



H A R V A R D | B U S I N E S S | S C H O O L

Paying for Health Care

VBHC Intensive Seminar
Harvard Business School
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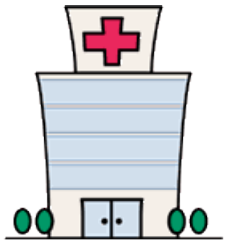
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Bundles for Acute & Chronic Conditions

Designing payment around integrated care models

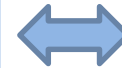
6 Key Design Elements

Provider



1. Define the medical condition and cycle of care
2. Assign the accountable entity
3. Define the patient population
4. Agree on outcomes benchmark
5. Define and manage risk
6. Determine the price

Payer



CMS Radiation Oncology Model

Strengths

- **Prospective** pricing
- **Site neutrality** – rates irrespective of location (hospital, outpatient, free standing centers)
- **Required** participation in selected geographic areas (like CJR)
- National base rates plus adjustments that include:
 - Geographic factors
 - Patient risk factors/case mix
 - Trend factors
- Quality considerations
 - Small number of factors like CAHPS
 - Impacts pricing

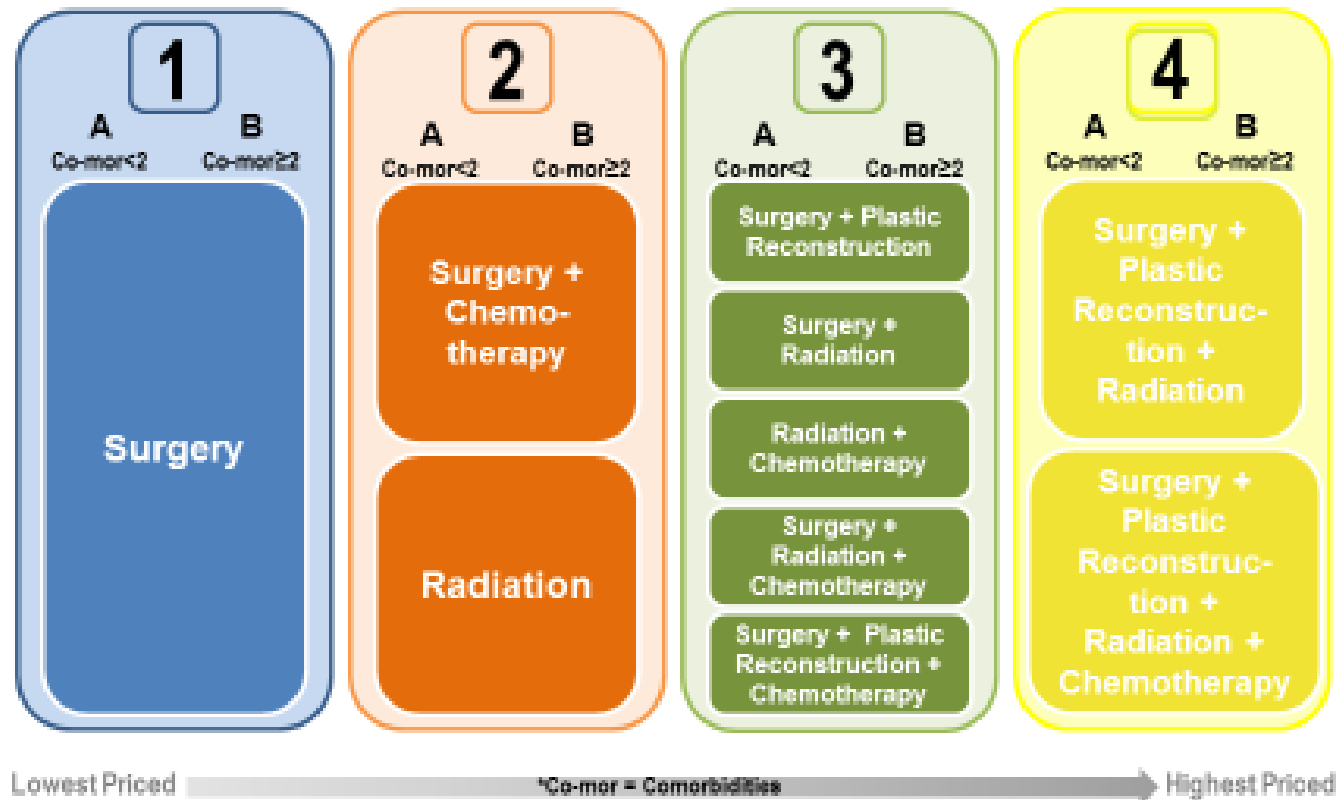
Weaknesses

- Discount factor of 4-5% off top of Medicare FFS equivalent
- Not Condition based
 - Lumps together 17 types of cancer (breast, head & neck, prostate, liver, etc.)
 - Not full care cycle for each cancer, only 90 days
 - Splits professional and technical components
- No outcome accountability
- Pricing is still somewhat tied to providers historical cost basis

The Importance of Risk-Adjustment

Addressing the concerns of cherry-picking

MD Anderson Head & Neck Treatment Bundles



8 separate bundles that risk-adjust for patient complexity

Appropriate Care is Critical for Value

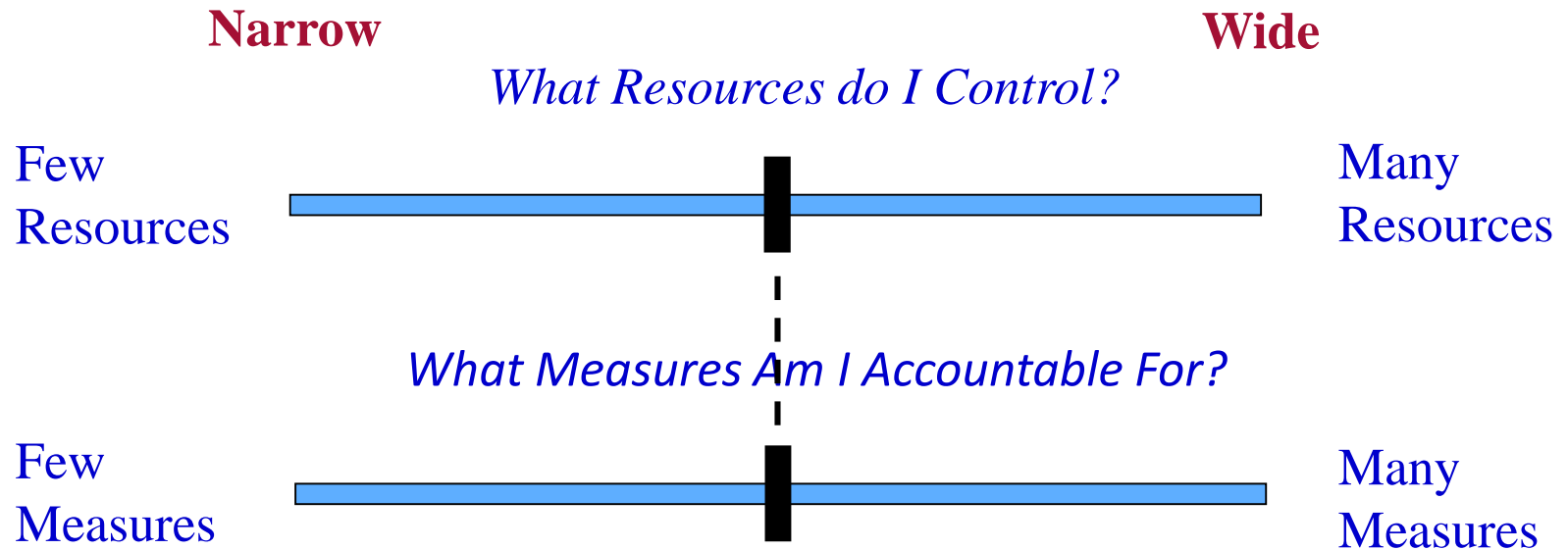
Not “fee-for-service on steroids”

There are three requirements that are necessary & sufficient for addressing appropriate use:

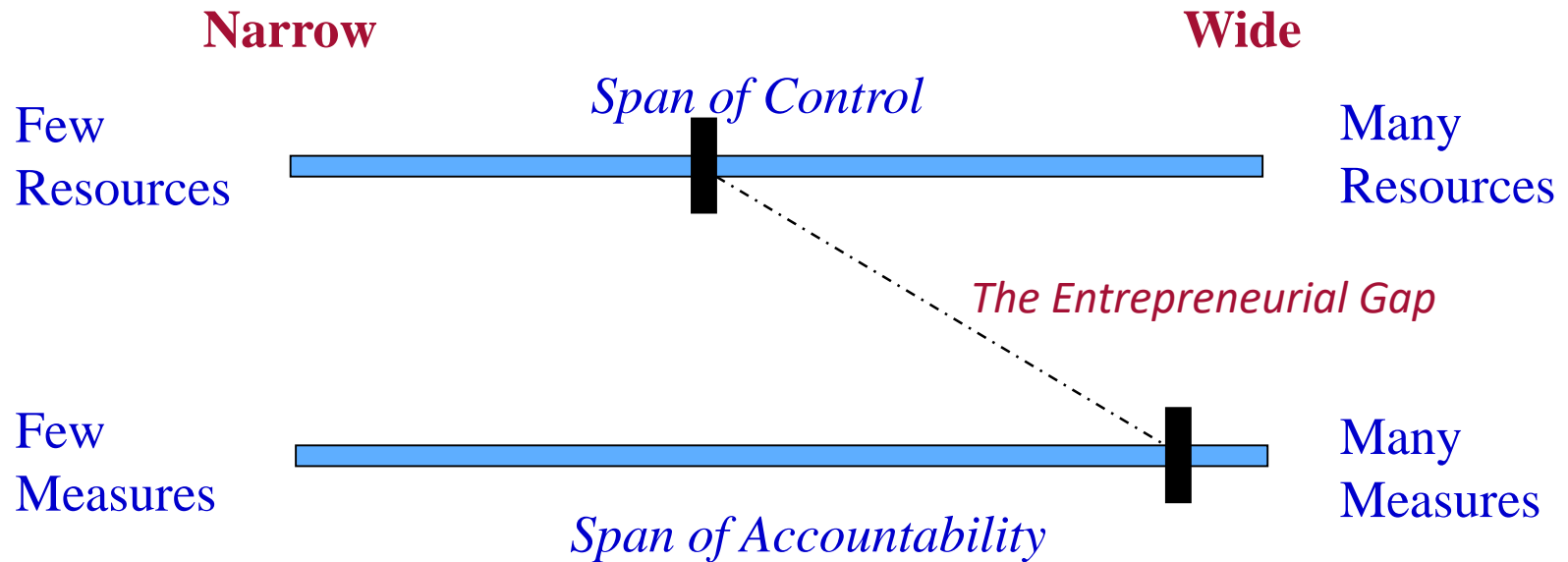
1. **Broadening definitions** for bundled payment to encompass the decision and outcomes of alternative treatment paths
2. Utilizing **evidence-based guidelines** for Appropriate Use Criteria (AUC)
3. **Accountability** for outcomes and costs (baseline and result)



Management Control 101, The Controllability Principle: How can I be responsible for care beyond the OR?



Bundled Payments will Stimulate Innovative, Entrepreneurial Behavior



*Entrepreneurs pursue opportunities — internally and externally
—without regard to the resources they currently control*

*Stevenson and Jarillo,
Harvard Business School
definition of Entrepreneurs*

Proper Accountability Sparks Care Integration

Looking Up- and Down-Stream

- Physicians are **accountable for outcomes** even when they **do not control** other clinicians

Rotator Cuff Tear Bundle

Fosters collaboration among involved providers and drives integrated care



Splitting Up the Check

Bundled Payment



Episode of Care (Pregnancy)

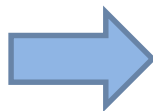
Typical Roles

- | | | | |
|------------|-----------------|------------------|---------------------|
| • OB/GYN | • Radiology | • OB/GYN | • Lactation Support |
| • Midwives | • Testing | • Surgical Techs | • Behavioral Health |
| • RN | • Social Worker | • RN | • PCP |
| • Staff | | | • Pediatrician |

Traditionally

Who does what?

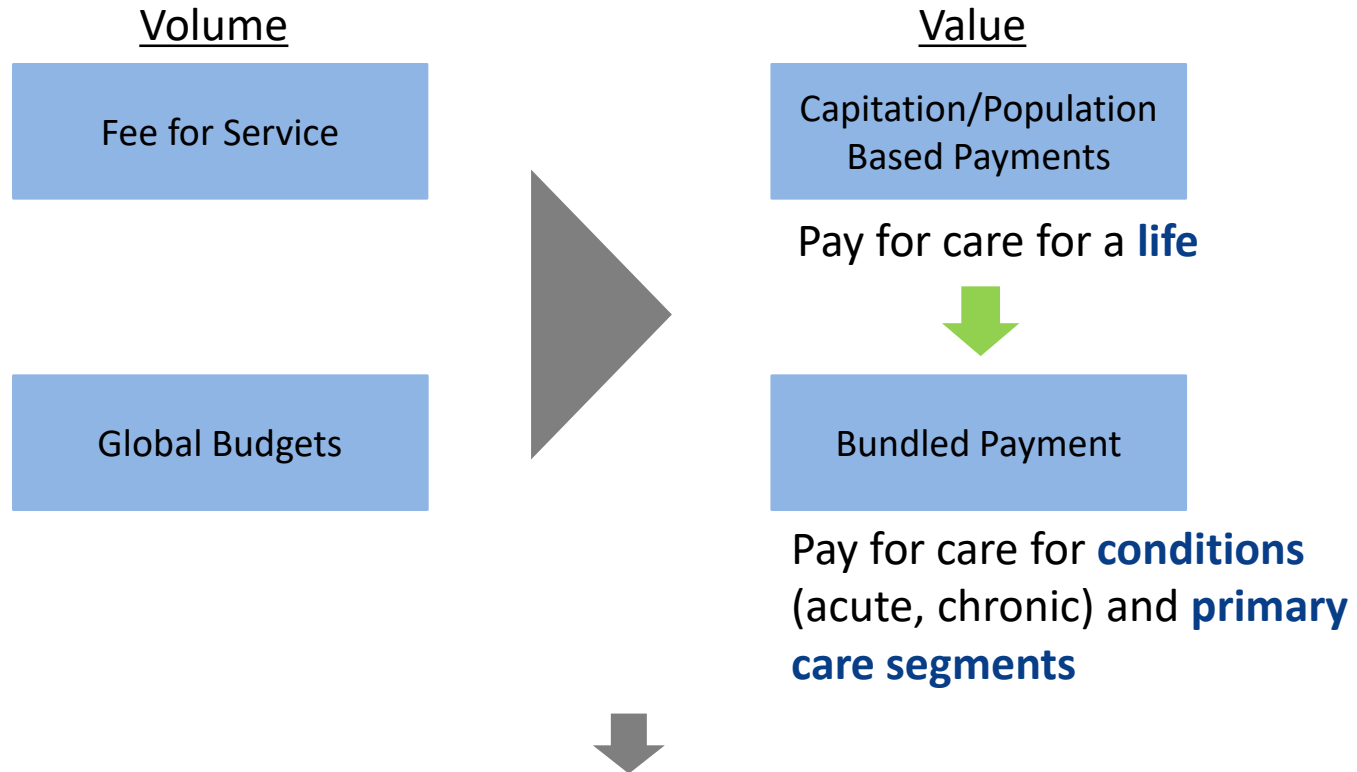
Typically based on volume of services



Theory of Value Creation

- I. Direct Patient Care (volume, outcome)
- II. Indirect value to System (oversight, managing team, training, process improvement)

Move to Value-Based Payment Models



- Both approaches create positive incentives for **reducing costs** and **separating payment** from performing particular services
- Capitation at the hospital or system level can **coexist** with bundle payment at the condition level

Accountable Care Organizations (ACOs)

Strengths:

- Easier to implement when ACO does not require change to underlying delivery network
- Strength in numbers (share risk and responsibilities across the provider network)
- Straight forward communication and coordination with specialists in the ACO
- Incentive to limit total cost of care
- Better aligned with primary care-led models

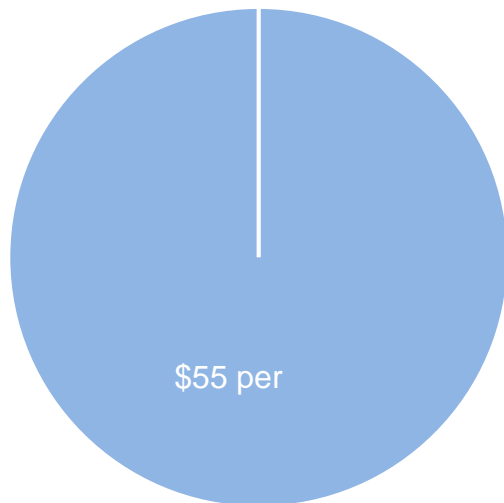
Weaknesses:

- Payment made at top down ACO level often little connection to clinical teams/decision-makers
 - Poor specialist engagement and incentives
- Incentive for internal referrals to protect against leakage
 - Evidence suggests it is hard to be good at everything
- Complex, inaccurate and non-transparent risk-adjustment when constructed around broad based population model
- Incentive to withhold care
- Destroys patient choice

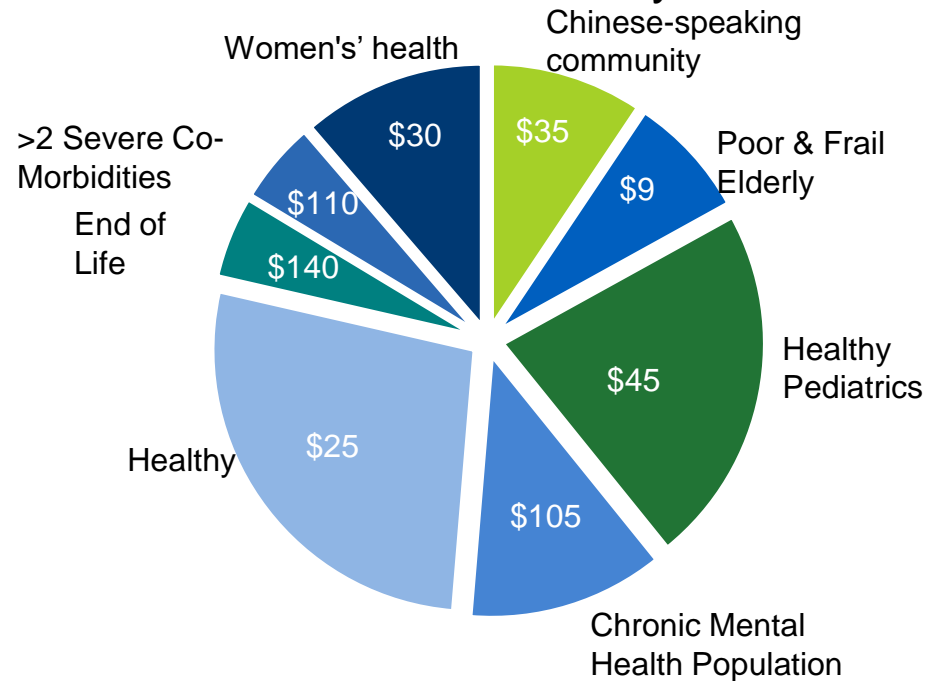
Primary Care Bundles

Segmentation around patient needs

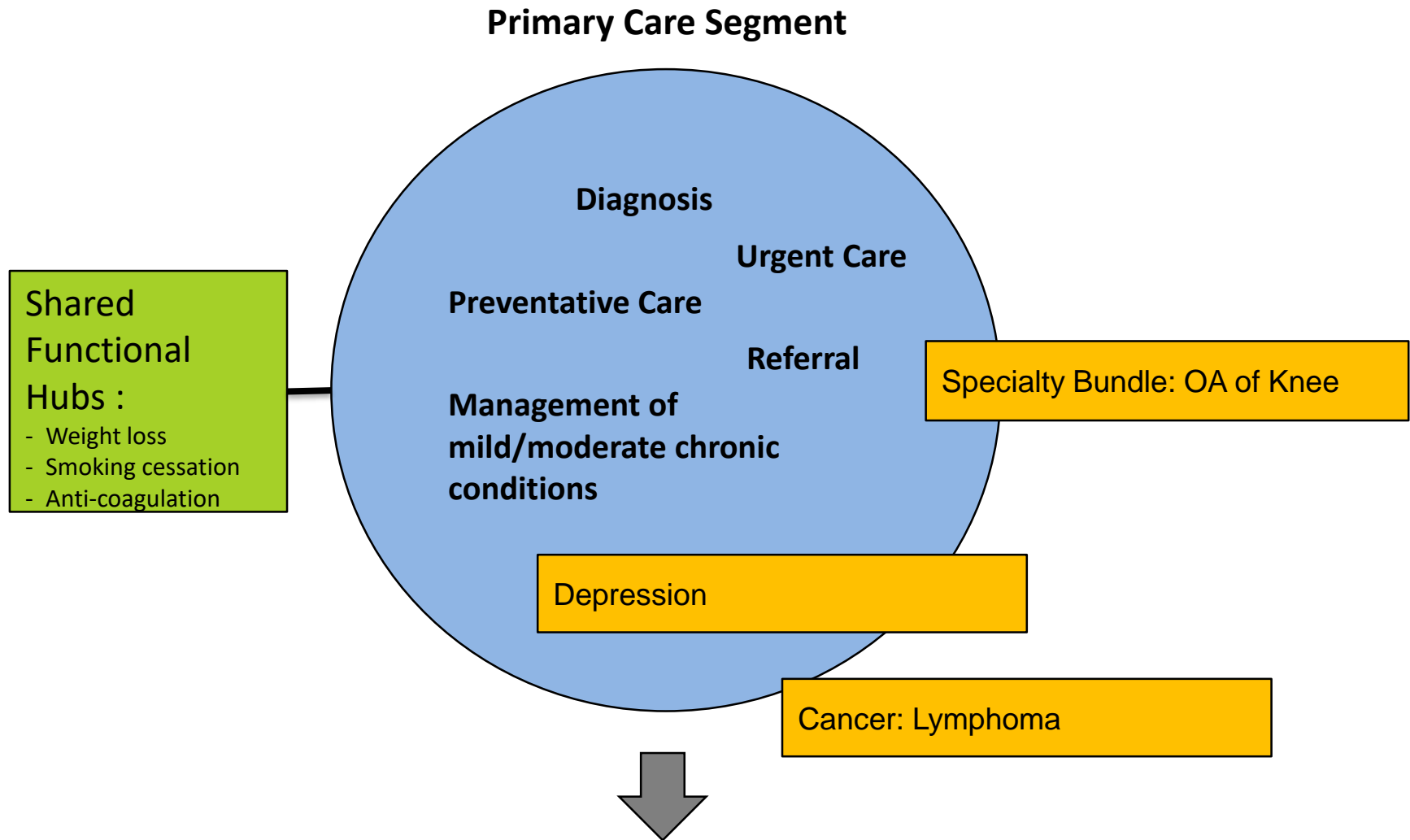
Global Capitation



Bundles for Primary Care



Overlap between Primary and Specialty Care Bundles



PCP shares in responsibility for cost, outcomes and can participate in 2 sided risk for specialty bundles

Adoption of Bundled Payments



JPMORGAN CHASE & CO.



MINISTRY OF HEALTH AND LONG-TERM CARE

Bundle Payment Takeaways

1. Bundle **design requires clinician input**
1. Value Creation (i.e. meaningful clinical and patient decisions) can only be made at the **condition level**
2. **Transitional considerations** are important for making this change (i.e. retrospective to prospective, upside only to two-sided risk, etc.)
3. **Market based competition** and **patient incentives** are needed to reward high-value providers
4. It is not value-based payment if it is not related to **outcomes**

“Medicare for All”

Health Care for All

- We believe this is the right answer (similar to Education for All)
- More efficient
- Strong consensus globally on this issue



National Health Insurance

100% Government
run National Health
Plan

Public-Private
Partnership

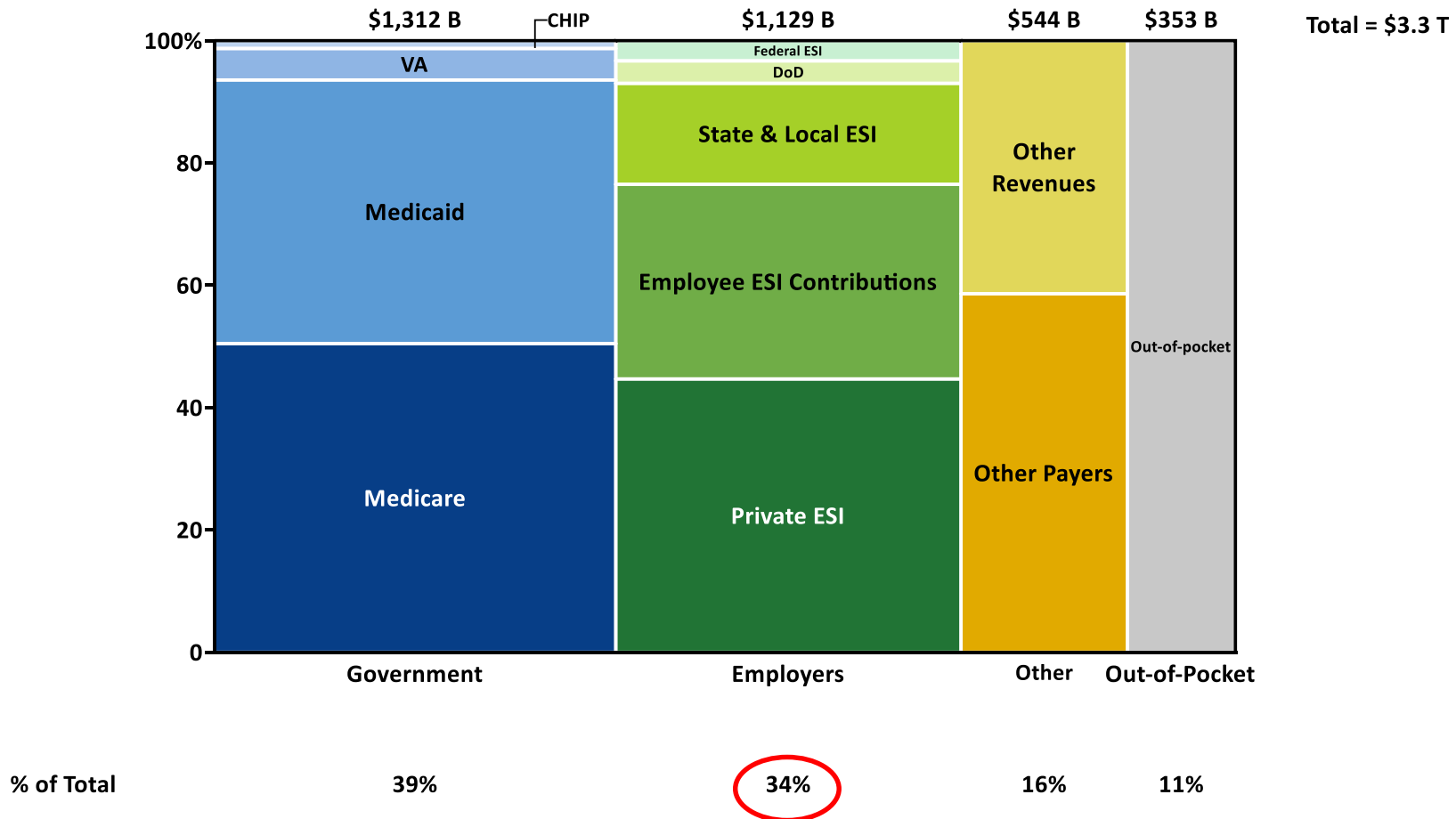
Public
Programs

Employer



Employer Sponsored Insurance represents over one-third of the U.S. Healthcare Market

2016 U.S. Health Care Expenditures



Source: HBS Analysis, based on CMS National Health Expenditure (NHE) historical data, 2016

Costs to Employers of Poor Health

- Absenteeism

- Cost of wage of replacement worker
- Administrative cost of managing absent worker & finding coverage
- Morale of overworked employees who have to “make up for those absent”
- Quality impact of replacement / temporary staff



Can be **>2x** out-of-pocket costs

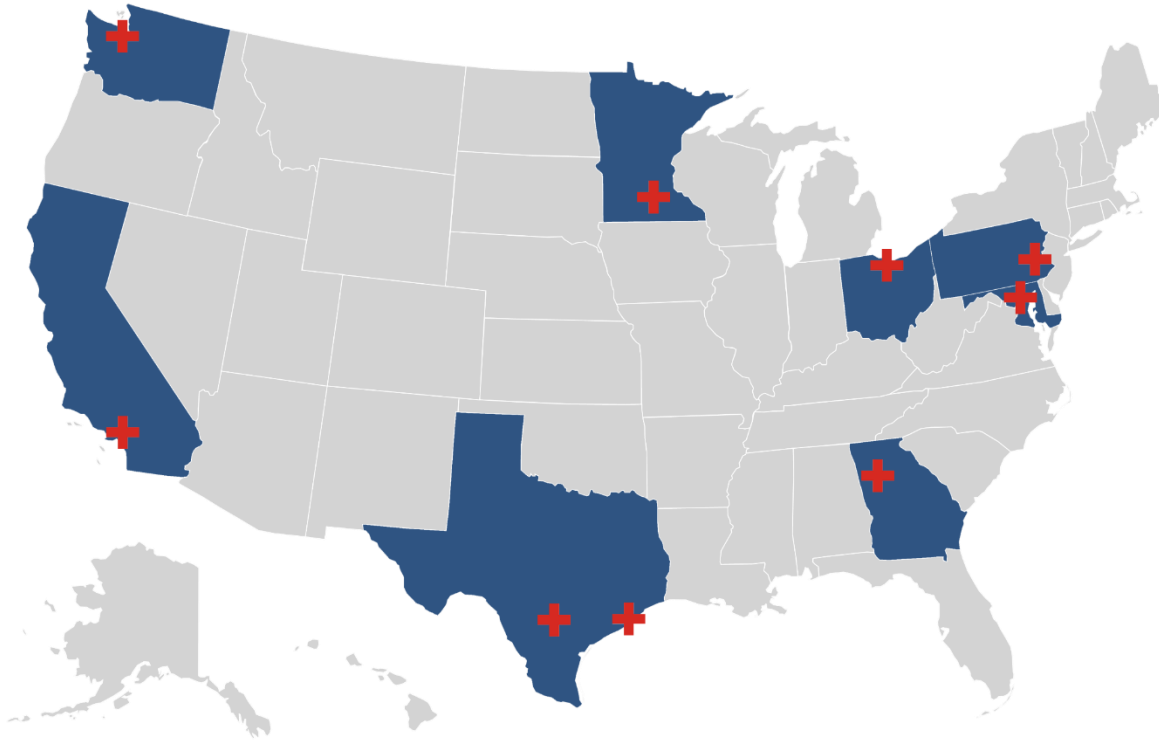
- Presenteeism

- Lack of productivity
- Decreased quality

Why Employers Should be Leading the Country in Value-Based Health Care

- Employers are a big share of the market and **hold tremendous leverage** on the health care system
 - Innovation does not require new legislation or working through the political system
- Better health and wellness for employees is a **strategic issue for U.S. businesses**
 - Direct health care spend is huge financial burden
 - Poor health is even more costly
 - Wellbeing of the workforce is a key opportunity to drive better performance
- Employer interests are **more closely aligned with patient interests**
 - Employers need healthy, high performing employees
 - Employers bear the costs of chronic health problems and poor quality care
 - The cost of poor health is 2 to 7 times more than the cost of health benefits
- Employers are **uniquely positioned** to improve employee health
 - Daily interactions with employees
 - Onsite or near site opportunity to engage employees with close and convenient access
 - Group culture of wellness

Walmart Centers of Excellence Programs



Partnerships:

Cleveland Clinic (OH)

Geisinger (PA)

Kaiser Permanente (CA)

Johns Hopkins (MD)

Mayo Clinic (MN)

Memorial Hermann (TX)

Northeast Baptist (TX)

Virginia Mason (WA)

Emory (GA)

Conditions:

- Cardiac
- Cancer
- Joint replacement
- Spine
- Transplant
- Weight loss

Source: compiled from news.Walmart.com and through publically available news and press releases

Transforming Health Systems: Washington State

Employer Role:

- Select providers based on value
- Pay with bundled contracts
- Utilize value based benefit design
- Extend mental health coverage
- Build culture of health & wellness at workplace

Employers:



Alliance Role:

- Adopt accepted outcome standards
- Conduct external outcome measurement evaluation & reporting
- Convene all stakeholders

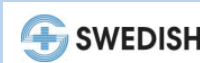
Alliance Organizations:



Health



Providers:



Health Plan Role:

- Support and require outcomes measurement from providers
- Create & standardize bundled payment contracts with market price
- Enable competitively-priced claims processing and IT / analytics

Provider Role:

- Provide integrated care for conditions or primary care populations in which they have expertise
- Care in the right location with systems integration
- Measure outcomes & costs

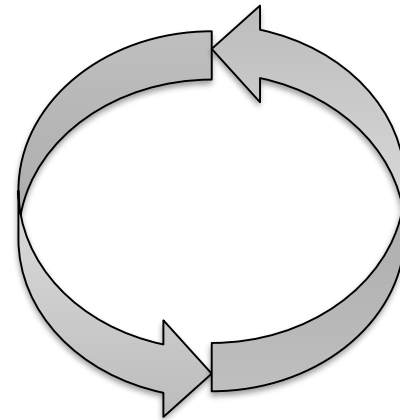
Employers need to get their act together...

Key Steps Needed by Employers

- Understand employee health as a **leadership & strategic** issue (CEO)
 - Shift from **reliance** on health plans to **owing this issue**
 - **Contract directly** for condition based and primary care
 - Contract for **integrated care** not discrete services
 - Demand **transparency** on outcomes and prices to support choice and low administrative transaction fees
 - Engage employees in their own health
 - **Stop shifting costs** to employees
 - Invest in education and **transparency** for employees to understand their needs
 - Make health care **convenient** and accessible equally for physical and mental health
 - Provide **incentives** to employees for seeking out high value care
 - Provide for **health plan continuity** for employees, rather than plan churning
 - Collaborate with **other employers** to accelerate system transformation
- 
- Shift from incremental cost reduction to **value creation**

Why Public & Private Partnership?

- **Public Sector Critical**
 - Non-employed portion of the population
 - Large single entity helps set direction of the market
- **Employer can offer strengths**
 - Closer alignment
 - More timely
 - Innovative
 - Less political instability
 - Less political baggage
- **Learn from each other**
 - Test & Innovate
 - Implement



Public – Private Partnership on Bundles

Medicare has **led the way** on bundled payments

- Straightforward design to maximize adoptability
- National payer gets attention of providers
- Drives adoption and **scale**

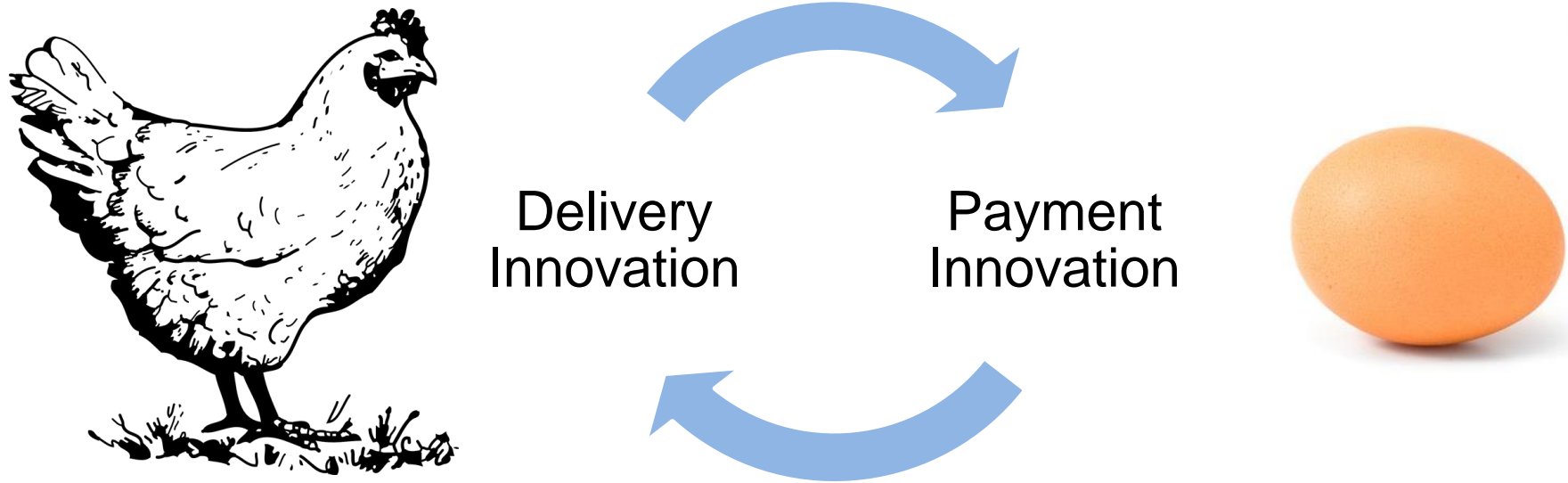


Employer led bundles have brought further innovation

- Robust design with broader definitions & prospective payments (Walmart, GE)
- Transparent regional pricing and outcome standards (WA State HCA)
- Medical device and Pharmaceuticals entering into value based arrangements

Universal access to high value care will require employers to take charge and not rely on government payers alone

Multi-stakeholder effort is critical



You can't just go home and work on improving processes, measuring outcomes, and cutting cost without working on changing the way you get paid. You also can't go back and try to do bundle payments without improving and aligning your care model.

It is joint effort between legislation, clinicians, hospital administrators, payers and patients.

Project Overview



Project Description

Implement comparable outcome and cost measurement sets in select conditions at leading providers throughout the U.S. and create risk adjusted benchmarks to generate systems improvement and reward high value providers.

Conditions

- 3 Surgical Conditions
 - Colon Cancer
 - Breast Cancer
 - Morbid Obesity
- Full cycle of care (including key surgical, medical, behavioral and social elements of care)

Sites

- 10-15 Sites per condition
- Leading Centers of Excellence across the U.S.

Measurement

- Measure outcomes and cost at the condition level
- Create playbook for implementation
- Develop scalable approach for risk adjusted benchmarking and systems improvement
- Inform value-based payments



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*Inspiring Quality:
Highest Standards, Better Outcomes*



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Competitiveness

THRIVE Initiative



Provider Sites



Payers

Patient Involvement &

Public & Private

Patient Outcomes

Medical & Clinical Leadership



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Management Direction



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Alignment critical for shifting health care from **SURVIVE** → **THRIVE**

Thank you