FROM MEDICAL DECISION-MAKING TO MEDICAL-COST-COMPARATIVE DECISION-MAKING

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In this article...

With the introduction of reimbursement reform, the days of doctors refusing to follow care guidelines may quickly come to an end.

WHEN A PHYSICIAN GATHERS A PATIENT'S history, runs diagnostic tests and performs an evaluation, he or she is performing medicine's most fundamental act: medical decision-making.

Patient care is all about physicians bringing their education, training and personal experience to bear with a particular patient and his or her particular symptoms, disease or injury. Frequently, the course of treatment is clear, for the cure immediately follows the diagnosis.

Other times, there may be a range of treatment options from the tried-and-true to newer, more recent interventions, surgery or medication. The question for the doctor is: "What is the best plan for this patient?" This is as it has been and as it should be. This is the defining act of the medical profession.

Simultaneously, we Americans are used to getting the care that we want. More specifically, we are accustomed to obtaining the care that we choose with our doctor's recommendation and explanation.

Well-insured patients, including Medicare beneficiaries, are comfortable with a health care system that honors (and reimburses) according to the decisions made between a physician and patient. In our tradition, care is planned, implemented and paid for because it is what the doctor ordered.

Historically, neither the patient nor the physician has given much thought to the payer (whether private insurance or Medicare) in the intimacy of the exam room. This changed somewhat with the dawn of managed care in the 1990s, but as reimbursement reform advances, payment (or refusal of payment) will increasingly become a determining factor in treatment.

Care that is thought best will no longer necessarily be care that is reimbursed. This already is becoming more commonplace on a patient-by-patient basis, creating confusion and anger among patients and physicians alike.

As difficult as all of this may be for physicians and patients who are denied reimbursement for the treatment they planned, we have yet to see the true impact of reimbursement reform.

In the not-too-distant future it is likely whole treatment options/technologies will be taken off the list for Medicare reimbursement — leaving those providers no option other than to seek full payment from the patients themselves, which of course is unlikely.

Worse still, if Medicare deems a treatment not sufficient for taxpayer dollars, private companies likely will follow suit.

Some doctors may see this coming; patients and the public certainly do not. As a country, we are about to see a widening gulf between medical decision-making and care actually received. This promises to be a challenge to individual physicians and physician leaders alike, so it may be helpful to review how we got to this point.

THREE DECADES OF COMPARATIVE RESEARCH — In the not-so-distant past, medicine operated as a cottage industry. Patient care followed generally accepted guidelines with a fair amount of variation from one doctor to the next.

Yesterday's physicians certainly did not make their treatment recommendations out of whole cloth. Their own professional opinion was always based on their knowledge as well as the standard of care that custom and authority within their

particular field of practice had established.

The definition of that standard has never been fixed; it has constantly evolved with research, demographic evidence and clinical outcomes over time.

In this traditional model, the definition of the "standard of care" was a process that evolved over years (if not decades). Even so, we never saw uniform adoption of the standard of care; significant personal variations remained among physicians who treated even the most common conditions.

From a policy maker's perspective, comparative effectiveness research (CER) was needed to establish clinical and cost efficiency in the treatment of every disease.

Accordingly, the Agency for Healthcare Research and Quality (AHRQ) was founded in 1989. However, 10 years later, in its groundbreaking report, "To Err is Human," the Institute of Medicine (IOM) found that lack of standardization in medical treatment was still the barrier to increased quality as well as decreased cost.

Jumping forward another decade, the Affordable Care Act was based in large part on the belief in CER and standardization of medical practice to cure the two ills of the American health care system — unsustainable increase in expenditures and unsatisfactory outcome measures.

The entire concept of "accountable care" is based on CER and best practices with transparency in reporting objective, measurable results to show an improvement in outcomes over time. In addition, the ACA created the Patient-Centered Outcomes Research Institute (PCORI) — with an allotment of 1.1 billion dollars.

Despite decades of emphasis on CER, treatment choices among physicians continued to vary significantly. Examples of resistance to practice protocols spanned across the profession, but a widely publicized 2011 study serves as a striking example; it revealed that cardiologists continued the use of an invasive procedure in post-heart attack patients that a 2008 study had found to be ineffective.

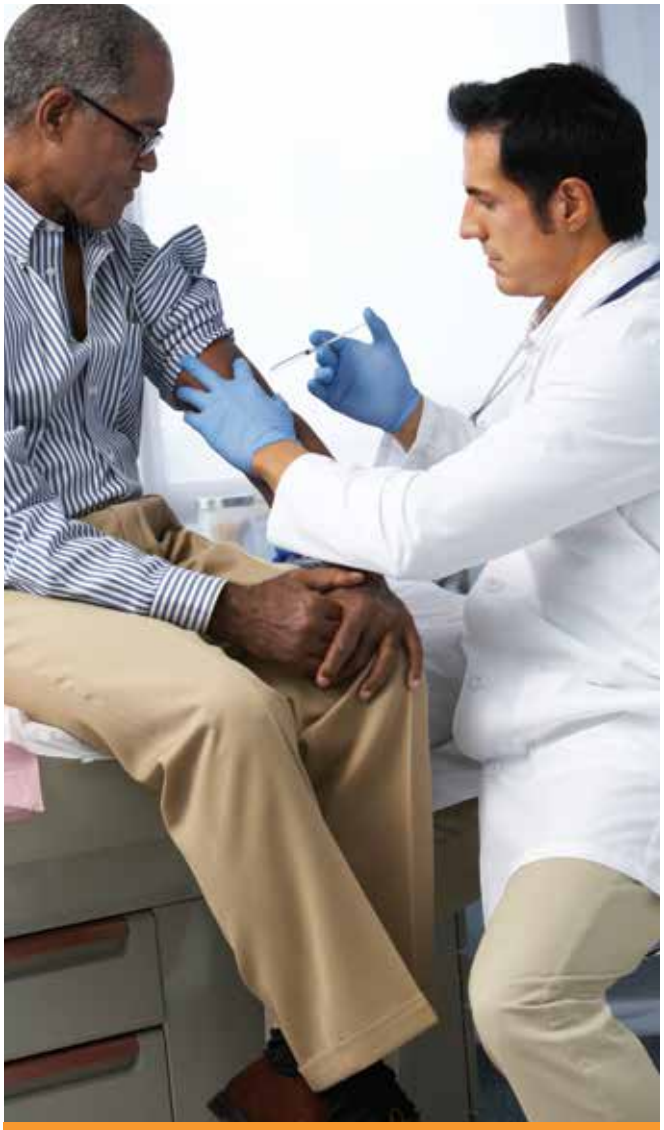
Even worse, recommendations from the American Heart Association and the American College of Cardiology urged doctors to discontinue the practice in 2007.

The message was that well-conducted, peer-reviewed, scientific research and practice protocols, even when derived from within a specialty, were unable to change doctors' practice patterns.

Recognition of the prevalence of nonbeneficial treatment in all areas of medicine is what prompted the American Board of Internal Medicine to create the "Choosing Wisely®" campaign in 2012, with a "goal of advancing a national dialogue on avoiding wasteful or unnecessary medical tests, treatments and procedures."

More than 70 specialty societies responded with lists of clinically needless tests, procedures and interventions that should be stopped, although not everyone agreed they had identified interventions that would really make a difference.

At the end of more than three decades of trying to build consensus and uniformity in medical care, the hope that all physicians, armed with information about treatment demonstrated to be clinically and cost effective, would move toward uniform adoption of those best practices was proving to be only a hope.



All physicians can still recommend any treatment within the elusive standard of care, and their patients are still free to follow their recommendations. What is clear, however, is that taxpayer dollars will not necessarily pay for it.

Far too many physicians would not alter their old, familiar treatment patterns as long as they were still being paid.

It was this reality that led to reimbursement reform. Reimbursement is the missing lever that could achieve what all the emphasis on CER had not: standardization of medical practice.

REIMBURSEMENT REFORM'S IMPACT — The idea of changing practice patterns on a patient-by-patient basis through reimbursement reform is certainly not new. Ever since the wave of managed care of the early 1990s, private insurance companies have increasingly based reimbursement decisions on the same CER.

Although there were some very early adopters such as Kaiser Permanente, the rest of the country first became familiar with "accountable care" 10 years ago, when the accountable care movement began — coupling quality improvement with cost containment in institutional settings.

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Medical homes and accountable care organizations have demonstrated this model across the country, and health care systems are increasingly adopting it. Even so, many individual physicians still opting for less-effective and less-efficient care still get paid.

That is about to change, particularly for Medicare. To date, the process of deciding what and how much Medicare would reimburse for any particular current procedural terminology (CPT) code has taken place through an obscure, secretive physician committee established by the American Medical Association in 1991.

Concern that this arcane process may not be entirely directed to the best care at the best cost (as established by CER) is one of the reasons the Independent Payment Advisory Board (IPAB) was included in the ACA.

As designed, the IPAB would review Medicare pricing decisions isolated from any possible lobbying or political pressure, similar to the military's Base Realignment and Closing Commissions (BRAC), the body that makes difficult decisions to close military facilities (with enormous effect on those communities) protected from political influence.

Many consider the IPAB to be the cornerstone of the ACA's goal to slow health care spending in the country.

The IPAB has not even been formed yet, but it is the focus of significant bipartisan repeal efforts in Congress; legislation introduced this spring has as many as 222 bipartisan cosponsors. More than 500 provider groups sent a letter to Congress in May supporting the repeal of the IPAB provisions in the ACA.

The prospect that reimbursement for some treatment modalities will be taken off the Medicare menu in a manner not subjected to lobbying or political influence clearly has the entire health care industry alarmed.

Perhaps because of this controversy, current Medicare reimbursement decisions are tightening up. The message seems to be clear: Regardless of how it happens, money must be cut off for treatments that can't be justified through CER. When that happens on the level of Medicare, the practice patterns of physicians still following inefficient treatment modalities will change.

Detractors from the ACA claim that the law will deny Medicare beneficiaries care, but it should be noted that none of these reforms, including the IPAB, will tell physicians that they can't practice as they chose.

All physicians can still recommend any treatment within the elusive standard of care, and their patients are still free to follow their recommendations. What is clear, however, is that taxpayer dollars will not necessarily pay for it.

As this new day rolls out, many physicians will bemoan the loss of the physician/payer decision-making process and cry "interference" as it relates to their own professional, medical decision-making.

To the physician, reimbursement reform is an abrogation of their professional standing. To the public, it is rationing care. And to the policy makers, it is finally bringing cost consciousness to medicine.

The key for physician leaders will be to maintain professionalism and the pivotal role of the physician in patient care, while also emphasizing the imperative of standardization of care with their peers. They must lead other physicians to a model in which treatment is based not on personal preference, but on adherence to established guidelines.

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