Paying for Value
Implications for Rural Hospitals

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

www.CHQPR.org
Concern Continues to Grow About Rising Healthcare Costs
Typical Solution #1: Cut Provider Fees for Services

- Cut Provider Fees

SAVINGS

Cut Provider Fees

TOTAL HEALTH CARE SPENDING

TOTAL HEALTH CARE SPENDING

TOTAL HEALTH CARE SPENDING

BY PAYERS
Typical Solution #2: Shift Costs to Patients

$ 

TOTAL HEALTH CARE SPENDING 

TOTAL HEALTH CARE SPENDING 

TOTAL HEALTH CARE SPENDING 

TOTAL HEALTH CARE SPENDING BY PAYERS 

Higher Cost-Share & Deductibles 

SAVINGS
Typical Solution #3:
Delay or Deny Care to Patients

$Savings$

TOTAL HEALTH CARE SPENDING

TOTAL HEALTH CARE SPENDING

TOTAL HEALTH CARE SPENDING

TOTAL HEALTH CARE SPENDING

Lack of Needed Care

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Results of These Win-Lose Strategies

- Small physician practices and hospitals forced out of business or forced to consolidate with large systems that can demand higher prices
- Hard-to-treat patients can’t get the care they need
- Deferral of needed services and delivery of unnecessary services results in more serious problems and more expensive care in the future
- Health insurance costs continue to rise and access to insurance coverage and healthcare services decreases
Health Insurance Premiums Continue to Grow

Employer-Sponsored Family Insurance Premiums, 2002-2014

- U.S. Family Premiums
- Inflation

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WA Premiums $6,000 More Expensive Than 12-Year Inflation

Washington Family Health Insurance Premiums

Washington State Family Premiums

Inflation

$6,119
Health Insurance Premiums Are Equal to 35% of Avg. Annual Pay

![Graph showing the percentage of Washington family insurance premiums as a percentage of average annual pay from 2002 to 2014. The premiums have increased over time, reaching 35% in 2014.]
Health Insurance Premiums Are Equal to 35% of Avg. Annual Pay

If insurance premiums in Washington State had increased at the same rate as inflation from 2002 to 2014, Washington employers could have increased wages by 11% or hired 11% more workers.
Medicare Isn’t Doing Any Better

Medicare Will Be Insolvent by 2028
Medicare Spending Is the Biggest Driver of Federal Deficits

Project Federal Spending, 2011-2022
(Billions)

Source: CBO Budget Outlook August 2012

46% of Spending Growth is Healthcare
Is There a Better Way?
Institute of Medicine Estimate: 30% of Spending is Avoidable
5-17% of Hospital Admissions Are Potentially Preventable

% of Hospital Stays That Were Potentially Preventable, 2008

<table>
<thead>
<tr>
<th>Category</th>
<th>Potentially Preventable Chronic Conditions</th>
<th>Potentially Preventable Acute Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private Insurance</td>
<td>2.1%</td>
<td>3.3%</td>
</tr>
<tr>
<td>Medicare</td>
<td>10.1%</td>
<td>6.8%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>1.6%</td>
<td>3.8%</td>
</tr>
<tr>
<td>Uninsured</td>
<td>3.1%</td>
<td>6.8%</td>
</tr>
</tbody>
</table>

Source: AHRQ HCUP
Millions of Preventable Events Harm Patients and Increase Costs

<table>
<thead>
<tr>
<th>Medical Error</th>
<th># Errors (2008)</th>
<th>Cost Per Error</th>
<th>Total U.S. Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressure Ulcers</td>
<td>374,964</td>
<td>$10,288</td>
<td>$3,857,629,632</td>
</tr>
<tr>
<td>Postoperative Infection</td>
<td>252,695</td>
<td>$14,548</td>
<td>$3,676,000,000</td>
</tr>
<tr>
<td>Complications of Implanted Device</td>
<td>60,380</td>
<td>$18,771</td>
<td>$1,133,392,980</td>
</tr>
<tr>
<td>Infection Following Injection</td>
<td>8,855</td>
<td>$78,083</td>
<td>$691,424,965</td>
</tr>
<tr>
<td>Pneumothorax</td>
<td>25,559</td>
<td>$24,132</td>
<td>$616,789,788</td>
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<tr>
<td>Central Venous Catheter Infection</td>
<td>7,062</td>
<td>$83,365</td>
<td>$588,723,630</td>
</tr>
<tr>
<td>Others</td>
<td>773,808</td>
<td>$11,640</td>
<td>$9,007,039,005</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1,503,323</td>
<td>$13,019</td>
<td>$19,571,000,000</td>
</tr>
</tbody>
</table>

3 Adverse Events Every Minute

Source: The Economic Measurement of Medical Errors, Milliman and the Society of Actuaries, 2010
Many Tests & Services Are Unnecessary & May Be Harmful

For pharmacological treatment of patients with gastroesophageal reflux disease (GERD), long-term acid suppression therapy (proton pump inhibitors or histamine2 receptor antagonists) should be titrated to the lowest effective dose needed to achieve therapeutic goals.

Don’t order annual electron microscopy for low-risk patients.

Many Tests & Services Are Unnecessary & May Be Harmful
20-50% Non-Adherence to Choosing Wisely Criteria

Rate of Non-Adherence to Choosing Wisely Guidelines

- Do not use routine biomarker tests and advanced imaging to screen for recurrence in asymptomatic breast cancer patients...
- Avoid anticancer therapy in patients with advanced solid tumors who are unlikely to benefit
- Do not use white-cell stimulating factors for patients undergoing chemotherapy with less than 20% risk of febrile neutropenia
- Do not use PET, CT and radionuclide bone scans in staging early prostate cancer at low risk of spreading
- Do not use PET, CT and radionuclide bone scans in staging early breast cancer at low risk of spreading

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Significant Variation in Avoidable Spending in WA

Figure 1. The percentage of patients who had an uncomplicated headache and had a potentially unnecessary CT scan or MRI imaging test, compared to the state commercial average of 22%, 2011-2012.*

Figure 13. The percentage of female patients who had too frequent Pap tests, compared by the commercial average of 59%, 2011-2012.*
The Right Focus: Spending That is Unnecessary or Avoidable

- AVOIDABLE SPENDING
- NECESSARY SPENDING

$TIME$
The Right Goal: Less Avoidable $,
The Right Goal: Less Avoidable $, More Necessary $
The Hoped-For Result: Win-Win for Patients & Payers

NECESSARY SPENDING

AVOIDABLE SPENDING

SAVINGS

Lower Spending for Payers

Better Care for Patients

TIME

$
Payer Efforts to Promote “Value” Rather Than Volume of Services

- Value-Based Purchasing
- Value-Based Payment
Private “Value-Based Purchasing” = Using “High-Value” Providers

Patients \[\rightarrow\] “High-Value” Providers

“Low-Value” Providers
How Do You Define “High Value?”

Patients → “High-Value” Providers

“Low-Value” Providers
Is This How to Define Value?

\[
\text{VALUE} = \frac{\text{QUALITY}}{\text{COST}}
\]
Which Oncologist Would You Use to Treat Your Cancer?

\[
\text{VALUE} = \frac{\text{QUALITY}}{\text{COST}}
\]

**ONCOLOGIST #1**
- 7 Year Survival
- $5,000/patient

**ONCOLOGIST #2**
- 10 Year Survival
- $10,000/patient
Oncologist #2 Rates Worse on the Standard Measure of “Value”

VALUE = \frac{QUALITY}{COST}

**ONCOLOGIST #1**

7 Year Survival: $5,000/patient

0.51 days of life per dollar

**ONCOLOGIST #2**

10 Year Survival: $10,000/patient

0.37 days of life per dollar
Assessing Value is a Lot Harder Than This

\[ \text{VALUE} \neq \frac{\text{QUALITY}}{\text{COST}} \]
All Too Often, “High-Value” Means “Willing to Accept Discounted Fee”

“High-Value” Providers (i.e., discounts)

“Low-Value” Providers
Step 2: Reward High-Value Providers With More Patients

More Patients

“High-Value” Providers (i.e., discounts)

“Low-Value” Providers
But Wait: Weren’t We Going to Stop Rewarding Volume???

More Patients → “High-Value” Providers (i.e., discounts) → “Low-Value” Providers

Volume → Value
What if the Network is Already “Narrow?”

More? Patients → One Provider in the Community
(Rural Area, Consolidated System, Etc.)
National Narrow Networks: “Centers of Excellence”

More Patients \rightarrow High-Value Providers in Other Cities

\rightarrow \times \rightarrow One Provider in the local Community
Walmart, Lowes, and Others Using “Centers of Excellence”
Will Every Cancer Patient Have to Go to Minnesota?
Critical Access Hospitals Could Be Harmed by Value-Based Purchasing

- CAHs don’t have published data on quality
- CAHs will not be able to underbid large hospitals
- Patients going to hospitals in other cities for treatment would reduce volumes in the CAH, making it more difficult to maintain high quality care in the CAH, creating a downward spiral
Paying Based on “Value” Rather Than Volume of Services

• Value-Based Purchasing
• **Value-Based Payment**
Value-Based Payment Provides “Incentives” for Higher Value Care

Fee for Service

Pay for Performance (“P4P”) Based on Quality and Cost Measures

Bonus

Penalty
Hospital Value-Based Payment

- Hospital Readmission Penalties
- Hospital-Acquired Condition Penalties
- Hospital Value-Based Purchasing
Hospital Readmission Penalties

- Current Payment & High Readmit Rate
- Reduce Readmissions
- OR
- Payments for All Admissions Will Be Cut

Revenue from High Readmit Rate
Revenue from Admissions
The Hope: Hospitals Will Reduce Readmissions to Avoid Penalties

Current Payment & High Readmit Rate

Revenue from High Readmit Rate

Revenue from Admissions

Lower Readmits & No Payment Cut

Revenue from Average Readmit Rate

Revenue from Admissions w/ no Change in Payment Rate
The Myth: Hospitals Control All of the Reasons for Readmissions

- Revenue from High Readmit Rate
  - Poor Access to Primary Care
  - Low Quality of Post-Acute Care
  - Patients w/o Capacity for Self-Care or Inadequate Home Support

- Revenue from Admissions
  - Lower Readmits & No Payment Cut

- Revenue from Average Readmit Rate
  - Current Payment & High Readmit Rate
  - Revenue from Admissions w/ no Change in Payment Rate
CONCLUSIONS AND RELEVANCE  Patient characteristics not included in Medicare's current risk-adjustment methods explained much of the difference in readmission risk between patients admitted to hospitals with higher vs lower readmission rates. Hospitals with high readmission rates may be penalized to a large extent based on the patients they serve.

*JAMA Intern Med.* Published online September 14, 2015. doi:10.1001/jamainternmed.2015.4660
Under Current Pmt System, Fewer Readmissions = Lower Margins

- **Current Payment & High Readmit Rate**
  - Revenue from High Readmit Rate
  - Revenue from Admissions
  - Hospital Costs
  - Margin

- **Lower Readmits & No Payment Cut**
  - Revenue from Average Readmit Rate
  - Revenue from Admissions w/ no Change in Payment Rate
  - Hospital Costs
  - (Don’t Decrease in Proportion to Revenues)

**Losses**

- Revenue from Admissions w/ no Change in Payment Rate
- Hospital Costs
- (Don’t Decrease in Proportion to Revenues)
So Hospitals Are Hurt Financially One Way or the Other

Current Payment & High Readmit Rate

- Reduced Revenue from Admissions Due to Readmission Penalties
- Revenue from High Readmit Rate
- Hospital Costs
- Losses

Lower Readmits & No Payment Cut

- Revenue from Average Readmit Rate
- Hospital Costs
- (Don’t Decrease in Proportion to Revenues)
- Revenue from Admissions w/ no Change in Payment Rate
- Losses
Hospital Value-Based Payment

- Hospital Readmission Penalties
- Hospital-Acquired Condition Penalties
- Hospital Value-Based Purchasing
  - Payment levels are cut across the board
  - Hospitals have to earn back the cuts based on quality measures and "resource use" measures
    - Medicare Spending Per Beneficiary measure calculates cost of all services that occur up to 30 days after discharge
    - Hospital is penalized if costs are higher than other hospitals for similar patients
Impact of VBP on Critical Access Hospitals

- CAHs not subject directly to Value-Based Purchasing
  - Affordable Care Act required a demonstration project to do this but CMS has not implemented one
- Resource Use measures for IPPS hospitals could discourage use of CAHs
  - If CAH SNF cost per day is high or if patient is readmitted to the CAH, IPPS hospitals could avoid using the CAH for post-acute care services
Most Value-Based Payment for Docs Has Been Quality Bonuses

QUALITY MEASURES
• Mammograms
• Colon Cancer Screening
• HbA1c Control
• LDL

FFS
P4P+
P4P Hasn’t Worked Terribly Well

- A small bonus may not be enough to pay for the added costs of improving quality
- A small bonus may not be enough to offset loss of fee-for-service revenue from healthier patients or lower utilization
- A small bonus may not be enough to offset the costs of collecting and reporting the quality data
Over-Emphasis on Narrow Quality Measures Can Harm Patients

Source: National Trends in US Hospital Admissions for Hyperglycemia and Hypoglycemia Among Medicare Beneficiaries, 1999 to 2011  JAMA Internal Medicine May 17, 2014
Solution? Add More Measures

QUALITY MEASURES
• Mammograms
• Colon Cancer Screening
• HbA1c Control
• LDL

QUALITY MEASURES
• Mammograms
• Colon Cancer Screening
• Flu Vaccine
• Tobacco Counseling
• Hypertension Control
• HbA1c Control
• LDL
• Eye Exams
• Aspirin Use
When That Didn’t Work, Bonuses Were Converted Into Penalties

QUALITY MEASURES
- Mammograms
- Colon Cancer Screening
- Flu Vaccine
- Tobacco Counseling
- Hypertension Control
- HbA1c Control
- LDL
- Eye Exams
- Aspirin Use

LOSSES/UNPAID SVCS
The End of Collaboration?

• In the CMS Value-Based Payment Modifier, bonuses are only paid to physicians who have above average quality if penalties are assessed on other physicians with below average quality.

• To maintain budget neutrality, the size of bonuses depends on the size of penalties.

• Under this system, why would high-performing physicians want to help under-performing physicians to improve?
MACRA

• MACRA (Medicare Access and CHIP Reauthorization Act) repealed the Sustainable Growth Rate (SGR) formula that was threatening to cut physician payment every year
• MACRA created two optional replacements
  – MIPS (Merit-Based Incentive Payment System)
  – APMs (Alternative Payment Models)
MIPS is P4P on Steroids

<table>
<thead>
<tr>
<th>Year</th>
<th>FFS + PQRS + MU + VBM</th>
<th>FFS + PQRS + MU + VBM</th>
<th>FFS + PQRS + MU + VBM</th>
<th>FFS + MIPS</th>
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<th>FFS + MIPS</th>
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<tbody>
<tr>
<td>2015</td>
<td>+x% -9%</td>
<td>+x% -9%</td>
<td>+x% -9%</td>
<td>+4% -10%</td>
<td>+5% -5%</td>
<td>+7% -7%</td>
<td>+9% -9%</td>
<td>+9% -9%</td>
<td>+9% -9%</td>
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<tr>
<td>2016</td>
<td>+x% -6%</td>
<td>+x% -6%</td>
<td>+x% -6%</td>
<td>+4% -4%</td>
<td>+5% -5%</td>
<td>+7% -7%</td>
<td>+9% -9%</td>
<td>+9% -9%</td>
<td>+9% -9%</td>
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<tr>
<td>2017</td>
<td>+x% -4.5%</td>
<td>+x% -4.5%</td>
<td>+x% -4.5%</td>
<td>+5% -4%</td>
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<td>+5% -4%</td>
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<tr>
<td>2018</td>
<td>+x% -6%</td>
<td>+x% -6%</td>
<td>+x% -6%</td>
<td>+5% -4%</td>
<td>+5% -4%</td>
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<td>+5% -4%</td>
<td>+5% -4%</td>
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MIPS “Merit-Based Incentive Payment System”

<table>
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<tr>
<th>Year</th>
<th>FFS + MIPS</th>
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<tr>
<td>2019</td>
<td>50% -&gt; 30%</td>
<td>50% -&gt; 30%</td>
<td>50% -&gt; 30%</td>
<td>50% -&gt; 30%</td>
<td>50% -&gt; 30%</td>
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<tr>
<td>2020</td>
<td>10% -&gt; 30%</td>
<td>10% -&gt; 30%</td>
<td>10% -&gt; 30%</td>
<td>10% -&gt; 30%</td>
<td>10% -&gt; 30%</td>
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<tr>
<td>2021</td>
<td>15%</td>
<td>15%</td>
<td>15%</td>
<td>15%</td>
<td>15%</td>
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<tr>
<td>2022</td>
<td>25%</td>
<td>25%</td>
<td>25%</td>
<td>25%</td>
<td>25%</td>
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<tr>
<td>2023</td>
<td>25%</td>
<td>25%</td>
<td>25%</td>
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<tr>
<td>2024</td>
<td>25%</td>
<td>25%</td>
<td>25%</td>
<td>25%</td>
<td>25%</td>
</tr>
</tbody>
</table>

Quality Ratio

- Resource Use
- "Clinical Practice Improvement Activities"
- EHR "Meaningful Use"

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Docs Will Be Rewarded for Using Fewer and Lower-Cost Services

Physicians’ Pay Will Be Based on Total Cost of Care For their Patients

FFS + PQRS + MU + VBM

2015: +x% -4.5%
2016: +x% -6%
2017: +x% -9%
2018: +x% -10%
2019: +4% -4%
2020: +5% -5%
2021: +7% -7%
2022: +9% -9%
2023: +9% -9%
2024: +9% -9%

FFS + MIPS

2015: +x% -4.5%
2016: +x% -6%
2017: +x% -9%
2018: +x% -10%
2019: +4% -4%
2020: +5% -5%
2021: +7% -7%
2022: +9% -9%
2023: +9% -9%
2024: +9% -9%

FFS

2015: +x% -4.5%
2016: +x% -6%
2017: +x% -9%
2018: +x% -10%
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2020: +5% -5%
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FFS + MIPS

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2024: +9% -9%

FFS + MIPS

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2018: +x% -10%
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2020: +5% -5%
2021: +7% -7%
2022: +9% -9%
2023: +9% -9%
2024: +9% -9%


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Critical Access Hospitals Could Be Harmed by MIPS

- **Quality Measures**
  - Small volumes of patients and safety net services could make quality measures for physicians look poor compared to those at other hospitals

- **Resource Use Measures**
  - Surgeons will be penalized if their patients use higher-cost post-acute care services
  - Primary care physicians will be penalized if their patients are hospitalized at higher-cost hospitals
  - If CAH cost per day or cost per admission is higher than other hospitals, physicians could avoid using the CAH for admissions or post-acute care services
MACRA Encourages “APMs”

- MACRA (Medicare Access and CHIP Reauthorization Act) repealed the Sustainable Growth Rate (SGR) formula that was threatening to cut physician payment every year.
- MACRA created two optional replacements:
  - MIPS (Merit-Based Incentive Payment System)
  - APMs (Alternative Payment Models)
HHS Announced Goal to Move Away From VBP & FFS+P4P

“Value-Based Purchasing”

FFS
• No payment for services that will benefit patients
• Lower revenues from reducing avoidable costs

P4P

FFS
• No payment for services that will benefit patients
• Lower revenues from reducing avoidable costs

HHS Goal for 2018

“Alternative Payment Models Built on a FFS Architecture”

P4P

FFS
HHS Announced Goal to Move Away From VBP & FFS+P4P

“Value-Based Purchasing”

FFS
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P4P

FFS
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HHS Goal for 2018

“Alternative Payment Models Built on a FFS Architecture”

P4P

FFS

What the heck is an “Alternative Payment Model Built on FFS Architecture?”

And is that better than FFS+P4P?
## CMS “Alternative Payment Models” Announced To Date

<table>
<thead>
<tr>
<th>TYPE OF PROVIDER</th>
<th>CMS PROGRAM</th>
</tr>
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<tbody>
<tr>
<td>Health Systems, Multi-Specialty Groups, PHOs, and IPAs</td>
<td>Accountable Care Organizations (MSSP &amp; Pioneer)</td>
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<td>Comprehensive Primary Care Initiative</td>
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<td>Oncology Care Model</td>
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<td>Hospitals and Post-Acute Care</td>
<td>Comprehensive Care for Joint Replacement</td>
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### CMS “Alternative Payment Models”
Don’t Change Current Payments

<table>
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<td>FFS + PMPM $ for Attributed Patients + Shared Savings on Attributed Total Spending (for State or Region)</td>
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<tr>
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Some Provide Additional Upfront Resources to Physicians…

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...Most Only Provide More $ After Other Spending is Reduced

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</table>
How “Shared Savings” Works

- Hospitals, physicians, skilled nursing facilities, etc. all get paid the same way they do today.
- CMS adds up all of your spending and compares it to what you spent the previous year to calculate the increase.
- CMS compares your increase to the increase in spending for other providers treating supposedly similar patients.
- If your increase is less than the other providers, CMS makes an additional payment to you next year based on a percentage of the difference between your increase and other providers’ increases (i.e., a share of the savings).

- “One-sided risk” means you can get an additional payment if your increase is lower than others, but no penalty if your increase is higher.
- “Two-sided risk” means you also have to pay money back to CMS if your increase is higher.
Problems With “Shared Savings”

• Providers receive no upfront resources to improve care management for patients

• Already efficient providers receive little or no additional revenue and may be forced out of business

• Providers who have been practicing inefficiently or inappropriately are paid more than others

• Providers could be rewarded for denying needed care as well as by reducing overuse

• Providers are placed at risk for costs they cannot control and random variation in spending
In Most ACOs, Physicians/Hospitals Are Paid the Same As Today

MEDICARE, MEDICAID
HEALTH PLAN

Fee-for-Service Payment

PATIENTS
- Heart Disease
- Diabetes
- Back Pain
- Pregnancy

ACO
- Hospitals
- Primary Care
- Cardiology
- Endocrinology
- Neurosurgery
- OB/GYN

© Center for Healthcare Quality and Payment Reform www.CHQPR.org
Most ACOs Spend a Lot on IT and Nurse Care Managers

**MEDICARE, MEDICAID HEALTH PLAN**

*Fee-for-Service Payment*

**ACO**
- Expensive IT Systems
- Nurse Care Managers

**PATIENTS**
- Heart Disease
- Diabetes
- Back Pain
- Pregnancy

**Primary Care**
- Cardiology
- Endocrinology
- Neurosurgery
- OB/GYN

**Hospitals**
Possible Future “Shared Savings” Doesn’t Support Better Care Today

MEDICARE, MEDICAID HEALTH PLAN

Fee-for-Service Payment

Shared Savings Payment??

ACO

Expensive IT Systems

Nurse Care Managers

Share of Shared Savings $ ??

PATIENTS
- Heart Disease
- Diabetes
- Back Pain
- Pregnancy

Primary Care
Cardiology
Endocrinology
Neurosurgery
OB/GYN

Hospitals
Medicare ACOs Aren’t Succeeding Due to Flaws in Payment Model

2013 Results for Medicare Shared Savings ACOs
• 46% of ACOs (102/220) increased Medicare spending
• Only one-fourth (52/220) received shared savings payments
• After making shared savings payments, Medicare spent more than it saved

2014 Results for Medicare Shared Savings ACOs
• 45% of ACOs (152/333) increased Medicare spending
• Only one-fourth (86/333) received shared savings payments
• After making shared savings payments, Medicare spent more than it saved
Private Shared Savings ACOs Are Also Floundering

Many private-payer ACOs fail to yield lower costs, better quality

By Bob Herman | October 15, 2015

CHICAGO—Medicare’s investment in accountable care organizations has inspired hospitals and doctors to create their own versions of ACOs with private insurers. But as with Medicare, not all private ACOs are achieving lower costs and higher quality.

Providers and insurers need to do a better job of reaching patients and employers, according to physician executives at four large health insurance companies. They gave their take on the private ACO movement at an event held by America’s Health Insurance Plans, the industry’s trade group.

Their experiences reflect that ACOs are still a new structure, and building a new payment and care model as complex as an ACO is not easy to roll out.

“Our alternative payment models are succeeding at a much lower rate than they should be,” said Dr. Stephen Ondra, chief medical officer at Health Care Service Corp., the Blue Cross and Blue Shield insurer for five states. “In the ACO, the consumer engagement is very, very low.”
Most “Alternative Payment Models” Are Just FFS + P4P

“Value-Based Purchasing”

FFS
• No payment for services that will benefit patients
• Lower revenues from reducing avoidable costs

P4P
• No payment for services that will benefit patients

“APMs Built on FFS Architecture”

Shared Savings
PMPM
• No payment for services that will benefit patients
• Lower revenues from reducing avoidable costs
Is There a Better Way?

“Value-Based Purchasing”

- No payment for services that will benefit patients
- Lower revenues from reducing avoidable costs

„APMs Built on FFS Architecture”

- No payment for services that will benefit patients
- Lower revenues from reducing avoidable costs

FFS

- No payment for services that will benefit patients
- Lower revenues from reducing avoidable costs

P4P

Shared Savings

PMPM
What If We Paid for Cars the Way We Pay for Care?
What If We Paid for Cars the Way We Pay for Care?

ACA

Affordable Car Act
What If We Paid for Cars the Way We Pay for Care?

ACA
Affordable Car Act

Goal:
Every citizen should have affordable transportation
What If We Paid for Cars the Way We Pay for Care?

ACA
Affordable Car Act

Goal:
Every citizen should have affordable transportation

Method for Achieving the Goal:
Give all citizens insurance that would cover the cost of new automobiles and repairs when needed
How to Control Spending on Cars If Insurance Is Paying For Them?
Should the Government Set Fees for Each Car Part…

HCPCS Codes (Hierarchical Car Parts Compensation System)
...And Pay Auto Workers Based On How Many Parts They Installed?

HCPCS Codes (Hierarchical Car Parts Compensation System)

AMA
Automobile Manufacturing Association

CPT System (Car Parts Tokens)

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The Result for Drivers If We Paid That Way…
The Result for Drivers If We Paid That Way…

Cars would get many unnecessary parts
The Result for Drivers If We Paid That Way…

Cars would get many unnecessary parts

Cars would be readmitted to the factory frequently to correct malfunctions
Spending on Cars Would Grow Rapidly
Spending on Cars Would Grow Rapidly

Car Manufacturing as % of GDP

Government Spending

- Car Subsidies
- Other Govt Spending
What to Do?
What to Do?
Cut Fees for Parts & Assembly
What to Do?
Cut Fees for Parts & Assembly

More Parts Used

Cut Fees for Parts & Assembly
What to Do?
Cut Fees for Parts & Assembly

Cut Fees for Parts & Assembly

More Parts Used

Factories Merge to Resist Fee Cuts

$
What to Do?
“Managed Cars”
What to Do?
“Managed Cars”

Waiting for Prior Authorization to Buy a New Car
What to Do?
“Managed Cars”

Waiting for Prior Authorization to Buy a New Car

Requirements to Try Lower-Cost Services First
What to Do?
“Shared Savings” Program

STEP 1
Continue Paying Factories & Workers Based on Parts
What to Do?
“Shared Savings” Program

STEP 1
Continue Paying Factories & Workers Based on Parts

STEP 2
After Cars Are Built & Sold, Compare Total Cost of Parts and Award “Shared Savings”

\[
\text{# of Parts} \times \text{Cost of Parts} > \\
\text{# of Parts} \times \text{Cost of Parts}
\]
What to Do?
“Shared Savings” Program

STEP 1
Continue Paying Factories & Workers Based on Parts

STEP 2
After Cars Are Built & Sold, Compare Total Cost of Parts and Award “Shared Savings”

Give Factory 0-50% of Difference in Cost of Parts Compared to Other Cars If Minimum Savings Threshold and Quality Targets Were Met
What to Do?
“Shared Savings” Program

STEP 1
Continue Paying Factories & Workers Based on Parts

STEP 2
After Cars Are Built & Sold, Compare Total Cost of Parts and Award “Shared Savings”

RESULT

# of Parts \times Cost of Parts

Give Factory 0-50% of Difference in Cost of Parts Compared to Other Cars If Minimum Savings Threshold and Quality Targets Were Met
## What to Do?

### “Shared Savings” Program

**STEP 1**
Continue Paying Factories & Workers Based on Parts

**STEP 2**
After Cars Are Built & Sold, Compare Total Cost of Parts and Award “Shared Savings”

<table>
<thead>
<tr>
<th># of Parts</th>
<th>Cost of Parts</th>
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<td></td>
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<td>Plus</td>
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<tr>
<td></td>
<td></td>
<td>Difference in Cost of Parts Compared to Other Cars If Minimum Savings Threshold and Quality Targets Were Met</td>
<td></td>
</tr>
</tbody>
</table>

**RESULT**

- Some factories would reduce parts, but not enough to get shared savings.
**What to Do?**

“Shared Savings” Program

**STEP 1**
Continue Paying Factories & Workers Based on Parts

**STEP 2**
After Cars Are Built & Sold, Compare Total Cost of Parts and Award “Shared Savings”

- Give Factory 0-50% of Difference in Cost of Parts Compared to Other Cars If Minimum Savings Threshold and Quality Targets Were Met

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- Some factories would reduce parts, but not enough to get shared savings
- Some factories would spend more to meet quality targets than they receive in shared savings
What to Do?
“Shared Savings” Program

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What to Do?
“Shared Savings” Program

STEP 1
Continue Paying Factories & Workers Based on Parts

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After Cars Are Built & Sold, Compare Total Cost of Parts and Award “Shared Savings”

RESULT
- Some factories would reduce parts, but not enough to get shared savings
- Some factories would spend more to meet quality targets than they receive in shared savings
- Some factories would leave out parts where there were no quality measures
- Most factories and workers would lose money and go back to business as usual
The Way We Actually Pay for Cars Is Much Better
Pay for Complete Cars With Warranties, Not Parts & Repairs

For more than a decade, America's Best Warranty hasn't just changed how our customers feel about their cars, it's changed how we build vehicles. To make sure we deliver automobiles worthy of a 10-year warranty, Hyundai initiated the Drive Defects to Zero plan. This program has a dedicated team of Hyundai engineers that are charged with catching, learning about and fixing any issue, no matter how small, before it gets to the customer.

America's Best Warranty
10-Year/100,000-Mile
Powertrain Limited Warranty
True “Value-Based” APMs Pay for Comprehensive Services

“Value-Based Purchasing”

- No payment for services that will benefit patients
- Lower revenues from reducing avoidable costs

“APMs Built on FFS Architecture”

- No payment for services that will benefit patients
- Lower revenues from reducing avoidable costs

FFS

P4P

Shared Savings

PMPM

Condition-Based Payments

Bundled/Warrantied Payments

Primary Care Medical Home Payments
Examples of How Good APMs Can Work

“Value-Based Purchasing”

- No payment for services that will benefit patients
- Lower revenues from reducing avoidable costs

“APMs Built on FFS Architecture”

- No payment for services that will benefit patients
- Lower revenues from reducing avoidable costs

Primary Care Medical Home Payments

Condition-Based Payments

Bundled/Warrantied Payments

FFS

P4P

Shared Savings

PMPM

Primary Care Medical Home Payments

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# A Hypothetical Case of Surgery

<table>
<thead>
<tr>
<th>COST TYPE</th>
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<tbody>
<tr>
<td>Physician Fee</td>
<td>$2,000</td>
</tr>
<tr>
<td>Hospital Cost</td>
<td>$20,900</td>
</tr>
<tr>
<td>Hosp. Margin (5%)</td>
<td>$1,100</td>
</tr>
<tr>
<td>Total Hospital Pmt</td>
<td>$22,000</td>
</tr>
<tr>
<td>Total Cost to Payer</td>
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</table>
Most of the Money Is Not Going to the Physician

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</table>

Physician receives 8% of total spending
What if the Surgeon Could Reduce The Hospital’s Costs?

<table>
<thead>
<tr>
<th>COST TYPE</th>
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<tbody>
<tr>
<td>Physician Fee</td>
<td>$2,000</td>
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</tr>
<tr>
<td>Hospital Cost</td>
<td>$20,900</td>
<td>-3% ($630)</td>
</tr>
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<td></td>
</tr>
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</table>
Today: All Savings Goes to the Hospital, No Reward for Physician

<table>
<thead>
<tr>
<th>COST TYPE</th>
<th>TODAY</th>
<th>CHANGE</th>
<th>SPLIT</th>
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</thead>
<tbody>
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<td>+ 0%</td>
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<td>$20,900</td>
<td>-3% ($630)</td>
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<td>$1,100</td>
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<tr>
<td>Total Cost to Payer</td>
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<td>-0%</td>
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</table>
Bundling Eliminates Boundary Between Hospital & Physician Pmt

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# Bundling Allows Savings Split Among Docs, Hospitals, Payers

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<td>+18% ($200)</td>
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<td>$1,100</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Cost to Payer</td>
<td>$24,000</td>
<td>-1% ($230)</td>
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So Price of Surgery is Lower But More Profitable

<table>
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<th>COST TYPE</th>
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<td>$20,270</td>
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<tr>
<td>Hospital Margin</td>
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<td>+18% ($200)</td>
<td>$1,300</td>
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<td>Total Cost to Payer</td>
<td>$24,000</td>
<td>-1% ($230)</td>
<td>$23,770</td>
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</table>
Opportunities to Reduce Hospital Costs

• Use of lower-cost medical devices and equipment, or negotiating for better prices on devices
• Better scheduling of scarce resources (e.g., surgery suites) to reduce both underutilization & overtime
• Coordination among multiple physicians and departments to avoid duplication and conflicts in scheduling
• Standardization of equipment and supplies to facilitate bulk purchasing
• Less wastage of expensive supplies
• Reduced length of stay
• Etc.
Medicare Acute Care Episode (ACE) Demonstration

- Bundled Medicare Part A (hospital) and Part B (physician) payments together for cardiac and orthopedic (hips & knees) procedures
- Total Medicare payment was 1%-8% lower than what the standard Medicare DRG + physician fee would have been
- Payment was made to a Physician-Hospital Organization, which then divided the payment between hospital and surgeon
- Surgeon could receive up to 25% above Medicare fee
- Patient cost-sharing reduced by up to 50% of Medicare’s savings
- CMS waived Stark rules for gainsharing
- Implemented in 2009/2010 in five hospital systems based on competitive bids:
  - Hillcrest Medical Center, Oklahoma (cardiac + orthopedic procedures)
  - Baptist Health System, Texas (cardiac + orthopedic procedures)
  - Oklahoma Heart Hospital, Oklahoma (cardiac procedures)
  - Lovelace Health System, New Mexico (cardiac + orthopedic procedures)
  - Exempla Saint Joseph Hospital, Colorado (cardiac procedures)
- Most hospitals achieved significant savings, and physicians received increases in payment for procedures
Yes, a Health Care Provider Can Offer a Warranty

Geisinger Health System ProvenCare℠

- A single payment for an ENTIRE 90 day period including:
  - ALL related pre-admission care
  - ALL inpatient physician and hospital services
  - ALL related post-acute care
  - ALL care for any related complications or readmissions

- Types of conditions/treatments currently offered:
  - Cardiac Bypass Surgery
  - Cardiac Stents
  - Cataract Surgery
  - Total Hip Replacement
  - Bariatric Surgery
  - Perinatal Care
  - Low Back Pain
  - Treatment of Chronic Kidney Disease
### ProvenCare® CABG Quality

#### Clinical Outcomes - (18. mos)

<table>
<thead>
<tr>
<th></th>
<th>Before ProvenCare (n=132)</th>
<th>With ProvenCare (n=181)</th>
<th>% Improvement/Reduction</th>
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</thead>
<tbody>
<tr>
<td>In hospital mortality</td>
<td>1.5 %</td>
<td>0 %</td>
<td>21 %</td>
</tr>
<tr>
<td>Patients with any complication (STS)</td>
<td>38 %</td>
<td>30 %</td>
<td>28 %</td>
</tr>
<tr>
<td>Patients with &gt;1 complication</td>
<td>7.6 %</td>
<td>5.5 %</td>
<td>17 %</td>
</tr>
<tr>
<td>Atrial fibrillation</td>
<td>23 %</td>
<td>19 %</td>
<td>60 %</td>
</tr>
<tr>
<td>Neurologic complication</td>
<td>1.5 %</td>
<td>0.6 %</td>
<td>43 %</td>
</tr>
<tr>
<td>Any pulmonary complication</td>
<td>7 %</td>
<td>4 %</td>
<td>22 %</td>
</tr>
<tr>
<td>Blood products used</td>
<td>23 %</td>
<td>18 %</td>
<td>55 %</td>
</tr>
<tr>
<td>Re-operation for bleeding</td>
<td>3.8 %</td>
<td>1.7 %</td>
<td>25 %</td>
</tr>
<tr>
<td>Deep sternal wound infection</td>
<td>0.8 %</td>
<td>0.6 %</td>
<td>44 %</td>
</tr>
<tr>
<td>Readmission within 30 days</td>
<td>6.9 %</td>
<td>3.8 %</td>
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**Readmission within 30 days**

- Before ProvenCare: 6.9%
- With ProvenCare: 3.8%
- Reduction: 44%
Central teachers gain $7G average
Super: Health-care savings balance raises in contract

By GARY PANG
Press Enterprise Writer

SOUTH CENTRE TWP. — Central Columbia teachers will see their average salary of $55,417 jump up by $7,000 under a new three-year contract, newspaper calculations show.

School directors recently gave 4.54 percent raises to their teachers, the largest in the area for the coming year.

But Superintendent Harry Mathias said the district can afford the pay increases because the teachers agreed to changes that will slash health insurance costs.

Teachers also agreed to pay more toward their health insurance.

The changes will let Central keep the lowest insurance costs among area school districts, he said.

The new contract costs $8.3 million in the coming year, Mathias estimated. However, retirements would reduce expenses, he added.

Higher starting salary
Pay raises were set at 4.54 percent for the coming year; 3.62 percent in the contract’s second year, 2010-11, and 4.36 percent in 2011-12.

These raises would push the average teacher salary up to $55,842 in the coming year, $57,864 in the second year and $60,387 in the third, calculations show.

Central also raised the starting salary for teachers. The $33,638 figure would jump up in three years by $4,774, calculations show.

The starting salary will be $35,656 in the coming year, $37,054 in the second year and $38,412 in the final year, Mathias said.

But the contract isn’t just about pay raises, he said.

New insurance
Back in April, Central was predicting a big rise in insurance premiums. To lower costs, the district switched from Capital Blue Cross to Geisinger Health Plan for all employees.

The switch will reduce costs by $130,000 to $140,000, Mathias estimated.

The union accepted the change as part of the new contract, Mathias said.

While other school districts are facing 7 to 8 percent increases in insurance costs, Central is dealing with just a 2.5 percent increase, the superintendent said.

Central’s average health insurance cost is $8,400 per teacher, Mathias estimated. He said other school districts are paying thousands of dollars more.

That’s because many school districts get health insurance through the Northeast Pennsylvania School Health Trust, he said.

Central, however, finds insurance and bargains on its own. That reduces district costs by $500,000.

Teachers’ concession
Teachers made another concession that might save Central an additional $20,000, Mathias said.

Before, teachers could choose between an ordinary plan and a more expensive one. If they chose the pricier plan, they paid more money toward the upgrade, but the district picked up some of the additional cost.

Now if they choose a pricier insurance plan, they’ll swallow all the extra expenses.

The pricier plan costs $250 more for single employees and $650 more for employees with families.

What they’ll pay
Teachers had been paying 10 percent of their insurance premiums. That will increase to 11 percent in the first year of the new contract, then 12 percent the second year and 13 percent the third year.

Mathias gave examples of what they might pay in the coming year. These figures do not include the “free” option.

• The premium for a single employee is $4,500, with the employee paying $500.

• The premium for a family plan is $10,500, so the employee pays $1,150.

The rate is different for non-teacher employees, Mathias noted. Support staff members pay 5 percent of their premiums, while administrators pay 6 percent of their premiums, plus .6 percent of their salaries.

Expense breakdown
The contract’s cost of $8.3 million for the coming year includes insurance expenses: $1 million for teachers and $800,000 to $900,000 for everyone else, Mathias estimated.

In 2008-09, Central paid about $7.17 million in teacher salaries and $1 million in benefits, Mathias said.

Despite the recent raises, the Central board is not increasing taxes in the coming year under its recently passed budget.
It Can Be Done By Physicians, Not Just Large Health Systems

• In 1987, an orthopedic surgeon in Lansing, Michigan and the local hospital, Ingham Medical Center, offered:
  – a fixed total price for surgical services for shoulder and knee problems
  – a warranty for any subsequent services needed for a two-year period, including repeat visits, imaging, rehospitalization and additional surgery

• Results:
  – Health insurer paid 40% less than otherwise
  – Surgeon received over 80% more in payment than otherwise
  – Hospital received 13% more than otherwise, despite fewer rehospitalizations

• Method:
  – Reducing unnecessary auxiliary services such as radiography and physical therapy
  – Reducing the length of stay in the hospital
  – Reducing complications and readmissions.

A Warranty is Not an Outcome Guarantee

- Offering a warranty on care does not imply that you are guaranteeing a cure or a good outcome.
- It merely means that you are agreeing to correct avoidable problems at no (additional) charge.
- Most warranties are “limited warranties,” in the sense that they agree to pay to correct some problems, but not all.
Prices for Warrantied Care Will Likely Be Higher
Prices for Warrantied Care Will Likely Be Higher

Q: “Why should we pay more to get good-quality care??”
A: In most industries, warrantied products cost more, but they’re desirable because TOTAL spending on the product (repairs & replacement) is lower than without the warranty
Example: $5,000 Procedure, 20% Readmission Rate

<table>
<thead>
<tr>
<th>Cost of Success</th>
<th>Added Cost of Readmit</th>
<th>Rate of Readmits</th>
</tr>
</thead>
<tbody>
<tr>
<td>$5,000</td>
<td>$5,000</td>
<td>20%</td>
</tr>
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</table>
Average Payment for Procedure is Higher than the Official “Price”

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<td>$5,000</td>
<td>20%</td>
<td>$6,000</td>
</tr>
</tbody>
</table>

So how much should you charge to offer this same procedure with a warranty?
## Starting Point for Warranty Price: Actual Current Average Payment

<table>
<thead>
<tr>
<th>Cost of Success</th>
<th>Added Cost of Readmit</th>
<th>Rate of Readmits</th>
<th>Average Total Cost</th>
<th>Price Charged</th>
<th>Net Margin</th>
</tr>
</thead>
<tbody>
<tr>
<td>$5,000</td>
<td>$5,000</td>
<td>20%</td>
<td>$6,000</td>
<td>$6,000</td>
<td>$ 0</td>
</tr>
</tbody>
</table>
Limited Warranty Gives Financial Incentive to Improve Quality

<table>
<thead>
<tr>
<th>Cost of Success</th>
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<th>Average Total Cost</th>
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<td>20%</td>
<td>$6,000</td>
<td>$6,000</td>
<td>$ 0</td>
</tr>
<tr>
<td>$5,000</td>
<td>$5,000</td>
<td>15%</td>
<td>$5,750</td>
<td>$6,000</td>
<td>$250</td>
</tr>
</tbody>
</table>

Reducing Adverse Events...  
...Reduces Costs...  
...Improves The Bottom Line
Higher-Quality Provider Can Charge Less, Attract Patients

<table>
<thead>
<tr>
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<td>$5,000</td>
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<td>15%</td>
<td>$5,750</td>
<td>$5,900</td>
<td>$150</td>
</tr>
</tbody>
</table>

Enables Lower Prices

Still With Better Margin
## A Virtuous Cycle of Quality Improvement & Cost Reduction

<table>
<thead>
<tr>
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<td>10%</td>
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<td>$5,900</td>
<td>$400</td>
</tr>
</tbody>
</table>

Reducing Adverse Events...  
...Reduces Costs...  
...Improves The Bottom Line
## Win-Win-Win Through Appropriate Payment & Pricing

<table>
<thead>
<tr>
<th>Cost of Success</th>
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<tr>
<td>$5,000</td>
<td>$5,000</td>
<td>10%</td>
<td>$5,500</td>
<td>$5,700</td>
<td>$200</td>
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<tr>
<td>$5,000</td>
<td>$5,000</td>
<td>5%</td>
<td>$5,250</td>
<td>$5,700</td>
<td>$450</td>
</tr>
</tbody>
</table>

- Quality is Better...
- ...Cost is Lower...
- ...Providers More Profitable
In Contrast, Non-Payment Alone Creates Financial Losses

<table>
<thead>
<tr>
<th>Cost of Success</th>
<th>Added Cost of Readmit</th>
<th>Rate of Readmits</th>
<th>Average Total Cost</th>
<th>Payment</th>
<th>Net Margin</th>
</tr>
</thead>
<tbody>
<tr>
<td>$5,000</td>
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<td>20%</td>
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<td>$6,000</td>
<td>$0</td>
</tr>
<tr>
<td>$5,000</td>
<td>$5,000</td>
<td>20%</td>
<td>$6,000</td>
<td>$5,000</td>
<td>-$1,000</td>
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<tr>
<td>$5,000</td>
<td>$5,000</td>
<td>10%</td>
<td>$5,500</td>
<td>$5,000</td>
<td>-$500</td>
</tr>
<tr>
<td>$5,000</td>
<td>$5,000</td>
<td>0%</td>
<td>$5,000</td>
<td>$5,000</td>
<td>$0</td>
</tr>
</tbody>
</table>
Many Variations Possible in Combining Bundles and Warranties
Starting with a Hospital Procedure…

PATIENT → Procedure

Hospital DRG

Physician Fee
Simplest Bundle, Already Working in CMS Demonstrations

PATIENT

SINGLE PMT

Procedure

Hospital DRG

Physician Fee
Bundling All Physicians Promotes More Care Coordination

SINGLE PMT

Procedure

Hospital DRG

Lead Doc. Fee

Consultant Fee

Consultant Fee
Not All Care Providers Are Inside the Hospital Walls

PROBLEM:
No incentive to reduce unnecessary use of expensive post-acute care
Bundling Inpatient and Post-Acute Care Promotes Coordination

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Post-Acute</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital DRG</td>
<td>Rehab</td>
</tr>
<tr>
<td>Lead Doc. Fee</td>
<td>Home Health</td>
</tr>
<tr>
<td>Consultant Fee</td>
<td>PCP</td>
</tr>
<tr>
<td>Consultant Fee</td>
<td>Specialist</td>
</tr>
</tbody>
</table>

SINGLE PAYMENT
Does the Bundle Stop When Things Go Bad in the Hospital?

**Problem:**
Hospital and physicians are paid more to treat expensive infections and complications.
Including a Warranty for Complications in the Bundle

<table>
<thead>
<tr>
<th>Procedure</th>
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<tbody>
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<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
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SINGLE PAYMENT

PATIENT
Including a Warranty for Post-Discharge Problems

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<th>Readmission</th>
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<tbody>
<tr>
<td>Hospital DRG</td>
<td>DRG/Outlier</td>
<td>Rehab</td>
<td>Hospital DRG</td>
</tr>
<tr>
<td>Lead Doc. Fee</td>
<td>Lead Doc. Fee</td>
<td>Home Health</td>
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<td>Consultant Fee</td>
<td>Specialist</td>
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Days Post-Discharge

15  30  90+
“Episode” Payments Are Bundles Over a Full Course of Treatment

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<td>Consultant Fee</td>
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<tr>
<td>Consultant Fee</td>
<td>Consultant Fee</td>
<td>Specialist</td>
<td>Consultant Fee</td>
</tr>
</tbody>
</table>

Days Post-Discharge: 15 30 90+
What If The Procedure Could Be Done Outside the Hospital?

PROBLEM: No incentive to use lower-cost setting, since payer gains all savings from lower facility fees.
A Facility-Independent Episode

SINGLE PAYMENT

**Procedure**
- Hospital DRG
- Lead Doc. Fee
- Consultant Fee
- Consultant Fee

**Complication**
- DRG/Outlier
- Lead Doc. Fee
- Consultant Fee
- Consultant Fee

**Post-Acute**
- Rehab
- Home Health
- PCP
- Specialist

**Readmission**
- Hospital DRG
- Lead Doc. Fee
- Consultant Fee
- Consultant Fee

**Alternate Setting**
- Facility Fee
- Physician Fee

**SOLUTION:** Providers keep some of the savings from moving procedures to lower-cost settings.
What if An Alternative Procedure Would Be Better or Cheaper?

**PROBLEM:** No incentive to use lower-cost procedures (or to use no procedure at all)
A Condition-Based (Not Procedure-Based) Payment

PATIENT

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<td>Specialist</td>
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</tr>
</tbody>
</table>

**Alternate Setting**

- Facility Fee
- Physician Fee

**Alternate Procedure**

- Facility Fee
- Prof. Fee

**SOLUTION:**
Provider keeps some of the savings from using lower-cost procedures
Opportunities for Lower-Cost Care for Many Conditions

• Knee Osteoarthritis
  – Home-based rehab instead of facility-based rehab
  – Physical therapy instead of surgery

• Maternity Care
  – Vaginal delivery instead of C-Section
  – Term delivery instead of early elective delivery
  – Delivery in birth center instead of hospital

• Chest Pain
  – Non-invasive imaging instead of invasive imaging
  – Medical management instead of invasive treatment

• Chronic Disease Management
  – Improved education and self-management support
  – Avoiding hospitalizations for exacerbations
Opportunities for Lower-Cost Care for Many Conditions

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TODAY
Savings for Payers = Lower Margins for Hospitals
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  – Non-invasive imaging instead of invasive imaging
  – Medical management instead of invasive treatment

• Chronic Disease Management
  – Improved education and self-management support
  – Avoiding hospitalizations for exacerbations
What About “Transparency?”

Care Bundle
Knee Arthroscopy With ACL Surgery
A knee arthroscopy is a surgery that uses small medical instruments and a camera to look inside the knee joint to treat certain

Detailed estimates for Uninsured Procedure

<table>
<thead>
<tr>
<th>Lead Provider</th>
<th>Estimated Charge Amount</th>
<th>Uninsured Discount Rate</th>
<th>Estimate of Amount Due</th>
<th>Typical Patient Complexity</th>
</tr>
</thead>
<tbody>
<tr>
<td>STRATHAM AMBULATORY SURGERY CENTER (PARADIGM LLC)</td>
<td>$7,830</td>
<td>0%</td>
<td>$7,830</td>
<td>HIGH</td>
</tr>
<tr>
<td>SPEARE MEMORIAL HOSPITAL</td>
<td>$9,496</td>
<td>3%</td>
<td>$6,542</td>
<td>MEDIUM</td>
</tr>
<tr>
<td>ALICE PECK DAY MEMORIAL HOSPITAL</td>
<td>$9,356</td>
<td>15%</td>
<td>$8,123</td>
<td>MEDIUM</td>
</tr>
<tr>
<td>HILLSIDE SURGERY CENTER</td>
<td>$10,077</td>
<td>0%</td>
<td>$10,077</td>
<td>MEDIUM</td>
</tr>
<tr>
<td>MEMORIAL HOSPITAL</td>
<td>$10,221</td>
<td>20%</td>
<td>$8,177</td>
<td>MEDIUM</td>
</tr>
<tr>
<td>CONCORD AMBULATORY SURGERY CENTER</td>
<td>$10,438</td>
<td>0%</td>
<td>$10,438</td>
<td>MEDIUM</td>
</tr>
<tr>
<td>FILLIPT ONE-DAY SURGERY CENTER</td>
<td>$10,589</td>
<td>0%</td>
<td>$10,589</td>
<td>MEDIUM</td>
</tr>
<tr>
<td>LITTLETON REGIONAL HOSPITAL</td>
<td>$11,085</td>
<td>33%</td>
<td>$7,413</td>
<td>MEDIUM</td>
</tr>
</tbody>
</table>

National Average
$11,045

IN YOUR AREA:
California State Average $18,234
San Francisco, California Average $16,420

Click here to change location.
Current Transparency Efforts Are Focused on Procedure Price

<table>
<thead>
<tr>
<th>Provider</th>
<th>Payment for Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider 1:</td>
<td>$25,000</td>
</tr>
<tr>
<td>Provider 2:</td>
<td>$23,000 (-8%)</td>
</tr>
</tbody>
</table>
What Hidden Costs Accompany the Lower Price?

<table>
<thead>
<tr>
<th>Provider 1:</th>
<th>Payment for Procedure</th>
<th>Payment and Rate of Complications</th>
</tr>
</thead>
<tbody>
<tr>
<td>$25,000</td>
<td>$30,000</td>
<td>2%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider 2:</th>
<th>$23,000</th>
<th>$30,000</th>
<th>10%</th>
</tr>
</thead>
<tbody>
<tr>
<td>-8%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Total Spending May Be Higher With the “Lower Price” Provider

<table>
<thead>
<tr>
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<th>Provider 2:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment for Procedure</td>
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</tr>
<tr>
<td>$25,000</td>
<td>$23,000</td>
</tr>
<tr>
<td>$30,000</td>
<td>$30,000</td>
</tr>
<tr>
<td>2%</td>
<td>10%</td>
</tr>
<tr>
<td>$25,600</td>
<td>$26,000</td>
</tr>
</tbody>
</table>

Provider 2 has a lower starting price, but is more expensive when lower quality is factored in.
### Bundled/Warrantied Pmts Allow Comparing Apples to Apples

<table>
<thead>
<tr>
<th>Payment for Procedure</th>
<th>Payment and Rate of Complications</th>
<th>Bundled/Episode Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Provider 1:</strong></td>
<td>2%</td>
<td>$25,600</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Provider 2:</strong></td>
<td>10%</td>
<td>$26,000</td>
</tr>
<tr>
<td></td>
<td>+2%</td>
<td></td>
</tr>
</tbody>
</table>

Bundled prices show that Provider 1 is the higher-value provider.
True “Value-Based” Alternative Payment Models…

“Value-Based Purchasing”
- No payment for services that will benefit patients
- Lower revenues from reducing avoidable costs

“APMs Built on FFS Architecture”
- Shared Savings
- PMPM
- No payment for services that will benefit patients
- Lower revenues from reducing avoidable costs

FFS
- No payment for services that will benefit patients
- Lower revenues from reducing avoidable costs

Condition-Based Payments
- Bundled/Warrantied Payments
- Primary Care Medical Home Payments
…Can Create Win-Win-Wins for Patients, Payers, & Hospitals

“Value-Based Purchasing”

FFS
• No payment for services that will benefit patients
• Lower revenues from reducing avoidable costs

P4P

FFS
• No payment for services that will benefit patients
• Lower revenues from reducing avoidable costs

Shared Savings

PMPM

FFS
• No payment for services that will benefit patients
• Lower revenues from reducing avoidable costs

“APMs Built on FFS Architecture”

Better Care for Patients

Lower Spending for Payers

Financially Viable Physician Practices & Hospitals
…Can Create Win-Win-Wins for Patients, Payers, & Hospitals

"Value-Based Purchasing"

FFS
• No payment for services that will benefit patients
• Lower revenues from reducing avoidable costs

P4P
• No payment for services that will benefit patients
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“APMs Built on FFS Architecture”

Shared Savings
• No payment for services that will benefit patients
• Lower revenues from reducing avoidable costs

PMPM

Better

BUT ONLY IF THEY’RE DESIGNED THE RIGHT WAY

Financially Viable Physician Practices & Hospitals

© Center for Healthcare Quality and Payment Reform www.CHQPR.org
CMS “Comprehensive Care for Joint Replacement”

EPISODE PAYMENT FOR SURGERIES

- Hospital Costs for Surgery
- Readmits
- Post-Acute Care (IRF, SNF, HH)
Principal Goal of CMS Proposal Is Reducing Post-Acute Care Cost

**EPISODE PAYMENT FOR SURGERIES**

- Hospital Costs for Surgery
- Readmits
- Post-Acute Care (IRF, SNF, HH)

**SAVINGS**
Proposed Structure Encourages Lower Spending, Not Better Care

**EPISODE PAYMENT FOR SURGERIES**

- No risk adjustment – target spending amount is the same for high-risk, poor functional status patients as low-risk patients
- No flexibility to deliver different types of post-acute care or to be paid differently – no change in current payment systems
Hospitals at Risk for Total Cost With Everyone Still Paid the Same

**EPISODE PAYMENT FOR SURGERIES**

- No risk adjustment – target spending amount is the same for high-risk, poor functional status patients as low-risk patients
- No flexibility to deliver different types of post-acute care or to be paid differently – no change in current payment systems
- Hospital is at risk for higher post-acute care spending
Over Time, CMS Keeps More of the Savings, If There Are Any

EPISODE PAYMENT FOR SURGERIES

- No risk adjustment – target spending amount is the same for high-risk, poor functional status patients as low-risk patients
- No flexibility to deliver different types of post-acute care or to be paid differently – no change in current payment systems
- Hospital is at risk for higher post-acute care spending
- Target spending is reduced every year to match lower FFS spending
If There Are Fewer Surgeries, CMS Keeps ALL of the Savings

EPISODE PAYMENT FOR SURGERIES

Hospital Costs for Surgery  Readmits  Post-Acute Care (IRF, SNF, HH)

Hospital Costs for Surgery  Readmits  Post-Acute Care  SAVINGS

Non-Surg. Treatment  SAVINGS

CMS

Hospital

Physicians and Post-Acute Care

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Critical Access Hospitals Could Be Harmed by CJR

- Hospitals will be penalized if their patients use higher-cost post-acute care services
- If CAH cost per SNF/swing day is higher than other hospitals, CJR hospitals could avoid using the CAH for post-acute care services
Good Ways and Bad Ways to Define Alternative Payment Models

HOW PAYMENT REFORMS ARE DESIGNED TODAY

- Medicare and Health Plans Define Payment Systems
- Providers Have To Change Care to Align With Payment Systems
- Patients and Providers May Not Come Out Ahead

THE RIGHT WAY TO DESIGN PAYMENT REFORMS

- Providers Redesign Care and Identify Payment Barriers
- Payers Change Payment to Support Redesigned Care
- Patients Get Better Care and Providers Stay Financially Viable
Three Paths to the Future

CURRENT PAYMENT SYSTEMS

PAY FOR PERFORMANCE
(“Value-Based Payment/Purchasing”)
(“Merit-Based Incentive Payment System”)

PAYER-DESIGNED ALTERNATIVE PAYMENT MODELS (APMs)

PROVIDER-DESIGNED ALTERNATIVE PAYMENT MODELS (APMs)
Learn More About Win-Win-Win Payment and Delivery Reform

www.PaymentReform.org
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