MEDPAC Medicare Payment Advisory Commission

TESTIMONY

Context for Medicare Payment Policy and Recommendations

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Statement of

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Chairman Pitts, Ranking Member Pallone, distinguished Committee members. I am Mark Miller, executive director of the Medicare Payment Advisory Commission (MedPAC). I appreciate the opportunity to be here with you this morning. MedPAC is a Congressional support agency that provides independent, nonpartisan policy and technical advice to the Congress on issues affecting the Medicare program.

Introduction

The Commission's goal is to achieve a Medicare program that ensures beneficiary access to high-quality care, pays health care providers fairly, rewards efficiency and quality, and spends tax dollars responsibly. When we examine Medicare's payment policies across payment models and across different sites of care, we observe several opportunities for policy development. In the testimony that follows, I will first summarize the context for Medicare payment policy in terms of health care spending growth and its impact on beneficiaries, tax payers, and the federal budget. Second, I will discuss the short-run policies the Commission has advanced to improve the Medicare program, both through changes to the level and structure of payments to providers and health plans, and through changes to the incentives faced by Medicare beneficiaries. Last, I will outline the Commission's longer run vision for the Medicare program, to align policies across Medicare's different payment models.

Context for Medicare payment policy

Medicare payment policies must be considered in the broader context of the nation's health care system. Health care accounts for a large and growing share of spending in the United States, more than doubling as a share of gross domestic product (GDP) in the period between 1972 and 2012, from about 7 percent to a little over 17 percent. Growth in spending has slowed somewhat in recent years. Although the causes of this slowdown are debated, a variety of factors could have contributed to the slowdown, including weak economic conditions, payment and delivery system reforms, and a slowdown in the introduction of new medical technologies.

The level of and growth in health care spending significantly affect federal and state budgets, since public spending on health care accounts for nearly half of all health care spending. If this spending continues to consume an increasing share of federal and state budgets, spending for

other public priorities—like education, investment in infrastructure, and scientific research—will be crowded out, and the federal government will have less flexibility to support states because of its own debt and deficit burdens. Medicare spending is projected to consume 15 percent of the federal budget this year. When combined with spending on Social Security, Medicaid, and the health care exchange subsidies, those programs are projected to consume 48 percent of the federal budget this year and their spending is projected to grow rapidly over the decade, averaging 6 percent annually.

Further, health care spending has a direct and meaningful impact on individuals and families. Evidence shows that increases in premiums and cost sharing have negated real income growth in the past decade. Likewise, premiums and cost sharing for Medicare beneficiaries are projected to grow faster than Social Security benefits. The lasting effects of the recent economic recession impacted the income, insurance status, and assets of many people, including Medicare beneficiaries and adults aging into Medicare eligibility.

Medicare spending per beneficiary over the next 10 years is projected to grow at a slower rate than in the past 10 years (4 percent annually compared with 6 percent annually), while the number of Medicare beneficiaries will grow notably faster as the baby-boom generation ages into the program (about 3 percent annually compared with about 2 percent annually in the past). The growth in per beneficiary spending has slowed generally due to a slowdown in the use of health care services as well as modest payment rate increases. That said, the Hospital Insurance trust fund is projected to be exhausted by 2030, and the program still faces substantial deficits over the long term.

There are indications that some share of health care dollars is not spent effectively or is simply misspent. First, the use of health care services varies significantly across different regions of the United States, even after accounting for differences in health status. Yet, studies show that populations in the higher spending and higher use regions do not consistently receive better quality care. Second, the United States has much higher per capita spending on health care compared with other developed countries. This is accounted for by higher payment rates for health care services (e.g., hospital stays, physician services, drugs). Yet, U.S. citizens have shorter life expectancy and poorer average health outcomes than people living in many other

developed countries. Finally, while minority Medicare beneficiaries represent a disproportionate share of high-spending beneficiaries, they tend to experience worse risk-adjusted health outcomes, suggesting that at least a portion of the high spending is not improving the health of minority beneficiaries.

Health care spending and its growth over time puts pressure on employer, government, and family budgets. For the Medicare program, this pressure is particularly acute given the outlook for the federal debt and the projected increases in Medicare enrollment. Medicare trends are undoubtedly influenced by broader trends in the economy and the health care delivery system. But because the Medicare program pays for just over one-fifth of all health care in the United States, it has an important influence on the shape of the health care delivery system as a whole. Therefore, the Commission remains focused on pursuing reforms that control spending and create incentives for beneficiaries to seek, and providers to deliver, high-value health care services.

Short-run policies to improve Medicare

Spending Medicare dollars wisely

The Commission has long emphasized the importance of using Medicare payments to encourage providers to deliver care efficiently.

Fee-for-service payment updates

MedPAC's research shows that provider costs are not immutable; they vary according to how much pressure is applied through payment rates. We find that providers under cost pressure have lower costs than those under less pressure, and Commission analysis demonstrates that providers can provide high-quality care even while maintaining lower costs relative to their peers. These findings have led the Commission to recommend modest and even negative updates to payment rates in the fee-for-service (FFS) payment systems.

The Commission's payment decisions are driven by sector-specific analyses, an orientation toward setting payments for the efficient provider (rather than the average provider), and by the principle that constraining payment updates creates incentives for providers to better control their costs, thus slowing the longer-term growth of Medicare spending. For 2015, the Commission

recommended zero updates for ambulatory surgical centers, outpatient dialysis, inpatient rehabilitation facilities (IRFs), long-term care hospitals (LTCHs), and hospices.

Recognizing the need for good stewardship of public dollars, the Commission has also recommended reducing provider payments through rebasing when provider responses to incentives in the payment systems indicate that base rates have become excessive. The Commission has recommended rebasing the payment rates for home health and skilled nursing facility (SNF) services and has reiterated these recommendations for several years.

Revising payment systems to improve accuracy and remove negative incentives

The Commission has long believed that Medicare's payment rates can have a strong impact on provider behavior. Therefore, when setting payment rates, it is important to consider the incentives that they create and ensure that the program is not unintentionally incentivizing poor care. We find that Medicare's current payment systems contain a number of incentives that encourage undesirable provider behavior, including furnishing unnecessary services and avoiding certain patients. Where the Commission has identified payment systems that contain poor incentives, it has made recommendations to correct them.

In 2008 we recommended revising the SNF payment system to eliminate a payment bias favoring rehabilitation therapy services, and in 2011 we made a similar recommendation for the home health payment system. While these recommendations are budget neutral, they are intended to accompany the aforementioned payment rate reductions to ensure that both the level of payment and the incentives within the system are accurate and fair.

Site-neutral payments

MedPAC has also identified areas where the choice of setting to treat a patient is driven by payment differentials between settings. In principle, the Medicare program should pay the same amount for the same service, regardless of the setting in which it is provided, unless payment differentials are justifiable by differences in patient mix, provider mission (e.g., maintaining stand-by capacity for emergencies), or other justifiable factors.

The Commission began its work in this area looking at services that are provided frequently in both freestanding physician offices and hospital outpatient departments, but at different payment

rates. In our March 2012 *Report to the Congress*, we focused on nonemergency evaluation and management (E&M) office visits because they are similar across settings. For these services, it is reasonable to equalize payment rates in the fee schedule for physician and other health professional services and the hospital outpatient prospective payment system (OPPS) because hospitals do not need to maintain standby capacity for E&M visits that are not provided in an emergency department, and because the unit of payment for E&M services is similar across the fee schedule and the OPPS. The Commission recommended that total payment rates for an E&M visit provided in an outpatient department (OPD) should be reduced to the amount paid when the same visit is provided in a freestanding office, which is the lower cost setting.

In our March 2014 *Report to the Congress*, the Commission identified 66 additional ambulatory services frequently performed in freestanding offices that receive higher Medicare payments in OPDs. The Commission recommended these services have their OPD payment rates aligned with the PFS rates, either by setting the rates equal or by reducing the difference from the current level. In order to protect the beneficiary's safety and the hospital's mission, the criteria the Commission used in selecting these services is: (1) the services are frequently provided in physician offices (an indication that the services can be safely and appropriately performed in that setting), (2) the risk profile of patients in the two settings is similar, (3) these services do not frequently occur along with a visit to an emergency department, and (4) the services have comparable units of payment. (This recommendation was packaged with two other hospital-related recommendations in that report.)

In our June 2014 *Report to the Congress* and at our recent Commission meetings, we have identified a set of conditions frequently treated in both the IRF and SNF settings. The beneficiaries receiving these services had similar health profiles (using diagnosis, functional status, and outcomes data), and the services were safely provided a majority of the time in the lower-cost SNF setting. In general, the payments for services in the IRF (including the add-on payments made to IRFs) are as much as 42 percent higher than those in the SNF for treating patients with similar care needs. The Commission is currently discussing a policy to align payments between these two settings for certain conditions. Any policy to address these payment disparities would be accompanied by regulatory relief for the IRFs to allow them to continue to serve these patients, but to streamline the cost of care.

In our March 2014 *Report to the Congress*, the Commission discussed the provision of care for chronically critically ill patients and observed that patients with similar care needs often receive care in different settings, some in LTCHs and others in acute care hospitals (ACHs). LTCHs have positioned themselves as providers of hospital-level care for long-stay chronically critically ill (CCI) patients—patients who typically have long, resource-intensive hospital stays often followed by post-acute care (PAC)—but nationwide most CCI patients are cared for in acute care hospitals, and most LTCH patients are not CCI patients. Medicare pays LTCHs much higher payment rates than those made for similar patients in the ACH. Studies comparing LTCH care with that provided in ACHs have failed to find a clear advantage in outcomes for LTCH users. At the same time, studies have found that, on average, episode payments are higher for beneficiaries who use LTCHs.

To reduce incentives for LTCHs to admit lower acuity patients—who could be appropriately cared for in other settings at a lower cost to Medicare—the Commission recommended that standard LTCH payment rates be paid only for LTCH patients who meet the CCI profile (defined as those who spent eight or more days in an intensive care unit during an immediately preceding acute care hospital stay). LTCH cases that are not CCI would be paid acute care hospital rates. The Commission also recommended that funds that would have been used to make payments under the LTCH payment system instead should be allocated to the inpatient prospective payment system outlier pool to help alleviate the cost of caring for costly CCI cases in acute care hospitals.

Payments to Medicare Advantage plans

The Commission strongly supports a private managed care plan option in Medicare. Beneficiaries should have a choice to select traditional FFS or a managed care setting to fit their care delivery and out-of-pocket (OOP) preferences. Moreover, managed care plans have incentives to control costs and maintain quality, as well as greater flexibility to innovate in plan design, cost sharing, and developing a network for care delivery. However, the Commission has strongly maintained that the Medicare program's payments should not favor one choice over the other. For many years, Medicare's payments favored Medicare Advantage (MA) over traditional FFS—at one point paying 16 percent more for a comparable patient in MA than in FFS. In addition to unnecessary program spending, this system gave rise to inefficient plans. That is,

plans were offering beneficiaries extra benefits not because they were more efficient than FFS, but because the extra benefits were paid for by taxpayers and higher beneficiary premiums. Plans were routinely bidding above the cost of FFS, and the fastest growing type of plan (private fee-for-service plans) did not seek to form networks and manage care, but instead simply processed claims and paid regular FFS rates—all while extracting an extra payment to do so.

To address this inequity, the Commission recommended financially neutral payments between FFS and MA plans. There are two ways to reach financial neutrality: (1) legislatively setting MA payment benchmarks to be equivalent to FFS or (2) having both FFS payments and MA payments determined through a competitively-set benchmark in a given market. The Congress chose the former, transitioning the benchmarks down to an average of FFS spending over time and making higher payments to those plans that have higher quality. Concerns were expressed that these changes would result in plans exiting the program and managed care enrollment falling. On the contrary, plan enrollment growth has continued (approximately 9 percent annually) and plans have remained widely available. In addition, many plans have become less costly relative to FFS (the average bid was 98 percent of FFS for 2014), and there have been savings to the program from reduced overpayments.

Most recently, in our March 2014 *Report to the Congress*, the Commission examined employer-group plans (a type of MA plan with availability limited to retirees whose Medicare coverage is supplemented by their former employer or union) and found that they consistently bid higher than other types of plans because they lack the competitive pressures that non-employer plans face. In 2014, employer-group plans bid on average 95 percent of their benchmarks, versus 86 percent of benchmarks for non-employer plans. To put greater competitive pressure on these plans, the Commission recommended the Congress set payments for employer plans in a manner more consistent with non-employer plans, such as using a national ratio of plan bids to benchmark for non-employer plans and applying that ratio to employer group plans. Also, to create more seamless care delivery in the MA benefit, in the same report the Commission recommended that the hospice benefit be included as part of the benefits that MA plans provide.

Improving care for Medicare beneficiaries

Supporting primary care

The Commission has been concerned about the current state of support for primary care. Primary care is essential to a well-functioning health care delivery system, but the Medicare physician fee schedule undervalues it relative to procedural care and does not explicitly pay for non-face-to-face care coordination. These and other shortcomings of the fee schedule have contributed to compensation disparities between primary care practitioners and specialists to the point that average compensation for some specialties can be more than double the compensation of primary care practitioners, measured either in aggregate or per hour worked. Faced with such compensation disparities, practitioners may increasingly opt for specialty practice over primary care practice, leaving few primary care resources available to provide coordinated care.

In response to those concerns, the Commission has made several recommendations to address the inadequacies of the fee schedule for physician and other health professional services. To rebalance the fee schedule, the Commission has proposed identifying overpriced services and pricing them appropriately, replacing the sustainable growth rate (SGR) formula with payment updates that are higher for primary care than specialty care, and establishing a primary care bonus funded from non-primary care services.

The Commission believes that the additional bonus payments to primary care practitioners enacted on the Patient Protection and Affordable Care Act should continue. While the amount of the primary care bonus payment is not large and will not drastically change the supply of primary care practitioners, allowing it to expire without a replacement sends a poor signal to primary care practitioners. The Commission is considering the option of continuing the additional payments to primary care practitioners, but in the form of a per beneficiary payment—in contrast to the per service payment made through the current primary care bonus program. Replacing the primary care bonus payment with a per beneficiary payment could help Medicare move from a service-visit-oriented FFS payment approach and toward a beneficiary-centered payment approach that encourages care coordination, including the non-face-to-face activities that are a critical component of care coordination. Of course, a per beneficiary payment in itself will not guarantee an increase in care coordination activities because practitioners could use the additional funds for other purposes, but it may be a step in the right direction.

Expand readmission policies to post-acute care providers in FFS

Over the last several years, Medicare has begun moving toward paying providers differentially for the quality of care they provide and the success of their care coordination efforts. This began with a focus on inpatient hospitals and has expanded to other provider types. If value-based payment policies are not applied to all providers who are involved in treating Medicare patients, the quality or care coordination outcomes they desire may not be achieved.

Based on analysis of the sources of variation in Medicare spending across episodes of care, in 2008 the Commission recommended that hospitals with relatively high risk-adjusted readmission rates should be penalized. As of October 2012, a readmission policy now penalizes hospitals with high readmission rates for certain conditions. There are imperfections in the current readmissions penalty policy, and corrections are outlined in the Commission's June 2013 *Report to the Congress*. Despite these imperfections, the penalty has resulted in a decline in readmission rates over the last few years.

In 2011, the Commission began to examine expanding readmission policies to PAC settings to reduce unnecessary rehospitalizations and better align hospital and PAC incentives. If hospitals and PAC providers were at similar financial risk for rehospitalizations, they would have a stronger incentive to coordinate care between settings. Aligned policies would emphasize the need for providers to manage care during transitions between settings, coordinate care, and partner with providers to improve quality. By creating additional pressure in the FFS environment, the policies would also create incentives to move to bundled payments or accountable care organizations (ACOs).

To increase the equity of Medicare's policies toward providers who have a role in care coordination, the Commission has recommended payments be reduced to both SNFs and home health agencies (HHAs) with relatively high risk-adjusted readmission rates. The SNF readmissions reduction program was recommended in the Commission's March 2012 *Report to the Congress*. In March 2014, as part of the Protecting Access to Medicare Act of 2014, the Congress enacted a SNF value-based purchasing program beginning in fiscal year (FY) 2019, which includes readmissions and resource use measures. The home health readmissions

reduction program recommendation was published in the Commission's March 2014 *Report to the Congress*.

Bundled payments

Under bundled payments, Medicare would make a single payment for an array of services provided to a beneficiary over a defined period of time, or an episode of care. There are various configurations for a bundle, but the most common trigger is the hospital admission. The two most common episode definitions are the hospital stay (a bundled payment for hospital services and physician services during the hospital stay) or the hospital stay plus some period (e.g., 30, 60, or 90 days) of PAC (e.g., home health, SNF, and IRF services). While there is variation in hospital and physician services provided during the hospital stay, there are much higher degrees of variation in readmission rates and the utilization of PAC services. A bundled payment either for the hospital stay or for the stay plus a period of PAC, coupled with quality outcome metrics, could help replace inefficient and unneeded care with a more effective mix of services. Bundled payments could also give providers that are not ready, or are unable to participate in more global payment models like ACOs, a way to gain experience coordinating care spanning a spectrum of providers and settings, thus facilitating progress toward larger delivery system reforms.

The Commission recommended testing bundled payments in 2008 and since then has examined a variety of bundle designs. In our June 2013 *Report to the Congress*, the Commission described the pros and cons of key design choices for a bundled payment policy: which services to include in the bundle, the duration of the bundle, how entities would be paid, and incentives to encourage more efficient provision of care. Each decision involves tradeoffs between increasing the opportunities for care coordination and requiring providers to be more accountable for care beyond what they themselves furnish. In that report, we laid out possible approaches to paying providers, comparing an all-inclusive payment made to one entity with continuing to pay providers FFS.

Engaging Medicare beneficiaries

In order to achieve a delivery system focused on coordinated care, both the provider of care and the beneficiary must be engaged. Medicare's FFS benefit design has largely been structurally unchanged since the program's inception. Under FFS, beneficiaries can receive care irrespective

of its effectiveness or the quality of the outcomes it produces, and some beneficiaries are exposed to the risk of significant financial liability.

Redesigning the FFS benefit

The FFS Medicare benefit package has remained essentially unchanged for Part A and Part B since the creation of the program in 1965. Under this structure, beneficiaries in FFS are not protected against high OOP medical expenses. To protect against such high expenses, most beneficiaries have some degree of supplemental coverage. This coverage provides protections but is often a low-value product for the beneficiary. At the same time, research has shown that supplemental coverage can lead to beneficiaries using more discretionary services because they have no financial incentive to consider the value of a service before choosing it. To address these concerns, in 2012 the Commission made a set of recommendations for a redesigned benefit package that give beneficiaries better protection against high OOP spending, while creating financial incentives for them to make better decisions about their use of discretionary care.

Specifically, the Commission recommended that a redesigned traditional FFS benefit include:

- Catastrophic protection through an out-of-pocket maximum;
- Rationalized deductible (or deductibles) for Part A and Part B services;
- Improved OOP predictability by replacing coinsurance with copayments; and
- Secretarial authority to alter or eliminate cost sharing based on the evidence of the value of services, including cost sharing after the beneficiary has reached the OOP maximum.

Under the recommended benefit design, the aggregate beneficiary cost sharing liability would remain unchanged. Beneficiaries who incur very high Medicare spending would see their liability reduced, while others who incur very low Medicare spending will experience higher liability. Some beneficiaries will experience very little change in liability. The added benefit protections would make supplemental coverage less necessary, so the Commission also recommended that an additional charge be placed on supplemental policies to cover at least some of the added costs imposed on Medicare for having first dollar coverage and send a clearer price signal to the beneficiary. Depending on the level of additional charge and the resulting take-up of supplemental coverage, net program savings are realized.

Medicare beneficiaries with limited incomes could have difficulty paying the OOP costs under a reformed benefit design. To address this, the Commission would align the Medicare Savings Programs' income eligibility criteria with the Part D low-income drug subsidy (LIS) income eligibility criteria, effectively increasing the Part B premium subsidy to Qualifying Individuals (QIs) with incomes up to 150 percent of the federal poverty level. This would give them resources to pay their OOP costs at the point of service. The Commission believes this is a targeted and efficient approach to help Medicare beneficiaries with limited incomes with their OOP medical expenses.

Modifying beneficiary copayments

The Commission also finds that there is opportunity within Medicare to help beneficiaries to be more cost conscious when making health care decisions. For example, the Commission has discussed at length alternative value-based payment and cost sharing arrangements, in which coinsurance and/or cost sharing would vary as a function of the clinical value of the service. As an initial step in this direction, in 2011 the Commission recommended implementing a copayment for home health care that is not preceded by a hospital stay. In the same vein, in March 2012, noting that low-income beneficiaries were using more high-cost brand-name drugs with generic substitutes than higher-income beneficiaries, we recommended that Part D cost sharing be changed for LIS enrollees to give them more of a financial incentive (such as no copay for generics) to weigh the benefits of continuing to take brand-name drugs or switching to a generic equivalent.

Long-term vision for Medicare

In addition to the short-term improvements we have offered to improve the Medicare program for beneficiaries, providers, and taxpayers, the Commission is also developing a vision for the program over the long run, one that looks across Medicare's payment models.

Under the current Medicare program, there are now three payment models through which beneficiaries can receive Medicare services: 30 million beneficiaries in are traditional FFS, nearly 16 million beneficiaries are enrolled in MA, and about five million beneficiaries receive their care in ACOs. Traditional FFS pays for individual services according to the payment rates established by the program. By contrast, under MA, Medicare pays private plans a capitated

payment rate to provide the Part A and Part B benefit package to plan enrollees. In the ACO model, an organized group of providers is paid FFS rates, but is held accountable for the Part A and B spending and quality of care for a group of beneficiaries attributed to the ACO. A major issue is that Medicare's payment rules and quality improvement incentives are different and inconsistent across the three payment models. The Commission believes that to reduce the potential inequity and inefficiency caused by these differences, several different program design issues will need to be resolved: setting a common financial benchmark, streamlining quality measurement, establishing common risk adjustment, and offering regulatory relief for providers who accept risk.

Setting a common benchmark

In the June 2014 *Report to Congress*, the Commission explored setting a common spending benchmark—tied to local FFS spending—for MA plans and ACOs. Using an analysis of early results from the Pioneer ACOs, we illustrate that no single payment model is uniformly less costly than another model in all markets across the country. The Commission maintains that to encourage beneficiaries to choose the model that they perceive as having the highest value in terms of cost and quality, the choice should be financially neutral to the Medicare program. This principle is similar to the position the Commission has taken with respect to FFS and MA. In the current context of three payment models, consistent with that principle, the benchmarks should ultimately be equal across payment models within a local market. Equal benchmarks, however, do not mean equal payments, because payments will reflect the various risk profiles of beneficiaries in one payment model versus another, they may be adjusted for quality, and whether a given payment model is more efficient than another.

Streamlining quality measurement

The Commission is considering alternatives to Medicare's current system for measuring the quality of care provided to the program's beneficiaries. A fundamental problem with Medicare's current quality measurement programs, particularly in FFS Medicare, is that they rely primarily on clinical process measures for assessing the quality of care provided by hospitals, physicians, and other types of providers, measures that may exacerbate the incentives in FFS to overuse services and fragment care. As well, some of the process measures are often not well correlated to better health outcomes, there are too many measures, and reporting places a heavy burden on providers.

We are exploring an alternative to the current measurement system: using population-based outcome measures (e.g., potentially avoidable admissions) to evaluate and compare quality within a local market across Medicare's three payment models. We consider a small set of measures that would be less burdensome to providers and directly related to health outcomes. A population-based approach could be useful for public reporting of quality for all three models and also for making payment adjustments within the MA and ACO models.

Establishing common risk adjustment

Currently, Medicare uses the CMS–hierarchical condition category (CMS–HCC) model to risk adjust MA payments. FFS and ACOs have different approaches to setting payments to capture the relative costliness of different patients or beneficiaries. However, if aligning policies across the three models is a goal, it will be important to consider how risk-adjustment methods affect equity among MA plans, FFS Medicare, and ACOs. For example, if the MA sector can attract low-cost beneficiaries and avoid high-cost beneficiaries, the risk-adjusted payments in the MA sector would exceed what their enrollees would cost in ACOs or FFS Medicare.

Offering regulatory relief for providers taking risk

Many current Medicare regulations are designed to prevent overuse of services and the resulting increase in Medicare spending. They are a reaction to the incentives built into the FFS system to increase volume of services. Over the long run, as the program moves to more risk-based and quality-driven payment models, providers will have much weaker incentives to increase volume and stronger incentives to improve quality. In this environment, many current FFS regulations (e.g., the three-day inpatient stay requirement for SNFs) could be waived for those willing to accept true risk.