

## Synthesis Workshop, May 20, 2008

### Organization of Care and Payment to Providers

*Stephen Shortell*

- Three problems (legs of stool)
  - Lack of access
  - Very costly
  - Quality variation
- The importance of context of care and payment to providers
- The science of healthcare delivery
  - Triangle
    - Incentives → capabilities → performance  
measurement/transparency/accountability → back to incentives
  - Need all three in order to get improved outcomes and improved value
  - Need to unpack all three
- More integrated care systems are needed
  - Better meet the needs of chronically ill people
    - Current system developed around the care of acute patients
    - Chronically ill account for overwhelming majority of healthcare costs
  - Implement 21<sup>st</sup> century medical advances
    - Really have 21<sup>st</sup> medical science trying to be implemented in a 19<sup>th</sup> century system
  - Need to provide accountability and transparency for the resources invested
  - Create greater value
- Physician structure is dysfunctional in US System
  - Solo practice accounts for 1/3 of all physicians
  - 1/4 is over 8 physicians
  - Rest somewhere in between
  - Physicians are neither leaders nor managers, and defend their autonomy
  - Disconnected practices
- Accountable Care System Concept
  - An entity that can implement organized process for improving the quality and controlling the costs of care and be held accountable for results
  - 6 models of care
    - Multi-specialty group practice
    - Hospital medical staff organization
    - Physician-hospital organization
    - Interdependent Practice Organization
    - Health Plan-Provider Organization / Network
    - Independent Practice Unit
  - Common features
    - Teams – care coordination
    - Data sharing – IT
    - Ability to improve care
    - Patient-centered culture
    - Leadership

- Provide a foundation to be able to respond to payment incentives and utilize technology and outcomes assessments
  - There is literature that supports linking physician group organizational attributes to quality of care
- There is a small but growing evidence that more organized forms of practices achieve results
- Payment and Related incentives
  - Recommend CMS reward physicians differentially based upon results
  - Also build in incentives and rewards for improvement
  - Create non-monetary recognition awards
  - Experiment with bundled payments
  - Create incentives for consumers to select the highest performing providers
  - Expand public reporting of cost and quality data
  - People pay more for worse physicians
  - Remove legal barriers that stand in the way of this
- Some issues
  - Who should be rewarded? Team? Individual? Organization?
  - What should be rewarded? Measurement issues
  - Selection / risk adjustment
  - Source of payment
- Need to turn the wheel faster
  - Measurement and accountability → capabilities → payments
- Questions for discussion
  - Do we agree that ACS's of some form are needed for comprehensive health care reform to succeed?
  - If so, what are some of the policy tools available to promote their creation?
  - What are the most significant obstacles that will have to be overcome?

## **Universal coverage**

### *Hal Luft*

- Economics of funding
  - Long run fiscal policy is a health policy problem
  - Need compulsion and subsidization
  - Myths of shared responsibility and middle class aide need to be skewered
  - Need around 6% of GDP in new federal funding
  - Dedicated tax is preferred to achieve budget limiting goals
    - Preference for VAT
  - Don't like most of the other funding options
  - Should assess the distortions w/r/t status quo, not the ideal tax structure
  - On average, a switch to VAT is best
- Politics of funding
  - Current funding is irrational, but politically entrenched
  - Anti tax sentiment is strong
  - Distinguish covering uninsured vs. reforming the system
  - Potential options all have problems
    - Tax expenditure would be regressive, but valued
    - Employer-sponsored coverage mandates are seen as intrusive
    - Payroll tax: social insurance, but politically impossible

- Pay or play: depends on opt-out costs and the public option
    - VAT: hidden money machine according to GOP, but the political feasibility of a sufficient % is politically feasible
    - Not enough sin for sin taxes
  - Current proposals are “faith-based” w/r/t cost controls
- Commentaries and Comments
  - Misperceptions (re incidence of premiums and taxes) may be useful
  - Illusion busting is a role for Congressional hearings
  - Dedicated taxes increases political will, but more than PAYGO
  - Should health expenditure be tied to GDP growth?
  - Is it harder to raise taxes or reduce benefits?
  - Fuchs/Shoven estimates of small differences due to substituting a VAT for premiums depend on numerous assumptions
  - Political assessments depend crucially on the players
  - How important is inertia (or the cost of uncertainty) in politics
  - Transition costs, winners and losers (and their identities) matter
  - Geographic and other limits to using vouchers
  - Creation of entitlements is the problem
  - Delivery system change is the goal, finance is just the price for that
  - Assessing and financing incremental vs. comprehensive reform
- Another view
  - VAT is probably the best options but... it will be impossible to raise enough to fund the whole system
  - GDP growth won't be enough for the whole system with increased aging population, so GDP+ what?
  - Not convinced that government-driven controls will be feasible, because of politics
  - It's the delivery system
  - If a mixed approach, some new taxes will be needed to allow income- based adjustments
- Questions
  - What are the political advantages and disadvantages to comprehensive vs. patchwork funding?
  - Can PAYGO concepts be extended to implicit long term obligation in an honest fashion
  - Funding questions often get stuck on equity/efficiency tradeoffs, can the politics change if the focus shifts to package of delivery and funding

## Thinking on Health Plan Competition

*Joseph Newhouse*

- Both presenters
  - Describe the policy choice to be between market-like competition among health plans vs. a single government plan
  - Question is the degree of market failure (selection) vs. government failure (lack of competition and inefficiency plus failure to satisfy heterogeneous preferences for plans)
  - “good enough” risk adjustment is a way out of market failure potential
- Van de Ven – Schut
  - Excellent exposition and analysis
  - The takeaways from this systems are too fresh
  - Very helpful to have an example

- Garber, Goldman, Lakdawalla
  - Because best forms for organization and finance are unknown, competition is better
    - Allows for learning and evolution
  - Netherlands, Israel, Germany, Switzerland approximate the managed competition model with mixed results
- Discussants
  - First
    - Would the Dutch system approximate Shortell's system
    - Bundling of supplementary insurance opens up selection, as do group discounts
    - Feasible to do individual mandate with managed competition
  - Pauly
    - Puzzling that plans differentiated by quality have not emerged
    - Largely sympathetic to managed competition approach
- Newhouse is biased towards market competition, not government intervention
- Employment based insurance
  - Health insurance is a complex product, need to help people with choices
  - Large employers are good at sifting through health care choices
- Government could act as a broker
- Too many choices can lead to bad choices
  - 401K plans are a good example
  - People don't do well with complicated products
- Minimizing selection
  - Both papers focused on selection
  - Risk adjustment to minimize supplier incentives to shun bad risks
  - Subsidies and mandates to minimize demand incentives
- Risk adjustment
  - What is good enough?
  - Don't know whether the Netherlands has done good job in risk adjustment
  - Newhouse not sure that it is good enough now right now in Medicare
  - In general this is a very new area, need more research
- Demand side → Subsidies and Take-up
  - What level of subsidies is needed to make good risks' opting out an unimportant issue?
  - Medicare Part B is 75%
  - Some would say that income levels above \$100k do not require a subsidy ...
    - This is not really the middle
  - Whatever level of subsidy is needed can it be financed by ending existing structures?
- Two potential problems with competition
  - Geographic variations, small markets
  - What happens to traditional Medicare/Medicaid

## Discussion

- Delivery and finance sides need both need reform
  - Need a clear end objective
  - Need to tell people what they are buying, define the product
- Consumer/patient perspective
  - What is adequate care?
  - How do you preserve/optimize choice?

- Employers
  - Lots of experiments among employers occurring below the radar screen that are effective
  - Employers are changing in some instances the system as it exists right now
  - These things are working, but there are a lot of skeptics of employers
  - Employers are fickle
  - Future for this part of the medical system is bleak
  - Not good bargainers
  - Large employers are entrenched players and it will take time for them to leave
  - There would be an economy-wide impact by removing employers
    - There could be a shift in the kinds of jobs
    - Employee lock-in was more relevant historically
  - Get rid of older employers
- Labor unions
  - They have an interesting role
  - They are a major player, but don't have the right incentives to make changes
  - Division in incentives between older and younger workers
- There is a need for some sort of intermediary
  - Union, employer, connector, etc.
  - Some kind of minimum offering, benefit design
  - Needs to align incentives with cost savings
  - Narrow choices through intermediary
- Transition
  - This is where the focus needs to be
  - Could we survive a transition?
  - Chicken/egg problem
  - Is it a transition to something that is actually better?
  - Distributional concerns during the transition
  - Medicare can be a part of the transition
  - Incentives and technology will help transition
  - Comprehensive vs. patchwork
    - Comprehensive – scrap everything now and start from scratch
    - Or you can provide some options under existing (Part C of Medicare) law and allow buy-in into that
    - This type of patchwork could facilitate transition
    - Incremental patchwork is more feasible politically
  - Understand context, dealing with regional variations
    - Systems should be tailored to regions
    - State by state solution
  - Could start with university medical centers because they have high fixed costs, permit diffusion
- Delivery
  - This is where all of the action will be
  - Need an organization with responsibility
- Capitation
  - There is a need to link to financing
  - What works is prepayment



**May 21, 2008**

## **Technology and Outcomes Assessment**

*Zeke Emanuel*

- Technology Related Changes in Medical Practice are the overwhelming percentage (50%) of the cost increases in healthcare
- Technology assessment:
  - Current system has limitations
    - poor coordination
    - weak legitimacy because of the lack of objectivity
    - lack of integration to influence actual delivery of care
  - Recommendation
    - New federal agency
      - Needs to be politically insulated
      - Federal Reserve type structure
      - No explicit power to link coverage decisions
    - Need to be able to assess existing data with new data
    - Resources
    - Need to be objective
    - Assessments must include costs
      - Comparative value of technologies is key
  - Beyond TA
    - There are a number of variables that cannot be assessed that are a part of healthcare provision
- Outcomes Assessments
  - Create accountable care organizations that take
  - Link performance to incentives, linking payment to absolute level of quality and improvements over time
  - Need new data collection system
- One Institute to do OA and TA
- Questions
  - Can we have OA without first having delivery system reform?
  - How should technology and outcomes assessment results be linked to money?
  - What are the politics of TA and OA?

## **Innovation in a Cost Constrained Environment**

*Sharon Levine*

- Accept the inevitable need for sustainable model for changing rate of growth of costs
- Major drivers
  - Technology
  - Delivery system design and organization
- Innovation is something new and valuable to society
- Biomedical innovation
  - In search of greater value, TA, comparative effectiveness, cost effectiveness
  - Impact of cost constraints on innovation
    - Drug development as a model to understand impact
    - Raise the threshold to proceed to clinical trials

- Mitigation of impact of cost constraints
  - Diversify portfolio
  - Spread risk
  - Enhance public investment in clinical trials
  - Government purchase guarantee of agents deemed essential
- Discussion
  - Cost control vs. cost effectiveness
  - Refocus entrepreneurial activity
  - Varying impacts on different parts of innovation
  - ...
- Innovation in Health System Reform
  - Constrains will drive and focus innovation: successful exploitation of new ideas to create value
  - Research agenda for operations improvement
  - System aims
    - Prevent that which is preventable
  - Federal role: standards to achieve equity and consistency in coverage
  - States/regional role: organize to deliver care
  - A laundry list of requirements
  - Discussion
    - Social determinants of health status
    - Integrate public health enterprise
    - Learning from existing regional models
    - Essential: infrastructure, information, incentives, accountability of quality and cost at the unit of organization
    - Inability to monetize system innovations
  - Big chart on drivers of health spending increases and how they create opportunities for intervention
- Outstanding issues
  - Answering value to whom question
  - Prying control out of states
  - Reform medical education
  - Anticipate disruptive innovation
- Questions
  - What leadership is required?
  - What would a transition look like?

## **Legal and Regulatory Reform**

*Vic Fuchs*

- Laws and regulations that affect health care ubiquitous, pervasive, often complex and in conflict
- Comprehensive health care reform requires resolution of the question of federalism and other jurisdiction
- Significant, sustainable reform needs to take place at the federal level
- Objectives of L&R
  - Protection of individual patients
  - Promotion of competition
  - Protection of providers from competition

- Redistribution to expand access to health care
- L&R are necessary but also result in higher costs of care
- L&R inhibits innovation in organization and delivery of care
- Greater competition in health care does not always increase consumer welfare
- VF opinions
  - L&R create frictions and unintended consequences
  - There is a bias in L&R towards quality of care for individuals and less attention to the well being of the entire population
  - Most lawyers are complacent about L&R effects on health care
  - Can't just deregulate (see financial industry)

## Discussion

- Process innovation
  - Public good problem
  - Question of differential, the problem is that there are stronger IP protections for other innovations. You don't have to give process patents, you may just need to decrease value of existing patents
- Is information alone a sufficient mechanism for reform?
  - Can we simply set standards (legal, regulatory, etc.) that say that things that are too inefficient (cost/benefit sense) will not be acceptable?
  - Basis for risk adjustment
- The cost of inefficiency in health care is buried in the overall cost because there is not a residual claimant in health care
  - Where you see this fixed is in organizations/entities with global budgets
- Innovation generally
  - Tied to payment scheme
  - Physician autonomy is a big driver of the lack of process innovation
  - Process innovation is a lot easier in larger entities because of returns for scale
  - Problem with the use of "innovation" as a singular term
  - Legal and regulatory environment stands in the way of innovation
  - Organizational innovation has high fixed costs
    - You're having to innovate in a continuing operation
  - Perverse incentives for R&D, no real reason to allocate resources for marginally lower quality with much lower cost
- Technology Assessment
  - High barriers to putting into effect in this country
  - FDA/CMS should not be in charge of this process, they should be safety, not cost effectiveness
  - Industry has had bad experiences with government doing assessments in medicine
  - Can do this in large organizations, they have the incentive to do this
  - This reform depends a lot on delivery system
  - Should do this in academic centers because they are already doing research
    - They are paid to do changes
  - Need Technology Assessment with Outcome Assessment
  - Need to account for lost revenues from doing things that are cost effective
- Legal and Regulatory
  - Doesn't serve interests of the poor

- Simply about access
  - Reform of this should be done last → don't bit off more than you can chew
- Has to rely more on incentives
- If you do it at the federal level, state regulation will go away
- Common perceptions are important about individual rights are important
- Leadership
  - Have to start with an agency that will be created
  - Need of bipartisanship in order to have reform
  - Won't get a president who will do that given the current political climate
  - Need cross-sector leadership
  - Do you need a major shock to the system to get change
  - Our challenge is not to figure out when will change happen, we need to list 8-10 things that can be done
  - Find ways to divide opponents by taking elements of proposals from different groups
- Sum up:
  - The market is not structured properly
  - Need to think about the output
  - What will it look like
  - There is a consensus on vision
  - It will take steps, incremental changes
  - See how all of this relates to long term care and mental health services
  - Financing is everything
  - Need to be ready to go at any point with a plan when the opportunity presents itself
  - Draw lessons from the early 1990s reforms, the Cooper bill