The Powers Report Podcast

Episode 14

Breaking up Is Hard to Do

Welcome to The Powers Report Podcast. I am your host, Janis Powers. The show brings you candid, unique and data-driven perspectives on the health care industry. I believe that any solution that is going to positively impact the American health care system has to satisfy two major criteria: financial viability and behavioral incentive alignment. In other words, access to high quality care can only be achieved if we can afford it, and if we behave in ways that optimize our health. Please subscribe to our show on iTunes or on your preferred podcasting platform and connect with us on social media. Again, this is Janis Powers, and welcome to The Powers Report Podcast.

This podcast is about doing the unthinkable: breaking up CMS. Yes, CMS, the organization that oversees Medicare and Medicaid. Many people want to expand Medicare with different permutations of Medicare-for-All. I think we need to do the exact opposite. And we should look at what's going on in the tech world for some guidance.

Anti-trust talk is sweeping the corridors in Washington with regard to the big tech companies. Facebook, Google and Twitter are under scrutiny because of their dominance in the social media world. What you post, what you like, what you are curious about…all of that is saved, sorted and sometimes, sold. There are legitimate concerns over how these and other companies use data and about their inability to control content on their platforms.

The European Union has already taken action. The General Data Protection Regulation, GDPR, outlines a series of regulations about how companies can collect and use your data in the EU (1). The companies must follow rules related to deleting information, having people opt in instead of opt out, allowing users to correct personal information, etc. It's great for consumers but a massive headache for the companies. There's concern that GDPR-type rules will find their way across the pond to the U.S.

That, or we could just break up the companies.

Facebook is the largest social media platform in the world. It has about 2.4 billion active users (2). It also owns Instagram, the popular image-intensive platform, and WhatsApp, a messaging service used predominantly internationally. Sometimes by terrorists. Alphabet is the parent company for Google and YouTube. Google is by far the largest search engine in the U.S., with about two-thirds market share. Five billion videos are watched on YouTube every day, with an average viewing time on the platform of 40 minutes (3).

These companies have been around for less than 20 years but their growth has been spectacular. Going from zero to several billion of anything – users, views, posts, videos – in just over a decade is a breakneck pace for any company. It would be hard to think that the proper security was in place from both a technological and procedural perspective. We've learned there are problems in both areas for many of the companies.

The damn broke a few years back with the Cambridge Analytica scandal. That when the profiles of 87 million Facebook users were exposed to a political consulting firm, Cambridge Analytica. Apparently, there was a loophole in the technology that was exploited, enabling the breach. It altered public opinion and trust in Facebook and many other social media platforms. Facebook's CEO, Mark Zuckerberg, appeared before Congress to testify about the breach in 2018. That's never good for PR.

Social media companies have had, and continue to have issues with fake news and imposter accounts mounting campaigns to influence opinion. There will always be bad actors and there will always be fraud in the system. The problem is that no matter how many bodies and bots and safeguards are put in place, breaches and scandals just keep coming. Lawmakers are concerned that these companies are just too big to be managed effectively.

When I hear that, I can't help but think about our $3.5 trillion health care industry. The one with the inefficient infrastructure, the misaligned incentives, the bloated policies and tragically, the largely unhealthy population. Tech companies are too big to be managed effectively? What about Medicare?

Medicare is ostensibly a government-run monopoly. All Americans aged 65 and older are eligible for the program, so right there, the program has a mandated, captive audience. One out of every five dollars spent in the American health care system is spent by Medicare. Medicaid spends about 17% of the dollars in the health care system (4). Together, the programs account for 37% of spend. All the private insurance companies together don't match that. They spend about a third of health care dollars. That makes Medicare is the largest single payer in the country.

I find it interesting that government officials are looking at breaking up social media giants because of their market dominance, but no one's talking about breaking up CMS. Maybe we should.

Well, you could argue that the reach of CMS isn't as dramatic as it is for social media companies. About 65 million people are on Medicaid (that's about one-fifth of the population) (5). Another 43 million or so are on Medicare. Those are 2017 numbers so they're bigger now. But scale-wise, it's over a 100 million people. That pales in comparison to the reach of social media companies with their billions of users and daily interactions.

Social media companies have access to reams of intimate personal information. That's scary. They can influence our minds…but a medical provider impacts our minds *and* our bodies. Think

about what your doctor knows about you. Or your pharmacist. Sure, Google probably knows this stuff too, because more than likely you've Googled a diagnosis you've received or a drug you've been prescribed. But there's nothing more intimate than having a doctor slice open your skin to remove an organ. Or having him tell you you're pregnant with twins. Or that you have cancer. Your health transcends everything – especially how many followers you have on Instagram.

We have to start thinking about the power and influence CMS has over our lives and whether such reach is, at this point, all good.

Then there's the money.

In 2018, Alphabet's revenue was almost $137 billion (6). Facebook generated about $56 billion (7). In 2017, the year prior, Medicare spent about $706 billion. That's over twelve and a half Facebooks.

But let's not stop there. Medicaid spent $582 billion in 2017. Together with Medicare, that's a combined $1.3 trillion – or about ten times the size of Alphabet.

Anyone who has concerns that social media companies have become too big to manage should have alarm bells going off about the size of CMS.

But wait…there's more.

Last year, I read a great editorial that compared Mark Zuckerberg to the architect of the Constitution, James Madison (8). The piece asserted that the Constitution was designed with checks and balances, assuming that power mongers would try to corrupt the system. In other words, it anticipated bad behavior. Facebook was designed assuming the opposite. Few checks and balances were put into the platform, enabling anyone to post whatever they wanted…and we've seen what happened. On the one hand, it's a terrible commentary about human nature. On the other, it's an excellent example of how the establishment of some rules can create a thematic legal backbone of how people should behave.

If Facebook is on one end of the spectrum and we've got the Constitution in the middle, then CMS is on the other end of the regulatory rainbow. Way too many regulations and too much power.

Because Medicare is the largest single payer in America, it wields incredible influence over everyone else. Think about it. People go to the hospital when they're sick. The older you are, the sicker you get. That means that the majority of people in hospitals are on Medicare. Most hospitals cannot survive without reimbursements from Medicare. If CMS wants to roll out a rule, then hospitals pretty much have no ability to challenge it. They have to accept the rule, or Medicare won't reimburse them anymore.

Isn't that a form or tyranny? The unrestrained exercise of power?

But their influence goes beyond Medicare enrollees. When CMS dictates terms of service, they are de facto setting the standard for patient care delivery in a facility. If Medicare pays for certain things, like a test as a result of a diagnosis, then a hospital is likely to perform that test when other patients who are not on Medicare also get that diagnosis. It's just too difficult and quite frankly dangerous for providers to be delivering different clinical protocols to patients based on who's paying. More often than not, if Medicare says so, then the other payers fall in line too.

The main priority of CMS is becoming a somewhat existential question. Back in the day, the organization used to be called the Health Care Financing Administration, or HCFA. In 2001 the name was changed to the Centers for Medicare and Medicaid Services. This shift is important, because the organization has expanded to become not just a financing entity that oversees payments, but also a regulatory agency. This dual role has, in my mind, created problems for providers and patients and taxpayers.

Over less than two decades, the organization has grown significantly in size and scope.

First, the number of Medicare beneficiaries has grown. Baby boomers aged into the program and people are living longer, expanding the reach and importance of Medicare. When the Affordable Care Act was rolled out, CMS' role got even bigger. First, Medicaid enrollment expanded in the majority of states across America. That increased CMS' size.

What's interesting in all of this is a recent study that came out by two Harvard economists (9). The study evaluated the payback that the government receives from investing in safety net programs. The key takeaway? The government saves money by investing in children and it loses it when investing in adults. Their logic drew on conclusions that investing in children's health and education gave kids a healthier start, enabled them to get better jobs, be more self-sufficient and rely less on governmentally-funded programs as adults. They calculated that a dollar invested in a child was paid back, and the government "saved" an additional 47 cents as kids shifted into adulthood.

The reverse was true for adults. A dollar invested in adults was lost, and adults spent an additional 60 cents per dollar on social services. Adults were either unable or unmotivated to become more self-sufficient as they received aid from government programs. We can't tease out the difference. But the facts don't lie and it should give us pause when we consider investing more and more in any program that subsidizes adults. I'm not saying we should stop it. We just need to be more circumspect with how we do it.

This study should have significant ramifications for folks who want to expand Medicaid in the 14 states that haven't done it yet as part of the ACA. It should also impact discussions around a single payer, which I will get to later in the show. But for now, let's talk about the enrollees in Medicaid and how this study should change the organization of the program.

Some could argue that this study bolsters the idea that a Medicaid expansion is a good thing because about half the enrollees in Medicaid are children (10). We just noted that it's a smart use of governmental funds to invest in kids, so a logical conclusion would be that expanding Medicaid is a smart use of government funds.

Here's the fatal flaw in that argument: kids don't spend 50% of the money in Medicaid.

The Kaiser Family Foundation shows the number of enrollees in Medicaid and the amount of money each type of these groups spent. Unfortunately the data is from 2014 and has not been updated. It reflects enrollment before expansion of Medicaid happened in a number of states. In this data, about 43% of Medicaid enrollees are kids (11). This 43% spent only 19% of the program's dollars (12). It would be great to see how much the current 50% of enrollees spend, but the point is that this group doesn't cost the program a lot. So when you expand Medicaid, you're expanding the majority of spending to adults. And per the study referenced, those dollars spent wind up costing the system much more than what was invested.

The smart thing to do would be to split Medicaid up and separate out the children from the rest of the enrollees. That way, the adult portion of the program could be managed better. No doubt many of the adults receiving Medicaid benefits need them. There is an expectation that some of us will not be able to "pay back" the system because of bad circumstances, out of the enrollees' control. I think we, as an American community, have a responsibility to these people.

But Medicaid also spends a lot of money in ways that must be re-evaluated. For example, 20% of the program's dollars go to long-term care (13). Another $19 billion is paid to Medicare. It would be great to separate those programs out too. Medicaid is known for underpaying providers, which limits access to enrollees and thus, contributes to the lower outcomes of the Medicaid community. It would be better for everyone if we knew that dollars that could be spent on non-elderly adults weren't being siphoned off for expensive long-term care facilities. I'd like to see more aging in place options and ways to reduce the high cost of long-term care.

Breaking up Medicaid is one way to help better manage a program that has been increasing in size.

But CMS also increased its role in oversight. The Center for Consumer Information and Insurance Oversight was established, and it oversees policies related to the ACA. Overseeing healthcare.gov, working with states to ensure ACA's regulations are in place…CMS does all of that.

So CMS is collecting money from providers while also dictating the terms of service for delivering the care. In the context of the tech world, it would be like Facebook collecting money for the services it provides, while also establishing the rules related to providing the services.

Here's an example.

The ACA brought about the implementation of so-called value-based programs. The idea is a good one. Providers should seek to deliver the best care as efficiently as possible instead of just charging for tests and procedures. But implementation of this idea is a lot harder than expected. What has happened is that CMS has established terms for outcomes and performance. Providers have to satisfy certain metrics set up by CMS or their payments get cut or worse yet, they're kicked out of the program.

It's one thing to say, hey hospital, you're going to get paid $6,535 to do this procedure for these patients. It's another to say, we made an agreement to pay you $6,535 to do this procedure for these patients but because you didn't do these other things over here, which may have nothing to do with the procedure, we're cutting your payment to $6,000.

In fiscal year 2019, 800 hospitals will have their Medicare payments cut because they fell in the bottom quartile of hospitals for metrics related to patient safety (14). The Hospital Acquired Conditions Reduction program was created as part of the ACA. Its goals are in the right place: it seeks to reduce infections and complications in order to improve patient care. Here's what's not good. Hospitals can improve year over year and still fall in the bottom quartile. Everyone can improve and the bottom quartile still gets punished. Some hospitals serve patient populations with much higher volumes, with care that requires more complexity, and they may still get punished. Instead of creating an absolute metric for hospitals achieve, they just punish the bottom quartile.

Then there's the Hospital Readmissions Reduction Program, also implemented as part of the ACA. I've mentioned this before. This is the program that penalizes providers if patients with certain conditions or procedures are readmitted within 30 days. The idea is that CMS doesn't want hospitals sending patients home too early only to have them re-admitted and have CMS pay the hospital again, to treat the same patient. It's important to note that some hospitals do abuse the system and patients by discharging them early, and a program like this can help reduce that behavior.

But the program is problematic for hospitals that operate in the urban core and serve the un or underinsured. These populations have lower levels of education, they may not have help at home or they may live in less than sanitary conditions. The hospital can't help this. But if the patients come back within 30 days because they didn't take their meds or they got an infection or they ate something they weren't supposed to…the hospital gets penalized.

And then… there are patients like my mother. And this gets to the heart of the problem with HRRP and with tying compliance to payments and maybe to why CMS hasn't articulated its mission.

My mother passed away this year. She was a life-long smoker with COPD. She had had open-heart surgery. These are conditions that are red flags for the HRRP program. Every few years my mother would have a major hospitalization. She'd get discharged and go to rehab. Something would happen – she'd get an infection at the rehab facility, her heart would crater, whatever –

and she'd have to go back to a hospital. Sometimes she'd get sent back to the hospital from whence she came. One time she was in the emergency room for over a day because they didn't want to admit her. She was stabilized and sent back to rehab. Another time she was sent to a completely different hospital. That generated a flurry of calls about Do Not Resuscitate Orders and pacemakers because the hospital didn't have familiarity with my mom's case. Nightmare. And I know many of you listeners have stories like this. And if you don't, you may soon will and I am sorry about that.

There's no value-based care program that was going to fix my mother. She was old and sick, and testing her and charging Medicare (and subsequently, taxpayers) for this care, most of which didn't help her, was crazy. Penalizing a hospital for her readmission was also ridiculous because there's nothing a hospital could have done to cure my mother.

Which brings us to CMS' identity crisis. On the one hand, they agree to pay providers to treat the sick. That's the financing/payment side, going back to the simpler HCFA roots.

But now they're also putting the responsibility on hospitals for keeping patients well. It's paradoxical to contract with someone to perform a service that has conflicting goals. CMS is paying providers to treat sick people and at the same time, penalizing them if the people don't stay well.

Given the size of the CMS and its conflicting programs, it's time to consider a break-up.

We need to separate out the financing and reimbursement part from the rules and regulations part. Both are necessary. But bunching them together is creating problems. I would hope the change would just be a organizational move, but separating these two functions will raise questions about how CMS should enforce their regulations. For one thing they should stop penalizing swaths of hospitals based on quartile performance. CMS should do a better job of setting specific targets.

There's no doubt that the entire value-based line of thinking needs to be reconsidered. Punishing providers for outcomes they can't control doesn't make sense and it's why value-based care has yet to be fully embraced by the industry. We need to put more accountability on patients – not on the providers. That is a cultural thing and it's a huge shift in perception. Nonetheless, some leadership around this from an organization like CMS could positively influence how people behave.

Further, we need to reduce the size of these programs. And this isn't just my idea. Take it from Seema Verma, CMS' current administrator. In an op-ed that appeared in *The Wall Street Journal* this year, she wrote against Medicare-for-All (15). It's ironic. A bureaucrat writing against a program that would dramatically increase her domain of responsibility. She wrote that Medicare's "… problems are the result of the inherent inefficiency of a program that lacks market incentives and meaningful consumer options." To expand that program would only make it worse. I couldn't agree more.

Instead of campaigning to make Medicare bigger, we need to make it smaller. One logical option is to increase the age of enrollment from 65 to 67 or even older. People are living longer than they did when Medicare was created in 1966. They should enroll in the program later, which can help save some money and reduce the program's size.

There are all kinds of things that can be done from a clinical perspective. As a result of value-based care, many hospitals have done some truly innovative things to reduce waste and improve patient care. These best practices need to be shared and more of them need to be encouraged.

But here's something else we can do to shrink the size of the program: allow people to opt-out.

Right now, about a third of Medicare enrollees are on Medicare Part C, or Medicare Advantage. Enrollment is growing. Part C is a "managed care" program where Medicare pays private insurers a set fee to manage the care of Medicare enrollees. In other words, the care for a third of Medicare's enrollees is managed by private insurers, not the government.

Wouldn't it be great if people were given the option to take that payment that's given to an insurer for Part C and use it to buy their own insurance? Not everyone needs all the services that Medicare provides. And they may not need them when they're 65. Or even 75. If the government is already outsourcing the management of some Medicare – and most of Medicaid too by the way - then it makes more sense to simply give the funds directly to individuals so they can select the options that work for them. I think the more freedom people have in their health care decision-making process, the more likely they'll act in ways that help them to be as healthy as they can be.

This is The Powers Report Podcast. Please subscribe to our show and please follow me, Janis Powers, on social media. Please see our website at powersreportpodcast.com to submit questions and ideas on the Contact page. I look forward to hearing from you. Thanks so much for listening!

1. "General Data Protection Regulation (GDPR)," EU GDPR.org, https://eugdpr.org/.
2. "The Top 20 Valuable Facebook Statistics – Updated July 2019," Zephoria Digital Marketing, https://zephoria.com/top-15-valuable-facebook-statistics/.
3. "YouTube by the Numbers: Stats, Demographics and Fun Facts," Omnicore.com, January 6, 2019, https://www.omnicoreagency.com/youtube-statistics/.
4. "National Health Expenditure Data Projected," Centers for Medicare & Medicaid Services, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html, NHE Projections 2017-2026 – Tables.zip, Table 03, "National Health Expenditures by Source of Funds".
5. "Health Insurance Coverage of the Total Population," Henry J. Kaiser Family Foundation, https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

6. “Annual Revenue of Alphabet from 2011 to 2018 (in million US dollars),” J. Clement, May 28, 2019, statitista.com, https://www.statista.com/statistics/507742/alphabet-annual-global-revenue/.
7. “Facebook’s Annual Revenue from 2009 to 2018 (in million US dollars),” J. Clement, February 4, 2019, statitista.com, https://www.statista.com/statistics/268604/annual-revenue-of-facebook/.
8. “Mark Zuckerberg Is No James Madison,” Paul Bergevin, March 20, 2018, *The Wall Street Journal*, https://www.wsj.com/articles/mark-zuckerberg-is-no-james-madison-1521585114.
9. “When the Safety Net Pays for Itself,” Soo Oh and Janet Adamy, July 22, 2019, *The Wall Street Journal*, https://www.wsj.com/articles/when-the-safety-net-pays-for-itself-11563800405.
10. “April 2019 Medicaid and CHIP Enrollment Highlights,” Medicaid.gov, https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html.
11. “Medicaid Enrollees by Enrollment Group,” Henry J. Kaiser Family Foundation, https://www.kff.org/medicaid/state-indicator/distribution-of-medicaid-enrollees-by-enrollment-group/?dataView=1&currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.
12. “Medicaid Spending by Enrollment Group,” Henry J. Kaiser Family Foundation, https://www.kff.org/medicaid/state-indicator/medicaid-spending-by-enrollment-group/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.
13. “Distribution of Medicaid Spending by Service,” Henry J. Kaiser Family Foundation, https://www.kff.org/medicaid/state-indicator/distribution-of-medicaid-spending-by-service/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.
14. “Medicare Trims Payments to 800 Hospitals, Citing Patient Safety Incidents,” Jordan Rau, March 1, 2019, *Kaiser Health News*, https://khn.org/news/medicare-trims-payments-to-800-hospitals-citing-patient-safety-incidents/.
15. “Medicare for All Means Hope for None,” Seema Verma, March 27, 2019, *The Wall Street Journal*, https://www.wsj.com/articles/medicare-for-all-means-hope-for-none-11553727544?mod=searchresults&page=1&pos=9.