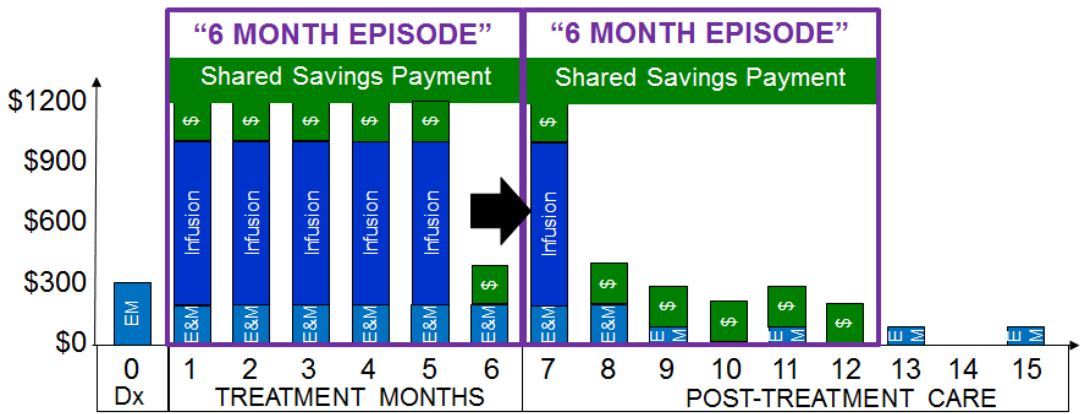


But CMMI Says It's a *New Episode* With $960 More in Payments

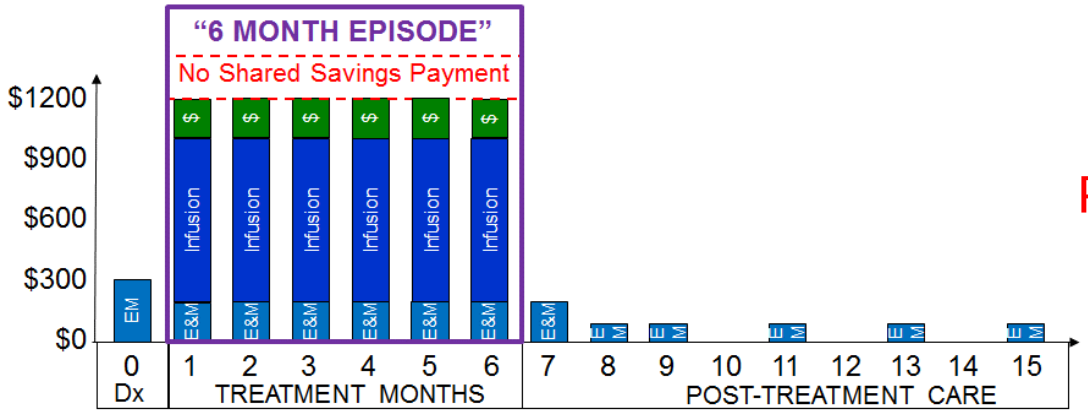


And Shared Savings Is More Likely With Same Spending in 2 Episodes

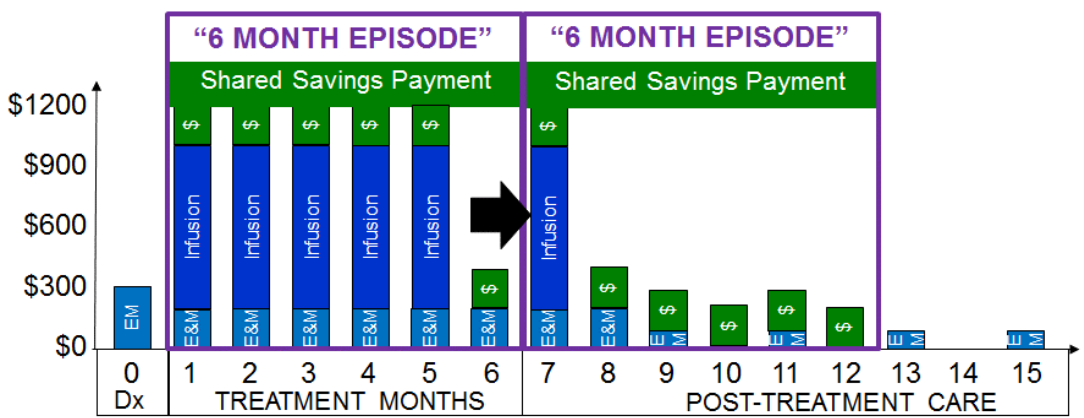




Undesirable New Incentives for Oncology Practices



Penalty for Helping Patients Avoid Side Effects?



Incentive to Stretch Out Treatment?

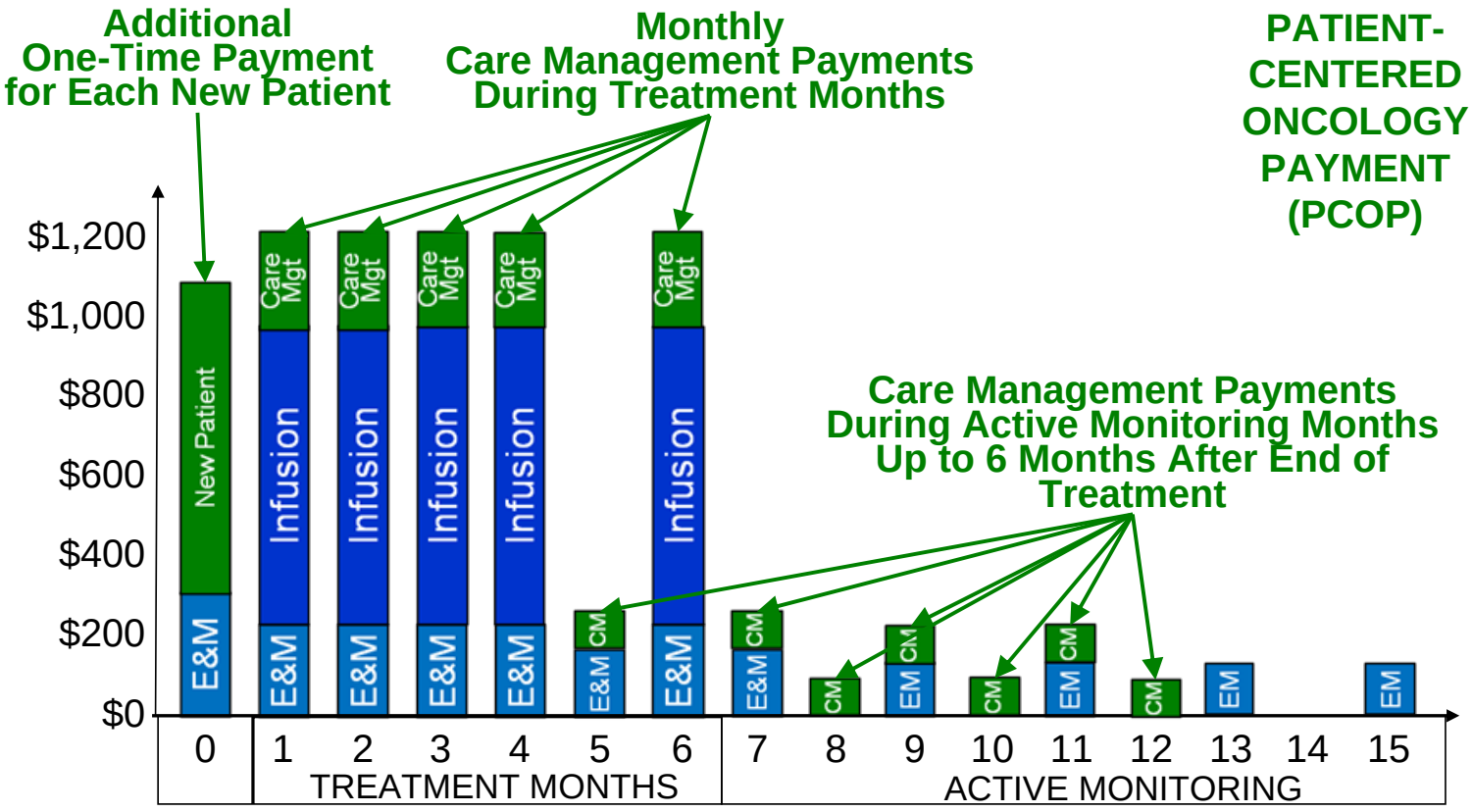
Bottom Line on the CMMI "Oncology Care Model"

- What's Good: $160/month extra payment for practices

Bottom Line on the CMMI "Oncology Care Model"

- What's Good: $160/month extra payment for practices
- What's Bad:
  - Burdensome requirements for service delivery and quality measures
  - Could encourage delaying treatments in order to receive more PMPM payments & shared savings
  - Could encourage stinting on care to achieve shared savings
  - Oncology practice is accountable for all spending on their patients, even for health problems unrelated to cancer
  - Target spending level is based on historical spending for the practice's own patients, so it rewards practices that are currently overusing and managing patient care poorly
  - Effectiveness of methodology for adjusting spending targets to deal with new drugs, new evidence about effectiveness of treatments, etc. is not known.

Basic PCOP Model Improves But Does Not Replace Current FFS



New Fee Codes Easy to Implement But Preserve a Complex System

50+ Current Billing Codes

99211 Established Patient Office Visit – Level 1
99212 Established Patient Office Visit – Level 2
99213 Established Patient Office Visit – Level 3
99214 Established Patient Office Visit – Level 4
99215 Established Patient Office Visit – Level 5
99231 Subsequent Hospital Care – Level 1
99232 Subsequent Hospital Care – Level 2
99233 Subsequent Hospital Care – Level 3
96401 Subcutaneous chemotherapy administration
96402 Subcutaneous chemotherapy administration
96405 Intralesional chemotherapy administration
96406 Intralesional chemotherapy administration
96409 Push chemotherapy administration
96411 Push chemotherapy administration
96413 Infusion chemotherapy administration
96415 Infusion chemotherapy administration
96416 Infusion chemotherapy administration
96417 Infusion chemotherapy administration
96420 Intra-arterial push chemotherapy
96422 Intra-arterial infusion chemotherapy
96423 Intra-arterial infusion chemotherapy
96425 Intra-arterial infusion chemotherapy
96440 Pleural cavity chemotherapy
96446 Peritoneal cavity chemotherapy
96450 CNS chemotherapy
96521 Refilling and maintenance of portable pump
96522 Refilling and maintenance of implantable pump
96523 Irrigation of implanted venous access device
96542 Chemotherapy injection via subcutaneous reservoir
96549 Unlisted chemotherapy procedure
79005 Oral radiopharmaceutical therapy
79101 Radiopharmaceutical infusion
79200 Radiopharmaceutical intracavitary administration
79300 Radiopharmaceutical therapy
79403 Radiopharmaceutical therapy infusion
96365 Intravenous infusion, non-chemotherapy
96366 Intravenous infusion, non-chemotherapy
96367 Intravenous infusion, non-chemotherapy
96368 Intravenous infusion, non-chemotherapy
96369 Subcutaneous infusion, non-chemotherapy
96370 Subcutaneous infusion, non-chemotherapy
96371 Subcutaneous infusion, non-chemotherapy
96372 Injection, non-chemotherapy
96373 Intra-arterial injection, non-chemotherapy
96374 Intravenous push, non-chemotherapy
96375 Intravenous push, non-chemotherapy
96376 Intravenous push, non-chemotherapy
96379 Unlisted injection or infusion, non-chemotherapy
96360 Intravenous infusion, hydration
96361 Intravenous infusion, hydration

+

+ 4 New Codes

1. New Patient Treatment Planning
2. Care Management During Treatment
3. Care Management During Active Monitoring
4. Participation in Clinical Trials

PCOP Option A: Consolidate Existing & New Codes

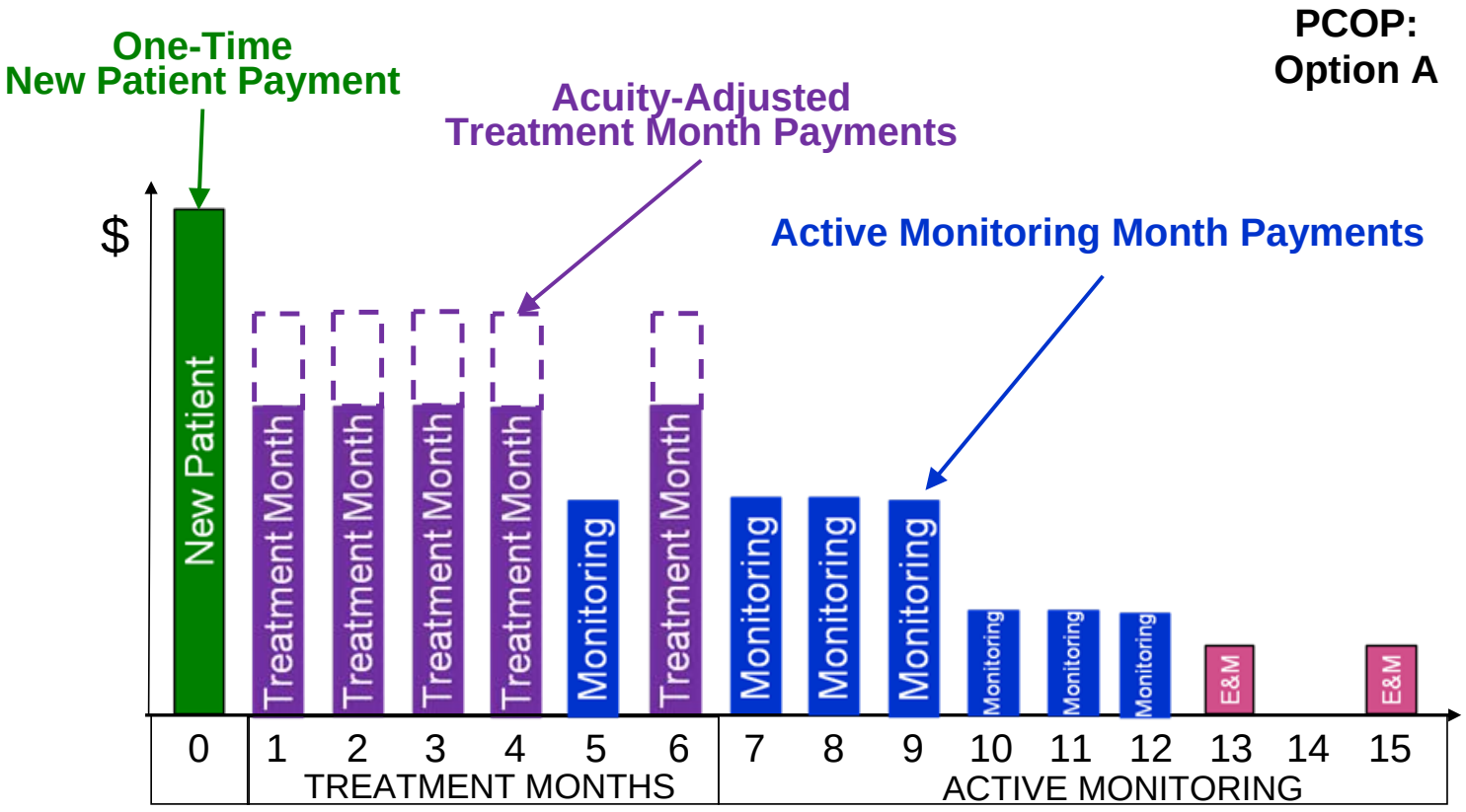
50+ Current Billing Codes

99211 Established Patient Office Visit – Level 1
99212 Established Patient Office Visit – Level 2
99213 Established Patient Office Visit – Level 3
99214 Established Patient Office Visit – Level 4
99215 Established Patient Office Visit – Level 5
99231 Subsequent Hospital Care – Level 1
99232 Subsequent Hospital Care – Level 2
99233 Subsequent Hospital Care – Level 3
96401 Subcutaneous chemotherapy administration
96402 Subcutaneous chemotherapy administration
96405 Intralesional chemotherapy administration
96406 Intralesional chemotherapy administration
96409 Push chemotherapy administration
96411 Push chemotherapy administration
96413 Infusion chemotherapy administration
96415 Infusion chemotherapy administration
96416 Infusion chemotherapy administration
96417 Infusion chemotherapy administration
96420 Intra-arterial push chemotherapy
96422 Intra-arterial infusion chemotherapy
96423 Intra-arterial infusion chemotherapy
96425 Intra-arterial infusion chemotherapy
96440 Pleural cavity chemotherapy
96446 Peritoneal cavity chemotherapy
96450 CNS chemotherapy
96521 Refilling and maintenance of portable pump
96522 Refilling and maintenance of implantable pump
96523 Irrigation of implanted venous access device
96542 Chemotherapy injection via subcutaneous reservoir
96549 Unlisted chemotherapy procedure
79005 Oral radiopharmaceutical therapy
79101 Radiopharmaceutical infusion
79200 Radiopharmaceutical intracavitary administration
79300 Radiopharmaceutical therapy
79403 Radiopharmaceutical therapy infusion
96365 Intravenous infusion, non-chemotherapy
96366 Intravenous infusion, non-chemotherapy
96367 Intravenous infusion, non-chemotherapy
96368 Intravenous infusion, non-chemotherapy
96369 Subcutaneous infusion, non-chemotherapy
96370 Subcutaneous infusion, non-chemotherapy
96371 Subcutaneous infusion, non-chemotherapy
96372 Injection, non-chemotherapy
96373 Intra-arterial injection, non-chemotherapy
96374 Intravenous push, non-chemotherapy
96375 Intravenous push, non-chemotherapy
96376 Intravenous push, non-chemotherapy
96379 Unlisted injection or infusion, non-chemotherapy
96360 Intravenous infusion, hydration
96361 Intravenous infusion, hydration

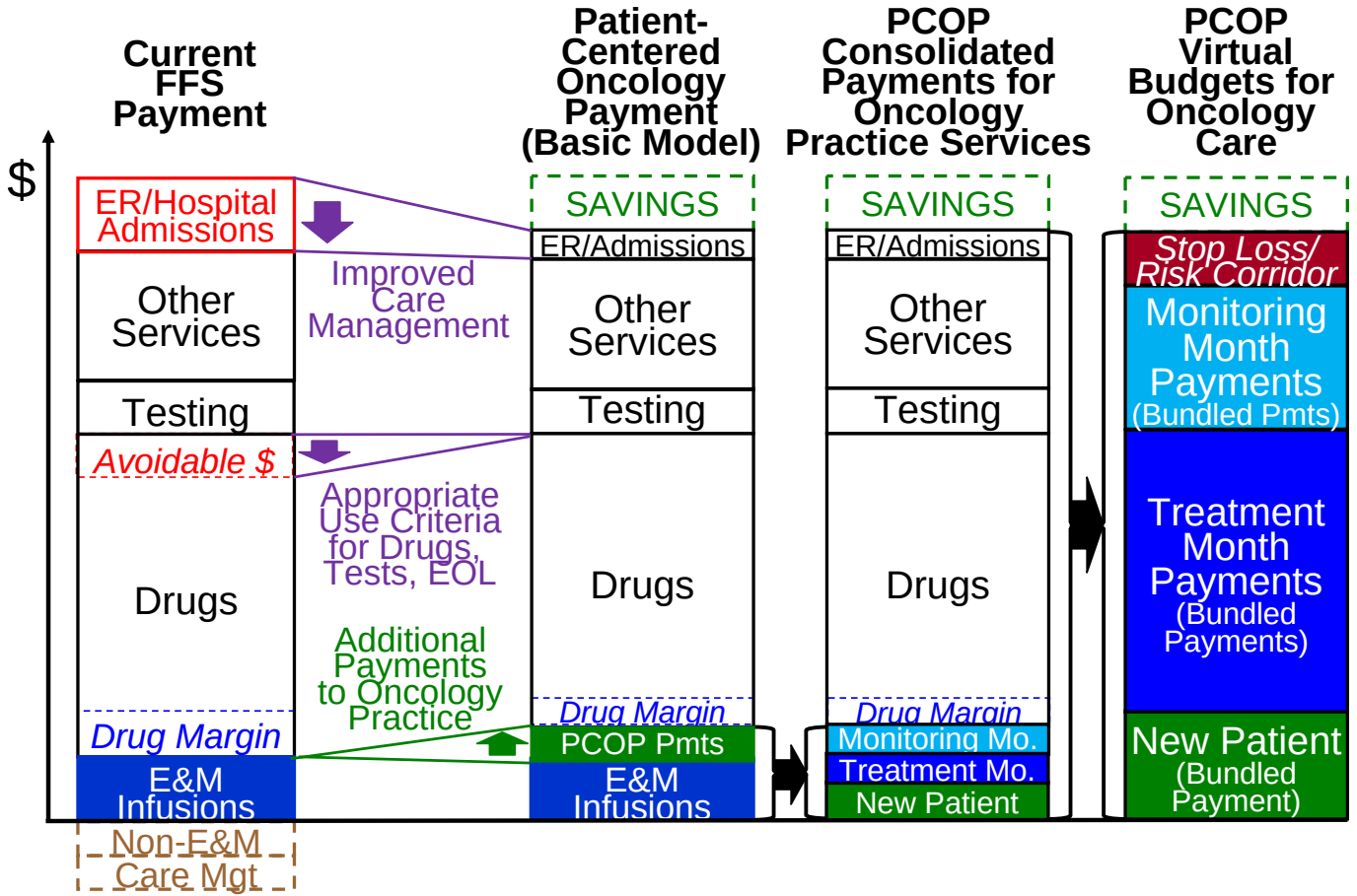
< 10 New Codes

- New Patient Payment
- Treatment Month (4-6 Levels)
- Patient characteristics
- Treatment characteristics
- Transitions
- Clinical Trials
- Active Monitoring Month (2 Levels)

PCOP Option A: Consolidated Payments Match Service Costs



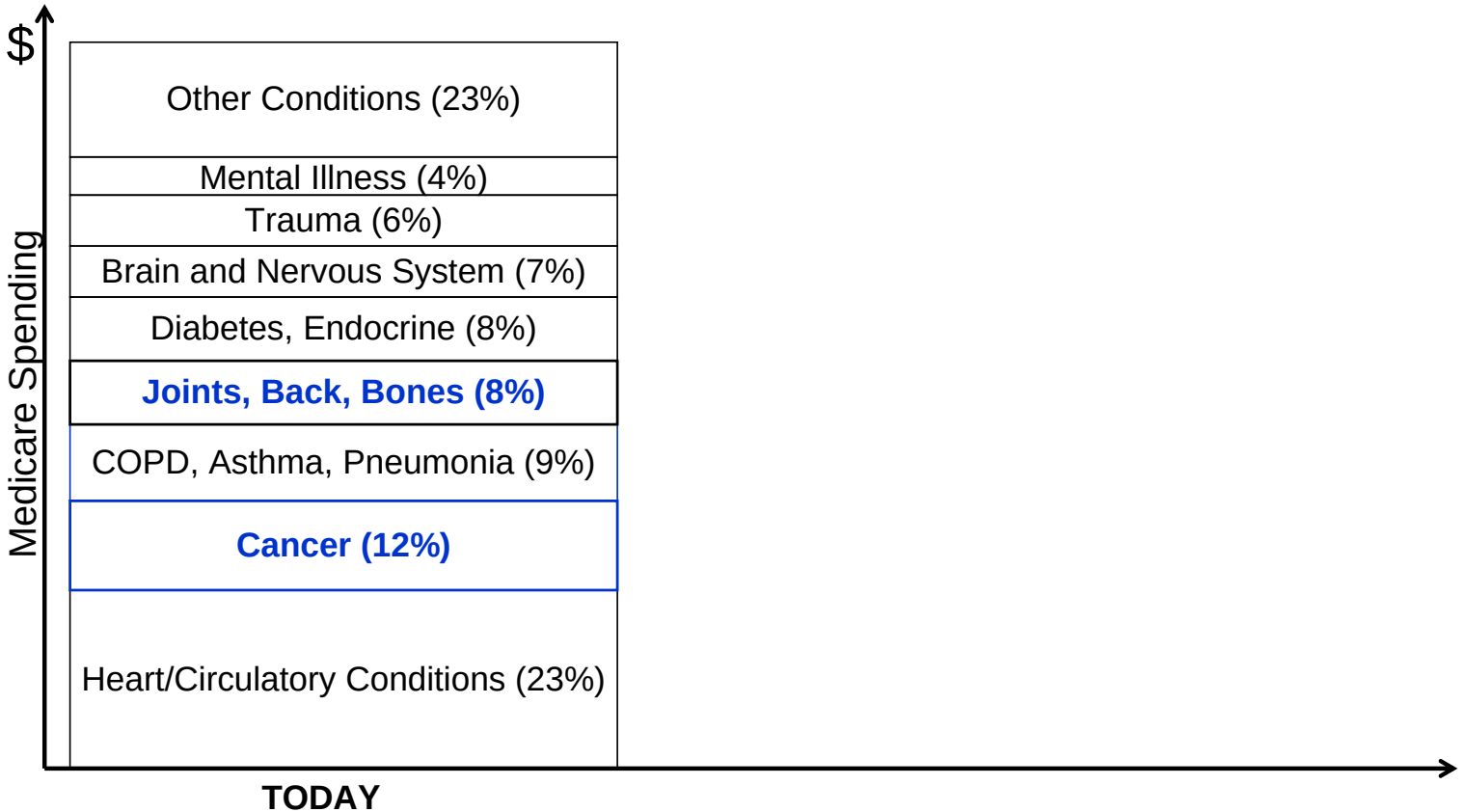
PCOP Option B: Bundled Monthly Budgets



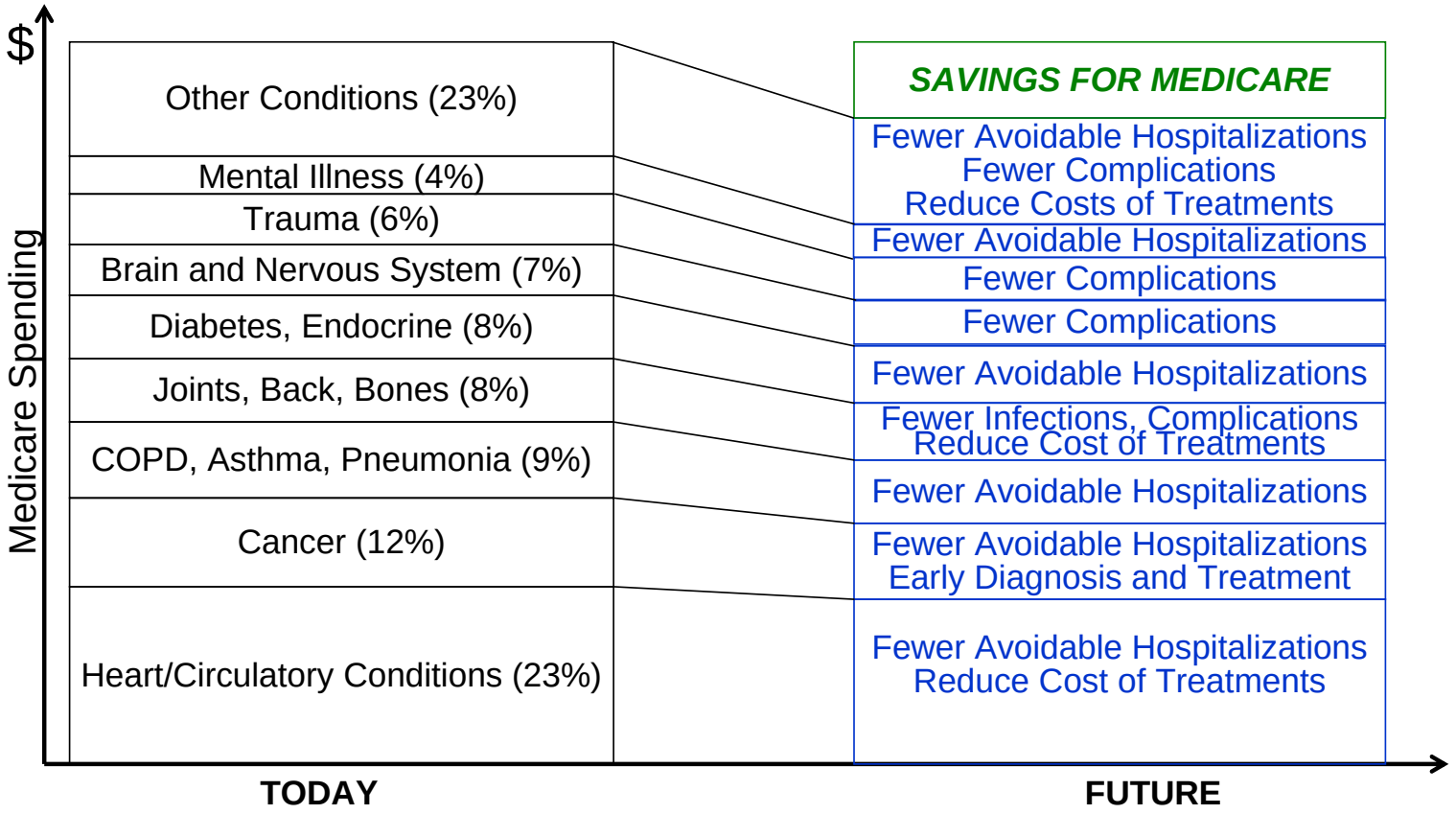
Hill Physicians Group
Oncology Case Rate (OCR) Model

- Monthly bundled payments cover oncology practice services to patients and cost of drugs administered
- No prior authorization for drugs included in bundled payments
- Risk-stratified into 9 types of cancer and 4 phases of treatment
- Stop-loss for unusually expensive patients
- Payment amount increased by up to 10% for performance on
  - ASCO QOPI measures
  - ED visits and hospital admissions/days
  - Patient experience
- Payment amounts adjusted to accommodate new treatments, new evidence, experience in redesigning care
- Succeeding in controlling the cost of cancer care

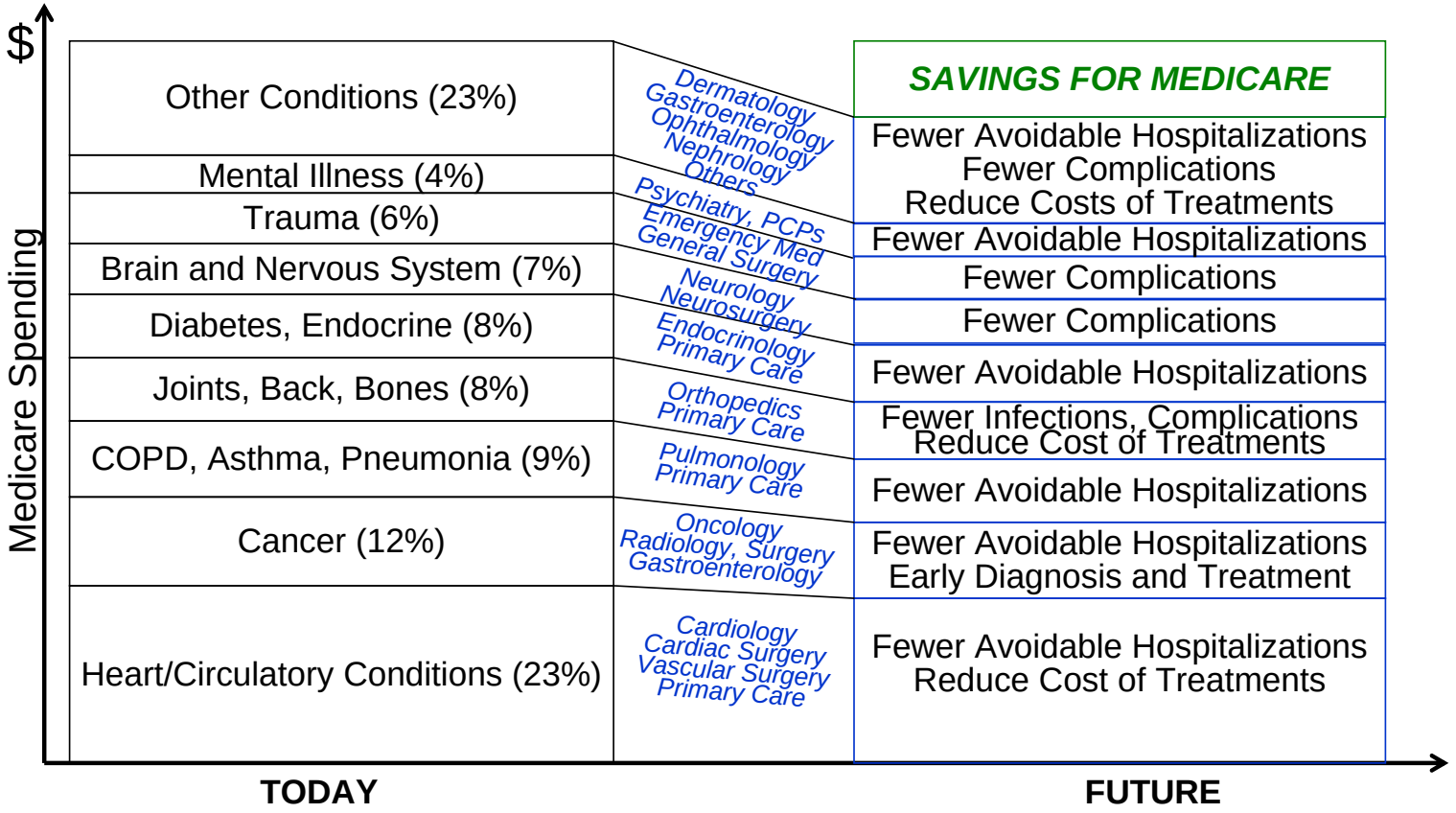
Arthritis and Cancer Are Just Two of Many Conditions Patients Have



Savings Needed for All Conditions In Order to Truly Impact Costs



All Specialties Need to Be Involved and Paid in Better Ways



The CMS Models Are NOT the Only Way to Define APMs

CMS APM Models

- Primary Care Medical Home
- Episode Payment to Hospital
- Upside-Only Shared Savings
- "Two-Sided Risk" Shared Savings
- Full-Risk Capitation

There are More & Better Ways to Create *Physician-Focused* APMs

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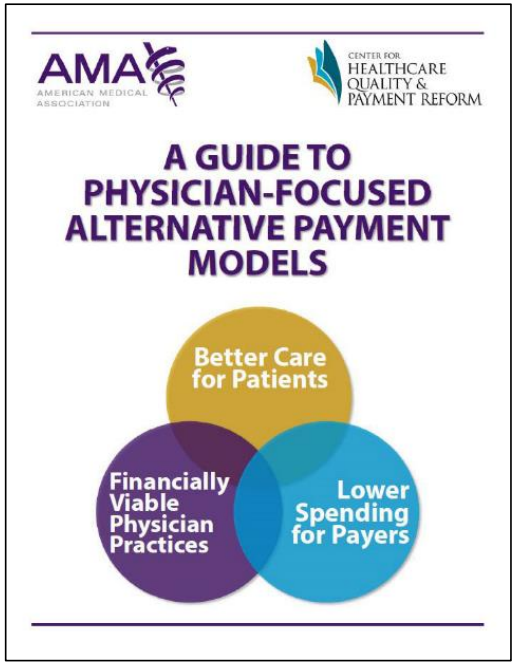


Primary Care Medical Home

Episode Payment to Hospital

Upside-Only Shared Savings

"Two-Sided Risk" Shared Savings

Full-Risk Capitation

APM #1: Payment for a High-Value Service

APM #2: Condition-Based Payment for a Physician's Services

APM #3: Multi-Physician Bundled Payment

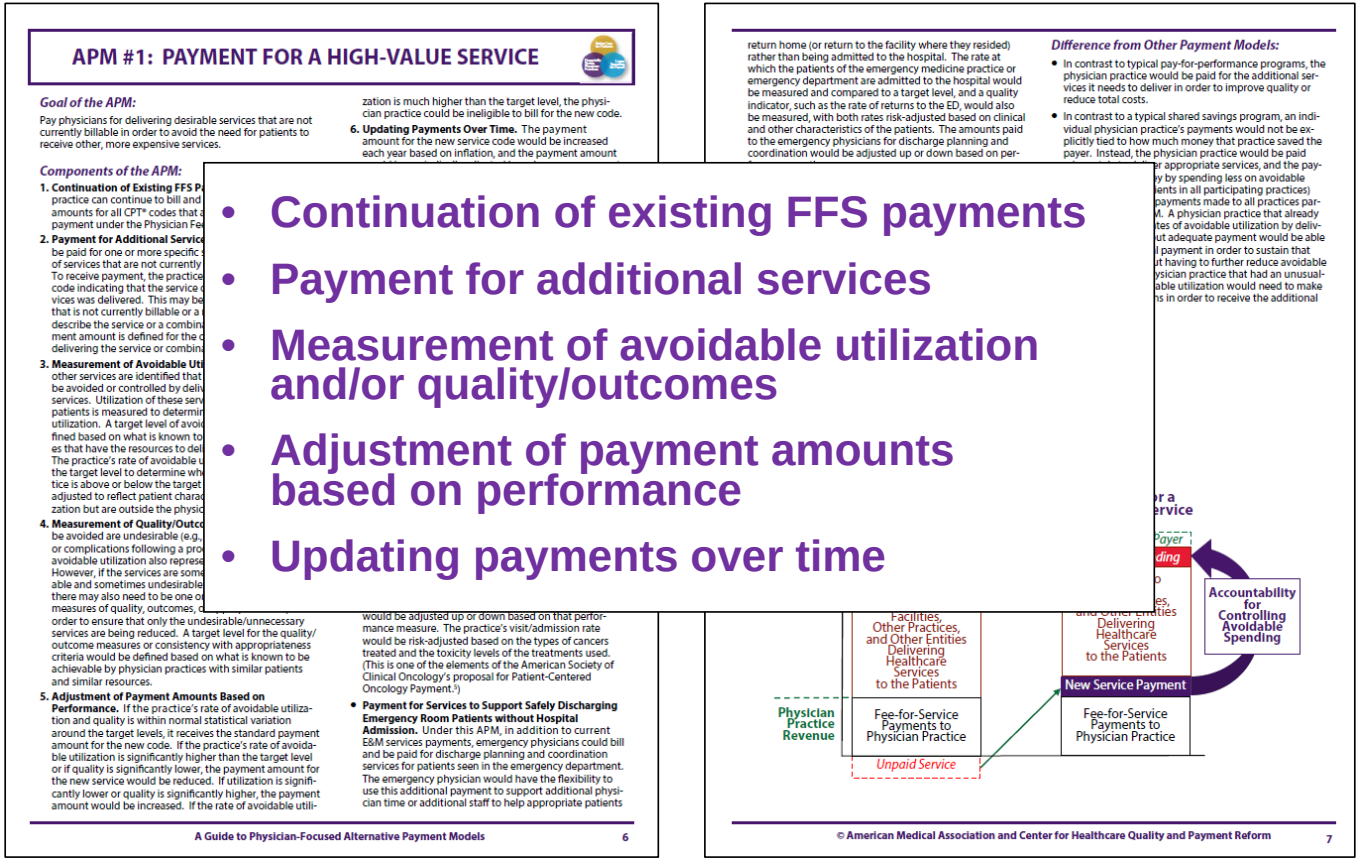
APM #4: Physician-Facility Procedure Bundle

APM #5: Warrantied Payment for Physician Services

APM #6: Episode Payment for a Procedure

APM #7: Condition-Based Payment

APM #1: Payment for a High-Value Service



APM #1: PAYMENT FOR A HIGH-VALUE SERVICE

Goal of the APM:

Pay physicians for delivering desirable services that are not currently billable in order to avoid the need for patients to receive other, more expensive services.

Components of the APM:

1. **Continuation of Existing FFS P** practice can continue to bill and amounts for all CPT® codes that payment under the Physician Fe
2. **Payment for Additional Servic** be paid for one or more specific of services that are not currently To receive payment, the practice code indicating that the service vices was delivered. This may be that is not currently billable or a describe the service or a combin ment amount is defined for the delivering the service or combin
3. **Measurement of Avoidable Uti** other services are identified that be avoided or controlled by deliv services. Utilization of these serv patients is measured to determi utilization. A target level of avoi fined based on what is known to es that have the resources to del The practice's rate of avoidable the target level to determine wh tice is above or below the target adjusted to reflect patient charac zation but are outside the physic
4. **Measurement of Quality/Outco** be avoided are undesirable (e.g., or complications following a pro avoidable utilization also repres However, if the services are som able and sometimes undesirable there may also need to be one o measures of quality, outcomes, order to ensure that only the undesirable/unnecessary services are being reduced. A target level for the quality/outcome measures or consistency with appropriateness criteria would be defined based on what is known to be achievable by physician practices with similar patients and similar resources.
5. **Adjustment of Payment Amounts Based on Performance.** If the practice's rate of avoidable utilization and quality is within normal statistical variation around the target levels, it receives the standard payment amount for the new code. If the practice's rate of avoidable utilization is significantly higher than the target level or if quality is significantly lower, the payment amount for the new service would be reduced. If utilization is significantly lower or quality is significantly higher, the payment amount would be increased. If the rate of avoidable utilization is much higher than the target level, the physician practice could be ineligible to bill for the new code.
6. **Updating Payments Over Time.** The payment amount for the new service code would be increased each year based on inflation, and the payment amount would be adjusted up or down based on that performance measure. The practice's visit/admission rate would be risk-adjusted based on the types of cancers treated and the toxicity levels of the treatments used. (This is one of the elements of the American Society of Clinical Oncology's proposal for Patient-Centered Oncology Payment.[1])

- **Payment for Services to Support Safely Discharging Emergency Room Patients without Hospital Admission.** Under this APM, in addition to current E&M services payments, emergency physicians could bill and be paid for discharge planning and coordination services for patients seen in the emergency department. The emergency physician would have the flexibility to use this additional payment to support additional physician time or additional staff to help appropriate patients return home (or return to the facility where they resided) rather than being admitted to the hospital. The rate at which the patients of the emergency medicine practice or emergency department are admitted to the hospital would be measured and compared to a target level, and a quality indicator, such as the rate of returns to the ED, would also be measured, with both rates risk-adjusted based on clinical and other characteristics of the patients. The amounts paid to the emergency physicians for discharge planning and coordination would be adjusted up or down based on per-

Difference from Other Payment Models:

- In contrast to typical pay-for-performance programs, the physician practice would be paid for the additional services it needs to deliver in order to improve quality or reduce total costs.
- In contrast to a typical shared savings program, an individual physician practice's payments would not be explicitly tied to how much money that practice saved the payer. Instead, the physician practice would be paid

A Guide to Physician-Focused Alternative Payment Models 6

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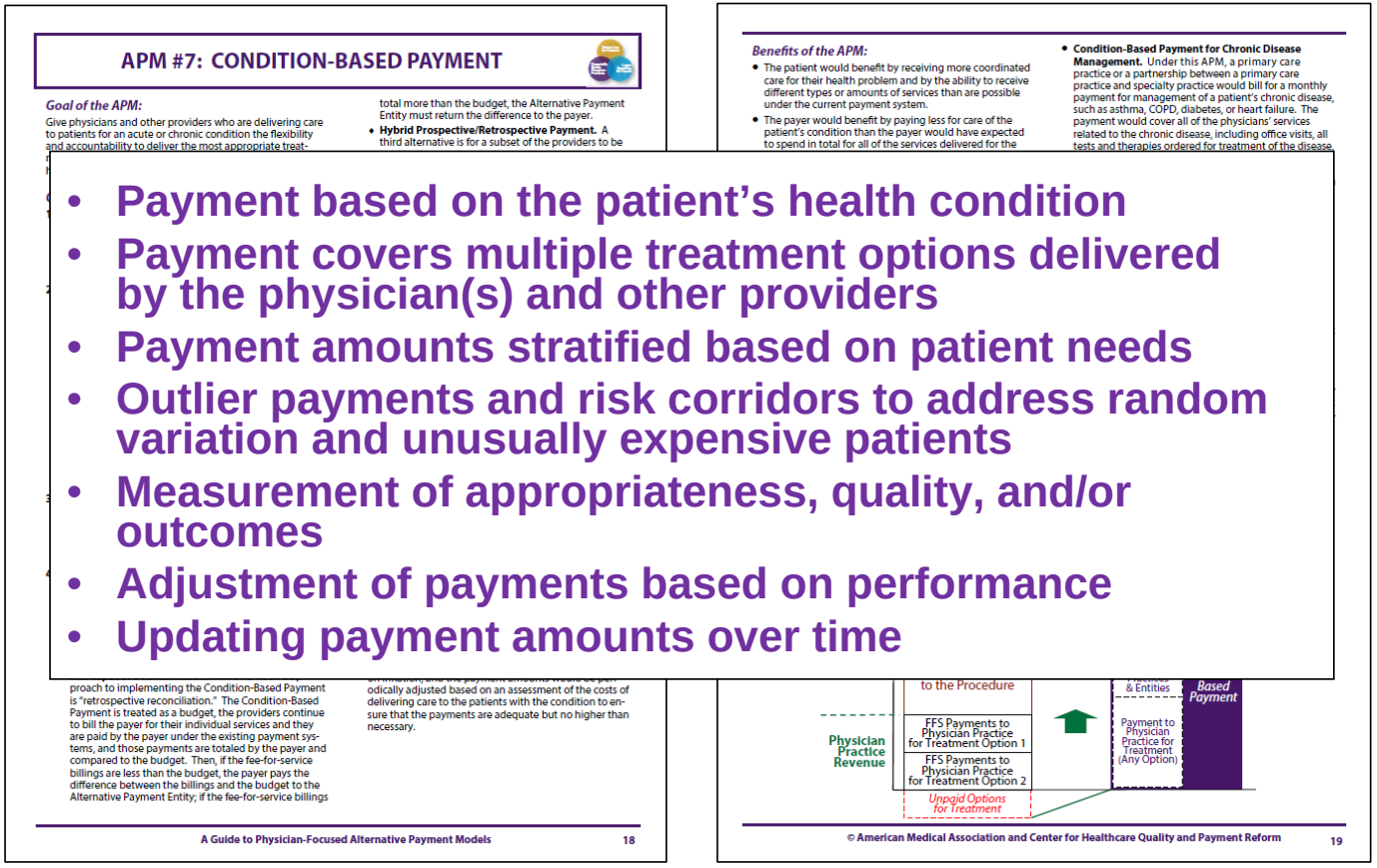
- **Continuation of existing FFS payments**
- **Payment for additional services**
- **Measurement of avoidable utilization and/or quality/outcomes**
- **Adjustment of payment amounts based on performance**
- **Updating payments over time**

APM #7: Condition-Based Payment



APM #7: CONDITION-BASED PAYMENT

Goal of the APM:

Give physicians and other providers who are delivering care to patients for an acute or chronic condition the flexibility and accountability to deliver the most appropriate treat-

total more than the budget, the Alternative Payment Entity must return the difference to the payer.

- **Hybrid Prospective/Retrospective Payment.** A third alternative is for a subset of the providers to be

proach to implementing the Condition-Based Payment is "retrospective reconciliation." The Condition-Based Payment is treated as a budget, the providers continue to bill the payer for their individual services and they are paid by the payer under the existing payment systems, and those payments are totaled by the payer and compared to the budget. Then, if the fee-for-service billings are less than the budget, the payer pays the difference between the billings and the budget to the Alternative Payment Entity; if the fee-for-service billings

odically adjusted based on an assessment of the costs of delivering care to the patients with the condition to ensure that the payments are adequate but no higher than necessary.

A Guide to Physician-Focused Alternative Payment Models 18

Benefits of the APM:

- The patient would benefit by receiving more coordinated care for their health problem and by the ability to receive different types or amounts of services than are possible under the current payment system.
- The payer would benefit by paying less for care of the patient's condition than the payer would have expected to spend in total for all of the services delivered for the

- **Condition-Based Payment for Chronic Disease Management.** Under this APM, a primary care practice or a partnership between a primary care practice and specialty practice would bill for a monthly payment for management of a patient's chronic disease, such as asthma, COPD, diabetes, or heart failure. The payment would cover all of the physicians' services related to the chronic disease, including office visits, all tests and therapies ordered for treatment of the disease

to the Procedure

& Entities

Based Payment

Physician Practice Revenue

FFS Payments to Physician Practice for Treatment Option 1

FFS Payments to Physician Practice for Treatment Option 2

Payment to Physician Practice for Treatment (Any Option)

Unpaid Options for Treatment

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- **Payment based on the patient's health condition**
- **Payment covers multiple treatment options delivered by the physician(s) and other providers**
- **Payment amounts stratified based on patient needs**
- **Outlier payments and risk corridors to address random variation and unusually expensive patients**
- **Measurement of appropriateness, quality, and/or outcomes**
- **Adjustment of payments based on performance**
- **Updating payment amounts over time**

Many Specialties Working on Alternative Payment Models

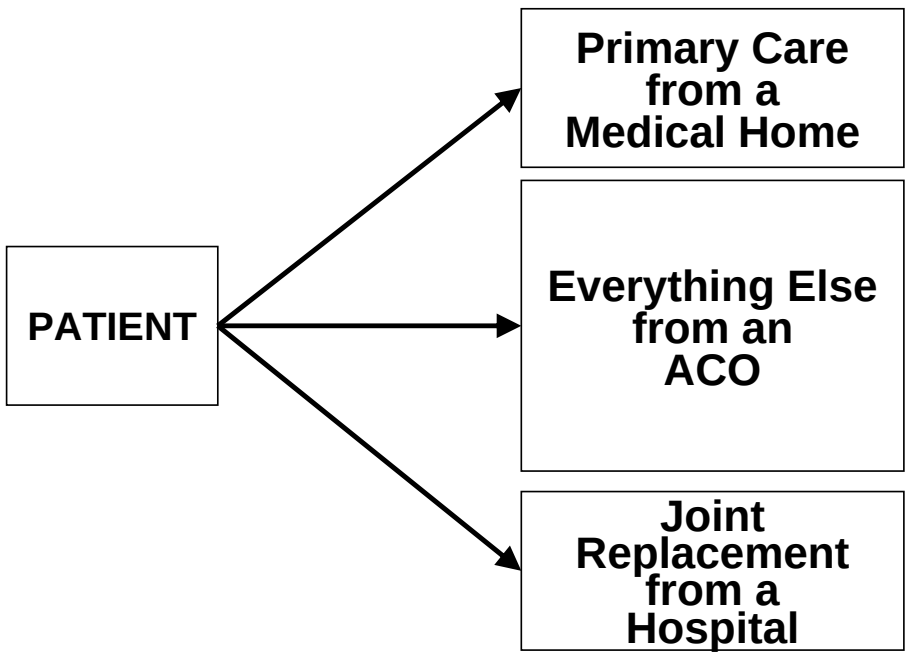
	Opportunities to Improve Care and Reduce Cost	Barriers in Current Payment System	Solutions via Accountable Payment Models
Cardiology	• Use less invasive procedures when appropriate • Reduce exacerbations of heart failure	• Payment is based on procedure is used, not the outcome • No payment for patient education & care mgt	• Condition-based payment for stable angina • Condition-based payment for HF
Orthopedic Surgery	• Reduce infections and complications of surgery • Use non-surgical care instead of surgery	• No support for shared decision-making • Lack of resources for good home-based care, patient education	• Bundled and warrantied payment for surgery • Condition-based payment for arthritis
Neurology	• Avoid unnecessary hospitalizations for epilepsy patients • Reduce strokes and heart attacks after TIA	• No flexibility to spend more on preventive care • No payment for patient education & care mgt	• Condition-based payment for epilepsy • Episode or condition-based payment for TIA
OB/GYN	• Reduce use of elective C-sections • Reduce early deliveries and use of NICU	• Similar/lower payment for vaginal deliveries	• Condition-based payment for total cost of delivery in low-risk pregnancy

Other Examples of Specialty-Specific Payment Models

	Opportunities to Improve Care and Reduce Cost	Barriers in Current Payment System	Solutions via Accountable Payment Models
Psychiatry	• Reduce ER visits and admissions for patients with depression and chronic disease	• No payment for phone consults with PCPs • No payment for RN care managers	• Joint condition-based payment to PCP and psychiatrist
Gastroenterology	• Reduce unnecessary colonoscopies and colon cancer • Reduce ER/admits for inflammatory bowel d.	• No flexibility to focus extra resources on highest-risk patients • No flexibility to spend more on care mgt	• Population-based payment for colon cancer screening • Condition-based pmt for IBD
Oncology	• Reduce ER visits and admissions for dehydration • Reduce overuse of tests and drugs	• No payment for care management services • Inadequate payment for diagnosis and treatment planning	• Payment for care management svcs • Accountability for hospital admissions & use of guidelines
Primary Care	• Reduce avoidable hospitalizations for chronic disease pts • Reduce unnecessary tests and referrals	• No payment for nurses to work with chronic disease patients • No payment for phone consults w/ specialists	• Monthly payments for chronic care management • Payments to support PCP-specialist partnerships

Instead of a Vision That Won't Work and Patients Don't Want…

What CMS's Vision Appears to Be



"Coordinated"
Low Quality
High-Priced
Health Care

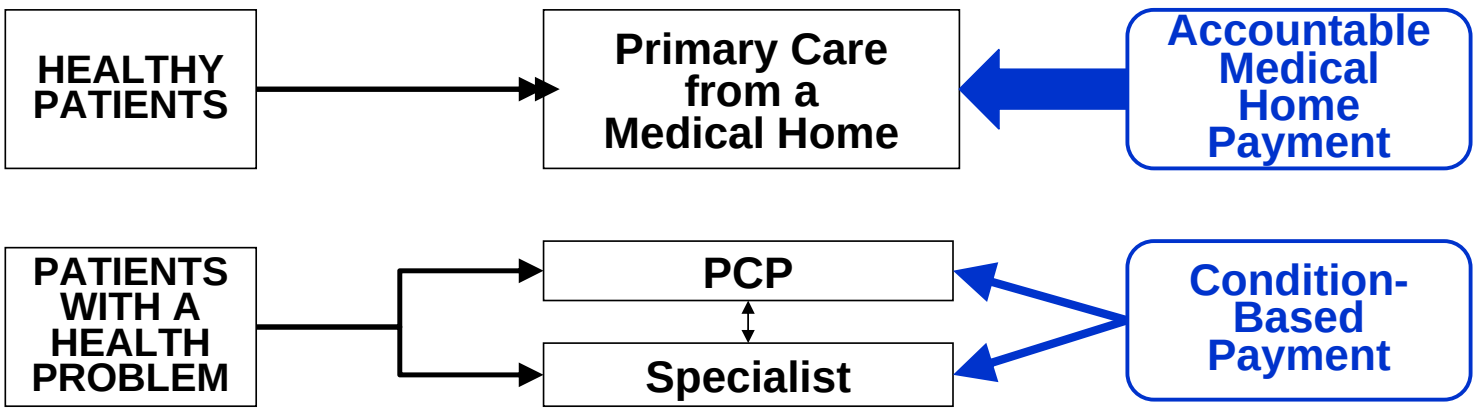
Pursue a Vision That Will Benefit Patients, Providers & Payers

Pursue a Vision That Will Benefit Patients, Providers & Payers

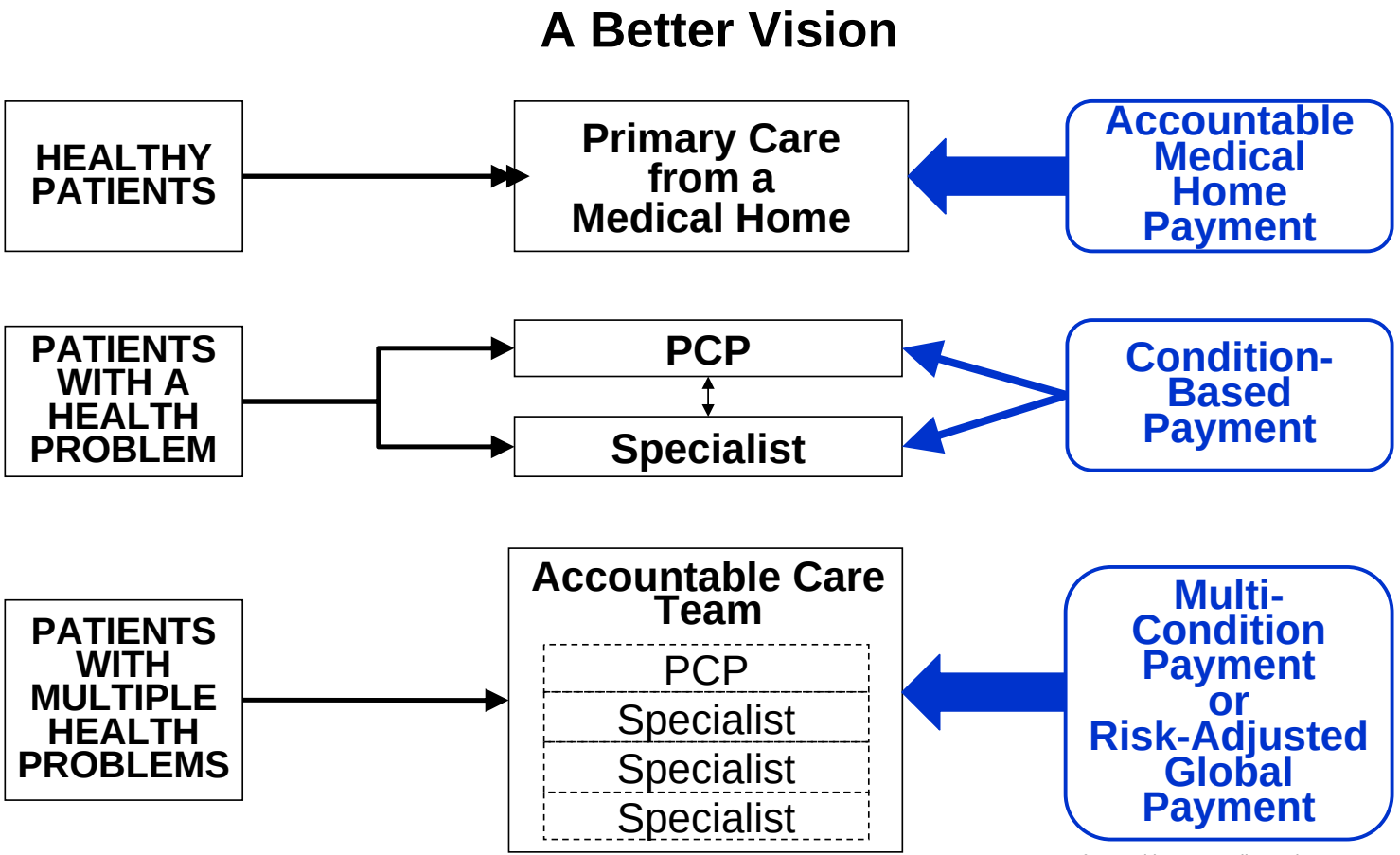
A Better Vision

Pursue a Vision That Will Benefit Patients, Providers & Payers

A Better Vision



Pursue a Vision That Will Benefit Patients, Providers & Payers



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

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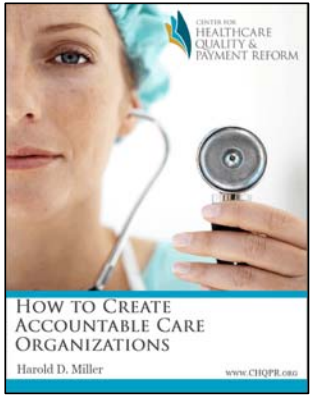

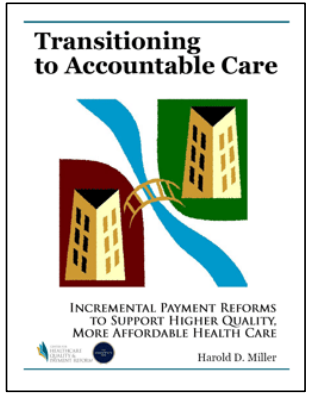

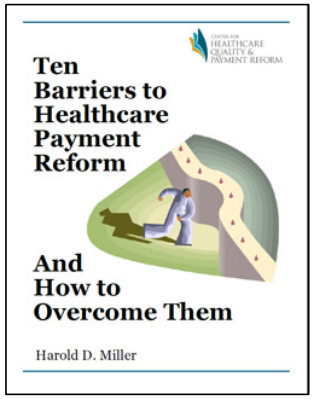

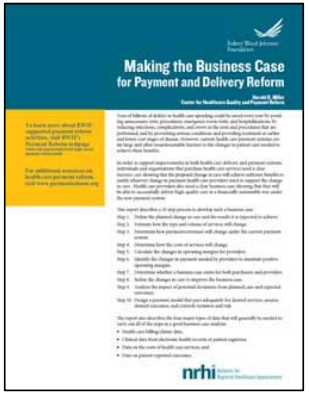

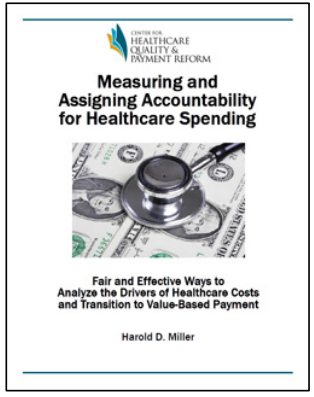

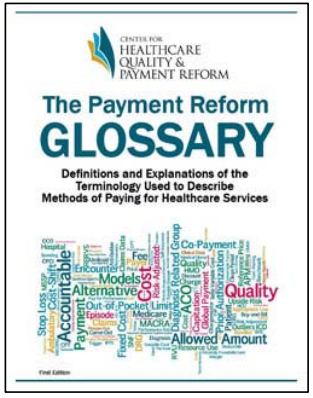

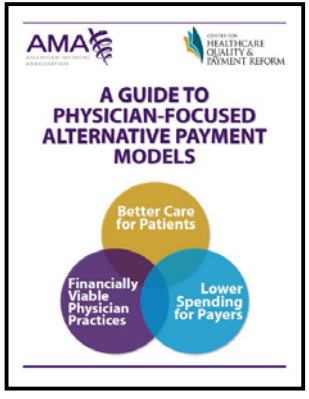

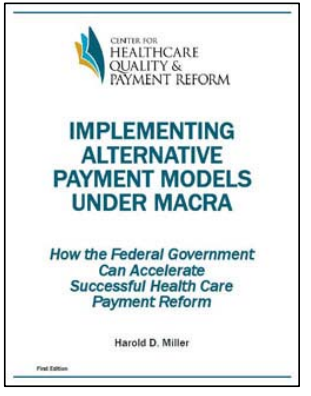

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