USING VALUE-BASED PAYMENTS TO CREATE A SUSTAINABLE HEALTH SYSTEM

Harold D. Miller
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www.CHQPR.org
How Do You Control the Growth in Healthcare Spending?
Typical Cost Control Strategy #1:
Cut Provider Fees for Services

Health Care Spending

Cut Provider Fees

Payer Savings

Lower Spending for Payers

Losses for Providers
Typical Cost Control Strategy #2: Shift Costs to Patients

Health Care Spending

$\downarrow$

Shift Costs to Patients

Payer Savings

Lower Spending for Payers

Higher Cost-Share & Deductibles
Typical Cost Control Strategy #3: Delay or Deny Care to Patients

- Delay/Deny Needed Care
- Lower Spending for Payers
- Payer Savings

Health Care Spending

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Typical Strategies Benefit Payers But Harm Patients

- Fee cuts
- High patient cost-sharing
- Delays & care denials
- Reduced access to services
- Worse health outcomes

Lower Spending for Payers
Worse Care & Access for Patients

Health Care Spending
Concern: Healthcare Spending is Taking Increasing % of the GDP
Assumption: Lower Healthcare $
Assumption: Lower Healthcare $ Allows More Spending Elsewhere

Lower Health Care Spending

More GDP Available for Other Purposes

Higher Wages & More $ for Other Social Needs

Lower Spending for Payers

Other Parts of the Economy

Other Parts of the Economy

Health Care Spending

GDP
Spending Cuts That Harm Patients Could Also Harm the Economy

- Health Care Spending
- Other Parts of the Economy
- Less GDP Available for Other Purposes
- Lower Health Care Spending
- Other Parts of the Economy
- Loss of Productivity
- Poorer Worker Health & Reduced Work Capacity
- Lower Spending for Payers
Instead of Traditional Approaches to Reducing Spending…

- Fee cuts
- High patient cost-sharing
- Delays & care denials
- Reduced access to services
- Worse health outcomes

Lower Spending for Payers

Worse Care & Access for Patients

Health Care Spending

Payer Savings

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A Better Way: Value-Based Care for Patients

Health Care Spending

$\downarrow$

Value-Based Care Delivery

Payer Savings

Lower Spending for Payers

Better Care for Patients
What is “Value-Based Care”?

Necessary Services

Avoidable Spending

Reducing Avoidable Spending

Avoidable Spending

Payer Savings

Improving Necessary Services

Necessary Services

$
What is “Avoidable Spending?”

Avoidable Spending

Services that are:

• expensive for payers
  AND
• unnecessary or harmful for patients

Necessary Services
Avoidable Spending Exists in All Areas of Healthcare

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

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

- **CANCER TREATMENT**
  - Progression of disease before diagnosis
  - Use of unnecessarily-expensive drugs
  - ED visits/admits for complications
  - Fruitless treatment at end of life

- **SURGERY**
  - Unnecessary surgery
  - Use of unnecessarily-expensive implants
  - Infections and complications of surgery
  - Overuse of inpatient rehabilitation
Reducing *Avoidable Spending* is a *Win-Win* for Payers & Patients

- **Avoidable Spending**
- **Necessary Services**

![Graph showing the reduction of avoidable spending and its impact on payer savings and better care for patients.]

- **Lower Spending for Payers**
- **Better Care for Patients**

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Sustainability = Value-Based Care That Supports Economic Growth

$\uparrow$

Avoidable Spending

Necessary Services

Productivity Loss From Poor Health

Improved Worker Productivity

Payer Savings

Avoidable Spending

Necessary Services

Better Care for Patients

Lower Spending for Payers
Barriers in the Payment System Create a Win-Lose for Providers

BARRIERS TO VALUE IN THE CURRENT PAYMENT SYSTEM

Avoidable Spending

Necessary Services

Lower Spending for Payers

Payer Savings

Better Care for Patients

$
Barrier #1: Inadequate Payments for Higher-Value Services

Avoidable spending often occurs because there are no payments (or inadequate payment) for alternative, higher-value services:

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

Delivering these services can reduce avoidable services and improve value for payers and patients, but will cause financial losses for healthcare providers.
Barrier #2: “Avoidable Spending” is Part of Providers’ Revenue

![Diagram showing the relationship between Payer and Provider revenue with a breakdown of Necessary Services and Avoidable Spending]
Providers Use the Revenue to Pay for the Costs of Services

- **Avoidable Spending**
- **Necessary Services**
- **Provider Revenue**
- **Cost of Delivering Services**
- **Profit Margin**

Payer

Provider
The Majority of Provider Costs Are Fixed (in the Short Term)

Provider Revenue

- Avoidable Spending
- Necessary Services

Fixed Cost of Delivering Services

- Physician Practice Fixed Costs
  - Office space lease
  - Office staff (MA, receptionist)
  - Liability and business insurance

- Hospital Fixed Costs
  - 24/7 (standby) staff (ED, radiology, labs, maternity, etc.)
  - Equipment leases

Variable Costs
- Drugs
- Medical Devices & Supplies
- Part-Time Staff

$
When Healthcare Providers Reduce Avoidable Services…

- **Avoidable Spending**
- **Necessary Services**
- **Fixed Cost of Delivering Services**
- **Provider Revenue**

**Profit Margin**

$\uparrow$

Payer   Provider

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…Variable Costs Decrease, But Fixed Costs Do Not
FFS Revenues Decrease in Direct Proportion to Service Volume…

- Avoidable Spending
- Necessary Services
- Provider Revenue
- Provider Cost
- Variable Cost
- Fixed Cost of Delivering Services
- Profit Margin

$
Resulting in Financial Loss for Healthcare Providers

\[ \text{Provider Revenue} - \text{Variable Cost} - \text{Fixed Cost of Delivering Services} = \text{Profit Margin} \]

\[ \text{Avoidable Spending} + \text{Necessary Services} = \text{CURRENT SPENDING ON NECESSARY SERVICES} \]

\[ \text{Loss} = $ \]
Providing High-Value Services Without Payment Increases Losses

Necessary Services

Avoidable Spending

Provider Revenue

New Services

Variable Cost

Fixed Cost of Delivering Services

Provider

Payer

Profit Margin

Loss

$
Win-Lose: Savings for Payers, Losses for Providers

- Lose - Win - Win - Lose

$\uparrow$

Avoidable Spending

Necessary Services

Provider Revenue

Variable Cost of Services

Fixed Cost of Delivering Services

Payer Savings

New Services

Variable Cost

Fixed Cost of Delivering Services

Provider Revenue
Payment Reforms Are Needed to Remove Barriers to Better Care

**BARRIER #1**

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**BARRIER #2**

[Diagram showing financial comparisons between payers and providers.]
Value-Based Care & Payment for Inflammatory Bowel Disease (IBD)

Lawrence Kosinski, MD
Gastroenterologist
Chicago, USA

“Project Sonar”
www.SonarMD.com
Value-Based Care & Payment for Inflammatory Bowel Disease (IBD)

AVOIDABLE SPENDING OPPORTUNITY:
• >50% of spending for inflammatory bowel disease paid for hospital admissions of patients with exacerbations
• <33% of hospitalized patients saw their physician in the 30 days prior to hospital admission

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VALUE-BASED CARE REDESIGN:
• Proactive outreach to patients and monitoring of their symptoms using a smartphone app (“Sonar”)
• Early intervention by nurse and physician when problematic symptoms are identified

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BARRIER TO IMPLEMENTATION:
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PAYMENT CHANGE:
- Additional payment to physician practice to hire nurse and use symptom monitoring technology
Result: Better Care at Lower Cost for IBD

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RESULTS:
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- 10% reduction in total spending even with higher payments to physician practice for nurse and technology
- Improved quality of life and productivity for patients
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Most patients can’t get this kind of care because:
• specialists are paid for office visits, not for proactively contacting patients
• patients are discouraged from seeing specialists in order to reduce spending
Do Current “Value-Based Payments” and Alternative Payment Models Remove the Barriers to Value-Based Care??
Typical Value-Based Payment: No Change in Standard Fees

Under typical Value-Based Payments, Alternative Payment Models, and Accountable Care Organizations (ACOs):

- Physicians and hospitals are still paid the same amounts for the same services as under standard fee-for-service payments.
- There are no new payments or higher payments for high-value services.
If Healthcare Providers Reduce Avoidable Spending *This* Year...

<table>
<thead>
<tr>
<th>Current Payment</th>
<th>“Value-Based” Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fees for Necessary Services</td>
<td>Fees for Necessary Services</td>
</tr>
<tr>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

YEAR 1

- *Payer Savings*
- *Avoidable Services*
- *Low Payment for High-Value Services*
…Payers Pay the Providers More
Next Year

Under typical Shared Savings payments, the only change in payment is a bonus paid based on savings or quality/cost performance in a previous year.
Providers Lose Money This Year Under Current Payment System

Current Payment

“Value-Based” Payment

YEAR 1

Fees for Avoidable Services

Payer Savings

Avoidable Services

Fees for Necessary Services

Fees for Necessary Services

Low Payment for High-Value Services

Losses on High-Value Services

How does provider cover upfront costs of high-value care?
Even If Provider Qualifies for a Bonus Next Year…

Current Payment

$\uparrow$

Fees for Necessary Services

Fees for Avoidable Services

Payer Savings

Avoidable Services

YEAR 1

“Value-Based” Payment

How does provider cover upfront costs of high-value care?

Losses on High-Value Services

YEAR 2

“Value-Based” Payment

Low Payment for High-Value Services

P4P/Shared Svgs

Avoidable Services

Fees for Necessary Services

Fees for Necessary Services

Losses on High-Value Services
…the Bonus is Generally Less Than Added Costs & Losses

Current Payment

| $ | Fees for Avoidable Services | Fees for Necessary Services | Low Payment for High-Value Services |

“Value-Based” Payment YEAR 1

| $ | Payer Savings | Avoidable Services | How does provider cover upfront costs of high-value care? |

“Value-Based” Payment YEAR 2

| $ | Payer Savings | Avoidable Services | Losses on High-Value Services |

Provider Revenue

| $ | New Services | Variable Cost | Fixed Cost of Delivering Services |

Bonus may not cover losses
Result: “Value-Based” Payments Are Typically Still a Win-Lose
# Medicare (U.S.) Value-Based Pmts Have *Increased* Payer Spending

<table>
<thead>
<tr>
<th>Medicare Alternative Payment Model</th>
<th>Medicare Losses</th>
<th>Medicare Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accountable Care Organizations (ACOs)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MSSP 2013-2016</td>
<td>-0.2%*</td>
<td>0.5%*</td>
</tr>
<tr>
<td>MSSP 2017-2018</td>
<td></td>
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<tr>
<td>MSSP 2019</td>
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<tr>
<td>MSSP 2020 (Pandemic Year)</td>
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<tr>
<td>MSSP 2021</td>
<td></td>
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<tr>
<td>Next Generation ACO Model</td>
<td>-0.3%</td>
<td></td>
</tr>
<tr>
<td>Comprehensive Primary Care Initiative (CPCI)</td>
<td>-1.0%</td>
<td></td>
</tr>
<tr>
<td>Comprehensive Primary Care Plus (CPC+) Track 1</td>
<td>-2.0%</td>
<td></td>
</tr>
<tr>
<td>Comprehensive Primary Care Plus (CPC+) Track 2</td>
<td>-3.0%</td>
<td></td>
</tr>
<tr>
<td>Comprehensive Care for Joint Replacement (CJR)</td>
<td></td>
<td>0.4%</td>
</tr>
<tr>
<td>Bundled Payments for Care Improvement (BPCI) Model 2</td>
<td>-1.0%</td>
<td></td>
</tr>
<tr>
<td>Bundled Payments for Care Improvement (BPCI) Model 3</td>
<td>-3.0%</td>
<td></td>
</tr>
<tr>
<td>Bundled Payments for Care Improvement Advanced (BPCI-A)</td>
<td>-0.4%</td>
<td></td>
</tr>
<tr>
<td>Comprehensive ESRD Care</td>
<td>-0.8%</td>
<td></td>
</tr>
<tr>
<td>Oncology Care Model (OCM)</td>
<td>-0.7%</td>
<td></td>
</tr>
<tr>
<td>Independence at Home (created by Congress, not CMS)</td>
<td></td>
<td>1.0%</td>
</tr>
</tbody>
</table>

* Savings estimate is not based on rigorous evaluation
Problems With Current Value-Based Payments

1. Current approaches to value-based payment do not remove the barriers to delivering care in different and better ways
Problems With Current Value-Based Payments

1. Current approaches to value-based payment do not remove the barriers to delivering care in different and better ways.

2. Current approaches to value-based payment can encourage undertreatment of patients & reduced access for high-need patients.
Will Savings Come From Reducing *Avoidable* Spending?

<table>
<thead>
<tr>
<th>Current Payment</th>
<th>Shared Savings Payment YEAR 1</th>
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</thead>
<tbody>
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<td>Necessary Services</td>
<td>Payer Savings</td>
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</table>

$\downarrow$ Avoidable Spending

Avoidable Spending
Or Will Savings Come From Reducing Necessary Services?

Examples of Savings at Expense of Quality/Outcomes
- Using lower-cost treatments that are less effective
- Reducing frequency of preventive screening or delaying diagnostic testing
Bonuses Are Paid Regardless of How Spending is Reduced

- **Current Payment**
  - Avoidable Spending
  - Necessary Services

- **Shared Savings Payment YEAR 1**
  - Payer Savings
  - Avoidable Spending
  - Necessary Services

- **Shared Savings Payment YEAR 2**
  - Payer Savings
  - Avoidable Spending
  - Necessary Services

Win for Payers: Lower Spending
Loss for Patients: Worse Care & Access

Reduced Access to Care

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Don’t Quality Measures Protect Against Undertreatment?

23 ACO Quality Measures

- **At-Risk Population (25%)**
  - Diabetes Control (> 9% HbA1c)
  - Hypertension Control
  - Depression Remission

- **Preventive Health (25%)**
  - Influenza Immunization
  - Tobacco Use Screening/Intervention
  - Depression Screening/Follow-up
  - Colorectal Cancer Screening
  - Breast Cancer Screening

- **Care Coordination/Safety (25%)**
  - Hospital Readmission Rate
  - Hospitalizations for Patients with Multiple Chronic Conditions
  - AHRQ Prevention Quality Indicator
  - Screening for Fall Risk

- **Patient/Caregiver Experience (25%)**
  - Timely Appointments
  - Provider Communication
  - Provider Rating
  - Access to Specialists
  - Health Education
  - Shared Decision Making
  - Health & Functional Status
  - Stewardship of Patient Resources
  - Courteous and Helpful Office Staff
  - Care Coordination
ACOs Are at Risk for Total Cost, But Not for Total Quality of Care

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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
- Access to and quality of care for many other conditions
Healthcare Providers Don’t Need “Incentives” or Significant Financial Risk in Order to Improve Care and Reduce Spending…
Healthcare Providers Don’t Need “Incentives” or Significant Financial Risk in Order to Improve Care and Reduce Spending...

...They Need True Value-Based Payments That Remove the Barriers to Higher-Value Care.
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…They Need True Value-Based Payments That Remove the Barriers to Higher-Value Care.

How Do You Create Successful Value-Based Payments?
Step 1: Identify Specific Areas of Potentially Avoidable Spending

Examples of Potentially Avoidable Spending

**Chronic Disease**
- Preventable chronic conditions
- ED visits for exacerbations
- Hospital admissions and readmissions
- Preventable progression of disease

**Maternity Care**
- Unnecessary C-sections
- Early elective deliveries
- Underuse of birth centers

**Cancer Treatment**
- Progression of disease before diagnosis
- Use of drugs that are more expensive than necessary
- ED visits/hospital admissions for complications
- Fruitless treatment at end of life

**Surgery**
- Unnecessary surgery
- Use of devices that are more expensive than necessary
- Infections and complications of surgery
- Overuse of inpatient rehabilitation
Step 2: Design Services That Will Reduce The Avoidable Spending

Examples of High-Value Services

- Wellness care & screening
- Adequate time for diagnosis of new symptoms
- Care management and symptom monitoring for patients with chronic conditions
- Birth centers for low-risk pregnancies
- Telehealth for minor acute conditions & behavioral health
- Hospital at Home for certain serious acute conditions
- Transportation for patients who have difficulty accessing services
- Palliative care for serious illnesses
If Current Payments Do Not Support Value-Based Care…

Under current payment systems, providers can lose money if they deliver higher-value care.

- Avoidable Spending
- Necessary Services
- Services That Reduce Avoidable Spending
- Current Fee-for-Service Payments
- No Payment or Payment < Cost
- Payer Savings
- Provider Loss

Current Fee
- Payments

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Step 3: Pay Adequately to Support Higher-Value Services

- Avoidable Spending
  - Necessary Services
  - Avoidable Spending
  - Services That Reduce Avoidable Spending
  - Adequate Payment for Value-Based Care

Payer Savings
Adequacy Requires Knowing the Cost of Higher-Value Care

- Avoidable Spending
- Necessary Services
- Avoidable Spending
- Services That Reduce Avoidable Spending
- Cost of Services
- Adequate Payment for Value-Based Care

Payer Savings

Profit Margin

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Step 4: Accountability for Delivering Value-Based Care

Avoidable Spending

Necessary Services

Services That Reduce Avoidable Spending

Cost of Services

Avoidable Spending

Adequate Payment for Value-Based Care

$
Value-Based Payment Can Be a Win-Win-Win

Win for Patients: Better Care Without Unnecessary Services

Win for Providers: Adequate Payment for High-Value Services

Win for Payers: Lower Spending

Avoidable Spending

Necessary Services

Avoidable Spending

Services That Reduce Avoidable Spending

Cost of Services

Avoidable Spending

Adequate Payment for Value-Based Care

Accountability for Delivering Value-Based Care

Payer Savings

Profit Margin
Adequacy Requires Knowing the Cost of Higher-Value Care

Profit Margin

Cost of Services

Adequate Payment for Value-Based Care

$
Cost ≠ Spending, & It’s Not Enough to Know Current Costs

• Claims data tells you what is *paid* for services, not what they *cost to deliver*

• Time-Driven Activity-Based Costing and other cost-accounting systems can tell you what it *currently* costs to deliver *non-value-based care*, but not what it *will* cost to deliver *value-based care*.

• A *Cost Model* is needed to determine how costs will *change* as value-based care is implemented:
  - What will it cost to deliver new, high-value services?
  - How much of the cost of *current* services is:
    - *Variable*, i.e., it will change with each unit change in services (e.g., drugs, disposable items)
    - *Semi-Variable*, i.e., it will change only with large changes in volume (e.g., personnel, equipment)
    - *Fixed*, i.e., it can only be changed over a longer time horizon

• Future costs will depend on expected number and types of patients
Payment Amount Must Cover the Cost of Value-Based Care

- Adequate Payment for Value-Based Care
- Profit Margin
- Fixed Cost of Services
- Variable Cost of Services
What Payment Method Should Be Used?

$\text{Method for Providing Adequate Payment ????}$
There Are (Only) Three Ways to Change Payments for Services

- Change Fee Amounts
- Create New Fees
- Bundle Payments
In Some Cases, New Fee(s) May Be Simplest/Best Approach

- **No Payment or Payment < Cost**
- **Current Fee-for-Service Payments**
- **Provider Loss**
- **Add New Fee(s) for High-Value Services**
- **Continue Current Fee-for-Service Payments**

There are no financial data points available in the image.
In Other Cases, a Bundled Payment is Most Appropriate

- Current Fee-for-Service Payments
  - Provider Loss
  - No Payment or Payment < Cost

- Bundled Payment
  - support for:
    - services paid for by current fees
    - services for which there are no fees currently

$
Too Little Bundling $\rightarrow$ Overuse
Too Much $\rightarrow$ Undertreatment

Fees for Narrowly-Defined Services

Less Bundled Payment $\rightarrow$ More Bundled Payment

Risk of Overuse

Risk of Undertreatment

Capitation Payment for Each Patient
Good Value-Based Payment Has to Strike the Right Balance

- Less Bundled Payment
- Risk of Undertreatment
- More Bundled Payment
- Risk of Overuse

Fees for Narrowly-Defined Services

Payment for Value-Based Care

Capitation Payment for Each Patient
What (Exactly) Should Providers Be Held Accountable For?

$\text{Payer Savings}\$

- Avoidable Spending
- Adequate Payment for Value-Based Care

Accountability for Delivering Value-Based Care
Fee-for-Service Pays for Services Regardless of the Outcome

**Good Outcome**
- Fee-for-Service Payment
- Services Delivered to Patient
- Good Outcome

**Poor Outcome**
- Fee-for-Service Payment
- Services Delivered to Patient
- Poor Outcome
Should Value-Based Payment Tie Payments to Outcomes?

**Fee-for-Service Payment**
- Services Delivered to Patient
  - Good Outcome
    - Outcome-Based Payment
  - Poor Outcome
    - Lower Payment or No Payment

**Payment**
- Fee-for-Service
- Outcome-Based

**PATIENT**
Problem #1: Outcomes Occur Long After Services Are Delivered

**Good Outcome**
- Colon cancer screening
- Heart disease management
- Diabetic care
- No colon cancer
- No heart attack
- No amputation

**Poor Outcome**
- Lack of preventive care
- Poor chronic condition care
- Colon cancer
- Heart attack
- Amputation

PATIENT → Services Delivered to Patient → Outcome-Based Payment

PATIENT → Services Delivered to Patient → Lower Payment or No Payment
Problem #2: Outcomes Are Only Partially Controlled by Providers

Good Outcome

- Services Delivered to Patient
- Uncontrollable Factors

Outcome-Based Payment

Poor Outcome

- Services Delivered to Patient
- Uncontrollable Factors
- Comorbidities
- Unwillingness or inability to adhere to treatment plan
- Poverty

Lower Payment or No Payment
Problem #3: Risk Adjustment Fails to Adjust for All Key Factors

- **Good Outcome**
  - Services Delivered to Patient
  - Outcome-Based Payment
  - Uncontrollable Factors

- **Poor Outcome**
  - Services Delivered to Patient
  - Uncontrollable Factors
  - Lower Payment
  - Uncontrollable Factors
    - Comorbidities
    - Unwillingness or inability to adhere to treatment plan
    - Poverty

Risk Measure

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Problem #4: “Outcomes” Improve by Avoiding Higher-Risk Patients

- **Services Delivered to Patient**
  - Outcome-Based Payment
  - Good Outcome
  - Uncontrollable Factors
  - Risk Measure

- **PATIENT**
  - No Services Delivered to Patient
  - Very Poor Outcome
  - Comorbidities
  - Failure to receive evidence-based treatment
  - Poverty
How Do Providers Actually Achieve Better Outcomes?

PATIENT ➔ Services Delivered to Patient ➔ Good Outcome

PATIENT ➔ Services Delivered to Patient ➔ Poor Outcome
By Using Services That Evidence Shows Will Improve Outcomes

PATIENT → Appropriate, Evidence-Based Services → Good Outcome

Use of Evidence-Based Guidelines → Poor Outcome

PATIENT → Unnecessary, Ineffective, or Incomplete Services → Poor Outcome

Failure to Use Evidence-Based Guidelines → More likely

Good Outcome

More likely

Less likely

Good Outcome

Less likely

More likely
Guidelines Identify Which Services Will Improve Outcomes

What Services Should Be Delivered
Guidelines Also Identify Ways to Reduce Avoidable Spending

- **What Services Should Be Delivered**
- **What Services Should Not Be Delivered**

---

**ICSi Institute for Clinical Systems Improvement**

*Health Care Guideline: Adult Depression in Primary Care*

*Seventeenth Edition March 2016*

---

**2015 American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis**

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**Glycemic Control Algorithm**

---

**Choosing Wisely**

- Don’t do imaging for low back pain within the first six weeks, unless red flags are present.
- Don’t routinely prescribe antibiotics for acute mild-to-moderate sinusitis unless symptoms last for ten or more days, or symptoms worsen after initial clinical improvement.
- Don’t use dual-energy x-ray absorptiometry (DEXA) screening for osteoporosis in women younger than 65 or men younger than 70 with no risk factors. DEXA is not cost-effective in young, low-risk patients, but it is cost-effective in older patients.
- Don’t order annual electrocardiograms (EKGs) or any other cardiac screening for low-risk patients without symptoms.
- Don’t perform Pap smears on women younger than 21 or who have had a hysterectomy for non-cancer disease.
Value-Based Payment Should Pay for Evidence-Based Care

PATIENT → Appropriate, Evidence-Based Services → Good Outcome
- Use of Evidence-Based Guidelines
  - More likely
- Poor Outcome
  - Less likely

PATIENT → Unnecessary, Ineffective, or Incomplete Services → Poor Outcome
- Failure to Use Evidence-Based Guidelines
  - More likely
- Lower Payment or No Payment
  - Less likely

Good Outcome
- Good Outcome
  - Less likely
- Poor Outcome
  - More likely
How “Payment for Outcomes” Can Harm Patients & Providers

Standard Diabetes Outcome Measure:
% of Diabetic Patients with HbA1c > 9.0
Evaluating the Quality of Care for 3 Hypothetical Patients

PATIENT #1, #2, and #3

Standard Diabetes Outcome Measure: % of Diabetic Patients with HbA1c > 9.0

<table>
<thead>
<tr>
<th>HbA1c at Start of Year</th>
<th>Care Delivered During Year</th>
<th>HbA1c at End of Year</th>
<th>Quality of Care:</th>
</tr>
</thead>
</table>

© Center for Healthcare Quality and Payment Reform  www.CHQPR.org
Patient #1 Receives Appropriate Care and Improves Significantly

**PATIENT #1**

Standard Diabetes Outcome Measure:
% of Diabetic Patients with HbA1c > 9.0

<table>
<thead>
<tr>
<th>HbA1c at Start of Year</th>
<th>Care Delivered During Year</th>
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</tr>
</thead>
<tbody>
<tr>
<td>13.0</td>
<td>Patient receives all appropriate evidence-based care</td>
<td>10.0</td>
<td></td>
</tr>
</tbody>
</table>
Diabetes Outcome Measure Ignores the Patient’s Improvement

**PATIENT #1**

<table>
<thead>
<tr>
<th>Standard Diabetes Outcome Measure:</th>
<th>Quality of Care:</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of Diabetic Patients with HbA1c &gt; 9.0</td>
<td>According to the Measure:</td>
</tr>
<tr>
<td><strong>HbA1c at Start of Year</strong></td>
<td><strong>Care Delivered During Year</strong></td>
</tr>
<tr>
<td>13.0</td>
<td>Patient receives all appropriate evidence-based care</td>
</tr>
</tbody>
</table>
In Reality, The Patient May Have Improved As Much As Possible

**PATIENT #1**

**Standard Diabetes Outcome Measure:**
% of Diabetic Patients with HbA1c > 9.0

<table>
<thead>
<tr>
<th>HbA1c at Start of Year</th>
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<td>13.0</td>
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<td>Poor quality</td>
<td>Good quality</td>
</tr>
</tbody>
</table>
**Patient #2 Receives Poor Care and HbA1c Worsens**

**PATIENT #2**

**Standard Diabetes Outcome Measure:**
% of Diabetic Patients with HbA1c > 9.0

<table>
<thead>
<tr>
<th>HbA1c at Start of Year</th>
<th>Care Delivered During Year</th>
<th>HbA1c at End of Year</th>
<th>Quality of Care:</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.0</td>
<td>Patient does not receive evidence-based care</td>
<td>8.5</td>
<td>According to the Measure:</td>
</tr>
</tbody>
</table>

According to the Measure:

- **According to the Measure:**
  - In Reality:
Diabetes Outcome Measure
Ignores the Patient’s Deterioration

PATIENT #2

Standard Diabetes Outcome Measure: 
% of Diabetic Patients with HbA1c > 9.0

<table>
<thead>
<tr>
<th>HbA1c at Start of Year</th>
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In Reality, The Patient Should Have Received Much Better Care

### PATIENT #2

**Standard Diabetes Outcome Measure:**
% of Diabetic Patients with HbA1c > 9.0

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</table>
### Patient #3 Can’t Afford Diabetes Medications

#### PATIENT #3

**Standard Diabetes Outcome Measure:**
% of Diabetic Patients with HbA1c > 9.0

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<tr>
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<td>10.0</td>
</tr>
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## Diabetes Outcome Measure Ignores What Is Feasible

### PATIENT #3

Standard Diabetes Outcome Measure: % of Diabetic Patients with HbA1c > 9.0

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## PATIENT #3

### Standard Diabetes Outcome Measure:
% of Diabetic Patients with HbA1c > 9.0

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<td>Best quality feasible for patient</td>
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</tbody>
</table>
### The Outcome Measure Gives the Wrong Result in Each Case

**Standard Diabetes Outcome Measure:** % of Diabetic Patients with HbA1c > 9.0

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# Outcome-Based Payment Would Reward the Wrong Thing

**Standard Diabetes Outcome Measure:**

<table>
<thead>
<tr>
<th>HbA1c at Start of Year</th>
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</table>

The table shows the relationship between HbA1c levels at the start and end of the year, care delivered during the year, and the resulting HbA1c levels. The table also highlights the difference between outcome-based payment and reality. In reality, good quality care does not necessarily result in lower HbA1c levels.
## Standard Diabetes Outcome Measure:

% of Diabetic Patients with HbA1c > 9.0

<table>
<thead>
<tr>
<th>HbA1c at Start of Year</th>
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<th>HbA1c at End of Year</th>
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<th>Payment for Evidence-Based Care</th>
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Many Important Outcomes Are Not Controllable by Providers

**Outcomes Inappropriate for Provider Accountability**

- Vital signs or test scores affected by patient access to medications, patient adherence, or other factors outside clinician control (e.g., HbA1c level, blood pressure)
- Remission of cancer and other diseases where success is not routinely achieved
- Complications caused by services ordered or delivered by other providers
- Morbidity or mortality due to conditions not being managed by the provider
Delivering Evidence-Based Care is Best Way to Improve Outcomes

Outcomes *Inappropriate* for Provider Accountability

- Vital signs or test scores affected by patient access to medications, patient adherence, or other factors outside clinician control (e.g., HbA1c level, blood pressure)
- Remission of cancer and other diseases where success is not routinely achieved
- Complications caused by services ordered or delivered by other providers
- Morbidity or mortality due to conditions not being managed by the provider

Payment for *Evidence-Based Care*

- Payment only if evidence-based guidelines are followed for the condition the provider is managing, with deviations permitted for documented patient-specific reasons
- Outcomes are measured and used to improve evidence-based guidelines
### Some Outcomes Can Be Controlled by Providers

<table>
<thead>
<tr>
<th>Outcomes Inappropriate for Provider Accountability</th>
<th>Outcomes Appropriate for Provider Accountability</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Vital signs or test scores affected by patient access to medications, patient adherence, or other factors outside clinician control (e.g., HbA1c level, blood pressure)</td>
<td>• Preventing infections and complications of a procedure delivered by the provider</td>
</tr>
<tr>
<td>• Remission of cancer and other diseases where success is not routinely achieved</td>
<td>• Avoiding complications caused by ordering or delivering the wrong treatment for a medical condition</td>
</tr>
<tr>
<td>• Complications caused by services ordered or delivered by other providers</td>
<td>• Use of a correctly-functioning prosthetic or medical device</td>
</tr>
<tr>
<td>• Morbidity or mortality due to conditions not being managed by the provider</td>
<td>• Improvement in patient function routinely achieved following treatment of similar patients (e.g., cataract surgery &amp; hip surgery)</td>
</tr>
</tbody>
</table>

### Payment for Evidence-Based Care

- Payment only if evidence-based guidelines are followed for the condition the provider is managing, with deviations permitted for documented patient-specific reasons.
- Outcomes are measured and used to improve evidence-based guidelines.
Use Outcome-Based Payments If Outcomes Can Be Controlled

Outcomes Inappropriate for Provider Accountability

- Vital signs or test scores affected by patient access to medications, patient adherence, or other factors outside clinician control (e.g., HbA1c level, blood pressure)
- Remission of cancer and other diseases where success is not routinely achieved
- Complications caused by services ordered or delivered by other providers
- Morbidity or mortality due to conditions not being managed by the provider

Outcomes Appropriate for Provider Accountability

- Preventing infections and complications of a procedure delivered by the provider
- Avoiding complications caused by ordering or delivering the wrong treatment for a medical condition
- Use of a correctly-functioning prosthetic or medical device
- Improvement in patient function routinely achieved following treatment of similar patients (e.g., cataract surgery & hip surgery)

Payment for Evidence-Based Care

- Payment only if evidence-based guidelines are followed for the condition the provider is managing, with deviations permitted for documented patient-specific reasons
- Outcomes are measured and used to improve evidence-based guidelines

Payment for Controllable Outcomes

- Warranty for complications (i.e., no additional payment to treat avoidable complications)
- No payment if controllable outcome is not achieved
Goal: Payments That Work for Patients, Providers, & Payers

Win for Patients:
Better Care Without Unnecessary Services

Win for Providers:
Adequate Payment for High-Value Services

Win for Payers:
Lower Spending

Avoidable Spending
Necessary Services
Services That Reduce Avoidable Spending
Variable Cost of Services
Fixed Cost of Services
Adequate Payment for Value-Based Care

Avoidable Spending

Payer Savings
Profit Margin

Accountability for Delivering Evidence-Based Services

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What Would a Comprehensive, Patient-Centered, Value-Based Care and Payment System Look Like?
Priority #1: Provide the Services Needed to Keep Patients Healthy

**Patient-Specific Needs**

**Patient-Centered Care**

Patient → Healthy → Wellness Care
#2: Support Accurate Diagnosis When New Problems Appear

Patient-Specific Needs

Patient

Healthy

New Symptom

Patient-Centered Care

Wellness Care

Diagnosis

Patient-Wellness-Care-Needs-Patient-Centered-Care-Diagnosis
#3: Provide Appropriate Care for the Patient's Condition

**Patient-Specific Needs**

- **Patient**
  - Healthy
  - New Symptom
    - Minor Acute Condition
    - Chronic Condition
    - Major Acute Condition

**Patient-Centered Care**

- **Wellness Care**
- **Diagnosis**
  - Minor Acute Care
  - Chronic Condition Care
  - Major Acute Care
Opportunities to Improve Outcomes & Reduce Spending in Each Area

Patient-Specific Needs

- Healthy
  - Wellness Care • Preventable heart attacks, strokes, cancer, & infectious disease

New Symptom

- Minor Acute Condition
  - Minor Acute Care • Use of unnecessary treatments • Use of unnecessarily expensive treatments or sites of care

- Minor Acute Condition
  - Diagnosis • Misdiagnosis or delayed diagnosis • Use of unnecessary tests

- Chronic Condition
  - Chronic Condition Care • ED visits for preventable exacerbations • Use of unnecessarily expensive treatments

- Major Acute Condition
  - Major Acute Care • Unnecessary procedures & treatments • Unnecessarily expensive treatments • Infections and complications of treatment
Separate Value-Based Payments Needed for Each Type of Care

Patient-Specific Needs

Patient
- Healthy
  - Wellness Care
  - Wellness Care Payment
    - Adequate payment
    - Accountability for quality

- New Symptom
  - Diagnosis
    - Diagnosis Payment
      - Adequate payment
      - Accountability for quality
  - Minor Acute Condition
    - Minor Acute Care
      - Minor Acute Care Payment
        - Adequate payment
        - Accountability for quality
  - Chronic Condition
    - Chronic Condition Care
      - Chronic Condition Care Payment
        - Adequate payment
        - Accountability for quality

- Major Acute Condition
  - Major Acute Care
    - Major Acute Care Payment
      - Adequate payment
      - Accountability for quality

Patient-Centered Care & Payment

• Adequate payment
• Accountability for quality
Many Services Can & Should Be Delivered by Primary Care

Patient-Specific Needs

Patient

Healthy

New Symptom

Minor Acute Condition

Chronic Condition

Major Acute Condition

Wellness Care

Diagnosis

Minor Acute Care

Chronic Condition Care

Primary Care
Specialty Care Will Be Needed for Many Patients & Conditions

Patient-Specific Needs

Patient

Healthy

New Symptom

Minor Acute Condition

Chronic Condition

Major Acute Condition

Primary Care

Wellness Care

Diagnosis

Minor Acute Care

Chronic Condition Care

Specialty Care

Specialty Diagnosis

Specialty Chronic Care

Specialty Acute Care

- Cancer diagnosis
- Neurologic symptoms
- Complex & rare chronic conditions
- Complex treatments
- Joint surgery
- Cardiac surgery
- Maternity care

Patient-Specific Needs

- Cancer diagnosis
- Neurologic symptoms
- Complex & rare chronic conditions
- Complex treatments
- Joint surgery
- Cardiac surgery
- Maternity care
We Need Primary Care Payment That Supports Good Primary Care

Patient-Specific Needs

- Healthy
- New Symptom
  - Minor Acute Condition
  - Chronic Condition
  - Major Acute Condition

Patient-Centered Care & Payment

- Primary Care
  - Wellness Care
  - Diagnosis
  - Minor Acute Care
  - Chronic Condition Care

- Primary Care Payment
  - Wellness Care Payment
  - Acute Care Payment
  - Chronic Condition Care Payment

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We Also Need to Pay Specialists Appropriately for High-Quality Care
“Global” Payments Don’t Solve the Problem of How to Pay Providers

GLOBAL PAYMENT TO ACCOUNTABLE CARE ORGANIZATION

Patient

Healthy

New Symptom

Minor Acute Condition

Chronic Condition

Major Acute Condition

Wellness Care

Diagnosis

Minor Acute Care

Chronic Condition Care

Specialty Diagnosis

Specialty Chronic Care

Specialty Acute Care
Part 1: How Should We Pay for Primary Care?

Patient-Specific Needs

- Patient
  - Healthy
  - New Symptom
    - Minor Acute Condition
    - Chronic Condition

Patient-Centered Care & Payment

- Primary Care
  - Wellness Care
  - Diagnosis
    - Minor Acute Care
    - Chronic Condition Care

- Primary Care Payment
  - Wellness Care Payment
  - Acute Care Payment
  - Chronic Condition Care Payment
"Primary Care" Isn’t One Service, It’s 3 Distinct Services

<table>
<thead>
<tr>
<th>PRIMARY CARE SERVICES</th>
<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Wellness Care</td>
</tr>
<tr>
<td></td>
<td>Acute Care</td>
</tr>
<tr>
<td></td>
<td>Chronic Condition Care</td>
</tr>
</tbody>
</table>
Each of These Services Must Be Delivered in a Different Way

<table>
<thead>
<tr>
<th>PRIMARY CARE SERVICES</th>
<th>Service</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Wellness Care</td>
<td><strong>Proactive:</strong> Prevent health problems from occurring</td>
</tr>
<tr>
<td></td>
<td>Acute Care</td>
<td><strong>Reactive:</strong> Prompt diagnosis &amp; treatment when problems occur</td>
</tr>
<tr>
<td></td>
<td>Chronic Condition Care</td>
<td><strong>Proactive + Reactive:</strong> Prevent exacerbations &amp; promptly treat exacerbations that occur</td>
</tr>
</tbody>
</table>
# A 3-Part Payment Designed for the 3 Primary Care Services

<table>
<thead>
<tr>
<th>PRIMARY CARE SERVICES</th>
<th>Service</th>
<th>Patient-Centered Payment</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Wellness Care (proactive)</td>
<td>Monthly Wellness Care Payment; higher amount for new &amp; complex patients</td>
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<tr>
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<td>Acute Care Fee for diagnosis &amp; treatment of a new acute problem</td>
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Provider Should Only Be Paid if the Patient Receives Appropriate Care

<table>
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<tr>
<th>PRIMARY CARE SERVICES</th>
<th>Service</th>
<th>Patient-Centered Standard of Quality</th>
<th>Accountability for Quality</th>
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<tbody>
<tr>
<td><strong>Wellness Care</strong> (proactive)</td>
<td>Wellness Care Payment; higher amount for new &amp; complex patients</td>
<td>• Deliver evidence-based preventive care services unless patient is unwilling or unable to receive them&lt;br&gt;• Contact patient regularly to assess status of health</td>
<td>No payment for the month for the patient unless standard of care is met for that patient</td>
</tr>
<tr>
<td><strong>Acute Care</strong> (reactive)</td>
<td>Acute Care Fee for diagnosis &amp; treatment of a new acute problem</td>
<td>• Provide prompt diagnosis and treatment when a new problem occurs&lt;br&gt;• Follow evidence-based clinical practice guidelines</td>
<td>No payment for the acute event unless the standard of care is met for that patient</td>
</tr>
<tr>
<td><strong>Chronic Condition Care</strong> (proactive + reactive)</td>
<td>Monthly Chronic Condition Care Payment; higher amount for patients with complex needs</td>
<td>• Follow evidence-based clinical practice guidelines to diagnose and manage the chronic condition&lt;br&gt;• Contact patient regularly to identify problems and address them promptly</td>
<td>No payment for the month for the patient unless standard of care is met for that patient</td>
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### Better Than Both Fee-for-Service and Capitation Payment Systems

<table>
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<tr>
<th>Service</th>
<th>Patient-Centered Payment</th>
<th>Advantages Over Both FFS and Capitation</th>
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<tr>
<td><strong>Wellness Care (proactive)</strong></td>
<td>Monthly Wellness Care Payment; higher amount for new &amp; complex patients</td>
<td>• Supports services by both PCP &amp; staff&lt;br&gt;• No loss of revenue if patient stays healthy&lt;br&gt;• Higher payment for patients with complex needs&lt;br&gt;• No payment unless wellness care is provided</td>
</tr>
<tr>
<td><strong>Acute Care (reactive)</strong></td>
<td>Acute Care Fee for diagnosis &amp; treatment of a new acute problem</td>
<td>• Flexibility to deliver care in different ways&lt;br&gt;• Supports additional time needed for multiple problems&lt;br&gt;• No extra payment for unneeded return visits&lt;br&gt;• No payment unless care is provided</td>
</tr>
<tr>
<td><strong>Chronic Condition Care (proactive + reactive)</strong></td>
<td>Monthly Chronic Condition Care Payment; higher amount for patients with complex needs</td>
<td>• Supports proactive &amp; reactive services by both physician &amp; staff&lt;br&gt;• No loss of $$ if patient avoids exacerbations&lt;br&gt;• Higher payment for complex patients&lt;br&gt;• No payment unless care is delivered</td>
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</table>

**PRIMARY CARE SERVICES**
More Details on Patient-Centered Payment for Primary Care

PatientCenteredPayment.org

Patient-Centered Payment for Primary Care

Harold D. Miller

Second Edition
July 2021

P A T I E N T-C E N T E R E D P A Y M E N T
F O R PR I M A R Y C A R E

1. The Services Delivered by Primary Care Practices

High-quality primary care is an essential component of a high-value healthcare system. However, designing a payment system that successfully supports high-quality primary care is challenging because “primary care” is not one service but several different services. Since patients have different needs and different preferences for how their needs should be addressed, each patient will need and want to receive different types and numbers of these primary care services. As a result, “high quality primary care” will mean different things to different patients.

Primary care practices deliver three basic types of services:

- Wellness Care. Primary care practices help patients stay healthy by educating them about what they should do to maintain and improve their health and by ensuring that patients have obtained appropriate preventive care services, such as vaccinations and cancer screenings.
- Chronic Condition Management. For patients who have one or more chronic diseases or long-term health problems, primary care practices not only prescribe appropriate treatments but also help patients understand how best to manage their condition(s) in a way that minimizes the number and severity of complications and slows the progression of the disease.
- Non-Emergency Acute Care. For patients who experience a new symptom or have an injury that does not require emergency care, the primary care practice can either diagnose and treat the problem or arrange for appropriate testing and treatment from other healthcare providers.

There are some fundamental differences in the ways primary care practices need to deliver the services in these categories:

- Acute care is inherently a reactive service — a patient only receives the service if they have an injury or experience a new symptom. Even if the problem is not an emergency, diagnosis and treatment should occur as soon as possible to prevent more serious problems from occurring and to minimize time away from work, school, etc.
- In contrast, wellness care and chronic condition management should be primarily proactive. I.e., the goal should be to prevent health problems and chronic disease exacerbations before they occur, and to identify new health problems and treat them in early stages, rather than only
Part 2: Paying Specialists Appropriately for High-Quality Care

Patient-Specific Needs

- Patient
  - Healthy
  - New Symptom
    - Minor Acute Condition
    - Chronic Condition
      - Major Acute Condition

Patient-Centered Care & Payment

- Specialty Care
  - Specialty Diagnosis
    - Chronic Condition Care
      - Acute Condition Care
Priority Area for Most Payers: Management of Chronic Disease
The Wrong Approach: Treating Specialists as “Avoidable” Spending

Typical value-based payment and managed care models focus solely on ways to reduce referrals to specialists or identify “low cost” specialists.
The Right Approach: Improve Value in Each Phase of Chronic Care

Patient → Healthy

New Symptom → Diagnosis of Chronic Condition

Care Planning → Initial Treatment & Management

Ongoing Treatment & Management

Symptoms Not Due to a Chronic Condition
Different Types of Avoidable Spending in Each Phase of Care

**AVOIDABLE SERVICES FOR CHRONIC CONDITION CARE**

- **Patient**
  - Healthy
  - New Symptom

**Diagnosis of Chronic Condition**
- Unnecessary tests
- Misdiagnosis

**Care Planning**
- Unnecessary treatments
- Failure to use cost-effective treatments

**Initial Treatment & Management**
- Ineffective treatment
- Avoidable complications of treatment

**Ongoing Treatment & Management**
- Avoidable exacerbations
- Unnecessary visits & tests

**Symptoms Not Due to a Chronic Condition**

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Different Services Need to Be Delivered in Each Phase of Care

VALUE-BASED CARE FOR A CHRONIC CONDITION

- Fewer Avoidable Services
- Fewer Avoidable Services
- Fewer Avoidable Services
- Fewer Avoidable Services

Patient

Healthy

New Symptom

Diagnosis of Chronic Condition

Care Planning

Initial Treatment & Management

Ongoing Treatment & Management

Symptoms Not Due to a Chronic Condition
Different Value-Based Payments Needed for Each Phase of Care

VALUE-BASED CARE FOR A CHRONIC CONDITION

Patient

Healthy

New Symptom

VALUE-BASED PAYMENT FOR CHRONIC CONDITION CARE

Symptoms Not Due to a Chronic Condition

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4 Separate Payments for 4 Distinct Phases of Chronic Care

<table>
<thead>
<tr>
<th>Specialty Chronic Condition Care</th>
<th>Patient-Centered Payment</th>
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<tbody>
<tr>
<td>Diagnosis</td>
<td>One-Time Diagnosis Payment</td>
</tr>
<tr>
<td>Care Planning</td>
<td>One-Time Care Planning Payment</td>
</tr>
<tr>
<td>Initial Treatment &amp; Management</td>
<td>One-Time or Monthly Initial Treatment and Management Payment</td>
</tr>
<tr>
<td>Ongoing Treatment &amp; Management</td>
<td>Monthly Chronic Condition Care Payment; higher amount for patients with complex needs</td>
</tr>
</tbody>
</table>
Provider Should Only Be Paid if the Patient Receives Appropriate Care

<table>
<thead>
<tr>
<th>Service</th>
<th>Patient-Centered Payment</th>
<th>Patient-Centered Standard of Quality</th>
<th>Accountability for Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis</td>
<td>One-Time Diagnosis Payment</td>
<td>• Deliver evidence-based diagnostic services</td>
<td>No payment unless standard of care is met for <em>that</em> patient</td>
</tr>
<tr>
<td>Care Planning</td>
<td>One-Time Care Planning Payment</td>
<td>• Develop an evidence-based care plan, adjusted to patient needs and preferences</td>
<td>No payment unless standard of care is met for <em>that</em> patient</td>
</tr>
<tr>
<td>Initial Treatment &amp; Management</td>
<td>One-Time or Monthly Initial Treatment and Management Payment</td>
<td>• Implement the care plan, monitor patient response, and make adjustments to maximize effectiveness &amp; avoid complications</td>
<td>No payment unless standard of care is met for <em>that</em> patient</td>
</tr>
</tbody>
</table>
| Ongoing Treatment & Management  | Monthly Chronic Condition Care Payment; higher amount for patients with complex needs | • Follow evidence-based clinical practice guidelines to manage the condition  
  • Contact patient regularly to identify/address problems | No payment for the month unless standard of care is met for *that* patient |
Many Medical Specialties Have Developed Payment Models Like This

<table>
<thead>
<tr>
<th>Condition</th>
<th>Specialists</th>
<th>Patient-Centered Value-Based Payment Models</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td>American College of Allergy, Asthma &amp; Immunology (ACAAI)</td>
<td>Patient-Centered Asthma Care Payment (PCACP)</td>
</tr>
<tr>
<td>Headache</td>
<td>American Academy of Neurology (AAN)</td>
<td>Patient-Centered Headache Care Payment (PCHCP)</td>
</tr>
<tr>
<td>Chest Pain &amp; Ischemic Heart Disease</td>
<td>American College of Cardiology (ACC)</td>
<td>SMARTCare</td>
</tr>
<tr>
<td>Cancer</td>
<td>American Society of Clinical Oncology (ASCO)</td>
<td>Patient-Centered Oncology Payment</td>
</tr>
<tr>
<td>Inflammatory Bowel Disease</td>
<td>Lawrence Kosinski, MD (Gastroenterology)</td>
<td>Project SONAR</td>
</tr>
<tr>
<td>Rheumatoid Arthritis</td>
<td>American College of Rheumatology (ACR)</td>
<td>APM for Rheumatoid Arthritis Care</td>
</tr>
</tbody>
</table>

[CHQPR.org/APMs.html]
More Details on Patient-Centered Payment for Specialty Care

PatientCenteredPayment.org

Patient-Centered Payment for Care of Chronic Conditions

Harold D. Miller
What About Hospitals?
A Lot of Avoidable Spending is Related to Hospital Services

$%

Avoidable Spending on Hospital Services

Necessary Hospital Services & Spending

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

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

CANCER TREATMENT
- Progression of disease before diagnosis
- Use of unnecessarily-expensive drugs
- ED visits/admits for complications
- Fruitless treatment at end of life

SURGERY
- Unnecessary surgery
- Use of unnecessarily-expensively implants
- Infections and complications of surgery
- Overuse of inpatient rehabilitation
Hospitals Have Large Fixed Costs to Maintain Essential Services

- **Avoidable Spending on Hospital Services**
- **Necessary Hospital Services & Spending**
- **Variable Cost of Services**
- **Fixed Cost of Delivering Services**

- **Provider Revenue**
- **Profit Margin**
Reducing Avoidable Hospital Services Saves a Lot for Payers…

- **Avoidable Spending on Hospital Services**
- **Necessary Hospital Services & Spending**
- **Provider Revenue**
  - **Fixed Cost of Delivering Services**
  - **Variable Cost of Services**
- **Profit Margin**
- **Avoidable Spending**
- **Necessary Hospital Services & Spending**
- **Payer Savings**

Reducing Avoidable Hospital Services Saves a Lot for Payers…
...But Losses for Hospitals Can Jeopardize Essential Services

WIN - LOSE

Avoidable Spending on Hospital Services

Necessary Hospital Services & Spending

Variable Cost of Services

Fixed Cost of Delivering Services

Avoidable Spending

Necessary Hospital Services & Spending

Fixed Cost of Delivering Services

Payer Savings

Profit Margin

Provider Revenue

Provider Revenue

WIN

LOSE

$
FFS Revenue is Proportional to Volume, But Costs Are Not

Provider Revenue = Fee for service

Profit Margin = Fixed Cost of Delivering Services

Variable Cost of Services

Loss = 25% Reduction in Services

25% Reduction in Revenue

15% Reduction in Cost

Variable Cost

Fixed Cost of Delivering Services
Global Budgets Don’t Produce Savings From Higher-Value Care

- **25% Reduction in Services**
- **0% Reduction in Revenue**
- **15% Reduction in Cost**

- **Global Budget**
- **Provider Revenue**
- **Fixed Cost of Delivering Services**
- **Variable Cost of Services**
- **Profit Margin**

$
A Better Way: Two Payments for Different Aspects of Hospital Care

Service-Based Fees
- For variable cost of delivering an additional service
- Paid when an insured member receives the service

Standby Capacity Payment
- For fixed cost of essential services for community
- Payment for each insured member living in community (regardless of whether the member receives services)
A Better Way: Two Payments for Different Aspects of Hospital Care

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- For fixed cost of essential services for community
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Fire departments aren't paid based on the number of fires.
Police departments aren't paid based on the number of crimes.
Why should hospitals be paid for essential services only when people are sick?
Each Payment is Designed to Support Different Types of Costs

- Service-Based Fees
- Standby Capacity Payment
- Variable Cost of Services
- Fixed Cost of Delivering Services

$ Profit Margin
Standby Capacity Payment Isn’t Affected by Changes in Volume

25% Reduction in Services

Profit Margin

Service-Based Fees

Standby Capacity Payment

Variable Cost of Services

Fixed Cost of Delivering Services

Fixed Cost of Delivering Services
Service Fee Revenue Decreases in Proportion to Variable Cost

- 25% Reduction in Services
- 15% Reduction in Revenue
- 15% Reduction in Cost

Profit Margin

Service-Based Fees
- Standby Capacity Payment
- Fixed Cost of Delivering Services
- Variable Cost of Services

Variable Cost
- Fixed Cost of Delivering Services
Hospital Margin is Preserved: Savings Matches Reduced Cost

WIN - WIN

Service-Based Fees

Standby Capacity Payment

Variable Cost of Services

Fixed Cost of Delivering Services

Service-Based Fees

Standby Capacity Payment

Variable Cost

Fixed Cost of Delivering Services
More Details on Sustainable Payments for Hospitals

RuralHospitals.org
How Do We Move to Win-Win-Win-Win Value-Based Payment?
Payment & Care Delivery Must Be Designed *Together*
By Themselves, Payers Will Design Things So *Payers* Win

**PAYER PREFERENCE:**

- Maximum reduction in total spending
- Minimum change in payment methods and administrative costs
- Shift in financial risk from payer to provider

---

Design

[Diagram showing Payer Payment Model and Care Delivery Model with arrows indicating flow between them.]

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By Themselves, Providers Will Design Things so *Providers* Win

**PAYER PREFERENCE:**
- Maximum reduction in total spending
- Minimum change in payment methods and administrative costs
- Shift in financial risk from payer to provider

**PROVIDER PREFERENCE:**
- Higher payments for existing services
- New payments for new services
- No accountability for outcomes
- No financial risk

**Design**

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*Payer Payment Model* → *Care Delivery Model* → *Provider Care Delivery Model*
Payers & Providers Must Collaborate for a Win-Win Design

Collaborative Process

- Savings based on avoidable spending
- Adequate payment for services based on number & type of conditions

• Delivery of services using most efficient, effective methods
• Accountability for controllable cost & outcomes of care

Payment Model  Care Delivery Model
Keys to Success: Facilitation, Shared Data, & Trust

Collaborative Process

- Payer
- Neutral Facilitator
- Shared Data
- Mutual Trust
- Provider

- Savings based on avoidable spending
- Adequate payment for services based on number & type of conditions

Payment Model

Care Delivery Model

- Delivery of services using most efficient, effective methods
- Accountability for controllable cost & outcomes of care
We Need a Healthcare System That Supports Economic Growth
Value-Based Care Must Be Patient-Centered Care
A Win-Win-Win Approach to Value
Is the Only Sustainable Strategy
More on Value-Based Payment for Sustainable Healthcare

PaymentReform.org

PatientCenteredPayment.org

4 Steps to Successful Value-Based Payment

1. Identify Specific Types of Pain
2. Step 1:
3. Step 2:
4. Step 3:
5. Step 4:

5 Fatal Flaws in Total Cost of Care & Population-Based Payment Models

1. What Is Needed to Move Value-Based Payment?-
2. Model of current payment based payment programs is
3. Model of current payment based payment programs is
4. Model of current payment based payment programs is
5. Model of current payment based payment programs is

Why Quality Measures Don’t Measure Quality

The Use of Quality Measures in Value-Based Payment

Why Value-Based Payment Isn’t Working, and How to Fix It

Creating a Patient-Centered Payment System to Support Higher-Quality, More Affordable Health Care

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