

FRESH Thinking

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Workshop on Organization and Delivery of Care and Payment to Providers

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BOLD indicates consensus

Dr. Shortell

1. Everything (financing, tech. assessment, outcomes assessment, public reporting, benefit design, payment) having to do with comprehensive health care reform has to go through a delivery system
 - a. Discussing only the 47 million uninsured misses the point: the broader issues involved with the whole delivery system
2. Delivery system reform is a function of incentives and capabilities
 - a. Where capabilities = organizations that carry out the health care
3. Delivery System Core Capabilities (circle with improved health care value at core)
 - a. Change management
 - i. Leadership
 - ii. Culture
 - b. Performance accountability
 - c. Care coordination
 - d. Teamwork
 - e. Knowledge management (does right hand know what the left hand is doing)
 - f. Information technology
 - g. Redesigned care process
4. An Accountable Care System (ACS) is an entity that is clinically and fiscally accountable for the entire continuum of care that patients may need
5. Models for an ACS
 - a. Multi-Specialty Group Practice (MSGP)
 - b. Hospital Medical Staff Organization (HMSO)
 - c. Physician Hospital Organization
 - d. Health Plan Provider Organization / Network (HPPO/HPPN)
 - e. Interdependent Physician Organization (IPO)
6. These various models are compared along the various dimensions of capabilities
 - a. The results appear to be descending, with MSGP faring the best in the categories and IPOs faring worst
7. The different models also have different efficacies relative to a payment structure

Dr. Cortese

1. Knowledge dissemination between physicians in organizations is poor
 - a. Docs find out about things at national meetings
 - b. Giving credit for getting this kind of information (strong incentives)
2. Easiest thing to get to done health care reform is insuring everyone
3. Need a system where you pay for value
 - a. Contrast with current federal system (Medicare/Medicaid) which pays the most dollars for the worst care
4. Integration is important
 - a. Need to retrain physicians

- b. This needs to be done at the medical school level
- b. Have to create team based approach in medical school
- c. Right now docs have no idea how to work in teams, don't know integration
- d. If you want systematic approach, you have to undo cultural dynamics
- 5. Back to Shortell chart
 - a. Intermountain (PHO) runs a great diabetic center, where very few docs just run system and people get care from non docs
 - i. Pay on outcomes and not on piecework
 - b. Agrees with the general matrix
 - c. Thinks there are exceptions
 - d. Thinks you need an additional few columns
 - i. Which ones create value
 - ii. What are the common characteristics of these high value orgs.
 - iii. Value = quality vs. cost over patient life
 - e. Example of transplant medicine, which works very well without the type of accounting systems that are employed by insurance/Medicare
 - f. Lets set the incentives to pay for the value and in addition lets look at the characteristics that produce value
 - g. Care coordination is very important

Dr. Meltzer

1. Agrees with main basic findings and characterization of challenges
2. The part that is most interesting/controversial is the one on different delivery system models
 - a. In theory MSGP is the best
3. He thinks a payment system could trump delivery
 - a. If a system were set up with a capitated payment you could have a market that would answer that question
 - i. Rather than designing an organization from the top down
 - b. Think of this in terms of theory of the firm (Ronald Coase)
 - i. Do inside the firm vs. contracting outside
 - c. When you get too deep into structuring incentives, you harm the incentives
4. Second point: management
 - a. Talent to do this well is not present in the US
 - b. There is not an excess of extraordinary managers
 - c. If you are a good manager, you will go run a successful multi-billion dollar company
5. Great systematic changes are difficult to implement
 - a. Healthcare includes individualized production
 - b. We can think about top down, but we need to remember that healthcare is about bottom up
 - c. Constantly changing systems is disabling to the individuals
6. Have to have a great deal of patience in delivery system reform
 - a. Example of hospitalists

Dr. Newhouse

1. Paper is short on incentives
2. One size doesn't fit all

3. We don't know what is a good solution
4. Doesn't have full-on recommendation

Free discussion

1. Incentives

a. In health care clients don't know what they need and they don't have to pay → incentive problems

- i. You don't want patients attempting to figure things out for themselves
- ii. Physicians are more knowledgeable

b. Need incentives for technology adoption

c. One idea: standard incentives story:

- i. Start by identifying what the transactions are
- ii. Those transactions which you can measure performance, pay based on outcomes
- iii. Others you have to do time and materials
- iv. Use proxies where feasible
- v. Benchmarking
 1. Need a non-market based entity for providing information and benchmarks

d. Nonpecuniary incentives

- i. This was a recurring theme
- ii. Doctors value pensions, leisure, and evaluations in the newspaper
- iii. **Social Norms**
 1. Doctors regard of one another is very important in medicine

e. Prospect theory and reference points

- i. People care about losing money and not as much about making an additional dollar

f. Pay for performance

- i. This was mentioned a lot but actually not much substantively was added aside from referencing the idea
- ii. Objections:
 1. Data don't correlate with outcomes
 2. Compliance with process is what pay for performance means in practice
 3. No objection to paying for bundles

g. Pay for results

- i. Difficult to achieve because there will always be some degree of risk adjustment which muddies the waters

h. Volume is not an appropriate metric for compensation in healthcare

2. The institutional aspects of health care are daunting
 - a. Large barriers to entry for organizations
3. Payment vs. Organization: Chicken and egg problem
 - a. A delivery system does matter, but so does payment system
 - b. The reason why we have chicken/egg problem is nobody wins
 - i. Second best is always do nothing
4. Subsidizing organizational models

- a. Do we know enough about an optimal form of organization such that we would want to subsidize or incentivize that type of an organization?: Should we be talking about policies that reward types of organizations? Or should we focus more on direct incentives and payments in general?
- b. Not sure there is one best type
 - i. The evidence is thin to do this
 - ii. To have to pick winners and losers is premature
 - iii. There is still the problem of aligning incentives and organization system
- c. Should reward desired behavior
 - i. E.g. report your data, if you don't, you lose out
 - ii. Reward improved performance (level and improvement)
 - iii. Over time physicians will get into a organization that allows this to
- 5. Business perspective:
 - a. Integration
 - i. The chart outlining various aspects of delivery looks like a typical organizational chart for a company
 - ii. Other industries are fully integrated and medicine appears to be highly disaggregated
 - iii. Hard to create an incentive system for a disaggregated system
 - iv. How do you organize a system in a virtual fashion? Doesn't think we can.
 - v. Need to work on a fully integrated model
 - b. Partial integration (Toyota model)
 - i. Can contract out many things, as long as responsibility for the bottom line lies with one party
- 6. Endogeneity of policy
 - a. Independent doctors are an important factor and have a great deal of lobbying power through the AMA
 - i. Some thought that the AMA is a dying entity
 - ii. Though, nearly all of the medicine that is provided in the US comes from very small practices
- 7. Practicing physician perspective
 - a. IPA model can work
 - b. Example of Hill Physicians
 - i. Leadership → management of physicians
 - ii. Accountability → delivering value, pay for performance
 - iii. Group decision making
 - iv. Best possible care for customers
 - v. Integrated IT and data collection
 - c. Health plans are important → they market services
 - d. Main drawback to an IPA is that oftentimes it is maintained on life support far too long. Should be allowed to fail and go into bankruptcy.
 - e. Problem with hospitals
 - i. Hospitals want to fill hospital beds filled
 - ii. Hospital managers are bad doctor managers
 - 1. They don't drive policy/strategy

8. Idea of an “accountable entity”

- a. Right now physicians are not accountable for results
- b. In health care self-interest of players is different (self contradictory)
- c. There needs to be a way to be accountable for a longer period of time, not just the time during coverage

9. Size matters

- a. Large enough to capture efficiencies but small enough to facilitate management
- b. Anything above 200 doctors was considered too large
- c. Size is also a factor in ability to experiment with delivery systems

10. Leadership matters

- a. This is not just about institutions, it is about individuals
- b. Cult mentality may work (see Mayo)
- c. Need charismatic physician leader
 - i. Needs to galvanize physicians
- d. But also needs to be a good manager, and have good managers underneath
- e. In the existing structure there are not these kind of good leader/managers
- f. Notion of retraining and rethinking of physicians is important in this regard
- g. Need some appreciation of the system

11. Information technology

- a. It reduces redundancies
- b. But doctors make money through redundancies

12. Problem of scaling up

- a. Analogy to education reform
 - i. In that arena, individual leadership also important
- b. Things work in individualized settings, harder to replicate

13. Capacity creation in the market

- a. Right now supply driving demand
- b. “If you build it they will come”
- c. Without some optimal capacity creation, information will drive hypochondria
- d. More is not necessarily better
 - i. Both in terms of patients or society

14. Health vs. Illness

- a. Should the organization just be about curing ailments or also about prevention
- b. No consensus about single or bifurcated approach

15. Market for organizations

- a. Let those that succeed flourish and those that don’t perish

16. Information/Data

- a. The data can sometimes be bad
- b. Important to get doctors to write information down that is useful
- c. Pay for filling out a form
- d. Ensure accuracy through auditing

17. Not looking outside the US because organization is so closely linked to culture

- a. Disagreement as to whether this was appropriate

18. Questions and Hypos

- a. Hypo: universal coverage, no Medicare, just insurance companies, and objectives are known, can insurance influence and pay for them?

- i. Intellectually: Yes
 - ii. Operationally: end states are hard to define
 - 1. Multiple objectives
 - 2. For simple things you can achieve objectives
- b. Could Medicare use its purchasing power to force docs into groups/
particular types of groups?
 - i. There should be requirements to this
 - ii. Congress has too much of a short term agenda and would need to be tempered in its propensity to meddle
 - iii. Medicare has to get out of the “guilty until proven innocent” way of doing business with providers
 - iv. The issue is that Medicare could not manage process and just look at outcomes
- c. What do we want to do that is practical? (in order of ease)
 - i. Easiest thing is covering people
 - ii. Pay for value.
 - 1. Require clinical information in a standard format
 - 2. Medicare requires this, and then insurance companies line up behind this
 - 3. Create a new entity, that is arms length, not in government, but of government that looks at information and analyzes
 - a. There was an analogy made to an SEC type organization
 - b. Business reaction to SEC/Sarbanes Oxley was to shudder at the thought of a giant government entity
 - 4. Have some basis for making changes
- d. Why has delegated risk not gone outside of CA?
 - i. Managed care backlash, stopped capitation
 - ii. There was thought of CA as being cooky
 - iii. There were good physician groups already

Day 2

Dr. Luft

- 1. Present insurance structure is problematic
 - a. Conflicting and unintended incentives
 - b. Decisions are not rational
 - c. Increased insurance leads to increased demand
 - d. Complications that arise from selection (1) across plans, (2) self-selection and (3) employee selection
 - e. Patients are where the costs lie
 - i. But present incentives lie with physicians
 - f. Chronic care very problematic and costly
 - i. 20% costs to patient are covered, 80% fall in deductible
- 2. Proposal
 - a. Need insurance for chronic illness & hospitalization
 - b. Pool for major events & chronic illness

- i. No selection
- ii. Broad base

Dr. Garber's commentary

1. Current plans are more than transaction processors, but also bear risk, such that they benefit if they reduce cost
 - a. There was debate as to as to who bears financial risk: pool or plan.
2. Payment for chronic diseases is problematic
 - a. There are stratified levels of chronic diseases
 - b. There is random variability between patients
3. Need to leave the decision making out of the government's hands to reduce gaming of system.
 - a. It will likely occur but should do so in a free market system and not government.
4. Co-payment is better than coinsurance
5. Question of who pays whom?
 - a. Why would physician choose a given carrier?
 - b. Plan would sell to provider
 - i. Mutual fund model
 - c. Problem with this is that a lot dimensions of care would fall though crack

Dr. Newhouse's commentary

1. With respect to contracting for medical service
 - a. Don't know enough about good package
 - b. What bundle? Long history of experiments and nothing clear has emerged.
2. Operational problems in deciding which services fit which bucket. I.e. mental health, dugs
3. How are things defined? How flexible to move services between buckets?
4. Risk adjustment for patient severity/non-compliance is very hard to do well
5. How much does doc know about patient cost share?

Dr. Meltzer commentary

1. Worried about the benefit from such a major adjustment. Is it worth it?
 - a. Changes the flow of money without obvious gain in productivity
2. Can't things be accomplished better with a capitation and free market system?
3. Care delivery idea
 - a. How do bundles of care interact?
 - b. Issue with incentives for trigger reviews
4. Patient side
 - a. Incentives for chronic vs. preventive care. Hard to distinguish between these due to large crossover
 - b. Price change does not affect behavior in DM experience. Wiser policy to view payment change at patient level together with delivery system that develops its own internal incentive systems

Free Discussion

1. Positives of this idea

- a. Some found the idea of doctors choosing insurance plan and not the consumer very appealing
 - b. This system favors a capitation
 - i. It would allow for things to be sorted out internally
 - c. This is a stealth way of delivery system changes
2. Problems
- a. Acute hospitalization component
 - b. “Edge” problems
 - i. Setting up buckets creates problems
 - ii. There can be gaming
 - iii. The set-up of what belongs where can be arbitrary
 - c. Boundaries are not clear
 - i. Inpatient v. outpatient is not fixed
 - d. Risk adjustment
 - i. Regardless how the base system is designed, risk adjustment will creep in and trump any market benefits
 - e. Public doesn’t have an appetite for “value care”
 - i. Look at how managed care floundered in the public’s eye
 - ii. Most are healthy and don’t care
 - iii. But the precipice is drawing near
3. Extensions
- a. Different mechanisms for different diseases
 - b. New institutions**
 - i. Need mechanisms that will keep the systems honest
 - ii. Truth and advertising analogy in healthcare
 - iii. Something like the base closing commission
 - iv. Need tech assessment
 - v. Need data definitions
 - vi. There has to be a feedback mechanism
 - vii. Need multiple entities
 - 1. Don’t want a monolith
 - c. Need to explain what the incremental benefit will be given the cost
 - i. What is going to be enough to have people take this seriously
 - d. Need to address the extent to which patients are moving across the different categories
 - i. Chronic → acute → chronic
 - e. Where do you fix accountability in this system
 - i. That doesn’t come through
4. Previous changes in payment systems
- a. The healthcare system has undergone previous changes in how things are paid for
 - b. Ultimately, physicians figure out a way to game the system
 - c. Solving for problems in one area results in other problems
5. New technologies’ impact on care
- a. More people are going into intensive care
 - b. Outpatient services are changing
 - c. New technology does not necessarily lead to lower labor costs

- i. Healthcare is different than other industries
 - d. We need to create incentives to get people out of hospitals
 - e. Things take time to work their way through the system
- 6. Cost and price relationship
 - a. This relationship breaks down in hospitals
 - b. Again, healthcare is very different than other industries
- 7. Proper reference point
 - a. This proposal should not be compared against an ideal plan that does not exist
- 8. Data
 - a. Things may not show up in the statistics (morbidity)
 - b. Maybe we should look at whether things actually improve
- 9. Can't use a claims system to measure efficacy**
- 10. Incentives
 - a. Some suggested too much focus on incentives
 - b. Focusing too much on individual actors as opposed to the final output
- 11. Simplicity**
 - a. Simplifying things will get us very far
 - b. But the problem is that there isn't a discrete goal, we can't tell when things work and when they don't
 - c. Healthcare has too many things that make it unique
 - d. Business wants one person to write a check to
 - i. Problem is that there isn't just one person
 - e. Hilary Care was too complex, too many moving parts
- 12. Role of government
 - a. Private insurance has been burned before
 - b. The government will always eat away at profits, even if it initially is ok with them
- 13. Present system is not functioning**
 - a. The pricing system is very screwed up
 - i. Can't explain to people how the hospital charges people
 - ii. One hospital can't change this, this is a system thing
 - b. A lot of time and money is spent on admin
- 14. Unions in healthcare
 - a. Big impact on the healthcare systems
 - b. In a hospital 50% of your costs is employees
 - c. They are big piece of the puzzle that we are not addressing this