

Getting Serious About Excessive Medicare Spending: A Purchasing Model

Opportunities for reducing excessive Medicare spending are everywhere.

by **Robert A. Berenson**

ABSTRACT: It is now well documented that Medicare spending varies widely across the country and that higher spending does not produce differences in quality, access, or even patient satisfaction. Yet for various reasons, policy analysts have tended to minimize the importance of the fact that as much as 30 percent of Medicare spending might be excessive and unnecessary. There is an imperative to transform the traditional Medicare program from that of a claims payer to that of a strategic purchaser, able to adopt a broad array of approaches and to use a comprehensive set of tools used by private plans, but in a more transparent and accountable way.

IN A REMARKABLE SERIES OF STUDIES extending over two decades, John Wennberg and his colleagues have explored geographic variation in use, costs, and quality of health care in the United States. They recently found not only that per capita spending is much higher in some regions, but also that the increased local spending produces no apparent difference in quality, access, or even patient satisfaction.¹

The potential savings gleaned from reducing excessive spending on services of little or no value, estimated to be as much as 30 percent of current spending levels, would itself pay for a generous Medicare prescription drug benefit.² Obviously, the political system would not permit a seamless transfer of program savings into benefit expansions. Nevertheless, under either Republican or Democratic visions of Medicare's future, prompt attention must be devoted to excessive spending. Under a system where private plans are induced to compete with the traditional Medicare program, the Republican approach, traditional Medicare should be enabled to address excessive spending, to be a more effective competitor.³ Under continuation of a dominant traditional Medicare program in a defined-benefit program, the Democratic approach, aggressively addressing overspending would

Bob Berenson, rberenso@ui.urban.org, is a senior fellow at the Urban Institute in Washington, DC. He was director of the Center for Health Plans and Providers and acting deputy administrator of HCFA (now the Centers for Medicare and Medicaid Services) during 1998–2001.

solidify the program's financial underpinnings, relieving the pressure for new financing, restricted eligibility, and reduced benefits. It is important to note that the recently enacted Medicare prescription drug legislation uses county-level expenditures in traditional Medicare as the basis for overpaying private health plans, thereby effectively assuring the continuation of geographically based overspending.

That the Medicare program tolerates much geographic spending variation has been a policy reality for many years, but one that has never been tackled head on. It has, however, provided a rationale for promotion of private health plans in Medicare—that is, that private “regulators” can accomplish in cost containment what the publicly accountable, politically constrained Medicare program cannot. This rationale seems to be based on a view that excessive spending is inevitable in traditional Medicare. A main purpose of this paper is to challenge that widespread assumption.

In this paper I first review the common critiques of the implications of the Wennberg data, which together produce pervasive policy nihilism. Next, I argue that seeking a “big idea” solution to the problem of geographic spending variations is fanciful and impractical, whereas opportunities for reducing excessive spending in Medicare are everywhere, although the Centers for Medicare and Medicaid Services (CMS) lacks the authority, resources, and political standing to act on many of the opportunities. After discussing strategic considerations, I present a strategic purchasing model that addresses the problems of both regional spending variations and overspending in the program overall.

Policy Critiques Of The Wennberg Data

■ **The critiques.** In recent years three kinds of dismissive critiques of findings on geographic spending variations have emerged. The first acknowledges that there is inappropriate spending but asserts that there is no practical way to separate out appropriate care from inappropriate operationally, and so there is nothing to be done.⁴ The second critique is that the traditional program is incapable of addressing spending variations. The first variant of this position is that traditional Medicare is stuck using only “Soviet-style price controls” and thus is incapable of addressing excessive spending. Another variant presents the realpolitik view that the traditional program could deal effectively with spending but for a variety of legal, political, and practical reasons will never be allowed to do so.⁵ Finally, there are those who argue, from an abundance of caution, that the regional variations probably do represent inefficiency and, perhaps, inequity, but until we know precisely how any particular intervention to reduce excessive regional spending would play out, we should not go there. For example, the Wennberg team itself rejects regional budgetary caps for overall or sector spending: “Physicians practicing conservative medicine in high-intensity areas would be punished the most.”⁶

■ **The responses.** Taking the appropriateness issue first, the group's recent

work has gone a long way toward resolving this concern. The findings demonstrate that geographic spending differences do not occur among “effective services” or “preference-sensitive services” but rather are confined to “supply-sensitive services,” which do not represent necessary medical care.⁷ So something can be done, without compromising appropriate care.

Further, many potentially effective approaches to reducing excessive spending do not actually require a determination of whether particular services are, in fact, appropriate. To illustrate the point, the recent use of imaging for the presence of coronary calcification has produced a plague of “incidental” but possibly important findings of tiny lung nodules of uncertain clinical significance. Cautious radiologists are recommending repeated follow-up imaging studies to see if they are growing as a tumor would. A recent radiology report I reviewed concluded, “There is a 2.5 mm nodule in the right lung...Recommend follow-up CTs at 3 months, 6 months, 9 months, one year, and then 2 years.”

Ideally, clinical research would produce evidence-based guidelines that would modify these expansive clinical recommendations and could become the basis for a Medicare coverage policy on use of CT scans for tracking abnormal tiny lung nodules. Until then, payment policy might be able to modify unit payment, without having to make a judgment about whether the radiologist’s proposed recommendations are clinically appropriate. Rather, administrative prices could move from paying average costs toward paying marginal costs as volume increases.

Regarding the various forms of the critique that traditional Medicare is not capable or permitted to do the job, thoughtful commentators tend to propose major, all-purpose “magic bullet” solutions and then despair over the difficulty inherent in their implementation. Thus, some recommend professional leadership leading to voluntary adherence to evidence-based guidelines or development of national benchmarks for acceptable practice patterns with examination of deviations.⁸

The Wennberg team itself calls for the development of complex new delivery-system structures to restrain costs by establishing Comprehensive Centers for Medical Excellence (CCMEs), which would be collaborations among competing providers in an untested governance structure.⁹ In effect, proponents of addressing excessive regional spending tend to express concern that many ambitious solutions to the problem represent “blunt tools” that would have untoward side effects but then go on to recommend idealized and untested approaches that face major organizational and political hurdles.

The policy community accepts with remarkable equanimity that many Medicare beneficiaries receive poor-quality care, which reflects the relatively poor quality of care in the U.S. health system and demonstrates sizable regional variations.¹⁰ In contrast, on the issue of excessive spending, there is an apparent overabundance of caution about not causing any harm to quality or access. The result is policy nihilism, where the problem of excessive regional spending gets better defined, but nothing is done about it.

Opportunities For Reducing Excessive Spending

The broad set of findings presented in Wennberg and colleagues' *Dartmouth Atlas* data show that differences occur in all service lines and across the spectrum of clinical problems, from rates of minor procedures and elective surgery to care for the dying. The potential to find targets of opportunity to reduce excessive spending are almost boundless.

Take the case of home health spending, which overall represents about 4 percent of Medicare spending but varies remarkably by region.¹¹ The 1998 *Dartmouth Atlas*, presenting 1995 Medicare spending data, showed that the national average, input price-adjusted reimbursement for home health services was \$495. But the average in the Baton Rouge, Louisiana, service area was \$1,948 and in the McAllen, Texas, area, \$2,380.¹² These excessive payments persisted for years until such extravagance reached a political choking point.

Through a series of concerted activities under the CMS's existing authority, including Balanced Budget Act (BBA) reductions in payments, 3,500 agencies either merged, withdrew from Medicare, or closed. Home health spending declined a cumulative 34 percent between 1997 and 2000, certainly producing major decreases in many high-cost areas.¹³

For decades there has been an ongoing debate about whether policy activity to constrain costs should be directed at relatively few "big-ticket" items or, rather, to millions of "small-ticket" items that cumulatively account for a lot of spending.¹⁴ The current vogue in commercial plans, now being recommended by some for Medicare, is to concentrate cost containment on the small number of beneficiaries who are responsible for disproportionately high spending. In Medicare, 5 percent of beneficiaries account for 50 percent of program spending.¹⁵

One problem with focusing just on high-cost patients is that they do not necessarily have big-ticket expenses. For example, much of the spending for the high-cost cohort of Medicare beneficiaries who have fatal diseases is associated with small-ticket items—such as specialty visits, intensive care unit (ICU) days, medical tests, and imaging services.¹⁶ Moreover, providers do not maintain different financial accounts for "high-cost" patients and "low-cost" patients and might not distinguish the different cohorts clinically. Thus, in considering how to use payment policy to reduce costs, a division between high-cost beneficiaries and the rest would not be practical.

Strategic Considerations

Political opposition will surely arise against any concerted effort by the CMS to administer a comprehensive, cost-constraining purchasing approach. Indeed, adopting a broad array of activities might coalesce providers' opposition. Bruce Vladeck has characterized Medicare's political nature as providing "a de facto political entitlement to providers."¹⁷ That reality would need to be confronted.

It is also true that Medicare faces a number of structural, financial, and other

“The most important spending-reduction tool that the CMS might have is its ‘bread and butter’: basic payment policy.”

.....

barriers in trying to move decisively to increase the value of the services provided. The CMS confronts inadequate resources, congressional micromanagement, antiquated information systems, and restricted contracting authority.¹⁸ There are also general concerns about Medicare’s exercise of market power and the requirements of the Administrative Procedures Act (APA) that limit agency discretion and create a lengthy decision-making process.¹⁹ Little discussed is the division of the Medicare budget between “mandatory” dollars to pay for services and “discretionary” dollars to pay for administration. In short, in many situations the CMS cannot spend \$1 million to save \$10 million.

In addition, many of the tools for reducing costs that offer promise in Medicare, some pioneered in managed care, have gotten bad reputations and correctly would be opposed by beneficiaries and health professionals if executed in the manner that many managed care organizations have done. For example, there are good reasons to perform prior authorization instead of relying on after-the-fact review of cases for appropriateness.²⁰ Importantly, prior authorization removes the need to try to deny payment after resources have been committed. However, prior authorization in managed care suffered from poor execution, became viewed as highly intrusive, and is being abandoned by many commercial insurers.²¹ What went wrong? Certainly, some of the problem was related to blind adherence to fragments of evidence of appropriateness, such as those that led to “drive-through deliveries,” thereby aligning the interests of consumers with those of providers.

Another major execution problem resulted from the assumption of health plan managers and benefit consultants that if some prior authorization is good, more must be better. As a result, prior authorization requirements became commonly applied not only to high-cost, relatively rare events, such as particular elective hospitalizations, but also to routine ambulatory care encounters, dramatically raising administrative costs and the amount of intrusion into the clinical practice and the doctor-patient relationship. Similarly, this particular cost-reducing tool was not targeted to problem providers, based on profiling, but rather applied broadly, thereby arousing the ire and opposition of potential physician allies in addressing unnecessary and excessive spending.

In Medicare, prior authorization would have to be developed in a transparent process, in accordance with the APA and based on professionally considered, evidence-based guidelines, in a way that would also take into account cultural values, individual patients’ preferences, and administrative feasibility. As a tool that does address the issue of appropriateness, prior authorization in Medicare should be considered, even if just for high-cost geographic areas, for elective procedures and services that have a high unit cost, are relatively infrequent, and rely on clini-

cal judgment based on objective clinical information, among other criteria.²²

Despite these rigorous criteria, there are, in fact, a number of very high-cost procedures that would meet these criteria.²³ The obligations in Medicare for transparency and fair process do not compromise the appropriate use of this managed care tool but, rather, might lead to better processes and greater acceptance among providers and beneficiaries.

A similar argument could be made for the use of what should not be called “gatekeepers.” Instead of requiring all beneficiaries to select or be assigned to a primary care physician who then must approve all referrals, as many health maintenance organizations (HMOs) used to do and many European countries do now, Medicare could put into place a voluntary care manager program initially offered only to beneficiaries with multiple, interacting chronic conditions.²⁴ Many beneficiaries would prefer dignity and caring that might be fostered by a care coordinator over the intensive care from ICUs and specialists that they are receiving from an assortment of independent specialists.²⁵

Finally, it is important to emphasize that the most important spending-reduction tool that the CMS might have is its “bread and butter”: basic payment policy. Although a strategic purchaser would certainly target high-cost regions for careful evaluation and possible intervention, the incentives in basic payment policy drive much of the behavior that becomes manifest in regional spending variations.

This is not rocket science. When Medicare pays relatively more generously for surgical diagnosis-related groups (DRGs) than for medical DRGs in relation to underlying costs, the delivery system responds by producing more surgical services. For example, for one medium-size hospital, payment for cardiac procedures, most performed on Medicare patients, provided the hospital’s entire 2.5 percent margin.²⁶ When Medicare pays generously for cardiac procedures and provides a specific “whole hospital” exemption from Stark self-referral restrictions, the delivery system responds, at least in a number of communities, with specialized cardiac hospitals and, with their development, the associated problems of increased capacity and potential for induced demand.²⁷

A Strategic Purchasing Model For Medicare

Some solutions to excessive regional spending fall under the traditional purview of Medicare administration, as demonstrated in the concerted effort to gain control over home health spending. Still, some assert that a “Soviet-style, fee-for-service program” is inherently incapable of becoming a purchaser that can move health care delivery systems in ways that improve quality and efficiency.

However, some European social health insurance systems are moving from paying claims to purchasing care. In the past, social health insurers might have shown interest in the total amount of spending and the boundaries of the benefit packages they fund but generally took a passive role in trying to influence the nature of the care they finance.²⁸ As in Medicare, many of these social health insurance sys-

tems have inherited traditions of deferring to professional and other provider interests, with countries such as Germany formally deferring to “self-regulation among providers.”²⁹ However, in recent years there has been increased attention to the performance of health systems, to fairness not only in financing and costliness but also in system responsiveness and population health.³⁰ These broader considerations have spawned interest in development of models of strategic purchasing and specific purchasing approaches.

■ **Identifying the problem.** Obviously, a core activity in strategic purchasing is problem identification, which for large systems must be grounded in routine data collection and analysis. Routinely collected administrative data can provide important information pointing to the need for intervention if one looks. For example, the 1998 *Dartmouth Atlas* showed that Redding, California, had by far the highest rate of coronary artery bypass graft (CABG) surgery in the country. Only in 2002 was it revealed that physicians at the Tenet Hospital in Redding were recommending and performing unnecessary cardiac surgery.³¹

Administrative data are sufficient for some strategic purchasing interventions, such as recalibrating DRG payment rates. However, to provide a focus on particular high-cost geographic areas for specific interventions would also involve sending in review teams, with or without embedded journalists, to determine what is happening on the ground.

■ **Higher quality at acceptable cost.** For years there have been calls for Medicare to become what has variously been labeled a “value purchaser,” a “prudent purchaser,” or a “strategic purchaser,” but possibly because of providers’ resistance to even straightforward purchasing initiatives, such as competitive bidding for durable medical equipment (DME), the details of how Medicare might proceed have remained sketchy.³² Although some would separate purchasing for quality improvement from purchasing to manage costs, the model presented here considers the two concepts inevitably intertwined and inseparable. The objective should be purchasing higher quality at an acceptable cost.

■ **Choosing the tools.** The actual tools from which Medicare as a strategic purchaser would choose can be grouped into the following categories, although in execution many of the specific purchasing approaches would draw simultaneously from various categories. The categories, with an example for each, include the following: (1) provider eligibility requirements that govern who is allowed to receive Medicare payments (example: hospital Conditions of Participation, or COP); (2) benefit design (example: lower cost sharing for certain preventive services); (3) coverage policy (example: covering organ transplants in designated transplant centers); (4) payment policy (example: paying physicians based on estimates of resource costs of production, rather than charges or value); (5) technical assistance to providers to improve performance (example: Quality Improvement Organizations, or QIOs); (6) consumer information and education (example: National Beneficiary Education Program); (7) paying for performance (example: bonuses to Medicare+

Choice plans for achieving national standards for care for enrollees with congestive heart failure); (8) collaboration among purchasers to achieve common goals (example: active participation in the National Quality Forum); and (9) intervention directly in health care delivery, usually through contracting arrangements (example: disease management demonstrations). I consider each of these tools in turn.

Provider eligibility. In practical, political reality, it is very difficult to use COP requirements except as a way to protect the fundamental integrity of the program; that is, it is better at protecting the floor than raising the ceiling. As demonstrated with the home health example, some of the excessive regional spending is associated with paying providers that simply do not belong in the program.

Some ambitious proposals for improving the quality and efficiency of the program would raise the standards for provider eligibility. As such, using this tool represents a form of selective contracting, which in Medicare is not unprecedented; for example, not all medical centers are allowed to perform organ transplants on Medicare beneficiaries. Some would require hospital-based computer physician order entry (CPOE) systems as a COP. Others might require shared electronic medical records and commitments to use evidence-based guidelines or might emphasize commitments to shared decision making. If adopted broadly, these and any number of other desirable attributes of reformed clinical practice might well address aspects of excessive regional spending and improve quality.³³

The difficulties with aggressively applying COPs are numerous. Restricted provider entry could limit access for beneficiaries, although in areas of oversupply that might not be a major problem. There is concern about government's ability as a monopsony purchaser to distort prices and to have inordinate power to pick winners and losers. A related concern is that using entry barriers to exclude might lead to undesirable tiering; that is, those institutions and medical practices in better financial situations because of their locations and constituencies would be able to comply with the favored COPs of the day, while less-well-off institutions, perhaps safety-net providers, might be excluded.³⁴ Finally, there would be a direct political reaction from providers and suppliers, correctly concerned that restricted entry to Medicare could affect their financial well-being.

In practice, except for basic issues of program integrity, this tool generally would be used not to exclude particular providers and suppliers but, rather, to give preferred status to some, perhaps by allowing additional functions under COPs for which the provider could bill or providing exemptions from certain kinds of regulatory oversight.

The CABG demonstration is a good example of how preferred contracting might improve quality and reduce costs, and represents the use of a number of contracting tools in combination.³⁵ The demonstration cut program costs by an estimated 10 percent for 10,000 CABG surgeries, reduced expected mortality, and was well received by beneficiaries. It was also opposed by providers, some of whom have been able to forestall a planned follow-up demonstration.³⁶

“Coverage policy that permitted consideration of cost-effectiveness would be an important tool in reducing excessive regional spending.”

.....

Benefit design. Theoretically, one could require higher cost sharing in high-cost regions, perhaps in an attempt to influence demand for care, although beneficiaries or their sponsors are already spending more for supplemental insurance in these regions. But this approach raises equity concerns and would generate political opposition.

More achievable would be uniform, national policies that modify benefits based on the characteristics of Medicare beneficiaries, wherever they reside. For example, the 30 percent of beneficiaries who have four or more chronic conditions are responsible for almost 80 percent of program spending in any year. Those with five or more chronic conditions fill an average of forty-nine prescriptions, see fourteen different physicians, and are in the hospital more than seven days a year, but these amounts vary greatly by region.³⁷ To better identify patients at risk for costly complications, Medicare is well positioned to use the risk-adjustment tool developed to adjust payment to Medicare+Choice (M+C) plans to stratify the risk of individual beneficiaries and determine who might benefit from targeted additional benefits or services.

For better clinical and cost management of these patients, Medicare could establish a monthly care management payment for professionals to act as managers for patients who are most in need of care coordination. Physicians might get financial support for care coordination for their patients, who would be encouraged to seek care and any needed referrals through this designated physician. Or Medicare might capitate Part B professional services to organizations able to manage such risk and committed to following the core components of Edward Wagner’s chronic care model, including patient-centeredness, use of electronic medical record and decision supports, and multidisciplinary teams.³⁸

Coverage policy. For more than twenty-five years Medicare has tried to promulgate rules to implement the broad statutory directive to pay only for items and services that are “reasonable and necessary,” to clarify Medicare’s legal authority and to describe specific criteria for evaluation of new technology. Specifically, in 1989 and 2000 the CMS proposed rules that would have introduced basic cost into the mix of elements that help define reasonable and necessary care. Yet each time the medical device industry was able to produce *regula mortis*, or dead rule.³⁹ Coverage policy that permitted consideration of cost-effectiveness of alternative technologies would be an important tool in reducing excessive regional spending.⁴⁰

A current example of the need to control use of new technology is the CMS’s consideration of paying for implantable cardioverter defibrillators (ICDs), a treatment for life-threatening ventricular arrhythmias that costs Medicare nearly \$40,000 for the device, implantation, and immediate follow-up care.⁴¹ Recently, in

a controversial decision, the CMS expanded coverage of ICDs but not for the large population of patients who had suffered a heart attack and had had congestive heart failure but had not yet experienced serious arrhythmias.⁴²

For the most part, Medicare makes a cover or no-cover decision related to specific clinical conditions and then lets the health care delivery system and patients respond. That is, it makes no attempt to influence decision making on which patients would benefit from the technology in question—in this instance, the ICD.

Many patients who receive ICDs, unfortunately, are no longer permitted to die a relatively painless death from a cardiac arrhythmia but rather suffer much more from the clinical manifestations of other fatal diseases they may have.⁴³ Also, some patients with severe dementia or other overwhelming conditions might be better off without the ICD even when they meet the cardiac-related clinical criteria.

Although the CMS might consider restricting coverage to specified circumstances that take into consideration patients' comorbidities and social circumstances, such an approach would necessarily involve the interplay of various religious and cultural values. Setting up strict, evidence-based rules restricting coverage would be controversial and probably counterproductive. In this "life and death" situation, it would be preferable to rely on professionals to handle these difficult issues in a decentralized, patient-specific manner.⁴⁴ The CMS, as a strategic purchaser, possibly under the auspices of QIOs, could convene involved clinicians to try to encourage shared and informed decision making. At the same time, providing information and education to affected patients and families could help empower patients' preferences and control. Using traditional managed care-type tools, the CMS might mandate second opinions for this procedure or subject the procedure to prior authorization, with special attention given to assuring that truly informed consent had been obtained.

Another promising approach might be to emulate the form of selective contracting used with organ transplant centers—that is, to specify regional centers that would be designated as the only providers authorized to insert ICDs.⁴⁵ These centers would have to meet specified conditions of participation, including meeting high standards for obtaining informed consent.

The main point is that the CMS's role in approving and paying for new technology should extend well beyond the national or local coverage decision. The purchasing model provides a set of interventions that might appropriately influence how any approved technology was used. And in having this set of tools to apply, the basic coverage decision might actually be more generous.⁴⁶

Payment policy. One of the most important things Medicare should continuously do is assess and recalibrate prospective payment amounts to avoid distorting market decisions about capital expansion and clinical decision making—for example, creating excessive supply-sensitive services. Likely candidates for this kind of payment adjustment would be hospital-based, procedural DRGs. For example, after the volume threshold associated with better outcomes is achieved, for volumes

“The CMS has some experience in paying for performance but little statutory authority.”

.....

beyond a certain tolerance level, reimbursements might be reduced. Simply put, whether the volume of services is appropriate or not, at some point hospitals get too much if every payment is based on average cost. They have incentives to increase volume because most of the resultant income goes right to the bottom line.

Another use of payment policy to address excessive use and spending is the often mentioned and always rejected “areawide volume performance standard” for physician and other services. As noted above, the approach is criticized because it is a crude approach and because it would penalize the good guys. Yet under the current national system of limiting expenditure growth for physician services based on the sustainable growth rate formula, physicians in Oregon and Minnesota are already facing payment reductions because of the behavior of physicians in Miami and Manhattan.

If effective budgets that led to marginal payment reductions were regional, there would at least be the possibility of examining the organizational structures and cultural norms in regional delivery systems. On a local basis, cost-conscious physicians might have avenues through which to channel their unhappiness, perhaps in the kinds of local professional organizations that Wennberg envisions.

Given choices, the CMS is most likely to engage in more creative application of administered prices than other pricing approaches because these approaches are more amenable to formula setting and uniform application, attributes the agency values highly. Still, the agency should also promote other payment approaches, including competitive bidding and even negotiation.⁴⁷

Finally, one could envision that when the CMS, through administrative data and site-visit analysis of high-cost regions, understands the reasons for excessive spending, it might be allowed to modify in payment rates and specify terms and conditions on providers in these areas.

Technical assistance to providers. Most of the CMS’s technical assistance to providers is in the area of quality improvement, mostly accomplished through the QIO program. Another successful project has been a joint effort by the CMS, its eighteen end-stage renal disease (ESRD) networks, the Renal Physicians Association, and the National Kidney Foundation Dialysis Outcomes Quality Initiative to issue dialysis guidelines and otherwise help dialysis providers to improve patient care and outcomes.⁴⁸

The business case for quality—that improving quality improves financial margins—is a difficult one to make.⁴⁹ Nevertheless, much overuse and misuse, where many quality problems reside, represent wasted spending as well as poor quality. Also, some underuse represents failure to prevent more expensive, avoidable sequelae.

A strategic purchaser would not have to field a universal and balanced portfolio of quality-enhancing initiatives. QIOs, the ESRD networks, and other technical assistance activities initially might be targeted to poor quality that also produces excessive regional spending—for example, unwanted, supply-sensitive care in the latter stages of life for people with fatal chronic diseases. The ESRD experience showed that information and attention did improve the performance in dialysis, in ways that reduce both mortality and hospitalization rates.⁵⁰

Consumer information and education. Most now agree that providing information about performance to help patients make point-of-service provider selections and to help Medicare consumers choose among various health plan options is an important role for the CMS. Although many beneficiaries with good supplemental insurance might not directly face the cost consequences of their choices, high cost and high quality are not correlated. A better-informed patient population might, in fact, be open to receiving high-quality care from more efficient providers.

Although there is agreement on the goal, the technical difficulties of providing timely, valid, and useful information on performance have made it elusive.⁵¹ Nevertheless, outgoing CMS Administrator Tom Scully has reactivated agency efforts to publish information on performance of a number of provider types—initially nursing homes, home health agencies, and dialysis facilities—with the promise of hospital ratings soon to follow.⁵²

While work continues to improve the accuracy of clinical outcomes and patient satisfaction reporting, there is a potential opportunity to inform patients much more about providers than now occurs. The CMS could require provider institutions to answer questions about their commitment to and specific policies on shared decision making; on providing cultural and linguistically appropriate services; on their use of CPOE and alternative approaches to reducing medication errors; on their use of electronic medical records and patients' access to them; and on how they promote and follow patients' advance directives. In short, the CMS could collect and provide to beneficiaries useful information about organizations' policies, procedures, and commitments on topics beneficiaries should care about. If the Institute of Medicine (IOM) is correct, providers who “cross the quality chasm” are also more efficient and would help bring costs down.⁵³

Paying for performance. Paying for performance differs from current administrative pricing policy in that providers are paid differentially based on achieving specified performance targets rather than uniformly through a national formula. Although payment for performance generally has focused on bonuses for achieving targets of quality performance, as noted above, a strategic purchaser initially can preferentially select measures that also will reduce costs, such as performance on treatment of congestive heart failure, the leading cause of hospitalization in Medicare.

The CMS has some experience in paying for performance but little statutory authority. Recently, the CMS committed to a payment-for-performance demonstration with Premier Inc., providing up to 2 percent bonuses to hospitals that

“Medicare payment and related policies often establish the bases for the behavior that providers adopt in their markets.”

.....

score well on treatment of five common conditions.⁵⁴ Although paying for performance is now receiving attention as a new tool in private payer initiatives, Medicare might actually be better positioned than private plans to pay for performance.⁵⁵ Indeed, in a recent open letter published in *Health Affairs*, former CMS administrators and other prominent health care experts called for Medicare to lead paying-for-performance efforts.⁵⁶ In many markets, even the largest health plan may not provide enough market share for providers to seriously respond to well-intentioned payment incentives. In these situations, the engine of payment incentives—for example, to put people in the hospital—may be much more powerful than the caboose of modest bonuses for approaches that keep patients out of the hospital.

There are many design issues related to paying for performance. For example, should bonuses be based on national leadership, market-area leadership, or a provider's own improvement, or some combination?⁵⁷ This issue is complicated by the well-documented variations in quality by state and region.⁵⁸

Collaboration among private purchasers and Medicare. The work to date on collaboration among payers has been mostly in the quality improvement area, focused on gaining agreement on measurements that are meaningful to all payers and therefore can simplify the administrative burden on providers. Regarding cost, most private purchasers might naturally assume that heightened Medicare attention to cost containment, whether nationally or concentrated on high-cost areas, would simply result in the shifting of more costs to them.

Yet Medicare payment and related policies often establish the bases for the behavior that providers adopt in their markets, behavior that ultimately will help determine what private purchasers pay for health services. Thus, Medicare payment policy itself permits and rewards the development of cardiac hospitals in Indianapolis, and it will likely take an altered Medicare policy to reverse the trend.⁵⁹ And it is Medicare coverage policy itself that approves the use of positron emission tomography (PET) scans, which then are used in the health system by other payers and for clinical reasons beyond their original approved purpose.⁶⁰ Private payers face the cost consequences from this added system capacity, enabled by Medicare policies.

In short, there is a greater alignment of public and private payers' interests than is generally appreciated. At the very least, private purchasers should take greater advantage of their opportunity to participate in the public rule-making process to register their views on the direction of Medicare policy. When Medicare tries to change policy to address excessive spending, it needs allies from the employer community to counter the political strength of affected provider interests. Simi-

larly, Medicare tends to stay out of some policy issues, such as how provider market concentration affects market prices, because Medicare is protected through application of administered prices. Medicare and private purchasers should actively explore collaborative activities to pursue as both sectors try to contain costs and improve quality.

Intervention in the delivery system. In the end, despite its best efforts at education, modifying incentives, rewarding results, and so on, inertia may continue in high-cost communities because organizational structure, culture, and income expectations are not easy to change. After all, the basic incentives in the traditional Medicare system are to keep beds filled and services flowing. In such circumstances, the CMS should be permitted to intervene through contract with the private-sector programs used by private plans, such as disease management companies, to directly affect how services are delivered.

Another example of such an intervention would be the use of hospitalists. Now, in many parts of the country, partly to improve efficiency, transfer of care from the patient's personal physician to a full-time, hospital-based team of physicians has become the norm.⁶¹ Although Medicare generally is protected against excessive lengths-of-stay through paying by case rates, it remains vulnerable to unnecessary hospitalizations.

Traditional Medicare might contract with a hospitalist-type programs that provide board-certified specialists in the emergency department (ED), prior to admission, for common and serious problems such as chest pain and emphysema. With the patient's and private physician's concurrence, the hospitalist would take over the care in the ED and throughout the hospitalization if the patient is admitted, reducing both the number of hospitalizations and lengths-of-stay. With such a policy, Medicare would be intervening to add an important care option in the context of a difficult delivery system culture, just as private plans sometimes do.

The problems that might be addressed through intervention in service delivery can be identified by examining the particular dynamics of individual, high-cost regions. In all likelihood, private payers, facing similar cost problems, will have already stimulated approaches that the CMS could seek to emulate, generally through contractual relationships. The goal would be to offer alternative care approaches to beneficiaries in a voluntary, noncoercive manner.

Concluding Comments

Although it would be desirable to identify which purchasing tools could be adopted immediately and which need barriers to be removed, it is not that simple. For example, the Medicare statute permits examining the cost-effectiveness of new technology as part of the coverage process, but the CMS has not been able to promulgate rules that explicitly activate such a process. Yet some allege that the agency, nevertheless, is using cost implicitly in making policy in this area.

In the web of legal authority, available resources, expertise, and political recep-

tivity in which the CMS finds itself, it would appear that the agency is best positioned to recalibrate national payment policies that give distorted incentives and to better manage how newly covered technologies and services are provided to beneficiaries. Another target of immediate opportunity would be to demonstrate and then implement care coordination programs for beneficiaries with multiple chronic conditions.

Targets of opportunity aside, policymakers need to recognize and accept that the traditional Medicare program is the dominant payer shaping the nature of the U.S. health system. Functioning in an environment that requires public accountability and transparency, the CMS should begin to analyze, plan, and implement a comprehensive purchasing strategy designed to improve the value of services received by Medicare beneficiaries and attack the wasteful spending that plagues the program.

.....
 This paper is based on a working paper presented before the Council on Health Care Economics and Policy, 15–16 May 2003, in Princeton, New Jersey. The purchasing model presented here is an expansion of one developed by Steven Jencks and colleagues at the Centers for Medicare and Medicaid Services (CMS) Office of Clinical Standards and Quality. The author thanks Jencks, Jeff Kang, Patricia MacTaggart, and colleagues at the CMS with whom he worked on purchasing concepts for Medicare. He also thanks Tom Hoyer and Joanne Lynn for very helpful comments on earlier drafts.

NOTES

1. E.S. Fisher et al., “The Implications of Regional Variations in Medicare Spending,” Parts 1 and 2, *Annals of Internal Medicine* 138, no. 4 (2003): 273–298.
2. *Ibid.*
3. I have chosen to use the term “traditional Medicare” rather than “fee-for-service Medicare” to emphasize the fact that Medicare no longer relies on fee-for-service reimbursement for many providers.
4. G.R. Wilensky, “The Implications of Regional Variations in Medicare—What Does It Mean for Medicare?” *Annals of Internal Medicine* 138, no. 4 (2003): 350–351.
5. Note that H.R. 1, the House version of Medicare restructuring, sets up a model of competition between private plans and traditional Medicare but does not attempt to address the barriers that would permit the traditional Medicare program to compete effectively.
6. J.E. Wennberg, E.S. Fisher, and J.S. Skinner, “Geography and the Debate over Medicare Reform,” 13 February 2002, www.healthaffairs.org/WebExclusives/Wennberg_Web_Excl_021302.htm (31 October 2003).
7. *Ibid.*
8. K.I. Shine, “Geographic Variations in Medicare Spending,” *Annals of Internal Medicine* 138, no. 4 (2003): 347–348; and Wilensky, “The Implications of Regional Variations in Medicare.”
9. Wennberg et al., “Geography and the Debate over Medicare Reform.”
10. M.A. Schuster, E.A. McGlynn, and R.H. Brook, “How Good Is the Quality of Health Care in the United States?” *Milbank Quarterly* 76, no. 4 (1998): 517–563.; E.A. McGlynn et al., “The Quality of Health Care Delivered to Adults in the United States,” *New England Journal of Medicine* 348, no. 26 (2003): 2635–2645; and S.F. Jencks, E.D. Huff, and T. Cuerden, “Change in the Quality of Care Delivered to Medicare Beneficiaries, 1998–1999 to 2000–2001,” *Journal of the American Medical Association* 289, no. 3 (2003): 305–312.
11. K. Levit et al., “Trends in U.S. Health Spending, 2001,” *Health Affairs* (Jan/Feb 2003): 154–164.
12. J.E. Wennberg, *The Dartmouth Atlas of Health Care 1998* (Chicago: American Hospital Publishing, 1998).
13. Levit et al., “Trends in U.S. Health Spending.”
14. See, for example, W.V. Stoughton, “Medical Costs and Technology Regulation: The Pivotal Role of Hospitals” in *Critical Issues in Medical Technology*, ed. B.J. McNeil and E.G. Cravalho (Boston: Auburn House, 1982),

- 37–50; and T.W. Moloney and D.E. Rogers, “Medical Technology—A Different View of the Contentious Debate over Costs,” *New England Journal of Medicine* 301, no. 26 (1979): 1364–1369.
15. In recommending focusing on high-cost beneficiaries, senior Congressional Budget Office staff found that the top 1 percent of beneficiaries spent 17 percent and the top 5 percent, 47 percent of overall spending between 1995 and 1999. S.M. Lieberman et al., “Reducing the Growth of Medicare Spending: Geographic versus Patient-Based Strategies,” 10 December 2003, www.healthaffairs.org/WebExclusives/Lieberman_Web_Excl_121003.htm.
 16. Fisher et al., “The Implications of Regional Variations in Medicare Spending.”
 17. B.C. Vladeck, “The Political Economy of Medicare,” *Health Affairs* (Jan/Feb 1999): 22–36.
 18. K.M. King, S. Burke, and B. Docteur, eds., *Improving Medicare’s Governance and Management*, Final Report of the Study Panel on Medicare’s Governance and Management—Matching Problems with Solutions (Washington: National Academy of Social Insurance, July 2002).
 19. W.J. Scanlon, “Medicare: Successful Reform Requires Meeting Key Management Challenges: United States General Accounting Office,” Testimony before the House Committee on the Budget, 2001, www.gao.gov/new.items/d011006t.pdf (31 October 2003).
 20. R.A. Berenson and D.M. Harris, “Using Managed Care Tools in Traditional Medicare—Should We? Could We?” *Law and Contemporary Problems* 65, no. 4 (2002): 139–168.
 21. G.P. Mays, R.E. Hurley, and J.M. Grossman, “An Empty Toolbox? Changes in Health Plans’ Approaches for Managing Costs and Care,” *Health Services Research* 38, no. 1, Part II (2003): 375–393.
 22. P.D. Fox, “Applying Managed Care Techniques in Traditional Medicare,” *Health Affairs* (Sep/Oct 1997): 44–57; and Berenson and Harris, “Using Managed Care Tools in Traditional Medicare.”
 23. A controversial contemporary example is ocular photodynamic therapy, an elective treatment for a particular form of macular degeneration that might be used, inappropriately, for a much larger group of Medicare beneficiaries at a cost of billions of dollars. Berenson and Harris, “Using Managed Care Tools in Traditional Medicare.” See also the national coverage decision by Medicare, “Ocular Photodynamic Therapy with Verteporfin—National Coverage Decision,” 5 September 2002, www.medicarenhic.com/articles/verteporfin_0902.htm (31 October 2003).
 24. R.A. Berenson and J. Horvath, “Confronting the Barriers to Chronic Care Management in Medicare,” 22 January 2003, www.healthaffairs.org/WebExclusives/Berenson_Web_Excl_012203.htm (31 October 2003).
 25. SUPPORT Principal Investigators for the SUPPORT Project, “A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients: The Study to Understand Programs and Preferences for Outcomes and Risks of Treatment (SUPPORT),” *Journal of the American Medical Association* 274, no. 20 (1995): 1591–1598.
 26. C.S. Lesser and P.B. Ginsburg, “Health Care Cost and Access Problems Intensify,” Issue Brief no. 63 (Washington: Center for Studying Health System Change, May 2003).
 27. K.J. Devers, L.R. Brewster, and P.B. Ginsburg, “Specialty Hospitals: Focused Factories or Cream Skimmers?” Issue Brief no. 62 (Washington: HSC, April 2003).
 28. M. McKee and H. Brand, “Purchasing to Promote Population Health,” in *Purchasing to Improve Health Systems Performance*, ed. J. Figueras et al. (Philadelphia: Open University Press, 2004).
 29. R. Freeman, “Competition in Context: The Politics of Health Care Reform in Europe,” *International Journal for Quality in Health Care* 10, no. 5 (1998): 395–401; and L.D. Brown and V.E. Amelung, “Manacled Competition: Market Reforms in German Health Care,” *Health Affairs* (May/June 1999): 76–91.
 30. World Health Organization, *Health Systems: Improving Performance*, World Health Report 2000 (Geneva: WHO, 2000).
 31. K. Eichenwald, “How One Hospital Benefited from Questionable Surgery,” *New York Times*, 12 August 2003.
 32. Medicare Payment Advisory Commission, “Using Market Competition in Fee-for-Service Medicare,” chap. 8 in *Report to Congress: Variation and Innovation in Medicare* (Washington: MedPAC, June 2003).
 33. Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the Twenty-first Century* (Washington: National Academies Press, 2001).
 34. B.C. Vladeck, “If Paying for Quality Is Such a Bad Idea, Why Is Everyone for It?” *Washington and Lee Law Review* 4, no. 4 (2004).
 35. MedPAC, “Using Market Competition in Fee-for-Service Medicare.”
 36. *Ibid.*; and Berenson and Harris, “Using Managed Care Tools in Traditional Medicare.”
 37. Berenson and Horvath, “Confronting the Barriers to Chronic Care Management.”

38. E.H. Wagner, B.T. Austin, and M. Von Korff, "Organizing Care for Patients with Chronic Illness," *Milbank Quarterly* 74, no. 4 (1996): 511–544.
39. S.B. Foote, "Why Medicare Cannot Promulgate a National Coverage Rule: A Case of Regula Mortis," *Journal of Health Policy, Politics and Law* 27, no. 5 (2002): 707–730.
40. As distinguished from a broader cost-benefit analysis that determines whether a technology is worth the expense from a societal perspective.
41. M. Peterson, "U.S. to Back Heart Device in More Cases," *New York Times*, 7 June 2003.
42. Ibid.
43. Statement of Joanne Lynn, director, Washington Home for Palliative Studies, to the Medicare Coverage Advisory Committee, 12 February 2003.
44. M.A. Hall and R.A. Berenson, "Ethical Practice in Managed Care: A Dose of Realism," *Annals of Internal Medicine* 128, no. 5 (1998): 395–402.
45. I thank Joanne Lynn for this suggestion. Lynn, personal communication, 1 May 2003.
46. In commenting on the decision to expand coverage for PET scans, Sean Tunis, then director of the Medicare coverage group, observed that although cost was not an explicit consideration, expensive new technologies get more attention than inexpensive ones, suggesting that cost implicitly can be a factor influencing coverage decisions. R.L. Rundle, "How a Small Firm Pushed PET Scans into Mainstream," *Wall Street Journal*, 29 November 2003.
47. An important, but unappreciated, part of the competitive pricing demonstration for durable medical equipment was the fact that once bids reduced the number of potential vendors for the service area, the CMS was able to engage in negotiation to assure that threshold requirements for quality and service were met. MedPAC, "Using Market Competition in Fee-for-Service Medicare."
48. Centers for Medicare and Medicaid Services, *2001 Annual Report: ESRD Clinical Performance Measures Project* (Baltimore: CMS, December 2001).
49. S. Leatherman et al., "The Business Case for Quality: Case Studies and an Analysis," *Health Affairs* (Jan/Feb 2003): 17–30; and Midwest Business Group on Health, in collaboration with the Juran Institute Inc. and the Sevryn Group Inc., *Reducing the Costs of Poor-Quality Health Care through Responsible Purchasing Leadership* (Chicago: Midwest Business Group on Health, 2002).
50. CMS, *2001 Annual Report*.
51. D. Shaller et al., "Consumers and Quality-Driven Health Care: A Call to Action," *Health Affairs* (Mar/Apr 2003): 95–101.
52. To access comparative quality information, see list of optional search tools at www.medicare.gov/default.asp (1 October 2003).
53. IOM, *Crossing the Quality Chasm*.
54. R. Pear and M.W. Walsh, "Medicare to Pay Bonuses for Best of Hospital Care," *New York Times*, 11 July 2003.
55. R. Galvin, "Purchasing Health Care: An Opportunity for a Public-Private Partnership," *Health Affairs* (Mar/Apr 2003): 191–195.
56. "Paying for Performance: Medicare Should Lead" (Open Letter), *Health Affairs* (Nov/Dec 2003): 8–10.
57. L. Etheredge, R. Berenson, and J. Ebeler, *Quality Incentives for Medicare+Choice Plans* (Washington: Health Insurance Reform Project, George Washington University, August 2002).
58. Jencks et al., "Change in the Quality of Care."
59. HSC, *Community Health Report, Fourth Visit: Competition Heats Up the Indianapolis Health Care Market* (Washington: HSC, Winter 2003).
60. R.L. Rundle, "PET Scanners Become New Rx for Diagnostics," *Wall Street Journal*, 6 May 2003.
61. R.M. Wachter and L. Goldman, "The Hospitalist Movement Five Years Later," *Journal of the American Medical Association* 287, no. 4 (2002): 487–494.