Aligning Incentives for Value and Quality in the Medicare Program

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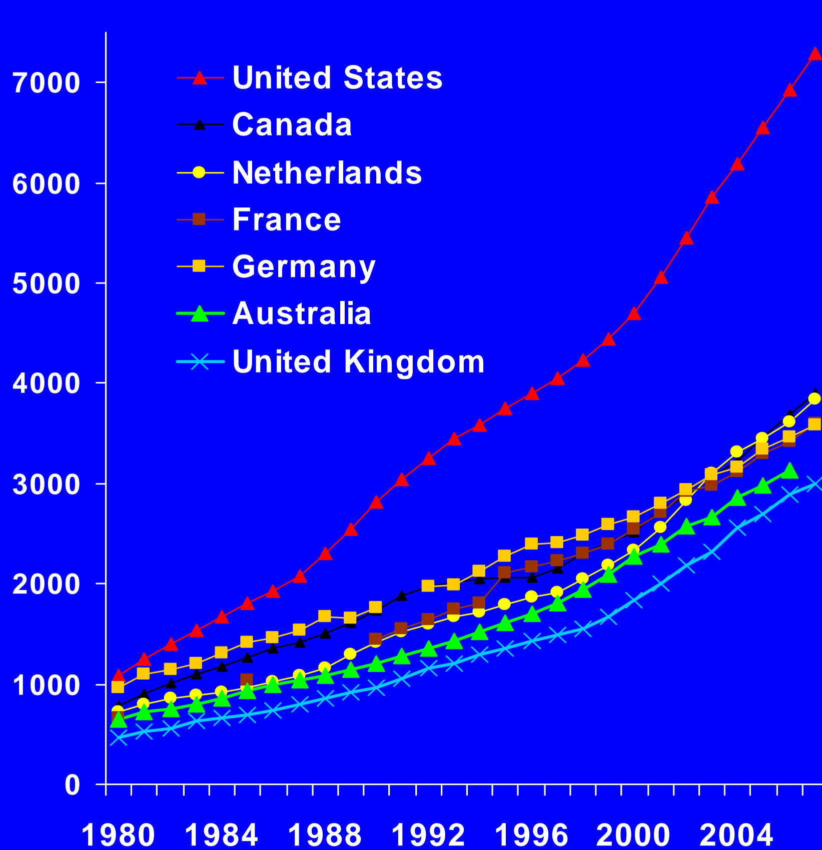
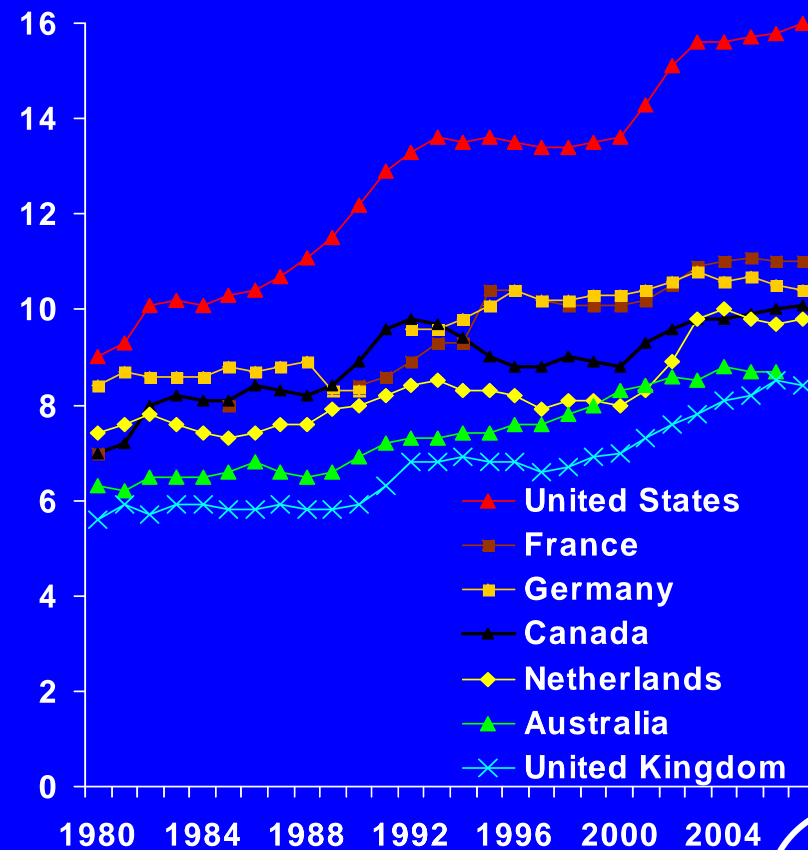
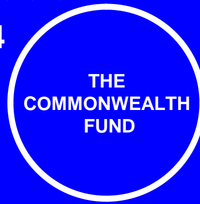
We have the most expensive health care system in the world

International Comparison of Spending on Health, 1980–2007







Data: OECD Health Data 2009 (July 2009).

Total National Health Expenditures, 2009–2019: Current Projection and Constant Proportion of GDP

Note: GDP = Gross Domestic Product.
Data: Estimates by Centers for Medicare & Medicaid Services, Office of the Actuary, January 2010.

Cumulative Changes in Components of U.S. National Health Expenditures and Workers' Earnings, 2000–2008

Percent

* 2007 and 2008 NHE projections.

Data: Calculations based on A. Catlin et al., "National Health Spending in 2006" *Health Affairs*, Jan./Feb. 2008; and S. Keehan et al. Health Spending Projections through 2017" *Health Affairs* Web Exclusive (Feb. 26, 2008). Workers earnings from Henry J. Kaiser Family Foundation/Health Research and Educational Trust, *Employer Health Benefits Annual Surveys, 2000–2008.*

But how do we stack up in terms of health system performance?

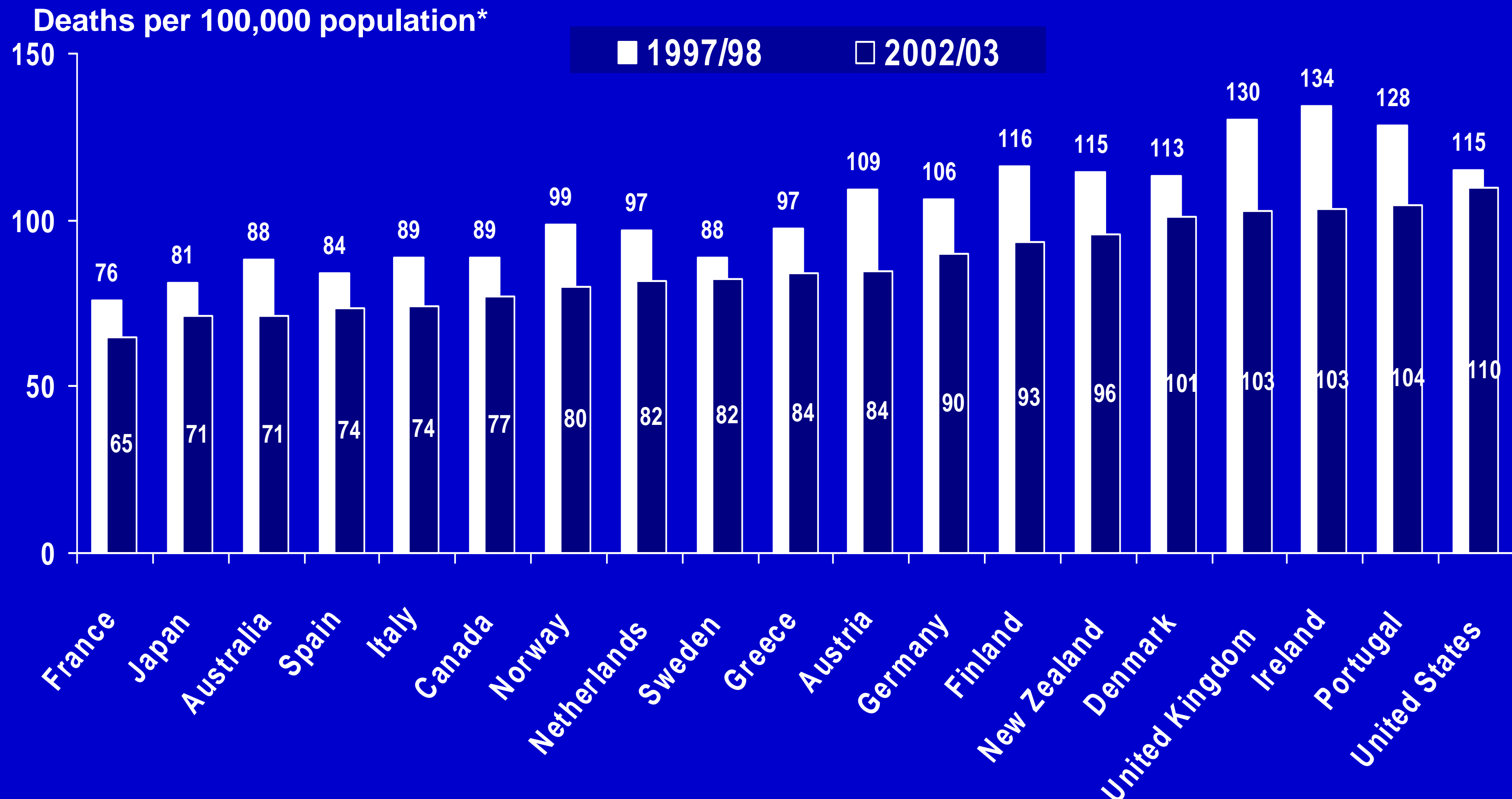
How the U.S. Health System Scores on Dimensions of a High Performance Health System

	2006 Revised	2008
Healthy Lives	75	72
Quality	72	71
Access	67	58
Efficiency	52	53
Equity	70	71
OVERALL SCORE	67	65

0 100

Source: Commonwealth Fund Commission on a High Performance Health System. *Why Not the Best? Results from the National Scorecard on U.S. Health System Performance* (New York: The Commonwealth Fund, July 2008)

Mortality Amenable to Health Care



* Countries' age-standardized death rates before age 75; including ischemic heart disease, diabetes, stroke, and bacterial infections.
See report Appendix B for list of all conditions considered amenable to health care in the analysis.
Data: E. Nolte and C. M. McKee, London School of Hygiene and Tropical Medicine analysis of World Health Organization mortality files (Nolte and McKee 2008).

Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008

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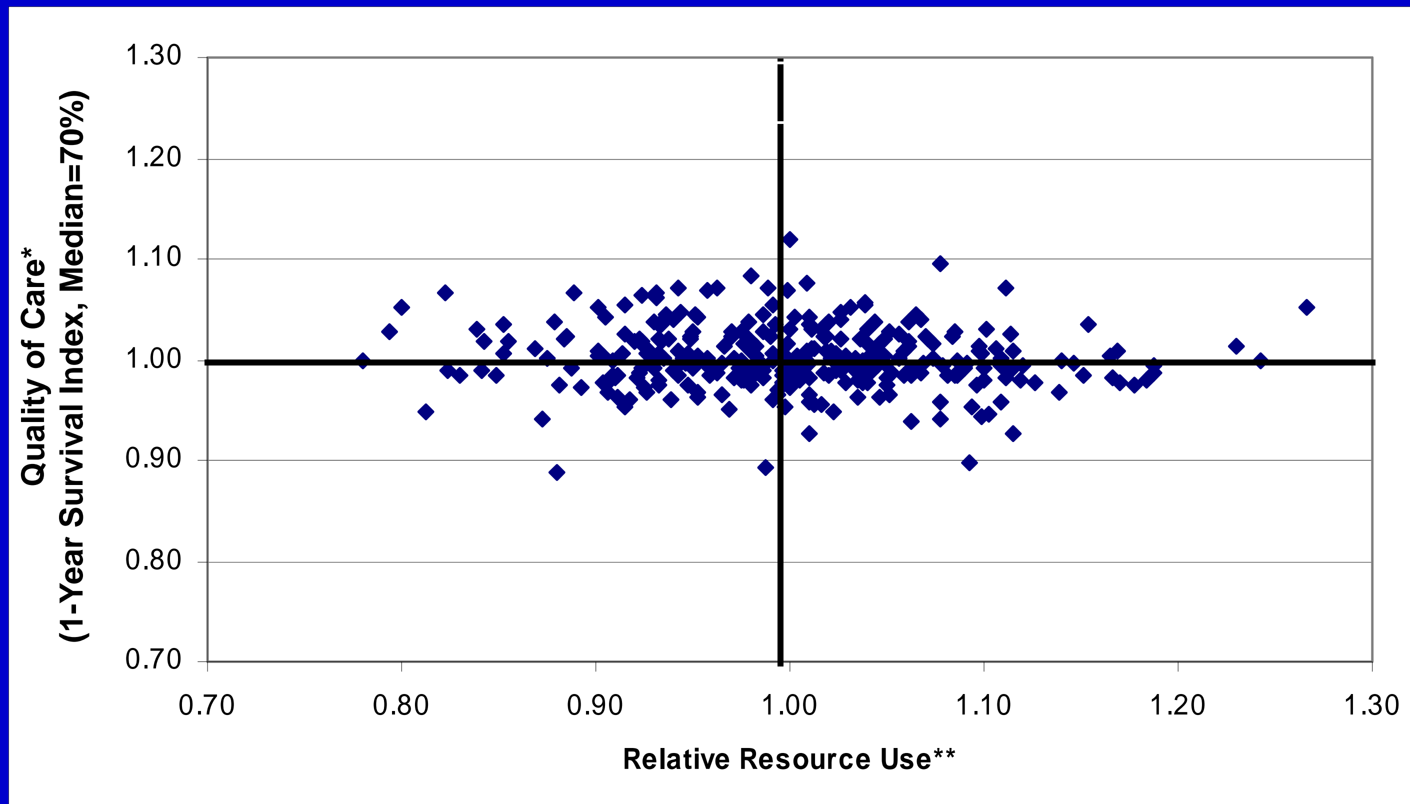
Quality and Costs of Care for Medicare Patients Hospitalized for Heart Attacks, Hip Fractures, or Colon Cancer, by Hospital Referral Regions, 2004



* Indexed to risk-adjusted 1-year survival rate (median=0.70).

** Risk-adjusted spending on hospital and physician services using standardized national prices.

Data: E. Fisher, J. Sutherland, and D. Radley, Dartmouth Medical School analysis of data from a 20% national sample of Medicare beneficiaries.

Source: The Commonwealth Fund Commission on a High Performance Health System, *Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2008*, (New York: The Commonwealth Fund, July 2008).

Receipt of Recommended Screening and Preventive Care for Adults

Percent of adults (ages 18+) who received all recommended screening and preventive care within a specific time frame given their age and sex*

U.S. Average
2002
49
2005
50
U.S. Variation 2005
400%+ of poverty
58
200%–399% of poverty
47
<200% of poverty
39
Insured all year
53
Uninsured part year
46
Uninsured all year
32
0
20
40
60
80
100

* Recommended care includes seven key screening and preventive services: blood pressure, cholesterol, Pap, mammogram,
fecal occult blood test or sigmoidoscopy/colonoscopy, and flu shot. See report Appendix B for complete description.
Data: B. Mahato, Columbia University analysis of Medical Expenditure Panel Survey.
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008

Support for More Accessible, Coordinated, Well-Informed Care

Percent reporting it is very important/important that:	Total: Very important or important	Very important	Important
You have one place/doctor responsible for primary care and coordinating care	91	66	25
On nights and weekends, you have a place to go besides ER	89	58	30
You have easy access to your own medical records	94	68	27
All your doctors have easy access to your medical records	96	72	24
You have information about the quality of care provided by different doctors/hospitals	95	63	32
You have information about the costs of care to you before you actually get care	88	57	31

Note: Subgroups may not sum to total due to rounding.

Source: Commonwealth Fund Survey of Public Views of the U.S. Health Care System, 2008.

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Medicare spending growth: a unique problem, but with a shared cause

Federal Spending on Medicare and Medicaid and Total Federal Spending as a Percentage of GDP, 1962-2082

Percentage of GDP

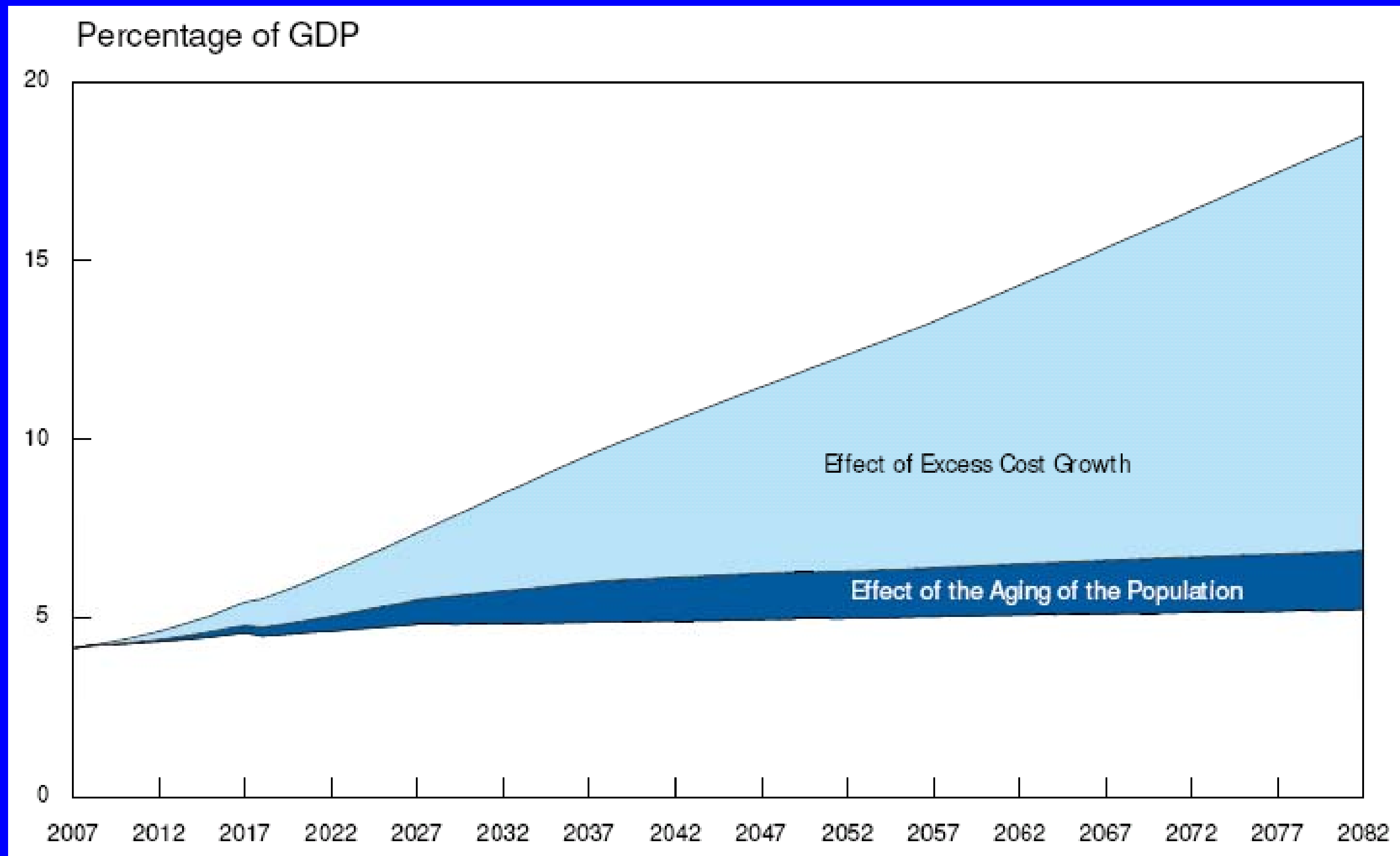
35
30
25
20
15
10
5
0

Medicare and Medicaid — Total*

1962 1972 1982 1992 2002 2012 2022 2032 2042 2052 2062 2072 2082

*Total includes all federal non-interest spending.
Note: Figures for 2007-2082 are projections.
SOURCE: Congressional Budget Office. *Budget Outlook.*

Sources of Growth in Projected Federal Spending on Medicare and Medicaid, 2007 to 2082



Source: Congressional Budget Office (2007). *The Long-Term Outlook for Health Care Spending*. Washington, DC, as presented by P. Orzag at the New America Foundation, November 2007, accessible at: http://www.newamerica.net/files/Orzag%20PPT%20111307.pdf

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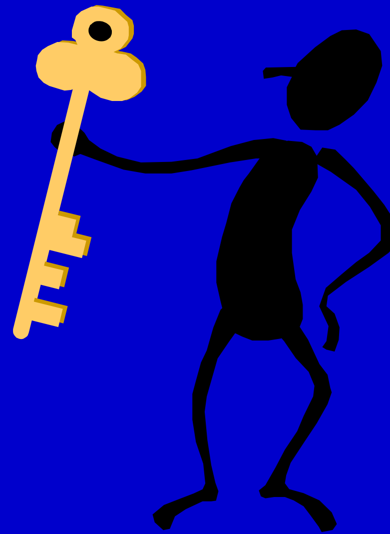
The only way out: Payment and system reform



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The Problems with the Current Payment System and Goals of Reform

- Problems:
  - Fragmented care
  - Lack of coordination
  - Variable quality
  - High and rapidly-growing costs

- Goals:
  - Create incentives for providers to take broader accountability for patient care, outcomes, and resource use
  - Provide rewards for improved care coordination among providers
  - Slow growth in health spending
  - Put in place an infrastructure to support providers in improving quality and efficiency

The Relationship Between Payment Methods and Organizational Models

Source: Adapted from A. Shih, K. Davis, S. Schoenbaum, A. Gauthier, R. Nuzum, and D. McCarthy, Organizing the U.S. Health Care Delivery System for High Performance, The Commonwealth Fund, August 2008.

Implications for Payment and System Reform

- **There is an array of organizational models in the health care system, and corresponding arrays of payment approaches and approaches to rewarding high performance**
- **We aren’t starting from a single point on the continuum of organization, and we won’t end up at one point—even high-performing, integrated systems can be very different from each other**
- **We shouldn’t fall into thinking that there’s a single ‘right’ way for care to be organized or to pay for care**
- **But the results we demand from our health system should be consistent everywhere, and we have a right to expect that those demands will be met everywhere**

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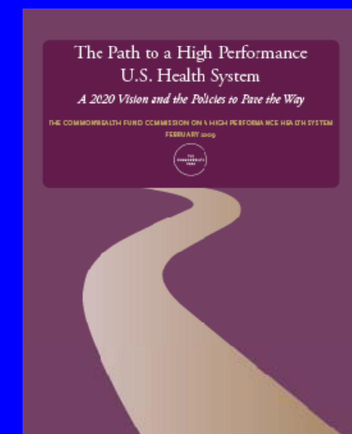
Key Strategies for Achieving Access for All, Better Health Care and Outcomes, and Slower Cost Growth

- Affordable coverage for all: access and foundation for payment and system reforms
  - Insurance exchange: choice of private and new public plan
  - Market reforms, affordability, and shared responsibility
- Align incentives: payment reform to enhance value
  - Accessible patient-centered primary care
  - Move from fee-for-service to more "bundled" payment, with accountability
  - Align price signals with efficient care and value
- Aim high to improve quality and health outcomes
  - Invest in infrastructure: information systems
  - Promote health and disease prevention
- Accountable, patient-centered, coordinated care
- Leadership and collaboration



The Path to High Performance: Payment Reform

- **Supporting primary care and coordination**
  - **Enhancing payment for primary care**
  - **Encouraging adoption of the Medical Home model**
- **Bundled payment for acute care episodes**
  - **Global DRG case rates including hospital care from admission to 30 days post-discharge**
  - **Global DRG case rates including hospital and post-acute care for from admission to 30 days post-discharge**
  - **Global DRG case rates including hospital, post-acute, and inpatient physician care from admission to 30 days post discharge**
- **Correcting market price signals**

Source: The Commonwealth Fund Commission on a High Performance Health System, *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way*, (New York: The Commonwealth Fund, February 2009).

Payment Reform Must be Supported by System Reform: Accountability, Transparency, and Better Information for Better Decision-Making

- **Accountability: Quality standards, reporting, and rewards**
- **Transparency: Medicare publishes quality, accountability, and provider profile information**
- **Information technology: Electronic medical records, health information exchange networks, personal health record accessible to beneficiaries**
- **Comparative effectiveness: Mechanism to coordinate evaluation of drugs, devices, and procedures with payment implications**

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Conclusions

- The U.S. health care system needs to improve along all three dimensions of performance: access, quality, and cost
- Addressing these dimensions together promises to be more effective than addressing them separately
- Regardless of whether comprehensive health care reform is enacted this year, the way we pay for and deliver health care should change
- System reform is essential to support and encourage the changes that are needed

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Thank You!

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