Bundles for Acute & Chronic Conditions

Designing payment around integrated care models

6 Key Design Elements

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
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

1. A: Co-mor<2  B: Co-mor≥2
   Surgery

2. A: Co-mor<2  B: Co-mor≥2
   Surgery + Radiation
   Surgery + Chemo-therapy

3. A: Co-mor<2  B: Co-mor≥2
   Surgery + Plastic Reconstruction
   Surgery + Radiation
   Radiation + Chemo-therapy
   Surgery + Plastic Reconstruction + Chemo-therapy

4. A: Co-mor<2  B: Co-mor≥2
   Surgery + Plastic Reconstruction + Radiation
   Surgery + Plastic Reconstruction + Chemo-therapy

8 separate bundles that risk-adjust for patient complexity
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?

What Resources do I Control?

Narrow
Few Resources
宽
Many Resources

What Measures Am I Accountable For?

Narrow
Few Measures
宽
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
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

Pre-Pregnancy Health → Prenatal Care → Delivery (Surgical, Vaginal) → Post-Pregnancy Health

Episode of Care (Pregnancy)

Typical Roles
- OB/GYN
- Midwives
- RN
- Staff
- Radiology
- Testing
- Social Worker
- OB/GYN
- Surgical Techs
- RN
- Lactation Support
- Behavioral Health
- PCP
- 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

**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
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

$55 per

Bundles for Primary Care

- Healthy
  - $25
- Pediatrics
  - $105
- Chinese-speaking community
  - $35
- Poor & Frail Elderly
  - $9
- Women's health
  - $30
- End of Life
  - $140
- Healthy Mental Health Population
  - $110
- >2 Severe Co-Morbidities
  - $140
Overlap between Primary and Specialty Care Bundles

Primary Care Segment

- Diagnosis
- Urgent Care
- Preventative Care
- Referral
- Management of mild/moderate chronic conditions

Shared Functional Hubs:
- Weight loss
- Smoking cessation
- Anti-coagulation

Specialty Bundle: OA of Knee

Depression

Cancer: Lymphoma

PCP shares in responsibility for cost, outcomes and can participate in 2 sided risk for specialty bundles
Adoption of Bundled Payments
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 Programs
Employer Sponsored Insurance represents over one-third of the U.S. Healthcare Market

2016 U.S. Health Care Expenditures

% of Total

Government 39%
Medicare 45%
Medicaid 16%
Private ESI 11%
Employee ESI Contributions 34%
Federal ESI 7%
DoD 2%
State & Local ESI 14%
Out-of-pocket 11%
Other Revenues 6%
Other Payers 17%
Out-of-Pocket 11%
CHIP 1%

Total = $3.3 T

Source: HBS Analysis, based on CMS National Health Expenditure (NHE) historical data, 2016
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 $>2\times$ out-of-pocket costs
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
    o 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

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

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)

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

**Alliance Role:**
- Adopt accepted outcome standards
- Conduct external outcome measurement evaluation & reporting
- Convene all stakeholders

**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:**
- Boeing
- Starbucks
- Washington State Health Care Authority
- Teamsters Welfare Trust

**Alliance Organizations:**
- WHA Washington Health Alliance
- BREE Collaborative

**Providers:**
- Virginia Mason
- SWEDISH
- UW Medicine
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
Alignment critical for shifting health care from SURVIVE → THRIVE
Thank you