

Delivery system reform

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Goals for reforming the payment and delivery systems

- Improve program sustainability
- Increase quality and reduce cost growth
- Other changes may still be necessary



Direction for payment and delivery system reform

Current FFS payment systems

Physician Inpatient Outpatient LTCH IRF Psychiatric SNF Home health DME Lab Hospice **Recommended tools**

Comparative effectiveness

Pay for performance

Reporting resource use

Individual services "bundled" within a payment system Potential system changes

Pay across settings and across time

For example: •Medical home •Payments "bundled" across existing payment systems •Accountable care organization

MECIPAC

Potential approaches

Medical home

- Emphasize primary care
- Increase care coordination
- Maintain patients health—reduce unnecessary admissions
- Physician-hospital payment bundling
 - Physician-hospital cooperation
 - Increase efficiency within the hospital stay
 - Decrease readmissions
- Accountable care organizations (ACOs)
 - Groups of physicians are jointly responsible
 - Broad set of services
 - Incentives for value over time



Physician-hospital integration lessons

- Financial incentives (e.g. bundling, ACOs) can lead to financial integration
 - Employment of physicians
 - Physician-hospital organizations
- Financial integration does not always mean a change in clinical practices
 - Some PHOs were focused on increasing volume and pricing power
 - Characteristics of individual markets can affect how physicians and hospitals integrate
- Payments to integrated entities should be designed to encourage physicians and hospitals to improve the value received by patients



For discussion

Is there consensus on goals of reform?

- Recommended tools (CE, P4P, resource use) are important but may not overcome all FFS limitations
- Additional approaches are needed that integrate across provider types and time

How should we further explore these approaches:

- Medical home
- Physician-hospital payment bundling
- ACOs

