
Executive summary

Executive summary

As part of its mandate from the Congress, each June the Commission reports on refinements to Medicare payment systems and on issues affecting the Medicare program, including broader changes in health care delivery and the market for health care services. In the seven chapters of this report we consider:

- ***Synchronizing Medicare policy across payment models***—In 2012, a third payment model, the accountable care organization (ACO), became available in addition to the traditional fee-for-service (FFS) and Medicare Advantage (MA) payment models. A major issue is that Medicare’s payment rules and incentives are different and inconsistent across the three payment models. To address that issue and start to synchronize Medicare policy across payment models, we examine setting a common spending benchmark—tied to local FFS spending—for MA plans and ACOs.
- ***Improving risk adjustment in the Medicare program***—Risk adjustment is currently used to ensure that Medicare’s payments track the expected costs of beneficiaries. We examine three models for improving how well risk adjustment predicts cost for the highest cost and lowest cost beneficiaries and suggest that, given the limitations of those models, administrative measures may be needed to better calibrate payments to expected costs.
- ***Measuring quality of care in Medicare***—Current quality measures are overly process oriented, too numerous, may not track well to health outcomes, and are a burden on providers; they may not be appropriate for each of the payment models discussed in Chapter 1. We examine which approaches to quality measures would be appropriate to each payment model and consider using population-based outcome measures (e.g., potentially avoidable admissions for the FFS population in an area) to evaluate and compare quality within a local area across Medicare’s three payment models. Provider-specific quality measures may still be needed for FFS payment adjustments.
- ***Financial assistance for low-income beneficiaries***—We discuss how changing income eligibility for the Medicare Savings Programs could help low-income Medicare beneficiaries afford out-

of-pocket (OOP) costs under a redesigned Medicare FFS benefit package.

- ***Paying for primary care using a per beneficiary payment***—The current FFS-based primary care bonus program expires in 2015. We consider an option to continue additional payments to primary care practitioners, but in the form of a per beneficiary payment. The current FFS approach encourages volume. A per beneficiary approach could help encourage care coordination.
- ***Medicare payment differences across post-acute settings***—Medicare’s payment rates often vary for treating similar patients in different settings, such as inpatient rehabilitation facilities (IRFs) and skilled nursing facilities (SNFs). We examine three conditions and assess the feasibility of paying IRFs the same rates as SNFs for those conditions.
- ***Measuring the effects of medication adherence on medical spending for the Medicare population***—We examine the effects of medication adherence for patients with congestive heart failure (CHF) and find that greater medication adherence is associated with lower medical costs, but that effect is dependent on the beneficiaries’ previous health status, decays over time, and is sensitive to the specifications of the model.

In an online appendix (available at <http://www.medpac.gov>), as required by law, we review CMS’s preliminary estimate of the update to payments under the physician fee schedule for 2015.

Synchronizing Medicare policy across payment models

Historically, Medicare has had two payment models: traditional FFS and MA. Traditional FFS pays for individual services, according to the payment rates established by the program. By contrast, under MA, Medicare pays private plans capitated payment rates to provide the Part A and Part B benefit package except hospice. Starting in 2012, Medicare introduced a new payment model: the ACO. Under the ACO model, a group of providers is accountable for the spending and quality of care of a group of beneficiaries attributed to them. The goal of the ACO program is to give groups of FFS providers incentives to reduce Medicare spending and improve quality, similar to the incentives given to private plans under the MA program.

A major issue is that Medicare’s payment rules and quality improvement incentives are different and inconsistent across the three payment models. There are various approaches to making those rules more consistent. From the program perspective, the Commission is examining synchronizing policy across payment models with respect to spending benchmarks, quality measurement, and risk adjustment and will be examining synchronizing regulatory oversight. The Commission is also interested in the beneficiary perspective on synchronizing policy across payment models, including how beneficiaries learn about the Medicare program, choose plans, and respond to financial incentives.

Chapter 1 represents the Commission’s initial exploration of synchronizing Medicare policy across payment models and is not intended to be a definitive or comprehensive discussion. In this initial analysis, we focus on setting a common spending benchmark—based on local FFS spending—for MA plans and ACOs as a key element of synchronizing Medicare policy across payment models. 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. Which model is less costly and which ACOs and MA plans may want to enter the program would be sensitive to how benchmarks are set.

Improving risk adjustment in the Medicare program

Health plans that participate in the MA program receive monthly capitated payments for each Medicare enrollee. Each capitated payment has two parts: a base rate, which reflects the payment if an MA enrollee has the health status of the national average beneficiary, and a risk score, which indicates how costly the enrollee is expected to be relative to the national average beneficiary. The purpose of the risk scores is to adjust MA payments so that they accurately reflect how much each MA enrollee is expected to cost.

Currently, Medicare uses the CMS–hierarchical condition category (CMS–HCC) model to risk adjust MA payments. This model uses beneficiaries’ demographic characteristics and medical conditions collected into hierarchical condition categories to predict their costliness. But, although it is an improvement over past models, the CMS–HCC model predicts costs that are higher than actual costs (overpredicts) for beneficiaries who have very low costs and lower than actual costs (underpredicts)

for beneficiaries who have very high costs. These prediction errors can result in Medicare paying too much for low-cost beneficiaries and not enough for high-cost beneficiaries. These underpayments and overpayments raise an issue of equity among MA plans. Plans that have a disproportionately high share of high-cost enrollees may be at a competitive disadvantage relative to those whose enrollees have low costs.

A related issue is how risk-adjustment inaccuracies affect equity among MA plans, FFS Medicare, and ACOs. If payment equity among these three payment models is a goal, risk adjustment that results in more accurate payments for high-cost and low-cost beneficiaries is vital. For example, if the MA sector can attract low-cost beneficiaries (for which Medicare overpays) and avoid high-cost beneficiaries (for which Medicare underpays), the risk-adjusted payments in the MA sector would exceed what their enrollees would cost in ACOs or FFS Medicare.

In Chapter 2, we investigate alternative methods discussed in the literature for improving how well risk adjustment predicts costs for the highest cost and lowest cost beneficiaries. We examine three models and find that all three would introduce some degree of cost-based payment into the MA program, which could reduce incentives for plans to manage their enrollees’ conditions to hold down costs. The Commission concludes that because of the limitations of these models, administrative measures may be needed to better calibrate payments to expected costs.

Measuring quality of care in Medicare

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. In Chapter 3, we examine which approaches to quality measurement are appropriate for each of the three payment models in Medicare: FFS Medicare, MA, and ACOs. We discuss an alternative to the current measurement system: using population-based outcome measures (e.g., potentially avoidable admissions for the FFS population in an area)

to evaluate and compare quality within a local area 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 for making payment adjustments within the MA and ACO models.

A population-based outcomes approach may not be appropriate for adjusting FFS Medicare payments in an area because FFS providers have not explicitly agreed to be responsible for a population of beneficiaries. Therefore, at least for the foreseeable future, FFS Medicare will need to continue to rely on provider-based quality measures to make payment adjustments. We find current provider-level quality measurement technology may not be sufficiently developed to support payment adjustments for all providers in all settings; for example, it may not address the full range of physician services. We discuss steps that Medicare could take in the short term to improve its provider-based quality measurement programs.

Financial assistance for low-income Medicare beneficiaries

In Chapter 4, we discuss how changing income eligibility for the Medicare Savings Programs (MSPs) could help low-income Medicare beneficiaries afford OOP costs under a redesigned Medicare FFS benefit package. The Commission has made two previous recommendations on this issue:

- The first recommendation, from 2008, was for the Congress to align the MSP income eligibility criteria with the Part D low-income drug subsidy (LIS) criteria, effectively increasing the full Part B premium subsidy to beneficiaries with incomes up to 150 percent of the federal poverty level. MSPs provide financial assistance with the Medicare Part B premium for beneficiaries with incomes up to 135 percent of the poverty level. Medicare's Part D prescription drug benefit incorporates a subsidy structure that provides assistance to beneficiaries with incomes up to 150 percent of the poverty level.
- The second recommendation, from 2012, was to redesign the FFS benefit package to balance two main goals: first, give beneficiaries better protection against high OOP spending, and second, create financial incentives for them to make better decisions about their use of discretionary care.

Because reducing beneficiaries' OOP costs (deductibles, copayments, or coinsurance) at the "point of sale" could undermine their incentives to make cost-conscious decisions about the health care they use, the redesigned FFS benefit package does not eliminate those costs. Without additional help, Medicare beneficiaries with limited incomes could have difficulty paying those OOP costs. Increasing the MSP income eligibility criteria to 150 percent of the poverty level would provide additional financial assistance to lower income beneficiaries by fully subsidizing their Part B premium, thus giving them resources to pay their OOP costs at the point of service. It therefore represents a targeted and efficient approach to help low-income beneficiaries. Chapter 4 also provides examples of variation in MSP eligibility across states.

Per beneficiary payment for primary care

The Commission has a long-standing concern that primary care services are undervalued by the Medicare fee schedule for physicians and other health professionals compared with procedurally based services. That undervaluation has contributed to compensation disparities: Average compensation for specialist practitioners can be more than double the average compensation for primary care practitioners. Such disparities in compensation could deter medical students from choosing primary care practice, deter current practitioners from remaining in primary care practice, and leave primary care services at risk of being underprovided. While Medicare beneficiaries generally have good access to care, in both patient and physician surveys, access for beneficiaries seeking new primary care practitioners raises more concern than access for beneficiaries seeking new specialists.

With the goal of directing more resources to primary care and rebalancing the fee schedule, the Commission made a recommendation in 2008 for a budget-neutral primary care bonus payment, funded by a reduction in payments for non-primary care services. The Patient Protection and Affordable Care Act of 2010 created a bonus program, but it was not budget neutral and thus required additional funding. The program provides a 10 percent bonus payment for primary care services provided by primary care practitioners, from 2011 through 2015.

The primary care bonus program expires at the end of 2015. The Commission believes that the additional payments to primary care practitioners should continue.

While the amount of the primary care bonus payment is not large and will probably not drastically change the supply of primary care practitioners, it is a step in the right direction. However, the Commission has become increasingly concerned that FFS is ill suited as a payment mechanism for primary care. FFS payment is oriented toward discrete services and procedures that have a definite beginning and end. In contrast, ideally, primary care services are oriented toward ongoing, non-face-to-face care coordination for a panel of patients.

In Chapter 5, we consider an option to continue the additional payments to primary care practitioners, but in the form of a per beneficiary payment. Replacing the primary care bonus payment with a per beneficiary payment could help move Medicare away from an FFS volume-oriented approach and toward a beneficiary-centered approach that encourages care coordination, including the non-face-to-face activities that are a critical component of care coordination. In establishing a per beneficiary payment for primary care, the Commission has considered several design issues: practice requirements for receipt of the payment, attribution of beneficiaries to primary care practitioners, and funding.

Site-neutral payments for select conditions treated in inpatient rehabilitation facilities and skilled nursing facilities

Site-neutral payments reflect the Commission's position that the program should not pay more for care in one setting than another if the care can safely and effectively be provided in the lower cost setting. In previous reports, the Commission has recommended site-neutral payments for certain services across the physician fee schedule and the hospital outpatient department payment system, as well as for select patients across long-term care hospitals and acute care hospitals.

In Chapter 6, the Commission focuses on site-neutral payment to two post-acute care facilities—IRFs and SNFs—that are paid under separate payment systems. Currently, payments for similar patients with the same condition can differ considerably between the two payment systems. Using several criteria, we selected three conditions frequently treated in IRFs and SNFs—major joint replacement, other hip and femur procedures (such as hip fractures), and stroke—and assessed the feasibility of paying IRFs the same rates as SNFs for these conditions. We found that the patients with the

two orthopedic conditions were very similar across the two settings. Differences in outcomes between IRFs and SNFs were mixed, with unadjusted measures showing larger differences between the settings and risk-adjusted measures generally indicating small or no differences between the settings. Thus, we find the two conditions represent a good starting point for a site-neutral policy. If IRFs were paid under current SNF policy for the two conditions, net IRF payments would decrease. However, the combined industry-wide effects on total payments to IRFs would be mitigated because under the design we explored IRFs would continue to receive add-on payments for the select conditions and current IRF payments for the majority of their cases. Patients recovering from strokes were more variable, and we conclude that more work needs to be done to more narrowly define the cases that could be subject to a site-neutral policy and those that could be excluded from it.

If payments for select conditions were the same for IRFs and SNFs, CMS should evaluate waiving certain regulations for IRFs, such as the requirements for intensive therapy and the frequency of physician supervision. Waiving certain IRF regulations would allow IRFs the flexibility to function more like SNFs when treating those cases. This flexibility would help level the playing field between IRFs and SNFs when treating patients with the site-neutral conditions.

Measuring the effects of medication adherence for the Medicare population

Medication adherence is viewed as an important component in the treatment of many medical conditions. Adherence to appropriate medication therapy can improve health outcomes and has the potential to reduce the use of other health care services. At the same time, improved adherence increases spending on medications. This issue has led to a proliferation of research on policies that encourage better adherence to medication therapy (e.g., reduced patient cost sharing) and the impact of improved medication adherence on health outcomes, typically measured by the use of other health care services.

In Chapter 7, we examine the effects of medication adherence on medical spending for the Medicare population. We examine how changes in cohort definitions and model specifications affect estimated effects on medical spending of Medicare beneficiaries with CHF adhering to a medication therapy.

The results of our analysis show that:

- Better adherence to an evidence-based CHF medication regimen is associated with lower medical spending among Medicare beneficiaries with CHF, but the effects likely vary by beneficiary characteristics (e.g., age).
- Beneficiaries who follow the recommended CHF therapies tend to be healthier before being diagnosed with CHF than nonadherent beneficiaries, with fewer medical conditions and lower medical spending.
- The effects of medication adherence diminish over time.

- The estimated effects of medication adherence on medical spending are highly sensitive to how they are modeled. For example, including whether beneficiaries died in the model reduced the effect on health care spending by half. The magnitude of the effect is also sensitive to how adherence is defined and the criteria used to select the study cohort.

Although our analysis examined only one condition (CHF) and is therefore not generalizable to other conditions or populations, our findings highlight the difficulty of estimating the effects of medication adherence. This difficulty may be exacerbated by the more complex health profiles of the Medicare population compared with the general population often used in studies of medication adherence. ■

