Caring For the Elderly: Is There Any Answer to Rising Health Costs?

Barry M. Straube, M.D.
Acting Chief Medical Officer
Acting Director, OCSQ
Centers for Medicare & Medicaid Services

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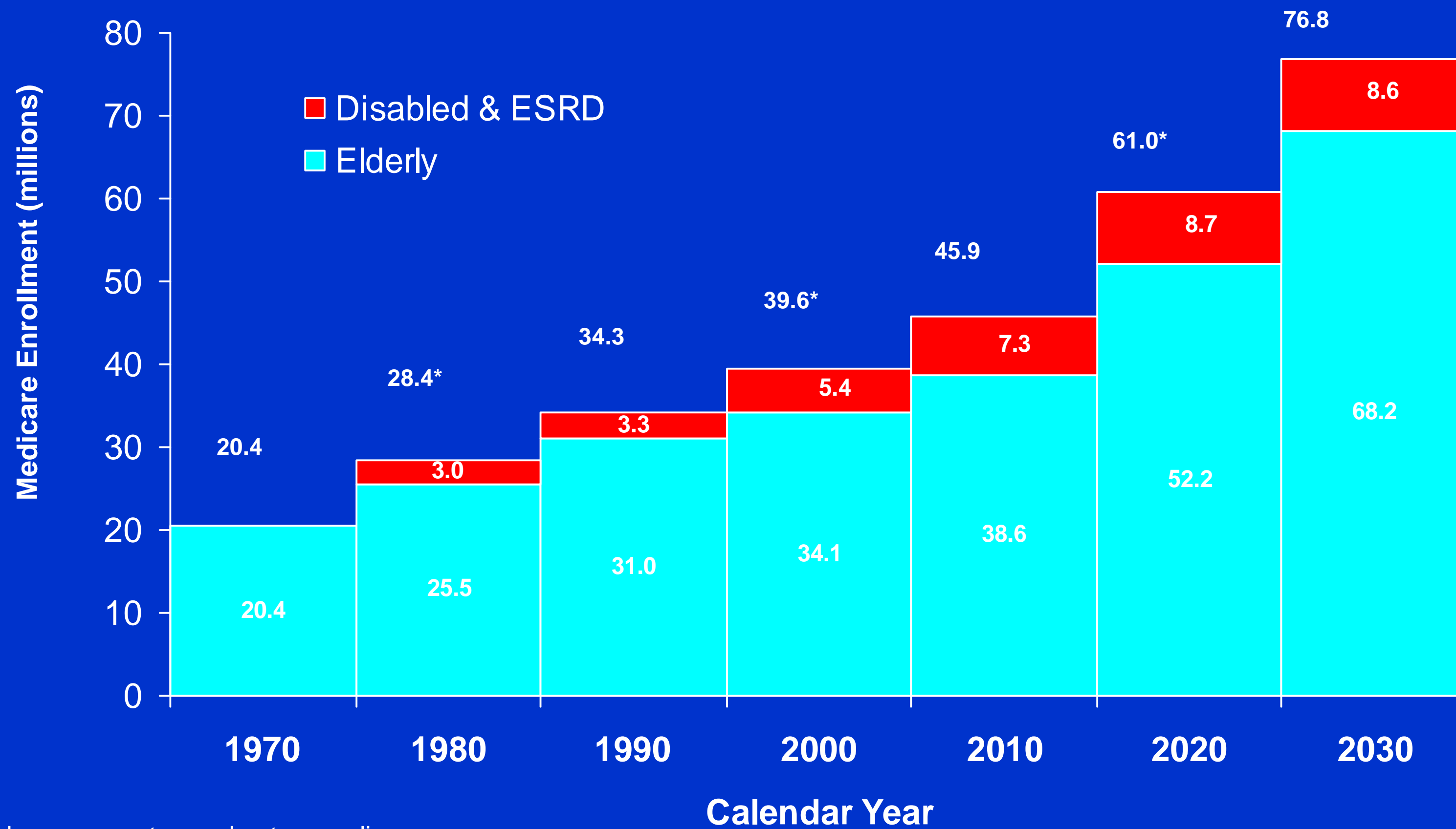
Alliance for Health Reform Briefing

Table 3.6
Number of Medicare Beneficiaries, 1970-2030

The number of people Medicare serves will nearly double by 2030.

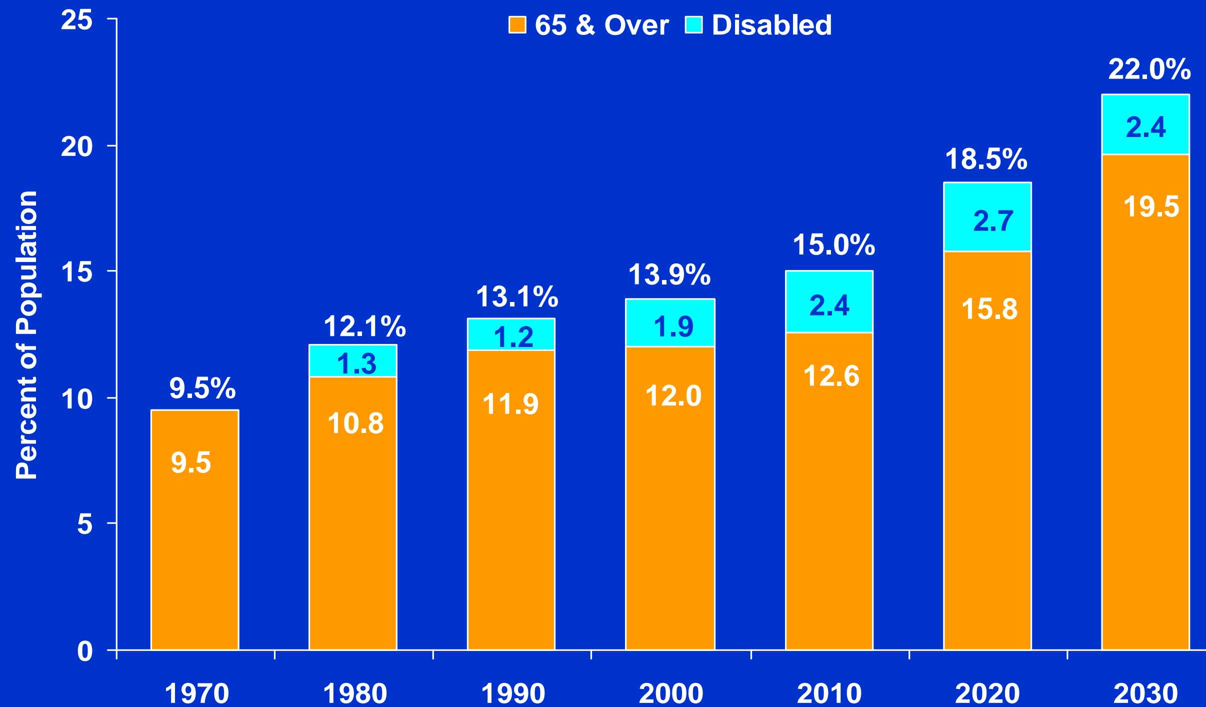


* Numbers may not sum due to rounding.

Source: CMS, Office of the Actuary.

Table 3.7
Medicare Beneficiaries as a Share of the U.S. Population, 1970-2030

The U.S. population will age rapidly through 2030, when 22 percent of the population will be eligible for Medicare.



Source: Social Security Administration, Office of the Actuary.

Medicare & Medicaid 2005

- 40th Anniversaries this summer
- Over $600 billion per year in combined programs
- Covers over 80 million Americans
- In early years
  - Institutionally-biased
  - Provider-driven
  - Long-term care setting default: institutional
  - Acute and chronic disease treatment focus: reactive
  - Lack of information, choice

Medicare & Medicaid 2005

- Current trends
  - Prevention
  - Patient-focused, optimal care for individual needs
  - Consumer choice and control in healthcare options
  - Decreased institutional bias
  - Personalized medicine
  - Team healthcare
  - Out-patient, community and home support
  - Incorporation of technology & innovation, pharmacy
  - Modernization of Medicare program to align it with evolution of the rest of medicine

CMS Quality Roadmap

- **VISION:** ***The right care for every person every time***
  - *Make care:*
    - *Safe*
    - *Effective*
    - *Efficient*
    - *Patient-centered*
    - *Timely*
    - *Equitable*

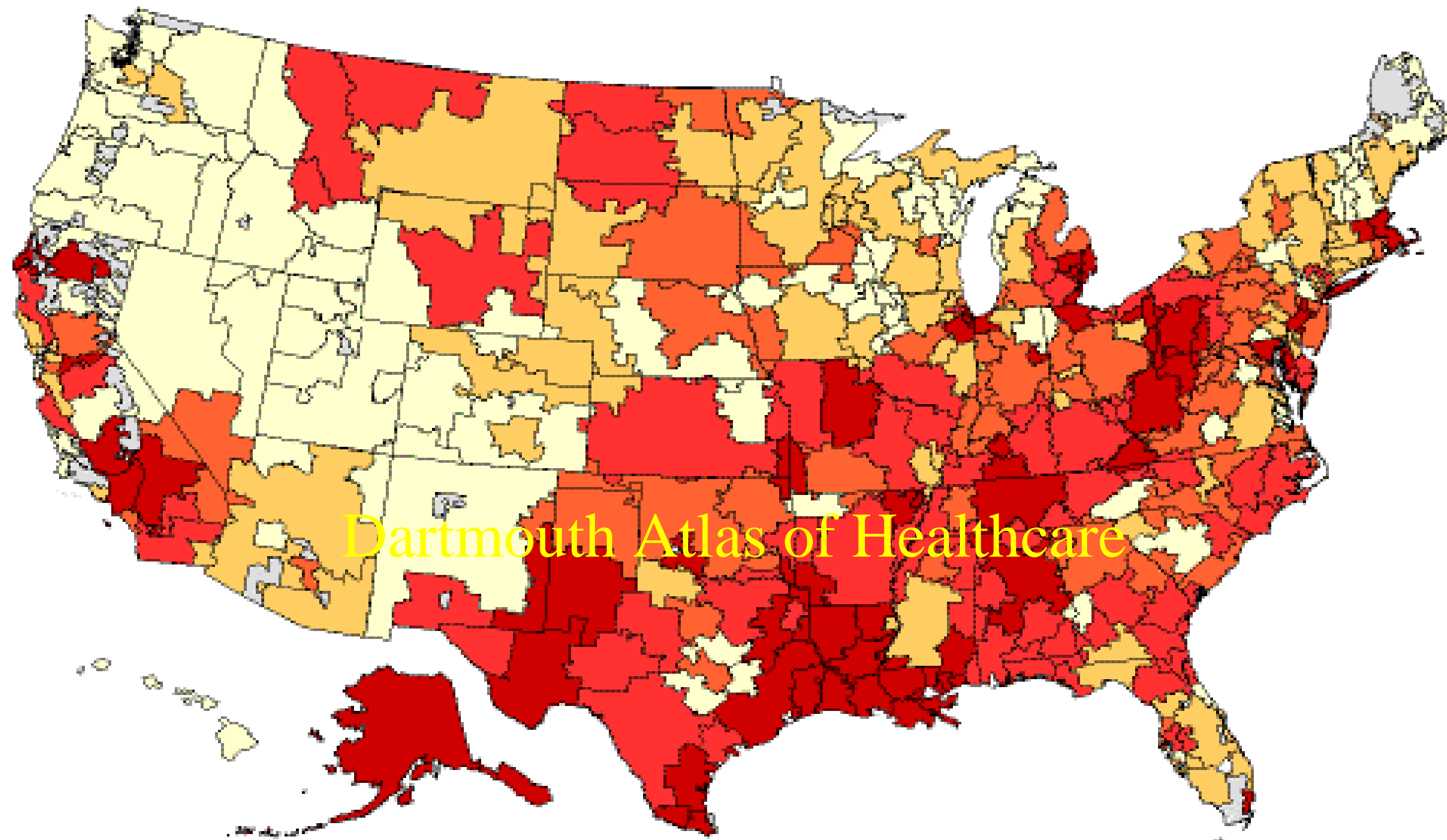
CMS Quality Roadmap: Strategies

1. Work through partnerships to achieve specific quality goals
2. Publish quality measurements and information as a basis for supporting more effective quality improvement efforts
3. Pay in a way that expresses our commitment to quality, and that helps providers and patients to take steps to improve health and avoid unnecessary costs

CMS Quality Roadmap: Strategies for QI

4. Assist practitioners in making care more effective and less costly, especially by promoting the adoption of HIT
5. Bring effective new treatments to patients more rapidly and help develop better evidence so that doctors and patients can use medical technologies and treatments more effectively

A Variation Problem



Map 2.5. Inpatient Hospital Services per Medicare Enrollee
by Hospital Referral Region (1995)

- $2516 to 3723 (61)
- 2321 to < 2516 (60)
- 2117 to < 2321 (61)
- 1893 to < 2117 (62)
- 1483 to < 1893 (62)
- Not Populated

Practical Drivers of Increased Cost

- New technologies: To cover or not?
- How much is reasonable reimbursement for a technology or service?
- Will technology or medical interventions be used appropriately and cost-effectively?
- How do we choose what to cover, how do we monitor utilization?
- What about quality, efficiency, value?
- Palliative and end-of-life care, when is enough?
- Who decides?

Steps to Coverage Determination and Payment

Outside of CMS:

- Congress determines benefit categories
- FDA approves drugs/devices as safe & effective

Within CMS:

- Coverage: Medically necessary & reasonable
- Benefit Category Determination
- Coding
- Payment

Key Factors Considered in National Coverage Determinations

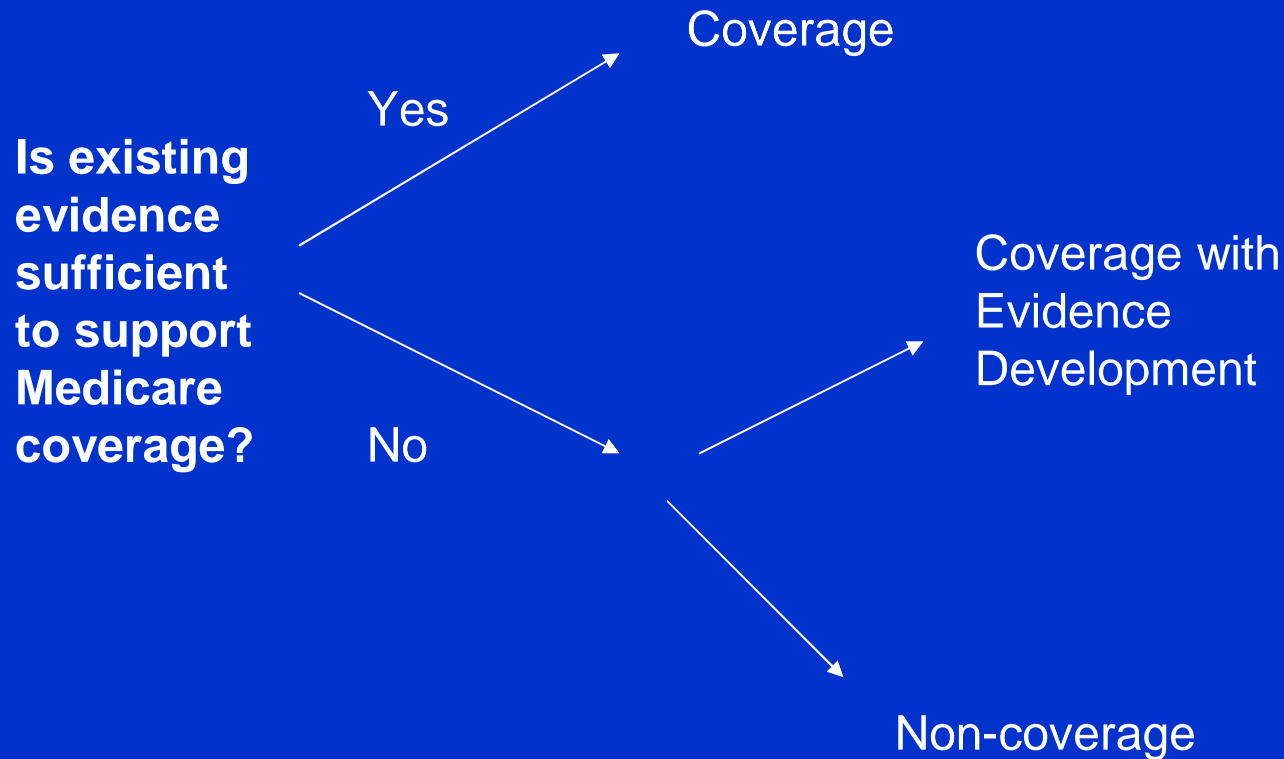
- Must be potentially a benefit of Medicare
- Evidence of improved health outcomes
- Appropriate for Medicare population
- Replicable in provider community

Coverage with Evidence Development (CED)

New variation – faster, more flexible:

- Used for promising innovations with insufficient evidence for individual patients or the Medicare population
- Also used when conclusive evidence is not available, but existing evidence strongly suggests probable benefit
- Offers prompt coverage linked with more evidence development
- Speeds access, safeguards patients, improves evidence for better decisions

Coverage With Evidence Development = *an alternative to non-coverage*



Flexible Coverage Processes
Examples

- Prophylactic implantable cardioverter defibrillator (ICD)
  - Data submitted to national registries, at low cost for participating hospitals all over the country
  - Otherwise would have more limited coverage
  - Expanded coverage to reach more patients

Flexible Coverage Processes
Examples

- Additional off-label uses of cancer drugs
  - No FDA-approved results, and no studies covered in medical references
  - Previously would not have been nationally covered
  - Evidence developed through clinical trials
- FDG-PET scanning
  - For dementia and neurodegenerative disorders
  - For cancer diagnosis, staging, monitoring
  - Evidence developed through clinical trials

Coverage with Evidence Development NCDs

PET for AD	Sep 04
CRC NCI Trials	Jan 05
ICDs	Jan 05
PET 6 Cancers	Jan 05
Cochlear Implant	Apr 05
US Fracture Healing	Apr 05

FDA/CMS Parallel Review

- FDA: “Safe & Effective”
- CMS: “Medically Necessary & Reasonable”
- FDA approval has predated CMS coverage determinations
- HHS desire to make available new technologies and treatment to doctors and patients more rapidly

Treatment Choice Levers

Local Availability

Physician Experience/Comfort

Referral Patterns

Cost/Reimbursement

Risk of Adverse Events

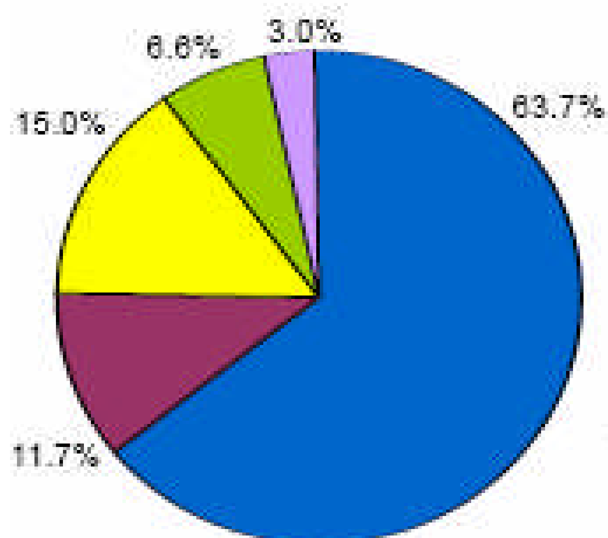
Patient Preference

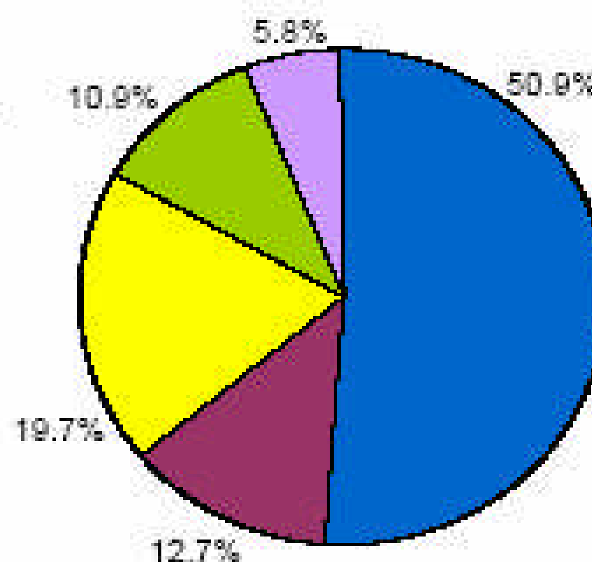
Theoretical Best Choice of Treatment

Average Annual Health Expenditures by Source of Payment, 1992-1999

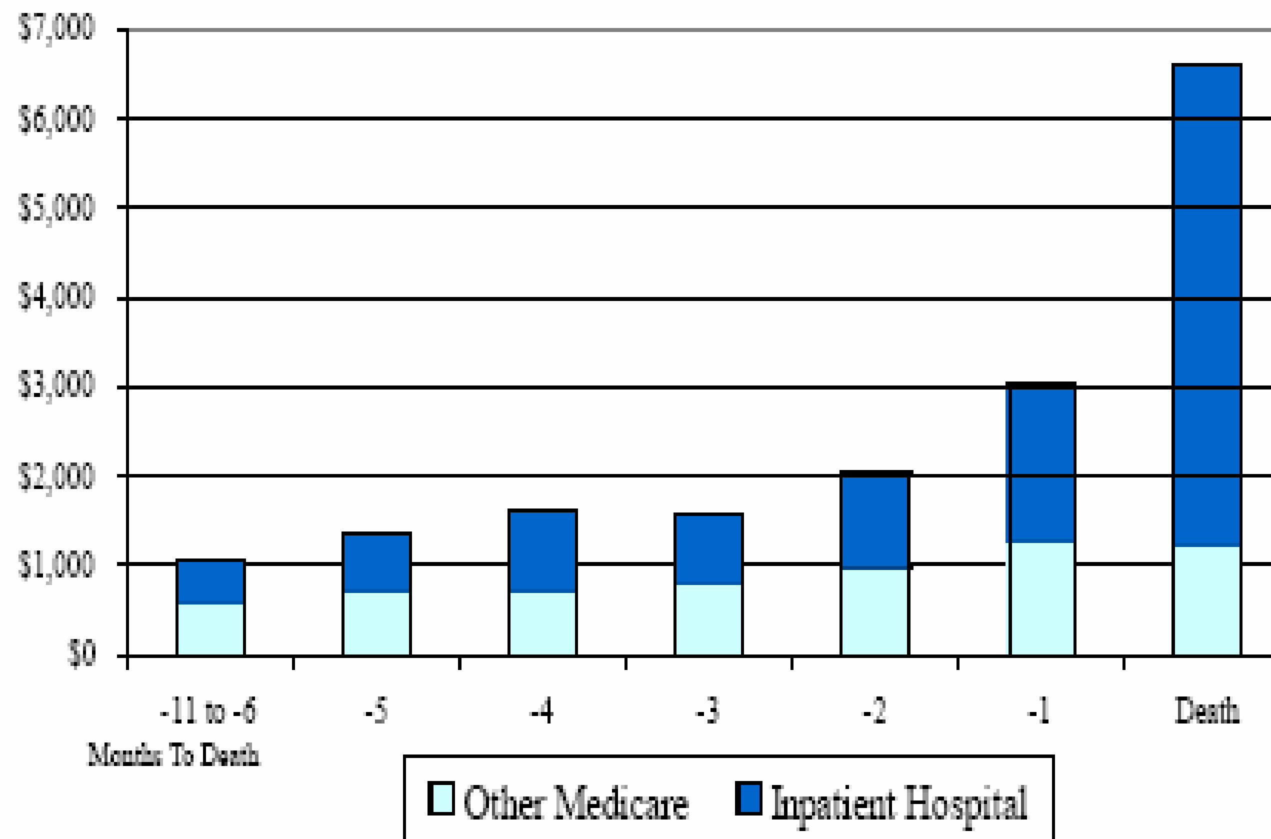
	Last Year of Life	Not in Last Year of Life
Total	$35,516	$7,661
Medicare	$22,588	$3,901
Medicaid	$4,167	$974
OOP	$5,345	$1,507
PHI	$2,341	$835
Other	$1,075	$443

Source of Payment





Monthly Medicare Inpatient Hospital Spending in the Last Year of Life



Quality of Life Year Costs: Preventive Screening

- Benchmark usually considered to be ≤$50,000 per QOLY
  - Colorectal cancer screening: $9,424 to $26,228
  - Mammography screening: $17,269
  - Cervical cancer screening: $4,535

Quality of Life Year Costs: New Technology Coverage

- Hemodialysis services
  - $50,000 - $90,000 per QOLY
- Implantable Cardioverter Defibrillators
  - $130,000 - $210,000 per QOLY
- Ventricular Assist Devices
  - $220,000 - $320,000 per QOLY

Economic Analysis in Healthcare Decision Making

- Analytic methods to maximize the value of health services
- Controversial, particularly with regard to medical necessity
- Evidence of benefit of cost effective analysis (CEA) in medical decision making variable

Decision Making Tensions

- Locus of Decision Making
  - Judgments and opinions of individual patients and their physicians
  - Does not assure correct decision making
  - Discomfort with payers as decision makers for medical necessity
- Process for medical decision making
  - Explicitness, Consistency, Transparency, and opportunity for outside input
  - What is the definition of medical necessity?

Decision Making Tensions

- Role of Evidence-based Medicine
  - When is evidence base adequate?
  - How should risks v.s. benefits be weighed?
- Other issues
  - Validity and transparency CEA methods
  - Uncertainty about motives for use of CEA
  - Difficulty in applying results to individual patients

CMS Quality & P4P Initiatives

- CMS as Public Health Agency
  - Transformational Change Concepts Across Healthcare
- Physicians
- Hospitals
- Nursing Homes
- Home Health Agencies
- End Stage Renal Disease Facilities
- Quality, Efficiency Focus

Contact Information

Barry M. Straube, M.D.
Acting Chief Medical Officer
Acting Director, Office of Clinical Standards & Quality
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Email: Barry.Straube@cms.hhs.gov
Phone: (410) 786-6841