



UST Executive Conference on the Future of Health Care

Reflections on Enticements, Barriers,
and Unintended Consequences

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Session Schedule

- 3:15 – 3:45 p.m. Presentation
- 3:45 p.m. Divide into Discussion Rooms:
SCH 421, SCH 419, SCH 420
- 3:45 – 4:05 p.m. Table Discussions
- 4:05 – 4:30 p.m. Facilitated Group Discussion

Health Care Reform: The Right Things

- Access
- Utilization / Cost / Quality / Value
 - New Care Models
 - Payment
- Personal Responsibility
- Delivery System Structure – Integration
- Science

Health Care Regulation: The Wrong Things

- The “Law of Unintended Consequences”
 - Often the result when a simple system (politics) regulates a complex one (healthcare).
 - We are busy regulating capitalist behavior that:
 - Is natural and encouraged in other industries; and
 - Is based on a system we are trying to escape (e.g., episodic care and volume-based payment methodologies).
- But health reform carries its own challenges ...
 - “For every complex problem, there is a solution that is simple, neat, and wrong.” – H.L. Mencken

Access and Coverage

- Patients and families who do not have health care access:
 - Have a higher mortality and morbidity.
 - Become a burden for the health care providers.
 - Become an expense for all of us: government, employers, insurers, individuals.

Access and Coverage: The Portico Story

- Portico is a small “health plan,” based in St. Paul, MN.
- Portico is provider (hospital) financed.
- Portico focuses on:
 - Access for the uninsured;
 - System entry and navigation;
 - Care Management through primary care providers and care managers.

The Portico Story: Results

Problem: CEO Perception of a Crisis

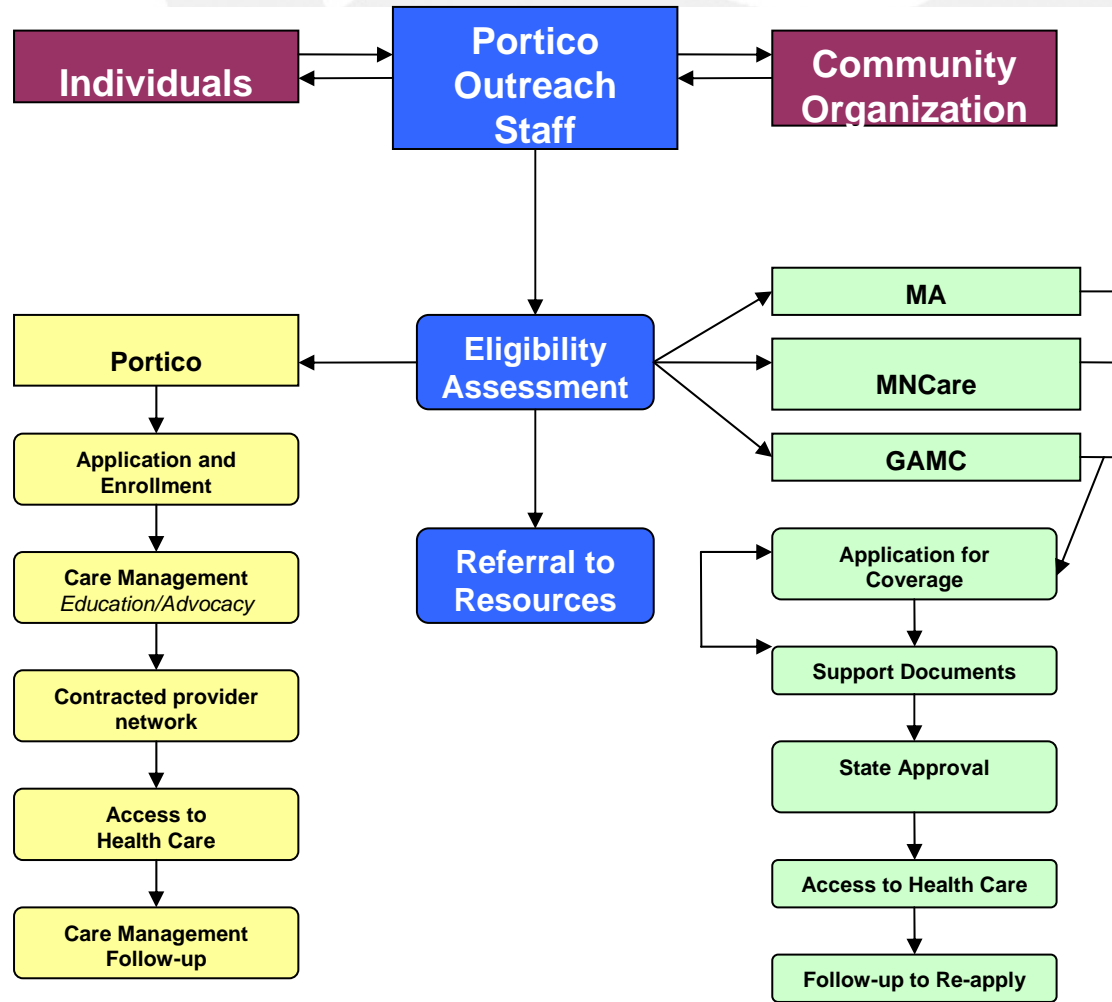
- When hospital CEOs were asked how they would like to see any additional funding for the industry used:
 - **#1: Coverage of the Uninsured (63%)**
 - #2: Information Technology (22%)
 - No other response was mentioned by even 10% of CEOs

Source: Deloitte, 10th Biennial Survey: The future of healthcare (2005)

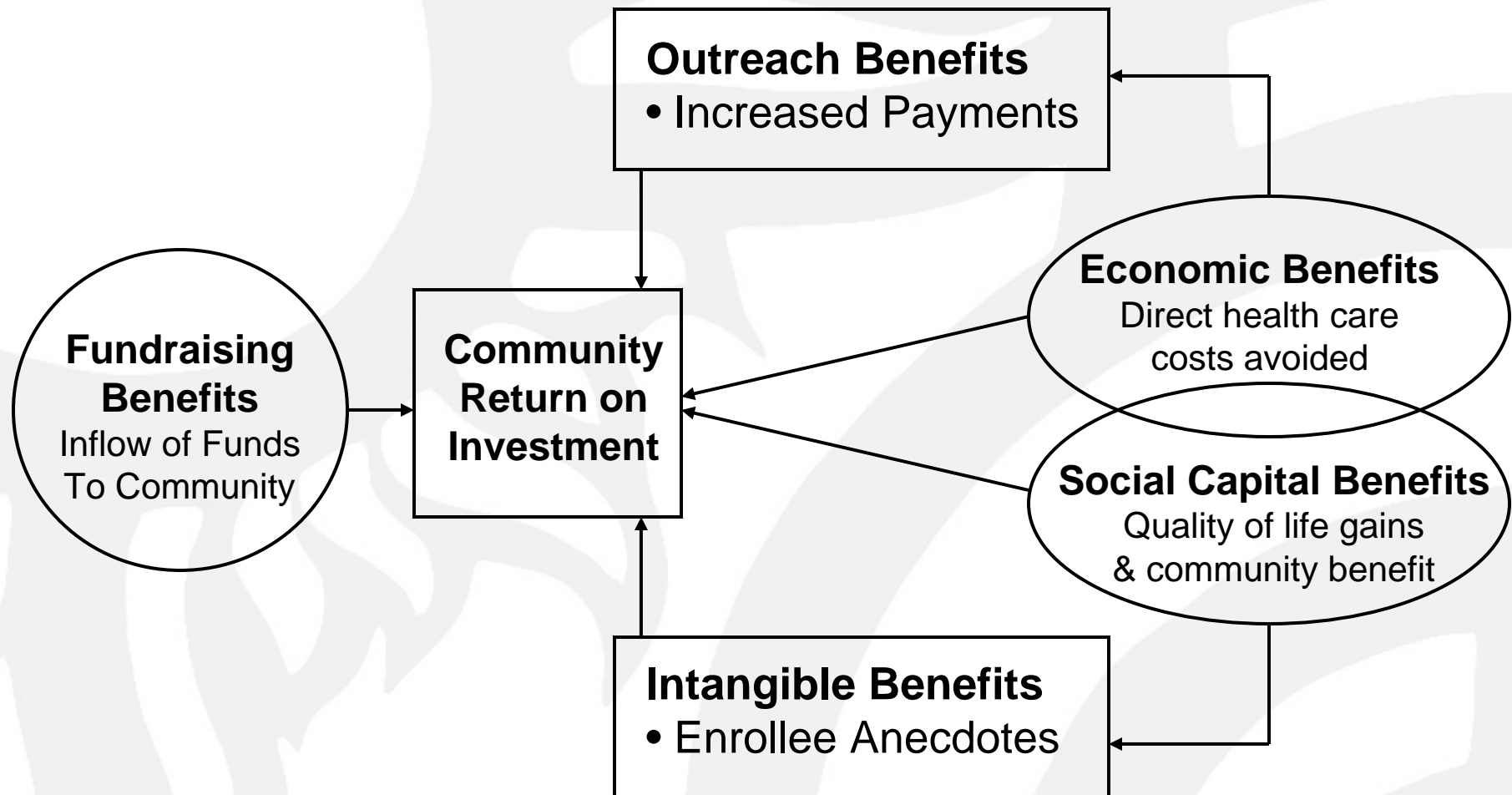
How Does Portico Help?

Our mission is to reduce the number of people without coverage for health care services.

Overview of Portico's Process



Portico ROI Components



Portico Results: Direct Health Care Savings

- **Inpatient visits dropped 35.3%**
 - From 55.3 visits per 1,000 to just 35.8
- **Emergency Department visits fell 32.9%**
 - From 118.7 visits per 1,000 to just 79.7
- **Primary care visits increased 31.9%**
 - All enrollees saw an MD within the year
 - *How about you?*

Portico ROI: The *Community* Perspective

- Partner contributions, combined with foundation/grant support generate multiple social and economic benefits.
- Total benefits over total expenses.
- Return \$2.55 for every \$1 investment.

Portico ROI: The Take-Home Message

- Portico achieves what it intends to do:
 - Increases use of consistent primary care provider and significantly reduces ED and Hospital visits.
 - Saves healthcare system resources and uncompensated care costs by effectively coordinating health care services and managing follow-up care.
 - Makes meaningful improvement in quality of life among medically indigent in the Twin Cities.
 - Reduces health disparities in the community.

Doing the Right Thing ... Access

- Incentives/disincentives to expansion of programs like Portico:
 - Outreach, eligibility assessment and care coordination are not reimbursed.
 - Risk of being characterized as unlawful activity under anti-kickback laws.
 - Requires strong primary care involvement, but primary care is underpaid and number of providers is insufficient.
 - Integration may help by providing capital, systems and income support.

Doing the Right Thing ... New Care Models

- Three illustrations of doing the right thing:
 - Advanced Medical Home
 - Chronic Disease Management
 - Surgical Avoidance

Care Settings: The Advanced Medical Home*

- Primary (Principal) Care Practices that:
 - Adopt the Chronic Care Model
 - Use evidenced based care guidelines
 - Apply health information technology
 - Demonstrate best practices
 - Agree to be measured and held accountable for quality and value

*Extracted largely from the American College of Physicians Policy Monograph, 2006.

The Advanced Medical Home: Why?

- Current model of primary care unattractive to physicians;
 - Information management pressures
 - Productivity pressures
 - Income
 - Job satisfaction
 - Shortages
- Current system is based on episodic care:
 - Patient needs are for chronic care management
- Current system produces poor outcomes:
 - Clinical
 - Access
 - Value

Advanced Medical Home: Attributes

- Logistics and care across a variety of settings.
- Providers support patients in health care system navigation.
- Team of health care professionals:
 - Working at the “top of their license”
 - Primary or principal physician
- Chronic care model:
 - Patient self management of health
 - Clinical decision support tools
 - Patient health education: monitoring performance
 - Use of community resources
 - Field workers

New Minnesota Legislation

- In May, 2008, the Minnesota Legislature passed a health care reform package that included the adoption of the medical home model.
- Referred to as "health care home" in the law.
- The law begins to change payment systems to reward physicians for care coordination for patients with chronic and complex conditions through promotion of patient-centered medical home model.

Payment in new MN Model

- Commissioner of Human Services and Commissioner of Health to develop payment system that provides per-person care coordination payments to certified health care homes.
- Bill directs care coordination fees paid as part of health care home to vary based on complexity of care provided.
- Development of payments system must be completed by January 1, 2010.
- For enrollees served under fee-for-service, payment is determined by the commissioner in contracts with certified health care homes.
- For enrollees served by managed care or county-based purchasing plans, the commissioner's contracts with these plans will require payment of care coordination fees to certified health care homes.

Advanced medical Home: What Will Make it Work?

- What incentives / disincentives are in system to make the Advanced Medical Home concept work?
 - Providers keen on being designated health care home to receive and control coordination payments.
 - Physicians may be ready for change:
 - Low job satisfaction;
 - Regulatory environment and risk of non-compliance limit ability to supplement income; *but*
 - These same laws limit ability to create other incentives, such as gainsharing, P4P, and value-based payments.
 - Piecemeal nature of financing system – must make separate arrangement with each payer yet remain compliant with federal regulatory framework based on old payment methodologies.

Doing the Right Thing ...

Chronic Disease Management

- The CEO of a large Minnesota-based integrated health system reports that the system has implemented an intensive, home monitoring based, care management program for patients with congestive heart failure.
- The results: 80% reduction in ED visits and inpatient admissions for this patient population.
- The unintended consequence: “Our system has been hurt financially by the new CHF management model.”

Doing the Right Thing: The PMC Story

- Physician Managed Care (“PMC”) was a novel “public/private” collaboration in home infusion care.
- Enteral and parenteral nutrition therapy (“ENT” and “PNT”) provided under active physician management.
- Physician direction not reimbursable (except for occasional office visits).
- ENT and PNT reimbursed on traditional volume basis.

The PMC Conceit

- ENT and PNT for the most difficult cases under intensive physician supervision.
- Detailed database with care and outcomes for all patients; publish results.
- Partnership created between faculty practice plan (physician management) and home infusion company (infusion capabilities and vast patient population).
- Contracting with payers, as possible, on basis of outcomes.

PMC Results

- Better outcomes: faster patient recovery and shorter time on ENT or PNT.
- Lower costs per patient with better results.
- Viewed as demonstration project, perhaps to be rolled out nationwide by home infusion partner.
- But then ...

PMC Legacy

- Investigation by OIG and suit by DOJ under anti-kickback laws.
- Muckraking investigation by local paper under “Money vs. Mission” headlines.
- Final chapter:
 - Partnership disbanded.
 - Database abandoned.
 - Cold comfort in eventual dismissal of all claims.

Doing the Right Thing ...

Surgical Avoidance

- A Minnesota-based physician practice has implemented a care and exercise protocol for patients with chronic low back pain who have been recommended for surgical intervention.
- More than 75% of the patients avoid surgery, have reduced imaging study costs, and have sustained high functional outcomes (Oswestry Scale).
- Who are the winners and losers? What are the incentives / disincentives in the system?

Personal Responsibility for Health

- Americans are themselves a significant cause of our nation's poor health status:
 - Diet
 - Exercise
 - Substance Abuse
 - Risk Behaviors
 - Family Support
 - Unwillingness to accept universal access as a value
- It is only recently that we have seen incentives / disincentives being put into the system on a pilot basis to change health risk behaviors ... What more could be done?

Doing the Right Thing ...

Physician – Hospital Integration

- Over the past three years, there has been another major phase of physician practices integrating into large health systems in the Twin Cities.
- We are now seeing the same thing occur in Greater Minnesota.
- What are the long term risks and benefits?

Physician – Hospital Integration

- Consolidation is a natural result of economic pressures and regulatory environment.
 - Is it the intended or unintended consequence of these forces?
- The payer side of the equation is already concentrated:
 - Nearly 60% of U.S. health benefits market resides in nine organizations.
 - Medicare and Medicaid hold 42% of “covered lives” market.

The Urge to Merge

- Providers, especially stand-alone physician organizations, face mounting pressures to consolidate:
 - Downward pressure on price and utilization.
 - Ever increasing regulatory barriers to ancillary revenue sources.
 - Transfer of financial risk to patients (e.g., HSAs and high-deductible plans).
 - Transfer of financial risk to providers (e.g., performance-based payments).

Is Bigger Always Better?

- Pros

- Better capitalized
- Better coordinated care, at least in theory
- Better platform for medical leadership
- Opportunities for efficiencies and economies of scale
- Uniform standards of care, at least in theory

- Cons

- Loss of entrepreneurship
- Loss of independent medical voice
- Sometimes results in loss of most efficient providers
- Uneven track record in achieving efficiencies
- Increased administrative infrastructure and cost

Barriers to Consolidation

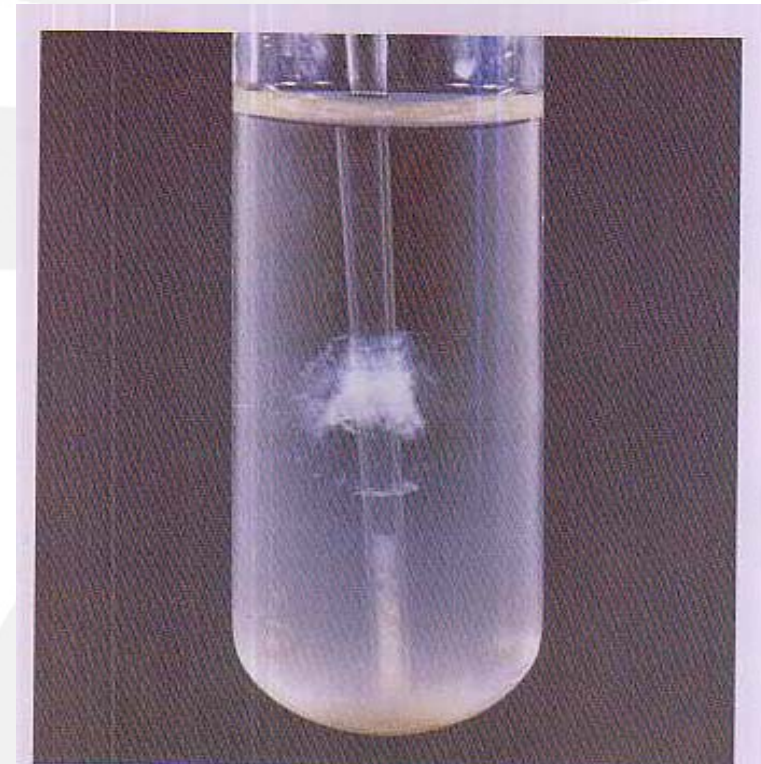
- Even as integration is encouraged, legal barriers remain:
 - Anti-kickback laws often impede well-intentioned integration efforts.
 - Antitrust laws often impede consolidation that, arguably, would benefit a region.
- Unresolved conflict as to the nature of the healthcare industry:
 - Is it a utility?
 - Can market forces be harnessed to achieve policy objectives?

Molecular Medicine: The Opportunity

- The sequencing of the Human Genome presents us with the opportunity to prevent and treat disease in ways that will profoundly impact the health of our population and the delivery of health care.

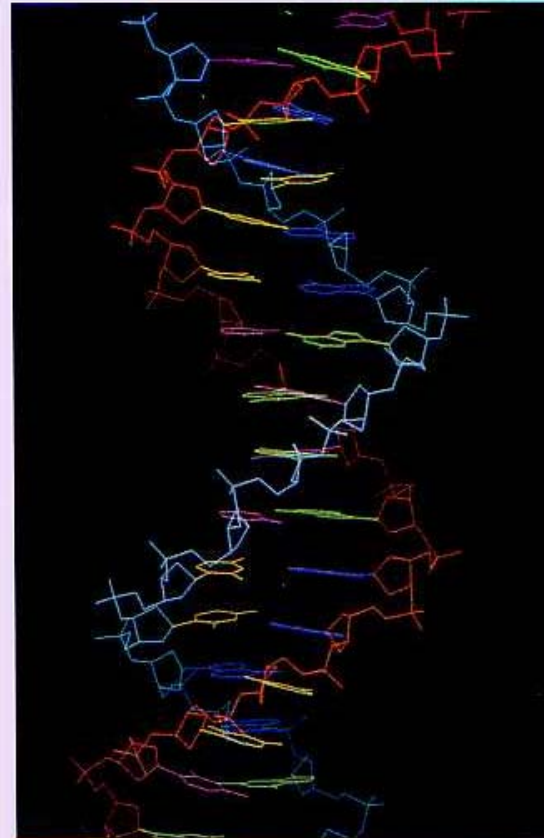
DNA and Molecular Biology – What We Know Today

The milky substance adhering to this glass rod is DNA that has been released from cells broken open by detergent. Despite its nondescript appearance, DNA is the molecular “secret of life”; information it carries directs the vital functions of all living things, and traces its ancestry back to the dawn of life.



DNA and Molecular Biology – What We Know Today

A computer-generated image of DNA reveals two chains whose coiled embrace creates a double helix. Each chain consists of a molecular backbone (one in red, the other in blue), along which are strung four bases; adenine (dark blue), thymine (yellow), guanine (green), and cytosine (purple). Bases pair up according to a strict formula – forming steps in a spiral staircase that carries the code of life.



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DNA and Molecular Biology – What We Know Today

1 ccgcccagcg ggcgggctcc ccagccaggc cgctgcacct gtcaggggaa caagctggag
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3121 gttttgtg atgaaaaaa aaaaaaaaaa a

Cystic Fibrosis Sequence

Molecular Medicine . . . What Will the Right Thing Be?

- The evolution of molecular medicine is sure to change the diagnosis and treatment of disease . . .
- How will our payment systems need to be changed?
- How will we define “the right thing” ethically?

The Call to Reform

- Is health reform really on its way?
 - Reform has sometimes seemed a certainty in the past, *yet ...*
 - We continue to labor under the patchwork of financing and delivery systems that have evolved over the past 50 years.
- Genuinely comprehensive reform should involve the removal of legal and market-based barriers that are tailored to old paradigms, not the new.

Parting Thoughts

- All agree, our system is broken, but even as we contemplate well-intentioned reform, some cautionary thoughts (with food as a common theme):
 - “An idealist is one who, on noticing that roses smell better than a cabbage, concludes that it will also make better soup.” – H.L. Mencken
 - “Those who love sausage and respect the law, should see neither being made.” – generally attributed to Otto von Bismarck