

Report to the Congress: Medicare and the Health Care Delivery System - June 2014

The Commission's June 2014 report examines a variety of Medicare payment system issues. In the seven chapters of this report we consider: synchronizing Medicare policy across payment models, improving risk adjustment in the Medicare program, measuring quality of care in Medicare, financial assistance for low-income Medicare beneficiaries, per beneficiary payment for primary care, site-neutral payments in post-acute care settings, and measuring the effects of medication adherence for the Medicare population.

SYNCHRONIZING MEDICARE POLICY ACROSS PAYMENT MODELS

- Historically, Medicare has had two main payment models: traditional fee-for-service (FFS) and Medicare Advantage (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. Starting in 2012, Medicare introduced a new payment model, the accountable care organization (ACO), which pays for care on a FFS basis but includes incentives for providers to reduce unnecessary care while improving quality.
- The Commission believes that, over the long run, Medicare's payment rules and quality improvement incentives will need to be reconciled across the three payment models. Without synchronization across the models, the program could be paying more to one model for the same or lower quality care than that provided by the other models in the same market.
- In this report, the Commission begins to explore ideas for synchronizing policy across payment models with respect to spending benchmarks, quality measurement, and risk adjustment.
- For this initial analysis, we focus on setting a common spending benchmark for MA plans and ACOs—illustrated using local FFS spending—as a key element of synchronizing Medicare policy across payment models. We illustrate that no single payment model is uniformly less costly than another model in all markets using an analysis of early results from the Pioneer ACOs. Which model is least costly and which ACOs and MA plans may want to enter the program in a given area would be sensitive to how benchmarks are set.
- In the future, the Commission plans to explore synchronizing regulatory oversight, as well as the beneficiary perspective on synchronizing policies across payment models, including how beneficiaries learn about the Medicare program, choose plans, and respond to financial incentives.

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 plans' payments so that they reflect the expected cost of each enrollee.
- 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 (HCCs) to predict their costliness.

- Although it is an improvement over past models, the Commission has found the CMS–HCC model predicts costs that are higher than actual costs (overpredicts) for beneficiaries who have very low costs and predicts costs that are 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.
- In this report, 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 alternative models, administrative measures, such as penalties for disenrollment of high-cost beneficiaries, may be needed to reduce incentives for plans to engage in patient selection.

MEASURING QUALITY OF CARE IN MEDICARE

- MedPAC is concerned that Medicare’s current quality measurement programs, particularly in FFS Medicare, rely primarily on clinical process measures for assessing quality. These are often not well correlated to better health outcomes. Additionally, the Commission believes there are too many measures, which—coupled with the diversity of measures required by private payers—places a heavy reporting burden on providers.
- In this report, we discuss an alternative to the current measurement system: using population-based outcome measures (e.g., potentially avoidable admissions for a FFS population in a given area) to compare quality within a local area across Medicare’s three payment models. We consider a small set of measures that would be less burdensome for 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. The Commission notes that 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 likely need to continue to rely on provider-based quality measures to make payment adjustments.

FINANCIAL ASSISTANCE FOR LOW-INCOME MEDICARE BENEFICIARIES

- In this chapter, we discuss how changing income eligibility for the Medicare Savings Programs (MSPs) could help low-income Medicare beneficiaries afford out-of-pocket costs under a redesigned Medicare fee-for-service benefit package. The Commission has made two previous recommendations on this issue:
 - The first recommendation, from 2008, was for the Congress to align the MSPs’ income eligibility criteria with the Part D low-income drug subsidy (LIS) criteria, effectively extending the full Part B premium subsidy to beneficiaries with incomes up to 150 percent of poverty. Currently, MSPs provide financial assistance with the Medicare Part B premium for beneficiaries with incomes up to 135 percent of the federal poverty level, while Medicare’s Part D prescription drug benefit incorporates a subsidy structure that provides assistance to beneficiaries with incomes up to 150 percent of poverty.
 - The second recommendation, from 2012, was to redesign the FFS benefit package to balance two main goals: first, give beneficiaries better protection against high out-of-pocket (OOP) spending, and second, at the same time create financial incentives for them to make better decisions about their use of discretionary care.

- Because reducing OOP costs (deductibles, copayments, or coinsurance) could undermine beneficiaries' incentives to make cost-conscious decisions about the health care they use, the redesigned FFS benefit package keeps those costs in place. However, 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 poverty would provide additional financial assistance to lower income beneficiaries by fully subsidizing their Part B premium, thus freeing up resources to pay their OOP costs at the point of service. The Commission believes this is a targeted and efficient approach to help low-income beneficiaries with their health care costs.

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 specialty services. That undervaluation has contributed to compensation disparities that 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.
- 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 (PPACA) of 2010 created a bonus program that includes 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. 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 this report, 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 would be a move away from a FFS volume-oriented approach and toward a beneficiary-centered approach that encourages care coordination.
- To develop the policy concept of 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 in freestanding offices and the hospital outpatient department and for select patients across long-term care hospitals and acute-care hospitals.
- In this report, the Commission focuses on site-neutral payments for inpatient rehabilitation facilities (IRFs) and skilled nursing facilities (SNFs), which 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 from which patients frequently recover in both IRFs and SNFs— major joint replacement, other hip and femur procedures (such as hip fractures), and strokes—and assessed the feasibility of paying IRFs the same rates as SNFs for these conditions.
- We find that the patients recovering from major joint replacement and other hip and femur procedures are similar across the two settings. Risk-adjusted outcome measures for patients with these two conditions generally indicate small or no differences between the settings. Thus, we find the two conditions represent a good starting point for a site-neutral policy.
- Our analysis shows that the Medicare program could achieve considerable savings if IRFs were paid under current SNF policy for the two conditions.
- Patients recovering from strokes were more variable and we conclude that more work needs to be done to define the cases that could be included in a site-neutral payment policy.
- 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.

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.
- We examine the effects of medication adherence on medical spending for the Medicare population. Although our analysis looks at only one condition—congestive heart failure (CHF)—and is therefore not generalizable to other conditions or populations, our findings highlight the complexity of interpreting estimates of the effects of medication adherence as measured by spending differentials between adherent and nonadherent individuals.
- 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 tended to be healthier prior to being diagnosed with CHF than nonadherent beneficiaries, with fewer medical conditions and lower medical spending. Thus, our estimated effects could reflect both the benefit of adhering to the recommended medication and the fact that adherent individuals were already healthier. This is just one example that reflects the difficulty of teasing out the effects of medication adherence from Medicare claims data.
 - The effects of medication adherence on medical spending diminish over time. Our analysis shows savings in the first six months of the medication regimen, but after 6 months, these savings decrease.
 - Estimates of the effects of medication adherence on medical spending are highly sensitive to how the effects are measured. Thus, even within the same data set, it may be possible to reach substantially different conclusions about the effects of adherence, based on how adherence is defined, which criteria are used to select the study cohort, and how the model is specified.