



Can Medicare Accelerate Delivery System Reform? Options for Creating a Sustainable US Healthcare System

*November 24, 2008
Washington, D.C.*

Conference Report

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The Health Industry Forum is based at Brandeis University and chaired by Professor Stuart Altman. The Forum brings together public policy experts and senior executives from leading healthcare organizations to address challenging health policy issues. The Forum conducts independent, objective policy analysis and provides neutral venues where stakeholders work together to develop practical, actionable strategies to improve the quality and value of the US healthcare system.

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Key Themes

Overview

Improving the quality and value of the US healthcare system requires moving the current delivery system towards a more coordinated, integrated model. This will not happen without payment reforms that shift the prevailing financial incentives from volume to value. As the nation's largest payer, Medicare must play a major role in driving payment reforms. New payment models must reward quality, efficiency, and coordinated care, as well as facilitate development of healthcare systems that are accountable for maintaining quality and managing expenditures. The Centers for Medicare and Medicaid Services should receive sufficient new administrative resources to support these reforms. Congress should also consider modifying Medicare's governance structure to give CMS' managers more flexibility to adopt innovative purchasing models.

Context

On November 24, 2008, The Health Industry Forum brought payers, providers, government, and manufacturers together to discuss how Medicare policy could help drive fundamental changes in the healthcare delivery system that would lead to more efficient, effective healthcare for all Americans.

Presenters and respondents discussed why Medicare must lead in making payment system reforms, what new payment models might look like, whether incremental or "disruptive" changes are necessary, and adjustments in the Medicare's structure and governance that would improve its ability to catalyze delivery system change.

Key Themes

- **The problems plaguing US healthcare are largely due to a fragmented delivery system and a payment system that rewards utilization without regard to value.**

The healthcare system's quality and cost problems are well documented. The root causes of these problems stem from a fragmented delivery system where care is delivered in silos by individual providers, and reimbursed on a fee-for-service basis. Currently, providers generate revenue through volume rather than through quality, efficiency, or value.

- **As country's dominant payer, Medicare must drive payment system reform.**

Today the federal government, mainly through Medicare, is the country's dominant payer. Government payments now represent 55% of hospital revenue. As the population ages, Medicare's share of national health spending will increase. Federal reforms to cover the uninsured could significantly increase the pool of government-sponsored beneficiaries. But, Medicare's dominant

market share provides an opportunity for it to lead significant payment reform as it did in the 1980s with DRGs. Charlie Baker, CEO of Harvard Pilgrim, remarked that Medicare plays the tune to which private payers dance. If Medicare doesn't drive systemic payment reforms, it will be very difficult for private payers to do so.

- **Payment reform should be combined with "enabling tools" that support high quality care and expanded Medicare purchasing authority.**

There are many payment reform options that could support more integrated and coordinated healthcare delivery. These include expansion of pay-for-performance, new payments for care coordination, episode payments, and global payments for covered enrollees. One option that builds on Medicare's current structure is the shared savings program that Medicare uses in its physician group practice demonstration. Dr. Casalino also proposed a model where Medicare's annual payment updates would increase as providers move from "status quo" delivery to certified medical homes, to accountable care organization that would be responsible for both cost and quality.

Payment reforms will be more effective if combined with enabling tools like support for information technology and comparative effectiveness research. Medicare could also drive change more effectively with broader purchasing authority that allows it to expand competitive bidding, and develop new mechanisms to steer beneficiaries to high quality efficient providers. Medicare is experimenting with this approach with reduced Part B premiums for members that choose selected hospitals in Medicare's acute care episode demonstration.

- **CMS needs expanded resources and increased management flexibility to become an effective catalyst for delivery system reform.**

The size, scope, and complexity of the Medicare program make it nearly impossible to manage. Despite a huge program budget, Medicare has relatively limited administrative resources, making it difficult for the agency to focus on more than one or two major initiatives at a time. Furthermore, Congress remains closely involved with Medicare management, limiting CMS' ability to make politically difficult choices. Previous studies have offered options for changing Medicare's governance structure, including creating an independent Medicare agency or establishing an independent Medicare governing board that would oversee the program based on broad Congressional guidelines. However, giving up its current level of control will be challenging for the Congress. In the meantime, expanding Medicare's administrative resources, and providing mechanisms to promote longer tenure for CMS administrators and senior managers would be one place to start.

A Call to Action: The Urgent Need for Federal Policies to Accelerate Delivery System Reform

Presenter: **Stuart Altman, PhD**, Professor, Brandeis University

Overview

The demographic and policy changes projected over the coming years will result in Medicare becoming responsible for a substantially larger share of US healthcare spending. As the healthcare system's dominant payer, sustainable healthcare reform requires changing Medicare. Simply lowering provider payment rates will not solve the country's healthcare cost problems. Medicare will need to use its market power to begin changing payment system incentives to reward quality, value, and care coordination.

Context

To set the stage for the conference, Professor Altman described why Medicare policy must drive reform of the country's healthcare delivery system.

Key Takeaways

- **Increases in the number of Medicare beneficiaries will have significant implications for the overall healthcare system.**

Medicare is the largest payer in the US healthcare system. Today, government programs (predominantly Medicare and Medicaid) account for 54% of all hospital revenues. By 2025, as the baby boom generation ages into Medicare, government's share of total hospital revenue is projected to rise to 66%, while the proportion of privately insured patients will decline.

This is problematic because Medicare payments have historically been below hospitals' average costs. Thus, hospitals must make up revenue shortfalls by increasing rates for privately insured patients. As the percentage of Medicare and Medicaid patients increases, private payers will be pressured to pay higher and higher prices in order to keep hospitals financially viable.

This situation could be exacerbated if the number of publicly-sponsored beneficiaries increases under federal healthcare reform. The Obama reform proposal includes a government-run program that would compete with private insurance. The Lewin Group estimates that a public program which "looks like Medicare" and adopts Medicare's payment policies would add 48 million people to the rolls of government insurance. Other ideas such as lowering Medicare eligibility to 55 would further increase the number of beneficiaries.

This combination of demographic and policy changes could result in government becoming the sponsor for the vast majority of covered Americans. As such, the argument that "Medicare is only responsible for Medicare beneficiaries" is no longer acceptable. Policymakers must recognize that Medicare policy is inexorably linked to broader healthcare policy.

"The federal government can no longer just think about the impact of legislation on Medicare beneficiaries, because Medicare will dominate healthcare."

— Stuart Altman

The extreme pressure to lower costs will tempt government to cut provider payments further, creating more pressure for cost shifting. If Medicare payments were reduced to the same payment-to-cost ratio that existed in the early 1990s, private payers would have to pay 60% above costs to compensate for government shortfalls. If private rates did not increase to accommodate cuts, substantial reductions in quality and access are likely. This is neither sustainable nor desirable.

- **Changes in the payment model—not just the rates—are needed to encourage delivery system change.**

Systemic delivery system changes that create greater value are urgently needed. The best way to bring about change is by using Medicare as a lever to change the payment system, which in turn will drive delivery system reform.

"If we don't change the payment system, we will never change the delivery system—it is just not possible. We have to move beyond fee-for-service."

— Stuart Altman

The current fee-for-service payment system simply must be replaced. It under-pays for primary care, encourages excessive specialty care, and provides no incentives for care coordination, which is urgently needed.

Participant Discussion

- **Inside the payment-to-cost ratio.** Stuart Guterman remarked that when looking at the payment-to-cost ratio it is important to consider the cost side of the equation. In the early 1980s and mid-1990s, the Medicare payment-to-cost ratio rose sharply. This was not because Medicare rates grew faster, but rather because providers sharply reduced cost growth. Achieving a sustainable health system will require significant progress on the cost side of the equation.
- **Does quality save money?** Bruce Vladeck pointed out the inconsistency in participants' comments regarding quality. On the one hand, people are emphatic that better quality will cost less. Yet, on the other hand, others argue that lower reimbursement will result in lower quality. It seems that people always claim that quality is affected, either positively or negatively, to support their arguments for policy change.
- **Demonstration projects.** While demonstration projects are a common pathway for testing new ideas for Medicare, the

group expressed skepticism that they will be a vehicle for sustainable policy change. One participant noted that there are plenty of new demonstration projects in the works, but despite the need to improve provider integration, most of the demonstration projects are still focused on silos of care.

Demonstration projects have limits and are often ineffective. Tests occur; they may or may not work; and then CMS pulls the plug. Policymakers can't rely on demonstration projects to create the systemic change. Dr. Casalino argued that major change takes time. Demonstrations are temporary, and enroll

only a small portion of any provider's patients, making them reluctant to make significant investment in process change.

- **Concierge medicine.** The current payment system results in an increasingly tiered delivery system. As physician fees decline, more physicians are opting to provide concierge services, and more individuals are opting to pay for these services. Further payment reductions will exacerbate this trend.

Building Model Delivery Systems for the 21st Century

Presenter: **Lawrence Casalino, MD, PhD**, Chief, Division of Outcomes & Effectiveness Research,
Department of Public Health, Weill Cornell Medical College

Respondent: **Nicholas Wolter, MD**, CEO, Billings Clinic; former MedPAC Commissioner

Overview

Changing the delivery system to provide more integrated, higher-quality, lower-cost healthcare will be extremely difficult. Because the delivery system is so fragmented currently, it is not feasible to move as fast as many would like away from Medicare fee-for-service and toward capitated or bundled payments. One option for Medicare is to begin reimbursing providers differentially based on their level of integration, ability to coordinate services across the full continuum of care, share risk, and meet quality targets. Small practices could continue to be paid fee-for-service and those able to meet the criteria for medical homes would receive higher payments. Accountable Care Systems (ACSS) that could manage the medical and financial responsibility for larger populations would receive additional rewards for performance. This mixed-model approach takes into account where the delivery system is today and the necessity to use financial rewards to create incentives for integration and value.

Context

Dr. Casalino discussed how Medicare might catalyze the development of more effective delivery systems. Dr. Wolter responded to Dr. Casalino's remarks and shared his thoughts on Medicare reform. Participants then shared their perspectives.

Key Takeaways (Casalino)

The premise of Dr. Casalino's presentation was that there is little to forestall decline in the US healthcare system if the delivery system doesn't change radically, and this will not happen unless Medicare makes it happen.

- **Fragmentation of the current healthcare system poses a major obstacle to improving the quality and efficiency of care.**

Dr. Casalino described the context of the current healthcare delivery system, emphasizing the fragmentation of physician practices.

— *There are no easy fixes.* Entrenched interests and organizational inertia will make change difficult. Physicians and hospitals must work together to develop coordinated care that improves quality and controls cost. This will require investments of time and money, which physicians are often reluctant to make.

— *Pushing individual physicians to try harder won't work.* Current efforts based on standardized quality measurements and pay-for-performance contracts at the individual physician level are based on the premise that they will cause physicians to work harder. This won't work.

— *Most small physician practices can't coordinate care.* The fragmented delivery system presents major challenges. Today, 43% of physicians work in practices of five or fewer physicians. Small practices lack the time, skills, infrastructure, and economies of scale to deliver a broad range of services, such as nurse care managers, disease management, and electronic medical records. There has been very little growth in multi-specialty group practices. Although there has been a slight increase in medium-sized practices, these have tended to be driven by single-specialty consolidation.

— *It will be hard to create payment methods that change the behavior of small practices.* Not only does the small number of patients per physician raises problems in risk adjustment and statistical reliability, but it simply isn't appropriate to put individual physicians at high financial risk especially when they have control over only a portion of the patient's care.

These issues present several problems: it is difficult for payment reform to improve quality and lower costs in a highly fragmented delivery system, yet the system will remain fragmented without strong incentives that encourage physicians to move into larger groups. Even then, many physicians will prefer small practices because they provide more intimate human interaction.

"Because the delivery system for physicians is so fragmented, it is hard to devise a rational payment system to get where we must go."

— Lawrence Casalino

- **Medicare and other payers should explore a new system that varies payment to providers based on their level of delivery system integration.**

Dr. Casalino argued that delivery system reform must allow beneficiaries to choose their own providers and for providers to choose their practice setting. It should encourage organizational innovation, specifically use of organized care coordination processes by providers.

Dr. Casalino discussed three types of organizations and proposed that Medicare pay each differently. The payment level and potential rewards would vary based on an organization's level of integration, ability to measure performance, and the amount of financial risk the organization takes.

— *Status quo organizations.* These are the organizations that exist today. Their payment/reward would take into account their limited ability to measure performance or take financial risk.

— *Medical homes.* These would be practices that take on responsibility for managing a patient's care. (In later discussion, participants wanted more specificity around the services delivered by medical homes.)

—*Accountable Care Systems (ACSs)*. An ACS must be accredited as a medical home, must be willing to take responsibility for the overall costs and quality of care for a population of patients, and must have the size and scope to do so effectively. ACS's could include integrated systems, large medical groups, large hospital systems with employed physicians, and possibly virtual organizations.

For hospitals, the components of payment could include: DRG-based payments, quality bonuses, a patient experience bonus, payments for avoidable complications, and payments for reporting. The components and amount of the payment would depend on whether the hospital was part of an ACS.

Payment for physicians could be based on whether a practice was part of an ACS, was a medical home, or was neither. The elements of payment would vary based on the services provided.

While this proposal continues using fee-for-service for small physician practices, it would pay an additional amount for medical homes. The annual update for ACSs would be pegged to their performance.

Moving to this type of payment system is feasible. Some legal changes would be necessary and the political challenges would be large. Many aspects of this model are desirable. Patients and providers retain choice. Innovation and quality are rewarded. It balances quality and cost incentives. Costs would be controlled, and quality would likely improve.

Key Takeaways (Wolter)

Dr. Wolter agreed with Dr. Casalino's framework and offered comments on other aspects of delivery system reform.

—*Episode-based payment*. More integrated care will be driven by paying for episodes of care. This type of payment will force the delivery system to move from silos to integration.

—*High-volume/high-cost areas*. Medicare should focus on high-volume/high-cost areas, particularly those with high variability and availability of evidence-based guidelines.

—*Not budget neutral*. Requiring that changes to Medicare be budget neutral isn't always the right policy. It may be necessary to increase payments to primary care physicians for provision of medical home services.

—*Sense of urgency*. While Dr. Wolter personally feels a sense of urgency to bring about delivery system change, he questioned whether other key players are committed to significant reforms. Reforming the delivery system will take strong leadership and require massive cultural changes.

Participant Discussion

- **Transforming under fee-for-service.** Some questioned whether it will ever be possible to reform the delivery system while fee-for-service remains a significant part of the payment system. Dr. Casalino reiterated his belief that a system that incrementally rewards integration could work and would give providers time and an incentive to change.
- **Services provided by plans versus providers.** One participant asked how insurers would react to ACS's if they provide services that have traditionally been under the domain of health plans, such as disease management. Several participants, including health plan representatives, responded that these services are best delivered by providers. But to date providers have lacked the resources or interest to deliver these services. In the absence of provider programs, plans stepped in to fill the void. One payer commented that "whatever Medicare does the health plans will follow."
- **Culture issues and leadership.** Participants agreed with Dr. Wolter's comments about the importance of leadership to change the culture in healthcare delivery systems. Changing from a culture of silos to one of coordination is seen as a massive undertaking. There was some skepticism whether current hospital CEOs have the managerial skills to pull this off.
- **IT/data systems.** For a provider to be successful as an integrated delivery system it is essential to have data systems that allow them to track performance in real time. To date, health plans have invested in such data systems but providers have not.
- **Funding delivery reform.** Stuart Altman raised the three paths for delivery reform: 1) budget neutrality; 2) spending more; and 3) spending less. While Dr. Wolter suggested that spending more may be required to transform the delivery system, Professor Altman is concerned that politicians may try to push through reform with less spending.
- **Budget neutrality.** Stuart Guterman noted that it is important to define "budget neutrality." Are we talking about current spending, or budget neutrality compared to projections, which show healthcare spending doubling in the next ten years?
- **Lack of urgency.** Kevin Schulman commented that the financial crisis provides an example of catastrophes that can occur that elicit urgent responses. For all of the talk about healthcare, there still doesn't seem that there is much urgency around significant change.

Moving from Here to There: How can Medicare Drive Delivery System Reform?

Presenters: **Francis J. Crosson, MD**, Senior Medical Director, Senior Fellow, the Permanente Federation and Kaiser Permanente Institute for Health Policy
Charles Baker, President and CEO, Harvard Pilgrim Healthcare

Overview

Participants generally agreed with the goal of reform: moving from today's fragmented delivery system with fee-for-service payment to an integrated system with bundled payment. There was also consensus that the process should start with payment reform. Participants disagreed, however, about the extent to which changes should be incremental versus a "big bang" approach.

Legislation is needed for significant changes to Medicare payment policy. This will call for significant political will. Some participants also support giving Medicare expanded purchasing authority so that it could create tiered networks and implement benefit designs that give enrollees financial incentives to select efficient, high quality providers. Such changes will face serious political opposition. Ultimately, these ideas and others—like comparative effectiveness research—will test how serious the country is about payment and delivery system reform.

Context

Dr. Crosson described how the payment and delivery systems are linked and offered suggestions for changing both. Mr. Baker shared his views on how to bring about changes to the delivery system, calling for bold, radical changes versus an incremental approach. Participants then shared their perspectives on how to bring about effective change.

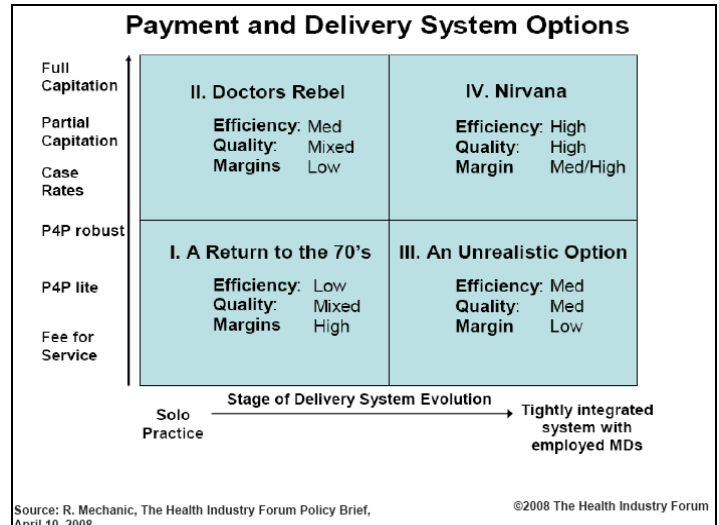
Key Takeaways (Crosson)

Dr. Crosson shared his thoughts on how to alter the status quo to a new system where Medicare is leading healthcare delivery reform. He described the key elements required for change and offered some "controversial" reform proposals.

- **True delivery system reform requires payment changes, structural transformation, and enabling tools.**

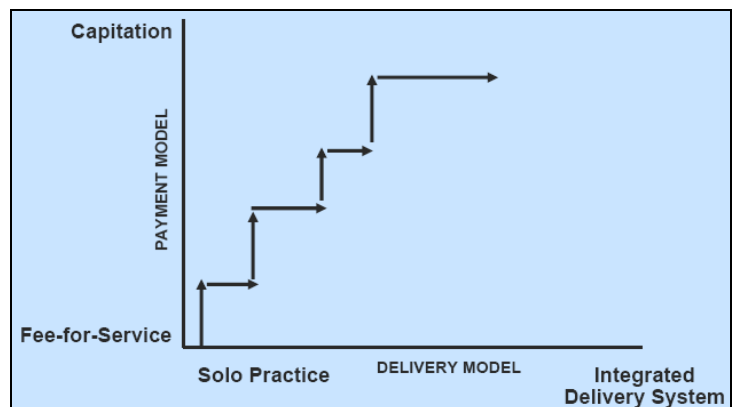
The elements of payment and delivery system structure are linked in a chicken-and-egg problem. It is impossible to change delivery system structure without first changing the payment system. But the payment system can't change radically if the delivery system is unable to adapt to new financial incentives.

In recent months, analysts have shared models similar to those pictured here. These models show the payment system as a continuum (ranging from fee-for-service to full capitation) and the delivery system as a continuum (ranging from



solo practice to tight integration). The current system is in the bottom left-hand corner; the desired state is top right.

It is not possible to move overnight from today's fragmented delivery system with fee-for-service payment to a tightly integrated delivery system with full capitation. This is a process that will take time and a series of steps. Importantly, the first move must be a change in the payment system that will drive a corresponding change in the delivery system, as shown below.



"Payment reform has to be the first move. We have to change payment to drive change in delivery."

— Francis J. Crosson

Among the ideas for payment/incentive changes are:

- Pay-For-Performance (P4P)*. By meeting quality targets, providers can earn additional revenue. But gathering data and improving performance to earn P4P bonuses will be hard for a disaggregated delivery system. It is possible that P4P could play a role in driving consolidation.
- Care coordination payments*. This may require paying providers for managing some aspect of care; however it is difficult for a primary care provider to coordinate the services of specialists and care coordination would be more successful in an integrated delivery system.
- Bundled payments*. If Medicare and other insurers paid one amount for a unit of care (say, for the care of the entire workup, surgery, and rehabilitation of a knee replacement), then hospitals and doctors would have to work together to figure out how best to dictate care and divide up the payment. Such payments are likely to change the structure of delivery.
- Gain sharing*. Rather than getting paid for more activities and hospitalizations under FFS, gain sharing would allow providers to split the savings for preventative care with insurers. Hospitals and physicians would then have an incentive to reduce admissions by working together. (This would require legal changes.)
- Group practice demo*. In trying to determine if Medicare should support payment reform that leads to delivery reform, Medicare has implemented a group practice demonstration project where care is coordinated and monitored for quality. This project is showing good results.

Ideas for structural changes are:

- Medical home*. While this term is now used widely to mean many different things, the idea of having a central physician or organization that can coordinate all of a patient's care coordinator is a good one.
- Physician-hospital integration*. Tighter integration that can be achieved by merging physician groups and hospitals into one entity, whether this is accomplished contractually or through physicians becoming employed by hospitals.
- Accountable Care Organizations*. As described by Dr. Casalino, ACO can be virtual organizations, comprised of local hospitals, physicians, and supporting health care delivery systems. These groups are better able to seamlessly manage patient care by aggregating all the settings and units of healthcare into one network.

Payment and structural changes can be aided through enabling tools. The most important tools are clinical information technology, clinical effectiveness research, and primary care manpower. It is important to keep in mind that these tools are not the changes that are needed; they are the means to the ends.

- **There are several proposals for reforming Medicare that may be viewed by some as controversial, but have merit.**
These reform proposals include:

- Enhance Medicare's purchasing authority*. Allowing Medicare to contract and purchase in a similar fashion as private health plans could increase the value of services purchased. Medicare could choose to purchase only from selected providers as opposed to all providers—a technique used by private payers that has been an effective cost-management technique. Greater purchasing authority could also allow Medicare to engage in competitive bidding.
- Enhance Medicare's benefit design authority*. Flexibility to offer new benefit designs would help Medicare steer patients toward more cost-effective choices. For example, Medicare might create a tiered copay structure where the amount of the copay is based on the provider used.
- Provide targeted updates*. Currently all providers of the same type get the same update. But it may be possible to provide different update amounts to practices that manage care and costs more effectively.

Key Takeaways (Baker)

Mr. Baker shared his thoughts on delivery system reform, arguing that incrementalism is unlikely to work.

- **While Medicare reform has been a constant topic of debate, the situation has worsened over the past decade.**

Going back to 1998 and imagining what would occur by 2008, the actual changes would have seemed unthinkable. In the past ten years: the uninsured population has doubled; healthcare premiums and costs have gone up more than 10% per year; the primary care physician has become a dying breed; capitation is gone and most services are paid under fee-for-service; and employees on average pay 25% of their premium along with a deductible and copays.

Clearly, the system is broken. There are negative incentives throughout it, reform is desperately needed, and the situation appears unsustainable—yet, very little seems to change. If anything, the situation seems to get worse. If people are really serious about changing healthcare, then at least one if not all of Dr. Crosson's proposals should be pursued.

- **Changing the delivery system faces some key barriers.**

Among the big barriers:

- Employers don't speak with one voice*. Employers say they want cost containment but their views on how to get there vary – a lot. Many seem to be unwilling to take even relatively small steps to decrease costs—like support for the concept of selective networks or fixed contribution policies.
- Economizers have to benefit from the economizing*. The case is fairly clear for how employers and the government would benefit from cost control, but it is not so clear for patients and providers.
- Culture crushes strategy*. Most physicians see themselves as autonomous operators. They see medicine as an individual sport; not a team sport. It is who they are – and for the most part how they were trained. Changing this mindset, getting people who are

fundamentally individual contributors, to behave as members of a team will be very difficult.

—*Providers struggle to imagine a different paradigm for healthcare delivery.* As part of a panel at a recent conference, Mr. Baker was asked to imagine a different world for health plans in ten years, which he did; a long-term care executive was asked to do the same, which he did; but an acute care executive was unable to imagine any type of delivery model other than one with a hospital at the center. Over time, treatment options and technologies change. Somehow, healthcare leaders need to be able to consider operating models that are different than the ones that dominate today's landscape.

- **We need a “big bang” to drive change.**

Since the failure of the Clinton plan in the 1990s, the only thinking in healthcare policy has been incremental. Based on the past ten years, incremental thinking isn't producing results. We may need a bigger bang in policy and approach to secure the kind of change that's required to disrupt the status quo.

formularies. Medicare should leverage this familiarity to incorporate such features as part of Medicare.

- **Medical home/PCP model.** Some participants expressed support for models where PCPs coordinate care. However others argued that while PCPs can provide preventive services and make sure that patients receive certain types of care, it is unrealistic to believe that a medical home model will lessen the amount of specialist care or decrease costs.
- **Don't abandon incrementalism.** While a big bang to disrupt the system could be beneficial, it was seen by many as unlikely. Therefore, in the absence of a big bang, incrementalism must continue to drive change.
- **Comparative effectiveness research.** Among all of the ideas to improve Medicare, the most obvious seems to be having some form of comparative effectiveness research. A mechanism is required to ensure that services provided have value.

Participant Discussion

- **Medicare's charter.** Medicare is criticized for not taking various actions. However, by law, Medicare's authority is limited. Essentially all that Medicare can do to lower costs is to cut rates. It is necessary to give Medicare greater authority and trust in areas of purchasing and benefit design. In addition, Medicare needs greater flexibility to work on programs with private payers on a local/regional basis.
- **Medicare's organizational structure.** Within Medicare there aren't clear goals or definitions of success. Medicare's leaders need to define “success” more clearly.
- **Risk-sharing models.** Historically, people in healthcare have behaved as if the only models are fee-for-service or full capitation. However, there are many models in between, including various forms of risk-sharing.

A barrier for hospitals-physician risk sharing is that these groups have limited experience working together to figure out such arrangements—and lack both tools and trust.

Selective networks. Since Medicare is such a significant portion of the market, creating a selective network is difficult. But even if the network included nine out of ten hospitals in a market, excluding even one would send a strong signal.

- **Voice of the beneficiary.** Absent from this conversation has been the voice of the beneficiary. Whatever changes are made must be made with the beneficiary in mind and must be effectively communicated to explain why these changes create a better healthcare system. Beneficiaries need to be more fully engaged in their care and be given greater power. As an example, this process could be used to create living wills and power of attorney to help address costs at the end of life.
- **New beneficiaries.** As the baby boomers become beneficiaries, they are familiar with tiered networks and

Making Medicare an Effective Agent for Delivery System Change: Potential Changes in Governance, Capacity, and Culture

Presenter: **Thomas Ault**, Principal, Health Policy Alternatives, Inc.

Respondents: **Bruce Vladeck, PhD**, Executive Director and Senior Health Policy Advisor, Ernst & Young, LLP

Thomas B. Valuck, MD, MHSA, JD, Medical Officer and Senior Advisor, Center for Medicare Management at the Centers for Medicare & Medicaid Services

Overview

Many analysts look to Medicare to play a lead role in changing the US healthcare payment system. But Medicare faces many challenges. It is a large complex program with a wide array of constituents, competing priorities, limited administrative resources, and subject to substantial Congressional involvement.

Moving forward with Medicare payment reform will require legislation and changes in governance that give Medicare greater authority and flexibility. Possible governance models discussed include establishing Medicare as an independent agency (like the Social Security Administration) or creating an independent governing board (like the Federal Reserve) to insulate policy decisions from politics.

The goals of any governance scenarios must include accountability and transparency. If Medicare is to effectively implement reforms, policymakers must resolve the extent of congressional micromanagement and legislative specificity, the degree of flexibility afforded Medicare, and the availability of administrative resources, which today are sorely lacking.

Context

Mr. Ault described Medicare's history, structure, and governance and summarized alternative governance models. Drs. Vladeck and Valuck shared their thoughts on Medicare's governance and participants offered their perspectives.

Key Takeaways (Ault)

- **Medicare governance is complex, partly because there are many "cooks in the kitchen."**

Among the key actors involved in Medicare governance are:

- *Career staff.* Medicare's career staff are generally very competent, but, they are over-worked, pulled in many directions, and paid less than they would earn outside government; CMS has little flexibility on hiring, salaries, or bonuses. Career staff typically try to establish and maintain principles, which are generally good but can limit creativity to deal with special situations. They are sometimes insular and can be out of touch with the real world, usually as a result of limited resources. A high percent of career staff are eligible to retire in the near future.
- *Political leadership.* The political leadership defines Medicare's focus and influences program direction. New political leadership provides an opportunity for fresh evaluation and

new ideas. But new leaders often have a steep learning curve and the political agendas that accompany new leadership can shift focus away from on previous initiatives before results are achieved. With the exception of the late 1980s, controlling cost has not been a priority of political leadership.

- *Congress.* Congress is deeply involved in Medicare, typically creating very specific and detailed legislation. Congress is also involved through authorizing and appropriation committees along with demonstration projects.
- *Contractors.* Contractors that actually administer Medicare including MACs, DMACs, RACs, QIOs, and more which oversee large portions of Medicare operations.
- *Stakeholders.* These include beneficiaries; providers, practitioners, and suppliers; manufacturers; and plans.

Also affecting Medicare are recommendations from MedPAC, the GAO, and OIG, as well as the media.

A typical scenario that shows the involvement of multiple factors goes as follows: a Medicare stakeholder has a concern. This concern leads to a press story, which is followed by a congressional and/or White House reaction. This leads to legislation and/or a change in CMS policy, which must then be implemented by CMS staff.

- **Future CMS reform efforts must consider opportunities and administrative successes.**

In his presentation, Mr. Ault shared a list of 17 missed opportunities for cost containment or quality improvement over the past 20 years. Among them were multiple instances of overpriced services being identified but not changed.

At the same time, there have been several occasions when bold Medicare administrative actions have succeeded. These include a moratorium on certifying new home health agencies in 1998 and DRG refinement in 2006-2008. Medicare has succeeded when its proposed policies have been technically sound, based on a recognized need, supported by a strong rationale, and with champions outside of CMS. Success has been more likely when CMS developed a coordinated strategy to overcome opposition – however, this has not always been possible as it is extremely resource intensive.

- **Medicare governance needs attention. There are several options for possible governance changes.**

Medicare's size, scope, and complexity make it nearly unmanageable, especially when combined with lack of resources and congressional micro-management. Even when it

has been successful with initiatives like hospital DRGs or physician payment reform, the agency was unable to achieve the full potential of the proposed initiatives or success diminished over time.

Several good studies have looked at Medicare governance. One is the 2000 National Association of Social Insurance (NASI) Study. Since the study's publication in 2000, some important elements have changed. For example, in 2000, CMS was under siege and the report called for "a greater sense of trust and comity," which has been achieved. Also, at the time CMS was viewed as struggling to implement new laws. Today that is not seen as a problem.

However, the NASI Study also noted that CMS faces "a pervasive and persistent shortage of resources" and that congressional involvement in the management of Medicare remains large, both of which hold true today.

The NASI Study identified four possible governance models for Medicare: 1) an independent agency, like the Social Security Administration; 2) an independent board, like the Federal Reserve Board; 3) a performance-based organization; and 4) a government corporation. Of these, the first two options are getting the most serious consideration.

- *Independent agency.* If structured like the Social Security Administration, an independent agency would have a commissioner appointed for a six-year term. The agency's budget request would be submitted directly to Congress, along with the President's budget. This structure would promote a degree of autonomy and reduce bureaucratic layers. Concerns about this model include a potential loss of advocacy and some degree of protection by the Secretary. Some believe that an independent agency would be more at the mercy of special interests. This model could also be challenging because Medicare is more complex than Social Security.
- *Independent board.* A board would provide oversight, set standards and coverage requirements, and could establish major programs, like value-based purchasing. This vision for a board is solely as a standard-setting entity; not as an executing entity. Among the questions to be resolved include whether there should be a separate health board just for Medicare and what is the link between the board and the administrative bureaucracy.

In any governance structure, Medicare must address a number of key questions: how to create regional and local flexibility within the structure of a national program; how to provide sufficient administrative resources (one idea is that resources should be a percentage of benefit payments); how to achieve political insulation while maintaining openness, transparency, and accountability; and what is the proper degree of statutory specificity?

Key Takeaways (Vladeck)

Dr. Vladeck agreed with Mr. Ault's comments and raised a few additional points regarding Medicare governance.

- **There are many ideas to improve Medicare, but the agency's ability to implement them is limited.**
In each and every one his 1,571 days as Administrator of the Health Care Financing Administration (now CMS), Dr. Vladeck received at least one idea from someone on how Medicare could save money. Of these ideas, HCFA had already thought of about 95% of them. Half were bad ideas and the other half were good ideas that couldn't be implemented due to some systemic barrier.
- **In many ways, Medicare is in a "can't-win" situation.**
While a national program, Medicare is administered regionally. For various reasons, spending varies significantly by geography. While reducing spending in high-cost regions is an attractive policy proposition, it generates highly charged political opposition. In contrast, across the board spending cuts cause lower-spending areas to complain that "Medicare spends less here already." Similarly, while reducing payments for specialty providers and increasing primary care funding has a compelling policy rationale; the politics of such a reallocation is exceedingly difficult.
- **The underlying problem with Medicare governance is the problem with the governance of the nation.**
The challenge of reforming Medicare and governing it in a thoughtful, transparent way is emblematic of the broader problem of governing the country. While there is much rhetoric for change in the political system, the political machinery seems incapable of producing significant change. Can our political system facilitate meaningful healthcare reform? The answer is far from clear.

Key Takeaways (Valuck)

Dr. Valuck, who spoke as a representative of CMS, shared his thoughts on value-based purchasing in CMS.

- **There is consensus that CMS should move toward a value-based purchasing approach.**
The CMS leadership agrees with both the concept of value-based purchasing and the notion that CMS is in a unique position to lead change in the overall healthcare system.

Concepts such as pay-for-performance, gain sharing, medical home, and Accountable Care Systems—which tie financial incentives to performance—all relate to value-based purchasing. Medicare is making some progress in putting building blocks in place that will enable an evolution to value-based purchasing. This includes creating a data infrastructure related to "pay-for-reporting."
- **CMS needs help to accelerate the movement towards value-based purchasing.**
— *Visionary, savvy leadership.* CMS wears a big hat and needs a big bat. Essentially, CMS is an organization with "535 board

members." Navigating the Congress requires strong leadership.

- Greater authority from Congress.* CMS can discuss creative options and run demonstration projects, but to truly bring about change CMS requires greater authority and flexibility. Draft legislation for value-based purchasing has been prepared.
- Resources to do it right.* This includes both human resources and infrastructure, such as IT systems.

Participant Discussion

- **Congressional micromanagement.** It was not clear to participants how the alternative governance structures that were discussed would necessarily decrease congressional micromanagement. One suggestion was to try to shift congressional involvement from setting specific payment formulas to creating rule-based processes. This would give CMS greater flexibility within the rules established by Congress. However, one participant argued that since Medicare is 3% of GDP and involves payment to vendors, congressional micromanagement is not necessarily a bad thing.
- **Changing Medicare's entitlement status.** In 2010, the Medicare Trust Fund will begin being drawn down. This will occur as expenditures by Medicare will exceed the revenues coming into the Trust Fund. One participant suggested that instead of having Medicare as an entitlement, it could be approved by Congress as part of the normal budget approval process. This would force Congress to address the fact that Medicare represents a larger and larger share of government spending.

The competing argument is that Medicare represents a promise from the government to the citizens of the United States to provide health care and making Medicare part of the budget process would threaten this promise. However, while Medicare is a promise, the structure of Medicare and the benefits provided under Medicare have not been specified and could be changed (which differs from Social Security, where a specific payment amount is promised to each citizen).