Value-Based Health Care Delivery: Reimbursement

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This presentation draws on Redefining Health Care: Creating Value-Based Competition on Results (with Elizabeth O. Teisberg), Harvard Business School Press, May 2006; "A Strategy for Health Care Reform—Toward a Value-Based System," *New England Journal of Medicine*, June 3, 2009; "Value-Based Health Care Delivery," *Annals of Surgery* 248: 4, October 2008; "Defining and Introducing Value in Healthcare," *Institute of Medicine Annual Meeting*, 2007. Additional information about these ideas, as well as case studies, can be found on the Institute for Strategy & Competitiveness Redefining Health Care website at http://www.hbs.edu/rhc/index.html.

Creating a Value-Based Health Care Delivery System

The Strategic Agenda

1. Organize Care into Integrated Practice Units (IPUs) around Patient Medical Conditions
   - Organize primary and preventive care to serve distinct patient segments
2. Measure Outcomes and Cost for Every Patient
3. Reimburse through Bundled Prices for Care Cycles
4. Integrate Care Delivery Across Separate Facilities
5. Expand Geographic Coverage by Excellent Providers
6. Build an Enabling Information Technology Platform

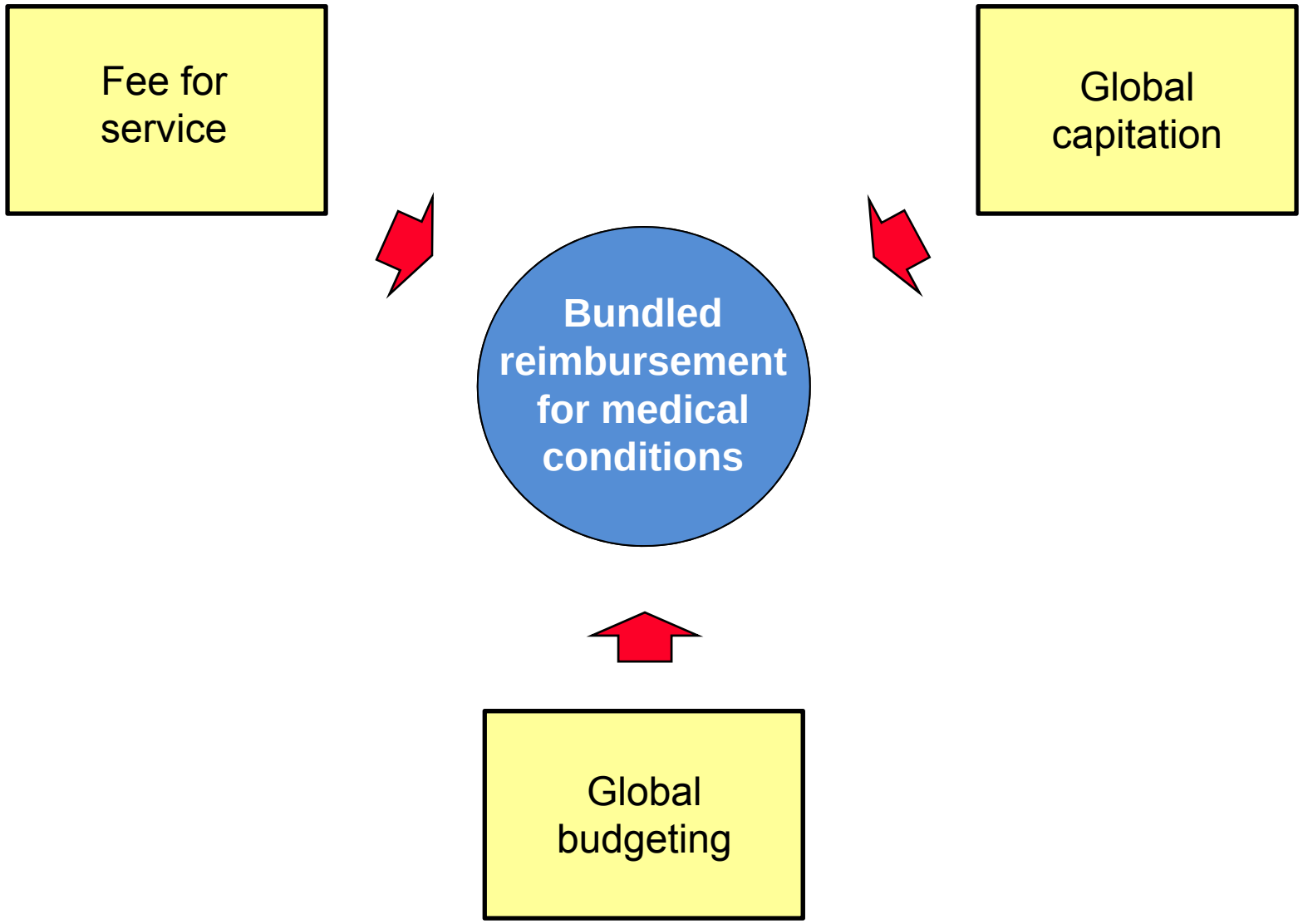
Creating The Right Kind of Competition

- Patient **choice** and **competition** for patients are powerful forces to encourage continuous improvement in value and restructuring of care
- But today's competition in health care **is not aligned with value**

Financial success of system participants	≠	Patient success

- Creating positive-sum **competition on value** for patients is fundamental to health care reform in every country

3. Reimbursing through Bundled Prices for Care Cycles



What is a Bundled Payment?

- A **total package price** for the full care cycle for an acute **medical condition**
  - "Medical condition capitation"
- Time-based reimbursement for **managing a chronic condition**
- Time-based reimbursement for **primary / preventative service bundles** to **defined patient segments**

- Bundles should include responsibility for **avoidable complications**
- Bundles should be **severity adjusted**

What is Not a Bundled Payment?

- **Separate** payments for physicians and facilities
- Payment for a **short** episode (e.g. inpatient only, procedure only)
- **Carve-outs** for drug, behavioral health, or disease management
- **Pay-for-performance** bonuses
- "**Medical Home**" payment for care coordination

The Rationale of Bundled Reimbursement

- **Decouples** payment from performing particular services in particular ways
- Fosters **integrated care delivery** (IPUs)
- Promotes provider **control and accountability** for outcomes at the **medical condition level**
- Creates **strong incentives to improve value** through reducing delays, avoidable complications, and unnecessary services
- Reinforces focus on **areas of excellence**
- Payment is aligned with areas providers can **directly control**

- Aligns reimbursement with **value creation**
- Accelerates care delivery **integration**

Bundled Payment vs. Global Capitation

Bundled Payment

- Fosters **integrated care delivery** (IPUs)
- Payment is aligned with areas the provider can **control**
- Promotes provider accountability for the **quality** of care **at the medical condition level**
- Creates **strong incentives to improve value** and reduce avoidable complications

Aligns reimbursement with **value creation**

Global Capitation

- Shifts overall **insurance risk to providers**
- Largely **decouples payment** from what providers can **control**
- Introduces pressure to **ration services**
- Encourages provider systems to offer **overly broad services lines**
- Amplifies provider incentive to **target generally healthy patients**

Aligns reimbursement with **overall insurance risk**

Bundled Payment in Practice
Hip and Knee Replacement in Stockholm, Sweden

- **Components** of the bundle

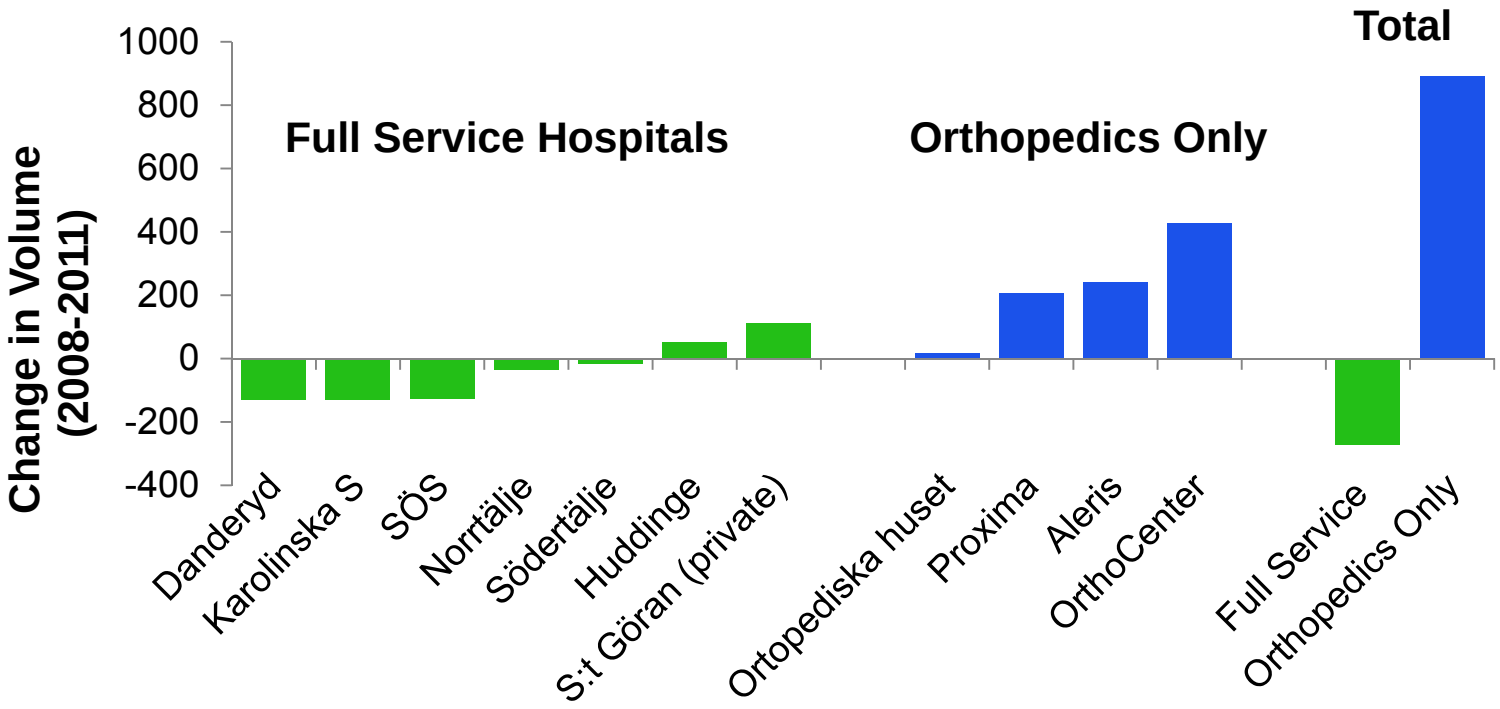
- Pre-op evaluation	- All physician and staff fees and costs
- Lab tests	- 1 follow-up visit within 3 months
- Radiology	- Any additional surgery to the joint within 2 years
- Surgery & related admissions	- If post-op infection requiring antibiotics occurs, guarantee extends to 5 years
- Prosthesis	
- Drugs	
- Inpatient rehab, up to 6 days	

- Currently 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
- **Mandatory reporting** by providers to the joint registry plus supplementary reporting
- Applies to **all** qualifying patients. Provider participation is **voluntary**, but all providers are continuing to offer total joint replacements

- The Stockholm bundled price for a knee or hip replacement is about **US $8,000**

Hip and Knee Replacement in Stockholm, Sweden

Provider Response



- Under bundled payment, volumes shifted from full-service hospitals to **specialized orthopedic hospitals**
- Interviews with specialized providers revealed the following **delivery innovations**:

– Care pathways	– More patient education
– Standardized treatment processes	– More training and specialization of staff
– Checklists	– Increased procedures per day
– New post-discharge visit to check wound healing	– Decreased length of stay

Bundled Price for Cancer Diagnosis and Treatment Planning

Cancer Treatment Centers of America

- Bundle covers full **diagnosis** and a **comprehensive treatment plan**
- Bundles for **four cancer types**: Breast, Colorectal, Lung, Prostate
- Guaranteed **minimum** set of services
- Guaranteed completion within **5 days**
- Pricing based on **85th percentile** of patients
- Lay off some **outlier risk** through insurance
- Bundled price ranges from $10,000 to $15,000
- Marketing **directly to employers**, not just health plans and individuals

Steps to Creating a Bundled Pricing System
1. Defining the Bundle

- Determine the **scope** of the medical condition
- Identify the **range of services** included
  - Expand coverage to be more **inclusive** over time
- Decide which **complications** and **comorbidities** are included
  - Include **preventable** complications that providers can control
- Set the **duration** of the care cycle (or time period) and care guarantee
  - Extend the care cycle to include all outpatient and inpatient care
  - Make providers responsible for defined complications beyond the service period
- **Revise** the bundle over time

Steps to Creating a Bundled Pricing System
2. Pricing the Bundle

- Utilize activity-based costing to determine the **actual costs** over the care cycle
- Set the bundled price relative to the **sum of current costs**
  - Provider **total cost with efficient processes** is lower bound
  - Current reimbursement is upper bound
  - Determine the extent of the **incentive** to participate in the bundle and improve value through reducing **avoidable** complications and improving **efficiency**
- Determine the extent of "**guarantees**"
  - Determine the level of responsibility providers will have for avoidable complications
- Define the extent of **severity/risk** adjustments
  - Refine the risk-adjustment mechanism over time
- Devise a mechanism for handling **outliers** and **unanticipated** complications
  - Determine **outlier criteria** and the complications that will fall **outside** the bundle
  - Negotiate how reimbursement for these patients will be handled

Steps to Creating a Bundled Pricing System
3. Implementing the Bundle

- Require **outcome measurement** for all covered patients
  - Minimize incentives to limit value-enhancing services
  - Measure success
- Encourage **large employers** to begin negotiating bundles for high-volume medical conditions as a transitional step
- Develop **provider** billing processes
  - Negotiate the internal **distribution of payment** among providers (dividing the pie)
  - Determine the degree of risk sharing by specialty
- Develop the **payor claims management processes** and infrastructure
- Establish **regional or national bodies** to set standards for medical condition bundles
  - **Extend the care cycle** over time

Moving to Bundled Pricing: Obstacles and Enablers

- Obstacles
  - Existing **siloed** care delivery structure
  - **Fragmentation** of providers and payors
  - Lack of accurate **cost data** by patient medical condition and care cycle
  - Absence of **outcome** measurement
  - Existing insurer **reimbursement and adjudication infrastructure**
  - Absence of **interoperable EMRs** across the units involved in care
  - **Legal impediments** such as gain-sharing rules
  - **Resistance** by physicians
- Enablers
  - **Employed** physicians
  - Established **IPUs**
  - Medical condition-based **cost accounting** (TDABC)
  - Established **outcome measurement**
  - Direct negotiation with **employers**

Moving to Bundled Pricing

Leverage Points for Government

- **Modify legal requirements** to encourage care integration (e.g., Stark Laws, gain-sharing)
- Create a **national bundled pricing framework** and **rollout schedule**
  - Start with the 20 most costly medical conditions, which account for more than 25% of all medical costs[1]
- Work with providers and private payors to **standardize the definition of bundles** and the **adjudication process** for implementing them
  - Bundle scope, duration, and guarantees
  - Process for determining related complications

[1]Cutler, D. Ghosh, K. NEJM, 366;12: 1075-1077