BETTER CARE AT LOWER COST?
Results of U.S. Initiatives and How to Create a More Patient-Centered System

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

www.CHQPR.org
U.S. Healthcare Spending is the Biggest Driver of Federal Deficits

Projected Federal Budget Spending, 2016-2027 (Billions)

- Debt Interest
- Medicare
- Medicaid
- Social Security
- Other Mandatory
- Discretionary Spending

Source: CBO

- 94% Increase ($1 Trillion)
- 85% Increase ($770 Billion)
- 25% Increase ($400 Billion)
Increasing Share of State Budgets Goes to Medicaid Spending

State Medicaid Spending as % of All State Funds in State Budgets

1/6 of All State Funds Are Now Used for Medicaid

Source: NASBO
Private Insurance Premiums Increasingly Unaffordable

Source: Medical Expenditure Panel Survey & Bureau of Labor Statistics

Growth in Family Insurance Premiums, Annual Earnings, and Inflation

- Premiums
- Worker Pay
- Inflation

Cumulative Growth in Premium
Cumulative Growth in Earnings
Cumulative Increase in Inflation

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High Cost & Low Quality Often Blamed on “Poor Coordination”

**UNCOORDINATED CARE DELIVERY**
- Siloed delivery of services
- Lack of communication between physicians
- Poor transitions from hospital to rehab to home
- Lack of electronic records

**HIGH SPENDING AND POOR OUTCOMES**
- Spending on duplicate tests
- Unnecessary visits to ED
- Unnecessary visits to specialists
- Polypharmacy
- Failure to receive preventive care
How Do You Create More Coordinated/Integrated Care?

**UNCOORDINATED CARE DELIVERY**
- Siloed delivery of services
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**COORDINATED CARE**

**LOWER SPENDING & BETTER OUTCOMES**
Approach So Far: Give Providers Financial “Incentives” to Improve

UNCOORDINATED CARE DELIVERY
- Siloed delivery of services
- Lack of communication between physicians
- Poor transitions from hospital to rehab to home
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HIGH SPENDING AND POOR OUTCOMES
- Spending on duplicate tests
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- Failure to receive preventive care

FINANCIAL “INCENTIVES”

COORDINATED CARE

LOWER SPENDING & BETTER OUTCOMES
3 Types of Financial Incentives to Improve Coordination of Care
3 Types of Financial Incentives to Improve Coordination of Care

#1: Episode Payments for Hospitalizations
3 Types of Financial Incentives to Improve Coordination of Care

#1: Episode Payments for Hospitalizations

#2: Accountable Care Organizations (ACOs)
3 Types of Financial Incentives to Improve Coordination of Care

#1: Episode Payments for Hospitalizations

#2: Accountable Care Organizations (ACOs)

#3: Primary Care Medical Homes (PCMH)
Episode Payments for Hospital Admissions: CJR

RECENT FEDERAL INITIATIVES

#1: Episode Payments for Hospitalizations

1a: Joint Replacement (CJR)

#2: Accountable Care Organizations (ACOs)

#3: Primary Care Medical Homes (PCMH)
CJR: Budget for Hip & Knee Surgery + 90 Days Post-Discharge

<table>
<thead>
<tr>
<th>CJR</th>
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<tbody>
<tr>
<td>(Comprehensive Care for Joint Replacement)</td>
</tr>
<tr>
<td>Hospitalization + All Services 90 Days After Discharge (Rehab, HH, readmits, physician svcs)</td>
</tr>
<tr>
<td>Mandatory Participation</td>
</tr>
<tr>
<td>Hospitals Only</td>
</tr>
<tr>
<td>2 Types of Episodes:</td>
</tr>
<tr>
<td>• Hip Replacement</td>
</tr>
<tr>
<td>• Knee Replacement</td>
</tr>
<tr>
<td>• Hospitals share in savings if spending is below episode price</td>
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<tr>
<td>• Hospitals at risk if spending exceeds episode price</td>
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</tbody>
</table>
$1,000 Lower Payments Per Episode in CJR

Change in Spending, Hip/Knee Replacements in CJR, 2015-2017

Gross Savings is Shared With Hospitals, Reducing Net Savings

In Percentage Terms, Net CJR Savings Has Been <1%

Change in Spending, Hip/Knee Replacements in CJR, 2015-2017

-0.7%

Where Has Savings Come From?
Less Inpatient Post-Acute Care

Change in Spending, Hip/Knee Replacements in CJR, 2015-2017

Episode Payments for Hospital Admissions: BPCI

RECENT FEDERAL INITIATIVES

#1: Episode Payments for Hospitalizations
   1a: Joint Replacement (CJR)
   1b: Other Hospitalizations (BPCI)

#2: Accountable Care Organizations (ACOs)

#3: Primary Care Medical Homes (PCMH)
## BPCI: 48 Types of Episodes

<table>
<thead>
<tr>
<th>CJR (Comprehensive Care for Joint Replacement)</th>
<th>BPCI (Bundled Payments for Care Improvement)</th>
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<td>Hospitalization + All Services 90 Days After Discharge (Rehab, HH, readmits, physician svcs)</td>
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<td>Mandatory Participation</td>
<td>Voluntary Participation</td>
</tr>
<tr>
<td>Hospitals Only</td>
<td>Hospitals Physician Groups Post-Acute Care Providers</td>
</tr>
</tbody>
</table>
| 2 Types of Episodes:  
  - Hip Replacement  
  - Knee Replacement | 48 Types of Episodes  
  - Hip Replacement  
  - Knee Replacement  
  - Other Inpatient Surgical Procedures  
  - Medical Admissions |
|  • Hospitals share in savings if spending is below episode price  
  • Hospitals at risk if spending exceeds episode price |  • Providers share in savings if spending is below episode budget  
  • No penalty if spending exceeds episode budget |
Gross Savings Achieved in BPCI for Most Types of Episodes

Source:
Lewin Group, CMS BPCI Models 2-4: Year 5 Evaluation and Monitoring Annual Report, October 2018

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Most of the Savings Came From Less Inpatient Post-Acute Rehab

Source:
Lewin Group,
CMS BPCI Models 2-4: Year 5 Evaluation and Monitoring Annual Report, October 2018
Most of the Savings Came From Less Inpatient Post-Acute Rehab

Source: Lewin Group, CMS BPCI Models 2-4: Year 5 Evaluation and Monitoring Annual Report, October 2018
BPCI Achieved Gross Savings…

Gross Change in Spending, All Episodes, BPCI Demonstration, 2013-2016

Source: Lewin Group, CMS BPCI Models 2-4: Year 5 Evaluation and Monitoring Annual Report, October 2018
But Providers Shared in Savings, So Net Spending *Increased* by 1%

**Source:**
Lewin Group, CMS BPCI Models 2-4: Year 5 Evaluation and Monitoring Annual Report, October 2018
Small Net Savings (<1%) If Providers Had Had Downside Risk

Source: Lewin Group, CMS BPCI Models 2-4: Year 5 Evaluation and Monitoring Annual Report, October 2018
Small Savings Is Not Surprising: The Opportunity is Relatively Small

SAVINGS OPPORTUNITIES IN HOSPITAL EPISODE PAYMENTS

• Reduce use of inpatient post-acute rehabilitation
• Reduce hospital readmissions due to complications
No New/Different Payments for Redesign of Post-Acute Care

SAVINGS OPPORTUNITIES IN HOSPITAL EPISODE PAYMENTS

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

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

SAVINGS OPPORTUNITIES IN HOSPITAL EPISODE PAYMENTS

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

In BPCI/CJR, the trigger is the inpatient surgery or hospital admission, so if outpatient surgery is used, or if the hospital admission can be avoided altogether, there is no “savings” credited to the program and many providers lose revenue.
Potential Reward for Avoiding Higher-Risk Patients

SAVINGS OPPORTUNITIES IN HOSPITAL EPISODE PAYMENTS

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

In BPCI/CJR, there is only limited risk-adjustment, so avoiding patients who would need significant post-acute care or be at high risk of readmissions would result in “savings” and associated bonus payments.
Accountable Care Organizations: Savings on Total Cost of Care

RECENT FEDERAL INITIATIVES

#1: Episode Payments for Hospitalizations
   1a: Joint Replacement (CJR)
   1b: Other Hospitalizations (BPCI)

#2: Accountable Care Organizations (ACOs)
   2a: Shared Savings (MSSP)
   2b: Downside Risk (MSSP & Other)

#3: Primary Care Medical Homes (PCMH)
# ACOs: Shared Savings/Risk for Total Spending on Patients

**MSSP**  
(Medicare Shared Savings Program)

<table>
<thead>
<tr>
<th>Voluntary Participation</th>
<th>Payments for all inpatient, outpatient, and physician services during a year to patients who are attributed to the ACO based on frequency of office visits to primary care physicians who are part of the ACO</th>
<th>No change in current fee-for-service payments for physicians, hospitals, post-acute care providers, or others</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Primary Care Practices • Hospitals employing PCPs</td>
<td></td>
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</tr>
</tbody>
</table>

- **Track 1 ACOs** ("Upside only"): ACO shares in savings if spending is below benchmark spending level
- **Tracks 2&3** ("Downside risk"): ACO repays Medicare if spending exceeds benchmark spending level
On Average, Small Gross Savings From ACOs Every Year

% Change in Medicare Spending in All MSSP ACOs, 2013-2017

Source: Centers for Medicare and Medicaid Services ACO Public Use Files
But ACOs Share in Savings, So Net Spending Has *Increased*

Source: Centers for Medicare and Medicaid Services ACO Public Use Files
ACOs Vary Widely In Performance

Source: Centers for Medicare and Medicaid Services ACO Public Use Files
Upside-Only ACOs Did Better Than Downside Risk ACOs in 2017

% Change in Spending Net of Shared Savings Bonuses/Penalties 2017

- Higher Spend
- Lower Spend

Upside Risk ACOs: 0.34% Savings
Downside Risk ACOs: 0.24% Savings

433 Track 1 ACOs
39 Downside Risk ACOs

Source: Centers for Medicare and Medicaid Services ACO Public Use Files
Net Savings Overall Was Low From All Types of ACOs

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

Net Change in Spending Per Beneficiary 2017

Higher Spend

Lower Spend

Upside Risk ACOs: $37 per beneficiary per year

Downside Risk ACOs: $27 per beneficiary per year

433 Track 1 ACOs

39 Downside Risk ACOs
Why Isn’t Coordinated Care By ACOs Reducing Spending?
Answer: No Change in the Way Physicians or Hospitals Are Paid

Fee-for-Service Payment

PATIENTS
- Heart Disease
- Cancer
- Back Pain
- Pregnancy

MEDICARE

ACO

Primary Care, Cardiology, Oncology, Neurosurgery, OB/GYN
Providers Still Face All the Barriers in the Current Payment System…

MEDICARE

ACO

Fee-for-Service Payment

• No payment for high-value services
• Inadequate revenues to cover costs when fewer services are delivered

PATIENTS

Heart Disease
Cancer
Back Pain
Pregnancy

Primary Care
Cardiology
Oncology
Neurosurgery
OB/GYN
...With Only the *Possibility* of Receiving Future “Shared Savings”

**MEDICARE**

**ACO**

**Fee-for-Service Payment**

- No payment for high-value services
- Inadequate revenues to cover costs when fewer services are delivered

**PATIENTS**

- Heart Disease
- Cancer
- Back Pain
- Pregnancy

**Primary Care**
- Cardiology
- Oncology
- Neurosurgery
- OB/GYN
ACOs Try to “Coordinate Care” Without Fixing Payment Barriers

MEDICARE

Shared Savings Payment Next Year???

ACO

Expensive IT Systems
Care Coordinators

Fee-for-Service Payment

• No payment for high-value services
• Inadequate revenues to cover costs when fewer services are delivered

PATIENTS
Heart Disease
Cancer
Back Pain
Pregnancy

Primary Care
Cardiology
Oncology
Neurosurgery
OB/GYN

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Possibility of Future Bonuses Doesn’t Overcome Current Barriers

- Expensive IT Systems
- Care Coordinators
  - Part of Shared Savings??
- No payment for high-value services
- Inadequate revenues to cover costs when fewer services are delivered

PATIENTS
- Heart Disease
- Cancer
- Back Pain
- Pregnancy

Fee-for-Service Payment

ACO

Primary Care
Cardiology
Oncology
Neurosurgery
OB/GYN

MEDICARE

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More Financial “Risk” Could Cause Undertreatment of Patients

- Heart Disease
- Cancer
- Kidney Disease
- Pregnancy

Primary Care

- Cardiology
- Oncology
- Nephrology
- OB/GYN

Fee-for-Service Payment

Medicare

Downside Risk

Expensive IT Systems

Care Coordinators

• No payment for high-value services
• Inadequate revenues to cover costs when fewer services are delivered
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
- Access and quality of care for many other conditions
Rural Areas Aren’t Big Enough to Form ACOs or Take Risk

Minimum of 5,000 Medicare FFS Beneficiaries Needed to Form an ACO

Number of Counties by Number of Medicare FFS Beneficiaries, 2015
Primary Care Initiatives Have Provided Additional Payments

RECENT FEDERAL INITIATIVES

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#2: Accountable Care Organizations (ACOs)

2a: Shared Savings (MSSP)
2b: Downside Risk ACOs

#3: Primary Care Medical Homes (PCMH)

Comprehensive Primary Care (CPCI)
Comprehensive Primary Care: New Payments for Care Mgt

<table>
<thead>
<tr>
<th>CPCI (Comprehensive Primary Care Initiative)</th>
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<tbody>
<tr>
<td><strong>Voluntary Participation</strong></td>
</tr>
<tr>
<td>• First, private health plans must agree to participate</td>
</tr>
<tr>
<td>• Primary Care Practices can then apply</td>
</tr>
<tr>
<td><strong>Risk-adjusted monthly Care Management Payment</strong> for each patient in addition to fee-for-service payments for visits and procedures</td>
</tr>
<tr>
<td>• $8-$40 pmpm (avg $20) in years 1-2</td>
</tr>
<tr>
<td>• $6-$30 pmpm (avg $15) in years 3-4</td>
</tr>
<tr>
<td><strong>Opportunity to receive share of savings if total spending decreased for patients of all participating practices in the state/region</strong></td>
</tr>
</tbody>
</table>
Gross Savings Achieved by Primary Care Practices

Source:
Mathematica Policy Research, Evaluation of the Comprehensive Primary Care Initiative, May 2018
But Savings Not Sufficient to Offset Additional Payments

Source: Mathematica Policy Research, Evaluation of the Comprehensive Primary Care Initiative, May 2018
Total Spending on Patients *Increased* by 0.7%

% Change in Spending, Years 1-4, Comprehensive Primary Care Initiative

- Gross Change in Spending
- Care Management Fees
- Net Change in Spending

Higher Spend
Lower Spend

Source: Mathematica Policy Research, Evaluation of the Comprehensive Primary Care Initiative, May 2018
Net Cost of the Program Rose As PCP Payments Decreased

Change in Spending by Year, CPCI

Source: Mathematica Policy Research, Evaluation of the Comprehensive Primary Care Initiative, May 2018
Net Spending Increased Even More for High-Risk Patients

Source: Mathematica Policy Research, Evaluation of the Comprehensive Primary Care Initiative, May 2018
Why Didn’t Payments For Primary Care Providers Reduce Spending?

MEDICARE & HEALTH PLANS

Primary Care Payment

Primary Care
Most Short-Run Spending is Controlled by Specialists, Not PCPs

PATIENTS
- Heart Disease
- Cancer
- Back Pain
- Pregnancy

Primary Care Payment

MEDICARE & HEALTH PLANS

Primary Care

Cardiology
Oncology
Neurosurgery
OB/GYN
Specialists Are All Still Paid the Same Way

MEDICARE & HEALTH PLANS

Primary Care Payment

PATIENTS
- Heart Disease
- Cancer
- Back Pain
- Pregnancy

Primary Care
- Cardiology
- Oncology
- Neurosurgery
- OB/GYN

Standard Fee-for-Service Payment
Even the Primary Care Physician’s Pay Is Still Primarily FFS
Little or No Savings From Major Alternative Payment Models

RECENT FEDERAL INITIATIVES

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   2a: Shared Savings (MSSP)
   2b: Downside Risk ACOs

#3: Primary Care Medical Homes (PCMH)
   Comprehensive Primary Care (CPCI)
Current Federal Plans: More of the Same

RECENT FEDERAL INITIATIVES

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   Comprehensive Primary Care (CPCI)

CURRENT/PLANNED INITIATIVES

Mandatory Hospital Risk for Other Surgical Episodes
Current Federal Plans: More of the Same

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#3: Primary Care Medical Homes (PCMH)

Comprehensive Primary Care (CPCI)

CURRENT/PLANNED INITIATIVES

Mandatory Hospital Risk for Other Surgical Episodes
Voluntary Episode Payments for Hospital Admissions & Procedures (BPCI Advanced)
Current Federal Plans: More of the Same

**RECENT FEDERAL INITIATIVES**

1: Episode Payments for Hospitalizations
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3: Primary Care Medical Homes (PCMH)
   - Comprehensive Primary Care (CPCI)

**CURRENT/PLANNED INITIATIVES**

- Mandatory Hospital Risk for Other Surgical Episodes
- Voluntary Episode Payments for Hospital Admissions & Procedures (BPCI Advanced)
- Downside Risk ACOs
Current Federal Plans:
More of the Same

RECENT FEDERAL INITIATIVES

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- Comprehensive Primary Care (CPCI)

CURRENT/PLANNED INITIATIVES

- Mandatory Hospital Risk for Other Surgical Episodes
- Voluntary Episode Payments for Hospital Admissions & Procedures (BPCI Advanced)
- Downside Risk ACOs
- Hospital/State Global Budget
Longest ED Wait Times in Only State With Global Budgets
Current Federal Plans: More of the Same

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   - Comprehensive Primary Care (CPCI)

CURRENT/PLANNED INITIATIVES

- Mandatory Hospital Risk for Other Surgical Episodes
- Voluntary Episode Payments for Hospital Admissions & Procedures (BPCI Advanced)
- Downside Risk ACOs
- Hospital/State Global Budget
- Primary Care Capitation + Care Management Fees + Utilization Accountability (CPC+)
What Hasn’t Been Pursued: Condition-Based Payments

**Condition-Based Payments**

### RECENT FEDERAL INITIATIVES

1. **Episode Payments for Hospitalizations**
   - 1a: Joint Replacement (CJR)
   - 1b: Other Hospitalizations (BPCI)

2. **Accountable Care Organizations (ACOs)**
   - 2a: Shared Savings (MSSP)
   - 2b: Downside Risk ACOs

3. **Primary Care Medical Homes (PCMH)**
   - Comprehensive Primary Care (CPCI)

### CURRENT/PLANNED INITIATIVES

- Mandatory Hospital Risk for Other Surgical Episodes
- Voluntary Episode Payments for Hospital Admissions & Procedures (BPCI Advanced)
- Downside Risk ACOs
- Hospital/State Global Budget
- Primary Care Capitation + Care Management Fees + Utilization Accountability (CPC+)

**RECENT FEDERAL INITIATIVES**

**CURRENT/PLANNED INITIATIVES**
What’s a “Condition-Based Payment?”
Episode Payments Require the Patient to Be Hospitalized

SAVINGS OPPORTUNITIES IN HOSPITAL EPISODE PAYMENTS

- Reduce use of inpatient post-acute rehabilitation
- Reduce hospital readmissions due to complications
In a Condition-Based Payment Model, the trigger is the patient's condition, so if a different procedure is used, or a hospitalization is avoided, the provider is rewarded through the Condition-Based Payment.
Condition-Based Payment Has More Benefits Than Episodes

BENEFITS OF CONDITION-BASED PAYMENTS

- Reward for avoiding complications
- Reward for avoiding expensive post-acute care
- Ability to pay for new/different services
- Reward for using lower-cost treatments & facilities
- Reward for avoiding unnecessary procedures

Condition-Based Payment

High Spending on Complications & Post-Acute Care

Low Complication & PAC Spending

New Types of In-Home Rehab and Post-Discharge Services to Address Health Problems

PCP + Condition Specialist

Inpatient Hospital Care

Outpatient Hospital Procedure

Alternative Procedure or Medical Management

Alternative Procedure or Medical Management
Value-Based Payment Is Being Designed the *Wrong* Way Today
Value-Based Payment Is Being Designed the *Wrong* Way Today

**TOP-DOWN PAYMENT REFORM**

Payers Define Payment Systems
Value-Based Payment Is Being Designed the \textit{Wrong} Way Today

\textbf{TOP-DOWN PAYMENT REFORM}

Payers Define Payment Systems

Physicians and Hospitals Have To Change Care to Align With Payment Systems
Value-Based Payment Is Being Designed the *Wrong* Way Today

**TOP-DOWN PAYMENT REFORM**

- Payers Define Payment Systems
- Physicians and Hospitals Have To Change Care to Align With Payment Systems
- Patients Get Worse Care and Providers Close/Consolidate

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Is There a Better Way?

TOP-DOWN PAYMENT REFORM

Payers Define Payment Systems

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

Patients Get Worse Care and Providers Close/Consolidate

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Start By Identifying Ways to Improve Care & Reduce Costs…

TOP-DOWN PAYMENT REFORM

- Payers Define Payment Systems
- Physicians and Hospitals Have To Change Care to Align With Payment Systems
- Patients Get Worse Care and Providers Close/Consolidate

BOTTOM-UP PAYMENT REFORM

- Physicians and Hospitals Identify Ways to Improve Care for Patients and Eliminate Avoidable Costs
…Pay Adequately & Expect Accountability for Outcomes…

**TOP-DOWN PAYMENT REFORM**

- Payers Define Payment Systems
- Physicians and Hospitals Have To Change Care to Align With Payment Systems
- Patients Get Worse Care and Providers Close/Consolidate

**BOTTOM-UP PAYMENT REFORM**

- Payers Provide Adequate Payment for Quality Care & Providers Take Accountability for Quality & Efficiency
- Physicians and Hospitals Identify Ways to Improve Care for Patients and Eliminate Avoidable Costs

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...So the Result is Better, More Affordable Patient Care

TOP-DOWN PAYMENT REFORM

Payers Define Payment Systems

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

Patients Get Worse Care and Providers Close/Consolidate

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

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

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Top Down is the Default Unless Hospitals/Physicians Take Charge

TOP-DOWN PAYMENT REFORM

Payers Define Payment Systems

BOTTOM-UP PAYMENT REFORM

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

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

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
### Better Care at Lower Cost for Crohn’s Disease

**Physician Leader:** Lawrence R. Kosinski, MD  
Managing Partner, Illinois Gastroenterology Group

<table>
<thead>
<tr>
<th>Opportunities to Improve Care and Lower Costs</th>
<th>Barriers in the Current Payment System</th>
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• 3.5% of spending goes to gastroenterologists | • No payment to support “medical home” services in gastroenterology practice:  
➢ No payment for nurse care manager  
➢ No payment for clinical decision support tools to ensure evidence-based care  
➢ No payment for proactive telephone contact with patients |
**Better Care at Lower Cost for Crohn’s Disease**

**OPPORTUNITIES TO IMPROVE CARE AND LOWER COSTS**

- Health plan spends $11,000/year/patient on patients with Crohn’s
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- <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

**BARRIERS IN THE CURRENT PAYMENT SYSTEM**

- No payment to support “medical home” services in gastroenterology practice:
  - No payment for nurse care manager
  - No payment for clinical decision support tools to ensure evidence-based care
  - No payment for proactive telephone contact with patients

**RESULTS WITH ADEQUATE PAYMENT FOR BETTER CARE**

- Hospitalization rate cut by more than 50%
- Total spending reduced by 10% even with higher payments to the physician practice
- Improved patient satisfaction due to fewer complications and lower out-of-pocket costs

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

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Better Care at Lower Cost for Cancer

PHYSICIAN LEADER: Barbara McAneny, MD
CEO, New Mexico Cancer Center
Better Care at Lower Cost for Cancer

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OPPORTUNITIES TO IMPROVE CARE AND LOWER COSTS

• 40-50% of patients receiving chemotherapy are hospitalized for complications of treatment
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**PHYSICIAN LEADER:** Barbara McAneny, MD  
CEO, New Mexico Cancer Center

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• 43% fewer admissions  
• 22% reduction in total cost of care ($4,784 over six months) |

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- No payment for triage services to enable rapid response to patient complications.
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- 36% fewer ED visits.
- 43% fewer admissions.
- 22% reduction in total cost of care ($4,784 over six months).
Instead of Treating Everyone Alike and Hoping for the Best...

ACO BLACK BOX

- Healthy Patients
- Patients with a Health Need
- Patients with Multiple Health Problems

Global Budget
Create a Patient-Centered Delivery & Payment System
Create a Patient-Centered Delivery & Payment System

Healthy Patients → Primary Care from a Medical Home → Accountable Medical Home Payment
Create a Patient-Centered Delivery & Payment System

- **HEALTHY PATIENTS**
  - Primary Care from a Medical Home
  - Accountable Medical Home Payment

- **PATIENTS WITH A HEALTH NEED**
  - PCP
    - Specialist
  - Condition-Based Payment
Create a Patient-Centered Delivery & Payment System

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  - Primary Care from a Medical Home
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  - PCP
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- **PATIENTS WITH MULTIPLE HEALTH PROBLEMS**
  - Accountable Care Team
    - PCP
    - Specialist
    - Specialist
  - Multi-Condition Payment or Risk-Adjusted Global Payment
Learn More About Win-Win-Win Payment and Delivery Reform

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