Confronting Costs: Medicare Payment Innovation - Opportunities to Build and Spread

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Panel on Medicare’s Future: Challenges and Opportunities
37th Annual APPAM Fall Research Conference, Miami Florida
November 14, 2015

Abstract:

Medicare pays for more than one-fifth of total national health care spending and even greater shares of hospital, physician, home health and other services covered by the program. Medicare decisions on how to pay for care thus have an impact on providers across the country with the potential to spur delivery system reform to improve outcomes while lowering costs of care. Past innovations in the way Medicare pays physicians and hospitals have spread to private insurers. The Affordable Care Act (ACA) expanded Medicare’s authority to experiment with payment reforms such as shared savings programs. The ACA also instituted new Medicare value-based payment incentives, including penalties for excessive hospital readmissions rates. In part due to ACA and earlier actions, growth in Medicare spending per person slowed dramatically from 2009 to 2014, while still improving health care outcomes. However, Medicare continues to use fee-for-service as the primary way to pay for care and even hospital “bundles” do not include all care provided during a hospital stay. Looking forward, there are opportunities to build on and expand payment policy innovations in ways that provide strong incentives to eliminate duplicative or ineffective care, give preference to lower-cost treatment alternatives, and improve care coordination and outcomes. Importantly, the ACA created a Center for Medicare and Medicaid Innovation (CMMI) with funding over 10 years to test innovative models of payment and service delivery that show promise of improving outcomes, patient experiences of care, or lowering cost. This paper will describe some promising options for alternative payment models and examine opportunities to build on and extend innovative policies, including expanding partnerships with private and Medicaid payers to provide a more unified approach and common financial incentives.

OVERVIEW

The U.S. health system is plagued by fragmented care, variable quality, and high and rapidly growing costs. Often identified as underlying these problems is the prevalence of a fee-for-service payment system in which health care providers are paid per visit, test, or procedure. This approach fails to reward efficiency, quality, or favorable outcomes, and it encourages the provision of unnecessary care and often discourages coordination of care and management of patients across providers and settings. Concomitantly, the share of the U.S. economy devoted to health spending is substantially higher than in any other country in the world, while it ranks in the middle or near the bottom of the pack relative to other industrialized countries on a variety of health system performance measures. The U.S. also spends relatively little on social services.

Volume-based, fee-for-service payment and its resulting problems often are associated with Medicare, but Medicare adopted this system from Blue Cross system when the Medicare
program was founded in 1965. Fee-for-service has been the predominate method for paying providers for both public and private payers—and even among managed care plans, which generally are not thought of as paying on a fee-for-service basis. Medicare, though, as the largest payer for health services in the U.S., often has been a leader in payment reform, and can and must continue to play an important role in moving toward alternative payment models. The Affordable Care Act (ACA) and other recent legislative and policy actions have accelerated the pace of payment reform in Medicare and Medicaid, as well as increasing the focus on multi-payer approaches.

A broad array of policy experts have called for the adoption of alternative approaches to paying for health care. But how do we move our $3 trillion health system from fee-for-service payment to other approaches? In this paper, we describe some of the most promising initiatives intended to move from Medicare volume-based payment to alternative payment systems that reward high performance, and discuss some of the challenges faced in identifying, implementing, evaluating, and spreading successful initiatives. We then discuss approaches for making these initiatives more effective in Medicare and also the importance of aligning incentives across both public and private payers.

THE NEED FOR PAYMENT AND DELIVERY SYSTEM REFORM

The fragmentation of the U.S. health care delivery system is a key issue. Even when each individual health care service that is provided to a patient meets high standards of clinical quality, the problem is that coordination of care, which may be delivered by multiple providers in multiple settings, often is lacking. Inadequate communication among providers, and between providers and patients and their families, is also common. There is a vacuum of accountability for the total care of patients, the outcomes of their treatment, and the efficiency with which medical resources are used.

The way health care is paid for has fueled this fragmentation and fostered this lack of accountability. The fee-for-service payment that has been, and still is, prevalent throughout the health system, emphasizes the provision of health services by individual providers, rather than care that is coordinated across providers to address the patient’s needs. Under this system, providers are offered strong incentives to deliver complex services and procedures, even when there may be better, simpler, and lower-cost ways to treat the patient. Volume is rewarded, while efforts to coordinate care and improve outcomes generally are not—moreover, no support is provided for the infrastructure required to make such efforts successful. The current payment system complicates efforts to promote accountability in the health care system, with no clear lines of responsibility for the overall quality, outcomes, or costs of patient care. This produces waste and inefficiency in the provision of care and a lack of coordination across providers and settings and between providers and patients (Exhibit 1).

The fragmentation of the health care system is illustrated by the variation in the quality of care across geographic areas (Exhibit 2). The lack of correlation between quality and the level of Medicare spending indicates that there is waste in the system—that is, that more spending does not necessarily produce higher quality—but it also indicates the potential for improvement along
the dimensions of quality and cost by observing, and attempting to replicate, the best behavior of providers that practice in areas with both high quality and low spending.\textsuperscript{13}

It is not surprising that the misplaced incentives in the current payment system and the resulting fragmentation, variation, and inefficiency have generated steadily rising health spending. Despite slower growth in recent years, national health expenditures still are projected to grow as a percentage of gross domestic product (GDP) from 17.4 percent in 2013 to 19.6 percent in 2024 (Exhibit 3).\textsuperscript{14} Medicare spending alone is projected to grow from 3.5 percent to 4.3 percent of GDP over the same period—indicating that Medicare, while accounting for about 20 percent of total national health spending, is expected to account for about 35 percent of the projected increase in health spending.\textsuperscript{13}

If the objectives of health reform—improved access, higher quality, and slower cost growth—are to be achieved, the health care delivery system must be reformed to provide coordinated, appropriate, and effective care, with accountability for patient outcomes and population health, and more diligent stewardship of the nation’s health care resources. But changing the way health care is organized and delivered requires a change in the way it is paid for—the development of alternative approaches that would better align financial incentives with societal goals, and enable and encourage providers to consider their patients’ needs in a broader context, collaborate to provide the care that they need, and take mutual responsibility for patient outcomes and cost.

**MEDICARE PAYMENT REFORM: CRITICAL ISSUES**

Many of the challenges faced by the U.S. health system, including the need to improve the quality of care and the outcomes it produces and the desire to slow the growth of health spending, apply to both the public and private sectors. But the way that health care is financed—with Medicare, Medicaid, and numerous other public programs, as well as a multiplicity of private payers—is fragmented, and that array of different and sometimes conflicting payment approaches has exacerbated the shortcomings of health care delivery. One study estimated that the annual cost of time spent interacting with health plans cost physician practices nationwide is between $23 billion and $31 billion.\textsuperscript{16} The implication is that there is much work to be done to align the incentives imbedded in the payment approaches used by different payers, as well as the processes involved in implementing those approaches.\textsuperscript{17} More importantly—and more difficult to quantify—is that different incentives from different insurers make it more challenging for providers to change behavior, since these incentives often are contradictory.

That said, aligning incentives across payers is not as simple as having every payer adopt the same policies; we do have a multi-payer financing system for health care, and each payer may face its own issues. We will return below to the issue of aligning incentives across different payers; we first describe some problems that are unique to Medicare—either in the fact that they apply specifically to the aged and disabled population or to circumstances related to the Medicare’s role as a large public program and the largest single payer for health care.

**Spending Growth**

Like the rest of the health system, Medicare has been plagued by rapidly rising costs.\textsuperscript{18} One factor that distinguishes Medicare from other payers is that it is an important part of the federal
budget, accounting for more than one-sixth of total spending by the federal government.\textsuperscript{19} In 2009, prior to the ACA, Medicare was spending an estimated average of $11,723 per beneficiary for its 46.6 million beneficiaries, and the Medicare Hospital Insurance Trust Fund (which pays for hospital inpatient and other facility-based services covered by Medicare and is financed by a designated payroll tax) was projected to become insolvent by 2017.\textsuperscript{20} Spending per beneficiary has slowed dramatically in recent years, growing at only a 1.3 percent annual rate from 2009 to 2014, and as a result the projected solvency of the HI Trust Fund has been extended to 2030.\textsuperscript{21}

Still, Medicare faces a great challenge as the “boomer” generation born after World War II ages into coverage—by 2030, the number of beneficiaries is projected to rise more than 50 percent, from 53.8 million to 81.7 million, prompting concern about how to respond to the rising share of the federal budget and the nation’s resources that will be devoted to financing health care for the elderly and disabled. Although spending per beneficiary has been growing slowly in recent years, and is projected to continue to grow slowly for the immediate future, the increasing number of beneficiaries will drive Medicare spending to grow faster than the economy as a whole (Exhibit 4).

Moreover, Medicare does not exist in a vacuum. Private payers tend to pay substantially more than Medicare for the same care and often pay using very different methods; this discrepancy in payment rates and lack of coherency of methods threatens Medicare beneficiaries’ access to the care they need. Plus, it adds to complexity for doctors and hospitals confronted with different reporting requirements as well as different incentives and methodologies for determining payment rates.

Policymakers are confronted, therefore, with the question of how to continue to slow the growth of total Medicare spending when the spending per beneficiary already is increasing at only about the same rate as inflation. Shifting more of the cost of meeting their health care needs onto beneficiaries themselves—which has been proposed as one way to control Medicare program spending—would be problematic, however, since the aged and disabled include some of the poorest and sickest Americans, and they are least prepared to bear that additional burden.\textsuperscript{22}

The Growing Number of Beneficiaries With Chronic Conditions
As in many other industrialized countries, the population in the United States is aging, with an increased prevalence of chronic conditions.\textsuperscript{23} In 1960, life expectancy at birth in the U.S. was 70; in 2010, it was 79.\textsuperscript{24} As both medical science and health care delivery have changed, so have the needs of Medicare beneficiaries. Now, 37 percent of Medicare beneficiaries have 4 or more chronic conditions—those beneficiaries account for 74 percent of total Medicare spending (Exhibit 5). Medicare beneficiaries with multiple chronic conditions are more likely to have preventable hospitalizations, experience adverse drug interactions, undergo duplicate tests, and receive contradictory information from doctors.\textsuperscript{25} Moreover, many of these beneficiaries have high Medicare costs over several years: nearly one half of the beneficiaries who were among the top 25 percent of the Medicare population in terms of cost in 1997 (a group that accounted for approximately 85 percent of total Medicare spending) were also in the top 25 percent the following year. This is not surprising, since more than 75 percent of those high-cost beneficiaries had been diagnosed with one or more of seven major chronic conditions.\textsuperscript{26}
The health care delivery and financing system, however, is not designed to care for individuals with chronic conditions or pay for the kind of care they need. Payment reform can begin to address this problem, if it focuses on rewarding improved treatment of chronic conditions and other complex conditions experienced by a growing aged and disabled population.27

**The Interaction of Provider Payment and Benefit Design**

Currently, Medicare beneficiaries who enroll in traditional Medicare must patch together multiple plans to receive adequate financial protection and prescription drug benefits. This creates complexity and confusion for beneficiaries and results in higher administrative expenses because of the multiple insurance carriers involved and the lack of integrated claims administration. The need to obtain coverage from multiple sources also makes it difficult for Medicare to incorporate value-based benefit designs that use patient cost-sharing to provide incentives to seek high-value care and compare alternative treatment choices. By offering separate medical and drug coverage, the current design creates a disincentive to achieve hospital and specialty care savings through appropriate medication management. The availability of first-dollar supplemental coverage in the current Medigap market makes it difficult for Medicare to adopt incentives for beneficiaries to register and seek care from primary care practices and medical home teams or seek care from accountable health care systems with a track record of high quality and lower costs.

The combination of fragmented and first-dollar coverage thus raises total cost and confronts beneficiaries with complex choices at high administrative expense. And current benefits fail to protect beneficiaries from catastrophic out-of-pocket costs if they cannot afford private supplements. The only option available to beneficiaries who want integrated comprehensive coverage is to enroll in a private Medicare Advantage plan, with a more limited provider network. A more comprehensive Medicare benefit design that offered could simplify and strengthen beneficiary protection and complement the payment and system reforms that are needed to control costs and improve value.28

In addition, the fragmented nature of the traditional Medicare benefit, and the lack of consistency between the incentives faced by beneficiaries and those faced by providers creates a disconnect that detracts from the effectiveness of either set of incentives. There has been some effort recently to align the incentives faced by providers and beneficiaries more directly, but it has been limited.29

**ACCELERATING PAYMENT REFORM**

Medicare has made significant improvements in the original payment methods put in place in the 1960s, and recent actions by Congress and the Secretary of Health and Human Services (HHS) have focused on accelerating that change.

**The Affordable Care Act**

The ACA was known mostly for its provisions covering uninsured Americans, but it also includes an array of provisions that are laying the foundation for fundamental Medicare payment reform, linking payment to patient outcomes and experiences of care, and giving providers an incentive to limit spending by rewarding reductions in the projected spending for their Medicare
patients. It created a new category of provider organization, accountable care organizations (ACOs), which are groups of providers who agree to accept joint responsibility for the quality and cost of the Medicare patients they treat. ACOs can share in the savings they generate by improving coordination of the care provided to their patients across all settings covered by Medicare.

The ACA also established the Center for Medicare and Medicaid Innovation (CMMI), with $10 billion in funding over 10 years to develop and test new models of payment and health care delivery, including accountable care, bundled payment, and primary care transformation initiatives, to increase the value of care received by Medicare beneficiaries, as well as initiatives to coordinate payment reform across multiple public and private payers. Perhaps more importantly, the Secretary of Health and Human Services has the authority to implement initiatives that have been successful.

Many of those initiatives represent far-reaching reforms, and put providers at financial risk for a portion or all of the cost of providing Medicare services. Among the most prominent activities being conducted by the CMMI are several aimed at transforming primary care, and several of its models involve a bundled payment for specified sets of hospital and/or post-acute care related to specific procedures or conditions. These initiatives are having mixed results in the early evaluations, but in many cases the programs are improving over time as they learn what is associated with success and the payment incentives are modified.

The Medicare Shared Savings Program (MSSP) began in 2012 as a permanent part of the Medicare program, rather than a demonstration, although participation was voluntary and was subject to approval by the Centers for Medicare and Medicaid Services (CMS). As of April 2015, there were more than 400 ACOs participating in the program, serving more than 7 million Medicare beneficiaries in 49 states, the District of Columbia, and Puerto Rico. To give ACOs some time to develop and implement the approaches necessary to achieve the cost reductions that would be required to achieve success, a one-sided risk model (in which ACOs that failed to keep their Medicare spending below their target would not be penalized—i.e., upside risk but no downside risk) was in place at the outset. Early results from the MSSP participants indicated that, as a whole, they have achieved modest savings and generally improved the quality of care. In the first year, 54 percent of the organizations for which results were available spent less than their targets and 24 percent earned shared-savings bonuses. In the second year, 54 percent spent less than their targets and 26 percent earned shared savings bonuses; although total net savings relative to the ACOs’ targets were positive, they were not large enough to offset the bonus payments paid. Savings were correlated with the ACO’s tenure in the program, but they also were correlated with the level of the spending target. Several refinements indicated by these results (particularly in the methods used to determine the spending targets) have been addressed in the latest MSSP regulations. A fundamental problem with the shared savings model is that ACOs can receive more money if they do not save than if they achieve savings, since in the one-sided risk model they pay no penalty for failing to achieve savings and, even in a two-sided risk model in which there is a penalty for excess spending, they share the risk with Medicare.

The CMMI designed the Pioneer ACO Model for early adopters of coordinated care. It offers a larger share of achieved savings in return for a two-sided risk model. When it began in 2012
there were 32 participating organizations in 18 states; the number of Pioneer ACOs has fallen to 19 as of 2015, but most of the organizations that left the Pioneer ACO Model switched to the MSSP. Over the first two years of the program, total Medicare expenditures increased more slowly for beneficiaries aligned with Pioneer ACOs than for beneficiaries in traditional Medicare, with little difference in patient experience.\textsuperscript{40} These findings established the Pioneer ACO Model as the first CMMI initiative to meet the ACA criteria (proven potential to reduce Medicare spending while maintaining the quality of care) for expansion to other areas and organizations. Results from the third year indicate continued savings and quality improvement.\textsuperscript{41}

Since 2012, CMS has been collaborating with commercial and state health insurance plans to offer population-based care management fees and shared-savings opportunities to participating primary care practices in order to support prevention, access to care, care coordination, chronic care management, and shared decision-making among patients and their providers. As of May 2015, the \textbf{Comprehensive Primary Care Initiative} includes 475 sites in seven regions, including more than 2,800 providers who serve 2.7 million patients, of which 400,000 are Medicare and Medicaid beneficiaries. Altogether, there are 38 public and private payers participating in this initiative.\textsuperscript{42} Results from the first year are mixed: there was a statistically significant reduction in total Medicare expenditures per beneficiary, but not quite enough to offset the care management fees paid to the practices; several quality measures improved among participants, but none of the changes was statistically significant.\textsuperscript{43}

Through the \textbf{Multi-Payer Advanced Primary Care Practice Demonstration}, begun in 2011 with eight states participating, CMS is participating in multi-payer reform initiatives to make advanced primary care practices more available.\textsuperscript{44} The demonstration, which was originally planned for three years, has been extended through 2016 with 5 of the original states; it is anticipated that approximately 1,200 medical homes, serving more than 900,000 Medicare beneficiaries, will participate. In the first year, only two of the seven states for which data were available generated savings; no evidence is yet available on access to or quality of care.\textsuperscript{45}

Bundled payment is designed to provide financial incentives to improve the continuity and effectiveness of care, reduce the use of unnecessary services, and slow spending growth by creating financial incentives for providers to coordinate care across settings. The CMMI has developed the \textbf{Bundled Payments for Care Improvement Initiative}, which provides a single payment amount for a specified course of inpatient and/or post-hospital care.\textsuperscript{46} Four payment models cover different combinations of those services, with almost all of the approximately 7,000 participating providers opting for Model 2 (acute and post-acute care episodes) or Model 3 (post-acute care only). Evaluation of first-year performance indicates that Model 2 may decrease variation in the use of post-acute care, which has been a major factor in health spending differences across regions.\textsuperscript{47,48}

More recently, CMS has proposed a new model intended to support better and more efficient care for beneficiaries undergoing hip and knee replacements—the most common inpatient surgeries for Medicare beneficiaries—in the \textbf{Comprehensive Care for Joint Replacement Model}.\textsuperscript{39} Under this initiative, hospitals would be held financially accountable for the quality and costs (including services covered under Medicare Hospital Insurance and Supplementary Medical Insurance) of an episode of care for patients with hip and knee replacements, extending
for 90 days after the patient’s discharge from the hospital. CMS has proposed to implement this model in 75 metropolitan statistical areas around the country, with all hospitals located in those areas (except for those participating in the Bundled Payments for Care Improvement Initiative) required to participate. The requirement that all hospitals in selected areas participate in a payment initiative is new for Medicare—demonstrations historically have been voluntary—and there promises to be much discussion of the advisability of this model and the details of the initiative.50

Although the initial results from several of these initiatives have been mixed, these models may show some promise for providing vehicles for increasing the emphasis on primary care and facilitating more coordinated care. More time may be needed to overcome the adverse incentives and fragmented delivery and payment systems that still predominate in the U.S. health system.51

**The Medicare Access and CHIP Reauthorization Act**

In April 2015, Congress repealed the sustainable growth rate formula (SGR) that had been put in place in 1998 to limit Medicare physician spending by adjusting the fee schedule if spending exceeded a target. The SGR had been intended to counter the incentive to increase the volume and intensity of services under a fee-for-service payment system that reimbursed physicians and other medical professionals for every service they provided.

Under the SGR, the physician spending target was based on overall economic growth; with robust economic growth in the early 2000s, the SGR produced generous updates, but beginning in 2002, slower economic growth produced SGR-mandated reductions in the physician fee schedule. Concerned about payment adequacy, but unable to agree on how to offset the cost of permanently undoing the SGR cuts, Congress enacted a series of temporary deferrals of those cuts beginning in 2003 while leaving the SGR mechanism in place.52 The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) permanently repealed the SGR and replaced it with provisions focused on rewarding high-performing providers while supporting alternative payment models such as accountable care organizations and patient-centered medical homes.53

The volume-based cuts to fees under the SGR will be replaced with modest updates. A physician fee increase of 0.5 percent was implemented in June 2015 and then each year from 2016 through 2019, with fees remaining at the 2019 level through 2025—but high-performing providers and providers participating in alternative payment models will have the opportunity for additional payments.

To accelerate the move from volume-based to value-based payment, a Merit-based Incentive Payment System (MIPS) will be established beginning in 2019. The MIPS will replace three previous incentive programs with a combined value-based payment program that assesses the performance of each eligible provider based on quality, resource use, clinical practice improvement activities, and meaningful use of certified electronic health record technology.

The Secretary of HHS will have substantial flexibility—within legislatively-specified guidelines—to determine the quality measures to be used in determining the MIPS payment adjustment and to update the list of measures as appropriate. The Secretary also will be
responsible for developing the methodology for assessing the performance of each provider and the formula for calculating payment adjustments, as well as setting the threshold for bonus payments for exceptional performance. Technical assistance will be available to small practices and practices in health professional shortage areas.

Providers who participate in alternative payment models can receive extra payments, such as shared savings for accountable care organizations and care management fees or shared savings for patient-centered medical homes. In addition, a five percent bonus will be available each year from 2019 through 2024 for those who receive a substantial portion of their revenues through those models. Providers who choose to participate in the MIPS will be subject to positive or negative payment adjustments based on their performance, with $500 million in funding each year from 2019 through 2024 to provide an additional adjustment for providers with exceptional performance.

Beginning in 2026, fees would increase by 0.75 percent each year for providers who participate in an alternative payment model and 0.25 percent per year for those who do not; all providers not participating in alternative payment models also would be subject to the MIPS payment adjustments beginning in 2026.

Several components of this legislation have been controversial, including that its estimated costs have not been fully offset by provisions that produce additional savings or revenues. The Congressional Budget Office (CBO) estimates that, over the next decade, federal spending will be $141 billion higher than it would be under current law; at the same time, the Centers for Medicare and Medicaid Services (CMS) chief actuary has expressed concern over whether Medicare payments beyond the 10-year budget window will be sufficient to cover providers’ costs. But a lot depends on how these policy changes are implemented.

The lack of solid evidence on the cost impact of alternative payment models has kept estimates of their potential savings low, so they do not provide much of an offset to the high estimated cost of repealing the SGR. But this is often the case when major policy changes are considered, and an analysis of CBO’s cost estimates for some of the major health initiatives implemented over the years indicates a tendency to underestimate their potential savings. Although the connection between payment and delivery reform and cost savings has not been definitively determined, both national health expenditures and Medicare spending have slowed considerably at the same time that these reforms have gained momentum in both the public and private sectors. If alternative payment models do succeed in slowing health spending by improving the effectiveness and efficiency of health care, both the cost of the SGR repeal and the long-term estimates of provider costs reported by the CMS actuary may be overstated.

In the end, the overriding consideration is that the repeal of the SGR would provide CMS with substantive additional mechanisms and resources it could use to hasten the development of alternative payment models that hold the promise of lowering costs and improving care. It is the job of policymakers, payers, providers, and patients to collaborate in achieving this goal, and this legislation provides additional tools with which to do so.
Setting Explicit Goals for Payment Reform
In March, the HHS Secretary announced a goal of linking 85 percent of traditional Medicare provider payment to quality or value by the end of 2016, and 90 percent by the end of 2018.58 A recent study indicates that, as of the end of 2013, 42 percent of provider payments in traditional Medicare are tied to the value of care.59 This represents significant progress, but much still remains to be done in a short time (Exhibit 6). Many initiatives that were not included in that study are in place now or will soon be implemented, supporting expectations that the percentage will increase considerably over the next few years.

One powerful tool that the HHS secretary possesses is the authority, granted by the ACA, to adopt innovations found to save money and improve quality for use throughout the Medicare program. In addition to continuing to test how well different incentives improve value, HHS is focused on improving the way care is delivered through learning networks such as the recently announced Health Care Payment Learning and Action Network.60 It also aims to increase the availability of information to guide decision-making, by increasing the use of health information technology, enhancing transparency, and generating information through the Patient-Centered Outcomes Research Institute that can guide care decisions.

KEYS TO SUCCESSFUL PAYMENT REFORM
An array of payment reforms is available—and, most likely, necessary—for moving toward a payment system that rewards high performance in the delivery of health care.

Focusing and Strengthening Incentives for High Performance
As described above, recent legislation provides strong impetus to support Medicare’s movement toward payment that focuses on value, rather than volume: MACRA provides 5 percent fee increases to physicians who receive a significant portion of their revenue from an alternative payment model, such as a blended, bundled, or global payment model, or from care provided through patient-centered medical homes or ACOs. In addition, funding is provided to increase the rewards for providers who achieve exceptionally high performance on measures of health care quality, patient experience, and efficiency. Successfully moving away from fee-for-service payment with no link to value may require the continued widening of the differential in payment rates for providers based on participation in alternative payment models that reward value.

Improving the Current System as a Basis for Payment Reform
Further legislation may be necessary to fix the flawed fee-for-service physician payment system, since it is likely to remain a component of payment methods for some time.61 In fact, with improvements to address its basic flaws, it may be desirable to incorporate elements of the fee-for-service model in payment reforms that use a hybrid of alternative payment approaches.62,63

Aligning Incentives for Providers and Patients
Making sure that the incentives faced by Medicare beneficiaries are consistent with those imbedded in provider payment is also important. The current fragmentation of Medicare’s benefit structure makes it difficult enough to provide beneficiaries themselves with a consistent set of incentives, much less to align those incentives with the stated goals of provider payment reform. An approach to addressing this problem is described more fully in a separate paper.
presented at this session, which proposes an integrated Medicare benefit package with cost-sharing designed to provide positive incentives for preventive and primary care as well as high-value care systems. Introducing financial incentives for Medicare beneficiaries to choose high-value care from providers paid through innovative payment methods can accelerate health system transformation and yield savings to both beneficiaries and taxpayers. Further attention needs to be paid to the interaction of Medicare benefit design with provider payment, and how the two can be made mutually supportive in achieving program goals. Rewarding beneficiaries for seeking care from high-value providers would align provider and beneficiary incentives, and could go a long way toward supporting the success of those incentives. Such alignment has the potential to accelerate the spread of delivery system reform by further supporting systems that innovate. This also would require that beneficiaries be given access to useful information on the quality of participating providers and networks.

**Transmitting Incentives So They Are Effective at the Point of Care**

In addition, payment policy should recognize the distinction between macro- and micro-level incentives. The way payment policy is perceived and the responses it elicits may be very different for plans and provider organizations, and the way it affects the nexus of interaction between providers and patients also may be very different. For example, although a Medicare Advantage plan may receive a capitated payment that depends on the number of beneficiaries who are covered and their risk profiles, the individual providers within the plan may be paid on a fee-for-service basis, or otherwise may not be subject to the same incentives to which the plan is subject—the same issue may apply in the case of a group of providers versus the individual providers in that group. Moreover, it is not just payment methods, but how those payments are implemented and other elements of the practice culture that may determine how providers react to those incentives.

**Aligning Incentives Across Payers**

A key requirement for the success of Medicare payment reform is changing the health care delivery system and the choices that providers and patients make with regard to the way health care is organized and delivered—but Medicare, although it is the largest single payer and has been and continues to be a leader in developing innovative approaches to health care payment and delivery, is not alone, and cannot change the health care system by itself. Medicare, as described above, has developed and implemented several multi-payer initiatives that aim to align payment approaches across Medicare, Medicaid, and private insurers, to eliminate the confusion caused by conflicting payment approaches and to enhance the effectiveness of consistent incentives to improve care and population health and reduce cost growth.

The lack of correlation between Medicare and commercial spending per beneficiary is a manifestation of those inconsistent incentives (Exhibit 7). The wide variation in Medicare spending per enrollee are largely driven by wide differences in the utilization of post-acute care and home health care, while private insurance spending is driven in large part by the prices paid for services. Although the rate of spending growth has slowed for both Medicare and private payers, Medicare spending has been growing much more slowly (Exhibit 8).
Currently, private payers often look to Medicare for changes in levels and ways of paying doctors and hospitals. Payment reform will be much more effective if Medicare is able to develop partnerships with private insurers, state Medicaid, and other federal programs that adopt value-based payment methods. The challenge is for Medicare to develop initiatives that can be easily implemented by the private insurers.

Payment reform and efforts to slow the growth of costs for all populations, including those who are under-65, could also benefit if a modernized Medicare could be offered to the under-65 population as a plan choice. With the advent of healthcare marketplaces under the ACA, such integration across age groups would smooth transitions as adults become eligible for Medicare and enhance Medicare’s purchasing power to drive innovation. The ultimate goal is to transform the delivery of care to benefit everyone, improving patient outcomes, access, and care experiences while lowering costs. Reducing or eliminating avoidable, unnecessary, and ineffective care, and redeploying those savings to provide better financial protection for beneficiaries as well as lowering federal outlays, would be a major step toward improving the financial sustainability of the Medicare program in particular, and the U.S. health system in general.

Shared Resources to Support Payment and Delivery System Reform
Finally, payment incentives, even if they are effectively delivered to and received by plans, provider organizations, individual providers, and patients, may not be enough. Increasing attention is being paid to population health and, consequently, to population-level metrics of health system performance. But to attain system goals that extend beyond the capacity of individual providers, or even groups of providers, to accomplish, it may be necessary to make resources available at the community level upon which providers—and others who should participate in the process of ensuring and improving population health—can draw. Several initiatives to coordinate community resources have been developed, and that type of activity can enhance the effectiveness of payment incentives.

CONCLUSIONS
The need for payment reform—in Medicare and throughout the U.S. health system is clear. Alternative payment models are being developed to encourage and reward improved health care quality, patient experiences, coordination of care, patient outcomes, and resource costs. Medicare, however—although it has been a leader in payment reform and has been given expanded authority in recent legislation—cannot do it alone; Medicare and other public programs must work in concert with private payers to provide consistent incentives for improved performance. The need for consistent incentives is not limited to providers: patients, too, must be rewarded for making choices that lead to better, more effective, and more efficient care.

The array of broad-based incentives being developed in both the public and private sectors is encouraging. They must be coordinated, however, so as not to generate confusion about potentially conflicting incentives. That is not to say that the participants in this process must develop identical approaches to payment reform—in fact, it is likely that an array of approaches, tailored to the specific circumstances of each market, will be most successful. But the incentives with which providers and patients are presented should be consistent and the message should be
clear; the goal of all should be to achieve the triple aim: better care, better health, and lower cost.\textsuperscript{73}
NOTES


29 The Medicare Acute Care Episode Demonstration allows for payment to Medicare beneficiaries representing a portion of the savings achieved by Medicare under the demonstration, but the subsequent Bundled Payments for Care Improvement Initiative did not include provision for shared savings with beneficiaries.


### Exhibit 1. Elements of Poor Coordination of Care Reported by U.S. Adults, 2011

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<tr>
<th>Percent reporting in past two years:</th>
<th>Number of Doctors Seen</th>
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</tr>
<tr>
<td>After medical test, no one called or wrote you about results, or you had to call repeatedly to get results</td>
<td>27</td>
</tr>
<tr>
<td>Doctors failed to provide important information about your medical history or test results to other doctors or nurses you think should have it</td>
<td>23</td>
</tr>
<tr>
<td>Test results or medical records were not available at the time of scheduled appointment</td>
<td>18</td>
</tr>
<tr>
<td>Your primary care physician did not receive a report back from a specialist you saw</td>
<td>15</td>
</tr>
<tr>
<td>Your specialist did not receive basic medical information from your primary care doctor</td>
<td>12</td>
</tr>
<tr>
<td>Any of the above</td>
<td>47</td>
</tr>
</tbody>
</table>

Exhibit 2. Correlation Between Medicare Utilization and Avoidable Complications Across Geographic Areas

Note: PSI = Patient Safety Indicator, a set of indicators developed by the Agency for Healthcare Research and Quality to provide information on potential in hospital complications and adverse events following surgeries, procedures, and childbirth.

Exhibit 4. Projected Annual Growth Rates for Total Medicare Spending, GDP, Medicare Enrollment, Spending per Beneficiary, and GDP per Capita, 2014-2024

Although Medicare spending per beneficiary is projected to grow at a rate close to GDP per capita, total Medicare spending is projected to growing much faster than GDP.

- Total Medicare Spending: 7.1%
- GDP: 4.7%
- Medicare Enrollment: 2.9%
- Medicare Spending per Beneficiary: 4.0%
- GDP per Capita: 3.8%

Exhibit 5. Distributions of Number of Beneficiaries and Spending in Traditional Medicare Spending by the Number of Chronic Conditions, 2009

Exhibit 6. Percentage of Traditional Medicare Payment Tied to Quality or Value, and Goals for the Future

As of 2013: 42%
As of 2016 (Goal): 85%
As of 2018 (Goal): 90%

Exhibit 7. Relationship Between Commercial and Medicare Spending Across Referral Regions

Exhibit 8. Medicare and Private Health Insurance: Percent Change in Personal Health Care Spending per Enrollee, Selected Periods, 2001-2013

Note: Figures represent common benefits.