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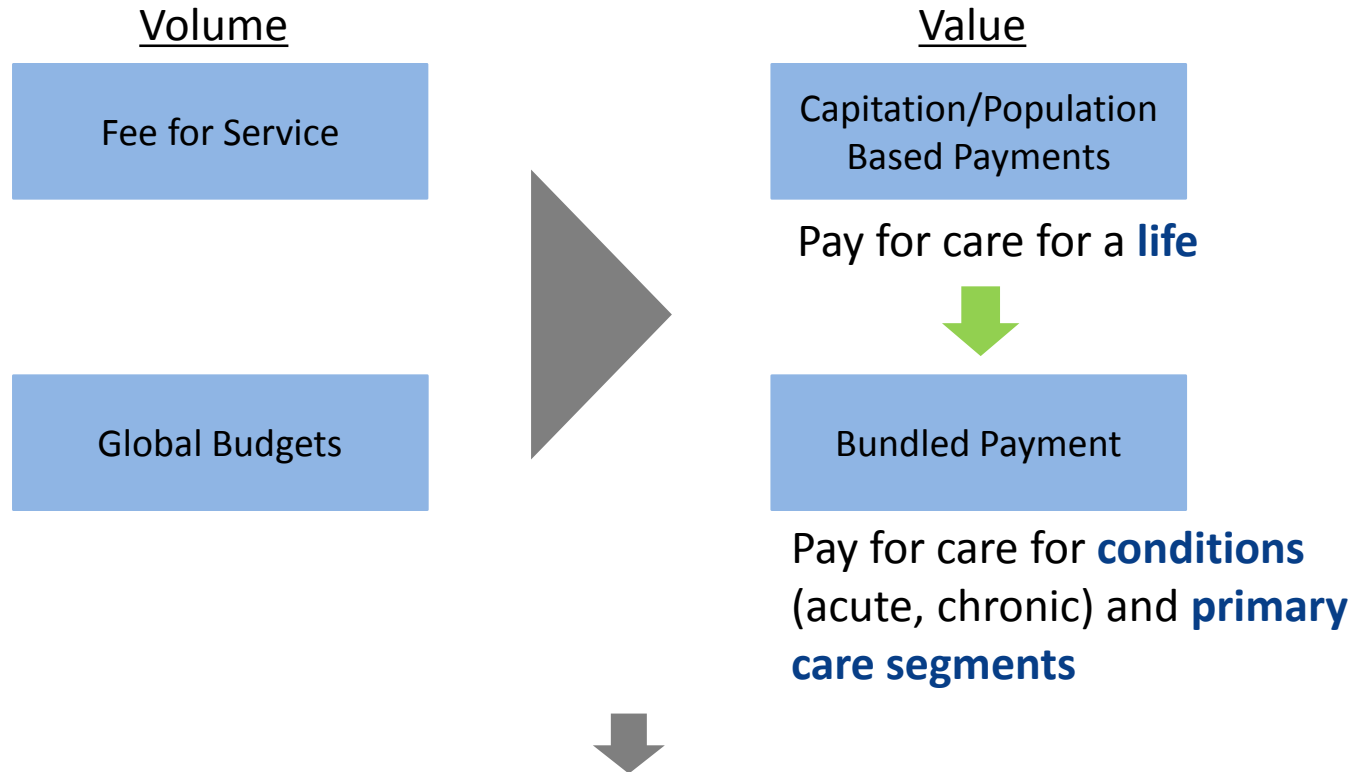
H A R V A R D | B U S I N E S S | S C H O O L

Paying for Health Care

Intensive Seminar
Harvard Business School
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Move to Value-Based Payment Models

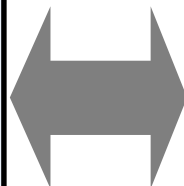


- Both approaches create positive incentives for **reducing costs** and **separating payment** from performing particular services
- Capitation at the hospital or system level can **coexist** with bundle payment at the condition level

Value-Based “Capitated” Payment Models

ACO Capitation

- A single risk-adjusted payment for the overall care for a **life**
- Responsible for **all needed care** in the broad covered population
 - Leads to focus on **generic high cost areas** across the population
 - Avoid “leakage”
- Accountable for **population level quality metrics**
 - Accurate **risk adjustment** is **highly challenging**
- Providers take **disease incidence risk**, not just execution/outlier risk
- Primary Care Physician led independent ACOs have better results

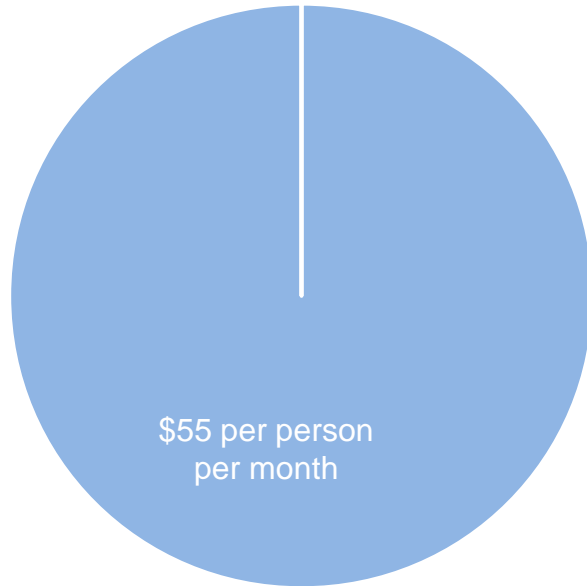


Bundled Payment

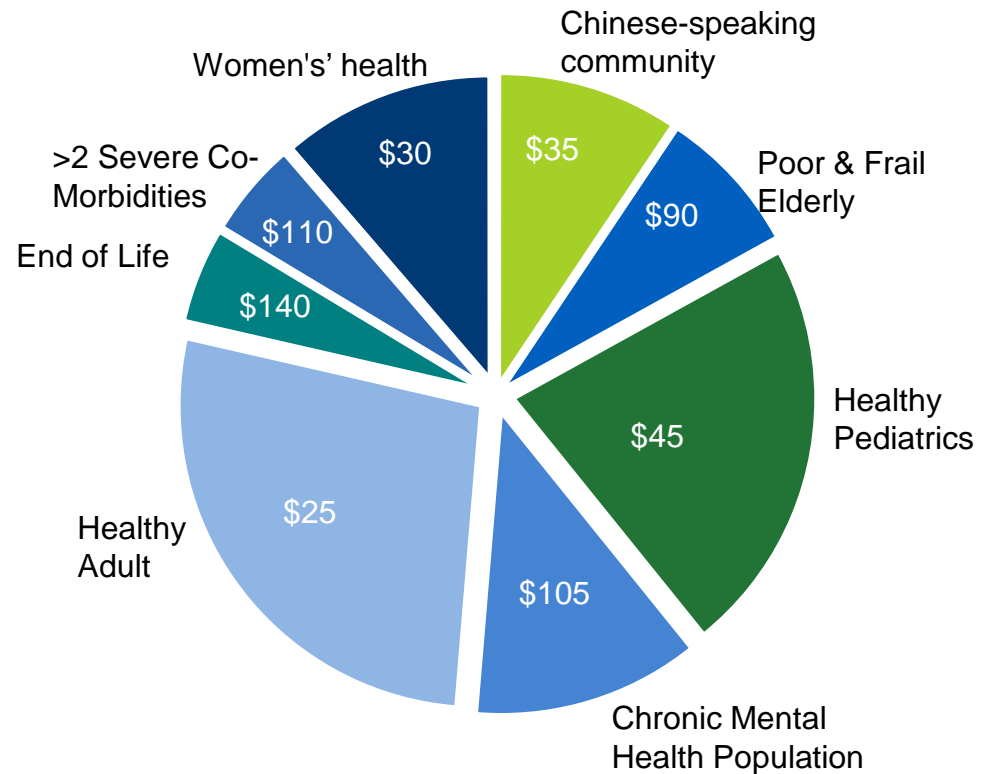
- A single risk adjusted payment for the overall care for a **condition or specific patient population**
- Covers the **full set** of services needed **over an acute care cycle**, or a **defined time period** for chronic care or primary care
- Contingent on **condition-specific outcomes patient by patient**
 - Including responsibility for avoidable **complications**
- At risk **for the execution** on the bundle of care
- Primary Care Bundle for a population segment

Primary Care: Capitation versus Bundled Payment

Global Capitation



Bundles for Primary Care

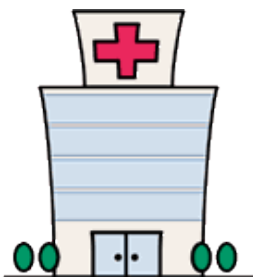


- Segmenting patients by primary and chronic care condition encourages multi-disciplinary practice groups to form and deliver better, more integrated and comprehensive care for that condition/sub-population.
- By measuring costs and outcomes for patients within each segment, we can offer a bundled, outcome-contingent, and risk-adjusted payment appropriate for that condition/sub-population.

Setting the Design of the Bundled Payment

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. Set condition-specific outcomes
5. Define and manage risk
6. Determine the price

Payer



Transparency



- Almost **all** hospitals could tell you their **parking prices**, but almost **none** could provide the **cost of a health care service**
- Even when available, **prices** are **worthless** if they are **unintelligible**
 - “HC PTC CLOS PAT DUCT ART” for \$42,596
 - “2-D ECHO TTE COMP NO CONTRST” for \$2,283
- **Outcomes measures** are also often **incomprehensible** to patients
 - There are currently 27 AHRQ Patient Safety Indicators including:
 - Decubitus ulcer; Iatrogenic pneumothorax



Informed consent – cannot happen without outcomes and cost impact to the patient

- Barriers: health plans hold this information hostage, providers refuse to measure outcomes, PCP who refer based on their friends

Adoption of Bundled Payments



JPMORGAN CHASE & CO.



Moving to Bundled Pricing

Common Concerns

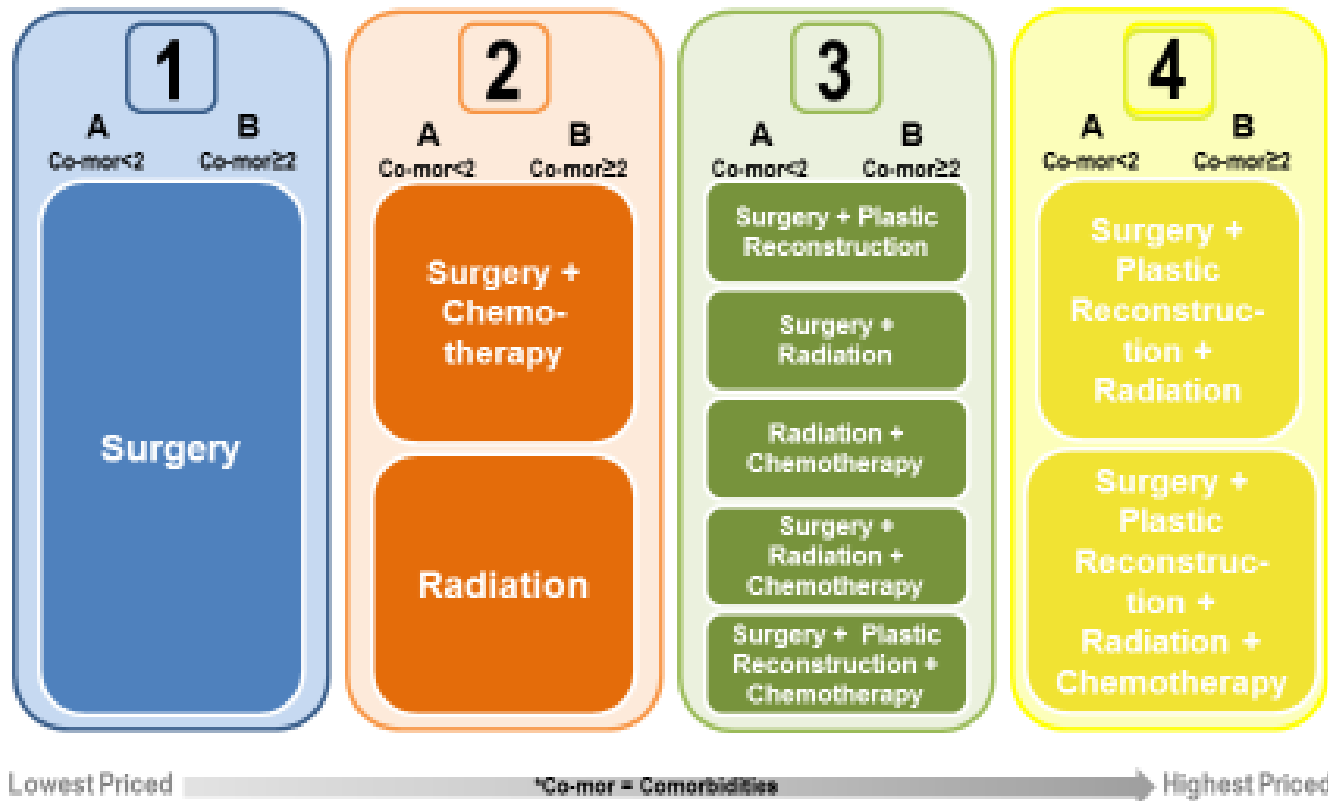
1. Providers **will cherry pick**, treating only younger, healthier patients while **avoiding high risk patients**

Moving to Bundled Pricing

Common Concerns

- Bundles are **risk-adjusted** (e.g., Swedish spine bundle) which will mitigate cherry picking and encourage treatment of sicker patients

MD Anderson Head & Neck Treatment Bundles



Moving to Bundled Pricing

Common Concerns

1. Providers **will cherry pick**, treating only younger, healthier patients while **avoiding high risk patients**
2. Procedure based bundles will foster **more procedures**

Appropriate Care is Critical for Value

Two types of appropriate use questions:

1. Is this the correct diagnosis (over or under diagnosing)?
2. Is this the correct treatment given the patient's condition?

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

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

Moving to Bundled Pricing

Common Concerns

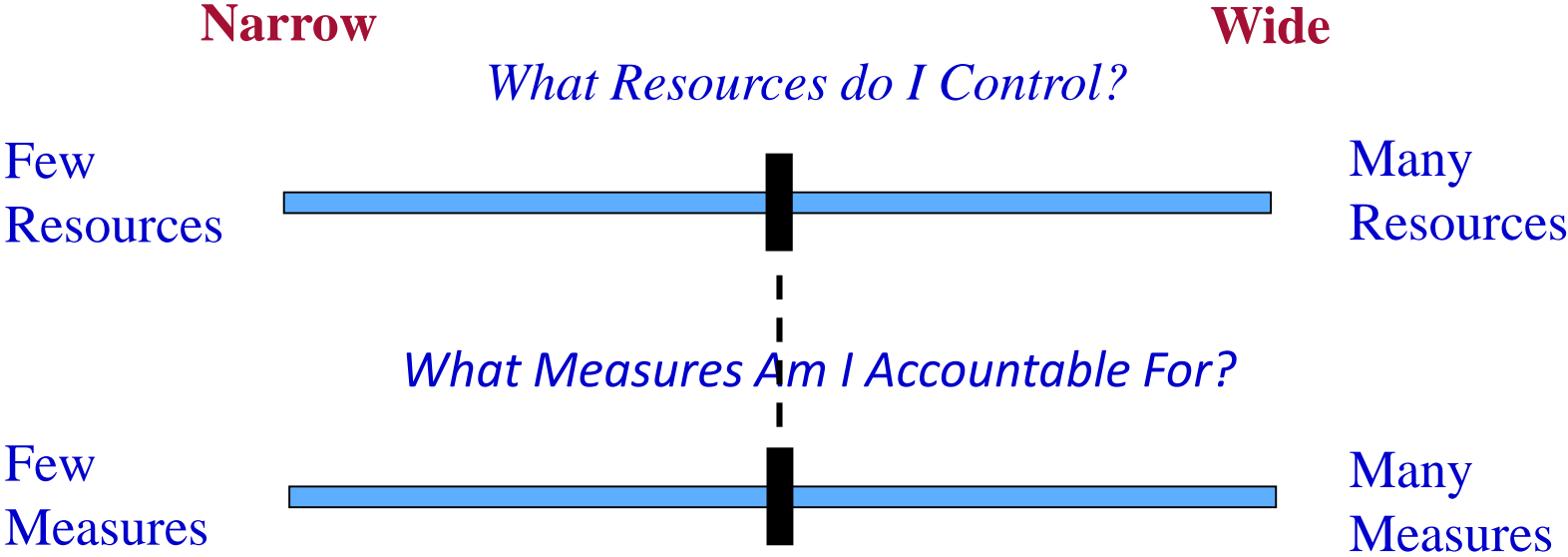
1. Providers **will cherry pick**, treating only younger, healthier patients while **avoiding high risk patients**
2. Procedure based bundles will foster **more procedures**
3. Physicians are **accountable for outcomes** even when they **do not control** other clinicians

Rotator Cuff Tear Bundle

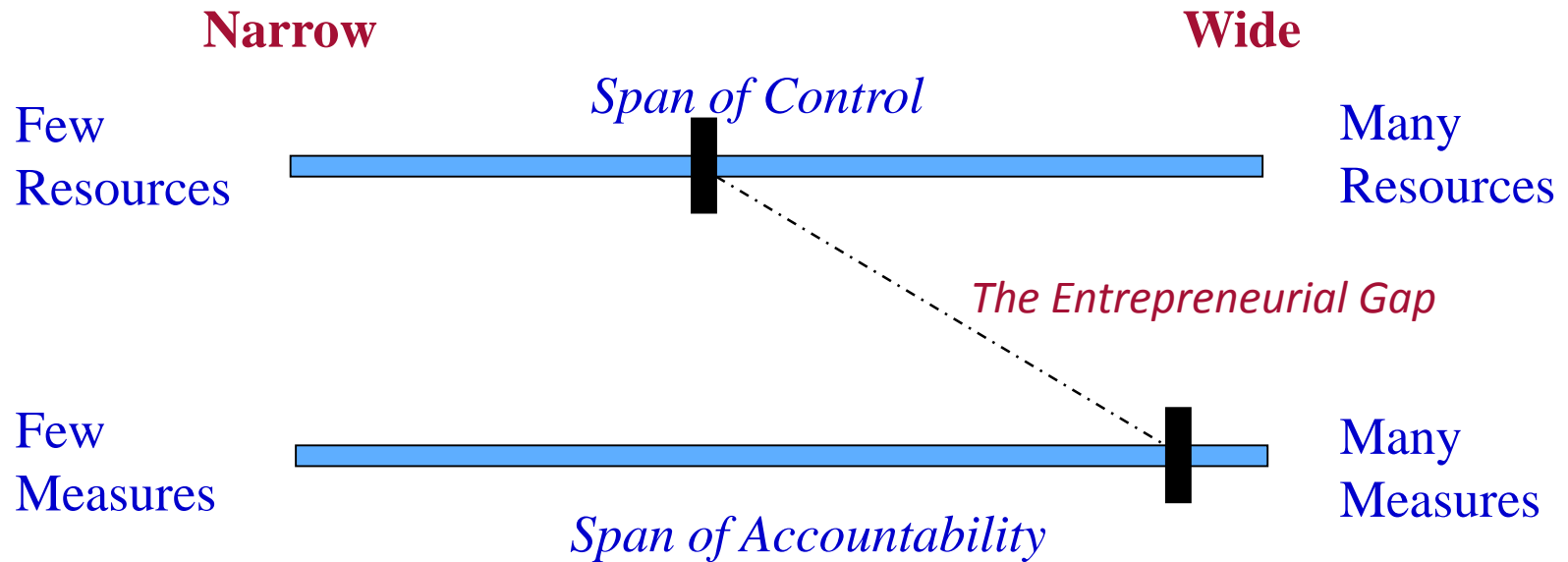
Fosters collaboration among involved providers and drives integrated care



Management Control 101, The Controllability Principle: Responsibility and Accountability



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*

Moving to Bundled Pricing

Common Concerns

1. Providers **will cherry pick**, treating only younger, healthier patients while **avoiding high risk patients**
2. Procedure based bundles can lead the **number of procedures** to increase
3. Physicians are **accountable for outcomes** even when they **do not control** all aspects of the care cycle
4. Bundles are practical for surgery with a highly standardized care cycle, but not for **medicine-based** conditions, **chronic** conditions, and **primary care**

- Bundles can be developed for non-surgical care, **chronic conditions**, and **primary care population segments** (e.g., healthy adults, adults with Type 2 diabetes, frail elderly with multiple co-morbidities).

Integrating Population and Condition Value Base Payments

Umbrella Model

Capitation/
Population
Based
Payments

Condition
Based
Bundled
Payments

Partnership Model

Primary
Care Bundle
or ACO for
specific
population

Condition
Based
Bundled
Payments

Fee for
Service

Global
Budgets

Shift to
Value



Pay for care for **primary care segments** and **conditions** (acute, chronic) with innovative partnership relationships

Capitation at the hospital or system level can **coexist** with bundle payment at the condition level

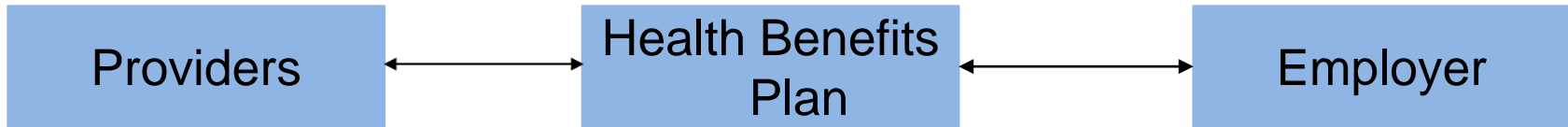


Both approaches create positive incentives for **reducing costs** and **detaching payment** from performing particular services

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

Private Health Insurance – Traditional Business Model

- Build networks
- Negotiate prices
- Claims Processing
- Payment processing
- Utilization review & prior authorization
- Set premiums
- Manage Benefits (customer service, bill pay, etc.)



Charge **15-20%** (above claims) for “insurance,” administrative expenses and profits

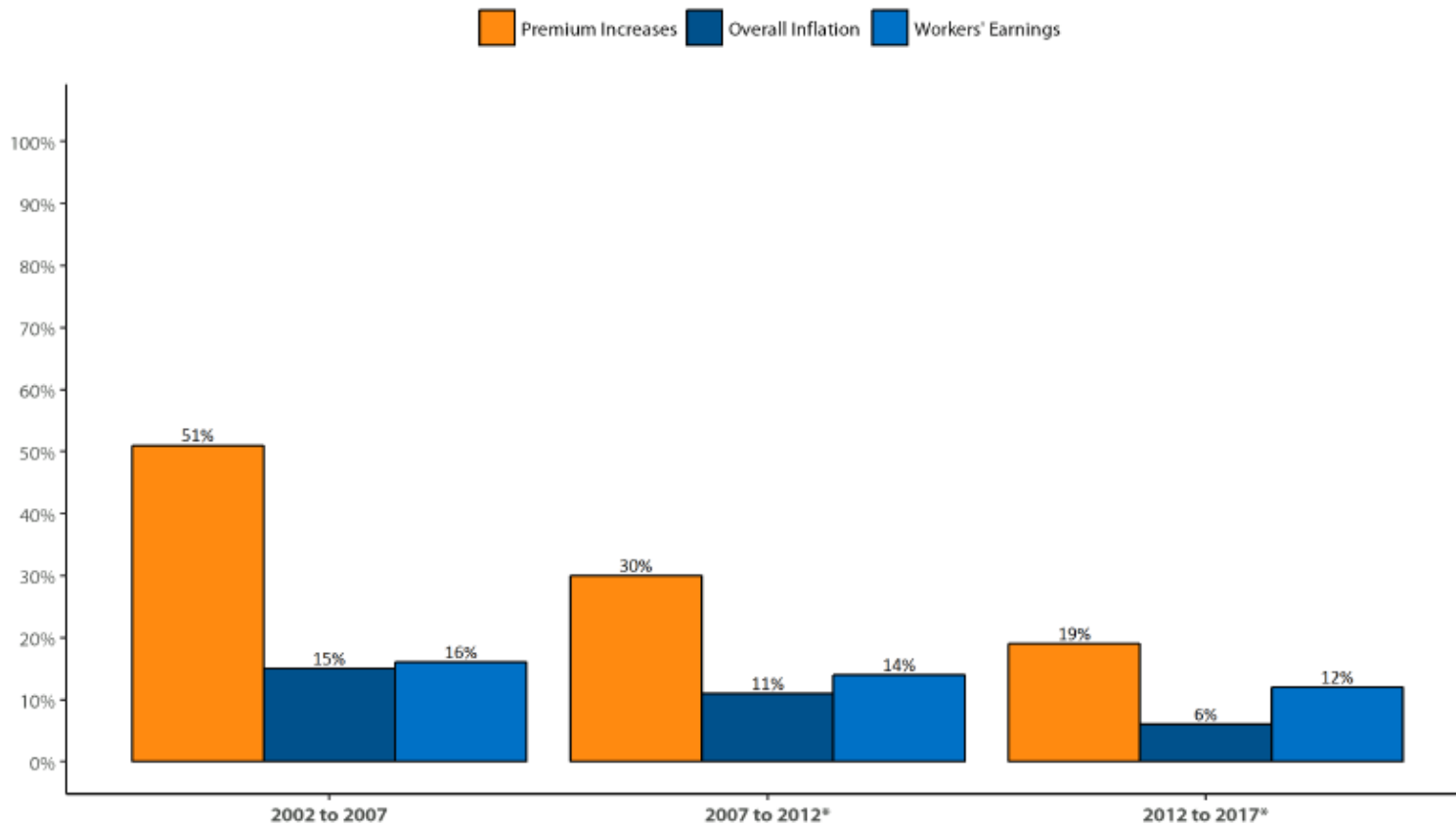
- Health care premiums for large employers are ~ 5% of total operating expenses.
- Employers receive little to no information about employee outcomes from their health benefits plans
- Experience rating => Employers ultimately bear the full risk for claims cost



Premium Growth vs Wage & Inflation

Figure 1.13

Cumulative Premium Increases for Covered Workers with Family Coverage, 2002-2017



* Percentage change in family premium is statistically different from previous five year period shown ($p < .05$).

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2002-2017. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 2002-2017; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 2002-2017 (April to April).

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

Thank you