Payment Reform 201: Can We Build Models that Work for Clinicians *and* Communities?

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Where Innovation Is Tradition

Overview

- Where are we now?
- The Missing Link
- The Race Against Time, Nature, and Politics
- OR
- What We Need Communities and HHS to Do

Where are we now?

- Magnitude of budget pressures cannot be overstated
- ACA “models” emerging in private sector, too

Innovation Center Portfolio

ACO Suite:

- Shared Savings Program
- Pioneer ACO Model
- Advance Payment ACO Model
- Accelerated and Learning Development Sessions

Primary Care Suite

- Comprehensive Primary Care Initiative (CPCI)
- Federally Qualified Health Center Advanced Primary Care Practice Demonstration
- Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration
- Independence at Home
- Medicaid Health Home State Plan Option

Bundled Payment Suite

- Bundled Payment for Care Improvement

Dual Eligible Suite:

- State Demonstration to Integrate care for Dual Eligible Individuals
- Financial Alignment to Support State Efforts to Integrate Care
- Demonstration to Reduce Avoidable Hospitalizations of Nursing Facility Residents
- Medicaid Health Home State Plan Option

Diffusion and Scale Suite:

- Partnership for Patients
- Million Hearts Campaign
- Innovation Advisors Program
- Care Innovations Summit

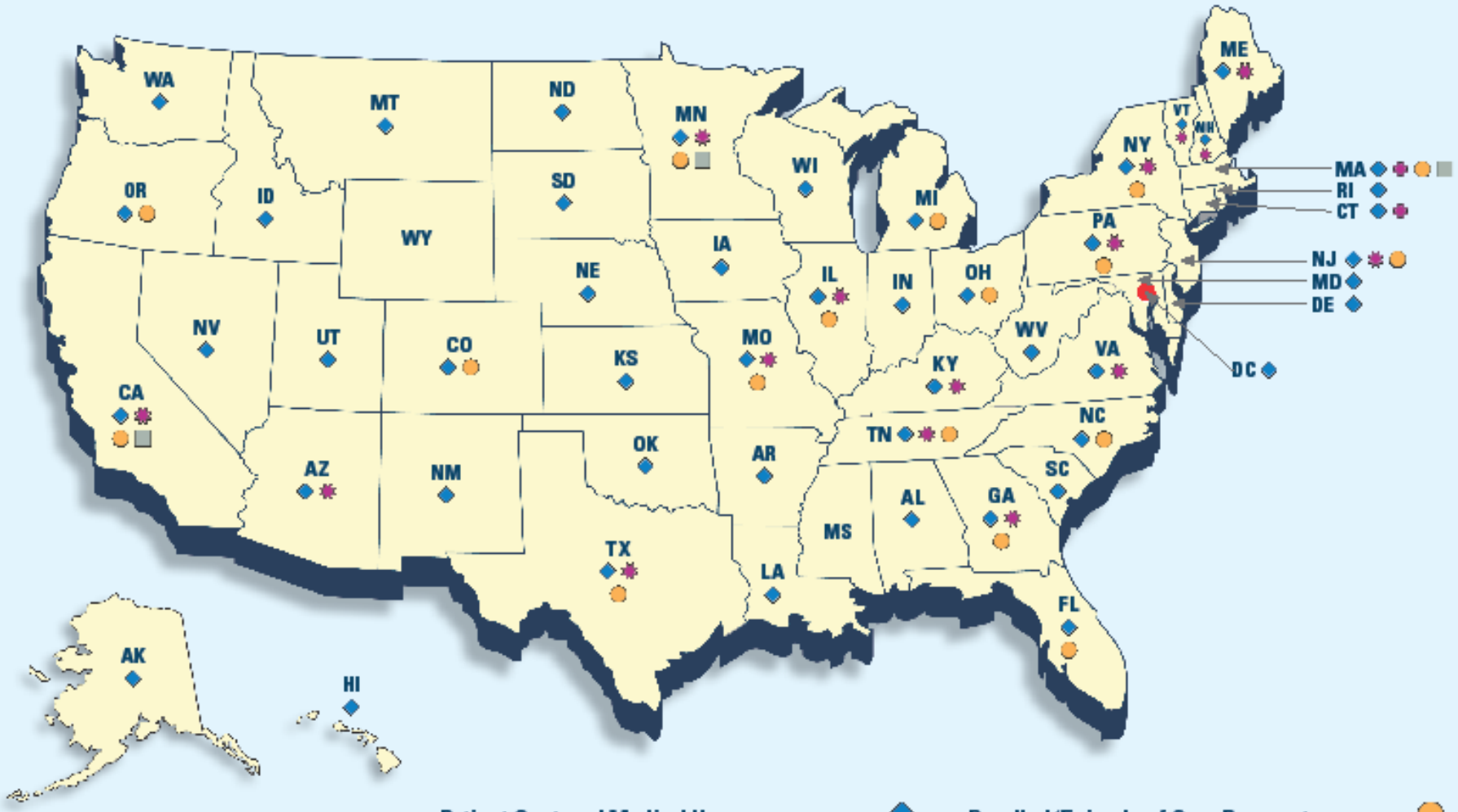
Healthcare Innovation Challenge

Rapid Cycle Evaluation and Research

Learning and Diffusion

CMS CENTERS for MEDICARE & MEDICAID SERVICES

Alternative Delivery and Payment Models—Private Sector Initiatives



NOTE: Icons may represent multiple partnerships within the state

*The map is current as of November 2011. As new programs are identified the map will be updated accordingly.

Let's be clear

- Fiscal balance requires lower total health spending
- Lower health spending can only come from:
  - Lower use w/ less inefficiency or less inappropriate care
  - Lower prices w/ countervailing power
  - Higher quality w/ coordination + information
  - Better health w/ VBID, wellness, pathways
- Reform mostly focuses on quantity and quality
- ***Someone is gonna lose here, but overall economy?***

Targets of Spending Reductions

• Poor care delivery		
➢ Unnecessary services	$210B	8% of NHE
➢ Inefficient delivery	$130B	5%
➢ Missed prevention	$ 55B	2%
• Excessive Admin Costs	$190B	8%
• Prices	$105B	4%
• Fraud	$ 73B	3%
• TOTAL	$765B	31%

OECD Says 25% higher

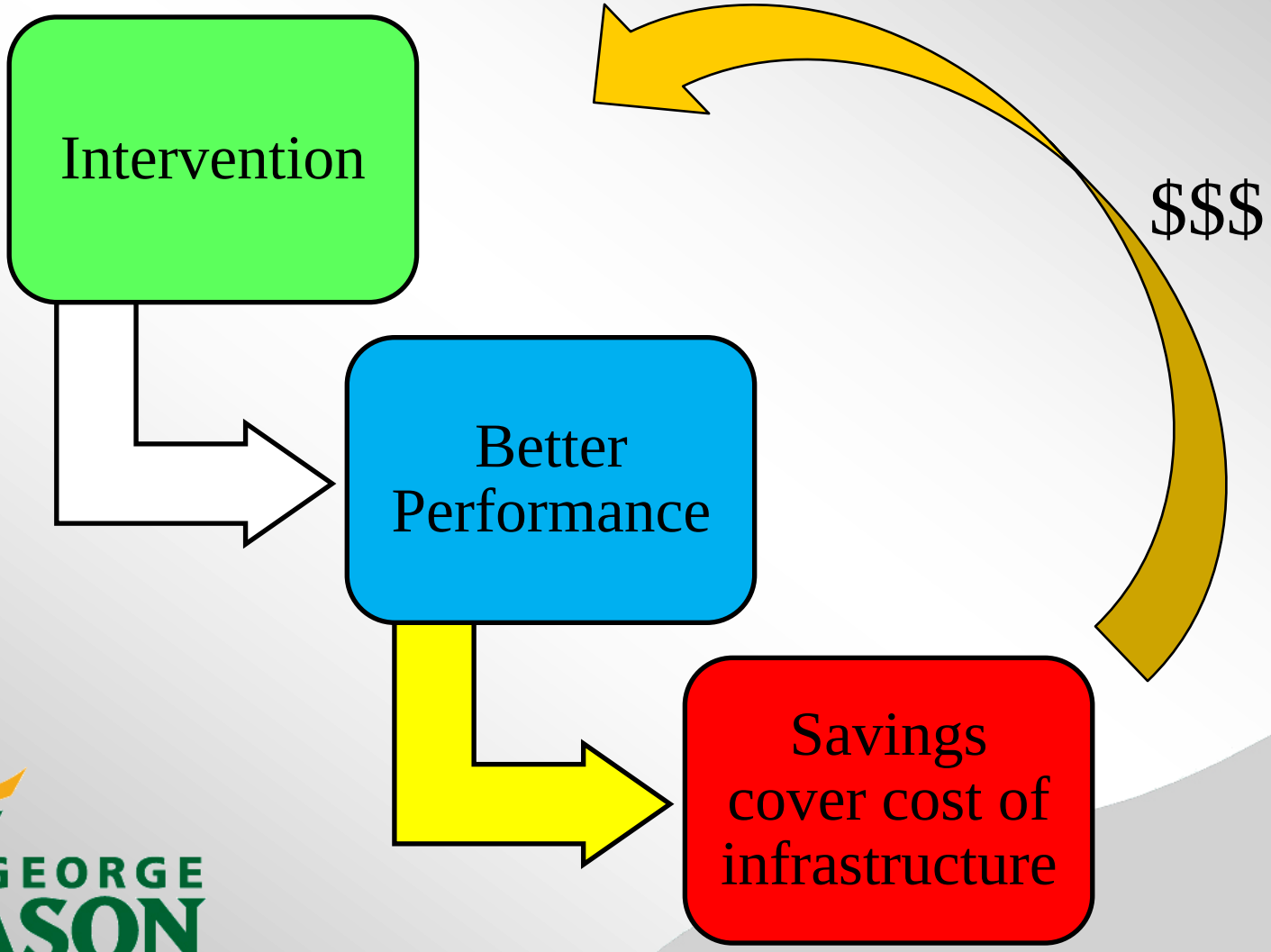
Expls. 1/2

D. Cutler, Senate Budget Testimony, citing IOM

"Theory" of payment reform

- Changing the way we pay will so change behavior that total costs will fall *AND* SOME MDs (plus SOME hospitals) will gain*
  - *(Compared to what? Which baseline?)
- AND this outcome will be sustained from new incentive structure
- When is this possible, and when not?

Sustainable Payment Reform



Pre-conditions for shared savings-based payment reform to work

- Savings must more than cover intervention
- Payers must share more than cost of intervention
  - Cost could be foregone revenue
  - Cost could be new services that must be added
- Current Baseline must be reference point, at least for a while

Simplest Possible Example

- Cardiologists doing x% inappropriate care in their offices
- Under simple but "reasonable" assumptions:
- Two parameters really matter:
  - SHARE (S) of savings returned to MD
  - MARKUP (M) earned on inappropriate use
    - M = Revenue/Cost of inappropriate use
    - Is GROSS margin (ex 120%, same as 20% net margin)

Simplest possible example

- (where S = share going to MD), then
- Cardiologist gains from reform IF
- (1-S)M < 1
  - = share kept by payer * markup on inapp use < 1
- Note, for all M ≤ 100%, any S > 0 => gain

Simplest possible example

- But M usually > 100%, need higher S
- Some S, M combos that ‘work’:
  - M = 120%, S > 20% => gain
  - M = 200%, S > 50% => gain
  - M = 400%, S > 75% => gain
- IF MDs accept lower baseline, then min S required is lower

Opportunity cost key concept

- Freed up physician time/hospital beds could have alternative uses
  - New patients?
- More generally, reducing low markup services may enable higher markup services or market share growth
  - NOTE: market share is zero sum, BUT 10-15% more Americans will gain coverage*

Many ways to re-structure payments

- Combine FFS, PMPM, and SHARE(Q)
  - could transition to bundle/global cap over time
- Medical "neighborhood" vs. home
- Communities must define who is in, and who is out, of the neighborhood
  - Safety net, patients, employers, etc.,

What Can/Must Communities Do?

Grand Junction, Rochester

Employers > Plans

Partnership With CMS/State

What Do We Need HHS To Do?

- Create Office of Local Collaboration = CMS
- Acknowledge the problem is bigger than CMS; requires data, analysis, technical assistance/collaboration, and *local* drivers
- Explain to Congress why flexibility is so key
- Hire some good "viceroys"