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

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

www.CHQPR.org
Healthcare Spending Is the Biggest Driver of Federal Deficits

Source: CBO Budget Outlook August 2012

46% of Spending Growth is Healthcare
Federal Cost Containment Policy Choices

MEDICARE SPENDING = SERVICES TO SENIORS \times FEES TO PROVIDERS

- Cut Services to Seniors?
- Cut Fees to Providers?
If It’s A Choice of Rationing or Rate Cuts, Which is More Likely?

MEDICARE SPENDING = SERVICES TO SENIORS × FEES TO PROVIDERS

Cut Services to Seniors?
Cut Fees to Providers?

Guess which one they’ll try to reduce?
In Medicaid & Private Insurance, Cuts in Services AND Fees Likely

MEDICAID, COMMERCIAL HEALTHCARE SPENDING = SERVICES TO PATIENTS \times FEES TO PROVIDERS

Cut Services to Patients?

Cut Fees to Providers?

Cuts in Both Are Likely
What Healthcare Providers Can Do That Payers Can’t

MEDICARE, MEDICAID, COMMERCIAL HEALTHCARE SPENDING = SERVICES TO PATIENTS \times FEES TO PROVIDERS

Redesign CARE to Reduce Spending Without Rationing

Redesign PAYMENT to Make Good Care Financially Viable
Reducing Costs Without Rationing: 
*Can It Be Done?*
Reducing Costs Without Rationing: Prevention and Wellness

Healthy Consumer → Continued Health → Healthy Consumer

Continued Health

Health Condition
Reducing Costs Without Rationing: Avoiding Hospitalizations

- Healthy Consumer
- Continued Health
- Health Condition
- No Hospitalization
- Acute Care Episode
Reducing Costs Without Rationing: Efficient, Successful Treatment

Healthy Consumer ➔ Continued Health ➔ Health Condition ➔ No Hospitalization ➔ Acute Care Episode ➔ Efficient Successful Outcome

- High-Cost Successful Outcome
- Complications, Infections, Readmissions
Reducing Costs Without Rationing Is Also Quality Improvement!

- Healthy Consumer
- Continued Health
  - Health Condition
  - No Hospitalization
  - Acute Care Episode
  - Efficient Successful Outcome
    - High-Cost Successful Outcome
    - Complications, Infections, Readmissions

Better Outcomes/Higher Quality
How Big Are the Opportunities?
5-17% of Hospital Admissions Are Potentially Preventable

% of Hospital Stays That Were Potentially Preventable, 2008

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>
</tr>
<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 Ways to Reduce Tests & Services Without Harming Patients

1. American Society of Nephrology
2. American Academy of Allergy, Asthma & Immunology
3. American Society of Clinical Oncology
4. American Academy of Family Physicians
5. Choosing Wisely

Choosing Wisely
An initiative of the ABIM Foundation

Don’t do imaging for low back pain if red flags are present.

Don’t routinely prescribe antibiotics for sinusitis unless symptoms worsen after initial clinical evaluation and examination.

Don’t use dual-energy x-ray absorptiometry for osteoporosis screening in women aged 70 with no risk factors.

Don’t order annual stress cardiac imaging or advanced non-invasive imaging as part of routine follow-up in asymptomatic patients.

Don’t perform stress cardiac imaging or advanced non-invasive imaging as a pre-operative assessment in patients scheduled to undergo low-risk non-cardiac surgery.

Don’t perform echocardiography as routine follow-up for mild, asymptomatic native valve disease in adult patients with no change in signs or symptoms.

Don’t perform stenting of non-culprit lesions during percutaneous coronary intervention (PCI) for uncomplicated hemodynamically stable ST-segment elevation myocardial infarction (STEMI).

© 2009-2014 Center for Healthcare Quality and Payment Reform www.CHQPR.org
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

- Healthy Consumer
  - Continued Health
    - Health Condition
      - No Hospitalization
        - Acute Care Episode
          - Efficient Successful Outcome
            - High-Cost Successful Outcome
            - Complications, Infections, Readmissions

© 2009-2014 Center for Healthcare Quality and Payment Reform www.CHQPR.org
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.)
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.)

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

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

**P4P**

**PMPM**

**Shared Savings**

© 2009-2014 Center for Healthcare Quality and Payment Reform www.CHQPR.org
Fortunately, There are Better Payment Systems Available

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

Accountable Medical Home
- Flexible, predictable payments not tied to office visits
Fortunately, There are Better Payment Systems Available

<table>
<thead>
<tr>
<th>FFS</th>
<th>Bundles/Warranties</th>
<th>Accountable Medical Home</th>
</tr>
</thead>
</table>
| • No payment for services that will benefit patients  
• Lower revenues from reducing avoidable costs | • Higher payment for fewer complications  
• Higher payment for lower-cost care | • Flexible, predictable payments not tied to office visits |

© 2009-2014 Center for Healthcare Quality and Payment Reform  www.CHQPR.org
Fortunately, There are Better Payment Systems Available

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

**Condition-Based Payment**
- No loss in payment for doing fewer tests/procedures

**Bundles/Warranties**
- Higher payment for fewer complications
- Higher payment for lower-cost care

**Accountable Medical Home**
- Flexible, predictable payments not tied to office visits

**FFS**
True Payment Reform Allows Win-Win-Win Solutions

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

<table>
<thead>
<tr>
<th>Condition-Based Payment</th>
<th>BETTER CARE FOR PATIENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• No loss in payment for doing fewer tests/procedures</td>
<td>+ SAVINGS FOR PURCHASERS</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Bundles/Warranties</th>
<th>BETTER PAYMENTS FOR PHYSICIANS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Higher payment for fewer complications</td>
<td></td>
</tr>
<tr>
<td>• Higher payment for lower-cost care</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Accountable Medical Home</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Flexible, predictable payments not tied to office visits</td>
<td></td>
</tr>
</tbody>
</table>

© 2009-2014 Center for Healthcare Quality and Payment Reform  www.CHQPR.org
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
  

- 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
  
We Don’t Pay for the Things That Will Prevent Overutilization

CURRENT PAYMENT SYSTEMS

Health Insurance Plan

Physician Practice

Office Visits
  Phone Calls
  Nurse Care Mgr

ER Visits
  Avoidable

Lab Work/Imaging
  Avoidable

Hospital Stay
  Avoidable

No payment for services that can prevent utilization...

...No penalty or reward for high utilization elsewhere
Option 1: Add New Fee Codes for Unreimbursed PCP Services

MEDICAL HOME PROGRAM

Health Insurance Plan

$ Office Visits

$ ER Visits

$ Avoidable

Avoidable

Avoidable

Higher payment for primary care

Physician Practice

Phone Calls

Lab Work/ Imaging

Hospital Stay

© 2009-2014 Center for Healthcare Quality and Payment Reform www.CHQPR.org
Option 2: Pay for Monthly “Care Mgt” to Cover Missing Services

MEDICAL HOME PROGRAM

Health Insurance Plan

- Office Visits
- ER Visits
- Hospital Stay
  - Avoidable

Physician Practice

- Monthly Care Mgt Payment
  - Phone Calls
  - RN Care Mgr
- Lab Work/Imaging
  - Avoidable

Higher payment for primary care
More $ for PCPs, But Any Savings Elsewhere?

MEDICAL HOME PROGRAM

Health Insurance Plan

$  
Office Visits

Monthly Care Mgt Payment
  Phone Calls
  RN Care Mgr

ER Visits

Avoidable

Lab Work/Imaging

Avoidable

Hospital Stay

Avoidable

...But no commitment to reduce utilization elsewhere

Physician Practice

Higher payment for primary care

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

SHARED SAVINGS MODEL

Health Insurance Plan

- Office Visits
- ER Visits
- Lab Work/Imaging
- Hospital Stay

Physician Practice

- Phone Calls
- Nurse Care Mgr

Portion of savings from reduced spending in other areas...

...but no upfront $ for better care

...Returned to physician practice after savings determined...
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

Health Insurance Plan

- Office Visits
- ER Visits
- Lab Work/Imaging
- Hospital Stay

Physician Practice

- Monthly Care Mgt Payment
- Phone Calls
- RN Care Mgr

Targets for Reduction in Utilization

More $ for PCP

P4P Bonus/Penalty Based on Utilization

© 2009-2014 Center for Healthcare Quality and Payment Reform www.CHQPR.org
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

Primary Care Medical Home

Resources & Incentives for More Coordinated Care

FFS Payment Based on Volume, Procedures, & Office Visits

(Non-Primary Care) Specialists

PATIENT
Pay Both PCPs & Specialists for Outcomes & Coordination

- Resources & Incentives for More Coordinated Care
- Payment for Consultation w/ PCP; Outcomes-Based Payment

Primary Care Medical Home → PATIENT

(Non-Primary Care) Specialists
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

Wait Time for New Patient Appointment (days)

Months since Initiation of E-referral

- Endocrinology
- Rheumatology
- Pulmonary
- Cardiology
- Nephrology
Option 5: Partial Comprehensive Care Payment

PARTIAL GLOBAL PMT (Professional Svcs)

Health Insurance Plan

Condition-Adjusted Per Person Payment

Physician Practice

Office Visits
Phone Calls
Nurse Care Mgr

Specialty Consults
ER Visits, Lab Work, Imaging

Avoidable

Hospital Stay

Avoidable

P4P Bonus/Penalty Based on Utilization

Flexibility and accountability for a condition-adjusted budget covering all professional services
Option 6: Risk-Adjusted Full Comprehensive Care Payment

COMPREHENSIVE CARE/YEAR-LONG EPISODE

Health Insurance Plan

Condition-Adjusted Per Person Payment

Physician Practice/ACO

Office Visits
Phone Calls
Nurse Care Mgr

Specialty Consults

ER Visits, Lab Work, Imaging

Avoidable

Hospital Stay

Avoidable

P4P Bonus/Penalty Based on Quality

© 2009-2014 Center for Healthcare Quality and Payment Reform www.CHQPR.org
Isn’t This Capitation?
No – It’s Different

**CAPITATION (WORST VERSIONS)**

- No Additional Revenue for Taking Sicker Patients
- Providers Lose Money On Unusually Expensive Cases
- Providers Are Paid Regardless of the Quality of Care
- Provider Makes More Money If Patients Stay Well
- Flexibility to Deliver Highest-Value Services

**COMPREHENSIVE CARE PAYMENT**

- Payment Levels Adjusted Based on Patient Conditions
- Limits on Total Risk Providers Accept for Unpredictable Events
- Bonuses/Penalties Based on Quality Measurement
- Provider Makes More Money If Patients Stay Well
- Flexibility to Deliver Highest-Value Services

---

© 2009-2014 Center for Healthcare Quality and Payment Reform  www.CHQPR.org
Transitioning to Accountable Care Payment

CARE MGT PAYMENT + UTILIZATION P4P

Health Insurance Plan

Physician Practice

Office Visits

Monthly Care Mgt Payment

ER Visits

Phone Calls

CARE MGT PAYMENT + UTILIZATION P4P

Partially Avoidable

Lab Work/Imaging

Hospital Stay

Avoidable

Targets for Reduction in Utilization

P4P Bonus/Penalty Based on Utilization

PARTIAL GLOBAL PMT (Professional Svcs)

Health Insurance Plan

Physician Practice

Office Visits

Phone Calls

Nurse Care Mgr

P4P Bonus/Penalty Based on Utilization

FULL COMP. CARE/GLOBAL PMT + QUALITY P4P

Health Insurance Plan

Physician Practice/ACO

Office Visits

Phone Calls

Nurse Care Mgr

P4P Bonus/Penalty Based on Quality

Condition-Adjusted Per Person Payment

Office Visits

ER Visits

Hospital Stay

P4P Bonus/Penalty Based on Utilization

### Flexibility and Accountability

- For a condition-adjusted budget covering all professional services
- Flexibility and accountability

© 2009-2014 Center for Healthcare Quality and Payment Reform  www.CHQPR.org
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

<table>
<thead>
<tr>
<th>CURRENT</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>$/Patient</td>
<td># Pts</td>
</tr>
<tr>
<td><strong>Physician Svcs</strong></td>
<td></td>
</tr>
<tr>
<td>PCP</td>
<td>$600</td>
</tr>
<tr>
<td><strong>Hospitalizations</strong></td>
<td></td>
</tr>
<tr>
<td>Admissions</td>
<td>$10,000</td>
</tr>
<tr>
<td><strong>Specialist</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$400</td>
</tr>
<tr>
<td><strong>Total Spending</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>500</td>
</tr>
</tbody>
</table>

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?

<table>
<thead>
<tr>
<th></th>
<th>CURRENT</th>
<th>FUTURE</th>
<th>Chg</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$/Patient # Pts Total $</td>
<td>$/Pt # Pts Total $</td>
<td></td>
</tr>
<tr>
<td>Physician Svcs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PCP</td>
<td>$600</td>
<td>500</td>
<td>$300,000</td>
</tr>
<tr>
<td>Hospitalizations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admissions</td>
<td>$10,000</td>
<td>250</td>
<td>$1,500,000</td>
</tr>
<tr>
<td>Specialist</td>
<td>$400</td>
<td>250</td>
<td>$100,000</td>
</tr>
<tr>
<td>Total Spending</td>
<td>500</td>
<td>$2,900,000</td>
<td>?</td>
</tr>
</tbody>
</table>
## Pay the PCP for Proactive Care Management

<table>
<thead>
<tr>
<th></th>
<th>CURRENT</th>
<th></th>
<th>FUTURE</th>
<th></th>
<th>Chg</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$/Patient</td>
<td># Pts</td>
<td>Total $</td>
<td>$/Pt</td>
<td># Pts</td>
</tr>
<tr>
<td><strong>Physician Svcs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PCP</td>
<td>$600</td>
<td>500</td>
<td>$300,000</td>
<td>$900</td>
<td>500</td>
</tr>
<tr>
<td><strong>Hospitalizations</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admissions</td>
<td>$10,000</td>
<td>250</td>
<td>$1,500,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Specialist</strong></td>
<td>$400</td>
<td>250</td>
<td>$100,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Spending</strong></td>
<td>500</td>
<td></td>
<td>$2,900,000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Pay the Specialist to Co-Manage The Patient’s Care

<table>
<thead>
<tr>
<th></th>
<th>CURRENT</th>
<th></th>
<th>FUTURE</th>
<th></th>
<th>Chg</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$/Patient</td>
<td># Pts</td>
<td>Total $</td>
<td>$/Pt</td>
<td># Pts</td>
</tr>
<tr>
<td><strong>Physician Svcs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PCP</td>
<td>$600</td>
<td>500</td>
<td>$300,000</td>
<td>$900</td>
<td>500</td>
</tr>
<tr>
<td>Specialist</td>
<td></td>
<td></td>
<td></td>
<td>$300</td>
<td>500</td>
</tr>
<tr>
<td><strong>Hospitalizations</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admissions</td>
<td>$10,000</td>
<td>250</td>
<td>$1,500,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Specialist (Inpt)</strong></td>
<td>$400</td>
<td>250</td>
<td>$100,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Spending</strong></td>
<td></td>
<td>500</td>
<td>$2,900,000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Provide Adequate Resources to Support Patients

<table>
<thead>
<tr>
<th></th>
<th>CURRENT</th>
<th></th>
<th>FUTURE</th>
<th></th>
<th>Chg</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$/Patient</td>
<td># Pts</td>
<td>Total $</td>
<td>$/Pt</td>
<td># Pts</td>
</tr>
<tr>
<td>Physician Svcs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PCP</td>
<td>$600</td>
<td>500</td>
<td>$300,000</td>
<td>$900</td>
<td>500</td>
</tr>
<tr>
<td>Specialist</td>
<td>$300</td>
<td>500</td>
<td>$150,000</td>
<td>$300</td>
<td>500</td>
</tr>
<tr>
<td>RN Care Mgr</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospitalizations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admissions</td>
<td>$10,000</td>
<td>250</td>
<td>$1,500,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist (Inpt)</td>
<td>$400</td>
<td>250</td>
<td>$100,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Spending</td>
<td></td>
<td>500</td>
<td>$2,900,000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Can We Afford a 127% Increase in Spending on Ambulatory Care?

<table>
<thead>
<tr>
<th></th>
<th>CURRENT</th>
<th>FUTURE</th>
<th>Chg</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$/Patient</td>
<td># Pts</td>
<td>Total $</td>
</tr>
<tr>
<td><strong>Physician Svcs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PCP</td>
<td>$600</td>
<td>500</td>
<td>$300,000</td>
</tr>
<tr>
<td>Specialist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RN Care Mgr</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td>$300,000</td>
</tr>
<tr>
<td><strong>Hospitalizations</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admissions</td>
<td>$10,000</td>
<td>250</td>
<td>$1,500,000</td>
</tr>
<tr>
<td><strong>Specialist (Inpt)</strong></td>
<td>$400</td>
<td>250</td>
<td>$100,000</td>
</tr>
<tr>
<td><strong>Total Spending</strong></td>
<td></td>
<td>500</td>
<td>$2,900,000</td>
</tr>
</tbody>
</table>
Yes, If It Succeeds In Reducing Hospitalizations

<table>
<thead>
<tr>
<th></th>
<th>CURRENT</th>
<th>FUTURE</th>
<th>Chg</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$/Patient</td>
<td># Pts</td>
<td>Total $</td>
</tr>
<tr>
<td><strong>Physician Svcs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PCP</td>
<td>$600</td>
<td>500</td>
<td>$300,000</td>
</tr>
<tr>
<td>Specialist</td>
<td>$300</td>
<td>500</td>
<td>$150,000</td>
</tr>
<tr>
<td>RN Care Mgr</td>
<td>$80,000</td>
<td>500</td>
<td>$450,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$300,000</td>
<td>500</td>
<td>$680,000</td>
</tr>
<tr>
<td><strong>Hospitalizations</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admissions</td>
<td>$10,000</td>
<td>250</td>
<td>$1,500,000</td>
</tr>
<tr>
<td>Specialist (Inpt)</td>
<td>$400</td>
<td>250</td>
<td>$100,000</td>
</tr>
<tr>
<td><strong>Total Spending</strong></td>
<td>500</td>
<td></td>
<td>$2,900,000</td>
</tr>
</tbody>
</table>
## But What About the Hospital?

<table>
<thead>
<tr>
<th></th>
<th>CURRENT</th>
<th></th>
<th>FUTURE</th>
<th></th>
<th>Chg</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$/Patient</td>
<td># Pts</td>
<td>Total $</td>
<td>$/Pt</td>
<td># Pts</td>
</tr>
<tr>
<td><strong>Physician Svcs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PCP</td>
<td>$600</td>
<td>500</td>
<td>$300,000</td>
<td>$900</td>
<td>500</td>
</tr>
<tr>
<td>Specialist</td>
<td></td>
<td></td>
<td></td>
<td>$300</td>
<td>500</td>
</tr>
<tr>
<td>RN Care Mgr</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td>$300,000</td>
<td>500</td>
<td></td>
</tr>
<tr>
<td><strong>Hospitalizations</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admissions</td>
<td>$10,000</td>
<td>250</td>
<td>$1,500,000</td>
<td>$10,000</td>
<td>150</td>
</tr>
<tr>
<td>Specialist (Inpt)</td>
<td>$400</td>
<td>250</td>
<td>$100,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Spending</strong></td>
<td></td>
<td>500</td>
<td>$2,900,000</td>
<td>500</td>
<td></td>
</tr>
</tbody>
</table>
What Should Matter to Hospitals is *Margin*, Not Revenues (Volume)
Hospital Costs Are Not Proportional to Utilization

Cost & Revenue Changes With Fewer Patients

- 20% reduction in volume
- 7% reduction in cost

#Patients

Costs

$1,000
$980
$960
$940
$920
$900
$880
$860
$840
$820
$800

© 2009-2014 Center for Healthcare Quality and Payment Reform www.CHQPR.org

55
Reductions in Utilization Reduce Revenues More Than Costs

Cost & Revenue Changes With Fewer Patients

- 20% reduction in volume
- 7% reduction in cost
- 20% reduction in revenue
Causing Negative Margins for Hospitals

Cost & Revenue Changes With Fewer Patients

Payers Will Be Underpaying For Care If Admissions, Readmissions, Etc. Are Reduced
But Spending Can Be Reduced Without Bankrupting Hospitals

Cost & Revenue Changes With Fewer Patients

Payers Can Still Save $ Without Causing Negative Margins for Hospital

$1,000 $900 $880 $860 $840 $820 $800

$000

#Patients

© 2009-2014 Center for Healthcare Quality and Payment Reform  www.CHQPR.org
# Analyze the Hospital’s Cost Structure

<table>
<thead>
<tr>
<th>Physician Svcs</th>
<th>CURRENT</th>
<th>FUTURE</th>
<th>Chg</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$/Patient</td>
<td># Pts</td>
<td>Total $</td>
</tr>
<tr>
<td>PCP</td>
<td>$600</td>
<td>500</td>
<td>$300,000</td>
</tr>
<tr>
<td>Specialist</td>
<td>$300</td>
<td>500</td>
<td>$150,000</td>
</tr>
<tr>
<td>RN Care Mgr</td>
<td>$80,000</td>
<td></td>
<td>$80,000</td>
</tr>
<tr>
<td>Total</td>
<td>$300,000</td>
<td>500</td>
<td>$300,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hospitalizations</th>
<th>CURRENT</th>
<th>FUTURE</th>
<th>Chg</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Fixed</td>
<td>$6,000</td>
<td>60%</td>
<td>$1,500,000</td>
</tr>
<tr>
<td>Hosp. Variable</td>
<td>$3,700</td>
<td>37%</td>
<td>$925,000</td>
</tr>
<tr>
<td>Hosp. Margin</td>
<td>$300</td>
<td>3%</td>
<td>$75,000</td>
</tr>
<tr>
<td>Total</td>
<td>$10,000</td>
<td>250</td>
<td>$2,500,000</td>
</tr>
</tbody>
</table>

| Specialist (Inpt) | $400 | 250 | $100,000 | $400 | 250 | $100,000 |     |
| Total Spending    | 500  | $2,900,000 | $2,900,000 |     |     |         |    |
## What Happens to Hospital Finances When Admissions Go Down?

<table>
<thead>
<tr>
<th>Physician Svcs</th>
<th>CURRENT</th>
<th></th>
<th>FUTURE</th>
<th></th>
<th>Chg</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$/Patient</td>
<td># Pts</td>
<td>Total $</td>
<td>$/Pt</td>
<td># Pts</td>
</tr>
<tr>
<td>PCP</td>
<td>$600</td>
<td>500</td>
<td>$300,000</td>
<td>$900</td>
<td>500</td>
</tr>
<tr>
<td>Specialist</td>
<td>$300</td>
<td>500</td>
<td>$150,000</td>
<td>$300</td>
<td>500</td>
</tr>
<tr>
<td>RN Care Mgr</td>
<td>$80,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>$300,000</td>
<td>500</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hospitalizations</th>
<th>CURRENT</th>
<th></th>
<th>FUTURE</th>
<th></th>
<th>Chg</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$/Pt</td>
<td># Pts</td>
<td>Total $</td>
<td>$/Pt</td>
<td># Pts</td>
</tr>
<tr>
<td>Hospital Fixed</td>
<td>$6,000</td>
<td>60%</td>
<td>$1,500,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hosp. Variable</td>
<td>$3,700</td>
<td>37%</td>
<td>$925,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hosp. Margin</td>
<td>$300</td>
<td>3%</td>
<td>$75,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>$10,000</td>
<td>250</td>
<td>$2,500,000</td>
<td>150</td>
<td></td>
</tr>
</tbody>
</table>

| Specialist (Inpt) | $400 | 250 | $100,000 | $0 |
| Total Spending    | 500  |     | $2,900,000 |   |
## Continue to Cover the Fixed Costs

<table>
<thead>
<tr>
<th></th>
<th>CURRENT</th>
<th>FUTURE</th>
<th>Chg</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physician Svcs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PCP</td>
<td>$600</td>
<td>$900</td>
<td>+50%</td>
</tr>
<tr>
<td>Specialist</td>
<td>$300</td>
<td>$300</td>
<td>+50%</td>
</tr>
<tr>
<td>RN Care Mgr</td>
<td>$80,000</td>
<td>$80,000</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>$300,000</td>
<td>$680,000</td>
<td>127%</td>
</tr>
<tr>
<td><strong>Hospitalizations</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Fixed</td>
<td>$6,000,000</td>
<td>$1,500,000,000</td>
<td>-0%</td>
</tr>
<tr>
<td>Hosp. Variable</td>
<td>$3,700</td>
<td>$925,000</td>
<td></td>
</tr>
<tr>
<td>Hosp. Margin</td>
<td>$300</td>
<td>$75,000</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>$10,000,000</td>
<td>150</td>
<td></td>
</tr>
<tr>
<td><strong>Specialist (Inpt)</strong></td>
<td>$400</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td><strong>Total Spending</strong></td>
<td>$2,900,000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Save on Variable Costs With Fewer Patients

<table>
<thead>
<tr>
<th>Physician Svcs</th>
<th>CURRENT</th>
<th>FUTURE</th>
<th>Chg</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$/Patient</td>
<td># Pts</td>
<td>Total $</td>
</tr>
<tr>
<td>PCP</td>
<td>$600</td>
<td>500</td>
<td>$300,000</td>
</tr>
<tr>
<td>Specialist</td>
<td>$300</td>
<td>500</td>
<td>$150,000</td>
</tr>
<tr>
<td>RN Care Mgr</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td>$300,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hospitalizations</th>
<th>CURRENT</th>
<th>FUTURE</th>
<th>Chg</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Fixed</td>
<td>$6,000</td>
<td>60%</td>
<td>$1,500,000</td>
</tr>
<tr>
<td>Hosp. Variable</td>
<td>$3,700</td>
<td>37%</td>
<td>$925,000</td>
</tr>
<tr>
<td>Hosp. Margin</td>
<td>$300</td>
<td>3%</td>
<td>$75,000</td>
</tr>
<tr>
<td>Total</td>
<td>$10,000</td>
<td>250</td>
<td>$2,500,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specialist (Inpt)</th>
<th>CURRENT</th>
<th>FUTURE</th>
<th>Chg</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$400</td>
<td>250</td>
<td>$100,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total Spending</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>500</td>
<td>$2,900,000</td>
<td></td>
</tr>
</tbody>
</table>
# Increase the Hospital’s Contribution Margin

<table>
<thead>
<tr>
<th>Physician Svcs</th>
<th>CURRENT</th>
<th></th>
<th>FUTURE</th>
<th>Chg</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$/Patient</td>
<td># Pts</td>
<td>Total $</td>
<td>$/Pt</td>
</tr>
<tr>
<td>PCP</td>
<td>$600</td>
<td>500</td>
<td>$300,000</td>
<td>$900</td>
</tr>
<tr>
<td>Specialist</td>
<td>$300</td>
<td>500</td>
<td>$150,000</td>
<td>$300</td>
</tr>
<tr>
<td>RN Care Mgr</td>
<td>$80,000</td>
<td>500</td>
<td>$400,000</td>
<td>$80,000</td>
</tr>
<tr>
<td>Total</td>
<td>$300,000</td>
<td>500</td>
<td>$680,000</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hospitalizations</th>
<th>CURRENT</th>
<th></th>
<th>FUTURE</th>
<th>Chg</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$/Pt</td>
<td># Pts</td>
<td>Total $</td>
<td>$/Pt</td>
</tr>
<tr>
<td>Hospital Fixed</td>
<td>$6,000</td>
<td>60%</td>
<td>$1,500,000</td>
<td>$1,500,000</td>
</tr>
<tr>
<td>Hosp. Variable</td>
<td>$3,700</td>
<td>37%</td>
<td>$925,000</td>
<td>$555,000</td>
</tr>
<tr>
<td>Hosp. Margin</td>
<td>$300</td>
<td>3%</td>
<td>$75,000</td>
<td>$82,500</td>
</tr>
<tr>
<td>Total</td>
<td>$10,000</td>
<td>250</td>
<td>$2,500,000</td>
<td></td>
</tr>
</tbody>
</table>

| Specialist (Inpt) | $400 | 250 | $100,000 |       |       | $0 |       |
| Total Spending    | 500  | $2,900,000 |         |       |       |       |
Hospital Gets Less *Total Revenue*, But is Better Off *Financially*

<table>
<thead>
<tr>
<th>Physician Svcs</th>
<th>CURRENT</th>
<th>FUTURE</th>
<th>Chg</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$/Patient</td>
<td># Pts</td>
<td>Total $</td>
</tr>
<tr>
<td>PCP</td>
<td>$600</td>
<td>500</td>
<td>$300,000</td>
</tr>
<tr>
<td>Specialist</td>
<td>$300</td>
<td>500</td>
<td>$150,000</td>
</tr>
<tr>
<td>RN Care Mgr</td>
<td>$80,000</td>
<td>500</td>
<td>$680,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$300,000</td>
<td>500</td>
<td>$300,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hospitalizations</th>
<th>CURRENT</th>
<th>FUTURE</th>
<th>Chg</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$/Pt</td>
<td># Pts</td>
<td>Total $</td>
</tr>
<tr>
<td>Hospital Fixed</td>
<td>$6,000</td>
<td>60%</td>
<td>$1,500,000</td>
</tr>
<tr>
<td>Hosp. Variable</td>
<td>$3,700</td>
<td>37%</td>
<td>$925,000</td>
</tr>
<tr>
<td>Hosp. Margin</td>
<td>$300</td>
<td>3%</td>
<td>$75,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$10,000</td>
<td>250</td>
<td>$2,500,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specialist (Inpt)</th>
<th>CURRENT</th>
<th>FUTURE</th>
<th>Chg</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$400</td>
<td>250</td>
<td>$100,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total Spending</th>
<th>CURRENT</th>
<th>FUTURE</th>
<th>Chg</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>500</td>
<td>$2,900,000</td>
<td>$0</td>
</tr>
</tbody>
</table>
And the Payer Still Spends Less

<table>
<thead>
<tr>
<th></th>
<th>CURRENT</th>
<th></th>
<th>FUTURE</th>
<th></th>
<th>Chg</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$/Patient</td>
<td># Pts</td>
<td>Total $</td>
<td>$/Pt</td>
<td># Pts</td>
</tr>
<tr>
<td><strong>Physician Svcs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PCP</td>
<td>$600</td>
<td>500</td>
<td>$300,000</td>
<td>$900</td>
<td>500</td>
</tr>
<tr>
<td>Specialist</td>
<td>$300</td>
<td>500</td>
<td>$150,000</td>
<td>$80,000</td>
<td></td>
</tr>
<tr>
<td>RN Care Mgr</td>
<td>$80,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$300,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hospitalizations</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Fixed</td>
<td>$6,000</td>
<td>60%</td>
<td>$1,500,000</td>
<td>$1,500,000</td>
<td></td>
</tr>
<tr>
<td>Hosp. Variable</td>
<td>$3,700</td>
<td>37%</td>
<td>$925,000</td>
<td>$555,000</td>
<td></td>
</tr>
<tr>
<td>Hosp. Margin</td>
<td>$300</td>
<td>3%</td>
<td>$75,000</td>
<td>$82,500</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$10,000</td>
<td>250</td>
<td>$2,500,000</td>
<td>150</td>
<td>$2,137,500</td>
</tr>
<tr>
<td><strong>Specialist (Inpt)</strong></td>
<td>$400</td>
<td>250</td>
<td>$100,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Spending</strong></td>
<td>500</td>
<td>$2,900,000</td>
<td></td>
<td>500</td>
<td>$2,817,500</td>
</tr>
</tbody>
</table>
## Win-Win-Win: Better Care, Higher Physician Pay, Lower Spending

<table>
<thead>
<tr>
<th>Physician Svcs</th>
<th>CURRENT</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th>FUTURE</th>
<th></th>
<th></th>
<th></th>
<th>Chg</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$/Patient</td>
<td># Pts</td>
<td>Total $</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$/Pt</td>
<td># Pts</td>
<td>Total $</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PCP</td>
<td>$600</td>
<td>500</td>
<td>$300,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$900</td>
<td>500</td>
<td>$450,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist</td>
<td>$300</td>
<td>500</td>
<td>$150,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$300</td>
<td>500</td>
<td>$150,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RN Care Mgr</td>
<td>$80,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$80,000</td>
<td></td>
<td></td>
<td></td>
<td>127%</td>
</tr>
<tr>
<td>Total</td>
<td>$300,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$680,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hospitalizations</th>
<th>CURRENT</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th>FUTURE</th>
<th></th>
<th></th>
<th></th>
<th>Chg</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$/Patient</td>
<td># Pts</td>
<td>Total $</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$/Pt</td>
<td># Pts</td>
<td>Total $</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Fixed</td>
<td>$6,000</td>
<td>60%</td>
<td>$1,500,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$1,500,000</td>
<td></td>
<td></td>
<td></td>
<td>-0%</td>
</tr>
<tr>
<td>Hosp. Variable</td>
<td>$3,700</td>
<td>37%</td>
<td>$925,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$555,000</td>
<td></td>
<td></td>
<td></td>
<td>-40%</td>
</tr>
<tr>
<td>Hosp. Margin</td>
<td>$300</td>
<td>3%</td>
<td>$75,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$82,500</td>
<td></td>
<td></td>
<td></td>
<td>+10%</td>
</tr>
<tr>
<td>Total</td>
<td>$10,000</td>
<td>250</td>
<td>$2,500,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>150</td>
<td>$2,137,500</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| 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?

<table>
<thead>
<tr>
<th></th>
<th>CURRENT</th>
<th>FUTURE</th>
<th>Chg</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$/Patient # Pts Total $</td>
<td>$/Pt # Pts Total $</td>
<td></td>
</tr>
<tr>
<td><strong>Physician Svcs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PCP</td>
<td>$600 500 $300,000</td>
<td>$900 500 $450,000</td>
<td>+50%</td>
</tr>
<tr>
<td>Specialist</td>
<td>$300 500 $150,000</td>
<td>$300 500 $150,000</td>
<td>+50%</td>
</tr>
<tr>
<td>RN Care Mgr</td>
<td></td>
<td>$80,000</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$300,000</td>
<td>500 $680,000</td>
<td>127%</td>
</tr>
<tr>
<td><strong>Hospitalizations</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Fixed</td>
<td>$6,000 60% $1,500,000</td>
<td>$1,500,000</td>
<td>-0%</td>
</tr>
<tr>
<td>Hosp. Variable</td>
<td>$3,700 37% $925,000</td>
<td>$555,000</td>
<td>-40%</td>
</tr>
<tr>
<td>Hosp. Margin</td>
<td>$300 3% $75,000</td>
<td>$82,500</td>
<td>+10%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$10,000 250 $2,500,000</td>
<td>150 $2,137,500</td>
<td>-15%</td>
</tr>
<tr>
<td><strong>Specialist (Inpt)</strong></td>
<td>$400 250 $100,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Spending</strong></td>
<td>500 $2,900,000</td>
<td>500 $2,817,500</td>
<td>-3%</td>
</tr>
</tbody>
</table>
You Don’t Want to Try and Renegotiate Individual Fees

<table>
<thead>
<tr>
<th>Physician Svcs</th>
<th>CURRENT</th>
<th>FUTURE</th>
<th>Chg</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$/Patient # Pts</td>
<td>Total $</td>
<td>$/Pt # Pts</td>
</tr>
<tr>
<td>PCP</td>
<td>$600 500</td>
<td>$300,000</td>
<td>$900 500</td>
</tr>
<tr>
<td>Specialist</td>
<td>$300 500</td>
<td>$150,000</td>
<td>$80,000</td>
</tr>
<tr>
<td>RN Care Mgr</td>
<td>$80,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>$300,000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hospitalizations</th>
<th>CURRENT</th>
<th>FUTURE</th>
<th>Chg</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$/Pt # Pts</td>
<td>Total $</td>
<td>$/Pt # Pts</td>
</tr>
<tr>
<td>Hospital Fixed</td>
<td>$6,000 60%</td>
<td>$1,500,000</td>
<td>$1,500,000</td>
</tr>
<tr>
<td>Hosp. Variable</td>
<td>$3,700 37%</td>
<td>$925,000</td>
<td>$555,000</td>
</tr>
<tr>
<td>Hosp. Margin</td>
<td>$300 3%</td>
<td>$75,000</td>
<td>$82,500</td>
</tr>
<tr>
<td>Total</td>
<td>$10,000 250</td>
<td>$2,500,000</td>
<td>$14,250 150</td>
</tr>
</tbody>
</table>

| 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*

<table>
<thead>
<tr>
<th>Physician Svc</th>
<th>CURRENT</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th>FUTURE</th>
<th></th>
<th></th>
<th></th>
<th>Chg</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP</td>
<td>$600</td>
<td>500</td>
<td>$300,000</td>
<td></td>
<td></td>
<td>$900</td>
<td>500</td>
<td>$450,000</td>
<td></td>
<td>+50%</td>
</tr>
<tr>
<td>Specialist</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$300</td>
<td>500</td>
<td>$150,000</td>
<td></td>
<td>+50%</td>
</tr>
<tr>
<td>RN Care Mgr</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$80,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td>$300,000</td>
<td></td>
<td></td>
<td>500</td>
<td></td>
<td>$680,000</td>
<td></td>
<td>127%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hospitalization</th>
<th>CURRENT</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th>FUTURE</th>
<th></th>
<th></th>
<th></th>
<th>Chg</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Fixed</td>
<td>$6,000</td>
<td>60%</td>
<td>$1,500,000</td>
<td></td>
<td></td>
<td>$1,500,000</td>
<td></td>
<td>-0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hosp. Variable</td>
<td>$3,700</td>
<td>37%</td>
<td>$925,000</td>
<td></td>
<td></td>
<td>$555,000</td>
<td></td>
<td>-40%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hosp. Margin</td>
<td>$300</td>
<td>3%</td>
<td>$75,000</td>
<td></td>
<td></td>
<td>$82,500</td>
<td></td>
<td>+10%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>250</td>
<td></td>
<td>$2,500,000</td>
<td></td>
<td></td>
<td>150</td>
<td></td>
<td>$2,137,500</td>
<td></td>
<td>-15%</td>
</tr>
</tbody>
</table>

| 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

<table>
<thead>
<tr>
<th></th>
<th>CURRENT</th>
<th>FUTURE</th>
<th>Chg</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$/Patient # Pts</td>
<td>$/Pt # Pts</td>
<td>Total</td>
</tr>
<tr>
<td><strong>Physician Svcs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PCP</td>
<td>$600 500</td>
<td>$900 500</td>
<td>$300,000</td>
</tr>
<tr>
<td>Specialist</td>
<td>$300 500</td>
<td>$300 500</td>
<td>$80,000</td>
</tr>
<tr>
<td>RN Care Mgr</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$300,000</td>
<td>500 $680,000</td>
<td>127%</td>
</tr>
<tr>
<td><strong>Hospitalizations</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Fixed</td>
<td>$6,000 60%</td>
<td>$1,500,000</td>
<td>-0%</td>
</tr>
<tr>
<td>Hosp. Variable</td>
<td>$3,700 37%</td>
<td>$555,000</td>
<td>-40%</td>
</tr>
<tr>
<td>Hosp. Margin</td>
<td>$300 3%</td>
<td>$82,500</td>
<td>+10%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>250 $2,500,000</td>
<td>150 $2,137,500</td>
<td>-15%</td>
</tr>
<tr>
<td><strong>Specialist (Inpt)</strong></td>
<td>$400 250</td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td><strong>Total Spending</strong></td>
<td>$5,800 500</td>
<td>$5,635 500</td>
<td>-3%</td>
</tr>
</tbody>
</table>
Use That Budget to Pay Doctors & Hospitals What They Really Need

<table>
<thead>
<tr>
<th>Physician Svcs</th>
<th>CURRENT</th>
<th></th>
<th>FUTURE</th>
<th></th>
<th>Chg</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$/Patient # Pts</td>
<td>Total $</td>
<td>$/Pt # Pts</td>
<td>Total $</td>
<td></td>
</tr>
<tr>
<td>PCP</td>
<td>$600 500</td>
<td>$300,000</td>
<td>500</td>
<td>$450,000</td>
<td>50%</td>
</tr>
<tr>
<td>Specialist</td>
<td></td>
<td></td>
<td>500</td>
<td>$150,000</td>
<td>-50%</td>
</tr>
<tr>
<td>RN Care Mgr</td>
<td></td>
<td></td>
<td></td>
<td>$80,000</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>$300,000</td>
<td></td>
<td>$680,000</td>
<td>127%</td>
</tr>
</tbody>
</table>

| Hospitalizations   |                  |          |       |                   |     |
|                    | $/Pt # Pts | Total $ | $/Pt # Pts | Total $ | Chg |
| Hospital Fixed     | $6,000 60% | $1,500,000 | 60% | $1,500,000 | 0%  |
| Hosp. Variable     | $3,700 37% | $925,000  | 37% | $555,000   | -40%|
| Hosp. Margin       | $300 3%   | $75,000   | 3%  | $82,500    | +10%|
| Total              |          | $2,500,000 |    | $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% |
## Condition-Based Payment Puts the Providers in Charge of Care & Pmt

<table>
<thead>
<tr>
<th></th>
<th>CURRENT</th>
<th>FUTURE</th>
<th>Chg</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$/Patient # Pts</td>
<td>Pmt</td>
<td></td>
</tr>
<tr>
<td><strong>Physician Svcs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PCP</td>
<td>$600 500</td>
<td>$450,000</td>
<td>50%</td>
</tr>
<tr>
<td>Specialist</td>
<td></td>
<td>$150,000</td>
<td>-50%</td>
</tr>
<tr>
<td>RN Care Mgr</td>
<td>$80,000</td>
<td>$80,000</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>$300,000</td>
<td>$680,000</td>
<td>127%</td>
</tr>
<tr>
<td><strong>Hospitalizations</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Fixed</td>
<td>$6,000 60%</td>
<td>$1,500,000</td>
<td>-0%</td>
</tr>
<tr>
<td>Hosp. Variable</td>
<td>$3,700 37%</td>
<td>$555,000</td>
<td>-40%</td>
</tr>
<tr>
<td>Hosp. Margin</td>
<td>$300 3%</td>
<td>$82,500</td>
<td>+10%</td>
</tr>
<tr>
<td>Total</td>
<td>$2,500,000</td>
<td>$2,137,500</td>
<td>-15%</td>
</tr>
<tr>
<td><strong>Specialist (Inpt)</strong></td>
<td>$400 250</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>Total Spending</td>
<td>$5,800 500</td>
<td>$2,817,500</td>
<td>-3%</td>
</tr>
</tbody>
</table>

© 2009-2014 Center for Healthcare Quality and Payment Reform  www.CHQPR.org
“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

- Patients with Serious Issues Receiving Principal Care Through Behavioral Health System
- Patient with BH issue
Some Are Identified by PCPs and Referred to Psychiatry/BH

Patients with Serious Issues Receiving Principal Care Through Behavioral Health System

Patient with BH issue

PCP Visits for Physical Complaints

Screening for BH Issues

Psychiatry/BH Referral

Psych./BH Visit

BH Therapy

Patient w/ Improved BH Issue
But Patients May Not Follow Through on the Referral

- Patients with Serious Issues Receiving Principal Care Through Behavioral Health System
  - PCP Visits for Physical Complaints
- Patient with BH issue
  - Screening for BH Issues
  - Psychiatry/BH Referral
  - No Visit
  - Psych./BH Visit
  - BH Therapy
- Patient w/ Improved BH Issue
- Patient w/ Unaddressed BH Issue

© 2009-2014 Center for Healthcare Quality and Payment Reform  www.CHQPR.org
Some Patients Treated for Physical Issues May Really Be BH Issues

- Patients with Serious Issues Receiving Principal Care Through Behavioral Health System

- Patient with BH issue

- PCP Visits for Physical Complaints

- Screening for BH Issues

- Psychiatry/BH Referral

- Specialty Referrals for Physical Complaints

- Diagnostic Tests for Physical Complaints

- Rx for Physical Complaints

- Psychiatric Medications

- Patient w/ Unaddressed BH Issue

- Psych./BH Visit

- BH Therapy

- Patient w/ Improved BH Issue

- No visit
Some Patients May Go to ER for Physical Issues; Really BH Issues

- **Patients with Serious Issues Receiving Principal Care Through Behavioral Health System**
  - Patient with BH issue
  - PCP Visits for Physical Complaints
    - Screening for BH Issues
    - Psychiatry/BH Referral
      - Specialty Referrals for Physical Complaints
        - Diagnostic Tests for Physical Complaints
          - Rx for Physical Complaints
            - Psychiatric Medications
          - No Visit
    - Psych./BH Visit
      - BH Therapy
    - ER Visits
      - Hospitalization
  - Patient w/ Unaddressed BH Issue
  - Patient w/ Improved BH Issue
Worse Outcomes for Chronic Disease w/o Addressing BH Issues

- Patients with Serious Issues Receiving Principal Care Through Behavioral Health System
- Patient with BH issue
- PCP Visits for Physical Complaints
  - Care Mgt for Chronic Disease
    - ER Visits
      - Hospitalization
  - Successful Chronic Disease Mgt
- Screening for BH Issues
- Psychiatry/BH Referral
  - Specialty Referrals for Physical Complaints
    - No Visit
    - Psych./BH Visit
      - BH Therapy
- Diagnostic Tests for Physical Complaints
  - Rx for Physical Complaints
    - Psychiatric Medications
- Patients with Serious Issues Receiving Principal Care Through Behavioral Health System
  - Patient w/ Unaddressed BH Issue
  - Patient w/ Improved BH Issue

© 2009-2014 Center for Healthcare Quality and Payment Reform www.CHQPR.org
How Care Would Be Redesigned:
1. Screening/Intervention at Visits

- Patients with Serious Issues Receiving Principal Care Through Behavioral Health System
- Patient w/ BH issue
  - PCP Visits for Physical Complaints
  - Care Mgt for Chronic Disease
  - ER Visits
  - Hospitalization
- On-Site Screening for BH Issues
- On Site BH Specialist
- Regular Care from PCP & BH Specialist
  - Psych. Phone Consult
  - Psychiatry/BH Referral
  - Specialty Referrals for Physical Complaints
- Diagnostic Tests for Physical Complaints
  - Rx for Physical Complaints
  - Psychiatric Medications
- Successful Chronic Disease Mgt
- Regular Care from PCP & BH Specialist
- No Visit
- Patient w/ Improved BH Issue
  - Psych./BH Visit
  - BH Therapy
  - Patient w/ Unaddressed BH Issue

© 2009-2014 Center for Healthcare Quality and Payment Reform www.CHQPR.org
How Care Would Be Redesigned: 2. Proactive Screening & Referral

- Patients with Serious Issues Receiving Principal Care Through Behavioral Health System
- Patient with BH issue
- Proactive Screening for BH Issues
- PCP Visits for Physical Complaints
- Care Mgt for Chronic Disease
- ER Visits
- On-Site Screening for BH Issues
- Successful Chronic Disease Mgt

- On Site BH Specialist
- Regular Care from PCP & BH Specialist
- Psych. Phone Consult

- Psychiatry/BH Referral
- Specialty Referrals for Physical Complaints
- Diagnostic Tests for Physical Complaints
- Rx for Physical Complaints
- Psychiatric Medications

- Patient with Unaddressed BH Issue
- Patient w/ Improved BH Issue
- BH Therapy
Expected Impacts on Costs and Outcomes

- Patients with Serious Issues Receiving Principal Care Through Behavioral Health System
  - Patient with BH issue
    - ER Visits
    - Hospitalization
    - Care Mgt for Chronic Disease
      - PCP Visits for Physical Complaints
      - On Site Screening for BH Issues
    - Successful Chronic Disease Mgt
    - Proactive Screening for BH Issues
    - On Site BH Specialist
      - Psychiatry/BH Referral
      - Specialty Referrals for Physical Complaints
    - Regular Care from PCP & BH Specialist
      - Psych. Phone Consult
      - Psych./BH Visit
      - No Visit
  - Patient w/ Improved BH Issue
  - Patient w/ Unaddressed BH Issue
  - Patients with Serious Issues Receiving Principal Care Through Behavioral Health System
  - Psych./BH Referral
  - Diagnostic Tests for Physical Complaints
    - Rx for Physical Complaints
    - Psychiatric Medications
  - BH Therapy
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
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

• **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
  – 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
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

- **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
  - 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

BEHAVIORAL HEALTH SERVICES AGENCY

Management of PCP-Based Behavioral Health Specialists

Primary Care Practice with 3+ PCPs

PCP  PCP
PCP

Primary Care Practice with 3+ PCPs

PCP  PCP
PCP  PCP
PCP  PCP

On Site BH Specialist

Registry/Admin Support
Staffing Model for Behavioral Health Specialists

BEHAVIORAL HEALTH SERVICES AGENCY

Management of PCP-Based Behavioral Health Specialists

Primary Care Practice with 3+ PCPs

- On Site BH Specialist
- Registry/Admin Support

Primary Care Practice with <3 PCPs

- Video Link

Primary Care Practice with <3 PCPs

- Video Link

Primary Care Practice with <3 PCPs
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
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

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

© 2009-2014 Center for Healthcare Quality and Payment Reform  www.CHQPR.org
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**

**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**
- **$166,000 Net Savings**
Additional Data/Modeling Needed to Determine Costs and Impacts

### Business Case Analysis for Behavioral Health/Primary Care Integration

<table>
<thead>
<tr>
<th>User-Selected Parameters Highlighted in Yellow</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of PCPs in Practice</strong></td>
<td>3</td>
</tr>
<tr>
<td><strong>Total Patients/PCP</strong></td>
<td>2,000</td>
</tr>
<tr>
<td><strong>Total Patients in Practice</strong></td>
<td>6,000</td>
</tr>
<tr>
<td><strong>% Patients with BH Issues</strong></td>
<td>3,936</td>
</tr>
<tr>
<td><strong>Patients w/ BH Issues in Practice</strong></td>
<td>1,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Current Units</th>
<th>Change in Units</th>
<th>% Change</th>
<th>Cost/Change in Payment</th>
<th>Current Units</th>
<th>Change in Units</th>
<th>% Change</th>
<th>Future Units of Service</th>
<th>Change in Units</th>
<th>% Change</th>
<th>Current Total $</th>
<th>Future Total $</th>
<th>Change in Total $</th>
<th>Change in $ Per PCP</th>
<th>PMPM Change</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Payment to PCP Practice</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Payment for All Screens</td>
<td>0.5%</td>
<td>0.13</td>
<td>250%</td>
<td>$30</td>
<td>300</td>
<td>1,050</td>
<td>$9,000</td>
<td>$11,500</td>
<td>$2,500</td>
<td>$7,500</td>
<td>$0.31</td>
<td>Two Alternative Approaches to Payment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Payment for All Screens</td>
<td>0.5%</td>
<td>0.13</td>
<td>250%</td>
<td>$0</td>
<td>600</td>
<td>5,400</td>
<td>4,800</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>Assumes PMPM Contracts for BH Support</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FMPM for BH Intervention</td>
<td>$216,000</td>
<td>$72,000</td>
<td>$3,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Available PCF-office visits for PCPs w/ BH Issues</td>
<td>-3.0%</td>
<td>$0</td>
<td>$150</td>
<td>$150</td>
<td>$150</td>
<td>$150</td>
<td>$150</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visits with New Patients</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adjustment for Practice Performance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>$154,888</td>
<td>$51,629</td>
<td>$2,545</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Based on Projected Savings</td>
</tr>
<tr>
<td><strong>Cost to PCP Practice</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BH Screenings</td>
<td>0.5%</td>
<td>0.13</td>
<td>250%</td>
<td>$9</td>
<td>600</td>
<td>1,000</td>
<td>$54</td>
<td>$625</td>
<td>$5,263</td>
<td>$16,250</td>
<td>$56,625</td>
<td>$16,875</td>
<td>$0.76</td>
<td>Cost is BH Practice</td>
<td></td>
</tr>
<tr>
<td>Cost of BH Specialist</td>
<td>$10,000</td>
<td>$50,000</td>
<td>$500</td>
<td>$500</td>
<td>$500</td>
<td>$500</td>
<td>$500</td>
<td>$500</td>
<td>$500</td>
<td>$500</td>
<td>$500</td>
<td>$500</td>
<td>$500</td>
<td>$500</td>
<td>Cost is Per PCP</td>
</tr>
<tr>
<td>Cost of Regional/Collect Support</td>
<td>$15,067</td>
<td>$50,000</td>
<td>$500</td>
<td>$500</td>
<td>$500</td>
<td>$500</td>
<td>$500</td>
<td>$500</td>
<td>$500</td>
<td>$500</td>
<td>$500</td>
<td>$500</td>
<td>$500</td>
<td>$500</td>
<td>Cost is Per PCP</td>
</tr>
<tr>
<td>Cost of Medical Services (Practices with 3 PCPs Only)</td>
<td>$5,000</td>
<td>$20,000</td>
<td>$200</td>
<td>$200</td>
<td>$200</td>
<td>$200</td>
<td>$200</td>
<td>$200</td>
<td>$200</td>
<td>$200</td>
<td>$200</td>
<td>$200</td>
<td>$200</td>
<td>$200</td>
<td>Cost is Per Practice</td>
</tr>
<tr>
<td>Payment to Psychologists for Phone Consultation</td>
<td>$100</td>
<td>$100</td>
<td>$100</td>
<td>$100</td>
<td>$100</td>
<td>$100</td>
<td>$100</td>
<td>$100</td>
<td>$100</td>
<td>$100</td>
<td>$100</td>
<td>$100</td>
<td>$100</td>
<td>$100</td>
<td>Cost is Per Practice</td>
</tr>
<tr>
<td><strong>Non-RS Services Outside of PCP Practice</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Available Specialty Referrals*</td>
<td>-0.5%</td>
<td>-0.13</td>
<td>-100%</td>
<td>$100</td>
<td>525</td>
<td>0</td>
<td>$525</td>
<td>$0</td>
<td>$525</td>
<td>$17,500</td>
<td>$0.73</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>External Behavioral Health Services</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>$0</td>
<td>0</td>
<td>0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>Cost is Per Practice</td>
</tr>
<tr>
<td>Psychiatric Hospitalizations</td>
<td>0.5%</td>
<td>0.03</td>
<td>-100%</td>
<td>$500</td>
<td>500</td>
<td>0</td>
<td>$500</td>
<td>$0</td>
<td>$500</td>
<td>$500</td>
<td>$500</td>
<td>$500</td>
<td>$500</td>
<td>$500</td>
<td>Cost is Per Practice</td>
</tr>
<tr>
<td><strong>Pharmaceutical Costs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatric Medications</td>
<td>3%</td>
<td>0.12</td>
<td>-50%</td>
<td>$100</td>
<td>12,800</td>
<td>6,400</td>
<td>$1,240,000</td>
<td>$618,000</td>
<td>$642,000</td>
<td>$210,000</td>
<td>$8.75</td>
<td>For BH Patients Only</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Available Medications*</td>
<td>-2%</td>
<td>-0.08</td>
<td>-50%</td>
<td>$100</td>
<td>12,800</td>
<td>6,400</td>
<td>$1,240,000</td>
<td>$618,000</td>
<td>$642,000</td>
<td>$210,000</td>
<td>$8.75</td>
<td>For BH Patients Only</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$154,888</td>
<td>$51,629</td>
<td>$2,545</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Based on Projected Savings</td>
</tr>
</tbody>
</table>

* avoidable=physical problems caused by unaddressed BH issues

© 2009-2014 Center for Healthcare Quality and Payment Reform  www.CHQPR.org
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

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
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
    2. Pay for all screens (positive or negative)
    3. Pay through a PMPM payment, not per screen
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
    2. Pay for all screens (positive or negative)
    3. Pay through a PMPM payment, not per screen

- **Immediate intervention following positive screen by BH Specialist**
  - **Current Payment:** Not currently paid for
  - **Options for Future:**
    1. Pay on a programmatic basis, i.e., cover the costs of the staff in a practice
    2. Pay on a PMPM basis
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
    2. Pay for all screens (positive or negative)
    3. Pay through a PMPM payment, not per screen

• Immediate intervention following positive screen by BH Specialist
  – Current Payment: Not currently paid for
  – Options for Future:
    1. Pay on a programmatic basis, i.e., cover the costs of the staff in a practice
    2. Pay on a PMPM basis

• Follow-up care by BH Specialist in PCP practice
  (For patients who warrant services before or instead of transfer to external BH services)
  – Current Payment: Depending on the credentials of the Behavioral Health Specialist, they (or the PCP practice) may or may not be eligible to bill for these services
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  
    2. Pay for all screens (positive or negative)  
    3. Pay through a PMPM payment, not per screen

• Immediate intervention following positive screen by BH Specialist
  – Current Payment: Not currently paid for  
  – Options for Future:  
    1. Pay on a programmatic basis, i.e., cover the costs of the staff in a practice  
    2. Pay on a PMPM basis

• Follow-up care by BH Specialist in PCP practice
  (For patients who warrant services before or instead of transfer to external BH services)
  – Current Payment: Depending on the credentials of the Behavioral Health Specialist, they (or the PCP practice) may or may not be eligible to bill for these services

• Follow-up care by external behavioral health services
  – Current Payment: Paid for
Potential Payment Model for Better BH Care in Primary Care

Patient with BH Issue

- PCP Visits for Physical Complaints
- Care Mgt for Chronic Disease
- ER Visits

- Proactive Screening for BH Issues
- On-Site Screening for BH Issues

- On Site BH Specialist
- Regular Care from PCP & BH Specialist
- Psych. Phone Consult

- Psychiatry/BH Referral
- Specialty Referrals for Physical Complaints

- Psych./BH Visit
- BH Therapy

- Diagnostic Tests for Physical Complaints
- Rx for Physical Complaints
- Psychiatric Medications

- Hospitalization

© 2009-2014 Center for Healthcare Quality and Payment Reform  www.CHQPR.org
Maintain FFS for Current Services

Current FFS to PCP for Office Visits

- Patient with BH issue
  - PCP Visits for Physical Complaints
    - Proactive Screening for BH Issues
      - On Site BH Screening
        - On Site BH Specialist
          - Regular Care from PCP & BH Specialist
            - Psych. Phone Consult
              - Psych./BH Visit
                - BH Therapy
      - Specialty Referrals for Physical Complaints
        - Diagnostic Tests for Physical Complaints
          - Rx for Physical Complaints
            - Psychiatric Medications
              - Psych./BH Visit
                - BH Therapy
  - Care Mgt for Chronic Disease
    - ER Visits
      - Hospitalization

Current FFS for Specialists, Medications, ER
Performance-Based PMPM for Additional/Enhanced Services

PAYER PAYER PAYER PAYER

PMPM Payment to PCP Practice for Screening and BH Specialist

+/- Adjustment to PCP Payment Based on Utilization of Specialists, Medications, ER

Current FFS to PCP for Office Visits

Patient with BH Issue

PCP Visits for Physical Complaints

Care Mgt for Chronic Disease

Proactive Screening for BH Issues

On Site Screening for BH Issues

On Site BH Specialist

Regular Care from PCP & BH Specialist

Psych. Phone Consult

Psych. BH Visit

BH Therapy

Specialty Referrals for Physical Complaints

Diagnostic Tests for Physical Complaints

Rx for Physical Complaints

Psychiatric Medications

Current FFS for Specialists, Medications, ER

ER Visits

Hospitalization

Psychiatry/BH Referral
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?
How Do You Develop Win-Win-Win Solutions?

1. Defining the Change in Care Delivery
   - How can care be redesigned to improve quality and reduce costs?
How Do You Develop Win-Win-Win Solutions?

1. **Defining the Change in Care Delivery**
   – How can care be redesigned to improve quality and reduce costs?

2. **Analyzing Expected Costs and Savings**
   – What will there be less of, and how much does that save?
   – What will there be more of, and how much does that cost?
   – Will the savings offset the costs on average?
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!
Making the Business Case for Payment and Delivery Reform

Robert Wood Johnson Foundation

Robert D. Miller
Center for Healthcare Quality and Payment Reform

Details on all the steps are in this free publication.

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, individual 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 at a financially sustainable way under the new payment system.

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

1. Define the planned change in care and the results it is expected to achieve.
2. Estimate how the type and volume of services will change.
3. Determine how payment/leverage will change under the current payment system.
4. Determine how the costs of services will change.
5. Calculate the changes in operating margins for providers.
6. Identify the changes in payment needed by providers to maintain positive operating margins.
7. Determine which of a business case exists for both purchasers and providers.
8. Define the changes in care to improve the business case.
9. Analyze the impact of potential deviations from planned care and expected outcomes.
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.

Center for Healthcare Quality and Payment Reform

www.PaymentReform.org
What Kind of Data Do You Need?
What Kind of Data Do You Need?

- **Healthcare Billings/Claims Data (Payers)**
  - Data on (billable) services delivered
  - Data on payment amounts for services, if released
    - *It’s hard to save someone money if they won’t tell you what they’re paying now*
  - Does not include information on unbillable services or costs
  - Does not include adequate information on patient characteristics
What Kind of Data Do You Need?

- **Healthcare Billings/Claims Data (Payers)**
  - Data on (billable) services delivered
  - Data on payment amounts for services, if released
    - *It’s hard to save someone money if they won’t tell you what they’re paying now*
  - Does not include information on unbillable services or costs
  - Does not include adequate information on patient characteristics

- **Clinical Data (Provider EHRs)**
  - Data on patient characteristics
  - Data on services
  - Only includes information on services patient received from the provider
  - Does not include information on costs or payments
What Kind of Data Do You Need?

• **Healthcare Billings/Claims Data (Payers)**
  – Data on (billable) services delivered
  – Data on payment amounts for services, if released
    • *It’s hard to save someone money if they won’t tell you what they’re paying now*
  – Does not include information on unbillable services or costs
  – Does not include adequate information on patient characteristics

• **Clinical Data (Provider EHRs)**
  – Data on patient characteristics
  – Data on services
  – Only includes information on services patient received from the provider
  – Does not include information on costs or payments

• **Data on the Costs of Services (Cost Accounting and Modeling)**
  – Information on what provider pays for staff, equipment, supplies used
  – Need to know not just what costs are *today*, but how costs will *change*
  – Cost accounting helps with baseline, but analytic models also needed
  – Variable costs is most important information in short run
What Kind of Data Do You Need?

- **Healthcare Billings/Claims Data (Payers)**
  - Data on (billable) services delivered
  - Data on payment amounts for services, if released
    - *It’s hard to save someone money if they won’t tell you what they’re paying now*
  - Does not include information on unbillable services or costs
  - Does not include adequate information on patient characteristics

- **Clinical Data (Provider EHRs)**
  - Data on patient characteristics
  - Data on services
  - Only includes information on services patient received from the provider
  - Does not include information on costs or payments

- **Data on the Costs of Services (Cost Accounting and Modeling)**
  - Information on what provider pays for staff, equipment, supplies used
  - Need to know not just what costs are *today*, but how costs will *change*
  - Cost accounting helps with baseline, but analytic models also needed
  - Variable costs is most important information in short run

- **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
How Do You Develop Win-Win-Win-Win Solutions?

1. **Defining the Change in Care Delivery**
   - How can care be redesigned to improve quality and reduce costs?

2. **Analyzing Expected Costs and Savings**
   - What will there be less of, and how much does that save?
   - What will there be more of, and how much does that cost?
   - Will the savings offset the costs on average?

3. **Designing a Payment Model That Supports Change**
   - 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

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

© 2009-2014 Center for Healthcare Quality and Payment Reform  www.CHQPR.org
More Information on Structuring Payment Models

Transitioning to Accountable Care

Incremental Payment Reforms to Support Higher Quality, More Affordable Health Care

Harold D. Miller

Center for Healthcare Quality and Payment Reform
www.PaymentReform.org
How Do You Develop Win-Win-Win-Win Solutions?

1. Defining the Change in Care Delivery
   - How can care be redesigned to improve quality and reduce costs?

2. Analyzing Expected Costs and Savings
   - What will there be less of, and how much does that save?
   - What will there be more of, and how much does that cost?
   - Will the savings offset the costs on average?

3. Designing a Payment Model That Supports Change
   - 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

4. Getting Payers to Use the Payment Model
Biggest Barrier? Medicare & Health Plans Don’t Want to Change

Medicare

Health Plans

Medicaid

FFS

Provider

Patient

Patient

Patient
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

Medicare

Better Payment

Health Plans

Better Payment

Medicaid

Better Payment

Provider

Patient

Patient

Patient
What About The Patient?

Patient  Provider
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

Diagram:
- Payment System
  - Ability and Incentives to:
    - Keep patients well
    - Avoid unneeded services
    - Deliver services efficiently
    - Coordinate services with other providers
- Patient
- Provider
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

Benefit Design

Patient

Ability and Incentives to:
- Keep patients well
- Avoid unneeded services
- Deliver services efficiently
- Coordinate services with other providers

Payment System

Provider
Example: Coordinating Pharmacy & Medical Benefits

Single-minded focus on reducing costs here...

...could result in higher spending on hospitalizations

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

**Pharmacy Benefits**

**Drug Costs**

**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

Center for Healthcare Quality and Payment Reform
www.PaymentReform.org
For More Information:

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

Miller.Harold@GMail.com
(412) 803-3650

www.CHQPR.org
www.PaymentReform.org