HEALTH CARE CRISIS:
SYSTEMS INSIGHT TO A PRACTICABLE APPROACH

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ABSTRACT

Because health care is a system responding to its own incentives, and a market dominated by Medicare policies, a systems approach is proposed to reshape that market with strong financial incentives to control cost and improve quality. The proposed paradigm, a new Medicare product, puts control in the hands of the clinician and patient, creating coordinated incentives for quality of care, patient satisfaction and prudent resource use, acting favorably on PCPs, their referred specialists, patients and hospitals. It offers a practicable approach to health care reform, and the opportunity for timely implementation by Medicare.

INTRODUCTION

No matter how sophisticated and effective medicine becomes, if we cannot support its costs, people will—and do—needlessly suffer and die. While health care contributes disproportionately to the growth of our national expenditures, its problems go beyond costs to include quality of and access to care. To forge a solution, health care must be understood as a complex system of interrelated incentives that both creates a unique market and responds to it. The dearth and dissatisfaction of primary care physicians (PCPs) is a major response to the market created by today's health care system. "Concierge medicine," nurse-practitioner clinics in chain stores, and medical tourism are other responses to the failure of today's health care system to meet people's health needs. Concierge medicine is a market response by primary care physicians anticipating more effective practice, and by patients able to afford it. Chain store clinics benefit many who can't get a timely visit to a PCP and instead spend hours in an Emergency Unit. Medical tourism arose out of patients' expectations that care abroad will be less costly but of comparable quality. These are "canaries in the coal mine," responses to the market created by our health care system. We need a new paradigm revising the market through

interrelated, balanced. and effective incentives that influence the behavior of all—physician, patient, hospital, and payer—to transform the system into one in which value-effective health care is maximized.

Why the high cost? The system generates its own excesses. Technology improvements, a growing population, and advancing age of patients are commonly cited, but of prime importance are (1) fee-for-service, today's common form of payment, and (2) leverage for cost control and quality in the hands of third-party payers, Medicare, Medicaid, and private insurers, rather than those of the physician. Fee-for-service—paying for each office visit, lab test and procedure—worked well decades ago when things were simpler; less was known in medicine, less could be done, and less was billed. Now, the proliferation of diagnostic and therapeutic tools leads to more charges and mounting costs. Physicians want to be helpful, utilize better or less invasive procedures and avoid possible malpractice issues, but doing more generates more cost. Patients, too, can encourage overuse through information they gather. Because neither physician nor patient has effective incentives to control costs, fee-for-service has become inherently inflationary with increasing numbers, complexity and cost of diagnostic and treatment options. Unable to address the specific clinical decisions of the doctor or patient, payers react piecemeal to rising costs by reducing or denying some payments, yet expenditures continue to skyrocket. Result? Quality problems, harried physicians, dissatisfied patients, hard-pressed employers, and frustrated payers.

In Medicare's payment for hospitalization, by contrast with its payment to physicians, the admitting diagnosis and complicating factors determine a fixed price rather than multiple payments for individual studies and procedures. Fixed payment puts responsibility on the hospital to improve efficiency and control costs. But directed only to the hospital – and not the entire health care system – that fixed payment is a piecemeal approach, and piecemeal "solutions" do not work. A whole systems approach is needed. Shortell and Casalino emphasized, "Comprehensive health care reform will require proposals that both expand coverage and redesign the delivery system so as to achieve greater value…."[1]

How then do we create a system with the potential to serve more people and serve them better, at a restrained *per capita* cost? Health care economist Alain Enthoven and colleagues concluded, "Recognition of the essential coordinating role of primary care, as part of an overall organized system of care, along with alignment of providers' incentives with patients' desires for high-quality, affordable and accessible care, could lay the foundation for truly redefining U.S. health care." [2]

We need a new paradigm, a new system of health care financing and delivery, rather than continuing to patchwork our existing flawed system. From our respective experiences – one with 30 years as CEO of a major teaching hospital and the other, a long-time consultant in health care payment and delivery systems – we propose a staged approach to restructuring the organization, delivery, and financing of the U.S. health care system, beginning with either pilot programs or an optional voluntarily selected PCP payment

arrangement, both through a new Medicare product offering shaped by the paradigm proposed here.

Stage One involves simple changes in the organization and payment of PCPs under the Medicare program, changes that can operate in the context of the current administrative systems of the Centers for Medicare & Medicaid Services (CMS). Interested PCPs would group together (e.g., 5–15) to form a "Team." This first stage places no restrictions on the Medicare beneficiaries, offering only Medicare health plan options currently available, and maintaining the current fee-for-service arrangements (the RBRVS* system). What is added will be supplemental incentive payments for the PCPs to encourage control of the costs of their Medicare patients.

[*Resource-Based Relative Value Scale: RBRVS assigns procedures performed by a physician or other medical provider a *relative value* that is adjusted by geographic region. Multiplied by a fixed conversion factor, this value is changed annually to determine the amount of payment.]

In Stage Two, CMS would offer an additional Medicare product, a dual option plan that would give each Medicare beneficiary strong incentives to select a PCP in one of the Teams, to use that PCP as their primary care physician and to follow the PCP's referrals for specialist and hospital care. In this stage, the RBRVS fee-for-service system for PCPs would be subordinated to a risk-adjusted capitation payment for each Medicare beneficiary registered with a PCP and Team. Under this capitation payment, the PCP would be paid substantially more than under today's RBRVS system, both in response to the current underpayment for PCP services and to provide compensation for the additional clinical management that this new Medicare product would encourage. Key to this stage will be incentives to control the total costs of care and incentives for improved quality and patient satisfaction.

We term this approach to health care organization, delivery, and payment, *"Balanced Incentives for Health"* (*BIH*). *BIH* creates a coordinated market system where Teams compete for patients on the quality of patient care, patient satisfaction, and reduced patient co-payments, and are rewarded for prudent, efficient and effective use of resources. *BIH* could be adapted for use by Medicaid programs and by private sector health plans where potential incentive payments to PCPs should encourage interest. Private insurers should welcome reduced expenditures in contrast to their present-day costly and frustrating micro-managing of both care and its administration.

We anticipate that some of the savings of each Team could benefit their Medicare patients. For example, a portion could be used to reduce the beneficiaries' payments under Part B. Teams might grow through more Medicare patients attracted to the program's benefits including reduced out-of-pocket costs. Growing Teams could expand to include specialists who would also be paid a fair salary on a capitation basis. Whether a Team were comprised only of PCPs or included specialists, it could evolve into and function as a Medical Home,[3] a concept of growing interest across the nation and illustrated, for example, by the 30-year experience of the Urban Medical group in Boston.[4]

BALANCED INCENTIVES FOR HEALTH (BIH): A MEDICARE INITIATIVE

Because Medicare is the largest health insurance program, its approaches to health care organization, delivery, and payment are generally mirrored by Medicaid programs and private insurers. Given that imminent congressional action mandating and then implementing a national system of organization, delivery, and payment is unlikely, the starting point for a systems approach to health care reform should be the policies of Medicare.

Changes in Medicare policy face three important constraints. Specifically the changes must accommodate:

- CMS's current administrative capacities including its enrollment, benefit adjudication, claims processing, and actuarial service capabilities

- The current Part A and Part B Medicare health plan options, options that feature freedom of choice of providers with no referral requirements

- The current network of participating Medicare providers

These conditions suggest that a Medicare cost containment initiative would have at least two stages. The first stage, while meeting those three constraints, would begin to create the framework of a system of organization, delivery, and payment with incentives for both physicians and patients ultimately capable of controlling Medicare expenditures.

STAGE ONE

In the first stage, Medicare will issue contract proposals to primary care physicians requesting that they voluntarily form PCP groups of 5-15 physicians (the Teams) based on the PCPs' current coverage arrangements. The Teams will pool a sufficient number of Medicare beneficiaries with Part A and Part B coverage to ensure that a target budget covering their collective Part A and Part B expenditures will be actuarially stable. Based on their claims history, each patient who received a PCP service will be assigned to the PCP (and Team) that provided the largest share of such services in that year. The assignment process will be transparent, that is, made clear to the Medicare beneficiaries, but the patients will continue to access the health care system in accordance with the freedom of choice, coverage, and benefits of their conventional Part A and Part B plans, including the absence of referral requirements.

Each year, CMS will compute a target budget for each panel of Medicare beneficiaries assigned to a particular Team. Age, sex, disabilities, and other factors influencing the services required by the Team's patient panel will be accounted for based on the actuarial classes and budgeting techniques currently used by CMS to create target budgets for Medicare HMOs and Advantage Plans. The target budgets are not bank accounts but rather accounting devices used to evaluate the expenditure levels of each Team. At the close of each year, having previously determined the target budget for the Team's

assigned beneficiaries, CMS will charge against this target budget all claims payments ("Chargeable Payments")made by CMS on behalf of the Team's assigned beneficiaries.

If the assigned beneficiaries' Chargeable Payments are below the Team's target budget, CMS will pay one-third of the surplus to the Team. If the beneficiaries' Chargeable Payments exceed the target budget, CMS will make no supplemental payments to the Team; in that case the Team's total payments for Medicare covered services will be the standard RBRVS fees paid by CMS to the PCPs as the covered services are rendered. This means that the Team (and its PCPs) are not at risk for overrunning the target budget. Stage One, therefore, is designed to foster the formation of Teams of PCPs and to encourage, through both financial incentives and the sharing of information on total costs, a focus on awareness and prudent commitment of resources by the Team's PCPs.

STAGE TWO, OPTION 1

In Stage Two, CMS will offer a product with incentives for each Medicare beneficiary to select a PCP and Team, to access care through the Team, and to follow the Team's referrals for specialist and hospital care. Stage Two will contain a dual option health plan, two modalities either of which the beneficiary may use for the services covered by Medicare, with no requirement to commit exclusively to one or the other.

The first of the dual options in Stage Two is the Standard Part A and Part B offering, enabling the Medicare beneficiary to maintain full freedom of provider choice along with the current Medicare coverage and benefits. This means that the beneficiary's participation in Stage Two involves no mandated change in the standard Part A and Part B access, coverage, or benefits for the beneficiary but offers the reduced costs and other advantages of the patient's voluntary use of Stage Two's second option.

STAGE TWO, OPTION 2

In the second option of Stage Two, the coverage and benefits will be the same as those of Medicare Part A and Part B, but with the following modifications:

- The Medicare beneficiary will have selected a PCP and, with the choice of PCP, the Team that includes the PCP.
- The PCP will provide basic and initial care and provide or arrange for specialist, hospital, and other care, referring the patient to providers specifically selected.
- A beneficiary who accesses care through the PCP (and Team), whether for primary care or specialty referrals, will be relieved of half of the co-payments for physicians' services otherwise applicable under Part B. This offers the patient the first of several incentives to access care through the PCP and to follow the PCP's referrals for specialist and hospital care.
- Even so, the beneficiary is not "locked in." Under the first of the Stage Two options, the beneficiary can reject the PCP's referral and self-refer to the specialist or hospital of his/her choice while maintaining Part A and Part B coverage with its conventional co-payments.

This second option of Stage Two places emphasis on clinical management of the patient as a whole rather than on the provision of individual diagnostic and therapeutic services. The PCP would no longer be paid fee-for-service, but instead a fixed monthly amount for each of the Medicare beneficiaries enrolled in the second option of Stage Two. The payment amounts would vary based on the beneficiary's actuarial class. The aggregate of these capitation payments would be paid monthly by CMS to the PCP (and Team) at a level substantially above the RBRVS fee schedule to compensate more fairly the PCP and also for the additional clinical management required by the second option. This additional payment would be feasible because of the ultimate cost saving anticipated through more prudent use of resources by the Team.

The RBRVS fee schedule will continue to be used for PCP services to beneficiaries in this arrangement who remain with the first option, conventional Part A and Part B, and for all services provided both by PCPs who are not members of the Team with which the patient is connected and by specialists selected by the patient outside of his or her PCP's recommendation.

Each Team will have a target total budget for all Medicare covered services to the group of Medicare beneficiaries registered with the Team under the dual option plan. At the close of each year the balances in that target budget will be determined and a proportion of any positive balance will be paid to the Team. The baseline proportion, as in Stage One, is proposed as one-third. In Stage Two, however, this payment will be increased or decreased based on quality evaluations and patient satisfaction surveys carried out by CMS. A Team with positive balance in its total target budget and highly favorable quality and patient satisfaction results might receive, say, 40 percent or more of the positive balance, while a Team with less favorable results might have its incentive payments reduced.

FINANCIAL FEASIBILITY AND SAVINGS PROJECTIONS

In Stage One of the initiative, CMS would incur one additional expense that relates to the asymmetric character of the target budget's incentive arrangement; a third of the positive balance in a target budget is shared with the Team, but a Team bears no risk for budget overrun. While it is not possible to project precisely the change in CMS expenditures, it is not unreasonable to predict over time a decrease in costs for the Stage One program.

In Stage Two, CMS would incur two additional one-time expenditures. The first is the increment to the PCP level of payment associated with the conversion from fee-for-service to overall capitation payment under the dual option plan. For this discussion, we project this increment at about one percent of total Medicare expenditures. There are also the costs to CMS of the reduced Part B co-payments afforded patients who access care through their PCP and through the PCP referrals to specialists under the second option. An upper limit to these expenditures can be calculated by assuming that all Medicare beneficiaries choose that second option, that all their primary care is obtained through their PCP, and that each patient accepts every referral made by the PCP and none

elsewhere. In this case, since about 25 percent of Medicare expenditures are for physician services, since the co-payment by the beneficiary is 20 percent, and since one half of the co-payments are waived in this plan, the (one time) addition to Medicare expenditures is, at most, 2.5 percent (25 percent x 0.20 x one half = 2.5 percent.) Thus 2.0 percent is a conservative estimate of the cost to CMS of the reduction in patient co-payments.

DISCUSSION

It is not possible to project the cost containment impact of *BIH* on Medicare expenditures in the long term, but we believe it reasonable to project a meaningful saving annually measured against projected Medicare expenditures *in the absence* of *BIH*. Emphasizing the marked regional variation in overall Medicare expenditures,[5] and major variation in discretionary decision making by individual physicians,[6] Fisher and colleagues concluded that "… small changes in annual per capita growth rates have enormous implications for the long-term solvency of Medicare and for the sustainability of expanded insurance coverage." Should Medicaid and private insurers adopt the proposed paradigm, the overall economic impact would grow further.

Consider the change in incentives. We have noted the success of Medicare hospital payment in controlling costs per case through prospective payment based on DRGs. The central idea was that hospitals needed to face incentives to reduce resource use per case. No comparable nationwide demonstrations have been tried with respect to physician payments, although the experience of Kaiser-Permanente and others reinforces the argument for the *BIH* approach. The fee-for-service incentives of the RBRVS are widely acknowledged as a major cause of excessive expenditure. It follows that a change from cost-inducing incentives of fee-for-service payment to an arrangement with clear incentives to control costs will improve the nation's efforts to temper escalation of health care expenditures.

We have been asked, "Why should *BIH* with teams, PCP capitation, and global budgeting work? With the exception of Kaiser-Permanente and a few others, many approaches to organization, delivery, and payment said to involve capitation have not been successful." Our response:

- One cannot have cost control without a budget. With fee-for-service, the overall budget is neither known nor relevant to the providers of care. Cost control is exerted *ex post facto* by the payer. With *BIH*, the Team knows the budget and monitors it. It is within the Team's power to stay within a fair budget limit, in part by providing service of such quality that the patient is unlikely, with rare exceptions, to go outside the plan.
- Most of the failed instances of so-called "capitation" and "managed care" have applied to only a minor fraction of a PCP's patients, have included weak incentives for controlling total costs and typically have put little or no restraint on the patient going outside the plan.
- In Kaiser-Permanente, 100 percent of the patients are within the capitation system and thus controls and incentives relate to the universe of the physicians' patients.

In most of the recent failed "managed care" trials, only a fraction of a physician's patients fell within the "capitation" program and these programs did not cover Medicare patients. In such a situation it becomes difficult if not impossible for the physician to deal with a minority of patients in one way (presumably more prudently to stay within a given budget) while the majority of patients remain handled in the inflationary fee-for-service mode.

- The argument that capitation can lead to physicians holding back on care in order to meet budget has not proven valid at Kaiser. The opposite, ordering too many procedures and tests – encouraged in a fee-for-service environment – is equally undesirable. It is doubtful that economic motives override most physicians' clinical decisions in either situation.

BENEFITS OF *BIH*

The *Balanced Incentives for Health* system anticipates more patient time with the primary care physician, fostering better care, better communication, and more gratifying experiences for both patient and physician. Does more time with a physician result in lower costs? It can lead to fewer visits to physicians' offices and emergency units, and better health, making for lower costs. *BIH* encourages the physician to spend time with the patient in useful efforts not paid for under fee-for-service, such as listening longer to the patient, planning with the patient for health in the years ahead or, for a patient with chronic illness, focusing on education, monitoring and home care. With this paradigm, the primary physician can involve nurse practitioners, physician assistants, and other members of the Team without concern that a fee-for-service system might not pay for their efforts. And the Team's incentives, based on value measures that include quality, cost and patient satisfaction, encourage greater value and more cost-effective care.

PCP capitation combined with incentives to control total patient expenditures are major keys to cost control and better care. Kaiser Permanente and others have demonstrated that care of high quality and patient satisfaction with cost control is achievable under capitation, but its specific approach cannot be a national model because the organizational structure of Kaiser Permanente does not reflect the relative independence of most physicians and hospitals in this country. Nonetheless, *BIH* takes a lesson from Kaiser Permanente. Initially calling for volunteer groupings of primary physicians, a *BIH* Team ultimately can become a multi-specialty group similar to, but smaller than that of the Permanente Medical Groups. What is different is that the Team can use or add specialists as it deems appropriate. The leverage for value remains with the Team. Unlike fee-for-service today, where economic behavior of one provider is typically independent of that of another, with *BIH* the incentives are coordinated to influence all participants – the primary care physician (and nurses, social workers and other Team members), other specialists, the patient, hospitals, and insurers.

Were *BIH* proven to be effective at controlling costs for Medicare, it could engender meaningful competition among private plans, requiring their adoption of more cost effective and patient-centered systems of organization, delivery, and payment. If the private sector is to participate in controlling costs, it must be subject to a competitive

standard that will promote an across-the-board change in the way virtually all insurers do business. And to broaden access, individuals without insurance could be given vouchers to purchase *BIH* or competing private sector plans.

Notions of a systems approach and capitation with interconnected incentives have been offered in the past. [7] It appears that the ideas then presented did not overcome preference for piecemeal reform efforts. Today, others are coming forth with thoughtful ideas, but tend not to deal with the system as a whole. [8,9,10,11,12]

These and other proposals suggest some of what is needed in a new paradigm, but none offers as workable an overall system as does *BIH,* nor as practicable an opportunity for timely pilot experimentation or for a voluntary nationwide roll-out. Critical to its success, both fair payment levels and effective information management are required, along with meaningful incentive payments to physician groups that meet the fiscal, quality and patient satisfaction criteria. As Victor Fuchs pointed out, "…several short- and intermediate-term actions and initiations can help lay the groundwork for long-term sustainable reform. Examples include . . . developing demonstration projects by Medicare for payment alternatives to current fee-for-service methods…." [13]

To determine utility and acceptability, pilot demonstrations or optional voluntary Team enrollments on a national basis should last over several years for reasonable evaluations to be made, allowing comparisons and adjustments as we learn. With successful reform, patients would gravitate to providers of care delivering better value as they, the patients, perceived it, and insurers would seek out providers delivering value as *they,* the insurers, perceived it. Ultimately, we believe *BIH*, once begun, will succeed in the marketplace we all share.

CONCLUSION

Balanced Incentives for Health revises the health care market, enabling the Primary Care Physician to resume the professional responsibility of managing the care of patients in return for a workable system of prepaid capitation, with incentives for value delivered—prudent use of resources, high quality of care, and patient satisfaction. For the participating specialist, market advantage accrues through similar performance. For the patient, *BIH* offers better-coordinated acute and chronic care and long-term promotion of health combined with both freedom of choice and the opportunity to cut out-of-pocket costs. For the hospital, the incentives on its physicians enhance quality of care and efficiency, lessen costs, increase patient satisfaction, and increase competitiveness. For the insurer, government or private, the benefit is relief from the burdens of clinical monitoring and management and of fee-for-service accounting and payment in return for a system of cost control that operates on incentives supporting value in health care. Neither the existing pattern of fee-for-service nor the recent experience with so-called and inherently flawed "managed care" offers comparable direction for effective reform.

A new and systemic approach is needed to create a health care market that supports the goals of quality of care, prudent use of resources, and the possibility of access for all. *Balanced Incentives for Health* is offered for that purpose and warrants trial. Its opportunity for timely implementation is an added advantage. We should explore its effectiveness and its capacity to foster more value in the health care of all Americans.

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NOTES

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