Using Payment Policy to Transform the Health Care System

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We have the most expensive health care system in the world
International Comparison of Health Spending, 1980–2005

Average spending on health per capita ($US PPP)

- United States
- Germany
- Canada
- France
- Australia
- United Kingdom


Total health expenditures as percent of GDP

- United States
- Germany
- Canada
- France
- Australia
- United Kingdom

Total National Health Expenditures, 2008–2017 Projected and Various Scenarios

Dollars in trillions

- Projected under current system
- Spending at current proportion (16.2%) of GDP

* Selected individual options include improved information, payment reform, and public health.
Source: Based on projected expenditures absent policy change and Lewin estimates.
Cumulative Changes in Annual National Health Expenditures and Other Indicators, 2000–2007

Percent change

- National health expenditures
- Health insurance premiums
- Workers’ earnings
- Out-of-pocket spending

Notes: Data on premium increases reflect the cost of health insurance premiums for a family of four/the average premium increase is weighted by covered workers. * 2007 national health expenditures and out-of-pocket spending are projections.
But how do we stack up in terms of access and quality?
How the U.S. Health System Scores on Dimensions of a High Performance Health System

- Long, Healthy & Productive Lives: 69
- Quality: 71
- Access: 67
- Efficiency: 51
- Equity: 71
- OVERALL SCORE: 66

Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006
How can we ‘bend the curve’?
System Reform

- **Accountability: Quality standards and quality reporting**
  - Physicians, hospitals, integrated delivery systems electing global payment must be accredited/certified as capable of assuming accountability for bundled services and meeting quality standards
  - All providers must report quality measures, with more comprehensive outcome and care coordination metrics for providers assuming accountability for bundled services
  - Payment rewards for quality and outcome results
  - Greater organization and accountability reap greater rewards

- **Transparency** – Medicare publishes quality, accountability, and provider profile information
System Reform

- Information technology – electronic medical records within five years; 1% assessment of private insurers and Medicare outlays to finance information exchange networks and safety net providers; personal health records accessible to beneficiaries
- Comparative effectiveness – center to evaluate comparative effectiveness of drugs, devices, procedures; benefit design tied to recommendations
Payment Reform

• Provider choice of per patient or per episode global fee payment

• Physician payment choices
  – Fee-for-service rebalanced toward primary care
  – Blended fee-for-service, patient-centered medical home fee
  – Primary care per patient global fee
  – Ambulatory care per patient global fee
  – Admitting physician inpatient care global fee, 90-day follow-up

• Hospital payment choices
  – DRG per hospitalized patient
  – Global DRG fee for hospitalization, 90-day warranty

• Integrated delivery system choices – above options, plus:
  – Global DRG fee for hospitalization and inpatient physician services, 90-day follow-up and warranty
  – Full capitation
Organization and Payment Methods

Continuum of P4P Design

Outcome measures; large % of total payment

Care coordination and intermediate outcome measures; moderate % of total payment

Simple process and structure measures; small % of total payment

Continuum of Organization

Less Feasible

More Feasible

Continuum of Payment Bundling

Integrated system capitation
Global DRG fee hospital and physician inpatient
Global DRG fee hospital only
Global ambulatory care fees
Global primary care fees
Blended FFS and medical home fees
FFS and DRGs

Small MD practice; unrelated hospitals
Primary care MD group practice
Multi-specialty MD group practice
Hospital System
Integrated Delivery System

Source: The Commonwealth Fund, 2008
Agenda for Change

• Offer Medicare Extra as a choice to small employers and individuals, eliminate two-year waiting period for disabled, and buy-in for older adults; financial protection for beneficiaries

• Rebalance physician fee schedule toward primary care

• Blended payment – FFS, medical home fee, rewards for quality

• Option of global fee payment options to physicians, hospitals, and integrated care systems
Agenda for Change

• Accountability for quality and care; rewards for results and for greater organization, care coordination, and accountability
• Transparency
• Health information technology and information exchange networks; personal health records for beneficiaries
• Comparative effectiveness
• National leadership and public-private collaboration
Thank You!

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