
# Are APMs Better Than FFS?

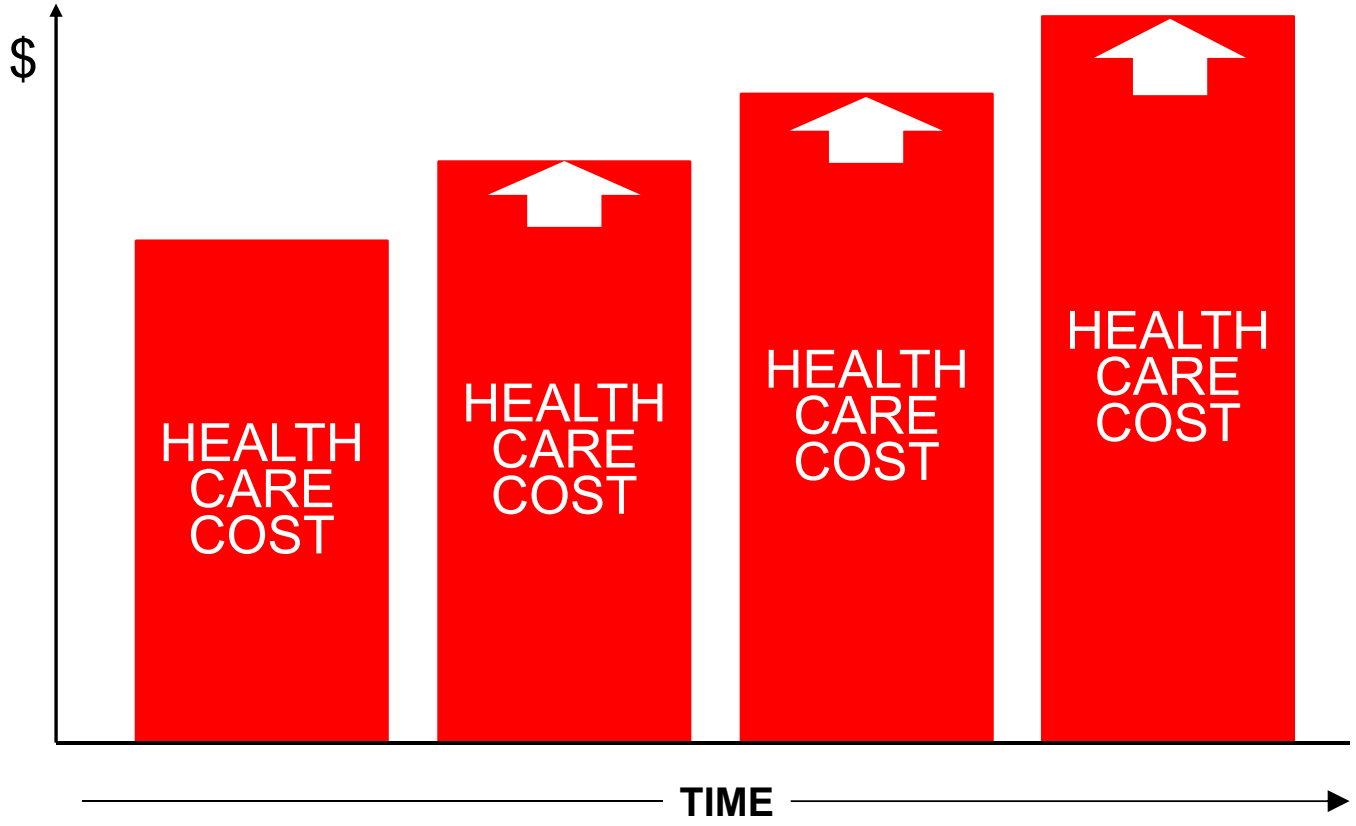
**Harold D. Miller**
**President and CEO**
**Center for Healthcare Quality and Payment Reform**

www.CHQPR.org

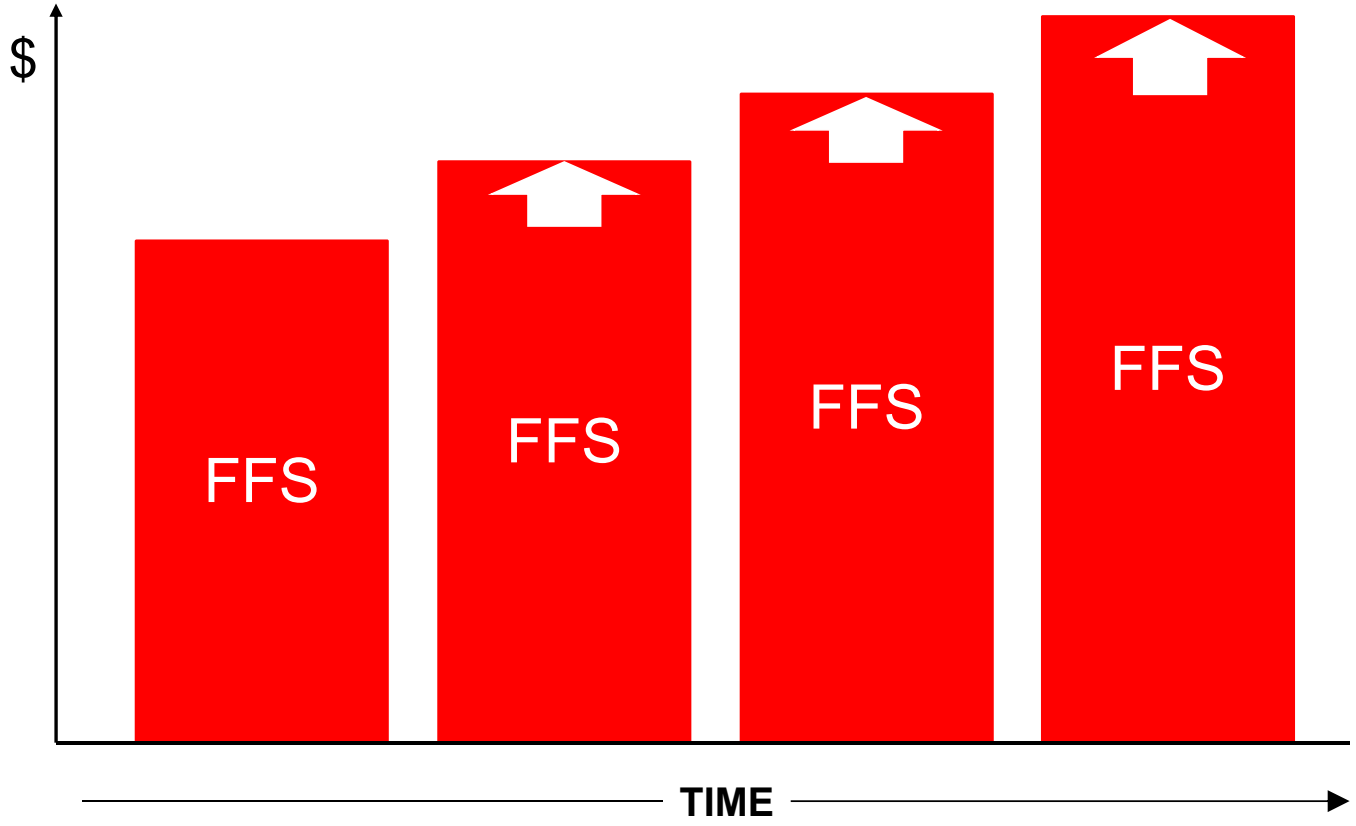
**PLEASE NOTE:**

Although I am one of the 11 members of the
Physician-Focused Payment Model
Technical Advisory Committee (PTAC),
my comments today reflect my
*personal* opinions;
my comments do not represent
official positions of the PTAC,
and other PTAC members
may or may not agree with them.

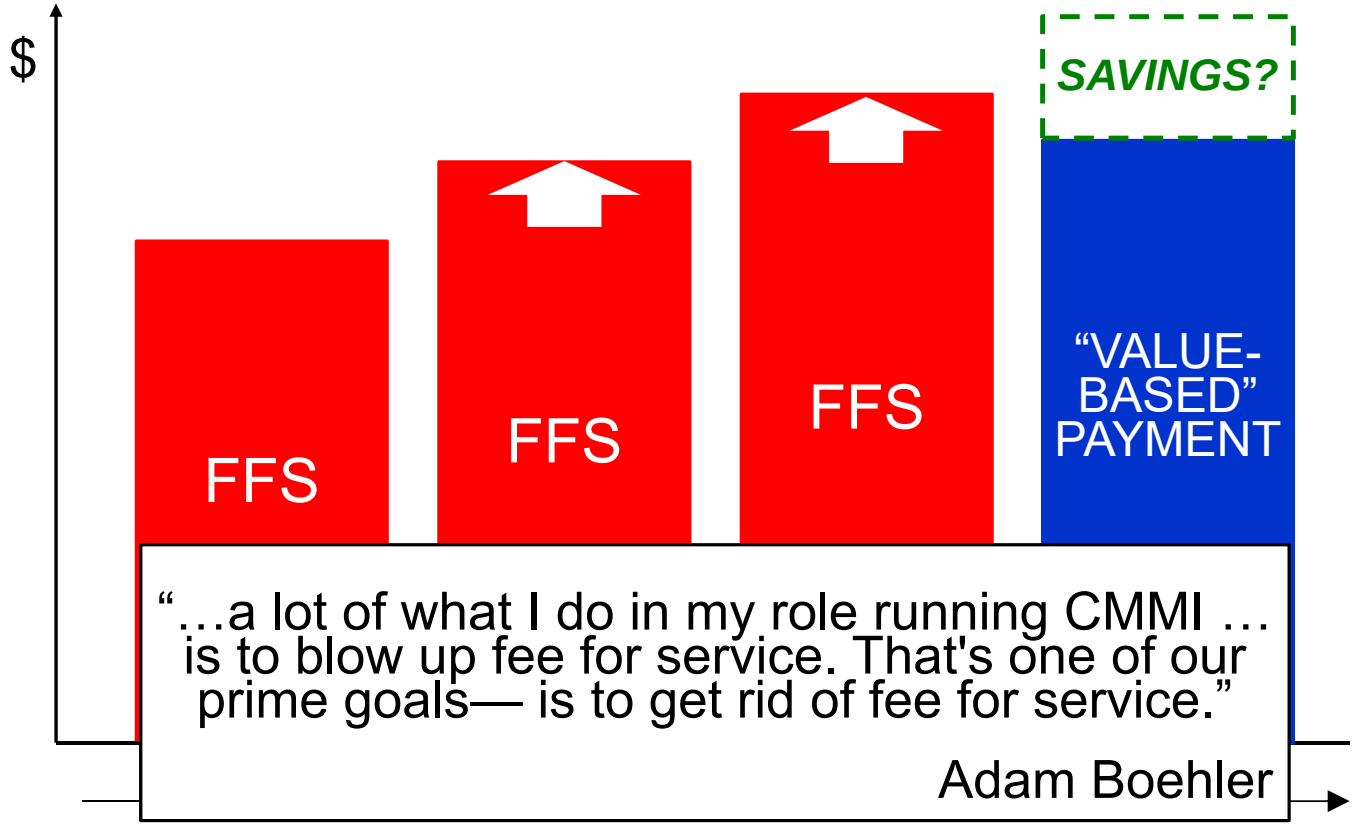
# The Biggest Barrier to *Coverage* is the High *Cost* of Health Care



# Is Fee for Service (FFS) Payment to Blame for High Cost Care?



# Will "Getting Rid" of FFS Solve the Problem?



# What Exactly is Wrong With Fee for Service?

# People Seem to Believe FFS is an Addiction Physicians Can't Control

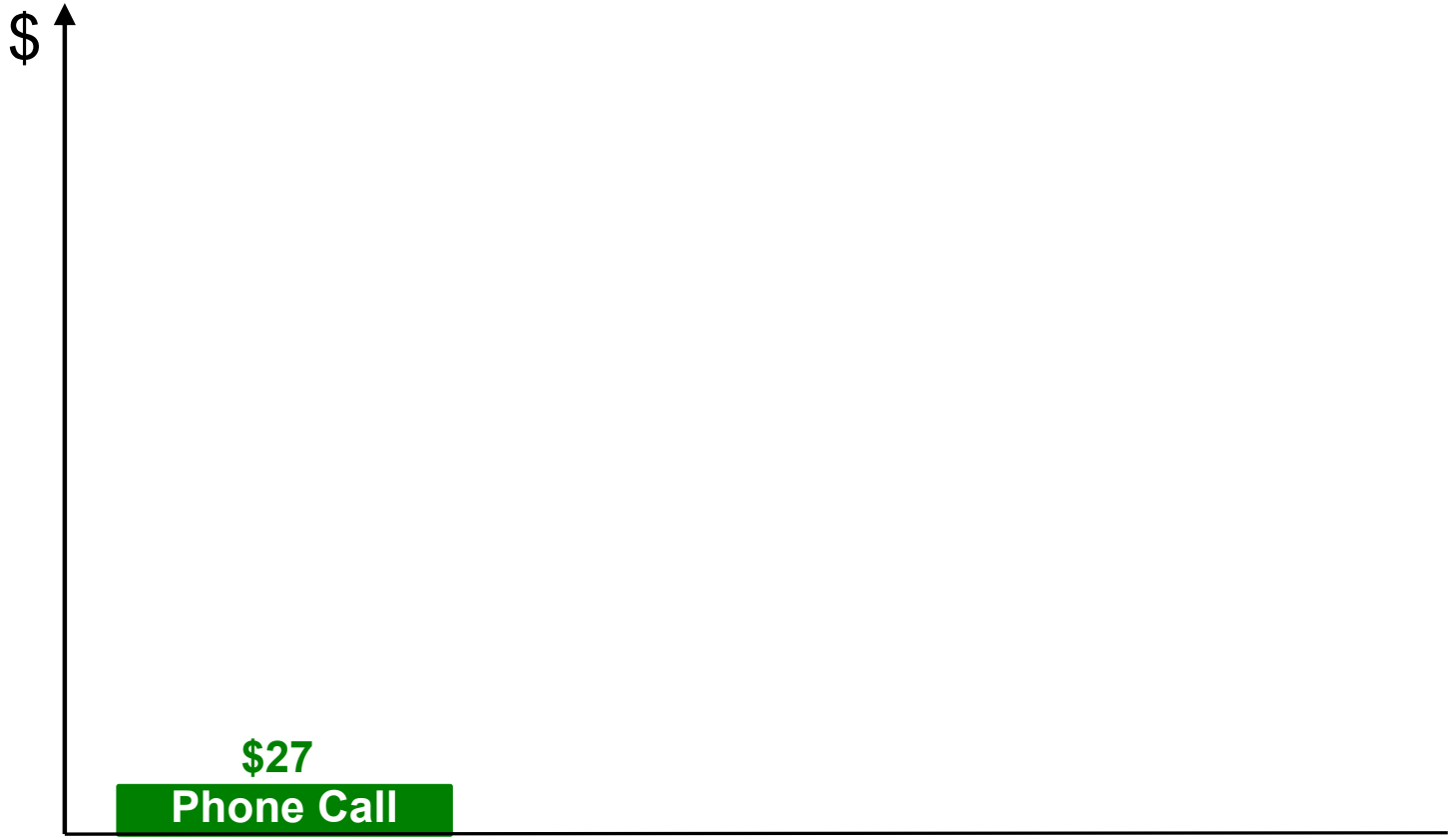
**"I wish I could stop ordering more services, but I can't control myself"**


# The Four (Real) Problems with (Current) FFS Payment Systems

# The Four (Real) Problems with (Current) FFS Payment Systems

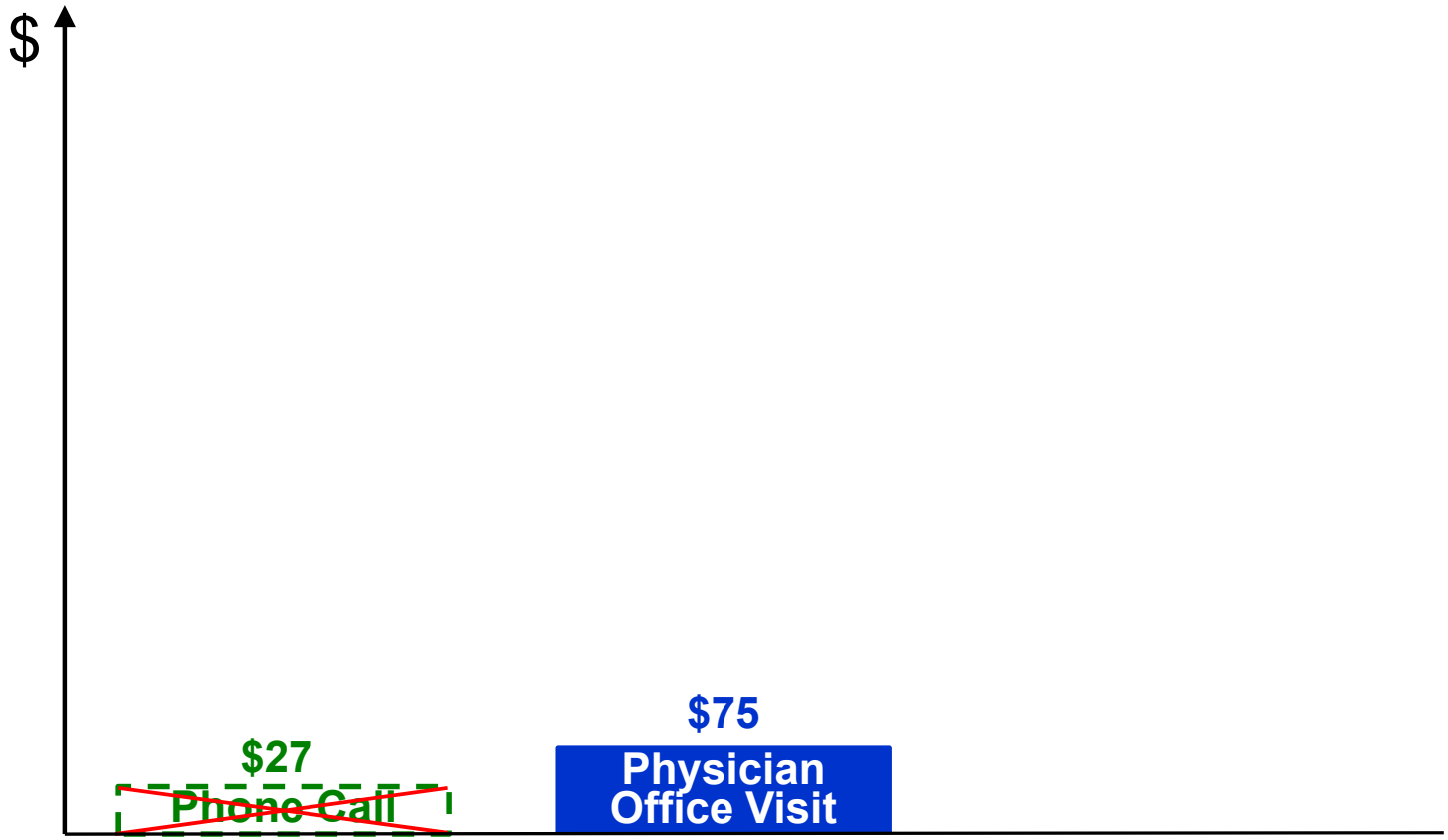
1. No fee for many high value services that could help patients and reduce overall healthcare spending

# Diagnosing a New Symptom: Call to Doctor Might Be Enough

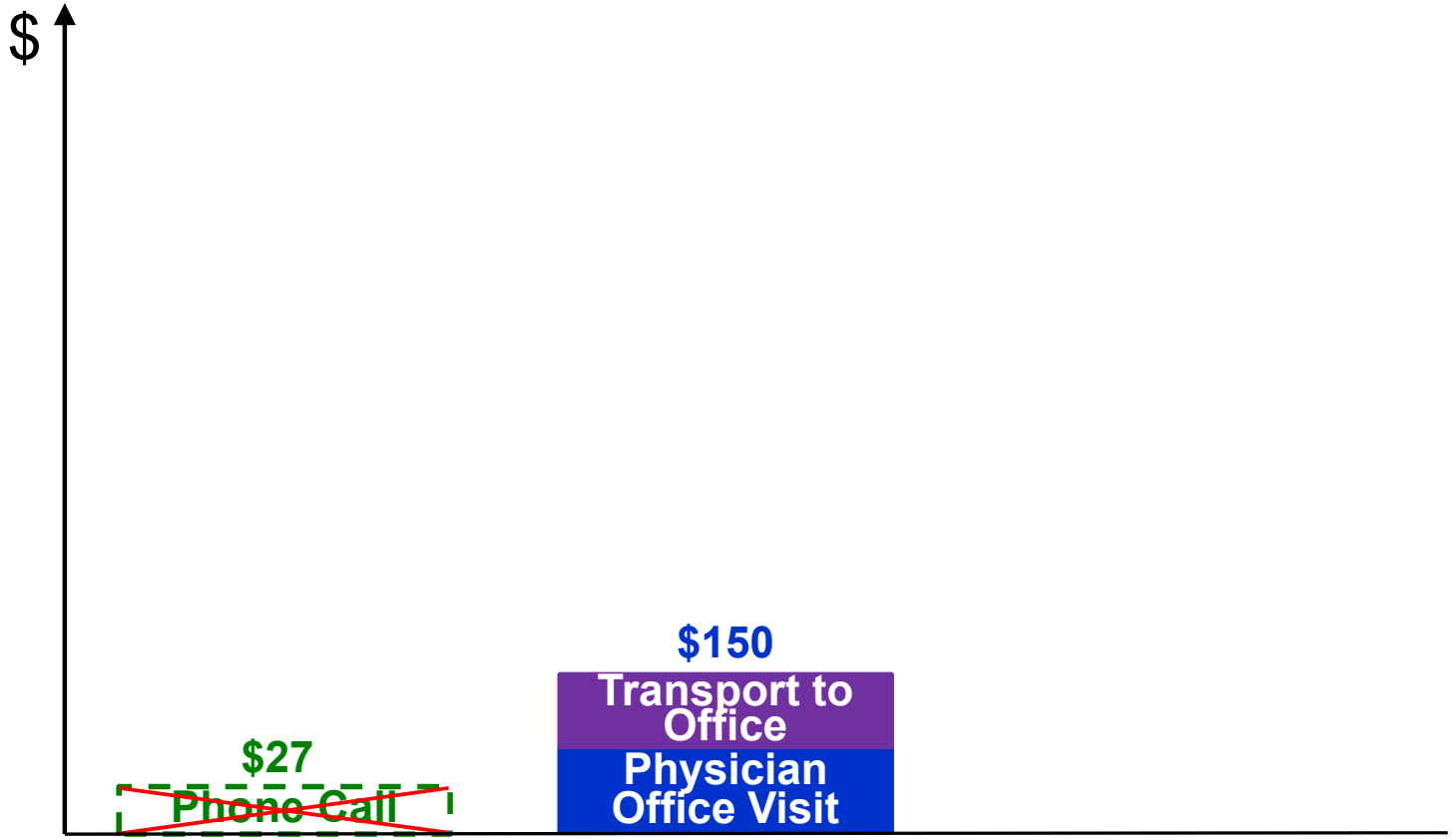


# Medicare Doesn't Pay for Phone Calls

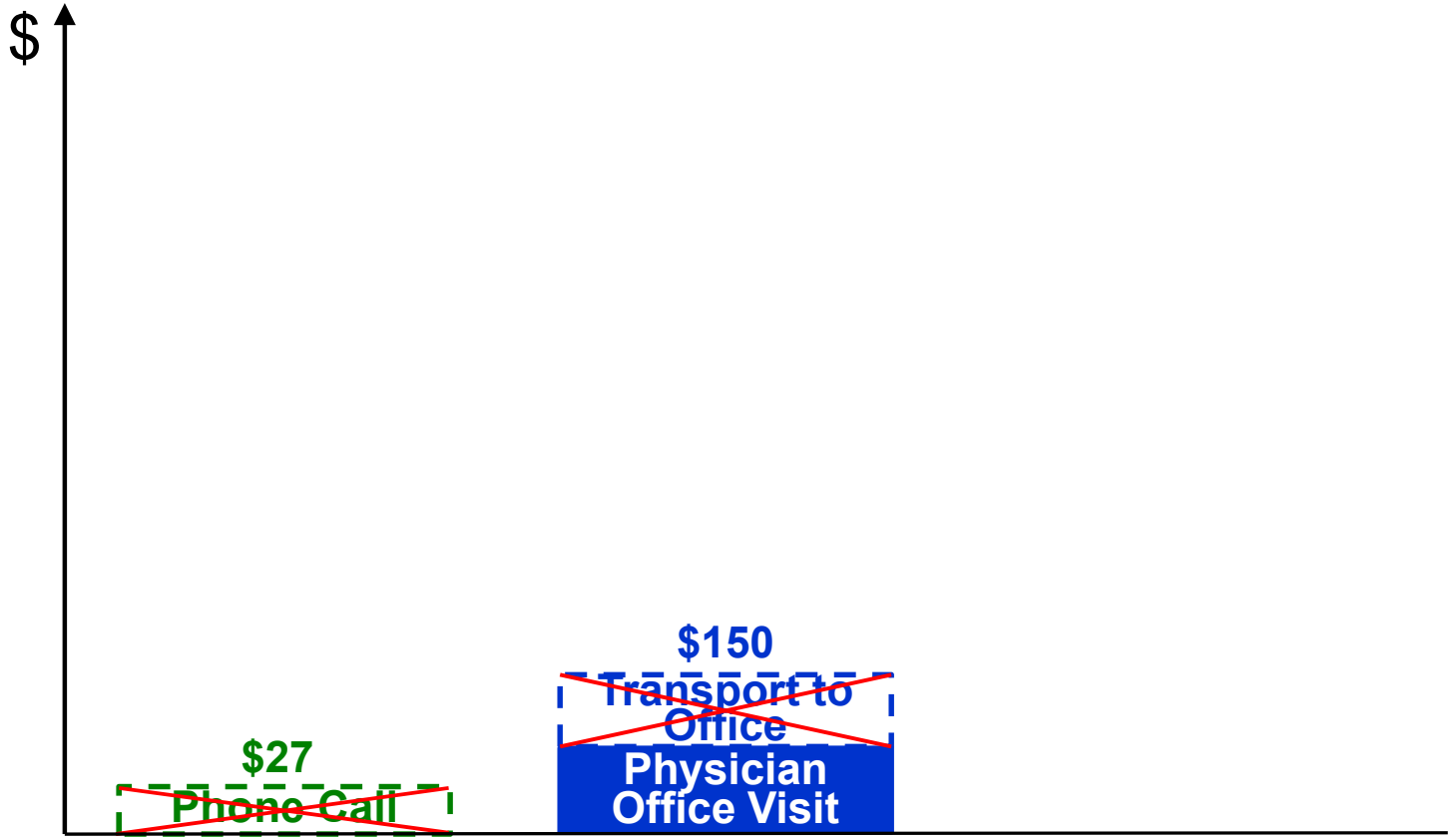
# Medicare Only Pays for Face-to-Face Visits with Physician



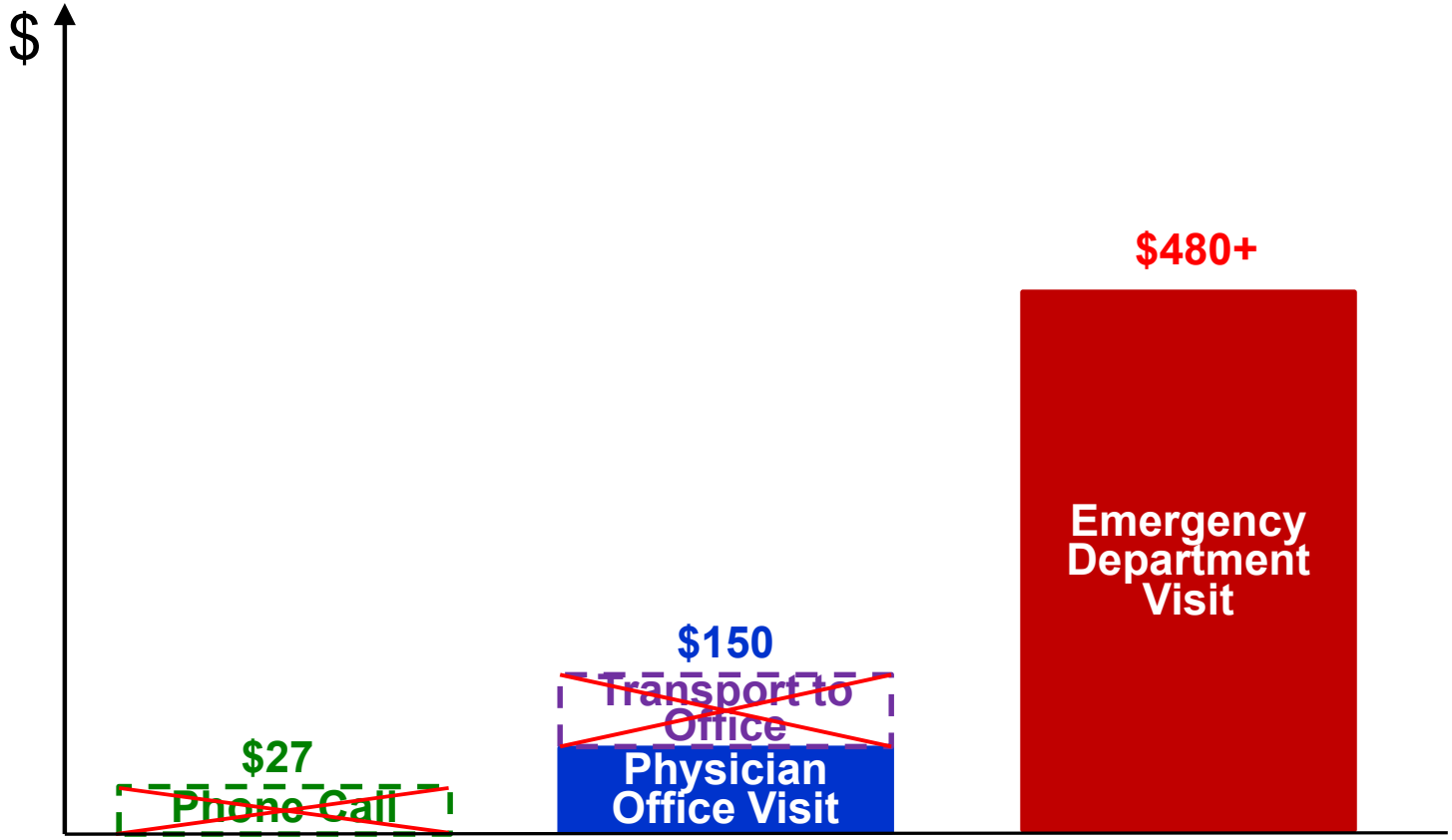
# What if the Patient is Too Sick to Drive or Has No Transportation?



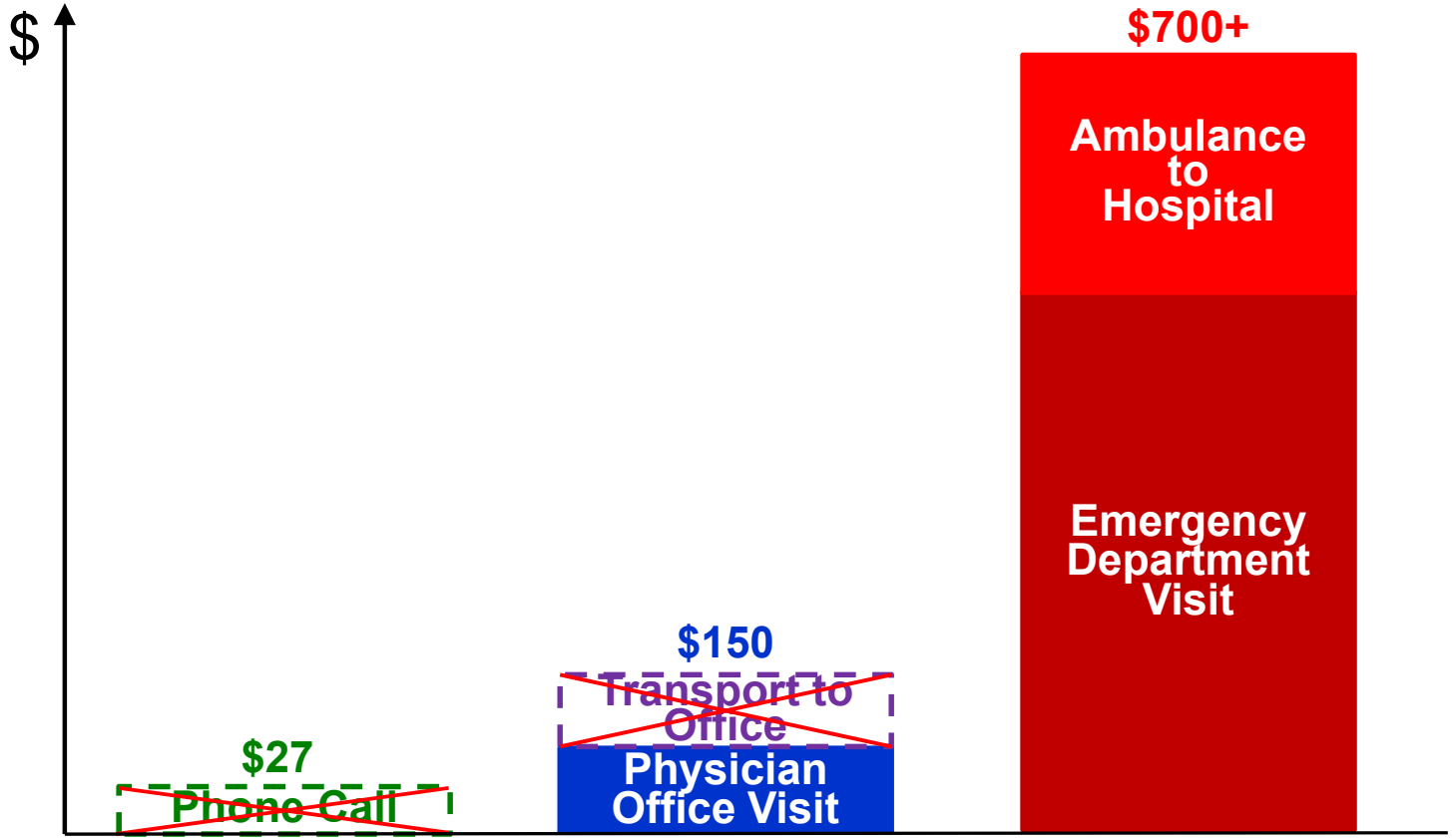
# Medicare Doesn't Pay for Transportation to Doctor's Office



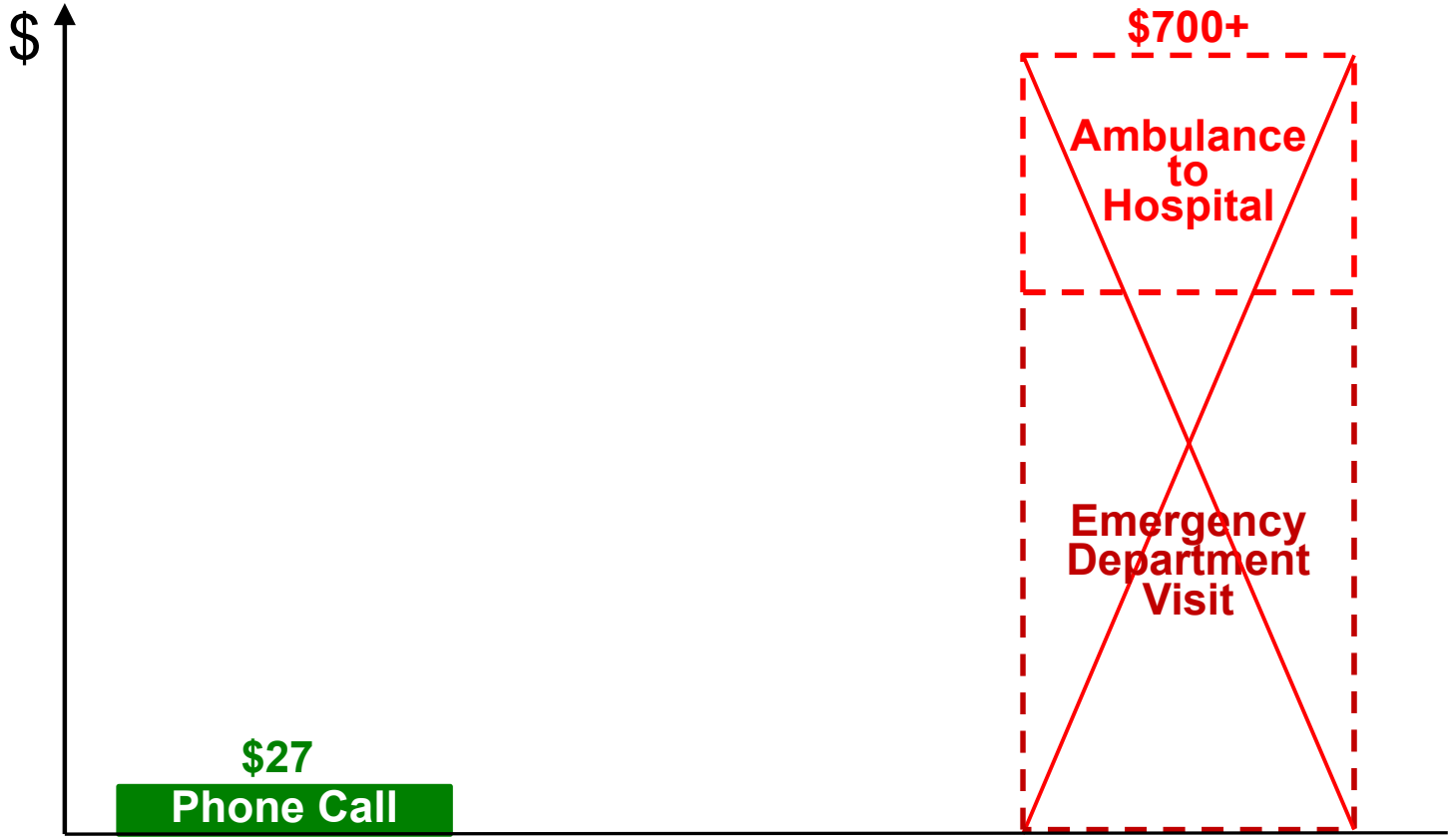
# Medicare WILL Pay for an ED Visit



# Medicare WILL Pay for an ED Visit AND the Ambulance to Get There



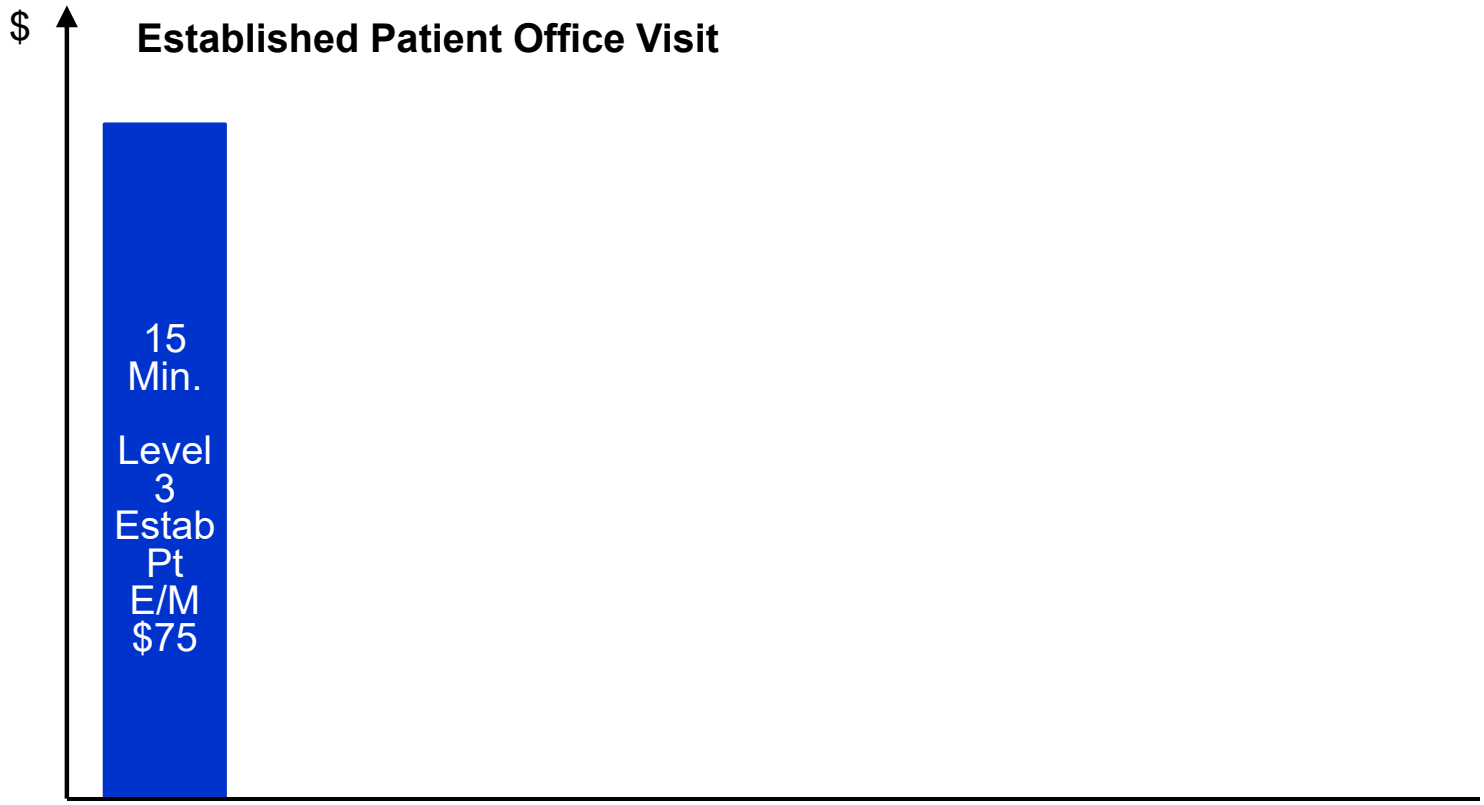
# A Phone Call That Prevented an ED Visit Would Save a Lot of $



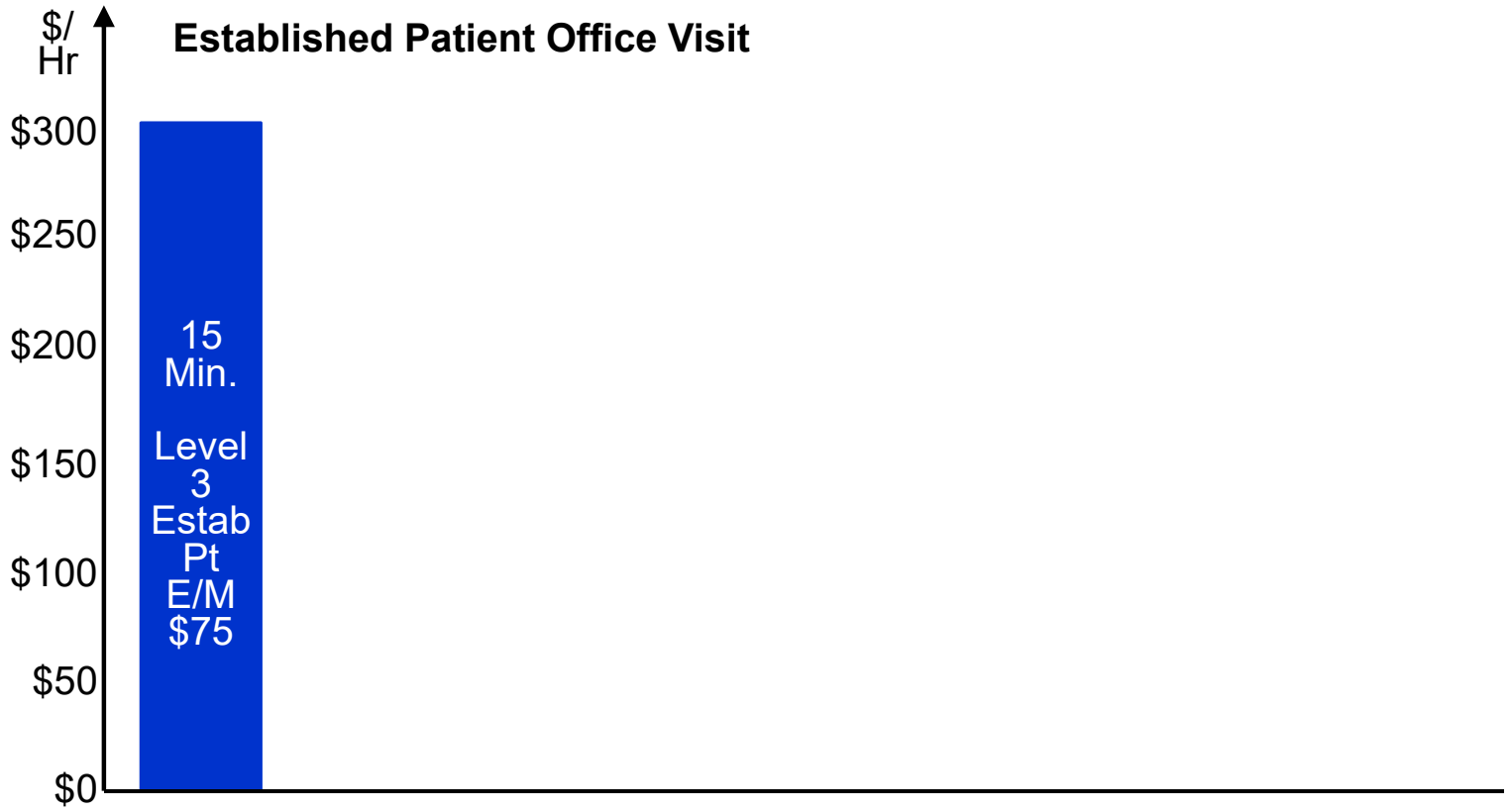
# The Four (Real) Problems with (Current) FFS Payment Systems

1. No fee for many high value services that could help patients and reduce overall healthcare spending
2. Fees don't match the cost of delivering high-quality care

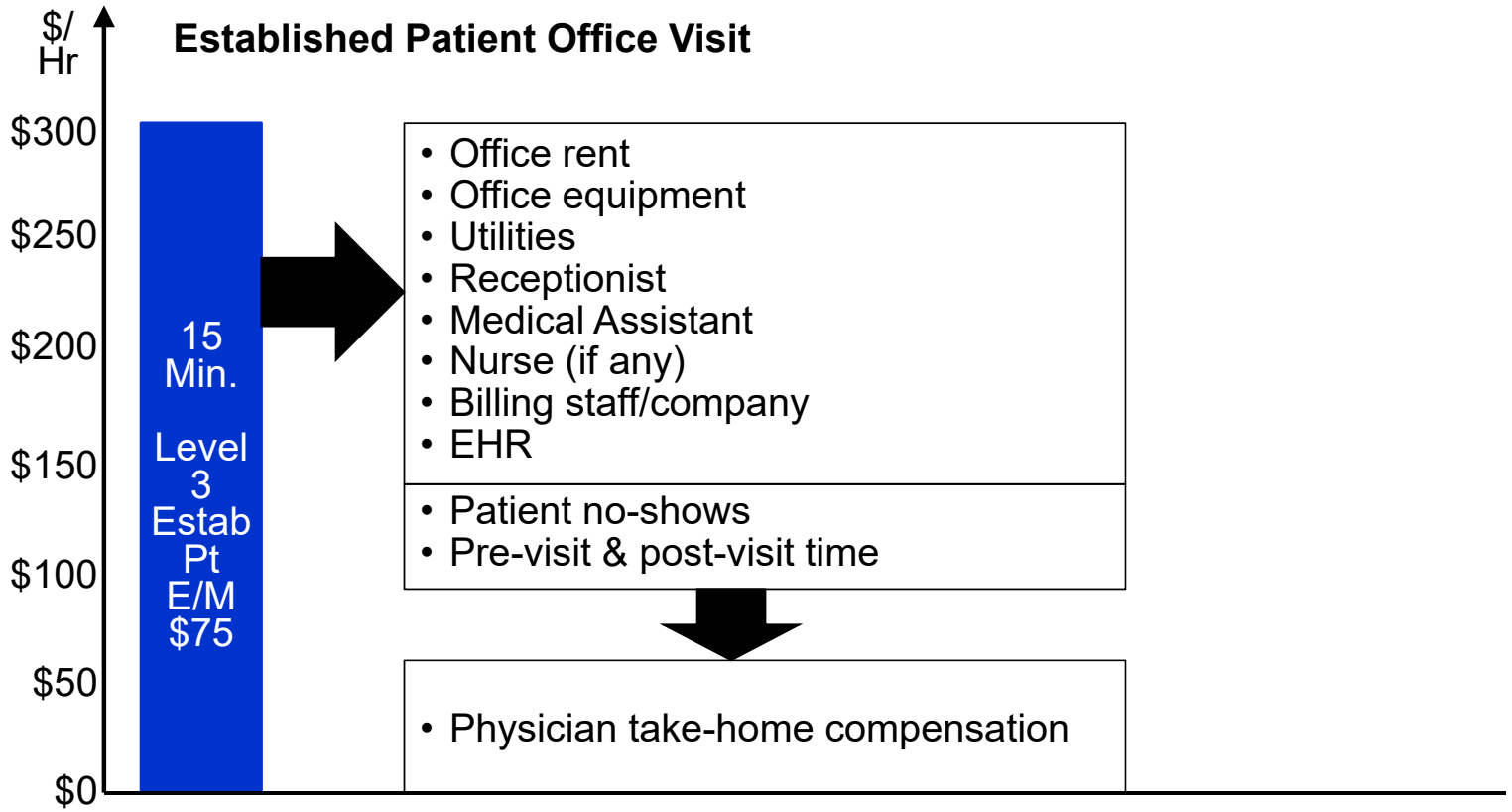
# Medicare Payment for Office Visit With Physician



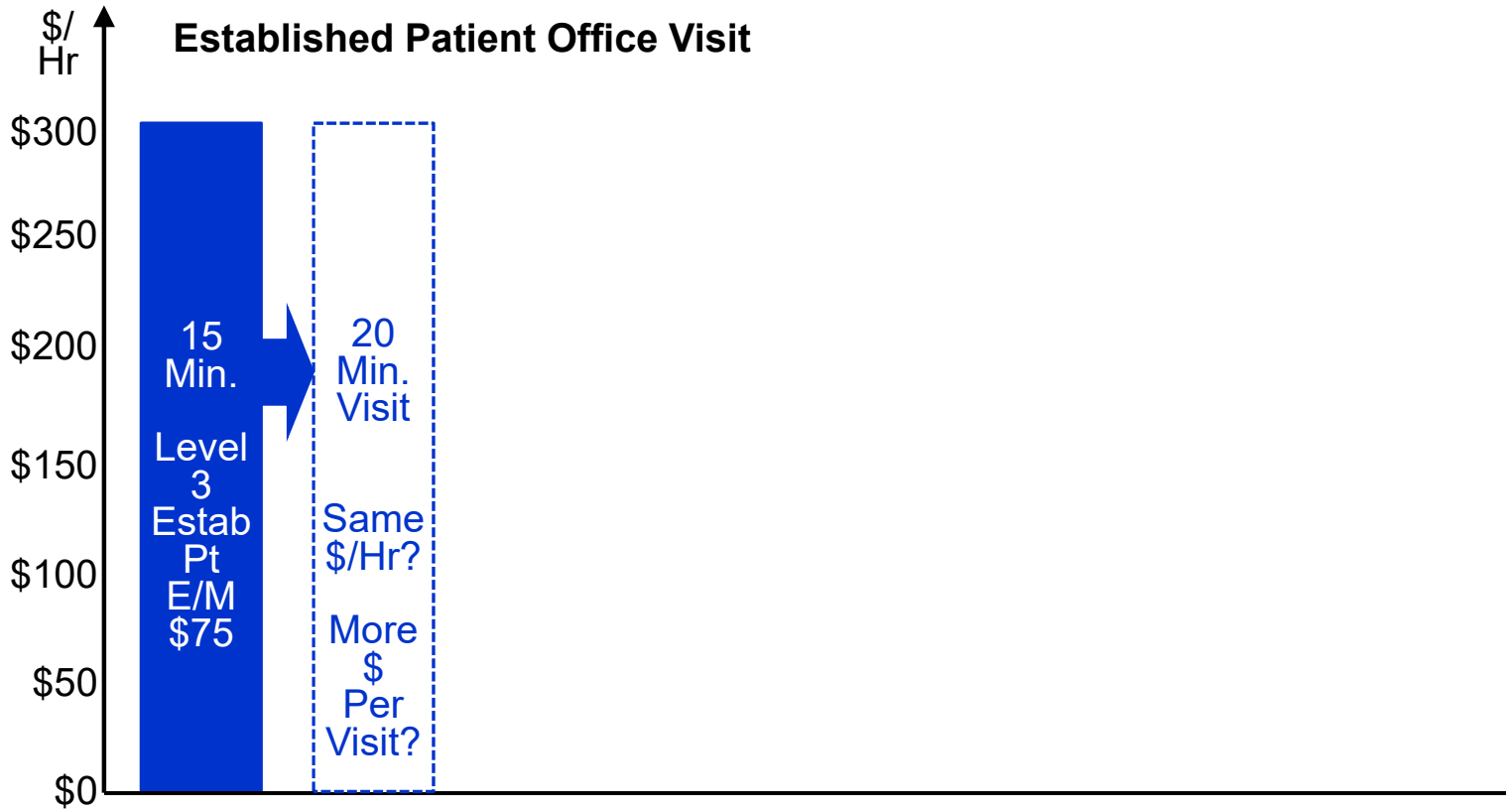
# $75 for 15 min = $300/Hour, Which Sounds Like a Lot…



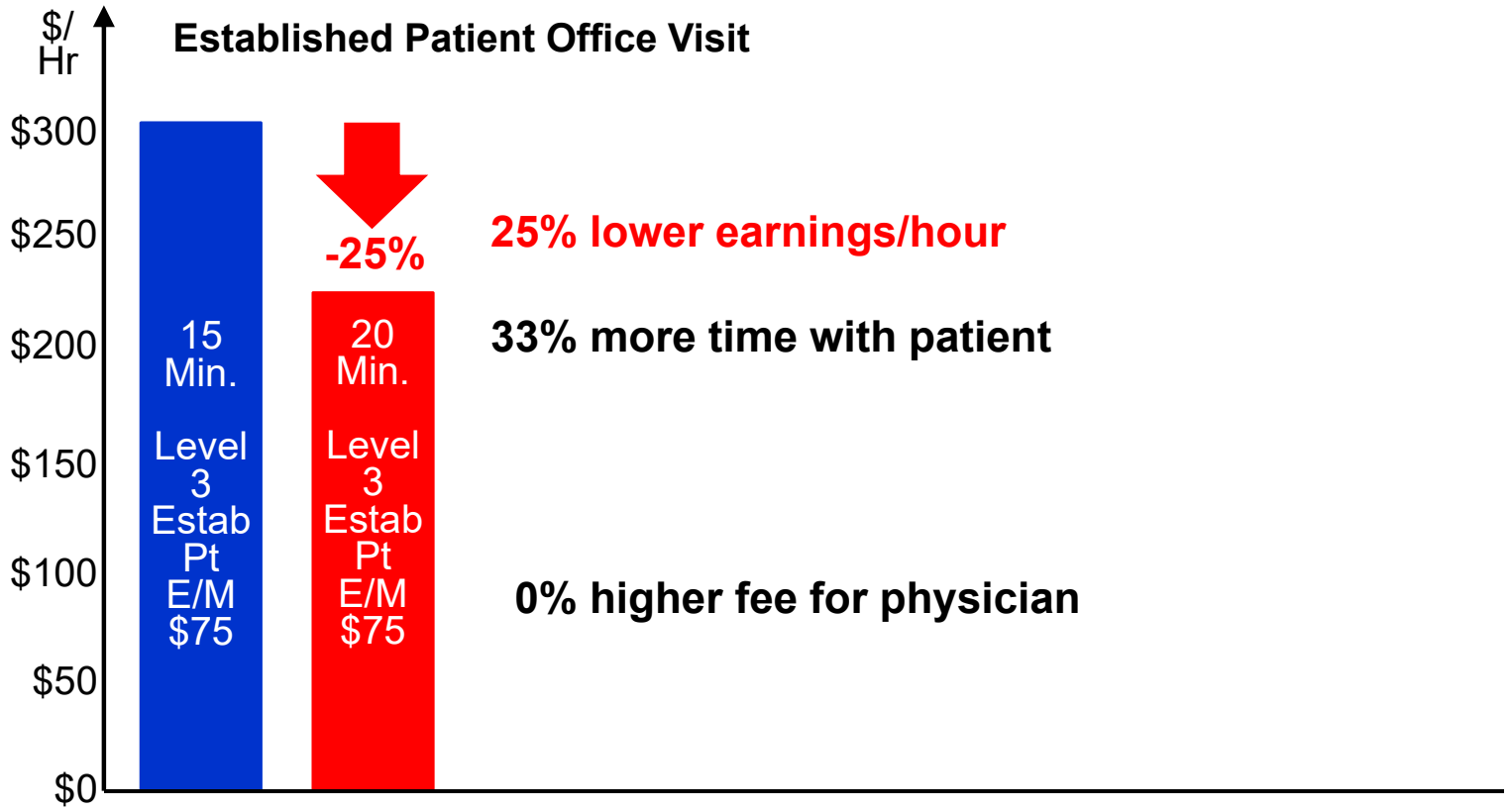
# …But Most of That Doesn't Go to the Physician



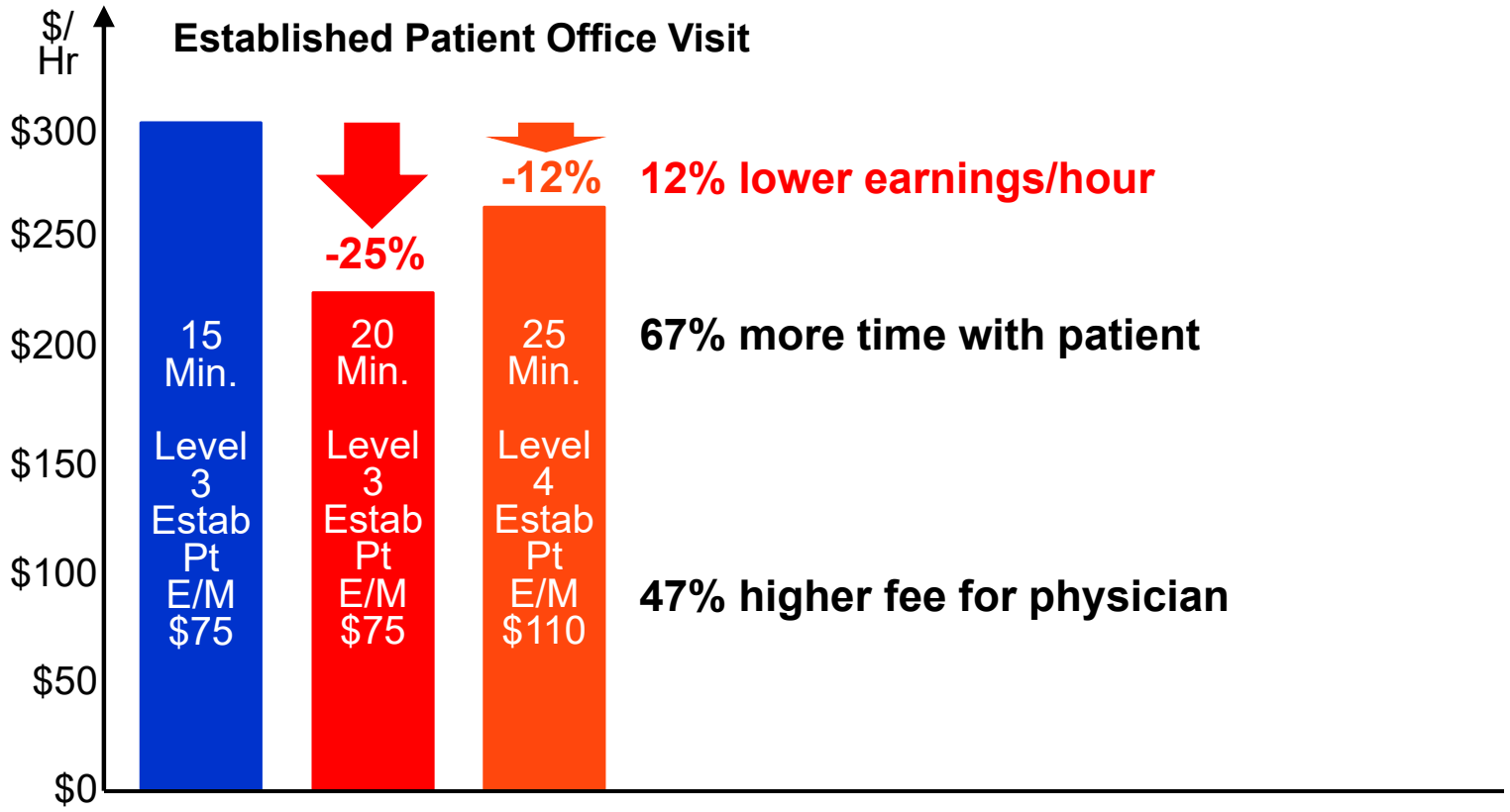
# What If The Physician Spends More Time With the Patient?



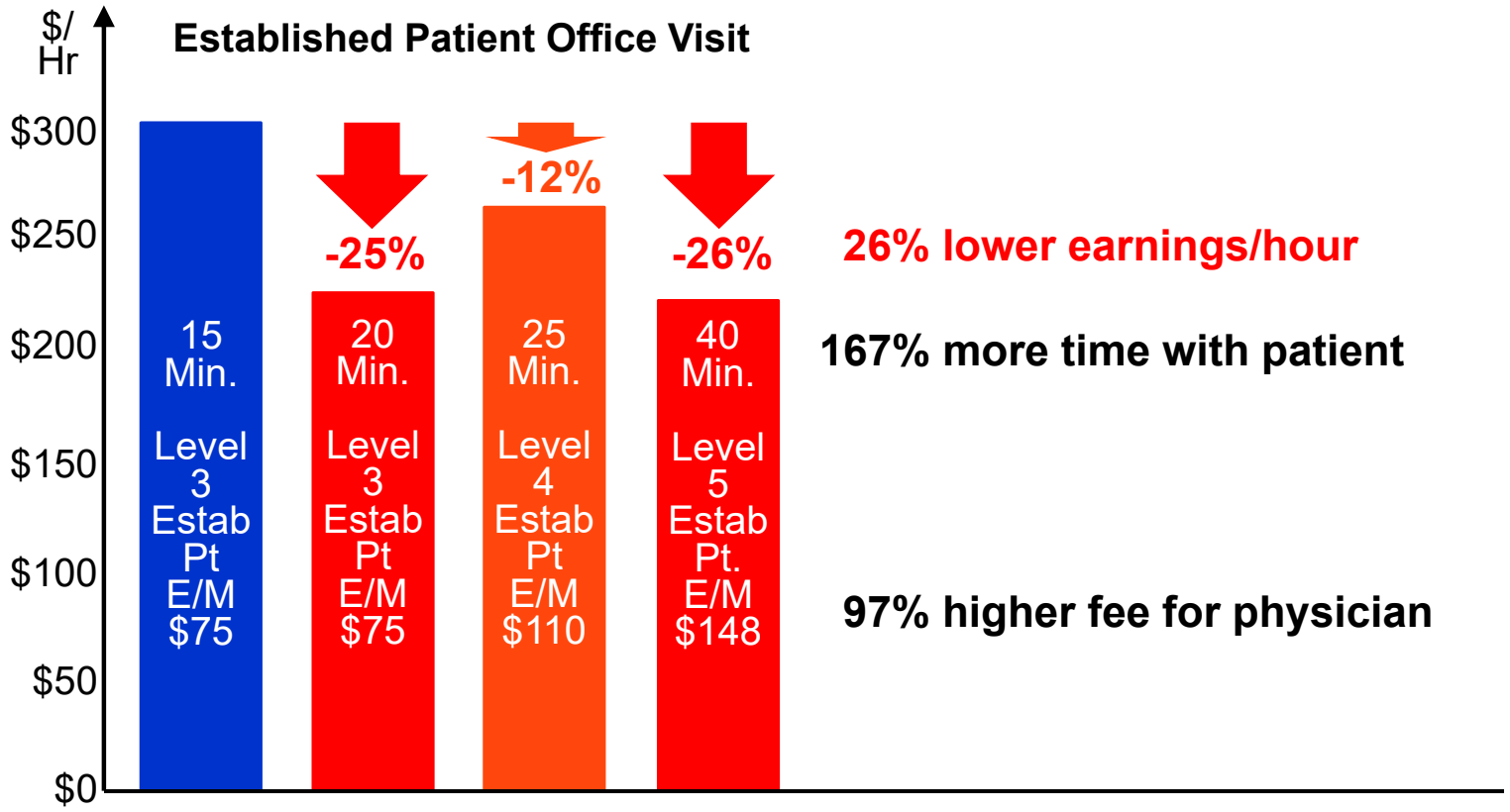
# Large Penalty for Spending More Time With Patients



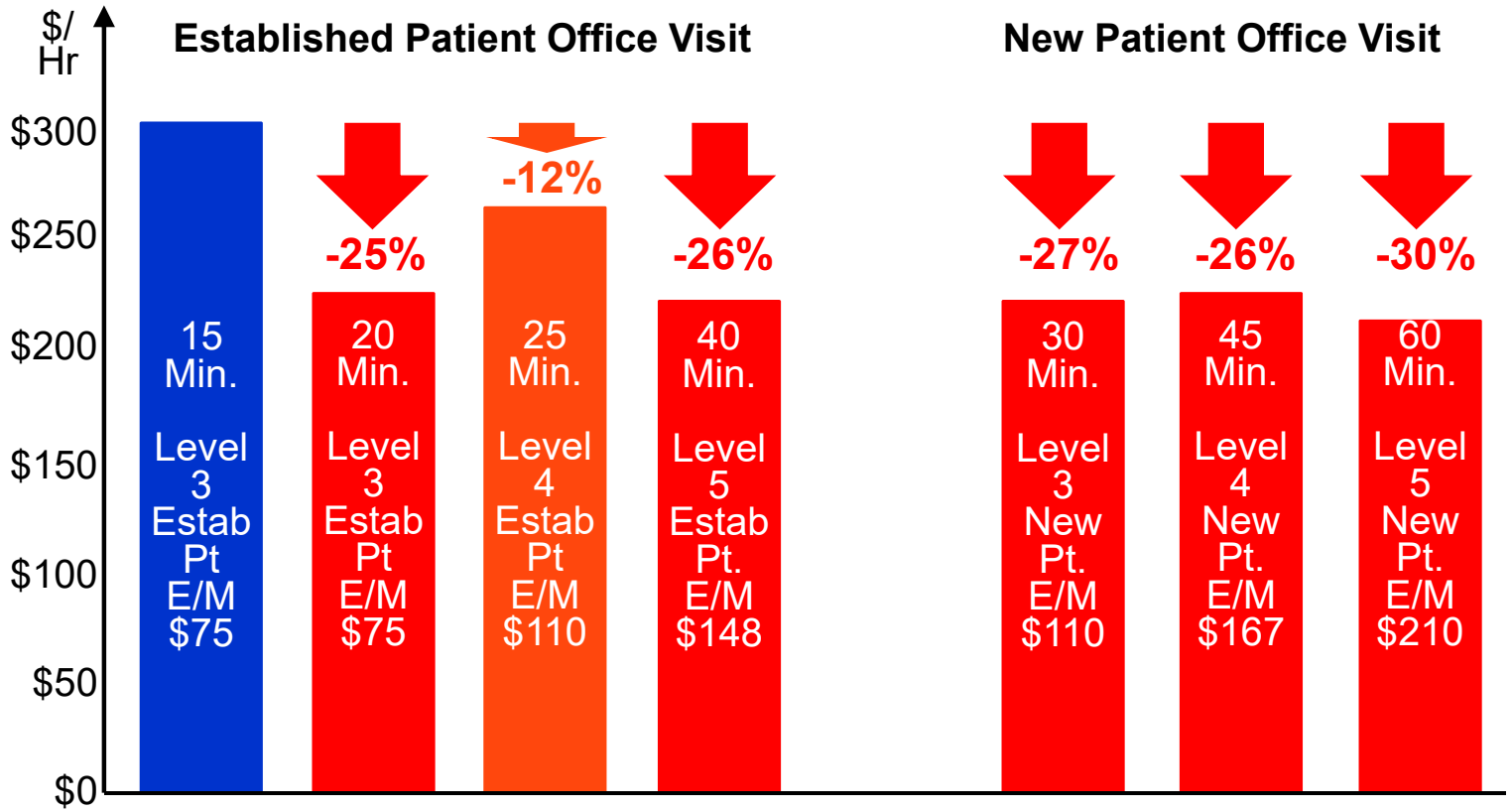
# Financial Penalty for Level 4 vs. Level 3 Visit



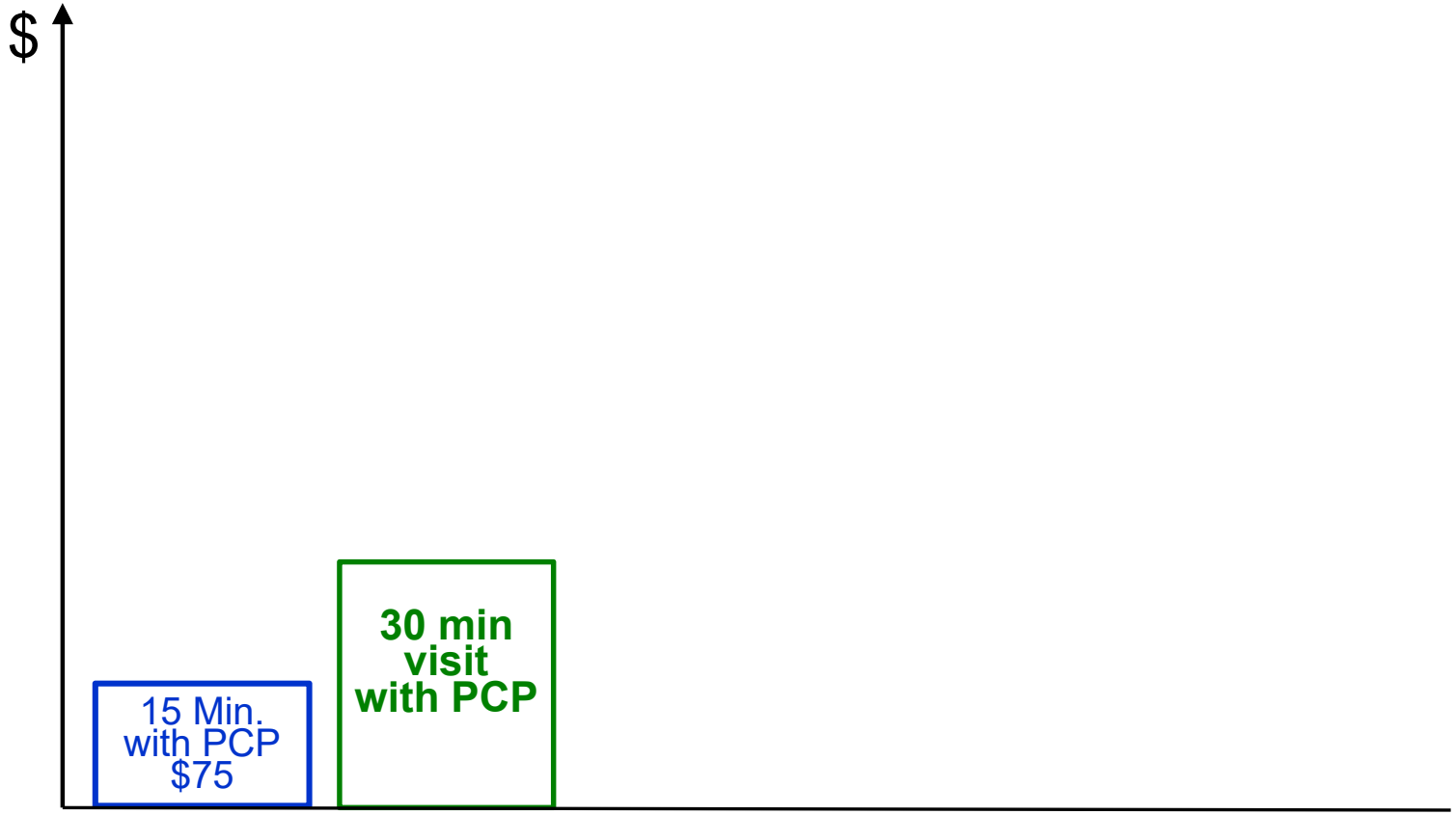
# Financial Penalty for Level 5 vs Level 4 Visit



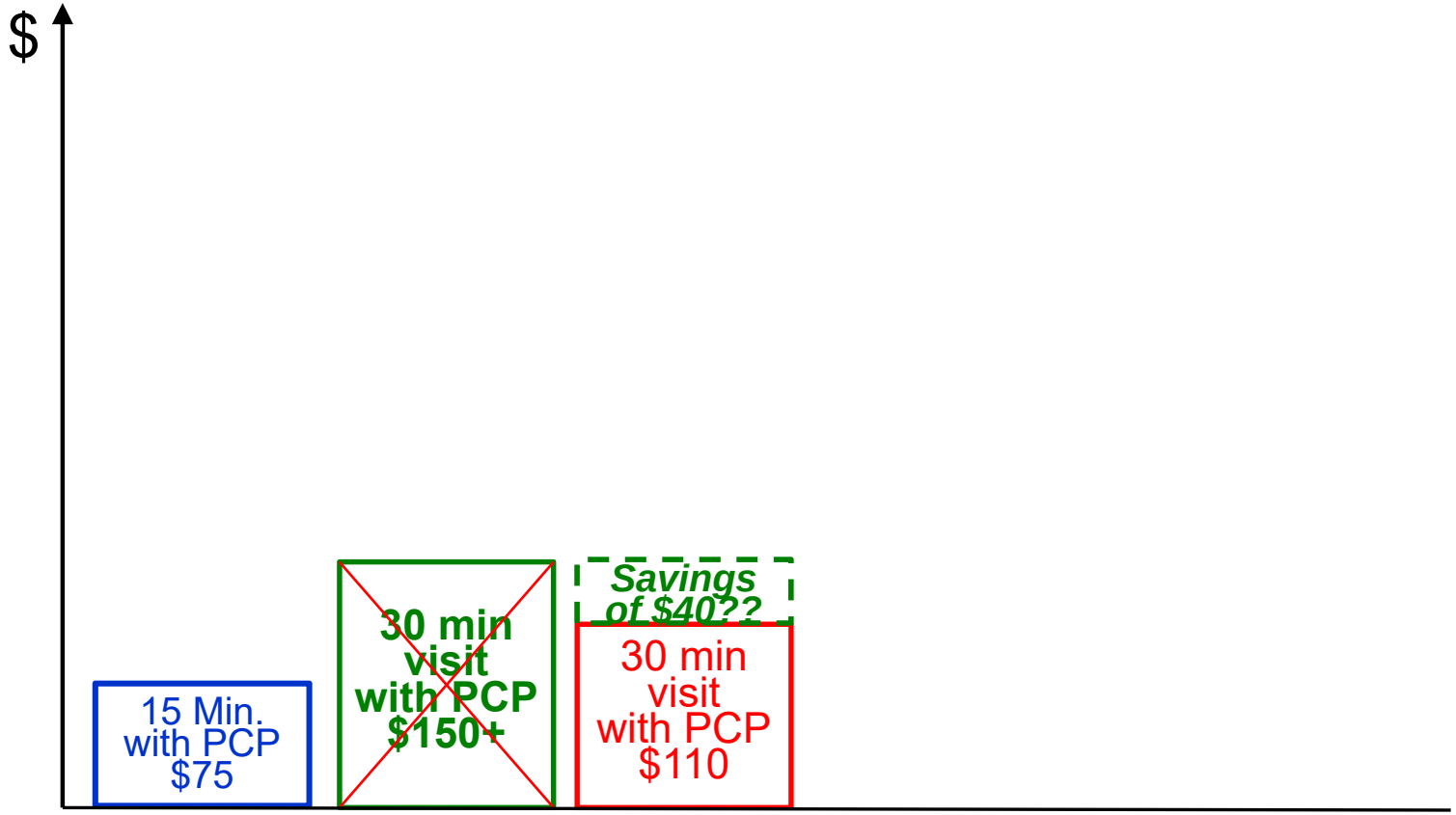
# Penalty for Seeing New Patients vs. More Visits w/ Current Patients



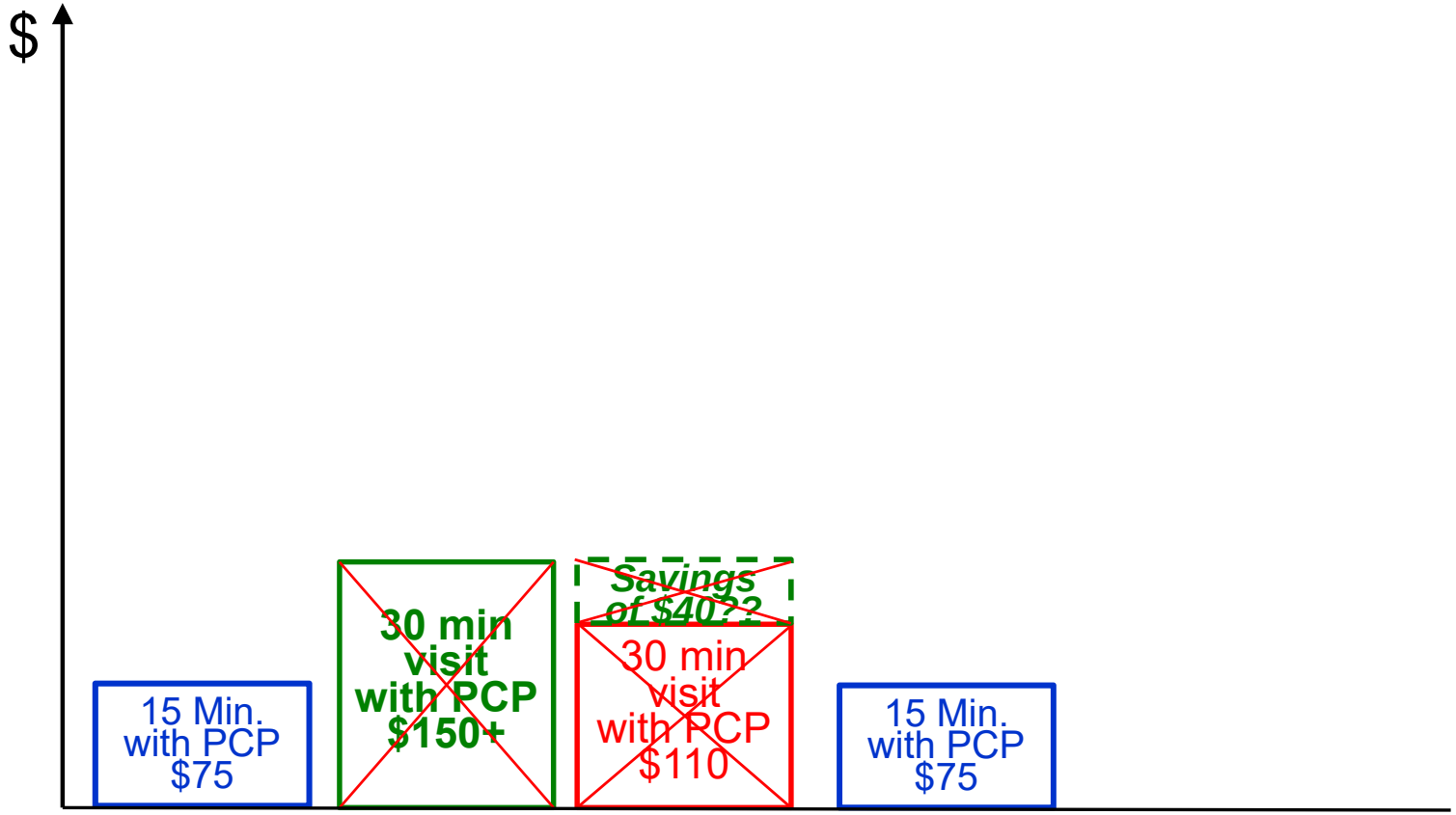
# What Happens if the Patient Needs 30 Minutes Instead of 15?



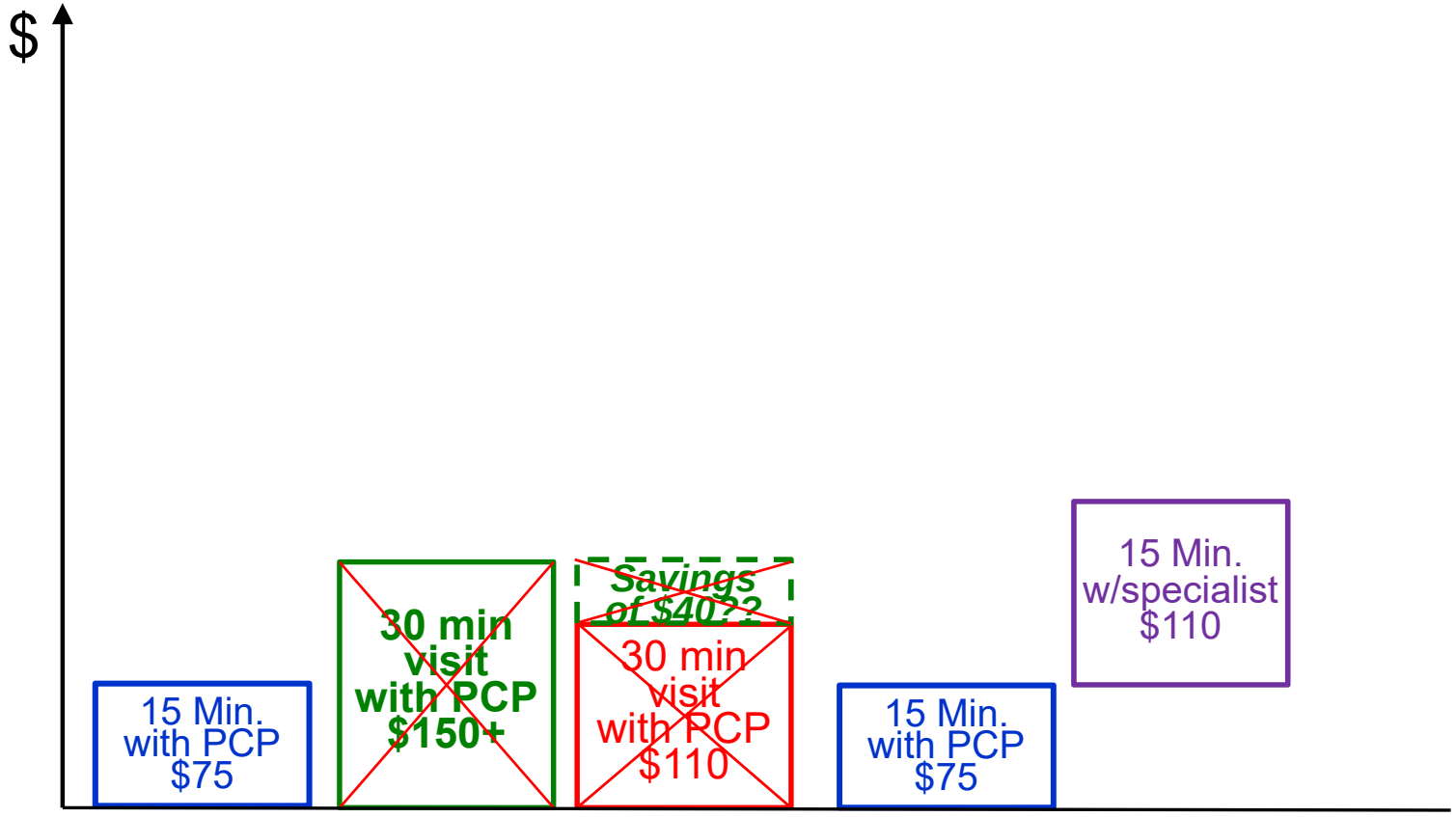
# Medicare Doesn't Pay Twice as Much



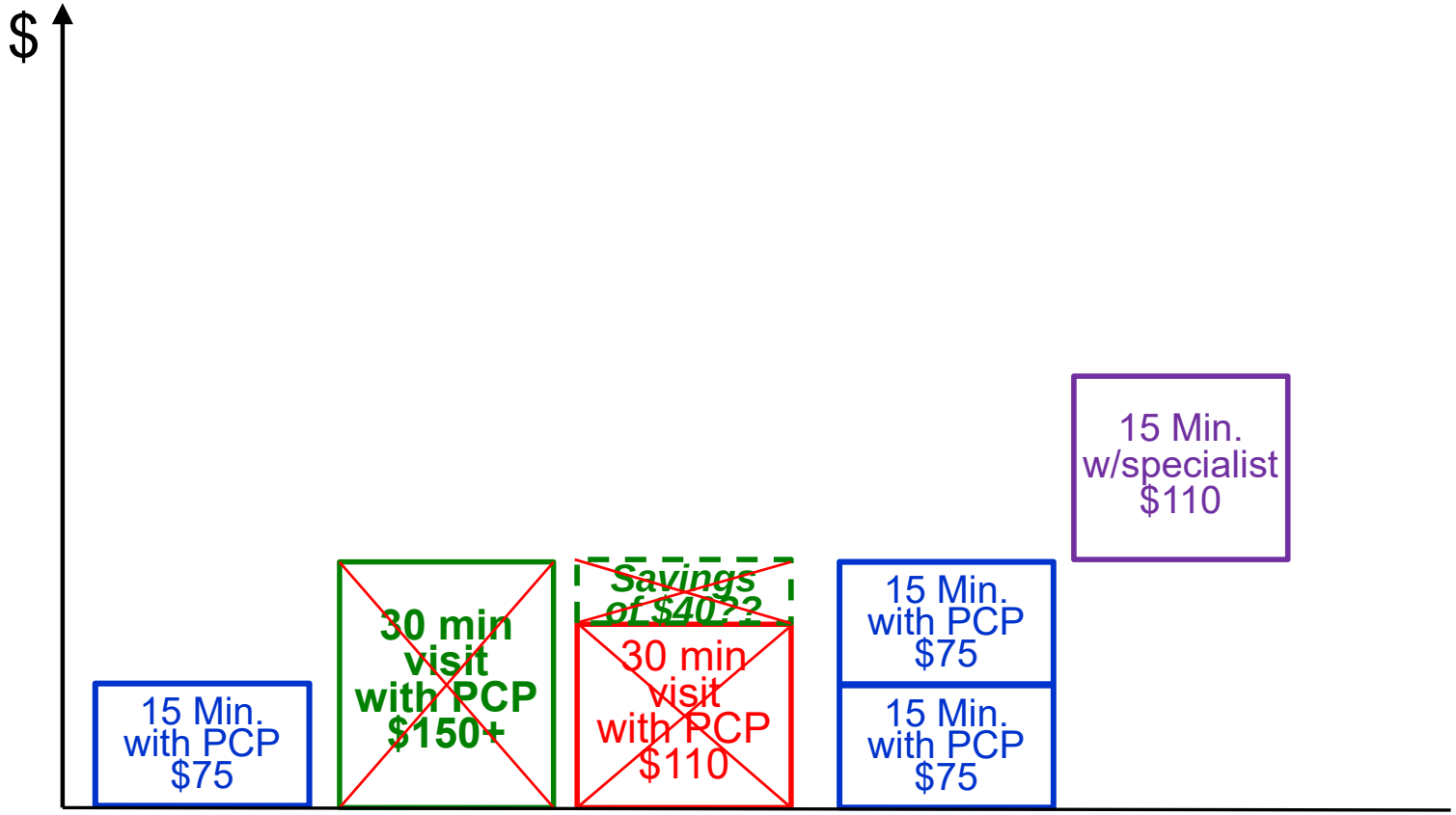
# The Result:
# (1) Shorter PCP Visit Than Needed



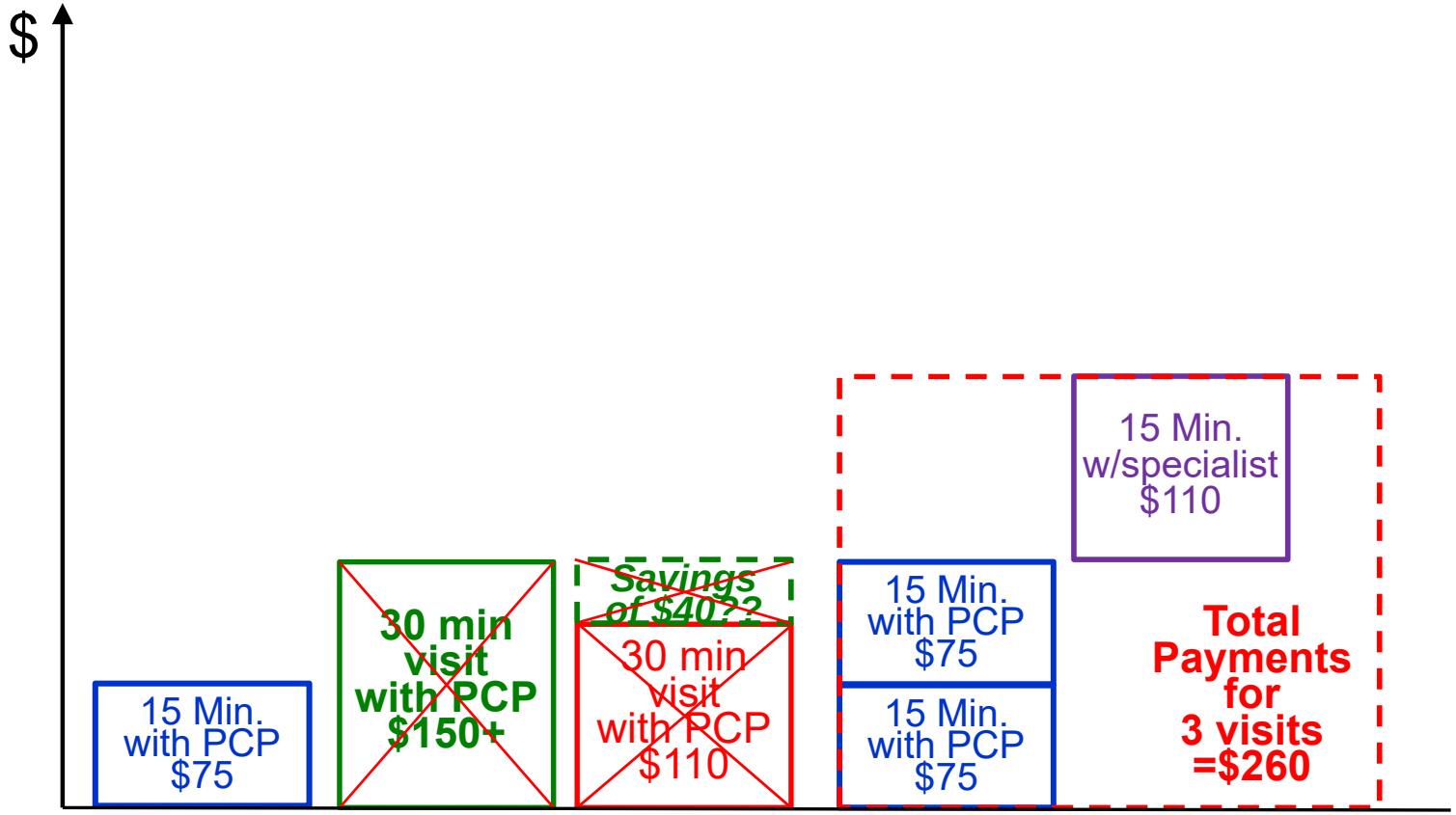
# The Result:
# (2) Unnecessary Specialist Visit



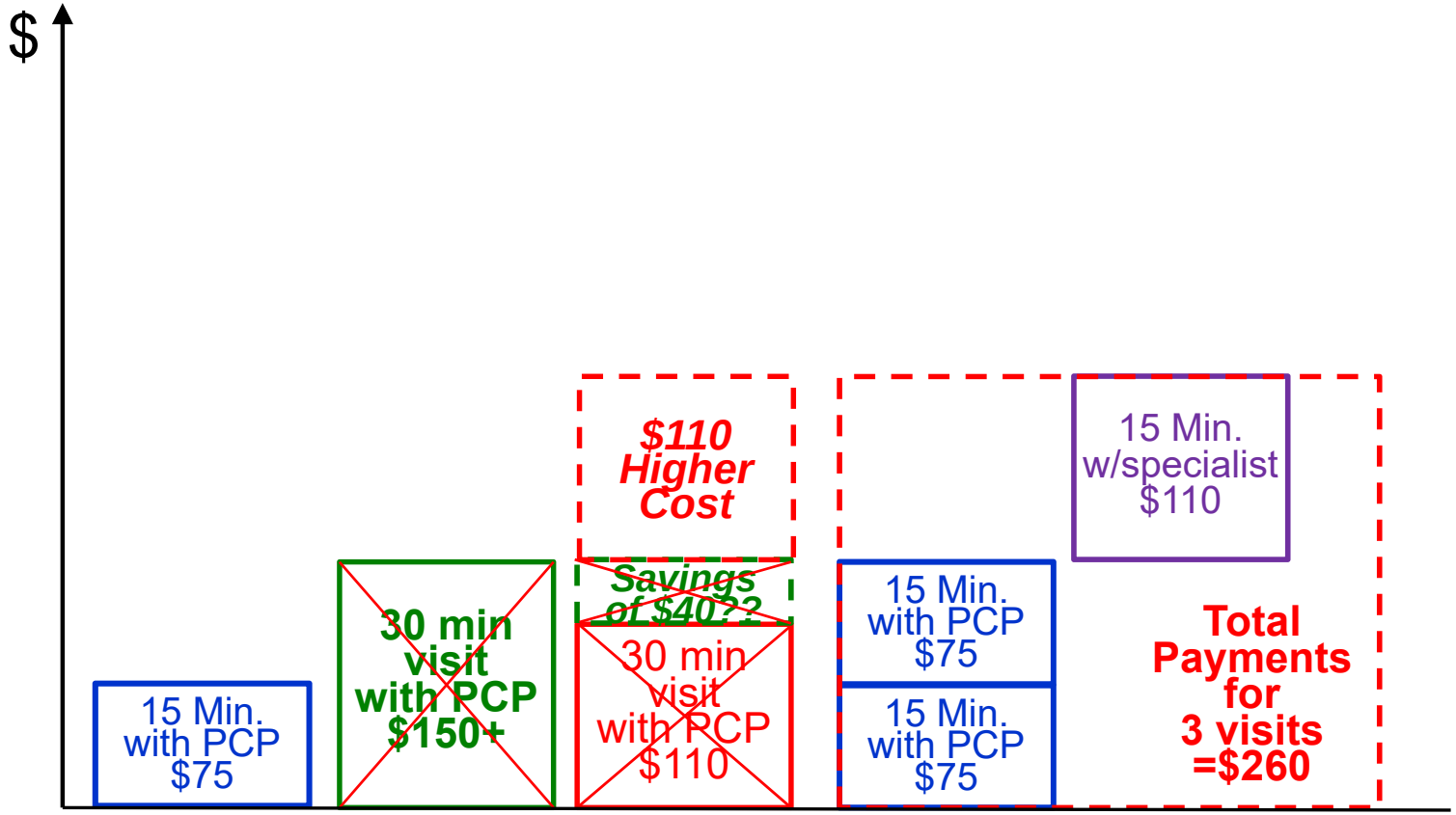
# The Result:
# (3) Return for Second Visit to PCP



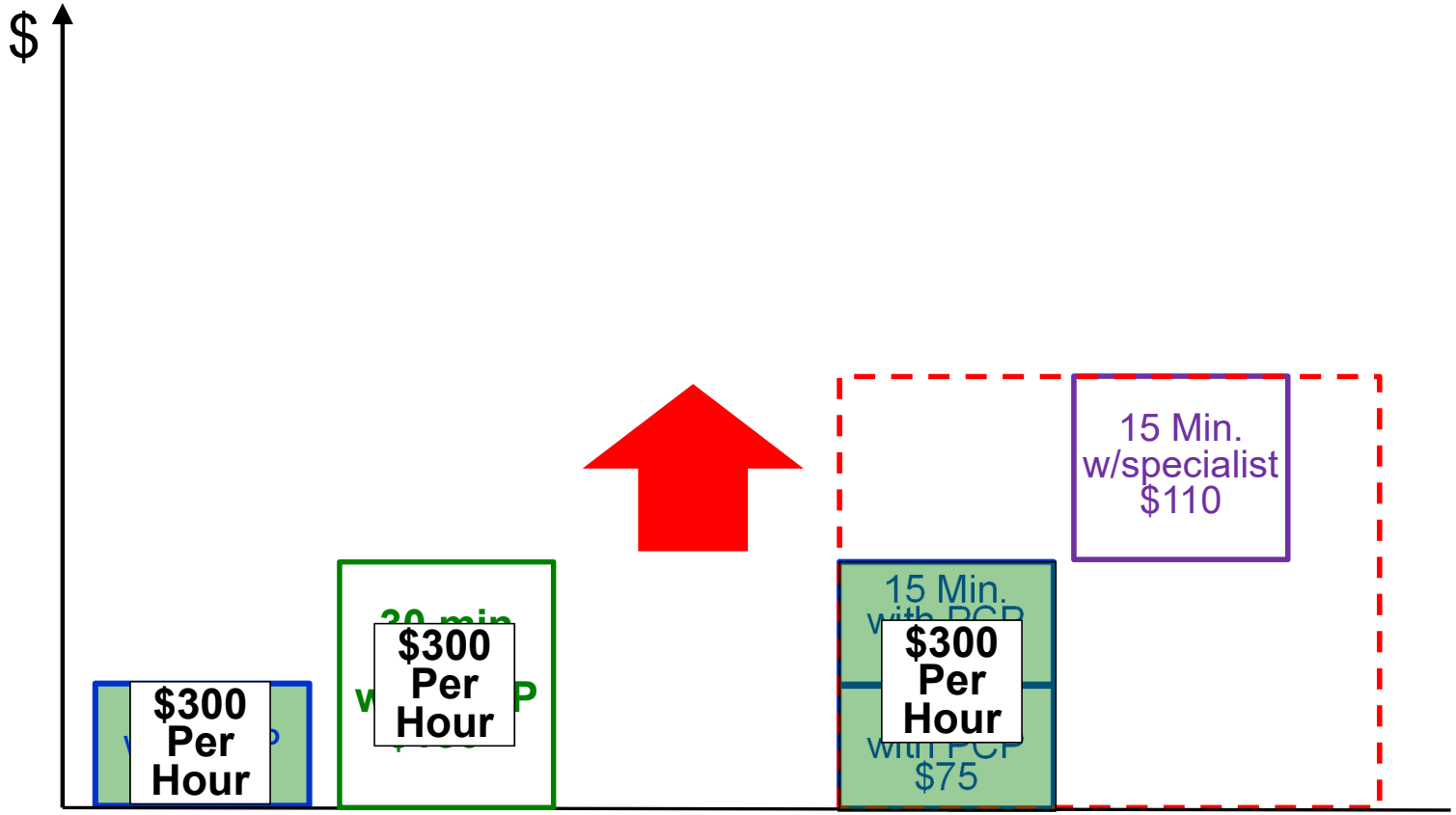
# The Result:
# Three Visits Instead of One



# The Result:
# Higher Spending, Not Savings



# The PCP Isn't Getting *Paid* More But Medicare *Spends* More



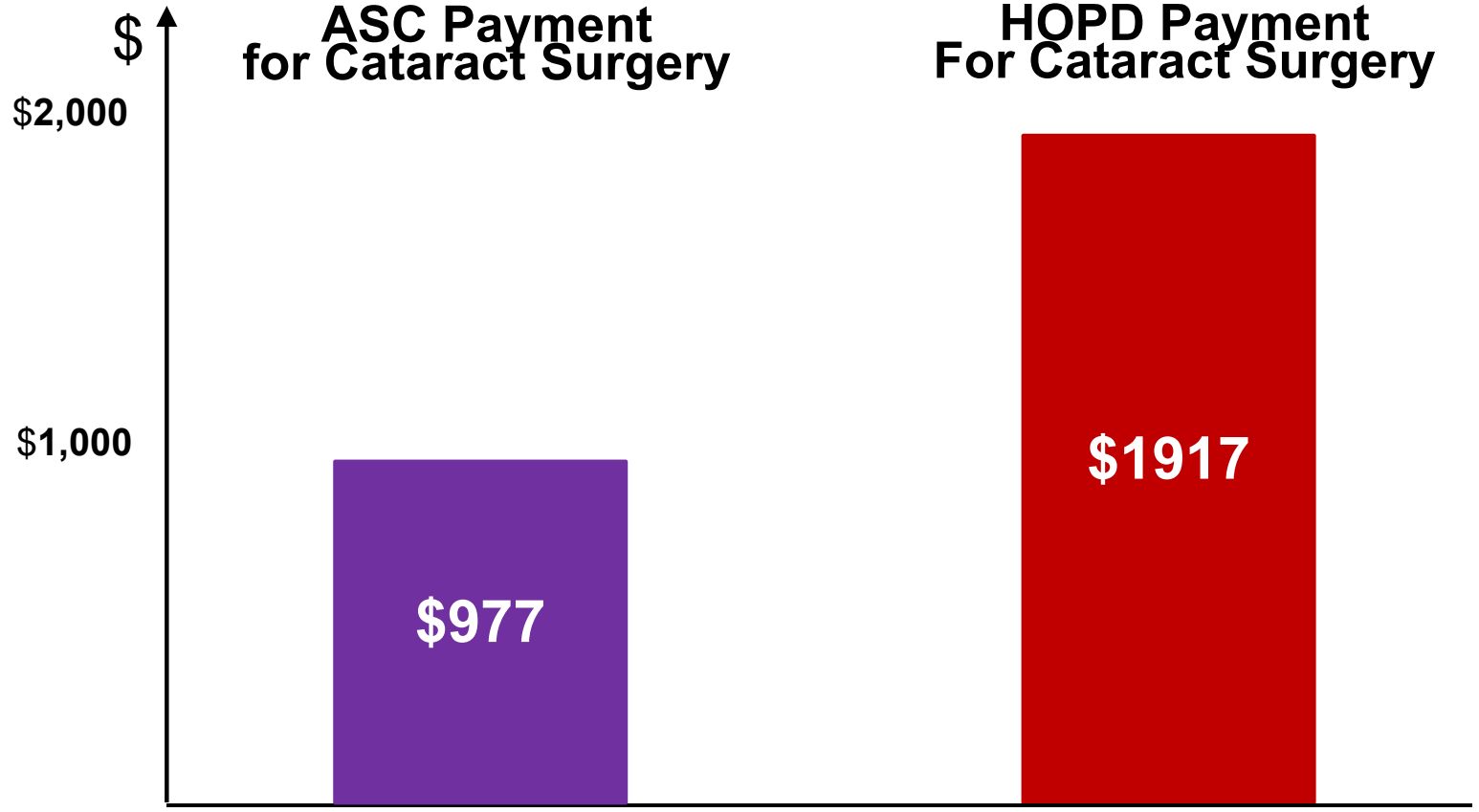
# Many Cases Where Low/$0 Fees Cause Higher Spending Elsewhere

| WE DON'T PAY (ENOUGH) FOR | SO WE END UP PAYING (MORE) FOR |
|---|---|
| Phone calls to assess symptoms | Emergency Department visits |
| Extended physician visits to accurately diagnose new symptoms | Multiple referrals to specialists, unnecessary tests, and repeat visits |
| Patient education on self-management | ED visits and hospital admissions |
| Physical therapy | Spine and joint surgeries |
| Vaginal delivery | Cesarean sections |
| Palliative care | Hospitalizations at end of life |
| Home rehabilitation | Skilled nursing facility stays |
| IV hydration at home or a physician office for complications of cancer treatment | ED visits and hospital admissions |

# The Four (Real) Problems with (Current) FFS Payment Systems

1. No fee for many high value services that could help patients and reduce overall healthcare spending
2. Fees don't match the cost of delivering high-quality care
   - Underpayment for diagnosis, preventive care, & low-cost treatment
   - Overpayment for services delivered in hospitals

# It Doesn't Cost Twice as Much to Do Surgery in a Hospital



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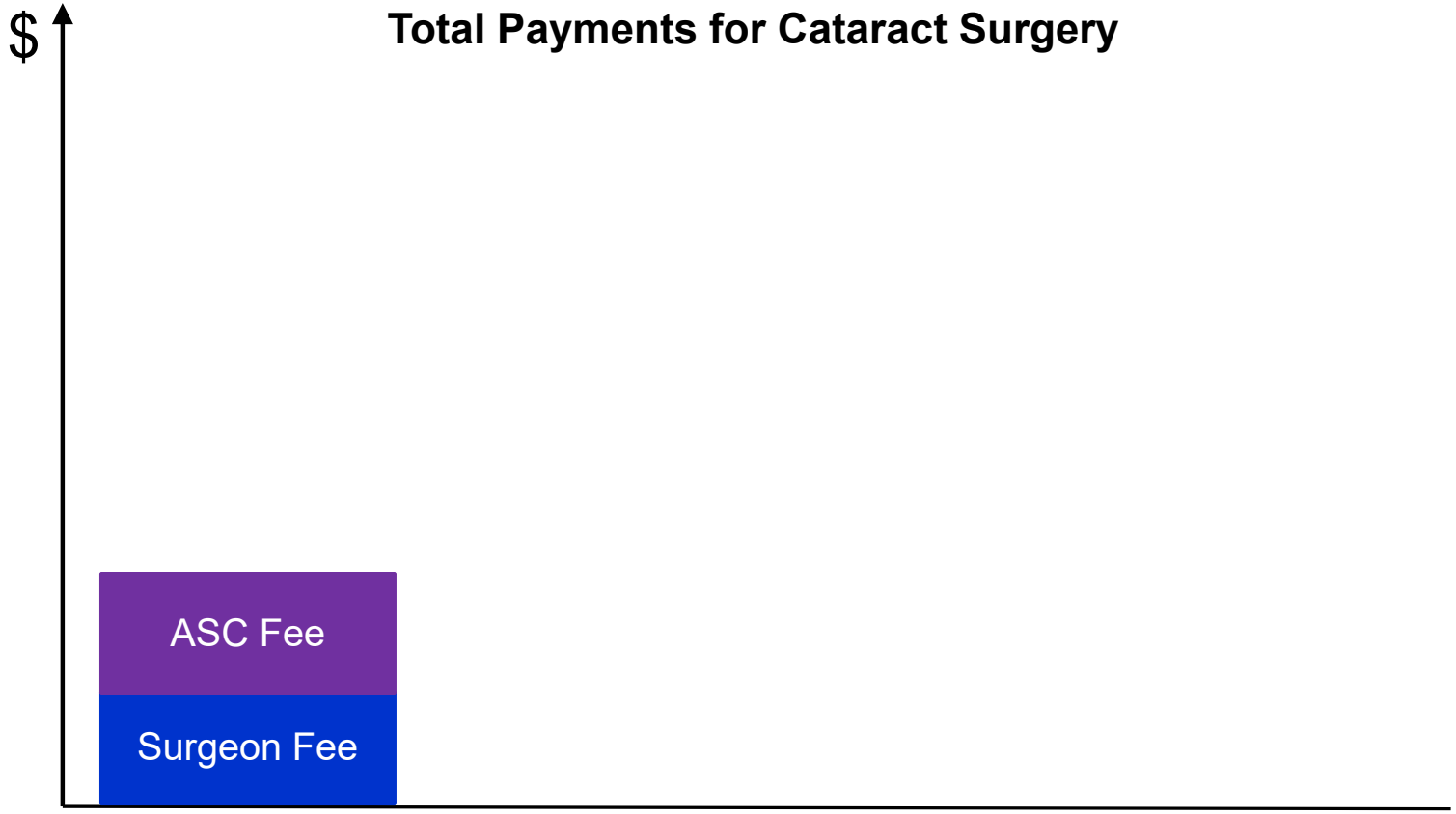
3. Impossible for patients or payers to know how much they will have to spend for treatment of a health problem

# How Much Will a Procedure or Treatment Cost, *In Total*?



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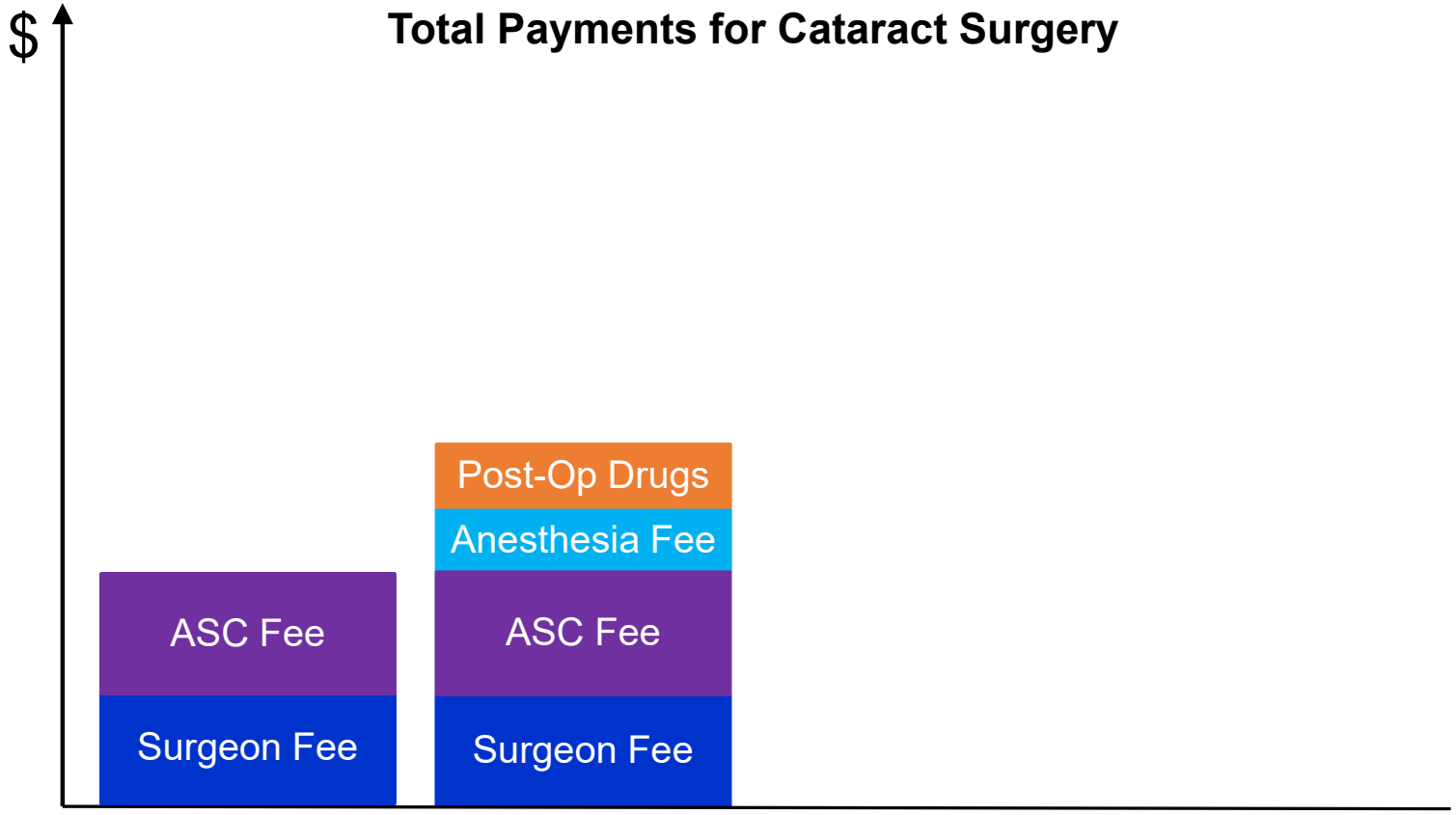

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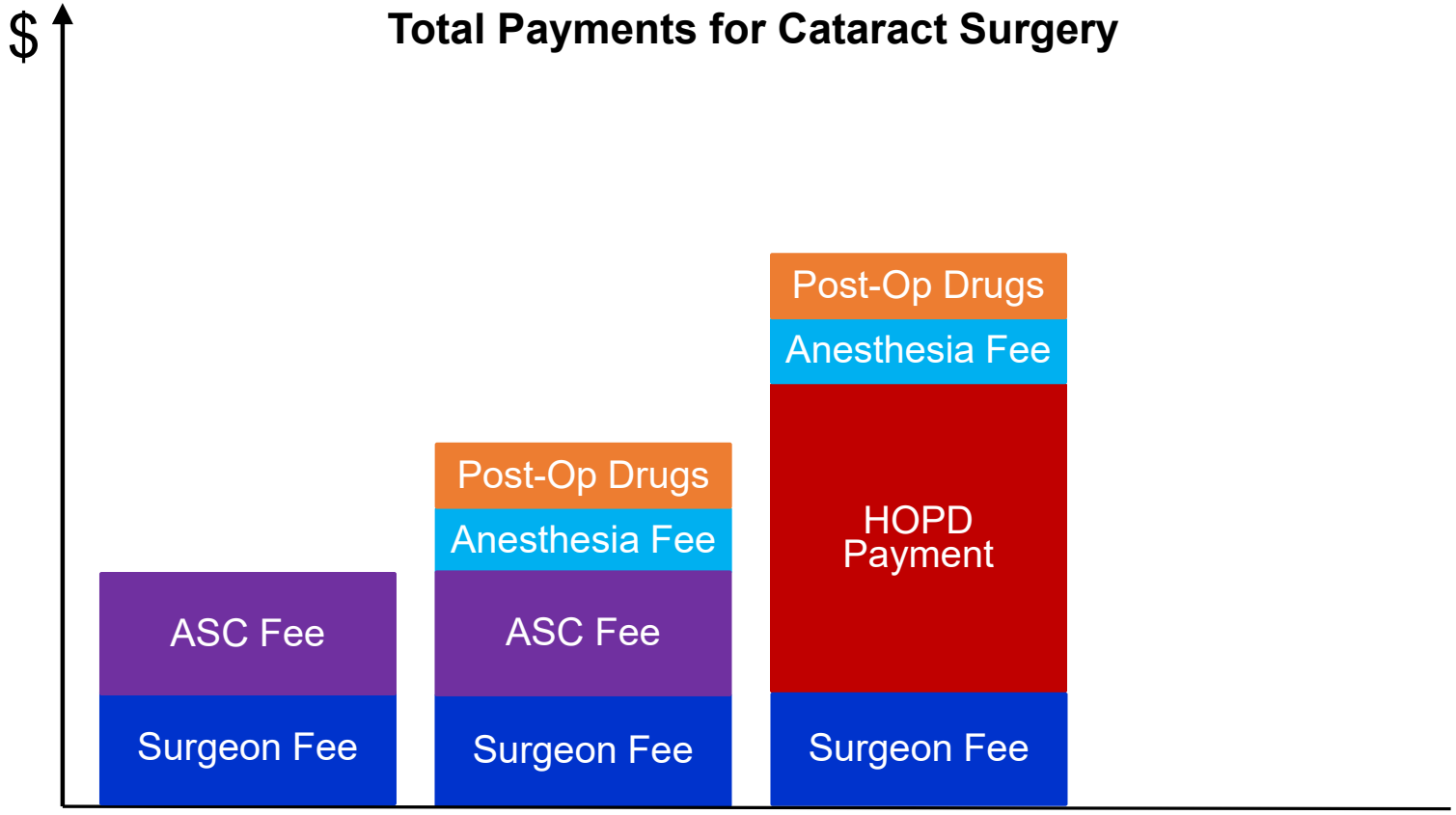

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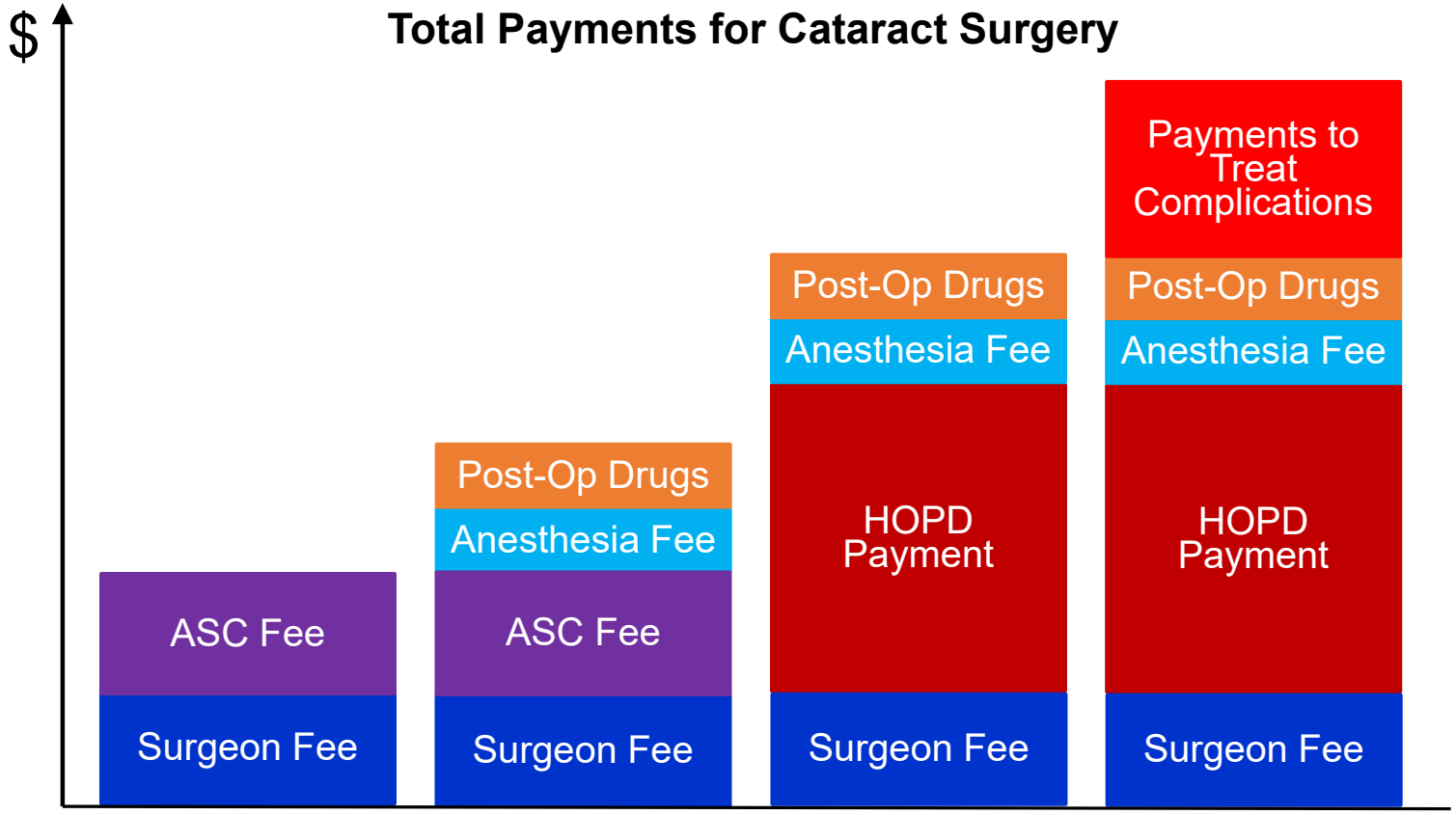

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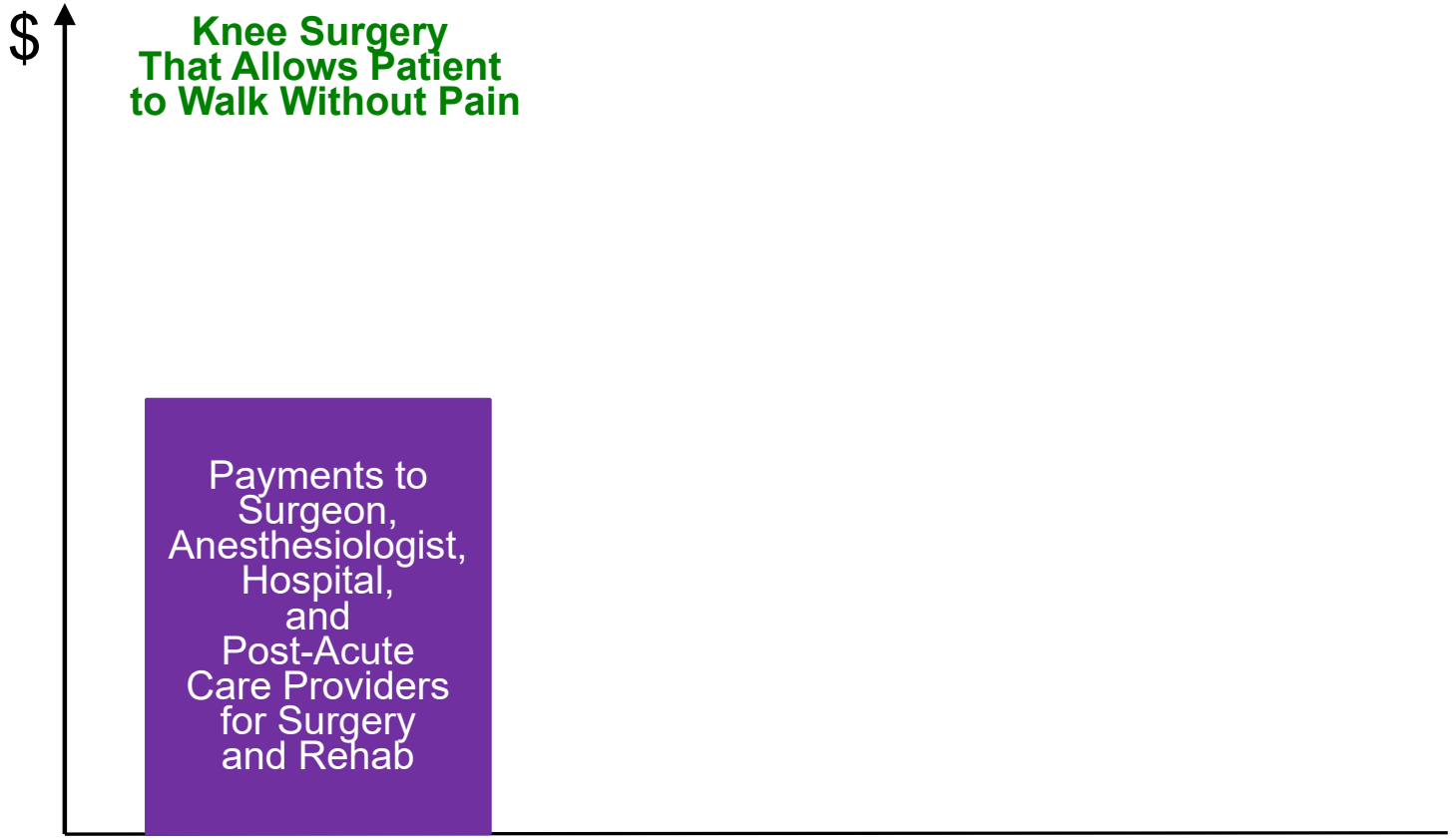
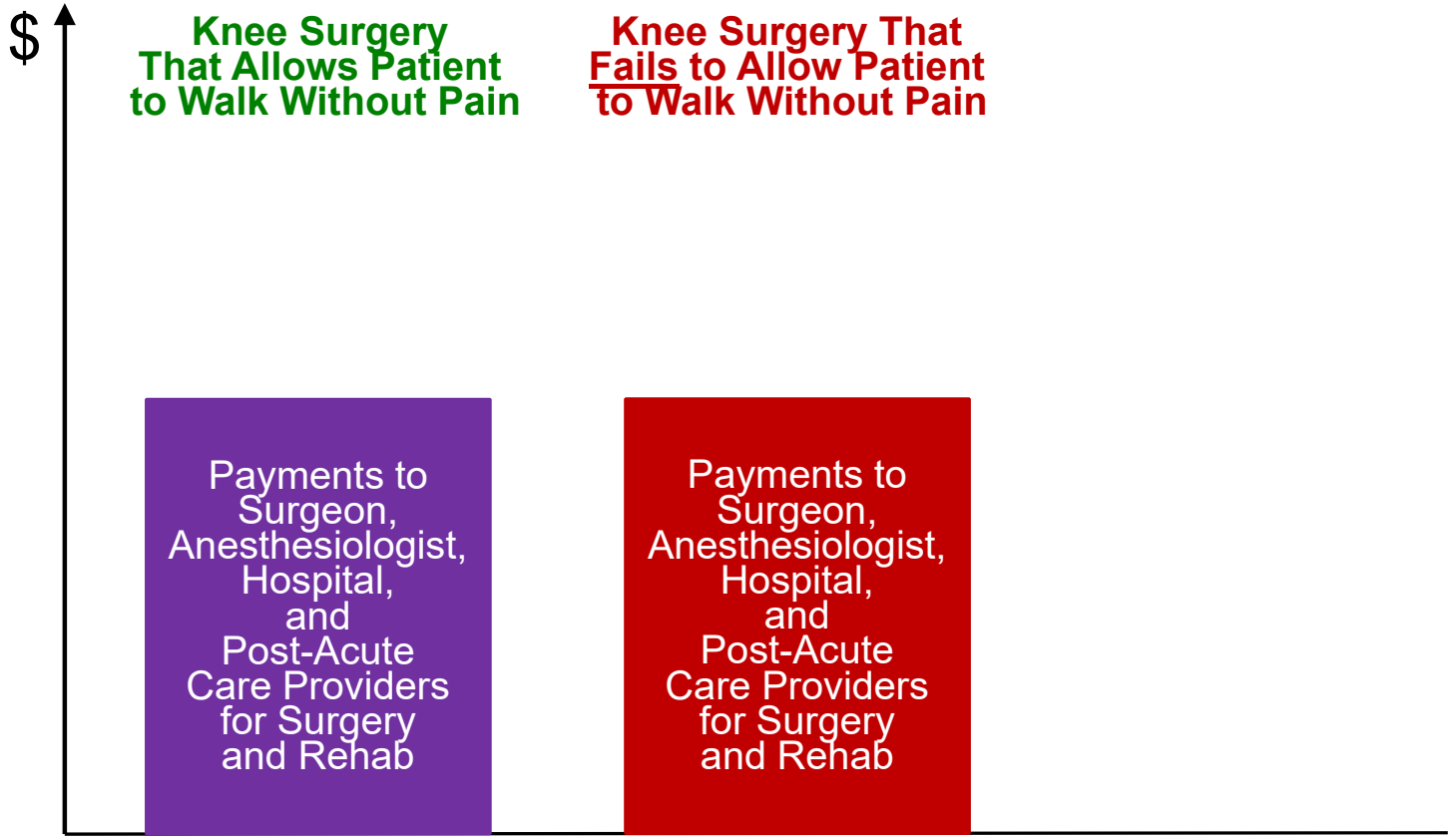
3. Impossible for patients or payers to know how much they will have to spend for treatment of a health problem
4. No assurance that a patient will receive high quality care

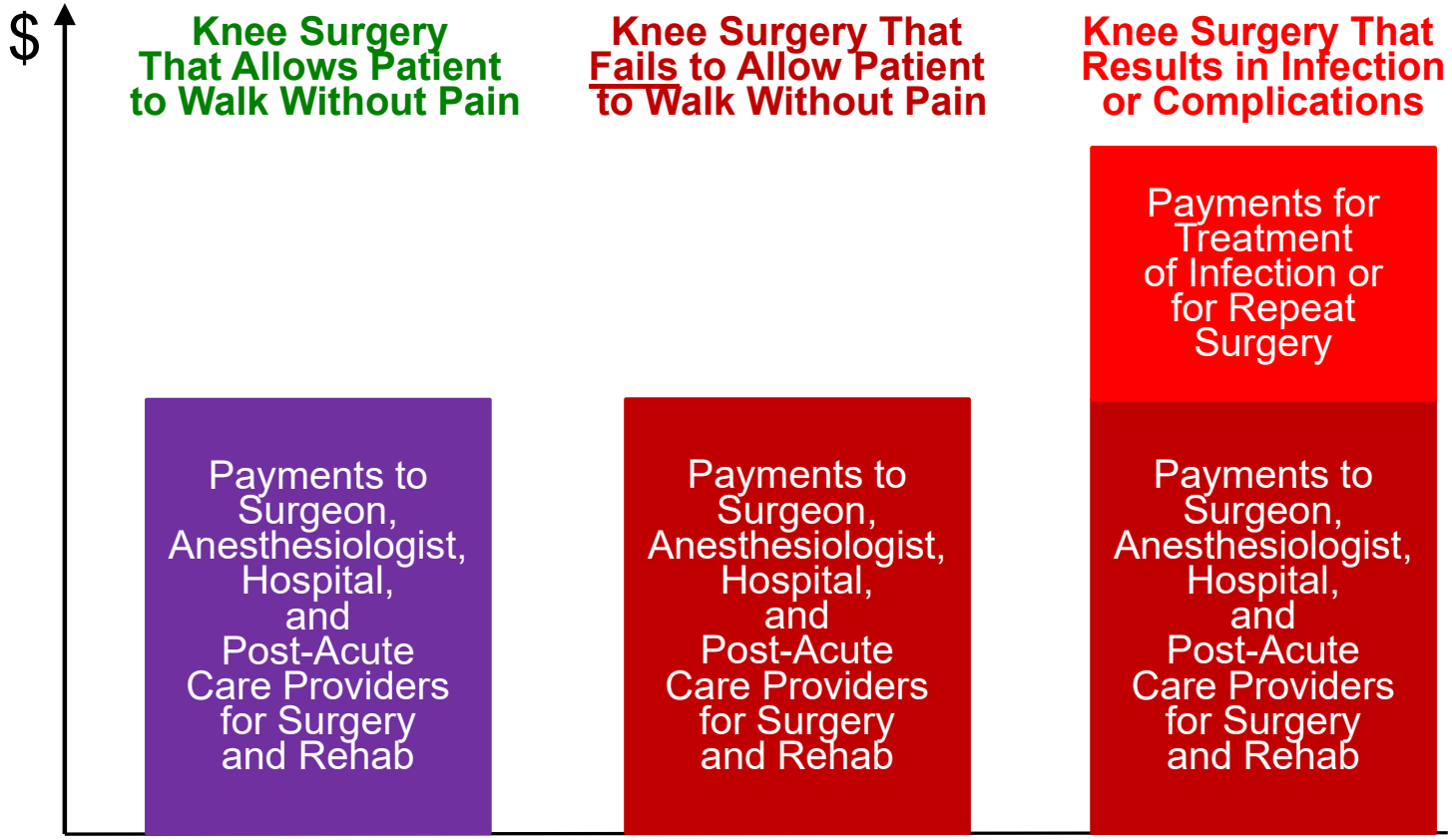
# Payment When the Treatment is Successful



# Payment When the Treatment is Unsuccessful



# Payment When the Treatment Makes Things Worse



# Current FFS Systems

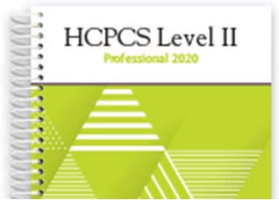
| | | FFS |
|---|---|---|
| **Weaknesses of Fee for Service** | | |
| | Payment for all high-value services? | NO |
| | Payment adequate to cover cost of services? | NO |
| | Ability to predict total payment for treatment? | NO |
| | Assurance of high-quality for each patient? | NO |

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

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

What if We Paid for *Cars* the Way We Paid for *Care*?

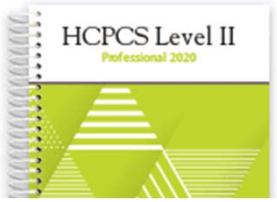
# The Government Would Set Fees for Each Car Part




HCPCS Codes (Hierarchical Car Parts Compensation System)

| | | | |
|---|---|---|---|
| 08108-09159 | Flange Weld on for Std Blow Off Valve | £ | 9.74 |
| 11001-AN001 | Turbine Kit SPL Single Z33 (VQ35DE) GT3037 RHD CARS ONLY! | £ | 4,603.50 |
| 11001-AN004 | Twin Turbo Setup Kit VQ35 2 x GT2530 RHD (see notes) | £ | 4,313.65 |
| 11001-AS003 | Turbo kit Swift ZC31S BOT+Foon IS+ I/C (w/CAT) | £ | 3,502.95 |
| 11001-KS001 | Turbo Kit Swift ZC31S BOT w/o Foon IS w/o I/C (no CAT) | £ | 1,919.50 |
| 11001-KS003 | Turbo kit Swift ZC31S BOT+Foon IS+ I/C (no CAT) | £ | 3,239.50 |
| 11001-KS004 | Turbo kit Suzuki SX4 BOT (Base Kit Only) | £ | 1,919.50 |
| 11003-AM001 | FTK GT3037S Evo 7/8/9 (inc intake system & f/pipe) | £ | 4,669.50 |
| 11003-AM001ZZ | FTK (w/o Turbine) Evo 7/8/9 (inc intake system & f/pipe) | £ | 2,799.50 |
| 11003-AM002 | Turbine Kit CZ4A GT3240 (5MT only!) | £ | 4,009.50 |
| 11003-AM003 | Turbine Kit CZ4A GT3240 (SST only!) | £ | 4,009.50 |
| 11003-AN001 | T04Z Turbine Kit S14/15 | £ | 4,944.50 |
| 11003-AN002 | T04Z Turbine KitGTR32 | £ | 5,219.50 |
| 11003-AN003 | T04Z Turbine Kit GTR33 | £ | 5,164.50 |
| 11003-AN004 | T04Z Turbine Kit GTR34 | £ | 5,164.50 |
| 11003-AN005 | NLA! Turbine Kit GT3037 S14/15 SR20DET see 11003-AN010 | £ | 2,950.00 |
| 11003-AN008 | T51R KAI BB Turbine Kit GTR34 | £ | 6,033.50 |
| 11003-AN010 | Turbine Kit Nissan S14/15 GT3037S 56T A/R0.61 RHD only! | £ | 3,025.00 |
| 11003-AN011 | GT800 FTK Nissan GTR35 | £ | 8,195.00 |
| 11003-AT001 | T04Z Special Full Turbine Kit JZA80 | £ | 5,335.00 |
| 11003-AT001ZZ | T04Z Special Full Turbine Kit JZA80 (No Turbine) | £ | 3,096.50 |
| 11003-AT004 | Turbine kit T51KAI BB JZA80 | £ | 6,033.50 |
| 11003-AZ001 | T04Z Turbine Kit FD3S | £ | 4,933.50 |
| 11003-AZ002 | T04S Turbine Kit FD3S | £ | 3,019.50 |
| 11003-KF001 | Turbine Kit Subaru GRB GT3037S (Single Scroll Ext W/gate) | £ | 3,795.00 |
| 11003-KF001ZZ | Turbine Kit Subaru GRB (No Turbine) (Single Scroll Ext W/G) | £ | 2,194.50 |

# And Pay Auto Workers Based On How Many Parts They Installed

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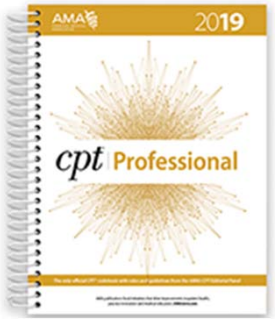
AMA
Automobile Manufacturing Association




CPT System (Car Parts Tokens)

# The Result for Drivers
# If We Paid That Way…

# The Result for Drivers
# If We Paid That Way…

Cars would get many unnecessary parts


# The Result for Drivers If We Paid That Way…

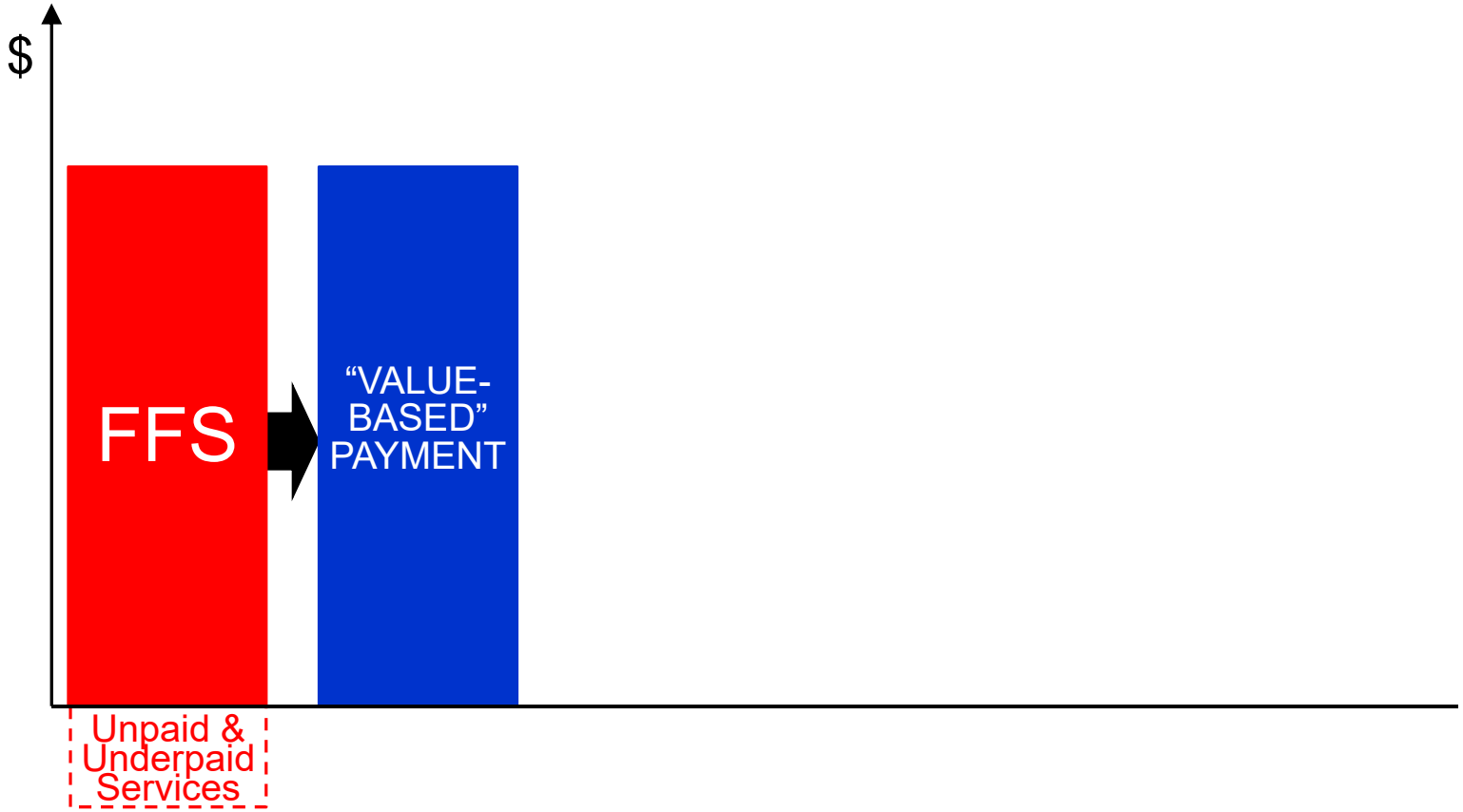
Cars would get many unnecessary parts

Cars would be readmitted to the factory frequently to correct malfunctions

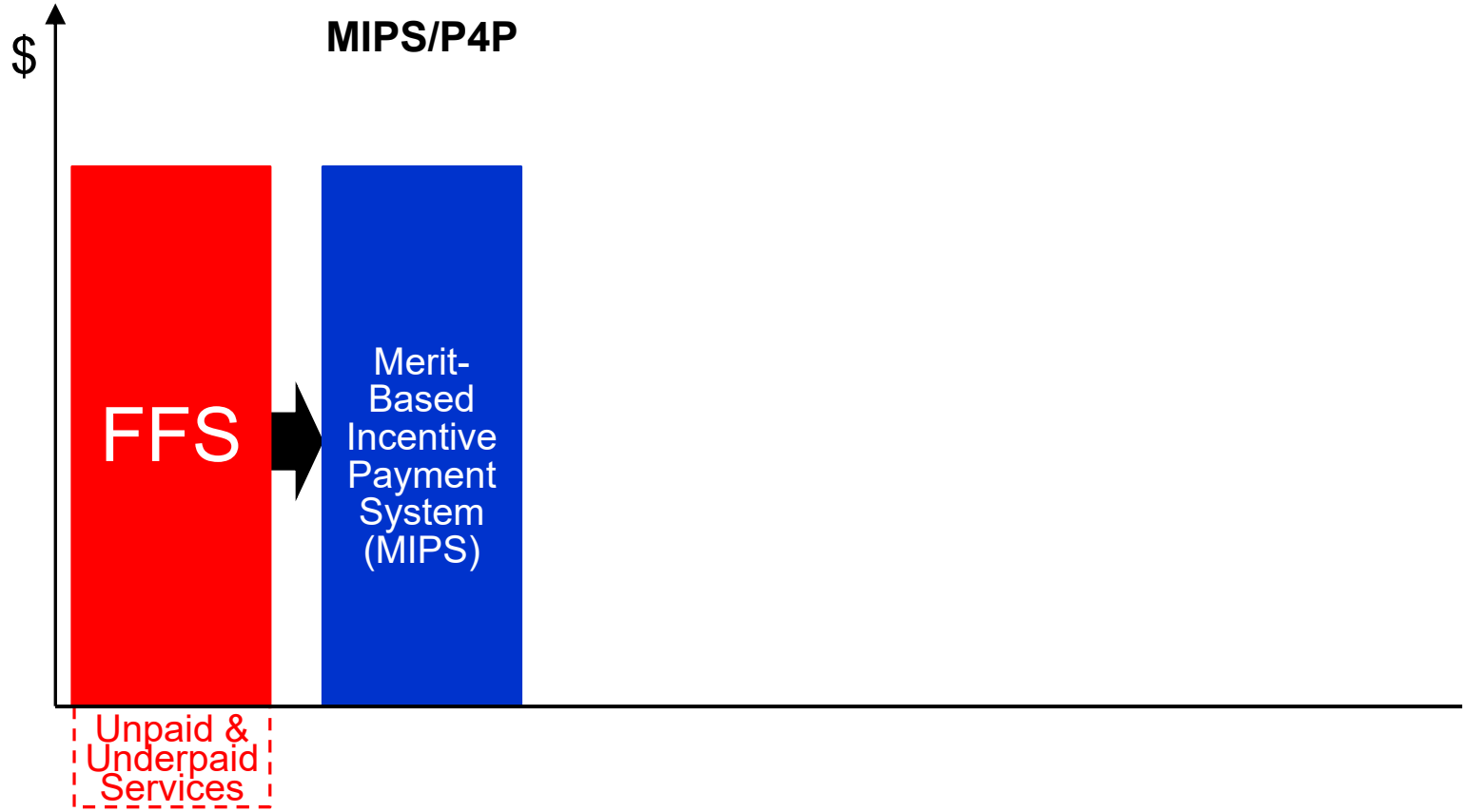
# We Won't Get "High-Value Care" Unless We Fix These Problems

| | | FFS |
|---|---|---|
| **Weaknesses of Fee for Service** | | |
| | Payment for all high-value services? | NO |
| | Payment adequate to cover cost of services? | NO |
| | Ability to predict total payment for treatment? | NO |
| | Assurance of high-quality for each patient? | NO |

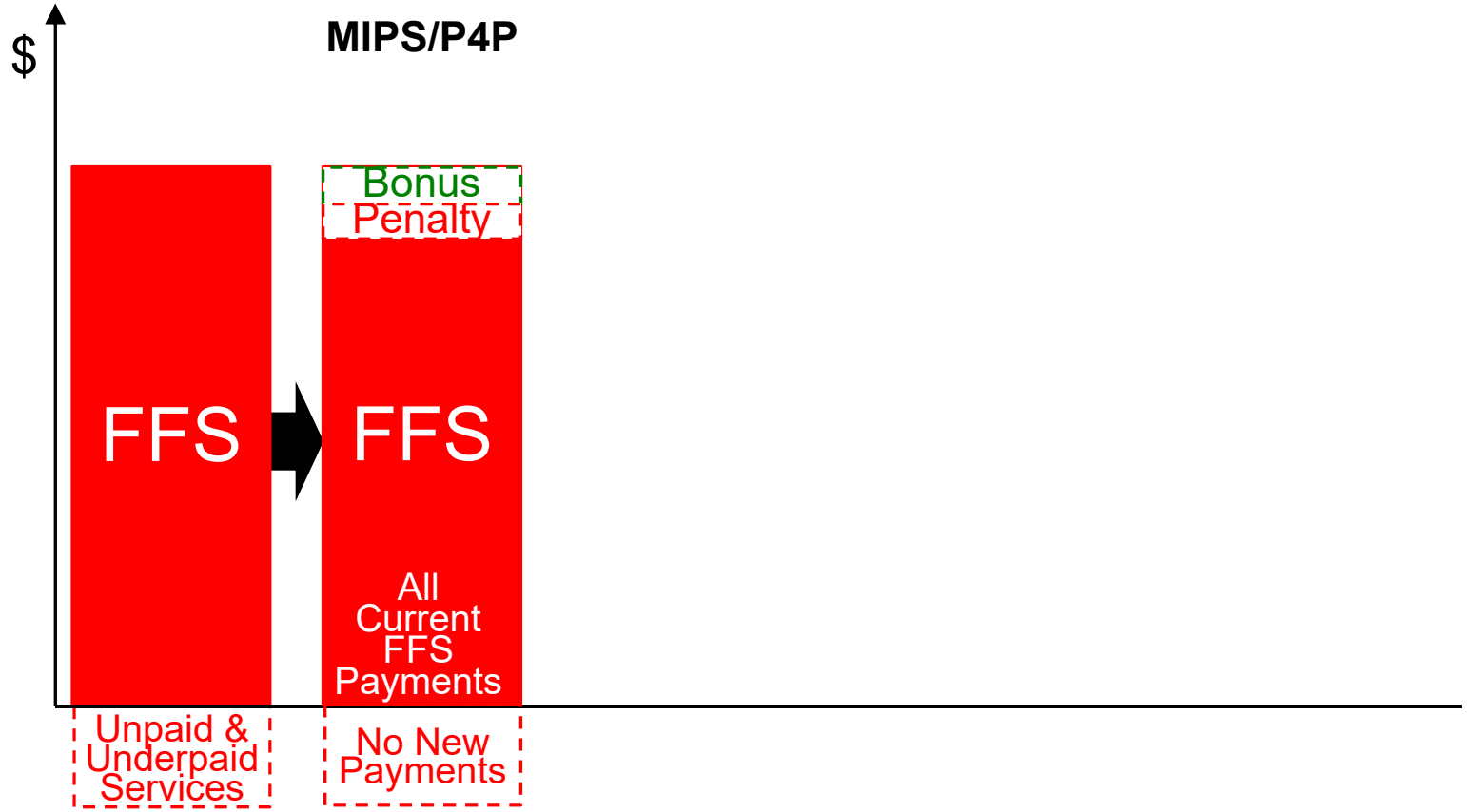
# Do “Value-Based” Payments Solve the Problems With FFS?



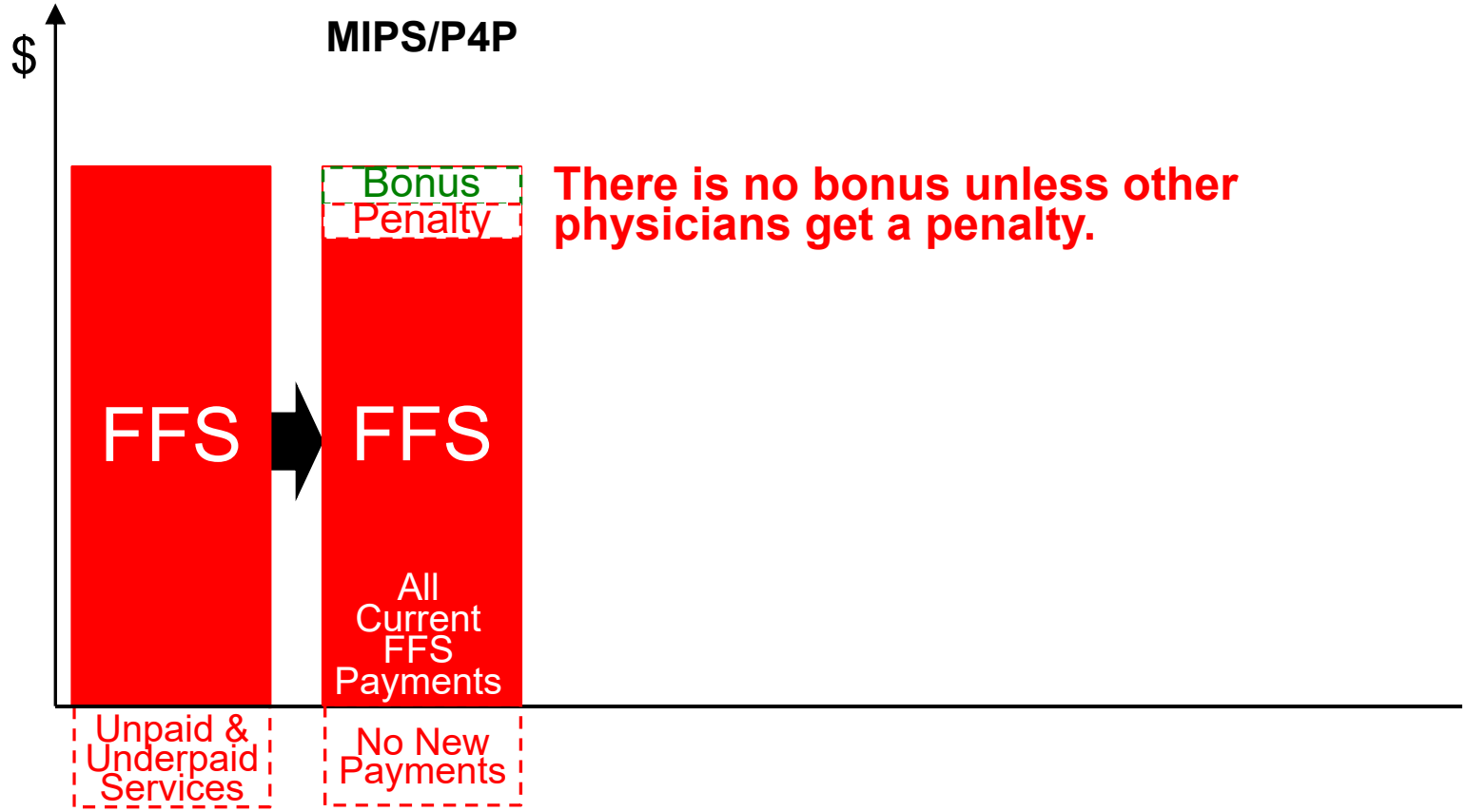
# The Most Common "Value-Based" Payment is P4P (MIPS)



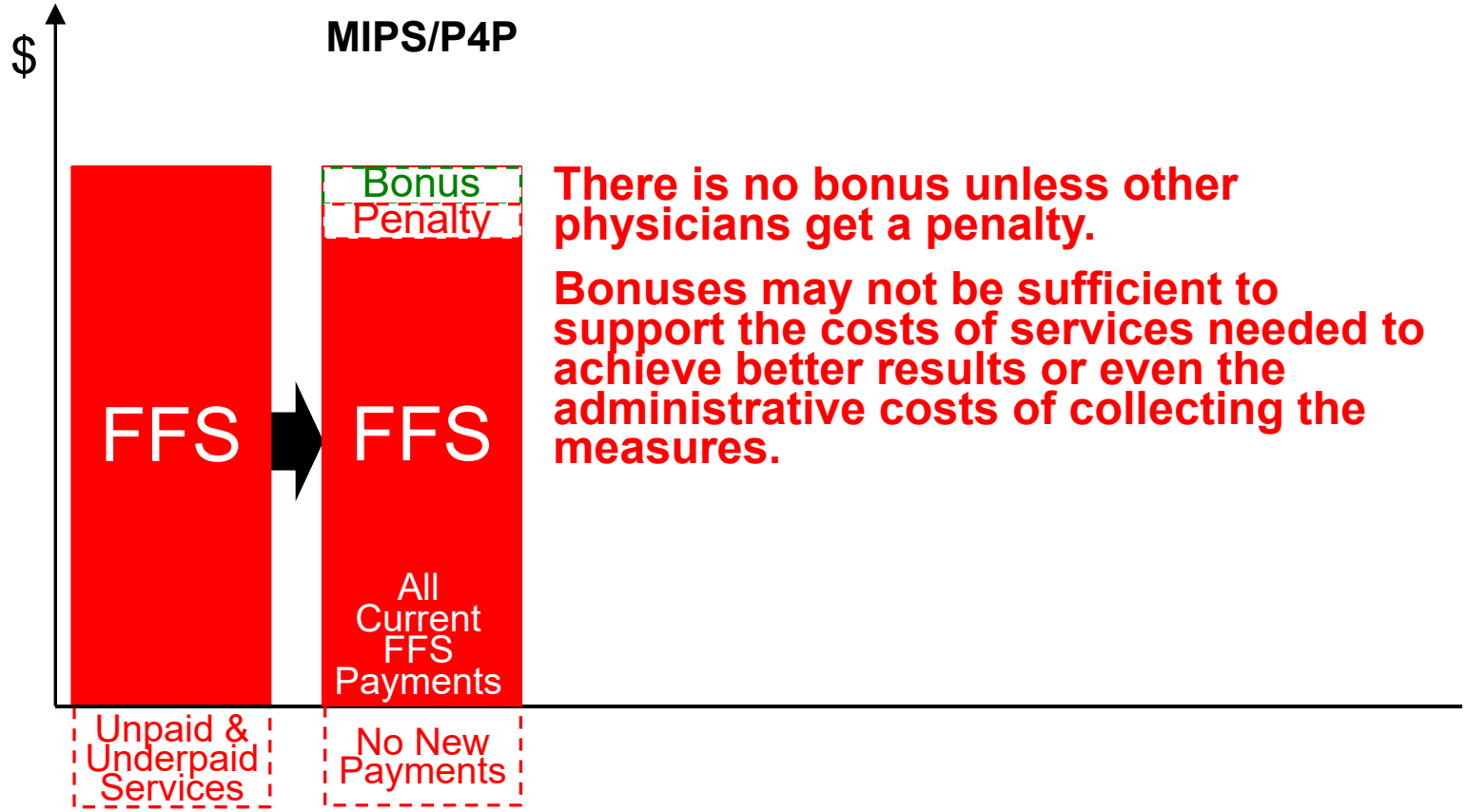
# MIPS/P4P Doesn't Add New Fees or Change Relative Fee Amounts



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



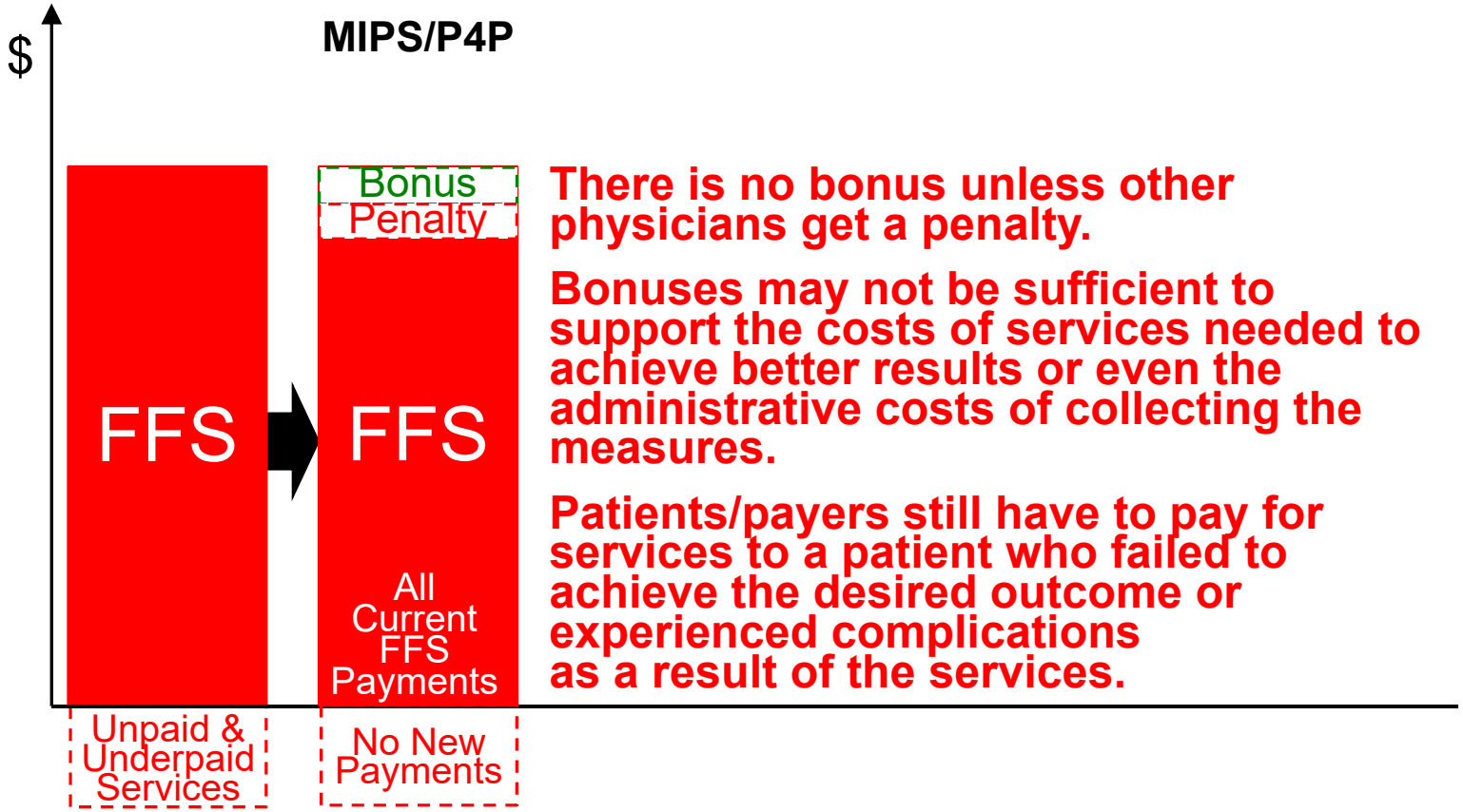
# MIPS/P4P Bonuses/Penalties Don't Enable or Ensure Quality




**There is no bonus unless other physicians get a penalty.**

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

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

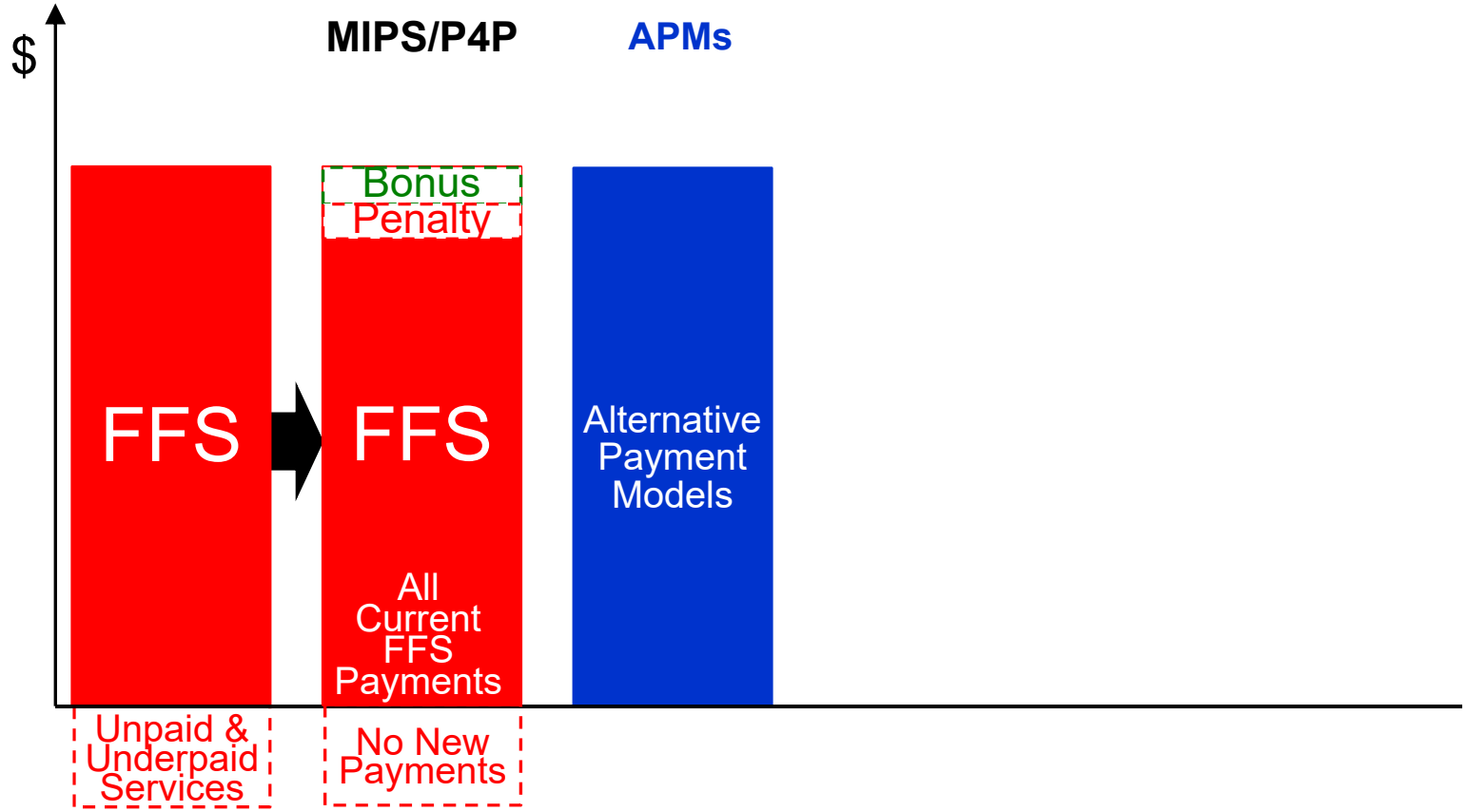



**There is no bonus unless other physicians get a penalty.**

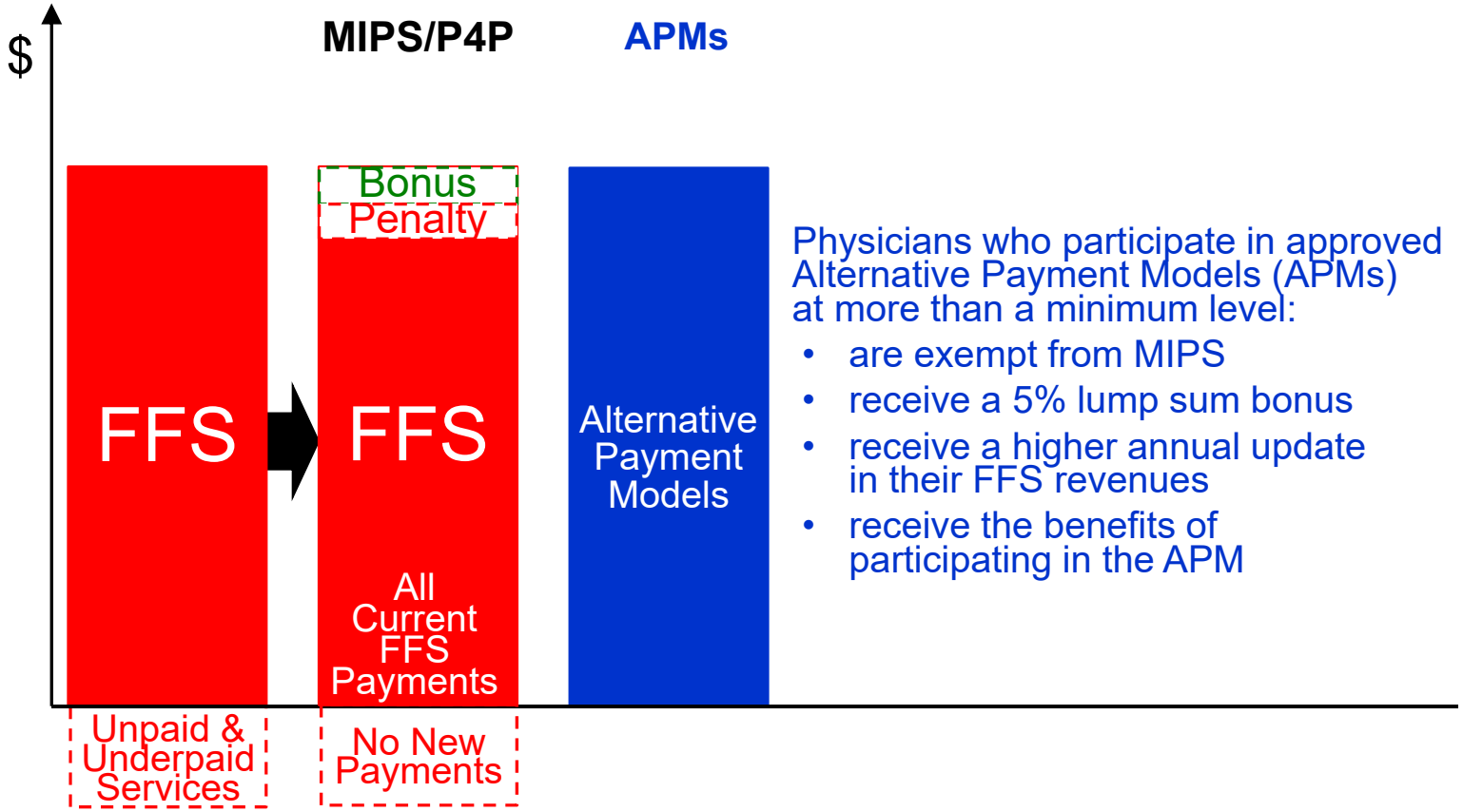
**Bonuses may not be sufficient to support the costs of services needed to achieve better results or even the administrative costs of collecting the measures.**

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

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



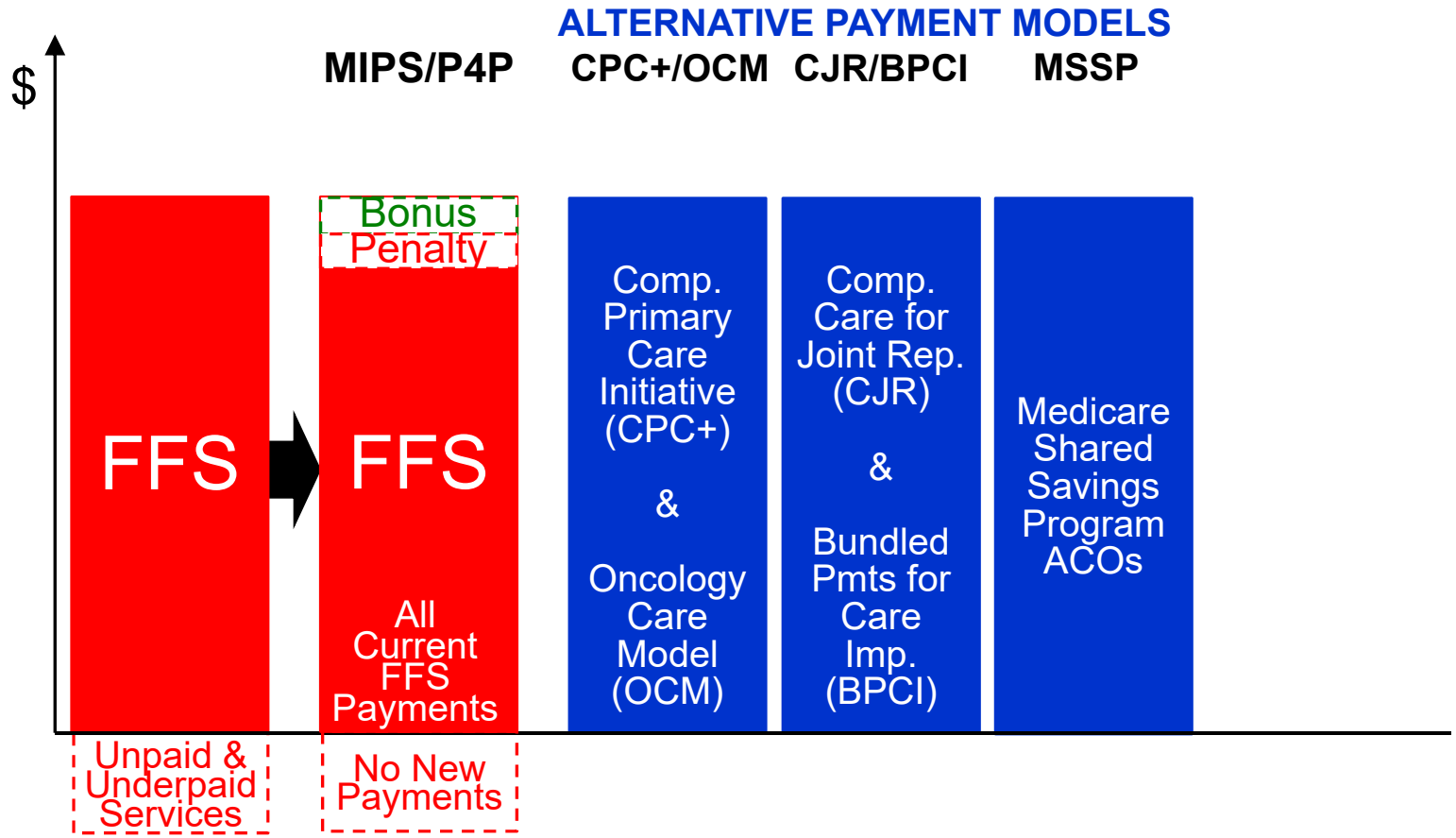
# In MACRA, Congress *Encouraged* Use of APMs Instead of MIPS



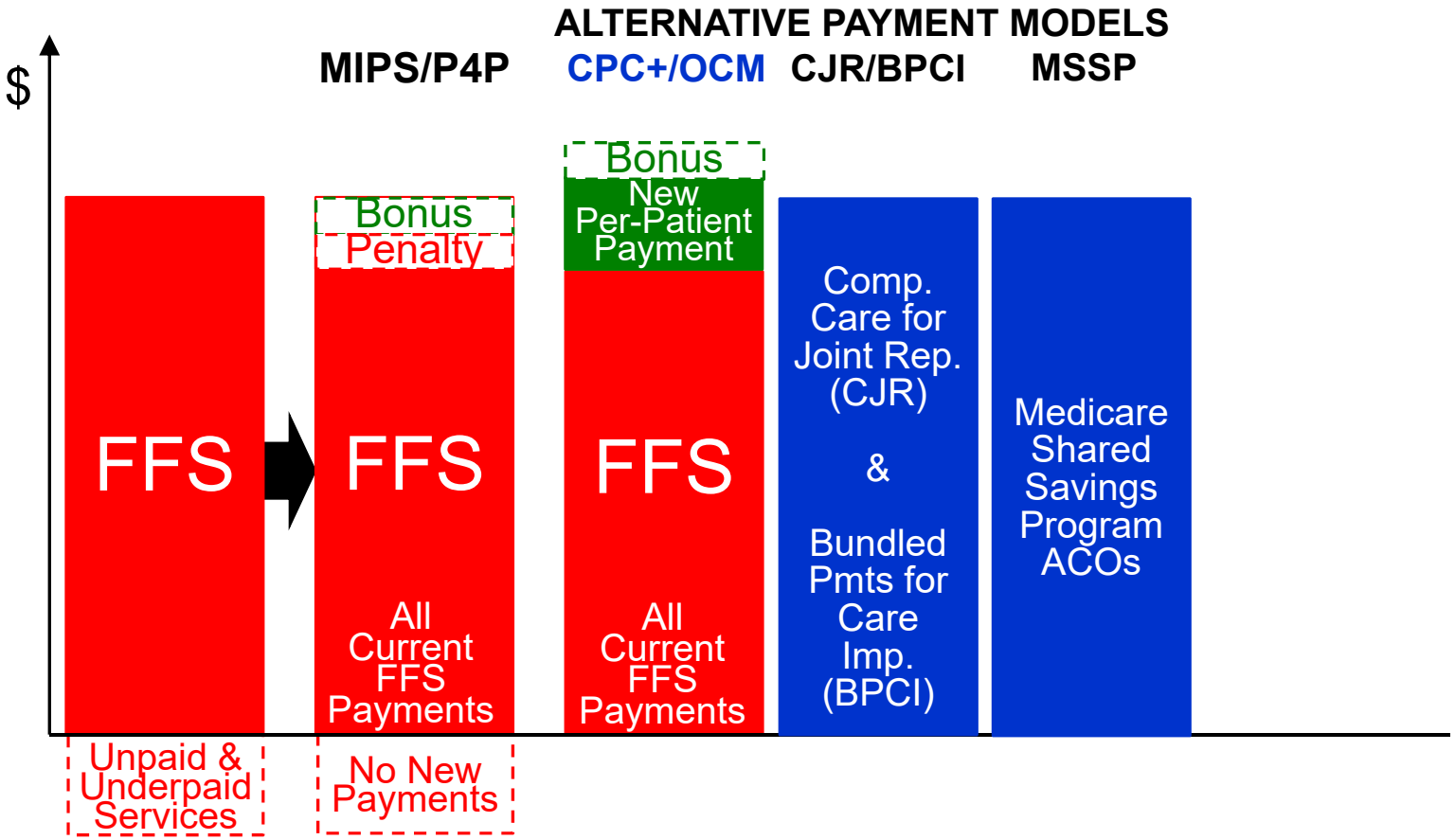

Physicians who participate in approved Alternative Payment Models (APMs) at more than a minimum level:

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

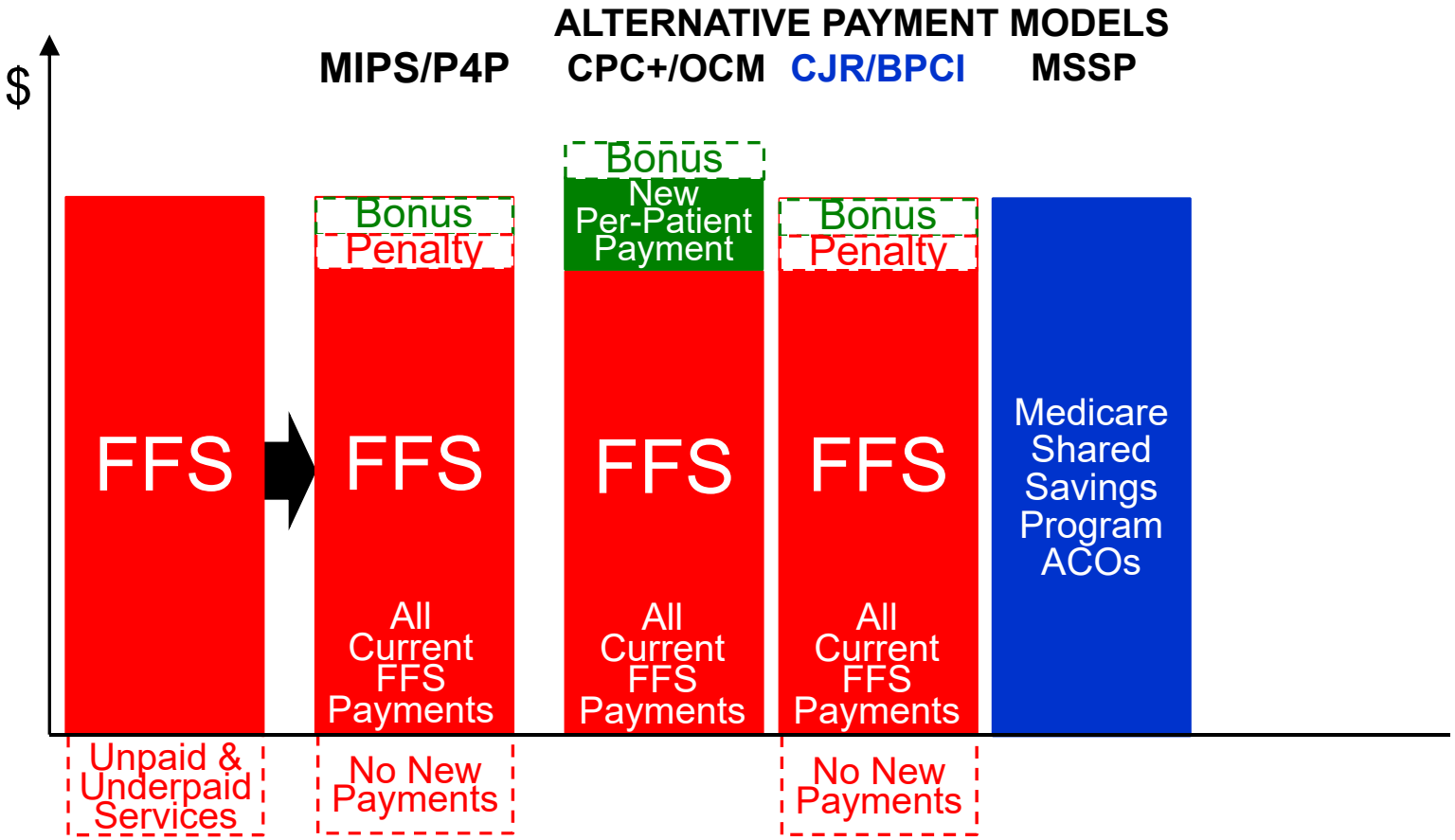
# CMS Has Only Implemented a Small Number of APMs



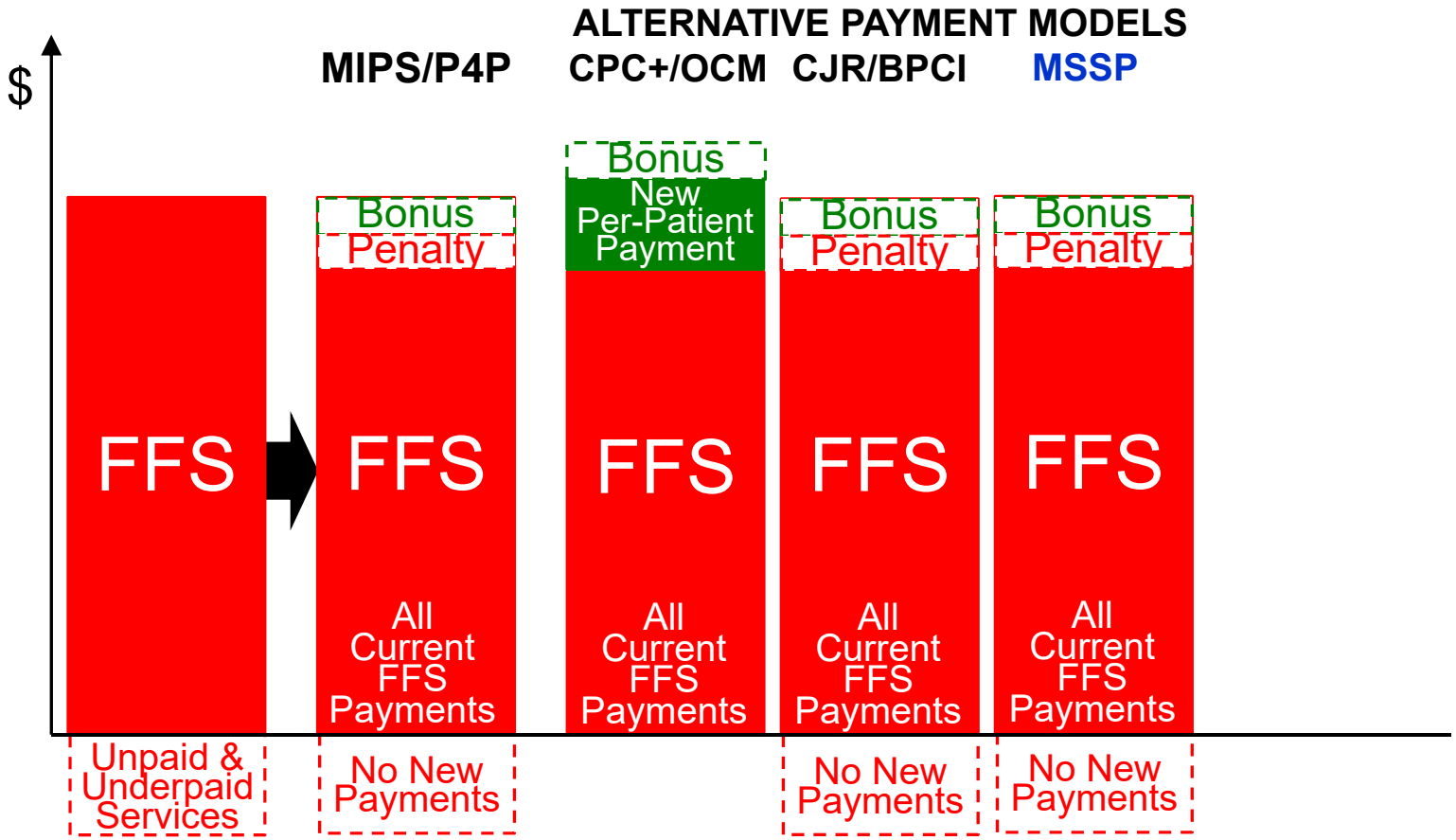
# Only 2 CMS APMs Pay for Things Standard FFS Doesn't Cover



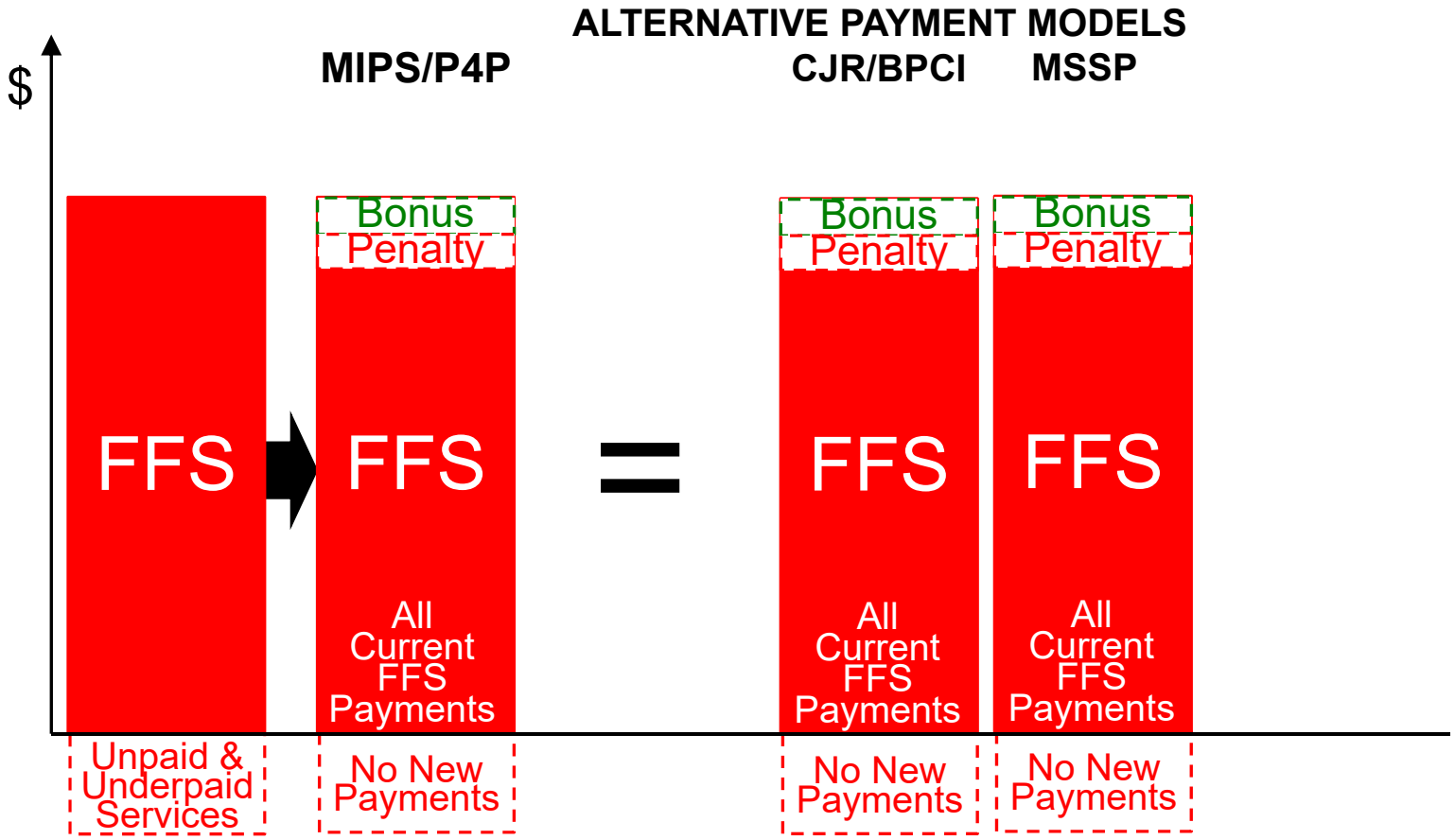
# "Bundles" Pay Standard FFS + Bonus/Penalty for Total Spending



# ACOs Get Standard FFS w/ "Shared Savings" Payments



# Most CMS "APMs" Are Just FFS + P4P Based on Spending



# If CMS APMs Don't *Change* FFS, They Can't *Solve* Its Problems

| | | FFS | CMS APMs |
|---|---|---|---|
| **Weaknesses of Fee for Service** | | | |
| | Payment for all high-value services? | NO | NO |
| | Payment adequate to cover cost of services? | NO | NO |
| | Ability to predict total payment for treatment? | NO | NO |
| | Assurance of high-quality for each patient? | NO | NO |

# Little Change in Payment Means Small Savings from CMS APMs

| CMS APM | | GROSS SAVINGS PER PATIENT | NET SAVINGS PER PATIENT AFTER PAYMENTS TO PROVIDERS | TOTAL ANNUAL NET SAVINGS TO CMS |
|---|---|---|---|---|
| CPCI | | $ 108 | ($ 72) | ($25 million) |
| CJR | Study 1 | $1,084 | $ 212 | $21 million |
| | Study 2 | $ 582 | ($289) | ($29 million) |
| BPCI | | $ 707 | ($268) | ($67 million) |
| NextGen ACOs 2017 | | $ 135 | $ 29 | $36 million |
| MSSP ACOs 2013-2016 | CMS | $ 69 | ($ 17) | ($96 million) |
| | Study | $ 115 | $ 29 | $166 million |
| MSSP 2017 (Track 1) | CMS | $ 123 | $ 37 | $291 million |
| MSSP 2017 (Risk) | CMS | $ 138 | $ 27 | $23 million |

# ACOs Savings is < Half the Cost of One Office Visit Per Pt Per Year

| CMS APM | | GROSS SAVINGS PER PATIENT | NET SAVINGS PER PATIENT AFTER PAYMENTS TO PROVIDERS | TOTAL ANNUAL NET SAVINGS TO CMS |
|---|---|---|---|---|
| CPCI | | $ 108 | ($ 72) | ($25 million) |
| CJR | Study 1 | $1,084 | $ 212 | $21 million |
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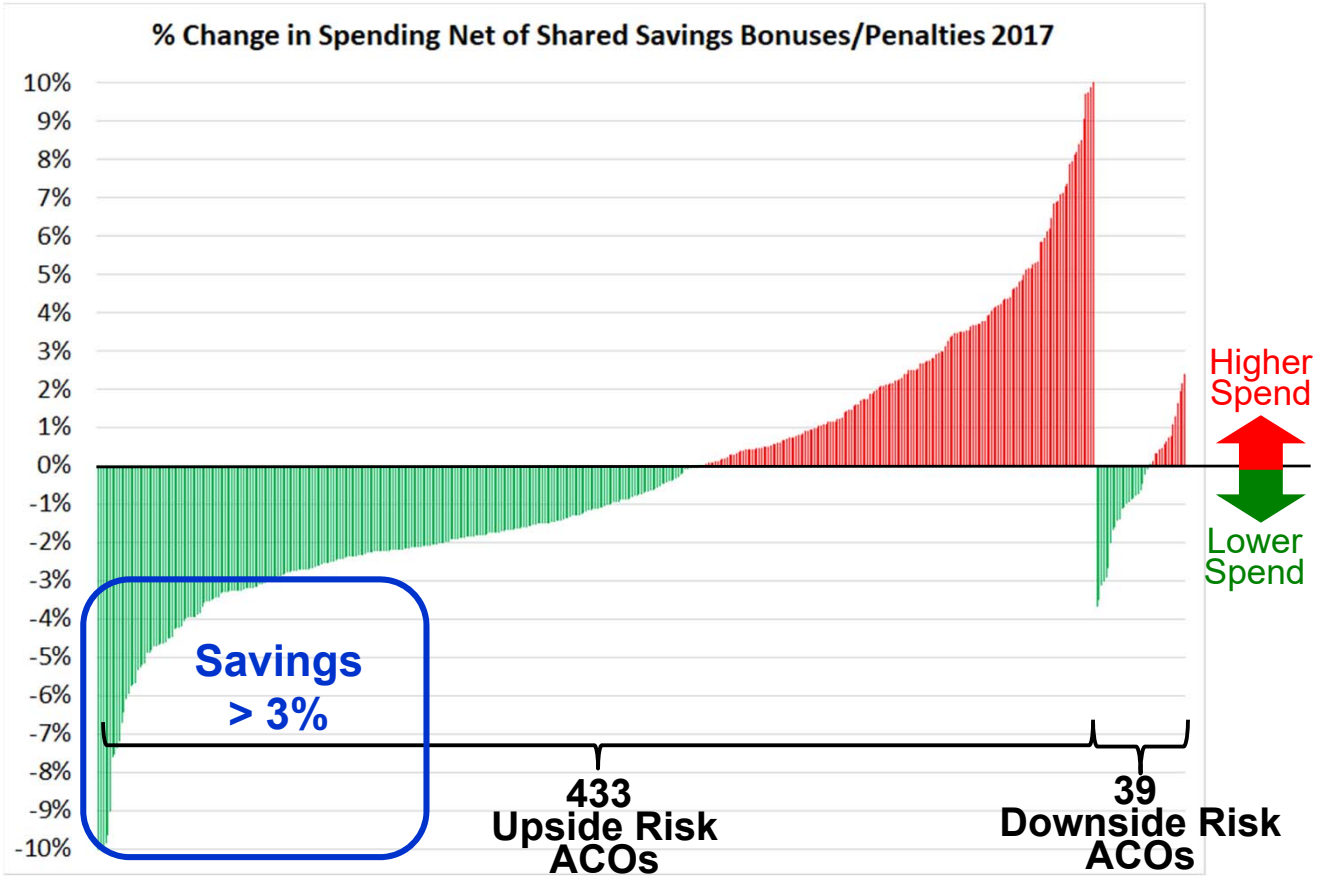
| | Study | $ 115 | $ 29 | $166 million |
| MSSP 2017 (Track 1) | CMS | $ 123 | $ 37 | $291 million |
| MSSP 2017 (Risk) | CMS | $ 138 | $ 27 | $23 million |

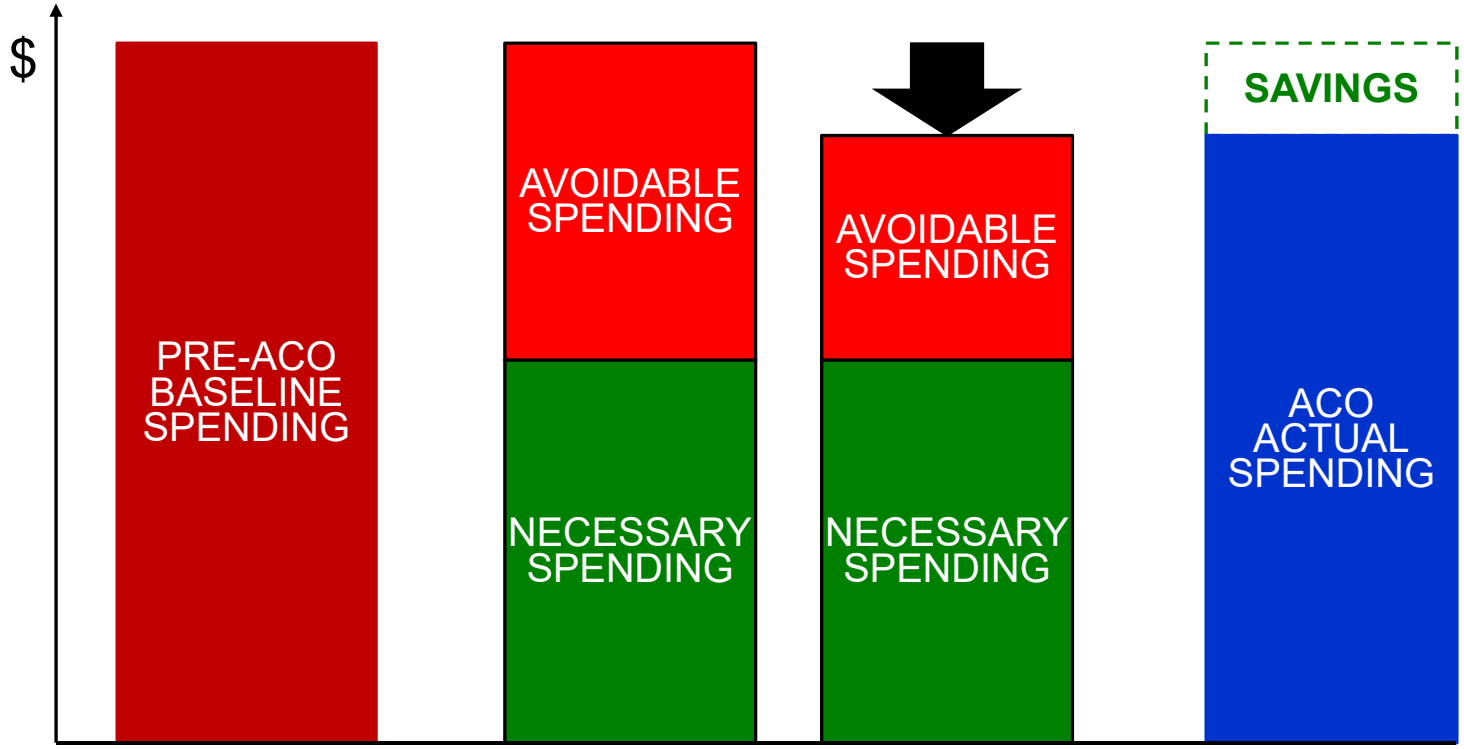
# Little Savings *Overall* From ACOs, But *Some* Are Saving a *Lot*



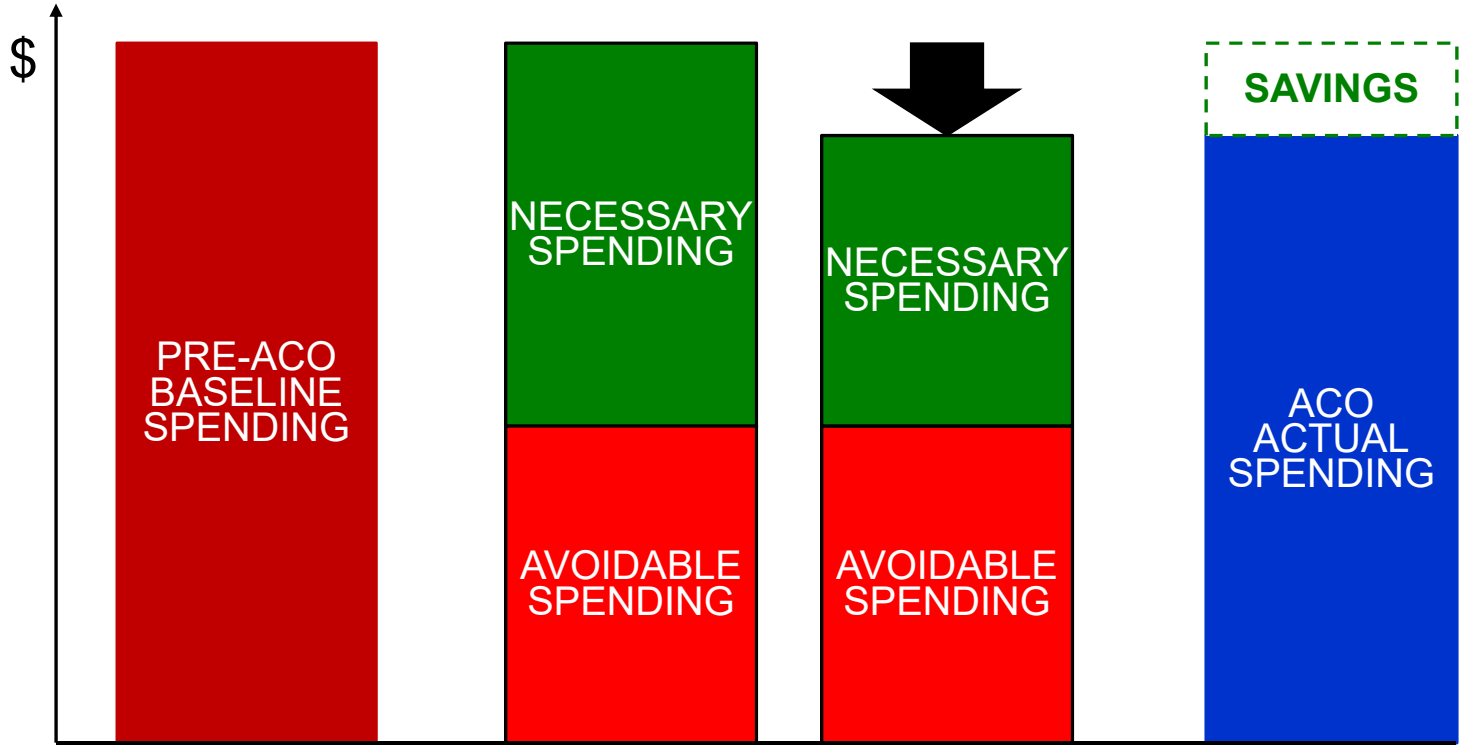

Source: Centers for Medicare and Medicaid Services ACO Public Use Files

# How Did the ACOs That Saved Money Achieve the Savings?

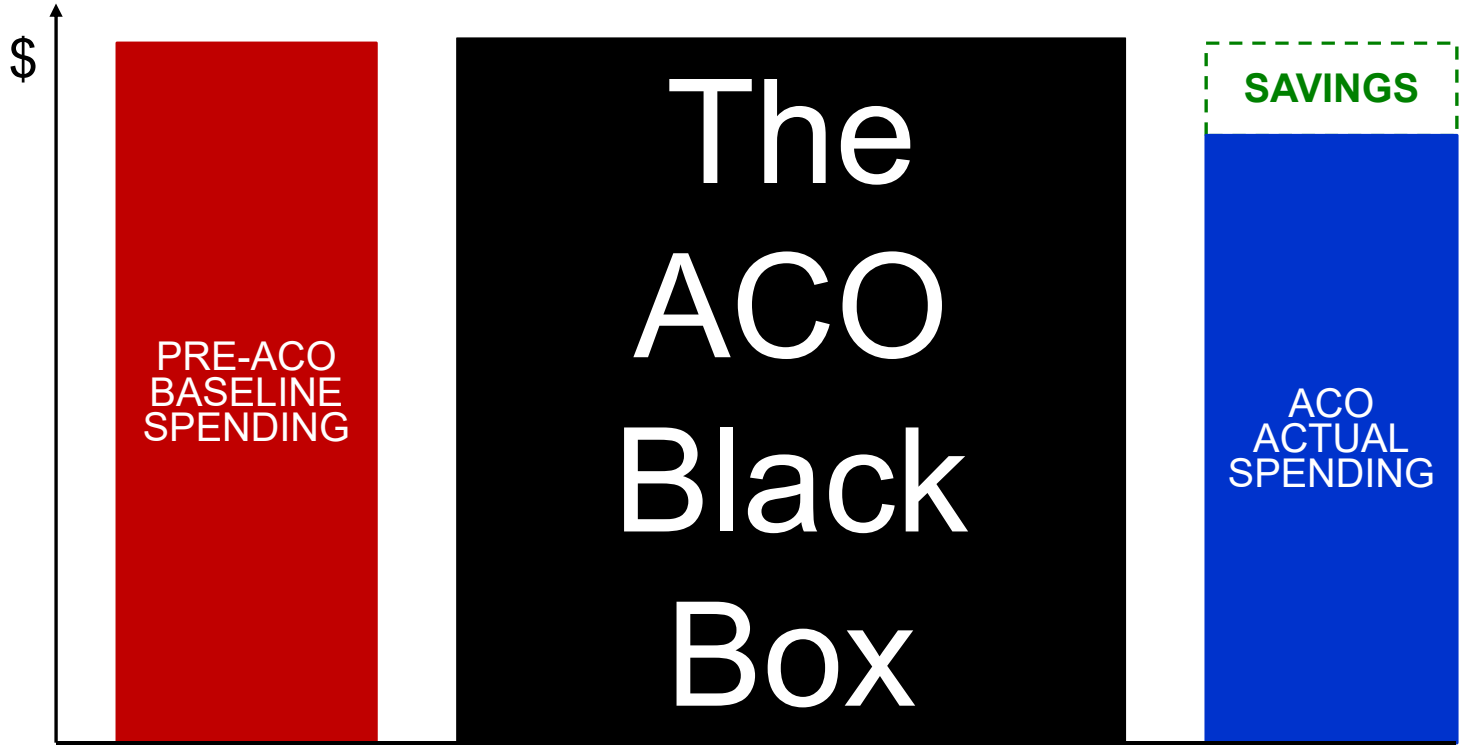
# Did They Reduce Spending on Undesirable/Unnecessary Svcs?



# Or Did They Stint on Necessary Care to Produce Savings?



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



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

**ACO Quality Measures**

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

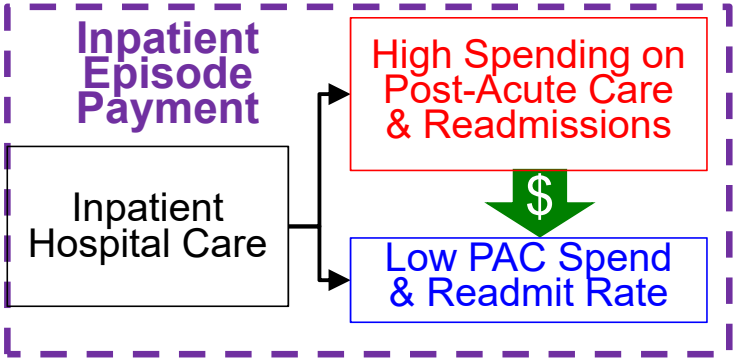
**No Measures to Assure:**

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

# Small Savings In Bundles Because The Opportunity is Relatively Small

**SAVINGS OPPORTUNITIES IN HOSPITAL EPISODE PAYMENTS**

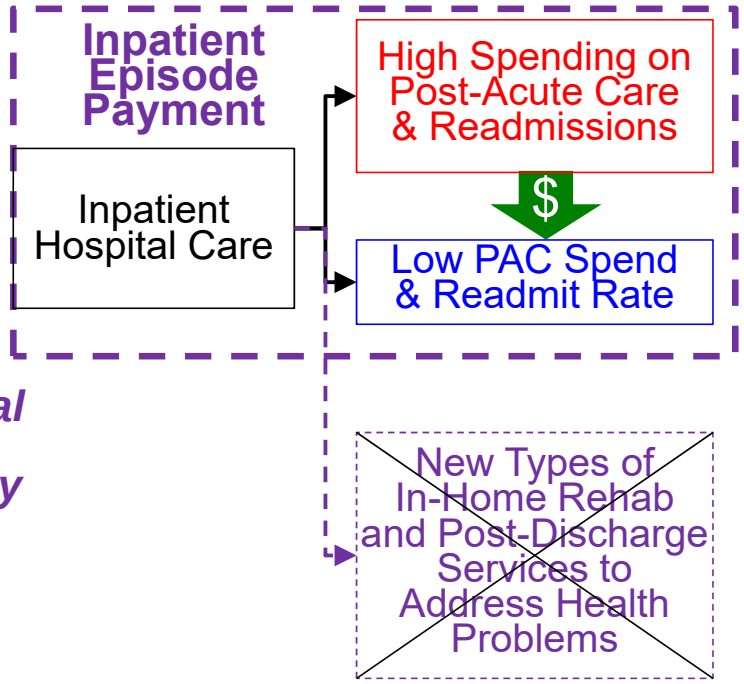
- Reduce use of inpatient post-acute rehabilitation
- Reduce hospital readmissions due to complications



# No New/Different Payments for Redesign of Post-Acute Care

**SAVINGS OPPORTUNITIES IN HOSPITAL EPISODE PAYMENTS**

- Reduce use of inpatient post-acute rehabilitation
- Reduce hospital readmissions due to complications



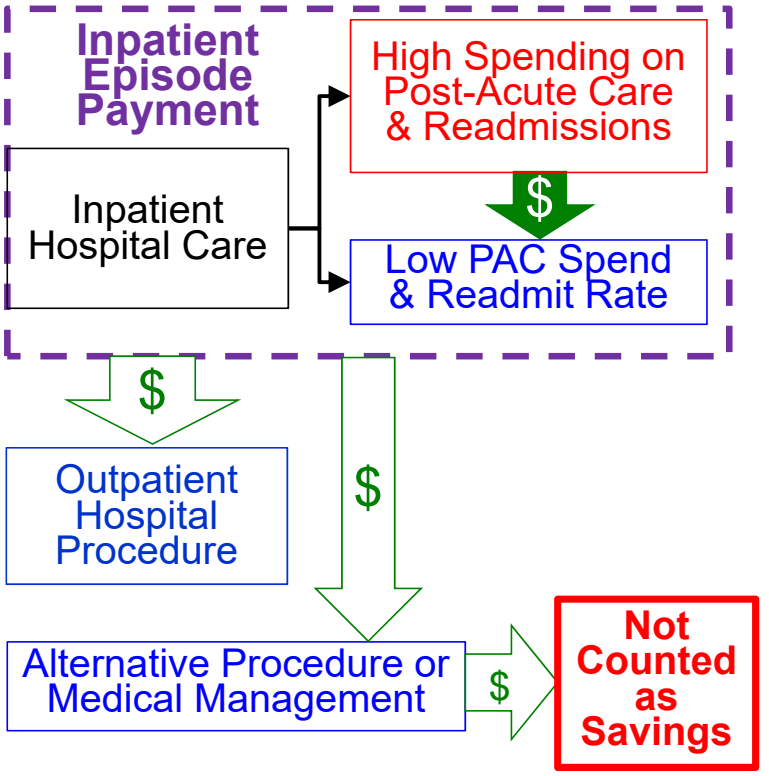

***In BPCI/CJR, only standard hospital and post-acute care services are paid for directly, so there is no easy way to develop new types of in-home rehabilitation services or to improve physician follow-up and care management after discharge***

# No Credit or Incentive for Biggest Savings Opportunities

**SAVINGS OPPORTUNITIES IN HOSPITAL EPISODE PAYMENTS**

- Reduce use of inpatient post-acute rehabilitation
- Reduce hospital readmissions due to complications

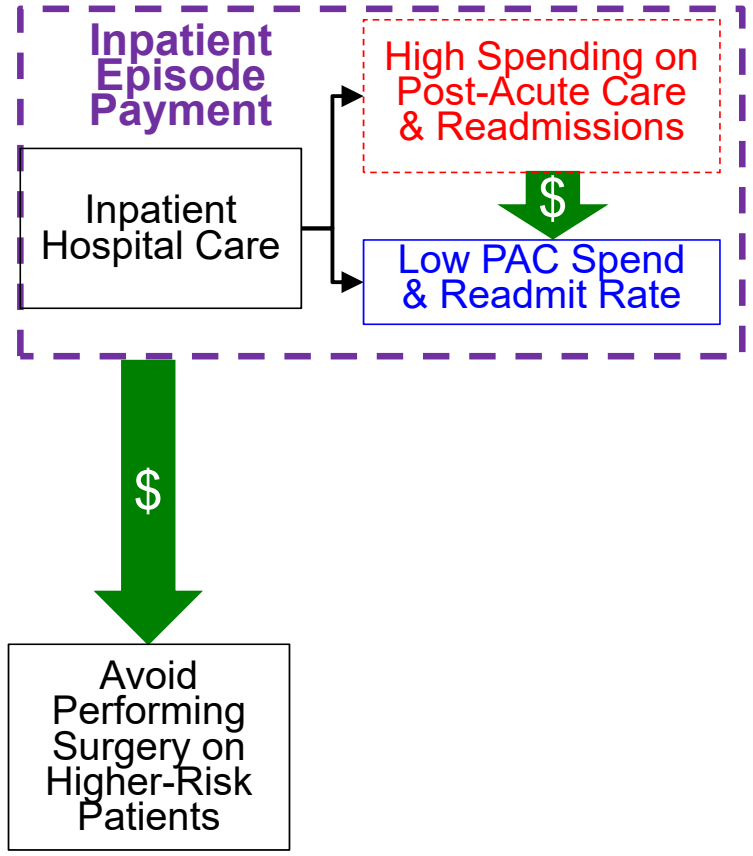
***In BPCI/CJR, the trigger is the inpatient surgery or hospital admission, so if outpatient surgery is used, or if the hospital admission can be avoided altogether, there is no "savings" credited to the program and many providers lose revenue***



# Potential Reward for Avoiding Higher-Risk Patients

**SAVINGS OPPORTUNITIES IN HOSPITAL EPISODE PAYMENTS**

- Reduce use of inpatient post-acute rehabilitation
- Reduce hospital readmissions due to complications




***In BPCI/CJR, there is only limited risk-adjustment, so avoiding patients who would need significant post-acute care or be at high risk of readmissions would result in "savings" and associated bonus payments***

# Growing Concerns About Negative Impacts of Current VBP

## The Hospital Readmissions Reduction Program — Time for a Reboot

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

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

Health Policy & Economics

The Journal of Arthroplasty 33 (2018) 2722–2727

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

Mark A. Cairns, MD, MS *, Peter T. Moskal, MD, Scott M. Eskildsen, MD, MS, Robert F. Ostrum, MD, R. Carter Clement, MD, MBA

*Department of Orthopaedics, University of North Carolina Health Care, Durham, North Carolina*

By Adam A. Markovitz, John M. Hollingsworth, John Z. Ayanian, Edward C. Norton, Nicholas M. Moloci, Phyllis L. Yan, and Andrew M. Ryan

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

DOI: 10.1377/hlthaff.2018.05407
HEALTH AFFAIRS 38,
NO. 2 (2019): 253–261

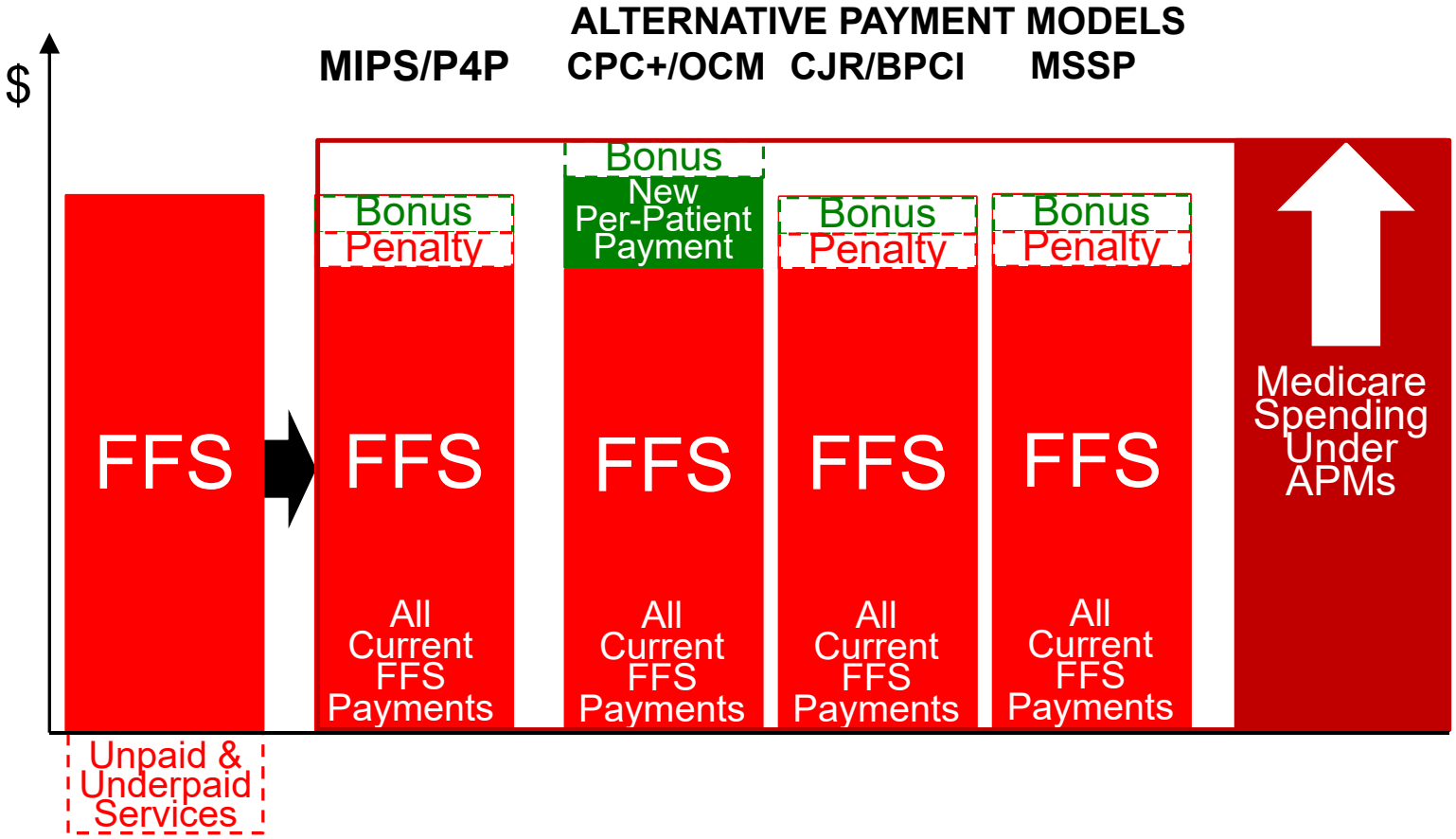

Modern Healthcare

May 22, 2019 05:56 PM

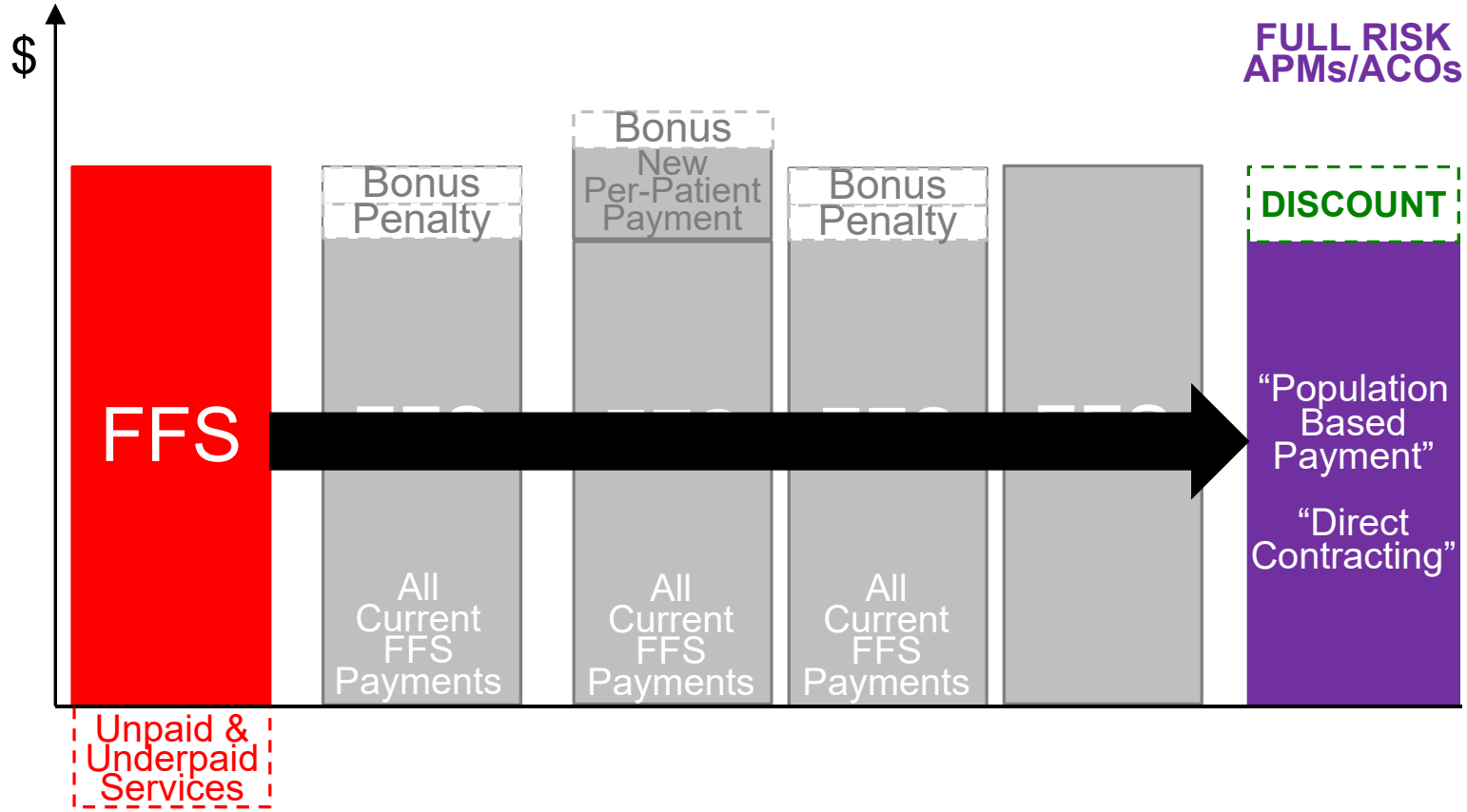
## Oncologists set to lose big under CMS payment model

STEVEN ROSS JOHNSON

# Since Current APMs Aren't Reducing Spending…



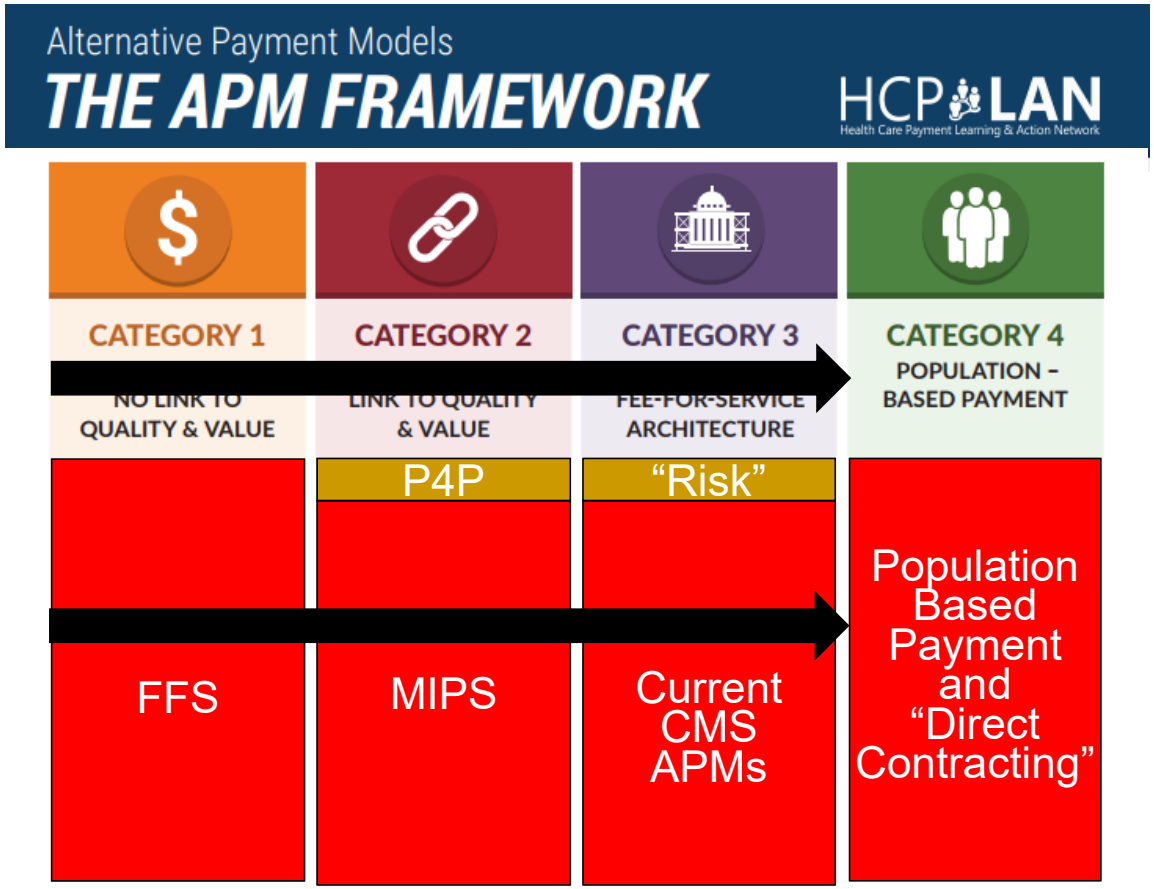
# …CMS Wants to Put Physicians at Risk for Reducing Spending



# Downside Risk ACOs Saved *Less* in 2017 Than Upside-Only ACOs

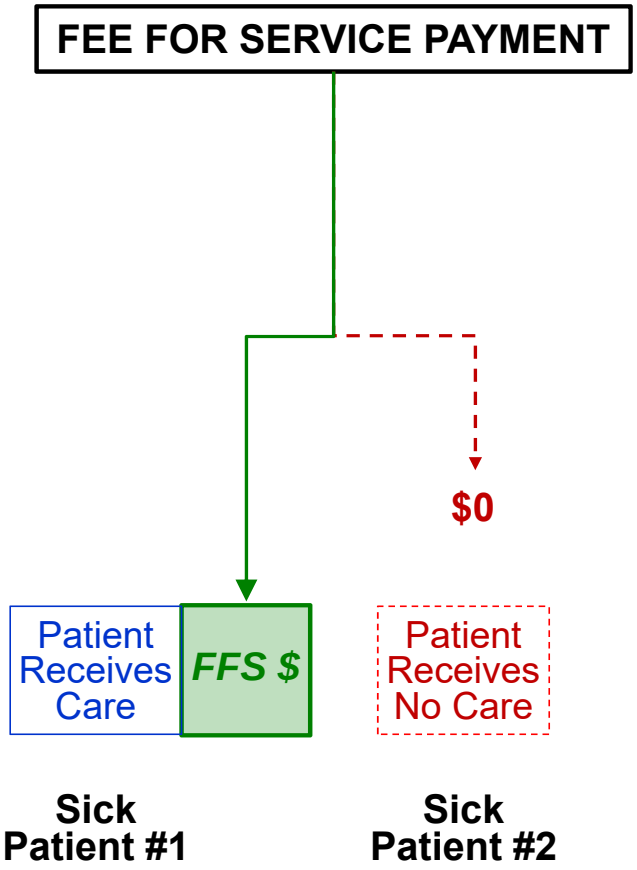
| | UPSIDE RISK | | DOWNSIDE RISK | |
|---|---|---|---|---|
| | Track 1 MSSP ACOs | | Two-Sided Risk MSSP ACOs | Next-Gen ACOs |
| **Net Savings Per Patient** | $37 | | $27 | $29 |
| **% Savings** | 0.34% | | 0.24% | 0.25% |

# CMS-Funded "LAN" Says Best APM is "Population-Based Pmt"

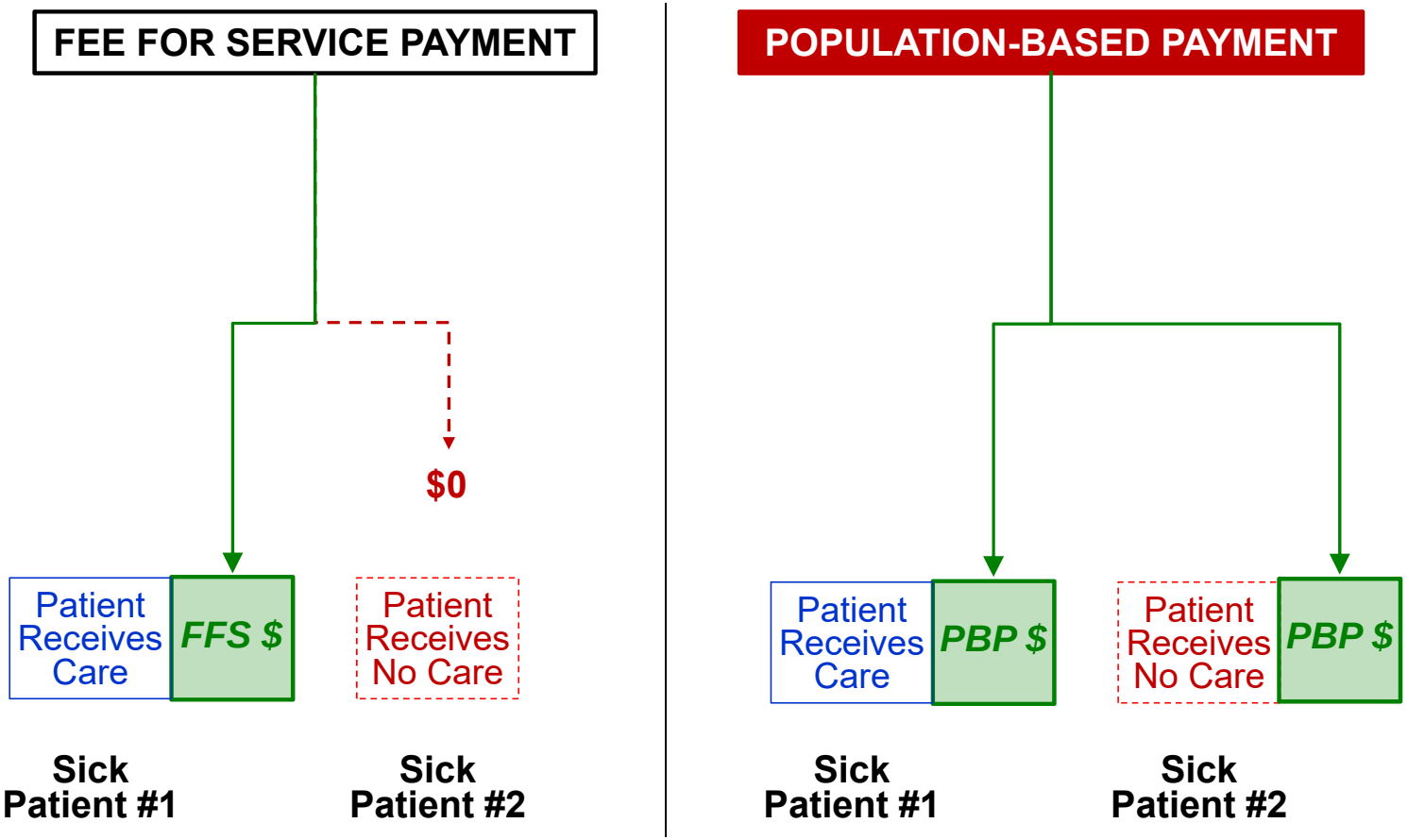


Is
“Population-Based Payment”
Better Than
Fee for Service?

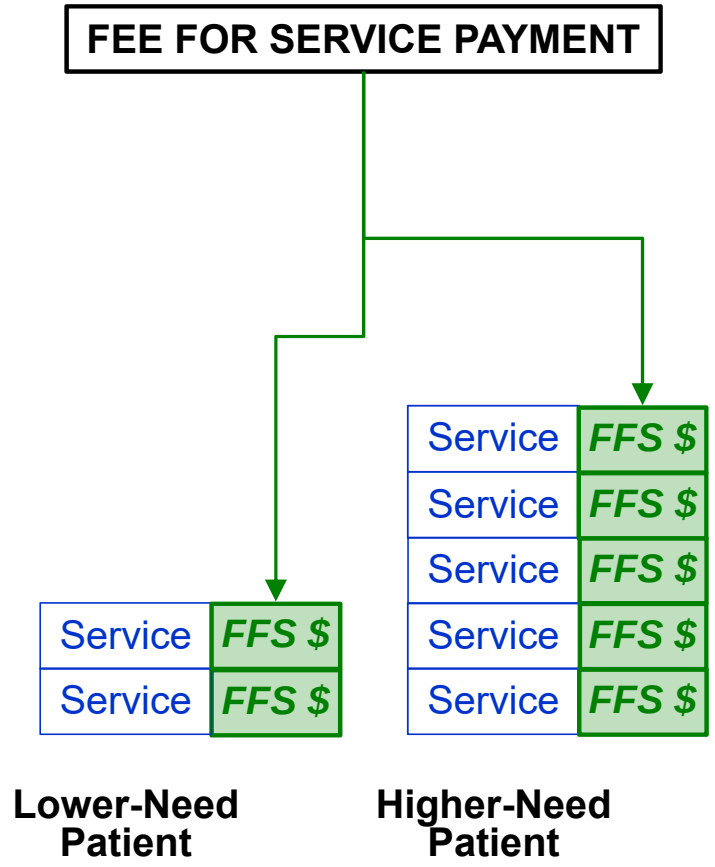
# A Strength of FFS:
# No $ Unless Patient Gets Care



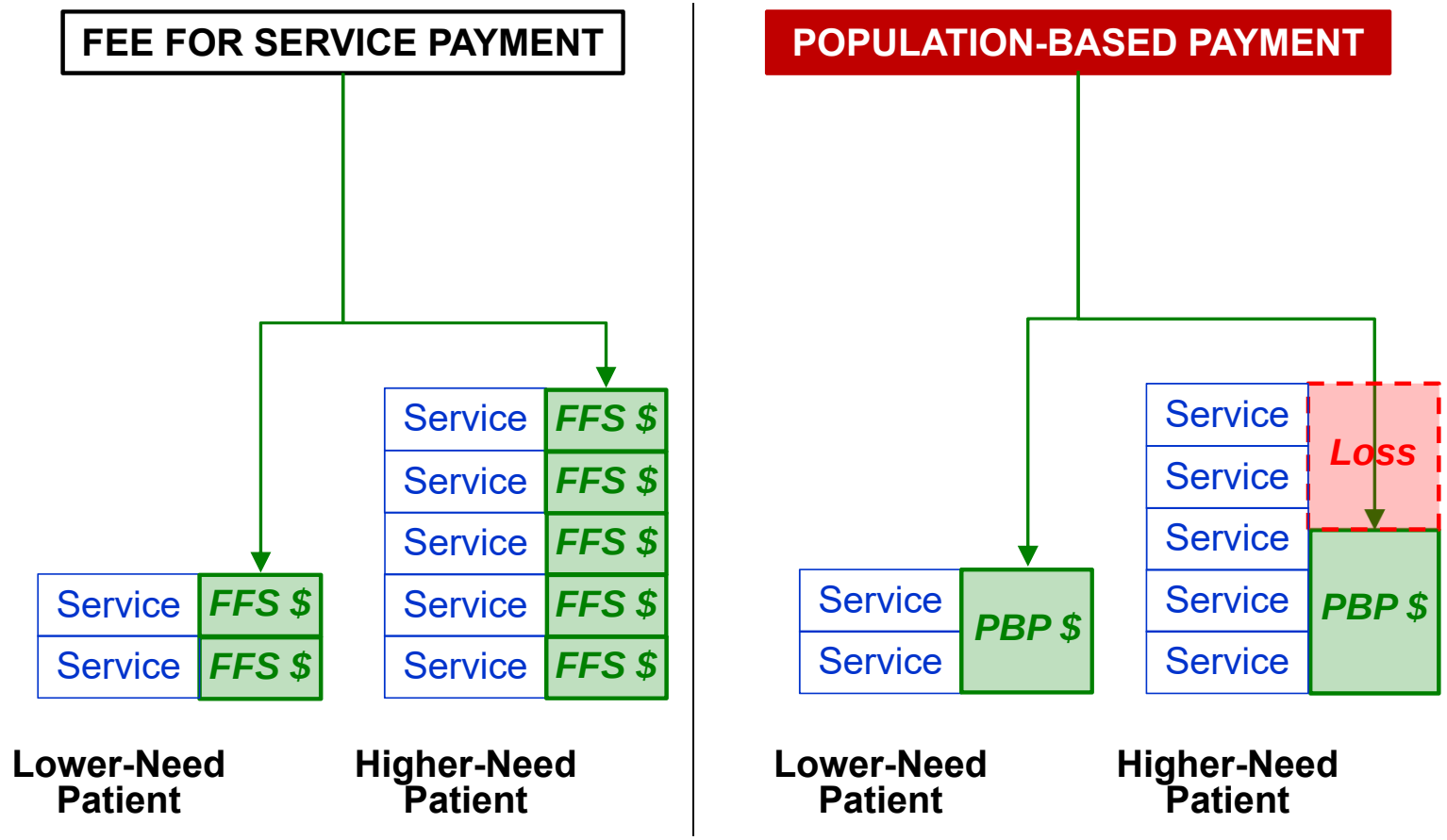
# In Population-Based Pmt (PBP): $ Paid if Patient is Denied Care



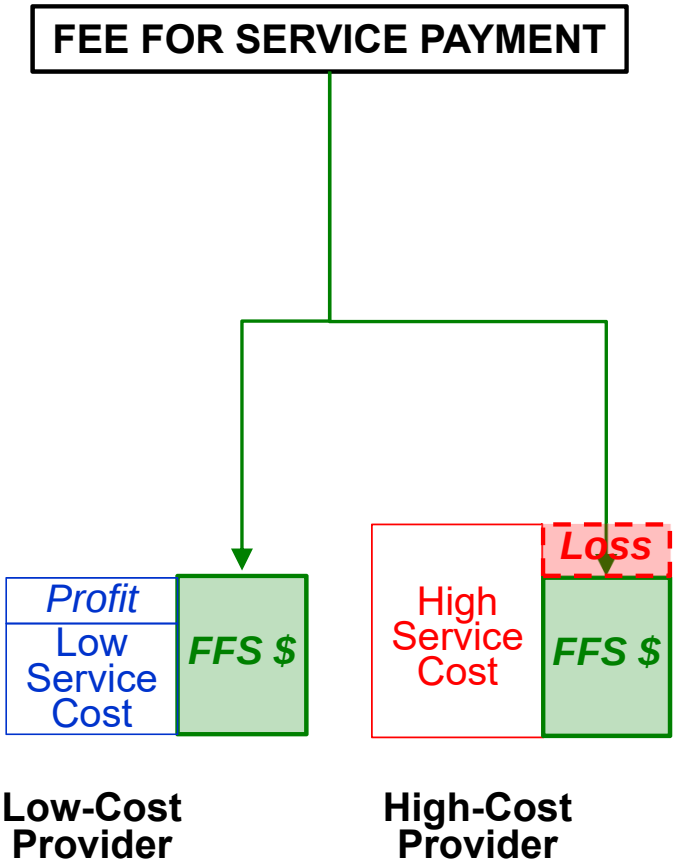
# A Strength of FFS: High-Need Patients Get More Care



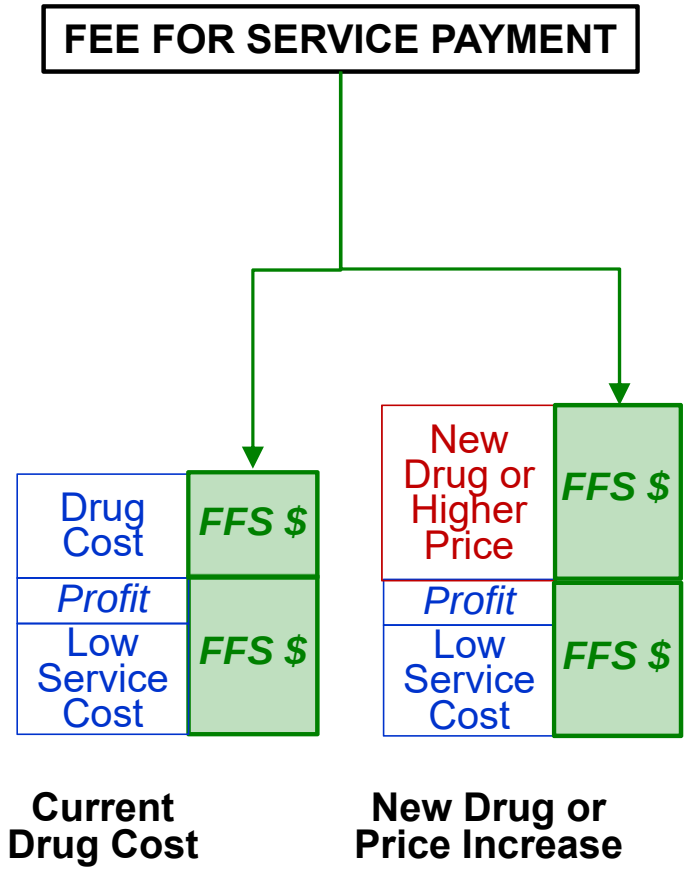
# In Population-Based Pmt (PBP): $ < Cost of High-Need Patients



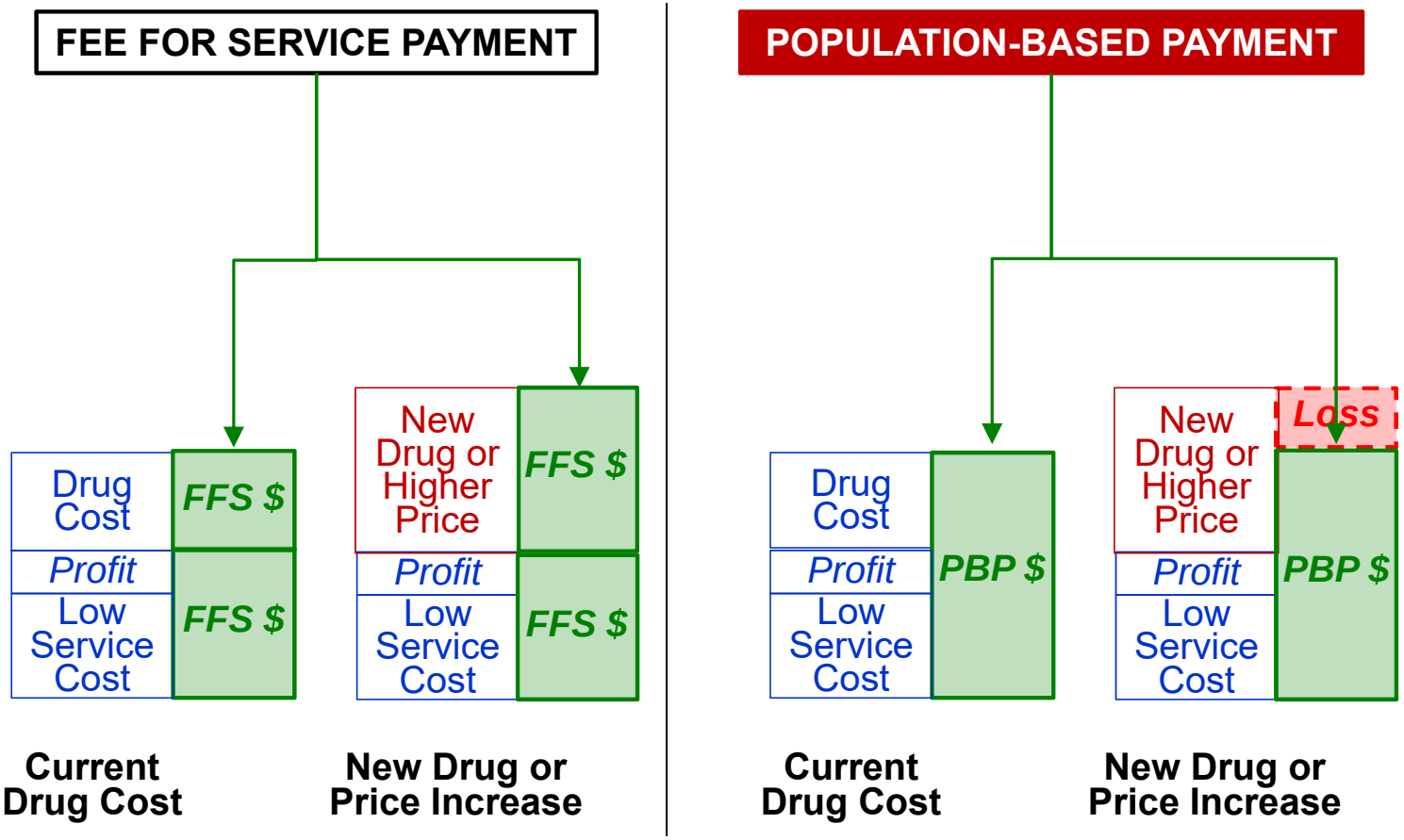
# A Strength of FFS: Fixed Fees Force Efficient Svcs



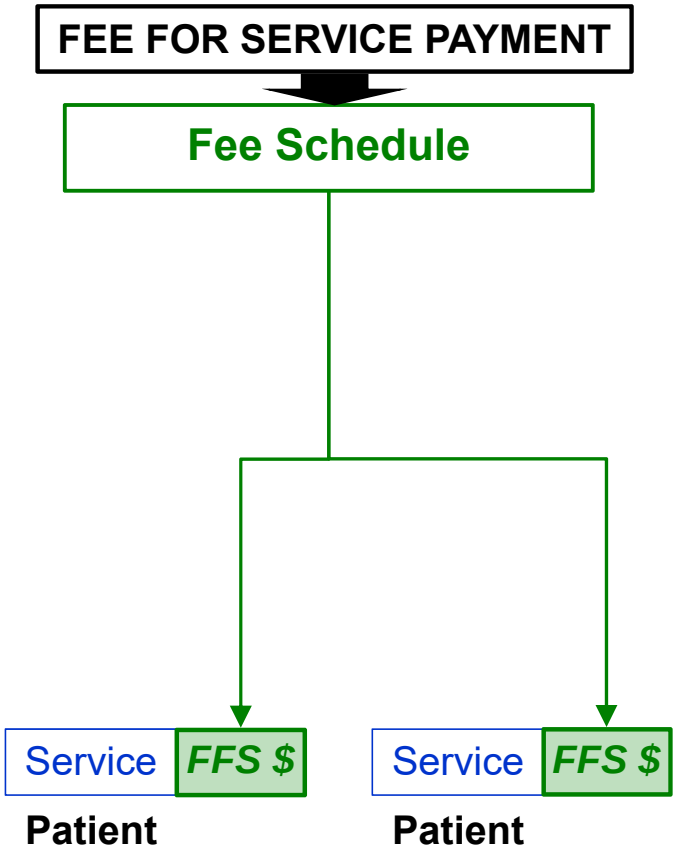
# A Strength of FFS: No Risk for *Uncontrollable* Cost



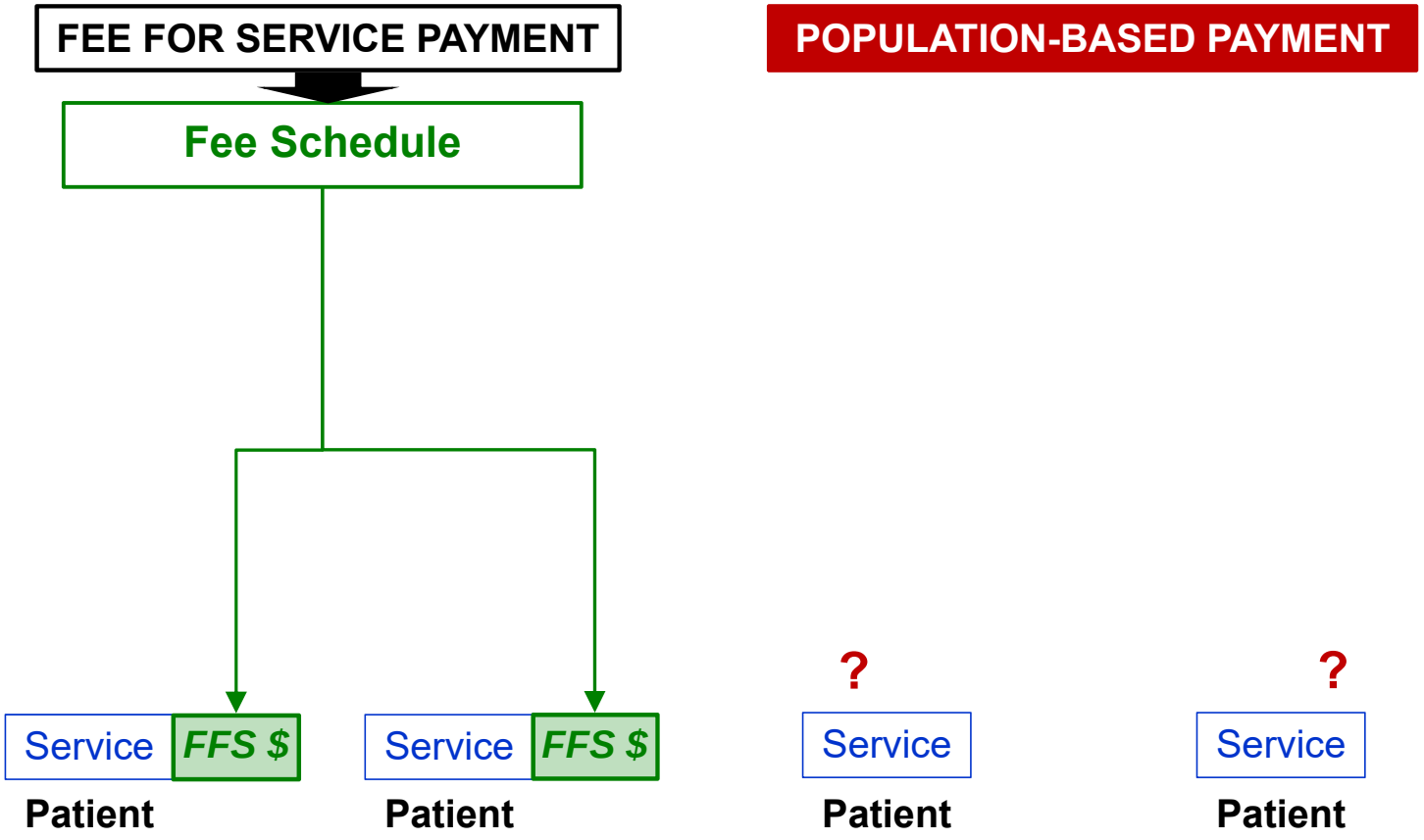
# In Population-Based Pmt (PBP): Risk for Uncontrollable Cost



# A Strength of FFS: Fee is Known Before Care is Given



# In Population-Based Pmt (PBP): How Much Will Be Paid for Care?



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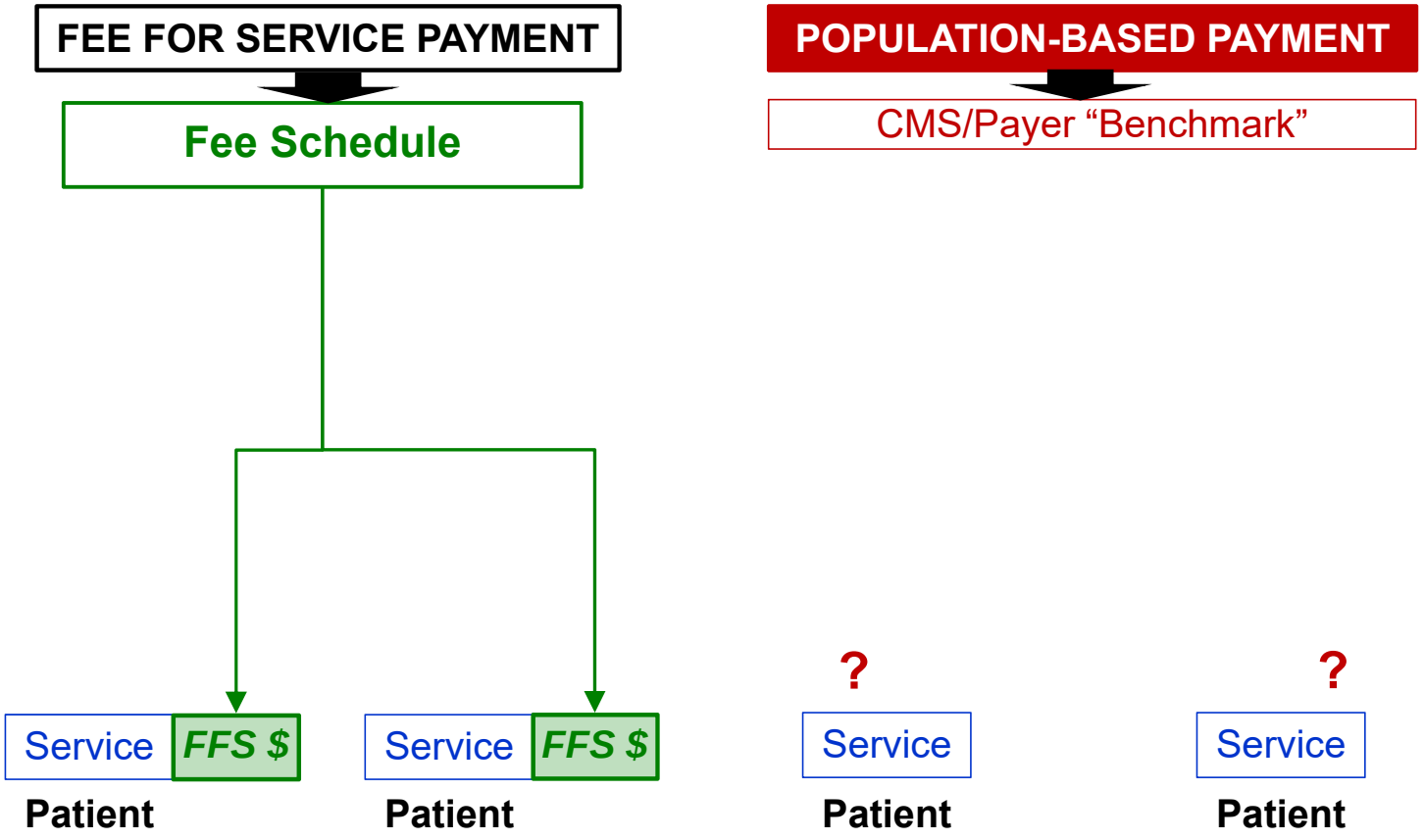

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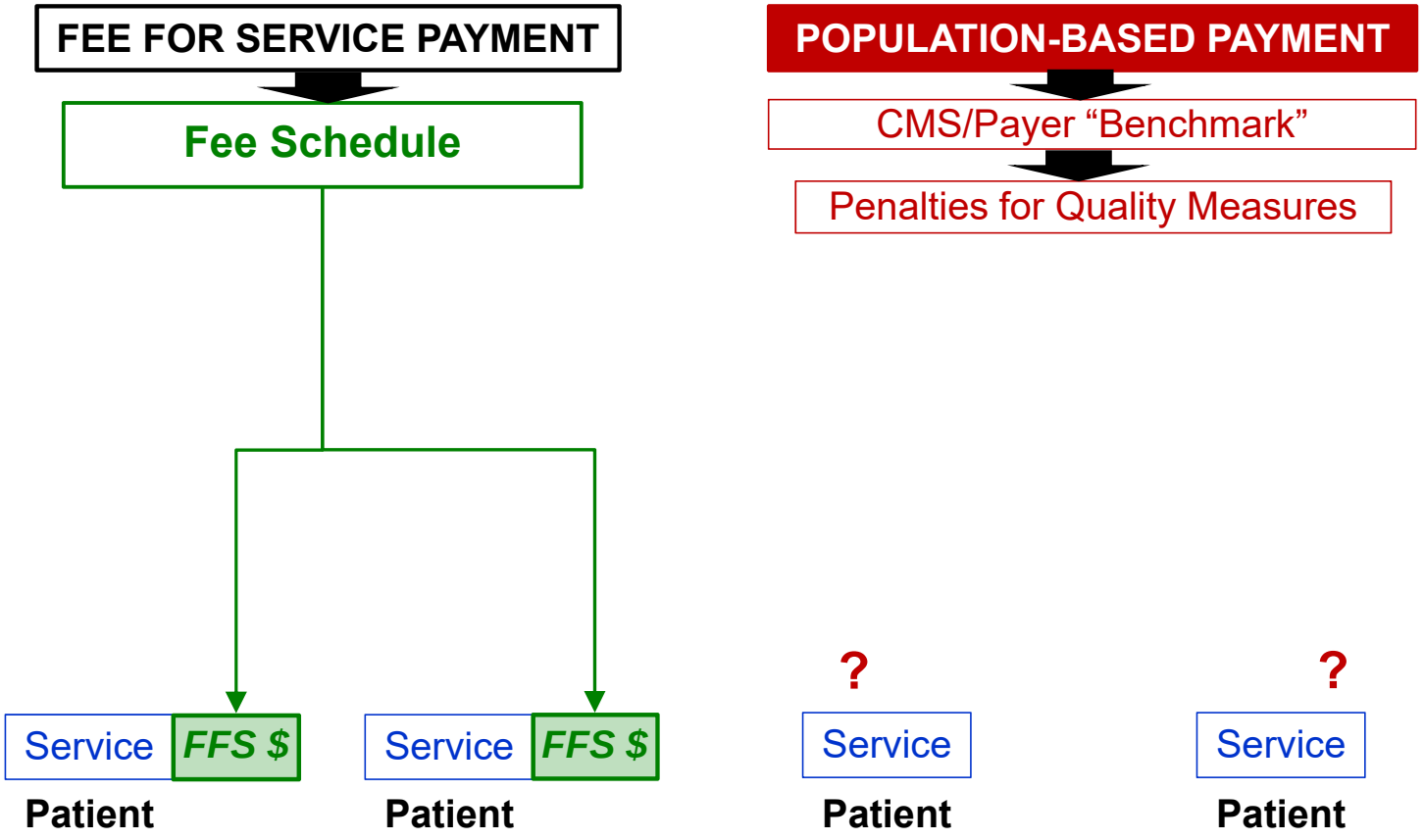

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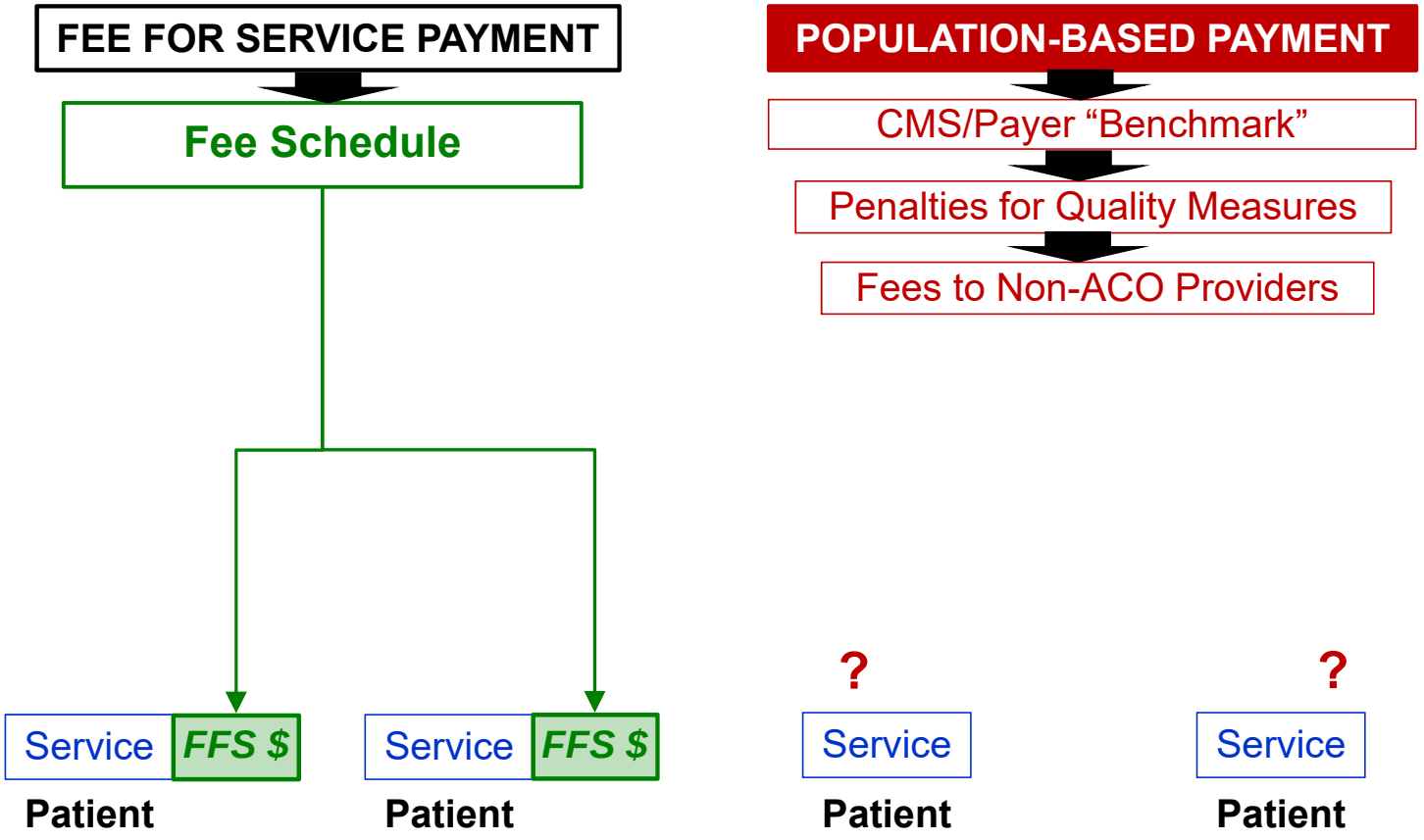

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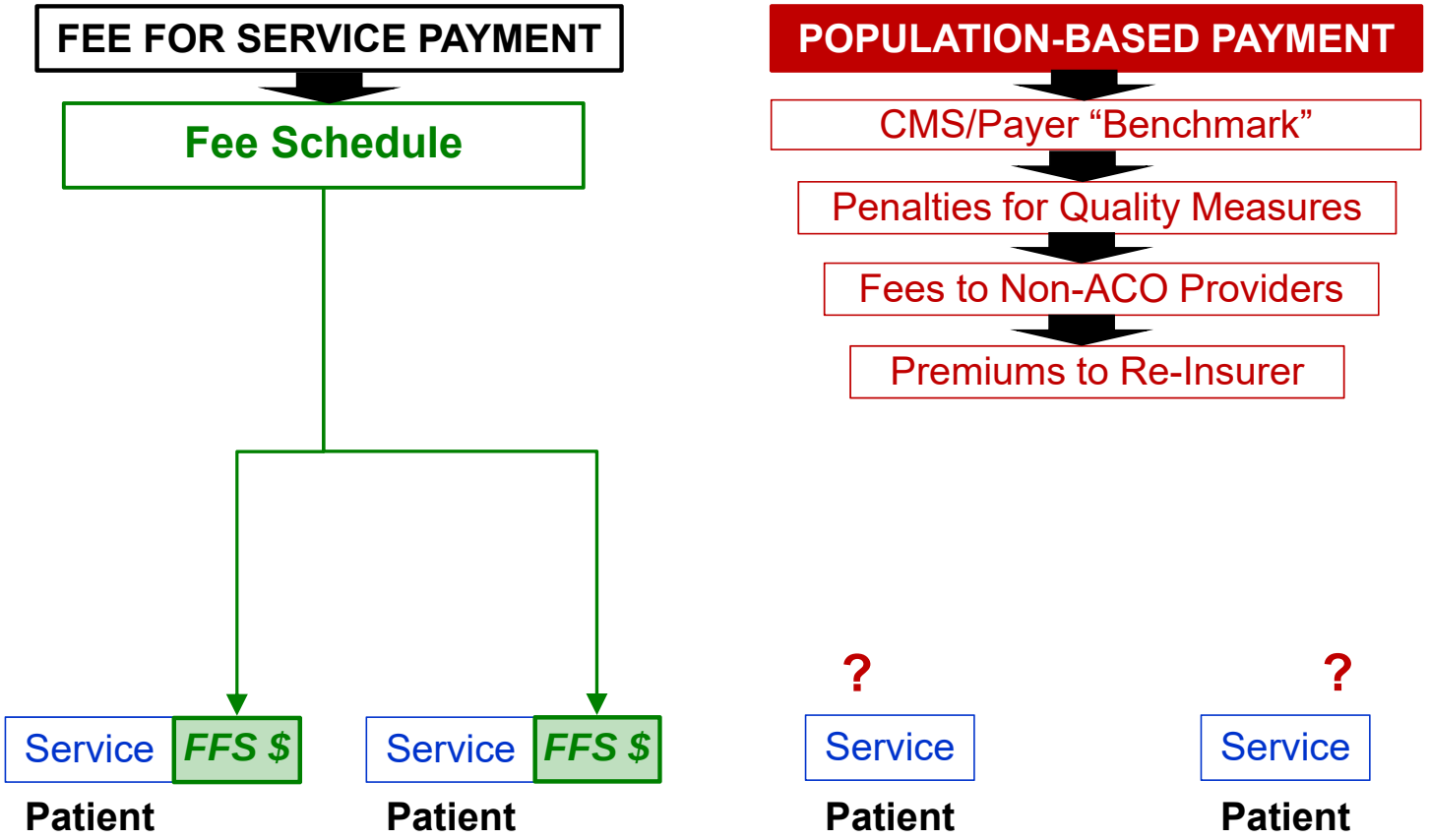
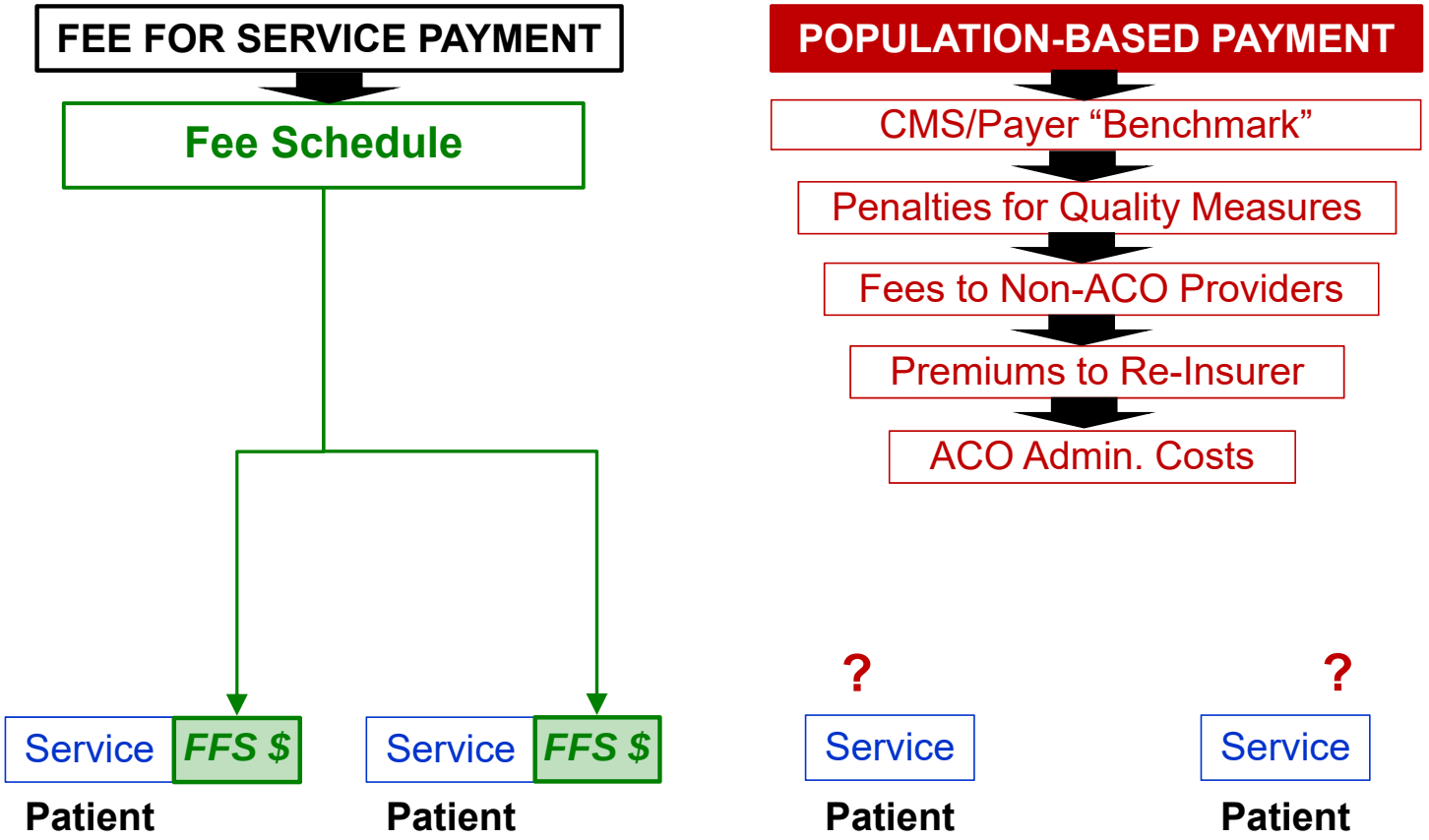
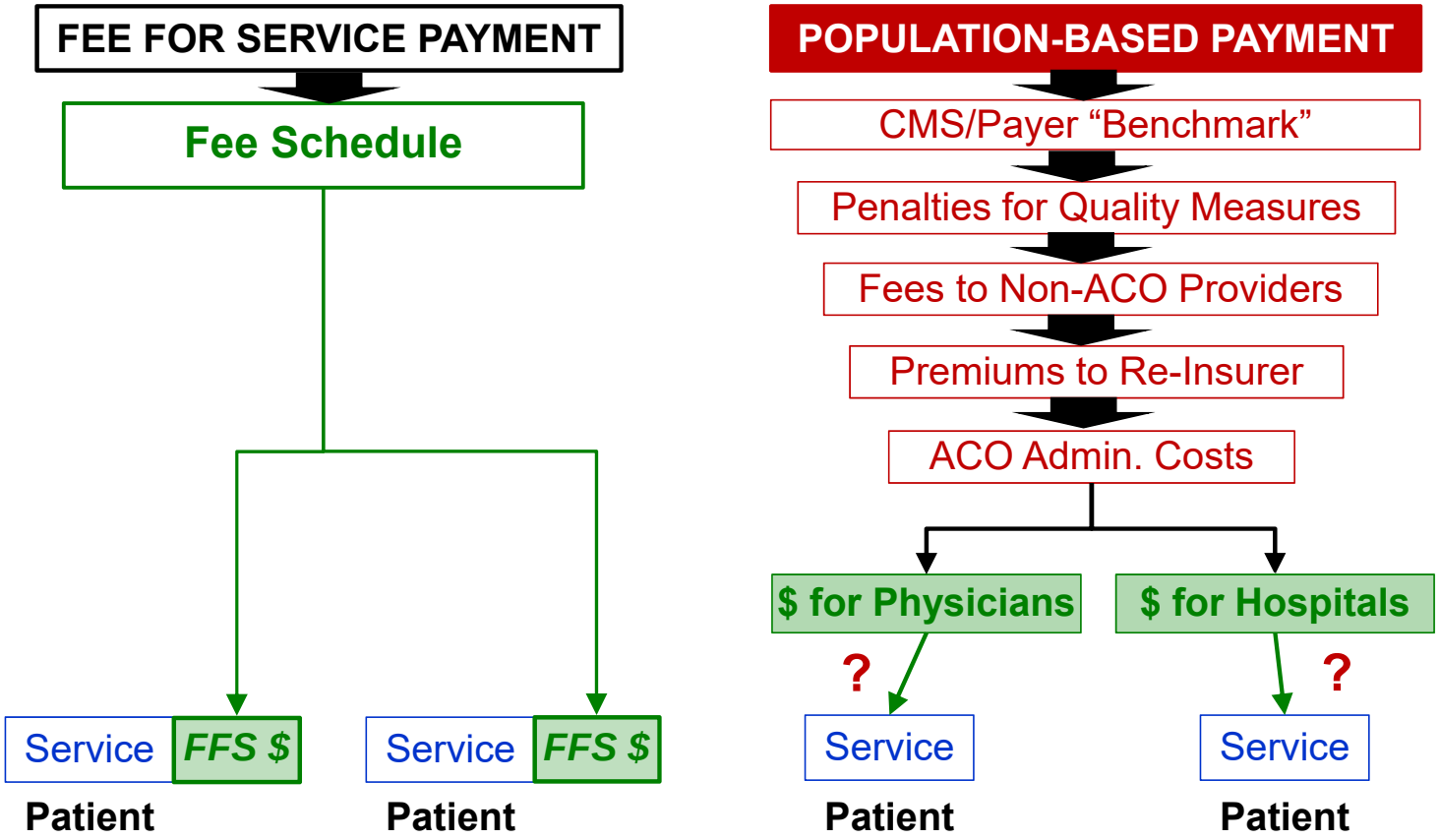


# In Population-Based Pmt (PBP): How Much Will Be Paid for Care?



# In Population-Based Pmt (PBP): Will Any $ Be Left for *Patient Care*?



# Population-Based Payment = "Hallway Healthcare" in Canada

**EDITORIAL:**
**Ontario health care needs major surgery**
Toronto Sun, January 31, 2019

Thursday's report by Dr. Rueben Devlin, chair of Premier Doug Ford's council on improving health care and ending hallway medicine, succinctly describes a major and long-standing problem with Ontario's health care system. It starts with a lack of long-term care facilities for patients who can no longer live at home. Because there aren't enough long-term care beds, many patients who require them occupy acute care beds in hospitals across the province, because there's no where else for them to go. **The average wait time for being transferred to a long-term care facility is 146 days**….Due to the backlog of these patients in acute care hospitals, the hospitals don't have enough beds to treat patients admitted through their emergency wards. As a result, **at least 1,000 patients a day across Ontario are being treated in hospital hallways.**


Patients wait in the hallway at the overcrowded Queensway-Carleton Hospital in Ottawa in 2016. (Errol McGihon/Postmedia)

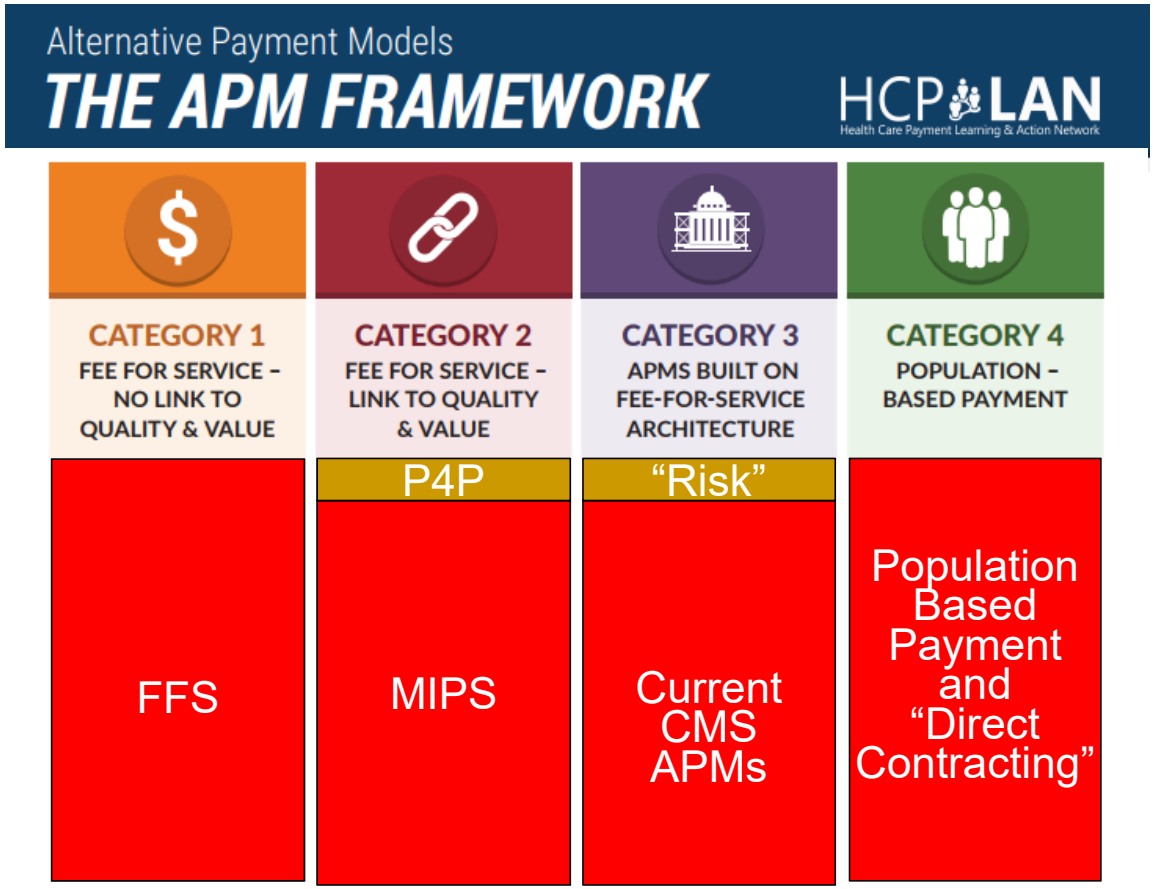
# Population-Based Payment Doesn't Fix FFS Problems and Makes Things *Worse*

| | FFS | CMS APMs | Pop. Pmt |
|---|---|---|---|
| **Weaknesses of Fee for Service** | | | |
| Payment for all high-value services? | NO | NO* | NO |
| Payment adequate to cover cost of services? | NO | NO | NO |
| Ability to predict total payment for treatment? | NO | NO | NO |
| Assurance of high-quality for each patient? | NO | NO | NO |
| **Strengths of Fee for Service** | | | |
| No payment unless care delivered? | YES | YES | NO |
| Higher amount for higher-need patients? | YES | YES | NO** |
| Payment based on what provider can control? | YES | NO | NO |
| Amount known before services delivered? | YES | NO | NO |

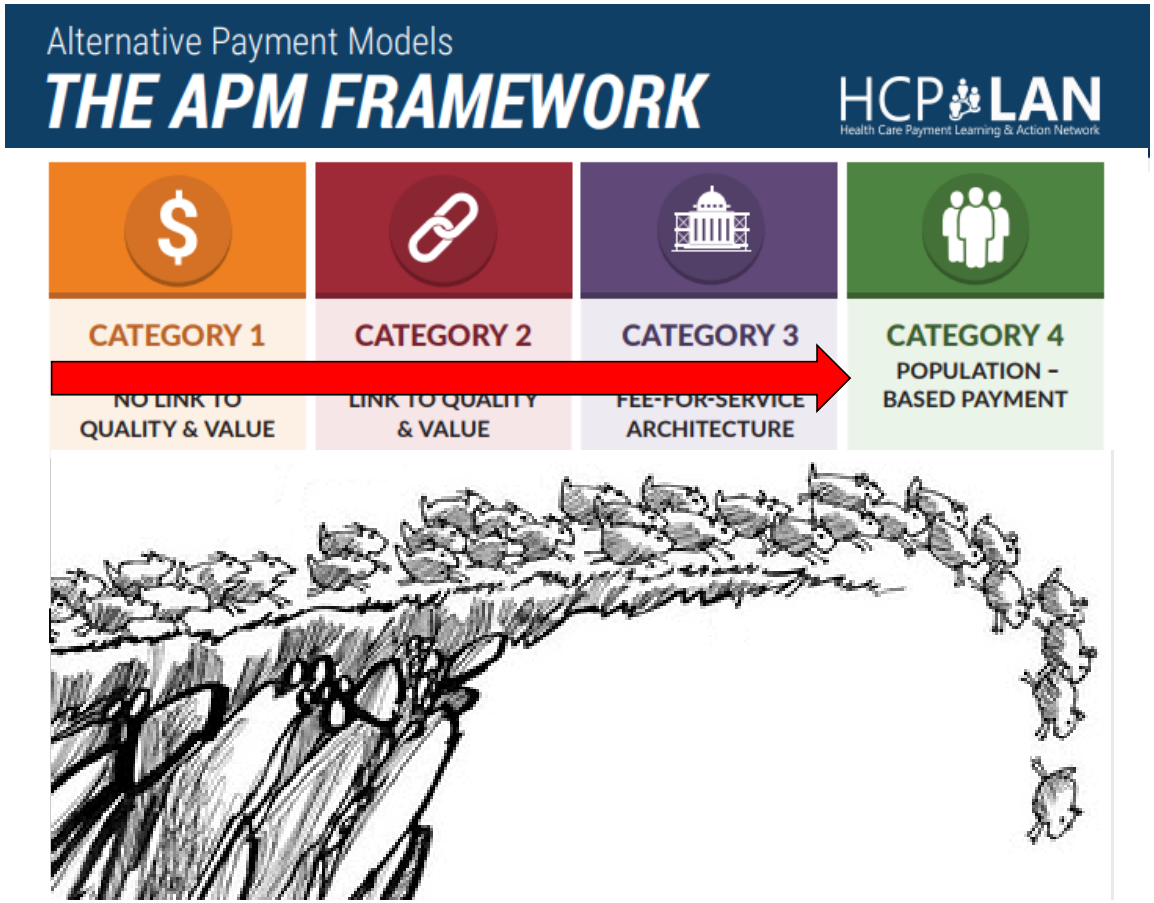
* CPC+ and OCM provide monthly payments that cover some additional services

** HCC risk adjustment identifies some but not all differences in patient needs

# This is NOT a Good "Framework" for Fixing Healthcare Payment…



# …And Following It Will Likely Make Things Worse, Not Better



# What Would a *Good* APM Look Like?

| | FFS | CMS APMs | Pop. Pmt | Good APM |
|---|---|---|---|---|
| **Weaknesses of Fee for Service** | | | | |
| Payment for all high-value services? | NO | NO* | NO | ? |
| Payment adequate to cover cost of services? | NO | NO | NO | ? |
| Ability to predict total payment for treatment? | NO | NO | NO | ? |
| Assurance of high-quality for each patient? | NO | NO | NO | ? |
| **Strengths of Fee for Service** | | | | |
| No payment unless care delivered? | YES | YES | NO | ? |
| Higher amount for higher-need patients? | YES | YES | NO** | ? |
| Payment based on what provider can control? | YES | NO | NO | ? |
| Amount known before services delivered? | YES | NO | NO | ? |

* CPC+ and OCM provide monthly payments that cover some additional services

** HCC risk adjustment identifies some but not all differences in patient needs

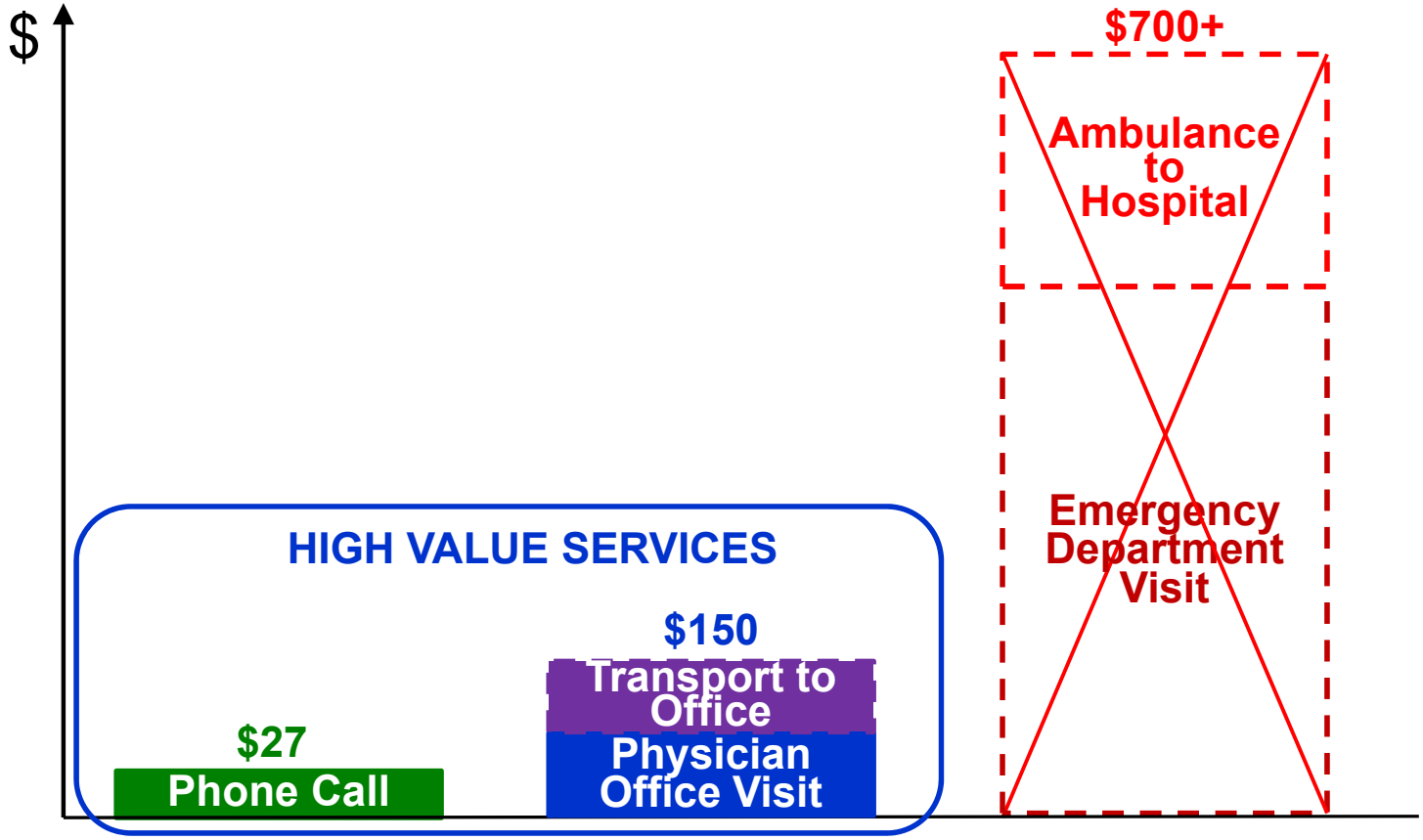
# A Good APM Would Correct the Weaknesses of FFS

| | FFS | | | Good APM |
|---|---|---|---|---|
| **Weaknesses of Fee for Service** | | | | |
| Payment for all high-value services? | NO | | | YES |
| Payment adequate to cover cost of services? | NO | | | YES |
| Ability to predict total payment for treatment? | NO | | | YES |
| Assurance of high-quality for each patient? | NO | | | YES |
| **Strengths of Fee for Service** | | | | |
| No payment unless care delivered? | YES | | | |
| Higher amount for higher-need patients? | YES | | | |
| Payment based on what provider can control? | YES | | | |
| Amount known before services delivered? | YES | | | |

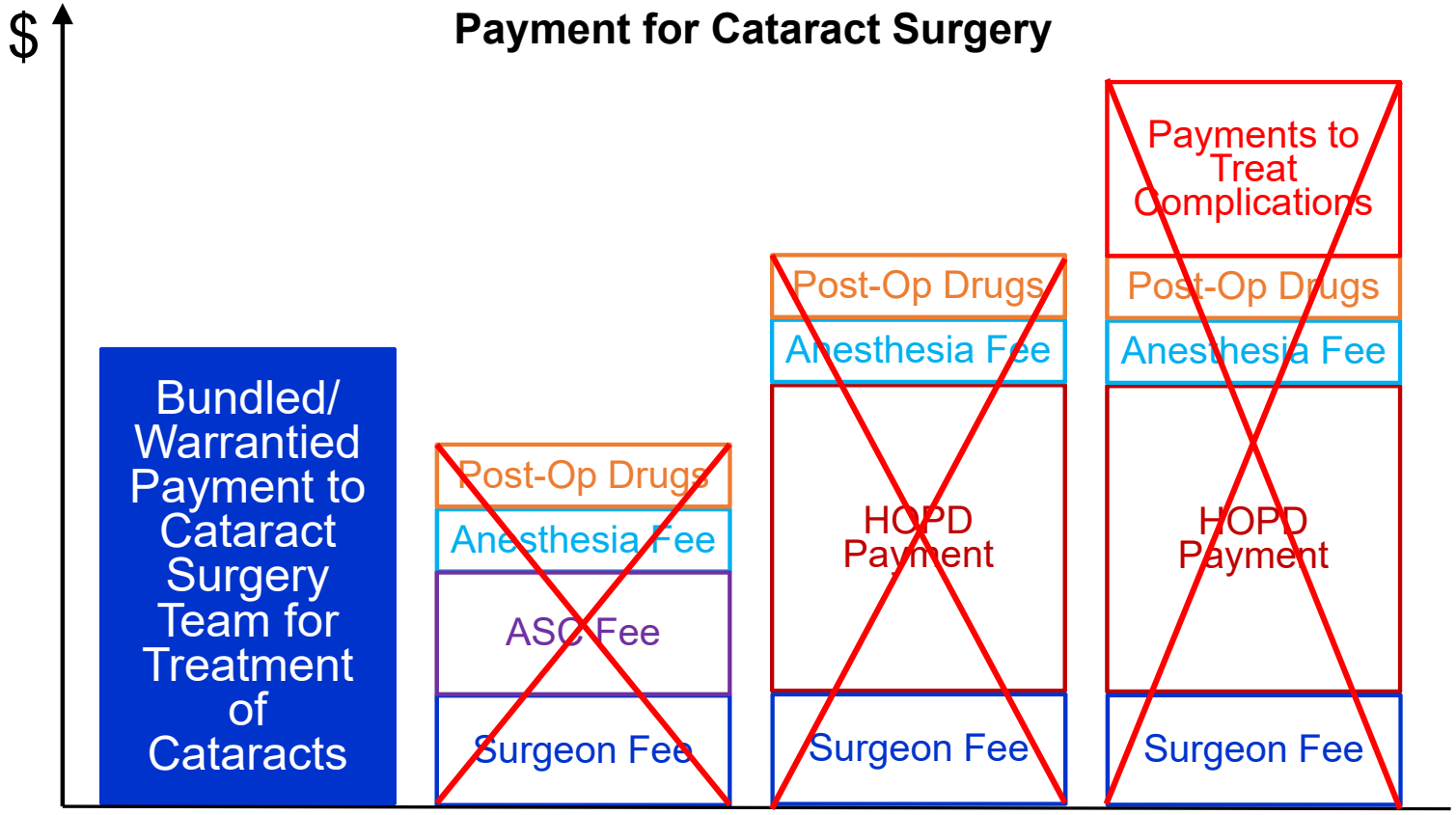
* CPC+ and OCM provide monthly payments that cover some additional services

** HCC risk adjustment identifies some but not all differences in patient needs

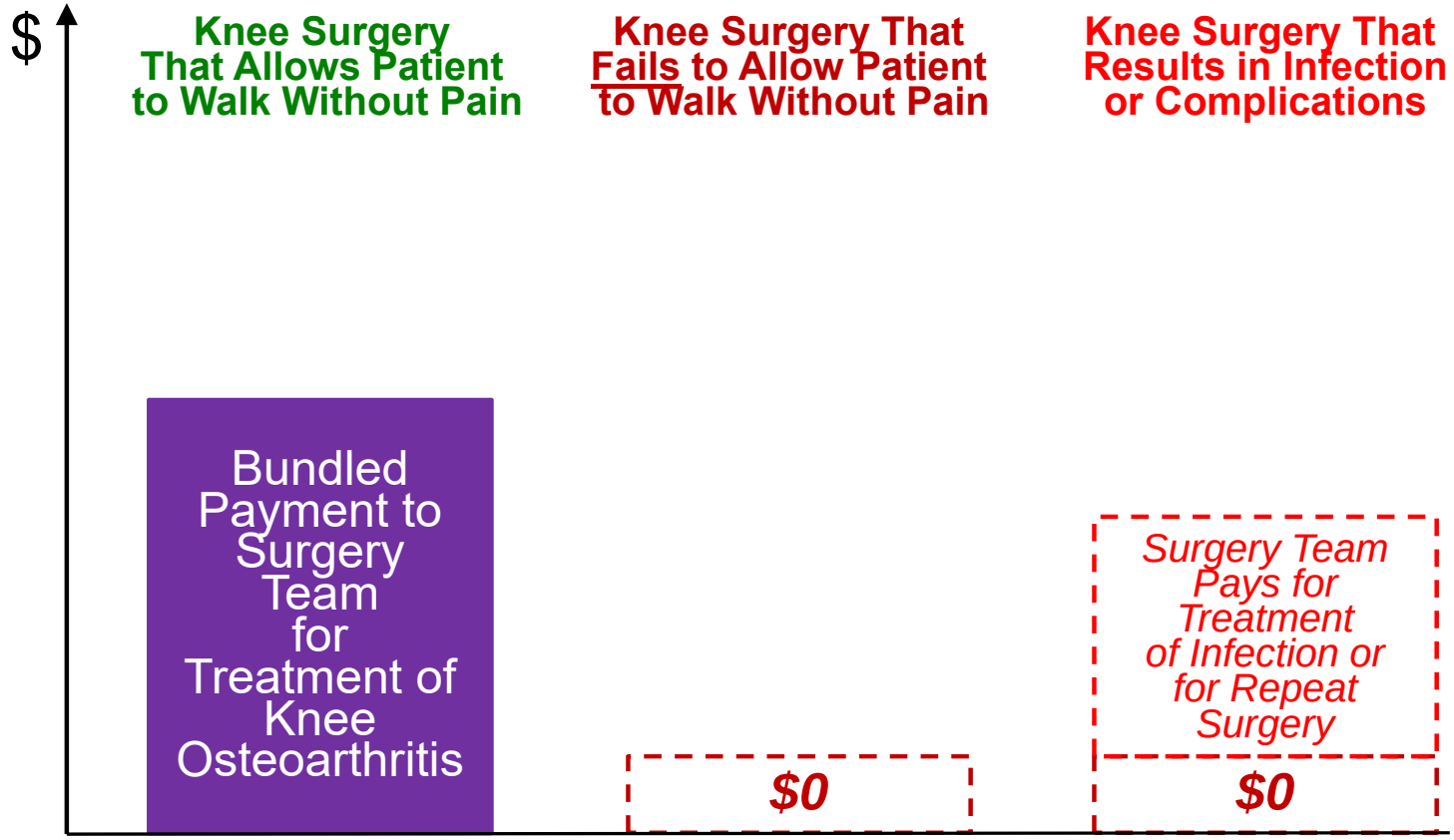
# Payment for High Value Services That Reduce Avoidable Services



# True Bundled Payment to a *Team* for *Treatment of the Condition*



# No Payment for Poor Quality Care and Penalties for Poor Outcomes



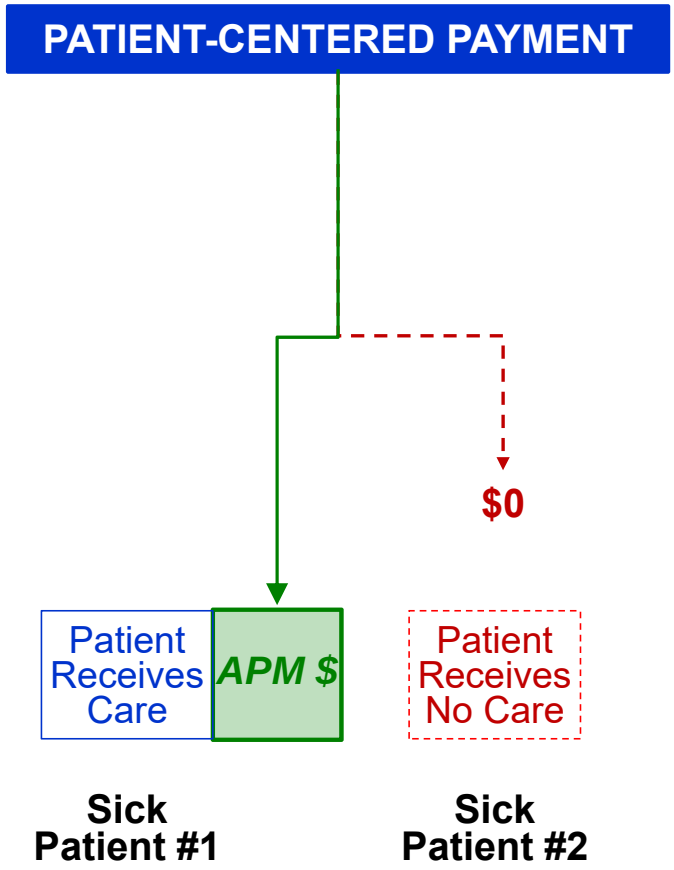
# A Good APM Would Also Preserve the Strengths of FFS

| | | FFS | | | Good APM |
|---|---|---|---|---|---|
| **Weaknesses of Fee for Service** | | | | | |
| | Payment for all high-value services? | NO | | | **YES** |
| | Payment adequate to cover cost of services? | NO | | | **YES** |
| | Ability to predict total payment for treatment? | NO | | | **YES** |
| | Assurance of high-quality for each patient? | NO | | | **YES** |
| **Strengths of Fee for Service** | | | | | |
| | No payment unless care delivered? | YES | | | **YES** |
| | Higher amount for higher-need patients? | YES | | | **YES** |
| | Payment based on what provider can control? | YES | | | **YES** |
| | Amount known before services delivered? | YES | | | **YES** |

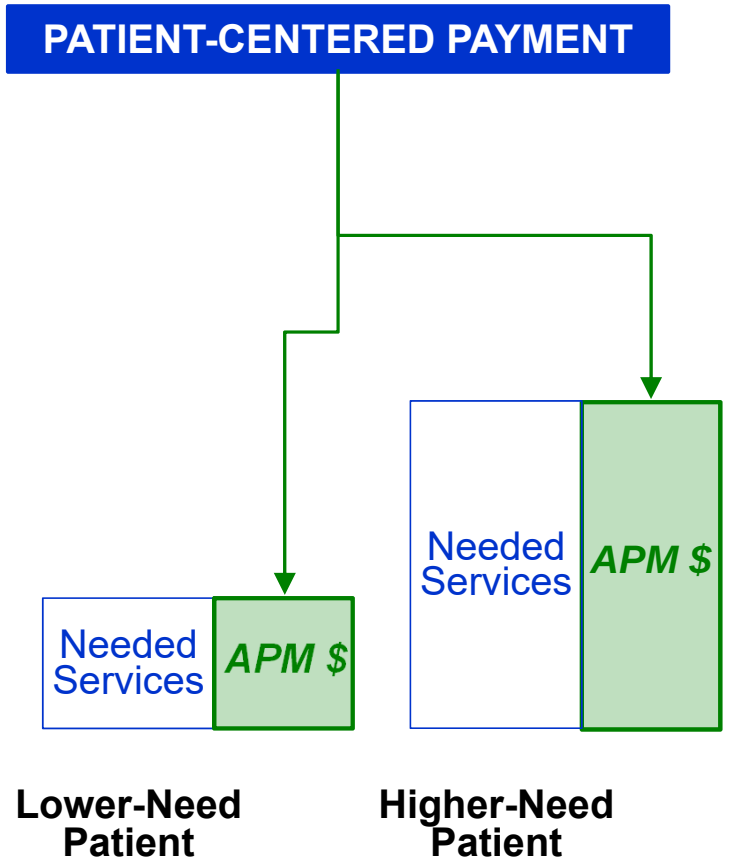
* CPC+ and OCM provide monthly payments that cover some additional services

** HCC risk adjustment identifies some but not all differences in patient needs

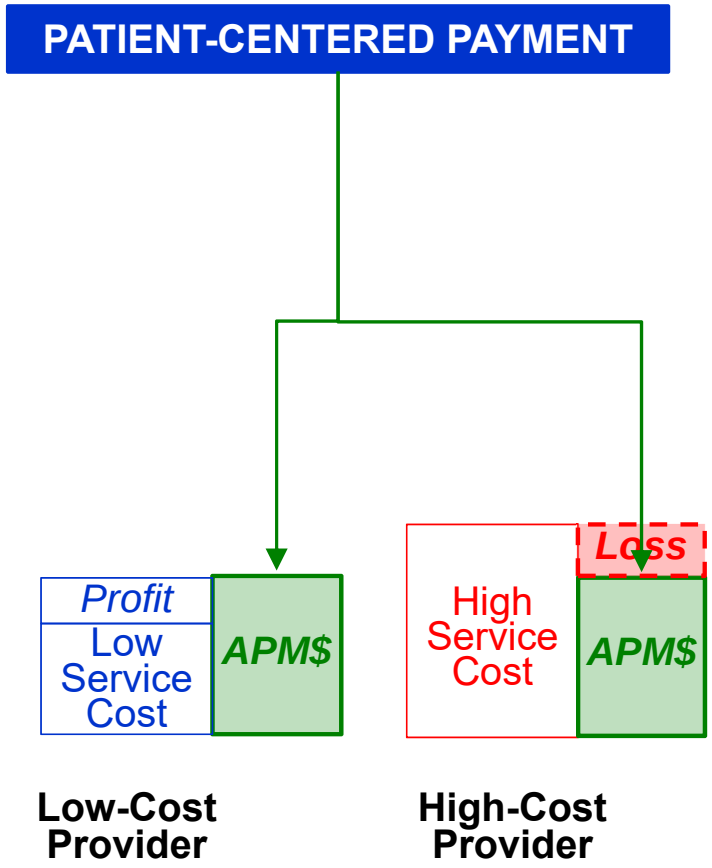
# No Payment Unless Patient Actually Receives Needed Care



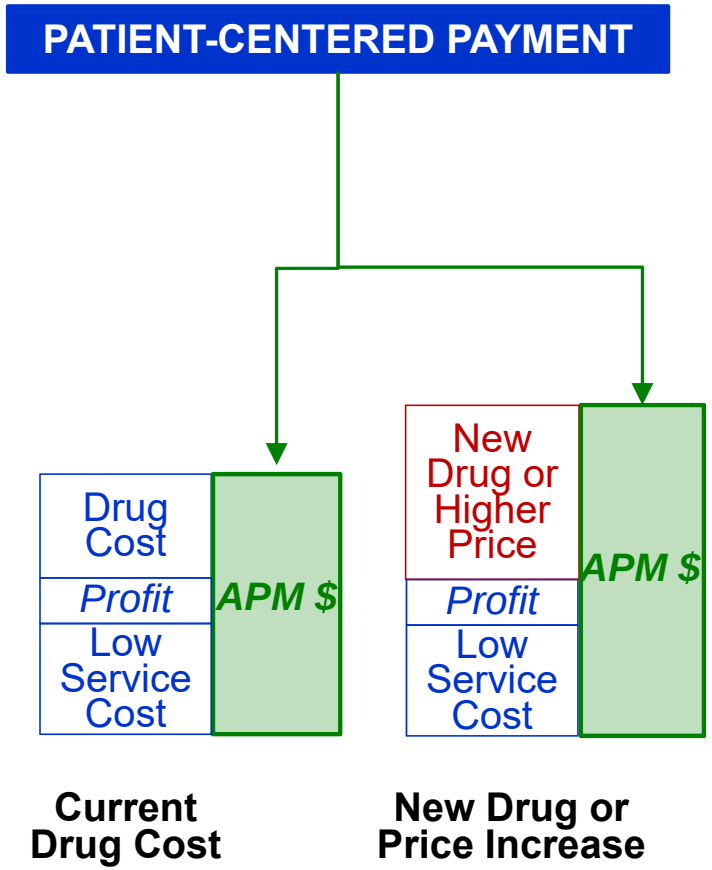
# Higher Payment for Patients With Greater Needs



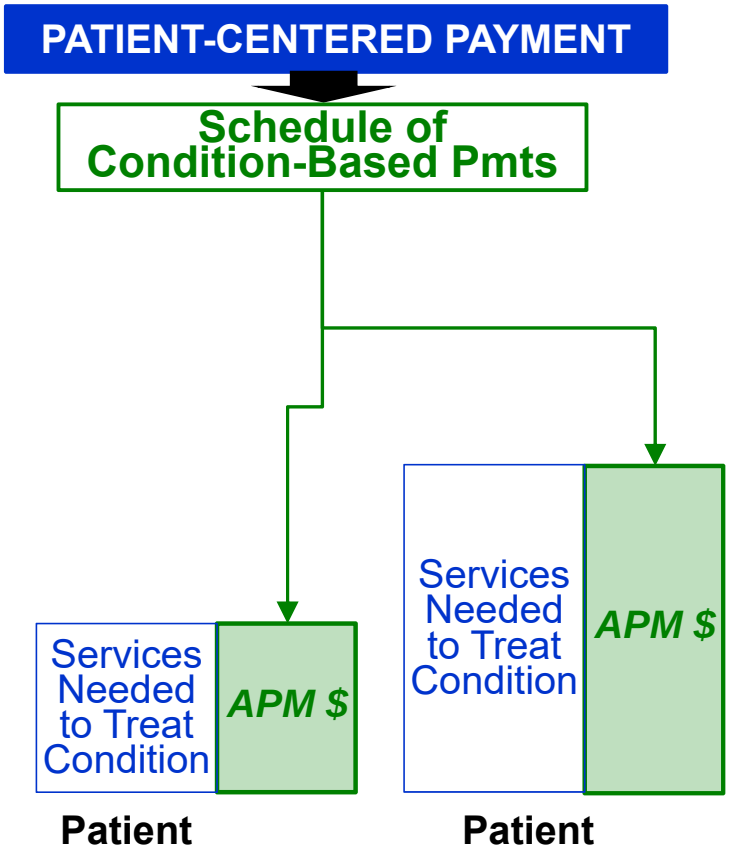
# Accountability for Costs Providers CAN Control



# No Risk for Costs
# Providers CANNOT Control



# Amount of Payment Known Before Care is Delivered

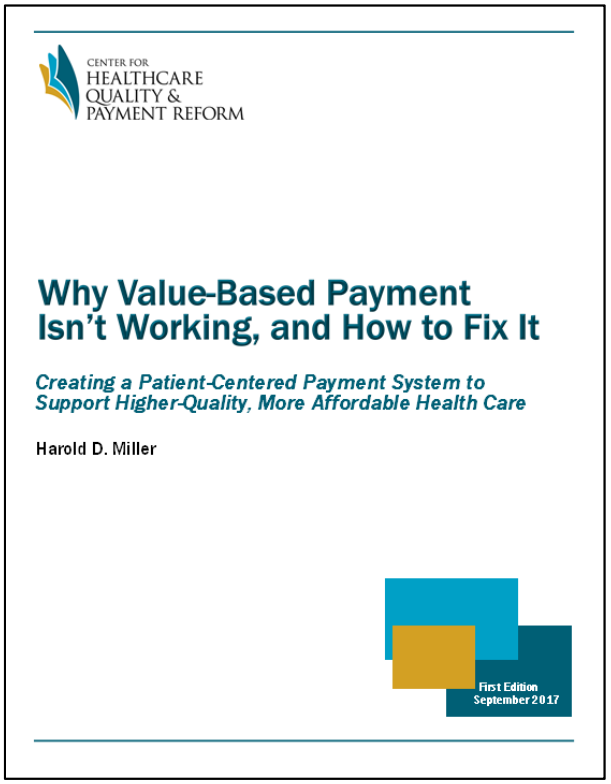


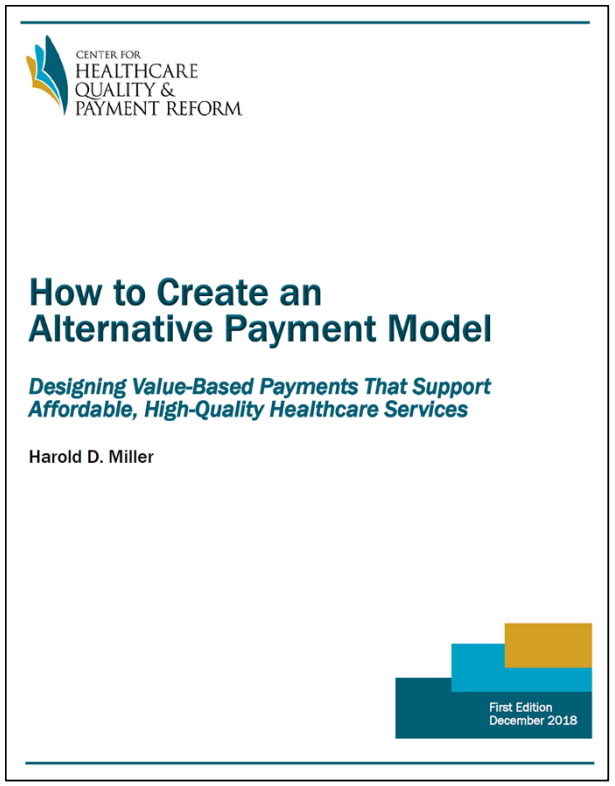
# Patient-Centered APMs Solve FFS Problems & Preserve Its Strengths

| | | Patient-Centered Payment |
|---|---|---|
| **Weaknesses of Fee for Service** | | |
| | Payment for all high-value services? | Flexible, *condition*-based fee |
| | Payment adequate to cover cost of services? | $ based on cost of best treatment |
| | Ability to predict total payment for treatment? | Bundled payment to provider team |
| | Assurance of high-quality for each patient? | $0 unless quality standards are met<br>$0 extra to treat avoidable problems |
| **Strengths of Fee for Service** | | |
| | No payment unless care delivered? | $0 unless care is provided |
| | Higher amount for higher-need patients? | More $ for higher-need patient |
| | Payment based on what provider can control? | Separate fees for costs and prices provider team cannot control |
| | Amount known before services delivered? | $ for care defined in advance |

# Details on Patient-Centered Payment and How to Create a Good APM

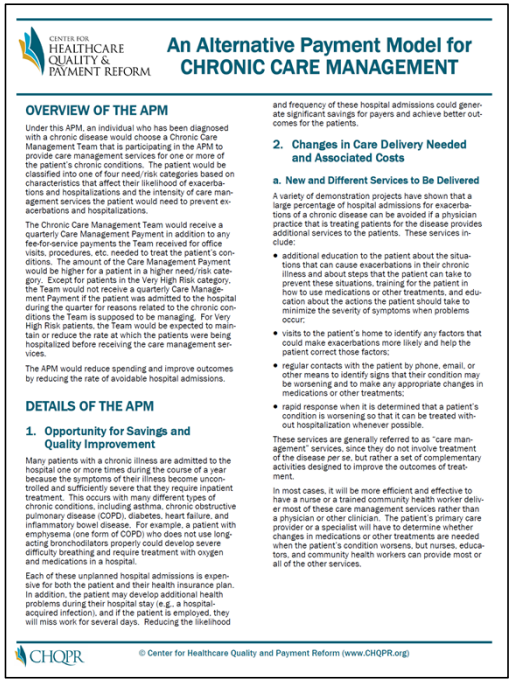
**www.PaymentReform.org**



# Detailed Examples of Good APMs

**www.PaymentReform.org**



CENTER FOR HEALTHCARE QUALITY & PAYMENT REFORM

## An Alternative Payment Model for CHRONIC CARE MANAGEMENT

### OVERVIEW OF THE APM

Under this APM, an individual who has been diagnosed with a chronic disease would choose a Chronic Care Management Team that is participating in the APM to provide care management services for one or more of the patient's chronic conditions. The patient would be classified into one of four need/risk categories based on characteristics that affect their likelihood of exacerbations and hospitalizations and the intensity of care management services the patient would need to prevent exacerbations and hospitalizations.

The Chronic Care Management Team would receive a quarterly Care Management Payment in addition to any fee-for-service payments the Team received for office visits, procedures, etc. needed to treat the patient's conditions. The amount of the Care Management Payment would be higher for a patient in a higher need/risk category. Except for patients in the Very High Risk category, the Team would not receive a quarterly Care Management Payment if the patient was admitted to the hospital during the quarter for reasons related to the chronic conditions the Team is supposed to be managing. For Very High Risk patients, the Team would be expected to maintain or reduce the rate at which the patients were being hospitalized before receiving the care management services.

The APM would reduce spending and improve outcomes by reducing the rate of avoidable hospital admissions.

### DETAILS OF THE APM

#### 1. Opportunity for Savings and Quality Improvement

Many patients with a chronic illness are admitted to the hospital one or more times during the course of a year because the symptoms of their illness become uncontrolled and sufficiently severe that they require inpatient treatment. This occurs with many different types of chronic conditions, including asthma, chronic obstructive pulmonary disease (COPD), diabetes, heart failure, and inflammatory bowel disease. For example, a patient with emphysema (one form of COPD) who does not use long-acting bronchodilators properly could develop severe difficulty breathing and require treatment with oxygen and medications in a hospital.

Each of these unplanned hospital admissions is expensive for both the patient and their health insurance plan. In addition, the patient may develop additional health problems during their hospital stay (e.g., a hospital-acquired infection), and if the patient is employed, they will miss work for several days. Reducing the likelihood and frequency of these hospital admissions could generate significant savings for payers and achieve better outcomes for the patients.

#### 2. Changes in Care Delivery Needed and Associated Costs

##### a. New and Different Services to Be Delivered

A variety of demonstration projects have shown that a large percentage of hospital admissions for exacerbations of a chronic disease can be avoided if a physician practice that is treating patients for the disease provides additional services to the patients. These services include:

- additional education to the patient about the situations that can cause exacerbations in their chronic illness and about steps that the patient can take to prevent these situations, training for the patient in how to use medications or other treatments, and education about the actions the patient should take to minimize the severity of symptoms when problems occur;
- visits to the patient's home to identify any factors that could make exacerbations more likely and help the patient correct those factors;
- regular contacts with the patient by phone, email, or other means to identify signs that their condition may be worsening and to make any appropriate changes in medications or other treatments;
- rapid response when it is determined that a patient's condition is worsening so that it can be treated without hospitalization whenever possible.

These services are generally referred to as "care management" services, since they do not involve treatment of the disease *per se*, but rather a set of complementary activities designed to improve the outcomes of treatment.

In most cases, it will be more efficient and effective to have a nurse or a trained community health worker deliver most of these care management services rather than a physician or other clinician. The patient's primary care provider or a specialist will have to determine whether changes in medications or other treatments are needed when the patient's condition worsens, but nurses, educators, and community health workers can provide most or all of the other services.

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CENTER FOR HEALTHCARE QUALITY & PAYMENT REFORM

## An Alternative Payment Model for CHRONIC CONDITIONS

Every chronic disease is different. Different treatments are needed for different diseases, the cost and effectiveness of treatments varies across different diseases, there are more alternative treatments for some diseases than others, and the severity of complications from over-treatment and undertreatment vary. There are additional differences and complexities when patients have additional health problems or face barriers in accessing healthcare services.

However, despite these differences, there are also many similarities in the opportunities for improvement, in the barriers that current payment systems create to improving care delivery, and in the ways in which payments could be changed to support higher-quality, more affordable care across a wide range of chronic diseases and combinations of diseases. This section will focus on some of the opportunities, barriers, and payment changes that are common to a number of different chronic diseases and combinations of diseases and how an Alternative Payment Model might address them. For simplicity, the term "chronic condition" will be used here to describe either a single chronic disease or a combination of two or more chronic diseases that need to be managed in close coordination.

### OVERVIEW OF THE APM

Under this APM, an individual who has the symptoms of a serious chronic disease or who has been diagnosed with the disease would choose one or more teams of providers that are participating in the APM to diagnose, treat, and manage the individual's condition. Seven types of payments would be available under the APM in order to match the different kinds of services that the patient would need and the different outcomes that can be achieved during five different phases of care:

1. **Diagnosis and Initial Treatment.** A Diagnosis Team would receive a one-time bundled Diagnosis and Initial Treatment Payment to cover most of the services needed to determine if the patient has the chronic disease, and if so, to treat the disease for an initial period of time. The payment would be higher for those patients who are diagnosed with the disease and initiate treatment.
2. **Continued Treatment for Patients with Well-Controlled Conditions.** A Treatment Team would receive a quarterly bundled Treatment and Care Management Payment to provide appropriate services for patients whose condition can be well-controlled with standard medications or other treatments. In some cases, the Treatment Team would be the same as the Diagnosis Team and in other cases it might be a different group of providers.
3. **Continued Treatment for Patients With Difficult-to-Control Conditions.** If the patient's condition proved difficult to control during the initial treatment period or if it could only be controlled using special medications or treatments that require careful monitoring, a Treatment Team would receive a quarterly bundled Treatment and Care Management Payment to provide appropriate services. The payment amounts would be higher than for patients with well-controlled conditions, reflecting the greater risk of complications and higher level of services needed.
4. **Hospitalization for an Exacerbation of the Condition.** Hospitals would receive three separate types of payments to cover the costs of their services to patients who need to be hospitalized for exacerbations of their condition:
   a. A Standby Capacity Payment for each patient who has the chronic condition, regardless of whether they needed to be hospitalized.
   b. A Bundled/Warrantied Payment if the patient requires a visit to the Emergency Department or an inpatient admission for symptoms related to their chronic condition. This would cover all of the costs of the ED visit or hospital admission and any post-acute care services needed for 30 days following discharge that were not provided by the patient's Treatment Team.
   c. An Outlier Payment if a patient required an unusually large number of services.
5. **Palliative Care for an Advanced Condition.** For patients whose condition has reached an advanced stage, a Palliative Care Team could receive a monthly Palliative Care Payment to provide palliative care services to the patient in addition to any treatment or care management services the patient was receiving from a Treatment Team.

The payments in each phase would be stratified into several need/risk-based categories so that higher payments are made for patients who have characteristics that typically require additional or more expensive services. The patient's need/risk classification could change at any time, and subsequent payments would reflect the new need/risk category.

Diagnosis Teams, Treatment Teams, hospitals, and Palliative Care Teams would receive no payment for a patient if the Team failed to meet evidence-based care standards in providing services to that patient. Payments to a Team or hospital would be reduced if desirable outcomes were not achieved. Treatment Teams would receive no payment for low- and moderate-risk patients if the patient visited the ED or was hospitalized.

The APM would reduce spending and improve outcomes by reducing the rate of avoidable emergency department visits and hospital admissions and by reducing the utilization of unnecessary medications, tests, and other services.

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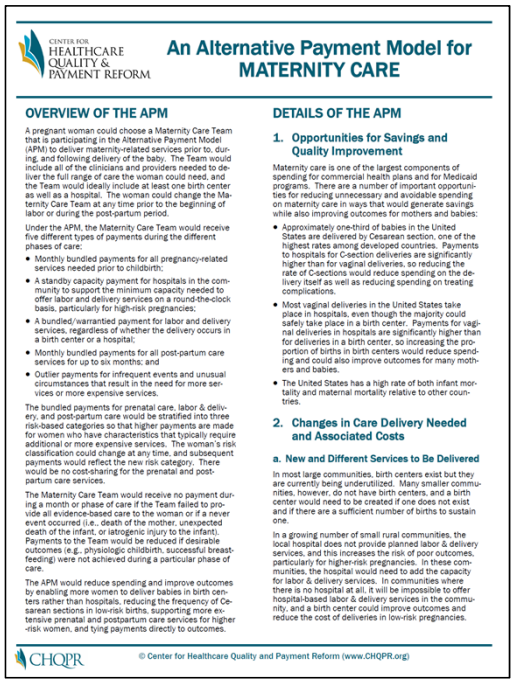

CENTER FOR HEALTHCARE QUALITY & PAYMENT REFORM

## An Alternative Payment Model for MATERNITY CARE

### OVERVIEW OF THE APM

A pregnant woman could choose a Maternity Care Team that is participating in the Alternative Payment Model (APM) to deliver maternity-related services prior to, during, and following delivery of the baby. The Team would include all of the clinicians and providers needed to deliver the full range of care the woman could need, and the Team would ideally include at least one birth center as well as a hospital. The woman could change the Maternity Care Team at any time prior to the beginning of labor or during the post-partum period.

Under the APM, the Maternity Care Team would receive five different types of payments during the different phases of care:

- Monthly bundled payments for all pregnancy-related services needed prior to childbirth;
- A standby capacity payment for hospitals in the community to support the minimum capacity related to offer labor and delivery services on a round-the-clock basis, particularly for high-risk pregnancies;
- A bundled/warrantied payment for labor and delivery services, regardless of whether the delivery occurs in a birth center or a hospital;
- Monthly bundled payments for all post-partum care services for up to six months; and
- Outlier payments for infrequent events and unusual circumstances that result in the need for more services or more expensive services.

The bundled payments for prenatal care, labor & delivery, and post-partum care would be stratified into three risk-based categories so that higher payments are made for women who have characteristics that typically require additional or more expensive services. The woman's risk classification could change at any time, and subsequent payments would reflect the new risk category. There would be no cost-sharing for the prenatal and post-partum care services.

The Maternity Care Team would receive no payment during a month or phase of care if the Team failed to provide all evidence-based care to the woman or if a never event occurred (i.e., death of the mother, unexpected death of the infant, or iatrogenic injury to the infant). Payments to the Team would be reduced if desirable outcomes (e.g., physiologic childbirth, successful breastfeeding) were not achieved during a particular phase of care.

The APM would reduce spending and improve outcomes by enabling more women to deliver babies in birth centers rather than hospitals, reducing the frequency of Cesarean sections in low-risk births, supporting more extensive prenatal and postpartum care services for higher-risk women, and tying payments directly to outcomes.

### DETAILS OF THE APM

#### 1. Opportunities for Savings and Quality Improvement

Maternity care is one of the largest components of spending for commercial health plans and for Medicaid programs. There are a number of important opportunities for reducing unnecessary and avoidable spending on maternity care in ways that would generate savings while also improving outcomes for mothers and babies:

- Approximately one-third of babies in the United States are delivered by Cesarean section, one of the highest rates among developed countries. Payments to hospitals for C-section deliveries are significantly higher than for vaginal deliveries, so reducing the rate of C-sections would reduce spending on the delivery itself as well as reducing spending on treating complications.
- Most vaginal deliveries in the United States take place in hospitals, even though the majority could safely take place in a birth center. Payments for vaginal deliveries in hospitals are significantly higher than for deliveries in a birth center, so increasing the proportion of births in birth centers would reduce spending and could also improve outcomes for many mothers and babies.
- The United States has a high rate of both infant mortality and maternal mortality relative to other countries.

#### 2. Changes in Care Delivery Needed and Associated Costs

##### a. New and Different Services to Be Delivered

In most large communities, birth centers exist but they are currently being underutilized. Many smaller communities, however, do not have birth centers, and a birth center would need to be created if one does not exist and if there are a sufficient number of births to sustain one.

In a growing number of small rural communities, the local hospital does not provide planned labor & delivery services, and this increases the risk of poor outcomes, particularly for higher-risk pregnancies. In these communities, the hospital would need to add the capacity for labor & delivery services. In communities where there is no hospital at all, it will be impossible to offer hospital-based labor & delivery services in the community, and a birth center could improve outcomes and reduce the cost of deliveries in low-risk pregnancies.

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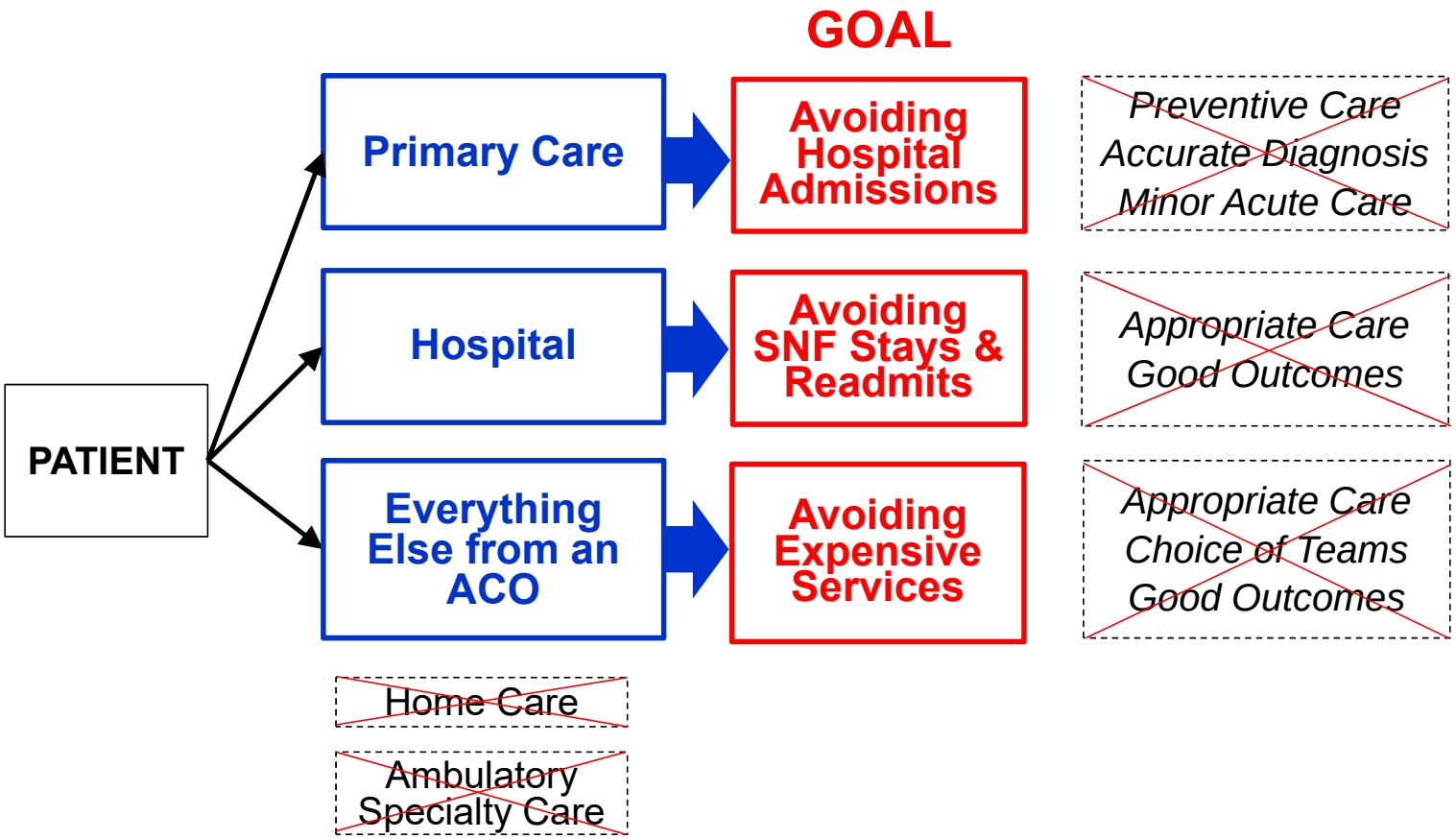
# Which Physician Would YOU Want to Care for You?

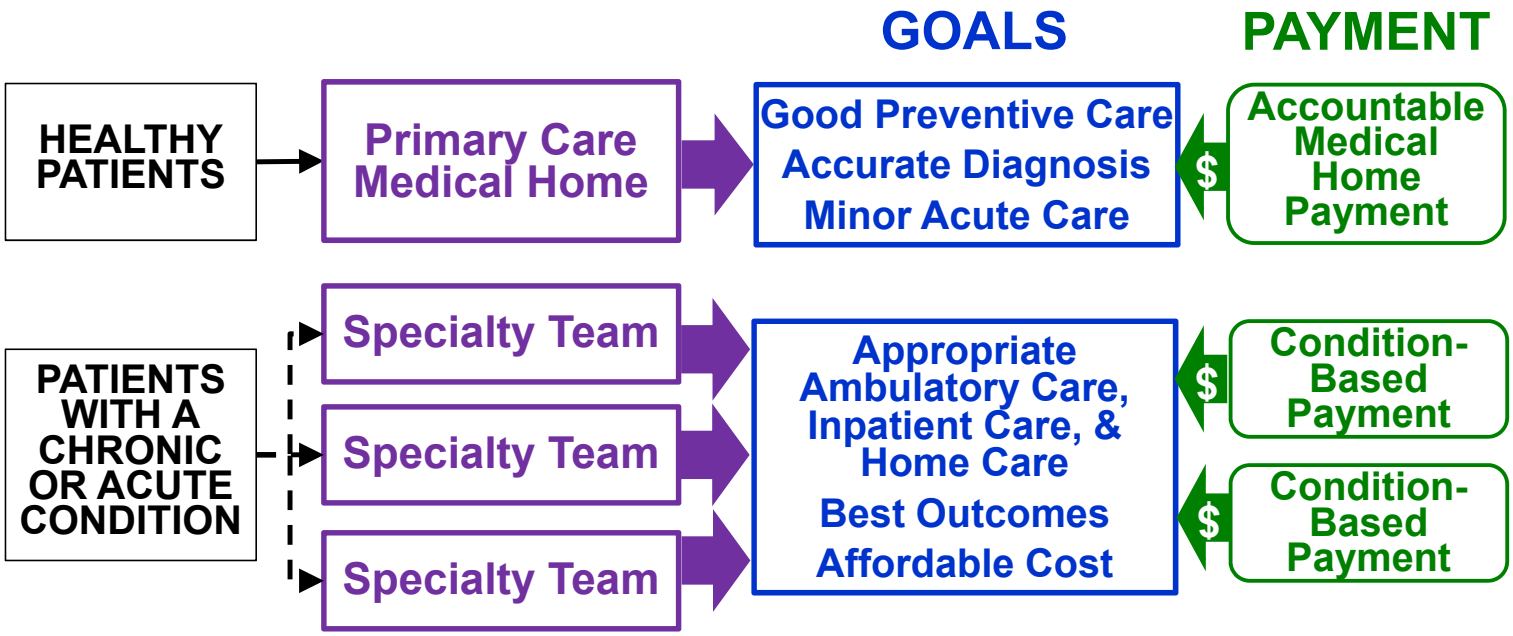
- **Physician A is paid Fee for Service**
  She makes less money if she keeps you healthy
- **Physician B gets "Pay for Performance"**
  She makes more money if she keeps her EHR up to date
- **Physician C gets a (Procedural) Episode Payment**
  She makes more money by efficiently delivering procedures you don't need
- **Physician D gets Shared Savings / Pop. Based Payment**
  She makes more money if you get less treatment than needed
- **Physician E is paid through Patient-Centered Payment**
  She's paid adequately to address your needs, and
  she makes more money if your health condition(s) improve

# Is This the Health System You Really Want?

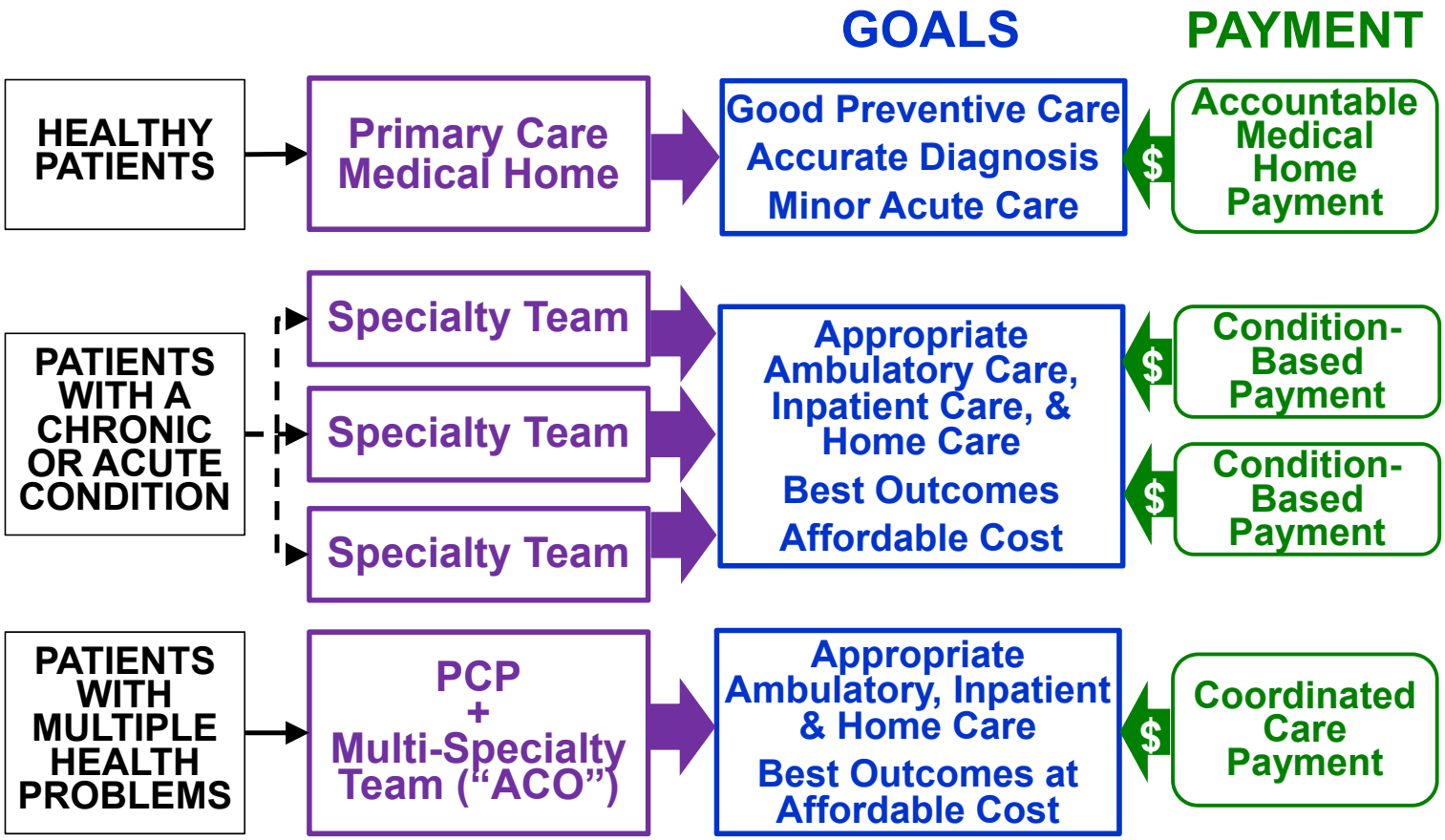


# Creating a Truly Patient-Centered Health Delivery System

# Creating a Truly Patient-Centered Health Delivery System



# Creating a Truly Patient-Centered Health Delivery System




# For More Information:

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