Re-designing Medicare: What does the public think?

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CENTER FOR HEALTHCARE DECISIONS
when there are no easy answers.
chcd.org

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1. Overview of CHCD and public deliberation
2. Use of CHAT® as a tool for deliberation
3. Select results of MedCHAT
4. Now what…..

Bringing the public's informed voice to healthcare policy

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Elements of public deliberation:

- Criteria: an issue of competing priorities or policies
- More than one strategy is possible
- Structured discussion process
  - Accurate, unbiased facts
  - Alternative approaches
  - Diverse perspectives are probed; detailed reason-giving
  - Neutral facilitation
- Identify the core beliefs/values that underlie decisions
- The societal perspective: what bests serves all

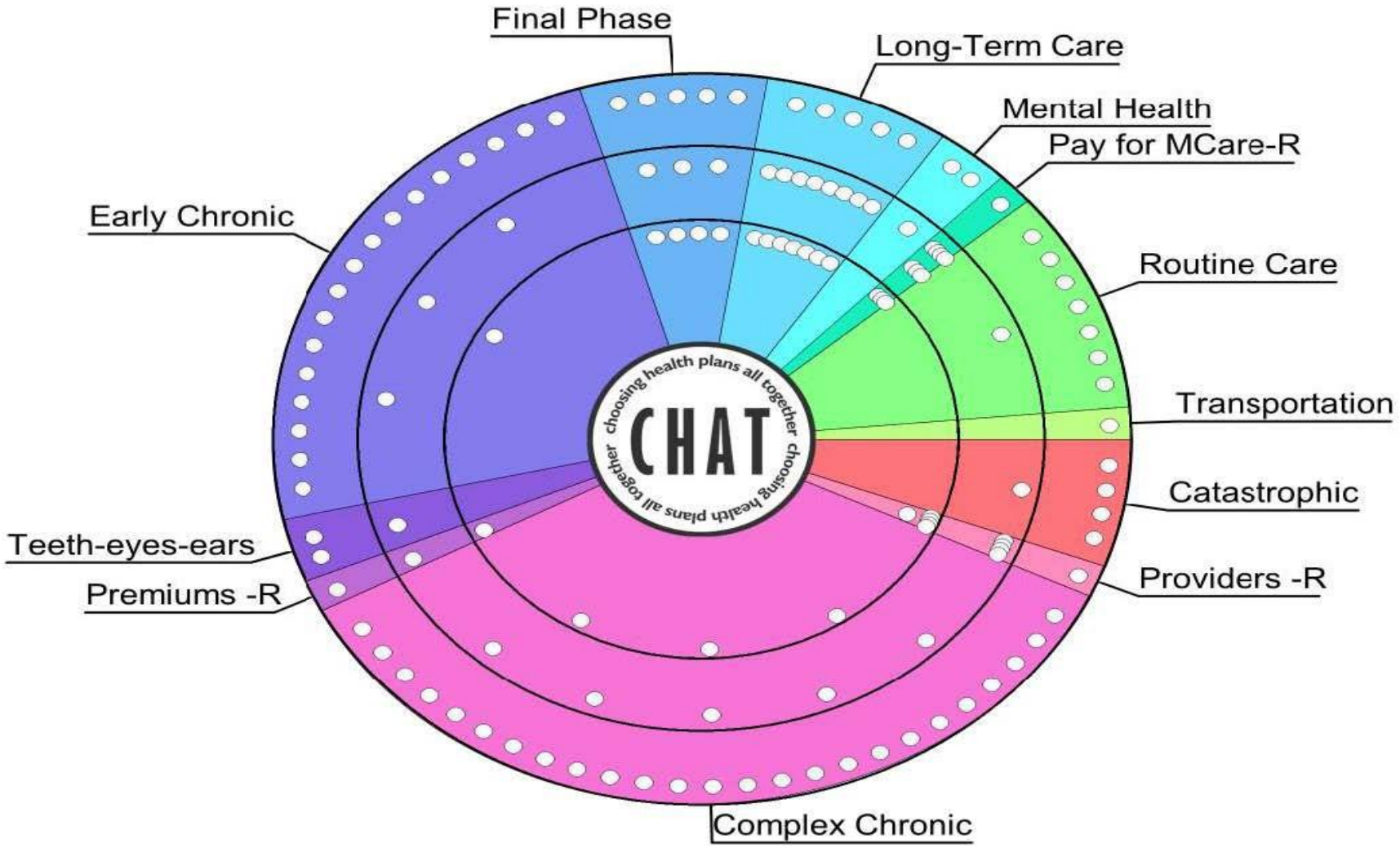

Can the public take a 'societal' perspective when it comes to health care?


Why MedCHAT?

CHAT® (Choosing All Together)

- Developed by physician-ethicists in 1999
- Education, engagement and research on coverage priorities
- 2 - 3 hour process, highly structured
- Other priority-setting beyond health plan design
- Paper ➡ laptops ➡ tablets via cloud technology

The MedCHAT pie chart: categories and tiers

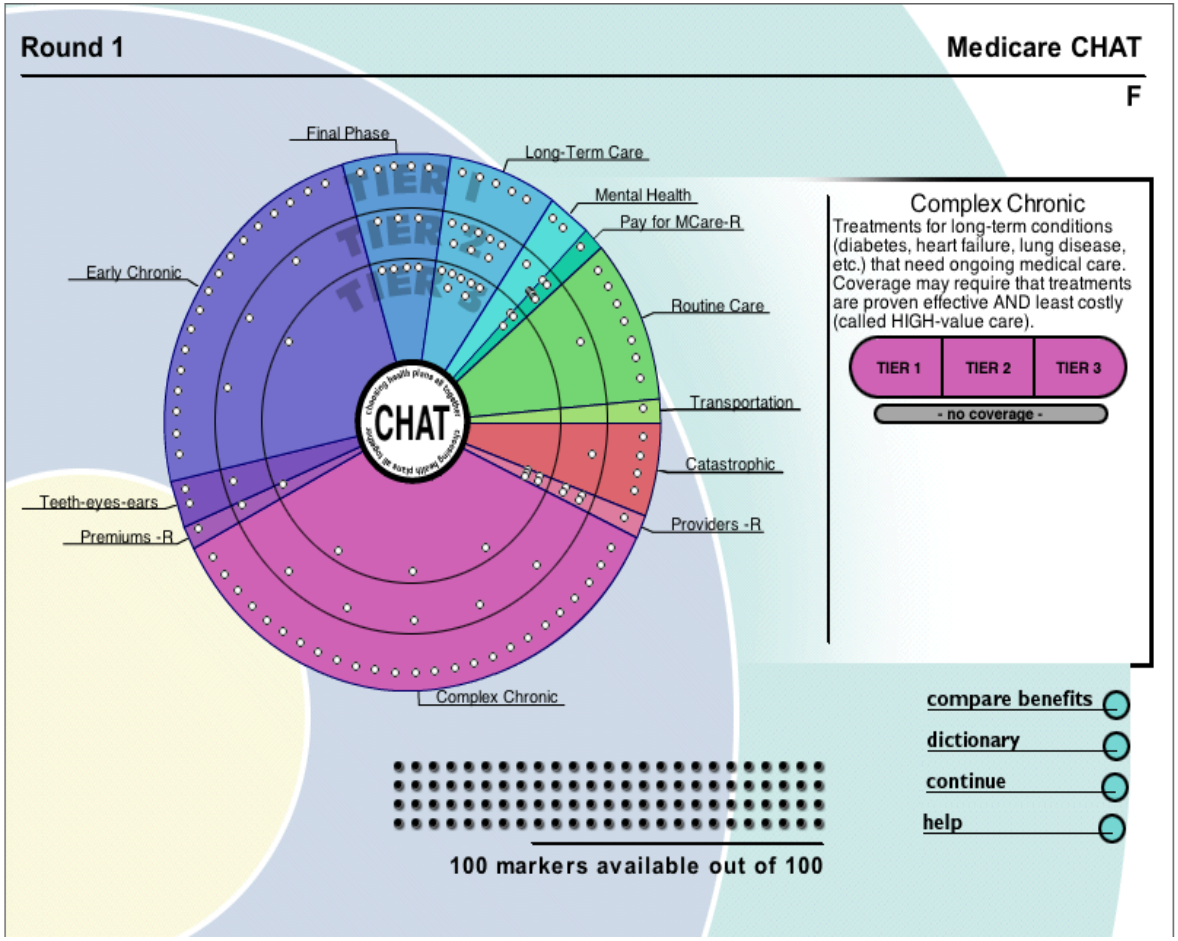


Where do priorities lie?

- How important is unrestricted choice of providers?
- Should limits be placed on covering “low-value” care?
- Should penalties/awards be used to promote compliance?
- What other services should Medicare cover?
- Should patients be required to use hospice?
- Should higher-income seniors pay more?




The CHAT® screen where decisions are made



There are 100 markers available representing the average amount that Medicare spends per person. There are 130 spaces.

4 rounds to create the “best” plan

Project Partners

- LeadingAge CA

- Alzheimer's Association, Northern California & Northern Nevada
- American Society on Aging
- Asian Community Center
- Blue Shield of California
- CA Department of Aging
- California Health Advocates
- Dignity Health
- Episcopal Communities & Services
- Episcopal Senior Communities
- Eskaton
- Huntington Hospital Senior Care Network
- Institute on Aging
- Keiro Senior HealthCare
- Legal Assistance for Seniors/Alameda HICAP
- Navigage
- Northern California Presbyterian Homes & Services
- Partners in Care Foundation
- Plymouth Village Retirement Community
- SCAN Health Plan
- Sutter Health
- TELACU

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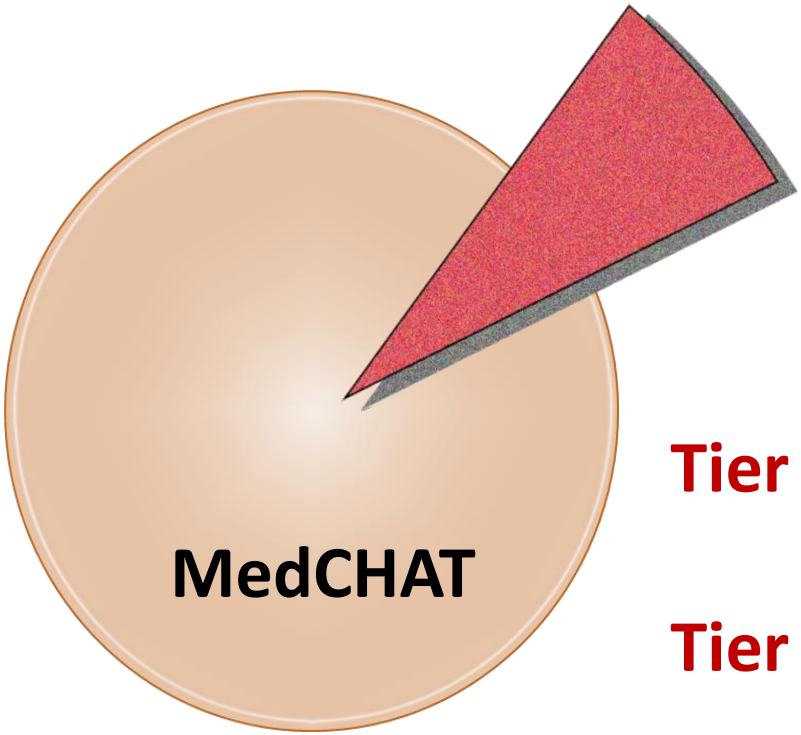
Select results: reductions in coverage

- Restricting provider choice
- Reducing coverage of low-value medical care
- Changing coverage of end-of-life care



Providers

N = 781

Tier 1: Provider network only **(1 marker)**

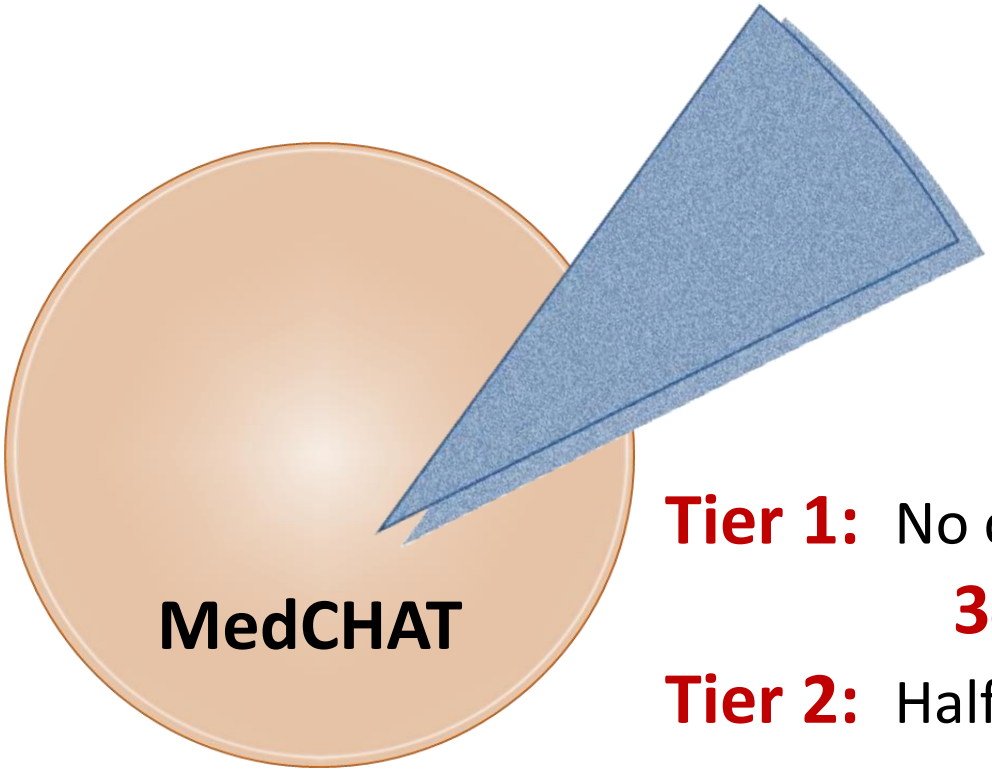
17%

Tier 2: Network w/wiggle room **(5)**

65%

Tier 3: Unrestricted (current) **(10)**

17%



Complex Chronic

N = 781

Tier 1: No coverage for low-value care **(25)**

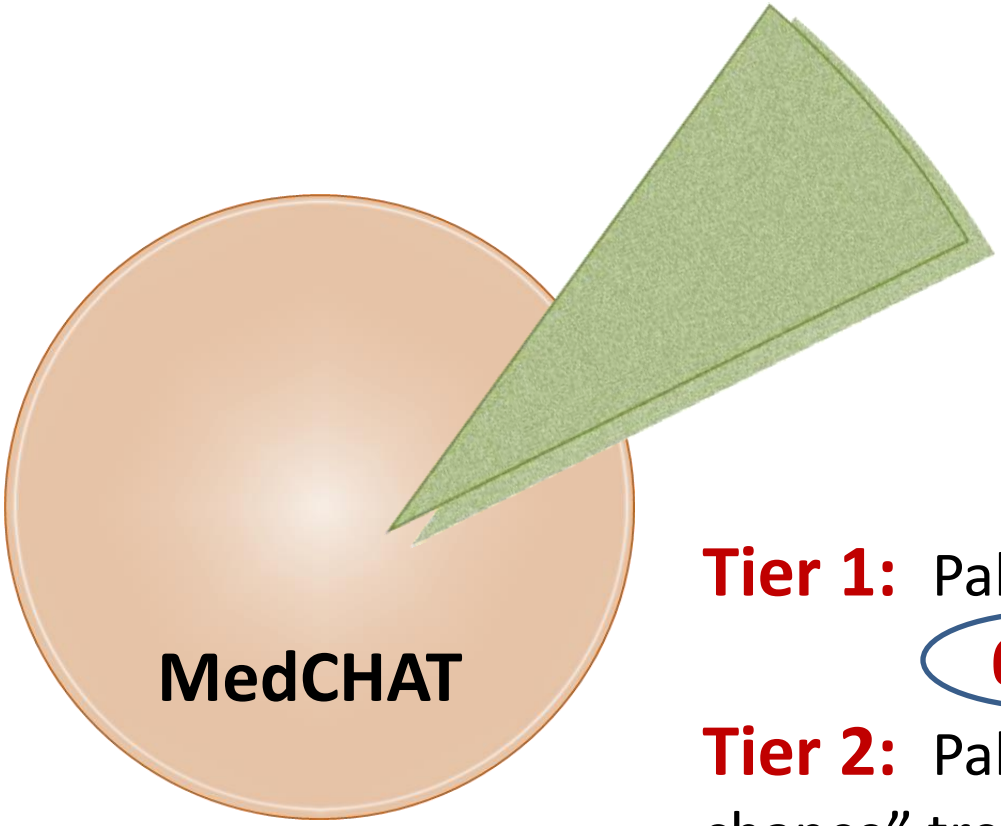
34%

Tier 2: Half coverage of low-value care **(30)**

54%

Tier 3: Low-value is covered (current) **(33)**

11%



Final Phase

N = 781

Tier 1: Palliative care/hospice only **(5)**

65%

Tier 2: Palliative care/hospice plus "last chance" treatment; no ICU when dying **(8)**

31%

Tier 3: All options covered (current) **(12)**

3%

increases in coverage

- LTC: one year with 10% co-insurance
- Dental, vision, hearing, transportation
- Mental Health services
- Extended Medicare's solvency for 50 years

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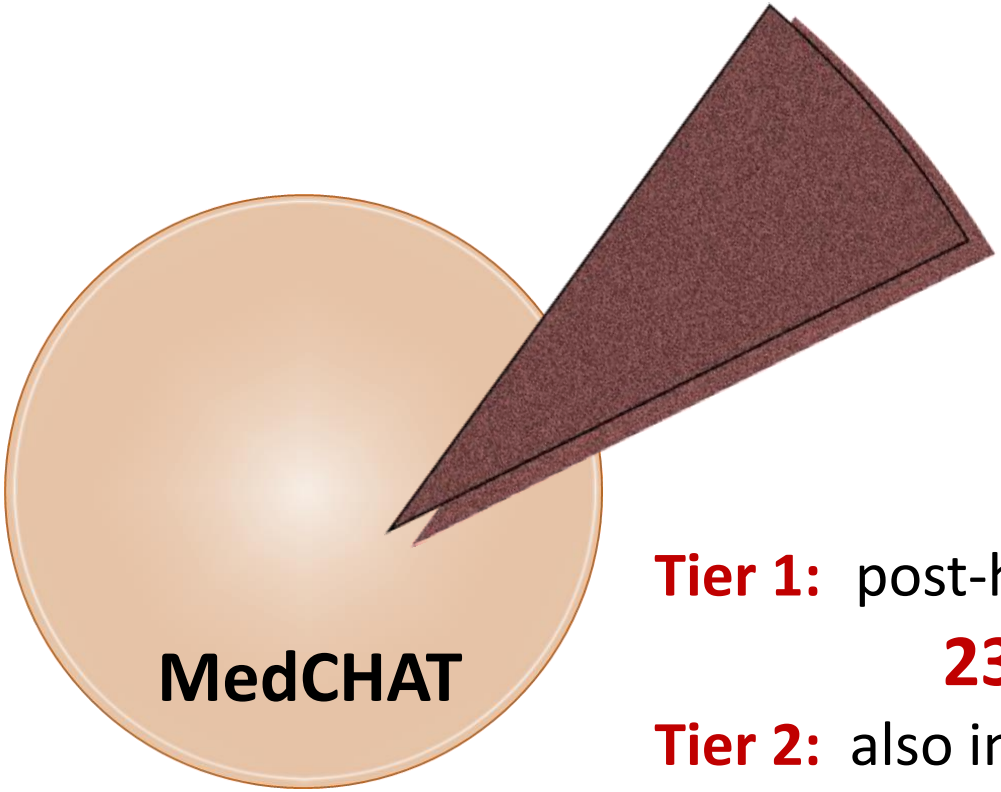

Long Term Care

N = 781

Tier 1: post-hosp, short-term SNF (current)**(5)**

23%

Tier 2: also includes 1 yr. LTC, home-based or institution, 10% co-pay **(12)**

62%

Tier 3: also includes 3 yrs. LTC coverage **(20)**

15%

Now what….?

- How do these findings relate to current policy interests/other research?
- Is it time for a deeper dive into how to reduce low-value care?
- Encourage others to replicate MedCHAT?
- Experiments (e.g., the TLC option)?

For the MedCHAT report, go to:

http://chcd.org/wp-content/uploads/2014/09/MedCHAT-full-report.pdf

for more information:

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