Executive summary

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The Medicare program enables millions of beneficiaries to obtain health care services but, in its current form, lacks many of the essential elements of a high-quality, high-value, efficient health system: Care coordination is rare, specialist care is favored over primary care, and quality of care is too often poor. Program spending and utilization have increased substantially, without corresponding improvements in beneficiaries' health. If those spending and utilization trends were to continue, they would threaten the long-term sustainability of Medicare.

In previous reports, the Commission has described the need for Medicare to move away from payment policies that encourage service volume and are indifferent to quality and toward policies that promote better value for Medicare and its beneficiaries. In the course of that work, we have focused largely on changes to payment policies that would affect provider incentives to work toward a reformed delivery system. We continue that work in this report but also develop policies that highlight the role of Medicare beneficiaries and CMS in achieving the goal of delivery system reform. The report includes:

- two chapters that touch on the themes of Medicare payment accuracy and moving away from the volume incentives in fee-for-service (FFS) Medicare,
- three chapters that highlight more systemic changes to better align provider incentives with a reformed delivery system,
- two chapters that focus on beneficiaries and their potential role in delivery system reform, and
- one chapter that discusses the role of CMS in a reformed delivery system.

In an appendix, as required by law, we review CMS's estimate of the physician update for 2011. We also acknowledge the passage of the Patient Protection and Affordable Care Act (PPACA) at the end of March 2010, which included provisions that are relevant to some of the issues discussed in this report. Where feasible, given the timing of enactment, we have included appropriate references to the effects of the new law.

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. In Chapter 1, we examine issues related to expanding Medicare's authorities in these two areas.

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. Two examples are reference pricing policies, under which a single payment is set for clinically comparable services, and coverage with evidence development, in which CMS requires the collection of clinical data as a condition of Medicare payment. Performance-based risk-sharing strategies, in which Medicare's payment is linked to beneficiaries' outcomes through risk-sharing agreements with product developers, is another innovative policy; allowing Medicare to negotiate with product developers would require a change in law.

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 authority to make such changes in its current payment systems.

We also examine giving the Secretary more flexibility in testing payment policy and health care delivery improvements and implementing those that prove to be successful in the demonstration stage. Funding and process constraints on Medicare's research and demonstration capacity have hindered how Medicare tests and disseminates policy innovations. We review the significant changes in this area made by the PPACA and present several approaches to increase the Secretary's flexibility to implement new policies that empirical evidence indicates will improve quality and reduce the rate of cost growth in the traditional FFS Medicare program.

Improving traditional Medicare's 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. In Chapter 2, we consider design reform of Medicare's traditional FFS benefit, along with that of supplemental coverage.

The current FFS benefit design has no upper limit on the amount of Medicare cost-sharing expenses a beneficiary could incur. As a result, more than 90 percent of Medicare beneficiaries take up supplemental coverage—for example, medigap policies. The most widely used types of supplemental coverage fill in all or nearly all of Medicare's cost sharing. We have found that when beneficiaries are insured against Medicare's cost-sharing requirements, on average they use more care and Medicare spends more on them.

In the near term, potential improvements to benefit design could, for example, involve adding a cap on beneficiaries' out-of-pocket (OOP) costs and, at the same time, requiring supplemental policies to have fixed-dollar copayments for services such as office visits and emergency room use instead of simply filling in all cost sharing. Such restrictions on supplemental coverage could lead to reductions in the 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 improving care coordination or quality. These strategies could also be coupled with cost-sharing protections for low-income beneficiaries so that they would not forgo needed care.

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, value-based insurance design lowers cost sharing for services that have strong evidence of substantial clinical benefit. A primary goal of this approach is to improve quality. However, to also achieve 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.

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 Chapter 3, we look 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 in 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.

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 workforce mix—including trends in specialization and limited socioeconomic diversity—and 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.

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.

The Commission's recommendations in Chapter 4 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 making a significant portion of Medicare's GME 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. 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. The amount saved 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's second recommendation—to make information about Medicare's payments and teaching costs available to the public—also fosters greater accountability for educational activities within the GME community. It is designed to encourage collaboration between educators and institutions on residency program funding decisions.

The final three recommendations call for studies to inform policymakers on better strategies for achieving the workforce we need in the 21st century:

- a rigorous analysis of our 21st century health care workforce needs driven by the requirements of a high-value, affordable health care delivery system;
- a specialty-specific analysis of the costs and benefits of residency programs to institutions, which would inform how Medicare could adjust its payments for residency programs to make them more economically efficient; and
- a study that outlines a strategy for achieving specific health care workforce-diversity goals, which would help optimize federal subsidies for this effort.

Coordinating the care of dual-eligible beneficiaries

Dual-eligible beneficiaries (those enrolled in both Medicare and Medicaid) are, on average, more costly to treat than other beneficiaries. However, we find in Chapter 5 that among dual-eligible beneficiaries are distinct groups of beneficiaries with widely different care needs and spending patterns. They make up disproportionate shares of 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. 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 by 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.

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 successfully implemented fully integrated care programs, illustrating that it is possible to overcome these obstacles.

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.

In Chapter 6, we survey the current status of IPFs. Using IPF cost reports and claims data from 2008, we find:

- 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.
- Almost three-quarters of IPF discharges are diagnosed with psychosis and thus receive the same base payment under the prospective payment system. Some patient characteristics that may substantially increase the cost of caring for an inpatient psychiatric patient, such as deficits in activities of daily living and suicidal and assaultive tendencies, are not recognized by the IPF payment system.
- The characteristics of distinct-part IPF units and freestanding IPF hospitals appear to differ, as do some of their patterns of care, sources of admission, discharge destinations, and patients served.
- The number of IPF distinct-part units in acute care hospitals continues to decline; 74 percent of IPFs were distinct-part units in 2008.

Monitoring the adequacy of payments to IPFs is necessary to ensure continued access to care for beneficiaries with severe mental illnesses. In the future, the Commission will analyze IPFs' financial performance under Medicare. As we consider IPFs' costs, it will be important to assess the extent to which any observed cost differences between freestanding IPFs and distinct-part units reflect real differences in service provision, mix of patients, or methods hospitals use to allocate hospital overhead to the unit.

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.

Shared decision making and its implications for Medicare

Medicare beneficiaries face certain challenges when making health care decisions. 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, which we investigate in Chapter 7.

Shared decision making is the process by which a health care provider communicates personalized information to patients about the outcomes, probabilities, and scientific 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, specialists have been more successful than primary care doctors at implementing shared decision-making programs because they are more likely to engage in shared decision making at a time when it is most useful to patients—before making a decision on procedures 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. These strategies are not mutually exclusive. Each has advantages and disadvantages. Policymakers would have to decide on the design and scope of the policy.

Addressing the growth of ancillary services in physicians' offices

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.

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, 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 are not clinically appropriate.

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.

We used Medicare claims data to examine the frequency with which services covered by the IOAS exception are provided on the same day as an office visit. In Chapter 8, we report 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.

Physician self-referral of ancillary services creates incentives to increase volume under Medicare's current FFS payment systems, which reward higher volume. 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 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 does not make any recommendations in Chapter 8, but it does explore 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.

Review of CMS's preliminary estimate of the physician update for 2011

In CMS's annual letter to the Commission on the update for physician services, the agency's preliminary estimate of the 2011 update was –6.1 percent. This update was to follow a 21.3 percent reduction in physician payment rates required—under the law pertaining when the letter was written—to occur on April 1, 2010. The 21.3 percent reduction was to occur because a series of temporary increases—enacted over several years—were to expire on March 31, 2010. Subsequent congressional action has delayed that expiration date. In Appendix A, we present our required technical review of CMS's estimate.

We find that CMS's calculations are technically correct. The combined effect of the 21.3 percent reduction, were that to occur, and the calculated update in 2011 would be a 26.1 percent decrease in physician payment rates. (The calculation is not strictly a sum; hence, 21.3 combined with 6.1 yields 26.1 percent.) We find that any changes in CMS's forecast of input price changes or spending growth would have a small effect compared with the magnitude of that decrease. ■