Summary

Improving the Quality and Efficiency of the Medicare Program Through Coverage Policy

Timely Analysis of Immediate Health Policy Issues

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Medicare coverage determinations can influence the appropriate use of medical technology and the creation of better evidence to support clinical and health policy decisions. But the process for making coverage decisions in the Medicare program falls short of its potential to contribute to improved health outcomes for beneficiaries. This paper offers several achievable steps in five topic areas to improve the coverage process.

The Centers for Medicare and Medicaid Services has recently emphasized their programmatic "Triple Aim" to improve patients' experience of care, improve population health and reduce the rise in per capita costs. These aims emphasize the desire to promote higher quality with more prudent and, likely, lower spending—consistent with a long-standing desire to promote value-based purchasing within the Medicare program. To improve the value of Medicare services, Congress and the Centers for Medicare and Medicaid Services (CMS) have emphasized delivery system reform and measurement of provider performance, and have begun to modify payment approaches to better align reimbursement with demonstrated provider quality and efficiency. However, the leading cause of increased health spending—adoption of new technology and increased use of existing technology—has not been included in recent initiatives, nor has there been any recent movement by Medicare to directly address the health effects or costs associated with use of technologies.

Medicare is authorized to pay for services that are reasonable and necessary for diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. Currently, Medicare defers most coverage decisions to regional contractors who process claims daily. The contractors are incentivized to efficiently process claims and not to accurately evaluate clinical effectiveness or appropriateness of the services provided. At the national level, CMS develops coverage determinations on a relatively small subset of technologies. These national coverage determinations most commonly begin at the request of a company or individual who is interested in expanding current coverage. While CMS is required to follow a formal and transparent process-making use of the best evidence available to reach a decision, high-quality evidence is often lacking. The agency is rarely proactive in beginning the national coverage process.

Medicare coverage determinations can act as a potent policy lever to influence both the appropriate use of medical technology and the creation of better evidence to support clinical and health policy decisions. This paper, written by four former senior officials at CMS with direct responsibility for core aspects of coverage and payment policy at the agency, provides a basic overview of the coverage policy process at CMS, explores particular operational defects in current implementation, and discusses a few, selected opportunities to better align coverage policy with the Triple Aim. The paper concludes with priority recommendations for reform. Some of these changes could be relatively easy to implement with sufficient leadership, political will and adequate administrative resources, whereas others would require more significant and politically difficult changes, sometimes requiring congressional commitments that do not now exist.

The authors argue that the process for making coverage decisions in the Medicare program underperforms as a policy tool and falls short of its potential to contribute to improved health outcomes for Medicare beneficiaries. The coverage process as currently applied does not prevent ineffective, unproven and/or harmful technologies from widespread adoption in Medicare, fails to identify and promote broad use of effective and high-value services, and is poorly coordinated with other Medicare policy mechanisms that aim to improve health outcomes for the Medicare population. There are also missed opportunities to promote high-priority clinical research relevant to Medicare recipients.

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The lack of high-quality evidence for making informed coverage decisions means that the vast majority of new technologies and services bypass any meaningful review. This is exacerbated by the absence of a coherent national policy framework for activating coverage. Even when CMS has strong, scientific evidence that casts doubt on whether a technology or service effectively improves patient health and well-being, progress has stalled, in part because of a political environment in which evidence-based policy-making meets strong resistance from affected stakeholders.

This paper explores five selected topics in more depth that could improve the coverage process. These include:

- Strengthening evidence-based policies that direct coverage to selected populations and/or settings of care—or "coverage with conditions;"
- Improving the evidentiary base of coverage policies through improved comparative effectiveness research;
- Using coverage with evidence development more consistently;
- Enabling some consideration of costs in making coverage and payment policies; and
- Adopting least costly alternative pricing strategies in particular circumstances.

The paper emphasizes that the potential of Medicare coverage and related payment policy is unrealized partly because of a lack of commitment and will, generally unrelated to controversial approaches that would require new or clearer statutory authority. Accomplishment of these more limited, but important, initiatives would require specification of objectives and implementation plans, sustained attention, and clear communication.

Among a number of opportunities CMS now has to improve coverage to support the Triple Aim, the paper explores greater use of the Medicare Evidence Development and Coverage Advisory Committee to craft a more systematic approach to identifying topics for review as national coverage determinations; selective use of prior authorization approval for high-cost services with demonstrated patterns of inappropriate use; and broader adoption into Medicare of underused high-value technologies, including opportunities to promote delivery system improvements, in coordination with the Center for Medicare and Medicaid Innovation.

Effectively implementing these changes would likely require additional resources and dedicated and trained staff. However, with a better targeted coverage policy supported by adequate resources, increased administrative costs would likely be more than offset by program savings resulting from reducing services that do not benefit—or actually harm—Medicare beneficiaries.

The authors also make some recommendations that would require statutory clarification or new authority. First, it would be useful to establish explicit legal authority that would allow CMS to apply coverage with evidence development to promising technologies of particular significance to Medicare beneficiaries, and for which important questions about clinical effectiveness require better evidence. Second, Congress should restore and, perhaps, expand Medicare's authority to apply least costly alternative pricing to products that are similar in their biological and/or physical characteristics and that achieve comparable clinical outcomes. Finally, statutory changes will be necessary to allow CMS to explicitly consider costs in any manner as part of national coverage decision

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About the Author and Acknowledgements

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