Executive summary

Executive summary

The entrance of the baby-boom generation into the ranks of Medicare beneficiaries brings into even sharper focus the issues of increasing use of services, gaps in quality, and achieving the best value for Medicare spending. The concept of efficiency, using fewer inputs to get the same or better outcomes, becomes ever more important. In this report, after describing the changing beneficiary profile in Medicare and its implications for the program, we examine several approaches to promote greater efficiency in the Medicare program.

The concept of efficiency should include not only getting more for a set amount of inputs, but getting more of the right care. One way we recommend to do so is to develop information on the comparative effectiveness of alternative therapies. Efficiency encompasses quality as well as quantity and cost, and we develop a design for a home health pay-for-performance (P4P) system that illustrates the issues and possible solutions in P4P programs in Medicare. Another aspect of efficiency is getting the right amount of care over an entire episode of care. One possibility we discuss in this report is to decrease the number of avoidable hospital readmissions through higher quality care, better care transition at discharge, and better care coordination.

Traditionally, MedPAC has been concerned with payment accuracy, because if a payment system sends the wrong signals through its prices, providers will be encouraged to provide a less-than-optimal mix of services. This report considers several improvements to payment accuracy. In response to a congressional mandate, the Commission recommends a new approach for computing the hospital wage index that will increase its accuracy. The wage index is used to adjust payments for differences in labor costs across geographic areas; there are issues about the current system's equity and accuracy. Another source of inefficiency in the program is the overlap between the new Part D program for prescription drugs and the previous limited drug coverage in the program under Part B. The report makes recommendations to sort out these overlaps and promote efficiency and convenience for the beneficiaries. The report also examines reforming the payment system for skilled nursing facilities (SNFs) and introducing new quality measures. Finally, the report discusses changes to physicians' practice expense (PE) payments—an important part of the physician fee schedule.

Medicare in the 21st century: Changing beneficiary profile

The profile of Medicare beneficiaries will change as the baby-boom generation enters and ages into the program, and those changes—discussed in Chapter 1—prelude important implications for the Medicare program. Basic demographic changes include changes in beneficiaries' age and ethnic mix as well as disparity in education and income. In addition, there are important trends in the characteristics of Medicare beneficiaries, such as an increasing proportion of beneficiaries being treated for multiple chronic conditions, a decreasing proportion of beneficiaries with disabilities and employer-sponsored health insurance, and changes in family structure that affect the availability of adult children to provide long-term care for their parents.

Changes in the characteristics of Medicare beneficiaries will affect program spending and the types of services beneficiaries will want and need in the future. Possible ways to change Medicare to address the needs of future beneficiaries include:

- facilitate care coordination in traditional Medicare;
- expand the use of health information technology, which may improve efficiency and quality of care to all beneficiaries and facilitate care coordination;
- increase the use of comparative-effectiveness analyses as a source of information and guidance for providers and beneficiaries (which we discuss in Chapter 2);
- implement public health efforts that promote healthy lifestyles; and
- modify the benefits and cost sharing of traditional Medicare.

Producing comparative-effectiveness information

Comparative-effectiveness analysis compares the clinical effectiveness of a service (drugs, devices, diagnostic and surgical procedures, diagnostic tests, and medical services) with its alternatives. In Chapter 2, we find that not enough credible, empirically based information is available for health care providers and patients to make informed decisions about alternative services for diagnosing and treating most common clinical conditions.

Many new services disseminate quickly into routine medical care with little or no basis for knowing whether they outperform existing treatments. Information about the value of alternative health strategies could improve quality and reduce variation in practice styles.

Although several public agencies conduct comparative-effectiveness research, it is not their main focus and their efforts are not conducted on a large enough scale. For private-sector groups, conducting this type of research is costly and, when it is made publicly available, the benefits accrue to all users, not just to those who pay for it. Because the information can benefit all users and is a public good, it is underproduced by the private sector; a federal role is necessary to produce unbiased information and make it publicly available.

Consequently, the Commission recommends that the Congress should charge an independent entity to sponsor credible research on comparative effectiveness of health care services and disseminate this information to patients, providers, and public and private payers. Such an entity would:

- be independent and have a secure and sufficient source of funding (the Commission prefers a public–private option to reflect that all payers and patients will gain from this information);
- produce objective information and operate under a transparent process;
- seek input on agenda items from patients, providers, and payers;
- re-examine the comparative effectiveness of interventions over time;
- disseminate information to providers, patients, and public and private health plans;
- have no role in making or recommending coverage or payment decisions for payers; and
- have an independent board to oversee it.

The entity's primary mission would be to sponsor studies that compare the clinical effectiveness of a service with its alternatives. Payers, including Medicare, could use this information to inform coverage and payment decisions. While cost effectiveness is not a primary mission, the Commission does not rule out the entity producing such analyses. In the simplest case, cost may be an important factor to consider for two services that are equally effective in a given population. But even when clinical effectiveness differs, it may be important for end users to be aware of costs.

Update on the Medicare Advantage program and implementing past recommendations

Private plans have the potential to promote greater efficiency in the delivery of health care and improved outcomes for enrollees; hence, the Commission supports their participation. However, we report in Chapter 3 that for most Medicare Advantage (MA) private plans the current approach to payment does not promote efficiency, primarily because county benchmarks—which are the basis of payment for MA plans—exceed Medicare fee-for-service (FFS) expenditure levels.

Benchmarks averaged 116 percent of expected FFS spending in 2006, and those high benchmarks enabled plans to offer extra benefits to attract enrollees, resulting in significant enrollment growth in MA. Enrollment growth has been greatest in private fee-for-service (PFFS) plans rather than in coordinated care plans. Yet, on average, PFFS plans provide the basic Medicare benefit package at a cost higher than the traditional FFS program, while HMOs do so for less. In other words, PFFS plans are providing extra benefits because of the higher payment rates, not because of greater efficiency.

The continuing growth in enrollment in high-benchmark counties (where PFFS enrollment is concentrated) and the growth in types of plans that are less efficient heighten our concerns about the MA program. Current MA payment policy is inconsistent with MedPAC's principle of payment equity between MA and the traditional FFS program. In the context of MA, equity would be achieved by setting benchmarks at 100 percent of FFS. However, the Commission recognizes that changing MA plan payment rates to achieve financial neutrality too quickly will cause disruptions for beneficiaries in some markets, and thus the Congress may want a transition period. The timing of a transition to a plan payment system that is financially neutral needs to take into account the effect on beneficiaries. We offer several options.

In addition to the variations in efficiency among plans, there are also wide differences in plan performance on quality measures. Such differences highlight the importance of the Commission's recommendation to

institute a P4P system in MA and the importance of having all plans report on quality measures. PFFS plans, for example, are exempt from most quality measurement requirements, which is an example of the unlevel playing field that exists in MA with regard to plan standards and contracting requirements. The Commission is concerned that differing standards provide an advantage to one plan type over another.

With respect to special needs plans (SNPs), we provide an update on plan availability and participation as of early 2007. In 2007, the number of SNPs has again risen, to 476, from 276 in 2006 and 125 in 2005. SNP enrollment as of March 2007 was about 843,000, compared to 532,000 enrollees in July 2006. We intend to continue studying what the proper role should be for SNPs in the MA program and what criteria might be established for these plans.

Value-based purchasing: Pay for performance in home health care

In the Deficit Reduction Act of 2005, the Congress asked the Commission to discuss the design of a P4P system in home health care to improve the value of health care that Medicare purchases. In Chapter 4, we have applied general principles for P4P design specifically to the home health sector; however, the principles could be used in other settings as well. The key aspects of program design are:

- ***Funding the reward pool.*** P4P should be budget neutral; it should not add money to or remove money from the system.
- ***Setting thresholds for performance.*** There are several ways to set thresholds; the most common one is to use a set percentage of providers. An alternative is to use a test of statistical significance: High performance is a score statistically significantly above the average, and poor performance is significantly below the average. Improvement could be regarded as a score significantly greater than the provider's previous score.
- ***Balancing rewards for attainment and improvement.*** If the rewards are exclusive (a provider can receive either an attainment reward or an improvement reward but not both), then less weight could be placed on the improvement rewards since those providers are, by definition, providing lower quality care as measured by the P4P system.
- ***Determining the size of the reward.*** In a budget-neutral system, the size of the reward is constrained by the size of the penalty placed on poorly performing providers; when money is removed from the system to fund the pool, then the entire reward pool should be spent on rewards. The size of the reward should be proportional to the provider's Medicare payments.

As we discuss each of these aspects of program design in Chapter 4, we offer a P4P model built from home health data to illustrate these points. However, the circumstances of home health care may pose particular challenges for P4P in that sector. Our analysis suggests that the current home health payment system overpays providers and pays inaccurately for some patients. Adding a quality incentive to a payment system that does not accurately pay providers for the costs of different patients could result in the quality incentive being overwhelmed by the current payment incentives. The Commission will continue to consider reforms to the payment system. P4P should be put in place at the same time as Medicare improves the payment system to create stronger incentives to improve quality.

Payment policy for inpatient readmissions

Medicare's hospital payment system provides no explicit encouragement or reward for hospitals that reduce readmissions, although readmissions indicate the possibility of poor care or missed opportunities to better coordinate care. Medicare pays for each admission based on the patient's diagnosis regardless of whether it is an initial stay or a readmission for the same or a related condition; almost 18 percent of admissions result in readmissions within 30 days of discharge. Yet research shows that hospital-based initiatives to improve communication with beneficiaries and other caregivers, coordinate care after discharge, and improve the quality of care during the initial admission can avert many readmissions—to the benefit of beneficiaries and the program.

To encourage hospitals to adopt strategies to reduce readmissions, Chapter 5 explores a two-step policy option that starts with public reporting of hospital-specific readmission rates for a subset of conditions. The second step of the policy is an adjustment to the underlying payment method to financially encourage lower readmission rates. For example, one could create a penalty for hospitals with high readmission rates and hold all other hospitals harmless.

We focus on the hospital's role but recognize that other providers can be instrumental in avoiding readmissions, including physicians and post-acute care providers. Similarly, beneficiaries have responsibility in the effort to avoid readmissions and should be encouraged to be engaged in their own care. Aligning incentives across all who can influence the patient's outcome is essential to induce the needed collaboration among FFS providers to reduce readmissions and, more broadly, foster greater "systemness" and integration in the delivery of health care.

An alternative method to compute the wage index

In the Tax Relief and Health Care Act of 2006 (TRHCA), the Congress mandated that the Commission report on a revision of the wage index. The TRHCA also requires the Secretary to consider the Commission's recommendations in the fiscal year 2009 inpatient prospective payment system proposed rule.

In Chapter 6, we explore an alternative method for calculating wage indexes for hospitals and other sectors. The wage index we develop addresses specific issues of concern to the Congress, including eliminating exceptions, minimizing variation in the wage index across county borders, and using the hospital wage index in other settings. It also addresses other issues in the current system, such as distinguishing between the effects of skill mix differences and wage differences. The MedPAC index is based on wage data from the Bureau of Labor Statistics and the Census Bureau, and benefits data are from the provider cost reports submitted to CMS.

The Commission recommends first that the Congress should repeal the existing hospital wage index statute including reclassifications and exceptions, and give the Secretary authority to establish new wage index systems. Second, the Commission recommends that the Secretary should use this new authority to establish a hospital compensation index that:

- uses wage data representing all employers and industry-specific occupational weights,
- is adjusted for geographic differences in the ratio of benefits to wage,
- is adjusted at the county level and smooths large differences between counties, and
- is implemented so that large changes in wage index values are phased in over a transition period.

Because it uses the same underlying data for all settings, the method can easily be tailored to SNFs and home health agencies. However, we find that the SNF, home health agency, and hospital wage indexes under the new approach are highly correlated. Therefore, the Commission also recommends that the Secretary should use that hospital compensation index for the home health and SNF prospective payment systems and evaluate its use in the other Medicare FFS prospective payment systems.

Issues in Medicare coverage of drugs

As Medicare's Part D prescription drug benefit becomes established, two issues have arisen that we address in Chapter 7: instances when there is an overlap in coverage for certain drugs between Part B and Part D, and delivery of Part D benefits to Medicare beneficiaries who reside in long-term care facilities.

We offer recommendations to address three issues with overlap drugs:

- Drugs that can be prescribed for many indications. Currently a drug plan must determine whether a drug should be covered under Part B before it can approve a claim, so plans often require prior authorization before the pharmacist can dispense the drug. The Commission recommends that the Congress change the law to allow CMS to identify selected overlap drugs that are covered under Part D most of the time and are low cost and direct plans always to cover them under Part D.
- For drugs that continue to be covered by Part B and Part D, permitting plans to cover a transitional supply of drugs under Part D. Until a plan determines whether a drug is covered under Part B or Part D, it is not allowed to provide emergency supplies to beneficiaries under Part D. We recommend that the Congress authorize prescription drug plans to approve transition supplies while coverage is being determined.
- New preventive vaccines that are covered under Part D instead of Part B. Because physicians administer the vaccines but cannot directly bill drug plans, patients might have to pay the physician and then seek repayment from their drug plan, which might discourage beneficiaries from getting vaccines. We recommend that the Congress should permit coverage for appropriate preventive vaccines under Part B instead of Part D.

About 5 percent of Medicare beneficiaries reside in long-term nursing facilities (NFs), and their drugs are often dispensed by long-term care pharmacies (LTCPs). Under Part D, LTCPs must negotiate with numerous plan sponsors over payments for services delivered to NF residents. Tensions have grown between some Part D plans and LTCPs over pharmacies' desire for timely dispensing and plans' desire to determine whether prescriptions are covered and appropriate before paying for them. Also, CMS is concerned that the separate rebates LTCPs receive directly from drug manufacturers could undercut the benefit management of the Part D plans and potentially raise program costs.

The Commission intends to monitor this issue and will look at data as they become available. The chapter does not make recommendations on this issue but does examine three potential options for providing Part D benefits in long-term care settings.

Skilled nursing facilities: The need for payment system reform

Chapter 8 discusses issues related to Medicare's payment system for SNFs and the measures used to assess the quality of care provided in them. The current design of the prospective payment system results in impaired access for certain beneficiaries who require expensive nontherapy ancillary (NTA) services and encourages providers to furnish therapy even when the services are of little or no value.

The chapter describes CMS's extensive research to refine the payment system and concludes that options can be designed that better target payments for NTA and therapy services and for stays with unusually high costs. Many of the options will require trade-offs between their predictive abilities and the burdens they impose on CMS and providers. Better data on the use of NTA services during the SNF stay, patient diagnoses, nursing costs, and patient assessment information at admission and discharge would facilitate redesign efforts.

We then consider why some hospitals continue to operate their SNFs, despite the SNFs' apparent poor financial performance, while other hospitals have closed their units. In site visits and interviews, hospital administrators told us their reasons—including nonfinancial factors—for keeping their SNFs open or for closing them. The administrators indicated that they consider how the SNF contributed to the combined financial performance of the hospital and the SNF. Our analyses found that hospital and SNF revenues together covered the combined direct costs (which do not include overhead and capital costs) of the patients. Losses on the SNF side can be offset by improved performance on the hospital inpatient side from shorter lengths of stay and alternative uses for scarce inpatient beds.

In our March 2007 report, we noted that two measures of SNF quality—risk-adjusted rates of discharge to the community and avoidable hospital readmissions—indicated that quality had declined between 2000 and 2004. Yet quality scores improved for the same facilities based on the publicly reported SNF quality measures. This difference in trend, combined with our previous concerns about the publicly reported measures, leads us to urge CMS to report community discharge rates and rehospitalization rates for Medicare patients. CMS should also reconsider our 2006 recommendation to change the timing of the patient assessment so that changes in health status are gathered for all patients.

Analysis of changes to physicians' practice expense payments

In Chapter 9, the Commission examines how CMS determines PE payment rates in the physician fee schedule; PE payments account for close to half of the $58 billion Medicare spent under the fee schedule in 2005. We describe the major changes that CMS has recently made to PE rates and their impacts, examine CMS's method for allocating indirect costs to specific services, and explore how the agency adjusts PE payment rates to account for geographic differences in input prices.

Beginning in 2007, CMS is using new methods to calculate direct and indirect PE relative value units (RVUs), using the same approach to calculate PE RVUs for services that both do and do not involve physician work, and using more current practice cost data to calculate indirect PE RVUs for eight specialty groups. In addition, CMS adopted significant changes to physician work RVUs, which affect both the physician work and the PE components of the fee schedule. Collectively, these changes represent the biggest revision to the methods and data used to calculate PE RVUs since 1999. CMS will phase in these changes over a four-year period.

The new PE methods and data redistribute PE payments across services. When CMS fully implements the changes in 2010, PE RVUs will increase by 7 percent for evaluation and management services and by 3 percent for other

(nonmajor) procedures and tests. By contrast, PE RVUs will decrease by 8 percent for major procedures and by 9 percent for imaging services.

Because indirect costs represent about two-thirds of total practice costs, we examine CMS's new method for calculating indirect PE RVUs and explore other methods to pay indirect practice costs. We also discuss the sensitivity of the PE RVUs to changes in the calculation method.

Finally, we examine how CMS adjusts PE payment rates to account for geographic differences in the price of inputs used in operating a physician practice. Payments would be more accurate if the payment system excluded costs that do not vary geographically, such as equipment and supplies, from the geographic adjustment.

Review of CMS's preliminary estimate of the physician update for 2008

Appendix A fulfills the Commission's requirement to review CMS's estimate of the 2008 update for physician services. CMS's preliminary estimate of the 2008 payment update for physician services is –5.1 percent. However, when combined with the effect of the TRHCA, CMS estimates the net change to the conversion factor from 2007 to 2008 to be –9.9 percent. Due to continued growth in expenditures on physician services and increased spending associated with legislative overrides to avert payment cuts for physician services, the sustainable growth rate (SGR) formula has called for negative updates since 2002.

In reviewing the technical details involved in estimating the update under current law (in accordance with the SGR formula), we find that CMS used estimates in calculating the update that are consistent with recent trends. Moreover, the Commission anticipates that no alteration in the factors of CMS's estimates would be large enough to eliminate the application of the statutory limit the SGR formula imposes. ■