The Presentation Will Review:

• Some challenges that the delivery system and payment policy face
• What is meant by value-based payment
• Pros and cons of different payment approaches
• Patient-centered medical homes – issues and some tentative answers
Hospitalizations by Number of Chronic Conditions

- 0 Chronic Conditions: 4%
- 1 Chronic Condition: 8%
- 2 Chronic Conditions: 12%
- 3 Chronic Conditions: 17%
- 4 Chronic Conditions: 22%
- 5+ Chronic Conditions: 32%

Percent of People with Inpatient Hospital Stays

Number of Chronic Conditions


Annual Prescriptions by Number of Chronic Conditions

- 0 Chronic Conditions: 3.7 annual prescriptions
- 1 Chronic Condition: 10.4 annual prescriptions
- 2 Chronic Conditions: 17.9 annual prescriptions
- 3 Chronic Conditions: 24.1 annual prescriptions
- 4 Chronic Conditions: 33.3 annual prescriptions
- 5 Chronic Conditions: 49.2 annual prescriptions

Average Annual Prescriptions*

Number of Chronic Conditions

*Includes Refills

Utilization of Physician Services by Number of Chronic Conditions

<table>
<thead>
<tr>
<th>Number of Chronic Conditions</th>
<th>Unique Physicians</th>
<th>Physician Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1.3</td>
<td>2.0</td>
</tr>
<tr>
<td>1</td>
<td>4.0</td>
<td>7.8</td>
</tr>
<tr>
<td>2</td>
<td>7.8</td>
<td>11.3</td>
</tr>
<tr>
<td>3</td>
<td>11.3</td>
<td>14.9</td>
</tr>
<tr>
<td>4</td>
<td>14.9</td>
<td>19.5</td>
</tr>
<tr>
<td>5+</td>
<td>19.5</td>
<td>37.1</td>
</tr>
</tbody>
</table>


Medicare Spending Related to Chronic Conditions

<table>
<thead>
<tr>
<th>Percent of Medicare Population</th>
<th>Percent of Medicare Spending</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 Conditions</td>
<td>22.1%</td>
</tr>
<tr>
<td>1 Condition</td>
<td>15.1%</td>
</tr>
<tr>
<td>2 Conditions</td>
<td>16.3%</td>
</tr>
<tr>
<td>3 Conditions</td>
<td>14.8%</td>
</tr>
<tr>
<td>4 Conditions</td>
<td>11.3%</td>
</tr>
<tr>
<td>5+ Conditions</td>
<td>20.3%</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Percent of Medicare Spending</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 Conditions</td>
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<tr>
<td>1 Condition</td>
</tr>
<tr>
<td>2 Conditions</td>
</tr>
<tr>
<td>3 Conditions</td>
</tr>
<tr>
<td>4 Conditions</td>
</tr>
<tr>
<td>5+ Conditions</td>
</tr>
</tbody>
</table>

Projected Total Medicaid Spending Per Enrollee

<table>
<thead>
<tr>
<th></th>
<th>Children</th>
<th>Adults</th>
<th>Disabled</th>
<th>Elderly</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 2001</td>
<td>$1,400</td>
<td>$2,000</td>
<td>$11,200</td>
<td>$16,300</td>
</tr>
<tr>
<td>FY 2006</td>
<td>$2,300</td>
<td>$3,200</td>
<td>$12,300</td>
<td>$17,200</td>
</tr>
</tbody>
</table>

Note: Includes federal and state spending on benefits.

Private Health Insurance Spending on Individuals with Chronic Conditions

<table>
<thead>
<tr>
<th>Number of Chronic Conditions</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 Chronic Conditions</td>
<td>13%</td>
</tr>
<tr>
<td>1 Chronic Condition</td>
<td>14%</td>
</tr>
<tr>
<td>2 Chronic Conditions</td>
<td>15%</td>
</tr>
<tr>
<td>3 Chronic Conditions</td>
<td>14%</td>
</tr>
<tr>
<td>4 Chronic Conditions</td>
<td>13%</td>
</tr>
<tr>
<td>5+ Chronic Conditions</td>
<td>31%</td>
</tr>
</tbody>
</table>

“The Tyranny of the Urgent”

“Amidst the press of acutely ill patients, it is difficult for even the most motivated and elegantly trained providers to assure that patients receive the systematic assessments, preventive interventions, education, psychosocial support, and follow-up that they need.” (Wagner et al. Milbank Quarterly 1996:74:511.)

The Pressure of the 15 Minute Office Visit

“Across the globe doctors are miserable because they feel like hamsters on a treadmill. They must run faster just to stand still…The result of the wheel going faster is not only a reduction in the quality of care but also a reduction in professional satisfaction and an increase in burnout among physicians.” (Morrison and Smith, BMJ 2000; 321:1541)
How Patients are Affected

Asking patients to repeat back what the physician told them, half get it wrong. (Schillinger et al. Arch Intern Med 2003;163:83)

Patients making an initial statement of their problem were interrupted by the PCP after an average of 23 seconds. In 23% of visits the physician did not ask the patient for her/his concerns at all. (Marvel et al. JAMA 1999; 281:283)

Incidents in the Past 12 Months

Among persons with serious chronic conditions, how often has the following happened in the past 12 months? (Harris, Survey 2000)

<table>
<thead>
<tr>
<th>Event</th>
<th>Sometimes or often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Been told about a possibly harmful drug interaction</td>
<td>54%</td>
</tr>
<tr>
<td>2. Sent for duplicate tests or procedures</td>
<td>54%</td>
</tr>
<tr>
<td>3. Received different diagnoses from different clinicians</td>
<td>52%</td>
</tr>
<tr>
<td>4. Received contradictory medical information</td>
<td>45%</td>
</tr>
</tbody>
</table>
The Issue of Readmissions

In Medicare, about 11% of patients are readmitted within 15 days and almost 20% within 30 days

50% of patients hospitalized with CHF are readmitted within 90 days

The majority of readmissions are potentially preventable – declining with time from index admission

Half of those discharged to community and readmitted within 30 days after medical DRG had no interval bill for physician services

What do We Mean By Value?

In policy parlance, Value = Quality/Costs and is used to mean getting a “bigger bang for the buck”

But there is no quantitative precision to the value equation

Is value increased when quality increases at a higher cost? There is no way to know
The Quality Numerator

Quality is measured differently for each measure, e.g., % compliance with a standard, mortality rate for a condition – there is no common metric, like quality-adjusted life years (QALYS), as used in cost-effectiveness research?

We have very good quality metrics in some areas with more coming every day. In other important areas, we have few measures, e.g. diagnostic errors, appropriateness of procedures.

The Cost Denominator

Costs are usually measured as dollars spent but can also represent the rate of increase in dollars spent.

But even with something as seemingly straightforward as dollars spent, there are disagreements on how to measure and report costs (which go beyond the usual error of mistaking charges or payments for costs).
Geographic Variation in Spending

Dartmouth research and the Dartmouth Atlas represent seminal work exploring spending variations in Medicare and demonstrating large cost variations with little or no differences in quality or patient experience. The variations prompted a Congressional food fight over whether to vary Medicare payments based on location using per capita cost variations – in general, rural vs. urban, Midwest and Northwest against East and South.

But It is More Complicated

The Atlas (as opposed to some Dartmouth research) fails to routinely adjust for patient health status, input price variations that are recognized in Medicare payments, and special payments such as GME and DSH. Need to adjust for Socio-economic status? Dartmouth also suggested Medicare spending variations were the same as non-Medicare variations. Missed the influence of prices on spending. So utilization varies as Dartmouth Atlas has found but not necessarily spending.
**Berenson Conclusion About a Value Index**

We are still far from quantitative measurement of value, particularly of health professionals, despite the value-index modifier inclusion in the ACA.

At the same time we can and should measure performance but be more humble in what we think we are measuring.

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**So There is Disagreement Over the Role of Measurement in Value-based Payment**

For some, value-based payment means literally measuring quality and costs and somehow rewarding the higher measured value.

For others, it means adopting payment methods that have a higher demonstrated relationship to desired outcomes of care (quality, cost, and patient experience) than does pure FFS.
The ACA Does It All – and Then Some

And in fact, those who emphasize measurement as the core of determine value for payment also want to use incentives, while the latter see an important role for measurement.

There is a difference in emphasis (as I will point out).

“There are many mechanisms for paying physicians, some are good and some are bad. The three worst are fee for service, capitation and salary.”

-- Robinson, Milbank Q, 2001
### Distinguishing Between Payment to Groups and Payment to Physicians Within Groups

Within physician organizations, 1/4 paid FFS, 1/4 paid by either capitation or pure salary, 1/2 on blends of retrospective and prospective methods

- Robinson, Shortell, et al. HSR, Oct, 2004

“Salary with productivity incentives” usually means measures of productivity as defined by FFS payment parameters, either actual billings or RVUs generated -- this approach may be counterproductive (pun intended)

### The Basic Problem with Current FFS Payment to Clinicians

- The Resource Based Relative Value Scale (RBRVS)-based fee schedule has limitations
- The relative values of 7000+ codes approximate resource costs, and not based on services beneficiaries need
- What attempts to be an objective process is, despite good intentions, inherently subjective
- MedPAC is calling for actual data to inform the CMS-RUC process, e.g., to determine actual time, not estimates, for work values and obtaining real data on practice expenses
FFS for Primary Care Has Been Rooted in Face-to-Face Encounters

There are plenty of reasons, e.g.,

– high transaction costs, associated with non-face-to-face, frequent, low dollar transactions;
– major program integrity concerns
– “moral hazard” driving expenditures

Yet, increasingly, face-to-face visits do not encompass the work of primary/principal care for patients with chronic conditions (most Medicare beneficiaries and the duals)

FFS Attributes

Advantages

– Rewards activity, industriousness
– Theoretically can target to encourage desired behavior
– Implicitly does case-mix adjustment
– Commonly used by payers and physicians

Disadvantages

– Can produce too much activity, physician-induced demand
– Maintains fragmented care provided in silos
– High administrative and transaction costs
– What is not defined as reimbursable is marginalized
– Complexity makes it susceptible to gaming and to fraud
PPPM (Comprehensive or Global Payment)

Advantages
- Internalizes allocation of activity and costs to meet needs
- Direct incentive to restrain spending
- Predictable and capped spending
- Administratively simple (until address some of the problems)
- Low transaction costs

Disadvantages
- May lead to stinting on care
- Susceptible to cream-skimming
- Incentive to cost shift to services outside the PPPM
- Can’t specifically promote desired activity
- May resist innovation/new services

Episode/Condition/Bundle/Case

Advantages
- Internalizes incentives for efficiency within the episode
- Potentially aligns incentives across siloed providers
- Arguably, is an intermediate step on the way to real integration

Disadvantages
- Does not fundamentally alter incentive to generate units of service
- Be careful about what you wish for, e.g. physician-hospital alignment without determination of appropriateness in a FFS environment
- Currently, political challenges in bundling among providers
- Technically challenging (esp. for ambulatory care) – vagaries of diagnosis (more episodes in Miami than Minnesota), bias to performance of a procedure in a case rate, sorting out where particular claims are assigned to
What is an Episode of a Chronic Disease, Such as Diabetes, CHF?

Maybe an oxymoron. Would patients with 5 or more chronic conditions have 5 or more 365-day payment episodes? With payments to different clinicians/providers?

To maintain any reasonably holistic approach to the patients with multiple chronic conditions, would need episodes of conditions that often cluster together, e.g. diabetes, hypertension, and renal failure

But then why not go right to population-based payment, i.e., PPPM?

Public Reporting and Pay-for-Performance (P4P)

Advantages

- provides a hybrid payment to mitigate disadvantages of pure models; some natural blends – PPPM and under-service measures
- *can start to actually reward desired performance, instead of rewarding volume of services produced*
- *can include measures of patient experience, which have been generally ignored in considerations of reformed payment approaches*

Disadvantages

- underdeveloped measure set – especially for physicians
- what gets measured gets done?
- marginal incentives may be insufficient to counter basic incentives in whatever base model it is superimposed over
- contributes more administrative complexity
Examples of Blended or Hybrid Payment Models

- PPPM with FFS carve outs or “bill aboves” and public reporting on underuse measures
- For PCMH, FFS for visits (possibly “discounted”), PPPM for medical home activities and P4P for patient experience
- Shared savings for ACOs
- Partial capitation – FFS/PPPM and/or risk corridors and/or particular sector (professional services, but not institutional)
- Any of the above with public reporting and/or pay-for-performance
  - quality measures where they exist, expenditure or utilization targets, patient experience measures

Patient-Centered Medical Homes
**Problems For Which Medical Home is Offered as a Solution**

Recognized deficiencies in “patient-centered” aspects of care, e.g. respect for patient values and preferences, access, availability, coordination, emotional support, etc. – most related to competing claims on physician time

The growing challenge of chronic care

Relatively poor primary care compensation and the difficulties in relying on FFS to support primary care activities

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**The Evolution of the PCMH Concept – The Confluence of Four Streams**

“Medical homes” in pediatrics – 40 year Hx, oriented to mainstream care for special needs children especially needing care coordination

The evolution of primary care deriving from WHO meeting in Alma Alta in 1978 – as summarized by Starfield, core attributes: first contact care, longitudinal responsibility for patients, coordination of care across conditions, providers and settings, comprehensive care
Evolution (cont.)

“Primary care case management” in commercial HMOs and a few Medicaid programs – with some success in latter and (probably in former despite disrepute)

Practice redesign focused around EHRs and, somewhat separately, around the Wagner Chronic Care Model (which includes use of EHRs)

“A 2020 Vision of Patient-Centered Primary Care”


An excellent synthesis of these four streams into a comprehensive and plausible set of attributes and expectations – although as discussed below not necessarily achievable in all practice situations
### Core Principles Agreed to by the Four Primary Care Societies in 2007

- Personal physician
- Physician directed medical practice
- Whole person orientation
- Care is coordinated and/or integrated
- Quality and safety
- Enhanced access
- Supportive payment

### Gaps in FFS Payments and the Patient-Centered Medical Home

Current payment policies do not support the activities that comprise the Wagner Chronic Care Model: non-physician care, team conferences, coordinating care, community resources, patient registries, evidence-based practice guidelines, EMR

So there are various payment approaches that attempt to support additional activities outside of the office visit
Five Specific Payment Options for the PCMH (not mutually exclusive)

Enhanced FFS payments for office visits
Reimburse for new CPT services
Regular FFS for office visits and small PPPM for medical home activities
Reduced FFS for office visits and larger PPPM for medical home activities
Comprehensive payment for medical services and medical home activities
Can also provide startup/seed money for developing MH capacity

Challenges to Adoption of the Patient-Centered Medical Home

Lack of agreement on operational definition and emphases – too much on infrastructure and not enough on patient-centered aspects
Practice size and scope – still dominance of solo and small groups – arguably without ability, even with new resources, to adopt many elements of PCMH. Should we have same expectations and same models for differently situated practices?
Challenges (cont.)

Shortage of primary care physician workforce combined with more demand for services when insurance coverage is expanded

Medical practice culture and structure – the “tyranny of the urgent” has not disappeared

To whom should the PCMH apply? All patients or those with special needs, e.g., in Medicare, those with multiple chronic conditions

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Challenges (cont.)

Should principal care physician practices, e.g. endocrinologists for diabetics, qualify?

Is there any kind of patient “lock-in” – or even a commitment to use the practice?

Implementation challenges – even in large groups with an interest, many elements not adopted so far – but there have been no payment incentives to do so
Challenges (cont.)

Unfettered expectations – every one has a favorite attribute to hang on the PCMH – care coordination, population health, shared decision-making, cultural competence, reducing disparities, detection of depression – or alcoholism – or cognitive deficits. The list goes on.

Early Experience with PCMH Initiatives

A remarkable amount of enthusiasm (and some hype)
Impressive anecdotal successes
Evidence-based success in integrated delivery systems – e.g., Geisinger and Group Health Cooperative, Puget Sound
TransforMed work with individual practices much emphasizes difficulties for small practices
PCMH and ACOs

Many have argued that an ACO is an amalgamation of medical homes into a medical neighborhood

But early findings may suggest that the ACO is needed for the success of the medical home

A Final Cautionary Note

“Primary care could also expand beyond its more restrictive role as provider of medical care… The danger, of course, is that primary care’s new role will be even more expansive and varied than today’s already diverse activities. A redefinition of primary care must be cognizant of this risk, focus on optimizing primary care’s strengths, and avoid assuming too many peripheral responsibilities in its formulation.” (Moore and Showstack, Ann Inter Med, 2003;138:244)