VALUE-BASED PAYMENT 3.0

How to Create a *Patient-Centered* Payment System

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

www.CHQPR.org

Value-Based Payment 1.0
Paying for Quality

2000 **2010** **2021**

VALUE-BASED PAYMENT 1.0
Pay for Performance
Quality Measures +
Bonuses/Penalties

Value-Based Payment 1.0 Has Failed to Achieve Goals

2000 **2010** **2021**

VALUE-BASED PAYMENT 1.0
Pay for Performance
Quality Measures +
Bonuses/Penalties

FAILURE:
- *Little Improvement in Quality*
- *Huge Administrative Burden*
- *Increase in Disparities*

Value-Based Payment 2.0
Alternative Payment Models

2000 **2010** **2021**

VALUE-BASED PAYMENT 1.0
Pay for Performance
Quality Measures +
Bonuses/Penalties

FAILURE:
- *Little Improvement in Quality*
- *Huge Administrative Burden*
- *Increase in Disparities*

VALUE-BASED PAYMENT 2.0
Alternative Payment Models
Quality Measures +
Risk-Based Payment

Value-Based Payment 2.0 Has Failed to Achieve Goals

2000 **2010** **2021**

VALUE-BASED PAYMENT 1.0
Pay for Performance
Quality Measures +
Bonuses/Penalties

FAILURE:
- *Little Improvement in Quality*
- *Huge Administrative Burden*
- *Increase in Disparities*

VALUE-BASED PAYMENT 2.0
Alternative Payment Models
Quality Measures +
Risk-Based Payment

FAILURE:
- *Little Savings*
- *Provider Consolidation*
- *Increase in Disparities*

What Should Be the Future of Value-Based Payment?

2000 — 2010 — 2021

VALUE-BASED PAYMENT 1.0
Pay for Performance
Quality Measures +
Bonuses/Penalties

FAILURE:
- *Little Improvement in Quality*
- *Huge Administrative Burden*
- *Increase in Disparities*

VALUE-BASED PAYMENT 2.0
Alternative Payment Models
Quality Measures +
Risk-Based Payment

FAILURE:
- *Little Savings*
- *Provider Consolidation*
- *Increase in Disparities*

VALUE-BASED PMT 3.0

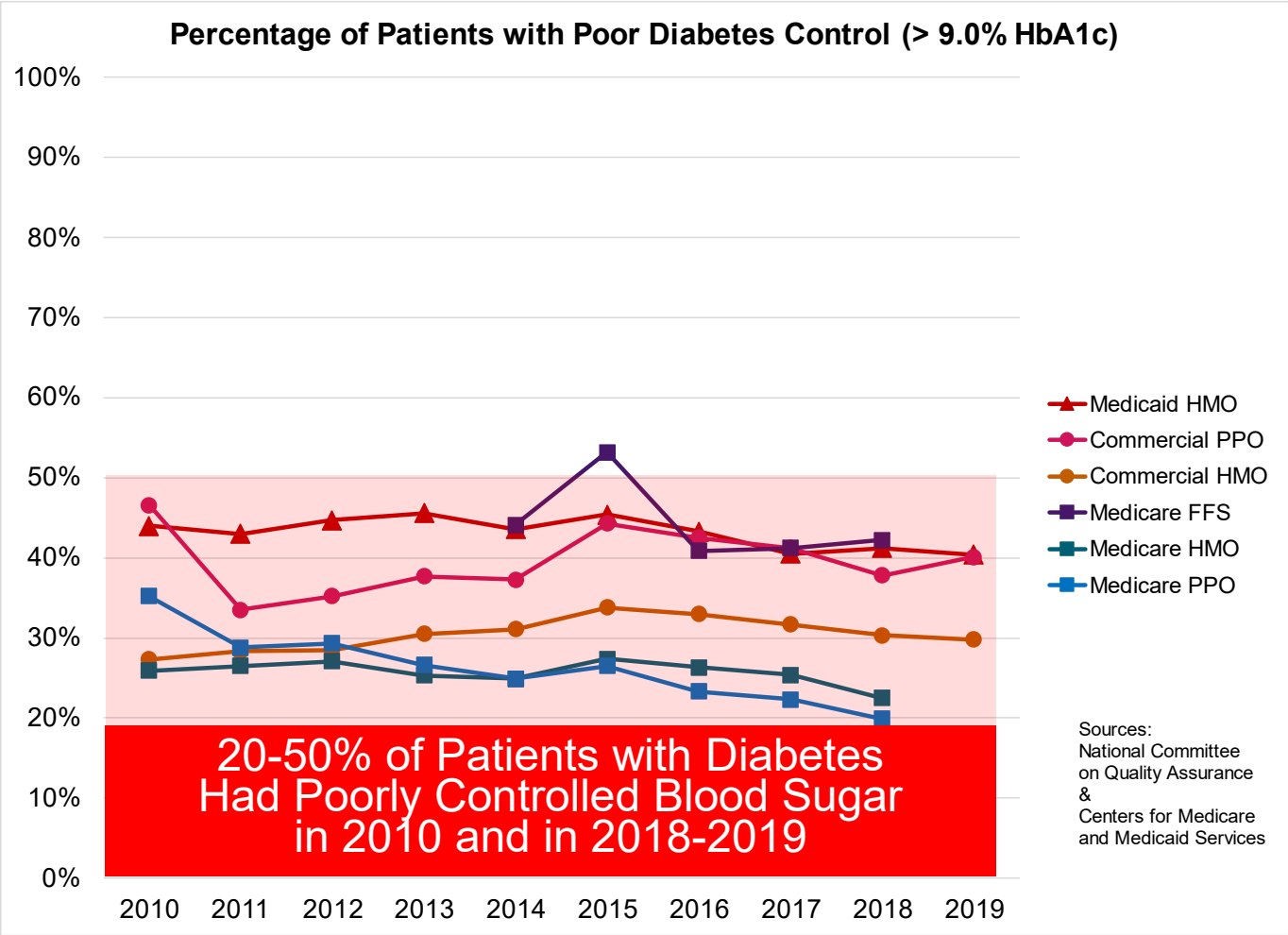
?

Why Basing Payment on Quality Measures Doesn’t Improve Quality

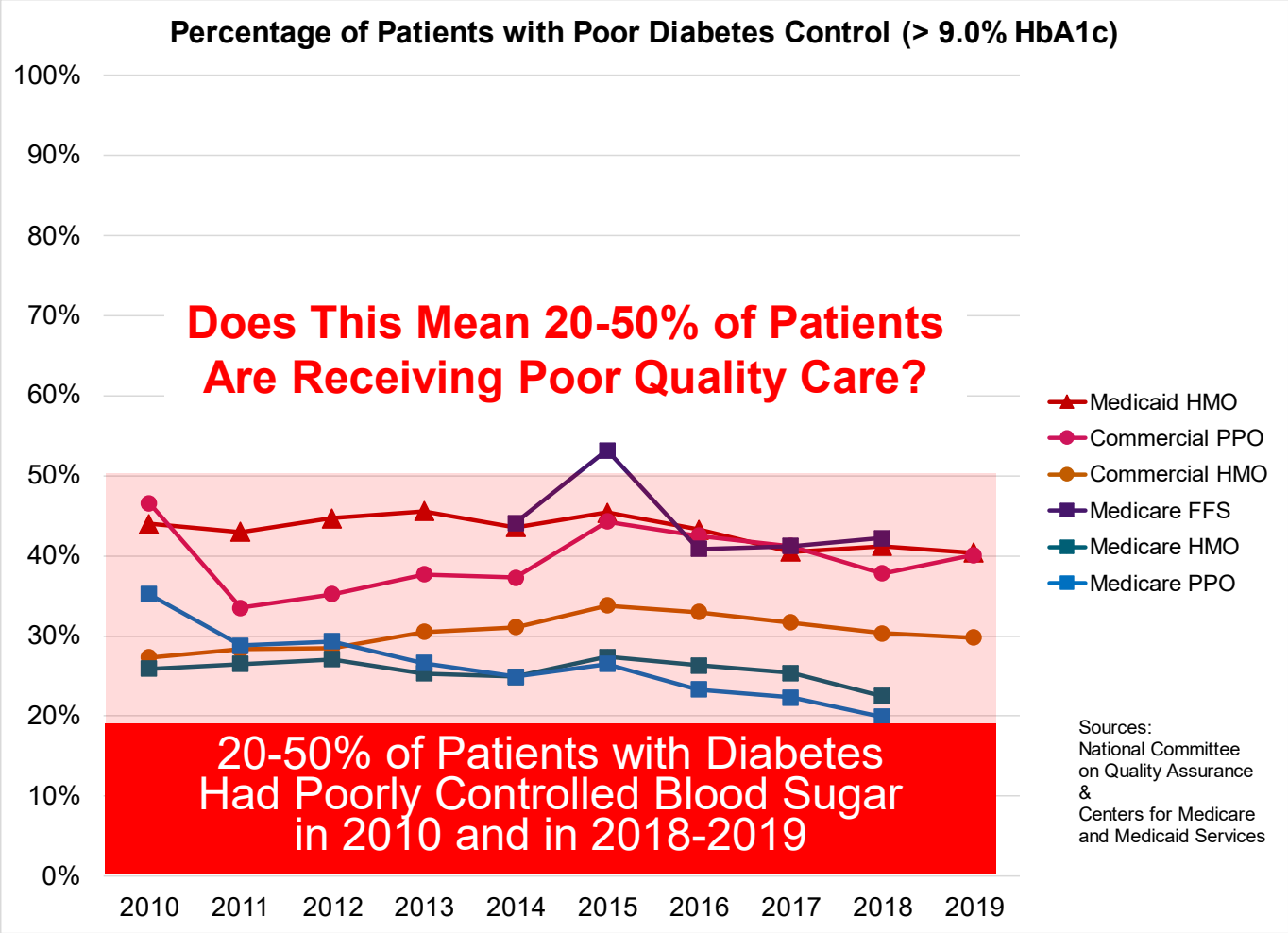
Why Basing Payment on Quality Measures Doesn’t Improve Quality

EXAMPLE
The most commonly used quality measure:
Poor Diabetes Control
(% patients with HbA1c > 9.0%)

Little Improvement in Quality After a Decade of P4P



Little Improvement in Quality After a Decade of P4P



Evaluating the Quality of Care for 3 Hypothetical Patients

Standard Diabetes Quality Measure: % of Diabetic Patients with HbA1c > 9%				Quality of Care:
HbA1c at Start of Year	→	Care Delivered During Year	→	HbA1c at End of Year	

Patient #1 Receives Appropriate Care and Improves Significantly

Standard Diabetes Quality Measure: % of Diabetic Patients with HbA1c > 9%			Quality of Care:
HbA1c at Start of Year	**Care Delivered During Year**	**HbA1c at End of Year**	**According to the Measure:**
13%	Patient receives all appropriate evidence-based care	10%	

Diabetes Quality Measure Ignores the Patient's Improvement

Standard Diabetes Quality Measure:
% of Diabetic Patients with HbA1c > 9%

HbA1c at Start of Year	Care Delivered During Year	HbA1c at End of Year	Quality of Care: According to the Measure:
13%	Patient receives all appropriate evidence-based care	10%	Poor quality

In Reality, The Patient May Have Improved As Much As Possible

Standard Diabetes Quality Measure: % of Diabetic Patients with HbA1c > 9%			Quality of Care:	
HbA1c at Start of Year	Care Delivered During Year	HbA1c at End of Year	According to the Measure:	In Reality:
13%	Patient receives all appropriate evidence-based care	10%	Poor quality	Good quality

Patient #2 Receives Poor Care and HbA1c Worsens

Standard Diabetes Quality Measure: % of Diabetic Patients with HbA1c > 9%			Quality of Care:	
HbA1c at Start of Year	**Care Delivered During Year**	**HbA1c at End of Year**	**According to the Measure:**	**In Reality:**
13%	Patient receives all appropriate evidence-based care	10%	Poor quality	Good quality
7%	Patient does not receive evidence-based care	8%		

Diabetes Quality Measure Ignores the Patient's Deterioration

Standard Diabetes Quality Measure:
% of Diabetic Patients with HbA1c > 9%

HbA1c at Start of Year	Care Delivered During Year	HbA1c at End of Year	Quality of Care: According to the Measure:	Quality of Care: In Reality:
13%	Patient receives all appropriate evidence-based care	10%	Poor quality	Good quality
7%	Patient does not receive evidence-based care	8%	Good quality	

In Reality, The Patient Should Have Received Much Better Care

Standard Diabetes Quality Measure: % of Diabetic Patients with HbA1c > 9%			Quality of Care:	
HbA1c at Start of Year	Care Delivered During Year	HbA1c at End of Year	According to the Measure:	In Reality:
13%	Patient receives all appropriate evidence-based care	10%	Poor quality	Good quality
7%	Patient does not receive evidence-based care	8%	Good quality	Poor quality

Patient #3 Can't Afford Diabetes Medications

Standard Diabetes Quality Measure: % of Diabetic Patients with HbA1c > 9%			Quality of Care:	
HbA1c at Start of Year	Care Delivered During Year	HbA1c at End of Year	According to the Measure:	In Reality:
13%	Patient receives all appropriate evidence-based care	10%	Poor quality	Good quality
7%	Patient does not receive evidence-based care	8%	Good quality	Poor quality
10%	Patient **cannot afford to take medications** needed for diabetes but primary care practice **helps patient avoid getting worse**	10%		

Diabetes Quality Measure Ignores What Is Feasible

Standard Diabetes Quality Measure:
% of Diabetic Patients with HbA1c > 9%

HbA1c at Start of Year	Care Delivered During Year	HbA1c at End of Year	Quality of Care: According to the Measure:	Quality of Care: In Reality:
13%	Patient receives all appropriate evidence-based care	10%	Poor quality	Good quality
7%	Patient does not receive evidence-based care	8%	Good quality	Poor quality
10%	Patient **cannot afford to take medications** needed for diabetes but primary care practice **helps patient avoid getting worse**	10%	Poor quality	

In Reality, The Patient Likely Received the Best Care Possible

Standard Diabetes Quality Measure: % of Diabetic Patients with HbA1c > 9%			Quality of Care:	
HbA1c at Start of Year	Care Delivered During Year	HbA1c at End of Year	According to the Measure:	In Reality:
13%	Patient receives all appropriate evidence-based care	10%	Poor quality	Good quality
7%	Patient does not receive evidence-based care	8%	Good quality	Poor quality
10%	Patient **cannot afford to take medications** needed for diabetes but primary care practice **helps patient avoid getting worse**	10%	Poor quality	Acceptable quality

What Happens if You Pay Physicians Based on Their Performance on the HbA1c Quality Measure?

Assume 10 New Diabetic Patients Enroll in a Primary Care Practice

10 Diabetic Patients:

Patient	Year 1 HbA1c
#1	6.5
#2	7.0
#3	7.5
#4	8.0
#5	8.5
#6	9.0
#7	9.5
#8	10.0
#9	10.5
#10	11.0

% > 9	40%

Physician A Improves HbA1c for All of the Diabetic Patients

10 Diabetic Patients:		Physician A	
Patient	Year 1 HbA1c	Year 2 HbA1c	Change
#1	6.5	6.5	0
#2	7.0	6.5	-0.5
#3	7.5	7.0	-0.5
#4	8.0	7.5	-0.5
#5	8.5	8.0	-0.5
#6	9.0	8.5	-0.5
#7	9.5	9.0	-0.5
#8	10.0	9.5	-0.5
#9	10.5	10.0	-0.5
#10	11.0	10.5	-0.5
% > 9	40%	30%	-10%

All patients have improved diabetes control

Quality measure improves

Physician B Helps 2 Patients, Ignores the Others

10 Diabetic Patients:		Physician A		Physician B	
Patient	Year 1 HbA1c	Year 2 HbA1c	Change	Year 2 HbA1c	Change
#1	6.5	6.5	0	7.5	+1.0
#2	7.0	6.5	-0.5	8.0	+1.0
#3	7.5	7.0	-0.5	8.5	+1.0
#4	8.0	7.5	-0.5	9.0	+1.0
#5	8.5	8.0	-0.5	9.0	+0.5
#6	9.0	8.5	-0.5	9.0	0.0
#7	9.5	9.0	-0.5	9.0	-0.5
#8	10.0	9.5	-0.5	9.0	-1.0
#9	10.5	10.0	-0.5	10.5	0.0
#10	11.0	10.5	-0.5	Dropped	XXX
% > 9	40%	30%	-10%	11%	-29%

5 patients have worse control of diabetes

2 patients improve control

1 patient leaves care

Quality measure improves even more

Which Physician is Delivering Higher-Quality Care??

		Physician A		Physician B	
Patient	Year 1 HbA1c	Year 2 HbA1c	Change	Year 2 HbA1c	Change
#1	6.5	6.5	0	7.5	+1.0
#2	7.0	6.5	-0.5	8.0	+1.0
#3	7.5	7.0	-0.5	8.5	+1.0
#4	8.0	7.5	-0.5	9.0	+1.0
#5	8.5	8.0	-0.5	9.0	+0.5
#6	9.0	8.5	-0.5	9.0	0.0
#7	9.5	9.0	-0.5	9.0	-0.5
#8	10.0	9.5	-0.5	9.0	-1.0
#9	10.5	10.0	-0.5	10.5	0.0
#10	11.0	10.5	-0.5	Dropped	XXX
% > 9	40%	30%	-10%	11%	-29%
% Improved		90%		20%	
% Worsened		0%		50%	
% Dropped		0%		10%	

The quality measure says Physician B is better even though most patients got worse

Under P4P, B Could Get a Bonus While A Might Be Penalized

10 Diabetic Patients:		Physician A		Physician B	
Patient	Year 1 HbA1c	Year 2 HbA1c	Change	Year 2 HbA1c	Change
#1	6.5	6.5	0	7.5	+1.0
#2	7.0	6.5	-0.5	8.0	+1.0
#3	7.5	7.0	-0.5	8.5	+1.0
#4	8.0	7.5	-0.5	9.0	+1.0
#5	8.5	8.0	-0.5	9.0	+0.5
#6	9.0	8.5	-0.5	9.0	0.0
#7	9.5	9.0	-0.5	9.0	-0.5
#8	10.0	9.5	-0.5	9.0	-1.0
#9	10.5	10.0	-0.5	10.5	0.0
#10	11.0	10.5	-0.5	Dropped	XXX
% > 9	40%	30%	-10%	11%	-29%

P4P (e.g. MIPS) **No Bonus or Penalty** **P4P Bonus**

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

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

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.

Backgrou
grams are

Purpose:
effects of P
gerial, or i
comes in a

Data Sou
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 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.

But Like a Zombie, P4P Refuses to Die

VALUE-BASED PAYMENT 1.0
Pay for Performance
Quality Measures +
Bonuses/Penalties

→

VALUE-BASED PAYMENT 2.0
Alternative Payment Models
Quality Measures +
Risk-Based Payment

Value-Based Payment 2.0 Focuses on *Spending*, Not *Quality*

VALUE-BASED PAYMENT 1.0
Pay for Performance
Quality Measures +
Bonuses/Penalties

Incentives to Improve Quality

→

VALUE-BASED PAYMENT 2.0
Alternative Payment Models
Quality Measures +
Risk-Based Payment

Incentives to Reduce Spending

Most Alternative Payment Models Have Failed to Reduce Spending

Medicare Alternative Payment Model	Medicare	
	Losses	Savings
Accountable Care Organizations (ACOs)		
MSSP 2013-2016	0.2%	
MSSP 2017-2018		0.5%
MSSP 2019		1.0%
MSSP 2020 (Pandemic Year)		*1.7%*
Next Generation ACO Model	0.3%	
Comprehensive Primary Care Initiative (CPCI)	1.0%	
Comprehensive Primary Care Plus (CPC+) Track 1	2.0%	
Comprehensive Primary Care Plus (CPC+) Track 2	3.0%	
Comprehensive Care for Joint Replacement (CJR)		2.0%
Bundled Payments for Care Improvement (BPCI) Model 2	1.0%	
Bundled Payments for Care Improvement (BPCI) Model 3	3.0%	
Bundled Payments for Care Improvement Advanced (BPCI-A)	2.0%	
Comprehensive ESRD Care	0.8%	
Oncology Care Model (OCM)	1.1%	
Independence at Home (created by Congress, not CMS)		3.0%

Only Three Models Have Achieved Savings

Medicare Alternative Payment Model	Medicare Losses	Medicare Savings
Accountable Care Organizations (ACOs)		
MSSP 2013-2016	0.2%	
MSSP 2017-2018		0.5%
MSSP 2019		1.0%
MSSP 2020 (Pandemic Year)		*1.7%*
Next Generation ACO Model	0.3%	
Comprehensive Primary Care Initiative (CPCI)	1.0%	
Comprehensive Primary Care Plus (CPC+) Track 1	2.0%	
Comprehensive Primary Care Plus (CPC+) Track 2	3.0%	
Comprehensive Care for Joint Replacement (CJR)		2.0%
Bundled Payments for Care Improvement (BPCI) Model 2	1.0%	
Bundled Payments for Care Improvement (BPCI) Model 3	3.0%	
Bundled Payments for Care Improvement Advanced (BPCI-A)	2.0%	
Comprehensive ESRD Care	0.8%	
Oncology Care Model (OCM)	1.1%	
Independence at Home (created by Congress, not CMS)		3.0%

How CMS Diagnoses the Problems and Proposes to Cure Them

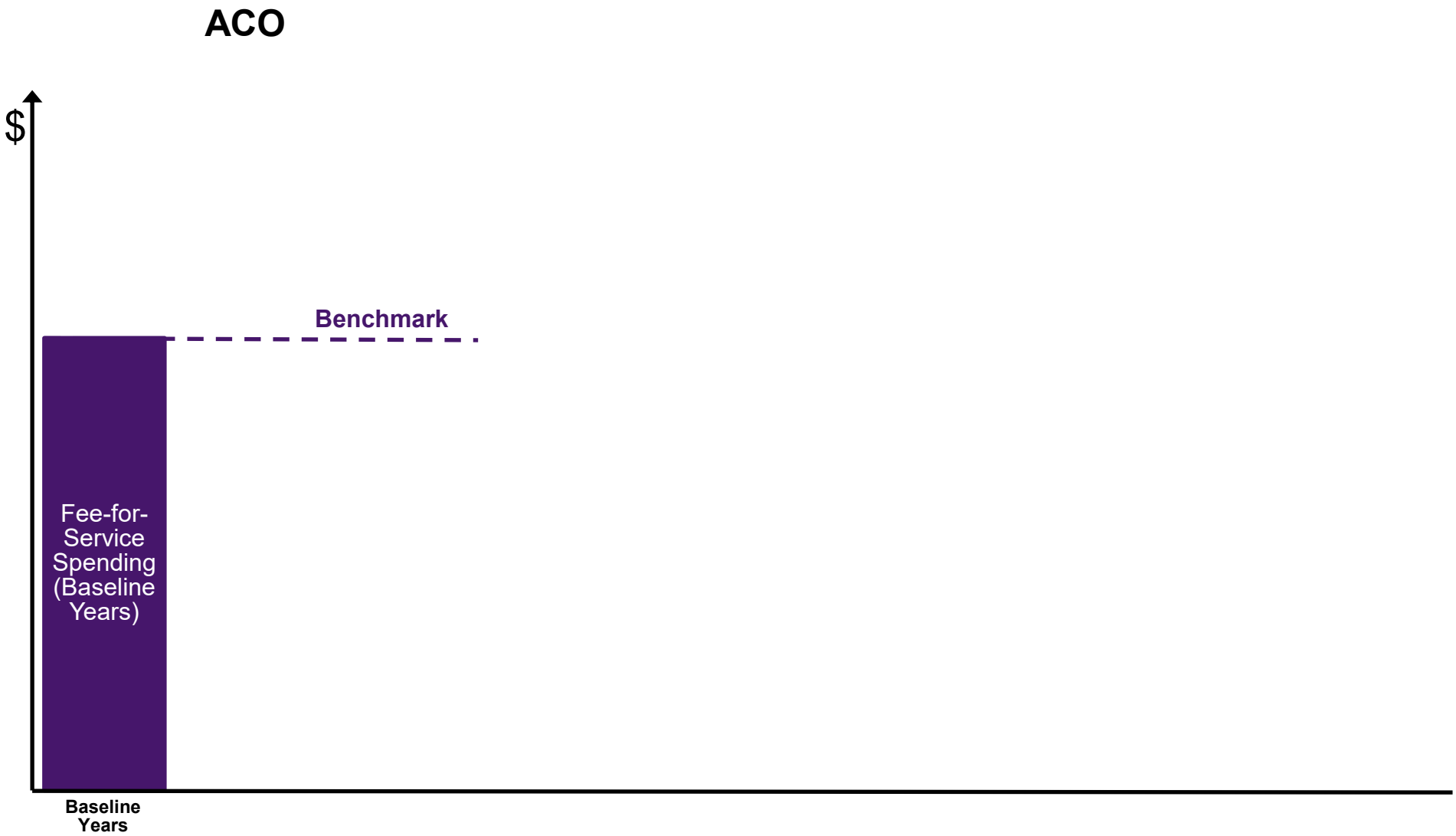
CMS Diagnosis	CMS Proposed Cure
"Voluntary models…limit the potential savings…because participants opt in when they believe they will benefit financially and opt out (or never join) when they believe they are at risk for losses."	Mandatory participation in CMS APMs

Why Wouldn’t Providers Want to Participate in CMS Alternative Payment Models?

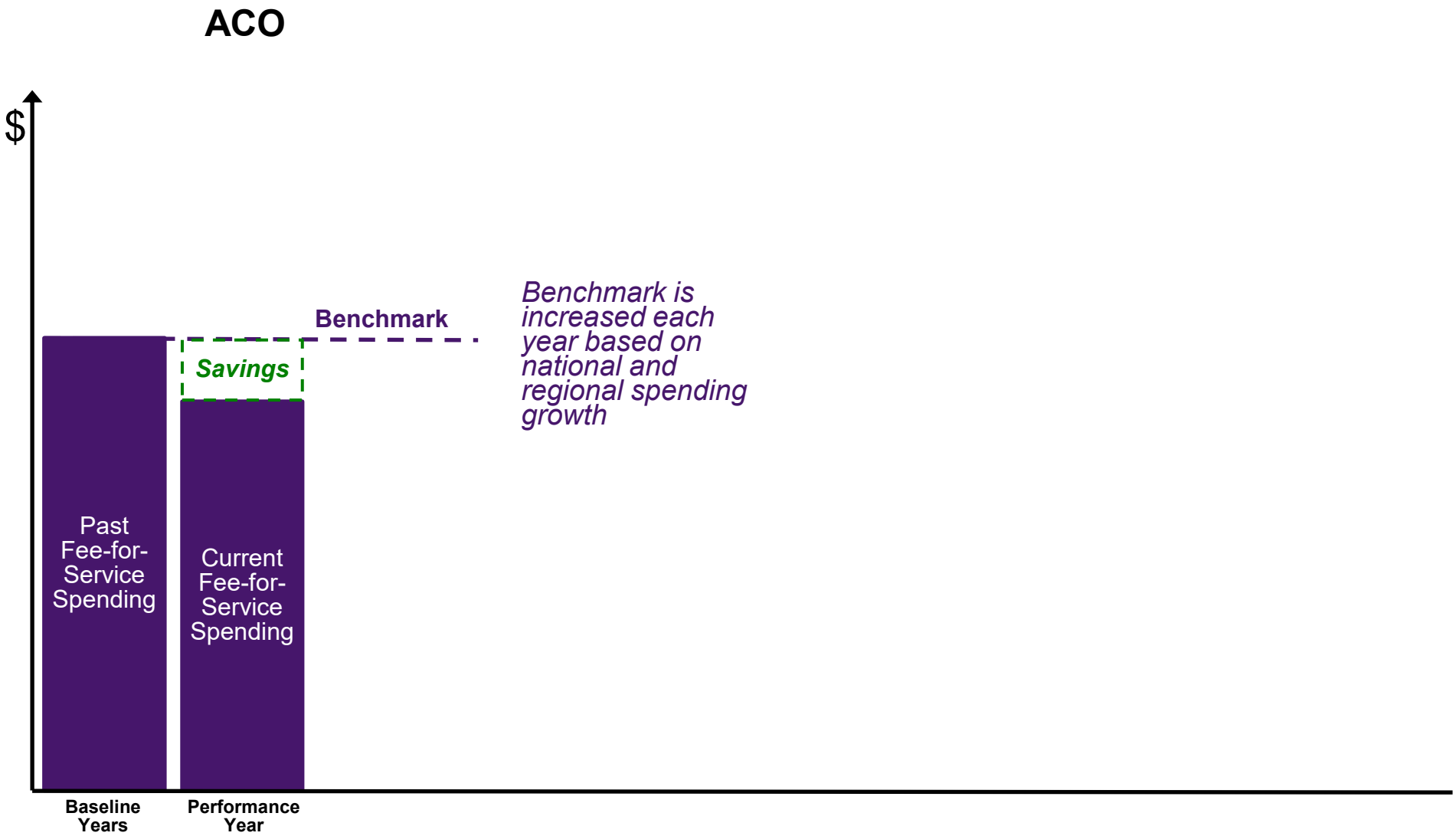
Why Wouldn’t Providers Want to Participate in CMS Alternative Payment Models?

EXAMPLE:
How Accountable Care Organizations (ACOs) are Paid Under the Medicare Shared Savings Program

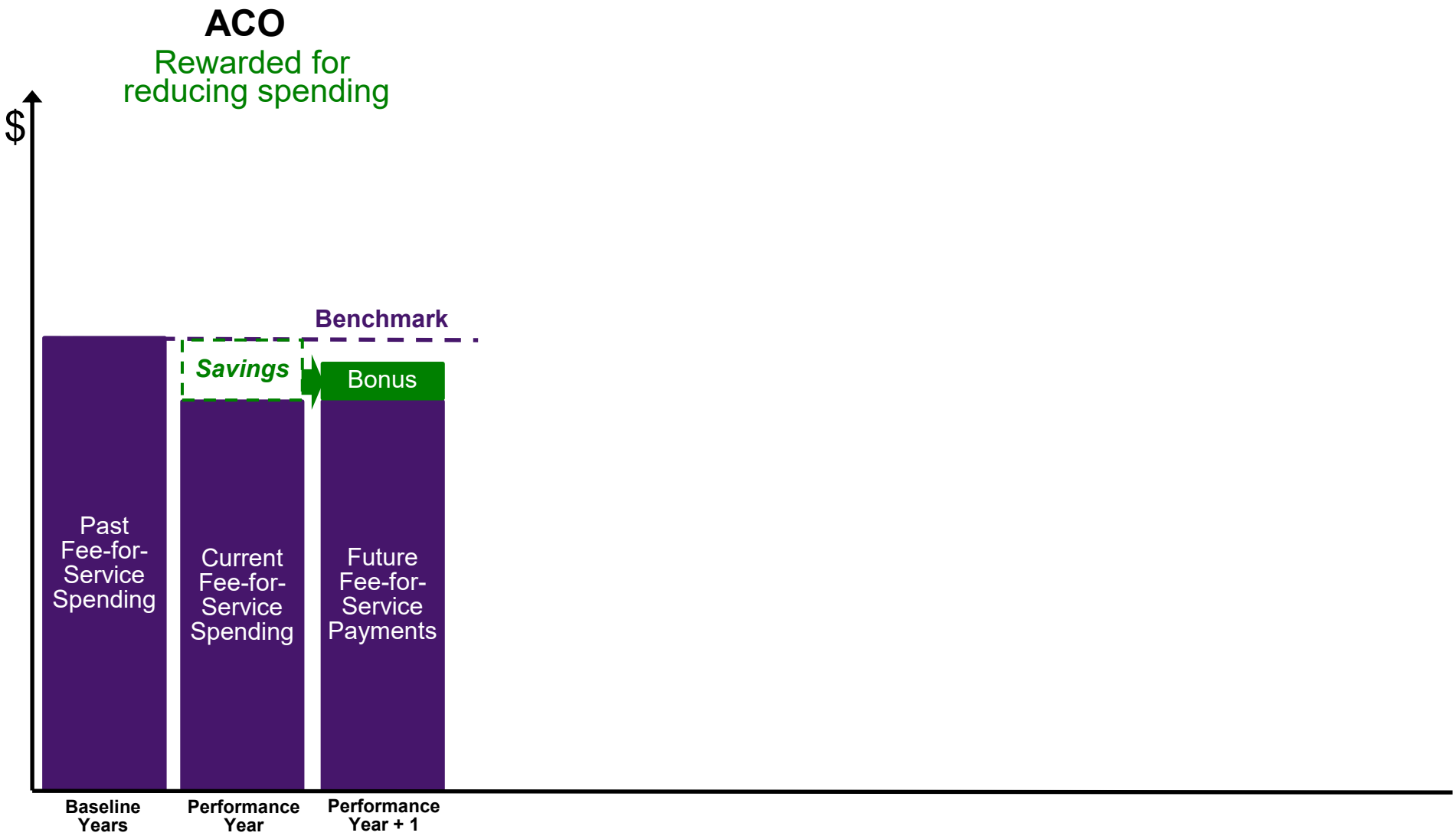
Step 1: Create "Benchmark" Based on Past ACO Spending



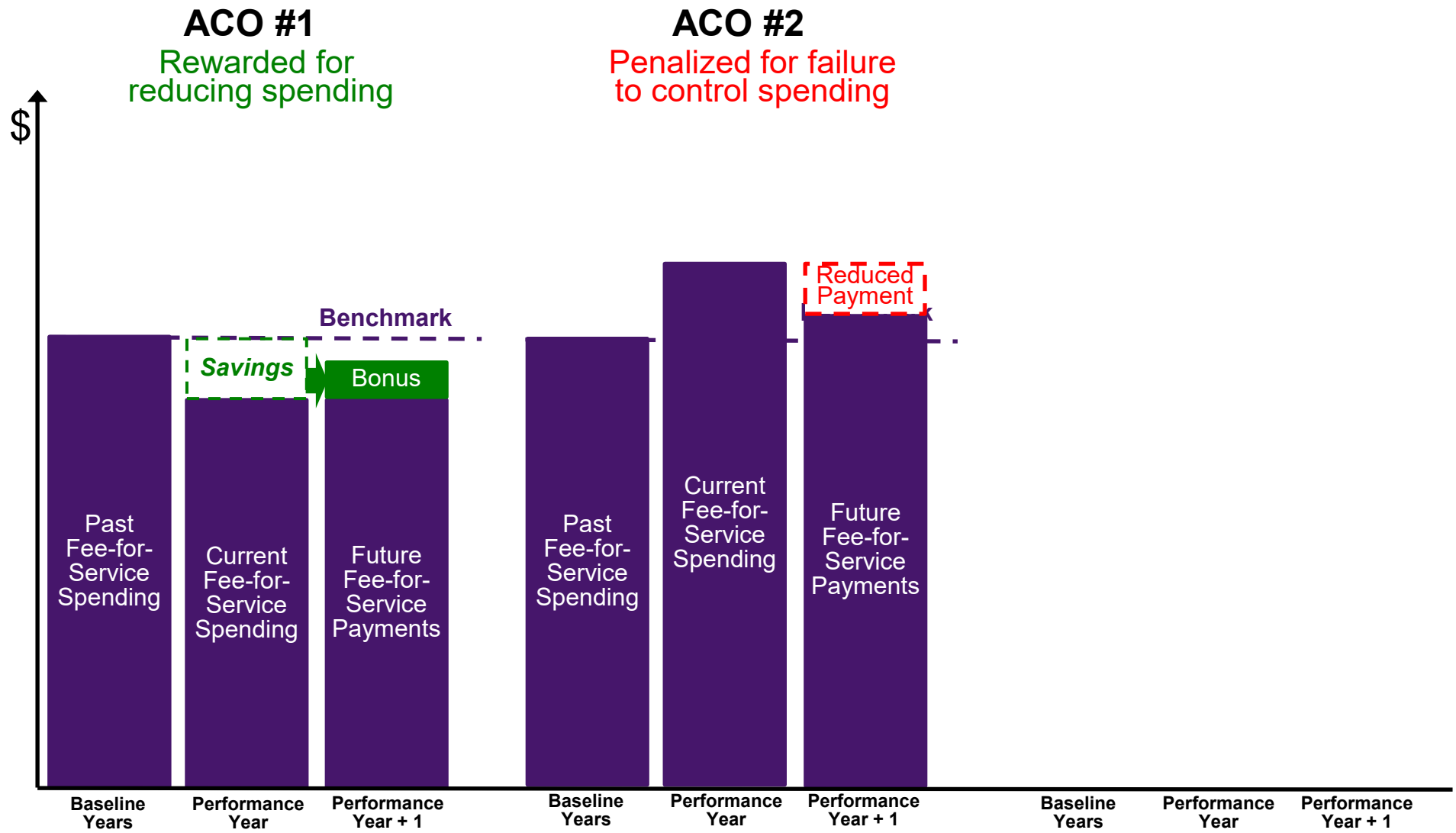
Step 2: Measure ACO's Current Spending Against Benchmark



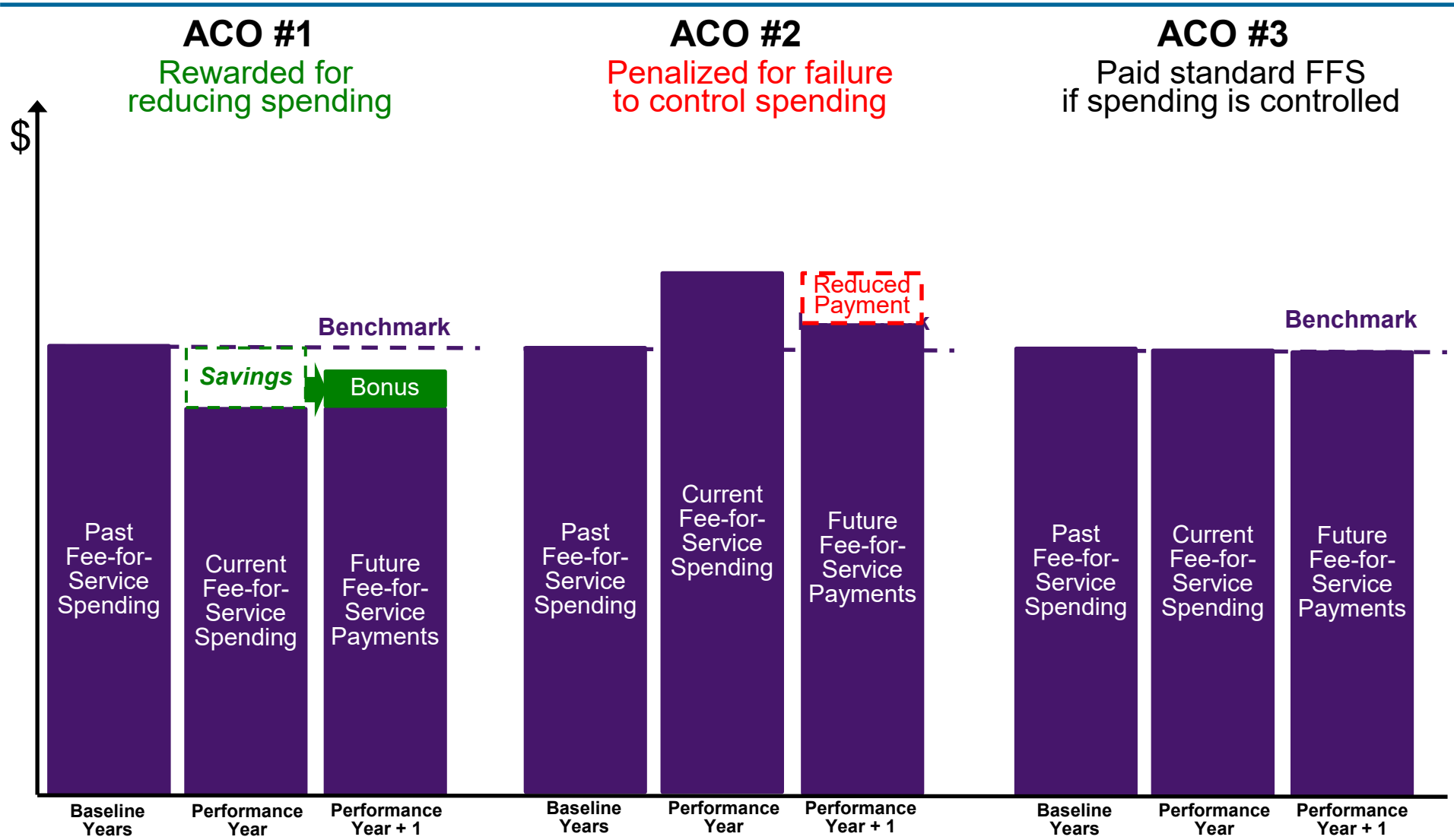
Step 3a: Pay a "Shared Savings" Bonus if Spending Decreases



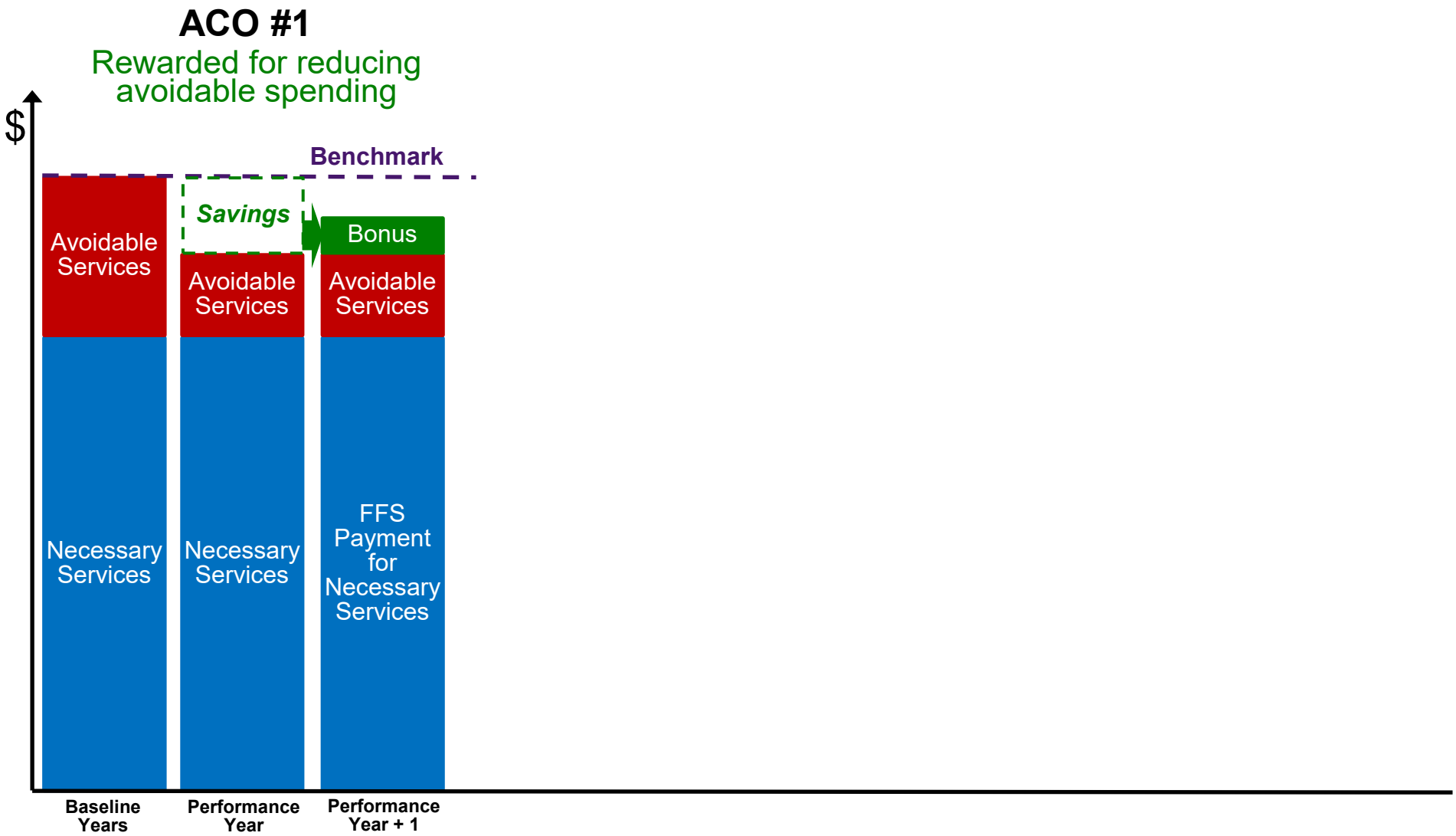
Step 3b: Penalize Downside Risk ACOs if Spending Increases



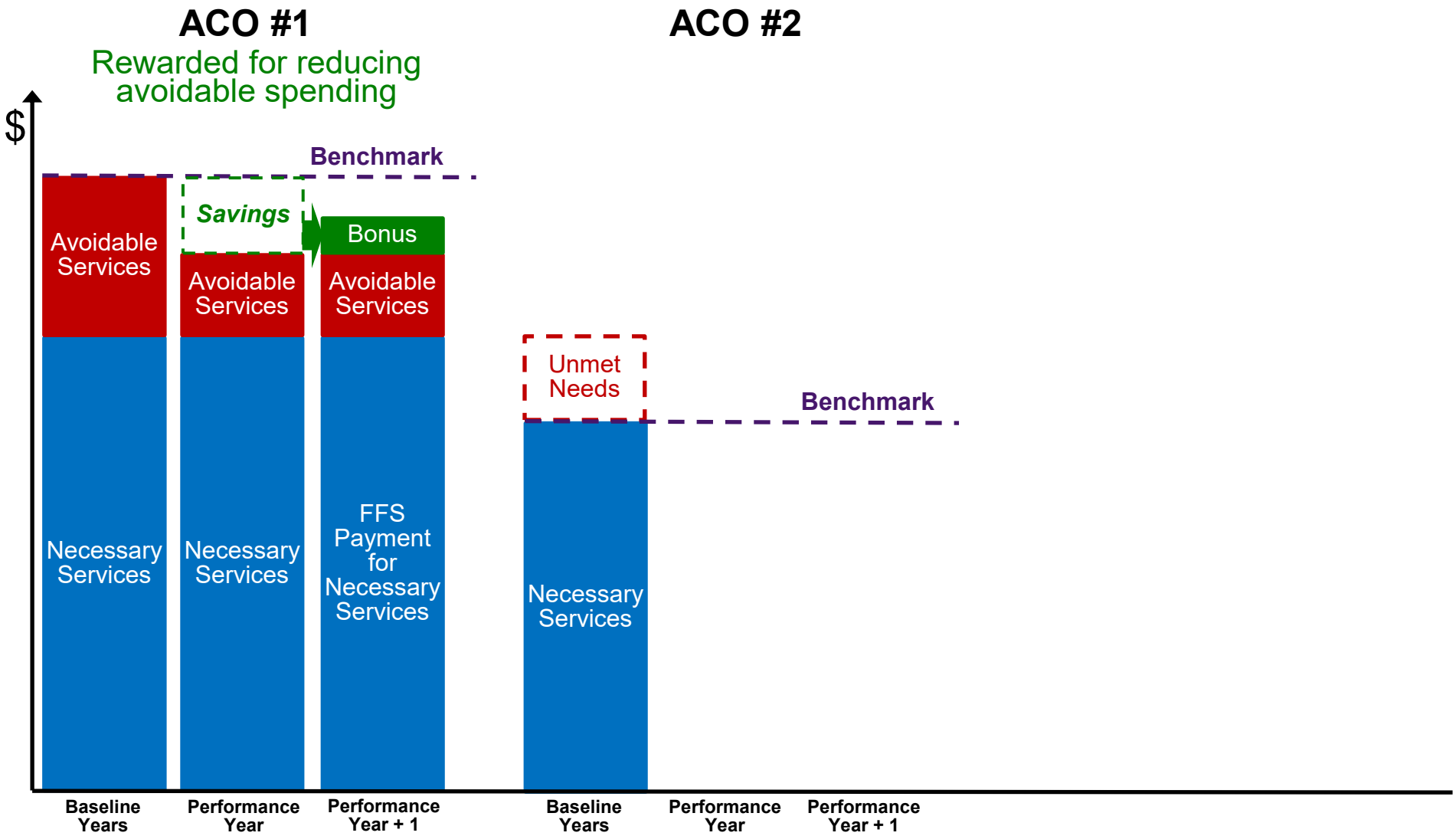
Step 3c: Pay Standard FFS if Spending = Benchmark



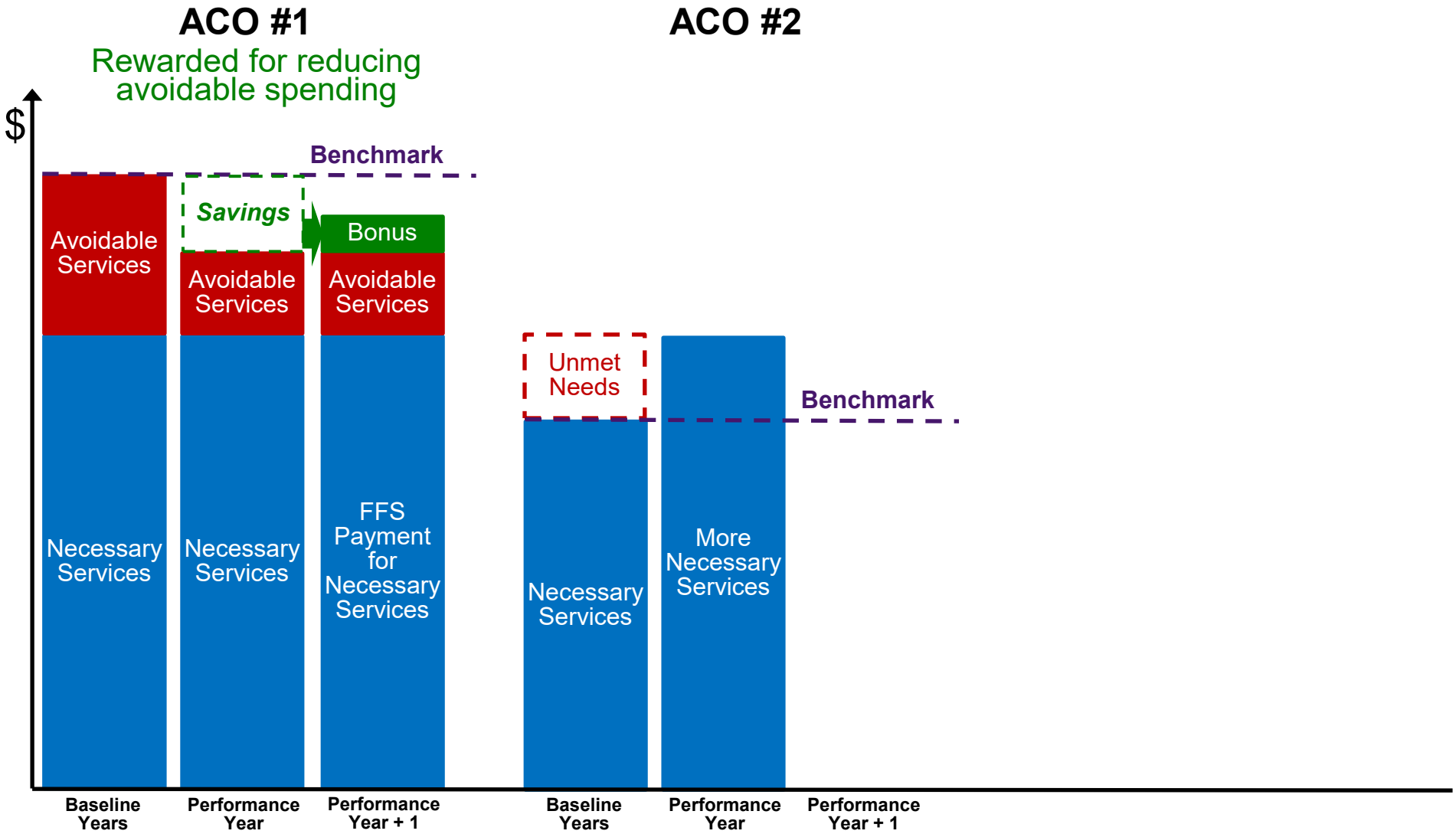
Works Well for ACOs With a Lot of Avoidable Spending



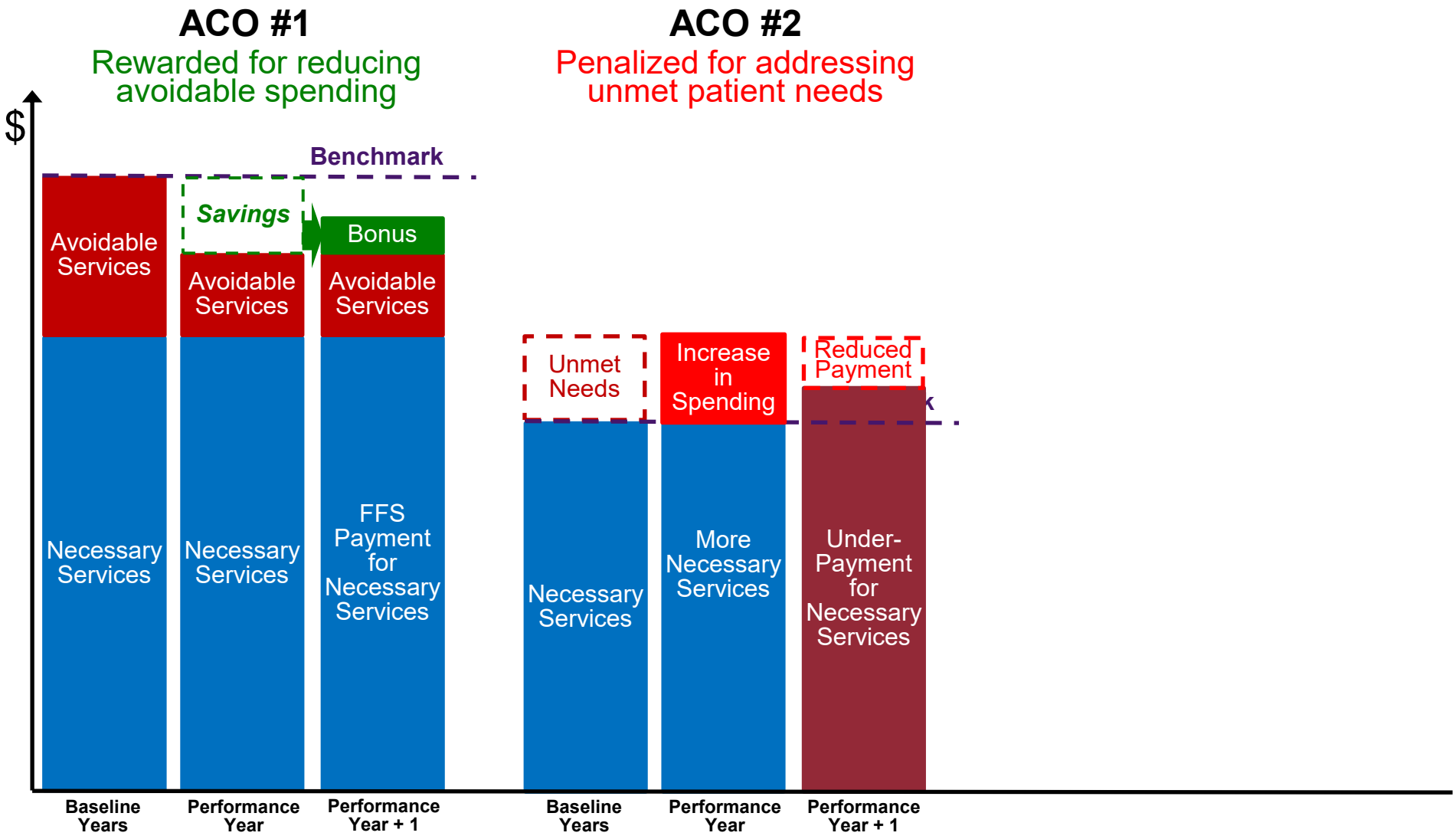
It Doesn't Work Well for ACOs Whose Patients Have Unmet Needs



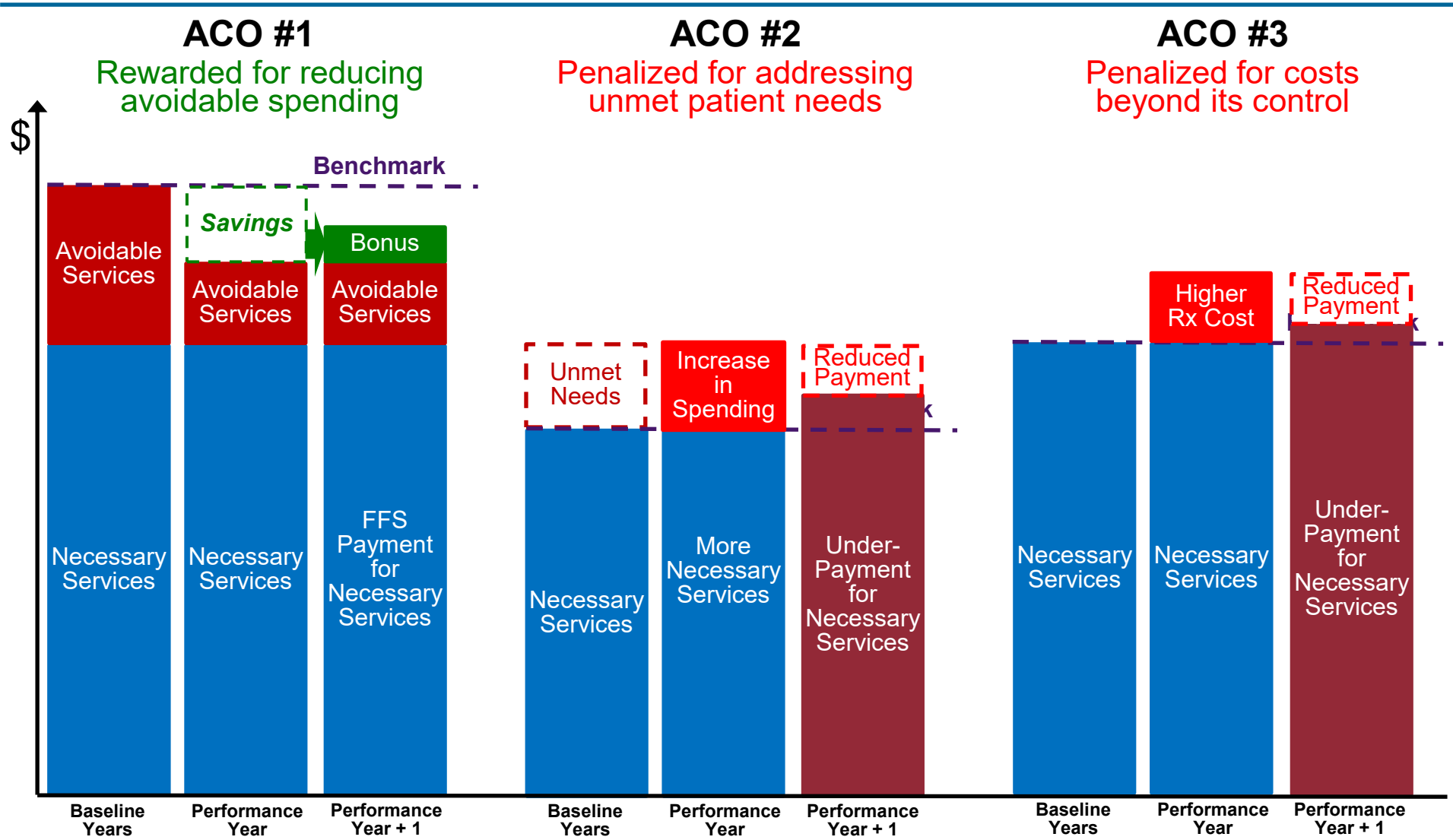
If the ACO Provides More Services to Address Unmet Needs…



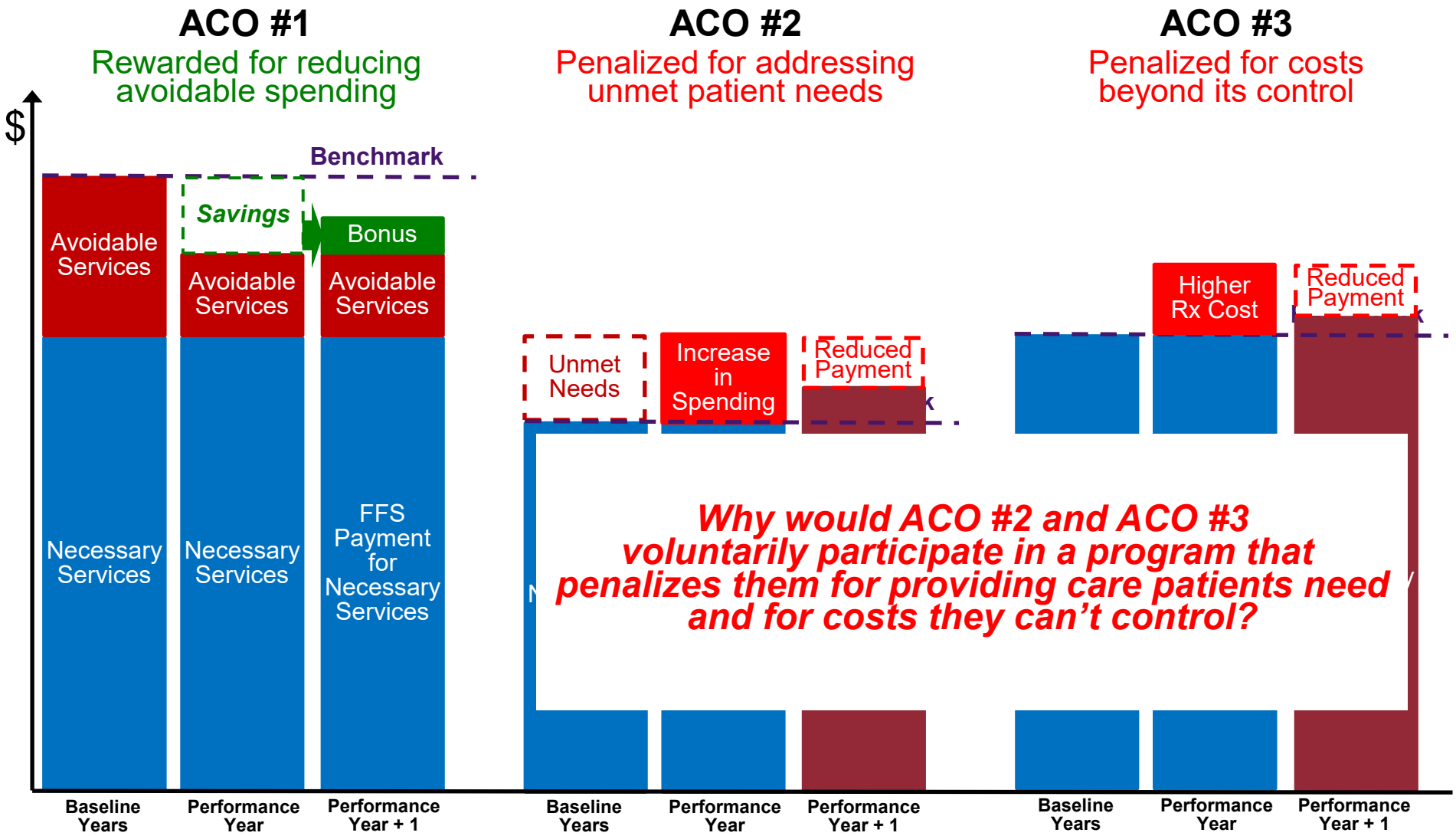
…That Increases Spending and Results in a Penalty



ACOs Can Also Be Penalized for Cost Increases They Can't Control

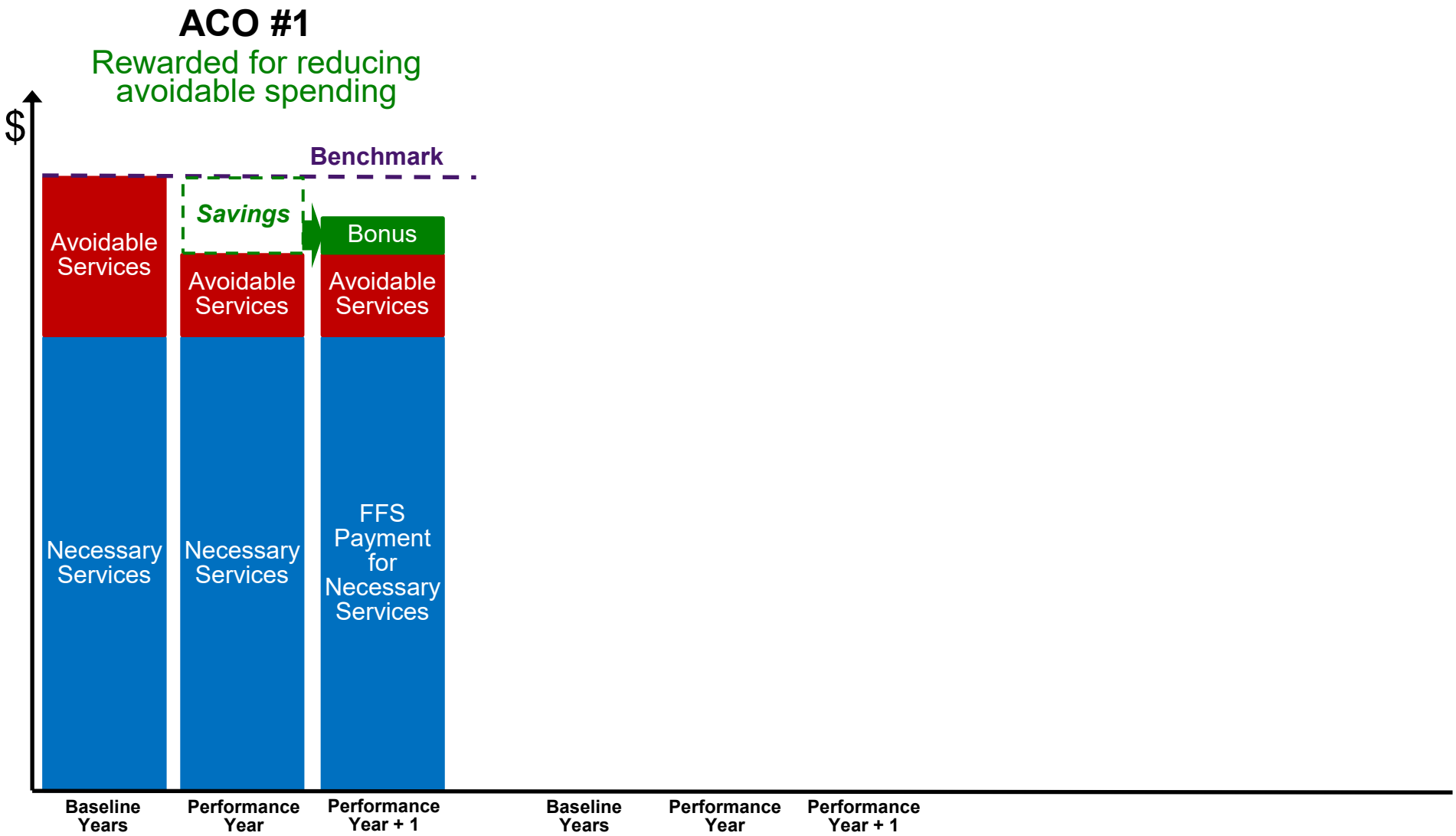


Is It Any Wonder Participation in MSSP Is Limited & Decreasing?

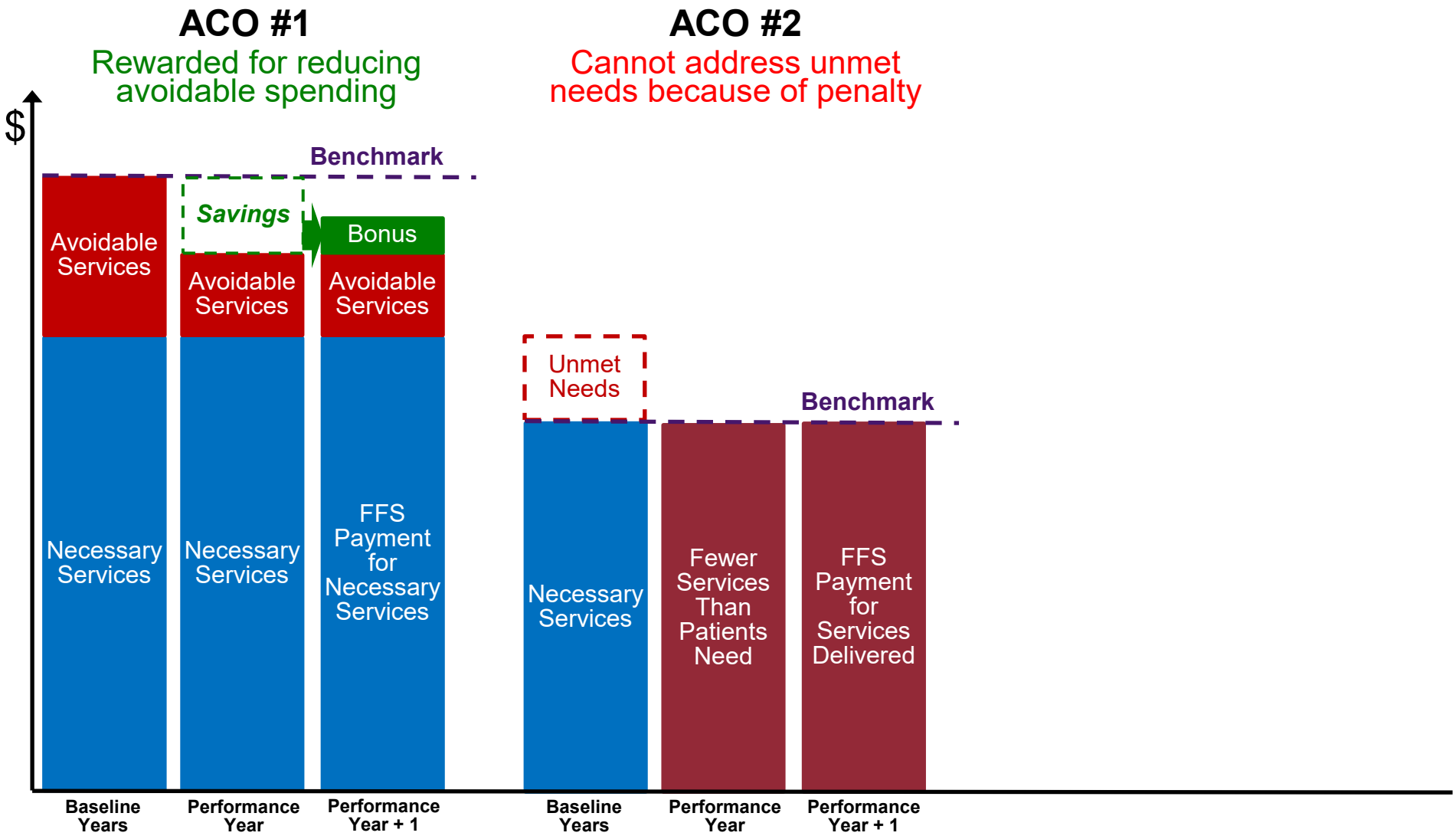


What Would Happen if Participation is Mandatory?

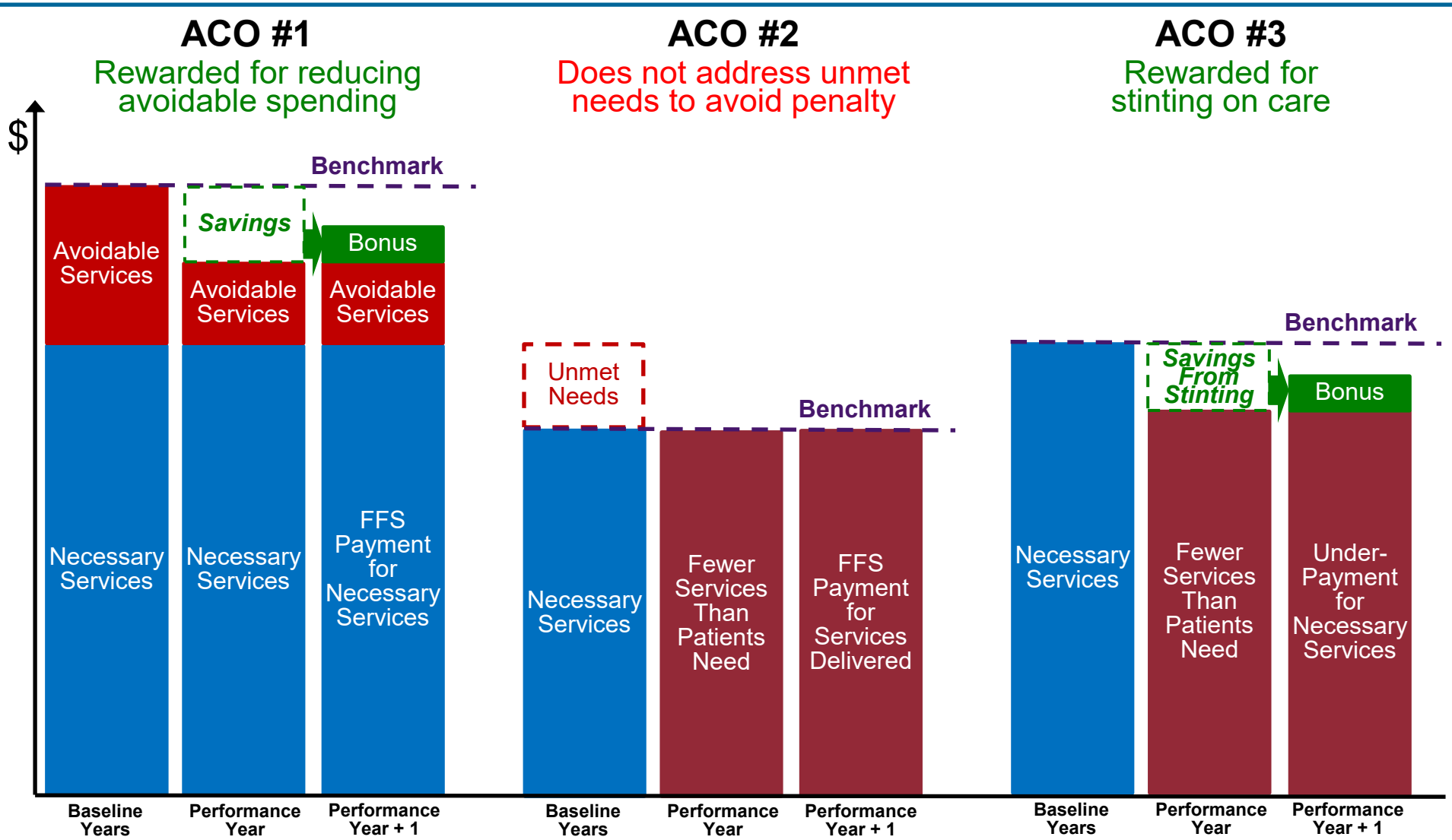
ACO #1 Would Continue to Receive Bonuses



ACO #2 Could Not Address Patient Needs Because of Penalties



Some ACOs Might Stint on Care to Avoid Penalties & Receive Bonuses



Don't ACO 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

23 ACO Quality Measures

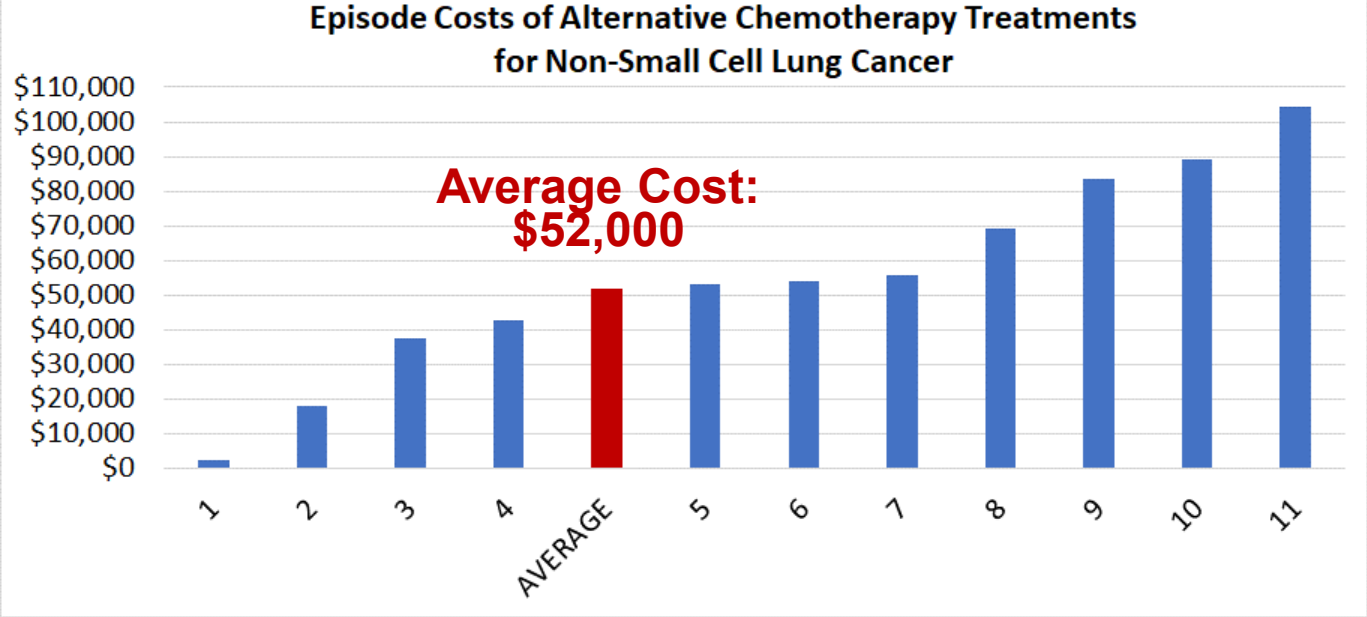
- **At-Risk Population (25%)**
  - Diabetes Control (> 9% HbA1c)
  - Hypertension Control
  - Depression Remission
- **Preventive Health (25%)**
  - Influenza Immunization
  - Tobacco Use Screening/Intervention
  - Depression Screening/Follow-up
  - Colorectal Cancer Screening
  - Breast Cancer Screening
- **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

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

How Much Could an ACO Save By Stinting on Care?

Treatment Costs Vary Dramatically Based on Type of Lung Cancer

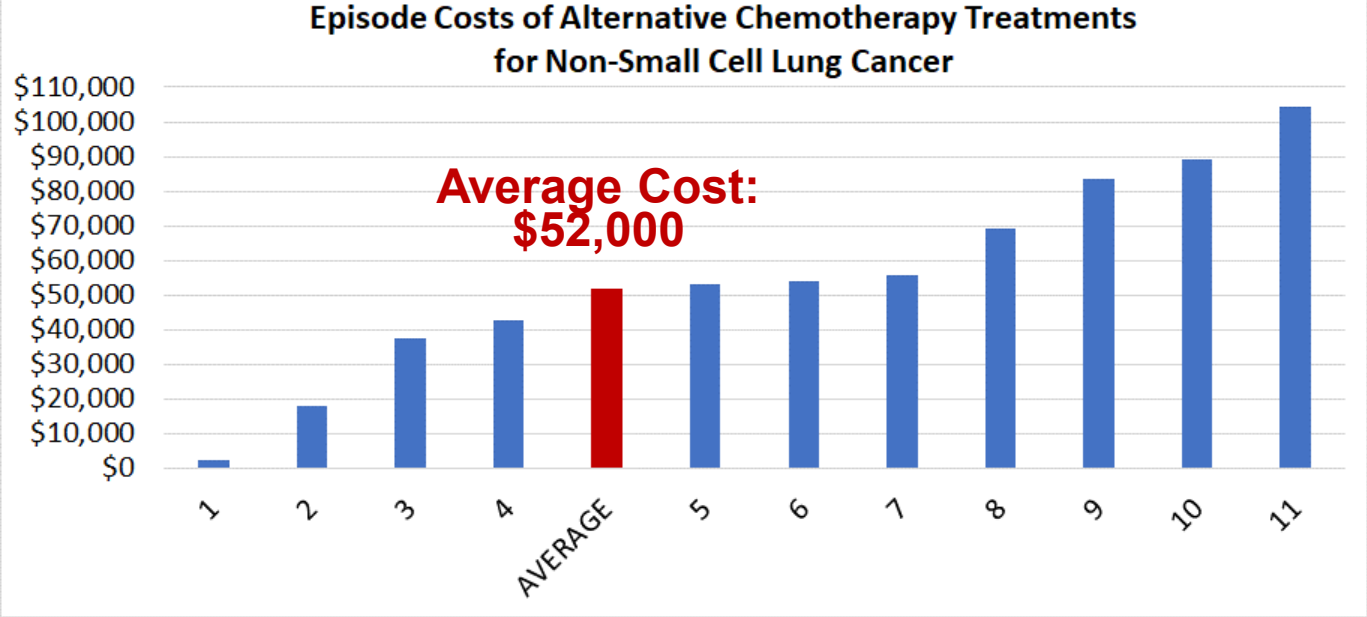


11 Different Chemotherapy/Immunotherapy Regimens
Ranging from $2,500 to $105,000
Depending on Patient Characteristics

Ward JC et al.
"Impact on Oncology Practices of Including Drug Costs in Bundled Payments"
Journal of Oncology Practice 14(5), May 2018

1	Carboplatin + Paclitaxel
2	Carboplatin + Paclitaxel +Neutropenia
3	Carboplatin + Paclitaxel + Bevacizumab
4	Carboplatin + Paclitaxel + Bevacizumab + Neutropenia
5	Carboplatin + Pemetrexed
6	Carboplatin + Pemetrexed + Neutropenia
7	Carboplatin + Pemetrexed + Bevacizumab
8	Carboplatin + Pemetrexed + Bevacizumab + Neutropenia
9	EGFR: Erlotinib
10	ALK-1/ROS-1: Crizotinib
11	PD-L1: Pembrolizumab

Lung Cancer Cases in an ACO Involve a Lot of Spending



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

= 30 Cases in a 10,000 Member ACO

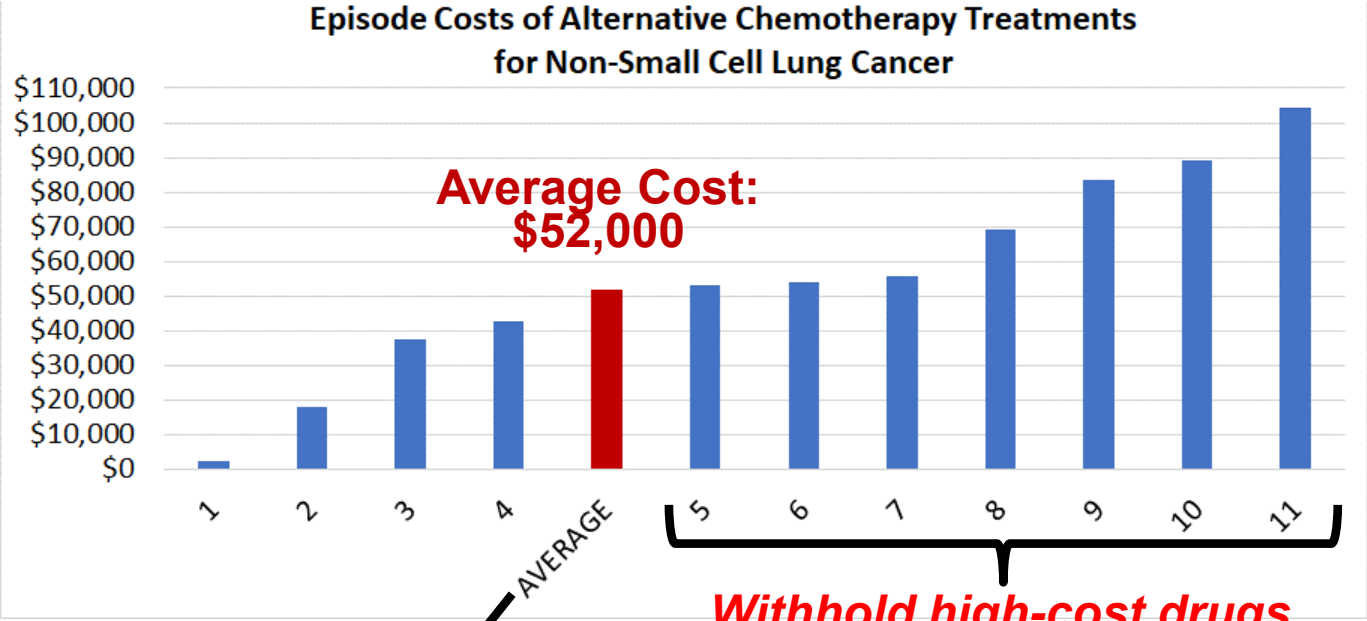
>$1.5 Million for Chemo Alone

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

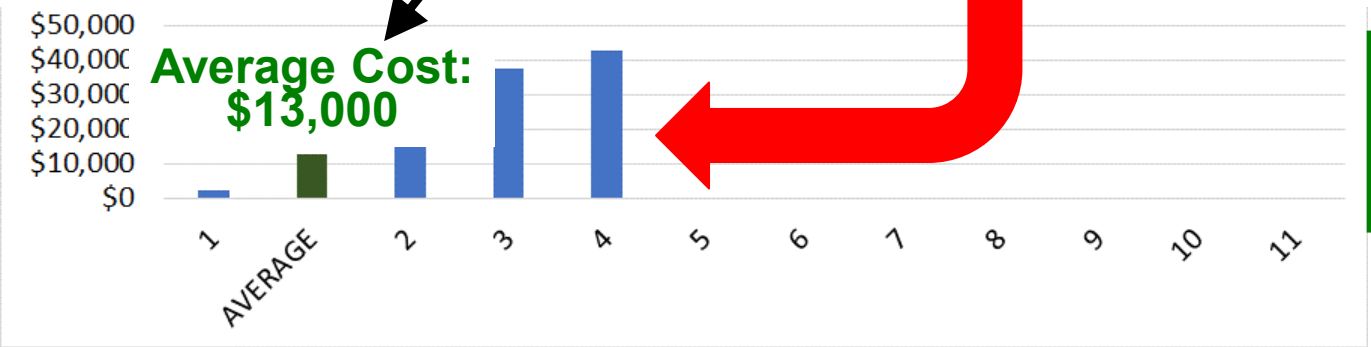
Ward JC et al.
"Impact on Oncology Practices of Including Drug Costs in Bundled Payments"
Journal of Oncology Practice 14(5), May 2018

1	Carboplatin + Paclitaxel
2	Carboplatin + Paclitaxel +Neutropenia
3	Carboplatin + Paclitaxel + Bevacizumab
4	Carboplatin + Paclitaxel + Bevacizumab + Neutropenia
5	Carboplatin + Pemetrexed
6	Carboplatin + Pemetrexed + Neutropenia
7	Carboplatin + Pemetrexed + Bevacizumab
8	Carboplatin + Pemetrexed + Bevacizumab + Neutropenia
9	EGFR: Erlotinib
10	ALK-1/ROS-1: Crizotinib
11	PD-L1: Pembrolizumab

Giving Inadequate Treatments to 15 Patients = 1.2% ACO Savings



Withhold high-cost drugs from patients who need them



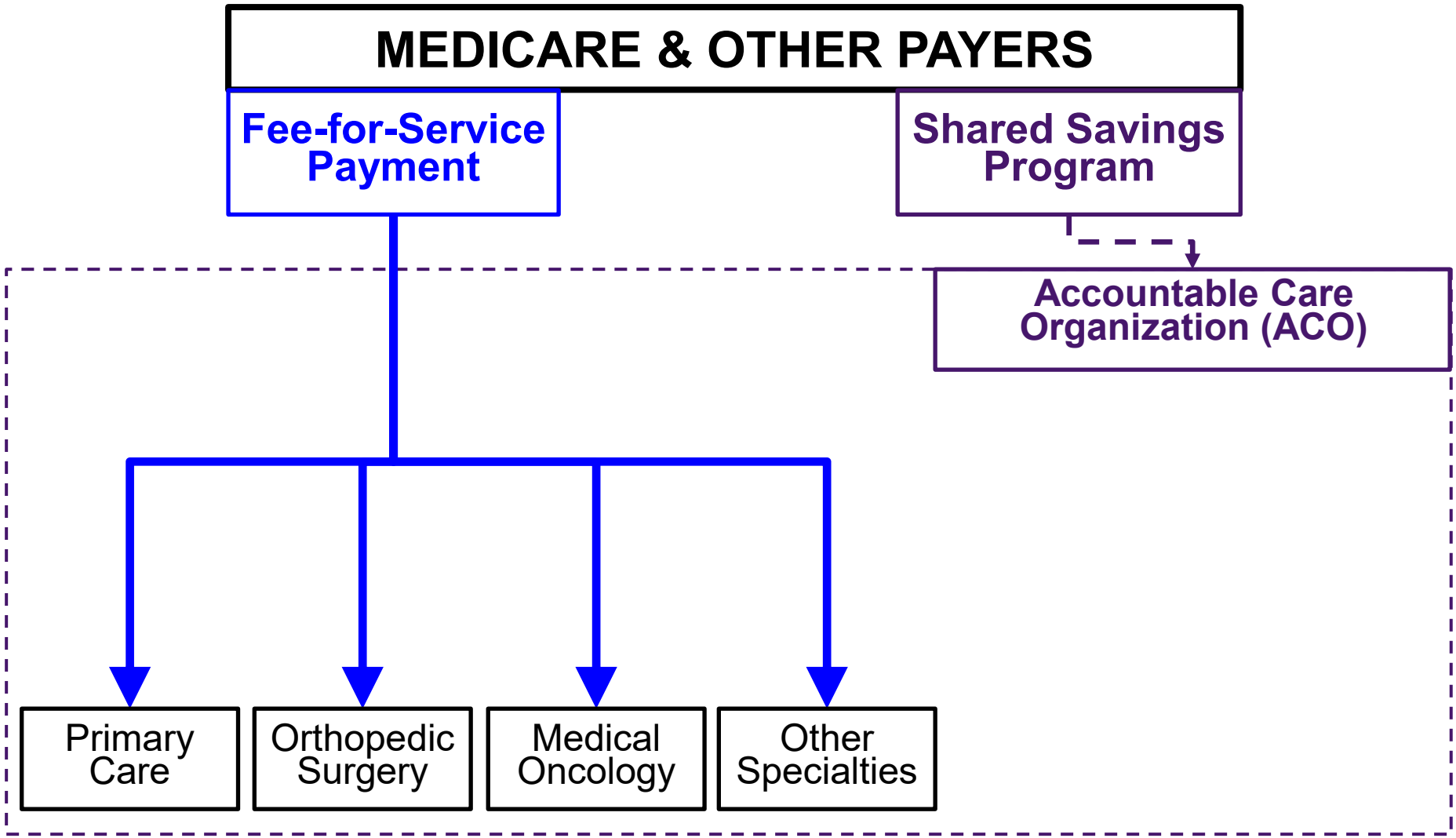
Lung Cancer Incidence in 65+ Population: 300/100,000

= 30 Cases in a 10,000 Member ACO

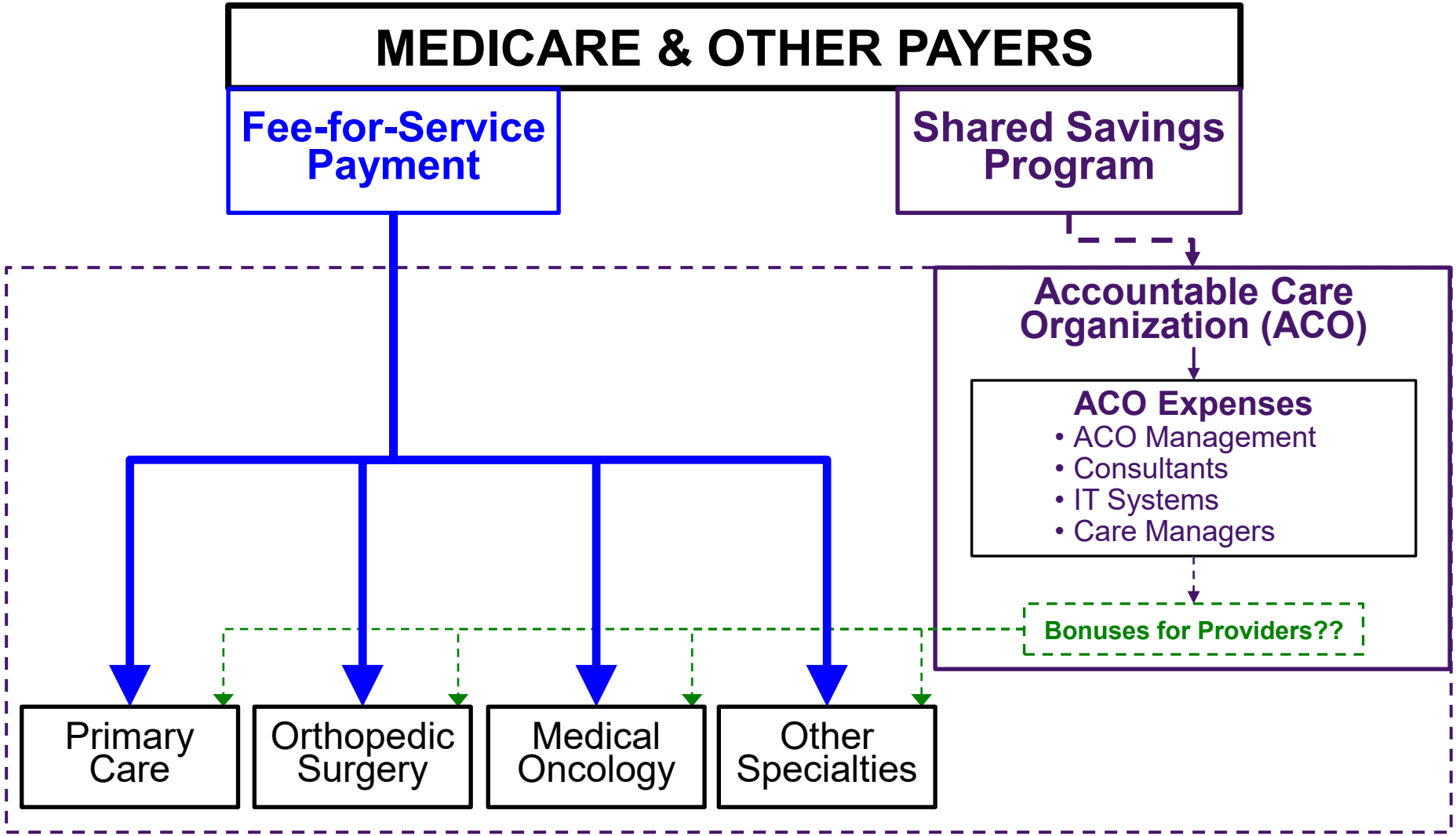
>$1.5 Million for Chemo Alone

Reduction in ACO's Total Spending: 1.2%

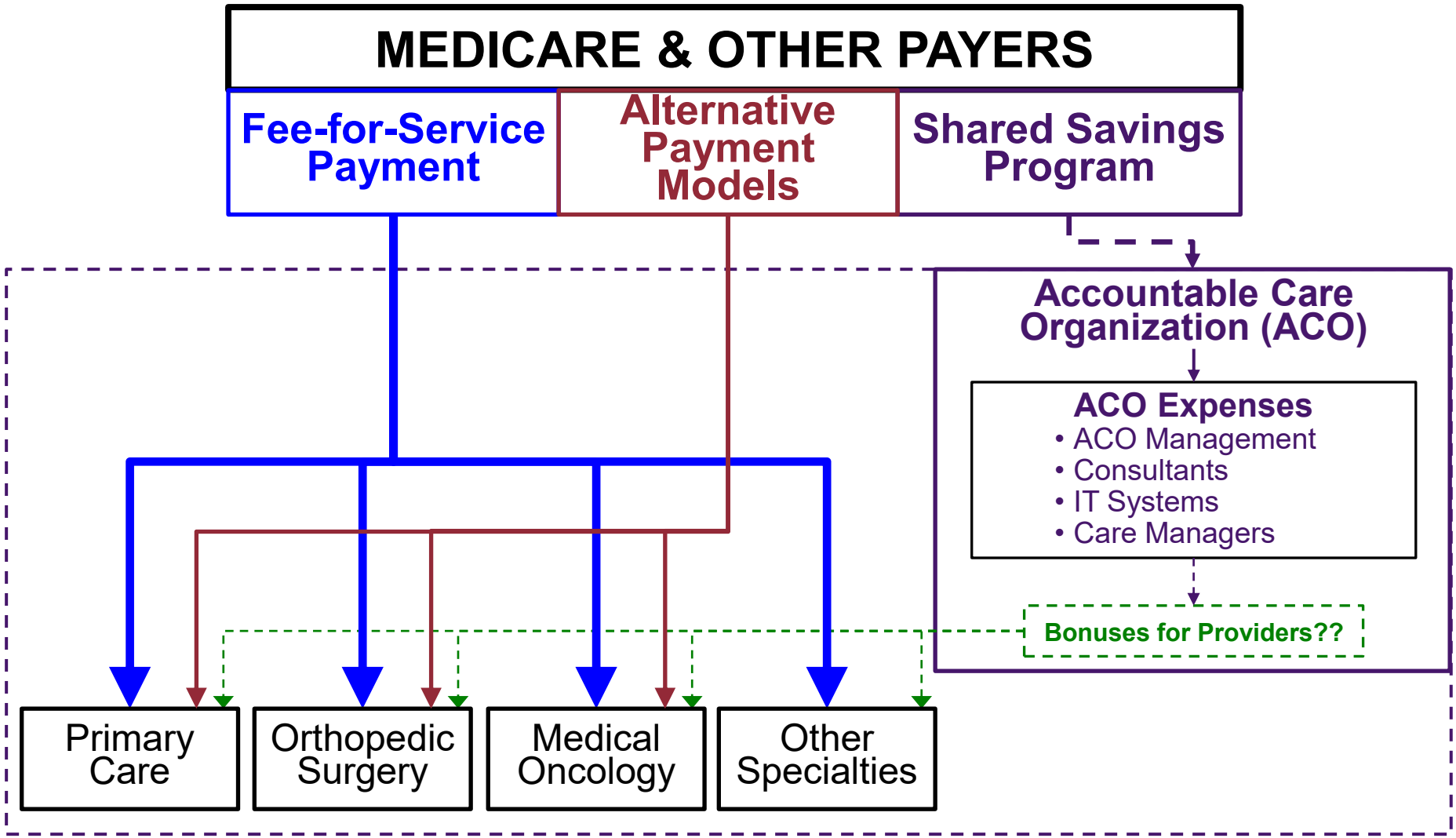
Specialists Aren't Directly Affected by Payments to ACOs



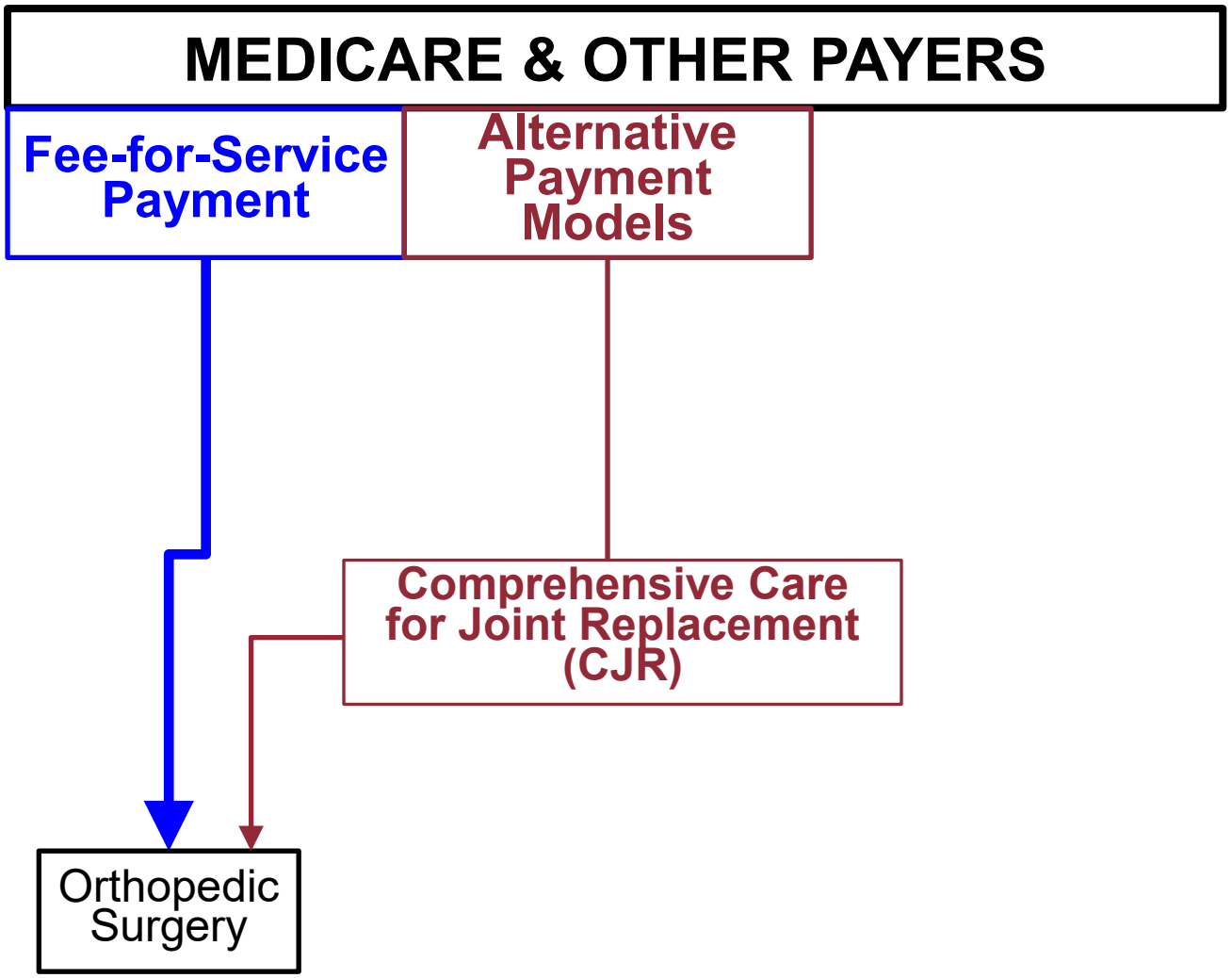
Even if the *ACO* Receives a Bonus, Little/None of It May Reach *Doctors*



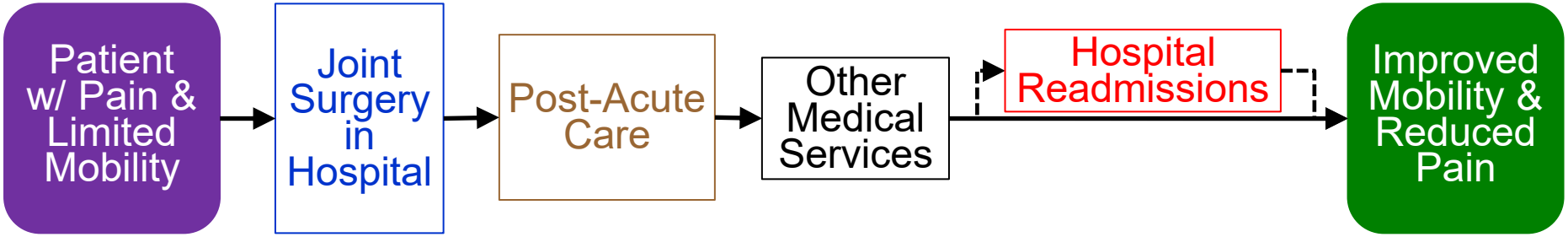
Very Few Payment Models Exist for Individual Specialties



Only the Joint Replacement APMs Have Reduced Spending

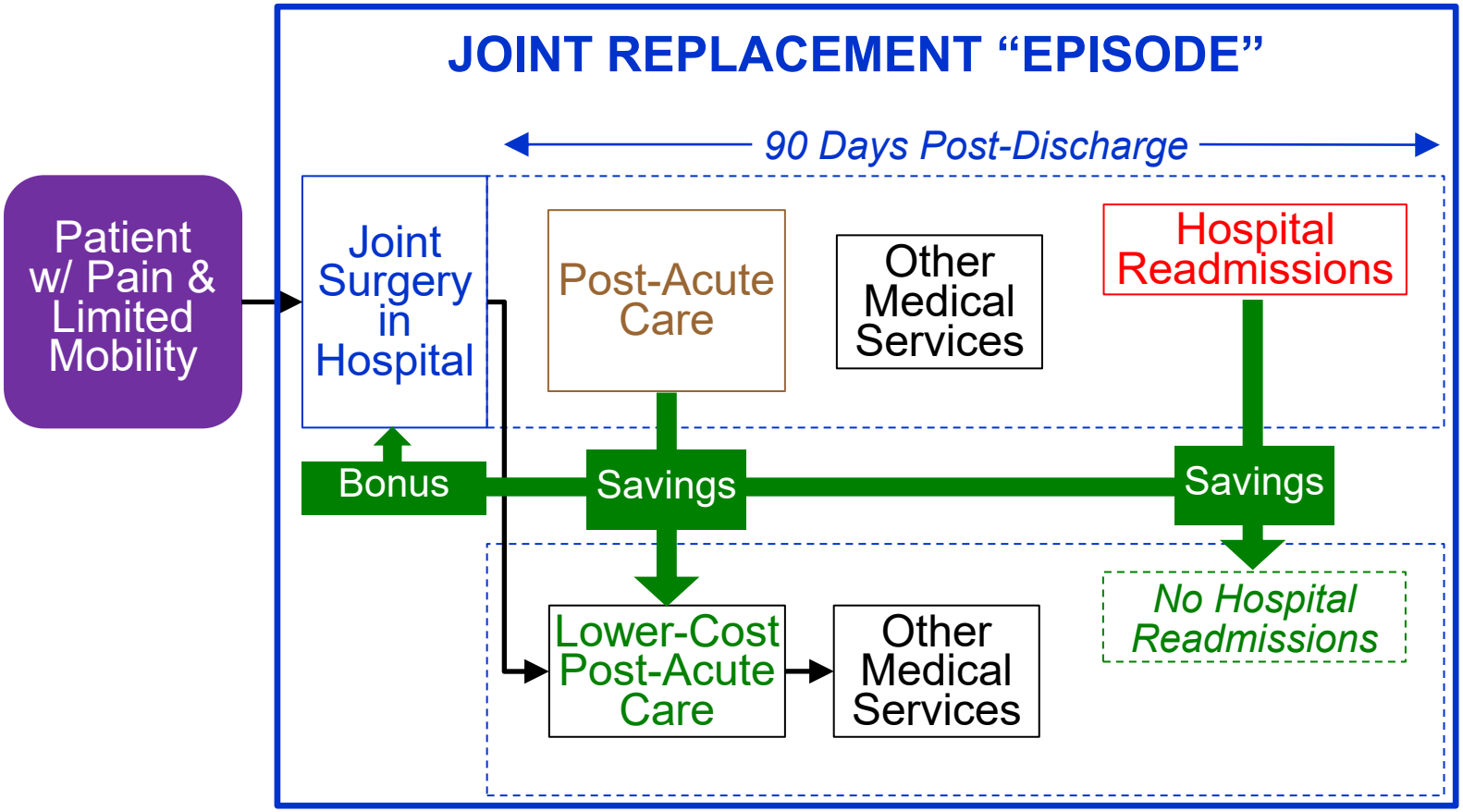


Joint Surgery Patients Receive Many Services After Discharge

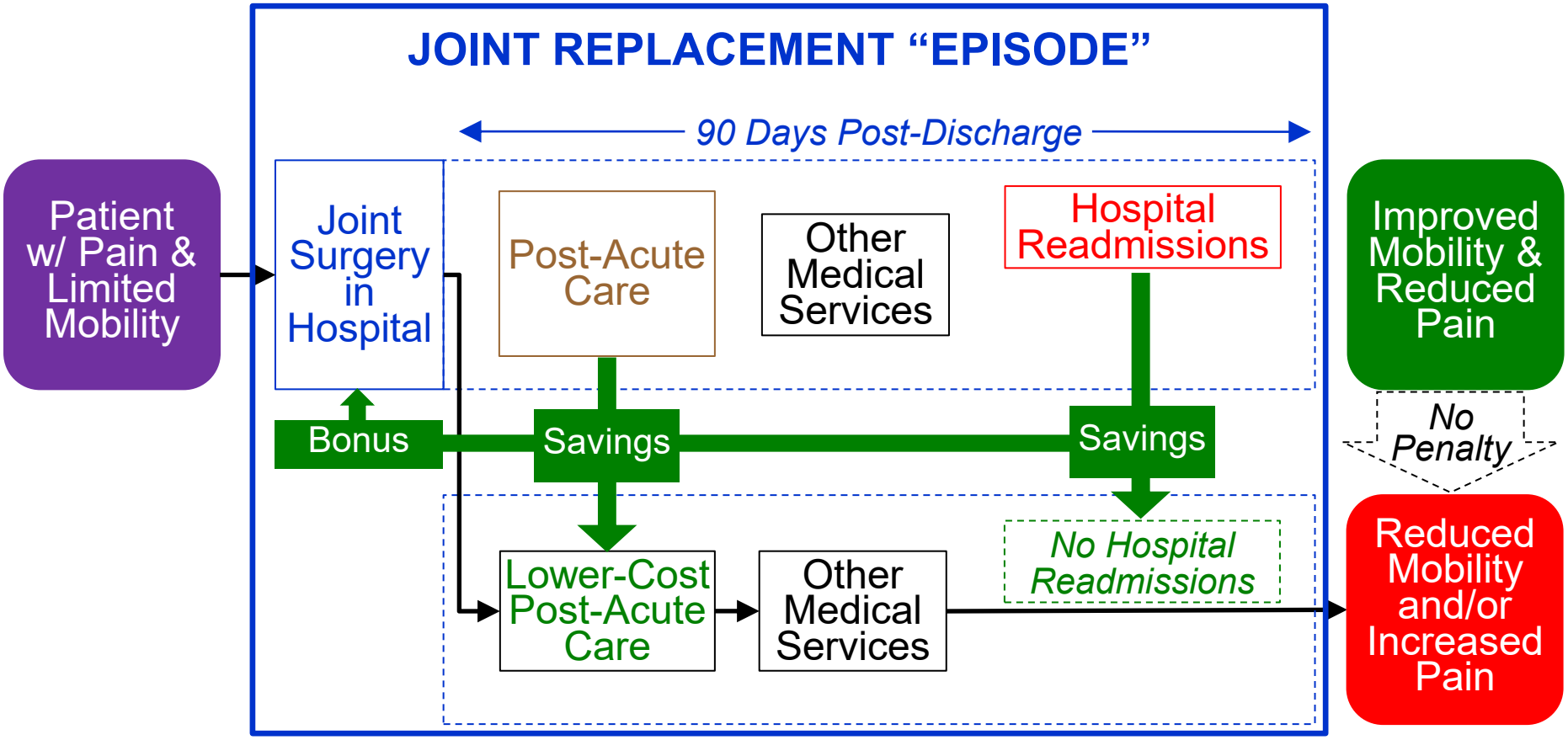


Goal of CJR: Reducing $ for Post-Acute Care & Readmissions

CMMI Comprehensive Care for Joint Replacement (CJR)



Problem #1 with CJR: No Penalty for Worse Outcomes



Measures of Complications & Experience, Not Outcomes/Pain

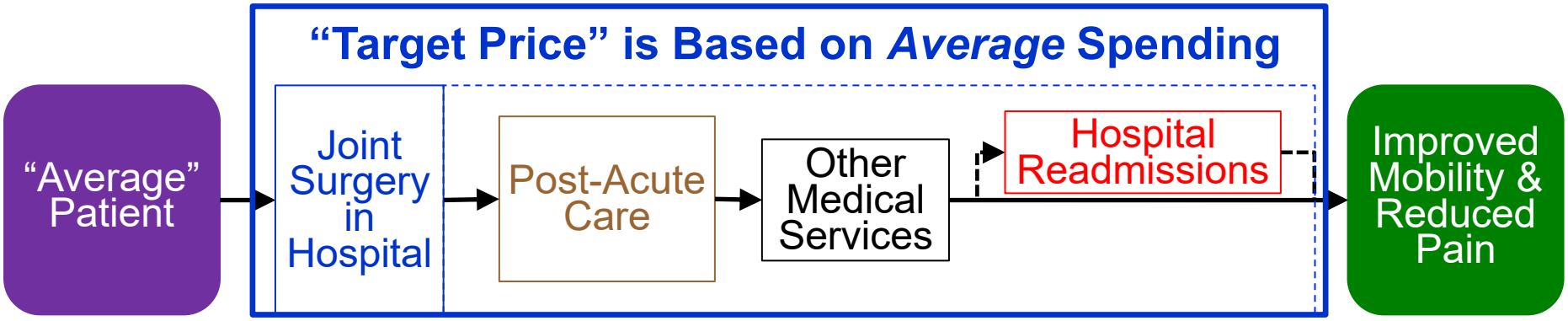
CJR Quality Measures

- Post-surgical complications during 90 days after surgery
- HCAHPS patient experience survey, except for pain management questions

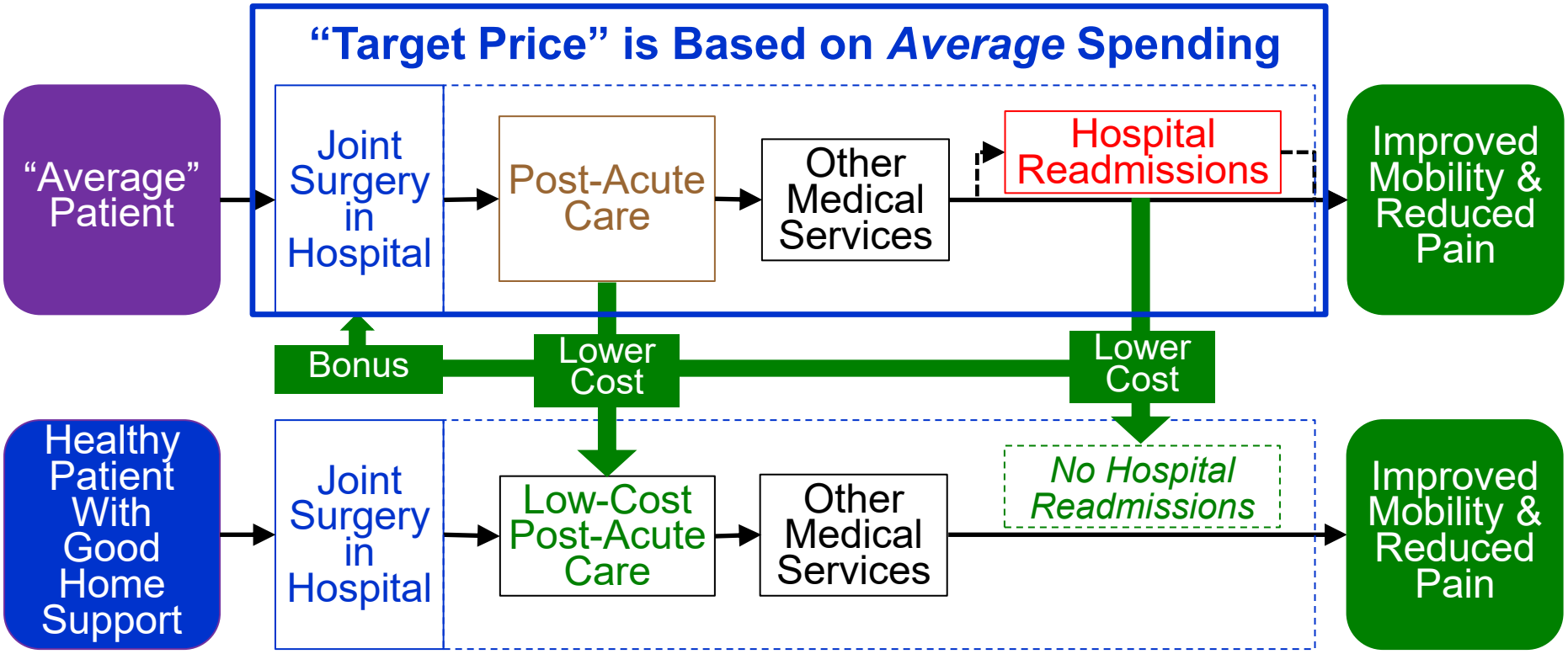
No Measures to Assure:

- Controlled post-surgical pain
- Improved ability to walk
- Reduction in osteoarthritis pain

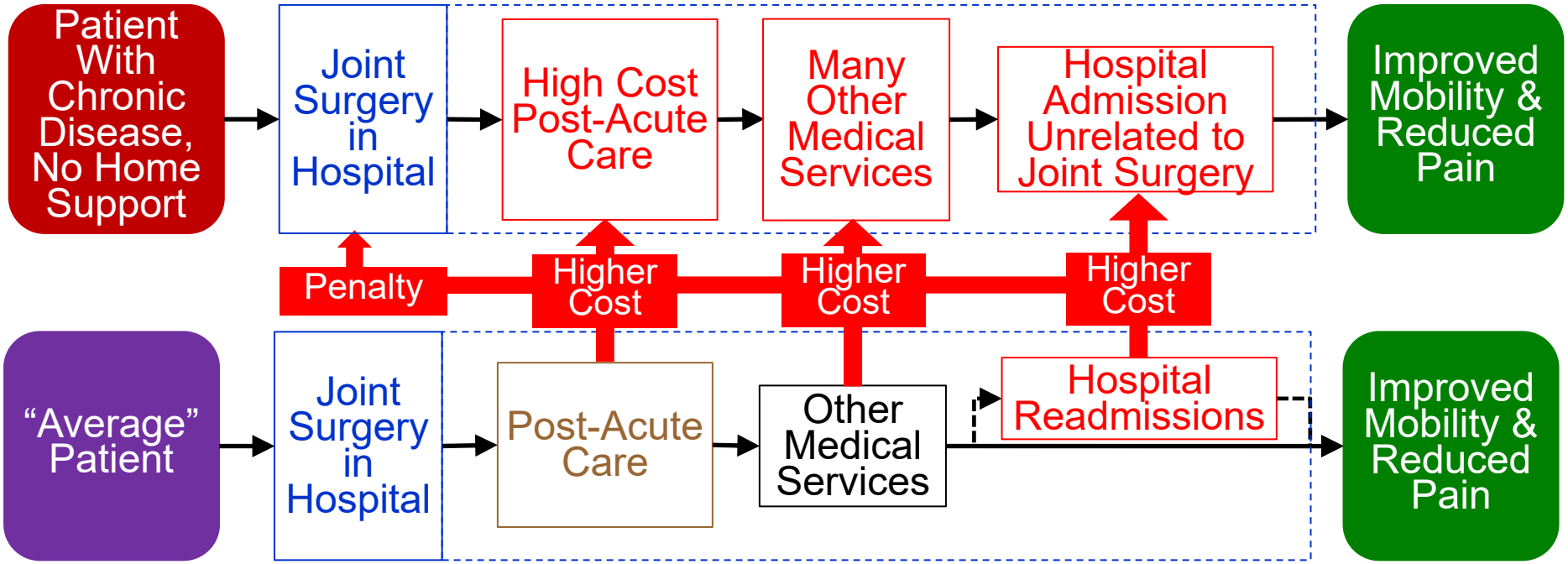
Problem #2: Target Prices Are Based on *Average Spending*



Hospitals With Lower-Need Patients Will Likely Get Bonuses



Hospitals With Higher-Need Patients Will Receive Penalties



Evidence of Financial Penalties for Serving Higher-Risk Patients

HOSPITALS

By Caroline P. Thirukumaran, Laurent G. Glance, Xueya Cai, Rishi Balkissoon, Addisu Mesfin, and Yue Li

DOI: 10.1377/hlthaff.2018.05264
HEALTH AFFAIRS 38,
NO. 2 (2019): 190–196

Performance Of Safety-Net Hospitals In Year 1 Of The Comprehensive Care For Joint Replacement Model

Caroline P. Thirukumaran (caroline_thirukumaran@urmc.rochester.edu) is an assistant professor in the Department of Orthopaedics and Department of Public Health Sciences, University of Rochester, in New York.

Laurent G. Glance is vice chair for research and a professor in the Department of Anesthesiology and Department of Public Health Sciences, University of Rochester.

Xueya Cai is a research associate professor in the Department of Biostatistics and Computational Biology, University of Rochester.

Rishi Balkissoon is an assistant professor in the Department of Orthopaedic University of Rochester.

Addisu Mesfin is an associ professor in the Departmen of Orthopaedics, University Rochester.

Yue Li is a professor in the Department of Public Healt Sciences, University of Rochester.

ABSTRACT The Comprehensive Care for Joint Replacement (CJR) model introduced in 2016 aims to improve the quality and costs of care for Medicare beneficiaries undergoing hip and knee replacements. However, there are concerns that the safety-net hospitals that care for the greatest number of vulnerable patients may perform poorly in CJR. In this study we used Medicare's CJR data to evaluate the performance of 792 hospitals mandated to participate in the first year of CJR. We found that in comparison to non-safety-net hospitals, 42 percent fewer safety-net hospitals qualified for rewards based on their quality and spending performance (33 percent of safety-net hospitals qualified, compared to

42% Fewer
Safety-Net Hospitals
Qualified for Bonuses,
and
Bonuses for
Safety-Net Hospitals
Were 39% Smaller
Than for
Non-Safety-Net Hospitals

payment reform that holds hospitals accountable for quality and spending during the inpatient stay and ninety days of postacute care for Medicare beneficiaries undergoing hip and knee replacements. In 2016, 794 acute care hospitals from sixty-seven Metropolitan Statistical Areas (MSAs) were mandated to participate in CJR.[2]

their scores by an additional 2 points if their quality performance improves significantly compared to that in the previous year. This scoring methodology remains constant through the five years of CJR. Hospitals are also assigned a prospective target price at the start of each performance year. For years 1 and 2 the price was two-

JAMA Network | Open

Original Investigation | Health Policy

Association of the Comprehensive Care for Joint Replacement Model With Disparities in the Use of Total Hip and Total Knee Replacement

Caroline P. Thirukumaran, MBBS, MHA, PhD; Yeunkyung Kim, PhD; Xueya Cai, PhD; Benjamin F. Ricciardi, MD; Yue Li, PhD; Kevin A. Fiscella, MD, MPH; Addisu Mesfin, MD; Laurent G. Glance, MD

Abstract

IMPORTANCE The Comprehensive Care for Joint Replacement (CJR) model is Medicare's mandatory bundled payment reform to improve quality and spending for beneficiaries who need total hip replacement (THR) or total knee replacement (TKR), yet it does not account for sociodemographic risk factors such as race/ethnicity and income. Results of this study could be the basis for a Medicare payment reform that addresses inequities in joint replacement care.

OBJECTIVE To examine the association of the CJR model with racial/ethnic and socioeconomic disparities in the use of elective THR and TKR among older Medicare beneficiaries after accounting for the population of patients who were at risk or eligible for these surgical procedures.

DESIGN, SETTING, AND PARTICIPANTS This cohort study used the 2013 to 2017 national Medicare data and multivariable logistic regressions with triple-differences estimation. Medicare beneficiaries who were aged 65 to 99 years, entitled to Medicare, alive at the end of the calendar year, and residing either in the 67 metropolitan statistical areas (MSAs) mandated to participate in the CJR model or in the 104 control MSAs were identified. A subset of Medicare beneficiaries with a diagnosis of ar

EXP

MAI
bene
post
non-
regr
time

RES
resic
com
eligi
non-
2.28
the (
asso
non-

point increase for non-Hispanic White dual-eligible beneficiaries, a 0.15 (95% CI, −0.29 to −0.01; $P = .04$) percentage-point decrease for non-Hispanic Black non-dual-eligible beneficiaries, and a 0.18 (95% CI, −0.34 to −0.01; $P = .03$) percentage-point decrease for non-Hispanic Black dual-eligible

(continued)

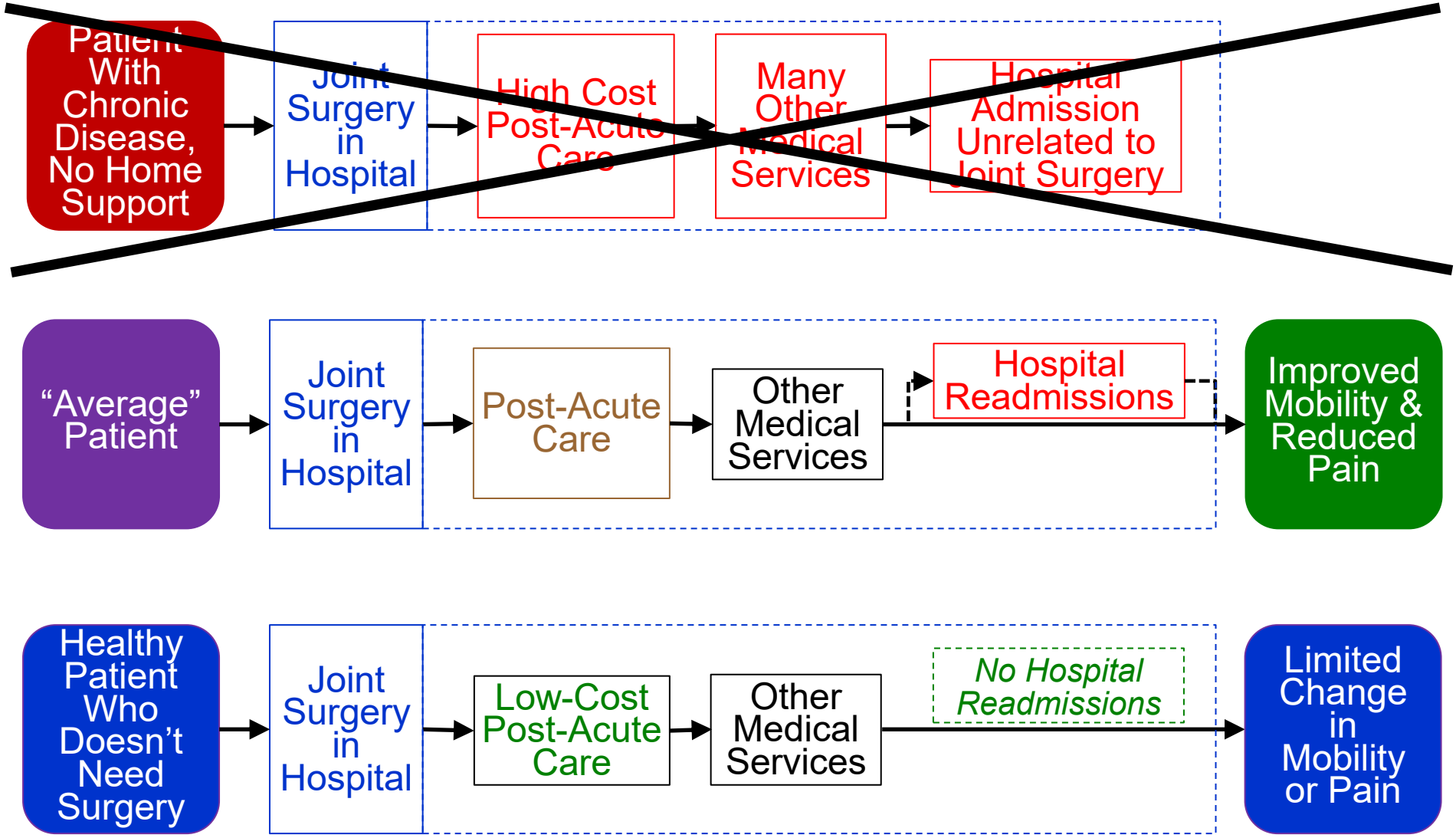
Key Points

Question Is the Comprehensive Care for Joint Replacement (CJR) model associated with worsening of racial/ethnic and socioeconomic disparities in total hip replacement or total knee replacement use among older Medicare beneficiaries?

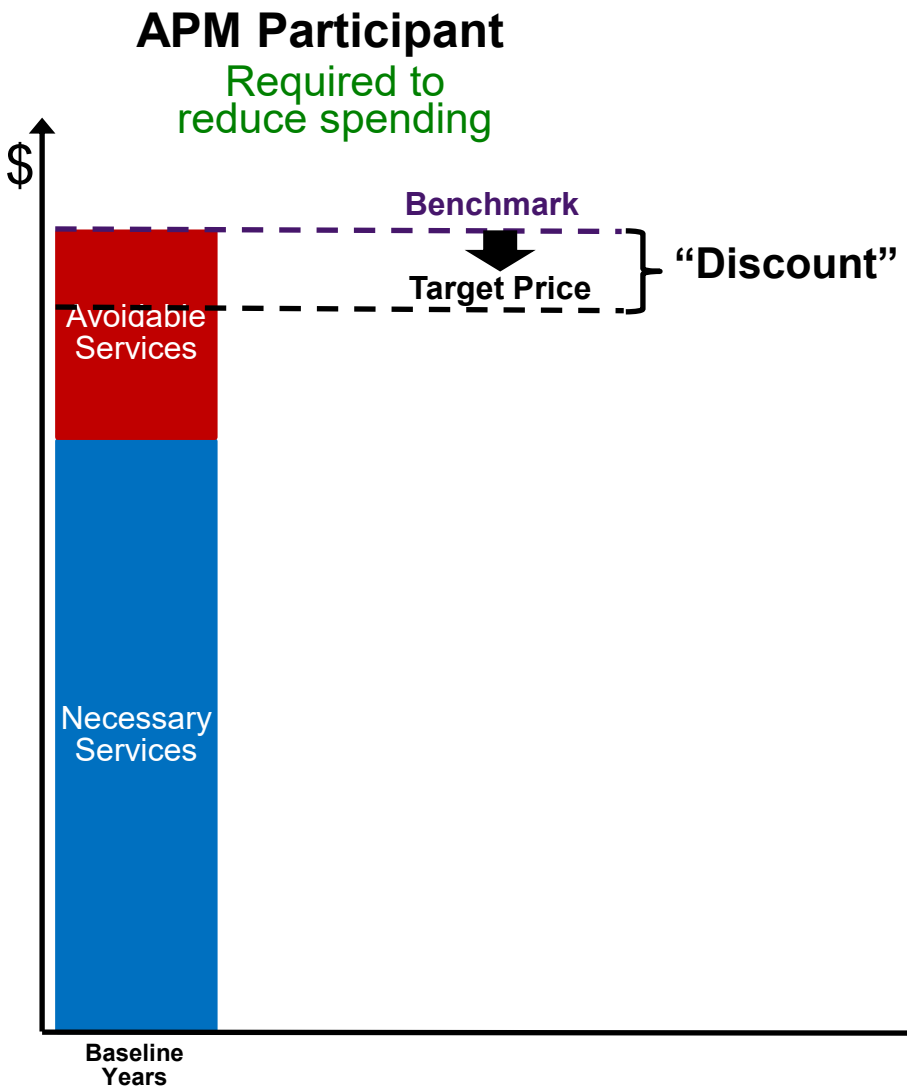
Findings In this cohort study of 4 447 205 Medicare beneficiaries, the CJR model was associated with an increase in total knee replacement use for non-Hispanic White beneficiaries and a decrease for non-Hispanic Black beneficiaries. The CJR model was also associated with widening of the gap in

"The [Comprehensive Care for Joint Replacement] model may have been associated with worsening of racial/ethnic and socioeconomic disparities in [Total Knee Replacement] use."

Mandating Participation Means High-Need Patients Won't Get Care



CMMI APMs Require a "Discount" on Spending Below the Benchmark

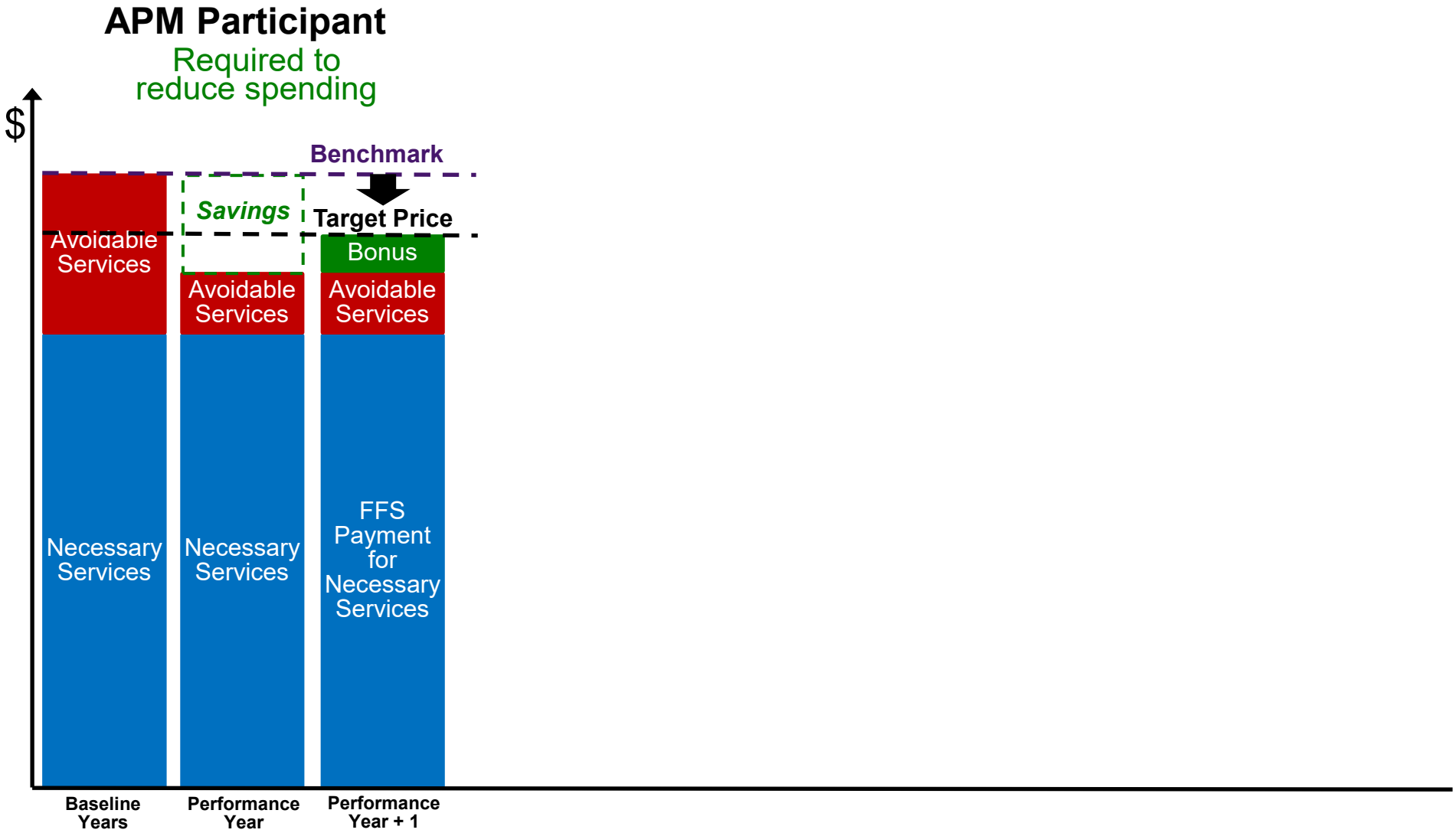


In contrast to the Medicare Shared Savings Program which merely *encourages* providers to reduce spending below past (benchmark) levels, CMMI tries to *guarantee* savings in APMs by requiring a "discount."

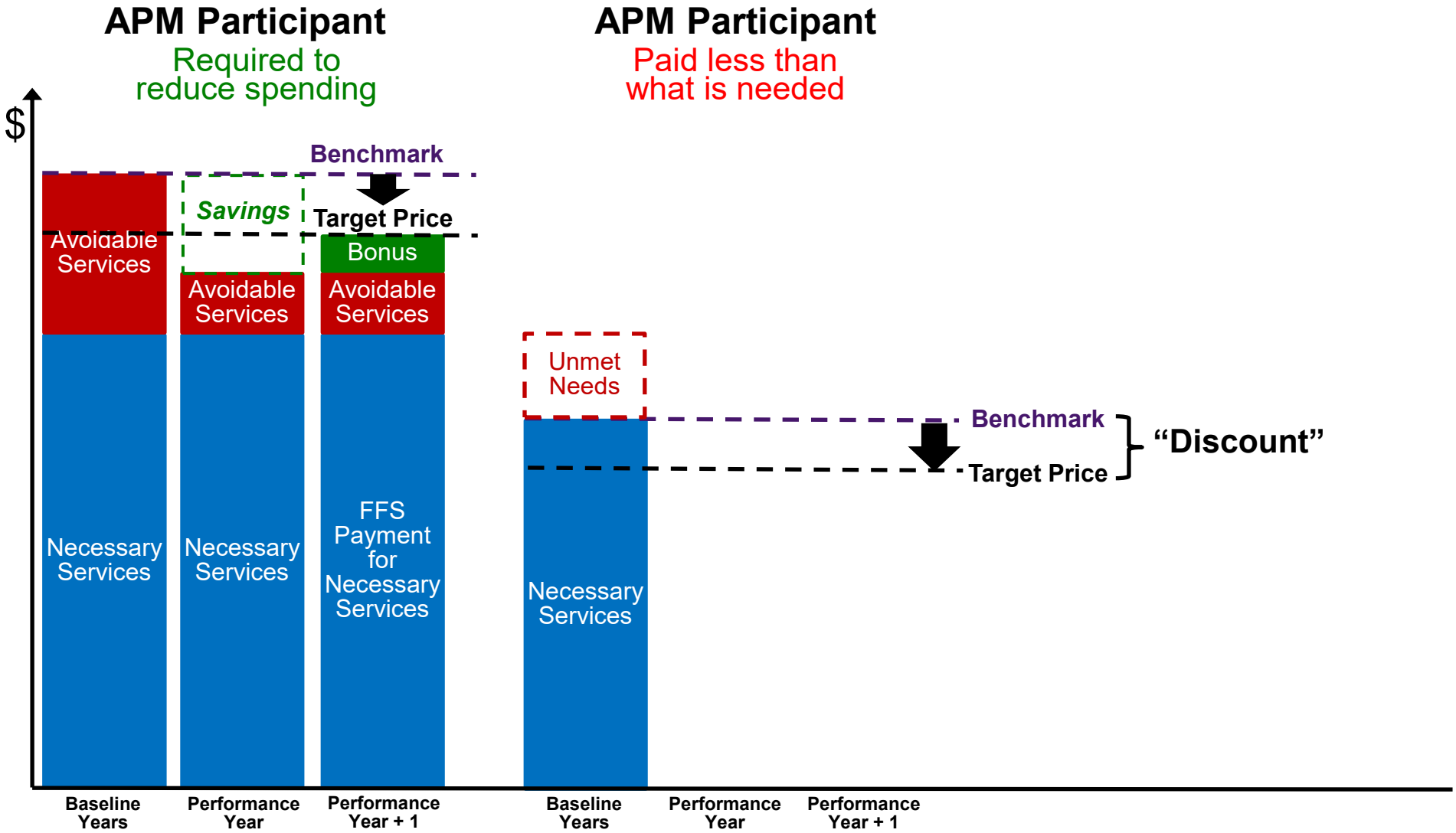
The discount is an arbitrary number (e.g., 2-3%) that applies to all APM participants regardless of whether the APM patients are currently receiving more or fewer services than they need.

Consequently, the "Target Price" may be higher or lower than what is needed for high-quality patient care.

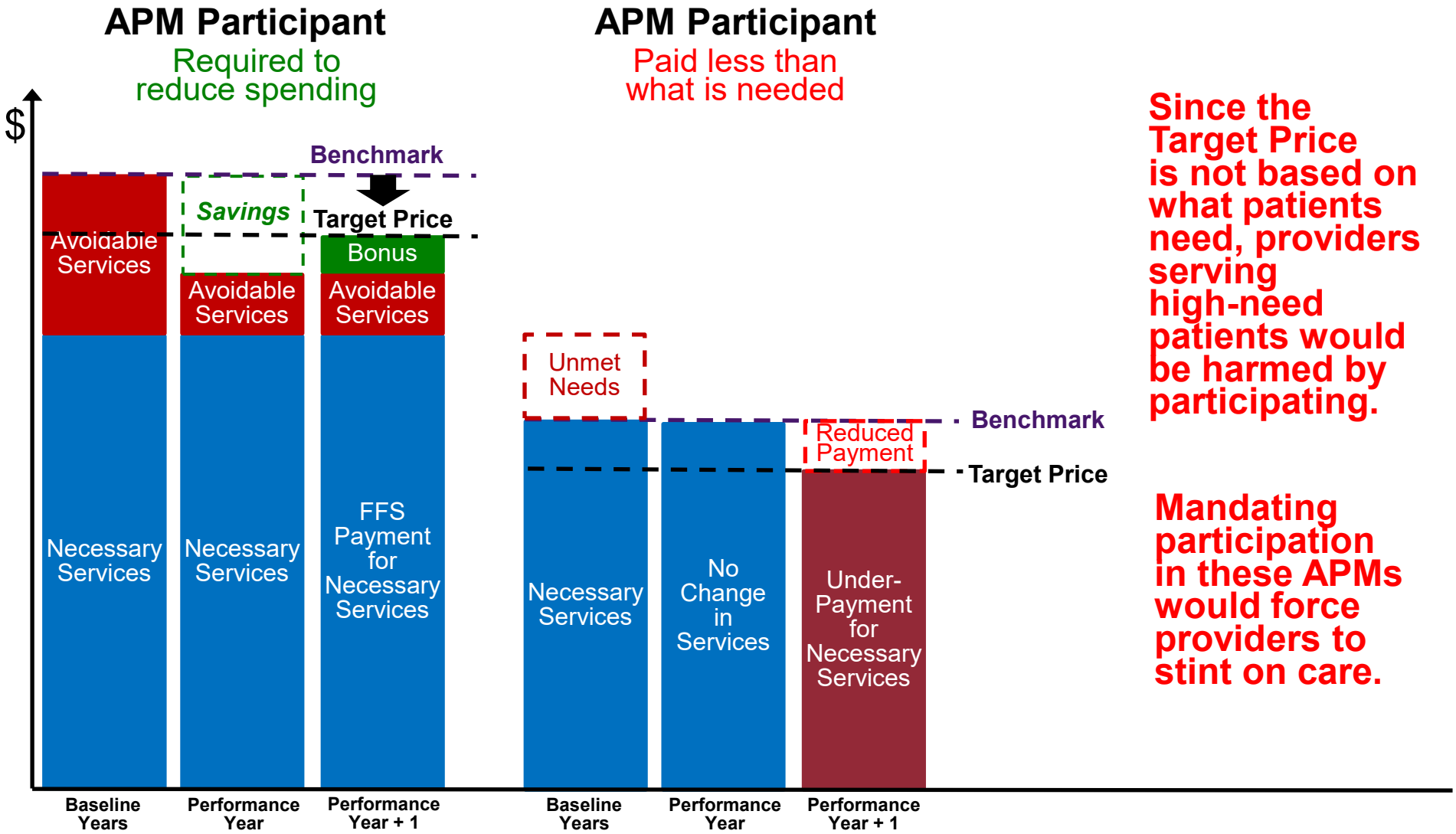
APM Participant is Only Rewarded if Spending < "Target Price"



CMMI Demands a Discount Even if Patients Need More Services



APM Participant May Be Underpaid For Delivering Necessary Care



Since the Target Price is not based on what patients need, providers serving high-need patients would be harmed by participating.

Mandating participation in these APMs would force providers to stint on care.

The Wrong Diagnosis Results in the Wrong Treatment & No Cure

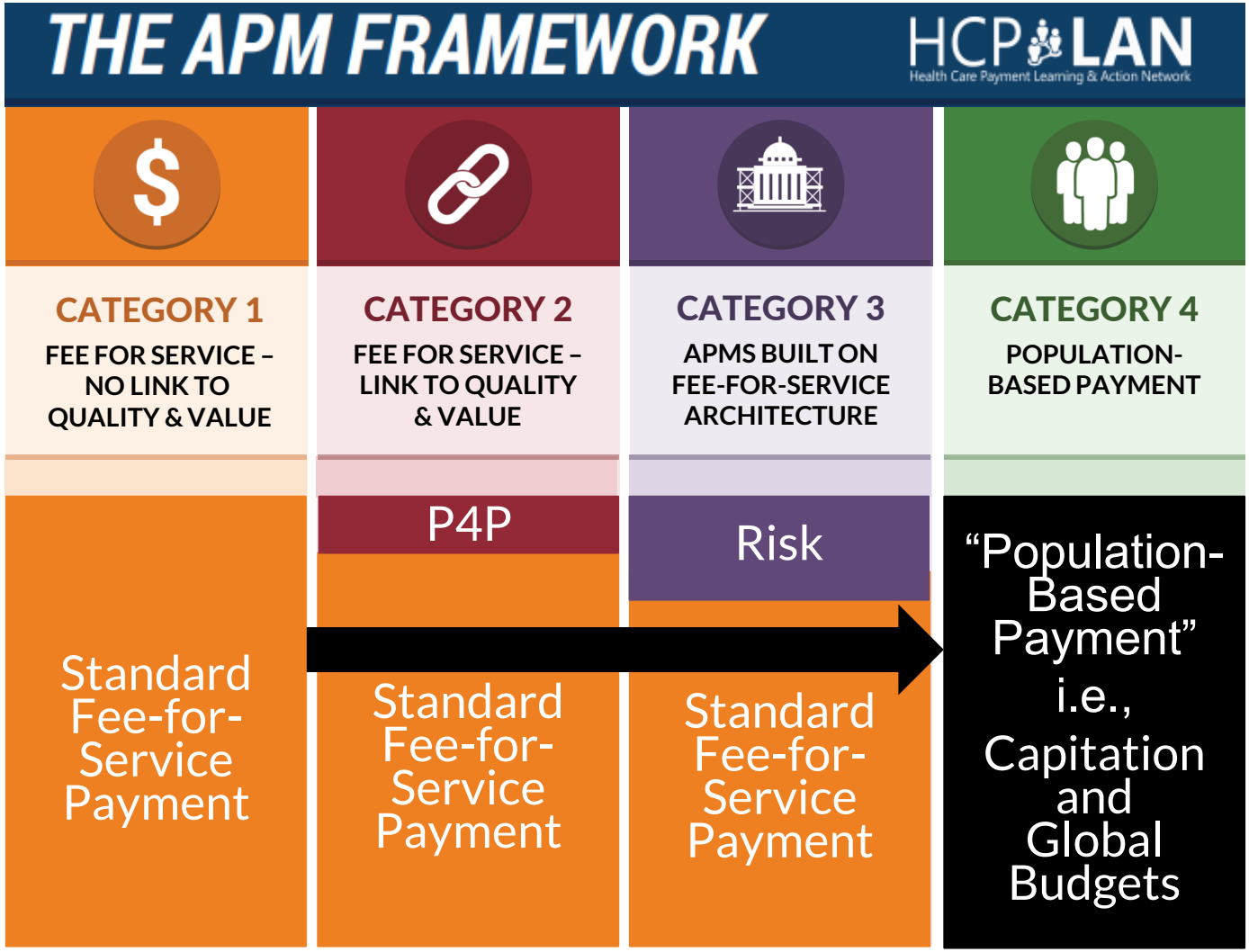
WRONG Diagnosis	Wrong Cure
"Voluntary models…limit the potential savings…because participants opt in when they believe they will benefit financially and opt out (or never join) when they believe they are at risk for losses."	Mandatory participation in CMS APMs

We Need Better Payment Models, Not Mandates for Bad Ones

~~WRONG Diagnosis~~	~~Wrong Cure~~
~~"Voluntary models…limit the potential savings…because participants opt in when they believe they will benefit financially and opt out (or never join) when they believe they are at risk for losses."~~	~~Mandatory participation in CMS APMs~~

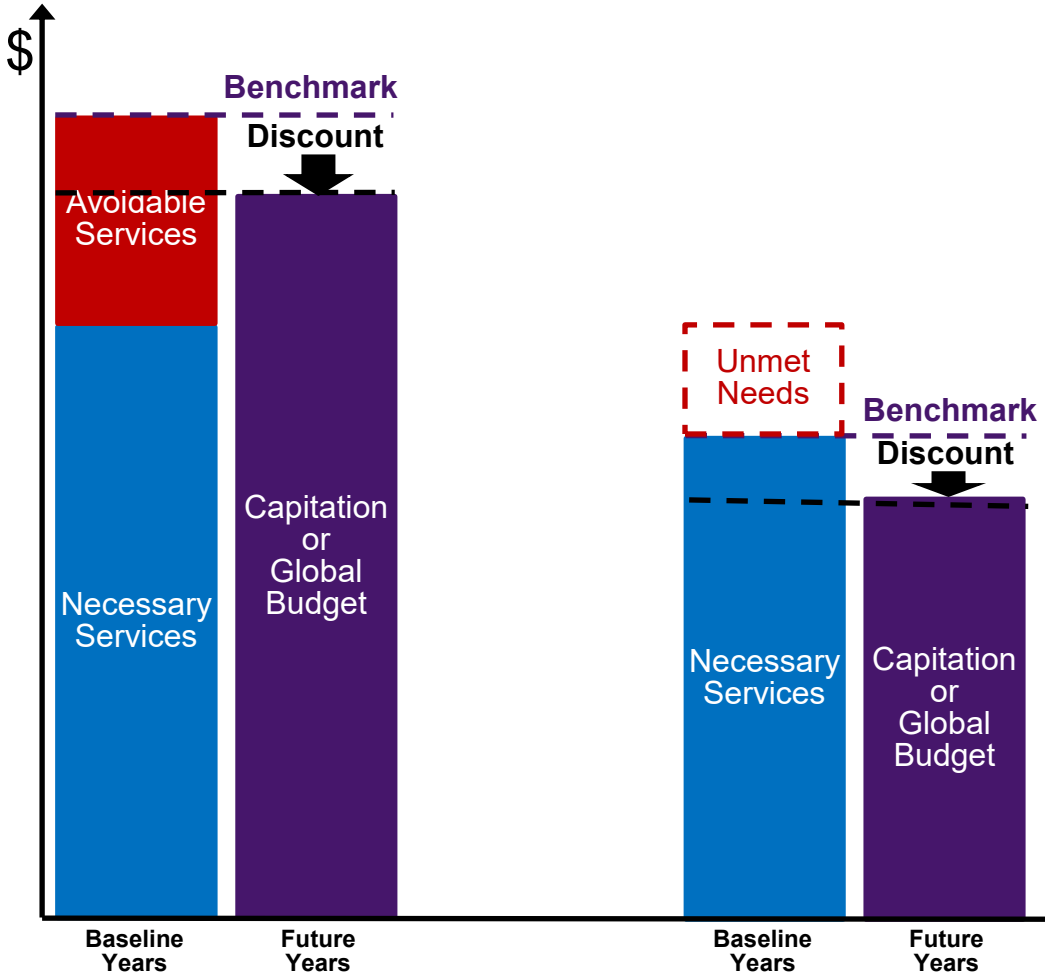
CORRECT Diagnosis	CORRECT Cure
CMS models penalize providers who care for higher-need patients and who deliver only necessary services.	Develop better payment models that enable providers to deliver high-quality care to all types of patients

CMS & Health Plans Say the Ideal is "Population-Based Payment"



"Population-Based Payment" Transfers Full Risk to Providers

Population-Based Pmt (Capitation/Global Budget)



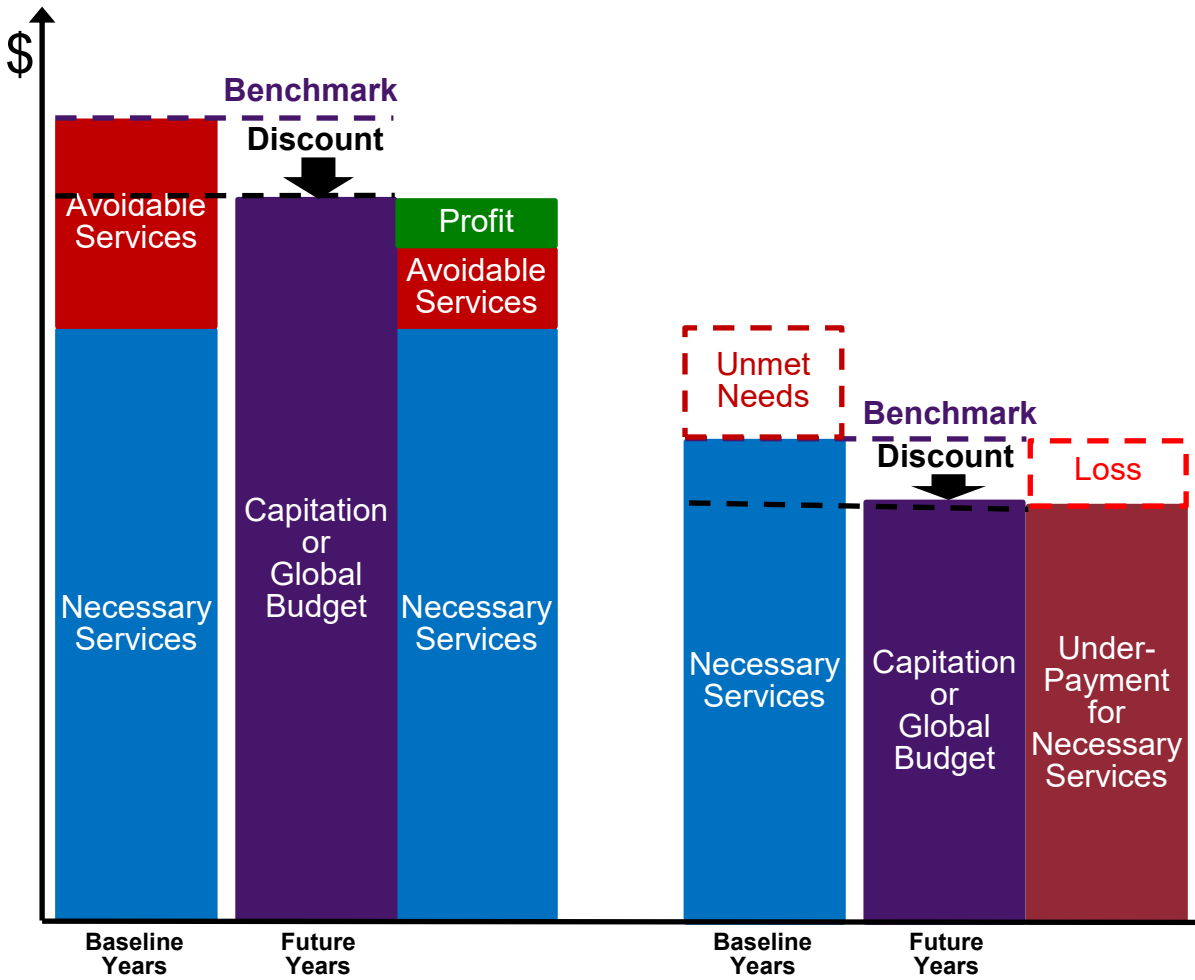
CMMI calculates capitation and global budget amounts by taking historical FFS payments and reducing them by a "discount" to guarantee Medicare savings.

The discount is an arbitrary number (e.g., 2-3%) that applies to all participants regardless of whether the patients are currently receiving more or fewer services than they need.

Consequently, the payments may be higher or lower than what is needed for high-quality patient care.

All of the Problems of APMs & Risk-Payment Are Magnified

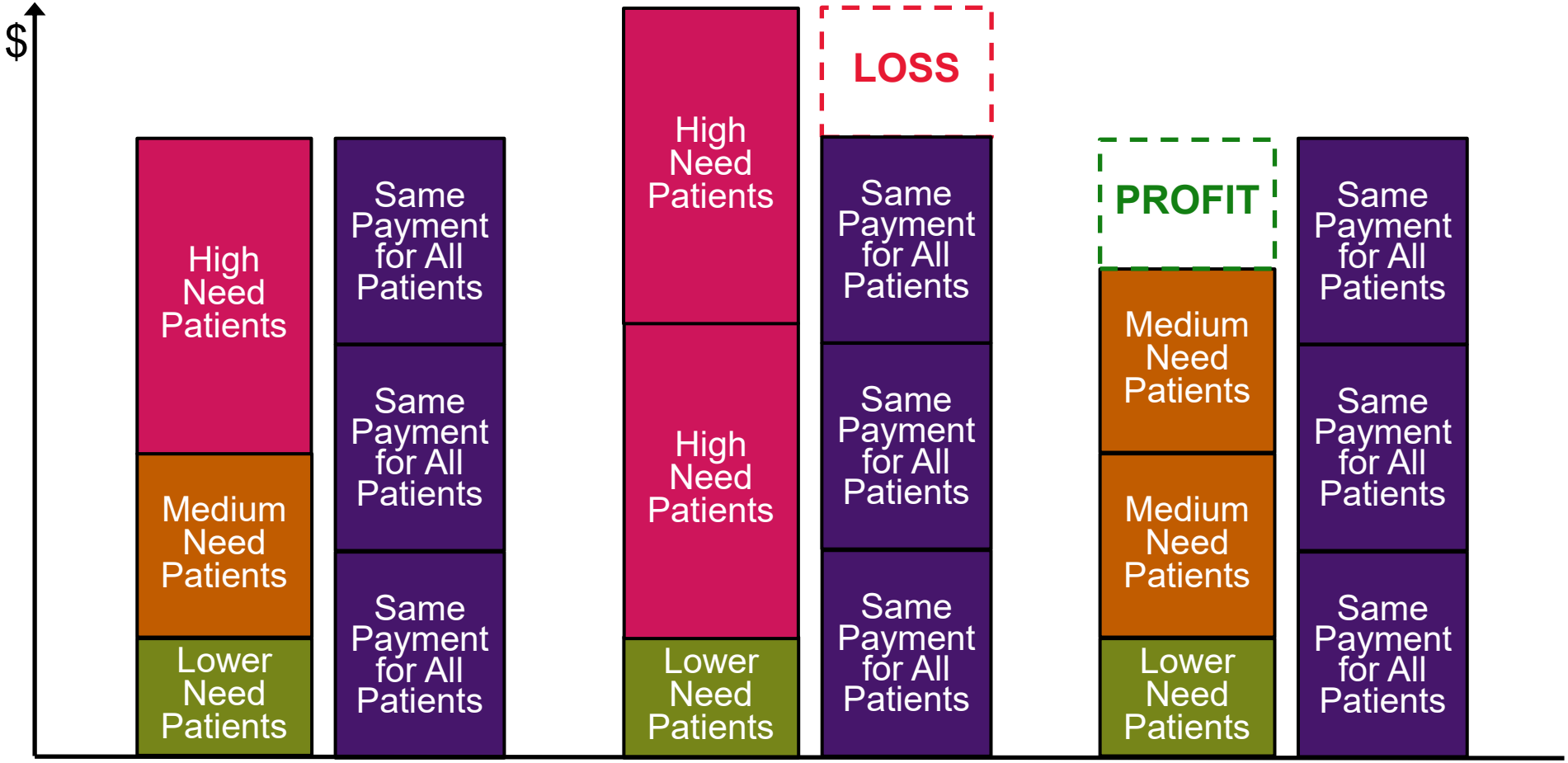
Capitation/Global Budget



Since the capitation payment or global budget is based on providers were paid in the past, not on what patients need, providers serving high-need patients would be harmed by participating.

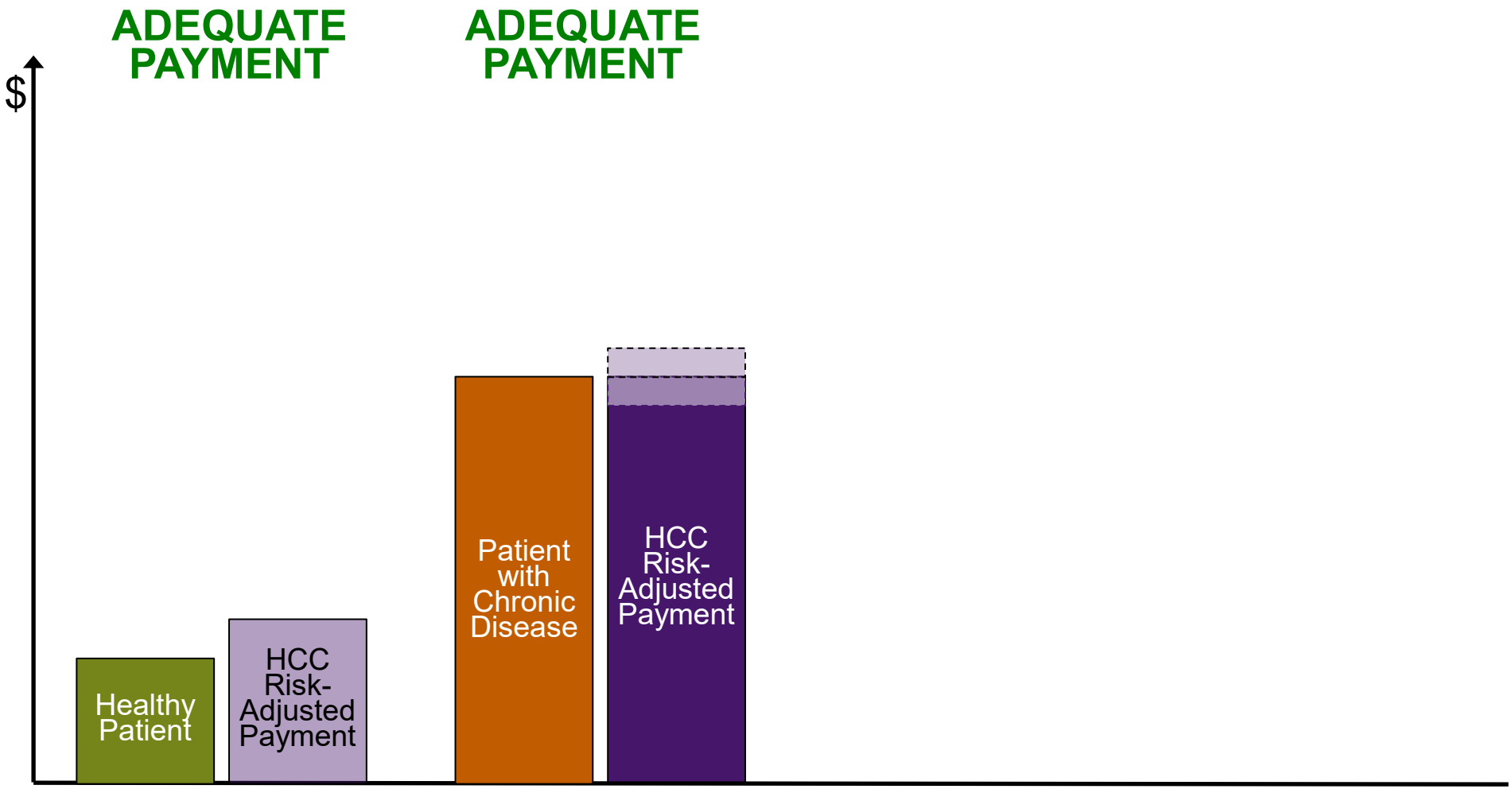
Mandating participation would force providers to stint on care.

Under Capitation Payment:
Cherry-Picking Patients = Profits

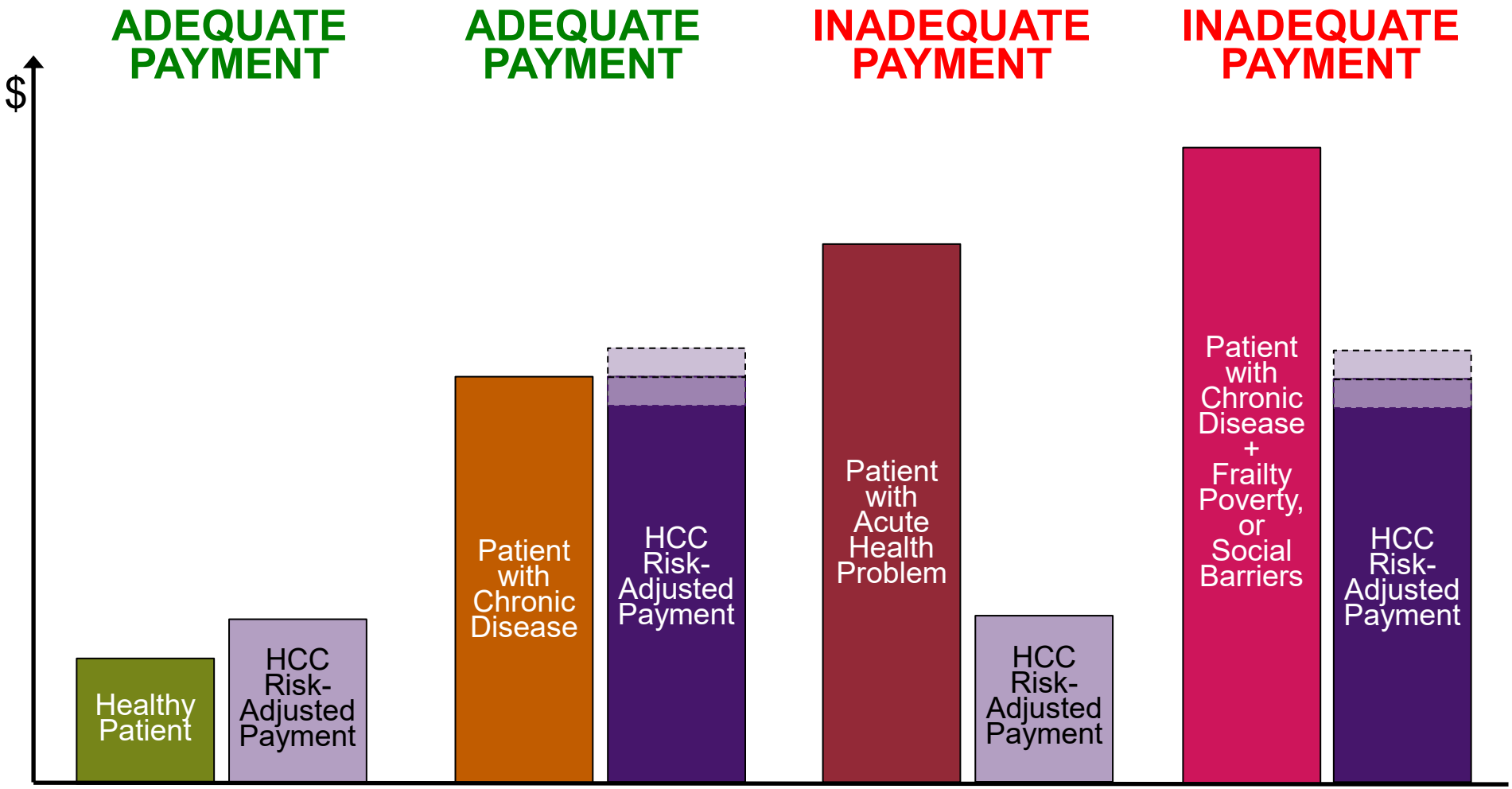


Won’t Risk-Adjustment Ensure Payments are Adequate?

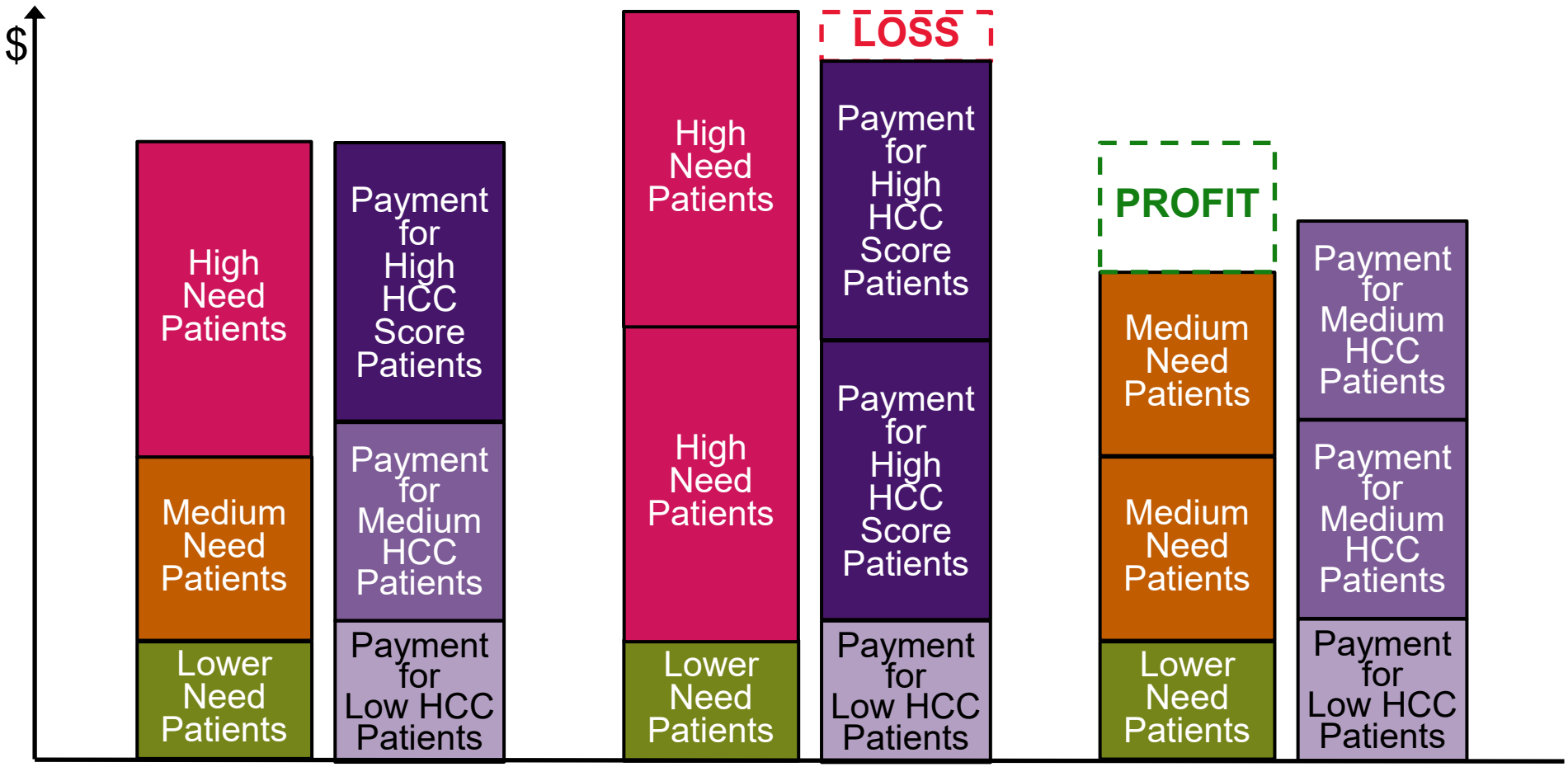
CMS's HCC Risk Adjustment Pays More for Chronic Diseases



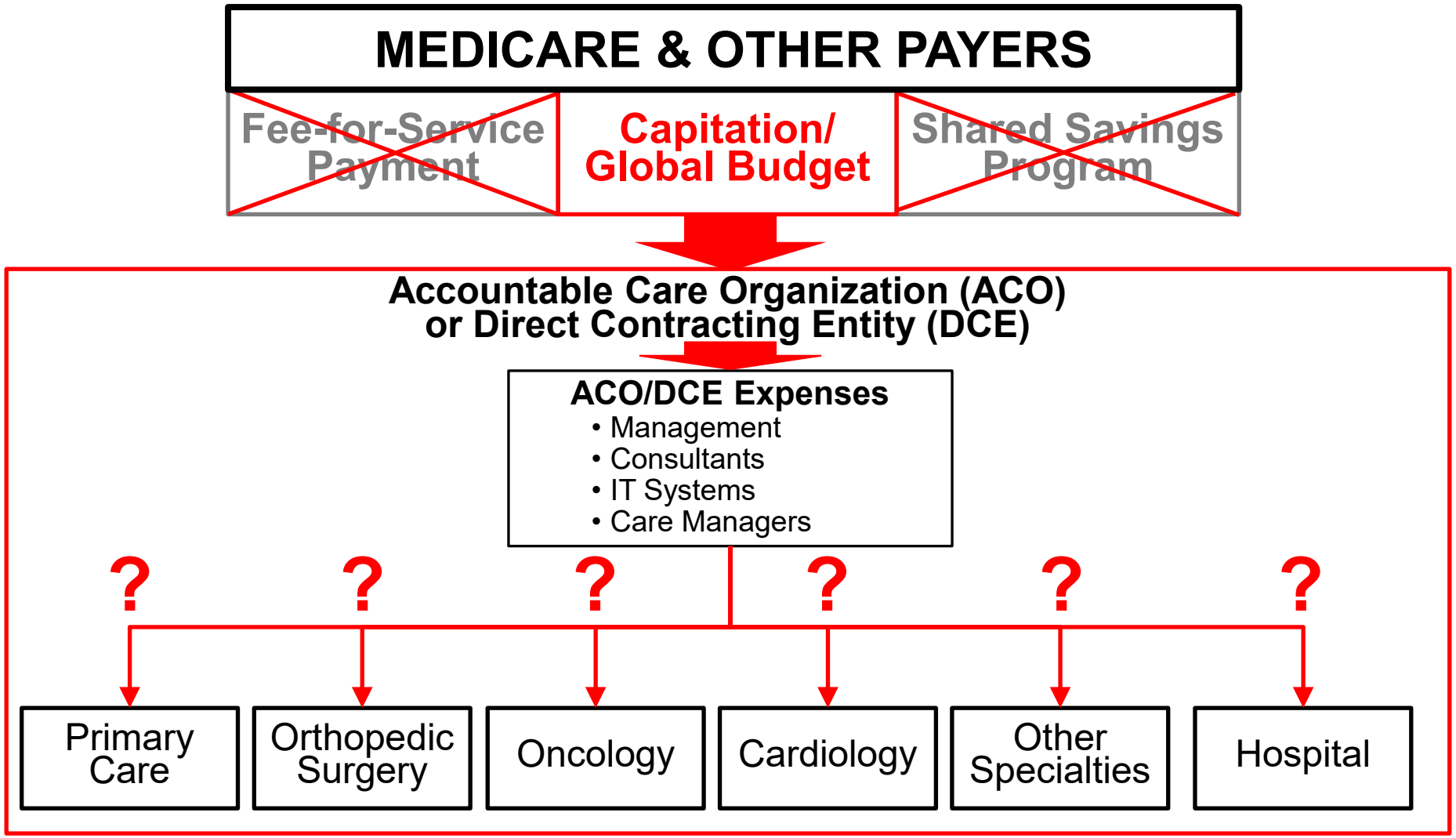
No Adjustment for Acute Conditions or Social Determinants of Health



Under Risk-Adjusted Capitation: Cherry-Picking Patients = Profits



How Will Physicians and Hospitals Be Paid Under Capitation??



The Risks to Patients Under Capitation Are Well Known

"Capitation rewards the denial of appropriate services, the dumping of the chronically ill, and a narrow scope of practice that refers out every time-consuming patient."

Robinson JC. "Theory and Practice in the Design of Physician Payment Incentives." *The Milbank Quarterly* 79(2):149-177

"...primary care capitation designs might encourage physicians to refer patients to other clinicians paid outside of the primary care capitation arrangement. Unnecessary referrals, in addition to increasing overall costs, could lead to fragmented, impersonal care – the consequence capitation is supposed to reduce.."

Berenson RA et al. *Refining the Framework for Payment Reform.* Robert Wood Johnson Foundation and Urban Institute

Problems with Risk Adjustment Can Increase Disparities in Care

ACCOUNTABLE CARE

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

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

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

ABSTRACT **The Medicare Shared Savings Program (MSSP) adjusts savings benchmarks by beneficiaries' baseline risk scores. To discourage increased coding intensity, the benchmark is not adjusted upward if beneficiaries' risk scores rise while in the MSSP. As a result, accountable care organizations (ACOs) have an incentive to avoid increasingly sick or expensive beneficiaries. We examined whether beneficiaries' exposure to the MSSP was associated with within-beneficiary changes in risk scores and whether risk scores were associated with entry to or exit from the MSSP. We found that the MSSP was not associated with consistent changes in within-beneficiary risk scores. Conversely, beneficiaries at the ninety-fifth percentile of risk score had a 21.6 percent chance of exiting the MSSP, compared to a 16.0 percent chance among beneficiaries at the fiftieth percentile. The decision not to upwardly adjust risk scores in the MSSP has successfully deterred coding increases but might discourage ACOs to care for high-risk beneficiaries in the MSSP.**

Encouraging organizations to care for high-risk beneficiaries while holding them accountable for spending and health outcomes is a central tension of payment reform.[1] In the Medicare Shared Savings Program (MSSP), accountable care organizations (ACOs) are eligible to receive shared savings bonuses if they lower spending below a financial benchmark based on the historical spending of the beneficiaries attributed to them. To avoid penalizing ACOs that care for beneficiaries with greater medical complexity and predicted spending, an ACO's financial benchmark is adjusted using each beneficiary's Hierarchical Condition Categories (HCC) risk score. To minimize ACOs' incentives to raise benchmarks by increased diagnostic coding, the benchmark is not adjusted upward if the risk score rises while the beneficiary is in the MSSP.[2–4] If the risk score falls, however, the benchmark is adjusted downward.

It is unknown whether the approach of the Centers for Medicare and Medicaid Services (CMS) to risk adjustment has appropriately balanced incentives for ACOs to care for high-risk beneficiaries against incentives to avoid increased coding intensity in the MSSP. Because CMS's approach does not capture growth in risk scores over time, many commenters have expressed concern during rule making that ACOs retain an incentive to avoid chronically or acutely ill beneficiaries.[2–4] For instance, ACOs may deliberately drop clinicians with high-risk beneficiary panels.[5] ACOs may also prevent high-risk beneficiaries from being attributed to them by submitting claims that cannot lead to attribution, submitting claims from a provider ineligible to participate in the MSSP (for example, a urologist), or billing under a provider group not included in the ACO's provider participant list.

At the same time, ACOs have an incentive to maintain their current levels of coding intensity.

Adam A. Markovitz is an MD-PhD candidate in the Department of Health Management and Policy, University of Michigan School of Public Health, and the University of Michigan Medical School, in Ann Arbor.

John M. Hollingsworth is an associate professor in the Dow Division of Health Services Research, Department of Urology, University of Michigan Medical School, in Ann Arbor.

John Z. Ayanian is the Alice Hamilton Collegiate Professor of Medicine in the Department of Internal Medicine, University of Michigan Medical School.

Edward C. Norton is a professor in the Department of Health Management and Policy in the University of Michigan School of Public Health, in Ann Arbor.

Nicholas M. Moloci is a senior statistician in the Dow Division of Health Services Research, Department of Urology, University of Michigan Medical School.

Phyllis L. Yan is a statistician in the Dow Division of Health Services Research, Department of Urology, University of Michigan Medical School.

Andrew M. Ryan (amryan@umich.edu) is the UnitedHealthcare Professor of Health Care Management in the Department of Health Management and Policy, University of Michigan School of Public Health.

The Journal of Arthroplasty 33 (2018) 2722–2727

Contents lists available at ScienceDirect

The Journal of Arthroplasty

journal homepage: www.arthroplastyjournal.org

ELSEVIER

Health Policy & Economics

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

Check for updates

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

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

ARTICLE INFO

Article history:
Received 11 February 2018
Received in revised form
28 March 2018
Accepted 2 April 2018
Available online 19 April 2018

Keywords:
bundled payments
hip arthroplasty
knee arthroplasty
CJR
risk stratification
reimbursement

ABSTRACT

Background: Bundled payments are meant to reduce costs and improve quality of care. Without adequate risk adjustment, bundling may be inequitable to providers and restrict access for certain patients. This study examines patient factors that could improve risk stratification for the Comprehensive Care for Joint Replacement (CJR) bundled-payment program.
Methods: Ninety-five thousand twenty-four patients meeting the CJR criteria were retrospectively reviewed using administrative Medicare data. Multivariable regression was used to identify associations between patient factors and traditional (fee-for-service) Medicare reimbursement over the bundle period.
Results: Average reimbursement was $18,786 ± $12,386. Older age, male gender, cases performed for hip fractures, and most comorbidities were associated with higher reimbursement ($P < .05$), except dementia (lower reimbursement; $P < .01$). Stratification incorporating these factors displayed greater accuracy than the current CJR risk adjustment methods ($R^2 = 0.23$ vs 0.17).
Conclusion: More robust risk stratification could provide more equitable reimbursement in the CJR program.
Level of Evidence: Large database analysis; Level III.

Bundled-payment programs have been designed and implemented by the Centers for Medicare and Medicaid Services (CMS) to replace fee-for-services reimbursement, which has been associated with increased spending. Bundled payments have been proposed as a method to decrease costs, and in theory, improve the coordination and quality of patient care. The field of orthopedic surgery has been a popular target for bundled payments as total joint arthroplasty contributes to 5.7% of Medicare expenditures, which is the biggest expense for treatment of a single diagnosis [1]. To date, the Comprehensive Care for Joint Replacement (CJR) program is the most noteworthy bundle in orthopedics. Implemented on April 1, 2016 for lower extremity joint arthroplasty, it was initially mandatory in 67 metropolitan areas across the United States. As part of this mandate, hospitals are responsible for costs associated with the surgery and a 90-day postoperative period. Penalties are imposed for hospitals with above-average reimbursement, while hospitals with lower reimbursement are rewarded. Despite the relative infancy of the program, there have already been significant decreases in costs as well as significant reductions in length of stay and discharges to inpatient facilities [2–5]. Still, it is too early to deem the current structure a success.

In the absence of sufficient risk stratification, bundled payments can have negative effects on treatment with inequitable reimbursement, especially for patients with significant health problems. Under the current program, payments are stratified according to the Diagnosis-Related Group (DRG) codes, geography, and the presence of a fracture [6]. However, previous reports have concluded that this proposal is inadequate [7–10]. Furthermore, the CJR bundled payments could incentivize hospitals to treat patients who are more profitable and artificially create barriers to care for certain patient populations. For example, 94% of joint arthroplasty surgeons surveyed thought bundled payments could provide an incentive to avoid high-risk patients [11]. Although it is crucial to reduce costs and improve overall patient care, this process should

One or more of the authors of this paper have disclosed potential or pertinent conflicts of interest, which may include receipt of payment, either direct or indirect, institutional support, or association with an entity in the biomedical field which may be perceived to have potential conflict of interest with this work. For full disclosure statements refer to https://doi.org/10.1016/j.arth.2018.04.006.

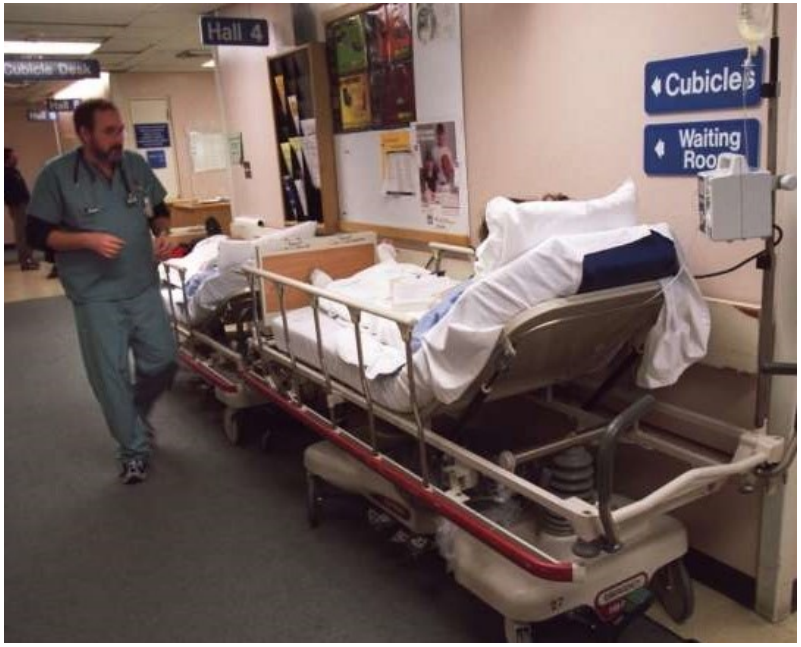
* Reprint requests: Mark A Cairns, MD, MS, Department of Orthopaedics, University of North Carolina Health Care, 8012 Mackenzie Court, Durham, NC 27713.

https://doi.org/10.1016/j.arth.2018.04.006
0883-5403/

Global Budgets = "Hallway Healthcare" in Canada

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

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



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

Think It Can't Happen in U.S.? Think Again…

Modern Healthcare

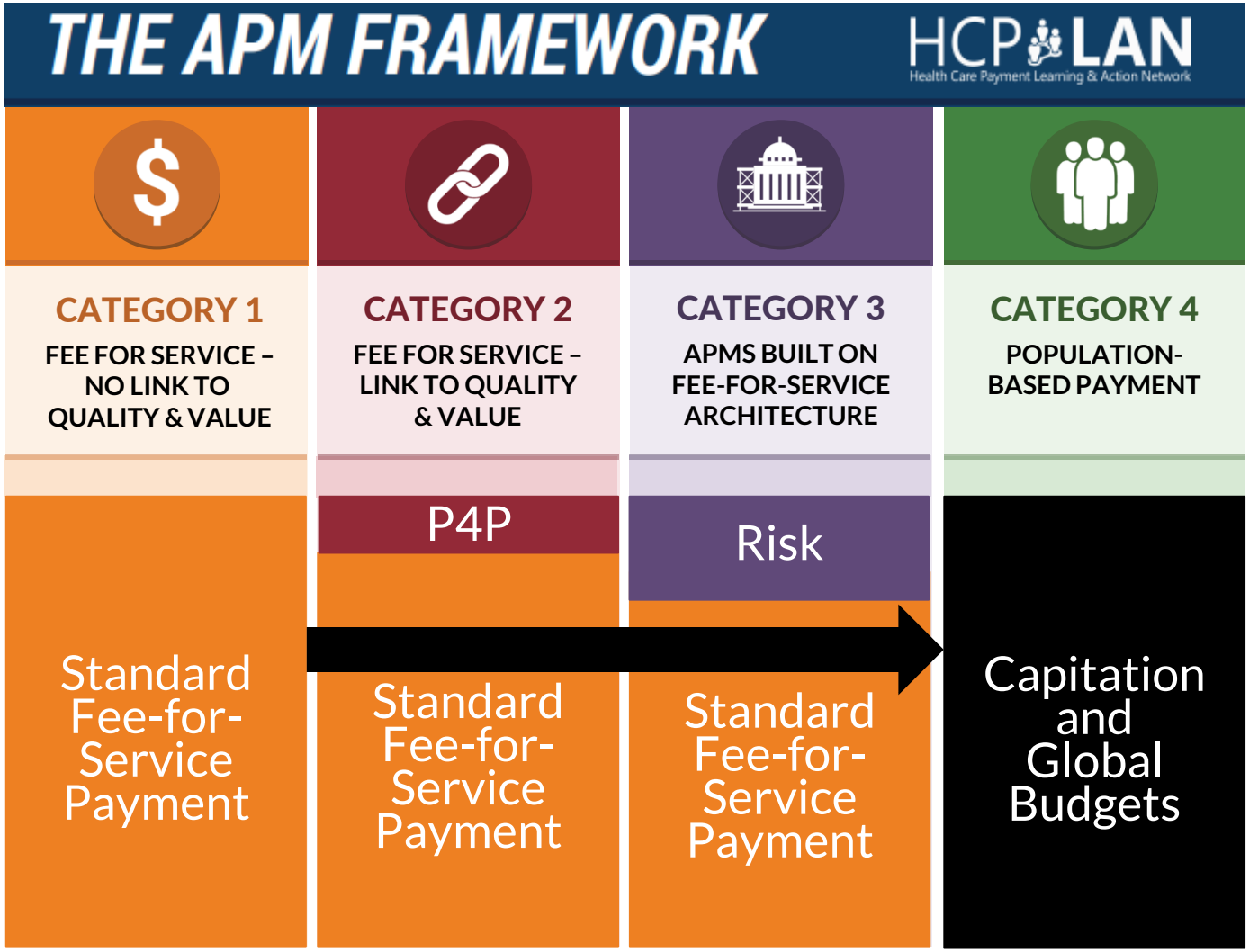
August 31, 2021 04:24 PM | 15 HOURS AGO

Hospitals say Medicare Advantage delays contribute to backlogs

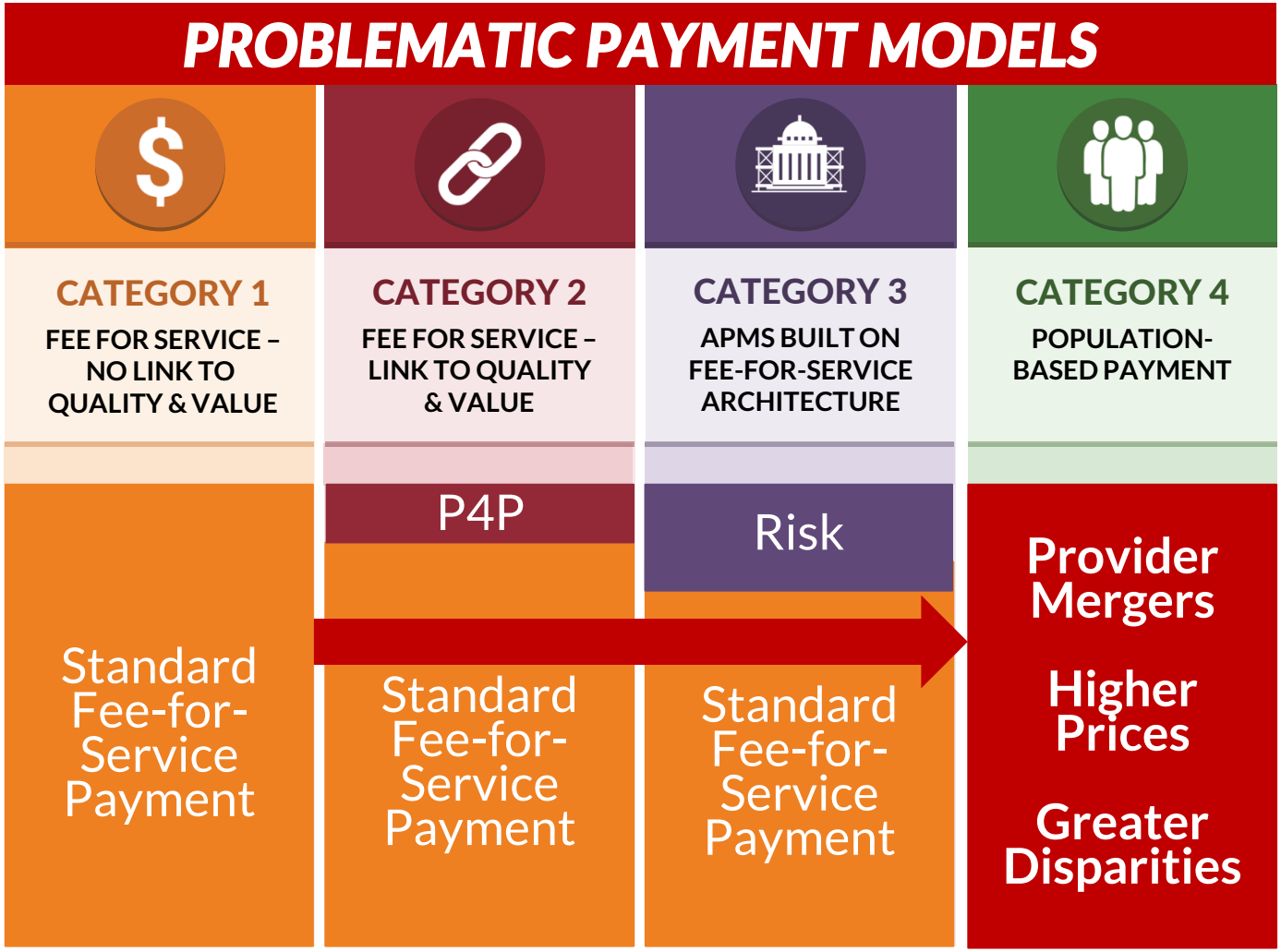
Hospitals in states with high COVID-19 case rates say restrictions set by Medicare Advantage plans are making it hard for them to discharge patients to other providers, exacerbating bed shortages.

The issue centers on the plans' prior authorization requirements for post-acute care. Hospitals in states like Florida, Louisiana and Oregon say Medicare Advantage plans have always been slow to approve care, but the problem is especially harmful during the pandemic, when they need to free up beds for new patients as quickly as possible.

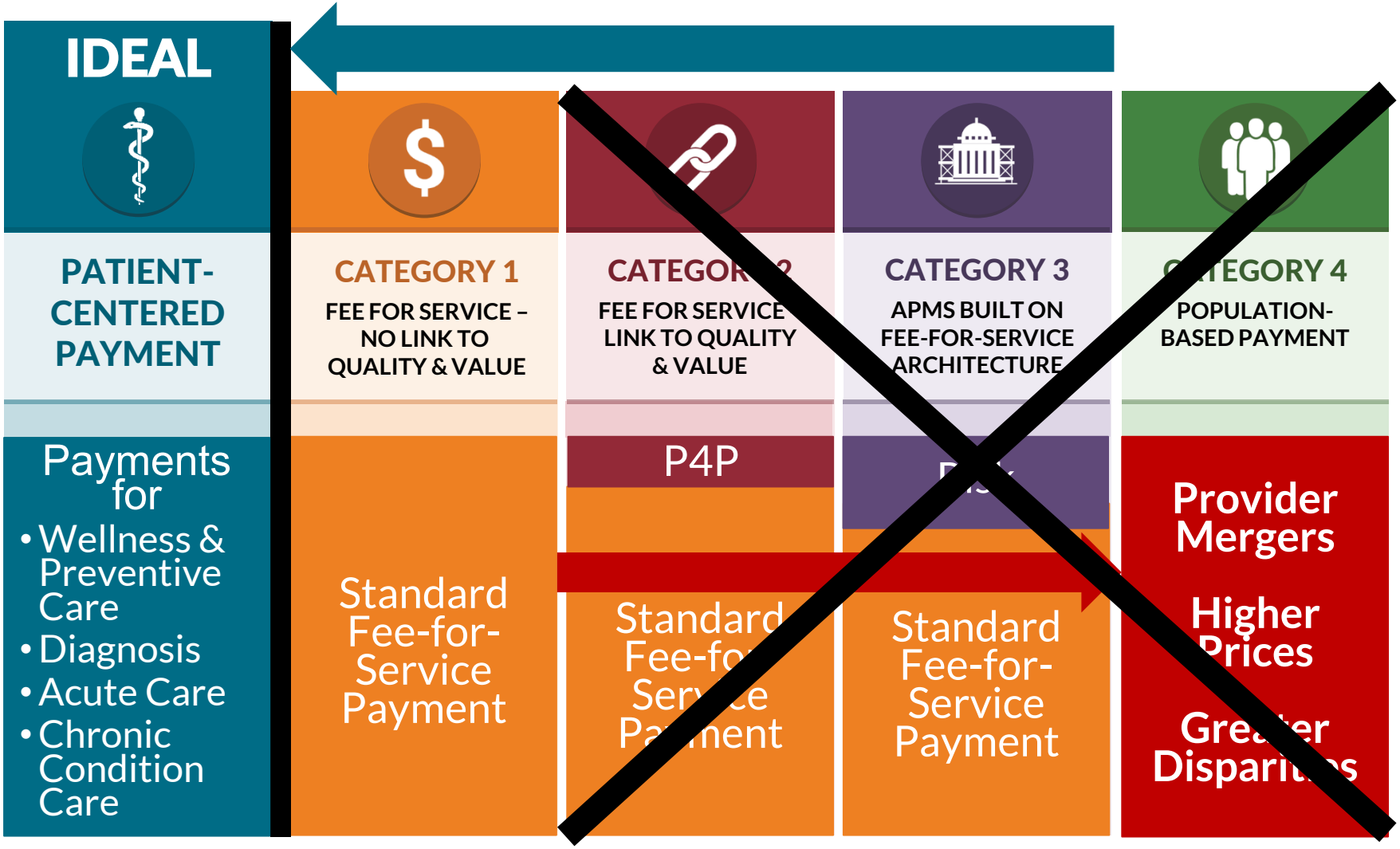
This is NOT a Good "Framework" for Fixing Healthcare Payment…



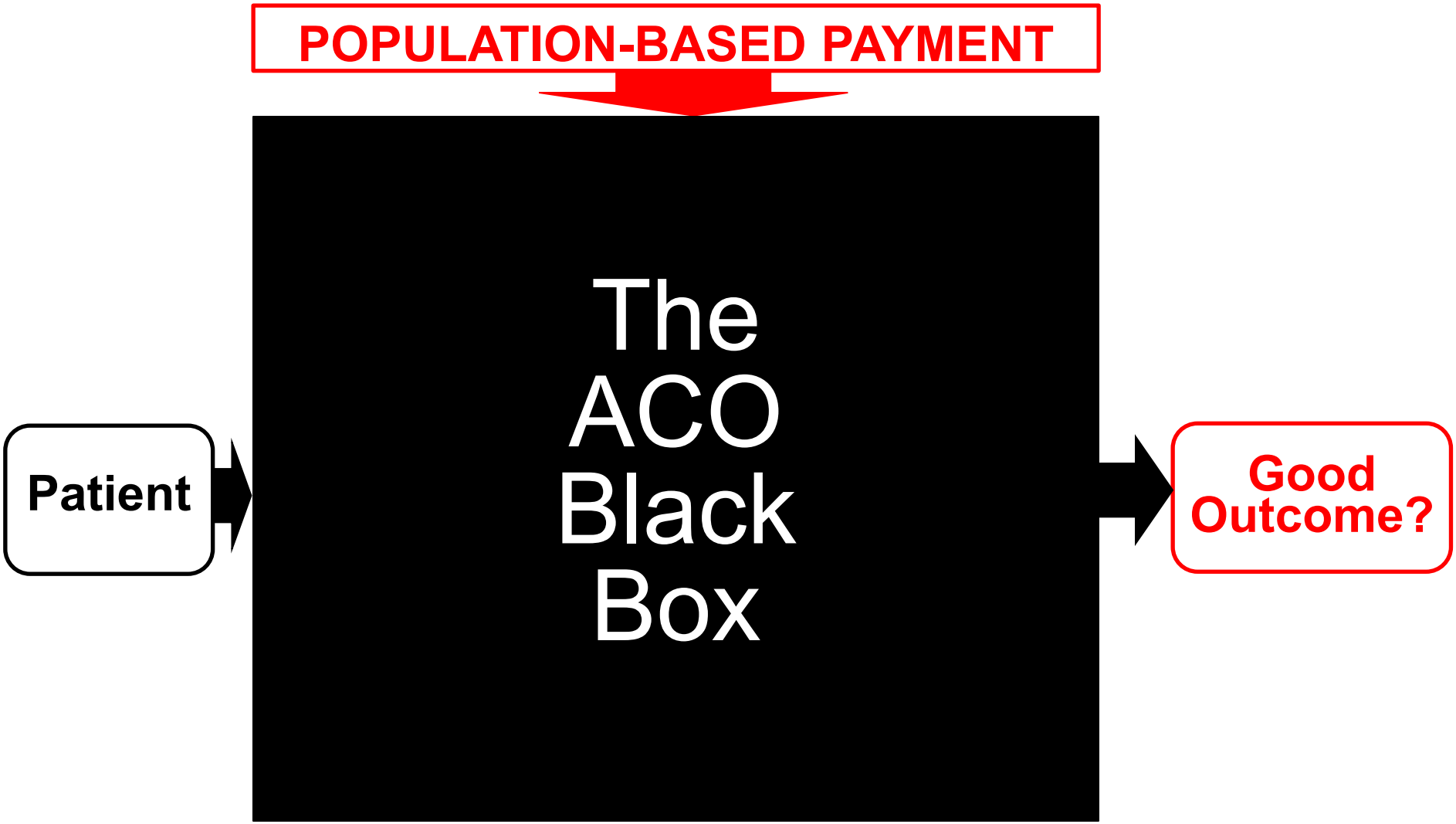
…And Following It Will Likely Make Things Worse, Not Better



We Need a Different Direction: *Patient-Centered Payment*



Instead of Sending Patients into a Black Box & Hoping for the Best…



…*Each* Patient Should Receive *All* of the Services They *Need*

Patient-Specific *Needs*

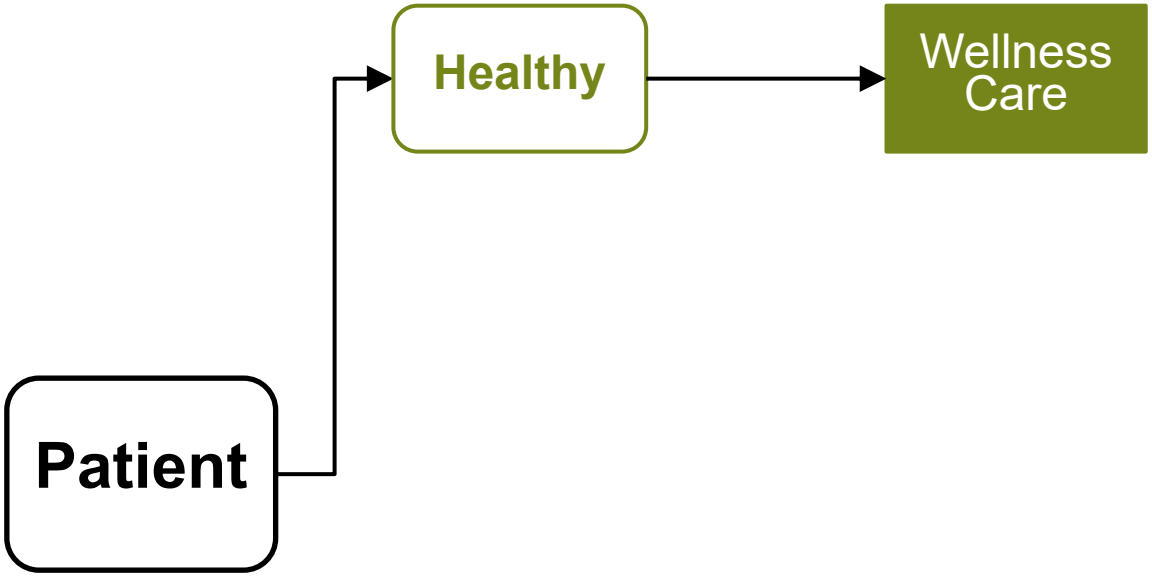
Patient-Centered *Care*

Patient

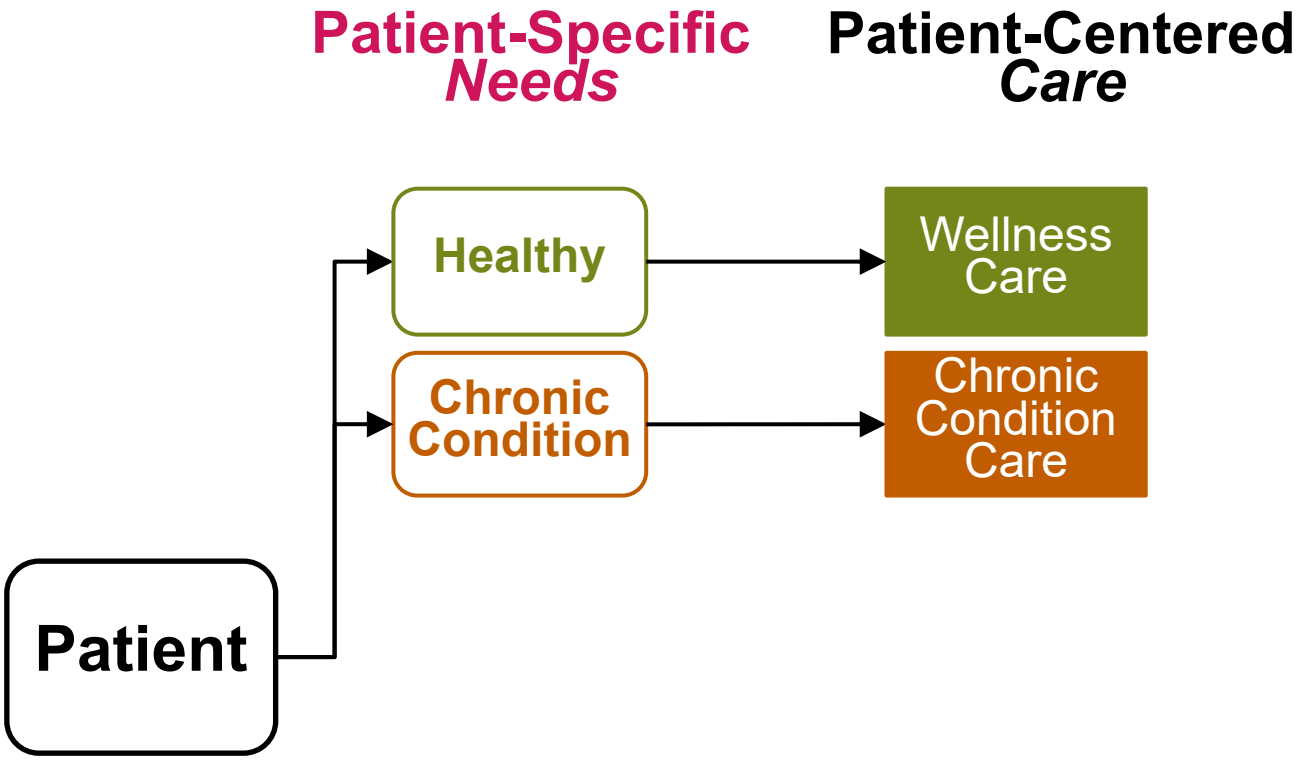
…*Each* Patient Should Receive *All* of the Services They *Need*

Patient-Specific *Needs*

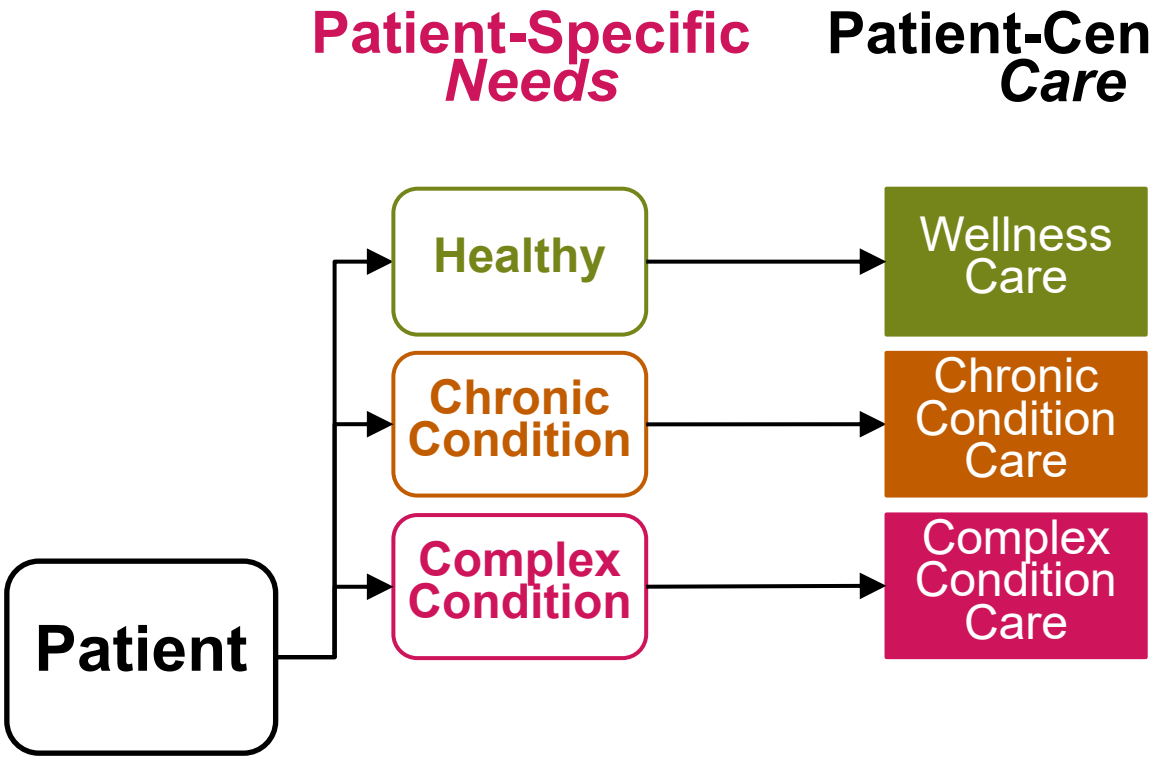
Patient-Centered *Care*



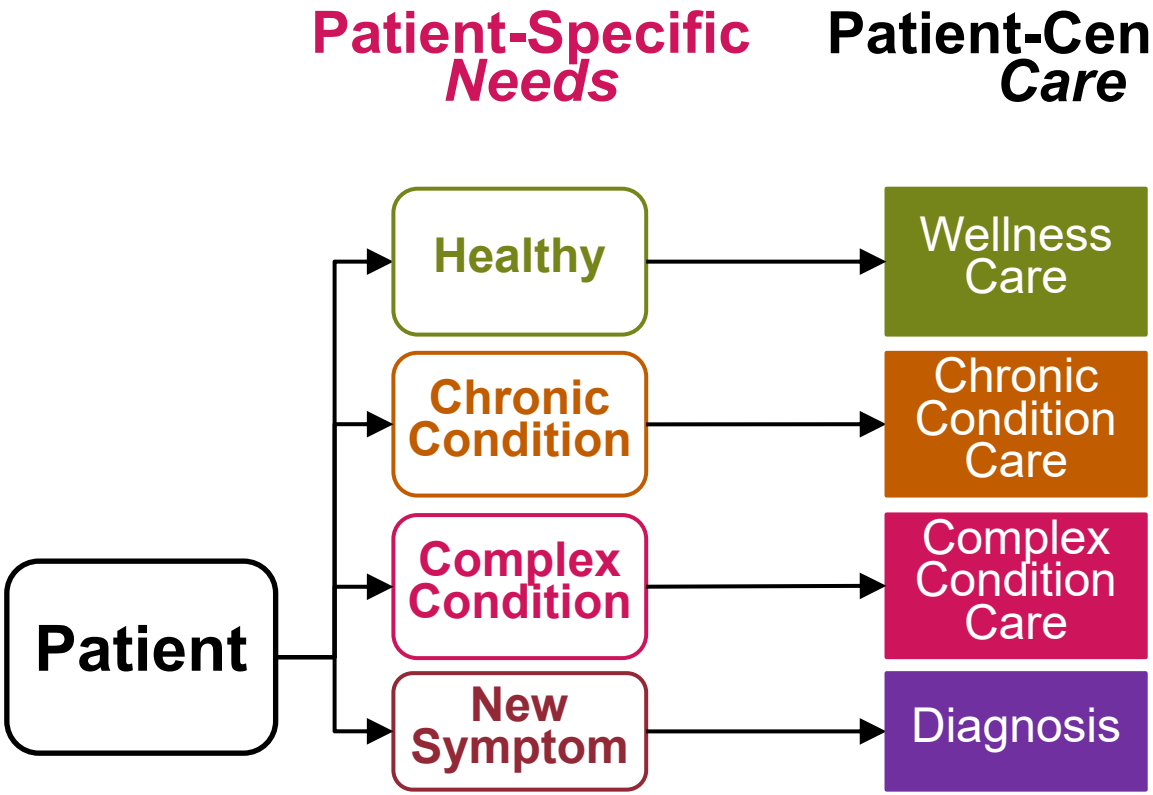
…*Each* Patient Should Receive *All* of the Services They *Need*



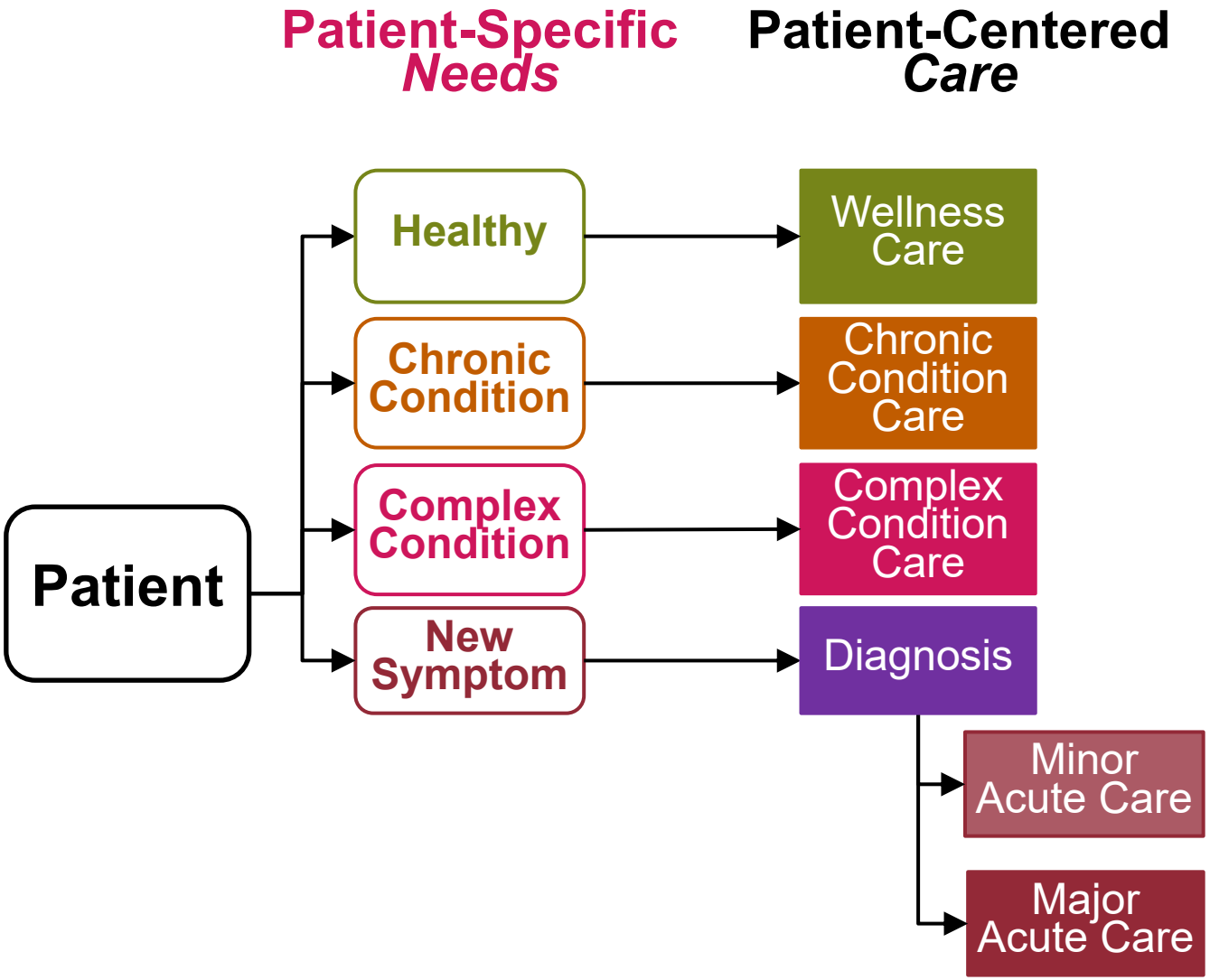
…*Each* Patient Should Receive *All* of the Services They *Need*



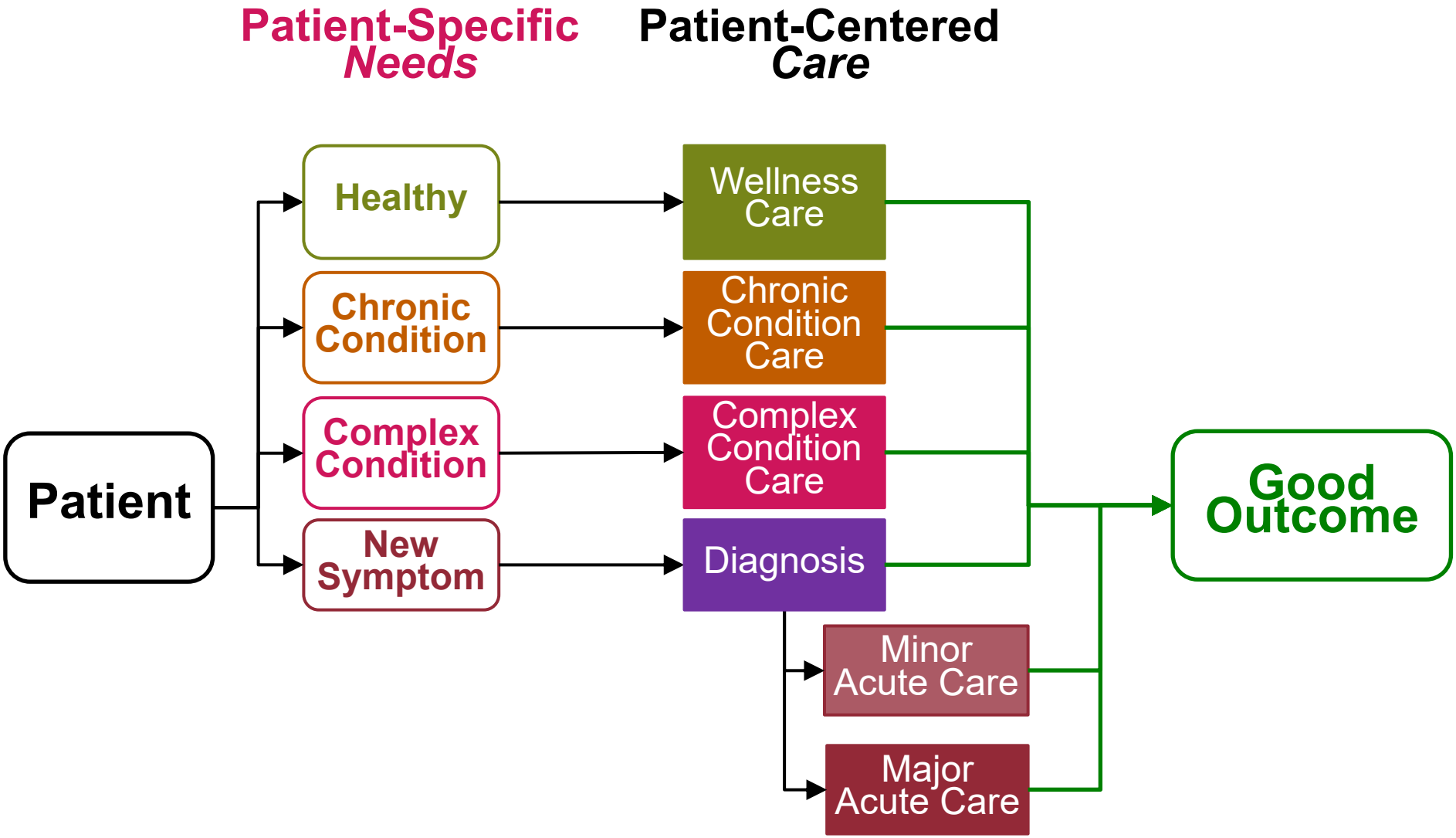
…*Each* Patient Should Receive *All* of the Services They *Need*



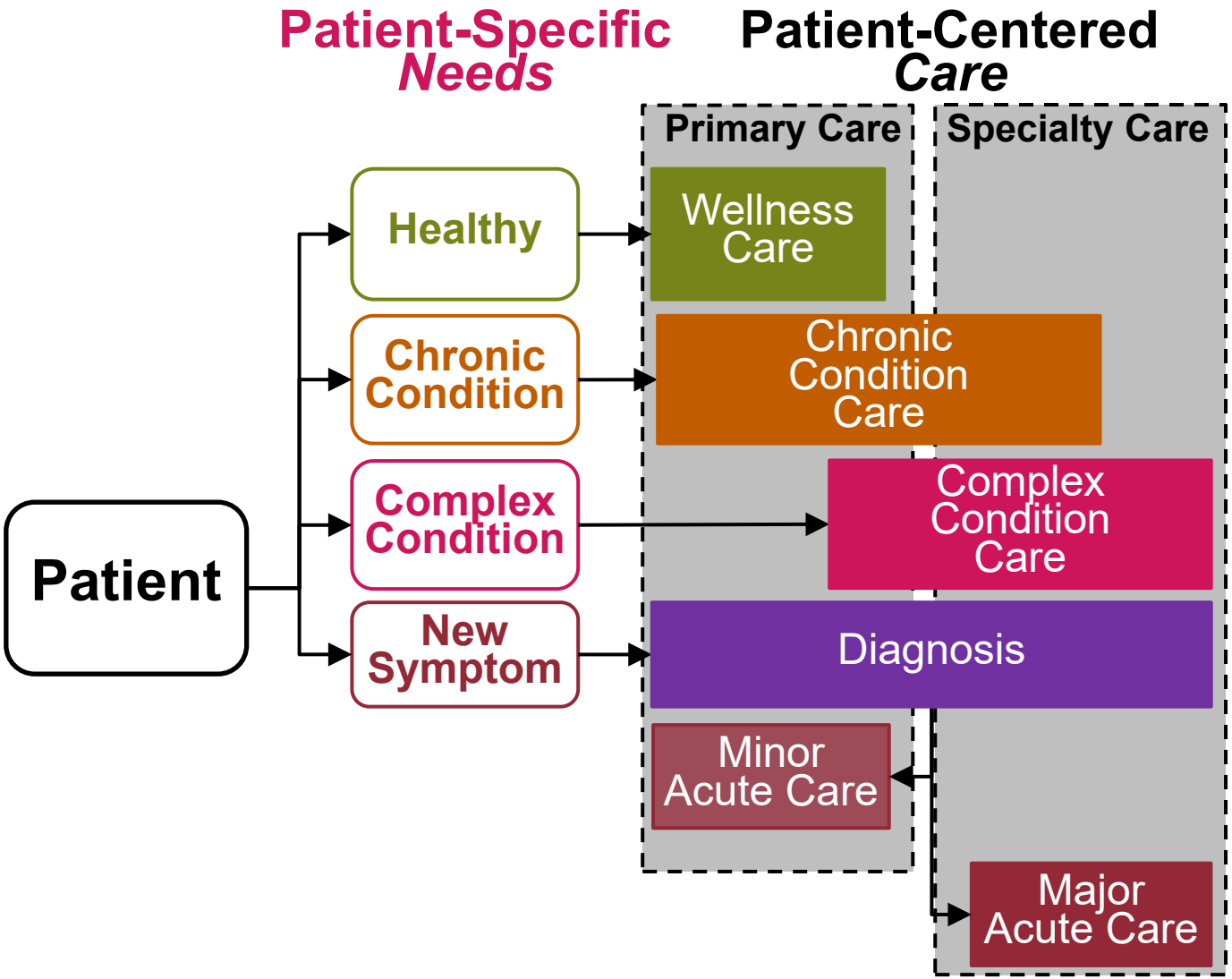
…*Each* Patient Should Receive *All* of the Services They *Need*



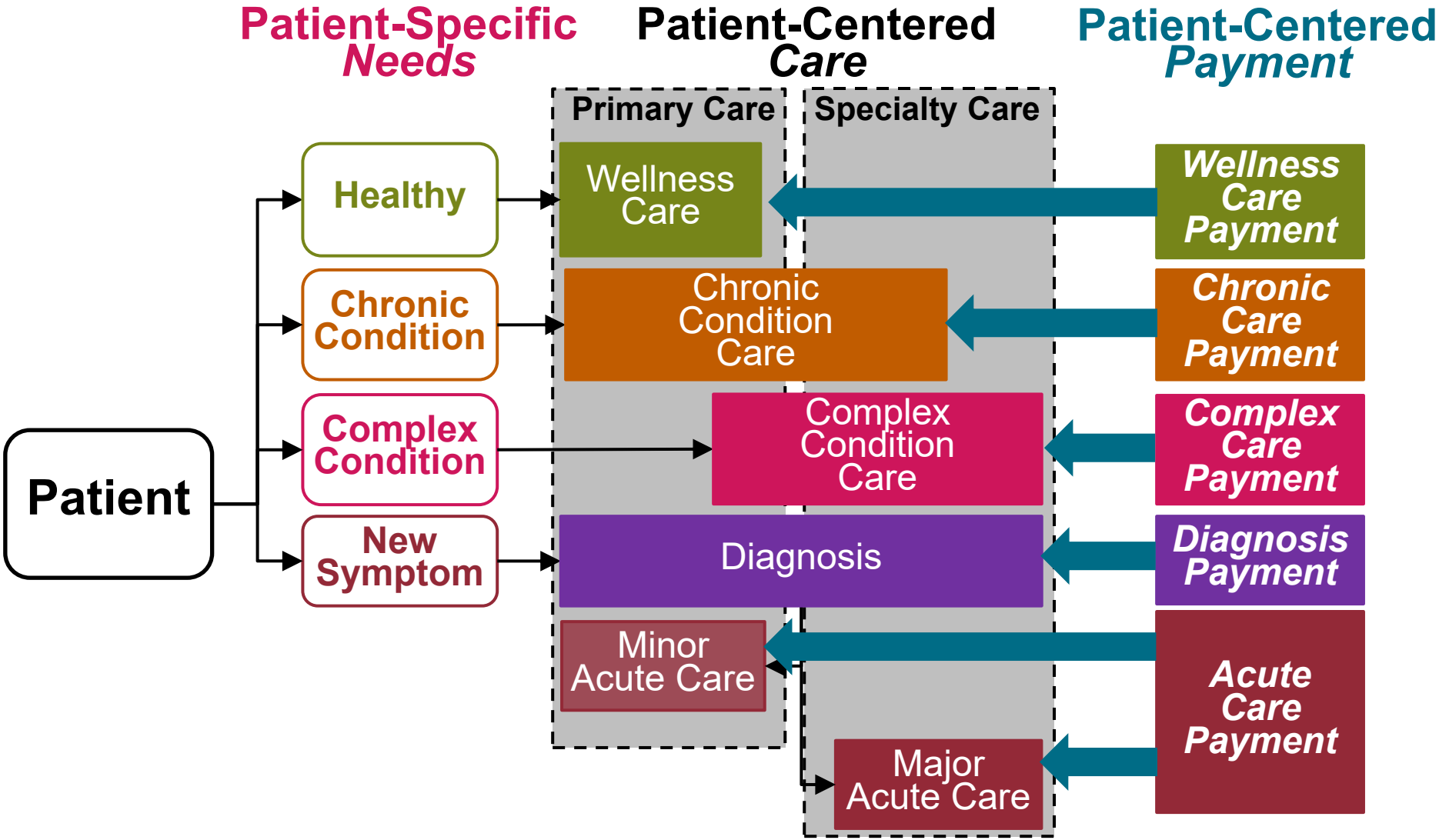
Patient-Centered Care is the Best Way to Achieve *Good Outcomes*



Both Primary & Specialty Care Are Essential for Patient-Centered *Care*



Patient-Centered *Payment* is Needed for Patient-Centered *Care*



How Would Patient-Centered Payments Differ from FFS & APMs?

Patient Problem	What Patient Needs	Current FFS & CMS APMs	Patient-Centered Payment

Patient-Centered Payment Pays for What the Patient *Needs*

Patient Problem	What Patient Needs	Current FFS & CMS APMs	Patient-Centered Payment
New Symptom	Diagnosis	Fees for Visits + Fees for Tests	Fee to Determine the Diagnosis

Patient-Centered Payment Pays for What the Patient *Needs*

Patient Problem	What Patient Needs	Current FFS & CMS APMs	Patient-Centered Payment
New Symptom	Diagnosis	Fees for Visits + Fees for Tests	Fee to Determine the Diagnosis
Acute Injury or Illness	Successful Treatment of the Condition	Fee for Procedure + Fee for Anesthesia + Fees for Consults + Fees for Post-Acute Care + Fees for Treatment of Complications	Bundled Payment for Evidence-Based Treatment of the Patient's Condition with a Warranty for Complications

Patient-Centered Payment Pays for What the Patient *Needs*

Patient Problem	What Patient Needs	Current FFS & CMS APMs	Patient-Centered Payment
New Symptom	Diagnosis	Fees for Visits + Fees for Tests	Fee to Determine the Diagnosis
Acute Injury or Illness	Successful Treatment of the Condition	Fee for Procedure + Fee for Anesthesia + Fees for Consults + Fees for Post-Acute Care + Fees for Treatment of Complications	Bundled Payment for Evidence-Based Treatment of the Patient's Condition with a Warranty for Complications
Chronic Illness	Effective Treatment & Management of the Condition	Fees for Visits + Fees for Tests + Fees for Treatment	Monthly Payment for Proactive Treatment & Management

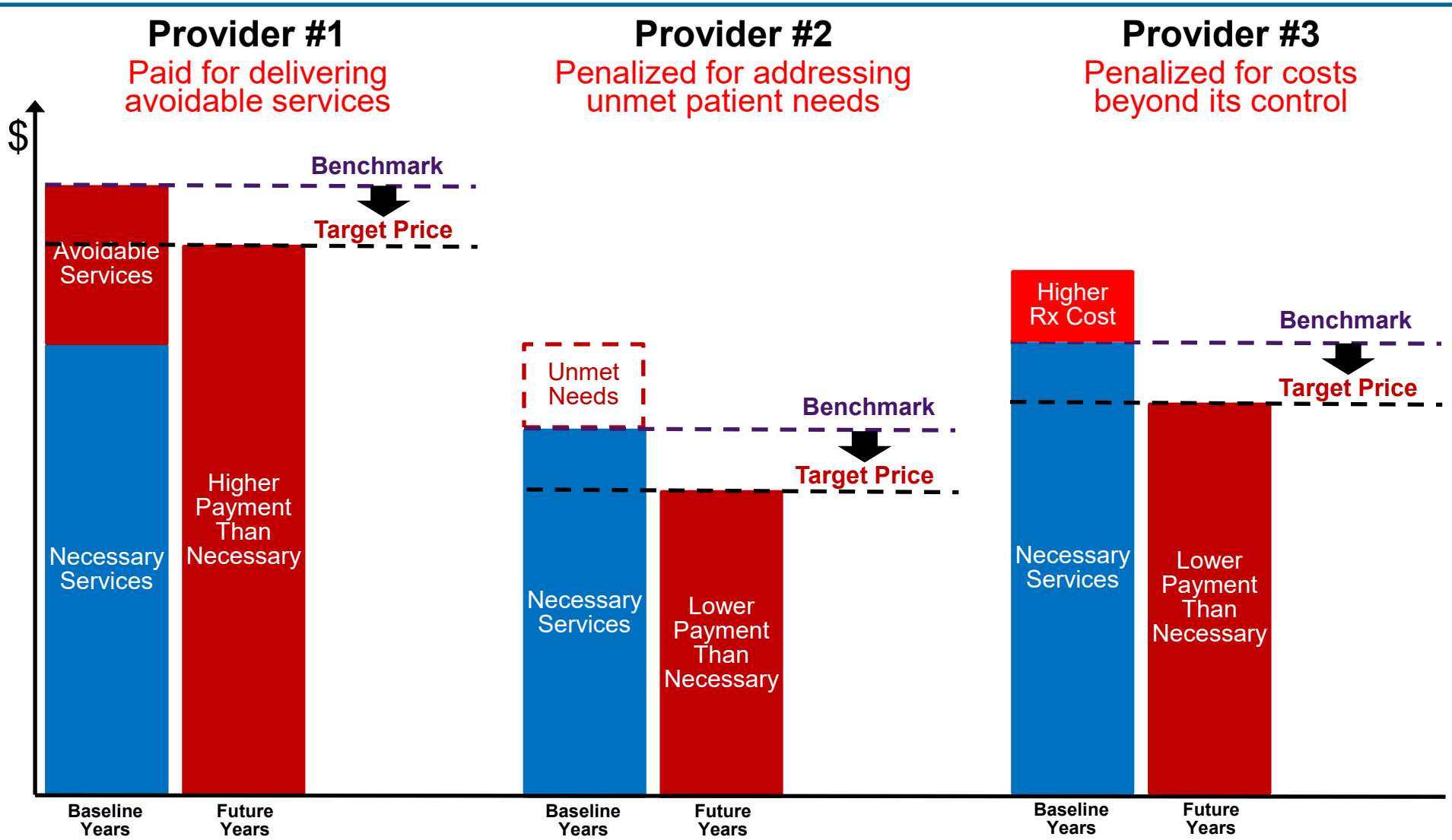
Patient-Centered Payment Pays for What the Patient *Needs*

Patient Problem	What Patient Needs	Current FFS & CMS APMs	Patient-Centered Payment
New Symptom	Diagnosis	Fees for Visits + Fees for Tests	Fee to Determine the Diagnosis
Acute Injury or Illness	Successful Treatment of the Condition	Fee for Procedure + Fee for Anesthesia + Fees for Consults + Fees for Post-Acute Care + Fees for Treatment of Complications	Bundled Payment Evidence-Based Treatment of the Patient's Condition with a Warranty for Complications
Chronic Illness	Effective Treatment & Management of the Condition	Fees for Visits + Fees for Tests + Fees for Treatment	Monthly Payment for Proactive Treatment & Management
Multiple/Complex Problems	Customized Care to Address Needs	Fees for Visits	Additional Monthly Payment to Support Special Assistance

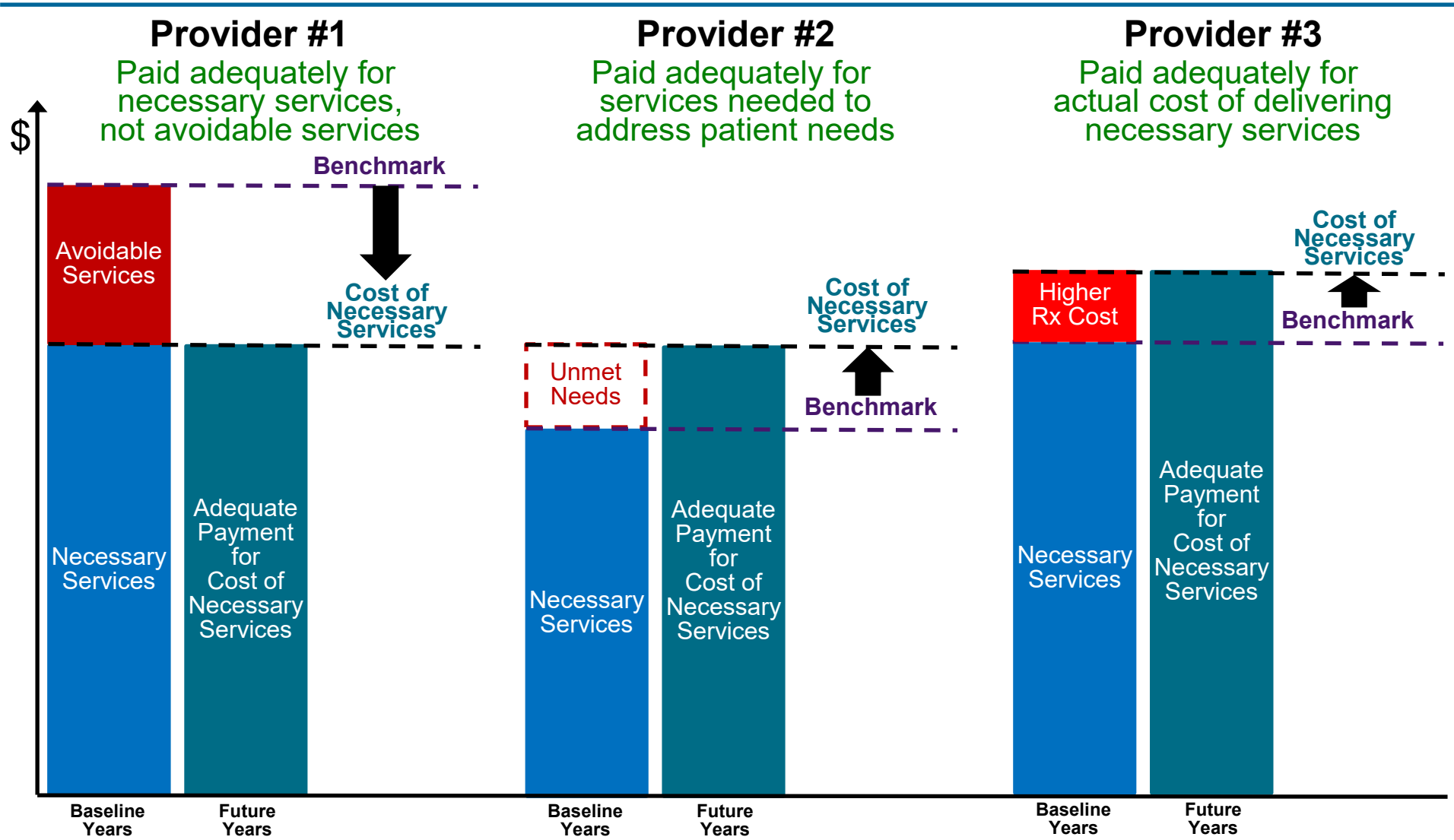
Patient-Centered Payment Pays for What the Patient *Needs*

Patient Problem	What Patient Needs	Current FFS & CMS APMs	Patient-Centered Payment
New Symptom	Diagnosis	Fees for Visits + Fees for Tests	Fee to Determine the Diagnosis
Acute Injury or Illness	Successful Treatment of the Condition	Fee for Procedure + Fee for Anesthesia + Fees for Consults + Fees for Post-Acute Care + Fees for Treatment of Complications	Bundled Payment Evidence-Based Treatment of the Patient's Condition with a Warranty for Complications
Chronic Illness	Effective Treatment & Management of the Condition	Fees for Visits + Fees for Tests + Fees for Treatment	Monthly Payment for Proactive Treatment & Management
Multiple/Complex Problems	Customized Care to Address Needs	Fees for Visits	Additional Monthly Payment to Support Special Assistance
No Health Problems	Wellness Care	Fees for Visits	Monthly Payment for All Appropriate Wellness Care & Preventive Services

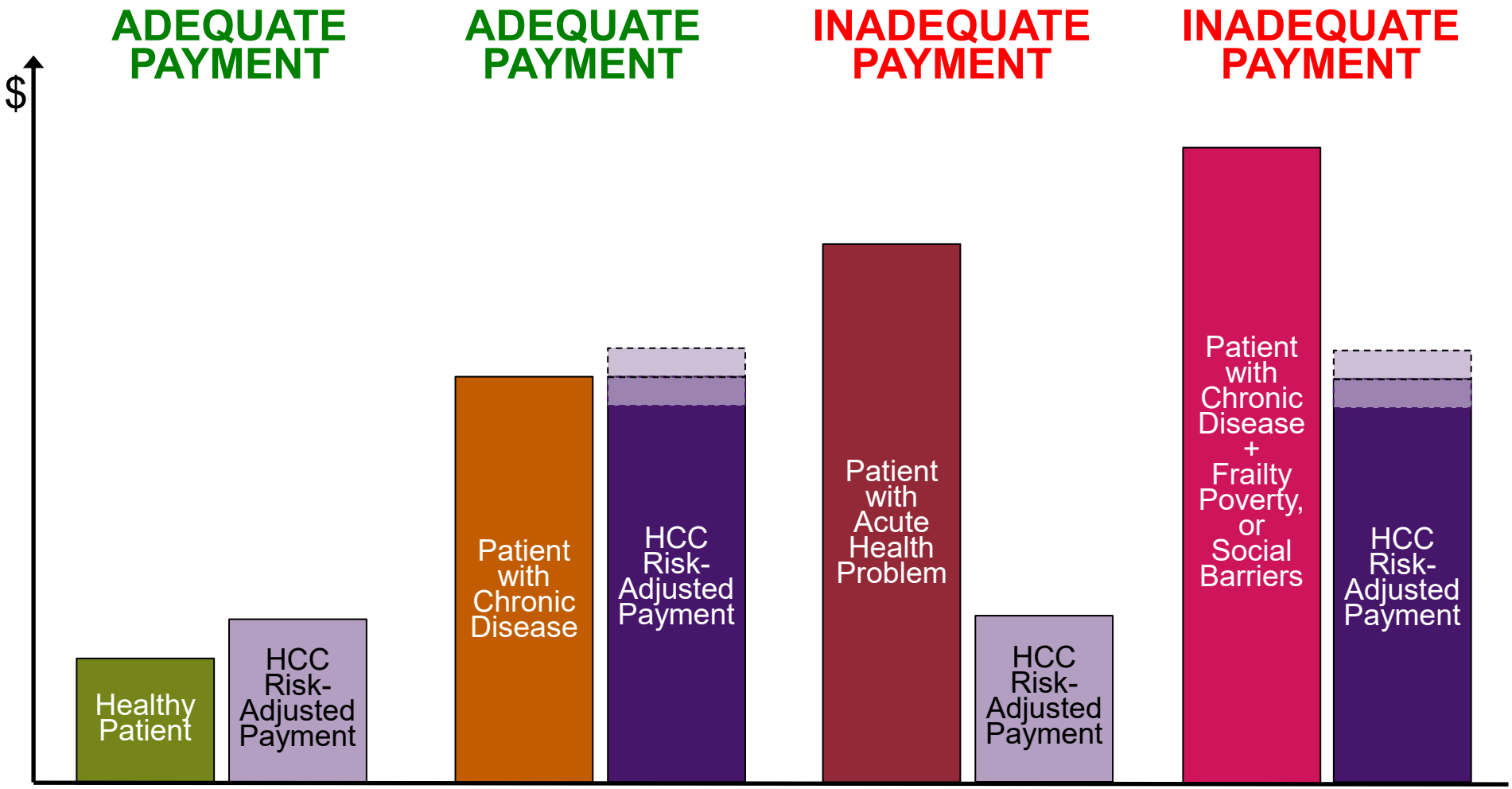
Instead of Basing Payments on Arbitrary Discounts from Past $…



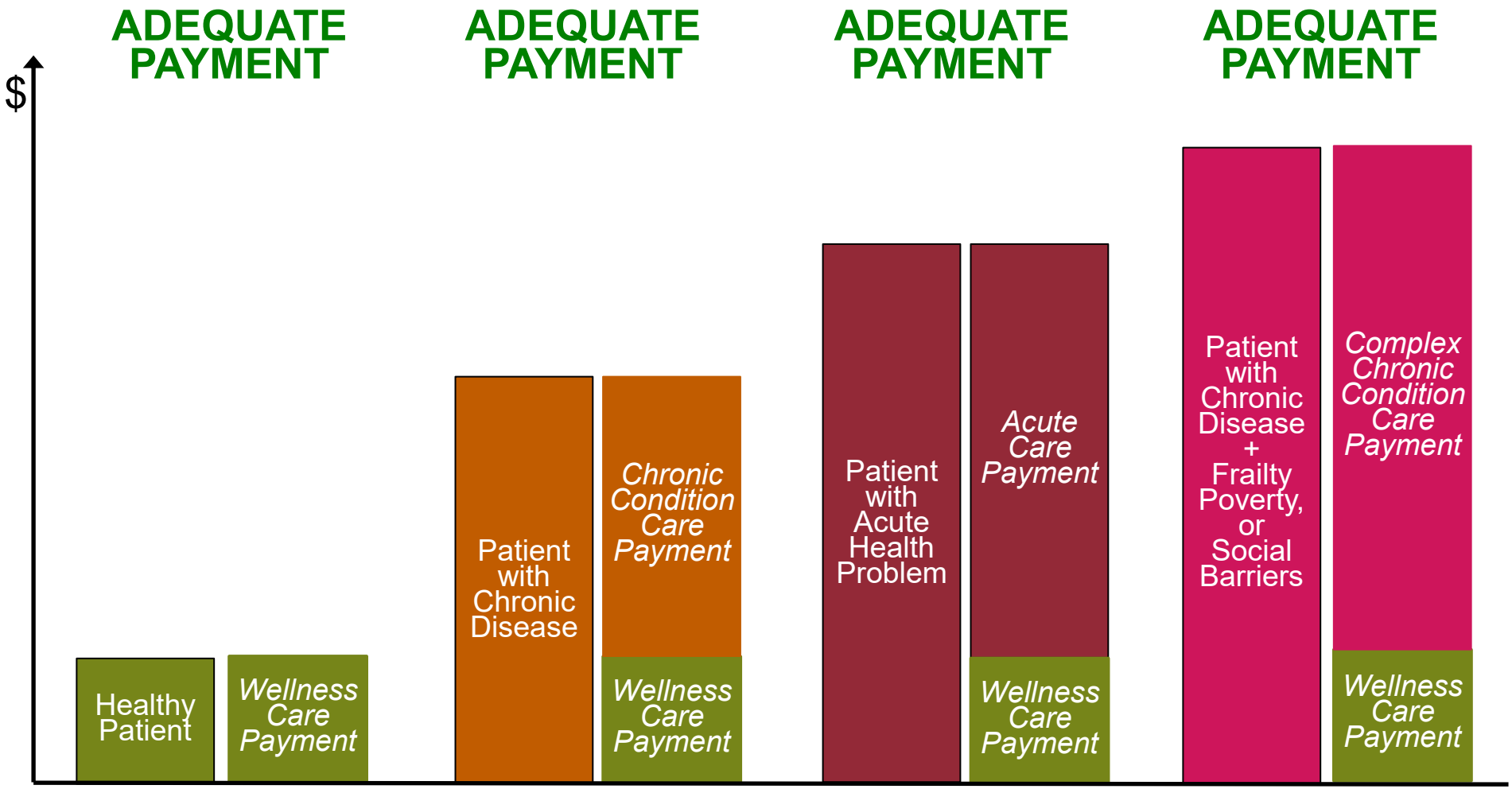
…Payments Should be Adequate to Cover *Cost of Necessary Services*



Instead of Using Problematic Risk Adjustment Systems…



…Patient-Centered Payments Automatically "Risk Adjust" Total $



Ensuring Quality, Achieving Savings, & Reducing Disparities

	Current Value-Based Payment
Ensuring the Quality of Care	• Payment is made for services to a patient regardless of the quality of care delivered; • Payment amount may be reduced in the future if performance is below average on a few quality measures; • There are no quality measures at all for many types of care

Ensuring Quality, Achieving Savings, & Reducing Disparities

	Current Value-Based Payment	Patient-Centered Payment
Ensuring the Quality of Care	• Payment is made for services to a patient regardless of the quality of care delivered; • Payment amount may be reduced in the future if performance is below average on a few quality measures; • There are no quality measures at all for many types of care	Payment is only made if patient has received services that are consistent with evidence-based clinical practice guidelines Patient needs and outcomes are proactively monitored

Ensuring Quality, Achieving Savings, & Reducing Disparities

	Current Value-Based Payment	Patient-Centered Payment
Ensuring the Quality of Care	• Payment is made for services to a patient regardless of the quality of care delivered; • Payment amount may be reduced in the future if performance is below average on a few quality measures; • There are no quality measures at all for many types of care	Payment is only made if patient has received services that are consistent with evidence-based clinical practice guidelines Patient needs and outcomes are proactively monitored
Achieving Savings	• Providers are paid for unnecessary services • Providers are rewarded for reducing spending below arbitrary targets even if patients do not receive the services they need	Payment is only made for appropriate, evidence-based services and for services specifically required to address patient needs

Ensuring Quality, Achieving Savings, & Reducing Disparities

	Current Value-Based Payment	Patient-Centered Payment
Ensuring the Quality of Care	• Payment is made for services to a patient regardless of the quality of care delivered; • Payment amount may be reduced in the future if performance is below average on a few quality measures; • There are no quality measures at all for many types of care	Payment is only made if patient has received services that are consistent with evidence-based clinical practice guidelines Patient needs and outcomes are proactively monitored
Achieving Savings	• Providers are paid for unnecessary services • Providers are rewarded for reducing spending below arbitrary targets even if patients do not receive the services they need	Payment is only made for appropriate, evidence-based services and for services specifically required to address patient needs
Reducing Disparities	• Simplistic quality measures, poor risk adjustment, arbitrary spending targets, and inadequate payments for needed services penalize providers who care for high-need and disadvantaged patients	Payments are adequate to cover the cost of delivering evidence-based care to all patients, particularly high-need and disadvantaged patients

Details on Patient-Centered Payment for Primary Care

VIEWPOINT

Aligning Payments, Services, and Quality in Primary Care

John H. Wasson, MD
Geisel School of Medicine at Dartmouth, Lebanon, New Hampshire.

Harold C. Sox, MD
The Patient-Centered Outcomes Research Institute, Washington, DC.

Harold D. Miller
Center for Healthcare Quality and Payment Reform, Pittsburgh, Pennsylvania.

A May 2021 report from the National Academies of Sciences, Engineering, and Medicine (NASEM) described the critical role of high-quality primary care in improving the health of the nation's population and reducing health disparities.[1] The authors concluded that "primary care in the United States is fragile and weakening," and recommended paying primary care practices using a "hybrid reimbursement model (part fee-for-service, part capitated)."[1]

However, the report stops short of defining the specifics of the proposed hybrid payment model. If each payer designs its own approach, primary care practices would be subject to a confusing array of different rules and incentives. The optimal approach may be an all-payer hybrid model that aligns payments with the types and intensity of services the patient needs.

Aligning Payments With Services

Effective primary care requires assigning tasks to the team members best able to perform them. The NASEM report emphasizes that "primary care practices organized in response to fee-for-service payment maximize revenue-producing in-person visits but are not configured to provide the integrated team-based care necessary to address…comprehensive preventive and chronic care needs…."[1] In a team-based practice, a high proportion of preventive and chronic care tasks can be delegated to nurses, medical assistants, and other practice staff, while most of a clinician's time will be spent on acute care.[2] Current risk adjustment systems, which are based on the amount of chronic disease in each clinician's attributed patient population, do not align capitation payments with clinician time and effort in acute care. A hybrid payment model must address this problem.

> Current payment systems do not independently measure what a physician has done or what the results have been for the patient.

The following approach could enable practice structure to be aligned with the services patients need:

Monthly Payments for Wellness Care and Chronic Disease Management

A capitation payment for wellness care and chronic disease management services would give the primary care practice predictable payments that could help maintain a wellness care and chronic disease management team with the appropriate mix of skills to customize proactive care for patients. The practice could then receive higher monthly payments for patients with chronic conditions or social risk factors to reflect the additional assistance they will likely need. Patients could enroll with the practice if they wish to receive these services, and the practice could bill health plans for the monthly payments for those patients. Enrollment could avoid the need for the complex systems currently used to "attribute" a patient to a practice based on the frequency of office visits.

Fees for Diagnosis and Treatment of New Acute Problems

In addition to the monthly payments, the physician or other clinician should be paid a fee when a patient has a new acute problem. (Treatment of chronic condition exacerbations could be covered by the monthly payments.) The fee must be large enough to allow the physician to spend adequate time to accurately diagnose the acute problem and work with the patient to develop a feasible treatment plan. Practices that have patients with multiple acute problems would be paid more for the additional time those patients will need. Cumulatively, the acute care fees, when added to the monthly fees for chronic and preventive care, could help ensure the practice's total revenue is "risk-adjusted" for patients who have acute problems as well as those with a chronic condition.

This hybrid payment system could enable the practice to manage care at a population health level by investing practice resources in proactive wellness and chronic care, while enabling the practice to devote adequate time to patients with acute care needs. A financial analysis of a specific primary care payment model that uses a combination of monthly payments for preventive and chronic care plus fees paid only for acute care visits found that this model would better align revenues with the costs of providing team-based care than either fee-for-service or risk-adjusted capitation payments alone, and that it could be implemented by primary care practices and health insurance plans using existing billing and claims payment systems.[3]

Assuring High-Quality Care for Each Patient

For several decades, pay-for-performance systems have provided incentives intended to improve the quality of primary care, but they have failed because they do not provide sufficient resources or flexibility to enable the delivery of better health care. The combination of adequate monthly payments and fees could address this problem.

Equally detrimental for assuring high-quality care for each patient has been the assessment of quality based on average rates of narrowly defined measures of outcomes achieved (eg, diabetes control) or services delivered (eg, screening tests done) during the care of a subset of the patients seen in primary care practices. The NASEM report is clear: current measures, "though numerous, are insufficient, and even harmful…."[1]

Corresponding Author: John H. Wasson, MD, One Dorset Ln, Lebanon, NH 03766 (john.h.wasson@dartmouth.edu).

https://jamanetwork.com/journals/jama/fullarticle/2782976

CENTER FOR HEALTHCARE QUALITY & PAYMENT REFORM

Patient-Centered Payment for Primary Care

Harold D. Miller

First Edition
April 2021

PatientCenteredPayment.org

Patient-Centered Payments for Specialists Have Been Developed…

Patient-Centered Payment Models Reviewed/Recommended by the Physician-Focused Payment Model Technical Advisory Committee (PTAC)

- Patient-Centered Oncology Payment Model
- Patient-Centered Asthma Payment
- Medical Neighborhood Payment
- CAPABLE Support for Seniors at Home
- MASON Oncology Payments
- Acute Unscheduled Care Payment
- Comprehensive Care Physician Payments
- Home Hospitalization Payments
- Advance Care Payments
- Intensive SNF Care Management Payments
- Palliative Care Payments
- Incident ESRD Episode Payments
- Hospital at Home Payments
- Oncology Bundled Payments
- Project SONAR Payments
- Advanced Alternative Payment Model

…But CMS Has Refused to Implement Any of Them

Patient-Centered Payment Models Reviewed/Recommended by the Physician-Focused Payment Model Technical Advisory Committee (PTAC)

- Patient-Centered Oncology Payment Model
- Patient-Centered Asthma Payment
- Medical Neighborhood Payment
- CAPABLE Support for Seniors at Home
- MASON Oncology Payments
- Acute Unscheduled Care Payment
- Comprehensive Care Physician Payments
- Home Hospitalization Payments
- Advance Care Payments
- Intensive SNF Care Management Payments
- Palliative Care Payments
- Incident ESRD Episode Payments
- Hospital at Home Payments
- Oncology Bundled Payments
- Project SONAR Payments
- Advanced Alternative Payment Model

https://aspe.hhs.gov/collaborations-committees-advisory-groups/ptac/ptac-proposals-materials#1061

PTAC Recommendations Implemented by CMS

(None)

Details on Patient-Centered Payment for Specialists/Hospitals

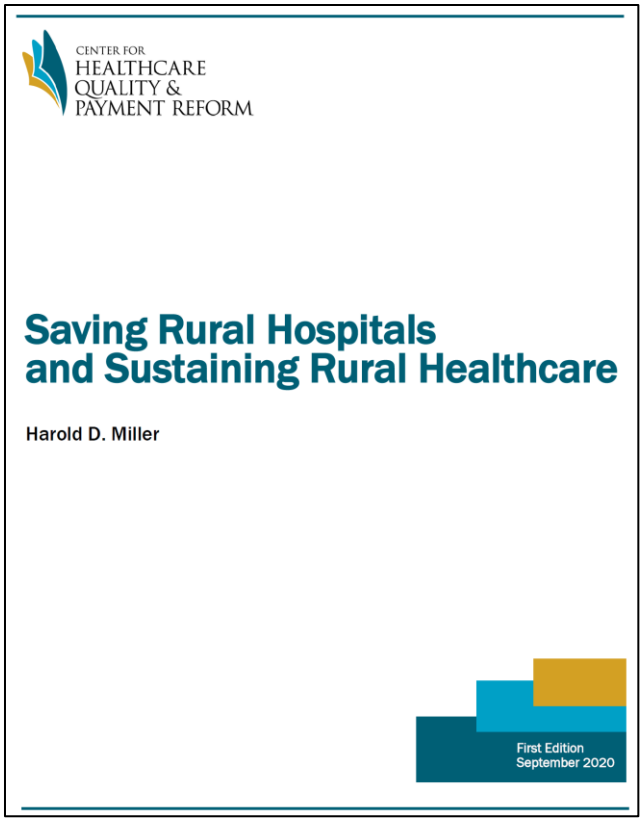
Patient-Centered Payment Home Overview Primary Care Specialty Care FAQ Vignettes Resources

2. Patient-Centered Payment for Specialty Care

Many patients have health problems that require specialized expertise to diagnose or treat. Specialty care providers deliver three types of services that complement the work that primary care practices do:

- **Diagnosis and Treatment Planning.** In some cases, it is difficult to determine the cause of a patient's symptoms without specialized training and experience. An inaccurate diagnosis can lead to unnecessary or harmful treatment for a non-existent problem and/or failure to properly treat the real problem. In addition, many patients receive unnecessary tests and/or unnecessarily expensive tests to rule out unlikely diagnoses. In some cases, these tests can lead to false positive results that contribute to inaccurate diagnoses and unnecessary treatments.
- **Management of Chronic Conditions.** Although many chronic conditions can be managed effectively by a primary care practice, some patients with a chronic condition will need or want to receive support from a specialty care provider, particularly patients with severe conditions, including serious behavioral health conditions, and patients for whom standard treatments are not effective or have problematic side effects. In addition, some patients with a chronic condition may need to temporarily receive treatment and proactive management services for that condition from a specialty practice rather than the primary care practice, such as when the patient experiences an acute condition that complicates management of the chronic condition (e.g., the patient becomes pregnant and the medications she had been taking for the chronic condition are problematic during pregnancy).
- **Treatment of Serious Acute Conditions.** Treatments and procedures for serious acute conditions may require not only special expertise, special equipment, or special facilities to perform, but multiple providers may need to contribute components of the necessary care. For example, a patient who needs surgery will require the services of a surgeon, an anesthesiologist, a hospital, and potentially other physicians and post-acute care providers in order to achieve the best outcome. All of these providers have to work

PatientCenteredPayment.org



RuralHospitals.org

Which Physician Would YOU Want to Care for You?

- **Physician A is paid Fee for Service**
  They are paid less if they keep you healthy
- **Physician B is "paid for performance" (e.g., MIPS)**
  They are paid more if other patients receive adequate care
- **Physician C is in a CMS Alternative Payment Model**
  They are paid more if you receive fewer services than you need
- **Physician D receives Population-Based Payment**
  They are paid whether they address your health needs or not
- **Physician E is paid through Patient-Centered Payment**
  They are paid adequately to address your needs, and they are not paid unless you receive evidence-based care

Value-Based Payments Should Be Patient-Centered Payments

2000 — 2010 — 2021

VALUE-BASED PAYMENT 1.0
Pay for Performance
Quality Measures +
Bonuses/Penalties

FAILURE:
- *Little Improvement in Quality*
- *Huge Administrative Burden*
- *Increase in Disparities*

VALUE-BASED PAYMENT 2.0
Alternative Payment Models
Quality Measures +
Risk-Based Payment

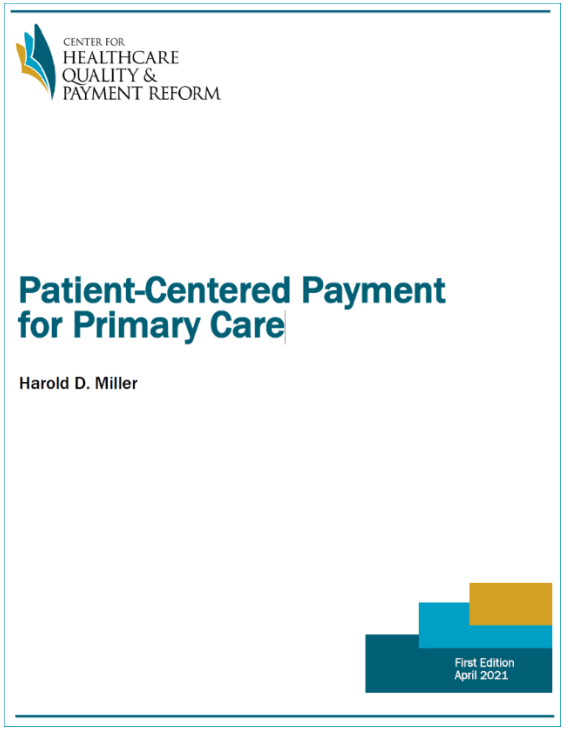
FAILURE:
- *Little Savings*
- *Provider Consolidation*
- *Increase in Disparities*

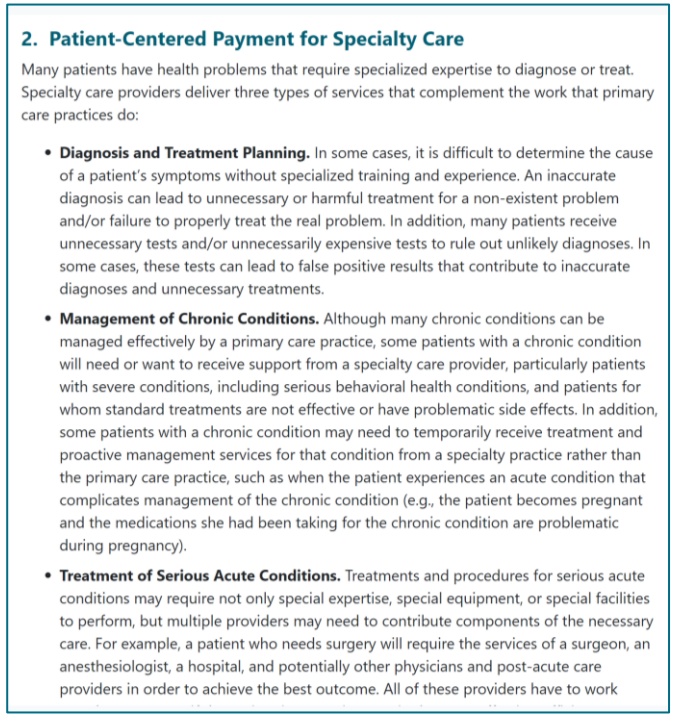
VALUE-BASED PMT 3.0
Patient-Centered Payment

Adequate Payment
to Deliver
Evidence-Based Care
to All Patients

PatientCenteredPayment.org

More Details on Patient-Centered Payment

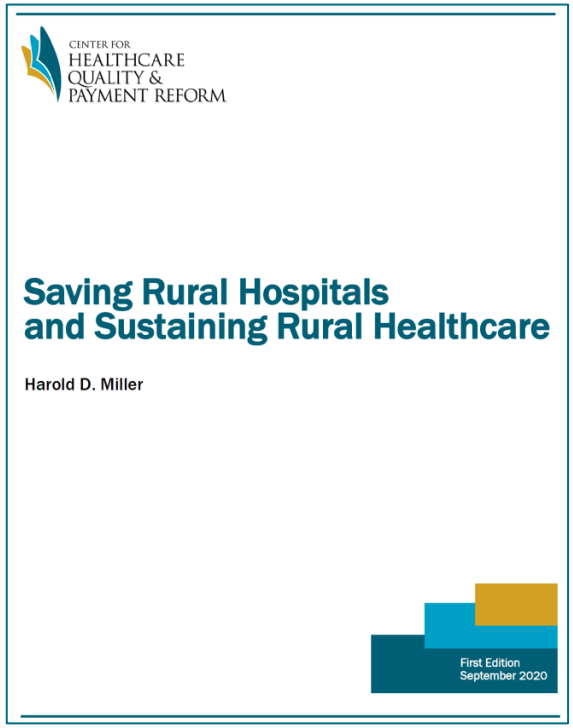




2. Patient-Centered Payment for Specialty Care

Many patients have health problems that require specialized expertise to diagnose or treat. Specialty care providers deliver three types of services that complement the work that primary care practices do:

- **Diagnosis and Treatment Planning.** In some cases, it is difficult to determine the cause of a patient's symptoms without specialized training and experience. An inaccurate diagnosis can lead to unnecessary or harmful treatment for a non-existent problem and/or failure to properly treat the real problem. In addition, many patients receive unnecessary tests and/or unnecessarily expensive tests to rule out unlikely diagnoses. In some cases, these tests can lead to false positive results that contribute to inaccurate diagnoses and unnecessary treatments.
- **Management of Chronic Conditions.** Although many chronic conditions can be managed effectively by a primary care practice, some patients with a chronic condition will need or want to receive support from a specialty care provider, particularly patients with severe conditions, including serious behavioral health conditions, and patients for whom standard treatments are not effective or have problematic side effects. In addition, some patients with a chronic condition may need to temporarily receive treatment and proactive management services for that condition from a specialty practice rather than the primary care practice, such as when the patient experiences an acute condition that complicates management of the chronic condition (e.g., the patient becomes pregnant and the medications she had been taking for the chronic condition are problematic during pregnancy).
- **Treatment of Serious Acute Conditions.** Treatments and procedures for serious acute conditions may require not only special expertise, special equipment, or special facilities to perform, but multiple providers may need to contribute components of the necessary care. For example, a patient who needs surgery will require the services of a surgeon, an anesthesiologist, a hospital, and potentially other physicians and post-acute care providers in order to achieve the best outcome. All of these providers have to work



PatientCenteredPayment.org

RuralHospitals.org

Harold D. Miller

President and CEO
Center for Healthcare Quality and Payment Reform

Miller.Harold@CHQPR.org
(412) 803-3650
@HaroldDMiller

www.CHQPR.org
www.PaymentReform.org
@PaymentReform