
Executive summary

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As part of its mandate from the Congress, each June the Commission reports on Medicare payment systems and on issues affecting the Medicare program, including changes in health care delivery and the market for health care services. In this report, we examine several issues within Medicare itself, including:

- payments for physician services, with one chapter that considers alternatives to the sustainable growth rate (SGR) system and another on ways to improve payment accuracy and promote appropriate use of ancillary services;
- the design of Medicare’s traditional fee-for-service (FFS) benefit package and its impact on beneficiaries and the program overall; and
- Medicare’s technical assistance to health care providers for quality improvement.

We also examine aspects of the broader health care system, including:

- improving coordination of the care of beneficiaries dually eligible for Medicare and Medicaid,
- the function of federally qualified health centers (FQHCs) and how they intersect with the Medicare program, and
- variation in private-sector payment rates for services across and within markets.

In an appendix, as required by law, we review CMS’s preliminary estimate of the update to payments under the physician fee schedule for 2012.

The Commission continues to be concerned with the sustainability of the Medicare program and continues to explore every avenue for protecting the access of Medicare beneficiaries to high-quality care while reducing the rate of growth in Medicare expenditures. Some efficiency can be derived from stronger incentives to better coordinate care and to use high-value versus low-value services. This report identifies opportunities to better coordinate care by increasing the emphasis on primary care in the physician fee schedule (discussed in Chapter 1 on the SGR), by coordinating services for beneficiaries dually eligible for Medicare and Medicaid, by changing the quality infrastructure, and through the use of FQHCs. It also

considers changing incentives for the use of high-value versus low-value care by changing the benefit structure in traditional Medicare and by making payment for in-office ancillary services more accurate. We will continue to examine Medicare’s payment systems and to reevaluate them in light of changes in the broader health care system. We will also look for opportunities to get good value for the program’s expenditures and to move away from FFS payment systems that pay providers more when they deliver more services without regard to the quality or value of those services.

The sustainable growth rate system: Policy considerations for adjustments and alternatives

In current law, a formulaic system—the SGR system—requires rates for physician and other health professional services to be cut about 30 percent in 2012. Although the Congress has repeatedly taken legislative action in recent years to override most of the SGR’s fee schedule reductions, these “fixes” have been temporary and the frequent need to override increasingly steeper cuts is undermining provider and patient confidence in Medicare, potentially jeopardizing beneficiaries’ future access to care.

As discussed in Chapter 1, there are two fundamental problems with the current SGR system. First, the formula aggregates spending across all physicians and practitioners who furnish services to Medicare beneficiaries and, therefore, does not provide incentives at a more granular level (e.g., individual physicians, group practices) to control volume growth or improve care quality. Accordingly, the current construct does little to counter the volume incentives that are inherent in FFS payments. Second, the budget cost of replacing or restructuring the SGR is very high. According to the Congressional Budget Office, eliminating the SGR fee cuts and replacing them with a 10-year freeze in fee schedule rates would cost \$300 billion or more. The Commission is committed to helping the Congress continue to find budgetary offsets within Medicare. For example, some Medicare policy changes—such as lower updates in other sectors, as recommended in our March 2011 report—could partially offset this amount. It is unlikely, however, that the full offset needed to eliminate the SGR cuts can be found easily in Medicare within the applicable budget window.

In considering replacement of the SGR system, a fundamental issue is whether to maintain an expenditure target—either narrowly (i.e., in the physician fee schedule) or more broadly throughout all of Medicare. Commissioners have expressed a concern that SGR targets currently are borne solely by physicians and clinical practitioners and have discussed how broader targets would spread cost restraints across sectors. However, a broader expenditure target could have the same flaws as the SGR system: little incentive at the individual provider level to control the volume of services and, if volume trends are not restrained, a need for large-scale, formulaic rate reductions.

Replacing the SGR and expenditure targets with a different payment structure—without the current scheduled cuts—presents an opportunity to introduce needed payment reforms. That is, in exchange for eliminating the future fee cuts, reforms could be made in FFS Medicare to improve the accuracy of payments under the physician fee schedule, to increase payments for cognitive (or nonprocedural) services relative to procedural services, and to give the Secretary discretion to adjust payments. For example, research shows that at least some of the fee schedule’s payment rates are likely too high, perhaps by a wide margin. The Congress could require that the Secretary identify and reduce payments for overpriced services. More precisely, the update for all physicians could be made contingent on the Secretary identifying and reducing the relative values for overpriced services. The amount of the reduction necessary for a full update would be set in law. Reforms could also include steps toward delivery system reform and alternative payment models such as accountable care organizations, medical homes, and bundling.

While the prospect of replacing the SGR could serve as a vehicle for hastening at least some elements of reform, it may not be necessary to delay an SGR replacement until all the elements of reform are fully implemented. Reform is not a single event. It is a multipart process that unfolds gradually. In the meantime, last-minute SGR “fixes” are taking a toll. Considering the time and effort that will be involved in determining how to structure future payments for physician and other health professional services, interim fee schedule updates should apply for a minimum of one year—ideally at least two years—to provide stability for CMS, claims-processing contractors, and the practitioners who bill Medicare.

Improving payment accuracy and appropriate use of ancillary services

An exception to the Ethics in Patient Referrals Act allows physicians to provide imaging, clinical laboratory tests, physical therapy, and radiation therapy in their offices. This provision is known as the in-office ancillary services exception.

In Chapter 2, we find that physician investments in diagnostic testing equipment have contributed to rapid growth of these services under the physician fee schedule and resulted in levels of utilization that are likely to include unnecessary services. On the one hand, the Commission recognizes that many of these services enable physicians to diagnose and treat illness with greater speed and precision and, in some cases, with greater convenience for patients. On the other hand, there is strong evidence that physicians who own imaging equipment generate more service volume. In addition, several types of imaging are usually not provided on the same day as an office visit, which raises questions about patient convenience. Rapid volume growth contributes to Medicare’s growing financial burden on taxpayers and beneficiaries, leads to concerns about the accuracy of physician fee schedule payment rates, and raises questions about inappropriate use.

But physician self-referral in and of itself is not the problem. Rather, physician self-referral of ancillary services leads to higher volume when combined with FFS payment systems, which reward higher volume, and mispricing, which makes some services more profitable than others. The preferred long-term approach to address self-referral is to develop payment systems under which providers are rewarded for constraining volume growth while improving the quality of care. Because it will take several years to develop new payment systems, we recommend the following policies that could be adopted sooner:

- The Secretary should accelerate and expand efforts to combine into a single payment rate multiple discrete services often furnished together during the same encounter by the same provider. The payment rates for these comprehensive codes should reflect efficiencies in physician work and practice expense that occur when two or more services are provided together.
- The Congress should direct the Secretary to account for efficiencies that occur in an imaging study’s professional component when multiple imaging services are provided to the same patient by a single

practitioner. This policy would reduce the payment rate for the second and subsequent services performed in the same session.

- The Congress should direct the Secretary to reduce the physician work component of imaging and other diagnostic tests that are ordered and performed by the same practitioner. This policy would account for efficiencies that occur in those cases (e.g., reviewing the patient's history). This recommendation would apply in all settings, including physicians' offices and hospitals.

The savings from these three recommendations should be redistributed to other physician fee schedule services.

We also recommend that the Congress direct the Secretary to establish a prior notification and prior authorization program for practitioners who order substantially more advanced diagnostic imaging services than their peers.

In the first stage, prior notification, CMS would compare outlier physicians' use of imaging to evidence-based clinical guidelines and educate physicians about the appropriate use of imaging. It is possible that providers could use clinical decision support systems (DSS) instead of participating in a prior notification program as long as the DSS uses the same guidelines as CMS and providers transmit data to CMS. In the second stage, outlier physicians who order imaging inappropriately would be required to participate in a prior authorization program, in which CMS or a contractor would review and approve their requests to order imaging services before they are provided. Outlier physicians who order imaging appropriately would not be subject to prior authorization. This flexibility would help ensure appropriate use of imaging by both self-referring and non-self-referring practitioners without subjecting all providers to prior authorization.

The Commission remains concerned about the potential for self-referral in an FFS context to lead to higher volume. Therefore, if these recommendations and delivery system reforms are not successful at stemming the growth of ancillary services and their inappropriate use, we may revisit options to narrow the in-office ancillary services exception.

Medicare's fee-for-service benefit design

The Commission has been examining reform of the traditional benefit package for several years, and we present our current findings in Chapter 3. Our objective is

to give beneficiaries better protection against high out-of-pocket (OOP) spending but at the same time promote incentives for them to weigh their use of discretionary care without discouraging needed care. A further objective is to slow the growth of Medicare spending so that the program will be sustainable, recognizing that cost-sharing changes alone will not fully accomplish this objective.

The current FFS benefit design includes a relatively high deductible for inpatient stays, a relatively low deductible for physician and outpatient care, and a cost-sharing requirement of 20 percent for most physician care and outpatient services. Under this design, no upper limit exists on the amount of Medicare cost-sharing expenses a beneficiary can incur. If not supplemented with additional coverage, the FFS benefit design makes Medicare beneficiaries face substantial financial risk and may discourage the use of valuable care.

To guard against the risk of high OOP expenses, more than 90 percent of beneficiaries take up supplemental coverage or have Medicaid, which mute the effect of OOP costs. However, researchers agree that Medicare beneficiaries with supplemental coverage tend to have higher use of services and spending than those with no supplemental coverage. As currently structured, many supplemental plans cover all or nearly all of Medicare's cost sharing, which removes any price sensitivity beneficiaries might have and leads to higher spending. Most costs of increased utilization are borne by the Medicare program.

In the short term, incremental changes to the FFS benefit, such as adding a cap to beneficiaries' OOP costs, could reduce financial risk for beneficiaries. At the same time, requiring supplemental policies to have fixed-dollar copayments for services such as office visits and emergency room use, could lead to reductions in use of Medicare services sufficient to help finance the addition of an OOP cap. These changes could be coupled with exceptions that waive cost sharing for services in certain circumstances—for example, if evidence identified them as leading to better health outcomes. The changes could also include cost-sharing protections for low-income beneficiaries so that they would not forgo needed care. In total, these changes would be costly unless specifically designed to be budget neutral.

However, incremental changes may not be sufficient to create a modern benefit design. For the longer term, the goal would be to design a benefit that supports innovations in provider payments and changes in health care delivery. Some payers have initiated innovative benefit designs to

steer enrollees toward high-value care. We interviewed public and private payers and identified four strategies they use to achieve this goal: lowering cost sharing for high-value services, raising cost sharing for low-value services, creating financial incentives for enrollees to see high-performing or low-cost providers, and providing incentives for enrollees to adopt healthier behaviors. The Commission will continue to consider the need to move toward benefit designs that give individuals incentives to use higher value care and discourage them from using lower value care.

Enhancing Medicare’s technical assistance to and oversight of providers

In recent years, the Commission has recommended numerous payment policy changes to encourage quality improvement, including pay for performance, medical homes, penalties for high rates of hospital readmissions, and bundled payment. In Chapter 4, the Commission concludes that additional policy levers—technical assistance and conditions of participation—could be redesigned to better complement and support the intent of recent changes in payment policy and contribute to quality improvement.

The record of Medicare’s primary vehicle for improving quality, the quality improvement organizations (QIOs), has been uneven. The Commission recommends fundamental changes to the current QIO program to:

- give providers and communities the choice of who assists them and flexibility in how they use quality improvement resources,
- increase the number and variety of technical assistance entities that can assist providers and communities to introduce a greater range of choices for assistance in quality improvement, and
- make technical assistance to low-performing providers and community initiatives a high priority as a strategy to complement payment policy and address persistent health care disparities.

We recognize that these recommendations are substantial and will require considerable effort on the part of CMS to implement. However, given the pronounced need for quality improvement, Medicare must try a new approach. Instead of a standing organization in every state financed by the federal government to ask providers to participate in quality improvement activities, funding would be made available directly to providers and communities to be used

by them to purchase technical assistance in the market. Recently enacted payment incentives and increasing transparency of performance on quality measures should motivate providers to seek the most effective technical assistance for quality improvement.

In addition, we recommend:

- updating the conditions of participation so that the requirements incorporate and emphasize evidence-based measures of quality care,
- increasing accountability of providers by expanding CMS’s use of interventions that promote system-wide remediation of quality problems among persistently low-performing providers, and
- increasing public recognition of high-performing providers that participate in learning networks to assist low-performing providers.

This package of recommendations should complement recent payment policy innovations and lead to substantial improvement in the quality of care beneficiaries receive.

Coordinating care for dual-eligible beneficiaries

Beneficiaries who qualify for Medicare and Medicaid often have complex care needs that result in high program spending, yet the care furnished to them is typically uncoordinated. In June 2010, the Commission reported that combined program spending on dual-eligible beneficiaries varied considerably by number of chronic conditions, whether the beneficiary had dementia, and whether the beneficiary received care in a nursing home. It noted that care for dual-eligible beneficiaries could be improved by integrating care financing across Medicare and Medicaid and coordinating care delivery across sectors.

In Chapter 5, we report on programs with the potential to integrate and coordinate services provided to their enrollees. Commission staff conducted interviews and site visits to understand how integrated programs coordinate care and what lessons can be learned. Under integrated programs, either a managed care organization or a provider receives capitated payments from the Medicare and Medicaid programs and assumes risk for the full spectrum of the dual-eligible beneficiaries’ care. Some care coordination programs retain the FFS system and pay providers a small monthly care coordination fee. While these programs do not align the financial and care

management incentives as the capitated programs do, they represent a step toward integration of Medicare and Medicaid benefits.

We found that these programs vary considerably in their design and in the scope of services they manage. No single approach seems likely to fit in every state, and the lack of comparable outcomes research on most approaches leaves open the question of which models are more effective. Nevertheless, we found two constants. First, administrators of integrated programs told us that the flexibility of capitated payments allowed them to deliver the mix of medical and social services each patient needed. Second, all the programs were similar in a number of key care coordination activities, including care transitions, medication reconciliation, patient education, and patient assessment with respect to risk for hospitalization or nursing home placement.

Expanding enrollment was a challenge for many of the programs. Program officials had ideas about how to grow enrollment but acknowledged that these ideas were likely to result in only incremental expansion. Many interviewees told us that requirements to recruit on a person-by-person basis were a key limitation to expansion of these programs. State officials also consistently commented on the lack of financial incentives for states to pursue integrated programs, most notably that states cannot share in Medicare savings.

Another avenue for coordination is dual-eligible special needs plans (D-SNPs), which are Medicare Advantage (MA) plans that target their enrollment to dual-eligible beneficiaries. D-SNPs have the potential to integrate and coordinate the services covered by both Medicare and Medicaid, but to evaluate whether they are doing so CMS may want to revise its reporting requirements. First, D-SNPs report “models of care” but the information submitted is too general to evaluate the plans’ care coordination activities or whether the D-SNPs integrate Medicare and Medicaid services; also, SNPs already report about those activities in their MA applications and in quality reporting. CMS should target and streamline its model-of-care requirements to those key elements that are not available elsewhere. Second, it is not possible to evaluate the quality of care furnished by most D-SNPs. The star rating information for most SNPs is included in the overall reporting under a larger MA contract. In addition, many measures are not publicly reported. Finally, the Commission encourages CMS to shift its quality focus to

publicly reported outcome measures, which would allow for comparisons across MA plans, SNPs, and FFS Medicare.

Federally qualified health centers

FQHCs provide access to primary care in areas where primary care resources are otherwise constrained (designated health care shortage areas). FQHCs are required to be community-centered, not-for-profit organizations that emphasize coordination of care. FQHCs also make use of physician assistants, advanced practice nurses, and clinical nurse midwives where appropriate. Patients at FQHCs are predominantly low income and largely either uninsured or covered by Medicaid.

Chapter 6 focuses on FQHCs for three reasons. First, FQHCs are illustrative of a team-based approach to primary care, relying on advanced practice nurses, physician assistants, and other nonphysician practitioners as well as physicians. Second, FQHCs are required to provide care in medically underserved areas and play a role in meeting primary care capacity challenges in low-density rural areas. Third, Medicare’s payment system for FQHCs is changing from a per visit cost-based reimbursement to a prospective payment system (PPS), which will likely result in higher payments, potentially altering their role. We plan to follow the PPS for FQHCs as it develops.

Variation in private-sector payment rates

In Chapter 7, we examine how payment rates in the private sector vary across and within geographic areas. A better understanding of the dynamics of private health care markets can inform the development of Medicare payment policies. Questions of particular interest are: to what extent are factors such as the market power of providers or insurers affecting the variation in private-payment rates and, if they are major factors that explain the variation, what does that mean for Medicare payment policy and policies that are intended to promote greater integration among providers?

In a preliminary analysis of private-sector payment rates for hospital and physician services, we find wide variation in payment rates geographically for both types of services, with greater differences for hospital services. Payment rates for some physician services—certain imaging services, for example—vary more across areas than others, such as payment rates for office visits and obstetric care. Within a given area, payment rates can vary markedly as well. We found no strong pattern of correlation between rates for physician services and those for hospital services;

that is, areas with relatively high rates for physician services do not necessarily have high rates for hospital services, and vice versa.

In future work, we will explore the reasons for variation in payment rates. Factors such as the market structure and relative market power of providers and insurers are likely to affect the payment negotiation process and the resulting payment rates. The exact nature of the relationship between market characteristics and variation in rates is likely to be complex. We plan to continue our data analysis and undertake a more in-depth look at specific markets. We will also seek alternative ways to measure provider and insurer market power and market concentration to examine their effect on variation in private-payment rates.

Review of CMS's preliminary estimate of the 2012 update for physician and other professional services

In CMS's annual letter to the Commission on the 2012 update to payments for physician and other professional services, the agency's preliminary estimate is -29.5

percent. Most of the prescribed reduction would result from the expiration of a series of temporary payment increases to override negative updates under the SGR formula—which would otherwise update Medicare's payment rates for physician and other professional services. Under current law, the temporary increases expire at the end of 2011, requiring the SGR formula to produce a negative update for 2012.

The appendix provides the Commission's mandated technical review of CMS's estimate. We find that CMS's calculations are correct and that—absent a change in law—expiration of the temporary increases and the formula's update for 2012 are very unlikely to produce an update that differs substantially from -29.5 percent. Some components of the SGR update for 2012 could change between now and when CMS would implement the update in January, but any such changes are likely to be small compared with the total reduction prescribed. While the appendix is limited to technical issues, the Commission has concerns about the SGR as a payment policy. Those concerns are discussed in Chapter 1 of this report. ■