

## **Patient-Centered Cost Control for Medicare and Medicaid**

There are several key drivers of health care inflation: 1) Disease care is becoming ever more expensive. 2) The aging of the baby boomers will soon increase the proportion of the public for whom Medicare must assume the cost of care. 3) Because our reimbursement formulas sharply reward specialty care to the detriment of primary care providers, our medical schools have trained twice the number of specialists we need; specialists generate their own business, often providing services that could be offered by less expensive personnel. 4) We reimburse by services performed, rather than for successful outcomes, with reimbursement levels much higher for specialists.

Currently we address increasing costs in three ways: federal and state governments reimburse healthcare providers at lower rates than the private market; managed-care services ration access to care; and businesses (including health insurance companies) set limits on services covered and paid-for by them, thereby shifting more and more costs to individual Americans. Each strategy shifts real costs to someone else. Our current high personal bankruptcy rate is one direct result of these policies.

We need new strategies that can address the cost problem more fundamentally. Medicare and Medicaid, the two largest areas of healthcare spending in the Federal Budget, are logical places to try new cost control approaches. However Medicare and Medicaid cost-savings efforts must improve the quality of care that is given to Medicare and Medicaid beneficiaries, not simply reduce budget outlays.

Senator Max Baucus' proposals rely heavily on three strategies for cost control in Medicare and Medicaid: (1) Value-based purchasing reimbursement formulas, which rate hospitals, physicians, drug companies and Medicare Advantage plans in terms of quality of care and cost-effectiveness and provide reimbursement formulas based on their Value ranking; (2) reimbursement incentives to providers to create "medical homes" which will coordinate the care of Medicare and Medicaid patients; and (3) financial incentives for Medicare and Medicaid enrollees to enroll in medical homes and to reduce their health risks. Each strategy has both promise and problems.

This report will offer suggestions for improving the impact of each of these strategies, as outlined in the Senate Finance Committee Chairman's Mark of the America's Healthy Future Act. And it will suggest an additional area for potential cost-saving: the targeted use of evidence-based wellness, prevention, lifestyle-based chronic disease management and integrated medicine to address health issues that now consume heavy costs. We identify four particular promising programs which, if they prove to be as cost-effective when scaled up as they have been in smaller demonstrations, could reduce Medicare and Medicaid costs by \$400 billion over ten years. Other suggested trials might reduce costs by an additional \$600 billion to \$900 billion over ten years. Savings on this scale, along with the other income sources proposed in the Chairman's Mark, would make it possible to include all Americans in coverage for health care without increasing the federal deficit.

The rest of this report does two things. It provides an overview of strategies to create patient-centered cost control in Medicare and Medicaid. An appendix then suggests specific changes in the language of the Chairman's Mark proposals that would improve these outcomes.

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, high quality care is possible. His 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 of evidence-based alternative "best practices" with 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.

What seems to be missing from the bill is awareness of the cost-saving potential of some innovations using evidence-based wellness, prevention, lifestyle-based chronic disease management and integrated medicine to address currently high-cost areas of health services. This report identifies particularly promising demonstrations that could be tested for feasibility for wider use and for cost effectiveness. If they work as well on a larger scale as they have in preliminary demonstrations, Medicare could save at least \$400 billion.

We propose trials involving the targeted use of evidence-based wellness, prevention, lifestyle-based chronic disease prevention and management, and integrated medicine with Medicare and Medicaid patients in areas of highest cost. As you will see, this is a very different use of such services than is currently proposed in either the House or Senate HELP healthcare reform bills, or the Senate Finance Committee Chairman's Mark. The potential cost-savings from the best, evidence-based approaches make them appropriate candidates for trials and then incorporation into "preferred best practices" reimbursement formulas.

This, we believe, would be consistent with broader CBO advice this summer: Previous CBO analysis of probable effects of the specific wellness and prevention measures proposed in House and Senate HELP healthcare reform bills found no budget-relevant cost-savings from their use. (We agree.) In an August 7, 2009, letter to the Honorable Nathan Deal, Douglas W. Elmendorf, director of the Congressional Budget Office (CBO) cited *New England Journal of Medicine* and *Circulation* articles summarizing available evidence on how preventive care affects costs.<sup>1</sup> A review of hundreds of previous studies of preventive care, he reports, show that slightly less than 20% of the services that were examined save money, while the rest increase costs. And he warns that prevention services that depend on increased use of pharmaceuticals to control blood pressure and cholesterol, while beneficial to the health of patients and perhaps preventing more expensive treatments later, must offset the increased costs to deliver such services with clear evidence that resulting cost-savings justify this expense. In an August 9, 2009, Director's Blog, Elmendorf wrote: "Evidence regarding the effect of wellness services on subsequent health spending is limited, and CBO is continuing to evaluate the evidence that does exist." Elmendorf also notes that the cost-effectiveness record for conventional medical treatments is similar: only 20% of conventional medical treatments are cost-savers. If that is so, why not sponsor trials making targeted use of the *best* evidence-based, high quality, cost-effective wellness treatments for use with Medicare and Medicaid patients in the highest cost areas of disease cost spending?

Specifically, we should:

**1. Introduce effective, cost-reducing prevention, wellness and integrated medicine for use in high-cost areas of care, including**

- Cardiac Surgery after-care: Research has shown that lifestyle changes help heart repair and could prevent at least 90-95% of all heart disease.<sup>2</sup> The disease that accounts for more premature deaths and costs Americans more than any other illness is almost completely preventable, and reversible, by changing lifestyle. With over one million Medicare-funded heart surgeries a year, if even a third of them were "treated" with best practice lifestyle approaches to cardiac care, savings would reach at least \$1 billion per year, or \$10 billion over a ten year period.

What we eat, how we respond to stress, whether or not we smoke cigarettes, how much exercise we get, and the quality of our relationships and social support may be as powerful

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<sup>1</sup> Joshua T. Cohen, Peter J. Neumann, and Milton C. Weinstein, "Does Preventive Care Save Monday? Health Economics and the Presidential Candidates," *N. Eng. J. Med.* 335:7 (Feb/ 14. 2008, 661-663. and Richard Kahn and others, "The Impact of Prevention on Reducing the Burden of Cardiovascular Disease," *Circulation*, 118(July 28, 2008, 576-585.

<sup>2</sup> Yusuf S, Hawken S, Ôunpuu S, et al. Effect of potentially modifiable risk factors associated with myocardial infarction in 52 countries (the INTERHEART study). *Lancet.* 2004; 364: 937-52.

as drugs and surgery in treating (not just preventing) many chronic diseases. People with severe coronary heart disease have been able to stop or reverse it by making intensive lifestyle changes, without drugs or surgery. Findings from early studies documenting this have now been replicated more widely.<sup>3</sup> For example, studies of the Ornish method for post-cardiac surgery treatment show there is some reversal of heart disease after one year, even more improvement after five years, and 2.5 times fewer subsequent cardiac events when participants are compared with a randomized control group.<sup>4</sup> Costs of care following surgery for patients using the Ornish treatment program average \$30,000 less per person during the first year than for patients using conventional treatments. A study using Blue Cross-Blue Shield patients showed that further follow-up costs were reduced by 50% after one year and by an additional 20-30% in years two and three when compared to a matched control group. Other researchers have replicated these findings across the country.

In contrast, bypass surgery and angioplasty don't work very well to solve heart problems over time. In 2006, according to the American Heart Association, 1.3 million angioplasties and stents were performed at an average cost of \$48,399 each, or more than \$60 billion.<sup>5</sup> In addition, 448,000 coronary bypass operations were performed at a cost of \$99,743 each, or more than \$44 billion -- i.e., more than \$100 billion for these two operations. However a major randomized controlled trial found that angioplasties and stents do not significantly prolong life or even prevent heart attacks in stable patients (i.e., in most patients who receive them).<sup>6</sup> Earlier randomized controlled trials of coronary bypass surgery found that this procedure prolongs life in only a small fraction of patients -- those with left main coronary artery disease or its equivalent or where there is left ventricular dysfunction (ejection fraction less than 30%). Moreover, a recent randomized, controlled trial in diabetics found that neither bypass surgery nor angioplasty prolonged life or prevented heart attacks.<sup>7</sup> Thus, expanding use of this integrated medicine treatment strategy in place of more conventional post-surgical treatment would not only save money, but also produce a higher quality of life for those who used it.

- **Provide pro-active outreach to “catastrophic-cost” Medicare patients for case-management and health improvement:** Five percent of the American population generates 44% of medical costs for care. Medicare recipients make up 45.1% of that group. A proposed demonstration/evaluation trial would work with a subset of these highest cost patients after they have sufficiently recovered from acute care to return to their abode. It would be based on a successful program introduced by Federal Express as a cost-control program with their high medical cost employees.

For an eight-year period during the 1980s, when health benefit costs were increasing at twice the rate of the general inflation, Federal Express discovered that the economist Pareto's prediction applied to their workforce, i.e., that in any given year 20% of its workforce generated 80% of its health care costs. Fed Ex hired Options and Choices, a benefits management vendor, to reach out proactively to employees they identified each year as their “Pareto group.” Specially trained nurses proactively reached out to these employees and remained in contact with them. The nurses helped them manage their disease more effectively, and provided an impartial sounding board as patients thought through the advantages and disadvantages of various treatment options being recommended. They also motivated these employees to work at actively improving their health, coaching and encouraging them as they attempted to do so. This program was well-

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<sup>3</sup> Lloyd-Jones D, Adams R, Carnethon M, et al. Heart disease and stroke statistics 2009 update. A report from the American Heart Association statistics committee and stroke statistics committee. *Circulation*. 2009;119:e1-e161.

<sup>4</sup> Ornish DM, Brown SE, Scherwitz LW, et al. Can lifestyle changes reverse coronary atherosclerosis? The Lifestyle Heart Trial. *Lancet*. 1990; 336:129-133.

<sup>5</sup> Ornish D, Scherwitz LW, Billings JH, et al. Intensive lifestyle changes for reversal of coronary heart disease. *JAMA*. 1998;280:2001-2007.

<sup>6</sup> Boden WE, O'Rourke RA, Teo KK, et al. Optimal medical therapy with or without PCI for stable coronary disease. *N Engl J Med*. 2007;356:1-14.

<sup>7</sup> The BARI 2D study group. A randomized trial of therapies for type 2 diabetes and coronary artery disease. *N Engl J Med*. 2009;360:2503-15.

received by employees. Result: Federal Express kept its health benefits budget increases equal to the general rate of inflation, during a period of time when health benefits costs elsewhere were increasing at twice that rate.

In the intervening years, motivational wellness counseling protocols have grown still more effective, as have strategies for providing social support that creates a culture of wellness among recipients of services and their friends. Peers can be trained to offer support and encouragement as new health-building efforts are undertaken. Specially-trained public health nurses could implement such a program.

We propose a demonstration/evaluation project targeting a subset of the Medicare patients whose costs for care account for 80% of the costs of disease-care utilization. (Many highest-cost Medicare patients, of course, would not be eligible for this program: about \$120 billion of the Medicare budget goes for care of people during their last month of life. This program, in contrast, would be directed to people who have recovered from acute medical episodes sufficiently to return to their place of abode.) Potential participants could be identified as part of hospital discharge planning. The public health infrastructure that would be needed to support such a trial already is in place. Costs for pro-active disease-management/wellness outreach services to this group of highest cost users of Medicare-funded services would range between \$200-\$400 per year per targeted recipient, depending on location and difficulty of contacting them. Savings could be substantial, and per-capita costs for the pilot group could be compared with per-capita costs of catastrophic-cost Medicare enrollees in the same geographic areas who were not in the pilot study.

Federal Express found that its health cost increases for its total employee population stayed level with overall inflation during an eight-year period when healthcare costs elsewhere were increasing at twice the rate of inflation. The general rate of inflation over the next ten years is projected to average of 2-3% per year, while healthcare costs are projected to rise by an average of 9% a year. If this outreach program were used nationwide, after preliminary trials, and were equally successful, Medicare savings in avoided cost-inflation would be substantial. By reducing health care inflation, Medicare would save approximately \$31.74 billion in the first year and \$365 billion over a ten-year period.

- **Guarantee patient choices regarding preferred care as they age.** Assisting patients and their families in discussing and documenting their wishes improves quality of life. If this were a regular part of geriatric care rather than something reserved for end-of-life medical emergencies, it could protect patients' quality of life and save \$100 billion in unwanted treatments over a ten-year period.

Until this year, reimbursement to doctors for end-of-life counseling to encourage patients and their families to document their care wishes and provide power of attorney had bipartisan support. Now opponents of the healthcare legislative proposals have distorted discussion of this measure, calling it "pull the plug on grandma" legislation. This proposal has been removed from current bills. Yet this service would improve the quality of life for older patients. If reimbursement for such counseling cannot be restored this election cycle, nursing and medical school training and continuing medical and nursing education courses could help healthcare providers develop skills to assist older patients and their families address these questions together and document their wishes before medical emergencies arise. Improvement in quality of life for older seniors could be substantial, and savings to Medicare budgets would, as well.

About 2.2 million Medicare enrollees die each year. One third of the \$529 billion Medicare budget is spent on these enrollees in their last year of life (i.e., \$176.3 billion), or about \$80,000 per dying person. Eighty percent of that is spent during the last month of their life, and about \$34.5 billion during their final week, as physicians apply high-tech life-support procedures to keep patients alive a few more days.<sup>8</sup> (ICU usage accounts for 30% to 40% of

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<sup>8</sup> C. Hogan et al., "Medicare Beneficiaries Costs of Care in the Last Year of Life," *Health Affairs*, 20.4, quoted in US Department of Health and Human Services, Office of Research, Development and Information, "Last Year of Life Expenditures" May 2003.

expenses in American hospitals.<sup>9</sup>) Many patients and their families may want these heroic interventions, but others prefer quality time with family members once they understand the end is near. A recent study documented medical care costs for cancer patients who received information about end-of-life choices, accompanied by discussion with them and their families about what mattered most to them during these final days. Costs for their care were compared with costs for the care of cancer patients who did not receive this kind of non-coercive counseling. Final-week costs were 36% less for the patients who received end-of-life counseling and who then made their own choices about use of high-tech life-sustaining interventions.<sup>10</sup> No rationing of care is involved. Instead, patient-centered care lets patients and their families decide what matters to them.

What makes the difference in costs? Hospice cost averages about \$155 per day; skilled nursing facility daily costs average about \$500 per day, while hospital costs during the final week of life can average \$3500 per day.<sup>11</sup> Medicare managed care plans have been encouraging use of hospice as life ends, and currently 40% of their Medicare enrollees who are dying make some use of hospice.<sup>12</sup> The typical hospice patient is there about two and a half weeks before dying. With a short hospital stay often preceding their move to hospice, their end-of-life costs average about \$7150, contrasted with average end-of-life costs of \$24,500 for Medicare enrollees who remain in the hospital until death. If all Medicare patients and their families received informative and non-coercive counseling about end-of-life choices, and if half of the remaining 60% of Medicare patients made choices similar to those now made by people who use hospice, the additional end-of-life savings could be about \$17,350 for each of these new hospice users, and would come to about \$6.73 billion annually, or \$67.3 billion over a period of ten years.

Savings could be higher still if best-practices in geriatric primary care included discussions with patients and their families about quality-of-life choices that will be important to them if their health declines and encouragement to create living wills and designate a trusted person as medical power of attorney. Dying well can be part of living well. If these questions are faced earlier in the life-death process, more elderly and their family members could participate in these discussions without the emotional pressure of the final days. Would it then be reasonable to predict that the half of Medicare's dying patients who would have chosen less expensive care during their final week, might instead choose to hospice services for their final month? If they did, quality at the end of life could improve for them, and final-month costs would be about \$4.3 billion, instead of the \$26.4 billion that otherwise would be spent. Medicare savings over ten years could be about \$221 billion.

- **Provide incentives for best-practice prevention and wellness programs for Medicare and Medicaid patients.** The Chairman's Mark proposes to rely on physician advice to improve health and provides financial incentives to those who are successful. But best-practice proactive wellness and disease management programs are community (or workplace) based. Such programs, adapted for use by Medicare and Medicaid enrollees, could result in significant savings.

Blue Cross/Blue Shield has a wellness incentive program similar to that proposed in the Chairman's Mark. It is not proving to be cost-effective. Alternative approaches, however, are having success. The problem to be addressed is this: chronic diseases (i.e., the result of premature aging of a particular organ system, relative to the rest of the body<sup>13</sup>), while having genetic components, are strongly influenced by lifestyle choices. Prevention-oriented check-ups involving health risk appraisals and biometric measurements are useful

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<sup>9</sup> E. Campion et al., "Medical Intensive Care for the Elderly, a study of current use, costs and outcomes," *JAMA* 246, 2052-2056.

<sup>10</sup> B. Zhang et al., "Health Care Costs in the Last Week of Life: associations with end-of-life conversations", *Archives of Internal Medicine*, (169) March 9, 2009, 480-488..

<sup>11</sup> Report from Office of Medicare

<sup>12</sup> EG Seferian and B Afessa, "Adult Intensive Care Unit Use at the End of Life: A Population-Based Study" *Mayo Clin Proc.* July 2006 81(7):896-901; doi:10.4065/81.7.896

<sup>13</sup> Dr. James F. Fries, Stanford Medical School. See for example, Fries, "The Compression of Morbidity: Near or Far?" *The Milbank Quarterly*, 67:2, 1989, 208-232.

devices for drawing patients' attention to their health risks, but most seniors already know that they are risk (e.g., that they are over-weight, or smoke, or drink too much, or don't exercise enough, and the like). Most have tried to change these health behaviors and have failed. Telling them every two years to try again, and offering Medicare discounts if they succeed, will result in changed health behaviors for only a minority of those at risk. Research, however, shows that 50% or more can be successful at lifestyle change when provided with motivationally-oriented health coaching adapted to their own personalities and lifestyles, with information reinforcement and social support that creates a culture of wellness to encourage and socially reward their own self-improvement efforts. Most people who try to improve health behaviors need early experiences of success. They also need regular reinforcement of their efforts so that they do not revert to earlier habits.

The most effective health improvement programs have been developed for use at worksites. The best of these programs produce a 3:1 return on investment. They proactively reach out to clients, use skilled, motivationally-oriented health coaching, help clients access and use internet or other education resources, and help organize the social environment to create a supportive culture of wellness. Where wellness and chronic disease management are done jointly, (at a monthly cost of about \$25 per person enrolled) the return on investment ratio is \$5 saved for every dollar invested.

Ninety-eight cents out of every Medicare dollar goes to treat people with one or more chronic diseases. Retirees and the unemployed (i.e. Medicare and Medicaid populations) pose a special challenge for use of these programs, however, because most have no regular workplace that can provide social support for wellness. HR 3200 includes trust funds for community-based wellness demonstration/evaluation trials. Some of these trials should target senior citizens, identifying and mobilizing naturally occurring social groups, including church groups, and develop peer support and peer coaching for health improvement among seniors.

In short, prevention, wellness, and management of chronic disease can be done more cost-effectively with Medicare and Medicaid enrollees through community institutions than through semi-annual visits to a doctor.

## **2. Sponsor trials of cost-saving innovations with procedures for encouraging widespread use of those which are successful.**

Because no single "magic bullet" is likely to permanently solve the cost problem, we need on-going identification, experimentation, and evaluation of healthcare practices and healthcare management techniques. We need to fund demonstration projects of innovative solutions to identified problems that can be carefully evaluated for impact on quality of health and on costs. As promising approaches are identified, we need to test the feasibility of scaling them up for wider use, and make changes in reimbursement practices that will encourage their wider use. HR 3200, Affordable Health Care for all Americans, creates mechanisms for identifying unsolved and critical problems of access, quality, and cost control, beginning with demonstration projects to provide primary care "medical homes" in underserved areas which would provide cost-effective primary care, prevention, and wellness services. Other demonstrations, to be designed under Centers for Disease Control and Prevention auspices, will address community public health needs. HR 3200 establishes trust funds to create such demonstrations and to evaluate them for effectiveness, cost-benefit, and feasibility for wider use. It also gives the Secretary of Health and Human Services authority and responsibility to develop reimbursement practices to encourage wider use of successful new "best practices," including those that emerge from demonstration studies. Any bill coming out of the Senate should preserve these features.

Additional areas for demonstration projects with potentially high payoffs in Medicare and Medicaid savings include:

- **Targeted use of integrated medicine in hospitals**

Developing optimal healing environments can shorten hospital stays with improved outcomes for patients and staff. In the past ten years hospitals have become much more interested in the practice of “integrated medicine,” which combines traditional scientific medicine with complementary and alternative medical approaches to healing. (“Healing is the process of recovery, repair, and return to wholeness, as contrasted with cure, the eradication of disease.”—Wayne Jonas, Samuelli Institute)

By 2005, 26.5% of American hospitals reported that they were using some form of integrated medical practice. Some allow alternative practitioners to work directly with patients. Others form collaborative teams of medically-trained staff and alternative practitioners that work jointly with patients and their families. Other hospitals have introduced programs that encourage the self-conscious creation of healing intentions among the hospital staff, patients, and their families, while still other hospitals restructure the hospital experience itself to optimize healing potential. A Samuelli Institute report calls attention to hospital integrated medicine practices that show promising results: e.g., citing a study that reported a 56% reduction in risk-adjusted mortality among cardiac surgery patients in a hospital that has developed a collaborative teamwork approach; shortened length of stay, improved outcomes, as well as improved staff morale and lessened staff turnover in a hospital that uses mind/body programs to create a *healing intention* among staff, patients and family members; and similarly improved *functional* health outcomes where complementary and alternative practitioners join the treatment team.

Senate legislation should include pilot projects to evaluate the feasibility of expanding hospital-based integrated medicine practices. Pilot projects should implement and evaluate two types of programs: 1, those in which alternative practitioners work cooperatively with traditional practitioners and 2, those in which hospital employees are trained to use and integrate a variety of alternative techniques into the traditional hospital practice.

- **Alternative mechanisms for hospital administration costs**

Single-payer plans now used in some other countries have strikingly lower costs for hospital administration because they use hospital budgets that reimburse on an annual basis, rather than for individual care episodes. In several countries that have multiple payers for disease care, hospital budgets are set annually through negotiations between hospitals, physicians, and the set of insurers who pay for their services. Annual budgets can be adjusted for individual hospitals, depending on types of services provided, whether it is a teaching hospital, the population mix it serves, and other relevant factors. The various payers then divide these costs among themselves, based on their share of the patient load. In the U.S., 31% of total health care spending (over \$600 billion annually) is for hospital costs, with administrative costs comprising 20% to 30% of the hospital costs, varying from hospital to hospital. In contrast, in Canada, which has hospital facilities similar to those in the U.S., but uses annual-budget hospital reimbursement, administrative costs for hospitals average 9 to 11% annually.<sup>14</sup>

Dramatic cost savings could result from the use of annual budgets, but it should be tested for feasibility and possible unforeseen consequences before being used more widely. Congress should ask the Assistant Secretary for HHS (proposed in HR 3200) to encourage a small number of states to pilot the creation of annual budgets for hospitals through negotiations between all the relevant payers and care providers. AHRQ could assist in evaluating the impact of reimbursement through annual budgets on hospital administrative costs and total expenditures for hospital care.

- **New approaches to treatment of depression and post-traumatic stress**

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<sup>14</sup> Steffie Woolhandler, Terry Cammpbell, and David U. Himmelstein, “Costs of Health Care Administration in the United States and Canada, *New England Journal of Medicine*. Vol 349, 768-775, August 21, 2003. (Note: Canadians seem to be generally pleased with their hospitals: In 2002, Michigan, New York, and Washington hospitals treated only 154 Canadians who came to border-area U.S. hospitals for elective care. Among “America’s Best Hospitals” only one reported treating more than 60 Canadians a year. In a survey of 18,000 Canadians, only 20 had gone to the U.S. seeking care in the past year.)

Treatment of trauma-related disorders in the U.S. cost \$68.1 billion in 2006,<sup>15</sup> and costs have continued to rise. Meanwhile, a program with quite different cost implications has been introduced in post-Katrina New Orleans, and used in Kosovo, Palestine and Israel. It could have major cost-saving implications if adapted for use with Medicaid populations and veterans returning from combat. Working with low-income populations, communities and others dealing with major traumas, including Post Traumatic Stress Disorder (PTSD), the Washington, DC Center for Mind-Body Medicine<sup>16</sup> has developed a comprehensive program which trains health and mental health professionals, educators and community leaders in simple ways to deal with stress and psychological trauma and to provide effective programs of self care and mutual care for entire communities. In Kosovo, CMBM trained 600 professionals to address trauma and stress with such mind-body techniques as relaxation, meditation, guided imagery, biofeedback, and yoga as well as self expression in words, drawings and movement in a supportive small group setting. This has become central to the entire community mental health system and now serves some 2 million people. CMBM has developed similar programs in Israel, Gaza and post-Katrina southern Louisiana.

The Center initially provides training and support to leaders in relevant institutions – administrators, teachers, clinicians – and works with them to bring the approach to troubled children and adults. CMBM reports that this model has been effective with both children and adults who are significantly disadvantaged financially and who are having difficulty holding a job or succeeding in school. The techniques and approaches taught give many participants a sense of mastery where they have felt hopeless and powerless. It allows them to have successful learning experiences which have usually been unavailable to them. It provides them with a supportive community which helps them to relieve their immediate stress, and to which they can turn in times of crisis. Thus these programs both reduce medical costs and increase the economic contribution these populations can make.

Pilot programs could use these techniques with different at-risk populations. One program could work within the VA system targeting military personnel with multiple deployments. Another could work with Medicaid-eligible, long term unemployed or victims of natural disasters. Both types of programs would permit evaluation of improvements in health outcomes, improvements in broader social outcomes, and cost-effectiveness.

- **Lessening use of “defensive medicine”**

Malpractice insurance and malpractice lawsuits add about 2- 3% to healthcare costs each year, but doctors report that concern about possible malpractice suits leads them to order about 25% more diagnostic tests and referrals each year than they would consider medically appropriate and necessary. A few countries, including Sweden, address this problem by using *No-Fault Insurance*. HHS could encourage a small number of states to experiment with various approaches to malpractice insurance and awards, for a period of five years, with careful evaluation of public satisfaction and of its impact on the volume and costs for various diagnostic tests. The Chairman’s Mark recommends experiments in several states with different approaches to malpractice insurance. We endorse that proposal, and suggest that changes in volume and costs for diagnostic tests and referrals following introduction of a malpractice innovation be part of any evaluation that is done.

### **3. Reduce dependence on specialists who receive higher reimbursement rates**

America has twice as many specialist physicians per capita than do other advanced industrial societies whose citizens have better health status with lower costs for care. In the US reimbursement rates for physicians vary by specialty. The difference this creates in annual income has motivated medical students to disproportionately enter medical specialties. Specialists create their own market for services, and many seniors are seen primarily by a specialist, often for primary care services or follow-up of specialty care that

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<sup>15</sup> Agency for Healthcare Research and Quality, Medical Expenditures Panel Survey, Statistical Brief #248.

<sup>16</sup> Dr. James S. Gordon, psychiatrist, founder and director. Gordon chaired the White House Commission on Complementary and Alternative Medicine Policy from 2000-2002.

could have been done by less expensive personnel. We are unlikely to reform reimbursement rates this year, but other changes could help correct this cost dynamic in the long run.

- **Incentives for “medical homes” will produce greater cost savings if these incentives go for creation of “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 conceived in the Chairman’s Mark, the “medical homes” incentive may not change this practice. A hospital or other institution could declare itself an Accountable Care Organization and yet assign tasks done more appropriately by other health professionals to higher-cost specialists because of the current staff ratios of specialists to primary care physicians. With slight rewriting of the Chairman’s proposal, it could work as intended.

- **Adjust medical school training slot allotments**

To correct the ratio of specialists to primary care physicians in the future, medical school allotments should be adjusted. This will lessen the flow of medical students into specialties with the highest remuneration and increase the number of physicians offering primary care.

- **Keep HR 3200’s proposed revisions offering higher reimbursement rates for high quality primary care services.**

A commission should examine the spread of reimbursement ratios and recommend appropriate adjustments in future reimbursement for Medicare and Medicaid services.

- **Offer debt forgiveness to medical students for periods of service in primary care in underserved areas.**

In sum, we recommend that healthcare reforms create trial demonstrations before imposing national changes to healthcare reimbursement policies. We recommend the creation of mechanisms to continuously explore possible cost savings, including:

- ❖ Targeted use of prevention, wellness, lifestyle-related chronic disease management and integrated medicine in highest-cost areas of Medicare and Medicaid spending
- ❖ Institutional innovations such as annual hospital budgets, malpractice insurance reform, and changes in practices that skew the primary care/specialist ratio
- ❖ Procedures for incorporating use of promising innovations into reimbursement policy changes

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