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Gail R. Wilensky, PhD

the future of Medicare

Improving the quality and cost of health care requires an ongoing commitment that would start in areas where we have better clinical information, such as hospitals. That's the thinking of Gail R. Wilensky, PhD, senior fellow at Project HOPE and former administrator of the Health Care Financing Administration. A proponent of using comparative clinical information to improve value, Wilensky sees value-based purchasing as an important component of healthcare reform.

She recently shared her thoughts on Medicare reform with *hfm*.

Q. As one who has been an insider to public policy development, as well as a close observer from outside government, what would you tell the healthcare industry about the prospects for significant healthcare reform to come in the next administration?

A. There will continue to be changes in Medicare in the next administration. The most likely is to revise the physician payment schedule—at least there will be a lot of pressure to try to do that—and to continue trying to introduce elements of value-based purchasing or pay for performance. But those are not fundamental reforms, in my view. I don't think the next administration will take on the issue of seriously reforming Medicare—that is, making Medicare financially viable—but the administration after that will be forced to. The unsustainable spend in Medicare will produce too much pressure on general revenue for the administration that starts in 2013 to avoid doing something. But I don't think it will be so great as to force significant change after the 2008 election.

In terms of more general healthcare reform, it's going to depend primarily on the composition of the Congress. As we saw in 1993 and 1994, it's not enough to have one party control both the White House and the Congress. I don't know whether there will be enough votes to pass the kind of reform that is being considered by, say, the top three contenders on the Democratic side, with projected costs of anywhere from \$70 billion to \$120 billion a year. Of course, there will be continued pressure to try to do something—including trying to get more quality and fewer errors into the system and maybe some changes in the reimbursement system as well.

It's certainly possible that the Congress will be ready to take on big healthcare reform, including the "big spend" component, but it's going to be tough, even assuming a Democratic president and Democratic majority, because of the large dollars involved. While the basic ideas in many of the proposals to moderate savings are not unreasonable, it would take several years at best until you would actually see savings, and the savings are much more uncertain than the spend, which is quite certain. That's going to make it hard when proponents go to the Congressional Budget Office for a "scoring"—that is, the official congressional estimate of the cost of the program—even assuming they're willing to substantially raise taxes, which most of the Democratic candidates have indicated they are, especially for the highest income individuals.

To me, that makes passage of major healthcare reform that significantly increases spending questionable.

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Q. You wrote in *Health Affairs* in November 2006 about the prospects for a Center for Comparative Effectiveness Information and the issues of where it could be located, how it could be funded, and the possible benefits. You indicated that while much of the focus up to then was on pharmaceuticals, a greater payoff than with drug spending might come from producing such data on medical procedures. The objective would be comparative information for use by consumers as well as for decision makers in both policy development and payment administration. At that time, it seemed any such progress would be glacial. What's the outlook now? Do you think the CMS value-based purchasing initiative will be something of a start in that direction?

A. The idea is generating a lot of interest in Washington, but interest and legislation are not the same thing. And it would take several years from roll out to get to a point where you're likely to get savings from it. Comparative effectiveness information is an important building block to learning how to spend smarter, but it is just providing the information. Ultimately, payers need to do a better job than has traditionally been done at differentiating what types of patient groups are likely to benefit from particular procedures or therapeutics. In the past, when a new procedure or a therapeutic came on line, it was sometimes adopted wholesale by anybody who appeared to be even remotely in the same category. The idea of comparative clinical effectiveness is to try to begin to understand better which subgroups in the population are likely to benefit substantially and which ones will benefit very little or not at all. Once the relative benefit is known, the cost for some groups relative to the likely benefit may seem totally out of proportion, but that is another issue.

The value-based purchasing initiative is an area that begins to move in the right direction. So is coverage with evidence development—a strategy that requires information to be provided through a registry in return for early coverage that helps

establish a body of information. These strategies are consistent with the spirit of helping to establish information on comparative effectiveness.

Legislation establishing a Center for Comparative Effectiveness *could* happen, but nothing is likely right now, other than re-authorizing SCHIP in some form and getting some of the spending bills through. But the issue is not going away.

I'm encouraged that Senators Clinton, Edwards, and Obama all have provisions related to comparative effectiveness and value-based purchasing in their programs, as does Senator McCain.

Q. From your involvement with the Maryland Health Care Commission, the Combined Benefits Fund of the United Mineworkers of America, and the Institute of Medicine, you no doubt have an opinion about how we can improve the quality of health care. What approach do you recommend?

A. We need to take a series of steps. I'm obviously a proponent of comparative effectiveness information. This is not a short-term, single fix. It is an ongoing commitment to investing in better information about the effectiveness of alternative therapies. The benefits from major new and existing clinical interventions may vary depending on the setting, and that is also important information to know.

I tend to view quality on a continuum, starting at the one end with patient safety and then extending to clinically appropriate care performed appropriately at the other end. I also support pay for performance; however, it's hard to implement because it requires better data than we now have, including better measurements and adjustments for risk. Of course, we're getting what we pay for now; we just don't like it. And the fact that pay for performance is hard is not a good enough excuse.

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Gail R. Wilensky

Gail R. Wilensky, PhD, an economist and a senior fellow at Project HOPE (an international health education foundation), analyzes and develops policies relating to healthcare reform and to ongoing changes in the health-care environment. She is a commissioner on the World Health Organization's Commission on the Social Determinants of Health, co-chair of the Department of Defense task force on the Future of Military Health Care, vice chair of the Maryland Health Care Commission, and a trustee of the Combined Benefits Fund of the United Mineworkers of America and the National Opinion Research Center. She is an elected member of the Institute of Medicine and has served two terms on its governing council. She is a former chair of the board of directors of Academy Health, a former trustee of the American Heart Association, and a current or former director on numerous other organizations. She is also a director on several corporate boards.

From 1990 to 1992, she was administrator of the Health Care Financing Administration, directing the Medicare and Medicaid programs. She also served as deputy assistant to President George H.W. Bush for policy development, advising him on health and welfare issues from 1992 to 1993. She chaired the Medicare Payment Advisory Commission from 1997 to 2001, and the Physician Payment Review Commission from 1995 to 1997. From 2001 to 2003, she co-chaired the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans. In 2007, she served as a commissioner on the President's Commission on Care for America's Returning Wounded Warriors.

have been required to provide more information. We have better information on hospitals because the Medicare Modernization Act increased the update for hospitals that reported quality data. Changes in physician payment that took effect in July—where physicians who report on agreed-upon measures will get an increase in their fee update—will help move physicians in that direction as well.

As I've indicated, we have to move on several fronts that collectively will provide for better information and better incentives. And we need to understand why it takes so long to disseminate new information about procedures and technology.

It would be easier, of course, if we had more physicians who were a part of multispecialty groups, but the fact is 75 percent of physicians practice in groups that have fewer than nine physicians. About

50 percent of physician groups have four or fewer physicians, most of which are single-specialty groups. These small groups make it harder to disseminate information and drive change.

Multispecialty group practices appear to provide peer interaction that promotes quality as well. There are strategies that could be adopted to make group practice more appealing, but we can't wait for institutional change. Many have been predicting moves to larger, more integrated practices, but it hasn't happened. We have to start trying to fix things given where we are, not where we'd like to have been.

Some specific strategies used by the United Mine Workers Health and Retirement Funds have a lot of appeal. They focus on the high spenders—providing extra support. For example, they have a geriatric case management program to support some

of the complex medical care needs of the highest users. And they are concerned about polypharmacy problems. All of their population tends to use a lot of pharmaceuticals, because it's an old, frail, sick population. But a couple of years ago, they spent time focusing on the highest users—those who use many, many prescriptions—and provided interaction with a geriatrician, who talked to some of the prescribing physicians to discuss the most appropriate use of pharmaceuticals.

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Targeting the highest spenders is key to improving quality and moderating spending. We know that healthcare spending in the United States and everywhere else in the developed world is very concentrated. Focusing on the 10 percent of highest spenders can make a big difference—to them and to the rest of us. Where appropriate, these same strategies could be used in the broader community.

Q. If Congress and the administration called upon you tomorrow and asked you to set the direction for Medicare by naming and directing (meaning you're going to have to deliver them) the five most important changes to the program, what would those be?

A. First, we've got to fix the physician fee schedule, which requires moving away from a disaggregated fee schedule, with an expenditure limit. And it means bundling, however we're going to do it. As I've indicated, I find the notion of bundling for chronic care and bundling for the high-cost/high-volume DRGs that have a lot of variation in them to be a way to start moving in

that direction. I'd start the effort to fix the physician fee schedule with a requirement that it be ready for implementation in three years.

The second is to begin to put in place pay for performance in the areas that appear to be ready and to drive improved measurement in the areas that are in the process of getting ready, which includes physicians and nursing homes. The areas that are probably ready now are renal centers, hospitals, and Medicare Advantage plans. Home care is in between; it's not quite ready for prime time. By introducing pay for performance first in the areas that are ready to go, you begin to drive payment in the direction that you want it to go in.

Third, we should adopt the federal employees health model for Medicare, which would include a traditional Medicare program. That is, it would include an administered pricing program that looks like traditional Medicare as one of the offerings and a variety of Medicare Advantage plans as other offerings. Seniors could choose the plan that they want, with the government's contribution being the same, irrespective of the plan that is chosen. This model is similar to the structure discussed by the Breaux-Thomas Commission in the late 1990s.

Fourth, I would continue the move toward income-relating Medicare that has begun with the Part B subsidy change that started in 2007. I would continue that as well, and move into more areas in Medicare.

And fifth, I would try to move Medicare into more evidence development. This would be a much broader initiative than just Medicare. And to the extent that it isn't Medicare-specific, I would start using the value-based purchasing strategies. ●