

Modernizing Medicare's Prevention Policies

A Prevention Policy Paper Commissioned by
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Executive Summary

Clinical preventive services can help prevent many diseases and detect them in their earliest, most treatable phase. These services include screening tests, immunizations, counseling (behavioral) interventions, and the use of drugs to prevent disease (chemoprevention).

Medicare, the national health care insurance system for the elderly and disabled, was created by Congress in 1965. At its inception, Medicare covered only diagnostic and treatment services. Preventive care was excluded by omission. Since 1965, Congress has amended the Medicare regulations numerous times, slowly adding individual clinical preventive services to the program.

This practice has resulted in an inconsistent set of covered preventive services, some with strong evidence supporting them, others lacking good evidence. Some proven services have not yet been included. What's more, each addition has required an act of Congress. It is clear that this is not the best way to create a comprehensive prevention policy.

The recently enacted Medicare Improvement for Patients and Providers Act (MIPPA) broke with 43 years of precedent and, for the first time, gave the Secretary of Health and Human Services, acting through the Centers for Medicare and Medicaid Services (CMS), the authority to add preventive services to Medicare *without Congressional action*. This creates an exciting opportunity for the Medicare program to craft a set of policies that will modernize Medicare's approach to prevention.

Given this opportunity, what should CMS do to improve population health through preventive care? Should changes only involve currently covered services, or are there other actions CMS could take to modernize Medicare's prevention policies to better promote health and prevent disease for its beneficiaries?

This paper presents and discusses some of the options available to the Medicare program. Most require no additional authorization from Congress. They include interventions to increase the use of currently covered preventive services by Medicare beneficiaries; increasing the use of the one-time only "Welcome to Medicare" visit introduced in 2005; decreasing racial and economic disparities in the use of preventive care; adding coverage of other proven preventive services to Medicare; emphasizing the use of chemoprevention; increasing Medicare's focus on preventive care for people already diagnosed with chronic diseases; using creative coverage mechanisms to expand coverage and to acquire new knowledge; and partnering with communities to improve health promotion and disease prevention.

Some changes would require Congressional action. These include removing copayments and deductible payments from all preventive services; changing the one-time Welcome to Medicare visit to be a regular, periodic benefit; including immunizations in the services that CMS can authorize; providing additional incentives for doctors and other clinicians to deliver preventive care; and withdrawing Medicare coverage for unproven preventive services.

Note: The views expressed in this paper are those of the author. They do not necessarily represent the views of Partnership for Prevention.

Introduction: Stating the Problem and the Potential

The problem, simply stated, is how to modernize Medicare's prevention policies to better promote health and prevent disease for its beneficiaries. The changes would be implemented through the use of clinical preventive services and other prevention strategies.

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This has resulted in an inconsistent set of covered preventive services, some with strong evidence supporting them, others lacking good evidence. Each addition required an act of Congress, since the original legislation did not provide for preventive care coverage. It is obvious that this is not the best way to create a comprehensive prevention policy.

The recently enacted Medicare Improvement for Patients and Providers Act of 2008 (MIPPA—PL 110-275) broke with 43 years of precedent and, for the first time, gave the Department of Health and Human Services (HHS) authority to add preventive services to Medicare *without Congressional action*. This creates an exciting opportunity for the Medicare program to craft a set of policies that will modernize Medicare's approach to prevention.

The key question is this: What should the Centers for Medicare and Medicaid Services (CMS) do to improve preventive care? And should changes involve only covered services, or should they expand into issues of uptake and implementation, as well as moving beyond individual clinical preventive services to coordinate with community preventive services?

In the next section, we will discuss these issues, presenting an argument that can be translated into effective strategies. The strategies are described in the final section of the paper.

Discussion

Leading Causes of Death in the Elderly

About 44 million Americans have Medicare health insurance.¹ Five-sixths of them are age 65 or over; one-sixth are younger but disabled or have chronic kidney disease. The ten leading causes of death in the elderly (age 65 or over) are listed in Table 1. The top four causes of death are heart disease, cancer, cerebrovascular diseases, and chronic lower respiratory diseases, all of which account for more than 65% of the deaths in this age group.

**Table 1. Leading Causes of Death in Americans, Age 65 and Over
2004²**

Rank	Cause	Number	Percent
	All causes	1,755,669	100.0
1	Diseases of heart	533,302	30.4
2	Malignant neoplasms	385,847	22.0
3	Cerebrovascular diseases	130,538	7.4
4	Chronic lower respiratory diseases	105,197	6.0
5	Alzheimer's disease	65,313	3.7
6	Diabetes mellitus	53,956	3.1
7	Influenza and pneumonia	52,760	3.0
8	Nephritis, nephrotic syndrome and nephrosis	35,105	2.0
9	Unintentional injuries ("accidents")	35,020	2.0
10	Septicemia	25,644	1.5
	All other causes (residual)	332,987	19.0

These data are taken from the causes of deaths listed on death certificates. McGinnis and Foege³ and Mokdad et al⁴ have shown, however, that when risk factors for the leading causes of death are considered and deaths are attributed statistically to the various risk factors, a different picture emerges. Thus, the actual leading causes of death for Americans are tobacco use, poor diet, and lack of exercise (Table 2). This finding points to the importance of behavioral risk factors in disease causation and prevention. Although these studies were not done specifically for the Medicare population, it is likely that the results would be similar for older age groups, because almost 75% of all deaths occur in those 65 and older.

Table 2
Estimated “Actual” Causes of Death, 2000⁴

Cause of Death	Number Attributed to Cause
Tobacco	435,000
Poor diet and physical inactivity	365,000*
Alcohol consumption	85,000
Microbial agents	75,000
Toxic agents	55,000
Motor vehicle	43,000
Firearms	29,000
Sexual behavior	20,000
Illicit drug use	17,000

*It is particularly difficult to estimate excess deaths associated with obesity and underweight. Other estimates of the number of such deaths are lower; see, for example, Flegal KM, Braubard BI, Williamson DF, and Gail MH. Excess deaths associated with underweight, overweight, and obesity. *JAMA* 2005; 293:1861-1867.

Clinical Preventive Services

Clinical preventive services are interventions delivered in the health care setting designed to prevent or detect diseases before they can sicken or kill patients. The four types of clinical preventive services are the following:

- Screening tests, such as Pap smears and mammography, where disease is detected in its early stages so that it may be treated and sometimes cured;
- Immunizations, such as flu shots and measles vaccine, in which diseases are prevented by the administration of one or more doses of the vaccines;
- Counseling, such as for smoking cessation or sexually transmitted disease prevention, in which patients learn how to change their health-related behaviors to eliminate risk factors and prevent disease; and
- Chemoprevention (or chemoprophylaxis), the use of medications such as aspirin or estrogen to delay or prevent the onset of disease.

Preventive care is often categorized into three levels. *Primary prevention*, which includes immunizations, counseling, and some chemoprophylaxis, is intended to prevent or delay the onset of disease and occurs before the disease process has started. *Secondary prevention*, including most screening tests, identifies asymptomatic disease early in its course, when treatment is often most effective and sometimes curative. *Tertiary prevention* is delivered to patients with established diseases in an attempt to minimize illness, complications, and disability. Although most research and discussion have been about interventions to improve primary and secondary prevention, in the elderly and disabled population, tertiary prevention is also important. It will be discussed later in this monograph.

The Importance of Clinical Preventive Services in the Elderly

There are now over 37 million Americans age 65 and over. Although 25% of them are in only fair or poor health, their average life expectancy at age 65 is long: 17 years for men and 20 years for women. Many elderly Americans have risk factors for the leading causes of death. In fact, 8-12% of persons age 65 and over smoke cigarettes. Between 65 and 75% of them are overweight. About 19% of those 65 and over have been diagnosed with diabetes, and between 62 and 82% have hypertension.⁵

Research has provided evidence that many clinical preventive services are effective in preventing disease and prolonging life.⁵ This includes preventive care for persons age 65 and older as well.^{6,7} A striking example is the benefit of smoking cessation in individuals with existing coronary heart disease; in the Coronary Artery Surgery Study, Hermanson and colleagues⁸ showed just as large an individual benefit from quitting among those age 65-74 as for those age 35-54 and 55-64.

Many of the preventive services recommended by the U.S. Preventive Services Task Force (USPSTF) and other authorities and covered by Medicare have important roles in promoting health and reducing disease from the leading causes of death. These services include the following:

- Cancer screening for colorectal, breast, and cervical cancers
- Cholesterol screening to prevent death and disability from heart disease and stroke
- Bone mineral density screening to diagnose and slow the progression of osteoporosis
- Abdominal ultrasound screening to diagnose and prevent death from abdominal aortic aneurysm
- Immunizations against influenza, pneumococcal disease, and hepatitis B
- Counseling to help patients who use tobacco products quit

In addition to providing clinical benefit, in some cases preventive services such as immunizations can lead to reduced medical expenses.⁹

Brief History of Clinical Preventive Services Coverage in Medicare

When Congress created Medicare in 1965, it provided insurance coverage only for diagnostic and treatment care. The law was worded as follows:

“No payment may be made under part A or part B [of Medicare] for any expenses incurred for items or services which ... are not reasonable and necessary for the *diagnosis or treatment* of illness or injury or to improve the functioning of a malformed body member...”¹⁰ (Social Security Act, italics added)

As a result of this wording, Medicare has been consistently interpreted as excluding coverage of any primary and secondary clinical preventive services. Tertiary preventive services, which are provided to patients who have been diagnosed with a disease, have usually been covered by Medicare.

In 1965, evidence for the effectiveness of preventive care had not been systematically reviewed, and there was little demand that these services be covered. But beginning shortly after Medicare was enacted, and continuing at a growing rate, bills were introduced in Congress to

add various preventive services to Medicare coverage. Initially, most bills addressed vision, hearing, and dental benefits. By the late 1970s, scores of bills were being introduced annually to cover a wide range of preventive services—cancer and high blood pressure screening, nutritional counseling, and immunizations.¹¹ For years, none of these bills passed both houses of Congress.

After 15 years of Medicare and the introduction of 350 unsuccessful bills to cover various preventive services, Congress approved coverage for Medicare's first preventive service in 1980: pneumococcal disease immunization, for which coverage began in 1981. Over the next 25 years, a small number of clinical preventive services have been added to Medicare, each time through legislation. Table 3 lists clinical preventive services currently covered by Medicare.

Table 3
Preventive Services Currently Covered by Medicare¹²

(Some services are only for individuals with a specific disease or diseases or at increased risk for developing those ailments.)

One-time “Welcome to Medicare” Visit

Screening Tests for

Abdominal aortic aneurysm
Breast cancer
Cervical and vaginal cancer
Cholesterol and other lipids
Colorectal cancer
Diabetes
Glaucoma
Osteoporosis
Prostate cancer

Immunizations against

Hepatitis B
Influenza (Flu)
Pneumococcal disease

Counseling/Behavioral for

Smoking cessation

Chemoprevention

Prescription drugs for prevention, through Medicare Part D

Tertiary Preventive Services Currently Covered by Medicare

Medical nutrition therapy for patients with diabetes and renal disease
Outpatient self-management training for patients with diabetes

In addition to individual preventive services, Congress authorized Medicare to pay for a one-time "Welcome to Medicare" (WMV) visit beginning in 2005. The visit, which was advocated by Partnership for Prevention,¹³ was designed to include education and counseling, screening tests, and immunizations for persons enrolled in Medicare's Part B.

With the passage of the Medicare Improvement for Patients and Providers Act (MIPPA) 2008, the biggest change in the regulations for Medicare coverage of preventive care has just occurred. MIPPA transfers authority to approve coverage for additional preventive services from Congress to the Medicare program, which will make those determinations through its well-established national coverage decision process beginning in 2009. Thus, for the first time since Medicare was created in 1965, preventive services will be treated like diagnostic and treatment services with respect to coverage policies and processes.

Use (Uptake) of Preventive Services and WMV by Medicare Beneficiaries

Medicare's own data on preventive services utilization are difficult to interpret. For a number of reasons, data based on claims paid for these services generally undercount the number of Medicare recipients receiving preventive care. Some services, such as immunizations, are also acquired outside the Medicare billing sector, in churches and other community settings. Other services, such as many screening tests, are recommended at frequencies less than annually, so annual reporting figures are not helpful. Over-reporting also occurs, mainly in beneficiary surveys in which many people do not remember whether they received specific tests or immunizations. And some screening tests, such as blood tests for cardiovascular screening and prostate cancer screening, are over-counted, because it is impossible to distinguish diagnostic testing from screening tests; the billing codes are the same.¹⁴

Despite these difficulties, however, researchers have been able to estimate the use of some of Medicare's preventive services, often by combining billing data with registry or self-reported information. They have generally found that despite Medicare coverage for effective preventive services of all types, the use of these services has been far from optimal.

Immunizations, for example, are particularly important for the elderly, who have more chronic diseases than younger people. These chronic conditions put them at increased risk for severe consequences from infection. Yet fewer than 6 in 10 Americans age 65 and over have ever had a pneumococcal vaccination. In the previous 12 months, only about two-thirds of the noninstitutionalized population age 65 and over report having had an influenza immunization.⁵ In addition, there are significant racial disparities in immunization rates among older Medicare beneficiaries. Even after adjustment for factors that might explain the numbers, such as health plan or physician characteristics, whites are between 52 and 82% percent more likely to get influenza and pneumococcal vaccinations than African -Americans.¹⁵

Elderly women receive significantly less mammographic screening for breast cancer than recommended by professionals and permitted by Medicare. In one study, over a two-year period, between 35 and 48% of the almost 150,000 women age 65 and over had had a mammogram.¹⁶ This research also found that non-white women undergo significantly less screening than white women. Similarly, a national survey of colorectal cancer screening and receipt of influenza and

pneumococcal immunization in persons age 65 and over found that only 37% of respondents were current with all three preventive services.¹⁷

Finally, the one-time Welcome to Medicare Visit has not been used extensively since it became available in 2005. Complete data from Medicare billing records for 2005 indicate that only 3.3% of eligible new Medicare enrollees had this comprehensive check-up and counseling session. Still incomplete data from 2006 show an increase from the 2005 levels, probably due to awareness of the service by more newly enrolled beneficiaries. Nonetheless, the proportion receiving the visit is likely to remain at lower than 10%.¹⁸

The same new law that has given Medicare the authority to add coverage for new preventive services has reduced restrictions on the WMV. Beginning in 2009, new beneficiaries will have one year (rather than six months) to use this benefit, and the visit will not be subject to Medicare's annual deductible charge. Both of these changes aim to-- and should--reduce barriers to obtaining this benefit.

Other barriers remain, however. Many patients and physicians don't know about the WMV and what it covers. The regulations for the benefit are fairly specific, essentially requiring that the physician design a visit around seven required elements.¹⁹ Some physicians may not feel it is worth the trouble to organize a separate system to deliver a visit that can be given only to the small number of patients who are new Medicare beneficiaries.

Strategies for Improving Health Promotion and Disease Prevention

Research and past experience suggest many health promotion and disease prevention strategies that could improve the health of Medicare beneficiaries. Some of these strategies could be accomplished without further Congressional action, while others would require new authorities from Congress. First we discuss strategies that would not require legislative changes.

Strategies that Could Occur without Congressional Action

Increase uptake of currently covered preventive services.

Given that the uptake and use of preventive services currently covered by Medicare is not optimal, CMS should continue to enhance campaigns to increase their use. Mailed reminders to beneficiaries have worked before to increase influenza immunization rates;²⁰ these could be repeated, and screening and counseling services could be included as well. During 2007, Medicare's *A Healthier US Starts Here* campaign included paper insert reminders about flu shots and other preventive services in explanation- of- benefit mailings to beneficiaries. Such campaigns cost very little if these notices are included in statements already being mailed to Medicare beneficiaries. Although there was no formal evaluation of the program, it led to increased uptake of preventive. (P.Lapin, CMS, personal communication, 2008). Such programs should be repeated and evaluated carefully.

Beneficiaries who call toll-free telephone numbers for Medicare assistance are now being offered a real-time updates of their preventive services status. Tracking reports show that this approach increases preventive care,²¹ although no formal evaluation has been done. There is a pending evaluation of beneficiaries who receive preventive medicine updates online via the

www.MyMedicare.gov Web portal. The results of that study should guide future policies in this area (P.Lapin, CMS, personal communication, 2008).

Use outreach to consumers and incentives for clinicians to increase uptake of preventive services.

The extensive outreach and assistance programs instituted to help beneficiaries with the new prescription drug benefit, Medicare Part D, provide an excellent model for another strategy that could be employed to increase the uptake of existing covered preventive services: community assistance, with public sessions, walk-in appointments, call-in lines, etc. There would not be the pharmaceutical industry support behind it, as there was with some of the Part D education, but perhaps community organizations could be mobilized around helping beneficiaries understand and obtain their immunizations, screening tests, and smoking cessation counseling.

Similarly, CMS should continue and expand the creation and dissemination of educational materials for clinicians about the preventive services currently available under Medicare. Materials have been created through the Medicare Learning Network to address questions about which preventive services are covered, technical delivery issues, recommended frequencies, and billing instructions.²² Additional programs like these should be sponsored by CMS, medical societies, and third parties. The impacts of such efforts should then be evaluated.

A further strategy to incentivize doctors and health plans to deliver Medicare-covered preventive services would be to ensure that these services are included in quality measures used to evaluate performance. Many preventive services are already included in quality measures, but major quality measurement organizations should be surveyed to ensure that all of Medicare's covered screening tests, immunizations, and counseling services are included. Health plans could be encouraged to link performance bonuses to effective delivery of preventive care to Medicare beneficiaries.

CMS has included preventive care as one of the targeted conditions in the Physician Group Practice (PGP) demonstration program, Medicare's first physician pay-for-performance initiative that includes ten large physician groups. Early results have yielded strategies to increase influenza vaccination rates among Medicare beneficiaries.²³

Increase uptake of the one-time Welcome to Medicare Visit (WMV).

Similar strategies could be employed to improve awareness among beneficiaries and providers about the WMV. Now that the 2008 MIPPA legislation has waived the deductible and doubled the eligibility period for the WMV to one year after Medicare registration, there should be more incentives for the delivery of this comprehensive session. But all of the interventions mentioned above for single preventive services also could be applied to the WMV: information campaigns, community outreach services, physician education programs, and quality measure incentives. In addition, because of the complexity of the WMV, incorporation of the visit into medical record flow sheets, electronic medical records, reminder systems, and billing software would likely help increase uptake, as will the knowledge that increasing the small number of patients who receive a WMV will likely also increase visits for newly uncovered complex problems, for which physicians can charge higher rates.

Decrease disparities in delivery of currently covered preventive services.

As in all populations, disproportionately fewer minority and lower-income Medicare recipients receive covered preventive services.^{15, 16, 24} To decrease these disparities in preventive care, interventions are needed at all levels: patient, provider, and community. All of the initiatives listed earlier should be put into place, with a special emphasis on system changes that would make preventive services routine and routinely available to minority populations.

In primary care, reminder systems, standing orders, audit and feedback, and quality improvement incentives could all be effective. Some preventive services, such as immunizations, can be delivered in community settings, and these should be pursued through churches and other minority community institutions. Reimbursement levels could be increased as a way to make preventive services attractive to providers. Demonstration programs modeled on successful immunization programs²⁵ should be extended to all preventive services in order to better understand how to reach minority and low-income populations.

Add coverage of other proven clinical preventive services to Medicare.

The 2008 MIPPA legislation has given CMS the authority add proven clinical preventive services to Medicare through the national coverage decision (NCD) process. CMS should immediately assess which services not currently covered by Medicare have received A or B ratings from the USPSTF and initiate the NCD process for them. Candidate services could include screening for alcohol misuse, depression, HIV disease, and syphilis and other sexually transmitted diseases, as well as counseling for aspirin use, healthy diet, and obesity.

Emphasize recommended chemoprevention agents through Medicare's Part D.

Medicare's Part D coverage for prescription drugs provides an excellent opportunity to emphasize current and future proven chemoprevention agents. While the number of chemoprevention recommendations from the USPSTF is not large, this is an area that is expected to increase as new drugs are developed and new uses are found for existing FDA-approved drugs. Currently, the Task Force recommends discussion of the use of chemoprevention with women at high risk of breast cancer. Subsequent use of tamoxifen or raloxifene by high-risk women who are Medicare beneficiaries enrolled in Part D should be a covered benefit. Medicare could publicize the use of approved preventive medications, both to beneficiaries and physicians, to increase their appropriate use.

Increase Medicare's focus on tertiary prevention.

Although extremely important in elderly and disabled populations, Medicare has not uniformly emphasized *tertiary prevention*. Tertiary preventive services are health promotion and disease prevention interventions designed to minimize disease progression and maintain health in patients with known illnesses. The goal is to prevent deterioration and reduce complications in those with chronic diseases. While it can be argued that this is not prevention at all—just good treatment—tertiary preventive services can make a huge difference in patient satisfaction, health outcomes, and costs. Examples range from regular eye and foot examinations and use of angiotensin-converting enzyme inhibitors in patients with diabetes to timely gastrostomy and tracheostomy for patients with amyotrophic lateral sclerosis (ALS).

The good news about tertiary preventive services is that they are already covered by Medicare as "...reasonable and necessary for the...treatment of illness or injury or to improve the functioning of a malformed body member..."¹⁰ While the USPSTF does not evaluate tertiary prevention, evidence-based clinical practice guidelines for numerous chronic diseases emphasize the importance of specific tertiary preventive services.²⁶

Medicare currently lists two tertiary preventive services under the preventive services it covers: medical nutrition therapy for patients with diabetes and renal disease and outpatient self-management training for patients with diabetes (Table 3). CMS could emphasize the appropriate use of additional tertiary prevention through clinician quality-improvement campaigns, patient education about self-management, and disease-specific initiatives.

Use creative coverage mechanisms to expand Medicare's prevention coverage.

In 2005, Medicare staff created a smoking cessation counseling benefit by crafting eligibility criteria that enabled it to be covered under existing regulations. They created a category called "smoking-related illnesses"—including heart, lung, cerebrovascular diseases and others—and extended tobacco cessation benefits both to those who have any of the illnesses and to those who take medications whose effectiveness is complicated by tobacco use.

Following this example, Medicare could expand diet counseling to those with "obesity-related" illnesses, as well as to those who take medications whose effectiveness is complicated by obesity. Or CMS could define obesity as an illness, which would then allow obesity counseling and other proven treatments to be covered.

Use "coverage with evidence development" to deliver counseling interventions in settings that allow the acquisition of new knowledge.

Given the burden of disease associated with health-related behaviors,^{3,4} effective counseling for behavior change could have important effects in disease prevention and health promotion. Although there is very strong evidence on the effectiveness of tobacco cessation counseling,²⁷ other counseling interventions—for improving diet and physical activity, for example—do not have conclusive evidence supporting their efficacy and effectiveness.⁶

In the past, CMS has provided coverage for "promising interventions" that were unproven by requiring data collection during the delivery of these services. Such "coverage with evidence development" allows coverage in the context of research and data acquisition. When sufficient evidence is acquired, broader regulations based on the new evidence can be issued.^{28,29}

Partner with communities and public health to help deliver selected community preventive services.

Finally, in a departure from Medicare's traditional focus on individual clinical care, CMS could partner with communities and public health to deliver selected community preventive services of proven value. The Centers for Disease Control and Prevention sponsors the Community Preventive Services Task Force, which has produced and updated the *Guide to Community Preventive Services*.³⁰

In particular, where Community Guide recommendations overlap or complement clinical preventive services, CMS could partner with communities to enhance preventive care and improve health promotion and disease prevention among Medicare beneficiaries in the community. Examples might include combined interventions to improve vaccine delivery and uptake; tobacco use restrictions in health care and community settings; increased age-appropriate athletic facilities and walking zones in communities of older residents; community cancer screening programs linked to clinical systems; and many others. The cost implications of such partnering need to be explored, but presumably combining resources could lead to cost offsets.

Strategies Requiring Congressional Action

Some reforms to improve the health promotion and disease prevention policies of Medicare would likely require Congressional legislation to amend Medicare authorities. Examples of these follow.

Remove copayment and deductibles from all preventive services.

Most preventive services require a copayment of 20%, although some screening tests and immunizations have no copayment required. Congress could eliminate the copayment on *all* preventive services and the Welcome to Medicare Visit, which would remove a financial barrier to care and likely increase uptake of the preventive services.

Similarly, Part B of Medicare has an annual deductible, currently \$131, which must be paid by beneficiaries before most benefits apply. While Congress waived the deductible for the Welcome to Medicare visit beginning in 2009, the deductible still serves as a barrier to other preventive care, such as some screening tests, immunizations, and counseling services. If the deductible were waived for *all* clinical preventive services, their use would most likely increase.

Make the Welcome to Medicare Visit a periodic benefit.

Current law allows the WMV to be reimbursed only once for each beneficiary, and only during the first year of the patient's Medicare eligibility. This has the effect of dramatically limiting uptake of this valuable service in several ways. Many new Medicare beneficiaries will not know about it or will not be able to see their doctors during their eligibility period. Also, no existing Medicare recipients are eligible for the benefit. And, finally, doctors are less likely to design a visit to provide the complex set of services described in the regulation if only a small proportion of their patients will be eligible for it each year.

If Congress modified the regulations to allow a recurring WMV, perhaps renamed as the "periodic comprehensive Medicare visit," all of these barriers would be removed and the delivery of clinical preventive services would likely be enhanced. This benefit could be allowed for all Medicare beneficiaries at a periodicity of every one to three years.

Include immunizations in the preventive services that CMS may authorize.

Medicare currently covers only three types of immunizations: influenza, pneumococcal disease, and hepatitis B. In the MIPPA regulations of 2008, Congress allowed the Department of Health and Human Services to cover new preventive services as long as they met several criteria, including a positive recommendation from the USPSTF. Since the Task Force no longer

evaluates immunizations (it refers instead to recommendations from CDC's Advisory Committee on Immunization Practices), CMS cannot add new immunizations to the list of Medicare covered services. They must instead be covered under Medicare's new Part D drug benefit, purchased separately and dispensed in office visits—a cumbersome process.

There are several effective immunizations that are of special interest to the elderly and disabled that are currently not covered. These include booster shots for tetanus and a new vaccine to prevent “shingles” (Herpes zoster). If Congress delegated the authority to cover vaccines to CMS, then effective new vaccines could be added to the list of covered interventions. As a result, more beneficiaries would likely receive these cornerstones of disease prevention.

Provide incentives for doctors to deliver preventive services to Medicare patients.

Pay-for-performance formulas, under which doctors benefit from providing high-quality health care, could be expanded from existing demonstration projects to all appropriate preventive services; this will provide a strong incentive to ensure that patients receive needed preventive services. Similarly, just as recent regulations about computerized drug prescribing has provided incentives to adopting this practice, Congress could provide incentives and subsidies to speed the adoption of computerized medical records systems, which would include reminder systems to improve preventive care delivery. These regulations would likely increase the delivery of clinical preventive services to Medicare and non-Medicare patients alike, improving the health status of the entire country.

Remove unproven preventive services from Medicare coverage.

Finally, CMS's new authority to “add” preventive services does not explicitly allow the agency to remove coverage for unproven services. During the years that Congress was solely responsible for adding preventive services to Medicare, strong political pressures were brought to bear by groups interested in coverage for preventive services for “their” diseases, leading to an uneven evidence base supporting the covered services. For example, at least two of the screening tests covered by Medicare are not recommended by the USPSTF: screening for glaucoma and screening for prostate cancer. Recently, the USPSTF further recommended *against* prostate cancer screening for men age 75 and older³¹ and against colorectal cancer screening in persons older than age 85.³²

Congress could extend to CMS the authority to withdraw coverage from unproven preventive services in order to focus the available funds and attention on proven services. Needless to say, this might be a controversial policy, although it would be a good precedent for similar evidence-based decisions for diagnostic and therapeutic services.

Conclusion

Medicare has come a long way in preventive medicine since its inception more than 40 years ago. Immunizations, screening tests, counseling interventions, and preventive medications are now covered for Medicare beneficiaries. There are, however, still multiple ways that Medicare could be modernized to improve coverage and delivery of preventive care. Many of these changes could be accomplished within the existing and new authorities that CMS has for administering Medicare. Some would require new partnerships but would remain within Medicare's current scope of activities. Others would require changes that only Congress could authorize. Appendix 1 organizes possible improvements as a series of options, with brief listings of the advantages and disadvantages of each.

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Appendix 1. Policy Options for Consideration

Strategy	Example(s)	Precedent?	Congressional Action Needed?	Advantages	Disadvantages
Increase use/uptake of currently covered preventive services	Mailed, phone, Web reminders	Immunizations	No	Inexpensive, proven effects	None
	Community assistance	Part D introduction	No	Proven	Unclear costs
	Improve doctor education	Yes	No	Not difficult	Variable value
	Incorporate into quality measures	Yes, in Medicare and health plans	No	Proven, not expensive	None
	Build into pay-for-performance programs	Yes, PGP [No	Reasonably effective; should be cost neutral	None
	Encourage computerized reminder systems	Yes	No	Effective	Expensive until health IT is widespread
Increase use of Welcome to Medicare Visit	Similar to first strategy, above				
Decrease disparities in delivery and uptake of preventive services	Similar to first strategy, above				
	Community outreach	Yes, for immunizations	No	Likely good return for investment	None
Add other USPSTF-recommended services	Alcohol screening, diet counseling	No, would be the first time (but now authorized)	No longer, since MIPPA 2008	Important problems, some effective interventions available	May be hard to operationalize
Emphasize recommended chemoprevention agents	Drugs to prevent breast cancer in high-risk women	Yes, other drugs (HRT, when it was recommended)	No	Would set precedent for Medicare’s interest in the area	Small number of recommended drugs at present
Increase focus on tertiary prevention	Eye and foot exams for diabetes, life-support for ALS	Yes: nutrition and diabetes training	No	Already covered by Medicare, but an important area to draw attention to	Increased costs

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Create new “illness categories”	“Obesity-related illnesses”	Yes: “smoking-related illnesses”	No	Important problem	May be controversial and difficult to operationalize
“Coverage with evidence development”	Counseling recommendations	Yes: lung volume reduction surgery coverage	No	Allows coverage while research data are collected	Complex to organize, takes a long time to gather data
Partner with communities on <i>community</i> preventive services	Immunizations, tobacco restrictions, athletic facilities, cancer screening programs	No	No	Extends the reach of Medicare, helps other populations as well	May be difficult to organize, could be criticized as going beyond CMS’s mission
Remove copayments and/or deductibles from preventive services	Screening tests, immunizations, counseling	Yes: Welcome to Medicare Visit, flu shots	Yes	Increases access to preventive services	Increases costs
Make the Welcome to Medicare Visit a periodic benefit	Every one to three years	Not directly	Yes	Increases eligibility for the service, increases uptake, doctor interest in providing it	Increases costs
Include immunizations in CMS’s authority	Zoster vaccine, tetanus shot	Yes, other immunizations	Yes	Allows coverage of new and previously uncovered vaccines	Increases costs
Provide P4P incentives for doctors to provide preventive care	Preventive services without such incentives	Yes, other P4P programs	Yes	Increases focus on preventive services and increases uptake	Increases costs
Provide subsidies for computerized medical records	Reminder systems, tracking systems for preventive care	No	Yes	Proven to increase uptake of appropriate preventive services	Likely very costly if an isolated investment in IT
Remove unproven preventive services	Glaucoma screening, prostate cancer screening	No	Yes	Will increase focus on proven preventive services	Would be controversial; advocacy groups and others would fight it

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