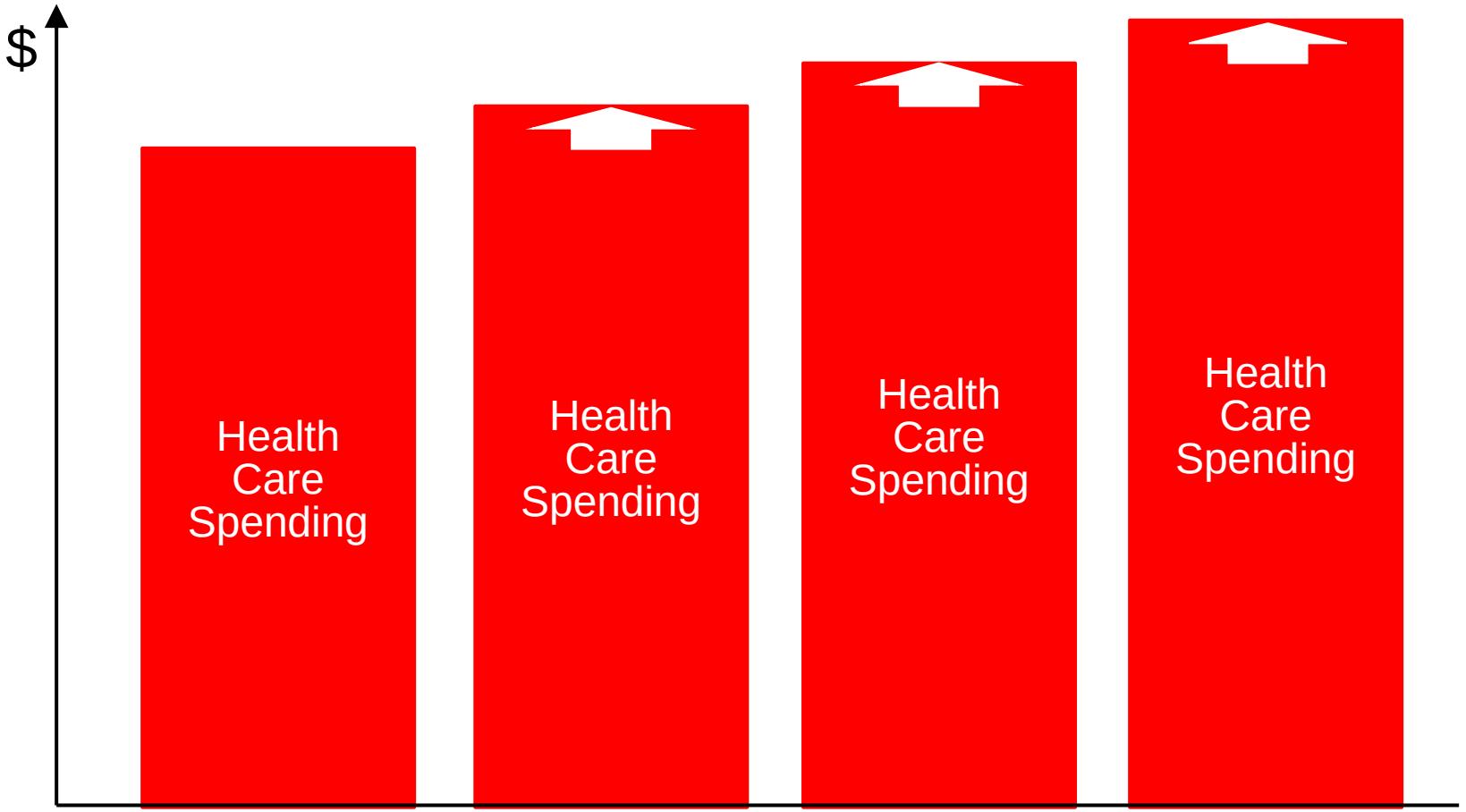
CENTER FOR HEALTHCARE QUALITY & PAYMENT REFORM

USING VALUE-BASED PAYMENTS TO CREATE A SUSTAINABLE HEALTH SYSTEM

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?



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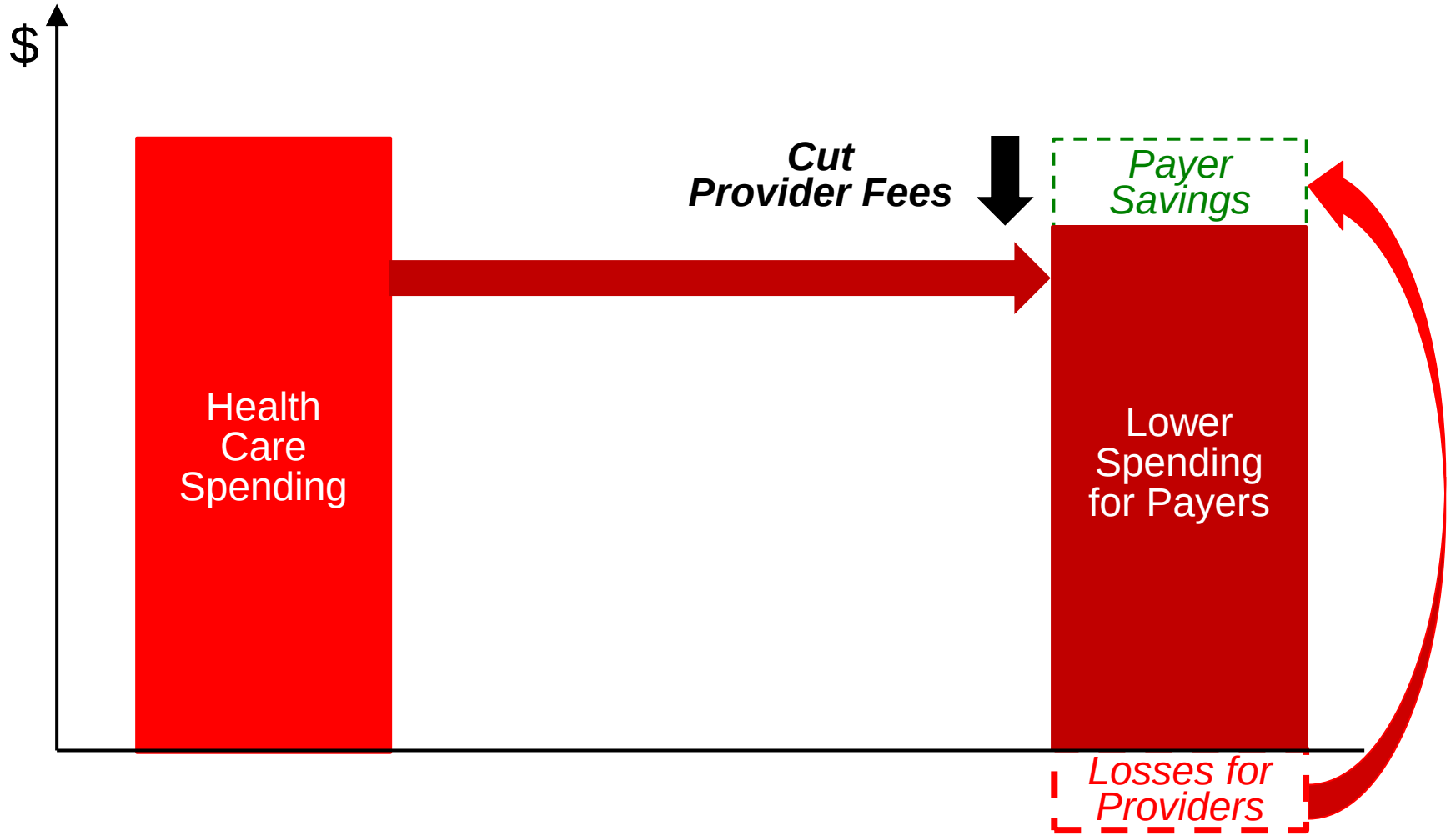
Typical Cost Control Strategy #1: Cut Provider Fees for Services



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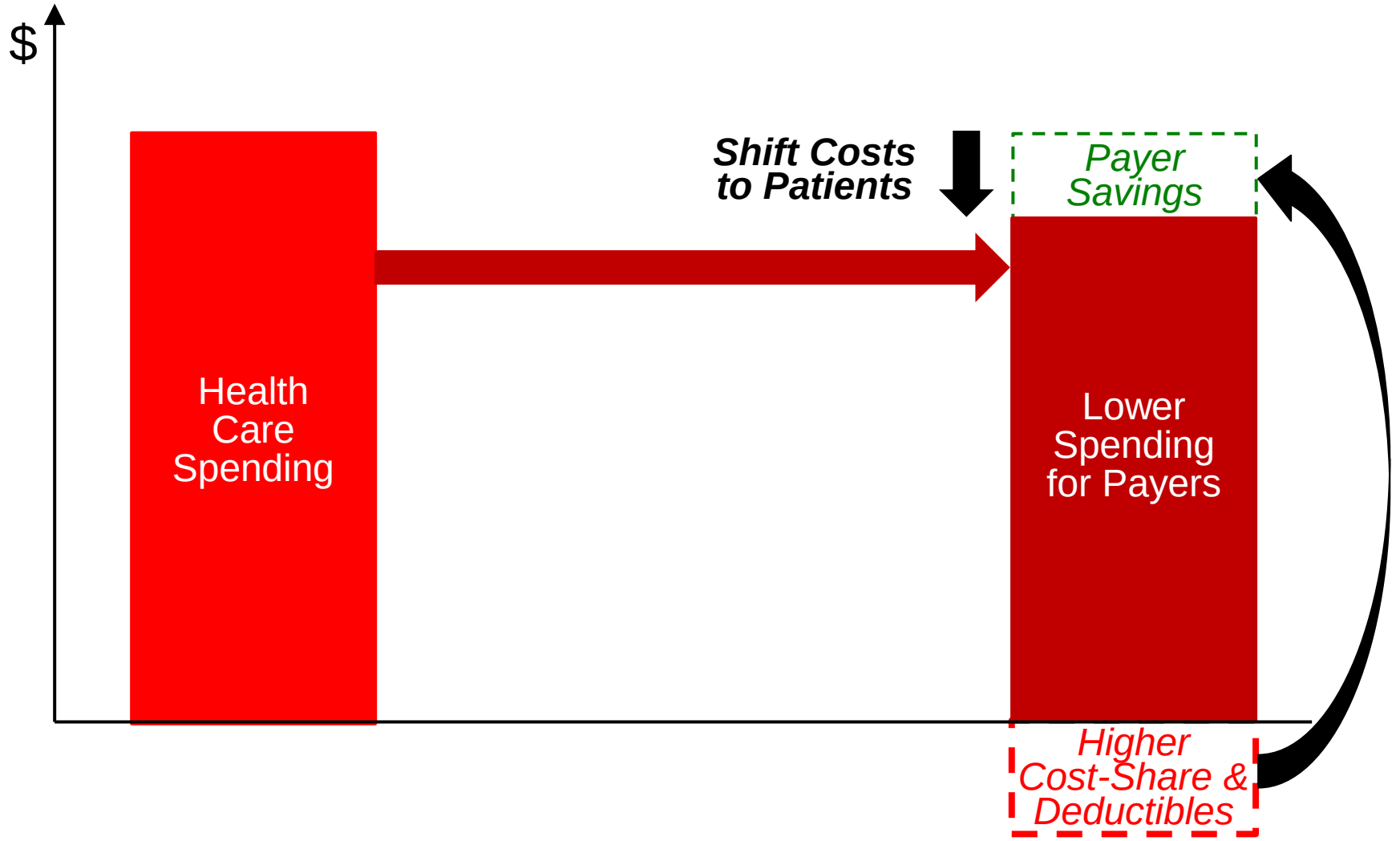
Typical Cost Control Strategy #2: Shift Costs to Patients



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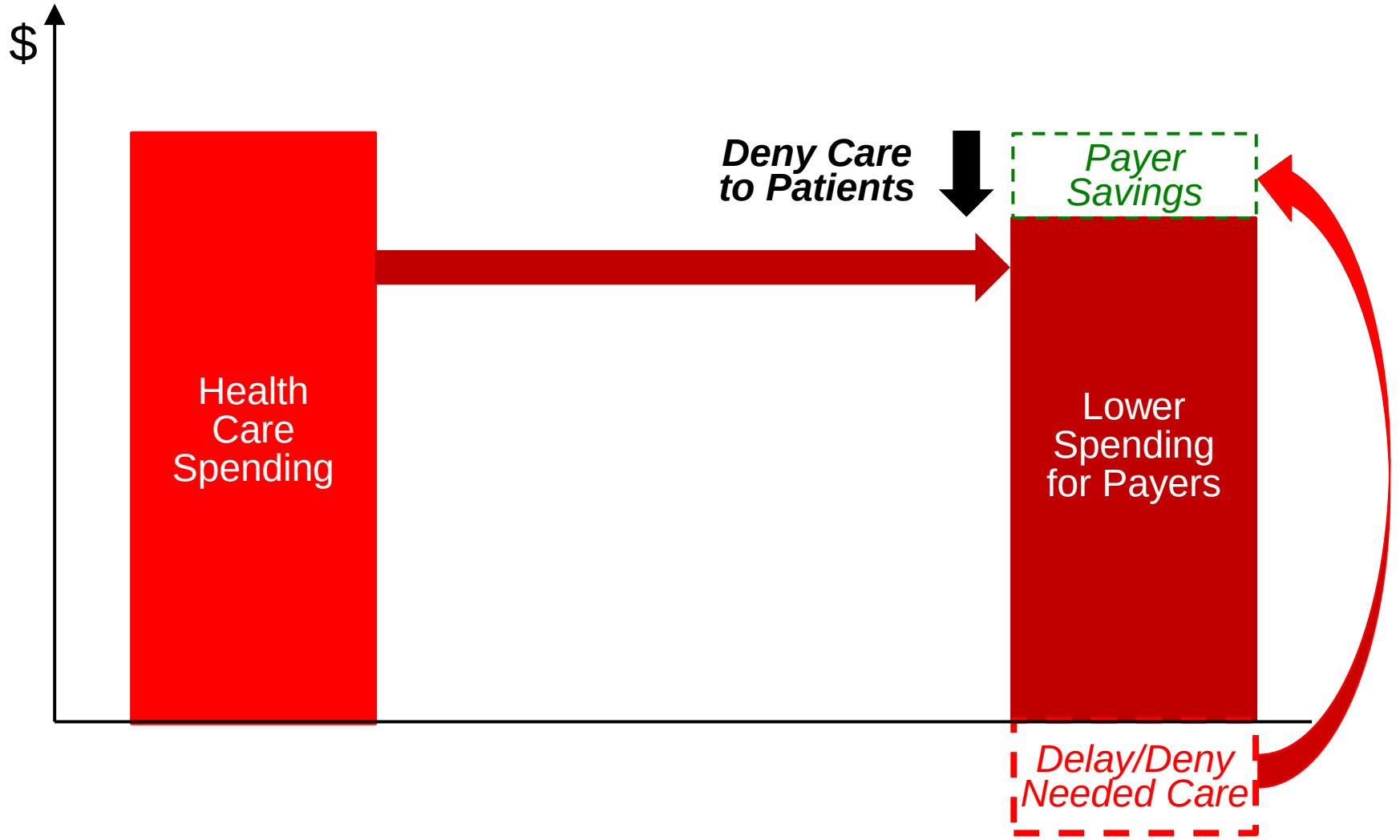
Typical Cost Control Strategy #3: Delay or Deny Care to Patients



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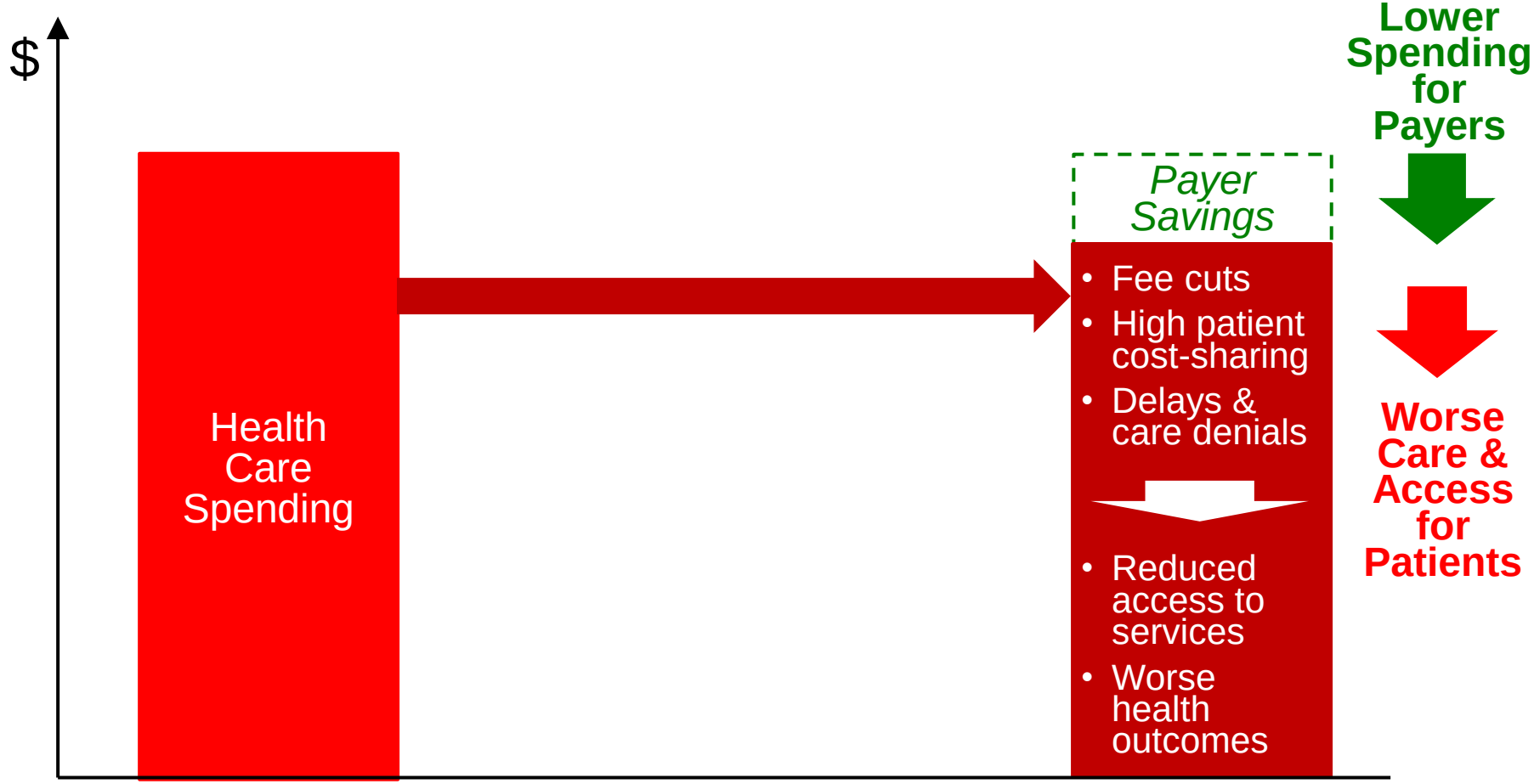
Typical Strategies Benefit *Payers* But Harm *Patients*



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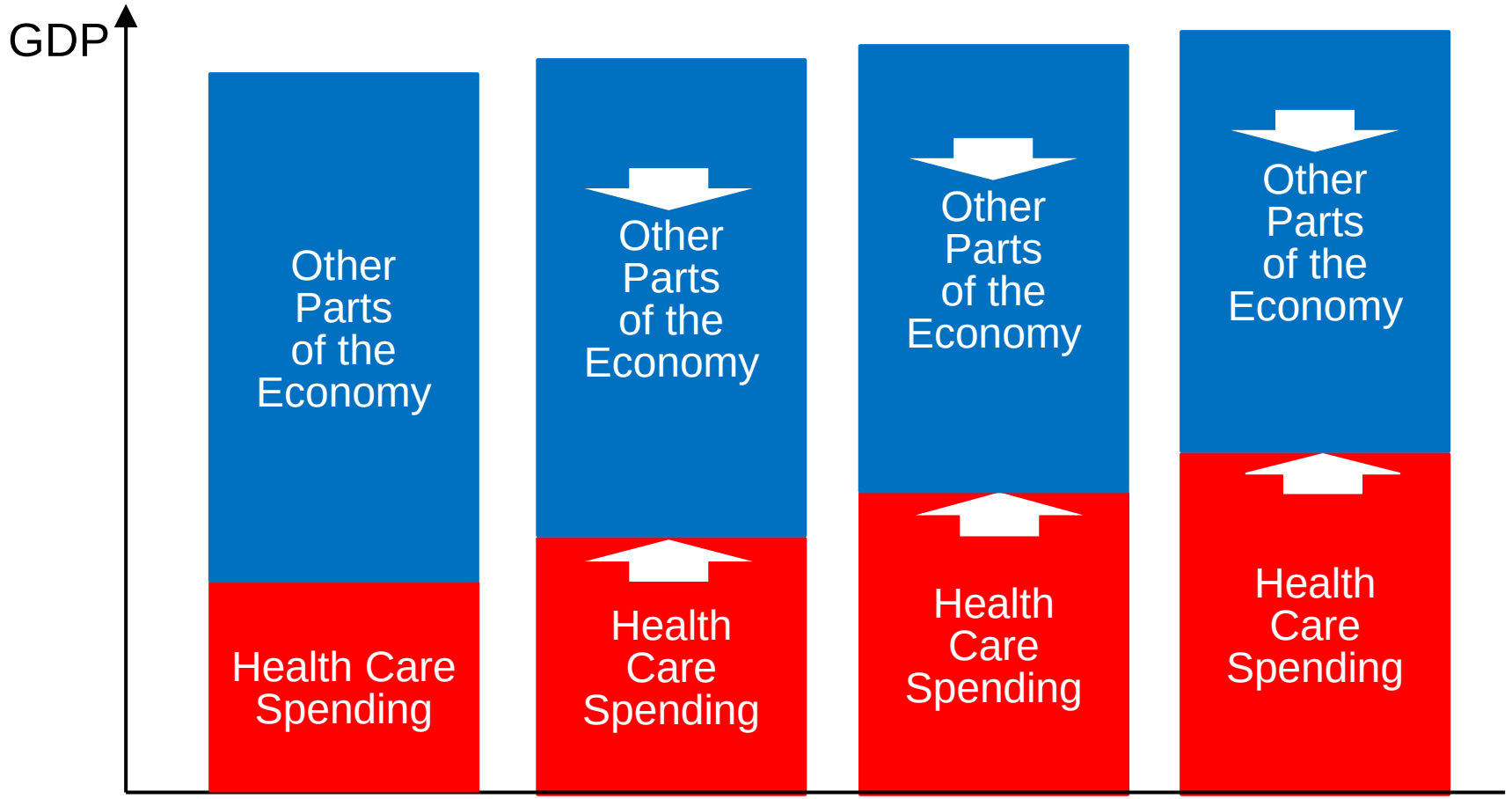
Concern: Healthcare Spending is Taking Increasing % of the GDP



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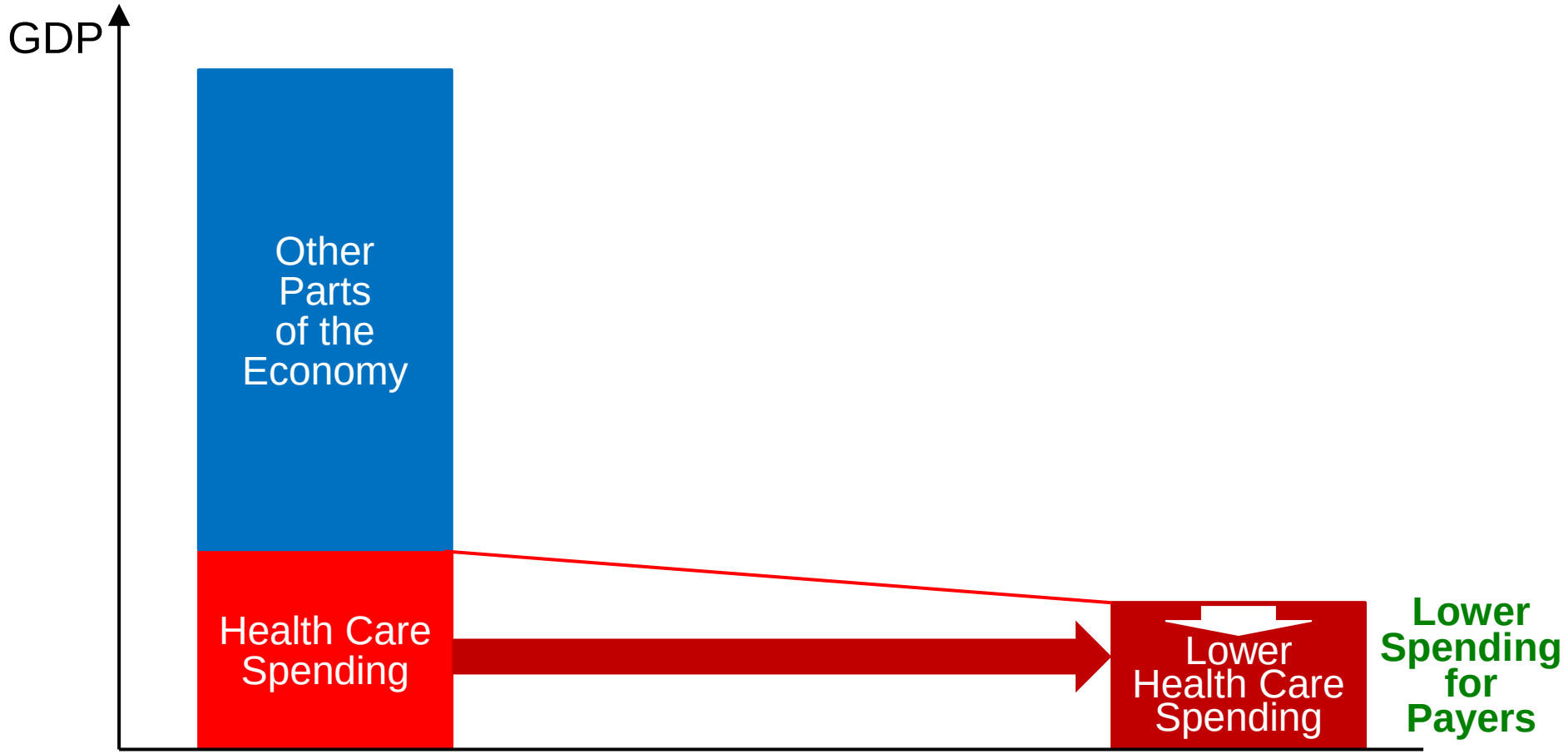
Assumption: Lower Healthcare $



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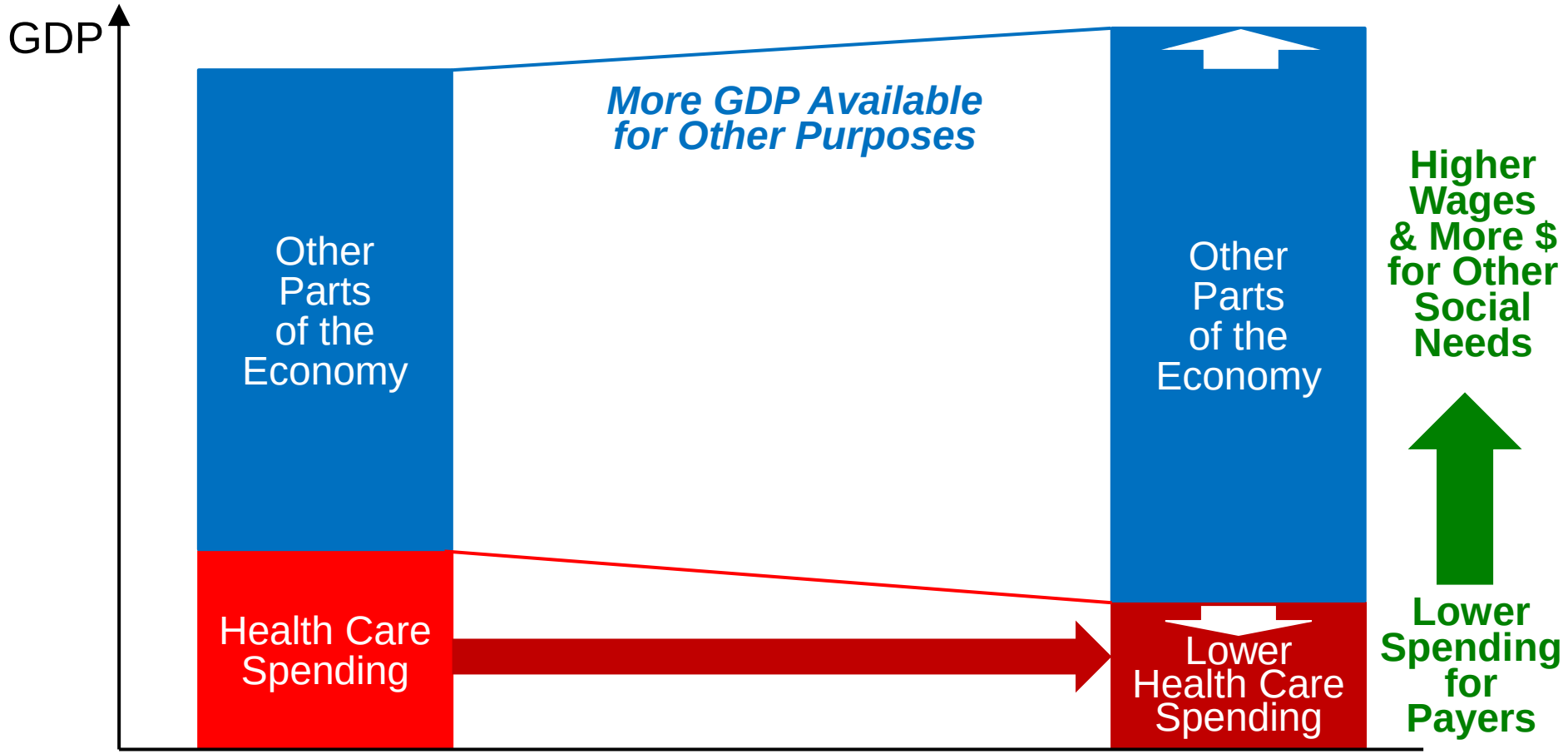
Assumption: Lower Healthcare $ Allows More Spending Elsewhere



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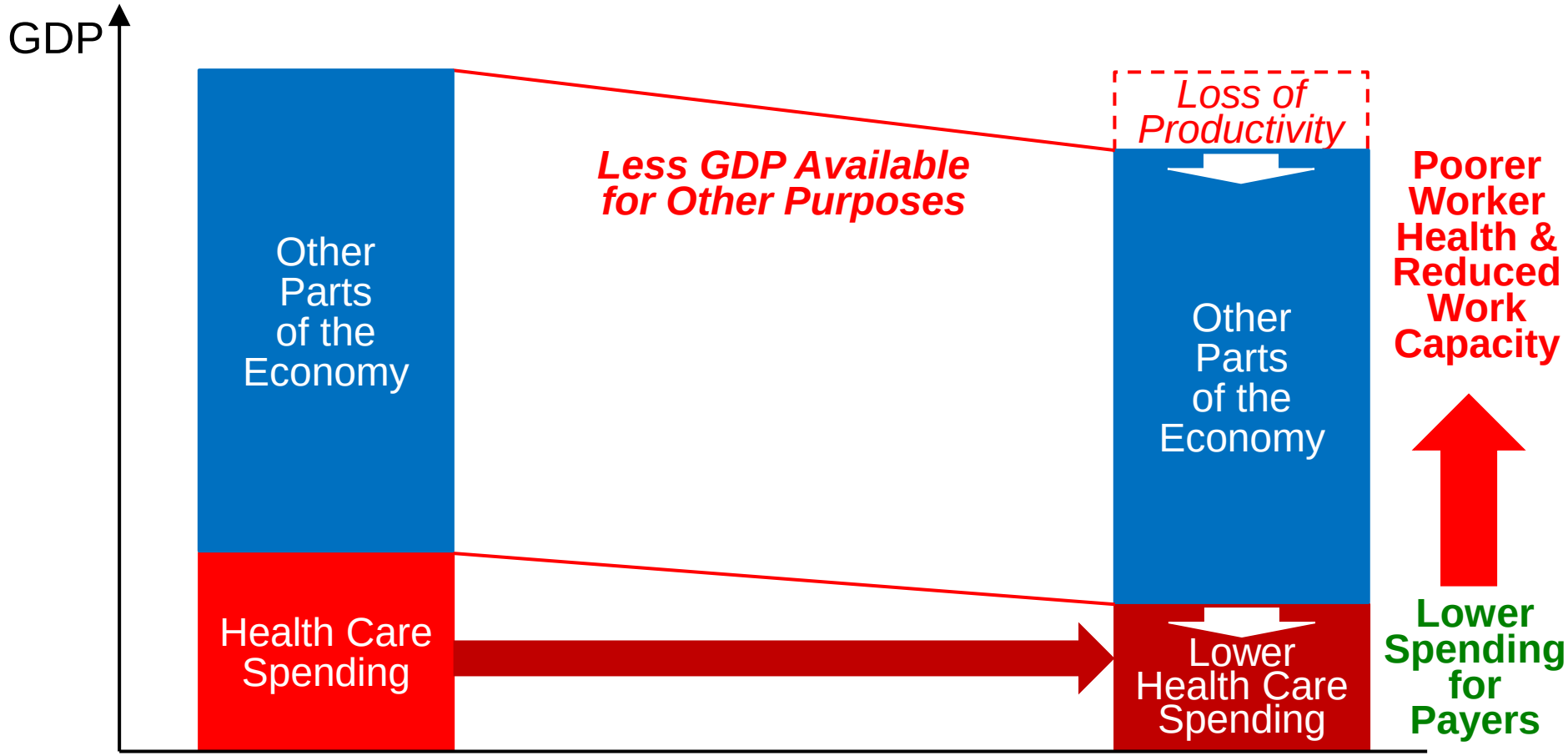
Spending Cuts That Harm Patients Could Also Harm the Economy



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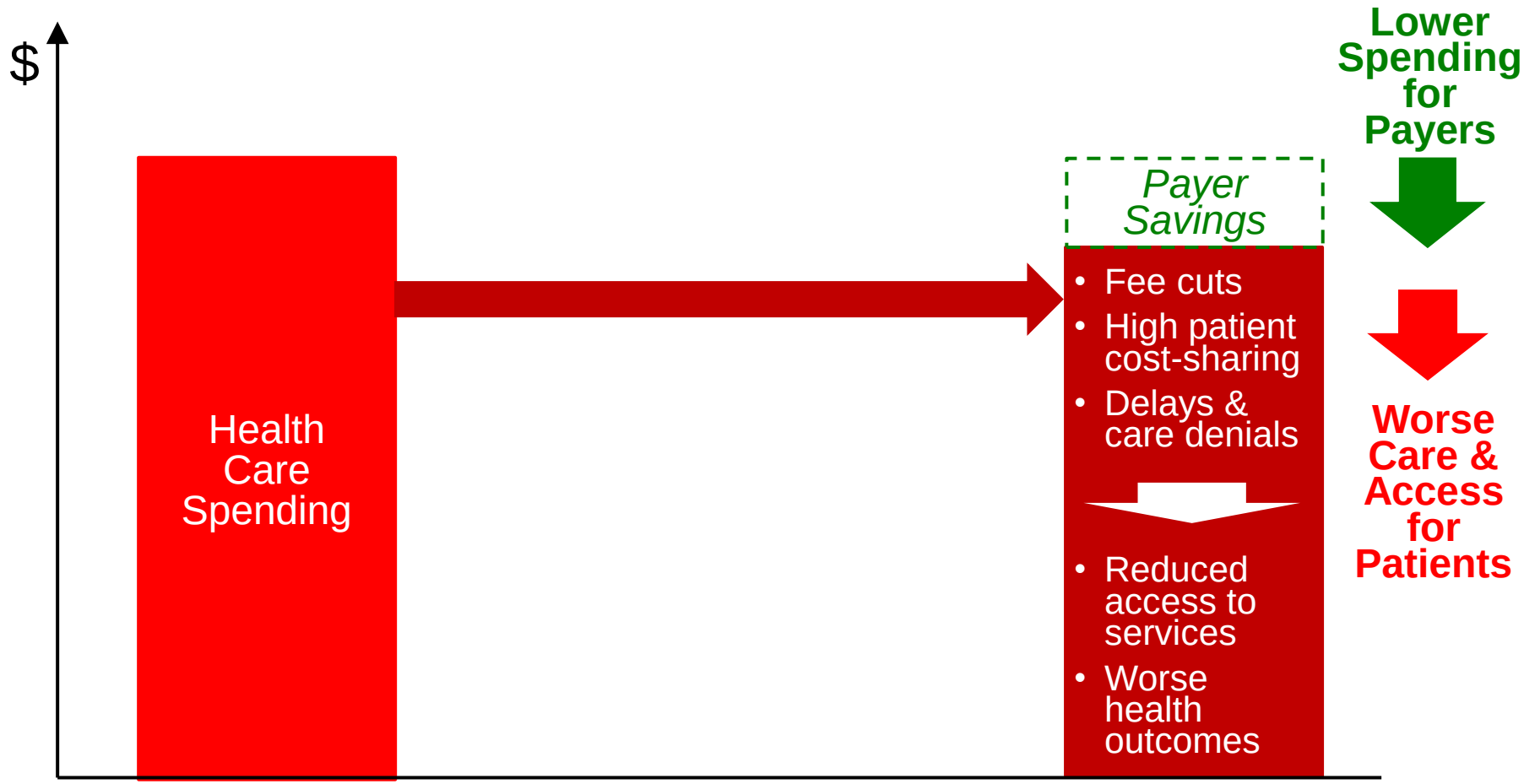
Instead of Traditional Approaches to Reducing Spending…



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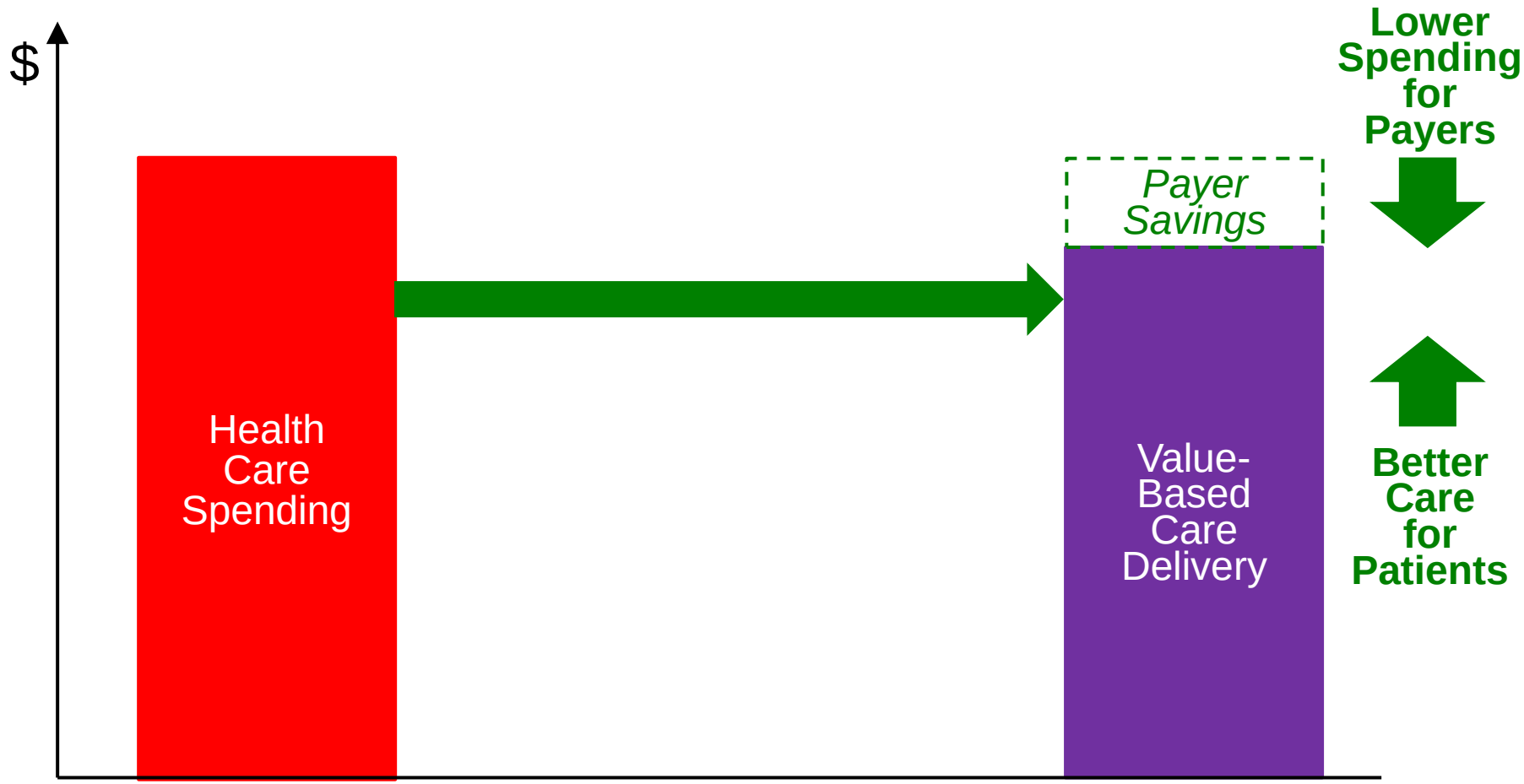
A Better Way: Value-Based Care for Patients



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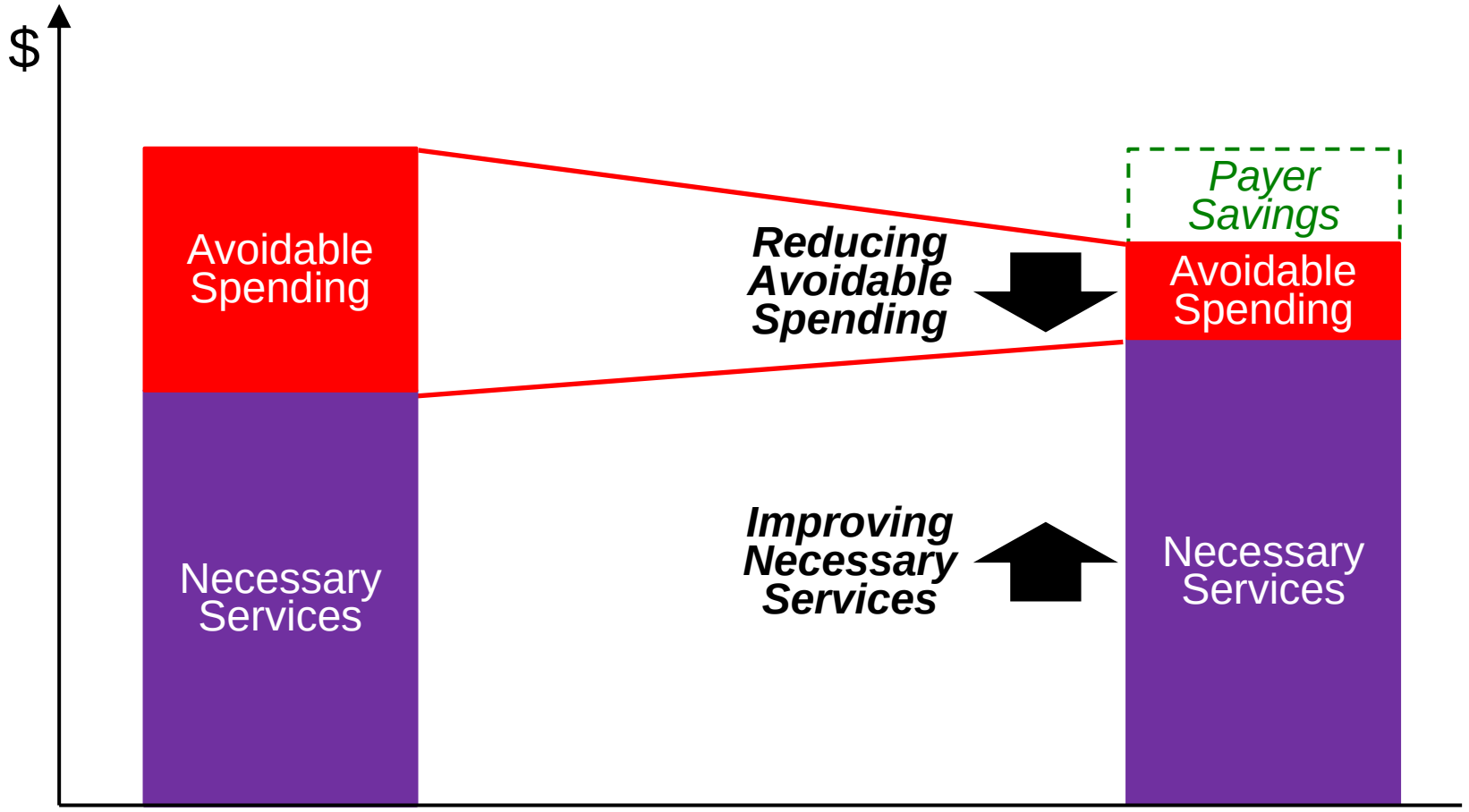
What is “Value-Based Care”?



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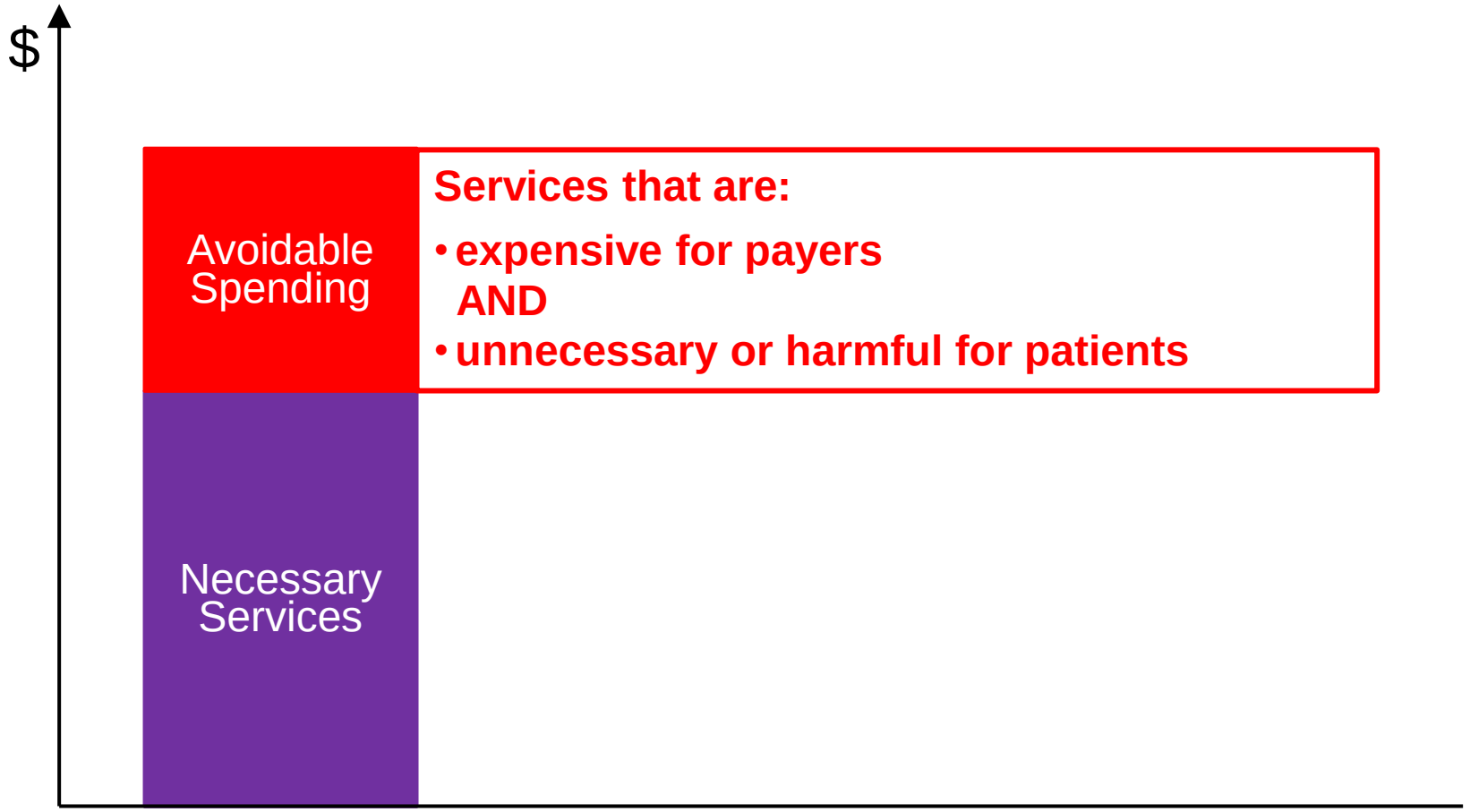
What is “Avoidable Spending?”



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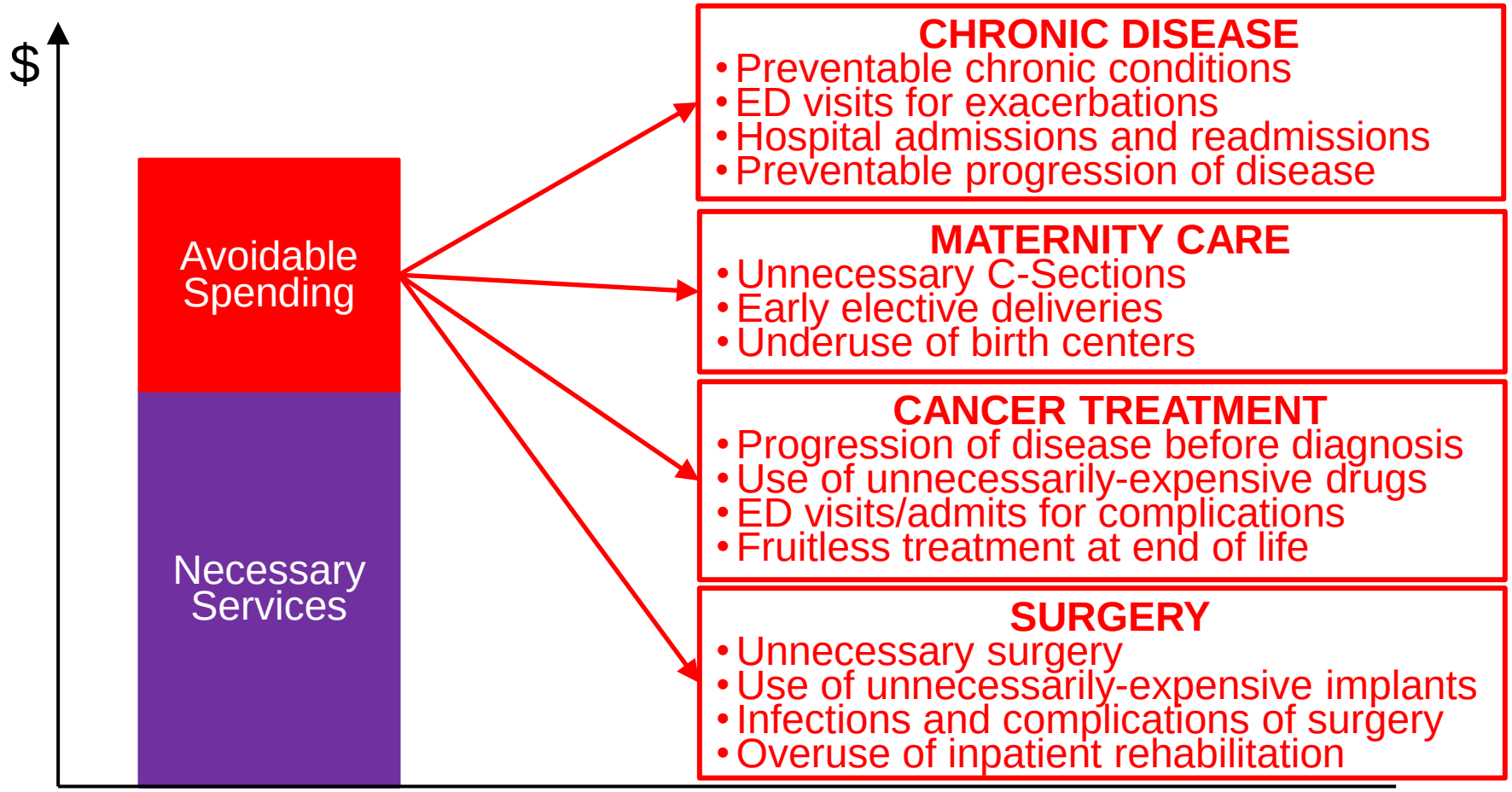
Avoidable Spending Exists in All Areas of Healthcare



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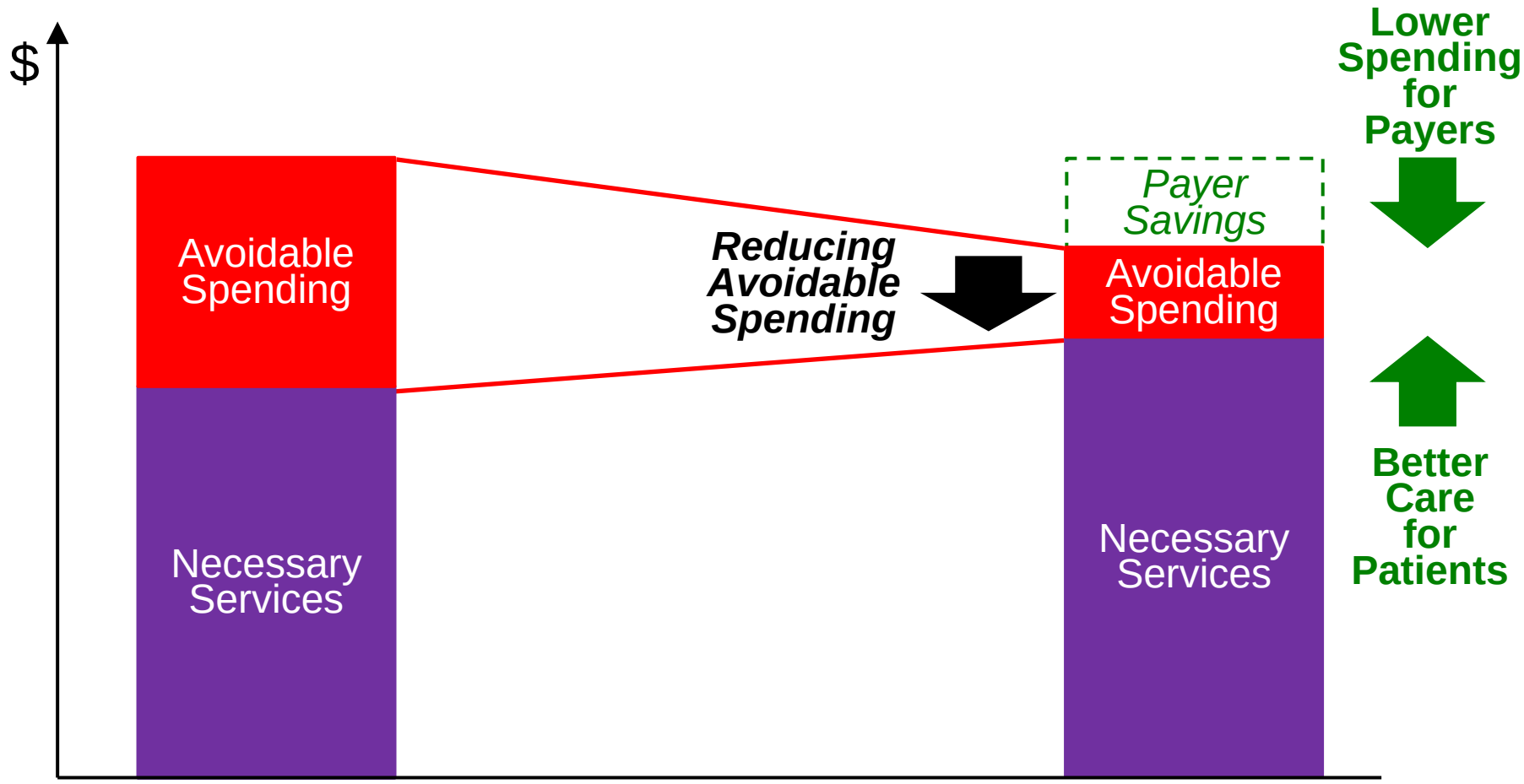
Reducing *Avoidable* Spending is a *Win-Win* for Payers & Patients



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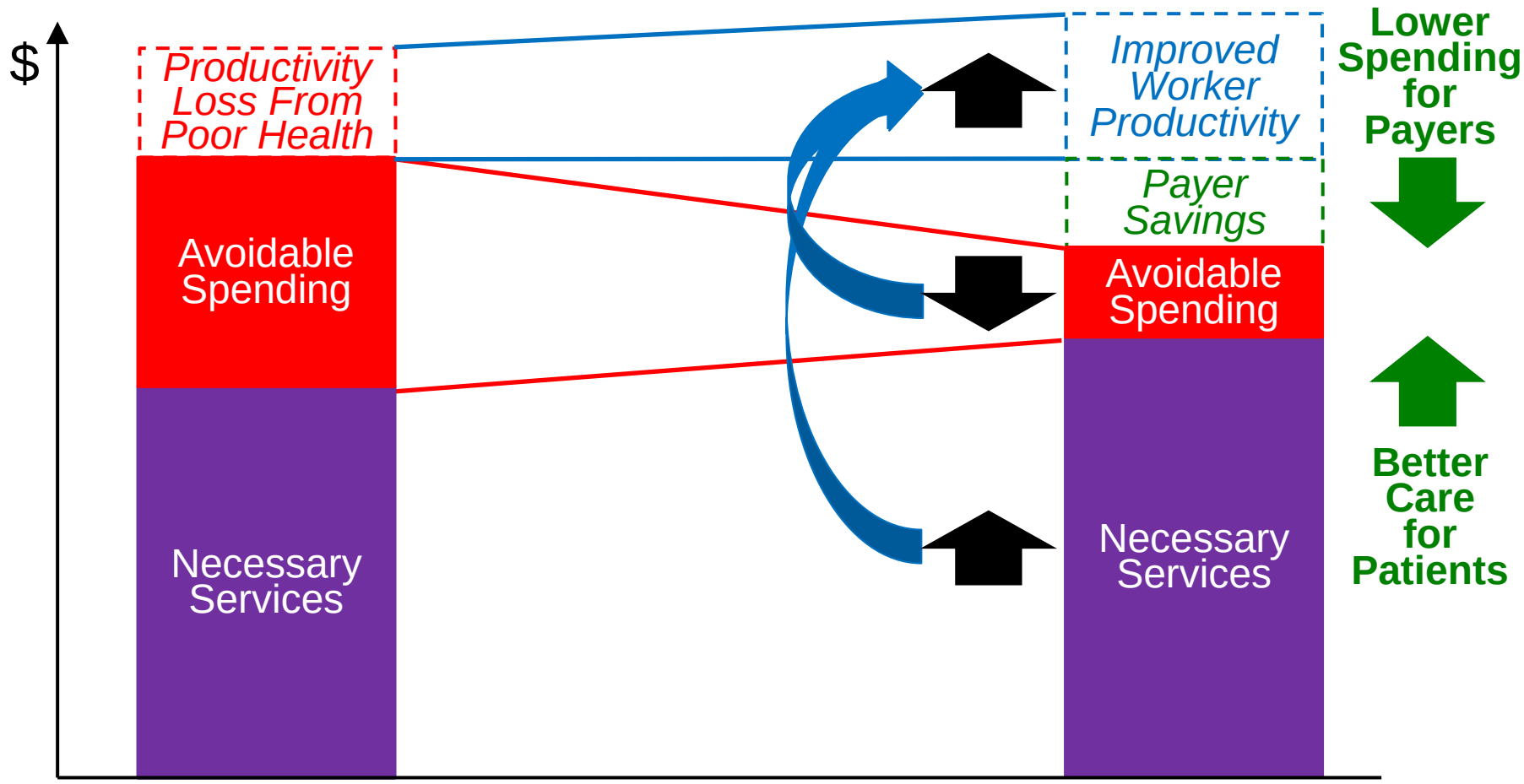
Sustainability = Value-Based Care That Supports Economic Growth



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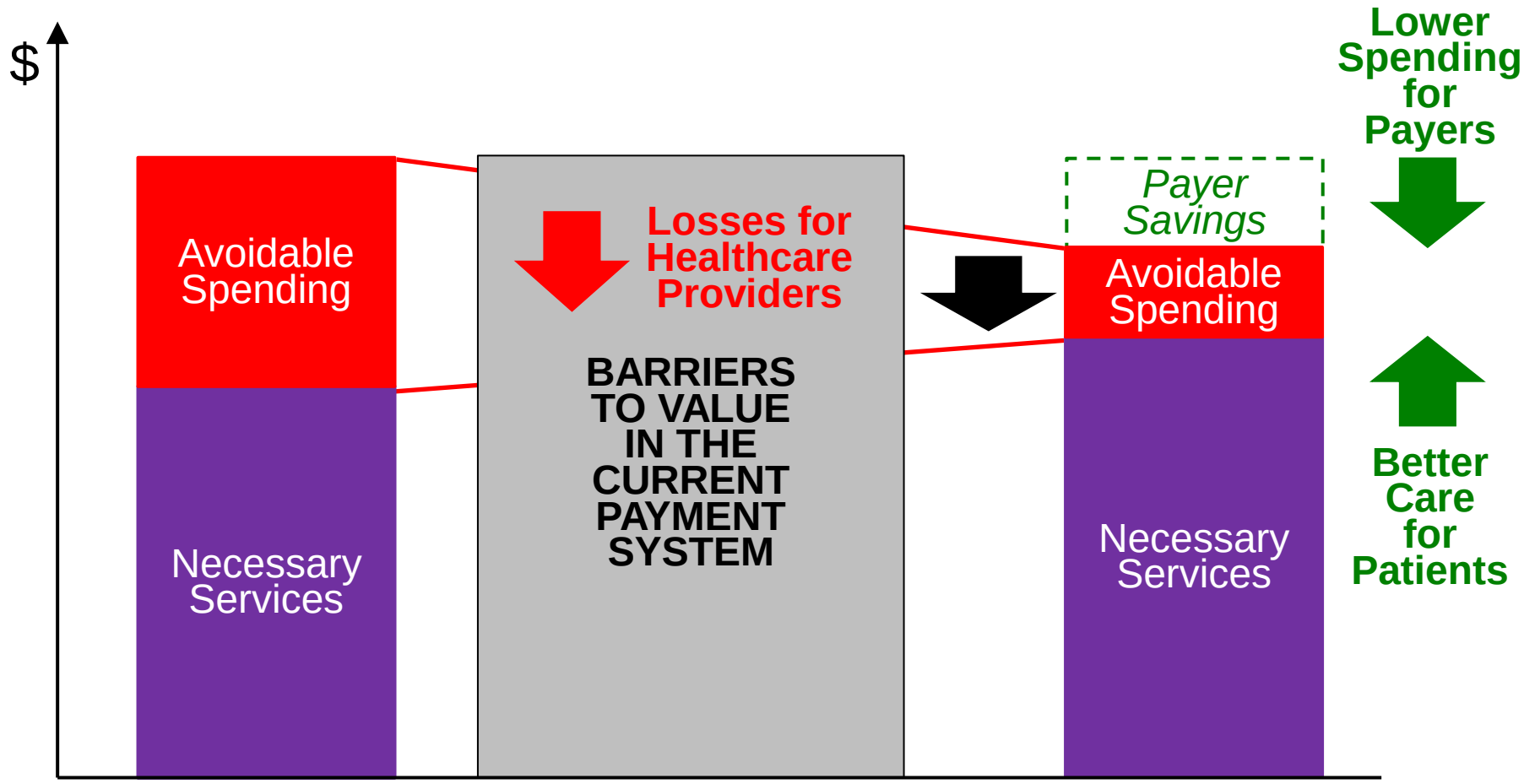
Barriers in the Payment System Create a Win-*Lose* for Providers



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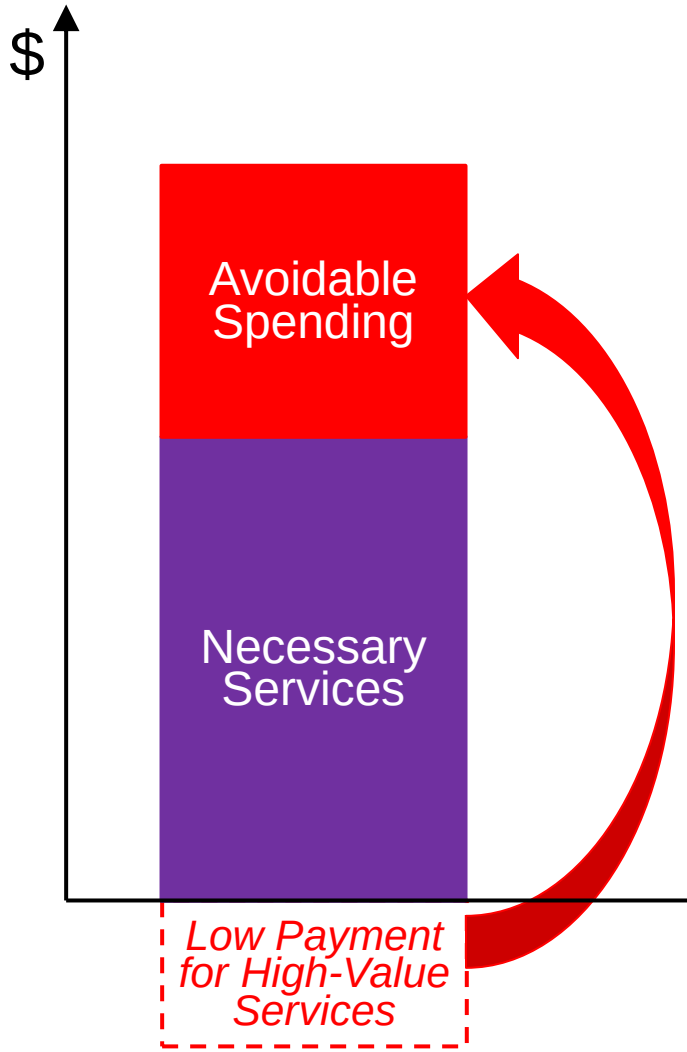
Barrier #1: Inadequate Payments for Higher-Value Services



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

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

Delivering these services can reduce avoidable services and improve value for payers and patients, but will cause financial losses for healthcare providers

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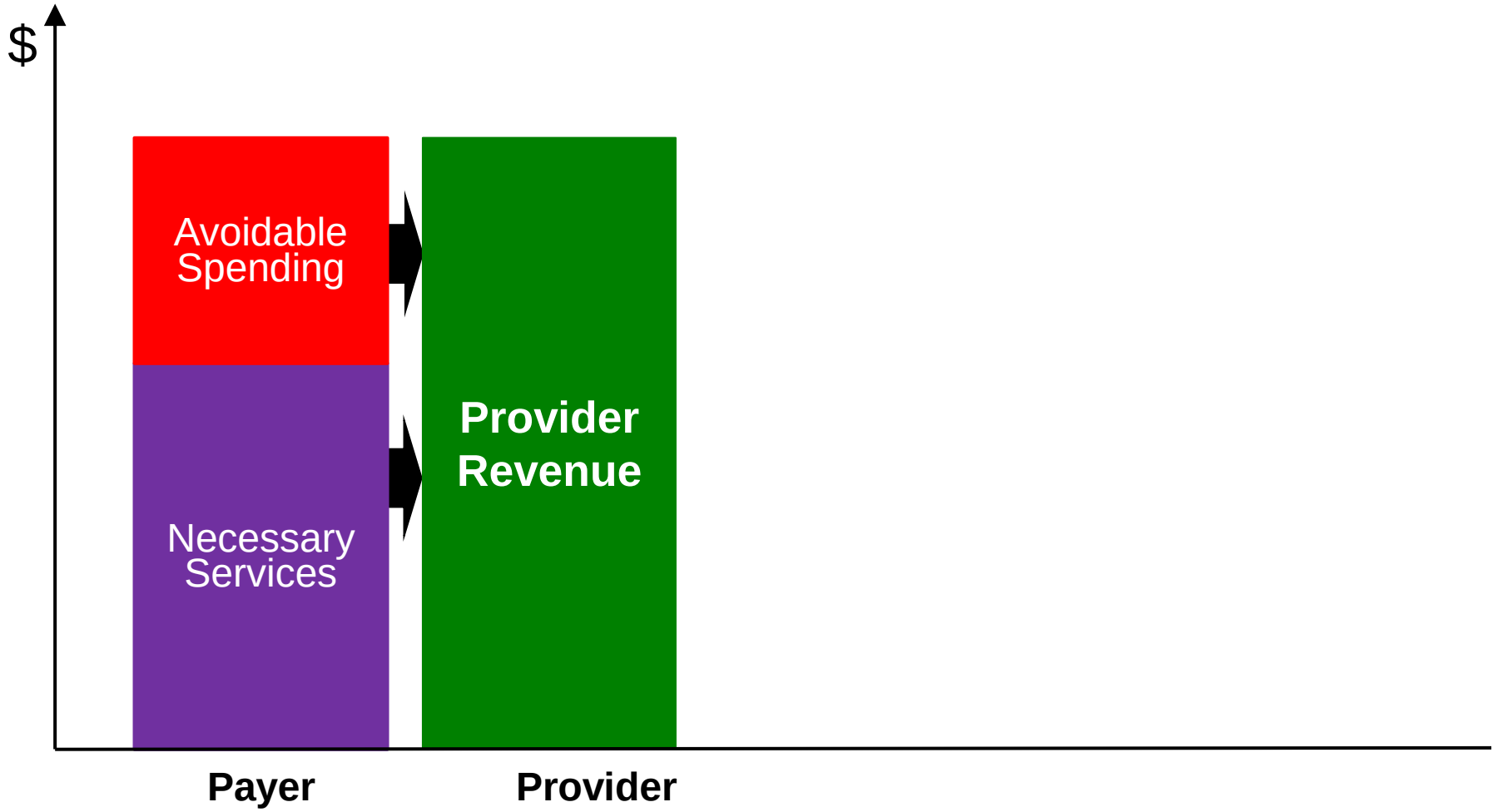
Barrier #2: "Avoidable Spending" is Part of Providers' *Revenue*



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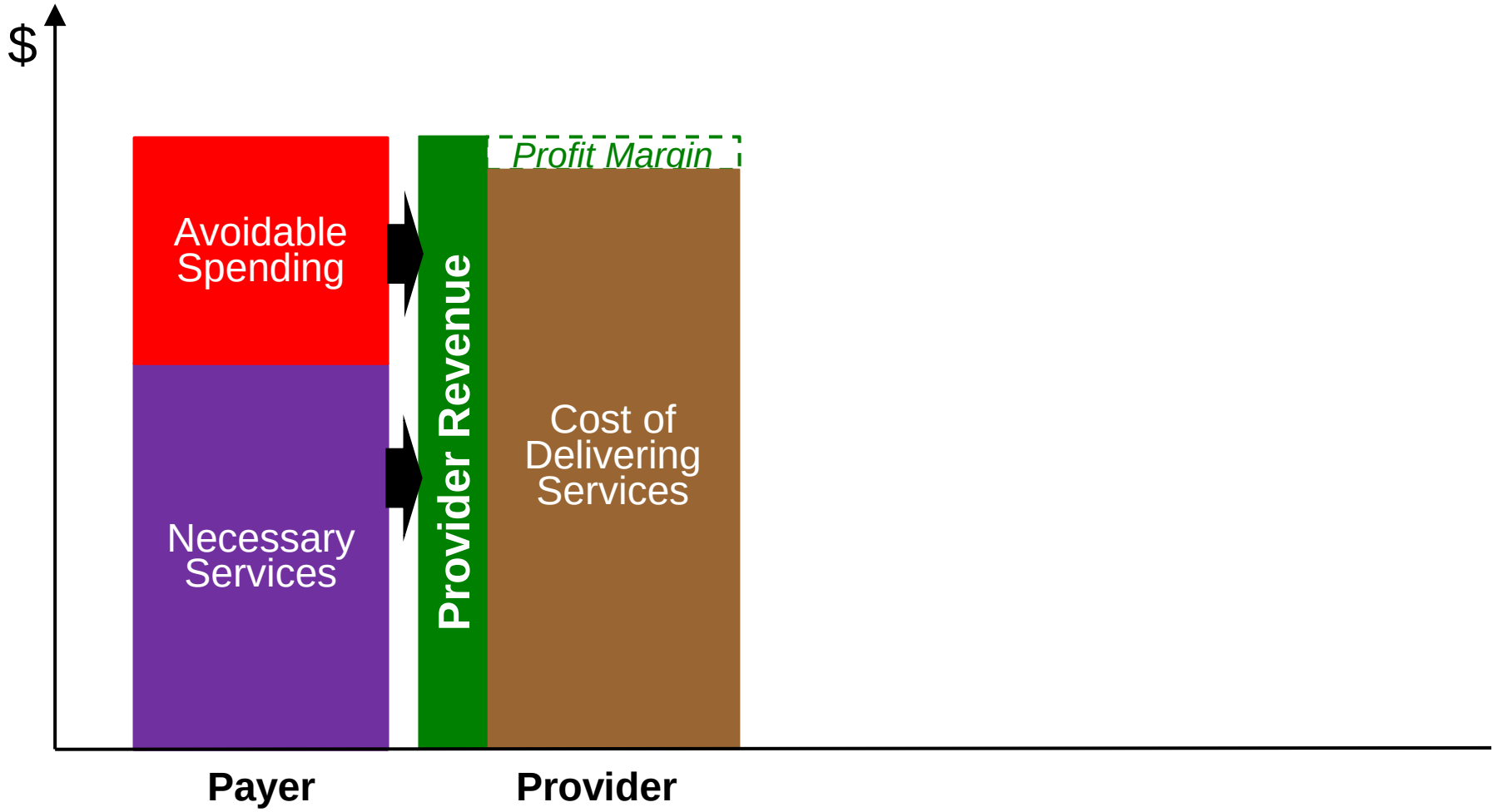
Providers Use the Revenue to Pay for the Costs of Services



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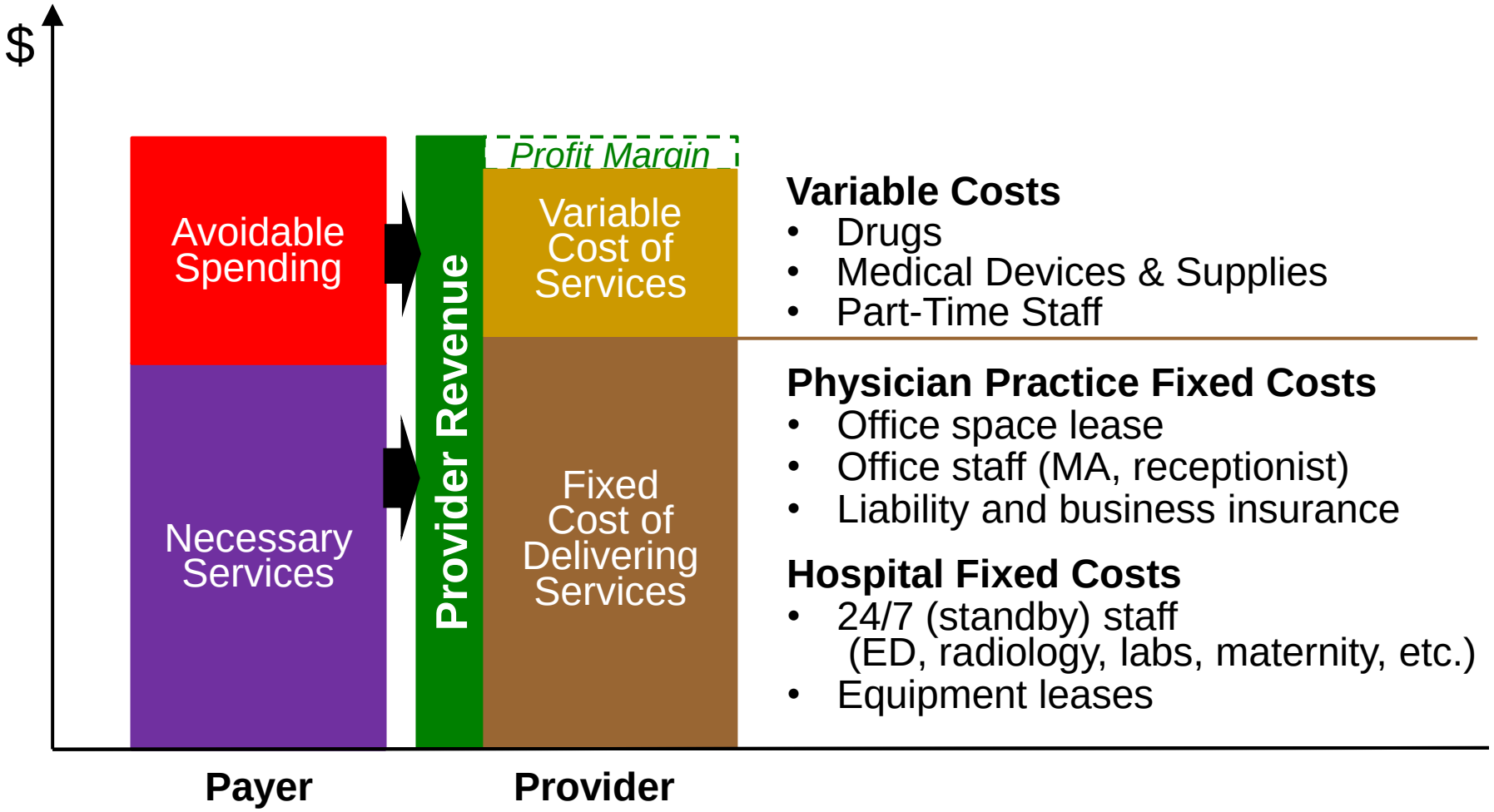
The Majority of Provider Costs Are Fixed (in the Short Term)



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

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

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

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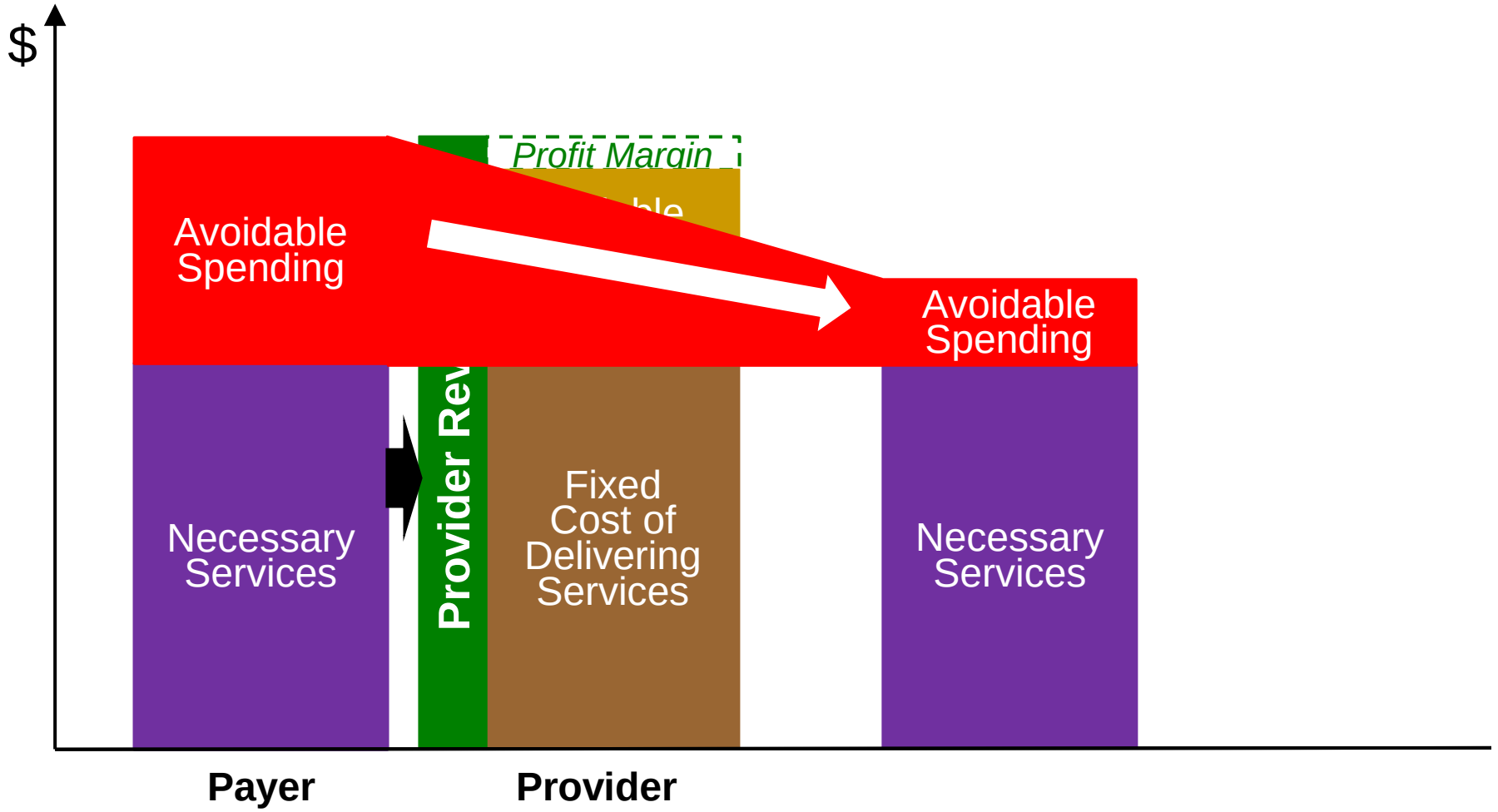
When Healthcare Providers Reduce Avoidable Services…



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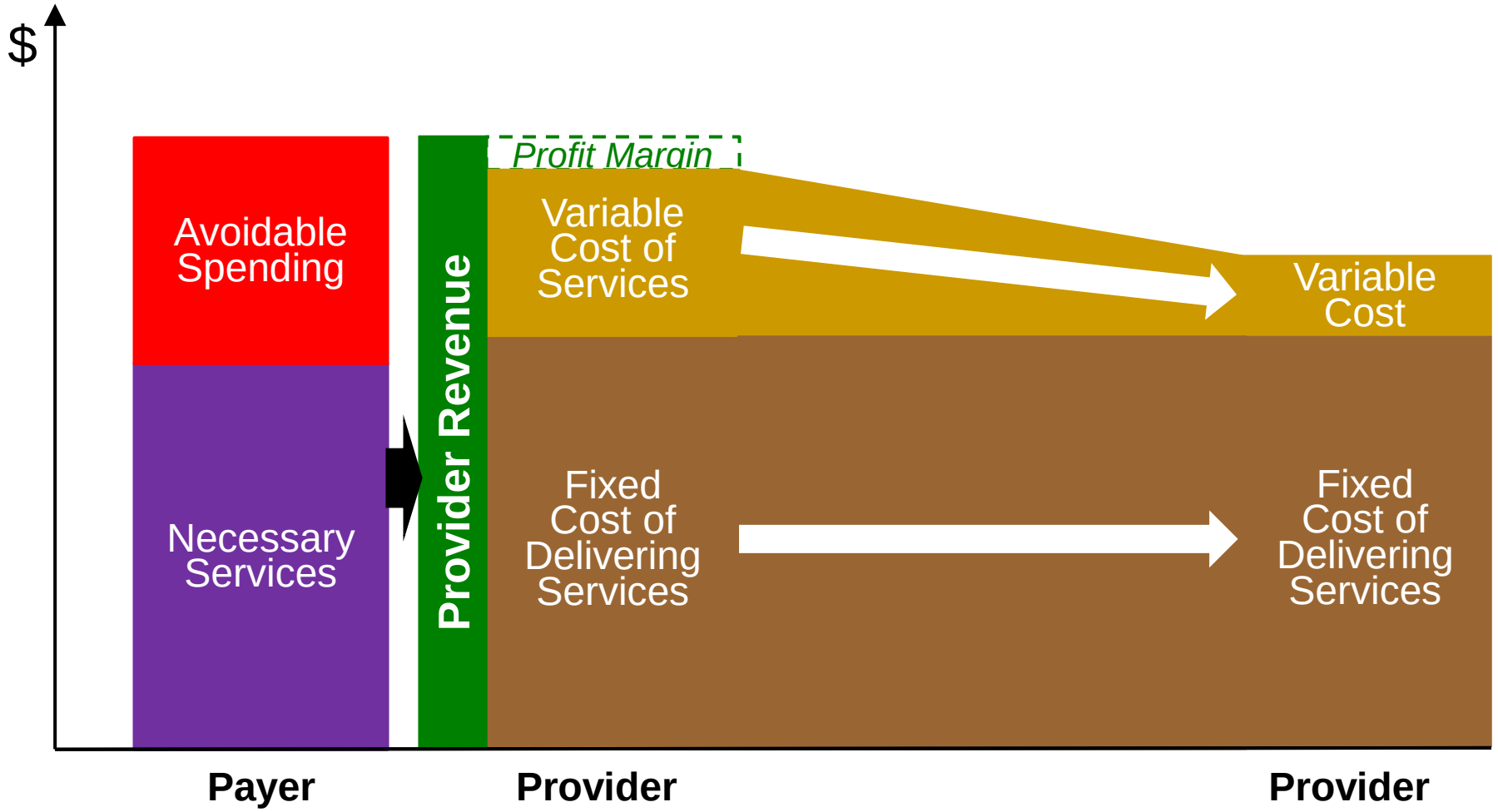
…Variable Costs Decrease, But Fixed Costs Do Not



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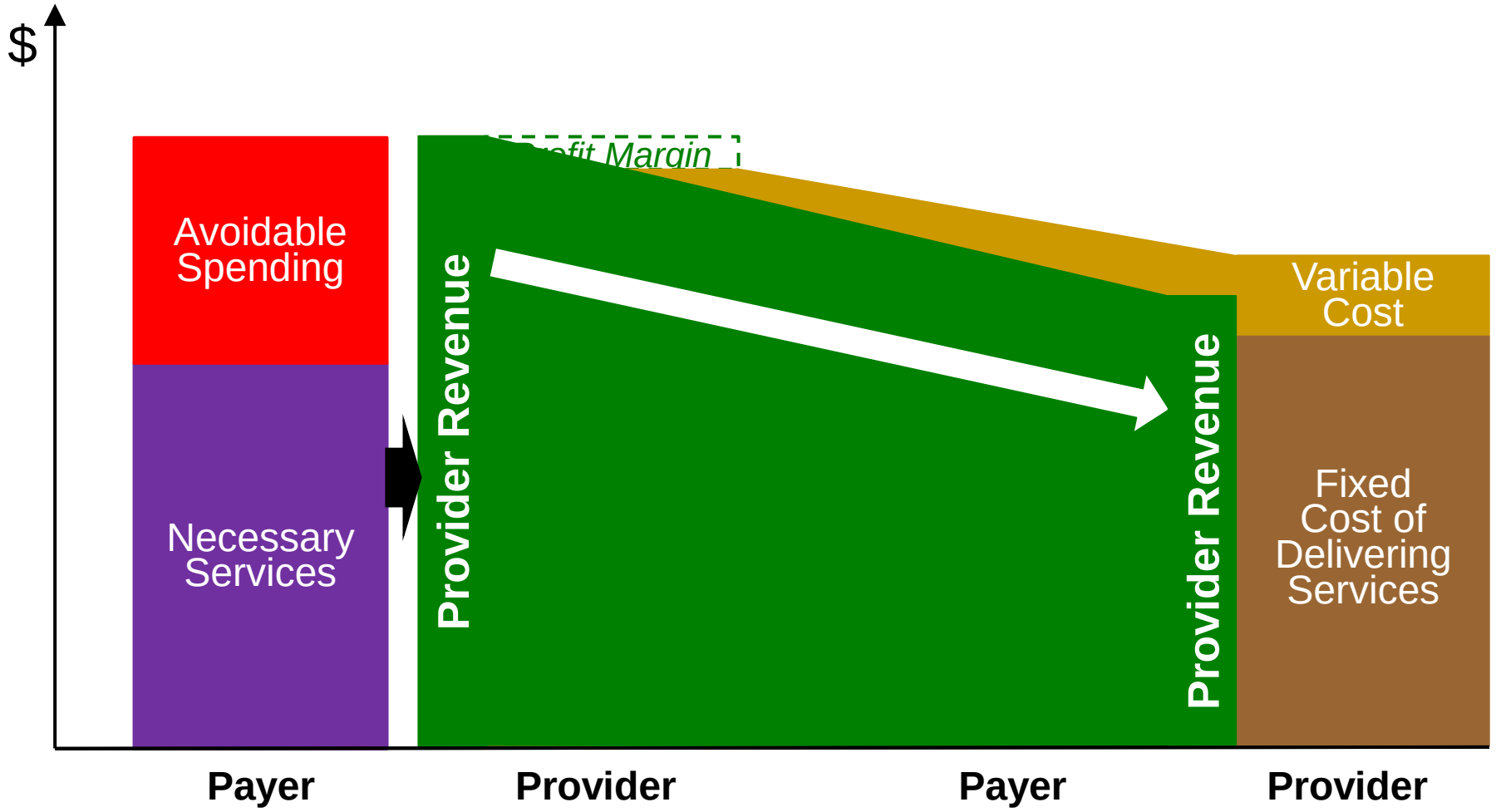
FFS Revenues Decrease in Direct Proportion to Service Volume…



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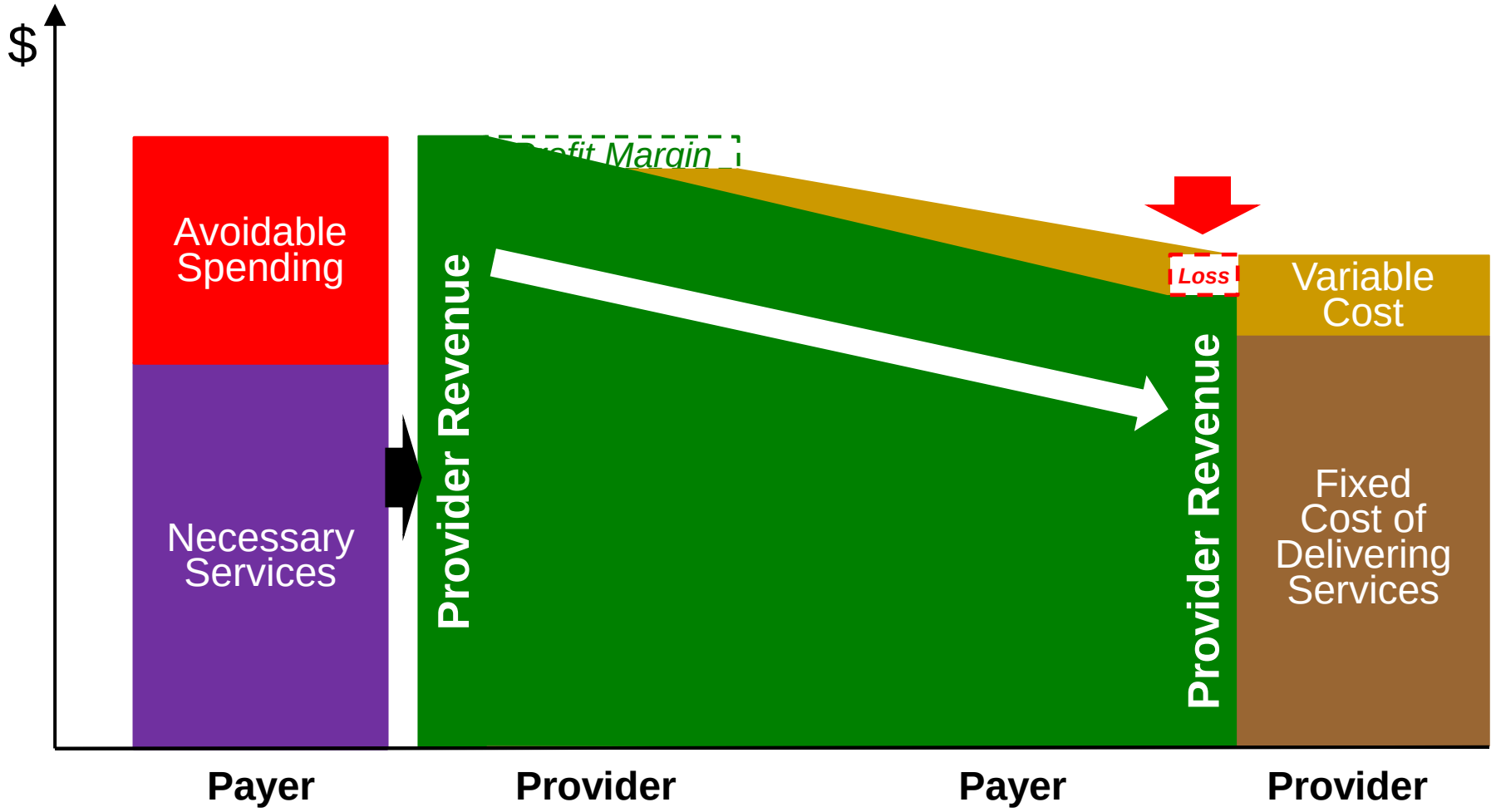
…Resulting in Financial Loss for Healthcare Providers



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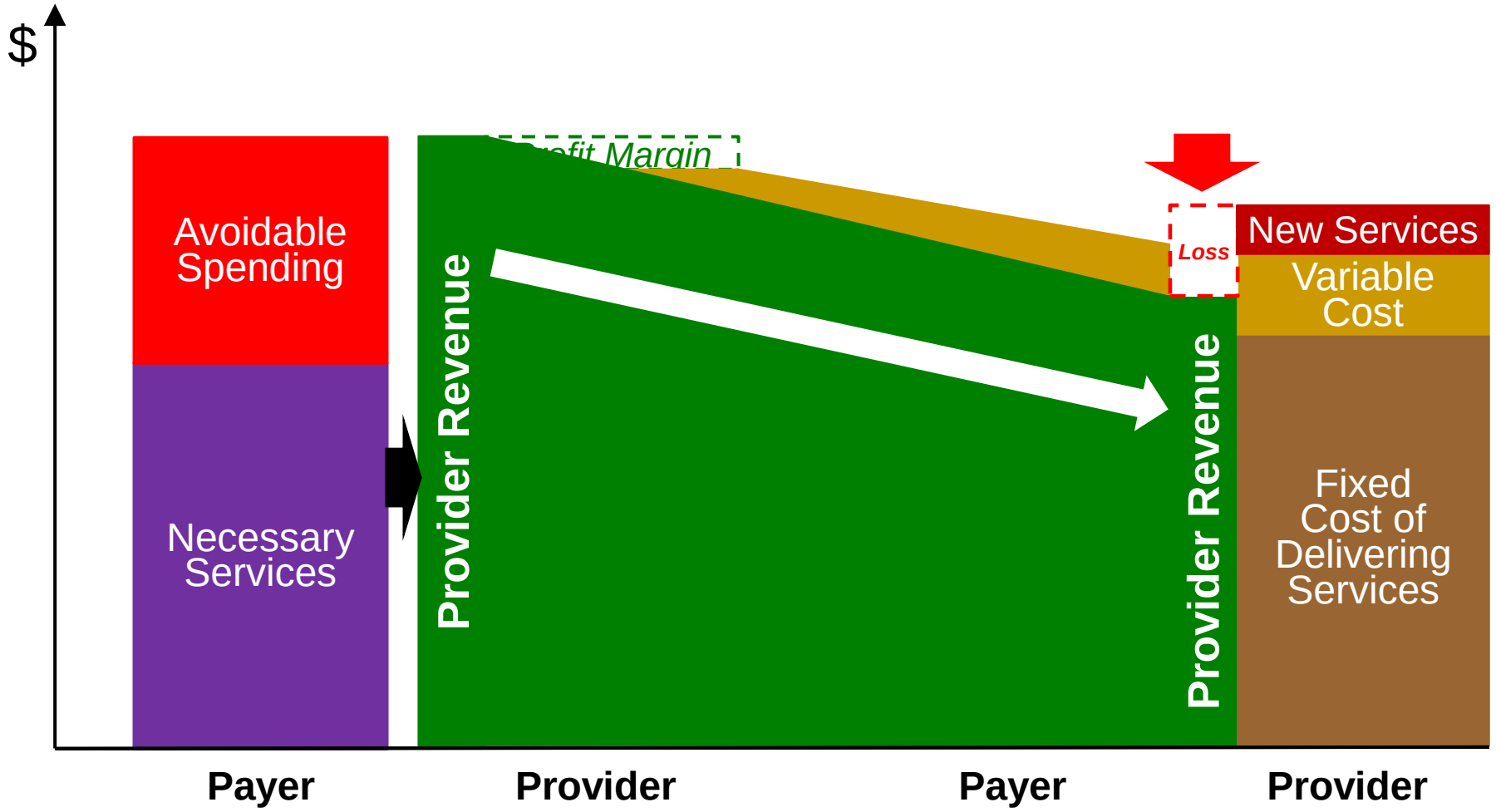
Providing High-Value Services Without Payment Increases Losses



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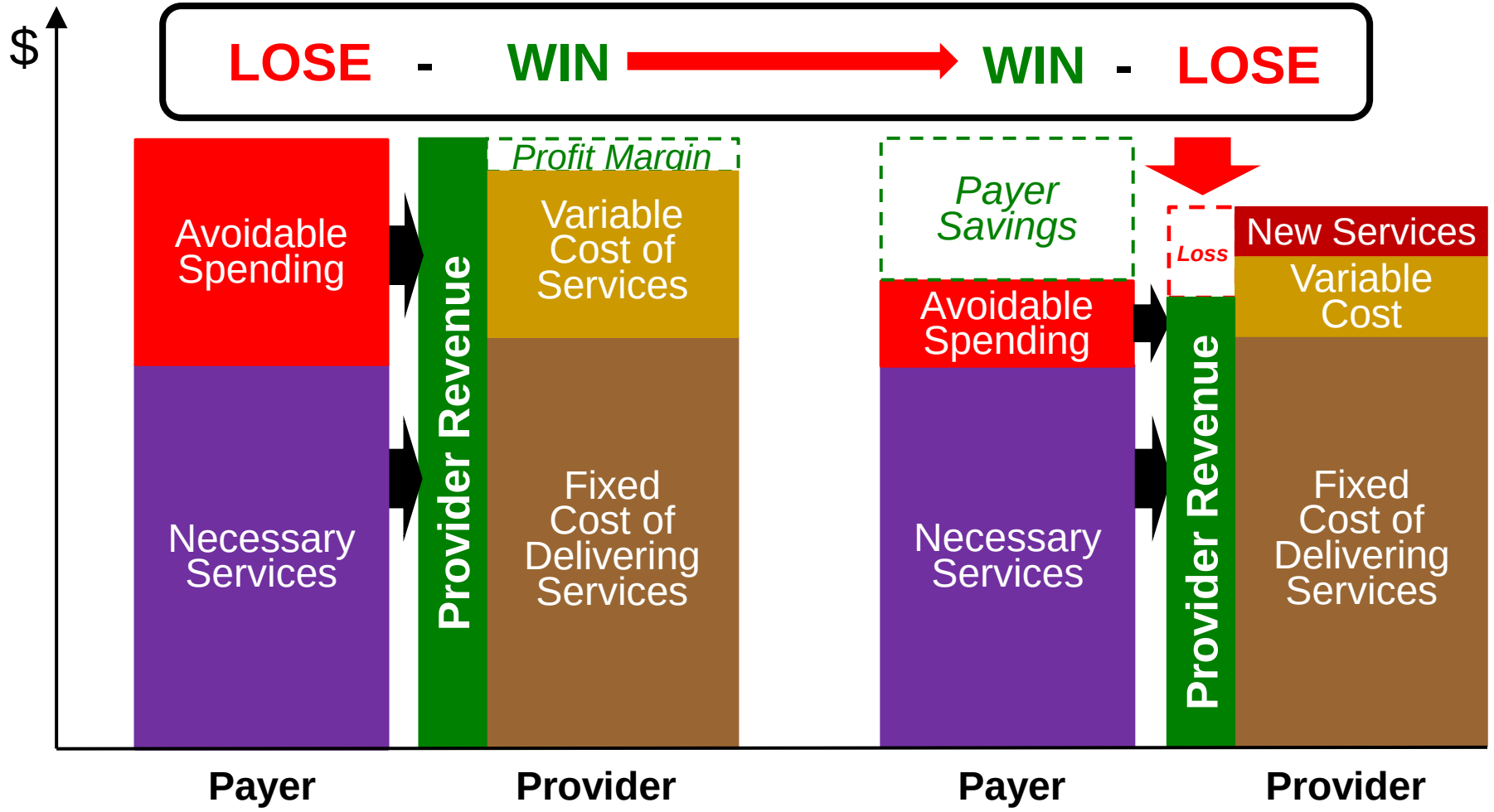
Win-Lose: Savings for Payers, Losses for Providers



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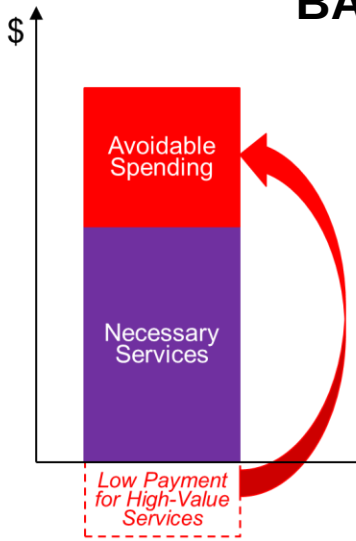
Payment Reforms Are Needed to Remove Barriers to Better Care

BARRIER #1



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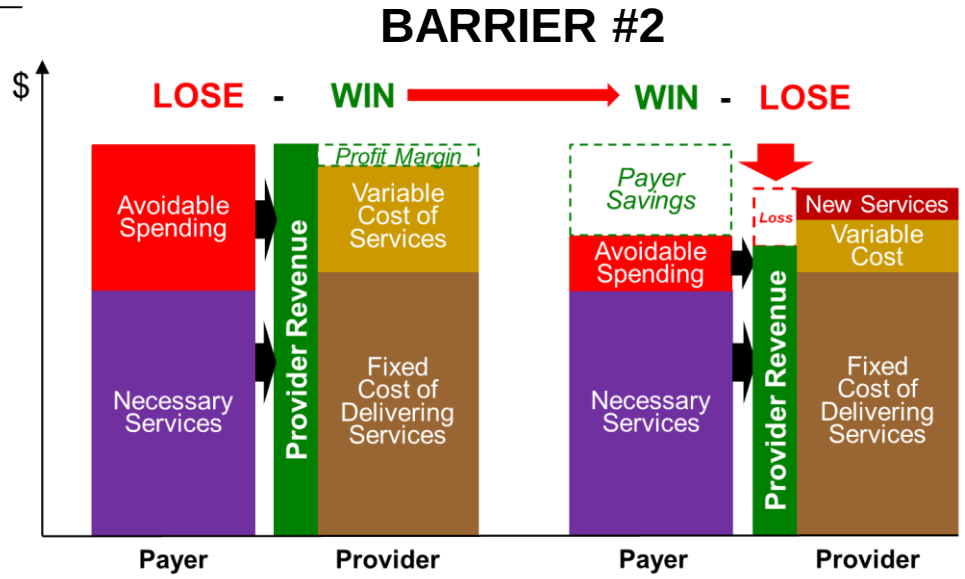
BARRIER #2



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Value-Based Care & Payment for Inflammatory Bowel Disease (IBD)

Lawrence Kosinski, MD
Gastroenterologist
Chicago, USA

“Project Sonar”
www.SonarMD.com

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AVOIDABLE SPENDING OPPORTUNITY:

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

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

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BARRIER TO IMPLEMENTATION:

- No payment for nurse or symptom monitoring

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PAYMENT CHANGE:

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

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Result: Better Care at Lower Cost for IBD

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Gastroenterologist
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PAYMENT CHANGE:

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RESULTS:

- 50% reduction in hospital admissions
- 10% reduction in total spending even with higher payments to physician practice for nurse and technology
- Improved quality of life and productivity for patients

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RESULTS:

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- Improved quality of life and productivity for patients

Most patients can't get this kind of care because:

- **specialists are paid for office visits, not for proactively contacting patients**
- **patients are discouraged from seeing specialists in order to reduce spending**

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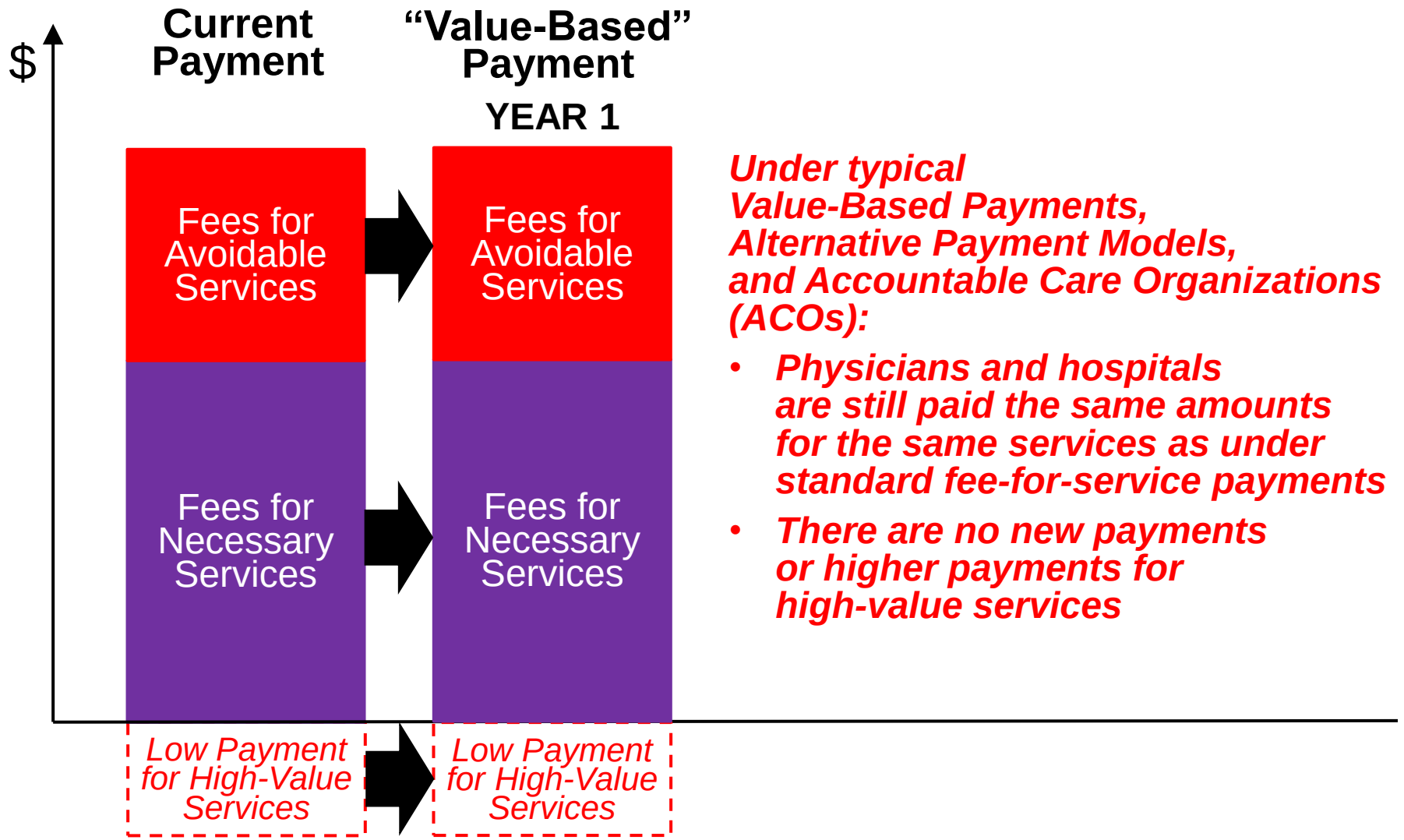
Do Current “Value-Based Payments” and Alternative Payment Models Remove the Barriers to Value-Based Care??

Typical Value-Based Payment: No Change in Standard Fees



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

- ***Physicians and hospitals are still paid the same amounts for the same services as under standard fee-for-service payments***
- ***There are no new payments or higher payments for high-value services***

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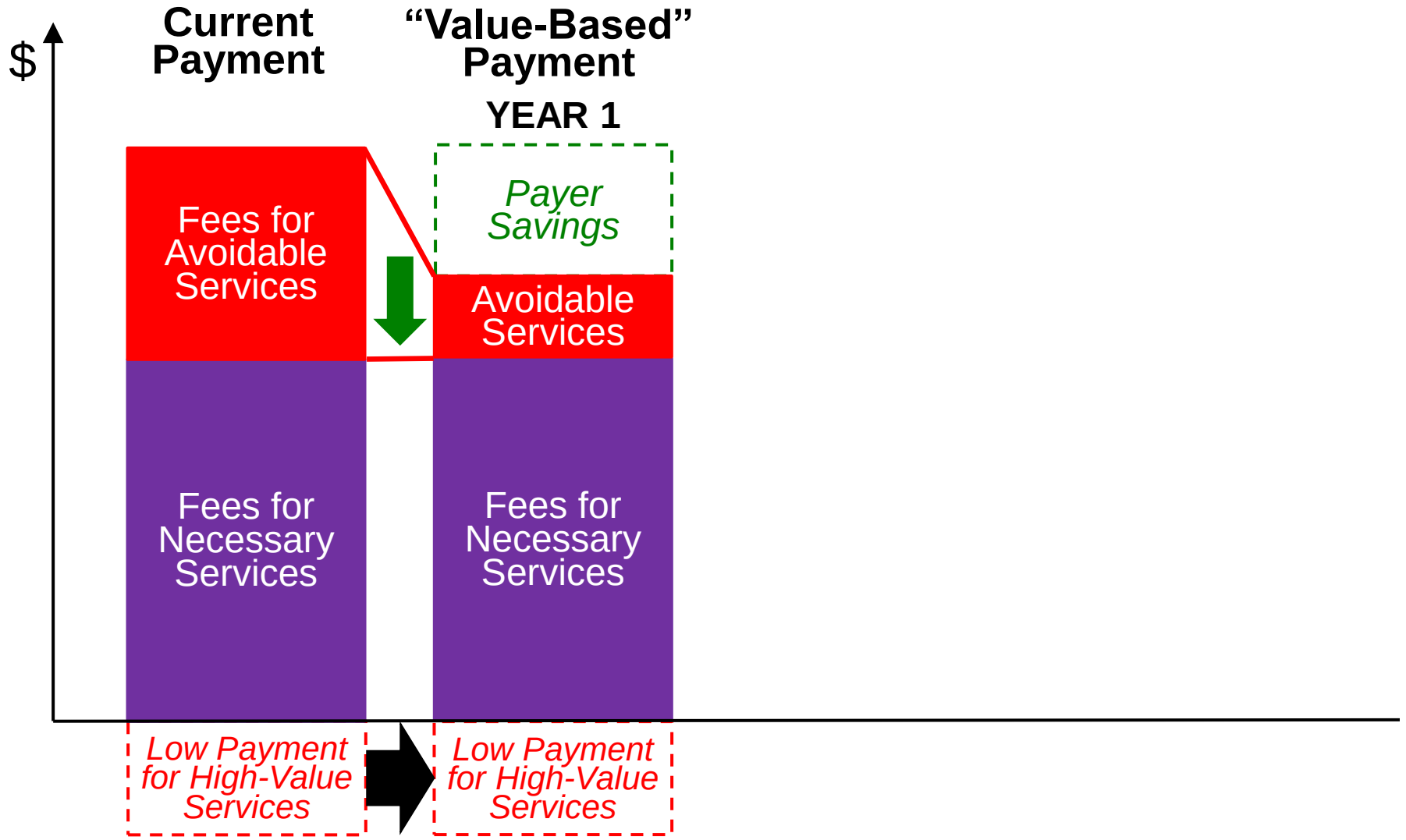
If Healthcare Providers Reduce Avoidable Spending *This* Year…



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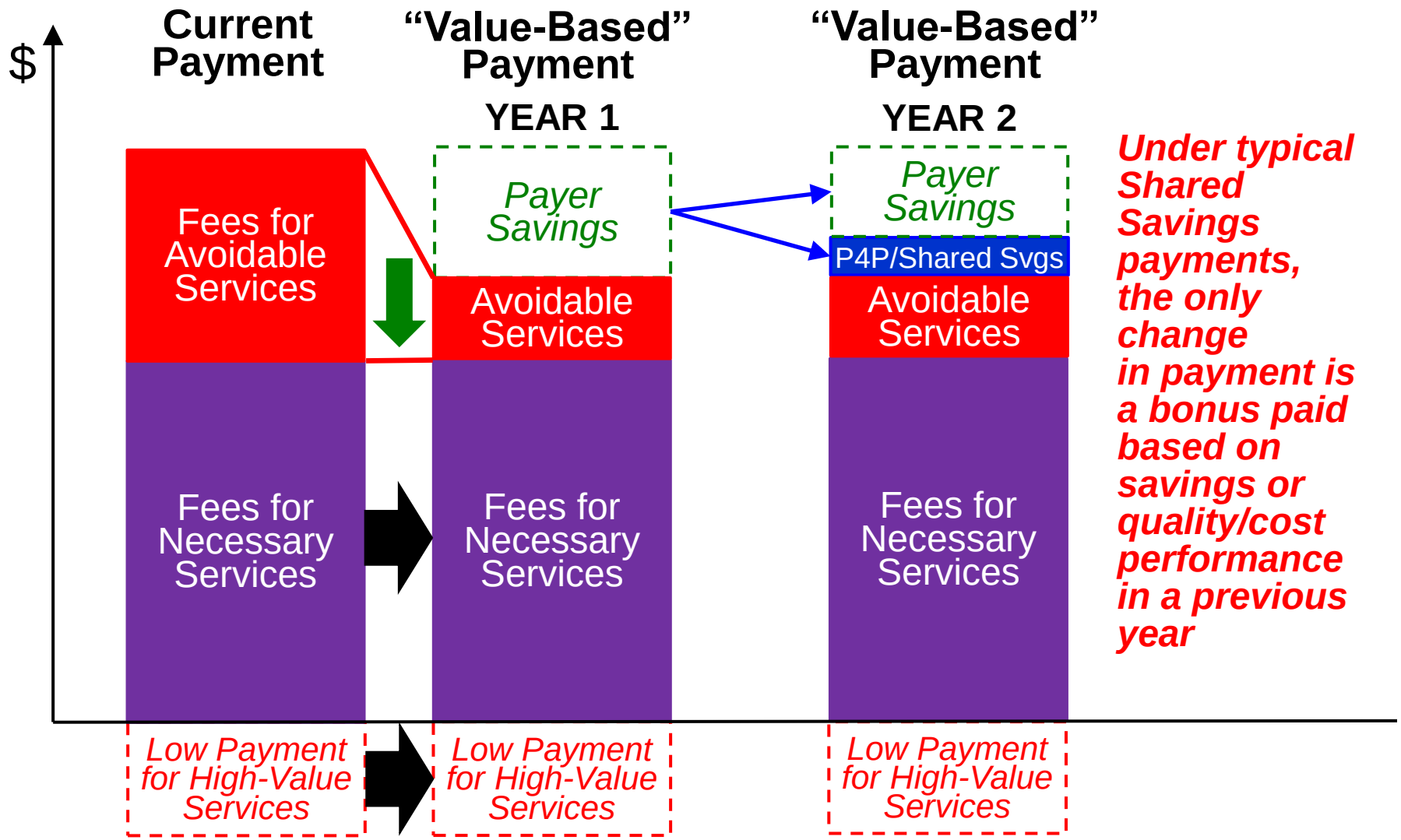
…Payers Pay the Providers More *Next* Year



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

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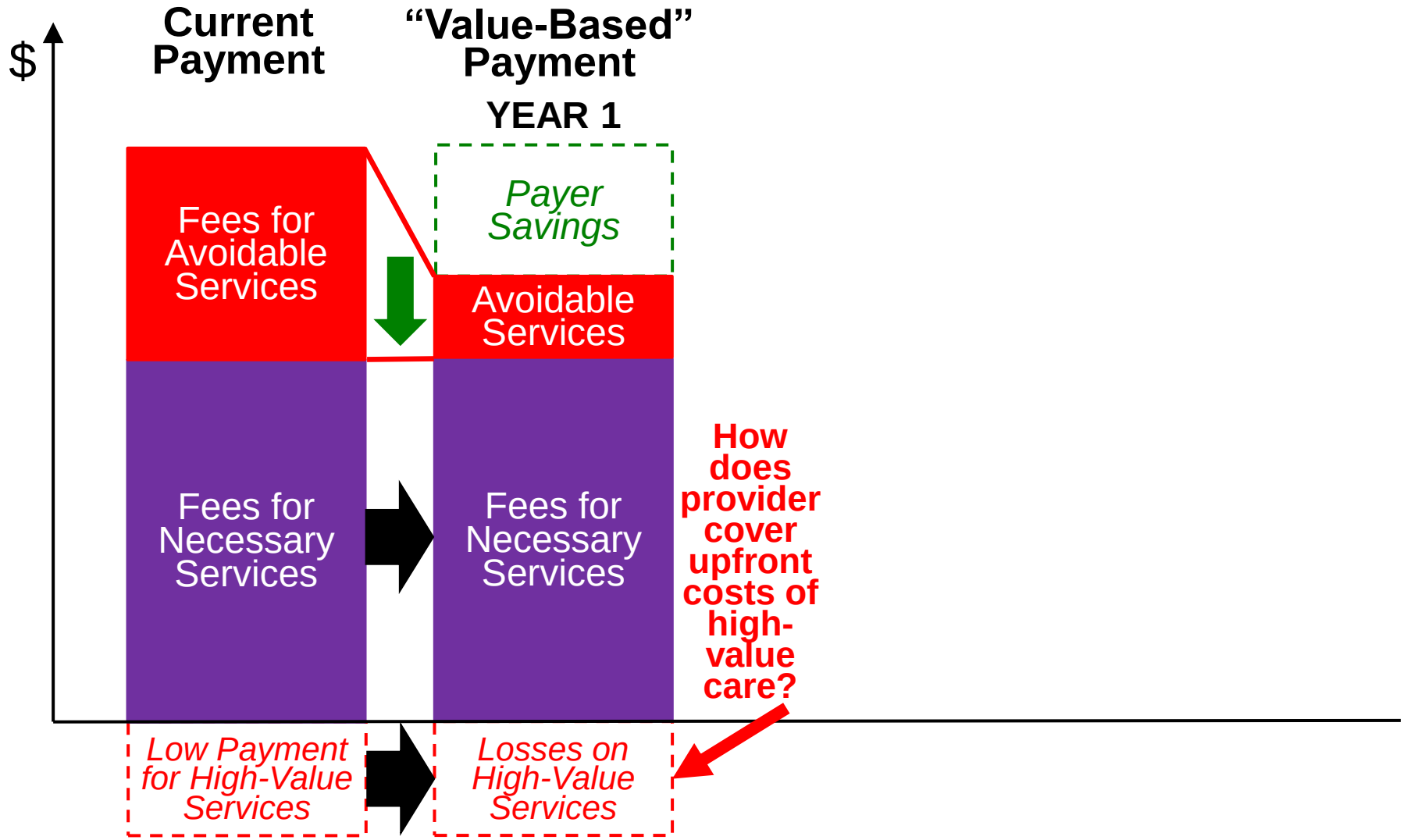
Providers Lose Money *This Year* Under Current Payment System



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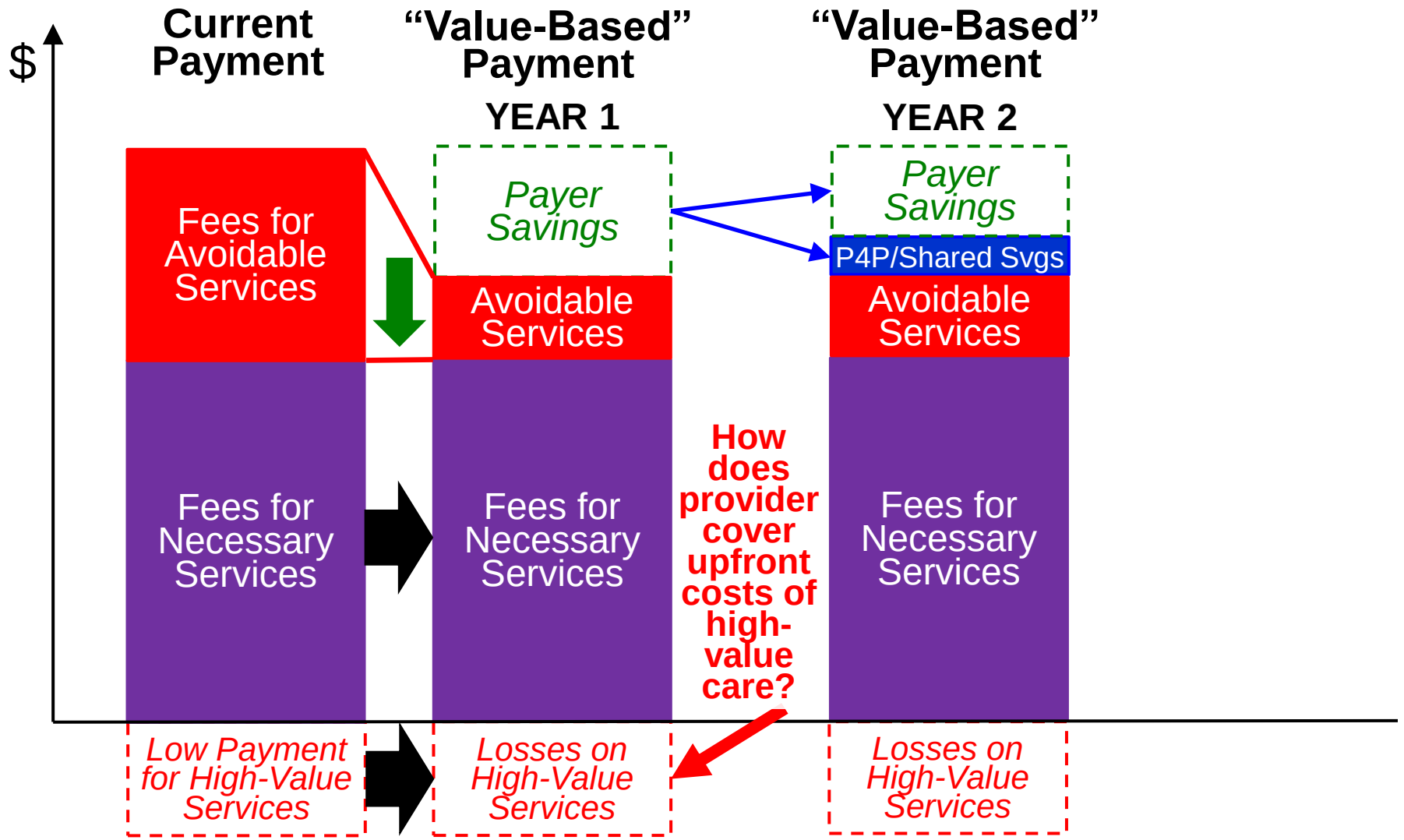
Even If Provider Qualifies for a Bonus *Next Year…*



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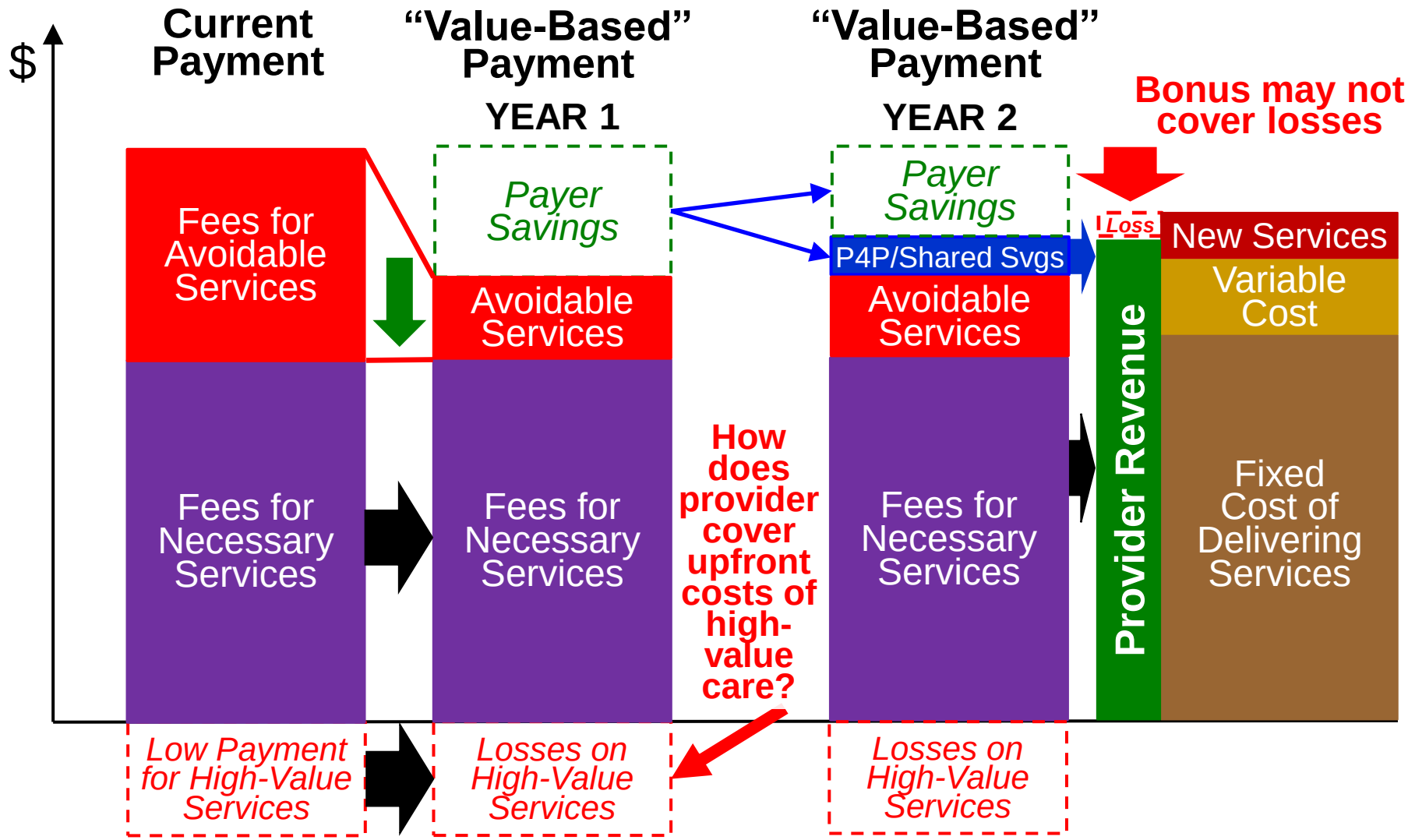
…the Bonus is Generally Less Than Added Costs & Losses



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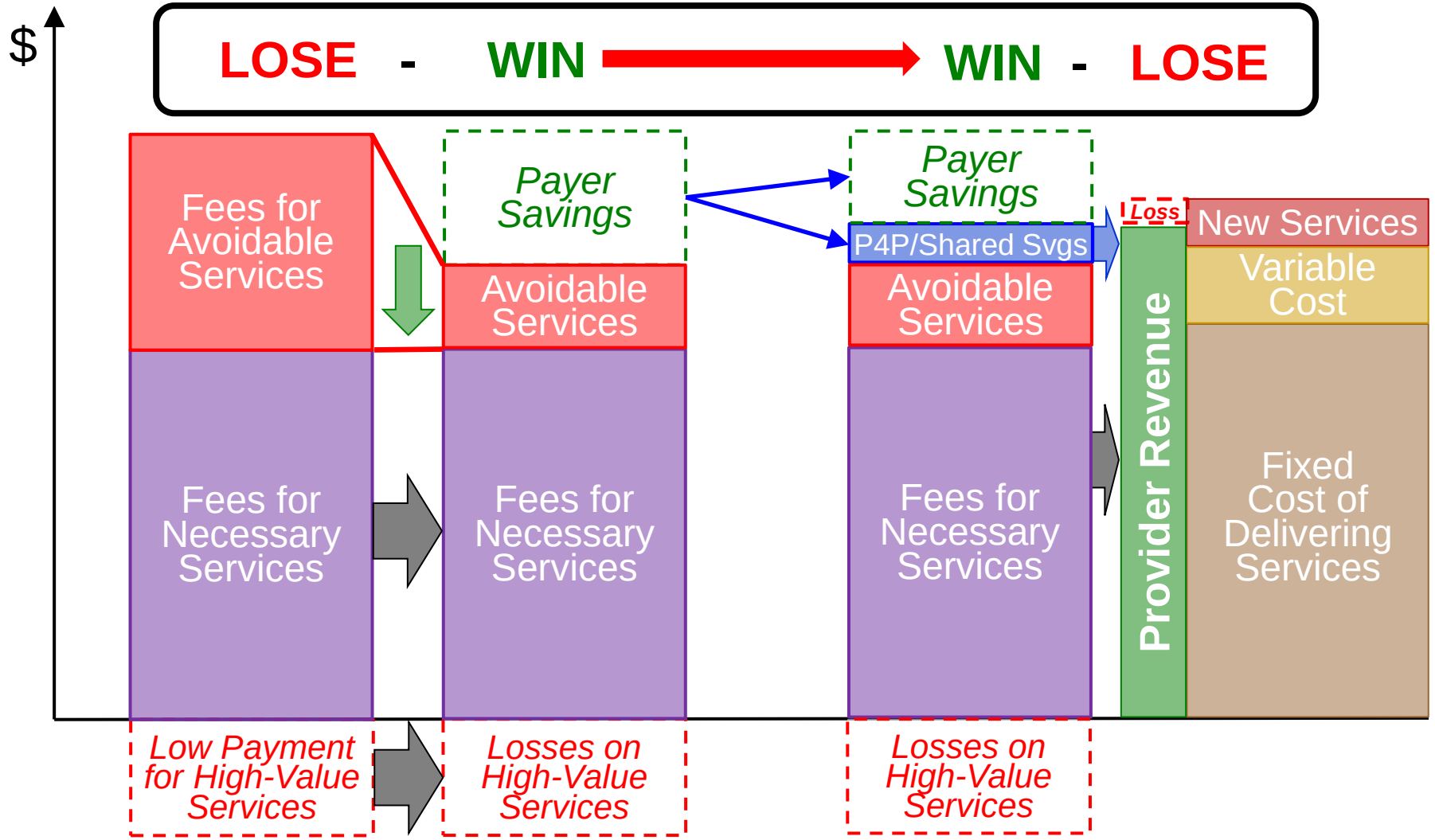
Result: "Value-Based" Payments Are Typically Still a Win-Lose



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Medicare (U.S.) Value-Based Payments Have *Increased* Payer Spending

Medicare Alternative Payment Model	Medicare	
	Losses	Savings
Accountable Care Organizations (ACOs)		
MSSP 2013-2016	-0.2%*	
MSSP 2017-2018		0.5%*
MSSP 2019		1.0%*
MSSP 2020 (Pandemic Year)		1.7%*
MSSP 2021		1.5%*
Next Generation ACO Model	-0.3%	
Comprehensive Primary Care Initiative (CPCI)	-1.0%	
Comprehensive Primary Care Plus (CPC+) Track 1	-2.0%	
Comprehensive Primary Care Plus (CPC+) Track 2	-3.0%	
Comprehensive Care for Joint Replacement (CJR)		0.4%
Bundled Payments for Care Improvement (BPCI) Model 2	-1.0%	
Bundled Payments for Care Improvement (BPCI) Model 3	-3.0%	
Bundled Payments for Care Improvement Advanced (BPCI-A)	-0.4%	
Comprehensive ESRD Care	-0.8%	
Oncology Care Model (OCM)	-0.7%	
Independence at Home (created by Congress, not CMS)		1.0%

* Savings estimate is not based on rigorous evaluation

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Problems With Current Value-Based Payments

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

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Problems With Current Value-Based Payments

1. **Current approaches to value-based payment do not remove the barriers to delivering care in different and better ways**
2. **Current approaches to value-based payment can encourage undertreatment of patients & reduced access for high-need patients**

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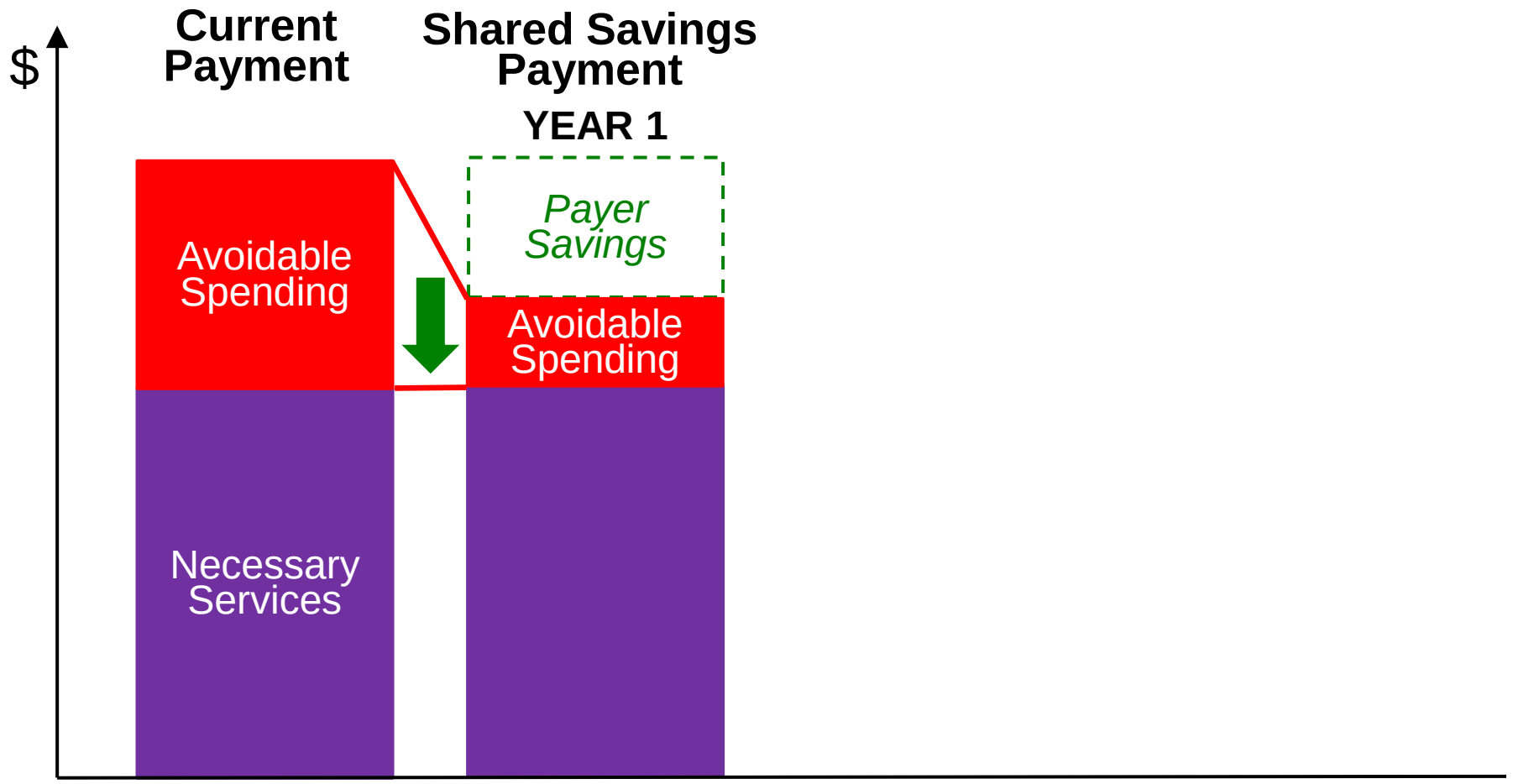
Will Savings Come From Reducing *Avoidable* Spending?



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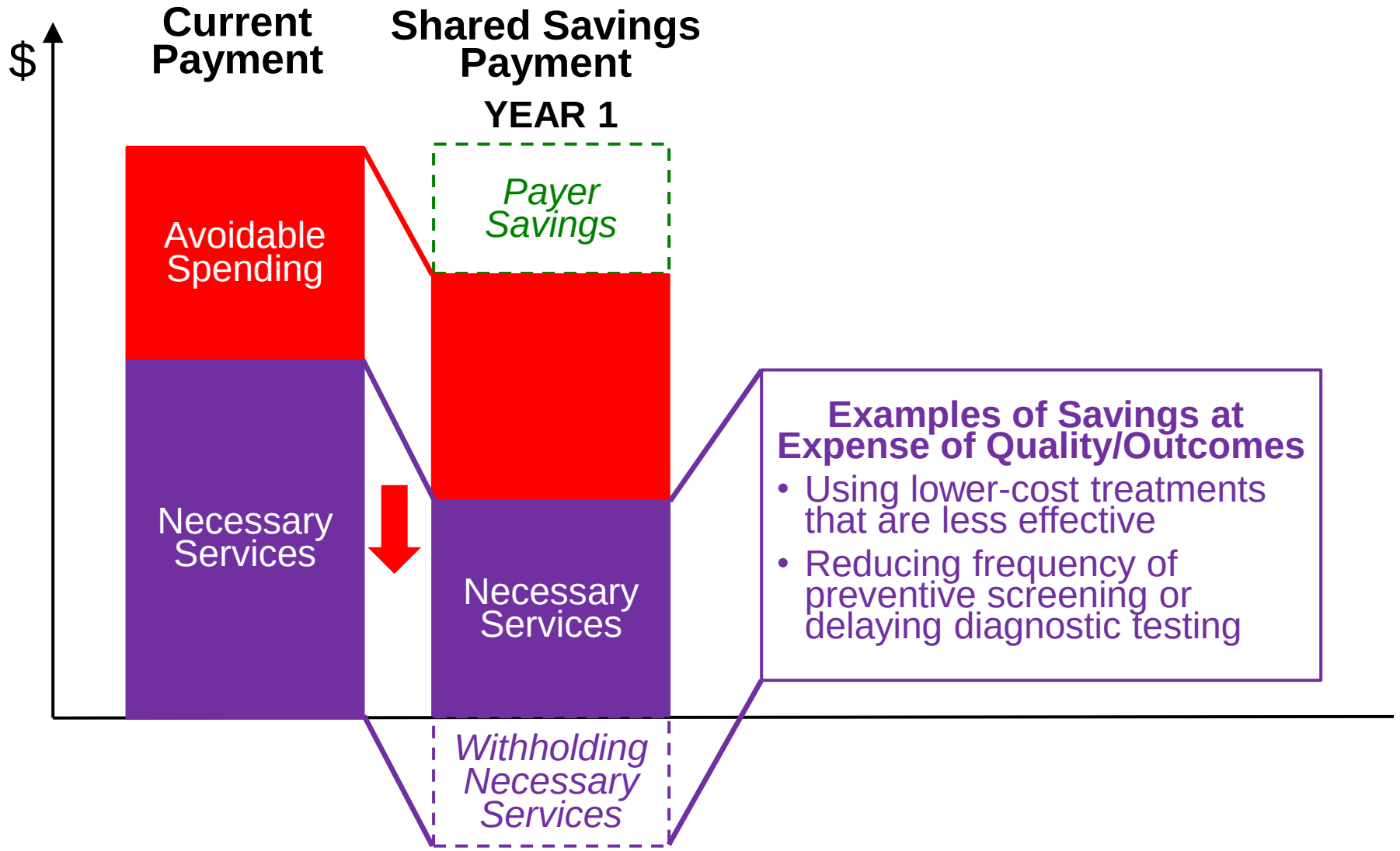
Or Will Savings Come From Reducing *Necessary* Services?



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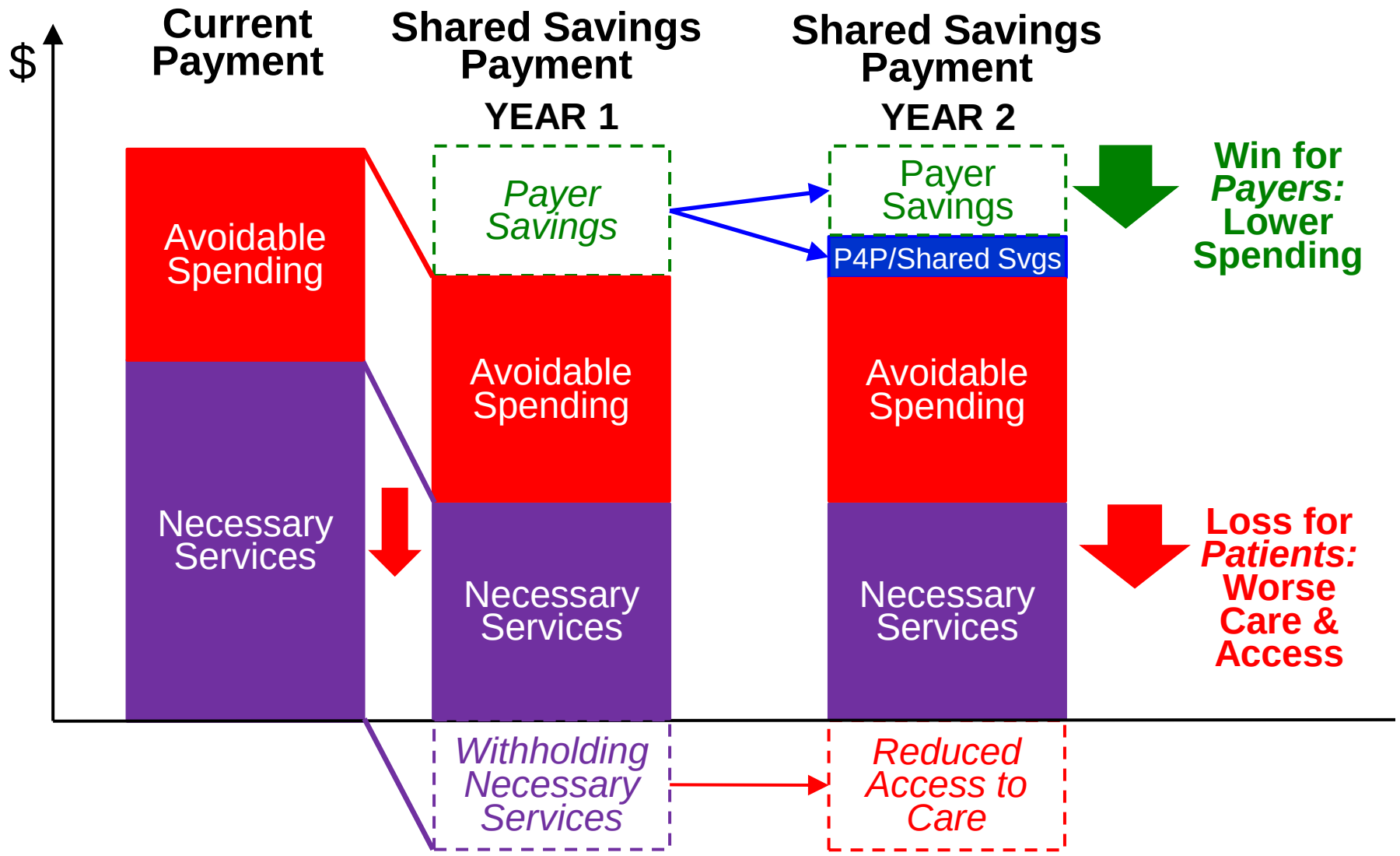
Bonuses Are Paid Regardless of How Spending is Reduced



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Don’t Quality Measures Protect Against Undertreatment?

23 ACO Quality Measures

- **At-Risk Population (25%)**
  - Diabetes Control (> 9% HbA1c)
  - Hypertension Control
  - Depression Remission
- **Preventive Health (25%)**
  - Influenza Immunization
  - Tobacco Use Screening/Intervention
  - Depression Screening/Follow-up
  - Colorectal Cancer Screening
  - Breast Cancer Screening
- **Care Coordination/Safety (25%)**
  - Hospital Readmission Rate
  - Hospitalizations for Patients with Multiple Chronic Conditions
  - AHRQ Prevention Quality Indicator
  - Screening for Fall Risk
- **Patient/Caregiver Experience (25%)**
  - Timely Appointments
  - Provider Communication
  - Provider Rating
  - Access to Specialists
  - Health Education
  - Shared Decision Making
  - Health & Functional Status
  - Stewardship of Patient Resources
  - Courteous and Helpful Office Staff
  - Care Coordination

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ACOs Are at Risk for Total *Cost*, But Not for Total *Quality* of Care

23 ACO Quality Measures

- **At-Risk Population (25%)**
  - Diabetes Control (> 9% HbA1c)
  - Hypertension Control
  - Depression Remission
- **Preventive Health (25%)**
  - Influenza Immunization
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  - Health Education
  - Shared Decision Making
  - Health & Functional Status
  - Stewardship of Patient Resources
  - Courteous and Helpful Office Staff
  - Care Coordination

No Measures to Assure:

- Evidence-based treatment for cancer
- Effective management of cancer treatment side effects
- Evidence-based treatment for rheumatoid arthritis
- Evidence-based treatment of inflammatory bowel disease
- Rapid treatment and rehabilitation for stroke
- Effective management for joint pain and mobility
- Effective management of back pain and mobility
- Access to and quality of care for many other conditions

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Healthcare Providers
Don’t Need “Incentives”
or Significant Financial Risk
in Order to Improve Care
and Reduce Spending…

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Don't Need "Incentives"
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…They Need
True Value-Based Payments
That *Remove the Barriers*
to Higher-Value Care.

Healthcare Providers
Don't Need "Incentives"
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…They Need
True Value-Based Payments
That *Remove the Barriers*
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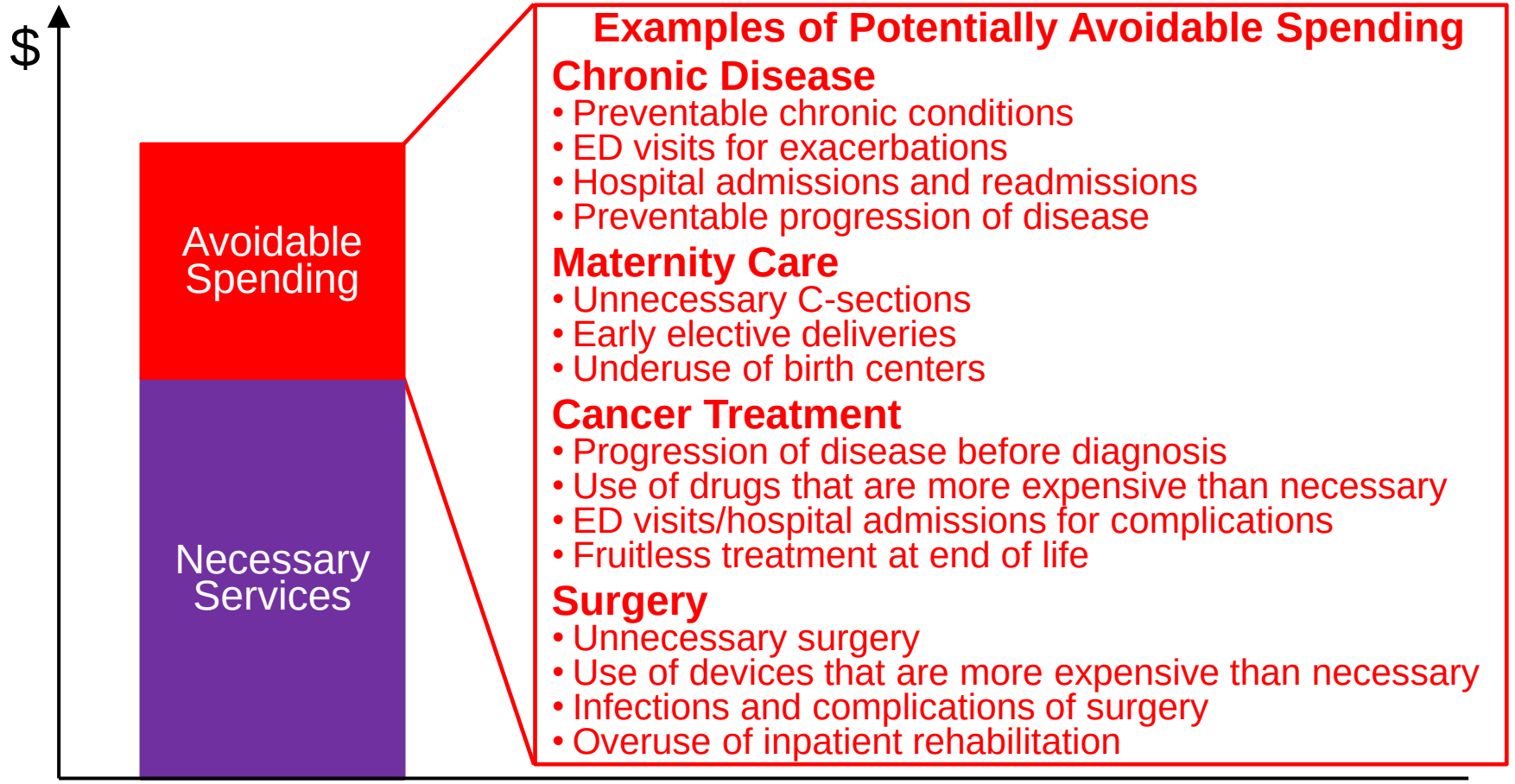
How Do You Create
Successful
Value-Based Payments?

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



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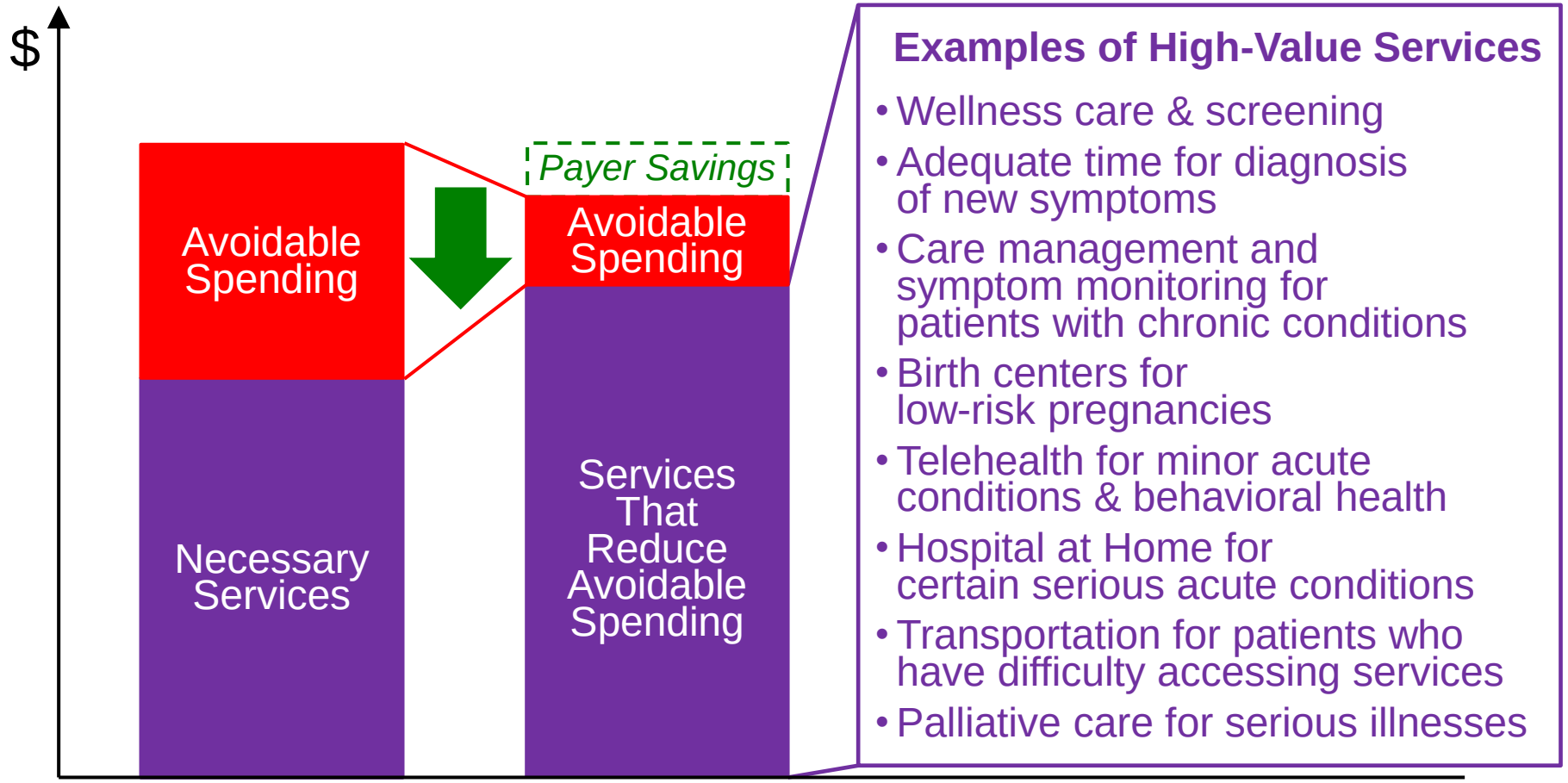
Step 2: Design Services That Will Reduce The Avoidable Spending



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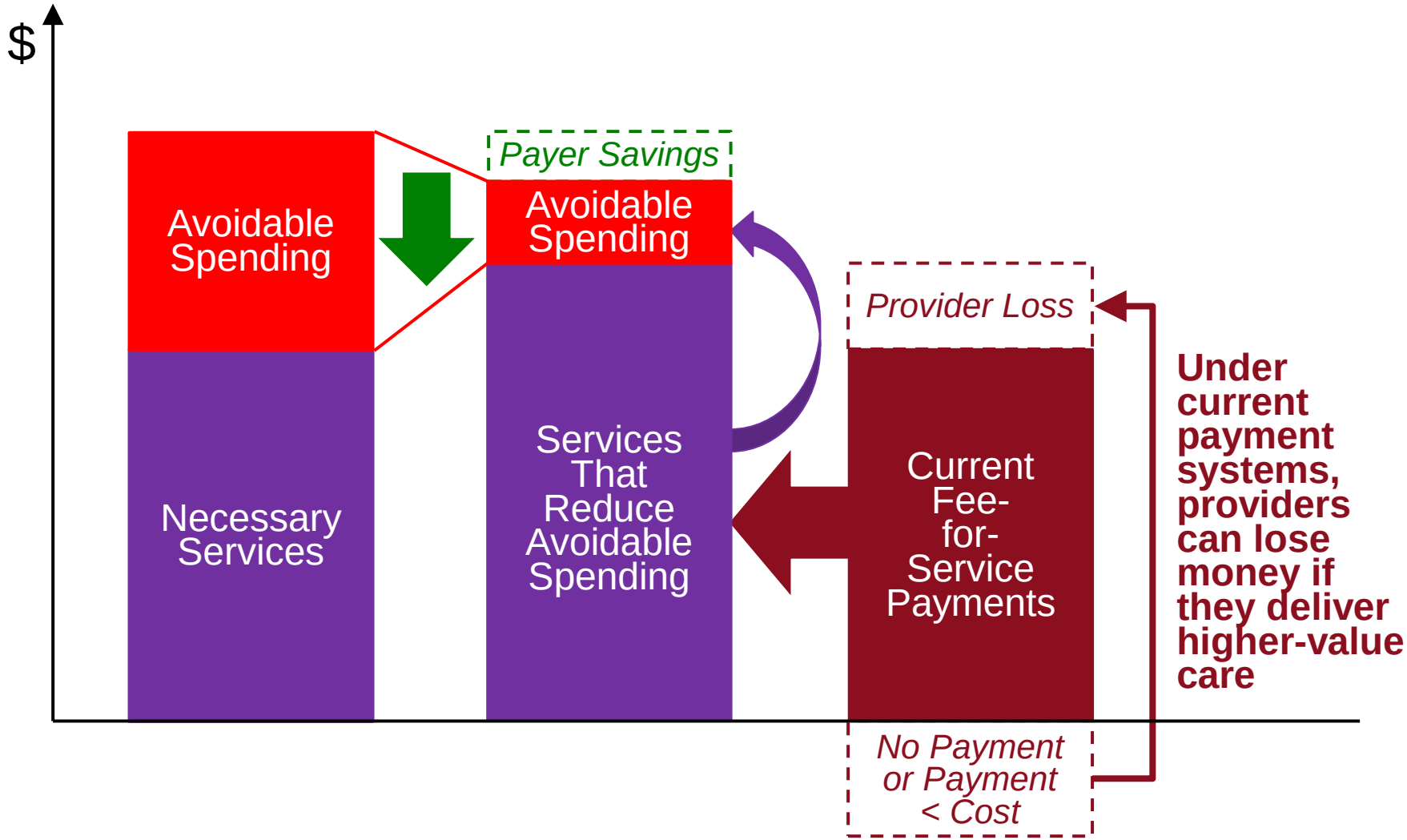
If Current Payments Do Not Support Value-Based Care…



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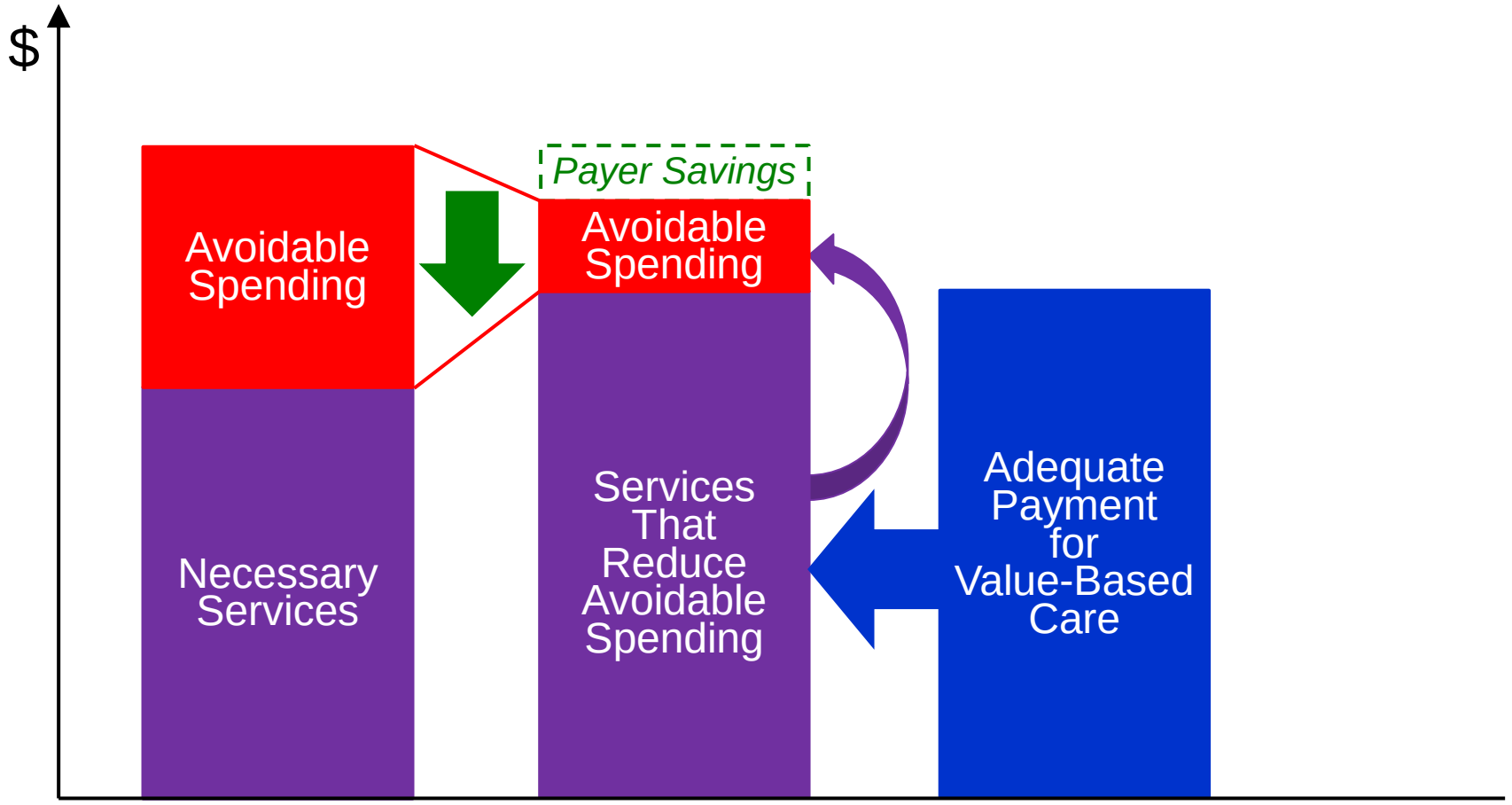
Step 3: Pay Adequately to Support Higher-Value Services



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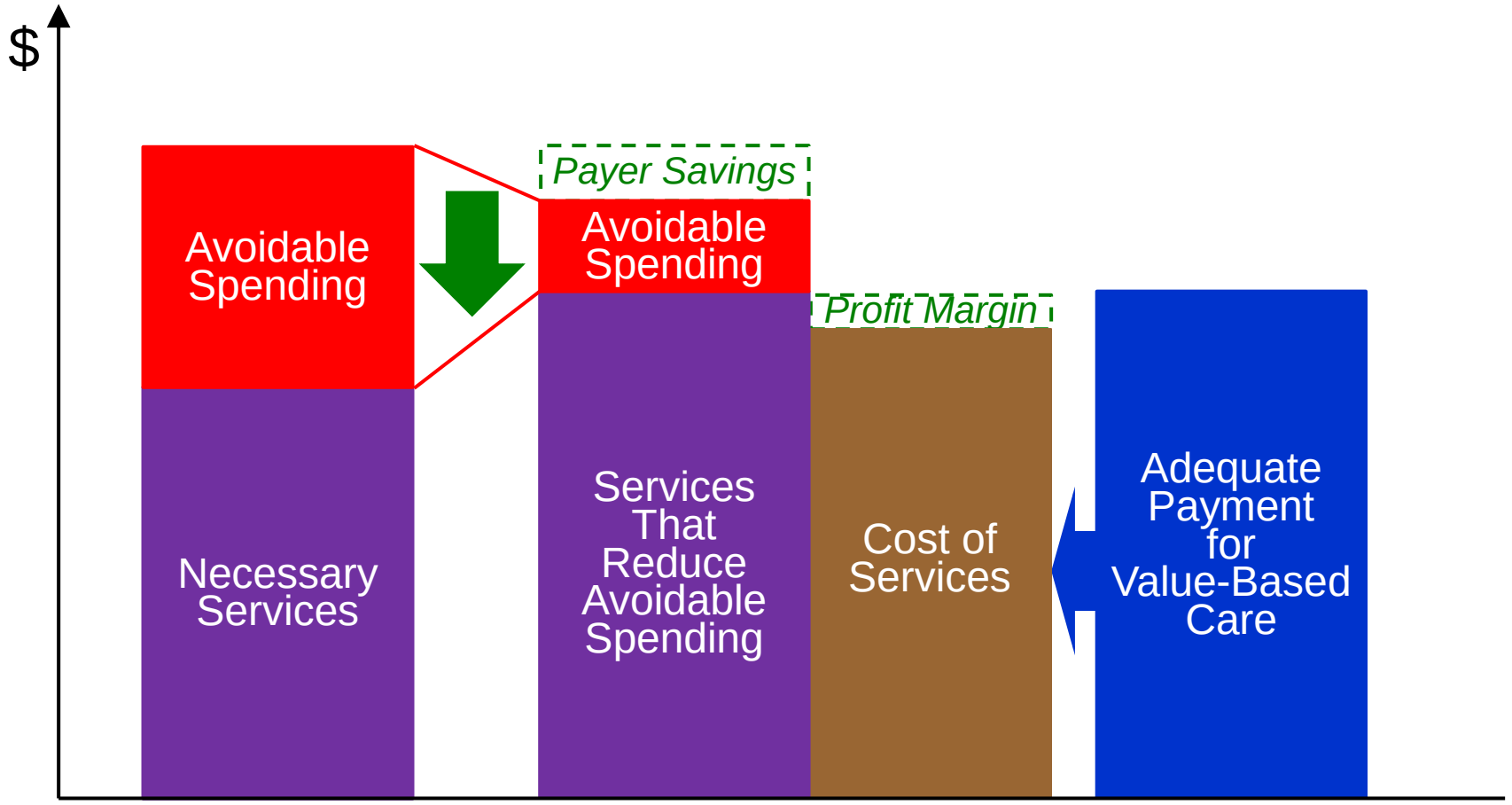
Adequacy Requires Knowing the *Cost* of Higher-Value Care



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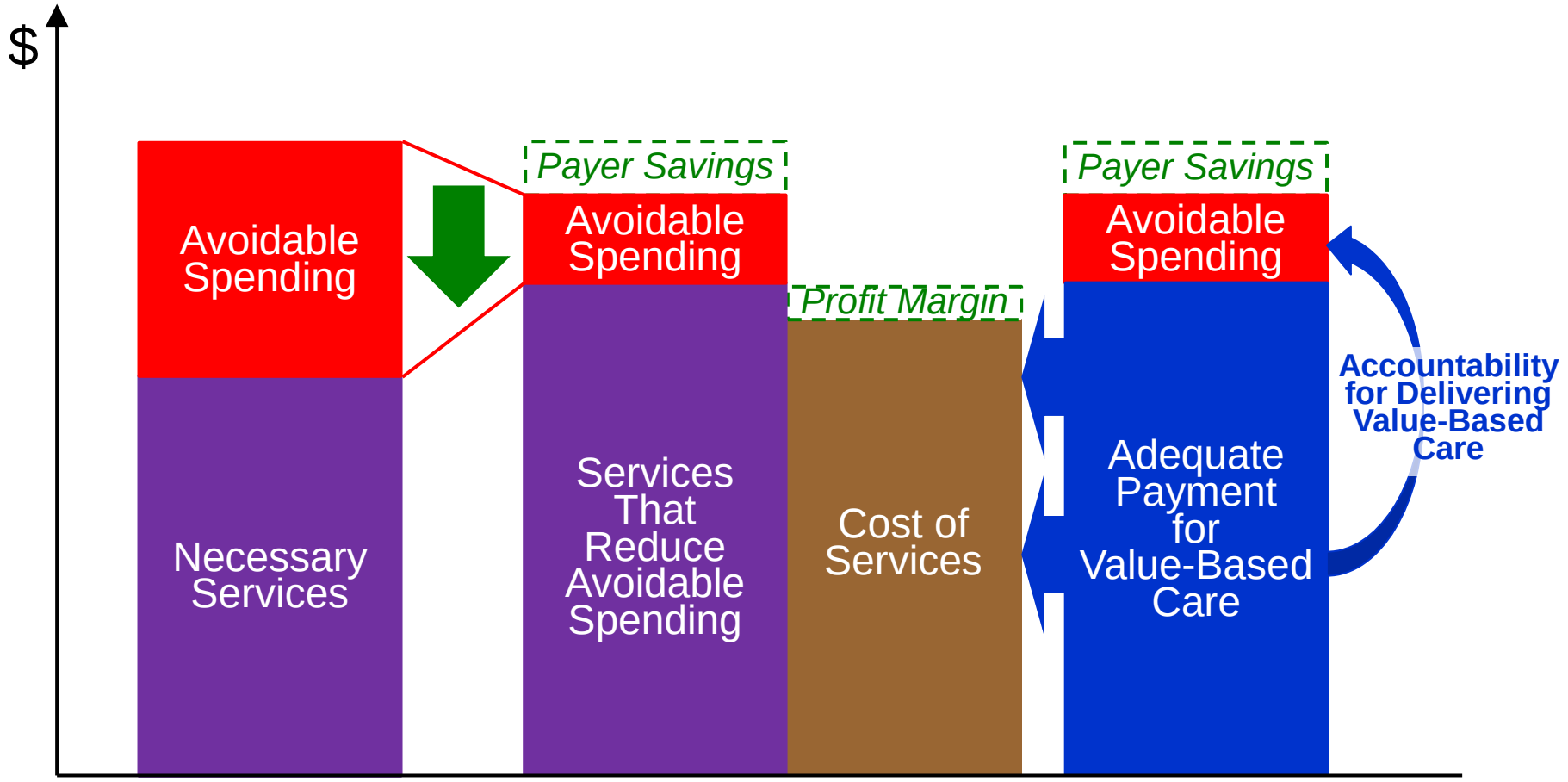
Step 4: Accountability for Delivering Value-Based Care



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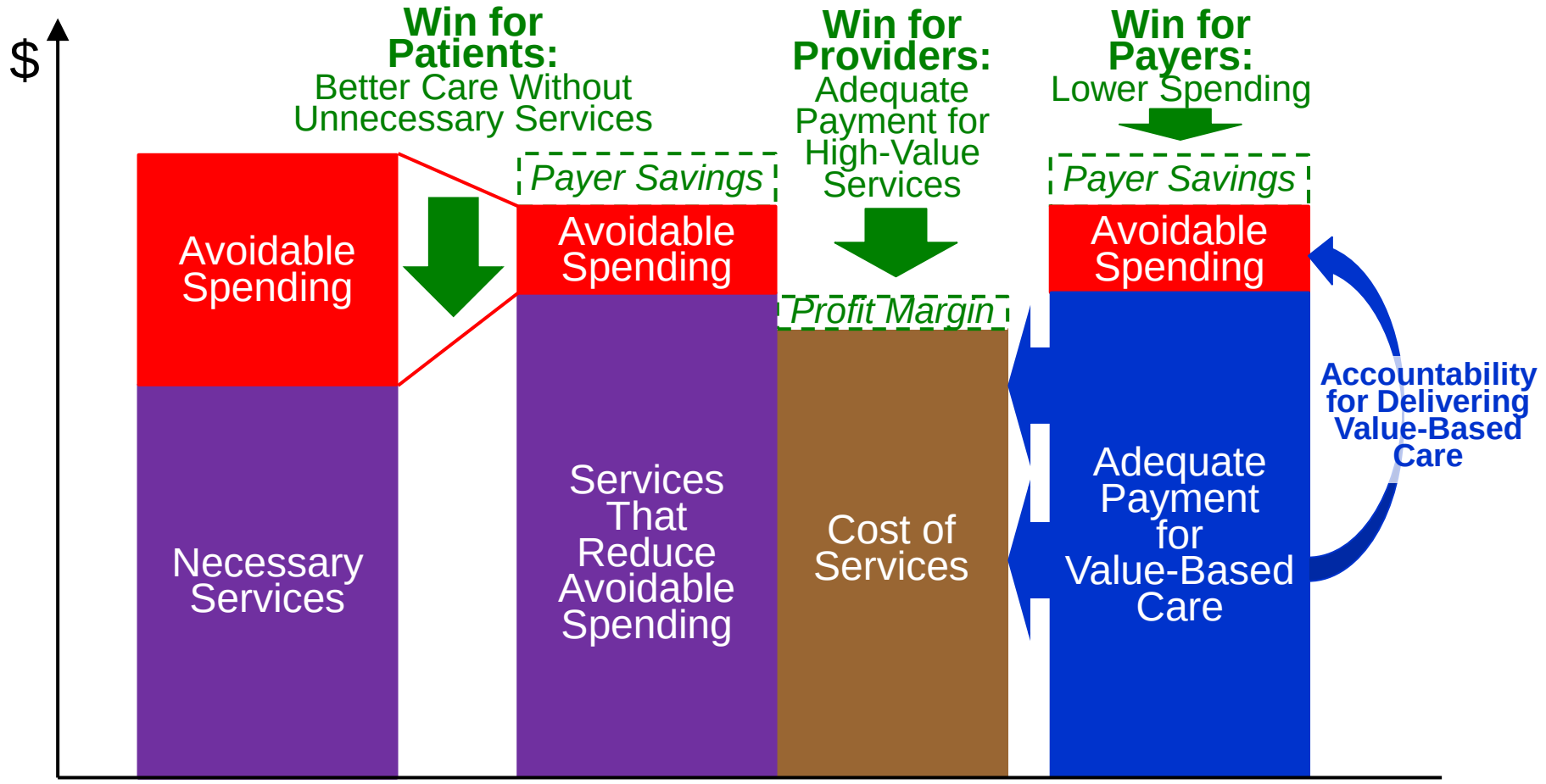
Value-Based Payment Can Be a Win-Win-Win



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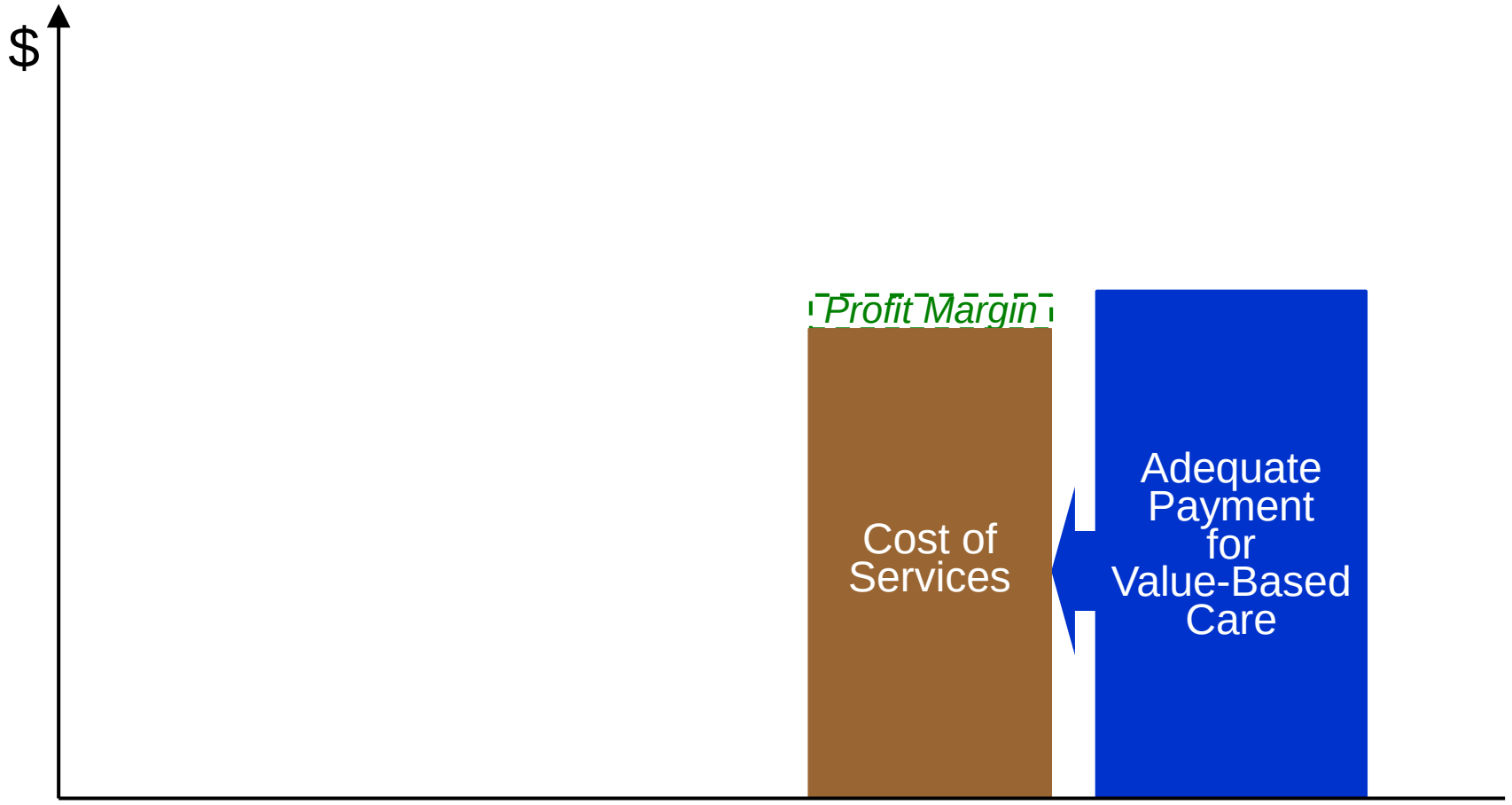
Adequacy Requires Knowing the *Cost* of Higher-Value Care



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Cost ≠ Spending, & It's Not Enough to Know *Current* Costs

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

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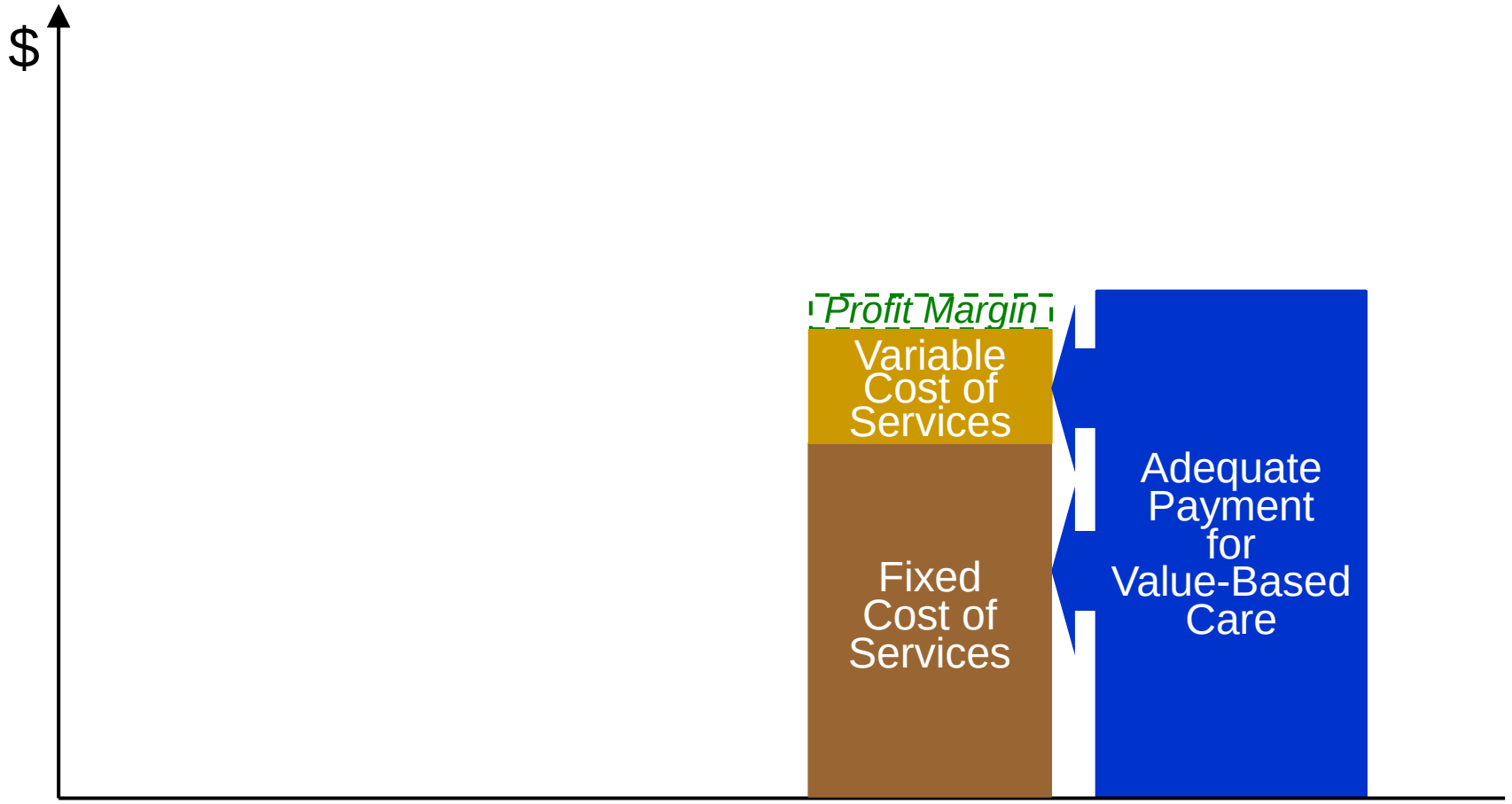
Payment *Amount* Must Cover the *Cost* of Value-Based Care



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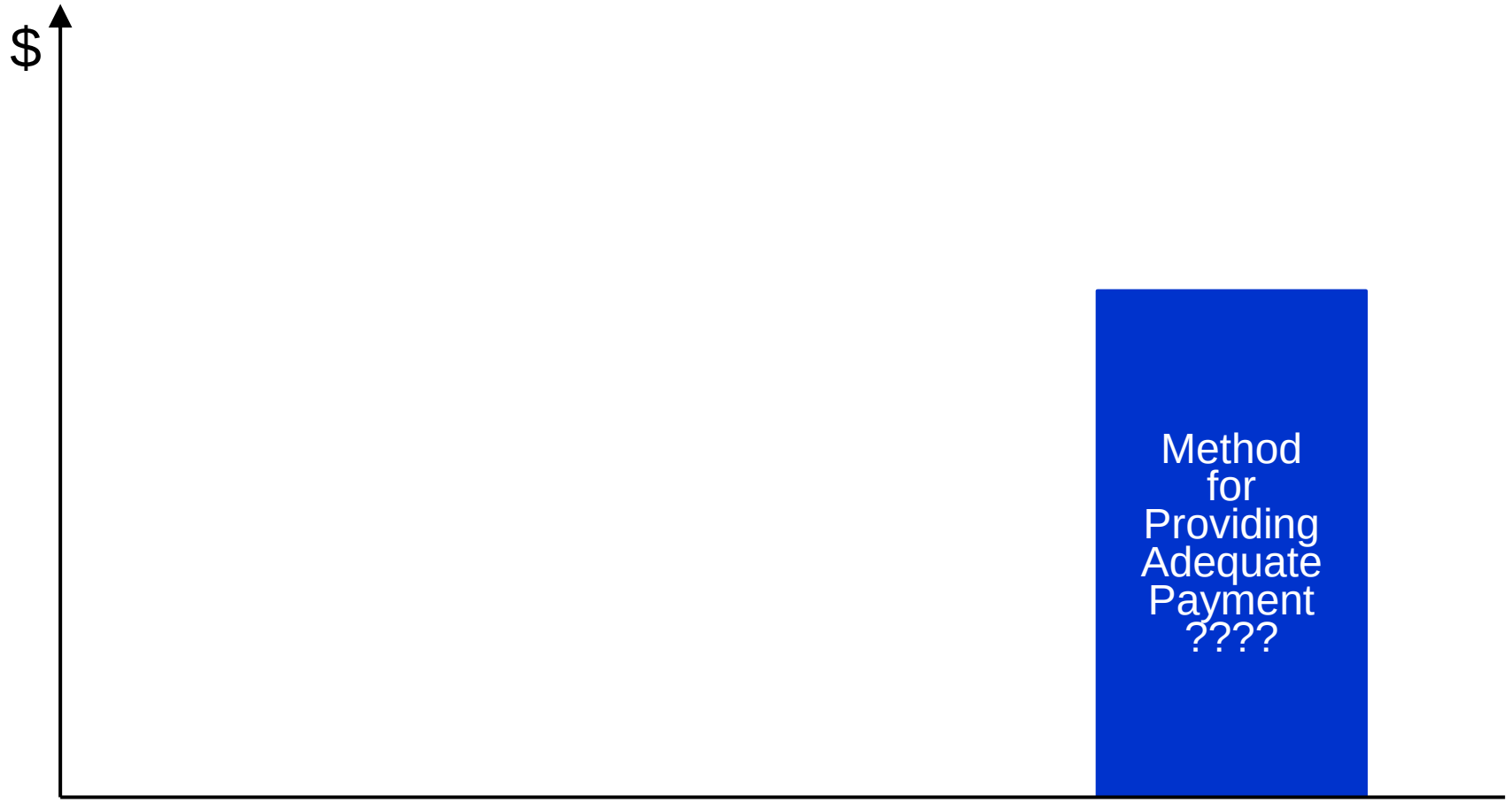
What Payment *Method* Should Be Used?



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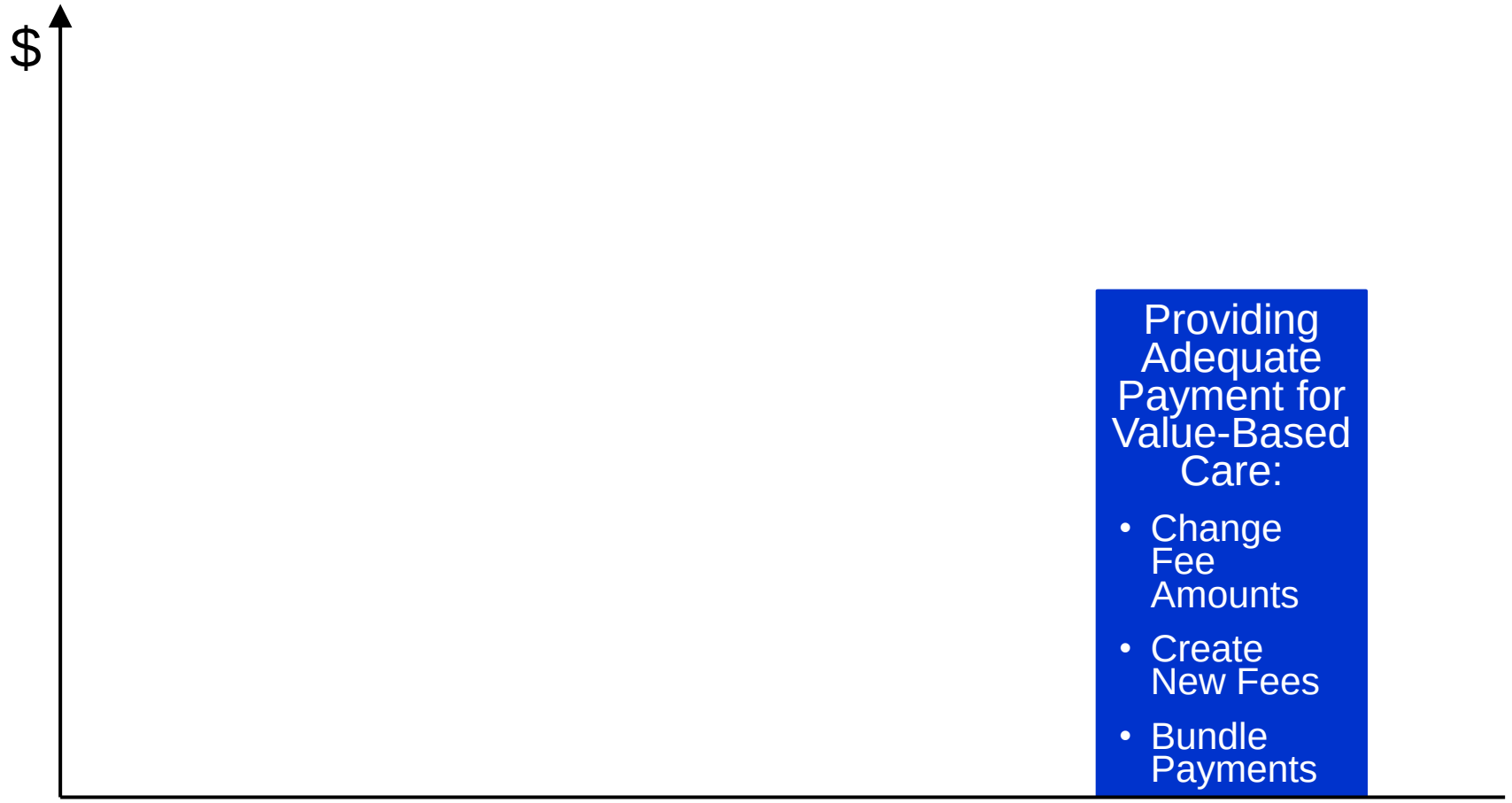
There Are (Only) Three Ways to Change Payments for Services



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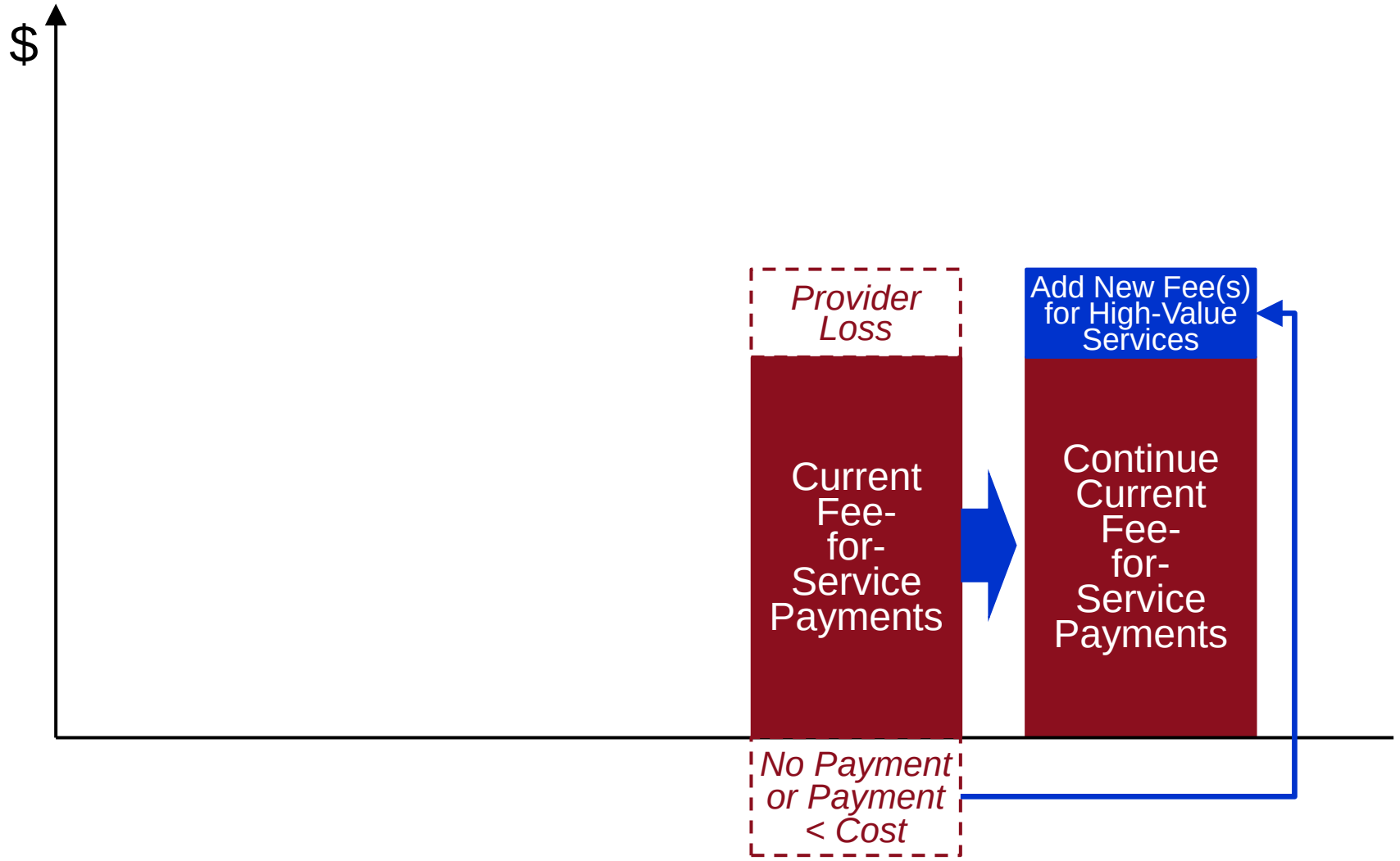
In Some Cases, New Fee(s) May Be Simplest/Best Approach



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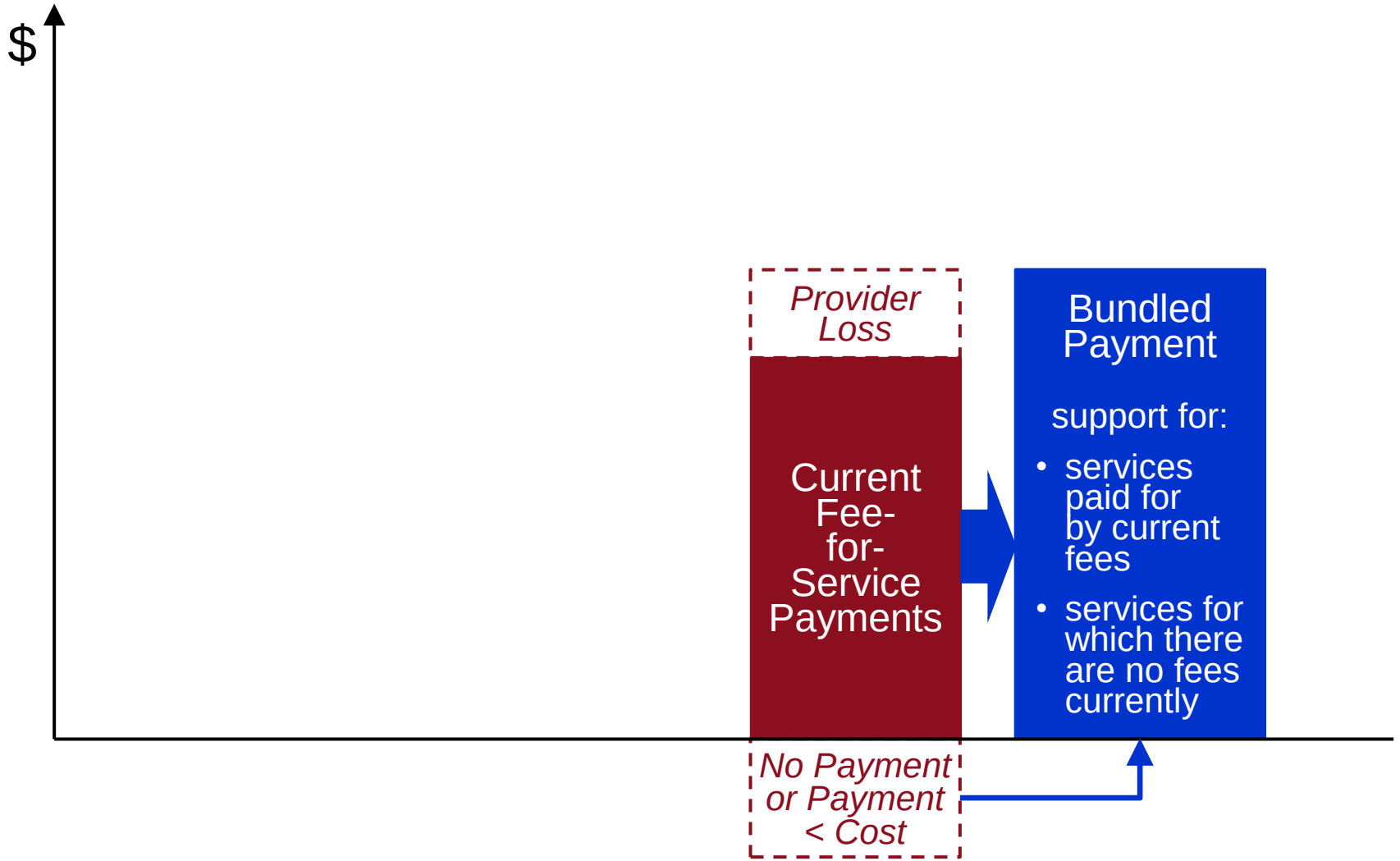
In Other Cases, a Bundled Payment is Most Appropriate



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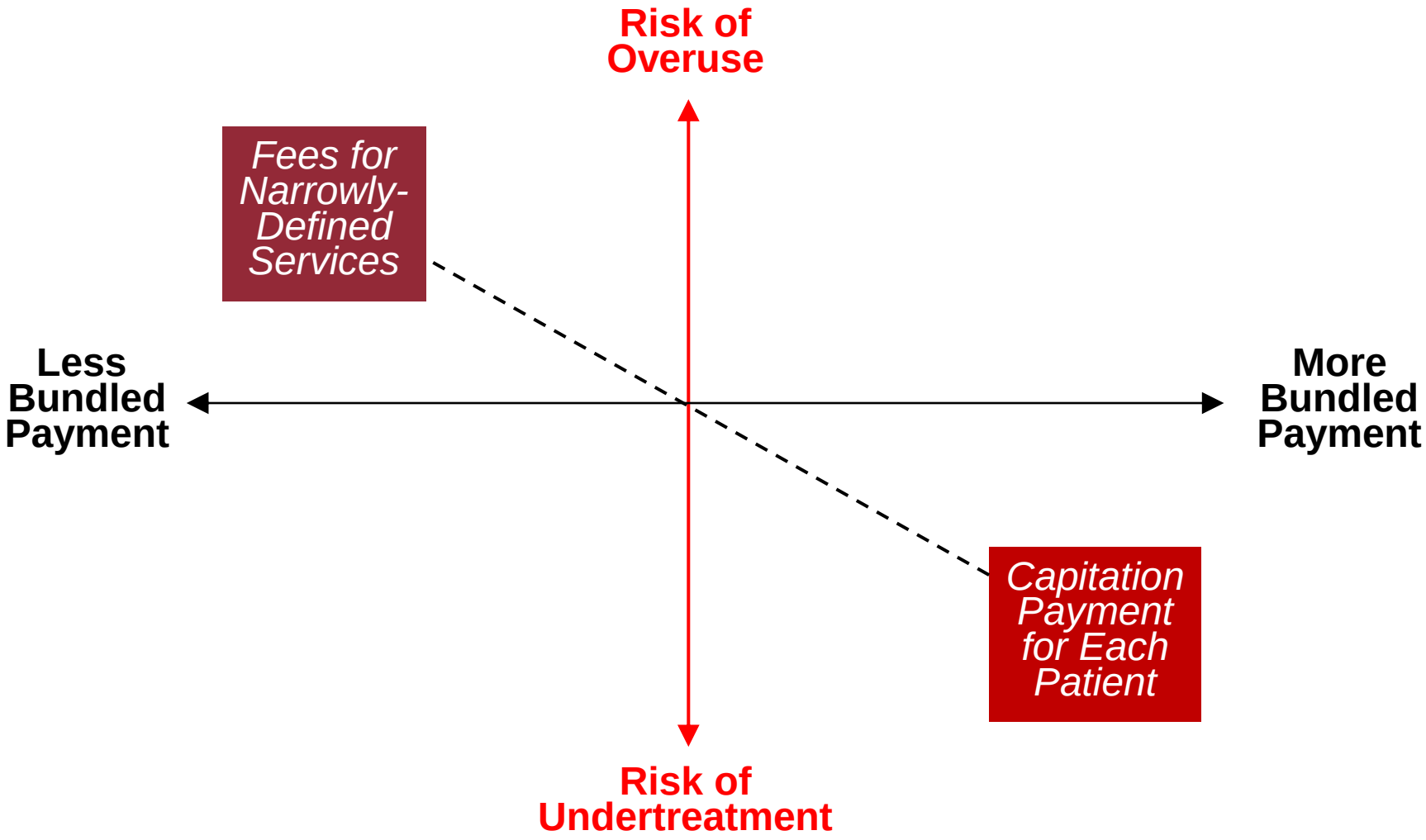
Too Little Bundling→ *Overuse*
Too Much→ *Undertreatment*



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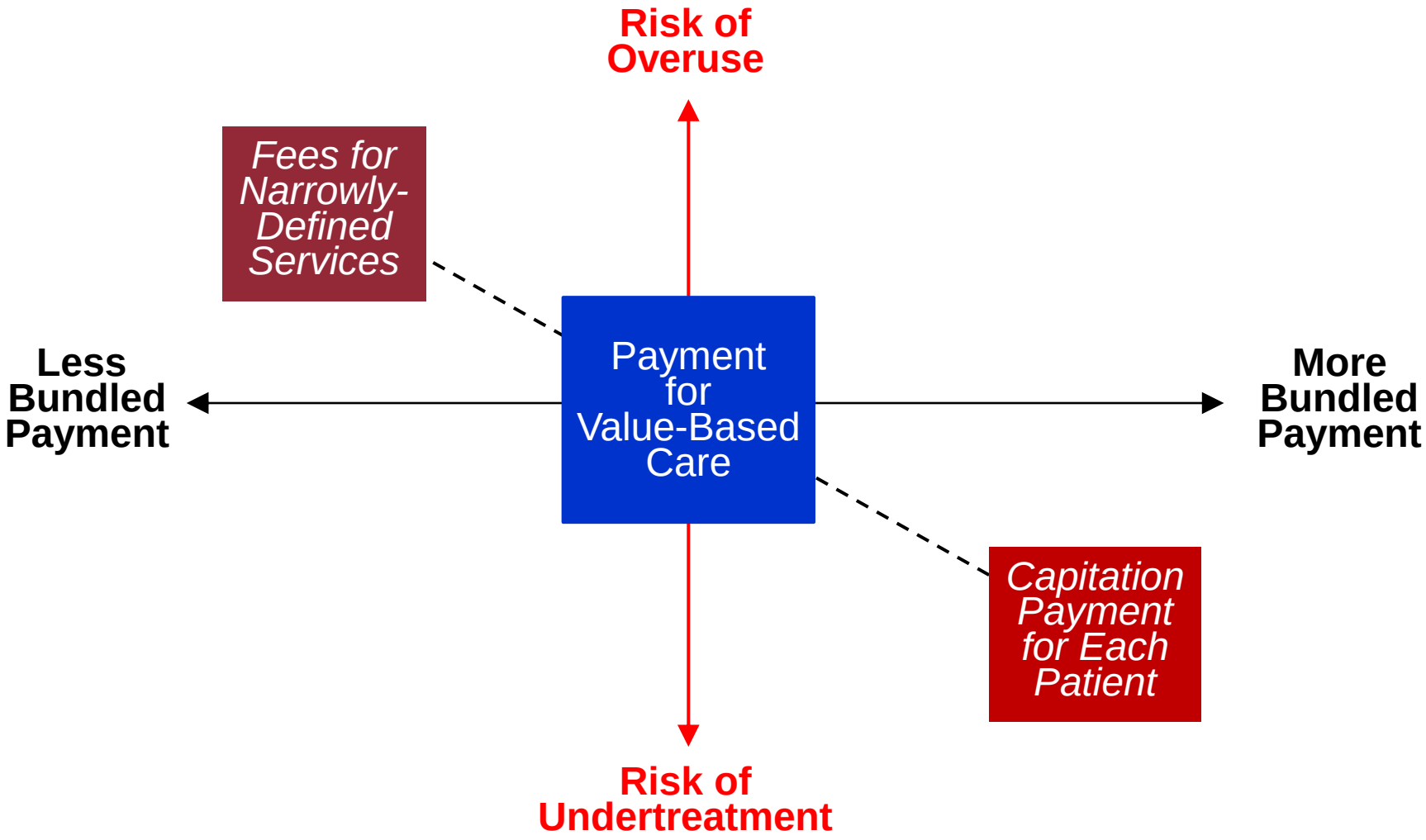
Good Value-Based Payment Has to Strike the Right Balance



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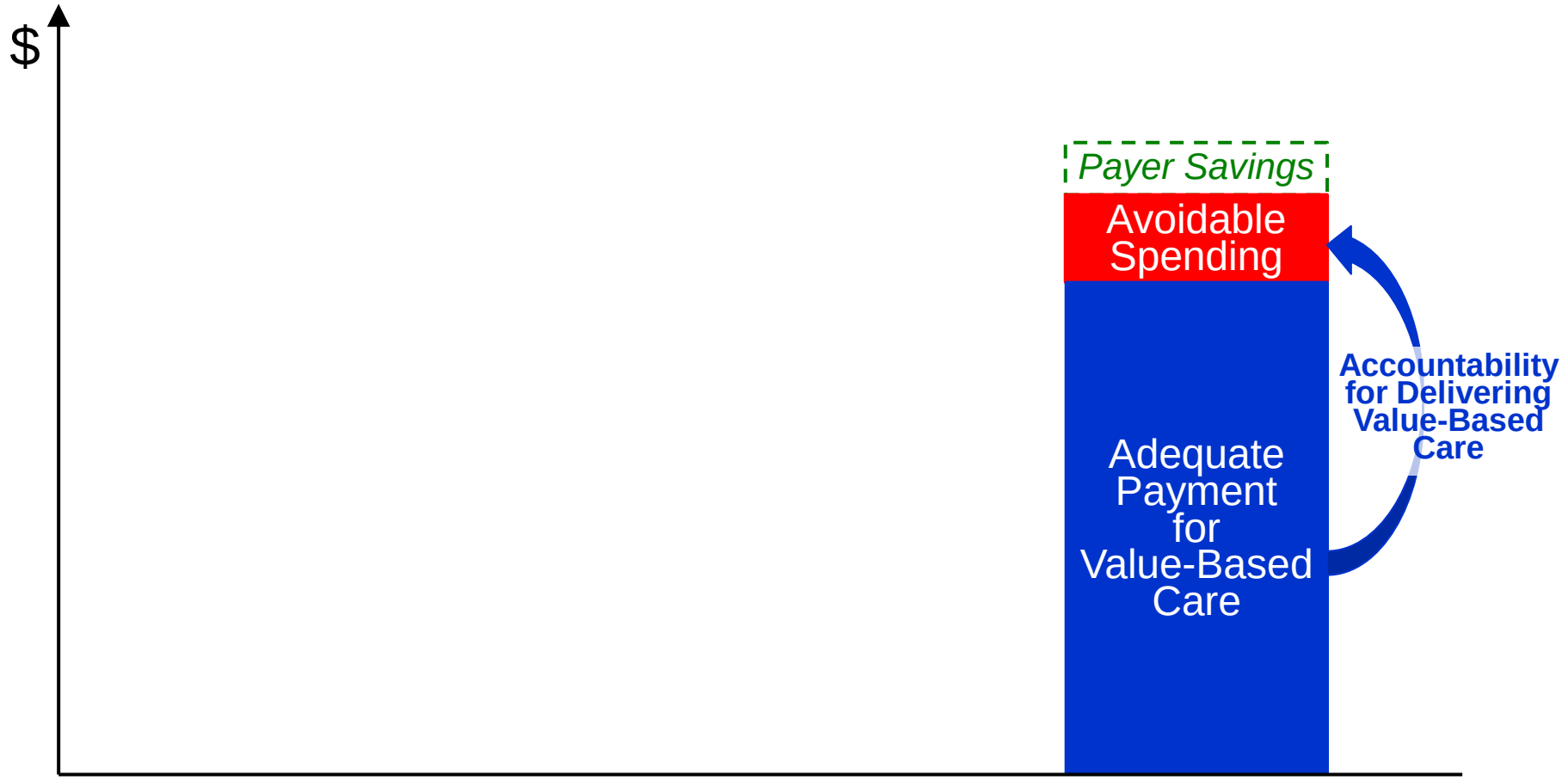
What (Exactly) Should Providers Be Held Accountable For?



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Fee-for-Service Pays for Services Regardless of the Outcome

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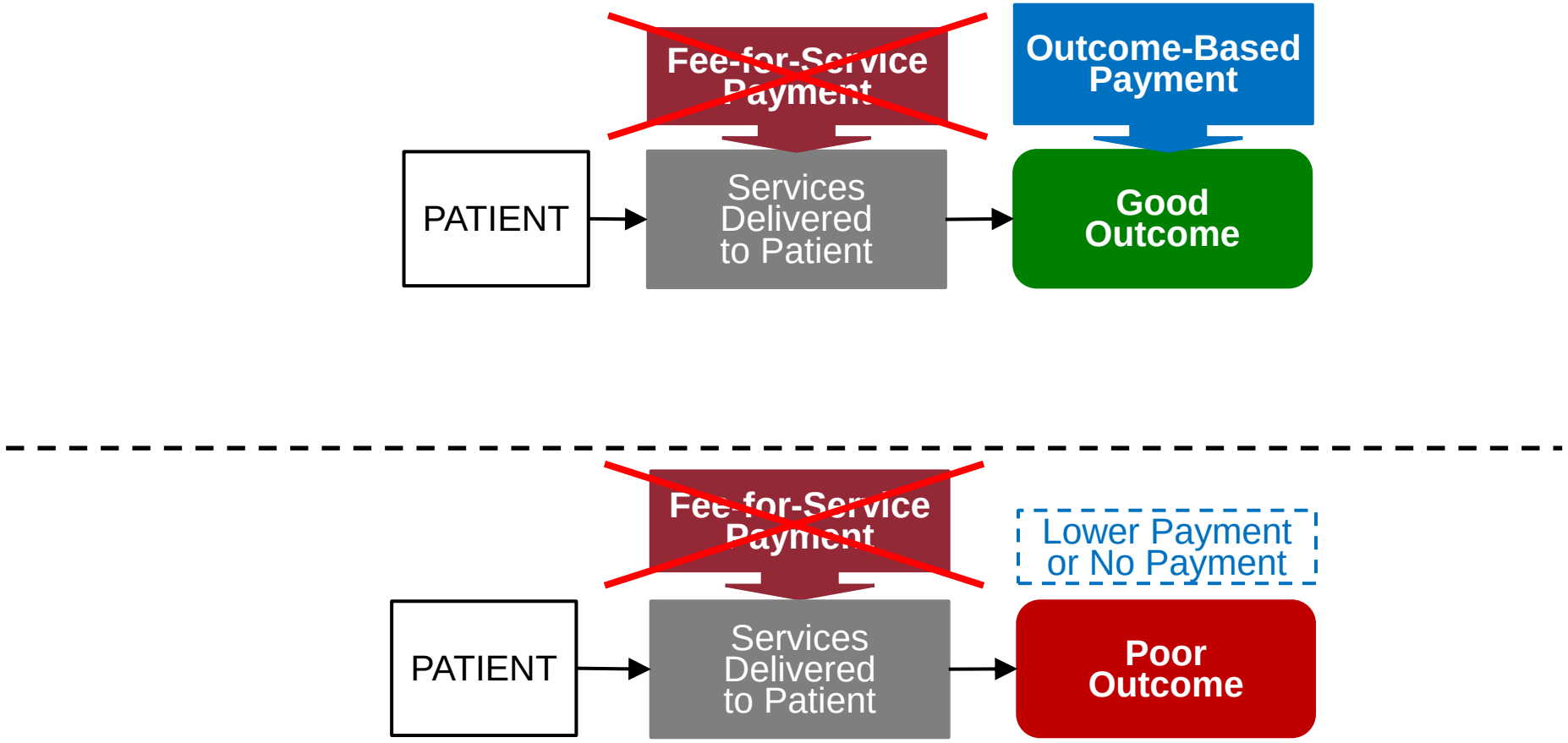
Should Value-Based Payment Tie Payments to Outcomes?



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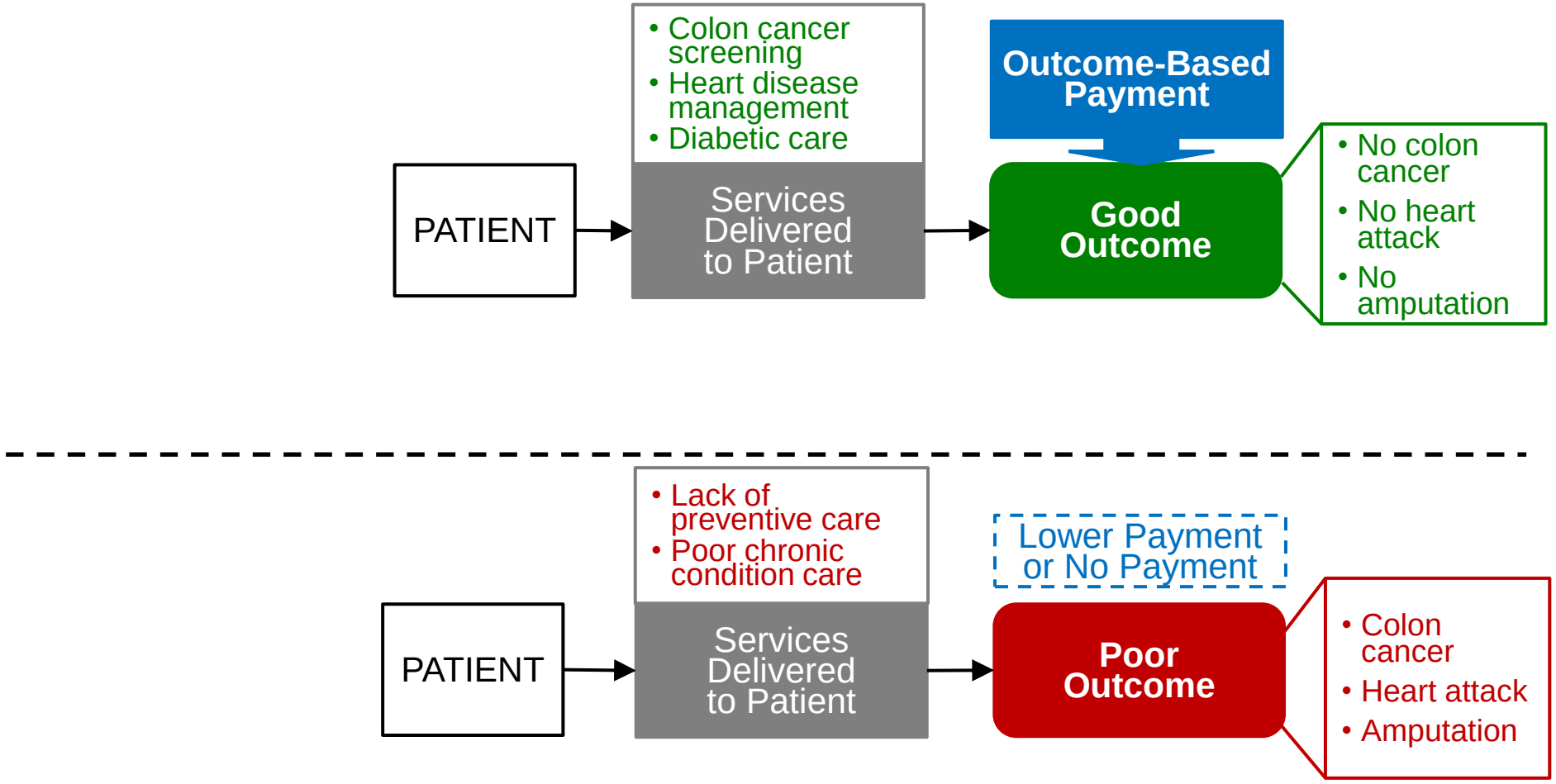
Problem #1: Outcomes Occur Long After Services Are Delivered



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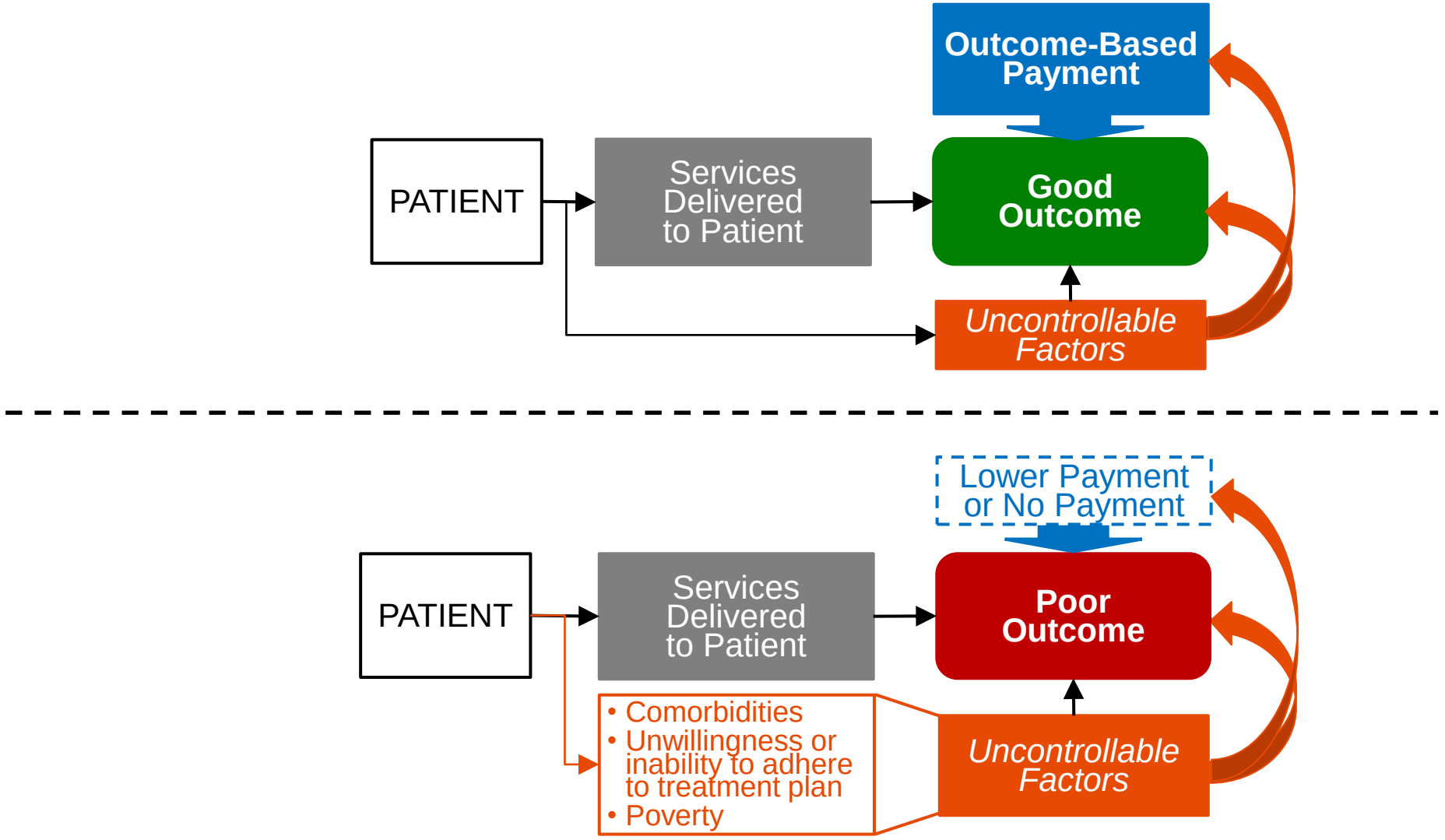
Problem #2: Outcomes Are Only Partially Controlled by Providers



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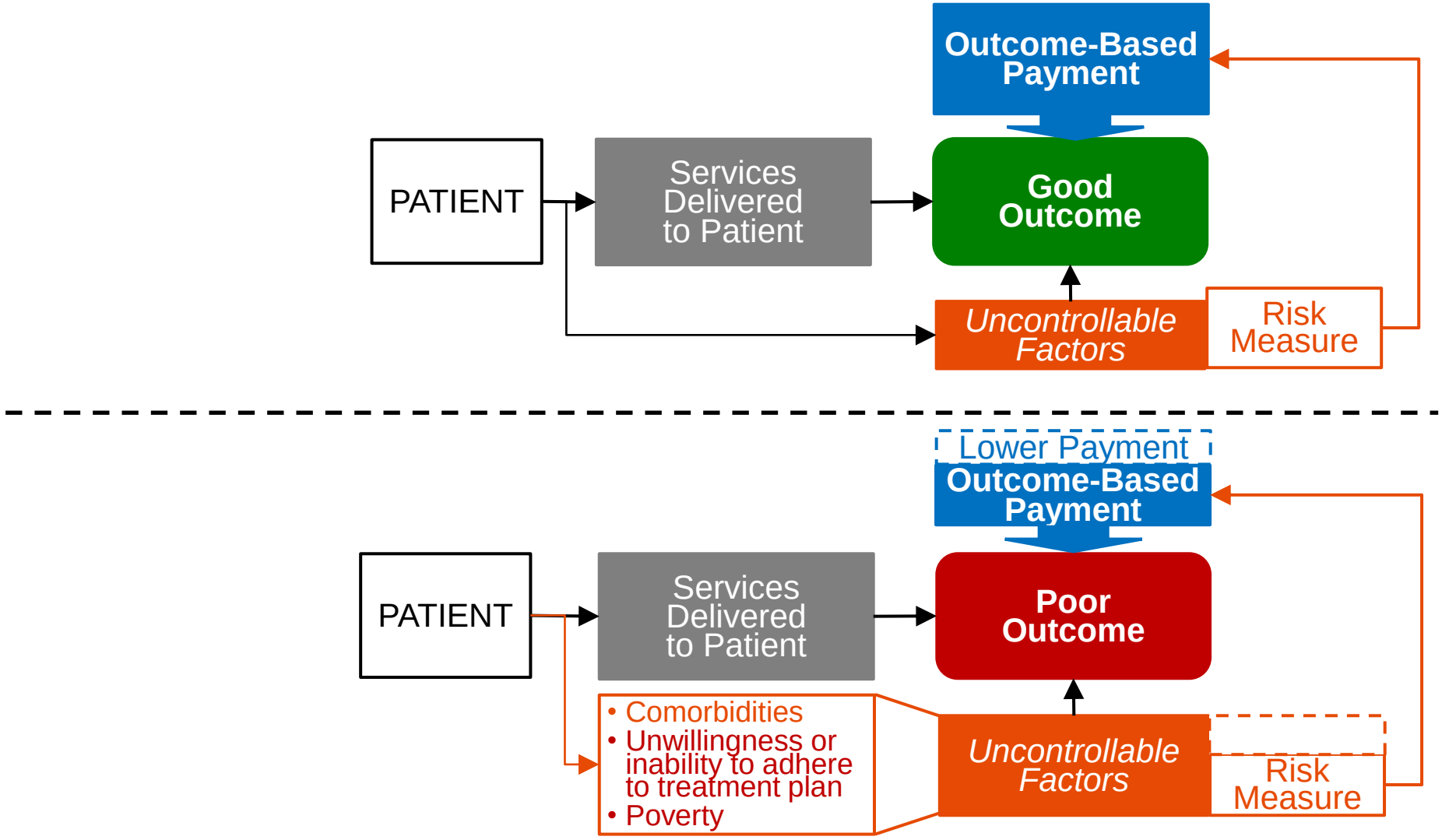
Problem #3: Risk Adjustment Fails to Adjust for All Key Factors



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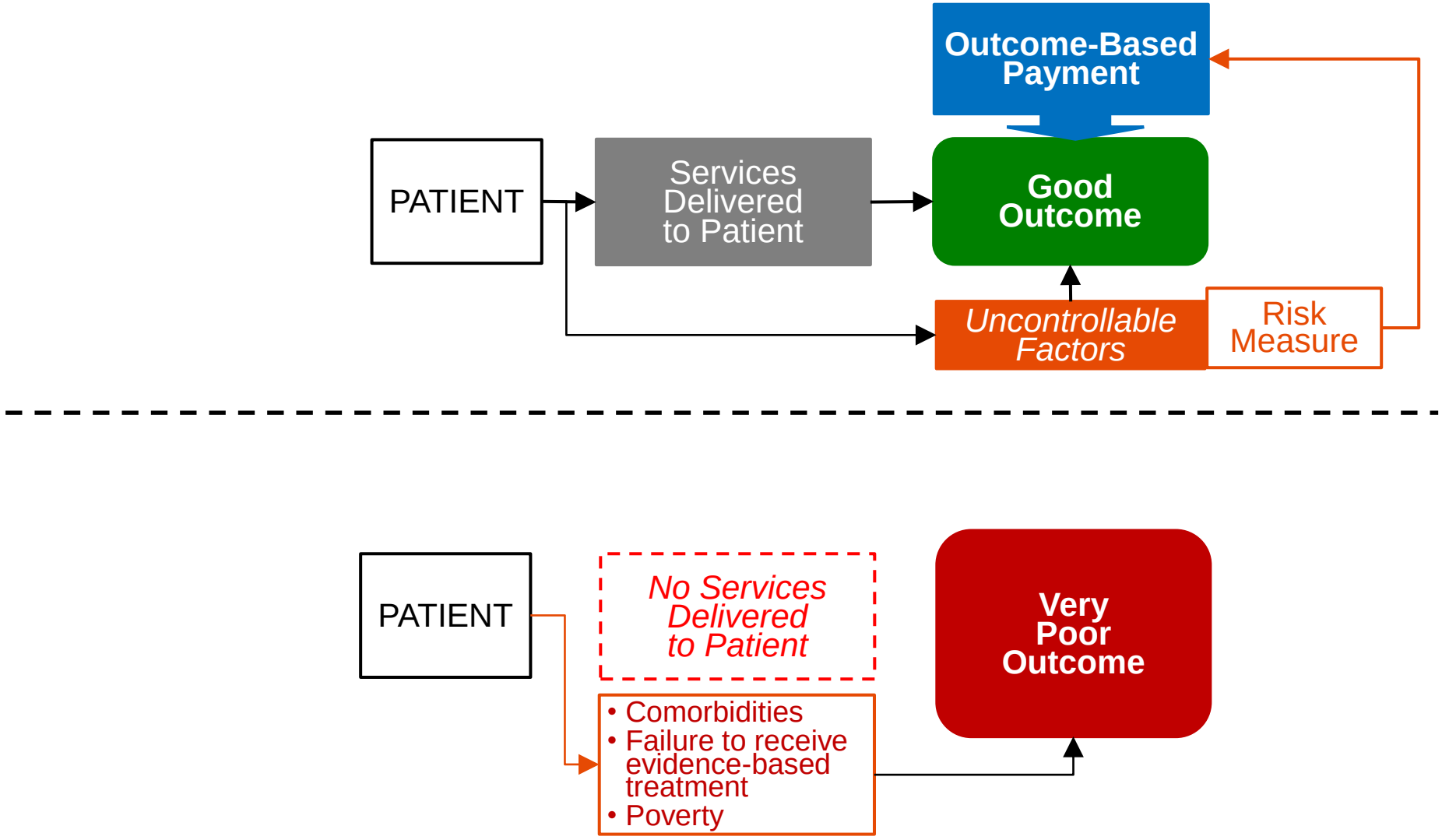
Problem #4: "Outcomes" Improve by Avoiding Higher-Risk Patients



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How Do Providers Actually Achieve Better Outcomes?

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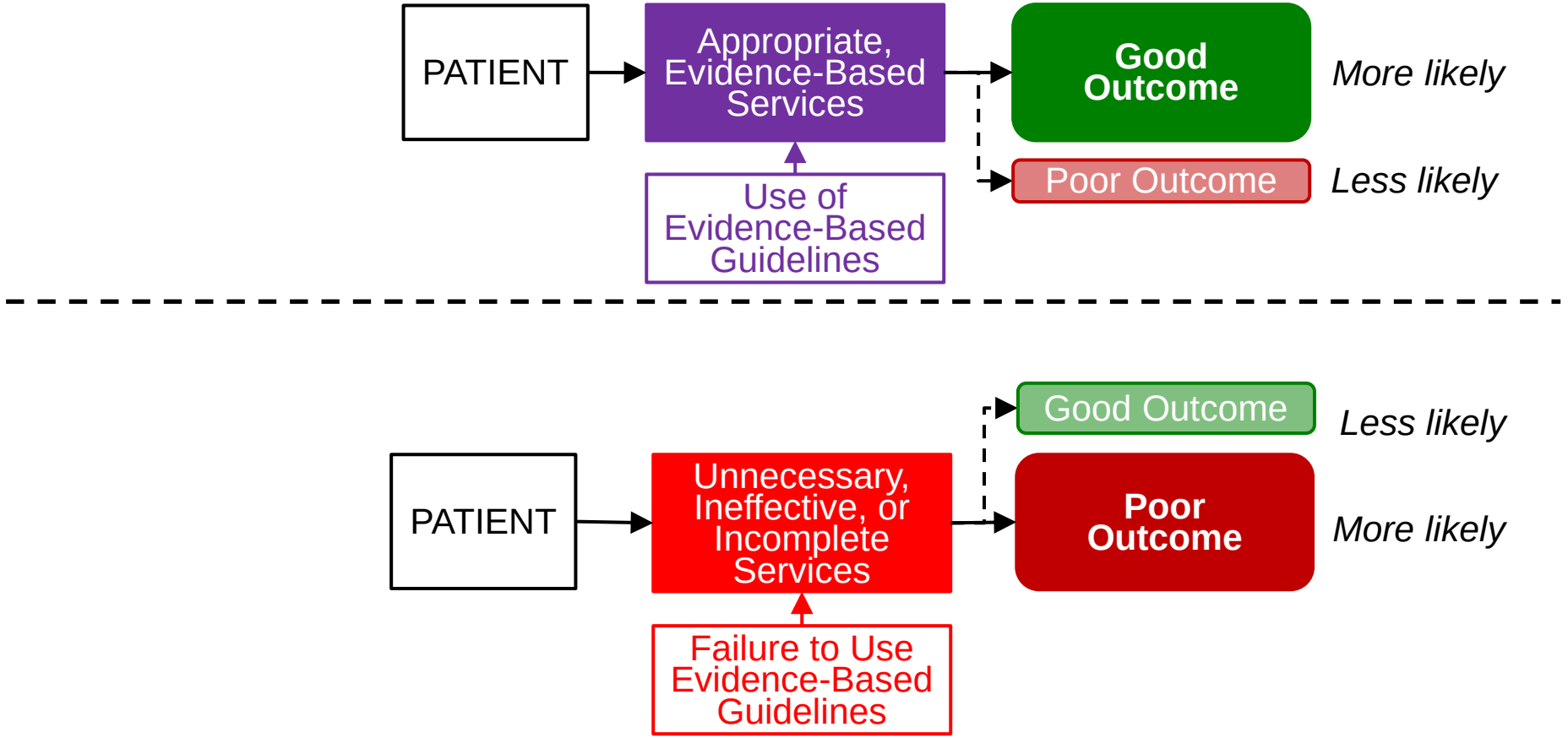
By Using Services That Evidence Shows Will Improve Outcomes



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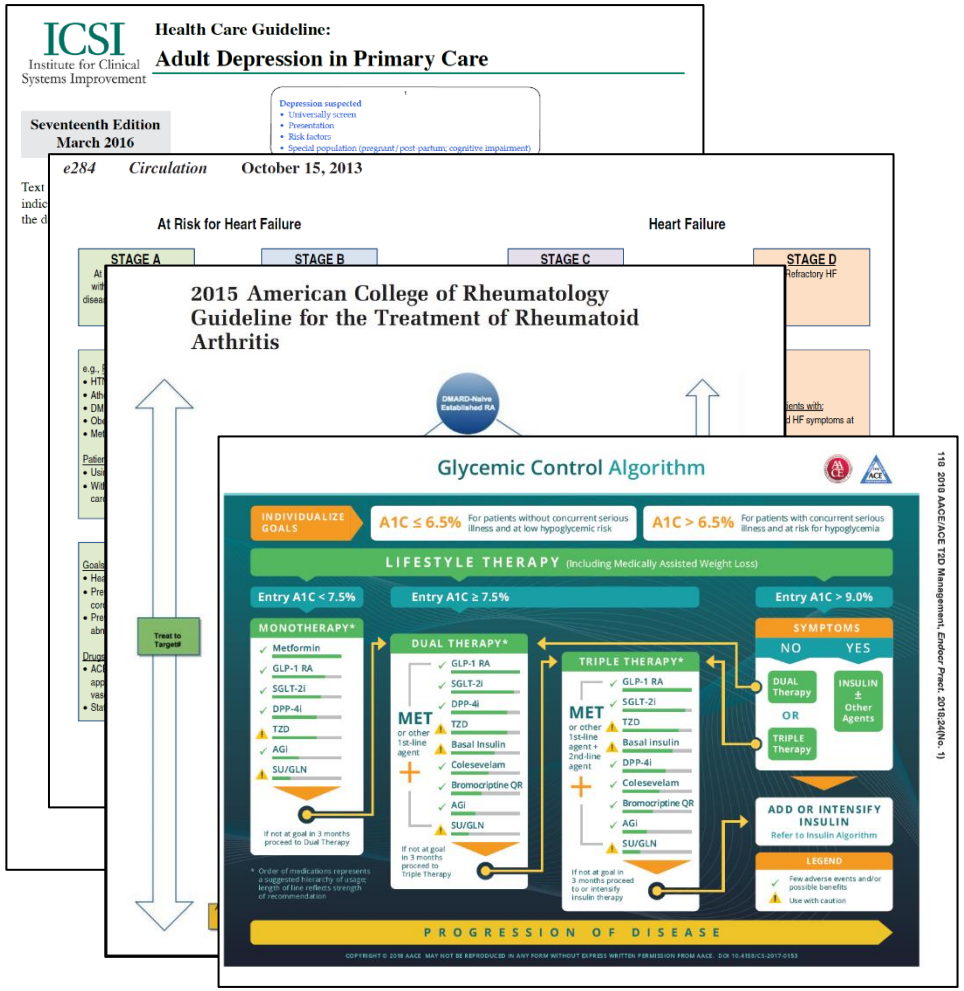
Guidelines Identify Which Services Will Improve Outcomes

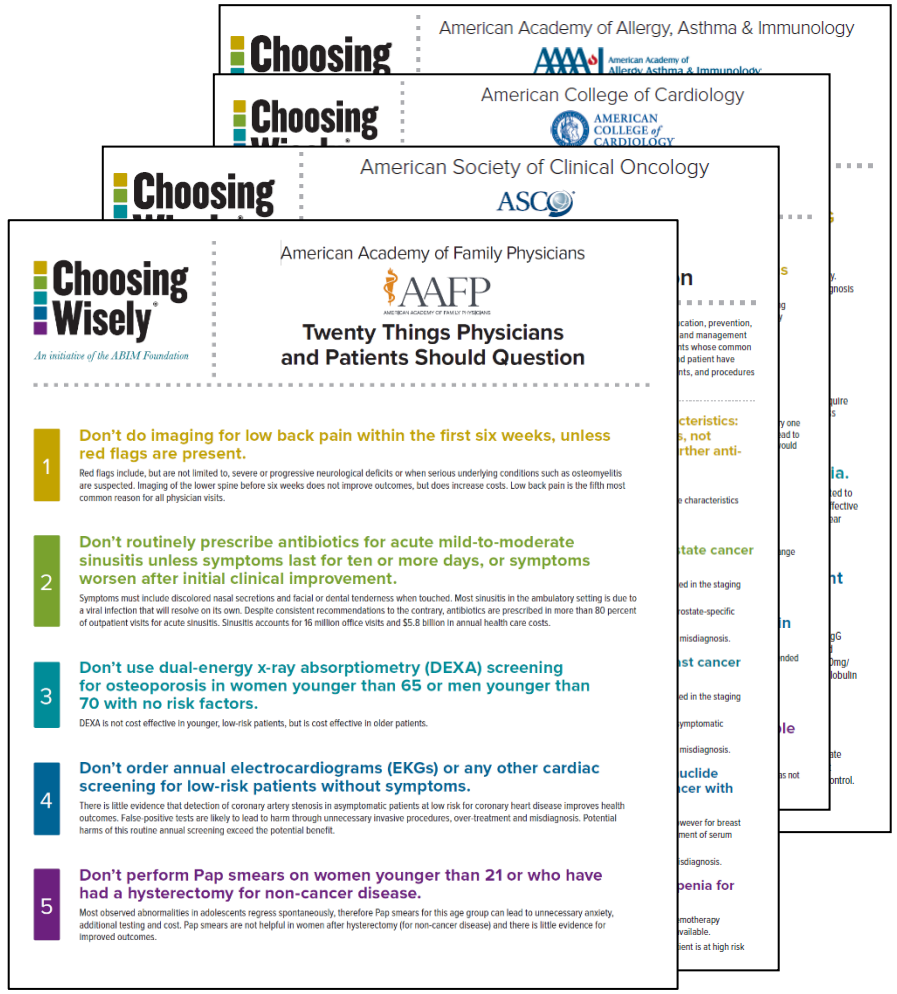
What Services *Should* Be Delivered



Guidelines Also Identify Ways to Reduce *Avoidable* Spending

What Services *Should* Be Delivered

What Services *Should Not* Be Delivered



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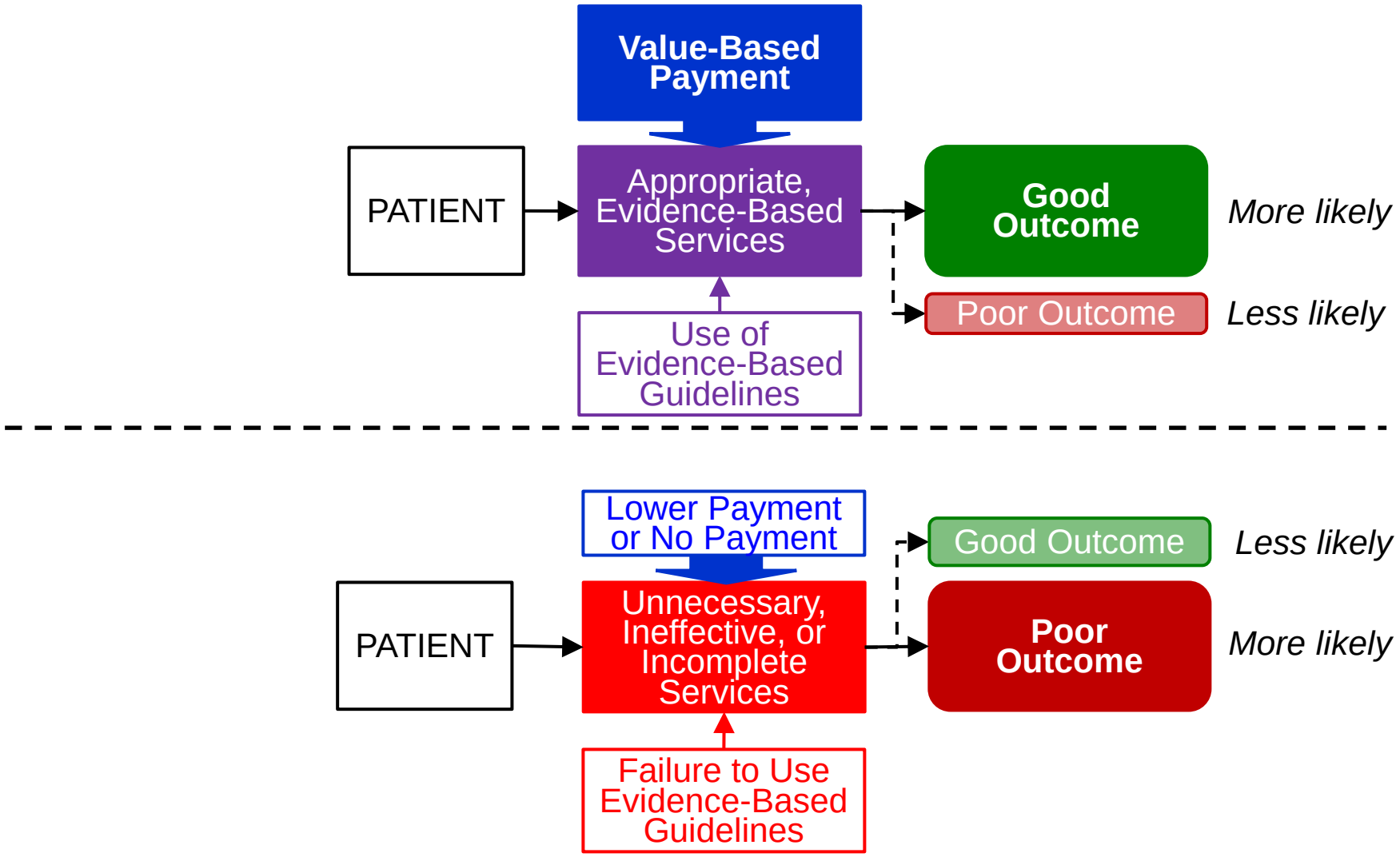
Value-Based *Payment* Should Pay for *Evidence-Based Care*



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How “Payment for Outcomes” Can Harm Patients & Providers

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

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Evaluating the Quality of Care for 3 Hypothetical Patients

PATIENT #1, #2, and #3

Standard Diabetes Outcome Measure: % of Diabetic Patients with HbA1c > 9.0			Quality of Care:	
HbA1c at Start of Year	→ Care Delivered During Year →	HbA1c at End of Year		

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Patient #1 Receives Appropriate Care and Improves Significantly

PATIENT #1

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

HbA1c at Start of Year	→ Care Delivered During Year →	HbA1c at End of Year	Quality of Care:	
13.0	Patient receives all appropriate evidence-based care	10.0		

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Diabetes Outcome Measure Ignores the Patient's Improvement

PATIENT #1

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

HbA1c at Start of Year	→ Care Delivered During Year →	HbA1c at End of Year	Quality of Care: According to the Measure:	
13.0	Patient receives all appropriate evidence-based care	10.0	Poor quality	

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

PATIENT #1

Standard Diabetes Outcome Measure: % of Diabetic Patients with HbA1c > 9.0			Quality of Care:	
HbA1c at Start of Year	**Care Delivered During Year**	**HbA1c at End of Year**	**According to the Measure:**	**In Reality:**
13.0	Patient receives all appropriate evidence-based care	10.0	Poor quality	Good quality

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Patient #2 Receives Poor Care and HbA1c Worsens

PATIENT #2

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

HbA1c at Start of Year	Care Delivered During Year	HbA1c at End of Year	Quality of Care: According to the Measure:	Quality of Care: In Reality:
7.0	Patient does not receive evidence-based care	8.5		

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Diabetes Outcome Measure Ignores the Patient's Deterioration

PATIENT #2

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

HbA1c at Start of Year	Care Delivered During Year	HbA1c at End of Year	Quality of Care: According to the Measure:	Quality of Care: In Reality:
7.0	Patient does not receive evidence-based care	8.5	Good quality	

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In Reality, The Patient Should Have Received Much Better Care

PATIENT #2

Standard Diabetes Outcome Measure: % of Diabetic Patients with HbA1c > 9.0			Quality of Care:	
HbA1c at Start of Year	**Care Delivered During Year**	**HbA1c at End of Year**	**According to the Measure:**	**In Reality:**
7.0	Patient does not receive evidence-based care	8.5	Good quality	Poor quality

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Patient #3 Can't Afford Diabetes Medications

PATIENT #3

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

HbA1c at Start of Year	Care Delivered During Year	HbA1c at End of Year	Quality of Care: According to the Measure:	Quality of Care: In Reality:
10.0	Patient cannot afford to take medications needed for diabetes but primary care practice helps patient avoid getting worse	10.0		

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Diabetes Outcome Measure Ignores What Is Feasible

PATIENT #3

Standard Diabetes Outcome Measure: % of Diabetic Patients with HbA1c > 9.0			Quality of Care:	
HbA1c at Start of Year	**Care Delivered During Year**	**HbA1c at End of Year**	**According to the Measure:**	**In Reality:**
10.0	Patient cannot afford to take medications needed for diabetes but primary care practice helps patient avoid getting worse	10.0	Poor quality	

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In Reality, The Patient Likely Received the Best Care Possible

PATIENT #3

Standard Diabetes Outcome Measure: % of Diabetic Patients with HbA1c > 9.0			Quality of Care:	
HbA1c at Start of Year	**Care Delivered During Year**	**HbA1c at End of Year**	**According to the Measure:**	**In Reality:**
10.0	Patient cannot afford to take medications needed for diabetes but primary care practice helps patient avoid getting worse	10.0	Poor quality	Best quality feasible for patient

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The Outcome Measure Gives the *Wrong Result* in Each Case

Standard Diabetes Outcome Measure: % of Diabetic Patients with HbA1c > 9.0			**Quality of Care:**	
HbA1c at Start of Year	**Care Delivered During Year**	**HbA1c at End of Year**	**According to the Measure:**	**In Reality:**
13.0	Patient receives all appropriate evidence-based care	10.0	Poor quality	Good quality
7.0	Patient does not receive evidence-based care	8.5	Good quality	Poor quality
10.0	Patient cannot afford to take medications needed for diabetes but primary care practice helps patient avoid getting worse	10.0	Poor quality	Good quality

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Outcome-Based Payment Would Reward the Wrong Thing

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

HbA1c at Start of Year	→ Care Delivered During Year →	HbA1c at End of Year	Quality of Care: Outcome-Based Payment	Quality of Care: In Reality:
13.0	Patient receives all appropriate evidence-based care	10.0	Poor quality	Good quality
7.0	Patient does not receive evidence-based care	8.5	Good quality	Poor quality
10.0	Patient cannot afford to take medications needed for diabetes but primary care practice helps patient avoid getting worse	10.0	Poor quality	Good quality

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True Value-Based Payment Should Pay for *Evidence-Based Care*

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

HbA1c at Start of Year	Care Delivered During Year	HbA1c at End of Year	Quality of Care: Outcome-Based Payment	Quality of Care: Payment for Evidence-Based Care
13.0	Patient receives all appropriate evidence-based care	10.0	Poor quality	Good quality
7.0	Patient does not receive evidence-based care	8.5	Good quality	Poor quality
10.0	Patient cannot afford to take medications needed for diabetes but primary care practice helps patient avoid getting worse	10.0	Poor quality	Good quality

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Many Important Outcomes Are Not *Controllable* by Providers

Outcomes *Inappropriate* for Provider Accountability

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

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Delivering Evidence-Based Care is Best Way to Improve Outcomes

Outcomes *Inappropriate* for Provider Accountability

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

Payment for *Evidence-Based Care*

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

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Some Outcomes *Can* Be Controlled by Providers

Outcomes *Inappropriate* for Provider Accountability

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

Outcomes *Appropriate* for Provider Accountability

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

Payment for *Evidence-Based Care*

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

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Use Outcome-Based Payments If Outcomes Can Be *Controlled*

Outcomes *Inappropriate* for Provider Accountability

- Vital signs or test scores affected by patient access to medications, patient adherence, or other factors outside clinician control (e.g., HbA1c level, blood pressure)
- Remission of cancer and other diseases where success is not routinely achieved
- Complications caused by services ordered or delivered by other providers
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Payment for *Evidence-Based Care*

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

Payment for Controllable *Outcomes*

- Warranty for complications (i.e., no additional payment to treat avoidable complications)
- No payment if controllable outcome is not achieved

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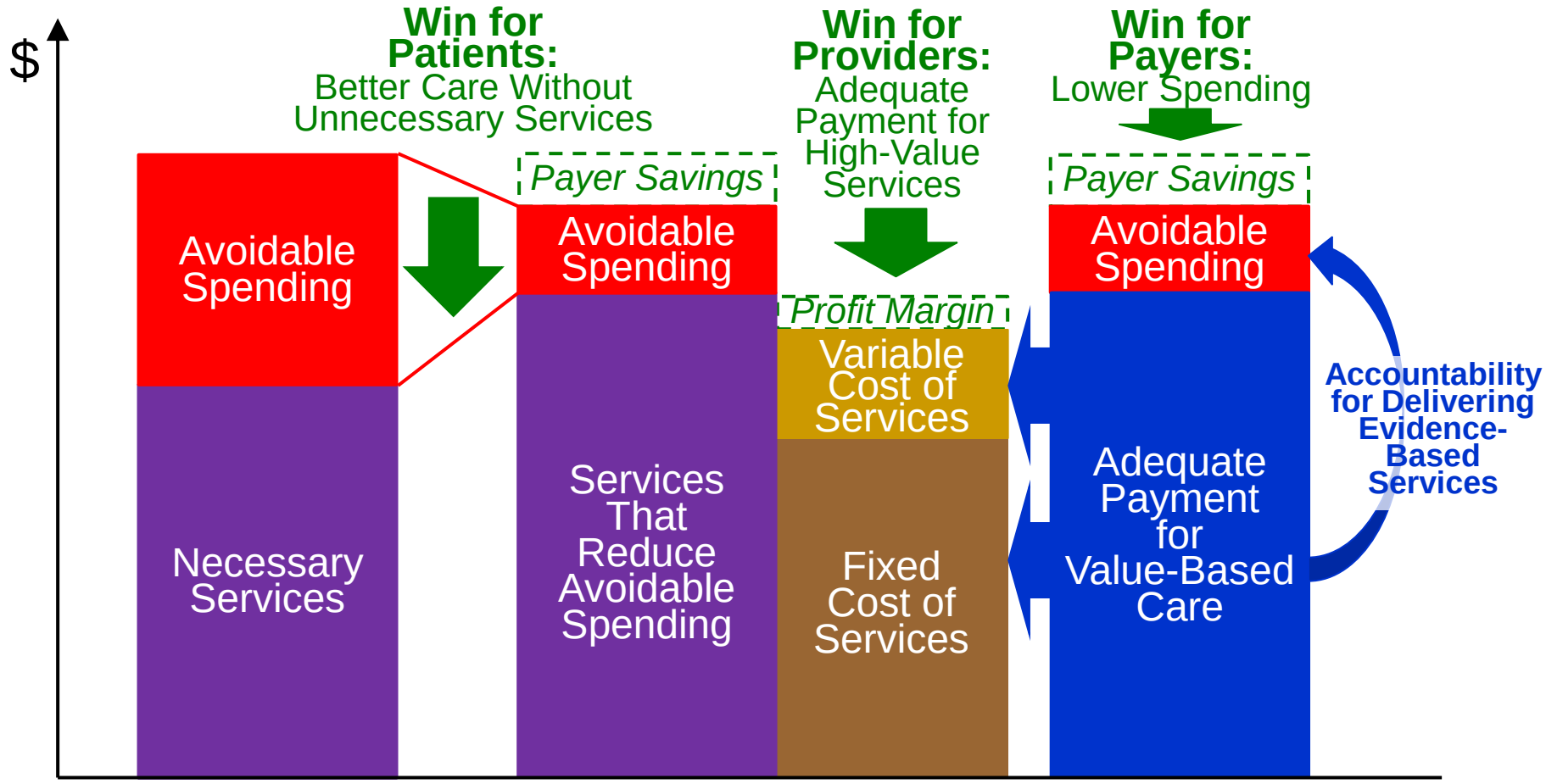
Goal: Payments That Work for Patients, Providers, & Payers



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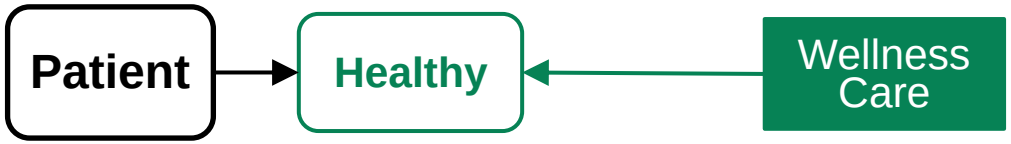
What Would a *Comprehensive*, *Patient-Centered,* Value-Based Care and Payment System Look Like?

Priority #1: Provide the Services Needed to Keep Patients Healthy

Patient-Specific *Needs*

Patient-Centered *Care*



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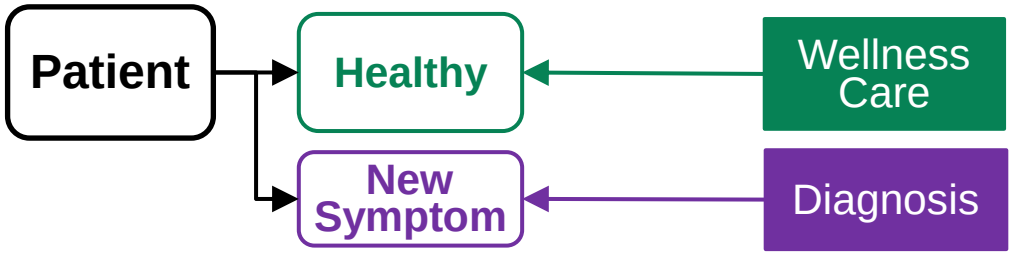
#2: Support Accurate Diagnosis When New Problems Appear

Patient-Specific *Needs*

Patient-Centered *Care*



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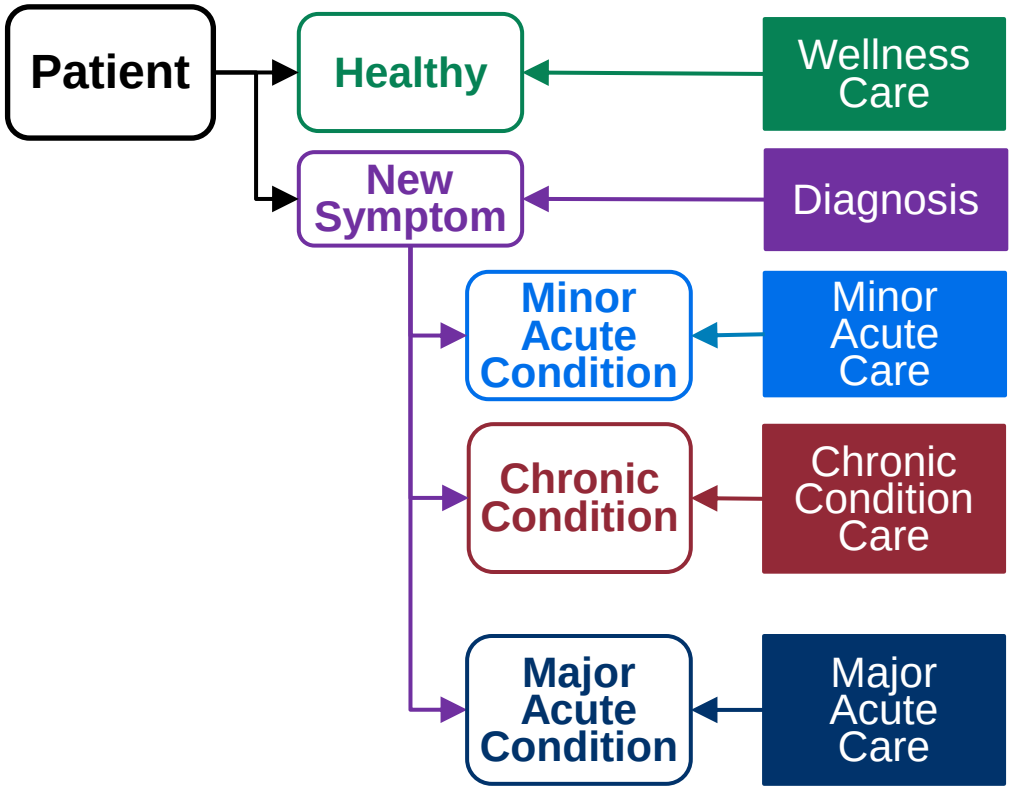
#3: Provide Appropriate Care for the Patient's Condition

Patient-Specific *Needs* **Patient-Centered *Care***



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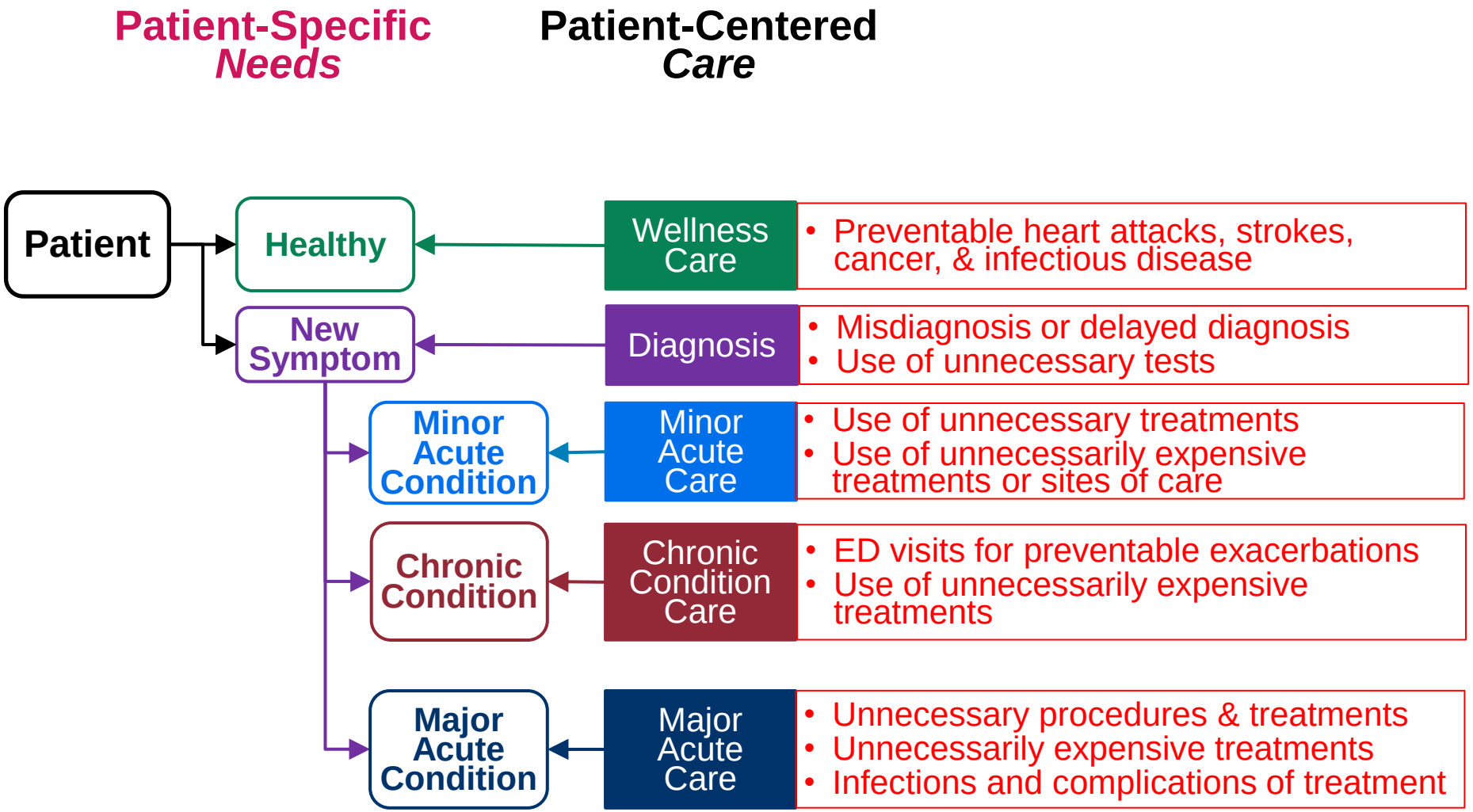
Opportunities to Improve Outcomes & Reduce Spending in Each Area



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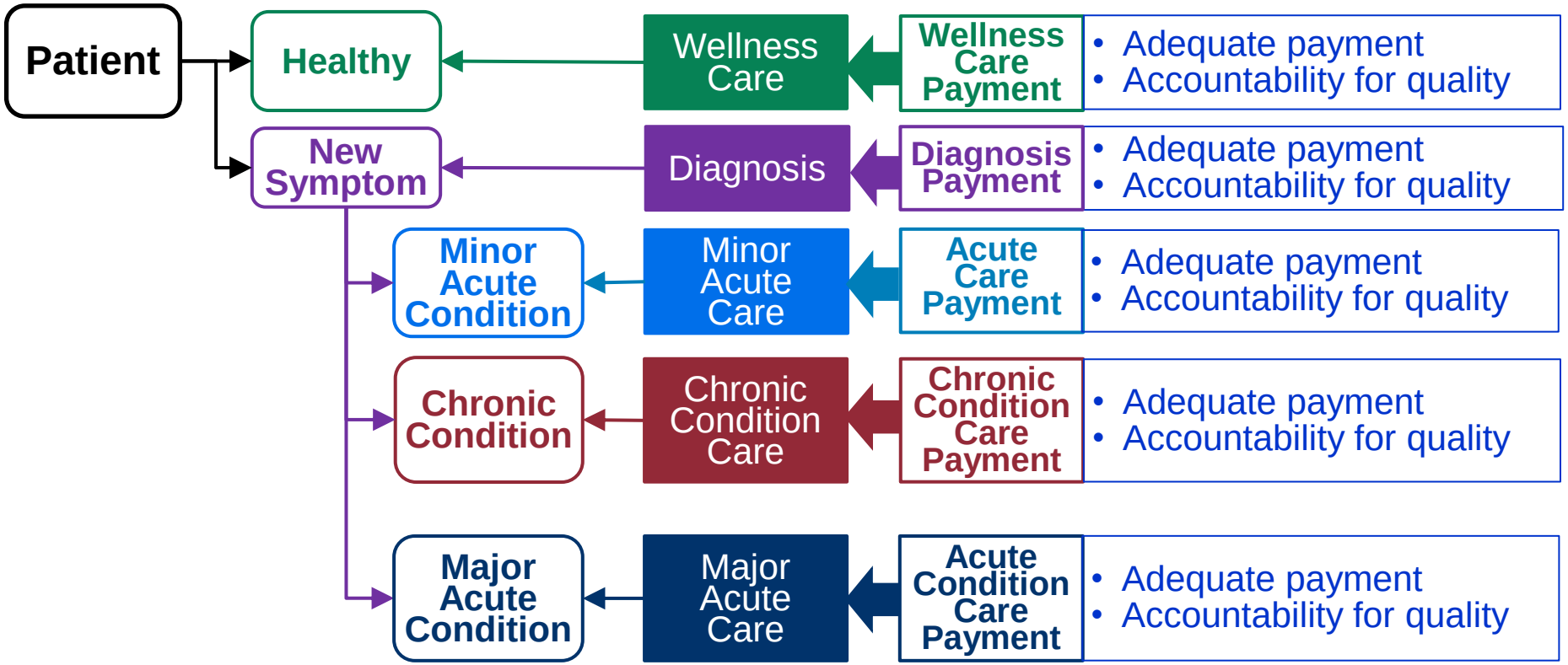
Separate Value-Based Payments Needed for Each Type of Care

Patient-Specific *Needs*

Patient-Centered *Care & Payment*



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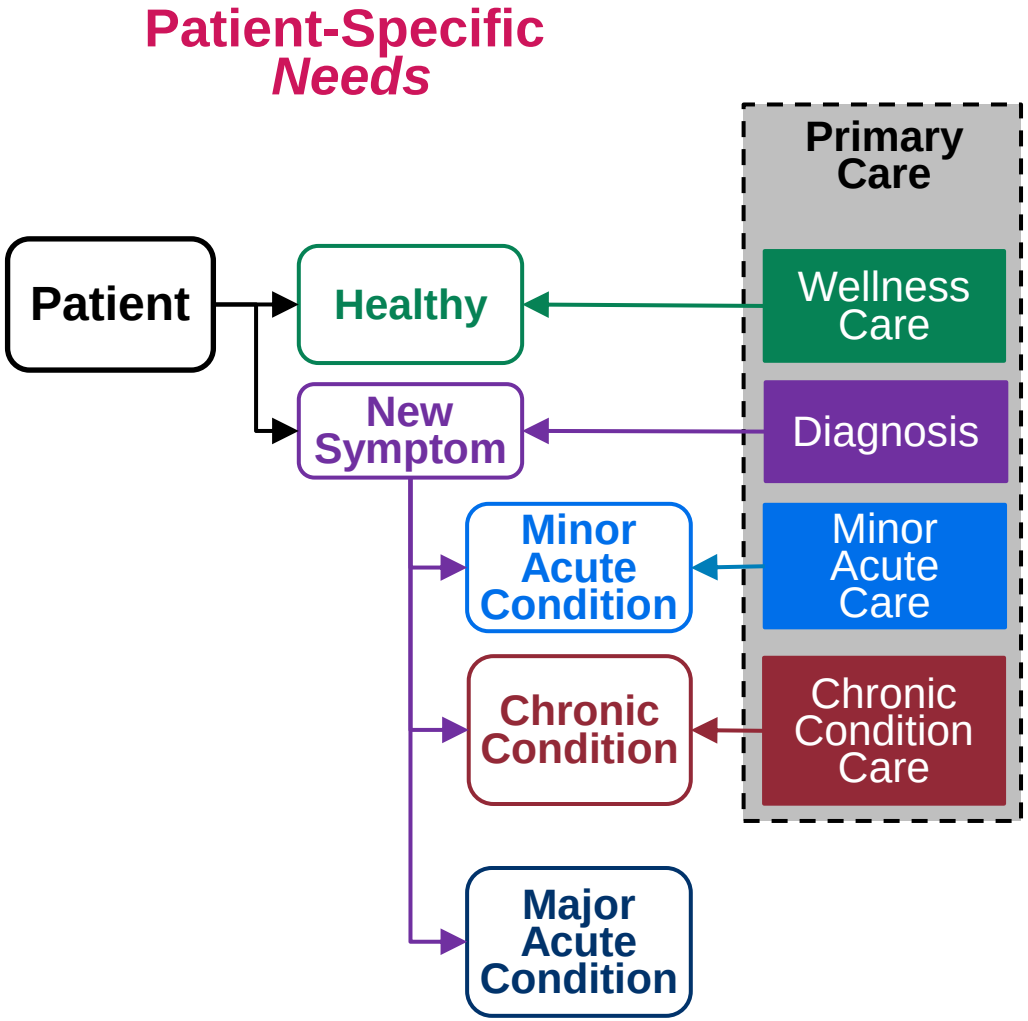
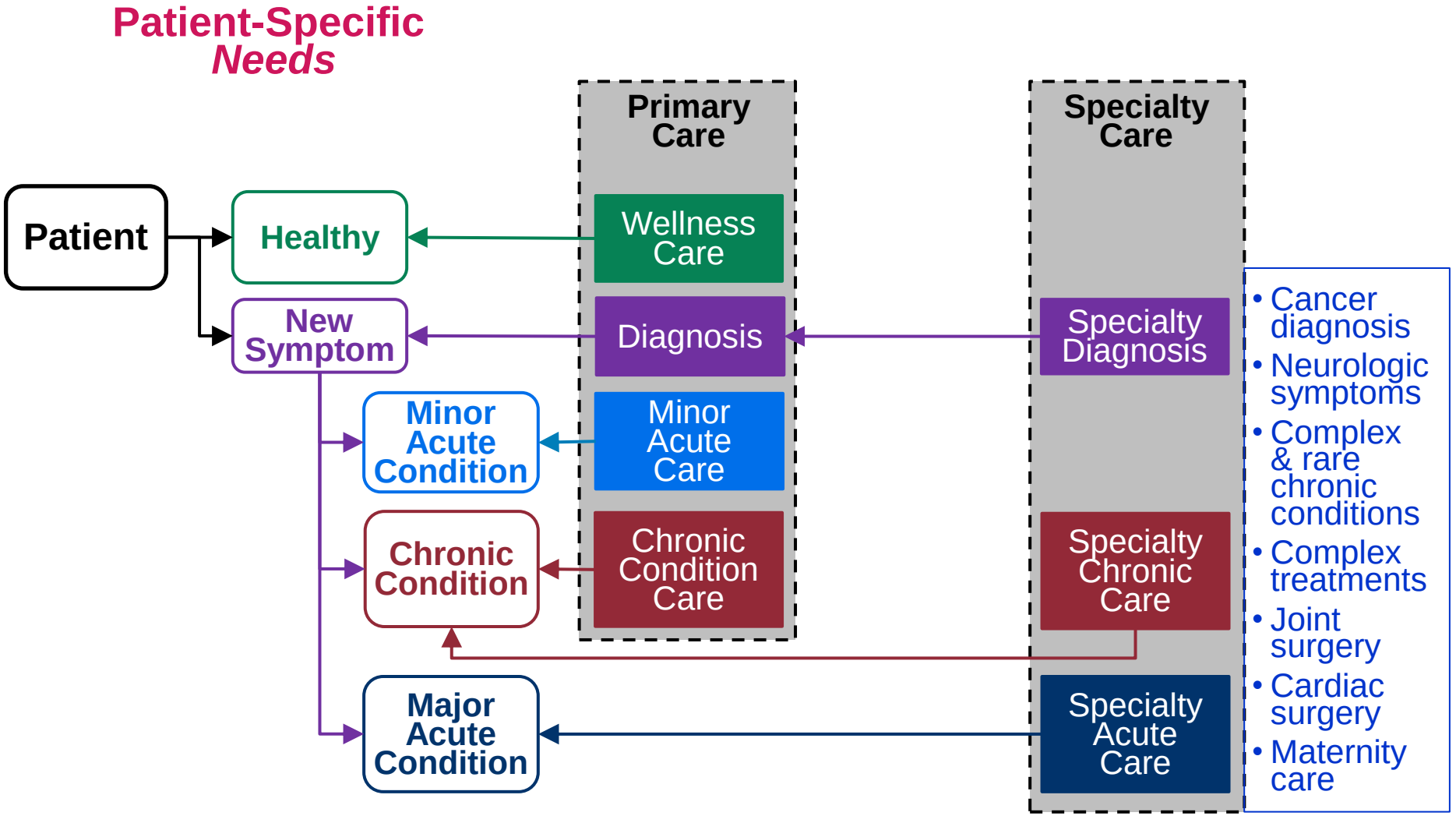
Many Services Can & Should Be Delivered by Primary Care



Specialty Care Will Be Needed for Many Patients & Conditions



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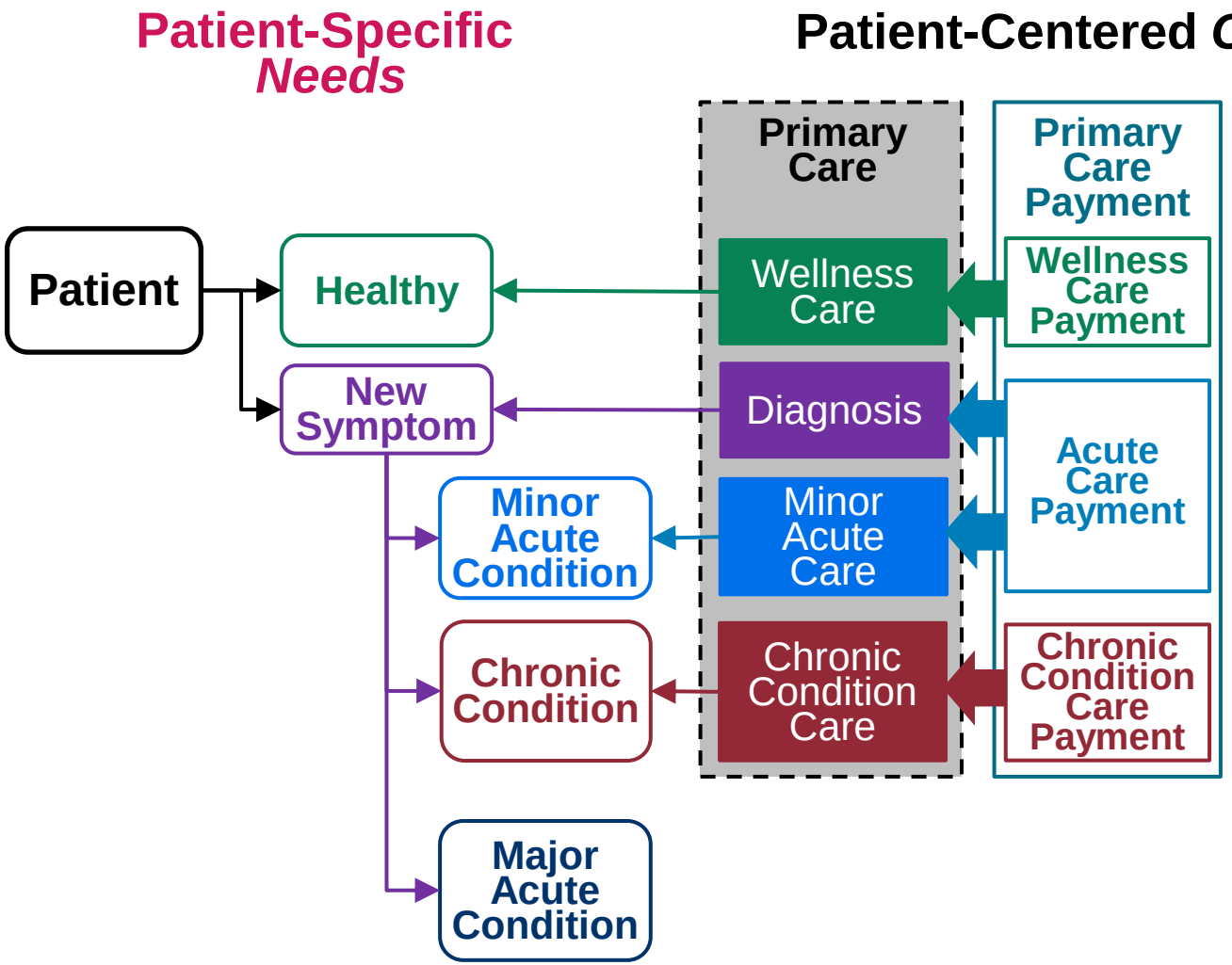
We Need Primary Care Payment That Supports Good Primary Care



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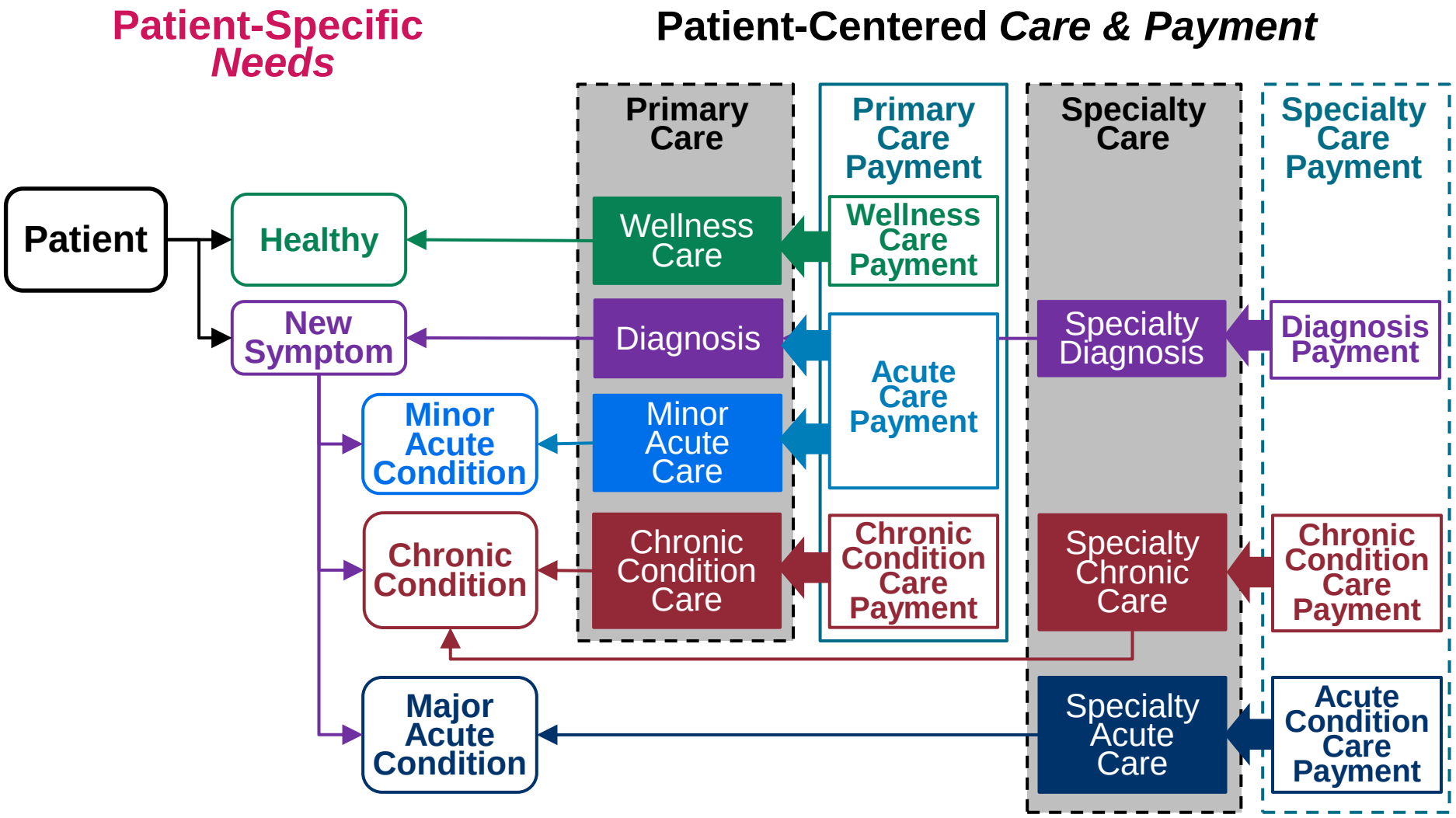
We Also Need to Pay Specialists Appropriately for High-Quality Care



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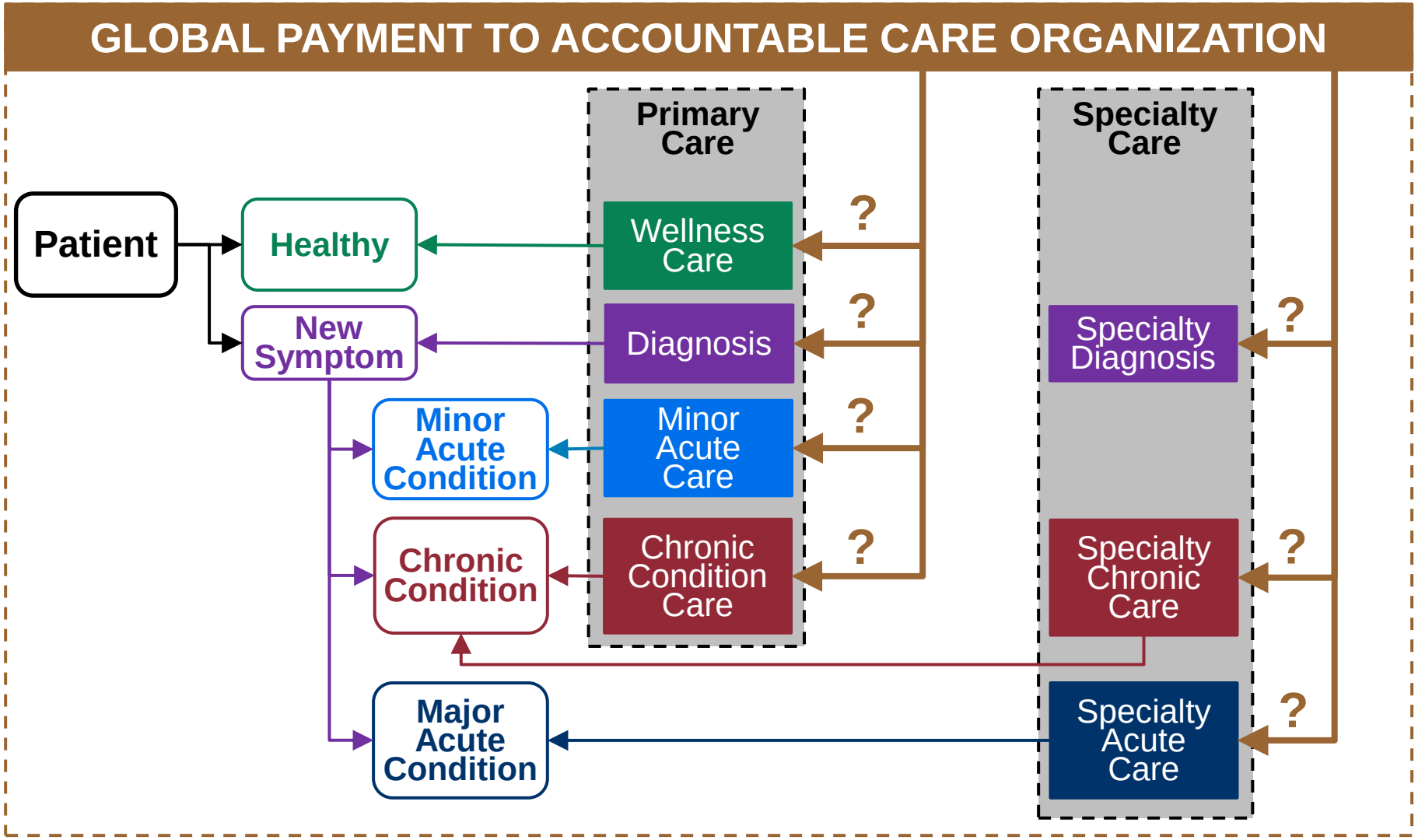
"Global" Payments Don't Solve the Problem of How to Pay Providers



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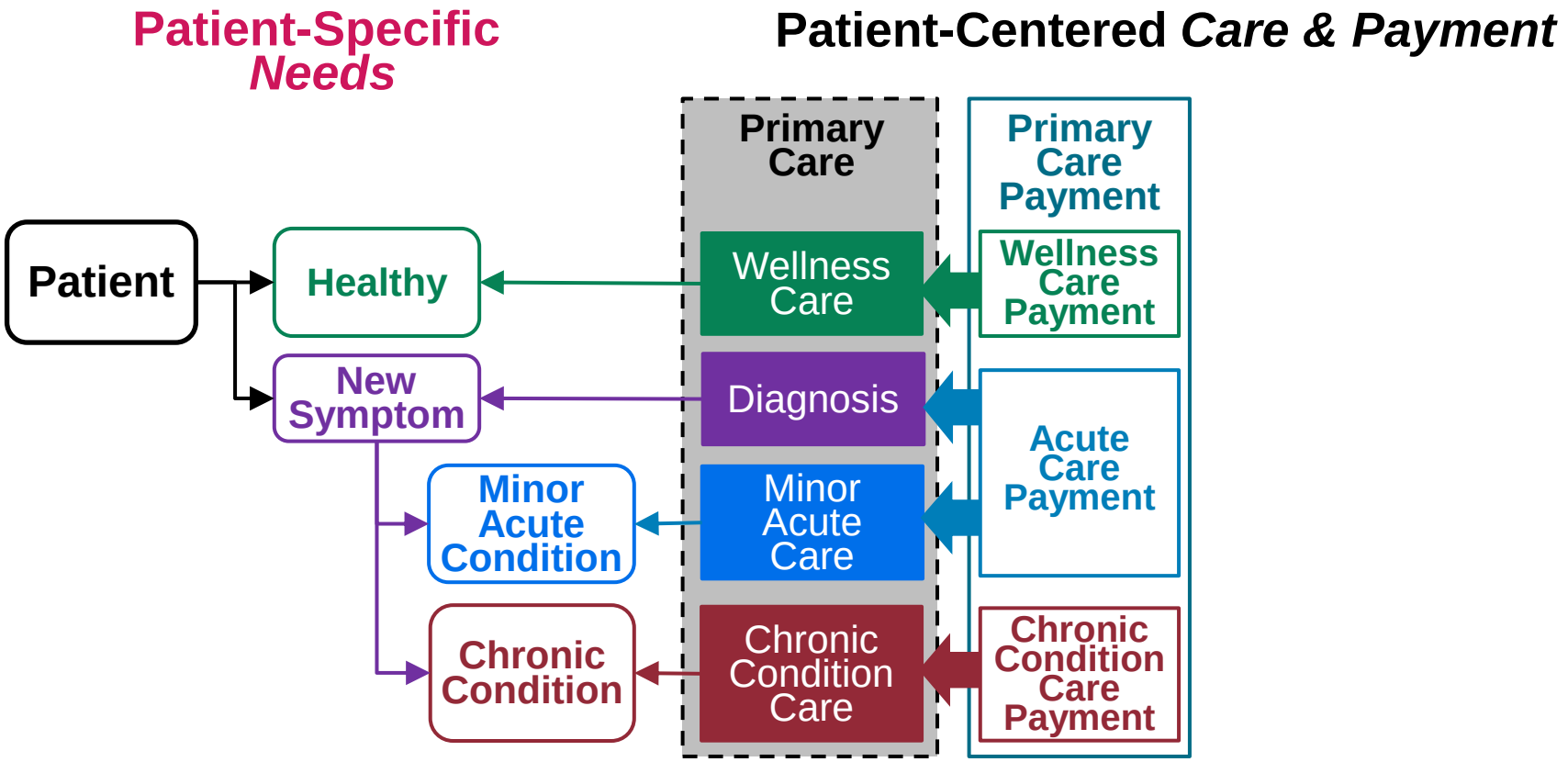
Part 1: How Should We Pay for Primary Care?



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“Primary Care” Isn’t One Service, It’s 3 Distinct Services

	Service
PRIMARY CARE SERVICES	Wellness Care
	Acute Care
	Chronic Condition Care

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Each of These Services Must Be Delivered in a Different Way

	Service	Goal
PRIMARY CARE SERVICES	**Wellness Care**	**Proactive:** Prevent health problems from occurring
	Acute Care	**Reactive:** Prompt diagnosis & treatment when problems occur
	Chronic Condition Care	**Proactive + Reactive:** Prevent exacerbations & promptly treat exacerbations that occur

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A 3-Part Payment Designed for the 3 Primary Care Services

	Service	Patient-Centered Payment
PRIMARY CARE SERVICES	**Wellness Care (proactive)**	Monthly Wellness Care Payment; higher amount for new & complex patients
	Acute Care (reactive)	Acute Care Fee for diagnosis & treatment of a new acute problem
	Chronic Condition Care (proactive + reactive)	Monthly Chronic Condition Care Payment; higher amount for patients with complex needs

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Provider Should Only Be Paid if the Patient Receives Appropriate Care

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

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Better Than Both Fee-for-Service and Capitation Payment Systems

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

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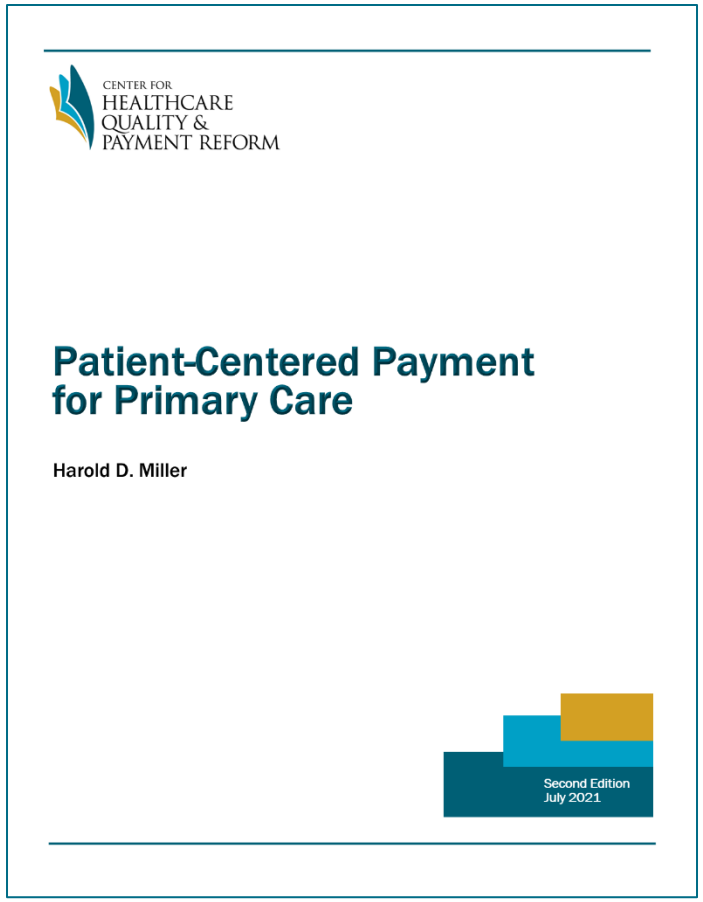
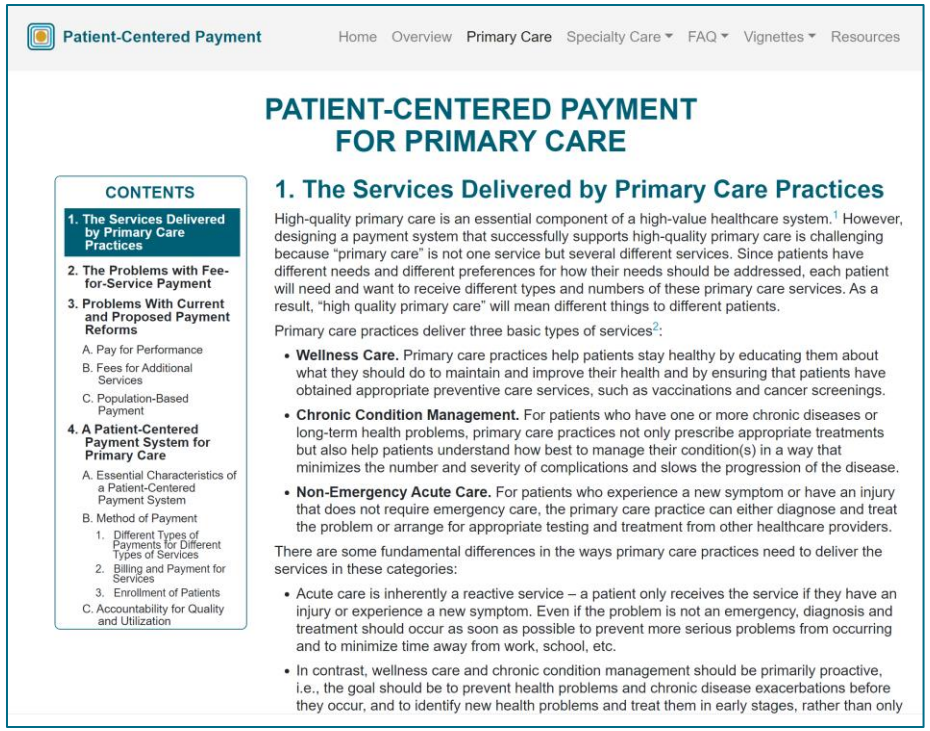
More Details on Patient-Centered Payment for Primary Care

PatientCenteredPayment.org





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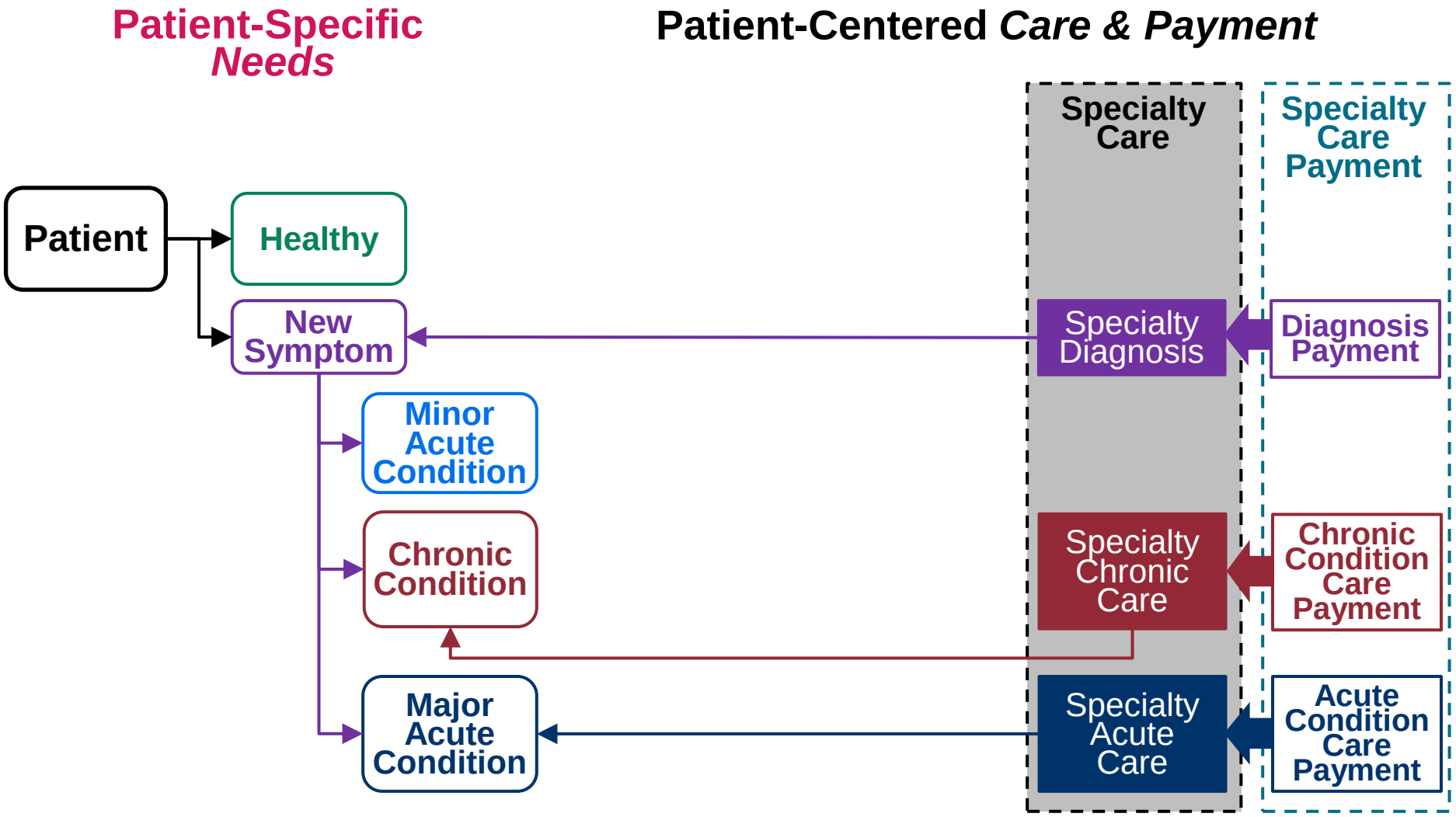
Part 2: Paying Specialists Appropriately for High-Quality Care



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Priority Area for Most Payers: Management of Chronic Disease

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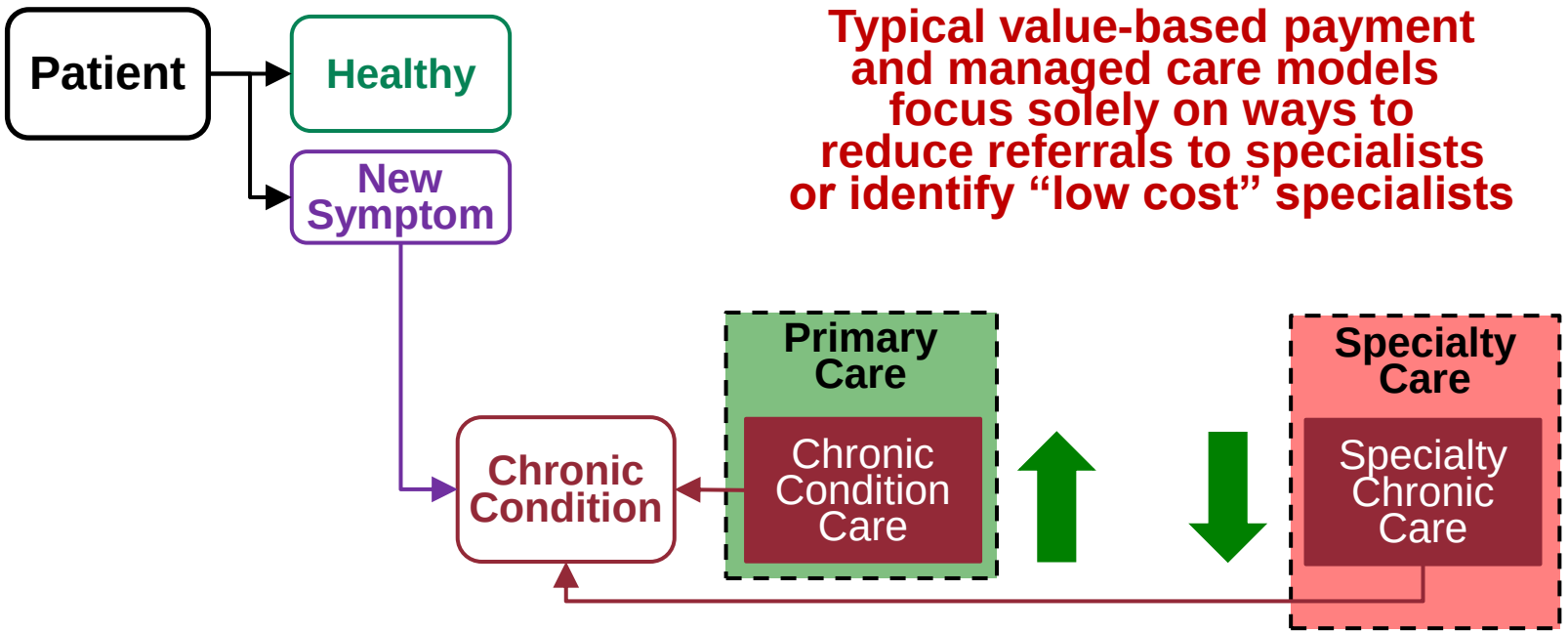
The Wrong Approach: Treating Specialists as “Avoidable” Spending



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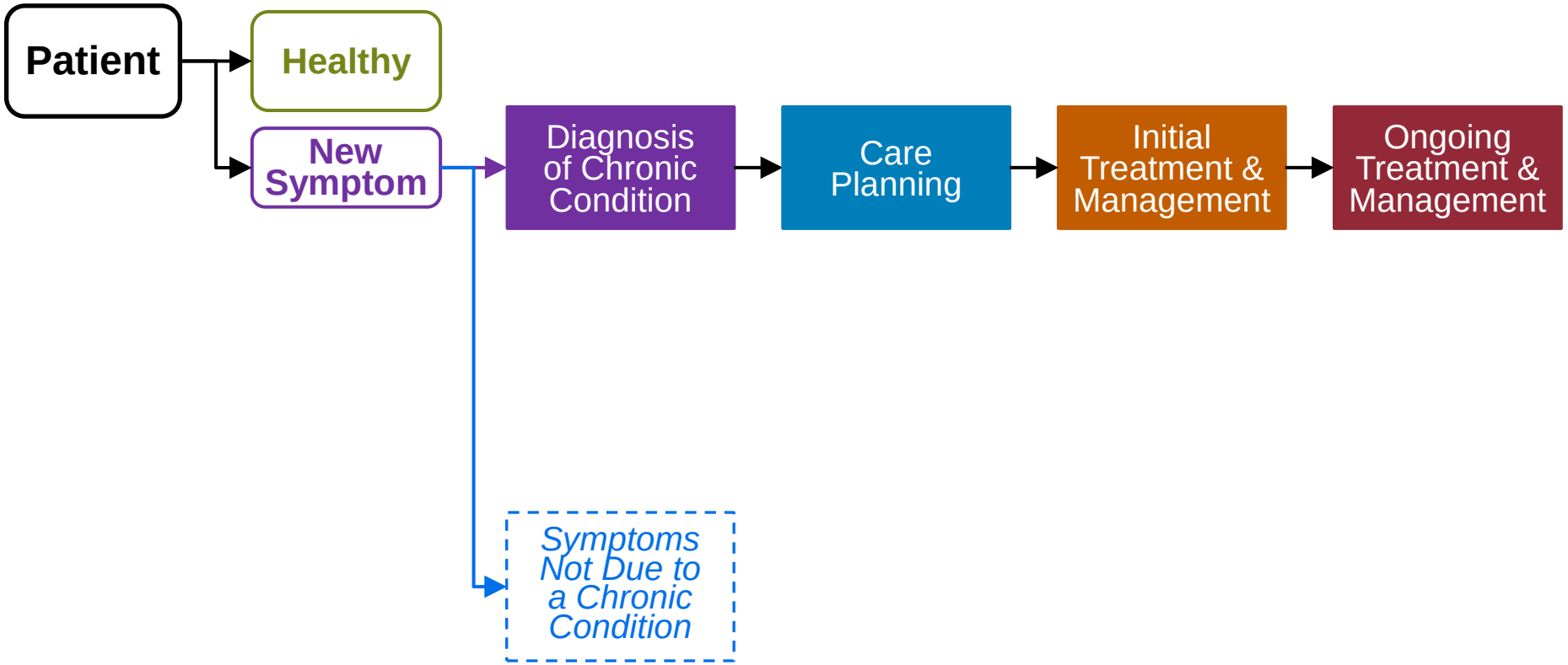
The Right Approach: Improve Value in *Each Phase* of Chronic Care



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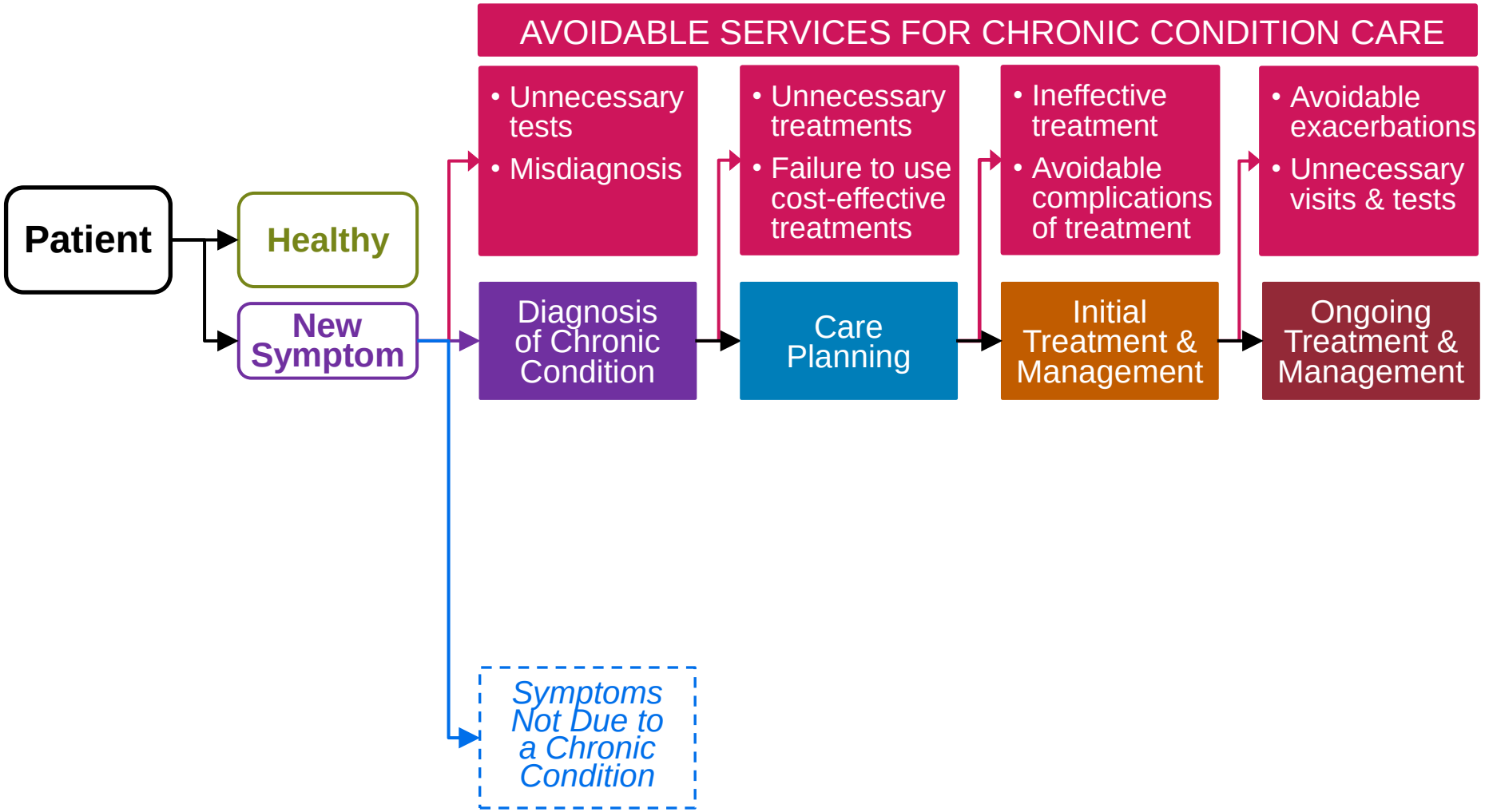
Different Types of Avoidable Spending in Each Phase of Care



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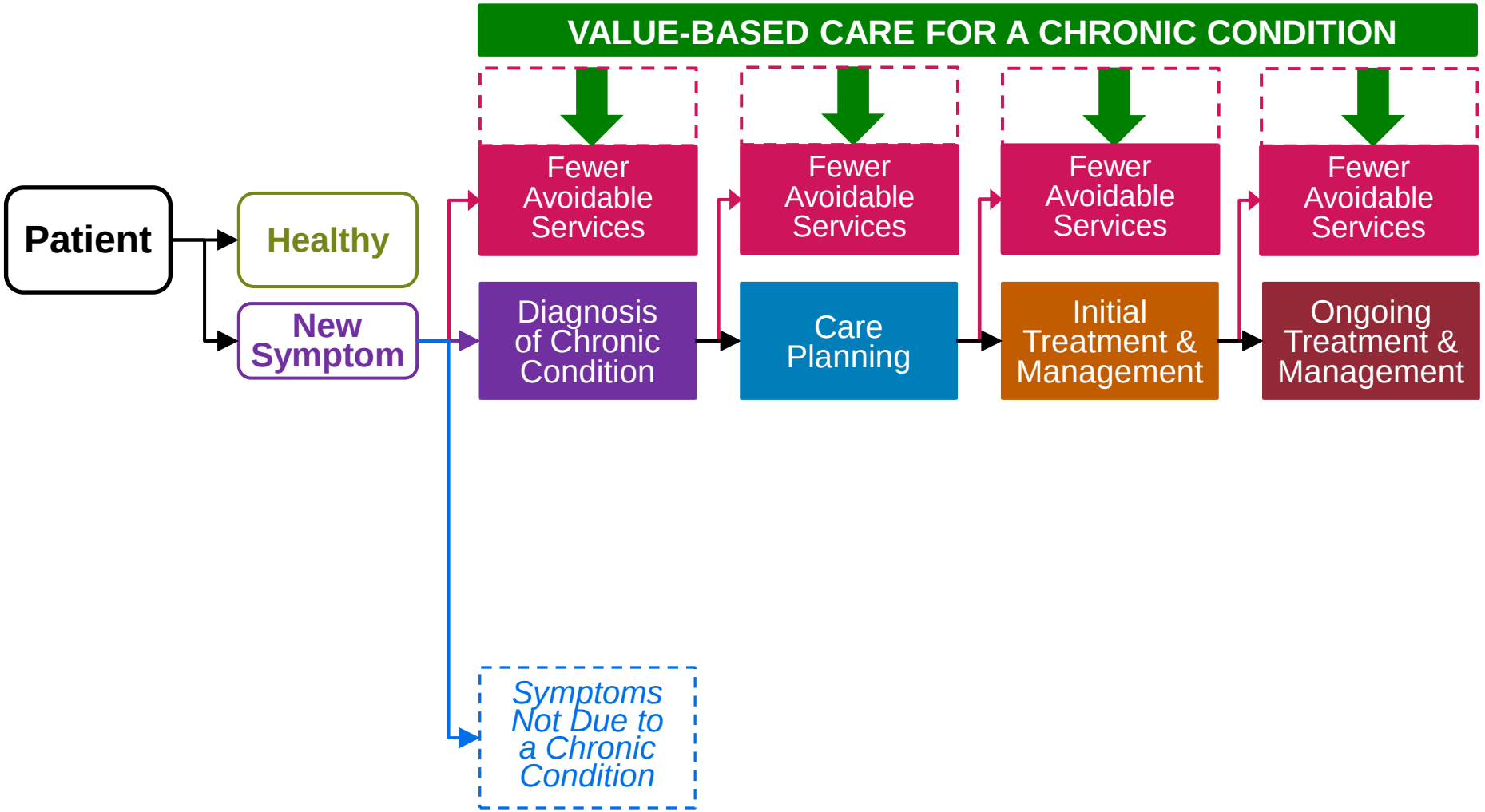
Different Services Need to Be Delivered in Each Phase of Care



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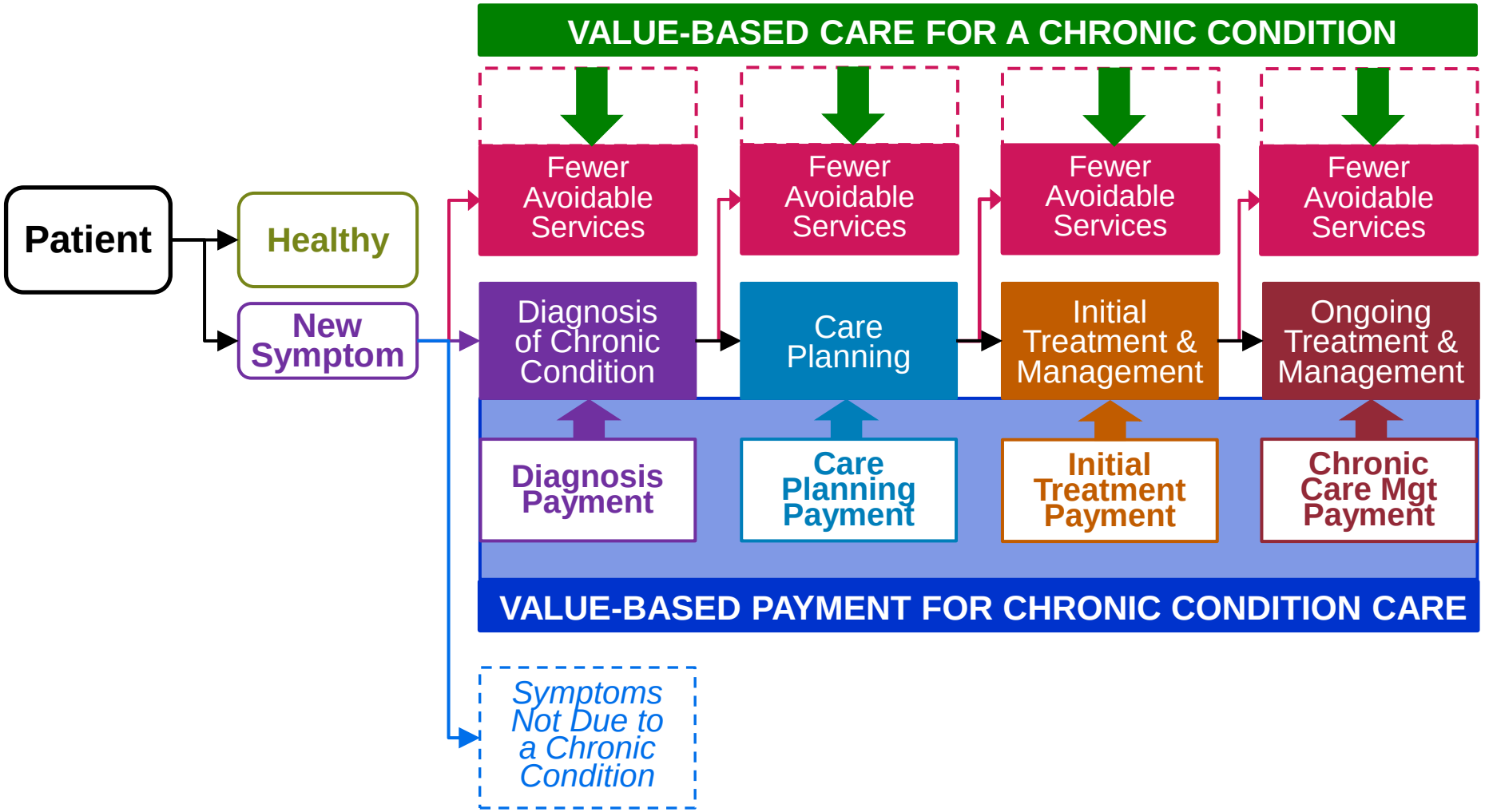
Different Value-Based Payments Needed for Each Phase of Care



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4 Separate Payments for 4 Distinct Phases of Chronic Care

	Service	Patient-Centered Payment
SPECIALTY CHRONIC CONDITION CARE	Diagnosis	One-Time Diagnosis Payment
	Care Planning	One-Time Care Planning Payment
	Initial Treatment & Management	One-Time or Monthly Initial Treatment and Management Payment
	Ongoing Treatment & Management	Monthly Chronic Condition Care Payment; higher amount for patients with complex needs

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Provider Should Only Be Paid if the Patient Receives Appropriate Care

	Service	Patient-Centered Payment	Patient-Centered Standard of Quality	Accountability for Quality
SPECIALTY CHRONIC CONDITION CARE	**Diagnosis**	One-Time Diagnosis Payment	• Deliver evidence-based diagnostic services	No payment unless standard of care is met for *that* patient
	Care Planning	One-Time Care Planning Payment	• Develop an evidence-based care plan, adjusted to patient needs and preferences	No payment unless standard of care is met for *that* patient
	Initial Treatment & Management	One-Time or Monthly Initial Treatment and Management Payment	• Implement the care plan, monitor patient response, and make adjustments to maximize effectiveness & avoid complications	No payment unless standard of care is met for *that* patient
	Ongoing Treatment & Management	Monthly Chronic Condition Care Payment; higher amount for patients with complex needs	• Follow evidence-based clinical practice guidelines to manage the condition • Contact patient regularly to identify/address problems	No payment for the month unless standard of care is met for *that* patient

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Many Medical Specialties Have Developed Payment Models Like This

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

CHQPR.org/APMs.html

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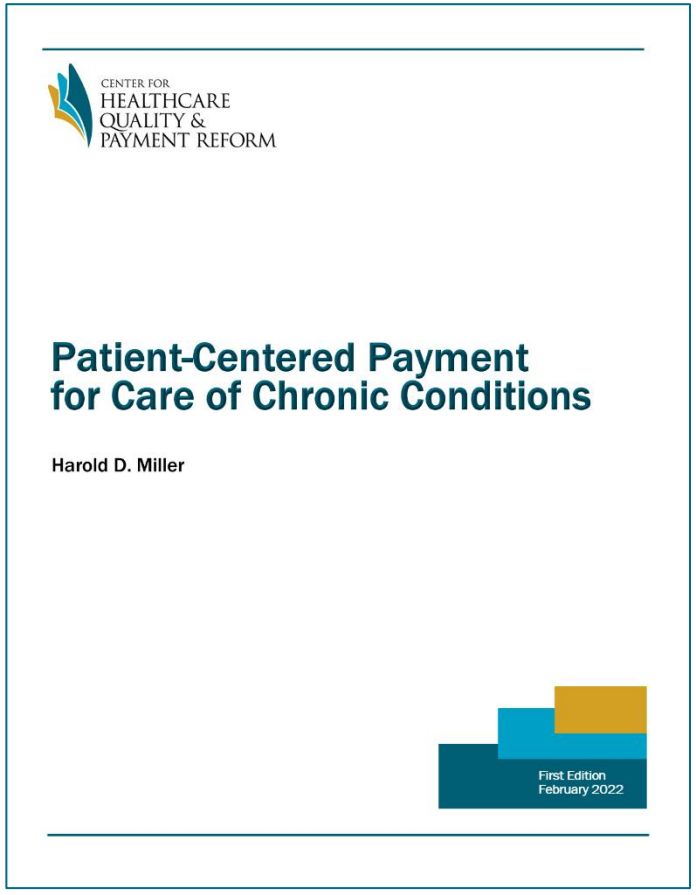
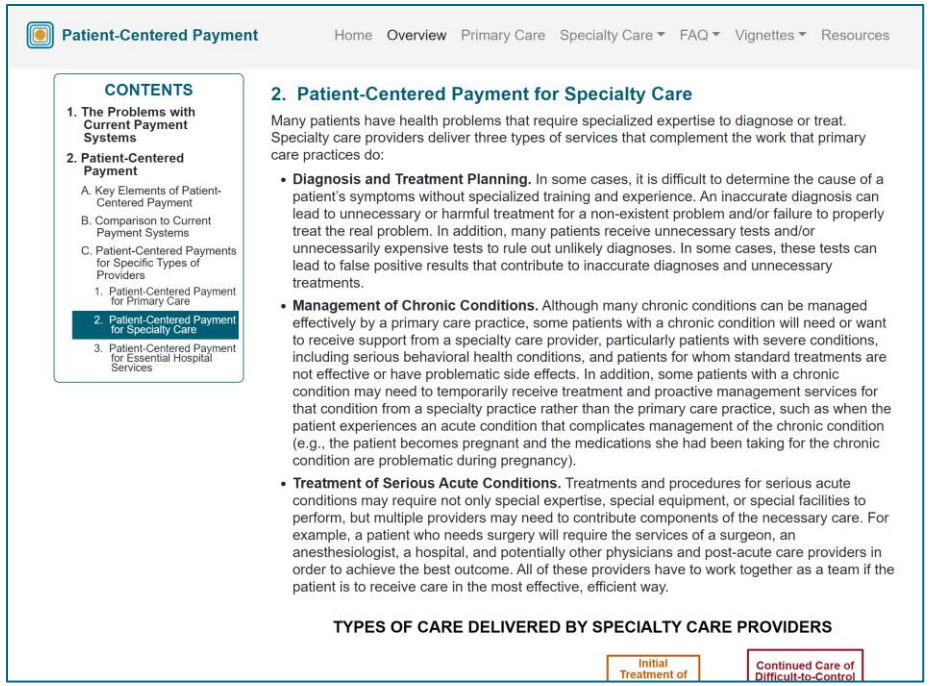
More Details on Patient-Centered Payment for Specialty Care

PatientCenteredPayment.org





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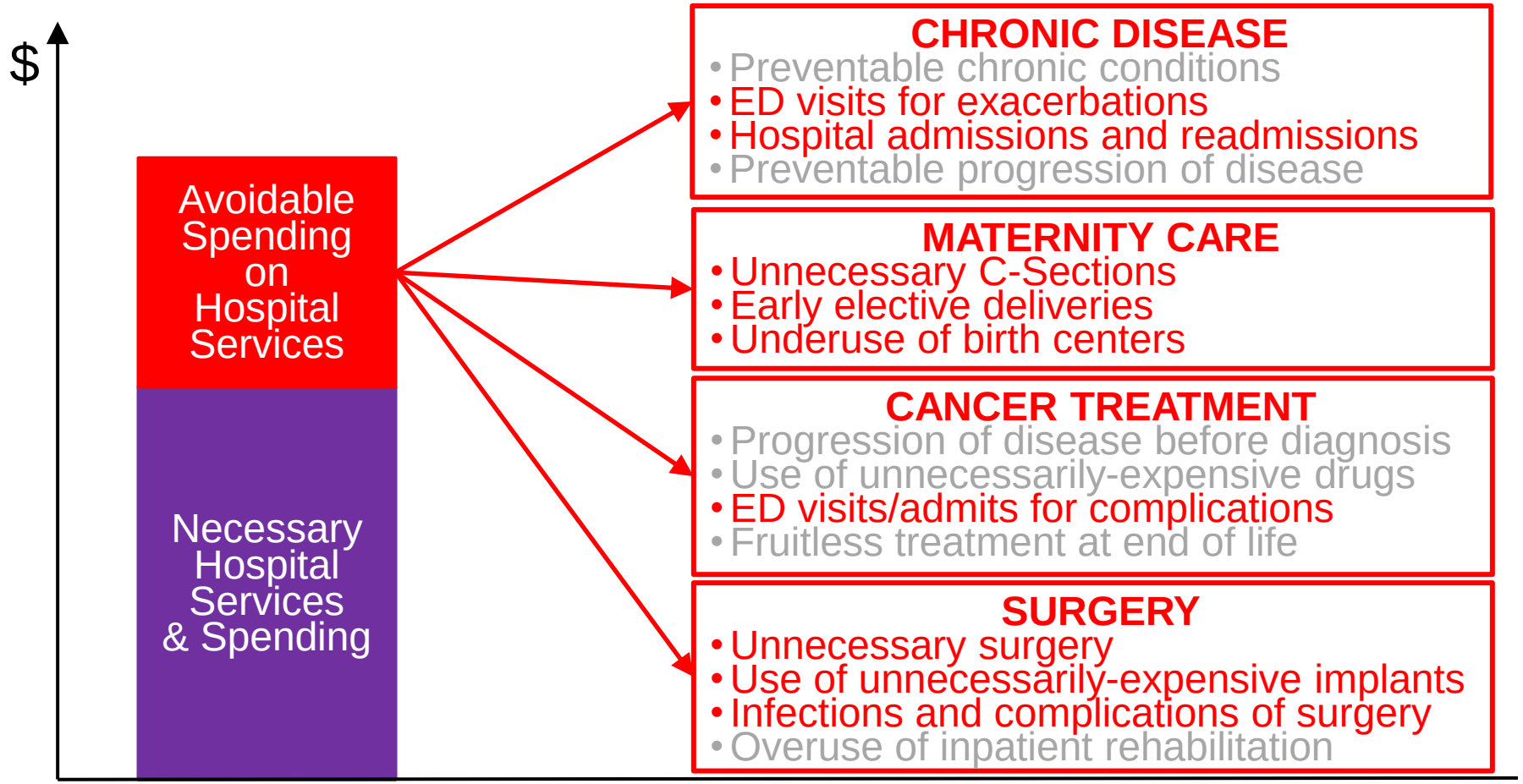
What About Hospitals?

A Lot of Avoidable Spending is Related to Hospital Services



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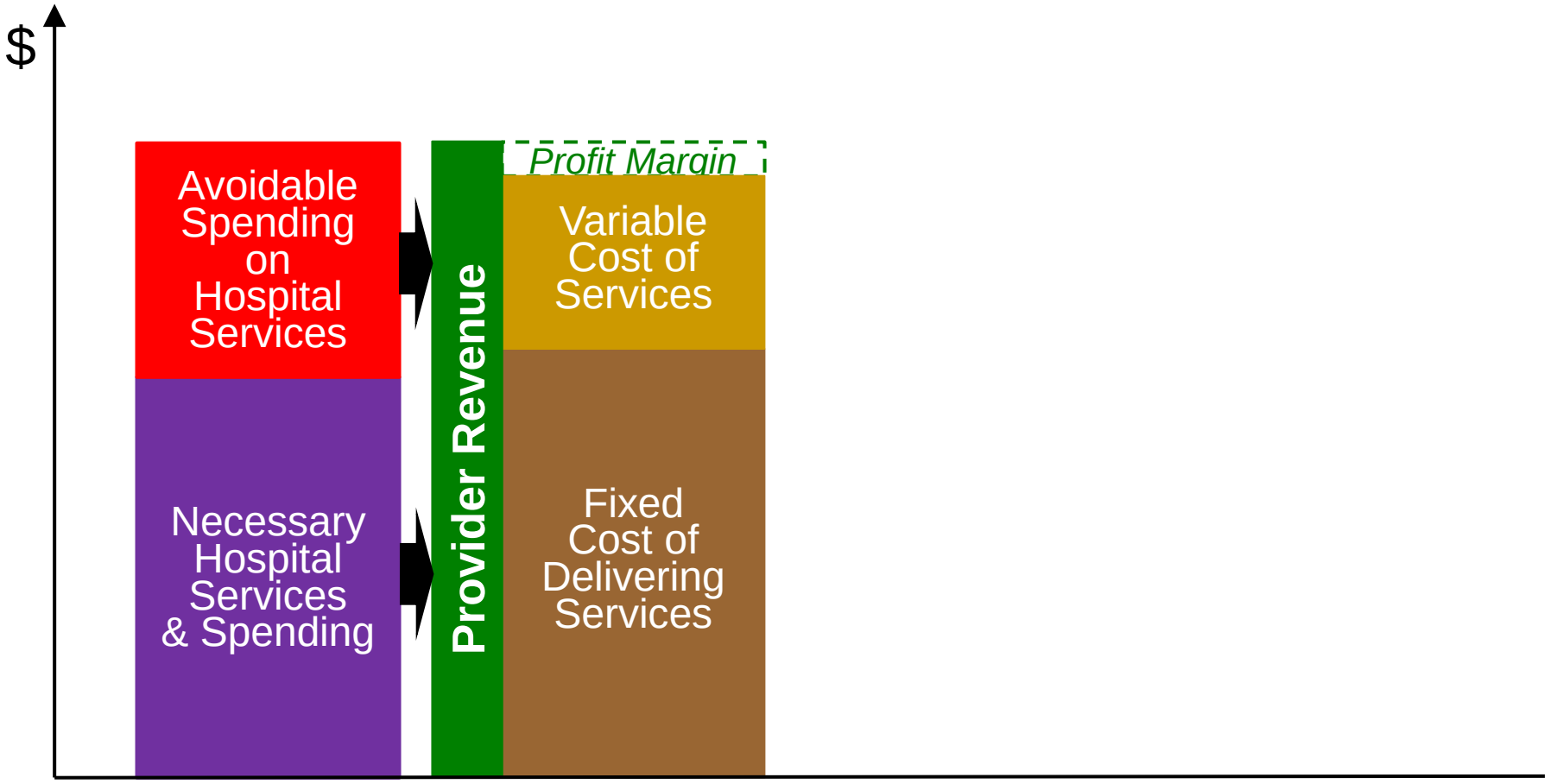
Hospitals Have Large Fixed Costs to Maintain Essential Services



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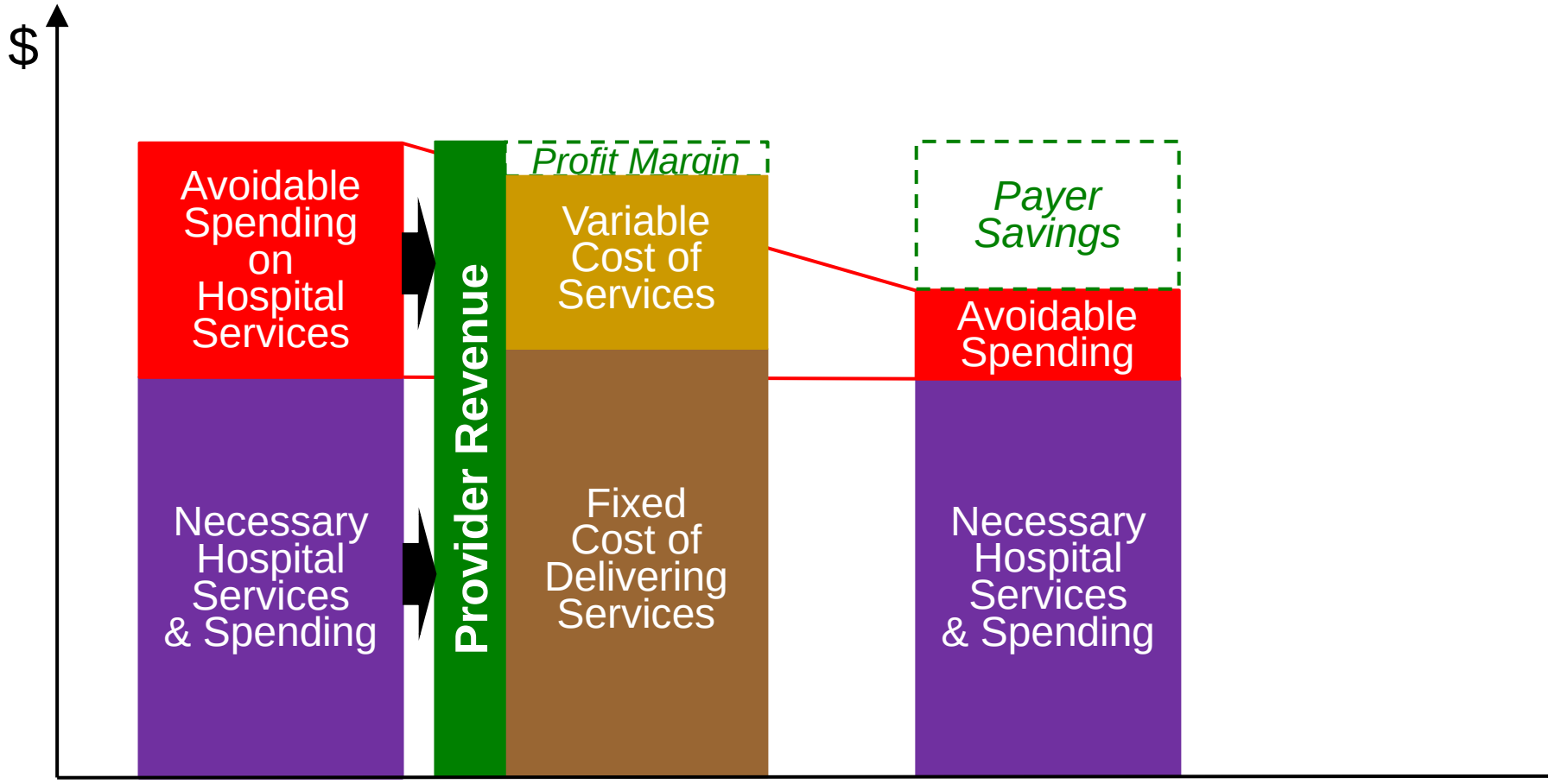
Reducing Avoidable Hospital Services Saves a Lot for Payers…



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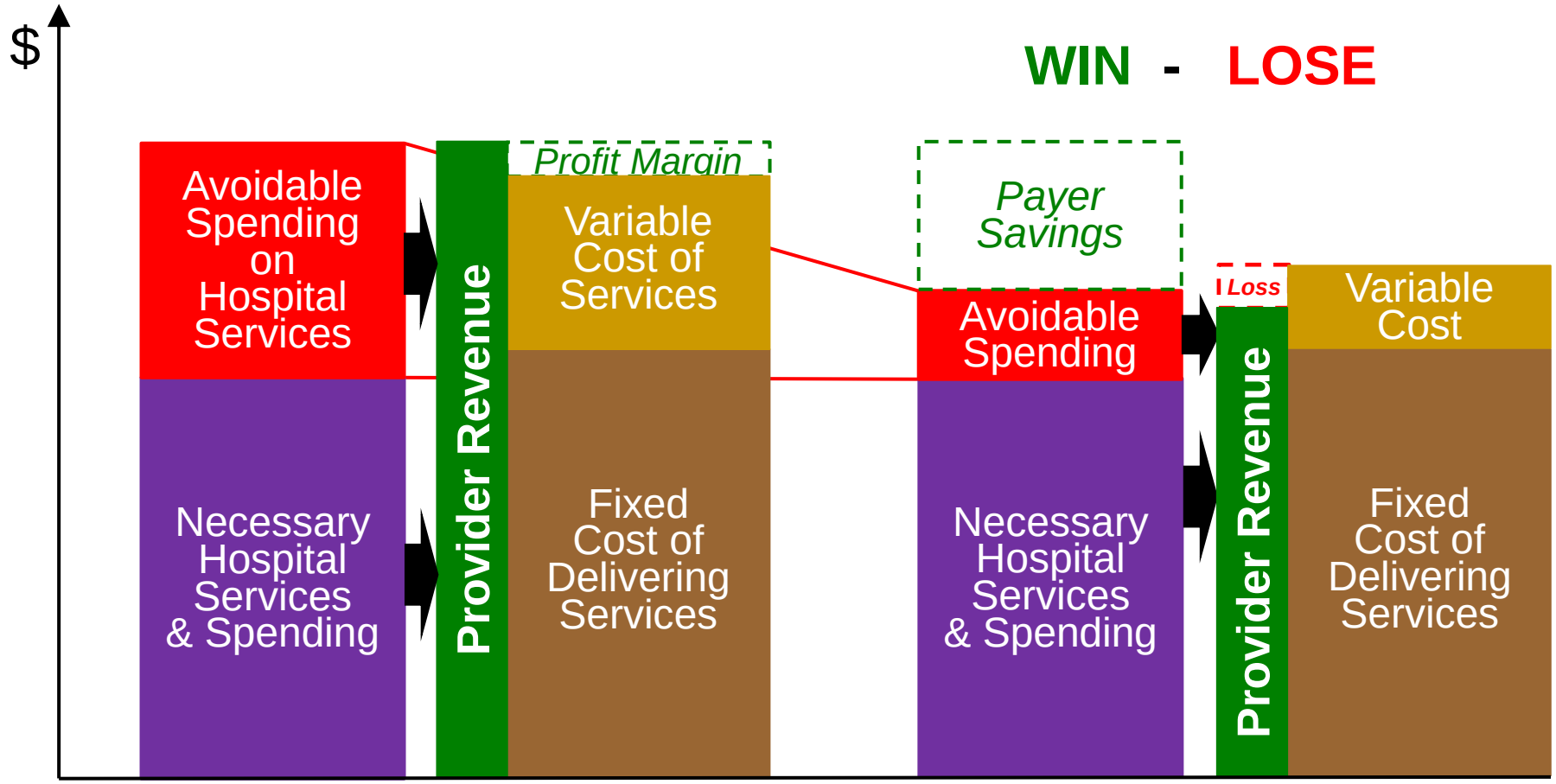
…But Losses for Hospitals Can Jeopardize Essential Services



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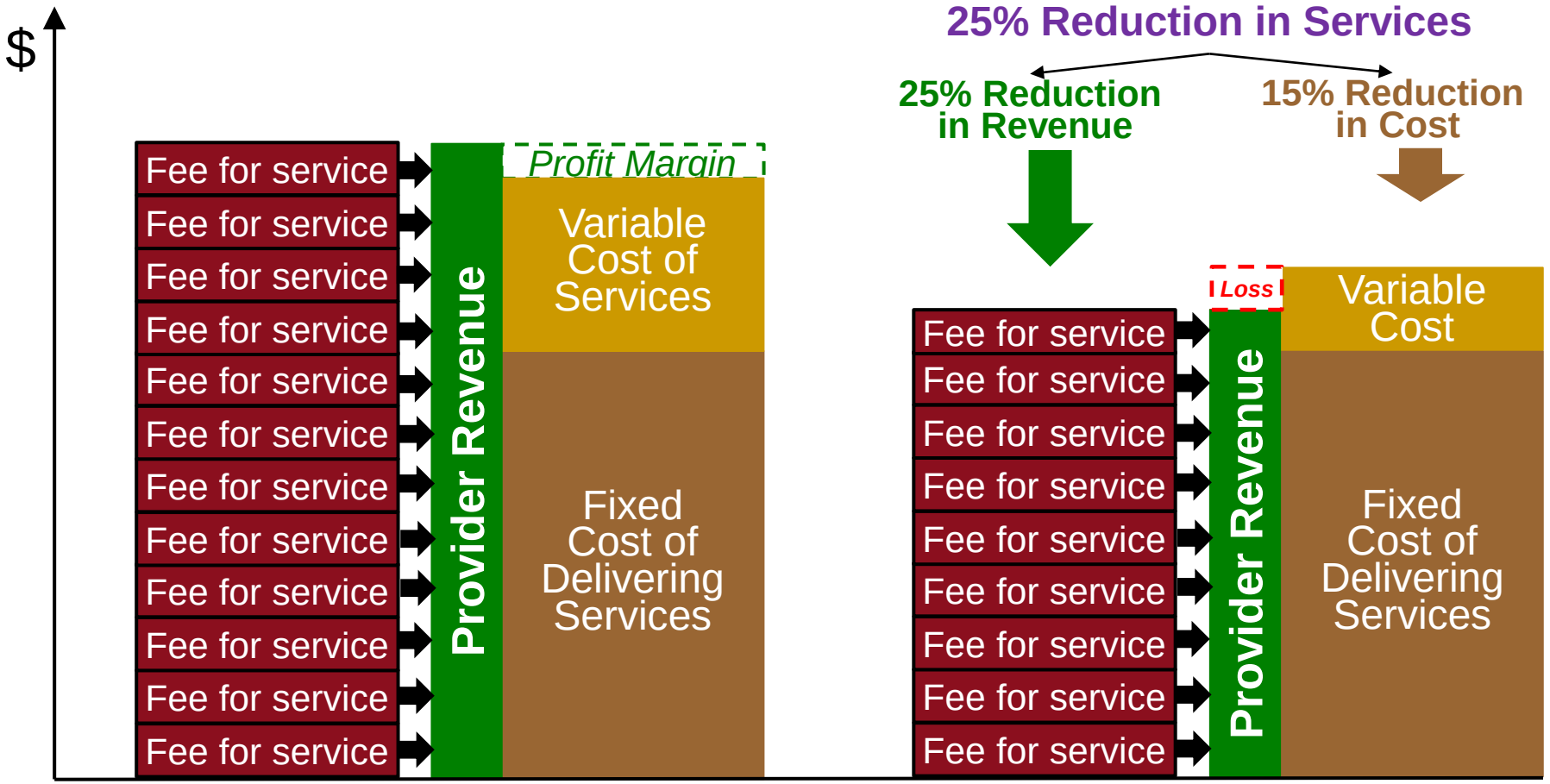
FFS Revenue is Proportional to Volume, But Costs Are Not



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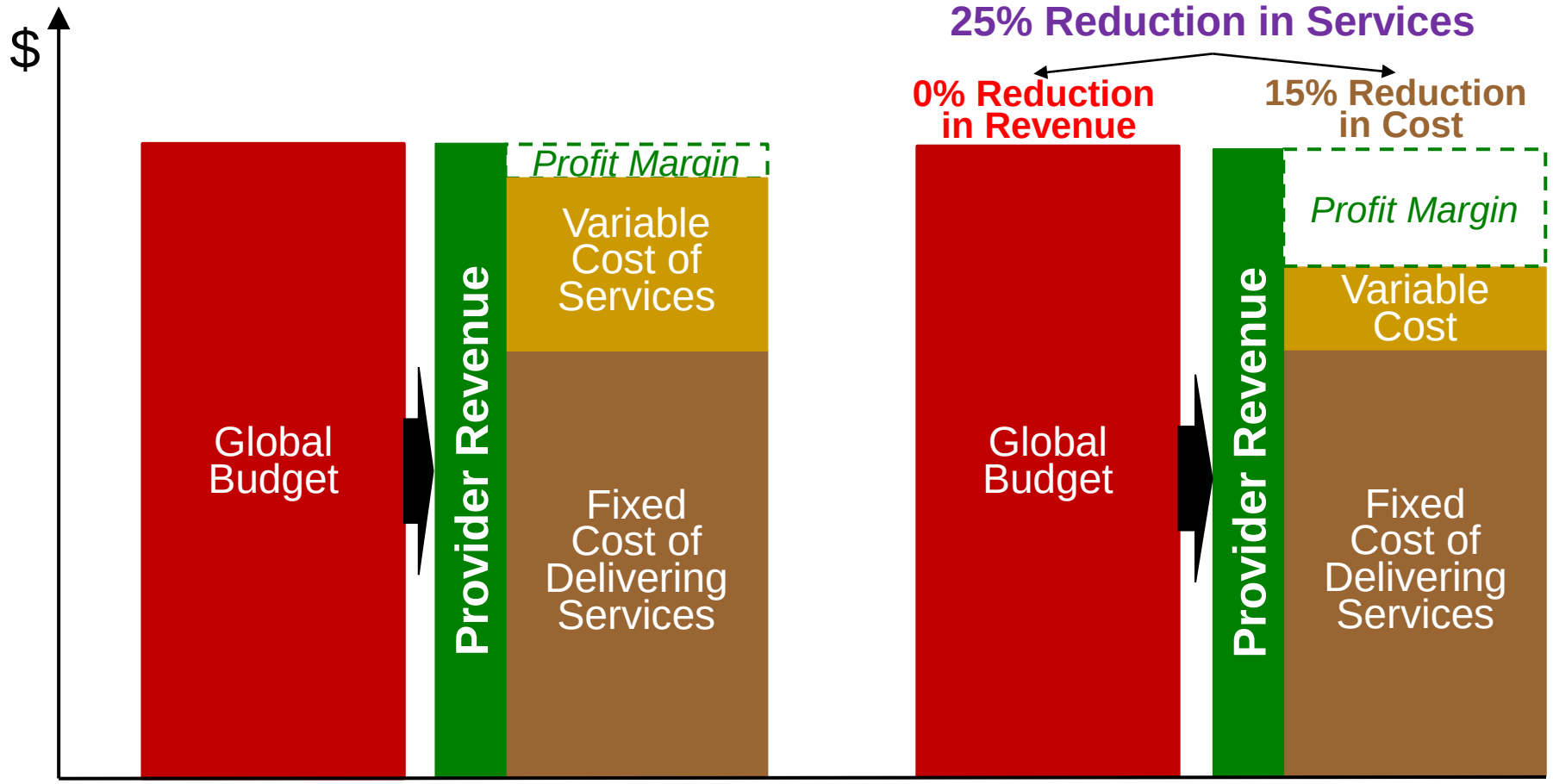
Global Budgets Don't Produce Savings From Higher-Value Care



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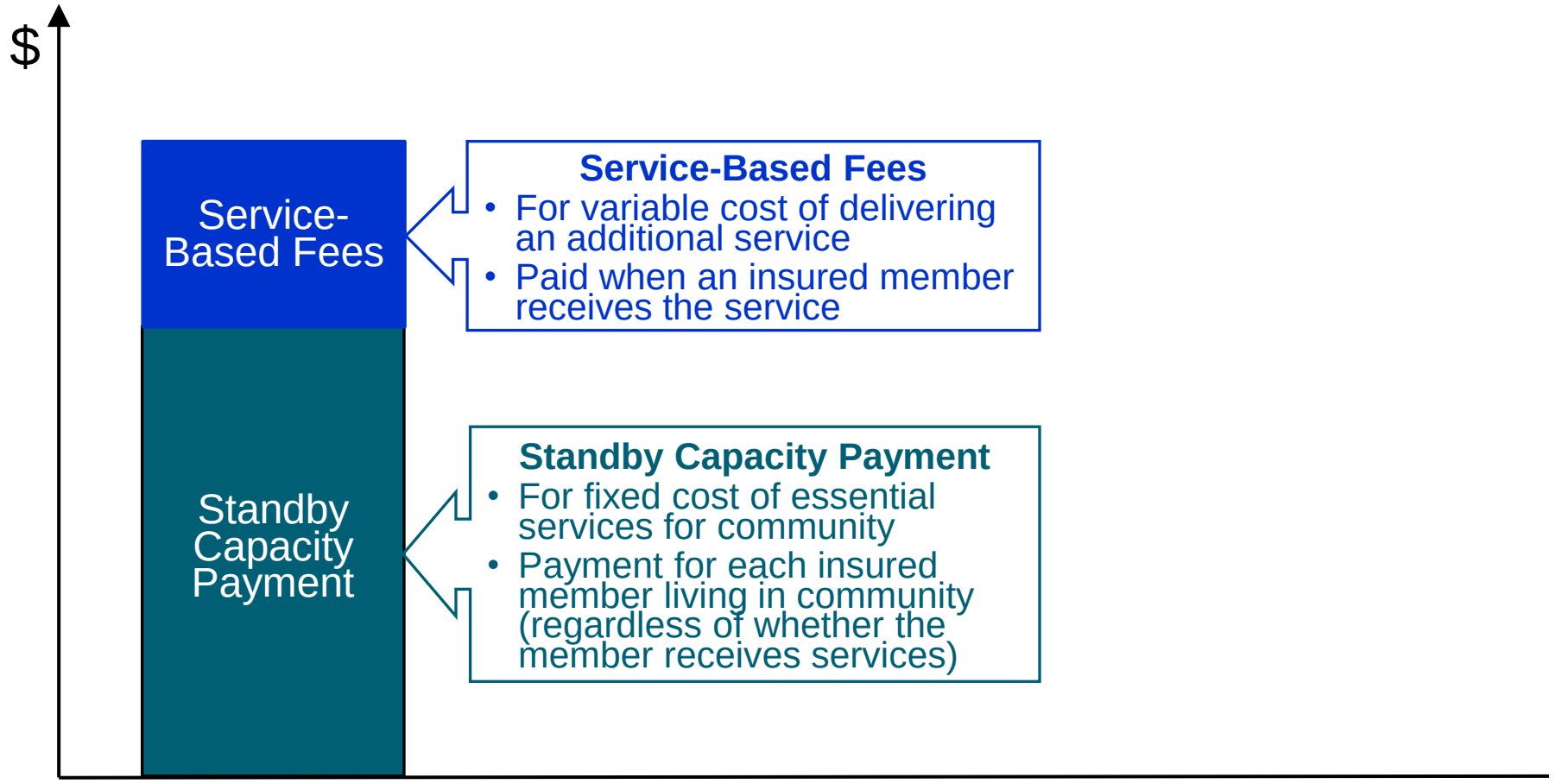
A Better Way: Two Payments for Different Aspects of Hospital Care



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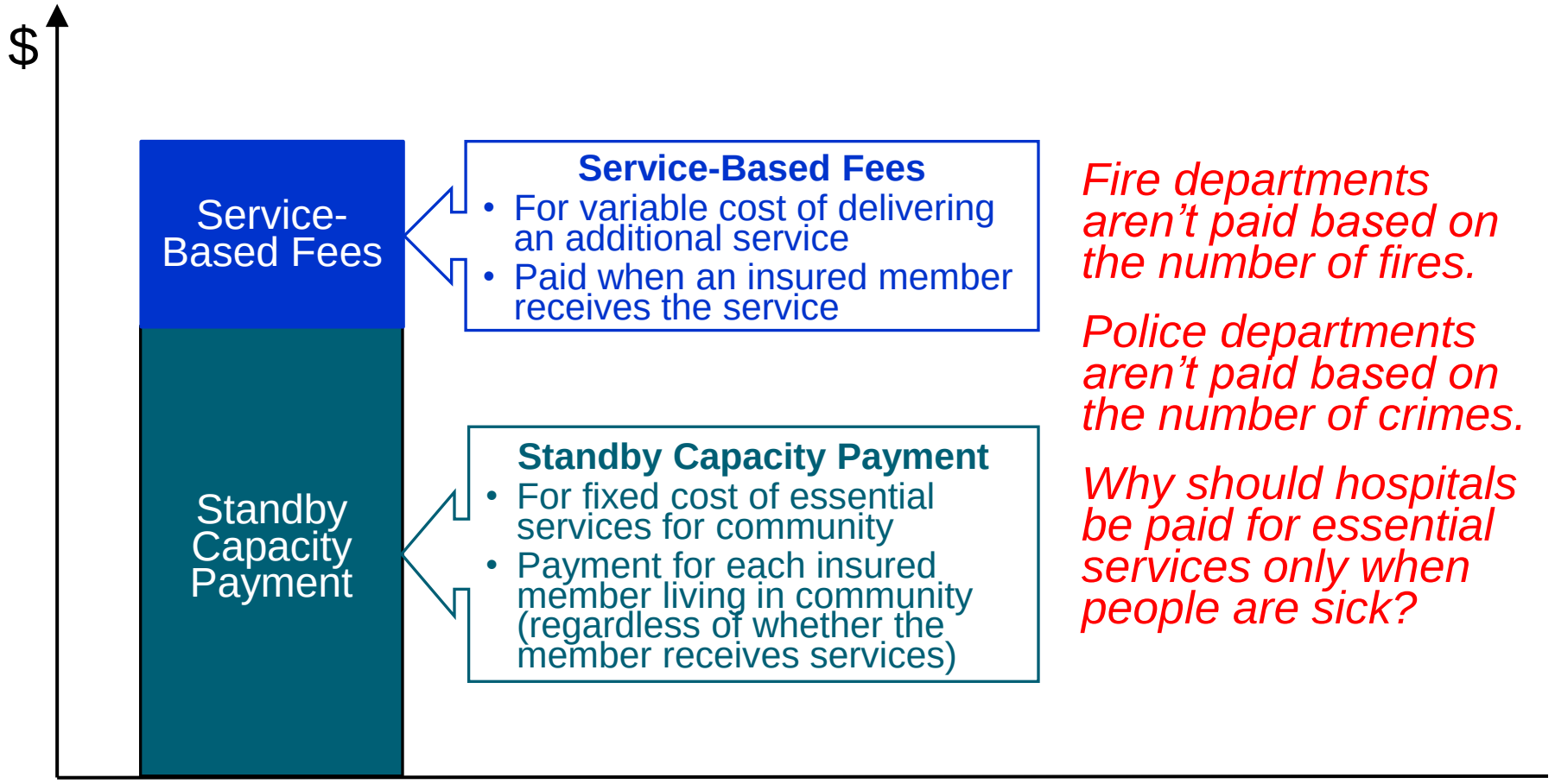
A Better Way: Two Payments for Different Aspects of Hospital Care



Fire departments aren't paid based on the number of fires.

Police departments aren't paid based on the number of crimes.

Why should hospitals be paid for essential services only when people are sick?

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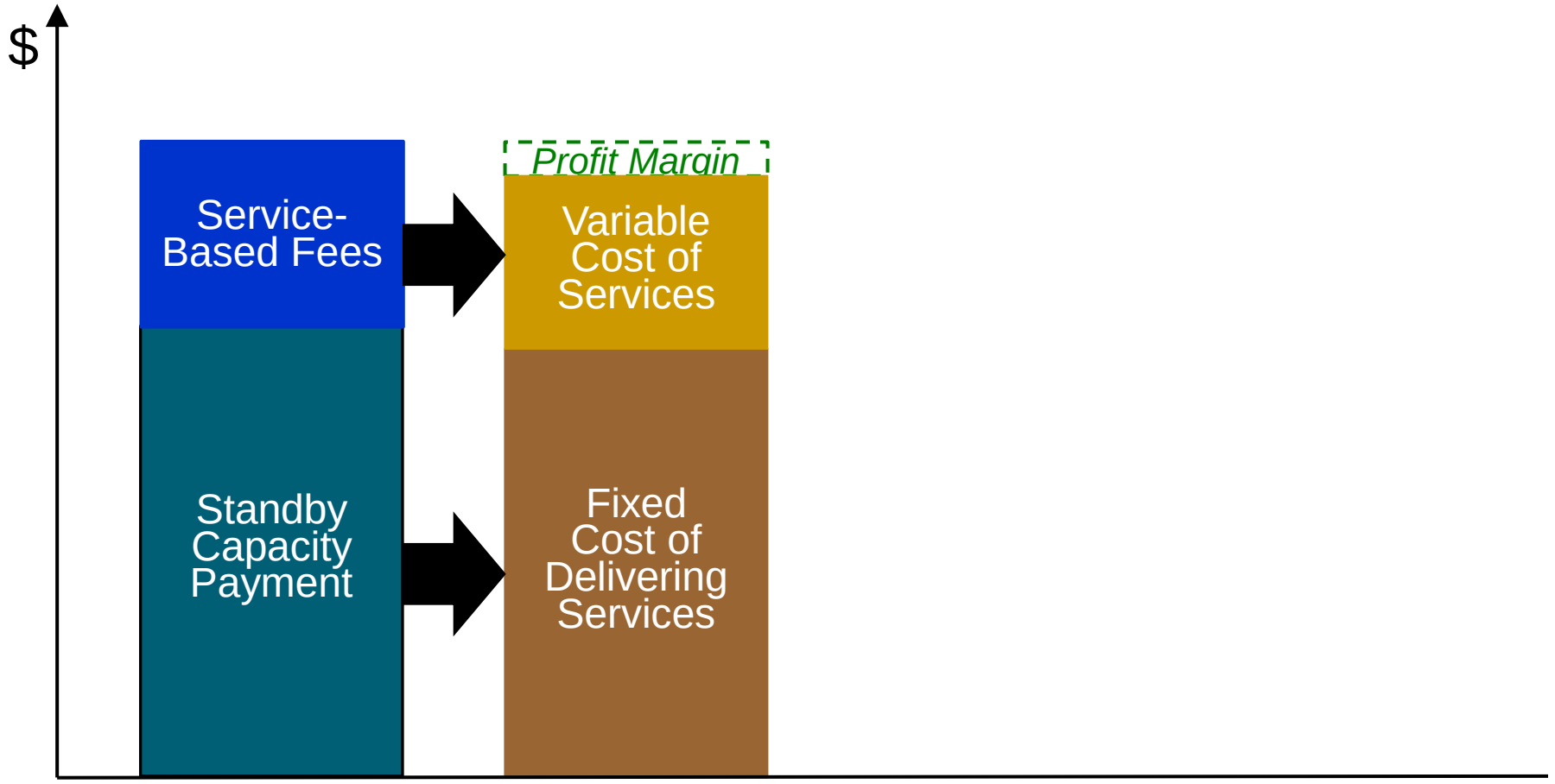
Each Payment is Designed to Support Different Types of Costs



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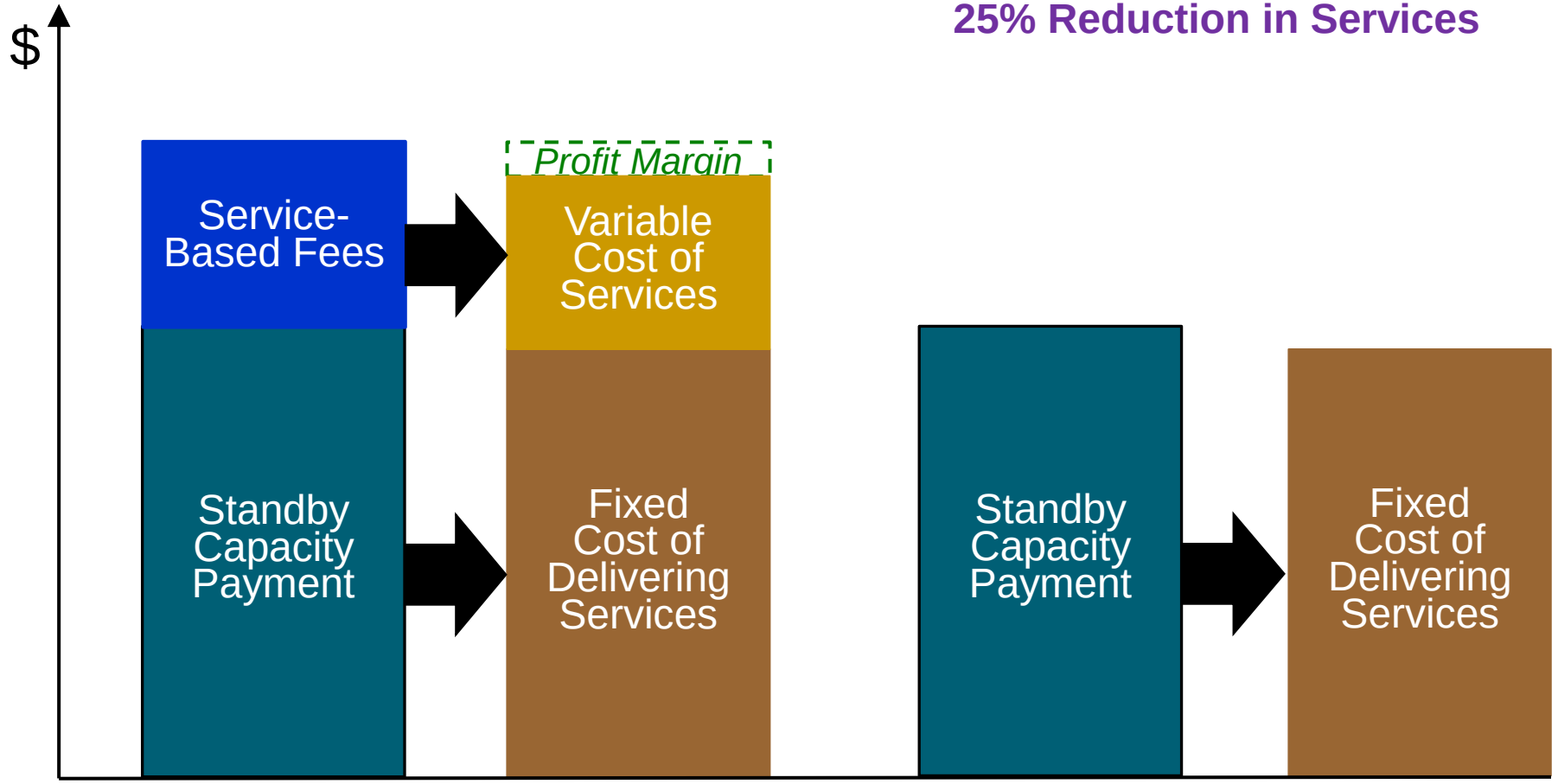
Standby Capacity Payment Isn't Affected by Changes in Volume



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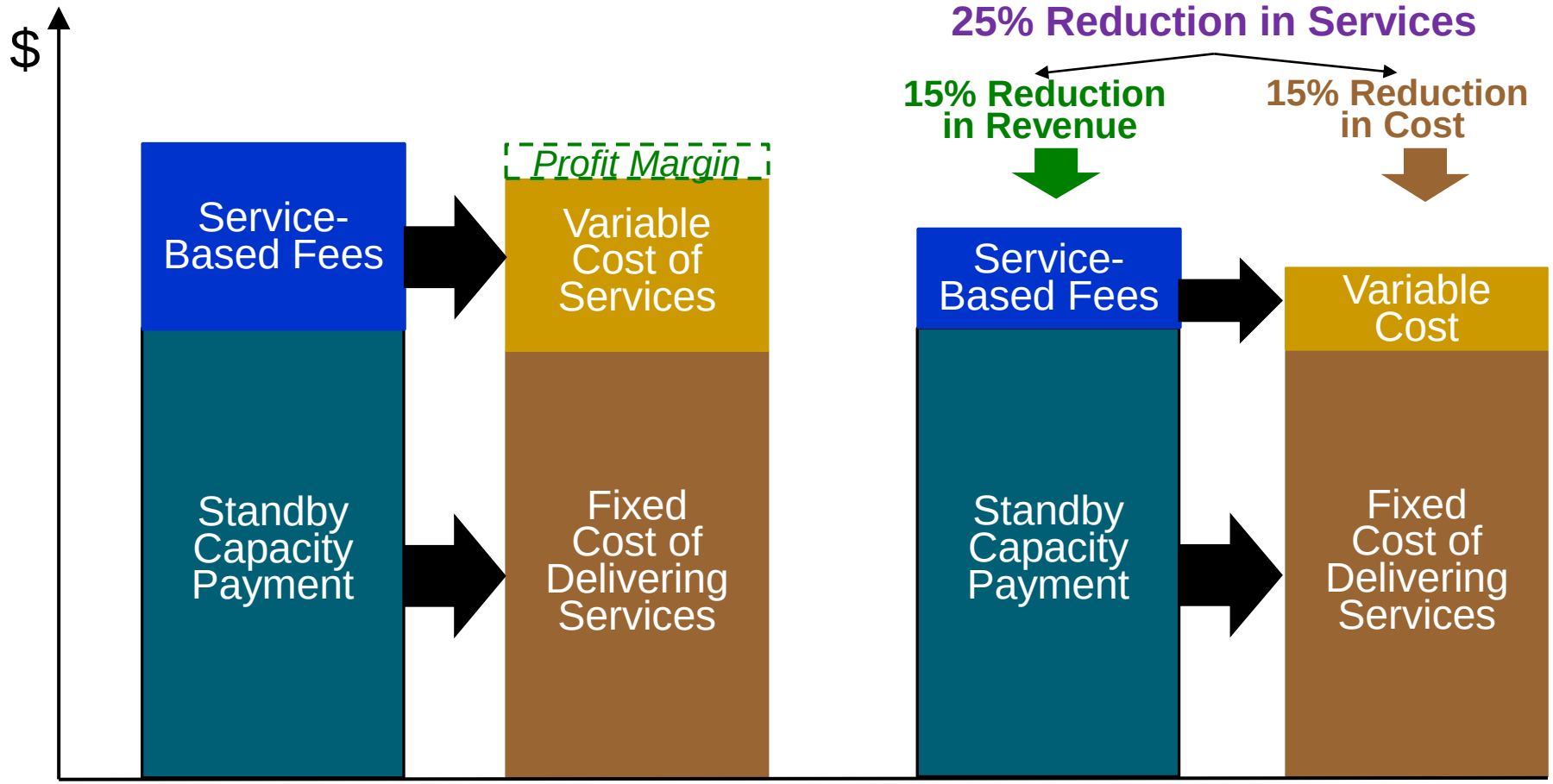
Service Fee Revenue Decreases in Proportion to Variable Cost



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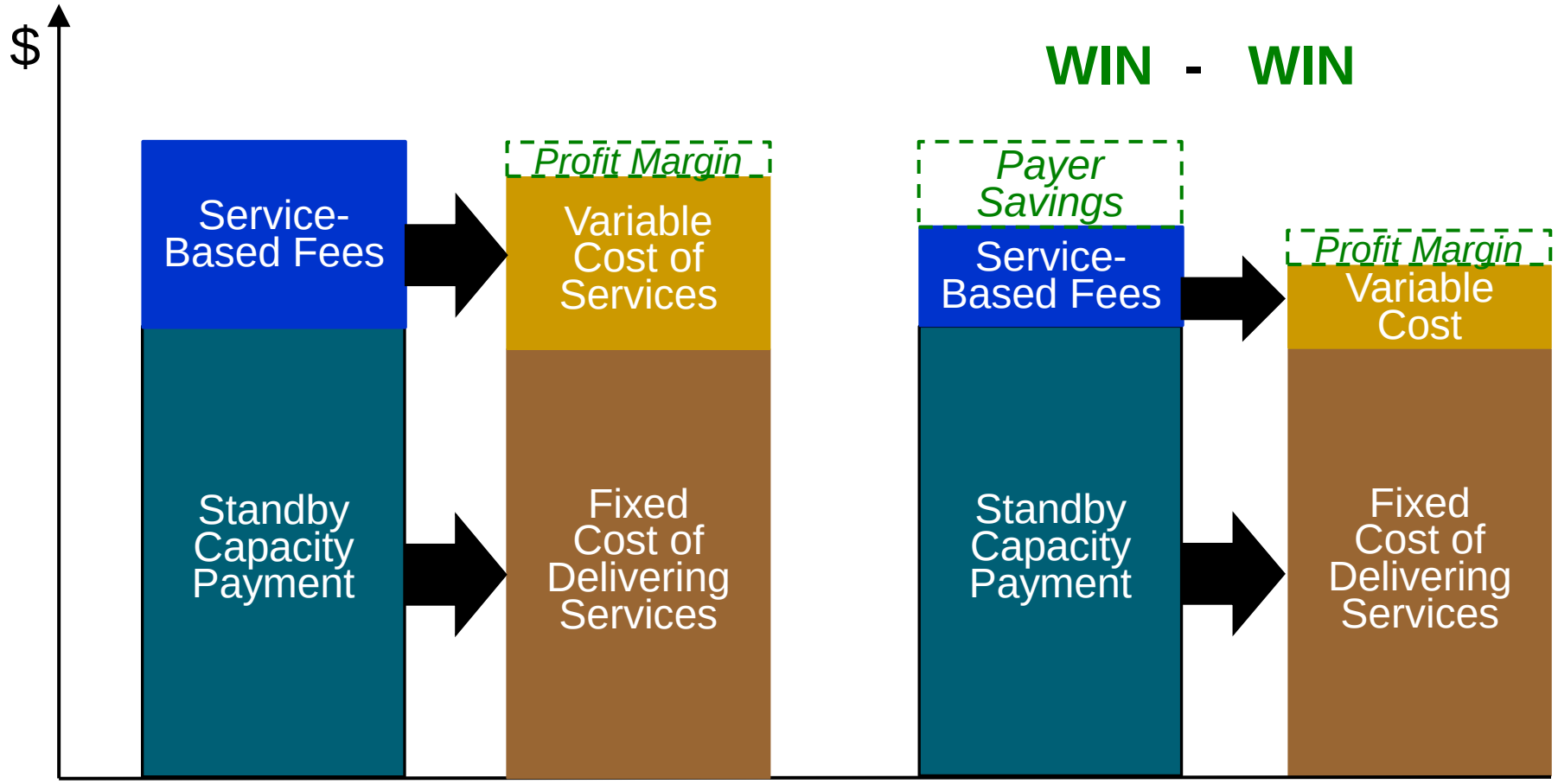
Hospital Margin is Preserved: Savings Matches Reduced Cost



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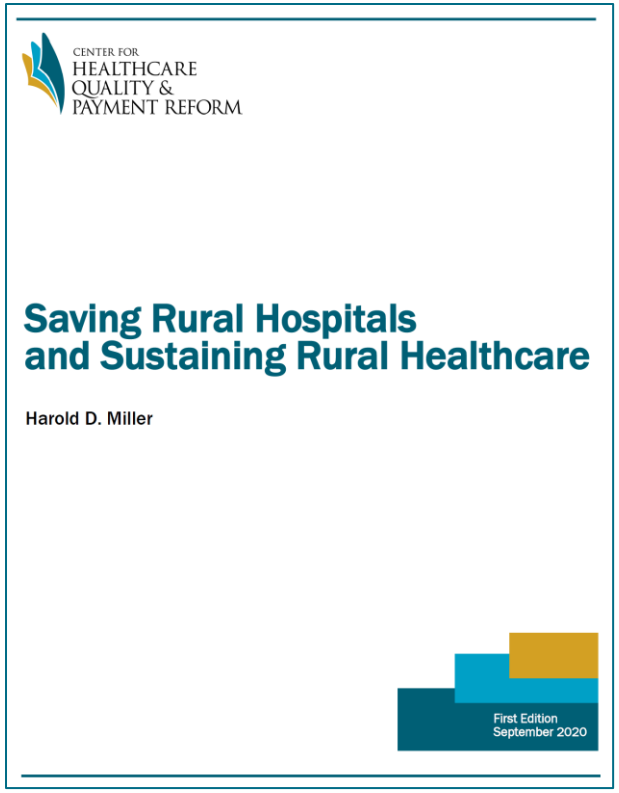
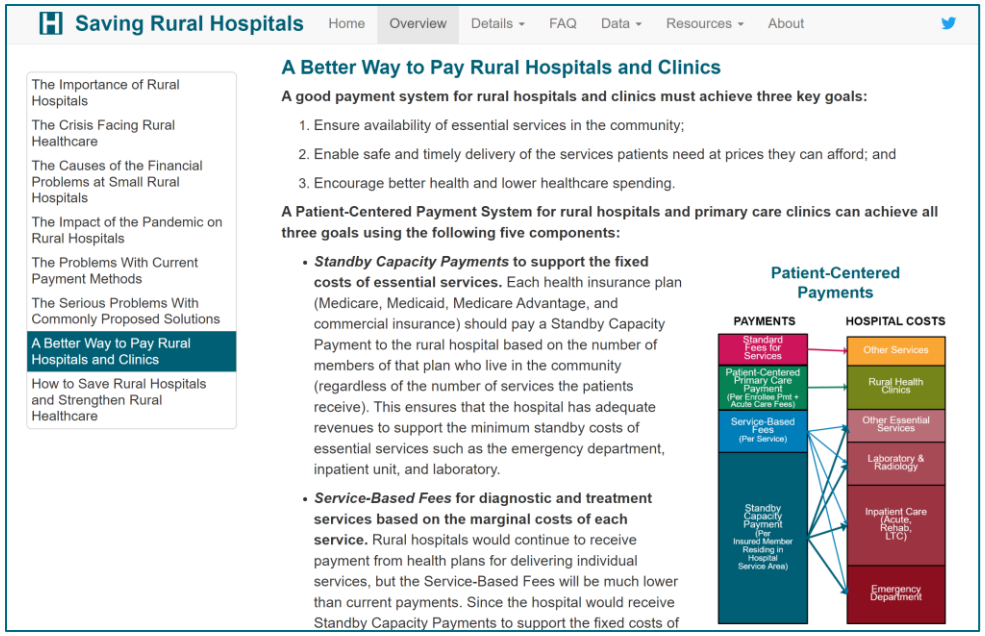
More Details on Sustainable Payments for Hospitals

RuralHospitals.org





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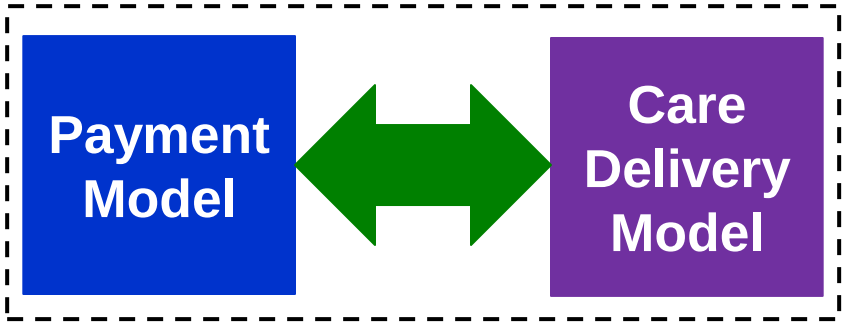
How Do We Move to Win-Win-Win Value-Based Payment?

Payment & Care Delivery Must Be Designed *Together*



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By Themselves, Payers Will Design Things So *Payers* Win

PAYER PREFERENCE:

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

Payer

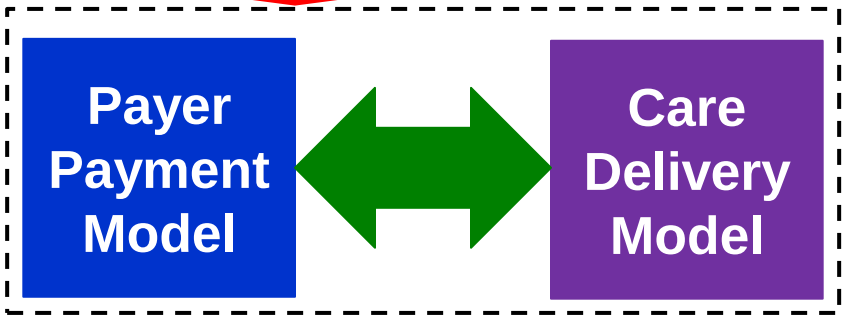
Payer

Payer

Payer

Payer

Design



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

PAYER PREFERENCE:

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

Payer

Payer

Payer

Payer

Payer

Design

Payer Payment Model ⟷ **Care Delivery Model**

Provider

Provider

Provider

Provider

Provider

PROVIDER PREFERENCE:

- Higher payments for existing services
- New payments for new services
- No accountability for outcomes
- No financial risk

Design

Payment Model ⟷ **Provider Care Delivery Model**

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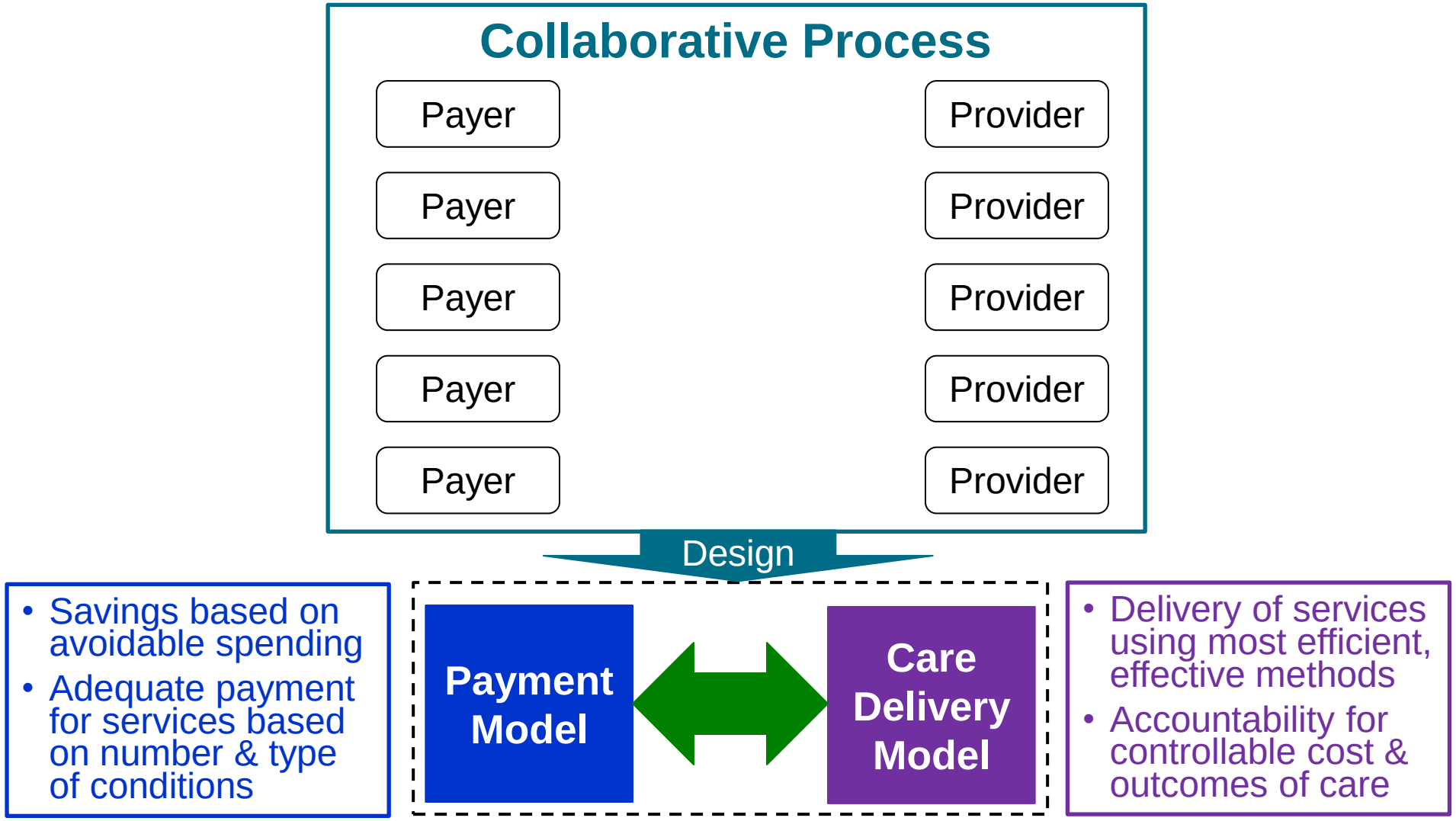
Payers & Providers Must *Collaborate* for a *Win-Win* Design



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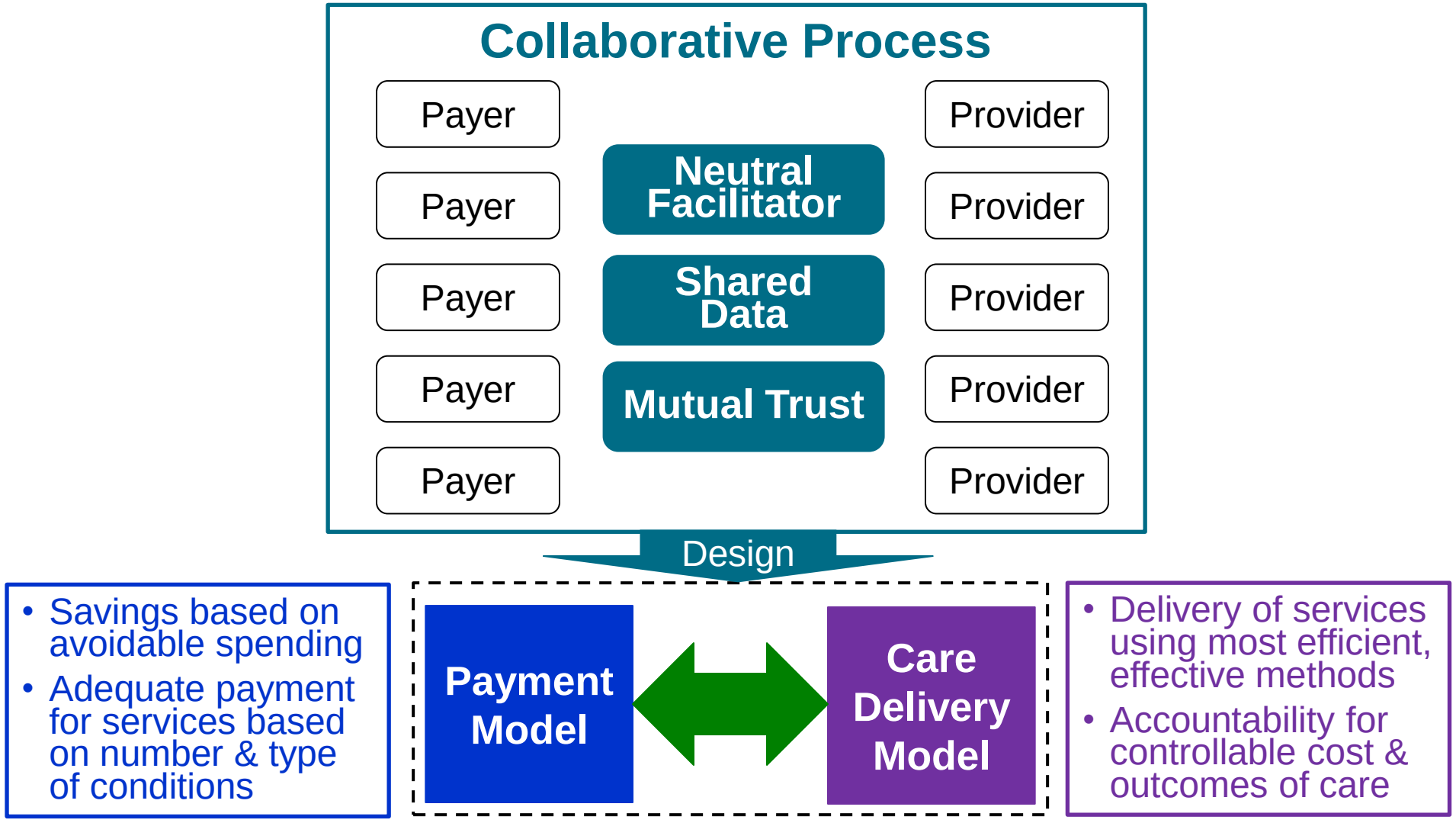
Keys to Success: Facilitation, Shared Data, & Trust



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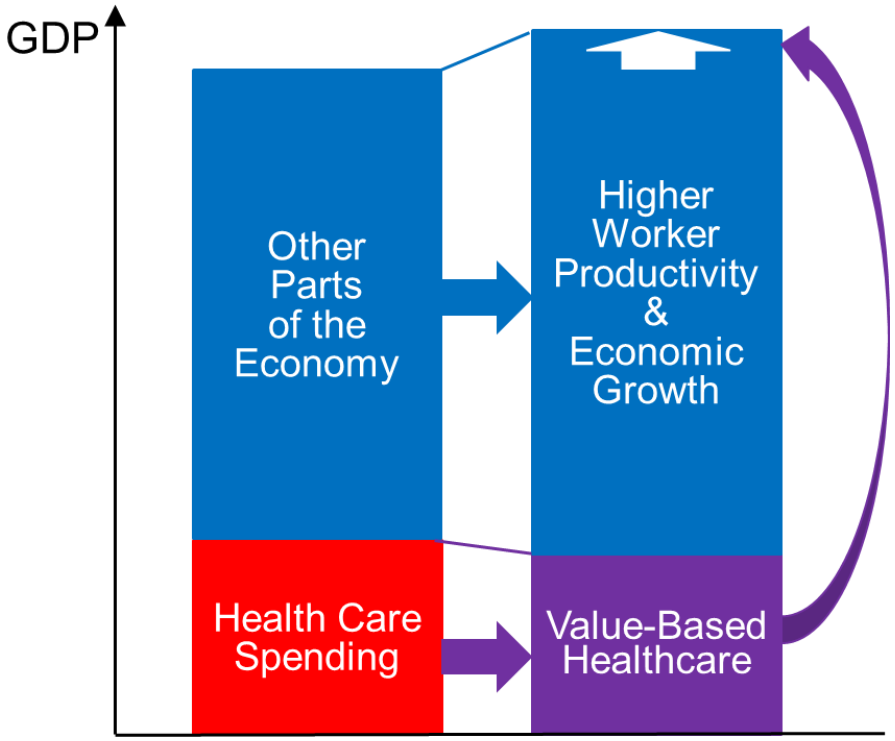
We Need a Healthcare System That Supports Economic Growth



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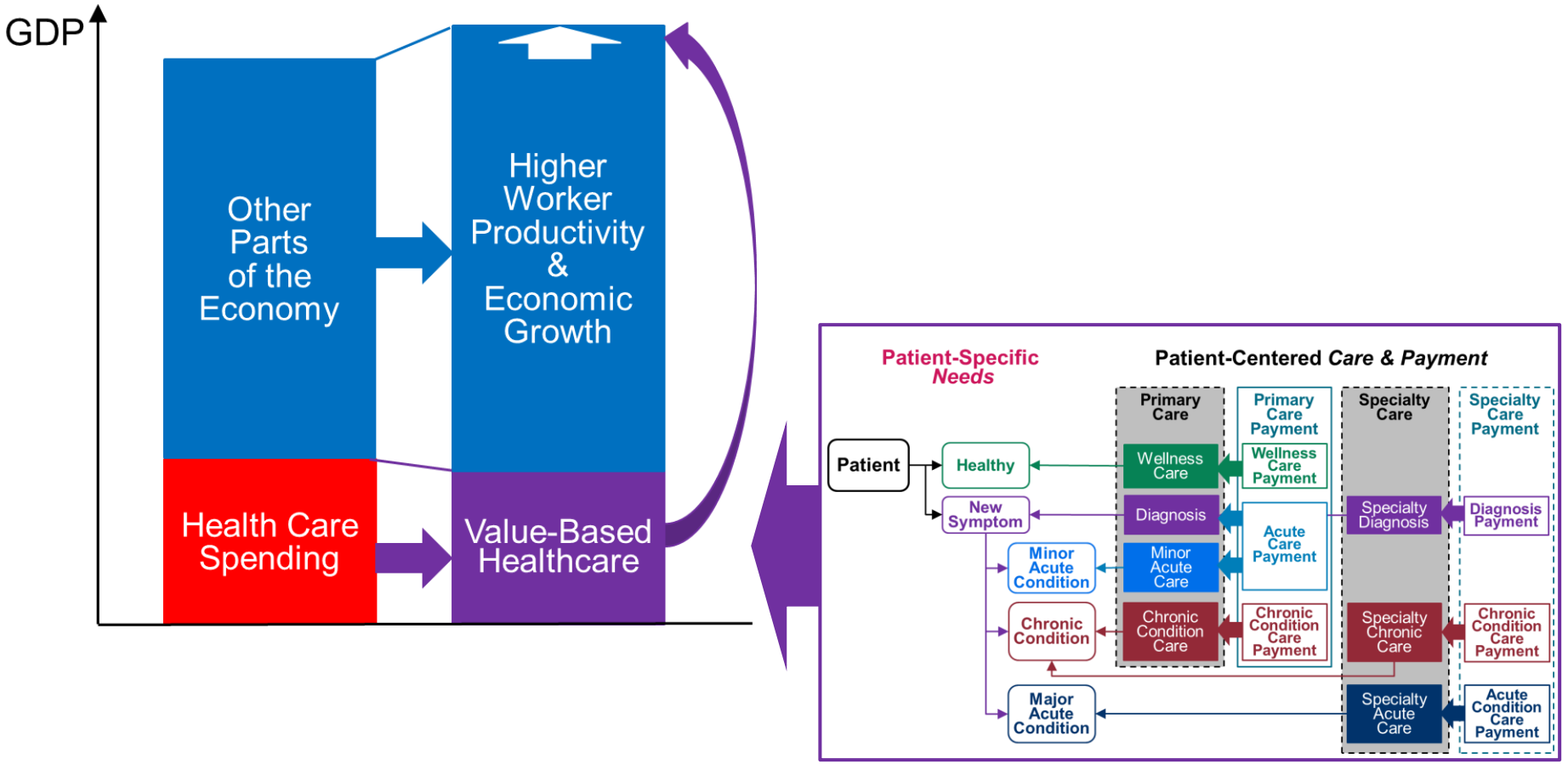
Value-Based Care Must Be *Patient-Centered* Care



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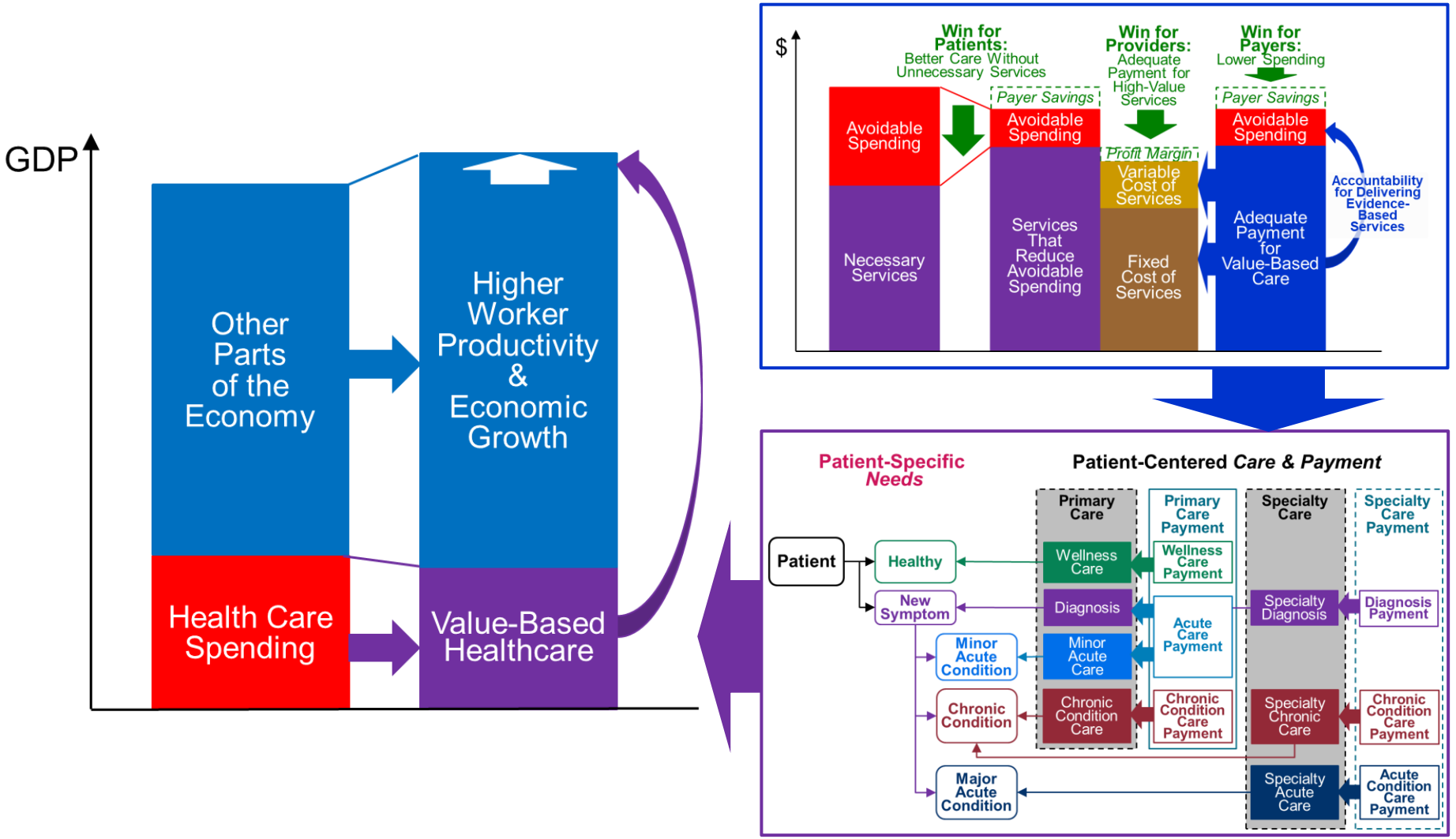
A Win-Win-Win Approach to Value Is the Only Sustainable Strategy



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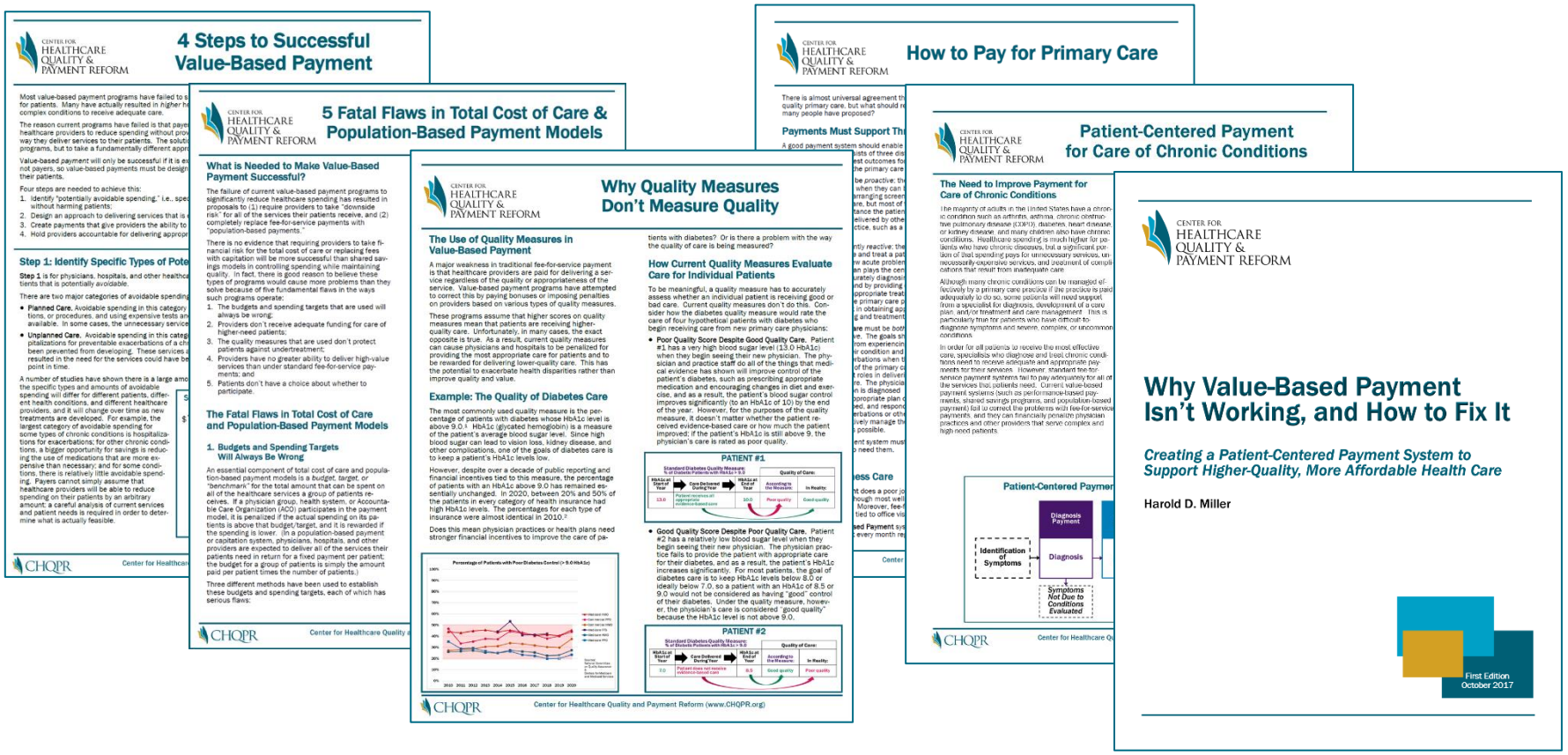
More on Value-Based Payment for Sustainable Healthcare

PaymentReform.org PatientCenteredPayment.org



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