

Annual Conference & Exhibition
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change is everywhere...opportunity is here

Healthcare Finance & Reimbursement

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transforming healthcare through IT™

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Session Objectives

- **Understand the fundamental economics of financing and reimbursement**
 - The supply and demand side challenges that are coming
- **Paint a picture of why the current model is unsustainable**
 - A look into my cloudy crystal ball
- **Where we go from here**
 - The noisy uncomfortable path through disequilibrium

The Demand Side

- The current state of affairs juices the system in an unsustainable manner
- Creates bad incentives and absolves insureds of accountability
- We make bad tradeoffs
- We will reverse the decades long trend of decreasing share out of pocket.

“A bitter evil little man”

- Conservative right wing country health economist from the bible belt.
- I like mayonnaise on my cheese fries
- I don't speed on my way to Hardees.

A personal perspective

- Yours truly – a balding middle aged slovenly obese man (BMI 28) with primary hypertension with a poor diet and crummy exercise habits.
 - Is this an education problem?
- The cocktail
 - Ace-inhibitor, Beta-Blocker, Superstatin
 - Cost \$50 / month

The role of medical technology

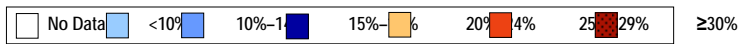
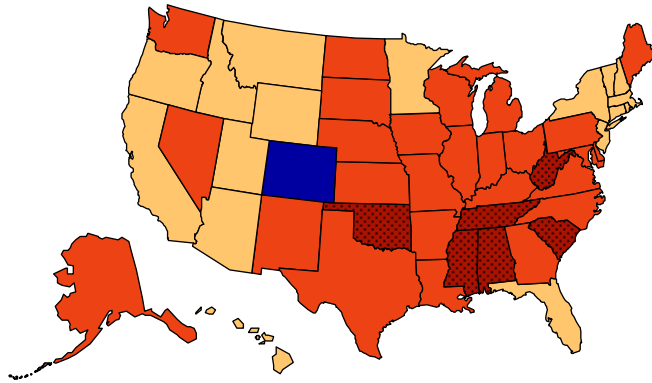
- Consider treatment today of heart disease
 - Pharmaceutical advances
 - Surgical advances
 - Minimally invasive techniques
- Consequences of poor health is not as dire.
- Costs borne by individual consumer are less.

Obesity Trends* Among U.S. Adults

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BRFSS, 2008

(*BMI ≥30, or ~ 30 lbs. overweight for 5' 4" person)



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SICKO?

The Employer Response?

Ray Van Horn,

Our records* show you still need to complete your yearly [Health Risk Assessment!](#)

The Go for the Gold deadline is the Sunday after Thanksgiving, November 30, 2008. Don't miss out on the opportunity to earn extra money while learning about your health through this [confidential](#) Health Risk Assessment.

Go for the Gold is available to full-time, active, benefits eligible Vanderbilt faculty and staff and their Spouses/Certified Domestic Partners on the Vanderbilt health plan *regardless of current health status*. Wellness credit will be paid each month of 2009.

Assistance is available at Health Plus during hours of operation.

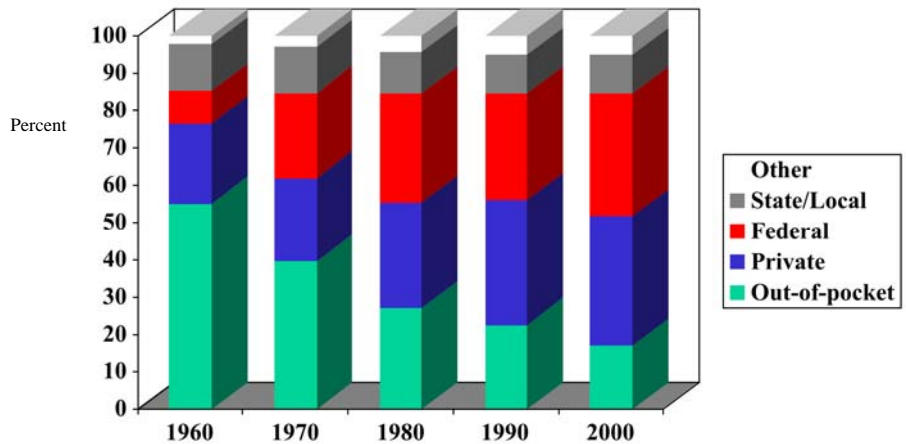
Questions? [E-mail HEALTH Plus](#)

*As of 3:45 PM, November 20, 2008



Employee ID: 0069312

Sources of funds



School of Public Health and Health Services, The George Washington University Medical Center
Source: Health, United States, 2001.

We need to put brakes on the system

- Employer shift to defined contribution – CDHP plans – will continue
 - What is the price elasticity for many services?
 - Does result in lower consumption – but doesn't attack the big cost drivers.
- A return to a focus on perceived value for a dollar
- A redefinition of the unit of purchase.

The Supply Side

- How we pay is what matters.
- Current per-click environment coupled with information asymmetry and inability to contract on output has lead to

The National Backdrop

- Standard & Poor's analyst Nikola Swann said Jan 10th that, all things being equal, by 2020 the net U.S. debt would represent roughly 242% of gross domestic product. "If nothing is done about <Medicare>, eventually that would lead to a downgrade," Mr. Swann said in an interview. "But we do expect something to be done, eventually." The S&P report said a downgrade could occur as soon as 2015.

Fun Facts

- When health care reaches 22% of GDP it structurally crowds out national defense.
 - Here come the Canadians!
- AARP is the second largest employer in Washington DC
- A trillion is a lot of seconds

Medicare

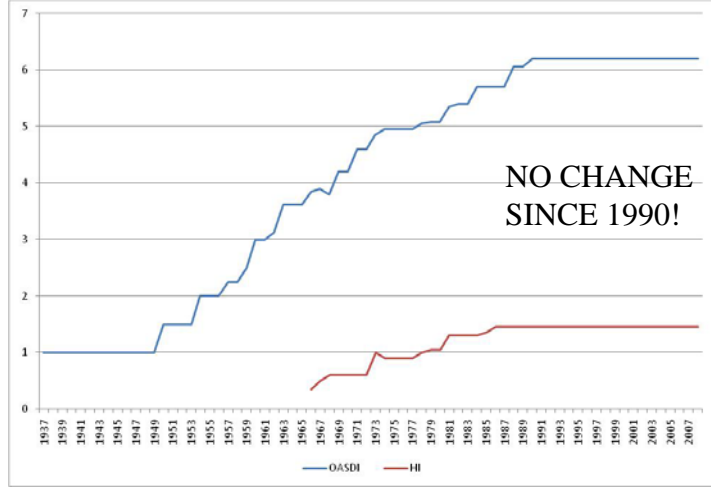
- The current Medicare trustees report states that we are currently **37 TRILLION** dollars short on our current obligations.
 - Since 2001 Benefits have increased by 15.5%
- Add Medicaid and other entitlements and we end up 54 TRILLION dollars short.
- To put this in perspective the US GDP is about 14 trillion.



How much did you pay into Medicare?

- Assume somebody turns 65 and becomes eligible for Medicare this year.
 - Started paying in 1967.
- Based on the average wage for a male over the 42 years he would have paid:
 - Medicare:
 - \$9443 in nominal dollars, \$14,866 in 2006 dollars
 - \$32,537 assuming 4% rate

Changing Nature of Tax Burden



Our goal

- Develop a reimbursement mechanism that rewards the system for providing the appropriate care in the appropriate location at the appropriate time.
- First best outcome: Pay for desirable outcomes per unit of cost (value)

Problems

- Unobservability of output.
- Nondeterministic nature of production process
- Information asymmetry between purchaser and provider
- Role of patient in outcome – compliance
- Lack of consensus on appropriate process of care.

What we know about provider behavior

- If you pay providers on a flat salary they will undersupply effort.
- If you pay providers on a piece rate they will oversupply effort.
- Theoretical research has shown that a second best approach is a blend of the two

Current state of payment

- Payment tied to the provider and site of service.
- Individual providers largely RBRVS – FFS
- Hospitals – DRG based case rate
- Incentive conflict between physicians and hospitals
- RESULT: Inefficiency and increased cost

Political support for Episode based approaches

- Daschle last fall was promoting episode based approaches because they would create “better outcomes and lower cost with less hassle”
- Baucus authored white paper last fall encouraged moving Medicare toward bundled payments for hospitalized patients.

Early efforts

- Geisinger Health System – ProvenCare system
 - Episodes for CABG, hip replacement, cataract surgery, bariatric surgery, lower back surgery, perinatal care.
- CMS – Medicare Acute Care Episode (ACE)
 - 28 cardiac & 9 orthopedic inpatient procedures
 - Bundled payment for part A and B
 - Baptist Health System (San Antonio, Texas)
 - Oklahoma Heart Hospital, LLC (Oklahoma City, Oklahoma)
 - Exempla Saint Joseph Hospital (Denver, Colorado)
 - Hillcrest Medical Center (Tulsa, Oklahoma)
 - Lovelace Health System (Albuquerque, New Mexico)

Early Efforts

- PROMETHEUS in collaboration with MassPRO
 - Clinical episodes associated with Diabetes, COPD, CHF, MI, CAD, Ortho procedures
 - Global fees for evidence-informed Case Rates (ECRs)
 - Implemented in 3 sites in 2009
 - Rockford, IL
 - Medica & Healthpartners in MN
 - Crozer-Keystone in Philadelphia

Early evidence

- Well it is scant and we are early
- Medicare Heart Bypass Demonstration (1998)
 - 3 of 7 hospitals experienced statistically significant declines of 10%-40% in ICU and nursing expenses
 - 2 hospitals saw a significant decline of 30% in pharmacy cost per case.
 - Significant negative trend in inpatient mortality
- ProvenCare
 - Percentage of CABG patients receiving all recommended processes went from 59% to 100%
 - Length of stay for CABG dropped 16%
 - Mean hospital charges fell by 5.2%

Condition Dimensions

		Acuity	
		Low	High
Chronic	Thyroid Disorder		CHF
Acute	Psoriasis URI	Stroke	Cardiac Arrest

The Challenges

- Definition of Episodes
 - Current approaches address only a fraction of patient care
 - Who will define the episodes?
- Implementation
 - Episode payment get paid to whom
 - How can this work in the current fragmented system
- The process of transition
 - Current incentives in place do not support
- Accountability of providers
 - What is the rule for allocation
- Data infrastructure needs

Punch Line

- Past / Present
 - DEMAND: Disengaged patients / price insensitive / entitlement mentality
 - SUPPLY: Churn and burn, FFS reimbursement, maximize throughput of 99213s are bread and butter.
- Future
 - DEMAND: Greater price sensitivity, patient engagement, service variation, transparency, confusion over value
 - SUPPLY: Bundled / episode payment, alternative visit types, episode patient management