REDUCING HEALTHCARE COSTS WITHOUT RATIONING: Using Bundling and Episode-Based Payment to Encourage Efficiency and Higher-Value Care

Harold D. Miller
President and CEO
Network for Regional Healthcare Improvement
and
Executive Director
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The Healthcare Problem Washington Is Trying to Solve

Goal:
Fewer People Uninsured

Expand Health Insurance Coverage

Individual Mandate?
Employer Mandate?
Public Plan?
Community Rating?
But How to Pay For It?

Goal:
- Fewer People Uninsured
- Expand Health Insurance Coverage
- Reduce Healthcare Costs?

Raise Taxes?

Goal: Fewer People Uninsured
Figuring Out the Right Way to Reduce Healthcare Costs

Goal:
- Fewer People Uninsured

Expand Health Insurance Coverage

Rate Cuts & Rationing?

Higher-Value Delivery?

Reduce Healthcare Costs?

Raise Taxes?

Goal: Fewer People Uninsured
Reducing Costs Without Rationing

Goal:
Fewer People Uninsured
Expand Health Insurance Coverage
Reduce Healthcare Costs?
Rate Cuts & Rationing?
Raise Taxes?

THE “HOLY GRAIL”:
Better, More Affordable Health Care Without Rationing

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Reducing Costs Without Rationing: Prevention

Healthy Consumer → Continued Health → Preventable Condition
Reducing Costs Without Rationing: Avoiding Hospitalizations

Healthy Consumer → Continued Health → No Hospitalization → Acute Care Episode

Preventable Condition
Reducing Costs Without Rationing: Efficient, Successful Treatment

- Healthy Consumer
  - Continued Health
    - Preventable Condition
      - No Hospitalization
        - Acute Care Episode
          - Efficient Successful Outcome
            - High-Cost Successful Outcome
            - Complications, Infections, Readmissions
Current Payment Systems
Reward Waste & Inefficiency

Healthy Consumer

Continued Health

Preventable Condition

No Hospitalization

Acute Care Episode

Efficient Successful Outcome

High-Cost Successful Outcome

Complications, Infections, Readmissions

$
“Episode Payments” to Address Problems Within Episodes

Healthy Consumer → Continued Health → Preventable Condition → No Hospitalization

Episode-of-Care Payment

Acute Care Episode

Efficient, Successful Outcome

High-Cost Successful Outcome

Complications, Infections, Readmissions
“Comprehensive Care Payments”
To Avoid Episodes

Healthy Consumer → Continued Health

Comprehensive Care Payment

Preventable Condition → No Hospitalization

Episode-of-Care Payment

Acute Care Episode → Efficient, Successful Outcome

Complications, Infections, Readmissions → High-Cost Successful Outcome
Defining a Bundled Payment for Major Acute Episodes

Providers and Services

Length of Time
Episode Component #1: Treatment as Expected

Treatment for Conditions Present on Admission

Length of Time

Providers and Services
Potential Episode Component #2: Treatment for Adverse Events

PROBLEMS:
• No penalty for quality problems
Potential Episode Component #3: Post-Acute Care

PROBLEMS:
• No penalty for quality problems

PROBLEMS:
• No incentive to use post-hospital care efficiently

Treatment for Conditions Present on Admission → Treatment for Hospital-Acquired Conditions → Post-Hospital Care

Length of Time

Providers and Services
Potential Episode Component #4: Readmissions

PROBLEMS:
• No penalty for quality problems

PROBLEMS:
• No incentive to use post-hospital care efficiently

PROBLEMS:
• No incentive to prevent readmissions

Providers and Services

Length of Time

Treatment for Conditions Present on Admission

Treatment for Hospital-Acquired Conditions

Post-Hospital Care

Hospital Readmission
Which Providers & Services Are “Bundled” Into Each Component?

- Treatment for Conditions Present on Admission
- Treatment for Hospital-Acquired Conditions
- Post-Hospital Care
- Hospital Readmission

**Length of Time**

**Providers and Services**

**PROBLEMS:**
- No penalty for quality problems
- No incentive to use post-hospital care efficiently
- No incentive to prevent readmissions
Non-MD Hospital Services Are “Bundled” Today Under DRGs

- Treatment for Conditions Present on Admission
- Hospital Services: Drugs & Devices, Non-MD Staff, Facilities/Equipment
- Treatment for Hospital-Acquired Conditions
- Post-Hospital Care
- Hospital Readmission

PROBLEMS:
- No penalty for quality problems
- No incentive to use post-hospital care efficiently
- No incentive to prevent readmissions

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But Physicians Are Paid Separately, Many on FFS

**Hospital Services**
- Drugs & Devices
- Non-MD Staff
- Facilities/Equipment

**Physician Services**

**PROBLEMS:**
- No incentive for MDs to improve hospital efficiency
- No penalty for quality problems
- No incentive to use post-hospital care efficiently
- No incentive to prevent readmissions
Treatment for Complications May Add Additional Services/MDs

Treatment for Conditions Present on Admission
- Hospital Services
  - Drugs & Devices
  - Non-MD Staff
  - Facilities/Equipment
- Physician Services
- Physician Services

Treatment for Hospital-Acquired Conditions
- Hospital Services
  - Drugs & Devices
  - Non-MD Staff
  - Facilities/Equipment
- Physician Services
- Physician Services

Post-Hospital Care
- Hospital Services
- Physician Services

Hospital Readmission
- Hospital Services
- Physician Services

PROBLEMS:
- No incentive to prevent readmissions
- No incentive to use post-hospital care efficiently
- No penalty for quality problems
- No incentive for MDs to improve hospital efficiency

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Many Different Providers Involved in Post-Acute Care

- Treatment for Conditions Present on Admission
  - Hospital Services
  - Drugs & Devices
  - Non-MD Staff
  - Facilities/Equipment
  - Physician Services
  - Physician Services

- Treatment for Hospital-Acquired Conditions
  - Hospital Services
  - Drugs & Devices
  - Non-MD Staff
  - Facilities/Equipment
  - Physician Services
  - Physician Services

- Post-Hospital Care
  - Rehab
  - Home Health
  - Long-Term Care
  - MD Services

- Hospital Readmission

PROBLEMS:
• No incentive for MDs to improve hospital efficiency
• No penalty for quality problems
• No incentive to use post-hospital care efficiently
• No incentive to prevent readmissions

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Some Readmissions Are Planned, Some Are Preventable

**PROBLEMS:**
- No incentive for MDs to improve hospital efficiency

**PROBLEMS:**
- No penalty for quality problems

**PROBLEMS:**
- No incentive to use post-hospital care efficiently

**PROBLEMS:**
- No incentive to prevent readmissions

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Inpatient Bundle:
Hospitals & MDs in a Super-DRG

**PROBLEMS:**
- No penalty for quality problems
- No incentive to use post-hospital care efficiently
- No incentive to prevent readmissions

**INPATIENT BUNDLE**
- Treatment for Conditions Present on Admission
  - Hospital Services
    - Drugs & Devices
    - Non-MD Staff
    - Facilities/Equipment
  - Physician Services
- Treatment for Hospital-Acquired Conditions
  - Hospital Services
    - Drugs & Devices
    - Non-MD Staff
    - Facilities/Equipment
  - Physician Services
- Post-Hospital Care
  - Rehab
  - Home Health
  - Long-Term Care
  - MD Services
- Hospital Readmission
  - No Readmit; Planned or Unpreventable Readmission
  - Readmission Preventable By Post-Acute Care
  - Readmission Preventable During Initial Admission
Inpatient Bundle Doesn’t Address Other Problems

PROBLEMS:
- No penalty for quality problems

PROBLEMS:
- No incentive to use post-hospital care efficiently

PROBLEMS:
- No incentive to prevent readmissions

INPATIENT BUNDLE

Treatment for Conditions Present on Admission

Treatment for Hospital-Acquired Conditions

Hospital Services
- Drugs & Devices
- Non-MD Staff
- Facilities/Equipment

Physician Services

Post-Hospital Care

Rehab

Home Health

Long-Term Care

MD Services

Hospital Readmission

No Readmit; Planned or Unpreventable Readmission

Readmission Preventable By Post-Acute Care

Readmission Preventable During Initial Admission

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Inpatient Warranty: No Additional Payment for Adverse Events

PROBLEMS:
- No incentive to prevent readmissions
- No incentive to use post-hospital care efficiently
Inpatient Warranties Don’t Address Post-Discharge Costs

PROBLEMS:
• No incentive to prevent readmissions

PROBLEMS:
• No incentive to use post-hospital care efficiently

INPATIENT BUNDLE

- Treatment for Conditions Present on Admission
- Treatment for Hospital-Acquired Conditions
- Post-Hospital Care
- Hospital Readmission

No Readmit; Planned or Unpreventable Readmission
- Rehab
- Home Health
- Long-Term Care
- MD Services

Readmission Preventable By Post-Acute Care
Readmission Preventable During Initial Admission
Inpatient + Post-Acute Bundling

PROBLEMS:
• No incentive to prevent readmissions

INPATIENT BUNDLE

INPATIENT WARRANTY

INPATIENT+POST-ACUTE BUNDLE

Treatment for Conditions Present on Admission

Treatment for Hospital-Acquired Conditions

Post-Hospital Care

Hospital Readmission

No Readmit; Planned or Unpreventable Readmission

Readmission Preventable By Post-Acute Care

Readmission Preventable During Initial Admission

Rehab
Home Health
Long-Term Care
MD Services
The Last Group of Problems: Preventable Readmissions

PROBLEMS:
• No incentive to prevent readmissions
Incorporating the Costs of Preventable Readmissions

- Treatment for Conditions Present on Admission
- Treatment for Hospital-Acquired Conditions
- Post-Hospital Care
- No Readmit; Planned or Unpreventable Readmission
- Readmission Preventable By Post-Acute Care
- Readmission Preventable During Initial Admission

INPATIENT BUNDLE
INPATIENT+POST-ACUTE BUNDLE
FULL EPISODE WITH WARRANTY

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Full Episode Payment With a “Limited Warranty”

- Treatment for Conditions Present on Admission
- Treatment for Hospital-Acquired Conditions
- Post-Hospital Care
- Hospital Readmission
  - Unpreventable Readmit

INPATIENT BUNDLE
INPATIENT WARRANTY
INPATIENT+POST-ACUTE BUNDLE
FULL EPISODE WITH WARRANTY
## Different Episode/Bundling Concepts for Different Problems

<table>
<thead>
<tr>
<th>PROBLEM/GOAL</th>
<th>PAYMENT METHOD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Encourage physicians to work with hospitals to eliminate inpatient inefficiencies</td>
<td>INPATIENT BUNDED PAYMENT</td>
</tr>
<tr>
<td>Encourage reduction in adverse events during inpatient care</td>
<td>INPATIENT WARRANTY</td>
</tr>
<tr>
<td>Encourage more efficient combinations of inpatient &amp; post-acute care</td>
<td>BUNDLED INPATIENT &amp; POST-ACUTE CARE PAYMENT</td>
</tr>
<tr>
<td>Encourage efficiency and quality across the full episode of care</td>
<td>FULL EPISODE PAYMENT WITH LIMITED WARRANTY</td>
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</table>
Potential Savings from Bundled Payments/Warranties: 10-40%

- Texas Heart Institute’s bundled payment for CABG surgery was 13% lower than what Medicare paid. (1987)

- Michigan orthopedic surgeon’s bundled price and 2-year warranty for shoulder and knee surgery was 40% lower cost than previously (savings from less radiography and physical therapy, shorter hospital stay, reduced complications/readmissions). (1987)

- Medicare’s Participating Heart Bypass Center Demonstration’s bundled payment for CABG surgery was 10-37% below previous payments at four hospitals (savings from reduced length of stay and avoidance of unnecessary hospital costs; costs decreased by 2%-23% in nominal terms in 3 of 4 hospitals). (1990s)
Alternatives to Warranties
Don’t Work Well

• P4P: Pay More for Lower Infections
  – incentive payments not enough to offset disincentives in FFS
  – requires accurate reporting

• Medicare: Don’t Let Infections Bump Up Payment
  – infection alone generally doesn’t bump up payment
  – infections cause other complications or outlier payments

• Medicare: Don’t Pay for Readmissions
  – most preventable readmissions aren’t preventable by the hospital,
    they require better primary care
  – assumes hospital will continue to treat without payment

• “Limited Warranty”
  – Internalizing the costs of failures into a single price gives the hospital
    both a financial AND a quality incentive to improve (similar to way
    DRGs internalized the incentive to reduce length of stay)
  – hospital can advertise that it is warranting its care (a positive selling
    point) rather than reporting its error rate or readmission rate
    (a negative selling point)
Payment Level (Price) is as Important as Payment System

**METHODS OF SETTING PRICES**

<table>
<thead>
<tr>
<th>Method</th>
<th>Description</th>
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<tbody>
<tr>
<td>Regulation</td>
<td>Maryland sets all-payer rates for hospital services</td>
</tr>
<tr>
<td>Large Payer Dictation</td>
<td>Congress/CMS establish the rates Medicare will pay</td>
</tr>
<tr>
<td>Small Payer Negotiation</td>
<td>Result varies depending on size of payer vs. provider</td>
</tr>
<tr>
<td>Competition</td>
<td>Providers set prices in order to attract more patients</td>
</tr>
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Prices for Warranted Care May Be Higher, But Spending Lower

• Q: “Why should we pay more to get good-quality care?”
• A: In most industries, warrantied products cost more, but they’re desirable because TOTAL spending on the product (repairs & replacement) is lower than without the warranty.
Prices for Warranted Care May Be Higher, But Spending Lower

• Q: “Why should we pay more to get good-quality care??”
• A: In most industries, warrantied products cost more, but they’re desirable because TOTAL spending on the product (repairs & replacement) is lower than without the warranty
• In healthcare, a DRG with a warranty would need to have a higher payment rate than the equivalent non-warrantied DRG, but the higher price would be offset by fewer DRGs w/ complications, outlier payments, and readmissions
  – Without Warranty:
    $10,000 DRG + 20% defects @ $20,000 = $14,000/case
  – With Warranty:
    $12,000/case – creates incentive to reduce defect rate to <10%
• A single, understandable, full-episode price will facilitate consumer choice and provider competition
Moving Back in the Value Chain: Choosing Higher-Value Providers

CHOICES OF PROVIDERS & TREATMENTS

PATIENT

DOCTOR

HOSPITAL 1
Inpatient Episode
Extent of Warranty

HOSPITAL 2
Inpatient Episode
Extent of Warranty

PROBLEMS:
• No incentive to choose lower cost provider
Once Treatment is Chosen, Who Is the Highest-Value Provider?

Average Commercial Payment for CABG (2005)

Choosing Higher-Value Treatments

CHOICES OF PROVIDERS & TREATMENTS

PATIENT

DOCTOR

HOSPITAL 1
Inpatient Episode

HOSPITAL 2
Inpatient Episode

HOSPITAL 1,2
Other Treatment

PROBLEMS:
• No incentive to choose lower cost provider

PROBLEMS:
• No incentive to choose lower cost treatment
Including Completely Different Venues/Treatments

CHOICES OF PROVIDERS & TREATMENTS

PATIENT

DOCTOR

HOSPITAL 1
Inpatient Episode

Extent of Warranty

HOSPITAL 2
Inpatient Episode

Extent of Warranty

HOSPITAL 1,2
Other Treatment

Extent of Warranty

NON-HOSPITAL TREATMENT

PROBLEMS:
• No incentive to choose lower cost provider

PROBLEMS:
• No incentive to choose lower cost treatment

PROBLEMS:
• No incentive to choose non-hospital treatment
Example: Avoiding Unnecessary Cesareans, Using Birth Centers

Average Facility Labor & Birth Charge, 2003

- Cesarean Delivery (No Complications)
- Vaginal Delivery (No Complications) - Hospital
- Vaginal Delivery - Birth Center

Source: Carol Sakala and Maureen Corry, *Evidence-Based Maternity Care: What It Is and What It Can Achieve*, Milbank Memorial Fund 2008

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Option 1: Give the Physician an Incentive for Higher Value Choice

CHOICES OF PROVIDERS & TREATMENTS

PATIENT

DOCTOR

P4P or Diagnosis-Based Payment

HOSPITAL 1
Inpatient Episode

Extent of Warranty

HOSPITAL 2
Inpatient Episode

Extent of Warranty

HOSPITAL 1,2
Other Treatment

Extent of Warranty

NON-HOSPITAL TREATMENT
Ideal: Payment Based on Diagnosis, Not Treatment

- DRGs are “Diagnosis Related Groups” but many are based on the treatment/procedure, not the diagnosis
  - MS-DRG 234: Coronary bypass surgery with cardiac catheterization without major complications
  - MS-DRG 236: Coronary bypass surgery without cardiac catheterization without major complications
  - MS-DRG 247: Percutaneous cardiovascular procedure with drug-eluting stent without major complications
- Treatment-based payment gives no incentive for using less expensive treatment
- Diagnosis-based payment would still be severity-adjusted, so that providers would receive higher payment for patients with more co-morbidities or more severe disease
20-40% Reduction in Surgery Through Shared Decision-Making

Option 2: Give the Patient an Incentive for Higher Value Choice

Patient Cost-Sharing

CHOICES OF PROVIDERS & TREATMENTS

PATIENT

DOCTOR

HOSPITAL 1
Inpatient Episode
Extent of Warranty

HOSPITAL 2
Inpatient Episode
Extent of Warranty

HOSPITAL 1,2
Other Treatment
Extent of Warranty

NON-HOSPITAL TREATMENT
What’s The Incentive to Use Higher-Value Providers/Services?

EXAMPLES:

- High-Cost Hospital vs. Low-Cost Hospital
- CABG vs. Medical Management
- Hospital vs. Birth Center
Copays/Coinsurance Don’t Reveal True Differences in Value

Current Cost-Sharing Mechanisms Provide Little Incentive to Choose Higher-Value Providers
Solution: Have Consumers Pay All or Part of the “Last Dollar”

Current Cost-Sharing Mechanisms Provide Little Incentive to Choose Higher-Value Providers

Paying a Share of the Difference in Total Cost Gives the Consumer an Incentive to Choose Higher-Value Providers
What If People Had Insurance for Auto Purchases?

HYUNDAI SONATA

MSRP: $19,900

LEXUS LS 460

MSRP: $63,825
## Copayment: Lexus Wins

<table>
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Coinsurance: Lexus Wins for Most People

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$1,000 $1,990 $6,383

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High Deductible Lexus Wins

HYUNDAI SONATA

MSRP: $19,900
$1,000 Copay: $1,000
10% Coinsurance: $1,990
High Deductible: $10,000

LEXUS LS 460

MSRP: $63,825
$1,000 Copay: $1,000
10% Coinsurance: $6,383
High Deductible: $10,000
Price Difference: Hyundai Wins for Most People

HYUNDAI SONATA

MSRP: $19,900

$1,000 Copay: $1,000

10% Coinsurance: $1,990

High Deductible: $10,000

Price Difference: $0 ✓

LEXUS LS 460

MSRP: $63,825

$1,000 Copay: $1,000 ✓

10% Coinsurance: $6,383 ✓

High Deductible: $10,000 ✓

Price Difference: $43,925
Benefit Design Changes Needed As Well As Payment Reform

Ability and Incentives to:
• Improve health
• Take prescribed medications
• Allow a provider to coordinate care
• Choose the highest-value providers and services

![Diagram showing the relationship between Benefit Design and Payment System with Patient and Provider]

Ability and Incentives to:
• Keep patients well
• Avoid unneeded services
• Deliver services efficiently
• Coordinate services with other providers

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Further Up the Value Chain: Avoiding Episodes

How the Health Care System “Manages” a Patient with Chronic Disease(s)

Patient w/ Chronic Disease(s) → No Hospitalization

Hospitalization Episode

Readmission
Goal: Supporting Primary Care to Avoid Admissions & Readmissions

How the Health Care System “Manages” a Patient with Chronic Disease(s)

- Patient w/ Chronic Disease(s) → Primary Care → No Hospitalization
- Hospitalization Episode → Readmission
Dramatic Reductions in Rate of Hospitalizations Are Possible

Examples:

• 40% reduction in hospital admissions, 41% reduction in ER visits for exacerbations of COPD using in-home & phone patient education by nurses or respiratory therapists (2003)

• 66% reduction in hospitalizations for CHF patients using home-based telemonitoring (1999)
  M.E. Cordisco, A. Benjaminovitz, et al, “Use of Telemonitoring to Decrease the Rate of Hospitalization in Patients With Severe Congestive Heart Failure,” *American Journal of Cardiology* 84(7), 1999

• 27% reduction in hospital admissions, 21% reduction in ER visits through self-management education (2005)
PCPs Can’t Get Paid for Many Tools To Avoid Hospitalization...

How the Health Care System “Manages” a Patient with Chronic Disease(s)

Patient w/ Chronic Disease(s) → Primary Care → No Hospitalization

- MD Office Visits
- E-Visits/Phone Calls
- Nurse Care Mgt
- Remote Monitoring
- Affordable? Drugs

Hospitalization Episode → Readmission
...While Tests and Consultations Are Paid For

How the Health Care System “Manages” a Patient with Chronic Disease(s)
Comprehensive Care Payment
Gives Resources + Accountability

How the Health Care System “Manages” a Patient with Chronic Disease(s)

Patient w/ Chronic Disease(s)

Primary Care

Tests
Specialist
More Tests

No Hospitalization

MD Office Visits
E-Visits/Phone Calls
Nurse Care Mgt
Remote Monitoring
Affordable? Drugs

Hospitalization Episode

Readmission

COMPREHENSIVE CARE PAYMENT

Specialist2
More Tests
Isn’t That Capitation?
No – It’s Different

Pay providers a single amount for all care needed by a patient in the course of a year, BUT:

• Adjust payment based on the conditions and characteristics of the patients being cared for
• Set payment levels adequately for good-quality care
• Make special provisions for unusually high-cost cases, such as outlier payments & reinsurance
• Don’t require providers to establish claims-payment systems
• Require providers to collect and publicly report measures of quality of care
• Give patients flexibility to choose high quality providers, but encourage them to use a consistent medical home
Examples of Comprehensive Care Payment

- **Patient Choice** ([www.patientchoicehealthcare.com](http://www.patientchoicehealthcare.com))
  - “care systems” bid on risk-adjusted (total) cost of patient care and patients select care systems based on cost/quality
  - built on fee for service, but with addition of new codes to cover previously unpaid services

- **PROMETHEUS Payment** ([www.prometheuspayment.org](http://www.prometheuspayment.org))
  - “Year-Long Episodes of Care” for major chronic diseases
  - Provides a prospective budget for spending

- **Alternative Quality Contract (Massachusetts BC/BS)** ([www.bluecrossma.com](http://www.bluecrossma.com))
  - Severity-adjusted capitation payment
  - Quality incentives
Different Payment Systems Solve Different Value Problems

- Inefficiency
- Cost Per Episode
- Underpayment
- Underuse
- Frequency of Episodes
- Overuse

Episode Payment for Treatments Where Overuse Is Not a Concern

Examples:
Hip Fractures,
Labor & Delivery

Harold D. Miller, From Volume to Value: Better Ways to Pay for Health Care, Health Affairs, September 2009
Comprehensive Care Payment
Where Overuse Is a Concern

- Inefficiency
- Cost Per Episode
- Underpayment

Episode Payment
- Examples: Hip Fractures, Labor & Delivery

Comprehensive Care Pmt. (or Year-Long Episodes)
- Examples: COPD, Congestive Heart Failure

Combination of Both to Reduce Overuse & Improve Efficiency

Inefficiency

Cost Per Episode

Underpayment

Episode Payment

Examples: Hip Fractures, Labor & Delivery

Comprehensive Care Pmt. + Episode Payment

Examples: Heart Disease, Back Pain

Comprehensive Care Pmt. (or Year-Long Episodes)

Examples: COPD, Congestive Heart Failure

Underuse

Frequency of Episodes

Overuse

Harold D. Miller, From Volume to Value: Better Ways to Pay for Health Care, Health Affairs, September 2009

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Fee for Service is Actually Desirable for Underused Services

- **Inefficiency**
  - **Episode Payment**
    - Examples: Hip Fractures, Labor & Delivery
  - **Comprehensive Care Pmt. + Episode Payment**
    - Examples: Heart Disease, Back Pain

- **Cost Per Episode**
  - **Fee for Service**
    - Examples: Immunizations, Simple Injuries
  - **Comprehensive Care Pmt. (or Year-Long Episodes)**
    - Examples: COPD, Congestive Heart Failure

- **Underpayment**
  - **Underuse**
    - Frequency of Episodes
  - **Overuse**


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For More Information on Alternative Payment Systems

www.PaymentReform.org
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