Silent majority

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Just over 50 years ago, Medicare, the universal federal health insurance program for Americans over age 65, was signed into law. This landmark federal legislation was designed to guarantee access to health care for older Americans at a time when half were not covered. While Medicare has provided valuable protection against catastrophic illness for millions of Americans, its ability to meet the needs of the growing number of Medicare beneficiaries with chronic conditions is far less secure.

In this issue of *Neurology: Clinical Practice*, Jones et al.¹ enhance our understanding of how Medicare pays neurologists to care for the increasing number of Medicare beneficiaries with a neurologic disorder. Apart from the headlines of fraud and abuse and outliers driven by misaligned financial incentives,² the majority (60%) of the \$1.2 billion Medicare payments directed to over 12,000 neurologists in 2012 was for evaluation and management services.^{1,3} The median neurologist received \$61,000 in payments, and neurology was not among the top 15 Medicare-compensated specialties.⁴ After accounting for typical overhead in a neurology practice (50%–60%),⁵ a typical neurologist earns as income (revenue less expenses) \$25,000 to \$30,000 per year from Medicare. Given the increasing demands of Medicare as a payor⁶ and its systematic undervaluing of care provision, the long-term participation of neurologists in the program (formally or informally) may decline.

Just as the financial benefits of Medicare to the majority of neurologists are modest, so may be the health benefits to the majority of Medicare beneficiaries. Approximately 80% of Medicare beneficiaries have at least one chronic condition,⁷ and yet many have trouble accessing appropriate care. For example, among Medicare beneficiaries with Parkinson disease, 42% do not see a neurologist, and those who do not are approximately 20% more likely to fracture a hip, be placed in a skilled nursing facility, or die.⁸ Moreover, those who do not see a neurologist are more likely to be hospitalized for a Parkinson disease–related condition.⁹ Perhaps as a result, almost one-quarter of Medicare beneficiaries with Parkinson disease currently reside in a long-term care facility.¹⁰ While distance and disability likely contribute to the access problem, financial incentives that continue to favor institutions over patients are likely a major contributing factor.¹¹

Considering that most neurologists receive modest financial benefits from an increasingly demanding payor, many beneficiaries currently are unable to access neurologic care, and the number of Medicare beneficiaries will increase from 50 to 70 million in 10 years,¹² change is needed. Change can come from within or outside Medicare. As part of the Affordable Care Act, a new Innovation Center was created within the Centers for Medicare and Medicaid Services. While the Innovation Center can and is evaluating new payment and promising delivery service models,¹³ the long-term effect of these investments is uncertain. Similarly, while accountable care organizations are touted for their potential to align financial incentives with provision of quality care, evidence for their value to date is modest.¹⁴ Perhaps most importantly, Medicare beneficiaries have little, and in many cases no, input into how Medicare spends their taxes. Without direct or indirect input from those who stand the most to benefit (and the most to lose), change in Medicare policies is likely to be slow.

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While change within Medicare may be slow, disruptive care models may come rapidly outside the program. Venture capital investment in digital health surpassed \$4 billion last year and is on pace for similar investment this year.¹⁵ Many of these investments are in care models¹⁶ that enable Americans, including older Americans,¹⁷ to receive care in the home.¹⁸ Many of these services (e.g., extended home care) are not covered by Medicare and often intentionally so. While their potential for improving care may be considerable, especially for those with means living in urban areas, some disruption may not reach those in greatest need. Whether Medicare beneficiaries, some of whom have contributed taxes to the program for half a century, and their increasing numbers of caregivers¹⁹ will tolerate such limitations remains to be seen. Transparency into how Medicare spends their taxes as well as reports like the one by Jones et al will hopefully enable the generally silent majority of neurologists and Medicare beneficiaries to see the limitations of Medicare's policies more clearly.

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