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Bring Medicare Into The Twenty-First Century

Posted By Alain Enthoven On August 16, 2012 @ 1:40 pm In All Categories,Competition,Consumers,Health Reform,Medicare,Payment,Policy,Quality,Spending | 3 Comments

Twentieth Century Medicare. Medicare, the federal medical and hospital insurance program for seniors and disabled, reflects the popular understanding of medical care 50 years ago: primarily treatment by doctors of acute episodes such as pneumonia. Medicare's design was based on the historical demands of the medical profession for "fee-for-service" (FFS) payment: "free choice of treatment" without accountability for quality and outcomes; Medicare to pay the doctor's "usual and customary" fees; solo practice and physician autonomy (without coordination or teamwork).

FFS means more money to the doctor for doing more and more costly services. The doctor who prevents the patient's costly medical problem or solves it quickly and inexpensively does not prosper in this model.

Primary care, the building block for most cost-effective systems, is also undervalued in comparison to procedures and specialist services, resulting in visits that are too short to meet the needs of patients with complex problems. "Continuous healing relationships," which include telephone and other contacts between visits, are not covered at all.

Additionally, Medicare is "open ended," which means no provider or patient feels any imperative to shepherd a limited resource wisely. Medicare spending is on track to double in the next 10 years. It is fiscally unsustainable. One way or another, it will be curtailed.

Medicare Is Out Of Date

Medicare's focus on acute episodes of care, which leads it to pay for doctor office visits rather than continuous healing relationships, is now out of date. Seniors' main medical problems now, from a cost and health point of view, are chronic conditions. In 2002, 93 percent of Medicare spending was associated with beneficiaries suffering from three or more chronic conditions, including, for example Diabetes (and its complications), Congestive Heart Failure (CHF), Coronary Artery Disease (CAD), and Asthma and Depression. These problems persist over years, and their acute exacerbations can lead to very costly acute episodes which largely could be prevented by proper team-based management.

The management of these conditions usually requires ongoing support, disease monitoring, adjustment of medications, and lifestyle modification, most of which can be done without a doctor office visit that can be billed to Medicare. For example, Diabetes management requires regular checking of blood sugar and medications; checking eyes, kidneys, and limbs for early signs of damage that can be arrested before disaster strikes; and advice on lifestyle modification and self-management to prevent costly complications. CHF requires regular monitoring of weight and adjustment of medications to prevent the gradual fluid buildup in the lungs that, over weeks, results in emergency hospitalization; such hospitalizations are very costly, and preventable if the patient is followed by a nurse who monitors daily weight.

Medicare does not pay for most of this (unless people pretend the doctor saw the patient.) Likewise, phone calls and emails, often preferable to frail seniors challenged by traveling to frequent doctor appointments, are not covered. As a result, patients often are told to schedule appointments just to get their lab results or have simple questions answered. FFS payment generates masses of paperwork in the form of Explanations of Benefits from Medicare intermediaries and supplemental insurance companies, unintelligible to seniors.

The Critical Role Of Integrated Delivery Systems

What these patients (and the taxpayers) need is mostly not office visits to solo doctors; it is care through physician-led teams that are organized to provide the necessary support to prevent acute exacerbations, supported by a periodic per capita payment that covers all necessary care regardless of who provides it. Such team care is primarily delivered through Integrated Delivery Systems (IDS) that organize and deliver continuous services to the chronically ill; IDS can coordinate care so that the several doctors and the other professionals patients see for their multiple conditions share complete patient information and can confer with each other about practice guidelines. Patients also need a primary care physician to oversee the whole process and be sure that important things do not fall between the cracks. *These IDS typically cost some 20 percent less (premium and out of pocket) than traditional FFS*.

The leading exemplar systems include Kaiser Permanente and the Group Health Cooperatives, Intermountain, Mayo, Marshfield, Dean and Geisinger Health Systems. There could be many more such systems, and these systems could cover many more people, if the insurance market were configured so they could market their superior performance and economy.

Why have these systems not become more widespread? Historically, the answer was that traditional medical societies opposed them fiercely with political action and economic boycotts. That was still happening in the years before Medicare was enacted in 1965. But the main problem today is that Medicare is mostly FFS. And most employers lock their employees into traditional FFS without a choice and without an opportunity to keep the savings if they choose a more economical system. Also, many employers find that IDS do not exist in their areas, or they prefer dealing with a simple uniform solution across the country, rather than dealing with many delivery systems. But many more IDS would be likely to form if there were a market for them in which consumers were offered responsible choices.

But some large employers (such as the Federal Government, some state governments and universities) do offer such a choice. And their experience shows that where such systems exist and are so offered, high percentages of employees choose them. For example, at the University of California, and for state employees in California and Wisconsin, the employer pays the cost of the low-priced plan (usually an IDS) and requires employees to pay the difference if they want more costly FFS. High percentages of employees choose the efficient models. Some people do not like the style of these systems or find their locations inconvenient, and of course they must be allowed to choose (and pay for) what they believe suits them best. Reform should come from the grass roots and not from the top down.

The implication for Medicare is that the government should sever its commitment to open-ended FFS and instead offer beneficiaries a fixed-dollar contribution adjusted for age, gender, diagnoses, and regional costs, and a menu of choices so that beneficiaries can choose among a number of competing, contracting health plans and integrated medical groups — *all of which would agree to accept all beneficiaries who choose them and provide all the care they need for a fixed periodic payment. Rural networks should be encouraged, perhaps with startup grants, to offer coverage in all areas where integrated delivery systems are not available*. Those that do an excellent job of preventing or managing costly chronic conditions would attract subscribers. Those that do not would have a powerful incentive to reorganize medical practice to keep from losing patients, strengthen their chronic disease management programs, and reward doctors for doing a good job with chronic disease patients.

Does The Affordable Care Act Move In The Right Direction?

The ACA is undoubtedly the boldest attempt to achieve full coverage for most Americans in a generation. However, the compromises required for passage resulted in a "work in progress" approach that at best is an opportunity to pilot different models for incentivizing value within Medicare, but also reveals a lack of clarity as to what is wrong and what can be done to transform Medicare into the program we need. Here are some of the main ideas in the ACA and their limitations.

The exchanges created under the ACA, so far not part of Medicare, could be very helpful in encouraging the spread of integrated delivery systems *if they included a much larger share of the covered population*. They are potentially an important step in the right direction. Unfortunately, the population covered through exchanges is far too limited, mainly to people without employer sponsors. Their market-opening power would be much greater if all employers up to size 100 or 200 employees or more were required to buy through exchanges as a condition for their employees to continue to receive the exclusion of employer contributions from their taxable incomes. (There needs to be powerful incentives for all in a large class of employers to join lest the exchanges suffer adverse selection.) This tax break must be limited to increase employees' incentives to seek value for money in choice of plan, as well as to save the federal budget hundreds of billions of dollars.

The excise tax on high cost insurance plans, "the Cadillac tax" coming into effect in 2018, will increase incentives to make economical choices. But it is defective in that it taxes excess premiums, and thus strongly biases choices in favor of high deductibles rather than the health plans offered by integrated delivery systems that are often mainly first dollar coverage. High deductibles are inappropriate for seniors with costly chronic conditions. They should be encouraged to seek first-dollar coverage for disease management services so that they will not postpone accessing these services until they have a serious acute exacerbation of their chronic condition.

A better tax would be a limit on tax-free employer contributions to employee health care set at the cost of an efficient plan.

The "Accountable Care Organizations" (ACOs) provided for in the ACA would appear to be steps toward the fundamental reform we seek. ACOs are groups or networks of providers that establish a mechanism for shared governance and become accountable for the costs and quality of care of Medicare FFS beneficiaries assigned to them. ACOs can be formed under the Medicare Shared Savings Program, which builds on the existing FFS payment structure, or under the Center for Medicare and Medicaid Innovation's "Pioneer ACO program, which allows groups to take on partial or full capitation.

ACOs, particularly Pioneer ACOs, move in the right direction. However, they seek to gain the benefits of the coordination and waste reduction characteristic of Integrated Delivery Systems without some important features of HMOs, such as patient commitment to a delivery system; patients are free to go to any Medicare provider without referral or authorization from the ACO.

Also, in the ACA model, the patients do not share in the savings which could be a powerful inducement for them to choose ACOs. Why shouldn't they? In the "managed competition premium support model" recommended by several bi-partisan sponsors and commissions, the patients who choose efficient systems would be able to keep all the savings associated with their choice. Experience shows that kind of shared savings is a powerful incentive for consumers to choose to commit to efficient integrated systems.

The prohibition on closed networks in the ACO program is based on a misreading of the managed care backlash experience in the 1990s. At least in California, the most satisfied insured patients were in Kaiser Permanente, with its comparatively narrow network. One reason for this is that they and their doctors were there by choice. On the other hand, the most dissatisfied patients were those whose HMO membership was forced upon them by their employers who dropped FFS and assigned their employees to an HMO where many did not have insured access to their favorite doctors. Naturally that made people angry. Similar research covering other states supported the same conclusion.

The ACA also provides for a national pilot program on **Bundled Episode Payments,** that is a single lump sum payment to all providers involved in an episode of treatment. There is less there than meets the eye in this superficially attractive idea. Despite years of trying, this idea has not caught on in the private sector. We have very limited experience with it, and practically nobody knows how to do this in a systematic way that can be replicated on a large scale. That's why the law proposes a pilot program. It will take years to develop, with an uncertain outcome. By contrast, we have experience over decades with millions of people under per capita prepayment.

Second, the bundled payments pilot focuses on episodes, while most of the cost and morbidity is associated with chronic conditions. Third, this method of payment fails to reward efforts at preventing episodes and the need for treatment. Fourth, it rewards inappropriate or unnecessary procedures; in fact, an unnecessary operation on a patient who is not very sick is the most profitable.

And fifth, this method is vulnerable to gaming: an "episode" begins at the earliest with expenditures 3 days before the hospital admission. The whole battery of costly diagnostic tests could be timed to end 4 or more days before admission and paid for outside the bundled payment.

By comparison, the boundaries in comprehensive per capita prepayment are much simpler and cleaner. To be sure, in the managed competition model, health plans may game the risk adjustment model, but this can be audited, measured, and adjusted for. CMS has been gaining experience with this in the Medicare Advantage program.

The ACA includes an **"Independent Payment Advisory Board" (IPAB)**, composed of 15 experts appointed by the President who serve full time on government pay with no outside financial connections or conflicts of interest. If Medicare spending growth exceeds the GDP + 1 percent target, the IPAB is charged to invent cost-cutting ideas, recommend them, and see them go into effect unless Congress substitutes equally effective measures or overrides them with a super-majority. The IPAB will work under tight constraints: for example, it cannot touch hospital payments until 2020 and cannot touch covered benefits.

These central planners are most unlikely to do as good a job as hundreds of doctors and managers in local delivery systems working under the strong incentives of competition and limited resources to improve value for money for their enrolled members. A report by the National Academy of Sciences estimates that 30 to 40 percent of health care spending is waste — that is, does not benefit patients. Most of this waste is local in nature, as are the potential cures through process redesign and improvement. But the IPAB is unlikely to focus effectively on local issues. The IPAB is now under heavy fire in the Congress by some Democrats as well as Republicans, and its survival is not assured.

But the fundamental problem of the IPAB approach is that it is focused on cost containment only and it does not alter the fact that Medicare FFS is 50 years out of date and needs to be replaced with a model oriented to the continuous management of costly chronic conditions. If it were empowered to eliminate FFS as a payment model without having to consult Congress, perhaps such a body could push through what is needed — elimination of the payment model that drives systematic mis- and over-treatment in Medicare. Sadly, the ACA limits on the IPAB make such a result impossible.
