Medicare reform

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Medicare Payment Advisory Commission

- Independent, nonpartisan, Congressional support agency
- 17 national experts selected for expertise, not representation
- Appointed by Comptroller General for 3-year terms (can be reappointed)
- Make recommendations to the Congress and the Secretary of HHS
- Vote on recommendations in public
## MedPAC approach to improving value

<table>
<thead>
<tr>
<th>Category</th>
<th>Key Components</th>
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<tbody>
<tr>
<td>Payment accuracy and efficiency</td>
<td>• Fiscal pressure on providers to constrain costs</td>
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<tr>
<td></td>
<td>• Price accuracy for health care services</td>
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<tr>
<td></td>
<td>• Measuring resource use</td>
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<tr>
<td>Quality and coordination</td>
<td>• Care coordination models (ACOs)</td>
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<tr>
<td></td>
<td>• Bundled payment for an episode of care</td>
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<td></td>
<td>• Gainsharing</td>
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<td></td>
<td>• Penalties for avoidable hospital readmissions</td>
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<td></td>
<td>• Patient-centered medical home</td>
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<td>Information for patients and providers</td>
<td>• Comparative effectiveness</td>
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<td></td>
<td>• Disclosure of physician financial relationships</td>
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<td>• Public reporting of quality</td>
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<td>Aligned health care workforce</td>
<td>• Incentives for residency programs that focus on quality, efficiency, and accountability</td>
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<td>• Strategies for fueling the workforce pipeline</td>
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<tr>
<td>Engaged beneficiaries</td>
<td>• Reformed benefit design and first dollar coverage</td>
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<td>• Shared decision-making</td>
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Provider payment

- Policy levers to pay accurately, restrain costs, and affect provider behavior
- Elements of payment policy
  - Level of payment (fiscal pressure)
  - Distributional equity (favoring some services or populations)
  - Preventing fraud and abuse
Provider payment examples

- Restrain updates (e.g. home health)
- Site-neutral payments: equalize or narrow payment differences between the physician office setting and hospital outpatient departments
- Normalize payments for therapy and non-therapy patients (e.g. SNFs)
- Increasing primary care payments relative to procedures
Medicare’s payments versus providers’ costs

- Some argue that Medicare’s prices are set too low relative to providers’ costs
- MedPAC argument
  - Costs are not immutable
  - Lack of fiscal pressure by private payers leads to higher payments, higher provider costs, and results in lower Medicare margins
- Provider consolidation allows providers to command higher payments from private payers, and in turn increased provider costs
Hospitals under financial pressure tend to keep their costs down

<table>
<thead>
<tr>
<th>Financial pressure</th>
<th>2004 to 2008</th>
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<tbody>
<tr>
<td>High pressure*</td>
<td>Low pressure**</td>
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</table>

<table>
<thead>
<tr>
<th></th>
<th>High pressure*</th>
<th>Low pressure**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of hospitals</td>
<td>756</td>
<td>1,747</td>
</tr>
<tr>
<td>Relative 2009</td>
<td></td>
<td></td>
</tr>
<tr>
<td>standardized cost</td>
<td>92%</td>
<td>104%</td>
</tr>
<tr>
<td>per discharge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2009 overall</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare margin</td>
<td>4.7%</td>
<td>-10.2%</td>
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</tbody>
</table>

* High pressure hospitals have a non-Medicare margin <1% and stagnant or falling net worth.
**Low pressure hospitals have a non-Medicare margin>5% and growing net worth.
### Comparing 2011 performance of relatively efficient hospitals to others

<table>
<thead>
<tr>
<th>Measure</th>
<th>Relatively efficient hospitals</th>
<th>Other hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of hospitals</td>
<td>14%</td>
<td>86%</td>
</tr>
<tr>
<td>30-day mortality</td>
<td>13% lower</td>
<td>3% above</td>
</tr>
<tr>
<td>Readmission rates (3M)</td>
<td>5% lower</td>
<td>1% above</td>
</tr>
<tr>
<td>Standardized costs</td>
<td>10% lower</td>
<td>2% above</td>
</tr>
<tr>
<td>Overall Medicare margin</td>
<td>2%</td>
<td>-6%</td>
</tr>
<tr>
<td>Share of patients rating the hospital highly</td>
<td>69%</td>
<td>67%</td>
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</tbody>
</table>

Note: medians for each group are compared to the national median  
Source: Medicare cost reports and claims data  

Preliminary data subject to change
Encouraging care coordination and restraining volume

- Payment policies to encourage providers to consider resource use and quality when delivering care
  - Traditional FFS
  - New FFS models
  - Competitive models (MA/Part D)
Examples of payment policies to encourage coordination and to restrain volume

- Traditional FFS
  - Readmissions penalty
  - Gainsharing
  - Medical review
  - Prior authorization

- New FFS models
  - Risk-based ACOs (population based)
  - Bundling around a hospitalization (episode based)

- Competitive models (MA and Part D)
  - At-risk capitation per beneficiary
  - Setting the federal contribution (administratively or competitively)
Changes in MA landscape

<table>
<thead>
<tr>
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<th>Benchmarks/FFS</th>
<th>Bids/FFS</th>
<th>Payments/FFS</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>112%</td>
<td>100%</td>
<td>109%</td>
</tr>
<tr>
<td>2013</td>
<td>110%</td>
<td>96%</td>
<td>104%</td>
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</tbody>
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Source: MedPAC analysis of CMS bid and rate data
Medicare’s policies can also focus on the beneficiary

- Medicare beneficiaries make decisions that affect overall Medicare spending in two main ways
  - At the point of service, when choosing whether and which health care services to obtain
  - At the point of enrollment, choosing whether to enroll in an MA or Part D plan
Examples of policies for beneficiary information and benefit design

- Information about value of services from providers or other sources (PCORI, Choosing Wisely)
- Catastrophic protections and clarity on cost sharing
- Address first dollar coverage
- Protections for the poor (targeting subsidies)
Private plans

- At-risk capitation per beneficiary
- Beneficiaries choose based on plan benefits and cost sharing/premiums
- Medicare Advantage
  - May limit spending by coordinating care through utilization management and networks
  - But, administratively-set benchmarks have led to program costs rather than savings
- Part D drug plans
  - May limit spending through formulary and utilization management, and networks
  - Program spending growth about 6% annually but variable, increased use of services, high satisfaction
Delivery system

**FFS**
- Pay by service or episode
- Silo-based
- Some VBP
- No risk

**ACO**
- Mixed payment:
  - FFS payment
  - +/- shared savings
  - All Part A&B
  - Quality incentive
- Limited risk

**MA**
- Pay for population
- Full capitation
- All Part A,B,D
- Quality bonus
- Full risk

Payment and delivery system integration

VBP = value based purchasing
Future issues

- Improving FFS-based delivery reforms (ACOs)
- Competitively set plan contributions (CPC)
  - Government subsidy based on competition among plans and FFS
  - Beneficiary chooses a plan based on premium
- Dual-eligible beneficiaries
  - Coordinated care models
  - Federal/state financing
  - Clinical/social services
- Role of advanced practice nurses (NPs, PAs)