Incentives

Team Stroke

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Introduction

1. Health Economics
2. Pay for Value
3. Reform Incentives to create a demand for health system reengineering

Health Economics

1. Health Care Spending Facts
2. Employer Provided Insurance
3. Government Provided Insurance
4. Bending the Cost Curve

Health Care Spending Facts

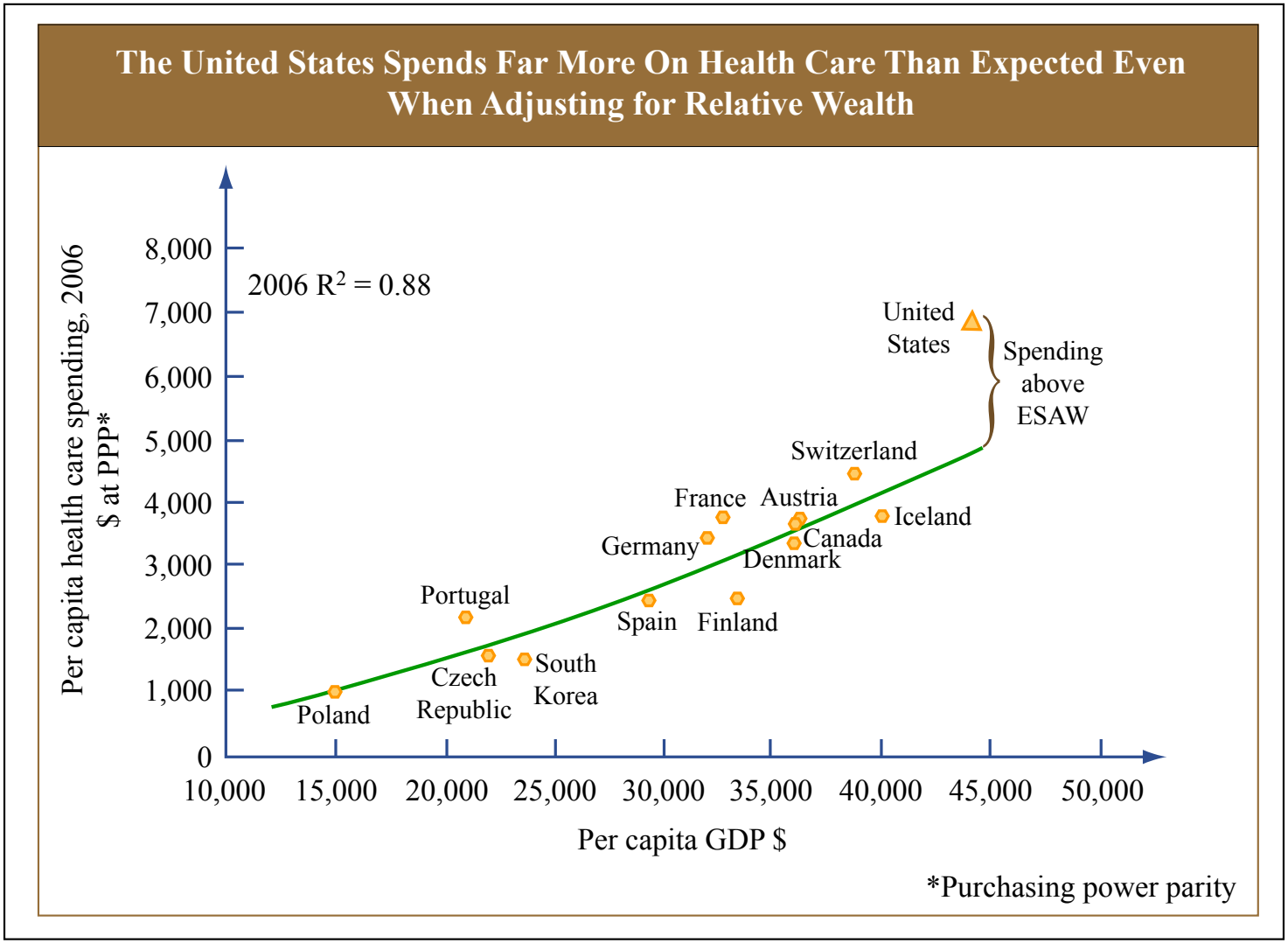

Image by MIT OpenCourseWare. Source: Organization for Economic Cooperation and Development (OECD).

Bottom Line: Spending on Health Care is Unsustainable

Drivers in Health Care Spending

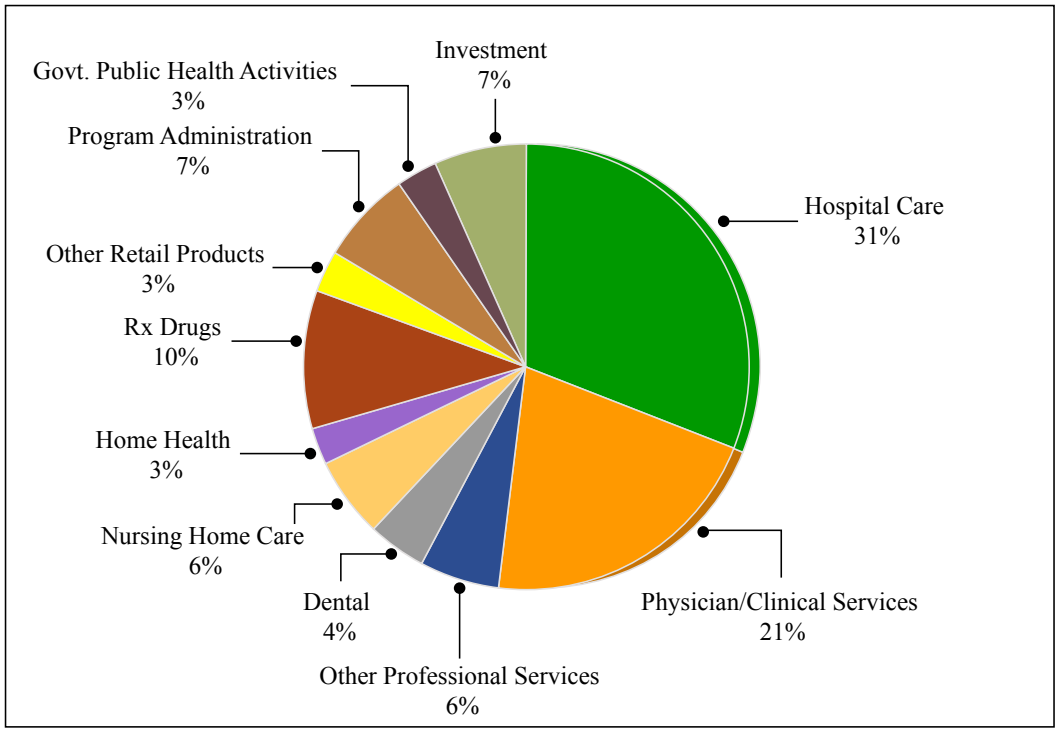

Image by MIT OpenCourseWare. Source: U.S. Centers for Medicare and Medicaid Services.

Major Contributors

- Clinical Services & Hospital Care: 52% of total spending
- Technology: 60% of total spending
- Chronic Disease: 75% of total spending

Source: Center for Medicare and Medicaid Services (CMS).

Employer Provided Insurance

Genesis: WWII and the accompanying wage controls led to employers providing health insurance as a non-taxable fringe benefit to circumvent the law.

Issues:

- Price Distortion Leads to Over-Subscription
- Tax Treatment is Regressive in Nature
- Loss of Tax Revenue : To the tune of ~$240 billion.

Government Provided Insurance

Genesis: Enacted as a result of President Lyndon Johnson's "Great Society" set of programs.

Model: Price control model uses fee-for-service (physicians) and bundled-payment (hospitals);

Issues:

- Fee-for-service model incentivizes volume
- Price fixing limits price competition
- Supplemental insurance further discourages value shopping

Bending the Cost Curve

Aligning Provider Incentives

Efforts to reward improvements in quality & efficiency based on process and/or outcome measures
"Medical Home" and "Pay-for-Performance" programs.

Aligning Patient Incentives

Value Based Insurance Design (VBID): Similar to the policy that supports different coverage for generic and branded drugs.

Application to Stroke Project

Hospitals rank diagnostic capacity as their top capital spending priority

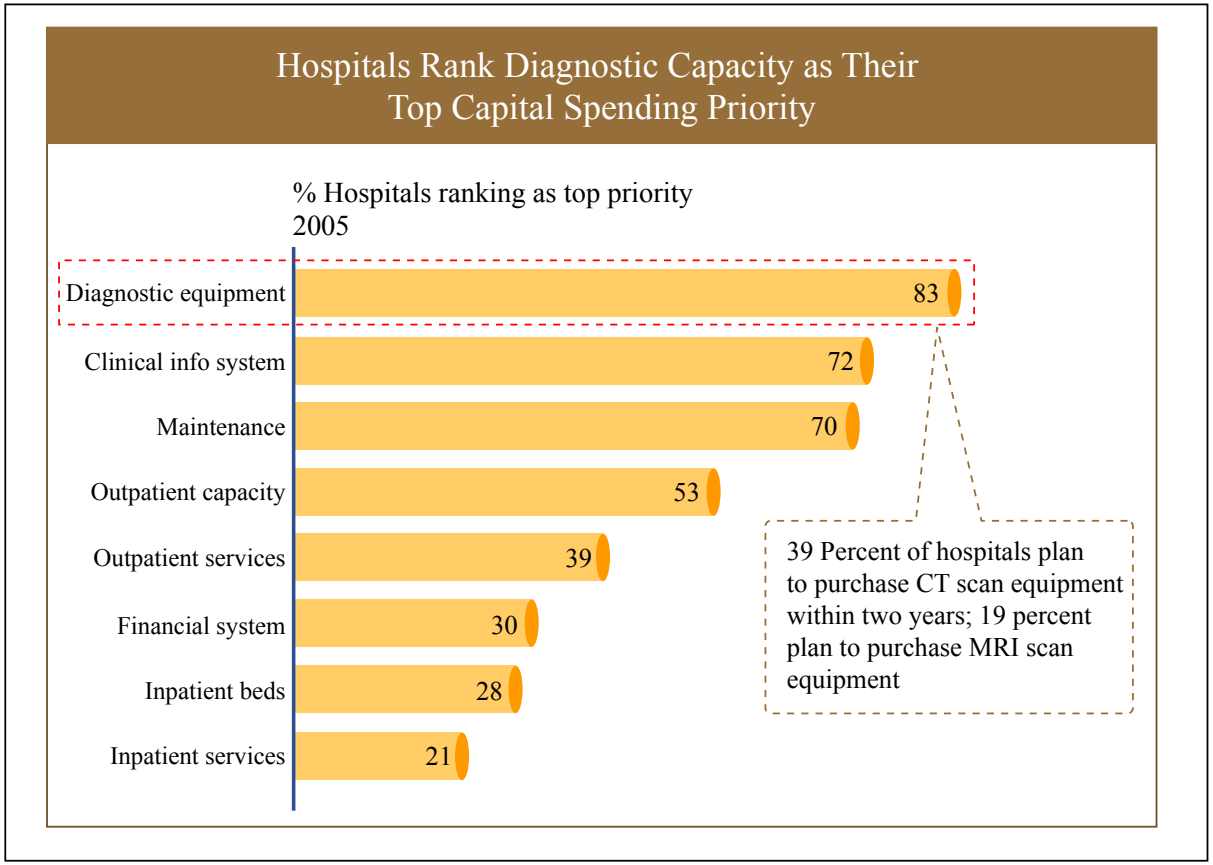

Image by MIT OpenCourseWare. Source: Bank of America Annual Hospital Survey.

Pay for value

1. Share Saving
2. Variable provider payment update
3. Chronic condition coordination payment
4. Share decision making
5. Accountable care organizations
6. Mini-Capitation
7. Applicability of potential pay for value schemes

Applicability of potential pay for value schemes

Payment approach	Acute conditions		Chronic conditions		Prevention
	Procedures	Complex, difficult to diagnose problems	High cost	Low cost	
Shared Saving (FFS)	✔	✔	✔		
Variable Payment Upgrades (FFS)	✔	✔	✔		
Chronic Care Coordination Payment			✔	✔	✔
Shared Decision Making	✔				
Accountable Care Organizations	✔		✔	✔	✔
Episode Based Payments	✔		✔		
Full Capitation	✔		✔	✔	✔

Share savings

The payer would share information about cost with each provider system, and offer to share savings in total cost per patient with each provider system

Pros: Savings from deduced medical expenses as well as increased productivity of workers

Cons: No across the board incentive to move to a more efficient care delivery approach

Variable provider payment update

A payer would risk adjust patient outcome measures on a provider specific basis as well as cost over a span over time

Pros: Teams could decide on appropriate outcome measures as well as the cost per episode would be calculated

Cons: The shared saving approach is weak

Chronic condition coordination payment

Patients with one or more chronic conditions would receive a periodic, prospectively-defined “care management payment” to cover those services; acute care would be covered regular insurance

Pros: The potential payoff from avoiding complications in the future

Cons: Investment for periodic “care management payment”

Share decision making

All patient candidates for selected, elective treatment options or surgery, would be offered an approved educational decision aid related to their specific disease or condition.

Pros: The potential for substantial savings appears to be significant.

Cons: Cost of education, plus unexpected results of education impact in patient decision.

Accountable care organizations

A group of physicians in a hospital would be responsible for quality and overall annual spending for their patients.

Pros: Saving cost

Cons: Necessary to change some of legal rules; hospital accounts high costs.

Mini-Capitation

Episode based payments for hospitalized patients – Or mini-capitation

A single bundled payment to hospitals and physicians managing the care for patients with major acute episodes.

Pros: Does not get bogged down trying to change payment schemes.

Cons: 10-15 % patients will account for 80% of total costs.

Applicability of potential pay for value schemes

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Episode Based Payments	✔		✔		
Full Capitation	✔		✔	✔	✔

Reform Incentives

Current State (USA) vs. Proposed Future State

- Competition among Providers
- Patient Care Accountability
- Health Plan Choice
- Patient Financial Incentives
- Optimizing Care
- Technology Effectiveness

Current State vs. Proposed Future State

Current State	Future State
• Limited Competition • No accountability • Employer based plan(s) • Expensive Technology not evaluated • No patient financial incentives • Unnecessary care	• Providers compete • Managed Care • Patient health plan choice • Comparative effectiveness • Informed cost conscious choice • Process Redesign

Competition among Providers

Current State	Future State
• Providers rely on recommendations from other providers • Patients trust their doctors to provide the best recommendation	• Providers compete for each patient based on cost and quality. • Providers compete with each other based on patient focused metrics such as wait times and accessibility

Patient Care Accountability

Current State

- Uncoordinated care
  - Example – Cancer patient must see radiologist, chemotherapist, surgeon for treatment
- No follow-up
  - No incentives for doctors to follow up with patients regarding their continued health

Doctor Focused

Future State

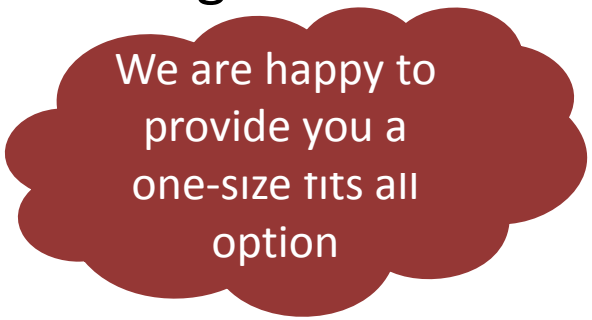
- Coordination specialist provided to the patient to help manage all their physicians
- New incentives for continued monitoring of patients

Patient Focused

Health Plan Choice

Current State

- Employers choose what health plans will be offered.
- Employers, especially smaller employers, forced into offering one health.



Future State

- Everyone is offered wide range of plans
- People can easily compare different plans based on cost and quality
- People choose a plan, not employers

Patient Financial Incentives

Current State	Future State
• Fee-for-services currently rewards volumes of services, but not quality • Limited patient incentives to not request extra tests or procedures • Cost-unconscious mentality	• Consumers receive a "premium support payment" from the government and are responsible for premium differences to see cost implications of their choices • Consumers make an informed decision at the time of annual enrollment

Optimizing Care

Current State

- "Come back and see the doctor more often" syndrome
- Extra steps in care process, which result in:
  - Extra doctor visits
  - Inefficient processes to diagnose & treat patients, often during critical treatment times

Future State

- Lean process improvements
- Delivery system takes advantage of information technology
- Cost-reducing innovations, such as MinuteClinic, staffed by Nurse Practitioners

Technology Effectiveness

Current State

- New technologies are seized upon without proper cost-benefit evaluation
- No incentive to engage in these practices
  - Ex: Payers (Medicare) instructed not to take cost into consideration

Future State

- Well-funded independent institute for comparative cost-benefit evaluation
- Study new and established medical technologies
- Publish results on the effectiveness, safety, and cost of technologies

Conclusion

Three broad topics covered:

1. Health Economics: Bending the cost curve

1. Pay for value: Potential pay for value schemes

1. Reform Incentives: Increase choice and effectiveness

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