Physician Consortium for Performance Improvement

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American Academy of Family Physicians
I don't make jokes. I just watch the government and report the facts.

-- Will Rogers
We stand today at a crossroads. One path leads to despair and utter hopelessness. The other leads to total extinction. Let us hope we have the wisdom to make the right choice.

Woody Allen
HEALTH CARE SPENDING IN THE UNITED STATES
“It's like the more money we come across, the more problems we see.”
-Notorious B.I.G
US health spending is much greater for all categories of care, particularly for ambulatory care and administration cost.

2010 (or latest year available)

Current health spending per capita (USD PPP)

- United States: $7,910 (193%)
- Switzerland: $5,270
- Canada: $2,852 (236%)
- Germany: $4,205
- France: $4,187
- Japan (2009): $3,835

Note: Health spending excludes investments. The percentages in the US bar indicate how much more the US spends per category compared with the average of the five other OECD countries.

Source: OECD Health Data 2012.
Per Capita Total Current Health Care Expenditures, U.S. and Selected Countries, 2010

- Austria: $4,162
- Belgium: $3,969
- Canada: $4,205
- Denmark: $4,300
- Finland: $3,093
- France: $3,835
- Germany: $4,187
- Iceland: $3,309
- Ireland: $3,589
- Italy: $2,852
- Luxembourg: $4,786
- Netherlands: $4,727
- New Zealand: $3,022
- Norway: $5,188
- Spain: $2,979
- Sweden: $3,561
- Switzerland: $5,270
- United Kingdom: $5,270
- United States: $7,910
Concentration of Health Care Spending in the U.S. Population, 2009

Percent of Total Health Care Spending

<table>
<thead>
<tr>
<th>Percent of Population, Ranked by Health Care Spending</th>
<th>Percent of Total Health Care Spending</th>
</tr>
</thead>
<tbody>
<tr>
<td>Top 1% (≥$51,951)</td>
<td>21.8%</td>
</tr>
<tr>
<td>Top 5% (≥$17,402)</td>
<td>49.5%</td>
</tr>
<tr>
<td>Top 10% (≥$9,570)</td>
<td>65.2%</td>
</tr>
<tr>
<td>Top 15% (≥$6,343)</td>
<td>74.6%</td>
</tr>
<tr>
<td>Top 20% (≥$4,586)</td>
<td>81.2%</td>
</tr>
<tr>
<td>Top 50% (≥$851)</td>
<td>97.1%</td>
</tr>
<tr>
<td>Bottom 50% (&lt;$851)</td>
<td>2.9%</td>
</tr>
</tbody>
</table>
WHAT DOES A $2.6 TRILLION HEALTH CARE SYSTEM GET US?
Some Themes Have Emerged

• “We should pay for quality not quantity.”
• “We should promote value over volume.”
• “We should create a health care system, not a sick care system.”
How Do We Achieve Quality Care?
How Do We Improve Quality?

Process

\[
\text{Variability} \quad \equiv \quad \text{Quality}
\]
How Do We Promote Value?

\[
\frac{\text{Quality}}{\text{Cost}} = \text{Value}
\]
PLACING A PRIORITY ON PRIMARY CARE
“Robust evidence shows that patient care delivered with a primary care orientation is associated with more effective, equitable, and efficient health services. Countries more oriented to primary care have residents in better health at lower costs. Health is better in U.S. regions that have more primary care physicians, whereas several aspects of health are worse in areas with the greatest supply of specialists. People report better health when their regular source of care performs primary care functions well. In addition to features promoting effectiveness and efficiency, there are fewer disparities in health across population subgroups in primary care–oriented health systems.”

Barbara Starfield, M.D., M.P.H.
MEDICARE PHYSICIAN PAYMENT & THE SGR
History of Physician Payment

1966-1992
• Reasonable Charge Payments

1989
• Medicare Volume Performance Standard (MVPS) established by OBRA

1989
• Medicare Physician Fee Schedule established by Omnibus Budget Reconciliation Act (OBRA)
  • Effective in 1992

2006
• Physician Quality Reporting Initiative

2006
• Sustainable Growth Rate established by Balanced Budget Act

2012
• Electronic Prescribing

2015
• Electronic Health Records

2015
• Physician Value-Based Modifier
How Most Physicians Feel

“You get to drink from the firehose!”
## Problems With Current Payment Model

<table>
<thead>
<tr>
<th>Problem</th>
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<tbody>
<tr>
<td>Episode-Based – with limited variation in payments for outcomes or QI</td>
</tr>
<tr>
<td>Volatile and Unpredictable</td>
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<tr>
<td>No alignment of incentives for desired care versus actual care provided</td>
</tr>
<tr>
<td>Physicians are paid for seeing patients in person – 21st Century is not a F2F world</td>
</tr>
<tr>
<td>Payments vary by physician, site of service, geographic location</td>
</tr>
<tr>
<td>Every physician gets paid separately leading to duplication of services</td>
</tr>
<tr>
<td>Payments are frequently below the actual cost of care delivery</td>
</tr>
</tbody>
</table>
The Era of Pigs and Bacon
<table>
<thead>
<tr>
<th>YEAR</th>
<th>FORMULA UPDATE</th>
<th>ACTUAL UPDATE</th>
<th>LEGISLATION</th>
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</thead>
<tbody>
<tr>
<td>2002</td>
<td>-4.8%</td>
<td>-4.8%</td>
<td></td>
</tr>
<tr>
<td>2003</td>
<td>-4.4%</td>
<td>1.4%</td>
<td>Consolidated Appropriations Resolution</td>
</tr>
<tr>
<td>2004</td>
<td>-4.5%</td>
<td>1.5%</td>
<td>Medicare Modernization Act (P.L. 108-173)</td>
</tr>
<tr>
<td>2005</td>
<td>-3.3%</td>
<td>1.5%</td>
<td>Medicare Modernization Act (P.L. 108-173)</td>
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<tr>
<td>2006</td>
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<td>Deficit Reduction Act of 2005 (P.L. 109-171)</td>
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<tr>
<td>2007</td>
<td>-5%</td>
<td>0%</td>
<td>Tax Relief and Health Care Act of 2006 (P.L. 109-432)</td>
</tr>
<tr>
<td>2008</td>
<td>-10.1%</td>
<td>0.5%</td>
<td>Medicare, Medicaid, SCHIP Extension Act of 2007 (P.L. 110-173)</td>
</tr>
<tr>
<td>January to June</td>
<td>-10.6%</td>
<td>0%</td>
<td>Medicare Improvements for Patients and Providers Act of 2008 (110-275)</td>
</tr>
<tr>
<td>July to December</td>
<td>-21.3%</td>
<td>0%</td>
<td>Department of Defense Appropriations Act (P.L. 111-118)</td>
</tr>
<tr>
<td>2009</td>
<td>0%</td>
<td>1.1%</td>
<td>Medicare Improvements for Patients and Providers Act of 2008 (110-275)</td>
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<tr>
<td>2010</td>
<td>-21.3%</td>
<td>0%</td>
<td>Temporary Extensions Act (P.L. 111-144)</td>
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<tr>
<td>January to February</td>
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<td>0%</td>
<td>Continuing Extensions Act (P.L. 111-157)</td>
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<tr>
<td>March</td>
<td>-21.3%</td>
<td>0%</td>
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<tr>
<td>April to May</td>
<td>-21.3%</td>
<td>0%</td>
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<tr>
<td>2010</td>
<td>-21.3%</td>
<td>0%</td>
<td>Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act (P.L. 111-192)</td>
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<tr>
<td>June to November</td>
<td>-23.6%</td>
<td>2.2%</td>
<td>The Physician Payment and Therapy Relief Act of 2010 (P.L. 111-286)</td>
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<td>December</td>
<td>-23.6%</td>
<td>0%</td>
<td>Medicare and Medicaid Extenders Act of 2010 (P.L. 111-309)</td>
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<tr>
<td>2011</td>
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<td>0%</td>
<td>Temporary Payroll Tax Cut Continuation Act of 2011 (P.L. 112-78)</td>
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<tr>
<td>2012</td>
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<td>Middle Class Tax Relief and Job Creation Act of 2011 (P.L. 112-96)</td>
</tr>
<tr>
<td>January to February</td>
<td>-27.4%</td>
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<td></td>
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<tr>
<td>March to December</td>
<td>-27%</td>
<td>0% -2% sequester</td>
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<tr>
<td>2013</td>
<td>-27%</td>
<td>0%</td>
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<tr>
<td>2014</td>
<td>-24.4%</td>
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SEQUESTER!

Great for Scrabble, horrible for budgeting.
I Should Offer You a Drink After Showing The Last Slide
NEW PAYMENT MODELS
The Search Is On
Priorities on Physician Payment Reform

• Repeal SGR & Establish Period of Stability
• Identify & Implement New Delivery Models
• Create Payment Models That Support Delivery Models
• Create Quality & Efficiency Incentives
  – Don’t measure for the sake of measuring
  – Practice/specialty specific & risk adjusted
• Remove barriers between Medicare programs to allow for system-wide analysis and savings.
• Create on-ramps and off-ramps for solo, small, and rural practices
Not All Physician Are the Same – So Why Do We Treat Them the Same?
Two Driving Factors

Cost

Quality
Key Elements of a New Payment Model

- Promote quality
- Implement advanced clinical processes
- Enhance coordination of services
- Decrease duplication/remove fragmentation
- Lower cost
  - Episode of care
  - Overall
What Direction Should We Go?

• Identify & implement new delivery models
  – Improve process of care delivery
  – Coordinate care
  – Reduce duplication
  – Reduce variability in care

• Develop & implement payment models that support delivery models – not delivery models that fit within payment models

• Gradually move away from fee-for-service
We Have To Get From This…
….To This
Analysis

• We are exceptional at curing complex medical conditions and average at managing chronic health conditions.
• We have a flawed delivery system that promotes episodes of care, facilitates duplication of services, and fails to coordinate care across the health care spectrum.
• The flaws in our delivery system are compounded by the fee-for-service payment structure, but probably need the FFS system to assist in incubation period.
• Focus should shift from episodes of care to continuous, comprehensive, and coordinated care that decreases the frequency of costly late-stage interventions.
• Site of service payment differential should worry us all.
Closing Thought

• Physician payment and delivery system reform is too often portrayed as a skirmish between physicians – especially primary care versus other physician specialties.

• To truly understand what opportunities may lie ahead, we must first identify our greatest obstacle….
Because I Love That Dirty Water
Questions & Discussion