

Aligning Incentives in Medicare

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Statement of
Glenn M. Hackbarth, J.D.

Chairman
Medicare Payment Advisory Commission

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Chairman Waxman, Chairman Pallone, Ranking Member Barton, Ranking Member Shimkus, distinguished Committee members. I am Glenn Hackbarth, chairman of the Medicare Payment Advisory Commission (MedPAC). I appreciate the opportunity to be here with you this morning to share the findings from our June 2010 *Report to the Congress: Aligning Incentives in Medicare*.

Current challenges in Medicare

Since 1997, MedPAC has provided independent, non-partisan policy and technical advice to the Congress on issues affecting the Medicare program. The Commission's goal is to achieve a Medicare program that ensures beneficiary access to high-quality care; pays health care providers and health plans fairly, rewarding efficiency and quality; and spends tax dollars responsibly.

However, numerous indicators suggest that goal is not being realized. Many studies show serious quality problems in the American health care system. Some individuals are not receiving the recommended care for their health conditions and others are receiving care that may not be clinically appropriate—care that does not appear to be related to improving patient outcomes or quality.

These shortcomings have significant fiscal consequences for the federal government. The share of the nation's GDP committed to Medicare is projected to grow to unprecedented levels, squeezing other priorities in the federal budget and constituting a growing financial liability for beneficiaries and taxpayers. The Medicare trustees reported the Hospital Insurance trust fund's expenses exceeded its income in 2008 and have expressed serious concern about its possible exhaustion in the future.¹

Many of the barriers that prevent Medicare from improving quality and controlling costs—obtaining better value—stem from the incentives in Medicare's payment systems. Medicare's payment systems are primarily fee-for-service (FFS). That is, Medicare pays for each service delivered to a beneficiary by a provider meeting the conditions of participation for the program. FFS payment systems reward providers who increase the volume of services they provide

¹ The 2010 trustees report is expected later this summer in order to reflect on recent legislative activity.

regardless of the benefit of the service. FFS systems are not designed to reward higher quality. (While much of MedPAC's work has focused on problems in the Medicare FFS payment systems, the Commission has also documented flaws in the payment system for Medicare Advantage (MA) plans.)

In previous reports, the Commission has recommended:

- creating pressure for efficiency by restraining providers' annual payment updates;
- improving accuracy in Medicare's payment systems to ensure Medicare pays adequately and fairly across different types of services and providers (e.g., increasing payments to primary care-focused practitioners);
- using payment incentives to promote care coordination and increase accountability among health care providers (e.g., pay for performance, readmissions penalties, piloting bundled payments); and
- broadening information available to patients and providers to enable them to choose high-quality, high-value health care services.

New report: Aligning Incentives in Medicare

The Commission's latest report discusses three areas that Medicare should address: (1) the training of the nation's health care workforce, (2) the role of the beneficiary in a reformed health care delivery system, and (3) the Centers for Medicare and Medicaid Services' (CMS's) ability to use value-based payment policies and to test and adopt innovative payment and delivery mechanisms.

We acknowledge that some of the topics raised in the Commission's June report were addressed at least in part by recent legislation. This overlap occurred because the Commission set its agenda for the year when the outcome and timing of the laws' enactment was not known.

Graduate medical education financing: Focusing on educational priorities

Despite the tremendous advances our graduate medical education (GME) system has brought to modern health care, the Commission finds that it is not aligned with the delivery system reforms essential for increasing the value of health care in the United States. Two specific areas of

concern are education and training in skills needed to improve the value of our health care delivery system—including evidence-based medicine, team-based care, care coordination, and shared decision making—and workforce mix—including trends in specialization and limited socioeconomic diversity.

We cannot accomplish delivery system reform without simultaneously ensuring that the providers we need have the skills necessary to integrate care across settings, improve quality, and use resources efficiently. In a recent *New England Journal of Medicine* article, prominent physicians assert that not only do residents need to learn relatively new skills, they need to develop a new perspective on what it means to be a “good doctor”—shifting emphasis, for example, from independent and autonomous practice to more patient-centered, team-based care.

The GME system is influenced not only by how Medicare subsidizes GME but also by how Medicare and other insurers pay for health care services. FFS payment systems reward volume without regard to quality, and the levels of payment for physician services tend to reward performing procedures over patient evaluation, management, and care coordination. These payment signals affect not only physician career choices but also institutional decisions about which residency programs to offer.

In *Aligning Incentives in Medicare*, the Commission makes five recommendations to the Congress to address these challenges. The recommendations rest on two principles: decoupling Medicare payments for GME from Medicare’s FFS payment systems and ensuring that resources for GME are devoted to meeting educational standards.

First, the Commission recommends decoupling a significant portion of Medicare’s GME payments from FFS payments to inpatient hospitals and making the payments contingent on reaching desired educational outcomes and standards. Under this recommendation, the Secretary of Health and Human Services would consult with organizations and individuals with the necessary expertise and perspectives to establish the desired standards—specifically, representatives from organizations such as program-accrediting bodies, certifying boards, training programs, health care organizations, health care purchasers, and patient and consumer groups. From these deliberations, the Secretary would develop a GME payment system that

fosters greater accountability for Medicare's dollars and rewards education and training that improves the value of our health care delivery system. To allow adequate time for development of rigorous educational standards and criteria, Medicare's new, more accountable payment approach should begin in three years, in October 2013. Funding for this initiative should come from the amount that Medicare is currently paying hospitals above their empirically justified costs for indirect medical education—currently estimated to be \$3.5 billion. Savings from this reduction should be used to fund incentive payments to institutions (such as teaching hospitals, medical schools, and other eligible entities that may sponsor residency programs) that meet educational standards. The Commission stressed that only those institutions meeting the criteria would be eligible for incentive payments. Conceivably, therefore, all, some, or none of this amount could be distributed. Distribution of payments would depend on program and institutional performance.

The Commission's second recommendation—to make information about Medicare's payments and teaching costs publicly available—also fosters greater accountability for educational activities within the GME community. During the Commission's examination of GME financing issues, some residency program directors voiced concerns that they have difficulty gaining information about their teaching hospitals' GME revenues because the GME payments go directly to the hospital. Consequently, it can be challenging for them to judge whether Medicare's GME payments are being distributed appropriately and equitably. This recommendation is designed to encourage collaboration between educators and institutions on residency program funding decisions. Although interpreting reported cost data may require some caveats, the transparency of this payment and cost information will recognize Medicare's significant investment in residency (and some nursing) training and education.

The final three recommendations call for studies to examine specific aspects of health workforce training. Currently, Medicare's payments for GME generally subsidize the specialty choices of both teaching hospitals (in their program offerings) and residents (in their career choices). The resulting physician mix of specialties is unlikely to ensure that the nation has an adequate supply of health professionals for well-functioning delivery systems, as evidenced by falling shares of physicians practicing primary care after their residencies.

The Commission recommends that a rigorous, independent analysis of our health care workforce needs be conducted on an ongoing basis. This analysis should be driven by the requirements of a high-value, affordable health care delivery system. Analyses that simply extrapolate demand projections based on current patterns of care compromise the nation's chances of fostering high-value health care systems. An improved delivery system will influence the total number of physicians and the mix of professionals needed in our health workforce. Consequently, any decisions about Medicare's funding of new residency positions should await the results of such a study.

Second, the Commission is interested in the net impact that residency programs of different specialties have on their hospitals' financial performance. Some residency programs may improve hospitals' financial performance, while other residency programs may not. For example, some specialties may require greater supervision costs, while others may attract higher volumes of more profitable services to the institution. Also in question is the optimal level of Medicare GME payments by resident specialty type. There is little research on these differences. A better understanding of these financial impacts could inform a more efficient distribution of GME dollars among residency programs. Therefore, the Commission recommends a specialty-specific analysis of net institutional costs and benefits.

A third workforce goal that deserves concerted attention is to find the most effective strategies for increasing the diversity of our pipeline of health professionals (i.e., increasing the share of professionals from underrepresented racial and ethnic minorities, from lower income families, and from rural hometowns). Research has found that a diverse health care workforce is associated with better care quality and access for disadvantaged populations, greater patient choice and satisfaction, and better educational experience for students in health professions. A number of programs, administered by the Health Resources and Services Administration, are designed to address this goal. While research on several specific programs shows some positive impact on health care workforce diversity, comprehensive evaluation of these programs' longitudinal effectiveness is not well studied. Therefore, in order to optimize federal subsidies for this category of programs, the Commission recommends a study that outlines a strategy for achieving health care workforce-diversity goals.

Beneficiaries' role in delivery reform

Benefit design. Reforming the design of the traditional Medicare FFS benefit offers an opportunity to align beneficiary incentives with the goal of obtaining high-quality care for the best value. Of particular importance, reforms could also improve financial protection for individuals who have the greatest need for services and currently face very high cost sharing.

The current FFS benefit design has several challenges with respect to beneficiary out-of-pocket expenses. There is no upper limit on the amount of Medicare cost-sharing expenses a beneficiary could incur, exposing Medicare beneficiaries to substantial financial risk and potentially discouraging the use of valuable care. In addition, a beneficiary's out-of-pocket expenses during the course of a year can be unpredictable and highly variable. As a result, more than 90 percent of Medicare beneficiaries have supplemental coverage through former employers or medigap policies, or they have additional coverage through Medicare Advantage plans, Medicaid, and other sources.

The most widely used types of supplemental coverage, such as standard medigap Plan C and Plan F policies, fill in all or nearly all of Medicare's cost sharing in return for a monthly premium. Although popular, some forms of secondary insurance are expensive, with administrative costs of 20 percent or more. Supplemental coverage addresses beneficiaries' concerns about the uncertainty of what cost sharing they might owe in the FFS Medicare benefit, but it also dampens financial incentives beneficiaries would otherwise face to control spending.² There is a similar dynamic in the MA program, in which high payments to plans (relative to FFS) enable insurers to offer zero-premium plans and extra benefits to beneficiaries. Since these features are subsidized through high payments, which mask the real costs of the benefits, they are not accurate price signals to the beneficiaries. In the current MA program, the beneficiary does not have a financial incentive to choose a high-quality, efficient plan.

Commission-sponsored work shows evidence that when elderly beneficiaries are insured against Medicare's cost-sharing requirements, they use more care and Medicare spends more on them.

² Recent legislation directs the National Association of Insurance Commissioners to revise standards for the most popular supplemental plans to include requirements for nominal cost sharing to encourage the use of appropriate physician services under Part B. New standards are due to be in place by January 1, 2015.

However, this higher spending often does not result in better health or improved outcomes and could reflect spending on low-quality health care. Under the current FFS payment systems neither the program nor beneficiaries can easily discriminate high- from low-value care. A body of health services research literature finds that cost sharing can have either beneficial or detrimental effects on beneficiaries' health outcomes, depending on how it is structured. Encouraging use of high-value care and discouraging use of low-value care are the great challenges of benefit design.

For the near term, potential incremental improvements to the FFS benefit and to supplemental coverage could begin changing beneficiaries' incentives. The aim of these improvements would be to reduce financial risk for beneficiaries with the highest levels of cost sharing, deter beneficiaries' use of lower value services, and avoid deterring beneficiaries from using higher value care—especially individuals with lower incomes. Potential improvements could include, for example, adding a cap to beneficiaries' out-of-pocket (OOP) costs in the FFS benefit and, at the same time, requiring supplemental policies to have fixed-dollar copayments for services such as office visits and emergency room use. Such restrictions on supplemental coverage could lead to reductions in use of Medicare services sufficient to help finance the addition of an OOP cap. These strategies could be coupled with exceptions that waive cost sharing for services in certain circumstances—for example, if evidence identified them as leading to better health outcomes. The strategies could also include cost-sharing protections for low-income beneficiaries so that they would not forgo needed care. Providing beneficiaries with clear information to help them consider their treatment options with their providers could also be complementary to changes in benefit design.

In the longer term, changes could involve developing the evidence base to better understand which treatments are of higher and lower value. As currently practiced, certain insurance designs attempt to encourage use of high-value care by lowering cost sharing for services that have strong evidence of substantial clinical benefit. A primary goal of this approach is to improve quality and possibly lower costs by avoiding the need for more expensive care in the future. However, to also ensure net savings, this approach requires careful targeting and

willingness to both lower cost sharing for services of high value and raise cost sharing for services of low value.

Shared decision making. Medicare beneficiaries face certain challenges when making decisions about the relative value of different health care services. Although they are insured, Medicare beneficiaries, on average, are more likely to be poorer, less educated, cognitively impaired, faced with multiple chronic conditions, and less health literate than other consumers. All these factors may increase their difficulty understanding the information they receive about their health conditions and the risks and benefits posed by different treatments. In an effort to mitigate these problems and to make care more patient-centered, some clinicians have adopted a model of shared decision making.

Shared decision making is the process by which a health care provider communicates personalized information to patients about the outcomes, probabilities, and uncertainties of available treatment options, and patients communicate their values and the relative importance they place on benefits and harms. It is a way to facilitate patient participation in decision making. Information is conveyed through patient decision aids that provide patients with evidence-based, objective information on all treatment options for a given condition.

Physicians, not patients, have the expertise to know which approach to surgery is best, for example, or the side effect profile of different medications, but only patients know what their feelings are toward particular risks and benefits. When the patient understands the risks and the physician understands the patient's concerns, the physician is better able to recommend a treatment that will address the medical problem and respect the patient's values. To date, shared decision making has been used more widely by specialists than primary care doctors because specialists are more likely to interact with patients around treatment options with more latitude for discrete decision making, like cancer treatment and back surgery.

Medicare could promote the use of shared decision making in a number of different ways: design a demonstration project to test the use of shared decision making for Medicare beneficiaries, provide incentives to practitioners who adopt shared decision making, provide incentives to

patients who engage in shared decision making, or require providers to use shared decision making for some preference-sensitive services.

Enhancing Medicare's ability to innovate

Innovative purchasing policies could be employed to improve the delivery of health care services, but Medicare currently has legislative limits that constrain it from adopting such policies expeditiously. Furthermore, Medicare might be able to improve health care quality and efficiency if it were given broader authority to demonstrate and implement policy innovations.

Purchasing policies. Medicare has attempted to use several innovative policies that have the potential to increase the value of the program for beneficiaries and taxpayers, but their application has been limited by lack of clear legal authority. Reference pricing, performance-based risk-sharing strategies, and coverage with evidence development (CED) are three examples. The three policies have the potential to improve payment accuracy and decrease knowledge gaps. In addition, they complement the recent federal investment in comparative-effectiveness research. Reference pricing and performance-based risk-sharing strategies use such information in establishing payment for a service or product. Coverage with evidence development focuses on collecting real-world clinical evidence that patients, providers, and policymakers need to reach better decisions about a service's or product's effectiveness. Medicare's use of each strategy has been hampered because the program's legal foundation is uncertain or lacking.

Some statutory limits even prevent Medicare from making technical changes to its current payment systems. For example, updating case mix and wage indexes in prospective payment systems would improve payment accuracy, but Medicare often lacks the authority to do so, even when the change is budget neutral. Similarly, a change in law is also necessary for Medicare to implement policies that pay providers based on their quality. Medicare needs clear authority to make such changes in its current payment systems.

Research and demonstrations. The Medicare program has used research and demonstrations for decades to test the conceptual and operational feasibility of new payment policies and health care

service delivery models. Over the last several years, the Commission and other observers have noted a growing disconnect between Medicare's urgent need to implement payment and service delivery innovations and the program's limited ability to research, test, and evaluate demonstrations that provide the information policymakers need to implement effective policy changes program wide.

The Commission most recently expressed its concerns about the pace of Medicare's demonstrations in a mandated report to the Congress on improving Medicare chronic care demonstration programs. Its analysis of four recent Medicare demonstrations suggested several larger issues with the structure and funding of research and development in Medicare, including: very low levels of funding for research, demonstrations, and evaluations relative to the overall size of the program; constraints on CMS's ability to redeploy research and demonstration funding as the program's needs change; and the existence of time-consuming and resource-intensive administrative requirements in the executive branch demonstration review process. Commissioners also have raised concerns about the level of Medicare resources allocated for health services research activities, such as funding and staffing for intramural and extramural research projects and to revamp the agency's data infrastructure to provide policymakers with timely access to program and demonstration data.

In March, the Congress authorized the creation of a Center for Medicare and Medicaid Innovation (CMI) within CMS with the intention of improving CMS's research and demonstration programs. The CMI is charged with testing innovative payment and service delivery models and can operate without many of the constraints currently imposed on CMS' research programs. For example, the law waives the requirement to demonstrate budget neutrality when a model is in initial testing phases, and exempts Paperwork Reduction Act review. The law also provides for \$10 billion in annual appropriations for activities initiated in 2011 to 2019. As this new approach to innovation is being implemented, there are several lingering issues that will need to be monitored. First, there will be an inherent tension between the speed of innovation and the quality of the evidence used to evaluate the new methods. In other words, obtaining the type of evidence that might be produced in an academic model of program evaluation may not be attainable in a dynamic, forward-looking innovation process.

Second, CMS will need sufficient administrative resources to effectively operationalize new payment methods, since the agency will likely be overseeing multiple models of new payment methods while continuing to maintain the current fee-for-service payment system for those providers who do not volunteer to participate in the CMI activities.

Additional topics addressed in MedPAC's June report

The report also includes four additional chapters that touch on payment accuracy and moving away from the volume incentives in FFS Medicare and highlight more systemic changes to better align provider incentives with a reformed delivery system.

Medicare's role in supporting and motivating quality improvement

There is wide variation in the quality of health care in the United States, and the pace of quality improvement has been frustratingly slow. The Commission has recommended payment incentives and public reporting to motivate better quality, but they may not be sufficient to induce the magnitude of quality improvement needed. In *Aligning Incentives in Medicare*, the Commission looks at two additional ways to motivate quality improvement: offering technical assistance to providers and reforming conditions of participation.

Some providers may need technical assistance in improving care. This assistance could be particularly helpful when improvement requires coordination among many providers during a patient's episode of care, management of a highly complex organization, or coping with the challenges of serving a rural or a low-income population. One source of technical assistance is Medicare's Quality Improvement Organization (QIO) program, but the performance of the QIO program has been variable and its benefits have been difficult to demonstrate. In addition to the QIOs, there may be advantages to allowing other entities (e.g., high-performing providers, professional associations, consulting organizations) to participate as technical assistance agents serving low performers. For example, under an alternative quality improvement model, low performers could choose which entity would be best suited to provide them Medicare-supported technical assistance.

Another way Medicare can stimulate quality improvement is by revisiting its conditions of participation (COPs)—the minimum standards that certain provider types are required to meet to participate in Medicare. Providers, state governments, and the federal government collectively spend millions of dollars annually preparing for and conducting surveys to ensure compliance with these standards, yet it is unclear how much these efforts have accelerated the pace of change. Various options exist that could reenergize the survey and accreditation process, including updating the COPs to align them with current quality improvement efforts, imposing intermediate sanctions for underperformers, creating higher standards that providers could comply with voluntarily to be designated publicly as a high performer, and using performance on outcomes measures (e.g., mortality rates) as a criterion for providers to be eligible to perform certain procedures.

Modifying the COPs in tandem with providing targeted technical assistance may introduce a new balance of incentives that could accelerate quality improvement and make health care safer for Medicare beneficiaries.

Coordinating the care of dual-eligible beneficiaries

Dual-eligible beneficiaries (those enrolled in both Medicare and Medicaid) are, on average, more costly for the program than other beneficiaries. In addition, the Commission finds that among dual-eligible beneficiaries are distinct groups with widely different care needs and spending patterns. Dual-eligible beneficiaries account for disproportionate shares of both Medicare and Medicaid spending relative to their enrollment, and yet neither program assumes full responsibility for coordinating all of their care.

The Medicare and Medicaid programs often work at cross-purposes in coordinating care for dual-eligible beneficiaries. Conflicting program incentives encourage providers to avoid costs rather than coordinate care, and poor coordination can raise total federal spending and lower quality. Conflicting incentives can also encourage providers to seek out higher payment rates, such as hospitalizing a long-term care resident in order to qualify for Medicare's skilled nursing facility payments.

Improving the care for dual-eligible beneficiaries requires two fundamental changes: First, the financing streams need to be more integrated to dampen current conflicting incentives that undermine care coordination; second, an integrated approach to care delivery is needed to ensure quality care for this complex population. Entities that furnish integrated care need to be evaluated using outcome measures such as risk-adjusted per capita costs, potentially avoidable hospitalization rates, rates of institutionalization, and emergency room use. In addition, condition-specific quality measures and measures that reflect the level and success of care integration need to be gathered so that the success of care integration for different subgroups of duals can be assessed.

Two approaches currently in use—the Program of All-Inclusive Care for the Elderly and managed care programs that contract with states for Medicaid and with Medicare as Medicare Advantage special needs plans—offer more fully integrated care. These programs combine funding streams so that the conflicting incentives of Medicare and Medicaid are mitigated. Entities are also at risk for all (or most) services, including long-term care, and provide care management services. Mixing Medicare and Medicaid dollars can create the opportunity for states to cost shift to Medicare. If arrangements are contemplated that provide funding for both Medicare and Medicaid services to the states, special attention to enforcement would be required to ensure state programs maintain levels of effort and beneficiary access, and fund the intended services.

While integrated approaches have the potential to succeed, they are few in number and enrollment in some programs is low. Numerous challenges inhibit expanding their numbers and enrollment. Challenges include the lack of experience managing long-term care, stakeholder (beneficiaries, their advocates, and providers) resistance, the initial program investments and financial viability, and the separate Medicare and Medicaid administrative rules and procedures. Also, by statute, Medicare beneficiaries must have the freedom to choose their providers and cannot be required to enroll in integrated care. However, several states have implemented fully integrated care programs, illustrating that it is possible to address these obstacles.

Addressing the growth of ancillary services in physician offices

Many physicians have expanded their practices in recent years to provide ancillary services, and these services have experienced rapid volume growth over the last five years. Rapid volume growth, along with the diffusion of new technologies to broad populations, raises questions about the equity and accuracy of physician payments. Moreover, there is evidence that some diagnostic imaging and physical therapy services ordered by physicians may not be clinically appropriate.

The Ethics in Patient Referrals Act, also known as the Stark law, prohibits physicians from referring Medicare patients for “designated health services” (DHS)—such as imaging, radiation therapy, home health, clinical laboratory tests, and physical therapy—to entities with which they have a financial relationship, unless the relationship fits within an exception. The in-office ancillary services (IOAS) exception allows physicians to provide most DHS to patients in their offices.

On the one hand, proponents of the IOAS exception argue that it enables physicians to make rapid diagnoses and initiate treatment during a patient’s office visit, improves care coordination, and encourages patients to comply with their physicians’ diagnostic and treatment recommendations. On the other hand, there is evidence that physician investment in ancillary services leads to higher volume through greater overall capacity and financial incentives for physicians to order additional services. In addition, there are concerns that physician ownership could skew clinical decisions—inciting physicians to provide certain tests or treatments that their clinical judgment would not otherwise lead them to order if they did not have a financial stake in the equipment.

To examine the frequency with which services covered by the IOAS exception are provided on the same day as an office visit, the Commission analyzed Medicare claims data. This analysis shows that outpatient therapy (such as physical and occupational therapy) is rarely provided on the same day as a related office visit. In addition, half or fewer than half of imaging, clinical laboratory, and pathology services are performed on the same day as an office visit. The finding that many ancillary services are not usually provided during a patient’s office visit raises

questions about one of the key rationales for the IOAS exception—that it enables physicians to provide ancillary services during a patient’s visit.

Under Medicare’s current FFS payment systems, which reward higher volume, physician self-referral of ancillary services creates incentives to provide more services. Under a different model, however, in which providers received a fixed payment amount for a group of beneficiaries (capitation) or an episode of care (bundling), they could still self-refer, but would not be able to generate additional revenue by ordering more services. Therefore, the preferred approach to address self-referral is to develop payment systems that reward providers for constraining volume growth while improving the quality of care. Because it will take several years to establish new payment models and delivery systems, policymakers may wish to consider interim approaches to address concerns raised by the growth of ancillary services in physicians’ offices. The Commission had not yet made recommendations, but it does explore the pros and cons of several options in more detail:

- excluding therapeutic services such as physical therapy and radiation therapy from the IOAS exception,
- excluding diagnostic tests that are not usually provided during an office visit from the exception,
- limiting the exception to physician practices that are clinically integrated,
- reducing payment rates for diagnostic tests performed under the exception,
- improving payment accuracy and creating bundled payments, and
- adopting a carefully targeted prior authorization program for imaging services.

Inpatient psychiatric care in Medicare: Trends and issues

Medicare beneficiaries with mental illnesses or alcohol- and drug-related problems who are considered a risk to themselves or others may be treated in inpatient psychiatric facilities (IPFs). To qualify as an IPF for Medicare payment, a facility must meet Medicare’s general requirements for acute care hospitals and must be primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill persons. In 2008, Medicare spent \$3.9 billion on IPF care. About 295,000 beneficiaries had almost 443,000 stays. Unlike in other settings, most Medicare beneficiaries treated in IPFs qualify for Medicare because of a disability.

As a result, IPF patients tend to be younger and poorer than the typical beneficiary. A majority (56 percent) of IPF patients are dually eligible for Medicare and Medicaid.

The Commission identified several characteristics of the IPF sector that raise questions about payment accuracy in the IPF PPS. Almost three-quarters of IPF discharges are diagnosed with psychosis and thus receive the same base payment under the prospective payment system. However, research has shown that within the category of psychosis, patients generally had either schizophrenia or a mood disorder—the costs of which may differ significantly. In addition, some patient characteristics that may substantially increase the cost of caring for an individual in an inpatient psychiatric setting, such as deficits in activities of daily living and suicidal and assaultive tendencies, are not recognized by the IPF payment system.

An important variable in assessing provider costs is the quality of care provided. Unfortunately, the development of outcomes measures for IPFs has lagged behind that for nonpsychiatric medical care. Ultimately, improving the quality of care furnished to beneficiaries with serious mental illnesses will necessitate looking beyond the IPF stay to ensure that patients receive adequate and appropriate outpatient mental health services. Such services can reduce severity of illness and improve beneficiaries' productivity and quality of life.

Conclusion

With this report, we present to you a number of opportunities and challenges for the Medicare program. The Commission believes these issues are important for ensuring access to high-quality care for current Medicare beneficiaries as well as sustainability of the program, to protect it for beneficiaries in the future. We appreciate the opportunity to discuss our report with you and look forward to your questions.