Reforming Medicare

Adapting a Successful Program to Meet New Challenges

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REFORMING MEDICARE: ADAPTING A SUCCESSFUL PROGRAM TO MEET NEW CHALLENGES

A Position Paper of The American College of Physicians

by

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EXECUTIVE SUMMARY

In June of 1996, the reports issued by the Board of Trustees for the Medicare and Social Security trust funds described the dire financial condition of the Medicare program. The reports said that the Hospital Insurance trust fund would become insolvent by 2001, and that program expenditures for the Medicare Supplementary Medical Insurance program were growing more rapidly than the economy as a whole.

Although the Medicare program has achieved many successes over the past 30 years, its financial condition leaves no doubt that it requires restructuring. Many observers have noted that the Medicare program is out-of-date with health care delivery system changes. This reduces health plan options for beneficiaries and hurts access to potentially beneficial care. Others have charged that the program's management tools are ineffective and have led to high costs and quality problems. For all these reasons, the next Congress and Administration, regardless of party affiliation or ideology, are expected to explore ways to reform Medicare.

In this context, the American College of Physicians presents its recommendations for Medicare reform and restructuring. The recommendations are based on the belief that Medicare must keep its commitment to program beneficiaries while maintaining its financial viability. There are no “quick fixes” to remedy Medicare’s financial problems. Although policy makers and politicians may propose cutting reimbursements to physicians and other providers, or increasing program beneficiaries’ cost sharing obligations, these proposals could have serious and lasting effects on the program. They do not address fundamental problems.

As the nation’s largest medical specialty society, representing more than 89,000 physicians who practice internal medicine, the ACP’s recommendations provide the internist’s perspective on Medicare’s ills and how to cure them. Internists are in a unique position to judge the quality and appropriateness of care provided to Medicare beneficiaries. Internal medicine is the only medical specialty that requires its residents to undergo training in geriatrics. Physicians who practice internal medicine and many of its subspecialties have Medicare participation rates ranging from 80-90%. Moreover, general internists receive 38% of their revenue from Medicare, the highest among all primary care specialties.
The College’s recommendations focus on providing care to older patients -- describing the
delivery systems that are most effective and the program changes needed to provide beneficiaries
access to them. In addition, the recommendations address structural and management reforms
that will enable Medicare to be more cost effective. They are grouped in four sections: caring for
patients; improving the fee-for-service program; ensuring appropriate use of services and
technology; and improving the Medicare managed care program.

In the first section, the paper notes that Medicare beneficiaries, particularly those with chronic
illnesses, will be well served by systems of coordinated care. Several models of coordinated care
are described that could function in either capitated or fee-for-service arrangements. Some of
these approaches should be developed and implemented as demonstration projects, while others
have already proven to be successful and should be replicated throughout the country. The
ACP’s recommendations are:

- HCFA should contract directly with physicians who demonstrate the ability and willingness to
  provide a coordinated and comprehensive set of benefits for chronically ill Medicare
  beneficiaries.

- HCFA should develop demonstration programs that use case management to coordinate
  services for patients with complex conditions. Providing capitated payments for primary care
  services to physicians leading an interdisciplinary team is a worthwhile approach.

- The “bundled payment” demonstration program for heart bypass surgery -- which creates a
  risk-sharing arrangement among providers by combining fee-for-service payments for specific
  services -- should be expanded, either by HCFA or through the enactment of legislation.

- HCFA should develop demonstration projects to test the use of capitated financing schemes to
  pay for home health care.

- Medicare should establish delivery systems that provide coordinated and comprehensive care
  for beneficiaries in fee-for-service suffering from chronic illnesses.

- HCFA should reimburse case management services under its fee schedule, and develop
  demonstration programs to test various case management models in fee-for-service settings.

- Medicare should provide for hospice-type services, including palliative care, pain relief, family
  counseling, and other psychosocial services, for terminally ill beneficiaries outside of a
  hospice.

- Medicare should provide for preventive care, including appropriate screening services, for
  beneficiaries.

Although enrollment in managed care plans by Medicare beneficiaries is increasing, the vast
majority of beneficiaries are enrolled in the fee-for-service program. Consequently, the College
advocates several changes that will help make the program more cost effective, while ensuring that enrollees receive high quality care. Many of these proposals have been successfully implemented by private sector indemnity plans. In addition, HCFA is encouraged to evaluate the impact of modifying the fee-for-service program’s product design to increase efficiency and decrease costs. The ACP recommends that:

- HCFA should consider competitive bidding, negotiation, and other methods to purchase supplies and scrutinize payments. Legislation should be enacted to provide HCFA with the management authority to implement these cost saving techniques.

- Medicare should adopt the successful management techniques used by private sector indemnity plans to improve care and reduce costs. HCFA could begin this process by soliciting proposals from its carriers and fiscal intermediaries.

- HCFA should evaluate the impact of changing the Medicare fee-for-service program’s benefits package and cost sharing requirements.

In its third section, the paper notes the cost and quality implications that stem from variations in the payment for and use of services in the Medicare program, as well as the inappropriate use and supply of technology. Increased health services research and educational efforts to inform both doctors and patients of the effectiveness of treatment options are recommended. Moreover, HCFA is urged to change its coverage criteria and policies to place more emphasis on the cost effectiveness of technology. Specifically:

- The College recommends increased funding for outcomes research, the development of clinical practice guidelines, and the creation of Quality Improvement Foundations to help identify successful clinical practices and disseminate information to physicians and their patients.

- Medicare should use cost effectiveness as an explicit criteria in its decisions regarding coverage for a new technology.

- Medicare should increase its usage of conditional or interim coverage rulings.

- Medicare should adopt more flexible pricing policies that cover the cost of the efficient use of technologies and provide incentives for the efficient use of resources.

Finally, recommendations are offered to improve Medicare’s managed care program. These recommendations emphasize approaches to ensure that beneficiaries receive high quality care. The paper also proposes changes to the payment rate methodology for Medicare HMOs to help ensure that savings are achieved and that health plans receive fair compensation and have no incentives to avoid the chronically ill. The ACP recommends that:

- Federal quality standards should be developed to ensure that Medicare beneficiaries receive high quality care in managed care environments. These standards should guarantee that health
plans adopt policies and procedures specifically designed for the elderly, and require health plans to disclose all relevant information to beneficiaries regarding access to care, cost sharing requirements and other issues.

- Enrollees should have access to performance measures that rate the quality of care provided by the plan on issues specific to Medicare beneficiaries, such as functional status or treatment of chronic conditions.

- "Gag rules" or other actions designed to improperly intrude on the doctor-patient relationship should be prohibited.

- Legislation should be enacted that authorizes HCFA to contract directly with provider-sponsored organizations (PSOs) to provide Medicare beneficiaries with the Medicare benefits package for a capitated payment.

- HCFA should evaluate different approaches to fix the payment methodology. Competitive bidding, adding new risk stratefiers, and establishing multi-county rates and payment thresholds all have the potential to improve the current system. In addition, payments for graduate medical education should be recaptured.

In sum, the ACP’s recommendations address issues of program management and structure, as well as necessary delivery system changes. These program improvements are an alternative to arbitrary funding cuts driven by budget needs rather than sound health policy. Although they will not solve all of Medicare’s problems, by adopting these reforms, policy makers will help ensure that the program provides beneficiaries with high quality and cost effective care, is financially viable, and is adaptable to the modern health care delivery system.
In June of 1996, the reports issued by the Board of Trustees for the Medicare and Social Security trust funds spelled out the dire financial condition of the Medicare program. The reports said that the Hospital Insurance trust fund would become insolvent by 2001, and that program expenditures for the Medicare Supplementary Medical Insurance program were growing more rapidly than the economy as a whole.

Because of the program's impact on the federal budget (Moon, Davis), and the political firestorm caused by the Board of Trustees' reports, the next Congress and Administration, regardless of party affiliation or ideology, will be forced to explore ways to reform the Medicare program (Wines, The New York Times).

It is, of course, possible that policy makers will try to use a "quick fix" to remedy Medicare's financial problems, such as cutting reimbursements to physicians and other providers, or increasing program beneficiaries' cost sharing obligations. The Medicare legislation in the last Congress contained both of these provisions (HR 2492).

While these proposals seem simple, they have serious ramifications. Medicare already reimburses physicians less than private insurance does (Medicine and Health), and further cuts will be difficult to absorb. In addition, many hospitals, particularly teaching hospitals, may not be able to sustain further cutbacks. Moreover, with such a large percentage of Medicare beneficiaries at low-income levels (Vladeck), asking them to pay more out of their own pockets seems unwise.

Therefore, as policy makers consider reform proposals, the College urges them to first examine ideas that will re-structure key elements of the Medicare program -- in both managed care and fee-for-service. These program improvements are an alternative to arbitrary funding cuts driven by budget needs.

In addition, many observers have noted that the Medicare program is out-of-date with health care delivery system changes (Medicine & Health). This has reduced health plan options for Medicare beneficiaries and hurt access to potentially beneficial care. Others have charged that the program's management tools are ineffective and have led to high costs and quality problems (Etheredge).
Internists are in a unique position to judge the quality and appropriateness of care provided to Medicare beneficiaries. Internal medicine is the only medical specialty that requires its residents to undergo training in geriatrics (AMA Residency Review Committee, Special Requirements for Internal Medicine). Physicians who practice internal medicine and many of its subspecialties have Medicare participation rates ranging from 80-90% (Part B News). Moreover, general internists receive 38% of their revenue from Medicare, the highest among all primary care specialties (PPRC 1995).

The American College of Physicians provides the following set of recommendations for long-term Medicare reform and re-structuring. These recommendations are based on the belief that it is critical to ensure not only that the program remains financially viable, but also that it retains its commitment to program beneficiaries. They address delivery system changes as well as issues of program management and structure.

Specifically, the College recommends that whenever possible, Medicare beneficiaries be given access to a coordinated set of benefits. The ACP also urges HCFA to modify its management of the fee-for-service program and adopt some of the successful techniques used in the private sector to improve quality and constrain costs. In addition, steps should be taken to educate physicians and patients about the effectiveness of different treatments, as well as to help ensure the appropriate use and supply of technology. Moreover, the ACP advocates changes to the Medicare risk program that will improve quality, modify the payment methodology for HMOs, and authorize new models of health care delivery.

Some of the ACP’s recommendations can be implemented immediately, while others may require testing through demonstration projects. Nonetheless, when taken as a whole, these recommendations will help ensure that Medicare beneficiaries have access to high quality care, while improving the program’s cost effectiveness.

It is important to note here that this paper does not address two important Medicare issues: Graduate Medical Education (GME); and modifications to the RBRVS. The ACP has a long history of advocacy on these two issues and our positions are clear. The College has consistently argued that all health care payers should contribute to the costs of graduate medical education, and has advocated policies to ensure that the physician workforce coincides with the needs of the health care delivery system (American College of Physicians). In addition, the ACP has recently reiterated its position that Medicare’s fee schedule should be modified to redress the imbalance between primary care and specialist reimbursement. This can be achieved by changes that will reward evaluation and management services, and the implementation of the resource-based practice expense calculation (American College of Physicians).

Thus, the absence of a discussion of these issues in this document is merely a recognition that the College has addressed these issues elsewhere (American College of Physicians).
Medicare's Successes

Any proposals to reform Medicare must recognize the many successes achieved by the program. Before the enactment of Medicare, few retired elderly or nonworking disabled persons had reliable health insurance coverage. They also feared bankruptcy from the costs of treatment for serious illness or the inability to receive treatment because they could not pay for it (Aaron, Reichauer). During the past thirty years, Medicare has provided the elderly and disabled with access to health care and greater economic security (Moon, Davis). In addition, since the enactment of Medicare, the poverty rate of America’s elderly has decreased from 29% in 1966 to 12% in 1993 (Health Care Financing Administration).

Medicare has provided elderly and disabled persons with access on a nondiscriminatory basis to the same health services that workers and their families enjoy (Aaron). Access to the successes of modern medicine have allowed almost 80% of the population in the United States to survive past age 65 (Cassel).

Dire Financial Straits

Despite its successes, Medicare faces severe financial difficulties. Pressures on the program have led many analysts to call for major reforms.

Medicare consists of Part A and Part B. Part A, the Hospital Insurance program, helps pay for hospital, home health, skilled nursing facility, and hospice care for the aged and disabled. It is financed primarily by payroll taxes paid by workers and employers. The taxes paid each year are used mainly to pay benefits for current beneficiaries. Income not needed for this purpose is held in a trust fund (Trustees Report).

Medicare Part B, the Supplementary Medical Insurance Program, pays for physician, outpatient, and other services for the aged and disabled. It is financed primarily by transfers from the general fund of the US Treasury and by monthly premiums paid by beneficiaries (Trustees' Report). Because it has an unlimited draw on the federal treasury, Part B does not face insolvency (Moon, Davis).

The Board of Trustees' reports left no doubt that the Medicare program is in financial trouble. The report on the hospital trust fund predicted that it faced bankruptcy early in 2001. Specifically, the report noted that program expenditures exceeded annual income beginning in calendar year 1995. By drawing down on trust fund assets, the report said, the program could maintain financial solvency until 2001. At that point, the trust fund will be depleted (Trustees' Report) (See Chart 1). At the same time, the Part B report warned that since premiums are expected to cover a declining share of program costs, more money in the form of general revenues will be necessary (Trustees Report).
These predictions are consistent with other forecasts. The Congressional Budget Office (CBO) noted that spending for Medicare has increased from 0.8% of the gross domestic product in 1975 to 2.5% in 1995, and that by 2006, it will reach 3.8% (Congressional Budget Office). In addition, the CBO projects that Part A outlays will increase at an average annual rate of 8.3% over the next decade, while Part B will increase at 10.3% (CBO).

The growth of Medicare costs is not new. Almost from its inception, Medicare has proved to be more costly than anticipated. In the 1970s, Medicare expenditures grew at an annual rate of 17.5%, and in the 1980s, at 12.1% (Aaron, Reichauer).

There are many reasons for the growth in Medicare spending. While researchers have found that some of the program's growth is attributable to increases in the number of beneficiaries, which has expanded by about 2.5% per year since 1968, as well as from benefit expansions, the major contributor to the explosive growth of Medicare has been the increased capabilities of medicine, especially the many new diagnostic tools, procedures, treatments, and drugs (Aaron, Reichauer). These medical innovations impose cost pressures on the program because of their inherent expense and because they have led to an increased life expectancy for Americans (Cassel). Moreover, it is virtually impossible to disentangle growth in Medicare spending from the larger issue of the growing cost of medical care in America (National Academy on Aging).
Nonetheless, the Board of Trustees' reports concluded that immediate action is necessary to prevent insolvency and control program costs in the short term. In addition, they warn of a deeper crisis starting in 2010, when the "baby boom" generation turns age 65 and begins to receive benefits (Trustees' Report). Other analysts have also noted this trend. In 1990, 21% of all Americans were age 55 or older. By 2010, 25% will be, and by 2020, those aged 55 and over will approach 30% of the population (National Academy on Aging).

As a result, in the long term, Medicare faces a serious financial crisis since there will be fewer contributors to the system and more beneficiaries drawing from the system (Moon, Davis). Consequently, although the current debate was sparked by warnings about the solvency of the Part A trust fund, a more important problem is the rate of growth of Medicare outlays, and the resources the nation is willing to commit to support the program (Moon, Davis).

Another rationale for cost reduction in Medicare is federal deficit reduction. Federal health and Social Security expenditures represent a greater and greater portion of the federal budget. Health, retirement, disability and interest on the national debt exceed two-thirds of all federal spending (National Academy on Aging) (See Chart 2). As a result, it is virtually impossible to reduce the size of the federal deficit without cutting Medicare spending (Moon, Davis). Indeed, virtually all recent Congressional deficit reduction proposals incorporate reductions in Medicare spending (HR 2491).
Thus, the Medicare program needs to be dramatically changed. All reform proposals, however, must ensure that beneficiaries have access to high quality care, while maintaining the financial integrity of the program.

I. Caring for Medicare Beneficiaries: New Approaches

Many Medicare beneficiaries suffer from chronic illness. In fact, one estimate found that 80% of persons 65 years of age or older have one or more chronic conditions that require regular health care (Collier, Early). Unfortunately, researchers have found that health care services for the elderly are fragmented and uncoordinated (Shelton, Schraeder, Britt, Kirby). As a result, the existing health care system is often inadequately prepared to address the long-term needs of the chronically ill (Anker-Unnever, Netting).

Even though providing coordinated care to the elderly could help ensure that they receive necessary care, Medicare’s current reimbursement system and benefit package often do not permit physicians to provide care in this manner. In addition, it is well documented that a small portion of the elderly account for a large share of Medicare program costs (Moon, Davis). Some studies have shown that methods exist for identifying these individuals (Anderson, Knickman).
coordinated, comprehensive services to these beneficiaries has the potential to improve the quality of their care and reduce program costs (Moon, Davis).

Capitated or Risk-Sharing Approaches

Some observers have expressed concern that the financial incentives inherent in capitation could lead to decreased quality of care, force physicians to behave unethically, or both. This could occur if an individual physician’s financial well-being is too closely related to specific treatment options for an individual patient (Berwick). To reduce this possibility and lead to improvements in care, capitation and other risk-sharing approaches should be designed to promote coordination of care, and system integration. In this way, capitation will provide incentives for groups of physicians to “consider the costs and benefits of clinical-management patterns for patients of a general type in the longer run.” (Berwick)

By using risk-sharing methods, some managed care plans successfully coordinate care for Medicare beneficiaries, who then receive the benefits of continuous care (Fox, Fama). Health plans’ ability to implement these programs stems from the discretion plans have in capitated settings to allow providers to allocate services (Schlesinger, Mechanic). Under capitated arrangements, physicians often have the flexibility to coordinate patient care by providing cognitive services that are not normally reimbursed by Medicare (Fox, Fama).

The Cooperative Health Care Clinic developed by the Kaiser Foundation Health Plan of Colorado is an example of an innovative program for Medicare beneficiaries sponsored by a managed care plan. Under this program, the clinic uses a multidisciplinary team to provide care to groups of elderly patients who are high users of services and have chronic conditions. The program consists of medical care, patient education, and health promotion. Outcome measurements of the pilot study included patient satisfaction, physician satisfaction, as well as quality and cost of care. These results were so encouraging that the Robert Wood Johnson Foundation is funding an expansion of the program (Scott).

In addition, there is evidence that prepaid plans that enroll Medicaid beneficiaries use a variety of methods to coordinate care for these beneficiaries. According to a recent U.S. General Accounting Office (GAO) report, states that enroll disabled Medicaid beneficiaries in prepaid plans often require the plans to take steps to ensure coordination and continuity of services as a means of guaranteeing access to appropriate care (US General Accounting Office).

Despite the success of some managed care plans in caring for Medicare beneficiaries, some observers have noted that health plans “may be at best ambivalent” about investing in care for the chronically ill (Jones). Medical expenses for persons with moderate chronic disabilities are two to three times higher than for persons of the same age without disabilities (Schlesinger, Mechanic). Consequently, if a health plan develops a reputation for caring for persons with a chronic condition, it could attract more enrollees with this condition, and thereby raise its costs (Jones).

Thus, in a competitive market, health plans may have a disincentive to treat the chronically ill. Although adjusting payments to plans to compensate for enrollees with chronic conditions would
help alleviate this problem, these “risk adjusters” are not yet in use (Newhouse). As a result, some chronically ill beneficiaries need an alternative delivery system that will provide coordinated care.

**Direct Contracting with Physician-Run Delivery Systems**

**HCFA should contract directly with physicians who demonstrate the ability and willingness to provide a coordinated and comprehensive set of benefits for chronically ill Medicare beneficiaries.** Unlike some health plans, physicians have experience providing care to these beneficiaries, and would likely be willing to do so in the future (Jones).

This concept should begin as a demonstration project to care for beneficiaries with a certain condition, such as congestive heart failure. The benefits package and delivery system should be developed by clinicians with expertise in caring for these beneficiaries, and provide for all services the clinicians deem necessary. The program should be voluntary -- physicians would not be required to participate, and Medicare beneficiaries with the specified condition would not be required to receive care from “participating” physicians. Nonetheless, it would be a delivery system option for people with chronic illness, and an opportunity for physicians to design and implement a benefits package. In order to participate in the program, however, physician groups and physician-centered delivery systems would be required to display the appropriate clinical expertise, infrastructure, and financial capability to provide care.

A global fee to care for the patients could be set either through a bidding process or negotiation between the physicians and HCFA. The physicians could accept full risk for the cost of care, or Medicare could enter into a type of risk sharing arrangement with them. As another alternative, HCFA could require the physicians to obtain reinsurance (Schlesinger, Mechanic).

Quality assurance mechanisms would also be established. In return for the authority to contract directly with HCFA, physicians should be held accountable for their performance through profiling of utilization and costs, performance measures, or other methods.

This model of care delivery has several advantages. For example, many experts have found that designing explicit capitation payment rates for selected prevalent chronic conditions has the potential to save money (Moon, Davis). In addition, patients will get improved care since studies have found that patients with chronic illnesses receive better care from plans that specialize in chronic conditions than from those that treat a relatively small proportion of enrollees with chronic illness (Schlesinger, Mechanic). It also would provide chronically ill beneficiaries with the benefits of coordinated care even if they are enrolled in Medicare fee-for-service.

Moreover, it would empower physicians and other clinicians to design benefits packages based on their knowledge of patient needs. The College has previously endorsed this model, and other physician integration efforts as a means of improving care and protecting the physician-patient relationship (American College of Physicians). In addition, as with provider sponsored organizations, these systems would avoid many of the administrative costs of traditional health plans (American Medical Association).
Although a new idea, there is some precedent for this type of arrangement. For example, many employers-purchasers already buy disease management packages for a variety of conditions (Medicine and Health). In addition, some health plans are referring sick and costly patients to separate "carveouts" that specialize in care for one specific high-cost condition (Rundle, The Wall Street Journal). Moreover, Medicare's End Stage Renal Disease (ESRD) program has operated in this manner since the 1970s. Under this program, Medicare reimburses physicians and renal facilities a capitated rate to provide necessary services to eligible beneficiaries (Smits).

As HCFA develops this demonstration project, there will be a variety of implementation issues to be worked out. Setting an appropriate payment rate is critical to ensure the success of the program. In addition, identifying eligible beneficiaries will be necessary. This care delivery model will likely work best for those who have one chronic condition that accounts for the vast majority of their medical care needs. Modification is needed to apply this approach to the many Medicare beneficiaries with more than one chronic condition.

Nonetheless, the College recommends that HCFA develop this concept as a demonstration project. These delivery systems have the potential to provide high quality and cost effective care to a large percentage of the Medicare population. A carefully planned demonstration can provide policy makers with valuable information about caring for a vulnerable and high-cost group of Medicare beneficiaries.

Case Management

HCFA should develop demonstration programs that use case management to coordinate services for patients with complex conditions. Providing capitated payments for primary care services to physicians leading an interdisciplinary team is a worthwhile approach.

Case management has the potential to improve care for Medicare beneficiaries. The term "case management" is used to describe a variety of approaches to reduce costs and improve quality through coordination of care. Since physicians often coordinate care for their patients, case management can describe a model that uses primary care physicians to perform this role, provide other primary care services, and make referrals for more specialized services (PPRC 1996).

By monitoring patients' health status at home, arranging transportation to physicians' offices, and arranging community services, case management can support primary care physicians. It also can provide physicians with a coordinated system of ongoing support, thereby enhancing their capabilities to care more effectively for their elderly patients (Anker-Unnever, Netting).

Case management has been shown to be successful in a number of delivery settings (Cohen, Cesta). It is particularly effective when implemented by an interdisciplinary team that provides long-term intervention for patients with chronic illnesses (Anker-Unnever, Netting) or the frail elderly at highest risk for hospitalization, those with dementia or depression, and those near the end of life (Collier, Early). Studies of collaboration among physicians, nurses, and others suggest that these approaches lead to improvement in care among frail older adults (Fagin).
Consequently, the ACP urges HCFA to develop demonstration projects that incorporate case management services in capitated arrangements. The College endorses a care delivery model that gives a capitated payment to interdisciplinary team led by a physician to provide primary care, including case management, to program beneficiaries with complex conditions.

**Bundled Payment**

The “bundled payment” demonstration program for heart bypass surgery -- which creates a risk-sharing arrangement among providers by combining fee-for-service payments for specific services -- should be expanded, either by HCFA or through the enactment of legislation.

The Medicare Participating Heart Bypass Demonstration involves the use of bundled fee-for-service payments to hospitals to encourage high quality and cost effective care for this procedure. Under the terms of the demonstration, Medicare contracts directly with providers for a specific service.

Seven hospitals have participated in the demonstration. Their reimbursement was a single “bundled payment” -- a combination of separate diagnosis related groups (DRGs) for bypass surgery and related care that was developed through negotiation with HCFA. The demonstration showed that using a payment mechanism that incorporated risk sharing concepts, gave hospitals and physicians incentives to perform cost effectively for a selected service, achieved savings to Medicare and provided high quality care to the patients (DHHS Extramural Research Report).

Provisions in the Health Security Act would have granted HCFA the authority to expand this program. Under the legislation, HCFA would have been allowed to enter into these types of bundled arrangements for coronary artery bypass surgery and cataract surgery with any hospital that met its criteria (S.1757).

Given the success of this demonstration, the American College of Physicians recommends that this program be expanded, either by HCFA or through the enactment of legislation.

**Home Health Care**

HCFA should develop demonstration projects to test the use of capitated financing schemes to pay for home health care.

Changes in the legal and regulatory provisions governing the Medicare home health benefit along with changes in HCFA’s policies have led to dramatic growth in the program (U.S. General Accounting Office). Spending on home health care under Medicare increased fivefold between 1989 and 1994, and now accounts for about 8% of total Medicare spending. Annual rates of growth for this period averaged almost 37% (Moon). As a result, the home health program will likely be a target of budget cutters in the next Congress.
However, physicians and policy experts have noted for some time that providing care in the home is an appropriate alternative to institutional care (Schlenker). Most of the expansion in the home health program occurred in the use of services, rather than payment levels. Between 1988 and 1994, the proportion of beneficiaries receiving home health services nearly doubled and the average number of visits per user almost tripled (Moon). Since home health services are reimbursed on a retrospective cost basis -- agencies are reimbursed for the reasonable costs incurred in providing covered visits to eligible beneficiaries -- this growth in utilization has significant financial implications (U.S. General Accounting Office). Consequently, solutions that attempt to constrain program costs must address service utilization rather than simply reimbursement.

One potential solution is to provide a capitated payment to physicians for the outpatient care of their patients including the use of Medicare home care services. By accepting risk, physicians and other providers have the incentive to provide care cost effectively, thereby reducing inappropriate care and its associated program costs while ensuring that patients who need care at home will get it. Giving physicians more control over care delivery will also improve the coordination of services.

A prospective payment system for home care services was included in legislation in the last Congress (HR 2491), but was criticized for its potentially detrimental effect on the quality of care Medicare beneficiaries would receive (Schlenker).

Thus, the ACP encourages the development of demonstration projects to test the feasibility of providing Medicare home care services under capitation arrangements. Appropriate quality assurance mechanisms should be established to protect program beneficiaries.

Coordinated Care in Fee-For-Service Systems

Because of its structure, providing coordinated care in a fee-for-service system is a greater challenge. Nonetheless, there are techniques that have succeeded in improving the cost effectiveness and quality of care received by patients. Since the percentage of Medicare beneficiaries that remain in its fee-for-service program remains high, these models merit further examination.

Targeted Conditions

Medicare should establish delivery systems that provide coordinated and comprehensive care for beneficiaries in fee-for-service suffering from chronic illnesses. One successful model, Maryland’s Diabetes Care Program (DCP), provides coordinated care to Medicaid beneficiaries suffering from that condition. Since 1991, Maryland has been operating the under a Medicaid waiver. The goal of DCP is to provide diabetics with comprehensive, coordinated services to reduce long-term acute complications and hospitalizations from this disease, improve health outcomes, and reduce costs (The University of Maryland).
If a Medicaid beneficiary chooses to enroll in the program, he or she receives additional services such as nutritional counseling, education, supplies, and therapeutic footwear. The patient can choose their own primary care physician, or one will be assigned. A primary care physician who agrees to participate (participation is voluntary) receives a $20 per member /per month “management fee” to help coordinate services. This program is similar to the model discussed earlier that involved direct contracting with physician-run delivery systems. However, the physician who participates in DCP is reimbursed fee-for-service for the medical care they deliver. By agreeing to participate, the physician also agrees to have the state profile their utilization patterns for this population and ensure that the physician follows practice guidelines for care of diabetics. The state provides a full-time case manager to help the patient understand their treatment options, arrange for support services, and help ensure compliance with the physician’s treatment recommendations.

An independent evaluation of the program has found that DCP meets its goals. Significant cost savings have been achieved, program participants have received high quality care with improved health outcomes, and patients have expressed satisfaction with the program (The University of Maryland).

Given the proven success of the Maryland program, the ACP recommends that HCFA expand this program and allow Medicare to establish these types of delivery systems for Medicare beneficiaries with chronic illnesses.

Case Management

HCFA should reimburse case management services under its fee schedule, and develop demonstration programs to test various case management models in fee-for-service settings.

As noted elsewhere in this paper, case management could improve health outcomes for Medicare beneficiaries. Like some managed care arrangements, many private indemnity plans successfully use case management approaches to provide cost effective and high quality care. For example, according to the results of a study of private health plan management sponsored by the Physician Payment Review Commission (PPRC), one particular plan implemented a program called Personal Care Management. The program is designed for patients with chronic, catastrophic, high-risk, or high cost conditions. If a patient is eligible for the program, and the patient and their physician agree, a case manager hired by the plan develops a coordinated benefits package. The services available often include personal care and other benefits not normally covered by the plan.

Plan representatives told the PPRC that the program is cost effective and that it is popular. In fact, the results of annual patient satisfaction surveys report that between 99% and 100% of former case management patients and their family members surveyed indicated they would use the service again (Dyckman, Knowlton).

Many experts have noted that Medicare could use case management to generate efficiencies in the treatment of very expensive illnesses and in chronic care (Moon, Davis). Others have argued that better and more extensive use of case management by Medicare would improve the care provided
to program beneficiaries and reduce costs. For example, the PPRC-sponsored study concluded that “an effective case management program could help Medicare patients who are chronically ill or who are facing costly, complex treatment options. Based on experience of private payers, these Medicare patients would receive more appropriate medical care and Medicare would experience lower claims cost relative to the current program, which lacks a coordination of care function” (Dyckman, Knowlton).

Despite these recommendations, Medicare has thus far made infrequent use of case management. However, there have been recent indications that HCFA is beginning to recognize its potential.

For example, although Medicare has generally not paid for case management services in its fee-for-service program, it has recently started reimbursing for similar services in a limited way. Current Procedural Terminology (CPT) code 99375 reimburses physicians for care plan oversight if a physician spends more than 30 minutes per month managing a patient’s home health or hospice care (American Medical Association).

Medicare has also attempted to introduce case management through demonstrations. The Medicare Case Management Demonstrations authorized the use of case management services to Medicare beneficiaries identified to be at risk of high-cost care. Once identified, the patients received condition-specific education and support services. Although the final report on the demonstrations is not yet available, interim reports indicate that physician and beneficiary apprehension led to less participation than anticipated (PPRC 1996).

Thus, the American College of Physicians recommends that HCFA reimburse for case management services under its fee-for-service fee schedule, and that it develop demonstration programs to test various case management models. Given its success as a technique in private indemnity plans and elsewhere, it has tremendous potential to improve the care provided to Medicare beneficiaries.

The College recommends that any case management approach be coordinated by a primary care physician. Skilled geriatric care must be provided and coordinated by the primary care physician to avoid fragmentation of services and to ensure a proper emphasis on economic, nutritional, psychosocial, and rehabilitative aspects of care (Shelton, Schraeder, Britt, Kirby).

“Medicaring”: Coordinated Care for the Terminally Ill

Medicare should provide for hospice-type services, including palliative care, pain relief, family counseling, and other psychosocial services, for terminally ill beneficiaries outside of a hospice.

Like those with chronic conditions, whether they are in a Medicare risk plan or the fee-for-service program, Medicare beneficiaries who suffer from terminal illnesses would benefit from a delivery system that provided coordinated care (Lynn). Many writers have advocated a broad based approach to caring for people who are terminally ill (Bulkin, Lukashok). They argue for palliative care, social services, counseling, pain relief and other services not typically reimbursed by Medicare (Lynn).
Hospice care is designed to meet these needs. The primary goal of hospice care is the palliation of patients' physical and mental suffering (Christakis, Escarce). Hospice services include supportive social, emotional, and spiritual services to the terminally ill, as well as support for the patient's family (Hospice Association of America).

A Medicare beneficiary with a terminal illness who elects hospice care receives noncurative medical and support services, many of which would not be otherwise covered, such as: nursing care, physician's services, medical appliances, drugs, short-term hospitalization, services of homemakers and home health aides, physical, occupational and speech therapy, psychological counseling, and social services (Christakis, Escarce).

A Medicare beneficiary is eligible for the hospice benefit only if their doctor and the medical director of the hospice certify that the patient is "terminally ill", defined as having a life expectancy of six months or less. By electing to receive hospice care, a beneficiary waives all rights to Medicare payment for curative treatment for his condition (Christakis, Escarce).

There are some indications that hospice care is cost effective. A 1995 report found that hospice beneficiaries who enrolled in the last month of life cost Medicare about $2,800 less than non-users (Lewin-VHI). This supports earlier studies suggesting that patients receiving hospice care generate fewer expenses than those receiving conventional care (Amado, Grow, Nofziger). In addition, hospice care is popular. A 1993 survey showed that Americans prefer the type of in-home care associated with hospice care (Hospice Association of America).

However, outside of a hospice, services for the terminally ill are often uncoordinated, not covered by insurance, and effectively unavailable. Since many illnesses do not lend themselves to accurate prediction, the six month life expectancy requirement limits many terminally ill patients' access to hospice-type services (Bulkin, Lukashok).

Some researchers have argued that care at the end of life can be improved by a distinct program to provide hospice-like supportive services efficiently to all persons with serious and eventually fatal conditions, regardless of their likely survival time. According to this model, known as "Medicaring", the care system's priorities should be: relief of pain, maintenance of function and control, support of family and personal relationships, avoidance of impoverishment, trustworthiness and continuity and spiritual issues (Lynn).

There are examples of capitation models that provide some of these services. Healthcare Partners, a Los Angeles-based multispecialty medical group offers its "OPTIONS" program to patients with "terminal, irreversible or debilitating" illness (Healthcare Partners Medical Guide). Funding is derived from its capitated payment from several managed care organizations.

In general, eligibility for the OPTIONS program is based on the following criteria: the patient is terminally ill; the patient is in the end stages of a disease process; the patient has a medical condition that affects long term quality of life; and the primary care provider has discussed the patient's diagnosis/prognosis with the patient and his or her family. The goals of the program are
to provide high quality, well-coordinated and cost effective care, emphasizing symptom management, pain control and improving the quality of the remaining life (Healthcare Partners Medical Guide).

By receiving a capitated payment, HealthCare Partners has the flexibility to design a benefits package to meet a patient’s needs. In general, patients who qualify for the OPTIONS program receive ambulatory case management and supportive care in their home. The group reports that its program is supported by its physicians and their patients and families.

Prior to its enactment on a national scale, the value of hospice care was shown through a demonstration project. Given the success of the hospice program, and the potential of other programs that can improve the quality of life for those with terminal illness, the ACP recommends that HCFA develop new demonstrations to test the feasibility of providing care systems that offer coordinated care for the terminally ill -- including services not typically reimbursed by Medicare outside of hospice care.

Preventive Care

Medicare should provide for preventive care, including appropriate screening services, for beneficiaries. The College has previously endorsed providing Medicare beneficiaries with a package of preventive benefits including an annual primary care physician visit, appropriate screening services, and immunizations (American College of Physicians). Studies have shown that a primary care physician visit will provide beneficiaries with a modest health benefit, without a negative cost impact (Burton, Steinwachs, German, Shapiro). In addition, Medicare claims data has illustrated the cost effectiveness of providing immunizations for influenza and pneumonia (American Medical Peer Review Association).

II. Improving Medicare Fee-For-Service

Although managed care enrollment is growing and has the potential to provide cost effective care to the elderly, Medicare’s fee-for-service program is still the plan of choice for over 90% of beneficiaries (Health Care Financing Administration). Even if trends continue and increasing numbers of the elderly enroll in managed care plans, a majority of Medicare beneficiaries and providers will be operating in the fee-for-service program for the indefinite future (Etheredge). In addition, there will always be program beneficiaries who find that managed care delivery systems do not meet their needs or are unavailable in their local market. The fee-for-service program will be a safe harbor for those beneficiaries (Institute of Medicine). Thus, maintaining the financial and clinical integrity of the fee-for-service program is critical.

Scholars have noted that over the years, Medicare’s fee-for-service program has developed an excellent record. Within its statutory constraints, the program has promoted innovation and efficiency (Medicine and Health). “Overall administrative efficiency” as well as investments in outcomes research and medical efficacy are examples of Medicare’s successes (Etheredge).
However, there are indications that reforms are necessary to ensure that beneficiaries in Medicare fee-for-service receive high quality and cost effective care. The fee-for-service program is facing many cost pressures. For example, without adequate risk adjusters, Medicare HMOs have incentives to avoid caring for the chronically ill. The result is that the fee-for-service program often ends up caring for the costliest beneficiaries (Jones, Etheredge). In addition, Medicare fee-for-service is under pressure from Congress to become more cost effective, as evidenced by recent proposals that imposed strict spending limits on the program (HR 2491). Consequently, changes are essential if it is to remain financially viable and able to compete with the new managed care options that are becoming available to program beneficiaries (Etheredge).

In general, Medicare fee-for-service needs to become more accountable for providing high quality care. Rather than simply paying claims, Medicare fee-for-service must act as an aggressive purchaser and innovative manager. If it does, it has considerable potential to gain savings for the program, improve plan performance for beneficiaries, and influence changes in the delivery of medical care (Wilensky).

Private Sector Management Approaches

Purchasing Supplies and Equipment

HCFA should consider competitive bidding, negotiation, and other methods to purchase supplies and scrutinize payments. Legislation should be enacted to provide HCFA with the management authority to implement these cost saving techniques.

Medicare should reform its procedure for purchasing supplies and equipment. The GAO found that in stark contrast to private plans, HCFA cannot promptly change the prices it pays for supplies and equipment to match those available in the market. Strict statutory constraints and burdensome regulatory and administrative procedures impede HCFA's ability to react quickly to market changes. The agency can adjust prices that are unreasonable, but since its authority to do so is limited and requires a long and complex process, it is rarely done. Thus, Medicare often overpays for medical supplies and equipment (U.S. General Accounting Office).

In fact, according to a recent Congressional report, Medicare pays far more than other government and private sector purchasers for medical supplies and equipment (Harkin Report). For example, Medicare pays $75.52 for a walker that the Veterans Administration (VA) pays $25.40 for, and is available wholesale for $39.28 (Harkin Report). An earlier study found that Medicare paid $2.32 for a gauze pad that sells wholesale for 14 cents, and the VA buys for four cents (U.S. General Accounting Office).

Under current law, Medicare purchases supplies and equipment according to a fee schedule. In contrast, the VA uses a competitive bidding process. Given the lower costs experienced by the VA, legislation was introduced in the last Congress to institute this system for Medicare (S.1193). Even if a competitive bidding process is not immediately implemented, Medicare should be able to negotiate lower prices from suppliers because of its size and market power.
Over the past few years, other examples of mismanagement have been identified. Medicare could save substantial sums of money by more scrupulously purchasing supplies and better managing its purchasing function (U.S. General Accounting Office). In addition to unnecessarily high costs, examples of over-spending by Medicare reduce the public's confidence in the program.

Consequently, the ACP recommends that HCFA consider competitive bidding, negotiation, and other methods to purchase supplies and scrutinize payments. If necessary, legislation should be enacted to provide HCFA with the management authority to implement these cost saving techniques.

*Improving Quality/Containing Costs*

Medicare should adopt the successful techniques used by private sector indemnity plans to improve care and reduce costs. HCFA could begin this process by soliciting proposals from its carriers and fiscal intermediaries.

Many analysts have found that private indemnity plans use more aggressive management techniques than Medicare to improve quality and contain costs. For example, Medicare does not use competitive bidding to price services, or state of the art technology to screen claims for overcharges or overutilization. Despite the success of private plans using these schemes, under current law, it is unclear whether they are authorized for general use by HCFA (US General Accounting Office).

According to at least one study, this lack of managerial authority has led directly to increased Medicare spending. The GAO found that home health agency and skilled nursing facility services each grew at an average annual rate of 28% from 1990 through 1996 (US General Accounting Office). That study found that Medicare's inability to monitor utilization and adjust its prices were major contributors to these cost increases. The study concluded that the experiences in the home health and skilled nursing programs "illustrate the damaging effects of reimbursement policies that fail to incorporate effective pricing and utilization management techniques" (US General Accounting Office).

The PPRC-sponsored analysis of 10 private indemnity plans identified the management techniques that these plans were using in 1995. The study considered only private insurance products that were structured similarly to traditional Medicare and plans that were known for applying the best available managed care practices within fee-for-service settings (PPRC 1996).

According to the study, almost all plans profile providers' service use, often to provide informational feedback on utilization and practice pattern analysis. Case management is also used by every plan, typically to provide coordinated care for high cost cases (Dyckman, Knowlton).

Moreover, all plans use sophisticated software to review claims and to ensure proper billing (PPRC 1996). For example, unbundling, or billing for two or more codes to describe a procedure when a single bundled (comprehensive) code exists, is a common error. Another error involves
bundled payment codes for major procedures that include related follow-up services within a specified time period.

Medicare’s use of these techniques is sporadic. For example, HCFA and the Medicare carriers have implemented profiling approaches to address high utilization rates. Typically, these processes compare providers’ rates of utilization with their colleagues to identify outliers. HCFA highlights any differences across carriers, and then the carriers perform a more detailed review. The carriers have flexibility in the type of profiling they perform and the way they dispense feedback or take corrective action.

While this program has potential, the quality of data and results varies across carriers. In addition, it is unclear whether the results are adjusted to account for beneficiary characteristics (PPRC 1996). Moreover, as mentioned previously, in contrast to private plans, HCFA does not generally use case management to coordinate and monitor expensive services (GAO).

Thus, certain private sector techniques that have the potential to save money and improve the quality of care beneficiaries receive are not fully utilized by Medicare. Interestingly, the PPRC study found that Medicare carriers that successfully implement cost containment initiatives in their private fee-for-service products do not use these initiatives in their Medicare policies. One reason is that Medicare carriers currently are not reimbursed for the administrative costs of a program that is not required under the standard Medicare program, even if it produced cost savings. Consequently, Medicare carriers have a strong financial disincentive to implement a cost saving initiative if it requires additional administrative expenses (Dyckman, Knowlton).

The College recommends that steps be taken to allow Medicare to adopt some or all of these methods, including reimbursement for any necessary administrative costs. It has been suggested that a coordinated management initiative incorporating several reforms would be a visible and appropriate approach (PPRC 1996). HCFA could begin this process by soliciting proposals from its carriers and fiscal intermediaries, who already have a relationship to the program and could provide necessary private sector expertise.

Fee-For-Service Product Design

HCFA should evaluate the impact of changing the Medicare fee-for-service program’s benefits package and cost sharing requirements.

Medicare has virtually no flexibility to change its product to meet market needs. (Etheredge, Jones) It cannot offer different cost sharing approaches or supplemental benefits. Instead, the Medicare fee-for-service program offers a single insurance plan designed to match the prevailing plans of 30 years ago (Kinney).

Medicare offers basic hospital coverage of 90 days per benefit period, with a 60-day lifetime reserve, and no coverage thereafter. The hospital coverage comes with high cost sharing requirements ($736 deductible per benefit period, $184 per day for days 61 through 90, $368 per day for the 60 lifetime reserve days). In addition, for physician services, there is a $100 annual
deductible and 20% co-payment, with no limit on out-of-pocket expenses. Moreover, Medicare does not pay for outpatient prescription drugs (Health Care Financing Administration).

This complex set of cost sharing requirements is confusing for beneficiaries (Moon, Davis). In addition, the cost sharing requirements and lack of supplemental benefits are two of the main reasons why some Medicare beneficiaries have enrolled in managed care plans (Fox, Fama). Moreover, studies have shown that although Medicare coverage is extensive, it covers less than half of per capita personal health care expenditures for persons aged 65 and over (Research Triangle Institute). This means that beneficiaries remain at risk for substantial health care costs.

As a result, between 70-80% of non-institutionalized Medicare beneficiaries obtain supplemental insurance (Research Triangle Institute). In 1992, premiums for this insurance totaled $27 billion (Etheredge 1/96). About half of this group are covered by so-called “medigap” policies. These are individually purchased health insurance policies that are intended to pay for Medicare cost sharing requirements, and sometimes charges in excess of amounts allowed by Medicare, or for services not covered by Medicare (Research Triangle Institute).

Medigap coverage can be costly for beneficiaries, with premiums that can exceed $3500 a year (The New York Times). In addition, use of medigap policies mitigates the intended effect of cost sharing requirements on program costs and utilization of services (Gornick, Beebe, Prihoda). Thus, these policies actually increase the budget cost of Medicare, by short-circuiting the economizing incentives of cost sharing requirements (Aaron, Reichauer).

Modifying Medicare’s cost sharing requirements will help alleviate these problems. The ill-fated Medicare Catastrophic Coverage Act of 1988 used this approach. That legislation eliminated most of the cost sharing requirements of Medicare Part A, and limited out-of-pocket expenses for beneficiaries for Part B services (Medicare Catastrophic Coverage Act of 1988, HR 2470, 100th Cong., 2nd Sess). It also created a new benefit to cover the cost of prescription drugs. Although it passed overwhelmingly, the bill was repealed during the next Congress, and similar changes have not been enacted since.

To appropriately change Medicare’s cost sharing requirements while avoiding the political pitfalls of the Medicare Catastrophic Coverage Act, Congress should create new, voluntary Medicare benefits packages. One package would be a “high option” Medicare benefits package with lower cost sharing requirements and out-of-pocket spending limits for beneficiaries (Etheredge). Studies have shown that capping out-of-pocket costs for Medicare beneficiaries would not be inordinately costly (Gornick, Beebe, Prihoda). Another would provide what are now popular supplemental benefits (such as prescription drugs, eye glasses, and hearing aids) through Medicare (Moon, Davis).

The result would be a set of competing benefit packages from which beneficiaries could choose: traditional Medicare fee-for-service with private medigap insurance; the high option benefits package; and the traditional or high option benefits package including supplemental benefits. To help defray any new program costs, those beneficiaries who chose the expanded Medicare packages could be asked to pay an additional premium. Given the inefficiencies and
administrative expense of the private medigap market, however, this will undoubtedly be lower than the costs of private supplemental insurance (Etheredge).

The College, therefore, recommends that HCFA evaluate the impact of changing the Medicare fee-for-service program's benefits package. Granting Medicare the authority to modify its benefit package could provide increased protection to beneficiaries, make the fee-for-service more attractive to those who might otherwise choose a managed care plan, and reduce program costs.

III. Ensuring the Appropriate Use of Services and Technology

Eliminating Variations in Care

The College recommends increased funding for outcomes research, the development of clinical practice guidelines, and the creation of Quality Improvement Foundations to help identify successful clinical practices and disseminate information to physicians and their patients.

There are tremendous variations in the use of and payment for Medicare-covered services across the country. These differences reflect interstate variations in DRG prices and RBRVS fees, salary levels, medical practice patterns and the propensity to use services (Aaron, Reichauer).

Examples of this phenomenon are numerous. Doctors in Lubbock, Texas, performed angioplasty and angiograms on Medicare patients about twice as often as the national average, while in Provo, Utah, back surgery was performed at 2.7 times the national average (Anders, The Wall Street Journal). The rates of coronary artery bypass grafting surgery per thousand Medicare enrollees range from 2.1 in Grand Junction, Colorado to 8.5 in Joliet, Illinois (The Dartmouth Atlas of Health Care). In 1992, Medicare reimbursements nationally averaged $4,341 per person, but varied from a low of $3,048 in Nebraska, to a high of $5,114 in Louisiana (Aaron, Reichauer).

In addition, over the past few years, use of certain procedures increased at dramatically high rates. While the growth rate of Part B services from 1991-4 averaged 3.5% annually, echocardiograms increased at a 19.3% rate, and angioplasty increased at a 17.1% rate (PPRC 1995). Moreover, a GAO study found that the level of services provided in Medicare's home health program varies widely across geographic areas (US General Accounting Office).

Compounding the problem of variations in care is that little is known about the relative effectiveness of many treatments. Failure to evaluate the outcomes of care makes it possible for different opinions on the risks and benefits of alternative treatments to co-exist (Dartmouth Atlas). Thus, the lack of outcomes data comparing the effectiveness of treatment alternatives means Medicare may be paying for procedures that are not effective, or not paying for procedures that are (Dartmouth Atlas).

As a result, Medicare program costs could be higher than necessary since beneficiaries may be receiving treatment in high cost ways that are no more effective than lesser expensive ones. Moreover, because of the lack of information comparing the effectiveness of different treatments,
patients may not be receiving the best care, or may be getting treatments where the risks exceed the benefits (Anders, The Wall Street Journal).

The use of radical prostatectomy for the treatment of prostate cancer is an example. Researchers have noted the wide geographic variation in radical prostatectomy rates. According to one study, all states in New England and the Mid-Atlantic regions had rates equal to or below 60 per 100,000 male Medicare beneficiaries. However, all states in the Pacific and Mountain regions had rates equal to or above 130 per 100,000 male Medicare beneficiaries (Lu-Yao, McLerran, et. al.). Since this procedure carries with it certain health risks -- particularly for older men -- and is more resource intensive than other treatment options, these differences have significant cost and quality ramifications.

A related problem is the potential for inappropriate use of technology. For many years, medical technology has been identified as a cause of increasing health care costs (HEW). Health economists agree that a significant share of annual health care cost growth, including Medicare cost growth, is attributable to medical technology (Cutler, OTA).

Technological change and advancement provides our society with many benefits. New technologies save lives, improve health status and improve the quality of care patients receive (Neumann and Weinstein). While the health of many Americans benefit from the advancements in medical technology, however, there is a lack of clinical data on the effectiveness of many medical tests and procedures and a lack of scientific knowledge of what constitutes appropriate care for many specific conditions or problems (American College of Physicians).

As a result, there is great potential for technology to be used inappropriately. In addition, a surplus of technology leads to utilization of procedures with little or no proven benefit (Brook) and patient demand for the latest treatment, especially if potentially life saving, before it has been shown to be effective (GAO). These factors could lead to unnecessary or potentially unsafe treatment for patients, and increased costs for the Medicare program.

What is needed, therefore, is an appropriate balance between innovation and the diffusion of knowledge, and the unrestrained use of technology or therapies whose clinical effectiveness is unknown (American College of Physicians). Thus, the College recommends increased funding for outcomes research to provide the scientific basis for Medicare coverage decisions as well as physician and patient education initiatives about best practices and effective treatments. At the federal level, this is done primarily by the Agency for Health Care Policy and Research.

Even though it has been shown to save money for the health care system and Medicare (AHCPR), many scholars have noted that research into health outcomes is undercapitalized (Wennberg). New technology needs to be assessed as early as possible and periodically during its life cycle (Gelijns and Rosenberg). Because of the rapid changes in our health care delivery system, and the evolution of new treatments and technologies, substantial investments in outcomes research and technology assessment are needed (Garber). In addition, given the variations in treatment for similar conditions, this research is needed to ensure appropriate care for patients.
Unfortunately, many special interests have objected to government funded efforts in health services research (Rettig). In the past few years, Congress has responded by cutting the budget of AHCPR and eliminating its Office of Technology Assessment. Thus, it is unclear whether Medicare will consistently have the scientific information necessary to make good decisions about payment for new technologies.

Another way to ensure appropriate care is through the development of clinical guidelines, which help define best practices. The College has long supported the use of clinical guidelines developed by the scientific community to educate physicians about effective treatments (American College of Physicians). To the extent that these guidelines also promote cost effective care, greater use by the clinical community could lead to greater cost savings (AHCPR).

Patient education efforts also have the potential for controlling the inappropriate use of technology. Consumers frequently demand the latest in technology, particularly those that are potentially life-saving (Rettig). As a result, public demand can frustrate efforts to evaluate a new technology for its effectiveness (GAO). Nevertheless, studies have shown that patients who receive information about what is known and not known about the costs and benefits of a technology choose conservative treatment more than their physicians (Wennberg). This shared decision-making model would be appropriate for choosing treatments for patients with a variety of common conditions including: angina, gallstones, benign hypertrophy of the prostate, and cataracts. Surgery for these conditions accounts for a large percentage of the total amount of major surgery performed in the United States (Wennberg).

In addition, the College has previously endorsed the creation of non-profit organizations known as Quality Improvement Foundations (QIFs), a network of organizations responsible for promoting quality improvement activities throughout the country. As a private, educational organization, a QIF's mission includes: identifying and disseminating information to physicians about best practices; monitoring and profiling the quality of health care; supporting outcomes research; and educating consumers on issues of medical effectiveness (Congressional Record).

By identifying clinical successes and providing educational feedback to physicians, QIFs hold the promise of helping doctors identify appropriate care and thereby reduce costs and improve outcomes (American College of Physicians). Providing patients and physicians with information about the effects of different treatments will lead to informed decision-making between doctors and their patients, which will encourage the appropriate use and supply of technology, diminish regional variations in care, and the correlating cost and quality concerns.

Medicare has adopted this type of approach in its ESRD program. The ESRD Networks, organized groups of Medicare-approved providers in an area that collectively furnish care for the ESRD patients in that area, implement continuous quality improvement (CQI) concepts in the dialysis setting. The Networks provide technical assistance, comparative data profiles for each facility, and work with individual providers to identify problems and take corrective action to improve performance (Latos).
Given the paucity of outcomes data available and the inconsistency of funding for the Agency for Health Care Policy and Research, the work of the QIFs becomes even more critical. Since they will improve the quality and cost effectiveness of treatment provided by health plans, it seems appropriate for plans to financially support QIFs. This is consistent with current law which requires managed care plans participating in Medicare to pay a fee used to fund the quality assurance activities of the local Quality Improvement Organization (formerly the Peer Review Organization) (Title XVIII, Section 1876).

**Medicare Coverage Decisions for New Technology**

**Cost Effectiveness**

Medicare should use cost effectiveness as an explicit criteria in its decisions regarding coverage for a new technology.

In 1989, HCFA issued a proposed regulation which would have incorporated cost effectiveness as an explicit criteria for developing Medicare coverage decisions. Under the proposed regulation, cost effectiveness would be used when reviewing “expensive new technologies that add little or nothing to the efficacy or effectiveness of existing alternatives” (Buto). HCFA is expected to issue a final regulation shortly.

While it is unusual for cost effectiveness to be an explicit criteria in determining the allocation of health care dollars, it has had an indirect and hidden impact on the approval processes for drugs and devices, insurance coverage decisions and guideline development and application (Garber). According to some observers, cost effectiveness analysis has been used widely to assist in policy formation and is gaining acceptance as an appropriate criterion for resource allocation (Neumann and Weinstein). For example, some manufacturers already have begun to develop cost effectiveness information as they perform clinical trials on the safety and efficacy of new technologies (NHPF). HCFA’s use of cost effectiveness analysis would further this trend (Gelijns and Rosenberg).

The ACP has previously argued that using cost effectiveness as a criteria for coverage decisions is an appropriate way to reduce overall health spending and improve clinical outcomes (American College of Physicians). The American College of Physicians supported the proposed regulation in 1989 and recently has reiterated its position (American College of Physicians).

**Conditional and Interim Coverage**

Medicare should increase its usage of conditional or interim coverage rulings. This would lead to the assessment of new technology as early as possible, as well as its evaluation periodically during its life cycle. The proposed coverage regulation would expand HCFA’s authority to use these measures.

Conditional or interim coverage decisions could take several forms. For example, they could limit coverage to specific indications for which the interventions have proven to be effective. In
addition, Medicare could cover certain procedures only in facilities meeting certain standards that may be crucial to the effectiveness of the procedure. This is similar to the approach taken by Medicare in covering heart and liver transplants in its “centers of excellence” program.

Interim coverage could also facilitate the evaluation of important new technologies by requiring providers and beneficiaries to participate in ongoing studies of that technologies’ effectiveness. This could be implemented through a federal initiative -- under the auspices of HCFA, NIH, or AHCPR -- to require a provider of an untested service to report data in a standard format on costs and outcomes. The appropriate agency must be responsible for data collection and coordination. This type of study would help Medicare learn about the usefulness of the new technology under clinical conditions prior to widespread diffusion, while giving beneficiaries access to the technology (PPRC).

Thus, the College urges HCFA to use cost effectiveness as an explicit criteria in coverage decisions, and increase its usage of conditional and interim coverage decisions when appropriate.

Reimbursement and Pricing Policy

**Medicare should adopt more flexible pricing policies that cover the cost of the efficient use of technologies and provide incentives for the efficient use of resources.**

A market oriented health care system relies on economic incentives to influence the supply and utilization of new technologies. If reimbursements are low, physicians will be slower to buy equipment or perform procedures than if reimbursements are high. One rationale behind the Medicare prospective payment system for hospitals and the fee schedule for physicians was to provide incentives to providers to use medical technology more cost effectively (Gelijns and Rosenberg).

Next year, HCFA plans to revise the practice expense component of the Resource-Based Relative Value Scale (RBRVS) which is used to set Medicare physician fees. Up until now the practice component has been based on historical charges, an unknown percent of which is capital costs. HCFA is currently developing resource-based practice expenses that will take into account the costs of labor, supplies, equipment and overhead.

On average, capital costs account for about five percent of physician practice costs, even though it can be much higher for certain specialties (Health Care Financing Administration). Many analysts have said the value for this component should be based on the costs incurred by high-volume, efficient providers (GAO). This would discourage physicians from purchasing equipment if their patient mix did not justify using the equipment often enough to recoup expenses. Others have noted, however, that once purchased, the physician has an incentive to use equipment as often as can be justified (Hillman).

In general, HCFA needs greater flexibility to modify its pricing decisions (GAO). Reimbursements for MRIs initially were set so high that even providers who did not use the machines very often could still make a profit (GAO). The payments were finally reduced by legislation rather than
HCFA action (GAO). This pricing flexibility should also apply to all components of the Medicare fee schedule. Other proposals discussed elsewhere in this paper (bundling, competitive bidding, etc.) would also influence the proliferation of new technologies since they encourage providers to consider the efficient allocation of resources.

Consequently, since financial incentives play a crucial role in the use of technology, the ACP urges HCFA to modify its reimbursement and pricing methodologies to provide incentives for cost effective use.

IV. Improving Medicare's Managed Care Program

More and more Medicare beneficiaries are enrolling in managed care plans. As of March, 1996, over 4 million beneficiaries were enrolled in a risk or cost-reimbursed HMO (Health Care Financing Administration). During the three years ending in April 1996, the number of health plans with Medicare risk contracts increased from 93 to 202 (Fox, Fama). In addition, in the last four years, enrollment in Medicare risk plans doubled (Wilensky, 4/30/96). This trend is caused by the confluence of market forces and government policy (American College of Physicians). As federal policy makers grapple with reform of the program, it is essential that they enact provisions that will fulfill the promise of managed care -- to provide high quality and cost effective care.

Assuring Quality

Federal Quality Standards

Federal quality standards should be developed to ensure that Medicare beneficiaries receive high quality care in managed care environments. These standards should guarantee that health plans adopt policies and procedures specifically designed for the elderly, and require health plans to disclose all relevant information to beneficiaries regarding access to care, cost sharing requirements and other issues.

Many experts argue that Medicare beneficiaries could benefit from managed care (American College of Physicians). Because of their often complex conditions, a system structured to provide coordinated care and case management could provide this population cost-effective and appropriate care. In addition, managed care's traditional focus on preventive care would provide the elderly with services that might prevent hospitalizations or the development of more serious conditions (Fox, Fama).

In contrast, some observers have noted that, as with the under-65 population, the growth of managed care for Medicare beneficiaries could mean a reduction in the quality of care received by patients (Clancy, Brody). Given the historical problem with some HMOs (Pitlick), as well as the incentives within managed care to limit access to services (Hillman, Pauly, Kirstein), they say, the spread of managed care raises concern about whether older Americans will continue to receive high quality care.
On balance, research data supports the contention that quality of care in managed care environments is comparable to fee-for-service. For example, the evaluation of the Medicare Risk Program for HMOs performed for the Department of Health and Human Services concluded that "for the most part, Medicare HMOs appear to deliver care that is neither better nor worse than that rendered in [fee-for-service], either for hospital or ambulatory care." (Mathematica). This finding is consistent with earlier research that found little or no evidence that the quality of care -- either defined as health outcomes or access to care -- for HMO enrollees or fee-for-service patients differed noticeably (Brown, Bergeron, Clement, Hill, Retchin). On the other hand, a recent study found that elderly patients treated by HMOs had worse physical health outcomes as measured by perceptions of health status, than those treated by fee-for-service doctors (Ware, Bayliss, Rogers, Kosinski, Tarlov).

Medicare HMOs also generally receive high scores on patient satisfaction. Specifically, Medicare HMO enrollees have expressed greater satisfaction than their fee-for-service counterparts with their out-of-pocket expenses (Clement, Retchin, Brown). Moreover, in a survey of Medicare beneficiaries, the great majority of enrollees in Medicare risk HMOs believed they got the Medicare services they needed (DHHS/OIG Report). However, other studies have shown that although overall satisfaction with services was high, on certain aspects of the quality of care they receive, patient satisfaction is somewhat less for Medicare enrollees in HMOs than for those in fee-for-service.(Clement, Retchin, Brown)

Thus, the literature published to date indicates that, in general, the elderly will not face an inherent quality problem simply by enrolling in a managed care plan. However, some quality problems have been identified. For example, a recent survey of Medicare beneficiaries found that many Medicare risk HMOs were out of compliance with certain federal quality standards (DHHS/OIG).

In addition, existing quality assurance mechanisms designed to protect Medicare beneficiaries may be flawed. A recent government report found that HCFA's process for monitoring and enforcing quality standards is limited (US General Accounting Office).

Another potential problem could be that as managed care plans flourish in the Medicare market, more of their enrollees will be newcomers to managed care. Since Medicare beneficiaries currently enrolled in managed care plans are healthier, perceive their health status as better and are less likely to use health care services when they are sick than non-enrollees, (Brown, Bergeron, Clement, Hill, Retchin) it is also likely that these new enrollees will be older and sicker.

In October of 1995 the College issued recommendations, developed by the ACP Task Force on Aging, designed to ensure that Medicare beneficiaries receive high quality care in managed care environments. Although they addressed delivery system structure and performance measurement issues, the gist of these recommendations was that federal quality standards are needed to ensure that beneficiaries in managed care settings receive high quality care (American College of Physicians). The College reiterates its recommendation that managed care organizations serving Medicare beneficiaries be required to adopt policies and procedures specifically designed for that population, to ensure that they receive high quality care (American College of Physicians). Since older patients have different problems and health needs than the rest of the population, health
plans that contract to care for them, must take necessary steps. This need is compounded because many Medicare beneficiaries have little experience with managed care, and many managed care plans have little experience caring for the elderly (Health Care Financing Administration).

In addition, since an increasing number of Medicare beneficiaries will have the option of enrolling in one or more managed care plans, it is essential that they be given all necessary information about the quality of the plan(s) prior to enrollment. A recent Institute of Medicine report found that many of the 70,000 Medicare beneficiaries who enroll in managed care plans each month do not have enough information to choose the best plan or to understand their coverage after they have enrolled (Improving the Medicare Market: Adding Choice and Protections, Institute of Medicine). The report recommended that a consumer-oriented information infrastructure for Medicare beneficiaries be developed at the national, state, and local levels to provide information and track complaints, grievances, and appeals (Institute of Medicine).

The College envisions a scenario where a Medicare beneficiary has the option to stay in fee-for-service, or enroll in one of several alternative managed care plans. It is essential that this individual has access to information about the quality of a plan when making this decision. Thus, health plans must disclose all necessary information to enable an informed choice, including information about access to care (including availability of specialists and out of network providers), benefits, and cost sharing requirements. A plan should also disclose whether it provides participating providers with any financial incentives.

Specific Performance Measures

Enrollees should have access to performance measures that rate the quality of care provided by the plan on issues specific to Medicare beneficiaries, such as functional status or treatment of chronic conditions.

A variety of organizations have developed measures to judge the quality of care provided by a health plan. Unfortunately, most of these measures are designed for the under-65 year old population, rather than Medicare beneficiaries. As a result, the College reiterates its call for the development and use of specific indicators that measure the quality of care provided to the elderly. These measures should, for example, monitor whether elderly enrollees receive appropriate continuity and coordination of care (American College of Physicians).

There is evidence that this is beginning to occur. According to a draft version of the latest iteration of the Health Plan Employer Data and Information Set (HEDIS 3.0), this widely used measurement tool has been modified in several ways to measure care received by Medicare beneficiaries (National Committee for Quality Assurance). For example, since participating health plans will be required to collect and report quality of care information for Medicare beneficiaries enrolled in their plan, HEDIS 3.0 integrates measuring the quality of care for Medicare beneficiaries with commercial enrollees.

In addition, HEDIS 3.0 requires health plans to measure the functional status of older adults as well as measures plans' success in providing certain preventive care to them (National Committee
for Quality Assurance). Inclusion in HEDIS is significant because it is used by over 300 health plans nationwide and forms the basis of many employer "report cards" (National Committee for Quality Assurance).

Gag Rules

"Gag rules" or other actions designed to improperly intrude on the doctor-patient relationship should be prohibited.

Some health plans have prevented physicians from communicating effectively with their patients (Woolhandler, Himmelstein). By including so-called "gag clauses" in their physician contracts, these health plans have unjustifiably intruded on the physician-patient relationship. Although they exist in many forms, these provisions typically prevent physicians from discussing certain treatment options with their patients, particularly those options not covered by the plan. For example, according to The New York Times, the Kaiser Permanente HMO in Ohio issued a directive to its physicians requiring an authorization from an outside company, Health Risk Management (H.R.M.), for certain procedures. The directive, since rescinded, said "Do not discuss proposed treatment with Kaiser Permanente members prior to receiving authorization. Do not discuss the H.R.M. process with members. Do not give out H.R.M. phone number to members." (Pear, The New York Times).

Legislation was introduced during the 104th Congress that would render gag clauses illegal and prohibit plans from contractually interfering with "medical communications" between physicians and patients (HR 2976). Given the necessity of a full and frank discussion about treatment options between a physician and patient, the ACP recommends that legislation outlawing gag clauses be enacted.

Provider-Sponsored Organizations

Legislation should be enacted that authorizes HCFA to contract directly with provider-sponsored organizations (PSOs) to provide Medicare beneficiaries with the Medicare benefits package for a capitated payment.

Over the past few years, the College has supported legislation that would authorize HCFA to contract directly with provider sponsored organizations (PSOs) to care for Medicare beneficiaries (American College of Physicians). With physicians and other health providers governing the decisions of the organization, PSOs not only hold the promise of providing high quality care, but also providing Medicare beneficiaries with the same delivery system choices available to the under-65 population.

While the exact size and structure of the PSO could vary, to be an eligible contractee the PSO would be paid on a capitation basis and be "financially at risk" to provide the Medicare benefits package. Essentially, it would function as a Medicare-risk plan, without the super-structure of an HMO. Advocates of PSOs argue that by removing the insurer, PSOs will be more cost effective because they will save some of the costs associated with plan administration, and will provide
higher quality care because physicians will have more control over medical decision-making (American Medical Association).

Although Medicare risk plans have been available to Medicare beneficiaries for several years, HCFA has argued that current law does not allow the creation of provider sponsored organizations (Health Care Financing Administration). To remedy this problem, the Medicare legislation passed by the last Congress allowed PSOs to directly contract with HCFA to accept a capitation payment and care for Medicare beneficiaries (HR 2491).

Although the Clinton Administration expressed support for this provision, the legislation became the focus of a budget battle between the President and Republican Congressional leaders, and was eventually vetoed. Thus, when the Congress debates Medicare legislation next year, the College recommends that HCFA be granted the authority to contract with PSOs.

Revising the Payment Rate for Medicare HMOs

HCFA should evaluate different approaches to fix the payment methodology. Competitive bidding, adding new risk stratefiers, and establishing multi-county rates and payment thresholds all have the potential to improve the current system. In addition, payments for graduate medical education should be recaptured.

The payment method for reimbursing Medicare risk HMOs needs reform (Newhouse). Analysts have noted a number of flaws including: wide geographic variation in payments, volatility over time, inclusion of medical education and disproportionate share hospital payments that may not reflect use of these providers by plans, and limits on Medicare’s ability to recapture cost savings achieved by participating health plans (Wilensky). In addition, the payment methodology does not adequately adjust capitation payments to better reflect variations in beneficiaries’ likely need for medical care (Newhouse).

These shortcomings affect beneficiaries’ access to managed care delivery systems and reduce the potential cost effectiveness of the Medicare risk program (Kilborn, The New York Times). Consequently, improving the payment method will stimulate greater HMO participation and achieve more acceptable per capita costs for Medicare (PPRC 1995). This, in turn, has the potential to increase beneficiaries’ choice of health plans while controlling Medicare spending (PPRC 1996).

Under federal law, HCFA establishes Medicare capitation payment rates each year based on an estimate of local fee-for-service adjusted average per capita costs (AAPCC). The capitation payment to the HMO for a Medicare beneficiary who lives in a given county equals 95% of the average amount that HCFA would expect to spend in fee-for-service reimbursements for a Medicare beneficiary who resides in that county, adjusted for age, sex, institutional status, and Medicaid eligibility (Mathematica).

Each year, a participating plan is required to compare its expected Medicare revenue with an estimate of what it would receive for providing coverage of Medicare-covered services under
commercial rates. If a plan's expected Medicare revenue exceeds this amount, it must return the surplus to Medicare or spend it by providing additional supplemental benefits to Medicare enrollees (PPRC 1996).

Rate Variation and Volatility

One of the problems with the current AAPCC payment methodology is the variation and volatility in rates paid to HMOs across the country. This disparity is not caused by geographic variation in HMOs' costs of providing medical care (Schmid). Rather, the link to local fee-for-service spending leads to the variation in rates (US General Accounting Office). Specifically, since the discrepancy in fee-for-service payments across the country is large (Dartmouth Atlas), the variation in HMO payments, which is based on these payments, is also large. According to the PPRC, the variation reflects local differences in provider input prices (i.e. costs of wages and supplies) and per capita service use patterns in Medicare's fee-for-service program (Wilensky).

The variation in rates across the country is huge. One analysis found that in 1995, rates ranged from $177 per month to $679 per month (PPRC 1996). Another showed that an HMO is paid 27% less for serving a beneficiary living in Montgomery County, Maryland, than for serving an otherwise identical beneficiary living in neighboring Prince George's County, Maryland, even if the two individuals are treated by the same doctor. Consequently, in some areas payment rates are too low to induce HMO participation in the program, while in others, payments are too high for Medicare to achieve savings that could come from capitation (US General Accounting Office).

Volatility results from fluctuations in service use patterns, and tends to be larger for areas with small Medicare populations (Wilensky). Volatility in rates means that health plans cannot easily predict their revenue, making it less likely that an HMO will enter and succeed in a given market. A PPRC analysis found that the levels of AAPCC-based rates and their volatility over time have influenced Medicare risk-plan enrollment rates (PPRC 1996). In another study, HMO executives were interviewed and said that the disparities in payment across counties within a metropolitan area, and the wide fluctuations from year to year in rates make the financial performance of risk plans unstable (Mathematica). Consequently, the volatility of payment rates also diminish HMO participation.

Cost Savings Not Realized

In addition, it has been noted that under the Medicare risk program, HCFA spends more money paying for services for enrollees in managed care plans than it would have had these beneficiaries been in fee-for-service (Vladeck). By design, the risk program should lower costs to HCFA by 5% relative to what would have been paid under fee-for-service since HMOs are only paid 95% of the AAPCC. However, studies have shown that that there is a tremendous amount of favorable selection in Medicare HMOs. That is, HMO enrollees are healthier and have lower costs than those in fee-for-service even when adjusted by broad risk categories (Retchin, Clement, Rossiter, Brown, Nelson).
Consequently, even though an HMO’s costs to care for enrollees is lower than HCFA would have spent on fee-for-service care for them, the Medicare program does not achieve these savings. In fact, an evaluation of the Medicare risk program found that HCFA paid HMOs about 5.7% more than it would have spent had those enrollees been in fee-for-service (Mathematica). Thus, although managed care has the potential to save money for Medicare, it is not realized since the program’s payment rate is set by formula and not related to an HMO’s actual resource use (Mathematica). Moreover, despite the ability to negotiate discounts with hospitals and other providers, Medicare HMOs do not pass those savings back to the program (Freudenheim, The New York Times).

**Risk Adjustment**

Many observers have noted that the existing system for reimbursing Medicare risk plans does not adequately modify HMO payments for expected variations in medical costs of enrollees (Wilensky). This flaw in the payment methodology leads to unwarranted financial rewards and penalties to plans, and provides incentives to avoid Medicare enrollees with chronic illness (Newhouse).

Risk adjustment can reduce the financial risk to HMOs of participating in Medicare. In addition, adopting better risk adjustment methods will help to reduce HMOs’ incentives to enroll relatively healthy Medicare beneficiaries. This will encourage health plans to compete on the quality and efficiency of their care, rather than through favorable selection (Ellis, Pope, et. al.).

Consequently, the ACP urges HCFA to research, develop, and test new risk adjustment methods. Researchers have noted that a good risk adjuster should meet certain operational criteria. Specifically, it should: be inexpensive to administer; reduce favorable selection; create incentives for HMOs to provide appropriate care; and not be subject to manipulation (GAO report). While no method developed meets all criteria, there are some ideas that hold promise (Ellis, Pope, et. al.).

**Inclusion of medical education payments**

Moreover, the ACP has previously called attention to the inclusion of a medical education payment in the AAPCC (American College of Physicians). While a payment for graduate medical education expenses is a logical part of the fee-for-service structure, these monies represent an overpayment to many health plans since they do not support medical education programs. New pricing schemes, such as competitive bidding, that de-link capitation rates from fee-for-service would eliminate this overpayment. Until that is achieved, however, the College reiterates its recommendation that this portion of the AAPCC be re-captured and used in Medicare’s graduate medical education programs.

**Possible Solutions**
HCFA should evaluate different approaches to fix the payment methodology. Competitive bidding, adding new risk stratifiers, establishing multi-county rates and payment thresholds all have the potential to improve the current system.

Some commentators have suggested a completely new method of payment for Medicare risk HMOs -- competitive bidding (PPRC 1995). According to its advocates, competitive bidding is superior to the existing system because it uncouples Medicare HMO payment rates from fee-for-service expenditures, and allows them to reflect the costs for an efficient HMO (PPRC 1995). In addition, it could encourage price competition among HMOs and thereby use market forces to restrain program costs (US General Accounting Office).

Although it could take many forms, a competitive bidding process requires HMOs to submit bids to provide Medicare benefits. Low bidders would be awarded the contract, while high bidders would face a penalty -- either exclusion or a financial penalty such as requiring enrollees to pay the added costs.

Competitive pricing is used extensively in managed care markets, and is becoming more popular for public programs. For example, Arizona currently uses this method to contract with HMOs to provide services to its indigent citizens (PPRC 1995). A recent study concluded that, compared with traditional Medicaid programs (mostly fee-for-service), Arizona achieved significant cost savings (US General Accounting Office).

Recognizing the potential for this process, HCFA has launched a demonstration project to test the feasibility of competitive pricing. Under this program, to be implemented in Baltimore, Maryland, Medicare’s payment rate will be based on bids submitted by all Medicare managed care plans in the demonstration site. Plans would bid on a “community standard” benefit package, representing the most common plan offered in the area. The rate derived from the bids will replace the current AAPCC rate (Vladeck).

Competitive pricing holds promise. It offers a market-based approach to generating a fair payment rate for HMOs that care for Medicare beneficiaries, and could reduce the rate variation and volatility endemic to the existing system. Nonetheless, there are important issues to monitor as the demonstration project goes forward. For example, it is unclear whether this program could ever be implemented in areas without active price competition among competitors. In addition, like any capitated payment, the rates paid under a competitive program must be risk adjusted. Moreover, if the process works and rates decrease, HMOs may no longer offer supplemental benefits at no additional costs to beneficiaries.

All these issues should be worked out through a series of demonstrations. The ACP urges HCFA to proceed with its efforts in Baltimore, and establish other programs elsewhere. Only by testing a variety of approaches and observing the effect on program costs and beneficiary care, can we find the proper approach.

While competitive pricing is being tested, however, it is imperative to fix the current payment scheme’s flaws. Since the potential efficiencies from managed care will not affect costs to HCFA
unless the payment mechanism is changed to reflect favorable selection, one option is to add an additional factor to the AAPCC rate structure. The Mathematica evaluation found that adding a history of cancer, heart disease or stroke, could eliminate the increased costs. By reducing the payment to plans with relatively healthy beneficiaries and encouraging more "neutral selection", this change would, according to one estimate, save Medicare 1.1% relative to fee-for-service costs (Mathematica).

Other changes should be implemented to reduce the variation and volatility in payment rates. The goal of any approach should be to provide payments to HMOs that are correlated with the cost of care in that plan's local market. Standardizing the rate paid within a given metropolitan area, or establishing multi-county rates are examples. Both of these approaches would make payment rates more closely correlated with local HMO markets, and would create areas with larger populations which would reduce the volatility of the AAPCC rates. In addition, establishing upper and lower payment thresholds have been found to reduce geographic variation in rates (PPRC 1996).

Conclusion

During its more than 30 years of existence, the Medicare program has been extraordinarily successful. It has provided America's elderly and disabled with access to health care and economic security. However, because of financial pressures and a changing health care delivery system, reform is inevitable.

In this paper, the College makes several recommendations for reforming the Medicare program. These recommendations address the financial condition of the program and, if implemented, will reduce program costs. At the same time, the ACP proposals will improve the quality of care Medicare beneficiaries receive.

Several models of care delivery have illustrated the value of coordinating a patient's care, and providing other support services not typically covered by Medicare. These models should be replicated, and other pilot projects testing similar concepts should be developed. Improving the coordination of care holds the promise of accomplishing several goals: improving care; containing program costs; and improving the satisfaction with the Medicare program among patients and physicians. Moreover, educational approaches to reduce variations in care, as well as technology assessment tools, will help ensure the appropriate use of services.

In addition, policy makers should adopt structural changes to Medicare's managed care and fee-for-service programs. These changes should address issues such as: quality assurance; program management; benefit package design; and payment for supplies and services. They hold the promise of making the program more efficient, while ensuring that beneficiaries have access to high quality care.

The changes recommended by the ACP will not solve all of Medicare's problems. However, by adopting these reforms, policy makers will help ensure that the Medicare program is cost
effective, provides beneficiaries with high quality care, and is adaptable to the modern health care delivery system.
References


Garber AM. Can Technology Assessment Control Health Spending? Health Affairs. Summer 1994; Vol 13, No 3, p. 116-126

Gelijns A and Rosenberg N. The Dynamics of Technological Change in Medicine. Health Affairs. Summer 1994; Vol 13, No 3, p. 29-46.


Health Care Financing Administration, “Profiles of Medicare”, May, 1996.


HealthCare Partners Medical Group, Policy Manual.


Hospice Association of America, “Information About Hospice”, 1996.

Jones, Stanley, and Etheredge, Lynn, “Paradigm Shifts in Medicare Reform”, April, 1996.


National Committee for Quality Assurance, “HEDIS 3.0 (draft)”, July 15, 1996.


Scott, John, “Presentation: Cooperative Health Care Clinic”.


Ware, JE, Bayliss, MS, Rogers, WH, Kosinski, M., Tarlov, AR, “Differences in 4-Year Health Outcomes for Elderly and Poor, Chronically Ill Patients Treated in HMO and Fee-For-Service Systems”, Journal of the American Medical Association, Vol. 276, October 2, 1996, p. 1039-47.

