

HOW CAN WE MAKE MEDICARE BETTER

Rochester Medicare Panel

Senator David Durenberger

August 17, 2008

The answer is to focus our major effort in Medicare reform on Part B, how Medicare pays physicians, and to do it now so it is the first Medicare reform of the new President, Democratic or Republican. This forum will tell you why. The proposals on the table for payment reform are all very rational, but unfortunately also quite political. My job this morning is to explain to you why with some history of the two key components: Physician Practice and Physician Payment.

In 1916, Doctor George Menninger sat in his railroad car as it sped him home to Kansas from Rochester MN. He wrote letters to his sons telling them to meet for dinner on Sunday because "I have been to see the brothers Mayo and I have seen the future." From that the Menninger Clinic was born. And so the early pioneers of clinical medicine, medical research and education, and medical technology focused on continually improving the practice of Medicine through integrating multiple medical talents and resources. The Mayo, the Olmsted Clinic, the Gunderson Clinic in LaCrosse. Etc.

So-called organized medicine in America was on an entirely different track. In the doctor patient relationship the doctor was in charge. His practice was his castle and the community his kingdom. By the 1930s, organized medicine had created Blue Shield to help finance their practices and Blue Cross to finance the hospitals in which they practiced. Free of charge. At the state level they legislated against any form of competition among doctors or from other practitioners, for insurance benefit mandates, and against cooperative organizations of multi-specialty or group practice physicians and surgeons.

When Medicare was proposed they fought hard and only bent to the will of President Johnson and Wilbur Mills when promised the government wouldn't try to change the system. Government would pay for usual and customary medically necessary services and the doctors would determine what that was and what they would charge. Blue Cross and Shield were employed to make sure Medicare did just that.

When I got to the U.S. Senate and its Finance Committee in 1979, the Democratic Congress and President Carter were desperate to contain escalating costs in Medicare and health care. In 1970 the business community had made health care cost containment its goal – when the national price tag was a mere \$60 billion. Eight years later Medicare and Medicaid alone were at \$60 billion. Republicans and Democrats worked together to keep Carter from imposing government budgets on hospitals and when Ronald Reagan became President, we decided to experiment with private health plan alternatives to traditional Medicare. They were called HMOs.

We had no way of measuring their effectiveness however. In 1983 we authorized HCFA to pay HMOs 95% of the amount they were paying doctors and hospitals. If HMOs could do quality care for less money, they could use the savings for additional services for beneficiaries. To compare effectiveness we created the AAPCC or average cost per county of beneficiary residence. That same year we decided to prospectively price hospital services for payment under Part A of Medicare. You know it as DRGs. So we were on a public-private track for the future of Medicare.

Both worked well. The DRG system meant hospitals that could safely reduce patient days and technology intensity could make money. It meant doctors could start doing in their clinics and offices what they had been doing in hospitals – and making money at it. Incentives were being realigned. On the HMO demonstration front it also worked marvelously well. But only in places where there existed a medical practice culture like the Mayo-Olmsted-Gunderson practice I referred to earlier. The upper Midwest especially MN-WI; the Pacific NW, Intermountain, Hawaii, Kaiser Permanente and some New England. In three years the new AAPCCs told us that providing doctors, hospitals, and insurers with mutually reinforcing incentives to practice less intense medicine where quality outcomes would permit it saved huge amounts of money.

This is the research we in Congress needed to provide people like me from a state like MN with the evidence we already suspected. That physician behavior and physician response to financial incentives varied remarkably across urban and rural communities, and between areas of the country in which prepaid medical groups and multi-specialty clinics predominated and those in which the fee for service doc was king.

By 1989 I was working with my chairman, Lloyd Bentsen Democrat of Texas to remedy the urban-rural differential across the country. He wanted to be helpful. When I suggested we also reduce the disparity in payments that resulted from the over-use of supply-induced medicine and technology he was less receptive. Texas was not Minnesota. Even though Scott White Clinic was a Mayo or an Olmsted. Then we knew the congressional board of directors needed the pressure of a national fiscal crisis or a national cost containment crisis to act in the national rather than parochial interest.

In 1989 we acted to curb the growing specialization of medical practice and the growth in diagnostics and surgery some of which was questionable. Thus was born the RBRVS system with volume performance standards to curb the natural instincts of doctors to prescribe more services when per episode costs were being restrained. In 1997 it was replaced by the Sustained Growth Rate limit (SGR) with disastrous consequences since 2001. I was told by HCFA in 1989 they would come up with an alternative to VPS to reward the more conservative practice pattern and they haven't. To this day they have not.

So today's challenge remains the same. The Medicare program costs seem uncontrollable. The payment disparity between technology-sensitive procedural medicine and family and community primary care has created surpluses in the former

(except ophthalmology and dermatology) and shortages of the latter which seriously threaten the future of access to health and medical services.

The answer lies in two areas: (1) Stop focusing on prices in medicine and start focusing on the elimination of harmful medical waste. Jack Wennberg, Elliot Fisher, Skinner et al at Dartmouth have used practice and geographic disparity to show us why this is essential and where to get the most for our political re-investment. Comparisons of hospital referral regions in the highest and lowest quintiles of per capita Medicare spending show us that high spending regions have more hospital stays, physician visits, specialist referrals, imaging and minor tests and procedures.

But all these additional expenditures apparently result in no better health outcomes, functional status, or patient satisfaction and, in some cases, are associated with slightly higher mortality.

If the gap between high and low spending areas could be compressed by changes in practice of medicine, very large cost savings could be achieved. A quality of care for patients substantially improved. Geographic disparity is a big one.

(2) Rebalance medical practice so primary care is more prominent (med education not bio-tech competition, stop hospital competition.)

MedPAC says Medicare can combine Parts A and B, bundle payments to physicians, pay for comparative results. As the system shows who is saving money by keeping people healthy and restoring health efficiently, leave the saved dollars with the decision-makers (Doctors not Insurers). That will encourage the integration of relationships among locally-based doctors, ancillary professionals, hospitals, and insurance plans. Medicare financing should focus on the leaders (high quality/high value) and on the losers (low quality, high cost, low value). Why? Because as the Wisconsin Collaborative on Healthcare Quality has proven, physicians all want to be the best and need to know they aren't and whom to emulate and what are the other rewards beyond professional satisfaction.

Because, as Amy Block, who runs the Medicare Advantage program told the students in my University of St. Thomas MBA Health Care class in April: "I hate to tell you this, but the MMA law requires us to pay 248% more to a private health insurance plan serving beneficiaries in Dade County (Miami) Florida, than it does in LaCrosse, Wisconsin." That kind of money should be used to reward the high quality, low cost docs in LaCrosse, not the insurance industry.