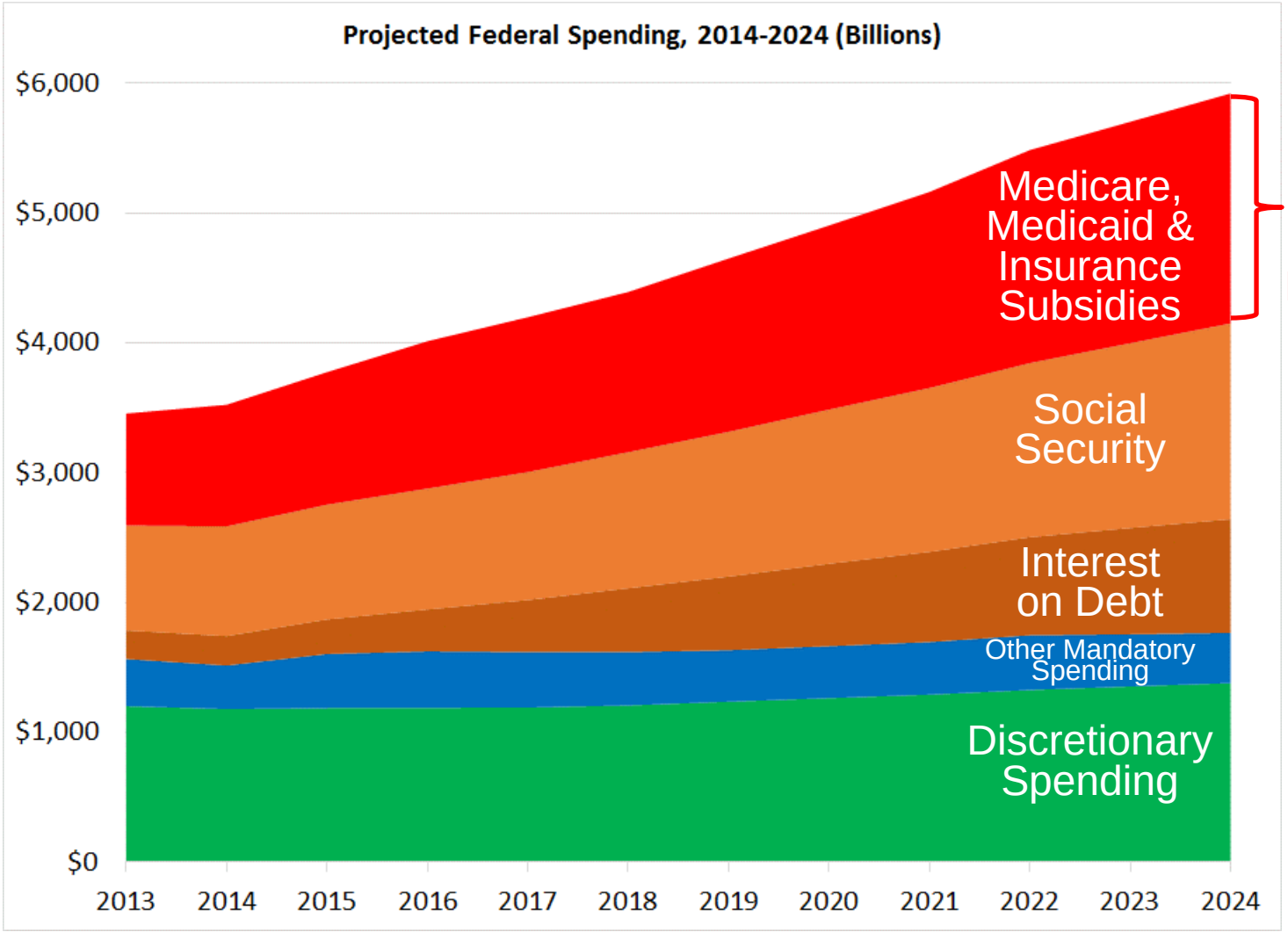
WIN-WIN-WIN APPROACHES TO ACCOUNTABLE CARE
How Physicians, Hospitals, Patients, and Payers Can All Benefit From Healthcare Payment & Delivery Reform

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

www.CHQPR.org

Healthcare Spending Is the Biggest Driver of Federal Deficits



Source: CBO Budget Projections April 2014

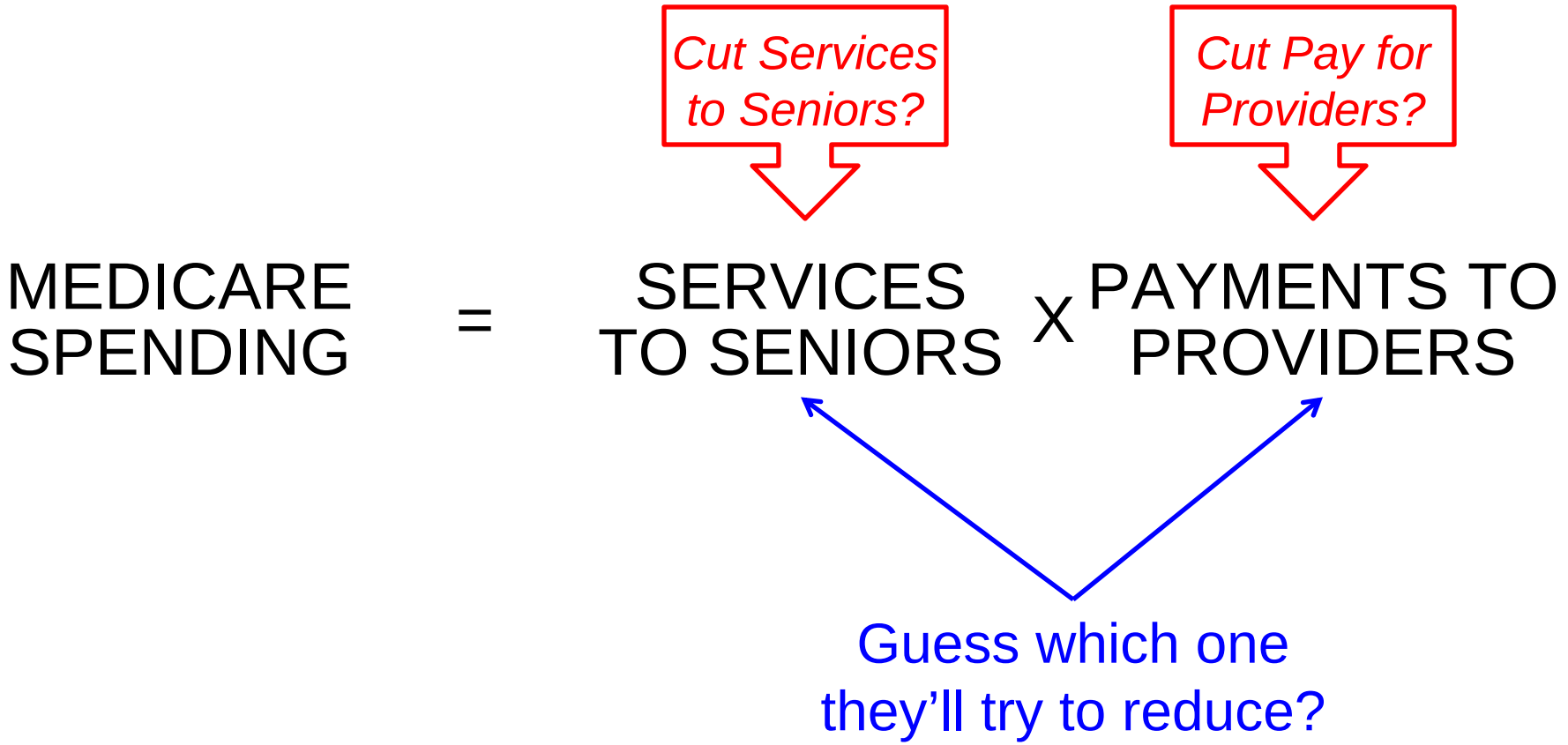
Federal Cost Containment Policy Choices

Cut Services to Seniors?

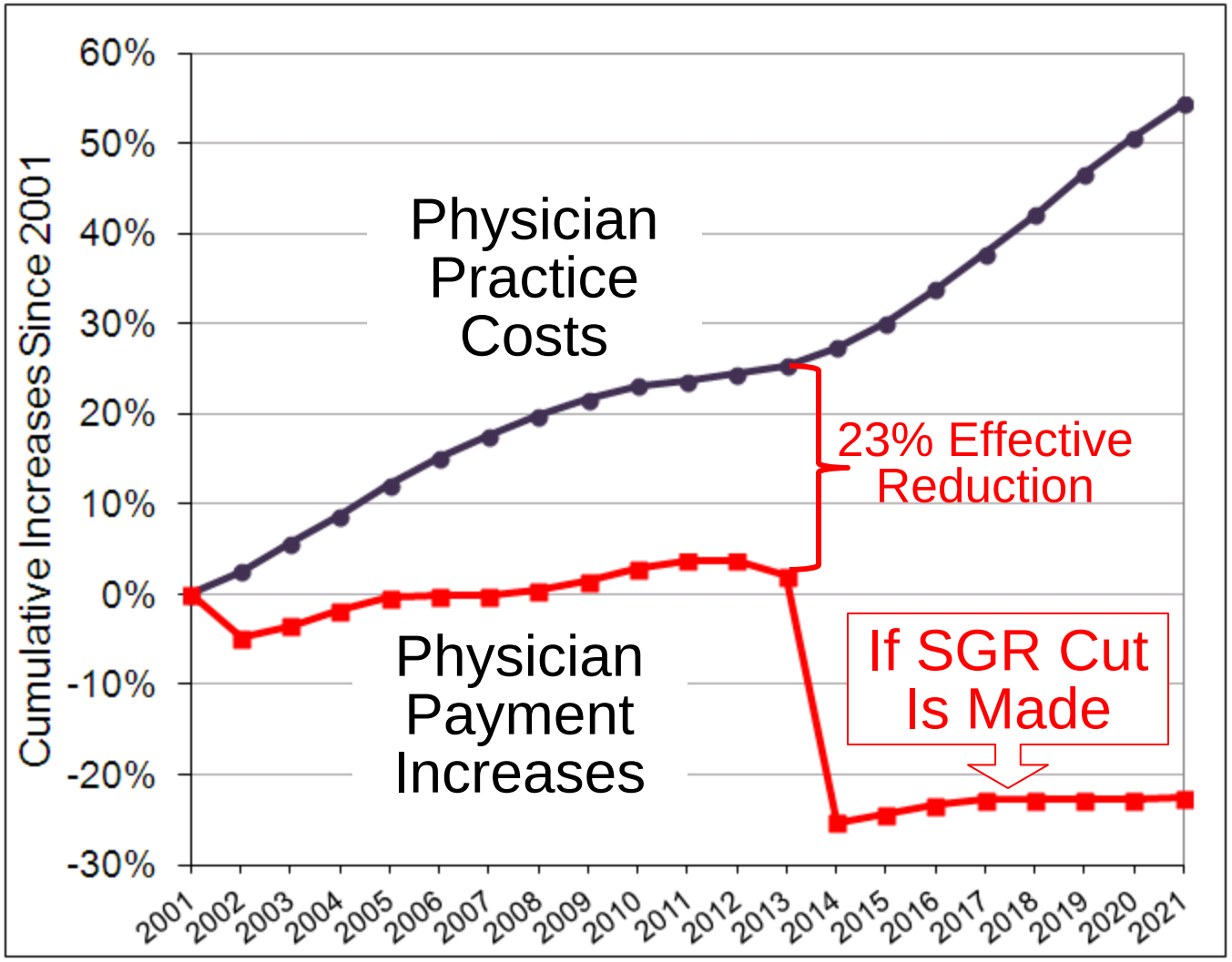
Cut Pay for Providers?

MEDICARE SPENDING = SERVICES TO SENIORS X PAYMENTS TO PROVIDERS

If The Choice is Rationing or Payment Cuts, Which is Likely?



What Other Industry Tries to Cut Pay for Key Professionals by 20%?



Repealing SGR Is Seen as Higher Payment That Increases Spending

MEDICARE SPENDING = SERVICES TO SENIORS X PAYMENTS TO PROVIDERS

Repealing SGR Increases Projected Spending

Repealing SGR "Increases" Physician Payment

So to Pay for SGR Repeal, Congress Looks for Other Cuts

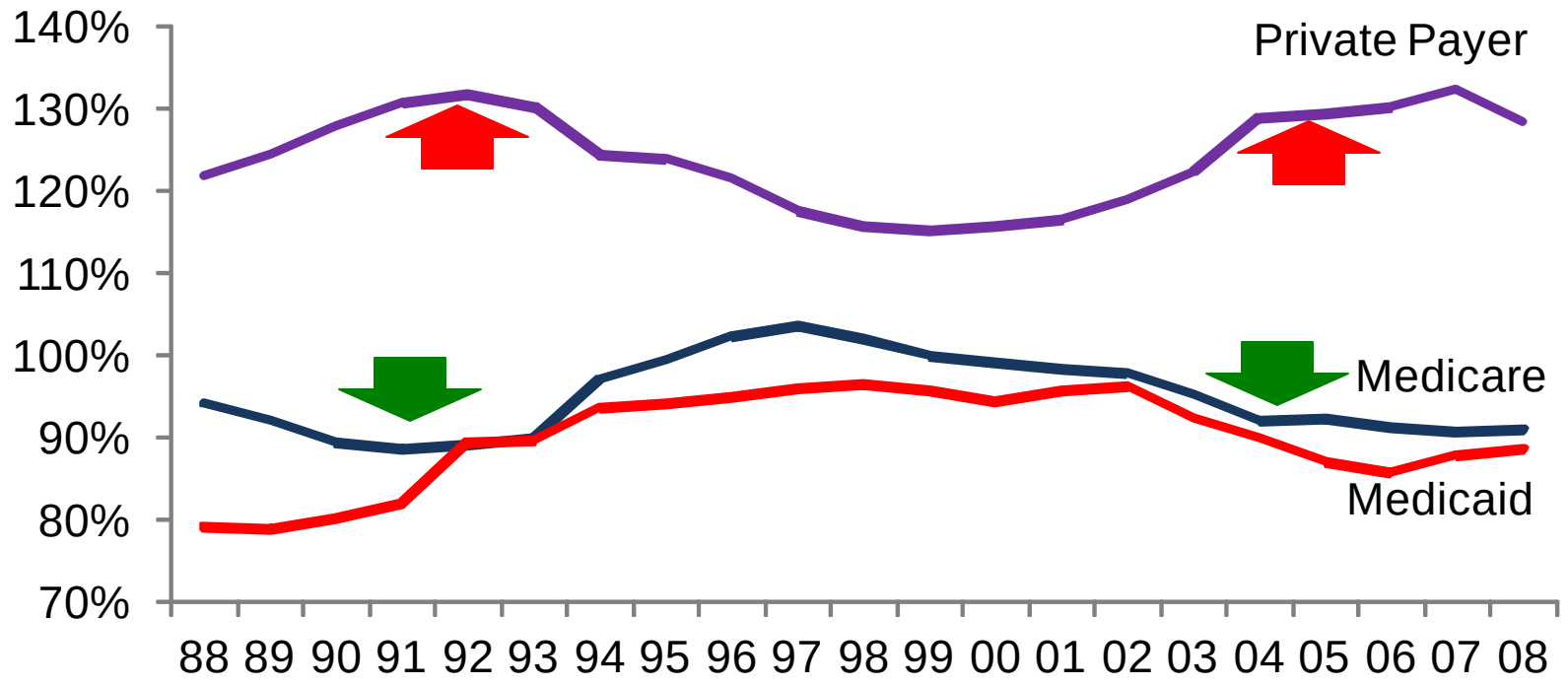
Cut Pay for Providers

MEDICARE SPENDING = SERVICES TO SENIORS X PAYMENTS TO PROVIDERS

Repealing SGR "Increases" Physician Payment

Government Cuts Lead to Cost-Shifting to Private Payers

Hospital Payment-to-Cost Ratios for Private Payers, Medicare, and Medicaid, 1988 – 2008



Source: Avalere Health analysis of American Hospital Association Annual Survey data, 2008, for community hospitals.

Is There a Better Way?

What If We Paid for *Cars* the Way We Pay for *Care*?

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ACA

Affordable Car Act

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Affordable Car Act

Goal:

Every citizen should have affordable transportation

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ACA

Affordable Car Act

Goal:

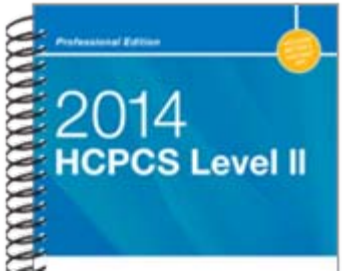
Every citizen should have affordable transportation

Method for Achieving the Goal:

Give all citizens insurance that would cover the cost of new automobiles and repairs when needed

How to Control Spending on Cars If Insurance Is Paying For Them?

To Control Spending, 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+Fcon IS+ I/C (w/CAT)	£	3,502.95
11001-KS001	Turbo Kit Swift ZC31S BOT w/o Fcon IS w/o I/C (no CAT)	£	1,919.50
11001-KS003	Turbo kit Swift ZC31S BOT+Fcon 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 (SMT 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
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11003-AZ001	T04Z Turbine Kit FD3S	£	4,933.50
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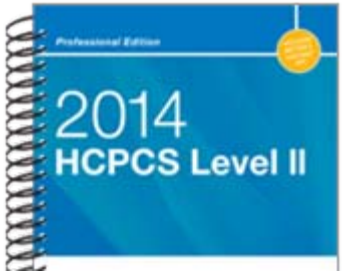
…And Pay Auto Workers Based On How Many Parts They Installed



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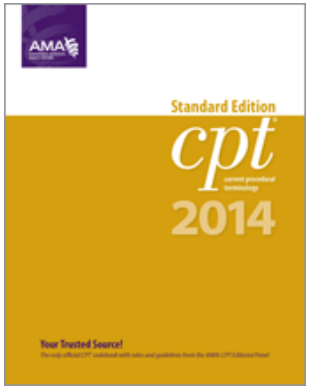
AMA
Automobile Manufacturing Association



CPT System (Car Parts Tokens)

The Result for Drivers?

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Cars would get many unnecessary parts

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Cars would be readmitted to the factory 20% of the time to correct malfunctions

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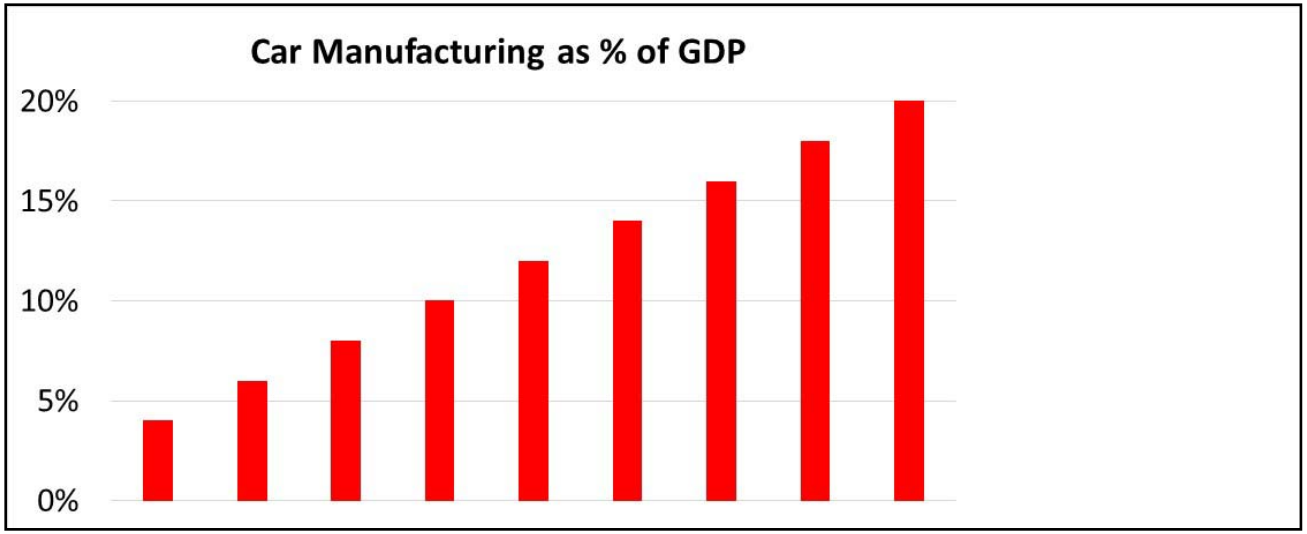
Cars would be readmitted to the factory
20% of the time to correct malfunctions

This would occur even though
all factories were accredited by
the Joint Commission (on Auto Creation)
and all auto workers were certified as
Personal Car Making Heros (PCMH) by the
National Committee on Quality Autos (NCQA)

Spending on Cars Would Grow Rapidly



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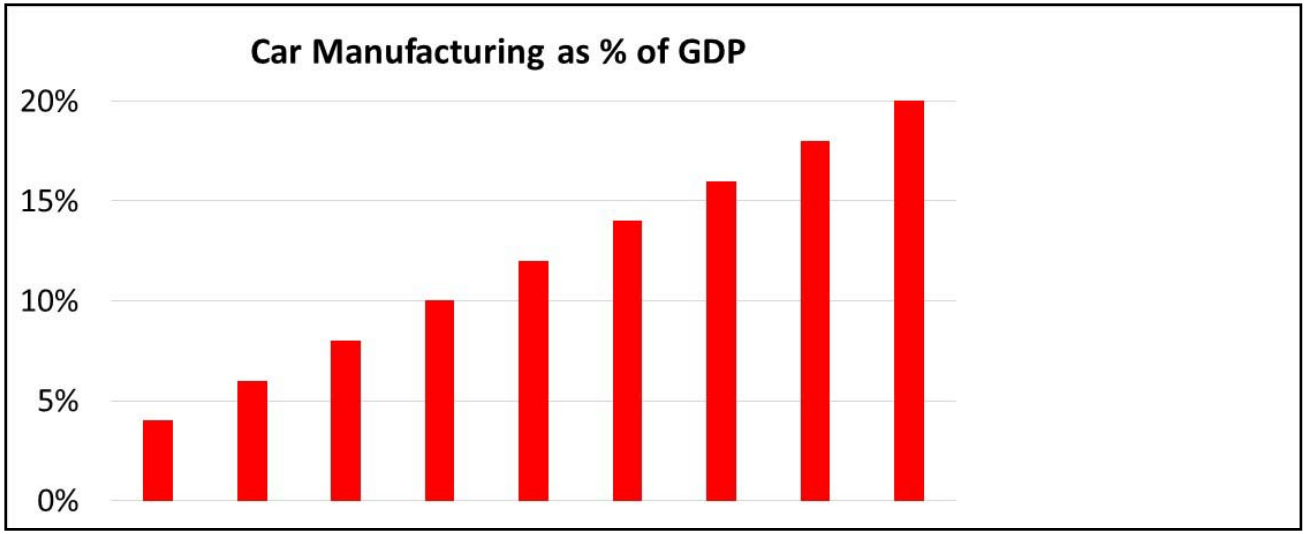

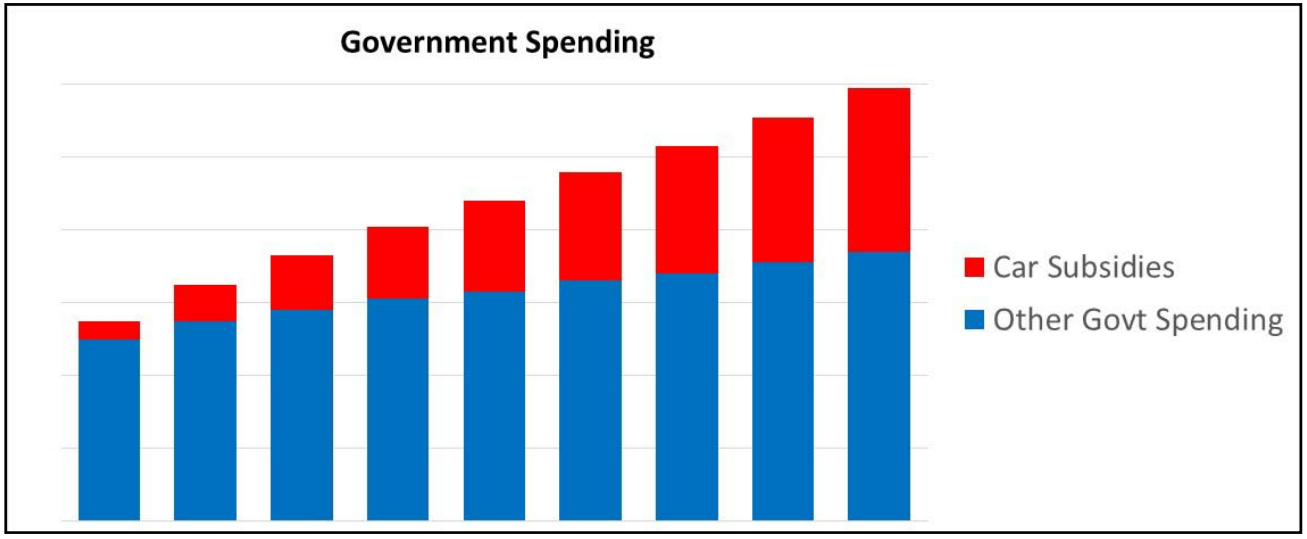

What to Do?

What to Do?
Cut Fees for Parts & Assembly

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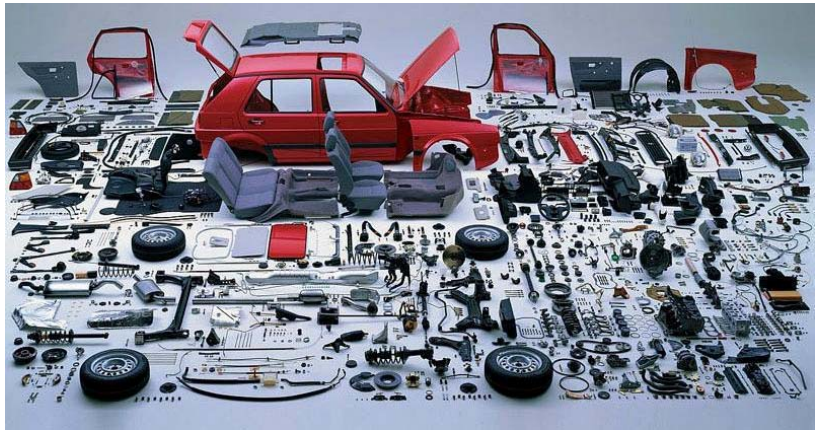
More Parts Used



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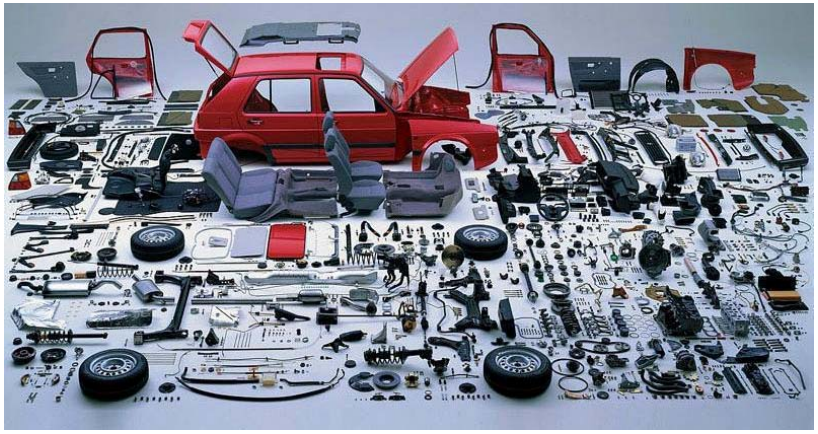
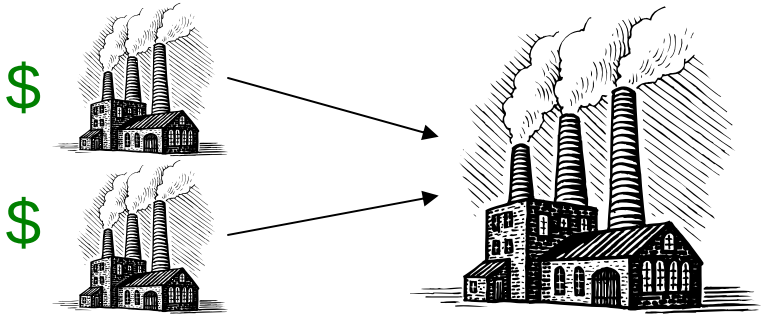


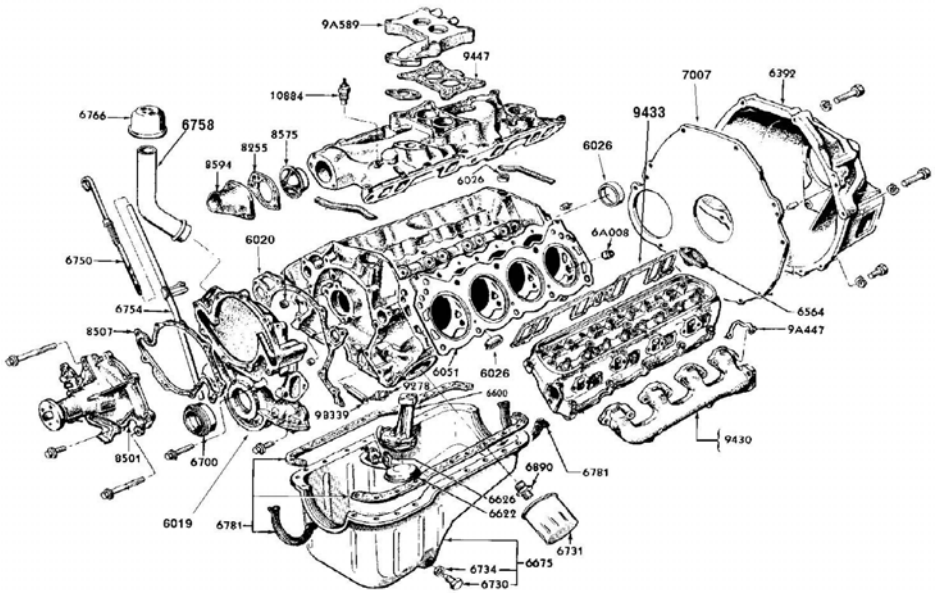
Cut Fees for Parts & Assembly

Factories Merge to Resist Fee Cuts



What to Do?
Pay for Bundles Instead of Parts

Driving Related Groups (DRGs)



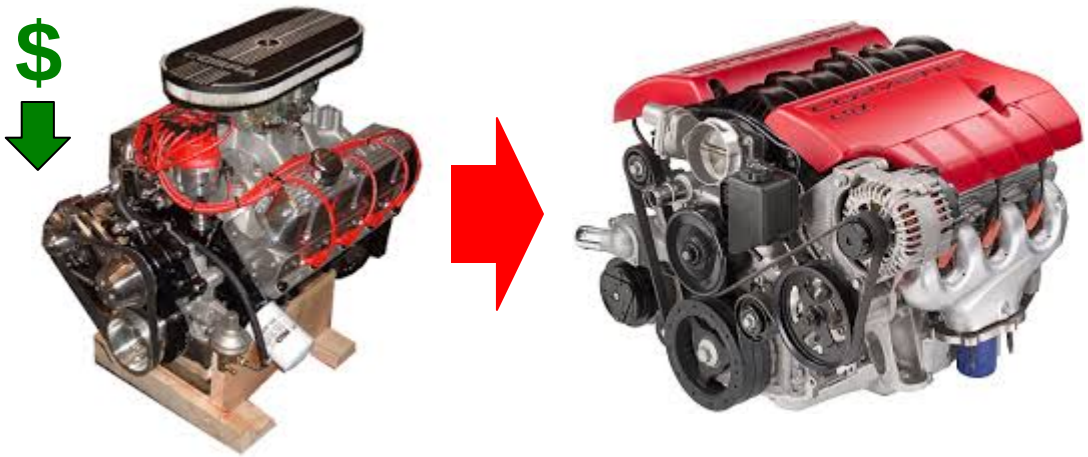
Cost Per Bundle Would Decrease

Lower-Cost Engines

Cost Per Bundle Would Decrease But More Expensive Bundles Used

Lower-Cost Engines

Bigger Engines



Cost Per Bundle Would Decrease But More Expensive Bundles Used

Lower-Cost Engines

Bigger Engines

Really Big Engines

Cost Per Bundle Would Decrease But More Expensive Bundles Used

Lower-Cost Engines

Bigger Engines

Really Big Engines

Consumers would get bundles they didn't need

What to Do?
“Managed Cars”

What to Do?
"Managed Cars"

Waiting for Prior Authorization to Buy a New Car

What to Do?
"Managed Cars"

Waiting for Prior Authorization to Buy a New Car

Requirements to Try Lower-Cost Services First

What to Do?
Consumer-Directed Car Payment

Consumer Share of Car Price
$1,000 Copayment
10% Coinsurance w/$2,000 OOP Max
$5,000 Deductible

People Would Think Twice About Whether to Buy a Car…

Consumer Share of Car Price	Price $18,000
$1,000 Copayment	$1,000
10% Coinsurance w/$2,000 OOP Max	$2,000
$5,000 Deductible	$5,000

… But Choose Expensive Cars Since Their Cost Is The Same

Consumer Share of Car Price	Price $18,000	Price $320,000
$1,000 Copayment	$1,000	**$1,000** ✓
10% Coinsurance w/$2,000 OOP Max	$2,000	**$2,000** ✓
$5,000 Deductible	$5,000	**$5,000** ✓

High Cost-Sharing Would Also Apply to Preventive Maintenance…

Consumer Share of Car Maintenance	Preventive Maintenance
Cost Sharing	Co-payment
High Deductible	Full Cost

People Would Avoid Maintenance Until Costly Repairs Were Needed

Consumer Share of Car Maintenance	Preventive Maintenance	Deferred Maintenance
Cost Sharing	Co-payment	Co-insurance
High Deductible	Full Cost	No More Than Out-of-Pocket Limit

What to Do?
"Shared Savings" Program

STEP 1
Continue Paying Factories & Workers Based on Parts

What to Do?
"Shared Savings" Program

STEP 1
Continue Paying Factories & Workers Based on Parts

STEP 2
After Cars Are Built & Sold, Compare Total Cost of Parts and Award "Shared Savings"

# of Parts
x
Cost of Parts

<

# of Parts
x
Cost of Parts

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# of Parts
x
Cost of Parts

<

# of Parts
x
Cost of Parts

+

Give Factory 0-50% of Difference in Cost of Parts Compared to Other Cars If Minimum Savings Threshold and Quality Targets Were Met

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Cost of Parts

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RESULT

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- Some factories would reduce parts, but not enough to get shared savings

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RESULT

- Some factories would reduce parts, but not enough to get shared savings
- Some factories would spend more to meet quality targets than they receive in shared savings

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- Some factories would leave out parts where there were no quality measures

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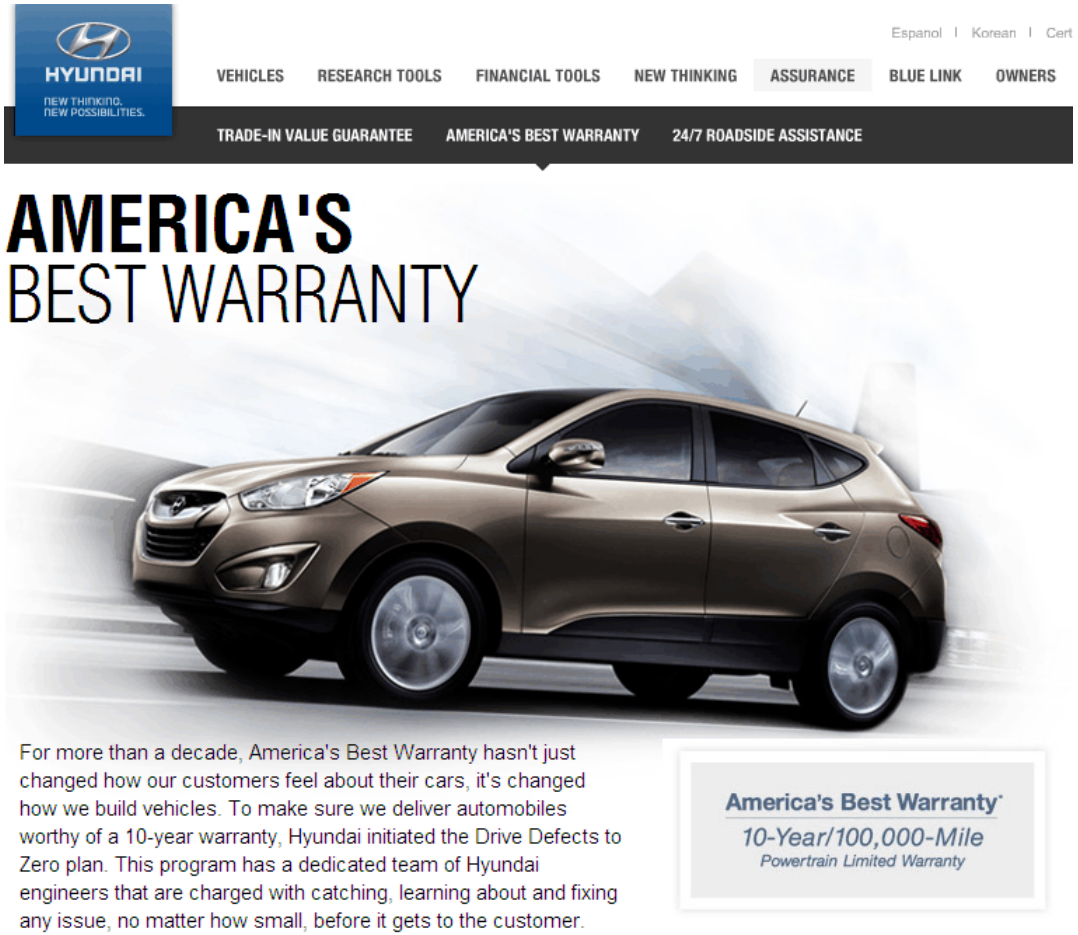
Give Factory 0-50% of Difference in Cost of Parts Compared to Other Cars If Minimum Savings Threshold and Quality Targets Were Met

RESULT

- Some factories would reduce parts, but not enough to get shared savings
- Some factories would spend more to meet quality targets than they receive in shared savings
- Some factories would leave out parts where there were no quality measures
- Most factories and workers would lose money and go back to business as usual

Is There a Better Way?

Pay for *Complete* Cars With *Warranties*, Not Parts & Repairs



Pay for *Complete* Cars With *Warranties*, Not Parts & Repairs

Paying for (all of) the parts
is not the same as
Paying part by part

Have People Pay the *Last* Dollar, Not the First Dollar for Cost-Share

Consumer Share of Car Price	Price $18,000	Price $320,000
$1,000 Copayment:	$1,000	$1,000 ✓
10% Coinsurance w/$2,000 OOP Max:	$2,000	$2,000 ✓
$5,000 Deductible:	$5,000	$5,000 ✓
Highest-Value:	**$1,000 ✓**	**$303,000**

Design Cost Sharing to Encourage *Preventive* Maintenance

Consumer Share of Maintenance	Preventive Maintenance	Deferred Maintenance
Value-Based Cost Sharing	No or Low Copay	Co-insurance
~~High Deductible~~		

Pay for What Consumers *Need*: *Transportation*, Not (Just) Cars

$

Allow the *flexibility* to deliver services that best meet the *individual's needs* with *accountability* for controlling costs

What Are the Lessons for Healthcare?

ACA

Affordable Care Act

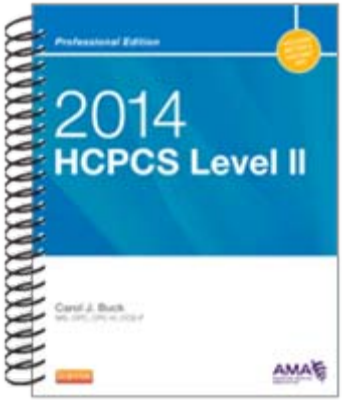
Goal:
Every citizen should have affordable healthcare

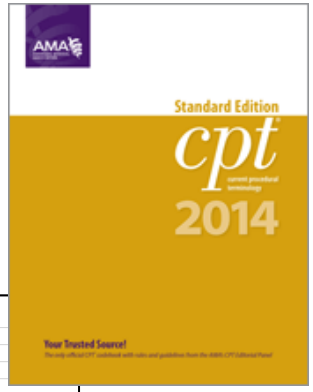
Method for Achieving the Goal:
Give all citizens insurance that would cover the cost of healthcare services when needed

How to Control Spending on Care When Insurance Is Paying?

Should We Keep Paying Part by Part?

Pay for Parts?

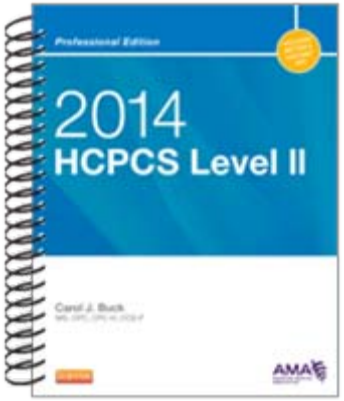


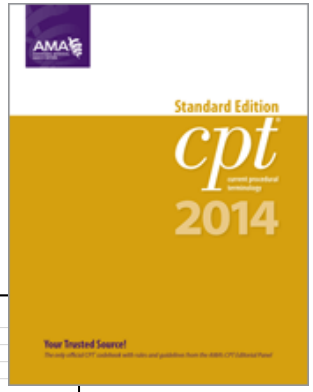


	DIAGNOSIS RELATED GROUP
001	CRANIOTOMY AGE >17 W CC
002	CRANIOTOMY AGE >17 W/O CC
003	CRANIOTOMY AGE 0-17
006	CARPAL TUNNEL RELEASE
007	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W CC
008	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC
009	SPINAL DISORDERS & INJURIES
010	NERVOUS SYSTEM NEOPLASMS W CC
011	NERVOUS SYSTEM NEOPLASMS W/O CC
012	DEGENERATIVE NERVOUS SYSTEM DISORDERS
013	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA
014	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION
015	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT
016	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC
017	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC
018	CRANIAL & PERIPHERAL NERVE DISORDERS W CC
019	CRANIAL & PERIPHERAL NERVE DISORDERS W/O CC
020	NERVOUS SYSTEM INFECTION EXCEPT VIRAL MENINGITIS
021	VIRAL MENINGITIS
022	HYPERTENSIVE ENCEPHALOPATHY
023	NONTRAUMATIC STUPOR & COMA
024	SEIZURE & HEADACHE AGE >17 W CC

Should We Keep Paying Part by Part?

Pay for Parts?





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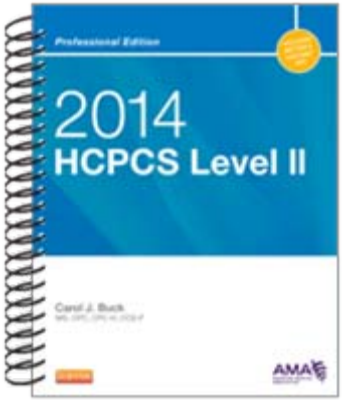
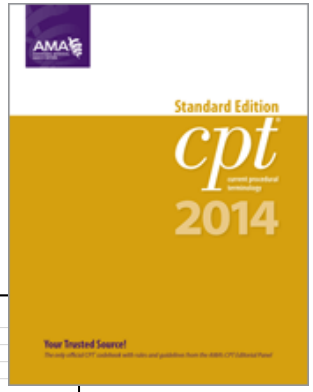
The Biggest Problem With Fee for Service is NOT That It "Encourages More Volume"

Should We Keep Paying Part by Part?

Pay for Parts?





	DIAGNOSIS RELATED GROUP
001	CRANIOTOMY AGE >17 W CC
002	CRANIOTOMY AGE >17 W/O CC
003	CRANIOTOMY AGE 0-17
006	CARPAL TUNNEL RELEASE
007	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W CC
008	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC
009	SPINAL DISORDERS & INJURIES
010	NERVOUS SYSTEM NEOPLASMS W CC
011	NERVOUS SYSTEM NEOPLASMS W/O CC
012	DEGENERATIVE NERVOUS SYSTEM DISORDERS
013	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA
014	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION
015	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT
016	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC
017	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC
018	CRANIAL & PERIPHERAL NERVE DISORDERS W CC
019	CRANIAL & PERIPHERAL NERVE DISORDERS W/O CC
020	NERVOUS SYSTEM INFECTION EXCEPT VIRAL MENINGITIS
021	VIRAL MENINGITIS
022	HYPERTENSIVE ENCEPHALOPATHY
023	NONTRAUMATIC STUPOR & COMA
024	SEIZURE & HEADACHE AGE >17 W CC

The Biggest Problem With Fee for Service is NOT That It "Encourages More Volume"

The Problem With Fee for Service is That It Creates *Barriers* to Better Care

The Problem with Fee for Service is the *Barriers* to Higher Value Care

Lack of Flexibility in FFS

- No payment for phone calls or emails with patients
- No payment to coordinate care among providers
- No payment for non-physician support services to help patients with self-management
- No flexibility to shift resources across silos (hospital <-> physician, post-acute <->hospital, SNF <-> home health, etc.)

The Problem Is the *Barriers* in Fee for Service

Lack of Flexibility in FFS

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- No payment to coordinate care among providers
- No payment for non-physician support services to help patients with self-management
- No flexibility to shift resources across silos (hospital <-> physician, post-acute <->hospital, SNF <-> home health, etc.)

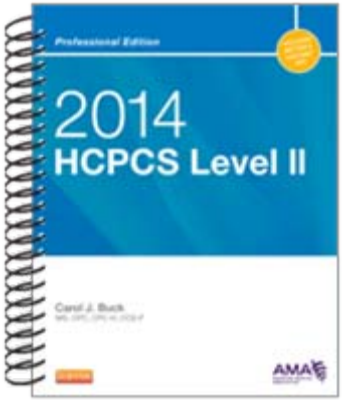
Penalty for Quality/Efficiency

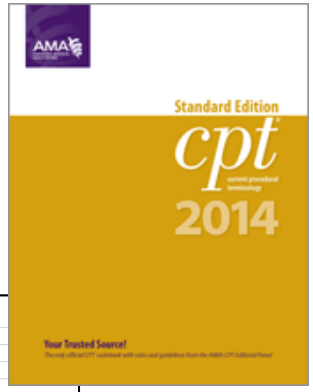
- Lower revenues if patients don't make frequent office visits
- Lower revenues for performing fewer tests and procedures
- Lower revenues if infections and complications are prevented instead of treated
- No revenue at all if patients stay healthy

Instead of Parts, We Should Pay for What We Really Want

~~Pay for Parts~~

Pay for High Quality, Coordinated Care with Good Outcomes at an Affordable Cost





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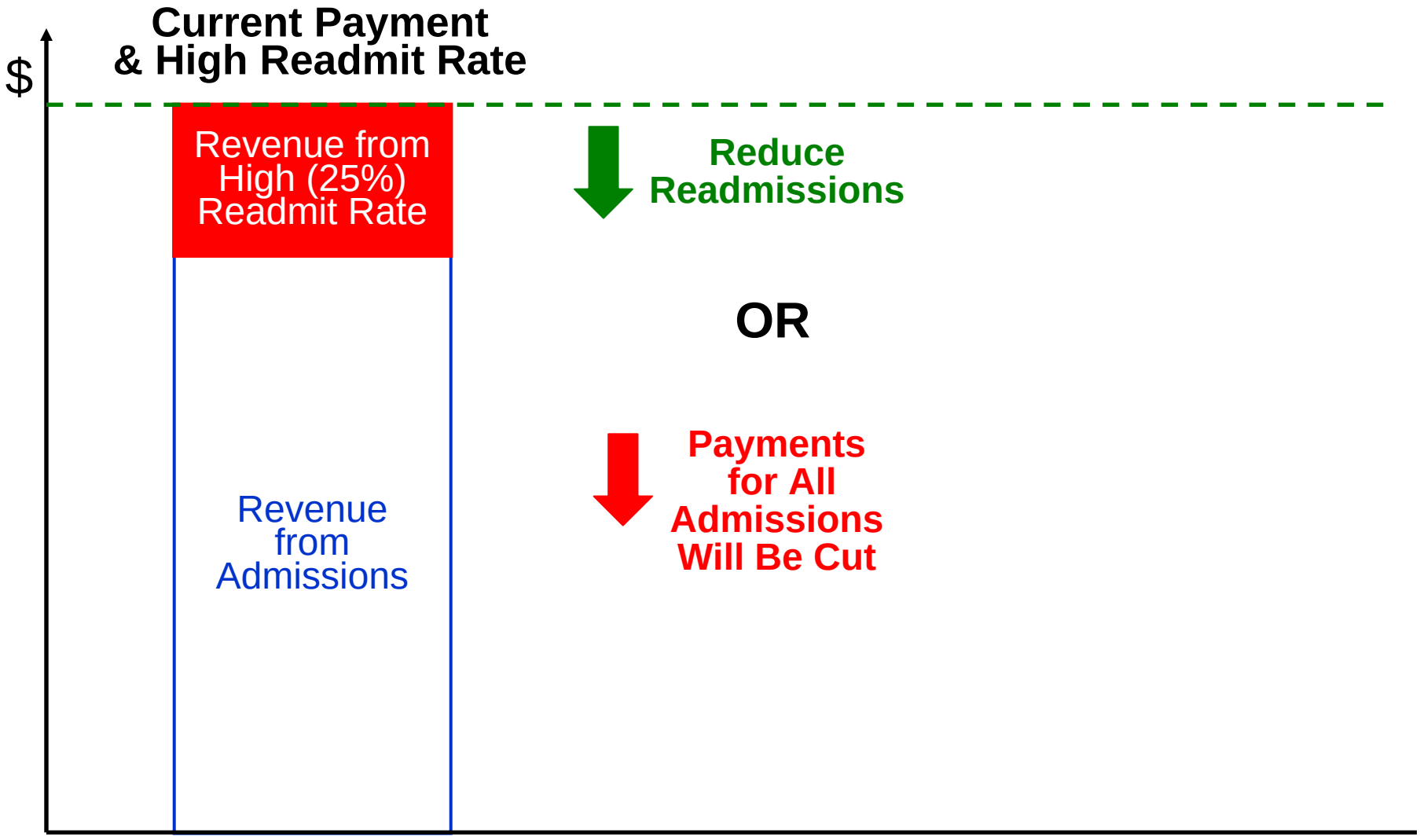
024	SEIZURE & HEADACHE AGE >17 W CC

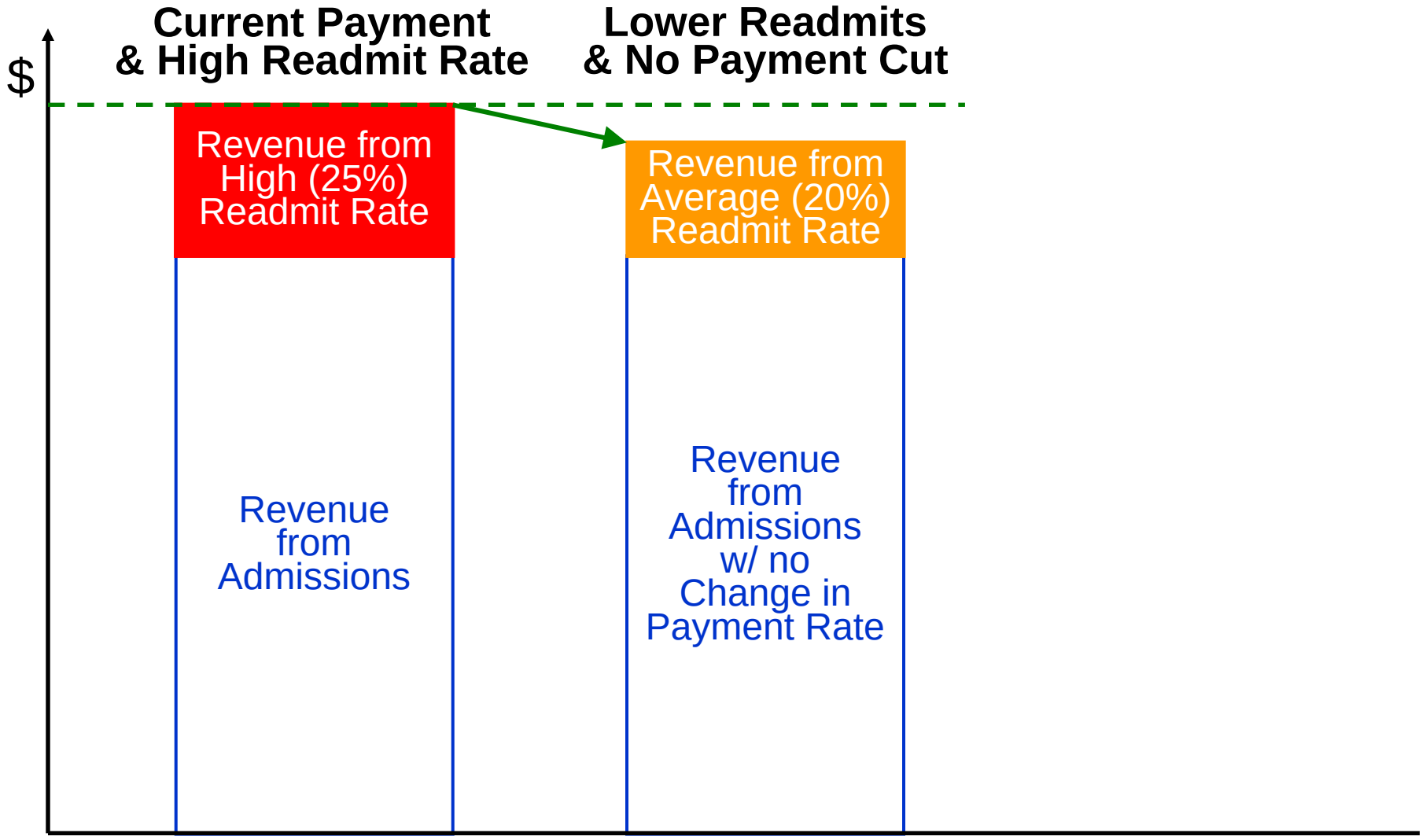
Is "Value-Based Purchasing" The Answer?

- Pay for Performance
  - Hospital Readmission Penalties
  - Hospital-Acquire Condition Penalties
  - Hospital Value-Based Purchasing
  - Physician Value-Based Modifier
- Transparency
- Narrow Networks
- Centers of Excellence

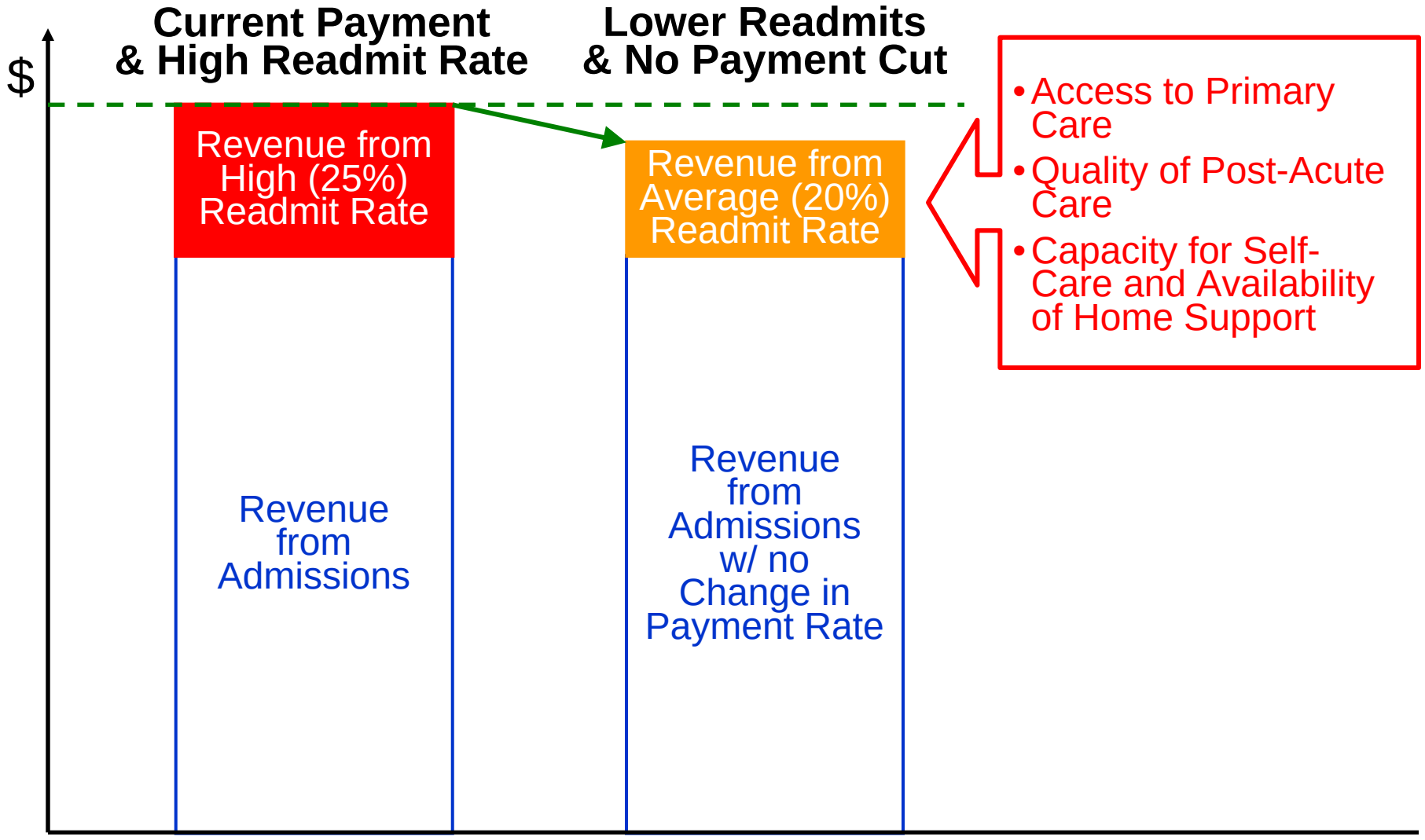
Hospital Readmission Penalties



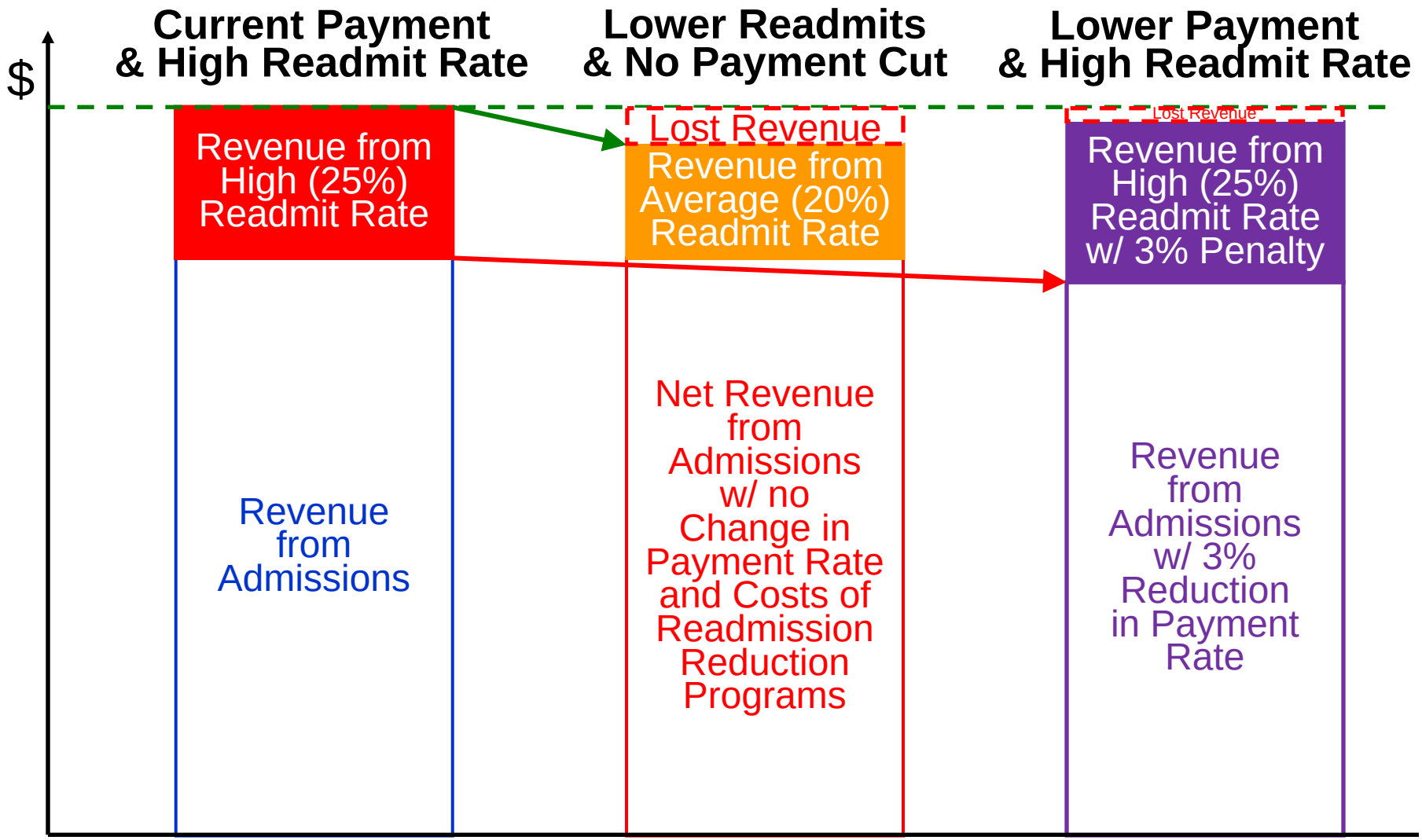
The Hope: Hospitals Will Reduce Readmissions to Avoid Penalties



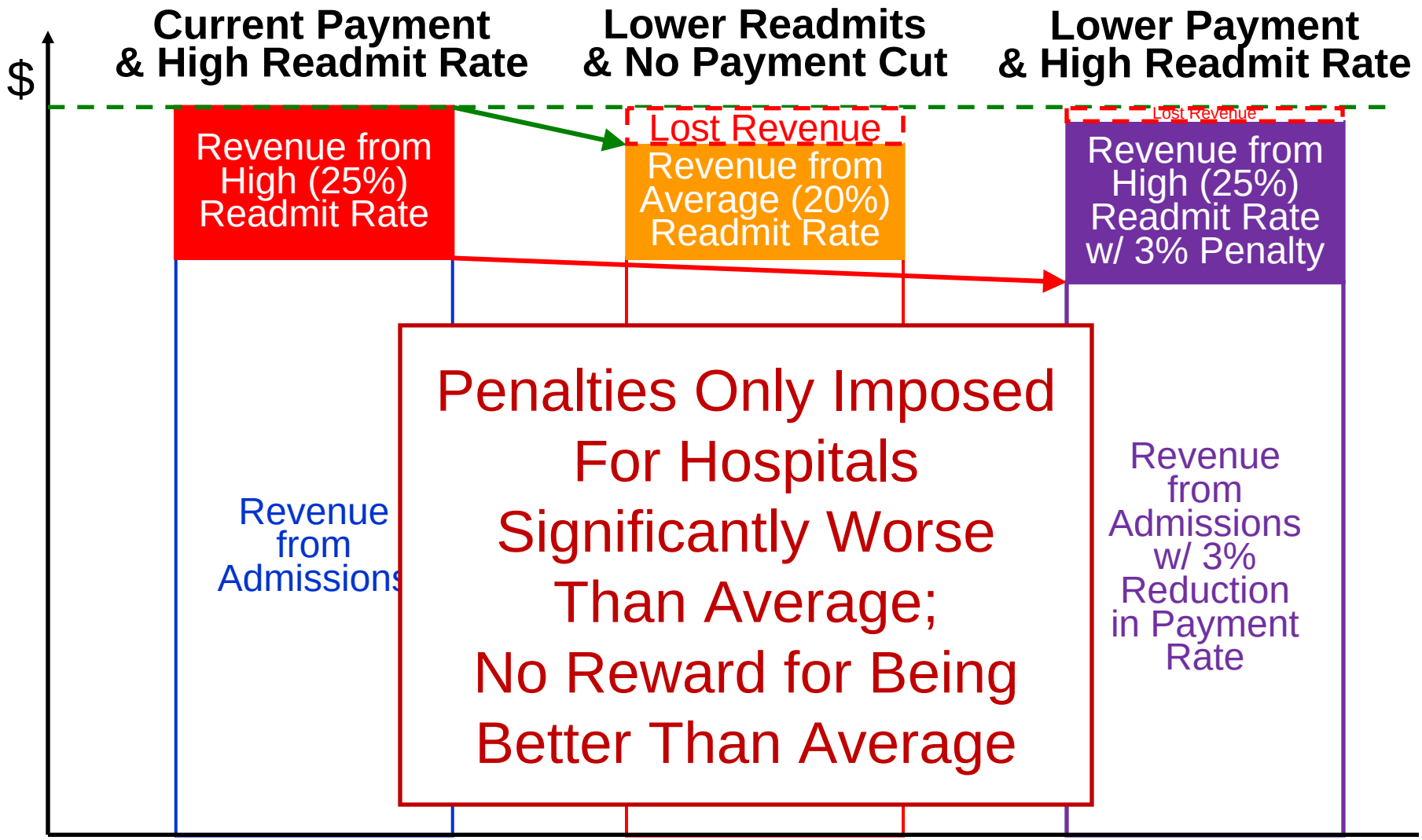
The Myth: Hospitals Control All of the Reasons for Readmissions



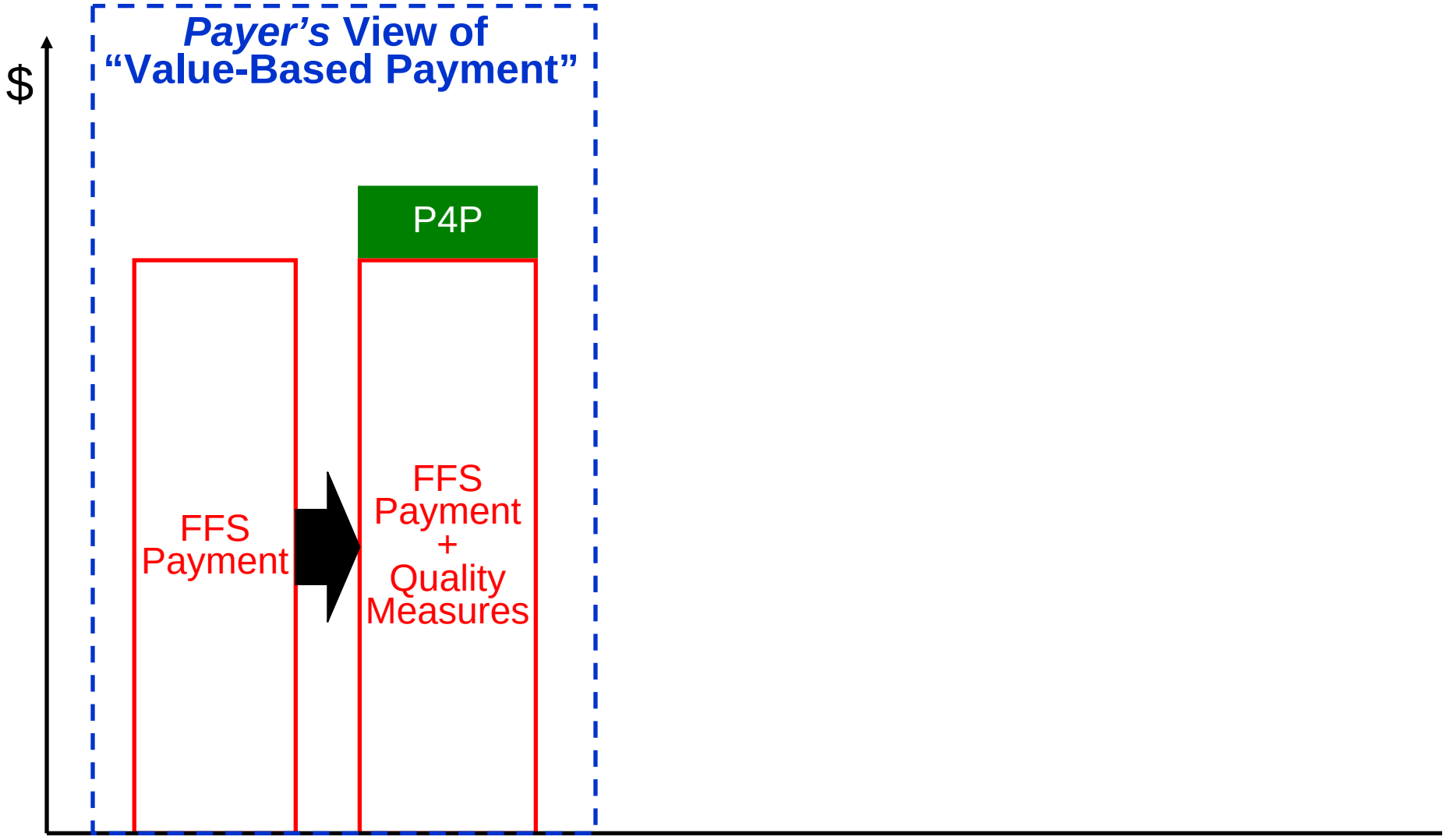
Losses From Fewer Readmits May Be Bigger Than the Penalty



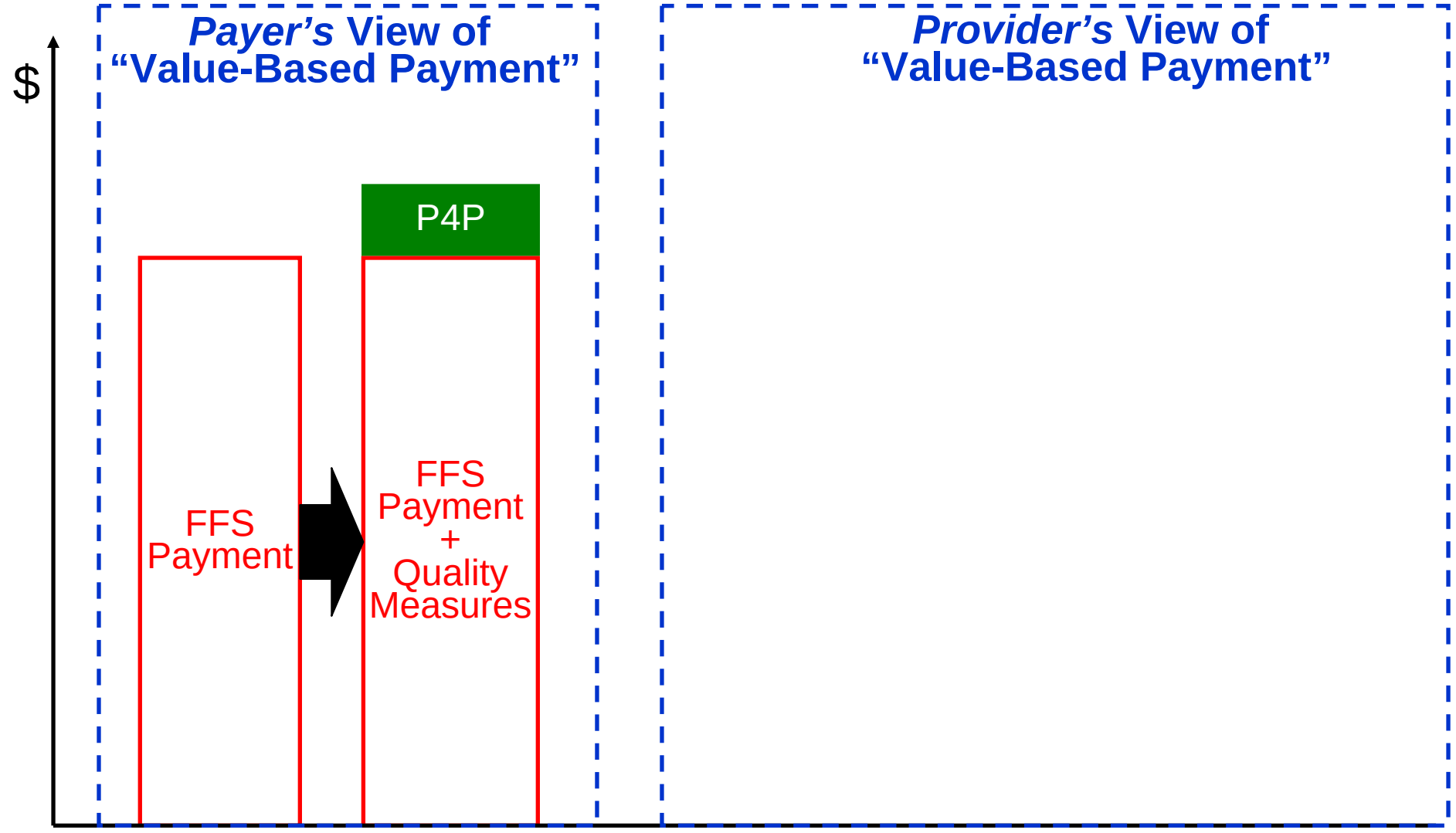
No Incentive to Be *Better* Than Average



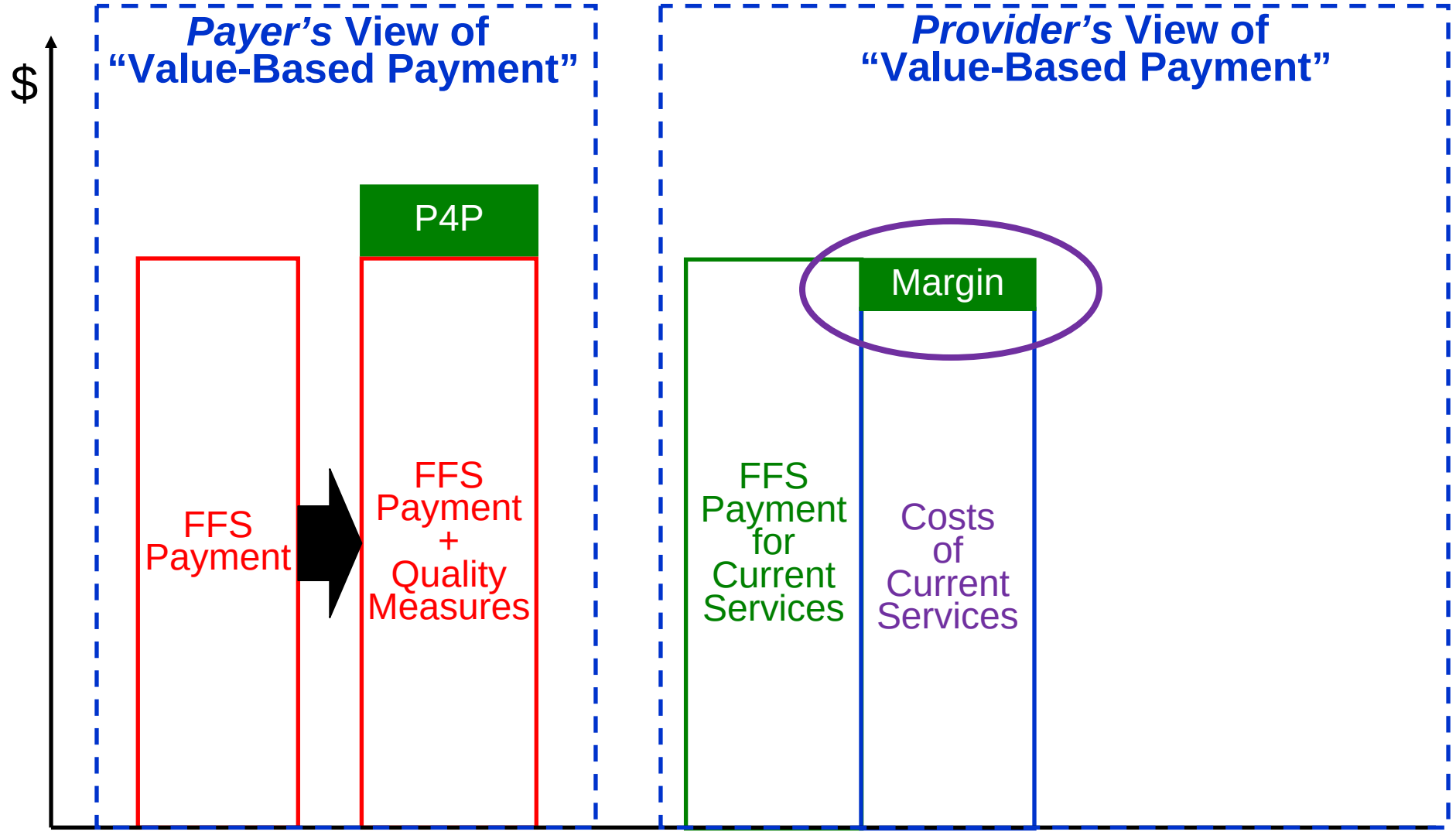
Do Bonuses for Higher Quality Provide the Right "Incentive?"



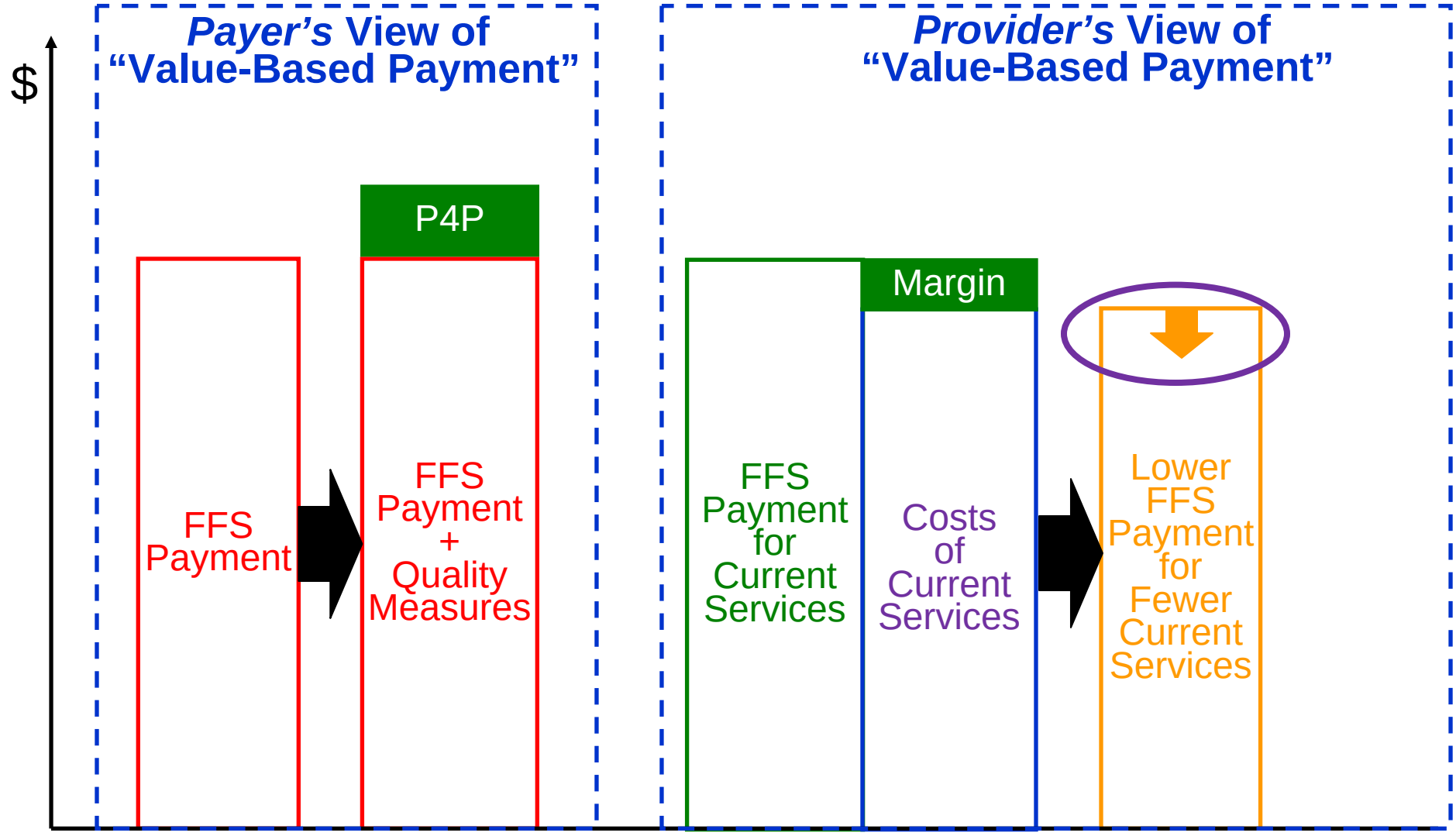
The Payer Only Sees *Payment*, But The Provider Also Sees *Cost*



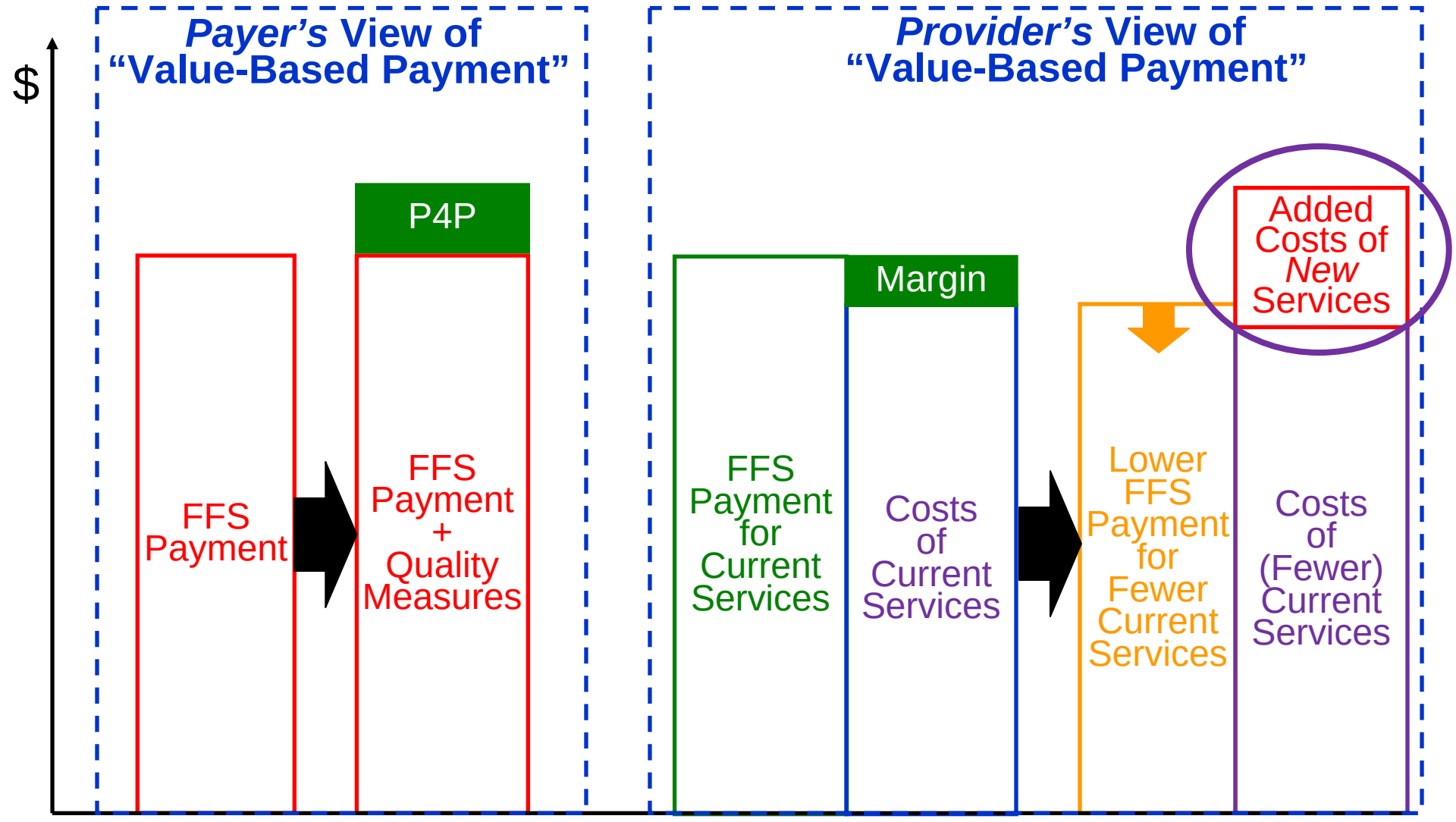
If the Provider Has Managed to Make FFS Payment Cover Costs…



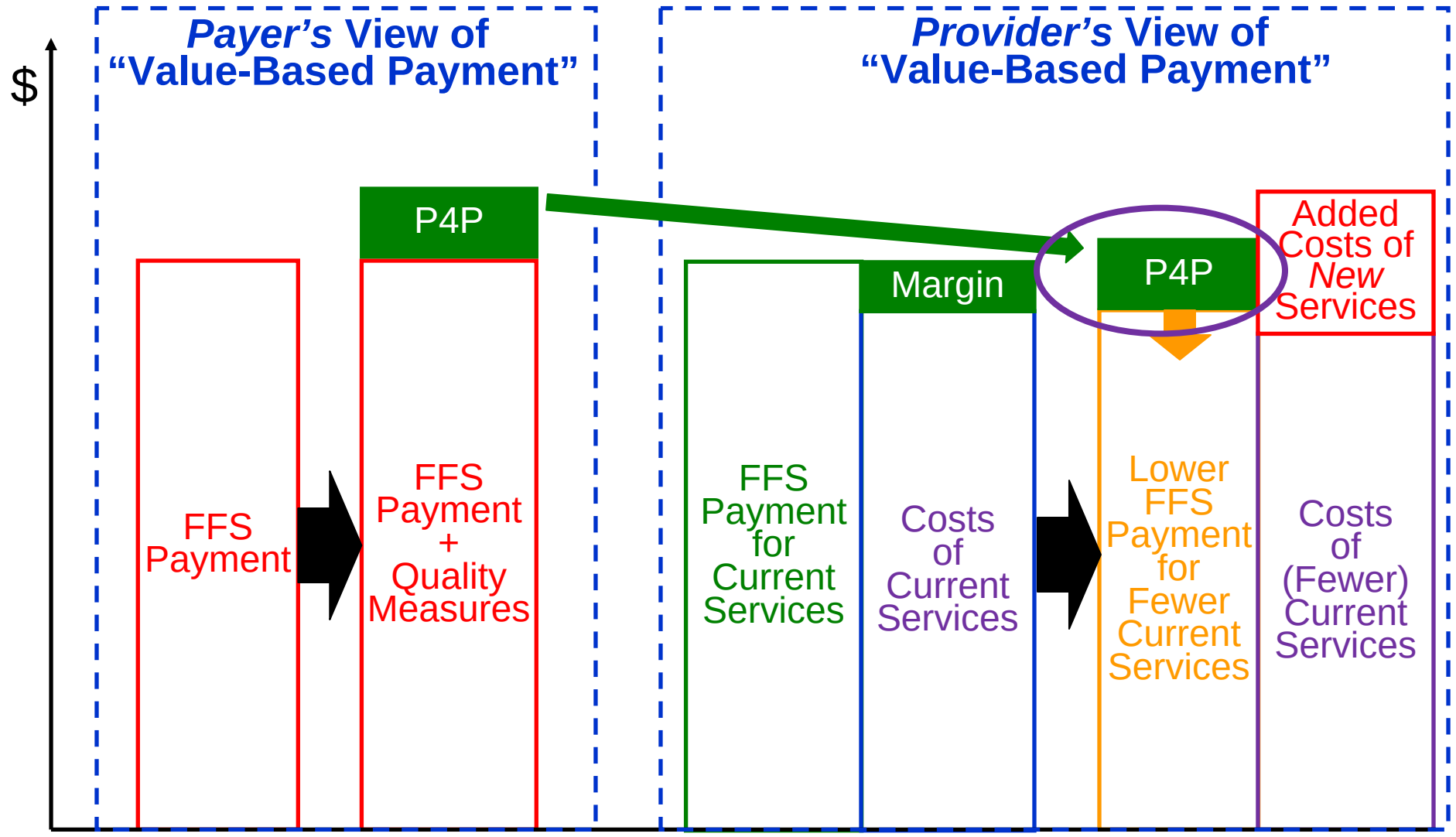
Higher Quality May Mean Lower FFS Revenues…



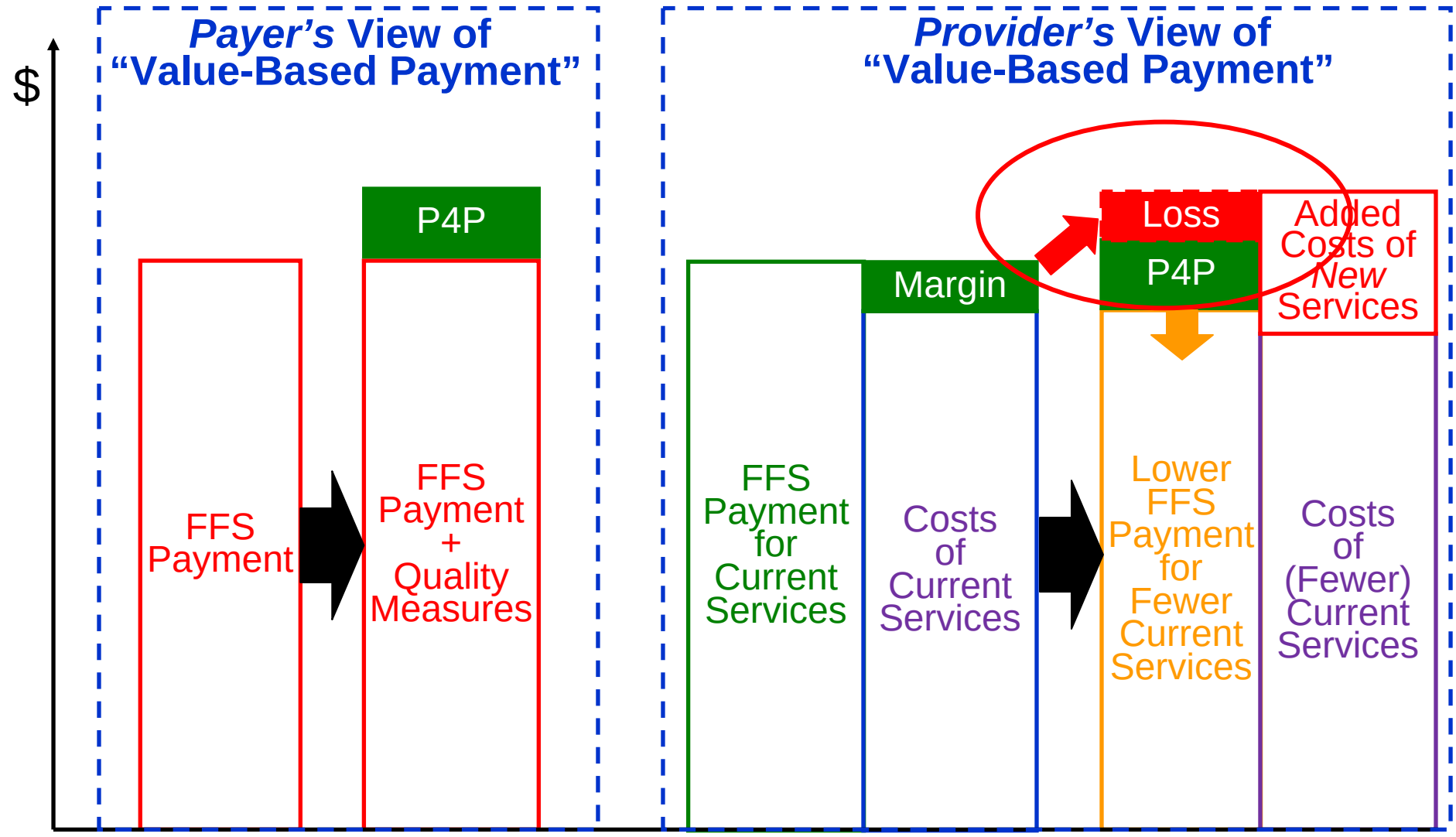
…And Added Costs to Achieve the Higher Quality



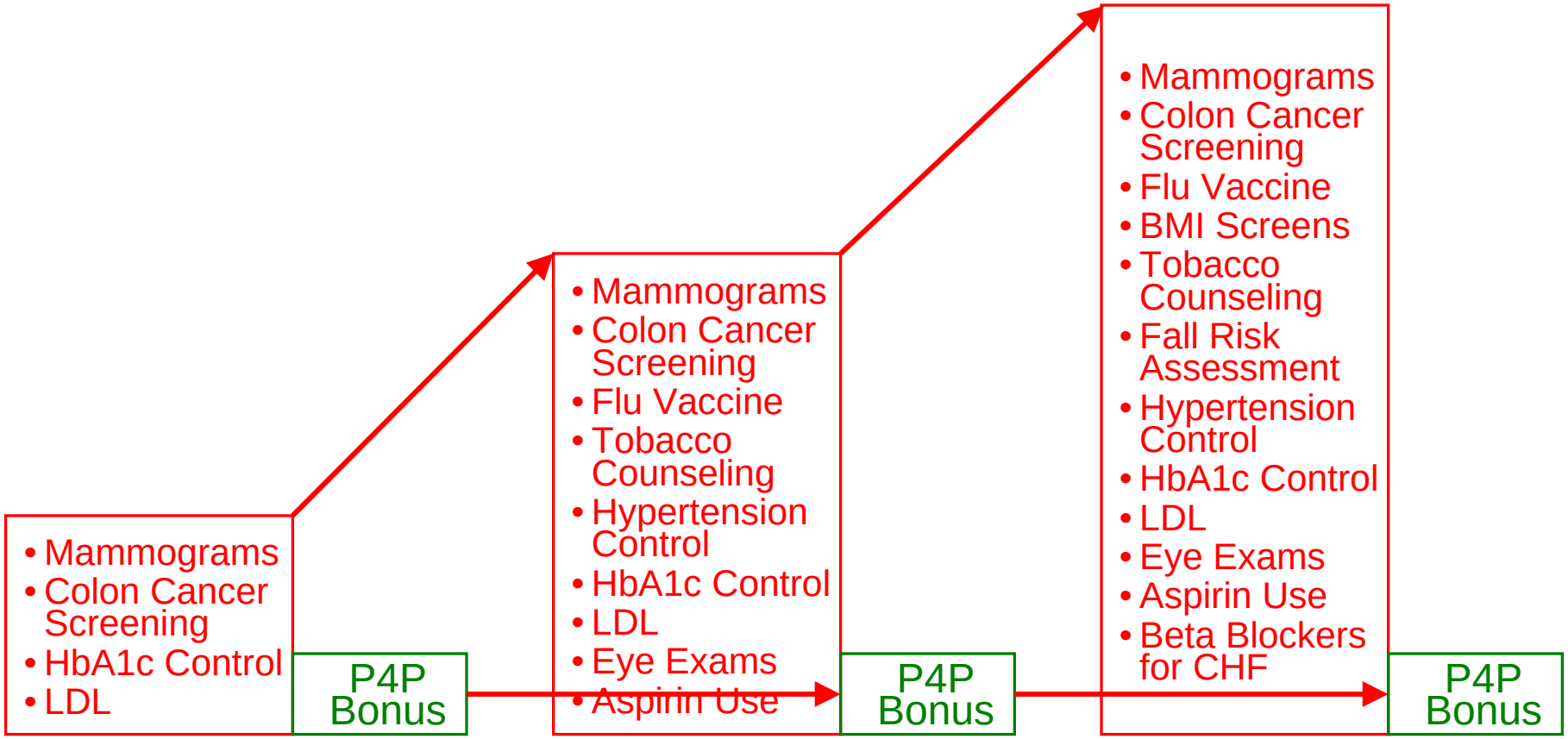
Even With the Payer's "Incentive" Payment...



…P4P May Not Offset Provider's Added Costs & Revenue Losses



More Measures Every Year, With the Same Small Bonuses

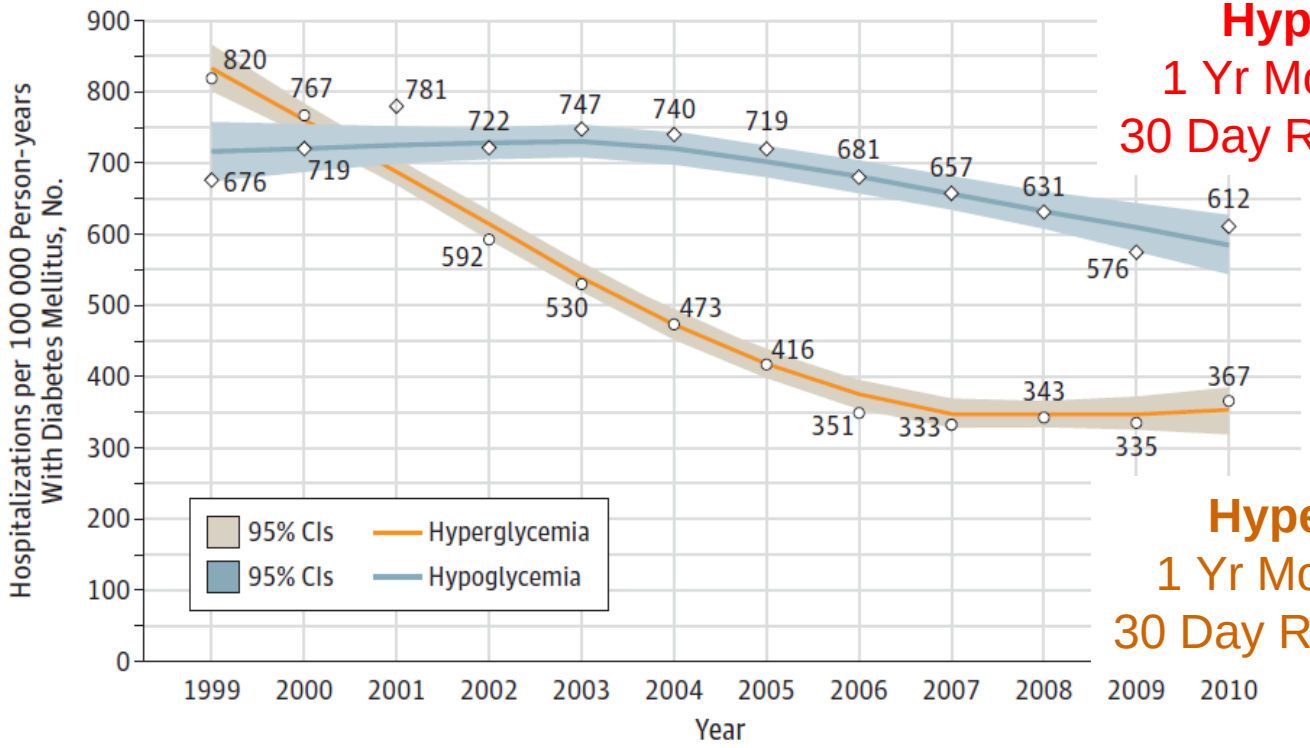


The End of Collaboration?

- In the CMS Value-Based Payment Modifier, bonuses are *only* paid to physicians who have above average quality *if* penalties are assessed on other physicians with below average quality
- To maintain budget neutrality, the size of bonuses depends on the size of penalties
- Under this system, why would high-performing physicians want to help under-performing physicians to improve?

Over-Emphasis on Narrow Quality Measures Can Harm Patients

Figure 2. Rates of Estimated Hospital Admissions for Hyperglycemia and Hypoglycemia Among Medicare Beneficiaries With Diabetes Mellitus, 1999 to 2010

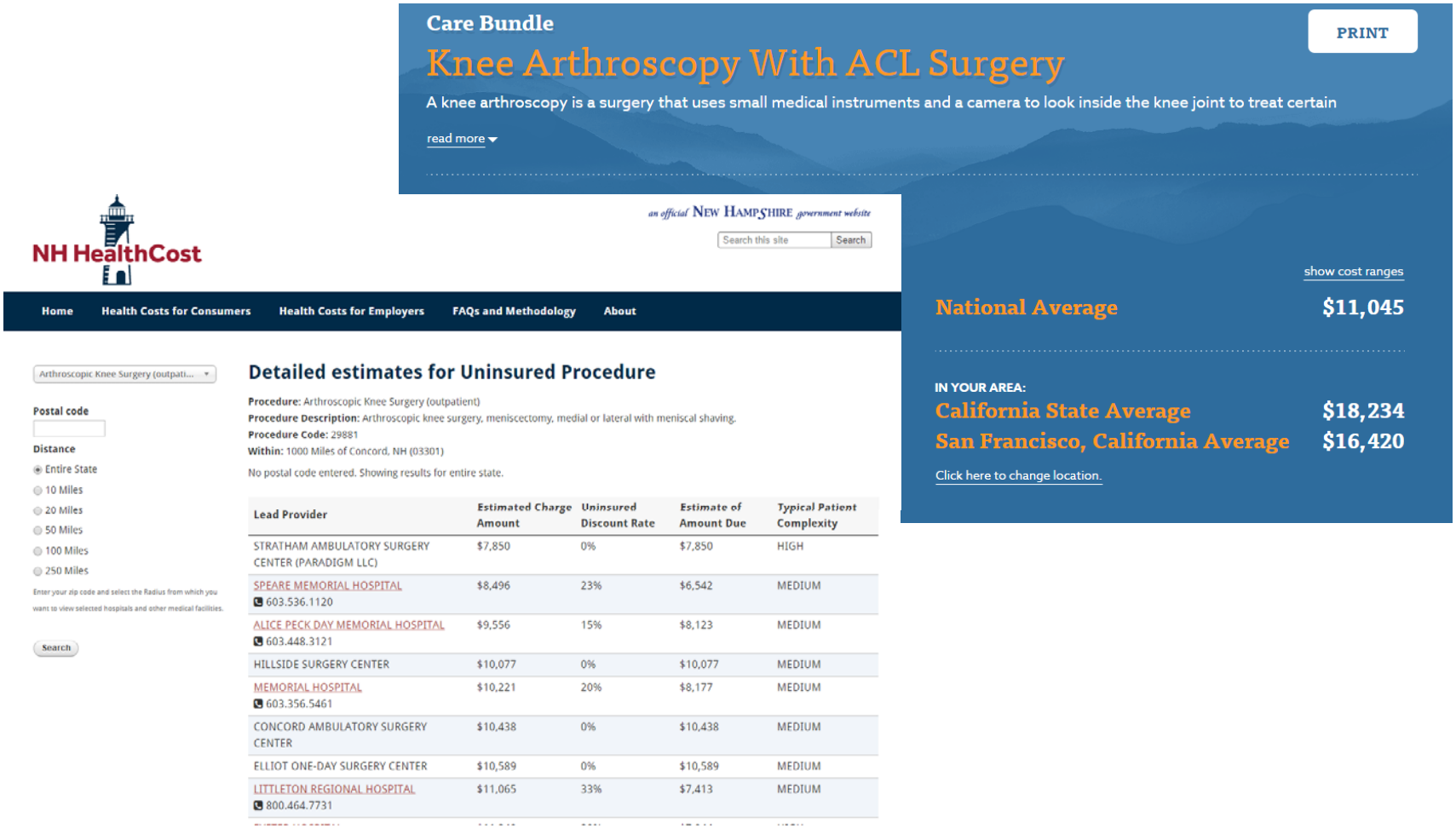


Hypoglycemia
1 Yr Mortality: 19.9%
30 Day Readmits: 16.3%

Hyperglycemia
1 Yr Mortality: 17.1%
30 Day Readmits: 15.3%

Source: National Trends in US Hospital Admissions for Hyperglycemia and Hypoglycemia Among Medicare Beneficiaries, 1999 to 2011 JAMA Internal Medicine May 17, 2014

Is “Transparency” the Answer?



Current Transparency Efforts Are Focused on the Price of Parts

Payment for Procedure

Provider 1:
$25,000

Provider 2:
$23,000
-8%

The Lower Cost Provider?

What Hidden Costs Accompany the Lower Price?

Payment for Procedure	Payment and Rate of Complications	
Provider 1:		
$25,000	$30,000	**2%**
Provider 2:		
$23,000	$30,000	**10%**
-8%		

More Costs Later

Total Spending May Be *Higher* With the "Lower Price" Provider

Payment for Procedure	Payment and Rate of Complications		Average Total Payment
Provider 1:			
$25,000	$30,000	**2%**	**$25,600**
Provider 2:			
$23,000	$30,000	**10%**	**$26,000**
-8%			**+2%**

Lower Price for Parts, Higher Total Cost

Transparency *Based on FFS* May Lead to *Wrong Conclusions*

Payment for Procedure	Payment and Rate of Complications		Bundled/ Episode Payment
Provider 1:			
		2%	**$25,600**
Provider 2:			
		10%	**$26,000**
			+2%

The True Lower Cost, Higher Quality Provider

Providers Don’t Need “Incentives” to Deliver Higher-Quality, Lower-Cost Care

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They Need a Sustainable Financial Model For Doing So

Providers Don’t Need
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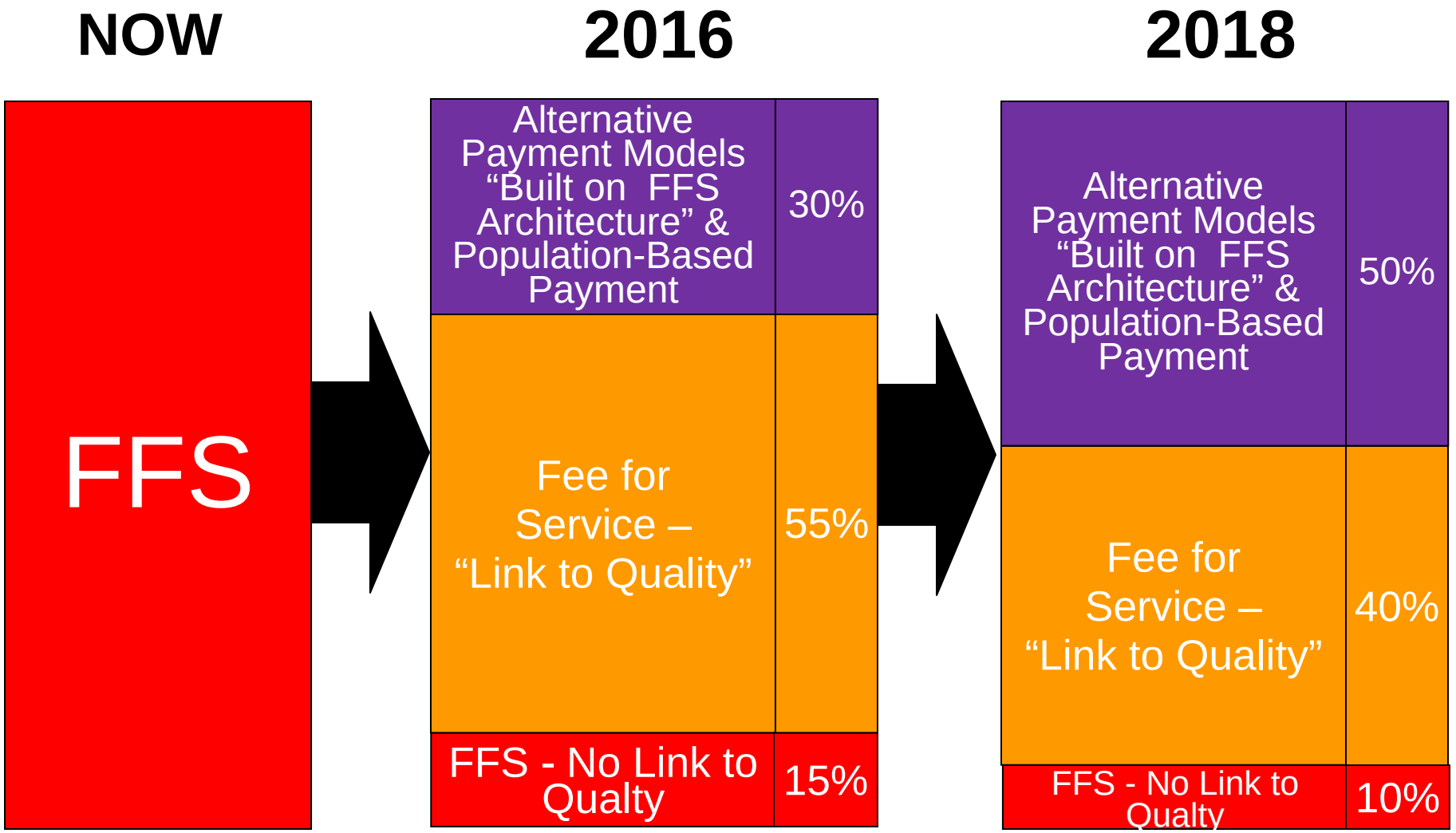
Current Fee-for-Service Systems
Don’t Provide That and
“Value-Based Payment”
Doesn’t Either

HHS Announced Its Intent to Move Away From VBP & FFS+P4P



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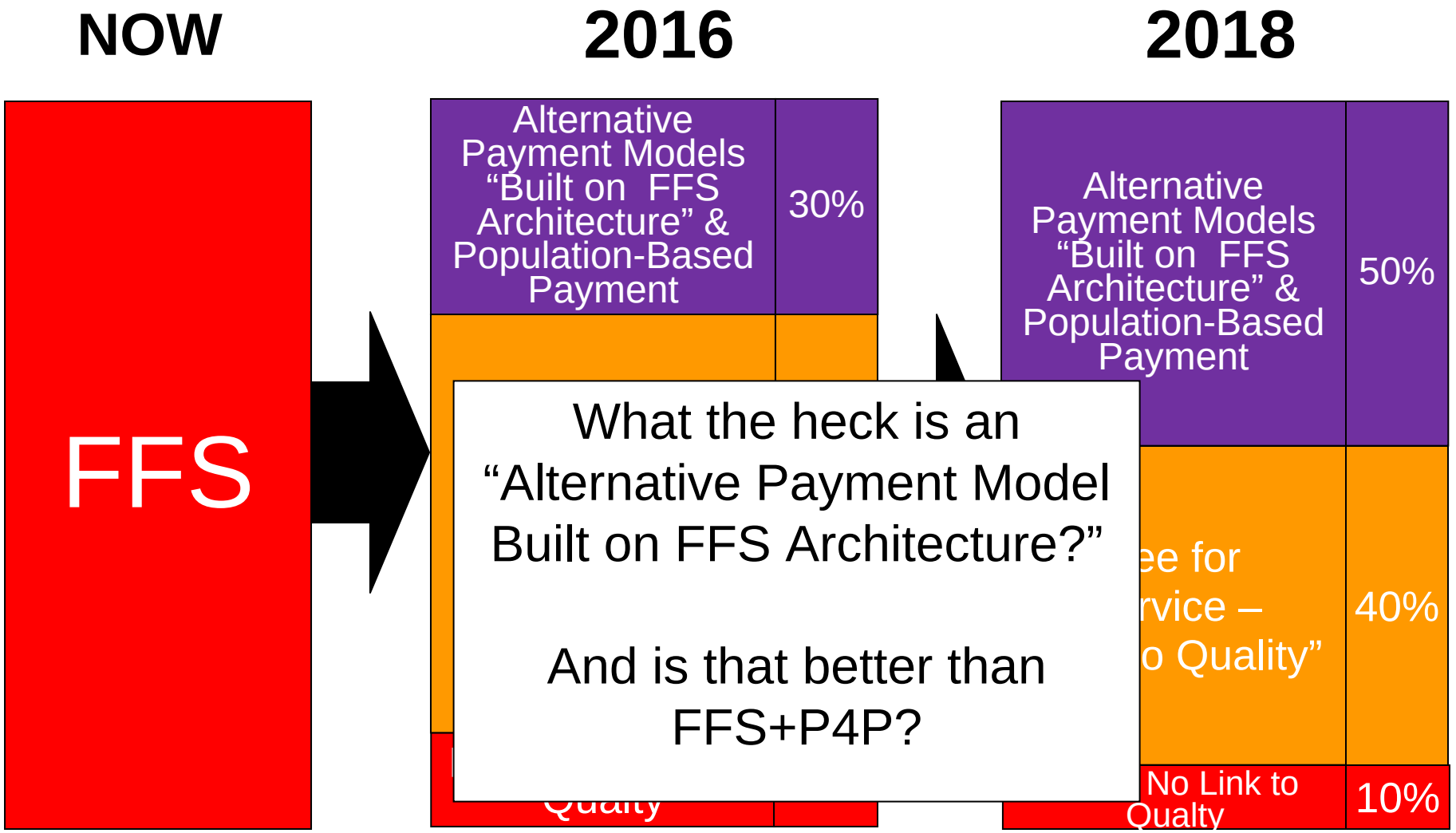

CMS "Alternative Payment Models" Built on FFS Architecture" To Date

TYPE OF PROVIDER	CMS PROGRAM	PAYMENT STRUCTURE
Health Systems, Multi-Specialty Groups, PHOs, and IPAs	Accountable Care Organizations (MSSP & Pioneer)	FFS + Shared Savings on Attributed Total Spending
Primary Care	Comprehensive Primary Care Initiative	FFS + PMPM $ for Attributed Patients + Shared Savings on Attributed Total Spending (for State or Region)
Specialty Care	Oncology Care Model	FFS + PMPM $ for Attributed Patients + Shared Savings on Attributed Total Spending (for 6-month window)
Hospitals and Post-Acute Care	Bundled Payments for Care Improvement Initiative	Discounted Bundles + Warranties

Mostly FFS With a New Add-On: PMPM + Shared Savings

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Most Systems Based on "Attributed" Patients and Spending

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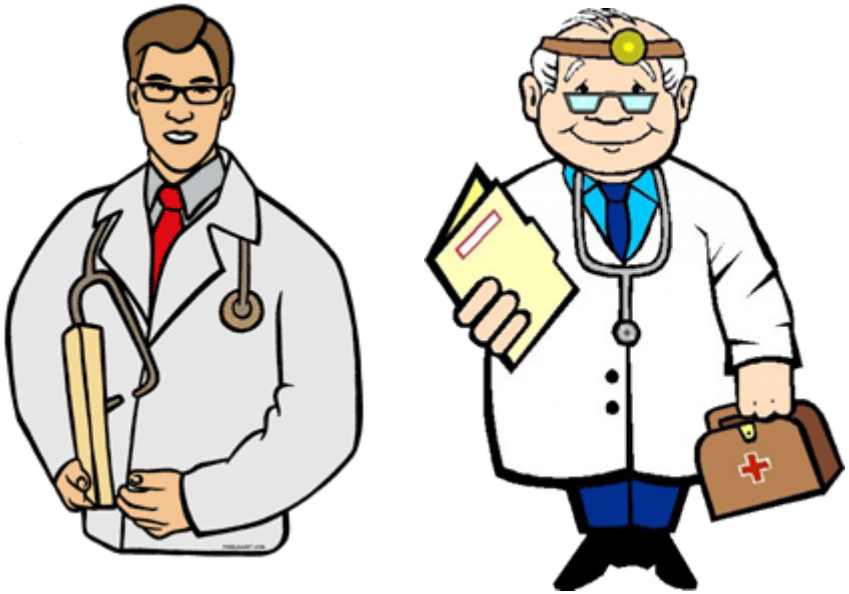
Problems with “Attributing” Patients and Spending to Doctors

- Inability for physicians to control attributed spending
- Attributed spending includes services before physician became involved
- Attribution results only known after care is delivered
- Many patients and spending not attributed to anyone

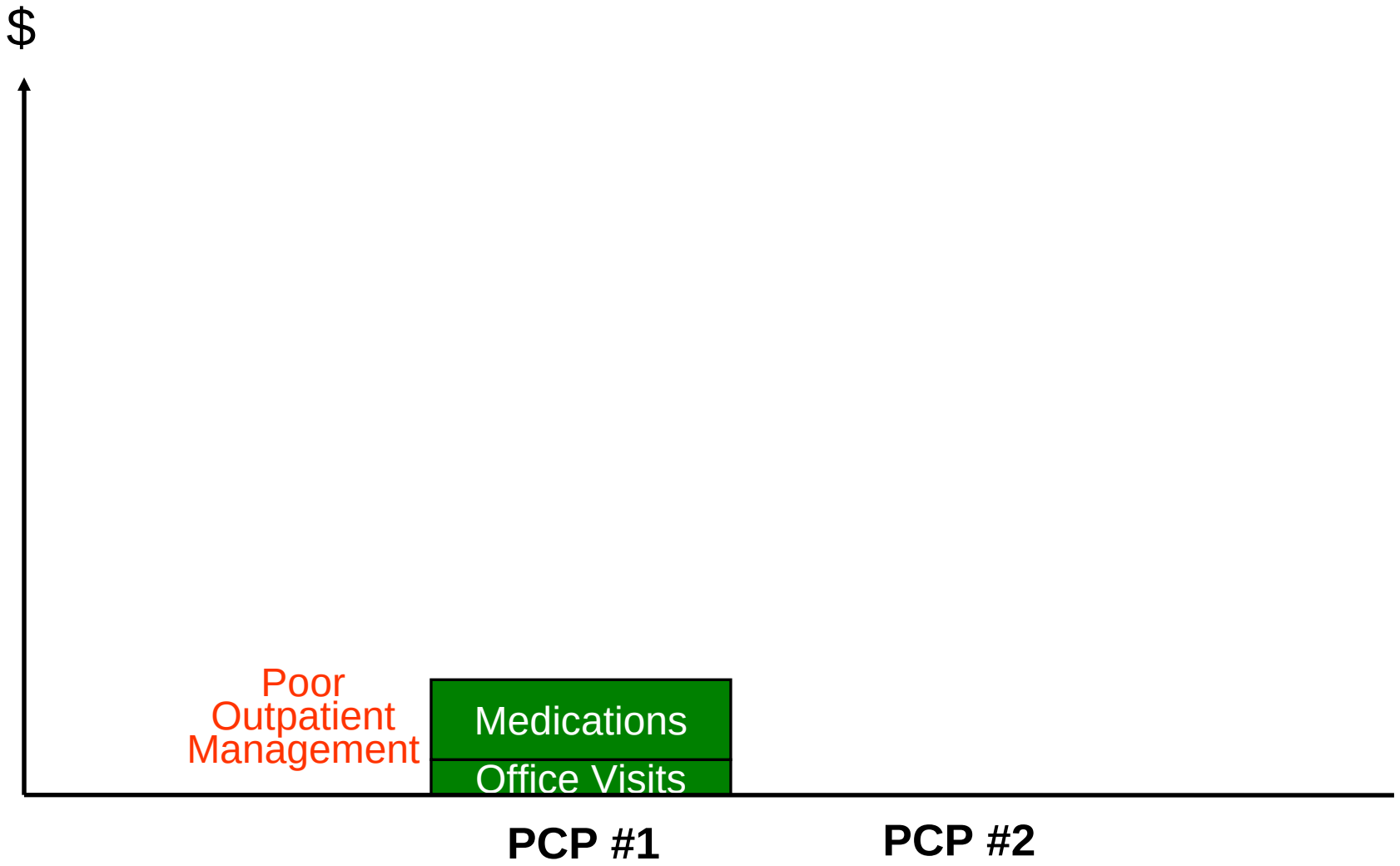
Two Hypothetical PCPs Caring for Chronic Disease Patients

$

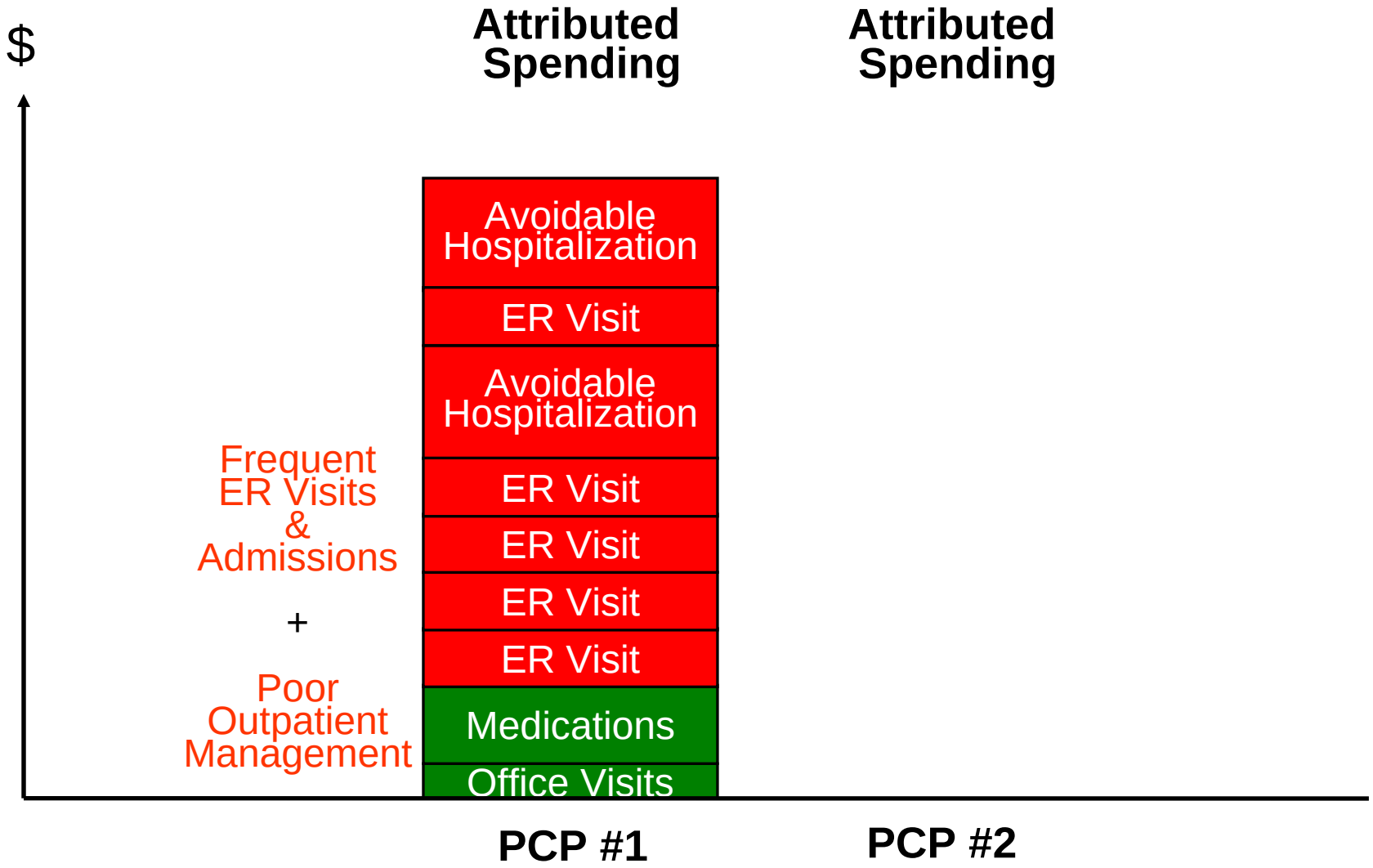


PCP #1 **PCP #2**

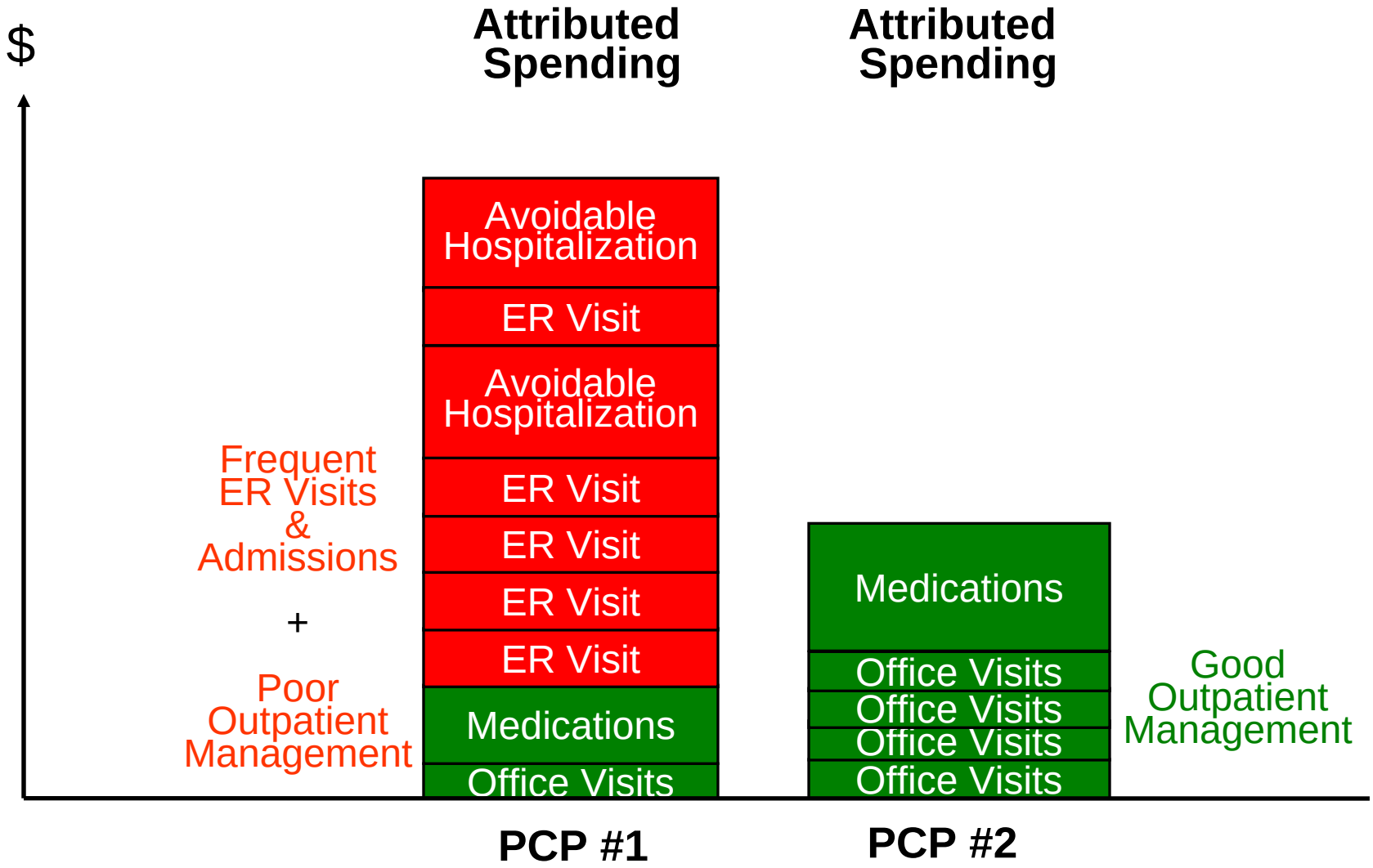
PCP #1: Sees Patients Infrequently, Poor Rx Adherence



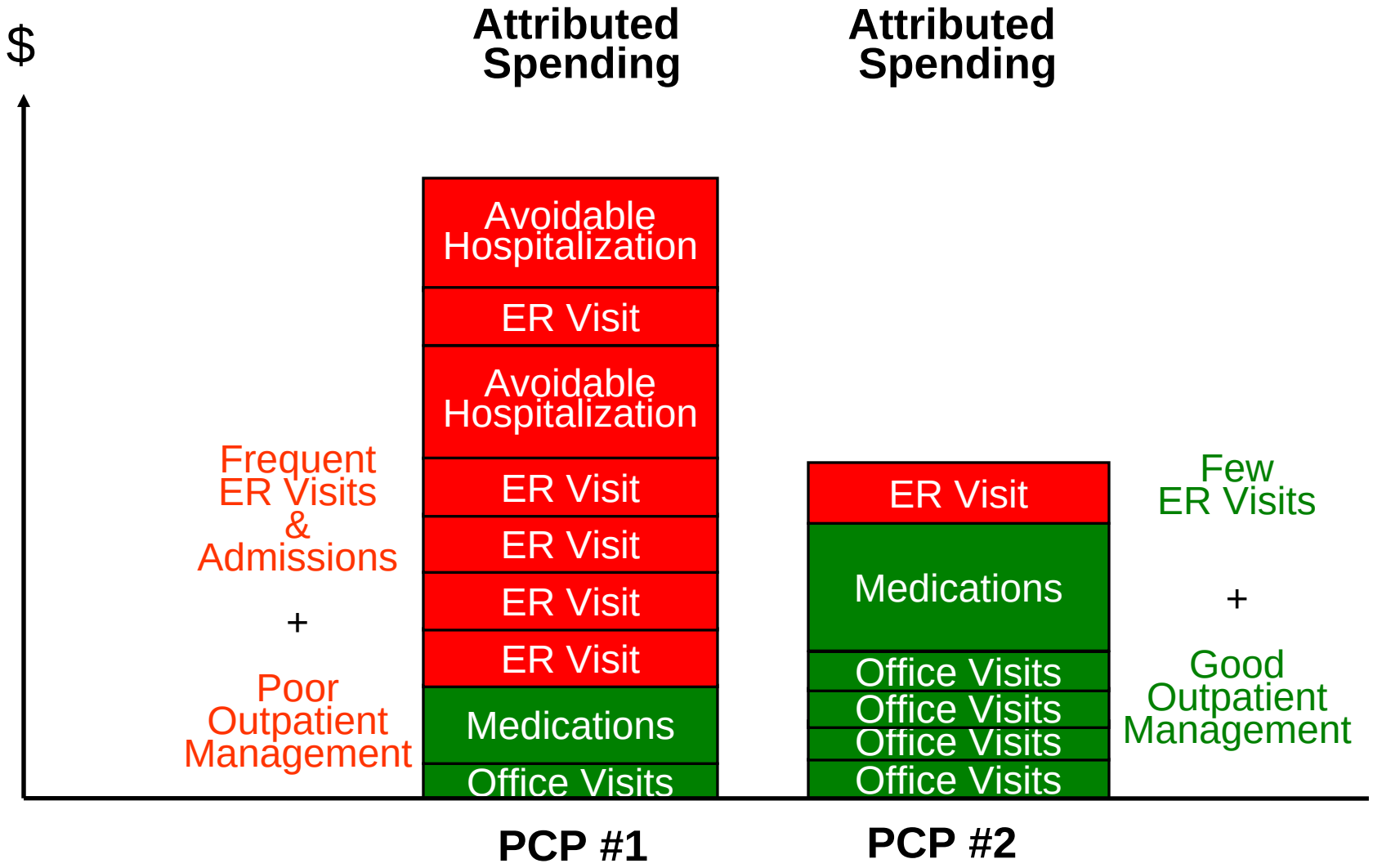
PCP #1: Patients Have Problems Frequently, Go to ER & Hospital



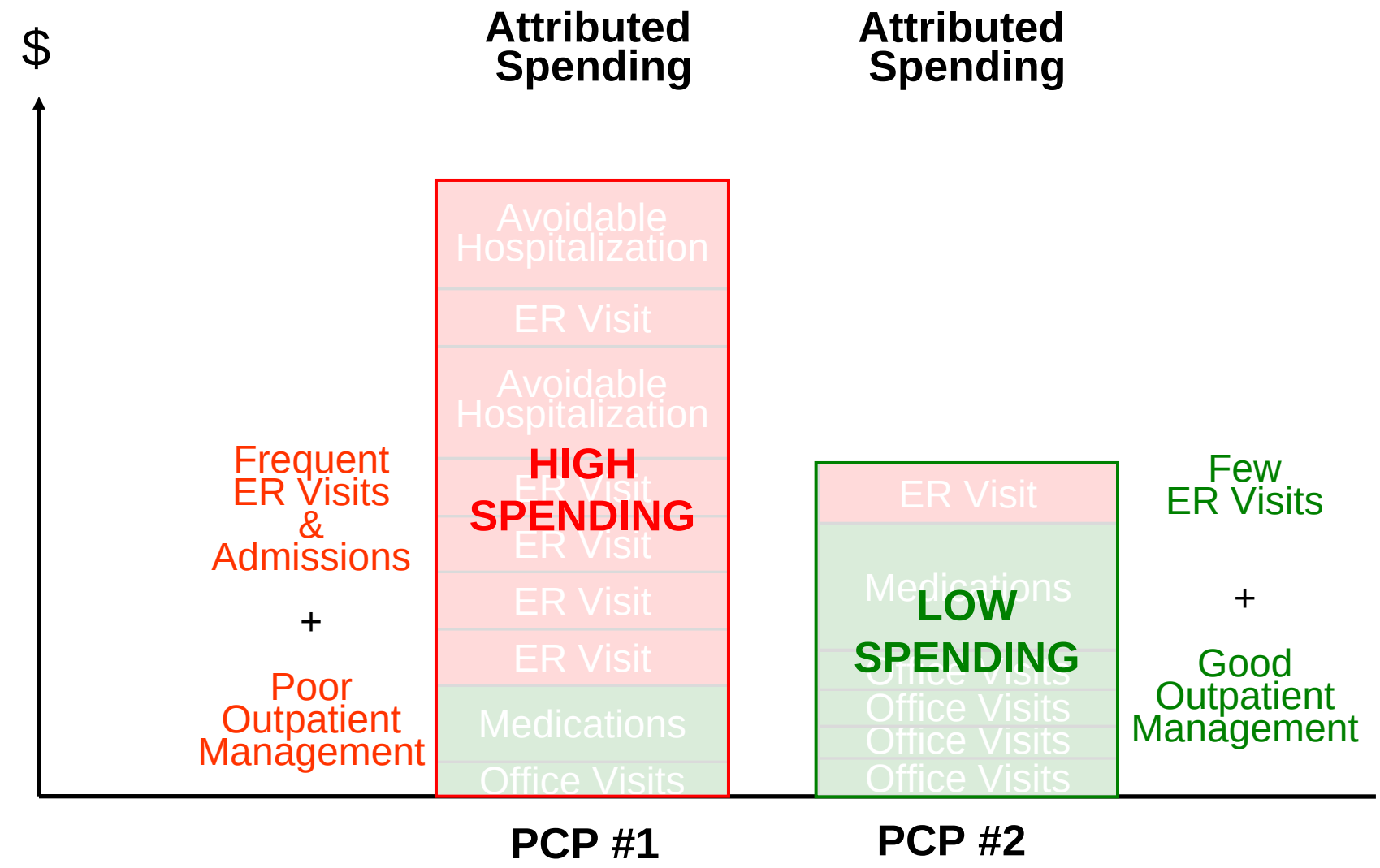
PCP #2: Sees Patients Frequently and Helps Them Manage Disease



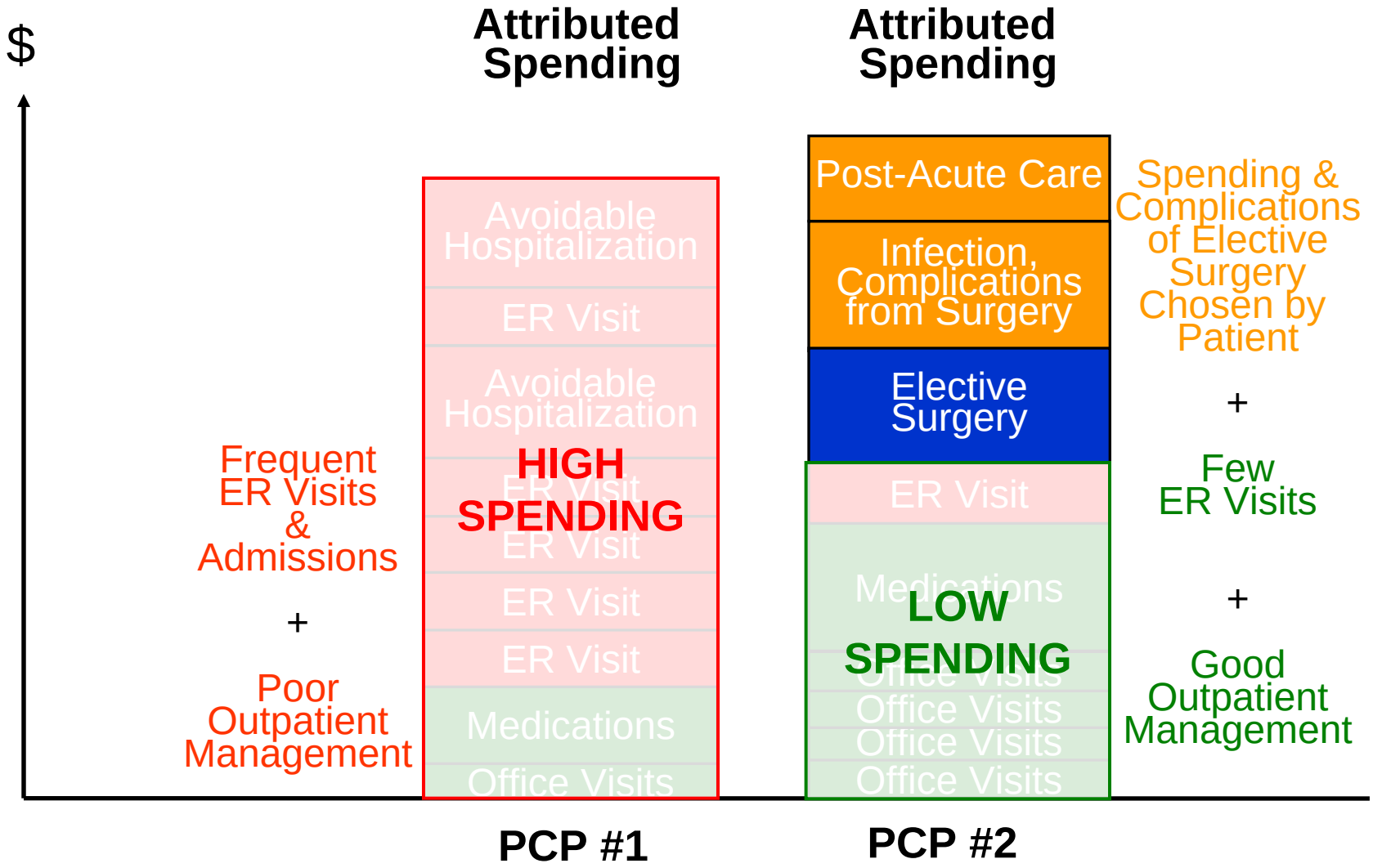
PCP #2: Well-Managed Patients Rarely Need ER Visits



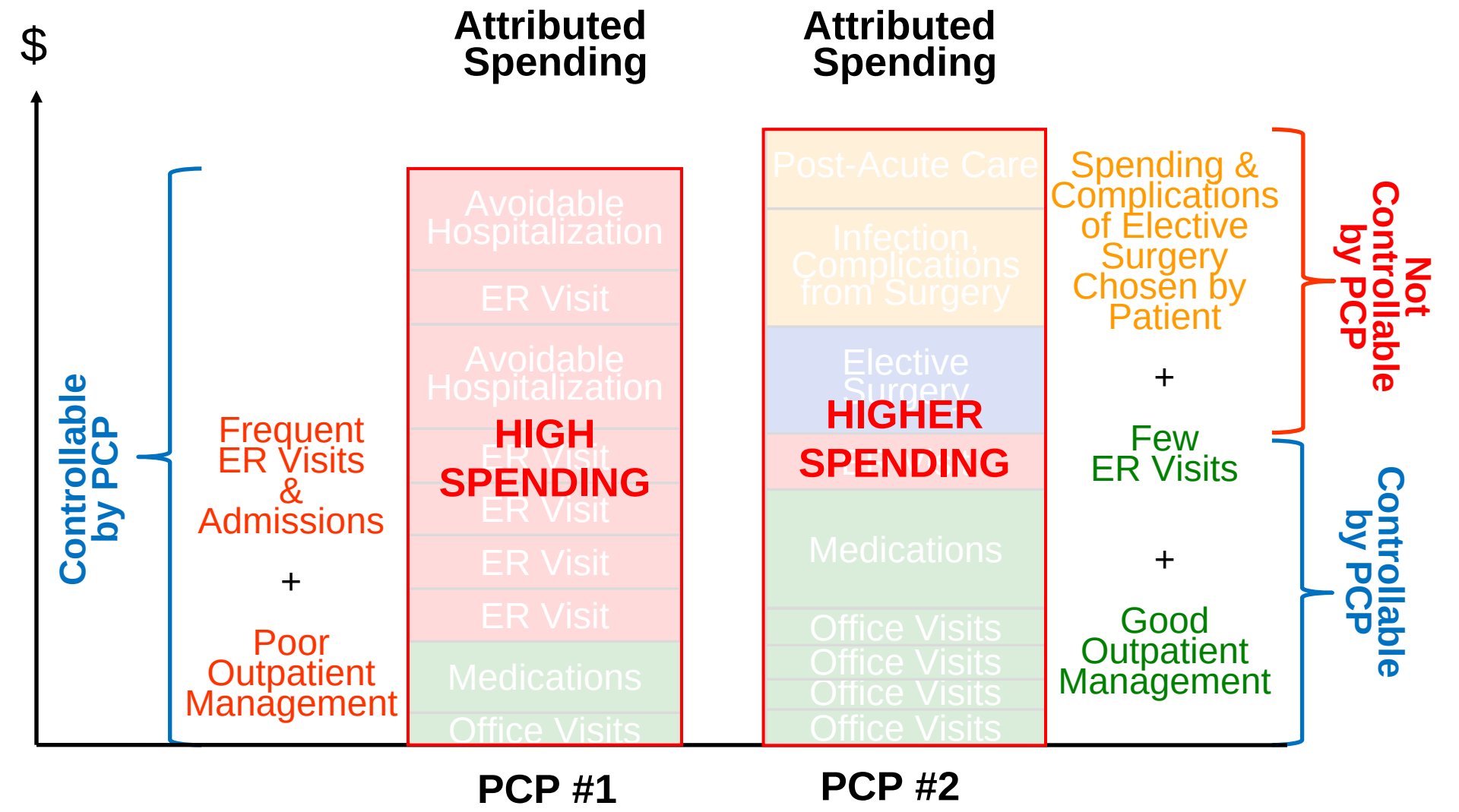
PCP #2 Is Doing the Better Job, Right?



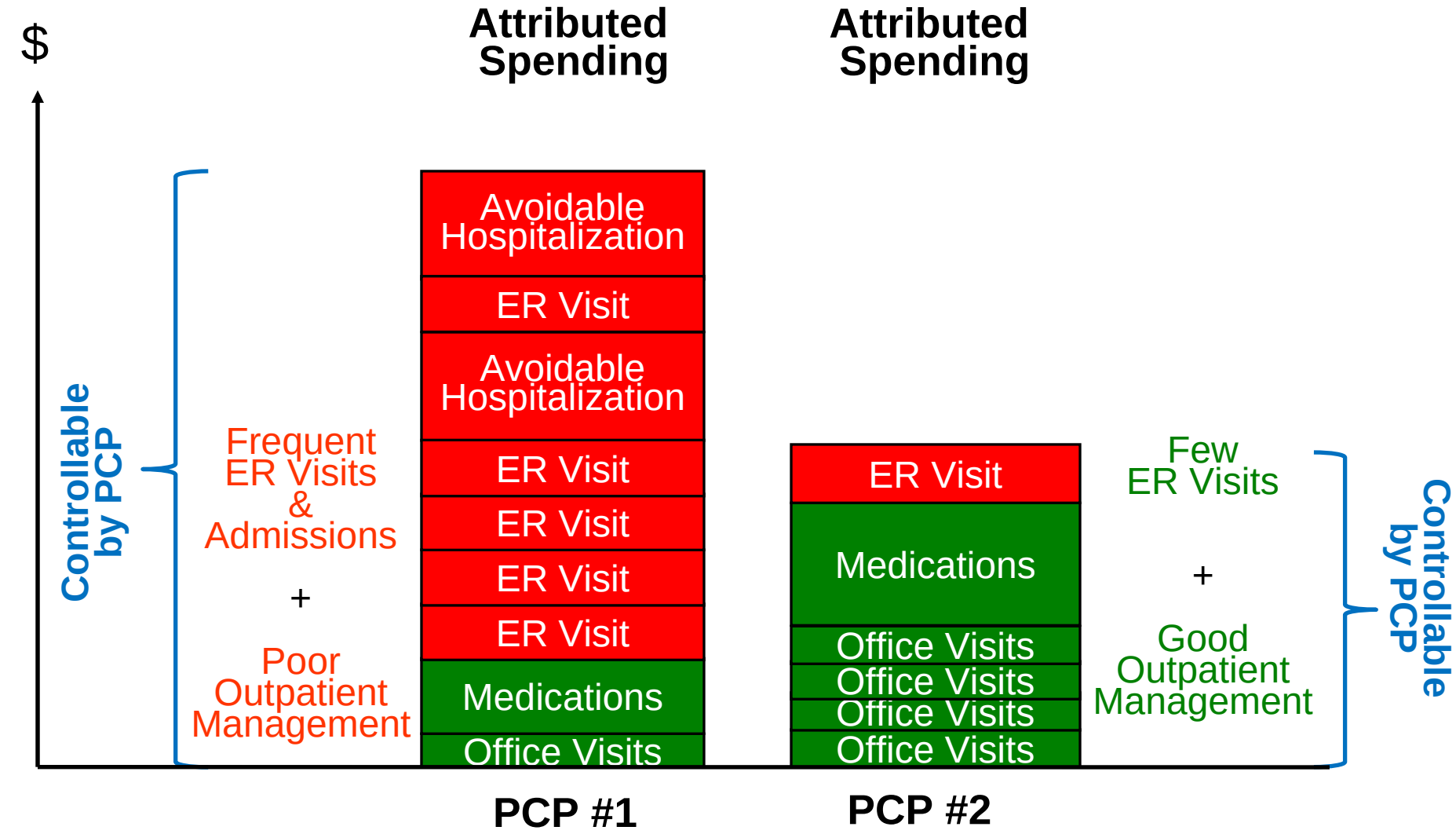
PCP #2 Is Attributed *All* Spending, Including What Other Doctors Do



Healthier Patients Getting Other Types of Care Make PCP Look "Bad"



Accountability Should Only Be for What Each Physician Can Control



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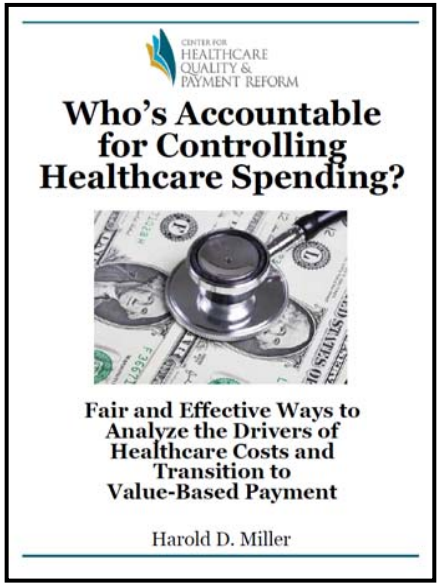
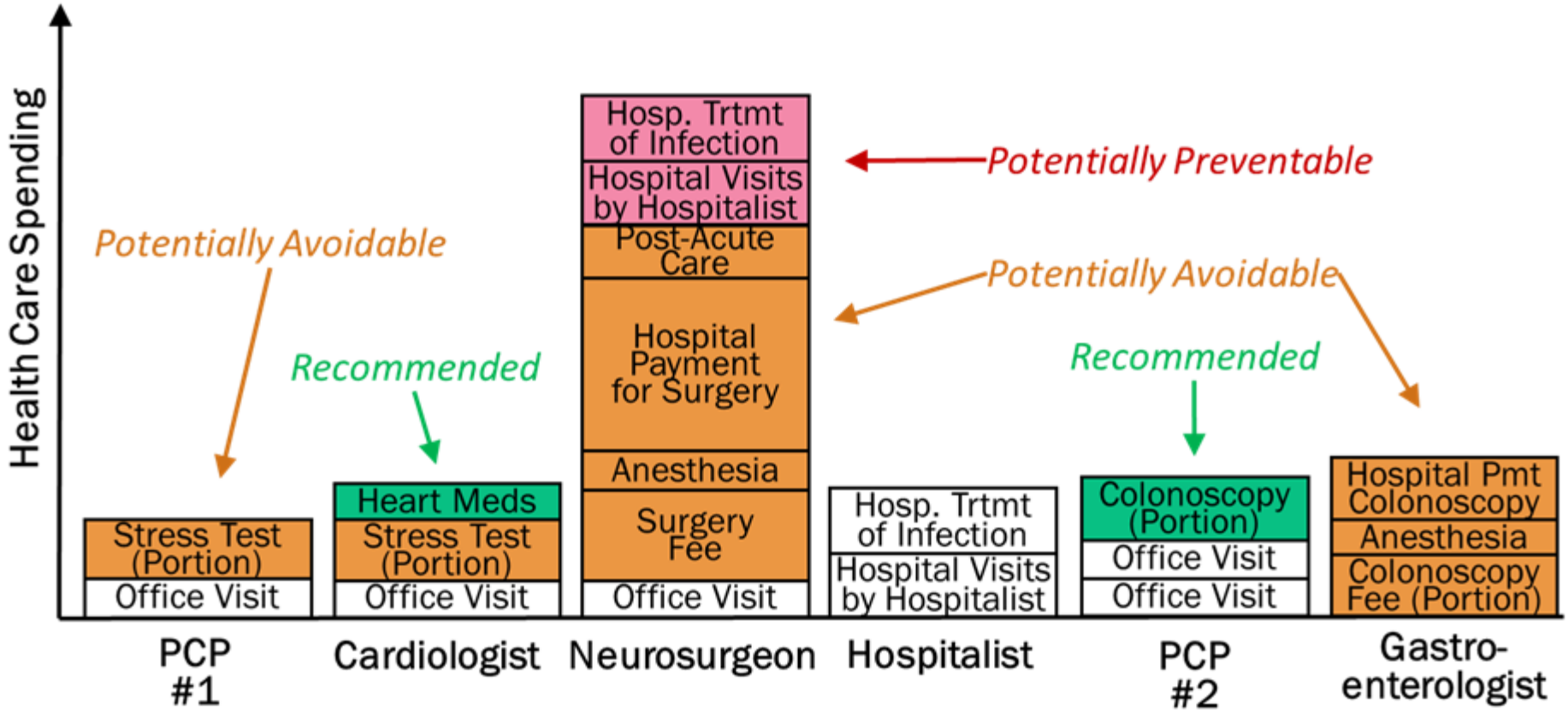
A Hypothetical Scenario of Fragmented Patient Care

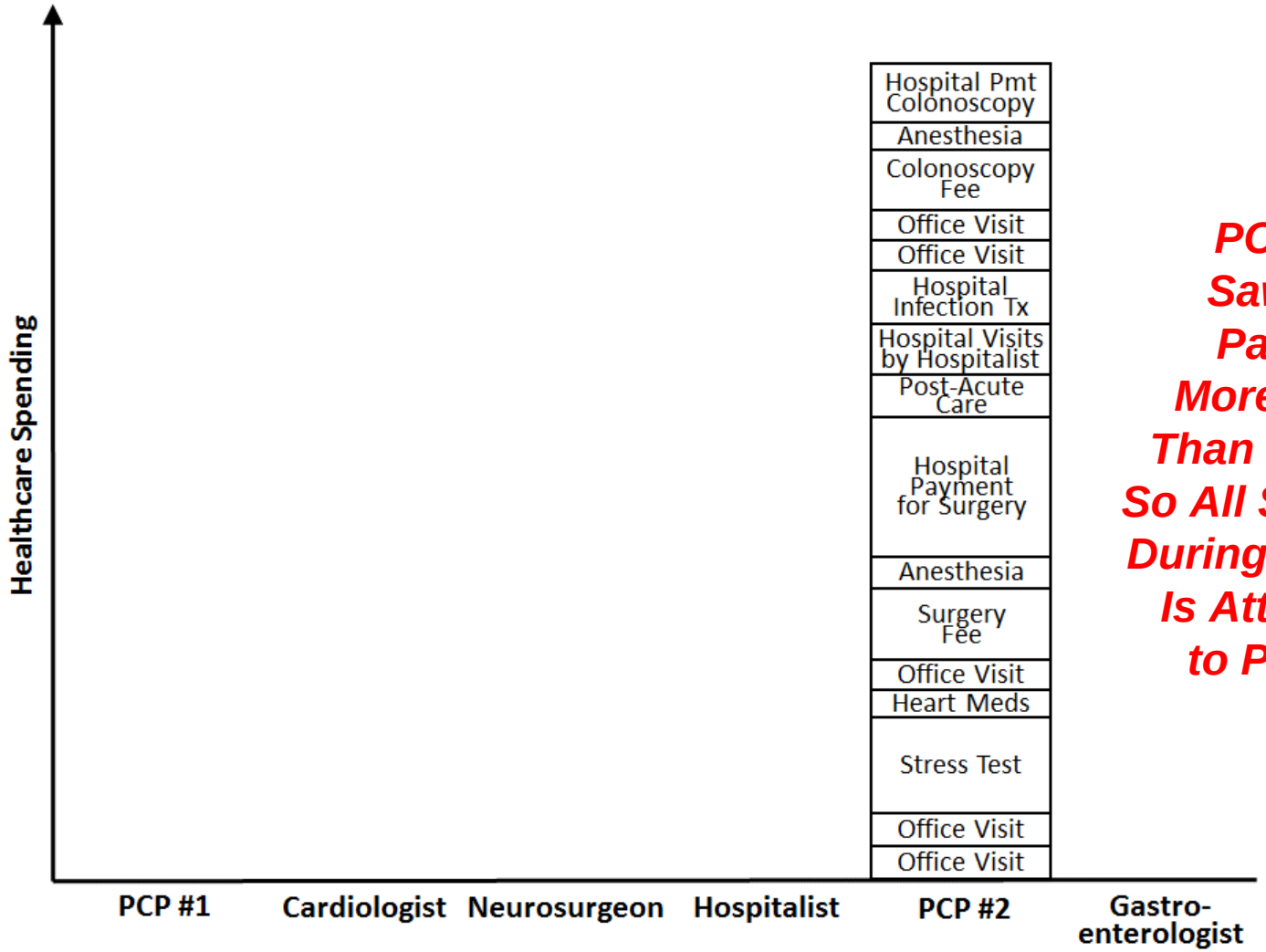
January:	Patient visits current PCP because of mild chest pain while exercising; PCP orders stress test.
February:	Cardiologist reviews stress test results, sees no indication of significant coronary artery blockage, orders medications to reduce risk factors.
March:	Patient directly contacts neurosurgeon about back pain, who recommends spinal surgery.
April:	Neurosurgeon performs surgery at a medical center fifty miles from patient home. Patient goes to SNF for rehabilitation rather than for outpatient physical therapy.
May:	Patient develops surgical site infection and is admitted to community hospital, where hospitalist successfully treats the infection and the patient is discharged. Hospitalist recommends patient see a PCP regularly.
June:	Patient begins seeing a new PCP (PCP #2).
October:	Patient sees PCP #2 again, who finds the patient has not had recommended screening for colon cancer and orders a colonoscopy.
November:	Gastroenterologist performs the colonoscopy at the community hospital and uses an anesthesiologist to administer sedation.



Each Physician Had Opportunities to Reduce Avoidable Spending

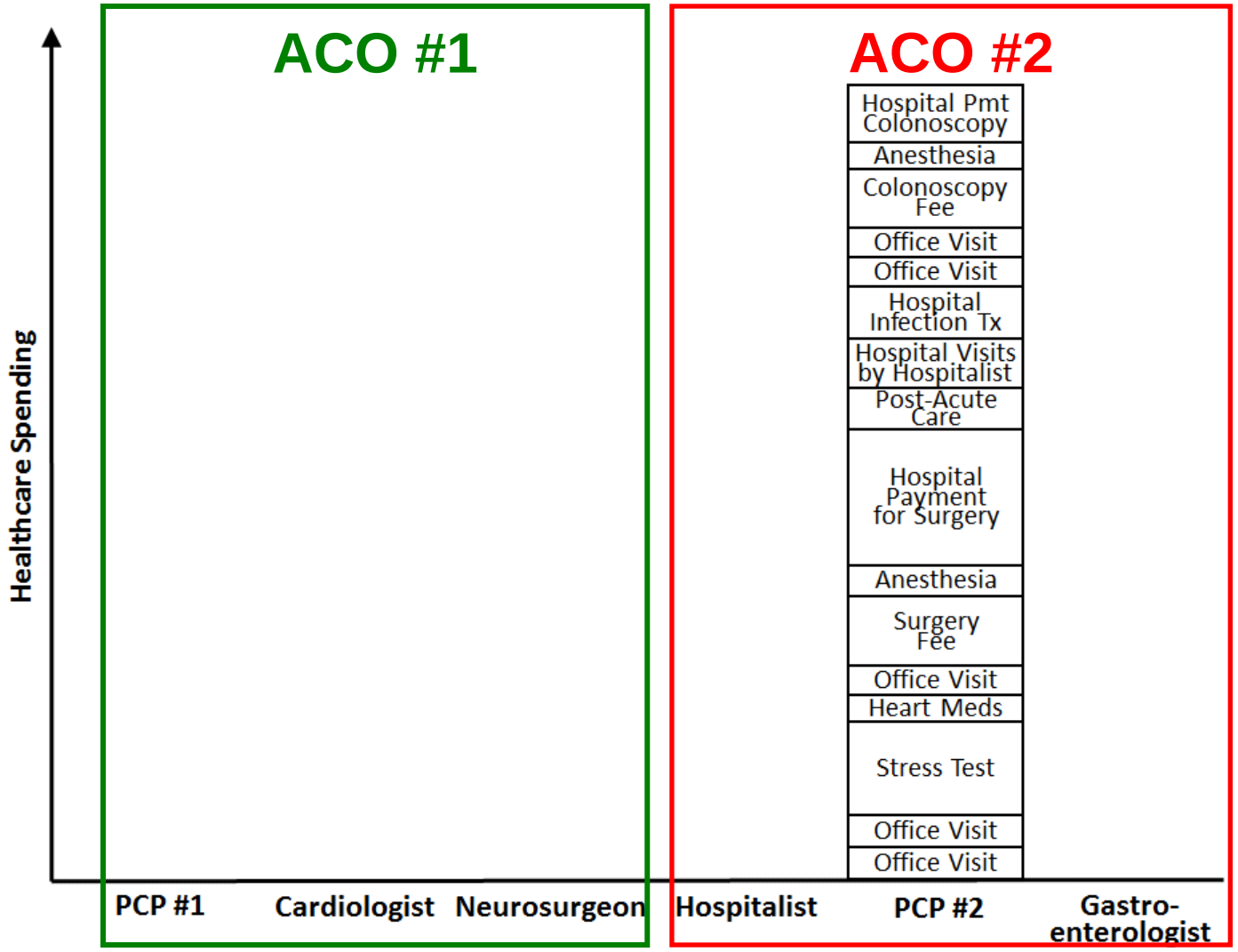


Most Attribution Rules Would Assign ALL the Spending to PCP 2



PCP #2 Saw the Patient More Often Than PCP #1, So All Spending During the Year Is Attributed to PCP #2

ACO #1 Looks Undeservedly Good, ACO#2 Looks Undeservedly Bad



CMS Innovation Center's First Specialty Payment: Oncology

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE & MEDICAID INNOVATION

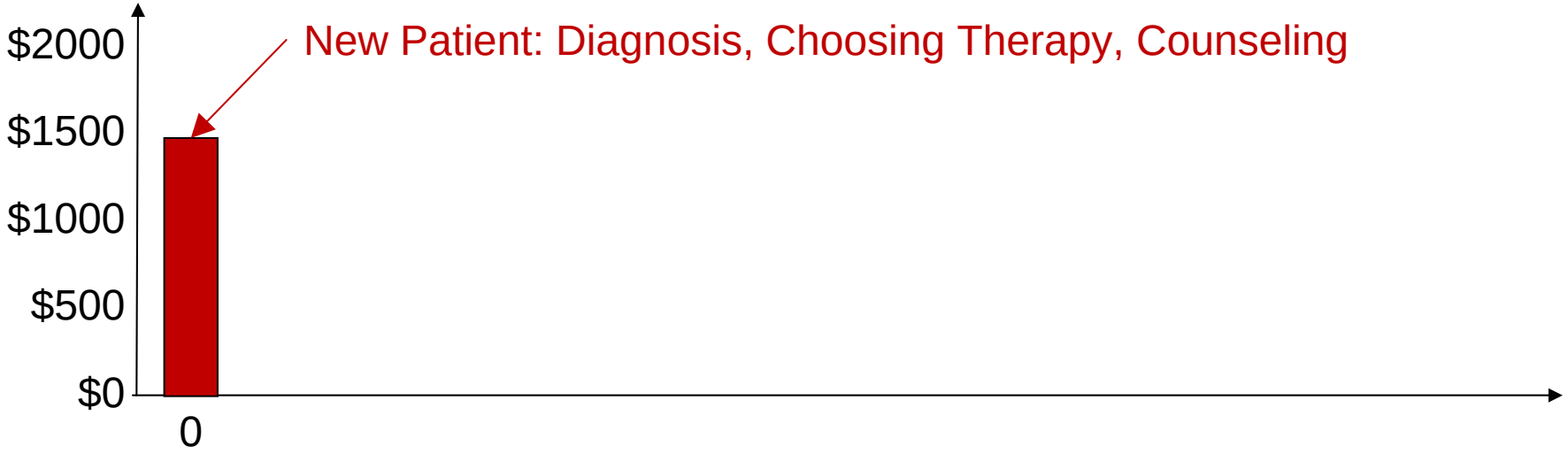
Oncology Care Model
Overview and Application Process

Centers for Medicare & Medicaid Services Innovation Center (CMMI)

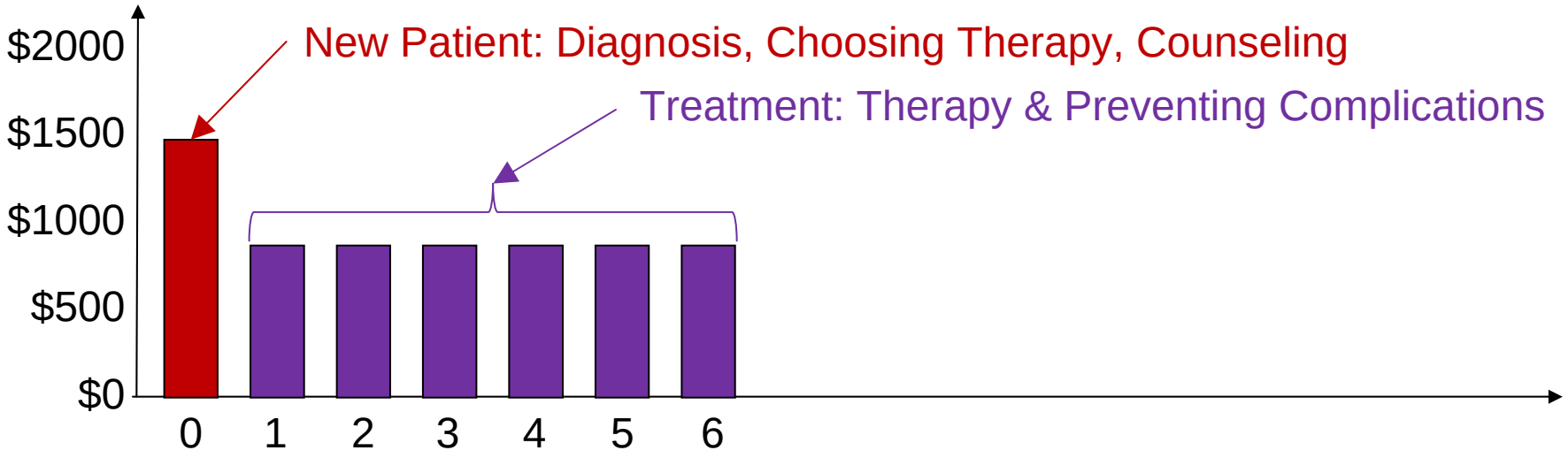
February 19, 2015

How Does an Oncology Practice Deliver High-Quality Cancer Care?

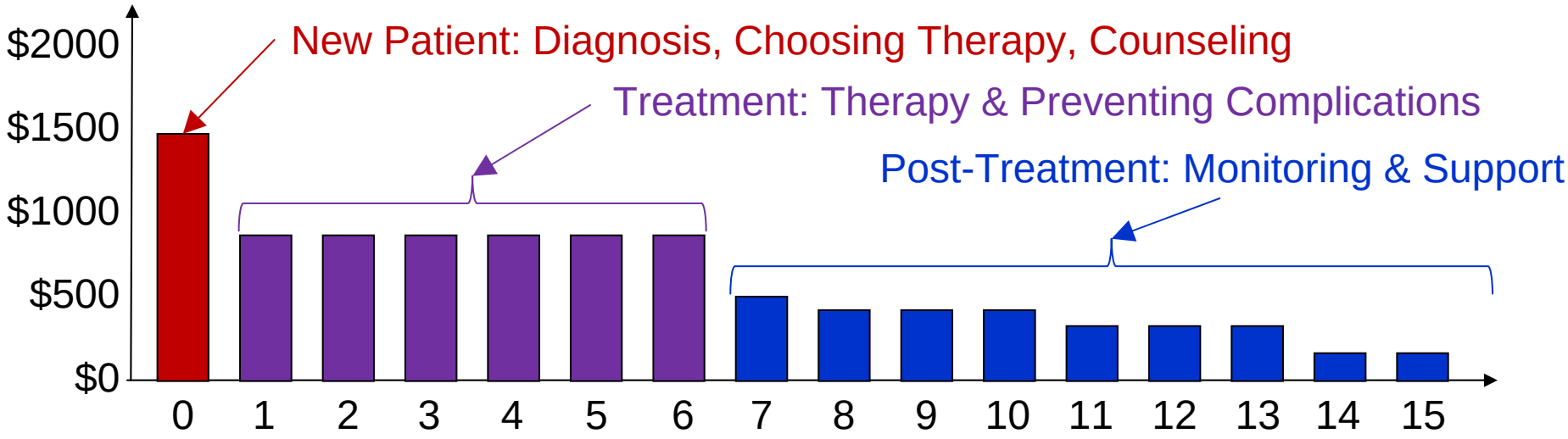
Considerable Time in Diagnosis, Treatment Planning & Counseling



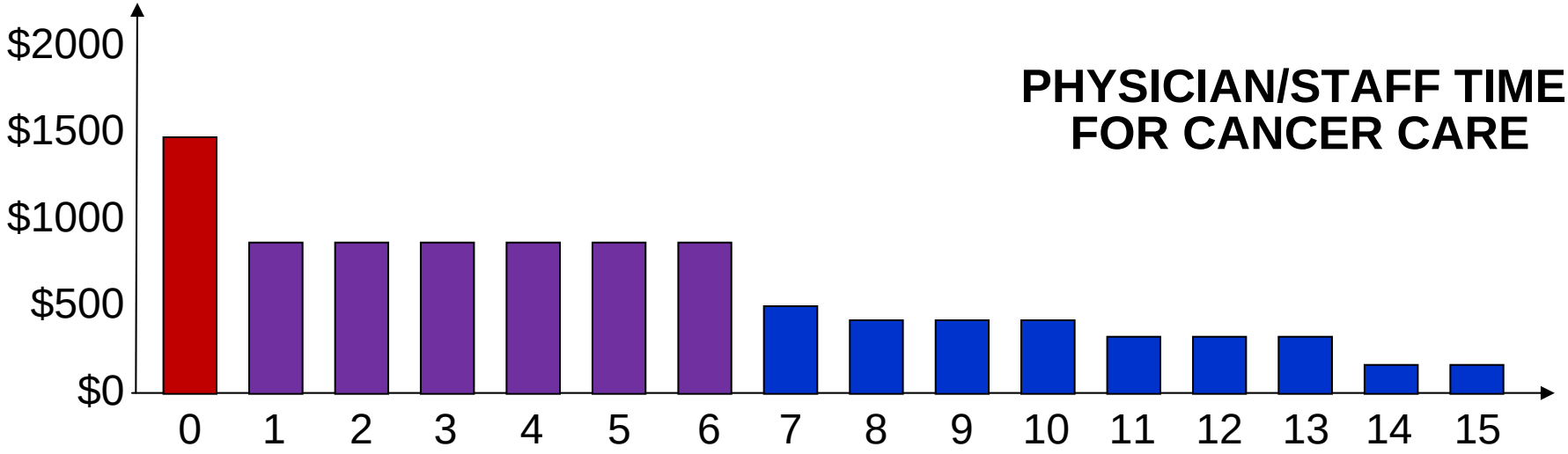
Time in Delivering Treatment & Helping Avoid Complications



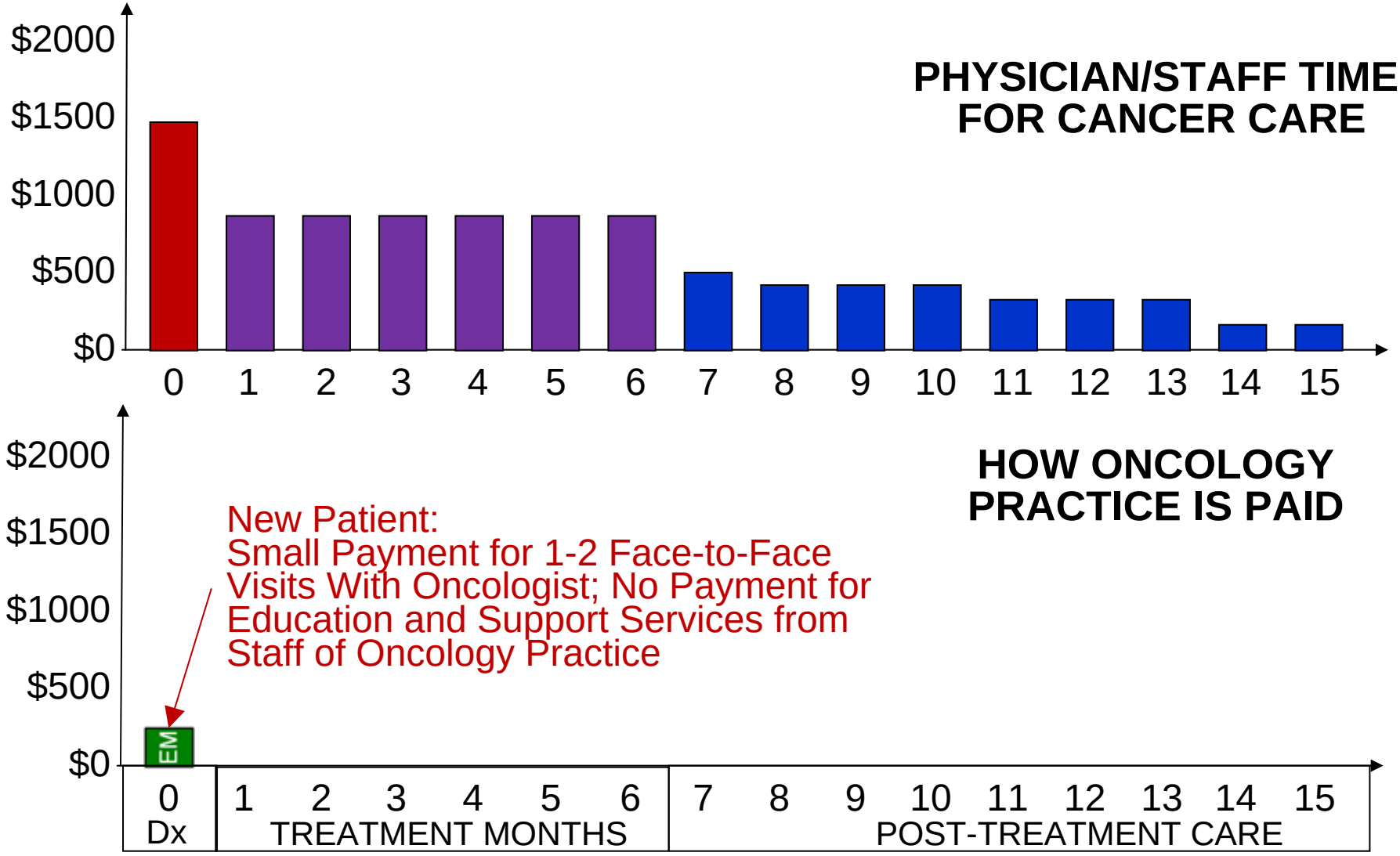
Many Months of Follow-Up Monitoring & Survivorship Care



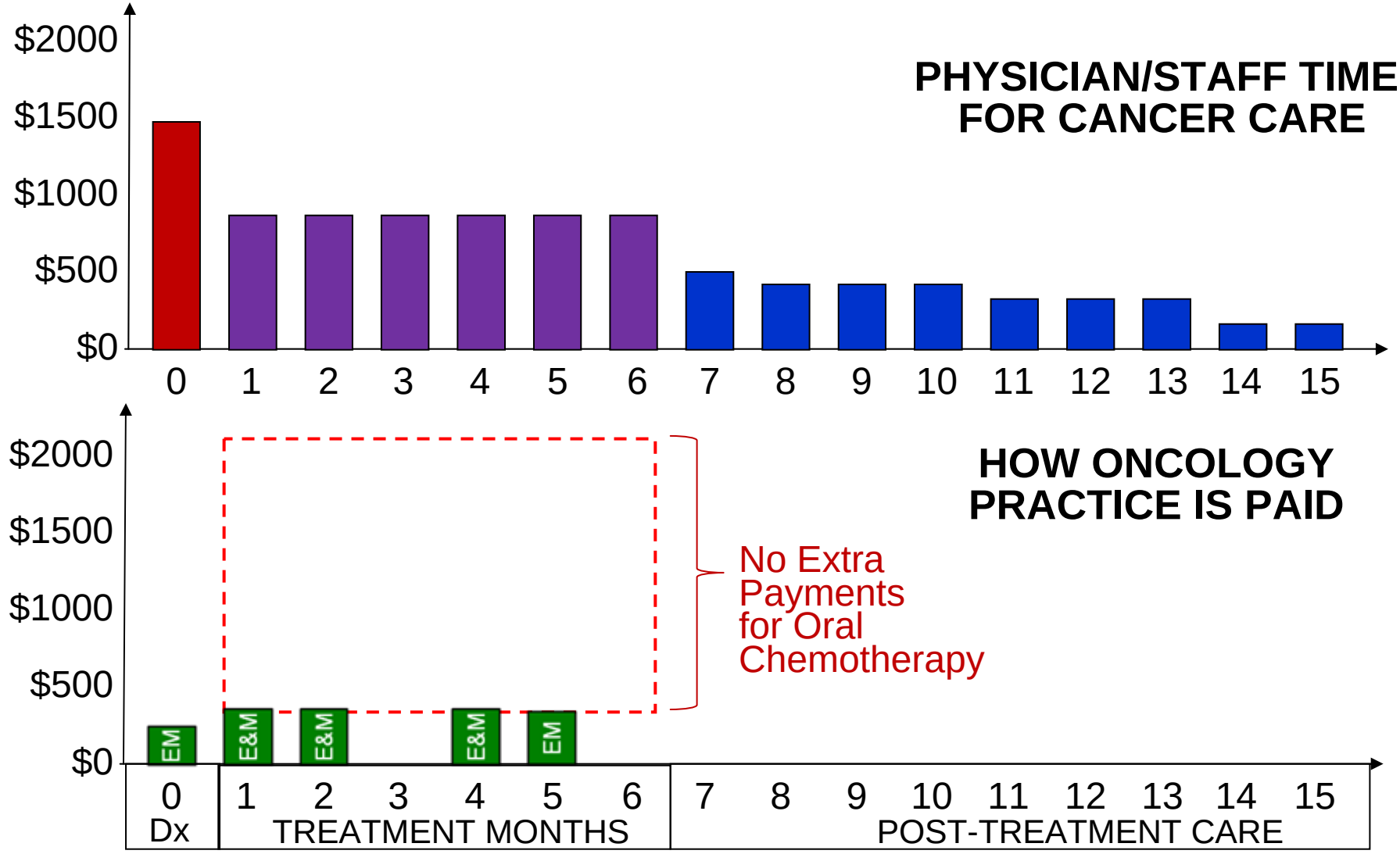
How is an Oncology Practice Paid for All of These Services?



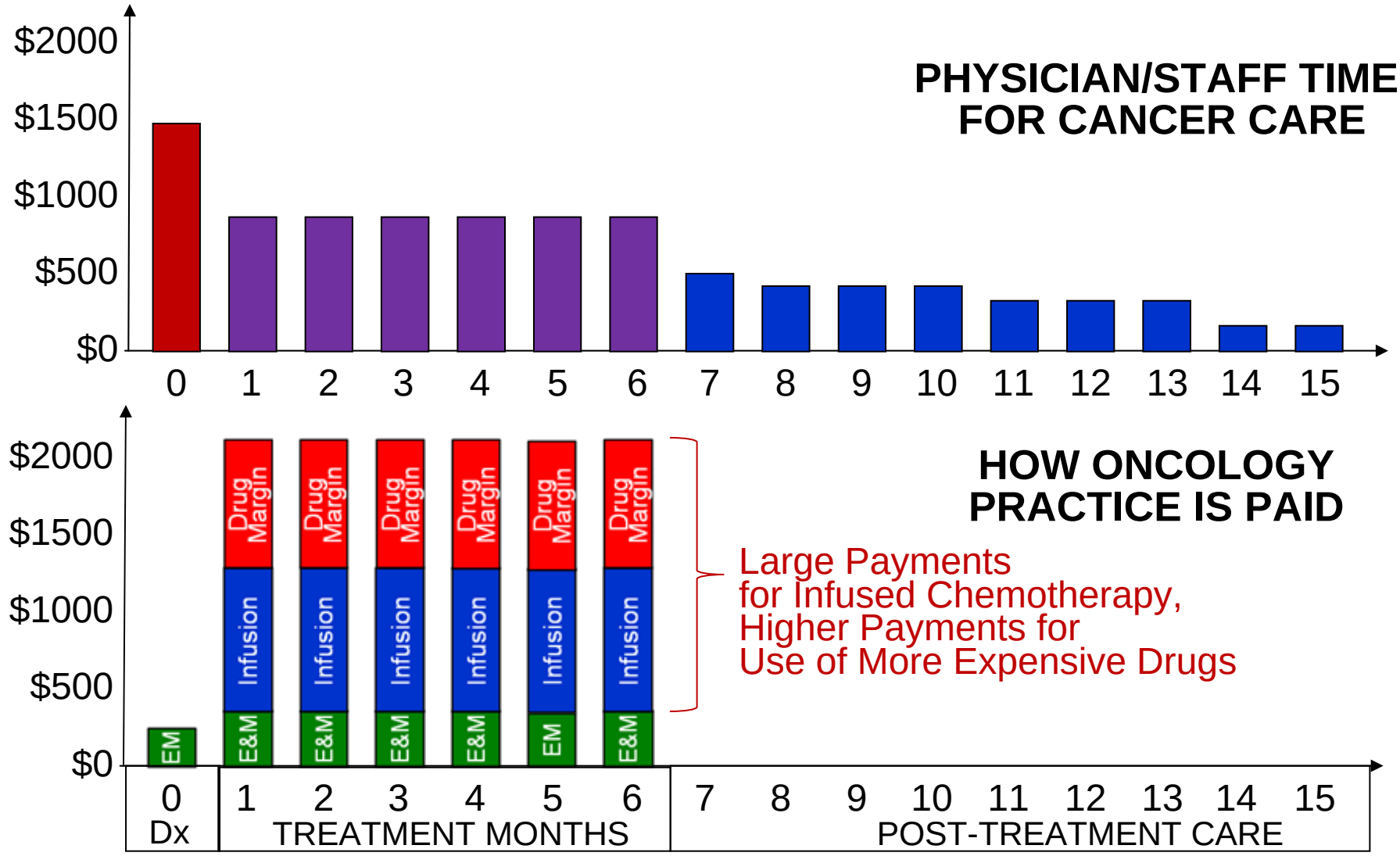
$200-300 for the Most Critical Phase: Diagnosis & Planning



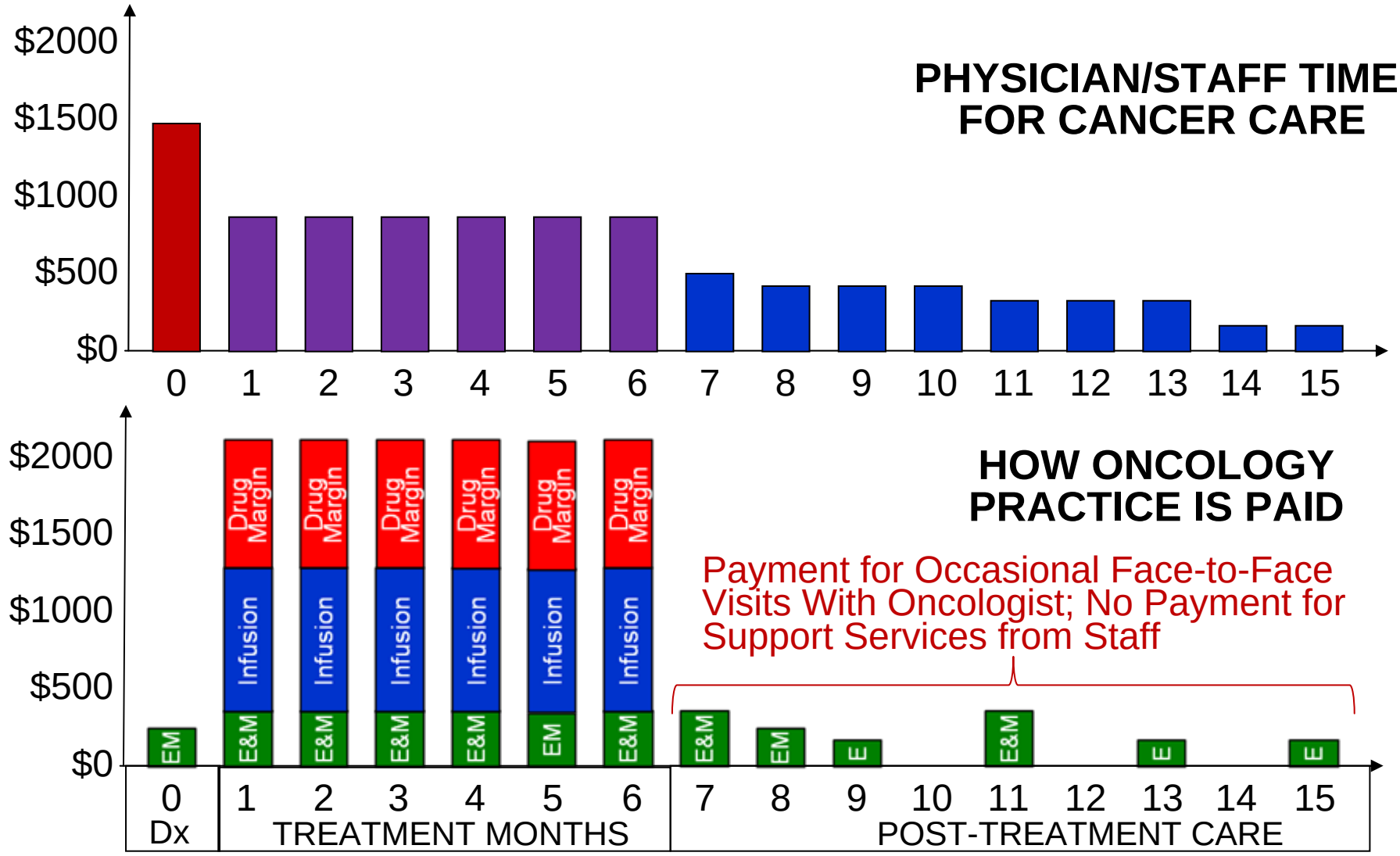
No Payment for Managing Patient Treated With Oral Chemotherapy



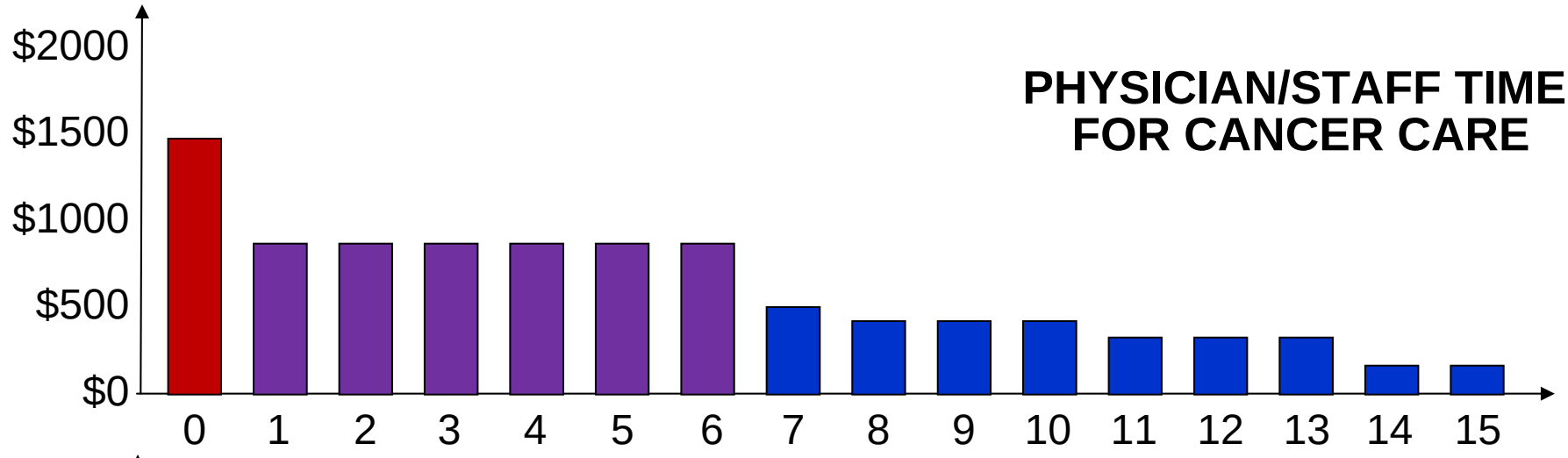
Most Revenue is Dependent on Use of Expensive, Infused Drugs

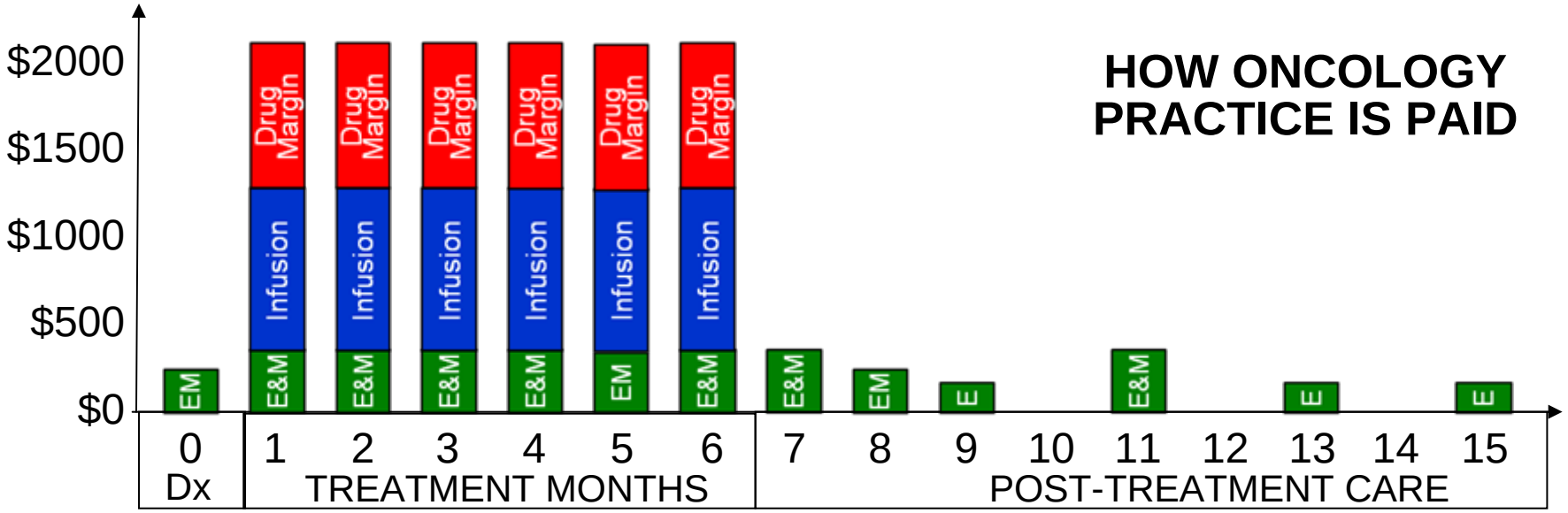


Little Payment for Patient Care After Treatment Ends

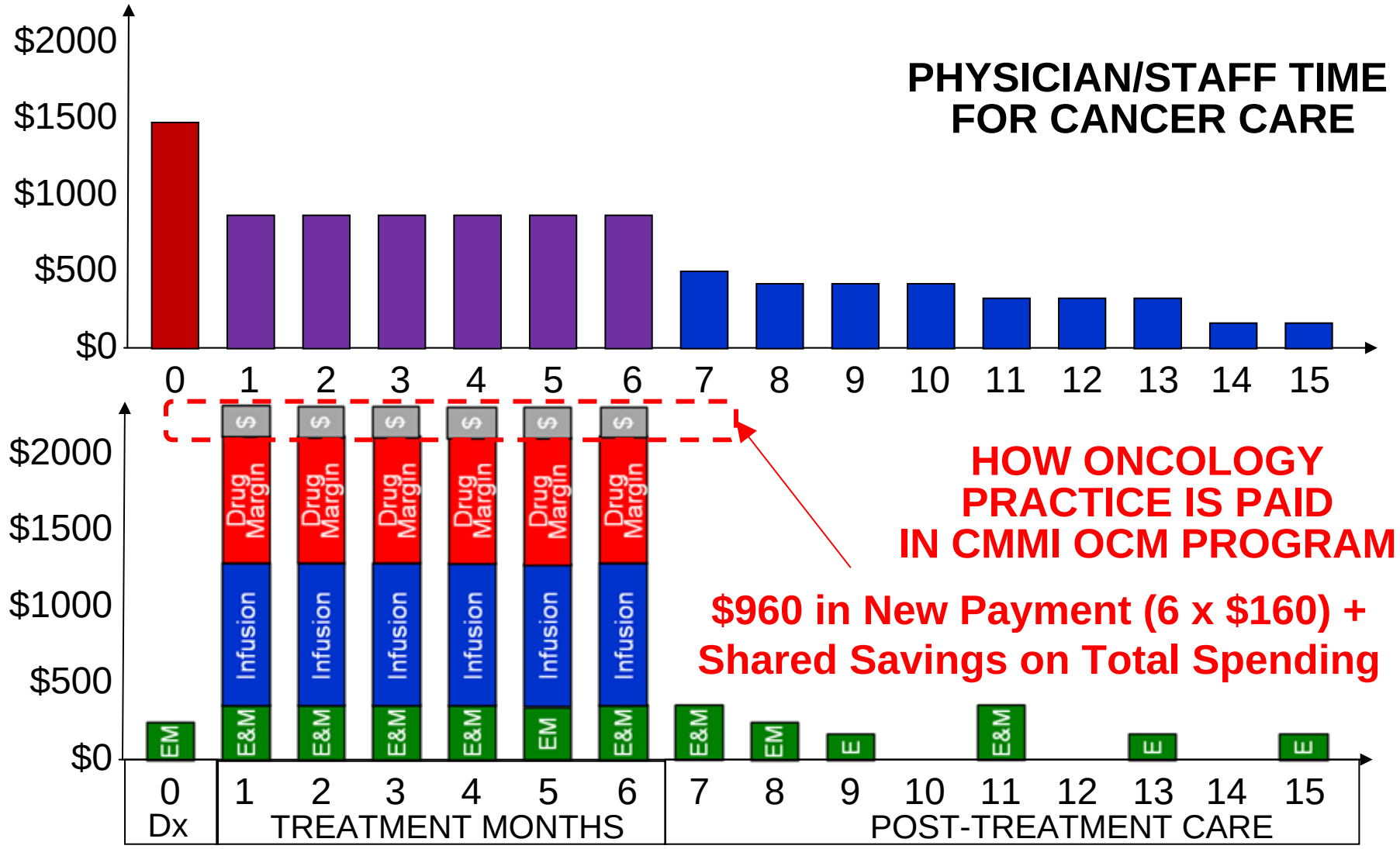


How Does the CMMI Oncology Model Fix the Payment System?

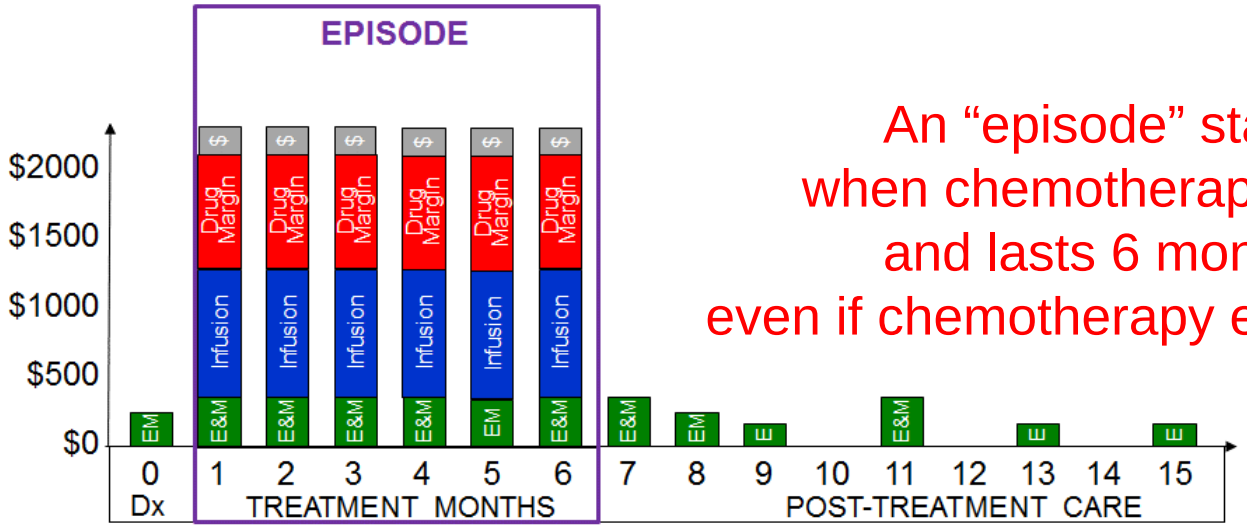




6 PMPMs During Treatment + Shared Savings on Total Spending

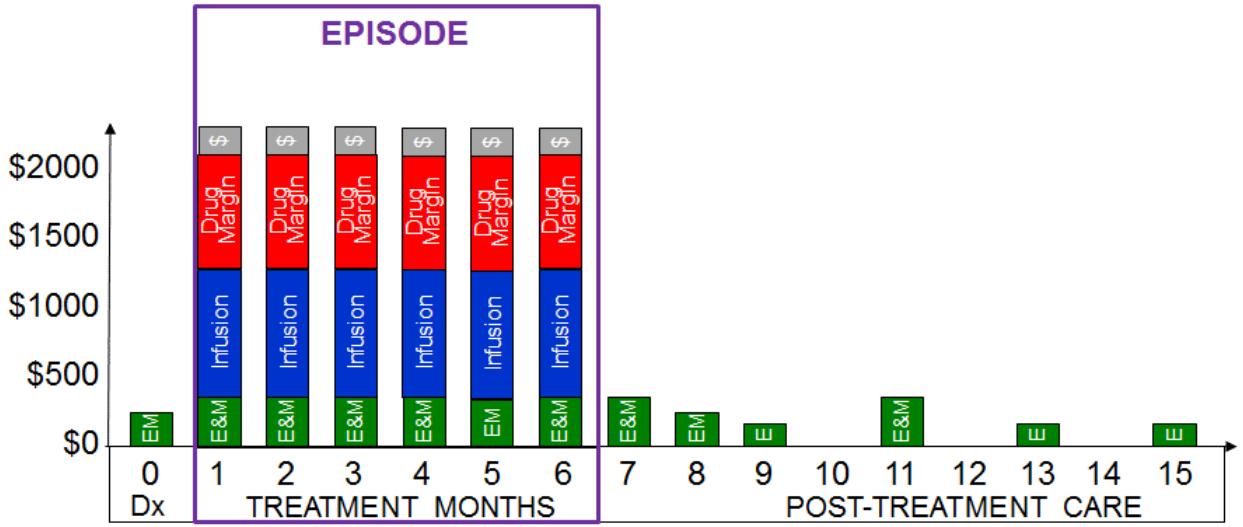


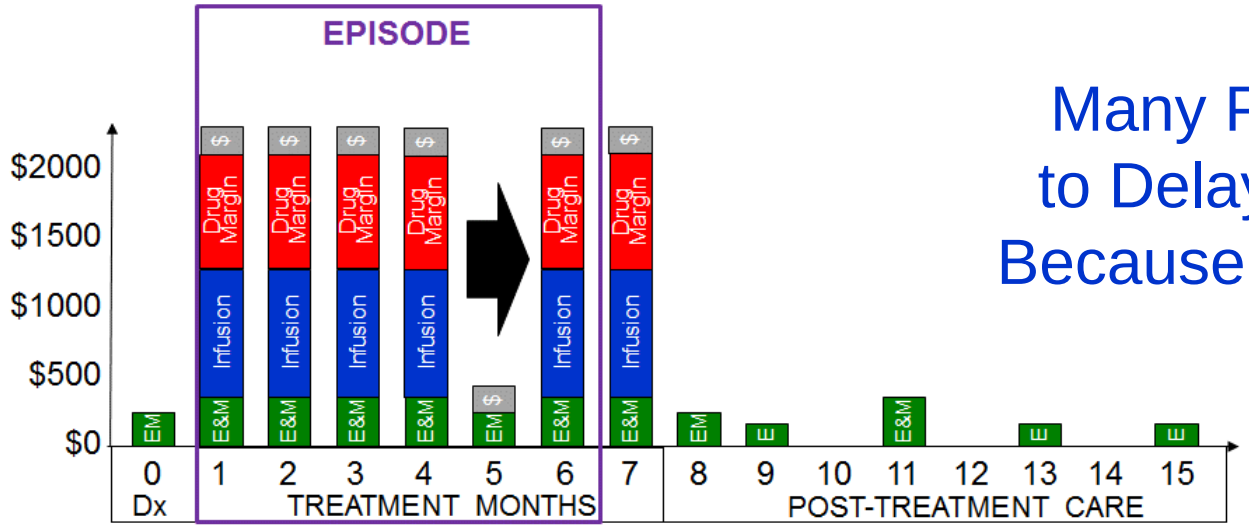
Extra Payments Are Made for *Fixed* 6 Month Episodes



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

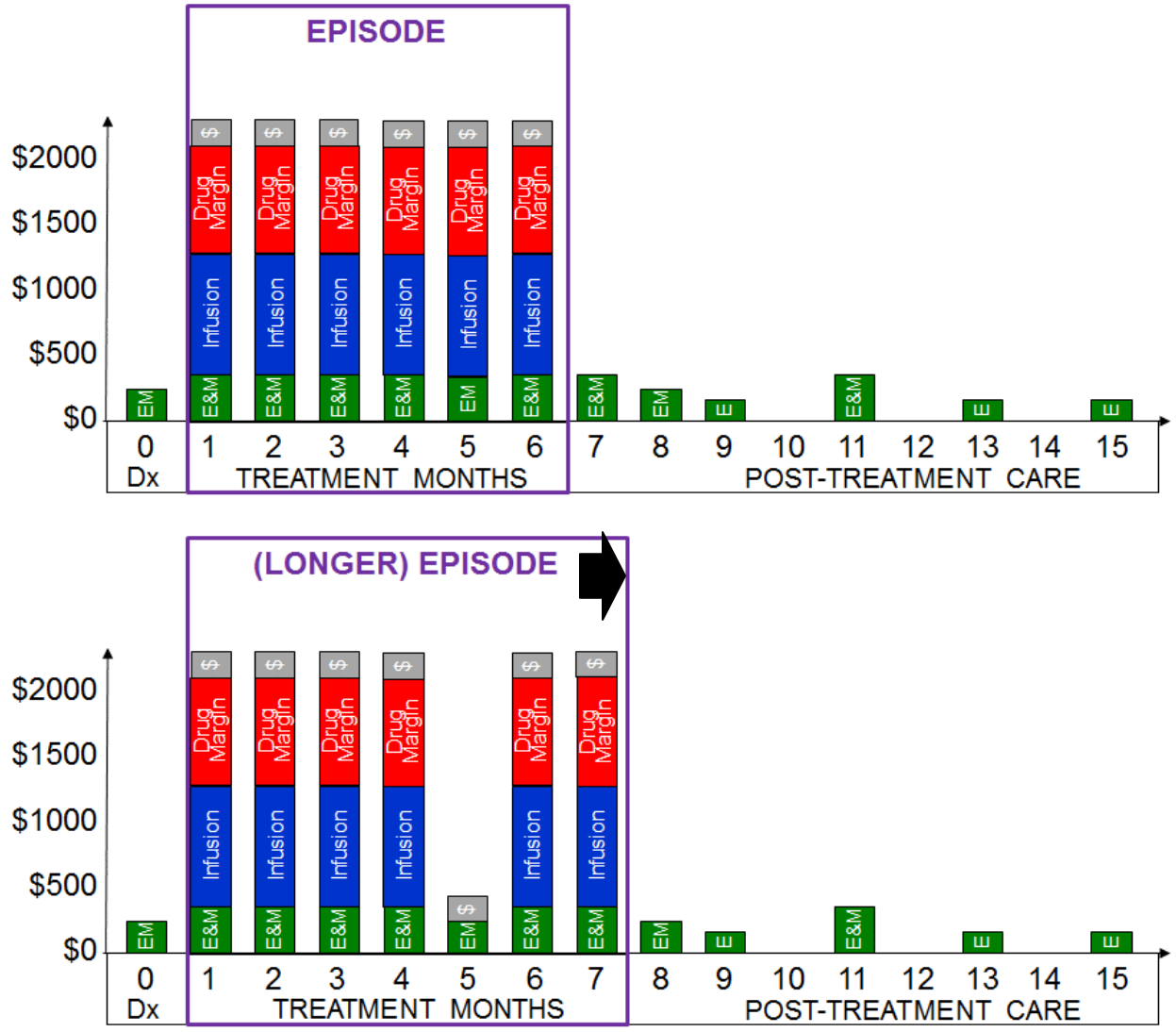
What Happens If One Of the Patient's Treatments is Delayed?



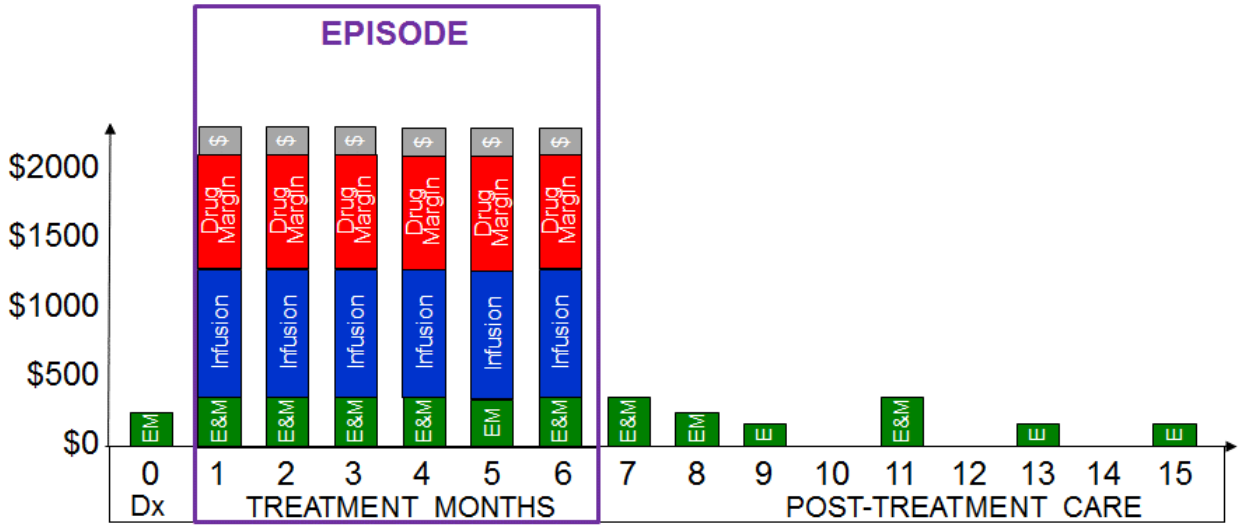


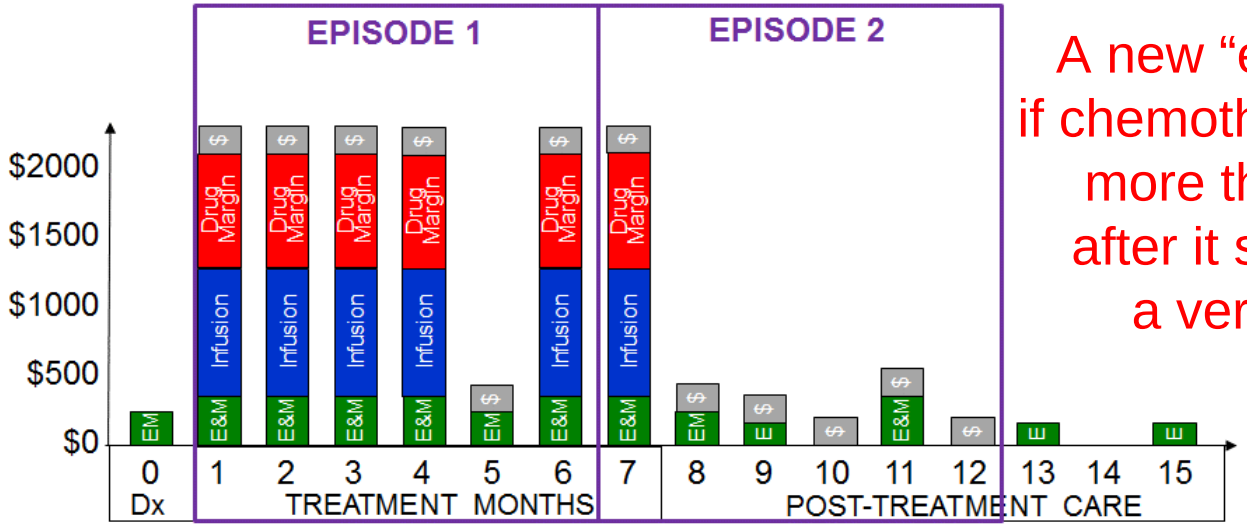
Many Patients Have to Delay a Treatment Because of Side Effects

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



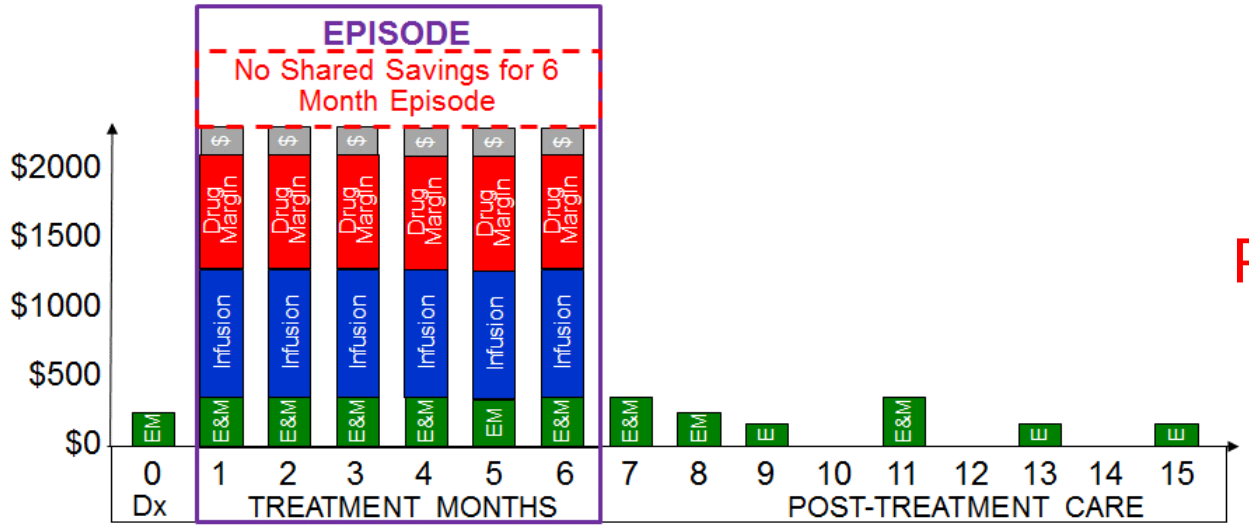
But CMMI Says It's a *New Episode* With $960 More in Payments



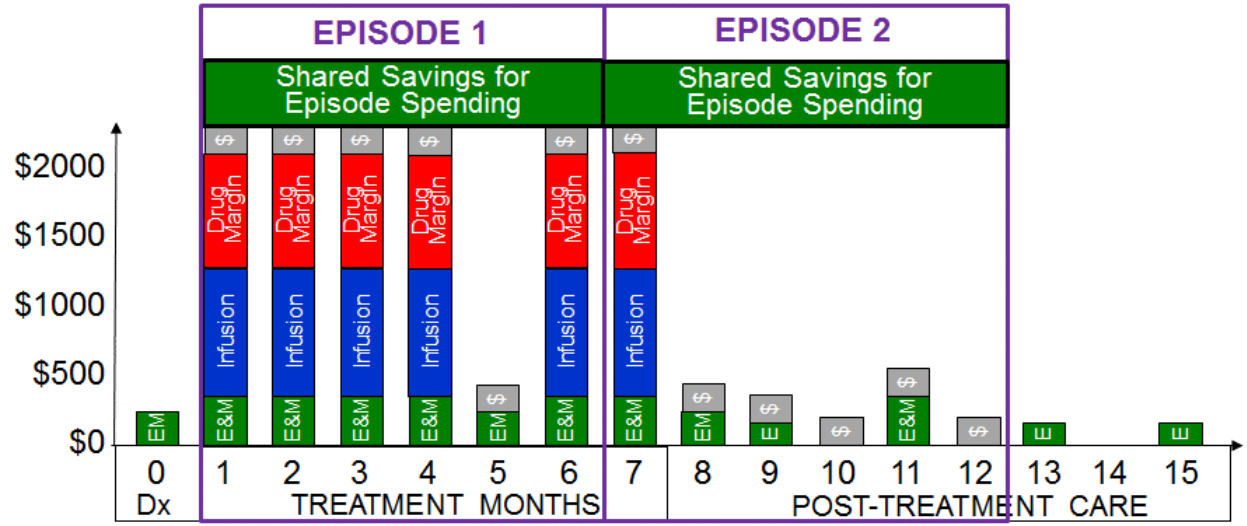


A new "episode" starts if chemotherapy continues more than 6 months after it starts, even for a very short time

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



Penalty for Helping Patients Avoid Side Effects?

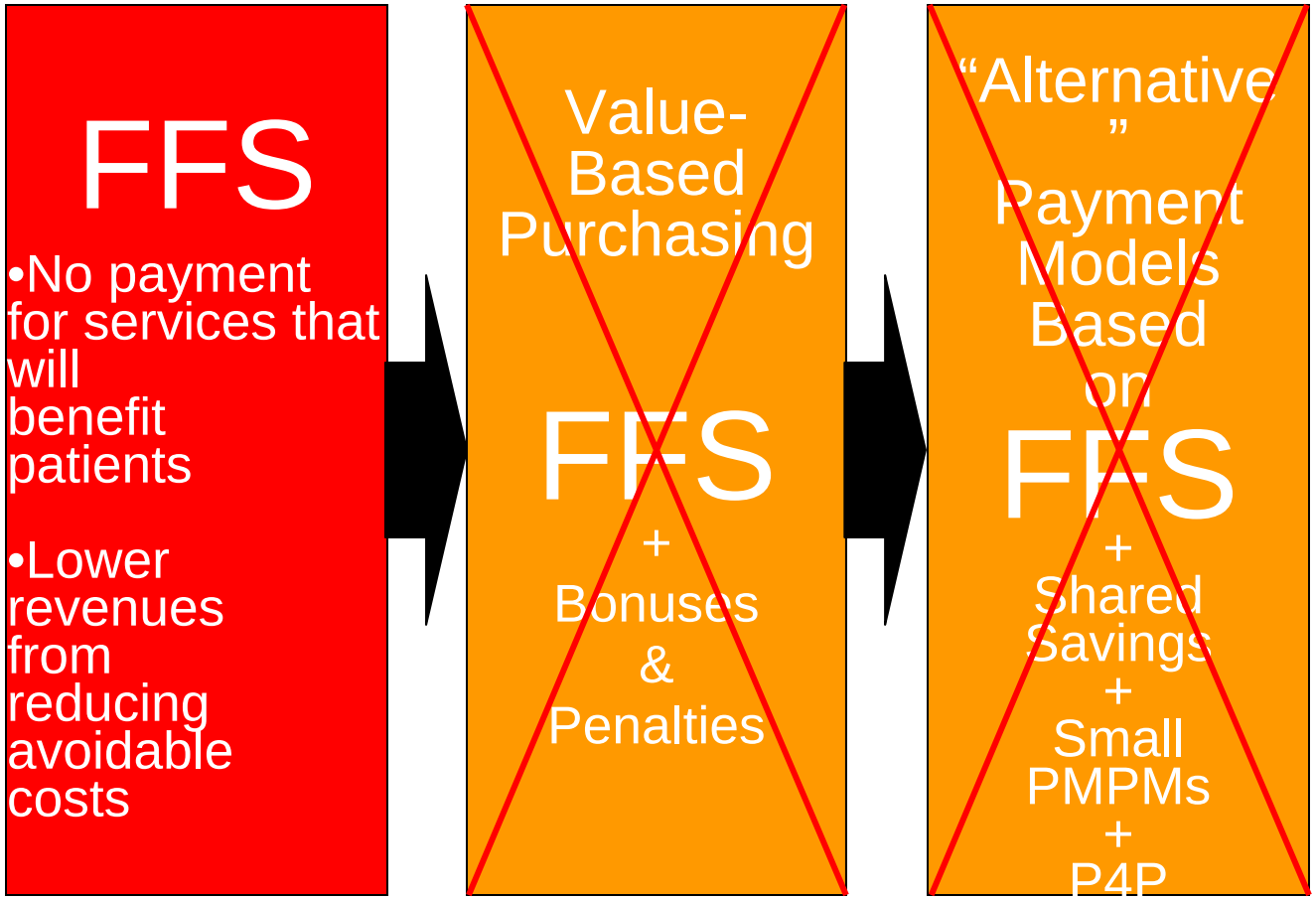


Incentive to Stretch Out Treatment?

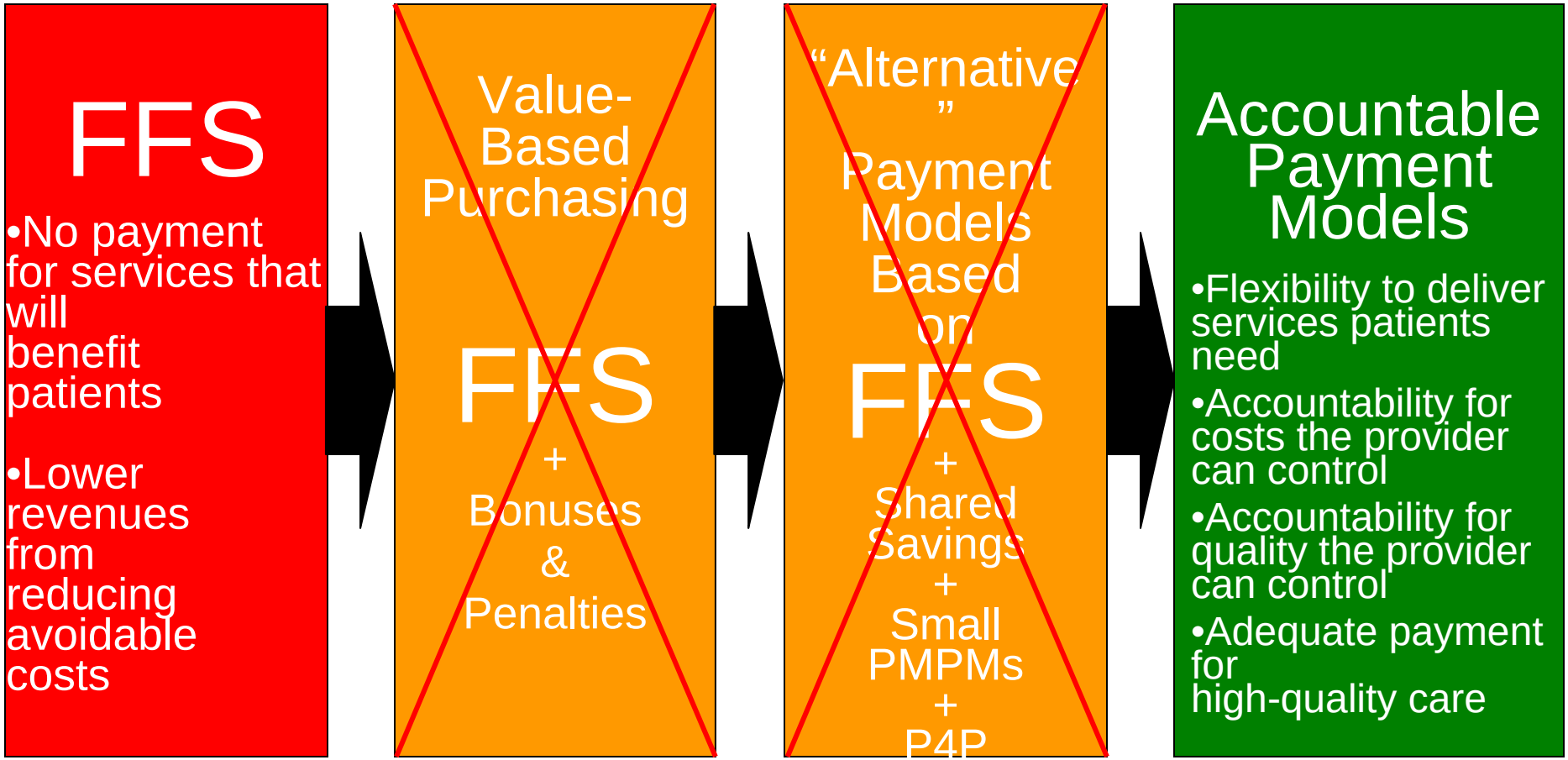
This is Not True Payment Reform

- What's Good: $160/month extra payment for practices
- What's Bad:
  - Could encourage delaying treatments in order to receive more PMPM payments & shared savings
  - Could penalize practices who have patients who respond better to treatment
  - No change to underlying FFS structure, so some savings will also reduce practice revenues
  - 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
  - Methodology for adjusting spending targets to deal with new drugs, new evidence about effectiveness of treatments, etc. has not been defined.

"Payment Reforms" Built on FFS Will Likely Have Limited Success



We Need *True* Payment Reforms: Accountable Payment Models



Three Major Types of Accountable Payment Models

PAYMENT MODEL	HOW IT WORKS
Bundled Payment	Single payment to ALL providers involved in delivering ALL of the care the patient needs

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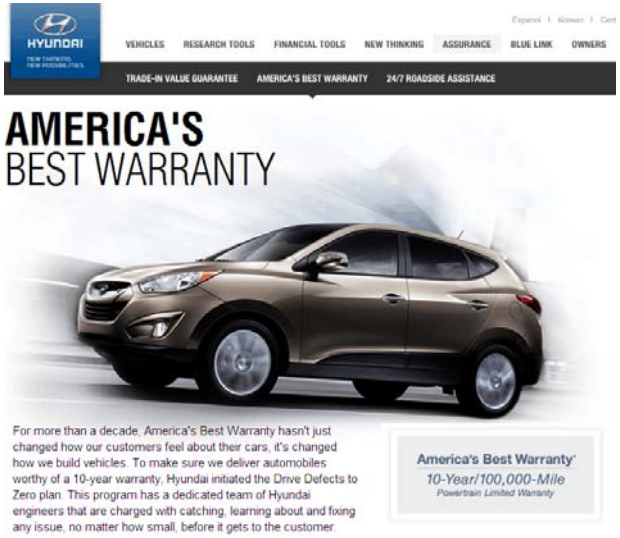
PAYMENT MODEL	HOW IT WORKS
Bundled Payment	Single payment to ALL providers involved in delivering ALL of the care the patient needs
Warrantied Payment	Higher payment for quality care, no extra payment for correcting preventable errors and complications

Most Major Industries Are Paid Using Bundles & Warranties

PAYMENT MODEL	HOW IT WORKS
Bundled Payment	Single payment to ALL providers involved in delivering ALL of the care the patient needs
Warrantied Payment	Higher payment for quality care, no extra payment for correcting preventable errors and complications



Condition-Based Payment Provides What Patients Most Want

PAYMENT MODEL	HOW IT WORKS
Bundled Payment	Single payment to ALL providers involved in delivering ALL of the care the patient needs
Warrantied Payment	Higher payment for quality care, no extra payment for correcting preventable errors and complications
Condition-Based Payment	Payment based on the patient's condition, rather than on the procedure used

Condition-Based Payment Is the Most Flexible Payment

PAYMENT MODEL	HOW IT WORKS
Bundled Payment	Single payment to ALL providers involved in delivering ALL of the care the patient needs
Warrantied Payment	Higher payment for quality care, no extra payment for correcting preventable errors and complications
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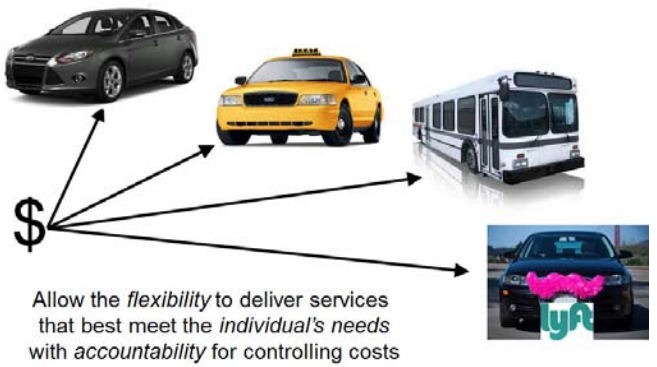


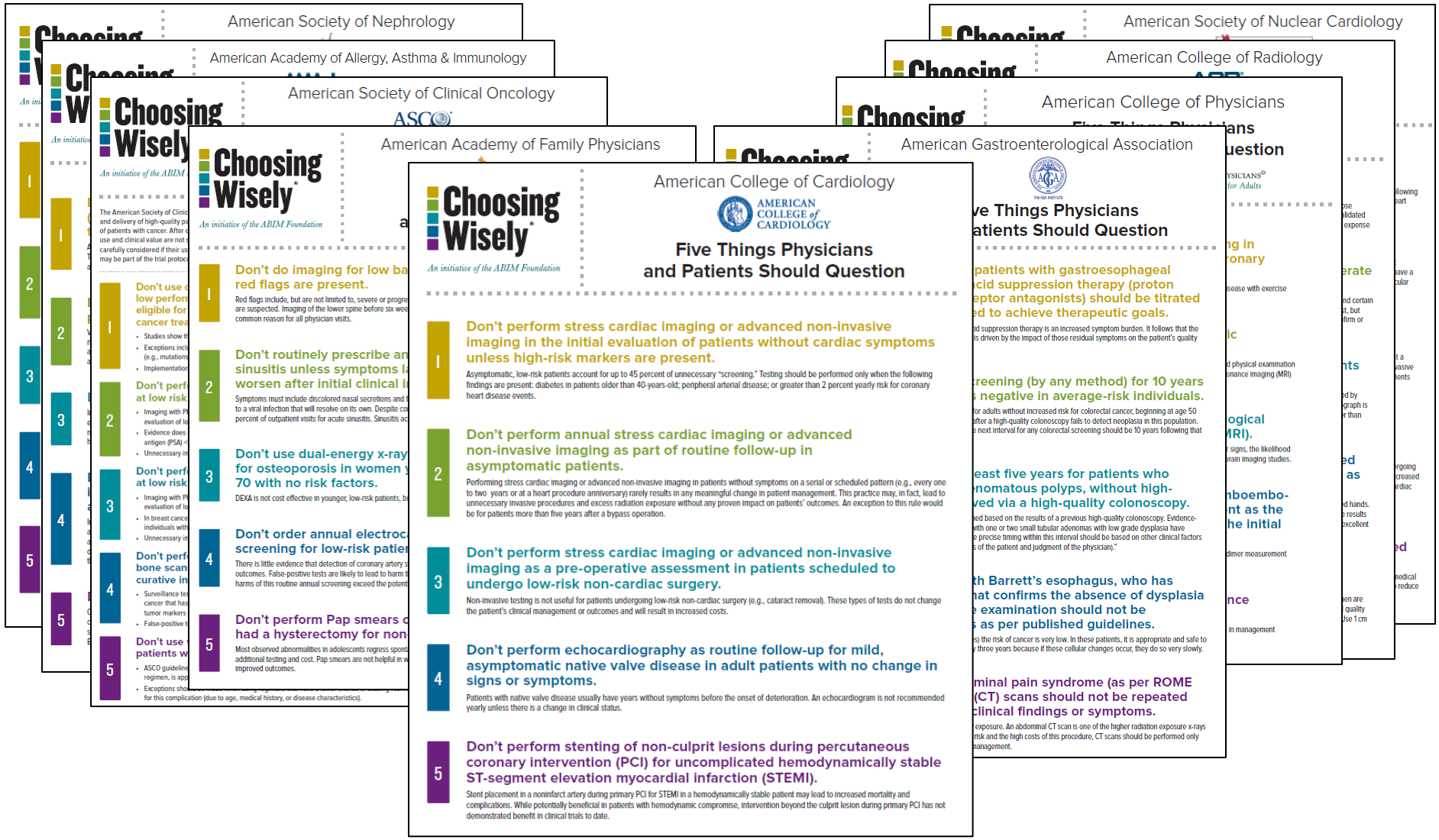
With *True* Payment Reform, There Can Be a Win-Win-Win

PAYMENT MODEL	HOW IT WORKS	WIN-WIN-WIN APPROACH
Bundled Payment	Single payment to ALL providers involved in delivering ALL of the care the patient needs	• Patients get better quality care • Payers spend less for care • Providers do better financially for delivering high-quality care
Warrantied Payment	Higher payment for quality care, no extra payment for correcting preventable errors and complications	
Condition-Based Payment	Payment based on the patient's condition, rather than on the procedure used	

CMS Is Pursuing Bundles & Warranties

- **Model 1 (Inpatient Gainsharing, No Warranty)**
  - Hospitals can share savings with physicians
  - No actual change in the way Medicare payments are made
- **Model 2 (Virtual Full Episode Bundle + Warranty)**
  - Budget for Hospital+Physician+Post-Acute+Readmissions
  - Medicare pays bonus if actual cost < budget
  - Providers repay Medicare if actual cost > budget
- **Model 3 (Virtual Post-Acute Bundle + Warranty)**
  - Budget for Post-Acute Care+Physicians+Readmissions
  - Bonuses/penalties paid based on actual cost vs. budget
- **Model 4 (Prospective Inpatient Bundle + Warranty)**
  - Single Hospital + Physician payment for inpatient care & readmissions

But Bundled Payments Don't Help If You Want Fewer Procedures



Significant Potential Savings From Lower Cost Procedures & Settings

- Maternity Care
  - Vaginal delivery instead of C-Section
  - Term delivery instead of early elective delivery
  - Delivery in birth center instead of hospital
- Back Pain
  - Less radical surgery
  - Physical therapy instead of surgery
- Chest Pain
  - History and exam before imaging
  - Lower cost imaging
  - Non-invasive imaging instead of invasive imaging
  - Medical management instead of invasive treatment

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Savings = Lower Revenues for Specialists and Hospitals

Significant Potential Savings From Lower Cost Procedures & Settings

- Maternity Care
  - Vaginal delivery instead of C-Section
  - Term delivery instead of early elective delivery

Why would any physician group or hospital do these things unless they were forced to??

Savings = Lower Revenues for Specialists and Hospitals

  - Lower cost imaging
  - Non-invasive imaging instead of invasive imaging
  - Medical management instead of invasive treatment

Example: Reducing Avoidable Procedures

	TODAY		
	$/Patient	# Pts	Total $
Physician Svcs			
Evaluations	$160	300	$48,000
Procedures	$2,000	200	$400,000
Subtotal			$448,000
Hospital Pmt	$22,000	200	$4,400,000
Total Pmt/Cost		300	$4,848,000

Optional Procedure for a Condition

- Physician evaluates all patients
- Physician performs procedure on 2/3 of evaluated patients
- Up to 10% of procedures may be avoidable through patient choice or alternative treatment

Most of the Money Isn't Going to the Physician

	TODAY		
	$/Patient	# Pts	Total $
Physician Svcs			
Evaluations	$160	300	$48,000
Procedures	$2,000	200	$400,000
Subtotal			$448,000
Hospital Pmt	$22,000	200	$4,400,000
Total Pmt/Cost		300	$4,848,000

Physician is only receiving 9% of the total spending

Typical Health Plan Approach: Prior Auth/Utilization Controls

	TODAY			w/ UTILIZATION CTRL			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Physician Svcs							
Evaluations	$160	300	$48,000	$160	300	$48,000	
Procedures	$2,000	200	~~$400,000~~	~~$2,000~~	180	$360,000	
Subtotal			$448,000			$408,000	
Hospital Pmt	$22,000	200	~~$4,400,000~~	~~$22,000~~	180	$3,960,000	
Total Pmt/Cost		300	$4,848,000		300	$4,368,000	-10%

Under FFS, Payer Wins, Physicians and Hospitals Lose

	TODAY			w/ UTILIZATION CTRL			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Physician Svcs							
Evaluations	$160	300	$48,000	$160	300	$48,000	
Procedures	$2,000	200	~~$400,000~~	~~$2,000~~	180	$360,000	
Subtotal			$448,000			$408,000	-9%
Hospital Pmt	$22,000	200	$4,400,000	$22,000	180	$3,960,000	-10%
Total Pmt/Cost		300	$4,848,000		300	$4,368,000	-10%

A Small Value-Based Modifier Won't Offset the Losses

	TODAY			w/ UTILIZATION CTRL			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Physician Svcs							
Evaluations	$160	300	$48,000	$160	300	$48,000	
Procedures	$2,000	200	$400,000	↑ $2,080	180	$374,400	
Subtotal			$448,000	**+4%**		$422,400	-6%
Hospital Pmt	$22,000	200	$4,400,000	$22,000	180	$3,960,000	-10%
Total Pmt/Cost		300	$4,848,000		300	$4,382,400	-10%

Is There a Better Way?

	TODAY			TOMORROW			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Physician Svcs							
Evaluations	$160	300	$48,000	?	?	?	
Procedures	$2,000	200	$400,000	?	?	?	
Subtotal			$448,000			?	
				?	?	?	
Hospital Pmt	$22,000	200	$4,400,000	?	?	?	
Total Pmt/Cost		300	$4,848,000	?	?	?	

A Better Way: Pay Physicians *Differently*

	TODAY			TOMORROW			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Physician Svcs							
Evaluations	$160	300	$48,000	$300	300	$90,000	
Procedures	$2,000	200	$400,000	$2,150	180	$387,000	
Subtotal			$448,000			$477,000	
Hospital Pmt	$22,000	200	$4,400,000				
Total Pmt/Cost		300	$4,848,000				

Better Payment for Condition Management

- Physician paid adequately to engage in shared decision making process with patients
- Physician paid adequately for procedures without needing to increase volume of procedures

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

	TODAY			TOMORROW			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Physician Svcs							
Evaluations	$160	300	$48,000	$300	300	$90,000	
Procedures	$2,000	200	$400,000	$2,150	180	$387,000	
Subtotal			$448,000			$477,000	+6%
Hospital Pmt	$22,000	200	$4,400,000	$22,000	180	$3,960,000	-10%
Total Pmt/Cost		300	$4,848,000		300	$4,437,000	-8.5%

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

	TODAY			TOMORROW			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Physician Svcs							
Evaluations	$160	300	$48,000	$300	300	$90,000	
Procedures	$2,000	200	$400,000	$2,150	180	$387,000	
Subtotal			$448,000			$477,000	+6%
Hospital Pmt	$22,000	200	$4,400,000	$22,000	180	$3,960,000	-10%
Total Pmt/Cost		300	$4,848,000		300	$4,437,000	-8.5%

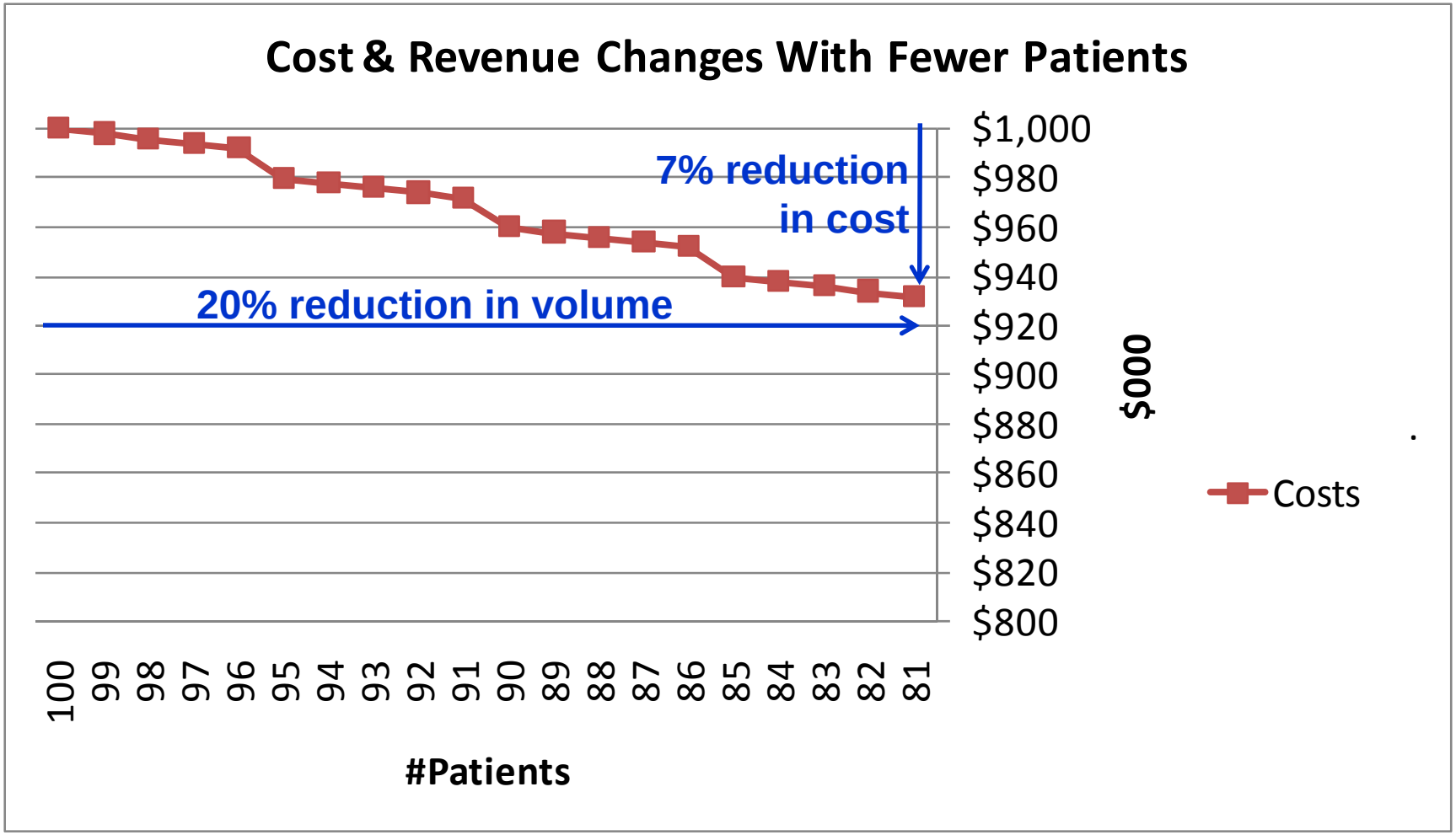
Physician Wins

Hospital Loses

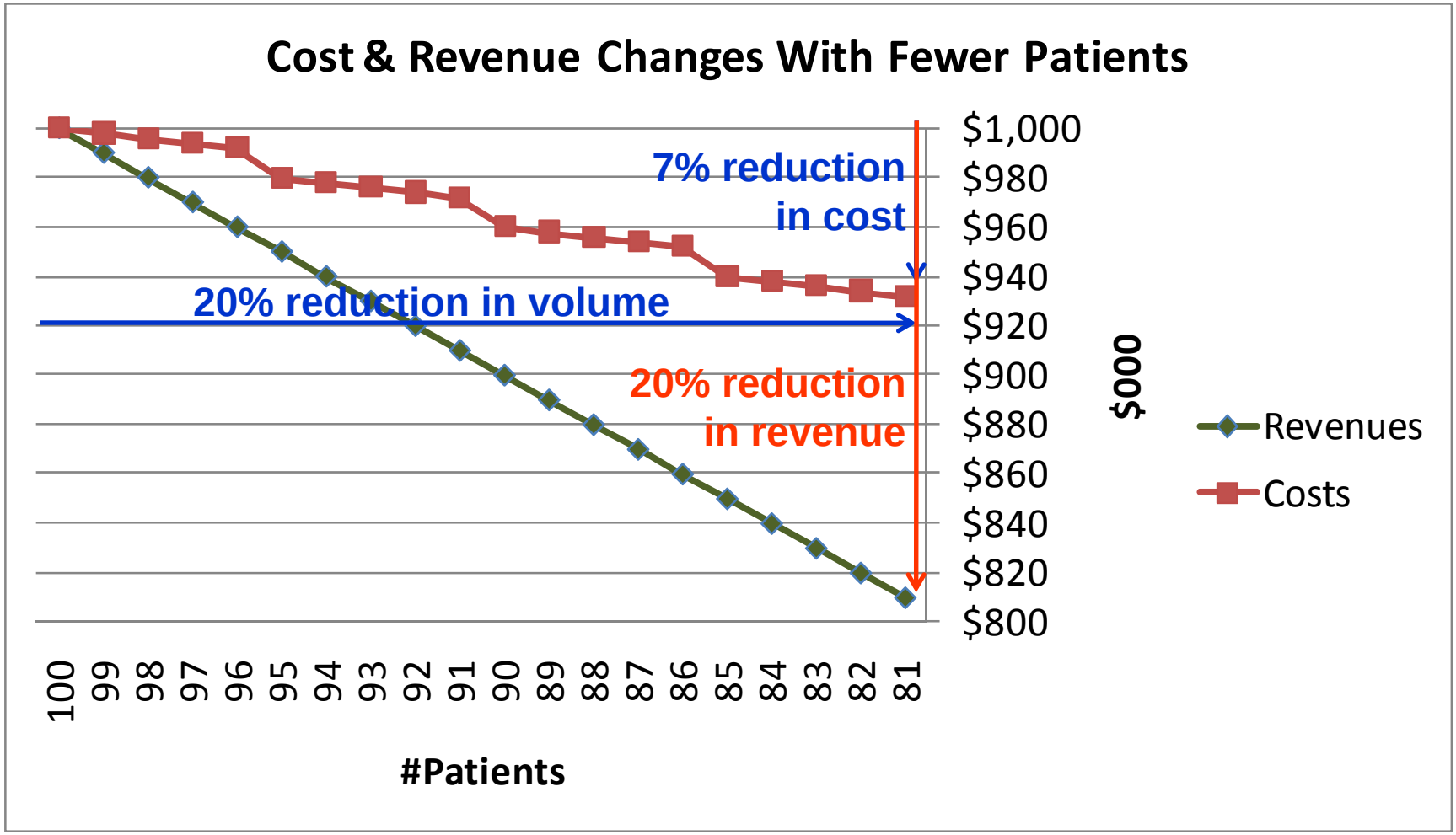
Payer Wins

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

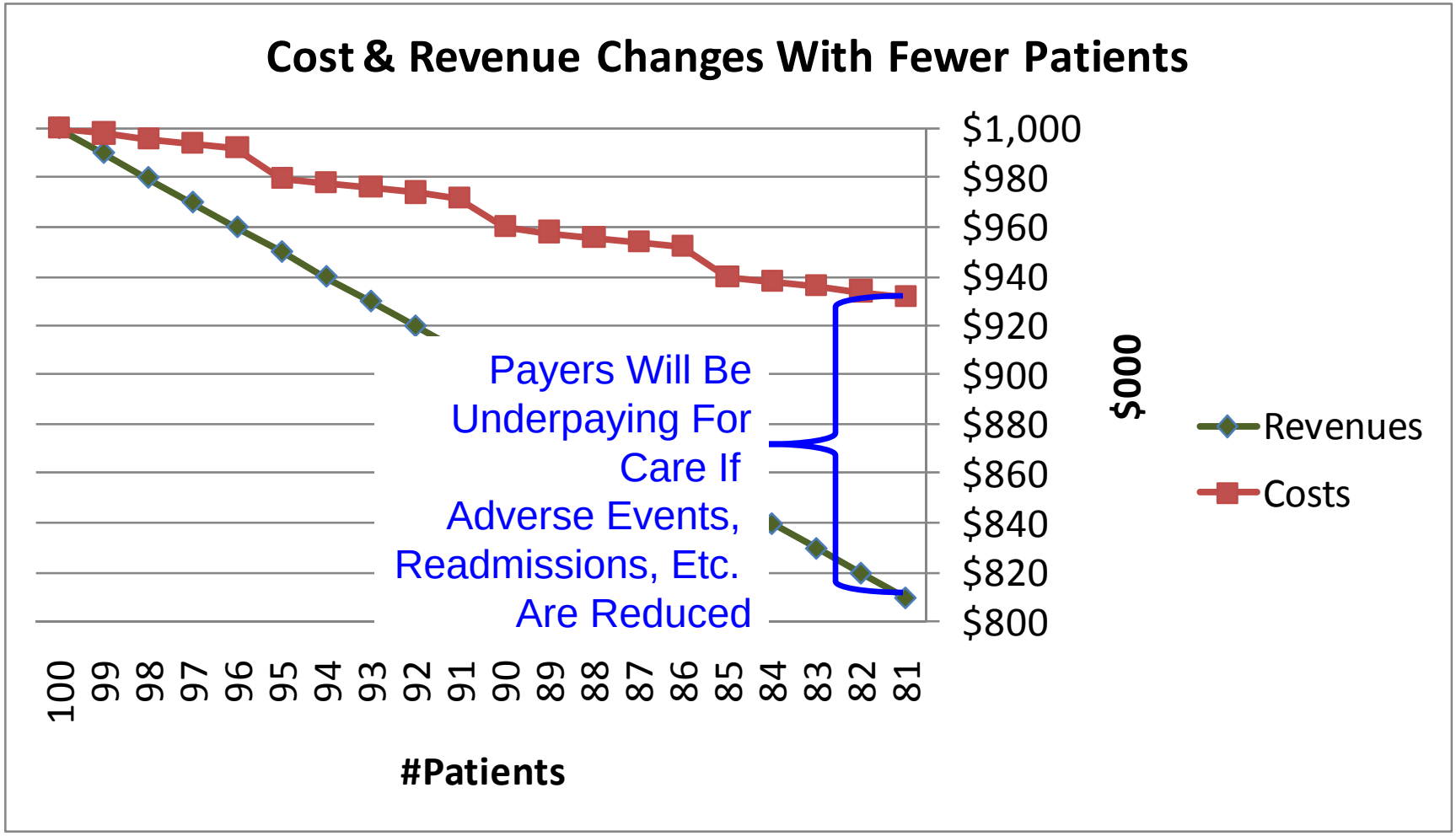
Hospital Costs Are Not Proportional to Utilization



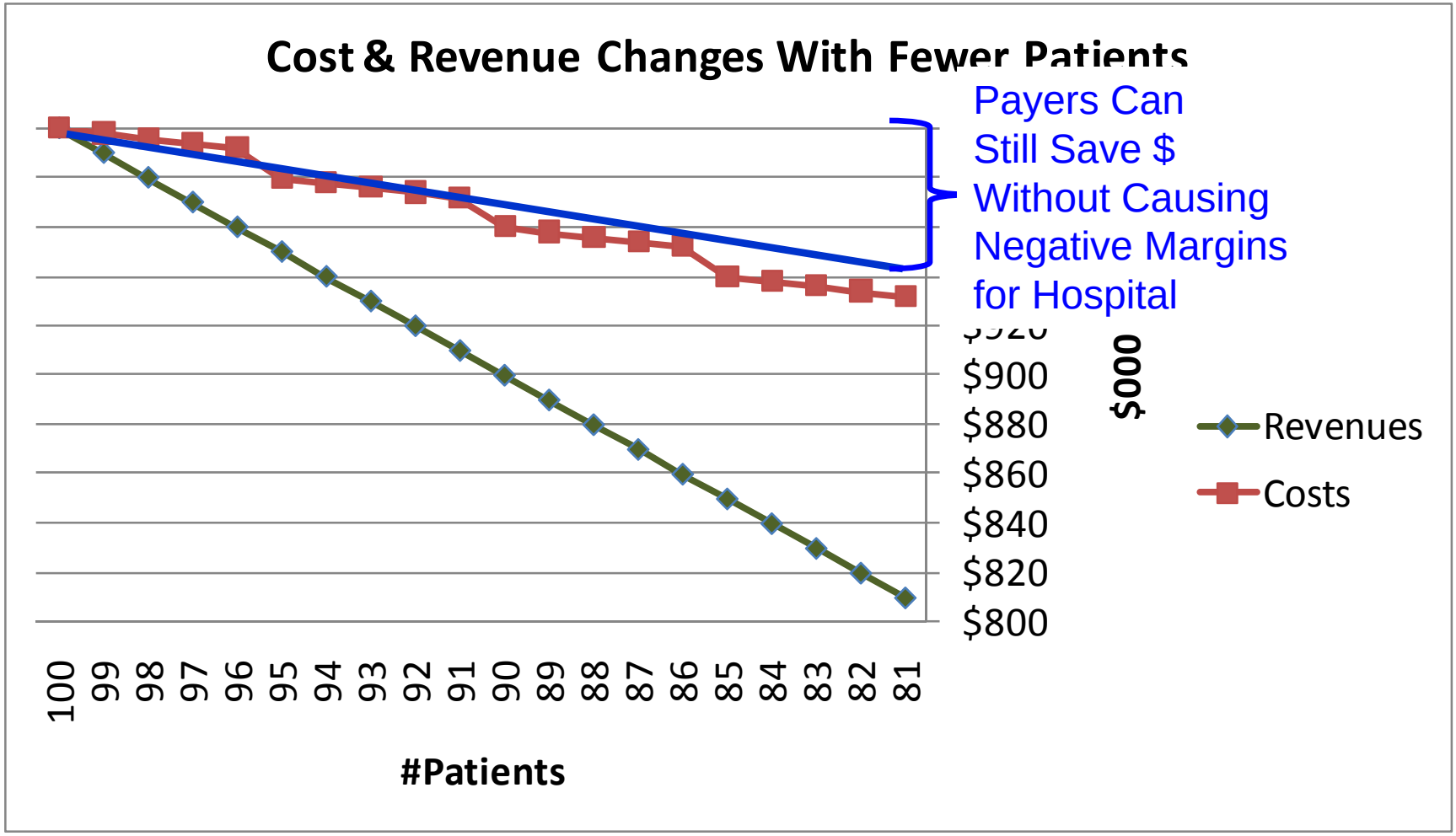
Reductions in Utilization Reduce Revenues More Than Costs



Causing Negative Margins for Hospitals



But Spending Can Be Reduced Without Bankrupting Hospitals



We Need to Understand the Hospital's Cost Structure

	TODAY			TOMORROW			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Physician Svcs							
Evaluations	$160	300	$48,000	$300	300	$90,000	
Procedures	$2,000	200	$400,000	$2,150	180	$387,000	
Subtotal			$448,000			$477,000	+6%
Hospital Pmt	$22,000	200	$4,400,000	$22,000	180	$3,960,000	-10%
Total Pmt/Cost		300	$4,848,000		300	$4,437,000	-8.5%

Adequacy of Payment Depends On Fixed/Variable Costs & Margins

	TODAY			TOMORROW			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Physician Svcs							
Evaluations	$160	300	$48,000	$300	300	$90,000	
Procedures	$2,000	200	$400,000	$2,150	180	$387,000	
Subtotal			$448,000			$477,000	+6%
Hospital Pmt							
Fixed Costs	$13,200	*60%*	$2,640,000				
Variable Costs	$7,700	*35%*	$1,540,000				
Margin	$1,100	*5%*	$220,000				
Subtotal	$22,000	200	$4,400,000				
Total Pmt/Cost		300	$4,848,000				

Now, if the Number of Procedures is Reduced…

	TODAY			TOMORROW			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Physician Svcs							
Evaluations	$160	300	$48,000	$300	300	$90,000	
Procedures	$2,000	200	$400,000	$2,150	180	$387,000	
Subtotal			$448,000			$477,000	+6%
Hospital Pmt							
Fixed Costs	$13,200	*60%*	$2,640,000				
Variable Costs	$7,700	*35%*	$1,540,000				
Margin	$1,100	*5%*	$220,000				
Subtotal	$22,000	200	~~$4,400,000~~		180		
Total Pmt/Cost		300	$4,848,000				

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

	TODAY			TOMORROW			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Physician Svcs							
Evaluations	$160	300	$48,000	$300	300	$90,000	
Procedures	$2,000	200	$400,000	$2,150	180	$387,000	
Subtotal			$448,000			$477,000	+6%
Hospital Pmt							
Fixed Costs	$13,200	*60%*	$2,640,000			$2,640,000	0%
Variable Costs	$7,700	*35%*	$1,540,000				
Margin	$1,100	*5%*	$220,000				
Subtotal	$22,000	200	$4,400,000		180		
Total Pmt/Cost		300	$4,848,000				

…Variable Costs Will Go Down in Proportion to Procedures…

	TODAY			TOMORROW			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Physician Svcs							
Evaluations	$160	300	$48,000	$300	300	$90,000	
Procedures	$2,000	200	$400,000	$2,150	180	$387,000	
Subtotal			$448,000			$477,000	+6%
Hospital Pmt							
Fixed Costs	$13,200	*60%*	$2,640,000			$2,640,000	0%
Variable Costs	$7,700	~~*35%*~~	~~$1,540,000~~	$7,700		$1,386,000	-10%
Margin	$1,100	*5%*	$220,000				
Subtotal	$22,000	200	$4,400,000		180		
Total Pmt/Cost		300	$4,848,000				

…And Even With a Higher Margin for the Hospital…

	TODAY			TOMORROW			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Physician Svcs							
Evaluations	$160	300	$48,000	$300	300	$90,000	
Procedures	$2,000	200	$400,000	$2,150	180	$387,000	
Subtotal			$448,000			$477,000	+6%
Hospital Pmt							
Fixed Costs	$13,200	*60%*	$2,640,000			$2,640,000	0%
Variable Costs	$7,700	*35%*	$1,540,000	$7,700		$1,386,000	-10%
Margin	$1,100	*5%*	$220,000			$233,200	+6%
Subtotal	$22,000	200	$4,400,000		180		
Total Pmt/Cost		300	$4,848,000				

…The Hospital Does Better With Less Total Revenue

	TODAY			TOMORROW			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Physician Svcs							
Evaluations	$160	300	$48,000	$300	300	$90,000	
Procedures	$2,000	200	$400,000	$2,150	180	$387,000	
Subtotal			$448,000			$477,000	+6%
Hospital Pmt							
Fixed Costs	$13,200	*60%*	$2,640,000			$2,640,000	0%
Variable Costs	$7,700	*35%*	$1,540,000	$7,700		$1,386,000	-10%
Margin	$1,100	*5%*	$220,000			$233,200	+6%
Subtotal	$22,000	200	$4,400,000		180	$4,259,200	-3%
Total Pmt/Cost		300	$4,848,000				

…And The Payer Still Saves Money

	TODAY			TOMORROW			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Physician Svcs							
Evaluations	$160	300	$48,000	$300	300	$90,000	
Procedures	$2,000	200	$400,000	$2,150	180	$387,000	
Subtotal			$448,000			$477,000	+6%
Hospital Pmt							
Fixed Costs	$13,200	*60%*	$2,640,000			$2,640,000	0%
Variable Costs	$7,700	*35%*	$1,540,000	$7,700		$1,386,000	-10%
Margin	$1,100	*5%*	$220,000			$233,200	+6%
Subtotal	$22,000	200	$4,400,000		180	$4,259,200	-3%
Total Pmt/Cost		300	$4,848,000		300	$4,736,200	-2%

I.e., Win-Win-Win for Physician, Hospital, and Payer

	TODAY			TOMORROW			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Physician Svcs							
Evaluations	$160	300	$48,000	$300	300	$90,000	
Procedures	$2,000	200	$400,000	$2,150	180	$387,000	
Subtotal			$448,000			$477,000	+6%
Hospital Pmt							
Fixed Costs	$13,200	*60%*	$2,640,000			$2,640,000	0%
Variable Costs	$7,700	*35%*	$1,540,000	$7,700		$1,386,000	-10%
Margin	$1,100	*5%*	$220,000			$233,200	+6%
Subtotal	$22,000	200	$4,400,000		180	$4,259,200	-3%
Total Pmt/Cost		300	$4,848,000		300	$4,736,200	-2%

Physician Wins
Hospital Wins
Payer Wins

If The Physician Can Reduce the Hospital's Costs Per Procedure….

	TODAY			TOMORROW			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Physician Svcs							
Evaluations	$160	300	$48,000				
Procedures	$2,000	200	$400,000				
Subtotal			$448,000				
Hospital Pmt							
Fixed Costs	$13,200	*60%*	$2,640,000				
Variable Costs	$7,700	~~*35%*~~	~~$1,540,000~~	$7,000		$1,260,000	-18%
Margin	$1,100	*5%*	$220,000				
Subtotal	$22,000	200	$4,400,000		180		
Total Pmt/Cost		300	$4,848,000		300		

Everyone Can Win Even More

	TODAY			TOMORROW			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Physician Svcs							
Evaluations	$160	300	$48,000	$300	300	$90,000	
Procedures	$2,000	200	$400,000	$2,250	180	$405,000	
Subtotal			$448,000			$495,000	+10%
Hospital Pmt							
Fixed Costs	$13,200	*60%*	$2,640,000			$2,640,000	0%
Variable Costs	$7,700	*35%*	$1,540,000	$7,000		$1,260,000	-18%
Margin	$1,100	*5%*	$220,000			$245,000	+11%
Subtotal	$22,000	200	$4,400,000		180	$4,145,000	-6%
Total Pmt/Cost		300	$4,848,000		300	$4,640,000	-4%

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

	TODAY			TOMORROW			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Physician Svcs							
Evaluations	$160	300	$48,000	$300	300	$90,000	
Procedures	$2,000	200	$400,000	$2,150	180	$387,000	
Subtotal			$448,000			$477,000	+6%
Hospital Pmt							
Fixed Costs	$13,200	*60%*	$2,640,000			$2,640,000	0%
Variable Costs	$7,700	*35%*	$1,540,000	$7,700		$1,386,000	-10%
Margin	$1,100	*5%*	$220,000			$233,200	+6%
Subtotal	$22,000	200	$4,400,000		180	$4,259,200	-3%
Total Pmt/Cost		300	$4,848,000		300	$4,736,200	-2%

Renegotiating Individual Fees is Impractical

	TODAY			TOMORROW			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Physician Svcs							
Evaluations	$160	300	$48,000	$300	300	$90,000	
Procedures	$2,000	200	$400,000	$2,150	180	$387,000	
Subtotal			$448,000			$477,000	+6%
Hospital Pmt							
Fixed Costs	$13,200	*60%*	$2,640,000			$2,640,000	0%
Variable Costs	$7,700	*35%*	$1,540,000	$7,700		$1,386,000	-10%
Margin	$1,100	*5%*	$220,000			$233,200	+6%
Subtotal	$22,000	200	$4,400,000	$23,662	180	$4,259,200	-3%
Total Pmt/Cost		300	$4,848,000		300	$4,736,200	-2%

Pay Based on the Patient's *Condition*, Not on the *Procedure*

	TODAY			TOMORROW			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Physician Svcs							
Evaluations	$160	300	$48,000	$300	300	$90,000	
Procedures	$2,000	200	$400,000	$2,150	180	$387,000	
Subtotal			$448,000			$477,000	+6%
Hospital Pmt							
Fixed Costs	$13,200	*60%*	$2,640,000			$2,640,000	0%
Variable Costs	$7,700	*35%*	$1,540,000	$7,700		$1,386,000	-10%
Margin	$1,100	*5%*	$220,000			$233,200	+6%
Subtotal	$22,000	200	$4,400,000		180	$4,259,200	-3%
Total Pmt/Cost	$16,160	300	$4,848,000		300	$4,736,200	-2%

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

	TODAY			TOMORROW			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Physician Svcs							
Evaluations	$160	300	$48,000	$300	300	$90,000	
Procedures	$2,000	200	$400,000	$2,150	180	$387,000	
Subtotal			$448,000			$477,000	+6%
Hospital Pmt							
Fixed Costs	$13,200	*60%*	$2,640,000			$2,640,000	0%
Variable Costs	$7,700	*35%*	$1,540,000	$7,700		$1,386,000	-10%
Margin	$1,100	*5%*	$220,000			$233,200	+6%
Subtotal	$22,000	200	$4,400,000		180	$4,259,200	-3%
Total Pmt/Cost	$16,160	300	~~$4,848,000~~	$15,787	300	$4,736,200	-2%

Use the Payment as a Budget to Redesign Care…

	TODAY			TOMORROW			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Physician Svcs							
Evaluations	$160	300	$48,000	$300	300	$90,000	
Procedures	$2,000	200	$400,000	$2,150	180	$387,000	
Subtotal			$448,000			$477,000	+6%
Hospital Pmt							
Fixed Costs	$13,200	*60%*	$2,640,000			$2,640,000	0%
Variable Costs	$7,700	*35%*	$1,540,000	$7,700		$1,386,000	-10%
Margin	$1,100	*5%*	$220,000			$233,200	+6%
Subtotal	$22,000	200	$4,400,000		180	$4,259,200	-3%
Total Pmt/Cost	$16,160	300	$4,848,000	$15,787	300	$4,736,200	-2%

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

	TODAY			TOMORROW			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Physician Svcs							
Evaluations	$160	300	$48,000	$300	300	$90,000	
Procedures	$2,000	200	$400,000	$2,150	180	$387,000	
Subtotal			$448,000			$477,000	+6%
Hospital Pmt							
Fixed Costs	$13,200	*60%*	$2,640,000			$2,640,000	0%
Variable Costs	$7,700	*35%*	$1,540,000	$7,700		$1,386,000	-10%
Margin	$1,100	*5%*	$220,000			$233,200	+6%
Subtotal	$22,000	200	$4,400,000		180	$4,259,200	-3%
Total Pmt/Cost	$16,160	300	$4,848,000	$15,787	300	$4,736,200	-2%

Would “Shared Savings” Achieve the Same Thing?

Same Example As Before…

	Year 0	# Patients	$/Patient
Physician Svcs			
Evaluations	$48,000	300	$160
Procedures	$400,000	200	$2,000
Subtotal	$448,000		
Hospital Pmt			
Procedures	$4,400,000	200	$22,000
Subtotal	$4,400,000		
Total Pmt/Cost	$4,848,000		

Optional Procedure for a Condition

- Physician evaluates all patients
- Physician performs procedure on 2/3 of evaluated patients
- Up to 10% of procedures may be avoidable through patient choice or alternative treatment

Year 1: Physicians & Hospitals Both Lose With Fewer Procedures

	Year 0	Year 1	Chg
Physician Svcs			
Evaluations	$48,000	$48,000	
Procedure	$400,000	$360,000	
		$0	
Subtotal	$448,000	$408,000	-9%
Hospital Pmt			
Procedure	$4,400,000	$3,960,000	
		$0	
Subtotal	$4,400,000	$3,960,000	-10%
Total Pmt/Cost	$4,848,000	$4,368,000	-10%
Savings		$480,000	

Reduce Procs by 10%

Year 1: Lower Revenue for Docs & Hospital

Year 2: Losses Are Lower If Shared Savings Are Paid…

	Year 0	Year 1	Chg	Year 2	Chg
Physician Svcs					
Evaluations	$48,000	$48,000		$48,000	
Procedures	$400,000	$360,000		$360,000	
Shared Savings		$0		$40,000	
Subtotal	$448,000	$408,000	-9%	$448,000	0%
Hospital Pmt					
Procedures	$4,400,000	$3,960,000		$3,960,000	
Shared Savings		$0		$200,000	
Subtotal	$4,400,000	$3,960,000	-10%	$4,160,000	-5%
Total Pmt/Cost	$4,848,000	$4,368,000	-10%	$4,608,000	-5%
Savings		$480,000		$240,000	

Reduce Procs by 10%

Year 1: Lower Revenue for Docs & Hospital

Year 2: Shared Savings Offsets Some Losses

…But Physicians and Hospitals Still Have Net 2-Year Losses

	Year 0	Year 1	Chg	Year 2	Chg	Cumulative
Physician Svcs						
Evaluations	$48,000	$48,000		$48,000		
Procedures	$400,000	$360,000		$360,000		
Shared Savings		$0		$40,000		
Subtotal	$448,000	$408,000	-9%	$448,000	0%	-$40,000
						-4%
Hospital Pmt						
Procedures	$4,400,000	$3,960,000		$3,960,000		
Shared Savings		$0		$200,000		
Subtotal	$4,400,000	$3,960,000	-10%	$4,160,000	-5%	-$680,000
						-8%
Total Pmt/Cost	$4,848,000	$4,368,000	-10%	$4,608,000	-5%	$720,000
Savings		$480,000		$240,000		-7%

It's Even Worse Than That…

- **There is no shared savings payment at all if a minimum total savings level is not reached**
- **If there is a shared savings payment, it's reduced if quality thresholds aren't met, even if the quality measures have nothing to do with where savings occurred**
- **The shared savings payment ends at the end of the 3-year contract period, even if utilization remains lower, and the payer keeps 100% of the savings in future years**

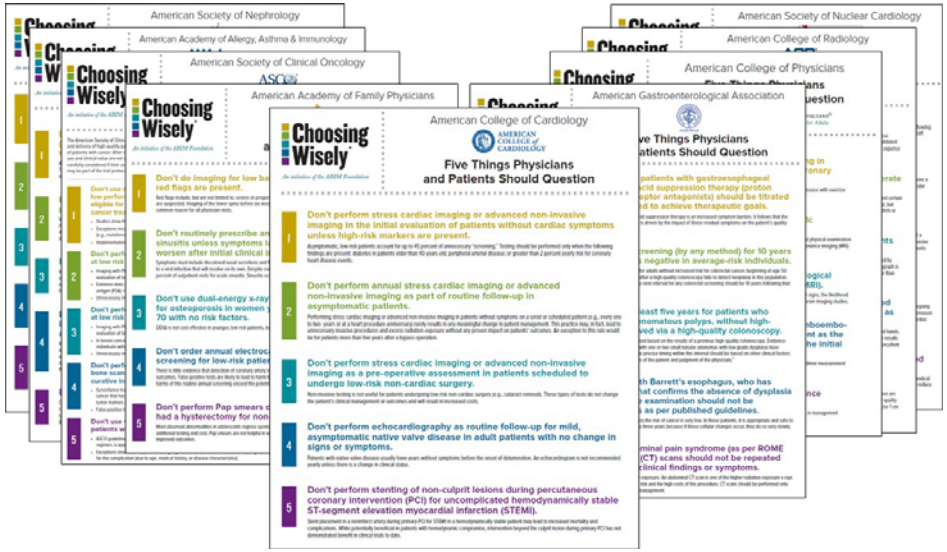
Condition-Based Payment Allows a True Win-Win-Win

	TODAY			TOMORROW			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Physician Svcs							
Evaluations	$160	300	$48,000	$300	300	$90,000	
Procedures	$2,000	200	$400,000	$2,150	180	$387,000	
Subtotal			$448,000			$477,000	+6%
Hospital Pmt							
Fixed Costs	$13,200	*60%*	$2,640,000			$2,640,000	0%
Variable Costs	$7,700	*35%*	$1,540,000	$7,700		$1,386,000	-10%
Margin	$1,100	*5%*	$220,000			$233,200	+6%
Subtotal	$22,000	200	$4,400,000		180	$4,259,200	-3%
Total Pmt/Cost		300	$4,848,000		300	$4,736,200	-2%

Physician Wins
Hospital Wins
Payer Wins

Opportunities for Reducing Spending Exist in Every Specialty

	Opportunities to Improve Care and Reduce Cost
Cardiology	• Use less invasive and expensive procedures when appropriate
Orthopedic Surgery	• Reduce infections and complications • Use less expensive post-acute care following surgery
Psychiatry	• Reduce ER visits and admissions for patients with depression and chronic disease
OB/GYN	• Reduce use of elective C-sections • Reduce early deliveries and use of NICU



Fee-for-Service Creates *Barriers* to Redesigning Care

	Opportunities to Improve Care and Reduce Cost	***Barriers in Current Payment System***
Cardiology	• Use less invasive and expensive procedures when appropriate	• Payment is based on which procedure is used, not the outcome for the patient
Orthopedic Surgery	• Reduce infections and complications • Use less expensive post-acute care following surgery	• No flexibility to increase inpatient services to reduce complications & post-acute care
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
OB/GYN	• Reduce use of elective C-sections • Reduce early deliveries and use of NICU	• Similar/lower payment for vaginal deliveries

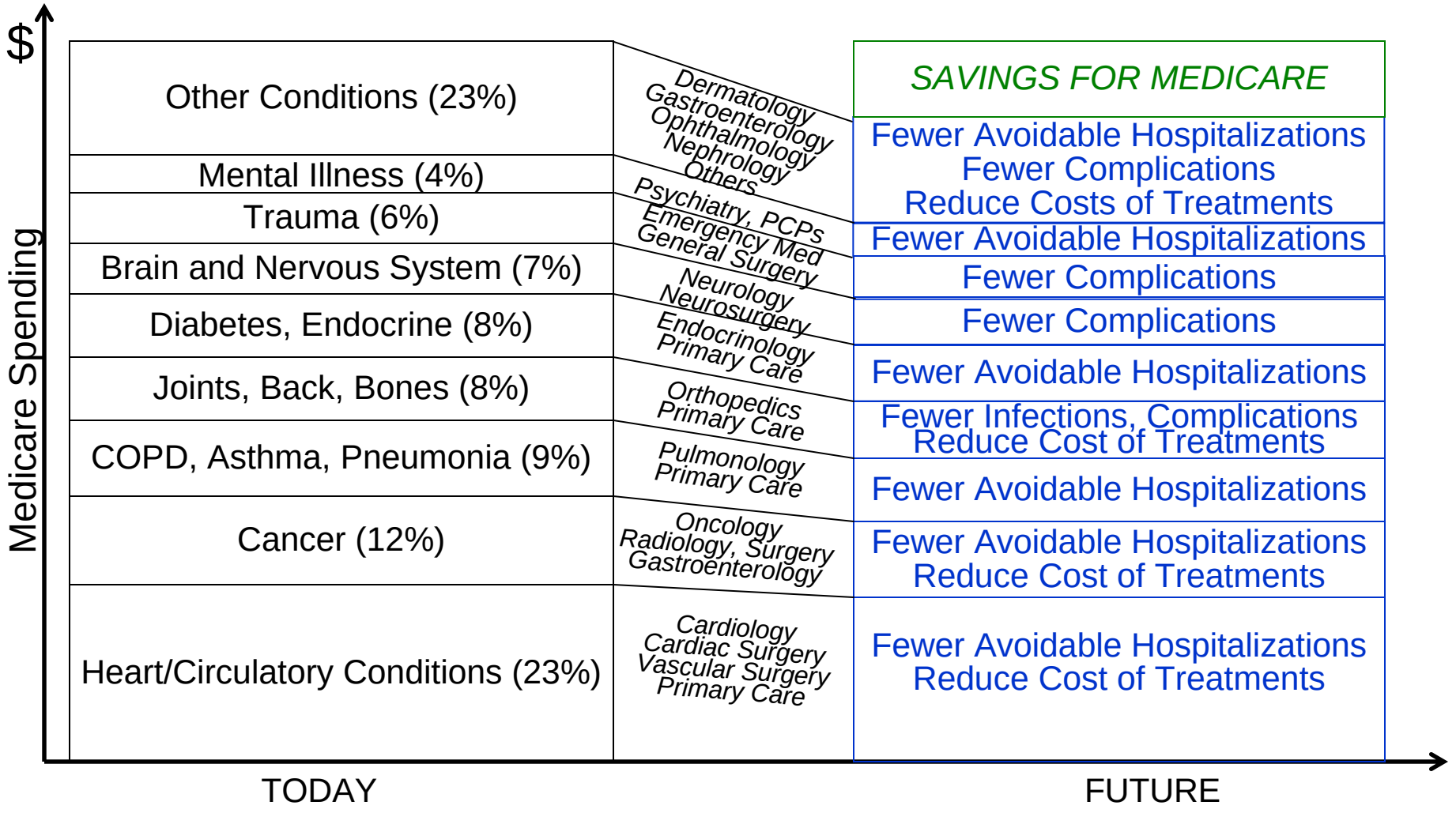
There Are Win-Win-Win Solutions Through Better Payment Systems

	Opportunities to Improve Care and Reduce Cost	Barriers in Current Payment System	Solutions via Accountable Payment Models
Cardiology	• Use less invasive and expensive procedures when appropriate	• Payment is based on which procedure is used, not the outcome for the patient	• Condition-based payment covering CABG, PCI, or medication management
Orthopedic Surgery	• Reduce infections and complications • Use less expensive post-acute care following surgery	• No flexibility to increase inpatient services to reduce complications & post-acute care	• Episode payment for hospital and post-acute care costs with warranty
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
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

Examples from Other Specialties

	Opportunities to Improve Care and Reduce Cost	Barriers in Current Payment System	Solutions via Accountable Payment Models
Neurology	• Avoid unnecessary hospitalizations for epilepsy patients • Reduce strokes and heart attacks after TIA	• No flexibility to spend more on preventive care • No payment to coordinate w/ cardio	• Condition-based payment for epilepsy • Episode or condition-based payment for TIA
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 anti-emetic drug costs	• No flexibility to spend more on preventive care • Payment based on office visits, not outcomes	• Condition-based payment including non-oncolytic Rx and ED/hospital utilization
Radiology	• Reduce use of high-cost imaging • Improve diagnostic speed & accuracy	• Low payment for reading images & penalty for 2x • Inability to change inapprop. orders	• Global payment for imaging costs • Partnership in condition-based payments

To Control Total Spending, All Specialties Must Be Engaged



Should Physicians Fear the Risks of Accountable Payment Models?

Risks Under Payment Reform

- Will the bundled payment be adequate to cover the services patients need?
- Will risk adjustment be adequate to control for differences in need?
- How will you control the costs of other providers involved in the care in the bundled payment?
- What portion of payments will be withheld based on quality measures?
- Will you have enough patients to cover the costs of managing the new payment?

It's Not *More* Risk Than Today, It's Just *Different* Risk

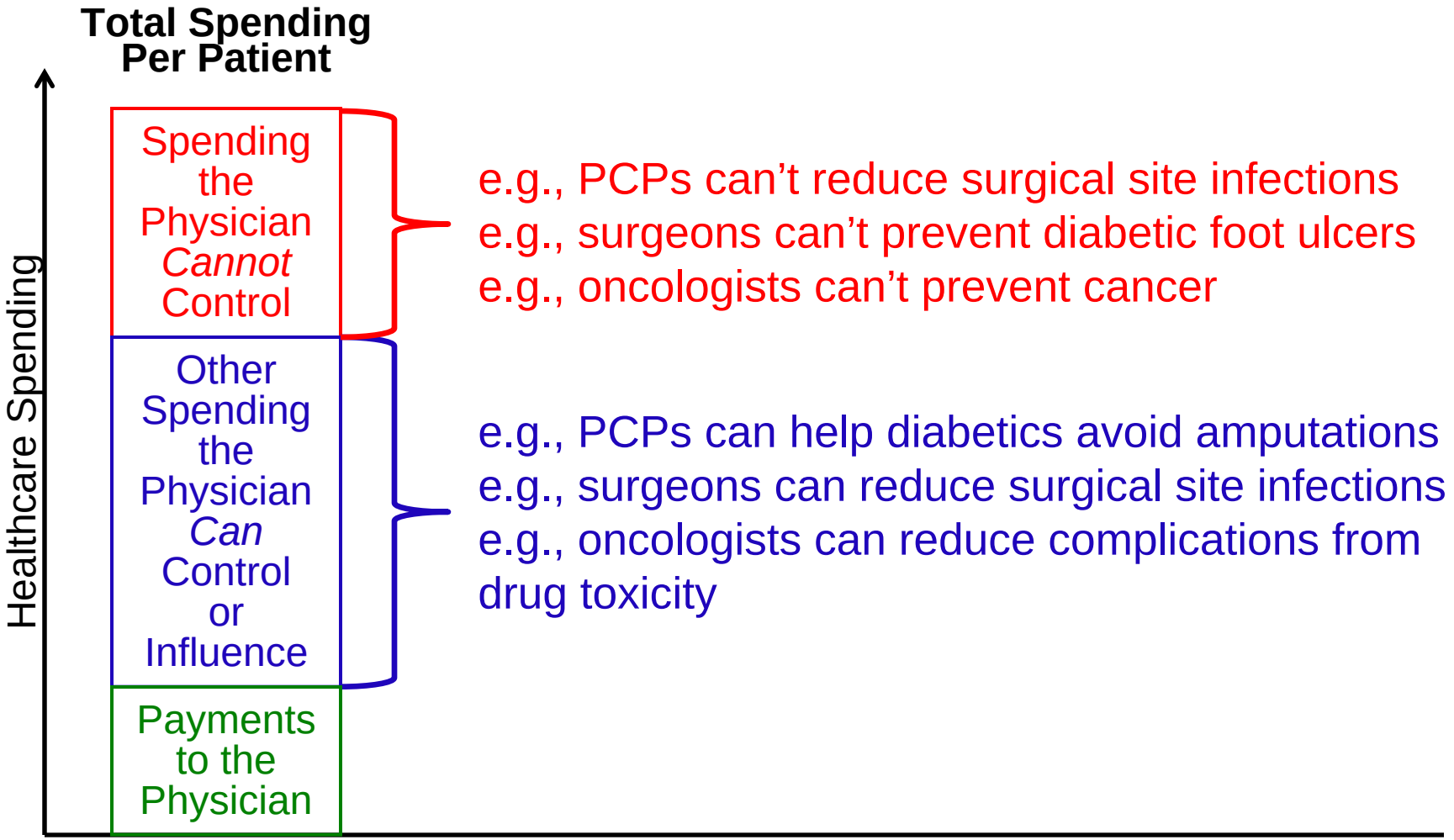
Risks Under FFS

- Will fee levels from payers be adequate to cover the costs of delivering services?
- What utilization controls will payers impose on your services?
- What "value-based" reductions will be made in your payments based on "efficiency" measures?
- What "value-based" reductions will be made in your fees based on quality measures?
- Will you have enough patients to cover your practice expenses?

Risks Under Payment Reform

- Will the bundled payment be adequate to cover the services patients need?
- Will risk adjustment be adequate to control for differences in need?
- How will you control the costs of other providers involved in the care in the bundled payment?
- What portion of payments will be withheld based on quality measures?
- Will you have enough patients to cover the costs of managing the new payment?

Accountability Must Be Focused on What Each Physician Can Influence



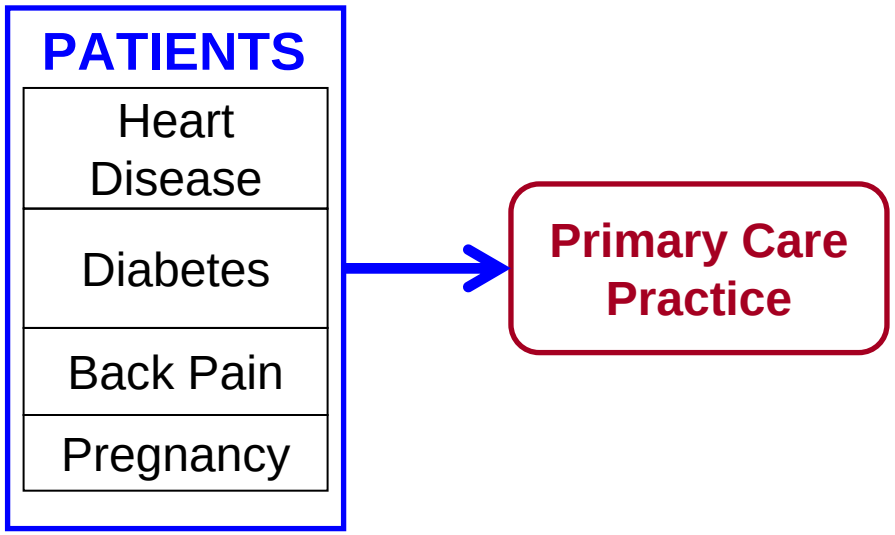
Protections For Providers Against Taking Inappropriate Risk

- **Risk Adjustment:** The payment rates to the provider would be adjusted based on objective characteristics of the patient and treatment that would be expected to result in the need for more services or increase the risk of complications.
- **Outlier Payment or Individual Stop Loss Insurance:** The payment to the provider from the payer would be increased if spending on an individual patient exceeds a pre-defined threshold. An alternative would be for the provider to purchase individual stop loss insurance (sometimes referred to as reinsurance) and include the cost of the insurance in the payment bundle.
- **Risk Corridors or Aggregate Stop Loss Insurance:** The payment to the provider would be increased if spending on all patients exceeds a pre-defined percentage above the payments. An alternative would be for the provider to purchase aggregate stop loss insurance and include the cost of the insurance in the payment bundle.
- **Adjustment for External Price Changes:** The payment to the provider would be adjusted for changes in the prices of drugs or services from other providers that are beyond the control of the provider accepting the payment.
- **Excluded Services:** Services the provider does not deliver, or order, or otherwise have the ability to influence would not be included as part of accountability measures in the payment system.

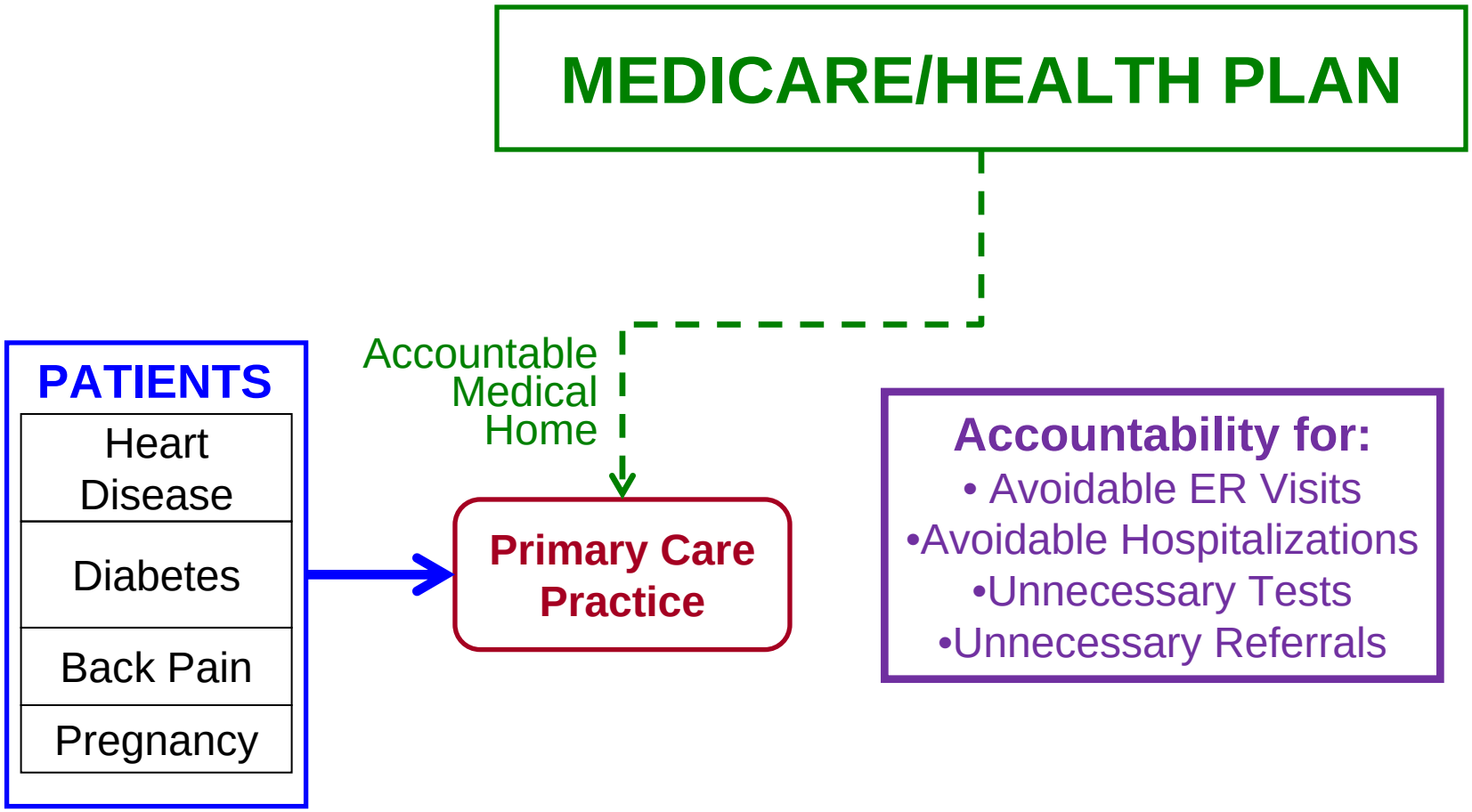
How Does This All Fit Into ACOs?

PATIENTS
Heart Disease
Diabetes
Back Pain
Pregnancy

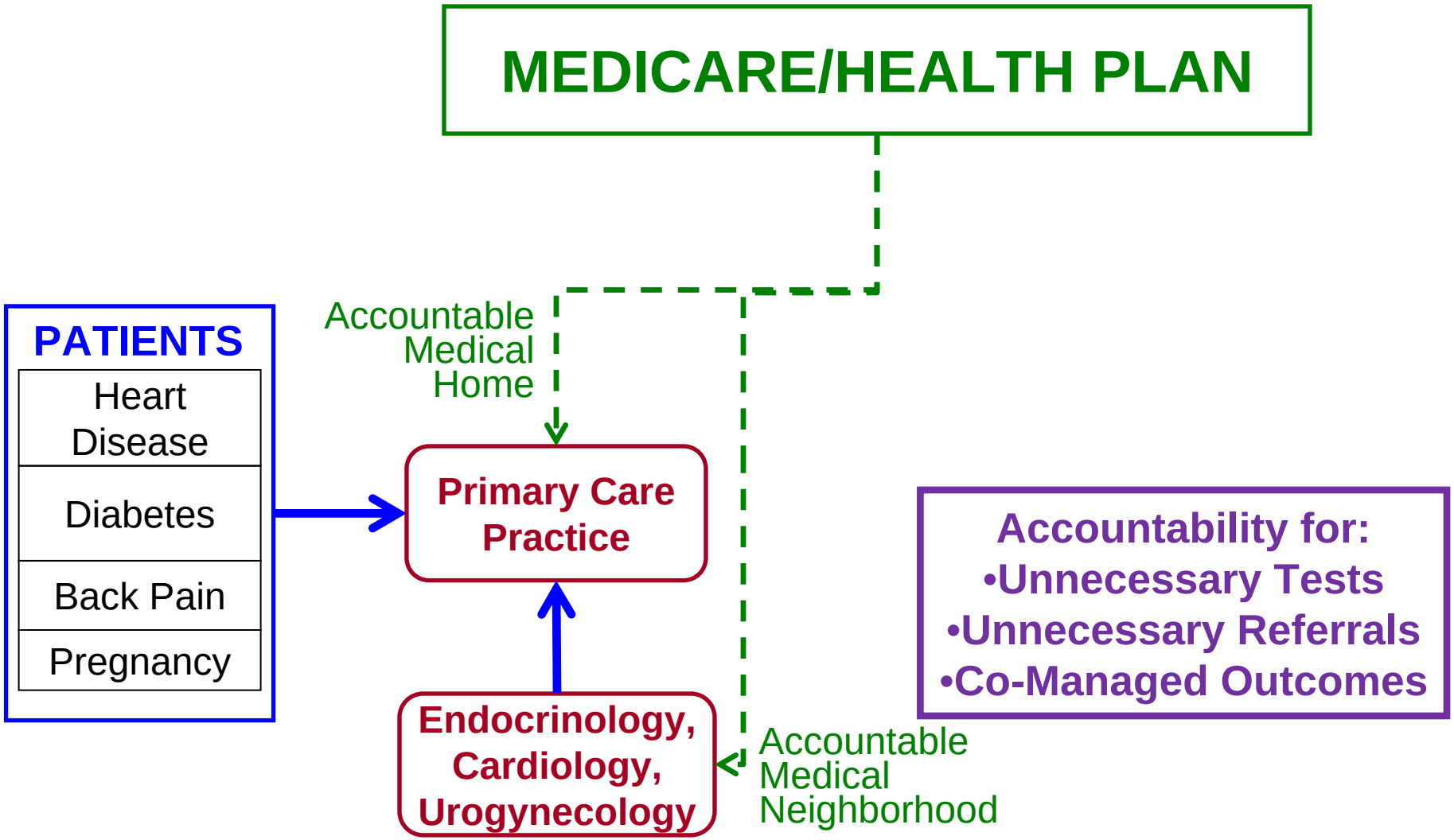
Each Patient Should Choose & Use a Primary Care Practice…



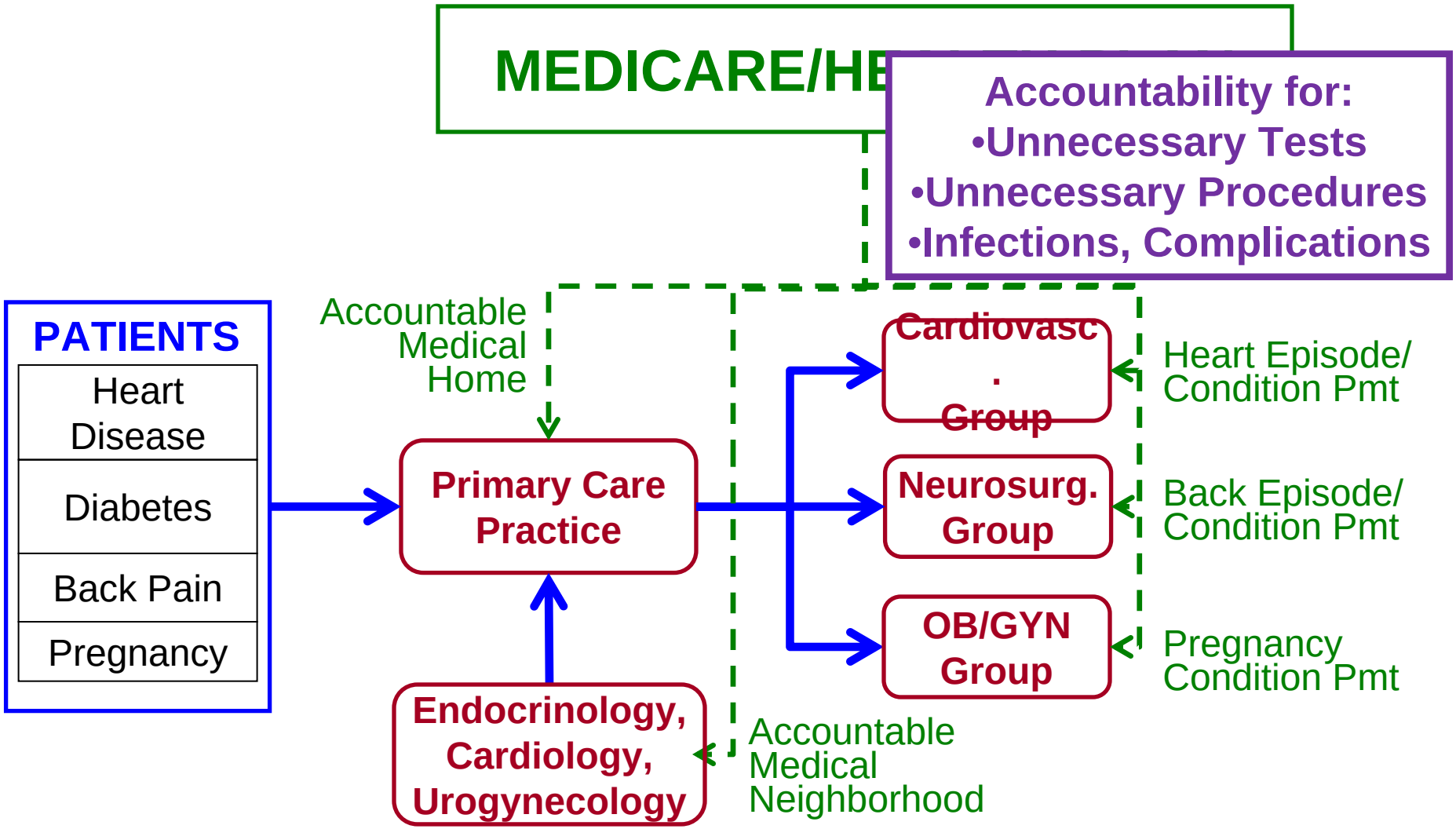
…Which Takes Accountability for What PCPs Can Control/Influence



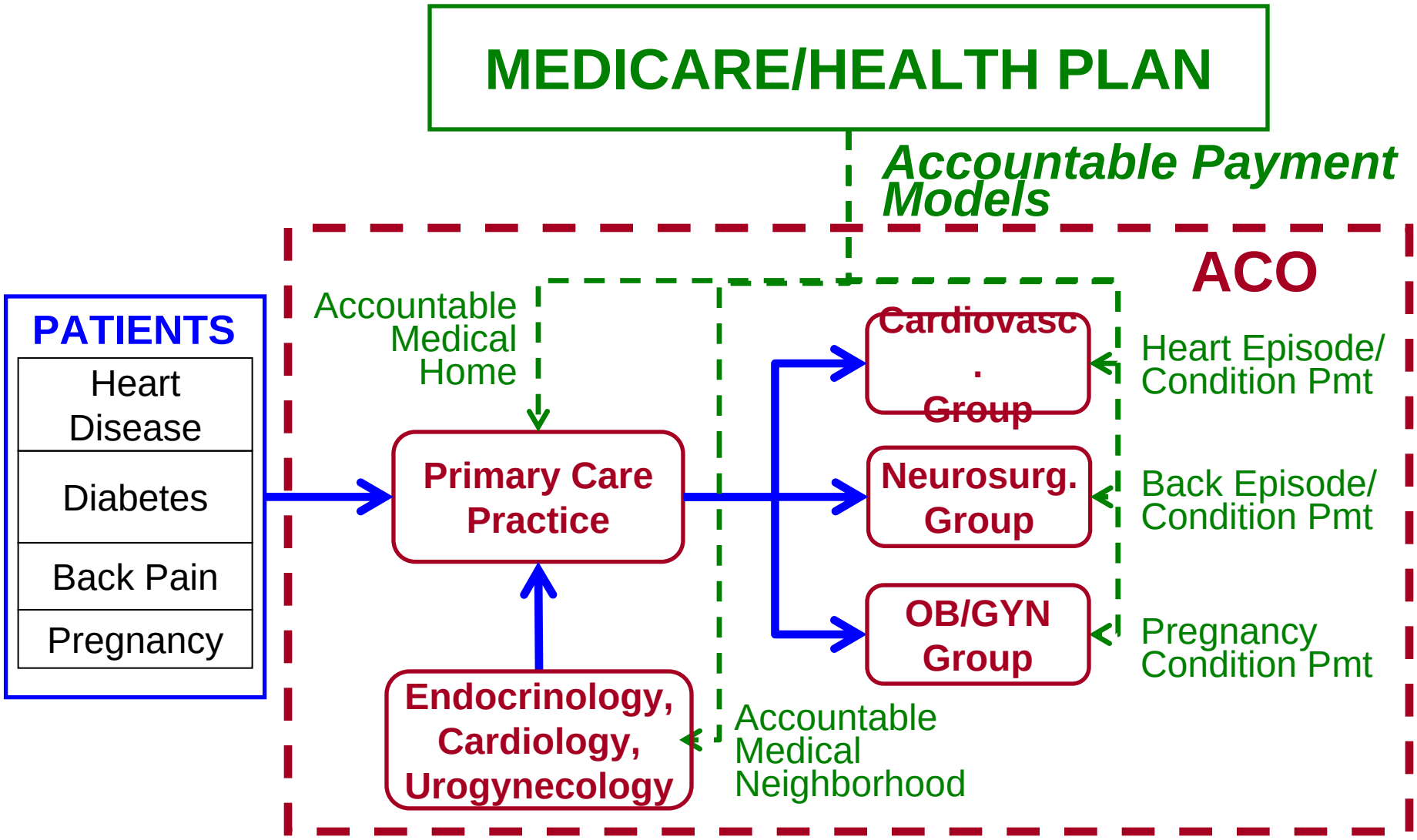
…With a Medical Neighborhood to Consult With on Complex Cases



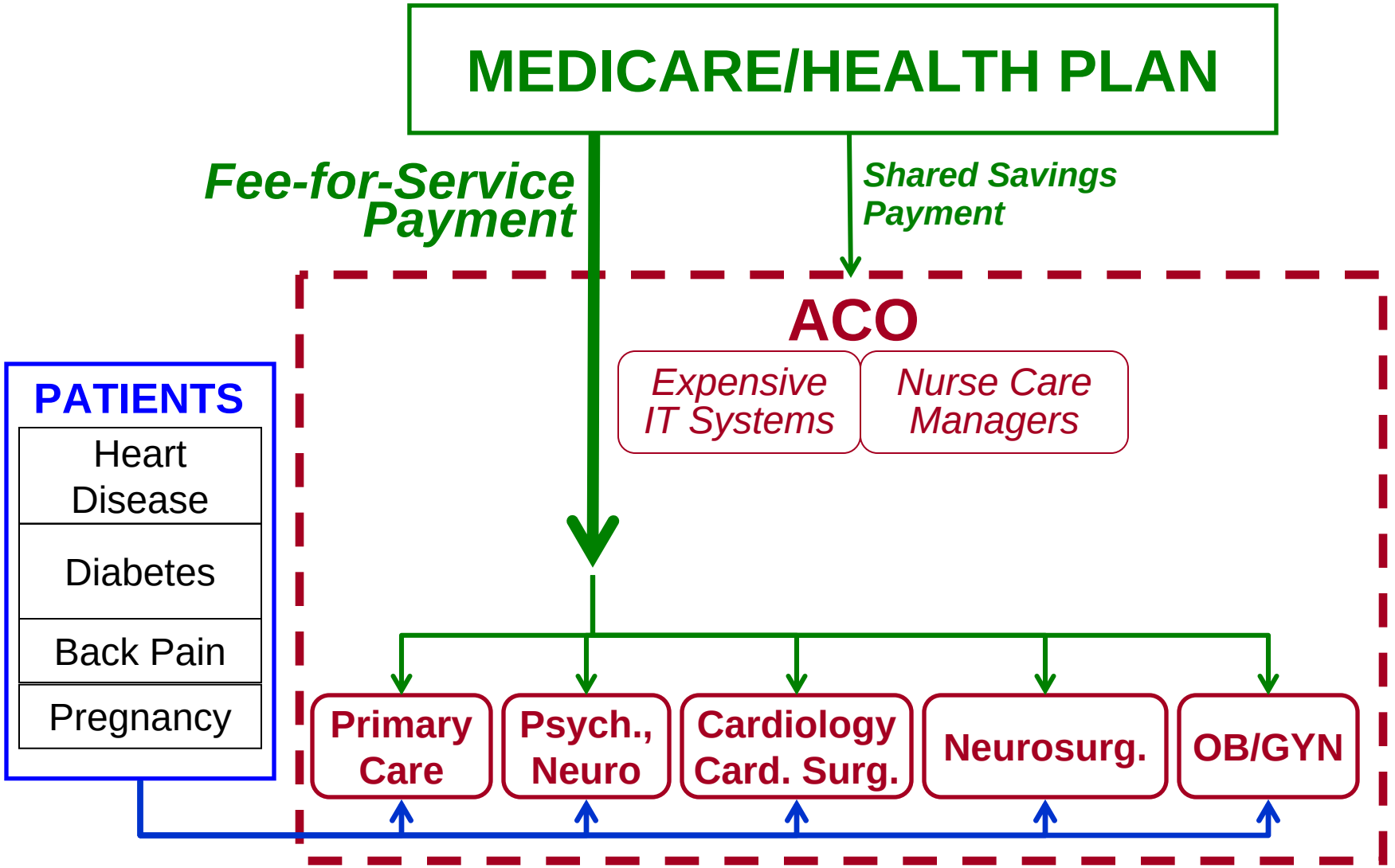
..And Specialists Accountable for the Conditions They Manage



That's Building the ACO from the Bottom Up



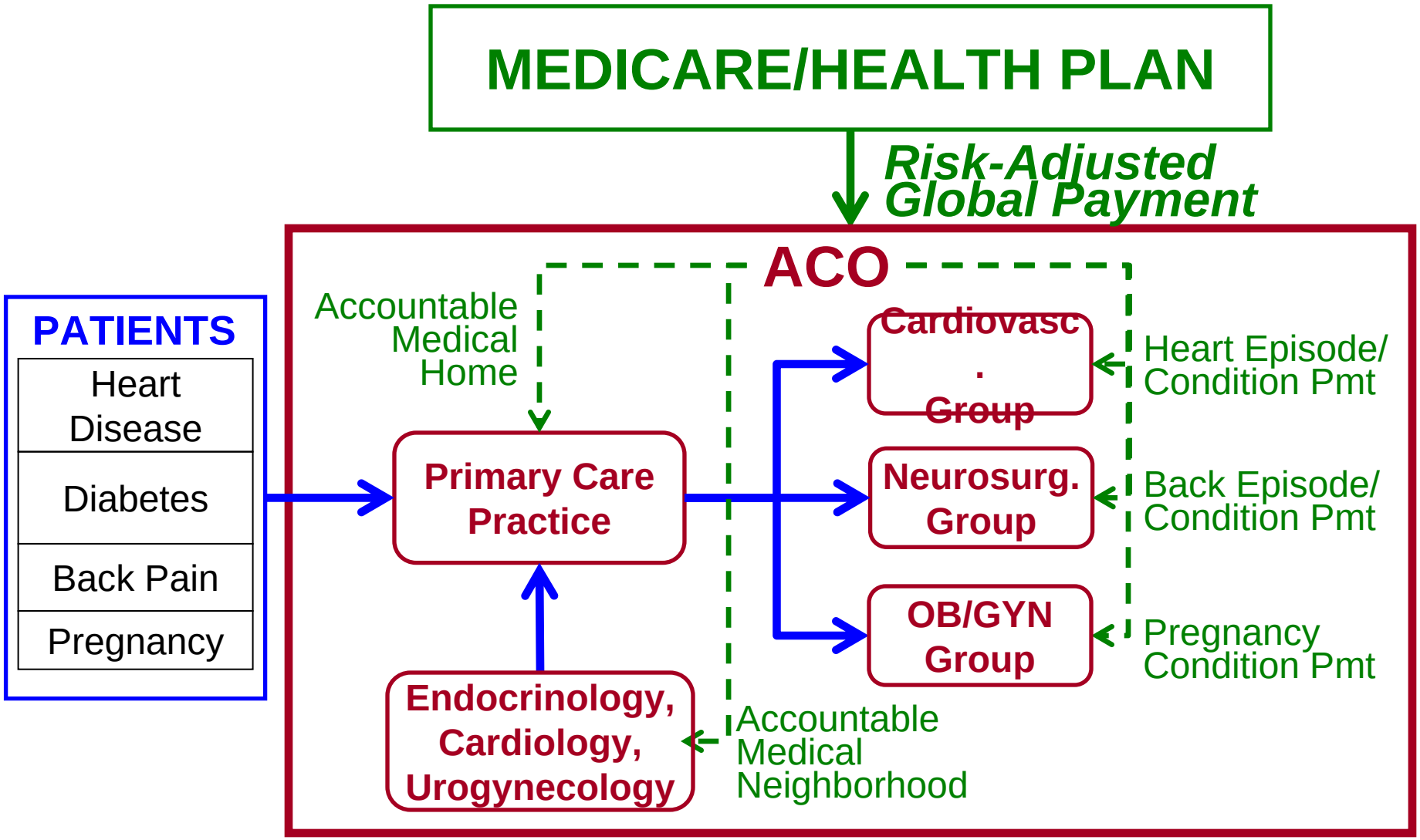
Most ACOs Today Aren't Truly *Reinventing Care*



It Hasn't Been Working Too Well in Medicare So Far

- Of the 109 Track 1 (Upside Only) ACOs that started in 2012:
  - 57 (52%) Track 1 ACOs did not achieve savings in 2013
  - 25 (23%) Track 1 ACOs achieved savings, but not enough to receive shared savings payments
  - 27 (25%) Track 1 ACOs received shared savings payments
- Of the 5 Track 2 (Downside Risk) ACOs that started in 2012:
  - 2 (33%) Track 2 ACOs received shared savings payments
  - 3 (67%) Track 2 ACOs had to repay a share of losses to CMS

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



Example: BCBS MA Alternative Quality Contract

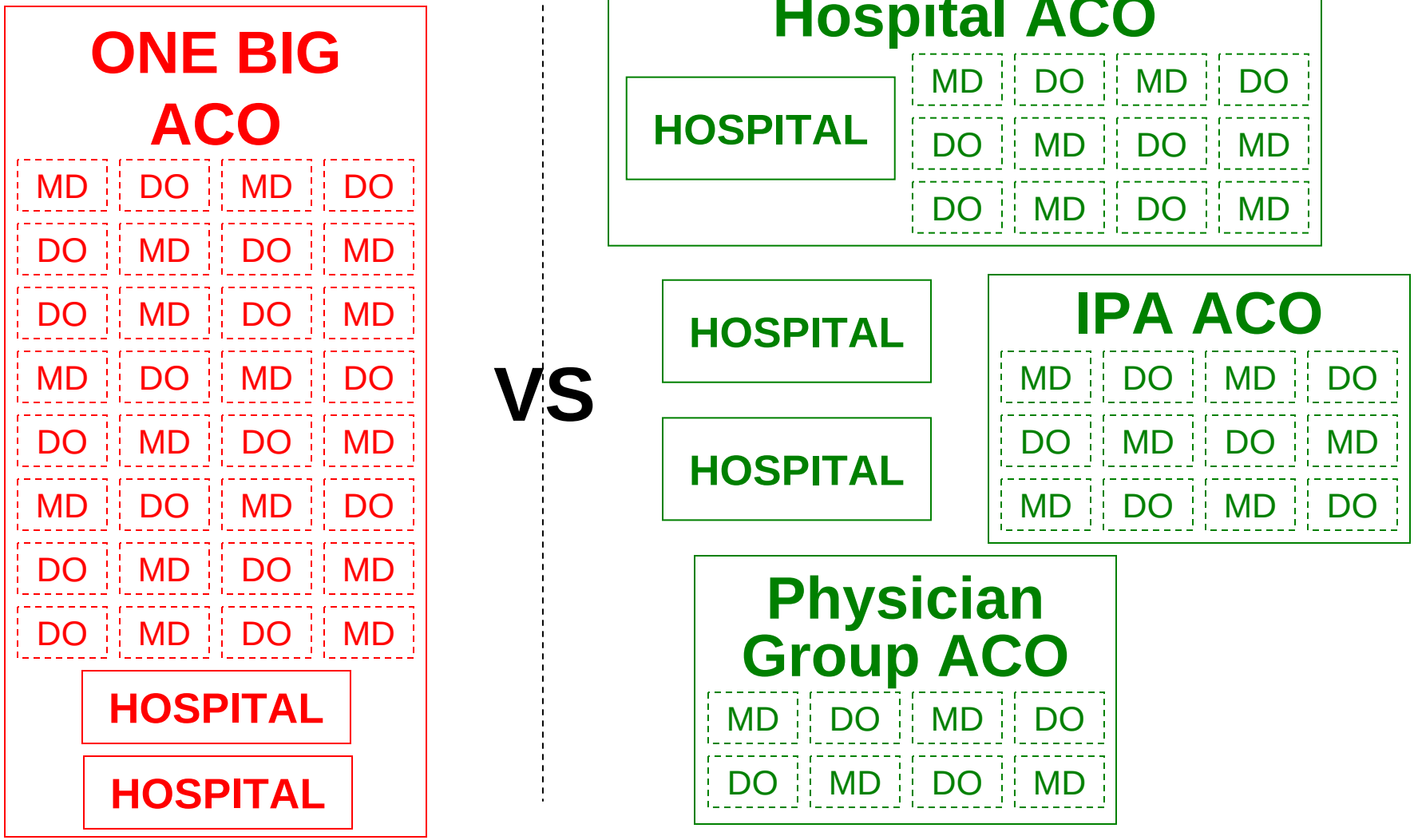
- Single payment for all costs of care for a population of patients
  - Adjusted up/down annually based on severity of patient conditions
  - Initial payment set based on past expenditures, not arbitrary estimates
  - Provides flexibility to pay for new/different services
  - Bonus paid for high quality care
- Five-year contract
  - Savings for payer achieved by controlling increases in costs
  - Allows provider to reap returns on investment in preventive care, infrastructure
- Broad participation
  - 14 physician groups/health systems participating with over 400,000 patients, including one primary care IPA with 72 physicians
- Better care at lower cost
  - Higher ambulatory care quality than non-AQC practices, better patient outcomes, lower readmission rates and ER utilization, lower costs

http://www.bluecrossma.com/visitor/about-us/making-quality-health-care-affordable.html

You Don't Need a Big Health System to Manage Global Payment

- Independent PCPs & Specialists Managing Global Payments
  - Northwest Physicians Network (NPN) in Tacoma, WA is an IPA with 109 PCPs and 345 specialists in 165 practices (average size: 2.4 MDs/practice). NPN accepts full or partial risk capitation contracts, operates its own Medicare Advantage plan, and does third party administration for self-insured businesses. www.npnwa.net
  - North Texas Specialty Physicians, a 600 physician multi-specialty IPA in Fort Worth, set up its own Medicare Advantage PPO plan and uses revenues from the health plan and capitation contracts to pay its PCPs 250% of Medicare rates and provides high quality, coordinated care to patients. www.ntsp.com
- Joint Contracting by MDs & Hospitals for Global Payments
  - The Mount Auburn Cambridge IPA (MACIPA) and Mount Auburn Hospital jointly contract with three major Boston-area health plans for full-risk capitation. The IPA is independent of the hospital; they coordinate care with each other without any formal legal structure. www.macipa.com

Which Is More Likely to Generate True Price Competition?



Does Global Payment Require Patients to Lock-In to an HMO?

- BCBS of Massachusetts Alternative Quality Contract, California delegated model, and other global payment structures are only used for HMO benefit designs requiring PCPs to serve as gatekeepers.
- Patients don’t want HMO gatekeeping
- Can global payment work in a PPO structure?

What Do Other Industries Do?

What the HMO Model Would Look Like in the Auto Industry

HMO Model

Purchasing a Car

- If you buy your car at our dealership, you can only get it repaired here

What Consumers Want, and Get

HMO Model

Purchasing a Car

•If you buy your car at our dealership, you can only get it repaired here

What Consumers Expect

Purchasing a Car

•Buy your car at our dealership and get it serviced wherever you can get the best service and price

What the HMO Model Would Look Like in the Airline Industry

HMO Model

Purchasing a Car

•If you buy your car at our dealership, you can only get it repaired here

Traveling by Air

•To buy a ticket on this flight from us, you have to buy all your flights on this airline for the next year

What Consumers Expect

Purchasing a Car

•Buy your car at our dealership and get it serviced wherever you can get the best service and price

What Consumers Want, and Get

HMO Model

Purchasing a Car

•If you buy your car at our dealership, you can only get it repaired here

Traveling by Air

•To buy a ticket on this flight from us, you have to buy all your flights on this airline for the next year

What Consumers Expect

Purchasing a Car

•Buy your car at our dealership and get it serviced wherever you can get the best service and price

Traveling by Air

•Buy a ticket for this flight with us, and decide next time who to fly with

What the HMO Model Would Look Like in Bookstores

HMO Model

Purchasing a Car

•If you buy your car at our dealership, you can only get it repaired here

Traveling by Air

•To buy a ticket on this flight from us, you have to buy all your flights on this airline for the next year

Buying a Book

•You can only buy a book at our store if you give up the right to buy a book anywhere else, and you can only read what we tell you

What Consumers Expect

Purchasing a Car

•Buy your car at our dealership and get it serviced wherever you can get the best service and price

Traveling by Air

•Buy a ticket for this flight with us, and decide next time who to fly with

What Consumers Want, and Get

HMO Model

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Buying a Book

•You can only buy a book at our store if you give up the right to buy a book anywhere else, and you can only read what we tell you

What Consumers Expect

Purchasing a Car

•Buy your car at our dealership and get it serviced wherever you can get the best service and price

Traveling by Air

•Buy a ticket for this flight with us, and decide next time who to fly with

Buying a Book

•Buy a book at Amazon today (no matter how trashy it is), and go elsewhere next time if you're not happy

Does That Mean Consumers Want Fragmented Service?

What the PPO Model Would Look Like in the Auto Industry

PPO Model

Purchasing a Car

•Buy our parts kit and assemble the car yourself. Call your auto insurance company for advice about how to connect the engine and transmission, if you can get through. They'll pay for your injuries if the brakes fail to work.

What Consumers Want, and Get

PPO Model

Purchasing a Car

•Buy our parts kit and assemble the car yourself. Call your auto insurance company for advice about how to connect the engine and transmission, if you can get through. They'll pay for your injuries if the brakes fail to work.

What Consumers Expect

Purchasing a Car

•If the car you buy here doesn't work, bring it back and we'll fix it free of charge. Major parts are guaranteed for many years. Basic maintenance is your responsibility, though.

What the PPO Model Would Look Like in the Airline Industry

PPO Model

Purchasing a Car

•Buy our parts kit and assemble the car yourself. Call your auto insurance company for advice about how to connect the engine and transmission, if you can get through. They'll pay for your injuries if the brakes fail to work.

Traveling by Air

•Buy plane tickets for each segment separately and hope the schedules don't change. Make sure you have an apartment in Chicago where you can stay when your flights don't connect.

What Consumers Expect

Purchasing a Car

•If the car you buy here doesn't work, bring it back and we'll fix it free of charge. Major parts are guaranteed for many years. Basic maintenance is your responsibility, though.

What Consumers Want, and Get

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Traveling by Air

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What Consumers Expect

Purchasing a Car

•If the car you buy here doesn't work, bring it back and we'll fix it free of charge. Major parts are guaranteed for many years. Basic maintenance is your responsibility, though.

Traveling by Air

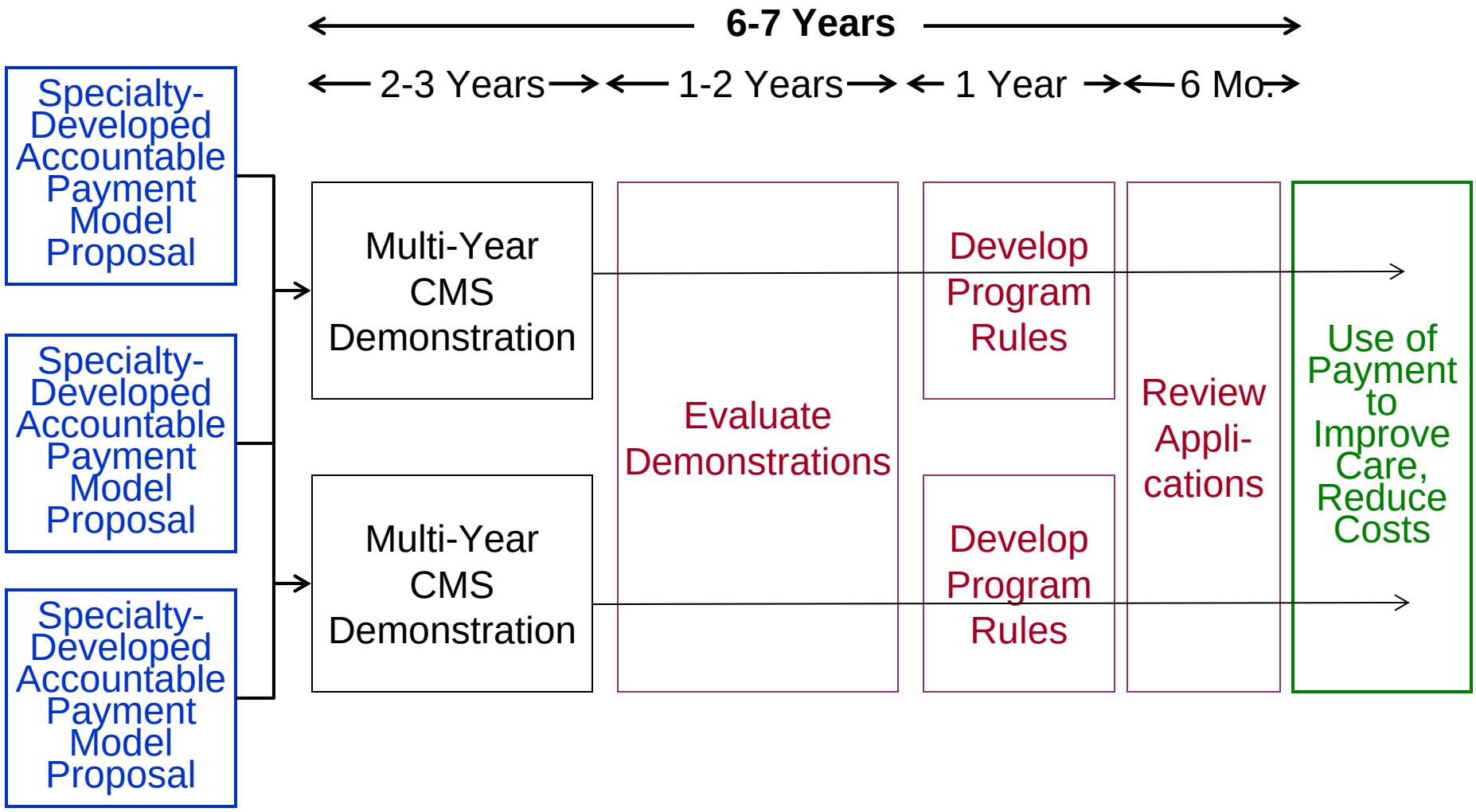
•Buy a single ticket for the whole trip, with guaranteed rebooking if there's a misconnect. We'll book you on another airline if necessary to get you there as soon as possible.

What Would a *Patient-Centered* ACO Look Like?

- The patient (and their employer) gets a 90 day money-back guarantee if they choose the ACO
- The ACO helps the patient find a primary care physician with the type of access, team, cultural competence, and personality the patient will be most comfortable with
- The PCP and ACO immediately work to welcome the patient and design a plan of care to match the patient's needs and preferences, and it regularly solicits feedback on performance
- If the patient has a specific health problem, the PCP & ACO commit to get the patient the *best care* for that problem at the *lowest cost*, *even if that is not from a provider in the ACO*
  - The ACO provides the patient with comparative information on the quality and cost of the ACO physicians and providers compared to all other providers (rather than forcing the patient to search the internet)
  - If the patient chooses a non-group provider, the patient will pay the difference in cost unless the other provider's quality is better
- The ACO pays physicians to manage the patient's conditions effectively, not based on office visits or procedures

How Long Will It Take to Get True Payment Reform in Place?

Everyone Wants to "Test" Models, Which Will Take Forever…



…And "Testing" May Not Convince Anyone Anyway

- Demonstrations and Pilots will not result in significant or rapid change or accurately predict future results
  - Physicians and hospitals are unlikely to fundamentally redesign care for temporary payment changes
  - Good or bad results for demonstration providers do not guarantee results for other providers in other communities

Testing Has Not Been Used in the Past for Major Payment Reforms

- Demonstrations and Pilots will not result in significant or rapid change or accurately predict future results
  - Physicians and hospitals are unlikely to fundamentally redesign care for temporary payment changes
  - Good or bad results for demonstration providers do not guarantee results for other providers in other communities
- Most major Medicare payment systems have been implemented without formal demonstrations and evaluations in advance
  - DRGs were implemented in 14 months after Congress required them, with no prior testing
  - RBRVS was phased in over a 5 year period with no prior testing
  - OPPS was implemented with no prior testing

Instead, Allow Providers to Voluntarily Implement Reforms

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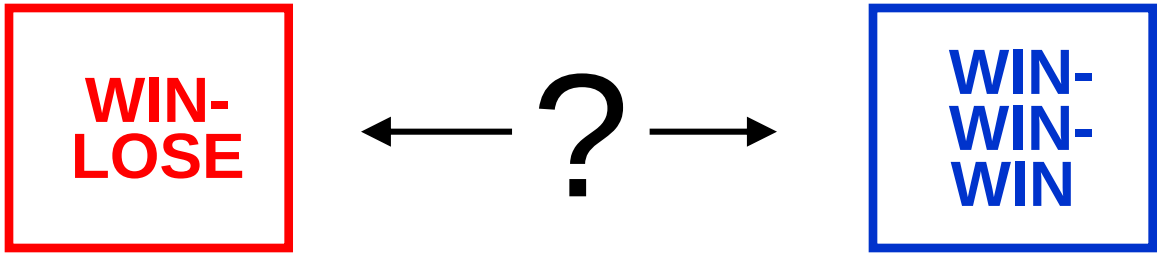
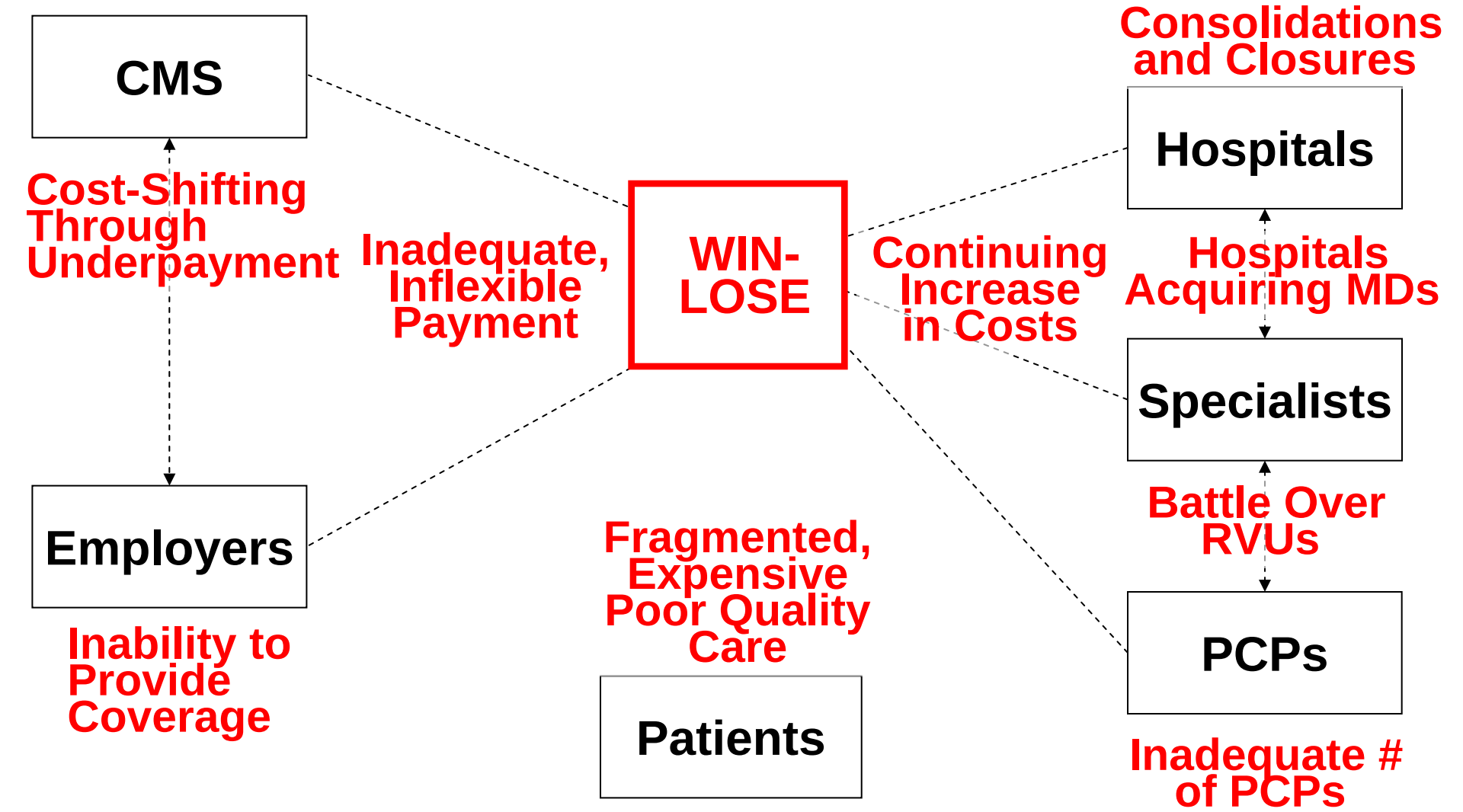
  - DRGs were implemented in 14 months after Congress required them, with no prior testing
  - RBRVS was phased in over a 5 year period with no prior testing
  - OPPS was implemented with no prior testing
- Instead of testing and evaluating, implement better payment models with willing providers and evolve over time
  - Allow “pioneers” to be paid differently without forcing everyone in
  - Provide short-run protections against big swings in revenue
  - Improve payment design, risk adjustment, etc. over time
  - Additional providers can join as they see the benefits

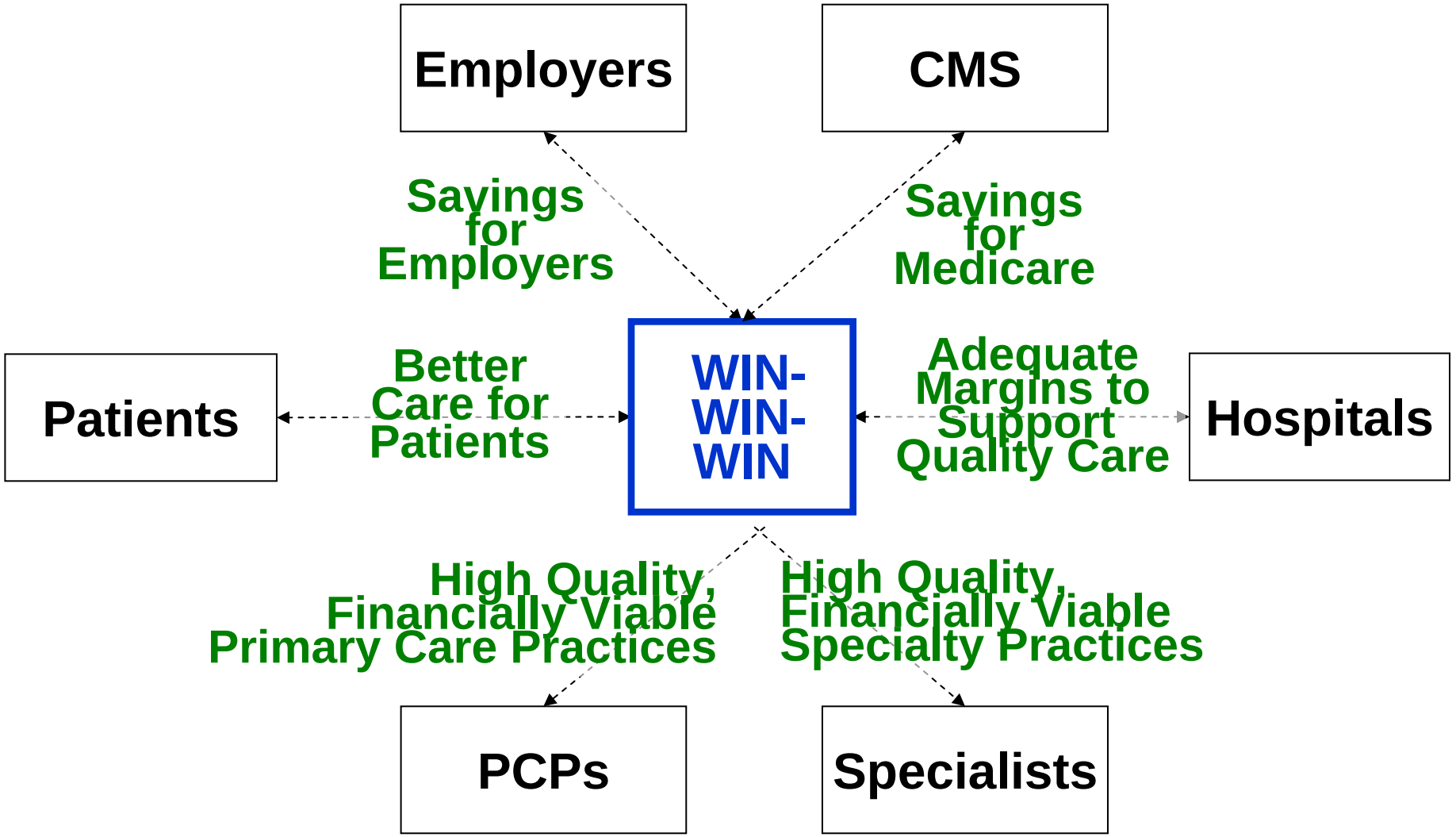
Which Way Will The Nation Go?



Instead of Win-Lose Approaches That Ultimately Harm Patients…



…We Need Collaboration That Benefits All Stakeholders



What Can You Do?

OPTION 1:

- Attend conferences, listen to PowerPoint presentations, and pay or deliver care the same way you always have.

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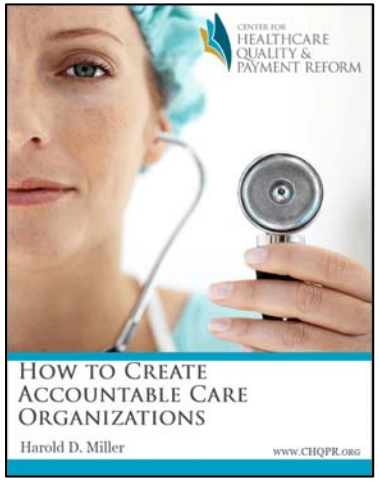
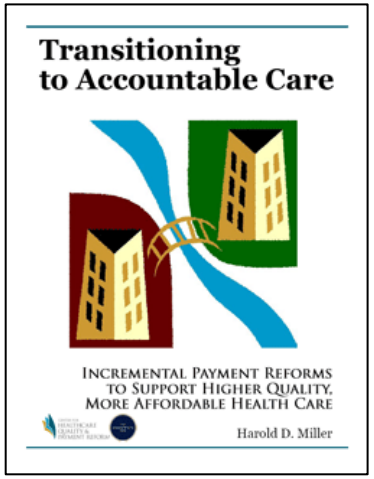
- Attend conferences, listen to PowerPoint presentations, and pay or deliver care the same way you always have.

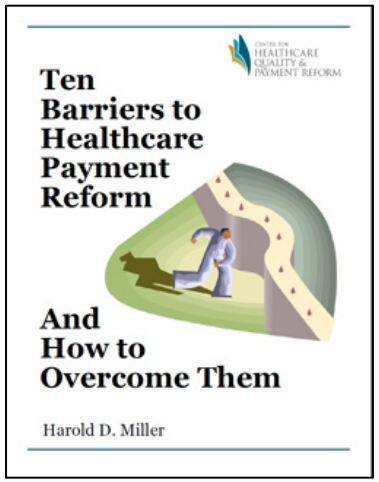
OPTION 2:

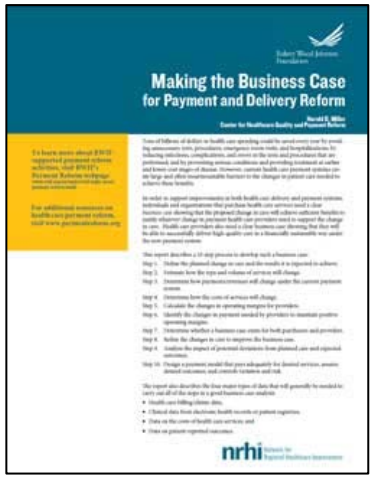
- Collaborate with the physicians, hospitals, employers, health plans, and other stakeholders in your communities to:
  - Identify ways to improve care and reduce costs
  - Develop the business case for a win-win-win approach
  - Change payment systems and benefit designs needed to support the changes in care delivery
  - Monitor implementation and make adjustments as needed to ensure win-win-win results
- Ask a neutral organization, like IHA and other members of the Network for Regional Healthcare Improvement (NRHI), to facilitate the discussions and help provide the data needed to identity and quantify opportunities.

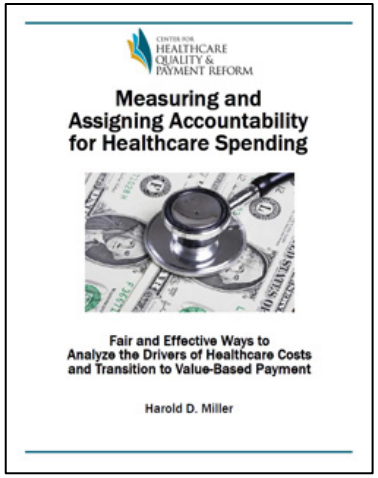
Learn More About Win-Win-Win Payment and Delivery Reform











Center for Healthcare Quality and Payment Reform
www.PaymentReform.org

For More Information:

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Center for Healthcare Quality and Payment Reform

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(412) 803-3650

www.CHQPR.org
www.PaymentReform.org

How Do You Develop Win-Win-Win Solutions?

Four Steps to Develop Win-Win-Win Solutions

1. **Defining the Change in Care Delivery**
   - How can care be redesigned to improve quality and reduce costs?

Best Way to Find Savings Opportunities? Ask Physicians

"I have zero control over utilization or studies ordered. I don't get paid for calling a referring doctor and telling him/her the imaging test is worthless."
Radiologist in Maine

"I strongly suspect overutilization of abdominal CT scans in the ER and in the hospital; CT scans lead to further CT scans to follow up lung and adrenal nodules. The hospital focuses on length of stay, but never looks at appropriateness of radiologic studies."
Internist at AMA HOD Meeting

"Patients often need to be in extended care to receive antibiotics because Medicare doesn't pay for home IV therapy. Patient stays in the hospital for 3 days to justify a nursing home/rehab stay."
Orthopedist at AMA HOD Meeting

"I do many unnecessary colonoscopies on young men. Give every PCP an anuscope to allow diagnosis of bleeding hemorrhoids in the office."
Gastroenterologist in Maine

Four Steps to Develop Win-Win-Win Solutions

1. **Defining the Change in Care Delivery**
   - How can care be redesigned to improve quality and reduce costs?
2. **Analyzing Expected Costs and Savings**
   - What will there be less of, and how much does that save?
   - What will there be more of, and how much does that cost?
   - Will the savings offset the costs on average?

A Critical Element is Shared, Trusted Data

- **Physician/Hospital** need to know the current utilization and costs for their patients to know whether the new payment model will cover the costs of delivering effective care to the patients
- **Purchaser/Payer** needs to know the current utilization and costs to know whether the new payment model is a better deal than they have today
- **Both** sets of data have to match in order for providers and payers to agree on the new approach!

Four Steps to Develop Win-Win-Win Solutions

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3. **Designing a Payment Model That Supports Change**
   - Flexibility to change the way care is delivered
   - Accountability for costs and quality/outcomes related to care
   - Adequate payment to cover lowest-achievable costs
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   - Protection for the provider from insurance risk
4. **Designing an Appropriate Internal Compensation System**
   - Changing payment to the provider *organization* does not automatically change compensation to *physicians*

California Physicians Have Solved This By Not Taking FFS, Right?

Medicare/ Health Plan

↓

FFS + Attribution for Spending

↓

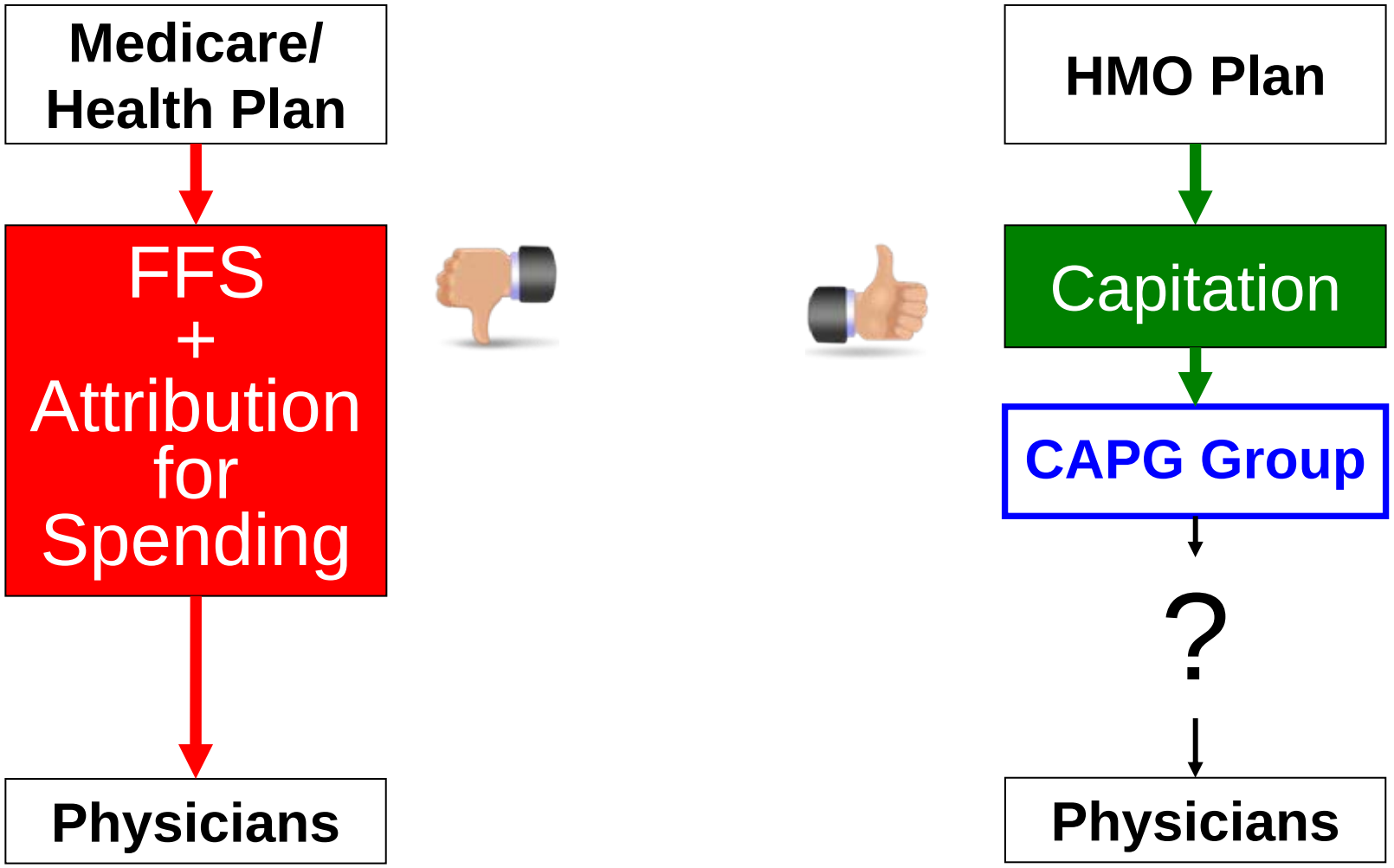
Physicians

HMO Plan

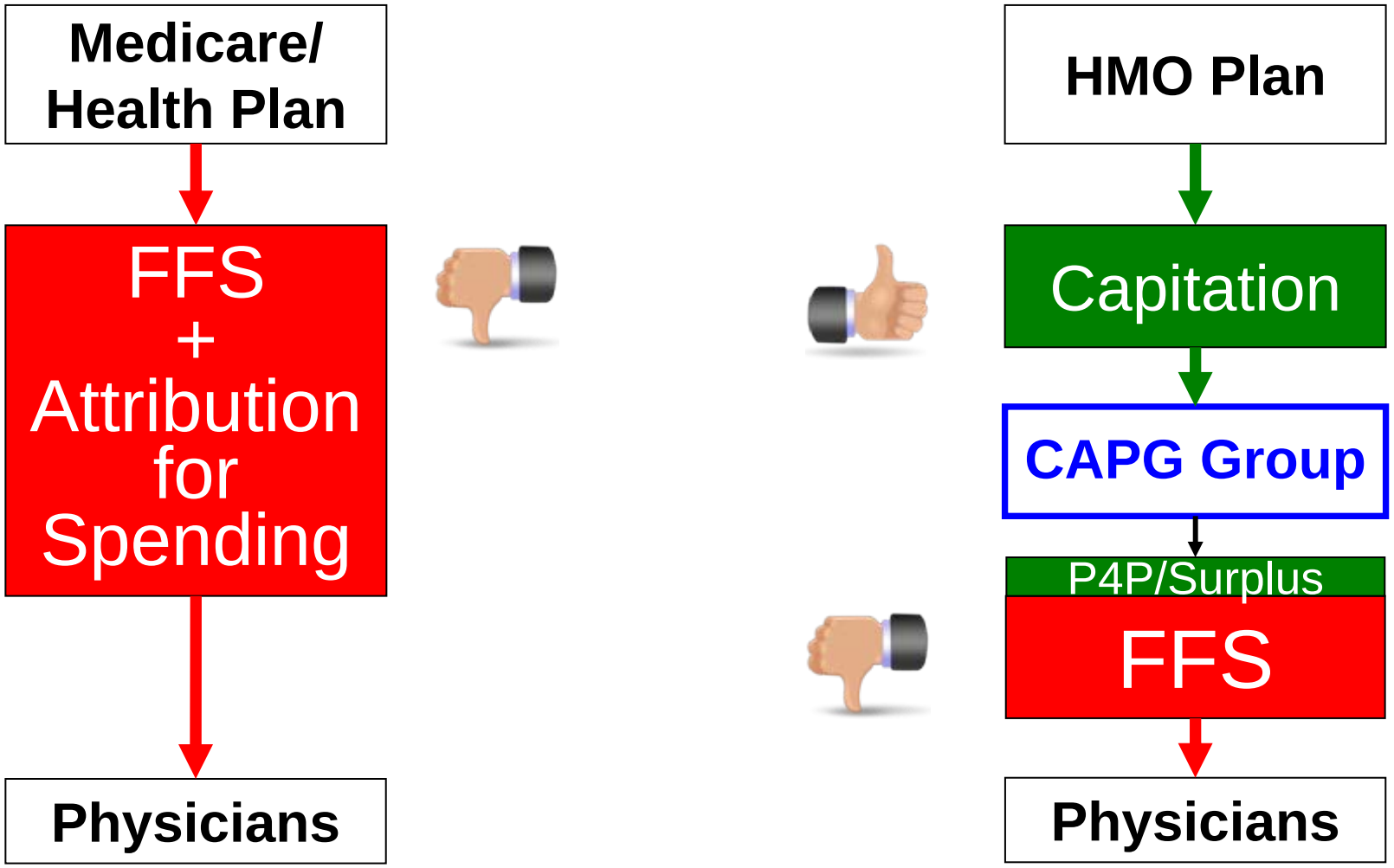
↓

Capitation

How Do the Individual Doctors Get Paid in Capitation?



CAPG Groups Pay Most Docs FFS ("RVUs") + A Little P4P



So EVERYBODY Is Still Paying Physicians Fee for Service