
# A Blueprint for a More Effective, Physician-Directed Health System

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Authored by: Jeff Goldsmith, Ph.D.
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## About The Physicians Foundation

The Physicians Foundation is a nonprofit 501(c)(3) organization that seeks to advance the work of practicing physicians and help facilitate the delivery of healthcare to patients. As the U.S. healthcare system continues to evolve, The Physicians Foundation is steadfast in its determination to strengthen the physician-patient relationship and assist physicians in sustaining their medical practices.

The Foundation participates in the national healthcare discussion by providing the perspective of practicing physicians on the many issues facing them today. This includes identifying how The Patient Protection and Affordable Care Act and other aspects of health system reform impact physicians, and what should be re-assessed or changed in order to achieve the following goals:

- Provide physicians with the leadership skills necessary to drive healthcare excellence
- Offer physicians resources to succeed in today's challenging healthcare environment
- Understand evolving practice trends to help physicians continue to deliver quality care to patients
- Meet the current and future needs of all patients by assessing the supply of physicians

The Physicians Foundation pursues its mission through a variety of activities including grantmaking, research, white papers and policy studies. The Foundation provides grants to nonprofit organizations, universities, healthcare systems and medical society foundations that support its objectives and, since 2005, has awarded numerous multi-year grants totaling more than $28 million.

The Physicians Foundation also examines critical issues affecting the current and future healthcare system by periodically surveying physicians and patients, and studying the impact on them of government healthcare policies. The Foundation believes that as America evaluates significant changes in healthcare, the perspectives of practicing physicians and all patients must be well-understood and addressed.

For more information, please visit www.PhysiciansFoundation.org

## Introduction

As it moves inexorably toward implementation, it is becoming clear that health reform, as envisioned in the Affordable Care Act of 2010, will not fix our health system. While providing coverage for perhaps 30 million Americans represents progress, fundamental flaws in the legacy health payment and care systems will result in squandering a lot of the new funding without improving Americans' health.

The US healthcare system has been changing rapidly in anticipation of health reform. Specifically, it has been consolidating into regional hospital monopolies that are narrowing patients' choices and driving up the price of healthcare to patients, businesses and health insurers. Hospital systems are also using their enhanced bargaining leverage with health plans and the resultant cash flow to absorb their physician communities, locking down healthcare markets. Further, in most American communities, two or fewer health insurers control half or more of the health insurance market. Patients and their physicians find themselves marginalized in an increasingly corporate and uncompetitive healthcare marketplace.

The central questions in health reform are how to obtain better value for the healthcare dollar and how to engage patients more effectively in improving their own health. Because they are the pivotal contact point for patients and their families, physicians can play a decisive role in achieving both better health for patients and a more effective health system overall – by helping patients manage their health risks and by finding the most cost-effective solutions to patients' health problems when intervention is required. If patients and physicians are submerged in vast bureaucracies, however, that potential will never be realized.

The purpose of this Blueprint is to delineate some principles for redesigning the US healthcare system to strengthen the patient-physician relationship, and to leverage effectively physicians' capacity to save their patients both money and suffering.

## A Vision

This Blueprint envisions a simpler, more balanced and more effective health system that covers everyone, a system built upon the foundation of a strengthened patient-physician relationship. Health costs should be reduced, not merely slowed down. To do this, we need to put patients back in charge of their healthcare, and give them not only better cost and quality information, but also a meaningful stake in saving money. Physicians need to be paid for maintaining relationships with patients and for providing complete solutions for their clinical problems. Healthcare payment, public and private, needs to be dramatically simplified to reduce overhead expenses and increase clinician time spent with patients.

## Core Principles

"A Blueprint for a More Effective, Physician-Directed Health System" proposes six core principles:

1) ***Offer Patients Multiple Choices in Relationships and Clinical Solutions*** and share with them the savings resulting from making high value choices

2) ***Consolidate and Simplify Payment Transactions*** to reduce both provider and insurer overhead expenses

3) ***Ensure that Everyone Bears Some of the Economic Risk and Cost*** based on their ability to pay

4) ***Strengthen the Patient-Physician Relationship*** by paying on a subscription basis for physicians' services; Patient-physician relationships should vary in intensity and focus based upon the patient's needs and health risks

5) ***Improve Teamwork and Continuity in Healthcare Provision*** by paying on a bundled basis for complete solutions to medical problems, including care planning and recovery / rehabilitation

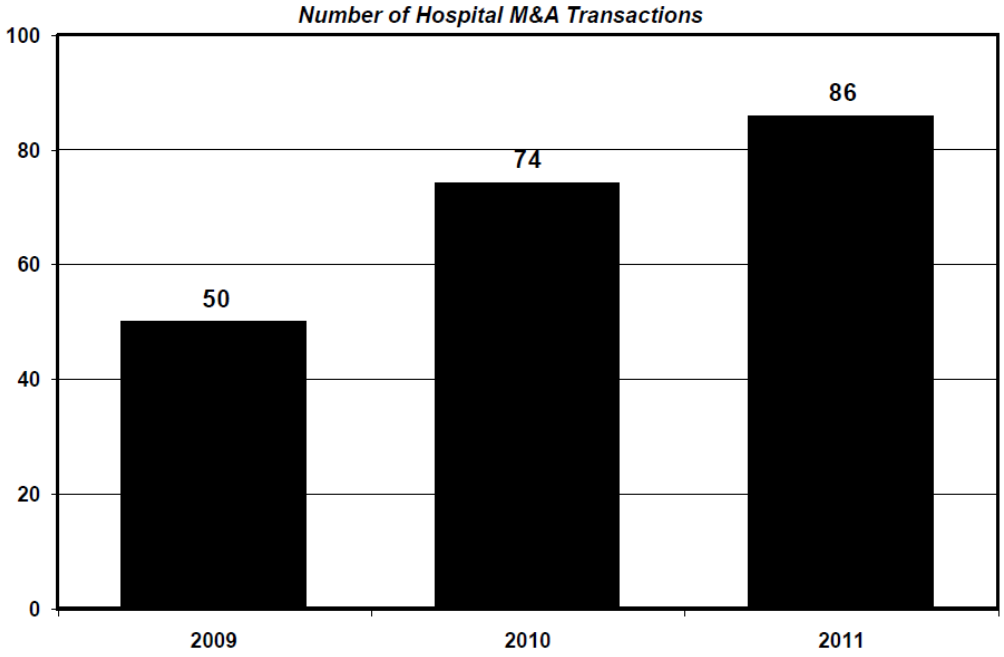
6) ***Encourage physicians in integrated delivery systems*** to assume clinical and cost management of their patient population

## A Rapidly Consolidating Healthcare System

Health reform has spurred a marked increase in merger and acquisition activity in US healthcare. Healthcare consultants and financial experts have convinced hospital boards that even $2 to $3 billion healthcare enterprises are "too small" to cope effectively with whatever health reform will bring. Though financially interested "experts" talk about economies of scale from hospital mergers, the evidence is extremely thin.[1] What is clear, however, is that near-monopoly hospital providers can force health insurers to pay them near-monopoly rents on their services. [2]

A recent *Los Angeles Times* analysis noted that northern California hospital expense is 56 percent higher per capita than in southern California.[3] Labor and capital costs in the two parts of the state are virtually identical. The crucial difference is that northern California has a highly consolidated hospital market dominated by three hospital systems – Sutter, Dignity Health (formerly Catholic Healthcare West) and the University of California System – while southern California remains highly competitive.

# Exhibit I
# HOSPITALS RESPOND TO HEALTH REFORM




Source: Kaufman, Hall, 2012

Hospital systems with dominant market positions have used those positions to generate extraordinary earnings (see Exhibit II). Hospitals are using the cash flow generated by near-monopoly status to acquire the practices of independent physicians in their communities. The American Hospital Association estimated in 2010 that hospitals employed 212 thousand physicians directly, a 32 percent increase from 2003.[4] That number is certainly higher now.

Not only do these acquisitions result in sharply higher prices for physician services.[5] But hospitals also exert pressure on the acquired physicians to redirect their imaging and surgical referrals from lower cost, freestanding providers to the hospital, which can charge as much as two to five times higher rates than freestanding providers for the same services.[6]

# Exhibit II
# HOSPITAL SYSTEM MARKET DOMINANCE

| Hospital System | Market Dominance | 2011 EBITDA |
|---|---|---|
| Sutter Health | Sacramento/SF Bay Area | $1.185 billion |
| Ascension Health | Austin/Nashville | $1.119 billion |
| Adventist/Sunbelt | Orlando | $998 million |
| U Pitt Med Center | Pittsburgh | $779 million |
| Providence Health | Portland/Spokane | $722 million |
| Intermountain HC | Utah | $715 million |
| Partners HC | Boston | $702 million |
| Baylor Health | Dallas | $557 million |
| Indiana Univ Health | Indianapolis | $490 million |
| Texas Health Res | Dallas | $460 million |
| Advocate Healthcare | Suburban Chicago | $460 million |
| Northshore LI J | Long Island NY | $459 million |
| BJC Health System | St. Louis | $449 million |

Source: EMMA Database, 2012

One rationale for hospital consolidation is that it is a response to highly concentrated health insurance markets. In the majority of large American metropolitan areas, two health insurers control more than half of the health insurance market. In a surprising number of states (nineteen, including DC), two health insurers comprise 70 percent or more of the market.[7]

Health insurers face numerous challenges from the escalating regulation brought by the Affordable Care Act. But they are less accountable to consumers in markets where one or two insurers dominate markets. Some large health insurers are acquiring physician practices to avoid being completely locked out of hospital-dominated physician markets.[8]

In states where hospital and health insurer markets have simultaneously consolidated, competitive forces have attenuated to the point where neither is capable of advocating effectively for the patient. The healthcare "market" in those states has degenerated into a

World War I style poisoned battlefield where hospitals and insurers have neither the incentive to compete, nor the leverage to drive down the cost of care.

## How Physicians Can Help

In highly consolidated hospital and insurance markets, physicians may be the only remaining leverage point to encourage cost-sensitive medicine. Physicians have a crucial role to play in controlling costs not only because they continue to direct individuals' healthcare, but also because they know where the waste lies. Independent physician services and physician controlled ambulatory care are also much less expensive than comparable hospital services. Large cost savings can be achieved by leveraging the physician's role in coordinating a patient's healthcare, and by using their knowledge of the patient's individual situation to reduce health spending for avoidable or preventable conditions.

## Healthcare Payment: Strangling Caregivers in Busywork

The US healthcare payment system is by far the most complex and costly in the world. US physician groups spend almost $83,000 a year per physician on the insurance billing process.[9] Caregivers of all stripes, not just physicians, devote a large and growing fraction of their workdays to generating documentation related to clinical billing. Despite declining office visit volume, American physicians added 162 thousand office staff between 2007-2011 to cope with escalating documentation demands as well as clinical IT support.[10]

While laudable in its aims, the clinical quality movement has dramatically expanded the physician's documentation burden with questionable consequences for actually improving care.[11] The logistical burden of the current system of micro-accountability has raised costs for every provider of healthcare – including hospitals, physicians, long term care providers and pharmacies – while diminishing the time available for health professionals actually to care for their patients.

**Pay for Relationships, Rather than Visits**

It is urgent that healthcare payment in the United States – both private and public – be simplified and the number and complexity of payment transactions be markedly reduced. To reduce this unmanageable burden, per-incident, fee-for-service payment for two large classes of health services should be replaced by simplified payment models. Instead of paying physicians they see regularly for visits and testing, patients should subscribe to their physicians' services, paying a single monthly fee for a continuing relationship. Fee-for-service payment does not disappear. Rather, it is reserved for unscheduled events where care use is unpredictable and therefore difficult to manage.

The relationships covered by subscription payment should vary in intensity and cost based upon the patient's age and health risks. The subscription should cover routine desktop dry chemistry testing and generic drugs should be made available at cost. But physicians should not be held at risk through these subscriptions for the rest of the patient's medical costs. They would be held at risk only for their own time and that of their supporting staff and overhead. A physician's staff and overhead can be deployed to improve service and increase the time that patients who need to visit can spend with their physician.

It is not only primary physicians who should be paid in this way. For patients with life-changing clinical risks – such as mental health, congestive heart failure, congenital defects, etc. – the appropriate specialists should be available through relationship-based payment as well. For the sickest patients, promising new care models that help patients address serious health risks should be funded through this approach. All patients who wish to have a relationship with a physician should be able to have one, either paid by private or public insurance or by patients directly from health savings accounts.

**Pay for Clinical Solutions, rather than Admissions and Procedures**

When patients become acutely ill or are diagnosed with conditions requiring clinical intervention (i.e., surgery, chemotherapy, interventional cardiology or radiology, etc.), providers of care, including physician teams, should be paid for providing complete solutions to that illness where possible – rather than be paid on a "piecework" basis. Instead of generating as many as a dozen separate streams of payment after the fact of care, clinical teams should receive a single, severity-adjusted payment determined in advance, which that covers not only the clinical intervention but also the recovery and rehabilitation from that episode.[12]

Physician-directed clinical teams will create clinical protocols based upon the latest available scientific evidence to guide care. Physicians should determine for themselves how and how much team members, including the hospital and post-acute providers, should be paid. Surgical complications, infections and readmissions would not generate additional payments to hospitals and consulting specialists, as they do today. Teams that can reduce complications by rigorous clinical management would generate bonuses if their costs came in below the fixed unified payment. To further support this approach, clinical teams should have access to reinsurance, to protect themselves against catastrophic case expenses and to narrow their economic risk.

**Fee-Based Payments Remain, but Inside a Global Budget**

For the balance of direct patient care – such as unscheduled care, emergency visits and hospitalizations – payment would continue to be made as it is now, subject to nominal patient copayments. However, these fee-based encounters should occur (wherever possible) within an annual fixed cost envelope managed by physician organizations for the patient populations under their care. Global budgeting for a defined patient population is the most effective tool for restraining the incentives to increase service volume beyond that which is strictly necessary for quality patient care.

New physician organizations should be formed to assume collective responsibility for overall annual health costs of enrolled populations within a fixed budget. The purpose of these organizations – such as Independent Practice Associations like Hill Physicians, multi-specialty physician groups like CareMore or HealthCare Partners, or physician-sponsored health plans like those of Geisinger or Marshfield Clinics – would be for physicians to assume collective responsibility for the costs of defined populations of patients, either through global risk contracting with health plans, or through direct health plan sponsorship.

Past efforts by physicians to assume global risk sometimes foundered on inadequate information provided by health plan partners, as well as on inadequate clinical data systems and poor communication inside the risk-bearing physician organization. Solving these problems with newly available technologies and connectivity is a vital precondition of successful global risk contracting.

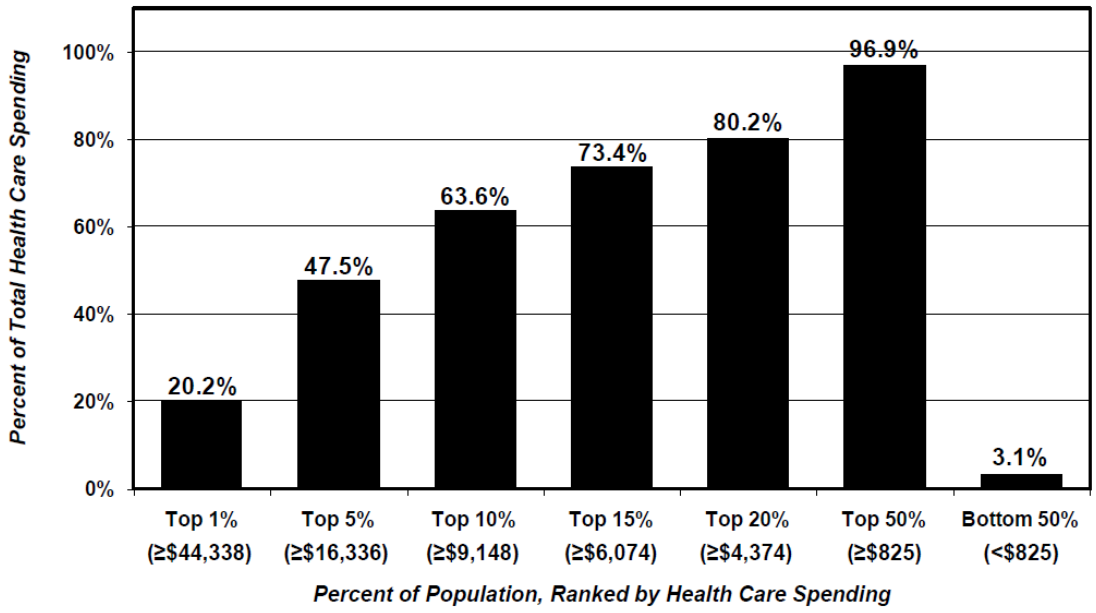
The first two forms of payment, subscriptions and clinical solutions, should take place within a global, physician-managed envelope of cost responsibility – which represents the third form of payment. In all three forms of payment – subscription, clinical solutions and global budgeting – physicians and their patients (not actuaries, insurance executives, utilization review nurses or hospital executives) will determine where and how patients' needs are best met. Employing all three levels of physician-directed care is the best defense against unnecessary healthcare use and cost.

## Paying for Relationships: How Would It Work?

A one-size-care-system not only does not fit all; rather it fits everyone badly. Matching the physician relationship to the health risks and circumstances of the patient will require diverse and flexible care models. As can be seen from the following graphic, the healthiest 50 percent of people in the US generate but three percent of overall health costs. These healthy folks need a different type of physician relationship than the sickest five percent, who generate almost 48 percent of overall health costs (see Exhibit III).

Even the sickest 5 percent are incredibly heterogeneous. This population includes children born with serious congenital defects, elderly patients with multi-function chronic illness, younger people who are para- or quadriplegic, the morbidly obese, HIV patients, people with complex cancer problems and people nearing or at the end of life – as well as patients with very expensive illnesses definitively resolved by a single intervention.

**Exhibit III**
**CONCENTRATION OF HEALTH CARE SPENDING IN THE U.S. POPULATION, 2008**




Source: Kaiser Family Foundation calculations using data from U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey (MEPS), 2008.

For the youngest and healthiest patients, relationships that leverage mobile computing and social networking technologies are likely to offer one answer.[13],[14] Finding an efficient way for physicians and their supporting staff to answer questions such as, "Is this something that needs immediate attention?" or "Should I continue taking the medication you prescribed?" or "Where can I get more information about condition X?" is the key. Perhaps 80 percent or more of interactions with these patients will be electronic in some form (i.e., telephone, IM / text, email, Twitter, videoconference).

Even many diagnoses (i.e., for skin conditions, infections, etc.) can be made with photo images conveyed by smartphone. In-person physician visits could then, in turn, be much longer because they are focused on problems that truly require an in-person encounter.

Moving up the intensity spectrum, patients with one or more chronic conditions probably require something resembling today's Patient Centered Medical Home (PCMH), a physician-directed clinical care model supported by advanced practice nurses and flexible electronic health records with patient portals.[15] Though this idea originated in pediatrics and has been developed extensively for family practice, this Blueprint's vision of the PCMH incorporates specialty care relationships as well.

## Exhibit IV
## RELATIONSHIP BASED PAYMENT: SOME MODELS

| Model | Target Population | Focus | Econ Risk to Physicians |
|---|---|---|---|
| Direct Pay | Healthiest 50% | Continuous Communication, Risk Evaluation | Low |
| Patient Centered Mecial Home | Single or Multiple Chronic Disease Risks | Care Co-ordination, Patient Compliance | Low/Moderate |
| Ambulatory ICU/ Extensivist | Serious Chronic Illness | Whole Life Management/ Aggressive Care Co-ordination | Variable |

Some chronic conditions, such as mental illness, congestive heart failure and some forms of cancer, are so pervasive in their effect on patient's wellbeing that effective care co-ordination directed by specialists in those conditions is the key to avoiding more expensive medical problems. The PCMH care model has become too complex and costly

for that healthiest 50 percent, and should be reserved for those patients with definable health risks requiring tighter clinical co-ordination and management.[16]

Rather than being paid on a per visit basis with an additional medical management fee, this form of relationship, like those for healthier patients, should be paid on a subscription basis – with the monthly subscription amount adjusted for severity of the patient's clinical condition (e.g., age, co-morbidities).

In all cases, a major goal of the subscription model to reduce both the volume and complexity of payment transactions, and enable the physician's supporting staff to focus not on documentation and getting paid, but rather on supporting the patient relationship. This goal is defeated by retaining fee-for-service billing and creating a shadow system for reconciling annual costs – a major problem with the so-called Accountable Care Organization and some of the other new payment models being studied by the CMS Innovation Center.

The subscription payment is also not capitation; the PCMH is not intended to function as a 1980's style "gatekeeper," nor is it to be held responsible for the cost of hospitalization or other complex care. The PCMH is intended to co-ordinate, not ration, care. PCMH providers have the limited risk of delivering a more complex primary care product for the sum of their subscribers, times the fixed price.

At the highest end of the acuity spectrum, there are patients so compromised by health risks and unstable living circumstances that they require what is being called "ambulatory intensive care." These are patients for whom the present "primary care" physician is oftentimes the hospital emergency room, and whose annual health costs can easily exceed $1 million.[17] Often, these so-called "super users" are homeless, with serious mental health co-morbidities or unstable family circumstances where there is no reliable caregiver. However, "super users" also exist in employed populations and could benefit from similar aggressive interventions and measures.[18]

Here, the relationship required encompasses the patient's living circumstances and requires aggressive, community-based outreach and continuous, high intensity contact with the clinical team operating under the supervision of an "extensivist" – a new type of internal medicine physician who specializes in community based practice for the seriously ill.

In all these cases, effective relationships can markedly reduce both emergency visits and hospitalizations. They also involve tighter co-ordination of pharmaceuticals, with the goal of encouraging adherence and avoiding adverse drug interactions. In a population health funding model such as advocated above, these reductions in institutional costs can generate significant savings to the risk-holding entity, whether physician controlled or not. But clinicians holding risk for those costs is not essential for the ambulatory intensive care model to work effectively.

**Pay for Clinical Solutions, Not Admissions and Procedures**

When patients become ill and are diagnosed with a complex clinical condition, effective care co-ordination and a predictable, high quality response often do not occur. As many as a dozen clinical actors, including specialty consultants, diagnostic providers and hospitals, may derive separate streams of payment for responding to the patient's problem. They are paid separately whether the job is done properly or not, and no single actor is responsible for seeing the clinical problem through to an appropriate conclusion. In effect, separate professionals who ought to be working closely together receive payment whether they cooperate or not.

The situation could be likened to attempting to construct a house without a general contractor. Under the present payment system, each subcontractor performs his or her own piece of the project and draws upon an unlimited budget, with no-one directly accountable for completing the work or assuring that what is constructed meets the owner's needs. In all too many cases, the patient's family serves the role of general healthcare contractor by default – though they lack understanding of illness and the

appropriate care processes, and have at best a limited view of the cost or quality of the care product.

Health insurers are poorly equipped to function as general contractors, receiving bills sometimes long after the services have been performed, or attempting to evaluate the medical necessity of individual elements of care from hundreds or thousands of miles away without any direct contact with the patient or the care team. They also lack clinical judgment and direct knowledge of the patient and their needs.

## A Reference Pricing Model for Clinical Solutions

Public and private health financing systems need to pay physicians to collaborate both in reducing the cost and improving the outcomes of care. In their 2006 book, Redefining Healthcare, Michael Porter and Elizabeth Teisberg proposed a model of "value-based competition," where patients with a serious clinical problem are presented with multiple choices for solutions to defined clinical conditions for fixed episode prices.[19] This system encourages patients and families to reach beyond highly consolidated local markets to search for more affordable solutions to clinical problems regionally or nationally.

Catalyst for Payment Reform, a new organization that represents large employers, has recently advocated adoption of the Porter and Teisberg model for clinical conditions with great variation in prices.[20] Under CPR's model, which was successfully tested by Safeway and other employers, patients who choose lower cost solutions have zero cost sharing. This model is termed "reference pricing."[21] Heath plans using this approach become market makers for clinical solutions, and share savings with subscribers who chose a provider below the "reference price" for a given service.

This Blueprint follows the principles Porter and Teisberg and CPR have laid out, but potentially affords physicians a crucial role in holding hospital systems accountable for the cost of their product. Physicians should become wherever possible the "general

contractors" for resolving clinical problems, either through single specialty or multi-specialty groups or Independent Practice Associations, and provide lower cost alternatives to hospital-driven "service lines." Because physicians can often minimize or eliminate the need for using the hospital, they hold the potential for offering the lowest cost clinical solution for a given medical problem. Reference pricing programs by employers, private payers and Medicare should explicitly encourage physicians to offer clinical solutions at a fixed price.

The Affordable Care Act mandates demonstration projects to test the feasibility of bundling payment for multiple physicians, diagnostic services and hospital inpatient care into a single severity-adjusted Medicare payment, building upon the successful Acute Care Episode (ACE) demonstration.[22] Unfortunately, though it does not explicitly exclude organized physician entities from participation, the new demonstration project launched in mid-2011 and titled Bundled Payment for Care Improvement, basically makes the hospital the physicians' paymaster.[23] Simply building upon Medicare's hospital diagnosis-related group (DRG) payment model, and rolling physician fees and post-acute costs into the DRG, would have the unfortunate effect of hardening hospital monopolies and accelerating the rolling up of physician practices into hospitals.

**Simplify the Medicare Program**

Medicare is a vital lifeline for 48.5 million people, of whom 8 million are disabled people under the age of 65. Unfortunately, Medicare is also a fragmented difficult to understand health benefit that has become progressively more complex and user unfriendly as the program nears its 50th anniversary. Medicare's payment models have become rigid and encrusted with onerous reporting clinical requirements. They also diffuse responsibility for effective physician care and resolution of clinical conditions.

As a result of nearly 50 years of tinkering, Medicare presently has four parts: A for inpatient hospital care; B for outpatient and physician care, as well as post-acute care, outpatient dialysis and durable medical equipment; D for drugs; and C for a private health

plan option consolidating the aforementioned benefits. Medicare's Parts A, B and D have separate funding sources and different cost sharing provisions which, because they are poorly coordinated, leave beneficiaries exposed to significant and open-ended out-of-pocket cost risk for complex illnesses.

Those choosing the traditional Medicare benefit can be at risk for hundreds of thousands of dollars of out-of-pocket expenses. The economic risks are significant enough that it is foolhardy for most Medicare patients, even wealthy ones, not to cover their out-of-pocket liabilities with supplemental MediGap insurance or retiree health coverage (both waning) or Medicare Advantage (Part C) private health plan coverage (rapidly growing).

All these mechanisms effectively eliminate the Medicare patient's economic stake in moderating the cost of their own care. Medicare patients that run out of funds become jointly eligible with state Medicaid programs, and the two programs uneasily share responsibility for their total care – with Medicaid paying most of the patient's long term care costs – as well as their Medicare premiums and cost shares. This split responsibility, like the multiple parts of the Medicare program, is an anachronism which seriously compromises efforts to manage the care of Medicare's most seriously ill patients effectively.

As of this writing, roughly 14 million Medicare beneficiaries (roughly 27 percent) receive their care through private health plans under Medicare Advantage, receiving unified benefits from a single source, with far less billing complexity, and frequently, no premium payment obligation.[24] The remaining 34 million beneficiaries receive care through an antiquated, needlessly complex regular Medicare program that cries out for simplification. Medicare's vaunted "lower administrative expenses" are misleading because so much cost and complexity from Medicare are shifted to physicians, hospitals, patients and their families.

**Simplify the Medicare Benefit and Focus it on Chronic Care Management**

Parts A, B and D of Medicare should be merged into a single benefit, with one payroll deduction, one premium payment, a single unified copayment applied to the totality of services provided and an affordable annual limit on cost sharing, all graded to the beneficiary's income.[25] This approach would close the present open-ended cost risk of the program, rendering MediGap insurance unnecessary and, crucially, restoring an affordable degree of cost responsibility to all Medicare patients.[26]

The merger of funding sources inside Medicare's diverse parts would have the collateral benefit of rendering the present Sustainable Growth Rate (SGR) funding / accounting crisis for part B moot, because Part B's "deficit" would be combined with Part A's Trust Fund surplus. Going forward, the program would pay its obligations as it went. And there would be a single payroll deduction, a single premium payment, a single deductible and maximum annual contribution for the totality of Medicare's services.

In addition, *Medicaid's* share of the costs for the "dual eligible" population (principally chronically ill and / or disabled individuals who have run out of funds or who simply have income too low to be able to pay Medicare's premiums), should be transferred, along with state governments' responsibility for the funding, to the Medicare program. This would enable the most seriously ill part of the Medicare population (roughly 20 percent of Medicare beneficiaries who generate 31 percent or better of Medicare's cost[27]) to receive care through a single, federal program.[28]

The remaining smaller Medicaid program (younger, not disabled people below 138 percent of poverty, per the Affordable Care Act) would become the principal responsibility of state governments, with a modest but significant federal match. Continued state effort in covering the younger population would be an ironclad condition of transferring their long-term care and cost sharing burdens to Medicare.

**Apply Relationship-Based Payment Models to Medicare Patients**

This consolidation would then enable Medicare to make physician-directed chronic care management its principal program focus. "Medical home" and, for the most seriously ill, "ambulatory ICU" relationships would be provided the sickest Medicare patients, paid for on a monthly subscription basis by Medicare. Physician relationships become vitally important for Medicare patients as the main mechanism for addressing the chronic illnesses that challenge, eventually, everyone who receives a Medicare benefit. Patients entering Medicare should be able to carry over "direct pay" physician relationships from private insurance or their own resources, unlike today where those relationships are not covered by Medicare.

**Bundle Payment for Acute Illnesses and Give Medicare Beneficiaries Multiple Choices**

When Medicare beneficiaries need acute care, the same funding principles discussed above would apply. Medicare would make a unified payment for resolving a clinical problem, abolishing the present absurd division between acute hospital (presently Part A) and physician / outpatient and post-acute care (presently Part B and Medicaid), enabling the clinical team to take responsibility for returning the patient to health.

This model would operate like private insurance on a reference-pricing basis. Medicare beneficiaries who choose less expensive "clinical solutions" should be rewarded either by reduced cost sharing or, for the lowest cost program, abatement of their premiums or even a cash bonus.

Physicians have a vital role to play as guarantors of future Medicare spending restraint, whether as global risk contractors (through IPAs or multi-specialty physician groups) with Medicare Advantage plans, as sponsors of health plans which cover Medicare's sickest (presently dual-eligible) population, as participants in relationship-based models like the Medical Home, which provide care co-ordination for the chronically ill, or as

"general contractors" for provision of clinical solutions to acute illness. They can work collaboratively with hospitals as they choose, or provide alternatives to hospital-driven service lines.

**Right Size Medicare's Physician Payments**

For the roughly half of Medicare patients' problems not covered by either subscription / relationships or clinical episode payments, 30 percent increases in Medicare's Evaluation and Management (E&M) and diagnostic code payments (20 percent above the 10 percent limited increase in E&M codes provided in the Affordable Care Act) will be needed to avert a serious shortage of physician coverage for a rapidly expanding Medicare population – particularly as the program grows from its present 48 million people to more than 70 million in the next 15 years.

At present, physician payments account for only about 14 percent of total Medicare spending. The proposed increases should be funded by a compensating reduction in Medicare HOPPS (hospital) outpatient rates and in imaging and surgical technical fees from Medicare's physician fee schedule – as well as through eliminating the "site of service" differential which enables hospitals to charge as much as 80 percent more for their employed physicians who provide the same service as a physician in private, office-based practice.

Presently, technical fees for imaging and other complex care can exceed fees for physicians exercising their professional judgment by as much as four or five-fold. This imbalance has encouraged an excess of facility investment at the expense of adequate professional compensation, and has encouraged physicians to rely excessively on owning and controlling capital and facilities for their income generating potential. Physicians should earn much more than they presently do for exercising their professional judgment, and less from facility related profits.

By taking the windfall profits out of hospital-based testing and "right sizing" Medicare physician compensation for exercise of professional judgment, one can correct the root cause of much medical inflation over the past twenty years. Meaningful tort liability reform (a subject beyond the scope of this Blueprint) could also have a salutary impact in reducing unnecessary testing and other forms of defensive medicine.

**Simplify Medicare's Documentation Requirements**

New consolidated payment models would markedly lower the administrative expenses of participating in Medicare by eliminating much fee-based billing, and consolidating clinical services payments into single transactions. Patient choice plays a crucial role in making this model work. It is important that Medicare beneficiaries have more than just cost information to decide who should care for them. Patients need to be able to evaluate the safety and reliability of the services they are choosing. Transparency in cost and quality is vital.

However, it is important to be transparent about things that matter – that is, validated clinical outcomes measures that directly reflect patient safety and clinical risk.
A Commission on Administrative Simplification in Medicine should be formed to examine all the administrative reporting requirements imposed by Medicare on physicians as a condition of program participation and payment. The goal of this Commission should be to rededicate millions of hours of clinician time – not just the time of physicians, but also that of nurses, pharmacists and others – from documentation to direct patient care. Documentation systems to be studied would include Medicare's E&M coding requirements, "meaningful use," the Physician Quality Reporting System (PQRS) and proposed new clinical coding schemes like ICD-10.

This Commission should conduct an audit of documentation time requirements imposed by each "core measure" and establish an empirical relationship of the costs of meeting documentation requirements to enhanced patient safety. This would then allow the

Commission to eliminate the "nice to have" documentation requirements that do not meet a sufficient hurdle rate of risk reduction relative to time / cost of documentation.

Given this Blueprint's focus on moving away from incident-based payment, and consolidating payment transactions, the postponed conversion of Medicare and private insurance coding to ICD-10 (an absurdly detailed incident-based coding scheme) should be abandoned. ICD-10 should replaced by a simplified coding scheme that accurately captures variation in clinical episodes.

**Medicaid Simplification**

The dramatic expansion of the Medicaid program proposed by the Affordable Care Act has been a highly controversial element of health reform. State Medicaid spending rose 22 percent in FY 2011, according to the CMS Actuary, two full years after the end of the recession and two full years before the projected 30 percent increase in Medicaid enrollment provided in ACA.[29] The Medicaid program is fundamentally broken. Simply to expand Medicaid without fundamental structural change will impose an unsustainable future financial burden on many states and their providers, even with ACA's enhanced federal financial participation.

The expanded Medicaid program will not survive the next recession without major surgery, including potentially ruinous further reductions in physician and hospital payment and diminished access for the program's 70 million plus beneficiaries. Physician participation in the Medicaid program is falling, leaving fewer and more costly options for care of this population – including hospital clinic systems, federally qualified health centers and hospital emergency rooms.[30]

This Blueprint proposes a fundamental redesign / shrinkage of Medicaid, removing from state Medicaid programs the responsibility for long term care funding, and transferring program and funding responsibility to the Medicare program (as discussed earlier in this

Blueprint). This would leave Medicaid responsible for a younger and healthier patient population, primarily families and single individuals below 138 percent of poverty.

There are three possible approaches for further simplifying and improving care to the remaining, smaller Medicaid population. One approach, which continues current policy, is to increase the contracting out of Medicaid management to private health plans, which presently cover almost 35 million of current Medicaid beneficiaries.[31] Most of these beneficiaries are in the current TANF (Temporary Assistance to Needy Families) part of Medicaid.

There are significant problems with this trend, however. State contracting with private health plans often deprives Medicaid beneficiaries of choice both of plan and provider, and creates unhealthy temptations for their contractors to cut corners on how hospitals and physicians are paid.

One alternative to state-directed managed care contracting is for states to provide individuals and families under 138 percent of poverty with vouchers to purchase private coverage under state or federal health exchanges created by the Affordable Care Act. If these individuals are insurable by private health plans, which they clearly are (or 35 million of them would not be covered by private plans in the first place), why not let the beneficiaries themselves, rather than state welfare bureaucrats, chose the coverage? No other major developed country in the world has a separate healthcare payment system that applies only to its poor. Under this option, Medicaid beneficiaries would be treated exactly the same as any other citizens who use the exchanges and Medicaid's sole role would be to fund the voucher.

An alternate approach that relies less upon private health plans would be to convert the remaining Medicaid program from a payment program to a capitated service benefit model. Under this approach, Medicaid would contract on a per capita basis with safety net providers such as the Veterans Administration (for veterans and their families), federally qualified community health centers (FQHC's), public health clinic systems and,

in rural areas, critical access hospitals (who already employ most or all of their community's physicians). These providers would offer comprehensive health services for all citizens in families with incomes under 138 percent of poverty who live inside their geographic catchment areas.

Under this approach, there would no longer be Medicaid claims for basic health services. Medicaid beneficiaries would simply receive care as needed from these public sources, subject only to a modest copayment based on income at the point of care. When Medicaid covered patients require hospitalization or other complex care, safety net institutions would contract for that care on a per capita basis if they do not operate hospitals themselves.

Physicians would be encouraged to volunteer their time at safety net institutions to strengthen their physician coverage, and be sheltered from medical liability when they did so under "sovereign immunity." They would also be encouraged to provide free care to Medicaid patients and the significant number of remaining uninsured by being able to write off the value of their services on their federal income tax returns.

## How Medical Societies Can Help

The proposed new payment models, while simpler than present fee-for-service, are still complex and will be difficult for physicians to execute. Physicians will need new infrastructure – administrative and clinical – to foster relationship-based payment models and, to an even greater extent, offer physician-sponsored "clinical solutions" under a fixed price.

Medical Societies can play a crucial role in helping physicians prepare for new relationships and responsibilities under this Blueprint. Medical societies can help educate physicians both about these payment models and why it is in physicians' interests to support and develop them. They can also help physicians anticipate the support requirements and control systems they will need to transition from their present payment

framework to the new one. Medical Societies can help physicians procure both the consulting help in making the conversions and IT and financial systems support they need to succeed in these new models – as well as to create "best practices" forums to bring physicians in contact with those who have succeeded in executing them.

Medical Societies can also assist their members in lowering their practice expenses, re-engineering physician workflows, creating new practice models incorporating advanced practice nurses and other care givers, gaining access to group purchasing discounts for their supplies and equipment, and creating temporary employment pools for their supporting staff. Large integrated group practices like HealthCare Partners and Independent Practice Associations such as Hill Physicians have highly effective Management Services Organizations (MSO's) that help their members and affiliated independent physicians remain competitive. These support structures must multiply many-fold to provide physicians the help they need in re-engineering their practices and lowering their practice expenses.

Many new physician-directed structures need to be created to implement this Blueprint. These include new Independent Practice Associations, mergers of smaller medical groups into larger ones and new physician sponsored health plans both for Medicare and commercial / exchange patients. Many physicians are not interested in taking on new economic risk or do not fully appreciate that their current practice structures will not enable them to function effectively in even limited risk payment arrangements – let alone the new models advocated in this Blueprint. Many current members simply expect their medical societies to expend their energy in preserving the status quo.

Medical society leaders should and must resist this temptation. Rather, they should expose their members to innovators, both physician leaders and managers that have successfully executed these models. They can also facilitate dialog with health plans anxious to avoid being cornered by regional hospital monopolies by creating better and more durable working relationships with physician communities.

## Conclusion

Physicians have a crucial role to play not only in reforming the care system, but also in creating cost and quality accountability in the care system. Physician care remains a bargain compared to institutional alternatives. And because they know where the waste is in the system and how to avoid it, physicians can play a key role in organizing the most cost-effective care when patients need it.

Physicians wishing an alternative future to becoming employees or civil servants will need to do three things:

1) Achieve the Mass and Scale to Organize Care More Effectively and Lower Costs
2) Develop New Care Models that Better Meet Patients' Needs
3) Assume More Risk and Responsibility for Managing the Cost of Care

In order for these things to happen, public financing programs and private health plans must forge new working relationships with physicians – as well as simplify their financial relationships with physicians to support these new models and encourage better teamwork in care provision. Physicians are the key to a more efficient, humane and effective US healthcare system.

## Endnotes

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