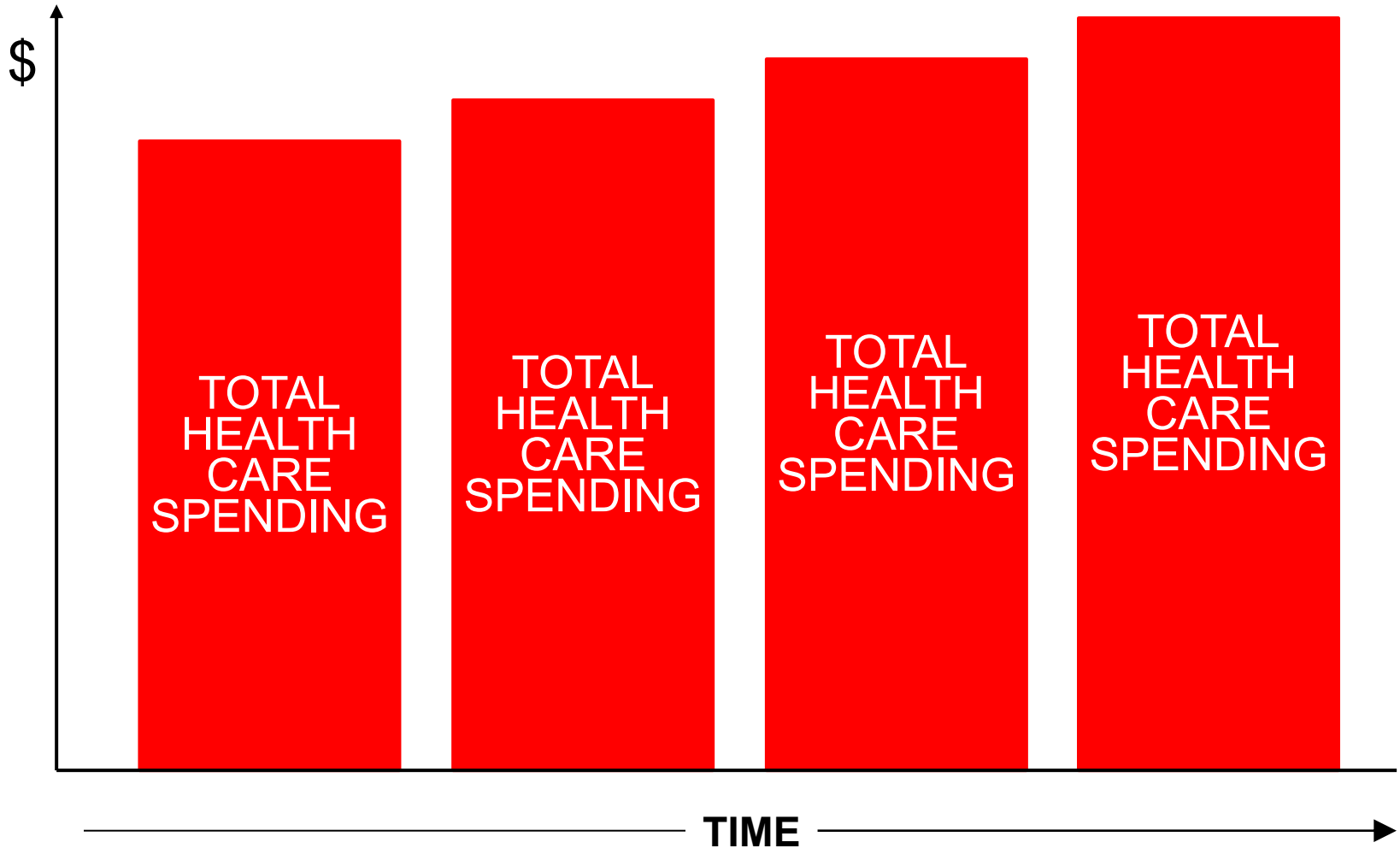
WHY "VALUE-BASED" PAYMENT ISN'T WORKING AND HOW TO FIX IT

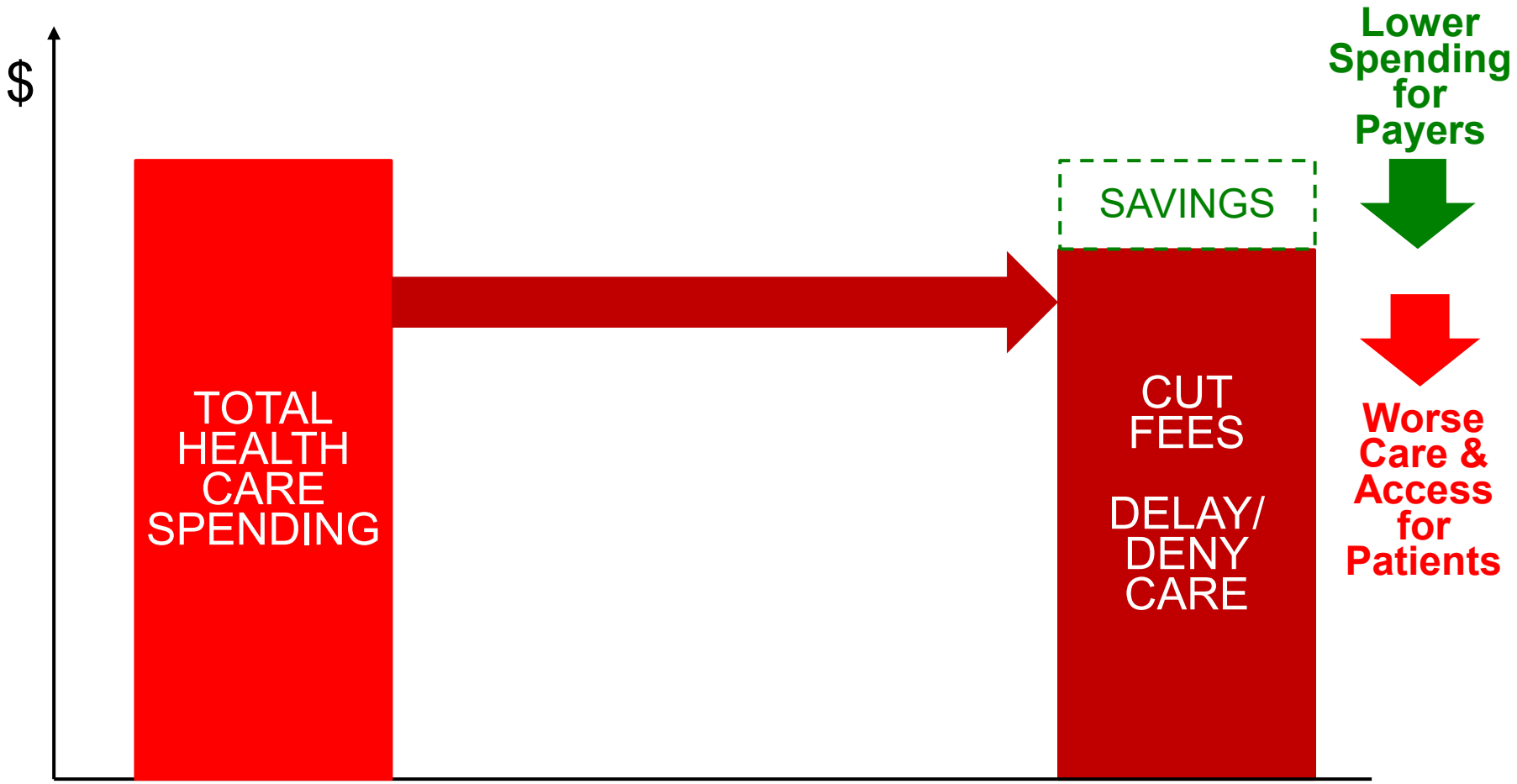
Harold D. Miller
President and CEO
Center for Healthcare Quality and Payment Reform

www.CHQPR.org

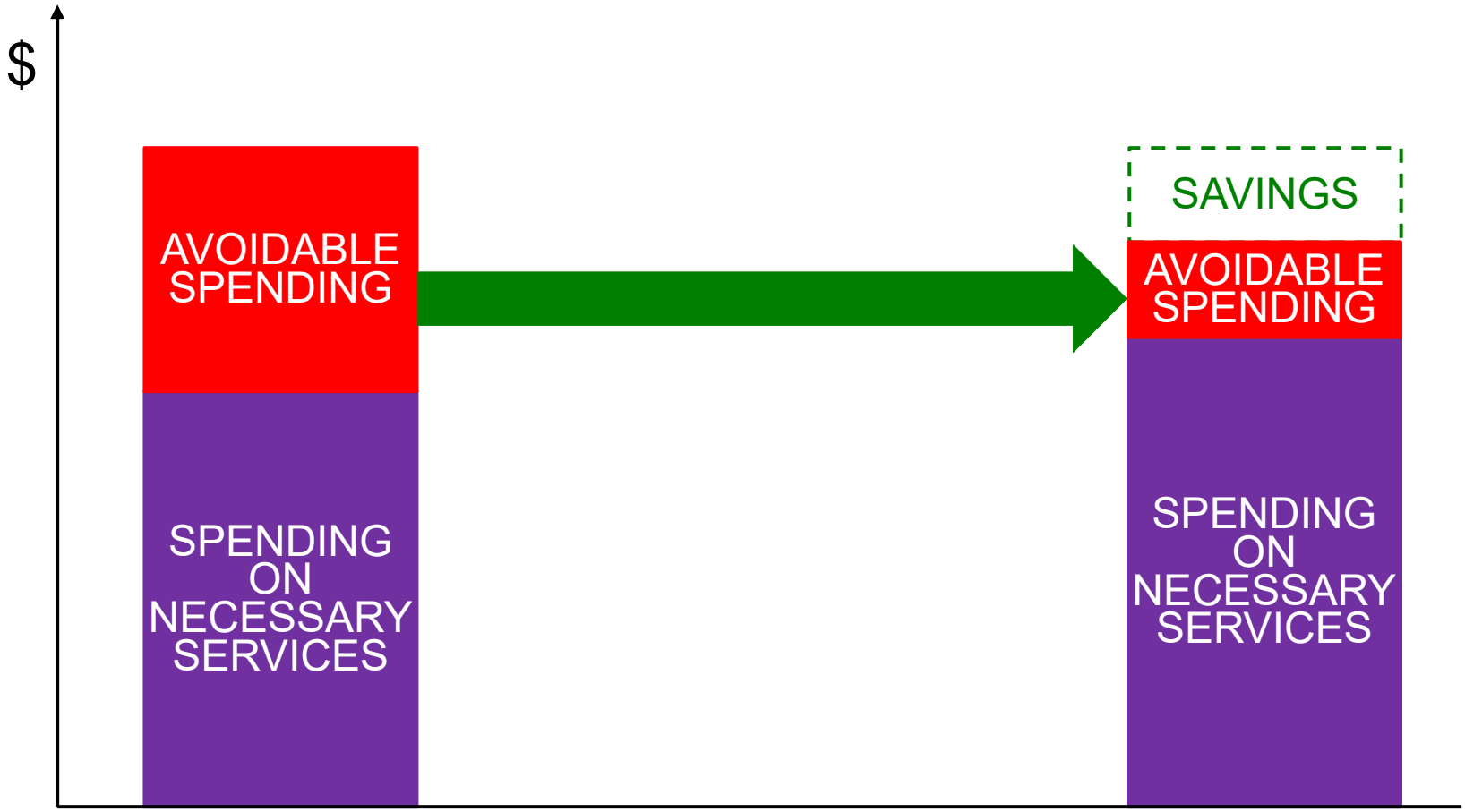
How Do You Control the Growth in Healthcare Spending?



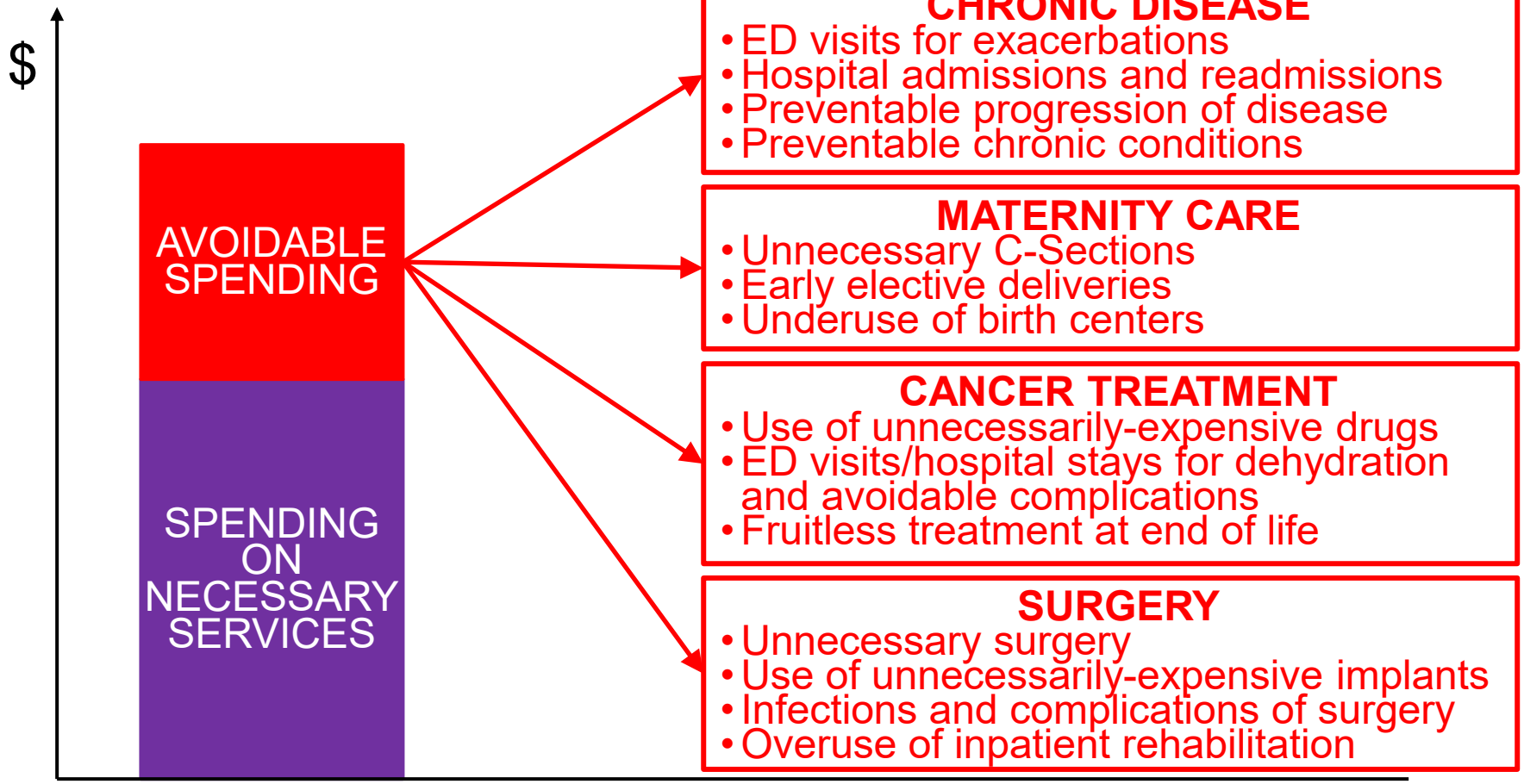
Wrong Ways: Cut Providers Fees or Delay/Deny Services to Patients



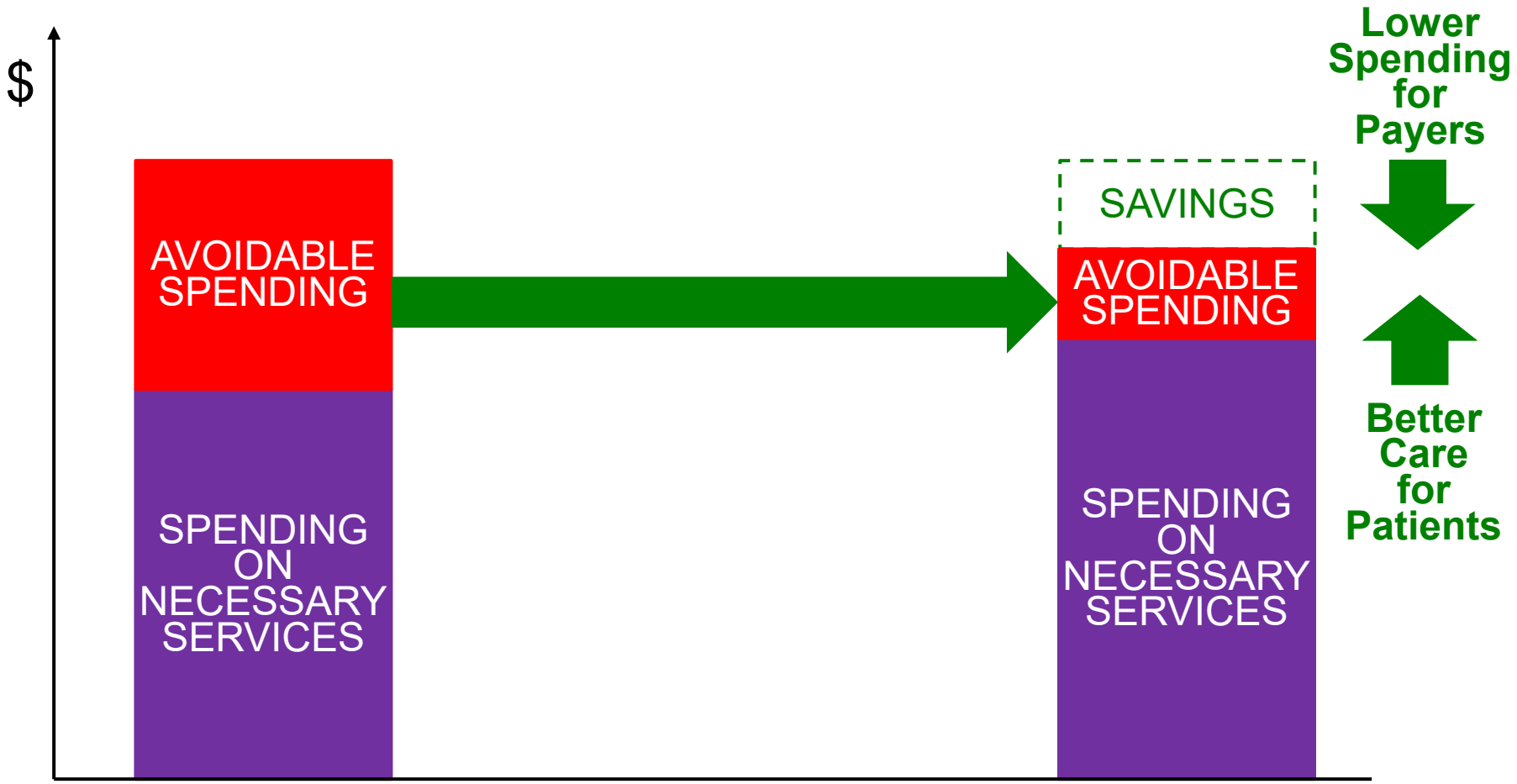
The Right Way: Reducing *Avoidable* Spending



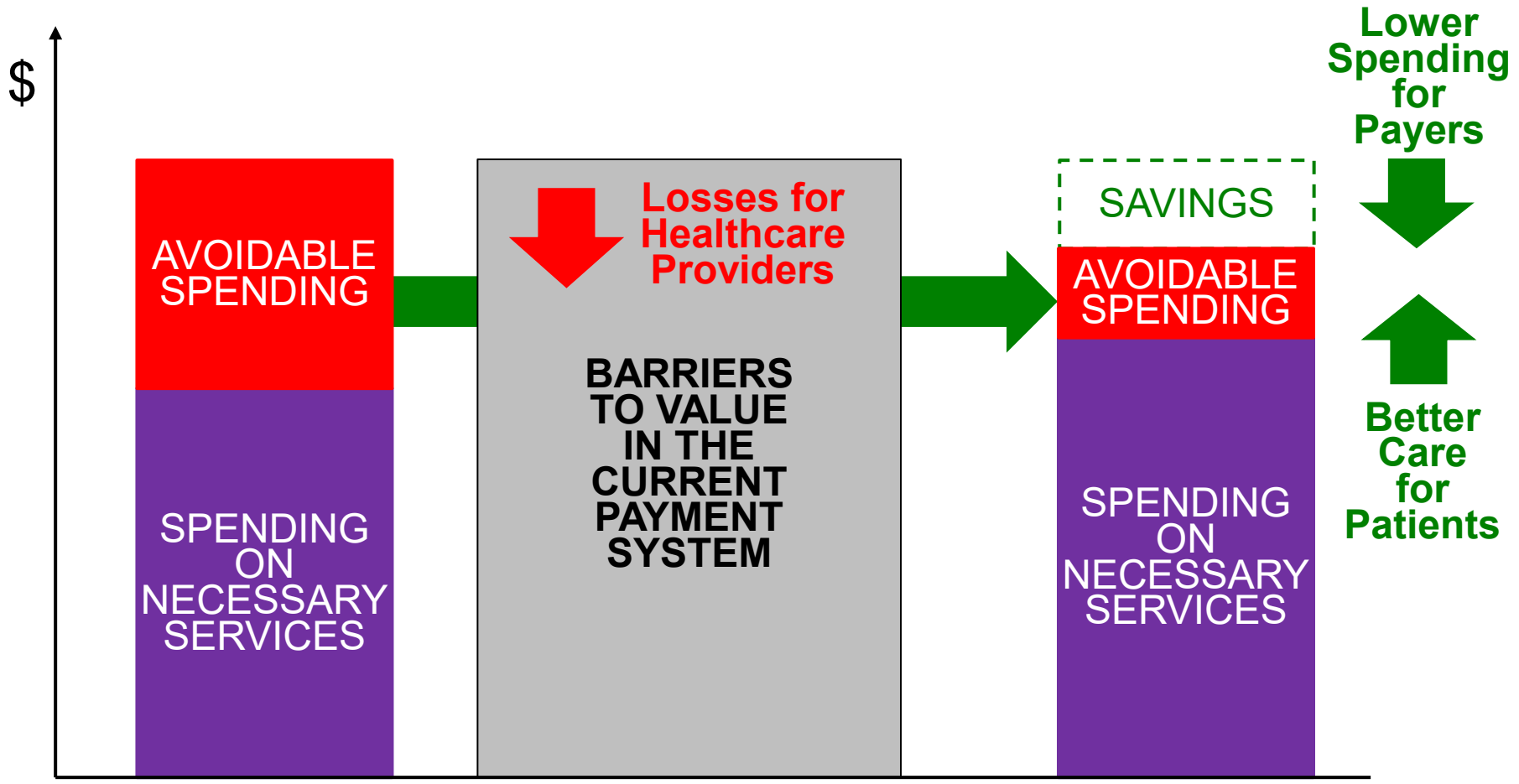
Avoidable Spending Exists In All Areas of Health Care



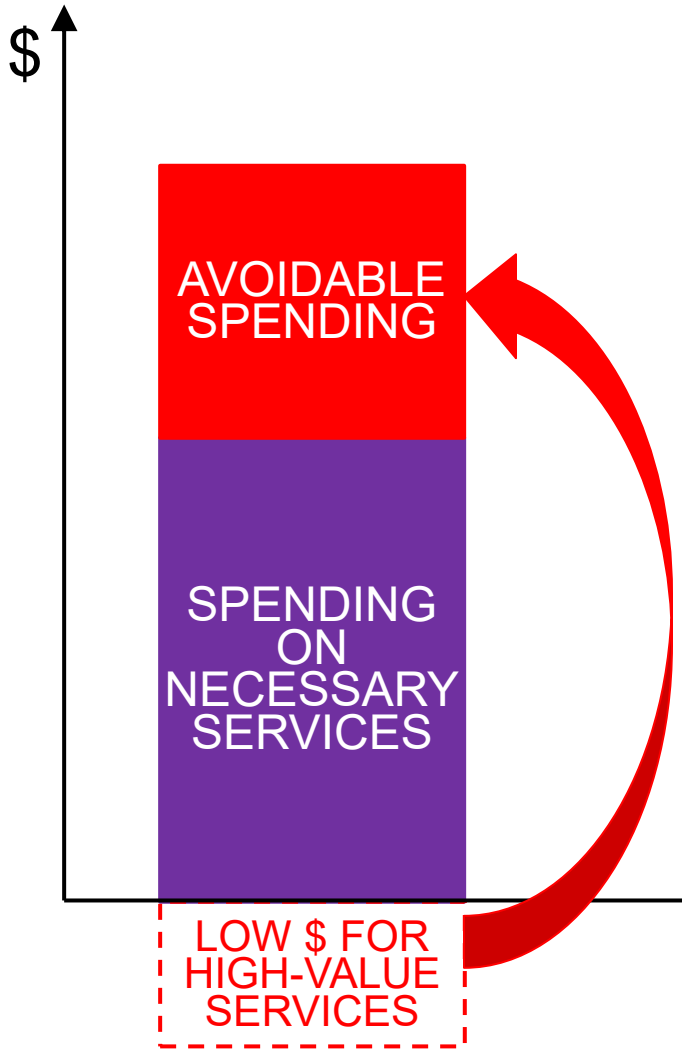
Reducing Avoidable Spending is a Win-Win for Payers & Patients



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



Barrier #1: Inadequate Payments for Higher-Value Services

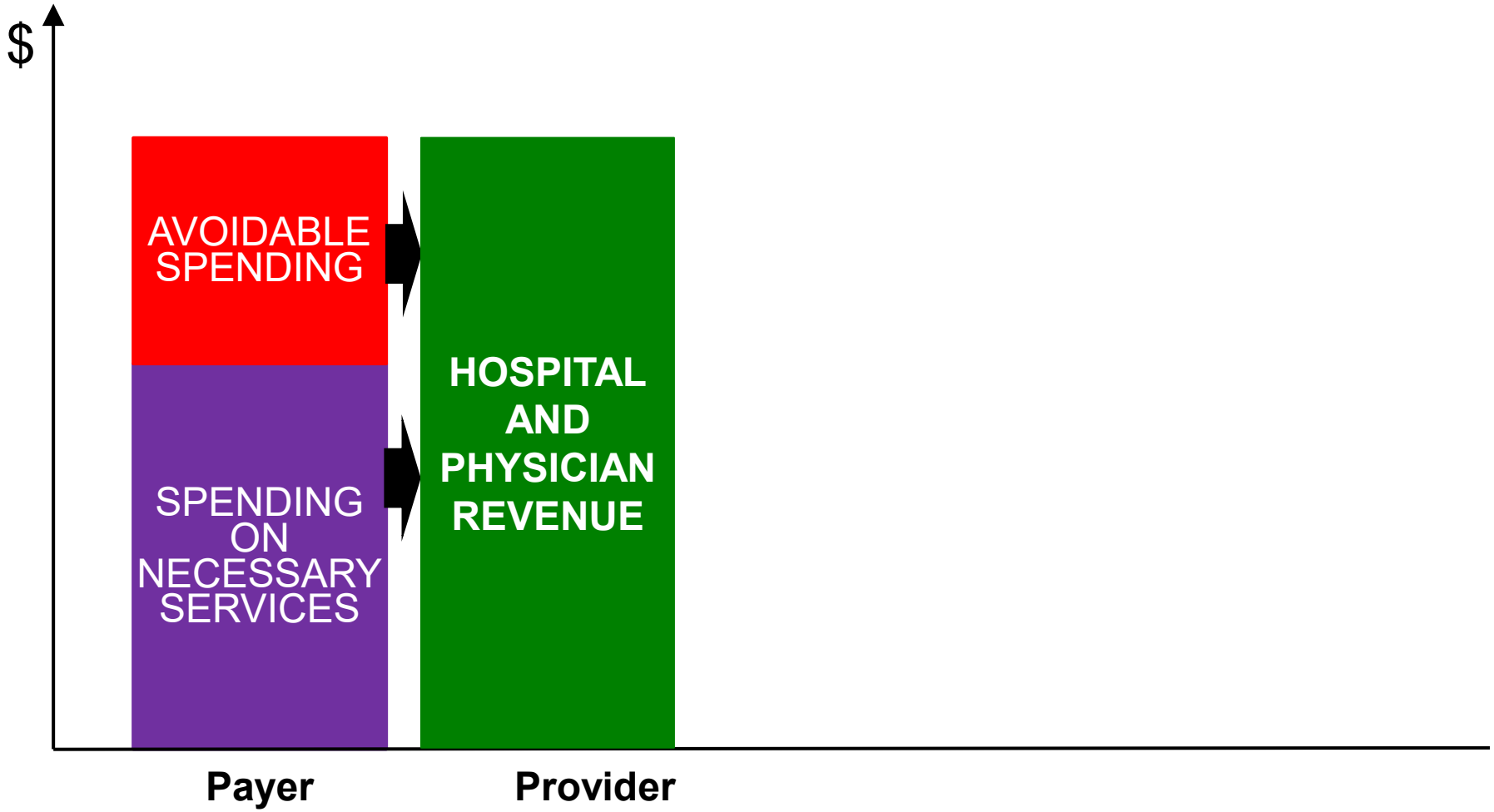


Avoidable spending often occurs because payments are inadequate (or non-existent) for alternative, higher-value services:

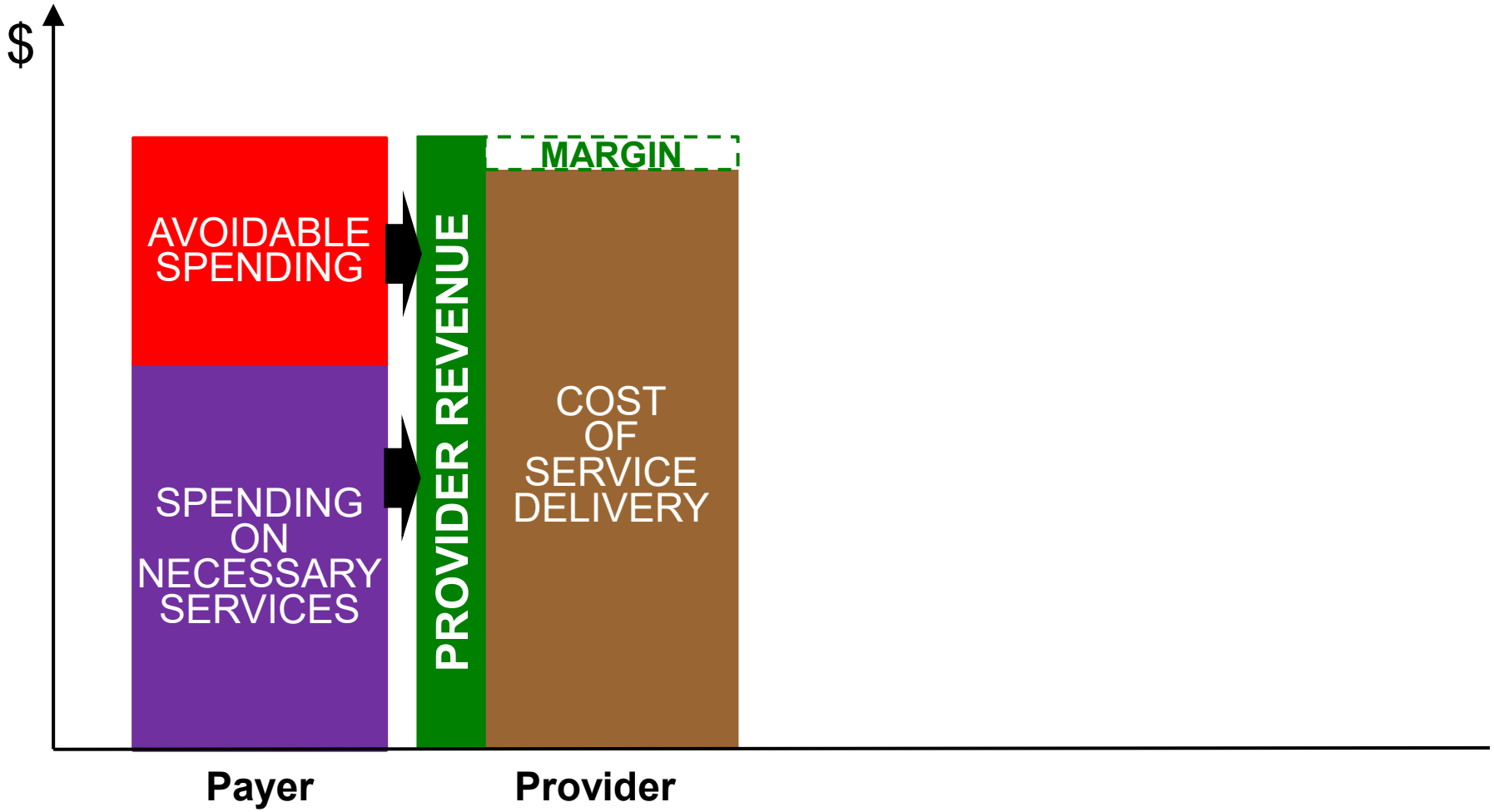
- Services other than office visits, such as phone calls, e-mails, etc.
- Services delivered by non-clinicians, e.g., nurses, community health workers, etc.
- Communication between physicians to ensure accurate diagnosis & coordinate care
- Non-medical services, e.g., transportation
- Palliative care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

Delivering these services improves value for payers and patients, but causes financial losses for healthcare providers

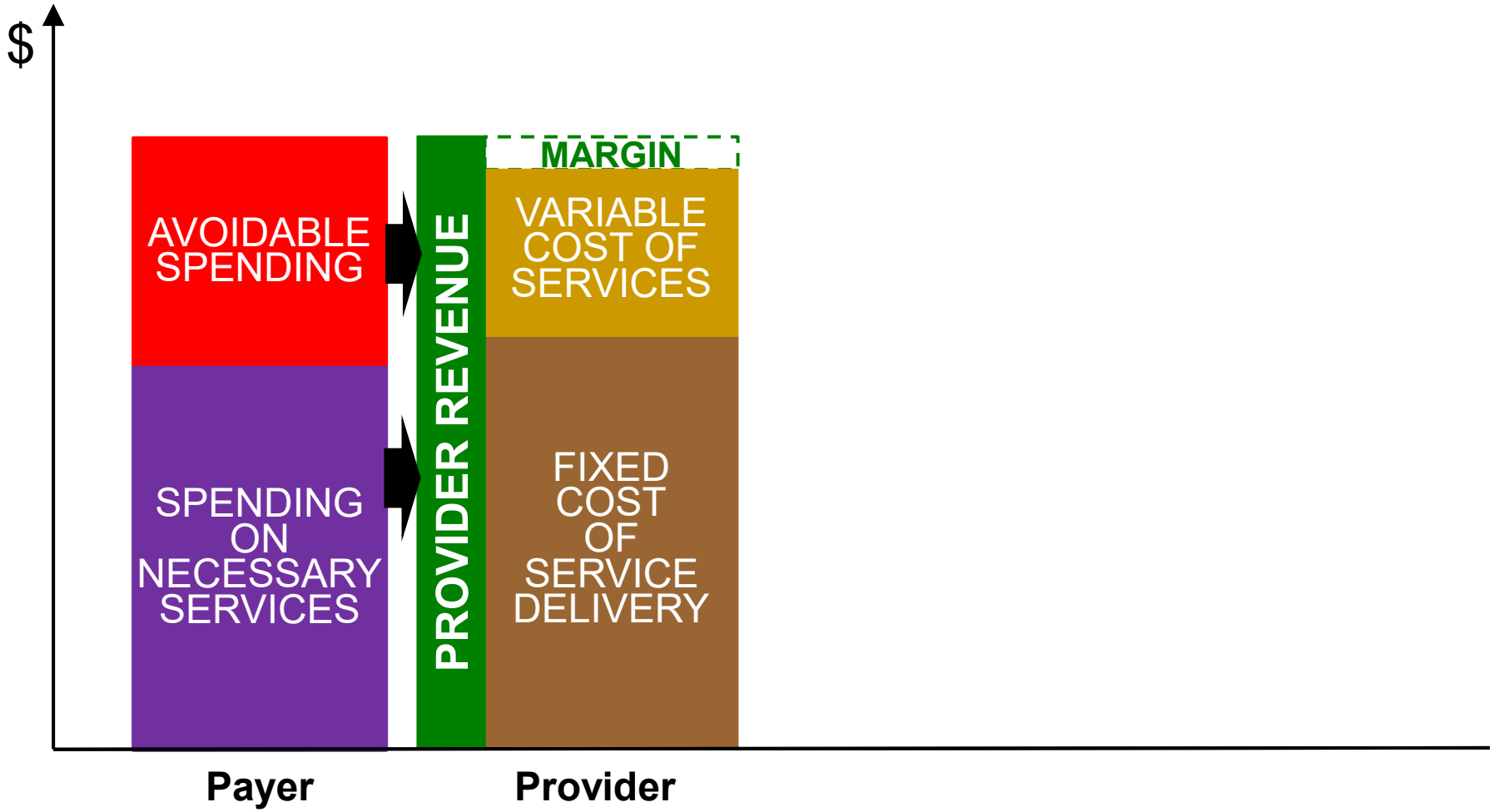
Barrier #2: "Avoidable Spending" is *Revenue* for Providers



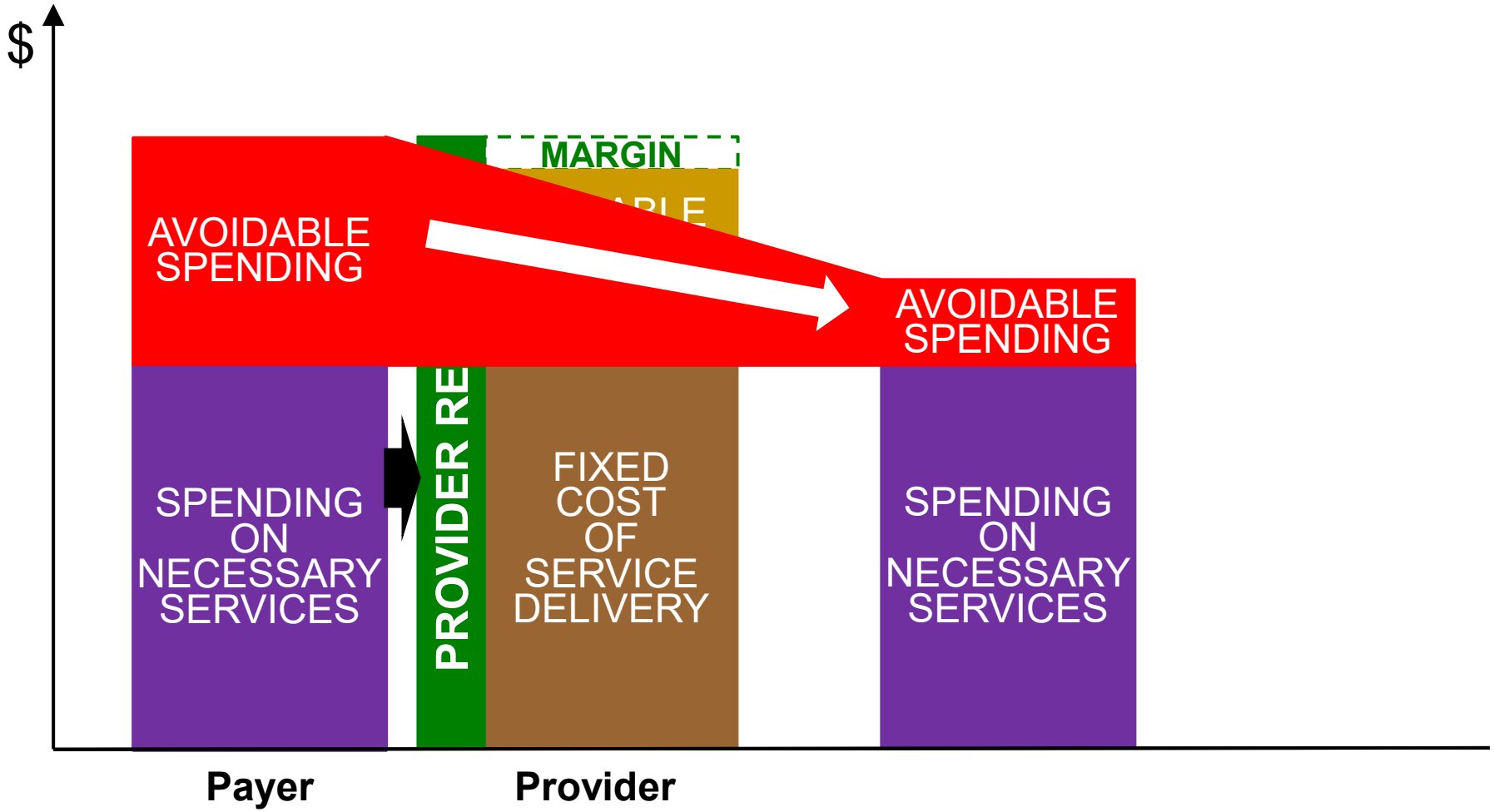
Providers Use the Revenue to Pay for the Costs of Services



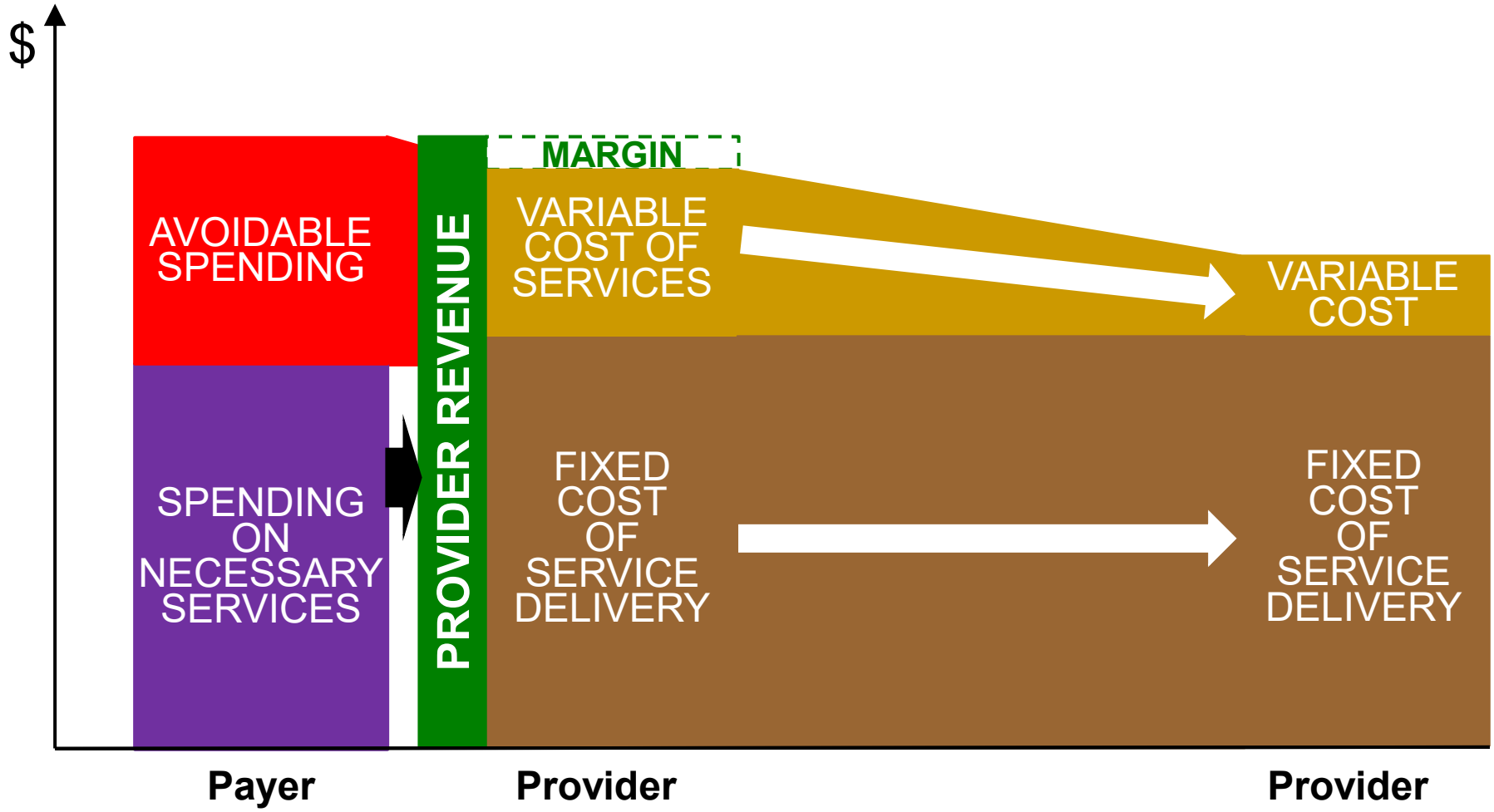
The Majority of Costs May Be Fixed (in the Short Term)



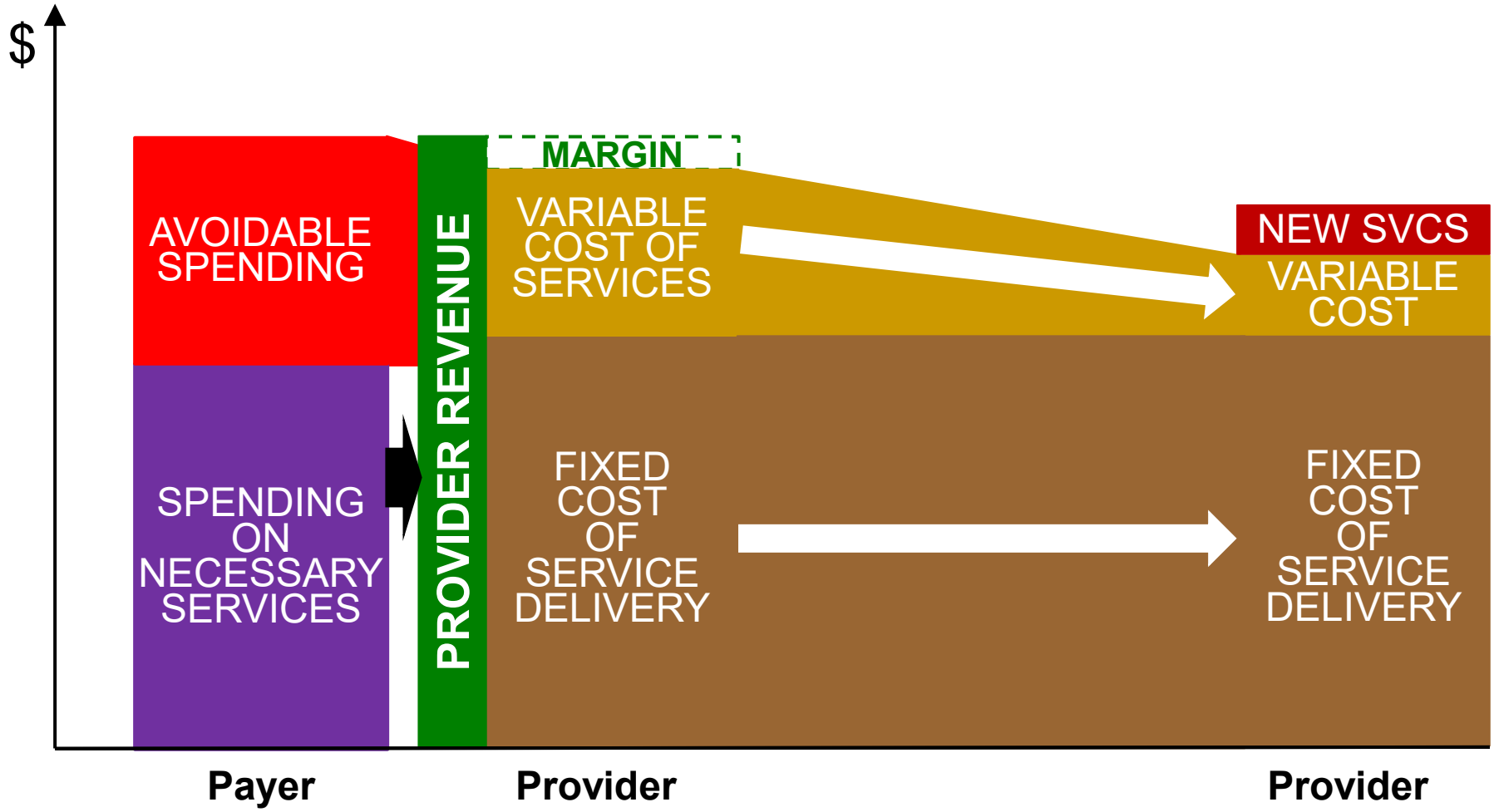
When Healthcare Providers Reduce Avoidable Services…



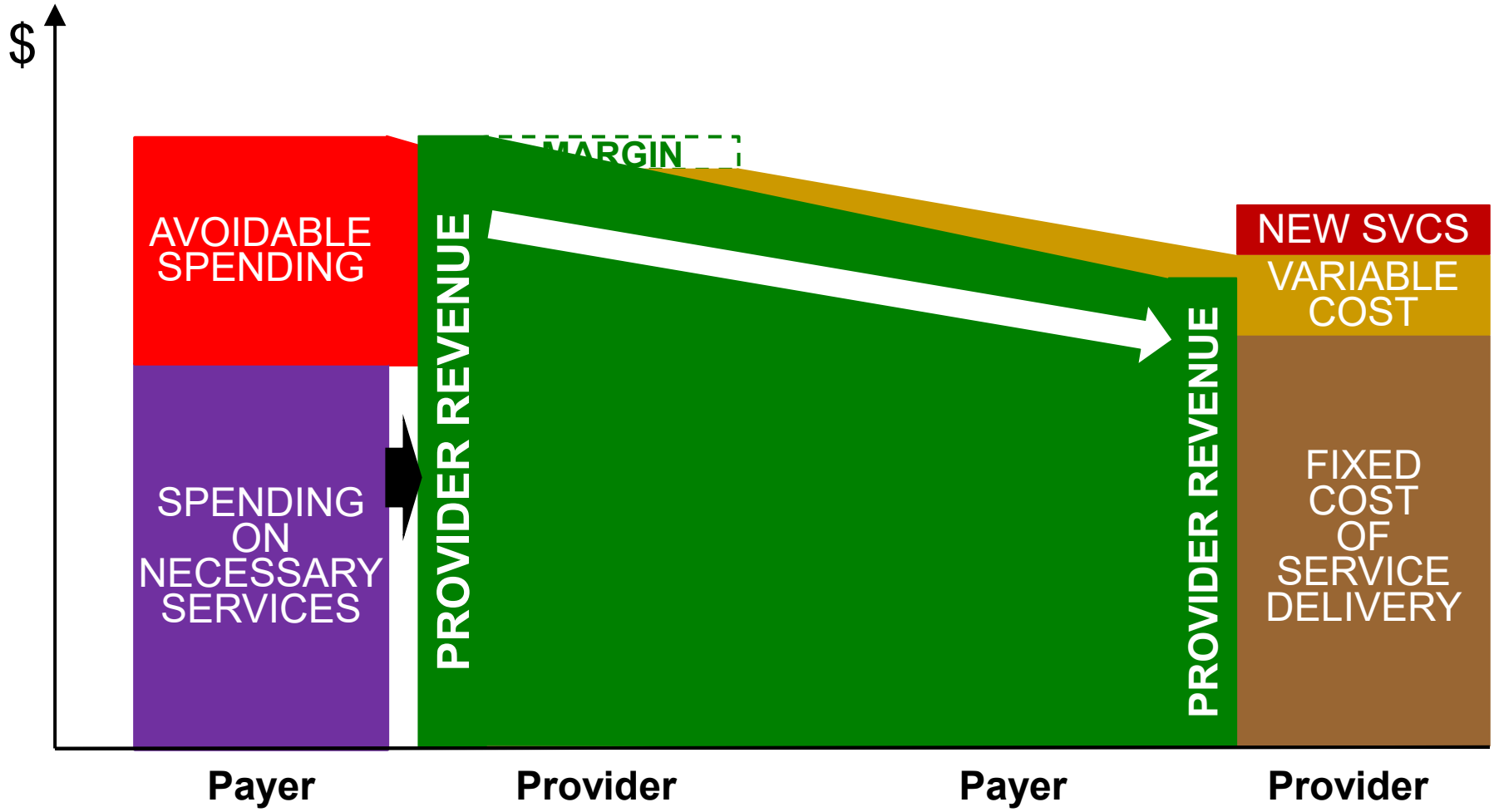
…Variable Costs Decrease, But Fixed Costs Do Not



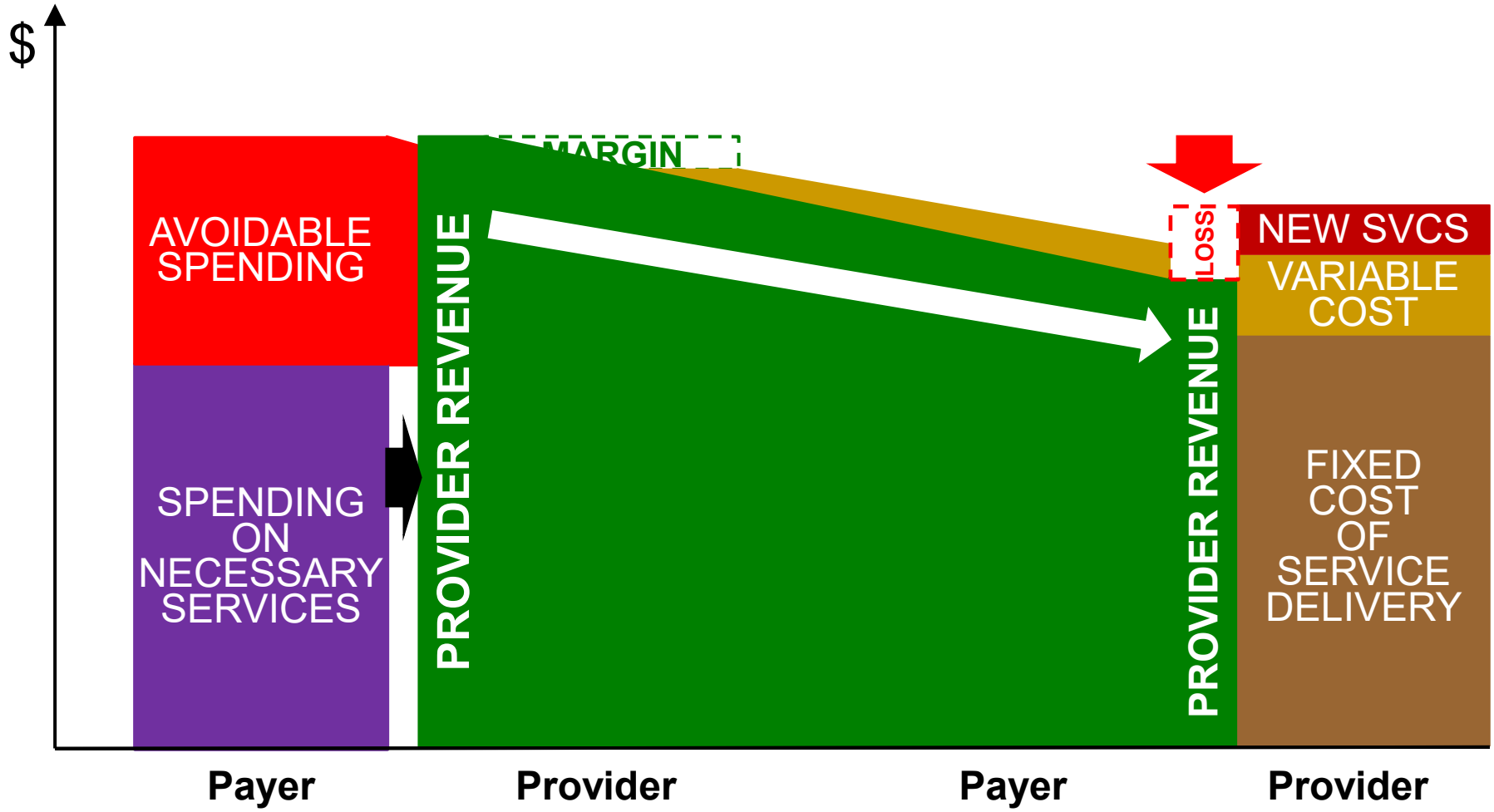
…Plus Added Costs of Delivering New High-Value Services



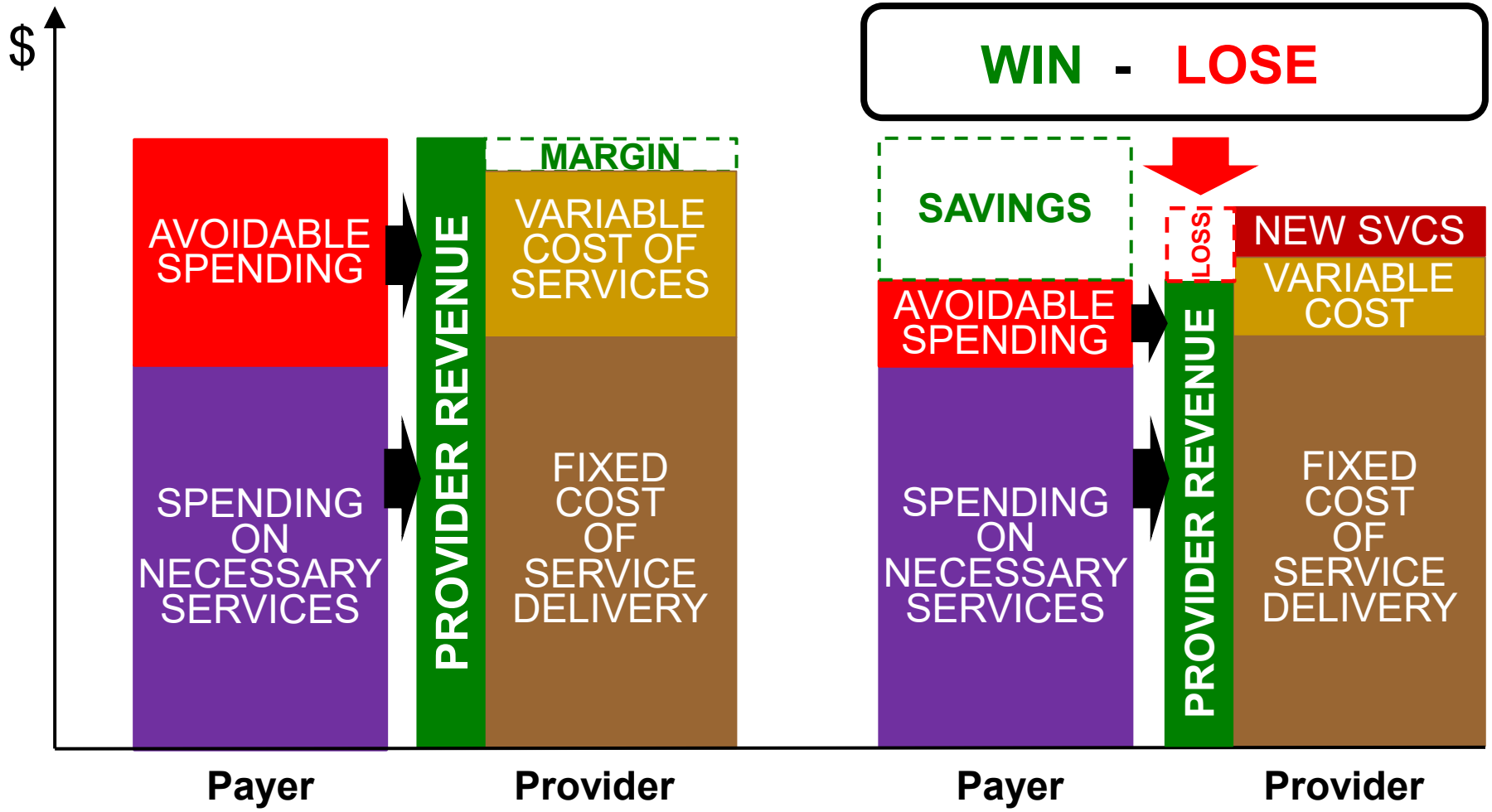
Revenues Decrease in Direct Proportion to Service Volume…



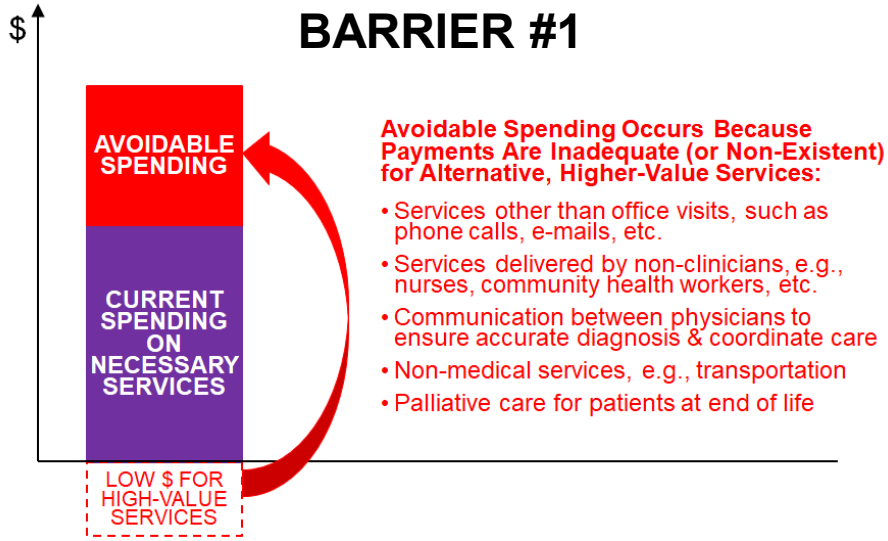
…Resulting in Financial Loss for Healthcare Providers

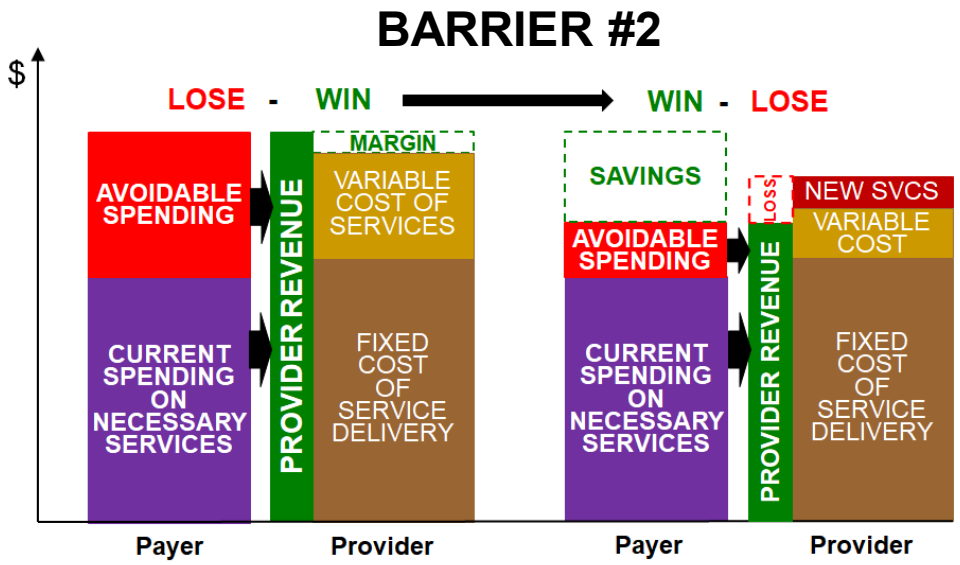


Win-Lose: Savings for Payers, Losses for Providers



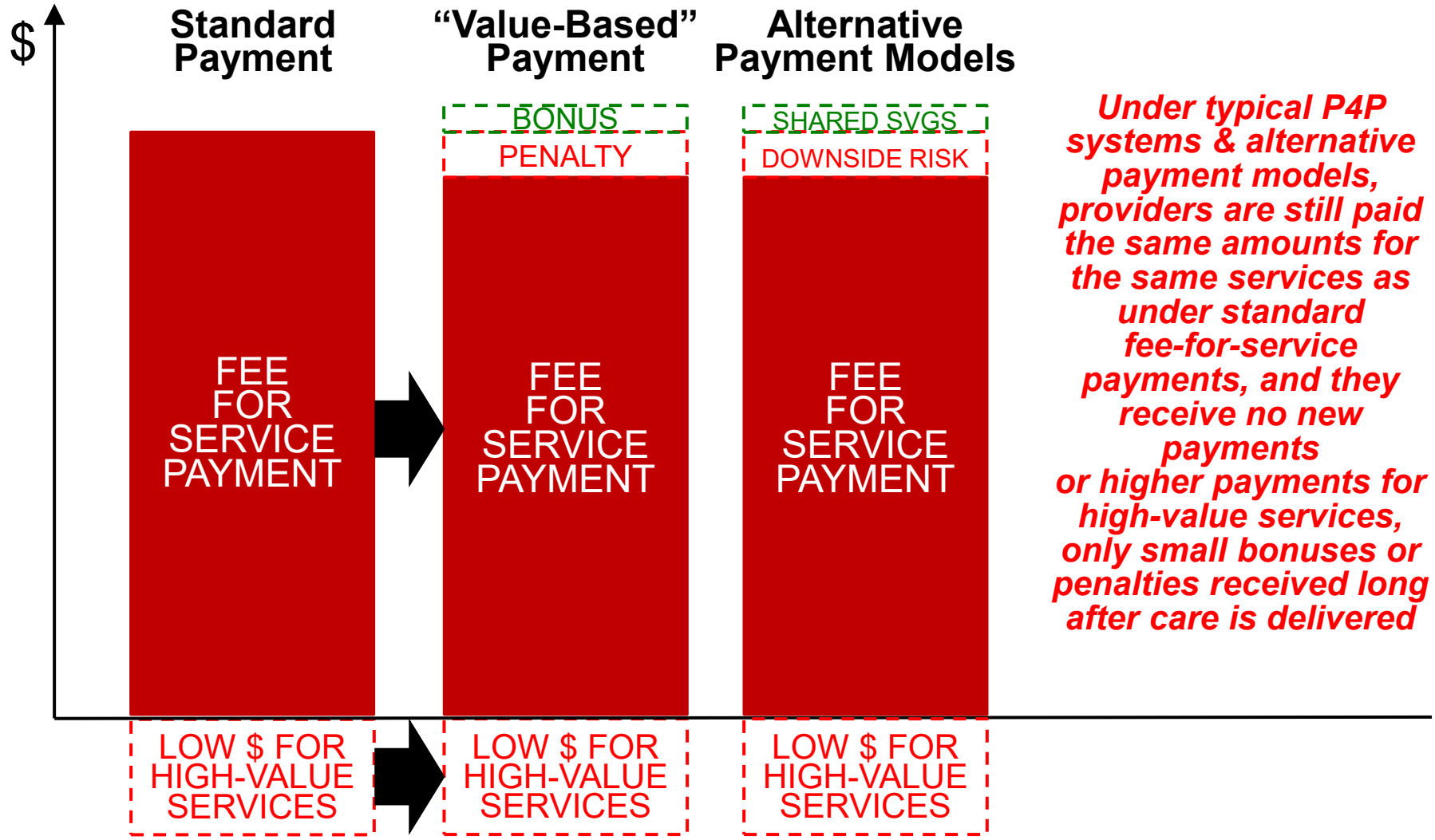
A Good Payment System Must Remove the Barriers to Better Care





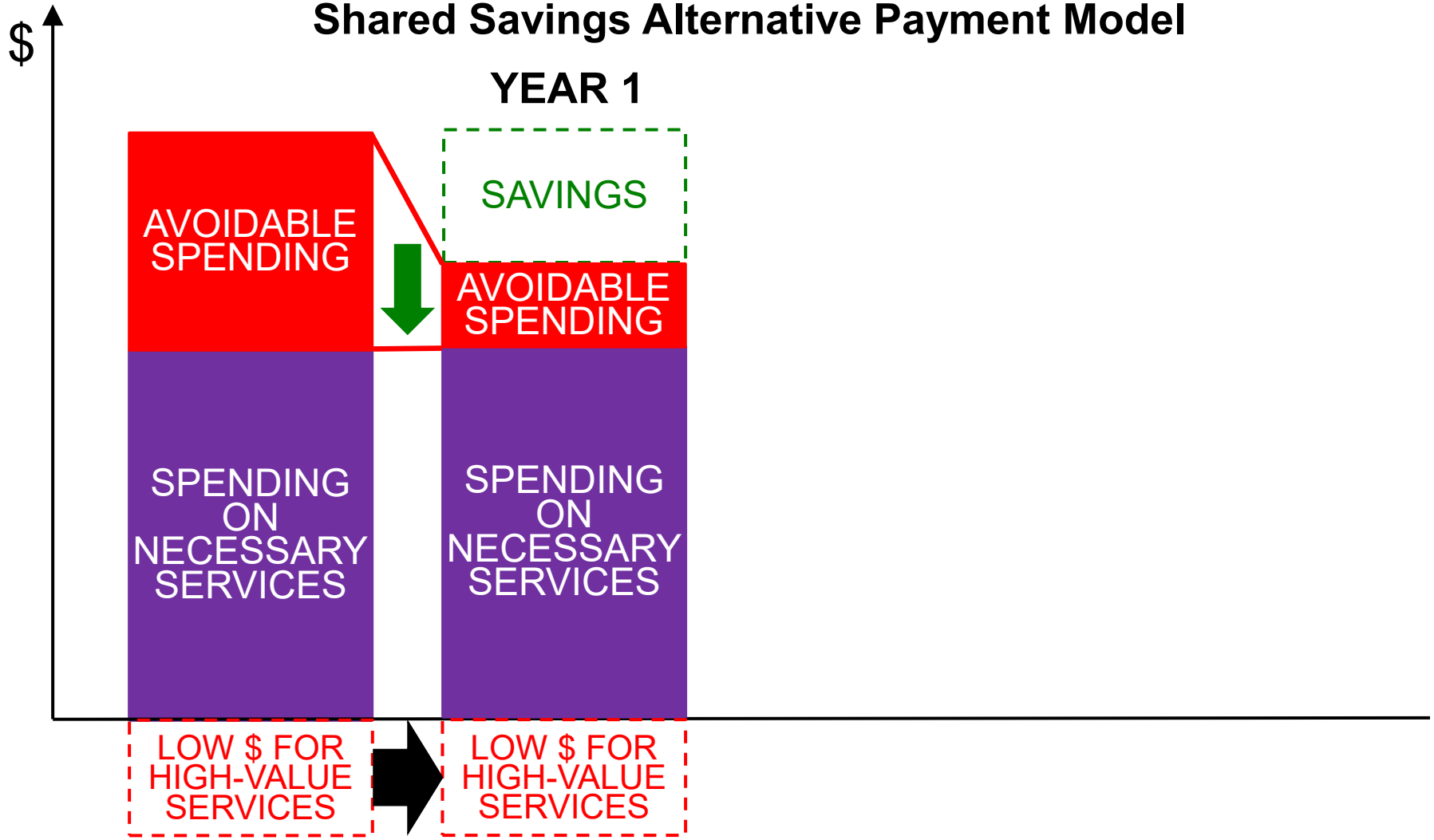
Do Current Value-Based Payment Systems and Alternative Payment Models Remove the Barriers to Value-Based Care?

Most "Value-Based Payment" is Fee for Service + "Incentives"

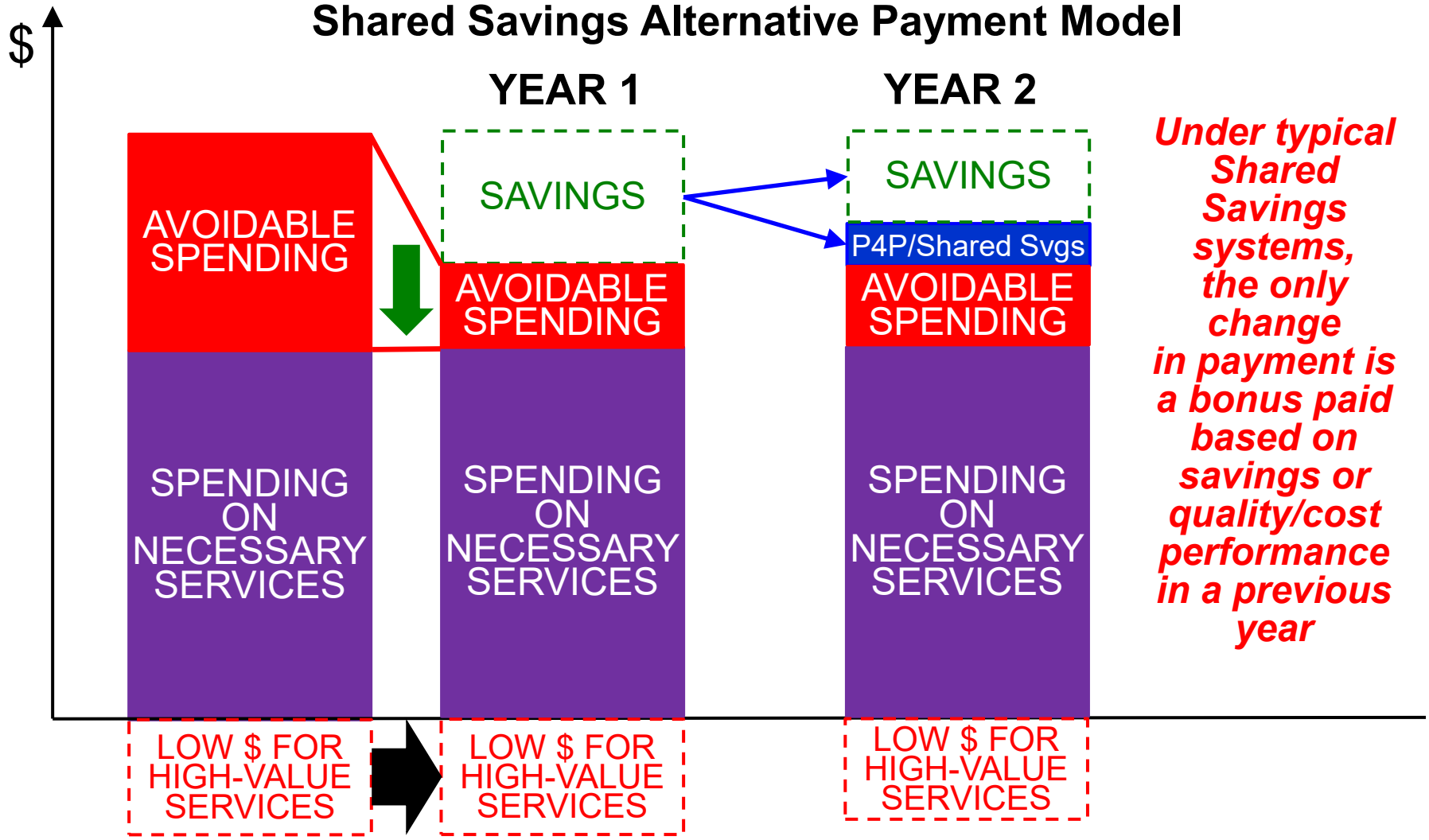


Under typical P4P systems & alternative payment models, providers are still paid the same amounts for the same services as under standard fee-for-service payments, and they receive no new payments or higher payments for high-value services, only small bonuses or penalties received long after care is delivered

Under Shared Savings APMs, If Payers Save $$ *This* Year…

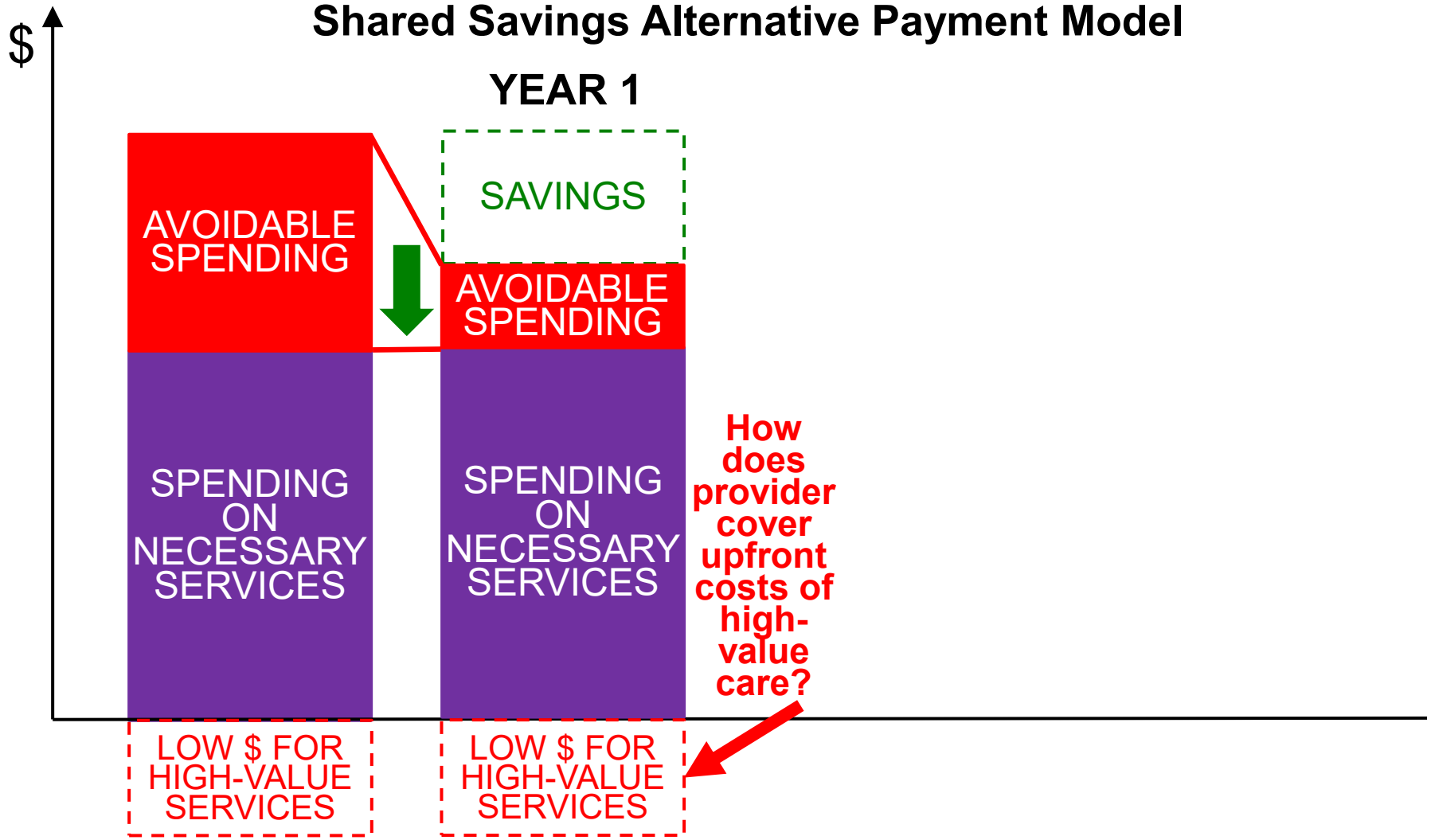


If Payers Save $$ *This* Year… Providers (*May*) Get $ *Next* Year

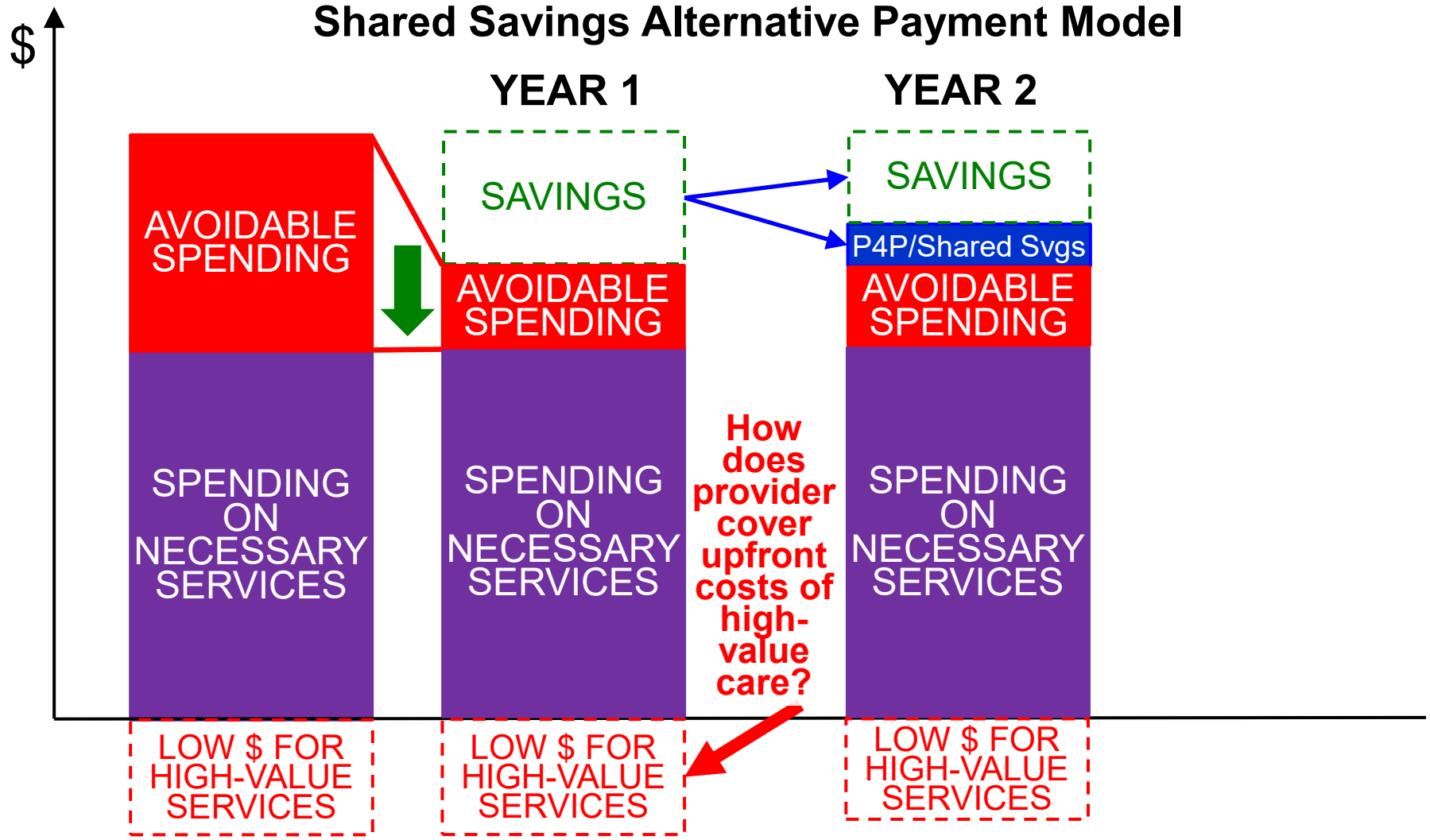


Under typical Shared Savings systems, the only change in payment is a bonus paid based on savings or quality/cost performance in a previous year

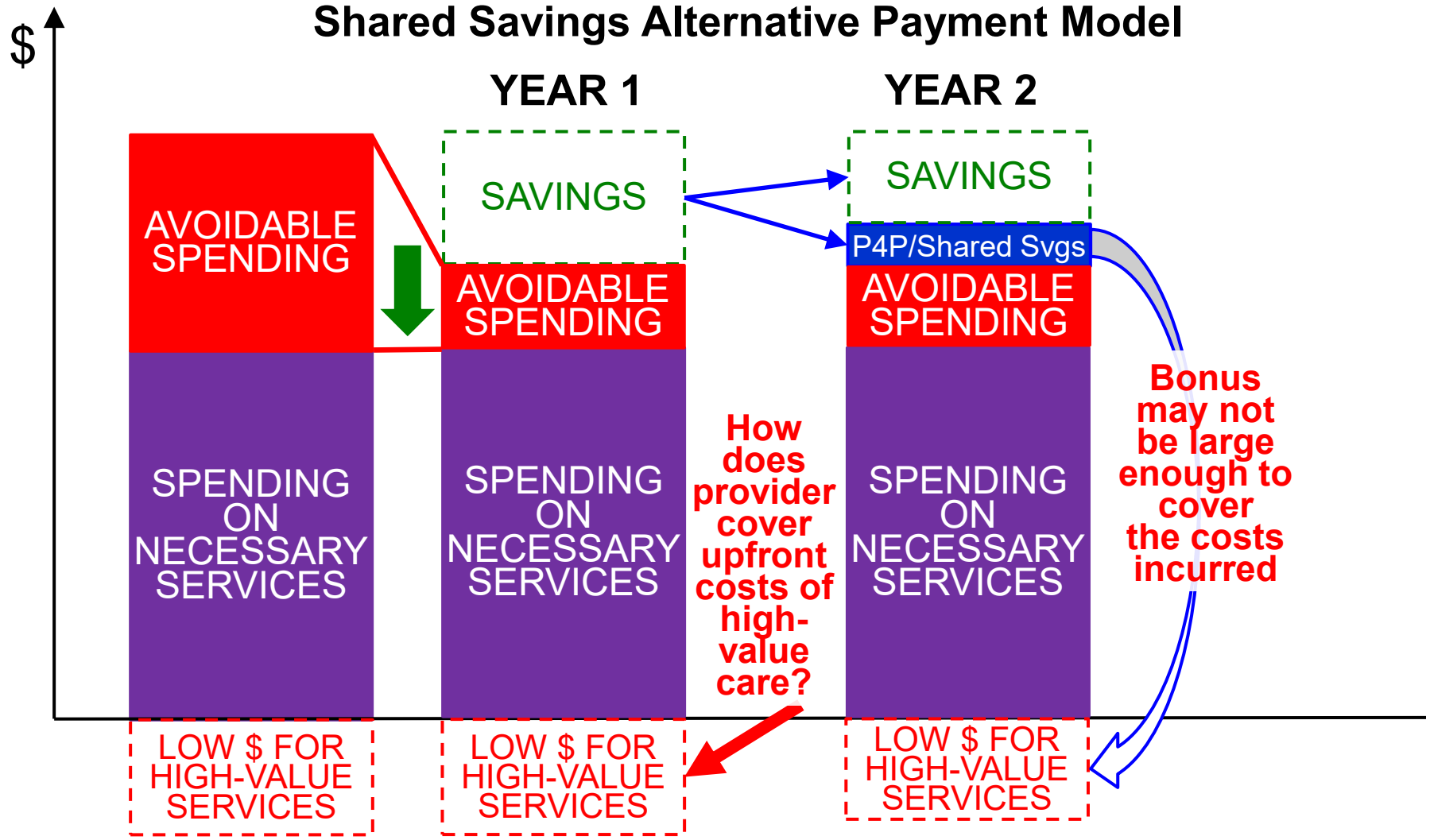
No Additional Payments for New High-Value Services



If Provider Qualifies for a Shared Savings Payment…



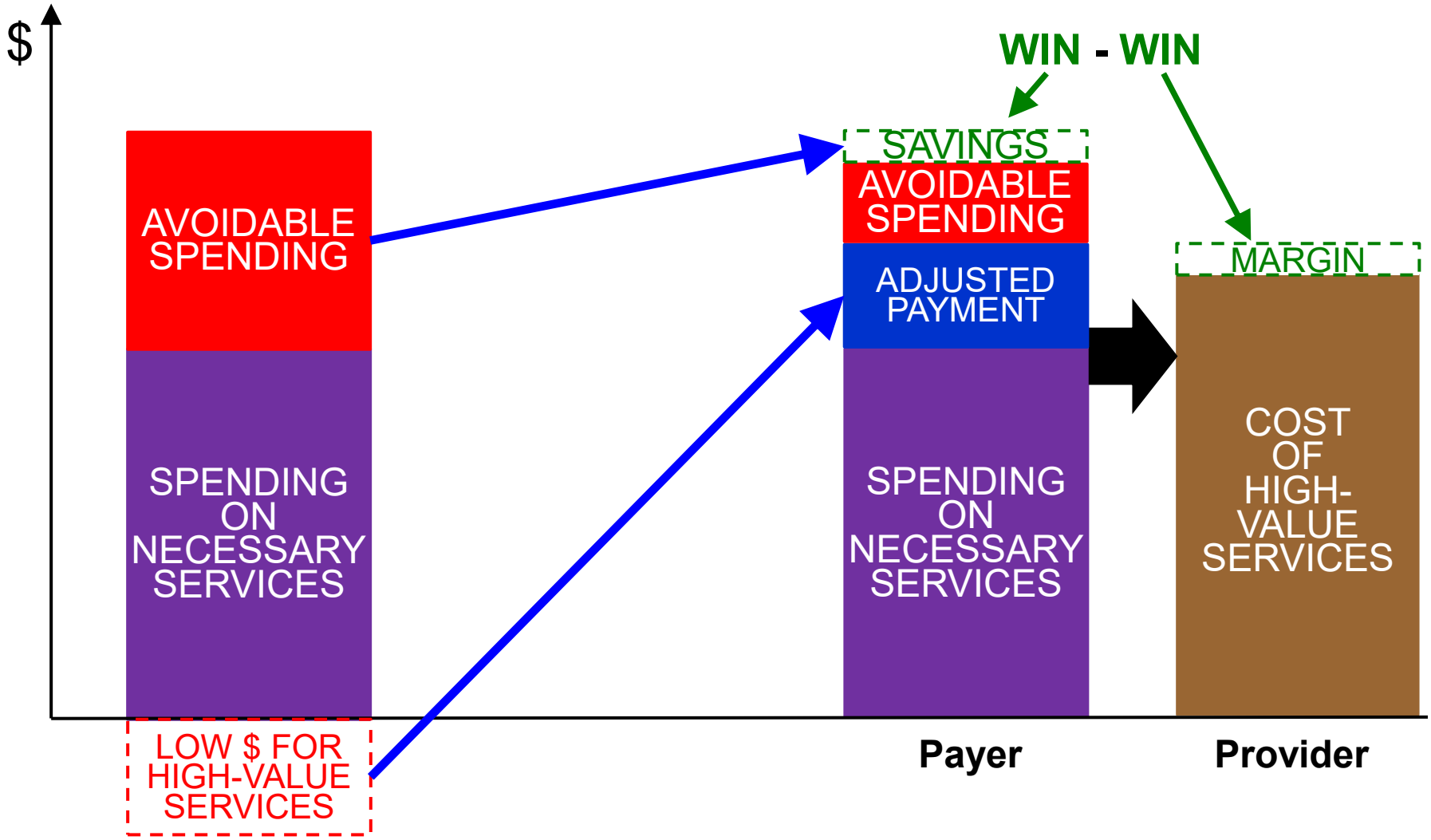
…Payment is Generally Less Than Added Costs & Losses



Little Change in Payment Means Little Savings from CMS APMs

CMS APM		Results
Accountable Care Organizations (ACOs)		
	MSSP ACOs 2013-2016	Increase in Medicare spending
	MSSP ACOs 2017	Savings of $36 (0.3%) per beneficiary
	MSSP ACOs 2018	Savings of $75 (0.7%) per beneficiary
	MSSP ACOs 2019	Savings of $118 (1.0%) per beneficiary
	NextGen ACOs	Increase in spending in first 2 years
Comprehensive Care for Joint Replacement (CJR)		Savings of $117 (0.4%) per episode
Bundled Payments for Care Improvement (BPCI)		Increase in Medicare spending
Oncology Care Model (OCM)		Increase in spending in first 3 years

Win-Win Requires Savings AND Adequate Payment for Services



Example: Value-Based Care for Inflammatory Bowel Disease (IBD)

Lawrence Kosinski, MD
Gastroenterologist
Chicago, USA

“Project Sonar”
www.SonarMD.com

Opportunity for Savings in IBD

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Gastroenterologist
Chicago, USA

"Project Sonar"
www.SonarMD.com

AVOIDABLE SPENDING OPPORTUNITY:

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

Higher-Value Approach to Care for IBD Patients

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Gastroenterologist
Chicago, USA

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- <33% of hospitalized patients saw their physician in the 30 days prior to hospital admission

CARE REDESIGN:

- Proactive outreach to patients and monitoring of their symptoms using a smartphone app ("Sonar")
- Early intervention by nurse and physician when problematic symptoms are identified

Change to Overcome Barriers in Current Payments

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- Early intervention by nurse and physician when problematic symptoms are identified

PAYMENT CHANGE:

- Additional payment to physician practice to hire nurse and use symptom monitoring technology

Result: Better Care at Lower Cost for IBD

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- Proactive outreach to patients and monitoring of their symptoms using a smartphone app ("Sonar")
- Early intervention by nurse and physician when problematic symptoms are identified

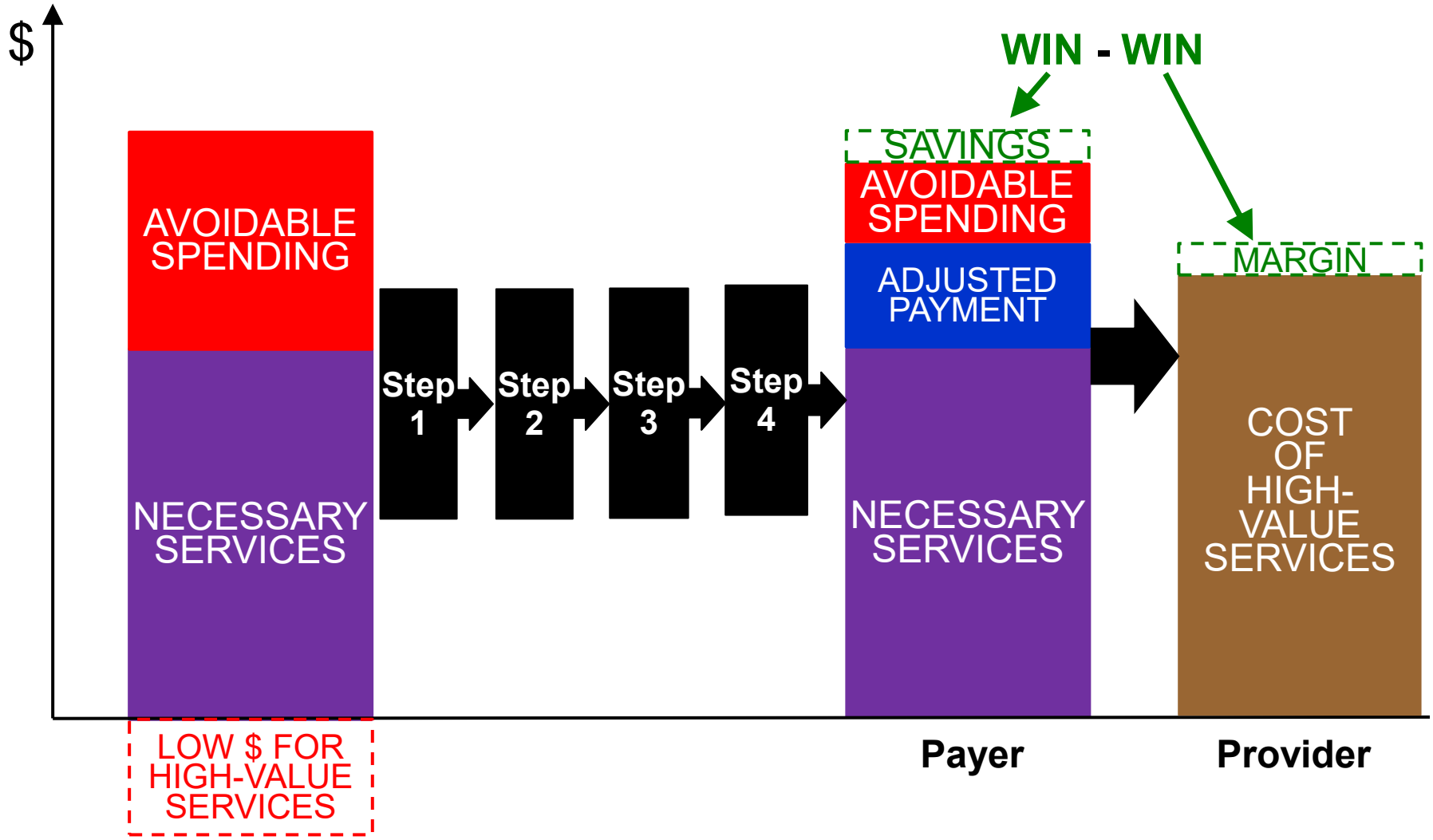
PAYMENT CHANGE:

- Additional payment to physician practice to hire nurse and use symptom monitoring technology

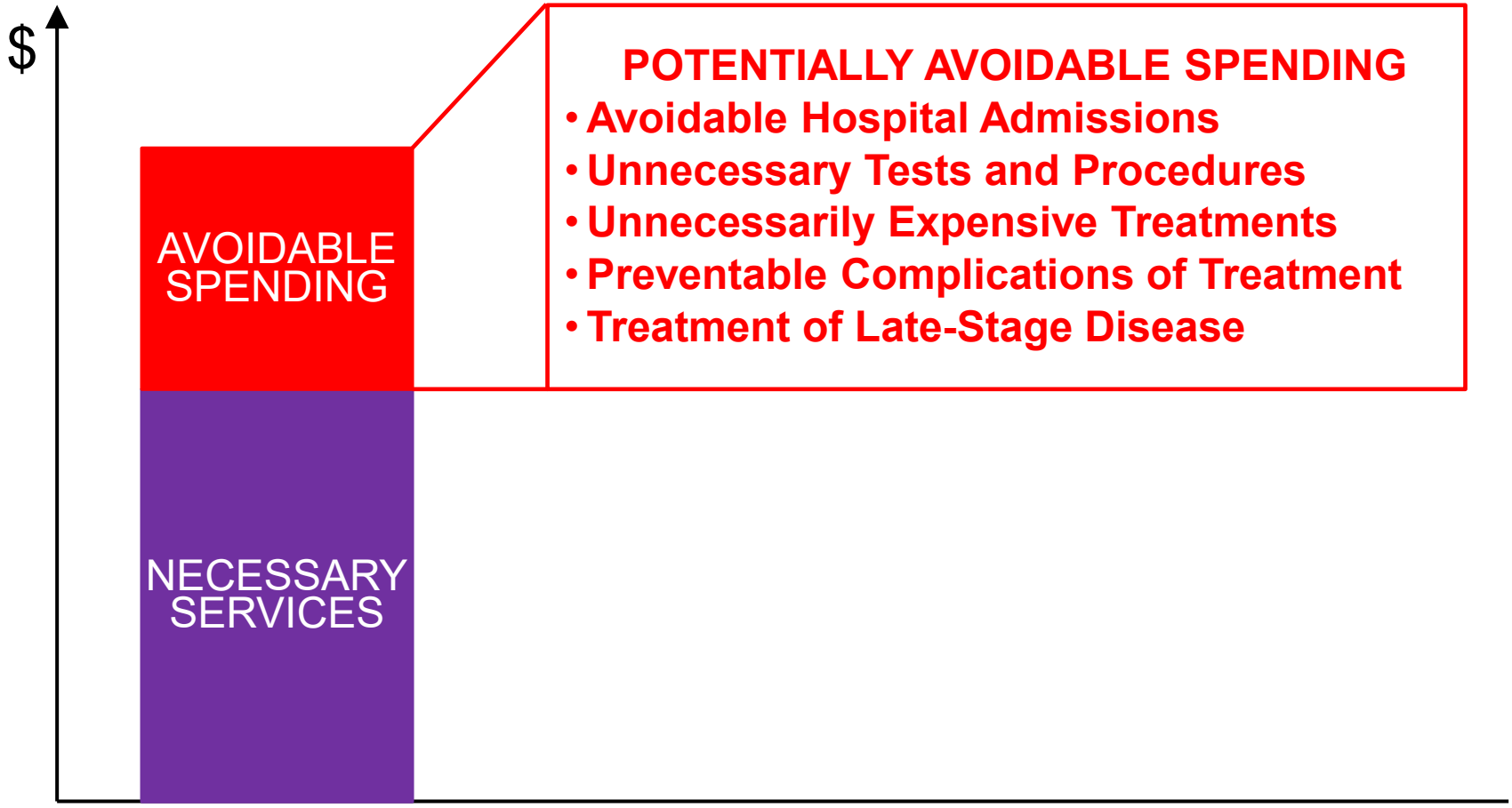
RESULTS:

- 50% reduction in hospital admissions
- 10% reduction in total spending even with higher payments to physician practice for nurse

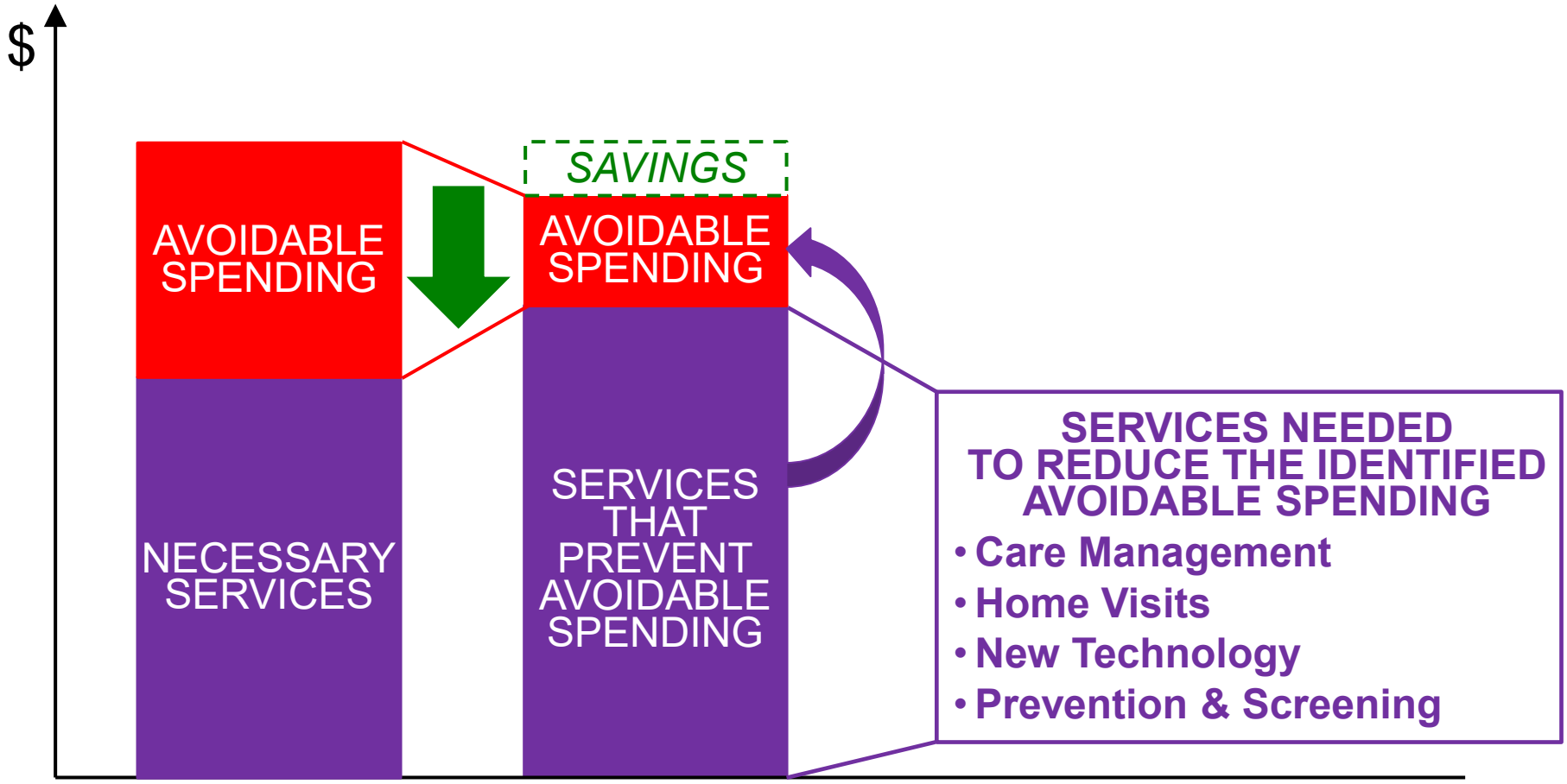
4 Steps for Creating *Successful* Value-Based Payments



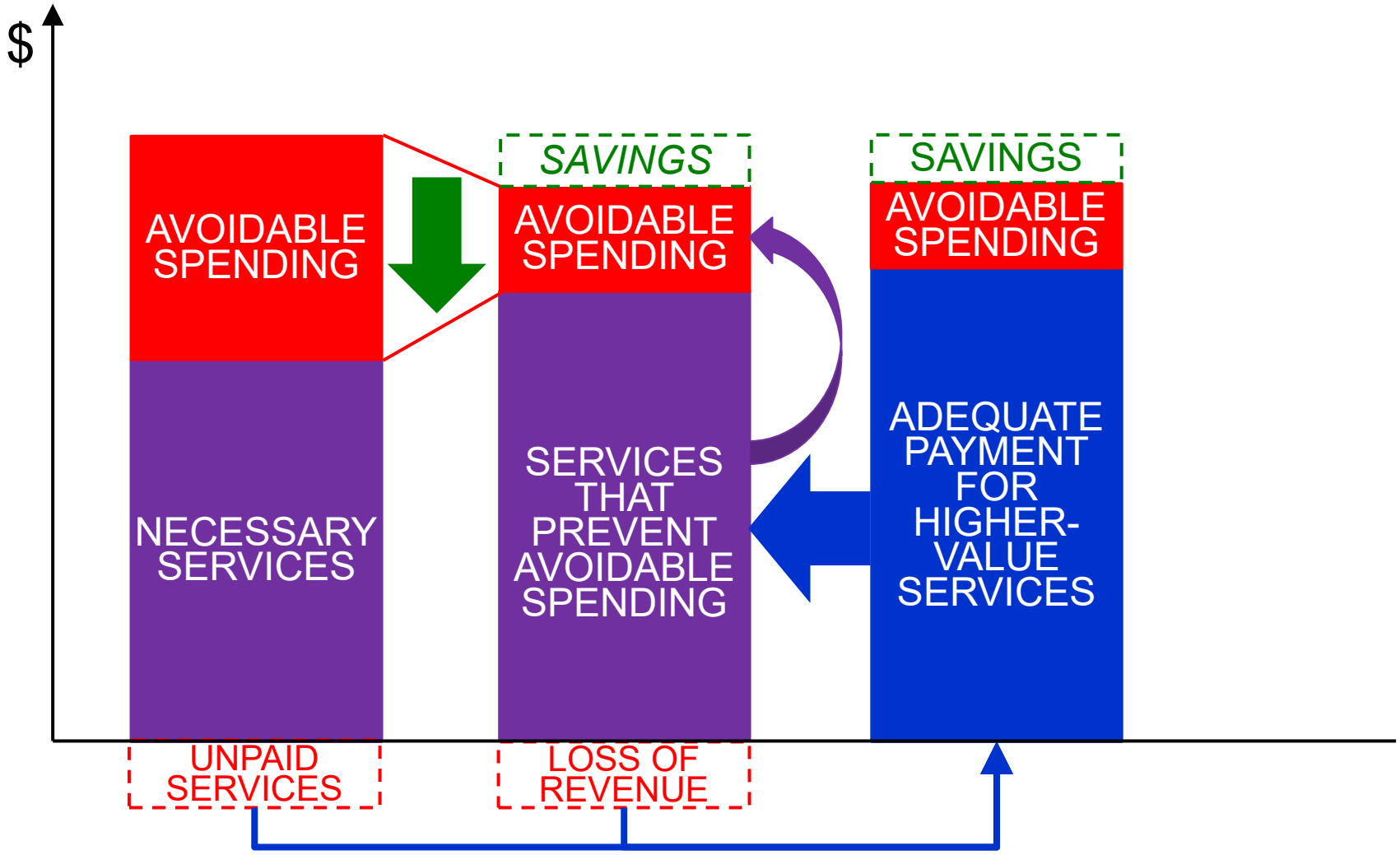
Step 1: Identify *Specific* Areas of Potentially Avoidable Spending



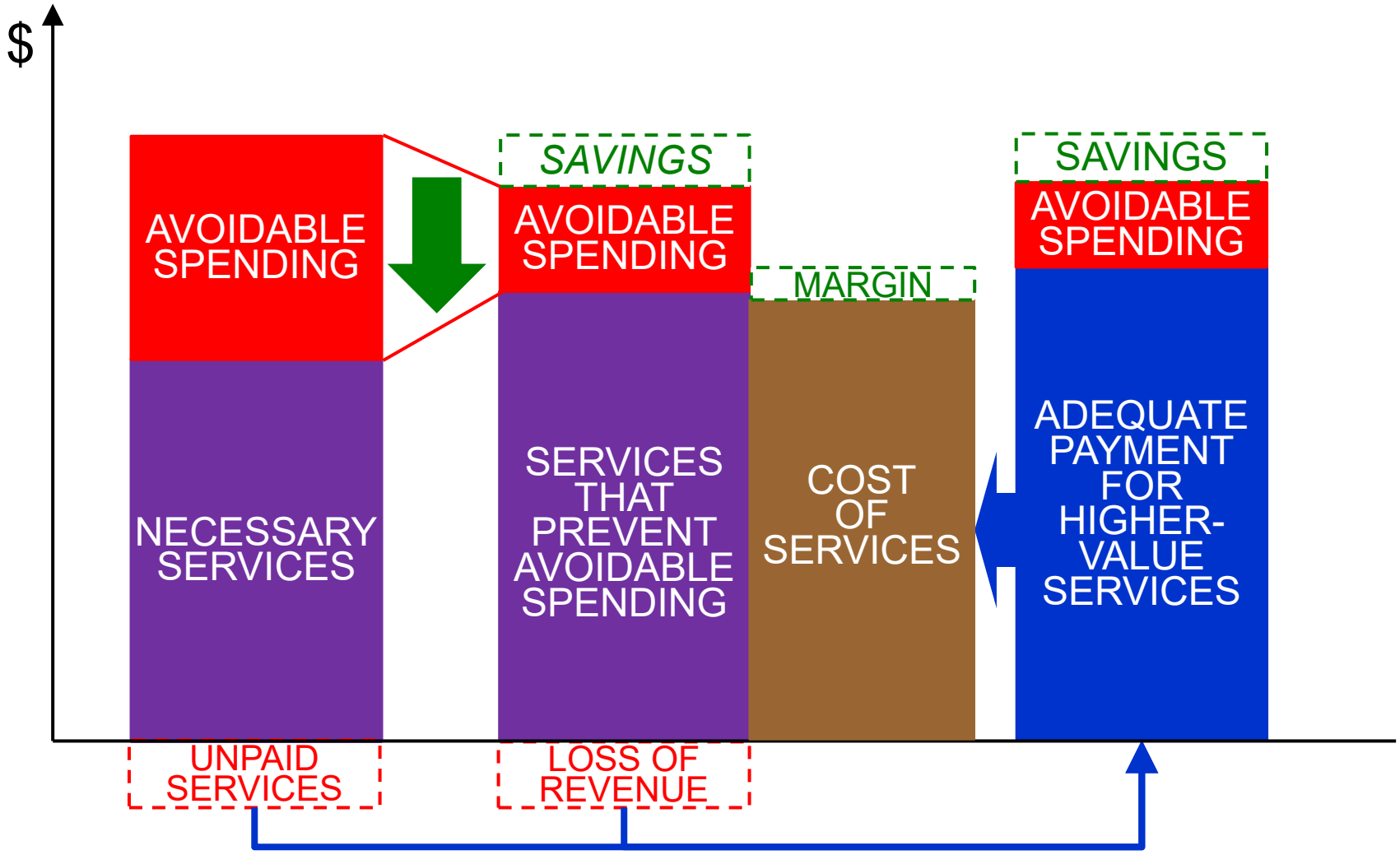
Step 2: Design Services That Will Reduce The Avoidable Spending



Step 3: Pay Adequately to Support Higher-Value Services



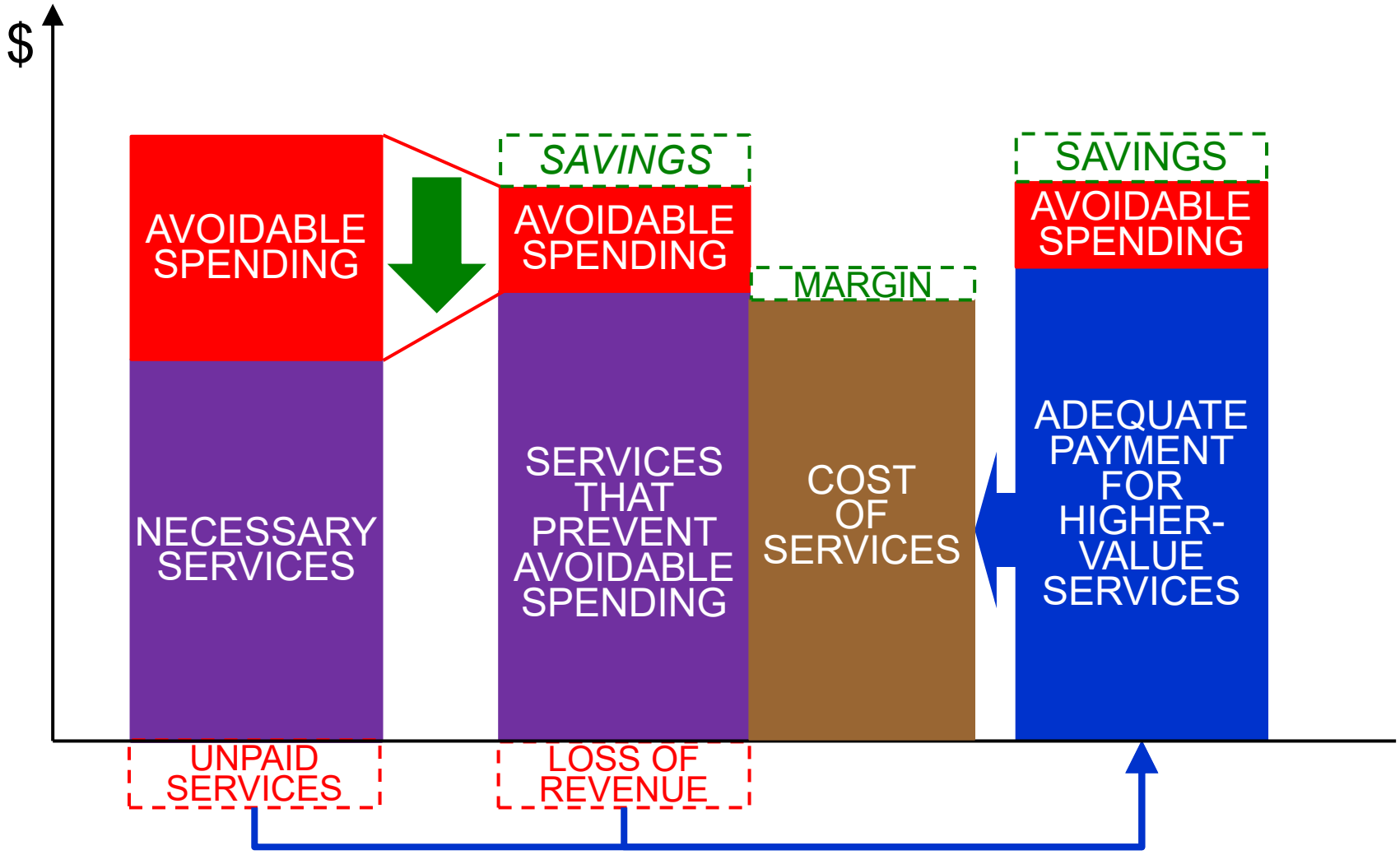
Adequacy Requires Knowing the Cost of Higher-Value Care



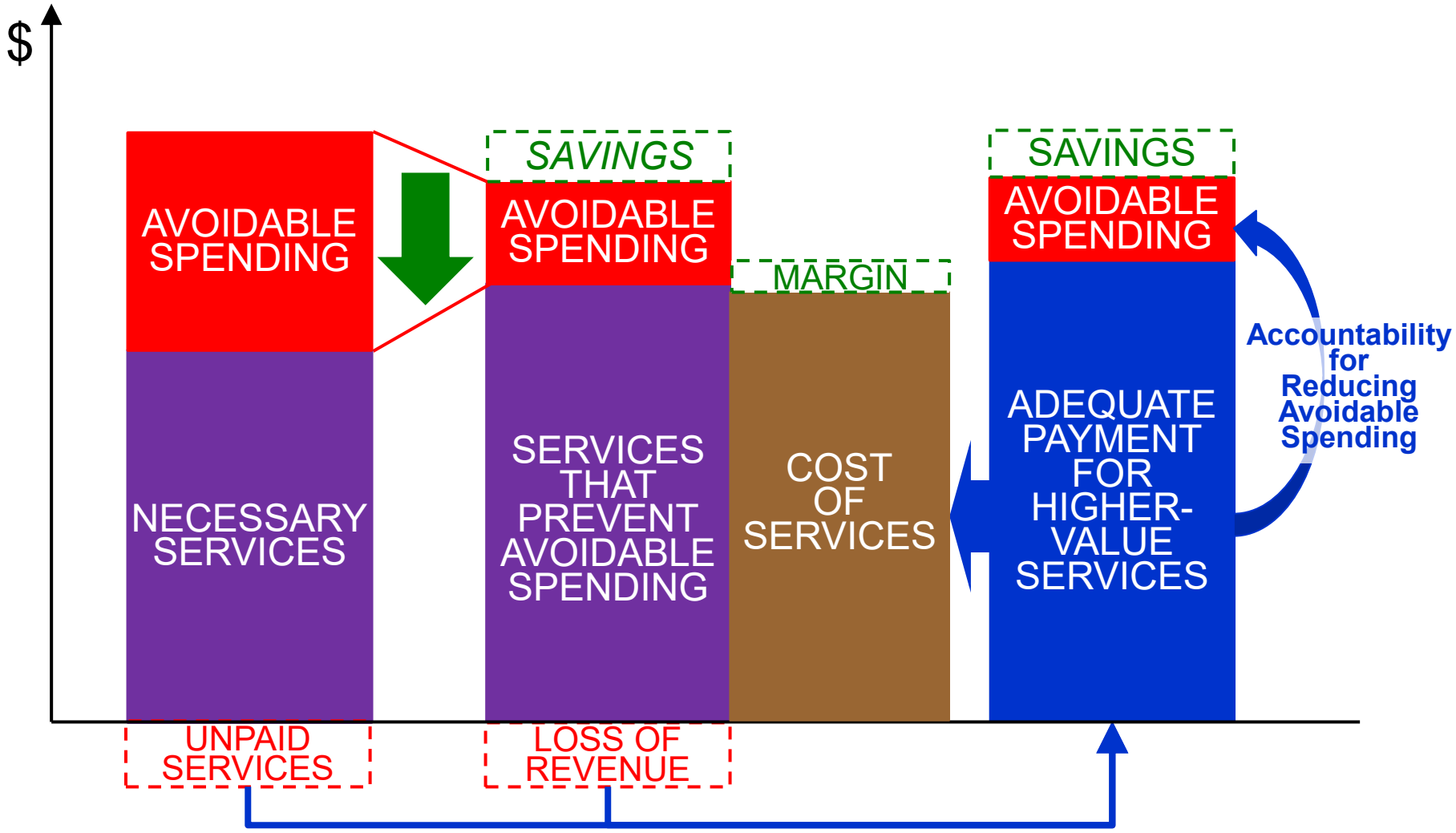
Knowing Your *Current* Costs Is Not Enough

- Time-Driven Activity-Based Costing and other cost-accounting systems can tell you what it *currently* costs to deliver *non-value-based care*, but not what it *will* cost to deliver *value-based care*.
- A *Cost Model* is needed to determine how costs will *change* as value-based care is implemented:
  - What will it cost to deliver *new*, high-value services?
  - How much of the cost of *current* services is:
    - Variable, i.e., it will change with each unit change in services (e.g., drugs, disposable items)
    - Semi-Variable, i.e., it will change only with large changes in volume (e.g., personnel, equipment)
    - Fixed, i.e., it can only be changed over a longer time horizon

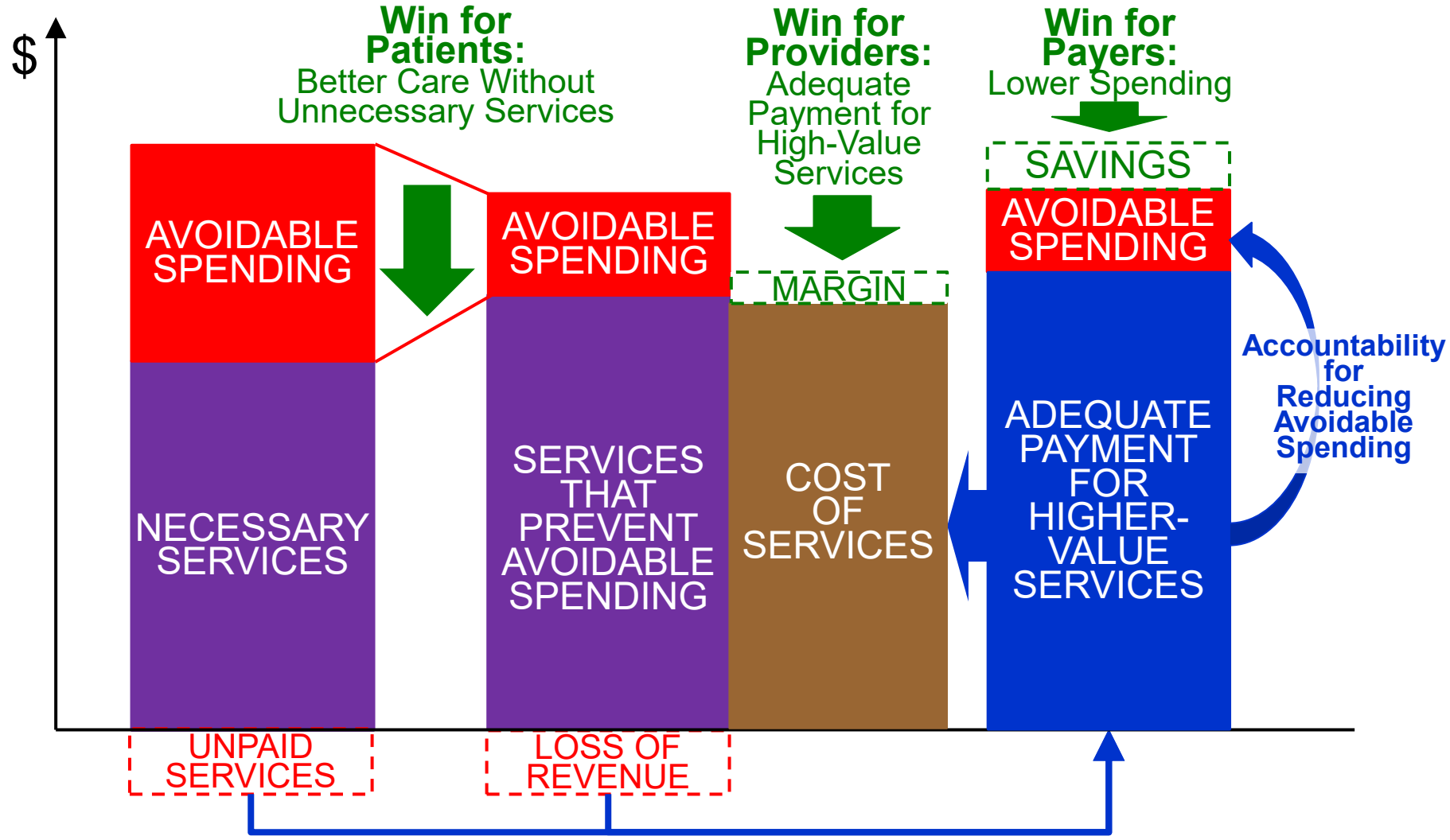
Step 3: Pay Adequately to Support Higher-Value Services



Step 4: Hold Providers Accountable for Results



Good Alternative Payment Models Can Be Win-Win-Wins



Three Key Components of APMs Needed To Ensure Success

KEY COMPONENT
Adequate Resources to Address Patient Needs
Adequate Resources to Support Costs of Services
Accountability for Spending and Quality

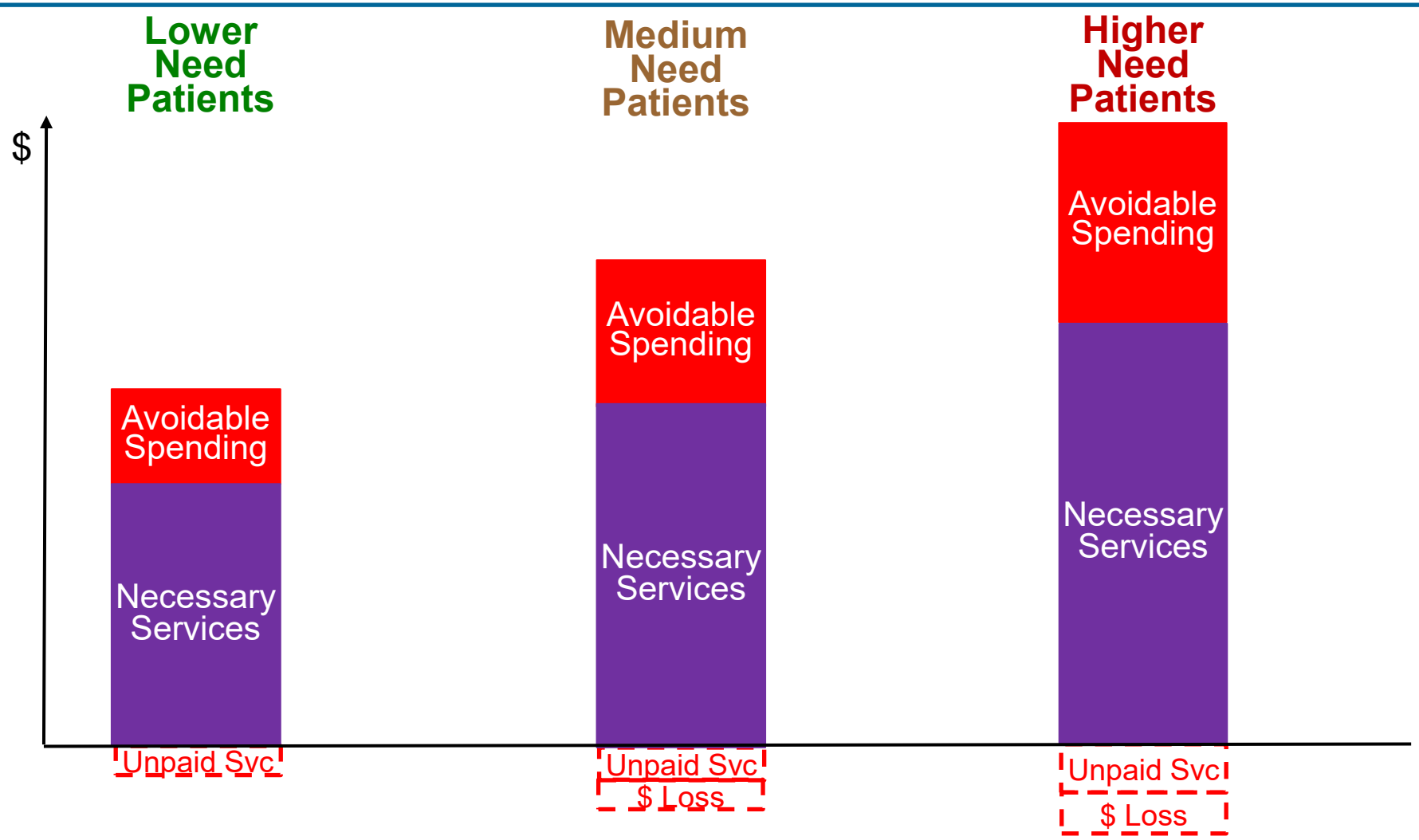
Success Requires Using the Right Approach to Each Component

KEY COMPONENT	BAD APPROACHES	GOOD APPROACH
Adequate Resources to Address Patient Needs		
Adequate Resources to Support Costs of Services		
Accountability for Spending and Quality		

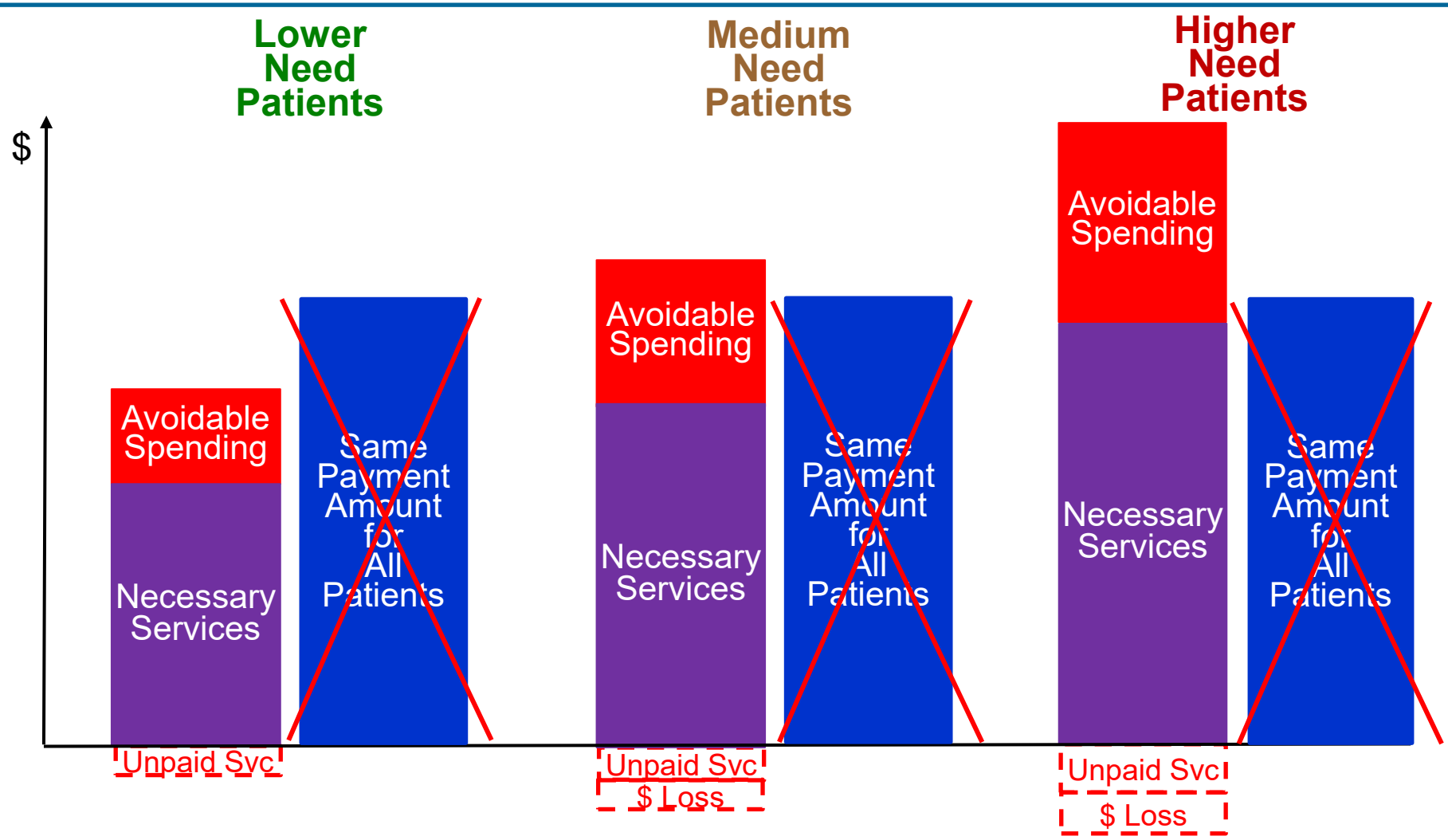
Component #1

KEY COMPONENT	BAD APPROACHES	GOOD APPROACH
Adequate Resources to Address Patient Needs		
Adequate Resources to Support Costs of Services		
Accountability for Spending and Quality		

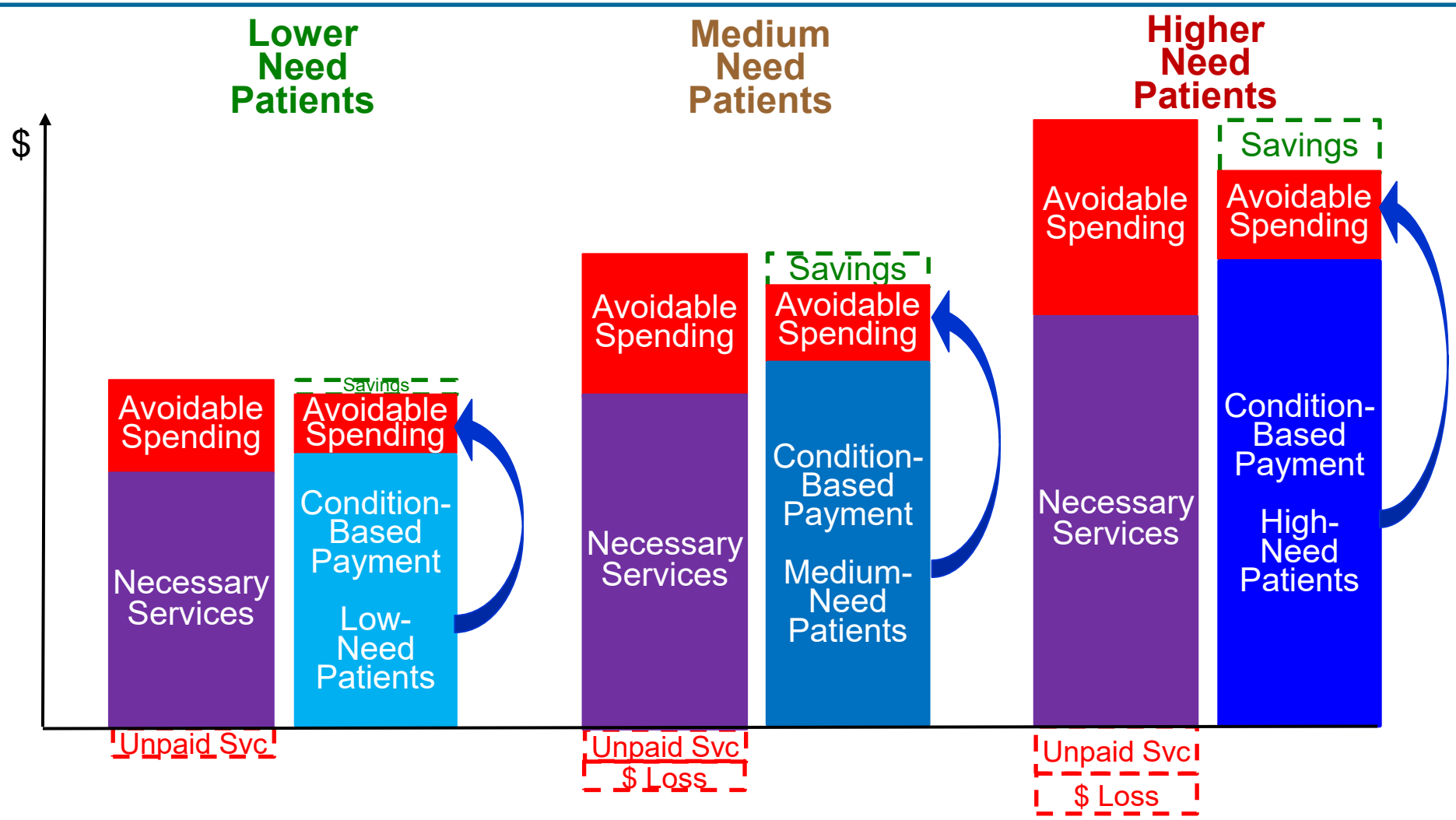
Necessary & Avoidable Services Differ Among Patients



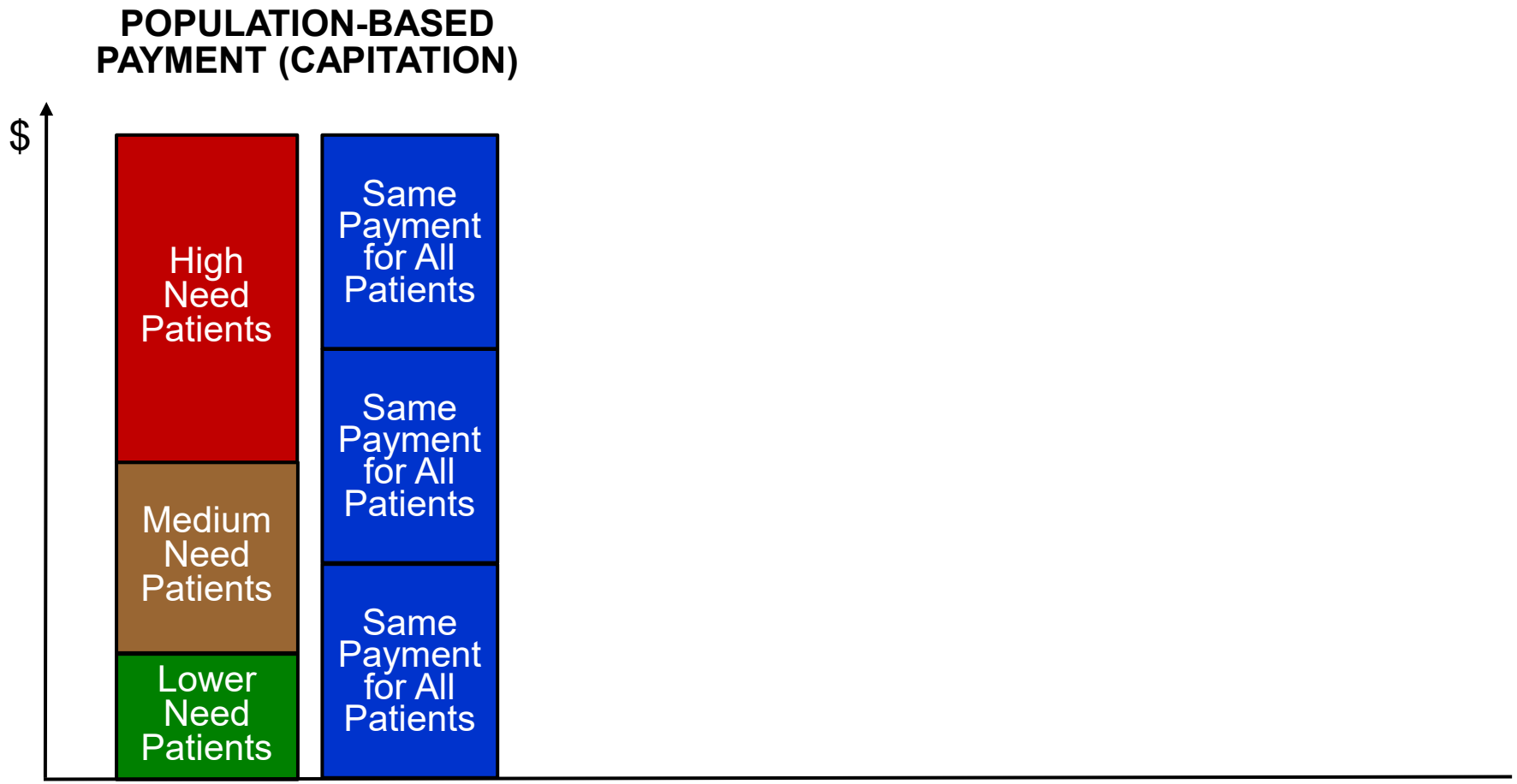
A Wrong Way: Paying the Same Amount for Every Patient



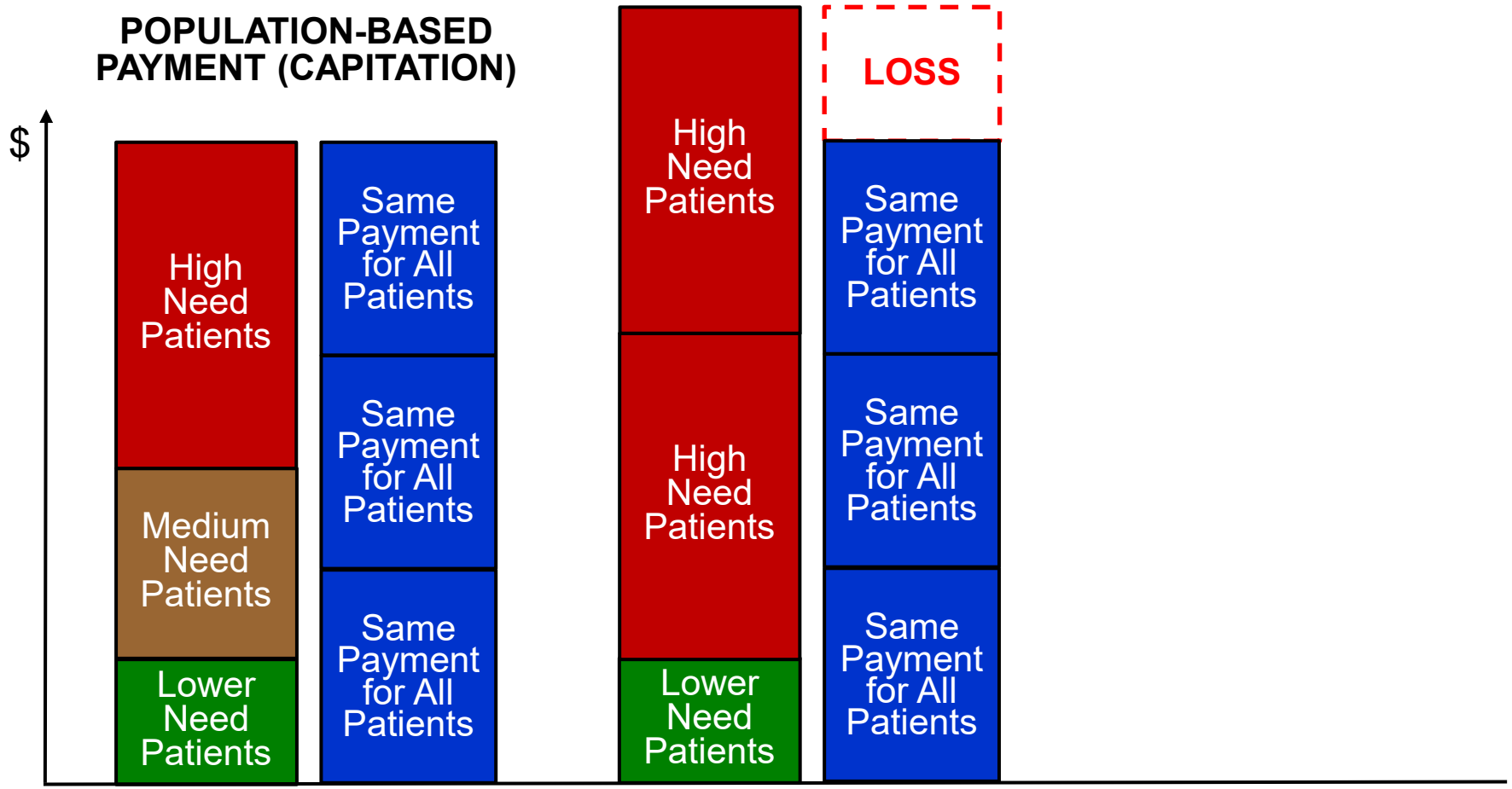
Condition-Based Payments Adjust for Differences in Patient Needs



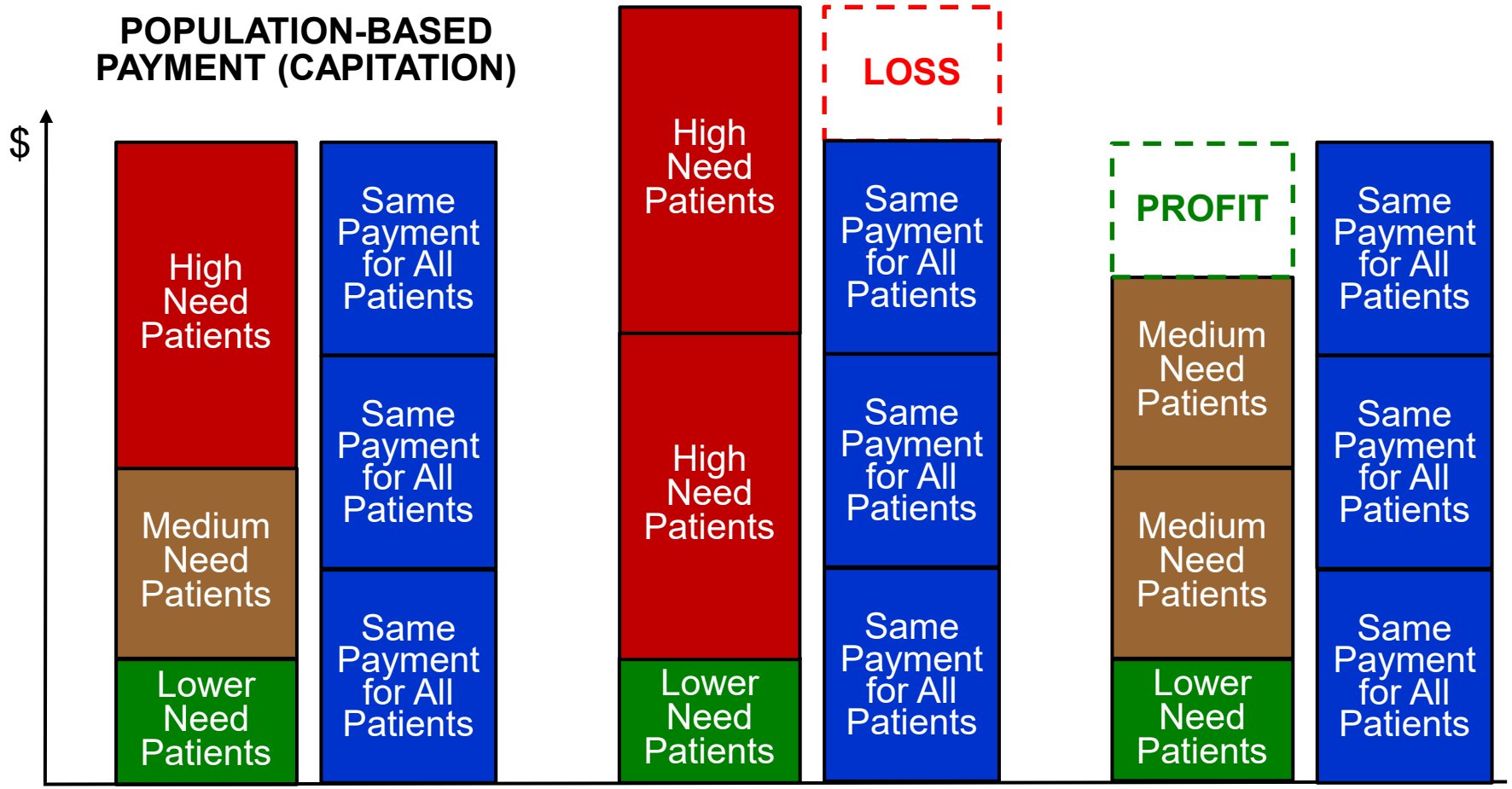
Under Population-Based Payment: Will It All Average Out?



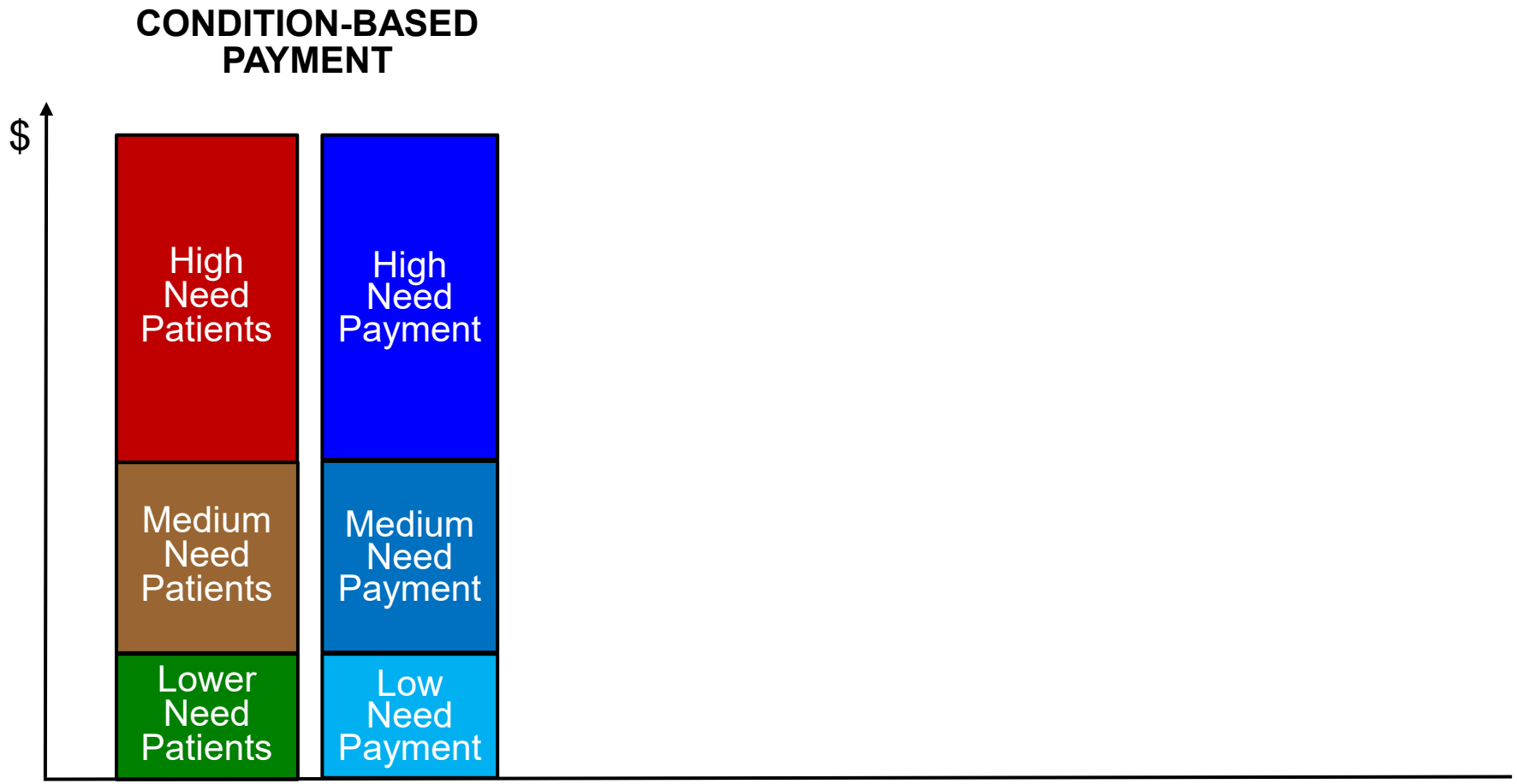
Under Population-Based Payment:
More High-Need Patients = Losses



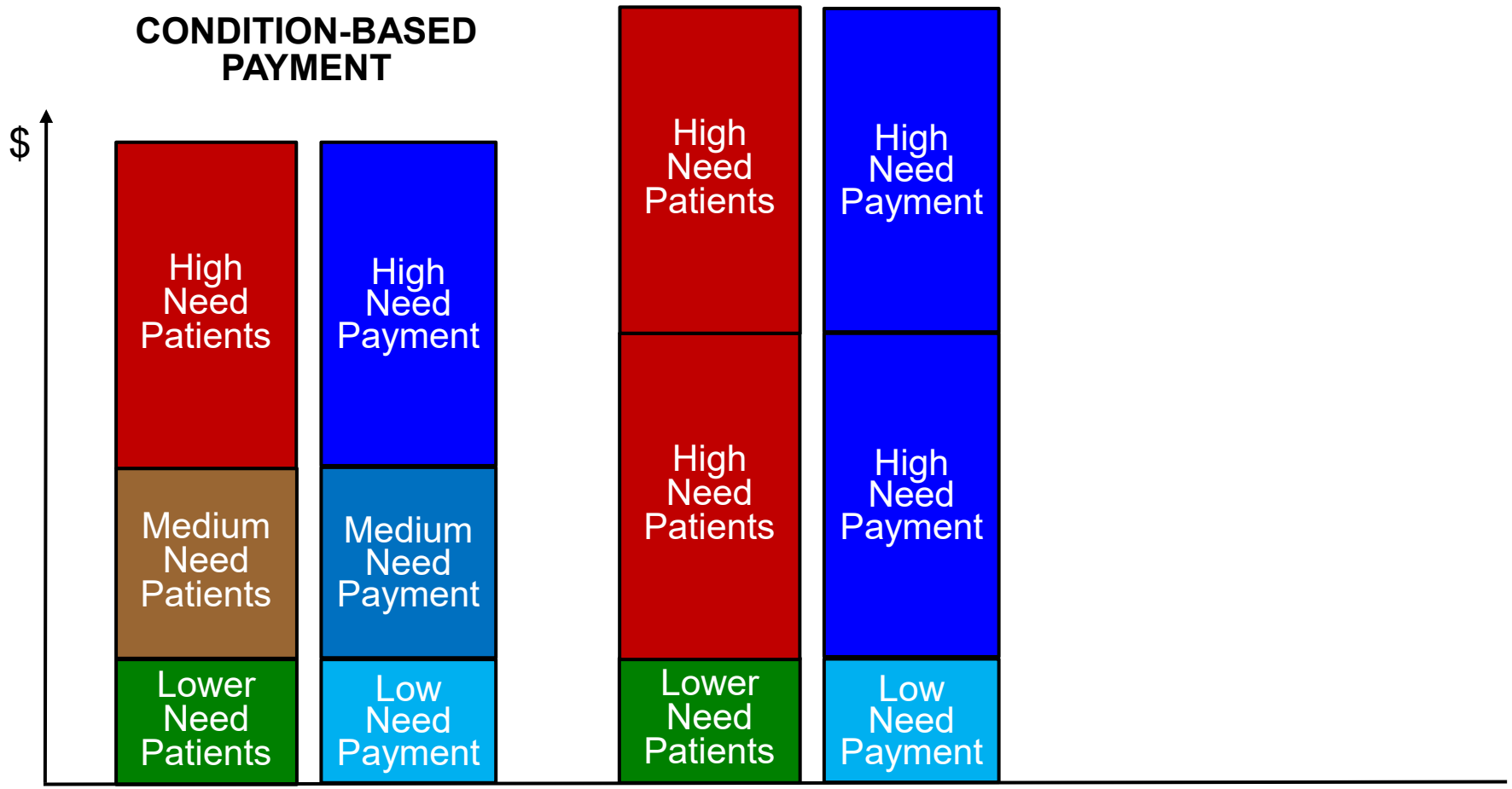
Under Population-Based Payment:
Cherry-Picking Patients = Profits



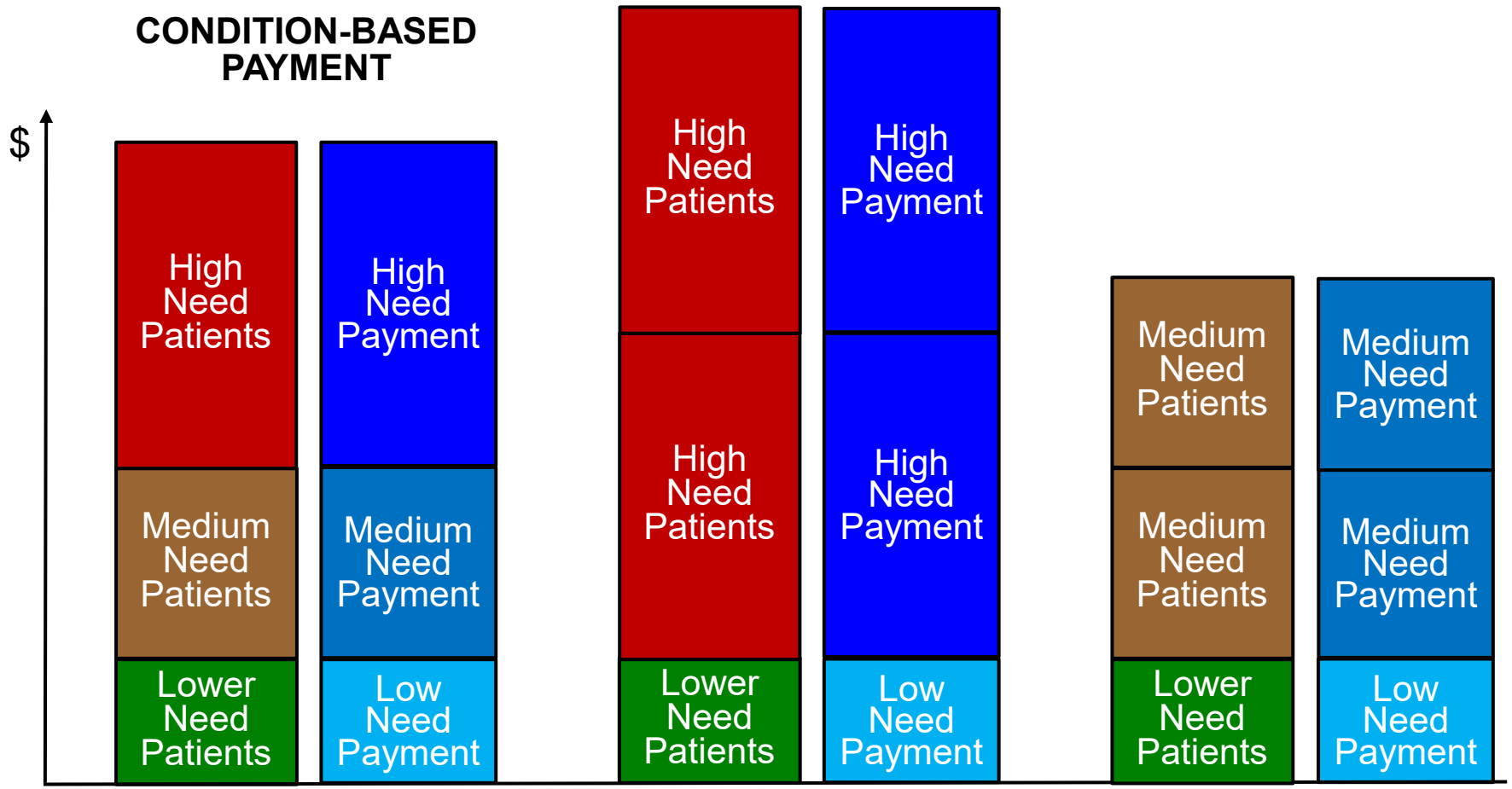
Under Condition-Based Payment: Payment Differs by Patient Need



Under Condition-Based Payment:
No Losses for Serving High Needs



Under Condition-Based Payment:
No Profits from Cherry-Picking



Population-Based Payment Can Worsen Health Disparities

	Fee-for-Service Payment (Fixed payment for each service, regardless of whether service is needed)	**Condition-Based Payment** (Fixed payment for all services that are related to a specific condition)	**Population-Based Payment** (Fixed payment for all services, regardless of patient's needs)
Rewards over-treatment?	**Yes**	**No**	**No**
Rewards under-treatment?	**No**	**No**	**Yes**

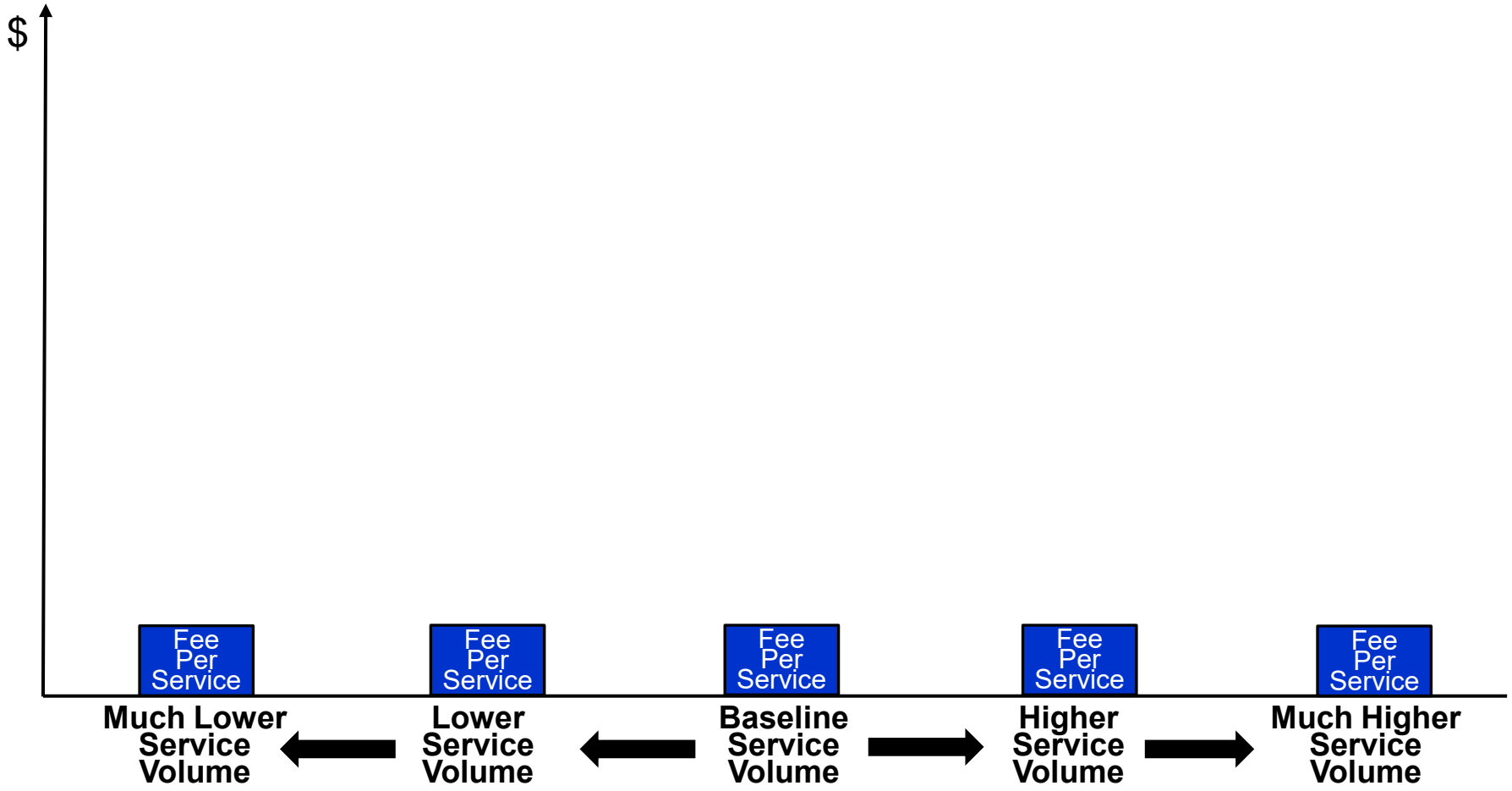
Success Requires Using the Right Approach to Each Component

KEY COMPONENT	BAD APPROACHES	GOOD APPROACH
Adequate Resources to Address Patient Needs	Same payment amount for each patient regardless of differences in health problems or other needs	Stratified payments with higher amounts for patients with greater needs
Adequate Resources to Support Costs of Services		
Accountability for Spending and Quality		

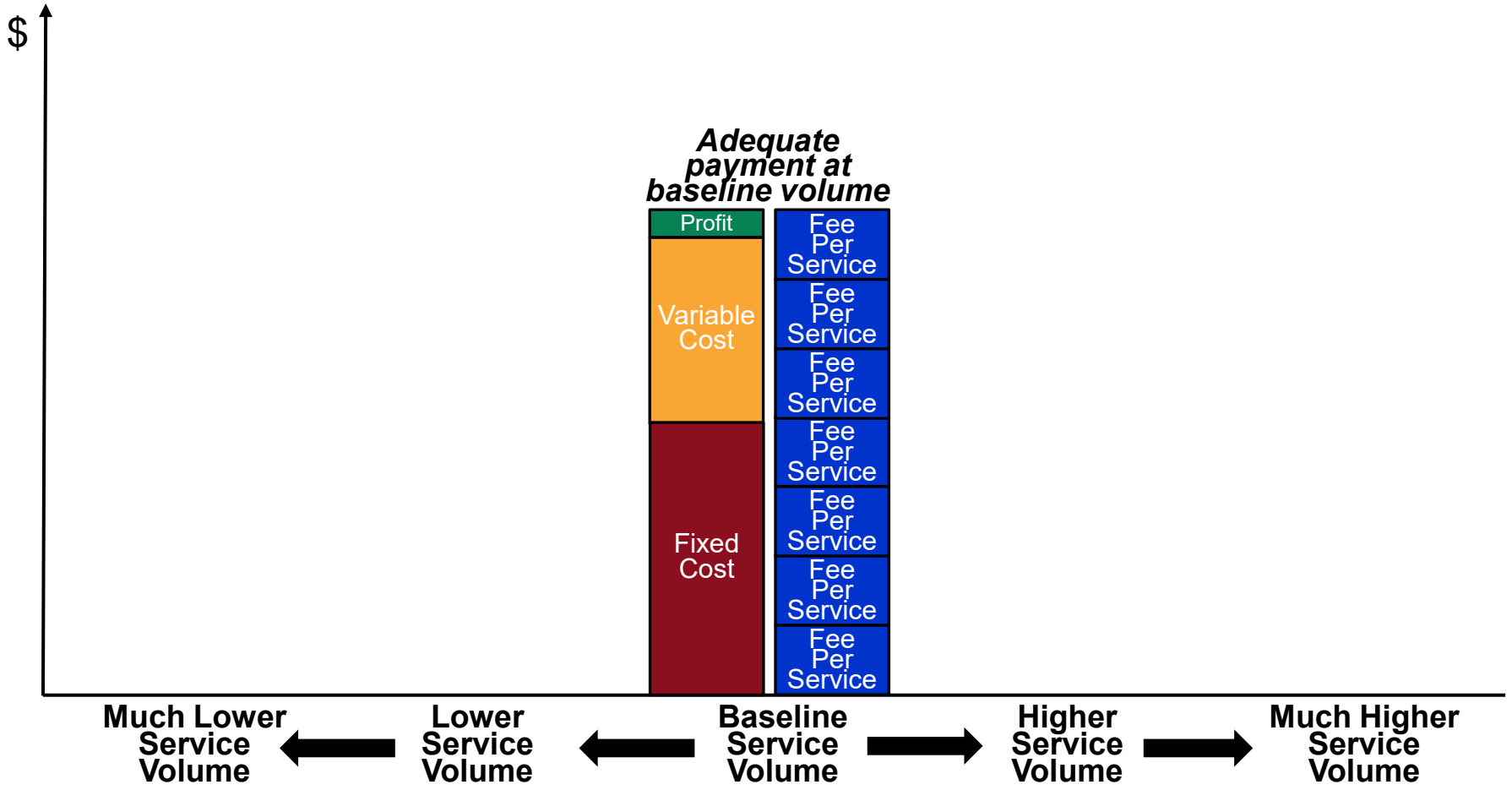
Component #2

KEY COMPONENT	BAD APPROACHES	GOOD APPROACH
Adequate Resources to Address Patient Needs	Same payment amount for each patient regardless of differences in health problems or other needs	Stratified payments with higher amounts for patients with greater needs
Adequate Resources to Support Costs of Services		
Accountability for Spending and Quality		

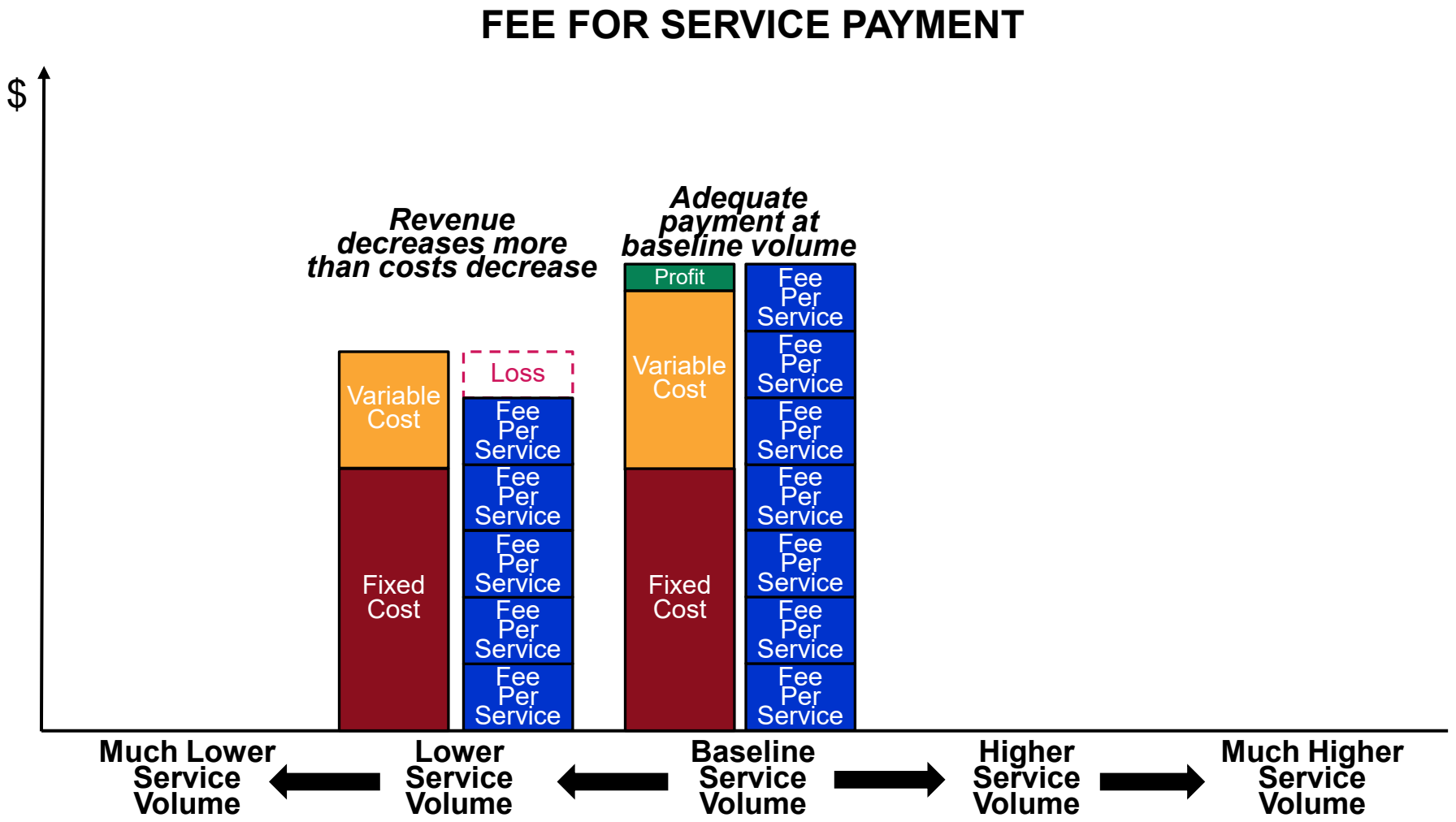
A Wrong Way: Paying the Same Fees Regardless of Volume



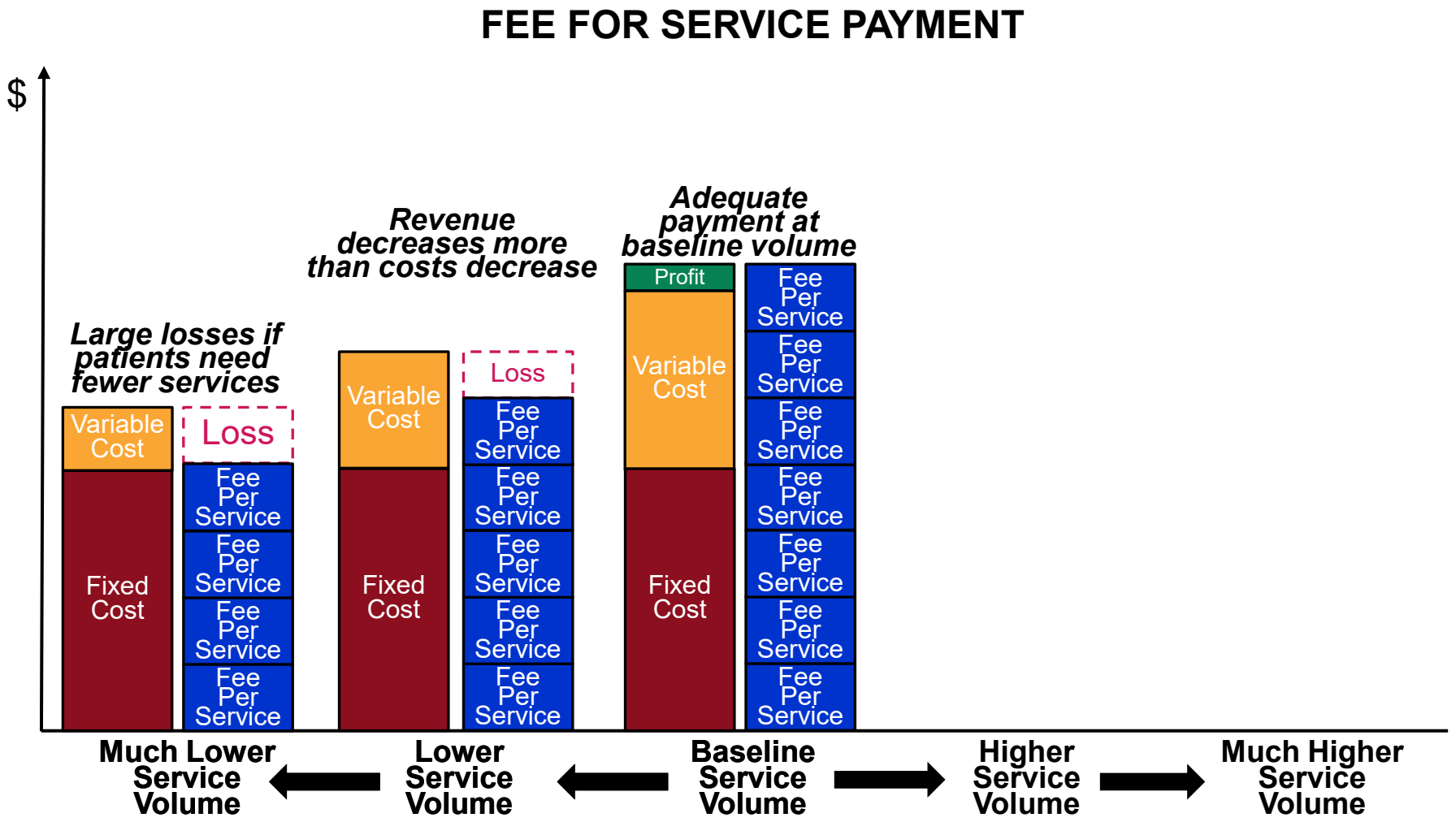
If Fees Are Adequate to Cover Costs at One Volume of Services..



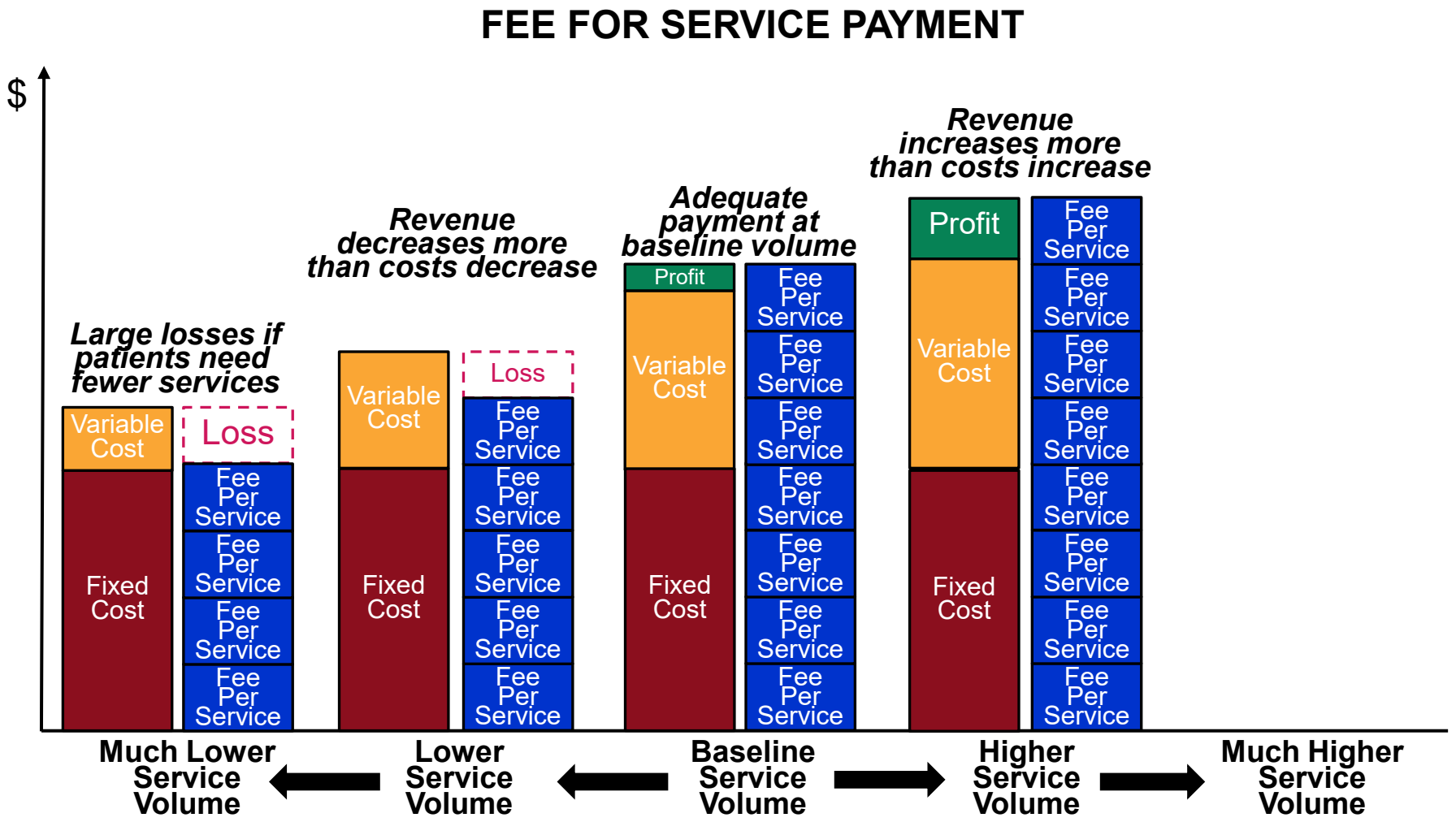
…The Fees Will Be Too Low When Volume Decreases…



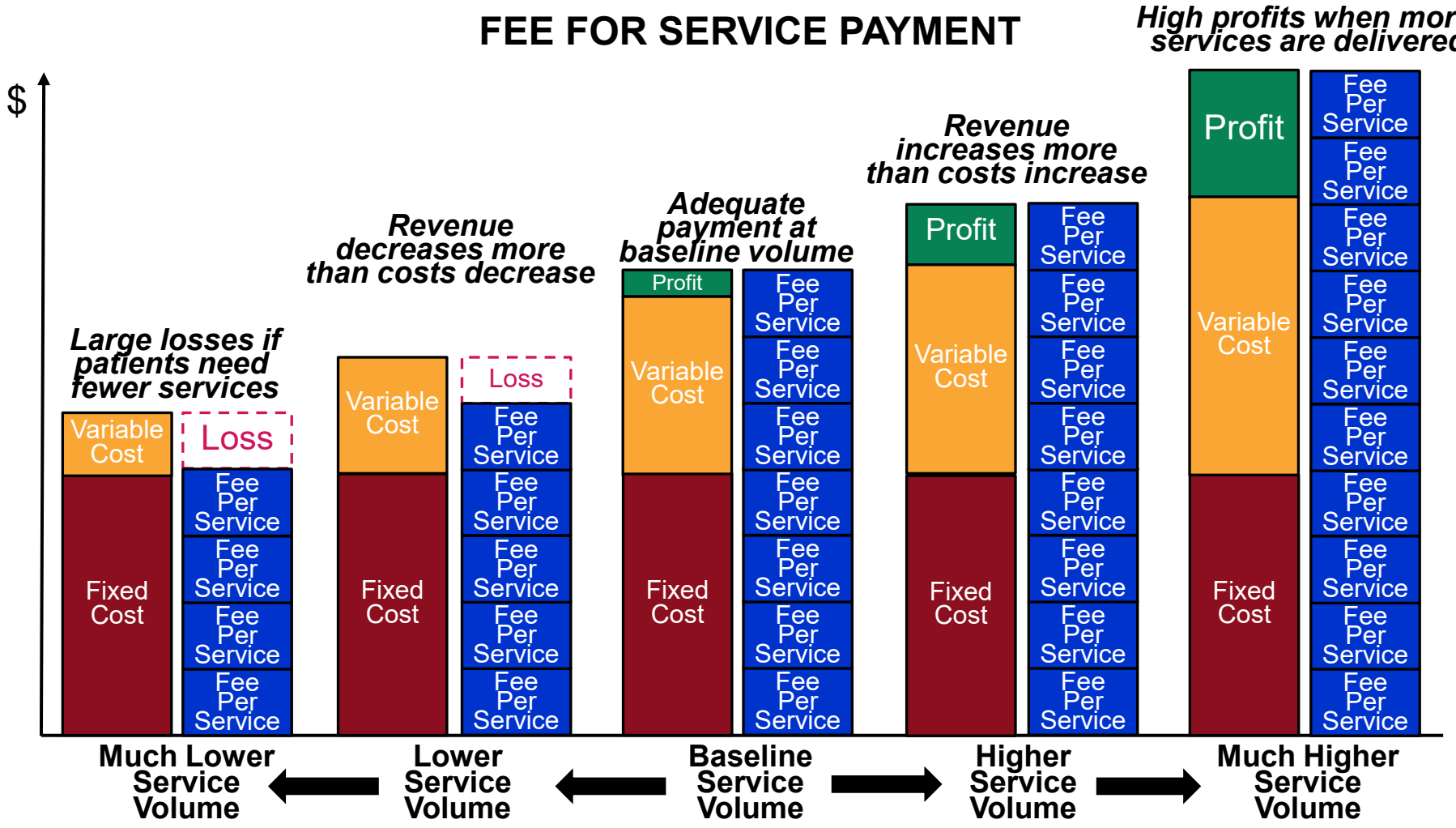
…Penalizing Efforts to Improve Patient Health and Outcomes



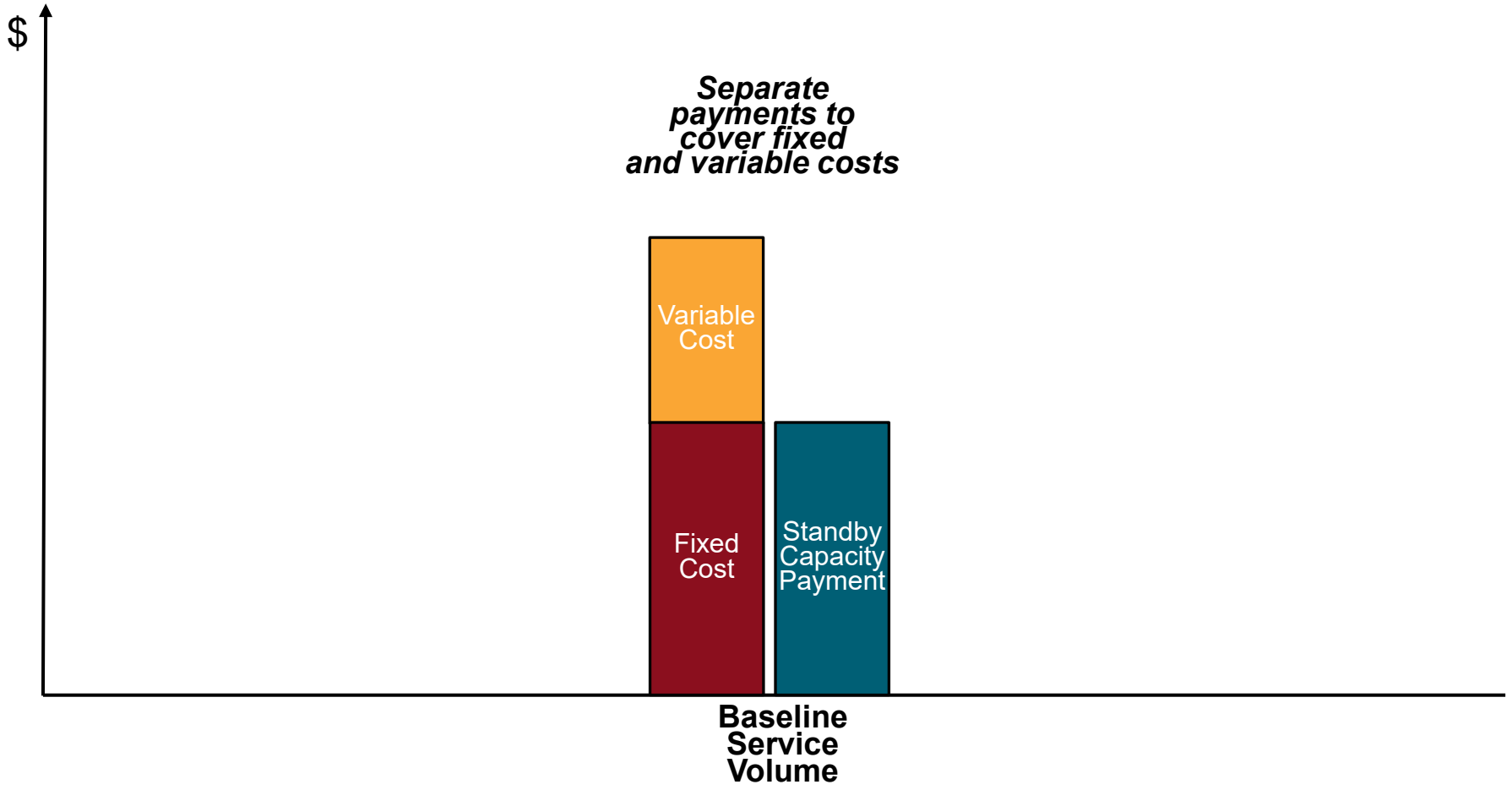
Conversely, Fees Will Be Higher Than Needed If Volume Grows…



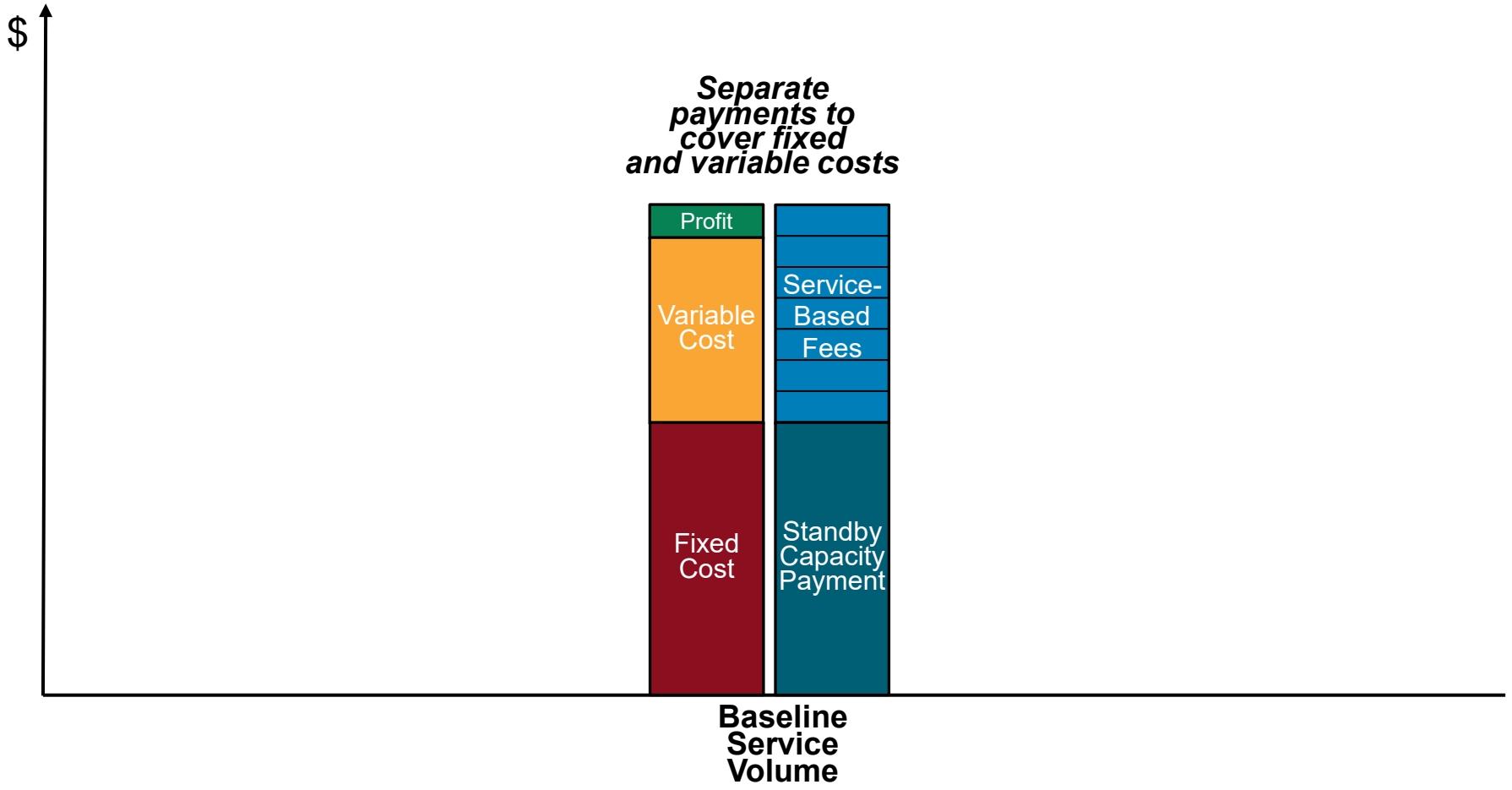
…Retaining a Financial Incentive to Deliver More Services



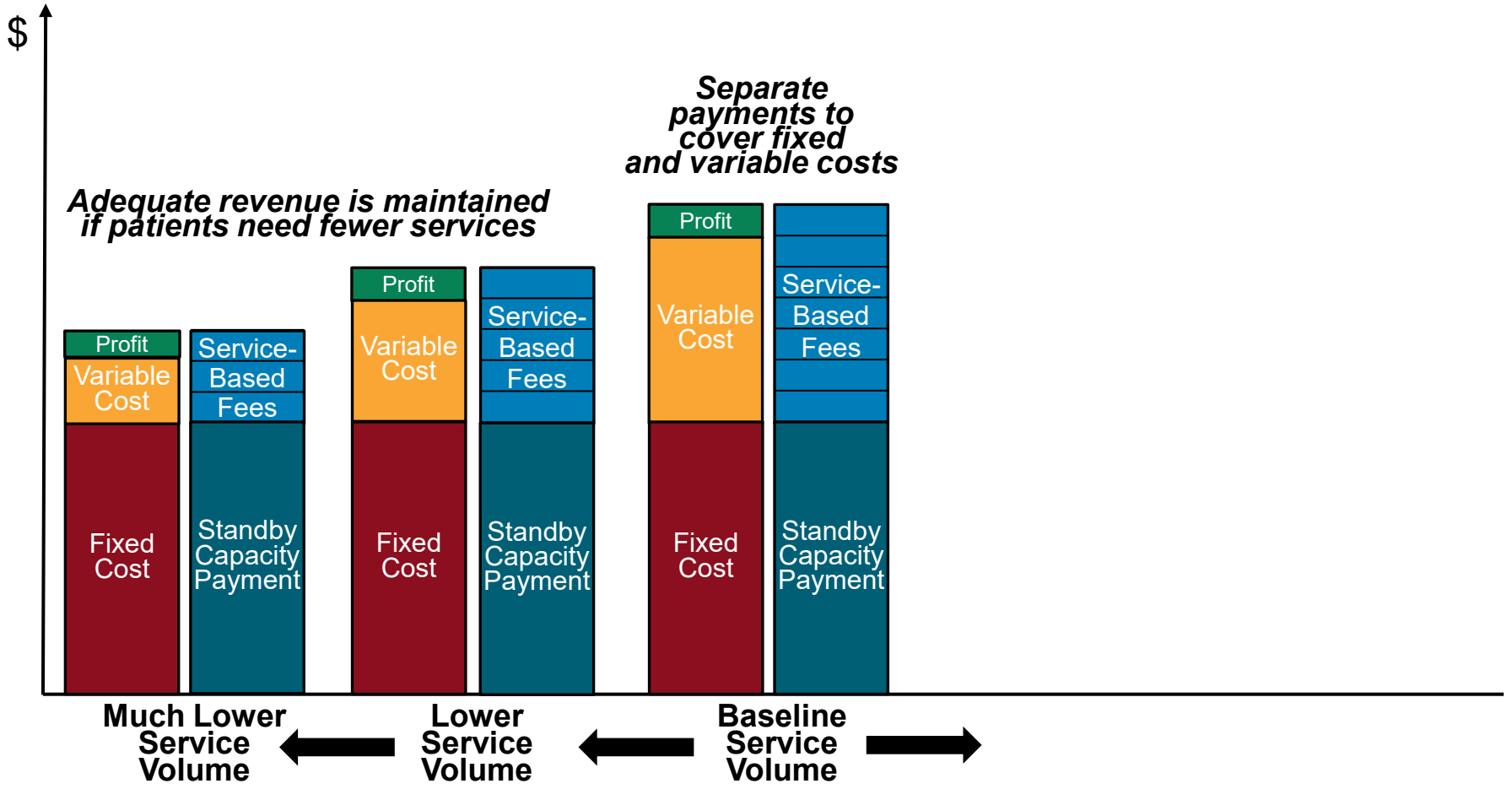
A Better Way: Standby Capacity Payments to Support Fixed Costs..



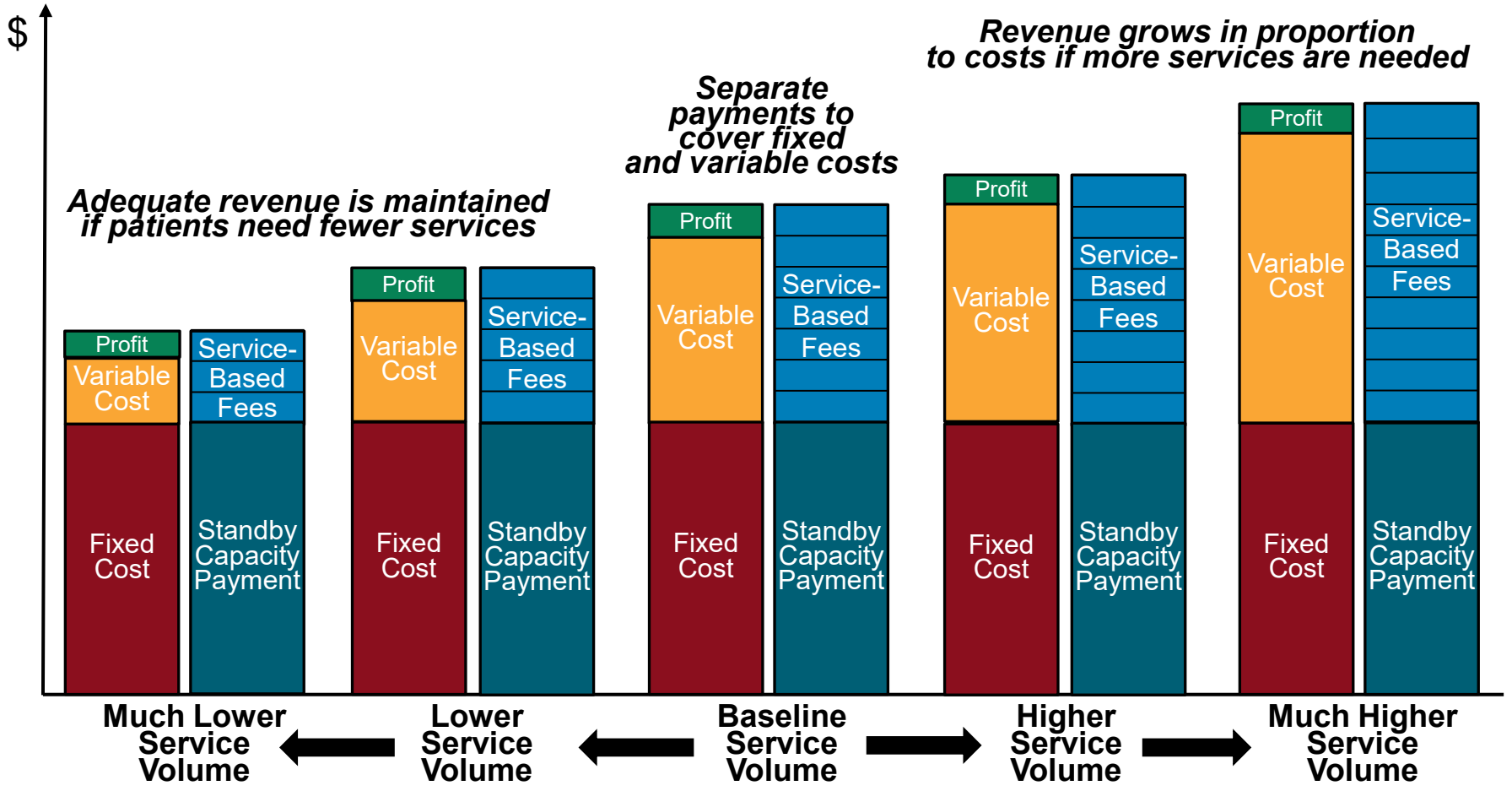
…With Service-Based Fees Tied to Variable Costs of Services



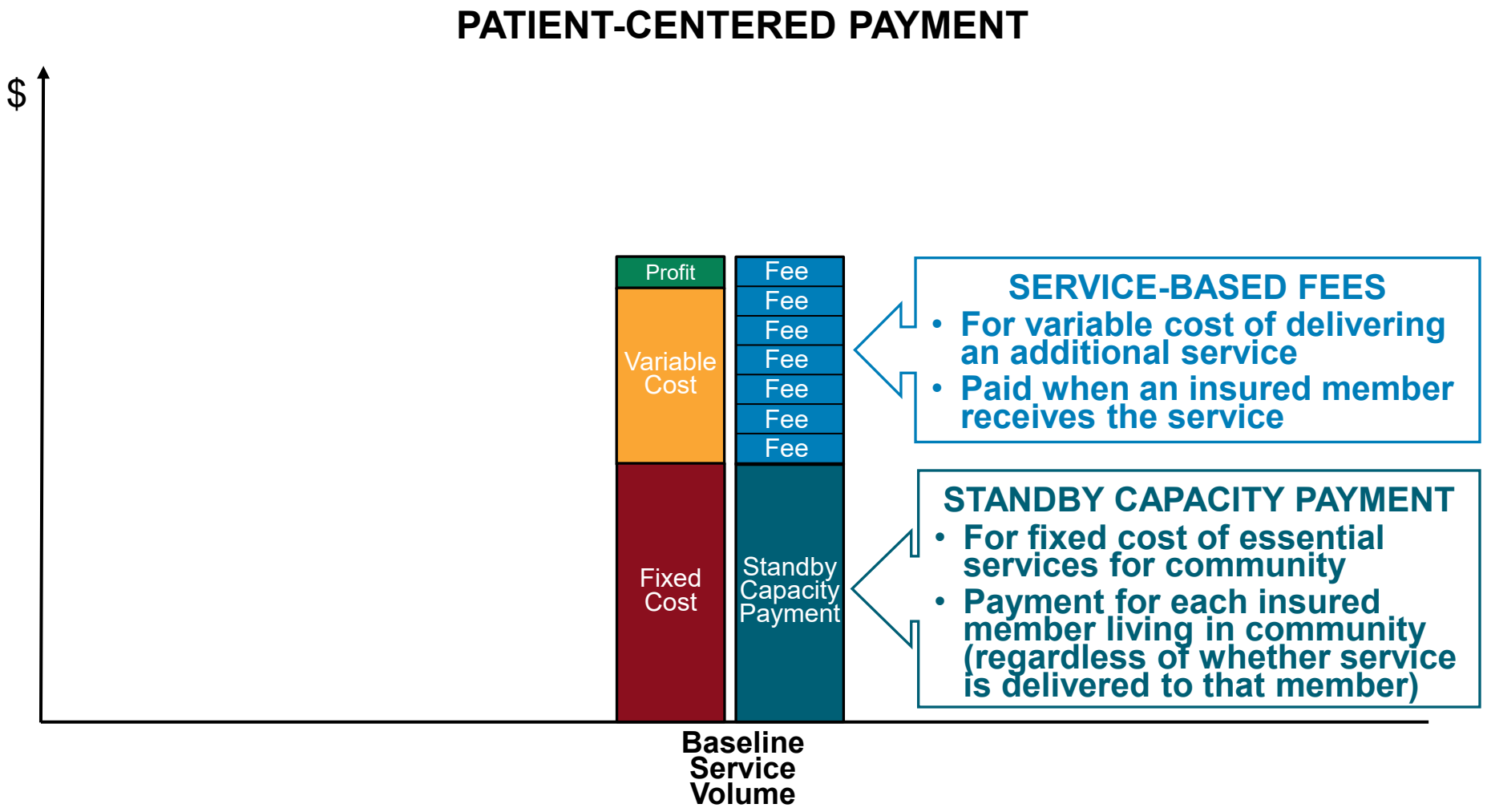
When Volume Decreases, Payment Still Covers Costs



When Volume Increases, No Windfall Profits



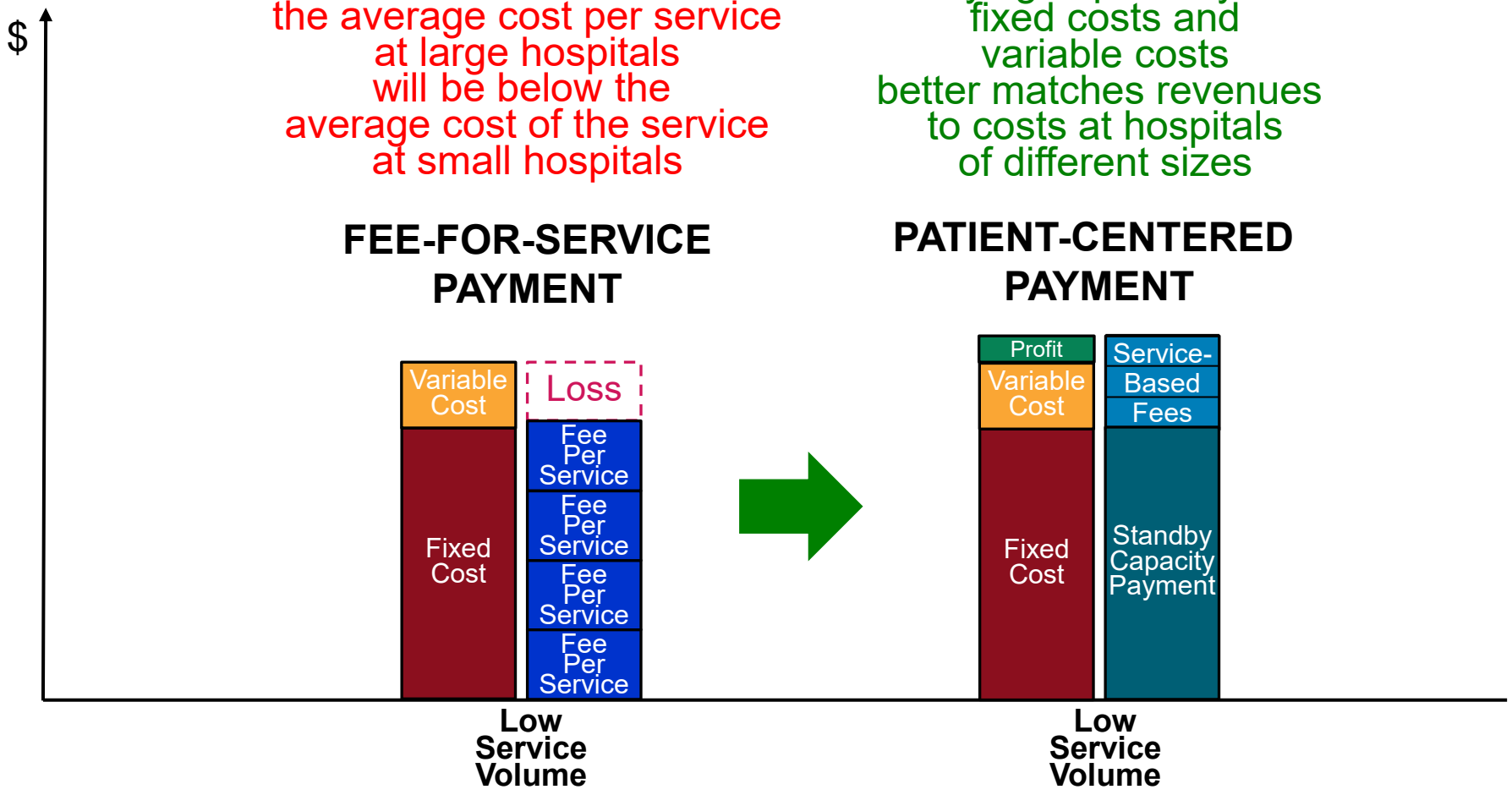
Combination of Per Member & Per Service Pmt



This Approach to Payment is Essential for Rural Hospitals

A fee for a service based on the average cost per service at large hospitals will be below the average cost of the service at small hospitals

Paying separately for fixed costs and variable costs better matches revenues to costs at hospitals of different sizes



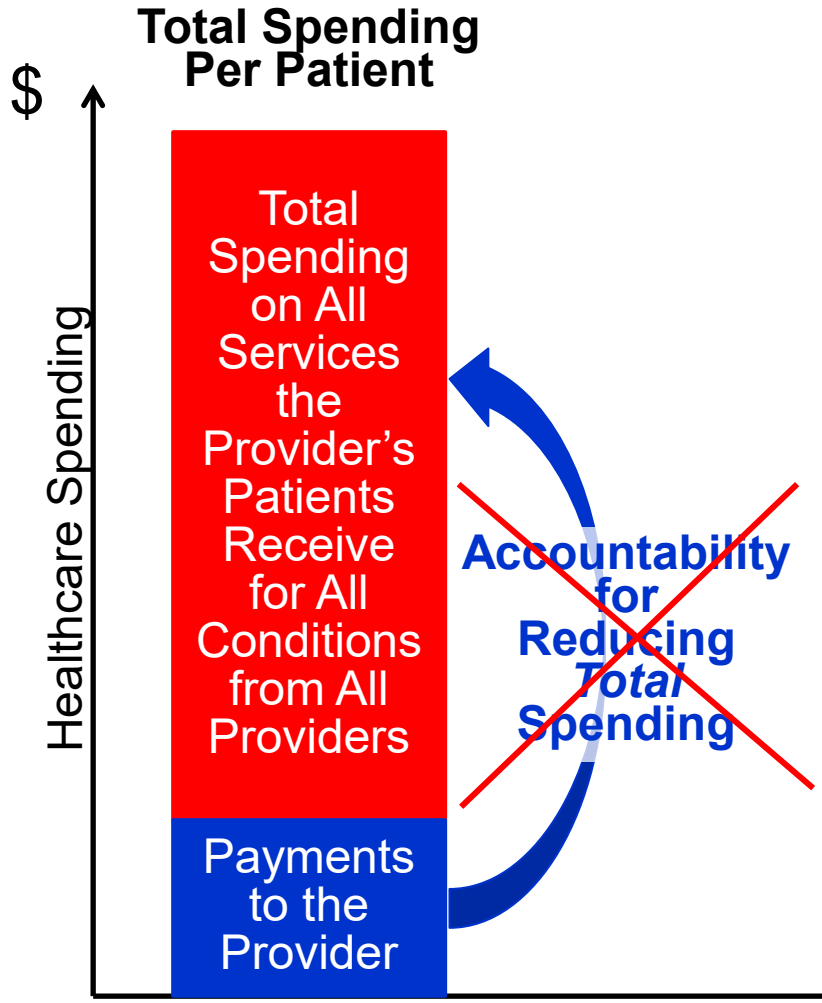
Success Requires Using the Right Approach to Each Component

KEY COMPONENT	BAD APPROACHES	GOOD APPROACH
Adequate Resources to Address Patient Needs	Same payment amount for each patient regardless of differences in health problems or other needs	Stratified payments with higher amounts for patients with greater needs
Adequate Resources to Support Costs of Services	Fixed fee per service or per patient regardless of number of patients treated	Standby Capacity Payment to support fixed costs of a service line (paid on a per member per month basis) Service-Based Fees and Patient-Based Payments based on semi-variable and variable costs
Accountability for Spending and Quality		

Component #3

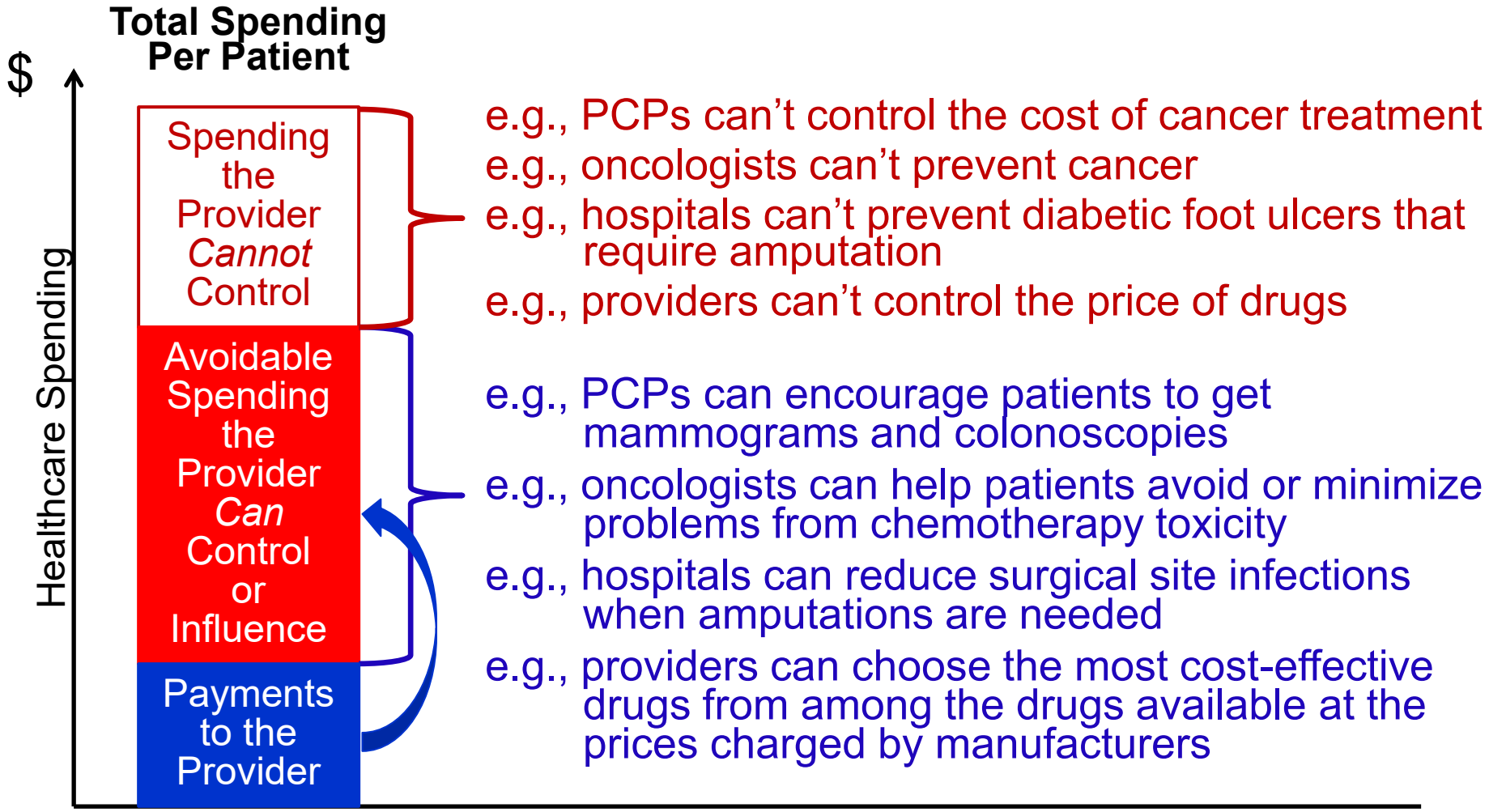
KEY COMPONENT	BAD APPROACHES	GOOD APPROACH
Adequate Resources to Address Patient Needs	Same payment amount for each patient regardless of differences in health problems or other needs	Stratified payments with higher amounts for patients with greater needs
Adequate Resources to Support Costs of Services	Fixed fee per service or per patient regardless of number of patients treated	Standby Capacity Payment to support fixed costs of a service line (paid on a per member per month basis) Service-Based Fees and Patient-Based Payments based on semi-variable and variable costs
Accountability for Spending and Quality		

A Wrong Way: Holding Providers Accountable for Total Cost of Care



Many "value-based" payment systems put a provider at financial risk for total healthcare spending on patients, including spending on services for unrelated health problems and increases in spending due to higher prices of drugs and medical devices that the provider cannot control

Accountability Must Be Focused on What Each Provider Can Influence



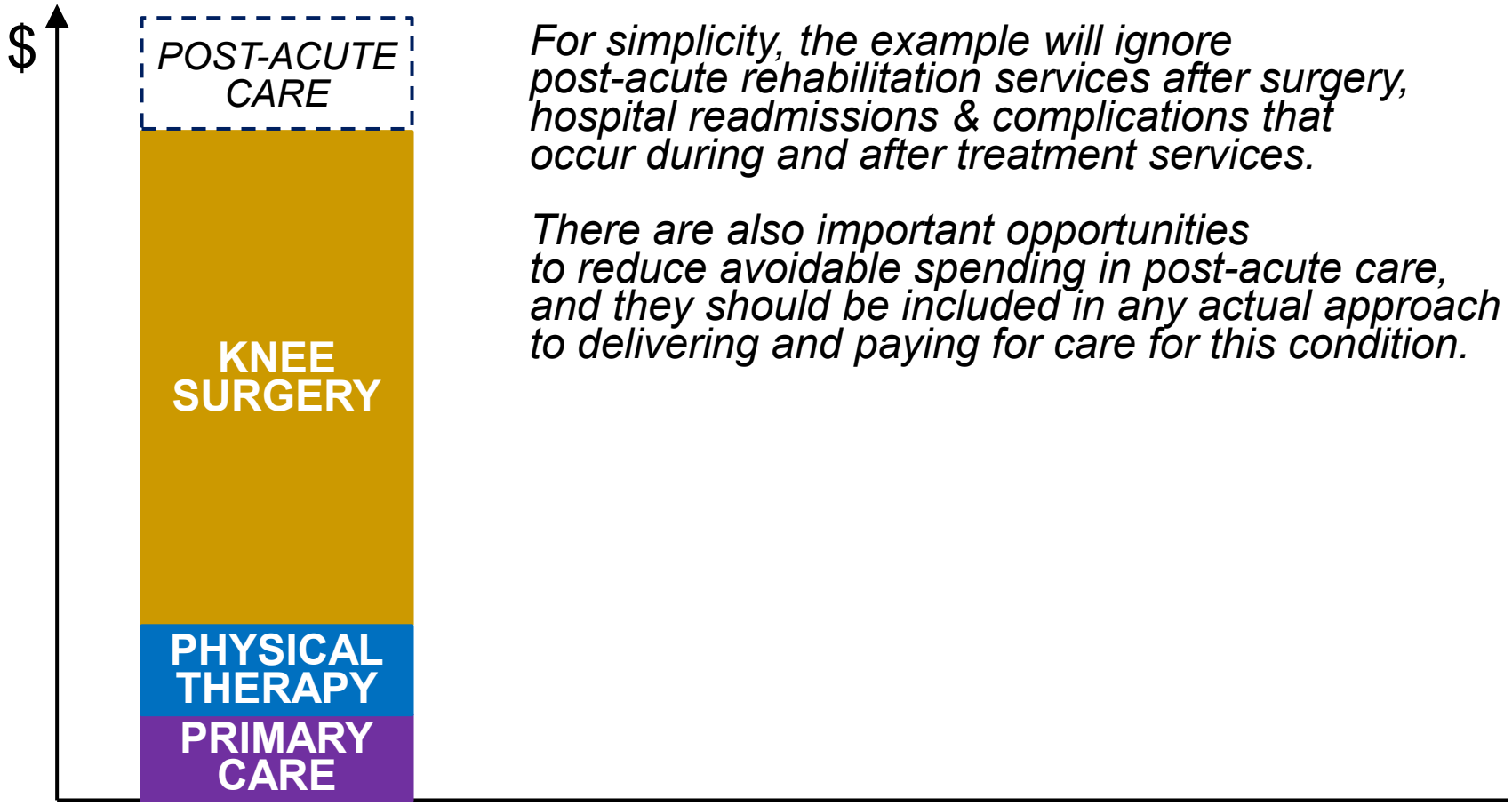
Success Requires Using the Right Approach to Each Component

KEY COMPONENT	BAD APPROACHES	GOOD APPROACH
Adequate Resources to Address Patient Needs	Same payment amount for each patient regardless of differences in health problems or other needs	Stratified payments with higher amounts for patients with greater needs
Adequate Resources to Support Costs of Services	Fixed fee per service or per patient regardless of number of patients treated	Standby Capacity Payment to support fixed costs of a service line (paid on a per member per month basis) Service-Based Fees and Patient-Based Payments based on semi-variable and variable costs
Accountability for Spending and Quality	Risk for total cost of care Risk for outcomes beyond the control of the physician or hospital	Accountability for costs and aspects of quality the physician or hospital can control

Quantitative Example of a Condition-Based Payment for Knee Osteoarthritis

Focus of Example: 3 Key Services for Knee Osteoarthritis

Focus of Example: 3 Key Services for Knee Osteoarthritis

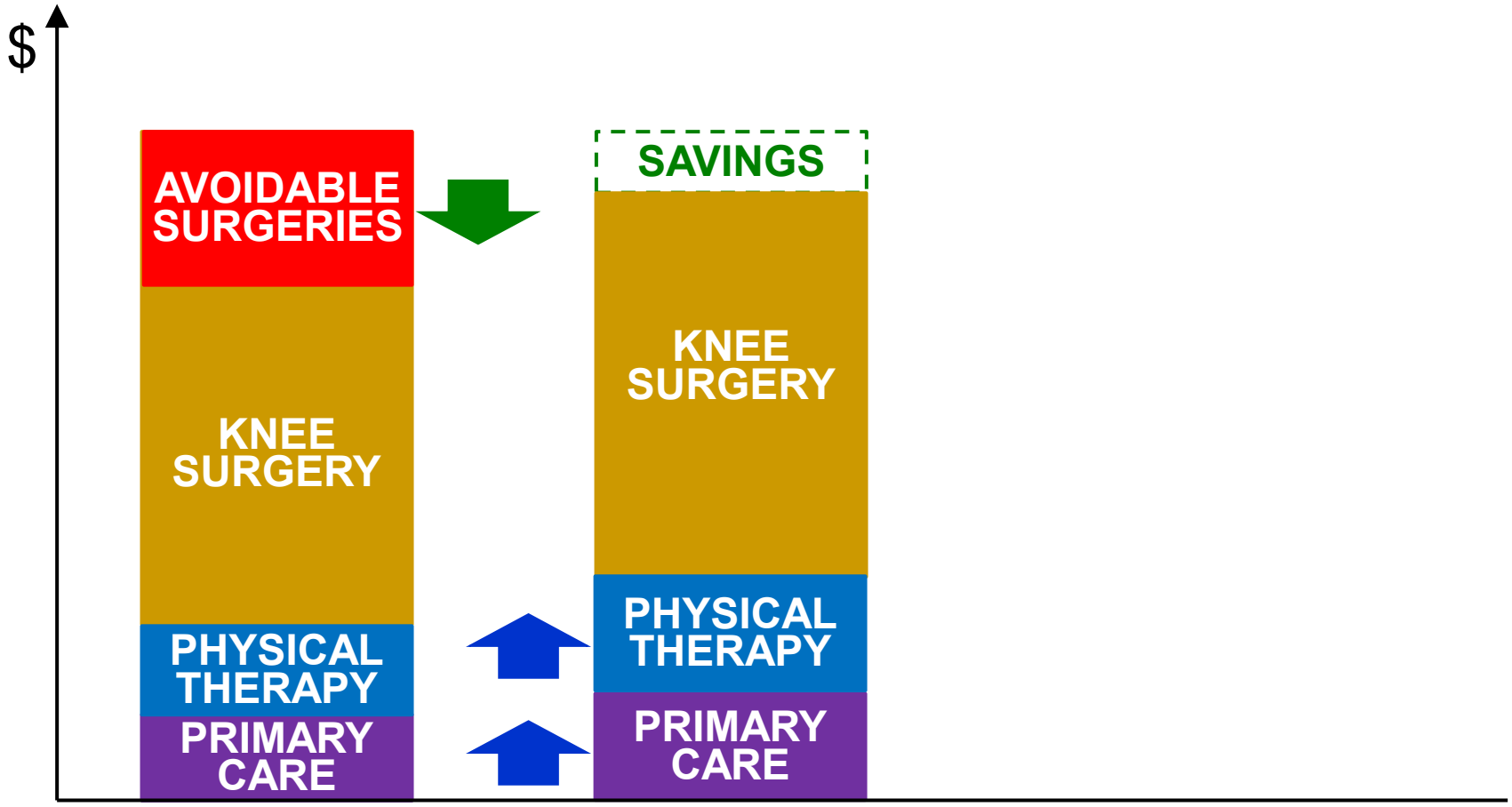


For simplicity, the example will ignore post-acute rehabilitation services after surgery, hospital readmissions & complications that occur during and after treatment services.

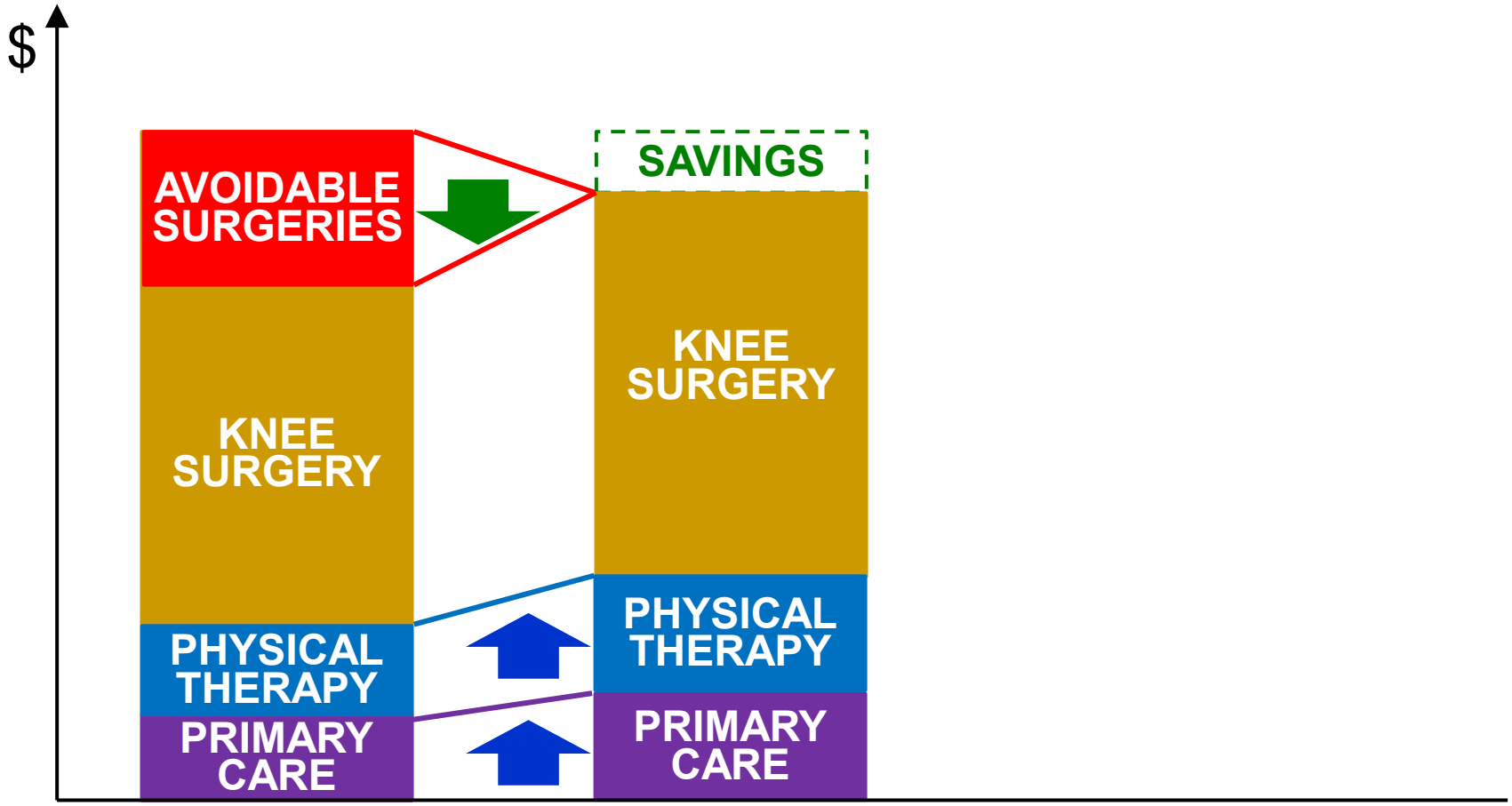
There are also important opportunities to reduce avoidable spending in post-acute care, and they should be included in any actual approach to delivering and paying for care for this condition.

Assumption: Some of the Surgeries Are Avoidable

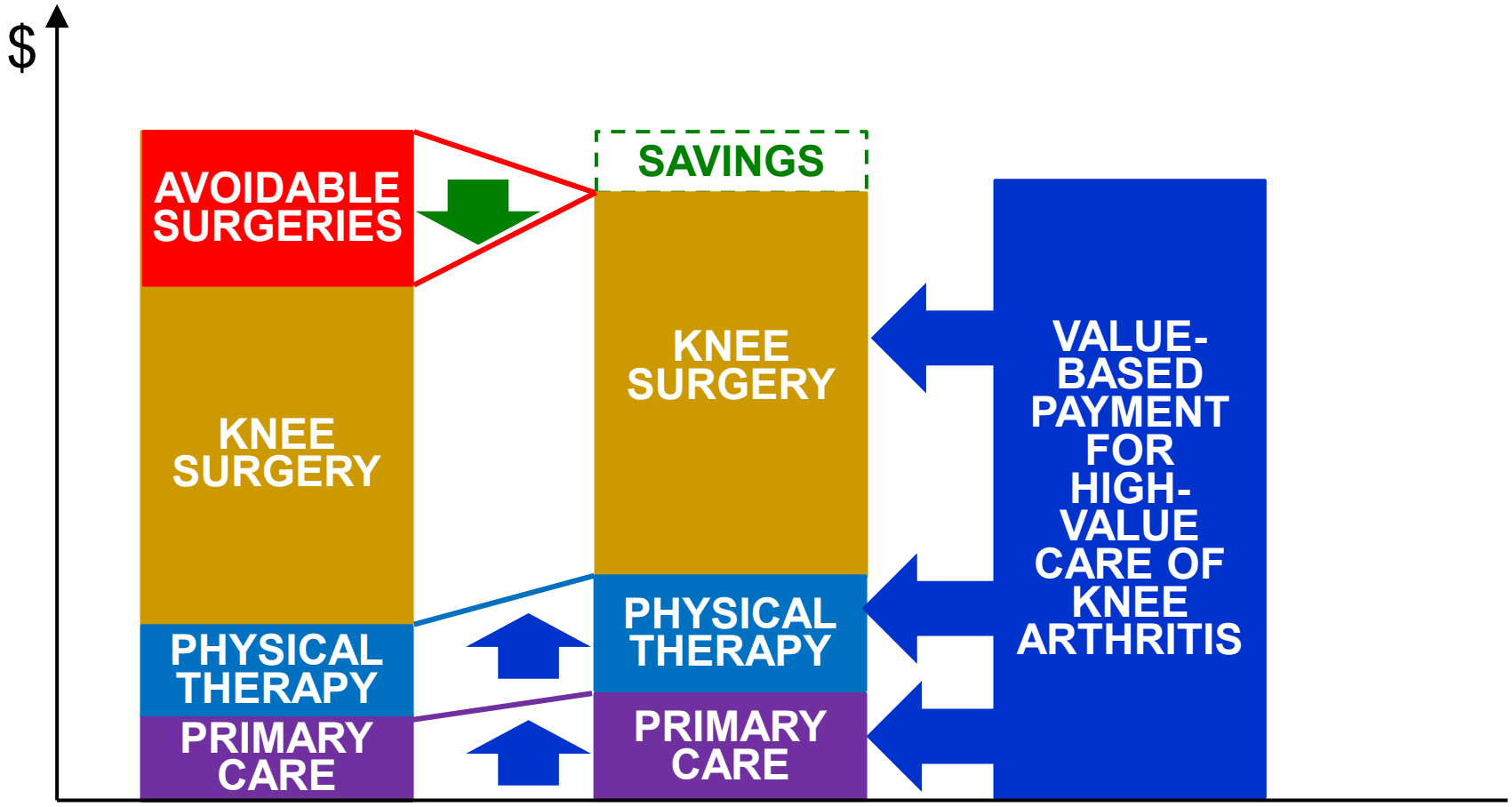
Premise: Better Primary Care + Therapy -> Less Need for Surgery



Value Improves if Savings is Greater Than Increased Cost



How Could a Value-Based Payment Model Support This?



Example: Reducing Avoidable Surgeries for Knee Osteoarthritis

	CURRENT		
	$/Patient	# Pts	Total $
Primary Care			
Evaluations	$100	100	$10,000

Treatment of Knee Osteoarthritis

- 100 patients with knee pain visit PCP/GP for evaluation

Example: Reducing Avoidable Surgeries for Knee Osteoarthritis

	CURRENT		
	$/Patient	# Pts	Total $
Primary Care			
Evaluations	$100	100	$10,000
Non-Surg.Tx			
Management	$200	20	$4,000
Phys. Therapy	$500	20	$10,000
Subtotal			$14,000

Treatment of Knee Osteoarthritis

- 100 patients with knee pain visit PCP/GP for evaluation
- Physical therapy used by 20% of patients

Example: Reducing Avoidable Surgeries for Knee Osteoarthritis

	CURRENT		
	$/Patient	# Pts	Total $
Primary Care			
Evaluations	$100	100	$10,000
Non-Surg.Tx			
Management	$200	20	$4,000
Phys. Therapy	$500	20	$10,000
Subtotal			$14,000
Surgeon	$1,400	80	$112,000
Hospital Pmt			
Surgeries	$12,000	80	$960,000

Treatment of Knee Osteoarthritis

- 100 patients with knee pain visit PCP/GP for evaluation
- Physical therapy used by 20% of patients
- Surgery performed on 80% of evaluated patients

Example: Reducing Avoidable Surgeries for Knee Osteoarthritis

	CURRENT		
	$/Patient	# Pts	Total $
Primary Care			
Evaluations	$100	100	$10,000
Non-Surg.Tx			
Management	$200	20	$4,000
Phys. Therapy	$500	20	$10,000
Subtotal			$14,000
Surgeon	$1,400	80	$112,000
Hospital Pmt			
Surgeries	$12,000	80	$960,000
Total Pmt/Cost		100	$1,096,000

Treatment of Knee Osteoarthritis

- 100 patients with knee pain visit PCP/GP for evaluation
- Physical therapy used by 20% of patients
- Surgery performed on 80% of evaluated patients
- Total current spending: $1.1 million/100 patients

Example: Reducing Avoidable Surgeries for Knee Osteoarthritis

	CURRENT		
	$/Patient	# Pts	Total $
Primary Care			
Evaluations	$100	100	$10,000
Non-Surg.Tx			
Management	$200	20	$4,000
Phys. Therapy	$500	20	$10,000
Subtotal			$14,000
Surgeon	$1,400	80	$112,000
Hospital Pmt			
Surgeries	$12,000	80	$960,000
Total Pmt/Cost		100	$1,096,000

Treatment of Knee Osteoarthritis

- 100 patients with knee pain visit PCP/GP for evaluation
- Physical therapy used by 20% of patients
- Surgery performed on 80% of evaluated patients
- Total current spending: $1.1 million/100 patients
- 25% of surgeries avoidable with better outpatient management

Under FFS, Low Payment for Diagnosis & Treatment Planning

	CURRENT		
	$/Patient	# Pts	Total $
Primary Care			
Evaluations	$100	100	$10,000
Non-Surg.Tx			
Management	$200	20	$4,000
Phys. Therapy	$500	20	$10,000
Subtotal			$14,000
Surgeon	$1,400	80	$112,000
Hospital Pmt			
Surgeries	$12,000	80	$960,000
Total Pmt/Cost		100	$1,096,000

Under FFS, Low Payment for Non-Surgical Options

	CURRENT		
	$/Patient	# Pts	Total $
Primary Care			
Evaluations	$100	100	$10,000
Non-Surg.Tx			
Management	$200	20	$4,000
Phys. Therapy	$500	20	$10,000
Subtotal			$14,000
Surgeon	$1,400	80	$112,000
Hospital Pmt			
Surgeries	$12,000	80	$960,000
Total Pmt/Cost		100	$1,096,000

Under FFS, High Payment for Surgery…

	CURRENT		
	$/Patient	# Pts	Total $
Primary Care			
Evaluations	$100	100	$10,000
Non-Surg.Tx			
Management	$200	20	$4,000
Phys. Therapy	$500	20	$10,000
Subtotal			$14,000
Surgeon	$1,400	80	$112,000
Hospital Pmt			
Surgeries	$12,000	80	$960,000
Total Pmt/Cost		100	$1,096,000

Under FFS, Fewer Surgeries = Losses for Surgeons & Hospitals

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Primary Care							
Evaluations	$100	100	$10,000				
Non-Surg.Tx							
Management	$200	20	$4,000				
Phys. Therapy	$500	20	$10,000				
Subtotal			$14,000				
Surgeon	$1,400	80	~~$112,000~~	~~$1,400~~	→ 60	$84,000	-25%
Hospital Pmt							
Surgeries	$12,000	80	~~$960,000~~	~~$12,000~~	→ 60	$720,000	-25%
Total Pmt/Cost		100	$1,096,000				

Is There a Better Way?

	CURRENT			FUTURE			Chg
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	
Primary Care							
Evaluations	$100	100	$10,000	?			
Non-Surg.Tx							
Management	$200	20	$4,000	?			
Phys. Therapy	$500	20	$10,000	?			
Subtotal			$14,000				
Surgeon	$1,400	80	$112,000	?			
Hospital Pmt							
Surgeries	$12,000	80	$960,000	?			
Total Pmt/Cost		100	$1,096,000				

A Better Way: Pay PCPs for Good Diagnosis & Treatment Planning

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Primary Care							
Evaluations	$100	~~100~~	~~$10,000~~	$200			
Non-Surg.Tx							
Management	$200	20	$4,000				
Phys. Therapy	$500	20	$10,000				
Subtotal			$14,000				
Surgeon	$1,400	80	$112,000				
Hospital Pmt							
Surgeries	$12,000	80	$960,000				
Total Pmt/Cost		100	$1,096,000				

Better Payment for Condition Management

- PCP/GP paid adequately to help patient decide on treatment options

A Better Way: Pay Adequately for Non-Surgical Management

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Primary Care							
Evaluations	$100	100	$10,000	$200			
Non-Surg.Tx							
Management	$200	20	$4,000	$500			
Phys. Therapy	$500	20	$10,000	$750			
Subtotal			$14,000				
Surgeon	$1,400	80	$112,000				
Hospital Pmt							
Surgeries	$12,000	80	$960,000				
Total Pmt/Cost		100	$1,096,000				

Better Payment for Condition Management

- PCP/GP paid adequately to help patient decide on treatment options
- Physiatrists & physical therapists paid to deliver effective non-surgical care

A Better Way: Pay Adequately For the *Necessary* Surgeries

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Primary Care							
Evaluations	$100	100	$10,000	$200			
Non-Surg.Tx							
Management	$200	20	$4,000	$500			
Phys. Therapy	$500	20	$10,000	$750			
Subtotal			$14,000				
Surgeon	$1,400	80	$112,000	$2,100			
Hospital Pmt							
Surgeries	$12,000	80	$960,000				
Total Pmt/Cost		100	$1,096,000				

Better Payment for Condition Management

- PCP/GP paid adequately to help patient decide on treatment options
- Physiatrists & physical therapists paid to deliver effective non-surgical care
- Surgeon paid more per surgery for patients who need surgery

If That Results in 25% Fewer Surgeries…

	CURRENT			FUTURE			Chg
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	
Primary Care							
Evaluations	$100	100	$10,000	$200	100		
Non-Surg.Tx							
Management	$200	20	$4,000	$500	40		
Phys. Therapy	$500	20	$10,000	$750	40		
Subtotal			$14,000				
Surgeon	$1,400	80	~~$112,000~~	~~$2,10~~	60		
Hospital Pmt							
Surgeries	$12,000	80	$960,000	$12,000	60		
Total Pmt/Cost		100	$1,096,000				

Physicians Could Be Paid *More…*

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Primary Care							
Evaluations	$100	100	$10,000	$200	100	$20,000	100%
Non-Surg.Tx							
Management							400%
Phys. Therapy	$500	20	$10,000	$750	40	$30,000	200%
Subtotal			$14,000			$50,000	257%
Surgeon	$1,400	80	$112,000	$2,100	60	$126,000	+13%
Hospital Pmt							
Surgeries	$12,000	80	$960,000				
Total Pmt/Cost		100	$1,096,000				

Physicians Could Be Paid *More*… While Still Reducing Total Spending

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Primary Care							
Evaluations	$100	100	$10,000	$200	100	$20,000	100%
Non-Surg.Tx							
Management	$200	20	$4,000	$500	40	$20,000	400%
Phys. Therapy	$500	20	$10,000	$750	40	$30,000	200%
Subtotal			$14,000			$50,000	257%
Surgeon	$1,400	80	$112,000	$2,100	60	$126,000	+13%
Hospital Pmt							
Surgeries	$12,000	80	$960,000	$12,000	60	$720,000	-25%
Total Pmt/Cost		100	$1,096,000		100	$916,000	-16%

Win-Win-Win for Physicians, Payers, & Patients

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Primary Care							
Evaluations	$100	100	$10,000	$200	100	$20,000	100%
Non-Surg.Tx							
Management	$200	20	$4,000	$500	40	$20,000	400%
Phys. Therapy	$500	20	$10,000	$750	40	$30,000	200%
Subtotal			$14,000			$50,000	257%
Surgeon	$1,400	80	$112,000	$2,100	60	$126,000	+13%
Hospital Pmt							
Surgeries	$12,000	80	$960,000	$12,000	60	$720,000	-25%
Total Pmt/Cost		100	$1,096,000		100	$916,000	-16%

Physicians Win **Patients Win** **Payer Wins**

What About the Hospital?

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Primary Care							
Evaluations	$100	100	$10,000	$200	100	$20,000	100%
Non-Surg.Tx							
Management	$200	20	$4,000	$500	40	$20,000	400%
Phys. Therapy	$500	20	$10,000	$750	40	$30,000	200%
Subtotal			$14,000			$50,000	257%
Surgeon	$1,400	80	$112,000	$2,100	60	$126,000	+13%
Hospital Pmt							
Surgeries	$12,000	80	$960,000	$12,000	60	$720,000	-25%
Total Pmt/Cost		100	$1,096,000		100	$916,000	-16%

Hospital Loses

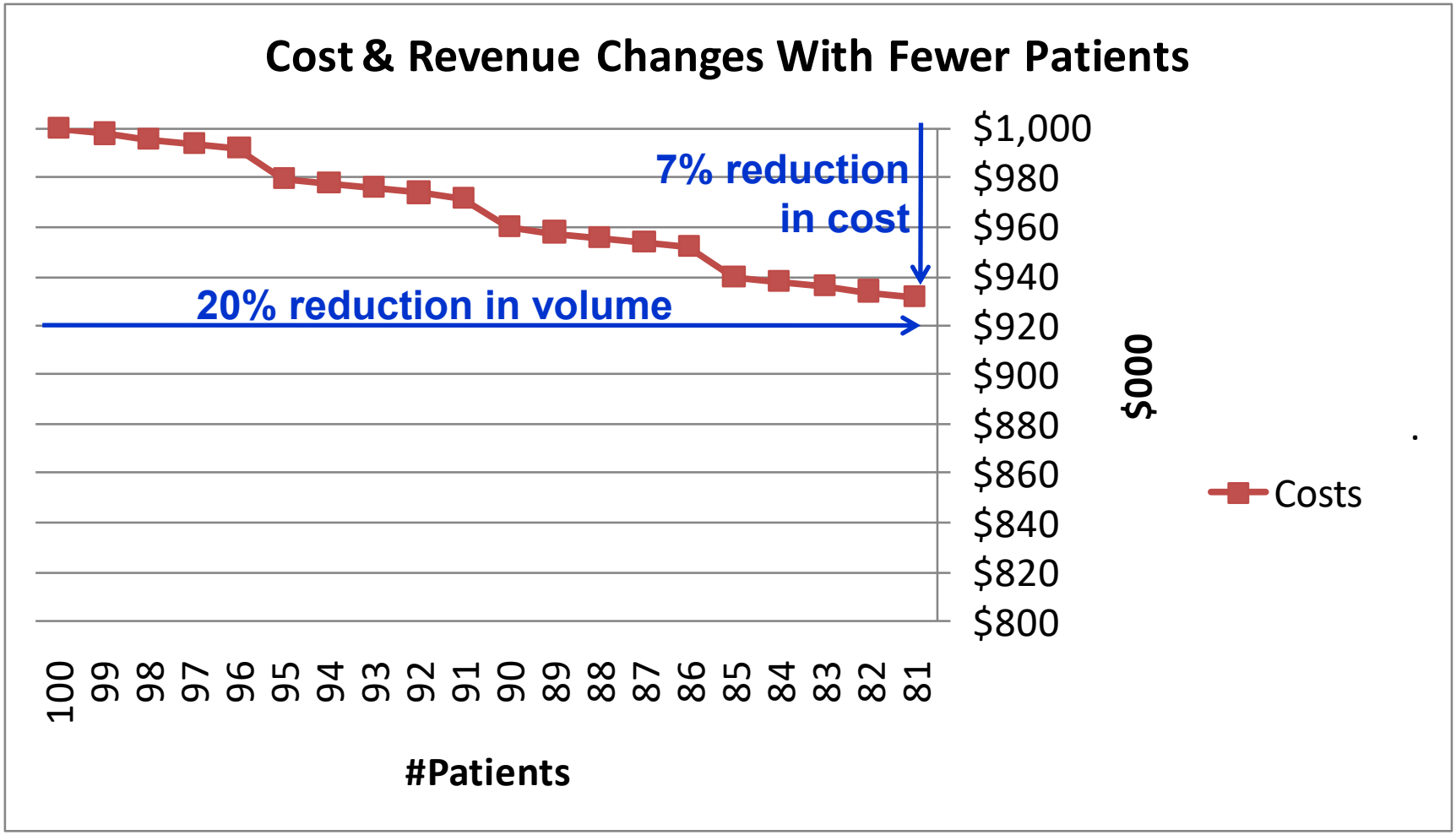
Do Hospitals Have to Lose In Order for Physicians & Payers To Win?

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Primary Care							
Evaluations	$100	100	$10,000	$200	100	$20,000	100%
Non-Surg.Tx							
Management	$200	20	$4,000	$500	40	$20,000	400%
Phys. Therapy	$500	20	$10,000	$750	40	$30,000	200%
Subtotal			$14,000			$50,000	257%
Surgeon	$1,400	80	$112,000	$2,100	60	$126,000	+13%
Hospital Pmt							
Surgeries	$12,000	80	$960,000	$12,000	60	$720,000	-25%
Total Pmt/Cost		100	$1,096,000		100	$916,000	-16%

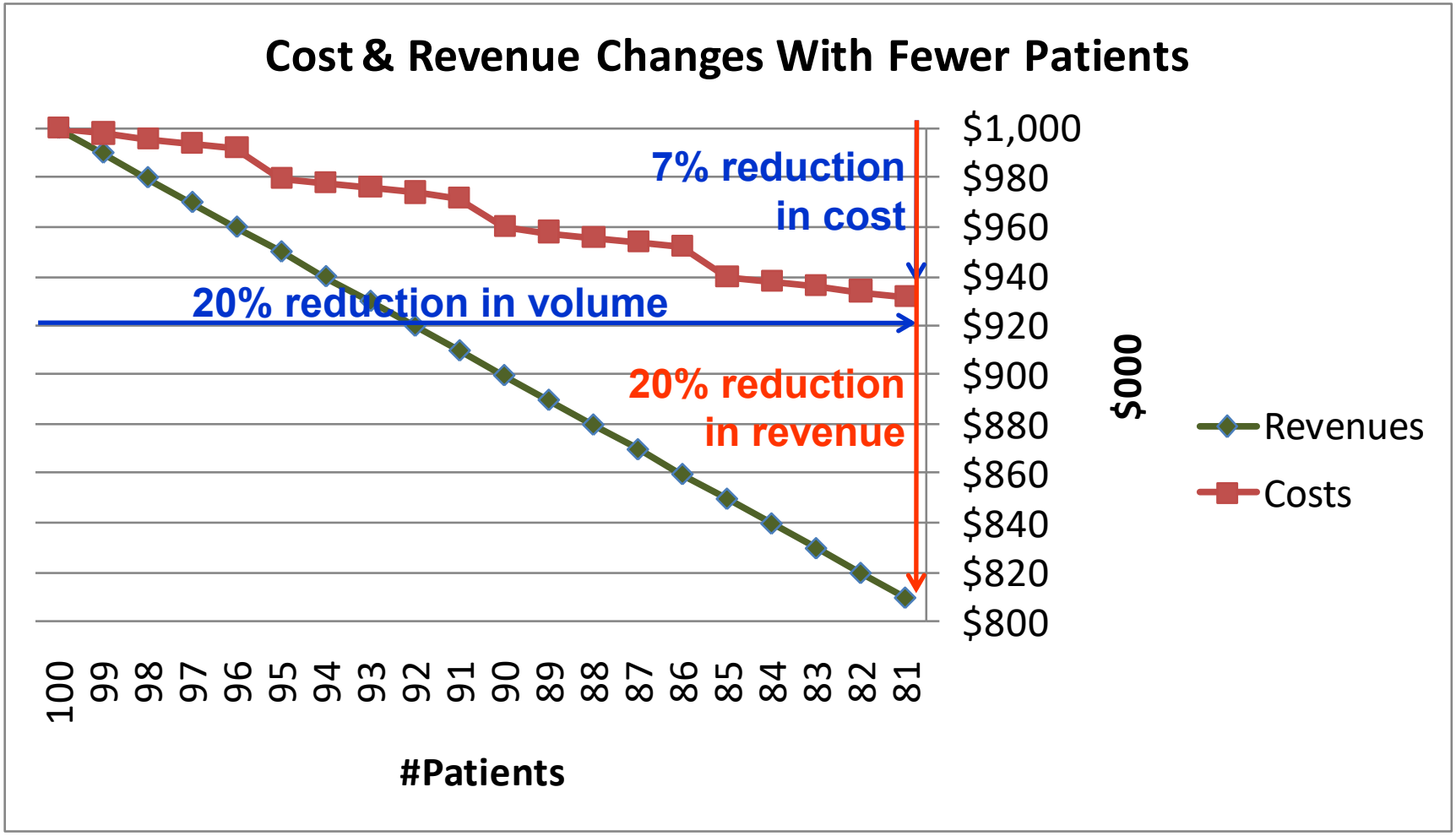
Physicians Win **Hospital Loses** **Payer Wins**

What Should Matter to Hospitals is *Margin*, Not Revenues (Volume)

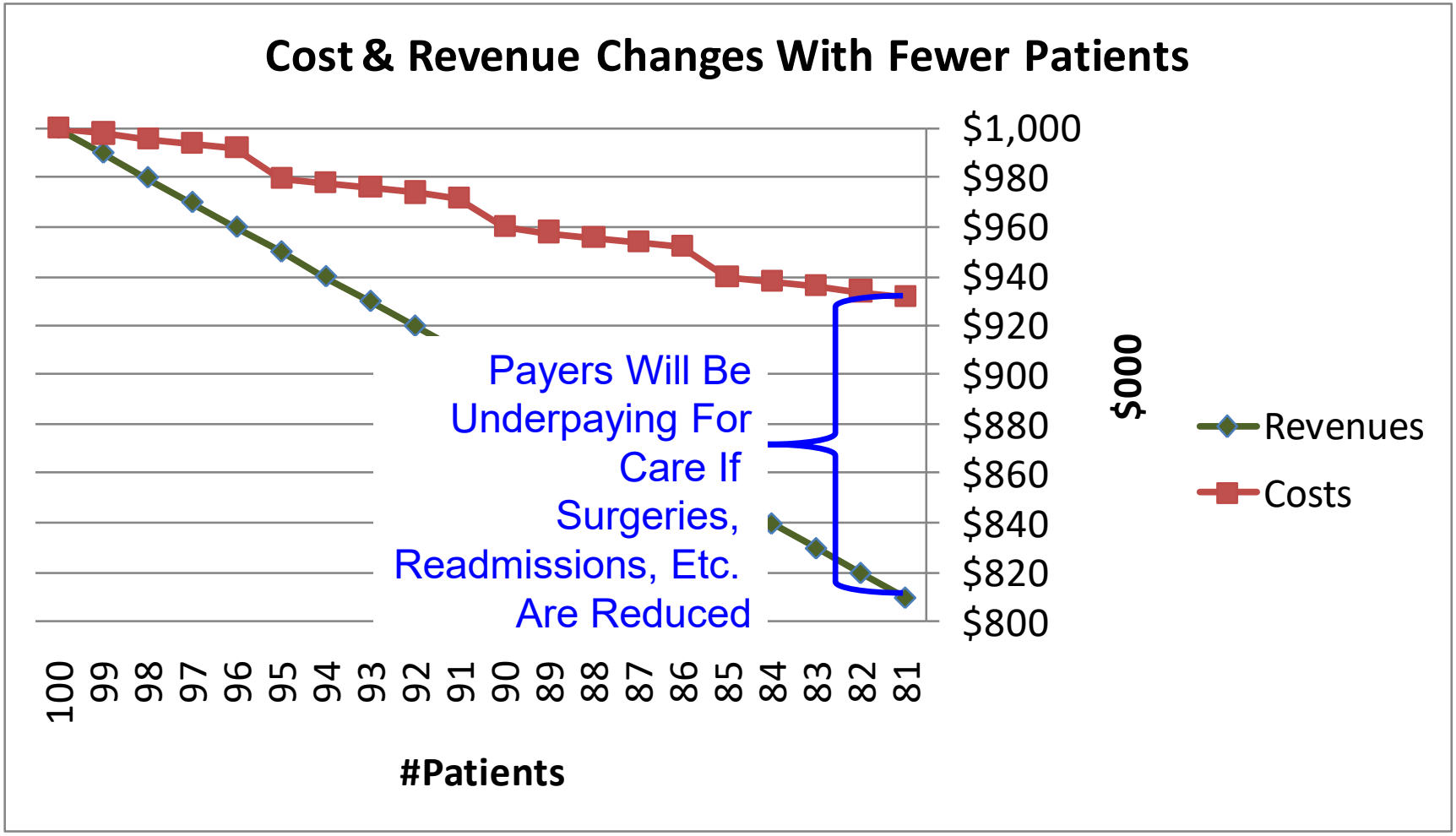
Hospital Costs Are Not Proportional to Utilization



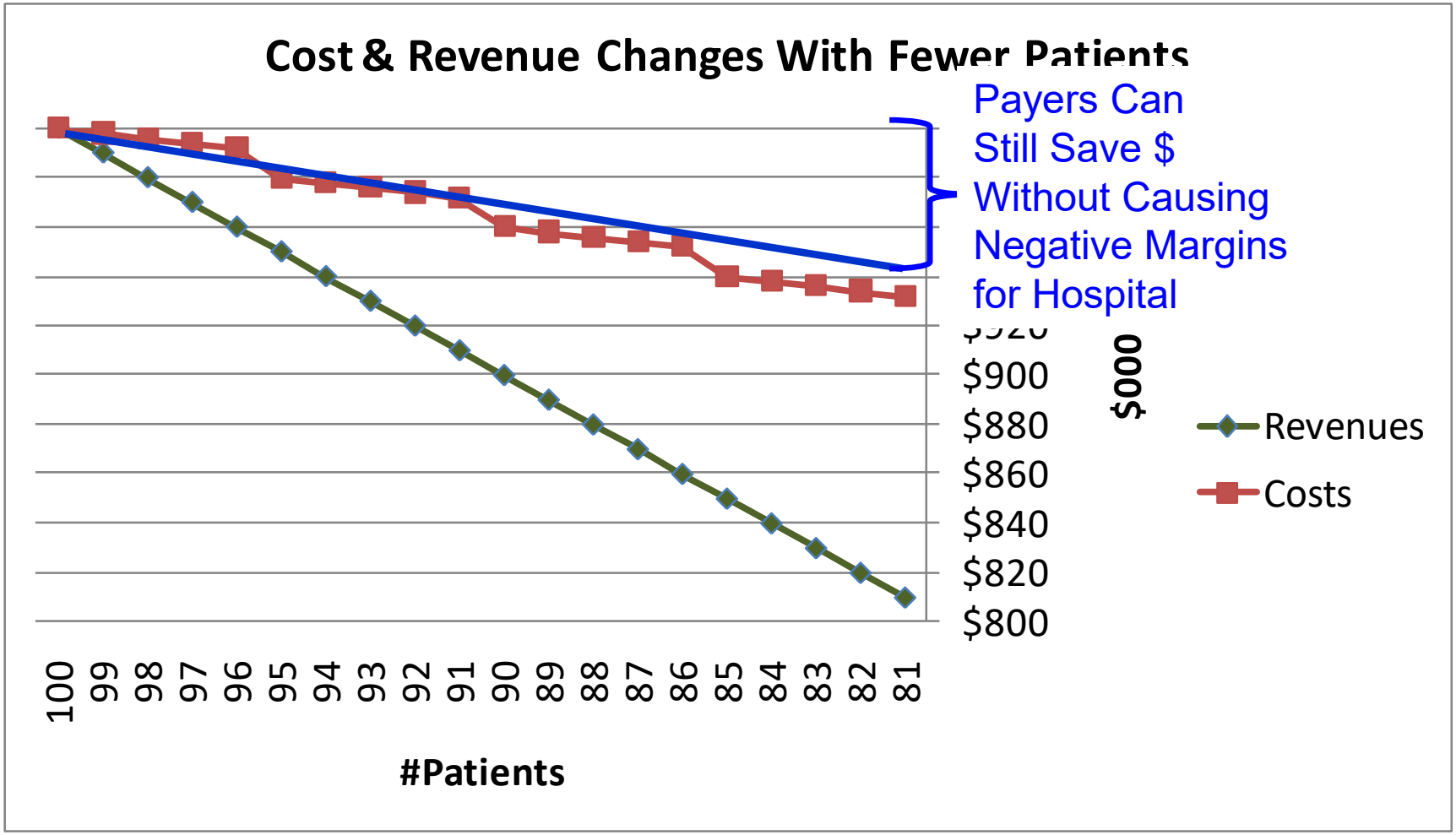
Reductions in Utilization Reduce Revenues More Than Costs



Causing Negative Margins for Hospitals



But Spending Can Be Reduced Without Bankrupting Hospitals



We Need to Understand the Hospital's Cost *Structure*

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Primary Care							
Evaluations	$100	100	$10,000	$200	100	$20,000	100%
Non-Surg.Tx							
Management	$200	20	$4,000	$500	40	$20,000	400%
Phys. Therapy	$500	20	$10,000	$750	40	$30,000	200%
Subtotal			$14,000			$50,000	257%
Surgeon	$1,400	80	$112,000	$2,100	60	$126,000	+13%
Hospital Pmt							
Surgeries	$12,000	80	$960,000	$12,000	60	$720,000	-25%
Total Pmt/Cost		100	$1,096,000		100	$916,000	-16%

It isn't sufficient to know the hospital's *current* cost per procedure; we need to know how the costs will *change* when the number of procedures *changes*

Adequacy of Payment Depends On Fixed/Variable Costs & Margins

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Primary Care							
Evaluations	$100	100	$10,000	$200	100	$20,000	100%
Non-Surg.Tx							
Management	$200	20	$4,000	$500	40	$20,000	400%
Phys. Therapy	$500	20	$10,000	$750	40	$30,000	200%
Subtotal			$14,000			$50,000	257%
Surgeon	$1,400	80	$112,000	$2,100	60	$126,000	+13%
Hospital Pmt							
Fixed Costs	$6,000	*50%*	$480,000				
Variable Costs	$5,400	*45%*	$432,000				
Margin	$600	*5%*	$48,000				
Subtotal	$12,000	80	$960,000				
Total Pmt/Cost		100	$1,096,000				

The actual mix of fixed and variable costs will depend on the procedure, the hospital, and the time horizon

If the Number of Procedures is Reduced…

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Primary Care							
Evaluations	$100	100	$10,000	$200	100	$20,000	100%
Non-Surg.Tx							
Management	$200	20	$4,000	$500	40	$20,000	400%
Phys. Therapy	$500	20	$10,000	$750	40	$30,000	200%
Subtotal			$14,000			$50,000	257%
Surgeon	$1,400	80	$112,000	$2,100	60	$126,000	+13%
Hospital Pmt							
Fixed Costs	$6,000	*50%*	$480,000				
Variable Costs	$5,400	*45%*	$432,000				
Margin	$600	*5%*	$48,000				
Subtotal	$12,000	80	$960,000		60		
Total Pmt/Cost		100	$1,096,000				

…Fixed Costs Will Remain the Same (in the Short Run)…

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Primary Care							
Evaluations	$100	100	$10,000	$200	100	$20,000	100%
Non-Surg.Tx							
Management	$200	20	$4,000	$500	40	$20,000	400%
Phys. Therapy	$500	20	$10,000	$750	40	$30,000	200%
Subtotal			$14,000			$50,000	257%
Surgeon	$1,400	80	$112,000	$2,100	60	$126,000	+13%
Hospital Pmt							
Fixed Costs	$6,000	*50%*	$480,000			$480,000	0%
Variable Costs	$5,400	*45%*	$432,000				
Margin	$600	*5%*	$48,000				
Subtotal	$12,000	80	$960,000		60		
Total Pmt/Cost		100	$1,096,000				

…But Variable Costs Will Go Down in Proportion to Procedures

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Primary Care							
Evaluations	$100	100	$10,000	$200	100	$20,000	100%
Non-Surg.Tx							
Management	$200	20	$4,000	$500	40	$20,000	400%
Phys. Therapy	$500	20	$10,000	$750	40	$30,000	200%
Subtotal			$14,000			$50,000	257%
Surgeon	$1,400	80	$112,000	$2,100	60	$126,000	+13%
Hospital Pmt							
Fixed Costs	$6,000	*50%*	$480,000			$480,000	0%
Variable Costs	$5,400	*45%*	$432,000	$5,400		$324,000	-25%
Margin	$600	*5%*	$48,000				
Subtotal	$12,000	80	$960,000		60		
Total Pmt/Cost		100	$1,096,000				

Let's Allow the Hospital to Get a Higher Margin Than Before

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Primary Care							
Evaluations	$100	100	$10,000	$200	100	$20,000	100%
Non-Surg.Tx							
Management	$200	20	$4,000	$500	40	$20,000	400%
Phys. Therapy	$500	20	$10,000	$750	40	$30,000	200%
Subtotal			$14,000			$50,000	257%
Surgeon	$1,400	80	$112,000	$2,100	60	$126,000	+13%
Hospital Pmt							
Fixed Costs	$6,000	*50%*	$480,000			$480,000	0%
Variable Costs	$5,400	*45%*	$432,000	$5,400		$324,000	-25%
Margin	$600	*5%*	$48,000			$52,800	+10%
Subtotal	$12,000	80	$960,000		60		
Total Pmt/Cost		100	$1,096,000				

The Hospital Gets Less *Total* Revenue But a Higher *Margin*…

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Primary Care							
Evaluations	$100	100	$10,000	$200	100	$20,000	100%
Non-Surg.Tx							
Management	$200	20	$4,000	$500	40	$20,000	400%
Phys. Therapy	$500	20	$10,000	$750	40	$30,000	200%
Subtotal			$14,000			$50,000	257%
Surgeon	$1,400	80	$112,000	$2,100	60	$126,000	+13%
Hospital Pmt							
Fixed Costs	$6,000	*50%*	$480,000			$480,000	0%
Variable Costs	$5,400	*45%*	$432,000	$5,400		$324,000	-25%
Margin	$600	*5%*	$48,000			$52,800	+10%
Subtotal	$12,000	80	$960,000		[illegible]	$856,800	-11%
Total Pmt/Cost		100	$1,096,000				

…And The Payer Still Saves Money

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Primary Care							
Evaluations	$100	100	$10,000	$200	100	$20,000	100%
Non-Surg.Tx							
Management	$200	20	$4,000	$500	40	$20,000	400%
Phys. Therapy	$500	20	$10,000	$750	40	$30,000	200%
Subtotal			$14,000			$50,000	257%
Surgeon	$1,400	80	$112,000	$2,100	60	$126,000	+13%
Hospital Pmt							
Fixed Costs	$6,000	*50%*	$480,000			$480,000	0%
Variable Costs	$5,400	*45%*	$432,000	$5,400		$324,000	-25%
Margin	$600	*5%*	$48,000			$52,800	+10%
Subtotal	$12,000	80	$960,000		60	$856,800	-11%
Total Pmt/Cost		100	$1,096,000		100	$1,052,800	-4%

Win-Win-Win-Win for Patients, Physicians, Hospital, and Payer

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Primary Care							
Evaluations	$100	100	$10,000	$200	100	$20,000	100%
Non-Surg.Tx							
Management	$200	20	$4,000	$500	40	$20,000	400%
Phys. Therapy	$500	20	$10,000	$750	40	$30,000	200%
Subtotal			$14,000			$50,000	257%
Surgeon	$1,400	80	$112,000			$126,000	+13%
Hospital Pmt							
Fixed Costs	$6,000	*50%*	$480,000			$480,000	0%
Variable Costs	$5,400	*45%*	$432,000	$5,400		$324,000	-25%
Margin	$600	*5%*	$48,000			$52,800	+10%
Subtotal	$12,000	80	$960,000		60	$856,800	-11%
Total Pmt/Cost		100	$1,096,000		100	$1,052,800	-4%

Physicians Win

Hospital Wins

Payer Wins

What Payment Model Supports This Win-Win-Win Approach?

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Primary Care							
Evaluations	$100	100	$10,000	$200	100	$20,000	100%
Non-Surg.Tx							
Management	$200	20	$4,000	$500	40	$20,000	400%
Phys. Therapy	$500	20	$10,000	$750	40	$30,000	200%
Subtotal			$14,000			$50,000	257%
Surgeon	$1,400	80	$112,000	$2,100	60	$126,000	+13%
Hospital Pmt							
Fixed Costs	$6,000	*50%*	$480,000			$480,000	0%
Variable Costs	$5,400	*45%*	$432,000	$5,400		$324,000	-25%
Margin	$600	*5%*	$48,000			$52,800	+10%
Subtotal	$12,000	80	$960,000		60	$856,800	-11%
Total Pmt/Cost		100	$1,096,000		100	$1,052,800	-4%

Renegotiating Every Individual Fee is Impractical…

	CURRENT			FUTURE			Chg
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	
Primary Care							
Evaluations	$100	100	$10,000	$200	100	$20,000	100%
Non-Surg.Tx							
Management	$200	20	$4,000	$500	40	$20,000	400%
Phys. Therapy	$500	20	$10,000	$750	40	$30,000	200%
Subtotal			$14,000			$50,000	257%
Surgeon	$1,400	80	$112,000	$2,100	60	$126,000	+13%
Hospital Pmt							
Fixed Costs	$6,000	*50%*	$480,000			$480,000	0%
Variable Costs	$5,400	*45%*	$432,000	$5,400		$324,000	-25%
Margin	$600	*5%*	$48,000			$52,800	+10%
Subtotal	$12,000	80	$960,000	$14,280	60	$856,800	-11%
Total Pmt/Cost		100	$1,096,000		100	$1,052,800	-4%

…What Assures The Payer That There Will Be Fewer Procedures?

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Primary Care							
Evaluations	$100	100	$10,000	$200	100	$20,000	100%
Non-Surg.Tx							
Management	$200	20	$4,000	$500	40	$20,000	400%
Phys. Therapy	$500	20	$10,000	$750	40	$30,000	200%
Subtotal			$14,000			$50,000	257%
Surgeon	$1,400	80	$112,000	$2,100	60	$126,000	+13%
Hospital Pmt							
Fixed Costs	$6,000	*50%*	$480,000			$480,000	0%
Variable Costs	$5,400	*45%*	$432,000	$5,400		$324,000	-25%
Margin	$600	*5%*	$48,000			$52,800	+10%
Subtotal	$12,000	80	$960,000	$14,280	60	$856,800	-11%
Total Pmt/Cost		100	$1,096,000		100	$1,052,800	-4%

Start With Team of Providers Managing the Condition

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Primary Care							
Evaluations	$100	100	$10,000	$200	100	$20,000	100%
Non-Surg.Tx							
Management	$200	20	$4,000	$500	40	$20,000	400%
Phys. Therapy	$500	20	$10,000	$750	40	$30,000	200%
Subtotal			$14,000			$50,000	257%
Surgeon	$1,400	80	$112,000	$2,100	60	$126,000	+13%
Hospital Pmt							
Fixed Costs	$6,000	*50%*	$480,000			$480,000	0%
Variable Costs	$5,400	*45%*	$432,000	$5,400		$324,000	-25%
Margin	$600	*5%*	$48,000			$52,800	+10%
Subtotal	$12,000	80	$960,000		60	$856,800	-11%
Total Pmt/Cost		100	$1,096,000		100	$1,052,800	-4%

They Should Function as a Team to Manage the Patient's Condition

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
PCP Evaluation	$100	100	$10,000	$200	100	$20,000	
Non-Surg.Tx	$700	20	$14,000	$1,250	40	$50,000	
Surgeon	$1,400	80	$112,000	$2,100	60	$126,000	
Subtotal			$136,000			$196,000	+44%
Hospital Pmt							
Fixed Costs	$6,000	*50%*	$480,000			$480,000	0%
Variable Costs	$5,400	*45%*	$432,000	$5,400		$324,000	-25%
Margin	$600	*5%*	$48,000			$52,800	+10%
Subtotal	$12,000	80	$960,000		60	$856,800	-11%
Total Pmt/Cost		100	$1,096,000		100	$1,052,800	-4%

Their Decisions Also Determine the Hospital's Variable Cost of Surgery

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
PCP Evaluation	$100	100	$10,000	$200	100	$20,000	
Non-Surg.Tx	$700	20	$14,000	$1,250	40	$50,000	
Surgeon	$1,400	80	$112,000	$2,100	60	$126,000	
Subtotal			$136,000			$196,000	+44%
Hospital Pmt							
Fixed Costs	$6,000	*50%*	$480,000			$480,000	0%
Variable Costs	$5,400	*45%*	$432,000	$5,400		$324,000	-25%
Margin	$600	*5%*	$48,000			$52,800	+10%
Subtotal	$12,000	80	$960,000		60	$856,800	-11%
Total Pmt/Cost		100	$1,096,000		100	$1,052,800	-4%

So Variable Costs Are Part of the Condition-Management Cost

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
PCP Evaluation	$100	100	$10,000	$200	100	$20,000	
Non-Surg.Tx	$700	20	$14,000	$1,250	40	$50,000	
Surgeon	$1,400	80	$112,000	$2,100	60	$126,000	
Hosp. Var. Cost	$5,400	80	$432,000	$5,400	60	$324,000	
Total Condition			$568,000			$520,000	-8%

Hospital Pmt	**Members**	**$**	**Total $**	**Members**	**$**	**Total $**	
Fixed Costs			$480,000			$480,000	
Margin			$48,000			$52,800	
Subtotal			$528,000			$532,800	

The Full Cost the Condition Team is Responsible For

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
PCP Evaluation	$100	100	$10,000	$200	100	$20,000	
Non-Surg.Tx	$700	20	$14,000	$1,250	40	$50,000	
Surgeon	$1,400	80	$112,000	$2,100	60	$126,000	
Hosp. Var. Cost	$5,400	80	$432,000	$5,400	60	$324,000	
Total Condition			$568,000			$520,000	-8%

Hospital Pmt	Members	$	Total $	Members	$	Total $	
Fixed Costs			$480,000			$480,000	
Margin			$48,000			$52,800	
Subtotal			$528,000			$532,800	

Use a *Per-Patient Payment* to Pay for Condition Management

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
PCP Evaluation	$100	100	$10,000				
Non-Surg.Tx	$700	20	$14,000				
Surgeon	$1,400	80	$112,000				
Hosp. Var. Cost	$5,400	80	$432,000				
Total Condition			$568,000				
Per Patient	$5,680	100		$5,280	100		-8%

Hospital Pmt	**Members**	**$**	**Total $**	**Members**	**$**	**Total $**	
Fixed Costs			$480,000			$480,000	
Margin			$48,000			$52,800	
Total Standby			$528,000			$532,800	

Use the Payment as Budget to Support the Work of the Team…

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
PCP Evaluation	$100	100	$10,000				
Non-Surg.Tx	$700	20	$14,000				
Surgeon	$1,400	80	$112,000				
Hosp. Var. Cost	$5,400	80	$432,000				
Total Condition			$568,000			$520,000	-8%
Per Patient	$5,680	100		$5,280	100	$520,000	

Hospital Pmt	**Members**	**$**	**Total $**	**Members**	**$**	**Total $**	
Fixed Costs			$480,000			$480,000	
Margin			$48,000			$52,800	
Total Standby			$528,000			$532,800	

…And Let the Team Members Decide How They Should Be Paid

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
PCP Evaluation	$100	100	$10,000	$200			
Non-Surg.Tx	$700	20	$14,000	$1,250			
Surgeon	$1,400	80	$112,000	$2,100			
Hosp. Var. Cost	$5,400	80	$432,000				
Total Condition			$568,000			$520,000	-8%
Per Patient	$5,680	100		$5,280	100	$520,000	

Hospital Pmt	**Members**	**$**	**Total $**	**Members**	**$**	**Total $**	
Fixed Costs			$480,000			$480,000	
Margin			$48,000			$52,800	
Total Standby			$528,000			$532,800	

The Hospital Needs to Cover Its Fixed Costs No Matter What

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
PCP Evaluation	$100	100	$10,000	$200	100	$20,000	
Non-Surg.Tx	$700	20	$14,000	$1,250	40	$50,000	
Surgeon	$1,400	80	$112,000	$2,100	60	$126,000	
Hosp. Var. Cost	$5,400	80	$432,000	$5,400	60	$324,000	
Total Condition			$568,000			$520,000	-8%
Per Patient				$5,280	100	$520,000	

Hospital Pmt	**Members**	**$**	**Total $**	**Members**	**$**	**Total $**	
Fixed Costs			$480,000			$480,000	
Margin			$48,000			$52,800	
Total Standby			$528,000			$532,800	

Support Standby Costs Through a Payment for Each *Plan Member*

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
PCP Evaluation	$100	100	$10,000	$200	100	$20,000	
Non-Surg.Tx	$700	20	$14,000	$1,250	40	$50,000	
Surgeon	$1,400	80	$112,000	$2,100	60	$126,000	
Hosp. Var. Cost	$5,400	80	$432,000	$5,400	60	$324,000	
Total Condition			$568,000			$520,000	-8%
Per Patient				$5,280	100	$520,000	

Hospital Pmt	**Members**	**$**	**Total $**	**Members**	**$**	**Total $**	
Fixed Costs			$480,000			$480,000	
Margin			$48,000			$52,800	
Total Standby			$528,000			$532,800	
Per Member				1,000	$533	$533,000	

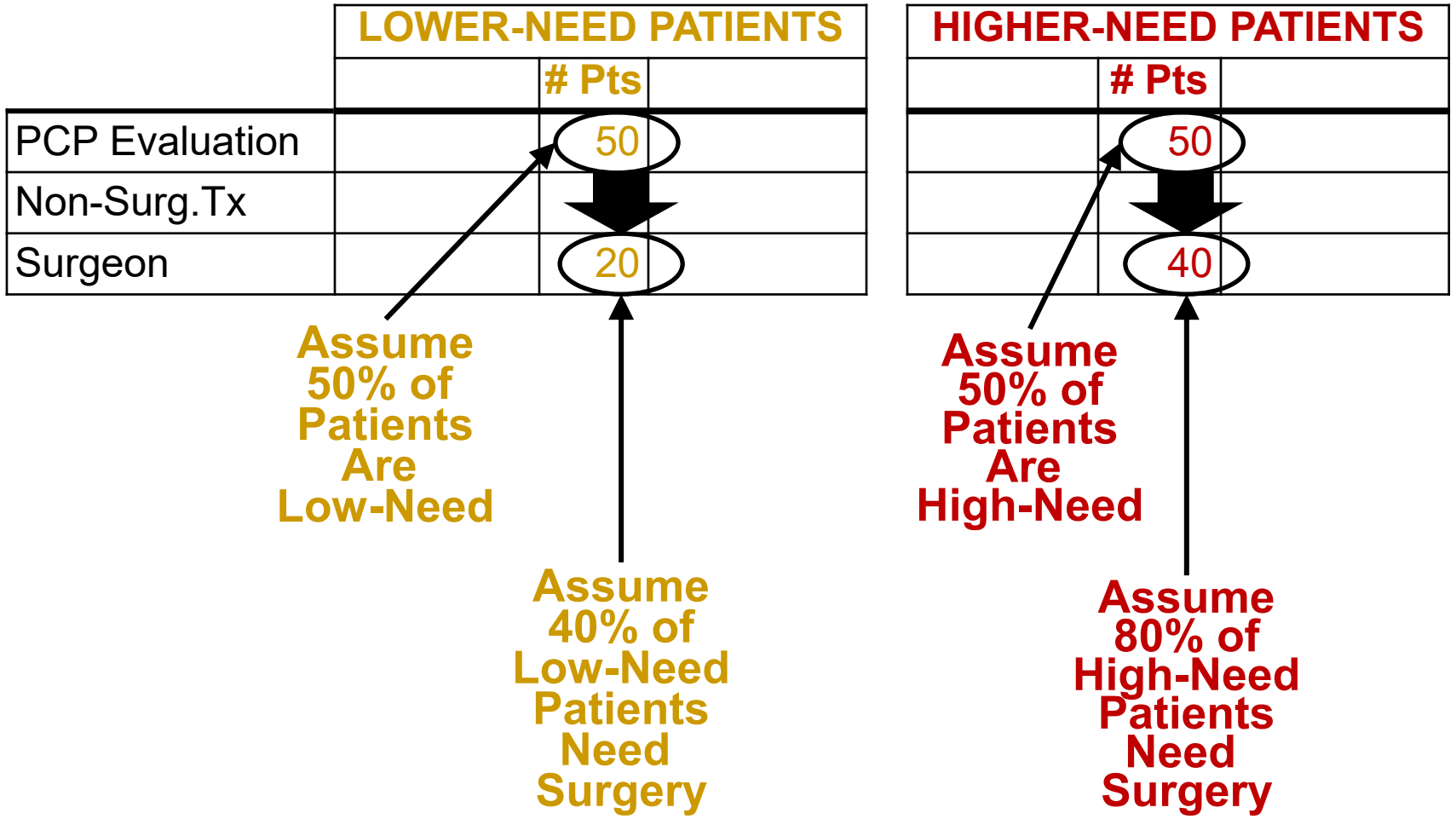
The Combination of Payments is Still Less Than Previously Spent

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
PCP Evaluation	$100	100	$10,000	$200	100	$20,000	
Non-Surg.Tx	$700	20	$14,000	$1,250	40	$50,000	
Surgeon	$1,400	80	$112,000	$2,100	60	$126,000	
Hosp. Var. Cost	$5,400	80	$432,000	$5,400	60	$324,000	
Total Condition			$568,000			$520,000	-8%
Per Patient				$5,280	100	$520,000	

Hospital Pmt	**Members**	**$**	**Total $**	**Members**	**$**	**Total $**	
Fixed Costs			$480,000			$480,000	
Margin			$48,000			$52,800	
Total Standby			$528,000			$532,800	
Per Member				1,000	$533	$533,000	

Total Pmt/Cost			$1,096,000			$1,053,000	-4%

Patients Differ in Their Need for Surgery vs. Alternative Treatment



Payment Amounts Must Be Stratified Based on Patient Needs

	LOWER-NEED PATIENTS			HIGHER-NEED PATIENTS		
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $
Primary Care	$200	50	$10,000	$200	50	$10,000
Non-Surg.Tx	$1,250	30	$37,500	$1,250	10	$12,500
Surgeon	$2,100	20	$42,000	$2,100	40	$84,000
Variable Costs	$5,400	20	$108,000	$5,400	40	$216,000
Total Cost		50	$197,500		50	$322,500
Per Member	$3,950	50		$6,450	50	

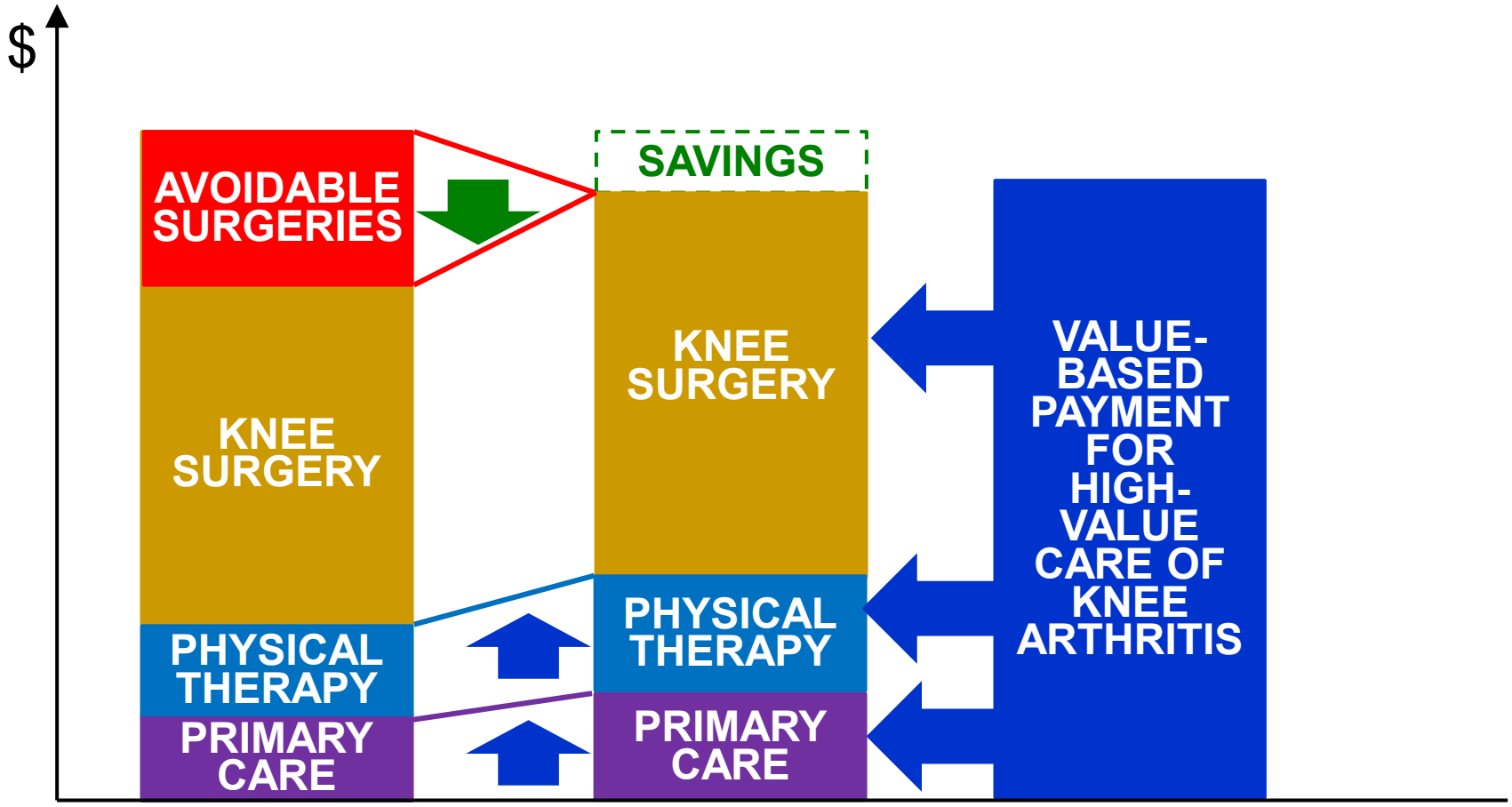
Lower Per-Patient Payment for Lower-Need Patients

Higher Per-Patient Payment for Higher-Need Patients

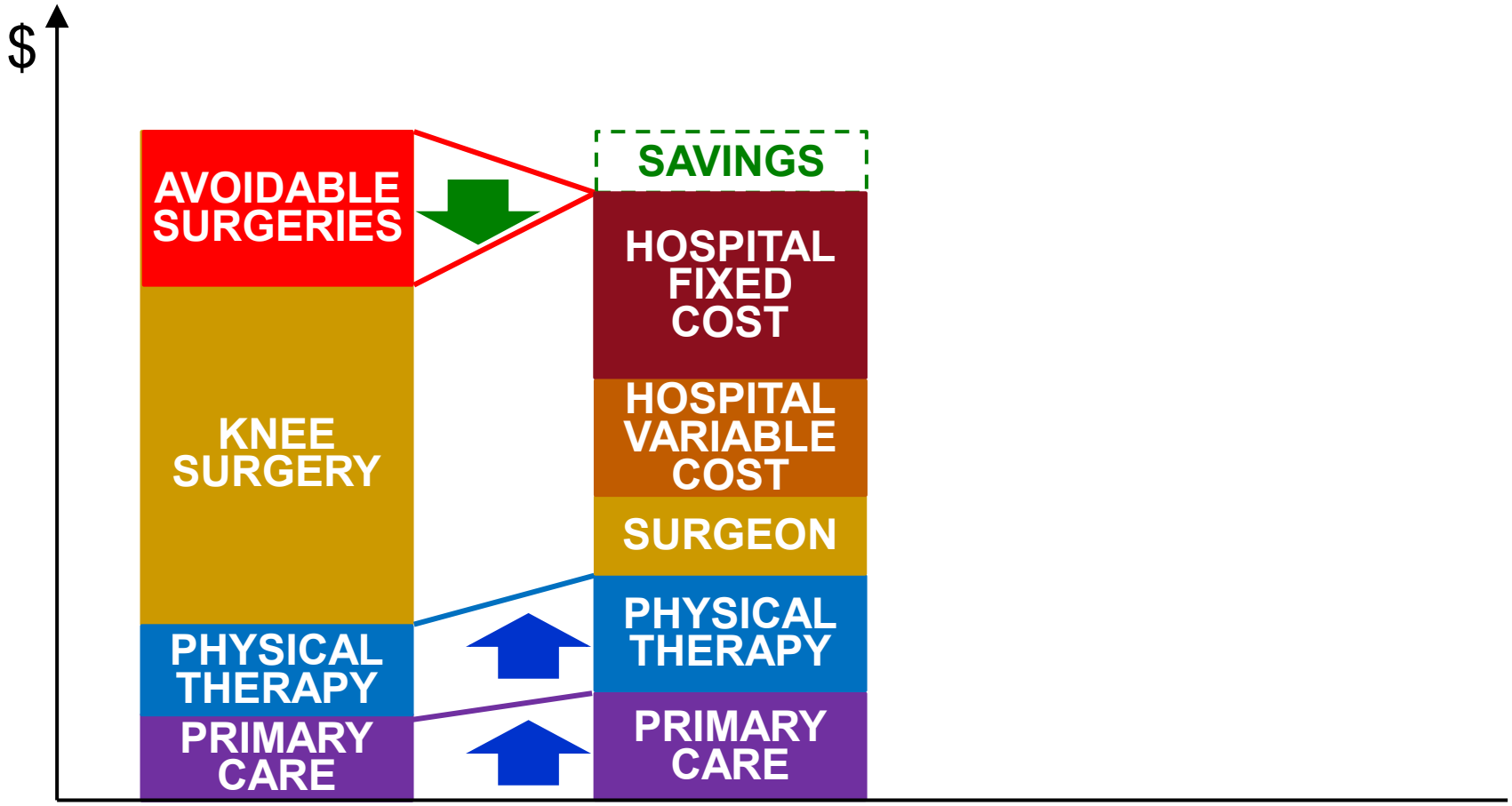
Protections For Providers Against Taking Inappropriate Risk

- **Risk Stratification:** The payment rates should vary based on objective characteristics of the patient and treatment that would be expected to result in the need for more services or increase the risk of complications.
- **Outlier Payment or Individual Stop Loss Insurance:** The payment should be increased if spending on an individual patient exceeds a pre-defined threshold. An alternative would be for the provider to purchase individual stop loss insurance (sometimes referred to as reinsurance) and include the cost of the insurance in the payment bundle.
- **Risk Corridors or Aggregate Stop Loss Insurance:** The payment should be increased if spending on all patients exceeds a pre-defined percentage above the payments. An alternative would be for the provider to purchase aggregate stop loss insurance and include the cost of the insurance in the payment bundle.
- **Adjustment for External Price Changes:** The payment should be adjusted for changes in the prices of drugs or services from other providers that are beyond the control of the provider accepting the payment.
- **Excluded Services:** Services the provider does not deliver, or order, or otherwise have the ability to influence should not be included as part of accountability measures in the payment system.

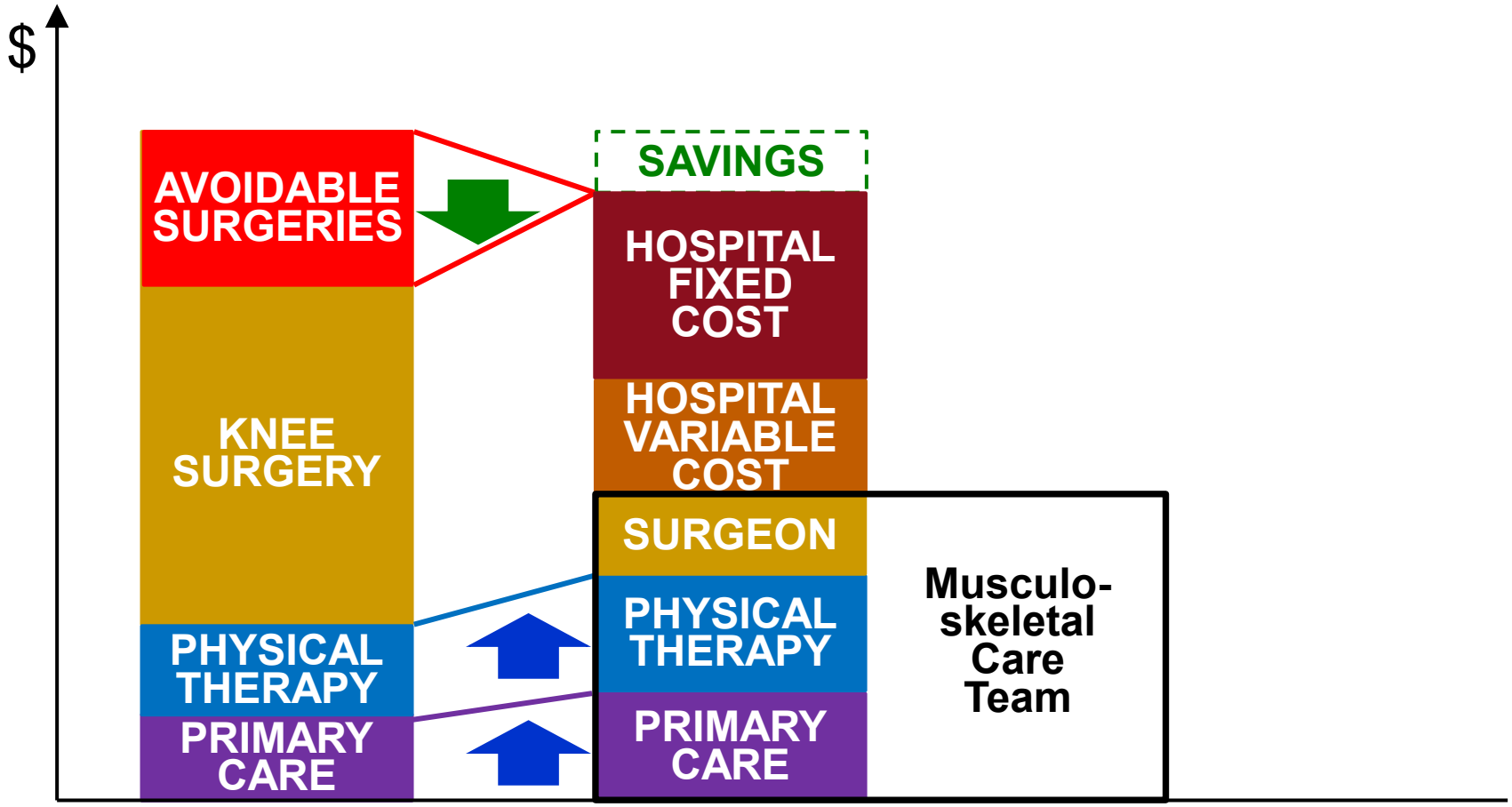
How Could a Value-Based Payment Model Support This?



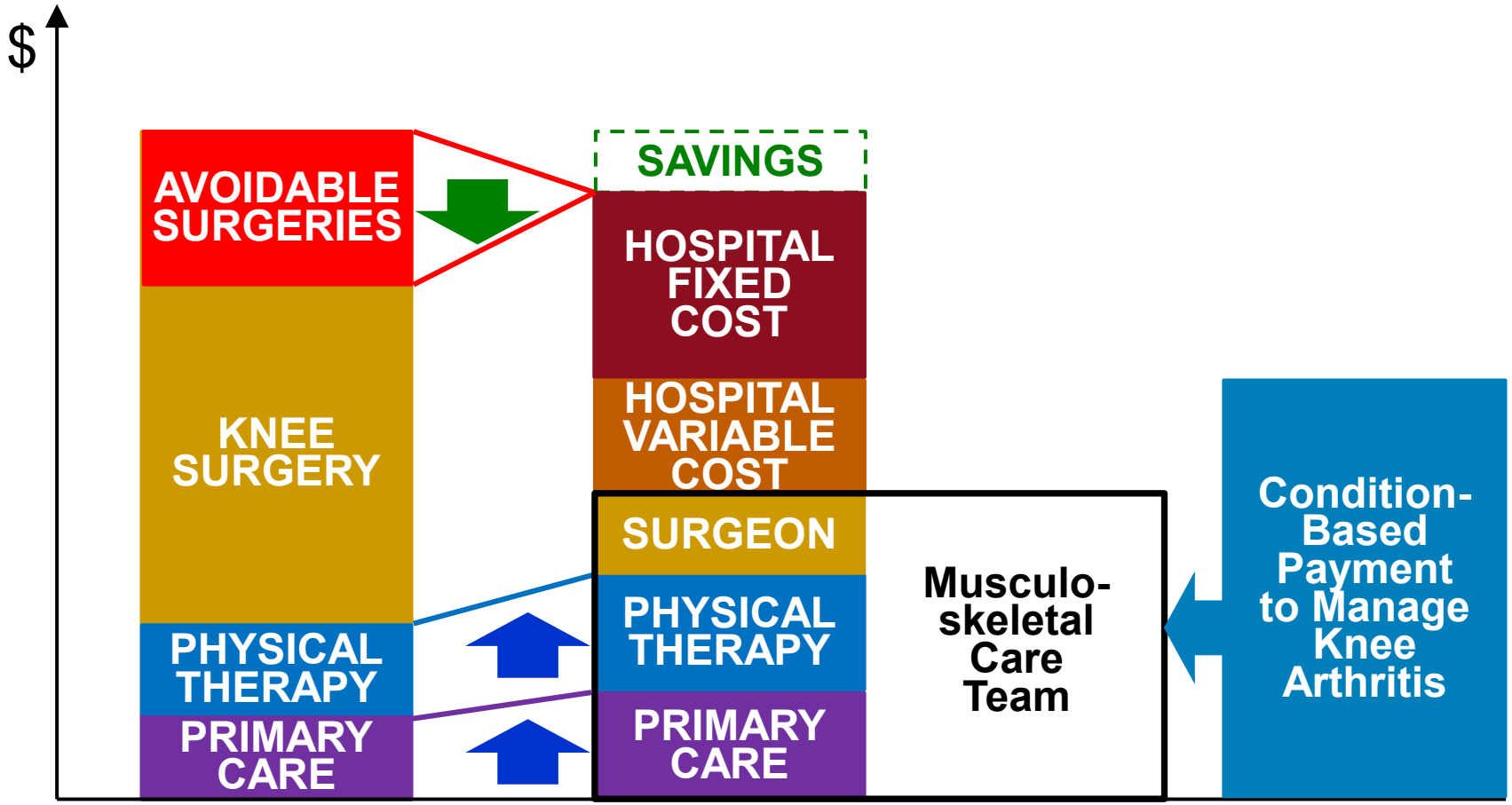
Identify the Components of the Cost of Surgery



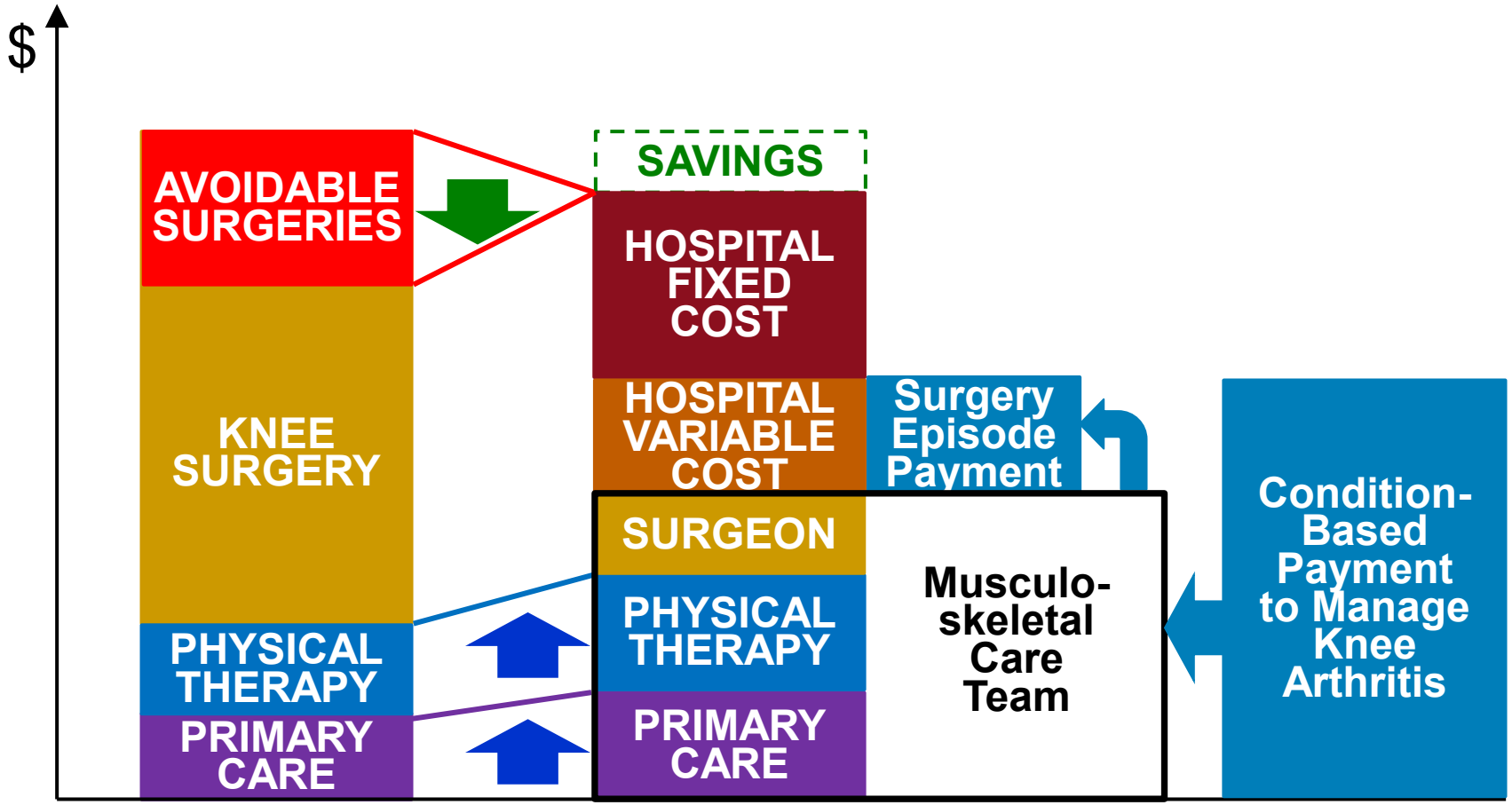
Define the Care Team That Will Manage the Patient's Condition



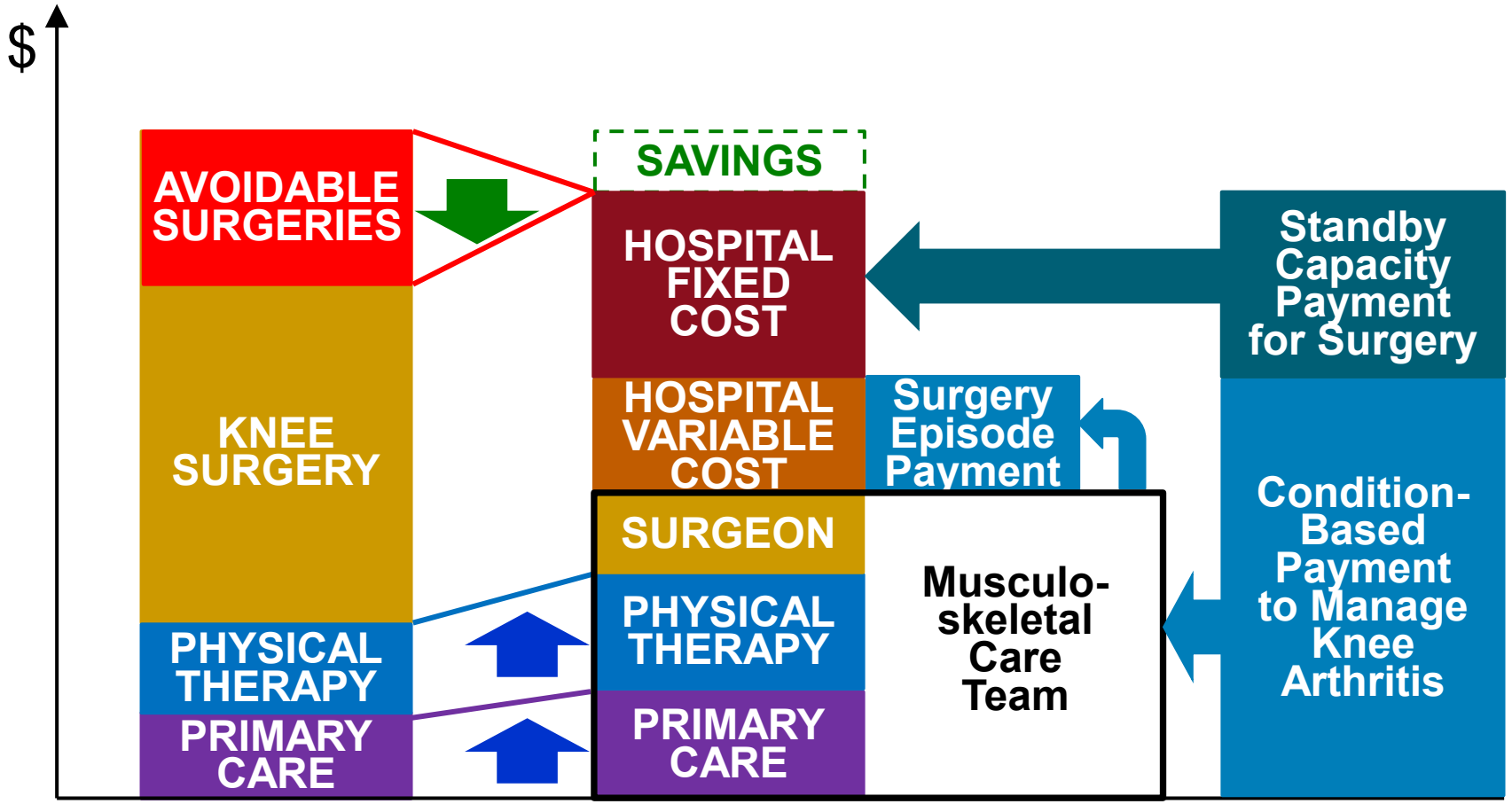
Pay the Care Team to Manage the Patient's Condition



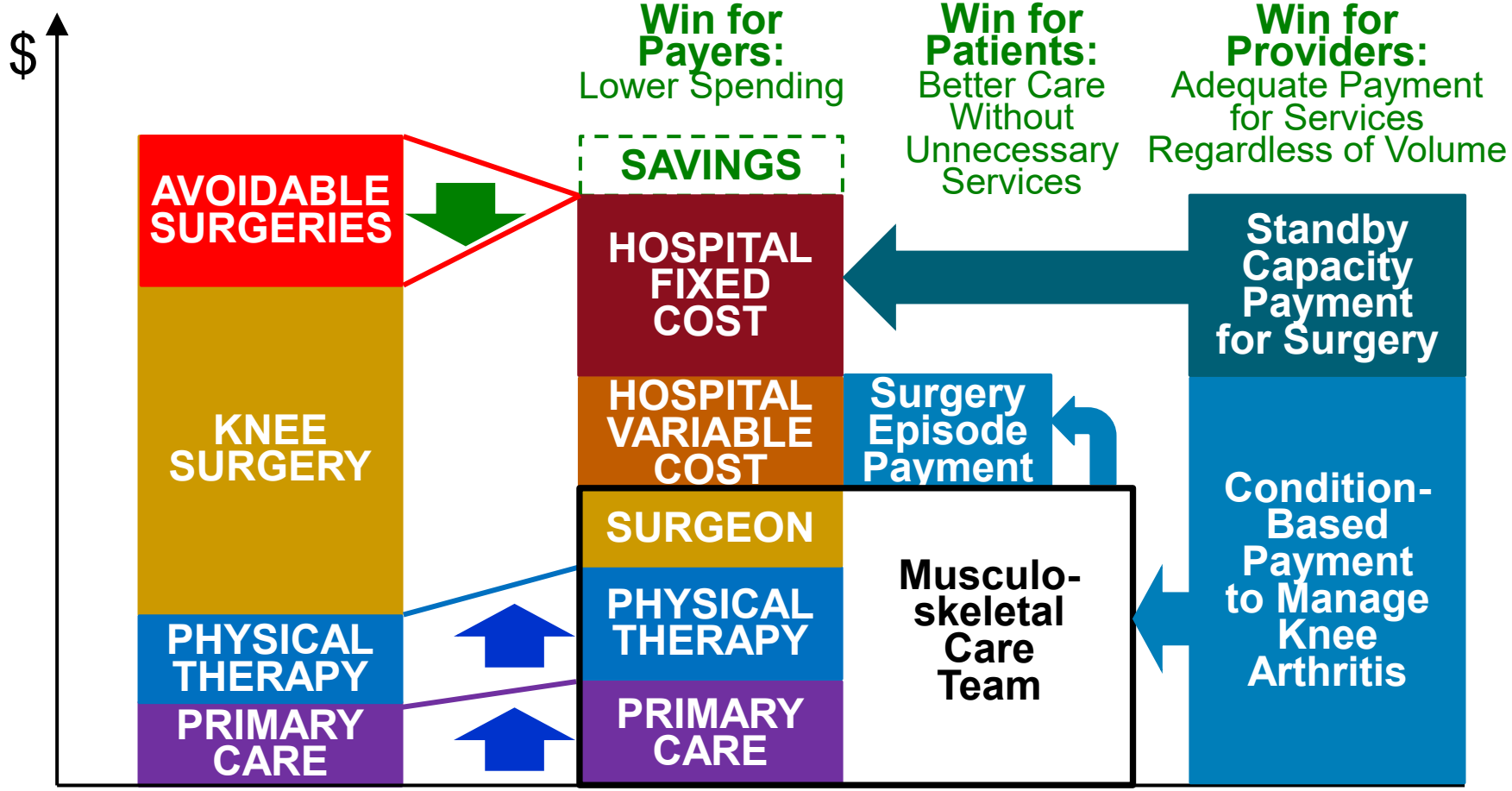
The Care Team Pays for the Incremental Cost of More Surgery



Hospital Receives Payment to Support Standby Capacity Cost



Win-Win-Win Through Good Value-Based Care and Payment



Implementing Good Alternative Payment Models

Implementing Patient-Centered Payments in Private Health Plans

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  - **Fully Insured Plans:** Insurance plans that charge premiums to individuals and small employers are subject to federal Minimum Medical Loss Ratio requirements. If healthcare spending decreases, they must reduce premiums, which reduces their profits. If they have to incur additional administrative costs in order to implement new payment models, the insurance companies have to increase premiums or reduce their profits.

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  - **Self-Insured Plans:** Health insurance companies that administer benefits for larger, self-insured employers incur the administrative costs for implementing new payment models but must pass on any savings in healthcare spending to the employers, so implementing a successful APM could mean the insurance companies either have to raise their fees to employers or reduce their profits.

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- **The solution? Hospitals and physicians should start talking to the *real* purchasers of healthcare, not health insurance companies.**

Employers & Individuals are the *True Purchasers* of Healthcare

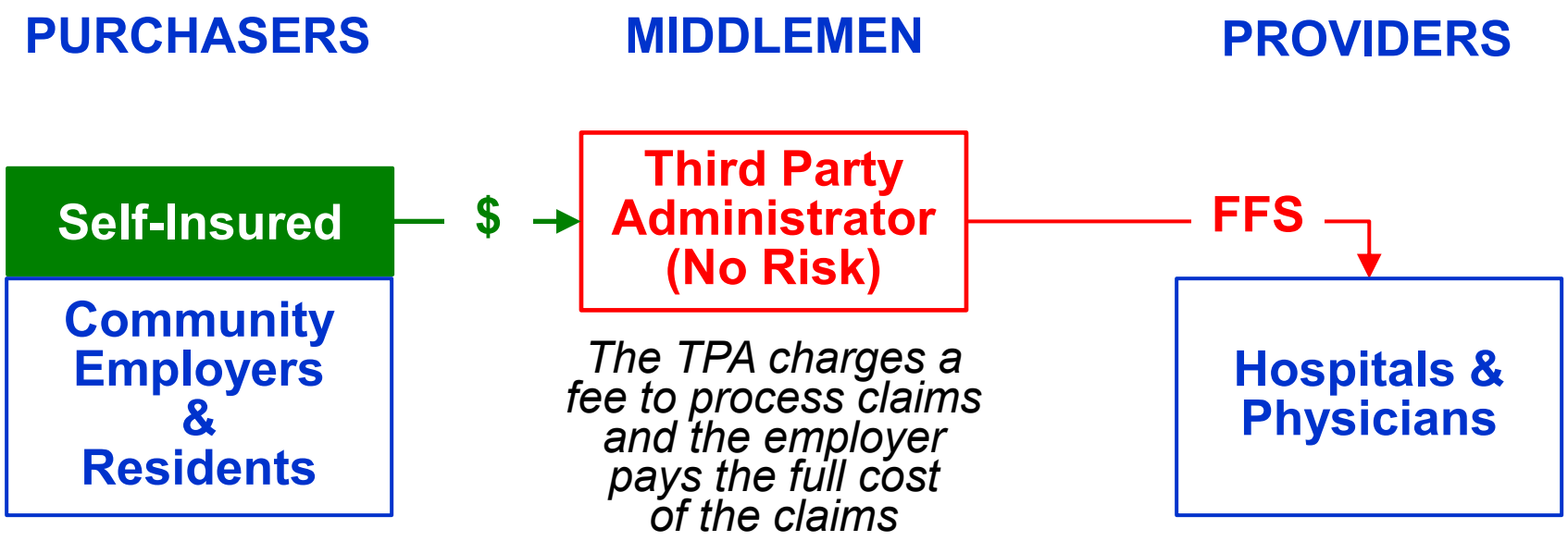
PURCHASERS

Community Employers & Residents

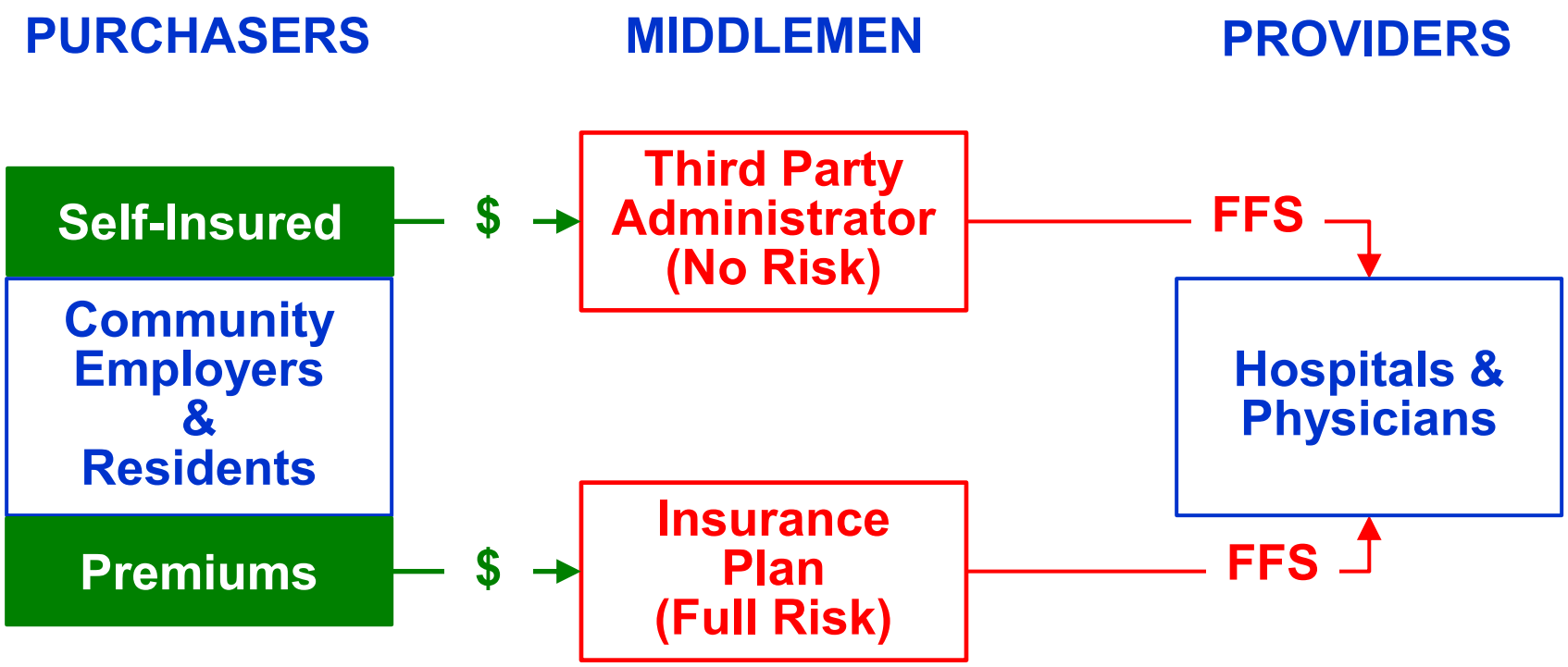
PROVIDERS

Hospitals & Physicians

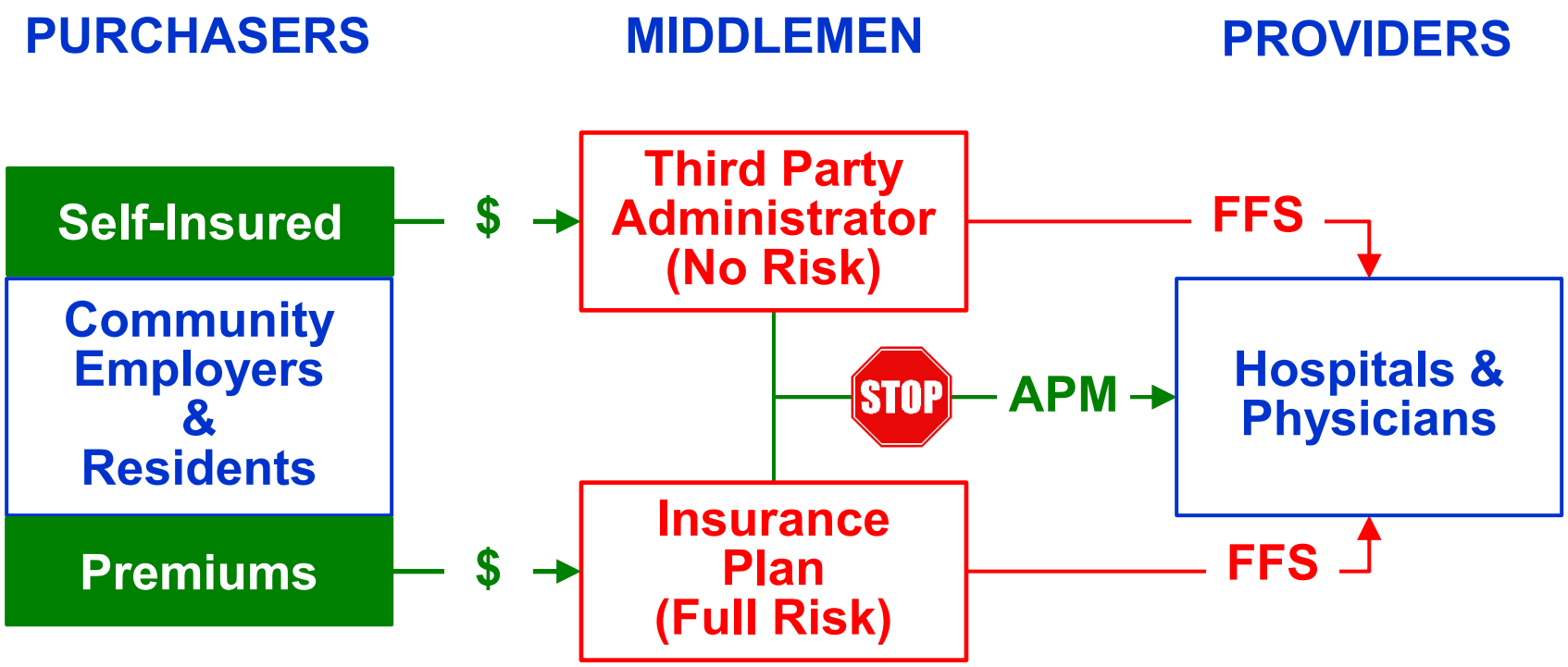
60%+ of Employed Workers Are in Self-Insured Plans



Small Employers & Individuals Purchase Insurance Plans

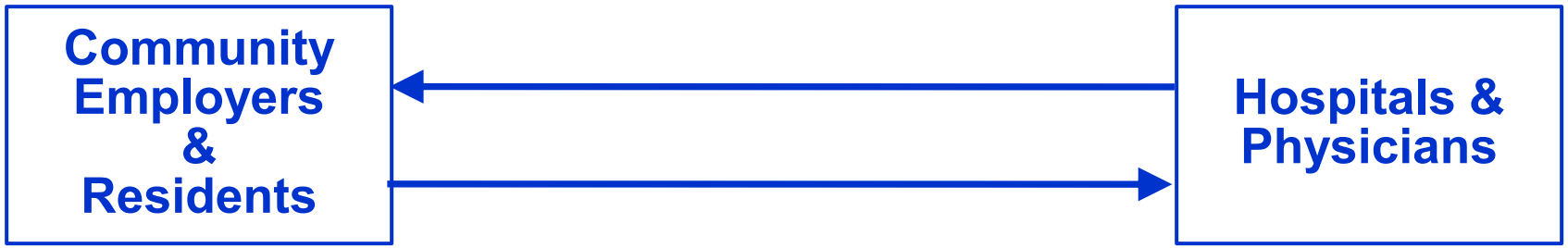


The Middlemen Refuse to Implement Better Payments



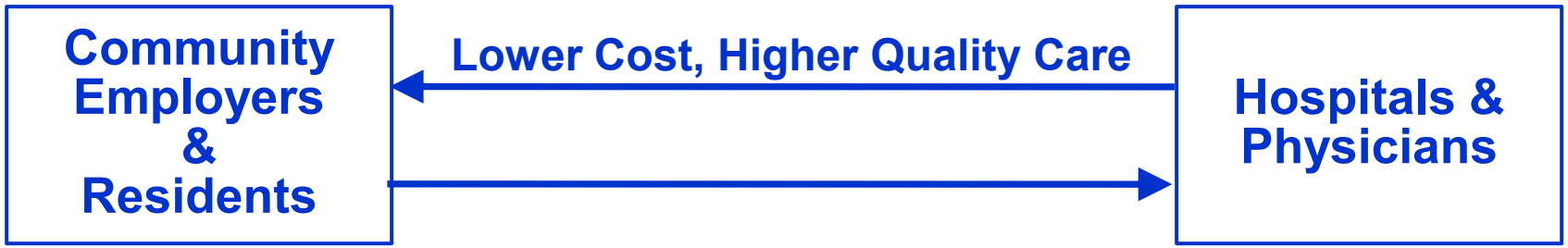
A Better Approach: Purchaser/Provider Partnerships

PURCHASERS ~~**MIDDLEMEN**~~ **PROVIDERS**



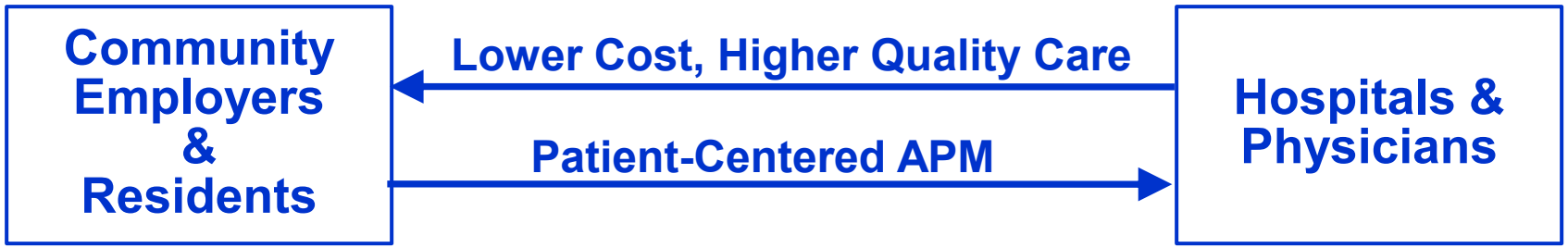
Physicians Offer a Better "Product" to Purchasers…

PURCHASERS **PROVIDERS**



…Purchasers Agree to Pay Adequately for That Product

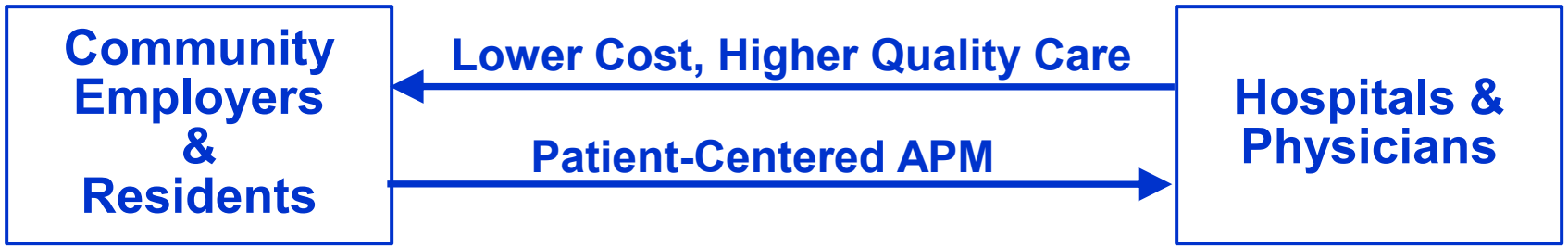
PURCHASERS **PROVIDERS**



The Result is a Win-Win for Purchasers & Providers

PURCHASERS

PROVIDERS



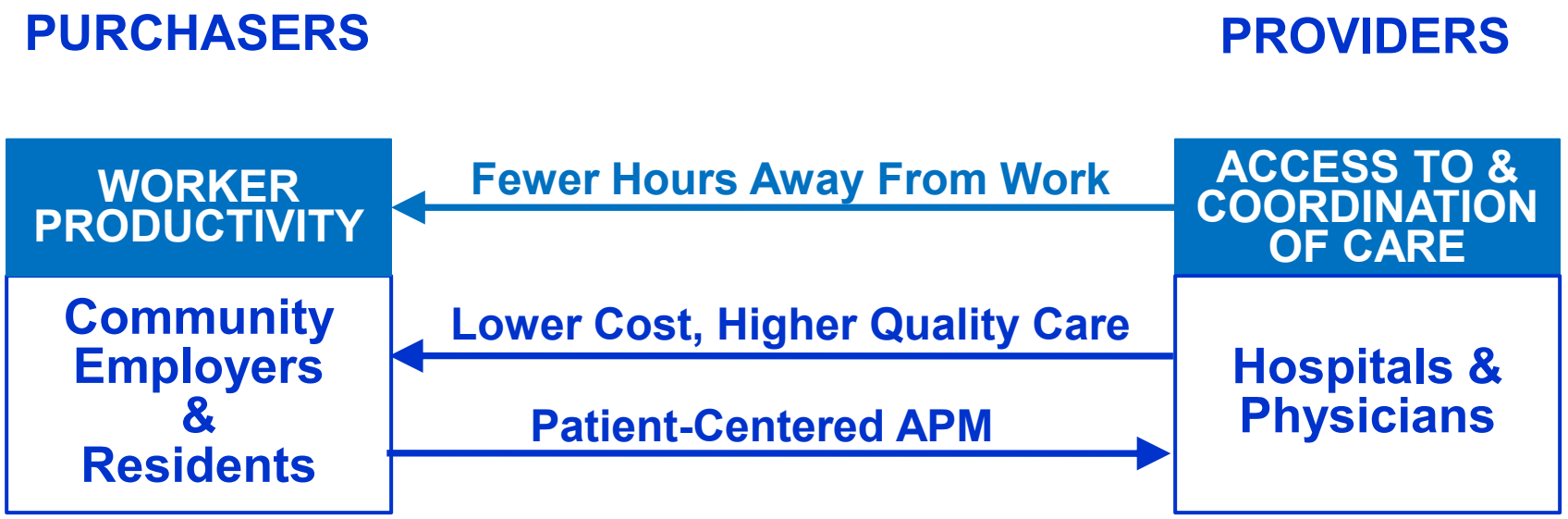
Employers and Patients "win" if:

- Patients receive the care they need
- Healthcare is more affordable

Providers "win" if:

- Providers can deliver the care patients need
- Payment is adequate to cover the cost of services

Purchasers (Not Plans) Can Pay for Improved Worker Productivity



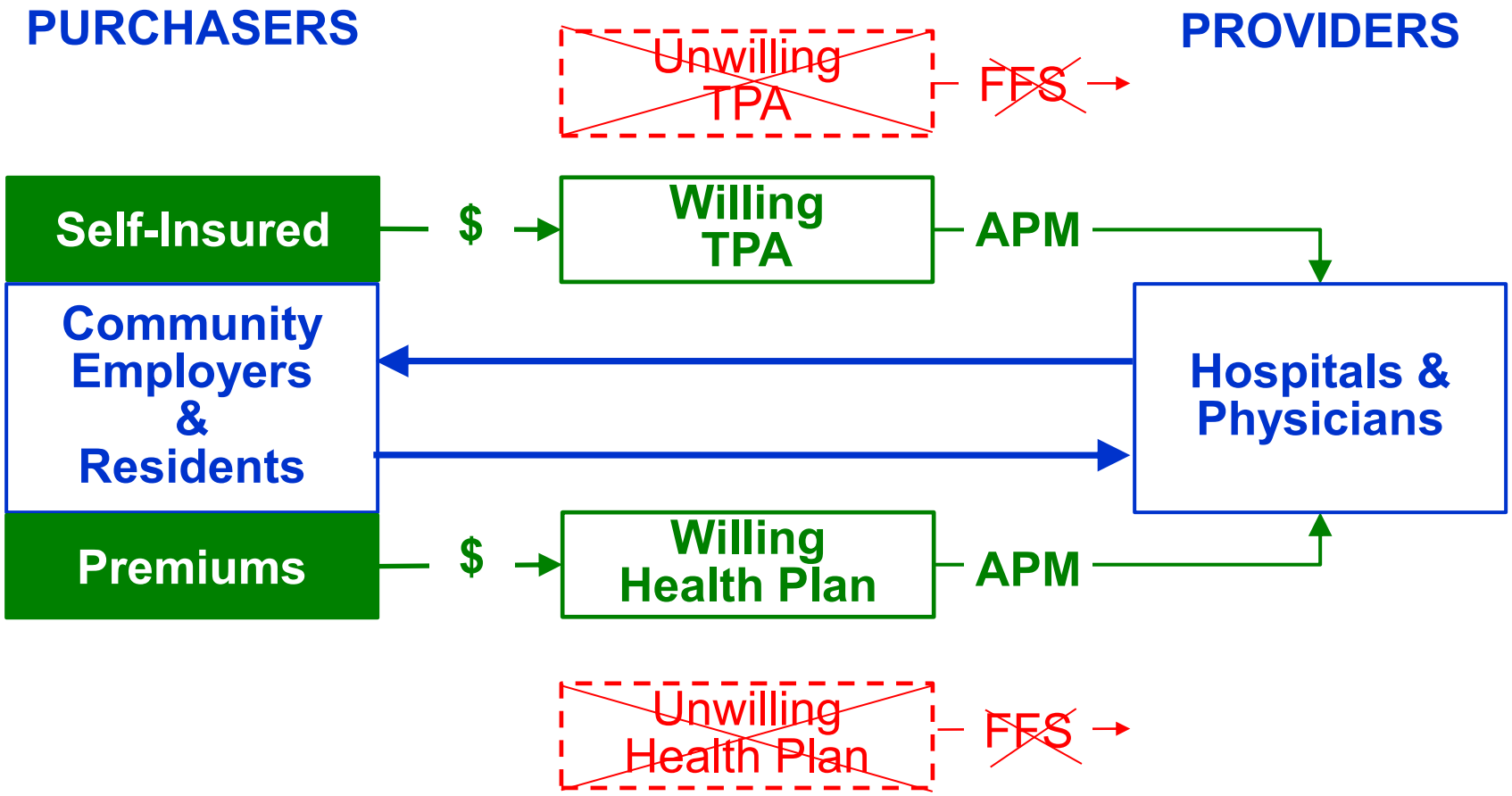
Employers and Patients "win" if:

- Patients receive the care they need
- Healthcare is more affordable
- **Employees return to work faster**

Providers "win" if:

- Providers can deliver the care patients need
- Payment is adequate to cover the cost of services
- **Providers have flexibility to redesign care delivery**

Purchasers & Providers Select Plans That Will Use the APM

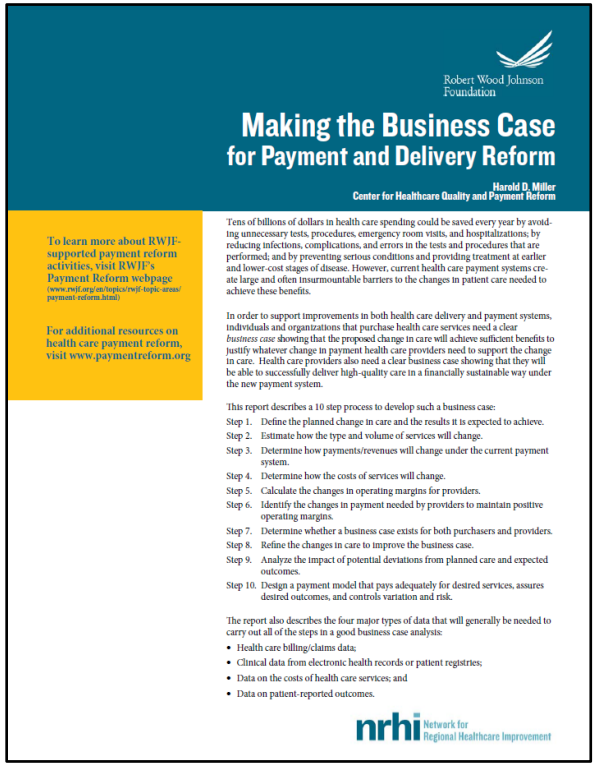


How to Create and Implement a Good Alternative Payment Model

- **Design the Payment Model to Support High-Value Care**
  1. Develop ways to deliver care that improve outcomes and reduce costs
     - Focus on opportunities to reduce healthcare spending or time away from work
     - Opportunities will differ for different patients and in different communities
  2. Estimate the costs and expected savings of value-based care
     - Costs will change when care is delivered in different ways
     - Improvements in outcomes need to be quantified and monetized
  3. Ensure there is a business case for both providers and purchasers
     - If not, revise the care delivery model to reduce costs or improve outcomes
  4. Design a payment model based on achievable costs and outcomes
     - Payments adequate but not excessive for costs at different levels of volume
     - Payments & outcome standards adjusted for differences in patient need/risk
     - Providers taking accountability for controllable spending and expected outcomes
- **Convince Purchasers to Implement the Payment Model**
  - Show the business case for purchasers and benefits for patients
  - Commit to ensuring a win-win approach for purchasers and providers
  - Select health plans that will implement the payment model

More Details on Creating Value-Based Payment Models

www.PaymentReform.org **www.RuralHospitals.org**



Robert Wood Johnson Foundation

Making the Business Case for Payment and Delivery Reform

Harold D. Miller
Center for Healthcare Quality and Payment Reform

To learn more about RWJF-supported payment reform activities, visit RWJF's Payment Reform webpage (www.rwjf.org/en/topics/rwjf-topic-areas/payment-reform.html)

For additional resources on health care payment reform, visit www.paymentreform.org

Tens of billions of dollars in health care spending could be saved every year by avoiding unnecessary tests, procedures, emergency room visits, and hospitalizations; by reducing infections, complications, and errors in the tests and procedures that are performed; and by preventing serious conditions and providing treatment at earlier and lower-cost stages of disease. However, current health care payment systems create large and often insurmountable barriers to the changes in patient care needed to achieve these benefits.

In order to support improvements in both health care delivery and payment systems, individuals and organizations that purchase health care services need a clear *business case* showing that the proposed change in care will achieve sufficient benefits to justify whatever change in payment health care providers need to support the change in care. Health care providers also need a clear business case showing that they will be able to successfully deliver high-quality care in a financially sustainable way under the new payment system.

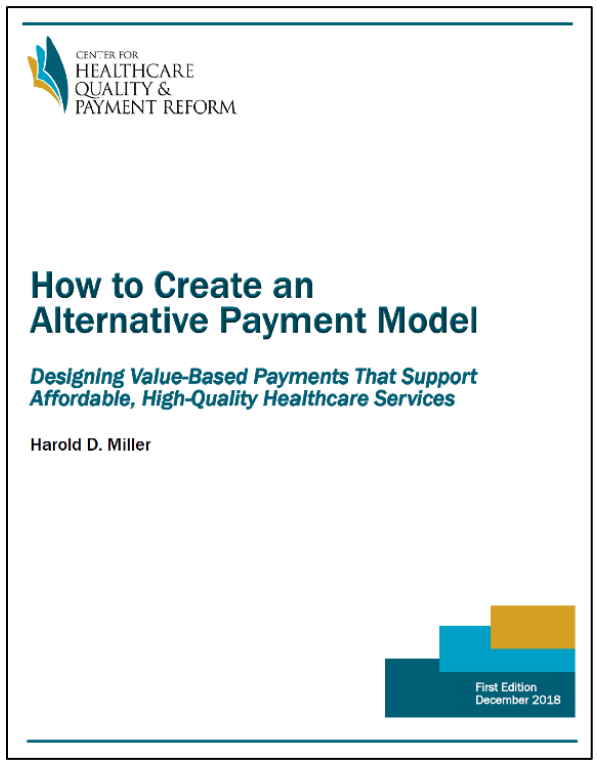
This report describes a 10 step process to develop such a business case:

Step 1. Define the planned change in care and the results it is expected to achieve.
Step 2. Estimate how the type and volume of services will change.
Step 3. Determine how payments/revenues will change under the current payment system.
Step 4. Determine how the costs of services will change.
Step 5. Calculate the changes in operating margins for providers.
Step 6. Identify the changes in payment needed by providers to maintain positive operating margins.
Step 7. Determine whether a business case exists for both purchasers and providers.
Step 8. Refine the changes in care to improve the business case.
Step 9. Analyze the impact of potential deviations from planned care and expected outcomes.
Step 10. Design a payment model that pays adequately for desired services, assures desired outcomes, and controls variation and risk.

The report also describes the four major types of data that will generally be needed to carry out all of the steps in a good business case analysis:

- Health care billing/claims data;
- Clinical data from electronic health records or patient registries;
- Data on the costs of health care services; and
- Data on patient-reported outcomes.

nrhi Network for Regional Healthcare Improvement



CENTER FOR HEALTHCARE QUALITY & PAYMENT REFORM

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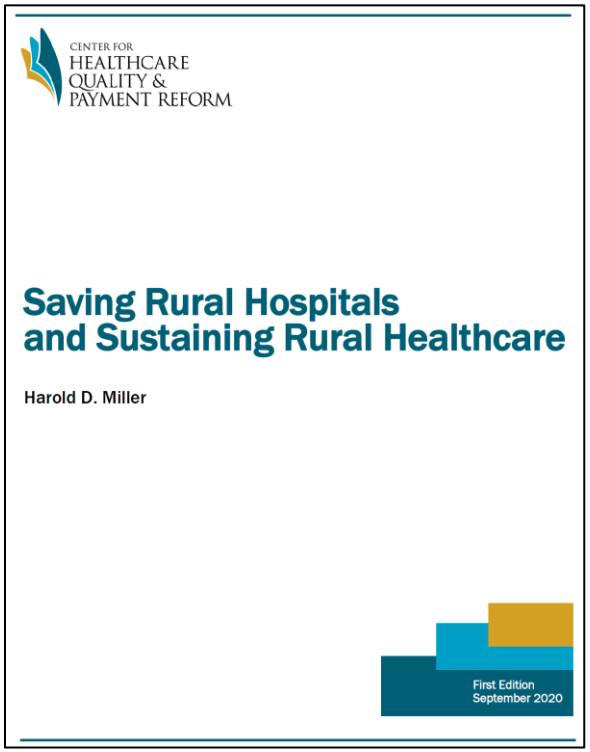
Designing Value-Based Payments That Support Affordable, High-Quality Healthcare Services

Harold D. Miller

First Edition
December 2018



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Saving Rural Hospitals and Sustaining Rural Healthcare

Harold D. Miller

First Edition
September 2020

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