



A New Federal Health Care Strategy

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patients examined in this study were taking cholinesterase inhibitors and 22% took memantine.

Without strong empirical data, clinical judgment must rule. David Knopman, MD, a professor of neurology at the Mayo Clinic in Rochester, Minnesota, usually opts to continue cholinesterase inhibitors for patients with dementia who live at home because he doesn't want to run the risk of precipitating

decline. But if a patient enters a skilled nursing facility, he is likely to stop the medications. "If upon stopping them, the patient worsened, more resources would be at hand," he said.

Topping the list of medications that Sachs considers stopping in patients with advanced illness are drugs to prevent osteoporosis. "They're difficult to take and several studies have shown that if you've been

on these medications for 5 years, their benefits carry on for some time beyond," he said.

Stephen Kates, MD, Hansjorg Wyss professor of orthopedics at the University of Rochester School of Medicine and Dentistry in New York, agreed. For patients with life-threatening cancer, advanced dementia, or end-stage pulmonary disease, his recommendation is decisive: "Stop the medicine altogether." ■

The JAMA Forum

A New Federal Health Care Strategy

David M. Cutler, PhD

Although Ebola has consumed the health care headlines of late, US consumers are worried about more than this dangerous viral disease. The cost and quality of medical care remain paramount in people's minds.

In September, between dealing with Ebola and unaccompanied children coming to the United States, Sylvia Mathews Burwell, secretary of the US Department of Health and Human Services (HHS), addressed these issues in a new value enhancement initiative. Having been secretary for barely 3 months, Burwell evidently felt that the value-oriented initiatives at HHS needed a reboot—not surprisingly, given that HHS has been preoccupied for some time by the insurance expansions spurred by the Affordable Care Act.

The secretary's new initiative has 3 elements:

- **Changing the incentives for delivering care**

It is impossible to imagine a medical care system focused on value when the payment system rewards volume. Medicare and Medicaid are the obvious policy levers here, and the secretary mentioned using them.

- **Providing clinicians the tools to drive change in their practices**

This includes technical assistance and grants in practice transformation and use of electronic records.

- **Information**

Both patients and physicians need the right information to use the system well. The secretary mentioned specifically the

recent release of Medicare data and an effort to make electronic medical records interoperable.

The themes Burwell stressed are good ones. Almost all efforts to reform health care delivery (for example, a report from the Bipartisan Policy Center, a bipartisan group convened by the Brookings Institution, a report from the Center for American Progress, my own recent book, and the writings of my *JAMA* Forum colleague Gail Wilensky) stress some combination of payment reform, information provision, and data infrastructure as keys to better performance.

What matters, though, are not the words but the actions. Burwell announced that more is coming. Let's hope she gets very specific. Here are 4 areas that I look for in turning this initiative into a real program:

A Timetable for Payment Transformation

Clinicians and health care institutions now live in a hybrid world. Most of the dollars they currently receive are on a fee-for-service basis, but they have been promised that value-based payments (which consider quality, cost, and outcomes) are coming. As a result, people and organizations are investing in costly initiatives such as readmission reduction programs and high-cost case management that are currently unprofitable, but would be profitable in a reformed system. If we do not change the payments soon to match the expectations, clinicians and care institutions will conclude they are unlikely to change, and will go back to the old way of practice.



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To address this, Burwell must advance a clear timetable for the transition to value-based payments. Because so much time has been lost, bold action is needed. I would recommend a specific plan leading to 80% of Medicare payments being made on a value basis within 3 years, with encouragement to states to hit the same target for Medicaid. Massachusetts legislation required such a transition in Medicaid, and it has changed the discussion in that state from whether payment reform should occur to how it should occur. The secretary could do the same nationally.

Price and Quality Transparency

US patients have significant financial "skin in the game" for health care. One-fifth of the population has high-deductible health

insurance policies, and even standard policies have family deductibles of \$2000 or more per year. Adding to the concern, there is virtually no way for people to know what various medical services cost or how quality is related to cost. We are setting ourselves up for a health care backlash if people have significant financial exposure but no recourse to figure out how to use care wisely.

Burwell can promote transparency in several ways. First, she can require that insurers participating in exchanges be able to tell enrollees in real time their cost sharing for any service from any clinician or health care institution. Massachusetts recently enacted such a requirement on insurers, and this information is for the first time available to consumers. Second, the secretary could promote agreed-upon quality metrics and delivery platforms that would bring that information to consumers.

In addition, Burwell could continue efforts to make Medicare data more widely available for quality assessment. Last summer's Medicare data release is only a start. True transformation requires combining information from all payers, not just Medicare. Many states have started compiling claims records from private insurers and Medicaid, but the federal government has been unhelpful with respect to Medicare. The US Department of Health and Human Services should jumpstart its fledgling efforts to combine Medicare, Medicaid, and private sector data. I suspect that HHS does not have the capacity to do the relevant analytics internally, but many states and private

organizations do have this capacity and, with modest funding, could take care of the analytics.

Real Time Information

Clinicians also need information if they are to manage their patients better. Many clinicians are responsible for population health without knowing what medical services the population they care for is using. Burwell can address this by pushing forward with basic information transfers, such as mandatory admission-discharge-transfer notification, and expanding from there. Some effort has already been under way for this, but progress has been too slow. The US Food and Drug Administration policy towards consumer health digital apps will also be central; private developers can help create consumer apps, but not if all health-related apps need a full clinical trial.

Administrative Costs

Policies to address administrative costs should be parallel to a focus on care processes. Total administrative costs in the United States are twice the amount spent on cardiovascular disease and 3 times the amount spent on cancer. Numerous studies have shown that significant administrative savings are possible. In almost all industries, administrative cost reduction is led by large buyers, and HHS could play that role in health care. This would involve standardizing billing features of insurance plans in exchanges and requiring linkage of electronic medical records to billing systems, so that information can

flow seamlessly from care provision to billing and payment. With some effort, administrative costs could fall markedly.

Avoiding Timidity

Given the massive problems with the roll-out of the federal health exchange, health-care.gov, Burwell is undoubtedly under pressure to avoid overpromising on value enhancement. The reality, though, is that the website failure should push the other way. The credibility of HHS is low, and it is hard to see how words alone will lead to much change. If Burwell is truly serious about making health care better and cheaper, she needs to put out specific, concrete plans with timetables and measures of success and failure to which she can hold herself and her team. Otherwise, all of the talk, no matter how thoughtful, will be no more than the background hum of a missed train leaving the station. ■

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