

RESTRUCTURING MEDICARE FOR THE LONG TERM PROJECT

Final Report of the Study Panel on
Fee-for-Service Medicare

**From a Generation Behind to a
Generation Ahead:**

Transforming
Traditional

Medicare

January 1998

NATIONAL
ACADEMY
OF SOCIAL
INSURANCE



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National Academy of Social Insurance Study Panel on Fee-For-Service Medicare

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The views expressed in this report are those of the members of Study Panel and do not necessarily reflect those of the organizations with which they are affiliated. Moreover, Ms. Snyder respectfully disagrees with the portion of the report regarding competitive procurement.

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Foreword

This report is the final product of a Study Panel convened by the National Academy of Social Insurance (NASI) as a part of its *Restructuring Medicare for the Long Term* project. The Study Panel's assignment has been to analyze options for Medicare's traditional fee-for-service (FFS) program for the next century. It includes experts drawn from medicine, public policy, law, and industry.

In a series of meetings, commissioned papers, and writing by individual Study Panel members and Academy staff over an 18-month period, the Study Panel on Fee-for-Service Medicare analyzed key characteristics and difficulties of the FFS program, state-of-the-art management practices among private insurers, and policy alternatives to prepare FFS Medicare for the next generation of beneficiaries.

With a budget of \$183 billion in 1997, FFS Medicare currently enrolls 33 million Americans, accounts for 88 percent of all Medicare spending and about 11 percent of the entire federal budget. Its beneficiaries include some of the sickest and most vulnerable individuals in our society. However, it is limited in its ability to meet the health needs of the growing numbers of beneficiaries with chronic conditions and disabilities. In addition, administrative structure of FFS Medicare remains much as it was designed in 1965 with little ability to try new ideas with which private health plans are increasingly experimenting. FFS Medicare needs significant modernization as it prepares for retirement of the Baby Boom generation.

In developing policy options to address the challenges facing FFS Medicare, the Study Panel chose to focus on potential management innovations from private health plans and elsewhere. The Panel decided not to address the option of increasing beneficiary cost-sharing; one might consider this alternative in hopes of providing consumers with an incentive to become more careful consumers of health care. The Study Panel judged this not to be politically feasible at this time. In addition, the potential of cost-sharing to change incentives is limited since 90 percent of beneficiaries have some form of supplemental insurance that all but eliminates cost-sharing. The Study Panel also did not explicitly consider changes in the FFS Medicare benefits package, even though its acute care focus is generally considered inadequate for current and future beneficiaries. However, some of the management innovations that the Study Panel found promising may provide needed and potentially cost-effective services not available in the current benefits package for those beneficiaries who participate in these innovations.

In order to move FFS Medicare from its traditional bill-paying philosophy to one more accountable for the quality of health care and costs of services provided to beneficiaries, the Panel recommends that Congress mandate an on-going period of experimentation and learning. To test new ways of organizing, delivering, monitoring, and paying for services (especially for those beneficiaries with chronic conditions), the Panel also recommends Congress provide HCFA with greater flexibility to test new ways of organizing, delivering, and paying for services and that Congress and its advisors monitor the impact of this new flexibility on the cost and quality of care.

Other study panels in the Academy's Restructuring Medicare for the Long Term project are examining capitation and choice, Medicare's larger social roles, and options for long-term program financing. An overall Steering Committee of additional Medicare experts provided charges to each of the Study Panels and will synthesize their results in policy-relevant reports of their own.

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Contents

Executive Summary	i
Introduction	1
Private Insurance in the 1990s	3
The Potential of Managed Care	3
Evidence of Effectiveness	5
Challenges for FFS Medicare in the 1990s	7
Quality Issues	8
Chronic and Post-acute Care	10
Implications for the Management of FFS Medicare	11
Gaps in Knowledge and Experience	12
Prospects for Innovation in FFS Medicare	13
FFS Medicare's Administration	13
Payment	13
Prohibition of Interference With the Free Practice of Medicine	14
Freedom of Choice	15
Statutory Limits to Innovation	15
Other Limits to Innovation	17
Innovations in the Current FFS Medicare Program	18
Innovations to Date	19
Limitations	20
Summary	21
Recommendations	21
Conclusion	30
Appendix A: Acknowledgments	31
Appendix B: Managed Care Tools Used by Private Insurance and Their Potential for Medicare	33
Appendix C: Recent and Mandated Innovations in FFS Medicare	47
Appendix D: Potential FFS Medicare Waiver Language	53
References	57

Executive Summary

This report is about the future of the fee-for-service (FFS) Medicare program, the traditional part of Medicare that covers all beneficiaries except those enrolled in the capitated Medicare+Choice program or its predecessor, the Medicare risk program.

Managing FFS Medicare represents one of the most important and difficult challenges facing the Executive Branch and Congress. With a budget of \$183 billion in 1997 and 33 million beneficiaries, FFS Medicare accounts for 88 percent of all Medicare spending and about 11 percent of the entire federal budget. Existing evidence reviewed in this report suggests the need for new management strategies to improve quality and reduce the costs of care in FFS Medicare.

Although enrollment in privately managed Medicare+Choice plans will increase over the next several years, there are still important reasons to improve the management of FFS Medicare. FFS Medicare will continue to be the dominant means of delivering and paying for Medicare services well into the future. In addition, some beneficiaries will not be willing to take on the potential restrictions found in private health plans, such as limitations in beneficiaries' choice of providers. Given that FFS Medicare will continue to cover substantial numbers of people, its beneficiaries (as well as the taxpayers who help pay for the program) deserve to realize the benefits of management innovations developed in private health plans and elsewhere. In addition, by more actively managing the quality of care beneficiaries receive, FFS Medicare could set benchmarks for Medicare+Choice plans to meet or exceed. To meet these objectives, FFS Medicare needs innovation and new

statutory authorities to prepare it for the 21st century.

THIS REPORT

This report is the final product of a Study Panel convened by the National Academy of Social Insurance and charged with analyzing options for improving FFS Medicare over the long term. It is part of a larger nonpartisan effort to define the challenges and options that the Medicare program faces as it heads into the next century. In a series of meetings, commissioned papers, and writing by individual Study Panel members and staff over an eighteen month period, the Study Panel analyzed key characteristics and difficulties of the FFS program, state-of-the-art management practices among private insurers, and policy alternatives to prepare FFS Medicare for the next generation of beneficiaries. The report synthesizes the Panel's work.

MANAGING PUBLIC AND PRIVATE INSURANCE

Medicare's architects built the program upon the model of private health insurance as it operated in the 1960s. Its basic features at that time included:

- fee-for-service reimbursement of bills;
- participation of most hospitals, physicians, and other providers;
- administrative emphasis on payment rate issues rather than on quality or volume of services.

As a result, FFS Medicare has primarily *paid itemized bills* for covered services provided to beneficiaries.

Over the last decade, private health insurance has moved away from a bill-paying orientation to adopt and develop many of the principles of managed care.¹ Among the key features of private managed care that the Study Panel concludes may hold promise for FFS Medicare are:

- **Disease and case management** — Flexibility in benefits and the use of certain management techniques may hold particular promise for both the cost and quality of care given to FFS Medicare beneficiaries with special health needs. Among the conditions where research and the experience of private insurers suggest FFS Medicare might realize cost savings and/or quality enhancements are:

1. congestive heart failure,
2. chronic obstructive pulmonary disease,
3. diabetes,
4. hypertension,
5. arthritis,
6. falls (prevention),
7. chronic pain, and
8. end-of-life care.

These techniques include:

1. case management,
2. prevention,
3. education to teach patients self-management of chronic conditions,
4. bundling of payments for physicians and other providers to coordinate care,

5. prior authorization and review for selected procedures, and
6. data analysis to help target such tools.

- **Incentives to use selected providers**— Although some private health plans restrict enrollees to providers who meet certain cost or quality criteria, others preserve enrollees' freedom of choice, while giving them financial incentives to choose preferred providers. FFS Medicare could also experiment with this latter approach, as it has done in some limited demonstrations.

- **Competitive procurement**—Private health plans use their buying power in the marketplace to realize savings in the cost of goods and services. Medicare is nation's single largest payer of health care. As has been mandated in Balanced Budget Act of 1997 (P.L. 105-33), Medicare could expand experimentation with competitive purchasing, especially in those geographic and purchasing areas where prices paid by private health plans are significantly below those paid by Medicare for comparable goods and services. However, in implementing any experiment with competitive purchasing, HCFA would want to protect beneficiaries' access to a broad range of providers and suppliers. In addition, HCFA would need to maintain enough viable providers and suppliers in the marketplace to assure an effective procurement process in future years. These considerations would be necessary given the substantial purchasing role Medicare plays in the health care marketplace.

To what extent has private insurance used these tools and with what results? Although

¹ In a separate report, another Academy Study Panel is examining the implications for Medicare over the long term of greater choice among private health plans that receive capitated payments from the federal government for their Medicare enrollees (45).

there are no systematic data, evidence indicates that private insurers have made use of many managed care tools. However, in developing and using these most private insurers have focused initially on controlling costs with less emphasis on managed care tools mainly intended to enhance quality. In addition, little evidence exists to associate specific managed care tools with observed health outcomes. In recent years, however, some private insurers have begun to develop and implement disease management, including programs to screen for preventable, treatable conditions, to increase treatment compliance, and to manage closely the complications of chronic diseases. Although their use is not yet widespread and the models that do exist tend to focus on only one or a few conditions, such as diabetes and congestive heart failure, experience with managed care tools that have the potential to reduce costs and enhance quality will grow over time.

The Study Panel believes FFS Medicare needs the capacity to take advantage of these opportunities in a timely manner as research results and private sector experience make them apparent. It is even possible that FFS Medicare itself could provide leadership to other health care organizations by developing and refining promising ways of managing care for elderly and disabled people that may not have been attempted among private health plans. FFS Medicare needs the capacity to test the potential of such tools to enhance beneficiaries' quality of care and to make broader use of those that work. FFS Medicare currently does not have this ability.

FFS MEDICARE IN THE 1990s

Why does FFS Medicare need new management tools? There is convincing evidence of overuse, underuse, and misuse of services

paid for by FFS Medicare. Both the volume and quality of care present significant challenges.

Variations in Care and Costs

The major policy innovations in FFS Medicare over the last two decades have focused on the price of goods and services for which the program pays. Policy makers have given much less attention to the volume of services given to beneficiaries despite substantial evidence that there is geographic variation in that volume not explained by differences in beneficiaries' health needs and not associated with their health outcomes. Such variations in medical care have led to great differences in overall Medicare spending across the country.

Quality Issues

Three types of threats to quality of care among Medicare beneficiaries also exist: (1) overuse, when beneficiaries receive services whose risks outweigh their benefits; (2) underuse, when beneficiaries do not receive services whose benefits exceed their risks; and (3) misuse, when appropriate services are provided poorly resulting in avoidable complications. Correcting any of the three leads to improvements in health outcomes; some corrections also may save money.

Chronic Care Needs

The quality and costs of chronic care are of particular relevance for FFS Medicare. The prevalence of chronic conditions and disability has grown since the program's inception as medical advancements have extended life expectancy and transformed the course of ailments such as heart disease from conditions with a high likelihood of death in the short term into a chronic illness requiring ongoing

monitoring and treatment. As the Baby Boom generation grows older, the burden of chronic illness for FFS Medicare will increase. The number of beneficiaries over 85 years old will more than triple between 1996 and 2040. Thirty-six percent of these particular Medicare beneficiaries currently report functional limitations in their ability to conduct activities of daily living.

FFS Medicare's emphasis on reimbursing for individual services impedes the program's ability to meet beneficiaries' chronic care needs. FFS Medicare by itself provides few incentives to providers to coordinate the array of inpatient, outpatient, and other services that constitute quality chronic care over time.²

Gaps in Knowledge and Experience

Although the health needs of elderly individuals differ from those of the younger population, there is less evidence about how best to treat the 65 and over population. In addition, the literature that does exist is more equivocal in its results than are studies of younger groups. More importantly for FFS Medicare, there is minimal experience in how to apply the knowledge that does exist for an elderly population to the management of a health plan. These gaps in understanding underscore the need for a period of learning and experimentation in using managed care techniques to help assure that beneficiaries who choose to remain in FFS Medicare have the opportunity to receive appropriate, cost-effective treatment.

PROSPECTS FOR INNOVATION

The administrative structure of FFS Medicare today largely reflects the choices available in the 1960s and 1970s. Addressing the challenges laid out above will require significant innovation in the program's management.

The 1965 legislation that created the Medicare program adopted the most prevalent principles of private insurance in existence at the time: (1) reimbursing providers on a FFS basis, (2) participation of most providers, and (3) an administrative emphasis on payment rates rather than volume or quality. Because the federal government lacked experience in administering insurance itself, the Medicare statute required FFS Medicare to contract with private insurers as "intermediaries" (Part A) and "carriers" (Part B) to pay claims on its behalf. The federal government's role in claims administration became largely regulatory.

The Medicare statute also prohibited the federal government from exercising "any supervision or control over the practice of medicine" in response to a fear of socialized medicine and the prevailing function of insurance at the time — to pay bills. Furthermore, the statute guaranteed beneficiaries the freedom to use any provider qualified to participate in Medicare, if the provider was willing to treat the beneficiary.

Limitations to Innovation

Achieving innovation in the program's management will not be easy. Changes in program philosophy or procedure will require new authorization in law. FFS Medicare's

2 Although this Study Panel did not consider potential changes to the FFS Medicare benefits package, the current package does not include coverage for outpatient pharmaceuticals, a significant component of care for many chronic illnesses.

current legal structure is designed to assure that public decisions are made in the public interest and that every qualified enterprise has an opportunity to do business with this public program. Among the legal restrictions the Health Care Financing Administration (HCFA), the federal agency that administers FFS Medicare, faces are:

- Procedural and analytic requirements that make most administrative decisions lengthy by requiring clearance from multiple agencies, public comment periods, and the potential for appeals.
- Procurement policies that can limit hiring practices as well as the types of organizations with whom HCFA can contract to carry out administrative functions.
- Restrictions that make FFS Medicare's authority to test new ways of providing or paying for services lengthy to initiate and that make successful demonstrations difficult to integrate into regular FFS Medicare operation without new statutory authority from Congress.
- Congressional tendencies not to allow the executive branch much latitude in decision-making and, over time, to constrain any latitude it may have provided in legislation.

The federal government also faces non-statutory barriers to bringing about the innovation this Study Panel believes is necessary for FFS Medicare:

- **The size and dominance of the Medicare program**—Innovations that deselect or steer FFS Medicare business away from some providers can potentially cause economic disruptions in the marketplace since FFS Medicare accounts for such a significant portion of revenue for physicians, hospitals,

other health care providers, and health care manufacturers.

- **Political intervention**—Executive Branch or congressional intervention at the behest of client or provider interests can hold up a decision or signal that a particular demonstration project or regulatory provision would likely provoke a punitive response.
- **Slowness in decision-making**—Beyond the need to follow legal procedure, government agencies often are slow in making decisions because of their size and organization.

Innovation in the Current FFS Medicare Program

Even in the face of these limitations, Congress and HCFA have begun to explore the applicability of certain managed care tools for FFS Medicare. HCFA has undertaken some demonstrations on its own to test new ways of providing and paying for high volume services and care for beneficiaries with particular conditions. The Balanced Budget Act (BBA) of 1997 (P.L. 105-33) mandates a few additional experiments, and the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (P.L. 104-191) provides new flexibility in how HCFA contracts with administrative organizations to prevent waste, fraud, and abuse.

Although these activities help to lay an important foundation for the changes necessary in FFS Medicare, they are significantly limited. Rather than encompassing a coherent, overall commitment to modernizing FFS Medicare, they represent innovation by exception. While experimentation on a small scale is necessary in order to learn, these activities lack a broad mandate from Congress for the flexibility necessary for ongoing improvement of FFS Medicare.

Reliance on Medicare's current demonstration authority means that experiments can take a long time to set up and are temporary by design. Furthermore, HCFA can not integrate successful demonstrations into FFS Medicare permanently without congressional action.

RECOMMENDATIONS

The Study Panel's analysis and findings lead it to make five recommendations designed to modernize FFS Medicare for the next generation:

Recommendation 1: Congress should mandate that FFS Medicare move beyond its traditional role as a bill-payer to become accountable for the quality and costs of services provided to beneficiaries.

Given that FFS Medicare will likely remain the predominant way in which Medicare benefits are provided well into the future and that FFS Medicare contains significant unrealized opportunities for quality improvement and cost containment, the Study Panel believes Congress should provide explicit support for an overall change in program philosophy and a commitment to systematic, on-going innovation in Medicare. A congressional commitment to such innovation in FFS Medicare would enable the program's administrators to place greater emphasis on assuring appropriate volume and quality of services paid for by FFS Medicare. It also would represent a commitment by Congress to assure that FFS Medicare is a viable, modern option as it "competes" with the private plans offered under the Medicare+Choice program mandated by the BBA of 1997 (P.L. 105-33).

Recommendation 2: Congress should direct HCFA to innovate FFS Medicare on an on-going basis by adapting (and going beyond) the best practices of private health plans. HCFA should experiment with new ways of managing services including disease and case management, especially for beneficiaries with chronic and other conditions, providing beneficiaries with incentives to use selected providers, and a unique competitive procurement process for FFS Medicare. HCFA should target these innovations toward the geographic areas and populations where they have the greatest potential to improve quality and cost outcomes.

The Study Panel believes FFS Medicare's use of these managed care tools should be characterized by experimentation, planning and evaluation, selectivity, and adaptation. First, FFS Medicare should be able to innovate in the way a private sector corporation innovates— i.e., to implement changes promptly based on the results of experimentation. HCFA should be allowed to try new ideas, abandon those that do not work, and replicate those that do. It should conduct these experiments within the context of a well-articulated and thoroughly reviewed innovation plan. In developing and updating this plan, HCFA should track developments in both clinical medicine and health plan management by monitoring research activities in the Public Health Service, the larger published research literature, and innovations among private health plans. As new opportunities to improve the management of health services become evident, FFS Medicare should be prepared to experiment promptly with their application among those geographic areas and populations of beneficiaries

where they may have the greatest potential. HCFA also should remain open to adapting each new tool with which it experiments to make it appropriate for a public program like FFS Medicare and its beneficiaries.

Recommendation 3: In order to carry out these experiments in the management of FFS Medicare, HCFA should have the authority to waive some statutory requirements.

After concluding that the current demonstration authority is too limited and that reconstituting HCFA as an independent, private, or semi-public authority would not, by itself, address the challenges that FFS Medicare faces, the Study Panel concluded that HCFA needs new statutory authority from Congress to manage innovation.

Under this new authority, Congress would permit the Secretary of Health and Human Services to waive certain requirements under the federal statute governing FFS Medicare in order to experiment with the managed care tools outlined above. When new clinical or administrative approaches to providing or paying for cost-effective, quality care become apparent through research or the experience of private health plans, this authority will provide FFS Medicare with the flexibility to try them in a more timely manner than the current demonstration authority allows.

HCFA could contract with a variety of qualified private organizations such as health plans, groups of providers, or organizations that specialize in particular services such as patient education, case management, or utilization review. The managed care tools could be administrative, clinical, or non-medical support services that may improve the

quality of health services and/or save money. HCFA would solicit ideas for experiments on a regular basis from the private sector as well as from state and local government. It would design each experiment to reflect beneficiary needs and the capacity of the health care system in each geographic area. Such geographic targeting will minimize the risk of widespread implementation of any unproven and potentially inappropriate technique.

Congress should grant HCFA the freedom to learn from this process of experimentation. Because some experiments will not live up to expectations of cost savings or quality improvement, HCFA should have the flexibility promptly to abandon or alter approaches that do not work. Furthermore, the Secretary should have the authority to make successful experiments part of the regular FFS Medicare program.

Congress should limit this new waiver authority so no enrollee is eligible for fewer benefits than those already provided under Medicare. In addition, FFS Medicare should preserve beneficiaries' freedom of choice of providers (even if some experiments incorporate incentives for beneficiaries to choose selected providers). In those cases where HCFA experiments with competitive procurement, HCFA will also need to maintain enough viable providers and suppliers to assure an effective procurement process in future years, given the substantial purchasing role Medicare plays in the health care marketplace.

Recommendation 4: Congress should require the Secretary of Health and Human Services to report annually on how HCFA has used its authority to innovate and with what results for quality,

costs, and access. Congress should designate an advisory body to respond to this report and advise Congress about potential improvements.

In return for granting higher discretion to HCFA in managing FFS Medicare, Congress should hold HCFA to a greater standard of accountability for cost and quality outcomes than it has previously. In an annual report to Congress, the Secretary of Health and Human Services would review HCFA's overall innovation management plan, actual projects undertaken, and evidence of how well HCFA is fulfilling Congress's mandate to transform FFS Medicare from a bill-paying program to one accountable for the quality and costs of services it covers. The Study Panel further recommends that Congress require the Medicare Payment Advisory Commission (MPAC) review the Secretary's report each year, comment on it, and recommend any changes in the waiver authority it believes appropriate.

Recommendation 5: To help Congress hold HCFA accountable to the public for the discretion described in Recommendation 3, HCFA should require that each experiment obtain evaluation data in order to learn quickly from the initiative.

Assessment of experiments is necessary in order to learn and for effective legislative oversight. FFS Medicare's current demonstration authority recognizes this necessity in its requirements for complete, rigorous evaluations of each demonstration project, but such studies can be a time-consuming

process. The Study Panel believes FFS Medicare needs the capacity to develop valid data more quickly so that policymakers can make timely decisions about whether to replicate, abandon, or alter each experiment. The Panel recommends that HCFA require the designers of each experiment to identify indicators that will allow for prompt, but valid information about how well each experiment is operating.

CONCLUSION

The BBA of 1997 increased Medicare beneficiaries' opportunities to receive their Medicare benefits through privately run health plans. Because these new choices will not be appropriate for all beneficiaries, beneficiaries also deserve a viable FFS option. Yet, managing FFS Medicare represents a significant challenge for the federal government. In order to advance the quality of care for Medicare's beneficiaries and to assure the taxpayers' money is well spent, FFS Medicare must modernize its management. A modern FFS Medicare program should have the capacity to apply new knowledge from research and the private sector about how best to manage health benefits for older Americans and those with disabilities, especially as the number of beneficiaries living with chronic conditions continues to grow. The changes in FFS Medicare needed to bring about this fundamental change will require strong leadership and bipartisan consensus among our elected officials. In order to prepare FFS Medicare for the next generation, this Study Panel believes we need to develop that consensus today.

Introduction

This report is about the future of the traditional fee-for-service (FFS) Medicare program, the part of Medicare that covers all beneficiaries except those enrolled in the capitated Medicare+Choice program or its predecessor, the Medicare risk program.

Managing Medicare's traditional FFS Medicare represents one of the most important and difficult challenges facing the Executive Branch and Congress. In 1997, FFS Medicare accounted for about \$183 billion, 88 percent of all Medicare spending and about 11 percent of the entire federal budget. It served over 33 million people, 86 percent of all Medicare beneficiaries and 12 percent of the entire American population (35). Variations in costs and treatment not explained by beneficiaries' health status and other evidence of opportunities for quality improvement suggest the need for new strategies to manage FFS Medicare.

The enactment of the Medicare+Choice program in 1997 suggests that larger numbers of beneficiaries will receive their Medicare benefits through privately managed health plans in future years. However, there are still important reasons to improve the management of FFS Medicare. FFS Medicare will continue to be the dominant means of delivering and paying for Medicare services well into the future. In addition, there will always be some beneficiaries not willing to take on the limitations found in private health plans, such as restrictions on beneficiaries' choice of providers. Given that FFS Medicare will continue to cover substantial numbers of people, its beneficiaries (as well as the taxpayers who help pay for the program) deserve to realize the benefits of management innovations developed in private health plans and else-

where. In addition, by more actively managing the quality of care beneficiaries receive, FFS Medicare will set benchmarks for Medicare+Choice plans to meet or exceed. To fulfill these objectives, FFS Medicare needs new statutory authorities to innovate for the 21st century.

INSURANCE IN THE 1960s

Medicare's architects built the program upon the model of private health insurance as it operated in the 1960s. Its basic features include:

- fee-for-service reimbursement of bills;
- participation of most hospitals, physicians, and other providers;
- administrative emphasis on payment rate issues rather than on quality or volume of services.

As a result, FFS Medicare has primarily *paid itemized bills* for covered services provided to beneficiaries. The program's original administrative structure remains intact except for the addition of administered prices for most covered services through the Prospective Payment System (PPS) for hospitals in 1983 and the Medicare Fee Schedule (MFS) for physician services in 1992. With the exception of a few added preventive services, Medicare's benefits package also remains largely unchanged since Congress established the program.

FFS MEDICARE IN THE 1990s

FFS Medicare today operates in a health care system that is substantially larger and more complex than it was in 1965. Technology allows medicine to provide many more services than it could a generation ago. FFS costs have steadily risen, with particularly dramatic increases in recent years in home health

care,¹ skilled nursing facilities, and other forms of so-called “post-acute care.” Costs per beneficiary are projected to continue to increase at an average of 8 percent per year over the next few decades (52, 54) as innovation continues to yield more expensive technology. The growth in the number of beneficiaries also contributes to the projected increases in spending and demands on the health care system. Between 1995 and 2030, Medicare beneficiaries are expected to grow from 14 percent of the population to 22 percent (54). Medicare processed 784.8 million claims in 1995, a 40-fold increase over the 19.1 million processed in 1967 (59). Furthermore, the number of services provided per capita under Medicare varies dramatically across the country, and this variation is not explained by beneficiaries’ health status. For example, the rate of coronary artery bypass surgery per thousand beneficiaries varied by a factor of over four across hospital referral regions nationwide (15). Today’s health care system presents management challenges for FFS Medicare that outstrip the administrative system established during the program’s early years.

Over the last decade, private health insurance has moved away from a bill-paying orientation to adopt many of the principles of managed care. In contrast to the health insurance models of the 1960s, managed care’s key features include:

- disease management, case management and other flexible tools to provide appropriate care for patients with particular health needs,

- incentives or requirements to use selected providers, and
- competitive procurement of goods and services for value and price.

These principles have come to characterize not just health maintenance organizations (HMOs) and other health plans that receive a set (“capitated”) amount of money for each enrollee regardless of the health services they use, but they are increasingly a part of what remains of private FFS medicine as well. Private health plans have begun to incorporate the tools of managed care, even if they do not adopt capitated payment. As will be seen, the private sector is only beginning to use some of these tools such as disease management.

THIS REPORT

This report is the final product of a Study Panel convened by the National Academy of Social Insurance and charged with analyzing options for improving FFS Medicare over the long term. It is part of a larger nonpartisan effort to define the challenges and options that the entire Medicare program faces as it grapples with increasing numbers of beneficiaries as the Baby Boom generation retires after 2010 and projected increases in health care costs. In a series of meetings, commissioned papers, and writing by individual Study Panel members and staff over an eighteen month period, the Study Panel examined FFS Medicare’s key difficulties and analyzed policy alternatives for addressing them. This report synthesizes the Panel’s work.

1 The growth in home health care costs followed a court decision (*Duggan v. Bowen*, 691 F. Supp. 1487 (D.D.C. 1099)) that effectively broadened the circumstances under which Medicare could pay for home health services (66).

The report begins by examining the evolution of private health insurance, not only to find management tools that may be appropriate for FFS Medicare, but also to identify opportunities for FFS Medicare to go beyond private efforts to improve quality and control spending. It then discusses the current and projected difficulties in managing FFS Medicare. The report also focuses on those features of FFS Medicare as a public program that limit policy choices in modernizing the program. It then examines relevant FFS innovations already attempted by HCFA or mandated by the Balanced Budget Act (BBA) of 1997 (P.L. 105-33) and other legislation. This analysis sets the stage for the Study Panel's policy recommendations, which follow in the last section of the report.

Private Insurance in the 1990s

Medicare exists within a larger health care system that comprises both private and public payers. Although the question of whether Medicare should provide its beneficiaries with insurance comparable to private insurance available to the under-65 working population is a value judgment, the state-of-the-art in managing private insurance may offer lessons for Medicare. In some cases, the experience of private health plans may reveal techniques or strategies that Medicare may wish to adopt. In other cases, the limitations of private insurers' experiences may indicate areas where Medicare could provide leadership to the whole health care system by developing and testing new ways of assuring quality and controlling costs. Hence, this Study Panel began its work with a review of management techniques used by private health plans.

FINDING

Private health plans are beginning to move from discounted FFS and incentive payments made to providers toward experimentation with a broader array of managed care tools. Although evidence of their extent and impact among private health plans is as of yet minimal, a number of these tools may be worthy of adaptation and experimentation by FFS Medicare.

THE POTENTIAL OF MANAGED CARE

Private health insurers constitute a large, diverse, and rapidly changing industry. For the purposes of this report, they include all models of health plans including HMOs. With the exception of HMOs, private health plans have generally maintained a FFS system in compensating providers. They have focused on controlling costs by exacting discounts from the amounts they paid for services provided. This type of financial arrangement is particularly characteristic of preferred provider organizations (PPOs), in which participating providers agree to the discounts in exchange for the volume of patients that providers receive from being part of the health plans' "network." Alternatively, health plans have given other types of financial incentives to providers for not overusing services (26, 21, 34).

In recent years, private health plans have begun experimenting with a variety of tools to help them be accountable for managing the care their enrollees receive. Beyond the specific tools they are (or could be) trying,

this experimentation represents a change from the bill-paying role that health plans maintained under a FFS system. This report refers to this new philosophy and the management tools that support it as “managed care.” In this context, managed care does not necessarily involve the tool of capitation, in which reimbursements for patients are fixed without regard to the number or nature of services provided in a set period of time.² This new philosophy involves using purchasing power, data, and management techniques to exact both economies and improvements in health outcomes for the lives they insure. This paradigm is different from the bill-paying, FFS paradigm that has dominated the traditional management of the Medicare program, although, as described later in this report, HCFA has begun limited experimentation with some of these ideas.

What managed care tools have private health plans tried? There are no systematic data, although research suggests that HMOs and similar types of health plans provide more preventive services to their enrollees than do traditional indemnity plans (42). Other literature suggests that private insurance is beginning to use these tools, but they are not yet widespread (17). Conversations between insurance executives and experts involved in the analysis for this report confirm that the predominant managed care tools to date have emphasized cost-cutting techniques such as discounted fees and utilization review. In recent years, however, some private health plans have begun to make important incursions into the world of quality enhancement (21). For example, several plans have developed self-management and prevention pro-

grams for diabetes and congestive heart failure (25)

Given the paucity of published data on the types of particular managed care tools used in private insurance, coupled with strong indications that this industry is only beginning to develop tools other than those designed primarily to cut costs, this Study Panel commissioned Peter Fox, a managed care consultant and social insurance expert, to provide as full an inventory as possible of the types of managed care tools used by private indemnity insurance and their potential relevance for Medicare. His analysis, summarized in Appendix B, serves as the basis for the Panel’s own findings. Other analysts have also surveyed the landscape of private insurance in recent years in search of lessons for FFS Medicare (18, 23).

Specifically, the Study Panel sees three general categories of these techniques that hold particular promise for FFS Medicare (although the reader should refer to Appendix B for a more complete discussion of the range of management techniques used by private insurance and their potential for FFS Medicare):

- **Case and disease management**—Private health plans are increasingly flexible in managing services, quality, and payment for particular populations. These techniques include data analysis to help identify underuse of needed care and other quality problems, bundling of payments for physicians and other providers to coordinate care (case management), prevention, and education to teach patients self-management of chronic conditions (19).³ Appendix B

2 Indeed, for this report, the Study Panel was interested in insurers’ use of managed care tools other than capitation.

discusses these techniques in greater detail. Among the health conditions being cited by geriatric experts and private health plan members as opportunities for FFS Medicare to realize potential cost and quality improvements by applying these tools are: congestive heart failure, chronic obstructive pulmonary disease, diabetes, hypertension, arthritis, falls, chronic pain, and end-of-life care (23).

- **Incentives to use selected providers**—Existing evidence suggests that private health plans commonly try to send business to those providers who do the best job (22). Although some private health plans restrict enrollees to only those providers who meet certain cost or quality criteria, others are increasingly preserving enrollees' freedom of choice, while giving them financial incentives to choose preferred providers (32). With its large market share and significant data resources, FFS Medicare is in a relatively good position to identify and select preferred providers on the basis of quality or costs, and the Study Panel believes it should try. Indeed, as discussed later in this report, Medicare has done so on a limited basis for selected conditions in its Centers of Excellence demonstration. FFS Medicare could seek to expand this model by establishing PPOs for selected services with providers who meet specified quality standards. FFS Medicare could contract with the best providers, probably at volume discounts, while giving beneficiaries the option to use other providers at greater cost.

- **Competitive procurement**—Private health plans use their buying power in the marketplace to realize savings in the cost of goods and services they procure (47). As the nation's single largest buyer of health care, FFS Medicare has \$183 billion of purchasing power and 33 million enrollees. As has been mandated in the Balanced Budget Act of 1997 (P.L. 105-33), FFS Medicare could expand experimentation with competitive purchasing for value and price, especially in those geographic and purchasing areas where prices paid by private health plans are significantly below those paid by FFS Medicare for comparable goods and services. However, in implementing any experiment with competitive purchasing, HCFA would want to protect beneficiaries' access to a broad range of providers and suppliers. In addition, HCFA would need to maintain enough viable providers and suppliers in the marketplace to assure an effective procurement process in future years. These considerations would be necessary given the substantial purchasing role Medicare plays in the health care marketplace.

EVIDENCE OF EFFECTIVENESS

How well have these tools worked in private insurance? As pointed out above, managed care has focused largely on cost control, with only recent (but growing) attention to prevention, case management, and other tools intended to enhance quality. And most research to date has focused on whether a health plan's organizational form (e.g., HMOs versus traditional indemnity plans) is

3 Education and other tools provided to patients to help them manage their own health and make informed, appropriate use of medical care are often referred to as "demand management" (67). Common examples of demand management include telephone and on-line computer "help-lines" staffed by nurses or other health professionals, and educational materials in the form of newsletters, other printed material, videotapes, and audio tapes.

associated with differences in costs or quality.⁴ While this literature shows that HMOs use hospitals, expensive services, and discretionary procedures significantly less and visits to doctors' offices and preventive services significantly more than do indemnity plans, it is equivocal about differences in health outcomes and other quality indicators (42). Evidence about the effectiveness of particular managed care tools is more scant, although researchers have found volume discounts from providers negotiated by purchasers and insurers and various forms of utilization review have resulted in spending and utilization reductions (37, 55, 75).

Recent interest in disease management and other innovations to improve quality outcomes suggest that there will be more tools for FFS Medicare to try in the future. The Study Panel believes that FFS Medicare should be prepared to experiment with these techniques as research findings, and the experiences of private health plans make their potential benefits apparent. Furthermore, it

is even possible that FFS Medicare itself could provide leadership to other health care organizations by developing and refining promising ways of managing care for elderly and disabled individuals that will not have been attempted among private health plans.

As discussed below, the capacity for FFS Medicare to innovate like a private health plan requires a flexibility and timeliness that FFS Medicare does not now possess. However, the Panel recognizes that FFS Medicare is not equivalent to private health plans. As a public program, FFS Medicare has responsibilities to the taxpayer that private plans do not face. Furthermore, the health care needs of FFS Medicare beneficiaries are more complex than those of other insurers since the program includes significant numbers of the country's most frail and chronically ill. The next sections of this report examine the most significant management challenges facing FFS Medicare and consider the extent to which managed care tools are appropriate to address these challenges.

4 Existing literature also provides limited insight into whether the form of managed care organization (e.g., staff models in which the HMO employs salaried physicians versus network models in which the HMO enters into a contractual agreement with physicians in private practice potentially with similar contracts with other HMOs) affects cost or quality (43, 26).

Challenges For FFS Medicare in the 1990s

What are FFS Medicare's most significant characteristics and challenges for the future? This section reviews the state of the FFS program, focusing on the substantial variations in the use of services by Medicare beneficiaries, their chronic care needs, and the gaps in our knowledge about how best to treat them.

FINDING

The volume and quality of care, particularly chronic and post-acute care, represent significant management challenges for FFS Medicare.

Since the mid-1980s, Medicare's major management tool has been its administered pricing systems. Beginning with the Prospective Payment System in 1983, which uses Diagnosis Related Groups (DRGs) to pay a set amount for each hospitalization and continuing with the implementation of the Medicare Fee Schedule (MFS) in 1992, Medicare reduced the rate of spending increases from an average of 17 percent annually between 1967 and 1983 to 10 percent annually between 1983 and 1994 (59).¹

By successfully managing the price of services, the volume and quality of such services have become the most challenging management problem for FFS Medicare's future. Evidence accumulated over the last two decades indicates that medical care given to

Medicare beneficiaries varies greatly across the country. Studies of surgical procedures in the 1970s and early 1980s showed large differences in the uses of hysterectomies, hernia repairs, appendectomies, and prostatectomies across small geographic regions (50, 56, 10).

More recently, the *Dartmouth Atlas of Health Care* has documented geographic variation in the practice of medicine, concentrating in particular on services provided to Medicare beneficiaries. Figure 1 presents geographic variation in the rate of three coronary procedures performed on Medicare beneficiaries in 1992 and 1993. The rates of coronary artery bypass grafting and percutaneous transluminal coronary angioplasty, two treatments to improve blood flow to the heart among patients with coronary disease, varied four-fold (Figure 1a) and eight-fold (Figure 1b) respectively across hospital referral regions nationwide. The rate of angiography, a diagnostic test to detect blocked arteries, varied almost five-fold nationwide (Figure 1c). The *Dartmouth Atlas* documents similar variation among many other procedures performed on Medicare beneficiaries (15).

One would expect to see such variations in health services if patients' health needs also varied geographically. However, researchers have found that measurable differences in patients' health needs do not explain the variation in health care provided to FFS Medicare beneficiaries. Rather, the likelihood of receiving a particular procedure is more related to capacity of the health care system and the practice styles of physicians in their area (49, 15). Although there is no indication that geographic areas with high rates of use of specific services have greater proportions of inappropriate services than areas with

1 Average annual increases in per capita Medicare spending fell from 14 percent during the period 1967-1983 to 8 percent during 1983-1994 (59).

low or average rates of use, there is also no evidence indicating that providing more health services (at a greater cost to Medicare) necessarily leads to better health outcomes (56).²

QUALITY ISSUES

How can we characterize threats to quality of care (whether that care is given to FFS

Medicare beneficiaries or to any other patient)? There are three types of quality problems: overuse, underuse, and misuse (11, 12). Each has implications for both patients' health and health care costs:

- **Overuse** occurs when the risks or costs of a health service outweigh its benefits. Studies since the 1980s have documented significant rates of overuse of cardio-

Figure 1a
Rate of Coronary Artery Bypass Grafting per 1000 Beneficiaries, 1992-1993
Selected Hospital Referral Regions

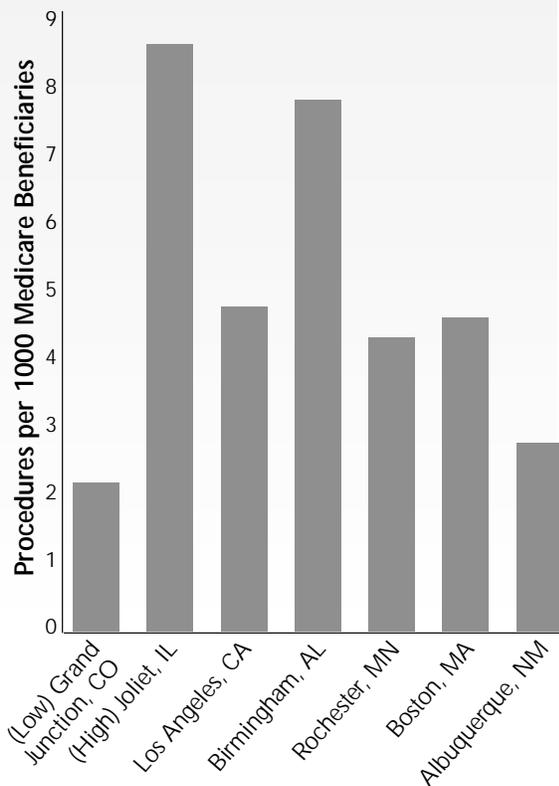
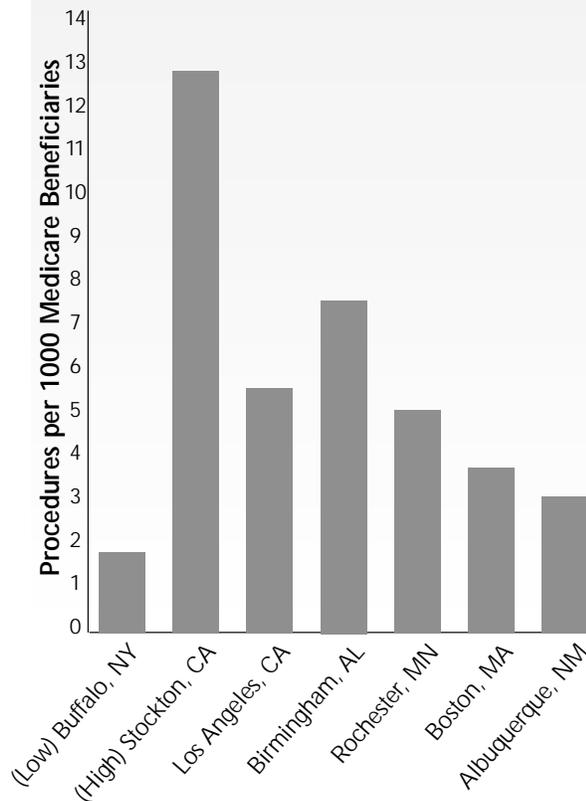


Figure 1b
Rate of Percutaneous Transluminal Coronary Angioplasty per 1000 Beneficiaries, 1992-1993
Selected Hospital Referral Regions



Source: National Academy of Social Insurance, 1997, using data from Dartmouth Atlas of Healthcare world wide web page, <http://www.dartmouth.edu/~atlas/>

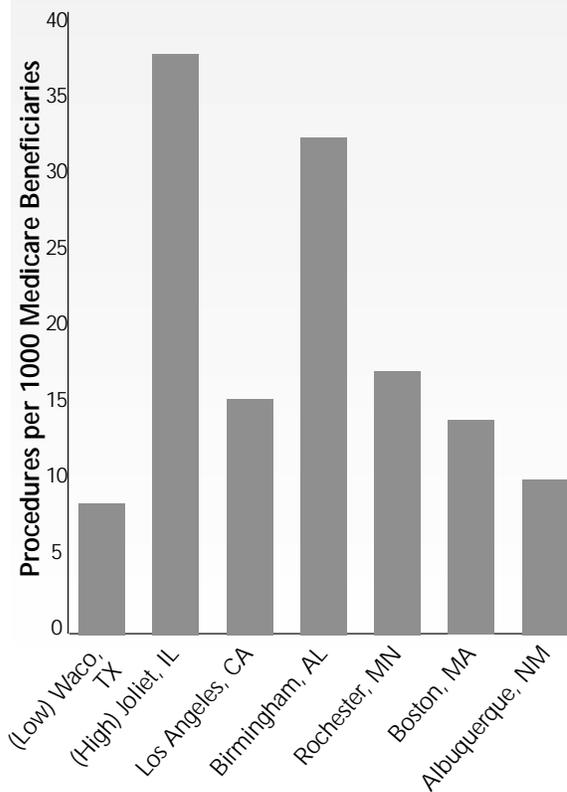
2 When examined from the perspective of individual physicians, this generalization does not hold. For some, usually relatively complicated, procedures, physicians and hospitals that perform them in higher volumes realize better outcomes for their patients than do those who perform them less frequently. For example, see Luft HS, Bunker JP, and Enthoven AC, "Should Operations Be Regionalized? The Empirical Relation Between Surgical Volume and Mortality," *New England Journal of Medicine*, 301(25): 1364-1369, 1979. The underlying hypothesis is that physicians become more skilled the more they perform the procedure.

vascular surgeries, pharmaceutical prescribing, and other procedures commonly received by Medicare beneficiaries. Overuse increases health care spending. As indicated earlier in this report, almost all managed care efforts used by private health plans to date have sought to lower health care costs by lowering use. No well-designed study has documented whether managed care has reduced overuse (as opposed to overall use) (12). Overuse also has been the focus of recent government estimates of significant fraud

and abuse in FFS Medicare program (62, 60), although all overuse is not necessarily the result of fraud and abuse. Like the other quality problems described below, overuse may result from the provider having inadequate information about the patient or about the risks and benefits of the service.

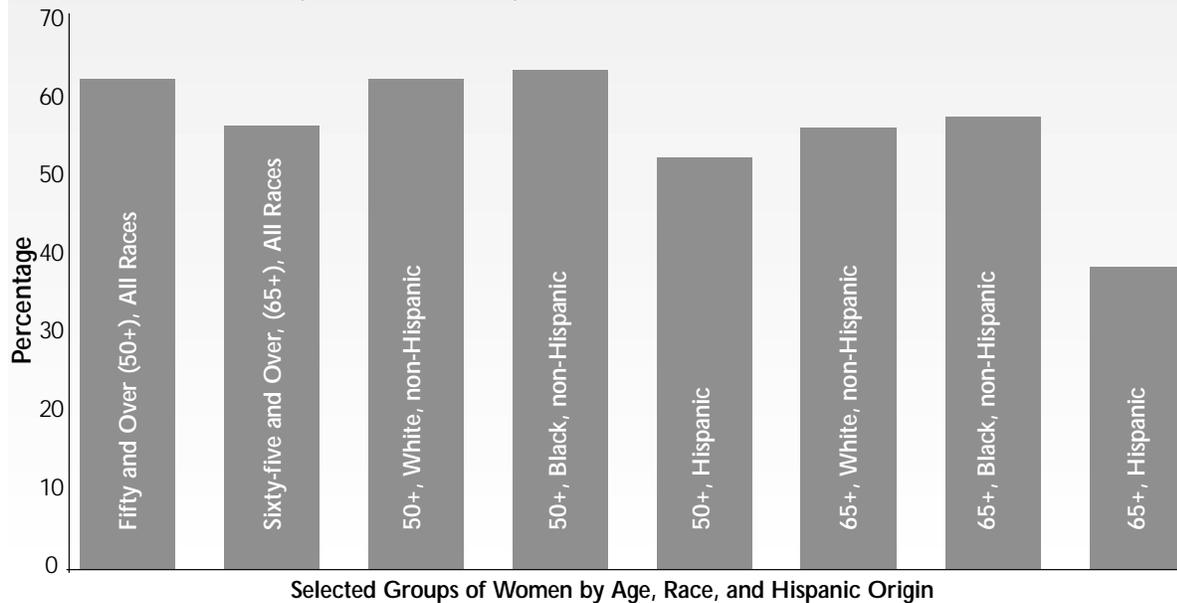
- **Underuse** occurs when a patient does not receive a service whose benefits exceed its risks or costs. Evidence has documented underuse under both FFS and capitated insurance plans, including FFS Medicare. Underuse may tend to reduce health care spending for a particular episode of care (which means that correcting the problem leads to higher health care costs), but the effect on overall costs is unclear since in some cases complications may trigger more intensive, expensive care subsequently.³ For example, although U.S. Preventive Services Task Force, among other groups, recommends that women over 50 receive a mammogram every one to two years, data from the National Health Interview Survey show that 40 percent do not. Among women 65 years and over, the number increases to 48 percent with higher levels among Hispanic women (see Figure 2). Other research has documented that many heart patients do not receive drugs such as thrombolytics (clot-dissolving medications), beta blockers, and aspirin clinically proven to reduce complications and the risk of death (12). The federal Centers for Disease Control recently found that the percent of elderly in nursing homes who receive recommended vaccinations was below 5 percent (41).

Figure 1c
Rate of Coronary Angiography per 1000 Beneficiaries, 1992-1993
Selected Hospital Referral Regions



3 On the other hand, in the extreme case of underuse resulting in early death, the health care system saves money by not having to treat future illnesses patients would have contracted had they lived.

Figure 2
Percentage of Women 50 Years and Older Reporting a Mammography in the Previous Two Years, United States, 1993



Source: National Academy of Social Insurance, 1997. Data from the National Health Interview Survey, reported in National Center for Health Statistics, Health, United States, 1995. Hyattsville, MD: Public Health Service. 1996.

- Misuse** occurs when appropriate services are provided poorly resulting in avoidable complications. Avoidable complications also cost money to treat, which means that quality improvements designed to reduce misuse can be cost-saving (12). Researchers have documented significant rates of avoidable errors in prescribing and dispensing of pharmaceuticals. Although FFS Medicare does not cover outpatient drugs, complications from medication mistakes can cost Medicare money and hurt beneficiaries. Evidence also exists documenting higher rates of mortality and morbidity following surgery by hospitals and surgeons who perform the procedures less often suggesting one strategy for decreasing the harms associated with misuse (39, 12).

CHRONIC AND POST-ACUTE CARE

The quality and costs of chronic and post-acute health care are of particular relevance

for FFS Medicare. The prevalence of chronic illness and disability among Medicare beneficiaries has grown since the program's inception, and it will continue to grow into the next century. The reasons are two-fold: (1) an increased likelihood of becoming very old (i.e., increased life expectancy); and (2) increased numbers of beneficiaries (i.e., aging of the Baby Boom generation).

The development of medical technology has brought about increases in life expectancy by transforming conditions like heart disease from an often fatal condition into a manageable chronic ailment with which beneficiaries live for many years, but which require ongoing monitoring and treatment. The oldest of the old (i.e., those who are over 85) are the fastest growing part of the Medicare population, and they are more likely than younger beneficiaries to have chronic illnesses or disability. Excluding the 5 percent of the over-65 population in nursing homes, 12 percent of elderly Medicare beneficiaries in 1992 reported at least one functional limitation in

an activity of daily living (ADL).⁴ Among those 85 and over, 36 percent reported such a limitation, one third of whom had limitations in three to five ADLs (36). Between 1996 and 2040, the number of persons over 65 will grow from 33.8 million to 75.2 million (16). The number over 85 will grow from 3.7 million to 13.6 million over the same period.

Disability and chronic care needs among FFS Medicare's beneficiaries causes difficulties in managing the volume and quality of health care services for which FFS Medicare pays. These needs underscore the limitations of FFS Medicare's acute care benefits package. Beneficiaries must rely on supplemental insurance or family resources to pay for needed chronic services, especially pharmaceuticals. Alternatively, forgoing needed chronic care can cause avoidable acute care problems that become the responsibility of FFS Medicare. For example, improper monitoring, diet, and pharmaceutical treatment of hypertension can lead to stroke. A lack of regular preventive care and monitoring of diabetics can lead to serious complications.

Furthermore, the FFS Medicare payment system focuses on payment for individual services. While appropriate for treating acute illness within a discrete period of time, it may not be well-designed for managing care for chronically ill patients who need longer-term care management over an open-ended period of time. FFS Medicare gives providers few incentives to coordinate the array of inpatient, outpatient, and other services that can constitute chronic care over time, a component of avoiding overuse, underuse, and misuse of services for these beneficiaries.

Another reason why the lack of chronic and long-term care has effects on FFS Medicare is that the line between acute and chronic care services is not necessarily clear-cut. Those covered Medicare services labeled as "post-acute care" are an example. Post-acute care usually refers to services provided by home health care agencies, skilled nursing facilities (SNF), rehabilitation hospitals, and long-term care hospitals. Increases in spending for these services in recent years have been particularly sharp. Between 1988 and 1994, the portion of total Part A payments going to post-acute providers tripled from 8 to 25 percent (66). While some of this increase reflects a substitution for hospital and other services reimbursed on a prospective basis (while post-acute care reimbursement remained "cost" based), it is also an indication of the chronic care needs of the FFS Medicare population.⁵ The recently enacted Balanced Budget Act of 1997 (P.L. 105-33) has attempted to rein in post-acute care costs by mandating prospective payment for SNF (phased in beginning in July 1998), home health services (by 1999), and rehabilitation hospitals (by 2001) (63).

IMPLICATIONS FOR THE MANAGEMENT OF FFS MEDICARE

The significant geographic variation in rates of health care services not explained by patients' needs is one piece of evidence that FFS Medicare needs to manage the volume and quality of services better. Recent reports of \$23 billion lost annually to Medicare fraud and abuse are another indication of the need.

With the appropriate will and resources, FFS Medicare has an opportunity to take a leader-

4 Functional limitations in ADLs are a common measure of disability and the need for long-term care (36).

5 The bulk of this increase was for home health care. In 1988, a court decision liberalized eligibility criteria for receiving the benefit allowing FFS Medicare to meet more of beneficiaries' needs for home health care. The number of visits per beneficiary grew following the decision, although the cost per visit has remained relatively stable compared to other Medicare services (66).

ship role in establishing a quality-driven strategy to contain costs. By focusing particularly on the problems of overuse and misuse, policy makers may be able to improve quality and save money at the same time (12). Although such a strategy could borrow from the managed care experiences of private insurance, FFS Medicare also should go beyond the private sector's emphasis on overuse to develop broader models of quality improvement that the private sector may, in turn, emulate. Given the increasing numbers of beneficiaries needing chronic care and or living with functional limitations, this strategy should give emphasis to experimentation with tools to manage services for chronically ill and disabled individuals within FFS Medicare.

GAPS IN KNOWLEDGE AND EXPERIENCE

FINDING

There is still much to learn about how to manage care for the over-65 and disabled populations.

Only in the last 20 years has there been a systematic effort to study how patients fare under alternative approaches to treating a given condition, and the amount of solid evidence to guide medical practice is still small relative to the array of potential conditions and treatments (56). A good understanding of how to treat particular segments of the population such as elderly and disabled patients is even more primitive. Not only is there less evidence about the 65 and over population compared to younger patients

(27), but the literature that does exist for those over-65 is more equivocal in its results and treatment implications (38).⁶ More importantly for FFS Medicare, there is minimal experience in how to apply what knowledge that does exist for an elderly population to the management of a health plan.

The health care needs of elderly individuals are different from those of the younger population. For example, as mentioned earlier, 12 percent of those 65 and over have some functional limitation and another 5 percent require nursing home care. By contrast, only 2 percent of those under 65 have any functional limitations and 0.1 percent reside in nursing homes. Differences between elderly and younger populations may reflect physical changes that occur in the aging process or particular social circumstances associated with being older (31). Differences in health status suggest that in some instances appropriate care may also differ.

Recent reports have called for increases in health services research that focuses on Medicare beneficiaries (30, 31, 44). From the perspective of FFS Medicare, this lack of understanding about the best way to treat elderly patients and those with disabilities means there is less of a clinical basis on which to manage care than there would be for other populations. Hence, FFS Medicare's experimentation with tools to manage care for quality enhancement and cost containment will require careful design, monitoring, and a willingness to abandon techniques that do not work. A period of sustained experimentation and learning would be an important component of management innovation in any health plan; it is particularly vital for FFS Medicare whose beneficiaries have been less studied and have more vulnerable health on average than do other populations.

⁶ These equivocal results are due, at least in part, to the fact that older individuals are more likely than younger people to have multiple health problems, making them more difficult to study (46).

Prospects For Innovation In FFS Medicare

This report began by examining how private insurance has the flexibility to experiment with managed care tools. Some of these tools, as well as others that are yet to be tested, may have potential to enhance the quality and reduce the costs of treating FFS Medicare beneficiaries. If successful, they may provide lower costs, improved functioning, and longer life. However, as a public program, FFS Medicare is not equivalent to private insurance. This section explores some of these differences and their implications for modernizing FFS. It begins by examining the historical context for the program's current administrative structure.

FFS MEDICARE'S ADMINISTRATION

FINDING

The administrative structure of FFS Medicare today largely reflects the choices available in the 1960s and 1970s. Such a system would not serve FFS Medicare well for the future.

In enacting Medicare in 1965, lawmakers sought to provide the elderly with health insurance comparable to that available from employers to their working-age employees (2). The original Medicare legislation (P.L. 89-97) adopted the most prevalent principles of private insurance at the time: (1) reimbursing providers on a fee-for-service basis, (2) participation of most providers, and (3) an administrative emphasis on payment rates

rather than on the quality or volume of services provided. It codified these principles in FFS Medicare's reimbursement formulas, in the restrictions it placed on the program, and in the administrative structure it put into place.

Payment

FFS Medicare originally established rules to reimburse hospitals according to "reasonable costs" and physicians according to "usual, customary, and reasonable" rates for services provided to Medicare beneficiaries.

Administratively, the Medicare statute directed the executive branch to contract exclusively with private organizations (called "intermediaries" for Part A and "carriers" for Part B) in each geographic area to process claims and carry out all other functions related to paying FFS Medicare's bills. Carriers and intermediaries are Blue Cross, Blue Shield, and other commercial insurers. Since the federal government had established a FFS Medicare benefits package that resembled private insurance of the time, it made sense to administer it through the organizations most experienced to do so. The federal government had no experience in paying claims and needed the expertise of organizations experienced in administering health insurance. By delegating FFS Medicare's actual bill-paying, the federal government's role became regulatory — to promulgate regulations governing payment rules; establish carrier, intermediary, and other contracts; and certify providers to participate in the program. By establishing systems of administered prices, the Prospective Payment System (PPS) adopted for hospitals in 1983 and the Resource Based Relative Value Scale fee schedule implemented for physicians in 1992, served to reinforce the federal government's regulatory role in FFS Medicare.

In 1996, Congress introduced a small amount of flexibility in how HCFA contracts for administrative services. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 (P.L. 104-191) included a provision that, for the first time, granted HCFA greater flexibility in contracting for administrative functions. The Medicare Integrity Program (MIP) allows the federal government to carve out particular functions that otherwise could only be part of claims processing contracts with carriers and intermediaries. However, Congress limited this flexibility to activities that help combat fraud and abuse (73).

Prohibition of Interference With the Free Practice of Medicine

The Medicare statute explicitly prohibits the federal government from exercising “any supervision or control over the practice of medicine.” The inclusion of this provision in the 1965 legislation reflected both a fear of socialized medicine (2) and the prevailing function of insurance at the time: to pay bills, not to manage health services (20). Hence, the system of quality assurance that developed for Medicare over the 1970s and 1980s relied heavily on peer review by providers, not on federal examination of medical practice. Although the program has evolved over the years, its basic structure and philosophy remains.

In 1970, the federal government established Experimental Medical Care Review Organizations (EMCROs), voluntary associations of physicians who reviewed Medicare and Medicaid-funded services on a demonstration basis. EMCROs became the model for Professional Standards Review Organizations (PSROs), established by Congress in 1972. The federally-funded PSRO program gave grants to nonprofit local physician organizations that attempted to reduce costs and improve quality (30). The PSRO program tried to balance these goals by funding both peer review to reduce hospital lengths-of-stay and medical care evaluation studies to try to improve quality (9).

With the adoption of PPS for hospitals in 1983, Congress replaced PSROs with Utilization and Quality Control Peer Review Organizations, or PROs. Congress’s charge to PROs placed a greater emphasis on cost control, and at their inception, PROs were originally more punitive in nature than PSROs. However, the basic principle of peer review with minimal direct HCFA involvement remained.⁷

Hence, the delegation of quality assurance to private organizations and the emphasis of those organizations on process and costs meant that Medicare’s own administrative structure has traditionally focused more on

7 PROs differ from PSROs in several other ways as well. Among them: (1) PROs have less autonomy from HCFA oversight than did PSROs; (2) PRO designations were awarded through competitively bid contracts, while PSROs received grants; (3) there are only 54 PROs, while there were 195 PSROs; (4) unlike PSROs, PROs cannot delegate quality assurance and utilization review responsibilities to individual hospitals deemed capable of carrying out these functions. A congressional-mandated study by the Institute of Medicine addressed the limitations of the PRO program by recommending that Medicare have explicit responsibility for assuring the quality of care for its enrollees (defined as “the degree to which health services for individuals and populations increases the likelihood of desired health outcomes and are consistent with current professional knowledge”) (30). Since 1990, PROs have begun to evolve from punitive programs toward more collaborative facilitators of quality improvements (9). This philosophical reorientation towards cost-effective health outcomes figures prominently among the recommendations of this NASI Study Panel as well.

the price of services provided compared to their volume and quality.

Freedom of Choice

The original Medicare legislation also guaranteed all beneficiaries the freedom to use any provider qualified to participate in Medicare, if the provider was willing to treat the beneficiary. In specifying qualifications for participation, the legislation provided few conditions for excluding providers licensed by a particular state. Hence, Medicare's original legislation provided no leeway for the federal government to select providers on the basis of cost or quality of care.

Taken together, these provisions gave FFS Medicare its primary role as a bill-payer and the federal government the role of defining eligibility and benefits as well as promulgating and enforcing the rules and regulations by which contractors paid FFS Medicare's bills. This administrative structure, state-of-the-art 30 years ago, remains today. It stands in contrast to the flexibility that private health plans have to experiment and learn on an on-going basis. As evidenced by the significant geographic variations in the rates of FFS Medicare services discussed earlier, a system in which relatively few federal employees are directly involved in quality assurance is difficult to manage. The Study Panel believes such a system would not serve FFS Medicare well for the future since it provides minimal opportunity to protect or improve quality in the volume and nature of services given to beneficiaries. The next section examines how some of the specific characteristics of FFS Medicare's current administrative structure impede innovation.

STATUTORY LIMITS TO INNOVATION

As a federal program, FFS Medicare faces statutory constraints that proscribe how HCFA conducts its business. One must keep these provisions in mind when contemplating efforts to innovate the ways in which HCFA administers FFS Medicare.

FINDING

Statute limits FFS Medicare's management and innovation capabilities; changes in program philosophy or procedure will require clear authorization in law.

There are reasons for FFS Medicare's current legal structure. It helps assure that public decisions are made in the public interest and that every qualified enterprise has an opportunity to do business with this public program — i.e., it regularizes HCFA's administrative processes and affords excluded vendors with the opportunity to protest the government's decision. Among the types of legal restrictions HCFA faces in administering FFS Medicare are:

- **Congressional limitations on flexibility.** In carrying out its responsibilities, Congress frequently does not allow the executive branch much latitude in decision-making. In addition, over time, Congress may constrain any latitude that it may provide when it first enacts legislation. Statutes, except for those that Congress repeals altogether, tend to become longer and more proscriptive over time.

- **Procedural requirements.** Because there is a reluctance to let government agencies exercise the level of discretion in managing public programs afforded private sector firms, Congress has established procedures and requirements for most aspects of FFS Medicare administration including choosing contractors to process claims or to serve as a PRO. These procedures appear in such laws as the Administrative Procedure Act (5 U.S.C. s. 553), as well as in the body of statute establishing and amending the FFS Medicare program itself. Regulations implementing aspects of Medicare law, such as those annually setting reimbursement amounts for each FFS Medicare hospitalization, physician procedure or covered piece of medical equipment, are subject to “notice and comment” procedures. Requirements to document the costs and other likely impacts, and the need to get clearances from the Office of Management and Budget, may apply to new regulations and paperwork. These requirements can be cumbersome and can delay decision-making. Rule-making procedures also give rise to judicial appeals of proposed regulations, creating further delays.
- **Procurement policies.** Government agencies face restrictions in procurement and hiring not faced by the private sector, thus allowing the private sector to operate often in a more expeditious fashion. For example, HCFA usually must use “request for proposal” (RFP) procedures that prescribe a very detailed process for contracting.⁸ In addition, HCFA traditionally has had little discretion to carve up the functions performed by carriers, intermediaries, and PROs in order to contract

with different types of organizations to perform particular aspects of claims processing, payment, and quality assurance. The MIP, created by Congress in 1996 and described in greater detail in Appendix C, gives HCFA somewhat broader discretion to contract selectively with carriers and fiscal intermediaries that pay bills, audit claims, construct physician profiles, and perform other services related to the payment process. Hiring also is subject to the restrictions and processes laid out in civil service statute, thus limiting or delaying any management strategy that involves changing or hiring new personnel.

- **Limitations of the Medicare demonstration waiver authority.** Similarly, the Medicare program’s process for conducting research and demonstrations is lengthy and subject to delays. HCFA must develop RFPs, receive clearance from the overall Department of Health and Human Services as well as the Office of Management and Budget to promulgate them, solicit responses, review and approve or reject them, agree on the specific terms of the demonstration, and evaluate its success. This process can include significant amounts of executive branch clearance and congressional oversight, which can protract the process. Although the demonstration authority allows HCFA to test innovative approaches to providing and paying for FFS Medicare benefits, they are for a limited amount of time. There is no general process whereby HCFA can integrate successful experiments or other knowledge gained through the demonstration process into the management of FFS Medicare without new statutory authority from

8 Although it must follow RFP procedures for many types of procurement, it has not generally chosen intermediaries and carriers, the claims processing contractors, on a competitive basis in the past (51).

Congress and signed into law by the President. The Study Panel addresses this latter constraint in greater detail later in this report.

- **Transparency.** Many decisions made by private health plans require managerial judgment and are made privately. In contrast, statute usually requires that government agencies make their decisions more openly and according to well-specified procedures. Such scrutiny, designed to bolster confidence that decisions are made in the proper fashion and by appropriate means, creates concern among government agencies about outside criticism — by the press, the Congress, and various investigative bodies such as the Inspector General and the U.S. General Accounting Office. Such concern can provide an incentive for inaction by government agencies.

Hence, any attempt to incorporate a philosophy of sustained innovation and flexibility into FFS Medicare will require a change in law. In changing current law, Congress will have to weigh the potential benefit of greater discretion in the administration of Medicare against the risk and costs of relaxing certain statutory restrictions. In the past, congressional reluctance to grant Medicare more discretionary authority is understandable. Congress has been able to achieve budget savings targets through its administered pricing systems for FFS Medicare services, and there have been few other health care management techniques in the private sector with well-established potential to improve quality and save money. For the future, FFS Medicare needs to be able to develop such capabilities within a context that assures appropriate accountability to the President and the Congress. The recommendations section of this report addresses the issue of accountability in greater detail.

OTHER LIMITS TO INNOVATION

FINDING

Politics and other factors pose additional limitations on HCFA's discretion in managing the FFS Medicare program.

The federal government also faces non-statutory barriers to using discretionary authority. These are inherent in the size of the program and the nature of the governmental enterprise:

- **The size and dominance of FFS Medicare.** FFS Medicare accounts for more than one-third of the patient volume of many providers, and in some cases (e.g., ophthalmologists, oncologists, many internists) more than half (1). Consequently, punitive measures such as termination from participation in FFS Medicare can make it difficult for the provider to earn a living, particularly since exclusion from Medicare requires exclusion from Medicaid and other federal health programs. Private payers also may exclude such providers from receiving reimbursements under their insurance plans. Similarly, businesses that supply FFS Medicare with durable medical equipment, supplies like oxygen, or other services may become dependent on FFS Medicare for their profitability. These same firms may employ large numbers of people within their communities, thus making deselection potentially economically painful and disruptive. At the very least, the congressional delegation representing such a supplier's district would have an incentive to prevent deselection.

- **Political intervention.** More generally, inaction or delay often results from executive branch or congressional intervention at the behest of client or provider interests, holding up clearance or signaling that a particular demonstration or regulatory provision would likely provoke a punitive response from Congress or the executive branch. Such actions can delay particular initiatives or lead to their abandonment.
- **Slowness in decision-making processes.** Government agencies often are slow in making decisions because of their size and how they are organized. For example, HCFA's issuance of a program regulation can take several years as can approval of an application to conduct a demonstration project. Although HCFA, or some successor agency, could improve its performance, some of the slowness is inherent in the nature of government and the levels of approval required for decision-making on the public's behalf. Juxtaposed against this are private health plans that are more nimble in their decision-making — e.g., changing payment mechanisms frequently and, also, making adjustments to reflect the circumstances of individual providers within the network.

This analysis suggests that statutory changes may not be sufficient for FFS Medicare to adapt or even experiment with many of the managed care techniques that are used or tried in private health insurance. Indeed, some techniques, like those that would involve the deselection of large numbers of FFS Medicare providers or suppliers dependent on the program for a large portion of

their revenue, may not be feasible or even appropriate in some communities.

In light of these observations, the Study Panel devoted considerable effort to analyzing how one might design a process for FFS Medicare to experiment and learn about the applicability of managed care techniques while preserving the accountability appropriate to a public program like FFS Medicare. The alternatives considered by the Study Panel ranged from working within existing Medicare research and demonstration authority to the creation of a new authority within HCFA to provide sustained innovation for FFS Medicare to turning HCFA into a public corporation analogous to the U.S. Postal Service. The recommendations section later in this report summarizes this analysis and elaborates on the option that the Study Panel chose.

INNOVATIONS IN THE CURRENT MEDICARE FFS PROGRAM

Within the boundaries of its current statutory authority and prevailing administrative structure, Congress and HCFA have begun to explore the applicability of managed care tools to FFS Medicare. In addition, the Balanced Budget Act of 1997 includes a few additional mandated demonstrations and added flexibility to explore other new ideas for FFS Medicare. Appendix C describes each of these activities in greater detail. Taken together, however, they show the limitations in HCFA's ability to introduce needed innovations in FFS Medicare.

FINDING

Some provisions in the Balanced Budget Act of 1997 and other HCFA demonstrations begin to test innovations in FFS Medicare; however, these activities are limited in the number of beneficiaries who can participate and the difficulty in incorporating successful demonstrations into regular program management.

Innovations To-Date

Within its existing authority, HCFA has undertaken:

- demonstrations to test whether FFS Medicare can realize volume-based savings while preserving, if not enhancing, quality by designating well-qualified facilities as specializing in high volume and/or high cost procedures (Centers of Excellence).
 - demonstrations to test the implications for cost and quality of bundling payments to hospitals and physicians for treating certain conditions.
 - to allow states to seek waivers from federal requirements in order to coordinate care for beneficiaries dually eligible for Medicare and Medicaid.
 - a number of demonstrations that bundle payments from Medicare and Medicaid to test coordinating care for dual eligibles, frail beneficiaries, and those with chronic illness and disability.
 - to fund the development and testing of new methods of doing physician profiling and other tools to identify physician practice patterns.
- In addition, in recent years, Congress has enacted legislation that has:
- allowed HCFA for the first time to contract competitively and selectively with organizations other than carriers and intermediaries for services to prevent waste, fraud, and abuse in the payment of FFS Medicare claims (the MIP created by the HIPAA of 1996, P.L. 104-191).
 - made the Program of All-Inclusive Care for the Elderly (PACE) a permanent option that states may offer for beneficiaries dually eligible for Medicare and Medicaid (BBA of 1997, P.L. 105-33). Before 1997, PACE was an 11-site demonstration designed to provide coordinated managed care services to frail elderly at risk of needing nursing home care.
 - added new diabetes self-management benefits (BBA of 1997).
 - mandated demonstrations in eight sites of new ways of providing care (including flexibility in the FFS Medicare benefits package and payment formulas) for beneficiaries with chronic illnesses (Medicare Coordinated Care Demonstration Project, BBA of 1997).
 - mandated five demonstrations in three sites each to test the competitive acquisition of services and items covered under Part B of FFS Medicare. Under this demonstration, Congress allows HCFA for the first time to contract selectively or even exclusively with suppliers as long as the exclusion does not create access or supply problems (BBA of 1997).

These activities help to lay an important foundation for the innovation necessary in FFS Medicare. In particular, they begin to experiment with competitive procurement, provider selection, and the flexibility to enhance and manage services, the tools identified earlier in this report as areas where those responsible for FFS Medicare should focus their efforts.

Limitations

At the same time, however, the efforts made by Congress and HCFA to date are limited in significant ways. Rather than encompassing a coherent, overall philosophy about how FFS Medicare should be managed, they represent individual exceptions to the historical and prevailing operation of FFS Medicare as a bill-payer. While experimentation on a small scale is necessary in order to learn, these activities are not part of a broad commitment on the part of the Congress to allow the flexibility necessary to allow innovation and quality improvement throughout FFS Medicare on an on-going basis.

In addition, in the absence of flexibility from Congress, much of HCFA's initiatives have rested on its demonstration authority. As discussed earlier, demonstrations can take a long time to set up as HCFA prepares solicitations for proposals, reviews them, and makes the final awards. Even when successful, demonstrations involve only a limited number of sites and can benefit only a limited number of FFS Medicare enrollees. Without congressional action, HCFA has limited options in replicating such successes in the larger pro-

gram. It can go through the process of setting up additional demonstrations at new sites (as HCFA is doing with its Centers of Excellence demonstration), or it can seek authority from Congress to make the innovation part of the regular FFS Medicare program (as Congress did with the PACE program).¹ The lack of a clear process for making use of the lessons learned through demonstrations underscores congressional ambiguity about the extent to which it wants to innovate within FFS Medicare.

Traditionally, the distinction between demonstrations and regular program management was heightened by the fact that different parts of HCFA administered them. A recent reorganization places demonstrations concerning payment within the Center for Health Plans and Programs, which has responsibility for day-to-day operation of FFS Medicare (6). However, demonstrations that study things other than payment remain removed from regular program management, and all successful experiments encounter the same barriers to expansion.

Finally, without congressional backing, some types of experimentation have remained largely off-limits, particularly those that would exclude potential providers of FFS Medicare supplies or services. Even if technically allowed under Medicare's demonstration authority, providers who might lose out under such a scheme can appeal to congressional representatives to intercede. An attempt in 1996 and 1997 to initiate a competitive bidding demonstration to set the federal payment for HMOs providing Medicare services in a

1 Occasionally, Congress specifies in law a process for replicating experiments that go well as it did in mandating the demonstrations of coordinated care for chronically ill beneficiaries and competitive procurement of Part B items and services in the BBA of 1997 (PL. 105-33). Even if these experiments prove successful and are replicated, they will still remain demonstrations, limited in number and scope, and outside regular program operations.

given area was stopped by the affected health plans who turned to both Congress and the courts for help.² Hence, the competitive acquisition demonstration mandated under Part B and the MIP created by HIPAA of 1996 do represent significant developments since they carry a congressional imprimatur to contract competitively and selectively.

Summary

Within the statutory and other limitations described earlier in this report, HCFA has engaged in limited, but significant attempts to innovate the way it manages portions of the FFS and other components of Medicare. Because FFS Medicare must carry out these activities under its current research and demonstration authority, they test only a limited number of potentially useful innovations, involve only fragments of the beneficiary population, and cannot be broadened without statutory changes. So far, the basic bill-paying orientation and administrative structure of FFS Medicare remains much as it has since the program's inception. This finding led the Study Panel to seek new mechanisms for continuous innovation and learning to improve quality.

Recommendations

The Study Panel's analysis and findings presented above lead it to make five recommendations designed to modernize FFS Medicare for the next generation. The Study Panel emphasizes that these recommendations affect only FFS Medicare and should be read within the context of NASI's overall *Restructuring Medicare for the Long Term* project. As part of that larger effort, three other NASI Study Panels are examining other aspects of Medicare's long term future — issues related to capitation and choice, Medicare's larger social roles, and financing issues. They will each issue their reports with findings and possible recommendations.

RECOMMENDATION 1

Congress should mandate that FFS Medicare move beyond its traditional role as a bill-payer to become accountable for the quality and costs of services provided to beneficiaries.

Given that FFS Medicare will likely remain the predominant way in which beneficiaries receive Medicare benefits and that FFS Medicare contains significant unrealized opportunities for quality and cost improvement, the Study Panel believes a change in FFS Medicare's overall thrust is vital in order to exploit these opportunities. In particular, the Panel recommends that FFS Medicare move beyond its traditional role as a bill payer to become more accountable for the quality and costs of services pro-

² The BBA of 1997 specifies a process for this particular experiment to go forward. The forthcoming final report of the National Academy of Social Insurance's Study Panel on Medicare Capitation and Choice contains further details about this demonstration (45)

vided to beneficiaries. What would this change mean for FFS Medicare?

A congressional commitment to such innovation in FFS Medicare would enable the program's administrators to place greater emphasis on assuring appropriate volume and quality of services paid for by FFS Medicare. Although the physician remains the professional most responsible for working with the patient in making medical decisions, FFS Medicare as a program would have greater flexibility to develop and use new tools to assure a range of clinically appropriate benefits available for patients, particularly those with chronic illnesses and other special health needs, and in achieving better quality and cost-effectiveness (if cost-savings)¹ of all FFS Medicare services.

Second, this philosophical shift recognizes that FFS Medicare is one among a number of options for receiving Medicare benefits available to many beneficiaries. FFS Medicare already "competes" in many areas with private health plans. The enactment of the Medicare+Choice program will increase the number of capitated options available to beneficiaries living in many areas of the country. In addition, for the first time, HCFA will ask beneficiaries on an annual basis to choose whether they want to be in FFS Medicare or one of the Medicare+Choice health plans for the following calendar year.² As a health pro-

gram, FFS Medicare would essentially compete for beneficiaries by seeking cost-effective innovations in the provision and administration of care, while remaining universally available to those who decide the Medicare+Choice plans do not meet their needs.

Third, this philosophical shift would imply greater flexibility in the administration of FFS Medicare. Understanding how best to reimburse claims is less complicated and less uncertain than knowing how best to improve quality and control costs. This accountability requires a commitment to experimentation and learning — to try new approaches, to adopt what is successful, and to abandon what is not successful. As discussed throughout this report, such flexibility runs counter to the way the federal government has administered the FFS Medicare program over the years. Furthermore, greater flexibility likely would require investing in the infrastructure of FFS Medicare, particularly in additional people and expertise perhaps not now found in HCFA. Congress would make this investment with the expectation of long-term benefits for both taxpayers and beneficiaries.

The Institute of Medicine's (IOM) Committee to Design a Strategy for Quality Review and Assurance in Medicare made a very similar recommendation in its 1990 report (30).³ The role of managed care organizations and techniques in the health

1 "Cost-effectiveness" in health care incorporates both health and economic impacts of alternative interventions. One intervention is more cost-effective than another if it uses fewer economic resources for an equal amount of benefit. For example, assume that one measures benefits in terms of extra years of life. If Intervention A costs \$15,000 per added year of life while Intervention B costs \$25,000 per extra year of life, then Intervention A is more cost-effective than Intervention B. "Cost savings," as the term implies, refers only to the economic impact. Intervention A achieves cost savings over Intervention B if it is produced with fewer economic resources, regardless of the benefits either provide.

2 Any beneficiary who does not return the annual election form will be enrolled in FFS Medicare.

3 The text of the IOM Committee's recommendation was: "Congress should expand the mission of Medicare to include an explicit responsibility for assuring the quality of care for Medicare enrollees, where quality of care is defined as the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge" (30).

care system as a whole has grown significantly since the release of that report. A more recent IOM committee called for reforming both the FFS and capitated programs in Medicare to make them accountable for beneficiaries' health care and more like the health plan options employers make available to their employees (31).

This recommendation is a starting point from which flows the Study Panel's other suggestions for modernizing FFS Medicare. Although the Panel believes the recommendations that follow represent the necessary, practical steps in carrying this more general mandate, the Study Panel nevertheless believes that Congress should explicitly mandate this change in philosophy to provide a clear mission for FFS Medicare.

RECOMMENDATION 2

Congress should direct HCFA to innovate FFS Medicare on an on-going basis by adapting (and going beyond) the best practices of private health plans. HCFA should experiment with new ways of managing services including disease and case management, especially for beneficiaries with chronic and other conditions, providing beneficiaries with incentives to use selected providers, and a unique competitive procurement process for FFS Medicare. HCFA should target these innovations toward the geographic areas and populations where they have the greatest potential to improve quality and cost outcomes.

The Study Panel's review of managed care techniques identified a number of tools that could hold promise for FFS Medicare. As research suggests clinical strategies for providing better care for elderly and disabled populations, and as private health plans begin to experiment with these ideas and other managed care tools, there will be new opportunities for FFS Medicare to apply and refine them as well. As described in the text of this report, the types of managed care tools that FFS Medicare should be prepared to try are:

- **Case and disease management and preventive services, particularly for beneficiaries with special health needs**— FFS Medicare should have the flexibility to contract with government, nonprofit, and for profit organizations with appropriate expertise to provide such services to beneficiaries. FFS Medicare should furthermore develop tools of data analysis to identify opportunities to enhance beneficiaries' quality of care and manage program costs. Among the conditions that may hold the greatest potential for cost and quality improvements as FFS Medicare begins this process of experimentation and learning are chronic conditions like congestive heart failure, chronic obstructive pulmonary disease, diabetes, hypertension, chronic pain, and arthritis as well as the prevention of falls and end-of-life care.
- **Incentives to use selected providers**— FFS Medicare should encourage beneficiaries to use providers who do the best job in terms of cost and quality. This might include expansion of the Centers of Excellence approach to include a much wider array of services and locations as well as experimentation with PPOs, perhaps in which beneficiaries face lower Medicare premiums in

exchange for a designated PPO physician.

- **Competitive procurement**— FFS Medicare should seek ways to use its buying power in the marketplace to realize savings (and maintain or augment quality) in the goods and services it purchases on behalf of beneficiaries. However, FFS Medicare should limit these experiments to geographic areas and purchases where: prices paid by private health plans are significantly below those paid by FFS Medicare for comparable goods and services. However, in implementing any experiment with competitive purchasing, HCFA would want to protect beneficiaries' access to a broad range of providers and suppliers. In addition, HCFA would need to maintain enough viable providers and suppliers in the marketplace to assure an effective procurement process in future years. These considerations would be necessary given the substantial purchasing role Medicare plays in the health care marketplace. Although the BBA of 1997 (P.L. 105-33) mandates five demonstrations for the competitive acquisition of selected Part B services and HIPAA (P.L. 104-191) allows competitive procurement of services to minimize fraud and abuse, the panel recommends broader experimentation with methods of competitive procurement, with the types of goods and services acquired, and with the geographic areas involved.

The Panel recommends that Medicare's use of these managed care tools be characterized by experimentation, planning and evaluation, selectivity, and adaptation:

- **Develop a culture of experimentation, innovation, and learning** — Medicare's goal should be to innovate

in the way a private sector corporation innovates — to move forthwith to implement changes based on recently realized successes and failures.

Evaluation remains an important component of this new philosophy, but the results of such evaluations should be directly incorporated into future practice. HCFA should try new ideas, abandon those approaches that do not work, and attempt to replicate those that do in other, appropriate locales. This notion is similar to the idea of "continuous improvement" found in the practice of total quality management (3). The Panel believes that changes in FFS Medicare should occur incrementally given its size, complexity, and the potential downside of mistakes for beneficiaries. Experiments should be tailored to local health care markets and involve specific populations and services. As HCFA identifies successes and their correlates, it should extend the innovation to other localities where it also shows promise. Incremental change also allows beneficiaries to adapt more easily and it permits policy makers to recognize and back away from mistakes more easily.

- **Develop and maintain a well-articulated, thoroughly reviewed plan to manage these innovations**— In creating and updating this plan, HCFA should track developments in both clinical medicine and health plan management. It should keep abreast of research activities funded by the Public Health Service, other published research literature, and innovations among all types of private health plans in order to identify new managed care tools as well as conditions that may be appropriate candidates for case management, prevention, and related interventions. This innovation plan should lay out the agency's

priorities for experimentation and learning within FFS Medicare, and it should invite suggestions for experiments from providers, state and local governments, the public, and other nonprofit and for-profit organizations. HCFA should update these priorities at least annually. A 1997 editorial in the *Journal of the American Medical Association* proposed creating an organization responsible for tracking threats to quality of care and valid evidence about the effectiveness of potential solutions for the health care system as a whole (40). This innovation plan could begin to fill that role for quality issues that affect FFS Medicare. In addition, the plan will help beneficiaries and Congress hold HCFA accountable for both cost and quality outcomes of services for which FFS Medicare pays

- As implied in the discussion above, FFS Medicare should **selectively target** its experimentation to those geographic areas and beneficiary populations where they have the greatest potential, rather than seeking to use each tool universally throughout the country. In developing the innovation plan described above and inviting suggestions for experiments from providers, state and local government, the public, and other organizations, HCFA may wish to focus on states or counties with noteworthy underutilization of needed health services, medical conditions associated with high levels of preventable mortality or morbidity, or particularly high utilization of inappropriate health care.
- In designing its experiments with managed care tools, HCFA should remain open to **adapting** each tool to make it appropriate for a public program like Medicare and for a beneficiary population that has more chronic conditions than those who are usually enrolled in

private health insurance plans. Furthermore, as outlined in the next recommendation, Congress should direct HCFA to adapt Medicare to allow it to develop and use managed care tools to improve the quality of FFS Medicare.

In a recent report, the American College of Physicians (ACP) similarly recommended that Medicare seek new ways to organize and finance care for beneficiaries (71). The ACP identified the clinical potential of case management and other managed care techniques like those this Panel envisions and recommended that Congress allow HCFA greater flexibility in experimenting with them.

RECOMMENDATION 3

In order to carry out these experiments in the management of FFS Medicare, HCFA should have the authority to waive some statutory requirements.

The Study Panel recommends that Congress provide HCFA with new authority to waive some of the normal requirements for the administration of FFS Medicare when it is in the best interest of beneficiaries and taxpayers — i.e., to test new strategies that show potential for enhancing quality or containing costs and to expand successful experiments to additional beneficiaries.

Options Not Chosen by the Panel

Once the Panel concluded that there are opportunities for FFS Medicare to develop managed care techniques to enhance quality and constrain costs, it turned its attention to the best way of structuring the process of

experimentation and innovation within HCFA. In one of its background papers (53) and in its own analysis, the Study Panel considered three basic approaches for institutionalizing innovation, including granting the new waiver authority ultimately recommended by the Study Panel. The two options not chosen by the Study Panel were to continue to use Medicare's current demonstration authority and to make HCFA an independent agency or public corporation:

■ **Use the current Medicare research and demonstration authority—**

Although HCFA has made good use of its demonstration authority, it represents “innovation by exception.” In its current incarnation, HCFA has limited connections with the day-to-day operations of FFS Medicare, and it is not governed by an overall philosophical mandate to transform the program. The Panel concluded that the current demonstration authority would not be sufficient to bring about the type of change FFS Medicare requires because of the long lead time necessary in setting up and expanding demonstrations. Furthermore, the structure of the current demonstration authority usually requires statutory changes in order to make successful demonstrations part of the regular program. The Study Panel believes HCFA should have greater flexibility to reap the benefits of successful innovations than it does now because there are relatively infrequent opportunities to legislate changes in the Medicare program.

■ **Recreate HCFA as an independent agency or public corporation—**The Study Panel and one of its commissioned papers (53) considered two examples of organizations that are charged with public functions in the

United States but are more independent than HCFA is currently — the Social Security Administration (SSA) and the Postal Service. The Study Panel used these two case studies to explore whether an organization, freed from some or many restrictions of administrative law and civil service procedure could function more like the private insurance companies who have the flexibility to try and adopt or abandon managed care techniques expeditiously.

The SSA, which became independent of the Department of Health and Human Services (DHHS) in March 1995, is similar in many ways to HCFA in that it administers a social insurance program. Although SSA can issue regulations and conduct other administrative business faster than it could as part of DHHS, this flexibility coupled with SSA's independent status may have actually left it more exposed to congressional questioning and intervention (53). In the case of the Postal Service, the special powers that it acquired upon becoming a public corporation in 1971 (e.g., expeditious hiring authority) would not be particularly helpful to the HCFA as it attempts to innovate the FFS program. Furthermore, the process of determining rates, a function that is likely to be important in experimenting with many managed care techniques, is still subjected to a complex and lengthy administrative process for the Postal Service (53). Hence, because Medicare is a public program, re-establishing the agency that manages it as an independent or semi-private organization conveys no particular advantage in bringing about needed innovation.

The option ultimately recommended by the Study Panel, the establishment of a new

waiver authority, would maintain the advantages of entrusting Medicare's management to a government agency — in particular, accountability to Congress and the American public. The accountability would keep HCFA responsive to potential public concerns about the innovations, especially that the pace of change be steady and progressive, but not be too fast.

As pointed out earlier in this report, Congress has been unwilling to provide HCFA with much managerial latitude. In the past, the political reluctance to grant HCFA more discretionary authority is understandable. Congress successfully has achieved budget targets mostly by regulating payment rates, and there have been few well-established health care management techniques available from the private sector. For the future, FFS Medicare must be able to develop such capabilities, although within a context that assures political accountability to the President and Congress.

How Would This New Waiver Authority Work?

Under the new waiver authority recommended by this Study Panel, Congress would permit the Secretary of DHHS to waive requirements under the federal statute governing FFS Medicare for a particular period of time (probably three or more years)⁴ in order to experiment with the managed care tools outlined above. In each case, the ultimate public policy goal would be to enhance the quality of care or improve its cost-effectiveness — i.e., to implement Recommendations 1 and 2 above. The Secretary also

would have the authority to alter, discontinue, renew, or expand each experiment as the HCFA learns what works and what does not.

Appendix D contains potential legislative language for a waiver authority consistent with the Panel's recommendation. It details the types of projects the waiver might encompass, limitations of the authority, and accountability for its use.

Types of Projects Envisioned— The Panel views this authority as a means of trying novel ways of organizing, managing, contracting for, and paying for care. The number and scope of these waivers would depend on the needs of patients in a given geographic area and the availability of qualified potential contractors. Potential contractors could be new or existing organizations. They could be health plans, networks, provider-sponsored organizations, and other groups that might be qualified to provide a diversity of services to Medicare beneficiaries. Alternatively, they could be organizations that specialize in particular goods and services (e.g., stand-alone clinical laboratories, organizations that specialize in patient education, or utilization review). They could be either for-profit or non-profit.

The managed care tools allowed under this authority could be either administrative or clinical in nature, or they could be support services with the potential to improve FFS Medicare's efficiency or quality. HCFA could pay contractors under a bid price, FFS, incentive, or risk basis, depending on the nature of the services they provide and the

4 It may take several years to determine the long-term effects of some managed care approaches even if there may be tentative indicators of success or failure before. However, the exact length of the waiver may be somewhat arbitrary since the Study Panel recommends that the Secretary be able to end, alter, renew, or expand any experiment once reliable results are available.

number of entities qualified to provide them in any given market.

Soliciting Ideas— As discussed under Recommendation 2, HCFA would establish and publicize initial priorities for the types of innovations it seeks test. It would review and update these priorities on a regular basis. Appendix D suggests one possible process for establishing these priorities and soliciting ideas to test particular ideas. The Study Panel envisions the bulk of specific experiments would be initiated by state and local authorities and private entities with relevant experience, although HCFA also should approach individuals whom they believe would be appropriate to design and/or manage innovations consistent with HCFA's priorities. HCFA would consider proposals for such experiments on a rolling basis and should be free to begin them as soon as it is convinced of their appropriateness and feasibility without any administrative delays. HCFA would want to start with a limited number of innovations in selected localities and expand its experiments as its capacity to do so grows.

A Local Focus— The Study Panel believes that each waiver project should reflect local conditions because of wide variation among beneficiaries, providers, and health care markets. Furthermore, it may not be appropriate to make every successful experiment available nationwide since the success of any particular experiment may depend on characteristics of the beneficiaries involved as well as the local health care market where it takes place. As HCFA seeks to expand successful innovations to new beneficiaries and locations, it should continue to target them where they have the greatest potential to improve quality and cost outcomes.

The need to focus innovations locally underscores the importance for the success of this innovation process of maintaining close ties with providers and other experts across the country. In addition, Congress should provide HCFA with both the mandate and resources necessary to develop a more significant infrastructure and staff at the regional level. By working incrementally, HCFA could build this infrastructure over time as the number of experiments also expands.

An Allowance for Learning— Because HCFA will not know in advance the precise outcomes of any given innovation, some experiments can be expected not to live up to expectations of cost savings or quality improvement. In giving this new authority to HCFA, Congress also should grant HCFA the freedom to learn from experiments that do not succeed. Furthermore, HCFA will not run the risk of widespread implementation of any unproven technique because it will target its experiments with managed care tools to particular medical conditions or to beneficiaries in selected communities and tailor the experiments to local conditions. As the BBA of 1997 (P.L. 105-33) mandates for the Coordinated Care Demonstration projects (see Appendix C), Congress could authorize the Secretary to integrate experiments that prove successful into the regular FFS Medicare program.

Limitations in the Waiver Authority— While the Study Panel believes in the necessity of increased flexibility in order to modernize FFS Medicare, there are two principles that the Panel believes HCFA should not violate in adapting any of these managed care techniques to FFS Medicare:

- No beneficiary should be eligible for fewer covered benefits than those already provided under FFS Medicare.
- FFS Medicare should preserve each beneficiary's freedom of choice of providers or suppliers (even if the program incorporates incentives for beneficiaries to choose selected providers). In those cases where HCFA experiments with competitive procurement, HCFA will also need to maintain enough viable providers and suppliers to assure an effective procurement process in future years, given the substantial purchasing role Medicare plays in the health care marketplace.

RECOMMENDATION 4

Congress should require the Secretary of Health and Human Services to report annually on how HCFA has used its authority to innovate and with what results for quality, costs, and access. Congress should designate an advisory body to respond to this report and advise Congress about potential improvements.

In return for granting higher discretion to HCFA, Congress should hold HCFA to a greater standard of accountability for cost and quality outcomes in FFS Medicare than it has previously. Although Congress and the American people have high expectations for FFS Medicare, the focus of accountability has been on the reimbursement process with less emphasis on the value of goods and services purchased.

The Panel recommends that Congress require the Secretary of DHHS to report to Congress annually about how HCFA has used the new authority described in Recommendation 3. In addition to providing an understanding of HCFA's overall innovation management plan and actual waiver projects undertaken, the report to Congress would provide evidence of how well HCFA is fulfilling Congress's mandate to transform FFS Medicare from a bill-paying program to one accountable for the quality and costs of services it provides to beneficiaries (Recommendation 1).

To help Congress further evaluate how well HCFA is managing innovation in FFS Medicare, the Study Panel also recommends that Congress establish an advisory body to comment on the Secretary's report each year and to recommend to Congress any changes Congress ought to make in HCFA's innovation waiver authority. This advisory commission should include representatives of health care purchasers (e.g., employers), providers, private health plans, beneficiaries, and others with relevant expertise.

Although Congress could create a new commission to fill this role, the Study Panel recommends that the responsibility to comment on HCFA's use of its new waiver authority should fall to the Medicare Payment Advisory Commission (MPAC). The Study Panel believes that as the successor to the Prospective Payment Assessment Commission (ProPAC) and the Physician Payment Review Commission (PPRC), MPAC already has the requisite experience in its staff and membership to fulfill this role. This responsibility is similar to the existing requirement that MPAC comment on all reports that the Secretary must provide by

law to Congress and that concern Medicare payment issues. Giving this annual assignment to an existing body also avoids the administrative expense and delay of establishing a new organization. The illustrative legislative language in Appendix D delineates in detail the potential responsibilities for both the Secretary of DHHS and MPAC.

RECOMMENDATION 5

To help Congress hold HCFA accountable to the public for the discretion described in Recommendation 3, HCFA should require that each experiment obtain evaluation data in order to learn quickly from the initiative.

Assessment of experiments is necessary in order to learn and for effective legislative oversight. FFS Medicare's current demonstration authority recognizes this necessity in its requirement for complete, rigorous evaluations of each demonstration project, but such studies can be a time-consuming process. The Study Panel believes FFS Medicare needs the capacity to develop valid data more quickly so that policymakers can make timely decisions about whether to replicate, abandon, or alter each experiment. The Panel recommends that HCFA require the designers of each experiment to identify indicators that will allow for prompt, but

valid information about how well each waiver is working.

Conclusion

The BBA of 1997 increased Medicare beneficiaries' choice of capitated managed care health plans. However, the vast majority of Medicare beneficiaries remain in FFS Medicare, and its management will remain a significant challenge for the federal government well into the next century. Research has documented significant opportunities to improve the quality of care paid for by FFS Medicare. Yet, the administrative structure of FFS Medicare remains much as Congress established it one generation ago. In order to advance the quality of care for Medicare's beneficiaries, and to assure that taxpayers' money is well spent, FFS Medicare must modernize its management. A modern FFS Medicare program will have the capacity to apply new knowledge from research and the private sector about how best to provide care to older Americans and those with disabilities, especially as the number of beneficiaries living with chronic conditions continues to grow. The changes in FFS Medicare needed to bring about this fundamental change will require strong leadership and a bipartisan consensus among our elected officials. In order to prepare FFS Medicare for the next generation, this Study Panel believes we need to develop that leadership and consensus today.

Appendix A

Acknowledgments

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Appendix B

Managed Care Tools: Use by Private Insurance and Potential for Medicare

Although available evidence suggests that private health insurance has made use of managed care tools to manage costs more than to enhance quality, and although there is little evaluative data so far of the impacts of any specific tools, health plans vary greatly in their attempts to employ managed care techniques and are still evolving. Many are beginning a process of experimentation in which they are trying a greater variety of tools both to control costs and to improve quality for selected patients, procedures, or diagnoses. In the absence of published evaluative literature, this Study Panel commissioned Peter Fox, a managed care consultant and social insurance expert, to review these tools.¹ This appendix is based largely his analysis (22). It reviews types of private health insurance organizations, describes the types of managed care tools such organizations are using or experimenting with, and then discusses in greater detail the potential for Medicare to adapt some of these tools for its FFS program.

Managed Care Organizations and Managed Care Techniques

Examples of prepaid health plans have existed since before Medicare, but health maintenance organizations entered the American health care landscape in 1973 with President Nixon's signing of the Health Maintenance Organization Act (P.L. 93-222). In recent years, their influence has extended throughout the health care system as purchasers of health insurance seek to constrain spending by borrowing tools developed largely in HMOs. This phenomenon is loosely referred to as "managed care."

It is useful to distinguish between managed care techniques and managed care organizations. Because definitions vary and the distinctions among different types of health plans are increasingly blurred, and because

any type of health plan (including a FFS plan) can make use of managed care techniques, this analysis focuses on the tools of managed care.

Employers and other organizations that purchase health care on behalf of individuals may also make use of managed care tools such as requiring prior authorization and review of inpatient stays in the hospital. Private employers, like HCFA, face limitations in their ability to engage in managed care since they are commonly reluctant to exercise direct control over the health care delivery system. For example, they are usually unwilling to capitate payments to primary care physicians or for specialty services, both of which are common cost containment techniques of HMOs (22).

1 At least one other researcher has also drawn on the experts from the private health insurance industry to survey its use of managed care techniques and to investigate their potential for Medicare. See Dychman, Z. and Knowlton, A., "Cost-Effectiveness Initiatives Implemented by Private Payers in Fee-for-Service Environments." Report submitted to the U.S. Physician Payment Review Commission. Center for Health Policy Studies, Columbia, Maryland. January 1996.

What are the managed care techniques available to health plans? And in particular, which ones have indemnity insurance plans, the private health organizations most similar to FFS Medicare, begun to experiment with or use in regular practice?

To date, according to insurance executives, most indemnity insurance plans have attempted to control costs through preauthorization of inpatient care and discounted FFS. Using a PPO or similar arrangement, they have cut FFS payments in exchange for helping to assure a volume of patients for participating providers. Some have also made use of other techniques (described below) intended to identify providers whose patients receive an extraordinarily high volume of services. Only recently have they begun to experiment with many of the other types of managed care techniques described below (21).

This section groups these techniques into six categories: (1) financial incentives, (2) administrative oversight, (3) selection and deselection of efficient providers, (4) development of a culture of efficiency, (5) prevention and demand management, and (6) data analysis.

Financial Incentives

One technique, used by some HMOs, is to place providers at varying degrees of risk for the quantity and intensity of services they deliver or prescribe. The underlying philosophy is to align the incentives of the providers with those of the health plan to achieve common objectives. When the payment a provider receives does not vary according to the services received by their patients, the provider has an incentive to use them sparingly (albeit without endangering their

patients' health). Many HMOs combine financial incentives for reducing utilization with payments that reflect measures of quality, access, and patient satisfaction. Examples of financial incentives include:

- capitating primary care physicians (PCPs) for primary care services;
- capitating specialty groups;
- capitating specific services such as behavioral health and laboratory services (sometimes referred to as “carve-outs”);
- payment for achieving specific clinical and non-clinical measures of success, such as mammography rates, extended office hours, and maintenance of continuing medical education status;
- creating incentives for PCPs to be conservative in their referral practices (e.g. bonuses), usually in conjunction with incentives to be concerned with quality, access, and patient satisfaction;
- sharing the financial risk associated with hospital care with physicians and/or hospitals.

With the dramatic rise in managed care among various types of health care organizations, there has been heightened attention to the appropriateness of financial incentives that place physicians and other providers at risk for their patients' use of health care. Little data yet exists on the extent of these practices or their impacts on costs or quality of care. There is also currently no consensus about what type and degree of financial incentives are inappropriate (49, 33, 14).

Administrative Oversight

Administrative oversight usually refers to requiring patients to receive precertification (prior approval) for inpatient hospital stays, review of ongoing hospital stays, and precer-

tification of expensive outpatient services that can be discretionary in some cases - e.g., magnetic resonance imaging (MRIs), the use of human growth hormone therapy, and selected ambulatory surgical procedures. Referrals to specialists may also require prior approval. A requirement for prior approval by a health plan or purchaser for certain services may be in addition to a requirement that the patient obtain a referral from a PCP.

One reason for administrative oversight is to control costs in situations where providers lack the incentive to do so. Consequently, health plans that make use of financial incentives in their payments to providers are less likely to have significant administrative oversight, and conversely.

Selection and Deselection of Efficient Providers

In choosing efficient health plans, health plans can use Medicare claims data and Prospective Payment System (PPS) cost reports to select institutions on the basis of their costs. Commonly, they choose hospitals willing to agree to prices dictated by the health plan.

Assessing physicians with regard to their efficiency is more problematic. Such evaluation usually requires that the health plan contract with the physician for sufficient time to accumulate adequate data about his or her practice patterns. In initially selecting physicians, health plans:

- lack systematic data parallel to the Medicare data available for hospitals.
- can only make limited use of anecdotal information on practice styles since many physicians are uncomfortable in assessing the quality or efficiency of their professional colleagues.

- may provide selected physicians with different financial incentives that change their preselection practice patterns, thus making their earlier patterns a poor predictor of their efficiency once they are part of the plan.

Hence, removing a physician from a health plan's network of approved providers once they have assumed responsibility for a sufficiently larger number of the plan's patients is more feasible than accurately selecting only efficient physicians at the outset.

Developing a Culture of Efficiency

Some medical groups and staff model HMOs seek to achieve savings by fostering a culture of efficiency rather than by adopting financial incentives or administrative controls. Tight knit medical groups are best able to foster such a culture, in contrast to organizations that bring together otherwise independent physicians in order that they might be part of a health plan's network or to share the costs associated with office management, billing, and collections.

Prevention and Demand Management

Health plans are increasingly undertaking prevention and demand management activities for persons with identified illness. Targeted experimentation with and use of these same techniques figures prominently in this Study Panel's recommendations below. As with other terms in managed care, there are no universally accepted definitions, and the field is evolving.

Demand management refers to education and other tools provided for patients to help them manage their own health and make informed and appropriate use of medical care (70) Common examples of demand management include telephone and on-line comput-

er “help-lines” staffed by nurses or other health professionals, and educational materials in the form of newsletters, other printed matter, videotapes, and audio tapes.

Prevention can take a variety of forms, especially for a chronically ill population. They can include demand management. Among interventions that health plans have adopted are:

- screening of Medicare enrollees to identify those with chronic illness to facilitate early intervention including case management;
- coordinating access to community-based social services such as nutrition programs, support groups, housing, and financial counseling;
- providing more extensive primary care than typically exists in the traditional Medicare program to maintain health and prevent more expensive acute care. For example, research has shown that primary care directed toward custodial-level nursing home patients can reduce emergency room and inpatient use; and
- friendly telephoning and visiting, particularly for enrollees who live alone. For example, health plans have undertaken voluntary programs to assure that congestive heart patients take their medications and to monitor their weight.

Data Analysis: Profiling, Outcomes Research, and Practice Guidelines

Critical to managed care is having data on practice patterns that are valid and presented in a user friendly manner. It is a truism that practice patterns are difficult to change without knowing what they are. The last few years have seen major advances in data systems that profile physicians, sold commercially by such firms.

In addition, in response to the documented variations in medical practice, there has been growing investment in outcomes research, systematic investigations to understand which medical interventions work and under what circumstances. The widespread use of randomized trials, the gold standard for clinical research, only dates back a generation and has been applied largely to new medical interventions. Much of current medical practice has never received systematic scientific scrutiny of its effectiveness. In recent years, public and private organizations have begun to develop such trials and to develop new methods to use existing, retrospective data sources (e.g., insurance claims and medical records) to clarify how well particular medical technologies work, especially those that are costly themselves or have less expensive alternatives (39).

The last few years have also witnessed the development of practice guidelines or clinical care pathways, which are generally disease or condition specific. Many are inpatient-oriented, although the more comprehensive ones encompass the full range of settings in which care is delivered. They have been developed by a variety of organizations including specialty societies and federal agencies. They reflect the perspective that physicians and other providers can come together and think more systematically than has been true historically about what constitutes appropriate care, including the site and timing of care, in order to reduce undesirable variations in medical practice, thereby enhancing quality and, more often than not, reducing costs.

POTENTIAL OF MANAGED CARE TECHNIQUES FOR FFS MEDICARE

This section discusses the application of some of the managed care tools used in managing

private FFS insurance for Medicare FFS. In addition to identifying each type of technique, the analysis considers each tool's *technical feasibility* (i.e., the extent to which it would be technically feasible for the Medicare program to implement it), its *institutional feasibility* (which reflects the presence of institutional constraints on the Medicare program) and, its *potential impact*, whether on cost or quality. The report addresses some aspects of political feasibility, but not completely since it can be fluid.

Before discussing particular techniques, the analysis suggests several general points:

1. Many of the ideas have not been fully researched. Consequently, the analysis of each technique in this report is not necessarily complete. HCFA is currently testing some variants of these techniques through its research and demonstration authority. Others are under consideration by HFCA, or represent extensions of demonstrations already under way. However, a major recommendation of this Panel is that Medicare FFS should adopt a culture of experimentation and learning through well-targeted and monitored attempts to incorporate these tools into FFS Medicare. Within such a culture, Medicare could, over time, answer the questions unanswered below and help policy makers understand and hone the ability of managed care tools to improve quality and control costs in Medicare.
2. Although this analysis discusses these tools separately, they are not mutually exclusive. Indeed, as pointed out, some require others. For example, the ability to provide prevention services to those patients or geographic areas where they have the greatest potential, or the ability

to evaluate their impacts requires data analysis. In any given community, a modern Medicare FFS program would *integrate* multiple managed care tools as appropriate.

3. Many of these tools would require greater statutory discretion and flexibility for HCFA in contracting with organizations other than traditional carriers and intermediaries, in establishing new payment and service delivery options for selected communities and condition, and in altering these arrangements in light of new information or changed conditions.

Private sector successes with managed care tools are characterized by flexibility in decision making, including their ability to make changes over time. Although government agencies are by nature constrained from acting as quickly as private plans, Congress and HCFA could seek means of accelerating decision-making such as in the time it takes to issue new regulations or make decisions on new demonstrations and initiatives.

4. The success of these tools may depend on their targeted, (rather than universal) use. Given the significant geographic variations in Medicare expenditures, greater efforts at program cost savings are warranted in high expenditure areas than low expenditure areas. Furthermore, the use rates of specific procedures correlates only imperfectly with aggregate expenditures. Thus, a successful set of interventions requires consideration of local circumstances. Indeed, the wide variations are likely to gain attention as a public policy issue as more beneficiaries enroll in HMOs with Medicare risk contracts. These HMOs are able to offer broader

benefits at lower premiums in high expenditure areas, leading to benefit variations that reflect accidents of geography. Although cost management interventions that differ geographically may be regarded as violating an underlying premise of the Medicare Act as a program that is uniform nationally, that uniformity is already being challenged by the growth in Medicare risk enrollment and the resulting benefit package variations.² Recognition of the need for different approaches to cost management, which will largely be invisible to the beneficiary, would appear to be far less problematic.

DATA ANALYSIS

Studies of areawide variations in utilization

The large and unexplainable, variations in Medicare spending, both in the aggregate and by type of service, are discussed above. Additional effort to analyze these variations can have value only if the analysis leads to action. At the milder end, the data could be broadly disseminated in order to stimulate providers, particularly physicians, in high cost/utilization areas to become more judicious in their practice styles. A more effective application of the data would be to target interventions. For example, prior authorization of selected high-cost services, provider profiling (perhaps with the application of sanctions), areawide expenditure targets, and

other managed care tools discussed elsewhere in this section might be performed only in areas where utilization is high.

Analysis of claims data to identify underservice

HMOs with Medicare risk contracts commonly use their data systems to identify individuals who need care but who are apparently not receiving it. These services are prevention oriented and in some cases result in documented cost savings. For example, several studies have been performed in HMOs of the effectiveness of reminders to obtain influenza inoculations.³ Since this is a Medicare covered service, the Medicare records could be scanned and communications sent to beneficiaries who may not have been immunized. Because of data lags, the communications might be sent in the few weeks prior to flu season to those who have not been inoculated the prior year.⁴ Another example where claims data might serve to identify underservice is for diabetics, for whom regular retinal and foot exams are important, but without which the need for expensive services is probable.⁵

Improved provider profiling

Recent advances in commercially-offered provider profiling systems have been striking. These systems rely on flexible relational data bases and have modules that can adjust uti-

2 There has always been lack of uniformity due to: (1) variations in the availability of medical resources and (2) differences among fiscal intermediaries in the interpretation of coverage and other rules. However, these differences are of a smaller magnitude than those caused by geographic variations in HMO premium and benefits, which currently exceed \$1,000 per beneficiary per year.

3 See, for example, Hanchak, NA, et al., "The Effectiveness of an Influenza Vaccination Program in an HMO Setting," *American Journal of Managed Care* 2(6):661-666.

4 One shortcoming of this approach is that beneficiaries may receive inoculations through community organizations that do not submit claims to Medicare.

5 An example of this use of claims data is the 1199 National Benefit Fund, which is one of the largest Taft-Hartley trust funds and administers health benefits on behalf service workers in the New York City area.

lization data to reflect relative patient mix or severity. The major market for these vendors is managed care plans, particularly HMOs. Although principally oriented towards identifying physicians with expensive practice styles, the systems can also identify problems in quality.

HCFA faces greater constraints than HMOs in using profiling data. The numbers of providers involved is larger by orders of magnitude; most HMOs require that enrollees elect a primary care physician who serves as “gatekeeper,” thereby enhancing the opportunities to hold a single physician accountable for the totality of services received by a given patient; HMOs have greater ability to contact individual physicians to discuss performance; and a private health plan is not subject to the due process requirements that characterize government agencies, particularly one like HCFA that is administering a national social insurance program.

Nonetheless, several forms of intervention might be considered, which vary in their feasibility and impact. First, the data could serve to educate physicians, using the PROs or other structure. Most physicians know little about how they compare with their peers, particularly in terms of practice styles. Key to such data affecting performance is that they be presented in a way that is clinically sensitive and user-friendly. An open question is the potential effectiveness of providing information not tied to payment. Second, the data could be used to sanction physicians who have particularly expensive practice styles. These sanctions might include the physicians’ thus identified being required to explain their practice styles to a local peer group, being subject to prior authorization requirements for certain services, and being precluded

from Medicare altogether, a measure that has historically been limited to providers who are guilty of fraud, and then only after a lengthy judicial process.

Comparative analysis of provider quality of care

Purchasers, including HCFA for HMOs with Medicare risk contracts, are increasingly requiring HMOs and other managed care entities to provide data on performance, although the measures extant are limited in scope. The most common ones are those developed as part of the Health Plan Employer Data and Information Set by the National Committee for Quality Assurance, an organization that accredits HMOs and other managed care plans. Similarly, outcomes or performance data could be published for individual providers for selected high prevalence conditions. As with the requirements on Medicare risk contractors, these need to be valid but not perfect. Such data can impact on patient care of two ways. The first is by making available objective comparisons to the providers in question. The second is through public disclosure, which has the potential for inducing patients to seek out the higher quality providers, who in turn compete for patient volume.

Collecting data about FFS practice is not equivalent to collecting data for HMOs or other managed care plans since beneficiaries do not enroll with a particular provider. Because beneficiaries can change providers with each encounter, there is no clear-cut population to serve as a denominator in measuring the percentage of patients receiving recommended disease screening or inoculations, or other outcomes. Nonetheless, it is possible to design measures that are intelligible and have the potential to influence med-

ical practice. One example cited by proponents was the dissemination of hospital- and physician-specific data for coronary artery bypass graft (CABG) surgery in New York state beginning in 1989. By 1992, the state observed a 41 percent decline in risk adjusted mortality (28).⁶ Providers did change their performance as a result of the comparisons being available; in contrast, the comparative data did not result in patients' changing providers, as would be evidenced by shifts in market share (10). These results, however, are not unequivocal since other states not engaged in such dissemination efforts observed similar reductions in CABG complication rates during the same period (24).

ADMINISTRATIVE CONTROLS ON UTILIZATION

Designation of a Primary Care Physician (PCP)

Many HMOs require that enrollees select a PCP who is responsible for delivering or authorizing all services, except those that are rendered out-of-area and emergency in nature. Similarly, many state Medicaid programs require, in their fee-for-service program that beneficiaries select a participating PCP who serves a gatekeeper function. The PCP is not placed at risk (i.e., she or he continues to receive reimbursements on a FFS basis rather than receiving a capitated payment for each patient), but may receive an additional monthly case management fee. This approach permits tracking most services

delivered to any given patient back to a single PCP and offers two advantages: The first is to achieve savings, as the experience of state Medicaid programs has documented (29).⁷ Second, physicians with a geriatric focus have long sought payment for telephone calls to patients and for dealing with family members and local social services agencies. The case management fee could represent compensation for these activities.

If mandating that Medicare beneficiaries designate PCPs is not politically feasible, financial incentives in the form of reduced cost sharing or Medicare premiums might be offered enrollees who agree voluntarily to obtain services through a PCP. One problem with reduced cost sharing is that almost 90 percent of the elderly face minimal cost sharing presently because they have coverage in addition to Medicare, including Medicare supplement policies ("Medigap"), retiree benefits, and Medicaid (13).

PPO arrangements based on practice profiles

PPOs for the commercial population achieve savings through a combination of provider discounts, utilization management, and provider selection, although the latter occurs more in theory than in practice. Enrollees face incentives to use network providers, typically in the form of differential cost sharing (i.e., reduced premiums or other out-of-pocket expenses).⁸ HCFA could potentially

6 Based on the New York experience, the authors argue for combining Medicare with other data for purposes of assessing quality. See Hannan, EL, et al., "Using Medicare Claims Data to Assess Provider Quality for CABG Surgery: Does It Work Well Enough?" *Health Services Research* 31(7):659-768, Feb. 1997.

7 One caveat regarding the interpretation of research results is that most of the Medicaid experience relates to the AFDC, not the SSI (i.e., aged and disabled), population.

8 Wide variability exists in the relationship between Medicare payments and what providers will accept from managed care plans. For example, in some market areas, many specialists accept payments that are 20 percent or more below Medicare fee levels, whereas in most markets, Medicare payment levels are viewed as low. This approach would be designed, in part, to achieve savings in markets where Medicare pays more than private health plans.

employ practice profiles to identify efficient physicians and negotiate arrangements with those willing to accept rates below those of Medicare or those who volunteer to cooperate with selected utilization management requirements such as prior authorization of services. Beneficiaries would have incentives (e.g., reduced cost sharing) to use these providers. In practice, this might be difficult to implement, particularly on a scale large enough to achieve meaningful savings:

- As noted earlier, 90 percent of Medicare beneficiaries have supplemental insurance that reduces or eliminates their Medicare cost-sharing requirements diminishing the potential effectiveness of such incentives on beneficiary behavior.
- In addition, it might be politically and practically difficult for a program that has little to no experience in choosing providers to participate to exclude providers who depend on Medicare for a large portion of their patients and income.

HCFA has made efforts to enter into PPO demonstrations with limited success. As described later in this report, the Medicare Choices demonstration program, which allows health plans to explore novel ways of providing Medicare benefits, is open to proposals for development of PPOs even though the agency has received no proposals to do so to-date. During 1997, the HCFA administrator expressed interest in exploring the potential for Medicare PPOs further (69).

PACKAGE PRICING

Package pricing can take multiple forms, the most comprehensive of which is capitation, the method of payment for HMOs with Medicare risk contracts. An important example of package pricing in the standard Medicare program is payment to acute care hospitals on a per admission basis using Diagnosis Related Groups (DRGs). Package pricing incorporates incentives to minimize costs within the “package” and to maximize the number of “packages” delivered. Cost minimization raises the specter of underservice. However, whether underservice occurs depends on countervailing pressures, in particular, the potential for losing patient volume, the cost of paying for “rework” if it is factored into the package, and the effectiveness of administrative oversight. (For example, the Medicare’s Prospective Payment System holds hospitals responsible for the cost of hospital re-admission within 60 days of discharge.) Package pricing arrangements raise the issues of: (1) how the “package” should be defined, (2) how it should be priced, and (3) how to protect or improve quality. Package pricing options are explored below.

One option would be to *bundle facility and physician payment for selected procedures*. As described later in this report, HCFA has conducted demonstrations, yielding promising results, of bundled pricing of facility and physician services for CABGs and cataract surgery,⁹ and it is in the process of extending this experience through its “Centers of Excellence” demonstration for heart and orthopedic procedures. This new demonstra-

9 For CABGs, HCFA was able to achieve significant savings with no deterioration in quality. See Cromwell, J., Medicare Heart Bypass Demonstration: Final Report (Waltham, MA: Health Economics Research, 1995). No evaluation of the cataract demonstration has been published.

tion would provide a single payment to the hospital that includes physician services and, unlike the earlier demonstrations, post-hospital services such as SNF, rehabilitation, and home health.

Other options include bundling payments for SNF services as part of the hospital DRG payments. Each of these payment reforms represent attempts to control the rapid growth of Medicare spending for post-acute care. As indicated earlier, the technical analysis of payment and other reforms in this area are beyond the scope of this Study Panel's work and have been more thoroughly considered by other expert groups, especially the U.S. Prospective Payment Assessment Commission (65).

PREVENTION AND CASE MANAGEMENT

These two topics are viewed as linked. Prevention for elderly or disabled populations can occur across a continuum of health status or level of functioning and can be categorized as follows:

- **Primary prevention**, directed at individuals who are fundamentally well and for whom exercise, inoculations, diet, not smoking, and so forth are important.
- **Secondary prevention**, directed at persons with conditions that are largely asymptomatic such as hypertension or diabetes, for whom self-care classes, out-

reach programs, printed materials, and so forth can be helpful.

- **Tertiary prevention**, directed at persons with known chronic conditions entailing functional deficits such as heart or pulmonary disease, designed to prevent further deterioration. Case management can be viewed as a form of tertiary prevention in addition for being a vehicle for coordinating services and assuring delivery in the least costly, appropriate setting.

It is with regard to prevention that the experiences of HMOs with Medicare risk contracts with extensive elderly-oriented programs is particularly instructive, recognizing that the FFS Medicare program cannot replicate the full range of interventions that HMOs have adopted. Many HMOs believe that key to financial success is the retardation of deterioration and the maintenance of function in order to reduce hospital utilization. A full exposition of these efforts is beyond the scope of this report; what is presented is merely indicative of the interventions that might be considered.¹⁰

However, two shifts in thinking regarding how the Medicare program functions would be required. First, Medicare has traditionally operated as a financing program rather than a health program, although recently it has made efforts to embed geriatric principles in its payment mechanisms. Second, the program generally operates independently of other federal programs. One option, which is explored below, is for grants to community

10 For examples of a variety of interventions by HMOs geared to a chronically ill see Kramer, AM, Fox, PD, and Morgenstern, N., "Geriatric Care Approaches in Health Maintenance Organizations," *Journal of the American Geriatric Society*, 40:1055-1067, 1992; Fox, PD and Fama, T., (eds.), *Managed Care and Chronic Illness: Challenges and Opportunities* (Gaithersburg, MD: Aspen Publishers, 1996); and Fox, PD and Fama, T., "Managed Care and the Elderly: Performance and Potential," *Generations* 20 (2): 31-36, Summer 1996. It should be noted that HMOs vary widely in the extent to which they have mounted programs that are focused specifically at elderly or disabled populations.

agencies that fall outside of HCFA's traditional purview but that could integrate with the Medicare program. The rationale for so doing is to avoid the budget exposure associated with expanding benefits through an open-ended FFS payment mechanism.

Enhanced payments for primary care to long-stay nursing home patients

For non-skilled level (typically, long-stay) patients, i.e., those for whom Medicare does not cover the daily room and board charges, the Medicare coverage rules require physician visits upon admission to the facility, at least every 30 days for the first 90 days, and every 60 days thereafter. In practice, visits of greater frequency are often questioned by the fiscal intermediary. Indeed, it is often easier to transfer a resident to the hospital rather than undertake the effort required to keep him or her in the nursing home. Doing so is also more lucrative — for the physician, the nursing home, and the hospital. Evidence also exists that nursing home residents who are transferred back and forth between the nursing home and the hospital experience decreased quality of life and a potential exacerbation of other physical and mental conditions (74).

The provision of additional services, whether by physicians or nurse practitioners, has the potential for reducing admissions.¹¹ HMOs have experienced large reductions in emergency room and hospital inpatient use as a result of enhanced primary care.¹² Thus, it is suggested that HCFA review its coverage and

payment rules to assure adequate primary care to long-stay nursing home residents.

Demand management for selected beneficiaries

Structured self-management and behavior change programs have been demonstrated to improve health outcomes and, presumably, reduce use of the medical care system for a variety of conditions including diabetes, heart disease, hypertension, and arthritis (70). A number of HMOs have adopted self-management programs and found them to be cost-effective. The challenge, however, is to implement them in a FFS environment. As with some of the other programs, an open ended payment mechanism is not recommended. However, national informational programs might be undertaken along with grants, perhaps on a pilot basis initially, to local community agencies such as Area Agencies on Aging (AAA), public health departments, or provider groups. One example of a successful program mounted in a FFS environment is that of the Medicaid program in Maryland for diabetics. Through a combination of structured outpatient education programs, which are viewed as the cornerstone of the effort, case management, and primary care providers' undergoing a five-hour course in diabetes management (for which they receive Continuing Medical Education credits), a 40-50 percent reduction in inpatient care and emergency room use has been achieved (8).

11 See, for example, Kane, RL, et al., "Improving Primary Care in Nursing Homes," *Journal of the American Geriatric Society* 39:359-367, 1991.

12 See, for example, Burl, JB, Bonner, A., and Rao, M., "Demonstration of the Cost-Effectiveness of a Nurse Practitioner/Physician Team in Long-Term Care Facilities," *HMO Practice* 8(4): 157-161, December 1994. David Reuben, MD, at U.C.L.A., is completing a study of three HMOs with enhanced primary care to long-stay nursing home residents; preliminary findings are encouraging.

Also, pilot projects of “nurse line” or “advice nurse” programs might be mounted in which enrollees can telephone a central (800) number and obtain information on self-care as well as whether medical care is needed and, if so, how immediate it is. In some cases, the conversation results in a referral to case management. Significant savings have been claimed for these programs.

Contracts with local organizations to conduct secondary and tertiary prevention

The Medicare program has little experience with joint endeavors with local agencies such as local health departments or the federally-funded AAAs, many of which have elderly health care programs. For example, many AAAs perform case management, but it is not integrated with Medicare nor is it oriented towards reducing use of medical, particularly, inpatient services. Grants might be made to such agencies (or existing funding reoriented) to mount programs to help elderly who are disabled or have functional limitations. Prospective grantees would have to present detailed plans to be eligible for funding. A block grant with limited strings attached is *not* intended; rather, the grantees should become contract agents of HCFA. Since many of the functions would be new, modest developmental moneys might be desirable.

Case management is one possible function.¹³
Research to-date on the cost impact of case

management for the Medicare population has been less than encouraging. The so-called channeling demonstrations of case management, conducted in the 1980s, failed to reduce costs for a frail elderly population, even with the availability of additional funds to purchase community-based services. Carefully controlled research has not been conducted in the HMO setting although many plans have case management programs, which they justify based on an evaluation methodology that entails comparing actual costs with an estimate of what costs would have been in the absence of case management.¹⁴ Two frequently-encountered problems in the HMO setting, which would be exacerbated if the locus of case management were a community agency, are: (1) coordination between the case manager and the PCP and (2) patients’ refusal of case management as an intrusion into their lives.

Nonetheless, one should ask whether the negative findings to date reflect the inherent shortcomings of case management or, instead, the manner in which it has been implemented. In contrast to the Medicare experience, the Maryland Medicaid program instituted case management in 12 large medical centers and reports savings of 24 percent (8)¹⁵.

Keys to case management’s cost-effectiveness include careful targeting of the population and limiting the resources that are invested.

13 A contract with a local organization to provide case management could be, in essence, an alternative to the use of a PCP gatekeeper (discussed earlier in this section) in funding and providing this service for selected beneficiaries.

14 Recognizing this lack of knowledge along with the central role that case management plays in coordinating care, evaluating the impact of case management has been a priority of The Robert Wood Johnson Foundation’s “Chronic Care Initiatives in HMOs” program. However, the research is still in progress.

15 The savings reported are based on estimates of the costs that would have occurred absent the intervention rather than on the experience of a control group. Notwithstanding limitations in the methodology, the order of magnitude of the savings is impressive.

Also, many HMOs use case management as the gateway to off-policy benefits. For example, the case manager may be authorized to pay for simple home repairs or additions, such as fixing steps or adding grab rails in bathrooms, in order to prevent falls. A limited amount of money might be available for such purposes.

Another function of the local grantee agency could be to conduct disease management programs for a limited number of conditions. For example, education and regular follow-up (e.g., to check problems with medication and weight) have been found to substantially reduce hospital re-admissions for persons with congestive heart failure.¹⁶ Other functions that the local community agency could perform, all of which are performed in some HMOs, include:

- home assessments, e.g., to spot problems such as low lighting, loose rugs, cords, etc. that can generate falls;
- developing support or self-help groups, e.g., for diabetics, cancer patients, griev-

ing widows, and caretakers of Medicare beneficiaries who are frail or disabled;

- developing or arranging for exercise programs that are geared to an elderly or disabled population; and
- mounting volunteer programs, e.g., friendly visiting and telephoning.

As an illustration of such a program, the Group Health Cooperative of Puget Sound and PacifiCare have teamed up with a senior citizens center in the Washington State to offer supervised health promotion and chronic illness self-management interventions to chronically ill seniors. The intervention, which entails a randomized, controlled trial, includes meetings with geriatric nurse practitioners to develop an individually tailored health promotion plan, medication reviews, classes, support groups, and volunteer mentors. Preliminary, as yet unpublished, findings suggest both cost savings and fewer health problems among the intervention group.

16 See, for example, Rich, MW, et al., "A Multidisciplinary Intervention to Prevent the Re-admission of Elderly Patients with Congestive Heart Failure," *New England Journal of Medicine*, 333(18): 1190-1195, Nov. 2, 1995.

Appendix C

Recent and Mandated Innovations in Fee-for-Service (FFS) Medicare

This appendix reviews attempts to innovate the way in which services are provided or paid for within Medicare's FFS program. It includes demonstrations recently completed, those that are on-going, and activities mandated in the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (P.L. 104-191) and the Balanced Budget Act (BBA) of 1997 (P.L. 105-33).¹ Although this portfolio of innovations includes experiments that may provide important insights into how the FFS program might be better managed in the interests of beneficiaries and other taxpayers, it demonstrates the limitations of Medicare's ability to innovate within the current legal structure and political environment. The text of this report discusses these limitations in greater detail.

CENTERS OF EXCELLENCE DEMONSTRATION

The Centers of Excellence (COE) program grew out of two prior demonstration projects, the Medicare Participating Heart Bypass Center (MPHBC) Demonstration and the Cataract Alternative Payment (CAP) Demonstration. These prior demonstrations evaluated the feasibility of negotiated all-inclusive prices covering physician, facility and supplies for heart bypass and cataract surgeries respectively. They each resulted in substantial savings for Medicare without measurable adverse impacts on the quality of care (57). The savings resulted from changes in patient management, such as shorter lengths of stay, substitution of generic drugs, and standardization of equipment.

The COE demonstration designates cardiovascular and orthopedic facilities willing to offer beneficiary incentives and reduced costs to the Medicare program for episodes of care for various resource-intensive cardiovascular procedures and total joint replacement procedures (57). At each facility, HCFA negotiates a global payment rate for hospital and related physician services provided during the episode of care at a savings to Medicare (57). Beneficiaries maintain free choice of providers. HCFA anticipates the COE will offer beneficiaries incentives, such as lower cost sharing, simplified claims processing, and transportation to and from the facility (57). The COE may use their designation as a marketing tool to increase referrals and patient volume (57).

1 The Medicare+Choice program included in the BBA of 1997 (PL. 105-33), the on-going Medicare Choices demonstration, and the Medicare Competitive Pricing Demonstration also mandated by the BBA of 1997 may also offer some insights useful for managing the FFS program. For example, the Medicare Choices demonstration and the Medicare+Choice program permit health plans to offer Preferred Provider Organization (PPO) options for beneficiaries, a form of provider selection considered by this Study Panel. However, since all three of these activities primarily represent attempts to innovate Medicare's (capitated) managed care program (as opposed to the traditional FFS program of interest to this Study Panel), they are not included in this appendix. The forthcoming final report of the Academy's Study Panel on Medicare Capitation and Choice and the March 1997 Academy report, *Securing Medicare's Future: What Are the Issues?* (45) discuss these programs in greater detail.

HCFA expects to select up to 100 demonstration sites by the end of December 1997 and begin the projects during the spring of 1998.

PROVIDER PARTNERSHIPS

In addition to the payment bundling tested through the COE project and its predecessor demonstrations mentioned above, HCFA has chosen eight sites in New York, New Jersey, and Pennsylvania for a demonstration to test a combined physician-hospital payment to physician-hospital organizations for all Diagnosis Related Groups (DRGs).² Each hospital must include at least 90 percent of all Medicare admissions and all major admitting specialties in the demonstration. For each case, the physician-hospital organization will receive a reimbursement based on historical Part A and Part B payments for the average mix of services provided for each DRG, although HCFA encouraged hospitals wishing to participate to include a discount off these payments in their proposals to participate.

The purpose of the study is to encourage partnerships between hospitals and physicians in managing inpatient care better and to align the financial incentives of hospitals and physicians. In evaluating the experiment, HCFA will examine how physicians and hospitals manage hospital care, the effects on quality of care and the overall efficiency of the health care system, and the impact on Medicare spending.

HCFA received 47 applications from 77 hospitals and their associated physician hospital

organizations. Currently in a one-year development phase, the demonstrations will operate for three years starting in 1998, with a possible extension for up to a total of six years.

PHYSICIAN PROFILING

Physician profiling compiles data about services provided by physicians within a particular group, health plan, or geographic area (18). Its purpose is to provide individual physicians with quantifiable information about how their practice style compares with that of their peers in order to alter deviations from the norm not justified by patients' health status (i.e., either overuse, underuse, or misuse).

HCFA and Medicare carriers have implemented profiling to address high utilization rates (64). The profiling process, called "focused medical review," compares utilization rates of individual physicians with the those of comparable physicians within a community (64). In addition to identifying high-cost outliers, the focus medical review provides broader information about the causes of spending growth and variations in spending within or between states (64).

Once a carrier has identified a provider whose utilization is significantly above the norm without medical justification, carriers can: (1) ask the provider to return reimbursements for services that the provider should not have provided; (2) send an educational letter advising that his or her practice patterns result in unusually high Medicare reimbursements, or (3) refer the case for

2 The DRG system is a clinically based inpatient classification that determines Medicare payments to hospitals. Each DRG represents a group of homogenous patients with respect to the amount of resources necessary for treatment. The intermediary assigns the appropriate DRG code to each patient bill record and pays the hospital the predetermined DRG rate for each discharge.

investigation of potential fraud or abuse (61). However, the U.S. General Accounting Office (GAO) has criticized HCFA's current profiling program for limitations in the types of data collected and analyzed, variations in the quality of data across carriers, and limited efforts to communicate the profiling results to providers (61).³

HCFA has also contracted with Los Alamos National Laboratories to draw on their computing facilities to develop new methods of physician profiling for Medicare (6).

MEDICARE COORDINATED CARE DEMONSTRATION PROJECT

The BBA of 1997 (P.L. 105-33) mandates HCFA to conduct demonstrations in five urban and three rural areas⁴ to test "case management and other models of coordinated care that improve the quality of care and reduce Medicare expenditures for beneficiaries with chronic illnesses enrolled in traditional [FFS] Medicare" (63). For the purposes of these demonstrations, the legislation allows HCFA to incorporate payment bundling for various facilities, physicians, and other providers and to go beyond the current HCFA benefits package in testing innovative ways of meeting the health needs of chronically ill beneficiaries (7).

The legislation directs the Secretary of Health and Human Services to design these experiments based on the results of a year-long evaluation of the best practices in the private sector. Once every two years, the Secretary will evaluate the demonstrations'

their cost-effectiveness, the quality of care provided, and beneficiary and provider satisfaction in a report to Congress. If the evaluation shows that the demonstrations save money or improve quality and satisfaction without increasing spending, the Secretary may continue the demonstration and expand the number of sites.

COMPETITIVE ACQUISITION OF PART B ITEMS AND SERVICES

The BBA of 1997 requires the Secretary of Health and Human Services to conduct demonstration projects of competitive procurement of services and items covered under Part B of Medicare. The Secretary can determine the services and items to be included in the experiments, but the law limits the total number of experiments to five with in three geographic areas each. One must include the competitive acquisition of oxygen and oxygen equipment. The Secretary can expand each experiment she or he deems successful after three years to additional geographic sites. In addition, in the interest of program savings the experiment includes the new authority to be exclusive or selective in choosing which providers can supply the relevant good or service as long the exclusion does not create access or supply problems (63).

DUALLY-ELIGIBLE BENEFICIARIES

Beneficiaries dually eligible for Medicare and Medicaid are not only low-income, but also include a large number of nursing home patients (20 percent of dual-eligibles).

3 HCFA began instructing carriers in 1990 to educate those providers whose profiling audits appeared significantly different from the average reports. However the GAO reports that the ensuing education letters based on carriers' profiling reports have created confusion, frustration, and a sense of harassment among providers (61).

4 An additional demonstration will occur in the District of Columbia if separate congressional action provides the necessary funds.

Compared with the Medicare-only population, they have greater prevalences of disability and chronic illness, and they are more likely to need costly services, including long-term care (51). As described in the text of this report, their needs for long-term and coordinated care mesh poorly with the current FFS program's focus on acute care and the payment of discrete services. Although states have increasingly used managed care to provide benefits and control costs for those enrolled in Medicaid only, initiatives to apply these tools to dual eligibles have been more limited.

Section 1115 Waivers

The predominant mechanism for states to test new, state-wide approaches to organizing and delivering Medicaid services has been to seek a waiver from federal Medicaid requirements under Section 1115 of the statute establishing the Medicaid program. These waivers provide states the opportunity to experiment not only with mandatory enrollment in managed care for all or parts of the Medicaid population (which can also be done under the 1915(b) "freedom of choice" waivers), but to change eligibility and coverage criteria, within approved parameters, as long as the program remains "budget neutral" (i.e., do not cost more than they would have without the waiver). Hence, if a state can realize savings in the provision of care (e.g., through decreased dependence on

emergency room care or fewer hospitalizations as a result of better care management), it can use the extra funds to enhance benefits or expand coverage to more individuals.

So far, Minnesota, Colorado, and Monroe County, New York have waivers Section 1115 demonstration waiver that the Department of Health and Human Services have approved to integrate Medicare and Medicaid funding and provide coordinated care to dually eligible individuals in exchange for a capitated payment from the state.⁵ HCFA is currently reviewing an additional waiver applications to integrate Medicare and Medicaid in a consortium of six New England states. Also, HCFA is soliciting demonstration proposals that provide more varieties of approaches to care for dual eligible beneficiaries, although the agency has made any awards as of this printing (5).

Program of All-Inclusive Care for the Elderly

The Program of All-Inclusive Care for the Elderly (PACE)⁶ represents another model for integrating Medicare and Medicaid funding for dually-eligible beneficiaries, although it has been a demonstration project to-date in only 11 communities and involving limited numbers of beneficiaries (58). The BBA of 1997 (P.L. 105-33) makes the PACE program permanent meaning that states may choose to offer it to their dually-eligible pop-

5 Although the Minnesota waiver as well as the PACE and Social HMO program described subsequently pay providers on a capitated basis, they are not part of Medicare's managed care program (i.e., the Medicare Risk program in the pre-BBA 1997 world, and the Medicare+Choice program scheduled to begin operations in January 1999).

6 This appendix does not include a description of a somewhat similar set of demonstrations, the Social Health Maintenance Organizations (S/HMOs). Unlike PACE, S/HMOs include a broad cross-section of elderly in the community. They are not necessarily dually-eligible and they are not necessarily at-risk of requiring a nursing home. In addition, the providers of S/HMO services, usually large health plans also participating in the Medicare Risk program, receive a capitated payment that includes a dollar cap specifically on long-term care services (68).

ulations without seeking a waiver from the federal government.

PACE provides managed care service delivery to frail elderly living in the community but at-risk of requiring nursing home services (58). It is modeled on the On Lok program that serves San Francisco's Chinatown community and was run in the past as a demonstration program. The distinguishing features of the PACE approach are: (1) enrollment is limited to persons with severe impairments that qualify them for nursing home care; (2) sites offer comprehensive acute and long-term care services, either directly or contractually; (3) sites assume financial risk and receive funding through integrated Medicare and Medicaid capitated payments; (4) sites operate as geriatrics oriented, staff model HMOs using multi-disciplinary care management teams; and (5) participants attend adult day care centers for supportive, rehabilitative, and social programs (4; 72).

The PACE program uses savings from reduced hospital and nursing home use to pay the incremental costs of comprehensive services, such as preventive care, transportation to receive health services, and rehabilitation (72). PACE receives a capitated payment from the state for each beneficiary in lieu of fee-for-service Medicare and Medicaid reimbursements.

NEW BENEFITS FOR DIABETICS

In addition to adding enhanced disease screening benefits⁷ to Medicare, the BBA of 1997 added new chronic care benefits for diabetes. In particular, it authorizes reimbursement for educational and training services by physicians and other Medicare providers to help beneficiaries with diabetes to self-manage their conditions on an outpatient basis. It also allows reimbursement of blood glucose monitors and test strips for all beneficiaries diagnosed with any type of diabetes.⁸ The Secretary of Health and Human Services will establish reimbursement rates for these services using the Relative Value Resource-Based Scale methodology used for other Part B services. In a move toward making Medicare more accountable for the health outcomes of diabetics (as opposed to only paying for covered services), the legislation also directs the Secretary to develop appropriate outcome measures to evaluate improvements in the health status of beneficiaries with diabetes.

CONTRACTING AUTHORITY IN THE MEDICARE INTEGRITY PROGRAM

The Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) contains new authority that allows HCFA to contract directly and exclusively with entities other than carriers and intermediaries to perform certain tasks intended to prevent fraud, abuse, and other overpayments. The

7 The BBA added new benefits for bone mass measurements to detect osteoporosis, colorectal cancer screening, and prostate cancer screening. In addition, it allows for more frequent mammograms for women over 65 and enhanced cervical cancer screening, extends a campaign to encourage the uptake of influenza and pneumococcal vaccines, and mandates a study of additional preventive benefits that Congress may consider for future inclusion in Part B of Medicare.

8 Previous law allowed reimbursement for such services in more limited circumstances.

Medicare Integrity Program (MIP) allows such contracts for five activities: medical utilization reviews; audits of cost reports; coordination of benefits from other payers and recovery of overpayments; education of providers about program integrity and quality assurance; development of guidance on the coverage of medical equipment and supplies.

In the past, HCFA had no clear authority to contract for these activities outside of their agreements with carriers and intermediaries to process claims. Furthermore, the law allows HCFA to be a more “prudent purchaser” of these services by choosing MIP contractors competitively.

Appendix D

Potential Fee-for-Service (FFS) Medicare Waiver Language

To give the reader a better sense of how Congress might implement the waiver authority described in Recommendations 3 and 4 of the text, this appendix provides legislative language for one possible formulation of that authority. The language in the bolded brackets indicates where we have based the proposed waiver language on language from current statutory waiver authorities. In many cases, this language originates from Section 1915(b), the Medicaid Freedom of Choice waiver authority, or Section 1115(a) of the Social Security Act, the broader Medicaid waiver authority, both of which allow the Secretary to grant more flexibility to states in how they arrange for Medicaid covered services. However, the language concerning the process of granting waivers and HCFA's accountability to Congress reflect concerns arising from FFS Medicare, not Medicaid. Some of this language is based on aspects of the Medicare demonstration authority, section 402 of the Social Security Amendments of 1967, as amended by section 222 of the Social Security Amendments of 1972. The Study Panel emphasizes that this language is for illustrative purposes only. Other formulations could equally support the Study Panel's recommendations.

SECTION XXXX OF THE SOCIAL SECURITY ACT

- (a) The Secretary, to the extent and for the period he or she finds it to be cost-effective and efficient and not inconsistent with the purposes of this title (not to exceed five years, but subject to additional five year renewal periods), may waive such requirements of this title as may be necessary to achieve the following public policy objectives—**[language from s. 1915(b)]**
- (1) to promote cost effective delivery of services through the use of case management for particular conditions, either when case management is used alone or in conjunction with the authority described below in paragraph (3);
 - (2) to promote cost effective delivery of items and services by contracting

with providers, suppliers, and physicians for the provision of specified items and services at a rate below that rate otherwise available under the current payment structure, although such limitations may not affect generally the applicable quality standards or conditions of participation otherwise required under this title. The Secretary may share savings from a waiver project under this paragraph with beneficiaries (through the [provision of] changes in cost sharing requirements) where those savings result from the beneficiary's utilization of the specified items or services through those providers, suppliers, physicians and other health professionals that participate in such a waiver project; **[language based on s. 1915(b)(3)]**

- (3) to promote cost effective delivery of services through the use of bundled payments for the treatment of particular conditions, but only so long as such a waiver project does not substantially impair the beneficiaries' access to services of adequate quality when medically necessary; **[protective language based on s. 1915(b)(1) and (2)]**
 - (4) to promote better coordination of services available from state and local entities by contracting with such entities or private third parties to coordinate the provision of such care with that available under this title. Priority should be given to coordination of services to persons who are eligible under both this title and title XIX and who utilize a disproportionate share of expenditures under these titles. The authority granted under this subparagraph may be used in conjunction with that available under Section 1115(a) of the Act;
 - (5) to promote better coordination of utilization of covered services by contracting, directly or through a third party, for specific goods and services within local markets;
 - (6) to promote beneficiary health education and individual control of health care utilization by contracting with entities to provide prevention and demand management for particular conditions;
 - (7) to promote access to high quality, cost effective care by providing incentives to beneficiaries who utilize providers that demonstrate quality medical outcomes while maintaining cost effectiveness;
 - (8) to promote access to high quality, cost effective care through any other program identified by the Secretary or recommended to Congress by the "Medicare Payment Advisory Commission" (MPAC) as appropriate for testing in the context of the Medicare fee-for-service sector. The public may submit suggestions for such projects as detailed below in subsection (e); and
 - (9) to promote access to high quality, cost effective care by creating a mechanism to provide physicians and other providers and suppliers with information on their history of patient outcomes and services utilization.
- To the extent that any waiver project conducted under this subsection includes items or services not otherwise authorized currently under this title, coverage of and payment for such items or services shall be considered authorized under this title so long as otherwise in conformance with the standards and requirements stated herein for the period prescribed by the Secretary in accordance with this paragraph. **[Based on s. 1115(a)(2)]**

- (b) No waiver under this subsection shall limit the scope of benefits otherwise available under this title or title XIX.
- (c) No waiver under this subsection shall restrict the beneficiaries' freedom of choice of provider or supplier as guaranteed in section 1802 of this title (42 U.S.C s. 1395a), except that an individual may voluntarily enroll in any program operated under this section with a participating provider or entity as may be prescribed in regulations. Notwithstanding this paragraph, the Secretary shall have the authority under paragraph (a) to limit the number of providers with whom she contracts for specified times or services in a defined geographic area. In granting a waiver, the Secretary shall take into consideration:
- (1) the need to maintain beneficiaries' access to a broad range of providers and suppliers, and
 - (2) the need to maintain enough viable providers and suppliers in the marketplace to assure an effective procurement process in future years given the substantial purchasing role that Medicare plays in the health care marketplace.
- (d) (1) The Secretary shall report annually to the Congress describing the status of each waiver project that has been approved under paragraph (a) and describing the projects under consideration for approval. Within that report, the Secretary should describe to the Congress how each approved waiver project meets the standards described in the relevant subsection of section (a) on which the waiver project is based and the necessary safeguards included by the Secretary (including adequate standards for provider participation) to protect the health and welfare of individuals that access Medicare services under the waiver project. The Secretary should also describe how he or she will assure the financial accountability of funds expended under the approved projects with respect to included services. The MPAC shall comment on the Secretary's yearly report, including on the effectiveness and appropriateness of the approved and proposed projects, and shall make recommendations to the Congress on any changes to the waiver authority under the section that it considers are warranted.
- (2) The Secretary, either directly or through contracts, shall collect data to help identify opportunities for future waiver projects as well as data on approved waiver projects to monitor each project's effectiveness and assess the feasibility of broader application within Medicare program.
- (e) Within 90 days of enactment of this legislation, the Secretary shall publish in the Federal Register the types of innovations described in (a) that it considers to be of highest priority for approval, including a description of the process by which interested parties and the public may submit suggestions for waiver projects and/or applications by providers,

suppliers, physicians or other health care professionals or entities, for participation in a waiver project. The Secretary will determine priorities for approval of waiver projects under this section based on the potential of the proposed innovations to improve health outcomes and

be cost-effective relative to those services otherwise available under the Medicare fee-for-service program. The Secretary must publish such notice at least annually, but should update the notice when the previously published Program priorities have changed.

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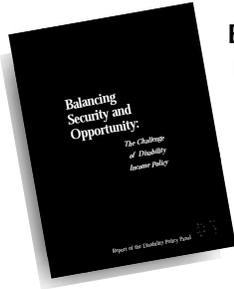
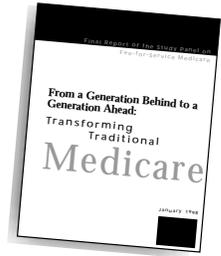
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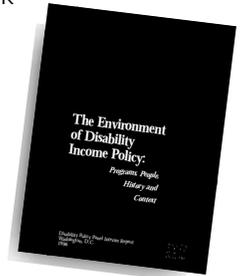


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