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

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

VALUE-BASED PAYMENT 1.0
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FAILURE:
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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

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Quality Measures + Bonuses/Penalties

FAILURE:
• Little Improvement in Quality
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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?

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

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VALUE-BASED PAYMENT 2.0
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FAILURE:
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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

Percentage of Patients with Poor Diabetes Control (> 9.0% HbA1c)

20-50% of Patients with Diabetes Had Poorly Controlled Blood Sugar in 2010 and in 2018-2019

Sources:
National Committee on Quality Assurance & Centers for Medicare and Medicaid Services
Little Improvement in Quality After a Decade of P4P

20-50% of Patients with Diabetes Had Poorly Controlled Blood Sugar in 2010 and in 2018-2019

Does This Mean 20-50% of Patients Are Receiving Poor Quality Care?

Sources:
National Committee on Quality Assurance & Centers for Medicare and Medicaid Services
Evaluating the Quality of Care for 3 Hypothetical Patients

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

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

Quality of Care:
Patient #1 Receives Appropriate Care and Improves Significantly

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

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<td>Quality of Care:</td>
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</table>
Diabetes Quality Measure Ignores the Patient’s Improvement

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

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

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<th>Standard Diabetes Quality Measure: % of Diabetic Patients with HbA1c &gt; 9%</th>
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Patient #2 Receives Poor Care and HbA1c Worsens

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% of Diabetic Patients with HbA1c > 9%

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Diabetes Quality Measure Ignores the Patient’s Deterioration

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InReality,ThePatientShouldHaveReceivedMuchBetterCare

StandardDiabetesQualityMeasure:
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## Patient #3 Can’t Afford Diabetes Medications

**Standard Diabetes Quality Measure:**

% of Diabetic Patients with HbA1c > 9%

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In Reality, The Patient Likely Received the Best Care Possible

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% of Diabetic Patients with HbA1c > 9%

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<td>Poor quality</td>
<td>Acceptable quality</td>
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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

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<tr>
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<tr>
<td>#1</td>
<td>6.5</td>
</tr>
<tr>
<td>#2</td>
<td>7.0</td>
</tr>
<tr>
<td>#3</td>
<td>7.5</td>
</tr>
<tr>
<td>#4</td>
<td>8.0</td>
</tr>
<tr>
<td>#5</td>
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<tr>
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<tr>
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</tr>
<tr>
<td>#9</td>
<td>10.5</td>
</tr>
<tr>
<td>#10</td>
<td>11.0</td>
</tr>
</tbody>
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% > 9: 40%
Physician A Improves HbA1c for All of the Diabetic Patients

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<thead>
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<th>Patient</th>
<th>Year 1 HbA1c</th>
<th>Year 2 HbA1c</th>
<th>Change</th>
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<tr>
<td>#1</td>
<td>6.5</td>
<td>6.5</td>
<td>0</td>
</tr>
<tr>
<td>#2</td>
<td>7.0</td>
<td>6.5</td>
<td>-0.5</td>
</tr>
<tr>
<td>#3</td>
<td>7.5</td>
<td>7.0</td>
<td>-0.5</td>
</tr>
<tr>
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<td>-0.5</td>
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% > 9 40%  30%  -10%

All patients have improved diabetes control

Quality measure improves
Physician B Helps 2 Patients, Ignores the Others

<table>
<thead>
<tr>
<th>10 Diabetic Patients:</th>
<th></th>
<th></th>
<th></th>
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<tr>
<td>#10</td>
<td>11.0</td>
<td>10.5</td>
<td>-0.5</td>
</tr>
<tr>
<td>% &gt; 9</td>
<td>40%</td>
<td>30%</td>
<td>-10%</td>
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</tbody>
</table>

Physician A

Physician B

Quality measure improves even more
Which Physician is Delivering Higher-Quality Care??

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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:

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<td>+1.0</td>
</tr>
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<td>-0.5</td>
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<tr>
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<td>10.5</td>
<td>-0.5</td>
<td>Dropped</td>
<td>XXX</td>
</tr>
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% > 9  40%  30%  -10%  11%  -29%

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

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.
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 +
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Incentives to
Reduce Spending
Most Alternative Payment Models Have Failed to Reduce Spending

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

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<td>Comprehensive Primary Care Plus (CPC+) Track 1</td>
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<td>Comprehensive Primary Care Plus (CPC+) Track 2</td>
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<td>Comprehensive Care for Joint Replacement (CJR)</td>
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<td>Oncology Care Model (OCM)</td>
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<tr>
<td>Independence at Home (created by Congress, not CMS)</td>
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<td>3.0%</td>
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</table>
# How CMS Diagnoses the Problems and Proposes to Cure Them

<table>
<thead>
<tr>
<th>CMS Diagnosis</th>
<th>CMS Proposed Cure</th>
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<tr>
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<td>Mandatory participation in CMS APMs</td>
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</table>
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

Fee-for-Service Spending (Baseline Years)

Benchmark

Baseline Years

$
Step 2: Measure ACO’s Current Spending Against Benchmark

ACO

Benchmark is increased each year based on national and regional spending growth.
Step 3a: Pay a “Shared Savings” Bonus if Spending Decreases

ACO
Rewarded for reducing spending

$.

Past Fee-for-Service Spending

Current Fee-for-Service Spending

Future Fee-for-Service Payments

Baseline Years

Performance Year

Performance Year + 1

Savings

Benchmark

Bonus
Step 3b: Penalize Downside Risk ACOs if Spending Increases

ACO #1
Rewarded for reducing spending

ACO #2
Penalized for failure to control spending

Past Fee-for-Service Spending
Current Fee-for-Service Spending
Future Fee-for-Service Payments
Past Fee-for-Service Spending
Current Fee-for-Service Spending
Future Fee-for-Service Payments
Baseline Years
Performance Year
Performance Year + 1
Baseline Years
Performance Year
Performance Year + 1
Baseline Years
Performance Year
Performance Year + 1

Savings
Bonus
Benchmark
Reduced Payment
Step 3c: Pay Standard FFS if Spending = Benchmark

**ACO #1**
Rewarded for reducing spending

**ACO #2**
Penalized for failure to control spending

**ACO #3**
Paid standard FFS if spending is controlled
Works Well for ACOs With a Lot of Avoidable Spending

ACO #1
Rewarded for reducing avoidable spending

Baseline Years
Performance Year
Performance Year + 1

Avoidable Services
Necessary Services
Avoidable Services
Necessary Services
Avoidable Services

Savings
Benchmark
Bonus

FFS Payment for Necessary Services
It Doesn’t Work Well for ACOs Whose Patients Have Unmet Needs

ACO #1
Rewarded for reducing avoidable spending

- Avoidable Services
- Necessary Services

ACO #2

- Avoidable Services
- Necessary Services
- FFS Payment for Necessary Services
- Unmet Needs

Baseline Years | Performance Year | Performance Year + 1
--- | --- | ---
Baseline Years | Performance Year | Performance Year + 1

Savings
Bonus
Benchmark
Benchmark
If the ACO Provides More Services to Address Unmet Needs...

ACO #1
Rewarded for reducing avoidable spending

Baseline Years
Necessary Services
Avoidable Services

Performance Year
Necessary Services
Avoidable Services

Performance Year + 1
Necessary Services
Avoidable Services

Baseline Years
Performance Year
Performance Year + 1

ACO #2

Baseline Years
Necessary Services

Performance Year
Necessary Services

Performance Year + 1
More Necessary Services

Bonus
Savings

Unmet Needs

Benchmark
…That Increases Spending and Results in a Penalty

ACO #1
Rewarded for reducing avoidable spending

ACO #2
Penalized for addressing unmet patient needs

Baseline Years | Performance Year | Performance Year + 1 | Baseline Years | Performance Year | Performance Year + 1

Avoidable Services | Savings | Bonus | Avoidable Services | Unmet Needs | Increase in Spending | Reduced Payment

Necessary Services | FFS Payment for Necessary Services | Necessary Services | More Necessary Services | Under-Payment for Necessary Services

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

**ACO #1**
Rewarded for reducing avoidable spending

**ACO #2**
Penalized for addressing unmet patient needs

**ACO #3**
Penalized for costs beyond its control

- **Baseline Years**
- **Performance Year**
- **Performance Year + 1**

**Avoidable Services**
**Necessary Services**
**FFS Payment for Necessary Services**

**Savings**
**Bonus**

**Unmet Needs**
**Increase in Spending**
**Reduced Payment**

**Higher Rx Cost**
**Reduced Payment**
**Under-Payment for Necessary Services**
Is It Any Wonder Participation in MSSP Is Limited & Decreasing?

ACO #1
Rewarded for reducing avoidable spending

ACO #2
Penalized for addressing unmet patient needs

ACO #3
Penalized for costs beyond its control

Why would ACO #2 and ACO #3 voluntarily participate in a program that penalizes them for providing care patients need and for costs they can’t control?
What Would Happen if Participation is Mandatory?
ACO #1 Would Continue to Receive Bonuses

**ACO #1**
Rewarded for reducing avoidable spending

<table>
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<tr>
<th>Avoidable Services</th>
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Baseline Years | Performance Year | Performance Year + 1

Savings

Bonus
ACO #2 Could Not Address Patient Needs Because of Penalties

ACO #1
Rewarded for reducing avoidable spending

ACO #2
Cannot address unmet needs because of penalty

Baseline Years | Performance Year | Performance Year + 1
--- | --- | ---
Avoidable Services | Necessary Services | FFS Payment for Necessary Services
Avoidable Services | Necessary Services | Fewer Services Than Patients Need
Avoidable Services | Necessary Services | FFS Payment for Services Delivered

$ Savings | Bonus | Benchmark

Unmet Needs

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

**ACO #1**
Rewarded for reducing avoidable spending

**ACO #2**
Does not address unmet needs to avoid penalty

**ACO #3**
Rewarded for stinting on care

Some ACOs might stint on care to avoid penalties and 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

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  - 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
Lung Cancer Cases in an ACO Involve a Lot of Spending

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


Average Cost: $52,000

Episode Costs of Alternative Chemotherapy Treatments for Non-Small Cell Lung Cancer

Lung Cancer Incidence in 65+ Population: 300/100,000 = 30 Cases in a 10,000 Member ACO

>$1.5 Million for Chemo Alone

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

Lung Cancer Incidence in 65+ Population: 300/100,000
= 30 Cases in a 10,000 Member ACO
>$1.5 Million for Chemo Alone

Episode Costs of Alternative Chemotherapy Treatments for Non-Small Cell Lung Cancer

Average Cost: $52,000

Average Cost: $13,000

Withhold high-cost drugs from patients who need them

Reduction in ACO’s Total Spending: 1.2%

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Specialists Aren’t Directly Affected by Payments to ACOs

MEDITCARE & OTHER PAYERS

Fee-for-Service Payment

Shared Savings Program

Accountable Care Organization (ACO)

Primary Care
Orthopedic Surgery
Medical Oncology
Other Specialties

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

**MEDICARE & OTHER PAYERS**

- **Fee-for-Service Payment**
- **Shared Savings Program**

**Accountable Care Organization (ACO)**

- **ACO Expenses**
  - ACO Management
  - Consultants
  - IT Systems
  - Care Managers

**Bonuses for Providers??**

- **Primary Care**
- **Orthopedic Surgery**
- **Medical Oncology**
- **Other Specialties**
Very Few Payment Models Exist for Individual Specialties

MEDICARE & OTHER PAYERS

Fee-for-Service Payment

Alternative Payment Models

Shared Savings Program

Accountable Care Organization (ACO)

ACO Expenses
- ACO Management
- Consultants
- IT Systems
- Care Managers

Bonuses for Providers??

Primary Care
Orthopedic Surgery
Medical Oncology
Other Specialties
Only the Joint Replacement APMs Have Reduced Spending

MEDICARE & OTHER PAYERS

Fee-for-Service Payment

Alternative Payment Models

Comprehensive Care for Joint Replacement (CJR)

Orthopedic Surgery
Joint Surgery Patients Receive Many Services After Discharge

- Patient w/ Pain & Limited Mobility
- Joint Surgery in Hospital
- Post-Acute Care
- Other Medical Services
- Hospital Readmissions
- Improved Mobility & Reduced Pain

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

CMMI Comprehensive Care for Joint Replacement (CJR)

JOINT REPLACEMENT “EPISODE”

90 Days Post-Discharge

Patient w/ Pain & Limited Mobility

Joint Surgery in Hospital

Post-Acute Care

Other Medical Services

Hospital Readmissions

Bonus

Savings

Savings

Lower-Cost Post-Acute Care

Other Medical Services

No Hospital Readmissions

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Problem #1 with CJR: No Penalty for Worse Outcomes

JOINT REPLACEMENT “EPISODE”

Patient w/ Pain & Limited Mobility

Joint Surgery in Hospital

Post-Acute Care

Other Medical Services

Hospital Readmissions

90 Days Post-Discharge

Bonus

Savings

Lower-Cost Post-Acute Care

Other Medical Services

Savings

No Hospital Readmissions

Improved Mobility & Reduced Pain

No Penalty

Reduced Mobility and/or Increased Pain

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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

“Average” Patient → Joint Surgery in Hospital → Post-Acute Care → Other Medical Services → Hospital Readmissions → Improved Mobility & Reduced Pain

“Target Price” is Based on Average Spending
Hospitals With Lower-Need Patients Will Likely Get Bonuses

“Target Price” is Based on Average Spending

- "Average" Patient
  - Joint Surgery in Hospital
  - Post-Acute Care
  - Other Medical Services
  - Improved Mobility & Reduced Pain
  - No Hospital Readmissions
  - Lower Cost
  - Bonus

- Healthy Patient With Good Home Support
  - Joint Surgery in Hospital
  - Low-Cost Post-Acute Care
  - Other Medical Services
  - Improved Mobility & Reduced Pain
  - No Hospital Readmissions
  - Lower Cost
Hospitals With Higher-Need Patients Will Receive Penalties

- **Patient With Chronic Disease, No Home Support**
  - Joint Surgery in Hospital
  - High Cost Post-Acute Care
  - Many Other Medical Services
  - Hospital Admission Unrelated to Joint Surgery
  - Penalty
  - Higher Cost
  - Improved Mobility & Reduced Pain

- **“Average” Patient**
  - Joint Surgery in Hospital
  - Post-Acute Care
  - Other Medical Services
  - Hospital Readmissions
  - Higher Cost
  - Higher Cost
  - Improved Mobility & Reduced Pain
Evidence of Financial Penalties for Serving Higher-Risk Patients

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

42% Fewer Safety-Net Hospitals Qualified for Bonuses, and Bonuses for Safety-Net Hospitals Were 39% Smaller Than for Non-Safety-Net Hospitals.
Mandating Participation Means High-Need Patients Won’t Get Care

- Patient With Chronic Disease, No Home Support
  - Joint Surgery in Hospital
  - High Cost Post-Acute Care
  - Many Other Medical Services
  - Hospital Admission Unrelated to Joint Surgery

- "Average" Patient
  - Joint Surgery in Hospital
  - Post-Acute Care
  - Other Medical Services
  - Hospital Readmissions
  - Improved Mobility & Reduced Pain

- Healthy Patient Who Doesn’t Need Surgery
  - Joint Surgery in Hospital
  - Low-Cost Post-Acute Care
  - Other Medical Services
  - No Hospital Readmissions
  - Limited Change in Mobility or Pain

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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”

APM Participant
Required to reduce spending

Baseline Years

Performance Year

Performance Year + 1

Necessary Services

Avoidable Services

Benchmark

Savings

Target Price

Bonus

FFS Payment for Necessary Services

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CMMI Demands a Discount Even if Patients Need More Services

APM Participant
Required to reduce spending

- Avoidable Services
- Necessary Services

Benchmark

Savings
Target Price
Bonus

Unmet Needs

APM Participant
Paid less than what is needed

- Avoidable Services
- Necessary Services

Baseline Years
Performance Year
Performance Year + 1

Target Price
Benchmark

"Discount"
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.

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### The Wrong Diagnosis Results in the Wrong Treatment & No Cure

<table>
<thead>
<tr>
<th><strong>WRONG Diagnosis</strong></th>
<th><strong>Wrong Cure</strong></th>
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# We Need Better Payment Models, Not Mandates for Bad Ones

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## CORRECT Diagnosis

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<td>CMS models penalize providers who care for higher-need patients and who deliver only necessary services.</td>
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## CORRECT Cure

<table>
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<td>Develop better payment models that enable providers to deliver high-quality care to all types of patients</td>
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CMS & Health Plans Say the Ideal is “Population-Based Payment”

**THE APM FRAMEWORK**

<table>
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<td>FEE FOR SERVICE - LINK TO QUALITY &amp; VALUE</td>
<td>APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE</td>
<td>POPULATION-BASED PAYMENT</td>
</tr>
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</table>

- **P4P**
  - Standard Fee-for-Service Payment
- **Risk**
  - Standard Fee-for-Service Payment

"Population-Based Payment" i.e., Capitation and Global Budgets
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.

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Under Capitation Payment: Cherry-Picking Patients = Profits

High Need Patients

Same Payment for All Patients

Same Payment for All Patients

High Need Patients

Same Payment for All Patients

Same Payment for All Patients

Lower Need Patients

Same Payment for All Patients

Same Payment for All Patients

Lower Need Patients

Medium Need Patients

Same Payment for All Patients

Same Payment for All Patients

Medium Need Patients

Same Payment for All Patients

Same Payment for All Patients

Lower Need Patients

Same Payment for All Patients

Same Payment for All Patients

Lower Need Patients

Floor

$
Won’t Risk-Adjustment Ensure Payments are Adequate?
CMS’s HCC Risk Adjustment Pays More for Chronic Diseases

- ADEQUATE PAYMENT
- ADEQUATE PAYMENT

Healthy Patient

HCC Risk-Adjusted Payment

Patient with Chronic Disease

HCC Risk-Adjusted Payment
No Adjustment for Acute Conditions or Social Determinants of Health

- ADEQUATE PAYMENT
  - Healthy Patient
  - HCC Risk-Adjusted Payment

- ADEQUATE PAYMENT
  - Patient with Chronic Disease
  - HCC Risk-Adjusted Payment

- INADEQUATE PAYMENT
  - Patient with Acute Health Problem
  - HCC Risk-Adjusted Payment

- INADEQUATE PAYMENT
  - Patient with Chronic Disease + Frailty
  - Poverty, or Social Barriers
  - HCC Risk-Adjusted Payment
Under Risk-Adjusted Capitation: Cherry-Picking Patients = Profits
How Will Physicians and Hospitals Be Paid Under Capitation??

MEDICARE & OTHER PAYERS

Fee-for-Service Payment

Capitation/Global Budget

Shared Savings Program

Accountable Care Organization (ACO)
or Direct Contracting Entity (DCE)

ACO/DCE Expenses
- Management
- Consultants
- IT Systems
- Care Managers

? Primary Care
? Orthopedic Surgery
? Oncology
? Cardiology
? Other Specialties
? Hospital
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.”

Problems with Risk Adjustment Can Increase Disparities in Care

By Adam A. Markovitz, John M. Hollingsworth, John Z. Ayanian, Edward C. Norton, Nicholas M. Molok, Phyllis L. Yee, and Andreic M. Ryan

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 increasing risk 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 ninetieth 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. 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 increasing diagnostic coding, the benchmark is not adjusted upward if the risk score rises while the beneficiary is in the MSSP. 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 commentators have expressed concern during rule making that ACOs retain an incentive to avoid chronically or acutely ill beneficiaries. For instance, ACOs may deliberately drop clinicians with high-risk beneficiary panels. 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 sole proprietor), 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.
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)
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…

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</table>
…And Following It Will Likely Make Things Worse, Not Better

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<tr>
<th>CATEGORY 1</th>
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<td>Greater Disparities</td>
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PROBLEMATIC PAYMENT MODELS
We Need a Different Direction: Patient-Centered Payment

- CATEGORY 1: Fee for Service - No Link to Quality & Value
- CATEGORY 2: Fee for Service - Link to Quality & Value
- CATEGORY 3: APMS Built on Fee-for-Service Architecture
- CATEGORY 4: Population-Based Payment

Payments for:
- Wellness & Preventive Care
- Diagnosis
- Acute Care
- Chronic Condition Care

Standard Fee-for-Service Payment

IDEAL

Patient-Centered Payment

We Need a Different Direction: Patient-Centered Payment

- P4P
- Fee

Provider Mergers
- Higher Prices
- Greater Disparities

Payments for:
- Wellness & Preventive Care
- Diagnosis
- Acute Care
- Chronic Condition Care
Instead of Sending Patients into a Black Box & Hoping for the Best…

POPULATION-BASED PAYMENT

The ACO Black Box

Patient

Good Outcome?
...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
Each Patient Should Receive All of the Services They Need

- Patient-Specific Needs
  - Healthy
  - Chronic Condition

- Patient-Centered Care
  - Wellness Care
  - Chronic Condition Care
Each Patient Should Receive All of the Services They Need

Patient-Specific Needs

- Healthy
- Chronic Condition
- Complex Condition

Patient-Centered Care

- Wellness Care
- Chronic Condition Care
- Complex Condition Care
...Each patient should receive all of the services they need.
…Each Patient Should Receive All of the Services They Need

Patient-Specific Needs
- Healthy
- Chronic Condition
- Complex Condition
- New Symptom

Patient-Centered Care
- Wellness Care
- Chronic Condition Care
- Complex Condition Care
- Diagnosis

- Minor Acute Care
- Major Acute Care
Patient-Centered Care is the Best Way to Achieve Good Outcomes

Patient-Specific Needs
- Healthy
- Chronic Condition
- Complex Condition
- New Symptom

Patient-Centered Care
- Wellness Care
- Chronic Condition Care
- Complex Condition Care
- Diagnosis

Patient

Good Outcome
- Minor Acute Care
- Major Acute Care
Both Primary & Specialty Care Are Essential for Patient-Centered Care

Patient-Specific Needs

- Healthy
- Chronic Condition
- Complex Condition
- New Symptom

Patient-Centered Care

Primary Care
- Wellness Care
- Chronic Condition Care
- Complex Condition Care
- Diagnosis

Specialty Care
- Minor Acute Care
- Major Acute Care
Patient-Centered *Payment* is Needed for Patient-Centered *Care*

[Diagram showing the interconnection between patient-specific needs, patient-centered care, and patient-centered payment.

- **Patient-Specific Needs:**
  - Healthy
  - Chronic Condition
  - Complex Condition
  - New Symptom

- **Patient-Centered Care:**
  - Primary Care
    - Wellness Care
  - Specialty Care
    - Chronic Condition Care
    - Complex Condition Care
    - Diagnosis
    - Minor Acute Care
    - Major Acute Care

- **Patient-Centered Payment:**
  - Wellness Care Payment
  - Chronic Care Payment
  - Complex Care Payment
  - Diagnosis Payment
  - Acute Care Payment

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

<table>
<thead>
<tr>
<th>Patient Problem</th>
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## Patient-Centered Payment Pays for What the Patient Needs

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Instead of Basing Payments on Arbitrary Discounts from Past $…

Provider #1
Paid for delivering avoidable services

Provider #2
Penalized for addressing unmet patient needs

Provider #3
Penalized for costs beyond its control

Avoidable Services
Higher Payment Than Necessary

Necessary Services
Baseline Years
Future Years

Benchmark
Target Price

Unmet Needs
Baseline Years
Future Years

Higher Rx Cost
Baseline Years
Future Years

Benchmark
Target Price

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Payments Should be Adequate to Cover Cost of Necessary Services

- **Provider #1**: Paid adequately for necessary services, not avoidable services.
  - Avoidable Services
  - Necessary Services
  - Adequate Payment for Cost of Necessary Services
  - Benchmark

- **Provider #2**: Paid adequately for services needed to address patient needs.
  - Unmet Needs
  - Benchmark

- **Provider #3**: Paid adequately for actual cost of delivering necessary services.
  - Higher Rx Cost
  - Adequate Payment for Cost of Necessary Services
  - Benchmark

Baseline Years | Future Years | Baseline Years | Future Years | Baseline Years | Future Years
Instead of Using Problematic Risk Adjustment Systems…

- Adequate Payment
- Adequate Payment
- Inadequate Payment
- Inadequate Payment

Healthy Patient

HCC Risk-Adjusted Payment

Patient with Chronic Disease

HCC Risk-Adjusted Payment

Patient with Acute Health Problem

HCC Risk-Adjusted Payment

Patient with Chronic Disease + Frailty Poverty, or Social Barriers

HCC Risk-Adjusted Payment
…Patient-Centered Payments
Automatically “Risk Adjust” Total $
### Ensuring the Quality of Care

<table>
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## Ensuring Quality, Achieving Savings, & Reducing Disparities

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• 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

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<tr>
<td></td>
<td>• 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</td>
<td>Payments are adequate to cover the cost of delivering evidence-based care to all patients, particularly high-need and disadvantaged patients</td>
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</table>
Details on Patient-Centered Payment for Primary Care

A May 2021 report from the National Academies of Sciences, Engineering, and Medicine (NASEM) describes the critical role of high-quality primary care in improving the health of the nation’s population and reducing health disparities. 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).”

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 type 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 a manner to augment the fee-for-service payment maximum 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.”

In a team-based practice, a high proportion of preventive and chronic care tests can be delegated to nonphysicians, medical assistants, and other staff, while most of a clinician’s time will be spent on acute care. “Care risk adjustment systems, which are based on the amount of chronic disease in the 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.”

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 skills to customize preventive 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 adjust health plans for the monthly payments for these patients. Enrollment could avoid the need for complex systems currently used to “attribute” a patient to a practice based on the frequency of office visits.

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 conditions and 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 these 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 with multiple acute problems as well as those with a chronic condition.

The hybrid payment system could enable the practice to manage care at a population health level by directing 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 in primary care practices and health insurance plans using existing billing and claims payment systems.

Assuring High-Quality Care for Each Patient

For several decades, pay-for-performance systems have provided incentives intended to increase 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 (e.g., diabetes control) or services delivered (e.g., 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.”

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

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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

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• Project SONAR Payments
• Advanced Alternative Payment Model

PTAC Recommendations Implemented by CMS

(None)

https://aspe.hhs.gov/collaborations-committees-advisory-groups/ptac/ptac-proposals-materials#1061
Details on Patient-Centered Payment for Specialists/Hospitals

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...
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

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

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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
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@PaymentReform