CHAPTER 4

Purchasing strategies

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To understand what steps other purchasers are taking to increase the value of their health care spending, this chapter describes the strategies they use and begins to consider whether they might be applicable to the Medicare fee-for-service program. These strategies are intended to reduce spending while maintaining or improving quality. Some examples are measuring and reporting resource use and quality to providers, encouraging beneficiaries to make more cost-conscious health care decisions, using hospitalists, and aligning financial incentives across settings. In response to the growth of imaging services, purchasers are using additional strategies, including enforcing safety standards for imaging equipment, limiting the type of providers qualified to deliver a service, and reviewing appropriateness of claims. Evaluating the feasibility and value of particular strategies for Medicare fee-for-service, however, requires consideration of the program's ability to administer these strategies effectively and the potential impact on beneficiaries and the health care delivery system.

As cost pressures intensify, policymakers may be increasingly interested in ways to improve the efficiency of the health care that Medicare beneficiaries receive—that is, to reduce spending while maintaining or improving quality. Private health plans available to beneficiaries under Medicare Part C were created to allow Medicare to take advantage of the efficiency-enhancing management tools available to private sector payers. Some policymakers may decide that health plans are the vehicle for improving the efficiency of beneficiaries' care and that the current fee-for-service system should remain unfettered. Other policymakers may want to support innovation by private plans and at the same time improve the efficiency in fee-for-service Medicare to constrain spending growth.

The majority of beneficiaries—about 86 percent—are enrolled in fee-for-service Medicare. Even with the recent legislation that encourages enrollment in managed care plans, both CMS and the Congressional Budget Office project that the majority of beneficiaries will remain in the traditional program for years to come.

Fee-for-service Medicare, which reimburses individual providers for each medical good or service rendered to a beneficiary, poses challenges for program administrators seeking to improve program efficiency. Although Medicare has been able to use its statutory authority to control payment rates to levels that are, in some places, below private sector rates, efforts to implement efficiency-enhancing strategies in the permanent program are limited by Medicare's size, statute, and limited administrative resources, among other factors. At times, these limitations have been overcome: Medicare has implemented prospective payment systems, selectively contracted with facilities for organ transplant services, and implemented coding edits subsequently adopted by private insurers.[1] Furthermore, CMS has run or attempted to launch a number of innovative demonstration programs to improve the efficiency of health care delivery.[2]

On the whole, however, Medicare's current approach to purchasing services and goods in fee-for-service may fall short in several ways. For example, in many cases, current policy:

- *Provides insufficient incentives for providers and beneficiaries to supply and consume, respectively, the optimal amount of health care.* Furthermore, mechanisms for identifying or penalizing inefficient providers or inefficient use of services are limited. MedPAC analysis, along with a growing body of research, shows that greater use of health care services does not necessarily produce better outcomes (MedPAC 2003). Thus, in some areas of the program, fewer services could be delivered without compromising quality. Similarly, Medicare does not encourage beneficiaries to weigh costs and benefits in making health care decisions, seeking preventive care or making lifestyle changes. Indeed, for many beneficiaries, supplemental coverage insulates them from the financial implications of their decisions.

- *Does not encourage providers to coordinate care efficiently.* Although Medicare's prospective payment systems provide incentives for providers to minimize their own costs, it pays for different types of services separately. As such, care is fragmented and providers have little incentive to increase efficiency by better coordinating care across services and over time.

- *Sets prices that inaccurately reflect costs of providing goods or services efficiently*. Obtaining timely, accurate knowledge of efficient providers' costs is difficult, though some information is available through cost reports and surveys. As a result, for some services (e.g., certain types of medical equipment), Medicare payment does not closely align with costs (GAO 1998).

What strategies could be considered to improve the incentives and slow spending growth? To begin to answer this question, MedPAC staff surveyed private purchasers and insurers about their strategies to improve efficiency. These purchasers face many of the same cost pressures as Medicare, but may have greater agility and flexibility in experimenting with innovative strategies. They operate on a smaller scale than Medicare and are not nearly as constrained by statute or public scrutiny.

MedPAC found a community of purchasers, insurers, and consultants exploring new and revisiting old ideas to slow spending growth.

First, nearly all of those we interviewed are interested in checking growth in the volume of services. Many are measuring provider efficiency to encourage providers to

reconsider their practice styles and adjusting cost-sharing requirements to induce consumers to temper their demand for care. We focus in greater detail on these strategies, reflecting heightened interest in them among both the Commission and the purchasing experts we consulted.

Second, purchasers reported using strategies that encourage greater productivity in delivering certain services. To the extent that improved productivity lowers costs, the price paid for services could be reduced. Thus, a third overarching type of strategy is aimed at paying prices that better reflect the cost of the service. These pricing strategies range from competitive bidding to tiering to lowering payment when multiple services are performed during an encounter.

Given our interest in the appropriate use of imaging services, MedPAC conducted a focused examination of private sector purchasing strategies for those services. We found that private sector purchasers, concerned about the quality and maintenance of imaging equipment, are imposing and enforcing safety standards. In addition, they are restricting payment for imaging services to those delivered by certain specialties, such as radiology and cardiology, to constrain the proliferation and poor quality of services by some nonradiologists. Finally, we found that private purchasers are applying coding edits to detect improper billing and limit spending.

At the conclusion of the chapter, we take a first step in assessing these strategies for application to Medicare fee-for-service. We consider the extent to which Medicare policy already includes aspects of them and review aspects of Medicare and current law that might affect implementation of such strategies.

A few caveats are in order. First, because we sought out innovators in the field, the accounts of the various purchasers in this chapter are neither representative of the larger marketplace nor are they inclusive of all potential strategies. Second, this chapter is a snapshot in time; it does not fully explore the evolution of the various strategies, many of which purchasers have experimented with for decades. Third, we include the strategies reported to us regardless of their potential applicability to Medicare.[3] As discussed at the end of the chapter, many factors must be considered in such an evaluation, and it is likely that all strategies discussed in this chapter are not equally pertinent to Medicare.

Strategies used by innovative purchasers

In the next section, we report on a range of strategies to reduce spending while maintaining or improving quality. Our summary is largely based upon our interviews with health plans (including one integrated delivery system), large employer purchasers (including one coalition), a public employee purchaser, and benefit consultants, supplemented by a review of the literature. In this chapter, we define purchasers as both health plans and employers.

Modifying the volume of services

These purchasing strategies aim to encourage providers to deliver appropriate care and discourage delivery of inappropriate care. In addition, they try to temper beneficiary demand and direct patients to providers who tend to use fewer services without reducing quality of care.

Identifying efficient providers and promoting efficient care patterns

Nearly all of the private purchasers we spoke with are considering or implementing strategies to identify efficient providers—that is, those that use the fewest resources to provide quality care. Most seek to direct patients to those providers and encourage less efficient providers to improve. The success of this approach largely hinges on the ability to measure efficiency as well as quality. Our interviewees all acknowledged that the science behind each is evolving, but has not been mastered.

Research shows that efficient care can be compatible with high-quality care (MedPAC 2003). Hospitals and physicians in the 10 percent of communities that spend the least per capita achieve this result by providing fewer specialist physician tests, visits, minor procedures, nonsurgical hospitalizations, and admissions to the intensive care unit. And while the volume of care is lower in those communities, the quality of care, patient health status, and patient satisfaction with care is the same as or higher than in the other communities that spend more. Researchers estimate that if hospitals and physicians in

other communities adopted similarly efficient patterns of service use, per capita Medicare spending would be 30 percent less (Fisher et al. 2003).

Purchasers seeking to encourage appropriate utilization often first profile providers by measuring their performance on efficiency and, ideally, quality measures. Some compare price only, which may not accurately reflect the overall resources used to provide care. Then, the purchaser uses at least one of three types of incentives to change beneficiary and provider behavior to improve efficiency: information-based, financial, or participation incentives.

Profiling providers One way to measure providers' relative efficiency or quality is through profiling and creating a report card for providers. The following are among the key design issues in profiling.

Selecting providers to profile Experience varies among those with whom we spoke. Some profile either physicians or hospitals. Some do both. Of those profiling physicians, some focused more attention on specialists than primary care physicians (PCPs), and some focused on a subset of specialists. Others included PCPs.

One reason for focusing on specialists is that they are more likely to be responsible for high-cost tests, procedures, or treatments associated with a particular episode of care. In addition, specialists more frequently have an adequate sample of similar cases. It can be more difficult to assign patients' health care costs to a PCP because in many instances the PCP is not in control of the full spectrum of care patients receive.

Another difference among purchasers seeking to measure performance was whether to focus on group practices or individual physicians. Group performance was the focus in areas where physician groups dominate the market. In other areas of the country, purchasers profiled individual physicians.

Of those plans also measuring hospital performance, some looked at only particular high-cost services, such as transplants and cardiac care. Others assessed overall performance.

Selecting measures of physician efficiency The measures vary, but most profilers use measures based on claims data rather than more costly chart or peer review methods. A preponderance of plans indicated that they were using software tools designed to measure physicians'—particularly specialists'—costs associated with an episode of care. In general, this software measures actual total costs of an episode of care, compares it with expected costs, and produces a score for each physician. The tools adjust for differences in the case mix of each provider's patients. Some interviewees viewed measuring the episode of care as an improvement over other measures that reflect unit costs only (e.g., length of stay or price of procedure), and thus fail to capture costs associated with redoing a procedure, high complication rates, or poor patient management.

The adequacy of episode-based measurement tools is controversial. Some purchasers and providers believe that current measures are not sufficiently refined and may inaccurately attribute legitimate cost differences to an inefficient practice style. This could occur if classification rules assigned cases with serious comorbidities to only moderate risk categories. If measures inadequately account for such case-mix differences, providers might avoid more complicated patients, creating access problems or unfairly penalizing those who take harder cases.

Others believe that while not perfect, the current episode-based measures are sufficiently accurate. These purchasers believe it is important to start measuring and incorporate improvements over time, rather than wait for a more refined measurement system.

Purchasers reported using other types of measures as well:

- Referral patterns and use of generic drugs, particularly for primary care physicians.
- Frequency with which surgeons are selecting candidates that meet the selected criteria for certain surgeries (e.g., hand and back). This approach requires chart review to verify that clinical findings are consistent with recommended criteria for these surgeries.
- Use of ambulatory surgical centers instead of outpatient departments for certain types of surgery.

Selecting measures for hospital efficiency One large insurer reported measuring hospital performance as the basis for designation as a regional center of excellence for cardiac, orthopedic, and cancer care. The insurer uses a range of quality standards, including Leapfrog Group

standards and training standards for specialists in intensive care (intensivists), as well as efficiency measures.[4] It measures total costs of an episode of care beginning 3 months before to 12 months after the hospitalization, and is able to track failed therapy rates. This insurer also designates national centers of excellence for transplants. The measures for transplant centers tend to mirror Medicare criteria, which focus on mortality data and years of life after the procedure and are used to select which hospitals Medicare pays for transplants.

Obtaining sufficient data for profiling To begin to identify efficient providers, purchasers must, at a minimum, have enough claims data to evaluate providers in the area. Because care is concentrated in a relatively small number of hospitals, obtaining this data for hospital services is less problematic than for physicians. Even large insurers find that in some market areas they have less confidence in their profiling results or may not profile at all because of insufficient data. To improve their access to claims data, several public or self-insured purchasers require their third-party administrators to share claims data for their full book of business with the purchaser.

Nearly all the purchasers we spoke with are interested in getting Medicare claims data—the largest single source of claims that exists—to assist them in profiling providers. CMS is currently considering the issue and has concerns about protecting beneficiaries' privacy, the reliability of the physician identification numbers, and the ability of the data to be used for profiling of primary care physicians.[5] The purchasers we spoke with felt strongly that beneficiaries' privacy could be protected in this exchange.

Pairing efficiency measures with quality measures Virtually all those interviewed indicated that the efficiency measures should be paired with quality measures to reflect value. Interviewees indicated varying levels of success in relating the two. One used data on adherence to evidence-based practice standards to identify quality providers; some have used the Leapfrog Group standards on the use of specially trained inpatient physicians, electronic prescribing systems, and volume of services.[6] Others look at complication rates for proceduralists. Still others indicated that they were looking for better ways to measure and reflect quality differences among providers. Some of these measures are considered efficiency-only measures (e.g., number of referrals), while others (e.g., infection and complication rates) reflect the intersection of quality and efficiency measurement. (MedPAC's June 2003 report provides further discussion of quality measures.)

Managing provider relations In general, plans report mixed provider response to measuring performance. Plans that have long been measuring physician performance that are also in areas with group practices (some of which accept capitation) report few issues. Others acknowledge some resistance, particularly among those who do not compare with their peers favorably. Many note that physicians are more likely to be receptive to measurement and feedback if they feel that it would help their patients receive better care, the measures are transparent and fully disclosed, and it is clear that the measures are evidence based and consistent with good medical practice. One plan involved physicians in the development of measures and sought continued feedback in meetings with providers on their implementation. Several interviewees noted that when plans used the profiling data as a basis for financial incentives for efficiency, providers responded better to positive incentives (e.g., bonuses) rather than negative ones (e.g., withholds).

Changing behavior to contain costs Profiling can contain costs if it influences the way beneficiaries use care, the way providers deliver care, or the proportion of care delivered by more efficient providers.

Disseminate information to enrollees and providers Information-based strategies offer providers and patients the information to make cost-effective decisions about health care services without direct financial consequences. Nearly all the purchasers we spoke with plan to or already feed the profiling data back to participating providers and to the public (usually on the Internet and in marketing materials). Indeed, movement on releasing provider report cards appears to be gathering momentum. Recently, a group of 28 large employers announced that they are teaming up to develop scorecards to help employees choose their doctor based on cost and quality information (Landro 2004).

A number of purchasers we spoke with found that when providers received quality and efficiency data, performance improved. One insurer that disclosed performance on quality indicators to enrollees as well as providers found that some enrollees immediately began shifting to better-performing providers and that about 3 percent of enrollees continue to shift each year.

Others were less persuaded that feeding the information back, in the absence of other incentives, would induce much change. One purchaser, while intent on releasing the profiling information publicly, acknowledged that enrollees do not always use this information effectively. Yet, the purchaser felt obliged to provide it when available. One also noted that beneficiaries may not know how to interpret efficiency data; beneficiaries may assume that higher use is always better.

Create payment incentives Payment incentives generally seek to induce patients or providers to use cost-effective care by creating stronger rewards or penalties around care decisions. Beneficiary cost sharing, for example, could be adjusted depending upon the relative efficiency of the provider chosen. Providers' payment could vary with provider efficiency. Some interviewees felt that it was best to adjust both the beneficiary cost-sharing and the provider payment. These incentive options are illustrated in arrangements known as tiered networks, centers of expertise, and shared savings strategies.

Tiered networks. Tiered networks are arrangements in which providers—generally physicians and hospitals—are assigned to specific tiers; beneficiary cost-sharing requirements then vary depending on the tier of their selected provider. Assignment to a tier may be based on profiling criteria that can range from blunt measures such as unit prices, average costs, and structural characteristics (e.g., a hospitals' teaching or sole community facility status), to more sophisticated longitudinal, risk-adjusted efficiency scores and indicators of quality.

In general, providers have the incentive to be in the preferred tier to increase or retain volume of patients. In some cases, providers in preferred tiers accept discounted payments in exchange for higher volume that may result from being on the preferred tier—but this generally works when the preferred tier is exclusive (similar to some arrangements with centers of expertise discussed below) or when strong beneficiary incentives guarantee higher volume. In other cases, providers in preferred tiers may get a higher base payment rate, such as an increment to fee schedule payments, because they can deliver more efficient care or higher quality (e.g., fewer referrals to specialists or better outcomes). In some plans, providers not initially assigned to the preferred tier may be ultimately assigned to it if they are willing to accept lower payments (which, by definition, improves one aspect of their efficiency rating).

Once providers are assigned to tiers, plans give enrollees a financial incentive to use lower-cost providers in the preferred tier. Often enrollees must pay higher copayments or coinsurance when they use nonpreferred providers. The differential in cost sharing does not capture most of the differences in cost across hospital tiers, and as such, is not intended to insulate health plans from hospital or physician cost variation. Instead, it informs and sensitizes the patient, who was previously insulated from and indifferent to the cost implications of care (Robinson 2003). (The text box opposite provides one example.)

A variation on this design is multiple networks of providers sorted into tiers. Networks in more efficient tiers have lower premiums, which can be further adjusted based on the level of cost-sharing associated with out-of-network care. Another type of tiering is achieved by plans and purchasers moving away from requiring a flat cost-sharing amount (i.e., a copayment) for services to a percentage of the cost of the service (i.e., coinsurance). This method exposes beneficiaries to the price variation among providers, which can be considerable (given, for example current estimates of $1,000 variation in hospital costs per day). Newer benefit designs with coinsurance rates as high as 40 percent for hospitalizations and 50 percent for certain outpatient services expose beneficiaries to even more of the cost difference (Robinson 2003).

Whether tiering improves providers' efficiency or beneficiaries' cost-effective decision making is uncertain:

- The magnitude of the cost differential needed to affect beneficiary choice is not known.
- Patients may not know about the differential at the time they need care. Patients may rely more on physician recommendations (which rarely take price into account) than cost differences.
- Tiering of hospital products may not target the source of inefficiency if cost effectiveness of different departments varies significantly within the hospital.
- Purchasers may want to support and maintain relationships with institutions with special missions (e.g., teaching and treating uninsured), which may increase costs (Robinson 2003).

Tiering providers: An example

Several state agencies, including those in Minnesota, Wisconsin, and Washington, have introduced benefit programs for state employees that include tiered networks.

The Minnesota Advantage Health Plan, which covers about 130,000 lives (state, college, and university system employees, dependents, and retirees), is now in its third year of operation. The tiered plan design links the risk-adjusted costs of primary care clinic systems with the level of out-of-pocket cost sharing that enrollees pay at the point of service. To obtain the information needed to assign providers to tiers, the state built a comprehensive claims data warehouse, including all the health and pharmacy claims for their covered population. Based on analysis of the data, the Department of Employee Relations assigns providers to one of four tiers (the fourth tier was added in 2004), based on their risk-adjusted cost profile. Data from the warehouse also support wellness programs and risk and disease management initiatives for target conditions including asthma, diabetes, and heart disease (Haugen 2003). The benefit is administered by three insurance carriers, each of which develop provider networks that serve state employees (State of Minnesota 2004).

Enrollee cost sharing creates clear incentives to use providers in the better-rated tiers. The deductible for Cost Level 1 plan providers in 2004 is $30 for individuals and $60 for families; for Cost Level 4, the annual deductible is $500 for individuals and $1,000 for families. Cost sharing for office visits, inpatient stays, lab costs, and outpatient therapy copayments also vary across tiers. Maximum out-of-pocket liability, prescription drug benefits, and hospice and nursing home benefits are the same for all the tiers; no cost sharing is required for preventive services (State of Minnesota 2004).

Early assessments of the program suggest that it has lowered costs. Following the initial adoption of the model, discussions with several clinics that had been assigned to the higher-cost tiers led to the renegotiation of their reimbursement rates, which reduced their costs sufficiently to be reassigned to more favorable tiers. Enrollees seem to understand the plan, and most (75 percent in 2002) are in the lowest cost tier. Initial estimates suggest that in the first two years of the program, the state and its employees saved $33 million in premiums compared with estimated costs if the previous health benefits plan had remained in place unchanged (Haugen 2003). ■

- Experience in implementing these plans has been mixed. Some plans facing hospitals or provider groups with strong market leverage exclude very few providers from their preferred network. Other plans encountered such provider resistance that they had to drop the idea, and some plans operated in communities with too few providers to make it a viable strategy. (Mays et al. 2003)

Nevertheless, some suggest that tiering has great promise. Success can be achieved by redirecting patients away from only a small minority of providers—those that are vastly more inefficient than others and may even be considered bad actors. One consultant noted that while encouraging all patients to use marginally more efficient providers could generate savings, significantly more savings could be achieved if persistently costly patients could be redirected from inefficient to more efficient providers.

The availability of more usable and accessible information for consumers improves the effectiveness of tiering. More purchasers are sharing provider report cards with consumers (see earlier discussion on profiling). However, tiering may not work for all types of providers. Primary care providers, for example, may be less interested than other providers (e.g., specialists) in being in the preferred tier. If their practices or facilities are full, providers may not value the increased volume of patients that the preferred tier promises.

Centers of expertise. Centers of expertise (or excellence) differ from tiered networks in that differential cost sharing or payment only applies to certain types of procedures or care, rather than to the broader spectrum of care. Insurers and purchasers tend to use a centers-of-expertise approach for high cost procedures, such as transplants or cardiac, orthopedic, and cancer care.

Two key implementation questions emerged in our interviews. First, how can the purchaser increase patient volume at the designated centers of expertise? One of the obstacles plans face is the reluctance of patients who have an established relationship with a physician unaffiliated with the center to change their physician. One plan has attempted to overcome this problem by promoting its program on its nurse telephone line that offers decision support to patients. Another obstacle can be patients' anxiety about the distance of the regional center from home. Some plans have addressed this concern by paying for the families' hotel stays.

Second, how can plans foster continued competition after the initial designations are made? Successful centers of expertise can expect to have increased patient volume and name recognition. To the extent that this outcome results in the "winner" increasing capital investment in both equipment and space, other facilities with less capacity may be at a disadvantage in future competition. On the other hand, as evidenced by the growth in specialty hospitals, volume can shift quickly, particularly as physicians change their referral patterns. One plan we interviewed acknowledged the concern of maintaining a competitive environment, and hopes to resolve it by making annual designations and naming different hospitals as centers of excellence for different procedures.

Expenditure targets and shared savings. Some plans we spoke with reward providers who are more efficient than others by paying them a bonus, refunding the portion of payments withheld at initial payment for services, or increasing payment rates for care provided in the next contract cycle. In effect, this approach sets an expenditure target and shares the savings with more efficient providers, which in turn, encourages maximum efficiency. Plans tend to pair this approach with quality measures to address incentives to stint on care. For example, plans reported measuring physicians' adherence to clinical standards in caring for diabetic, asthmatic, and cardiac patients, as well as their performance in delivering preventive care services.

Basing payment on expenditure targets can be desirable for providers. For example, one integrated delivery system (IDS), Intermountain Health Care, found that by implementing techniques and a care protocol that improved cardiac medications and reduced admission rates for congestive heart failure patients, the hospital lost more revenue than it saved in costs. Thus, even though the more efficient processes (which also lead to higher quality) produced systemic savings, they lost money for the IDS. In response, the IDS used actuarial data to negotiate with purchasers to create expenditure targets for groups of physicians and nurses who routinely work together. They identified populations for certain clinical programs (e.g., cardiovascular) and compared actual costs with actuarially expected costs. If actual costs were below predicted levels, the savings were shared among the hospital, physicians, and the purchaser (James 2002).

The Buyers Health Care Action Group provides another example. Expenditure targets were set quarterly for care systems, or groups of providers, for episodes of care, including hospitalizations. Providers were paid a higher amount if they kept costs below targets and a lower amount if they exceeded the targets (Christianson and Feldman 2002).

Use of exclusive contracting Under this approach, insurers or purchasers do not contract with providers that fail to meet their efficiency and quality criteria. The result is a smaller network of providers from which enrollees can receive covered health care and no coverage for out-of-network care. Some plans indicated that they were planning to respond to employers' interest in offering an exclusive network product.

The experience of Pitney Bowes, a large employer in southern Connecticut, offers some insight into the potential and challenges of exclusive contracting. In the mid-1990s, the company offered employees two health plans: a point-of-service plan and an exclusive provider organization (EPO) plan, which excluded the 100 least efficient physicians identified through profiling. During the two-year experiment, Pitney Bowes' health care costs rose much more slowly than costs in the state of Connecticut as a whole. One published evaluation (Cave et al. 1995) found that more than two-thirds of the savings came from steering enrollees to the more efficient providers in the EPO. Nevertheless, the program was

discontinued after its third year when the physician group that comprised the EPO was sold and the new owner decided not to continue the contract.

Pay only for appropriate care, regardless of provider efficiency

Another strategy that can moderate the volume of services provided is to pay for only medically necessary care. Under this strategy, purchasers can either inform providers that certain care does not meet standards of evidence-based care or deny payment for care delivered outside these standards. Two approaches stand out:

- *Preauthorization for services* requires patients or providers to obtain approval from the health plan for coverage for a nonemergency procedure. Managed care plans used this tool widely in the 1990s. In the backlash, many have reevaluated its use and have implemented more targeted preauthorization requirements. For example, one plan requires preauthorization only for those procedures that they are unlikely to cover.

  Plans continue to assess the role of preauthorization, however. Some plans experienced a dramatic increase in volume after lifting pre-authorization requirements, particularly with imaging services, and responded by reinstating some of their requirements (Draper 2004).

- *Coding edits* can identify when care is inappropriate or should not be covered. A coding edit might, for example, reject claims for more than a target number of ultrasounds for pregnant women. Most plans we spoke with buy a commercial product that applies coding edits, and one plan stated that it generated a 5 percent savings. (See discussion under imaging services, p. 107.)

Encourage beneficiaries to take greater responsibility

More recently, purchasers have turned to strategies intended to encourage beneficiaries to assume greater responsibility for their health and reduce their demand for inappropriate care. First, purchasers have increased beneficiaries' financial stake in their care, both when they choose among plans and when they choose among providers at the point of service. Such strategies are often considered examples of consumer-driven benefit design.

Second, purchasers have invested in programs that inform beneficiaries about ways to stay healthy and treatment options when they are sick. Third, many have implemented care management programs that encourage patients to manage their chronic conditions (see discussion in Chapter 2).

Increasing beneficiaries' financial stake in their care is being pursued in a number of ways. First, more purchasers and plans are increasing beneficiaries' choice of providers or network of providers, and giving them financial incentives to receive care from efficient or less costly providers (discussed under tiered networks). In part, this is a reaction to the managed care era when cost sharing was low and utilization was controlled by requiring referrals from primary care providers and other techniques. While increased cost sharing has been shown to induce patients to cut back on both appropriate and inappropriate care, research is inconclusive about the effect this response has on health outcomes for people over 65 (Rice and Matsuoka 2003).

Second, some employers and plans are offering enrollees high deductible plans, combined with a health reimbursement account (HRA), catastrophic insurance, and web-based medical information tools to assist in making better medical decisions. The HRA is an account from which consumers draw to make health care purchases. When the account is exhausted, enrollees must typically pay out of pocket until the annual deductible is met, after which the plan becomes a traditional major medical plan. Employers may fund the HRA with pretax dollars, which may be rolled over to the following year if they are not spent (Gabel 2002).

Purchasers also report that providing enrollees with more information on treatment options can produce savings. For example, one interviewee noted that when patients are shown a video that graphically describes their treatment and surgical options, fewer of them opt for more invasive surgery. Similarly, Humana has a tool that identifies patients who are currently using a high-cost drug and could possibly switch to one of two lower-cost drugs. Through an interactive voice response system, a computer calls patients and explains that the person can save money by taking a substitute drug. Humana found that 19 percent of these automated calls prompted patients to move to a lower-cost drug (Trude and Grossman 2004).

Wellness programs reduce demand by improving the health and well-being of employees or enrollees. Programs often include activities such as health appraisals and screenings, quarterly newsletters, targeted mailings, and 800 numbers. It is estimated that more than 80 percent of businesses with 50 or more employees and more than 70 percent of Fortune 500 firms have employee wellness programs (Pennsylvania Health Care Cost Containment Council 2001). Tracking the financial success of corporate wellness programs is challenging, but the joint General Motors and United Auto Workers wellness program was found to reduce both health care costs and absenteeism (McGlynn et al. 2003).

One large health plan developed a program that provides concrete rewards for consumers practicing healthier lifestyles. Consumers can earn points, or credits, for completing health risk assessments, enrolling in a disease management program, attending weight reduction programs, or completing an online nutrition education program. Plan members with enough credits are eligible for prizes and discounts on health promotion products (Ho and Pacificare Health Systems 2004).

Changing the costs of production

Another set of purchaser strategies encourages providers to change the cost of producing each unit of service. Some savings can be achieved by improving productivity within a site of service, while others may result from aligning payment incentives across service areas. These strategies may reduce the volume of care. However, when payment is for a bundle of services—such as with hospital inpatient stays—volume may not decline, but the individual services making up the bundle might. Ideally, prices could be adjusted to reflect the decline in resources comprising the bundle. The following are two examples of strategies that improve productivity within a site.

Add hospitalists and intensivists

Hospitalists and intensivists are physicians who focus their clinical efforts on the management and treatment of hospital and intensive care unit patients. Generally, a hospitalist or intensivist relieves primary care providers of their inpatient responsibilities, freeing up their time to see more patients outside the hospital. Studies have found that the use of hospitalists is associated with reduced lengths of stay and lower hospital costs. (Gregory et al. 2003, Diamond et al. 1998). One study found that this occurred without increasing the readmission rate or cost shifting to subacute providers (Gregory et al. 2003). Among those we interviewed, one executive called hospitalists "amazingly effective" and felt they that were continually learning how their role could be leveraged to improve efficiency.

Reengineer processes of care

One IDS executive also reported using techniques of the manufacturing industry to review their process for delivering care. These techniques include asking front-line employees to participate in redesign, measuring many aspects of performance (e.g., waste, wait times, organizational barriers to improvement), and improving inventory management. For example, by mapping a typical pneumonia visit, the IDS staff found that many steps, such as the requirement that patients walk to a separate laboratory to get blood drawn, could be eliminated (Wysocki 2004). Other facilities have adopted this approach as well, reducing medication errors, emergency room wait times, infection rates, and nursing turnover (Gabor 2004).

The following are some examples of strategies intended to improve productivity across sites.

Pay differentially

One plan increases surgeons' payments if they select a less costly site (e.g., ambulatory care center versus a hospital outpatient department) in which to perform the surgery.

Promote sharing of savings

Our interviewees reported three types of arrangements that encourage productivity improvements by sharing the savings among stakeholders (e.g., plans, purchasers, providers, beneficiaries). In each of these arrangements, plans should measure quality to mitigate incentives to skimp on care.

- Insurers measure providers' costs across an episode of care and pay efficient providers a higher rate or bonus payments. This technique can be used to promote appropriate use of services (discussed earlier) as well as to reduce costs associated with units of service. For example, to the extent that the cost of implantable devices (one source of growing costs cited by

interviewees) is factored into the total episode cost, physicians may be inclined to review their use of such devices.

- Insurers pay a bundled payment for an episode of care that is divided between the various services associated with the episode by the contracting entity (such as a hospital or IDS). Our interviewees adopted this approach only when paying centers of excellence for transplant and certain other services.
- Hospitals could give physicians a percentage of any reduction in the hospital's costs for patient care attributable to the physicians' efforts. This arrangement, known as gainsharing, is now prohibited for Medicare-covered care by the Office of Inspector General (see text box below).[7]

  One IDS executive opposed to the prohibition noted that when he had pressed one of his cardiologists about the potential overuse of costly drug-eluting stents, the cardiologist responded that the additional cost was not his problem; it was the hospital's. The executive firmly believes that he could achieve systemwide savings if he were allowed to pay physicians a portion of the savings gained from collaborating with the hospital to reduce costs.

Paying a price that reflects costs

An additional type of strategy is to pay a price that more closely reflects the cost of delivering the service. Some plans discussed pricing strategies. Two purchasers reported using competitive bidding for laboratory and specialty pharmacy services as well as durable medical equipment. One plan reported significant cost savings from using this approach; another indicated that it was worthwhile but noted it required more time and resources to issue a formal request for proposal than more typical price negotiations.

A number of plans indicated that they adjust their prices if multiple services are performed at a single encounter, paying the full price for the first (or primary service) and then a fraction of the price for the second or third service.

Tiered networks (discussed earlier) are also a type of pricing strategy. Plans or purchasers can accept the price offered by a provider and, based on that price, assign the

Gainsharing prohibitions in the Medicare fee-for-service program

The Office of Inspector General (OIG) has ruled that gainsharing violates the civil monetary penalty provision that broadly prohibits any hospital from knowingly making a payment directly or indirectly to physicians as an inducement to reduce or limit services to Medicare (or Medicaid) beneficiaries under the physician's care. Congress exempted such arrangements between health plans and providers from the prohibition and gave the Secretary regulatory authority to oversee these arrangements (OIG 1999).

The OIG acknowledges the potential positive aspects of gainsharing arrangements by citing a variety of ways savings can be generated without adversely affecting quality: substituting lower cost but equally effective medical supplies, items, or devices; reengineering hospital surgical and medical procedures; reducing use of medically unnecessary ancillary services; and reducing unnecessary lengths of stay. However, the OIG finds that gainsharing arrangements pose a high risk of abuse. In addition to concerns about stinting on patient care, the OIG notes the possibility that hospitals may use gainsharing to enhance payment to high-referring physicians.

The OIG's first opinion left little leeway for providers to tailor an acceptable arrangement that would not be either in violation or liable to prosecution. A later advisory opinion offers insight into conditions under which the OIG will use its prerogative to not enforce the civil monetary penalties provision, even if it is technically unlawful. The opinion found that a hospital that identified specific cost-saving techniques, measured savings in ways that avoided creating adverse incentives, and measured quality of care would not be prosecuted. The approach exemplified in this opinion may still present obstacles if providers feel that by specifying the measures so distinctly and publicly, they are more vulnerable to malpractice suits. ■

provider to a tier that requires higher beneficiary costsharing. Indeed, providers may respond to the threat of being placed in an unfavorable tier by lowering their price. Hospital and physicians, as well as providers of radiological services or other services, may do this.

Purchasing strategies for imaging services

Given questions about use of imaging services covered by Medicare, the Commission looked specifically at private sector strategies aimed at ensuring appropriate and safe use of imaging services. Use of imaging varies widely among geographic areas, raising questions about overuse and underuse of the services (MedPAC 2003). For example, a recent article described the rapid growth of imaging services in Syracuse, New York, where the number of magnetic resonance imaging machines has grown by over a third over three years, and the number of scans increased 23 percent (Abelson 2004). The story describes concerns about quality and duplication of capacity.

In addition, the volume of some imaging services has grown rapidly in recent years. From 2001 to 2002, for instance, volume growth per beneficiary for some imaging—magnetic resonance imaging, computed tomography, nuclear medicine, and heart echography—ranged from 13 to 17 percent (MedPAC 2004). Purchasing strategies might be a way for Medicare to address these issues.

To learn more about purchasing strategies, the Commission heard from a panel of experts about strategies used by private insurers to purchase imaging services. The panel included representatives from two private health plans and an executive from a firm that manages radiology benefits for multiple health plans.

In their presentations to the Commission, panelists acknowledged that advances in imaging technology are expanding the ability of physicians to diagnose and treat disease. They also expressed some concerns, including:

- proliferation of imaging equipment;
- lack of familiarity with new imaging modalities among nonspecialist physicians;
- self-referral, including ordering of imaging studies by physicians who furnish the studies with equipment in their offices;
- direct-to-consumer marketing of imaging services and associated questions about the need for demand management;
- defensive medicine in response to physician concerns about professional liability;
- repetition of imaging studies; and
- poor quality of imaging equipment in some settings.

In adopting their purchasing strategies, private insurers are working to control growth in the cost and utilization of imaging services while ensuring access to appropriate care.

Some of these strategies are similar to ones that we heard about during interviews with health plans, purchasers, and benefit consultants. Private insurers have just adapted them to emphasize the efficiency of imaging services. For instance, private insurers are profiling individual physicians or groups of physicians to compare patterns of imaging utilization among peers. The results are used to benchmark performance and provide information to physicians and enrollees to help them make cost-effective decisions. In addition, profiling results are used to design payment incentives for physicians who provide cost-effective care.

Private insurers are also using preauthorization to reduce utilization of imaging services that is inconsistent with practice guidelines. The strategy is viewed as an educational tool to help ensure that physicians are aware of practice guidelines.

To emphasize imaging services in their beneficiary education programs, private insurers make beneficiaries aware of their treatment options. In addition, the insurers provide information on the risks of exposure to radiation.

The panel discussed other strategies, including:

- coding edits, which are rules used during claims review to either detect improper billing codes or adjust payment for multiple imaging services on the same claim;
- safety standards for imaging equipment; and

- privileging, which includes certification of those who can bill for imaging services.

These strategies have features designed to address cost growth and the other concerns specific to imaging.

In starting to consider these strategies, we compared them to current policies of the federal government. We find the government already pursues some of these strategies, such as coding edits; could relatively easily implement others, such as promoting beneficiary education about the use of imaging; and cannot pursue others, such as tiering, under current law.

Coding edits

According to the panel, private insurers often use Medicare's coding edits. Known as Correct Coding Initiative (CCI) edits, these edits detect two forms of improper billing: unbundling and billing for mutually exclusive services.[8] Unbundling occurs when a claim includes two related billing codes and one code is defined as a component of the other code. Billing for mutually exclusive services includes billing for two services not typically furnished to the same patient. In all cases, CCI edits consider pairs of billing codes and detect instances in which both codes are not payable. Savings due to these edits totaled $333 million in 2002 (compared with total program spending of $45 billion), according to the CMS contractors who process claims. Savings may be larger than this, however, if providers know the coding edits and choose not to submit bills that would be edited.

Consistent with a MedPAC recommendation, CCI edits are transparent. They are made public and shared with the medical community and the American Medical Association's Correct Coding Policy Committee for review and comment before their implementation (MedPAC 2000).

Private insurers supplement the CCI edits with ones that are more extensive. Some of these compare billed services with practice guidelines. Others result in payment adjustments when multiple imaging services are billed on the same claim.

In adjusting payments for multiple imaging services, private insurers usually pay the full amount for the first service but a reduced amount for each additional service. This strategy is based on the premise that there are efficiencies when multiple services are provided during one patient encounter. Medicare has a similar policy, but it applies to surgical services only. For instance, under the physician fee schedule, Medicare pays the full fee schedule rate for the most expensive surgical service, but a discounted rate for the other services.

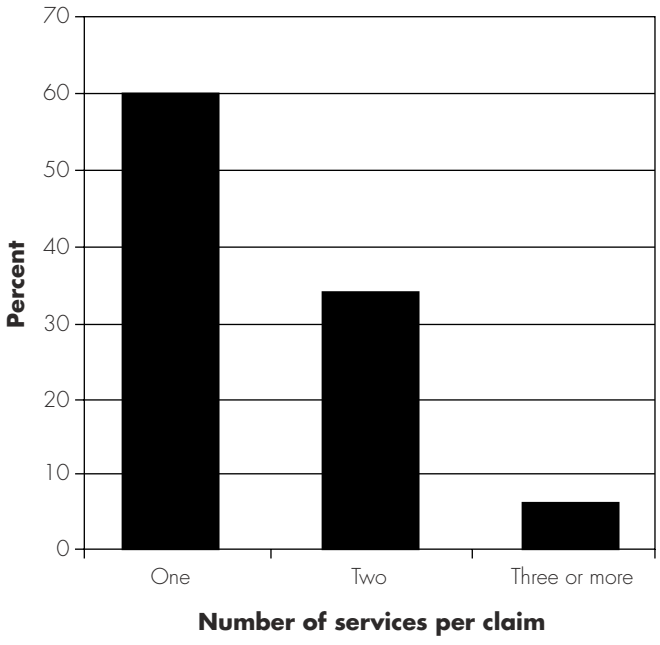
How often do claims submitted to Medicare include multiple imaging services? We have not analyzed the issue fully, but claims data for services billed under the physician fee schedule show that, for computed tomography (CT)—one type of imaging—about 40 percent of claims with any CT services include two or more CT services (Figure 4-1). Among these, CT of the abdomen and CT of the pelvis are the services that are billed together most frequently. When this occurs, the physician receives full payment for both services.

Safety standards for imaging equipment

Private insurers have implemented standards for imaging equipment in response to concerns about safety and technical quality of outpatient imaging facilities. To accomplish this, they inspect facilities periodically and assess:

FIGURE 4-1

Among claims with any CT services, 40 percent included two or more CT services, 2002



Note: CT (computed tomography).

Source: MedPAC analysis of claims data for 1 percent of Medicare beneficiaries.

- availability of equipment necessary to provide services,
- maintenance and safety of equipment,
- qualifications of staff,
- technical quality of radiographic and other images,
- procedures for ensuring quality control, and
- storage and management of records.

Performance is compared to standards developed by the American College of Radiology and other organizations.

In general, private insurers find that facilities comply with established standards. This can vary, however. Research has shown failure rates approaching 50 percent, depending on the type of practitioner operating the facility (Table 4-1). Such results may understate failure rates because they exclude facilities that withdraw from the market in anticipation of inspections (Verilli et al. 1998).

In some cases, facilities fail inspections because of the age of their imaging equipment. This problem can arise because facilities sometimes acquire used equipment from a hospital, for example, and continue to use the equipment beyond its useful life. The result for patients can be greater exposure to radiation than would occur with newer technology. In other cases, inspections reveal use of the incorrect type of equipment for a given imaging study. For instance, one inspection found use of dental equipment for x-rays of toes. Problems such as these raise questions about the extent to which some imaging facilities are achieving a minimum level of safety for their patients.

TABLE 4-1

Outpatient imaging failure rates vary by specialty

Practitioner or physician specialist	Number of sites inspected	Failures	
		Number	Percent
Chiropractor	144	70	49%
Podiatrist	49	22	45
Family or general practitioner	72	31	43
Internist	20	8	40
Urologist	14	5	36
Surgeon	12	3	25
Orthopedist	43	7	16
Obstetrics and gynecology	41	3	7
Radiologist	77	1	1

Source: Orrison and Levin 2002.

When private insurers implement safety standards for outpatient imaging facilities, their activities are similar to oversight of mammography facilities by the Food and Drug Administration (FDA). Under authority of the Mammography Quality Standards Act of 1992, the FDA establishes quality standards for mammography equipment and personnel. To enforce these standards, the agency annually inspects and certifies over 9,000 mammography facilities.

CMS is also engaged in such quality assurance efforts. Under authority of the Social Security Act, CMS establishes conditions of participation for entities meeting the definition of "provider of services," such as hospitals, skilled nursing facilities, and home health agencies. Conditions of participation are primarily structural requirements believed to ensure that providers can safely furnish quality health care (MedPAC 2000). They include standards for nurse staffing, radiologic services, laboratory services, medical records, infection control, discharge planning, and other aspects of health care delivery. Other entities, not defined as providers of services, are also subject to such standards—known as conditions of coverage. Those entities include renal dialysis facilities, ambulatory surgical centers, and portable x-ray suppliers.

Under authority of the Clinical Laboratory Improvement Amendments, passed in 1988, CMS also establishes quality standards for clinical laboratories. These laboratories are in physician offices, hospitals, skilled nursing facilities, and other locations.

To enforce conditions of participation, conditions of coverage, and quality standards for laboratories, CMS relies on others for inspections as part of the agency's survey and certification program. In some cases, state survey agencies conduct the certification surveys. In other cases, the surveys are conducted by private accreditation organizations, such as the Joint Commission on Accreditation of Healthcare Organizations. As long as the private organizations' standards meet or exceed CMS's standards, providers receiving private accreditation are deemed in compliance with the CMS standards.

MedPAC has recommended ways to improve the survey and certification process (MedPAC 2000). The Commission has recommended more frequent updates of conditions of participation and more frequent surveys of providers. The Commission has also recommended adequate levels of funding for survey and certification activities and sanctions that reflect the scope and severity of deficiencies found during surveys.

Physicians, and the services provided in their offices, are not subject to federal safety standards other than those for mammography and clinical laboratory services. Upon meeting the statutory definition of "physician," physicians can furnish diagnosis, therapy, and other services within the scope of medical practice for the state in which they are licensed.[9] States often regulate imaging services in physician offices through radiologic health initiatives.

Independent diagnostic testing facilities are another important source of imaging services (see text box below). CMS has established certain requirements for them, but they are not subject to survey and certification or other rigorous enforcement mechanisms.

Privileging

Privileging is another strategy private insurers have used to achieve efficiency and ensure quality. Privileging programs restrict payment for some imaging services to

Independent diagnostic testing facilities

Independent diagnostic testing facilities (IDTFs) are entities—independent of a hospital or physician office—in which nonphysician personnel furnish diagnostic procedures under physician supervision. An IDTF is considered to be independent of a physician's office if it:

- primarily bills for diagnostic tests rather than physician services (such as evaluation and management), and
- provides diagnostic tests primarily to patients whose conditions are not being treated by physicians in the practice.

A radiology practice that provides both the technical component and professional component (i.e, the test interpretation) of a test at the same location is not required to enroll as an IDTF.

Prior to 1998, freestanding diagnostic centers were classified as independent physiological laboratories, which were largely unregulated by either CMS or states. CMS and the Office of Inspector General (OIG) found evidence of fraudulent behavior by these entities and potential safety problems (HCFA 1997, OIG 1998). To address these issues, CMS created the IDTF category in 1997. IDTFs have certain requirements, which do not apply to physician offices that provide diagnostic services:

- They must have at least one supervising physician who oversees the quality of the testing, the proper operation and calibration of the equipment, and the qualifications of nonphysician staff.
- The nonphysician staff must be licensed by the state or certified by a national credentialing body.
- The beneficiary's treating physician must order all procedures performed by an IDTF in writing.
- They can only perform procedures that are approved in advance by their carriers.

Before enrolling IDTFs in Medicare, carriers must verify through document review and a site visit that the IDTF actually exists, the requirements above are met, and the equipment it uses is properly maintained and calibrated. However, enforcement of the standards is not rigorous: IDTFs are not subject to periodic survey and certification unless they wish to begin furnishing new types of services or if they open a new practice location. Under these circumstances, the carrier must perform an additional site visit. ■

physicians in certain specialties, such as radiology and cardiology. In addition to addressing the quality of imaging services, privileging counteracts problems that private insurers perceive with self-referral and proliferation of imaging equipment.

Medicare data illustrate the extent to which imaging services are provided by physicians in different specialties (Figure 4-2). Radiologists account for almost half of spending for imaging services furnished to Medicare beneficiaries. Cardiology also accounts for a relatively large proportion of spending for imaging. Still, much of the rest of spending is for services furnished by physicians in other specialties.

One effect of privileging is that it can reduce repeats of imaging studies. Studies are sometimes furnished by physicians or other practitioners who are not well-qualified to do so. The panel cited one example where podiatrists were interpreting MRIs. When this occurs, repeat studies are sometimes ordered. Privileging can prevent the problem by limiting payment to those most qualified to furnish imaging services.

In implementing their privileging programs, private insurers have found that certain operational details are important. For instance, privileging requires accurate information on physician specialty and, for nonphysicians, type of practitioner.[10] In addition, private insurers must waive privileging requirements in some rural areas to ensure access to care.

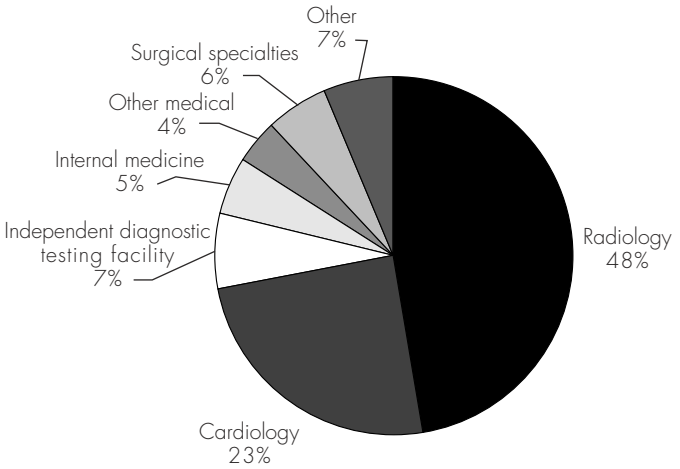
These privileging programs are not unlike some current Medicare policies. For example, chiropractors are permitted to bill Medicare for only one type of service: manual manipulation of the spine to correct a subluxation (dislocation). When chiropractors furnish other services, such as imaging, Medicare does not cover the services.

Privileging is also similar to Medicare coverage of power operated vehicles (POVs), also known as scooters. Under a campaign called Operation Wheeler Dealer, CMS will not cover a POV, unless it is ordered by a physician with a specialty in physical medicine, orthopedic surgery, neurology, or rheumatology (CMS 2003a). The campaign is a response to rapid growth in spending for the vehicles and evidence of rampant fraud and abuse in Harris County, Texas (CMS 2003b).

Restrictions on self-referral are another way to limit who can provide certain services, including imaging. Under the so-called Stark I and Stark II laws, physicians cannot refer Medicare (or Medicaid) patients to entities with which they, or members of their family, have a financial interest. The entities covered by the laws include those that provide radiology services as well as other services, such as clinical laboratory services, physical therapy, and home health. Certain types of referrals are exempt, including those within group practices.

Self-referral also includes a physician directing patients to imaging equipment within his or her practice (Kouri et al. 2002), but the Stark laws do not restrict this form of self-referral. In some respects, privileging is a private insurer response to this limitation of the Stark laws.

FIGURE 4-2 **Many provided imaging services in 2002**



Note: Other includes multispecialty clinic, portable x-ray supplier, and nuclear medicine.

Source: MedPAC analysis of physician claims data for 100 percent of beneficiaries.

Next steps

Should Medicare do more to emulate private insurers' strategies for purchasing imaging services? The answer to this question depends on the administrative feasibility—for both Medicare and the physicians and other providers who furnish services—of more closely aligning Medicare policy with the strategies of private insurers. It also depends on the effectiveness of those strategies for making the purchasing of imaging services more efficient. MedPAC plans to address these issues during the coming year.

Purchasing strategies for Medicare

In response to rising health care costs, insurers and employers in the private sector, as well as a growing number of public programs, have introduced strategies designed to promote efficiency in health care delivery. CMS has demonstrated a strong interest in value-based purchasing, and has introduced a variety of new programs. Notable examples are Medicare hospital and nursing home quality review and improvement programs, the development and dissemination of comparative information on provider quality for consumers, and the implementation of demonstration programs designed to test methods for improving the quality and effectiveness of health care in the fee-for-service program.

The purchasing strategies we have reviewed vary considerably. Some are variations or enhancements to systems or methods already present in some form in Medicare, such as consumer education and outreach programs or claims administration techniques like coding edits. Medicare contractors such as the quality improvement organizations (QIOs) are like their private sector counterparts in using profiling to review utilization and quality and educate providers about their performance. CMS has also developed data for consumers to use in comparing providers on measures of cost (as well as quality of care) for the new prescription drug cards and Medicare health plans. The introduction of some purchasing strategies, however, has been constrained by statute.

Recent legislative reforms have removed some significant barriers to implementing new purchasing strategies, but Medicare remains unique in the characteristics of its enrollee population, its legal complexity, and its size. Determining whether particular strategies should be pursued, or the manner in which strategies might be implemented successfully, will require careful analysis.

The statutory and regulatory context

The Medicare statute provides the basic structure for Medicare contracting; regulations that implement the statute and program policy shape how the program actually does its work. When Medicare was enacted in 1965, the legislation clearly reflected concern about government influence on the practice of medicine. The law specified that the program be administered by private entities that would, under contract, operate the program like large group insurance companies, and it set out basic criteria limiting the program's authority to affect health care. The first sentence of the Medicare title of the Social Security Act states,

> "Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person."

The second sentence is designed to preserve beneficiaries' access to their choice of providers. It states,

> "Any individual entitled to insurance benefits under this title may obtain health services from any institution, agency, or person qualified to participate under this title if such institution, agency, or person undertakes to provide him such services."

Broadly, these provisions—noninterference and beneficiary freedom of choice—provide a starting place for examining Medicare purchasing strategies. The context for interpreting these provisions, however, has changed over time. As Medicare has grown to be a major part of the health care system, policymakers have recognized that decisions about Medicare coverage and payment affect the American health care system in many ways.

The introduction of private plan options has also recast the role of the Medicare program. Private plans—primarily HMOs and preferred provider organizations—contracting with Medicare can use financial and management incentives to encourage providers to manage care more efficiently and effectively. Private plan options coexist with fee-for-service Medicare, and the same standards of coverage and beneficiary grievances and appeals apply across Medicare fee-for-service and private plans.

Despite the expansion of Medicare's role as a purchaser, however, implementing some strategies would require changes to Medicare law. Ongoing work commissioned by CMS is examining what changes would be needed to implement specific purchasing strategies, including:

- developing cost and/or quality profiles of providers that would form the basis of selective contracts;
- establishing differential payments related to meeting performance standards;
- reducing cost sharing for beneficiaries obtaining services from "preferred" providers;
- increasing covered services for beneficiaries obtaining services from "preferred" providers; or
- steering beneficiaries to providers through advertising and education campaigns.[11]

This analysis examines how federal antitrust provisions and other laws affecting providers' ability to form networks or establish other financial arrangements, data privacy law, and specific provisions of the Medicare statute and regulations could affect purchasing strategies. State law also may affect these strategies. Although federal law generally preempts state law on matters pertaining to Medicare, state law governing risk-sharing arrangements and provider participation in health plans (such as any willing provider laws) can, in effect, determine what types of provider organizations operate in local markets—and therefore are available to participate in Medicare. State policy regulating the licensing and certification of health care facilities and professionals also affects the availability of services and how they are used in local markets.

Medicare law would need to be changed to allow some purchasing strategies. For example, provisions governing fee-for-service Medicare do not currently permit differential beneficiary cost sharing.[12] Certain types of gain-sharing strategies or productivity bonus arrangements may not be permissible for fee-for-service providers under current anti-kickback provisions of federal or state law. It also appears that fee-for-service Medicare cannot increase covered services for beneficiaries who obtain care from preferred providers under current law.

Purchasing strategies that are not generally permissible under the statute may be allowable under fee-for-service demonstration programs, but this is not always clear. Different cost-sharing designs or augmented benefits might be permissible under demonstration authority, although there have been challenges to the designs proposed for some demonstrations (including a cataract care demonstration project and the Medicare Competition Pricing Demonstration).

Medicare may not currently have statutory authority to undertake any profiling activity that identifies or creates categories of "preferred providers." Legal challenges might center on the validity, or arbitrariness, of the measures and standards that CMS might use to categorize providers. A strategy that centered on categorizing individual practitioners as "preferred" or "more efficient" might also be challenged by practitioners not receiving the designation if the strategy did not allow for due process under the law.

Although the Medicare statute does not explicitly direct the Secretary to develop provider profiles, the authority to profile provider performance related to quality of care could be implied from provisions establishing the Medicare Peer Review Organizations (now called QIOs). The 1982 amendments to Medicare law that created the review organizations defined their functions to include the review of the quality of institutional and practitioner services and gave the Medicare program a broad authority to carry out the statutory provisions. The regulations implementing the QIO program charge them with examining whether "the quality of services meet professionally recognized standards of care." As part of the work they perform under contract with CMS, QIOs undertake national and local projects designed to improve quality of care for targeted conditions or diagnoses. These studies use CMS claims, medical records, and other data. QIO projects generally include profiling of provider practice and treatment variations, educational interventions designed in collaboration with providers, and feedback to providers on performance improvements (CMS 2003c).

CMS may seek to expand QIO profiling activities. The framework for the next contractor scope of work includes a section describing possible activities focused on developing QIOs' role in increasing the efficiency of care. Under the new contracts, for example, CMS has indicated that it may ask QIOs to make the QIO Clinical Data Warehouse a resource for partnerships to publish and

improve performance measures. Another section of the proposed framework lays out activities designed to expand QIOs' ability to "impact quality and costs." Examples include aligning QIO efforts with private sector programs to reduce inappropriate use of services, pharmaceuticals, and technology, and developing programs to prepare physicians for performance measurement using information technology (CMS 2003d).

CMS's contracting authority

Law and regulations governing Medicare's contracting authority define some of its options as a purchaser. Like other federal entities, CMS must follow the requirements of federal procurement regulations. These regulations are designed to ensure fair competition among eligible entities. In practice, the requirements can limit agencies' ability to move quickly to develop or amend contracts and restrict ways in which contracts can be constructed.

When Medicare was created, however, the statute included more extensive limits on the program's ability to engage in the contracts necessary to administer the program. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) substantially restructured the Secretary's authority to contract for Medicare administrative services, removing requirements for the nomination of contractors by eliminating the distinction between Part A and Part B contractors, and ending special procurement provisions. New contracts will be competed under the general federal procurement process rules (unless there are specific Medicare statutory provisions that conflict with the federal procurement rules).

Under these reforms, all of the functions of the current fiscal intermediaries and carriers processing Part A and Part B claims are assumed by new entities called Medicare Administrative Contractors (MACs). The Secretary will be able to renew MAC contracts for up to five years. The legislation calls for the Secretary to enter into new contracts with fiscal intermediaries without regard to the former nomination process no later than October 1, 2005. The full transition to the MAC contracts is to begin after October 1, 2005, and be completed by September 30, 2011.

The statute requires the Secretary to develop contract performance requirements addressing claims processing efficiency, customer service, provider education, and other activities, and to develop standards for assessing whether contractors meet these requirements. In developing performance standards, the Secretary must consult with beneficiary and provider organizations and organizations performing other Medicare functions. The Secretary must make the performance measures public, and include beneficiary satisfaction levels. The contractors do not, however, have to perform all of the claims administration, utilization review, education and outreach, and other functions associated with Medicare claims administration. The Secretary can design contracts that focus on specific activities. Previous legislation permitted this approach for only two services, durable medical equipment and home health; the MMA reforms will allow CMS to apply this approach to other types of services.

The new provisions governing Medicare contracting could provide opportunities for new purchasing strategies in at least two ways. First, the pool of contractors should expand, allowing organizations with special expertise in areas related to particular services or provider groups, or who have developed innovative approaches to claims management and review, medical review, provider profiling, and other activities, to compete as Medicare contractors. This flexibility may also provide some opportunity for CMS to review the various activities of the other contractors, including the program integrity contractors and the QIOs. It might be possible, for example, to use Medicare administrative data to develop more comprehensive analyses of provider profiles, focusing on variations in service volume, quality, or effectiveness of care. Second, the Secretary has been directed to incorporate performance measures and incentives into contracts. This could provide more impetus for contractors competing for Medicare business to devise strategies to inform providers about effective practice or to devise more effective claims screening protocols.

Next steps

Innovative purchasing strategies that are emerging in the private sector and in other large public systems suggest that there are ways Medicare can be a better purchaser of health care. There may also be opportunities for fee-for-service Medicare to take a more active role in the development and evaluation of purchasing strategies that could increase the efficiency and effectiveness of health care overall. There is, however, no clear consensus about how actively Medicare, directly or through its contractors, should manage purchasing decisions in the fee-for-service program.

Three broad questions arise in evaluating whether the Medicare fee-for-service program should pursue specific purchasing strategies:

- How would purchasing strategies affect Medicare beneficiaries?
- How would the purchasing strategy affect the delivery system that serves beneficiaries?
- Can the Medicare program administer the strategy effectively?

The Commission plans to take up these issues as it considers policy options over the course of the next year. ■

Endnotes

1 Coding edits are rules invoked during computerized claims processing to detect improperly coded claims for payment.

2 Various Medicare demonstrations have experimented with alternative strategies to improve efficiency, including the centers of excellence, competitive bidding, group practice, and disease management demonstrations.

3 Others have considered applicability of private sector strategies to Medicare (Berenson 2003, Etheredge 2003).

4 The Leapfrog group is a consortium of public and private organizations, organized by the Business Roundtable, that promotes programs designed to help large purchasers of health care initiate programs to advance quality of care and improve patient safety.

5 RTI International has prepared a report for CMS examining a range of issues related to selective contracting, physician profiling, and other purchasing strategies. The draft report, *Environmental scan for: Selective contracting practices with efficient (qualified) physicians and physician group practices; profiling techniques; incentive payments and barriers to selective contacting*, has not yet been revised to reflect CMS comments, nor has it been accepted by CMS in final form.

6 Recent research has raised questions about the ability of volume of services to serve as a proxy for hospital quality. One study found that the positive relationship between quality and high volume of coronary artery bypass graft surgeries was not observed in patients younger than 65 years or in those at low operative risk (Peterson et al. 2004).

7 CMS recently initiated a demonstration in New Jersey to test the impact of a gainsharing arrangement on Medicare spending. Before it was implemented, however, three hospitals that were not chosen to participate in the program sued the Secretary. The District Court of New Jersey halted the demonstration because of concerns that it violated the 1986 Federal civil monetary penalty statute (Albert 2004).

8 These edits apply to all physician services, not just imaging services.

9 This same principle applies to other professionals, including dentists, optometrists, podiatrists, and chiropractors.

10 Chiropractor is one type of nonphysician practitioner billing some private insurers for imaging services.

11 This discussion of legal issues surrounding the introduction of purchasing strategies in fee-for-service Medicare draws on the CMS draft report, prepared by RTI International, described in endnote 5.

12 Different cost-sharing arrangements are explicitly permitted for Medicare Advantage private plans.

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