

# Creating Patient-Centered Cost Control in Medicare and Medicaid

## Executive Summary

Medicare and Medicaid cost-savings efforts must improve the quality of care that is given to Medicare and Medicaid enrollees, not simply reduce budget outlays. Several proposals in Senator Baucus' Chairman's Mark proposal are laudable, including its encouragement of prevention, wellness, and health improvement services for Medicare and Medicaid recipients and its proposal to create value-based purchasing reimbursement practices. Suggestions here would increase cost savings and help move the current "sick care" system towards one more focused on health. Equally important, it could generate savings that could help finance premium subsidies for lower income Americans.

We see four, correctable, problems with the Chairman's Mark Medicare and Medicaid cost control proposals, as written: the excellent wellness and health improvement provisions can be sharpened to make use of some current "best practices." Other proposed reforms seem likely to encourage continued use of expensive specialists where more cost-effective care of high quality is possible. Proposals provide no counter-incentives to present trends that result from an over-emphasis on high-tech diagnostic and treatment procedures and expensive pharmaceuticals, whose costs are likely to increase over time. Nor do they encourage trial use of evidence-based alternative "best practices" that have a demonstrated promise for cost-savings. A few patient-centered innovations could begin to redirect the focus within healthcare towards greater emphasis on health improvement, not simply on disease care. We offer alternative suggestions:

1. In addition to expanding and evaluating use of value-based purchasing reimbursement formulas, and other payment methods, the CBO recommends evaluation of less conventional treatment strategies. The proposed CMS Innovation Center and the Patient-Centered Outcomes Research Institute should encourage and evaluate alternative treatment strategies that offer high quality, cost-effective alternatives to primary reliance on high tech diagnostic and treatment approaches. We believe it will be important to test the feasibility of scaling up successful, cost-effective and evidence-based wellness, prevention, and integrated medicine demonstrations, making targeted use of them with Medicare and Medicaid patients in areas of high cost. Examples:
  - **Cardiac surgery after-care**—Dr. Dean Ornish's well tested and validated, lifestyle-management-focused program for cardiac recovery and prevention saves \$30,000 per patient in the first year, reduces follow-up costs 50% after one year and by an additional 20-30% in years two and three. If introduced nation-wide as a Medicare reimbursable, preferred best-practice for post-cardiac recovery, this program could save Medicare at least \$59 billion over ten years.
  - **Follow-up care for other catastrophically expensive, acute medical episodes**—Proactive, patient-centered disease management and health maintenance counseling, similar to a Federal Express-sponsored program for employees with high medical costs, to Medicare enrollees who have recovered sufficiently to return to their place of abode, could save \$200 billion over ten years.
  - **Guaranteeing patient-choices regarding preferred quality of care as they age**—Helping patients and their families discuss and document their wishes improves quality of life. Making this an integrated part of regular geriatric care education rather than something reserved for end-of-life emergencies would protect patients' quality of life and save \$100 billion in unwanted treatments over a ten-year period.
  - **Adapting scientifically demonstrated best-practice proactive wellness and disease management programs for Medicare and Medicaid enrollees.** The most effective programs are often worksite- or community- based and rely on a wide variety of less expensive health and wellness professionals. Adapted for use with the retired or unemployed, these programs could save \$62 billion over ten years. If successful, these four innovations alone could save \$400 billion over ten years.

2. The CMS Innovation Center and the Patient-Centered Research Outcomes Institute should implement trials of additional cost-saving innovations, with procedures for implementing those which are successful. This could create additional savings. Examples include:
  - **Expanded trials of integrated medicine teams in hospitals.** Initial trials have resulted in reduced morbidity and mortality after surgery, shortened hospital stays, and less staff turnover in hospitals.
  - **Experiments at the state level with annual budgets for hospitals,** jointly determined through negotiation with payers and hospitals, adjusted for patient load characteristics. This would reduce administrative costs for hospitals and insurers and could save 10-15% in hospital administration costs (i.e., \$600 billion to \$900 billion over ten years.)
  - **Analysis of the effects of state-level experiments with malpractice insurance reform** (including “no fault” malpractice insurance) to reduce malpractice insurance costs for physicians and hospitals on use of diagnostic tests and procedures ordered as part of “defensive medicine” practices (which doctors estimate comprise at least 10-15% of their current diagnostic tests and referrals).
3. Incentives for “Medical Homes” will produce greater cost savings if they are designated for “**Medical Homes emphasizing primary care.**” Too many services that could be offered more cost-effectively by less expensive health care personnel now are provided by specialists who are reimbursed at higher rates. As now written in the Baucus Mark, the “medical homes” incentive might not change this practice. Accountable Care Organizations may assign tasks more appropriately done by other medical professionals to higher-cost specialists because of current staff ratios in their organization. With slight rewriting, proposals for Accountable Care Organizations (ACOs) and Medical Homes could move care in more cost-effective directions.
4. Quality and performance assessments as basis for value-based purchasing should include assessment of patient-satisfaction with the care they receive.

Adding these proposals would help correct a current over-emphasis on payment for disease care within conventional medicine, with no encouragement of less expensive and possibly more effective strategies for maintaining and improving the health of the population. It would create a dynamic in the legislation encouraging “healthcare reform,” not simply health insurance reform.

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