



UST Executive Conference on the Future of Health Care

The Future of Financing in the Health Care System

Minnesota Health Care Presentation

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Are we on the burning platform?

- Current state
 - Low value compared to other countries
 - Inherently inflationary system
 - Nature of “actuarial soundness”
 - Supplier of services often acts as purchasing agent
 - No good mechanisms to bring delivery innovations to the market



Challenges of the Health Care Market

- Purchaser is not the consumer
- Provider and consumer have vastly different amounts of knowledge
- Consumers (patients) do not have effective agents
- Decision makers have no stewardship accountability



How can we build a sustainable market?

What do we need to happen for a market to function?

- Purchaser/consumer alignment
- Choice
- Information gap
- Measurement



Purchaser/consumer alignment

- Who really makes the spending decisions?
 - Payer (private or public sector) - coverage limits
 - Health plan (TPA, fully insured, public sector)
 - authorization systems, selective contracting, etc.
 - Providers – referral patterns, integrated delivery systems, therapeutic and diagnostic decisions
 - Patients – provider and treatment choices



Information gap

- Quality

- Health outcomes

- Important tools

- Community Measurement – variability measurement
 - Risk adjustment

- Patient experience

- More nascent development
 - Satisfaction, engagement, activation
 - Diversity



Information gap

- Cost
 - Real costs and payments
 - Co pays
 - Deductibles
 - Discounts
 - Defining services
 - Professional vs. facility billing
 - Units of service vs. larger bundles



Information gap

- Asymmetrical medical information
 - Progressive nature of medical decisions
 - Complexity defies easy standardization
 - Medical complexity
 - Social complexity
 - Patient, family, and cultural preferences

Patients require an effective agent



Many Faces of Medicaid II

- 1/3 of Medicaid only patients have 3 or more CDPS diagnostic groups
- This group accounts for 2/3 of acute care expenditures
- In looking for correlations between **pairs** of diagnostic groups, the average correlation across all pairs (of CDPS diagnostic groups is 0.06. (The highest diabetes and cardiovascular disease = 0.34)

RG Kronick, M Bella, TP Gilmer, SA Somers *The Faces Of Medicaid II*, Center for Health Care Strategies, Inc. 2007



Primary care as the effective agent

- Relative information symmetry
- Ability to integrate medical complexity
- Ability to integrate patient preferences
- Potential to create a market with symmetrical information



For Primary Care

- Current market reality
 - Incentives for production
 - RUC based RVU compensation
 - Progressive eroding of compensation
 - No incentives for outcomes or coordination



Barbara Starfield, MD,

Professor of Health Policy & Management at John Hopkins

(Health Affairs, March 15, 2005)

- In the US, a 20 % increase in the number of primary care physicians is associated with a 5 percent decrease in mortality.



Primary Care Value

“Increasing the number of general practitioners in a state by 1 per 10,000 population (while decreasing the number of specialists to hold constant the total number of physicians) is associated with a rise in that state’s quality rank of more than 10 places as well as a reduction in overall spending of \$684 per beneficiary.

K Baicker and A Chandra. *Health Affairs* W4-184-197, 2004.



Minnesota Health Care Programs – Fee for service population

- ~200,000 participants at any time
- ~100,000 participants with disability status
- \$1.4 billion health care spending (not including long term care)
- ~\$30 million for Evaluation and Management and Preventative service reimbursement
 - ~2% of the total spending



Primary Care

Reimbursement based primarily on the quantity of services delivered, rather than on quality forces primary care physicians onto a treadmill, devaluing their professional work life. The short, rushed visits with overfilled agendas that cause patients dissatisfaction simultaneously breed frustration in physicians....*Public policy on primary care does not exist...A covenant is needed between those who pay for health care and those who deliver primary care: primary care must promise to improve itself, and in return, payer must invest in primary care.*

-Bodenheimer, NEJM 355:861-864



A model for better care and better health care economics

Primary care providers as

- Agents for patients within the health care system
- Locus of quality measurement
- Responsible stewards of resources



Can we get there from here?

Payment reform

- Blend
 - Fees for services
 - Care coordination
 - Quality rewards – pay for performance
- And make it fair
 - Risk adjust

www.pcpcc.net/content/proposed-hybrid-blended-reimbursement-model



Can we get there from here?

Measurement of the IHI Triple Aim

- Patient experience
- Health outcomes
- Cost



Minnesota legislation



2008 Omnibus Health Care Reform

- Uniform quality incentives
- Baskets of care/ price transparency
- Coverage expansion
- Public health investment
- Health care homes



Challenges for healthcare reform

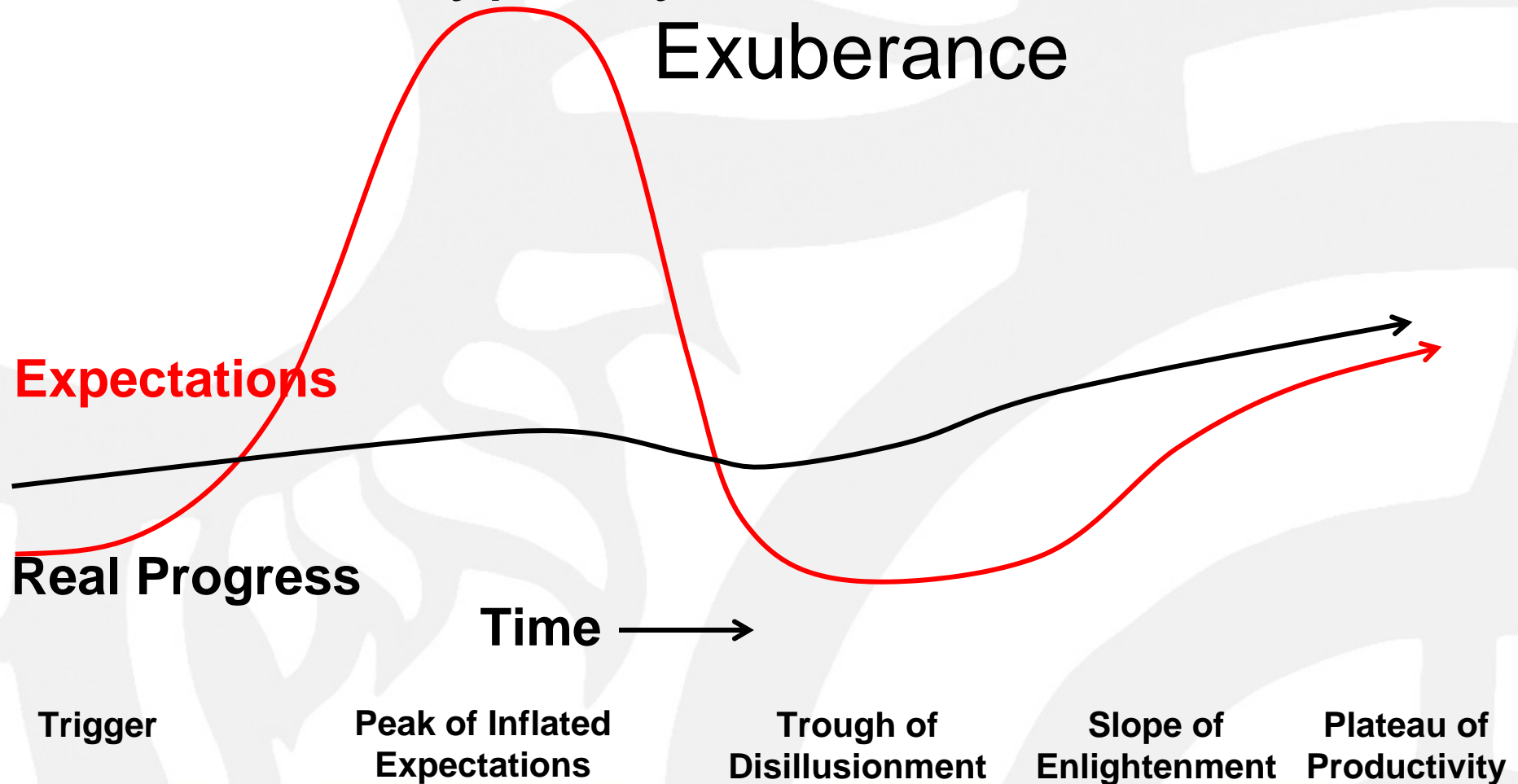
- Medical home
 - The correct payment blend
 - Defining robust care coordination/ primary care services
- Baskets of care
 - Limits of coverage
 - Products difficult to understand

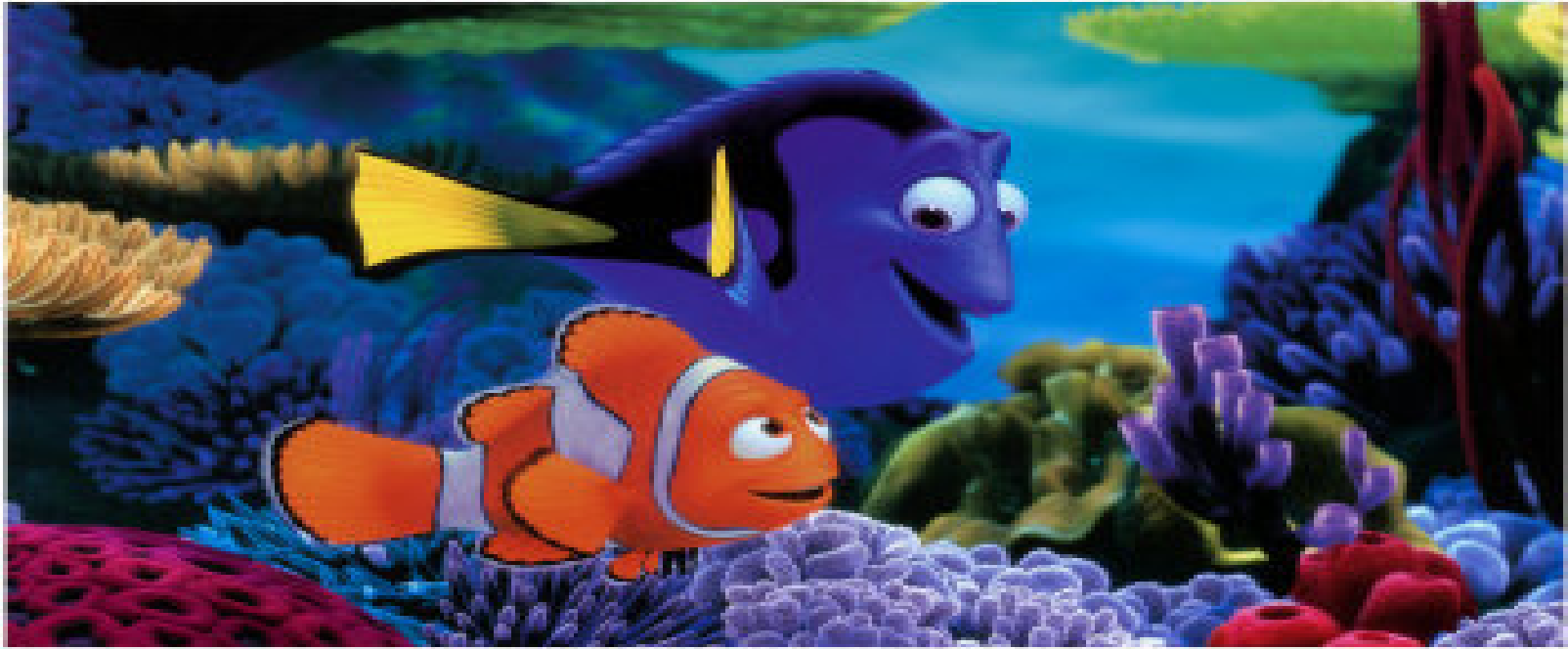


Challenges (continued)

- To narrow a definition of health and healthcare
- Adequate measurement
- Need for dynamic refinement of payment and measures
- Staying the course

The Hype Cycle: Waves of Irrational Exuberance





Searching for Nemo

