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A Brave New Medicare

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"Consistency is contrary to nature, contrary to life. The only completely consistent people are dead."

Aldous Huxley

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Next month the Affordable Care Act turns five, and by all accounts the influence of this historic legislation will forever change the landscape of health care in the United States, regardless of its ultimate fate. As each passing year introduces thousands of new regulatory pages to an already expansive body of federal and state law, praise for what has come to be known as health care reform is only rivaled by the relentless partisan calls for its repeal.

Recognition of the Affordable Care Act's more laudable accomplishments should not be overlooked, especially the elimination of preexisting conditions, an overall reduction in the number of uninsured, and, according to some experts, findings that point to an actual slowing in health care spending at a national level. On the other hand, we as a nation must also be mindful of any collateral damage caused by reform, especially when considering that the immediate statistical data used to document the success of reform tends to present itself easily, while the longer-term, potentially less favorable information upon which the Affordable Care Act can also be judged may take decades to unfold.

When Medicare turned five, Part A's deductible was $52 per year, and Part B charged a monthly premium of $4. To the medical providers serving the twenty million Medicare beneficiaries in 1970, reimbursement throughout the next two decades was effectively gauged on a "cost-plus" basis. As Medicare enrollment began to swell in its first twenty years, the program's budget followed suit. As a result, Medicare's financial impact on the national economy since its inception has spawned myriad Acts of Congress designed to reel things in, partly by the expansion of regulatory oversight targeting fraud, abuse and waste, clarification of the rules governing those who participate in the program, and, perhaps most importantly, by modifying the very essence of Medicare's reimbursement infrastructure. Congressional determination to change the ways in which Medicare pays health care providers reached its first peak in the 1980s with the introduction of the prospective payment system (PPS), and then rose to a higher summit in 2010 with the passage of the Affordable Care Act.

While early critics of PPS foretold of health care's apocalypse, much like those challenging the Affordable Care Act today, historical similarities should not distract attention from the truly epic changes happening now under Medicare's new system of reimbursement. If the word "cost" best described Medicare

reimbursement since 1965, the term "quality" now defines the program in its maturity. Unlike PPS, which applied only to hospitals and not directly to the individual physicians, the future of Medicare no longer discriminates, which at first blush is only fitting for a system just one year younger than the Civil Rights Act and the same age as the Voting Rights Act. Unfortunately, to ensure its survival, Medicare has no choice but to discriminate. However, today's judgment comes not in the form of race, color, religion, sex, national origin, age, or any other protected class codified throughout the years, but rather in terms of good vs. poor performance.

Although the implications on Medicare concerning its practical disregard for the composition of health care providers remains to be seen, - in particular size, financial condition, service line and geographic location - the impact on providers is already apparent. Medicare has recently implemented notions of quality and value into the health care system through programs such as value-based purchasing and hospital readmissions reduction, not to mention measures focusing on inpatient and outpatient quality reporting and the reduction, if not elimination, of hospital-acquired conditions and healthcare associated infections. In 2015, the failure of a health care provider to follow Medicare's quality-based directives may result in a loss of almost 10% in Medicare revenue. By 2018, Medicare plans to link 90% of all traditional Medicare payments to quality or value through the same programs mentioned above.

Historically, Medicare has served as a symbolic weathervane for health care payers in general, many of which implemented certain policies consistent with those espoused by the federal program. In 2015, however, the Federal Government will fortify, and perhaps even codify, what was previously only emulated through the Health Care Payment Learning and Action Network, a newly created consortium designed to foster collaboration between private payers, employers, consumers, providers, states and state Medicaid programs.

The idea that medicine is both a science and an art is not discussed within the canons of Medicare regulations, and the scientific standard to which providers are held has been in a constant state of refinement for the past 50 years. If nothing else, Medicare's evolution since 1965 is rather impressive in its continual attempt to right its own shortcomings while restructuring and modifying itself to fit the needs of the changing times. With its eligibility requirement set at age 65 since the beginning, Medicare's growth has in part been due to the national acceptance of the program, but it is also because over the years those individuals eligible for Medicare have stayed in the program longer.

Statisticians and actuarial analysts can predict with reasonable certainty the number of Medicare beneficiaries to be found well into the future. Unfortunately, no one can accurately predict the neighborhood in which a Medicare beneficiary lives, much less the condition of that neighborhood. This is a fundamental flaw in the Medicare program as it tries to enforce the inflexibility of its infrastructure upon a new freshman class each year. When used to describe a hospital, the words "small" and "community" are no longer terms of endearment, but rather warnings of impending hardships to those institutions with less means. Likewise, Medicare also takes a different spin in its approach to American folklore and the towns frequently painted by the likes of Norman Rockwell.

In the realm of modern health care, a "rural" distinction is not considered charming, so much as inconvenient. The word "urban" does not connote bustling, but poor, with higher rates of acuity to boot. Not surprisingly, a small, community hospital in a rural, financially distressed city may struggle with patient satisfaction surveys or fall short when it comes to the meaningful use requirements of electronic health records. To be sure, the infrastructure necessary to abide by Medicare's shift toward value and quality comes with a hefty price tag, but such concerns are seldom addressed within the pages of the Affordable Care Act itself. Each time another hospital is forced to close its doors forever, it serves as yet another reminder that in this brave new world of Medicare, resistance is not only futile, it may in fact be terminal.

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