
Executive summary

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Fundamental changes are needed in health care delivery in the United States and in Medicare. Although on average life expectancy is increasing and certain measures of health care outcomes are improving, there is still much room for improvement. Recent studies show that the U.S. health care system is not buying enough of the recommended care, is buying too much unnecessary care, and is paying prices that are very high, resulting in a system that costs significantly more per capita than in any other country. As a major payer, the Medicare program shares in these problems.

Medicare fills a critical role in our society—ensuring that the elderly and disabled have good access to medically necessary care. Along with that role comes a responsibility to make sure the resources entrusted to the program by taxpayers and beneficiaries are used wisely. Without change, the Medicare program is fiscally unsustainable over the long term. Moderating projected spending trends requires fundamental reforms in payment and delivery systems to improve quality, coordinate care, and reduce cost growth.

In this report, we investigate what direction these reforms should take, recognizing the limitations of current Medicare fee-for-service (FFS) payment systems and the need for greater accountability and care coordination. We consider a wide range of issues, including hospital–physician relationships and financial disclosure, and make the following recommendations: First, we recommend a new payment design around hospitalization episodes that holds providers accountable for care delivered over time and provides them an incentive to work together. It incorporates:

- reporting to hospitals and physicians about resource use around hospitalization episodes;
- reduced payments to hospitals with relatively high readmission rates for select conditions, coupled with gainsharing between hospitals and physicians; and
- a pilot program of bundled payments.

We also recommend promoting the use of primary care by establishing a payment adjustment within the physician fee schedule and initiating a medical home pilot project, which will increase care coordination for beneficiaries with multiple chronic conditions. Finally, we recommend

revising the prospective payment system (PPS) for skilled nursing facilities (SNFs) and requiring SNFs to provide better diagnosis, service use, and cost information to improve the accuracy of the SNF PPS. Our intent is to continue to improve the accuracy of current FFS payment systems such as the SNF PPS and hospice payment system, while creating new payment designs that will help coordinate care and overcome some of the limitations of current FFS payment systems—moving Medicare in the direction of payment and delivery system reform.

Direction for delivery system reform

In Chapter 1, we examine what long-term direction reforms should take. Medicare reforms should increase value, which means maintaining or increasing access to care, quality, and equity while controlling resource use. To increase value, reforms need to promote accountability and care coordination, create better information and tools to use it, change incentives to encourage efficiency and higher quality rather than increases in volume, and set accurate payment rates. Reforms should also protect beneficiaries from the catastrophic costs of needed care and promote alignment with the private sector and other government payers.

In previous reports, the Commission has recommended that Medicare adopt tools for increasing efficiency and improving quality within the current Medicare payment systems, including: encouraging the use of comparative-effectiveness information, linking payment to quality (pay for performance (P4P)), measuring resource use and providing feedback, and improving payment accuracy within Medicare payment systems. However, in the current Medicare FFS payment system environment, the benefit of these tools is limited for two reasons. First, they may not be able to overcome the strong incentives inherent in any FFS system to increase volume. Second, paying for each individual service and staying within current payment systems (e.g., the physician fee schedule or the inpatient PPS) inhibit changes in the delivery system that might result in better coordination across services and lead to efficiencies or better quality across these systems.

To increase value for beneficiaries and taxpayers, the Medicare program must overcome the limitations of its current payment systems. A reformed Medicare payment system would pay for care that spans across provider

types and time (encompassing multiple patient visits and procedures) and would hold providers accountable for the quality of that care and the resources used to provide it. This direction would create payment system incentives for providers that reward value and encourage closer provider integration, which in turn would maximize the potential of tools such as P4P and resource measurement to improve quality and efficiency.

Promoting the use of primary care

Patient access to high-quality primary care is essential for a well-functioning health care delivery system. Research suggests that improving access to primary care and reducing reliance on specialty care may improve the efficiency and quality of health care delivery. Despite these findings, primary care services—which rely heavily on cognitive activities such as patient evaluation and management (E&M)—are being undervalued and risk being underprovided relative to procedurally based services. Consequently, physicians may view primary care services as less valued and less profitable and hence careers in primary care as less desirable. In fact, the share of U.S. medical school graduates entering primary care residency programs has declined in the last decade, and internal medicine residents are increasingly choosing to subspecialize rather than practice as generalists. Additionally, the Commission found that among beneficiaries looking for a new physician in 2007, those looking for a new primary care physician (a small number of beneficiaries) were more likely to report difficulty finding one than those looking for a new specialist.

To improve payment for and access to primary care services, the Commission has explored incentives for encouraging desired services, activities, and the choice of primary care as a career. In our March 2006 report to the Congress, the Commission recommended improvements to the process for reviewing the relative value of physician services. These recommendations sought to address concerns that cognitive services—mainly E&M services—were being devalued over time, regardless of which type of practitioner was furnishing them. Although the formal process for reviewing the service values has not changed, CMS substantially increased the work component of certain E&M codes in 2007, following the recommendations of the Relative Value Scale Update Committee (RUC), and increased the practice expense component of E&M codes as well.

In Chapter 2, we recommend two new initiatives for promoting primary care. The first initiative increases fee schedule payments for primary care services furnished by clinicians focused on delivering primary care. This budget-neutral adjustment would redistribute Medicare payments toward those primary care services provided by practitioners—physicians, advanced practice nurses, and physician assistants—whose practices focus on primary care. A fee schedule adjustment for primary care would help overcome the undervaluation of primary care services. This adjustment, together with CMS’s increase in the work and practice expense components for E&M services, would add up to a significant change promoting primary care. Nonetheless, other factors (e.g., on-call schedules) would still affect physicians’ career choices.

The second initiative to promote primary care is to establish a medical home pilot program in Medicare. A medical home is a clinical setting that serves as a central resource for a patient’s ongoing care. Qualifying medical homes could include primary care practices as well as specialty practices that focus on care for certain chronic conditions, such as endocrinology for people with diabetes. A medical home pilot would create incentives for eligible medical practices to conduct care management and care coordination. This medical home pilot would include monthly, per beneficiary payments to qualifying medical practices for infrastructure and activities that promote ongoing comprehensive care management. To be eligible for these monthly payments, medical homes would be required to meet stringent criteria, including:

- furnish primary care (including coordinating appropriate preventive, maintenance, and acute health services);
- conduct care management;
- use health information technology (IT) for active clinical decision support;
- have a formal quality improvement program;
- maintain 24-hour patient communication and rapid access;
- keep up-to-date records of beneficiaries’ advance directives; and
- maintain a written understanding with each beneficiary designating the provider as a medical home.

In rural areas, the pilot could test the ability for medical homes to provide high-quality, efficient care with fewer structural requirements, particularly with respect to health IT.

Beneficiaries with multiple chronic conditions would be eligible to participate because they are most in need of improved care coordination. Beneficiaries would not incur any additional cost sharing for the medical home fees. Medical home practitioners would discuss with beneficiaries the importance of seeking guidance on selecting appropriate specialty services, although participating beneficiaries would retain their ability to see specialists and other practitioners of their choice. Medicare should also provide medical homes with timely data on patients' Medicare-covered utilization outside the medical home, including services under Part A and Part B and drugs under Part D.

The medical home pilot should be on a large enough scale to provide statistically reliable results to test the hypothesis that qualifying medical homes can improve the quality and efficiency of patient care, particularly for those with multiple chronic conditions. A pilot of this scale can also accelerate the speed with which innovations are tested and implemented and provides an excellent opportunity to implement and test physician P4P. However, increasing the scale of the pilot also increases its costs and the difficulty of discontinuing it—should that be indicated. Therefore, there must be clear and explicit results-based thresholds for determining whether the pilot should be expanded into the full Medicare program or discontinued entirely.

Examining hospital-physician collaborative relationships

Medicare's FFS payment systems create economic incentives for providers to increase the volume of medical services they perform. By paying piecemeal for each service, a FFS payment system will increase providers' revenues as long as they increase the number of services delivered. Providers' clinical decision-making authority and a FFS payment system combine to create powerful financial incentives for providers to increase volume. Hospitals and physicians, as well as other providers, have rationally responded to these incentives by implementing various financial and organizational arrangements that enable, encourage, or reward volume growth.

In Chapter 3, we explore a range of financial arrangements between hospitals and physicians and how they contribute to volume growth. By exploring the specific strategies that

hospitals and physicians are using to organize the delivery system, and how the drive to increase service volume becomes ingrained in the delivery system's structures, we underscore the need to reform current Medicare payment policies that contribute to this dynamic.

A path to bundled payment around a hospitalization

Medicare's FFS payment systems fail to encourage providers to cooperate with one another to improve coordination of beneficiaries' care and appropriately control the volume and cost of services delivered across an episode of care. In Chapter 4, we recommend changes in FFS payment for care provided around a hospitalization to start to address these failures. Bundling Medicare payment to cover all services associated with an episode of care can improve incentives for providers to deliver the right mix of services at the right time.

While bundling payment holds great potential, the Commission recognizes the complexity associated with it. Accordingly, the Commission recommends an incremental approach, composed of three separate, but related, policies.

- First, it recommends that the Secretary confidentially report to hospitals and physicians information about readmission rates and resource use around hospitalization episodes (e.g., 30 days postdischarge). This information would allow a given hospital and the physicians who practice in it to compare their risk-adjusted performance relative to other hospitals and physicians. Once equipped with this information, providers may consider ways to adjust their practice styles and coordinate care to reduce service use. After two years of confidential disclosure to providers, this information should be publicly available.
- Second, the Commission recommends changing payment to hold providers financially accountable for service use around a hospitalization episode. Specifically, it would reduce payment to hospitals with relatively high readmission rates for select conditions. The Commission recommends that this payment change be made in tandem with a previously recommended change in law to allow hospitals and physicians to share in the savings that result from reengineering inefficient care processes during the episode of care. Recognizing that readmissions account for only part of the variation in practice patterns around an admission, the Commission also recommends that the Secretary explore other

broader payment changes to encourage efficiency around hospitalization episodes and report back to the Congress within two years.

- Third, the Commission recommends that CMS conduct a voluntary pilot program to test bundled payment for all services around a hospitalization for select conditions. This pilot program would be concurrent with information dissemination and a change in payment for high rates of readmissions. Bundled payment raises a wide set of implementation issues. It requires not only that Medicare create a new payment rate for a bundle of services but also that providers decide how they will share the payment and what behavior they will reward. A pilot allows CMS to resolve the attendant design and implementation issues, while giving providers who are ready the chance to start receiving a bundled payment.

Producing comparative-effectiveness information

Comparative-effectiveness analysis evaluates the relative value of drugs, devices, diagnostic and surgical procedures, diagnostic tests, and medical services. By value, we mean the clinical effectiveness of a service compared with its alternatives. Comparative-effectiveness information has the potential to promote care of higher value and quality in the public and private sectors.

In our June 2007 report, the Commission recommended that the Congress establish an independent entity to produce and provide information about the comparative effectiveness of health care services. The entity's primary mission would be to sponsor, compile, and disseminate studies that compare the clinical effectiveness of a service with its alternatives.

In Chapter 5, we explore a number of issues that must be addressed in creating such an entity. The Commission supports a dedicated, broad-based financing mechanism to help ensure the entity's stability and independence. The funding should be from federal and private sources because the research findings will benefit all users—patients, providers, private health plans, and federal health programs. To ensure that the research is objective, an independent board of experts should oversee the entity's efforts. In designing a board, key issues will include the board's composition and size, the appointment process, the duration of terms, and rules governing conflicts of interest. Finally, we explore several options for the entity's structure and location: a federally funded research and

development center, an independent federal agency within the executive branch, an independent federal agency within the legislative branch, and a congressionally chartered nonprofit organization.

Public reporting of physicians' financial relationships

Physicians influence both the volume and type of health care services Medicare beneficiaries receive. They recommend when patients should receive a specific drug or medical device or use a specific facility. Physicians are also involved in developing clinical protocols and researching new drugs and devices. Medicare depends on physicians, in carrying out these responsibilities, to act in the best interest of patients. However, physicians may have financial relationships with drug and device manufacturers and facilities that could compromise their independence and objectivity.

Financial relationships between physicians and pharmaceutical and device manufacturers are pervasive. A physician survey conducted in 2003 and 2004 found that more than three-quarters of physicians received meals or drug samples from drug manufacturers in the last year and more than one-quarter were paid for consulting, giving lectures, or enrolling patients in clinical trials. Manufacturers of medical devices, such as artificial joints and spinal implants, frequently pay physicians consulting fees and royalties to develop new products, and subsidize their trips to attend conferences.

In addition, the number of physician-owned specialty hospitals more than doubled from 2002 to 2006 and the number of Medicare-certified ambulatory surgical centers (ASCs)—most of which have at least some physician ownership—grew by 31 percent over the same period. There has also been an increase in joint venture facilities owned by physicians and hospitals.

Payers, plans, patients, and the general public are often not aware of these potential conflicts of interest. If information about financial relationships between physicians and manufacturers, hospitals, and ASCs were publicly available, it would shed light on these interactions and could be used to examine the influence of these relationships on referral patterns and the overall volume of services.

In Chapter 6, we explore options for collecting data on physicians' financial relationships with manufacturers, hospitals, and ASCs. We describe three key design

questions for a potential federal law requiring drug and device companies to report their financial ties with physicians: How comprehensive should the reporting system be? What size and types of payments should be reported? How can the data be made readily accessible to the public? Next, we examine possible reporting requirements for hospitals and ASCs. Under the approaches we describe, the responsibility for public reporting would rest with pharmaceutical and device manufacturers, hospitals, and ASCs rather than physicians. Even if a reporting system were implemented, individual physicians, manufacturers, and facilities would continue to be responsible for ensuring that their financial relationships are ethical and further the best interests of patients.

A revised prospective payment system for SNFs

There are two key problems with Medicare's PPS for SNF services. First, it does not adequately adjust payments to reflect the variation in facility costs for nontherapy ancillary (NTA) services (e.g., intravenous (IV) medications, respiratory therapy, and drugs). Second, payments vary with the amount of therapy furnished, creating an incentive to furnish therapy services for financial rather than clinical reasons. In addition, the PPS does not include an outlier policy to defray the exceptionally high costs of some patients, which could make some providers reluctant to admit certain types of patients.

In Chapter 7, the Commission recommends implementing a revised PPS design that incorporates a separate NTA payment component, a revised therapy payment component, and an outlier policy based on exceptionally high ancillary costs per stay. Compared with the existing PPS, such a revised design would better target payments to stays with high NTA costs, more accurately calibrate therapy payments to therapy costs, and afford some financial protection to SNFs that treat stays with exceptionally high ancillary costs. Because the revised PPS would establish more accurate payments, SNFs would be less likely to avoid patients whom hospital discharge planners report having difficulty placing—those who require IV antibiotics, expensive medications, and ventilator care. For these beneficiaries, access would be improved.

The Commission also recommends directing CMS to require facilities to provide information on patient

diagnoses, service use during the SNF stay, and nursing costs. CMS could implement the revised PPS without these data, but better data would simplify implementation, further improve payment accuracy, and enable the value of care to be assessed by linking payments, costs, service use, and patient outcomes.

One drawback common to all prospectively set payments is that facilities may be encouraged to furnish fewer services inside an episode of care—in this case, less therapy than is clinically appropriate during a SNF stay. Under a revised PPS, CMS would need to monitor therapy provision and patient outcomes, underscoring the need to require SNFs to assess patients at discharge. A P4P program that links SNF payments to patient outcomes, as recommended by the Commission, would help counter incentives to stint on services, as poor beneficiary outcomes would result in lower payments.

Evaluating Medicare's hospice benefit

Hospice care has changed significantly in the 25 years since Medicare implemented the hospice benefit, with the most significant changes occurring in the last seven years. The hospice benefit provides palliative care and support services for terminally ill patients as an alternative to conventional care at the end of life. Now, nearly 40 percent of Medicare decedents had elected hospice, and the profile of the beneficiary population electing hospice is very different from when it originated in 1983. The profile of hospice providers has also changed. In 1983, most hospice providers were nonprofits, affiliated with religious or community organizations; now, for-profit hospices make up a majority of providers, with for-profit hospices constituting most of the new entrants into the Medicare benefit since 2000. CMS's Office of the Actuary estimates that Medicare spending under the hospice benefit exceeded \$10 billion in fiscal year 2007 and projects that Medicare spending for hospice will more than double again in the next 10 years.

In Chapter 8, we explore what has driven the growth in Medicare spending for hospice and what that implies about the hospice payment system. Spending increases have been driven by increased numbers of beneficiaries using the hospice benefit and increases in average length of stay in hospice. Part of this increase in length of stay reflects a change in the mix of patients electing hospice, from those with cancer and other relatively acute diagnoses to patients with diagnoses such as Alzheimer's disease, nonspecific debility, and congestive heart failure, which typically have long stays in hospice. However,

hospices with longer lengths of stay are more profitable, and for-profit hospices have a length of stay about 45 percent longer than nonprofit hospices. Certain hospices have an average length of stay greater than other hospices across all diagnoses—in particular, those exceeding the “hospice cap,” almost 90 percent of which are for profit. The hospice cap is an aggregate per beneficiary limit on Medicare payments to hospices implemented at the beginning of the benefit to ensure that hospice care would be an alternative to intense, costly, and intrusive end-of-life care and not become a de facto long-term care benefit.

Overall, Medicare payments to hospices appear adequate, but this assessment masks considerable variation. In 2005, nonprofit and provider-based hospices had small negative margins, while for-profit and freestanding hospices had large positive margins. Hospices that exceeded the cap had the highest Medicare margins in 2005 (before the return of overpayments—if overpayments were returned their margins would become slightly negative), as longer stays under this payment system led to larger profits. These findings suggest the presence of financial incentives in Medicare’s hospice payment system to provide long stays. Such incentives run counter to the intent of Medicare’s hospice benefit—to provide an alternative that is less intrusive and costly than conventional treatment.

During this period of major change, Medicare’s payment system for hospice care has changed relatively little. Payments have been updated over time, but otherwise the basic structure is much as it was in 1983, with per diem reimbursements for four types of care and few reporting requirements to assist in refinement or evaluation of the benefit. Substantially more data will be needed—data that have historically been uniquely lacking in hospice—to address these concerns about how the hospice benefit is being used and to modernize Medicare’s payment system for hospice.

Review of CMS’s preliminary estimate of the physician update for 2009

Appendix A fulfills the Commission’s requirement to review CMS’s estimate of the 2009 update for physician services. CMS’s preliminary estimate of the 2009 payment update for physician services is –5.4 percent. A negative update in 2009 would be in addition to a 10.6 decrease to occur on July 1, 2008, at the end of a temporary, six-month bonus that was included in the Medicare, Medicaid, and SCHIP Extension Act of 2007. The sustainable growth rate (SGR) formula has called for negative updates since 2002 because of continued growth in expenditures on physician services and increased spending associated with legislative overrides to avert payment cuts for physician services.

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 application of the statutory limit the SGR formula imposes. That limit is –7.0 percent, which, combined with expected inflation in input prices of 1.7 percent, yields the preliminary update estimate of –5.4 percent. The inflation estimate may change between now and January 1 when the update takes effect. ■