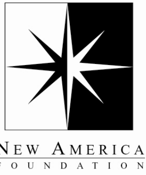

In Brief: Making Medicare Sustainable

A Project of the New America Foundation Health Policy Program

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The ever-growing cost of health care is the largest threat to our nation's long-term fiscal future. One way of tackling this problem is by using Medicare—the nation's largest purchaser of health care—as a catalyst for widespread efficiencies in the private sector. Medicare must become a more value-based purchaser to make the Program sustainable over time and incent the private sector toward change. It is imperative that we act decisively and soon. Yet, we believe embarking on a Medicare-only reform effort would be far less productive than comprehensive delivery system reform. Medicare buys health care from the broader delivery system. Therefore, if we fail to address our system as a whole, we will have failed to solve the Medicare Program's underlying problems. Delivery system reform must benefit all payers, patients, and providers who are willing to excel, but Medicare should and can lead the way.

The following synopses are excerpts from papers that make up a larger volume entitled: *Making Medicare Sustainable*. Each paper explains an aspect of Medicare reform that will help us control costs and improve quality in the Medicare Program and our health system as a whole.

Understanding the Medicare Financing Problem

Richard Kronick, Ph.D.
University of California at San Diego

Kronick analyzes the extent and the timing of Medicare's financing problem, the comparative growth rate of Medicare spending and private sector health spending, and the rate of growth in the use of health services in each sector. He uses this information to understand cost containment mechanisms in both systems to determine whether it is possible for the Medicare Program to take the lead in reducing health spending and whether cost containment must by system-wide rather than just in Medicare or the private sector. He concludes that:

- **Cost growth in Medicare is unsustainable.** While Medicare will not go bankrupt tomorrow, the crisis is looming. Without quick, effective action to cut costs — like investing in comparative effectiveness, requiring electronic prescribing, or other innovations outlined in this volume — politicians will be forced to drastically raise taxes or cut benefits to maintain the Program in the near future.
- **Rates of growth in both sectors differ, but both respond to policy interventions.** While the patterns in the rates of growth in both sectors may not decisively prove whether one sector "leads" the other, they do show that rates of growth do decrease (and increase) in response to specific policies and that both sector could learn from the practices of the other.
- **Medicare can lead reform.** Because of its role as the largest purchaser of health care, Medicare can achieve considerable cost growth control within the Program. It is likely that when Medicare succeeds in constraining costs, the private sector will follow.

Reforming Medicare's Governance to Enhance Value-Based Purchasing

Robert A. Berenson, M.D.	*Len M. Nichols, Ph.D.*	*Tom Emswiler*
Urban Institute	*New America Foundation*	*New America Foundation*

In addition to the mounting financing crisis created by rising health care costs, Medicare is also burdened by its failure to become a value-based purchaser of health care services. Nichols, Berenson, and Emswiler argue for an expanded definition of value-based purchasing (VBP) in Medicare. In the authors' version of VBP, Medicare would target interventions to the specific needs of the population – by identifying opportunities to improve the whole population's care — rather than simply focusing on individual interventions or diseases. They also propose a new, politically-isolated governance body to help move the Program toward a more value-based purchasing design. Specifically, Nichols, Berenson, and Emswiler suggest:

- **Expand the definition of VBP** to: "Value-Based Purchasing uses a variety of tools to try to obtain the right kind and mix of services, of desired quality, at a reasonable cost." By expanding our notion of VBP, we will be able to pay attention to important, but overlooked improvement opportunities like benefit design and Program initiatives targeted more carefully to specific needs of the population. By encouraging VBP to have a population focus, Medicare can improve care for their beneficiaries, while obtaining better value for patients and taxpayers outside the Program.
- **Design a new governance structure** (the "Guardians") that will insulate Congress from lobbying by stakeholders, free CMS to make decisions based on evidence and value, and ensure that the decisions made are in the public's best interest. The Guardians would be responsible for establishing which policy decisions — on coverage, pricing, and administrative matters — should be made by CMS officials and what choices should be left to Congress. It would also report to Congress on the performance of CMS.

BALANCING INCENTIVES: VALUE-BASED PURCHASING OPPORTUNITIES IN TRADITIONAL MEDICARE

Lawrence P. Casalino, M.D., Ph.D.
Weill Cornell Medical College

Casalino presents nine goals to move Medicare toward a more value-based purchasing design and offers 20 distinct policy suggestions to help Medicare achieve success. The policies are designed to bring higher-quality, lower-cost care to Medicare beneficiaries, preserve patient and physician choice, and reward providers who invest in increasing the quality of care they deliver. Three of the most innovative and substantial policy ideas include:

- **Support integrated systems**. Such systems include the traditional concept of the "medical home" as well as "Accountable Care Systems" (ACSs). These groups would offer high-quality, efficient care, and would likely incent other providers to offer high value care as well.
- **Change payment methods to reward quality and efficiency**. Revise current payments systems to reduce disparities between different types of care and reward care that adds value. Offer payment incentives to medical homes and ACSs. Base annual payment updates on the quality, not volume, of services provided. Ensure that all payment changes are budget neutral.
- **Strengthen the conditions of participation in Medicare**. In addition to maintaining an accurate count of medical providers and facilities, require electronic submission of physician information and ensure that medical providers and facilities meet certain, minimum quality standards to remain a part of the Medicare program.

VALUE-BASED PURCHASING IN TRADITIONAL MEDICARE: LEGAL ISSUES

Timothy Stoltzfus Jost, J.D.
Washington and Lee University, School of Law

Jost explores the legal constraints imposed on value-based purchasing by traditional Medicare, examines potential changes in the law to facilitate value-based purchasing, and identifies the agents responsible for making such changes. Specifically, Jost evaluates the legal changes necessary to implement Casalino's 20 recommendations and considers the legal impediments presented by: the Constitution, the Medicare statute, the Privacy Act, Freedom of Information Act, Federal Acquisition Regulations, existing Demonstration Projects, Antitrust Law, Anti-Kickback Prohibitions, and various state regulations.

- **Proposals that need new Congressional legislation include**: implementing a physician census; setting standards for in-office use of imaging equipment; excluding low-quality physicians and hospitals from Medicare; establishing medical homes; and, changing payment methods to reward quality and efficiency.
- **Proposals that would be executed by CMS or HHS include**: specifying which quality data should be collected; surveying patient satisfaction; providing researchers with data; risk-adjusting beneficiaries; incorporating rewards for quality and efficiency into new programs; and, building evaluation activities in new programs and changing existing programs.

PROTECTING MEDICALLY VULNERABLE OLDER AMERICANS

Chad Boult, M.D., M.PH., M.BA.
Johns Hopkins University, Bloomberg School of Public Health

Scientific evidence shows that the quality and effectiveness of mainstream health care for chronic conditions is suboptimal. As a result, many chronically ill older Americans succumb to their medical vulnerability and experience poor quality of life. To address these failings, researchers have created conceptual models and promising clinical innovations to improve chronic care. Boult highlights past research and examines which models of care should be "diffused" throughout the health care system. The most promising models include:

- **Interdisciplinary primary care** provided by co-located nurse-physician teams. The team rather than the physician is the provider of care. Teams are determined based on the specific needs of the chronically ill patient in question (e.g. a cardiac nurse for a patient with heart disease).
- **Supplements to primary care**: care management by a nurse or social worker to coordinate a patient's care; pharmaceutical care by pharmacists who provide advice and information about medications; self-management training to empower patients to be active in managing their conditions; proactive rehabilitation by rehab therapists to maximize patients' autonomy, safety, and quality of life; and, caregiver education and support for informal caregivers or family members to help them cope with new roles.
- **"Transitional care"** between hospital and post-acute settings. Led by a nurse, this model provides patients with a source of care once they leave the hospital. The nurse visits the patient at home until recovery and contacts the physician if necessary.
- **Dyadic primary care of nursing home residents** by advance practice nurses in partnership with primary care physicians. Nurses create a care plan and work in tandem with physicians to maximize a resident's quality of life.

"In Brief: Making Medicare Sustainable" is a short summary of the work included in *Making Medicare Sustainable*, Len M. Nichols and Robert A. Berenson (editors), 2009.
For more information, please visit: http://www.newamerica.net/health_policy.