Can Medicare Catalyze Development of Better Delivery Systems?

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Today's Talk

- Context/Assumptions
- The Chicken and the Egg, or . . . The Elephant in the Room
- Accountable Care Systems
- Policies to make ACSs feasible
- Let the market decide

"I see by your copy of 'Newsweek' that Lyndon Johnson has decided not to run for reëlection."

"Doctor, you must stop addressing your Medicare patients as Comrade."

Assumption 1

- THERE IS NO MAGIC BULLET, NO PANACEA.
- Nevertheless, steps can and should be taken to improve the delivery system.

Assumption 2

- What won’t work: pushing individual physicians to try harder.

Assumption 3

- What will work: physicians working together and with hospitals to develop organized processes to improve quality and control the costs of care
- This will require investments of time and money

One implication of the assumptions:

- Medicare P4P and/or public reporting for individual physicians in most specialties does not make sense, if these assumptions are correct

Most Physicians Work in Small Practices

	Percentage of Physicians in Practices by Number of Physicians				
	1-2 MDs	3-5	6-50	>50	Institutionally employed
1996	41%	12	13	3	31
2005	33%	10	18	4	36

Another Cut

	Percentage of Physicians in Practices by Number of Physicians			
	1-2 MDs	16-49	100+	Institutionally Employed
1980	46	5	4	16
1996	35	7	5	22
2001	32	9	5	26

Multispecialty Groups?

- beloved of many analysts
- but shift to medium-sized groups is to single specialty groups
- little or no movement toward large multispecialty groups

Assumption 4

- Physicians in small practices generally lack the time, skills, and economies of scale to implement a broad range of organized processes to improve care, e.g.
  - nurse care managers
  - EMR and gathering of data from EMR
  - disease management

Assumption 5

- For physicians in small practices (in primary care and many specialties), it will be difficult or impossible to devise a reliable and valid payment method that gives incentives for improving quality and controlling costs.

Why?

- Small number of patients (e.g. diabetics) per MD $\Rightarrow$ problems with risk adjustment and with statistical reliability
- Can’t/shouldn’t put individual physician at high financial risk (e.g. capitation for services other than own)
- How reward coordination of care?

The Chicken and the Egg

- Without strong incentives to improve quality and to control the costs of care, physician movement into large groups likely to continue to be slow
- But probably can’t give strong incentives to physicians in small practices

The Elephant in the Room

- analysts spend a great deal of time trying to devise payment schemes that will adequately incentivize higher quality and cost control within our current fragmented delivery system
- probably not possible to do this, but this fact is rarely pointed out

Medicare Should Not Pick Winners and Losers

- many physicians and patients prefer small practices
- small practices have some advantages:
  - human scale; patients, physicians, staff interact closely/know each other well
- possible to create “virtual integration” of small practices in IPAs or PHOs that have scale to implement organized processes to improve quality

Models

- Medical groups - e.g. Kaiser, Mayo, Billings, Geisinger
- IPAs and PHOs - e.g.
  - Advocate (Chicago PHO)
  - Partners (Massachusetts PHO)
  - Hill Physicians (SF Bay Area IPA)
  - Greater Rochester IPA (NY State)

Goals for Delivery System Reform

- Encourage innovation in:
  - the use of organized processes by providers
  - the organization of the delivery system
- Maintain:
  - beneficiary choice of providers
  - provider choice of practice setting
- Do not pick winners and losers

General Strategy

- Vary payment methods/rewards by organization type:
  - status quo
  - medical home
  - Accountable Care System
- Make potential rewards commensurate with:
  - range and importance of measures for which it is possible to reliably measure an organization's performance
  - amount of financial risk the organization takes

Medical Homes

- the medical home would be the practice (or the Accountable Care System), not the individual physician
- medical home patients would be able to see physicians outside their medical home without a referral

Accountable Care Systems

- To be defined as an ACS, an organization must:
  - be willing to take responsibility for the overall costs and quality of care for a population of patients
  - have the size and scope to fulfill this responsibility
  - be accredited as a medical home.

Possible Types of ACS

- integrated system (e.g. Kaiser, Geisinger)
- “virtual organization (e.g. IPA, PHO)
- large medical group
- large hospital or hospital system with employed physicians
- might or might not include rehab hospitals, LTC facilities, etc.

ACS Held Responsible for the Population of Patients Who

- choose the ACS as their medical home for $\geq$ 7 months in a year
- have not chosen the ACS, but receive most of their care there, as retroactively assigned by Medicare

Payment Methods and Public Reporting for Hospitals

	DRG-based Payment	Quality Bonus	Patient Experience Bonus	Payment for Avoidable Complications	Public Reporting
Not part of an ACS	National annual update	Based on the hospital's inpatient and outpatient care	Based on patients' experience with the hospital	Denied	Based on hospital quality and patient experience
Part of an ACS	Annual update specific to that ACS	Based on the quality of care received by the ACS's patients (even when received outside the ACS)	Same as above	Paid	Same as above

Payment Methods and Public Reporting for Physicians

	Cognitive Services	Preventive Services	Procedures	Quality Bonus	Patient Experience Bonus	Public Reporting of Quality	Public Reporting of Patient Experience
Not member of ACS or medical home	fee-for-service with national annual update			?*	based on the individual MD**	No	based on the individual MD
Member of med home; not of ACS	discounted ffs plus med home payment; national annual update***	Same as in the row above					
ACS member (also med home practice)	as in the cell above, except annual update specific to that ACS	same as in the rows above, except annual update would be specific to that ACS		quality of care received by the ACS's patients, wherever they received it	same as in the rows above	ACS quality would be reported	based on the individual MD

*Small amounts would be paid to individual physicians to the extent that reliable and valid risk-adjusted measurement can be done

** Would include questions about the practice, if any, of which the physician is a member.

***Reimbursement for non-medical home patients would be at the full fee-for-service rate.

Feasible?

- actions are technically difficult, but feasible
- legal changes would be necessary for many of the actions
- politically, challenges would be large

Desirable?

- retains patient choice of provider and provider choice of practice setting
- rewards high performance and innovation
- relatively simple to understand
- actions synergistic
- balances quality and cost incentives
- at a minimum, would control costs
- difficult to believe that would not improve quality

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Pilots and Demos: Con - They Can be “Artificial”

- do not include full range of balancing incentives - testing one action in isolation not a valid test
- providers and patients must deal with the rest of the delivery system, which is doing business as usual
- providers know program may be temporary; participating providers likely to underinvest
- insufficient time for patients and providers to become familiar with the concept