

Draft

Brief Summary of Workshop on March 1-2, 2007

“Organization and Delivery of Care and Payment to Providers”

1st Session

Shortell and Casalino emphasize the importance of the delivery system in any meaningful reform of health care. Delivery system reform is a function of incentives and capabilities. They advocate Accountable Care Systems (ACS). An ACS is an entity that is clinically and fiscally accountable for the entire continuum of care. They discuss five models for an ACS: Multi-Specialty Group Practice (MSGP); Hospital Medical Staff Organization (HMSC); Physician Hospital Organization (PHO); Health Plan Provider Organization/Network (HPPO/HPPN); and Interdependent Physician Organization (IPO). They evaluate the models for capabilities and for efficiency relative to the payment structure.

Invited Comments on Shortell and Casalino

Cortese: Knowledge and dissemination among physicians very important. Insuring everyone is easy; need a system where you pay for value. Medicare/Medicaid pays the most dollars for the worst care. Integration and teamwork very important. Asks what are the common characteristics of high value organizations.

Meltzer: Agrees with main findings and challenges. Prefers a system of capitated payment with the market deciding what kind of organization works best. Says good management scarce in health care because of competition from other industries.

Newhouse: One size doesn't fit all. We don't know what is a good solution. The MSGP model has been around for decades, but their market share has not markedly expanded. He emphasizes 1) the lack of or misalignment of incentives to change, and 2) the culture of individual physician autonomy. The market power of providers is great, especially in small markets. There is a chicken-and-egg problem if changes to physician culture require widespread formation of ACSs, but the latter requires changes in physician culture. ACSs are likely necessary to achieve significant gains but not clear how to get there from here.

General Discussion

Patients lack knowledge and incentives to make cost-effective choices. Physicians have more knowledge, but incentives are often misaligned. Need a non-market entity to provide information. Nonpecuniary incentives could be very important in motivating physician behavior. Volume is not an appropriate metric for compensation, but paying for results is problematic because of inadequate risk adjustment. Delivery system is important but so is payment system.

Chicken-and-egg problem. Also, some lose from any big change so second best is always do nothing. Don't know enough to pick best form of organization. Medical care appears to be highly fragmented relative to other industries. Could have partial integration with substantial outside contracting as long as responsibility for the bottom line lies with one party. IPA model can work (e.g., Hill Physicians) with right leadership, management of physicians and their practices accountability, group decision making, economies of scale for IT. Problem is some IPA stay on life support too long. Hospitals are problematic: 1) they want to fill their beds, 2) they are ineffective managers of physicians. Not enough good managers in health care.

2nd Session

Hal Luft emphasizes the heterogeneity of medical care. He argues that the value of insurance and the appropriate structure of insurance varies greatly depending on the type of “episode” of care: major acute illness, minor acute illness, chronic illness, and preventive care. Luft recommends different co-pays for different types of episodes. He would also vary the way physicians are paid for different episodes. For hospitalized patients, he would combine the fees to physicians and other providers with payment to the hospital in a single super DRG for each type of admission.

Invited Comments on Luft

Garber: Payment for chronic disease is problematic: there are stratified levels and much random variability. Need to leave decision making out of government hands. A lot of dimensions of care would fall through the cracks.

Meltzer: Worries that such a major change may not produce much benefit relative to the cost of change. Where are there obvious gains in productivity? Prefers capitation payment and then let the market figure out the best way to pay providers and vary co-pays. A capitated system could always organize itself along the lines suggested by Luft if it was beneficial to do so. We don't see current integrated system such as Kaiser moving in this direction. The system Luft proposes is very complex. Providers as well as patients would have difficulty understanding it.

Newhouse: it is not clear that financial arrangements can benefit all parties or that physician autonomy will not be a problem. Luft is headed in the right direction. There is a trade-off between greater bundling - a la Luft – and risk selection by providers. Medicare might try to implement some of Luft's suggestions, but even modest changes in reimbursement can cause noticeable amounts of redistribution across providers and Congressional districts. Medicare payment methods, once established, are difficult to change. Private plans would have difficulty implementing the suggested changes because even the largest of them usually have only a minor share of any local market.

General Discussion

Some participants liked the idea that physicians should choose the insurance plan. Problems: Boundaries not clear; risk adjustment crucial; not clear that public has an appetite for “value care”. Luft needs to explain what will be the benefit of the new system relative to the cost of

change. Where is accountability fixed. After past changes in payment systems, physicians figured out how to game them. Need to pay more attention to the problem (and potential) of new technologies. Luft's proposal should not be compared with ideal plan that does not exist. Simplicity is important. Clinton plan was too complex. The present system is not functioning well but big obstacles to change.

Available on request

Papers: Shortell and Casalino; Luft
Invited Comments: Cortese, Meltzer, Newhouse
Detailed notes by rapporteur Paul Vronsky

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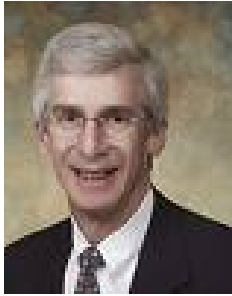
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