

# Improving Medicare Efficiency and Value

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Statement of  
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Chairman Pallone, Ranking Member Deal, distinguished Subcommittee members, I am Mark Miller, Executive Director of the Medicare Payment Advisory Commission (MedPAC). I appreciate the opportunity to be here with you this morning to discuss MedPAC's perspectives on ways to bring greater efficiency to Medicare. MedPAC has sought improvements in Medicare efficiency above and beyond our legislative mandate over the last several years, evidenced in our ongoing work on payment adequacy for Medicare fee-for-service (FFS) payment systems and payments to managed care plans under the Medicare Advantage (MA) program, as well as specific work on pay-for-performance, coordination of care, bundling of medical services, comparative effectiveness, and a host of more targeted studies on specific elements of Medicare payment policy such as payments for imaging services and the sustainable growth rate under the Medicare physician fee schedule. I would like to discuss several of these areas in greater detail today.

There is currently a great deal of interest in improving the efficiency of the Medicare program. This interest is driven not only by the desire to make Medicare a better program but also by growing concern about the sustainability of Medicare spending. Medicare as a public payer has suffered from the same persistently high growth in health care cost that has plagued all sectors of the health financing community. Medicare spending grew 9.3 percent annually between 1980 and 2004, on average, considerably higher than the average annual rate of growth in gross domestic product (GDP) of 6.5 percent for that same period. While growth in GDP—the measure of goods and services produced in the United States—is used as a benchmark of how much additional growth in expenditure society can afford, other measures illustrate the more direct impacts of growth in Medicare spending on the program's beneficiaries. Between 1970 and 2005, the average monthly Social Security benefit increased by an inflation-adjusted average annual rate of 1.6 percent; during the same period, Medicare Supplementary Medical Insurance premiums grew by more than 4 percent annually. Recent Part B premium increases have offset 30 percent to 40 percent of the dollar increase in the average Social Security benefit. Yet, despite this rapid growth in spending, a large body of evidence suggests the increased cost of health care has not come with a corresponding increase in quality. The

Institute of Medicine, in its 2001 report *Crossing the Quality Chasm*, suggested that while care may be improving in many settings, significant gaps remain between what is known to be good care and the care delivered, and it is still all too common for beneficiaries not to receive high-quality health care.

Slowing the increase in Medicare outlays is important; indeed it is becoming urgent. Medicare's rising costs, particularly when coupled with the projected growth in the number of beneficiaries, threaten to place a significant burden on taxpayers. It is likely that all available tools (efficiency gains, efforts to combat fraud and abuse, tax increases, and benefit restructuring) will be necessary to address the financial pressures facing Medicare. Much of MedPAC's work focuses on improved efficiency—getting more in terms of quality and outcomes for each Medicare dollar spent—as a way to help address Medicare's growing financial crisis.

The Commission has implicitly or explicitly dealt with the role of efficiency in many aspects of its ongoing work:

- *Payment updates*. Ensuring that provider productivity is taken into account in estimating recommended payment updates for FFS providers and identifying situations when payments are more than adequate;
- *Payment accuracy*. Ensuring that payments for health care goods and services accurately reflect providers' costs so that adverse incentives are not created (e.g., to select patients and provide higher profit services in lieu of services that provide the best outcomes);
- *Bundling*. Creating larger units of payment to give providers flexibility in the efficient provision of care, while minimizing incentives to increase profits by providing additional services;
- *MA plans*. Ensuring that capitated rates paid to plans are neutral to Medicare FFS, so plans have the incentive to be efficient, and so that beneficiaries will

be able to make choices about their coverage options based on “apples to apples” comparisons;

- *Pay-for-performance programs.* Designing payment system incentives to provide high-quality, appropriate care;
- *Measuring provider resource use.* Using Medicare administrative data to let providers know how their service utilization compares with that of their peers;
- *Care coordination.* Increasing quality of care and decreasing costs when multiple providers are involved by implementing payment incentives that promote coordination and thus reduce adverse events such as avoidable rehospitalizations following discharge; and
- *Comparative effectiveness.* Ensuring that new health care treatments and technologies represent advances in quality or efficiency in making health care decisions.

MedPAC believes there is considerable opportunity for improvements in program efficiency to increase the incentives for more efficient delivery of health care and, in so doing, help constrain the growth of program spending and increase the value of each dollar spent. Pricing policies can be powerful tools in creating these incentives; other program policies can complement changes to the payment systems. The likelihood of success of these measures in controlling spending will be enhanced if Medicare and other public programs can collaborate with private sector payers to ensure that these incentives are put in place across the board, rather than only in Medicare.

MedPAC believes it is essential to look hard at the value of the services Medicare pays for. For three-quarters of the program’s existence, Medicare’s reimbursement for services was relatively indifferent to the quality of care provided. In general, as long as claims were submitted in accordance with applicable administrative and policy requirements, Medicare paid them, regardless of whether the quality of the service (to the extent it was even a consideration) was in the top 10 percent or the bottom 10 percent, regardless of whether it resulted in an improved outcome for the patient, and regardless of whether the

service was the most appropriate for a given patient with a given condition. Persistent growth in Medicare spending led to passage of the watershed Balanced Budget Act of 1997 (BBA), which implemented a number of significant reforms to the program, most notably new prospective payment systems for providers that had previously been reimbursed on the basis of their costs and a new managed care program, Medicare+Choice. The rationale for the Medicare+Choice program was driven, at least in part, by the notion that managed care plans could deliver care to Medicare beneficiaries more efficiently than traditional FFS and thus in the long run would provide greater value for both the program and its beneficiaries. Such efficiencies would be leveraged even further by competition among plans, and one of the dimensions upon which plans were explicitly expected to compete was quality. Quality was also invoked in the BBA's authorization of a number of demonstration projects on the competitive acquisition of certain durable medical equipment.

The quality of care beneficiaries receive is not assured. Evidence shows that beneficiaries do not always receive the care they need and too often the care they do get is not high quality. There are also significant geographic variations in the amount of services beneficiaries receive, with little or no relationship to outcomes. This variation in care may expose some beneficiaries to unnecessary risk and is costly to beneficiaries and to the program.

Given the financial pressures facing Medicare, the program can no longer be indifferent to the value of the health care it pays for on behalf of its beneficiaries. The program must focus not only on achieving efficiency through calibrating payments, it must also pay much more attention to the quality and outcomes of the care its beneficiaries receive—in essence, looking not only at the price of health care but also at the value of the care that is purchased for that price.

## **Payment updates**

Each year, the Commission recommends payment updates and other policy changes for FFS Medicare. To help determine the appropriate level of aggregate funding for a given

payment system, the Commission considers whether current Medicare payments are adequate by examining information about beneficiaries' access to care; changes in provider supply and capacity; volume and quality of care; providers' access to capital; and, where available, the relationship of Medicare payments to providers' costs. As mandated by the Congress, MedPAC explicitly considers efficiency in making these assessments: Ideally, Medicare's payments should not exceed the costs of the efficient providers. Efficient providers use fewer inputs to produce quality services. We then account for expected cost changes in the next payment year, such as those resulting from changes in input prices.

Improvements in productivity should reduce providers' costs in the coming year. Medicare's payment systems should encourage providers to reduce the quantity of inputs required to produce a unit of service by at least a modest amount each year while maintaining service quality. Thus, in most cases where payments are adequate, some amount representing productivity improvement should be subtracted from the initial update value, which is usually an estimate of the change in input prices. Consequently, we apply a policy goal for improvement in productivity. This factor links Medicare's expectations for efficiency to the gains achieved by the firms and workers who pay taxes that fund Medicare. Under this construct, MedPAC has identified instances in which payments are more than adequate and, on several occasions in recent years, has recommended no annual updates to provider payments. Most recently, in our March 2007 report to the Congress, we produced a number of update recommendations for the 2008 payment year cognizant of potential provider efficiency gains that will generate program savings if implemented:

- Skilled nursing facility (SNF) services. The Commission recommended that the Congress eliminate the update to payment rates for SNF services for fiscal year 2008;
- Home health services. The Commission recommended that the Congress eliminate the update to payment rates for home health care services for calendar year 2008;

- Inpatient rehabilitation facility (IRF) services. The Commission recommended that the Congress update payment rates for IRFs for fiscal year 2008 by 1 percent;
- Long-term care hospitals (LTCH). MedPAC recommended that the Secretary eliminate the update to payment rates for LTCH services for 2008.

Medicare should exert continued financial pressure on providers to control their costs, much as would happen in a competitive marketplace. We have found, for example, that hospitals under financial pressure tend to control cost growth better than those that have non-Medicare revenues that greatly exceed their costs. The Commission is striving to pursue innovative means to increase value in Medicare while maintaining financial pressure in all its payment systems to restrain costs.

### **Payment accuracy**

Another component of encouraging efficiency through payment policy is to ensure that Medicare's payments for health care services are accurate. Misvalued services can distort the price signals for a wide variety of health care services. Some overvalued services may be overprovided because they are more profitable than others. Under Medicare Part B, mispricing may exacerbate the volume-inducing effects of the physician fee schedule. We identified similar situations in Part A. For example, our 2005 analysis of specialty hospitals showed that certain kinds of physician-owned specialty hospitals were extremely adept at identifying (and focusing on) more profitable diagnosis related groups (DRGs), and within those DRGs, the least sick (and most profitable) patients. By contrast, undervalued services may prompt providers to increase volume to maintain their overall level of payment. Conversely, some providers may opt not to furnish undervalued services, which can threaten access to care. For example, MedPAC has identified potential problems with Medicare's payment systems for both SNFs and hospices that may underpay and thus discourage these providers from accepting Medicare patients with complex medical conditions requiring expensive drug or nontherapy ancillary regimens as part of their treatment.

A service can become overvalued for a number of reasons. For example, under Medicare's physician fee schedule, the amount of physician work needed to furnish a service may decline as physicians become more proficient or when new technologies are incorporated. Services can also become overvalued when practice expenses decline. Likewise, services can become undervalued when physician work increases or practice expenses rise. Although CMS reviews the relative values assigned to physician services every 5 years, some services likely continue to be misvalued. In recent years, per capita volume for different types of services has grown at widely disparate rates, with volume growth in imaging and minor procedures outpacing that for visits and major procedures. Volume growth differs across services for several reasons, including variability in the extent to which demand for services can be induced and advances in technology that expand access and can improve patient outcomes. The Commission and others have voiced concerns, however, that differential growth in volume is due in part to differences in the profitability of services.

Differences in the profitability of services send signals to the market that go beyond incentives to over- or underfurnish services. For example, certain types of overvalued physician services may become more concentrated in some specialties than in others, such as primary care, that provide proportionately more low-profit services (such as evaluation and management services) that are less amenable to productivity gains. Facing these incentives, new physicians may be less willing to choose specialties that frequently provide undervalued services, resulting in reduced beneficiary access to certain physicians and certain services.

MedPAC has analyzed the issue of payment accuracy at great length in the context of Medicare's physician payment system. The Commission concluded in its March 2006 report to the Congress that CMS's process for reviewing the work relative values of physician services must be improved. To maintain the integrity of the physician fee schedule, we recommended that CMS play a lead role in identifying overvalued services



so that they are not ignored in the process of revising the fee schedule's relative weights. We also recommended that CMS establish a group of experts, separate from the Relative Value Scale Update Committee (RUC), to help the agency conduct these and other activities. This recommendation was intended not to supplant the RUC but to augment it. To that end, the group should include members who do not directly benefit from changes to Medicare's payment rates, such as experts in medical economics and technology diffusion and physicians who are employed by managed care organizations and academic medical centers. The Commission also urged CMS to update the data and assumptions it uses to estimate the practice expenses associated with physician services.

Ensuring the accuracy of payments to other providers—including hospitals and post-acute care providers—is also important. To this end, the Commission recommended refinements to the DRGs used in Medicare's hospital inpatient prospective payment system to capture differences in severity of illness among patients and thus reduce the potential for differential profitability of DRGs or individual patients within DRGs. We also recommended improving the case-mix systems used in Medicare's payment systems for post-acute care services, most notably the payment groups used under the SNF prospective payment system (PPS), to provide appropriate incentives for SNFs to treat patients requiring nontherapy ancillary services.

We recognize that CMS has many priorities and limited resources and that refinements to the various payment systems to ensure accuracy of payments will raise some difficult technical issues. These include the potentially increasing the number of payment groups, possible increases in spending from improvements in coding, and others. The Congress should take steps to ensure that CMS has the resources it needs to make the recommended refinements to Medicare's payment systems.

## **Bundling**

Another way to promote efficiency through pricing in the delivery of health care services to Medicare beneficiaries is through “bundling.” In bundling, a single payment is made for a group of related services, rather than making individual payments for each service

in the group. A larger unit of payment puts physicians and other providers at greater financial risk for the services provided and thus gives them an incentive to provide and order services judiciously. Medicare already bundles preoperative and follow-up physician visits into global payments for surgical services. Candidates for further bundling include services typically provided during the same episode of care, particularly those episodes for conditions with clear guidelines but large variations in actual use of service, such as diabetes treatment. In identifying the best candidates for bundling, one must consider that, while bundled payments could lead to fewer unnecessary services, they could also lead to stinting or unbundling (e.g., referring patients to other providers for services that should be included in a bundle). Medicare should explore options for increasing the size of the unit of payment to include bundles of services that physicians often furnish together or during the same episode of care, similar to the approach used in the hospital inpatient PPS.

MedPAC will be examining bundling the hospital payment and physician payment for a given DRG and for groups of DRGs, which could increase efficiency and improve coordination of care. This approach to bundling could be expanded in the future to capture periods of time (e.g., 1 or 2 weeks) after the admission but likely to include care (e.g., post-acute care, physician services) strongly related to the admission, further boosting efficiency and coordination across sites of care. We have also recommended broader bundling of services for patients with end-stage renal disease, most notably suggesting the inclusion of erythropoietin in the payment bundle (see above) to reduce the incentive to provide more of a given item or service to reap greater profits. Bundling services could be structured so that savings go to the providers, the program, or both.

### **Medicare Advantage**

The Commission has discussed the concept of efficiency at great length with respect to the MA program. Many of the positions and principles the Commission has adopted with respect to increasing efficiency through pricing of individual services or groups of services also apply to the calculation of payments for even larger groups of services—to wit, the capitated payments paid to managed care plans under MA. The Commission has

always supported a private plan option in Medicare, given the potential savings and expanded beneficiary choice the private plans can bring to Medicare.

In our March report, the Commission presented recent findings on the MA plans beneficiaries can join in lieu of traditional FFS Medicare. While the initial intent of the MA program may have been predicated on the idea that managed care represented a less costly alternative to FFS Medicare, our most recent findings suggest that payments to plans are generally higher—in some cases much higher—than corresponding payments would have been on behalf of the same beneficiaries under traditional FFS. The Commission believes that greater efficiency is achieved when organizations face financial pressure. The Medicare program needs to exert consistent financial pressure on both the traditional FFS program and the MA program. This financial pressure, coupled with meaningful measurement of quality and resource use to reward efficient care, will maximize the value of Medicare for the taxpayers and beneficiaries who finance the program.

Medicare's private plan option was originally designed as a program that would produce efficiency in the delivery of health care. Efficient plans could be able to provide extra benefits to enrollees choosing to enroll in such plans, and better efficiency would lead to higher plan enrollment. Unfortunately, MA has instead become a program with few incentives for efficiency. Although MA uses "bidding" as the means of determining plan payments and beneficiary premiums, the bids are against benchmarks that are not competitively set. Setting benchmarks well above the cost of traditional Medicare signals that the program welcomes plans that are more costly than traditional Medicare. Inefficient plans—as well as efficient plans—are able to provide the kind of enhanced coverage that attracts beneficiaries to private plans because of generous MA program payments that are in excess of Medicare FFS payment levels. All taxpayers, and all Medicare beneficiaries—not just the 18 percent of beneficiaries enrolled in private plans—are funding the payments in excess of Medicare FFS levels.

Our analysis of MA payments shows that the benchmarks (which are the reference level for plan bids and the maximum program payment) now average 116 percent of traditional Medicare FFS levels, and payments average 112 percent. The ratio of benchmarks and payments varies by plan type, although it exceeds the expected Medicare FFS expenditures for those beneficiaries for all types of plans. Table 1 shows that payments to HMOs are 110 percent of expected FFS costs. Payments for private FFS (PFFS) plans are 119 percent of expected Medicare FFS costs, because they are located in areas of the country where benchmarks are much greater than FFS, and because they are relatively inefficient at returning benefits to their enrollees.

**Table 1. Medicare Advantage benchmarks and payments in 2006 exceed expected Medicare fee-for-service expenditures for all types of plans**

	HMO/POS/ PSO*	Local PPOs*	Regional PPO*	PFFS
Enrollment as of July 2006 (in thousands)	5,195	285	82	774
Enrollment as of February 2007 (in thousands)	5,063	333	109	1,328
Net enrollment growth	-3%	17%	33%	72%
Benchmark relative to FFS cost	115%	120	112	122
Payments relative to FFS cost	110%	117	110	119
Bid (for Medicare A/B benefit) relative to FFS	97%	108%	103%	109%

Note: POS (provider of service), PSO (provider-sponsored organization), PPO (preferred provider organization), PFFS (private fee-for-service), FFS (fee-for-service). Payments relative to expected FFS costs for the beneficiaries enrolled in Medicare Advantage plans.

\* Data exclude special needs plans.

Source: MedPAC analysis of data from CMS on plan bids, enrollment, and benchmarks.

Private plans are given the flexibility and the incentives to improve the delivery of care and bargain with providers to negotiate payment rates that are expected to create program savings. However, the excess payments to private plans allow them to be less efficient than they would otherwise have to be, because inefficient plans can use the excess payments—rather than savings from efficiencies—to finance extra benefits that in turn attract enrollees to such plans. As shown in Table 1, enrollment has grown substantially

in MA as result of this situation. In 2006, 17 percent of beneficiaries were enrolled in MA plans, a level close to its all-time high.

Strikingly, almost half the growth in 2006 was in PFFS MA plans—the highest-paid and thus arguably least efficient—of the available types of MA plans. PFFS plans are nearly identical to Medicare FFS but with an added layer of marketing, operating and administrative costs, and profits. If the growth in enrollment in these plans reflected beneficiary preferences in the form of their willingness to pay higher premiums, such patterns would reflect a perceived benefit. However, it is likely that this growth has been fueled by program subsidies. PFFS plans primarily draw their enrollment from higher benchmark counties—specifically counties that were historically “floor” counties. MA benchmarks in these counties reflect a minimum payment level established by statute, resulting in benchmarks far above FFS expenditure levels in most cases. The statutory floor thus provides an implicit subsidy for these plans, and thus it is difficult to see the additional value such plans provide to Medicare beneficiaries for the additional cost to the program.

The Commission has always supported a private plan option in Medicare and has recommended lowering the MA benchmarks to help achieve a policy of financial neutrality between private plans and traditional Medicare FFS for several years. In addition to financial neutrality between MA and FFS, the Commission has also recommended neutrality between types of MA plans, including eliminating the stabilization fund for preferred provider organization plans and making bidding rules consistent across plan types. Further, the Commission has recommended a pay-for-performance program for MA plans, and calculating clinical measures for the FFS program that would permit CMS to compare quality in the FFS program with that in MA plans.

### **Obtaining greater value**

Ideally, payment systems not only reflect efficient and accurate pricing, but also give providers incentives to furnish better quality of care, to coordinate care (across settings,

in chronic conditions), and to use resources judiciously. However, Medicare pays its providers the same regardless of the quality of their care, which perpetuates poor care for some beneficiaries, mispends program resources, and is unfair to high-performing providers. Medicare's payment system does not reward providers for coordinating patients' care across health care settings and providers, nor does it encourage the provision of preventive and primary care services, even though such actions may improve quality of care and reduce costs.

To change payment incentives, the Congress and CMS must adopt policies that link payment to the quality of care provided. MedPAC's pay-for-performance recommendations would go some way toward correcting the problem of lack of incentives for quality care. At the same time, Medicare needs to explore measuring provider resource use and to encourage coordination of care and provision of primary care.

### **Comparative effectiveness**

Increasing the value of the Medicare program to beneficiaries and taxpayers requires knowledge about the costs and health outcomes of services. Until more information on the comparative effectiveness of new and existing health care treatments and technologies is available, patients, providers, and the program will have difficulty determining what constitutes good-quality care and effective use of resources.

Comparative-effectiveness information, which compares the outcomes associated with different therapies for the same condition, could help Medicare use its resources more efficiently. Comparative effectiveness has the potential to identify medical services that are more likely to improve patient outcomes and discourage the use of services with fewer benefits. CMS already assesses the clinical effectiveness of services when making decisions about national coverage and paying for some services, but to date FFS Medicare has not routinely used comparative information on the costs of services. Medicare Part D plans and other payers and providers, however, such as the Veterans Health Administration, do use such information—for example, in drug formulary

decision-making processes. Such information is critical for these entities, given the force of new technology in driving increased health care costs and the need for these payers to closely evaluate the comparative benefits of costly new technologies relative to existing treatments.

Private health plans and providers have not been at the forefront of effectiveness research. Private payers and providers may be reluctant to use comparative-effectiveness information extensively for fear that patients will criticize them as being more concerned about cutting costs than about patients' health. Litigation risks may also dissuade some private payers from using comparative-effectiveness information. In addition, private payers may anticipate problems keeping the information proprietary (thus aiding their competitors) and may fear that it would be difficult to capture the full return on their investment.

Medicare could use comparative-effectiveness information in a number of ways to improve the value of care beneficiaries receive. Medicare could use such information to inform providers and patients about the value of services, since there is some evidence developed by the Sacramento Healthcare Decisions group in 2001 and by Marjorie Ginsburg in 2004 that both might consider comparative-effectiveness information when weighing treatment options. Medicare might also use the information to prioritize pay-for-performance measures, target screening programs, or prioritize disease management initiatives. In addition, Medicare could use comparative-effectiveness information in its rate-setting process.

Given the potential utility of comparative-effectiveness information to the Medicare program, an increased role of the federal government in sponsoring the research may be warranted. Concerns have been raised by Moher and colleagues in the *Annals of Internal Medicine* about the variability and lack of transparency in methods and by Bekelman and colleagues regarding the potential bias of industry-sponsored researchers conducting

clinical- and cost-effectiveness research. MedPAC inventoried many of these concerns in our June 2006 report to the Congress.

A public-private partnership may more effectively address stakeholders' concerns about the use of comparative-effectiveness analysis than a noncollaborative process. A partnership that defines analytic standards would send researchers a clear, effective signal to improve their methods and develop valid and transparent comparative-effectiveness analyses. A partnership could help set priorities for clinical-effectiveness review and research. Services could be selected based on disease prevalence, high per unit cost, high total expenditures, and other factors.

Implementing the findings from comparative-effectiveness analysis may not save money for the Medicare program. Wider use of cost-effective, underutilized services could result in increased Medicare spending, which might not be offset with savings elsewhere. On the other hand, over the long run, comparative-effectiveness research could save the Medicare program money if it encourages manufacturers to develop services that are more cost-effective than current ones or if it helps inform providers and influences their patterns of care.

### **Pay-for-performance programs**

Medicare has a responsibility to ensure that its beneficiaries have access to high-quality care. Yet beneficiaries receive care from a system known to have problems with quality. Beth McGlynn and fellow researchers have noted that care is improving in many settings, but significant gaps remain between what is known to be good care and the care delivered. For example, Cathy Schoen, Karen Davis, and coauthors reported in 2006 that only about half the adults in the United States receive all recommended clinical screening tests and preventive services, and many quality indicators vary widely across states.

Measures of quality and guidelines for appropriate care are increasingly available. The Medicare program has been a leading force in efforts to develop and use quality measures, often leading initiatives to publicly disclose quality information, standardize



tools for data collection, and give feedback to providers for improvement. CMS has also revised its regulatory standards to require that providers, such as hospitals and home health agencies, have quality improvement systems in place. CMS is conducting a number of demonstrations to explore whether financial incentives can improve the quality of care providers furnish. CMS's focus on quality provides a strong foundation for future initiatives.

While these tools can begin to improve quality, financial disincentives to improve quality allow the quality gap to persist. Medicare pays all health care providers without differentiating on the basis of quality. Those providers who improve quality are not rewarded for their efforts. In fact, Medicare often pays more when poor care results in complications that require additional treatment. The same negative or neutral incentives toward quality exist in the private sector. Many private purchasers and plans are experimenting with mechanisms to counterbalance these forces and reward those who provide high-quality care. Yet, they agree that Medicare's participation in these efforts is critical because of its market power and because private sector efforts alone may take a much longer time to show effects.

In a series of reports, we have recommended that Medicare change the incentives of the system by basing a portion of provider payment on performance. In our June 2003 report to the Congress, we established criteria for measures to compare providers to determine whether pay for performance is feasible in settings where Medicare beneficiaries receive care. The Commission also developed design principles to provide guidance on how to administer and fund a pay-for-performance program, which should:

- Reward providers based on improving care and exceeding certain benchmarks,
- Be funded by initially setting aside a small proportion of payments,
- Distribute all payments that are set aside to providers who achieve the quality criteria, and
- Establish a process through which measures can continue to evolve.

In our March 2004 report to the Congress, we found that MA plans and the facilities and physicians that care for dialysis patients were settings where pay-for-performance strategies could be implemented. In our March 2005 report to the Congress, we evaluated the available measures and measurement activities for physicians by our criteria and found useful structural, process, and patient experience indicators. Outcomes measures could be used with additional data and research. Therefore, we recommended that the Congress establish a quality incentive payment policy for physicians in Medicare. We also recommended pay-for-performance strategies for hospitals and home health agencies. While such efforts are important in increasing the quality of care provided to Medicare beneficiaries, it is important to note that MedPAC does not consider adjusting payments to reflect quality of care to be the end goal of pay-for-performance systems. Rather, we believe that once the link between payments and quality is well established, Medicare should then use the “payment” aspect of pay for performance to further drive increased efficiency—reflected by the combination of quality and cost—in delivering health care service.

### **Measuring provider resource use**

In addition to implementing incentives via payment systems through pay-for-performance type mechanisms, Medicare could use other means of getting providers to think more consciously about the services they provide and thus enlist them as more active partners in the effort to ensure efficient care. One way to do this, as MedPAC has recommended previously, would be for the program to consolidate data on provision of services at the level of individual providers. Medicare could identify physicians and other providers with very high resource use relative to their peers. CMS could initially provide confidential feedback to these providers on an informational basis only. Once greater experience and confidence in resource-use measurement tools were gained, policymakers could use the results for additional interventions such as public reporting, targeting fraud and abuse, pay for performance, or differential updates based on relative performance.

Measuring provider resource use relative to a peer group, and providing such information to the providers, would promote individual accountability and would enable providers to more readily see a link between their actions and Medicare spending overall. However, a number of technical issues would need to be resolved. Providers will need to be confident that their scores reflect the relative complexity of their patient mix and that they are being compared with an appropriate set of peers. There would likely be considerable controversy around initial scores as some providers realized that their practice patterns were not in line with those of their peers.

MedPAC has made considerable progress in simulating how such a system might work in practice. In Table 2, we provide an example of comparing the resource use of an actual physician with the averages for his specialty within the market area. We demonstrate how the comparison can be broken down by type of case—both the stage of disease and the presence of comorbidities in patients. We then break down the comparison by the types of services that went into the selected episodes. The result is a comparison that can provide useful feedback to physicians about why their performance differs from that of their peers.

We use an individual cardiologist in Boston to compare a physician's clinical resource use with an overall expected value (an average across all specialties for the Boston metropolitan statistical area (MSA)) and with a specialty-specific expected value. We compare his actual clinical resource measurement with expected clinical resource measurement (based on the averages for all cardiologists treating hypertension in the Boston MSA) and calculate corresponding ratios. Ratios greater than 1.0 indicate higher than average values for clinical resource measurement (observed greater than expected) and ratios less than 1.0 indicate lower than average values for clinical resource measurement (observed lower than expected). When we use an expected clinical resource measurement value for cardiologists in Boston, his overall observed-to-expected ratio is 1.74, or not quite twice the average clinical resource measurement value.

**Table 2: Selected Boston cardiologist has higher clinical resource measurement for hypertension than his peers**

	All episodes	Overall patient complexity level (low to high)				
		1	2	3	4	5
<i>Stage 1 hypertension</i>						
Number of episodes	141	41	45	35	13	7
Clinical resource use	\$623	\$453	\$660	\$814	\$630	\$410
Selected Boston cardiologist						
Average for all Boston cardiologists	\$357	\$251	\$307	\$369	\$409	\$450
<i>Selected cardiologist's resource use score</i>	<i>1.74</i>	<i>1.80</i>	<i>2.15</i>	<i>2.21</i>	<i>1.54</i>	<i>0.91</i>

Note: Stage indicates progression of the disease, with 1 being the mildest form. Overall complexity level indicates the presence of other diseases. Resource use score is the ratio of the cardiologist's resource use to the average for cardiologists in Boston.

Source: MedPAC analysis of 100 percent sample of 2001–2003 Medicare claims using the Medstat Episode Group grouper from Thomson Medstat.

MedPAC believes there is tremendous potential in making these comparisons of resource use and has recommended that Medicare collect and consolidate information on provider resource use and provide feedback on resource use to individual providers. Physicians would then be able to assess their practice styles, evaluate whether they tend to use more resources than their peers (or what available evidence-based research recommends), and revise their practice styles as appropriate. Once greater confidence with the measurement tool was gained, Medicare could use the results for payments—for example, as a component of a pay-for-performance program that rewards both quality and efficiency. CMS could also use the measurement tool to flag unusual patterns of care that might indicate misuse, fraud, and abuse.

### **Care coordination**

In recent years, the Commission has explored multiple strategies to provide incentives for high-quality, low-cost care and thus improve efficiency in the Medicare program.

However, even if individual providers are efficient, a beneficiary may still receive less-than-optimal care if providers do not communicate well with each other or if they do not

monitor patient progress over time. To address this problem, we have considered ways to introduce care coordination and care management by creating incentives for providers to share clinical information with other providers, monitor patient status between visits, and fully communicate with patients about self-care.

The patients most in need of care coordination are those with multiple chronic conditions and other complex needs. Beneficiaries with chronic conditions represent a significant proportion of Medicare spending. In 2005, the Congressional Budget Office estimated that beneficiaries with more than one chronic condition made up 48 percent of the highest cost beneficiaries in 2001 but only 12 percent of the lowest cost beneficiary population. Yet, evidence continues to mount that beneficiaries with chronic conditions do not receive recommended care and may have hospitalizations that could have been avoided with better primary care. Researchers attribute this problem to poor monitoring of treatment—especially between visits—for beneficiaries and to a general lack of communication among providers. Coordinated care may improve patients’ understanding of their conditions and compliance with medical advice and, in turn, reduce the use of high-cost settings such as emergency rooms and inpatient care. Ideally, care coordination will improve communication among providers, eliminating redundancy and improving quality.

Care coordination is difficult to accomplish in the FFS program because it requires managing patients across settings and over time, neither of which is supported by current payment methods or organizational structures. Further, because patients have the freedom to go to any willing physician or other provider, it is difficult to identify the practitioner most responsible for the patient’s care, especially if the patient chooses to see multiple providers. The challenge is to find ways to create incentives in the FFS system to better coordinate care.

In our June 2006 report to the Congress, we outlined two illustrative care coordination models for complex patients in the FFS program: (1) Medicare could contract with providers in large or small groups that are capable of integrating the information technology and care manager infrastructure into patient clinical care, and (2) CMS could

also contract with stand-alone care management organizations that would work with individual physicians. In either model, payment for services to coordinate care would be contingent on negotiated levels of performance in cost savings and quality improvements. Given that Medicare faces long-term sustainability problems and needs to learn more about the most cost-effective interventions, the entities furnishing the care managers and information systems should initially be required to produce some savings as a condition of payment. Demonstrating continued savings may not be necessary or feasible once strategies for coordinating care are broadly used.

MedPAC has illustrated one of the ways in which lack of care coordination is manifested by low-quality, high-cost care in its recent discussion of hospital readmissions from a post-acute care setting. Under the inpatient hospital PPS, hospitals have a strong incentive to reduce their costs, which can be achieved in part by reducing patient length of stay. They have little, if any, financial incentive to invest in managing post-hospital discharge transitions. In some cases, hospitals may discharge patients prematurely, resulting in a readmission to the hospital in the event that the patient's condition deteriorates at home or in a post-acute care setting as a result of the premature discharge. Readmissions may also occur as a result of discharges hobbled by incomplete coordination with a post-acute care provider. In such events, not only does the beneficiary receive lower quality (and potentially even life-threatening) care, but additional costs are added to Medicare. The Commission is exploring a two-step means of reducing readmission rates, first by publicly reporting hospital-specific readmission rates for a subset of conditions, followed by an adjustment to the underlying payment method to penalize hospitals with higher readmission rates.

## **Conclusion**

In addition to taking efficiency into account when calculating payment rates or assessing the amount of annual provider payment updates, Medicare should institute policies that improve the value of the program to beneficiaries and taxpayers. Those policies should reward providers and health plans for efficient use of resources and create incentives to

increase quality and coordinate care. Policies such as pay for performance that link payment to the quality of care physicians and other providers furnish should be implemented. At the same time, Medicare should encourage coordination of care and provision of primary care, bundle and package services where appropriate to reduce overuse, and ensure that its prices are accurate. To reduce unwarranted variation in volume and expenditures, Medicare should collect and distribute information about how providers' practice styles and use of resources compare with those of their peers. Ultimately, this information could be used to adjust payments to physicians. Findings from comparative-effectiveness research should be used to inform payment policy and furnished to beneficiaries and providers to inform decisions about medical care. Finally, concerted efforts should be made to identify and prevent misuse, fraud, and abuse by strengthening provider standards, ensuring that services are furnished by qualified providers to eligible recipients, and verifying that services are appropriate and billed accurately and that payments for those services are correct.

Because there are numerous payers in the U.S. health care system, achieving gains in efficiency is difficult for any one payer. To engender broader changes among providers, Medicare will likely need to collaborate with other payers but can take a leading role in driving change. But if we want Medicare to function more efficiently, the Congress needs to provide CMS with the necessary time, financial resources, and administrative flexibility. CMS will need to invest in information systems; develop, update, and improve measures of quality and resource use; and contract for specialized services. In the long run, failure to invest in CMS will result in higher program costs and lower quality of care.