

Value-Based Health Care Delivery Part III: Reimbursement, the Role of Health Plans, and Enabling Government Policy

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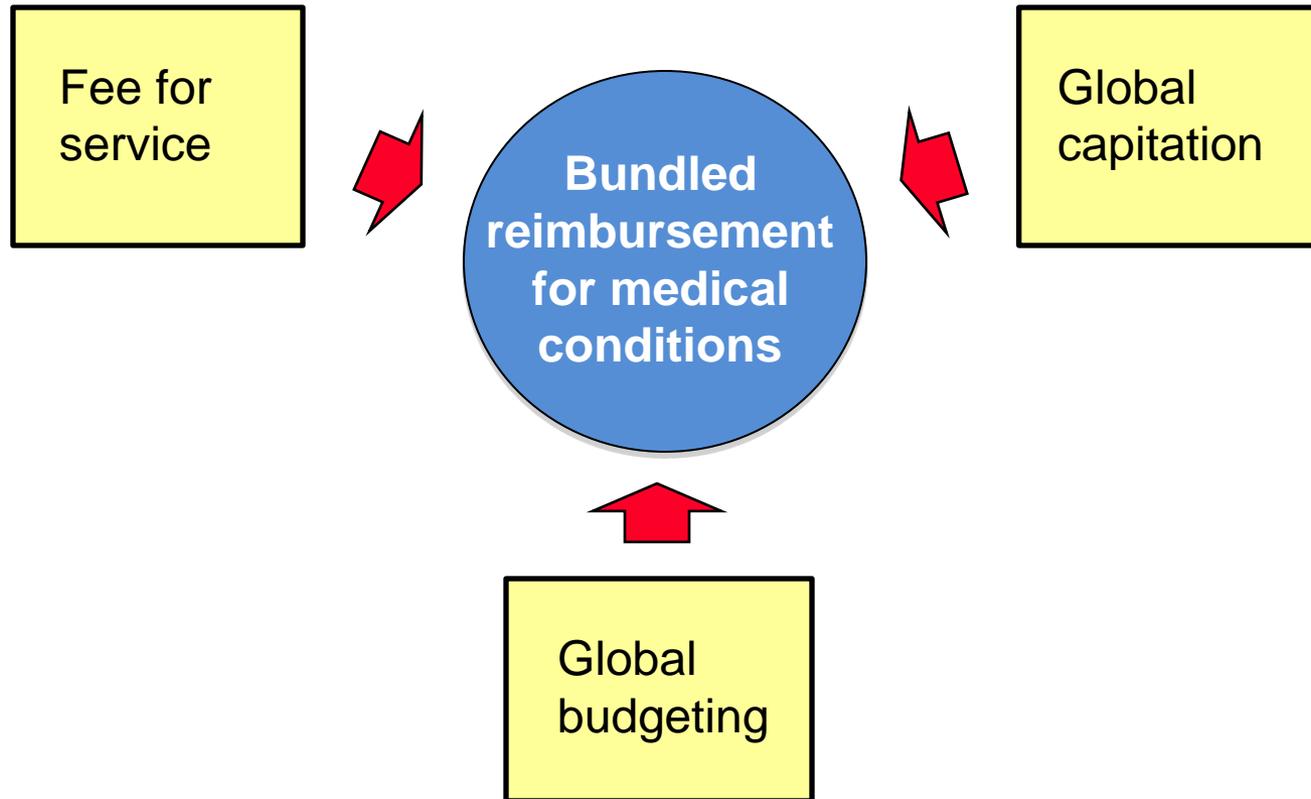
This presentation draws on Redefining Health Care: Creating Value-Based Competition on Results (with Elizabeth O. Teisberg), Harvard Business School Press, May 2006; "A Strategy for Health Care Reform—Toward a Value-Based System," *New England Journal of Medicine*, June 3, 2009; "Value-Based Health Care 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 the Institute for Strategy & Competitiveness Redefining Health Care website at <http://www.hbs.edu/rhc/index.html>. No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means — electronic, mechanical, photocopying, recording, or otherwise — without the permission of Michael E. Porter and Elizabeth O. Teisberg.

Creating a Value-Based Health Care Delivery System

The Strategic Agenda

1. Organize into Integrated Practice Units (IPUs) Around Patient Medical Conditions
 - Organize primary and preventive care to serve **distinct patient populations**
2. Establish Universal Measurement of Outcomes and Cost for Every Patient
3. Move to Bundled Prices for Care Cycles
4. Integrate Care Delivery Across Separate Facilities
5. Expand Excellent IPUs Across Geography
6. Create an Enabling Information Technology Platform

3. Move to Bundled Prices for Care Cycles



- Bundled reimbursement covers the **full care cycle** for an acute medical condition, **time-based reimbursement** for chronic conditions, or primary/preventive care for a defined patient population

What is a Bundled Payment?

- A **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

- **Separate** payments for physicians and facilities
- Payment for a **short** episode (e.g. inpatient only, procedure only)
- **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

Value-Based Reimbursement

Global Capitation vs. Bundled Payment

Bundled Payment

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



Aligns reimbursement with **value creation**

Global Capitation

- Shifts overall **insurance risk to providers**
- **Decouples payment** from what providers can **control**
- Introduces pressure to **ration services**
- Encourages large provider systems offering **overly broad services lines**
- Strengthens provider incentive to **attract 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 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 | |

- 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 or additional measures
 - Provider participation in the bundled model is **voluntary** but all providers are involved
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- 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: Key Choices
 - The bundled price relative to the **sum of current costs**
 - Extent of **incentive** to improve value by reducing avoidable complications, improving efficiency, etc.
 - Extent of “**guarantees**” by providers
 - Extent of **severity/risk** adjustments
 - Mechanism for handling **unanticipated** complications and true **outliers**
- Implementing the Bundle
 - **Claims** management process and infrastructure
 - **Provider** billing process
 - Internal **distribution of the 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

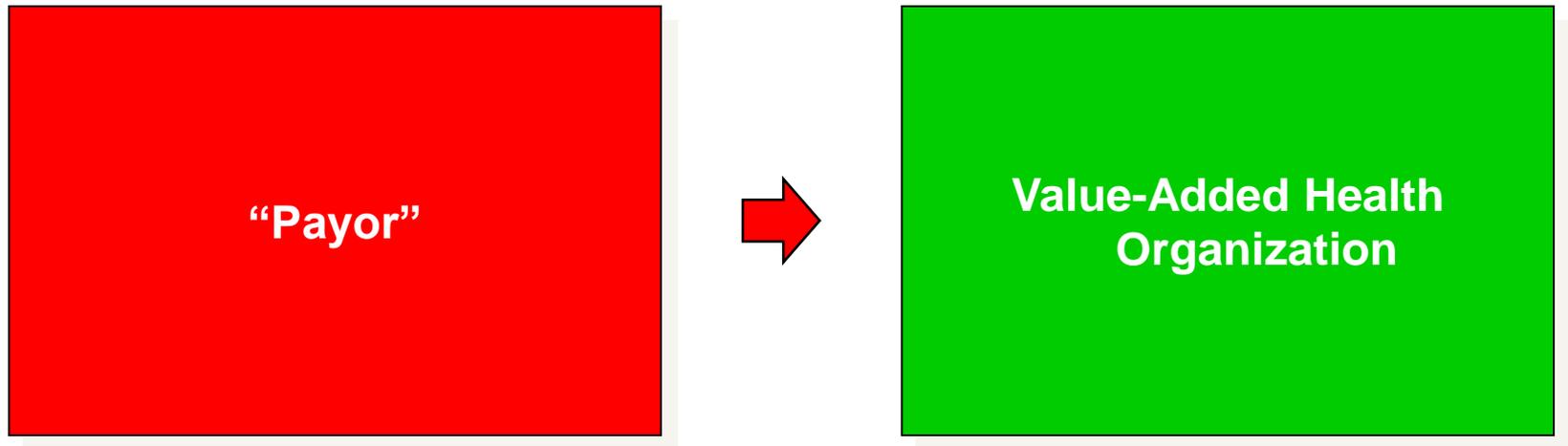
- Obstacles
 - Lack of historical **cost data** aggregated by patient and by medical condition
 - **Fragmentation** of providers and payors
 - Absence of **interoperable EMRs** across the units involved in care
 - The need to modify insurer **reimbursement infrastructure**
 - **Legal impediments** such as gainsharing
 - **Resistance** by physicians (e.g. risk-taking)
 - 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**
 - Established **outcome measurement**
 - Direct negotiation with **employers**

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

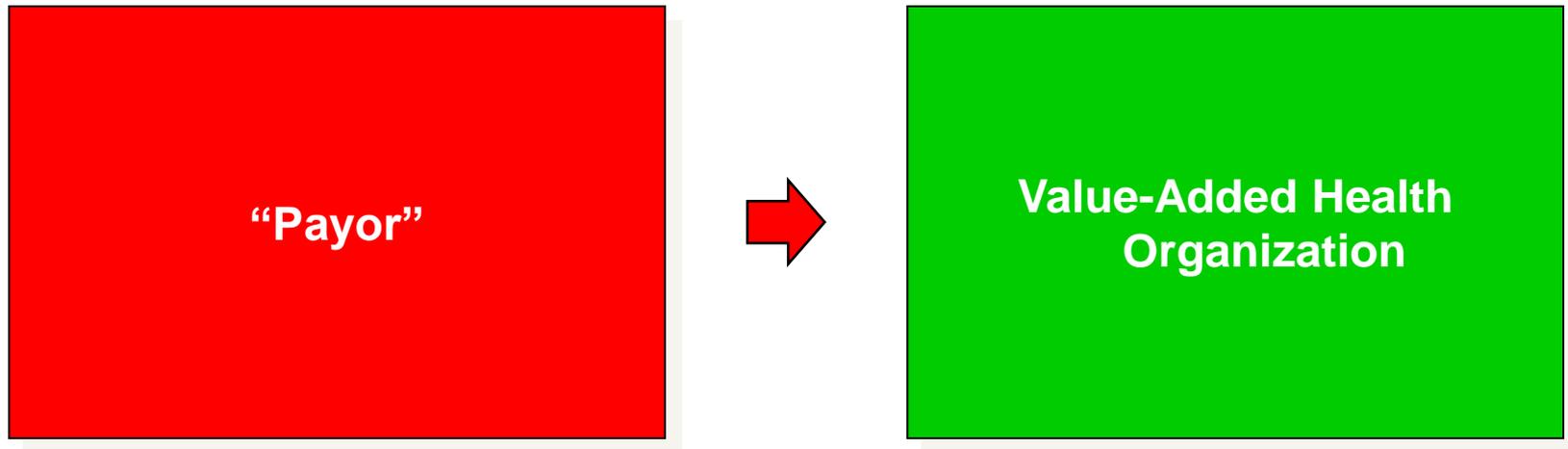
Value-Based Health Care Delivery: Implications for Contracting Parties/Health Plans



Value-Adding Roles of Health Plans

- Assemble, analyze, manage or coordinate 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
 - Measure and report **overall health results** for members by medical condition versus other plans
- 
- Health plans will require **new capabilities** and **new types of staff** to play these roles

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



- Providers can lead in developing new relationships with health plans through their role in **providing health benefits for their own employees**

Value-Based Health Care Delivery: Implications for Government

- Establish **universal measurement** and **reporting** of **health outcomes**
- Shift reimbursement systems to **bundled prices for care cycles**
- Remove obstacles to **integrated care for medical conditions**
- **Open competition** among providers and across geography
- Set policies to encourage greater **involvement and responsibility of individuals** for their health and their health care
- Set standards and mandate **EMR adoption** that supports integrated care and outcome measurement

Progress Toward the Strategic Agenda

Interim Steps for Government

1. Organize into Integrated Practice Units (IPUs) Around Patient Medical Conditions

- Introduce provider reporting and certification based on **structural measures of integration** (e.g. multidisciplinary teams, co-location, dedicated facilities)

2. Establish Universal Measurement of Outcomes and Cost for Every Patient

- Require provider reporting of **patient volume by medical condition**

3. Move to Bundled Prices for Care Cycles

- **Extend** DRG-based care episodes
- **Combine reimbursement** for Medicare Parts A & B

4. Integrate Care Delivery Across Separate Facilities

- Introduce **minimum volume standards** by medical condition for certification

5. Expand Excellent IPUs Across Geography

- Encourage **affiliations** between small/rural providers and qualifying centers of excellence

6. Create an Enabling Information Technology Platform

- Require universal **data definitions**, **interoperability**, and **reporting ability** among all HIT systems

For additional information on

Value-Based Health Care Delivery:

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