Medicare payment policy and its impact on program spending

James E. Mathews, Ph.D.
Medicare Payment Advisory Commission
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Outline of today’s presentation

- Brief background on MedPAC
- Medicare financials in context
- Medicare’s payment systems – overview
  - Components of fee-for-service payment systems (FFS)
  - Medicare Advantage (MA) and Part D (Medicare’s prescription drug benefit)
  - New payment model: Accountable Care Organizations
I. MEDPAC BACKGROUND
Medicare Payment Advisory Commission (MedPAC)

- Independent, nonpartisan legislative branch commission; 17 members representing broad cross-section of health care
- Commissioners appointed by the Comptroller General for 3-year terms; can be reappointed
- Make recommendations to the Congress and the Secretary of HHS
- Vote on recommendations in public
- Two standing reports to Congress; also various mandated reports
MedPAC’s principles for evaluating Medicare payment policy

- **Beneficiaries:** Ensure access to high quality care in an appropriate setting
- **Providers:** Give providers an equitable incentive to supply care efficiently
- **Taxpayers:** Appropriately control program spending and ensure Medicare obtains the best possible value for its program dollars
II. MEDICARE FINANCIALS IN THE BROADER BUDGET CONTEXT
The federal budget picture

- Federal debt = 74% of GDP at end of 2014, up from 36% of GDP in 2007
- Social Security, **Medicare**, Medicaid, other health insurance programs and net interest will be 15% of GDP by 2024 (CBO February 2014)
  - Total federal spending has averaged 19 percent of GDP over the past 40 years
  - Medicare alone = 3.5% of GDP in 2013; will grow to 4.8% of GDP by 2030, and 6.3% by 2085
Medicare faces serious challenges with long-term financing

- Medicare Part A trust fund will be depleted by 2030; will require more revenue or pay out fewer benefits
- Medicare Part B consumes 14% of all income tax revenue
- 41% of Medicare’s funding comes from general revenues
- An even larger share of general revenues will be required to finance the program in the future (45% in 2030)
- Medicare also consumes a greater share of beneficiaries’ Social Security benefits over time – e.g., SMI premiums and cost sharing equaled 23% of average Social Security benefit in 2014; share will increase to 44% by 2088

Source: 2014 Medicare Trustees Report
Medicare spending, by sector, 2013

Total spending 2013 = $575 billion

- Inpatient hospital: 24%
- Managed care: 25%
- Physician fee schedule: 12%
- DME: 1%
- Outpatient hospital: 7%
- Home health: 3%
- Hospice: 3%
- Prescription drugs provided under Part D: 12%
- Other: 8%
- SNF: 5%
- Managed care: 25%

Source: 2014 Medicare Trustees Report
Components of Medicare spending

\[
\text{Number of beneficiaries} \times \text{Number of services} \times \text{Payments per service} = \text{Total program expenditures}
\]

(population) (utilization) (payment rates)

*Growth in Medicare spending over time is affected by change in per-beneficiary spending & changes in enrollment*
III. MEDICARE PAYMENT POLICY
Components of Medicare

- **Fee-for-Service (FFS)**
  - Part A – Inpatient hospital, most post-acute care
  - Part B – Outpatient hospital, ambulatory care
- **Private plans**
  - Part C – Medicare Advantage (private health plans administering A&B benefits)
  - Part D – Prescription drug plans
- **Accountable Care Organizations (ACOs)**
## Elements of provider payment policy

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<tr>
<th>Unit of payment</th>
<th>e.g., episode vs. per diem, individual service vs. discharge</th>
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<tr>
<td>Level of payment</td>
<td>Home health payment rates</td>
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<td>Distributional equity within a payment system</td>
<td>Skilled nursing facility therapy payments; payment adjusters</td>
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<td>Equity across payment systems</td>
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<td>Incentives for quality and coordination</td>
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Unit of payment: What is the right increment in which Medicare should pay for a service?

- Pay per service = more services (e.g., advanced imaging; pre-PPS home health visits)
- Pay per diem = provider responses; site-neutral issues (e.g., SNF / IRF)
- Pay per discharge (e.g., hospital services) = more provider responses (e.g., LTCH length of stay)
- Pay per episode (or bundle of services) = who gets the payment?
Many LTCH cases discharged immediately after short-stay outlier threshold

Level of payment: Is Medicare paying enough...or too much?

- Medicare’s average payments to home health agencies have exceeded average costs by over 10% for over a decade.
- When home health payment rates were set in 2000, Medicare assumed an average of 31 visits per episode.
- By 2012, visits dropped to an average of 18 visits per episode.
Home health agencies’ Medicare margins have been high since the advent of PPS

Higher margins result if 2011 results are adjusted for findings from audit of Medicare cost reports
Reset home health payment rates to align better with costs

- MedPAC recommended resetting (rebasing) home health payment rates
- PPACA mandated CMS begin rebasing rates
  - Began in 2014
  - Reductions are offset by market basket increases
- MedPAC recommends accelerating and increasing rebasing reductions
Distributional equity: Is Medicare paying fairly for all patients and services?

- Patients are classified into payment groups based on diagnosis, procedures.
- Payments also adjusted for patient demographics and risk factors.
- Adjustments may be made for cost of staff wages, outliers, transfers.
- Providers may also receive special payments based on location or status, e.g., rural, teaching, or serving low-income patients.
Distributional equity: Skilled nursing facility example

- In skilled nursing facilities (SNFs), uneven financial performance among providers
- In part, a reflection of an imbalance in the SNF PPS
- Payments for therapy and non-therapy ancillary (NTA) services are inaccurate
  - PPS overpays for therapy services
  - PPS sometimes underpays for NTA services
- Longstanding MedPAC recommendation to revise the SNF PPS
Revised PPS would redistribute payments among providers

<table>
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<tr>
<th>SNF group</th>
<th>Percent change in payments</th>
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<tr>
<td>High share of all days that are:</td>
<td></td>
</tr>
<tr>
<td>Intensive therapy</td>
<td>-7%</td>
</tr>
<tr>
<td>Clinically complex &amp; special care</td>
<td>5 to 7</td>
</tr>
<tr>
<td>Hospital-based</td>
<td>21</td>
</tr>
<tr>
<td>For-profit</td>
<td>-1</td>
</tr>
<tr>
<td>Nonprofit</td>
<td>4</td>
</tr>
<tr>
<td>Rural</td>
<td>4</td>
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Source: Impacts relative to current policy estimated by the Urban Institute 2014.
Equity across payment systems: Medicare’s payments for the same services in different settings

- Many of the same services provided in free-standing physician offices and hospital OPDs
- Problem: OPPS rates typically much higher than physician fee schedule rates
  - e.g., mid-level office (E&M) visit 80 percent higher in OPD
- Recent trend of hospitals purchasing physician practices and services moving to the OPD
- Result: Increase program spending and beneficiary cost sharing; may not change clinical aspects of care
Addressing higher payment rates in OPDs

- Set OPPS rates so that payment rates are equal whether service is in OPD or freestanding practice?
- For specific services, do OPDs:
  - Have more complex patients?
  - Maintain standby capacity?
  - Have greater packaging of ancillaries than PFS?
- Commission recommendations: March 2012, March 2014
Incentives for quality and coordination: Reducing hospital readmissions

- In 2005, 13.3% of Medicare beneficiaries discharged from a hospital returned within 30 days on a potentially preventable readmission
- Medicare spent $12 billion on potentially preventable readmissions (2005)
- Avoidable readmissions represent poor patient outcomes and reveal uncoordinated care
- Beneficiaries are put at financial and health risk
PPACA created financial incentives to reduce hospital readmissions

- Hospital readmission reduction program enacted in 2010
- Payment penalty started in October 2012
  - Penalty based on 2009 – 2011 performance
  - Policy uses three conditions and requires NQF approved measures (AMI, heart failure, pneumonia)
  - In aggregate penalties equal about 0.3 percent of total base inpatient hospital payments in FY2013
  - Average penalty for hospitals with penalty about $125,000
- Penalty capped as 1% of base operating payment in 2013, 2%—2014, 3%—2015 and thereafter
Improving readmissions reduction program

- MedPAC approach to improving the hospital readmissions program
  - Use an all-condition, potentially preventable measure
  - Set the target in advance
  - Compare hospitals with like shares of low-income patients
- Expand readmissions penalty to SNF (enacted in 2013) and home health providers
Private plans: Medicare Advantage and Part D

- Medicare Advantage (MA) allows beneficiaries to receive Medicare A&B benefits through a private plan.
- Part D plans provide outpatient prescription drugs.
- MA and Part D plans are paid a capitated amount each month for each enrollee.
- Payments are adjusted based on patient diagnoses and other characteristics.
How MA and Part D payments are set

- Both programs rely on plan bids
- MA payments are based on bids and bidding targets (benchmarks)
  - If bid > benchmark, program pays benchmark, enrollee pays premium
  - If bid < benchmark Medicare keeps a share of the difference, beneficiaries get the rest extra benefits or lower cost sharing
- Part D plans bid and Medicare averages plan bids to determine what government contribution will be
  - Plans bids also determine what premium beneficiaries will pay
  - Medicare also makes additional payments for low income beneficiaries and those who reach the catastrophic cap
Issues with Medicare Advantage

- Few plans bid below FFS costs
- Medicare paid 4% more for enrollees in MA than if they were in FFS Medicare in 2014, and 105 percent of FFS in 2015, but historically has paid much more
- Costs of subsidies borne by tax payers and Medicare beneficiaries through Part B premiums
- Principle: Savings from efficiency allow plans to provide extra benefits and increase enrollment or guarantee plan availability everywhere?
Emerging trends in Medicare Advantage

- PPACA enacted changes to the MA benchmarks to reduce payments
- Benchmarks, bids, and payments are moving down relative to FFS Medicare and extra benefits have stayed at about $75 per month
- Some plans have demonstrated ability to provide the Medicare benefits for less than FFS Medicare
Trends in Part D

- High satisfaction among Part D enrollees
  - Stable premiums and good access to prescription drugs
  - Many plan options to choose from

- Cost trends are increasingly of concern
  - Costs for individual reinsurance and the LIS (where Medicare bears the risk) are growing much faster than the premiums
  - Prices of single-source drugs continue to grow aggressively and drug pipeline is shifting towards higher-cost biologics/specialty drugs
  - Large increases in prices of older generics
New Payment Model: Accountable Care Organization

- Per capita fee-for-service payments and quality measures against benchmark
- Providers and program share savings
- 5 million beneficiaries receiving care from an ACO

- Many of the same policy issues apply
  - Distributional equity across settings
  - Incentives for quality/coordination
  - How benchmarks are set
Questions or additional information?

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