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

The United States spends far more on health care than expected even when adjusting for relative wealth.

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

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

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

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.
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

<table>
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<tr>
<th>Payment approach</th>
<th>Acute conditions</th>
<th>Chronic conditions</th>
<th>Prevention</th>
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<tr>
<td></td>
<td>Procedures</td>
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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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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**
- Limited Competition
- No accountability
- Employer based plan(s)
- Expensive Technology not evaluated
- No patient financial incentives
- Unnecessary care

**Future State**
- Providers compete
- Managed Care
- Patient health plan choice
- Comparative effectiveness
- Informed cost conscious choice
- Process Redesign
## Competition among Providers

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<th>Future State</th>
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<td>• Providers rely on recommendations from other providers</td>
<td>• Providers compete for each patient based on cost and quality.</td>
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<tr>
<td>• Patients trust their doctors to provide the best recommendation</td>
<td>• Providers compete with each other based on patient focused metrics such as wait times and accessibility</td>
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## Patient Care Accountability

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| • 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.

*We are happy to provide you a one-size fits all option*

## 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

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

Ooo look! They changed the color of the device handle! Let’s buy this one!
Conclusion

Three broad topics covered:

1. Health Economics: Bending the cost curve
2. Pay for value: Potential pay for value schemes
3. Reform Incentives: Increase choice and effectiveness