Aligning Incentives for Value and Quality in the Medicare Program

Stuart Guterman
Assistant Vice President and Director, Program on Payment System Reform
The Commonwealth Fund

Hofstra Conference on
New Directions in American Health Care:
Innovations from Home and Abroad
Hempstead, NY
March 11, 2010
We have the most expensive health care system in the world
International Comparison of Spending on Health, 1980–2007

Average spending on health per capita ($US PPP)

Total expenditures on health as percent of GDP

Data: OECD Health Data 2009 (July 2009).

Note: GDP = Gross Domestic Product.

Net cost of private health insurance administration

Private insurance net of administration

Out-of-pocket spending

Workers’ earnings

* 2007 and 2008 NHE projections.

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

Deaths per 100,000 population*

<table>
<thead>
<tr>
<th>Country</th>
<th>1997/98</th>
<th>2002/03</th>
</tr>
</thead>
<tbody>
<tr>
<td>France</td>
<td>76</td>
<td>81</td>
</tr>
<tr>
<td>Japan</td>
<td>65</td>
<td>71</td>
</tr>
<tr>
<td>Australia</td>
<td>88</td>
<td>89</td>
</tr>
<tr>
<td>Spain</td>
<td>84</td>
<td>99</td>
</tr>
<tr>
<td>Italy</td>
<td>89</td>
<td>97</td>
</tr>
<tr>
<td>Canada</td>
<td>77</td>
<td>80</td>
</tr>
<tr>
<td>Norway</td>
<td>74</td>
<td>82</td>
</tr>
<tr>
<td>Netherlands</td>
<td>80</td>
<td>82</td>
</tr>
<tr>
<td>Sweden</td>
<td>82</td>
<td>88</td>
</tr>
<tr>
<td>Greece</td>
<td>89</td>
<td>97</td>
</tr>
<tr>
<td>Austria</td>
<td>100</td>
<td>97</td>
</tr>
<tr>
<td>Germany</td>
<td>110</td>
<td>106</td>
</tr>
<tr>
<td>Finland</td>
<td>109</td>
<td>116</td>
</tr>
<tr>
<td>New Zealand</td>
<td>106</td>
<td>115</td>
</tr>
<tr>
<td>Denmark</td>
<td>113</td>
<td>115</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>130</td>
<td>130</td>
</tr>
<tr>
<td>Ireland</td>
<td>103</td>
<td>103</td>
</tr>
<tr>
<td>Portugal</td>
<td>104</td>
<td>104</td>
</tr>
<tr>
<td>United States</td>
<td>110</td>
<td>110</td>
</tr>
</tbody>
</table>

* 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
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.
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*

<table>
<thead>
<tr>
<th>U.S. Average</th>
<th>2002</th>
<th>49</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2005</td>
<td>50</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>U.S. Variation 2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>400% + of poverty</td>
</tr>
<tr>
<td>200%–399% of poverty</td>
</tr>
<tr>
<td>&lt;200% of poverty</td>
</tr>
<tr>
<td>Insured all year</td>
</tr>
<tr>
<td>Uninsured part year</td>
</tr>
<tr>
<td>Uninsured all year</td>
</tr>
<tr>
<td>0</td>
</tr>
</tbody>
</table>

* 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

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

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

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

*Medicare and Medicaid  Total*

*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

The only way out: Payment and system reform
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

Continuum of Payment Bundling

- Global Payment
- Global Case Rates
- Blended FFS/Care Management fee
- Fee-for-Service

Continuum of Organization

- Small practices; unrelated hospitals
- Independent Practice Associations; Physician Hospital Organizations
- Fully integrated delivery system

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

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.
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

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
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
Thank You!

Karen Davis, President
kd@cmwf.org

Cathy Schoen, Senior Vice President
cs@cmwf.org

Heather Drake, Program Associate
hd@cmwf.org

Stephen Schoenbaum, Executive Vice President
scs@cmwf.org

Kristof Stremikis, Senior Research Associate
ks@cmwf.org

Stephanie Mika, Program Associate
sm@cmwf.org

For more information, please visit:
www.commonwealthfund.org