Why Payment Reform?

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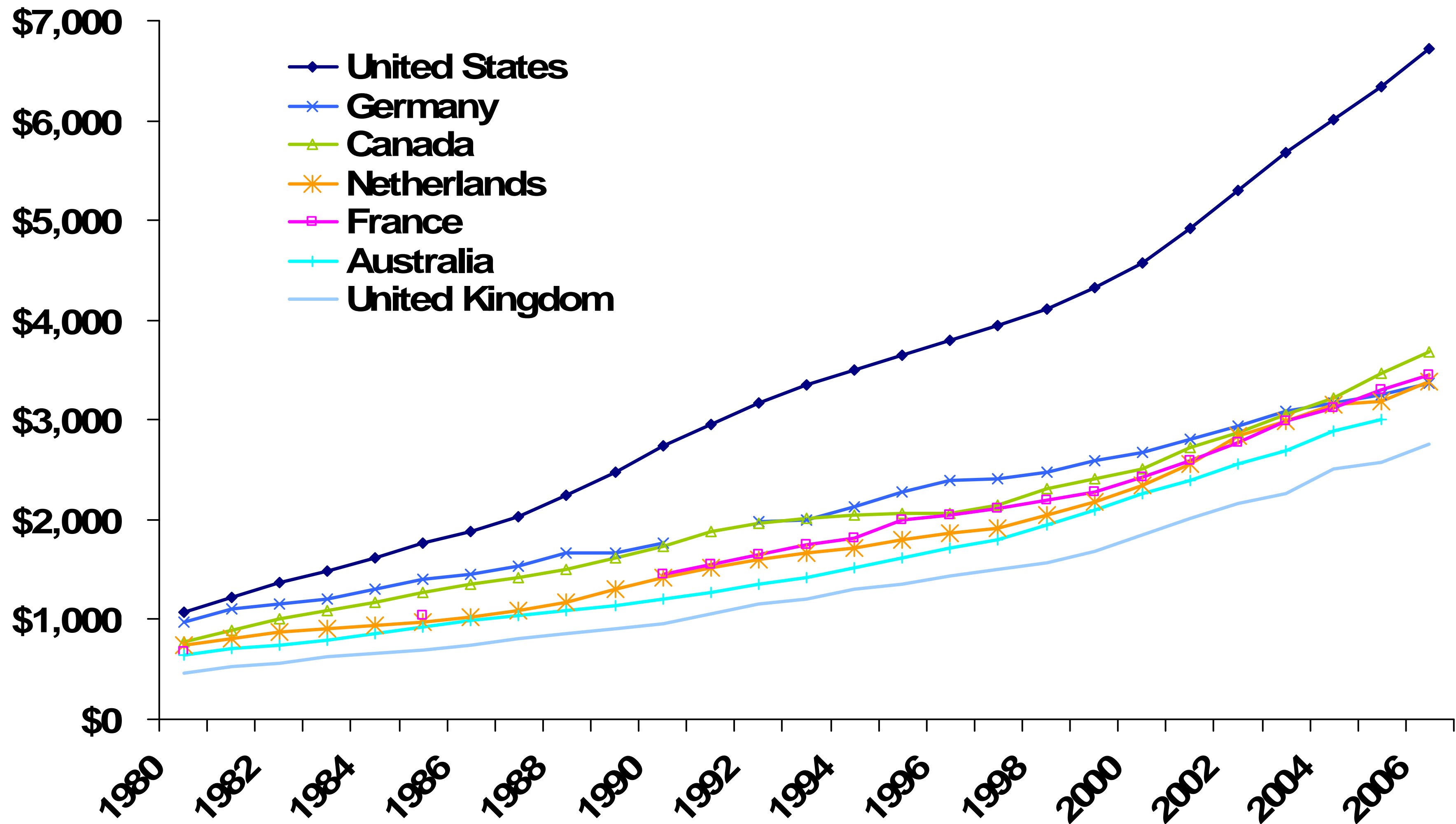
International Comparison of Spending on Health, 1980–2006

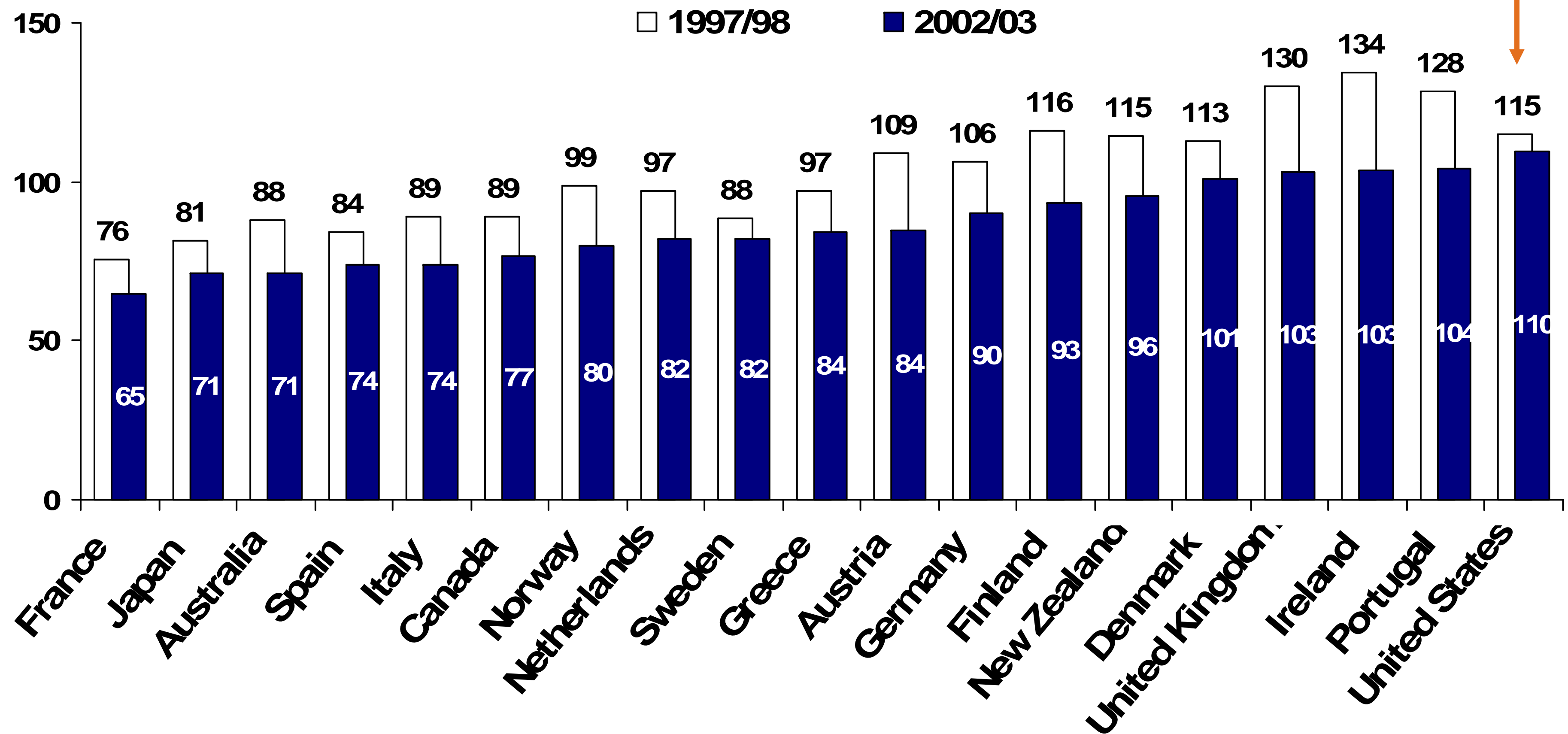


* PPP = Purchasing Power Parity.
Data: OECD Health Data 2008, June 2008 version.

Mortality Amenable to Health Care: U.S. Failing to Keep Pace with Other Countries

19th out of 19

Deaths per 100,000 population*



* Countries' age-standardized death rates before age 75; including ischemic heart disease, diabetes, stroke, and bacterial infections.

Data: E. Nolte and C. M. McKee, London School of Hygiene and Tropical Medicine analysis of World Health Organization mortality files (Nolte and McKee, *Health Affairs* 2008).

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

Achieving Benchmarks: Potential People Impact if the United States Improved National Performance to the Level of the Benchmark

	Current national average	2020 target*	Impact on number of people
Percent of adults (ages 19–64) insured, not underinsured	58%	99%	73 million increase
Percent of adults (age 18 and older) receiving all recommended preventive care	50%	80%	68 million increase
Percent of adults (ages 19–64) with an accessible primary care provider	65%	85%	37 million increase
Percent of children (ages 0–17) with a medical home	46%	60%	10 million increase
Percent of adult hospital stays (age 18 and older) in which hospital staff always explained medicines and side effects	58%	70%	5 million increase
Percent of Medicare beneficiaries (age 65 and older) readmitted to hospital within 30 days	18%	14%	180,000 decrease
Admissions to hospital for diabetes complications, per 100,000 adults (age 18 and older)	240	126	250,000 decrease
Pediatric admissions to hospital for asthma, per 100,000 children (ages 2–17)	156	49	70,000 decrease
Medicare admissions to hospital for ambulatory care-sensitive conditions, per 100,000 beneficiaries (age 65 and older)	700	465	640,000 decrease
Deaths before age 75 from conditions amenable to health care, per 100,000 population	110	69	100,000 decrease
Percent of primary care doctors with electronic medical records	28%	98%	180,000 increase

* Targets are benchmarks of top 10% performance within the U.S. or top countries (mortality amenable and electronic medical records). All preventive care is a target.
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, 2008* (New York: The Commonwealth Fund, July 2008), with benchmarks from top performance.

Why *Payment* Reform?

- Current payment system provides limited, if any, payment or incentives for:
  - Prevention and wellness
  - Quality and efficiency
  - Compliance with evidenced based practice
- Structured in a way that causes conflicting interests and priorities
  - Primary, Specialty, Hospital, LTC, Pharmacy, Insurance Systems

Why *Payment* Reform?

Crumbling primary care system

- Jeopardized workforce – current and future
- Reimbursement that fails to cover expenses

Physician spending 30 minutes performing a diagnostic, surgical or imaging procedure is paid about 3 times as much as a physician conducting a 30 minute visit managing a complex patient with diabetes, heart failure and depression[1]

1 T Bodenheimer, M.D, July 31, 2007. Presentation to the National Business Group on He Research, LLC, Vienna, VA, August 2003.

Why *Payment* Reform?

- We know from the Massachusetts experience
  - Solving for access alone only serves to exacerbate the problem
- Because we get what we pay for – so let's be deliberate about what we pay for

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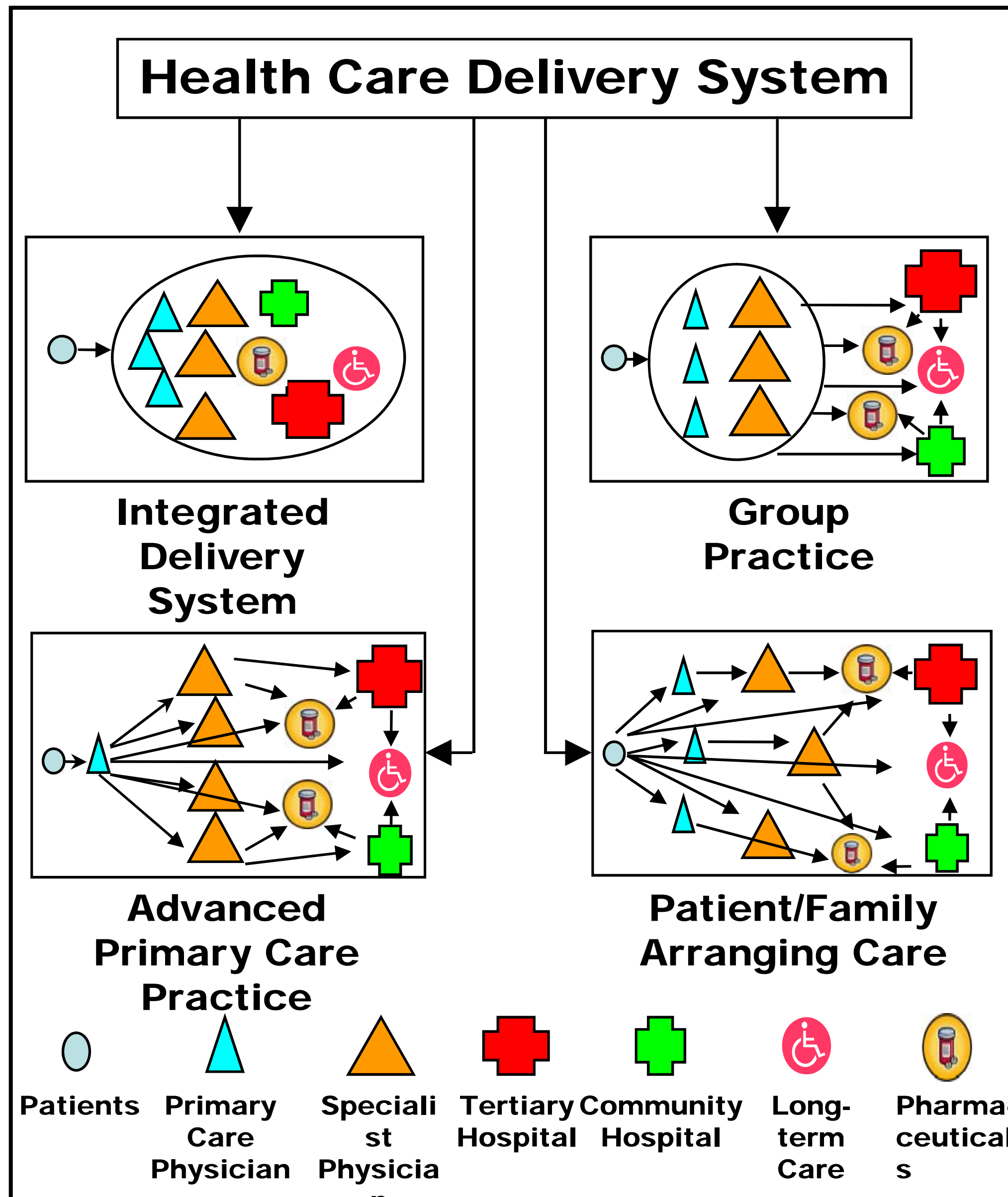
U.S. High Performing Systems

- Good evidence within the United States of high performance
  - Geisinger
  - Intermountain Health
  - Mayo Clinic
  - Kaiser Permanente

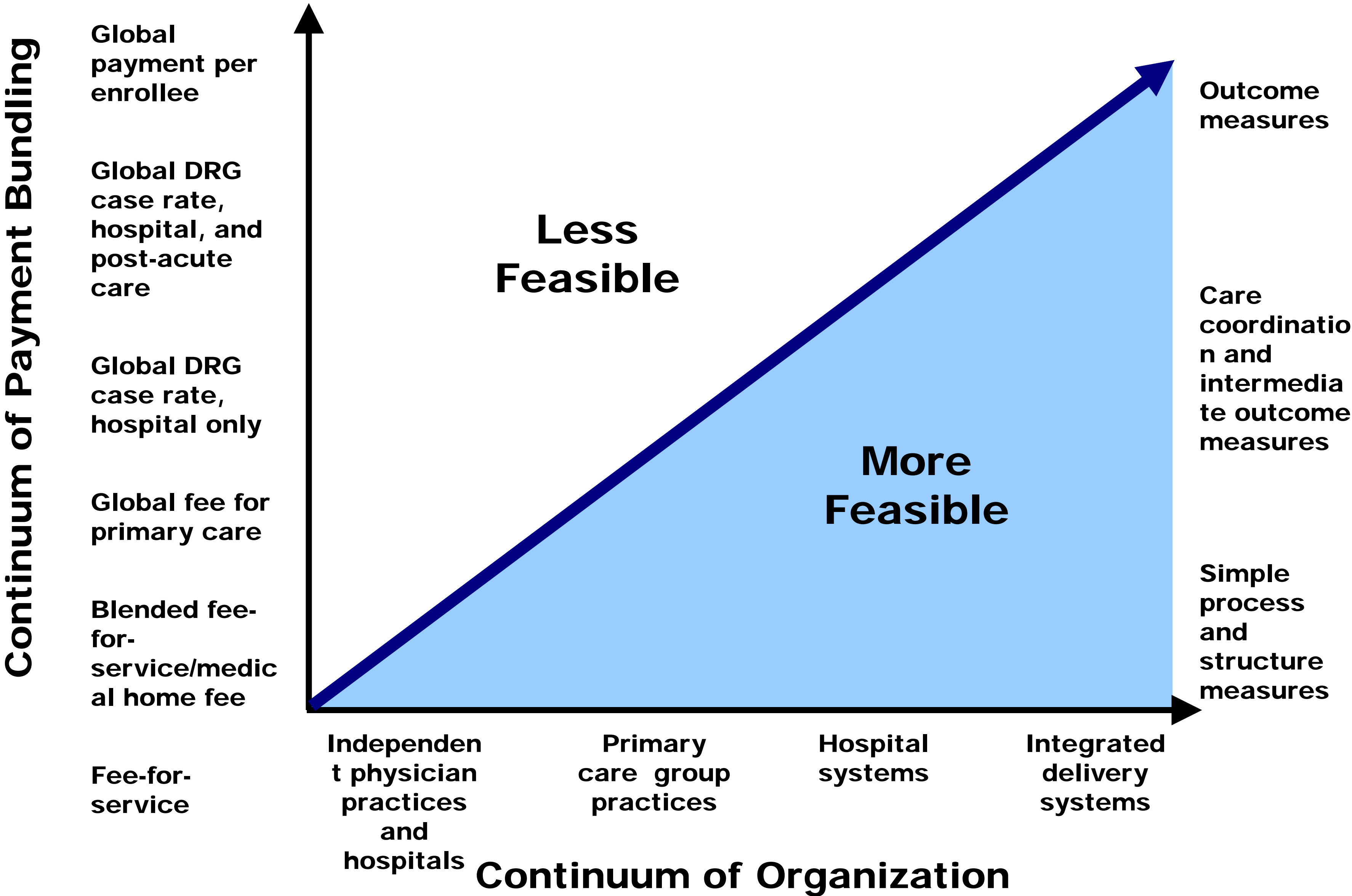
Delivery System Models for Care Coordination



- Incentives for public and private insurance enrollees to designate medical home with:
  - an advanced primary care practice;
  - a group practice; or
  - an integrated delivery system
- New payment methods for delivery systems assuming accountability for total patient care, patient outcomes, and resource use
- Performance standards for each of these delivery systems
- Funding for regional or state efforts to provide primary care practices with:
  - IT network portal and IT support;
  - case management support;
  - after-hours access;
  - QI and care redesign; and
  - data reporting and profiling feedback

Source: *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way*, February 2009.

Payment Models For Consideration



Source: *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way*, February 2009.

Payment Models For Consideration

LOW PROVIDER INCENTIVE TO LOWER THE NUMBER OF EPISODES OF CARE	⟷	HIGH PROVIDER INCENTIVE TO LOWER THE NUMBER OF EPISODES OF CARE

	Fee for Service	Per Diem	Episode of Care (Individual Provider)	Episode of Care (Multiple Providers)	Capitation: Condition-Specific	Capitation: Full

Providers	Lowest financial risk	⟷	Highest financial risk
Payers	Highest financial risk	⟷	Lowest financial risk
Consumers	Risk of overtreatment	⟷	Risk of undertreatment
Employers	Risk of high costs from inefficiency	⟷	Risk of high costs from undertreatment

Risks for stakeholders by payment type will largely depend on the incentive for providers to be efficient in the treatment process and lower the number of episodes of care.

Source: HFMA Healthcare Payment Reform: From Principles to Action (2008)

What should a reformed payment system look like?

- Aligned goals across the system
- Equitable
- Emphasis on wellness and prevention
- Incentives for quality, improvements in health status and evidence based practice

What should a reformed payment system look like?

- Transparent
- Recognizes and is reflective of:
  - Non-face-time efforts, paying for coordination and management of the population
  - Different population burdens

Contact Information

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