nrhi Network for Regional Healthcare Improvement

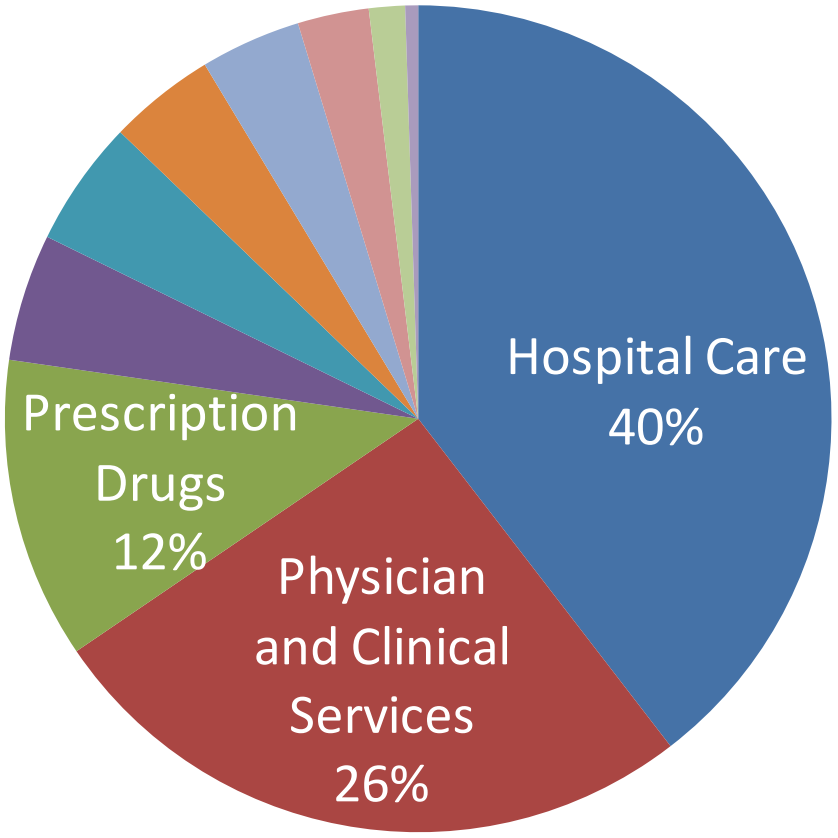
CENTER FOR HEALTHCARE QUALITY & PAYMENT REFORM

# OVERVIEW OF HOSPITAL PAYMENT ISSUES AND OPTIONS

**Harold D. Miller**
**President and CEO**
**Network for Regional Healthcare Improvement**
**and**
**Executive Director**
**Center for Healthcare Quality and Payment Reform**

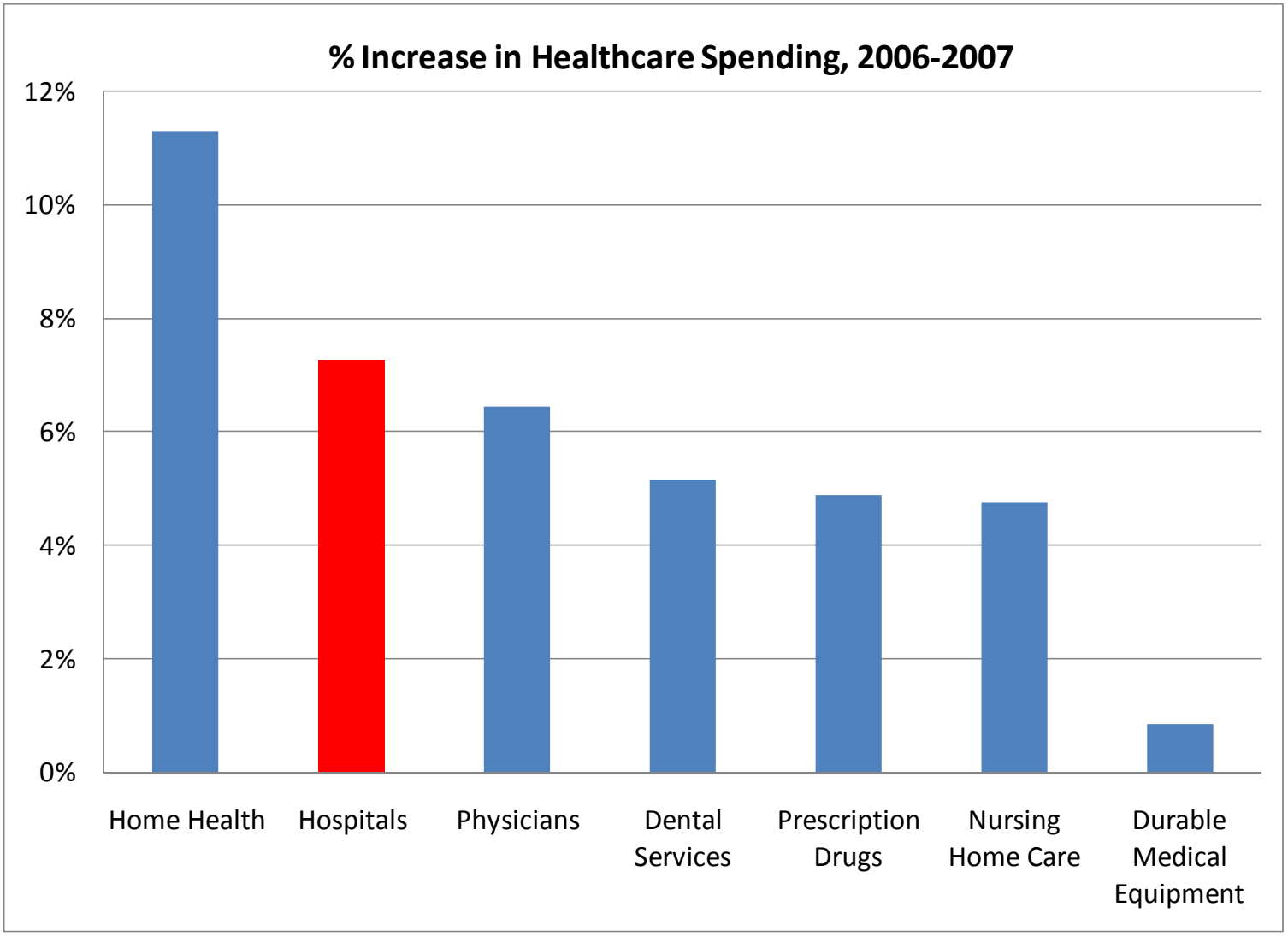
# Hospitals Are the Biggest Source of Increased Health Spending

**Contributions to Increased Personal Health Spending, 2004-2007**

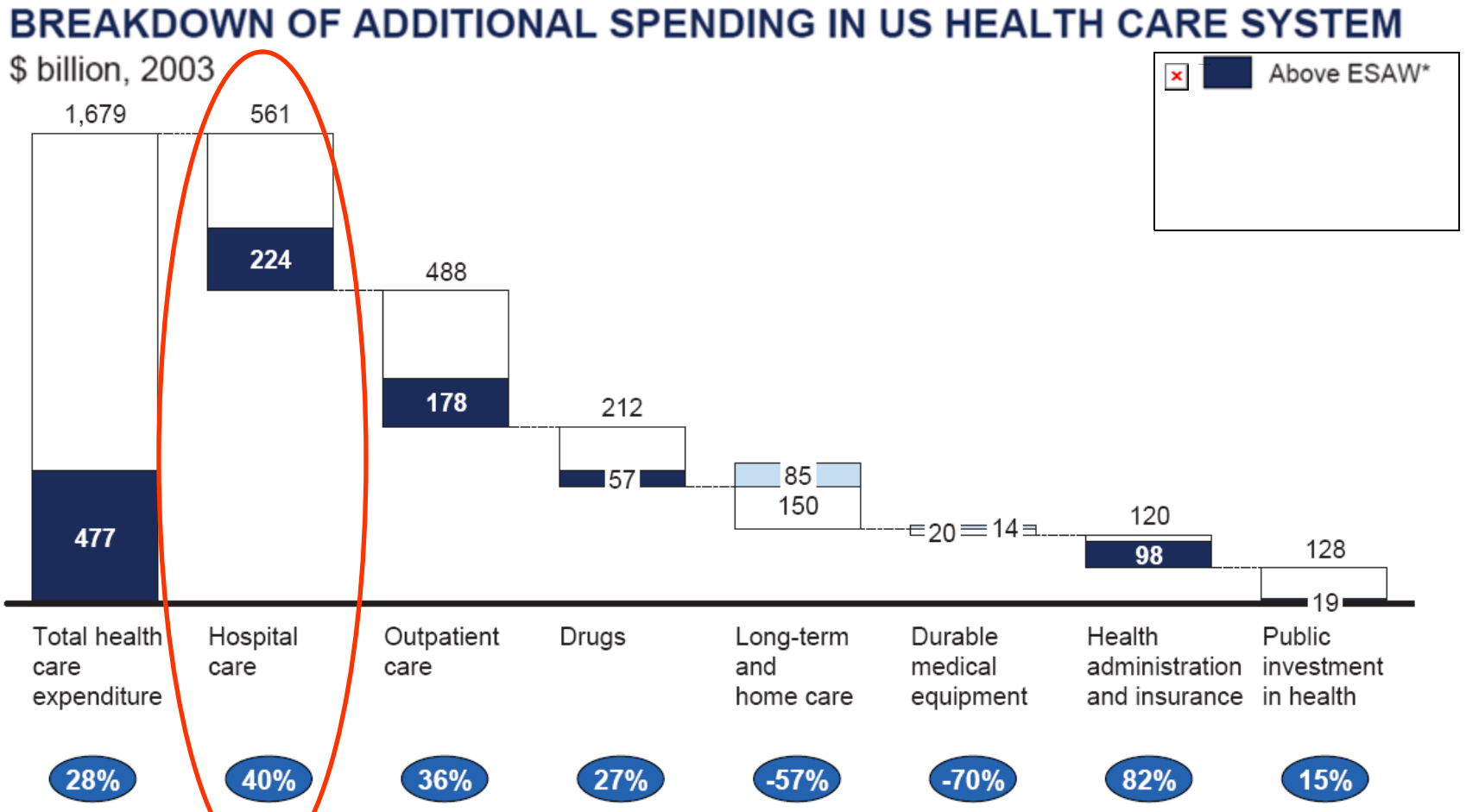



Hospital care contributed $130 billion of the $328 billion in increased personal health spending from 2004 to 2007

# Hospital Spending Increasing Faster Than Most Other Services



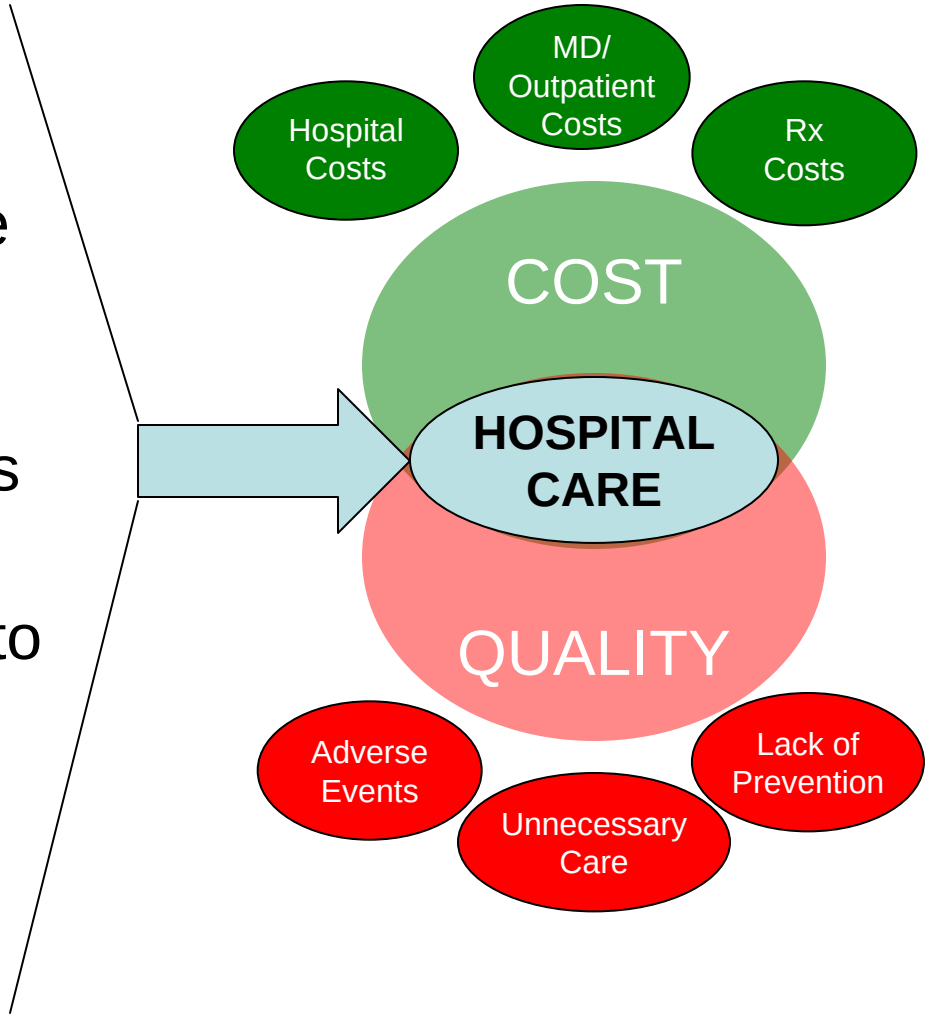
# Hospitals Are Biggest Difference in Spending from Other Countries




Source: McKinsey Global Institute,
"Accounting for the Cost of Health Care in the U.S."

# Reducing Healthcare Costs Means Spending Less on Hospital Care

- Biggest share of spending (41% of private spending)
- High rate of increase in private spending (27% growth, 2004-2007)
- A significant share of MD costs are hospital-based
- Hospital costs are higher due to adverse events
- Many hospital admissions are unnecessary or preventable



# Payment "Reforms" Being Discussed Today

- Cutting payment rates for hospitals
- Hospital price regulation
- Instituting pay-for-performance (P4P) for hospitals
- Penalizing hospitals for readmissions
- Refusing payment for infections and adverse events
- Bundled payment
- Episode payments
- Global payments
- Capitation

# The Health Care Cost Equation

## VARIABLES CONTRIBUTING TO THE COST OF CARE

$$\frac{\text{Cost}}{\text{Person}} =$$

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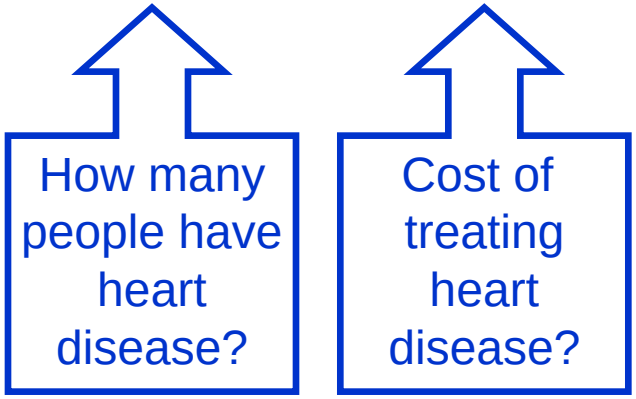

# The Health Care Cost Equation

## VARIABLES CONTRIBUTING TO THE COST OF CARE

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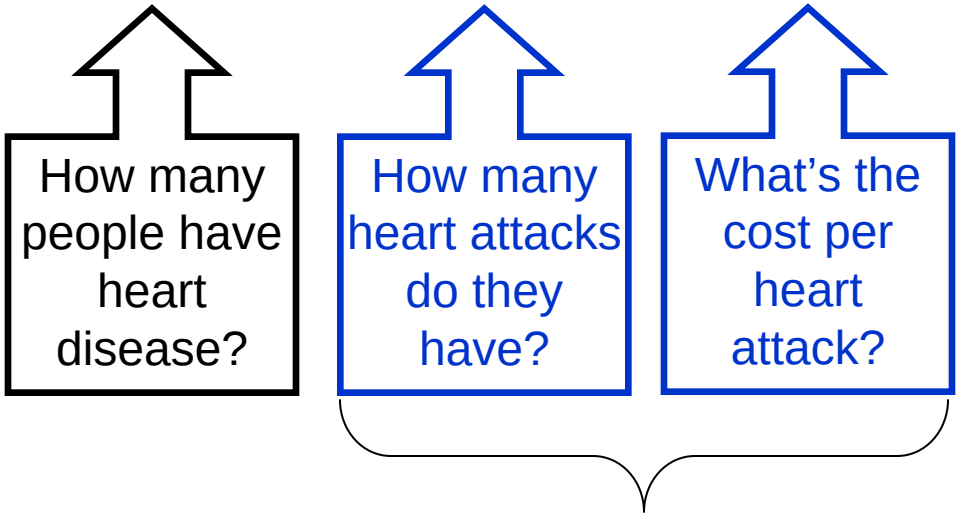

# The Health Care Cost Equation

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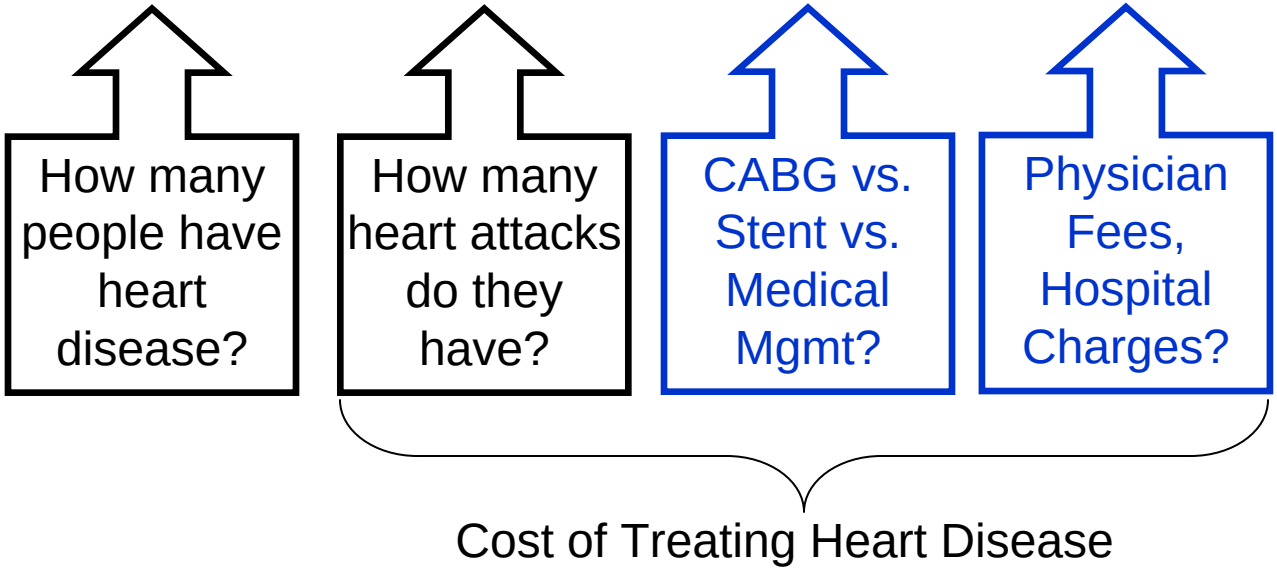

# The Health Care Cost Equation

## VARIABLES CONTRIBUTING TO THE COST OF CARE

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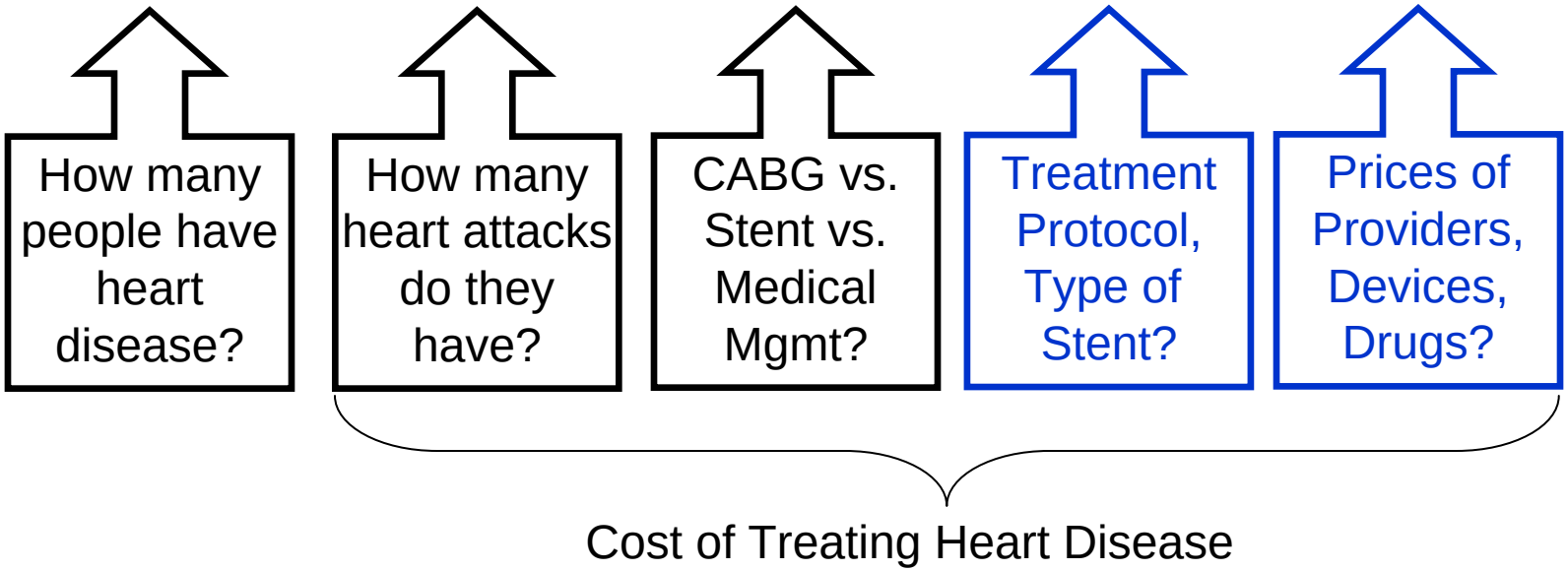


# Fee for Service System Only Controls A Small Part of Cost

**VARIABLES FOR WHICH THE PROVIDER IS AT RISK UNDER ALTERNATIVE PAYMENT SYSTEMS**

$$\frac{\text{Cost}}{\text{Person}} = \frac{\text{\# Conditions}}{\text{Person}} \times \frac{\text{\# Episodes of Care}}{\text{Condition}} \times \frac{\text{\#/Type Services}}{\text{Episode of Care}} \times \frac{\text{\# Processes}}{\text{Service}} \times \frac{\text{Cost}}{\text{Process}}$$

- FEE FOR SERVICE -

*i.e., a hospital or physician gets paid a specific, separate amount for each individual service provided (regardless of how many services are provided in total)*

# Health Care Costs Are Like a Balloon...

**VARIABLES FOR WHICH THE PROVIDER IS AT RISK UNDER ALTERNATIVE PAYMENT SYSTEMS**

$$\frac{\text{Cost}}{\text{Person}} = \frac{\text{\# Conditions}}{\text{Person}} \times \frac{\text{\# Episodes of Care}}{\text{Condition}} \times \frac{\text{\#/Type Services}}{\text{Episode of Care}} \times \frac{\text{\# Processes}}{\text{Service}} \times \frac{\text{Cost}}{\text{Process}}$$

- FEE FOR SERVICE -

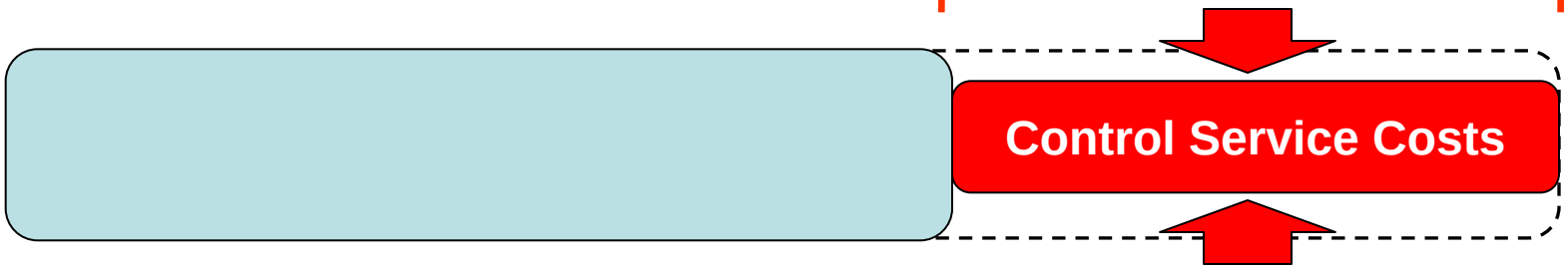
**The Health Care Cost "Balloon"**

# ...If You Try To Control a Part of the Costs...

**VARIABLES FOR WHICH THE PROVIDER IS AT RISK UNDER ALTERNATIVE PAYMENT SYSTEMS**

$$\frac{\text{Cost}}{\text{Person}} = \frac{\text{\# Conditions}}{\text{Person}} \times \frac{\text{\# Episodes of Care}}{\text{Condition}} \times \frac{\text{\#/Type Services}}{\text{Episode of Care}} \times \frac{\text{\# Processes}}{\text{Service}} \times \frac{\text{Cost}}{\text{Process}}$$

- FEE FOR SERVICE -



# ...They'll Increase Somewhere Else

**VARIABLES FOR WHICH THE PROVIDER IS AT RISK UNDER ALTERNATIVE PAYMENT SYSTEMS**

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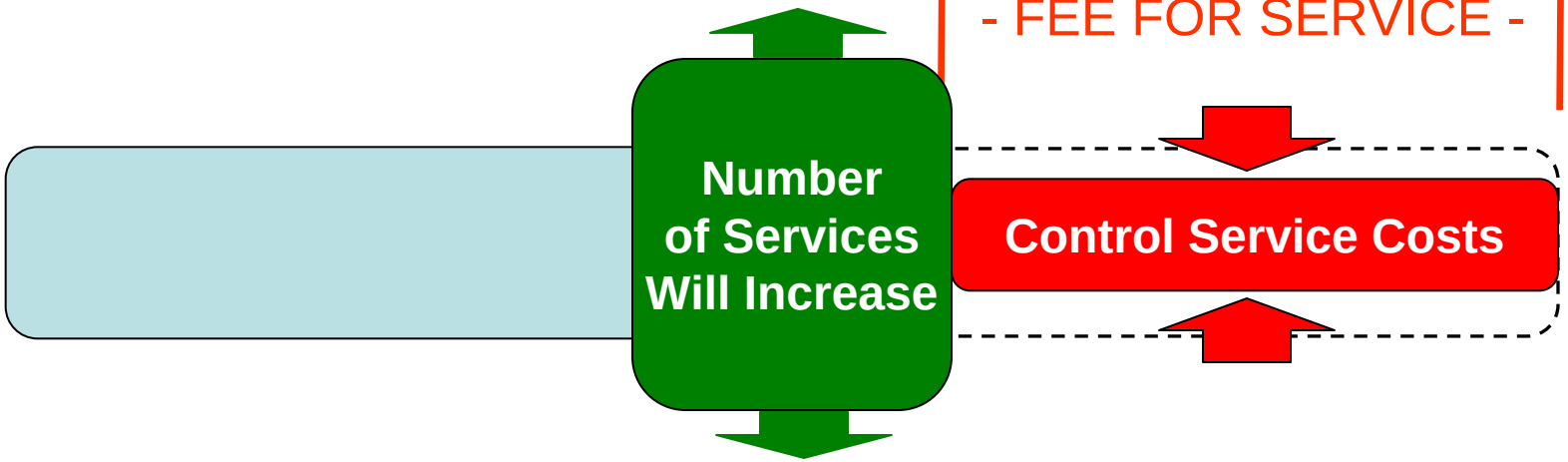
- FEE FOR SERVICE -



# Fee for Service System Result in Undesirable Effects…

**VARIABLES FOR WHICH THE PROVIDER IS AT RISK UNDER ALTERNATIVE PAYMENT SYSTEMS**

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- FEE FOR SERVICE -

- No Limit on # of Services
- Not All Services Paid For
- Not All Processes Provided

# …Which Payers Try to Solve By Layering on Controls & Incentives

**VARIABLES FOR WHICH THE PROVIDER IS AT RISK UNDER ALTERNATIVE PAYMENT SYSTEMS**

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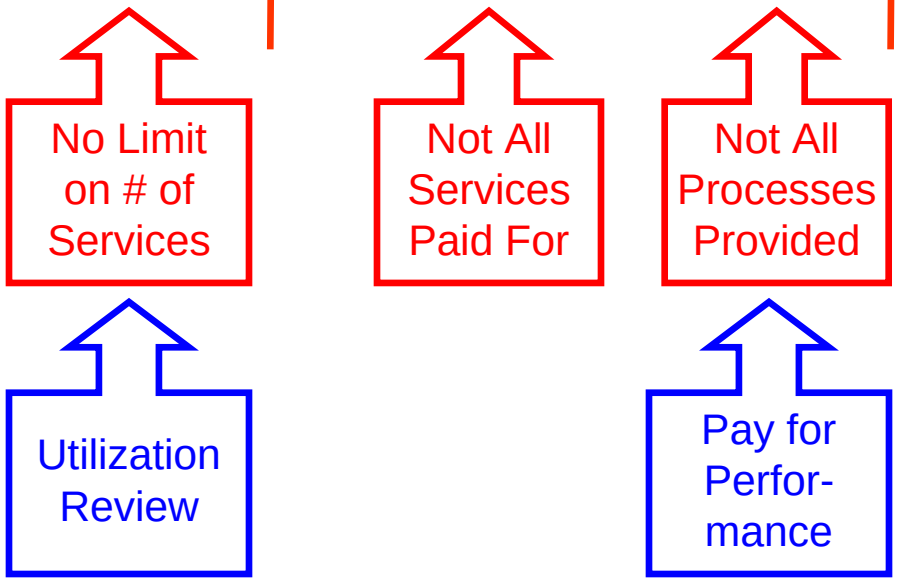
- FEE FOR SERVICE -



# Traditional Capitation "Solved" the Problems of Fee for Service…

**VARIABLES FOR WHICH THE PROVIDER IS AT RISK UNDER ALTERNATIVE PAYMENT SYSTEMS**

$$\frac{\text{Cost}}{\text{Person}} = \frac{\text{\# Conditions}}{\text{Person}} \times \frac{\text{\# Episodes of Care}}{\text{Condition}} \times \frac{\text{\#/Type Services}}{\text{Episode of Care}} \times \frac{\text{\# Processes}}{\text{Service}} \times \frac{\text{Cost}}{\text{Process}}$$

- FEE FOR SERVICE -

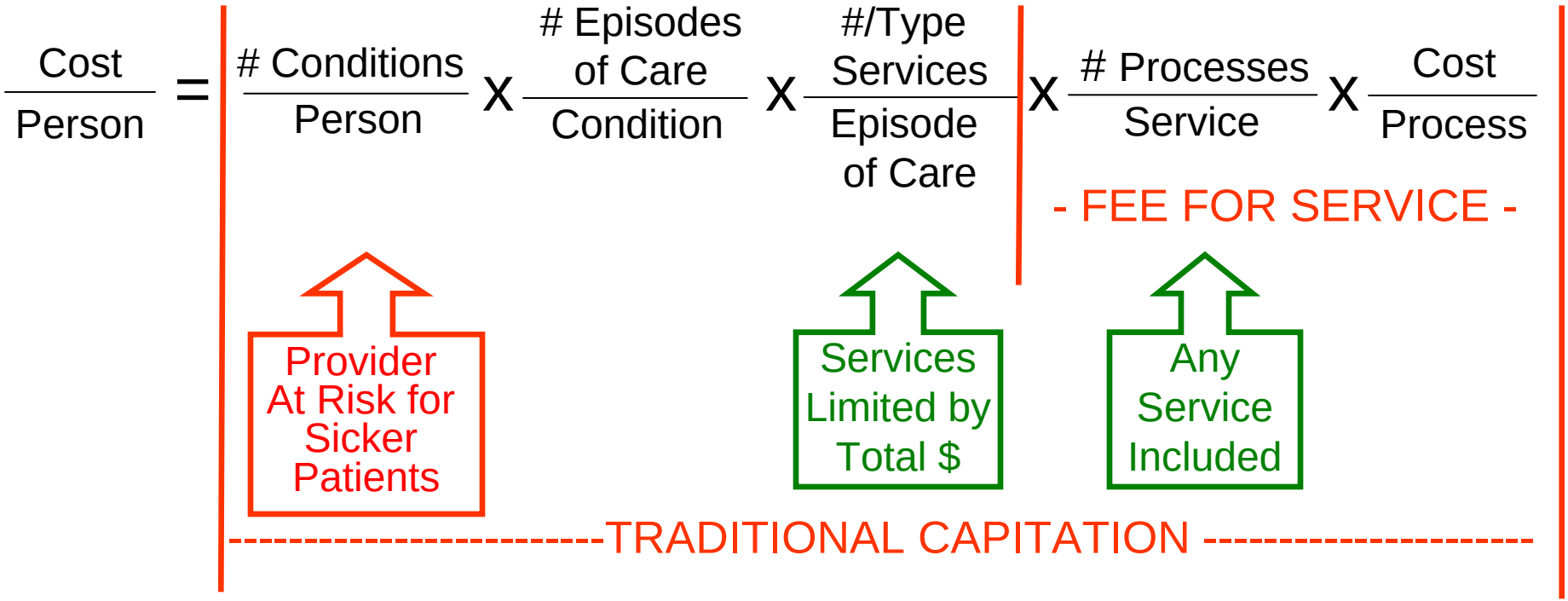
Services Limited by Total $

Any Service Included

----------TRADITIONAL CAPITATION ----------

# …But Went too Far in the Opposite Direction

**VARIABLES FOR WHICH THE PROVIDER IS AT RISK UNDER ALTERNATIVE PAYMENT SYSTEMS**



# Can We Strike the Right Balance Between Insurer & Provider Roles?

## VARIABLES FOR WHICH THE PROVIDER IS AT RISK UNDER ALTERNATIVE PAYMENT SYSTEMS

$$\frac{\text{Cost}}{\text{Person}} = \frac{\text{\# Conditions}}{\text{Person}} \times \frac{\text{\# Episodes of Care}}{\text{Condition}} \times \frac{\text{\#/Type Services}}{\text{Episode of Care}} \times \frac{\text{\# Processes}}{\text{Service}} \times \frac{\text{Cost}}{\text{Process}}$$

- FEE FOR SERVICE -

Provider At Risk for Sicker Patients

?

TRADITIONAL CAPITATION

PERFORMANCE RISK

INSURANCE RISK

# Middle Ground #1: Episode of Care Payment

**VARIABLES FOR WHICH THE PROVIDER IS AT RISK UNDER ALTERNATIVE PAYMENT SYSTEMS**

$$\frac{\text{Cost}}{\text{Person}} = \frac{\text{\# Conditions}}{\text{Person}} \times \frac{\text{\# Episodes of Care}}{\text{Condition}} \times \frac{\text{\#/Type Services}}{\text{Episode of Care}} \times \frac{\text{\# Processes}}{\text{Service}} \times \frac{\text{Cost}}{\text{Process}}$$

- FEE FOR SERVICE -

-- EPISODE OF CARE PAYMENT --

**PERFORMANCE RISK**

**INSURANCE RISK**

# Middle Ground #1: Episode of Care Payment

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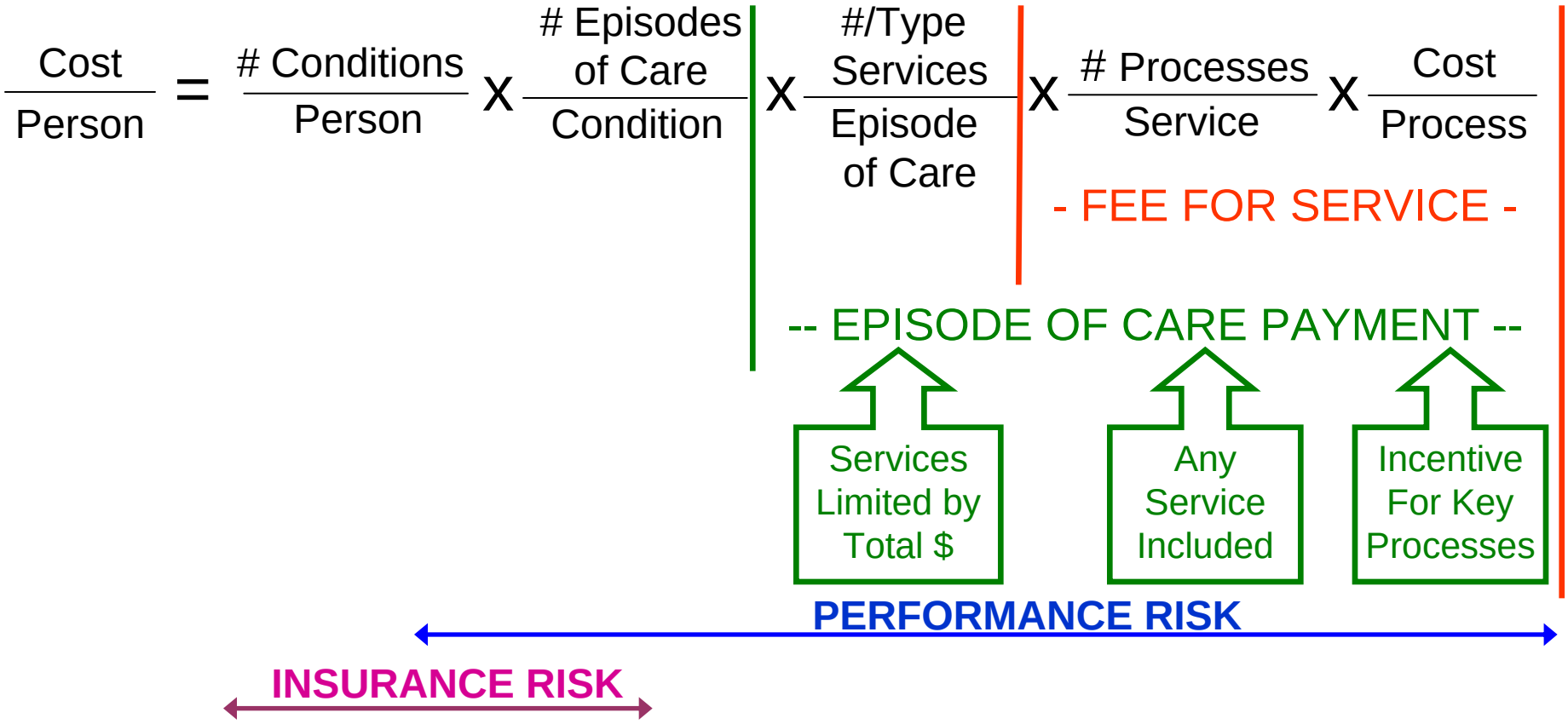
- FEE FOR SERVICE -

-- EPISODE OF CARE PAYMENT --

- How many people have heart disease?
- How many heart attacks do they have?
- CABG vs. Stent vs. Medical Mgmt?
- Treatment Protocol, Type of Stent?
- Prices of Providers, Devices, Drugs?

# Middle Ground #1: Episode of Care Payment

**VARIABLES FOR WHICH THE PROVIDER IS AT RISK UNDER ALTERNATIVE PAYMENT SYSTEMS**



# Episode Pmt Limits Cost *Within* Episodes, But Not # of Episodes

**VARIABLES FOR WHICH THE PROVIDER IS AT RISK UNDER ALTERNATIVE PAYMENT SYSTEMS**

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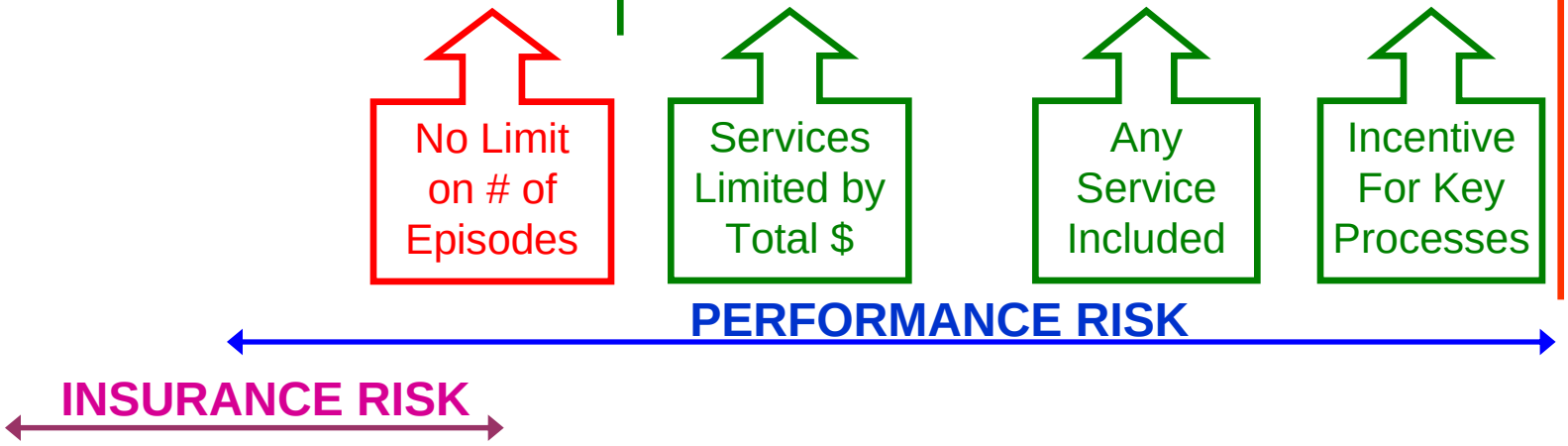
- FEE FOR SERVICE -

-- EPISODE OF CARE PAYMENT --



# Middle Ground #2: Comprehensive Care Payment

**VARIABLES FOR WHICH THE PROVIDER IS AT RISK UNDER ALTERNATIVE PAYMENT SYSTEMS**

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- FEE FOR SERVICE -

-- EPISODE OF CARE PAYMENT --

------- COMPREHENSIVE CARE PAYMENT ------

**PERFORMANCE RISK**

**INSURANCE RISK**

# Controlling # of Episodes: Comprehensive Care Payment

**VARIABLES FOR WHICH THE PROVIDER IS AT RISK UNDER ALTERNATIVE PAYMENT SYSTEMS**

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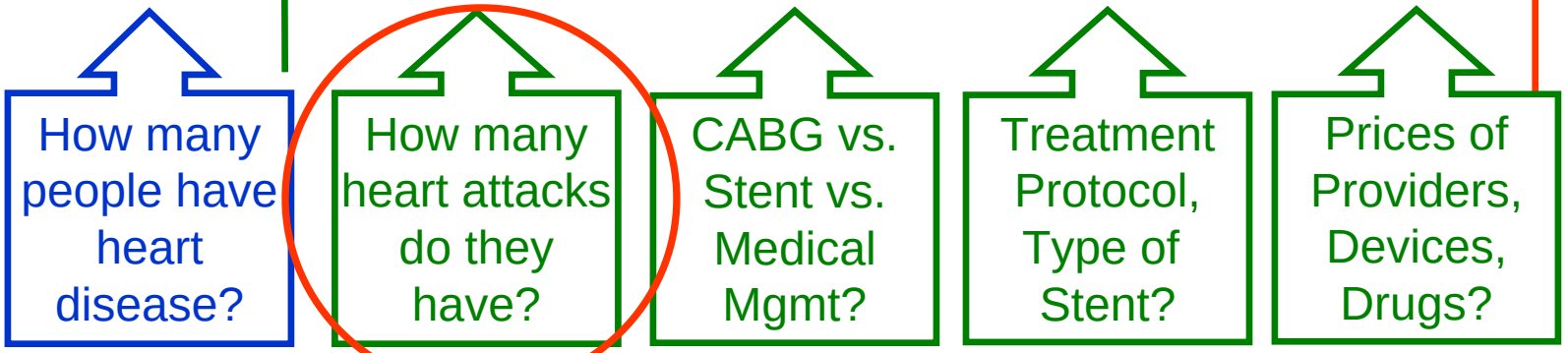
- FEE FOR SERVICE -

-- EPISODE OF CARE PAYMENT --

------- COMPREHENSIVE CARE PAYMENT ------



# How Hospitals Are Paid Today: Option 1- Cost-Based Payment

## VARIABLES FOR WHICH THE PROVIDER IS AT RISK UNDER ALTERNATIVE PAYMENT SYSTEMS

$$\frac{\text{Cost}}{\text{Person}} = \frac{\text{\# Conditions}}{\text{Person}} \times \frac{\text{\# Episodes of Care}}{\text{Condition}} \times \frac{\text{\#/Type Services}}{\text{Episode of Care}} \times \frac{\text{\# Processes}}{\text{Service}} \times \frac{\text{Cost}}{\text{Process}}$$

**Costs**

*e.g., Medicare Payments for Critical Access Hospitals*

# How Hospitals Are Paid Today: Option 2 – Fee for Service

**VARIABLES FOR WHICH THE PROVIDER IS AT RISK UNDER ALTERNATIVE PAYMENT SYSTEMS**

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**Costs**

**%Charges**

- FEE FOR SERVICE -

# Examples of Charges

| Cedars-Sinai Medical Center | | | | | |
|---|---|---|---|---|---|
| AB1045 Chargemaster Submission | | | | | |
| Prices Effective July 1, 2008 | | | | | |
| | | | | | |
| **Charge Code** | | **Description** | | **Price** | **CPT Code** |
| 1310504 | 1310504 | 02 CONNECTION TUBING MASK | $ | 183.50 | |
| 3830025 | 3830025 | 1 CHROMO ADD'L KARYO | $ | 162.81 | 88280 |
| 7927115 | 7927115 | 11-DEOXYCORTISOL | $ | 35.35 | 82634 |
| 7927128 | 7927128 | 17-HYDROXYPROGESTERONE | $ | 9.00 | 83498 |
| 880020 | 880020 | 2 CONTACT STRIP ELECTRODE | $ | 527.75 | |
| 1593053 | 1593053 | 23G BIPOLAR TAPERED FINE POINT | $ | 186.52 | |
| 1963053 | 1963053 | 23G BIPOLAR TAPERED FINE POINT | $ | 186.52 | |
| 860311 | 860311 | 24 HR ESOPHAGEAL PH STUDY | $ | 2,134.14 | 91034 |
| 860340 | 860340 | 24 HR PH PROBE | $ | 1,207.32 | |
| 6516019 | 6516019 | 3-0 SUTURE | $ | 122.96 | |
| 4090254 | 4090254 | 3D ULTRASOUND | $ | 1,219.23 | 76376 |
| 8378803 | 8378803 | 3MFCU - OBS, PER HR DIR-ADMIT | $ | 148.12 | G0379 |
| 8378801 | 8378801 | 3MFCU - OBSERVATION, PER HOUR | $ | 148.12 | G0378 |
| 8378802 | 8378802 | 3MFCU - SHORT STAY, PER HOUR | $ | 137.98 | |

# How Hospitals Are Paid Today: Option 3 – Per Diems, DRGs

**VARIABLES FOR WHICH THE PROVIDER IS AT RISK UNDER ALTERNATIVE PAYMENT SYSTEMS**

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**Costs**

**%Charges**

- FEE FOR SERVICE -

**Per Diem**

**DRGs**

-- EPISODE OF CARE PAYMENT --

# Examples of DRGs (Diagnosis-Related Groups)

| MS-DRG | Description |
|---|---|
| 001 | Heart transplant or implant of heart assist system w MCC |
| 002 | Heart transplant or implant of heart assist system w/o MCC |
| 010 | Pancreas transplant |
| 088 | Concussion w MCC |
| 089 | Concussion w CC |
| 090 | Concussion w/o CC/MCC |
| 193 | Simple pneumonia & pleurisy w MCC |
| 194 | Simple pneumonia & pleurisy w CC |
| 195 | Simple pneumonia & pleurisy w/o CC/MCC |
| 488 | Knee procedures w/o pdx of infection w CC/MCC |
| 489 | Knee procedures w/o pdx of infection w/o CC/MCC |
| 597 | Malignant breast disorders w MCC |
| 598 | Malignant breast disorders w CC |
| 599 | Malignant breast disorders w/o CC/MCC |
| 974 | HIV w major related condition w MCC |
| 975 | HIV w major related condition w CC |
| 976 | HIV w major related condition w/o CC/MCC |

# How DRGs Are Different From True Episode Payments

- Many “Diagnosis Related Groups” are really Treatment Related Groups, e.g., heart bypass surgery vs. treatment for moderate artery blockage
- Problems/diagnoses caused by the hospital are (in most cases) paid the same as those the patient was admitted with
- DRGs only include costs of the facility, drugs, devices, and non-physician staff; physicians are paid separately
- DRGs only include inpatient services, not post-acute care services, readmissions, etc.

# How Hospitals Are Paid Today: Option 4 – Capitation/Budgets

**VARIABLES FOR WHICH THE PROVIDER IS AT RISK UNDER ALTERNATIVE PAYMENT SYSTEMS**

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**Costs**

**%Charges**

- FEE FOR SERVICE -

**Per Diem**

**DRGs**

-- EPISODE OF CARE PAYMENT --

**Sub-Capitation**

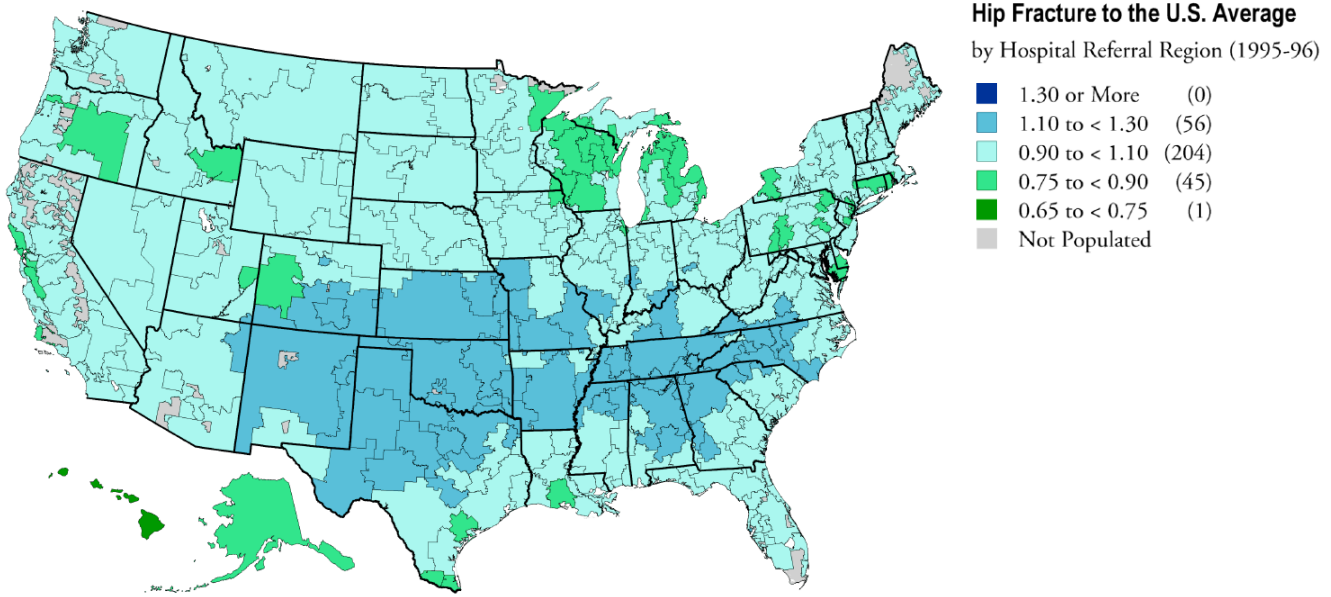
**Budgets**

------- COMPREHENSIVE CARE PAYMENT ------

# Episode or Comp. Care Pmt? Depends on What is Driving Costs

# For Some Conditions, # Episodes Is Independent of Healthcare...

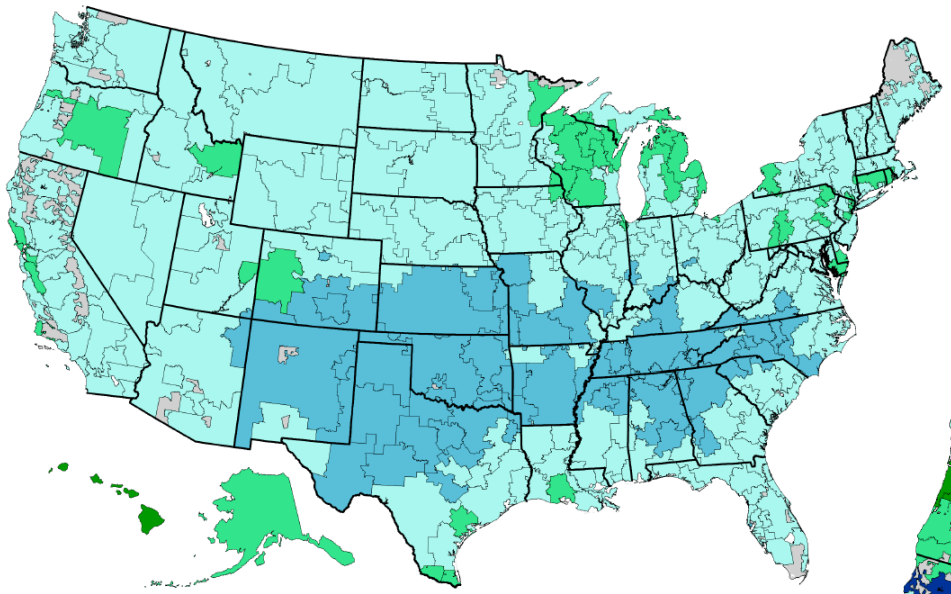
## Hip Fracture Surgery Rates




Source: Dartmouth Atlas

# ...For Other Conditions, Healthcare May Encourage More Episodes

## Hip Fracture Surgery Rates

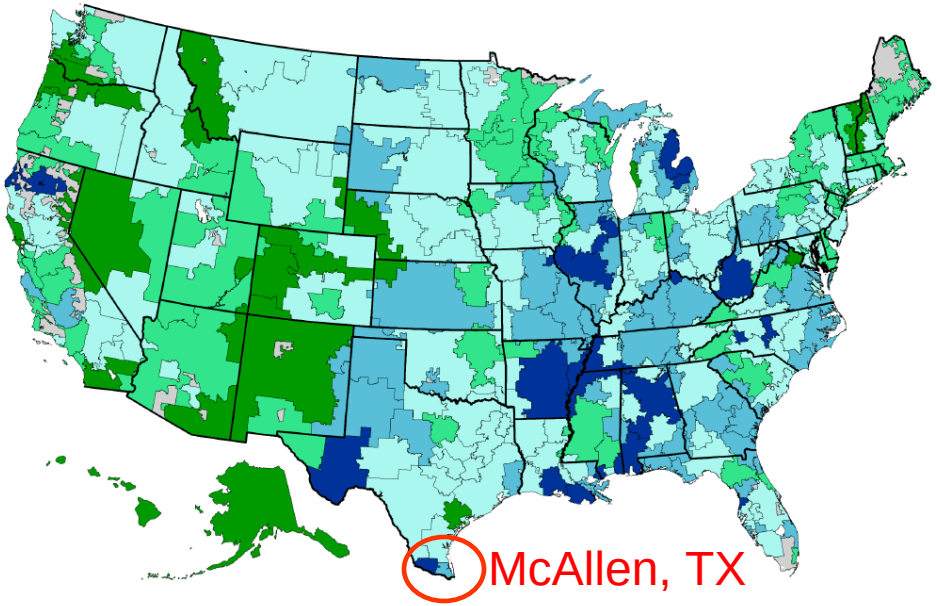


**Ratio of Rates of Surgical Repair of Hip Fracture to the U.S. Average**

by Hospital Referral Region (1995-96)

| | |
|---|---|
| 1.30 or More | (0) |
| 1.10 to < 1.30 | (56) |
| 0.90 to < 1.10 | (204) |
| 0.75 to < 0.90 | (45) |
| 0.65 to < 0.75 | (1) |
| Not Populated | |

## CABG Surgery Rates



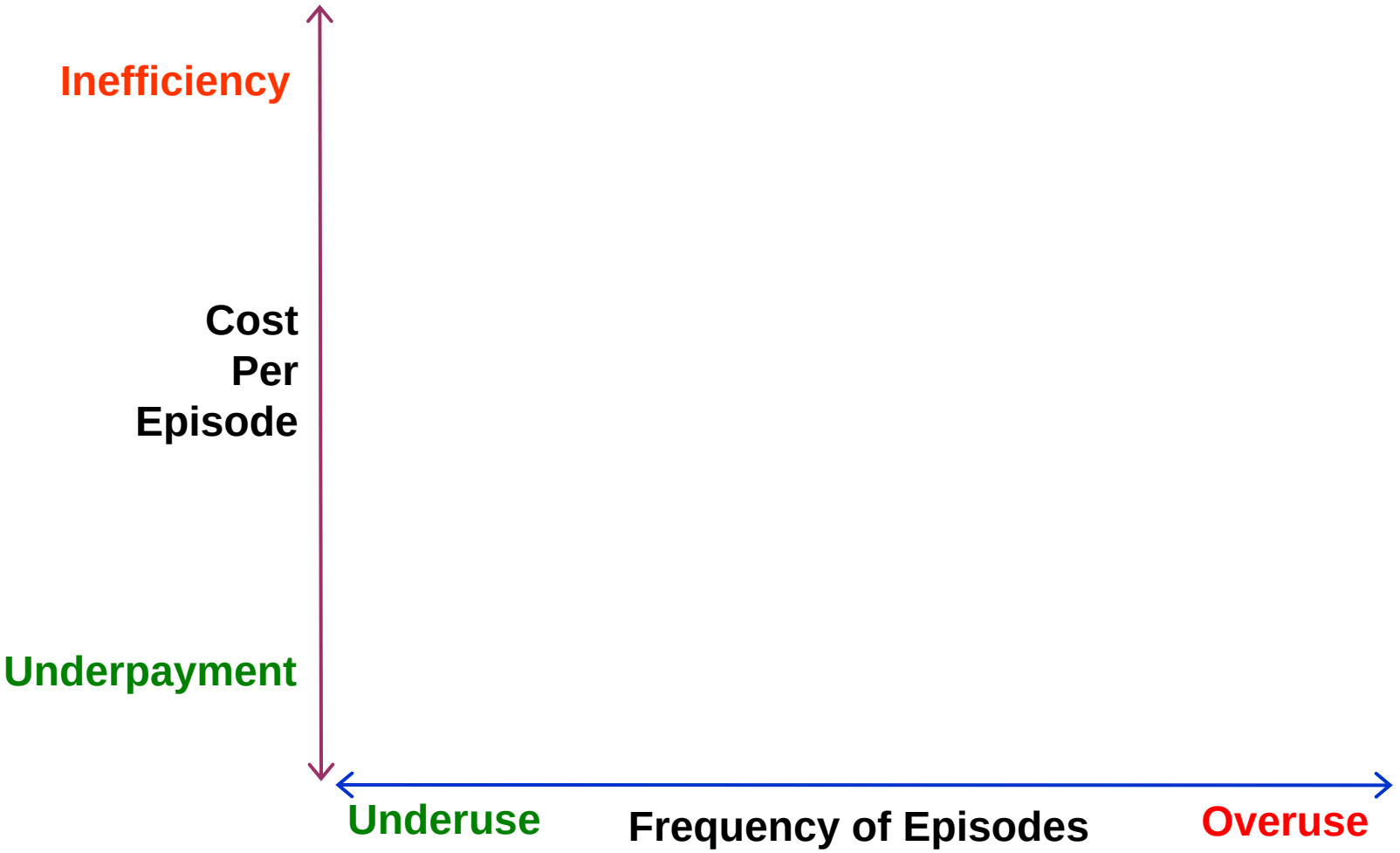

**Ratio of Rates of Coronary Artery Bypass Grafting Procedures to the U.S. Average**

by Hospital Referral Region (1995-96)

| | |
|---|---|
| 1.30 to 1.87 | (21) |
| 1.10 to < 1.30 | (69) |
| 0.90 to < 1.10 | (126) |
| 0.75 to < 0.90 | (71) |
| 0.50 to < 0.75 | (19) |
| Not Populated | |

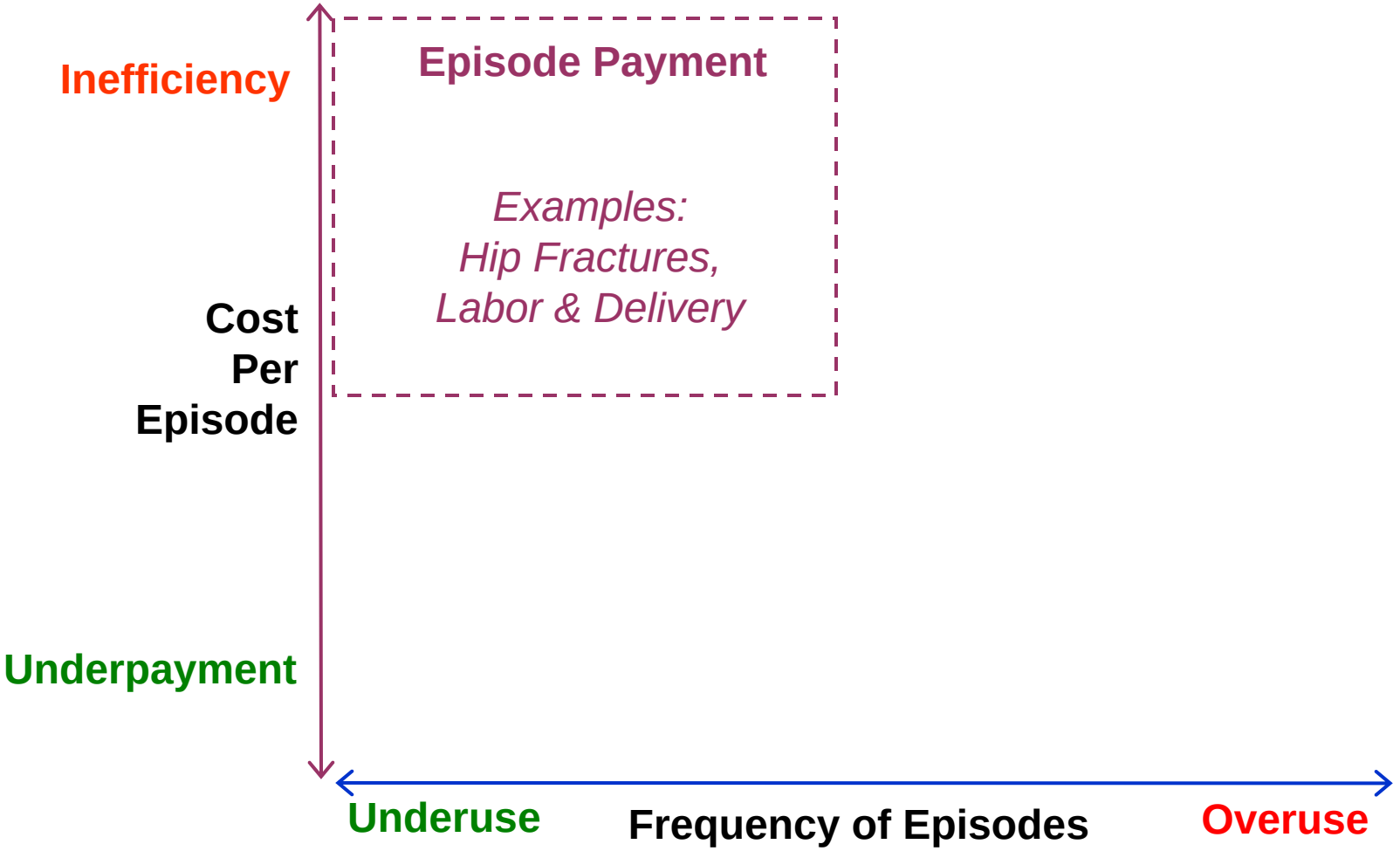
Source: Dartmouth Atlas

# Different Payment Systems Solve Different Value Problems




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

# Episode Payment for Treatments Where Overuse Is Not a Concern

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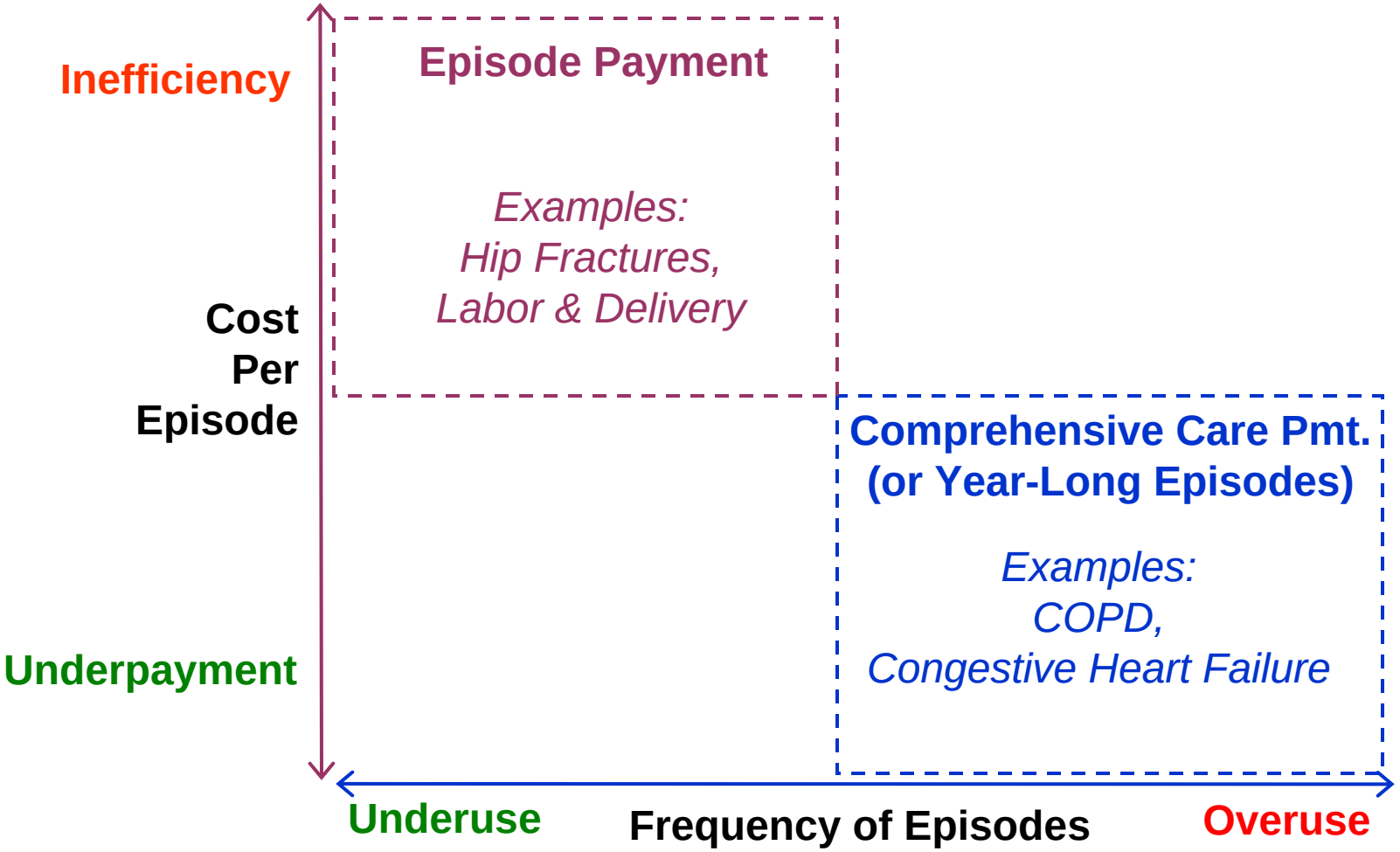
# Comprehensive Care Payment Where Overuse Is a Concern

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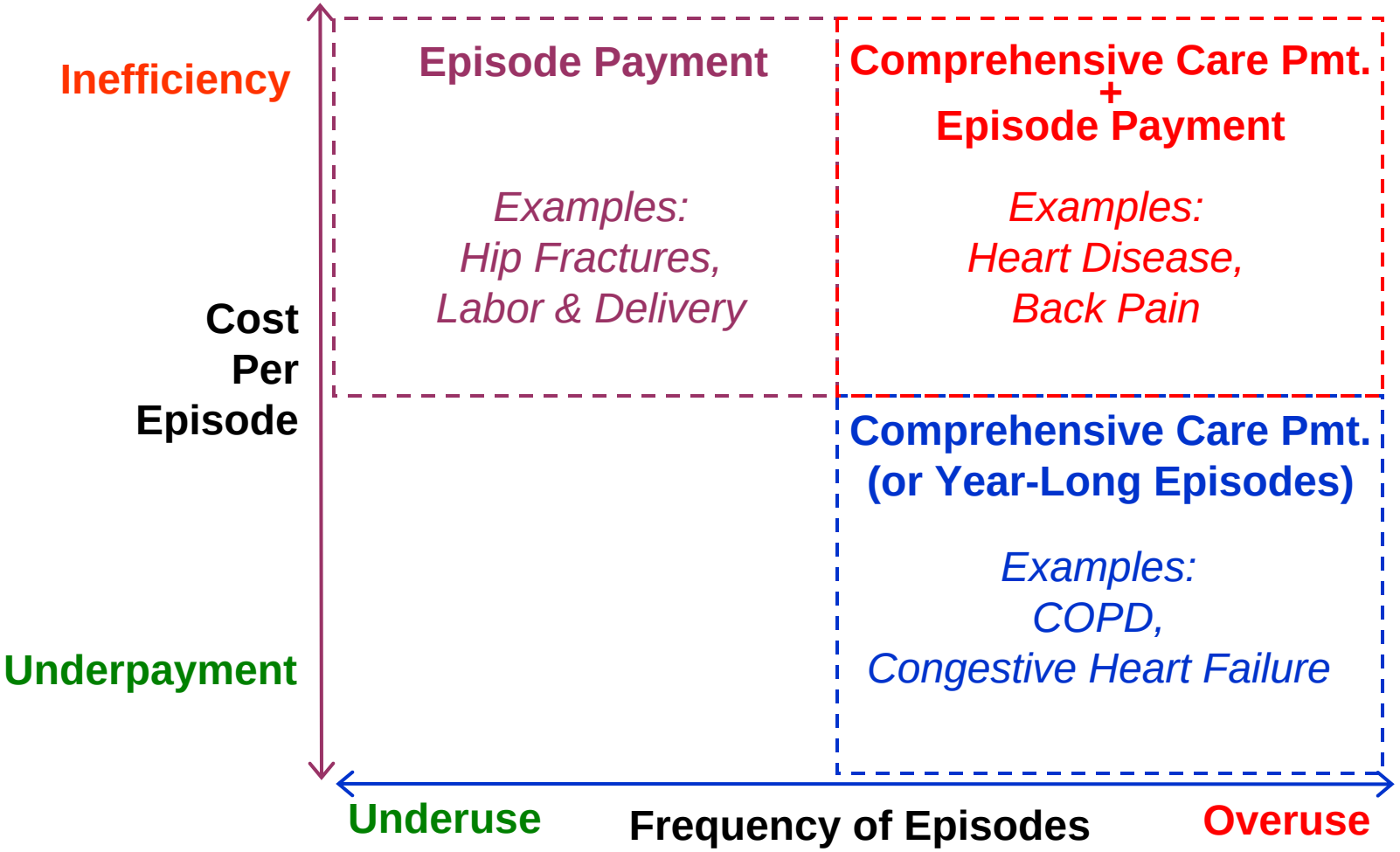
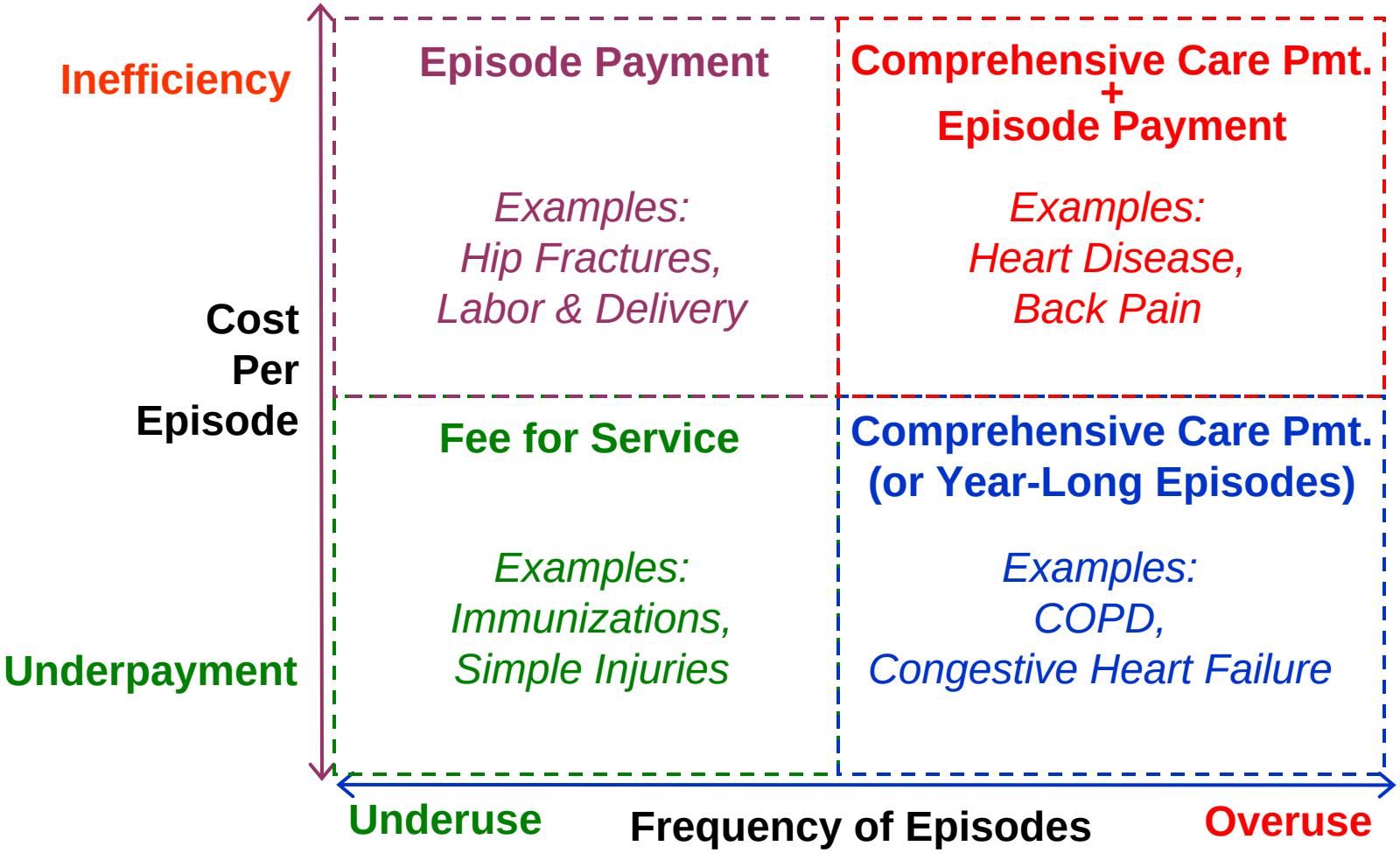
# Combination of Both to Reduce Overuse & Improve Efficiency




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

# Fee for Service is Actually Desirable for Underused Services




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

# Payment *Level* (Price) is as Important as Payment *System*

- If price is too high, inefficiencies will exist, regardless of what incentives may exist in the payment method
- If price is too low, providers will be unable to deliver high-quality care
- So how does the “right” price get determined?

# Payment *Level* (Price) is as Important as Payment *System*

## APPROACHES TO SETTING PRICES

| | |
|---|---|
| **Regulation** | Maryland sets all-payer rates for hospital services |

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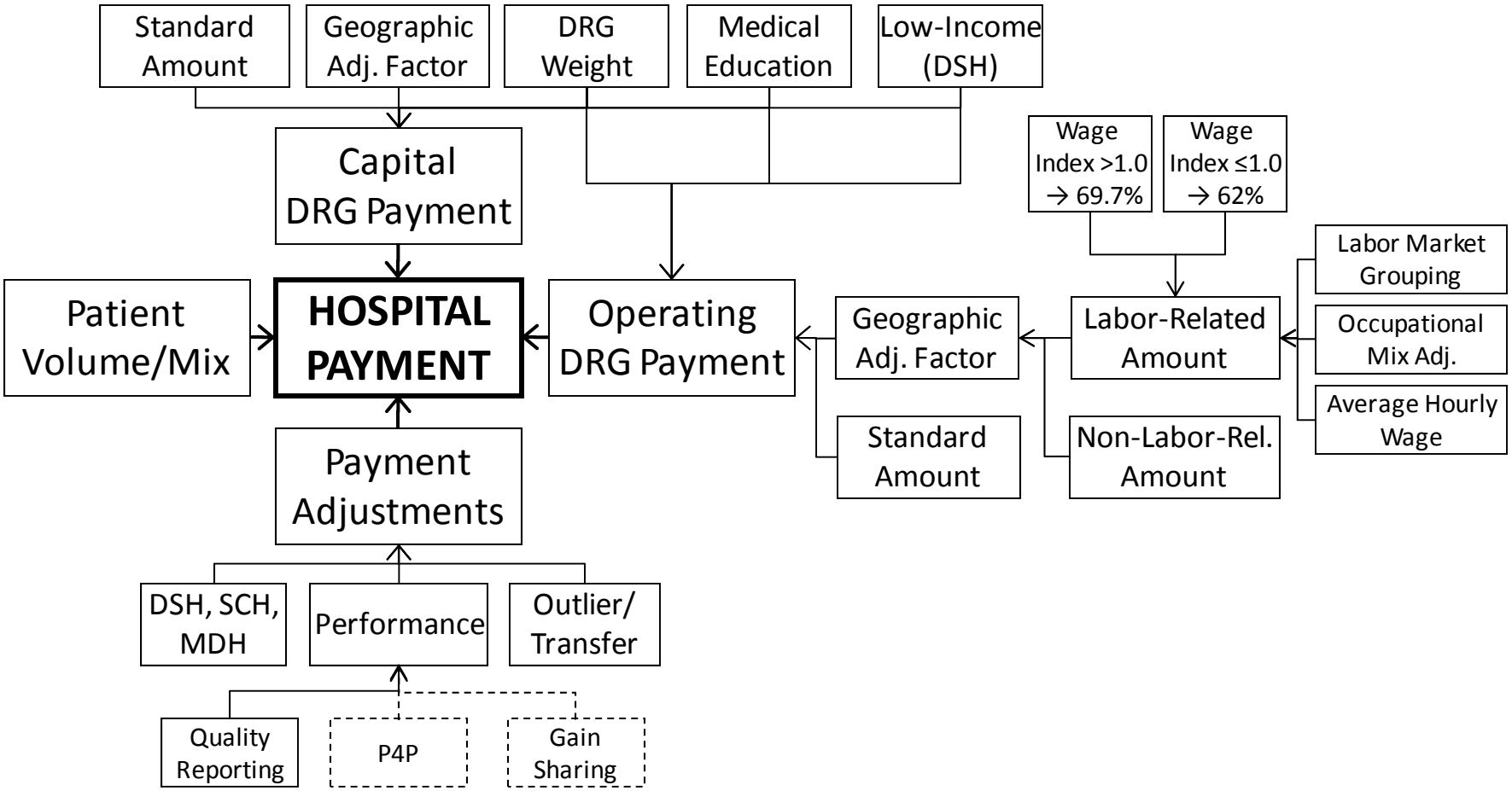
# The Complexities of Regulated Pricing Systems

## HOW HOSPITAL PAYMENTS ARE DETERMINED BY MEDICARE



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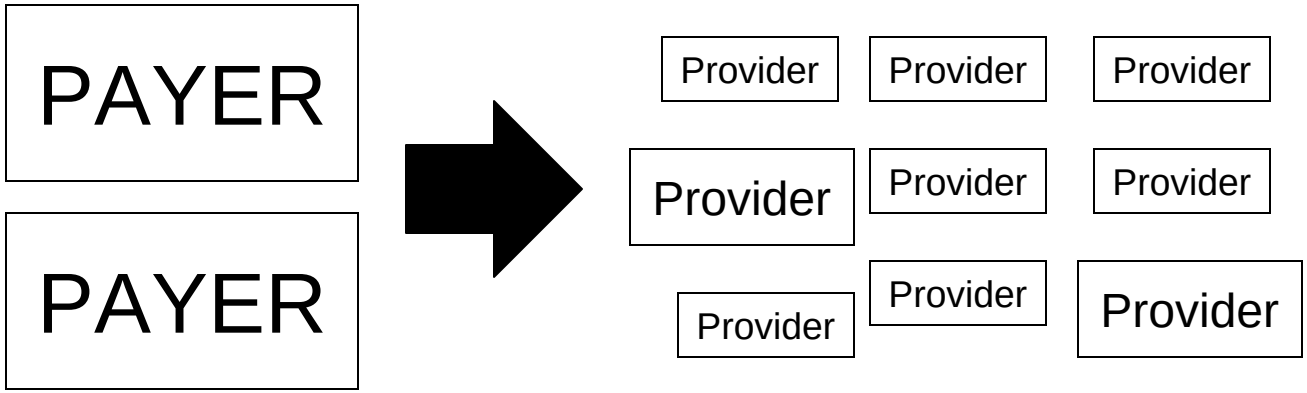
# Ability to Negotiate Depends on Market Power



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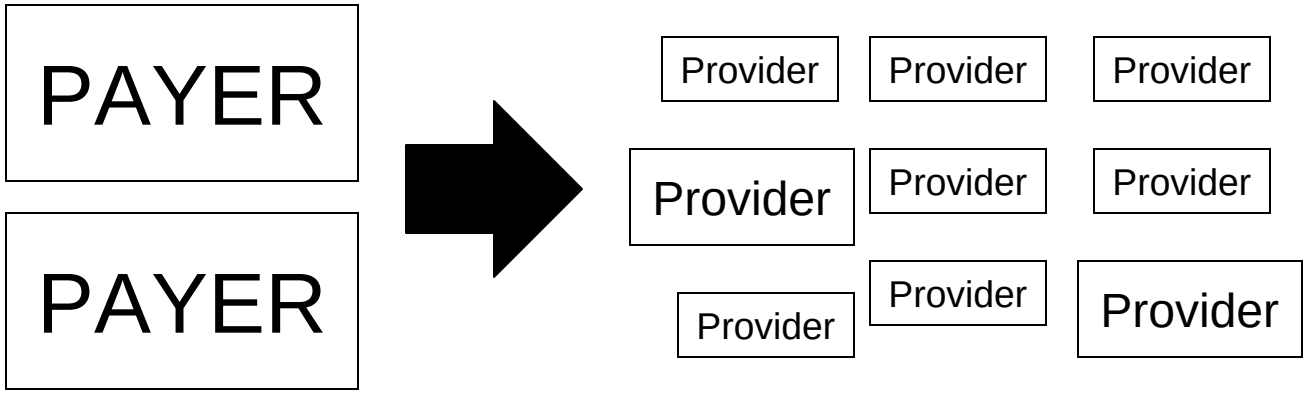
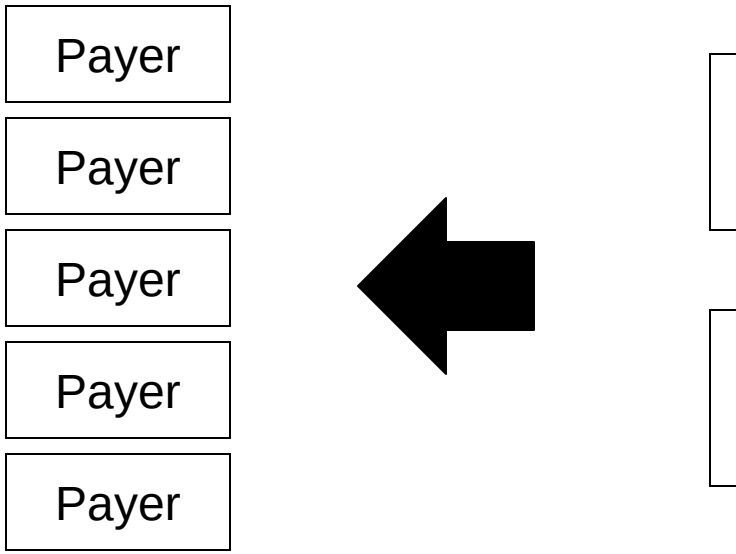


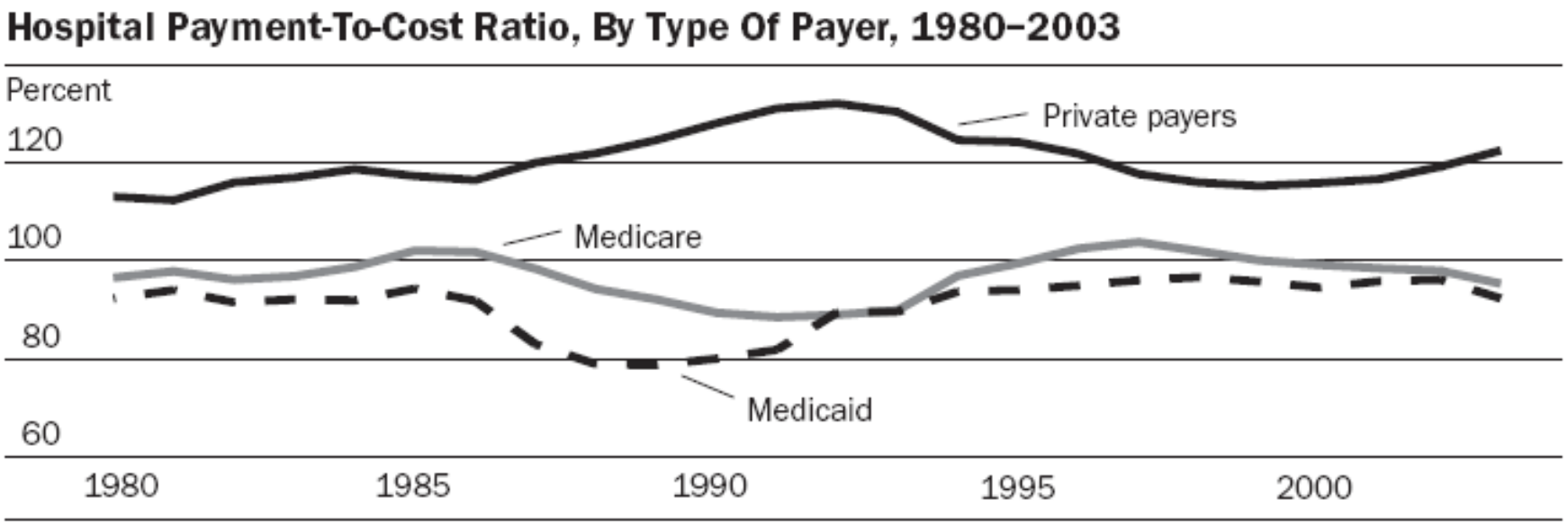
# Cost-Shifting Possible/Likely With Different Payer Sizes

*If a large payer reduces prices for its patients...*


*...rather than cutting costs, the provider can increase its prices to smaller payers to offset the revenue loss*

Study by Milliman claimed that Medicare and Medicaid payment levels are shifting $38 billion in physician costs and $51 billion in hospital costs to commercial insurers nationally

# Evidence of Cost-Shifting




Source: Christopher Tompkins, Stuart Altman, and Efrat Eilat,
"The Precarious Pricing System for Hospital Services,"
*Health Affairs*, Jan/Feb 2006, pp. 45-56

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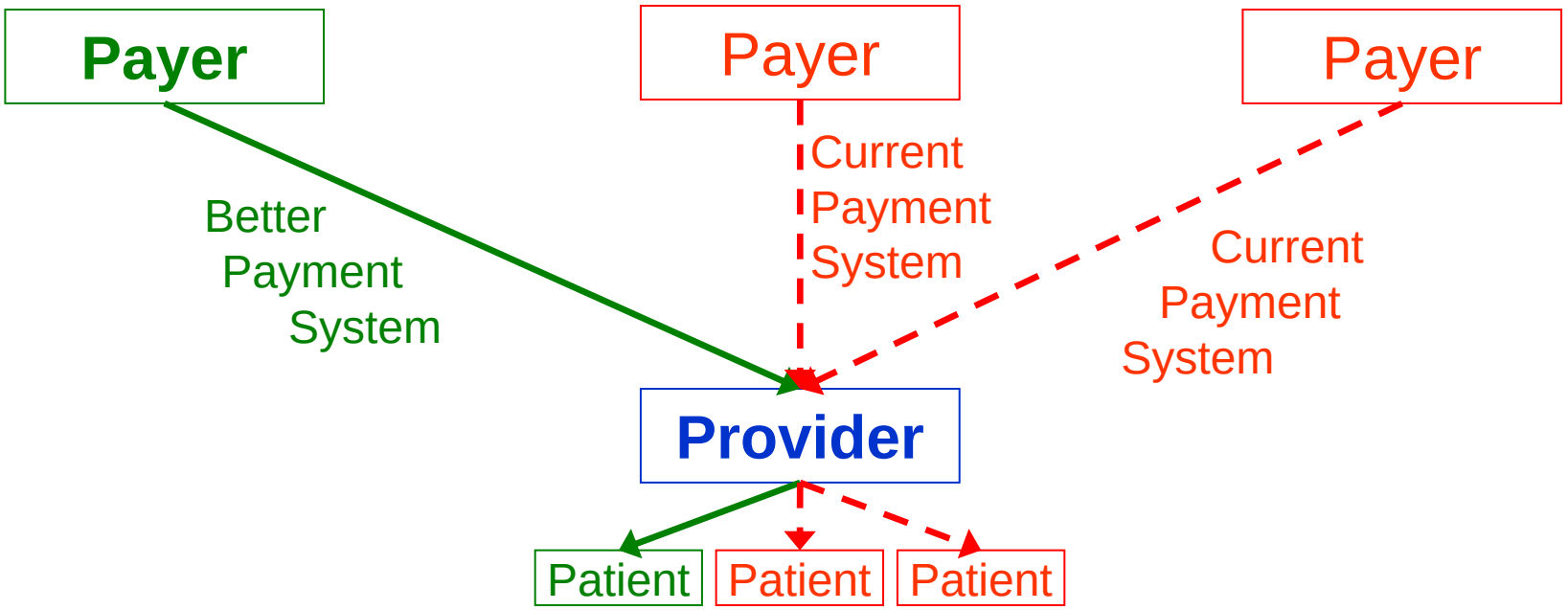
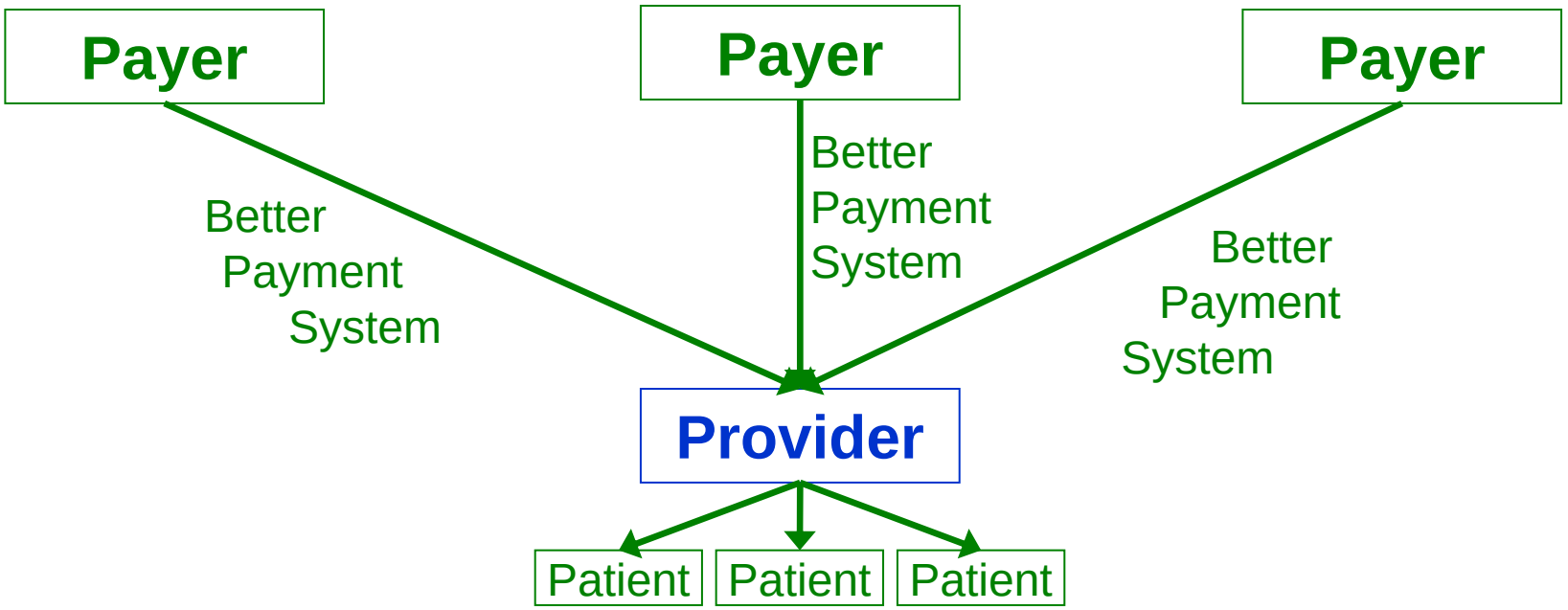
| **Competition** | Providers set prices in order to attract more patients |

# One Payer Changing is Not Enough for Providers to Change




***Provider is only compensated for changed practices for the subset of patients covered by participating payers***

# Payers Need to Align to Enable Providers to Transform



# Better Payment Systems Require Better Quality Measurement

- Concern: Giving healthcare providers more accountability for costs reduces the incentives for overuse, but raises concerns about whether patients will get too little care

- Solution: Measure healthcare quality and include incentives for providers to maintain/improve quality as well as reduce costs

# The Continued Role for Some Form of "P4P"

- To counteract the undesirable incentives in the fee-for-service system
- As a way of transitioning from current payment systems to episode-of-care and comprehensive care payment
- As a means of quality assurance for patients in more global/bundled/comprehensive payment models

# Agenda for This Morning

8:30 Pay-for-Performance Systems

*Christopher Tompkins*

9:15 Episode-of-Care Payments

*Harold Miller*

10:00 Break

10:30 Comprehensive Care Payment

*Ann Robinow*

11:15 Discussion/Q&A

12:00 Adjourn