THE HEALTH INDUSTRY Forum

Policy Brief

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Can Medicare Accelerate Delivery System Reform?

Over the past 40 years, efforts to slow the rate of growth in US healthcare spending have mostly been unsuccessful. The healthcare system is extremely resilient to change and its economic structure has not supported improvements in efficiency. Medicare, as the nation's largest payer, has sufficient market power to institute reforms that could help transform the entire system. However, Medicare was originally enacted to finance healthcare for America's seniors rather than as a force for influencing the nation's delivery system. As a result, many of its current policies, particularly its reliance on fee-for-service reimbursement, create financial disincentives for providers to organize services more efficiently, reduce the volume of marginally useful services, and invest in chronic care management infrastructure.

Past efforts to reform Medicare have primarily focused on extending the program's fiscal solvency through provider payment limits and new revenue sources. However, as the national healthcare cost crisis escalates, Medicare policies must focus more directly on encouraging a more efficient, sustainable delivery system for all Americans. But Medicare is large and complex with numerous stakeholders, many who will resist significant change. On November 24th The Health Industry Forum convened a meeting of leading policy analysts, industry executives, healthcare practitioners, and federal officials to discuss Medicare strategies for delivery reform. The meeting examined current delivery system characteristics, potential options for restructuring the system, and Medicare policies that could accelerate change. Participants then discussed options for enhancing CMS' ability to drive delivery reforms through changes in governance, organization, and resources. Key themes from the Forum are discussed below.

The concentration of physicians in small practices and hospital-owned practices creates challenges for delivery system restructuring.

In 2005, 33 percent of physicians practiced in groups of one or two, and 36 percent were institutional employees.[i] Physicians in small groups generally lack the resources or economies of scale to invest in electronic health records (EHR) or organized care management processes. Nor can small practices accurately predict the cost of patients in their care, making it unwise for them to participate in risk arrangements. Many analysts believe that multi-specialty group practices would be an ideal foundation for a restructured delivery system. However, over the past decade the number and size of multi-specialty groups has remained relatively flat. Greater integration of hospitals and their employed physicians offers another model for delivery reform. Many hospitals employ substantial numbers of physicians, however, their primary motivation for acquiring physician practices has historically been to capture profitable specialty referrals. To the extent that hospital managers control organized delivery systems, the current culture of revenue maximization will pose challenges for reform.

Virtual integration of physicians and hospitals into Accountable Care Systems (ACS) is a promising new model.

Among the goals for delivery system reform is to encourage innovation in resource use that increases the value of health services through integrated delivery models. Moving in this direction requires payment reform. However, a substantial proportion of the nation's physicians cannot realistically accept capitation or other payment models that force them to bear significant risk.

An alternative approach would be to promote virtual integration of physicians and hospitals into Accountable Care Systems (ACS) that accept responsibility for the overall cost and quality of care for a defined population.[ii] Payment policy could then vary based on the type of provider organization delivering care. Financial rewards could then be tied to organizational performance that can be reliably measured and to the degree of financial accountability accepted by each organization.[iii] Future limits on fee-for-service (FFS) reimbursement combined with enhanced performance-related payments and risk-sharing opportunities could hasten ACS development.

Medicare can accelerate delivery system reforms through payment policy changes and support for enabling tools.

Medicare has the capacity to drive structural change in the healthcare delivery system, but because of its size Medicare must be mindful that its policies do not diminish quality or disrupt beneficiary access to care. A key challenge is phasing in new financial incentives at a rate that providers can reasonably be expected to accommodate. This suggests an iterative process of policy changes designed to move the delivery system in the right direction without inciting the kind of backlash that occurred in the 1990s under managed care.[iv] Medicare could improve the current payment model by recalibrating fees to reduce payment for highly profitable services while paying more for primary care. It could also implement new payment incentives for efficiency, quality, and integrated service delivery through pay-for-performance, care coordination fees for certified medical homes, bundled payments that combine hospital and physician fees, and gainsharing policies like those in Medicare's Physician Group Practice demonstration. The federal government could complement payment reforms with new funding for clinical information system infrastructure, comparative effectiveness research, and investments in the nation's primary care workforce.

Enhanced purchasing and benefit design authority could help Medicare become a more effective catalyst for delivery reform.

Private health plans use selective contracting to establish cost effective provider networks and to help them negotiate more favorable rates. Plans also use benefit design to encourage patients to select lower cost, higher quality providers. Medicare is based on a principal of uniform benefits for all enrollees. With the exception of a few small demonstrations, traditional Medicare pays for care delivered by any Medicare certified provider. Opponents of Medicare selective contracting argue that it could put non-preferred providers out of business, and that it would materially reduce beneficiary access in many geographic regions. Proponents argue that by excluding just a few low quality, high cost providers Medicare sends a strong signal to the market that would have a material impact on behavior. Medicare's new acute care episode (ACE) demonstration incorporates many of these concepts: health systems in four states bid on a package rate for hospital and physician services for coronary bypass and joint replacement surgery. CMS will share savings with beneficiaries who select designated institutions by reducing their Part B premiums and market the program directly to Medicare enrollees. In the past, demonstration initiatives that have threatened powerful interests, like competitive bidding for durable medical equipment, have been killed by the Congress under pressure by affected parties. It remains to be seen whether future pressure to control health spending will change this dynamic.

CMS needs vision, leadership, new authority for action, and expanded resources to drive delivery reform. Changes in Medicare governance should aim to increase management flexibility and reduce political influence over program operations.

Experts assert that the size, scope, and complexity of the Medicare program make it nearly impossible to manage.[v] Although CMS and its predecessors have had important successes, it is difficult for the agency to focus on more than one or two pressing initiatives at a time given

current administrative resources. Furthermore, Congressional involvement in Medicare management remains significant. A variety of groups have examined options for modifying Medicare's governance, including establishing an independent Medicare agency and transferring program oversight to a national health board insulated from financial stakeholders and Congressional micromanagement. Challenges for Medicare governance include determining the appropriate level of statutory specificity, establishing an effective balance between program uniformity and flexibility to collaborate with state or regional health initiatives, and establishing greater political insulation while maintaining transparency and accountability to taxpayers.[vi] One place to start would be to substantially increase administrative resources for Medicare management, and to promote longer tenure for Medicare administrators and senior management.

Structural reform will be challenged by demand for immediate cost containment.

A major priority for Medicare policy should be moving away from unrestricted FFS reimbursement and towards new payment models that encourage delivery system integration. However, the need to improve Medicare's fiscal solvency will create pressure for short-term provider payment reductions. Long term success is more likely if new payment models are implemented prior to making cuts in payment rates, so that payment reforms have time to gain traction. If payment reform is viewed simply as a way to cut spending, providers will resist as they did during the 1990's. In contrast, new Medicare payment policies that allow providers to earn more as part of accountable care systems than as independent practitioners will advance future prospects for meaningful delivery system reform, especially if these policies are simultaneously adopted by private payers.

This policy brief was prepared by Robert Mechanic of Brandeis University
The policy brief draws heavily from presentations by Larry Casalino, Francis J. Crosson and Tom Ault on November 24th 2008. Copies of these presentations and a more detailed conference report are available at www.healthindustryforum.org

[i] L. Casalino, *Can Medicare Catalyze Development of Better Delivery Systems*, Presentation on November 24, 2008 (www.healthindustryforum.org)

[ii] S. Shortell and L. Casalino. "Health Care Reform Requires Accountable Care Systems" Journal of the American Medical Association 300, no. 1 (2008): 95-97.

[iii] L. Casalino, Ibid.

[iv] F. Crosson, *Can Medicare Lead Delivery System Reform?* presentation on November 24, 2008 (www.healthindustryforum.org).

[v] T. Ault, *Medicare Governance*, presentation on November 24, 2008 (www.healthindustryforum.org).

[vi] T. Ault, Ibid.

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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