Value-Based Health Care Delivery:
Reimbursement, System Integration, and Growth

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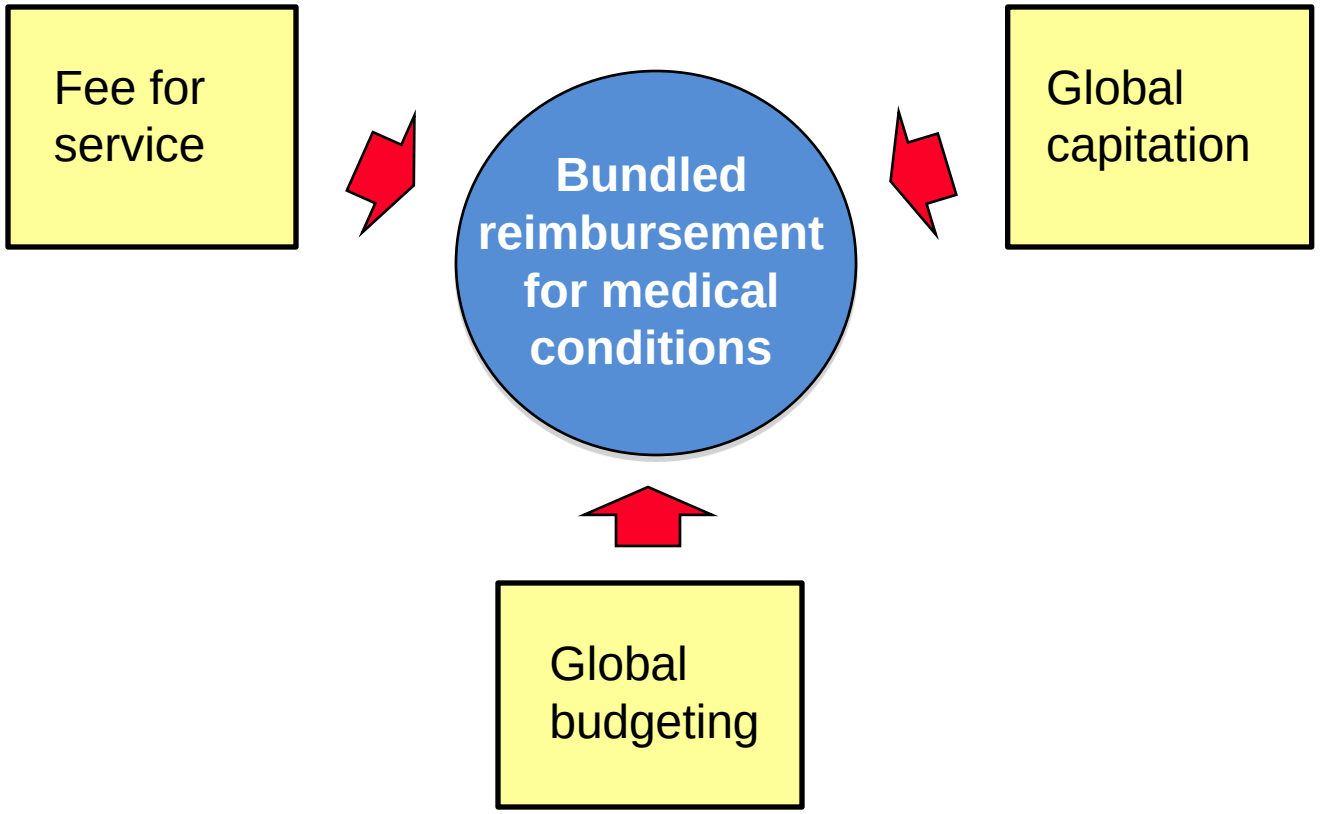
This presentation draws on Michael E. Porter and Elizabeth Olmsted Teisberg: Redefining Health Care: Creating Value-Based Competition on Results, Harvard Business School Press, May 2006, and "How Physicians Can Change the Future of Health Care," *Journal of the American Medical Association*, 2007; 297:1103:1111. Further information about these ideas, as well as case studies, can be found on the website of the Institute for Strategy & Competitiveness at http://www.isc.hbs.edu.

Alternative Reimbursement Models



What is a Bundled Payment?

- **Total package price** for the care cycle for a medical condition
  - Time-based bundled reimbursement for **managing chronic conditions**
  - Time-based reimbursement for defined **prevention, screening, wellness/health maintenance** service bundles
  - Should include responsibility for **avoidable complications**
  - "Medical condition capitation"
- The bundled price should be **severity adjusted**

What is Not a Bundled Payment

- Price for a **short** episode (e.g. inpatient only, procedure only)
- **Separate** payments for physicians and facilities
- **Pay-for-performance** bonuses
- "**Medical Home**" payment for care coordination

- DRGs can be a **starting point** for bundled payment models
- **Providers** and **health plans** should be proactive in driving new reimbursement models, not wait for government

Bundled Payment in Practice
Hip and Knee Replacement in Sweden

- Beginning in 2009, all joint replacements (hip and knee) in Stockholm County Council are reimbursed with a **bundled price** that includes:
  - Pre-op evaluation
  - Lab tests
  - Radiology
  - Surgery & related admission
  - Prosthesis
  - Drugs
  - Inpatient rehab, up to 6 days
  - 1 follow-up visit within 3 months
  - Any additional surgery to the joint within 2 years
  - If post-op infection requiring antibiotics occurs, guarantee extends to 5 years
- The bundled price applies to all **relatively healthy patients** (i.e. ASA scores of 1 or 2)
- The **same referral** process from PCPs is utilized as the traditional system
- There is **mandatory reporting** by providers to the joint registry plus supplementary reporting
- Provider participation is **voluntary** but all providers are involved
  - 6 public hospitals, 4 private hospitals
  - 3400 patients treated in 2009
- The bundled price for a knee or hip replacement is about **US $8,000**

Creating a Bundled Pricing System

- Defining the Bundle
  - **Scope** of the medical condition
  - **Range of services** included
  - **Complications and comorbidities** included/excluded
  - **Duration** of care cycle/time period
    - Must be long enough to minimize the risk of cost shifting
  - **Flexibility** on methods/process of care essential
- Pricing the Bundle: Choices
  - Price relative to **sum of current costs**
  - Amount of **incentive** to improve value by reducing avoidable complications, improving efficiency, etc.
  - Extent of "**guarantees**" by providers
  - Extent of **severity/risk** adjustment
  - Mechanism for handling **unanticipated** complications/outliers
- Implementing the Bundle
  - **Claims** management process
  - Internal **distribution of payment** among providers (dividing the pie)
    - Degree of risk sharing by specialty
  - **Outcome measurement** is essential to measure success and minimize incentives to limit value-enhancing services

Moving to Bundled Pricing: Challenges and Enablers

- Obstacles
  - Lack of historical cost data per patient
  - Absence of interoperable EMRs across units involved in care
  - The need to modify insurer reimbursement infrastructure
  - Legal impediments gainsharing
  - Resistance by physicians (e.g. risk-taking)
  - Fragmentation of providers and payors
  - Achieving stakeholder consensus
  - Difficulty of modifying care delivery structure
  - Absence of outcome measurement
- Enablers
  - Established **IPUs**
  - **Employed** physicians
  - Patient-based, medical condition-based **cost accounting**
  - Direct negotiation with **employers**
  - Established **outcome measurement**

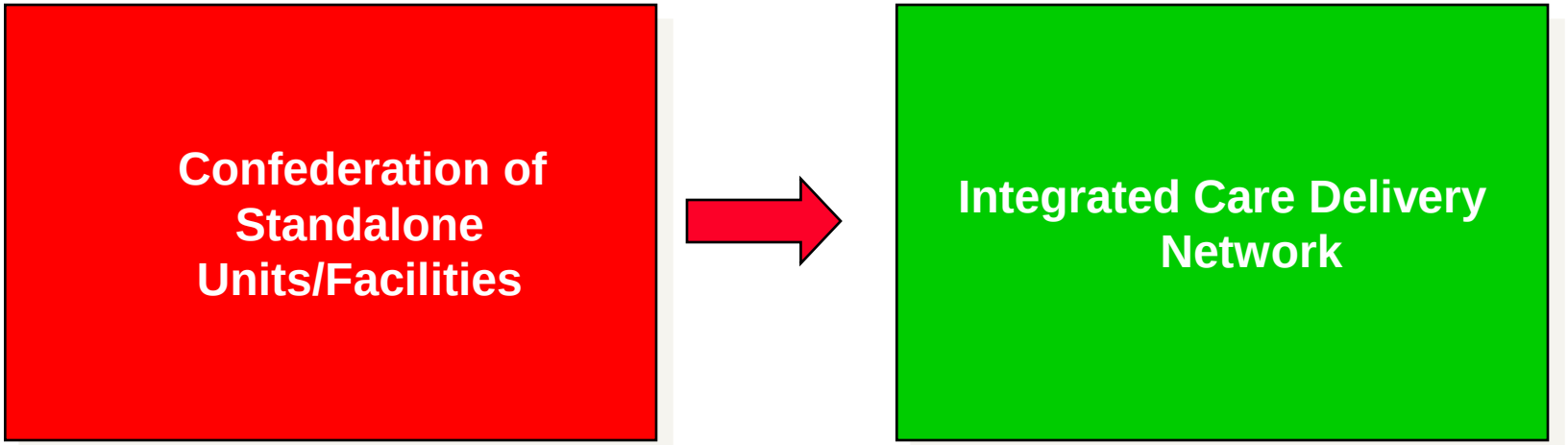
Bundled Pricing in Practice
Selected U. S. Examples

- Organ Transplantation
- Medicare Heart Bypass Demo (1991-1996)
  - DRGs, 106,107,108
  - Seven hospitals
  - Patient value improved
  - Insurer resistance/provider resistance
  - Pilot ended
- Geisinger ProvenCare
  - CABG
  - Includes 90 day complications
    - Bundle price includes 50% of average cost of avoidable complication
  - Achieved better outcomes, costs
  - Ongoing effort
- Medicare ACE Demonstration
  - Combined Part A/Part B
  - Cardiac and orthopedic surgery (11 areas)
  - 5 hospitals
  - In process
- Prometheus
  - Multiple pilots in various stages of development
  - Replicable methodology
  - Includes avoidable complications
- Blue Cross / Blue Shield of South Carolina
  - Diabetes care
- Minnesota Baskets of Care
- Fairview / Carol Corporation

4. Integrate Care Delivery Across Separate Facilities

- Expand geographic coverage
- Increase volume by medical condition
- Gather volume for high acuity facilities
- Reduce crowding at capacity constrained facilities
- Expand coverage of the care cycle

Creating a Provider System



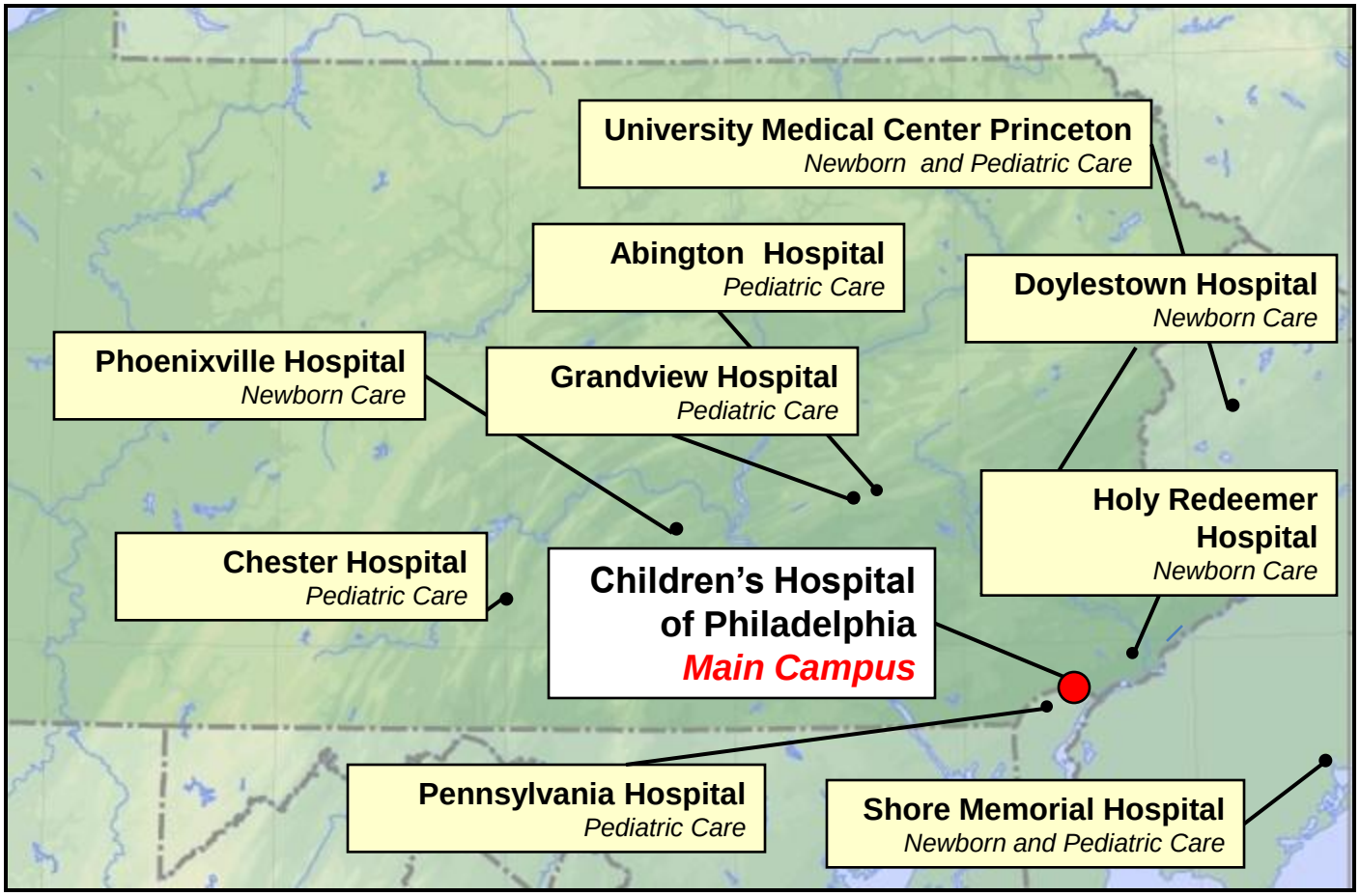
- Increase overall **volume**
- Benefits limited to **contracting** and **spreading limited fixed overhead**

- Increase **value**
- The network is **more than** the sum of its parts

Building an Integrated Care System

Children's Hospital of Philadelphia (CHOP)

Hospital Affiliates



Building an Integrated Care System

Children's Hospital of Philadelphia (CHOP)

Primary and Specialty Care Network

Levels of System Integration

- **Rationalize service lines/ IPUs** across facilities to improve volume, avoid duplication, and concentrate excellence
- **Offer specific services** at the **appropriate facility**
  - E.g. acuity level, cost level, need for convenience
  - Patient referrals across units
- Clinically integrate care **across facilities,** within an IPU structure
  - **Expand** and **integrate** across the care cycle
  - **Consistent protocols** throughout the network (IT enabled)
  - Connect **ancillary service units** to IPUs
    - E.g. home care, rehabilitation, behavioral health, social work, addiction treatment (organize within service units to align with IPUs)
  - Connect **preventive/primary care** units to specialty IPUs

Enabling System Integration

Practice Structure

- **IPU structure**
  - **"Virtual" IPUs** even if providers practice at different locations
  - First step is to increase **consistency** of protocols/processes across sites
  - **Case management structure** spanning units where appropriate

Scheduling

- Common or federated **patient scheduling service** across units

Physician Organization

- **Employed** physicians
- Formal **affiliations** with independent physicians
  - Support service as an inducement for affiliation (E.g. IT, back office)
- **Rotation** of staff across locations

Common Systems

- **Common EMR platform** which aggregates information across units
- Common **outcome and process measurement** systems

Cost Measurement

- Ability to accurately accumulate **cost per patient** across the entire care cycle
- Ability to measure **cost by location** for each service/activity

Culture

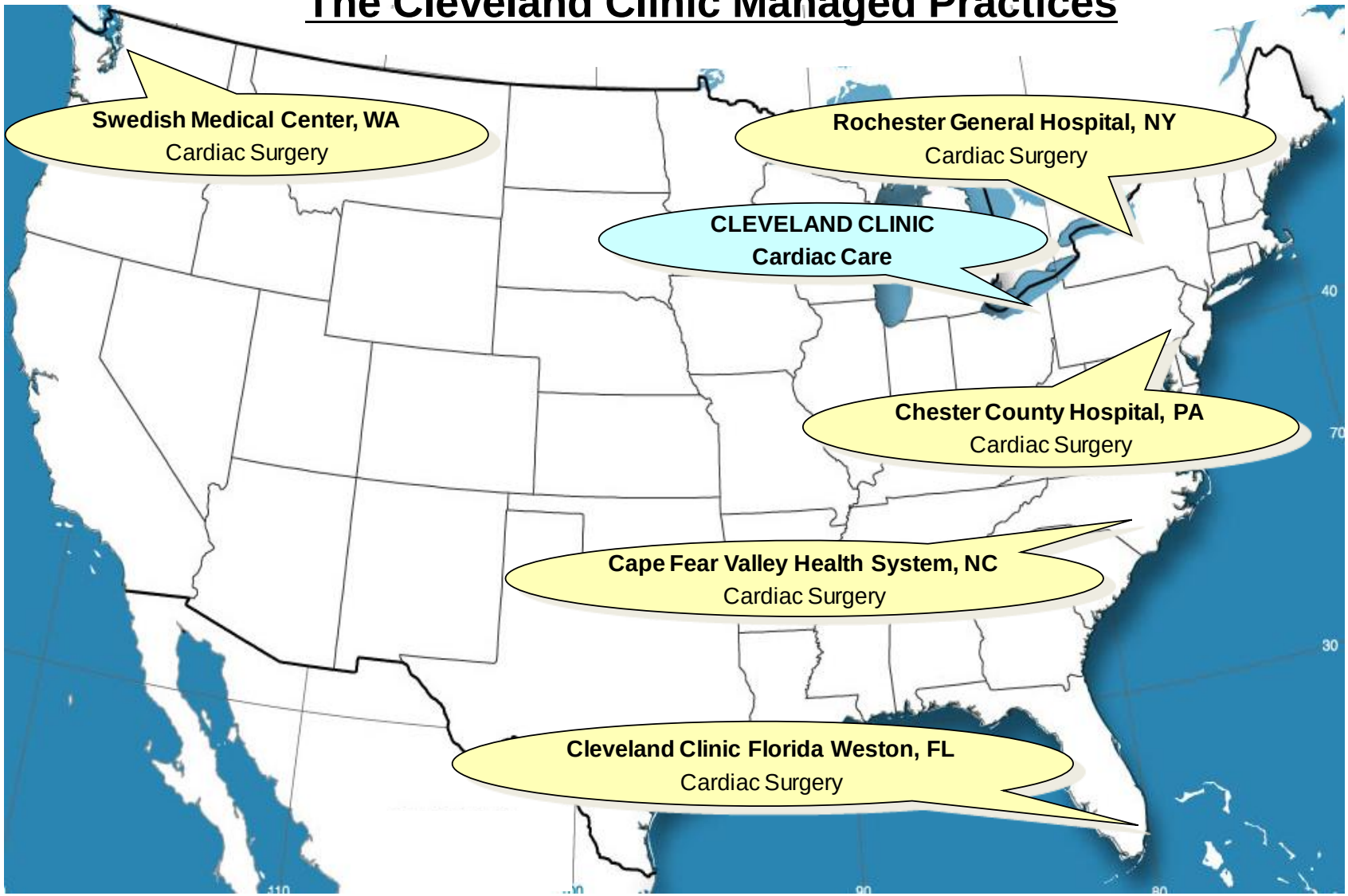
- Management practices that foster **affiliation with the organization,** developing **personal relationships,** and **regular contact** among dispersed staff

5. Grow by Expanding Excellent IPUs Across Geography

- Grow in ways that improve **value**, not just increase volume
- Grow **areas of excellence** and **leverage across locations**, rather than adding broad line, stand-alone units

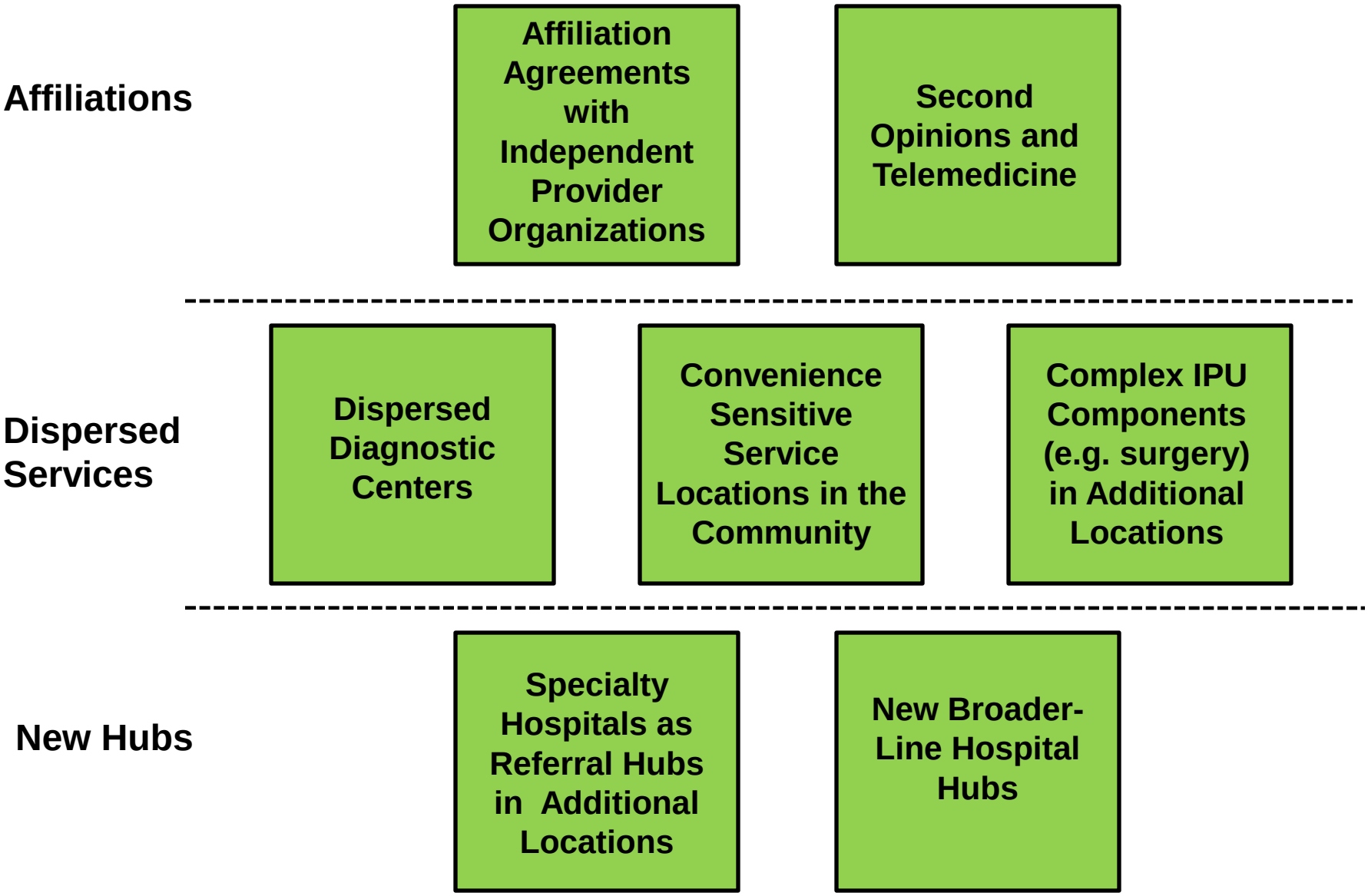
Grow by Expanding Excellent IPUs Across Geography

The Cleveland Clinic Managed Practices



- Grow in ways that improve **value**, not just volume

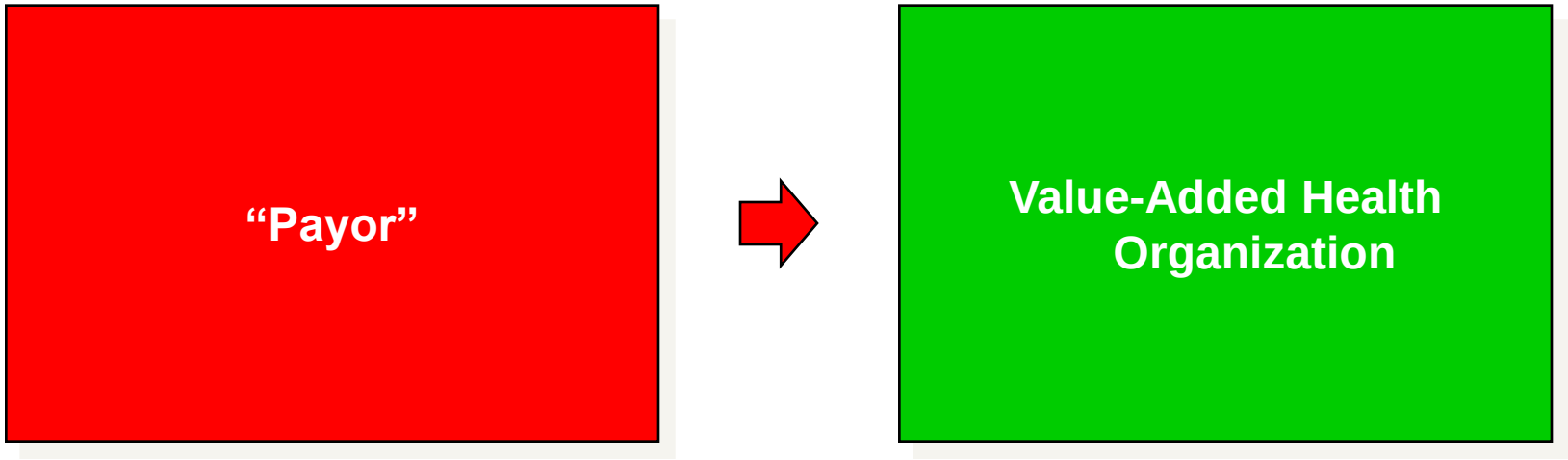
Models of Geographic Expansion



Value-Based Health Care Delivery
The Strategic Agenda

1. **Organize into Integrated Practice Units around the Patient's Medical Condition (IPUs)**
   - **Including primary and preventive care for distinct patient populations**
2. **Measure Outcomes and Cost for Every Patient**
3. **Move to Bundled Prices for Care Cycles**
4. **Integrate Care Delivery Across Separate Facilities**
5. **Grow by Expanding Excellent IPUs Across Geography**
6. **Create an Enabling Information Technology Platform**

Value-Based Healthcare Delivery:
Implications for Contracting Parties/Health Plans



Value-Adding Roles of Health Plans

- Measure and report **overall health results** for members by medical condition versus other plans
- Assemble, analyze and manage the **total medical records** of members
- Provide for comprehensive and integrated **prevention**, **wellness**, **screening**, and **disease management** services to all members
- Monitor and compare **provider results** by medical condition
- Provide advice to patients (and referring physicians) in selecting **excellent providers**
- Assist in coordinating patient care across the **care cycle** and **across medical conditions**
- Encourage and reward **integrated practice unit** models by providers
- Design new **bundled reimbursement structures** for care cycles instead of fees for discrete services

- Health plans will require **new capabilities** and **new types of staff** to play these roles

Value-Based Health Care: The Role of Employers

- Employer interests are **more closely aligned with patient interests** than any other system participant
  - 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
    - Absenteeism
    - Presenteeism
- Employers are **uniquely positioned** to improve employee health
  - Daily interactions with employees
  - On-site clinics for quick diagnosis and treatment, prevention, and screening
  - Group culture of wellness
  - Providers should establish **direct relationships with employers** to enable value based approaches

Value-Based Health Care Delivery: Implications for Government

- Remove obstacles to the **restructuring of health care delivery** around the integrated care of medical conditions
- Establish **universal measurement** and **reporting** of provider **health outcomes**
- Require universal reporting by health plans of **health outcomes for members**
- Shift reimbursement systems to **bundled prices for cycles of care** instead of payments for discrete treatments or services
- **Open up competition** among providers and across geography
- Mandate **EMR adoption** that enables integrated care and supports outcome measurement
  - National **standards** for data definitions, communication, and aggregation
  - **Software as a service** model for smaller providers
- Encourage greater **responsibility of individuals** for their health and their health care