CENTER FOR HEALTHCARE QUALITY & PAYMENT REFORM

REDESIGNING PAYMENT TO SUPPORT BETTER PATIENT CARE AND FINANCIALLY VIABLE HEALTHCARE PROVIDERS

Harold D. Miller
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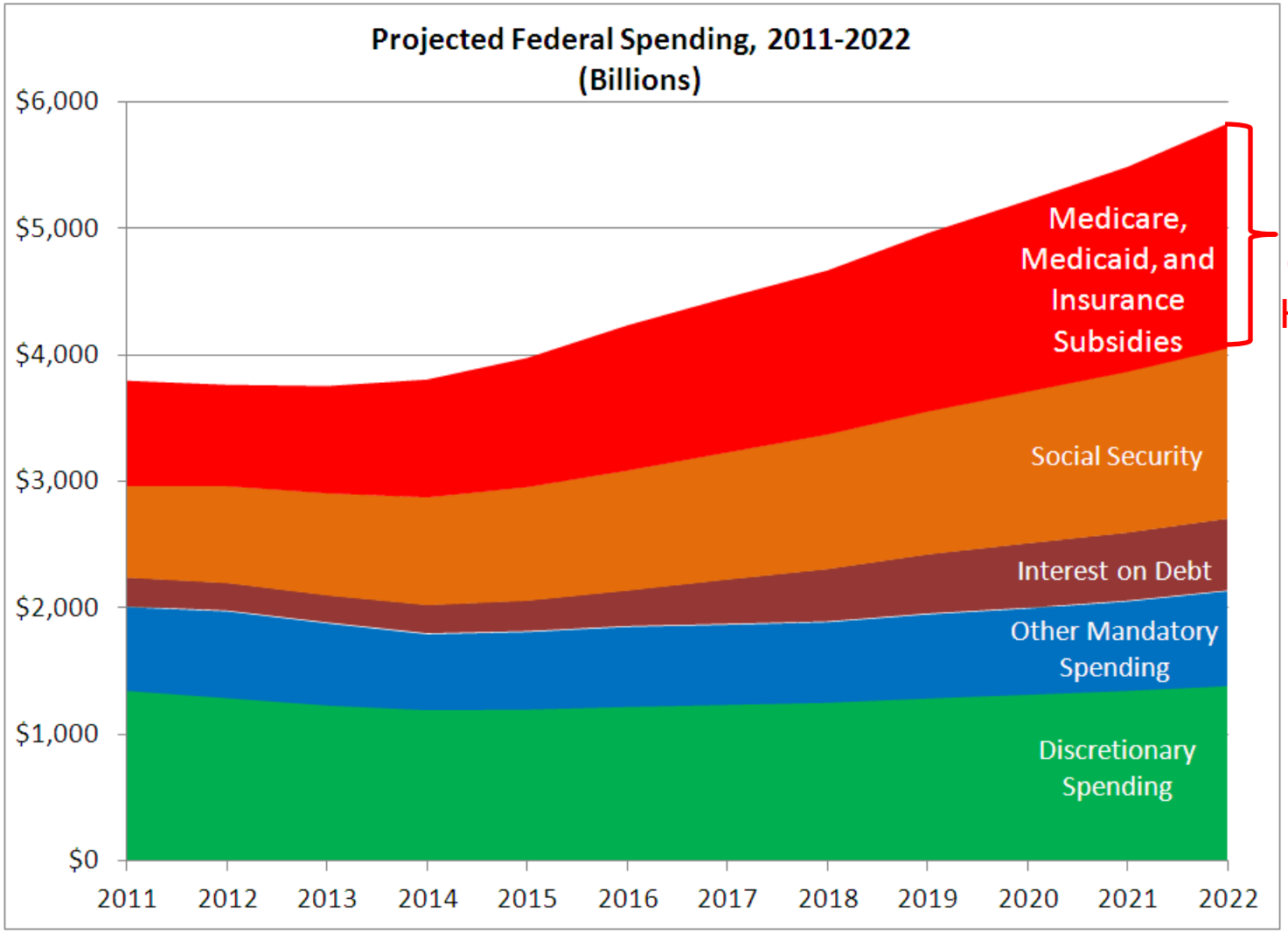
Center for Healthcare Quality and Payment Reform

www.CHQPR.org

Healthcare Spending Is the Biggest Driver of Federal Deficits



46% of Spending Growth is Healthcare

Source:
CBO
Budget Outlook
August 2012

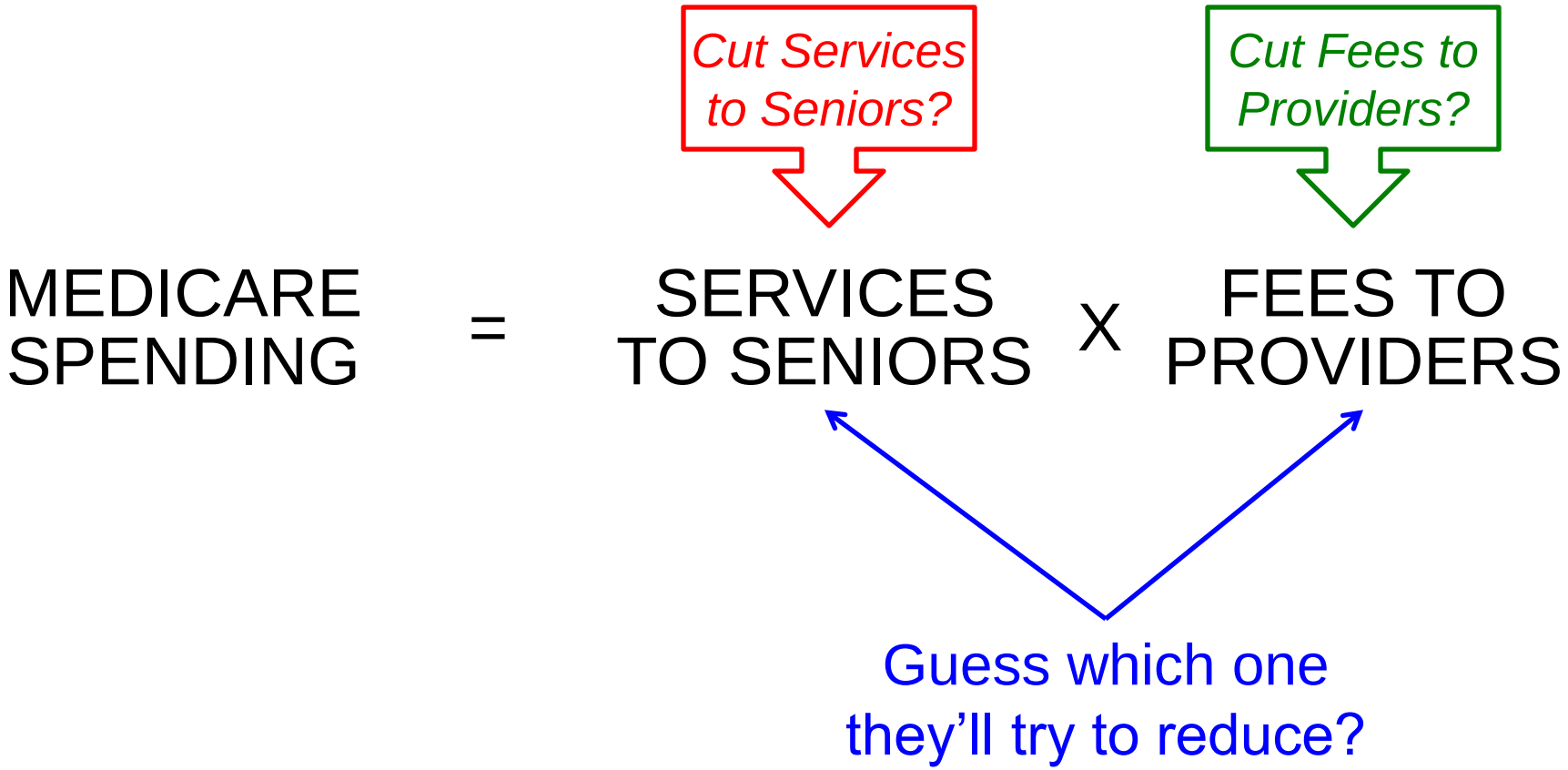
Federal Cost Containment Policy Choices

Cut Services to Seniors?

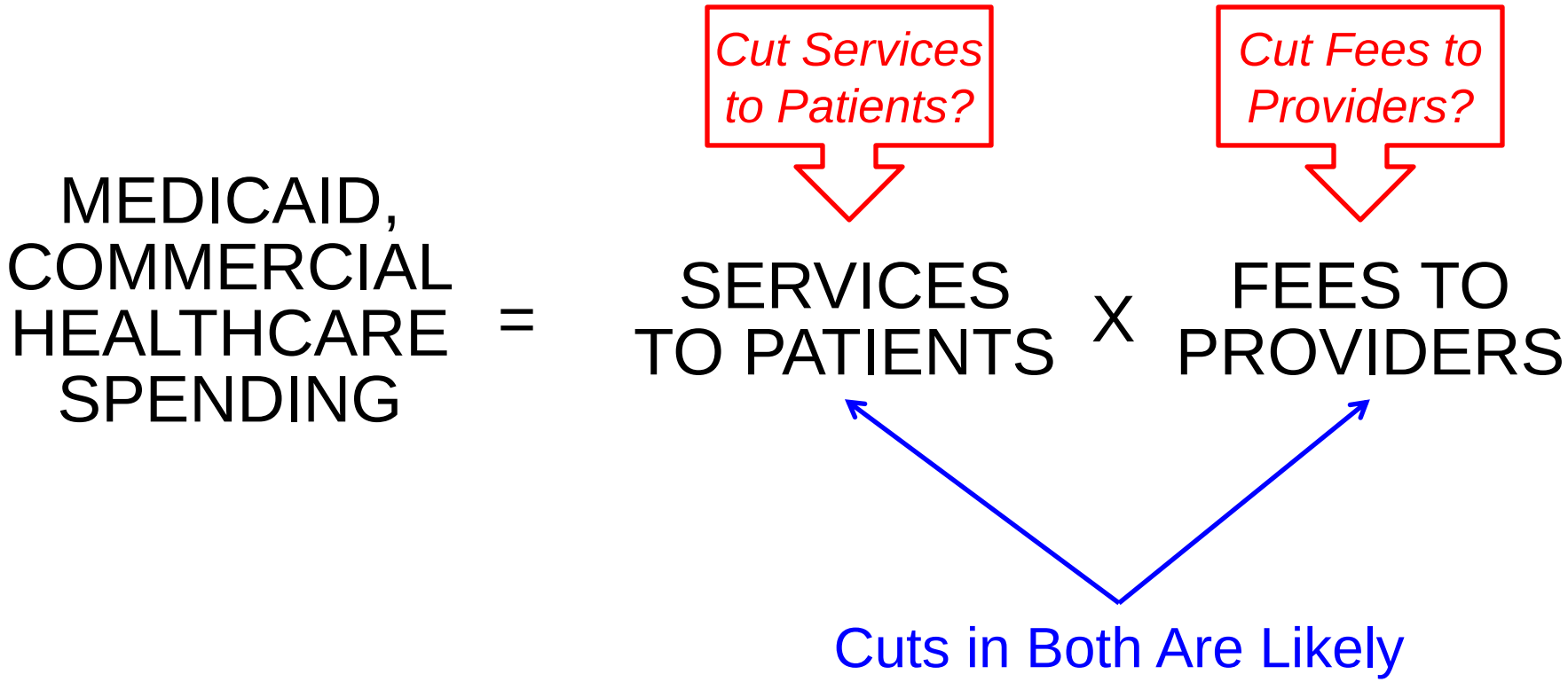
Cut Fees to Providers?

MEDICARE SPENDING = SERVICES TO SENIORS X FEES TO PROVIDERS

If It's A Choice of Rationing or Rate Cuts, Which is More Likely?



In Medicaid & Private Insurance, Cuts in Services AND Fees Likely



What Healthcare Providers Can Do That Payers Can't

MEDICARE, MEDICAID, COMMERCIAL HEALTHCARE SPENDING =

SERVICES TO PATIENTS

Redesign *CARE* to Reduce Spending Without Rationing

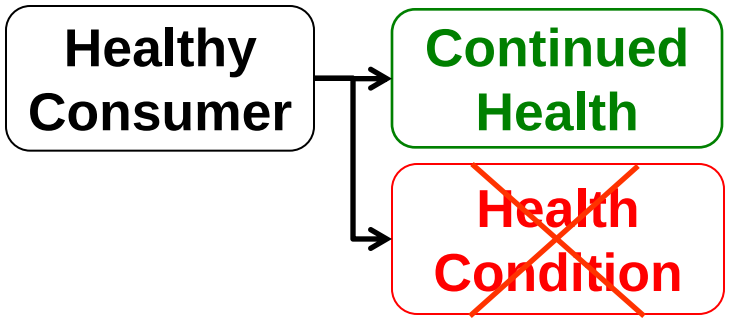
X

FEES TO PROVIDERS

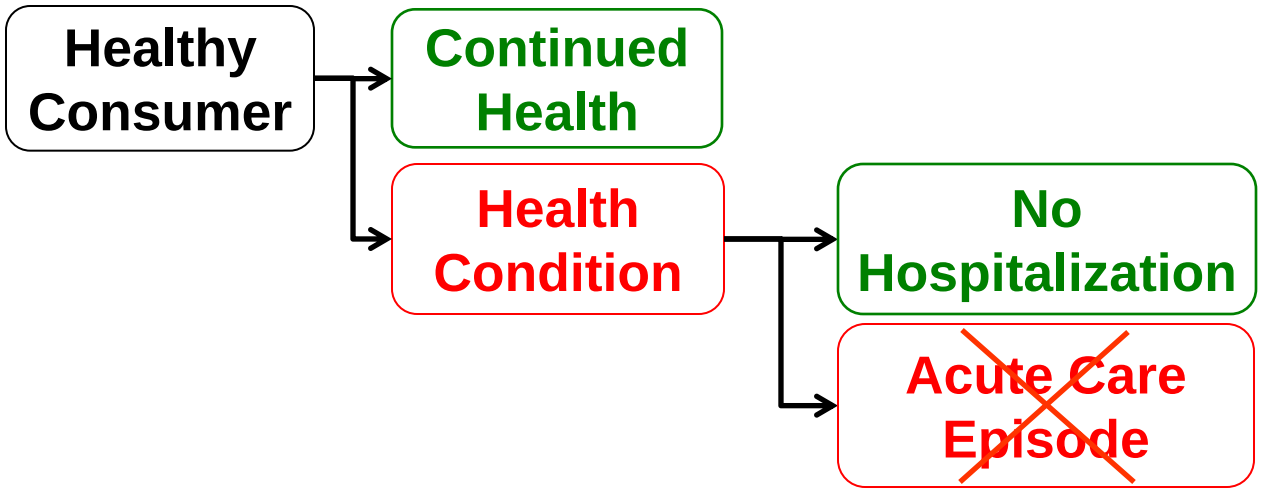
Redesign *PAYMENT* to Make Good Care Financially Viable

Reducing Costs Without Rationing: ***Can It Be Done?***

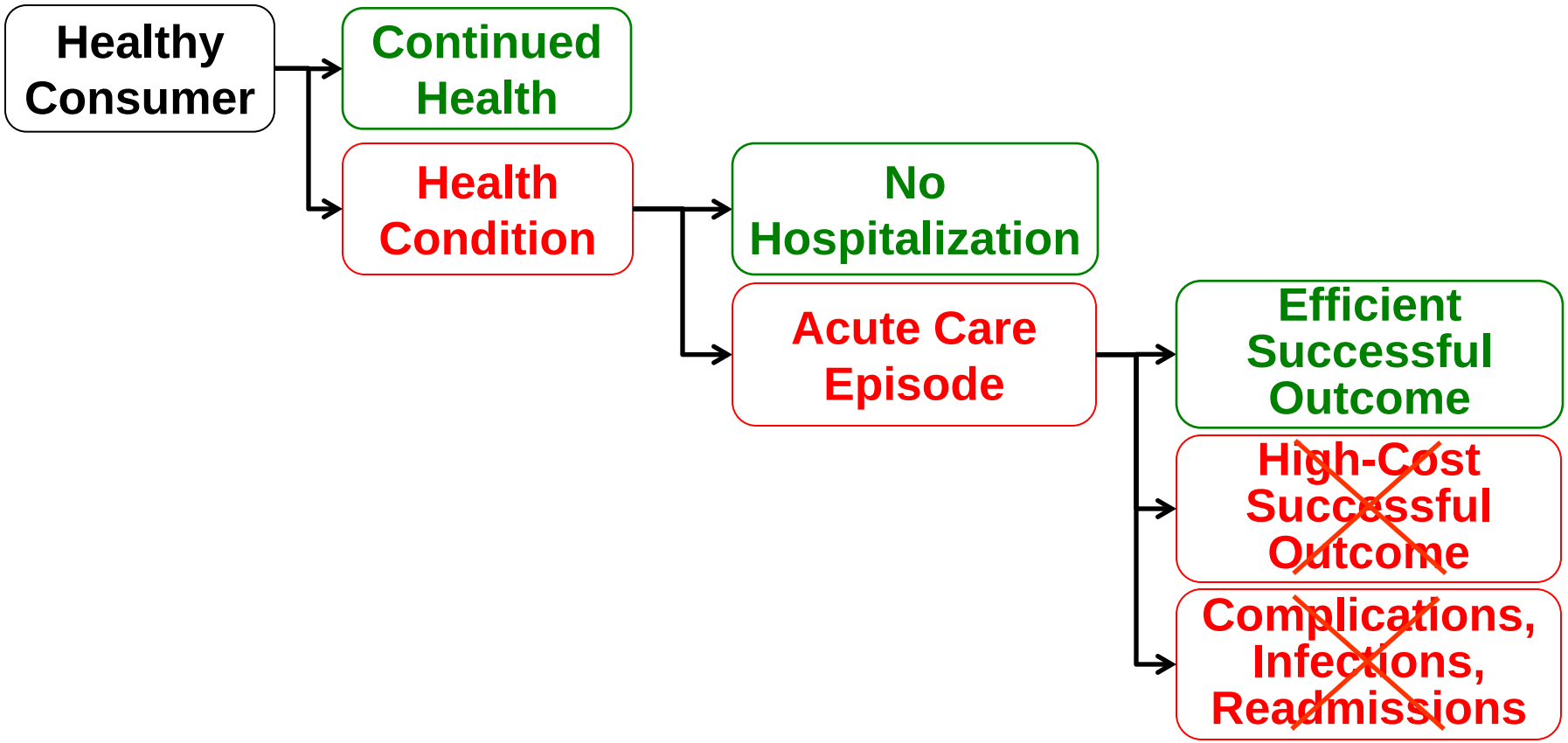
Reducing Costs Without Rationing:
Prevention and Wellness



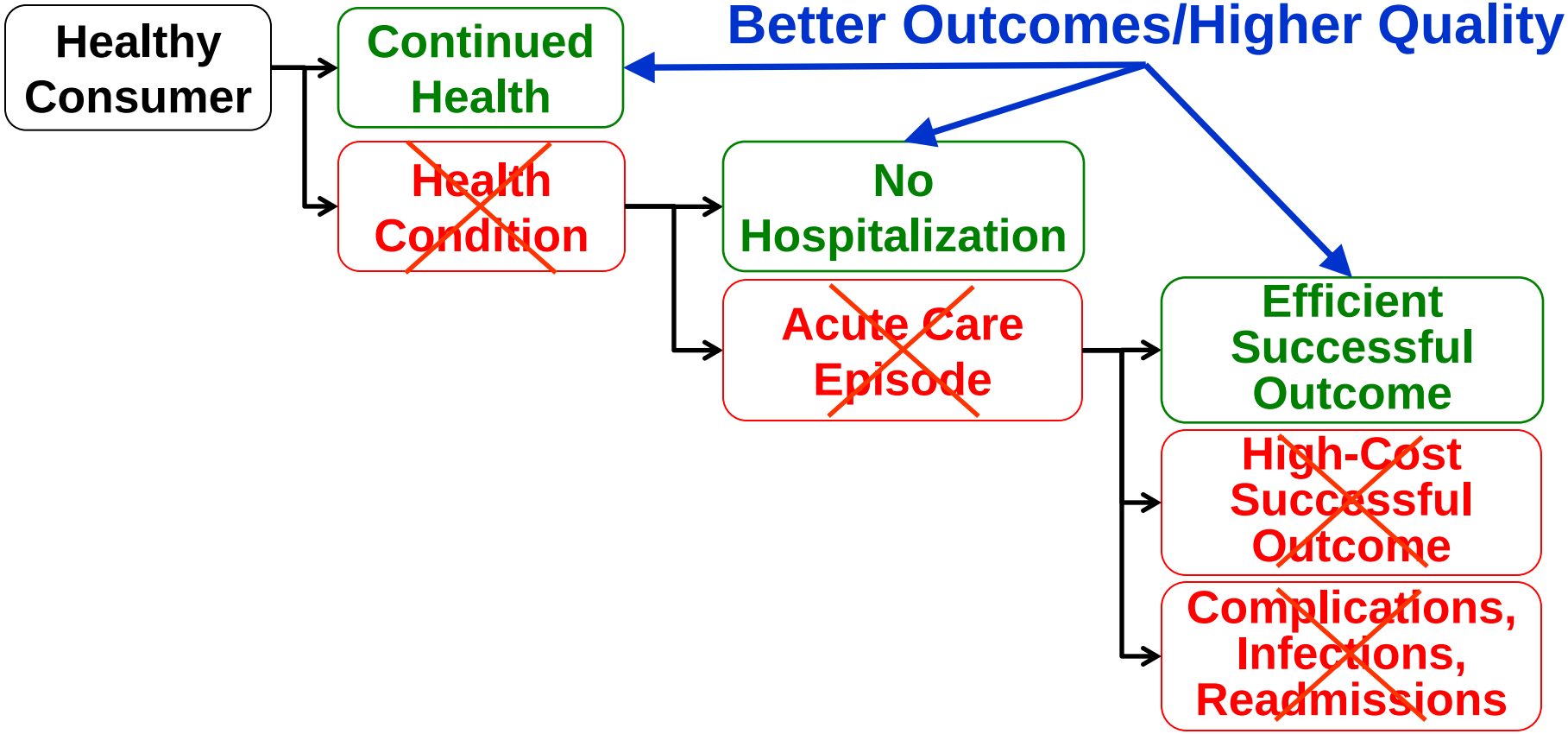
Reducing Costs Without Rationing: Avoiding Hospitalizations



Reducing Costs Without Rationing: Efficient, Successful Treatment

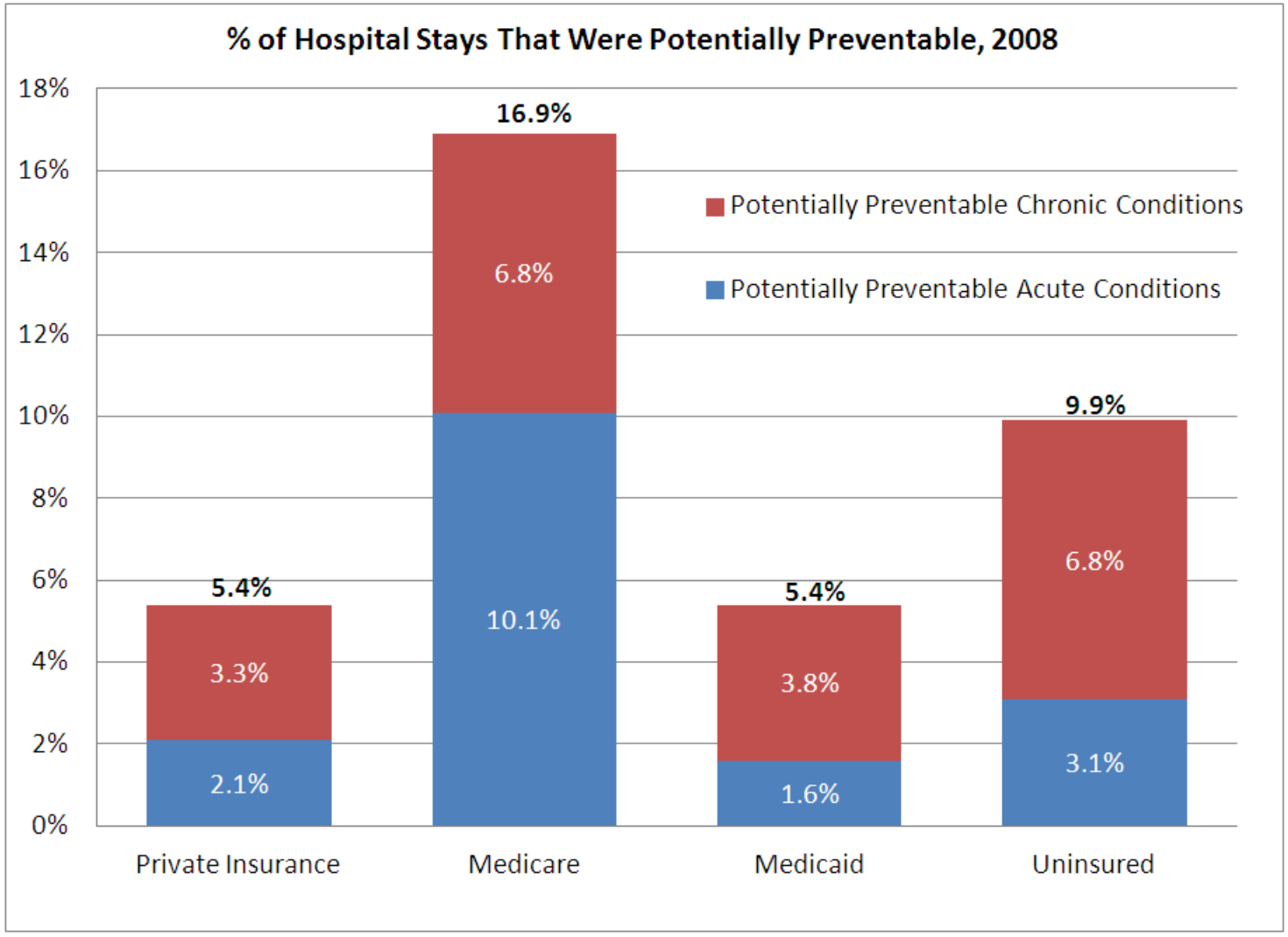


Reducing Costs Without Rationing Is Also Quality Improvement!



How Big Are the Opportunities?

5-17% of Hospital Admissions Are Potentially Preventable



Source: AHRQ HCUP

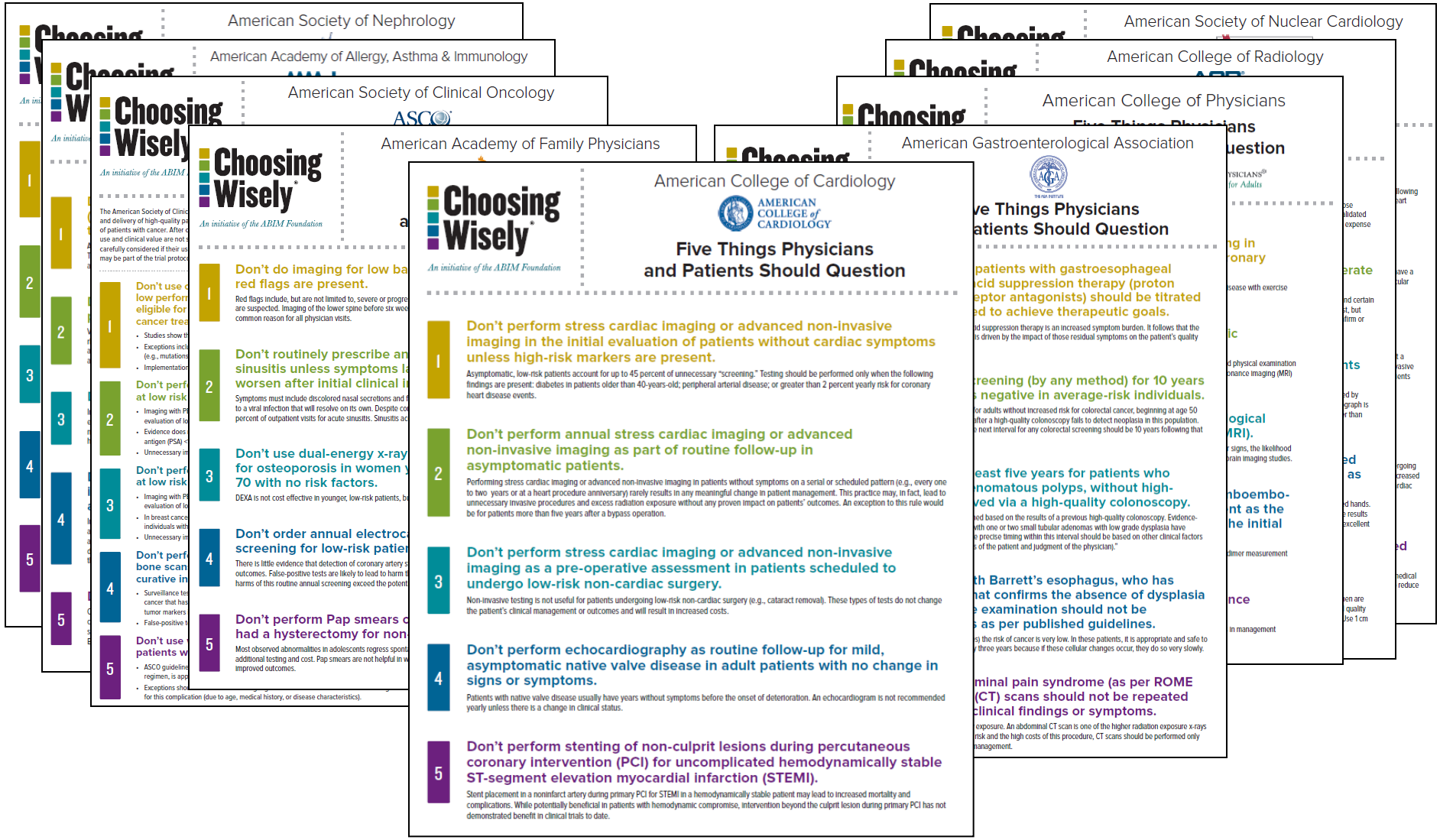
Millions of Preventable Events Harm Patients and Increase Costs

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

3 Adverse Events Every Minute

Source: *The Economic Measurement of Medical Errors*, Milliman and the Society of Actuaries, 2010

Many Ways to Reduce Tests & Services Without Harming Patients



Instead of Starting With How to *Limit* Care for Patients…

Contributors to Healthcare Costs

How Do We Limit:

- New Technologies
- Higher-Cost Drugs
- Potentially Life-Saving Treatment

We Should Focus First on How to *Improve* Patient Care

Contributors to Healthcare Costs

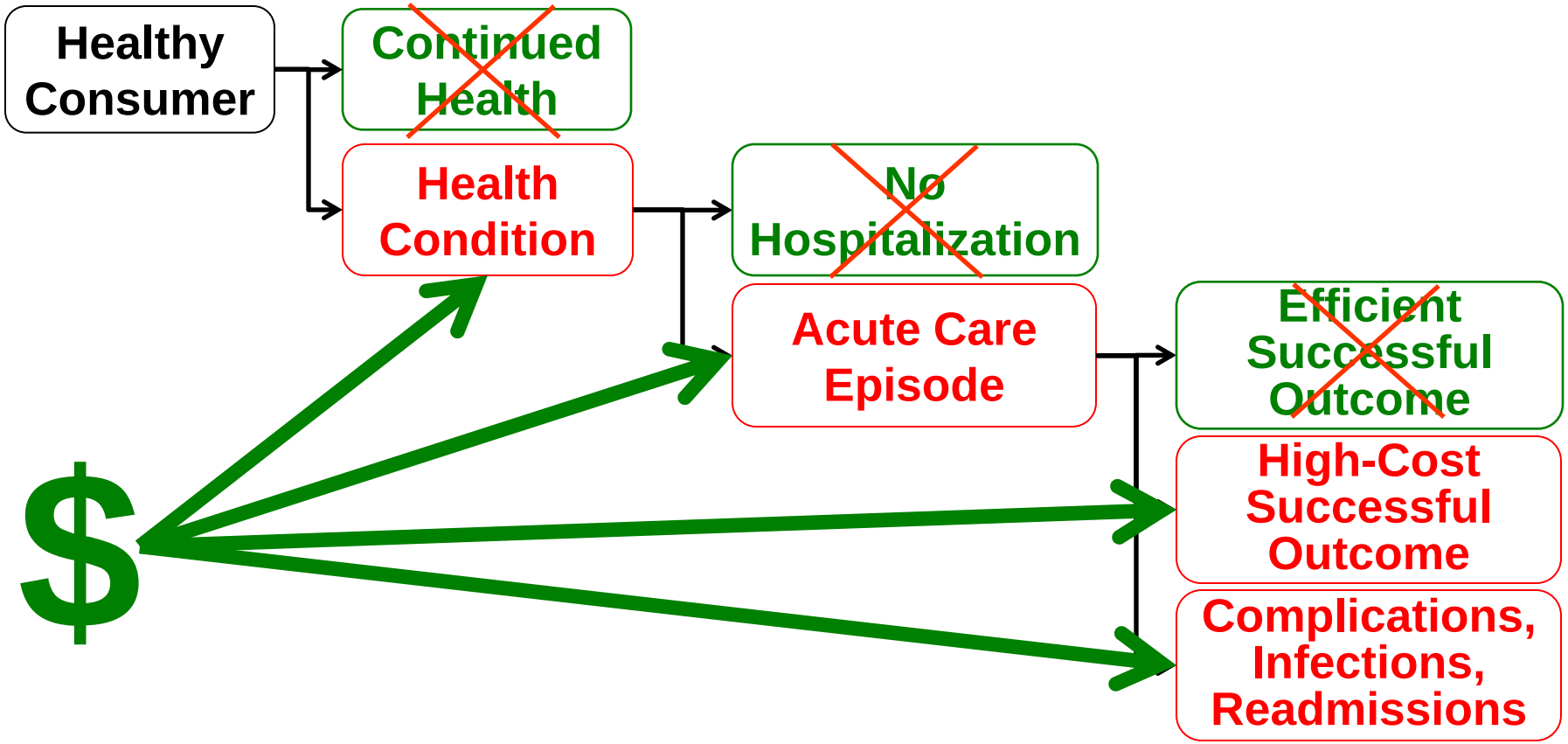
How Do We *Help*:

- Patients Stay Well
- Avoid Preventable Emergencies and Hospitalizations
- Eliminate Errors and Safety Problems
- Reduce Costs of Treatment
- Reduce Complications and Readmissions

How Do We Limit:

- New Technologies
- Higher-Cost Drugs
- Potentially Life-Saving Treatment

Current Payment Systems Reward Bad Outcomes, Not Better Health



It's Not a Lack of "Incentives," It's the *Barriers* in Fee for Service

It's Not a Lack of "Incentives," It's the *Barriers* in Fee for Service

Lack of Flexibility in FFS

- No payment for phone calls or emails with patients
- No payment to coordinate care among providers
- No payment for non-physician support services to help patients with self-management
- No flexibility to shift resources across silos (hospital <-> physician, post-acute <->hospital, SNF <-> home health, etc.)

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- No flexibility to shift resources across silos (hospital <-> physician, post-acute <->hospital, SNF <-> home health, etc.)

Penalty for Quality/Efficiency

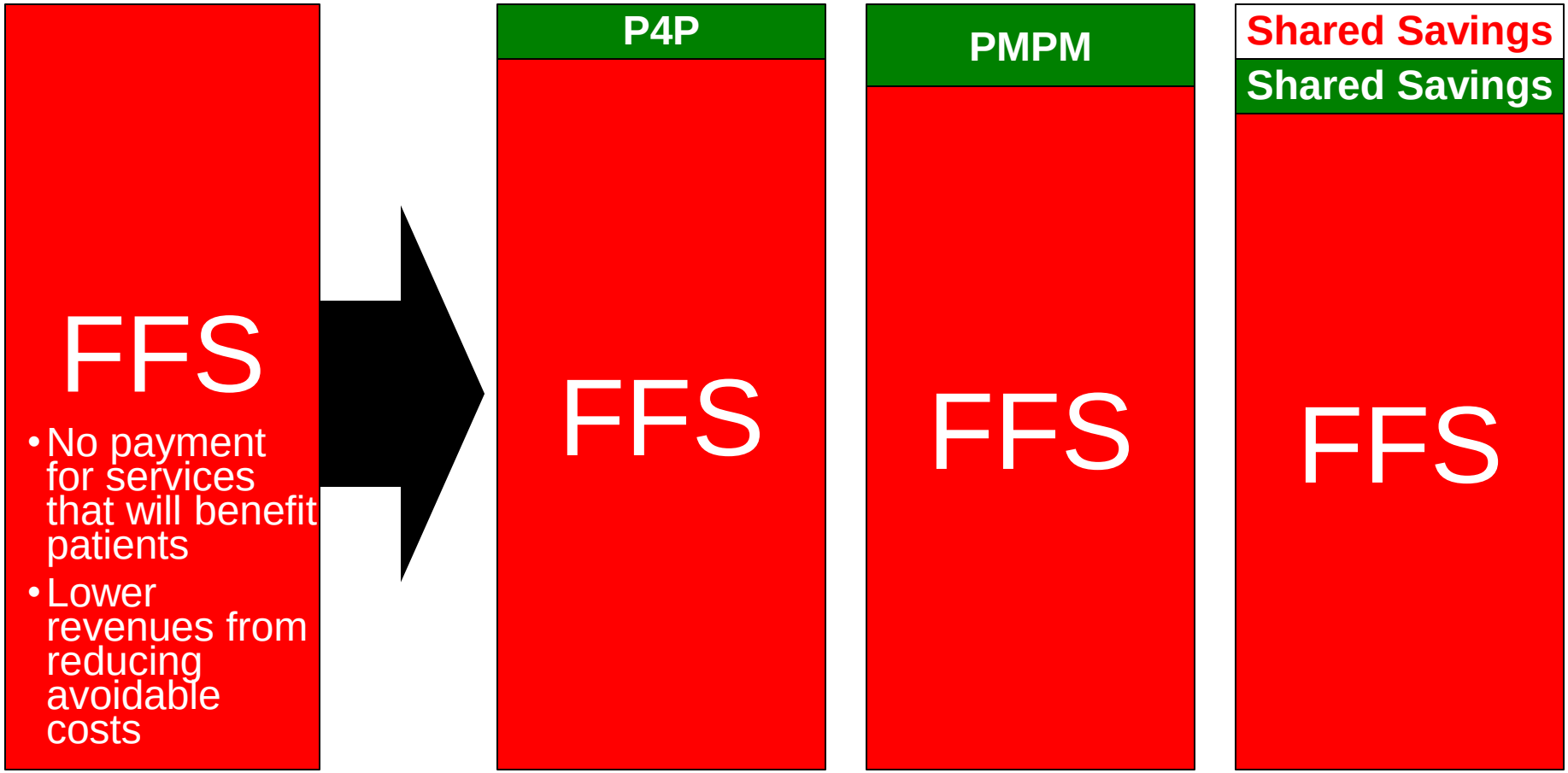
- Lower revenues if patients don't make frequent office visits
- Lower revenues for performing fewer tests and procedures
- Lower revenues if infections and complications are prevented instead of treated
- No revenue at all if patients stay healthy

There Is Broad Agreement That Payment Reforms Are Needed…

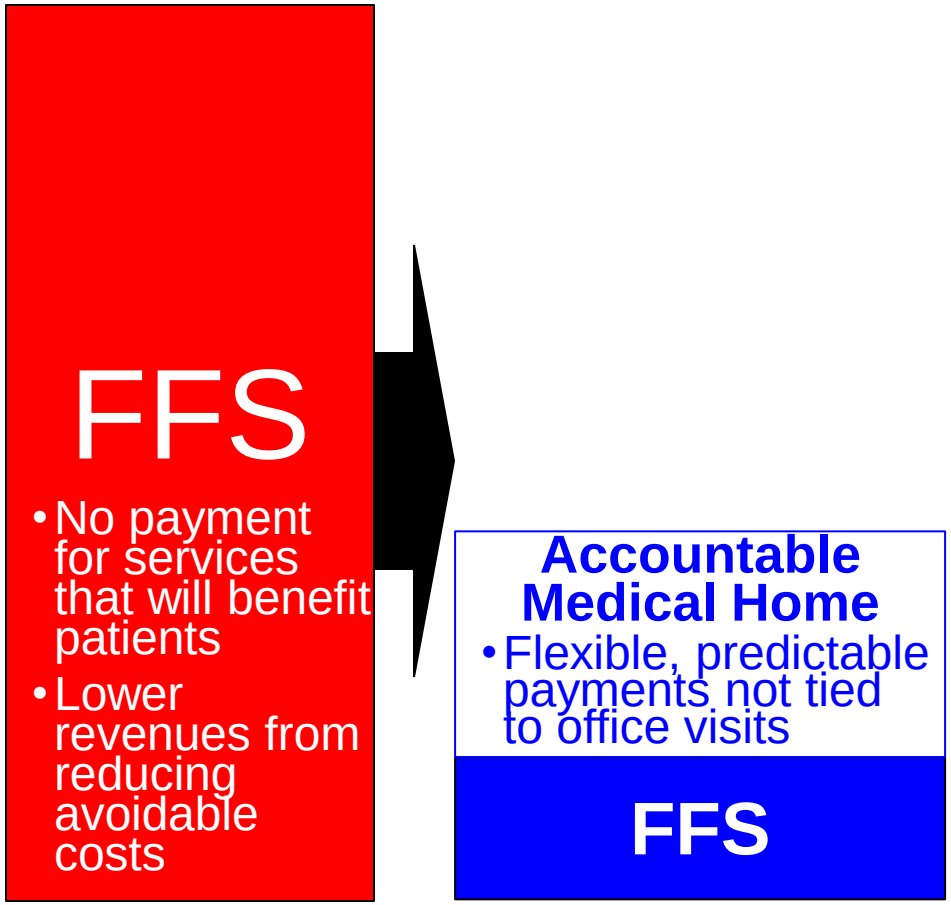
FFS

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

But Most "Payment Reforms" Don't Fix The Problems with FFS



Fortunately, There are Better Payment Systems Available



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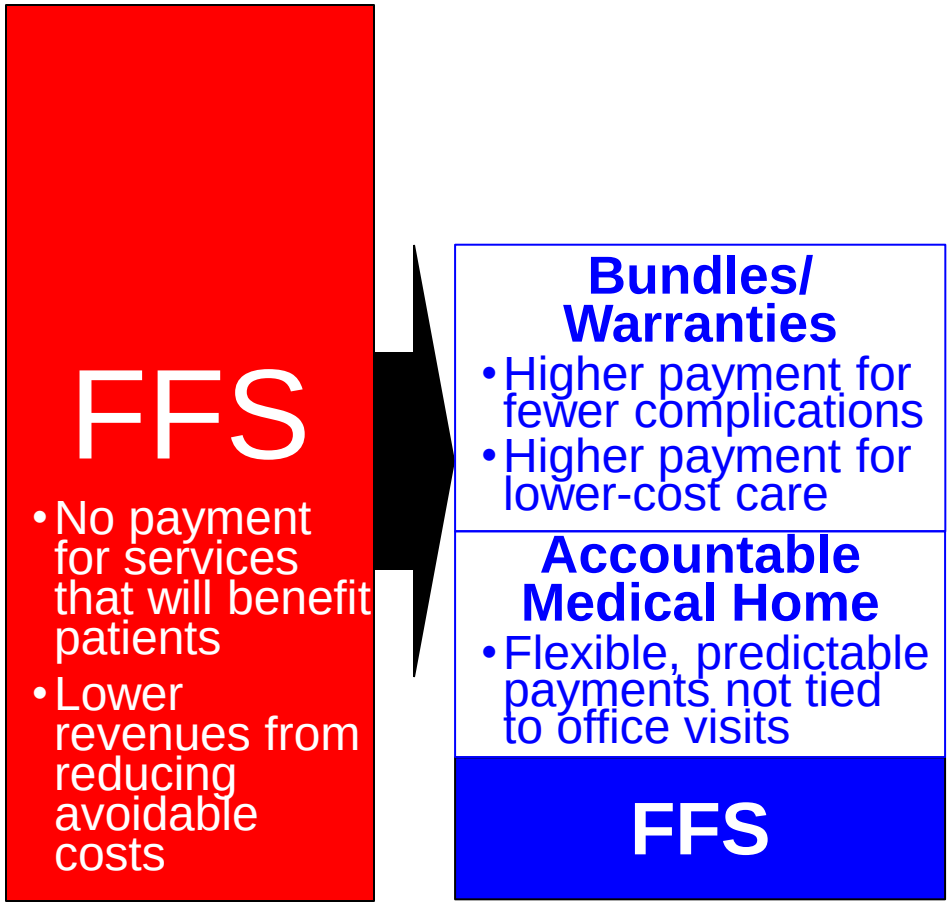

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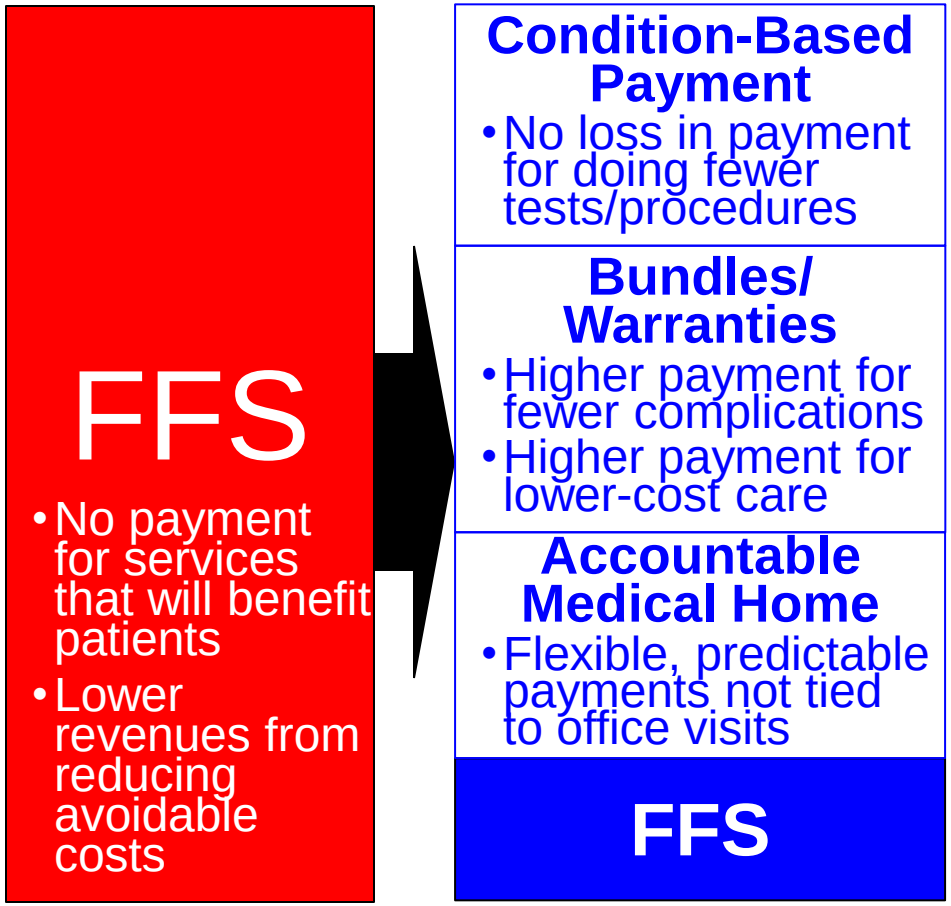
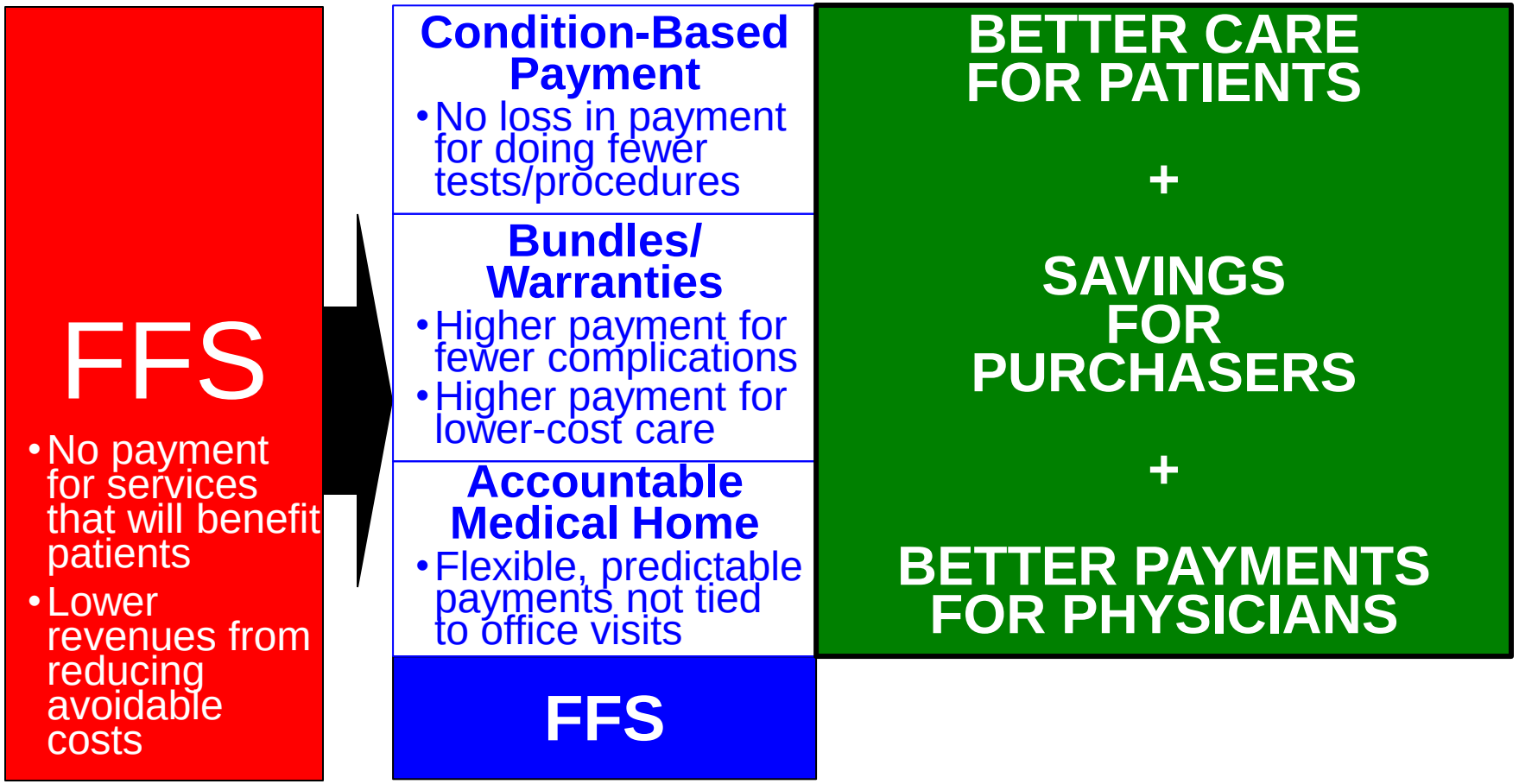


True Payment Reform Allows Win-Win-Win Solutions



Example: Big Reductions Possible in Chronic Disease Spending

Examples:

- 40% reduction in hospital admissions, 41% reduction in ER visits for exacerbations of COPD using in-home & phone patient education by nurses or respiratory therapists

  J. Bourbeau, M. Julien, et al, "Reduction of Hospital Utilization in Patients with Chronic Obstructive Pulmonary Disease: A Disease-Specific Self-Management Intervention," *Archives of Internal Medicine* 163(5), 2003

- 66% reduction in hospitalizations for CHF patients using home-based telemonitoring

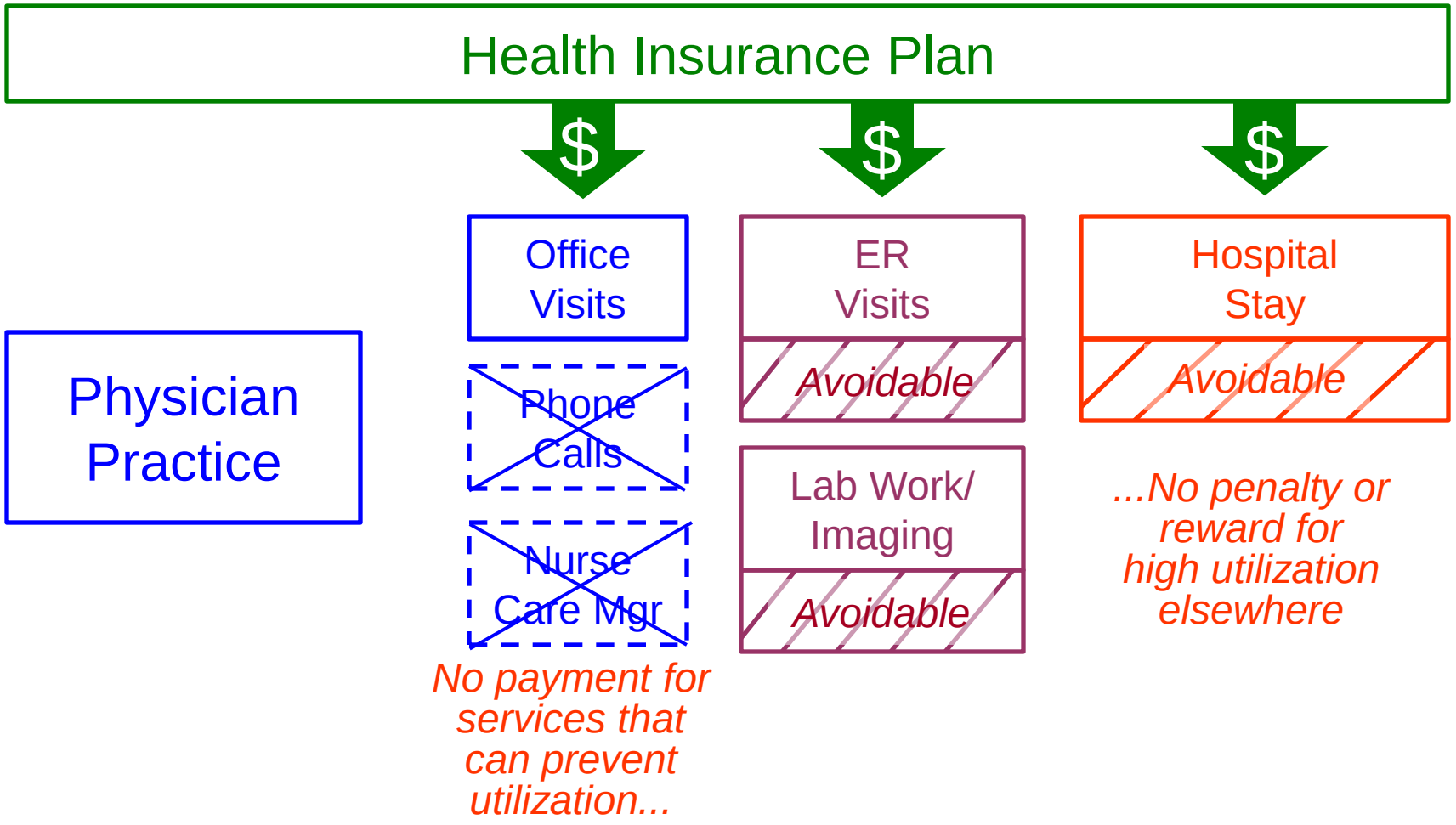
  M.E. Cordisco, A. Benjaminovitz, et al, "Use of Telemonitoring to Decrease the Rate of Hospitalization in Patients With Severe Congestive Heart Failure," *American Journal of Cardiology* 84(7), 1999

- 27% reduction in hospital admissions, 21% reduction in ER visits through self-management education

  M.A. Gadoury, K. Schwartzman, et al, "Self-Management Reduces Both Short- and Long-Term Hospitalisation in COPD," *European Respiratory Journal* 26(5), 2005

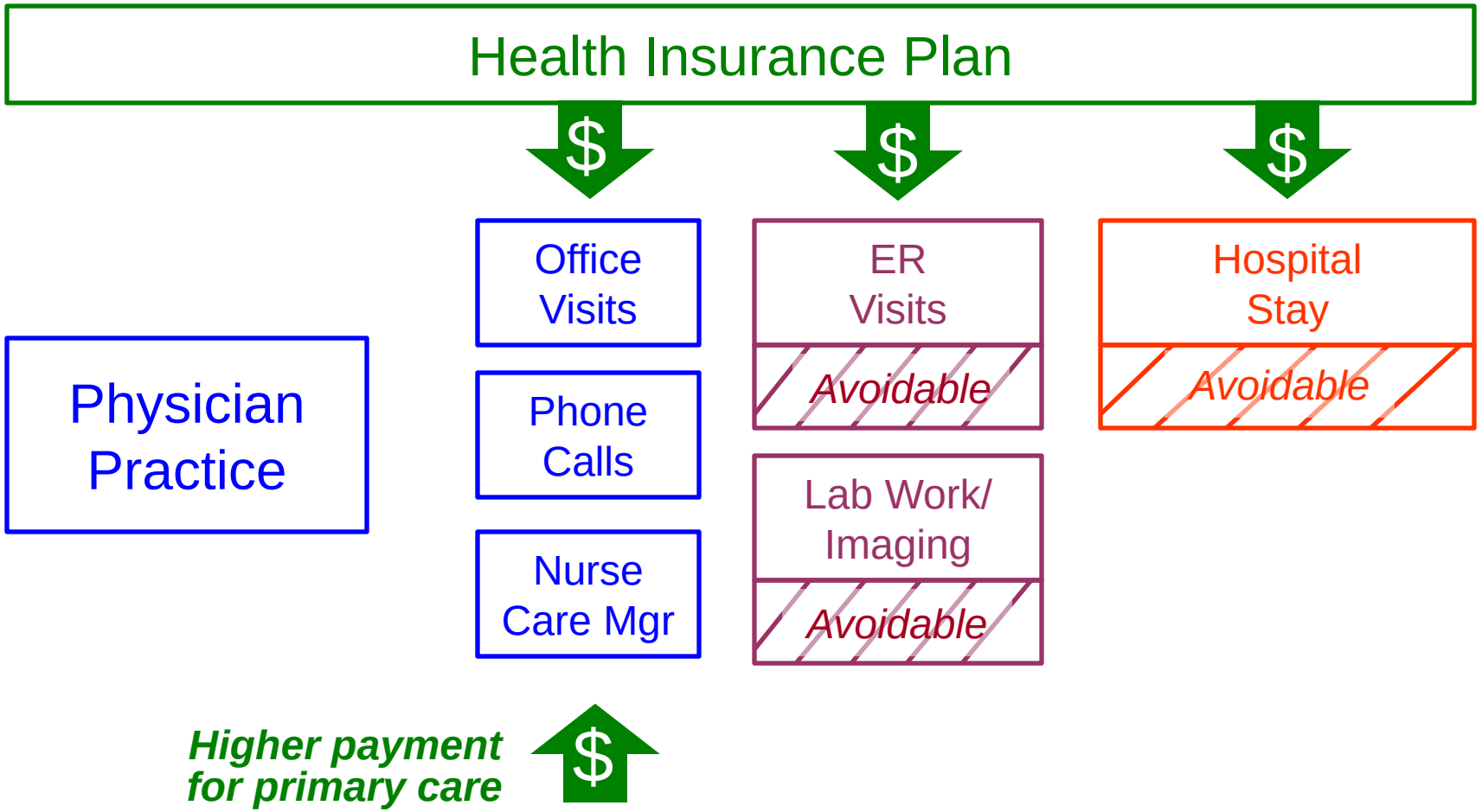
We Don't Pay for the Things That Will Prevent Overutilization

CURRENT PAYMENT SYSTEMS



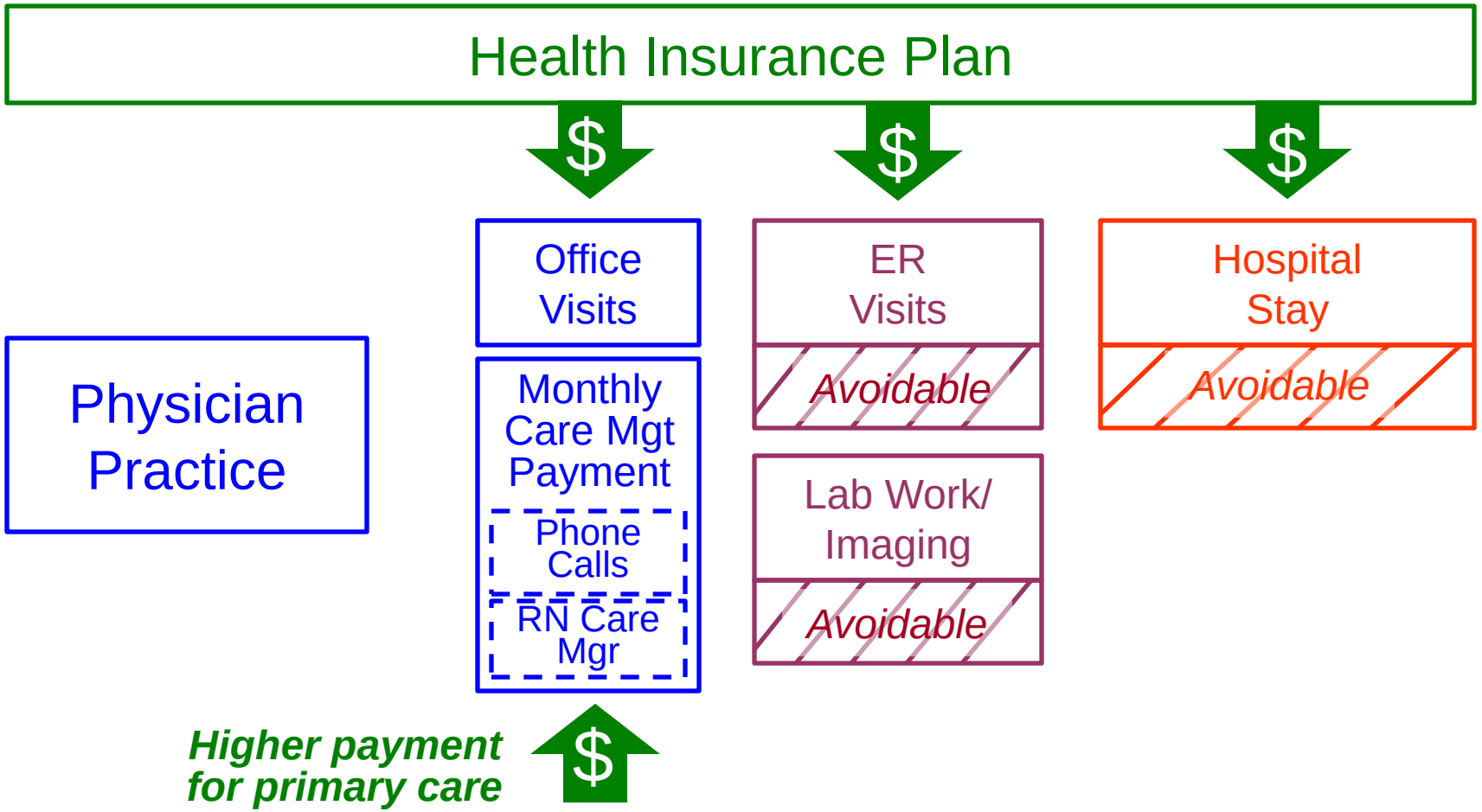
Option 1: Add New Fee Codes for Unreimbursed PCP Services

MEDICAL HOME PROGRAM



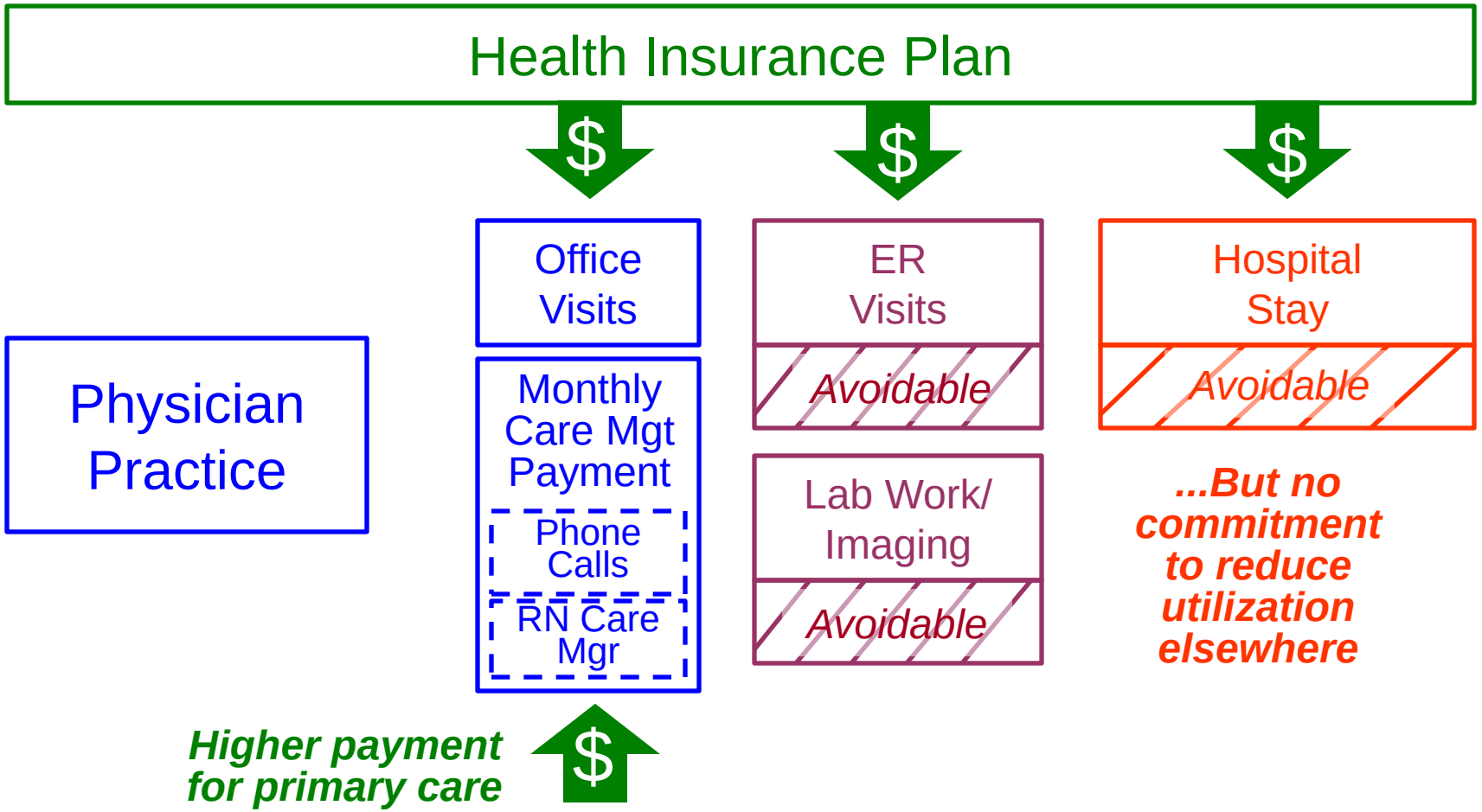
Option 2: Pay for Monthly "Care Mgt" to Cover Missing Services

MEDICAL HOME PROGRAM



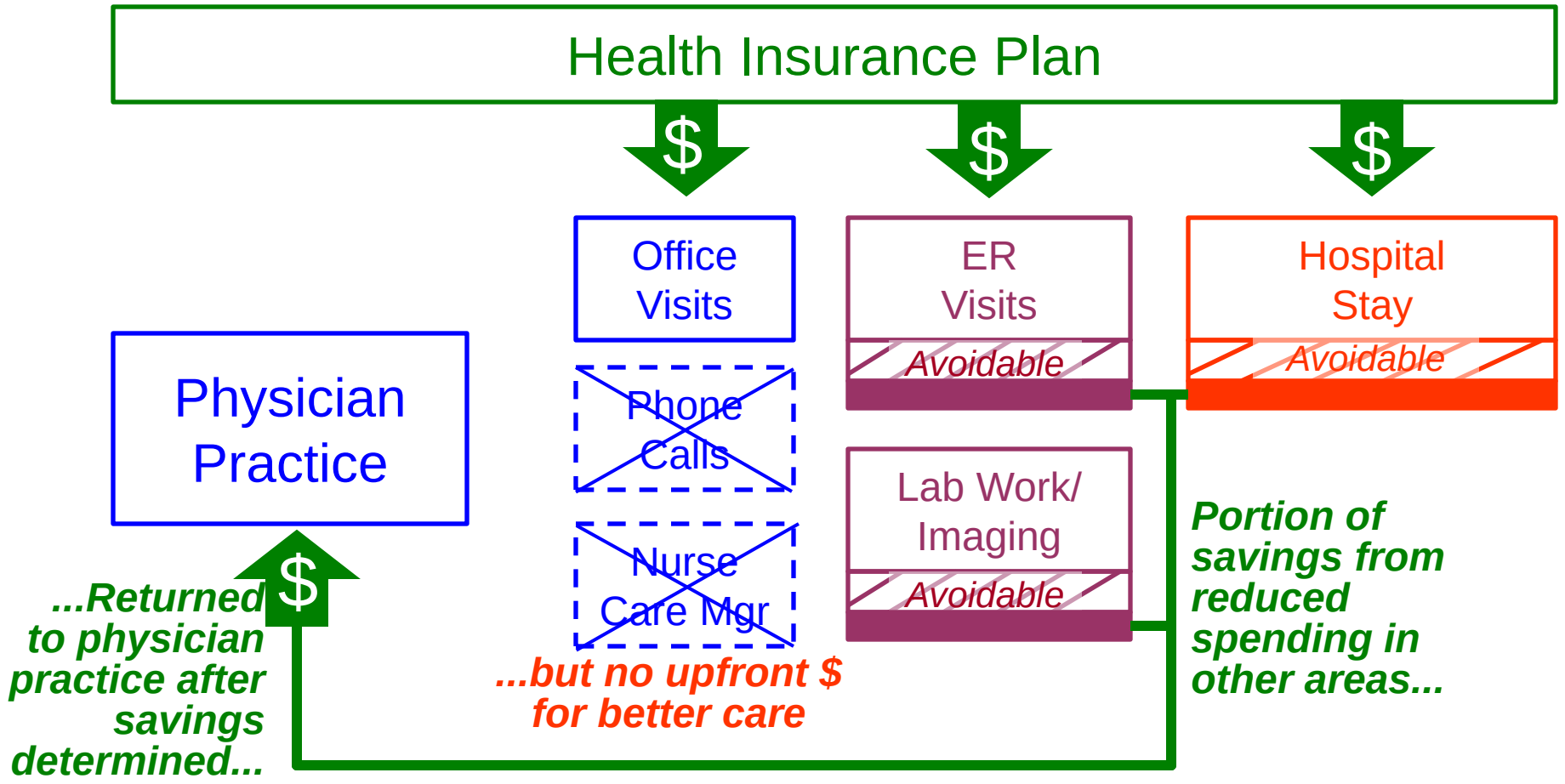
More $ for PCPs, But Any Savings Elsewhere?

MEDICAL HOME PROGRAM



Option 3: "Shared Savings" (More $ Only If Total Costs Decrease)

SHARED SAVINGS MODEL

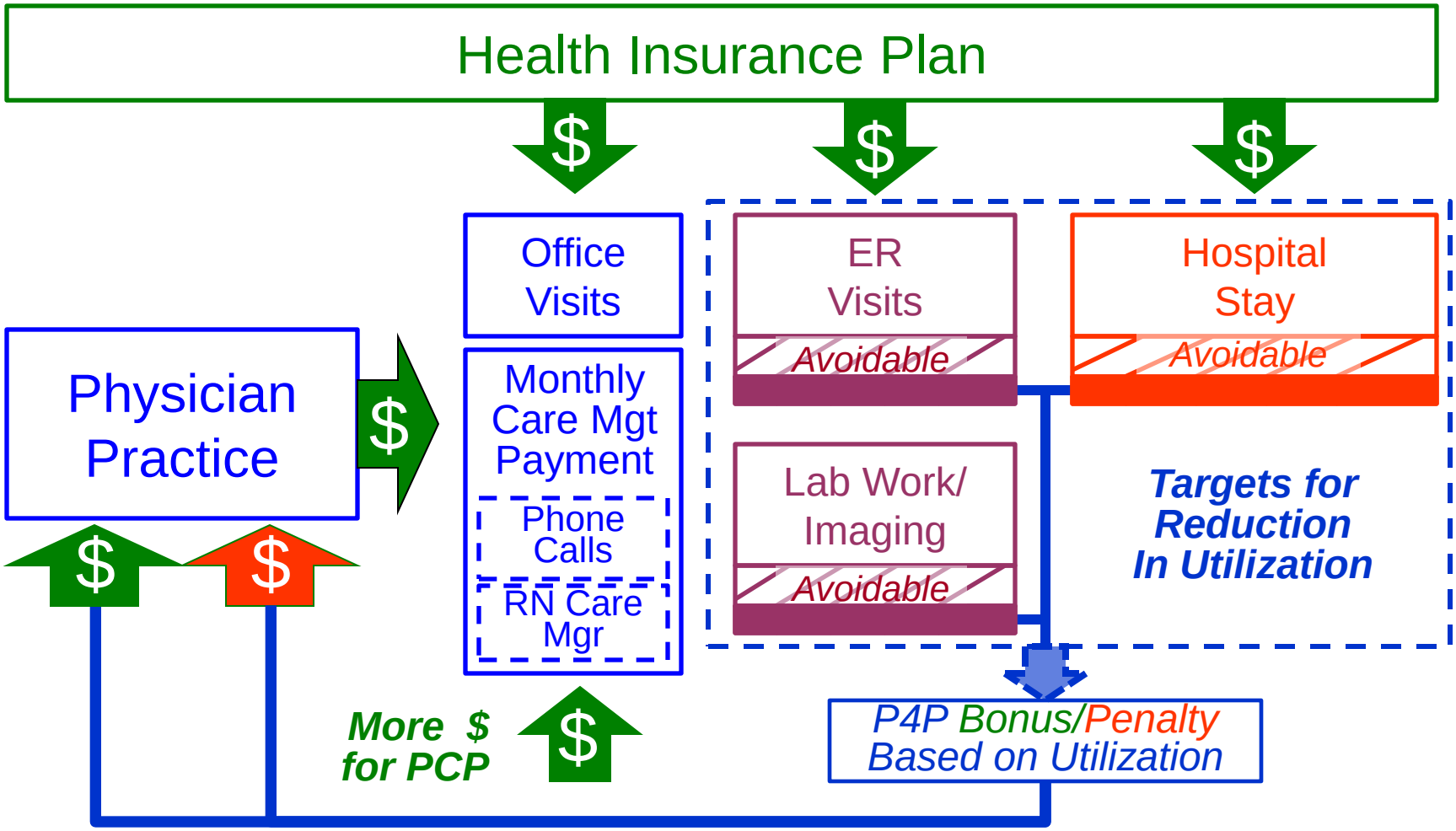


Weaknesses of "Shared Savings"

- Provides no upfront money to enable physician practices to hire nurse care managers, install IT, etc.; additional funds, if any, come years after the care changes are made
- The underlying fee for service incentives continue; losing less (via shared savings) is still losing compared to FFS
- Requires TOTAL costs to go down in order for the physician practice to receive ANY increase in payment, even if the practice can't control all costs
- Gives more rewards to the *poor* performers who improve than the providers who've done well all along
- I.e., it's not really true *payment reform*

Option 4: Resources + Accountability

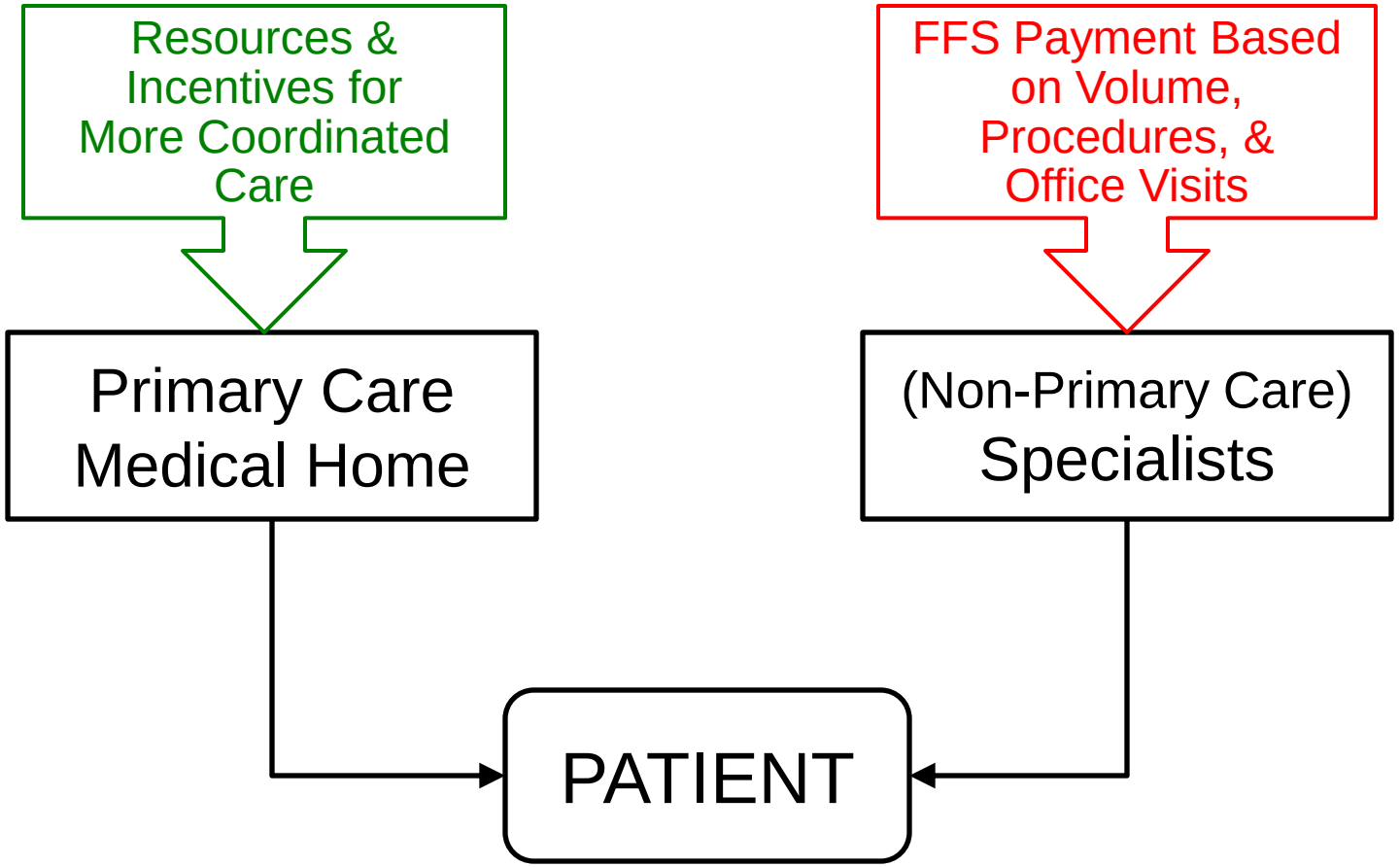
CARE MGT PAYMENT + UTILIZATION P4P



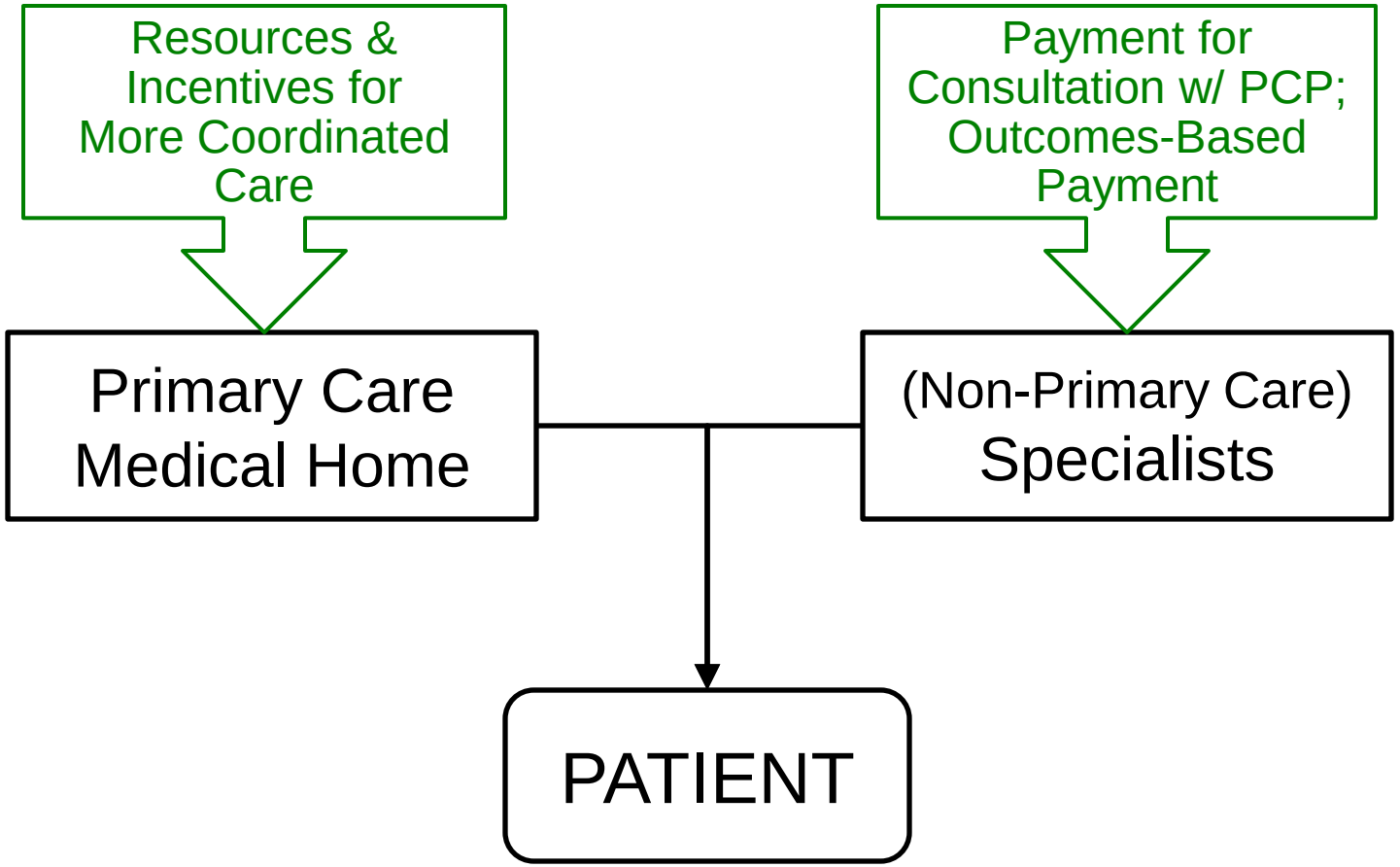
Example: Washington State Medical Home Pilot Program

- **Organized by Puget Sound Health Alliance and Washington State Health Care Authority**
- **4-Part Payment Model**
  - **Current FFS payments for PCP services**
  - **Additional PMPM payment for "care management"**
    - $2.50 per patient per month in Year 1 (part of year)
    - $2.00 per patient per month in Years 2 & 3
    - No restrictions on how money is used
  - **Targets for Reducing Preventable ER/Hospital Utilization**
    - Reduction targets large enough to repay health plans for upfront payments
    - Penalty for failure: Repayment of up to 50% of PMPM payment
  - **Bonus for success in reducing utilization beyond targets**
    - 50/50 split of payers' savings from reductions in ER visits and/or hospitalizations net of PMPM payment
    - Quality of care must be maintained based on quality measures
- **Implementation Began May 2011**
  - 7 health plans (5 commercial, 2 Medicaid)
  - 12 primary care practice sites (8 provider orgs), ~ 25,000 patients

Not Just PCPs, But The Medical Neighborhood, Too



Pay Both PCPs & Specialists for Outcomes & Coordination

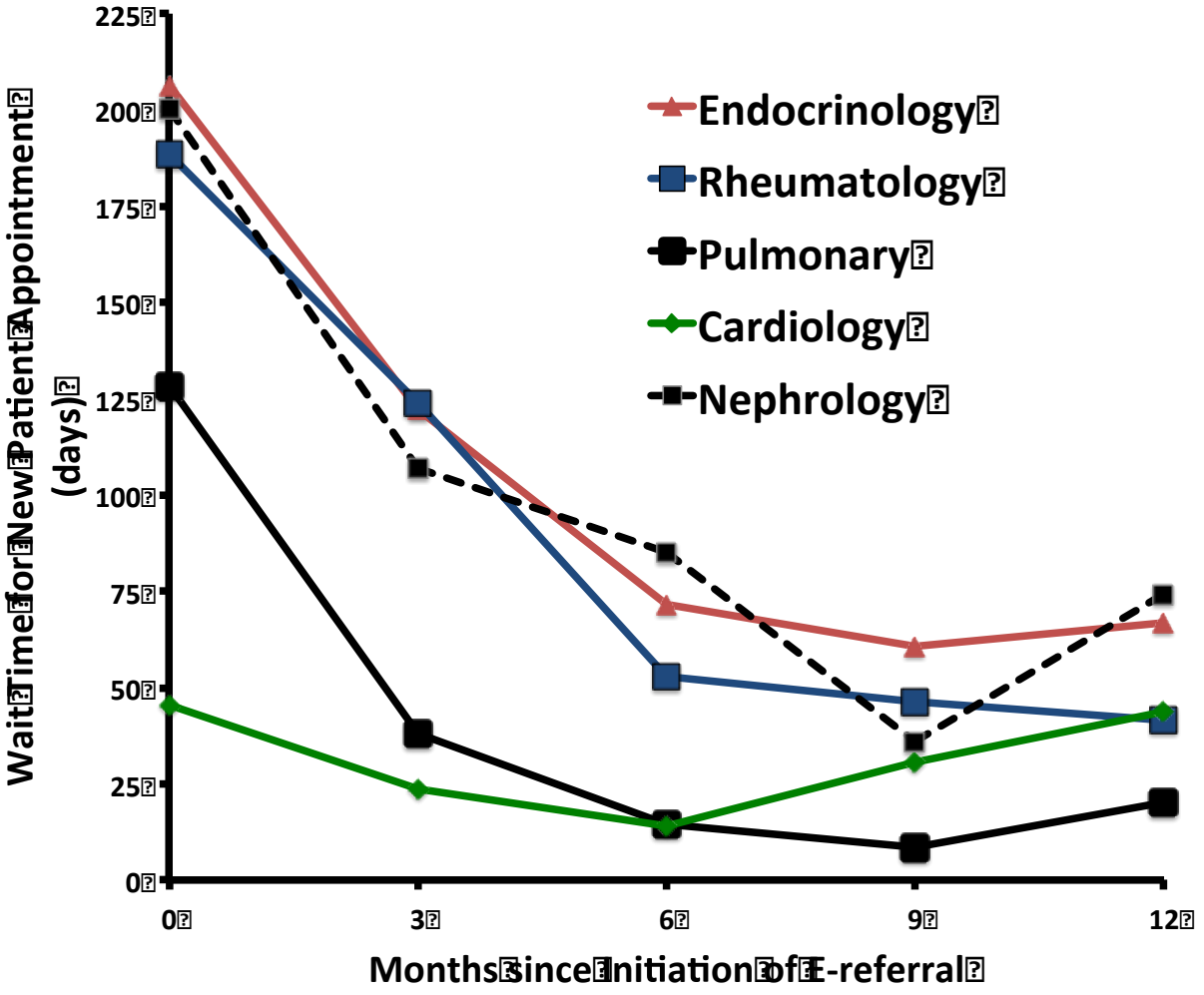


Minnesota's DIAMOND Initiative

- Goal: improve outcomes for patients with depression
- Convened all payers in Minnesota (except for Medicare) to agree on common payment changes for PCPs & specialists
- Payment changes:
  - Support for a care manager in the primary care practice
  - Psychiatrists paid to consult with PCP on how to manage patient's care comprehensively, rather than patient having to see psychiatrist separately
- Result: Dramatic improvement in remission rate

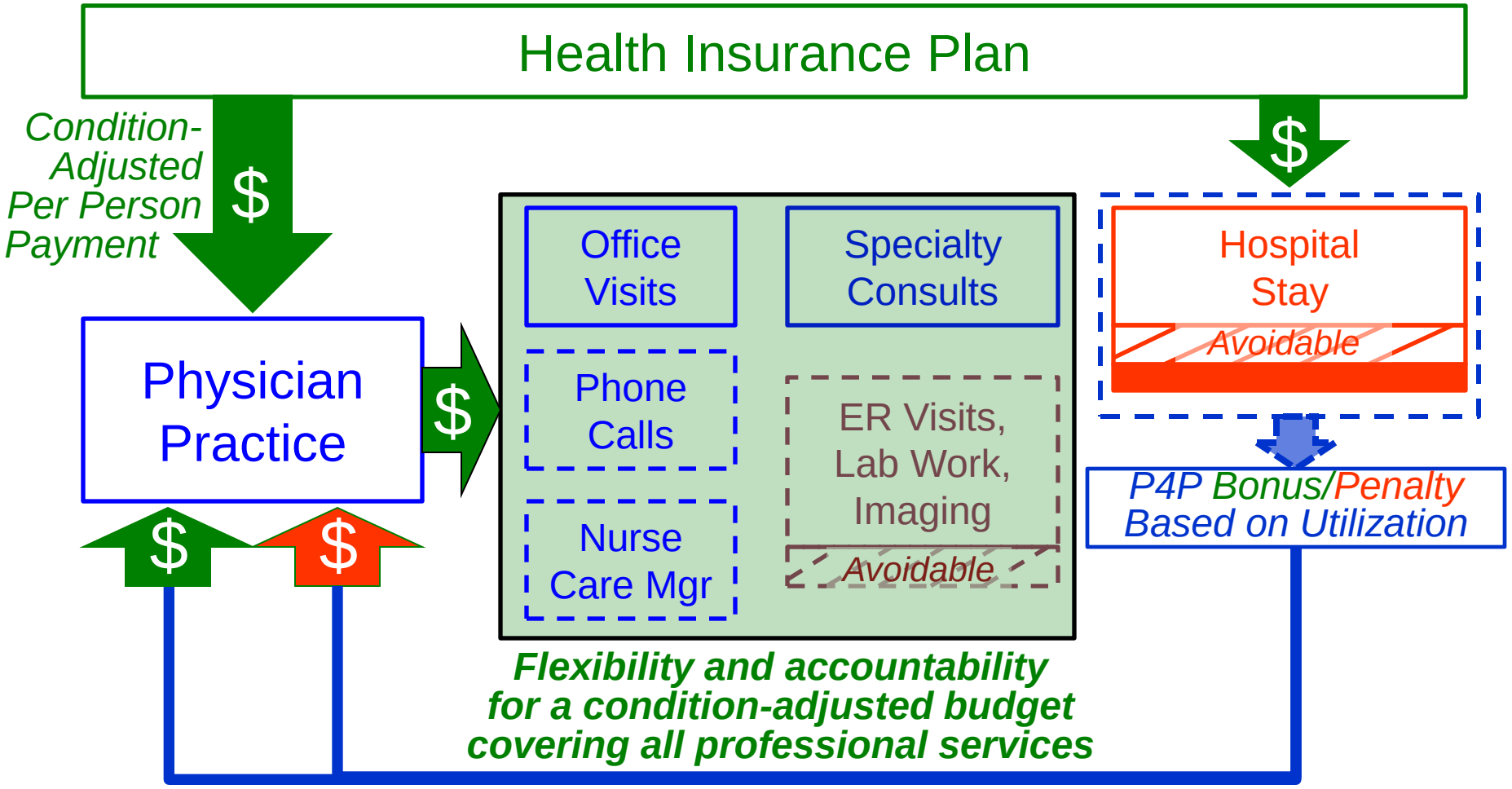
http://www.icsi.org/health_care_redesign_/diamond_35953/

Impact on Visit Wait Times of Paying for Non-Visit-Based Svcs



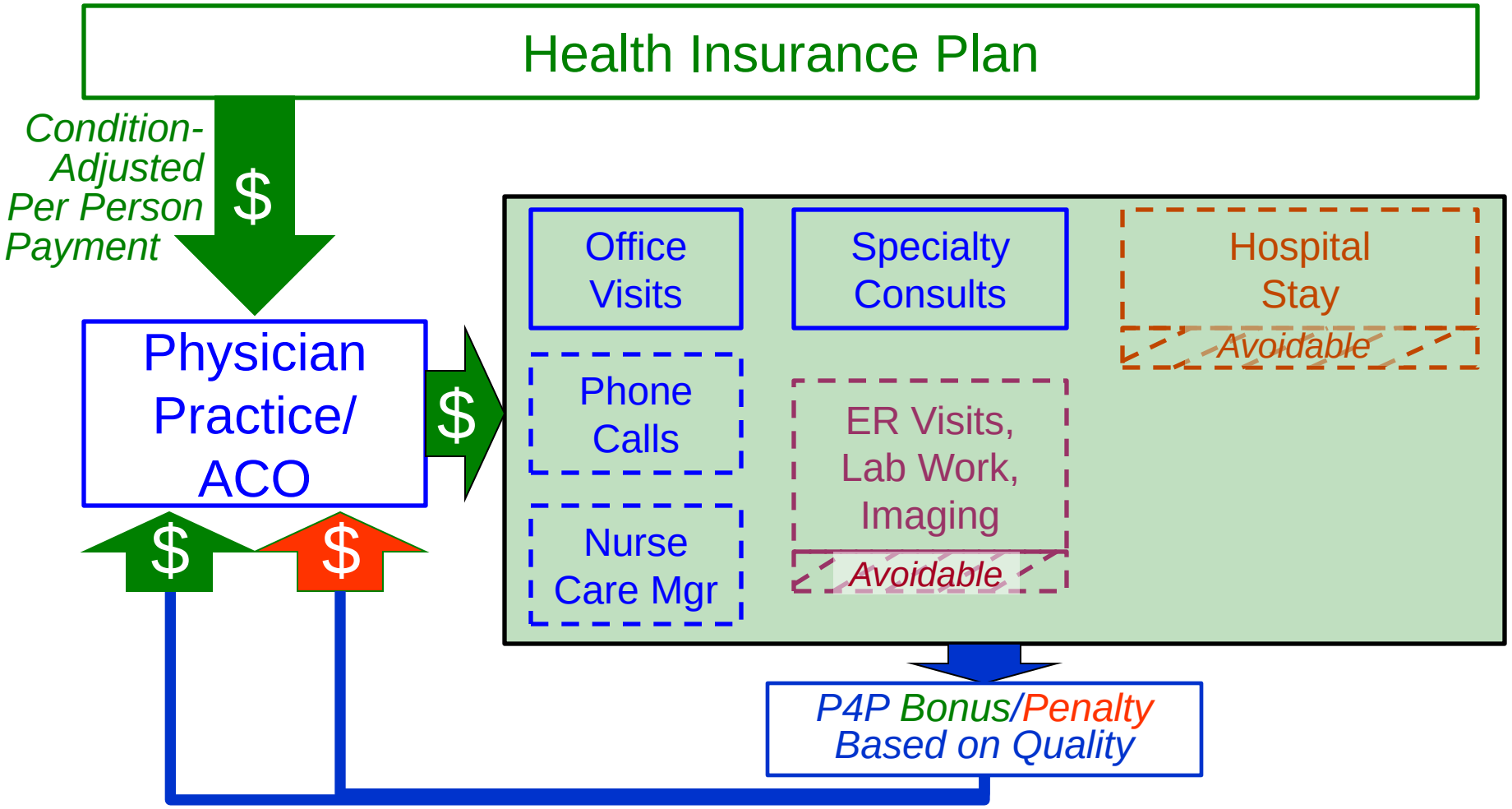
Option 5: Partial Comprehensive Care Payment

PARTIAL GLOBAL PMT (Professional Svcs)

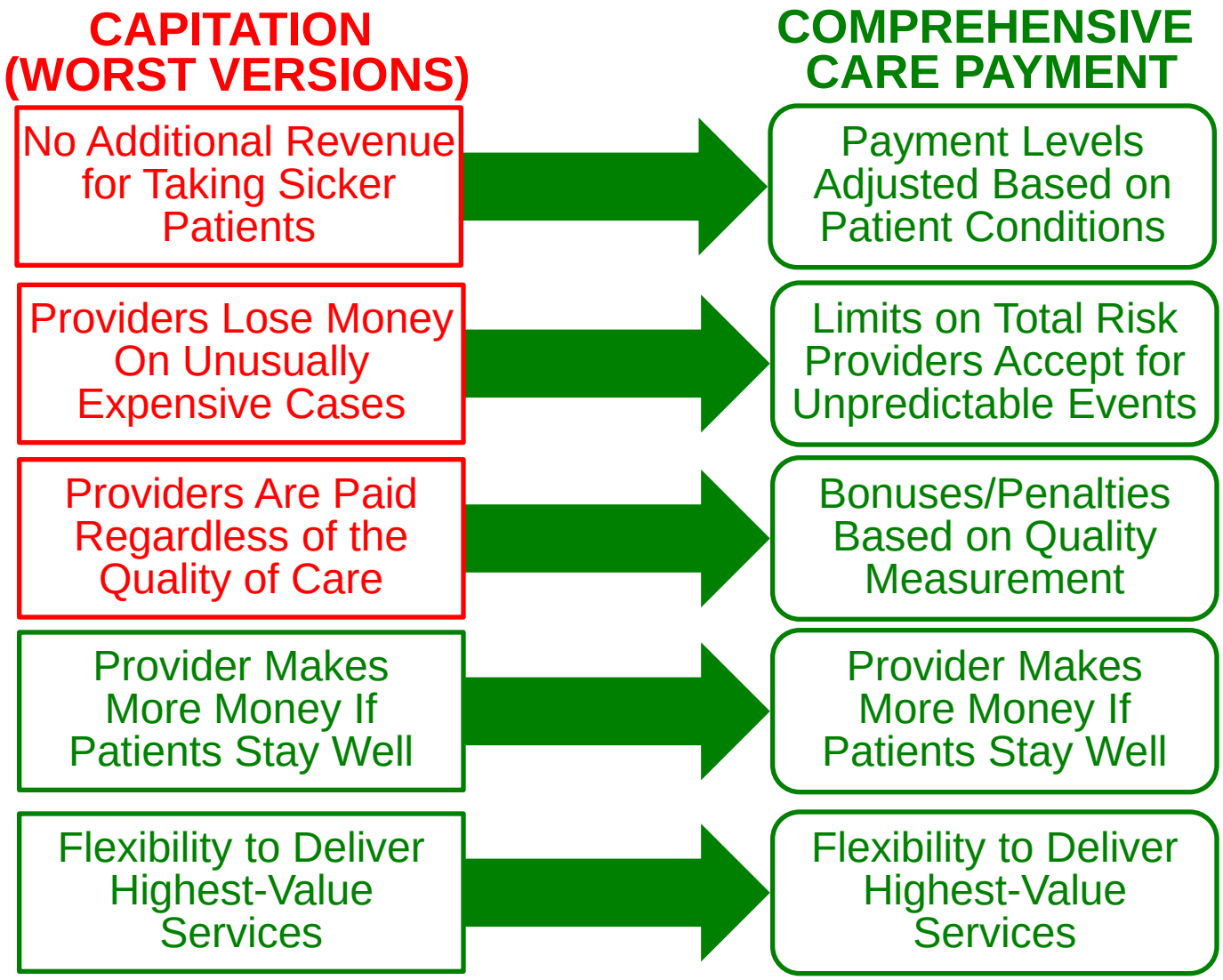


Option 6: Risk-Adjusted Full Comprehensive Care Payment

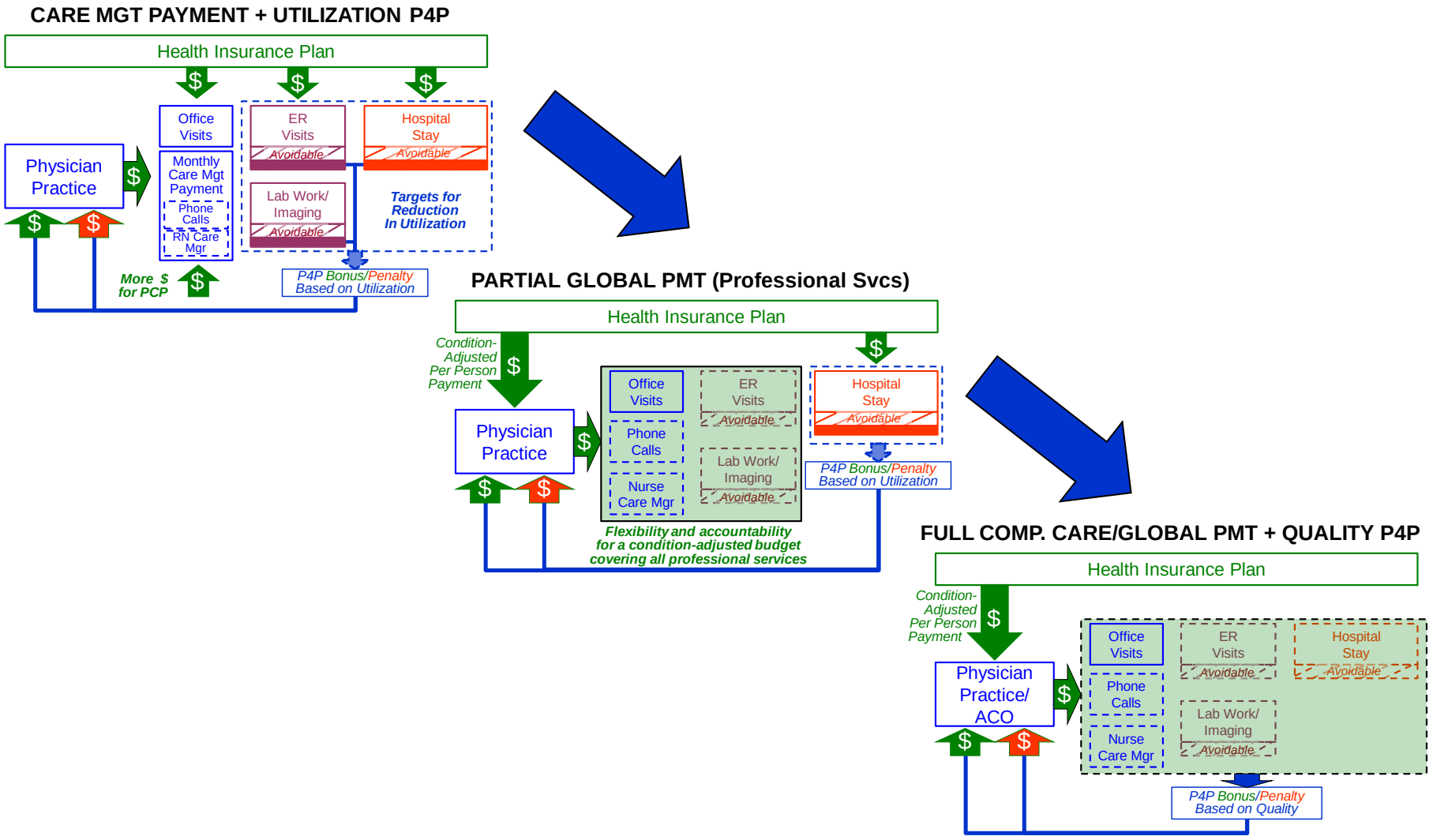
COMPREHENSIVE CARE/YEAR-LONG EPISODE



Isn't This Capitation? No – It's Different



Transitioning to Accountable Care Payment



Truly Flexible Payment Allows Truly Patient-Centered Care

- If you don't have to bring every patient into the office for a visit in order to be paid, you can focus more attention on the patients who have unique and complex problems and who need more time and attention
- If your profits are based on how healthy your patients are instead of on how many office visits they make or how many procedures you perform, you can focus resources on outreach to high-risk patients to get the preventive services they need to stay well, including sending staff to their home
- If you aren't constrained to spend money only on medical services, you can help patients address non-medical needs that are causing avoidable ER visits and hospitalizations, such as lack of transportation to see their PCP

Today: Reactive Care for Chronic Disease, Many Hospitalizations

	CURRENT		
	$/Patient	# Pts	Total $
Physician Svcs			
PCP	$600	500	$300,000
Hospitalizations			
Admissions	$10,000	250	$2,500,000
Specialist	$400	250	$100,000
Total Spending		500	$2,900,000

500 Moderately Severe Chronic Disease Patients

- PCP paid only for periodic office visits
- Patients do not take maintenance medications reliably
- 50% of patients are hospitalized each year for exacerbations
- Specialist only sees patient during hospital admissions

Is There a Better Way?

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Pt	# Pts	Total $	Chg
Physician Svcs				?		?	
PCP	$600	500	$300,000	?		?	
Hospitalizations				?		?	
Admissions	$10,000	250	$1,500,000	?		?	
Specialist	$400	250	$100,000	?		?	
Total Spending		500	$2,900,000	?		?	

Pay the PCP for Proactive Care Management

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Pt	# Pts	Total $	Chg
Physician Svcs							
PCP	$600	~~500~~	~~$300,000~~	$900	500	$450,000	+50%
Hospitalizations							
Admissions	$10,000	250	$1,500,000				
Specialist	$400	250	$100,000				
Total Spending		500	$2,900,000				

Pay the Specialist to Co-Manage The Patient's Care

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Pt	# Pts	Total $	Chg
Physician Svcs							
PCP	$600	500	$300,000	$900	500	$450,000	+50%
Specialist				$300	500	$150,000	+50%
Hospitalizations							
Admissions	$10,000	250	$1,500,000				
Specialist (Inpt)	$400	250	$100,000			$0	
Total Spending		500	$2,900,000				

Provide Adequate Resources to Support Patients

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Pt	# Pts	Total $	Chg
Physician Svcs							
PCP	$600	500	$300,000	$900	500	$450,000	+50%
Specialist				$300	500	$150,000	+50%
RN Care Mgr						$80,000	
Hospitalizations							
Admissions	$10,000	250	$1,500,000				
Specialist (Inpt)	$400	250	$100,000			$0	
Total Spending		500	$2,900,000				

Can We Afford a 127% Increase in Spending on Ambulatory Care?

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Pt	# Pts	Total $	Chg
Physician Svcs							
PCP	$600	500	$300,000	$900	500	$450,000	+50%
Specialist				$300	500	$150,000	+50%
RN Care Mgr						$80,000	
Total			$300,000		500	$680,000	127%
Hospitalizations							
Admissions	$10,000	250	$1,500,000				
Specialist (Inpt)	$400	250	$100,000			$0	
Total Spending		500	$2,900,000				

Yes, If It Succeeds In Reducing Hospitalizations

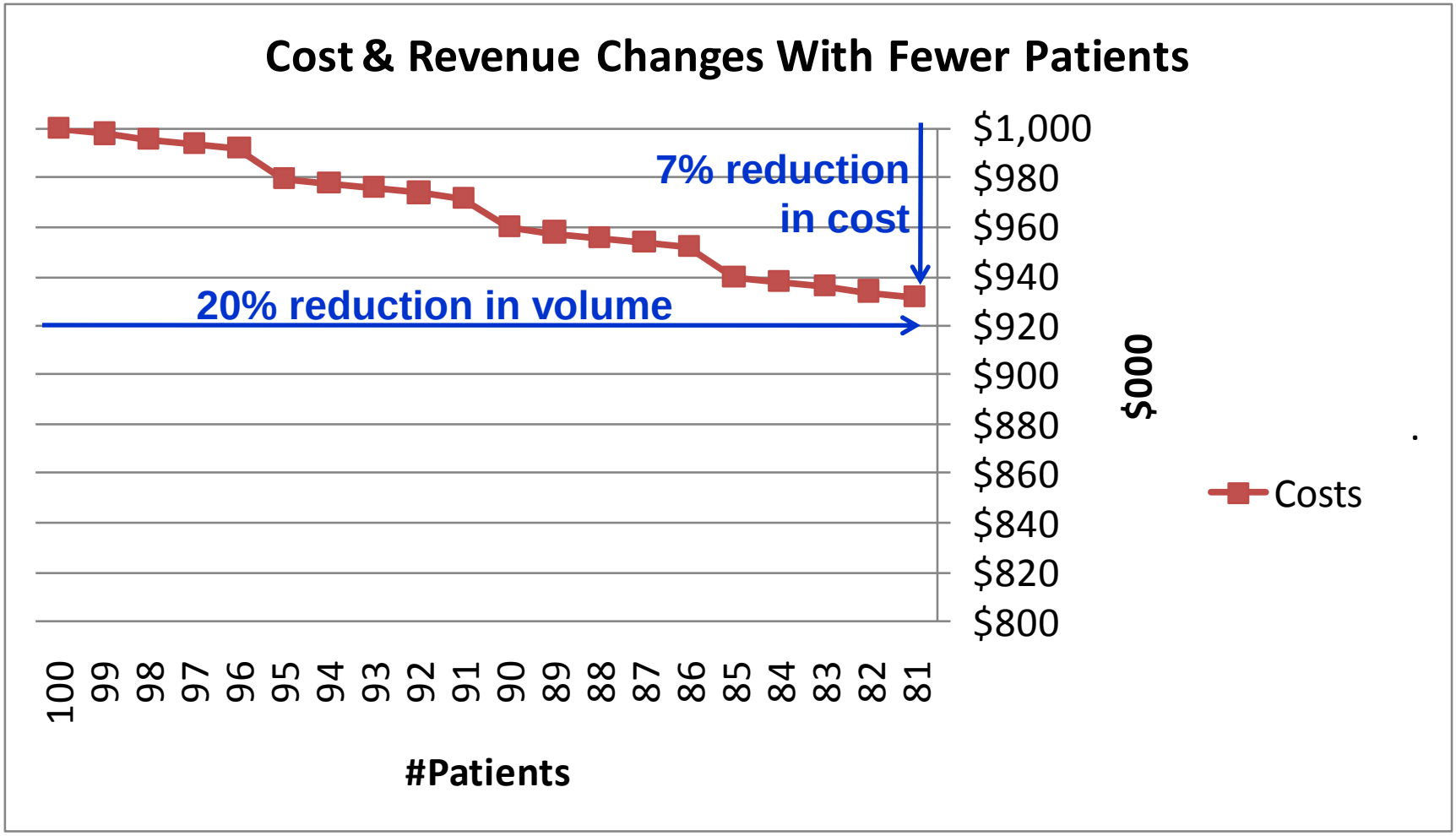
	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Pt	# Pts	Total $	Chg
Physician Svcs							
PCP	$600	500	$300,000	$900	500	$450,000	+50%
Specialist				$300	500	$150,000	+50%
RN Care Mgr						$80,000	
Total			$300,000		500	$680,000	127%
Hospitalizations							
Admissions	$10,000	250	~~$1,500,000~~	~~$10,000~~	150	$1,500,000	-40%
Specialist (Inpt)	$400	250	$100,000			$0	
Total Spending		500	$2,900,000		500	$2,180,000	-25%

But What About the Hospital?

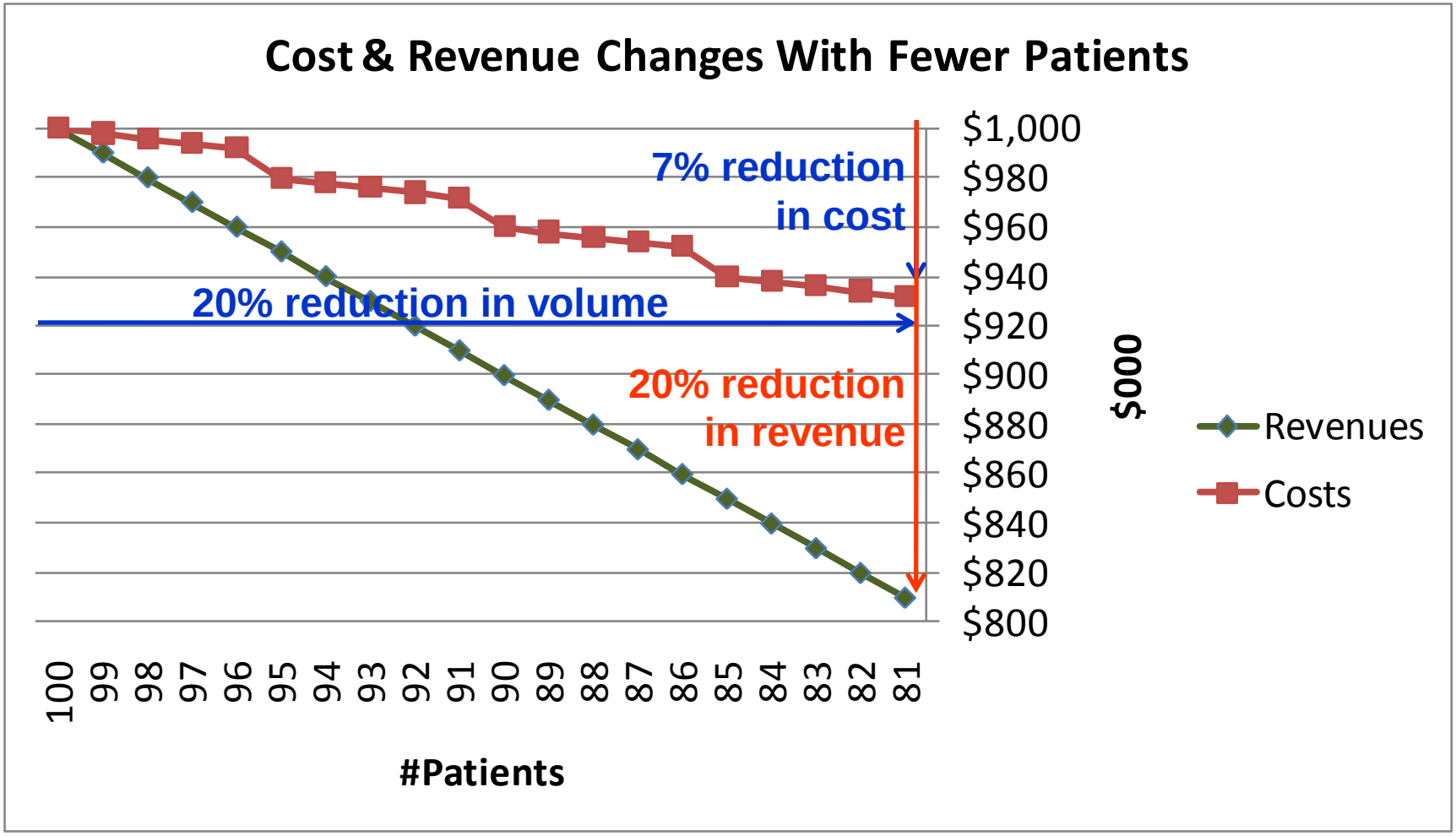
	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Pt	# Pts	Total $	Chg
Physician Svcs							
PCP	$600	500	$300,000	$900	500	$450,000	+50%
Specialist				$300	500	$150,000	+50%
RN Care Mgr						$80,000	
Total			$300,000		500	$680,000	127%
Hospitalizations							
Admissions	$10,000	250	~~$1,500,000~~	~~$10,000~~	150	$1,500,000	-40%
Specialist (Inpt)	$400	250	$100,000			$0	
Total Spending		500	$2,900,000		500	$2,180,000	-25%

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

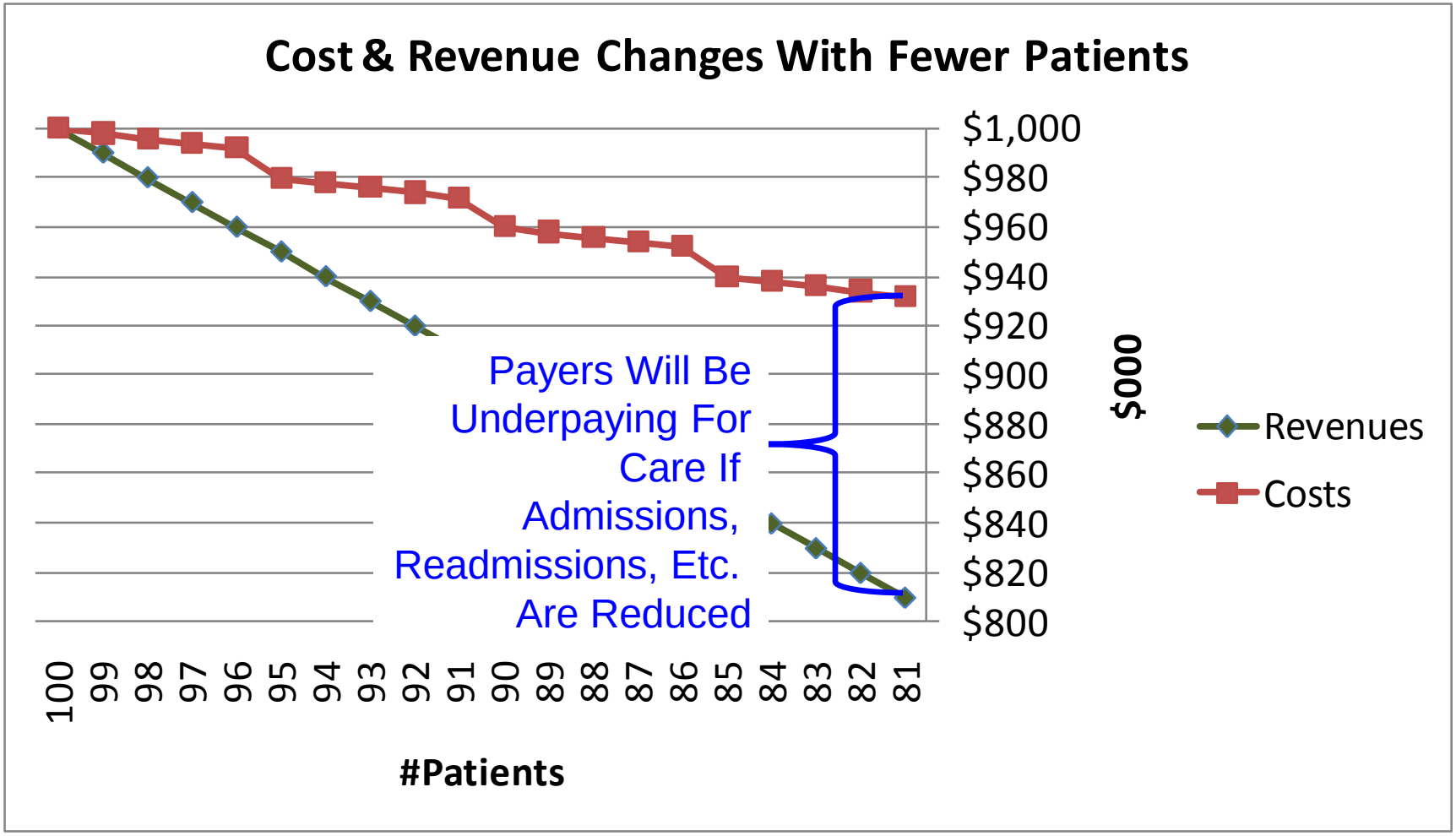
Hospital Costs Are Not Proportional to Utilization



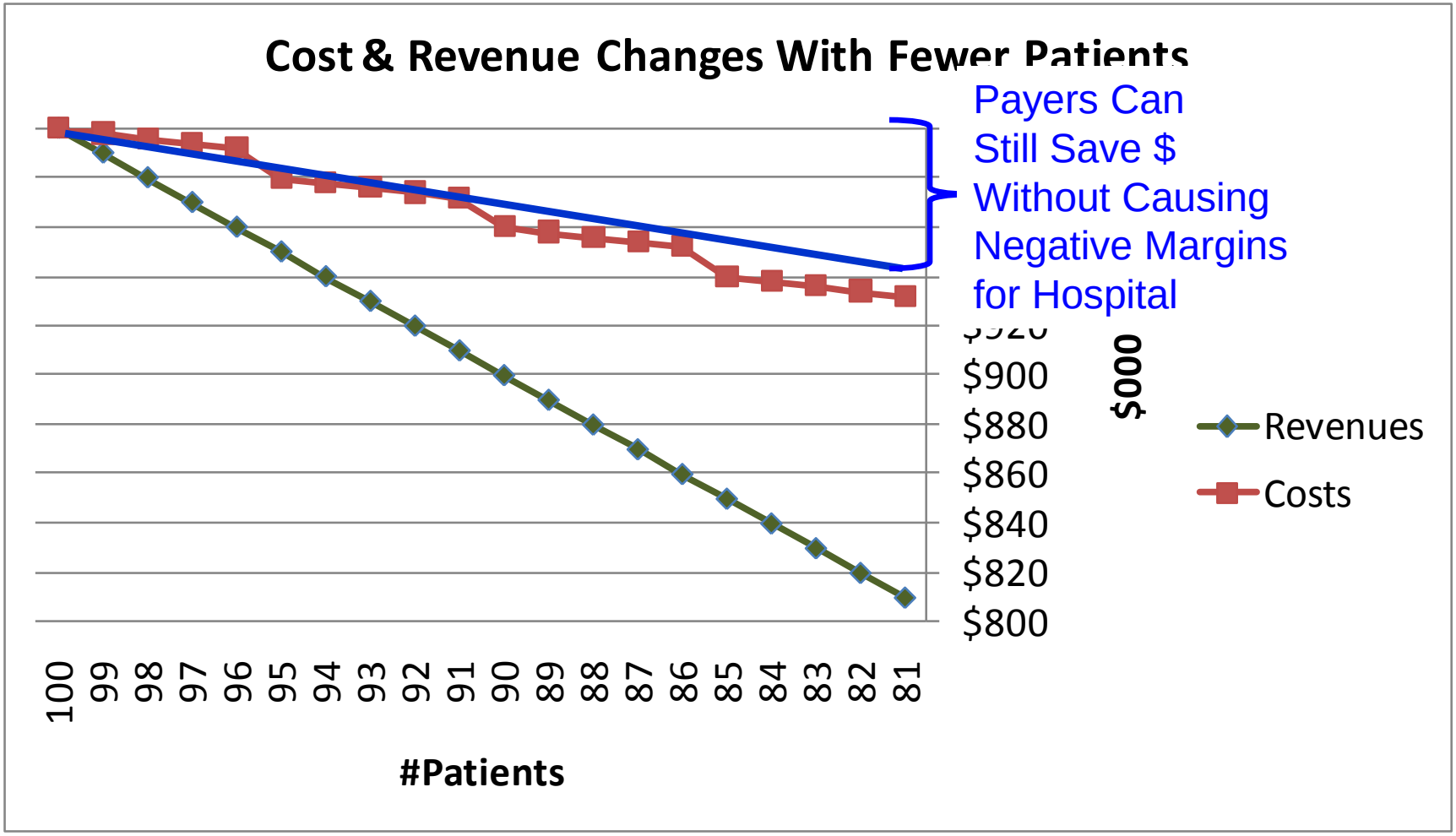
Reductions in Utilization Reduce Revenues More Than Costs



Causing Negative Margins for Hospitals



But Spending Can Be Reduced Without Bankrupting Hospitals



Analyze the Hospital's Cost Structure

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Pt	# Pts	Total $	Chg
Physician Svcs							
PCP	$600	500	$300,000	$900	500	$450,000	+50%
Specialist				$300	500	$150,000	+50%
RN Care Mgr						$80,000	
Total			$300,000		500	$680,000	127%
Hospitalizations							
Hospital Fixed	$6,000	60%	$1,500,000				
Hosp. Variable	$3,700	37%	$925,000				
Hosp. Margin	$300	3%	$75,000				
Total	$10,000	250	$2,500,000				
Specialist (Inpt)	$400	250	$100,000				
Total Spending		500	$2,900,000				

What Happens to Hospital Finances When Admissions Go Down?

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Pt	# Pts	Total $	Chg
Physician Svcs							
PCP	$600	500	$300,000	$900	500	$450,000	+50%
Specialist				$300	500	$150,000	+50%
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Hosp. Margin	$300	3%	$75,000				
Total	$10,000	250	~~$2,500,000~~		150		
Specialist (Inpt)	$400	250	$100,000			$0	
Total Spending		500	$2,900,000				

Continue to Cover the Fixed Costs

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Pt	# Pts	Total $	Chg
Physician Svcs							
PCP	$600	500	$300,000	$900	500	$450,000	+50%
Specialist				$300	500	$150,000	+50%
RN Care Mgr						$80,000	
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Total	$10,000	250	$2,500,000		150		
Specialist (Inpt)	$400	250	$100,000			$0	
Total Spending		500	$2,900,000				

Save on Variable Costs With Fewer Patients

	CURRENT			FUTURE			
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Physician Svcs							
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Specialist				$300	500	$150,000	+50%
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Hosp. Variable	$3,700	~~37%~~	~~$925,000~~	$3,700		$555,000	-40%
Hosp. Margin	$300	3%	$75,000				
Total	$10,000	250	~~$2,500,000~~		150		
Specialist (Inpt)	$400	250	$100,000			$0	
Total Spending		500	$2,900,000				

Increase the Hospital's Contribution Margin

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Pt	# Pts	Total $	Chg
Physician Svcs							
PCP	$600	500	$300,000	$900	500	$450,000	+50%
Specialist				$300	500	$150,000	+50%
RN Care Mgr						$80,000	
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Hosp. Margin	$300	3%	$75,000			$82,500	+10%
Total	$10,000	250	$2,500,000		150		
Specialist (Inpt)	$400	250	$100,000			$0	
Total Spending		500	$2,900,000				

Hospital Gets Less *Total Revenue*, But is Better Off *Financially*

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Pt	# Pts	Total $	Chg
Physician Svcs							
PCP	$600	500	$300,000	$900	500	$450,000	+50%
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Hosp. Margin	$300	3%	$75,000			$82,500	+10%
Total	$10,000	250	$2,500,000		150	$2,137,500	-15%
Specialist (Inpt)	$400	250	$100,000			$0	
Total Spending		500	$2,900,000				

And the Payer Still Spends Less

	CURRENT			FUTURE			
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Physician Svcs							
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Total	$10,000	250	$2,500,000		150	$2,137,500	-15%
Specialist (Inpt)	$400	250	$100,000			$0	
Total Spending		500	$2,900,000		500	$2,817,500	-3%

Win-Win-Win: Better Care, Higher Physician Pay, Lower Spending

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Pt	# Pts	Total $	Chg
Physician Svcs							
PCP	$600	500	$300,000	$900	500	$450,000	+50%
Specialist				$300	500	$150,000	+50%
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Total			$300,000		500	$680,000	127%
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Total	$10,000	250	$2,500,000		150	$2,137,500	-15%
Specialist (Inpt)	$400	250	$100,000			$0	
Total Spending		500	$2,900,000		500	$2,817,500	-3%

Physicians Win
Hospital Wins
Payer Wins

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

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Pt	# Pts	Total $	Chg
Physician Svcs							
PCP	$600	500	$300,000	$900	500	$450,000	+50%
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Specialist (Inpt)	$400	250	$100,000			$0	
Total Spending		500	$2,900,000		500	$2,817,500	-3%

You Don't Want to Try and Renegotiate Individual Fees

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Pt	# Pts	Total $	Chg
Physician Svcs							
PCP	$600	500	$300,000	$900	500	$450,000	+50%
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Hosp. Margin	$300	3%	$75,000			$82,500	+10%
Total	$10,000	250	$2,500,000	$14,250	150	$2,137,500	-15%
Specialist (Inpt)	$400	250	$100,000			$0	
Total Spending		500	$2,900,000		500	$2,817,500	-3%

Look at What is Being Spent Today in *Total* on the Patient's *Condition*

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Pt	# Pts	Total $	Chg
Physician Svcs							
PCP	$600	500	$300,000	$900	500	$450,000	+50%
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Hosp. Margin	$300	3%	$75,000			$82,500	+10%
Total		250	$2,500,000		150	$2,137,500	-15%
Specialist (Inpt)	$400	250	$100,000			$0	
Total Spending	$5,800	500	$2,900,000		500	$2,817,500	-3%

Tell the Payer You'll Do It For Less Than They're Spending Today

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Pt	# Pts	Total $	Chg
Physician Svcs							
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Total		250	$2,500,000		150	$2,137,500	-15%
Specialist (Inpt)	$400	250	$100,000			$0	
Total Spending	$5,800	500	~~$2,900,000~~	$5,635	500	$2,817,500	-3%

Use That Budget to Pay Doctors & Hospitals What They Really Need

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Pt	# Pts	Total $	Chg
Physician Svcs							
PCP	$600	500	$300,000		500	$450,000	+50%
Specialist					500	$150,000	+50%
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Total Spending	$5,800	500	$2,900,000	$5,635	500	$2,817,500	-3%

Condition-Based Payment Puts the *Providers* in Charge of Care & Pmt

	CURRENT			FUTURE			
	$/Patient	# Pts	Total $	$/Pt	# Pts	Total $	Chg
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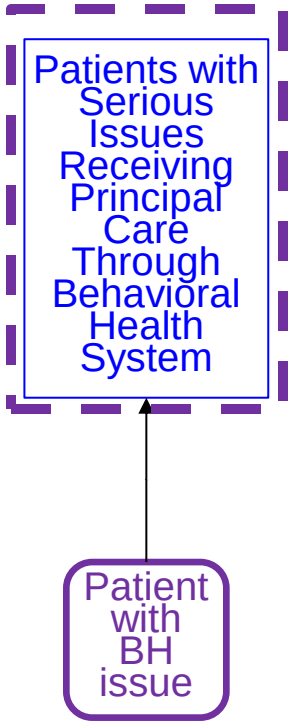
Specialist (Inpt)	$400	250	$100,000			$0	
Total Spending	$5,800	500	$2,900,000	$5,635	500	$2,817,500	-3%

"Shared Savings" Doesn't Solve the Problems with FFS

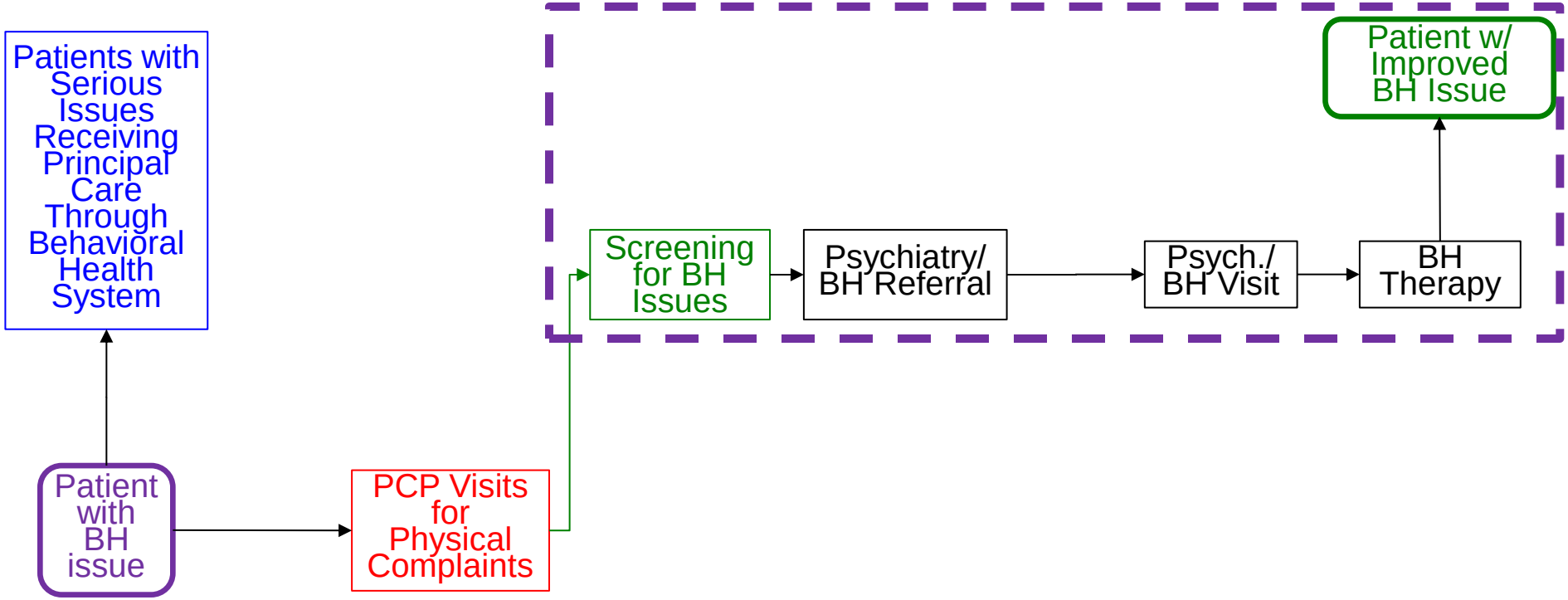
- No actual change in payment to the physicians
  - No funding for the nurse
  - No payment for phone calls instead of office visits
  - No flexibility to proactive outreach instead of reactive care
- Arbitrary "share" of savings may not be sufficient to cover higher costs of care or losses from FFS revenue
  - 50% of savings is not adequate if >50% of costs are fixed
- No shared savings payment at all unless minimum savings threshold is met, and shared savings payments are reduced if quality in other areas is not improved
- All savings goes back to Medicare/health plan at end of contract period, with no permanent change in payment for physicians

How Patients w/ Behavioral Health Issues Receive Care Today

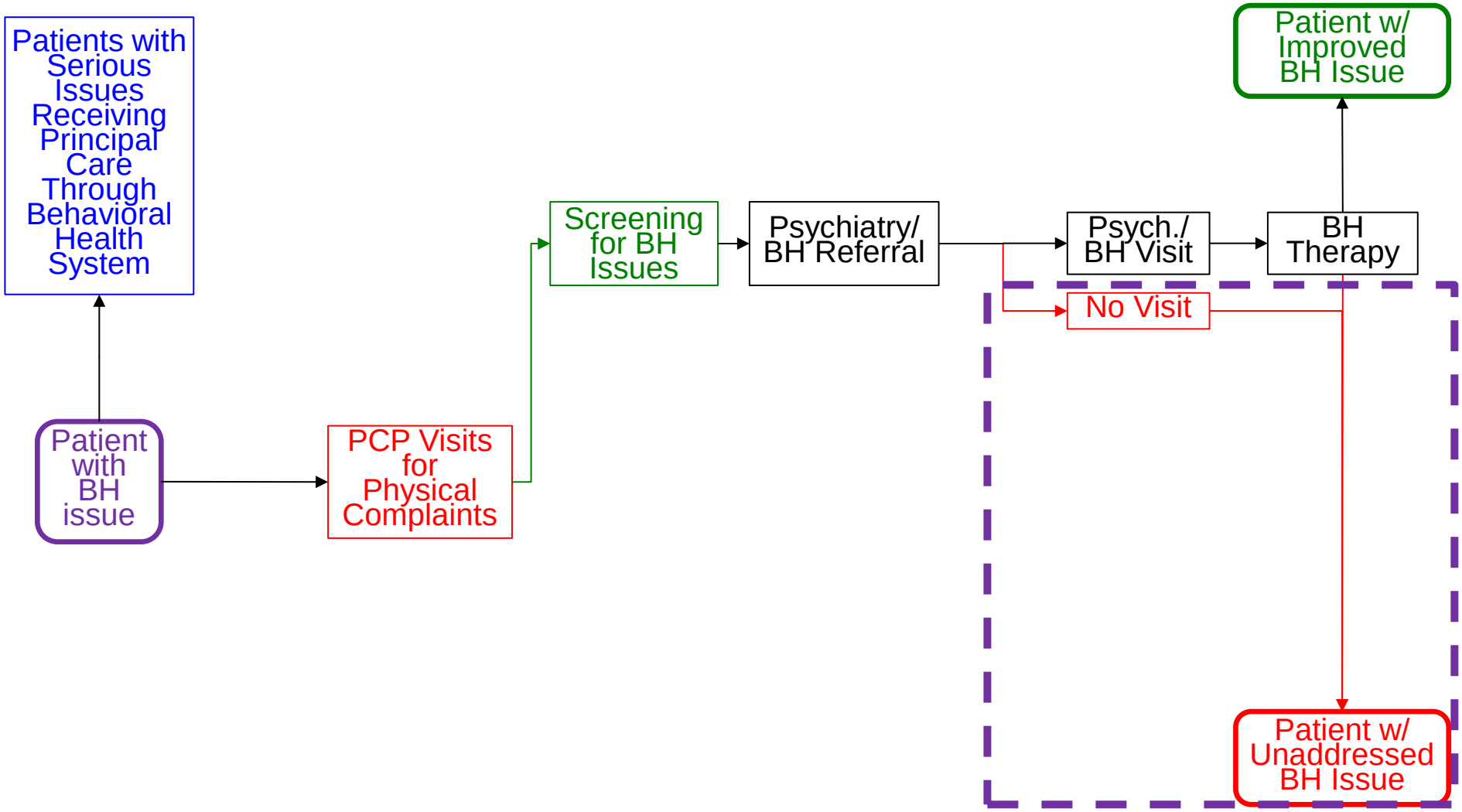
Some Have Serious BH Issues and Are Managed by BH System



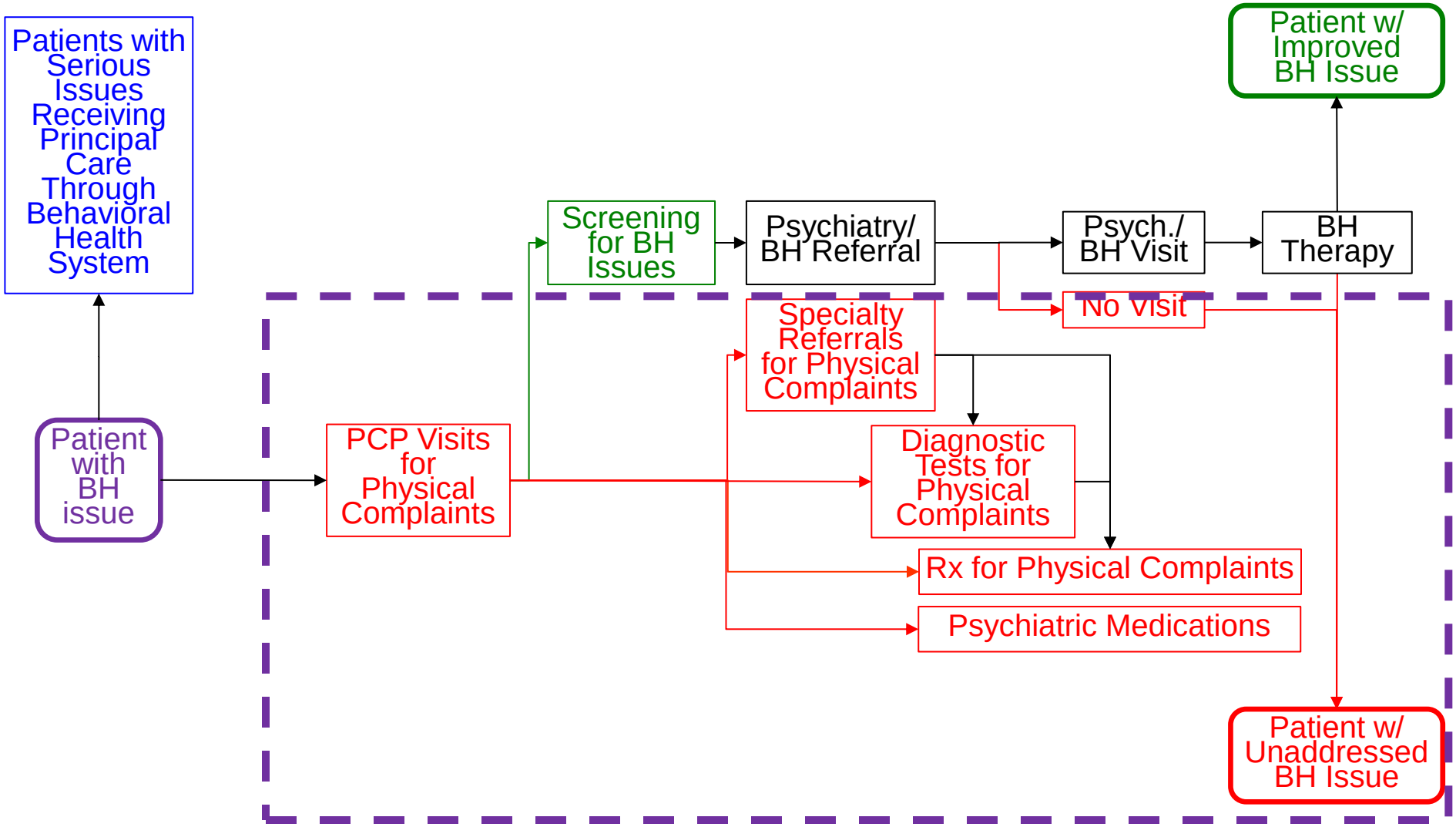
Some Are Identified by PCPs and Referred to Psychiatry/BH



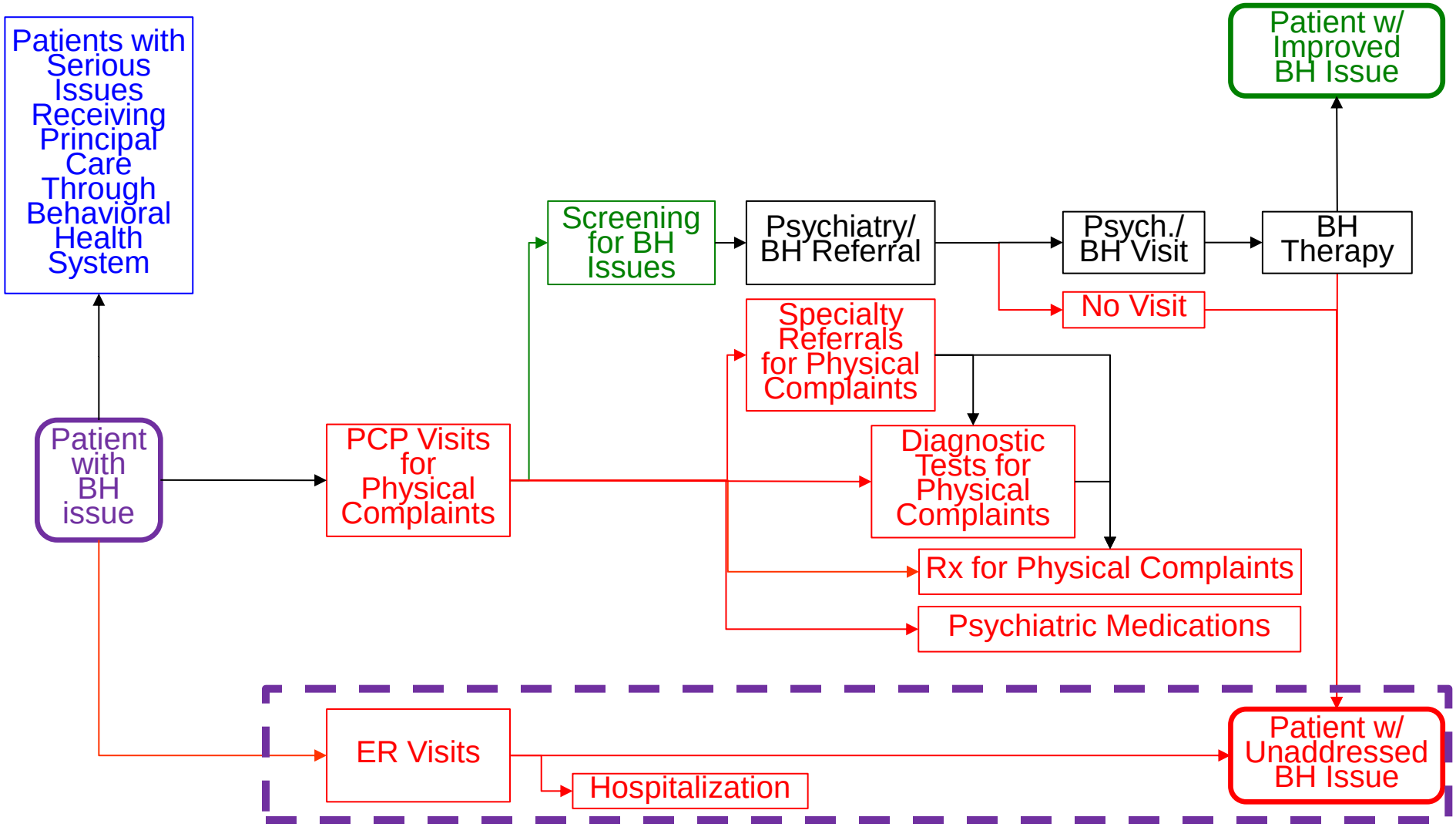
But Patients May Not Follow Through on the Referral



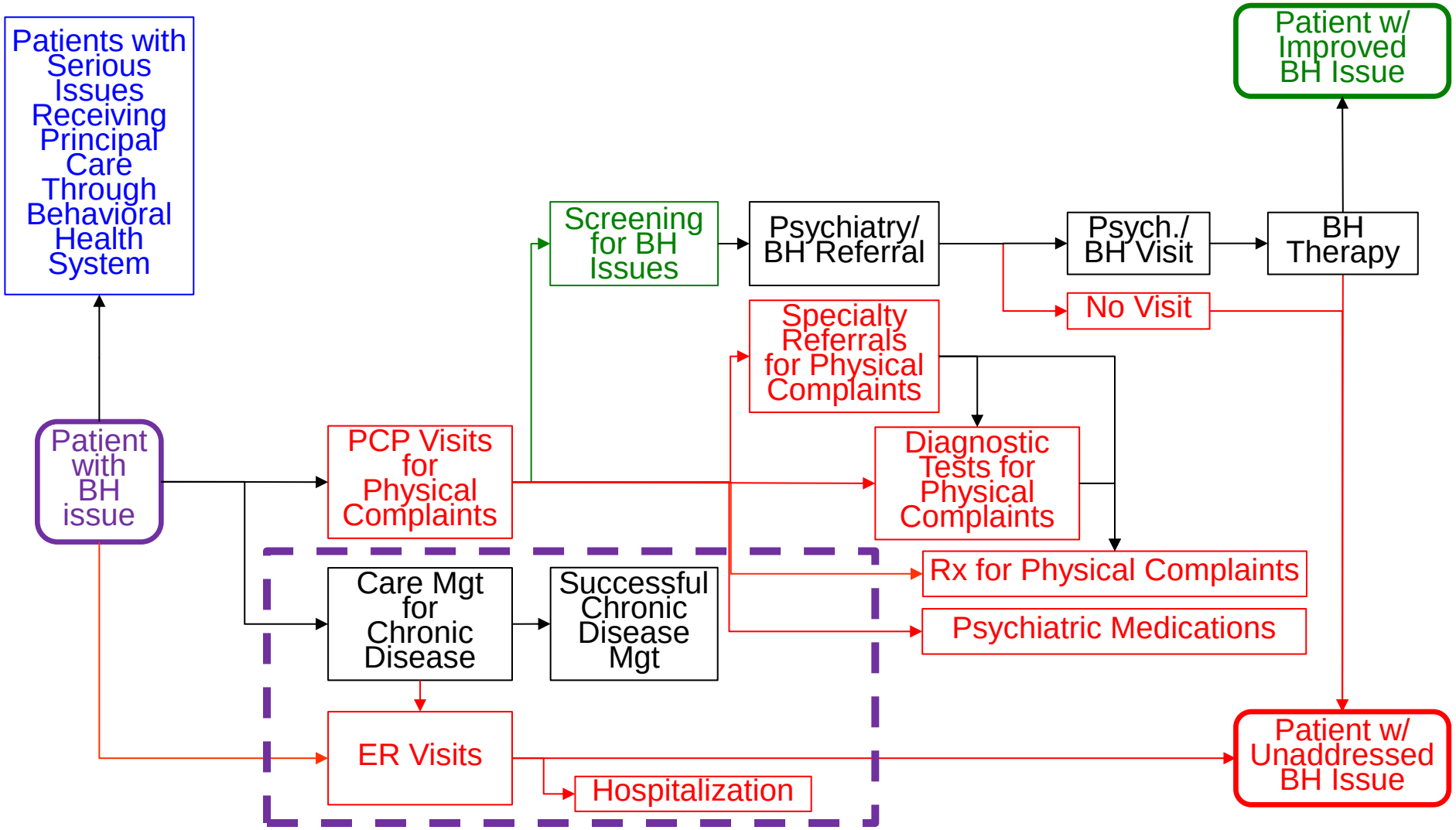
Some Patients Treated for Physical Issues May Really Be BH Issues



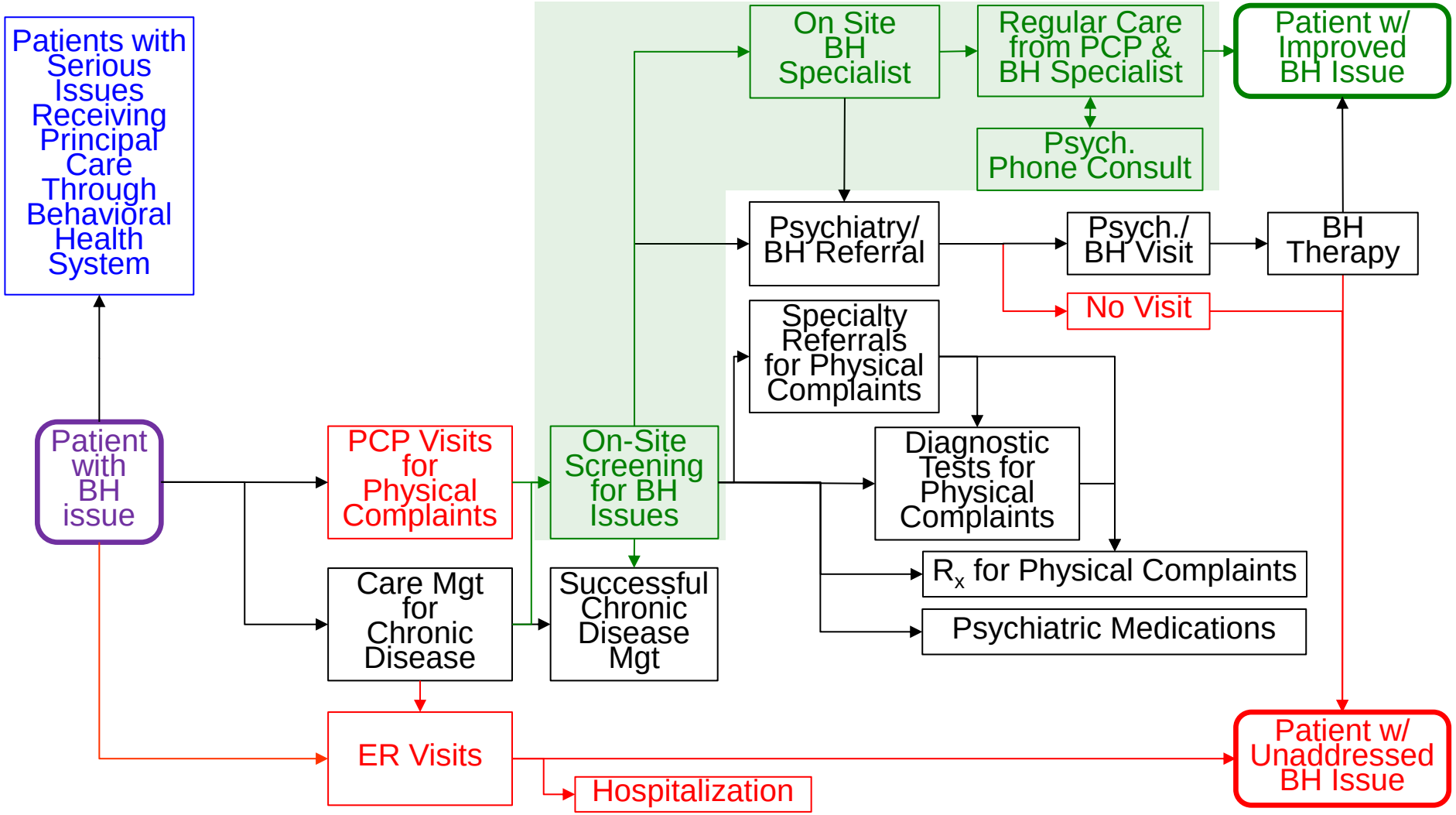
Some Patients May Go to ER for Physical Issues; Really BH Issues



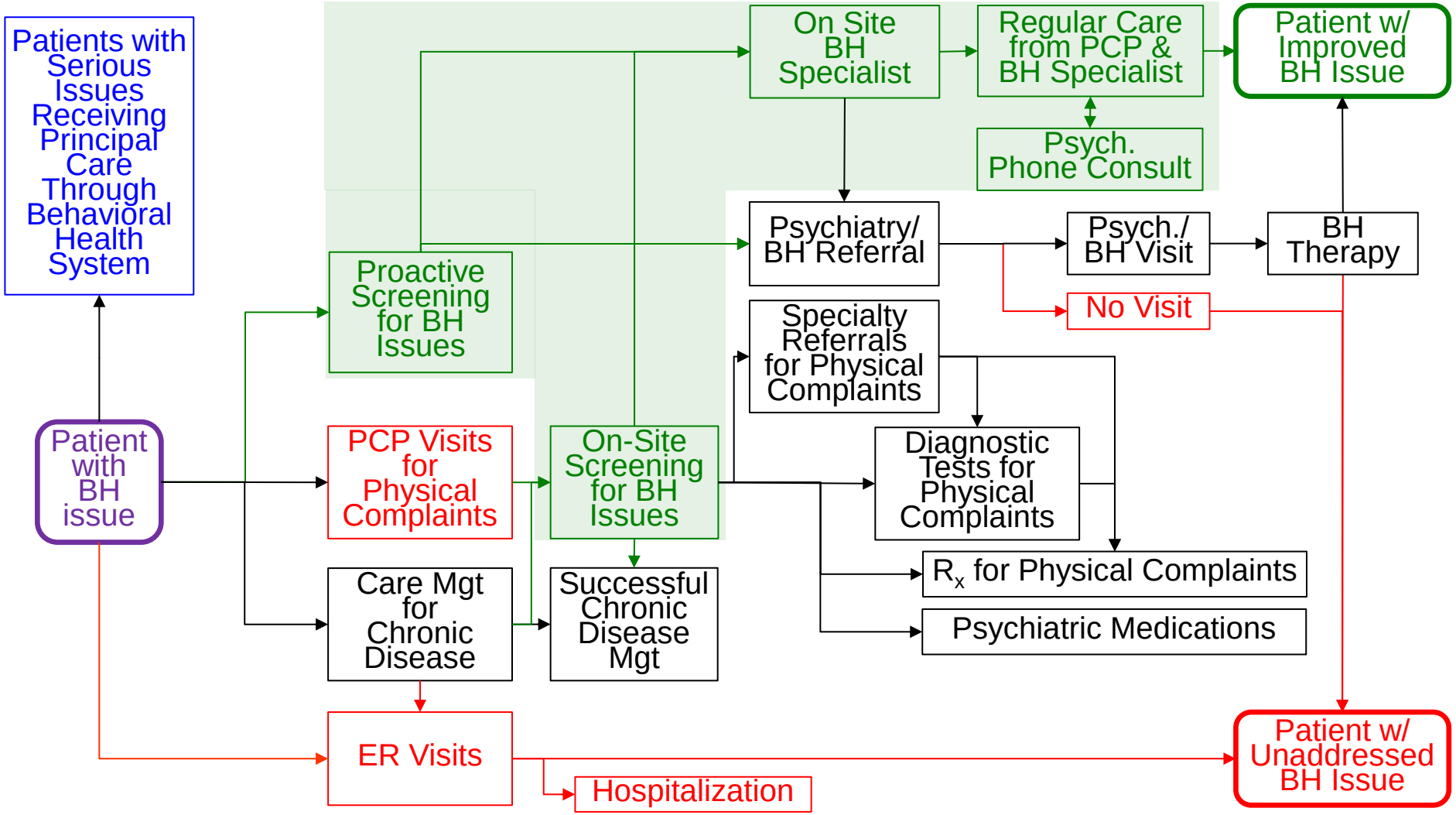
Worse Outcomes for Chronic Disease w/o Addressing BH Issues



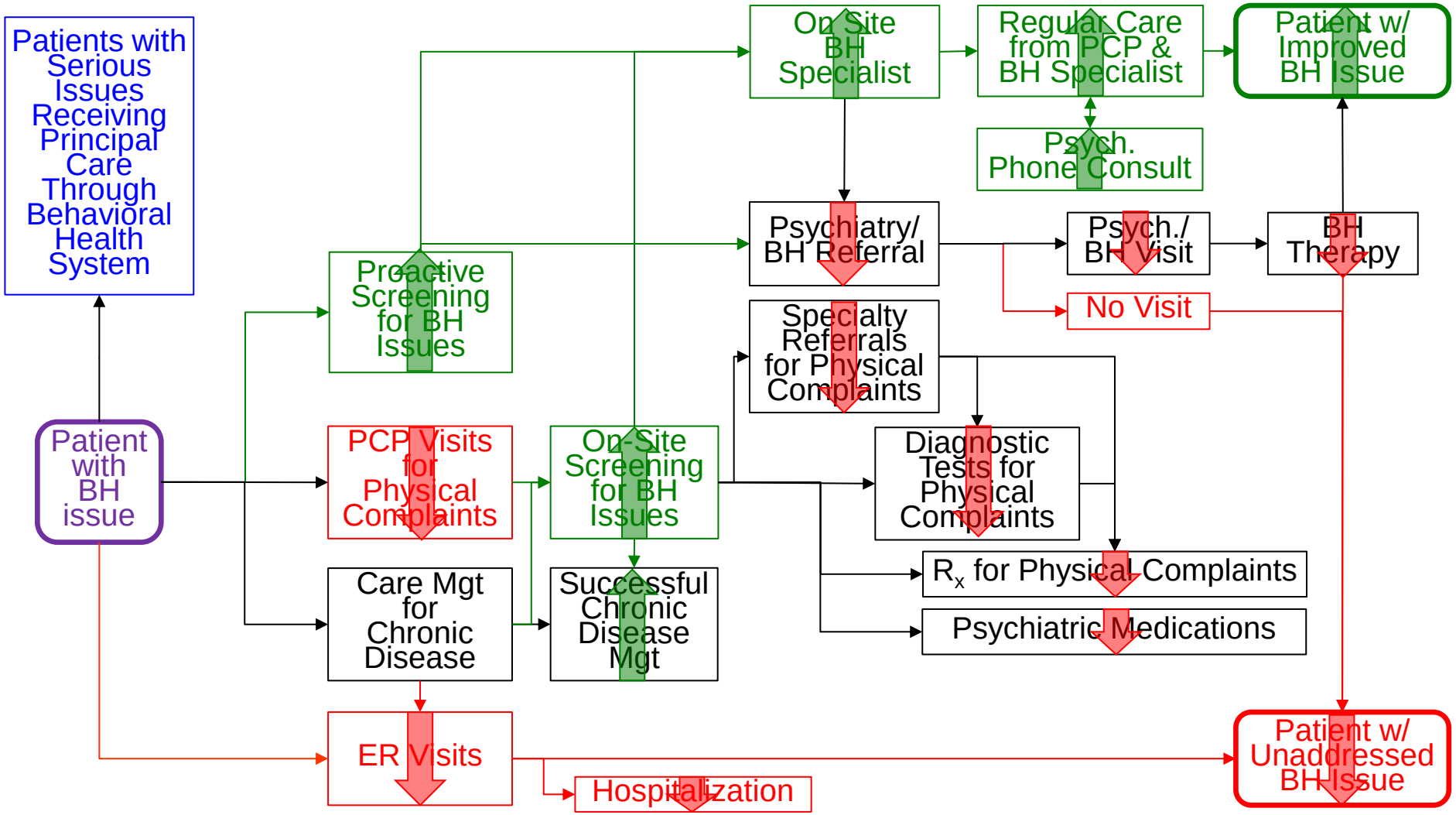
How Care Would Be Redesigned: 1. Screening/Intervention at Visits



How Care Would Be Redesigned: 2. Proactive Screening & Referral



Expected Impacts on Costs and Outcomes



What's the Right Number of BH Specialists Per Practice?

- **Workload for Behavioral Health Specialist for Immediate Intervention:**
  - PCP screening of 2,000 patient panel will result in 350 immediate referrals to the on-site Behavioral Health Specialist
  - For 350 warm handoff referrals:
    - 2 visits/patient @ 45 minutes/visit = 700 visits/500 hours
    - 1 phone call/patient @ 15 minutes/call = 350 calls/90 hours
    - Total: 590 hours/year = .3 FTE
    - Slack time needed to ensure immediate availability = .1 FTE?
  - 3-4 doc practice = 1 FTE Behavioral Health Specialist for warm handoffs

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- **Workload for Behavioral Health Specialist for On-Site Treatment:**
  - 50 patients may need ongoing behavior health support through PCP
    - 12 visits/patient/year @ 1 hour/visit = 600 hours/year = .3 FTE
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  - Both screening and treatment allows presence in small practices, but need to preserve slack time for immediate interventions

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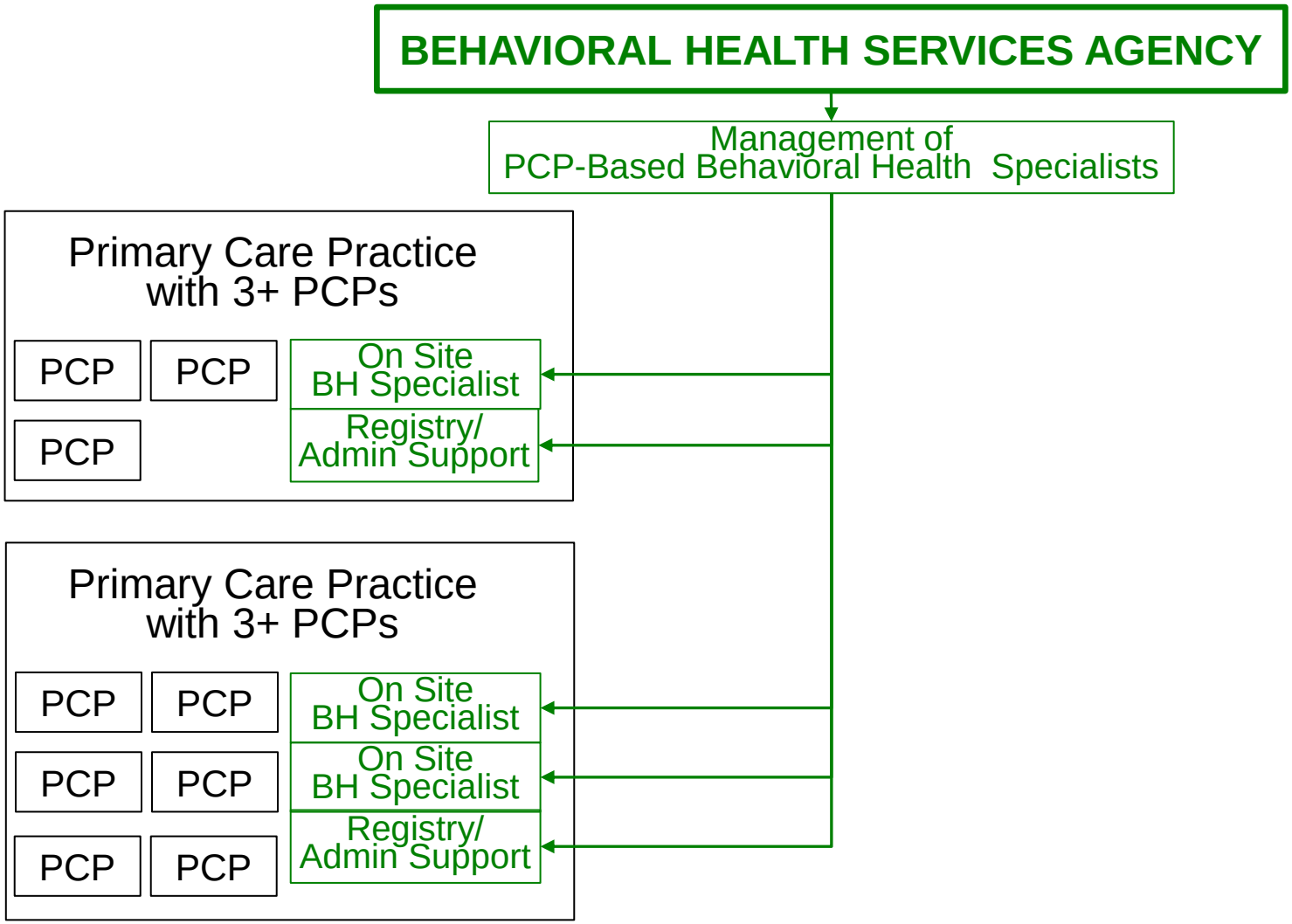
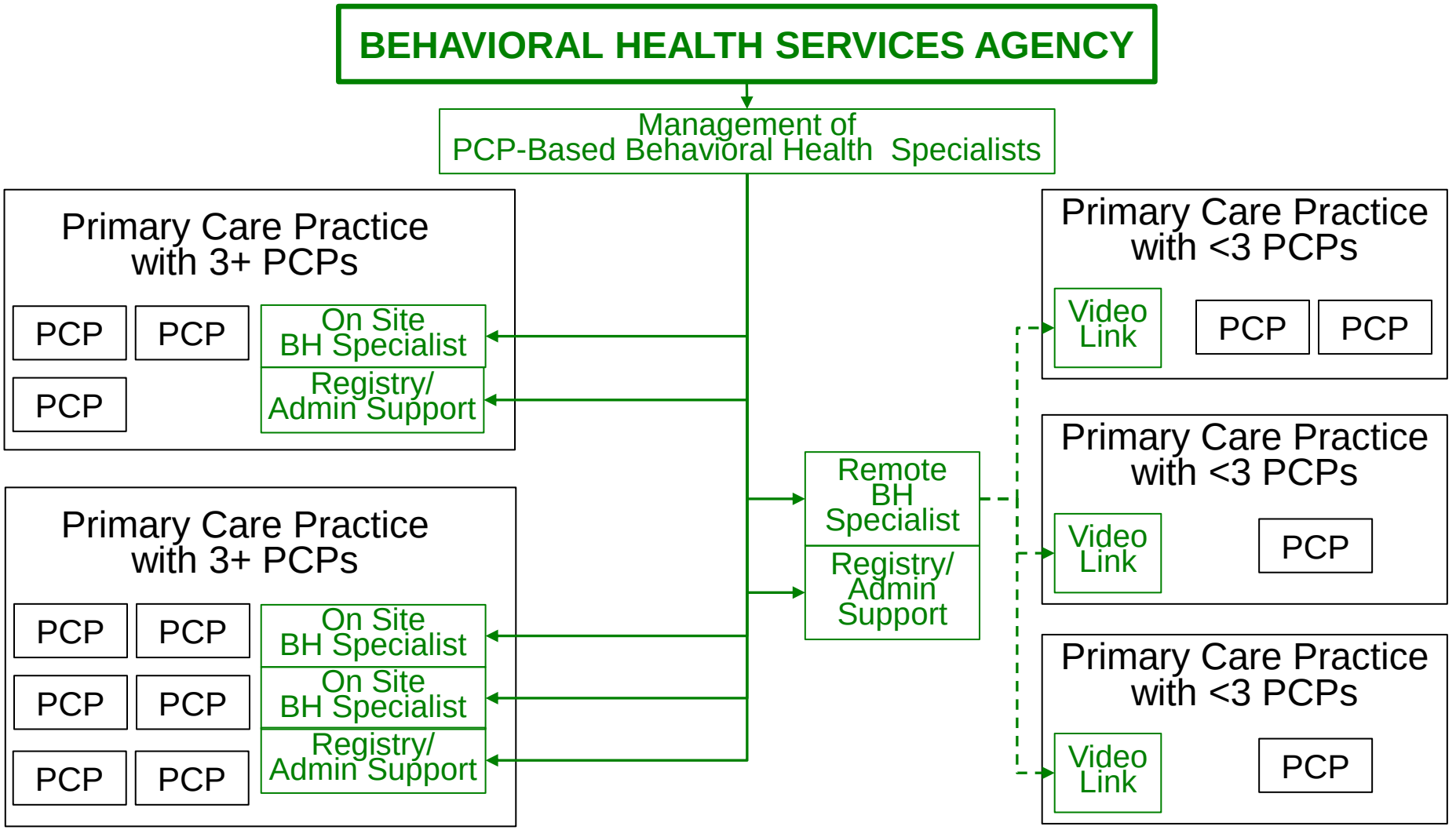
  - 3-4 doc practice = 1 FTE Behavioral Health Specialist for treatment
  - Both screening and treatment allows presence in small practices, but need to preserve slack time for immediate interventions
- **Cost of On-Site or Remote Behavioral Health Support**
  - $90,000 salary+benefits+overhead for Behavioral Health Specialist
  - $50,000 salary+benefits+overhead for registry/administrative support
  - $15,000 + $5,000/year for video link equipment and maintenance
  - $? for management, insurance, etc. from behavioral health agency

Staffing Model for Behavioral Health Specialists



Staffing Model for Behavioral Health Specialists



Preliminary Estimates of the Magnitude of Costs and Savings

Costs to PCP Practice

- $ 17,000 PCP time for screenings
- $ 47,000/PCP for BH specialist
- $ 2,400/PCP for psych consults
- $ 53,000 loss of office visit revenue

- $119,000 Total Cost Per PCP

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Savings in Other Services

- $ 50,000 fewer PCP office visits
- $ 18,000 fewer specialist visits
- $ 1,000 fewer ER visits
- $ 6,000 fewer hospital admissions
- $210,000 fewer psych. medications

- $285,000 Total Savings to Payers

Preliminary Estimates of the Magnitude of Costs and Savings

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- $210,000 fewer psych. medications

- $285,000 Total Savings to Payers

- **$166,000 Net Savings**

Additional Data/Modeling Needed to Determine Costs and Impacts

Business Case Analysis for Behavioral Health/Primary Care Integration

User-Selected Parameters Highlighted in Yellow

Number of PCPs in Practice:	3
Total Patients/PCP:	2,000
Total Patients in Practice:	6,000
% Patients with BH Issues:	17.5%
Patients w/ BH Issues in Practice:	1,050

	Current Units Per Patient Per Year	Change in Units Per Patient	% Change	Cost/ Payment Per Unit	Current Units of Service	Future Units of Service	Change in Units of Service	Current Total $	Future Total $	Change in Total $	Change in $ Per PCP	PMPM Change	Comment
Payment to PCP Practice													
Payment for Positive Screens	0.05	0.13	250%	$30	300	1,050	750	$9,000	$31,500	$22,500	$7,500	$0.31	Two Alternative Approaches to Payment
Payment for All Screens	0.10	0.90	900%	$0	600	5,400	4,800		$0	$0	$0	$0.00	
PMPM for BH Intervention										$216,000	$72,000	$3.00	Assumes PCP Contracts for BH Support
Avoidable PCP office visits for Pts w/ BH Issues		-3.0		$50			-3,150			-$157,500	-$52,500	-$2.19	
Visits with New Patients				$50						$0	$0	$0.00	
Adjustment for Practice Performance										$154,888	$51,629	$2.15	Based on Projected Savings
Total										$235,888	$78,629	$3.28	
Cost to PCP Practice													
BH Screenings	0.10	0.90	900%	$9	600	6000	5400	$5,625	$56,250	$50,625	$16,875	$0.70	Cost is PCP Time
Cost of BH Specialist				$30,000					$90,000	$90,000	$30,000	$1.25	Cost is Per PCP
Cost of Registry/Admin Support				$16,667					$50,000	$50,000	$16,667	$0.69	Cost is Per PCP
Cost of Video Link (Practices with < 3 PCPs Only)				$5,000					$0	$0	$0	$0.00	Cost is Per Practice
Payment to Psychiatrists for Phone Consultation				$100		72				$7,200	$2,400	$0.10	
Total										$197,825	$65,942	$2.75	
Non-Rx Services Outside of PCP Practice													
Avoidable Specialty Referrals*	0.5	-0.5	-100%	$100	525	0	-525	$52,500	$0	-$52,500	-$17,500	-$0.73	
External Behavioral Health Svcs					0	0	0	$0	$0	$0	$0	$0.00	
Psychiatric Referrals/Visits	0.025	-0.025	-100%	$100	26	0	-26	$2,625	$0	-$2,625	-$875	-$0.04	
Avoidable ER Visits*	0.006	-0.006	-100%	$500	6	0	-6.3	$3,150	$0	-$3,150	-$1,050	-$0.04	
Psychiatric Hospitalizations	0.0067	-0.0017	-25%	$10,000	7	5.25	-1.75	$70,000	$52,500	-$17,500	-$5,833	-$0.24	
Total										-$75,775	-$25,258	-$1.05	
Pharmaceutical Costs													
Psychiatric Medications	12	-6	-50%	$100	12,600	6,300	-6,300	$1,260,000	$630,000	-$630,000	-$210,000	-$8.75	For BH Patients Only
Other Avoidable Medications*													
Total										-$630,000	-$210,000	-$8.75	
Change in Net Revenue to PCP Practice Before Performance Payment										-$116,825	-$38,942	-$1.62	
Performance Payment to PCP Practice										$154,888	$51,629	$2.15	
Change in Net Revenue to PCP Practcie with Performance Payment										$38,063	$12,688	$0.53	Positive # is Good
Change in Payer Spending for Non-Rx Services (Including PMPM)										$5,225	$1,742	$0.07	
Change in Payer Spending for Medications										-$630,000	-$210,000	-$8.75	
Change in Total Payer Spending for All Services										-$624,775	-$208,258	-$8.68	
Performance Payment to PCP Practice (Based on Savings in Services and Medications)										$154,888	$51,629	$2.15	
Change in Total Payer Spending After Performance Payment										-$469,888	-$156,629	-$6.53	Negative # is Good

* avoidable=physical problems caused by unaddressed BH issues

Options for Payment Models

1. Add New Fee Codes for Unreimbursed Services
2. Pay Monthly “Care Management” Payments (PMPM) in Addition to Current FFS
3. Shared Savings
4. PMPM Payment + P4P Adjustments
5. Partial Comprehensive Care Payment
6. Full Comprehensive Care Payment

Most Likely Short-Run Options for Payment Models

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Options for Paying for Behavioral Health Services in Primary Care

- **Screening for behavioral health issues by PCP**
  - **Current Payment:**
    - Screens with negative results not currently paid for
    - Screens with positive results currently are paid for
  - **Options for Future:**
    1. Continue as today
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- **Follow-up care by BH Specialist in PCP practice**

  (For patients who warrant services before or instead of transfer to external BH services)
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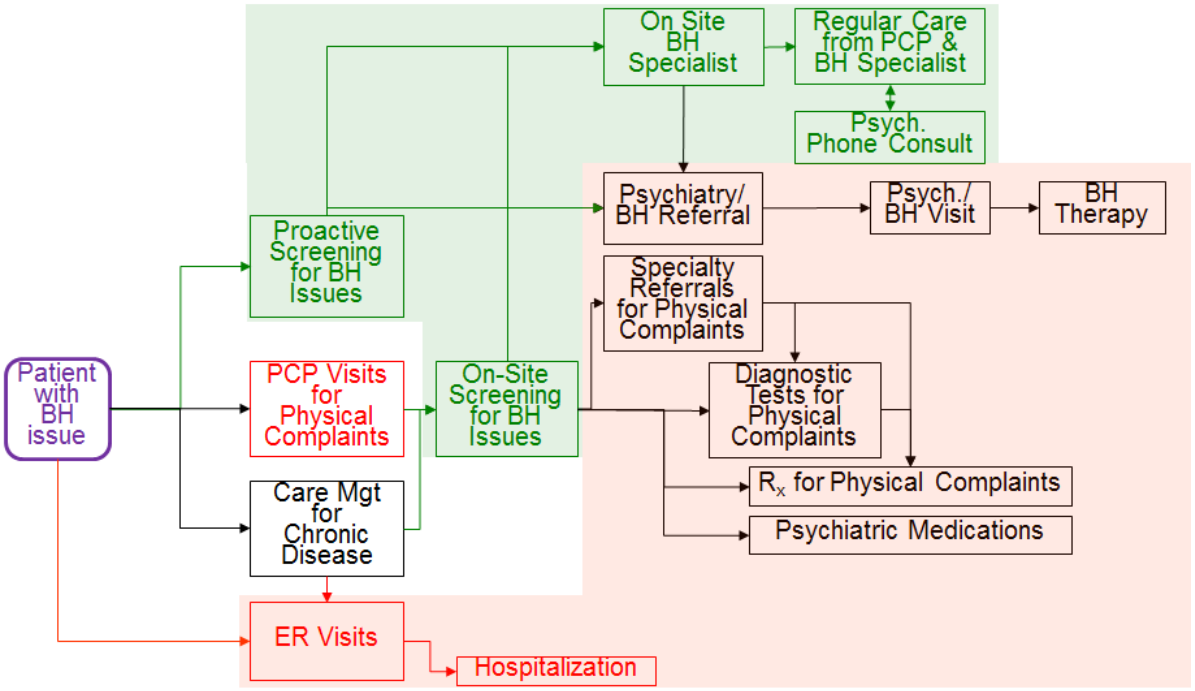
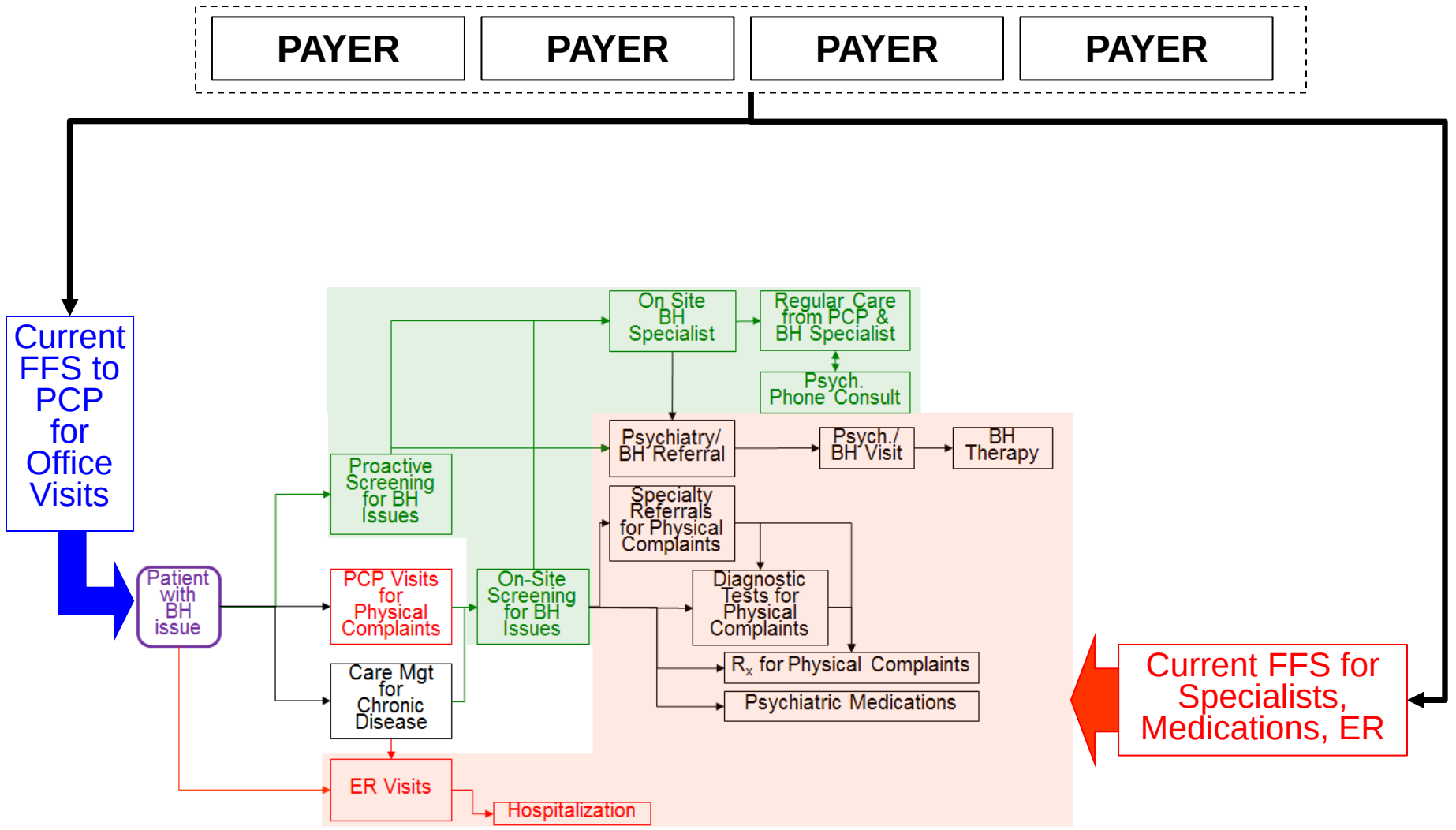
- **Follow-up care by external behavioral health services**
  - **Current Payment:** Paid for

Potential Payment Model for Better BH Care in Primary Care

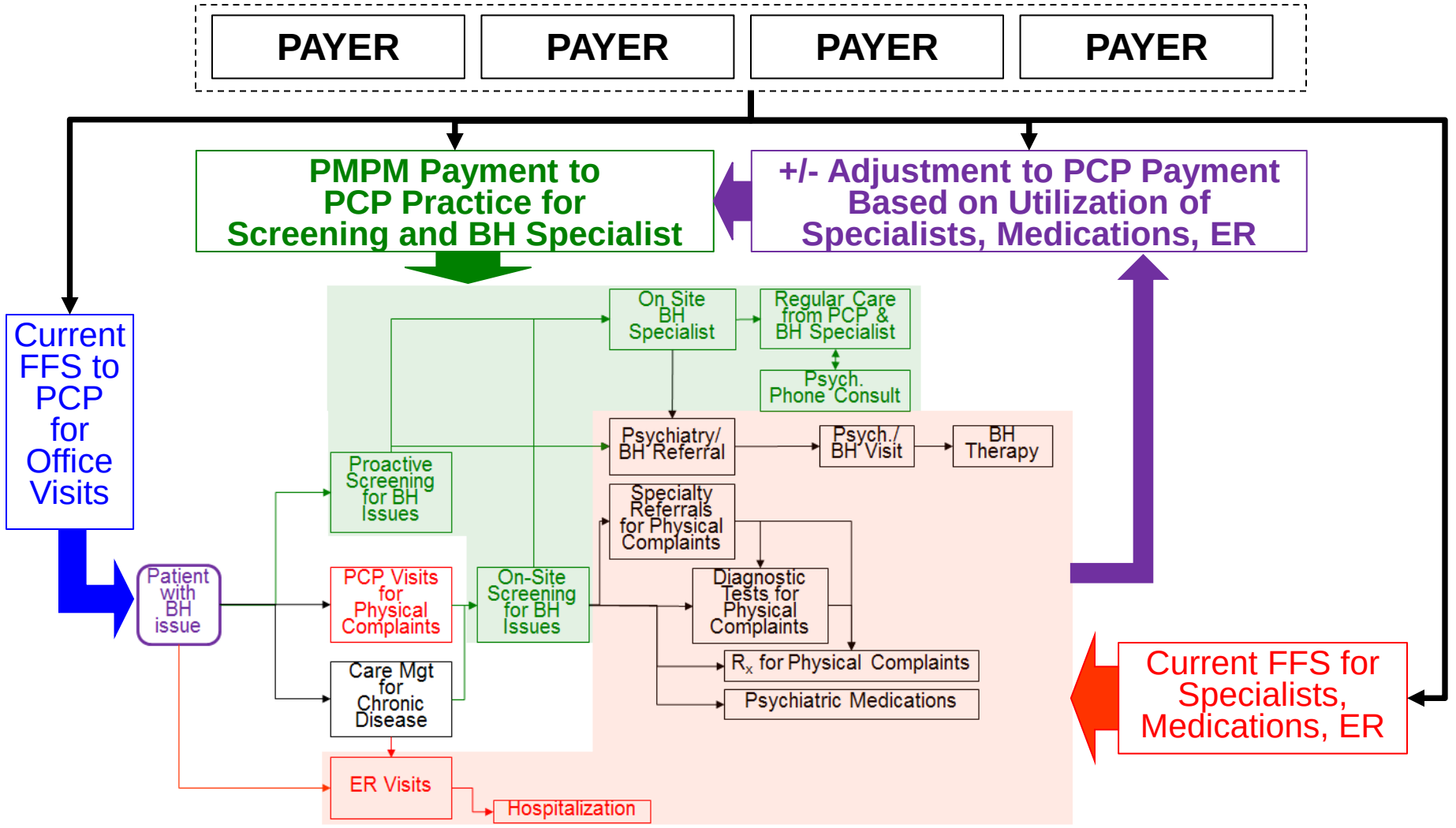
PAYER	PAYER	PAYER	PAYER



Maintain FFS for Current Services



Performance-Based PMPM for Additional/Enhanced Services



Potential Payment Model for Better BH Care in Primary Care

1. **Fee for Service Payment (Same as Current)**
   - Payment per office visits
   - Payment for use of SBIRT/IMPACT Screening Tool with positive result

2. **Per Member Per Month Payment (New)**
   - Payment covers costs of behavioral health specialists and support staff
   - Payment covers equipment for video links to offsite staff
   - Payment covers time for physician to do proactive screening
   - Payment offsets losses in office visit revenue from patients who would otherwise have returned for behavioral health-driven physical problems

3. **Pay for Performance (New)**
   - Increase in PMPM payment based on reduction in utilization of other services by practice patients (ideally should be combined with broader PCMH or chronic disease management support)
   - Reduction in PMPM payment for failure to carry out screening

Other Support Needed and Issues to Be Resolved

- **Support from all payers for improved care**
  - PCP practices won't be able/willing to do screening only for one payer's patients
  - If a significant portion of savings will come from psychiatric medications, the state will have to participate as a "payer"
- **Coordination with PCMH & chronic disease management programs**
  - Better for patients if BH & physical issues can be managed in a coordinated way
  - Difficult to separate impact of BH vs. other initiatives on avoidable ER visits, specialty referrals, medications, etc.
- **Coordination and information sharing among involved providers**
  - PCPs, psychiatrists, and BH providers will need clear protocols for referrals and communication of information
  - Legal barriers to sharing BH information will need to be addressed
- **Recruitment and training of behavioral health staff**
  - More trained Behavioral Health Specialists will be needed to work in PCP practices
  - Licensure/accreditation/certification requirements for BH services will need to change to allow billing for BH services delivered in PCP practices
- **Patient education and engagement**
  - Patients should be encouraged to talk to their PCPs about behavioral health issues
  - Patient cost-sharing barriers to PCP services need to be removed

How Do You Develop Win-Win-Win Solutions?

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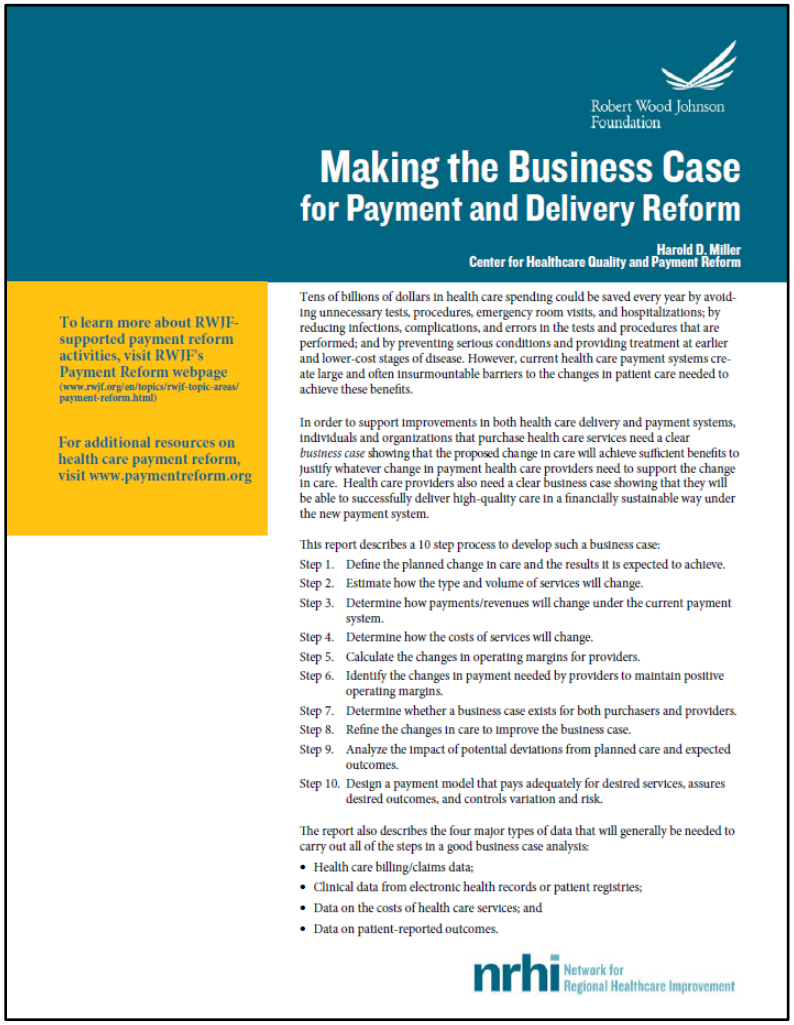
A Critical Element is Shared, Trusted Data

- **Physician/Hospital** need to know the current utilization and costs for their patients to know whether the new payment model will cover the costs of delivering effective care to the patients
- **Purchaser/Payer** needs to know the current utilization and costs to know whether the new payment model is a better deal than they have today
- **Both** sets of data have to match in order for providers and payers to agree on the new approach!

Details on All the Steps Are in This Free Publication



Robert Wood Johnson Foundation

Making the Business Case for Payment and Delivery Reform

Harold D. Miller
Center for Healthcare Quality and Payment Reform

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

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

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

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

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

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

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

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

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  - Does not include information on unbillable services or costs
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- **Data on Patient-Reported Outcomes (Surveys)**
  - Information on benefits to patients beyond the services they received, such as quality of life, ability to work and perform activities of daily living

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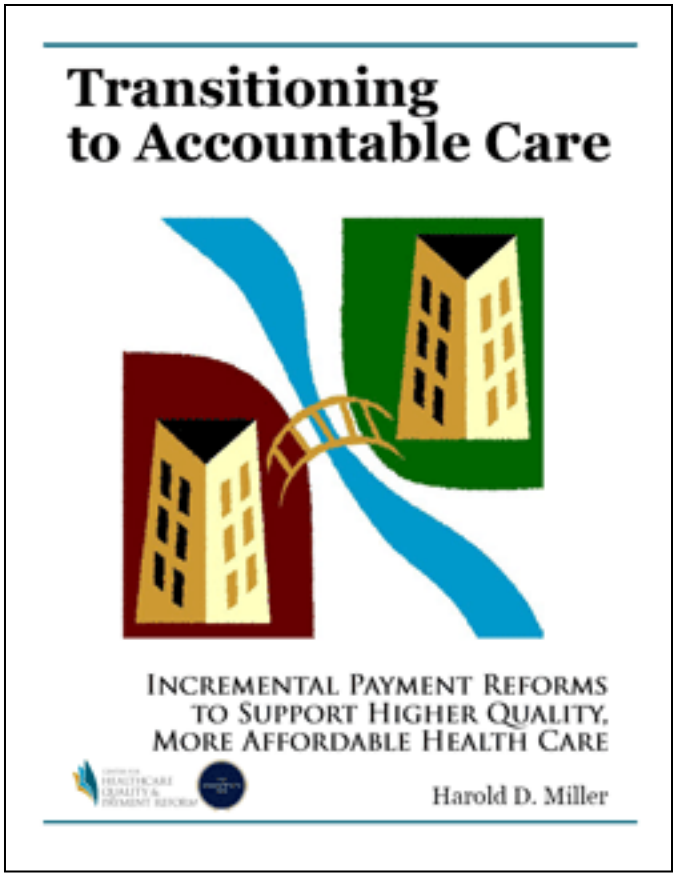
   - Flexibility to change the way care is delivered
   - Accountability for costs and quality/outcomes related to care
   - Adequate payment to cover lowest-achievable costs
   - Protection for the provider from insurance risk

Opportunities and Solutions Vary By Specialty

	Opportunities to Improve Care and Reduce Cost	Barriers in Current Payment System	Solutions via Accountable Payment Models
Cardiology	• Use less invasive and expensive procedures when appropriate	• Payment is based on which procedure is used, not the outcome for the patient	• Condition-based payment covering CABG, PCI, or medication management
Orthopedic Surgery	• Reduce infections and complications • Use less expensive post-acute care following surgery	• No flexibility to increase inpatient services to reduce complications & post-acute care	• Episode payment for hospital and post-acute care costs with warranty
Psychiatry	• Reduce ER visits and admissions for patients with depression and chronic disease	• No payment for phone consults with PCPs • No payment for RN care managers	• Joint condition-based payment to PCP and psychiatrist
OB/GYN	• Reduce use of elective C-sections • Reduce early deliveries and use of NICU	• Similar/lower payment for vaginal deliveries	• Condition-based payment for total cost of delivery in low-risk pregnancy

More Information on Structuring Payment Models



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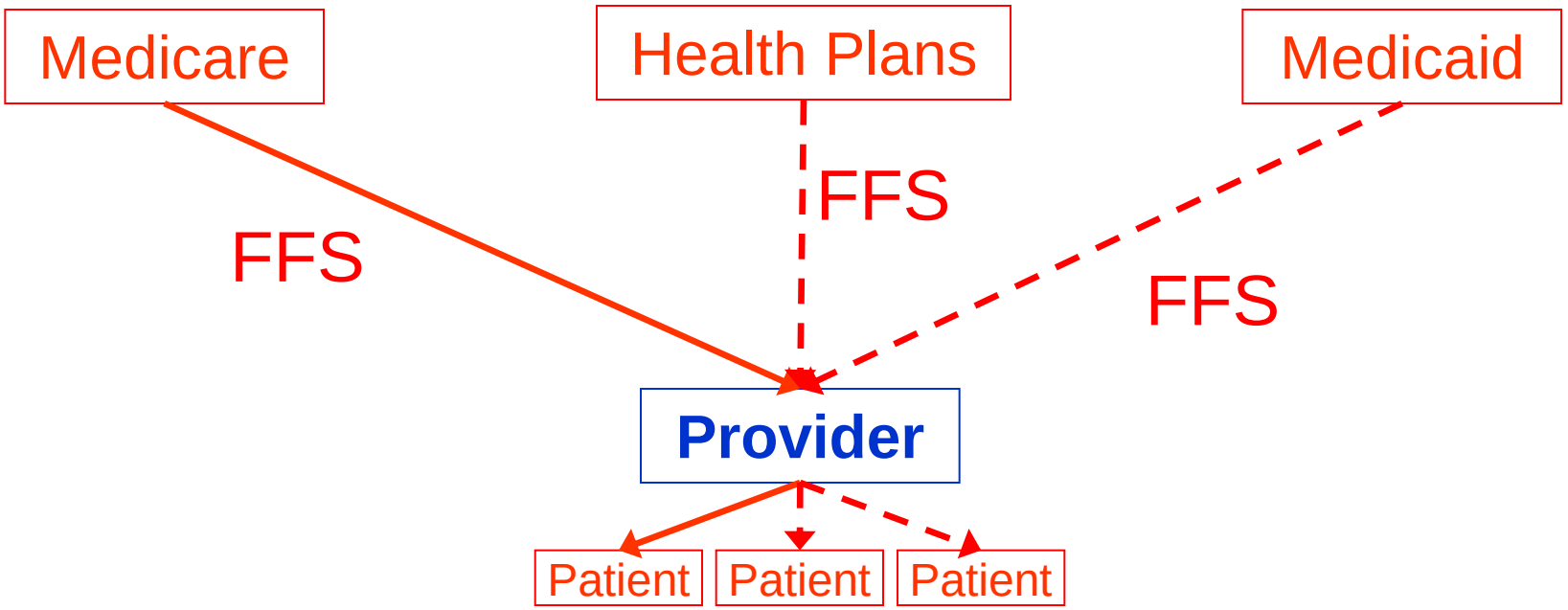
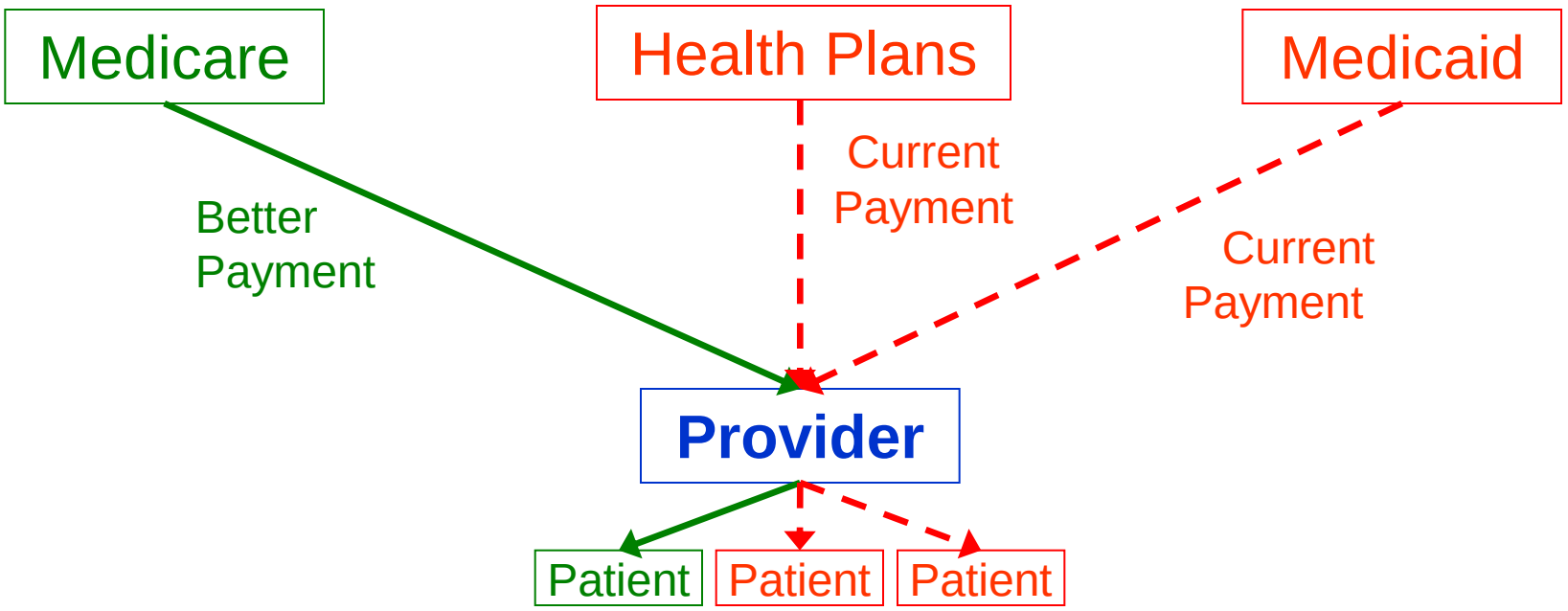
4. **Getting Payers to Use the Payment Model**

Biggest Barrier? Medicare & Health Plans Don't Want to Change

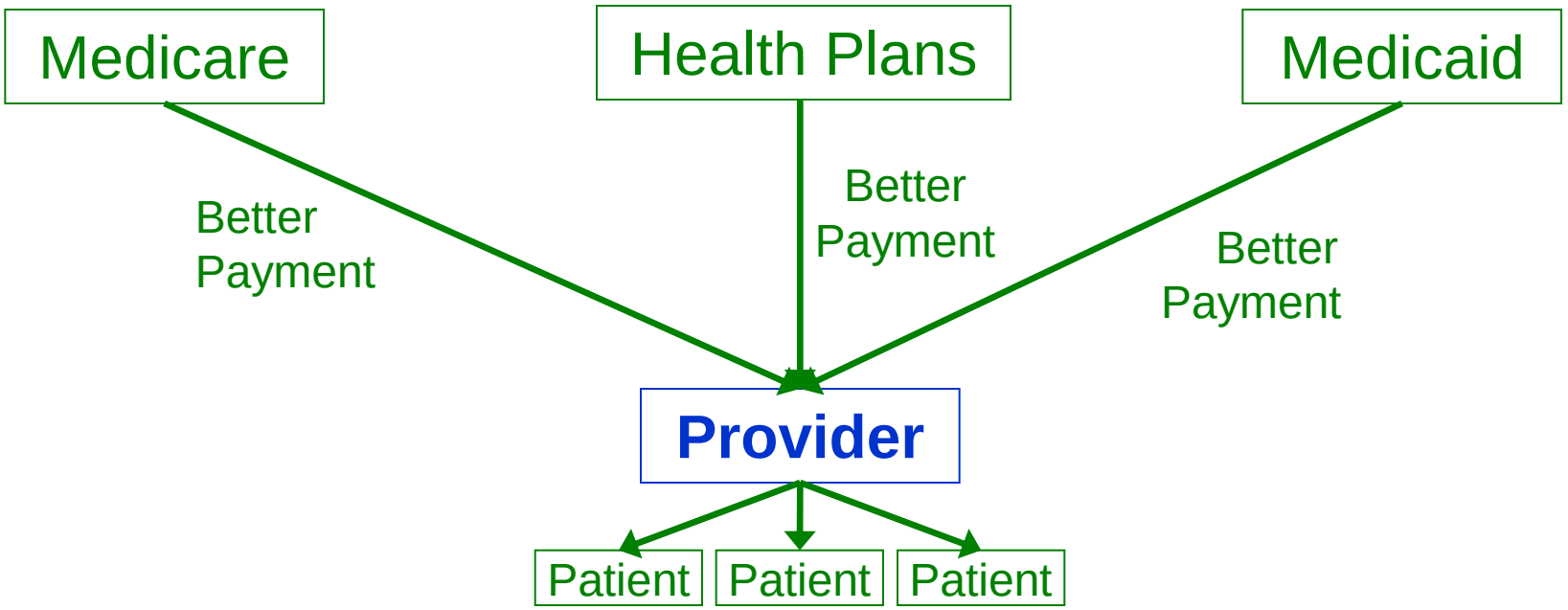


One Payer Changing Is Not Enough

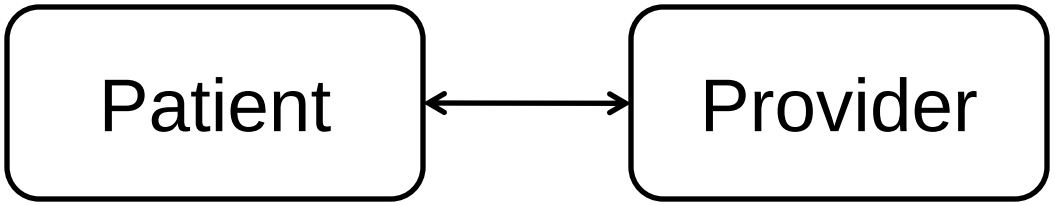


Provider is only compensated for changed practices for the subset of patients covered by participating payers

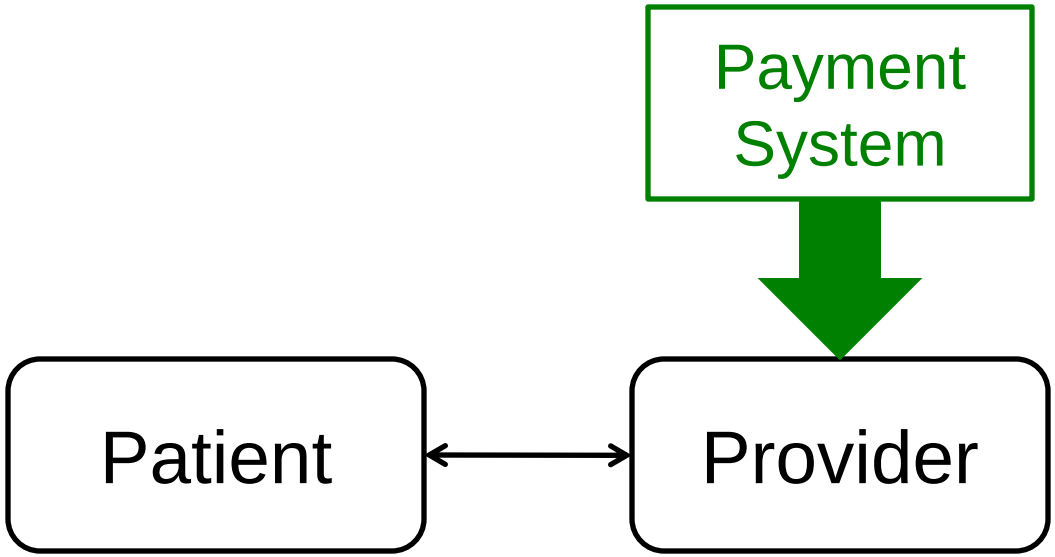
All Payers Need to Change to Enable Providers to Transform



What About The Patient?



Payment Reform Only Deals With Half of the Relationship



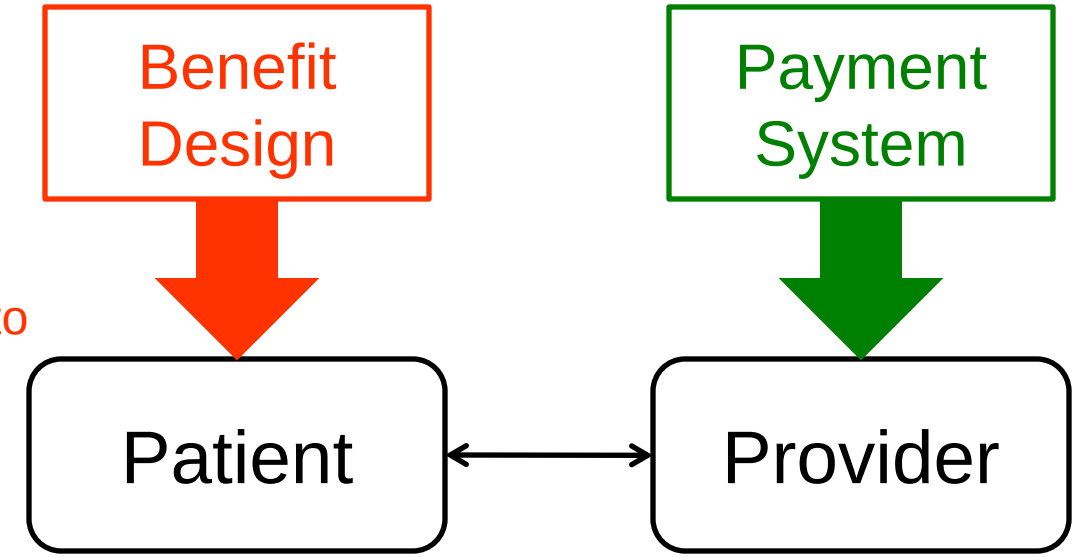
Ability and Incentives to:

- Keep patients well
- Avoid unneeded services
- Deliver services efficiently
- Coordinate services with other providers

Benefit Design Changes Are Also Critical to Success

Ability and Incentives to:

- Improve health
- Take prescribed medications
- Allow a provider to coordinate care
- Choose the highest-value providers and services



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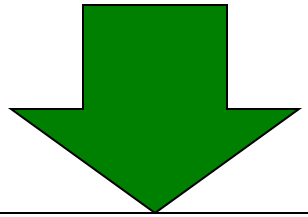
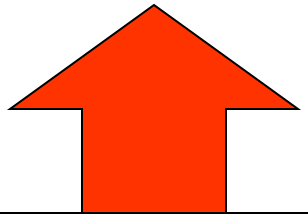
Example: Coordinating Pharmacy & Medical Benefits

Single-minded focus on reducing costs here...

...could result in higher spending on hospitalizations





Pharmacy Benefits

Drug Costs

- High copays for brand-names when no generic exists
- Doughnut holes & deductibles

Medical Benefits

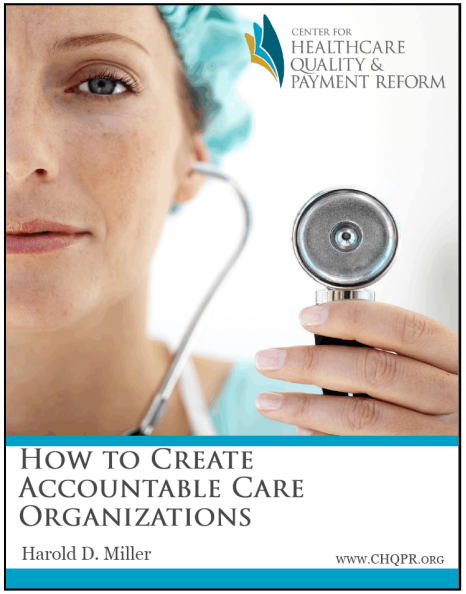
Hospital Costs

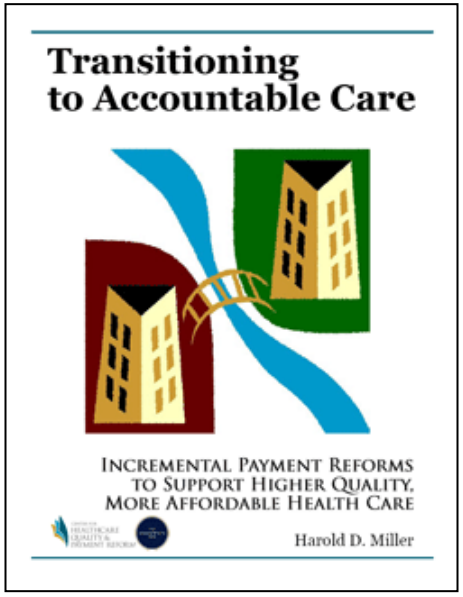
Physician Costs

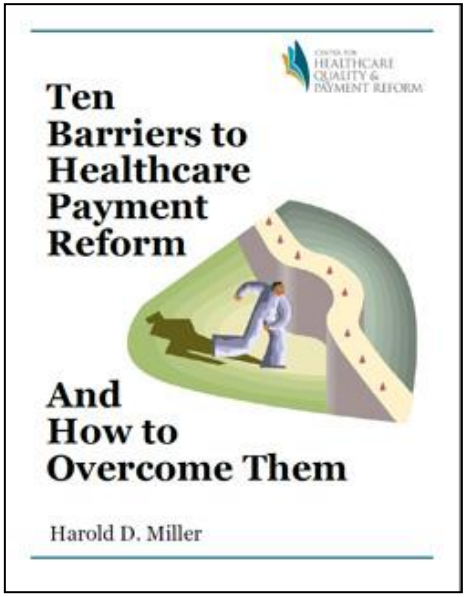
Other Services

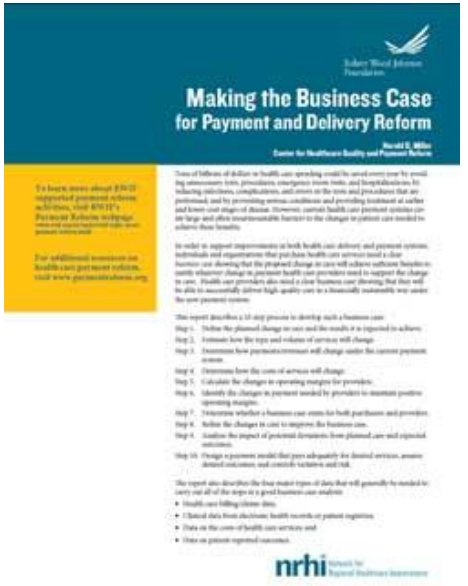
Principal treatment for most chronic diseases involves regular use of maintenance medication

Learn More About Win-Win-Win Payment and Delivery Reform









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