Advising the Congress on Medicare issues

Initial approach to the payment update and other policy options for physicians and other health professionals

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November 8, 2013

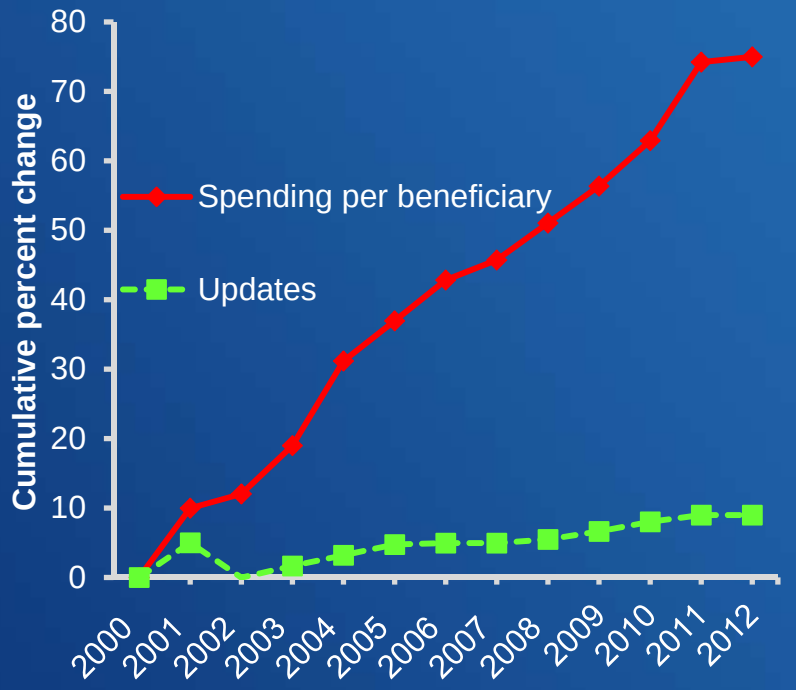
MEDPAC

Overview

- Commission's position on repeal of SGR
- March report chapter
  - Reiterate SGR recommendations
  - Consider rerunning additional recommendations
    - Establish an HHS panel on misvalued services
    - Improve payment accuracy and appropriate use of ancillary services
    - Reform graduate medical education (GME)
- Longer-term issues for subsequent meetings
  - Quality measurement
  - Payment for primary care

The SGR is fundamentally flawed

- Ties annual payment rate updates to aggregate expenditures
- No incentive for providers to restrain volume
- Congress has overridden formula every year after 2002



Source: 2013 Trustees' report and Office of the Actuary 2013.

Repeal of SGR is urgent

- Temporary overrides of deep cuts are creating instability
  - For 2013, formula's 27 percent payment cut overridden with a payment rate freeze
- Lower cost of repeal
  - In October 2011, 10-year freeze in payment rate ~ $300 billion
  - Currently, 10-year freeze in payment rate ~ $138 billion

Principles informing recommendations to repeal the SGR

- Repeal of the SGR is urgent
- Preserve beneficiary access
- Rebalance payments for primary care and other specialties
- Encourage movement toward reformed delivery systems

The Commission's recommendations

- 10-year path of legislated updates
  - Higher updates for primary care services than updates for other services
- Collect data to improve the relative valuation of services
- Identify overpriced and underpriced services and rebalance
- Encourage ACOs by creating greater opportunities for shared savings

Consider rerunning additional recommendations

- Establish HHS panel on misvalued services
- Improve payment accuracy and appropriate use of ancillary services
  - Comprehensive billing codes
  - Payment reduction
    - multiple studies in same session
    - studies ordered and performed by same practitioner
  - Prior authorization of imaging
- Reform payment for GME

Primary care: inadequate support under fee-for-service

- Access generally good but surveys raise concerns about primary care
- Overpricing of procedural services leads to passive devaluation of primary care
- Fee-for-service payment does not adequately support care coordination

Evidence on primary care

- Higher share of primary care physicians in a region's workforce found to be associated with higher quality and lower cost
- Early results of medical home demo include reduction in ED visits for ambulatory care-sensitive conditions
- But primary care may not reduce spending growth

Risks for primary care without delivery system reform

- Newly-insured likely to increase demand in 2014
- Retirement of baby boomers
  - More beneficiaries
  - Fewer practitioners
- Primary care must attract new practitioners

Current approaches to improving payment for primary care

- Primary care incentive payment
  - 10 percent bonus
    - Selected specialty designations
    - Practice focused on primary care
  - Expires in 2015
- Medical home demonstrations
  - Multipayer
  - Difficult to identify Medicare-specific effects

Overcoming limitations of fee-for-service payment for primary care

- Standing Commission recommendations: Rebalance the fee schedule
  - Legislate separate primary care update
  - Reduce payments for overpriced services
- Policy option: Blend fee-for-service payment with periodic (monthly or quarterly) per beneficiary payment
  - Pay for non-face-to-face activities
  - May dampen FFS incentive to increase volume
  - Build infrastructure for medical homes

Implementing a per-beneficiary payment for primary care

- Establish eligibility
  - Specialty
  - Share of allowed charges from primary care
  - Delivery of prerequisite services
  - Criteria similar to medical home (e.g., 24 hour access)
- Link beneficiaries to practices
  - Initial
  - Correction for inaccuracies

Implementing a per beneficiary payment for primary care (cont'd)

- Derive payment amount to supplement or partially replace FFS
  - Estimate care coordination costs or
  - Aim for share of practitioners' total payments
- Identify funding source
  - Budget neutral
  - Reduce payments for services other than primary care

Discussion: Plans for March report and longer-term issues

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  - Quality measurement
  - Payment for primary care