Eliminating Excessive, Unnecessary, and Wasteful Expenditures: Getting to a High Performance U.S. Health System

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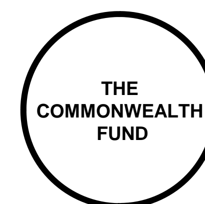
Excessive, Unnecessary, and Wasteful Expenditures in the Current U.S. Health System and Goals for Reform

- Problems:
  - High and rapidly-growing costs
    - Unnecessary hospital admissions and readmissions
    - Fragmented care
    - Lack of coordination
    - Variable quality
    - Administrative costs

- Goals:
  - Slow growth in health spending
  - Create incentives for providers to take broader accountability for patient care, outcomes, and resource use
  - Provide rewards for improved care coordination among providers
  - Put in place an infrastructure to support providers in improving quality and efficiency

Sources of Excessive, Unnecessary, and Wasteful Expenditures in the Current U.S. Health System



We Can't Continue on our Current Path: Growth in National Health Expenditures per Capita

Average spending on health per capita ($US PPP)

United States
Canada
France
Germany
Netherlands
United Kingdom

8000
7000
6000
5000
4000
3000
2000
1000
0

1980 1984 1988 1992 1996 2000 2004

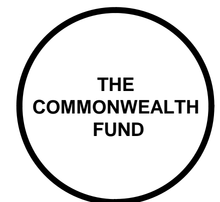
Data: OECD Health Data 2009 (July 2009)

Ambulatory Care–Sensitive (Potentially Preventable) Hospital Admissions for Select Conditions

Adjusted rate per 100,000 population

Condition	Group	2002/2003^	2004
Heart failure	U.S. Average	498	476
Heart failure	Top 10% states	258	246
Heart failure	Bottom 10% states	631	634
Diabetes*	U.S. Average	241	240
Diabetes*	Top 10% states	137	126
Diabetes*	Bottom 10% states	299	293
Pediatric asthma	U.S. Average	178	156
Pediatric asthma	Top 10% states	62	49
Pediatric asthma	Bottom 10% states	242	230

^ 2002 data for heart failure and diabetes; 2003 data for pediatric asthma. *Combines four diabetes admission measures: uncontrolled, short-term complications, long-term complications, and lower extremity amputations.
Data: National average—Healthcare Cost and Utilization Project, Nationwide Inpatient Sample; State distribution—State Inpatient Databases; not all states participate in HCUP (AHRQ 2005, 2007a).
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008.

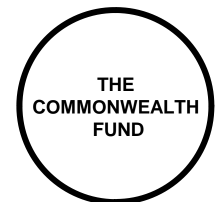


Medicare Hospital 30-Day Readmission Rates

Percent of Medicare beneficiaries admitted for one of 31 select conditions who are readmitted within 30 days following discharge*

U.S. Mean		Hospital Referral Region Percentiles, 2005				State Percentiles, 2005			
2003	2005	10th	25th	75th	90th	10th	25th	75th	90th
18	18	14	16	20	21	15	16	19	20

Data: G. Anderson and R. Herbert, Johns Hopkins University analysis of Medicare Standard Analytical Files (SAF) 5% Inpatient Data.
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008.

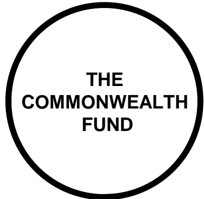


Average Risk-Adjusted Standardized Spending for Hospital Readmissions After Coronary-Artery Bypass, 2001-2003

	Spending
Spending at Hospitals, Bottom 25th Percentile	$947
Average Spending (Mean)	$1,887
Spending at Hospitals, Upper 75th Percentile	$2,911

Y-axis: $0, $500, $1,000, $1,500, $2,000, $2,500, $3,000, $3,500

Source: Hackbarth, G et al. "Collective Accountability for Medical Care — Toward Bundled Medicare Payments." N Engl J Med 359;1. July 3, 2008. Page 4.



Medicare Reimbursement and 30-Day Readmissions by State

Medicare reimbursement per enrollee

$8,500
$8,000
$7,500
$7,000
$6,500
$6,000
$5,500
$5,000
$4,500
$4,000

NJ
MA
LA
NY
CA
CT
FL
MD
TX
NV
MI
PA
RI
DE
IL
OK
MS
AL
OH
TN
KY
AK
DC
CO
AZ
KS
WV
SC
MO
GA
NC
IN
NH
AR
VT
WA
VA
ME
WI
WY
NE
MN
UT
MT
ID
NM
OR
IA
SD
ND
HI

$R^2 = 0.42$

10
15
20
25

Medicare 30-day readmissions as percent of total admissions

Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008.

Went to Emergency Room for Condition That Could Have Been Treated by Regular Doctor, Among Sicker Adults

Percent of adults who went to ER in past two years for condition that could have been treated by regular doctor if available

	2005	2007
United States	26	21
GER		6
NETH		8
NZ		8
UK		11
AUS		16
CAN		19

International Comparison: GER, NETH, NZ, UK, AUS, CAN

AUS=Australia; CAN=Canada; GER=Germany; NETH=Netherlands; NZ=New Zealand; UK=United Kingdom.
Data: 2005 and 2007 Commonwealth Fund International Health Policy Survey.
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008.

Poor Coordination: Nearly Half Report Failures to Coordinate Care

Percent U.S. adults reported in past two years:

Item	Percent
Your specialist did not receive basic medical information from your primary care doctor	13
Your primary care doctor did not receive a report back from a specialist	15
Test results/medical records were not available at the time of appointment	19
Doctors failed to provide important medical information to other doctors or nurses you think should have it	21
No one contacted you about test results, or you had to call repeatedly to get results	25
Any of the above	47

Axis: 0, 20, 40, 60

Source: Commonwealth Fund Survey of Public Views of the U.S. Health Care System, 2008.

Dartmouth Variations: Costs of Care for Medicare Beneficiaries with Multiple Chronic Conditions, by Hospital Referral Regions, 2005

	Average annual reimbursement					Ratio of percentile groups	
	Average	**10th percentile**	**25th percentile**	**75th percentile**	**90th percentile**	**90th to 10th**	**75th to 25th**
All 3 conditions							
2005	$38,004	$25,732	$29,936	$44,216	$53,019	2.06	1.48
Diabetes + Heart Failure							
2005	$23,056	$16,144	$18,649	$26,035	$32,199	1.99	1.40
Diabetes + COPD							
2005	$15,367	$11,317	$12,665	$17,180	$20,062	1.77	1.36
Heart Failure + COPD							
2004	$27,498	$19,787	$22,044	$31,709	$37,450	1.89	1.44

COPD=chronic obstructive pulmonary disease.
Data: G. Anderson and R. Herbert, Johns Hopkins University analysis of Medicare Standard Analytical Files (SAF) 5% Inpatient Data.
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008.

Percentage of National Health Expenditures Spent on Insurance Administration, 2005

Net costs of health insurance administration as percent of national health expenditures

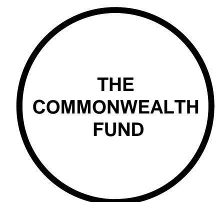
Country	Percent
Finland	1.9
Japan[a]	2.3
Australia[a]	2.8
United Kingdom[b]	3.3
Austria	3.9
Canada	4.2
Netherlands[a]	4.3
Switzerland	4.8
Germany	5.6
France	6.9
United States*	7.5

[a] 2004 [b] 1999

* Includes claims administration, underwriting, marketing, profits, and other administrative costs; based on premiums minus claims expenses for private insurance.

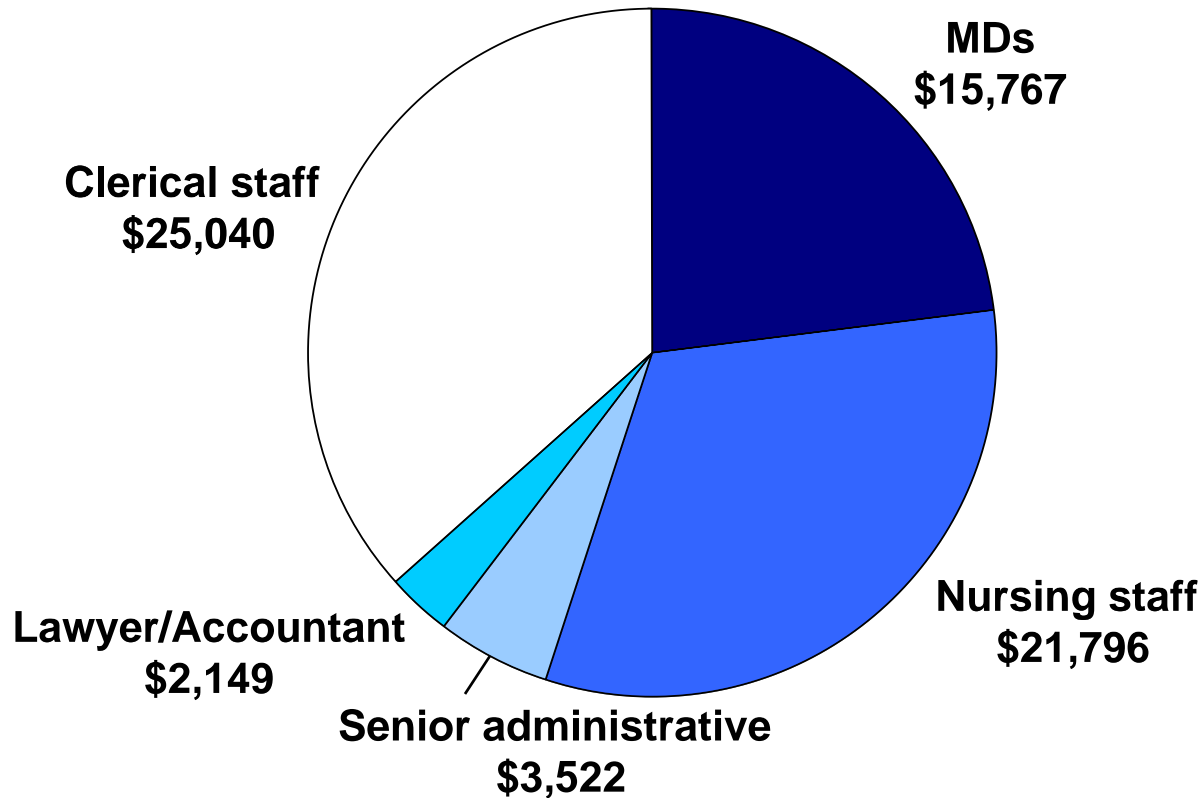
Data: OECD Health Data 2007, Version 10/2007.

Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008.



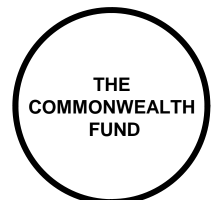
Total Annual Cost to U.S. Physician Practices for Interacting with Health Plans Is Estimated at $31 Billion[1]

Mean Dollar Value of Hours Spent per Physician per Year on All Interactions with Health Plans

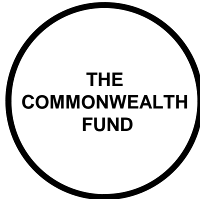


Total Annual per Practice Cost per Physician: $68,274

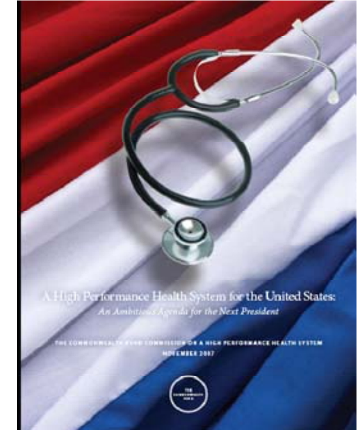
[1] Based on an estimated 453,696 office-based physicians.
Source: L. P. Casalino, S. Nicholson, D. N. Gans et al., "What Does It Cost Physician Practices to Interact with Health Insurance Plans?" *Health Affairs* Web Exclusive, May 14, 2009, w533–w543.



Eliminating Excessive, Unnecessary, and Wasteful Expenditures in the Current U.S. Health System



Five Key Strategies for High Performance



1. **Extending affordable health insurance to all**
2. **Organizing care to ensure accessible, patient-centered, coordinated care**
3. **Aligning financial incentives to enhance value and achieve savings**
4. **Meeting and raising benchmarks for high-quality, efficient care**
5. **Ensuring accountable national leadership and public/private collaboration**

Source: Commission on a High Performance Health System, A High Performance Health System for the United States: An Ambitious Agenda for the Next President, The Commonwealth Fund, November 2007

Promising Strategies for Payment Reform and Care Coordination

1. Patient-Centered Medical Home: Medical Home fee; global primary care fee
2. Multi-specialty physician group practice and accountable care organizations: global physician fee, Medicare group practice demonstration payment model, partial or full capitation
3. Hospital: global acute care case rate (discharge plus 30 days); global hospital case rate plus physician inpatient; global hospital case rate plus physician plus post-acute care
4. Integrated delivery system: global patient-level payment (capitation)

Supported by:
Rewards for high performance & shared savings

Organization and Payment Methods

Continuum of Payment Bundling

Global patient-level payment (capitation)

Global hospital and post-acute care case rate

Global hospital case rate

Global physician fee

Global primary care fee

FFS and DRGs

Less Feasible

More Feasible

Rewards for High Performance and Shared Savings

Disconnected MD practices, hospitals

Primary care MD group practices

Multispecialty MD group practices

Hospital systems

Integrated delivery systems

Continuum of Organization

Source: A. Shih, K. Davis, S. Schoenbaum, A. Gauthier, R. Nuzum, and D. McCarthy, *Organizing the U.S. Health Care Delivery System for High Performance*, (New York: The Commonwealth Fund, August 2008).

Bending the Curve:
Options that Achieve Savings
Cumulative 10-Year Federal Budget Savings

	Path estimate	CBO estimate	OMB estimate
Producing and Using Better Information			
• Promoting Health Information Technology	-$ 70 billion	-$ 61 billion	-$ 13 billion
• Comparative Effectiveness	-$174 billion	+$ 1 billion	---
Promoting Health and Disease Prevention			
• Public Health: Reducing Tobacco Use	-$ 79 billion	-$ 95 billion	---
• Public Health: Reducing Obesity	-$121 billion	-$ 51 billion	---
• Public Health: Alcohol Excise Tax	-$ 47 billion	-$ 60 billion	---
Aligning Incentives with Quality and Efficiency			
• Hospital Pay-for-Performance	-$ 43 billion	-$ 3 billion	-$ 12 billion
• Bundled Payment with Productivity Updates	-$123 billion	-$201 billion	-$110 billion
• Strengthening Primary Care and Care Coordination	-$ 83 billion	+$ 6 billion	---
• Modify the Home Health Update Factor	---	-$ 50 billion	-$ 37 billion
Correcting Price Signals in the Health Care Market			
• Reset Medicare Advantage Benchmark Rates	-$135 billion	-$158 billion	-$175 billion
• Reduce Prescription Drug Prices	-$ 93 billion	-$110 billion	-$ 75 billion
• Limit Payment Updates in High-Cost Areas	-$100 billion	-$ 51 billion	---
• Manage Physician Imaging	-$ 23 billion	-$ 3 billion	---

Source: R. Nuzum et al., *Finding Resources for Health Reform and Bending the Health Care Cost Curve*, (New York: The Commonwealth Fund, June 2009).

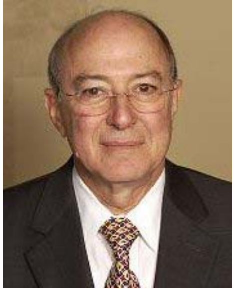
Health System Reform Proposals (effective 8-9-09)

	Path	Senate Finance Committee policy options	Senate HELP proposal 7/15/09	House of Representatives Tri-Committee 7/31/09
Payment reform				
Enhanced payment to primary care	Increase Medicare PCP payments 5%	✓		Increase Medicare and Medicaid PCP payments
Medical home / coordinated care	Payments to patient-centered practices; savings to patients with designated medical home	✓	Grants to support medical home model	Conduct pilot programs in Medicare, Medicaid; adopt if successful
Accountable care organizations	✓	Share cost-savings w/ physicians		Conduct pilot programs in Medicare, Medicaid; adopt if successful
Slowing rate of Medicare payments in high cost areas	✓	✓		✓
Bundled payments	✓	✓	✓	Conduct pilot programs in Medicare, Medicaid; adopt if successful
Productivity improvement	✓			✓
Rx and device savings	✓	✓		✓
Resetting Medicare Advantage rates	✓	✓		✓
[Independent MedPAC]	✓	✓		
Quality Measurement, Reporting, and Improvement	✓	✓	✓	
Comparative effectiveness	✓	✓	✓	✓
Health information technology	✓	✓	✓	
[Public Health and Prevention]	✓		✓	✓
Health goals and priorities for performance improvement	✓	?	✓	✓

Future Direction for Greater Care Coordination and Fundamental Payment Reform

- Center on Delivery and Payment System Innovation
- Rapid cycle multi-payment innovations in Medicare, Medicaid, other state payers, private payers (2010-2013)
- Harmonization of public and private payment in Medicare, public/co-op plan, private plans (2013 – on)
- Fundamental payment reform – accountable care organizations, medical homes, bundled hospital acute care, transitional care, and follow-on care
- Independent Payment Commission
- Establishment of Center on Medical Effectiveness and Health Care Decision-Making; link coverage and payment decisions to evidence-based findings
- Medicare budget savings targeted on high cost areas, high cost providers, waste, and unsafe or ineffective care:
  - Freeze on payment updates to hospitals and physicians in high-cost regions (possible exceptions for organized care system providers with median or below costs)
  - Incentives for reduced hospital readmissions
  - Pharmaceutical discounts for dual beneficiaries; global fees for sole source drugs

Thank You!



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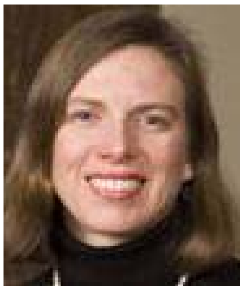

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