CREATING A PATIENT-CENTERED PAYMENT SYSTEM

Better Care for Patients, Lower Healthcare Spending, & Financially Viable Physician Practices & Hospitals

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

www.CHQPR.org

A Brief Quiz about Value-Based Payment

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#1: What bonus will a Track 1 ACO receive if 100% of attributed beneficiaries receive ALL recommended preventive care?

- 5% of total spending
- 2% of total spending
- $100 per beneficiary
- $0

A Brief Quiz about Value-Based Payment

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- 5% of total spending
- 2% of total spending
- $100 per beneficiary
- $0

Answer: **$0**

There are no bonuses for ACOs based on quality.

ACOs only receive bonus payments if they reduce Medicare spending.

A Brief Quiz about Value-Based Payment

#2: What penalty will be imposed on a two-sided risk ACO if 1/3 of its diabetic patients have blood sugar levels worse than the maximum recommended level (HbA1c >9%)?

- Loss of 10% of shared savings
- Loss of 2% of shared savings
- Repay CMS $95 per diabetic beneficiary
- $0

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- Loss of 2% of shared savings
- Repay CMS $95 per diabetic beneficiary
- $0

Answer: **$0**

An ACO can receive a perfect score on quality and receive 100% of earned shared savings even if 40% of patients with diabetes have HbA1c levels >9%.

A Brief Quiz about Value-Based Payment

#3: If oncologists fail to deliver evidence-based treatment to patients who have lung cancer, which Alternative Payment Model would impose the biggest financial penalty?

- Track 1 (Upside-only) MSSP ACOs
- Track 2-3 (Two-sided risk) MSSP ACOs
- Next Generation ACO
- Oncology Care Model (OCM)

A Brief Quiz about Value-Based Payment

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- Track 2-3 (Two-sided risk) MSSP ACOs
- Next Generation ACO
- Oncology Care Model (OCM)

Answer: **There are no penalties in OCM or in any of the ACO programs for failing to deliver recommended treatments to lung cancer patients.**

In all of the programs, the ACO or oncologists could receive a financial bonus for using cheaper drugs to treat lung cancer, even if the drugs aren't effective.

A Brief Quiz about Value-Based Payment

#4: Which of these would create more savings in private health insurance plans?

- 5% reduction in hospital prices
- 15% reduction in prescription drug prices
- 20% reduction in health plan administrative overhead

A Brief Quiz about Value-Based Payment

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- 15% reduction in prescription drug prices
- 20% reduction in health plan administrative overhead

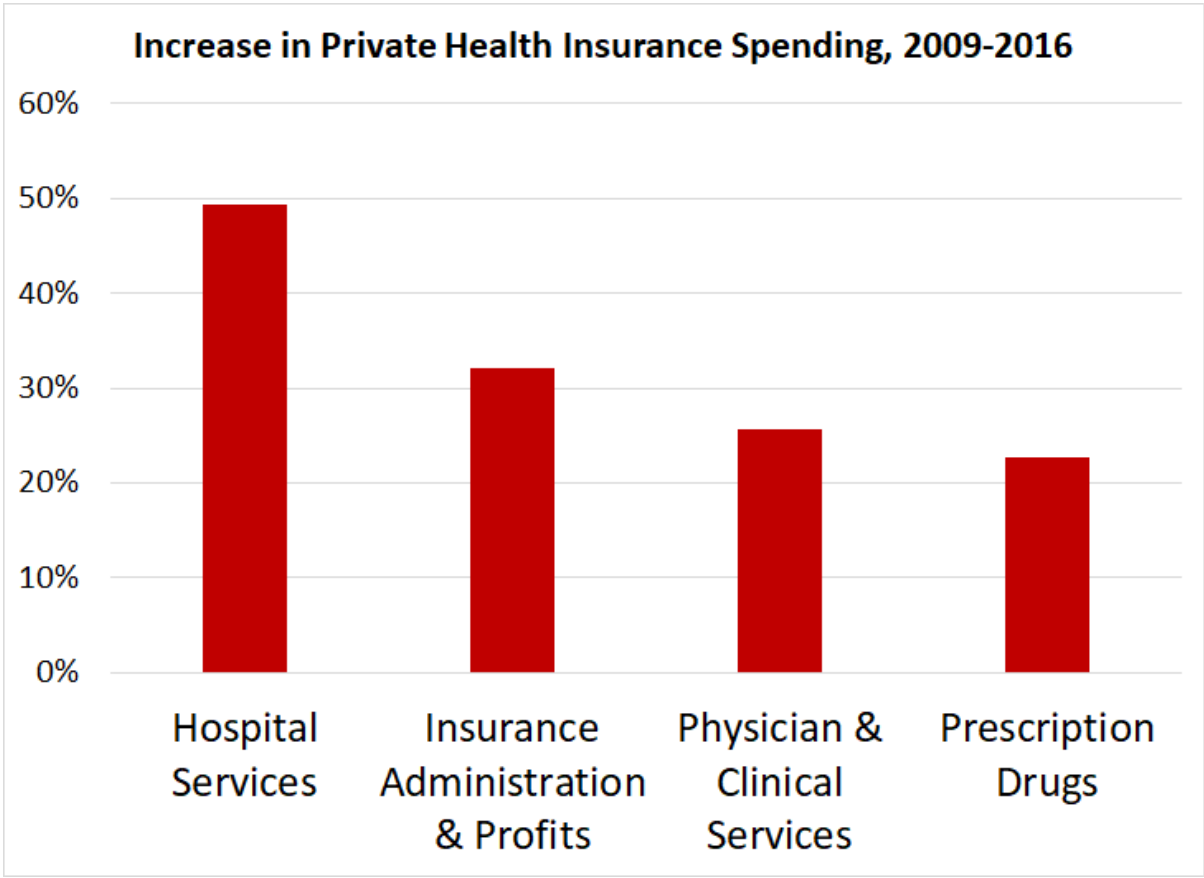
Answer: **20% reduction in health plan admin. costs/profits.**

In 2016, private health insurance plans spent:

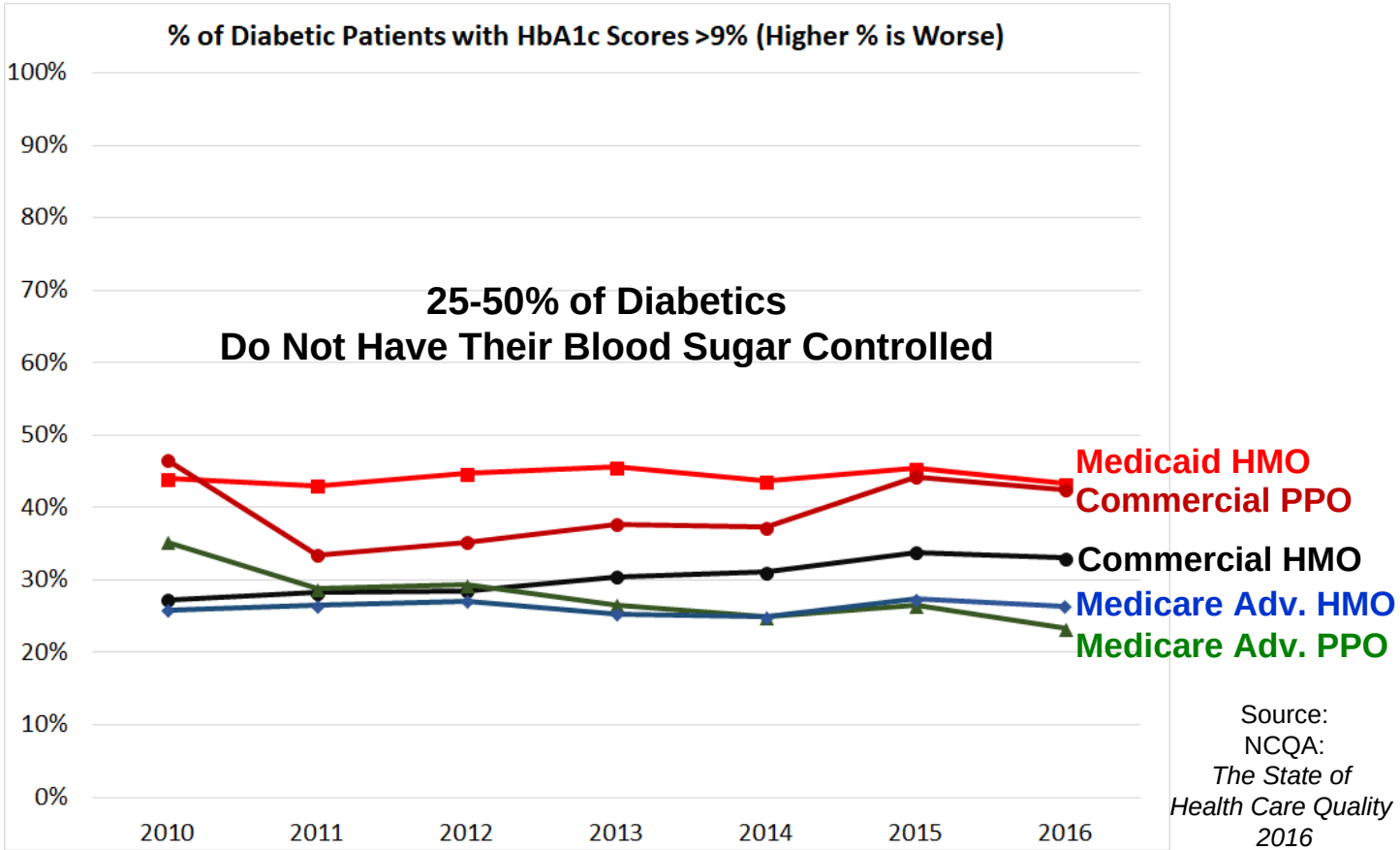
- $427 billion on hospital services
- $287 billion on physician & clinical services
- $143 billion on prescription drugs
- $130 billion on administration and profit

Private insurance plans spend almost as much on administration and profits as on prescription drugs.

Hospital Spending & Health Plan Admin/Profits Are Biggest $ Drivers



After Years of "Value-Based" P4P, Quality Has NOT Improved



Source:
NCQA:
The State of Health Care Quality 2016

It's Costing Everybody a Lot of Money With No Apparent Benefit

PHYSICIANS

By Lawrence P. Casalino, David Gans, Rachel Weber, Meagan Cea, Amber Tuchovsky, Tara F. Bishop, Yesenia Miranda, Brittany A. Frankel, Kristina B. Ziehler, Meghan M. Wong, and Todd B. Evenson

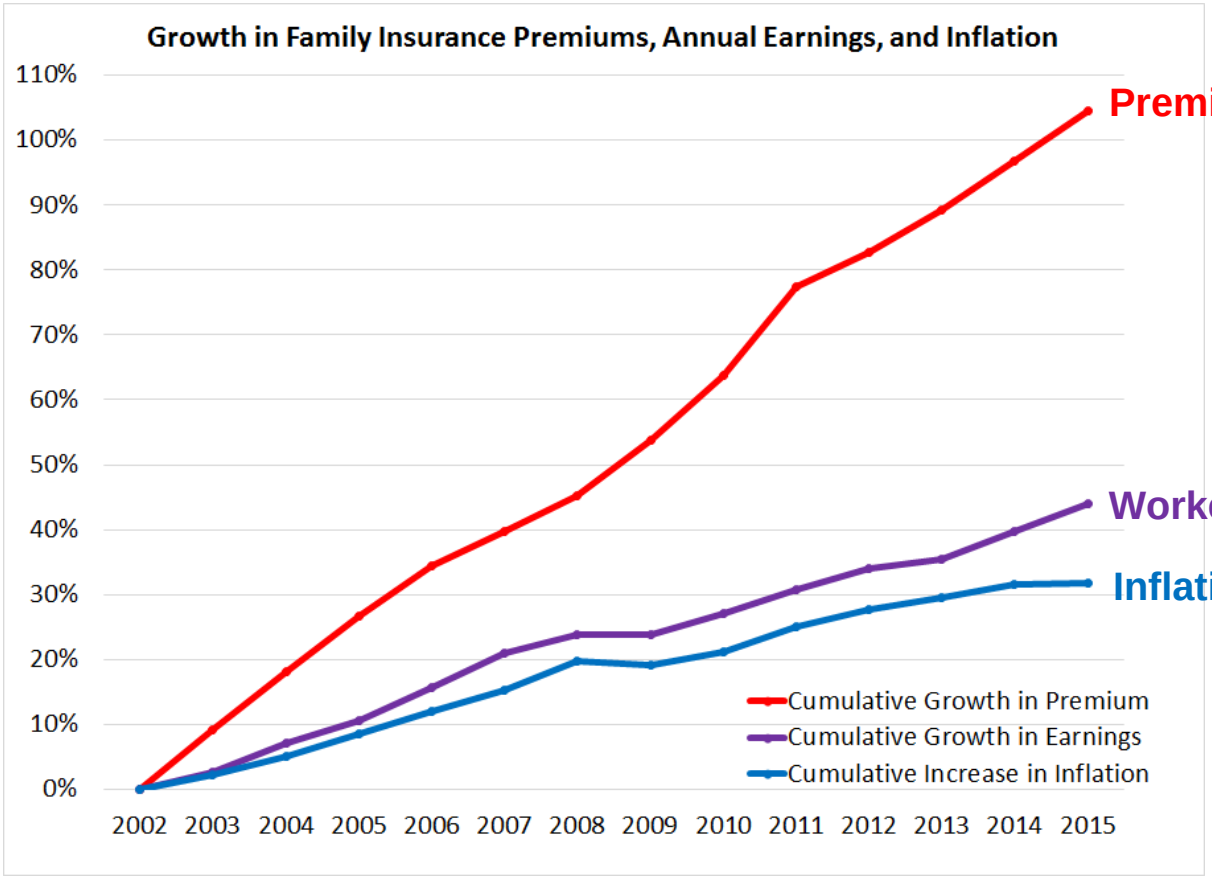
DOI: 10.1377/hlthaff.2015.1258
HEALTH AFFAIRS 35,
NO. 3 (2016): 401–406

DATAWATCH

US Physician Practices Spend More Than $15.4 Billion Annually To Report Quality Measures

Each year US physician practices in four common specialties spend, on average, 785 hours per physician and more than $15.4 billion dealing with the reporting of quality measures. While much is to be gained from quality measurement, the current system is unnecessarily costly, and greater effort is needed to standardize measures and make them easier to report.

Costs Clearly Aren't Being Controlled



Source: Medical Expenditure Panel Survey & Bureau of Labor Statistics

P4P Has Been Studied to Death &…

Annals of Internal Medicine REVIEW

The Effects of Pay-for-Performance Programs on Health, Health Care Use, and Processes of Care

A Systematic Review

Aaron Mendelson, BA; Karli Kondo, PhD; Cheryl Damberg, PhD; Allison Low, BA; Makalapua Motúapuaka, BA; Michele Freeman, MPH; Maya O'Neil, PhD; Rose Relevo, MLIS, MS; and Devan Kansagara, MD, MCR

Background: The benefits of pay-for-performance (P4P) programs are uncertain.

Purpose: To update and expand a prior review examining the effects of P4P programs targeted at the physician, group, managerial, or institutional level on process-of-care and patient outcomes in ambulatory and inpatient settings.

Data Sources: PubMed from June 2007 to October 2016; MEDLINE, PsycINFO, CINAHL, Business Economics and Theory, Business Source Elite, Scopus, Faculty of 1000, and Gartner Research from June 2007 to February 2016.

Study Selection: Trials and observational studies in ambulatory and inpatient settings reporting process-of-care, health, or utilization outcomes.

Data Extraction: Two investigators extracted data, assessed study quality, and graded the strength of the evidence.

Data Synthesis: Among 69 studies, 58 were in ambulatory settings, 52 reported process-of-care outcomes, and 38 reported patient outcomes. Low-strength evidence suggested that P4P programs in ambulatory settings may improve process-of-care outcomes over the short term (2 to 3 years), whereas data on longer-term effects were limited. Many of the positive studies were conducted in the United Kingdom, where incentives were larger than in the United States. The largest improvements were seen in areas where baseline performance was poor. There was no consistent effect of P4P on intermediate health outcomes (low-strength evidence) and insufficient evidence to characterize any effect on patient health outcomes. In the hospital setting, there was low-strength evidence that P4P had little or no effect on patient health outcomes and a positive effect on reducing hospital readmissions.

Limitation: Few methodologically rigorous studies; heterogeneous population and program characteristics and incentive targets.

Conclusion: Pay-for-performance programs may be associated with improved processes of care in ambulatory settings, but consistently positive associations with improved health outcomes have not been demonstrated in any setting.

Primary Funding Source: U.S. Department of Veterans Affairs.

Ann Intern Med. 2017;166:341-353. doi:10.7326/M16-1881 **Annals.org**
For author affiliations, see end of text.
This article was published at Annals.org on 10 January 2017.

P4P Has Been Studied to Death & It Doesn't Work…

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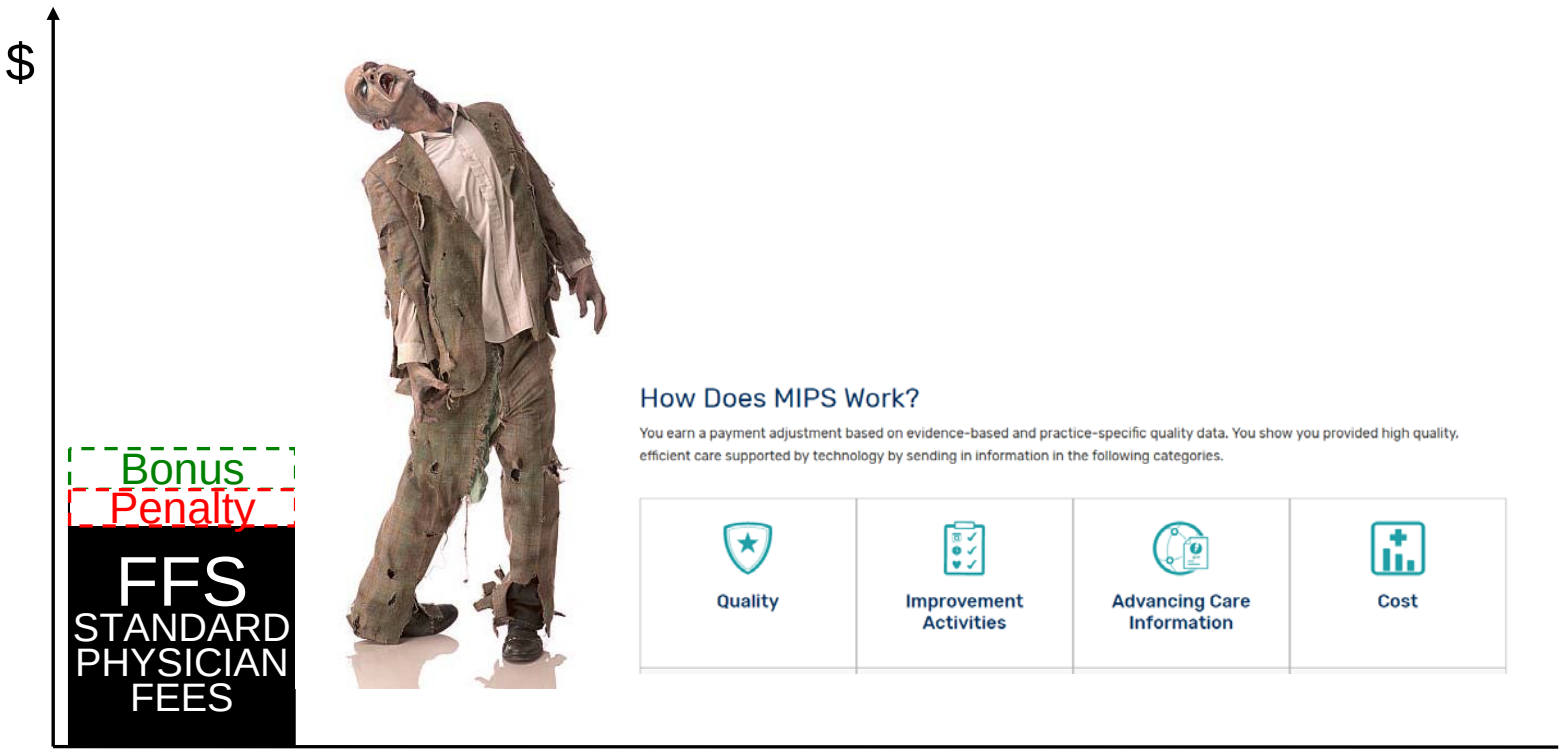
But Like a Zombie, P4P Keeps Coming Back

MIPS



How Does MIPS Work?

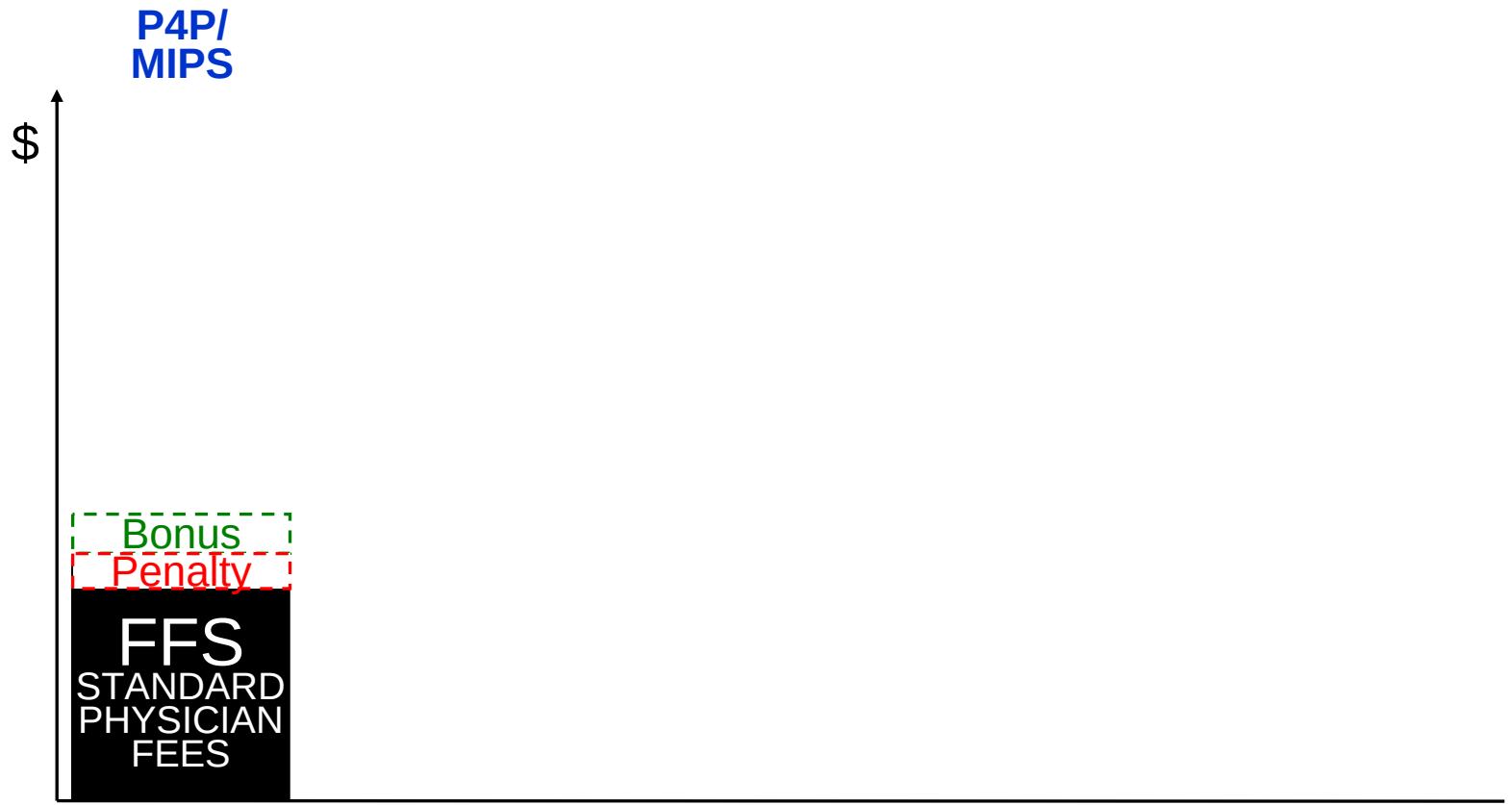
You earn a payment adjustment based on evidence-based and practice-specific quality data. You show you provided high quality, efficient care supported by technology by sending in information in the following categories.

Quality	Improvement Activities	Advancing Care Information	Cost

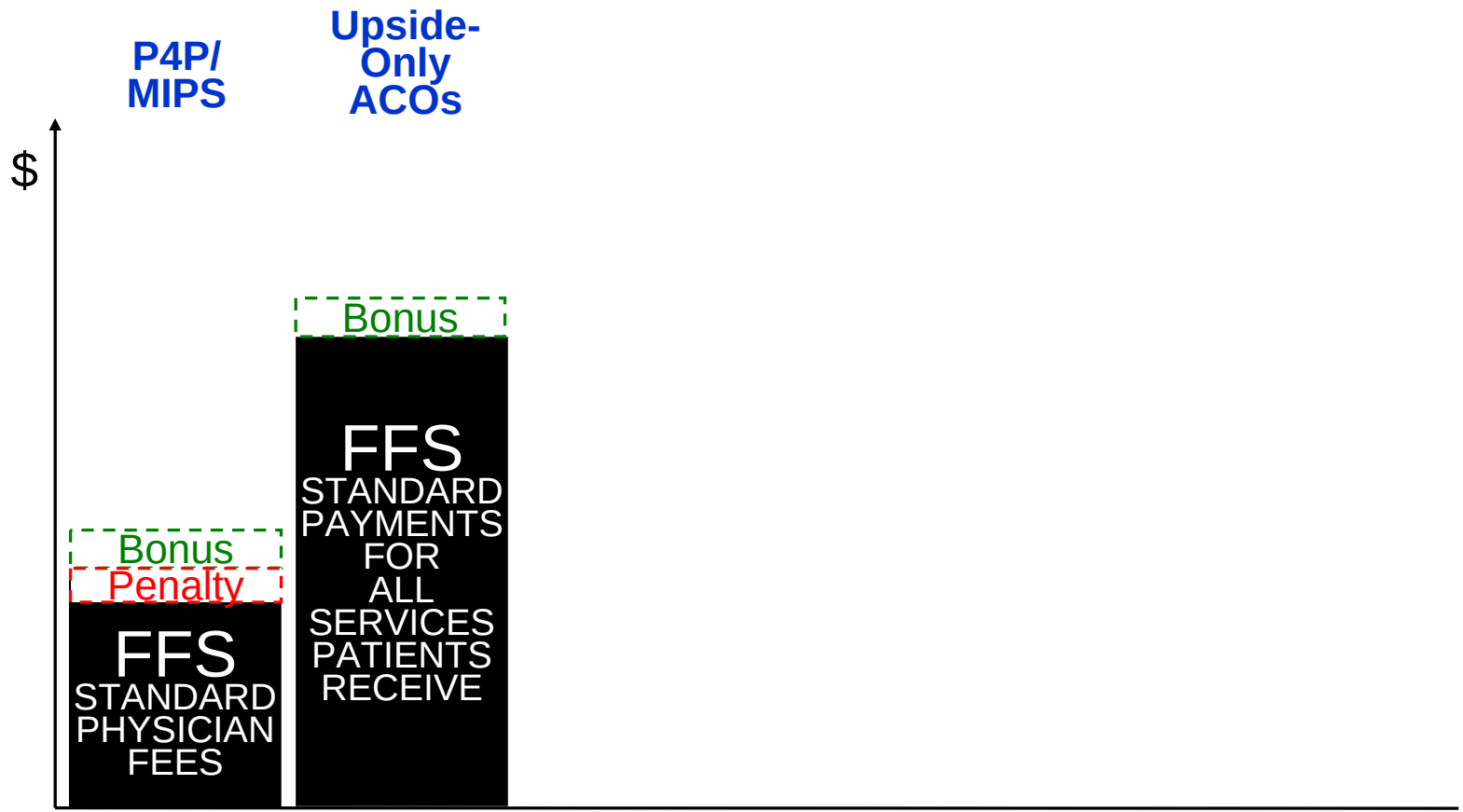
In MACRA, Congress *Encouraged* Use of APMs Instead of MIPS

- 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 (increase) in their FFS revenues
  - receive the benefits of participating in the APM

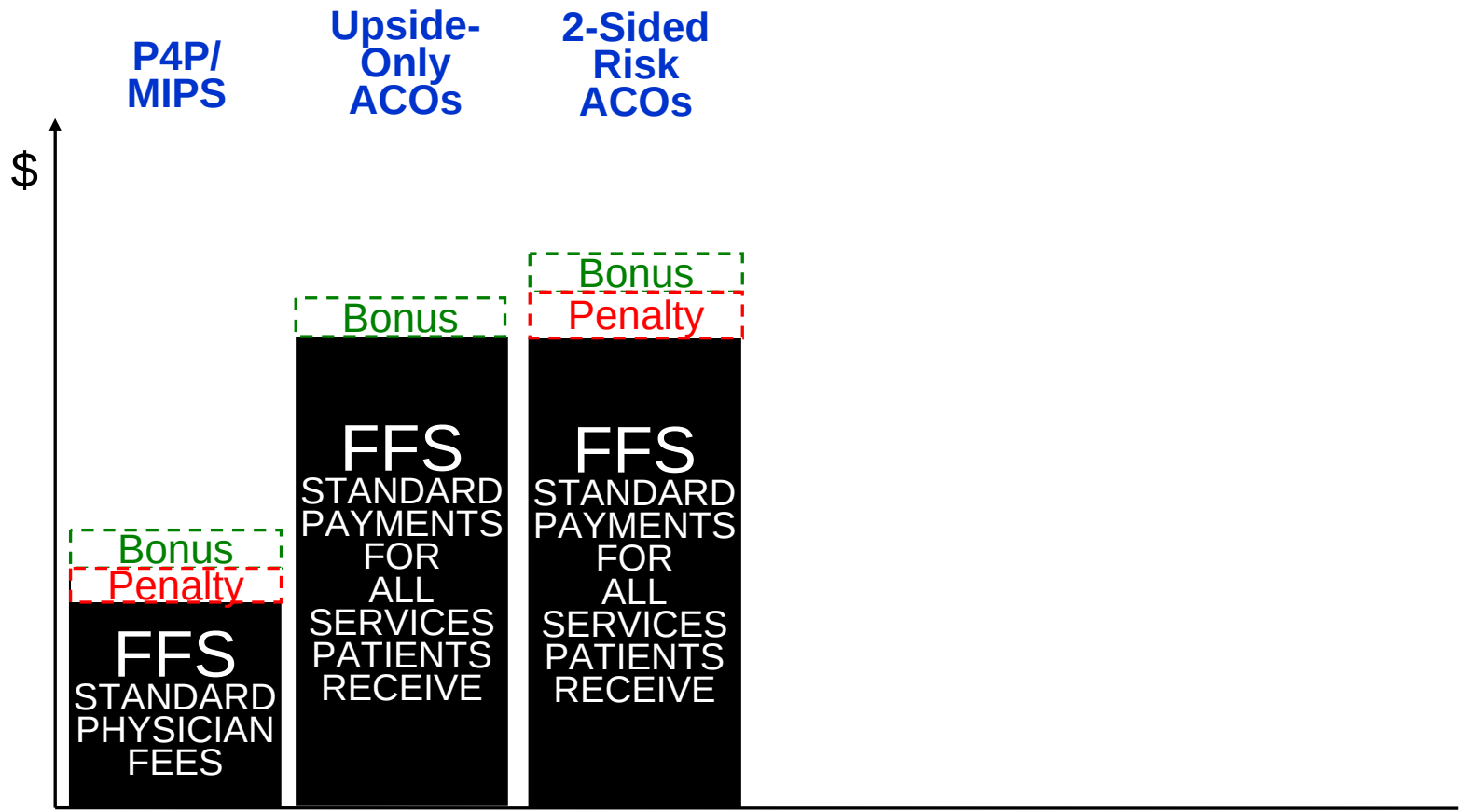
How Different Are CMS APMs From P4P and MIPS?



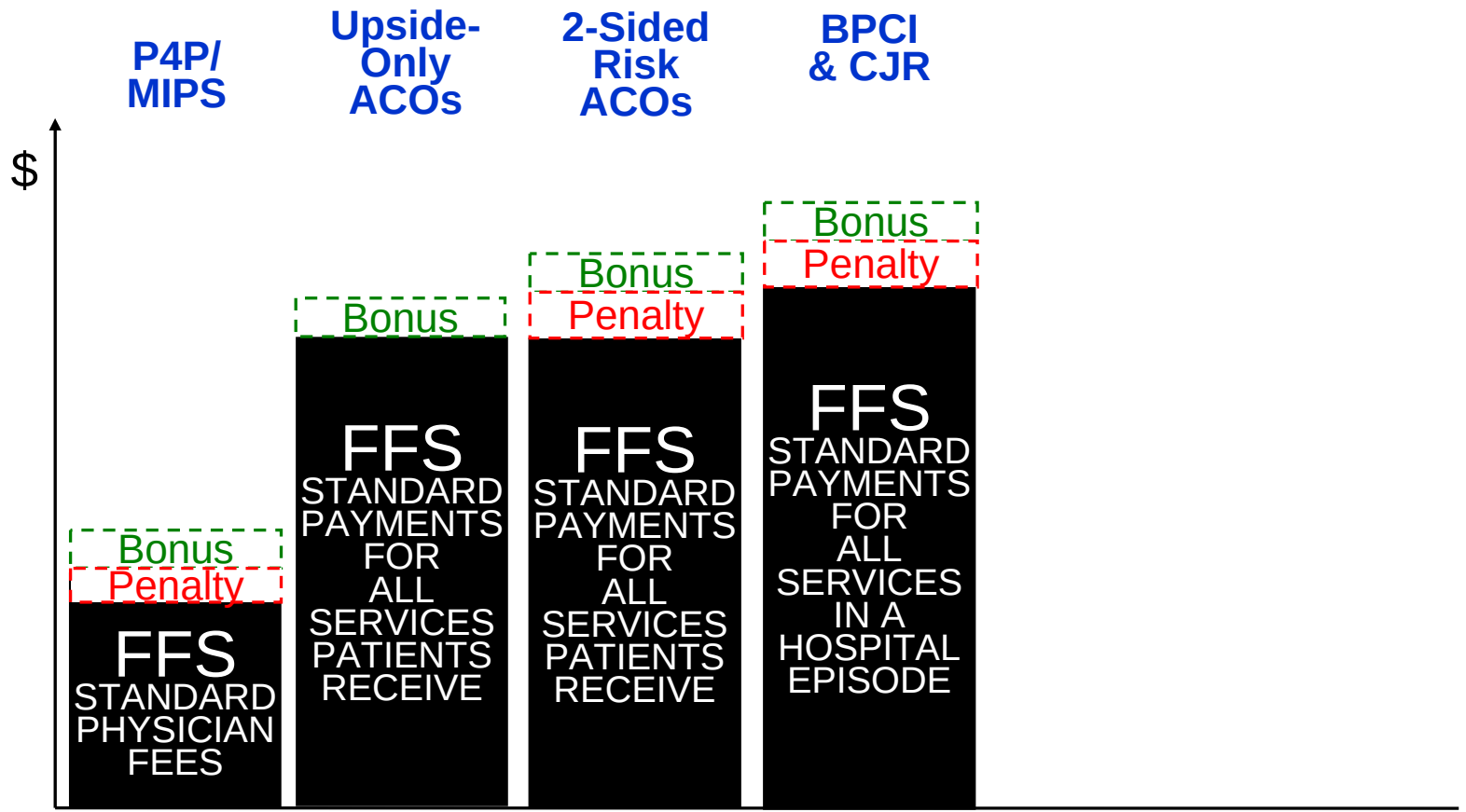
Track 1 MSSP ACOs: Regular FFS + Shared Svgs P4P



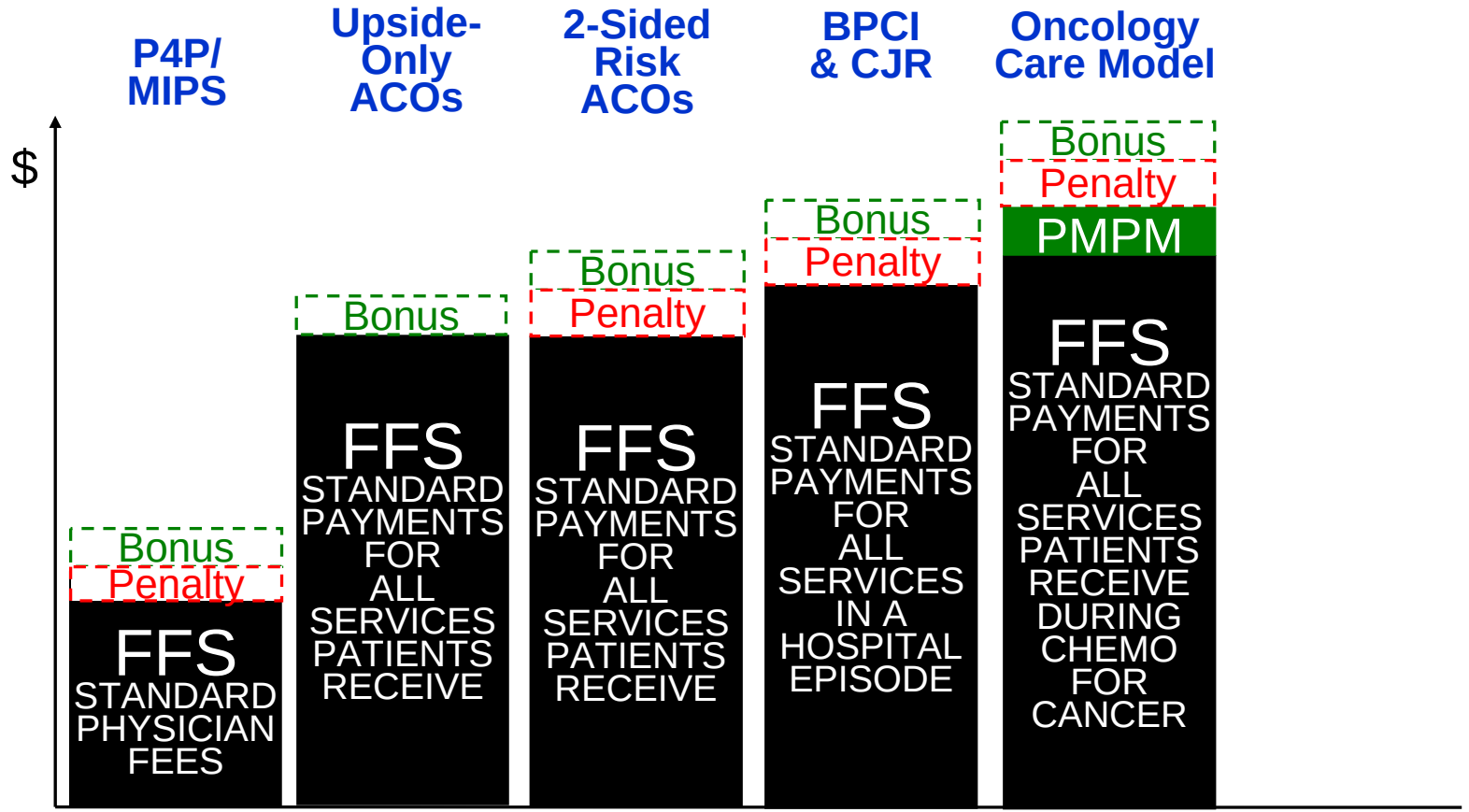
"Two-Sided Risk" ACOs: Regular FFS + P4P on Spending



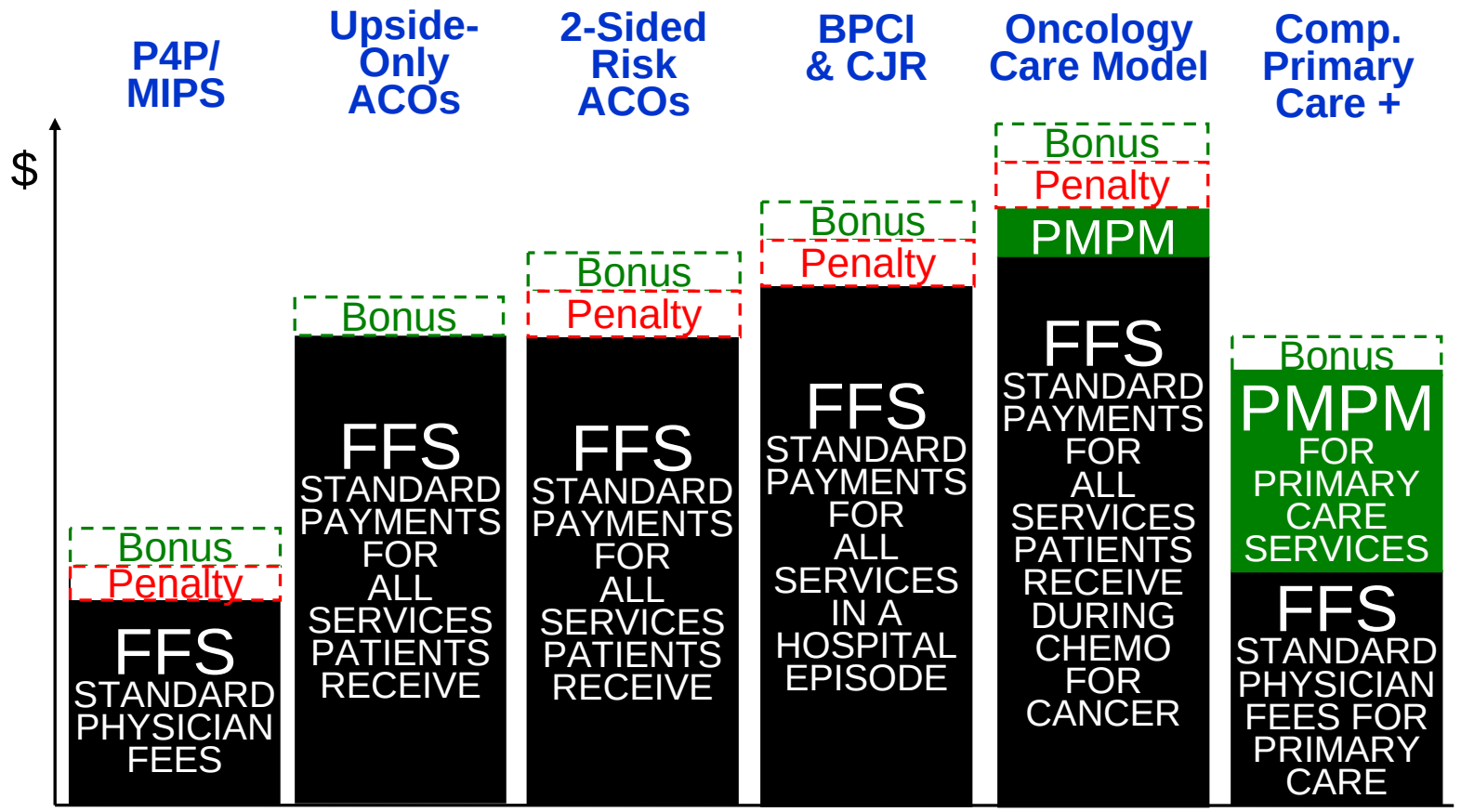
Bundled Payment Programs: Regular FFS + P4P on Spending



Oncology Care Model: FFS + PMPM + Spending P4P



Only Comp. Primary Care Plus is Significantly Different from FFS



Medicare's Shared Savings ACO Program Isn't Succeeding

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2013 Results for Medicare Shared Savings ACOs

- 46% of ACOs (102/220) *increased* Medicare spending
- Only 24% (52/220) received shared savings payments
- After making shared savings payments, Medicare spent more than it saved
- Net loss to Medicare: $78 million

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- 45% of ACOs (152/333) *increased* Medicare spending
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- 48% of ACOs (189/392) *increased* Medicare spending
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2016 Results for Medicare Shared Savings ACOs
- 44% of ACOs (191/432) *increased* Medicare spending
- Only 31% (134/432) received shared savings payments
- After making shared savings payments, Medicare spent more than it saved
- Net loss to Medicare: $39 million

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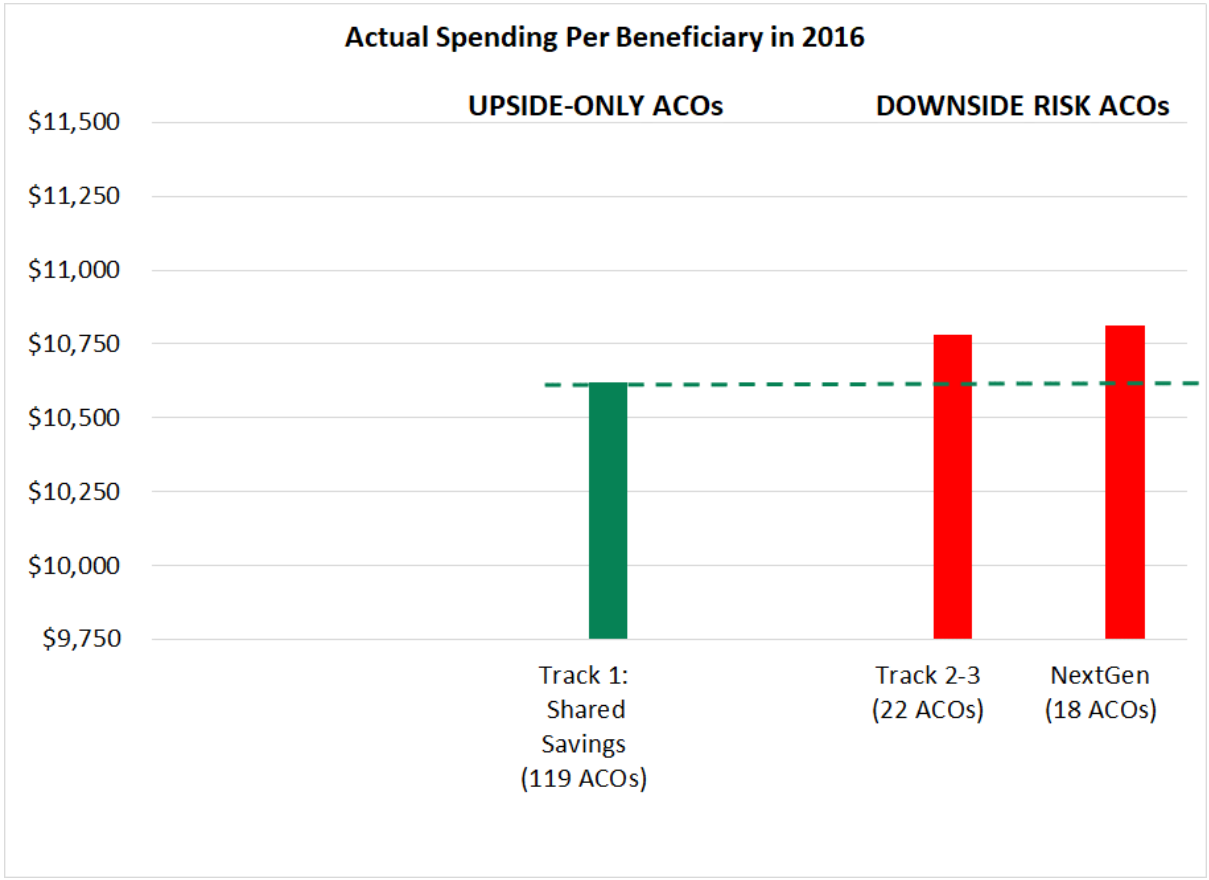
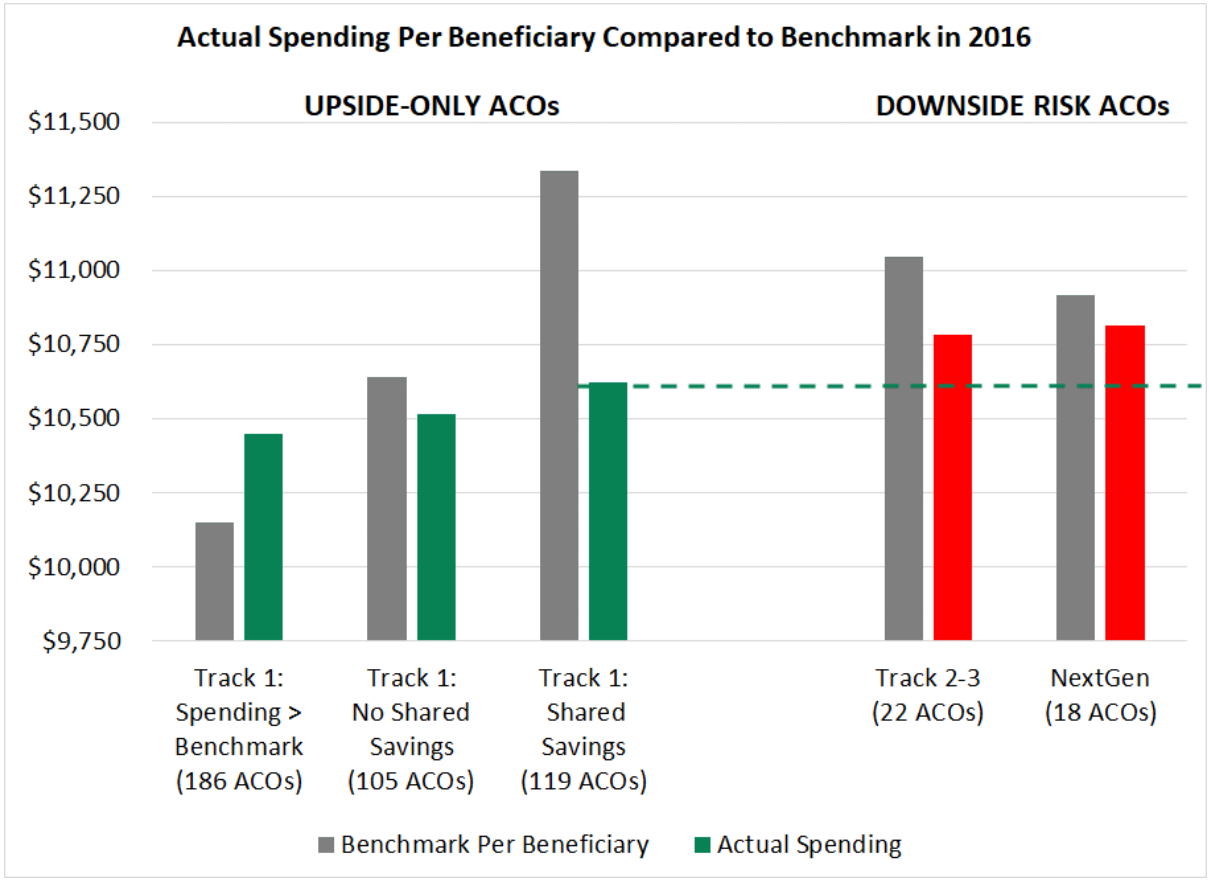
WILL
MORE FINANCIAL RISK
FOR ACOs
RESULT IN
MORE SAVINGS?

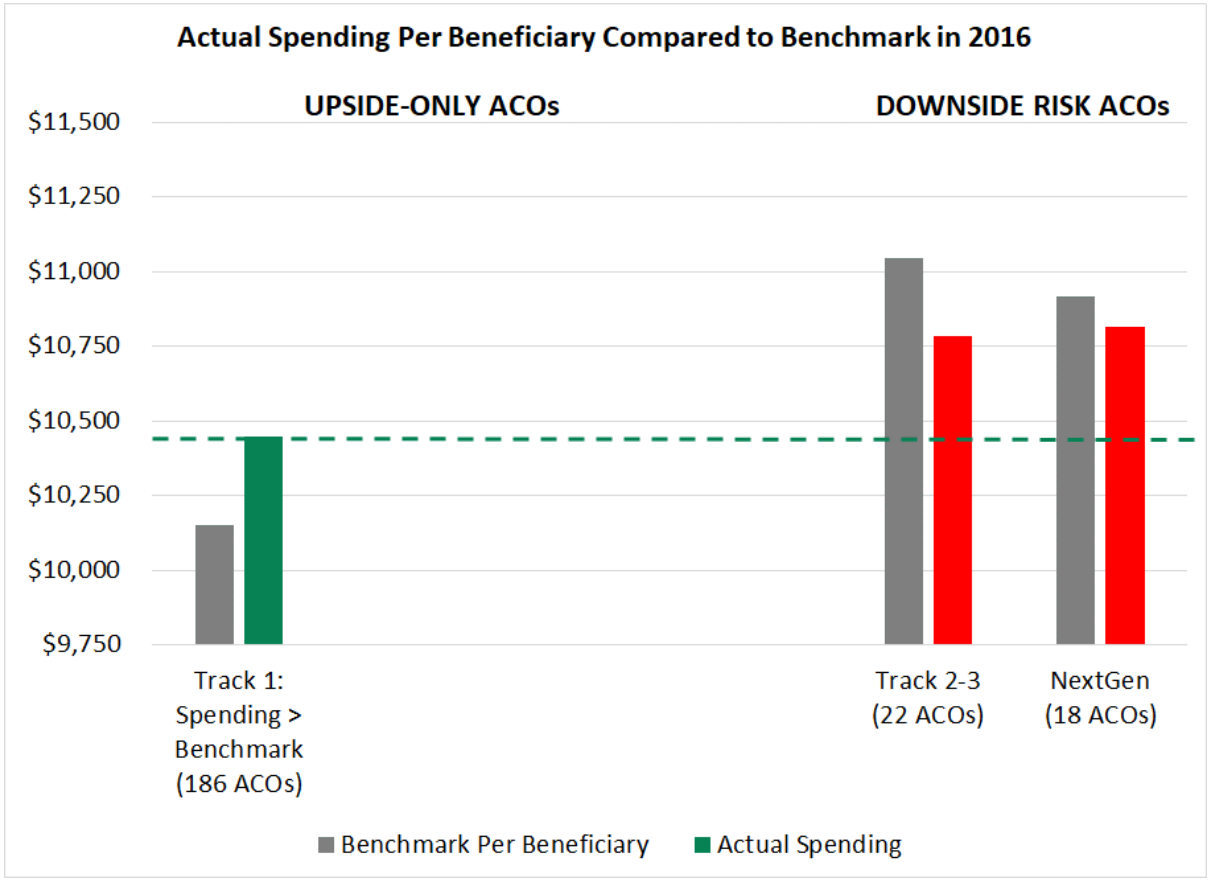
Downside Risk ACOs Spend More Than Upside Only ACOs



“Savings” is Because They Were Even More Expensive to Start

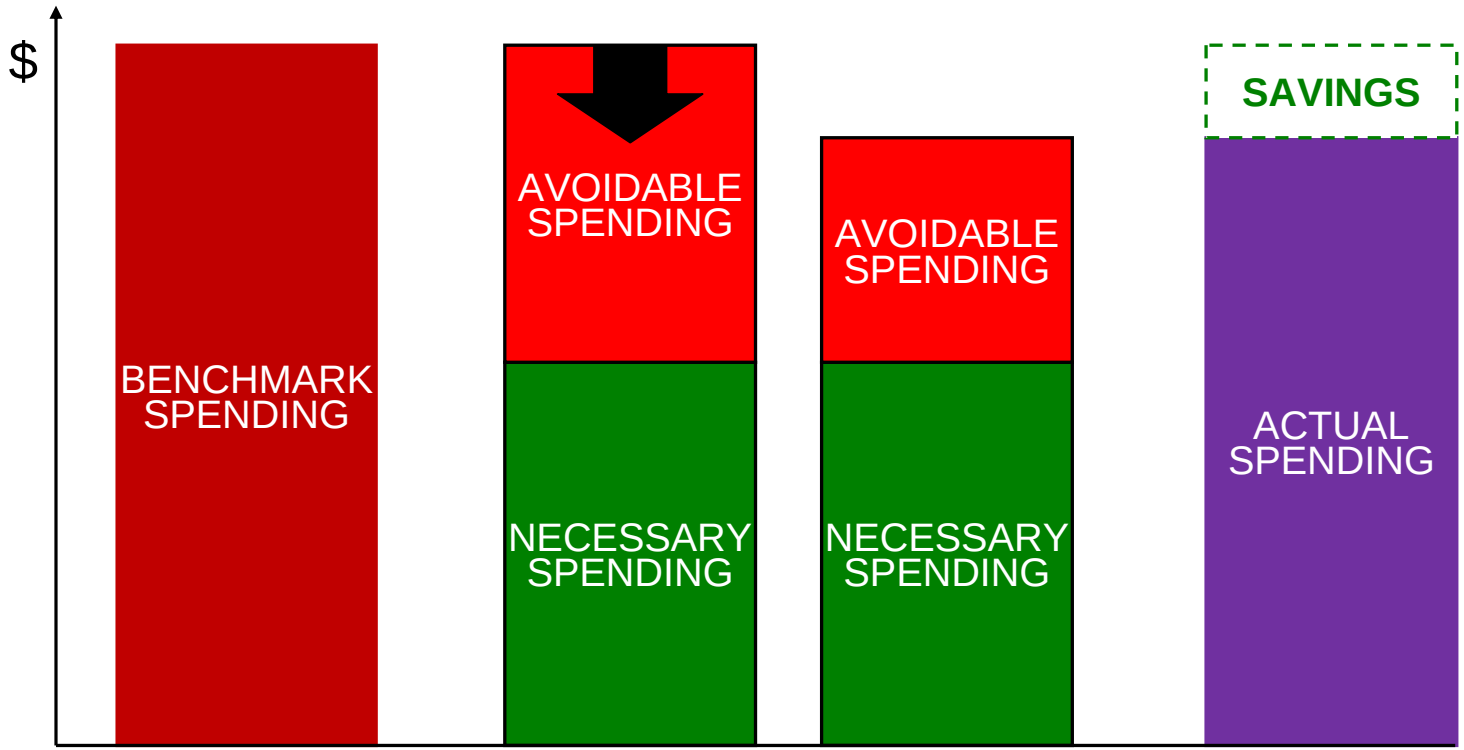


ACOs That "Increased Spending" Spent Less Than 2-Sided ACOs

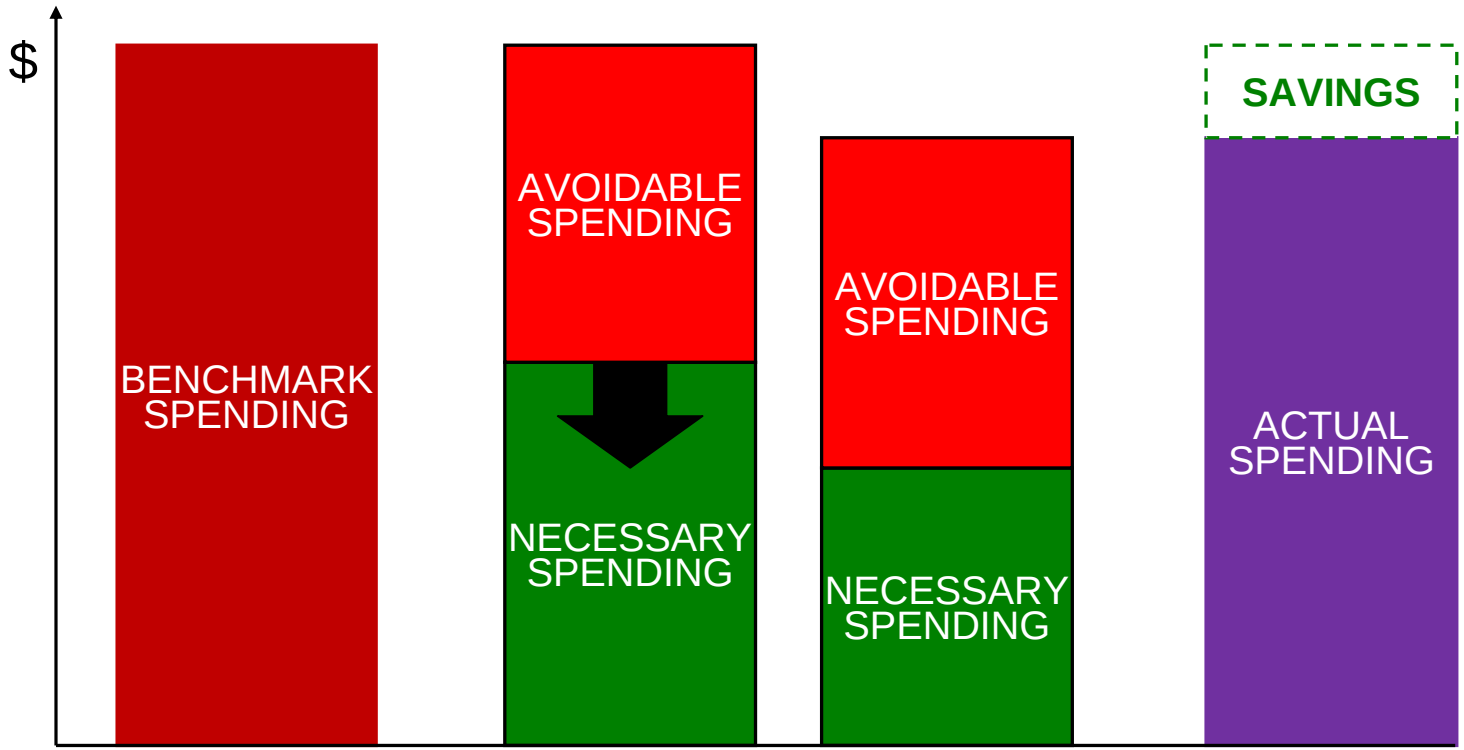


How Exactly Did Any of the ACOs Reduce Spending???

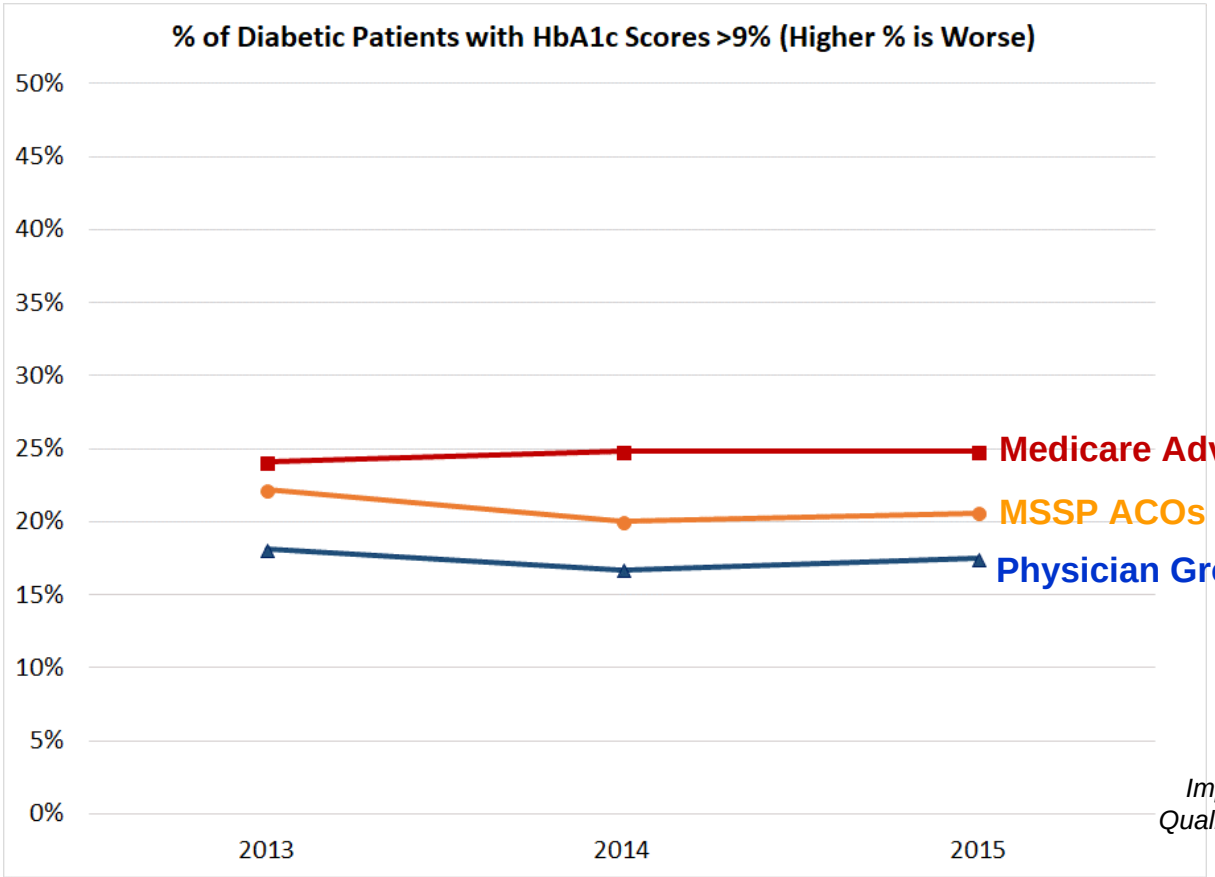
Did They Reduce Spending on Undesirable/Unnecessary Svcs?



Or Did They Stint on Necessary Care to Produce Savings?



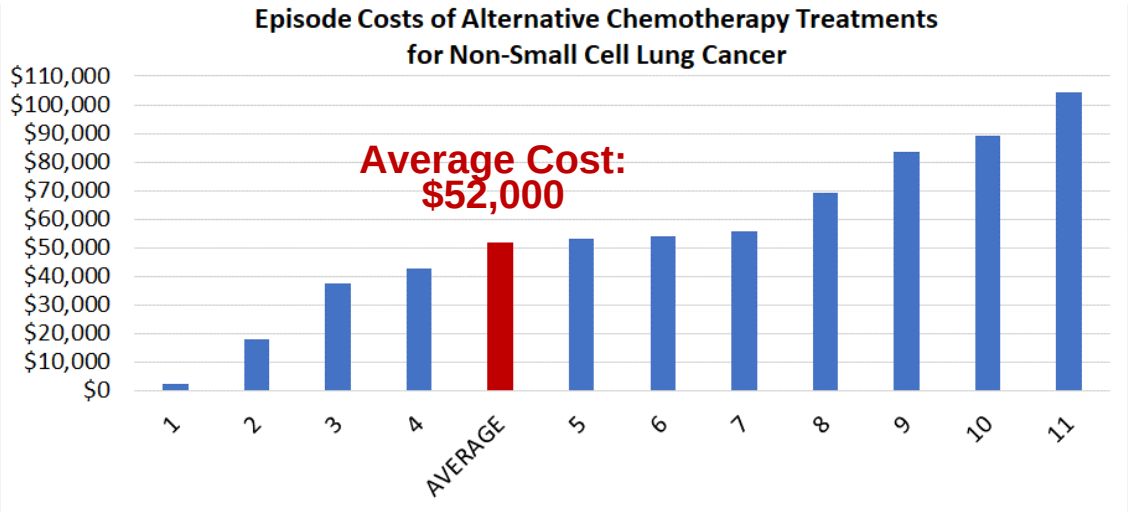
ACOs Didn't Save Money By Improving Quality



Source:
CMS:
2018 National Impact Assessment: Quality Measures Report

How Much Could an ACO Save By Stinting on Care?

A Small Number of Lung Cancer Cases Involve a Lot of Spending



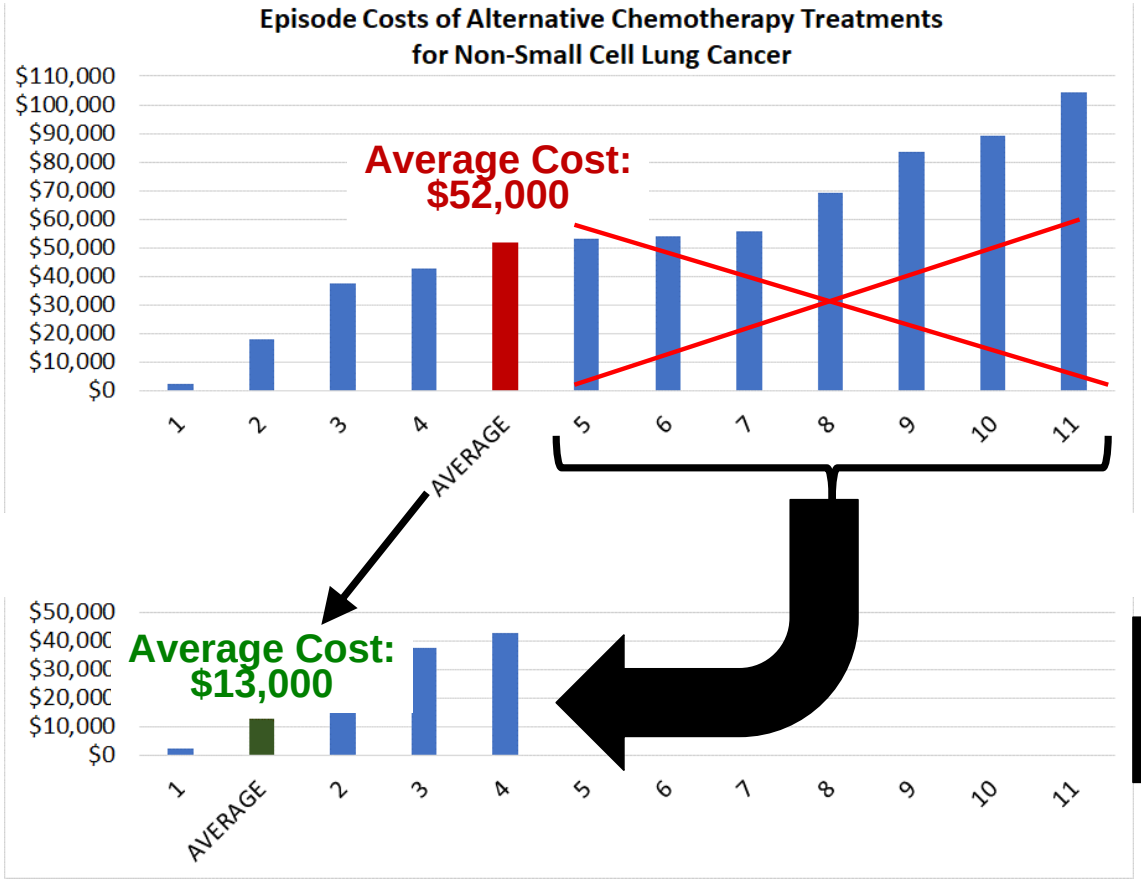
Lung Cancer Incidence in 65+ Population: 300/100,000

= 30 Cases in a 10,000 Member ACO

>$1.5 Million for Chemo Alone

11 Different Chemotherapy/Immunotherapy Regimens
Ranging from $2,500 to $105,000
Depending on Patient Characteristics

Using Cheaper Treatments for 15 Patients = 1.2% Savings



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Reduction in Total ACO Spending: 1.2%

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

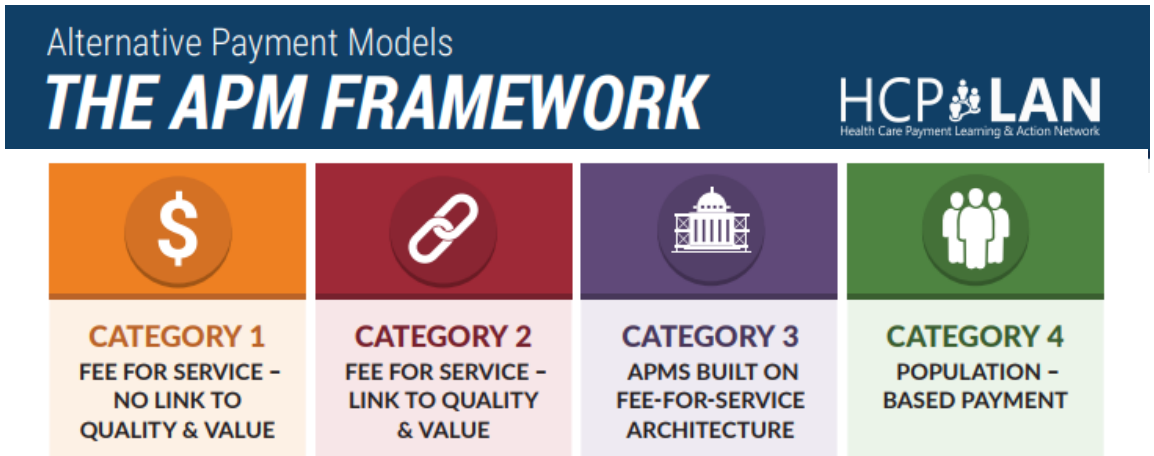
ACO Quality Measures

- 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

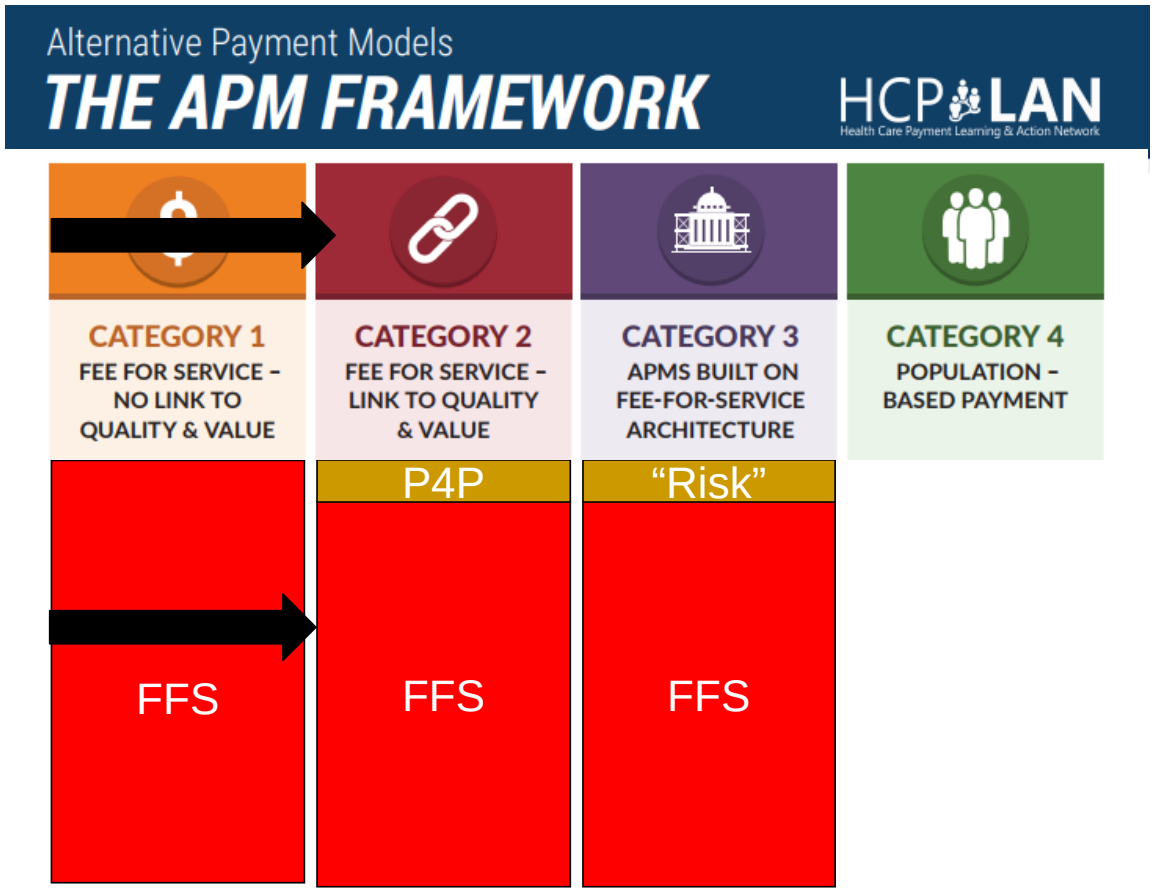
No Measures to Assure:

- 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

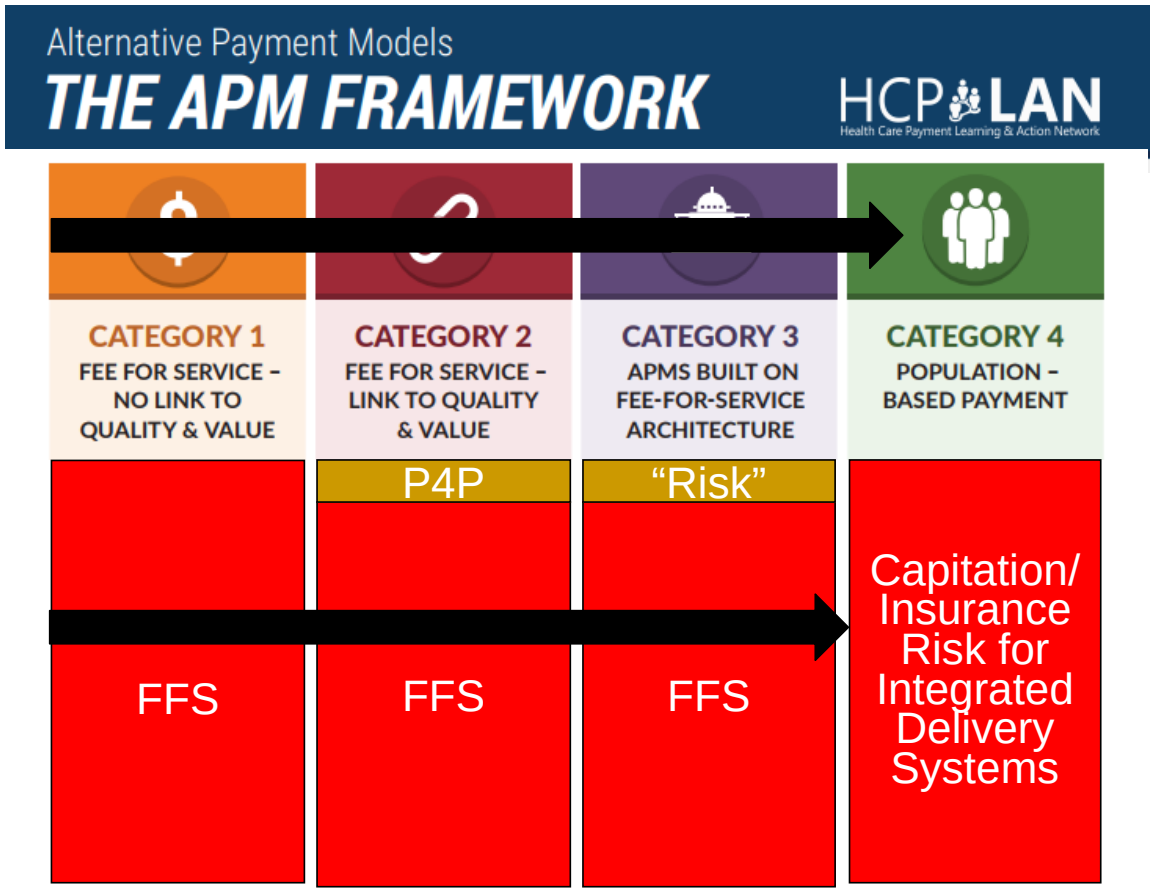
What Do Medicare, Health Plans, and Big Systems Recommend?



#1: Keep Doing the Bad P4P & Shared Risk Models…

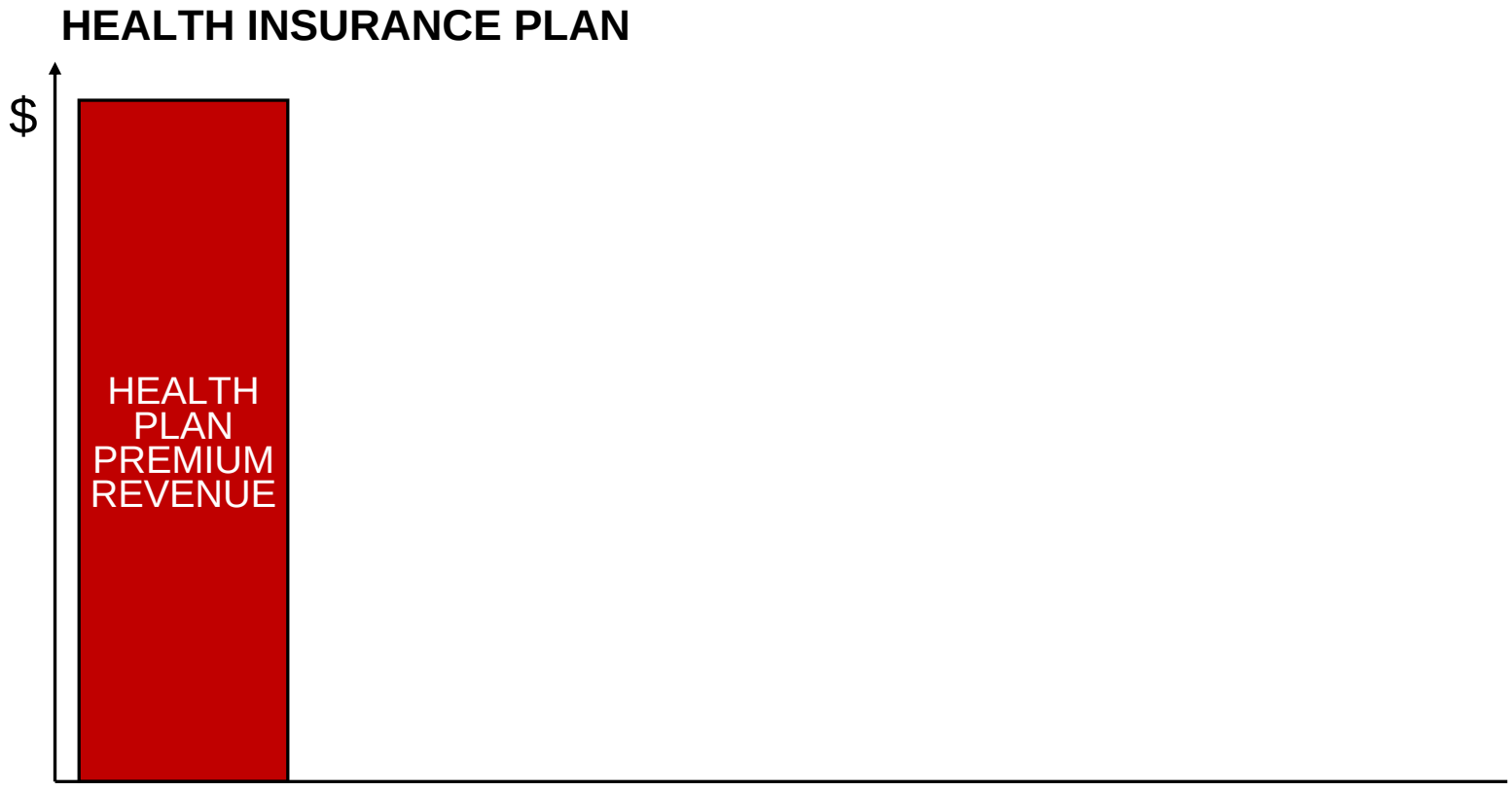


…Or #2: Implement "Population-Based Payment"

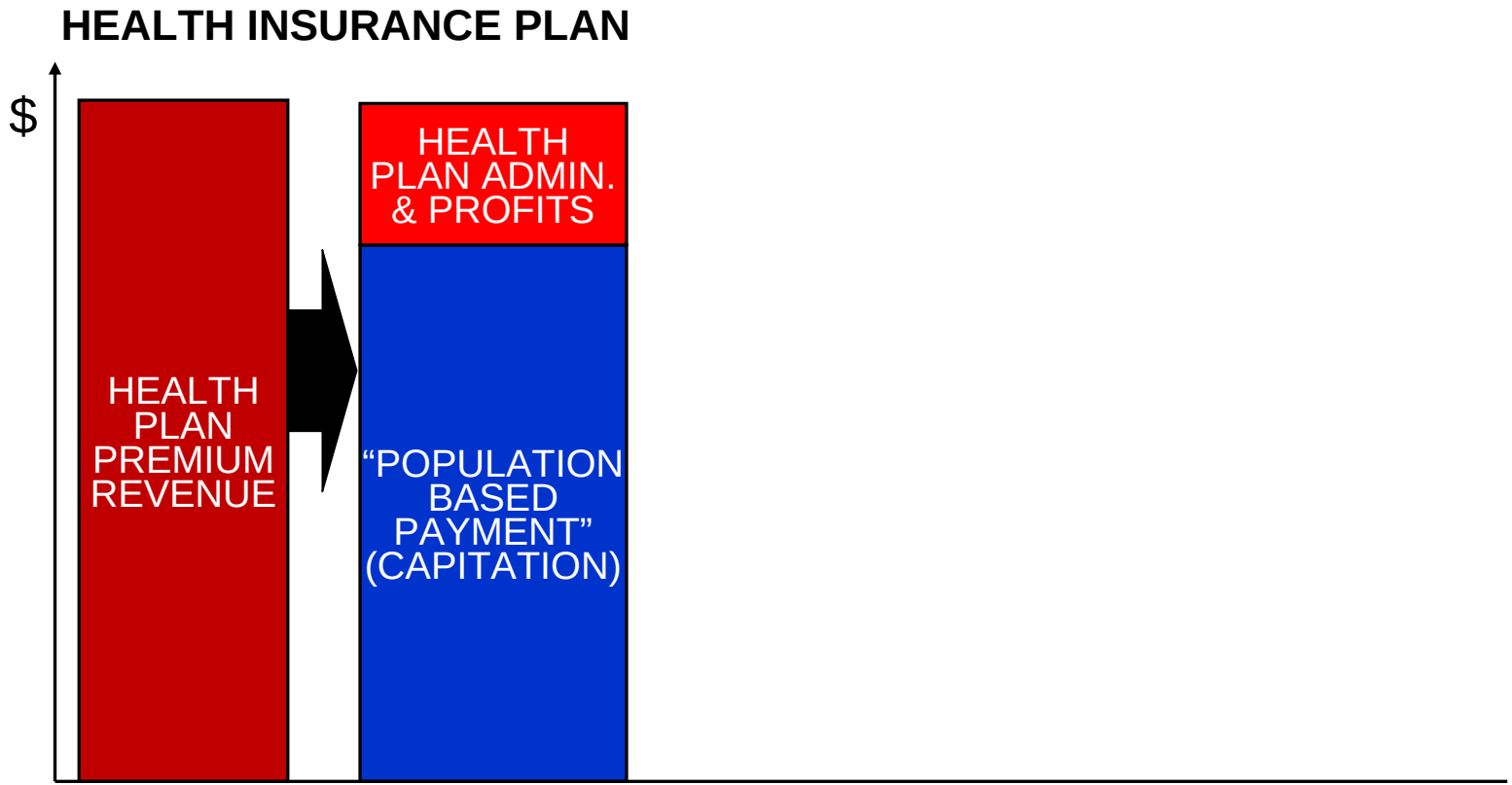


Why Wouldn't a Health Plan Want to Give Its Risk to Someone Else?

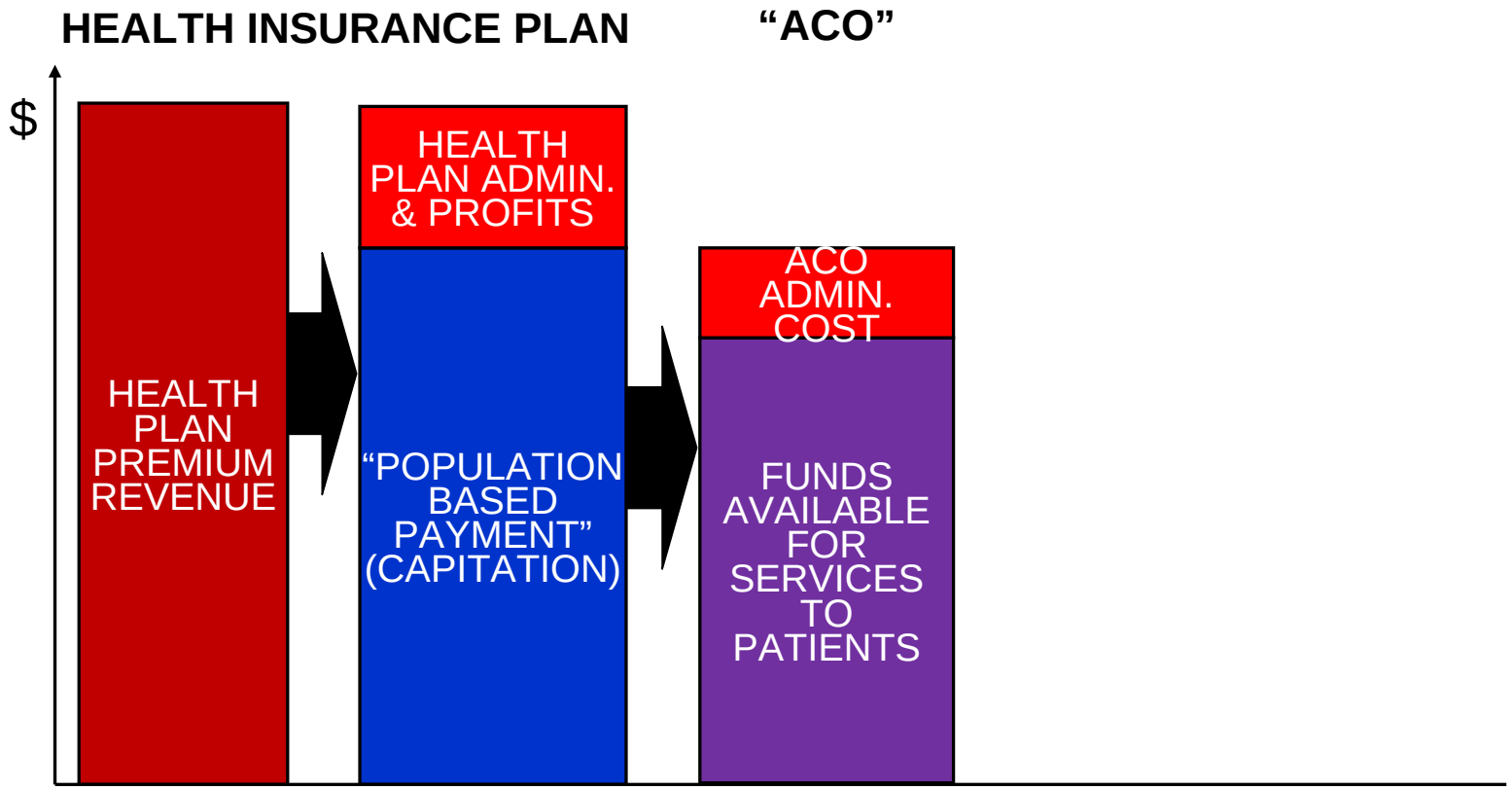
Health Plan Collects Premiums…



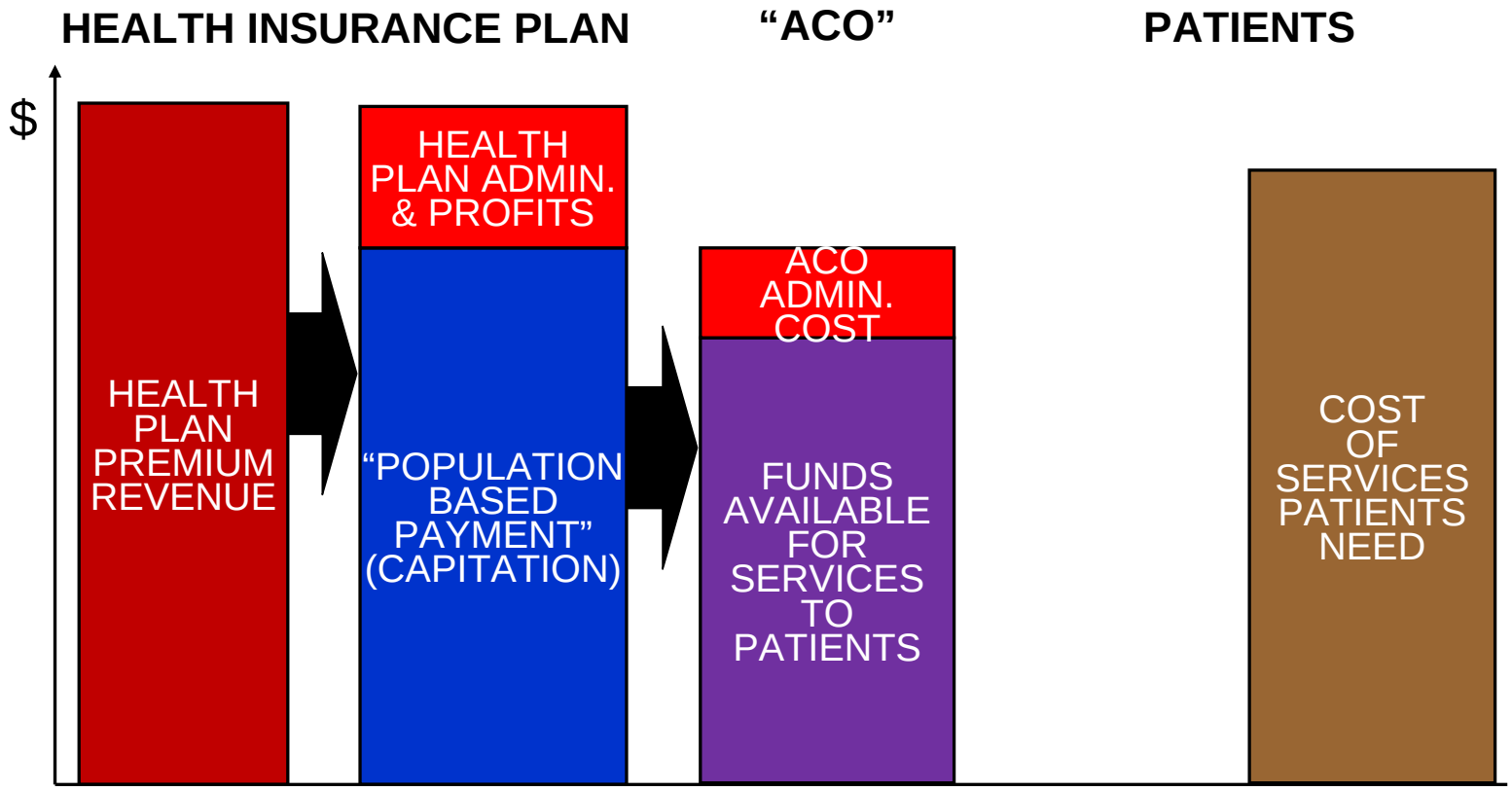
Takes Its Cut Off the Top & Uses the Rest for "Population Payment"



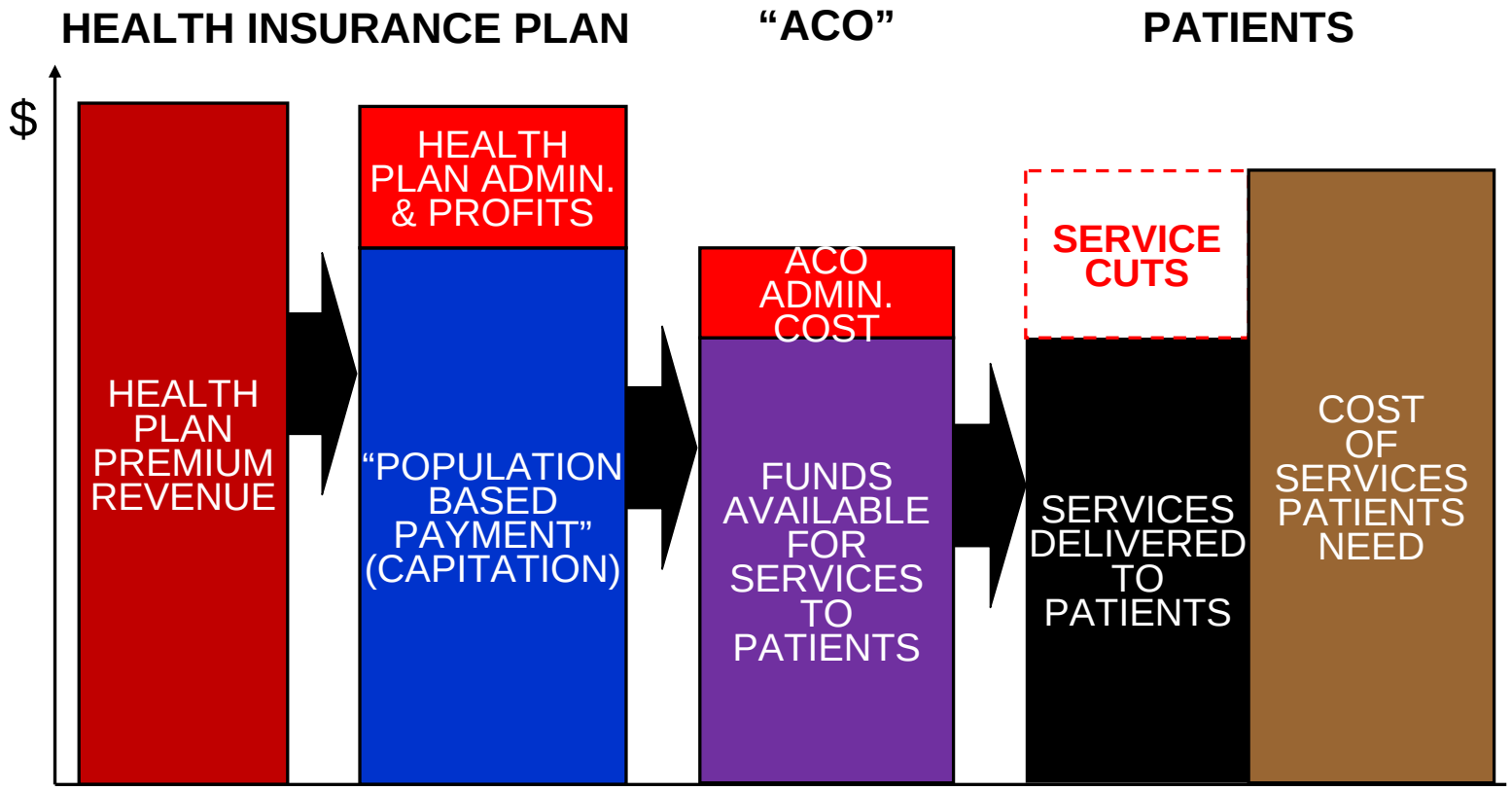
The ACO Then Has to Incur Admin. Costs to Manage Risk



…And if the Patients Need More Services Than Funds Available…



…Physicians are Forced to Figure Out Which Services to Withhold



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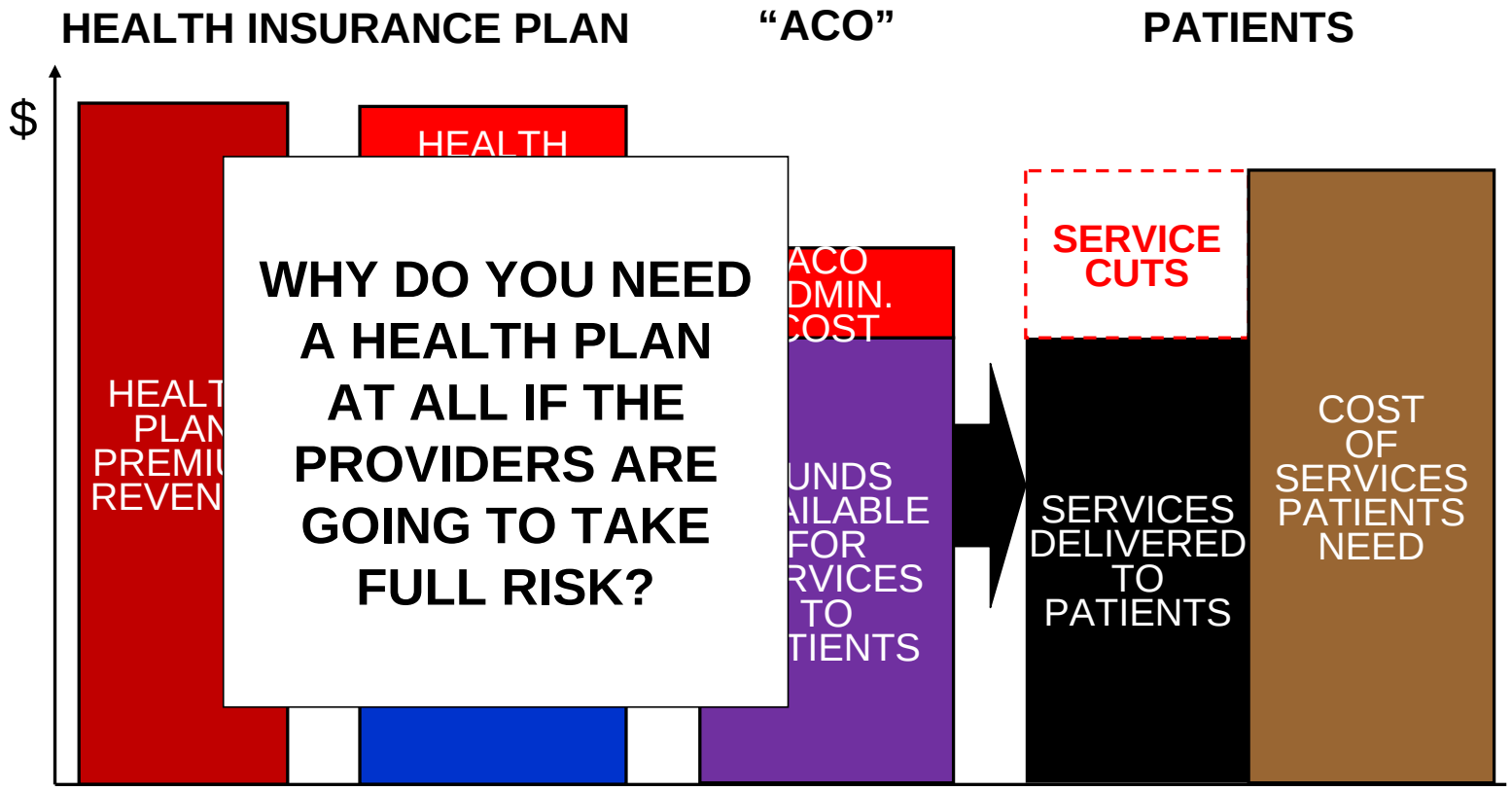
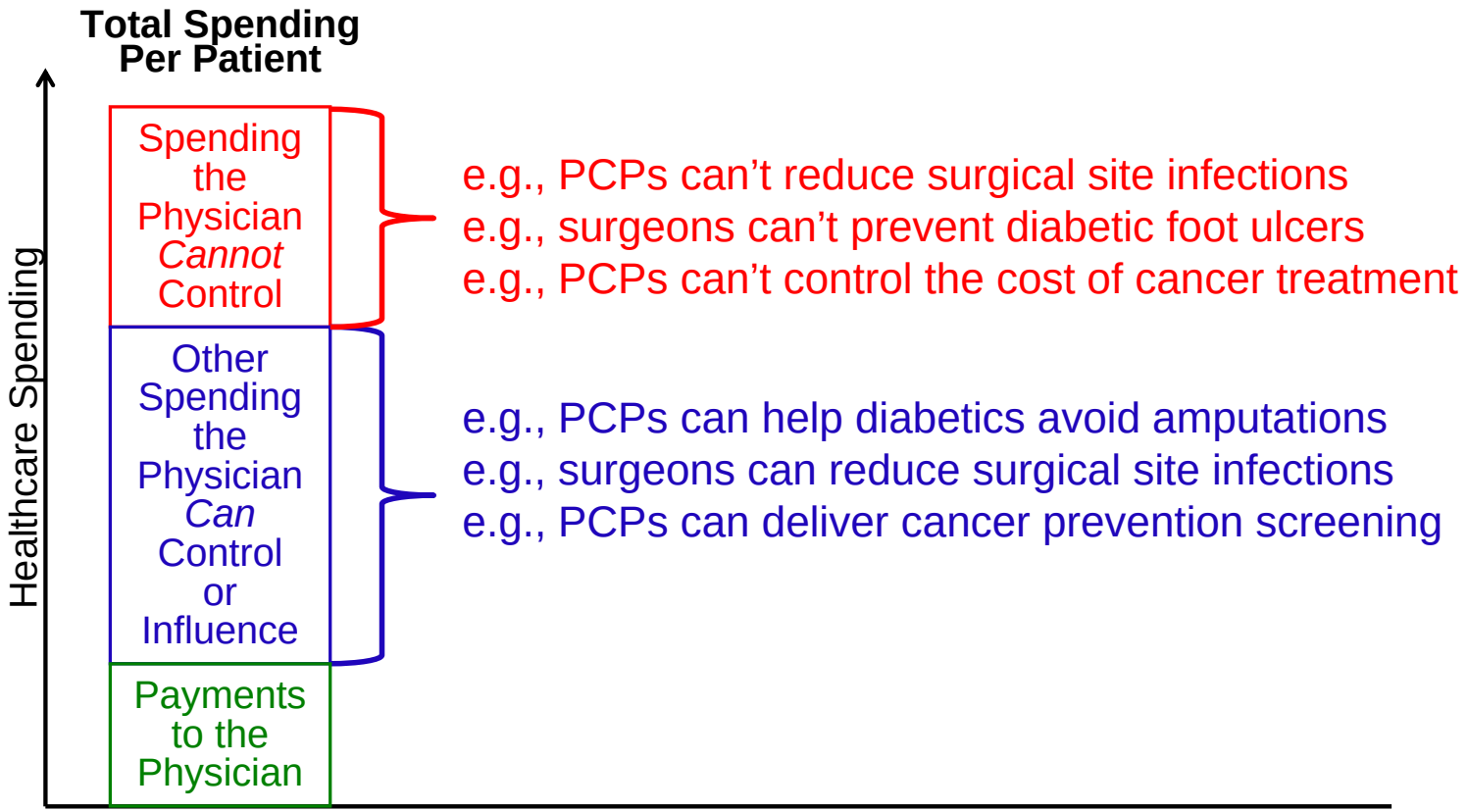
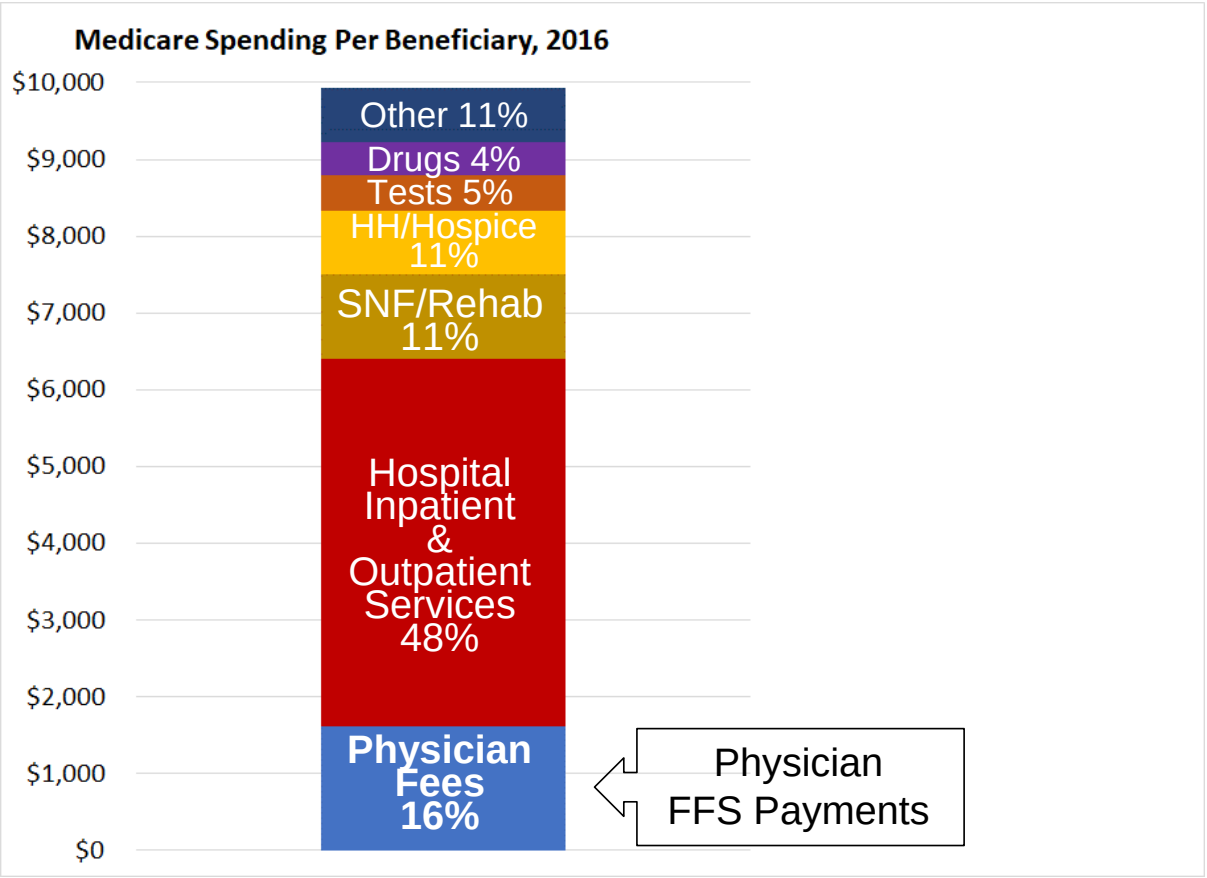


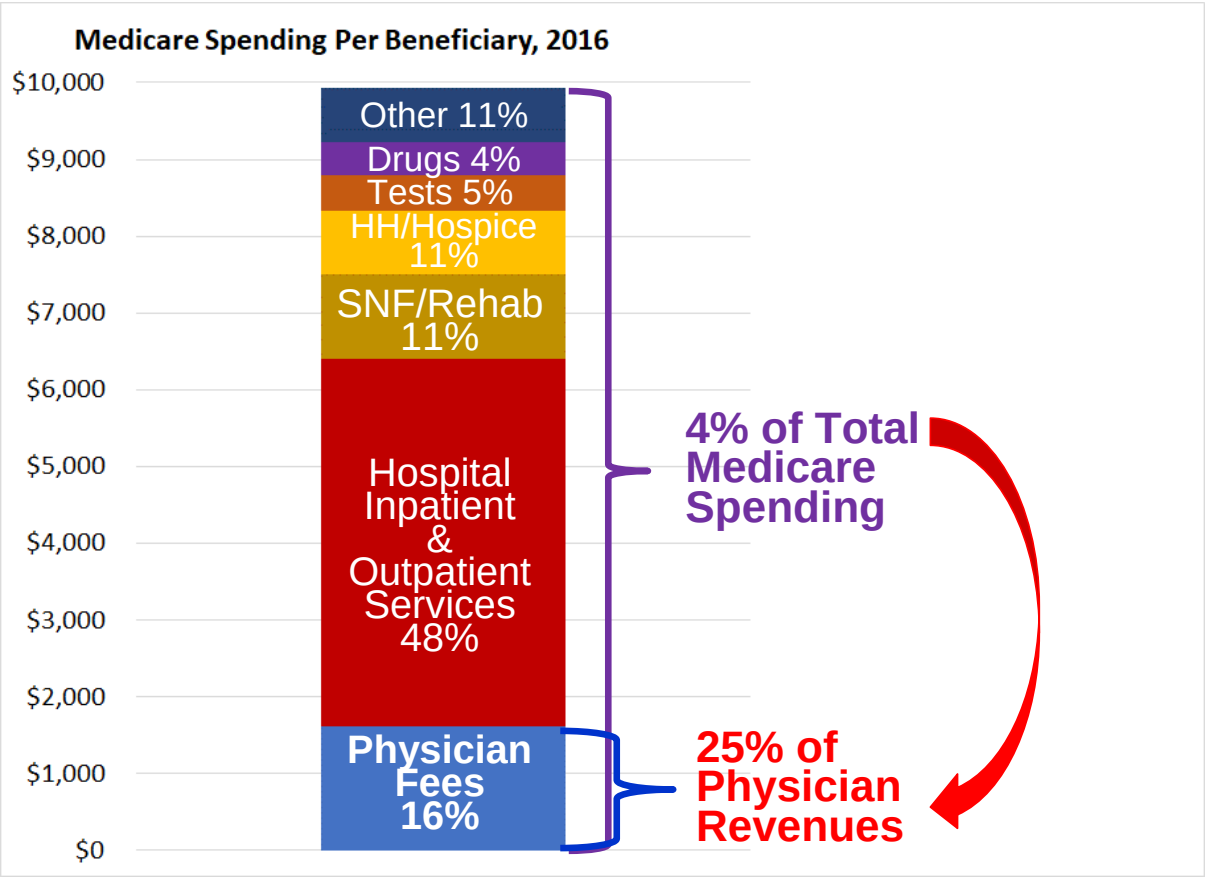
Individual Physicians Can't Control *Total* Spending



Only 16% of Medicare Spending Goes to *Physician Fees*



4% of Total Spending = Huge Risk for Average Physician

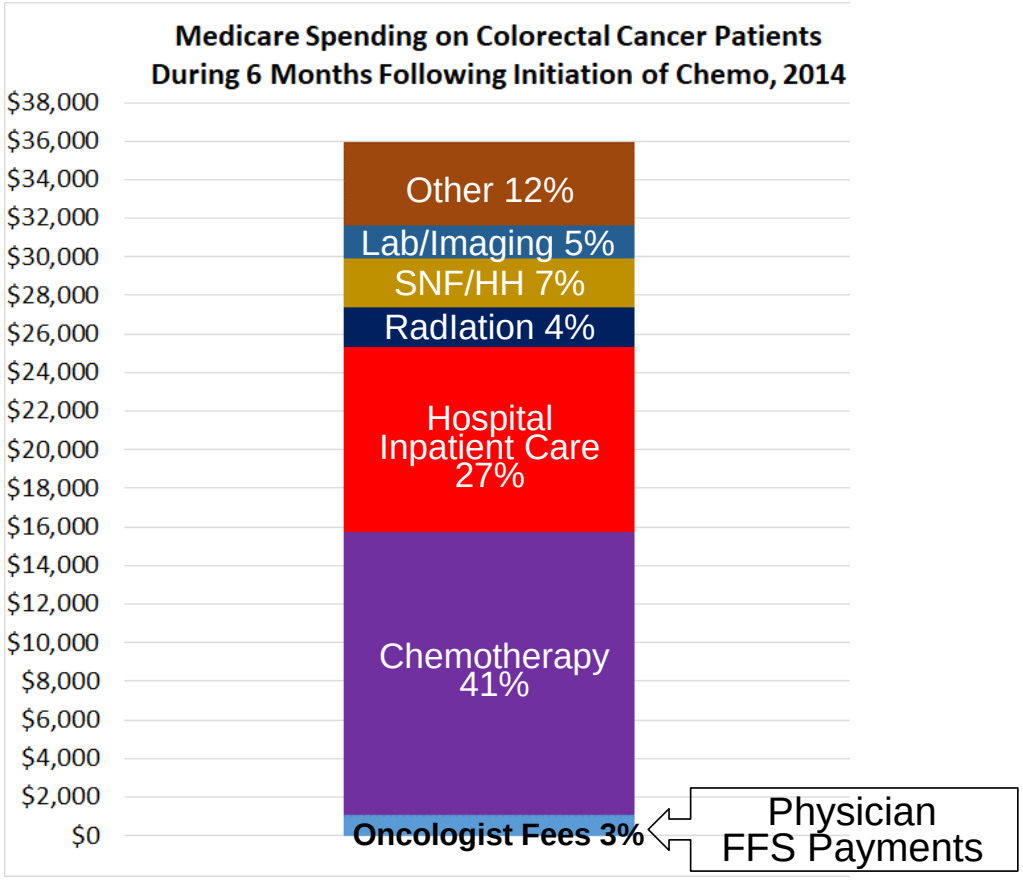


Medicare Tried Shared Savings for Medical Homes and Stopped

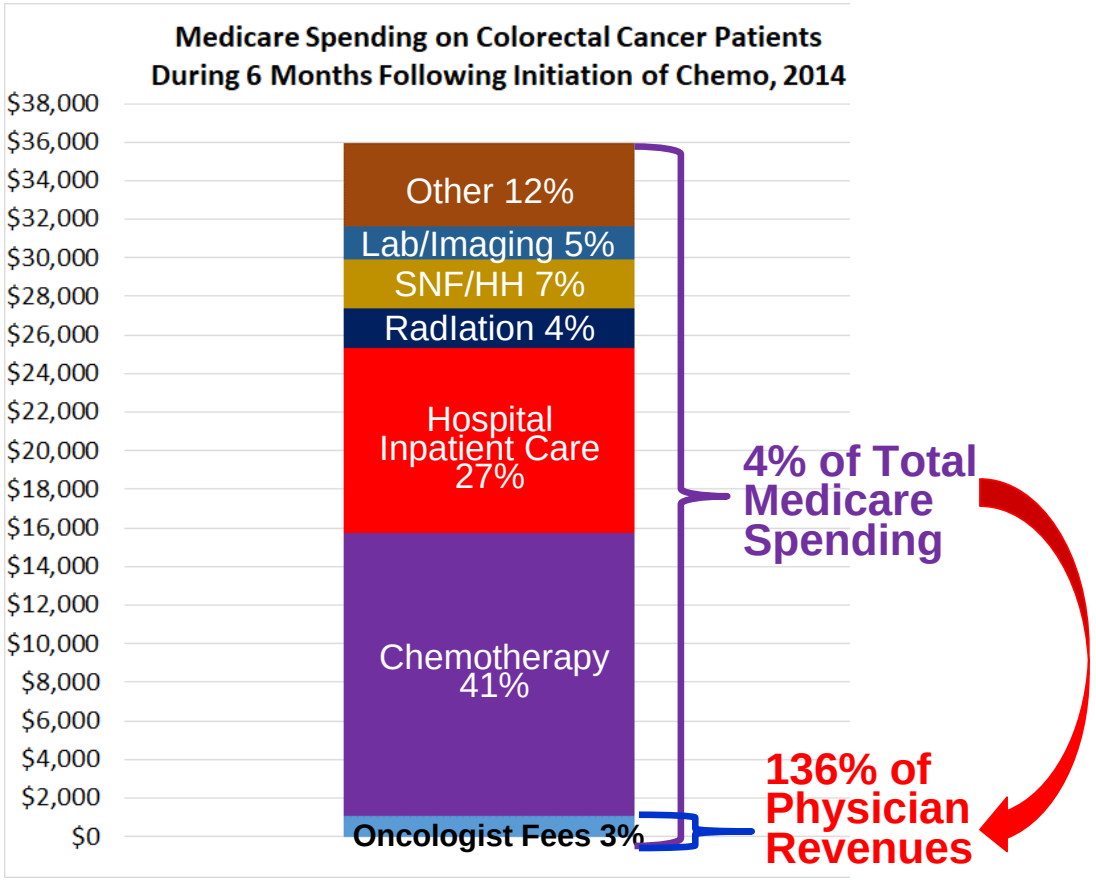
We have seen in the Original CPC Model that shared savings under that model has certain limitations in motivating practices to control total cost of care. For example: (1) individual practice control over the likelihood of a shared savings payment is attenuated because spending is aggregated at the regional level: (2) total cost of care may be challenging for small primary care practices to control and there are no independent incentives for improved quality; and (3) the amount of any shared savings payments is unknown in advance and the complexity of the regionally aggregated formula and paucity of actionable cost data leaves practices doubtful of achieving any return.

CMS FAQ on CPC+

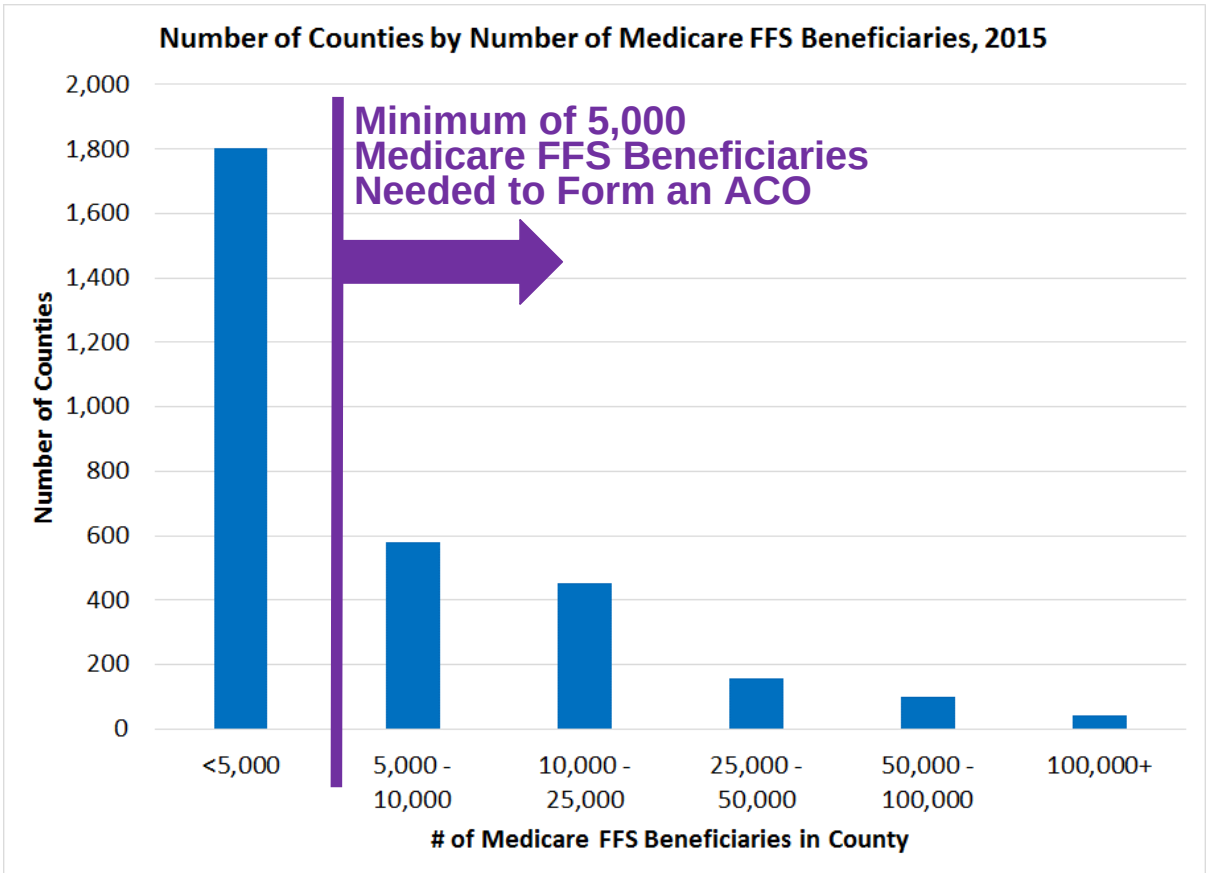
<5% of Spending During Chemo Goes to Physician Fees



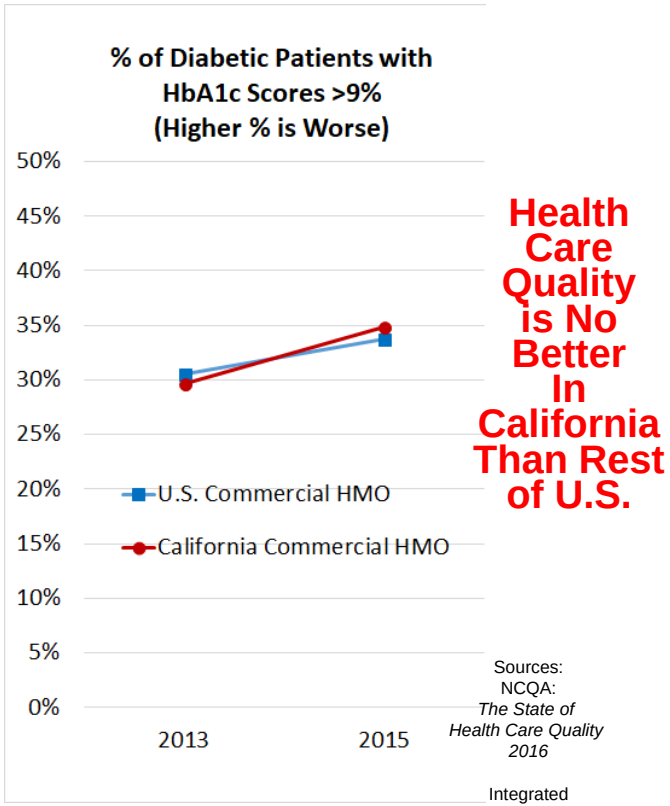
Risk for 4% of Total Spending > 100% of Oncologists' Fees



Most Counties Aren't Big Enough to Create a Medicare ACO



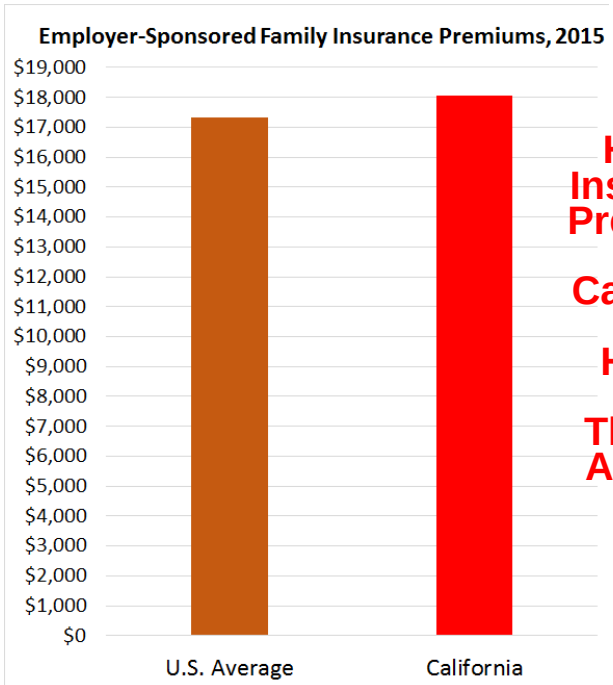
Capitation Has Not Transformed Care Where It's Being Used



Health Care Quality is No Better In California Than Rest of U.S.

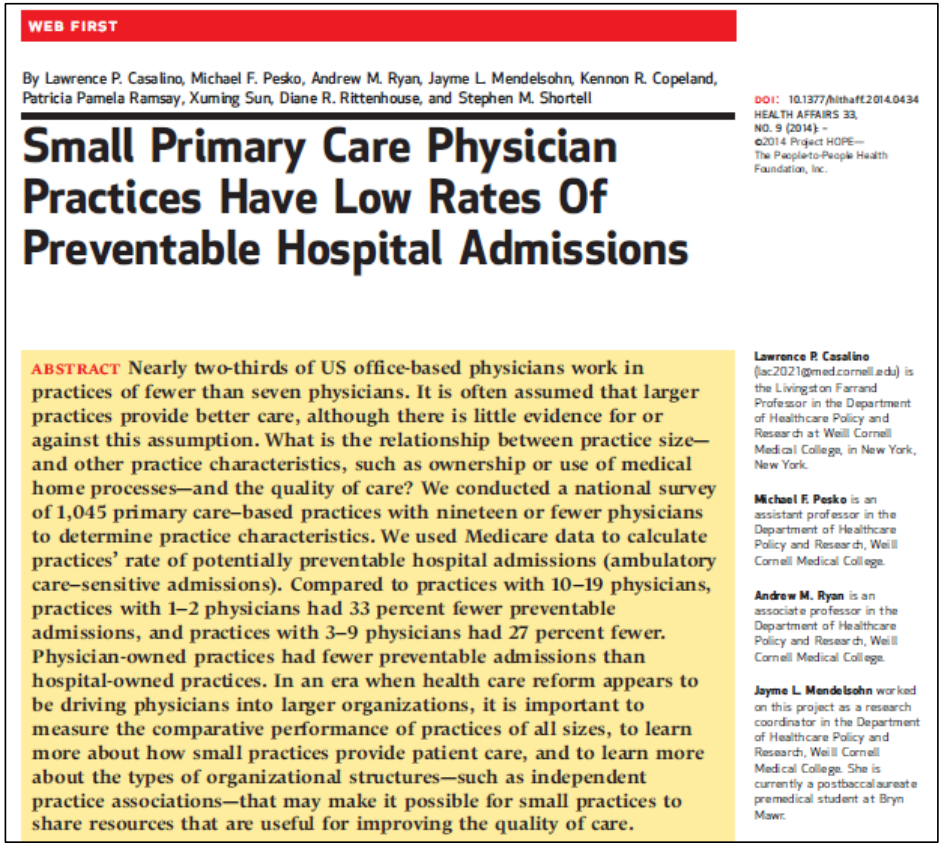
Sources:
NCQA:
The State of Health Care Quality 2016

Integrated Healthcare Association
California Regional Health Care Cost & Quality Atlas



Health Insurance Premiums in California Are Higher Than The U.S. Average

Small, Independent Practices Do Better Than Big Systems



WEB FIRST

By Lawrence P. Casalino, Michael F. Pesko, Andrew M. Ryan, Jayme L. Mendelsohn, Kennon R. Copeland, Patricia Pamela Ramsay, Xuming Sun, Diane R. Rittenhouse, and Stephen M. Shortell

Small Primary Care Physician Practices Have Low Rates Of Preventable Hospital Admissions

DOI: 10.1377/hlthaff.2014.0434
HEALTH AFFAIRS 33,
NO. 9 (2014): –

ABSTRACT Nearly two-thirds of US office-based physicians work in practices of fewer than seven physicians. It is often assumed that larger practices provide better care, although there is little evidence for or against this assumption. What is the relationship between practice size—and other practice characteristics, such as ownership or use of medical home processes—and the quality of care? We conducted a national survey of 1,045 primary care–based practices with nineteen or fewer physicians to determine practice characteristics. We used Medicare data to calculate practices' rate of potentially preventable hospital admissions (ambulatory care–sensitive admissions). Compared to practices with 10–19 physicians, practices with 1–2 physicians had 33 percent fewer preventable admissions, and practices with 3–9 physicians had 27 percent fewer. Physician-owned practices had fewer preventable admissions than hospital-owned practices. In an era when health care reform appears to be driving physicians into larger organizations, it is important to measure the comparative performance of practices of all sizes, to learn more about how small practices provide patient care, and to learn more about the types of organizational structures—such as independent practice associations—that may make it possible for small practices to share resources that are useful for improving the quality of care.

Lawrence P. Casalino (lac2021@med.cornell.edu) is the Livingston Farrand Professor in the Department of Healthcare Policy and Research at Weill Cornell Medical College, in New York, New York.

Michael F. Pesko is an assistant professor in the Department of Healthcare Policy and Research, Weill Cornell Medical College.

Andrew M. Ryan is an associate professor in the Department of Healthcare Policy and Research, Weill Cornell Medical College.

Jayme L. Mendelsohn worked on this project as a research coordinator in the Department of Healthcare Policy and Research, Weill Cornell Medical College. She is currently a postbaccalaureate premedical student at Bryn Mawr.

Big Delivery Systems Raise Prices

HOSPITAL PRODUCTIVITY

DOI: 10.1377/hlthaff.2013.1279
HEALTH AFFAIRS 33,
NO. 5 (2014): 756–763

By Laurence C. Baker, M. Kate Bundorf, and Daniel P. Kessler

Vertical Integration: Hospital Ownership Of Physician Practices Is Associated With Higher Prices And Spending

Laurence C. Baker is a professor of health research and policy at Stanford University, in California, and a research associate at the National Bureau of Economic Research, in Cambridge, Massachusetts.

M. Kate Bundorf is a professor of health research and policy at Stanford University and a faculty research fellow at the National Bureau of Economic Research.

Daniel P. Kessler (fkessler@stanford.edu) is a professor in the Law School and the Graduate School of Business, a professor (by courtesy) in the Department of Health Research and Policy, and a senior fellow at the Hoover Institution, all at Stanford University. He is also a research associate at the National Bureau of Economic Research.

ABSTRACT We examined the consequences of contractual or ownership relationships between hospitals and physician practices, often described as vertical integration. Such integration can reduce health spending and increase the quality of care by improving communication across care settings, but it can also increase providers' market power and facilitate the payment of what are effectively kickbacks for inappropriate referrals. We investigated the impact of vertical integration on hospital prices, volumes (admissions), and spending for privately insured patients. Using hospital claims from Truven Analytics MarketScan for the nonelderly privately insured in the period 2001–07, we constructed county-level indices of prices, volumes, and spending and adjusted them for enrollees' age and sex. We measured hospital-physician integration using information from the American Hospital Association on the types of relationships hospitals have with physicians. We found that an increase in the market share of hospitals with the tightest vertically integrated relationship with physicians—ownership of physician practices—was associated with higher hospital prices and spending. We found that an increase in contractual integration reduced the frequency of hospital admissions, but this effect was relatively small. Taken together, our results provide a mixed, although somewhat negative, picture of vertical integration from the perspective of the privately insured.

Research

JAMA Intern Med. doi:10.1001/jamainternmed.2015.4610
Published online October 19, 2015.

Original Investigation

Association of Financial Integration Between Physicians and Hospitals With Commercial Health Care Prices

Hannah T. Neprash, BA; Michael E. Chernew, PhD; Andrew L. Hicks, MS; Teresa Gibson, PhD; J. Michael McWilliams, MD, PhD

CONCLUSIONS AND RELEVANCE Financial integration between physicians and hospitals has been associated with higher commercial prices and spending for outpatient care.

Research

JAMA. 2014;312(16):1663-1669. doi:10.1001/jama.2014.14072

Original Investigation

Total Expenditures per Patient in Hospital-Owned and Physician-Owned Physician Organizations in California

James C. Robinson, PhD, MPH; Kelly Miller, BA

CONCLUSIONS AND RELEVANCE From the perspective of the insurers and patients, between 2009 and 2012, hospital-owned physician organizations in California incurred higher expenditures for commercial HMO enrollees for professional, hospital, laboratory, pharmaceutical, and ancillary services than physician-owned organizations. Although organizational consolidation may increase some forms of care coordination, it may be associated with higher total expenditures.

Patients Don’t See the Benefits of Big Systems and Capitation…

INTEGRATED CARE

By Michaela J. Kerrissey, Jonathan R. Clark, Mark W. Friedberg, Wei Jiang, Ashley K. Fryer, Molly Frean, Stephen M. Shortell, Patricia P. Ramsay, Lawrence P. Casalino, and Sara J. Singer

Medical Group Structural Integration May Not Ensure That Care Is Integrated, From The Patient's Perspective

DOI: 10.1377/hlthaff.2016.0909
HEALTH AFFAIRS 36,
NO. 5 (2017): 885–892

ABSTRACT Structural integration is increasing among medical groups, but whether these changes yield care that is more integrated remains unclear. We explored the relationships between structural integration characteristics of 144 medical groups and perceptions of integrated care among their patients. Patients' perceptions were measured by a validated national survey of 3,067 Medicare beneficiaries with multiple chronic conditions across six domains that reflect knowledge and support of, and communication with, the patient. Medical groups' structural characteristics were taken from the National Study of Physician Organizations and included practice size, specialty mix, technological capabilities, and care management processes. Patients' survey responses were most favorable for the domain of test result communication and least favorable for the domain of provider support for medication and home health management. Medical groups' characteristics were not consistently associated with patients' perceptions of integrated care. However, compared to patients of primary care groups, patients of multispecialty groups had strong favorable perceptions of medical group staff knowledge of patients' medical histories. Opportunities exist to improve patient care, but structural integration of medical groups might not be sufficient for delivering care that patients perceive as integrated.

Michaela J. Kerrissey (mkerrissey@hbs.edu) is a doctoral student at Harvard Business School, in Boston, Massachusetts.

Jonathan R. Clark is an assistant professor of management at the University of Texas at San Antonio.

Mark W. Friedberg is a senior natural scientist at the RAND Corporation in Boston.

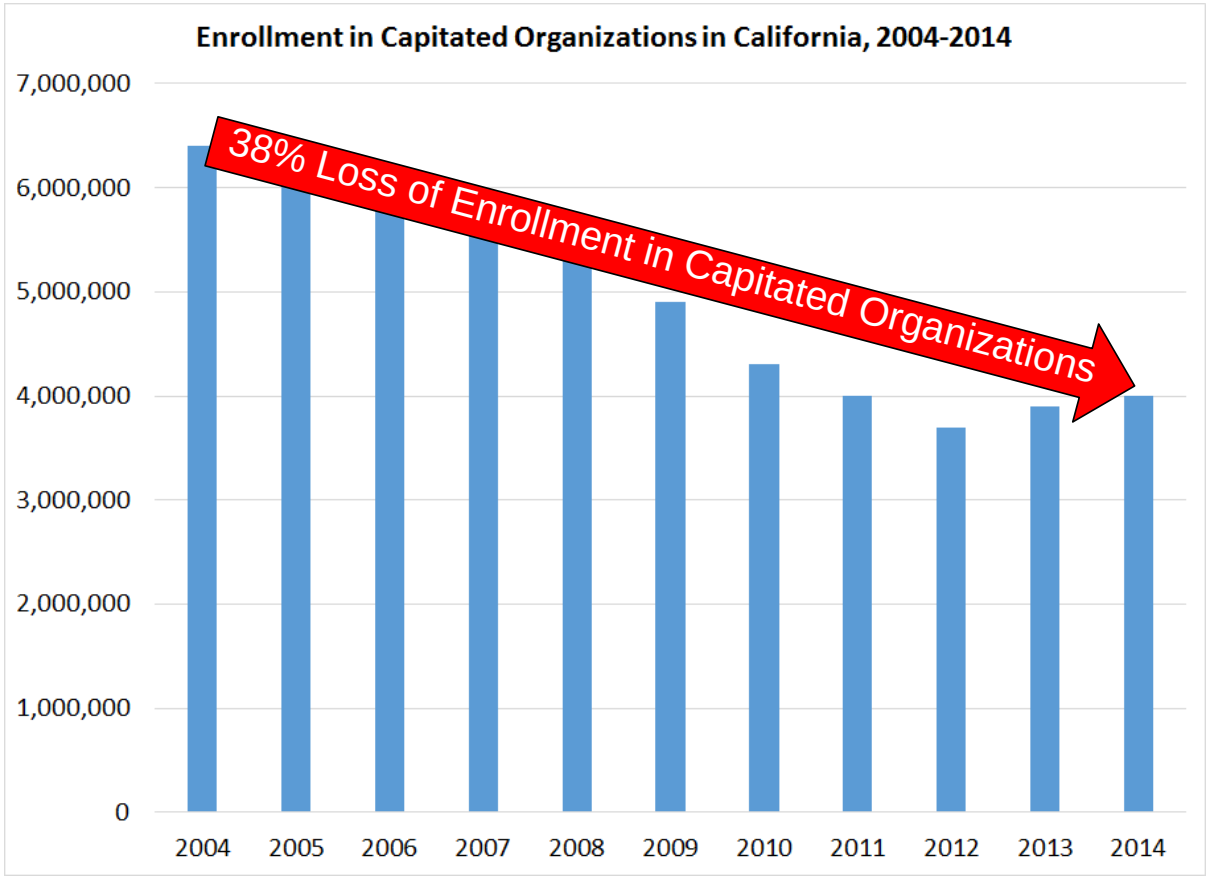
Wei Jiang is a manager of biostatistics at Brigham and Women's Hospital, in Boston.

Ashley K. Fryer is director of product strategy at Optum Analytics, in Boston.

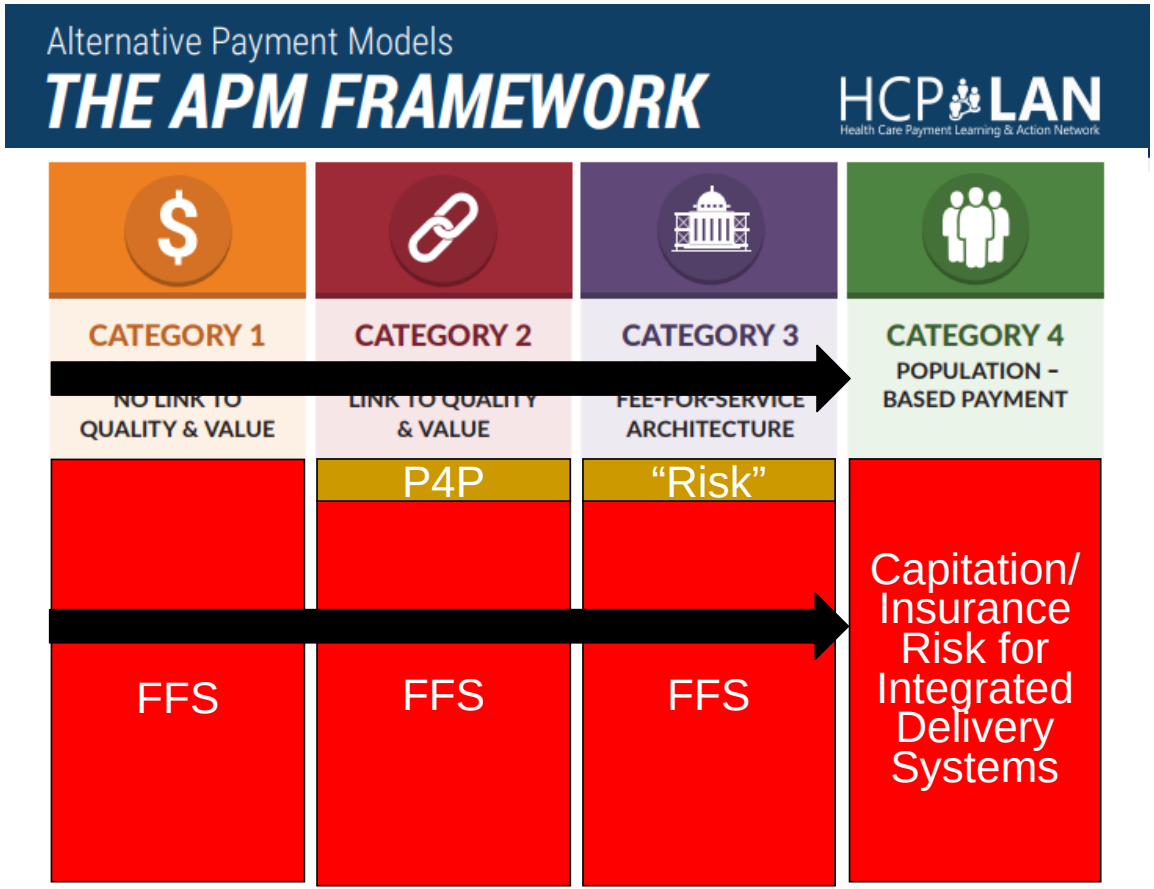
Molly Frean is a doctoral student at the Wharton School, University of Pennsylvania, in Philadelphia.

Stephen M. Shortell is the Blue Cross of California Distinguished Professor of Health Policy and

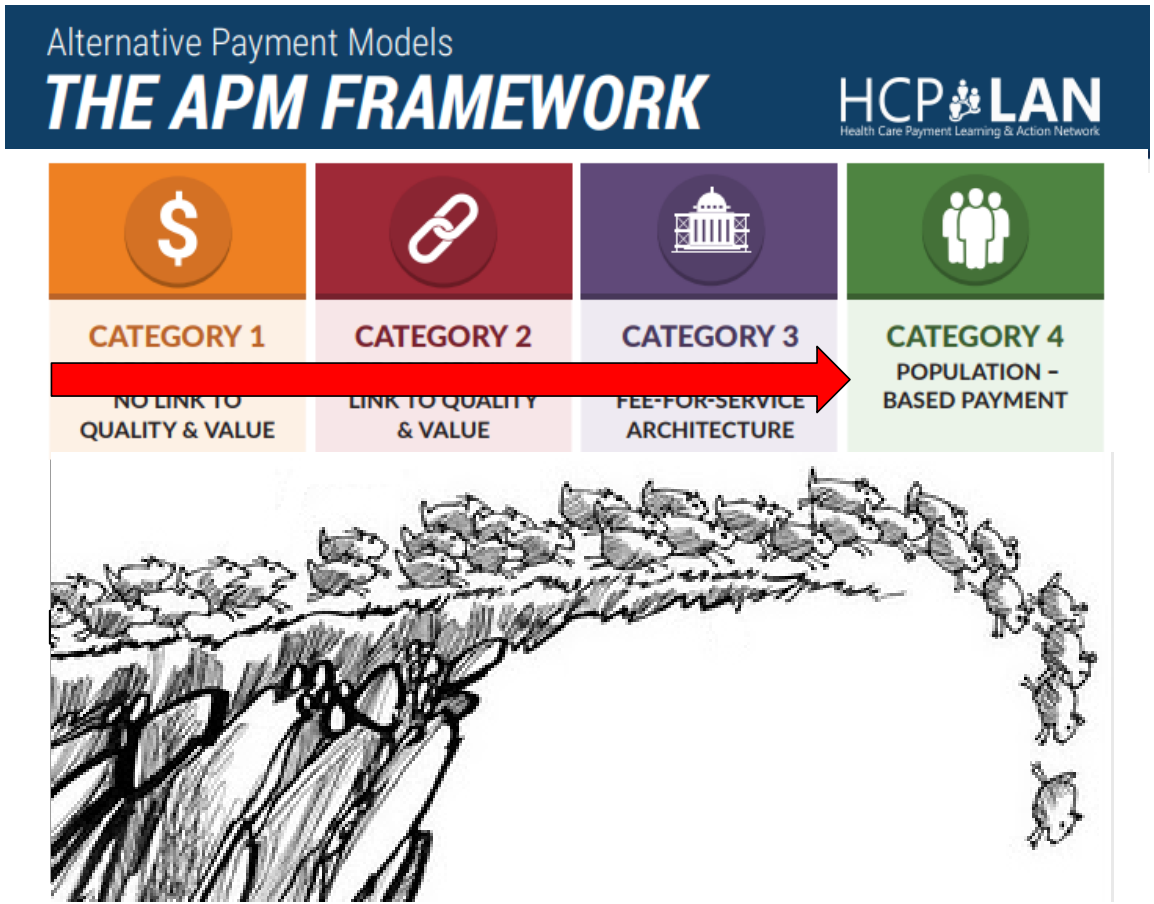
…And They're Voting (With Their Feet) For Other Options



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



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



Value-Based Payment Is Being Designed the *Wrong* Way Today

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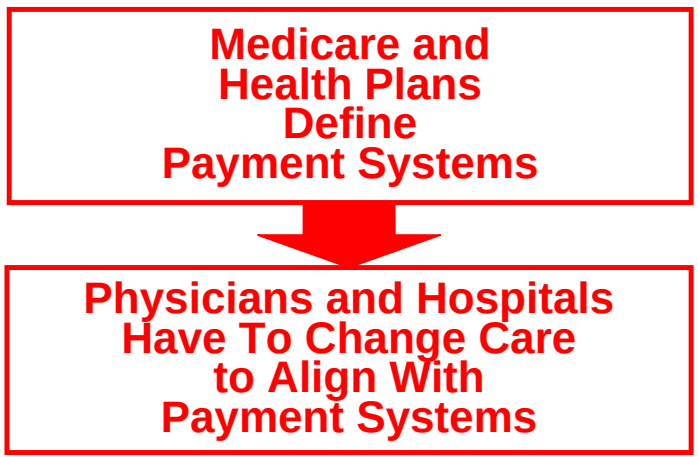
TOP-DOWN PAYMENT REFORM

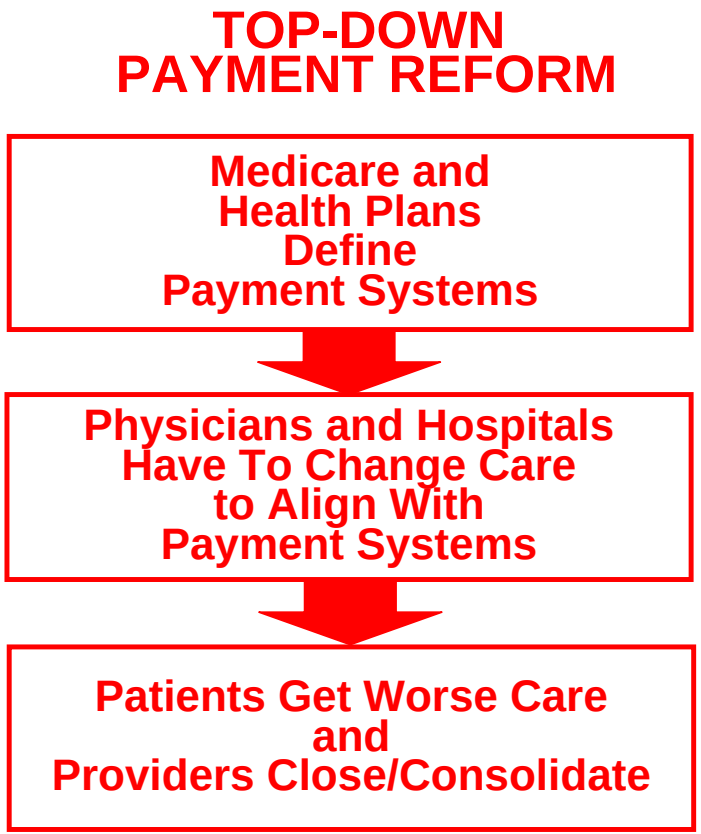
Medicare and Health Plans Define Payment Systems

Value-Based Payment Is Being Designed the *Wrong* Way Today

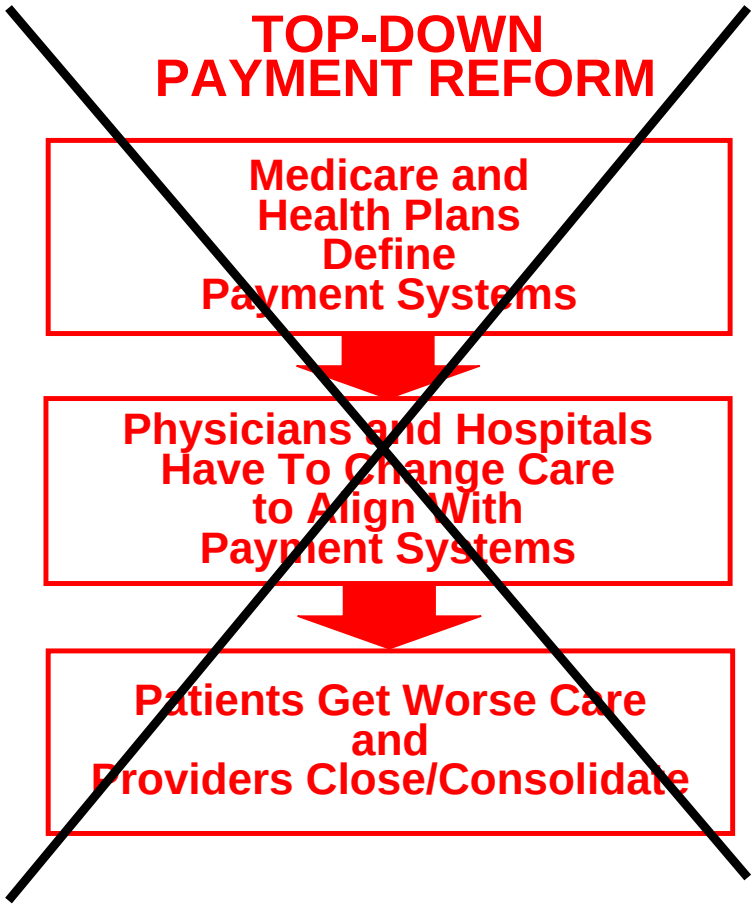
TOP-DOWN PAYMENT REFORM



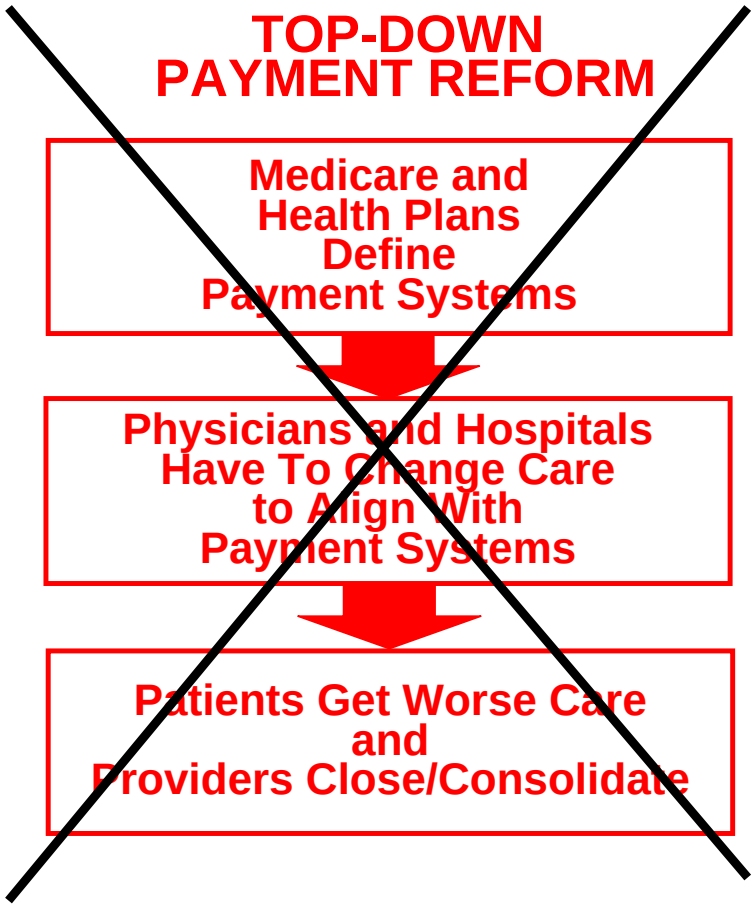
Value-Based Payment Is Being Designed the *Wrong* Way Today



Is There a Better Way?



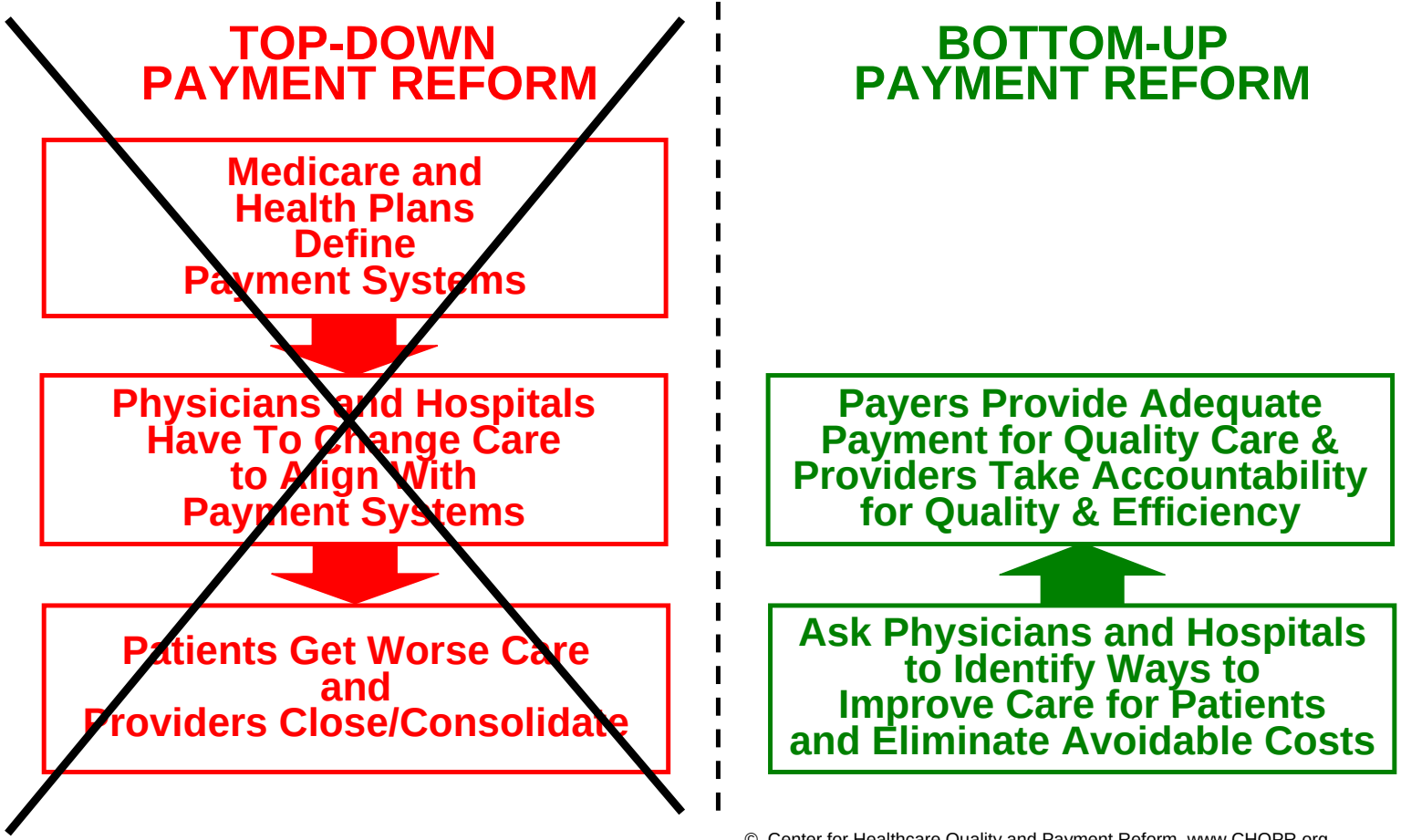
Start By Identifying Ways to Improve Care & Reduce Costs…



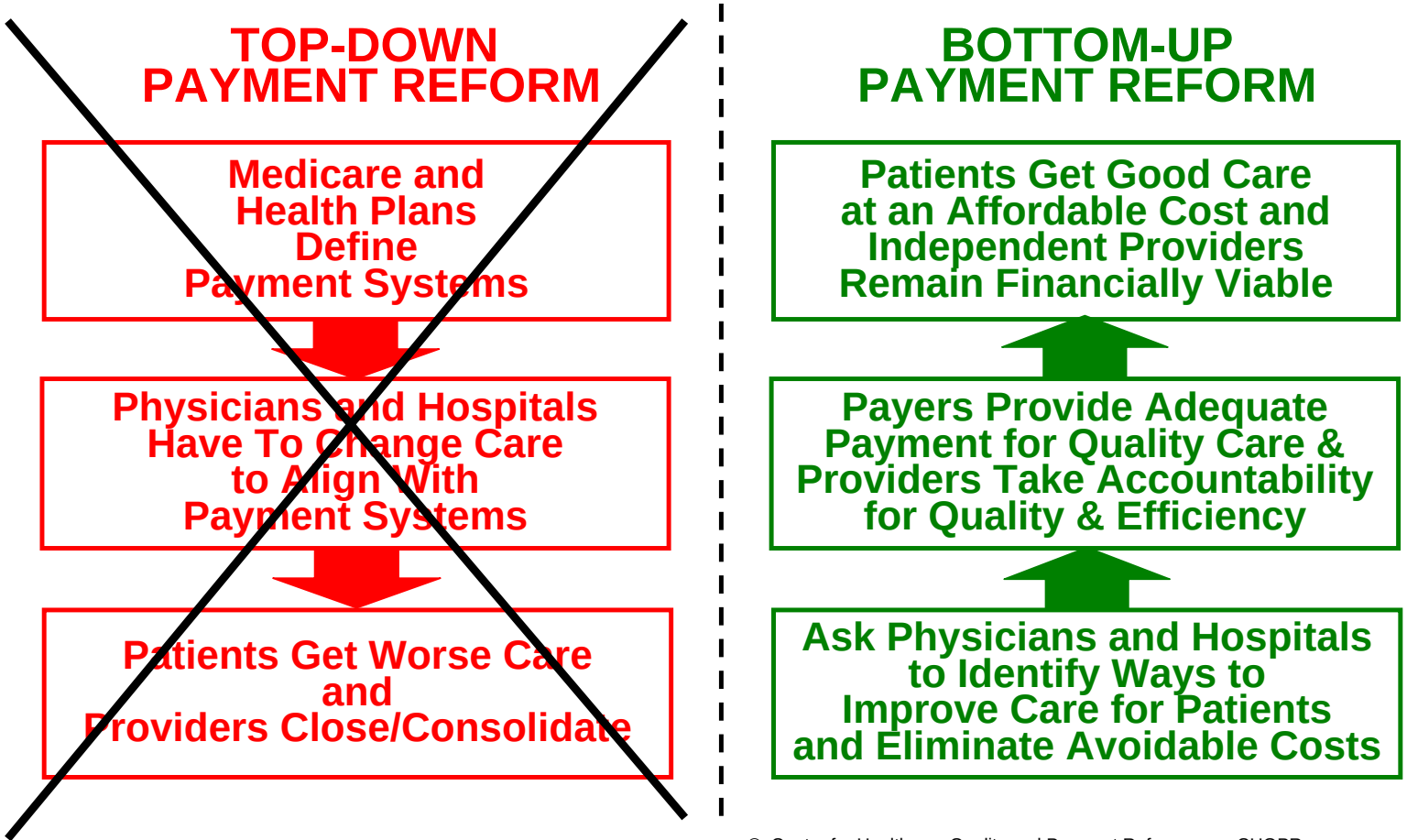
BOTTOM-UP PAYMENT REFORM

Ask Physicians and Hospitals to Identify Ways to Improve Care for Patients and Eliminate Avoidable Costs

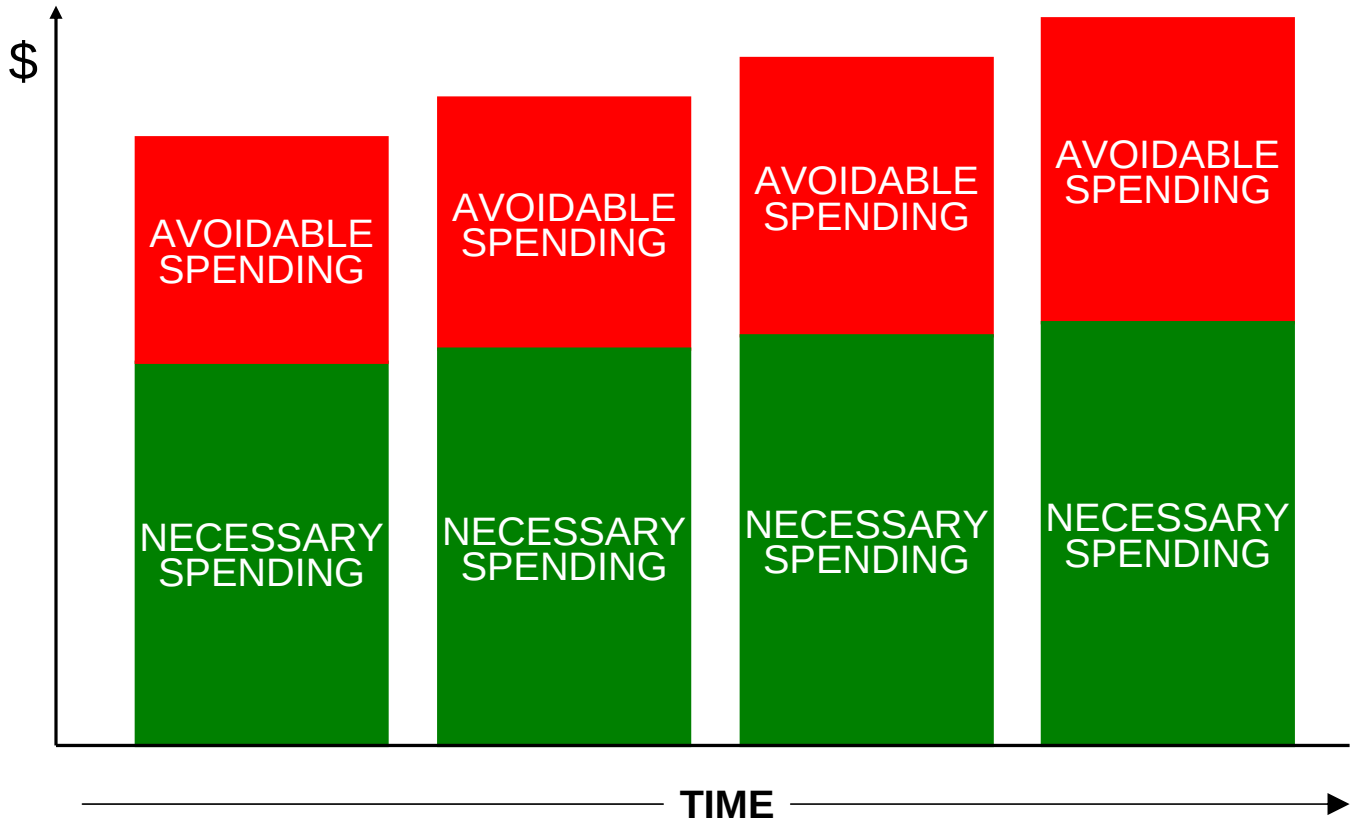
…Pay Adequately & Expect Accountability for Outcomes…



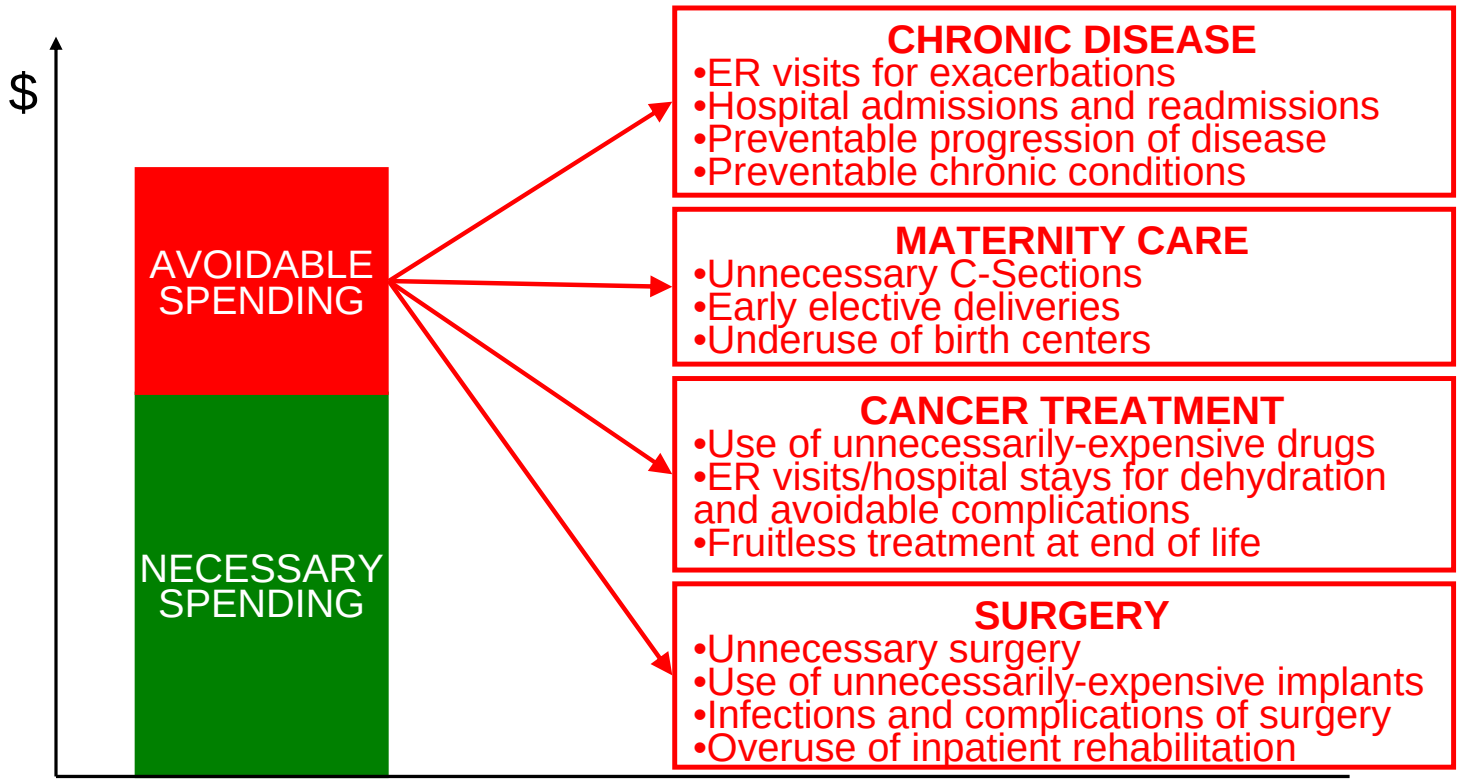
…So the Result is Better, More Affordable Patient Care



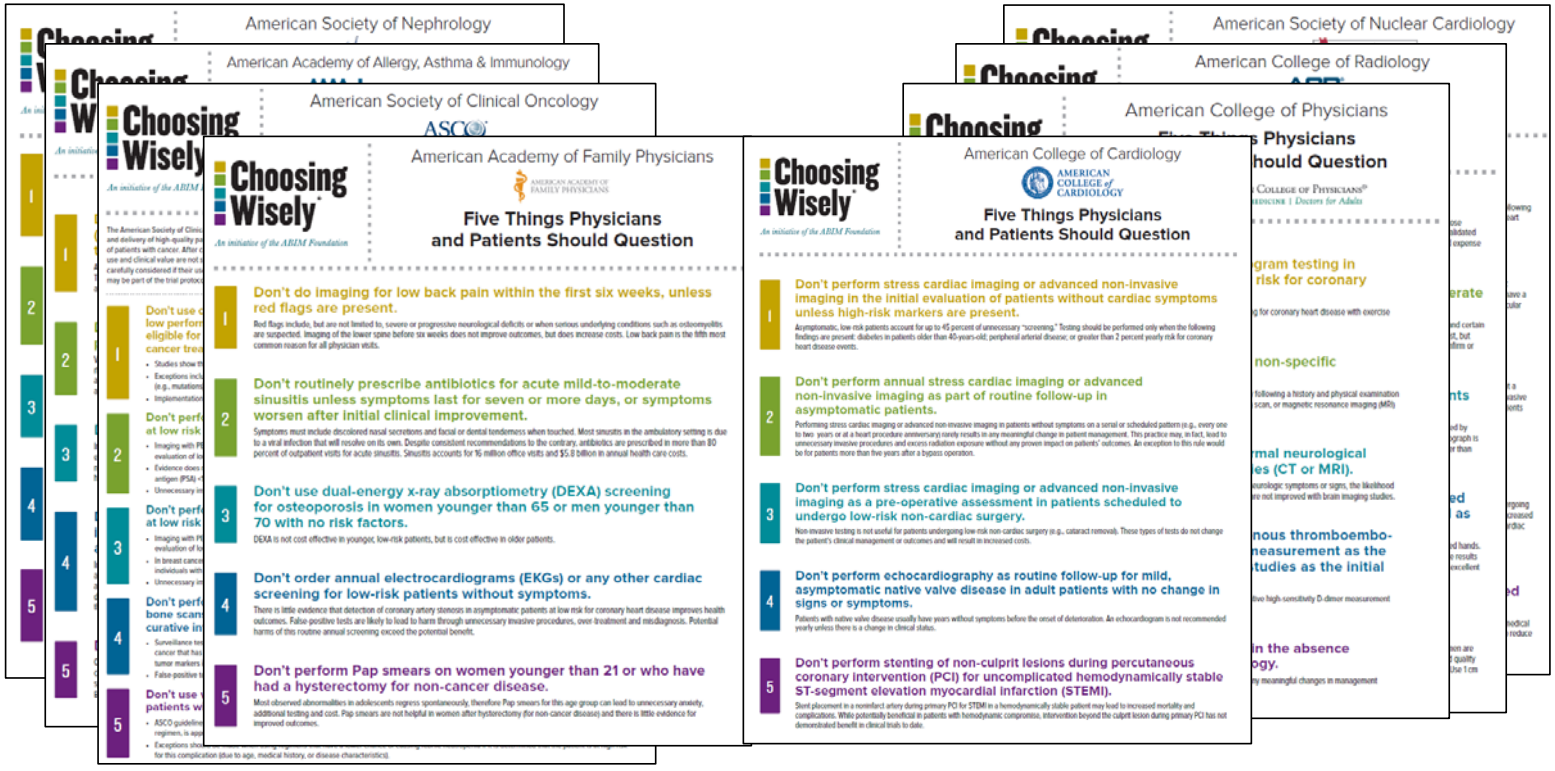
The Right Focus: Spending That is *Unnecessary* or *Avoidable*



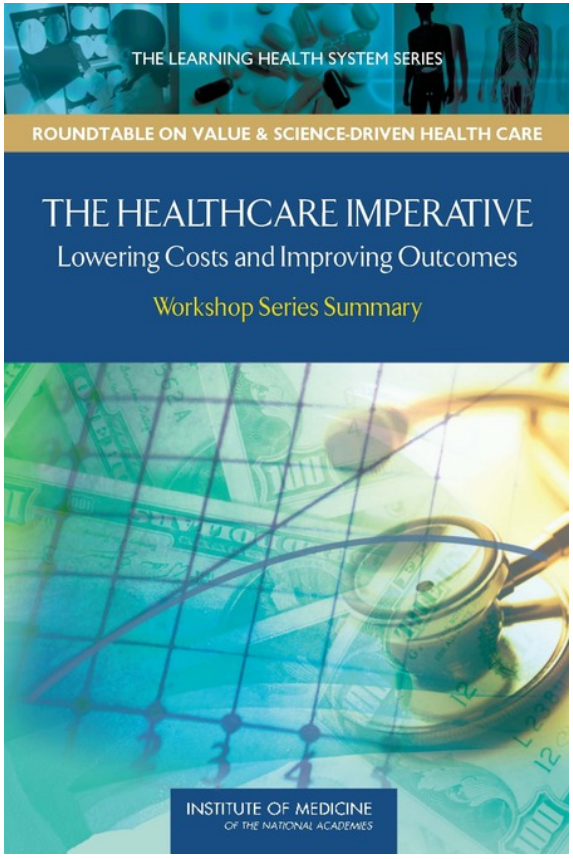
Avoidable Spending Occurs In All Aspects of Healthcare



Many Ways to Reduce Tests & Services Without Harming Patients



Institute of Medicine Estimate: 30% of Spending is Avoidable



Excess Cost Domain Estimates:
Lower bound totals from workshop discussions*

UNNECESSARY SERVICES — **Total excess = $210 B***
- Overuse: services beyond evidence-established levels
- Discretionary use beyond benchmarks
  - Defensive medicine
- Unnecessary choice of higher cost services

INEFFICIENTLY DELIVERED SERVICES — **Total excess = $130 B***
- Mistakes—medical errors, preventable complications
- Care fragmentation
- Unnecessary use of higher cost providers
- Operational inefficiencies at care delivery sites
  - Physician offices
  - Hospitals

EXCESS ADMINISTRATIVE COSTS — **Total excess = $190 B***
- Insurance-related administrative costs beyond benchmarks
  - Insurers
  - Physician offices
  - Hospitals
  - Other providers
- Insurer administrative inefficiencies
- Care documentation requirement inefficiencies

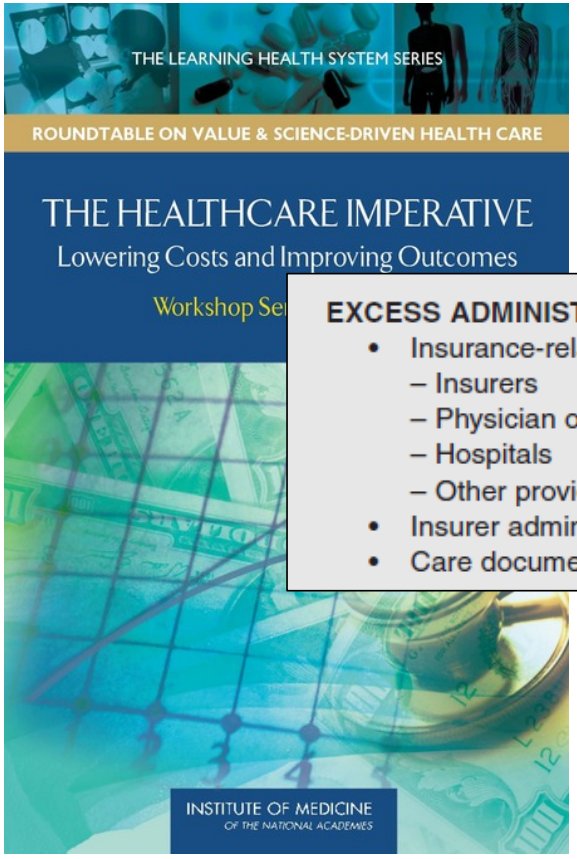
PRICES THAT ARE TOO HIGH — **Total excess = $105 B***
- Service prices beyond competitive benchmarks
  - Physician services
    - i. Specialists
    - ii. Generalists
  - Hospital services
- Product prices beyond competitive benchmarks
  - Pharmaceuticals
  - Medical devices
  - Durable medical equipment

MISSED PREVENTION OPPORTUNITIES — **Total excess = $55 B***
- Primary prevention
- Secondary prevention
- Tertiary prevention

FRAUD — **Total excess = $75 B***
- All sources—payer, clinician, patient

*Lower bound totals of various estimates, adjusted to 2009 total expenditure level.

25% of Avoidable Spending is Excess Administrative Costs



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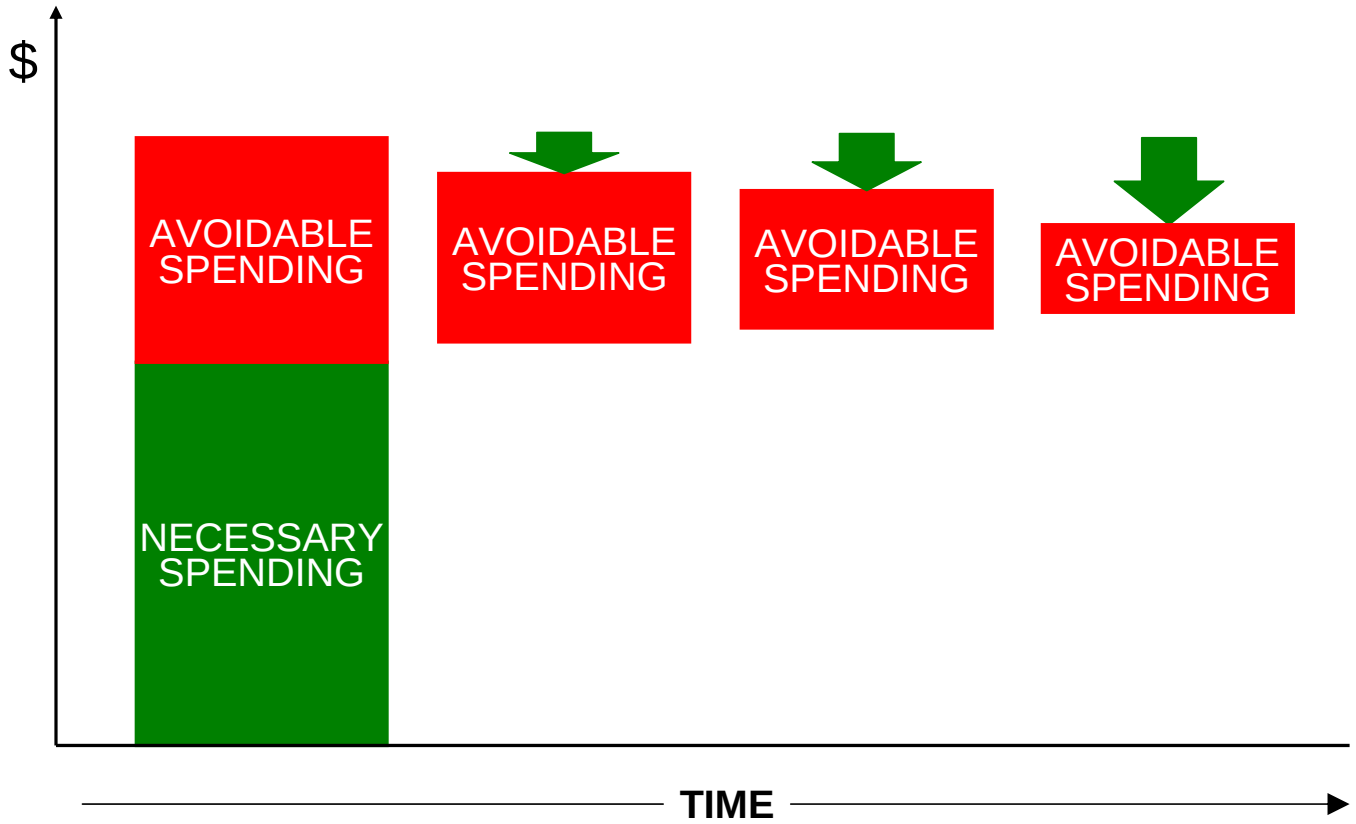
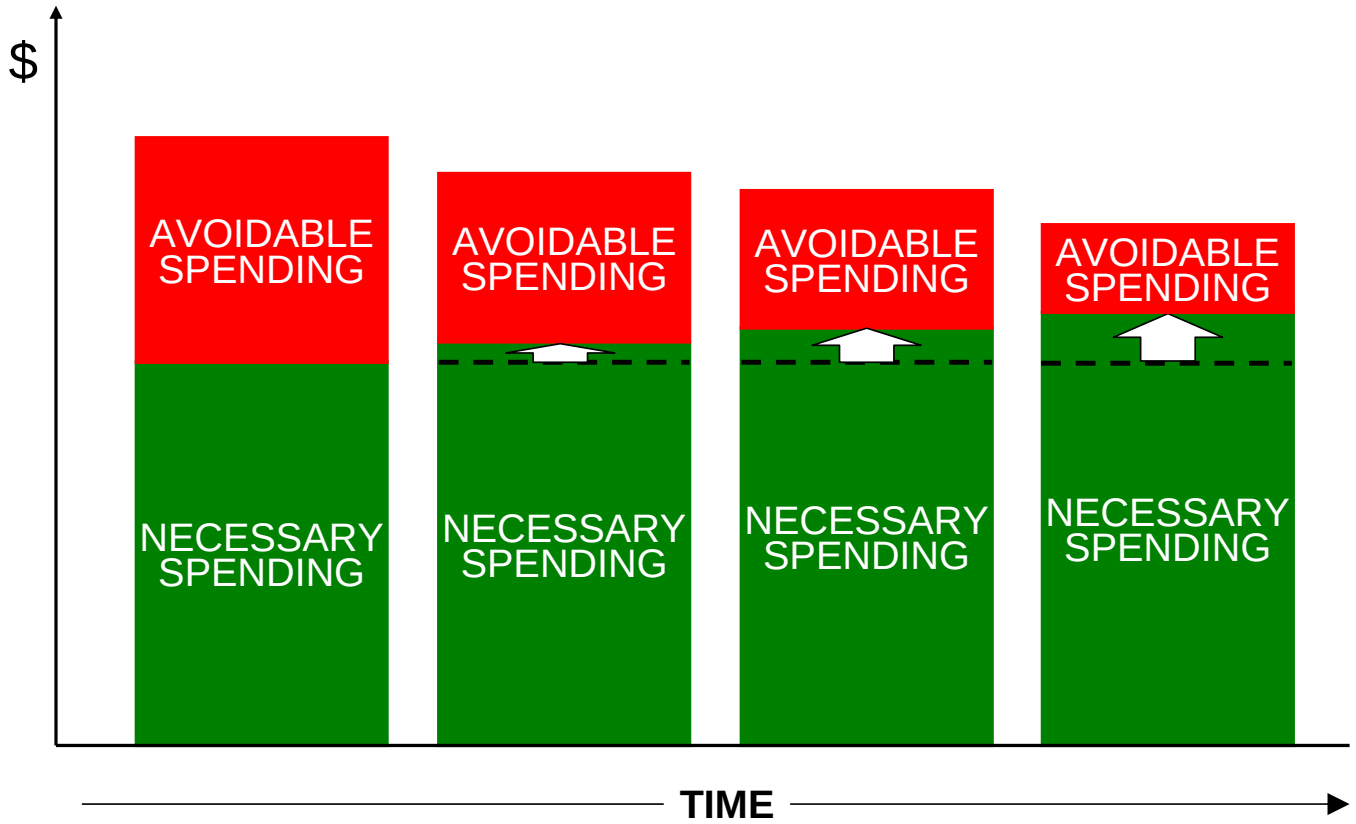
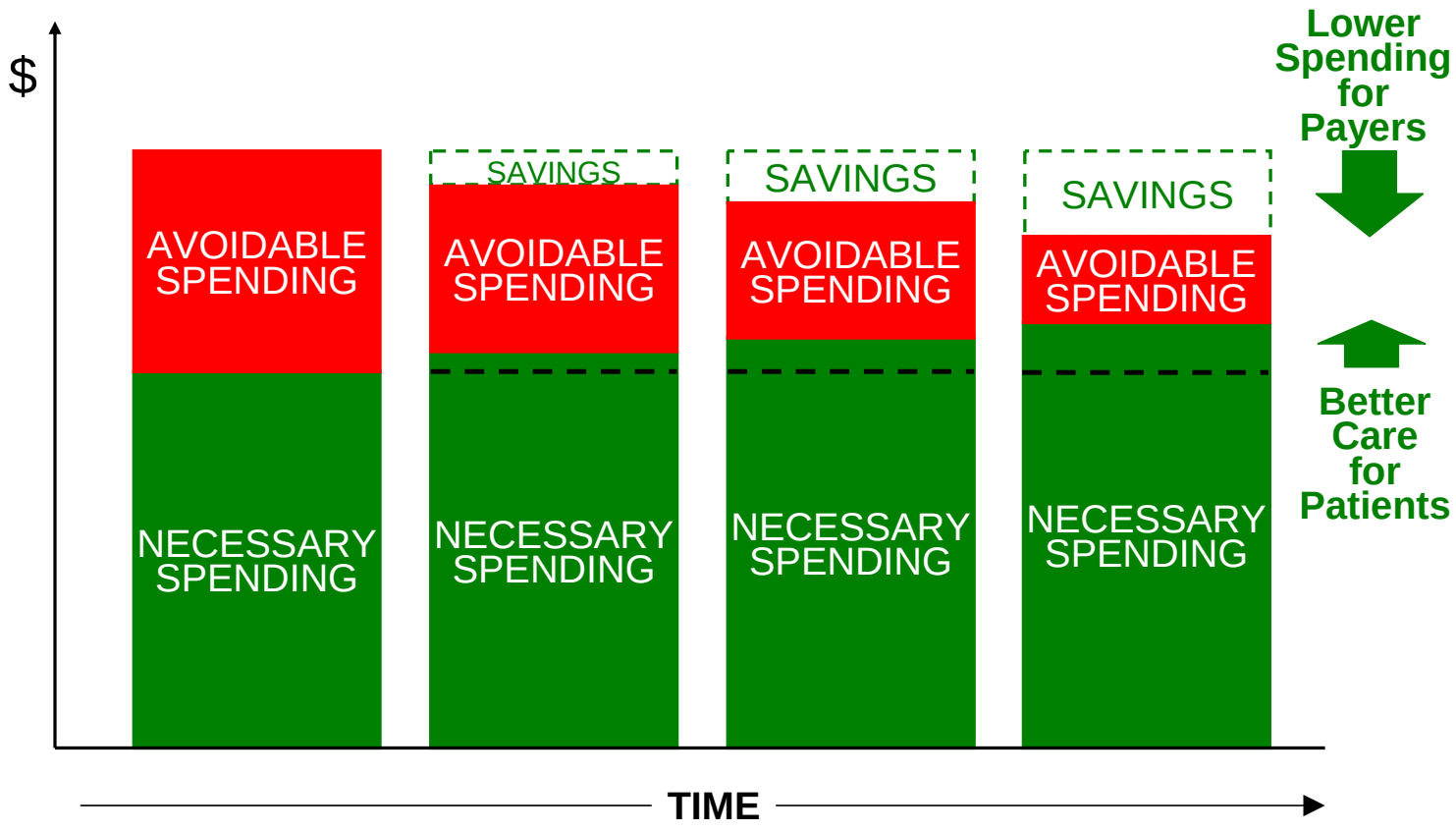
The Right Goal: Less Avoidable $,



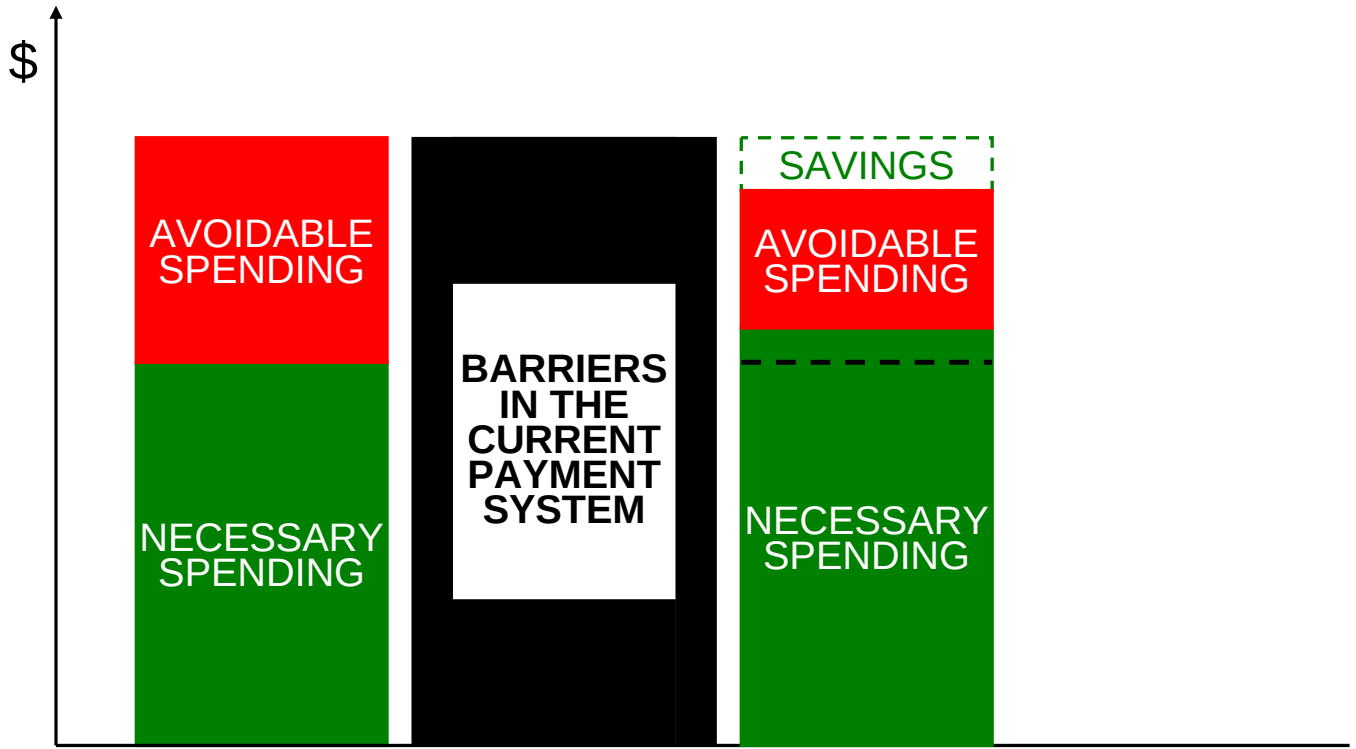
The Right Goal: Less Avoidable $, More Necessary $



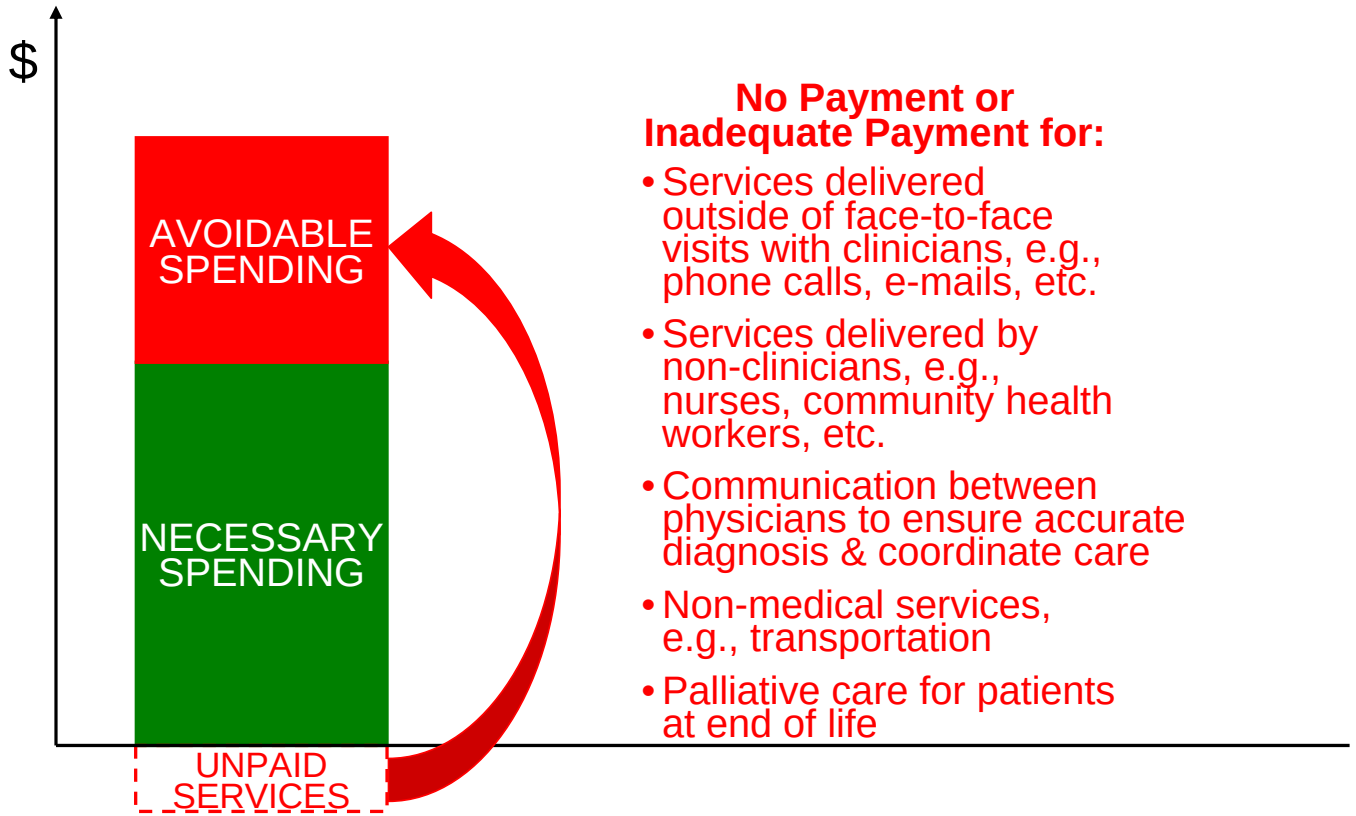
Win-Win for Patients & Payers



Barriers in the Payment System Create a Win-*Lose* for Providers



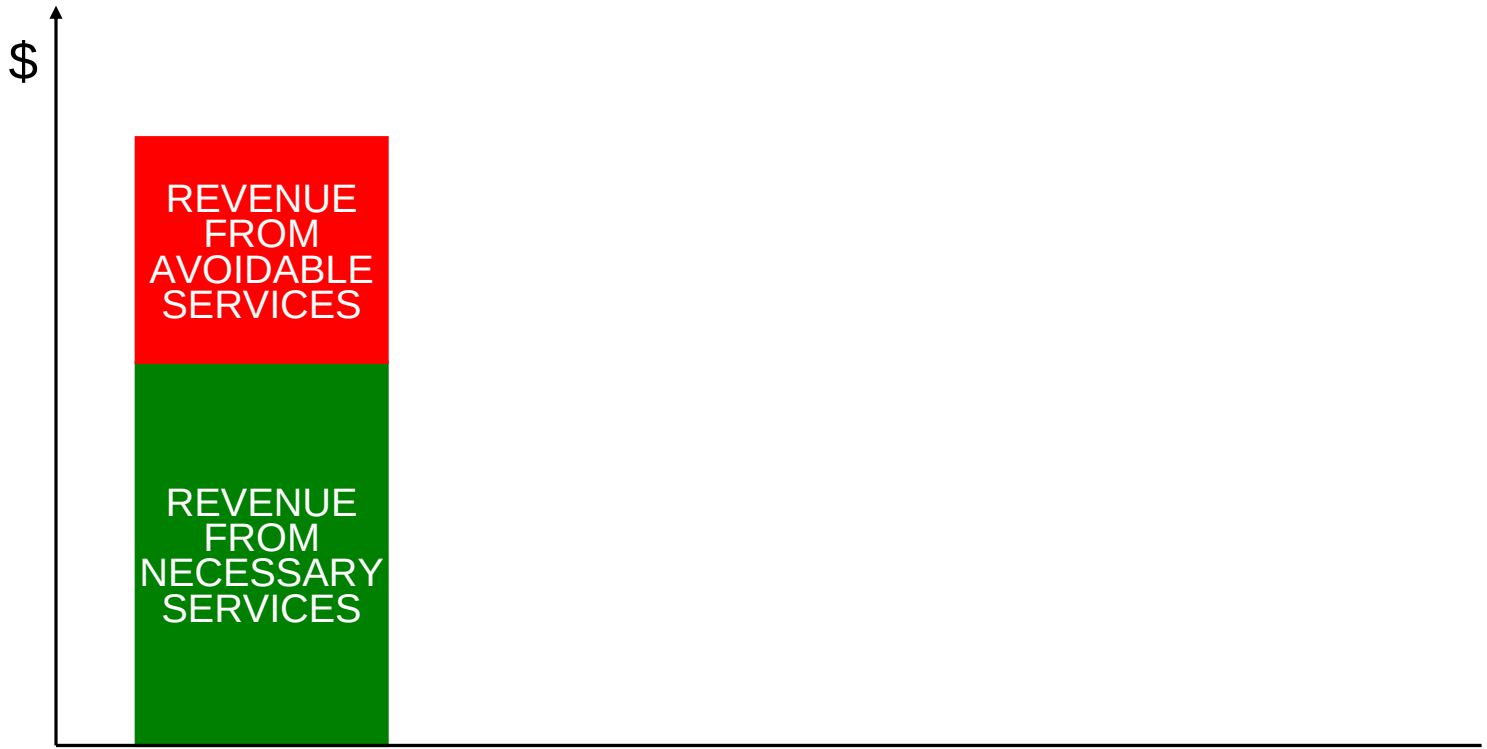
Barrier #1: No $ or Inadequate $ for High-Value Services



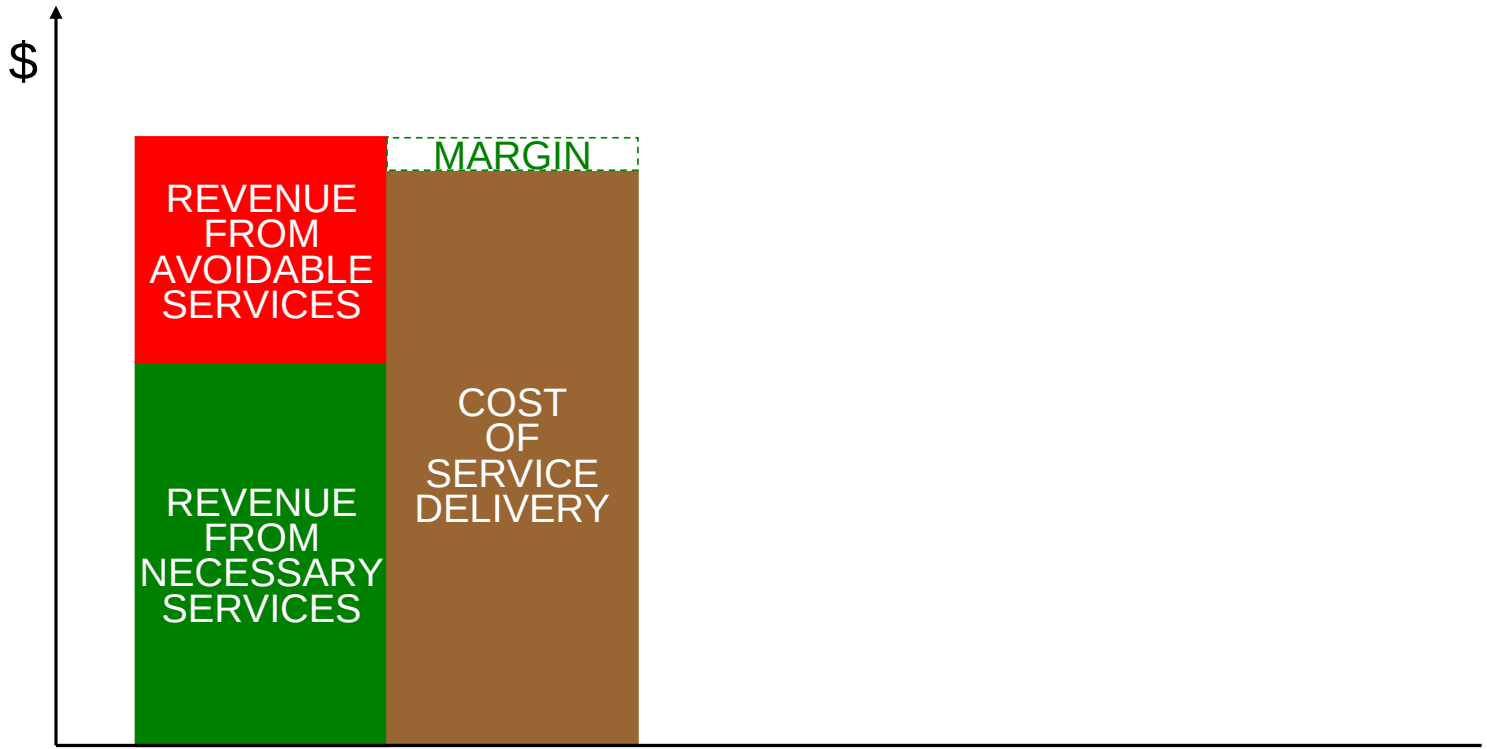
No Payment or Inadequate Payment for:

- Services delivered outside of face-to-face visits with clinicians, e.g., phone calls, e-mails, etc.
- Services delivered by non-clinicians, e.g., nurses, community health workers, etc.
- Communication between physicians to ensure accurate diagnosis & coordinate care
- Non-medical services, e.g., transportation
- Palliative care for patients at end of life

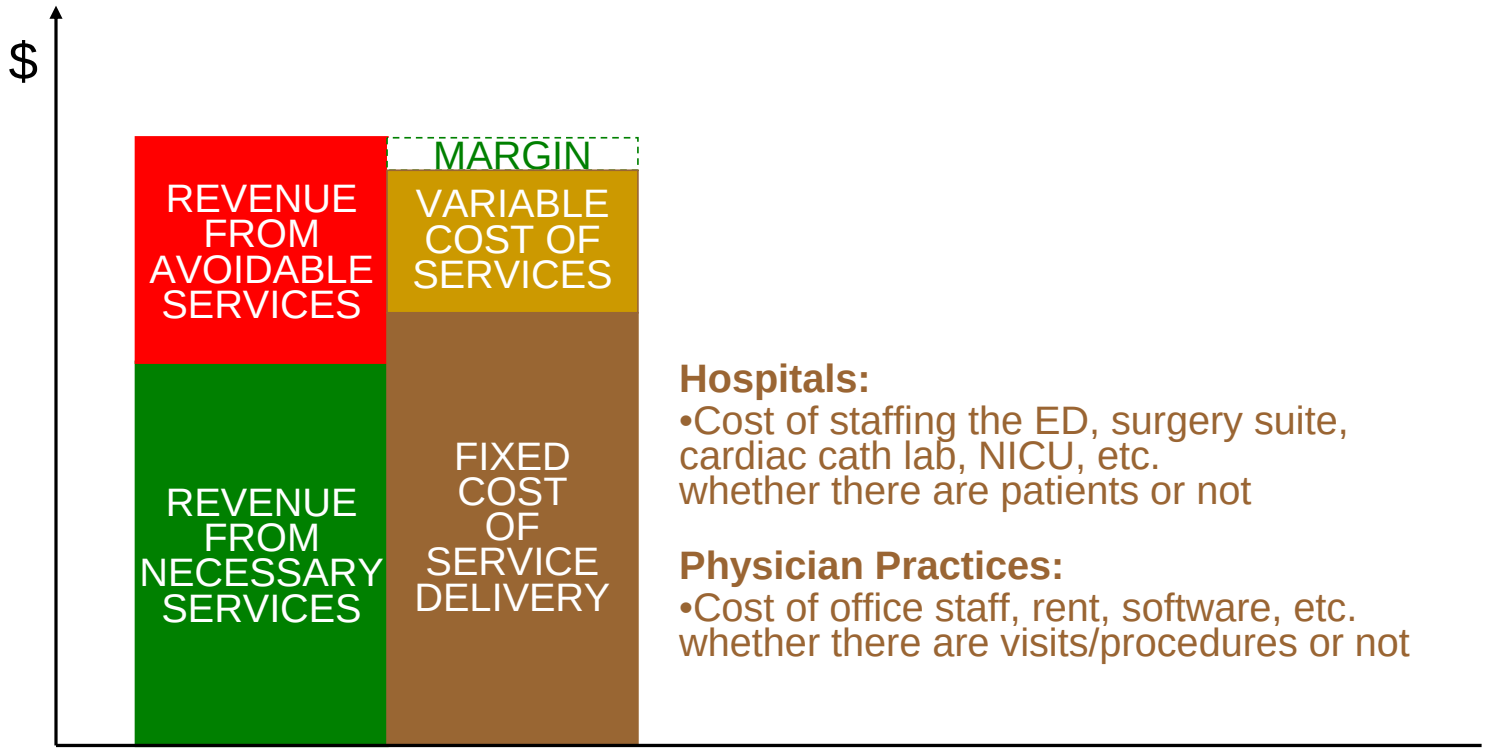
Barrier #2: Avoidable Spending Is Revenue for Providers…



Revenue from Avoidable Services Helps Cover Cost of Services



…Many Costs Are Fixed, At Least in the Short Run



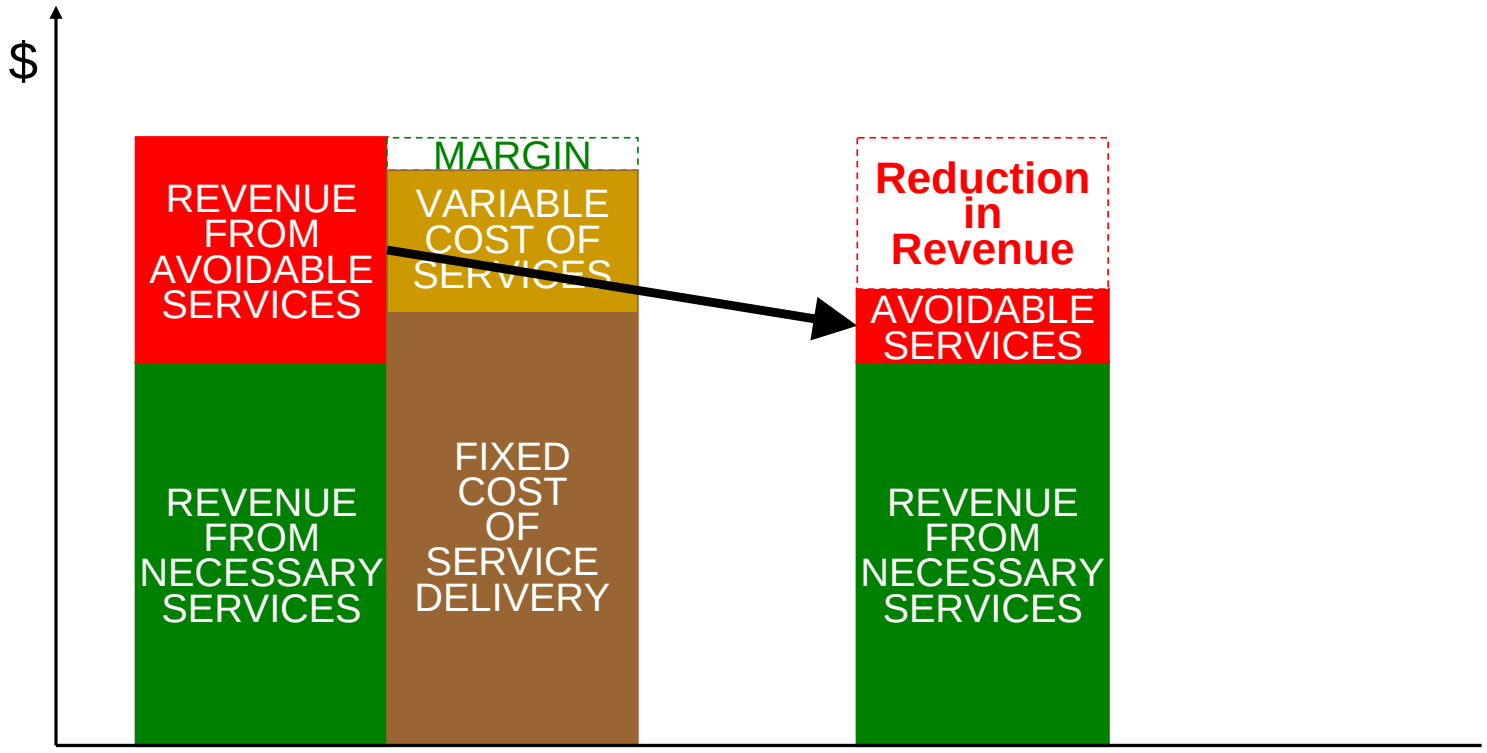
Hospitals:

•Cost of staffing the ED, surgery suite, cardiac cath lab, NICU, etc. whether there are patients or not

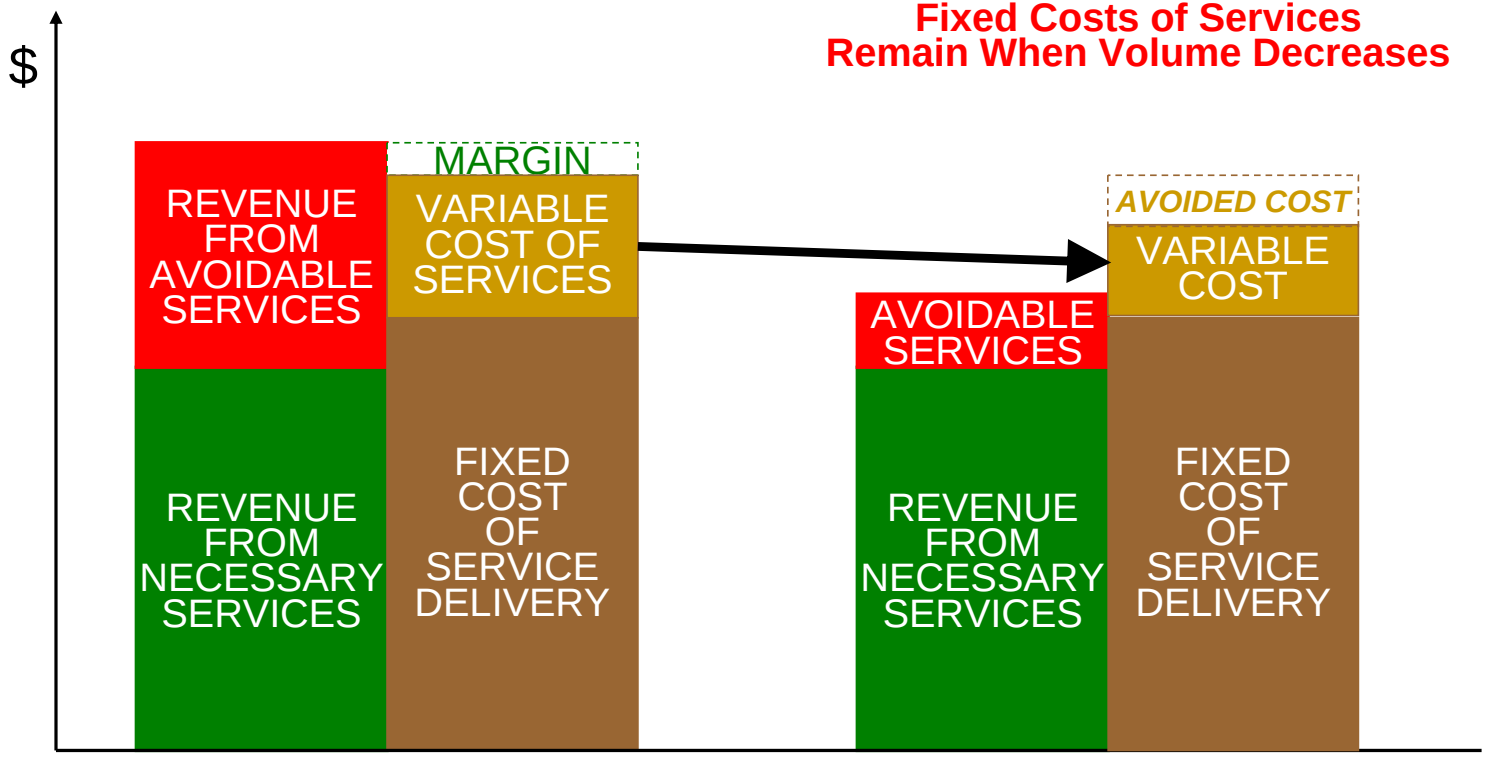
Physician Practices:

•Cost of office staff, rent, software, etc. whether there are visits/procedures or not

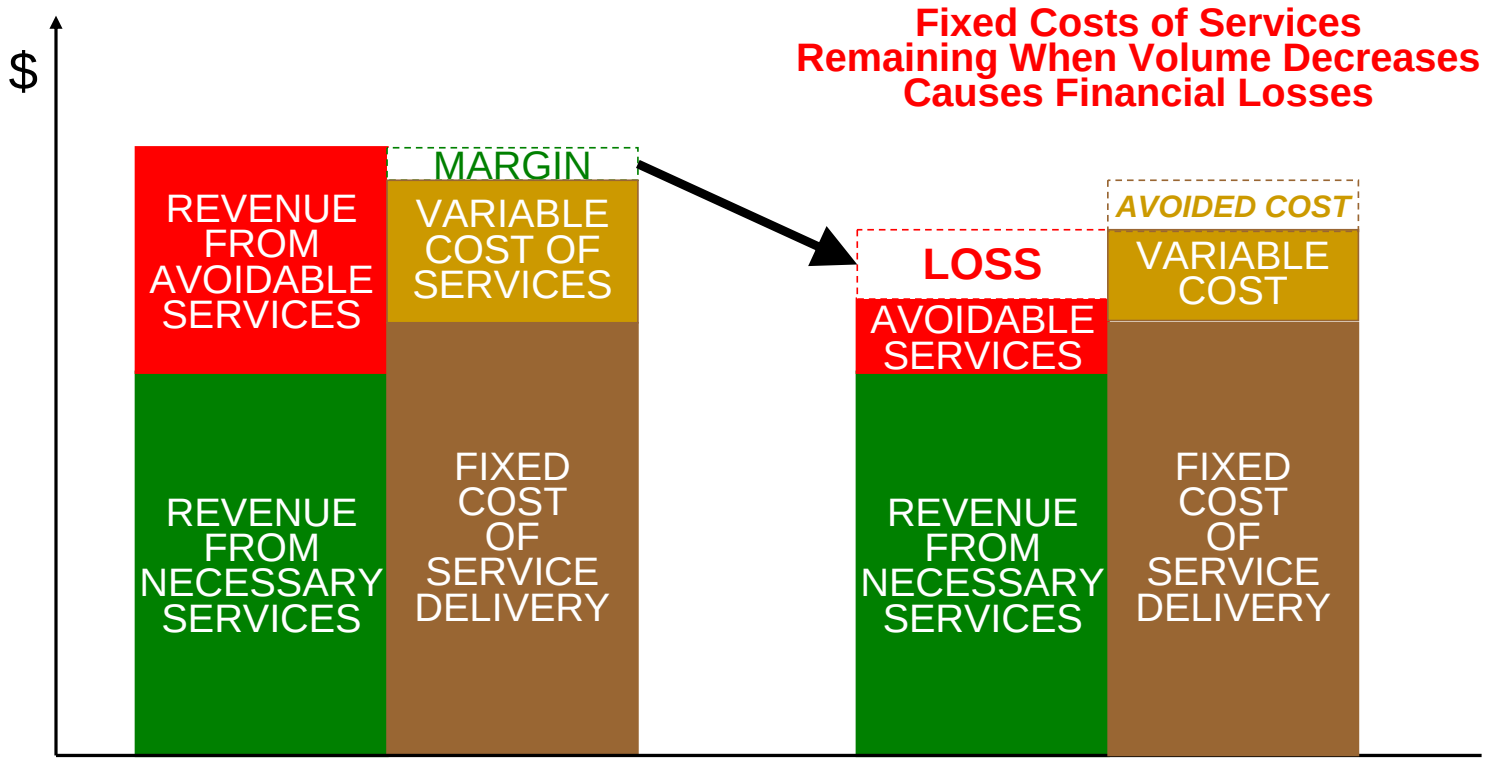
When Avoidable Services Are Reduced, Revenue Decreases…



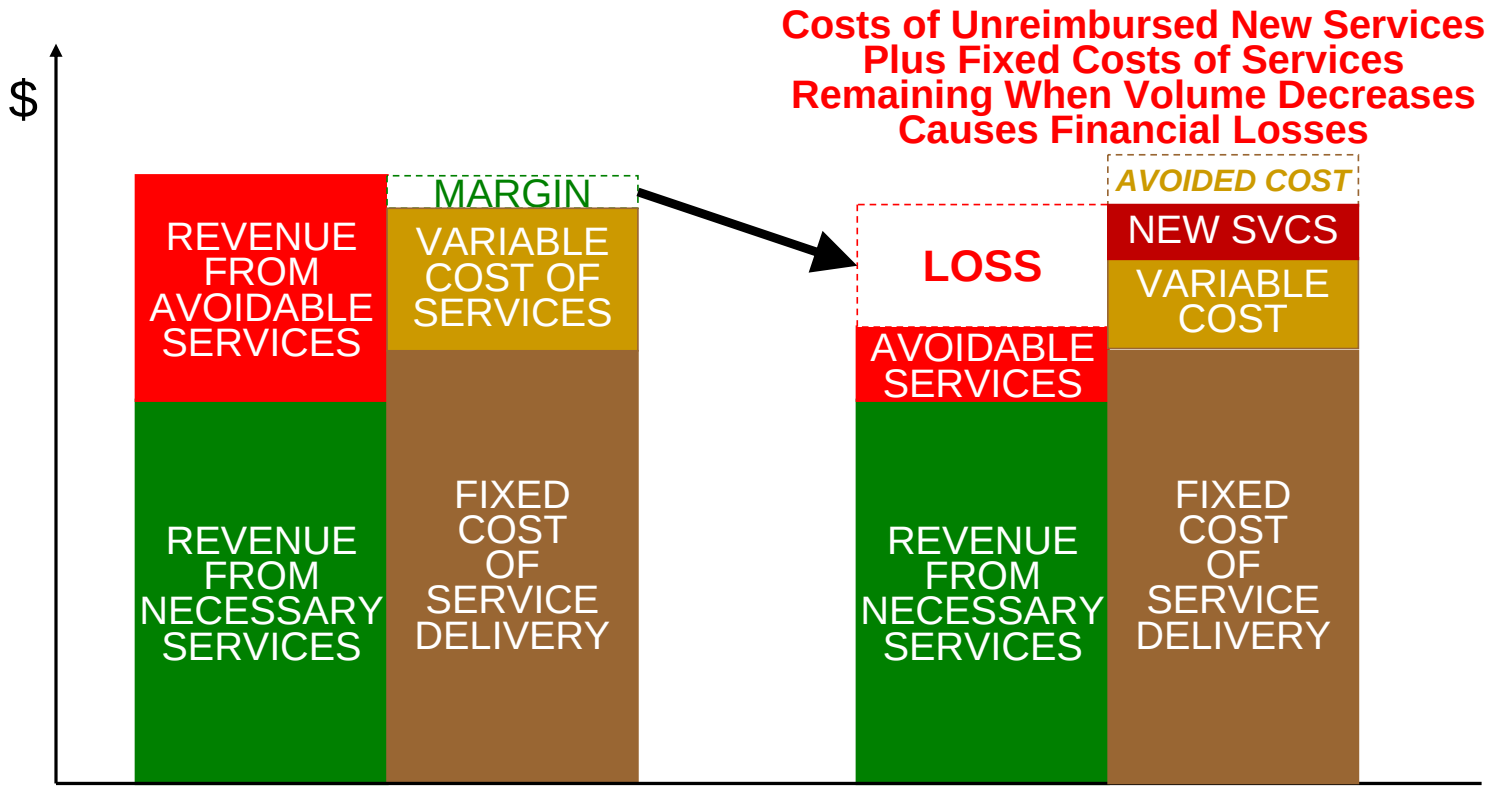
…Costs Decrease, But Not As Much as Revenue…



…Leaving Providers With Losses (or Bigger Losses Than Today)

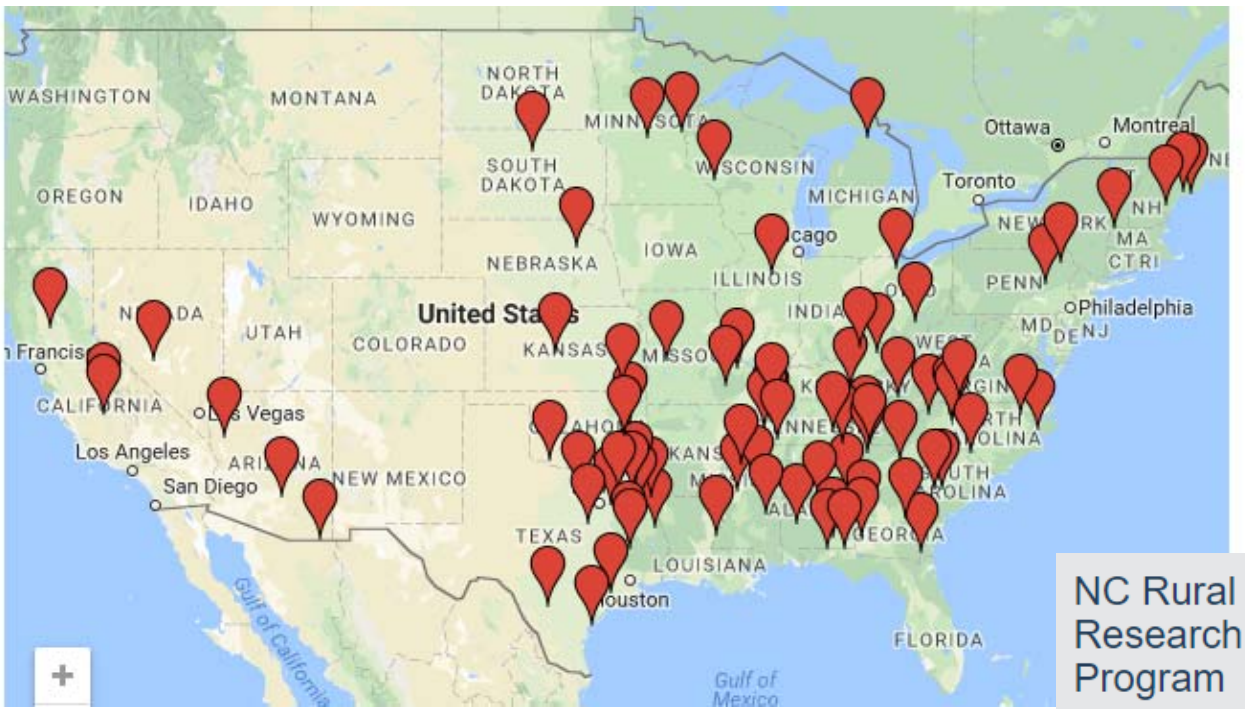


Underpayment for High-Value Services Makes Losses Greater



Many Rural Hospitals Are Closing Under Current Payment Systems

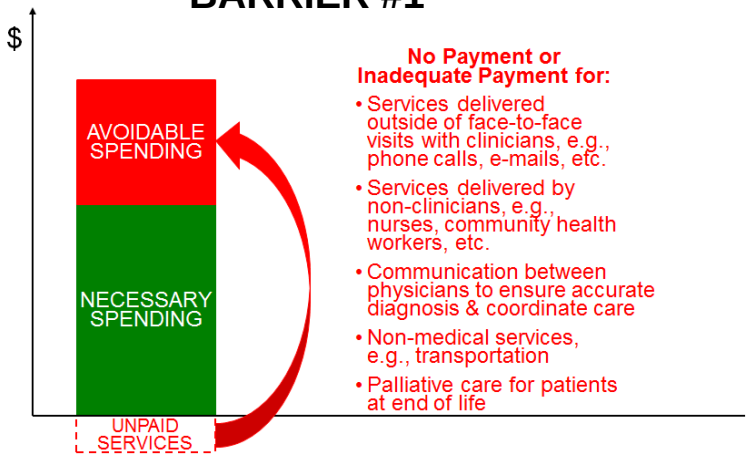
83 Rural Hospital Closures: January 2010 – Present



NC Rural Health Research Program

A Payment *Change* isn't *Reform* Unless It *Removes the Barriers*

BARRIER #1

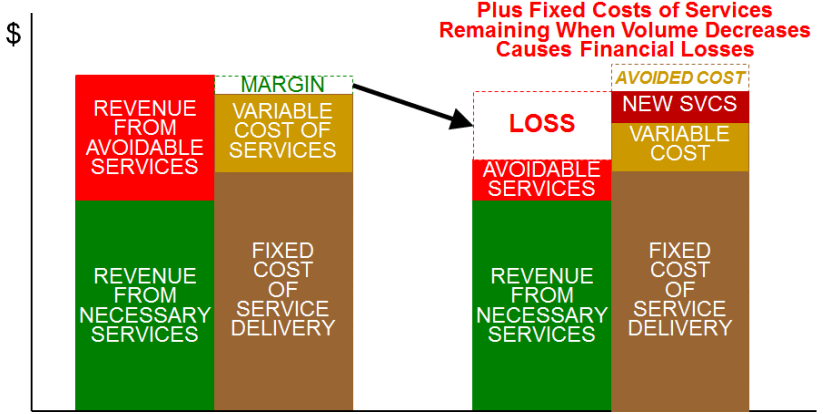


No Payment or Inadequate Payment for:

- Services delivered outside of face-to-face visits with clinicians, e.g., phone calls, e-mails, etc.
- Services delivered by non-clinicians, e.g., nurses, community health workers, etc.
- Communication between physicians to ensure accurate diagnosis & coordinate care
- Non-medical services, e.g., transportation
- Palliative care for patients at end of life

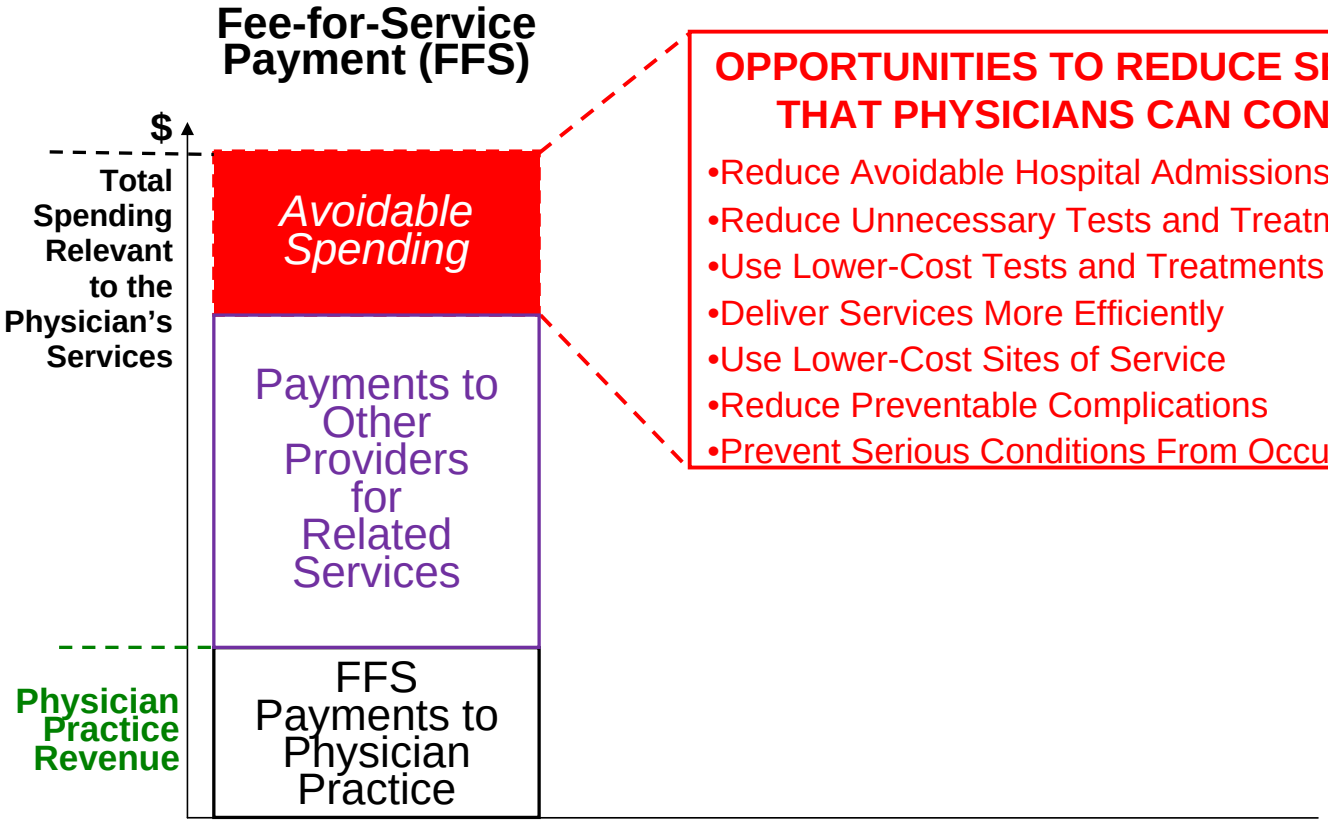
BARRIER #2

Costs of Unreimbursed New Services Plus Fixed Costs of Services Remaining When Volume Decreases Causes Financial Losses



How Do You Define a *Good* Alternative Payment Model?

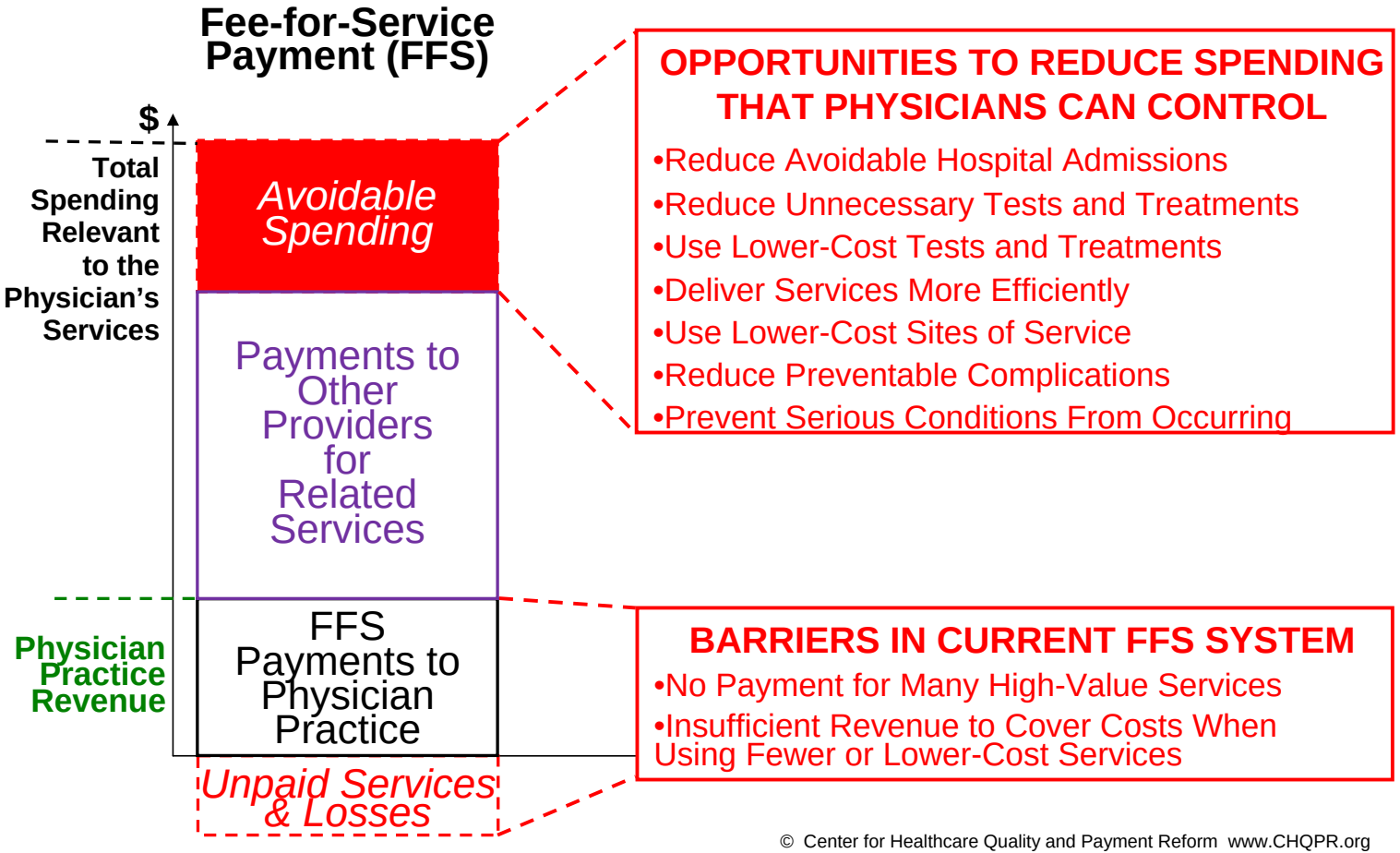
Step 1: Identify Opportunities to Reduce Avoidable Spending



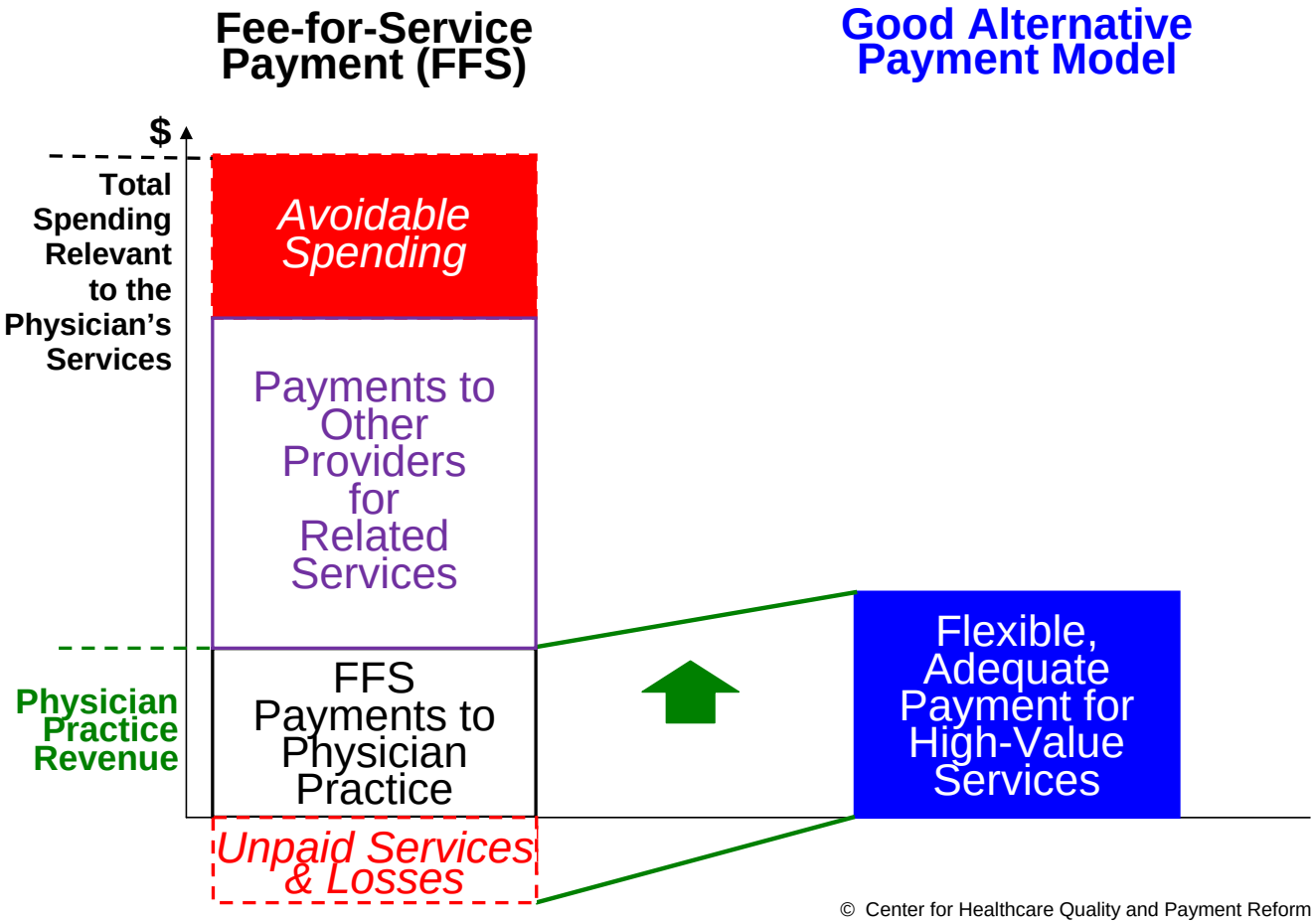
OPPORTUNITIES TO REDUCE SPENDING THAT PHYSICIANS CAN CONTROL

- Reduce Avoidable Hospital Admissions
- Reduce Unnecessary Tests and Treatments
- Use Lower-Cost Tests and Treatments
- Deliver Services More Efficiently
- Use Lower-Cost Sites of Service
- Reduce Preventable Complications
- Prevent Serious Conditions From Occurring

Step 2: Identify Barriers in Current Payments That Need to Be Fixed



Step 3: Pay Adequately for High-Value Services Patients Need



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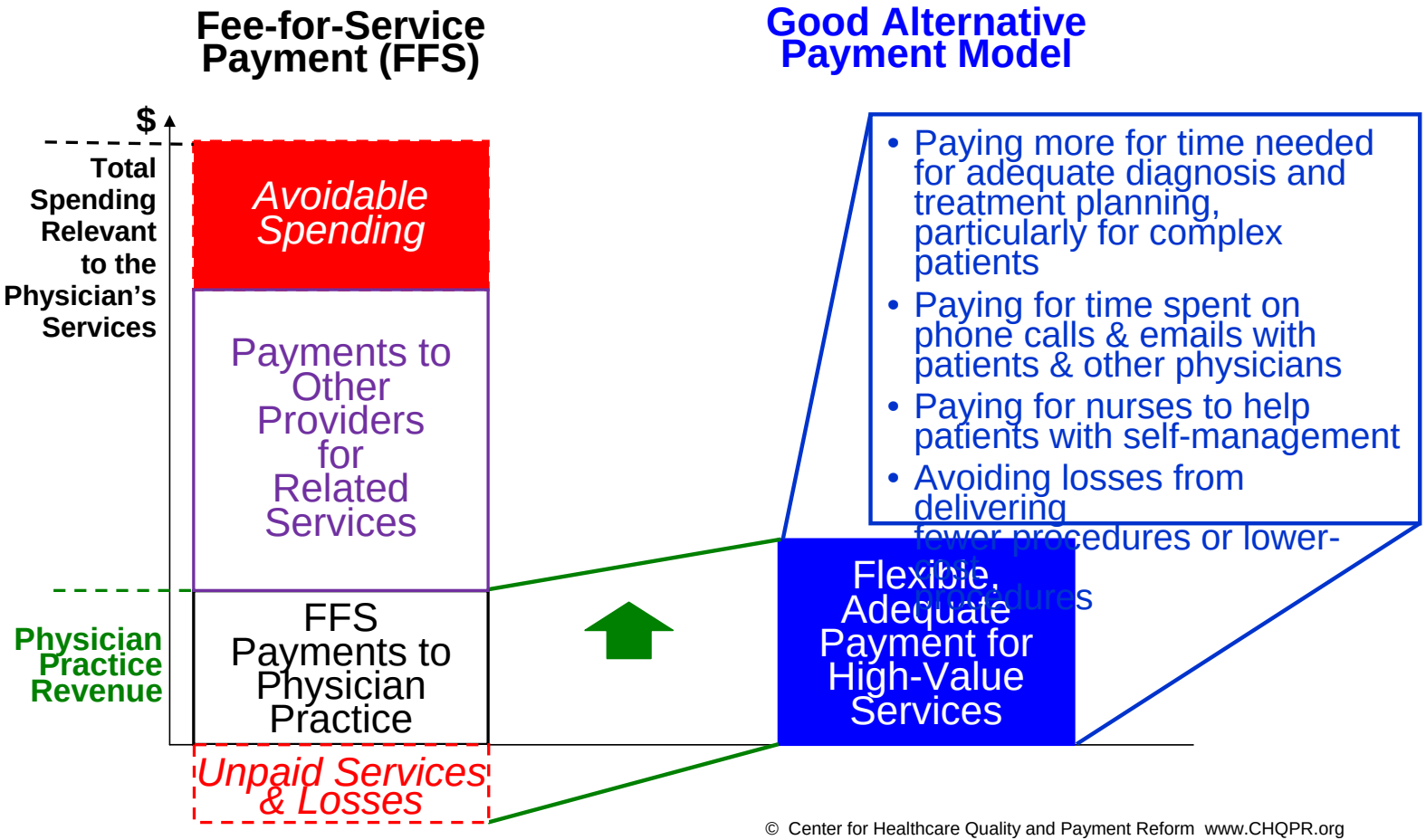
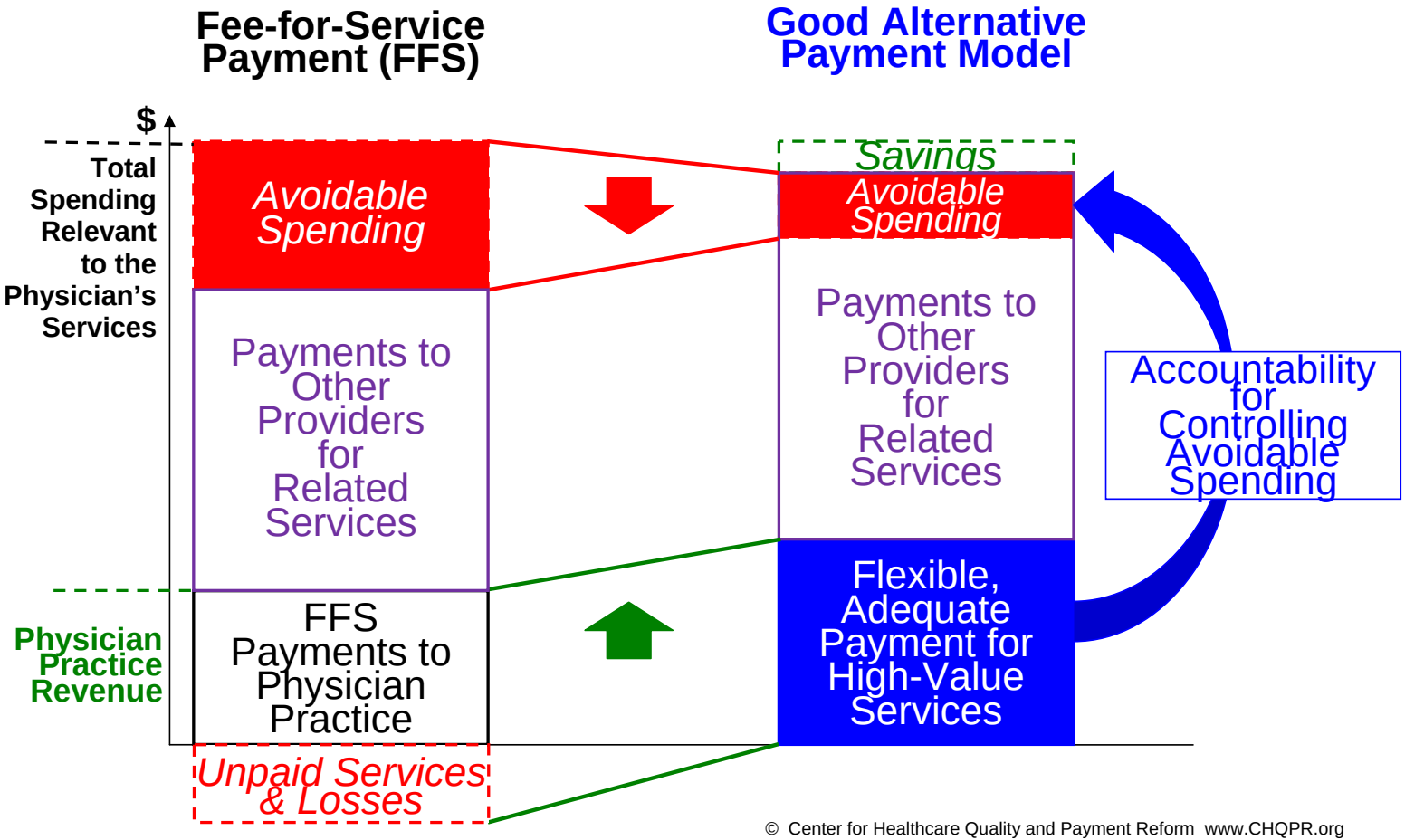
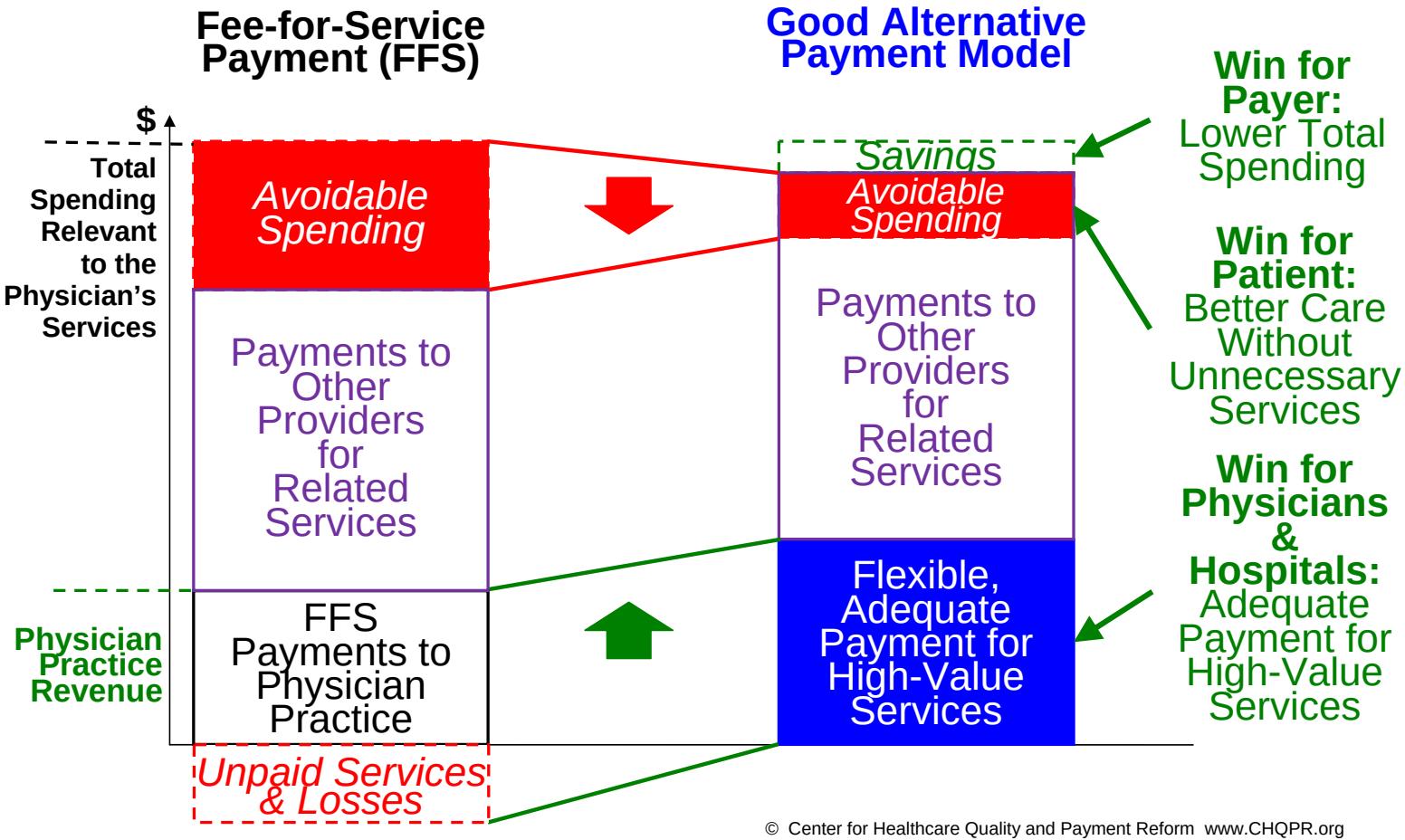


Step 4: Hold Providers Accountable for Cost/Quality They Can Control



Good Alternative Payment Models Can Be Win-Win-Wins



What Happens When You Design Care Delivery and Payment From the Bottom Up Instead of From the Top Down?

Better Care at Lower Cost for Crohn's Disease

PHYSICIAN LEADER: Lawrence R. Kosinski, MD
Managing Partner, Illinois Gastroenterology Group

Better Care at Lower Cost for Crohn's Disease

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OPPORTUNITIES TO IMPROVE CARE AND LOWER COSTS

- Health plan spends $11,000/year/patient on patients with Crohn's
- >50% of expenses are for hospital care, most due to complications
- <33% of patients seen by physician in 30 days prior to hospitalization
- 10% of expenses for biologics, many administered in hospitals
- 3.5% of spending goes to gastroenterologists

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OPPORTUNITIES TO IMPROVE CARE AND LOWER COSTS	BARRIERS IN THE CURRENT PAYMENT SYSTEM
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Better Care at Lower Cost for Cancer

PHYSICIAN LEADER: Barbara McAneny, MD
CEO, New Mexico Cancer Center

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• 40-50% of patients receiving chemotherapy are hospitalized for complications of treatment	• No payment for triage services to enable rapid response to patient complications • No payment for patient and family education about complications and how to respond • Inadequate payment to reserve capacity for IV hydration of patients experiencing problems

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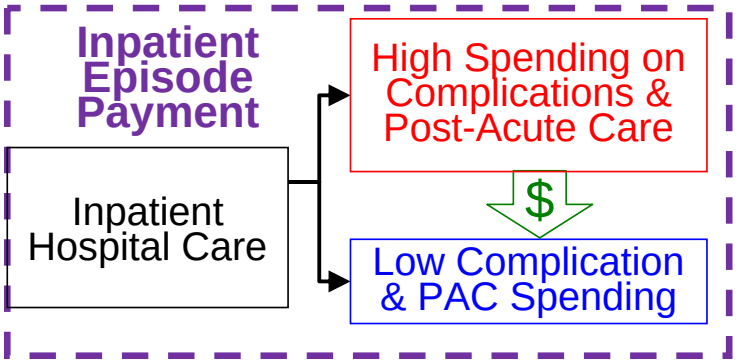
• 40-50% of patients receiving chemotherapy are hospitalized for complications of treatment	• No payment for triage services to enable rapid response to patient complications • No payment for patient and family education about complications and how to respond • Inadequate payment to reserve capacity for IV hydration of patients experiencing problems	• 36% fewer ED visits • 43% fewer admissions • 22% reduction in total cost of care ($4,784 over six months)

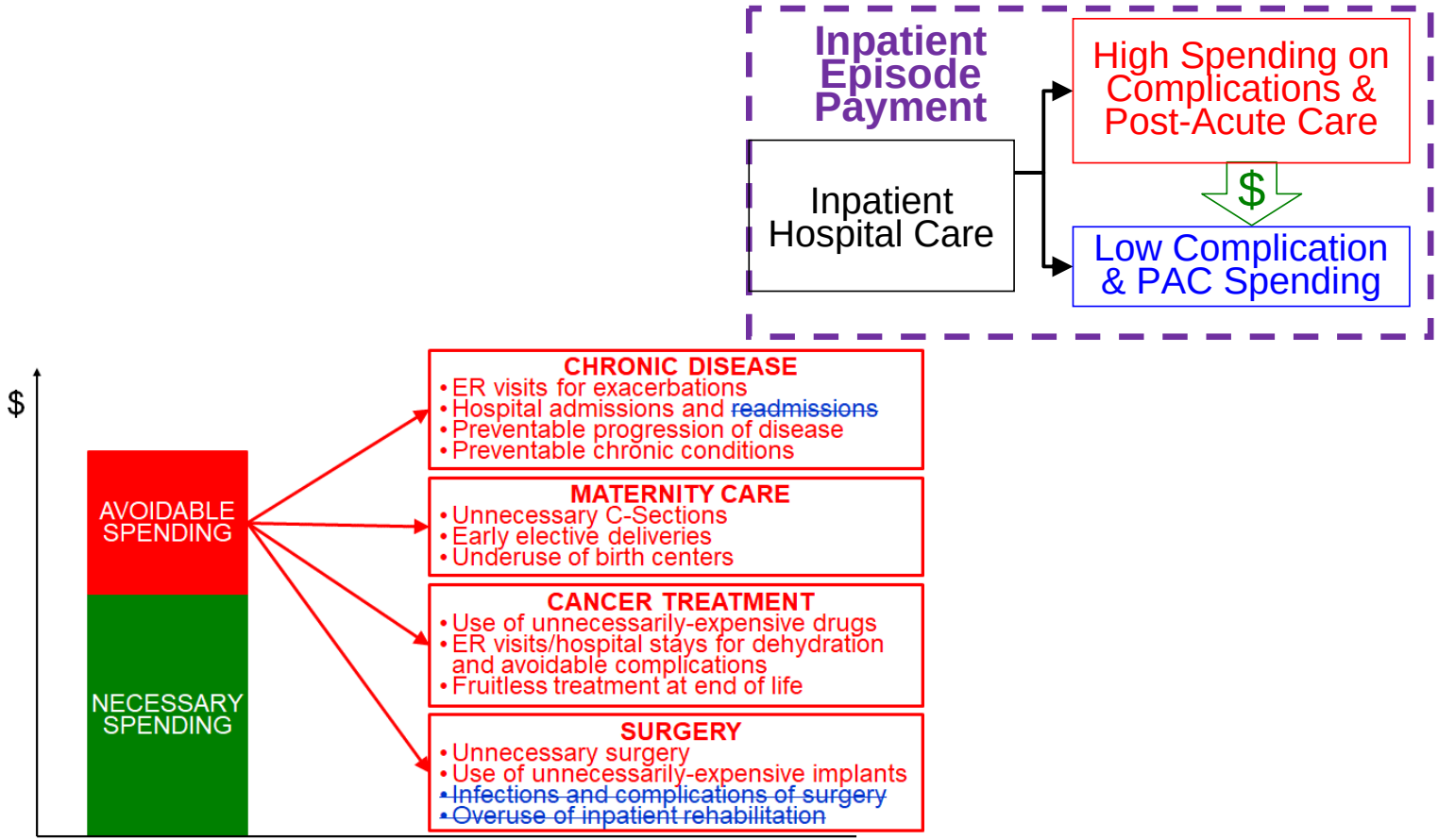
A Step in the Right Direction: Bundled Payments in Medicare

BENEFITS OF BUNDLED/WARRANTIED PAYMENTS

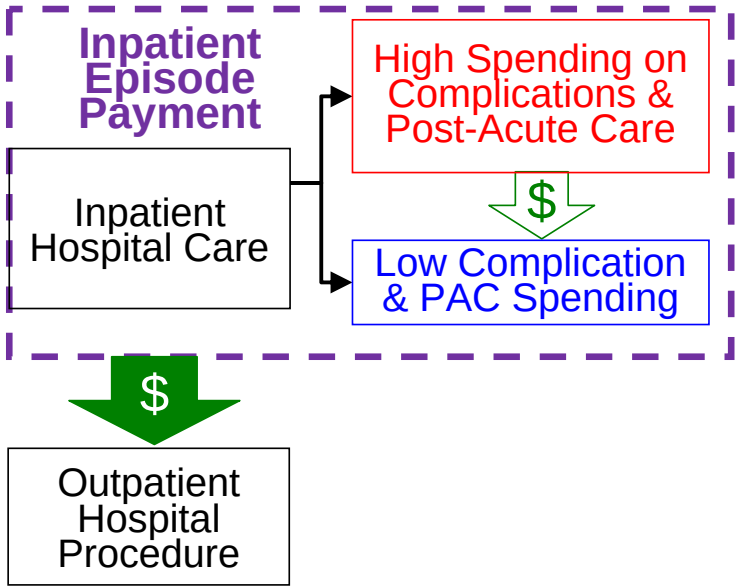
- Single price for all “parts” of care
- No reward for avoidable complications
- No reward for using expensive post-acute care



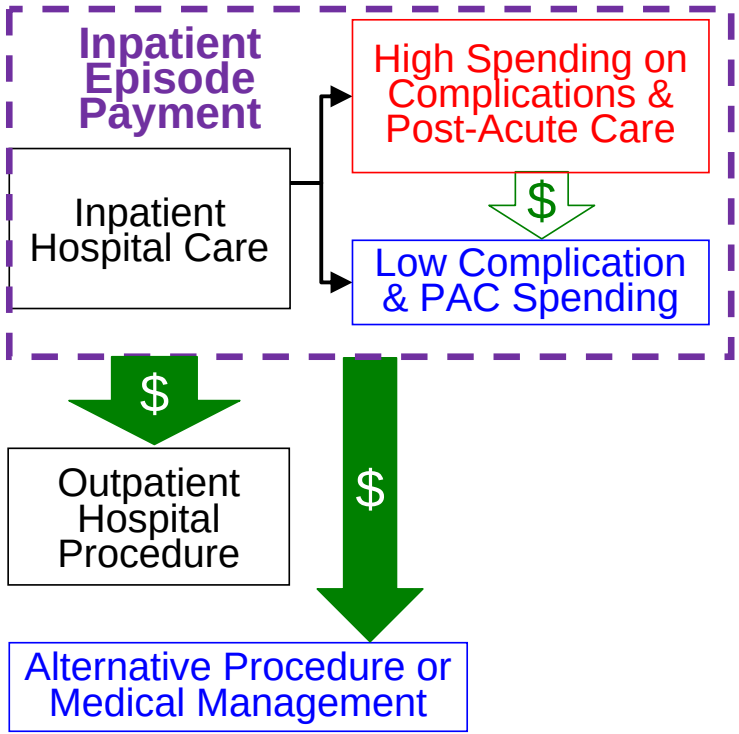
But BPCI Addresses Only a Fraction of Opportunities for Value



What If You Can Do The Procedure Outside the Hospital?

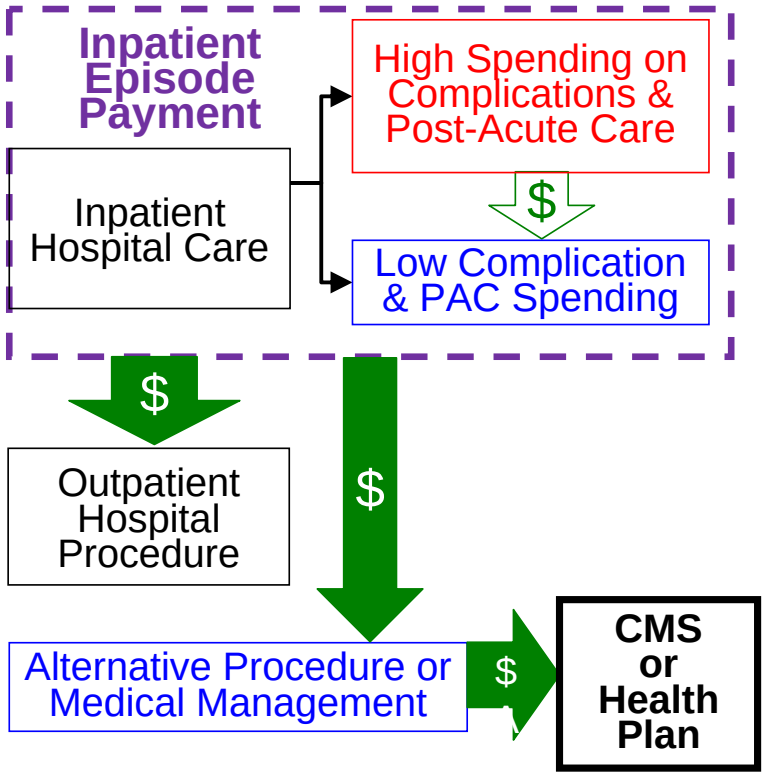


What if You Could Save Even More With a Different Treatment?



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

In BPCI, the trigger is the hospital procedure, so if a different procedure is used, or no procedure at all is used, care is paid through standard FFS and the payer keeps all the savings



Rewarding *Only* Inpatient Care Encourages *More* Inpatient Care

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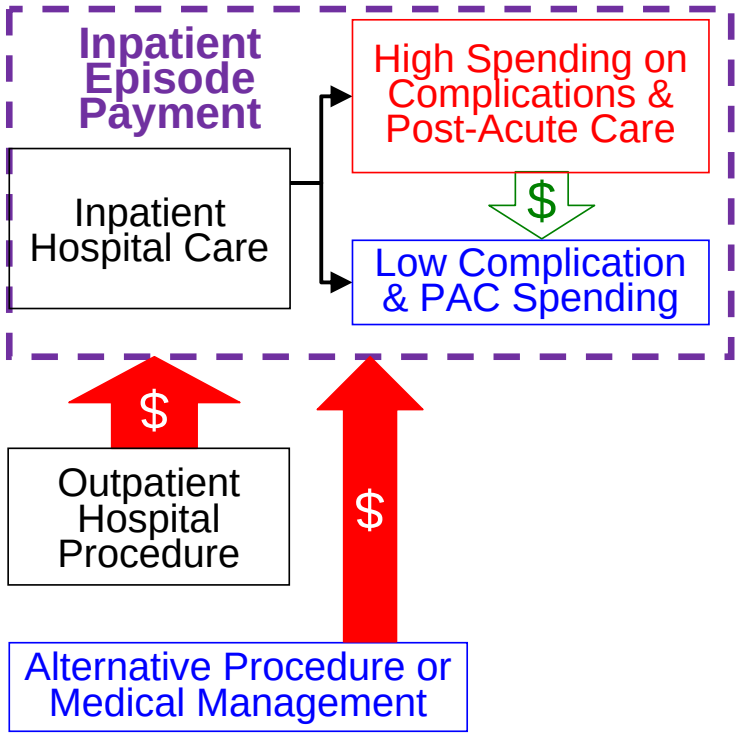
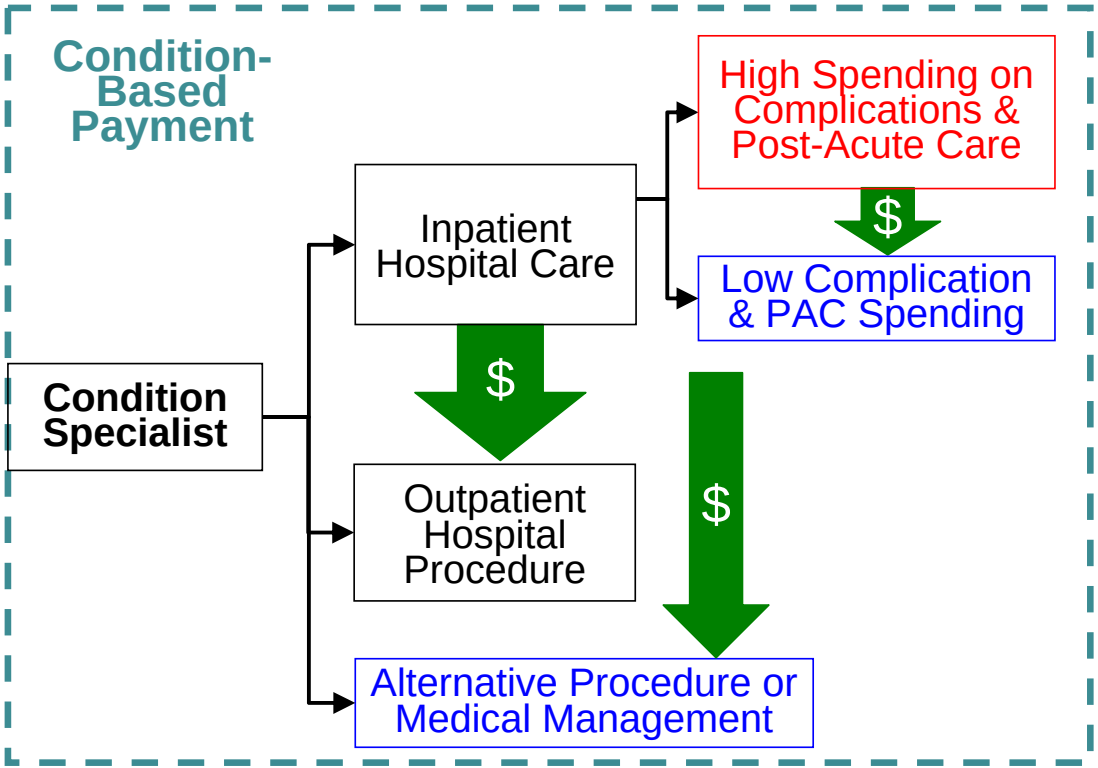


Use a *Condition*-Based Payment to Support Use of *Best* Treatment

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



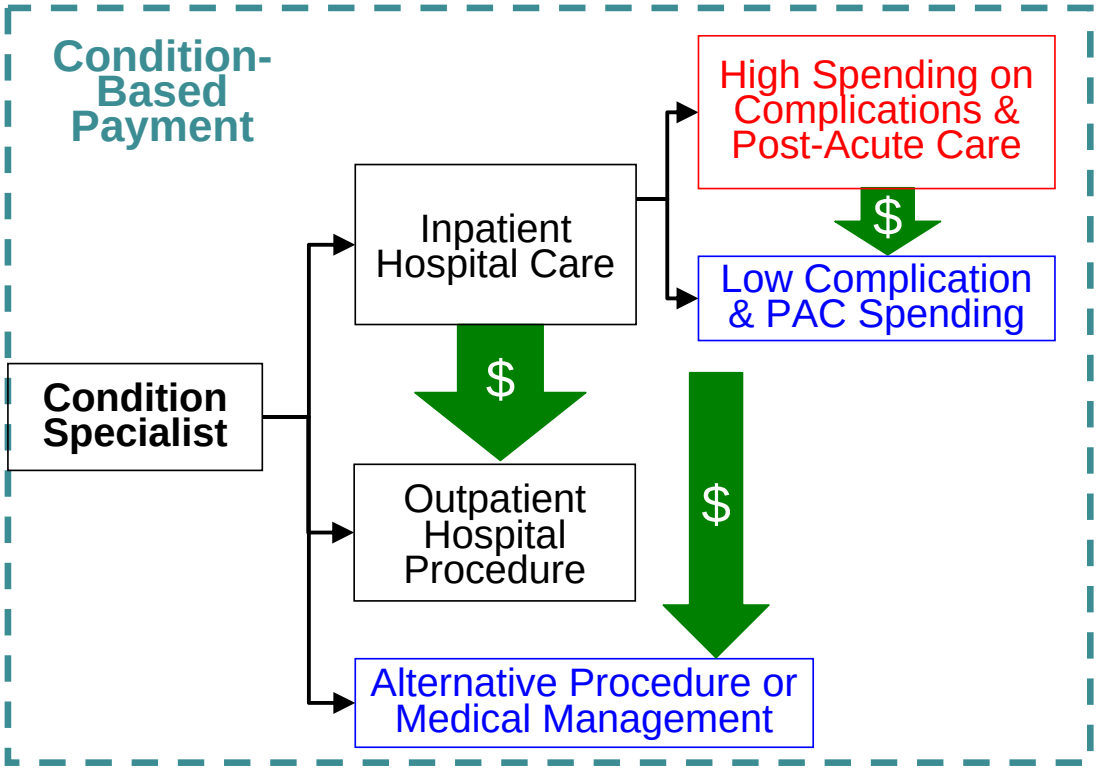
Condition-Based Payment Has *More* Benefits Than Episodes

BENEFITS OF CONDITION-BASED PAYMENTS

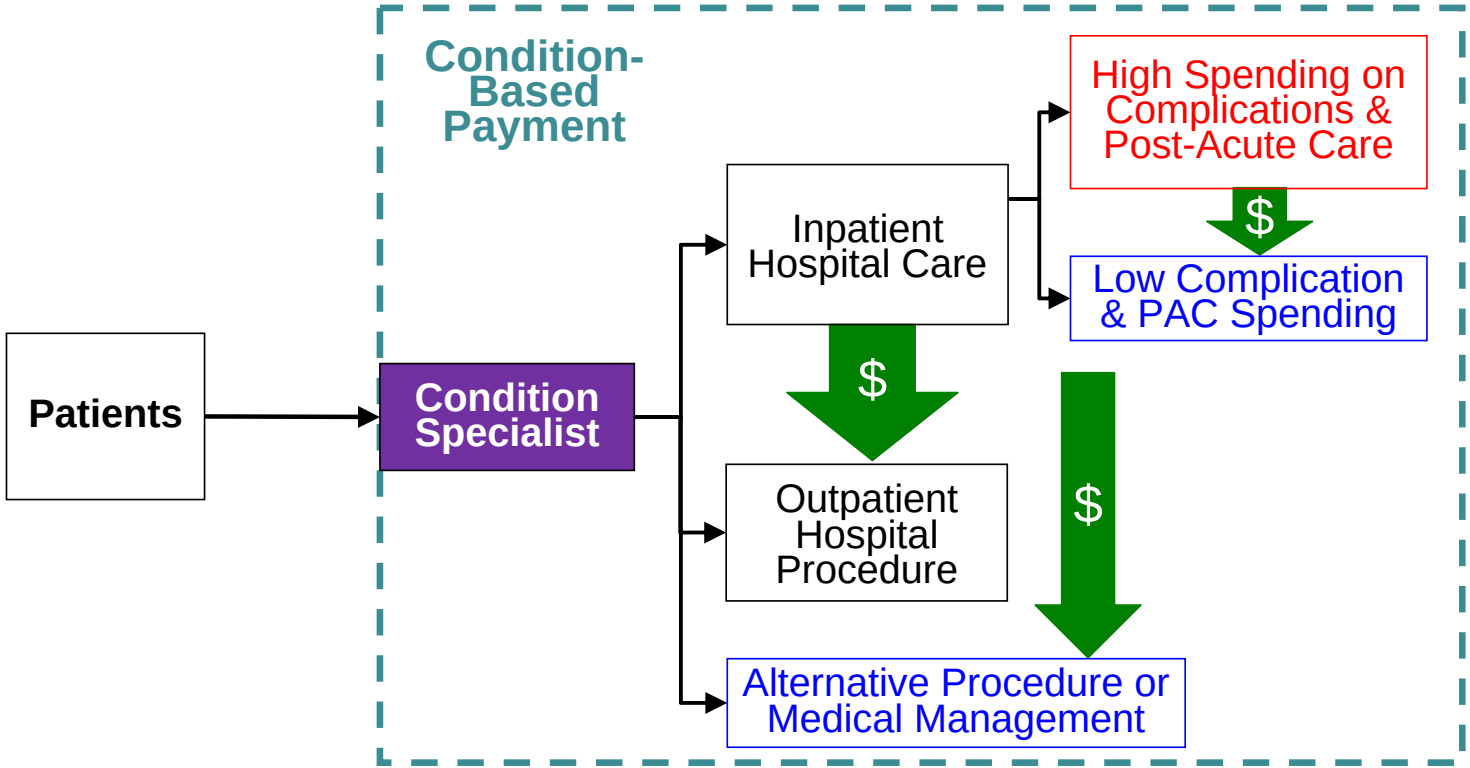
- No reward for avoidable complications
- No reward for using expensive post-acute care

+

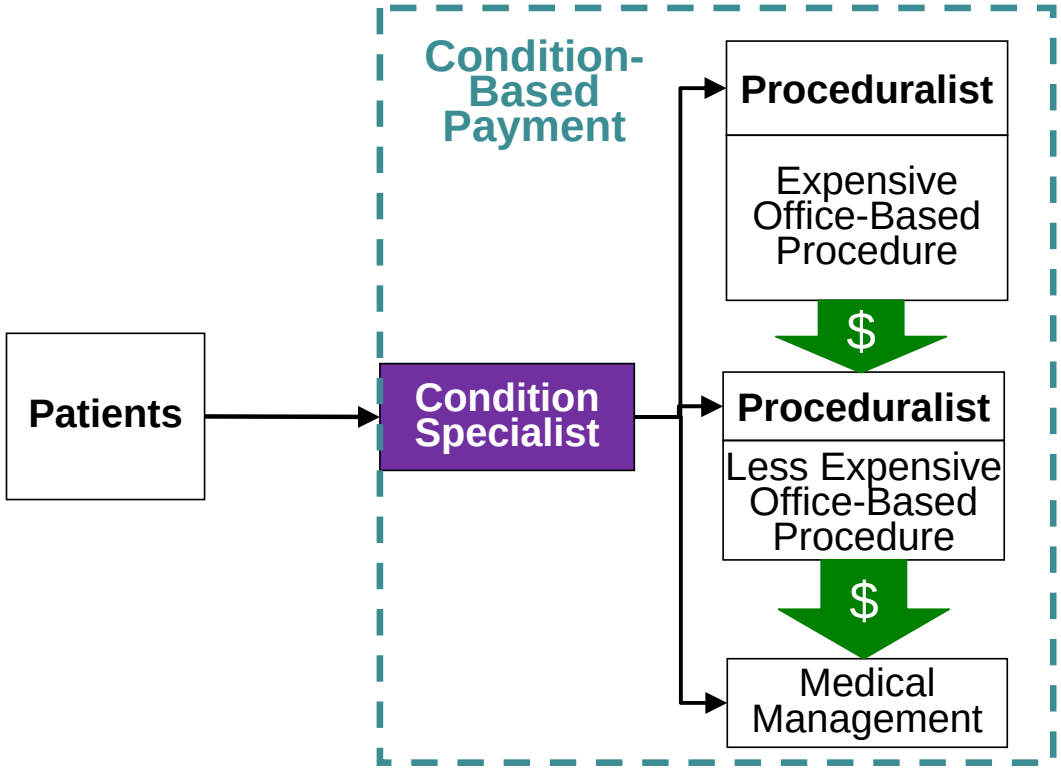
- No reward for using unnecessarily expensive facilities
- No reward for performing unnecessary procedures



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

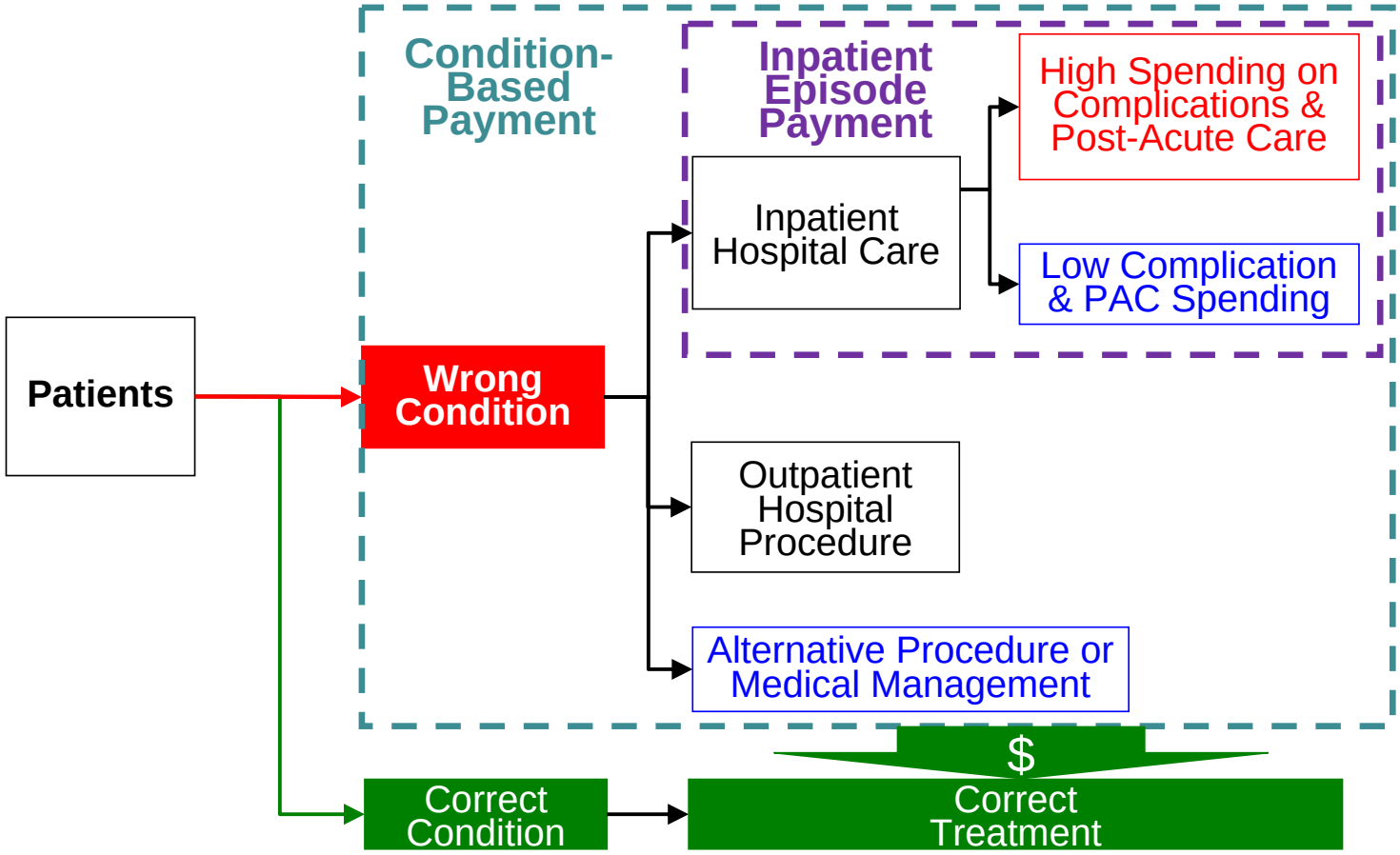


Many Condition-Based Payments Won't Involve Hospitals at All

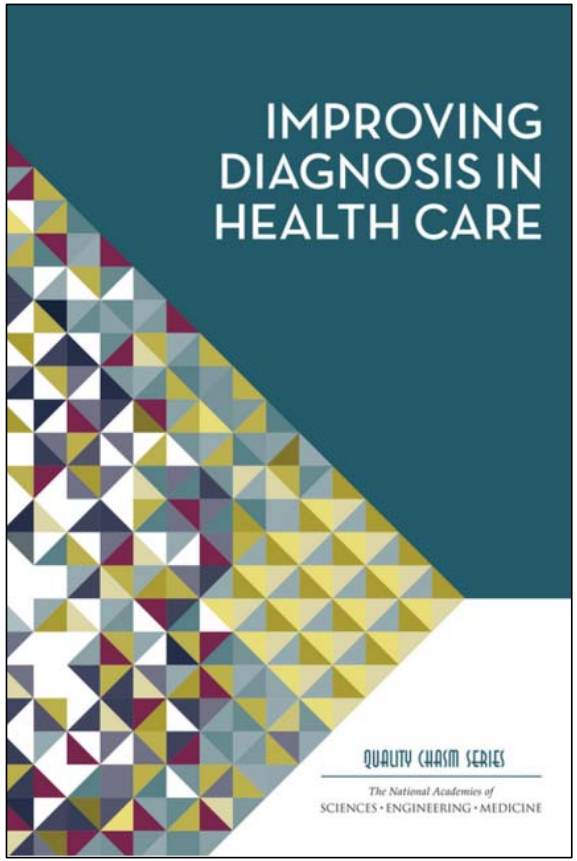


For many types of conditions, hospitalization represents a *failure* of treatment, not a *method* of treatment

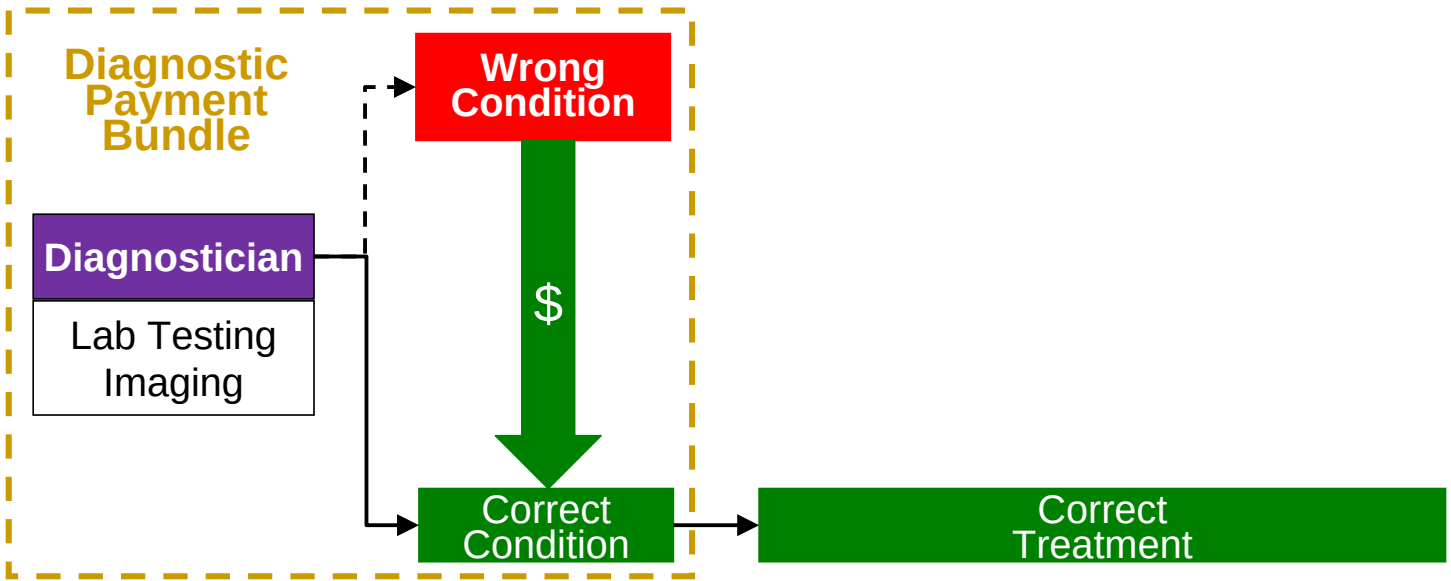
Are We Making the Payment for the Correct Condition??



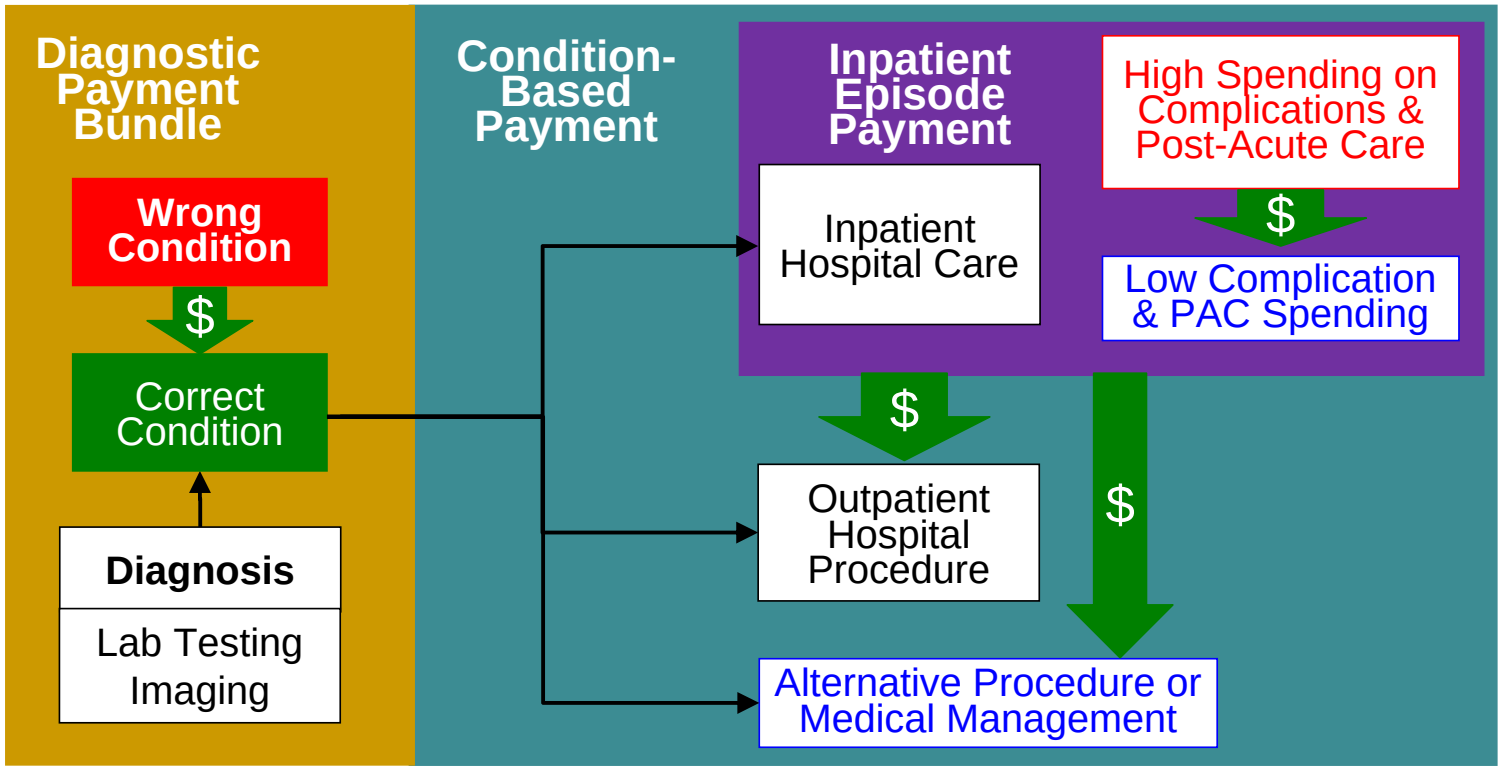
Diagnostic Error is a Fundamental Quality Issue Underlying All Others



We Need to Pay Adequately for Good Diagnosis, Too

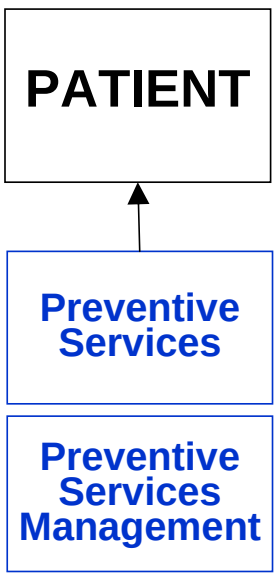


We Need Multiple Types of "Bundled" Payments

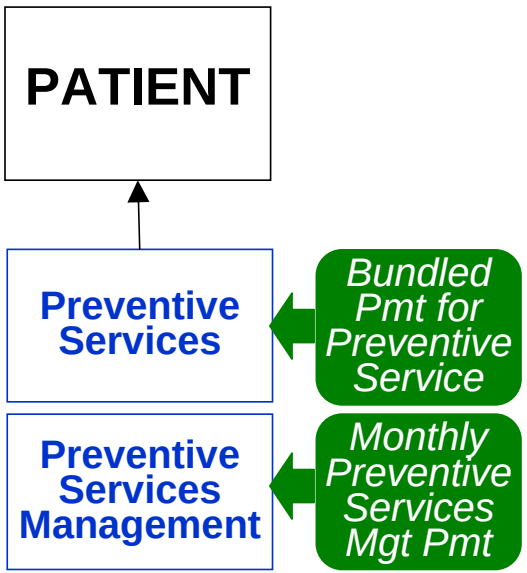


What Does a Patient-Centered Payment & Delivery *System* Look Like?

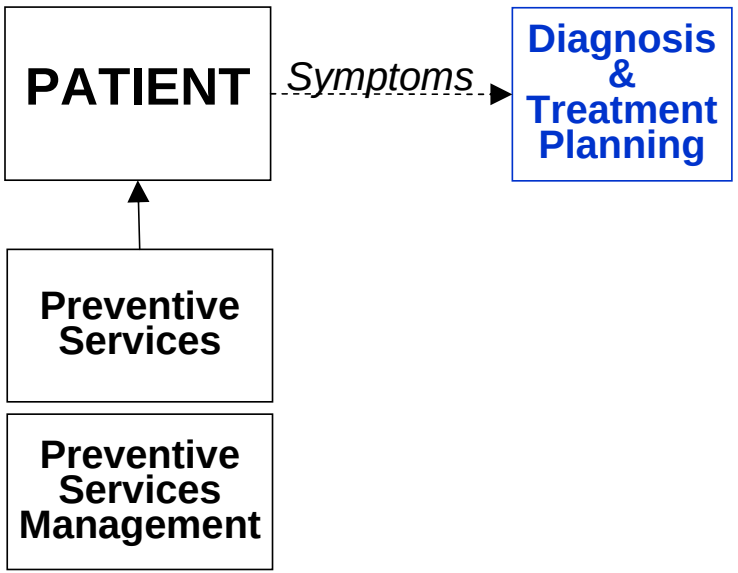
Patient-Centered Care: Provide Preventive Services



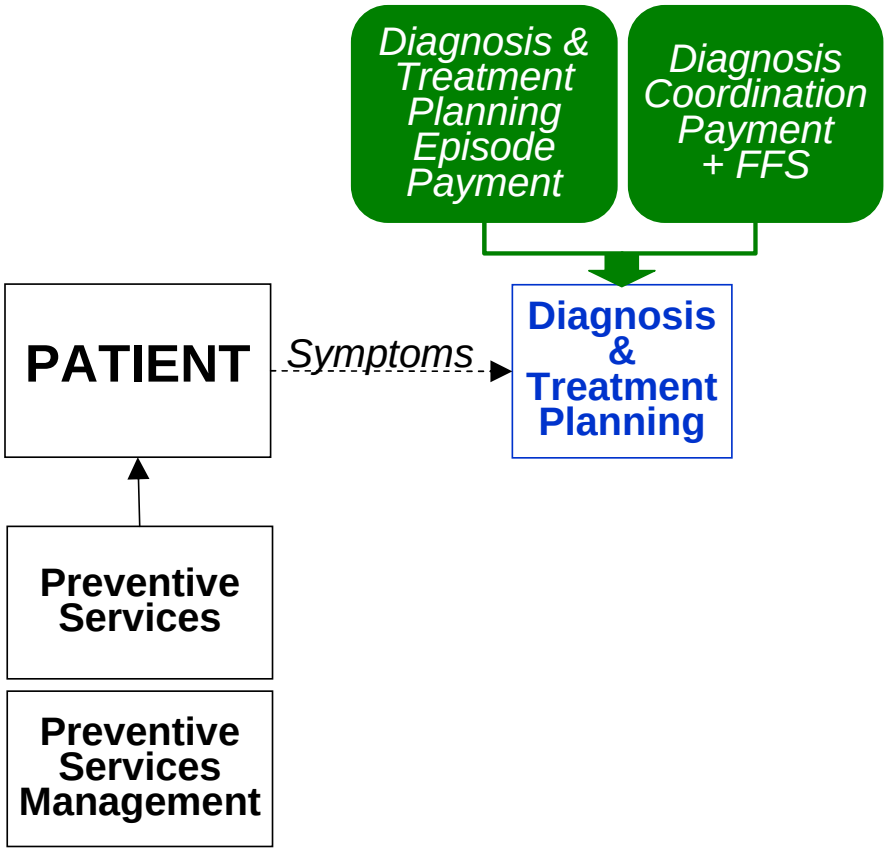
Patient-Centered Payment: Pay for Good Preventive Care



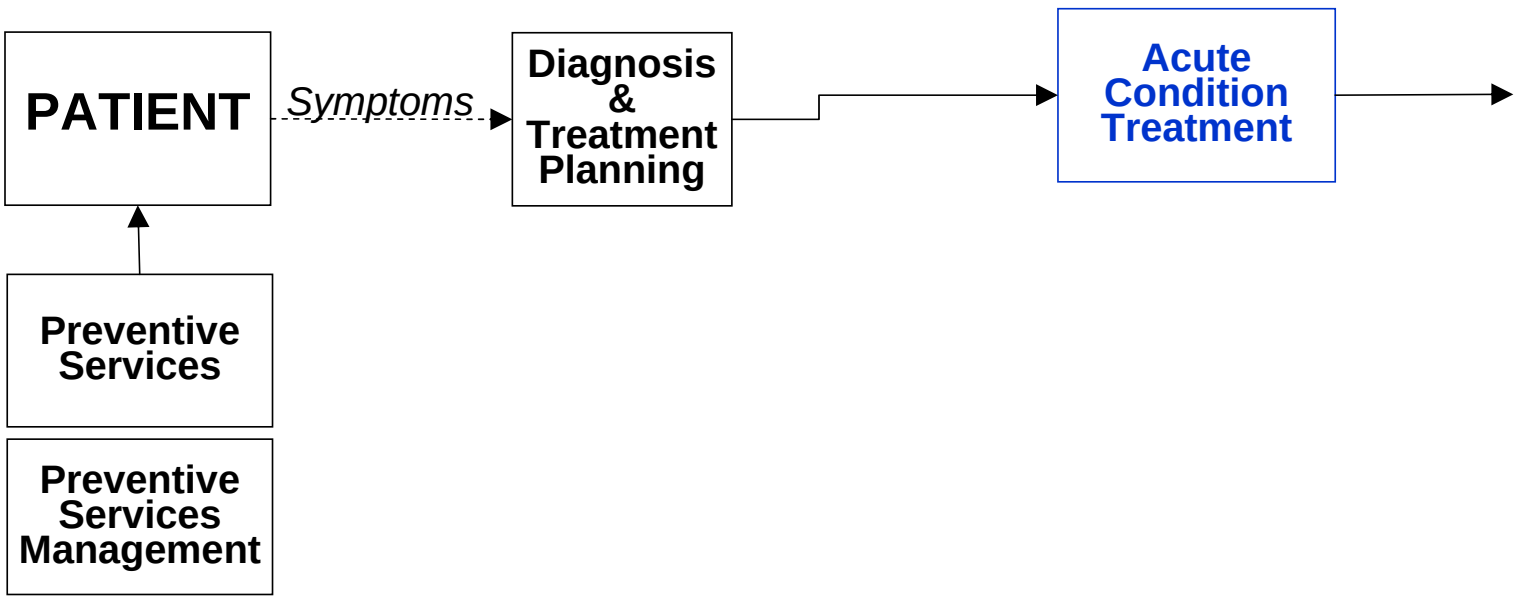
Patient-Centered Care: Accurately Diagnose Problems



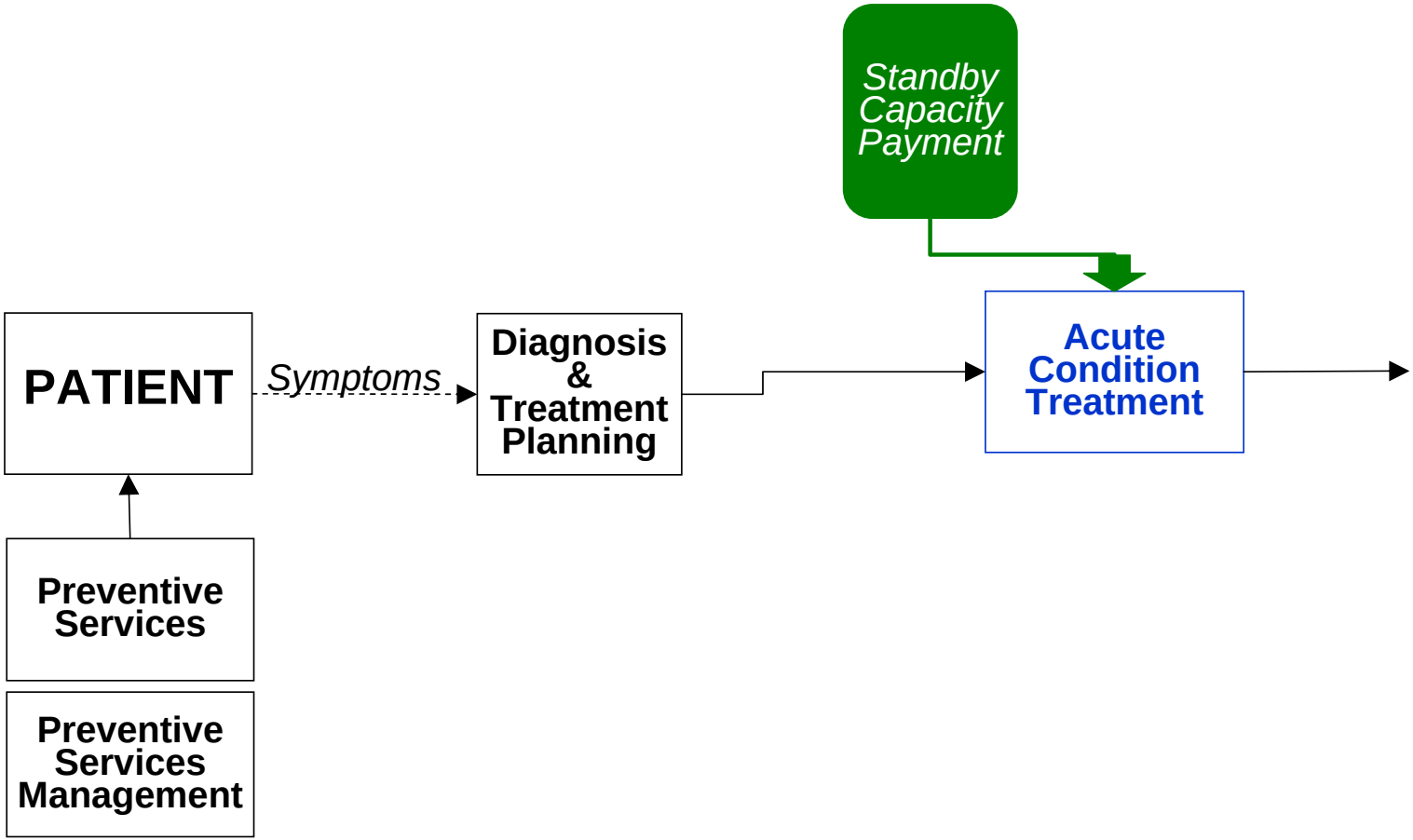
Patient-Centered Payment: Pay to Support Good Diagnosis



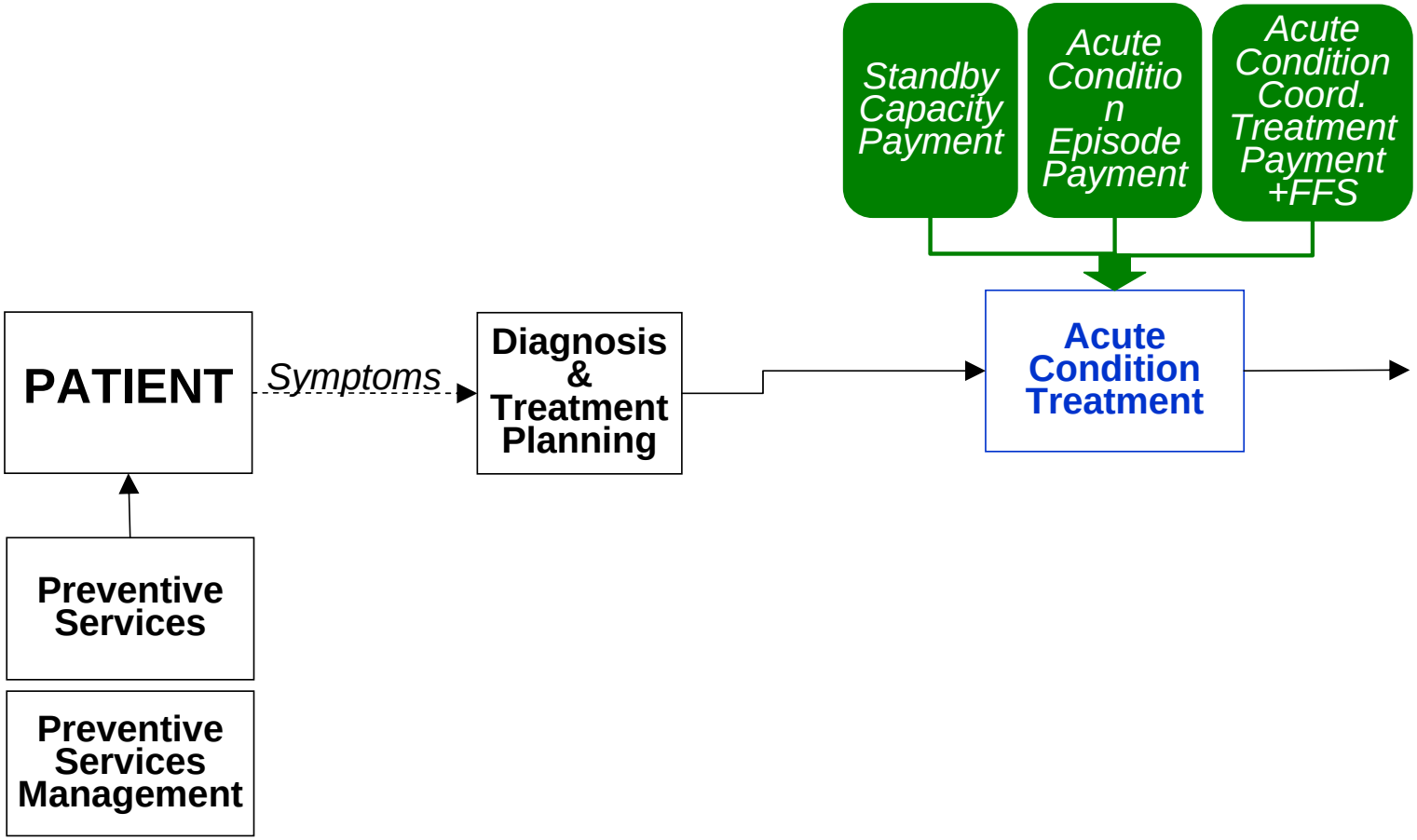
Patient-Centered Care: Treat Acute Conditions Effectively



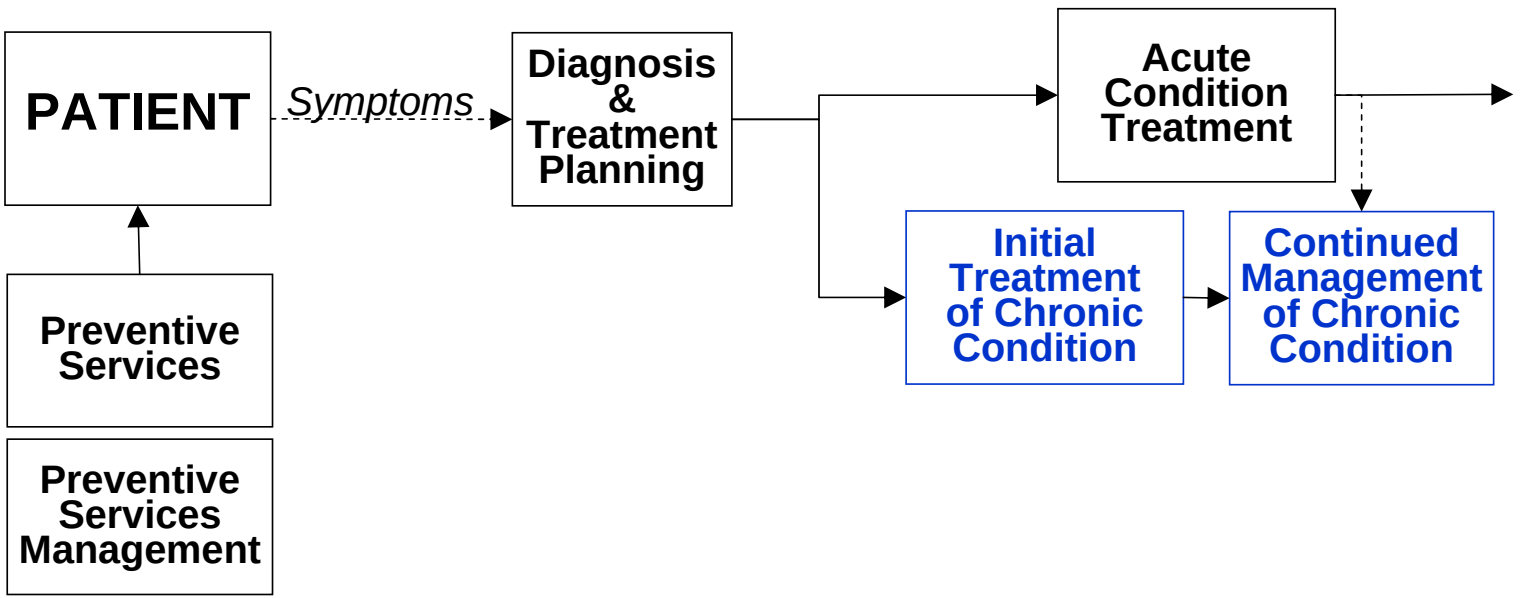
Patient-Centered Payment: Support Essential Hospital Svcs…



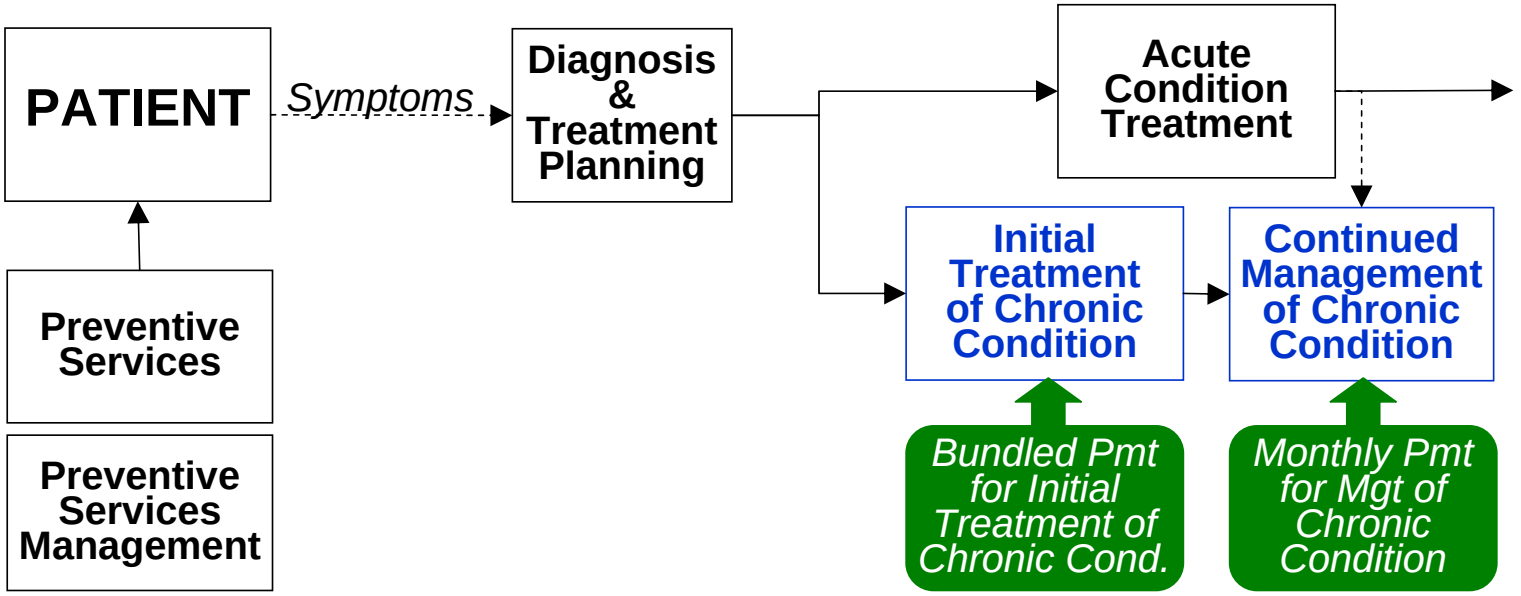
Patient-Centered Payment: Pay Teams for Full Tx Bundles



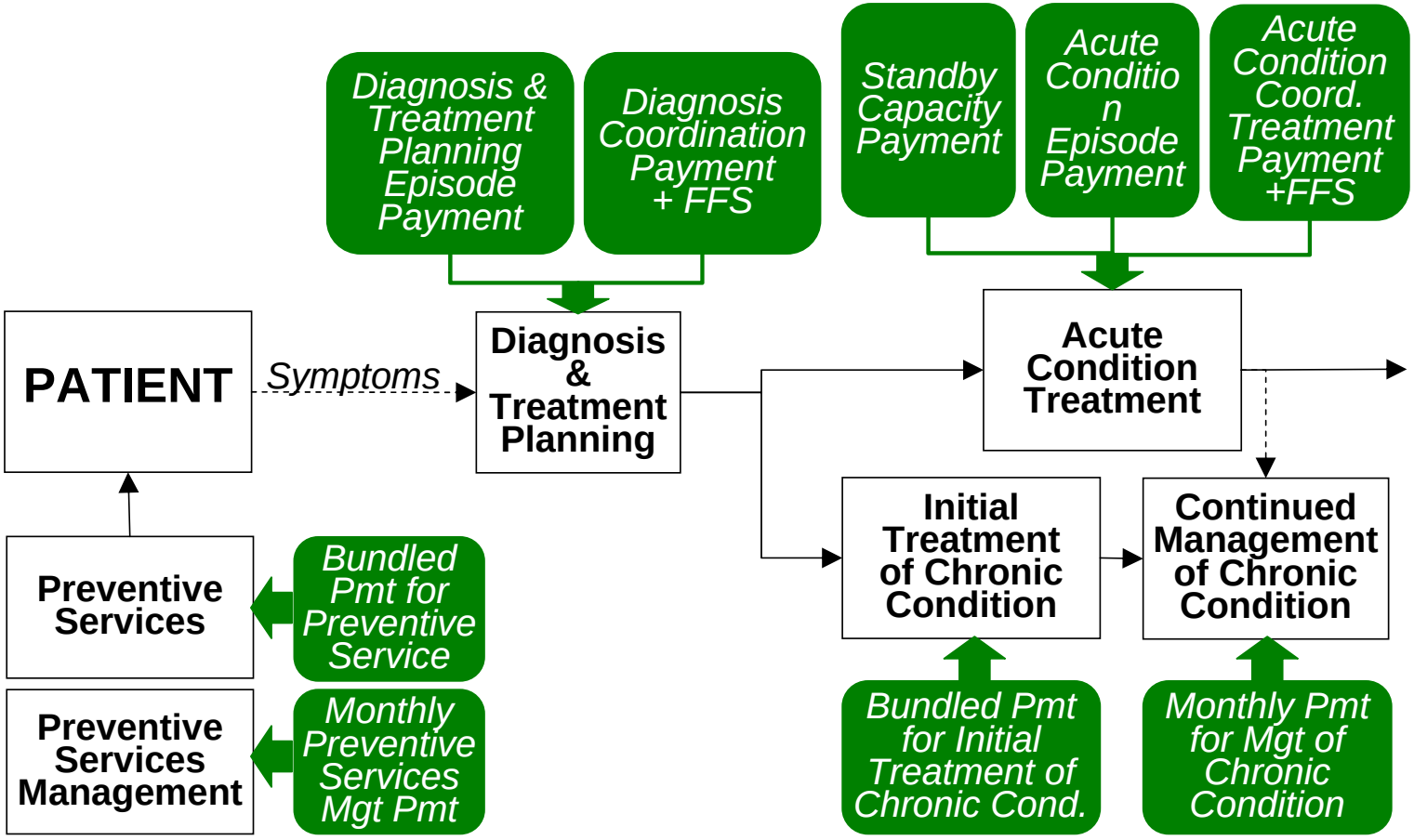
Patient-Centered Care: Effective Care of Chronic Disease



Patient-Centered Payment: Monthly Pmts for Condition Mgt

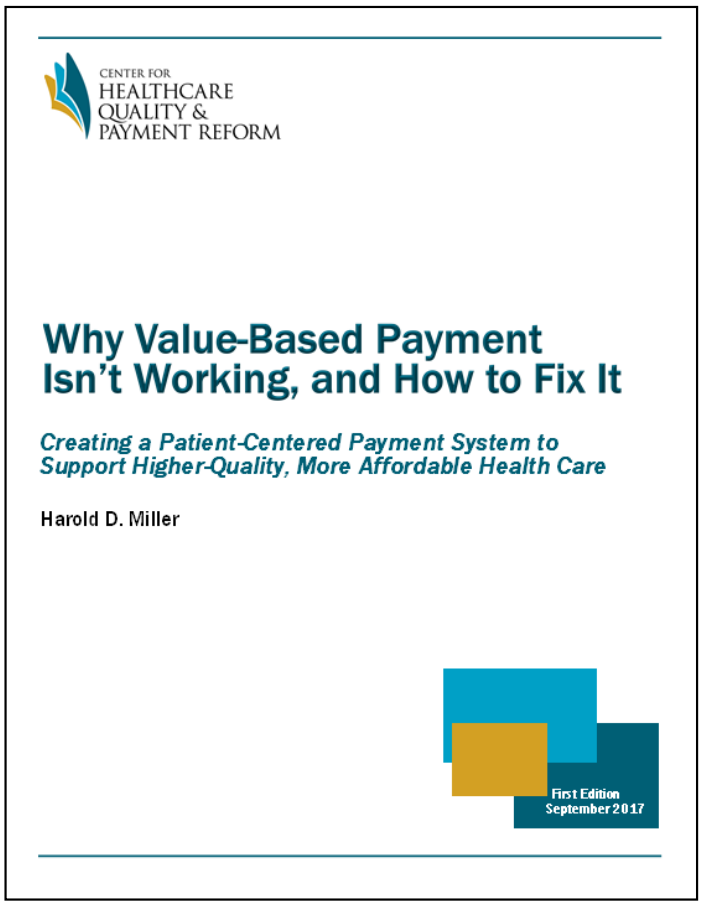


Patient-Centered *Payment* to Support Patient-Centered *Care*



For More Details on Patient-Centered Payment:

www.PaymentReform.org



Too Complex?

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Compared to What???

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Physician Fee Schedule

- 9,000+ CPT Codes
- 5,000+ HCPCS Codes
- MIPS Adjustments

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Inpatient Prospective Payment System
- 700+ MS-DRGs
- Hospital VBP
- Readmission Penalties
- HAC Penalties
- DSH Payments
- Outlier Payments

Outpatient Prospective Payment System
- 700+ Ambulatory Patient Classifications (APCs)

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Home Health Care Prospective Payment System
- 153 HHRGs

Skilled Nursing Facility Prospective Payment System
- 66 RUGs

Critical Access Hospital Payments
- 99% of eligible costs

Inpatient Rehab Facility Payments
- 92 Case Mix Groups

What Could Be More Complex Than the Current System?

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Ambulance Fee Schedule

DME Fee Schedule

Laboratory Fee Schedule

LTCH Payment System

Inpatient Psych. Payment System

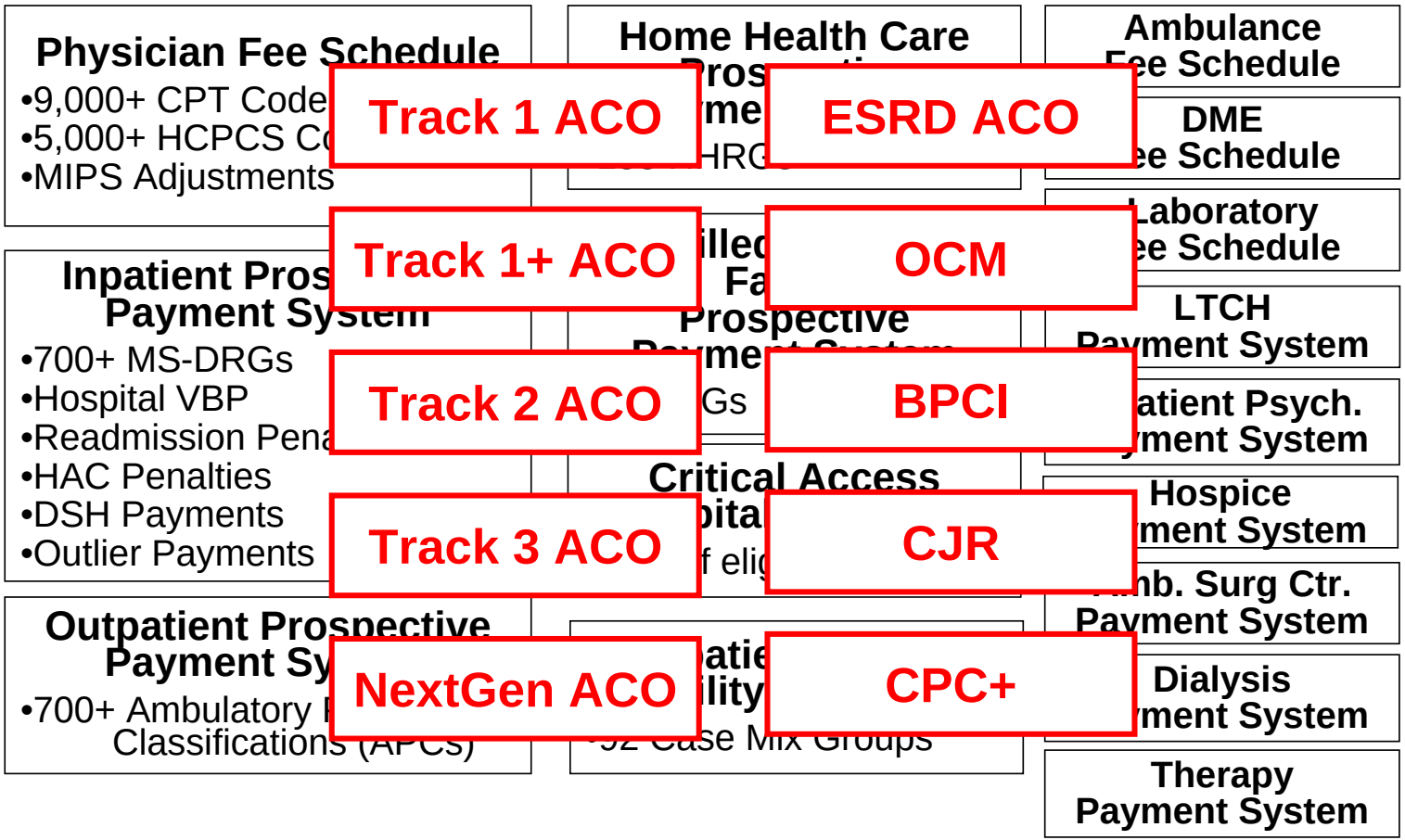
Hospice Payment System

Amb. Surg Ctr. Payment System

Dialysis Payment System

Therapy Payment System

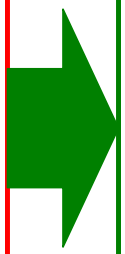
The Most Complexity is Adding More Layers On Top of FFS



A Much Simpler, Predictable, Accountable System Than Today

CURRENT PAYMENTS

- Physician Fee Schedule
- Inpatient PPS
- Outpatient PPS
- Home Health PPS
- Hospice Per Diems
- SNF PPS
- IRF PPS
- LTCH PPS
- ASC PPS
- IPF PPS
- Dialysis PPS
- CAH Payment
- FQHC/RHC Payment
- Clinical Laboratory Fee Schedule
- DME Fee Schedule
- Ambulance Services Payment
- Track 1 ACO
- Track 1+ ACO
- Track 2 ACO
- Track 3 ACO
- Next Generation ACO
- ESRD ACO
- BPCI Advanced
- CJR
- Oncology Care Model
- Comp. Primary Care Plus



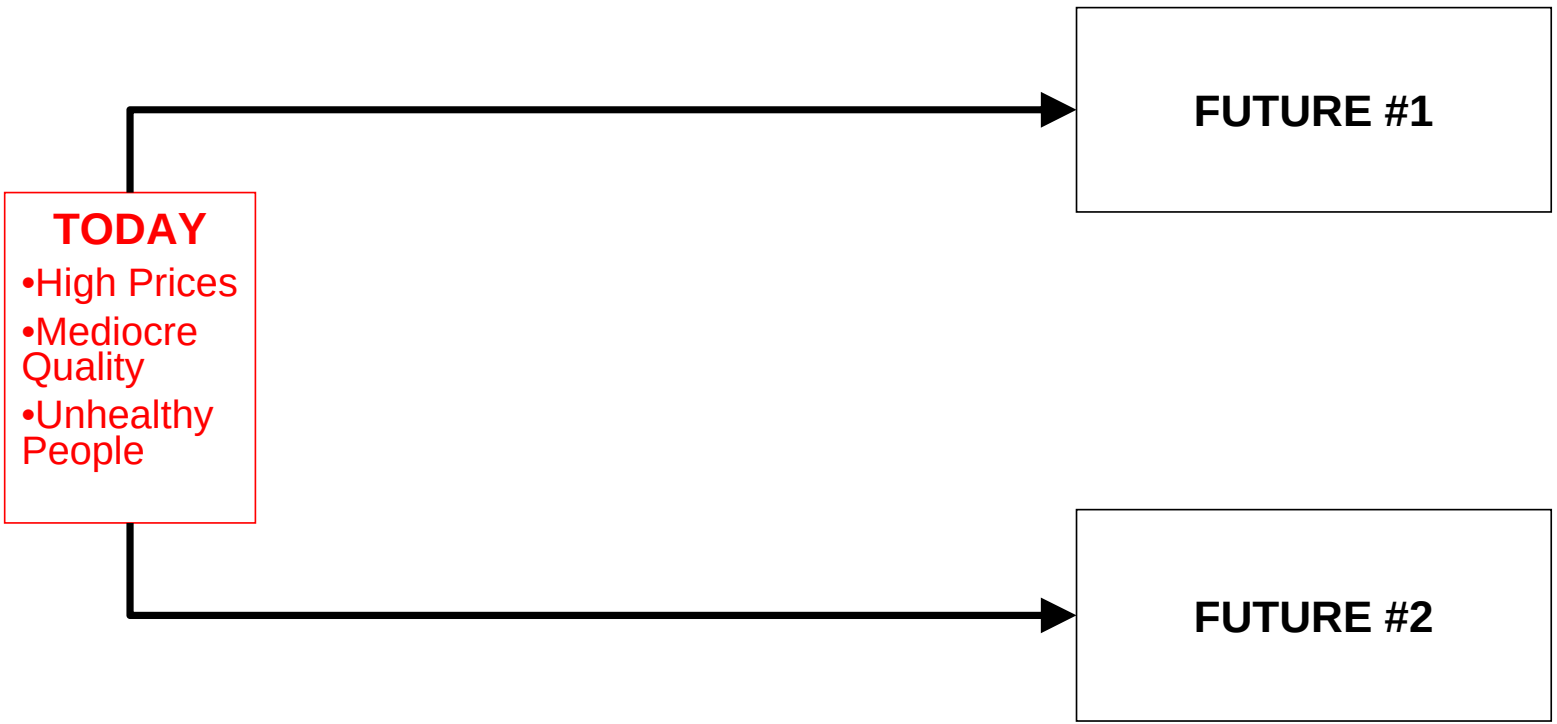
PATIENT-CENTERED PAYMENT

- Prevention/Wellness Mgt Pmt
- Preventive Service Bundled Pmts
- Diagnostic Bundled Payment
- Acute Condition Bundled Payment
- Standby Services Payment
- Chronic Condition Mgt Payment

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 Shared Savings**
  She makes more money if you get less treatment than needed
- **Physician D gets a "Population-Based Payment"**
  She gets paid whether she does anything for you or not
- **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

Which Path Will Your Community Choose?



Which Path Will Your Community Choose?

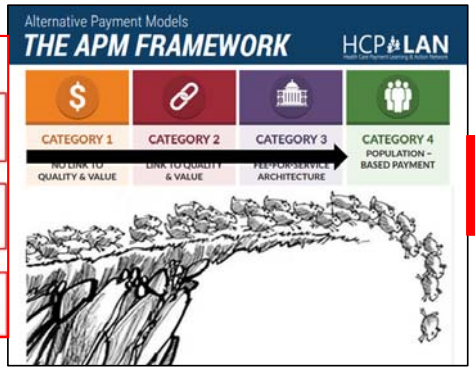
TODAY
- High Prices
- Mediocre Quality
- Unhealthy People

TOP-DOWN PAYMENT REFORM

Medicare and Health Plans Define Payment Systems

Physicians and Hospitals Have To Change Care to Align With Payment Systems

Patients Get Worse Care and Providers Close/Consolidate



FUTURE #1
- Higher Prices
- Mediocre Quality
- Limited Patient Choice
- Loss of Good Physicians
- Loss of Rural Hospitals

FUTURE #2

Which Path Will Your Community Choose?

TODAY
- High Prices
- Mediocre Quality
- Unhealthy People

TOP-DOWN PAYMENT REFORM

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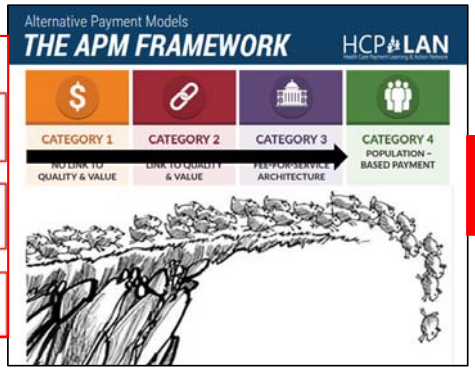
Patients Get Worse Care and Providers Close/Consolidate



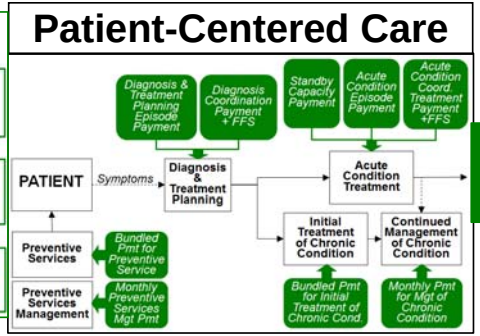
FUTURE #1
- Higher Prices
- Mediocre Quality
- Limited Patient Choice
- Loss of Good Physicians
- Loss of Rural Hospitals

BOTTOM-UP PAYMENT REFORM

Patients Get Good Care at an Affordable Cost and Independent Providers Remain Financially Viable

Payers Provide Adequate Payment for Quality Care & Providers Take Accountability for Quality & Efficiency

Ask Physicians and Hospitals to Identify Ways to Improve Care for Patients and Eliminate Avoidable Costs



FUTURE #2
- Affordable Prices
- Good Outcomes
- Choice of Providers
- Care Customized to Patient and Community Needs

Learn More in Mini-Summits 3, 8, & 13 This Afternoon

Mini-Summit 3: Hospital Global Budgets

- How Maryland is paying hospitals differently so they can reduce volume while paying adequately for essential fixed costs

Mini-Summit 8: APMs for Outpatient Specialty Care

- Ways to achieve significant savings and quality improvement by:
  - Finding opportunities for reducing truly avoidable spending
  - Providing individualized support to patients based on their needs
  - Providing hospital-level care in patient's homes

Mini-Summit 13: APMs for Small/Rural Practices & Hospitals

- Making APMs work for small physician practices and hospitals
  - How well do CPC+ and other medical home payment systems support solo PCPs and small rural practices?
- Making ACOs work in rural communities
  - What support do critical access hospitals and small physician practices need to effectively manage spending and quality?

For More Information:

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(412) 803-3650

www.CHQPR.org
www.PaymentReform.org

APPENDIX

Comparison of
Patient-Centered Payment
to
Current Alternative Payment Models

Current APMs Compared to Patient-Centered Payments

CURRENT VALUE-BASED PMT

- The patient (and payer) can only find out the total price of treating a health problem *after* all of the services have been delivered;
- The patient may be able to find out the percentage of *other* patients who were treated by (*some of*) the providers *two years ago* received care that met quality standards;
- The patient (and payer) *has to pay* even if the quality of care they received was poor or if the treatment didn't succeed, and if errors were made, the patient/payer *has to pay extra* to have them corrected; and
- The amount the patient (and payer) ultimately pays bears *no relationship to the costs* of the services provided

PATIENT-CENTERED PAYMENT

- The patient (and payer) are told *in advance* what the total price of treating the health problem will be;
- The patient is told what standards of quality *their* care *will* meet and the specific results *they* should expect to see from the care they will receive;
- The patient (and payer) *will not pay extra* for services to correct errors made by the providers, and they *will not pay at all* unless the care they received met quality standards and achieved the expected results; and
- The amount the patient (and payer) pays *is based on the cost* of delivering high-quality care with a warranty

APPENDIX

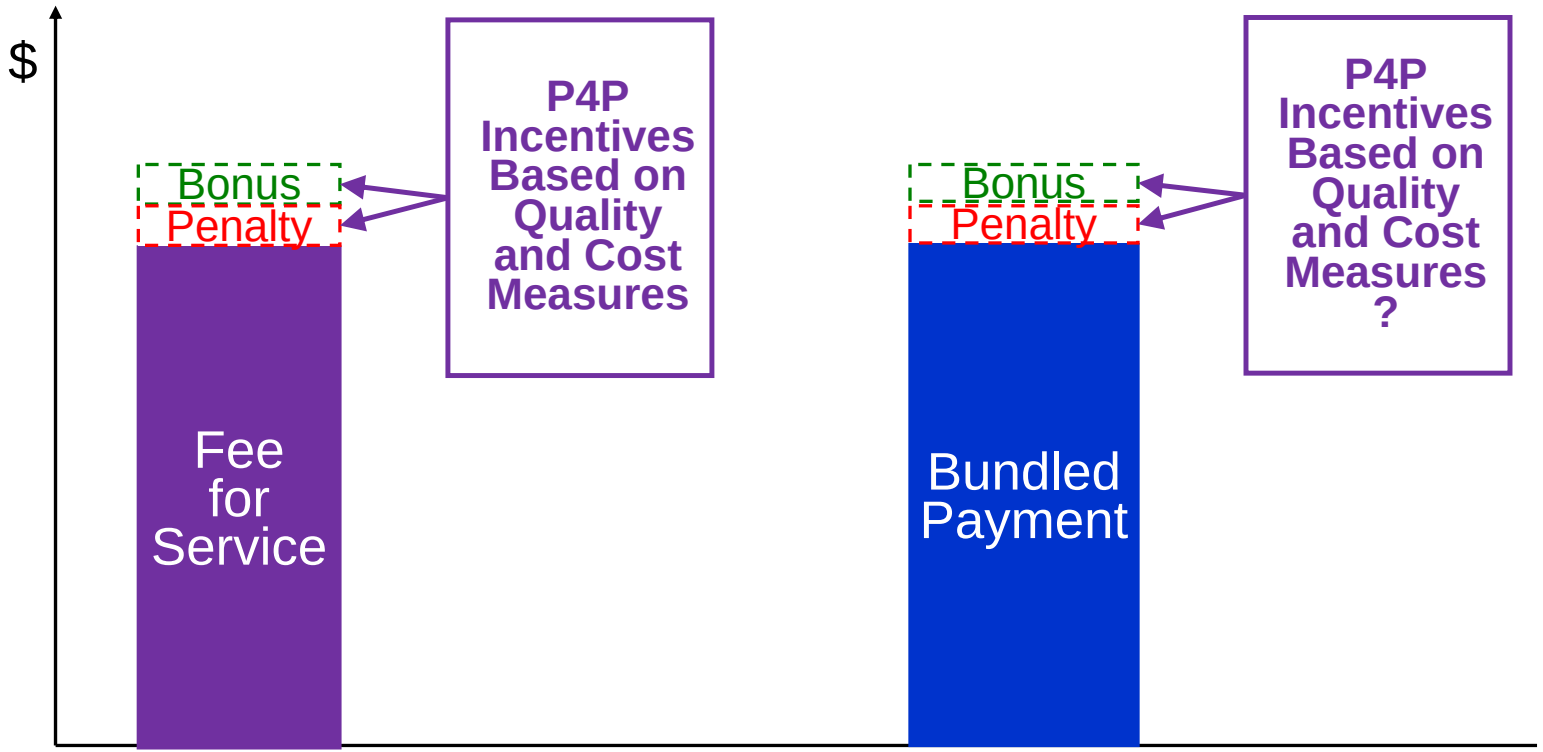
Accountability for Quality & Outcomes in Patient-Centered Payment

If You’re No Longer Paying Based on the Services Delivered, How Does the Patient Know They’re Not Being Undertreated?

To Prevent Undertreatment, Tie Payment to Quality & Outcomes

- Precautions to avoiding post-surgical infections
- Use of high-quality medical devices
- Patient return to functionality
- Lack of pain

Can P4P Assure Quality of Bundles When It Doesn't Work with FFS?



Hypothetical Procedure With a Bundled Payment

	FFS
# of Patients	100
Bundled Payment	$2,000
Revenue to Provider	$200K

Assume 10% of Procedures Don't Meet Quality Standard

	FFS
# of Patients	100
# Cases Meeting Quality Standard	90
# Not Meeting Quality Standard	10
Bundled Payment	$2,000
Revenue to Provider	$200K

Patients/Payers Pay the Same If the Standard is Met or Not

	FFS
# of Patients	100
# Cases Meeting Quality Standard	90
# Not Meeting Quality Standard	10
Payment When Standard Met	$2,000
Payment When Standard Not Met	$2,000
Revenue to Provider	$200K

What Happens if Quality Improves Under FFS?

	FFS		FFS
# of Patients	100		100
# Cases Meeting Quality Standard	90	→	99
# Not Meeting Quality Standard	10	→	1
Payment When Standard Met	$2,000		$2,000
Payment When Standard Not Met	$2,000		$2,000
Revenue to Provider	$200K		$200K
% Change			0%

No Change in Provider Revenue; Patients Still Pay for the Bad Care

	FFS		FFS
# of Patients	100		100
# Cases Meeting Quality Standard	90	→	99
# Not Meeting Quality Standard	10	→	1
Payment When Standard Met	$2,000		$2,000
Payment When Standard Not Met	$2,000	→	$2,000
Revenue to Provider	$200K	→	$200K
% Change			0%

Patients Still Pay if They Receive Poor Care

No Change in Provider Revenue

No Penalty if Quality Worsens, More Patients Pay for Bad Care

	FFS		FFS		FFS	
# of Patients	100		100		100	
# Cases Meeting Quality Standard	90		80		80	
# Not Meeting Quality Standard	10		20		20	
Payment When Standard Met	$2,000		$2,000		$2,000	
Payment When Standard Not Met	$2,000		$2,000		$2,000	
Revenue to Provider	$200K		$200K		$200K	
% Change			0%		0%	

P4P = Small Rewards & Penalties,

	FFS		FFS+ P4P		FFS+ P4P	
# of Patients	100		100		100	
# Cases Meeting Quality Standard	90		99		80	
# Not Meeting Quality Standard	10		1		20	
Payment When Standard Met	$2,000		$2,100	+5%	$1,900	-5%
Payment When Standard Not Met	$2,000		$2,100	+5%	$1,900	-5%
Revenue to Provider	$200K		$210K		$190K	
% Change			+5%		-5%	

P4P = Small Rewards & Penalties, Patients Still Pay for Bad Care

	FFS		FFS+ P4P		FFS+ P4P	
# of Patients	100		100		100	
# Cases Meeting Quality Standard	90		99		80	
# Not Meeting Quality Standard	10		1		20	
Payment When Standard Met	$2,000		$2,100	+5%	$1,900	-5%
Payment When Standard Not Met	$2,000		$2,100	+5%	$1,900	-5%
Revenue to Provider	$200K		$210K		$190K	
% Change			+5%		-5%	

P4P = Small Rewards & Penalties, Patients Still Pay for Bad Care

	FFS		FFS+ P4P		FFS+ P4P	
# of Patients	100		100		100	
# Cases Meeting Quality Standard	90		99		80	
# Not Meeting Quality Standard	10		1		20	
Payment When Standard Met	$2,000		$2,100	+5%	$1,900	-5%
Payment When Standard Not Met	$2,000		$2,100	+5%	$1,900	-5%

THIS IS NOT A PATIENT-CENTERED SYSTEM

What if Providers Charged *Nothing* When Standards Weren't Met?

	FFS	Pay for Quality
# of Patients	100	100
# Cases Meeting Quality Standard	90	90
# Not Meeting Quality Standard	10	10
Payment When Standard Met	$2,000	
Payment When Standard Not Met	$2,000	$0
Revenue to Provider	$200K	
% Change		

They'd Need to Charge More for Good Quality Care

	FFS	Pay for Quality
# of Patients	100	100
# Cases Meeting Quality Standard	90	90
# Not Meeting Quality Standard	10	10
Payment When Standard Met	$2,000	$2,222
Payment When Standard Not Met	$2,000	$0
Revenue to Provider	$200K	$200K
% Change		

Now, Provider is Rewarded for Better Quality…

	FFS	Pay for Quality	FFS+ P4P	Pay for Quality
# of Patients	100	100	100	100
# Cases Meeting Quality Standard	90	99	99	99
# Not Meeting Quality Standard	10	1	1	1
Payment When Standard Met	$2,000	$2,222	$2,100	$2,222
Payment When Standard Not Met	$2,000	$0	$2,100	$0
Revenue to Provider	$200K	$220K	$210K	$220K
% Change			+5%	+10%

…and Penalized for Poor Quality

	FFS	Pay for Quality	FFS+ P4P	Pay for Quality	FFS+ P4P	Pay for Quality
# of Patients	100	100	100	100	100	100
# Cases Meeting Quality Standard	90	[illegible]	[illegible]	[illegible]	[illegible]	80
# Not Meeting Quality Standard	10	[illegible]	1	1	[illegible]	20
Payment When Standard Met	$2,000	$2,222	$2,100	$2,222	$1,900	$2,222
Payment When Standard Not Met	$2,000	$0	$2,100	$0	$1,900	$0
Revenue to Provider	$200K	[illegible]	[illegible]	[illegible]	[illegible]	$178K
% Change			+5%	+10%	-5%	-11%

…and Penalized for Poor Quality & Patient *Doesn't Pay for Bad Care*

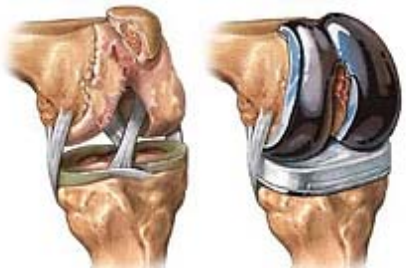
	FFS	Pay for Quality	FFS+ P4P	Pay for Quality	FFS+ P4P	Pay for Quality
# of Patients	100	100	100	100	100	100
# Cases Meeting Quality Standard	90	90	99	99	80	80
# Not Meeting Quality Standard	10	10	1	1	20	20
Payment When Standard Met	$2,000	$2,222	$2,100	$2,222	$1,900	$2,222
Payment When Standard Not Met		$0		$0		$0
Revenue to Provider	$200K	$200K	$210K	$220K	$190K	$178K
% Change			+5%	+10%	-5%	-11%

APPENDIX

How Do You Set/Control Prices Under Patient-Centered Payment?

Where Will You Get Your Knee Replaced?

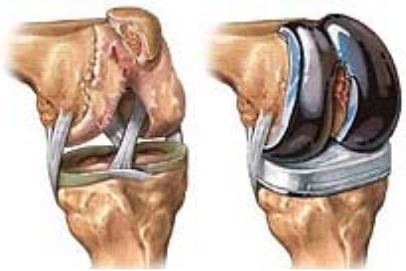
Knee Joint Replacement



	Price #1 $20,000	Price #2 $25,000	Price #3 $30,000

Current Cost-Sharing Encourages Use of Expensive Providers

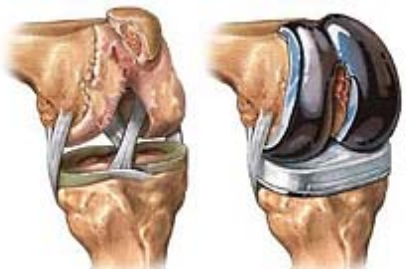
Knee Joint Replacement



Consumer Share of Surgery Cost	Price #1 $20,000	Price #2 $25,000	Price #3 $30,000
$1,000 Copayment:	$1,000	$1,000	**$1,000** ✓
10% Coinsurance w/$2,000 OOP Max:	$2,000	$2,000	**$2,000** ✓
$5,000 Deductible:	$5,000	$5,000	**$5,000** ✓

Patients Need to Pay the "Last Dollar" to Encourage Value

Knee Joint Replacement



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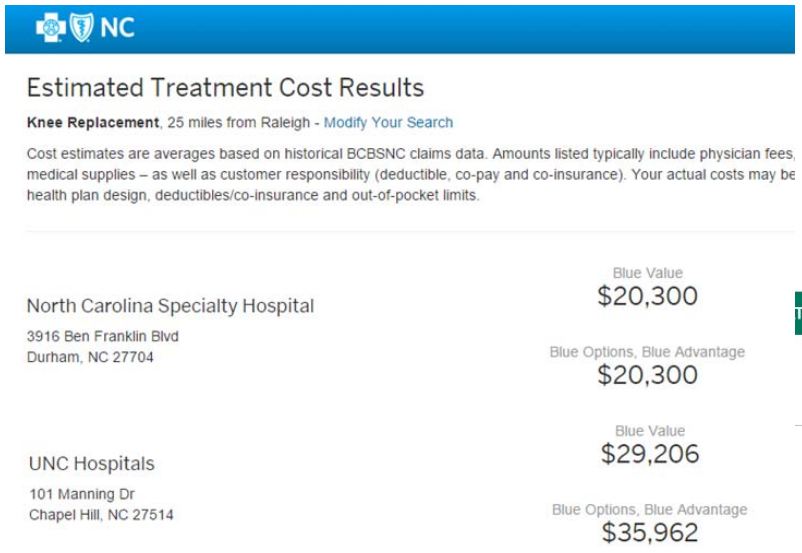
10% Coinsurance w/$2,000 OOP Max:	$2,000	$2,000	**$2,000** ✓
$5,000 Deductible:	$5,000	$5,000	**$5,000** ✓
Highest-Value:	**$0** ✓	$5,000	$10,000

Will Transparency About Prices Result in Better Choices?



NC

Estimated Treatment Cost Results

Knee Replacement, 25 miles from Raleigh - Modify Your Search

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be health plan design, deductibles/co-insurance and out-of-pocket limits.

North Carolina Specialty Hospital
3916 Ben Franklin Blvd
Durham, NC 27704

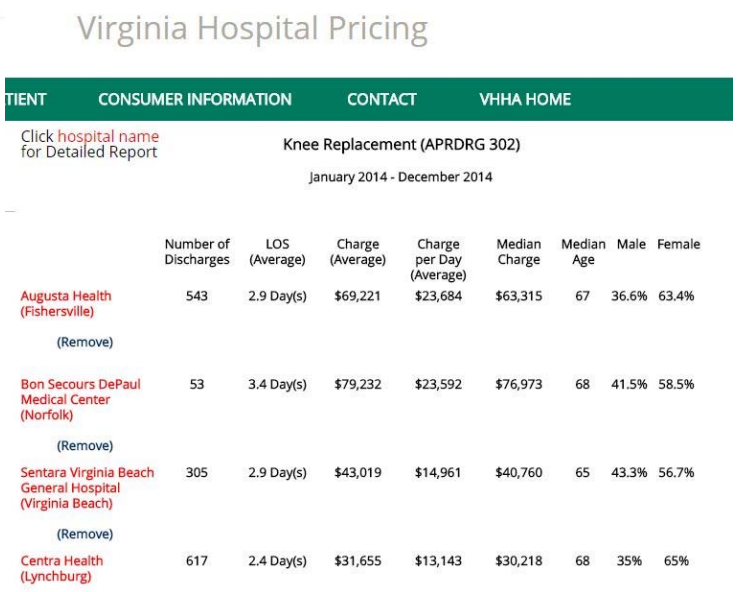
Blue Value
$20,300

Blue Options, Blue Advantage
$20,300

UNC Hospitals
101 Manning Dr
Chapel Hill, NC 27514

Blue Value
$29,206

Blue Options, Blue Advantage
$35,962



Virginia Hospital Pricing

TIENT | CONSUMER INFORMATION | CONTACT | VHHA HOME

Click hospital name for Detailed Report

Knee Replacement (APRDRG 302)

January 2014 - December 2014

	Number of Discharges	LOS (Average)	Charge (Average)	Charge per Day (Average)	Median Charge	Median Age	Male	Female
Augusta Health (Fishersville)	543	2.9 Day(s)	$69,221	$23,684	$63,315	67	36.6%	63.4%
(Remove)								
Bon Secours DePaul Medical Center (Norfolk)	53	3.4 Day(s)	$79,232	$23,592	$76,973	68	41.5%	58.5%
(Remove)								
Sentara Virginia Beach General Hospital (Virginia Beach)	305	2.9 Day(s)	$43,019	$14,961	$40,760	65	43.3%	56.7%
(Remove)								
Centra Health (Lynchburg)	617	2.4 Day(s)	$31,655	$13,143	$30,218	68	35%	65%

Current Transparency Efforts Are Focused on Procedure Price

Payment for Procedure
Provider 1:
$25,000

Provider 2:
$23,000
-8%

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%		

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%**

Provider 2 has a lower starting price, but is more expensive when lower quality is factored in

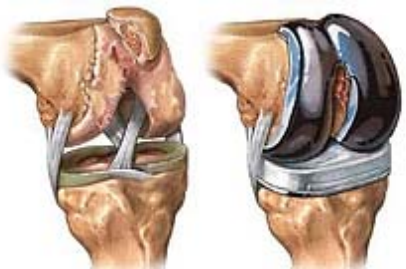
Bundled/Warrantied Pmts Allow Comparing Apples to Apples

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

Bundled prices show that Provider 1 is the higher-value provider

Choice & Competition Encourages Efficiency

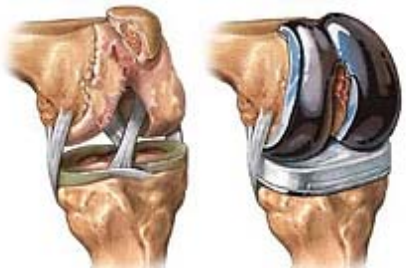
Knee Joint Replacement



Consumer Share of Surgery Cost	Price #1 $20,000	Price #2	Price #3 $30,000
Highest-Value:	**$0**	$5,000	$10,000

Loss of Choice & Competition Will Lead to Higher Costs

Knee Joint Replacement



Consumer Share of Surgery Cost	Price #1 $20,000	Price #2	Price #3 $30,000
Highest-Value:	$0	$5,000	$10,000