Medicare reform

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MEDPAC

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

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

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

	Financial pressure 2004 to 2008	
	High pressure*	Low pressure**
Number of hospitals	756	1,747
Relative 2009 standardized cost per discharge	92%	104%
2009 overall Medicare margin	4.7%	-10.2%

* 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.

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Comparing 2011 performance of relatively efficient hospitals to others

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

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

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

Benchmarks, bids, and payments relative to FFS

	Benchmarks/ FFS	Bids/ FFS	Payments/ FFS
2010	112%	100%	109%
2013	110%	96%	104%

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	ACO	MA
Pay by service or episode	Mixed payment: FFS payment +/- shared savings	Pay for population Full capitation
Silo-based Some VBP	All Part A&B Quality incentive	All Part A,B,D Quality bonus
No risk	Limited risk	Full risk

Payment and delivery system integration

VBP = value based purchasing

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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)