Paying for Health Care

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Mary Witkowski, M.D., M.B.A. Fellow at Harvard Business School
Harry Wolberg, M.P.P. Research Associate at Harvard Business School
Move to Value-Based Payment Models

- **Volume**
  - Fee for Service
  - Global Budgets

- **Value**
  - Capitation/Population Based Payments
  - Bundled Payment
    - Pay for care for a *life*
    - Pay for care for *conditions* (acute, chronic) and *primary care segments*

- 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
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

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
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
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
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

What Resources do I Control?

- Few Resources
- Many Resources

What Measures Am I Accountable For?

- Few Measures
- Many Measures
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**

- Fee for Service
- Global Budgets

**Shift to Value**

- Capitation/Population Based Payments
- Condition Based Bundled Payments

**Partnership Model**

- Primary Care Bundle or ACO for specific population
- Condition Based Bundled Payments

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.)

Providers ➔ Health Benefits Plan ➔ Employer

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
Figure 1.13
Cumulative Premium Increases for Covered Workers with Family Coverage, 2002-2017

- Premium Increases
- Overall Inflation
- Workers' Earnings

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

Costs to Employers of Poor Health

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

• Presenteeism
  o Lack of productivity
  o Decreased quality

Can be >2x out-of-pocket costs
Thank you