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How Obamacare Empowers the Medicare Bureaucracy: What Seniors and Their Doctors Should Know

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The Patient Protection and Affordable Health Care Act (PPACA) is projected to yield \$575 billion in Medicare savings over the next 10 years, mostly from Medicare payment reductions to doctors, hospitals, and health plans. But beneath these payment reductions, the PPACA also makes statutory changes that could challenge the autonomy of physicians to treat patients as they think best, undercut the freedom of physicians to remain in private practice, and threaten the continuation of fee-for-service medicine regardless of the preferences of doctors and patients.

The statutory text is an insufficient guide as to how exactly these provisions will affect seniors and their doctors. Forthcoming regulation will be revealing. Health and Human Services (HHS) Secretary Kathleen Sebelius and Dr. Donald Berwick, administrator of the Center for Medicare and Medicaid Services (CMS) will have primary responsibility for implementing Medicare changes. Berwick's recess appointment as CMS administrator spared him Senate confirmation hearings and a public exploration of his widely reported views praising the British National Health Service (NHS).

Getting “Evidence-Based Medicine” Right. Under Title VI, Section 6301, Obamacare created the Patient-Centered Outcomes Research Institute, which will establish research priorities and studies that compare the effectiveness of medical and surgical treatments. It will replace the 15-member Federal Coordinating Council for Comparative Effectiveness Research created in the stimulus bill last year.

There is nothing new, of course, about “evidence-based medicine.” When reliable and sufficient data become available, physicians here and abroad author papers published in professional, peer-reviewed journals that highlight effective treatments. This is how medicine evolves.

There is also nothing objectionable about the new institute if it merely serves to expand scientific knowledge secured through rigorous analyses of reliable data, thus strengthening the statistical significance of evidence-based studies. The Congressional Budget Office (CBO) in its December 2008 analysis of the impact of 115 options for controlling health care spending, however, concluded that “the results of that research would gradually generate modest changes in medical practice as providers responded to evidence on the effectiveness of alternative treatments, the net effect of which would be to reduce total spending on health care in the United States by an estimated \$8 billion over the 2010–2019 period (*or by less than one-tenth of 1 percent*).”¹

Standardizing Care? The key issue, to be resolved through regulation, is the precise relationship between providers' reimbursement and plan coverage and the findings of comparative effective-

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ness research. Under Title VI, Section 6301 of the PPACA, the Secretary can use “evidence and findings from [comparative effectiveness] research” to make coverage determinations under certain statutory conditions² and cannot deny coverage of items or services “solely” on the basis of that research. Nonetheless, these statutory conditions are not to be construed as “preventing” the Secretary from using such evidence in determining coverage or reimbursement. The turgid text will engender a rat’s nest of regulatory complexity.

The likely result: Doctors will be coerced into standardizing patient care. Veteran *New York Times* reporter Robert Pear notes that “Dr. Berwick said doctors and hospitals should follow ‘protocols, guidelines and algorithms for care,’ based on the idea that ‘someone knows or can discover the best way to carry out a task or reach a decision, and that improvement can come from standardizing processes and behaviors to conform to this ideal model.’”³

The day-to-day practice of clinical medicine is an inexact science. Evidence-based medicine is at its best when it informs a clinical decision rather than dictating it. Physicians know that treatments that prove effective for the vast majority of the population studied may not be the best for those who are two or three standard deviations from the mean. Statistical outliers are patients, too. Patient treatment should ultimately be determined by the physician’s decisions based upon what is best and most effective *for that individual patient* and not for a statistical population of patients. Preserving physicians’ professional independence is absolutely critical to good patient care.

Changing Physician Practice. In its 2008 Health Tracking Physician Survey, the Center for Studying

Health System Change found that 32 percent of American doctors practiced in solo or two-physician practices, and 15 percent practiced in group practices of three to five physicians. Payments for these 47 percent of practicing physicians are largely fee-for-service.

Under Title III, Section 3021 of the PPACA, Congress authorized the creation of the Center for Medicare and Medicaid Innovation within CMS. The new center is to propose alternatives to fee-for-service reimbursement by developing and testing “innovative payment and service delivery models to reduce program expenditures...while preserving or enhancing the quality of care furnished.” The HHS Secretary has the regulatory authority to “expand the duration and the scope of a model” that appears promising under the law’s evaluation standards. These models can be incorporated into Medicare and Medicaid.

These models may include:

- “Promoting broad payment and practice reform in primary care...and models that transition primary care practices away from fee-for-service based reimbursement and toward comprehensive payment or salary-based payment,”
- “Contracting directly with groups of providers of services and suppliers to promote innovative care delivery models, such as through risk-based comprehensive payment or salary-based payment,” and
- “Promote care coordination between providers of services and suppliers that transition health care providers away from fee-for-service based reimbursement and toward salary-based payment.”

It appears that this provision would give Dr. Berwick the authority to implement policies he

1. Congressional Budget Office, “Budget Options,” Volume I: Health Care, Option 45, Fund Research Comparing the Effectiveness of Treatment Options, p. 86 (italics added).
2. Under Section 6301, “The Secretary may only use evidence and findings from research conducted under Section 1181 to make a determination regarding coverage under Title XVIII if such use is through an iterative and transparent process which includes public comment and considers the effects on subpopulations.” The law amends Part D of Title XI of the Social Security Act and adds a new Section 1182, “Limitations on Certain Uses of Comparative Effectiveness Research.” Among other things, the provision specifies that its use must result from an “iterative” and “transparent” process of public comment and consider its effect on subpopulations; it cannot be used in such a fashion to discriminate in the treatment of older or younger patients; it cannot preclude an individual from choosing a valued alternative or employ a “dollars-per-quality-of-life years” measurement that discounts “the value of a life” because of a patient’s disability.
3. Robert Pear, “Settling Down to a New Job, but Hampered by Old Words,” *The New York Times*, July 27, 2010, p. 11.

advocated before he became CMS administrator. In his July 2008 address on occasion of the 60th birthday of the British National Health Service, he said, “In the United States, our care is in fragments. Providers of care, whether for-profit or not-for-profit, are entrepreneurs. Each seeks to increase his share of the pie, at the expense of others. And so we don’t have a rational structure of inter-related components; we have a collection of pieces—a caravan site.”⁴

One such change agent is an Accountable Care Organization (ACO). Created under Title III, Section 3022 of the PPACA, an ACO is a voluntary grouping of health care providers, including primary care physicians, who agree “to become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to it.” The HHS Secretary “shall determine an appropriate method to assign Medicare fee-for-service beneficiaries to an ACO based on their utilization of primary care services.”

In other words, the ACO will provide the bulk of beneficiaries’ primary care services. By law, an ACO is to have at least 5,000 Medicare fee-for-service beneficiaries assigned to it. If an ACO meets federal quality and efficiency thresholds, its participating health care providers may financially profit by sharing in the savings it achieves in caring for its assigned Medicare beneficiaries. While consortia of health care providers (including university hospitals and large clinics) have experimented with the concept, ACOs are still a work in progress.

Although Section 3022 specifies that the HHS Secretary shall assign fee-for-service Medicare beneficiaries to ACOs, the CMS Office of Legislation states, “Assignment will be invisible to the beneficiary, and will not affect their guaranteed benefits or choice of doctor. A beneficiary may continue to seek services from the physicians and other providers of their choice, whether or not the physician or provider is a part of an ACO.”

Despite that assurance, Title III is not an academic exercise. It is creating payment models resembling managed care to replace traditional fee-for-service Medicare, which enrolls 77 percent of Medicare beneficiaries and reimburses 47 percent of America’s practicing physicians. Unlike a fully transparent, patient-centered, “premium support” program—in which Medicare patients would control the flow of health care dollars to health plans and providers of their choice—Title III is “provider-centric” and bureaucratically supervised.

While there is obviously nothing wrong with experimenting with new models of physician payment, it should take place in an economic environment where patients control the flow of dollars in the system. It appears that the law’s replacement of traditional Medicare fee-for-service payment is to be coupled with a form of managed care, meaning that Medicare patients’ choice of physicians and treatment options is limited by those doing the managing. Without that “managing,” these “shared savings,” capitation, or similar reimbursement models will fail to achieve profits for the participating providers.

Finding Out What’s in It. Notwithstanding official Washington’s promise that nothing would change in the doctor–patient relationship, the PPACA will affect the private practice of medicine and surgery and impact Medicare patients enrolled in traditional fee-for-service Medicare. Millions of Americans have already expressed their misgivings about the new health care law. When the Medicare bureaucracy ramps up its issuance of regulations, they will learn, in detail, that its consequences for them are not quite what its congressional champions have advertised.

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4. Dr. Berwick’s speech is available from the Physicians for a National Health Care Program at <http://www.pnhp.org/news/2010/may/a-transatlantic-review-of-the-nhs-at-60> (August 24, 2010).