MEDPAC Medicare Payment Advisory Commission

FACT SHEET

Report to the Congress: Medicare and the Health Care Delivery System · June 2018

The Commission's June 2018 report examines a variety of Medicare payment system issues. In the 10 chapters of this report, we consider: the effects of the Hospital Readmissions Reduction Program; using payment to ensure appropriate access to and use of hospital emergency department services; rebalancing Medicare's physician fee schedule toward ambulatory evaluation and management services; paying for sequential stays in a unified prospective payment system for post-acute care; encouraging Medicare beneficiaries to use higher quality post-acute care providers; issues in Medicare's medical device payment policies; applying the Commission's principles for measuring quality to population-based measures and hospital quality incentives; recent performance of and long-term issues confronting Medicare accountable care organizations; managed care plans for dual-eligible beneficiaries; and Medicare coverage policy and use of low-value care.

THE EFFECTS OF THE HOSPITAL READMISSIONS REDUCTION PROGRAM

- The 21st Century Cures Act mandated that MedPAC study whether reductions in readmission rates under Medicare's Hospital Readmissions Reduction Program (HRRP) enacted in 2010 caused offsetting increases in outpatient and emergency services utilization. We conclude that the HRRP contributed to a significant decline in readmission rates without causing a material increase in observation stays or ED visits, or an adverse effect on mortality rates.
- Observation stays increased at a slightly faster rate after introduction of the HRRP. However, the increase in observation stays offset only a small share of the reductions in readmissions. The Commission also found similar rates of increase in observation stays among patients *without* an initial hospital admission, suggesting that other policies played a role in the small overall increase in observation stays.
- While ED visits increased following the introduction of the HRRP, this increase is likely related to reasons other than the HRRP. Changes in ED use following a hospital discharge were comparable for conditions covered by the HRRP and for all other conditions. Also, the growth in ED visits was similar for beneficiaries recently discharged from a hospital and those not recently discharged, and the share of all ED visits that were post discharge visits was the same before and after the introduction of the HRRP. Thus, it appears that the growth in ED visits is a phenomenon unrelated to the HRRP.
- Some researchers have asserted that efforts to reduce readmissions have resulted in higher mortality for heart failure patients. We examined heart failure mortality rates during the hospital stay and 30-days post discharge from 2010 to 2016 (before and after the implementation of the HRRP). We found no evidence to suggest that the readmission policy had a worsening effect on mortality rates. To the extent that there is any effect, we find the HRRP may have slightly improved (reduced) mortality rates.

USING PAYMENT TO ENSURE APPROPRIATE ACCESS TO AND USE OF HOSPITAL EMERGENCY DEPARTMENT SERVICES

- Maintaining access to emergency department (ED) services can be challenging in remote rural areas, where a single hospital may be the sole source of ED care. If that hospital closes, access to emergency care can be lost. In contrast, efficiency can be a challenge in urban areas, where EDs can be in oversupply. To reduce the risk of ED services being undersupplied in rural areas and oversupplied in urban areas, we recommend two changes to Medicare payment for ED services.

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- Hospitals in many isolated rural areas have seen their number of inpatient cases fall dramatically. However, Medicare will pay a facility for emergency services *only* if a hospital maintains its inpatient infrastructure. Therefore, small isolated communities must maintain a costly inpatient department to preserve access to ED services. The Commission recommends an alternative, voluntary payment model that would allow Medicare to pay for emergency services at outpatient-only hospitals in isolated rural areas.
- Under this model, isolated rural inpatient hospitals could choose to convert to outpatient-only hospitals and continue to receive standard prospective payment rates for ED visits. In addition, an annual block subsidy payment would be made to help cover the facility's fixed costs. These payments could be funded by better targeting existing subsidies without materially increasing overall Medicare spending. Importantly, shifting to an outpatient-only hospital would dramatically reduce cost sharing for many beneficiaries. Outpatient-only hospitals could decide to switch back to their prior status if community circumstances changed.
- By contrast, the numbers of stand-alone, off-campus EDs (OCEDs) in several urban markets has grown rapidly. Based on a review of the literature and interviews with ambulance operators, we observe that patients who seek care at OCEDs appear to have less complex care needs than patients served at on-campus EDs. While OCEDs have lower standby costs and treat less severe patients, the Medicare payment rates they receive (Type A ED payment rates) are equal to those of on-campus hospital EDs.
- The Commission recommends that for urban OCEDs that are within six miles of an on-campus hospital ED, Medicare should pay Type A payment rates reduced by 30 percent to better align payments with costs. The recommendation would curb the incentives to develop new OCEDs near existing sources of ED services, reduce cost sharing for Medicare beneficiaries served at OCEDs close to on-campus EDs, and lower Medicare spending.

Recommendations

1. The Congress should:
   - allow isolated rural stand-alone emergency departments (more than 35 miles from another emergency department) to bill standard outpatient prospective payment system facility fees and
   - provide such emergency departments with annual payments to assist with fixed costs.
2. The Congress should reduce Type A emergency department payment rates by 30 percent for off-campus stand-alone emergency departments that are within six miles of an on-campus hospital emergency department.

REBALANCING MEDICARE'S PHYSICIAN FEE SCHEDULE TOWARD AMBULATORY EVALUATION AND MANAGEMENT SERVICES

- Ambulatory evaluation and management (E&M) visits allow clinicians to manage patients' chronic conditions, develop care plans, coordinate care across providers and settings, and discuss patients' preferences. E&M services are critical for both primary care and specialty care. The Commission has long been concerned that, over time, E&M services have become undervalued in the Medicare physician fee schedule (the "fee schedule") relative to other services, such as procedures. This could limit beneficiary access to E&M services.
- Payment rates in the fee schedule are based on assessments of how much time and intensity (e.g. mental effort and technical skill) services require relative to one another. If estimates of time and intensity are not kept up to date, especially for services that experience efficiency improvements, payment rates become inaccurate. Because of advances in technology, efficiency improves more easily for procedures, imaging, and tests than for ambulatory E&M services, which are defined in large part on clinicians' time, and so do not lend themselves to efficiency gains. Because the fee schedule is budget neutral, the payment rates for ambulatory E&M services have become too low relative to payment rates for other services. We describe a

budget-neutral approach to rebalance the fee schedule that would increase payment rates for ambulatory E&M services provided by all clinicians, while reducing rates for other, relatively overpriced services.

PAYING FOR SEQUENTIAL STAYS IN A UNIFIED PROSPECTIVE PAYMENT SYSTEM FOR POST-ACUTE CARE

- Medicare uses separate prospective payment systems (PPSs) to pay for stays in each of the four post-acute care (PAC) settings—skilled nursing facilities (SNFs), home health agencies (HHAs), inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCHs). As a result, Medicare's FFS payments can differ substantially for similar patients treated in different settings. As mandated by the Congress, in June 2016, the Commission developed a prototype design and estimated the impacts of a unified PAC PPS. The Commission concluded that it is feasible to design a PAC PPS that spans the four settings and uniformly bases payments on patient characteristics.
- To further advance the unified PAC PPS, the Commission now examines two payment issues that would increase the accuracy of payments for cases that involve a course of PAC—that is, sequential stays, which we define as PAC stays within seven days of each other. The first issue has to do with the way the cost of a stay can vary, depending on where it falls in a sequence of PAC stays. The second issue involves how to identify, for payment purposes, distinct phases of care for a PAC provider that treats a patient "in place" as care needs evolve. Under a unified PAC PPS, there needs to be a way to trigger payments for different phases of care so that such providers are not financially disadvantaged.
- We find that *costs* of a sequence of home health care stays decline over the course of an episode more than *payments* would under our prototype PAC PPS, suggesting that payments for sequential home health stays need to be adjusted downward (as they are in the current HHA PPS). In contrast, PAC PPS payments for institutional stays would be generally well aligned with the cost of stays throughout a sequence of care.
- To make accurate payments to providers offering a range of services under the PAC PPS, Medicare could make a single payment for all post-acute care provided during an episode of PAC. The Commission will continue to explore episode-based payments for PAC. Shifting to an episode-based payment would reduce incentives to initiate additional PAC stays while holding to the most important tenets of a PAC PPS: correcting the biases of the current PPSs and increasing the equity of payments across all types of stays so that providers have less incentive to selectively admit certain beneficiaries over others. In the meantime, CMS should proceed with implementing a stay-based unified PAC PPS.

ENCOURAGING MEDICARE BENEFICIARIES TO USE HIGHER QUALITY POST-ACUTE CARE PROVIDERS

- About 40 percent of Medicare acute inpatient hospital discharges result in the use of PAC. The selection of a provider within a PAC category can be crucial because the quality of care varies widely among providers. Medicare discharge planning regulations make hospitals responsible for educating beneficiaries about their PAC provider choices, but hospitals cannot recommend *specific* PAC providers.
- The Commission's analysis of referral patterns of Medicare beneficiaries who were discharged to SNFs and HHAs indicate that many beneficiaries had another nearby provider that offered better quality care (though not all of the higher quality providers may have had available capacity). Ninety-four percent of beneficiaries who used HHA or SNF services had at least one provider within a 15-mile radius that was of higher quality than the provider that served them.
- Allowing hospital discharge planners to recommend specific PAC providers based on the quality of care they provide could help beneficiaries select better quality PAC providers. Medicare could expand the authority of discharge planners to recommend higher quality PAC providers in a number of different ways, ranging from prescriptive approaches that provide specific metrics that hospitals must use, to more flexible approaches that allow hospitals to decide on the metrics they use to identify high-quality PAC providers. Ultimately, beneficiaries should retain freedom of choice, but have better information to make that choice.

ISSUES IN MEDICARE'S MEDICAL DEVICE PAYMENT POLICIES

- We examine two distinct topics related to Medicare's payment policies for durable medical equipment, prosthetic devices, prosthetics, orthotics, and supplies (DMEPOS). First, we discuss the potential for Medicare to expand the use of competitive bidding to set payments for DMEPOS. Second, we examine ways to restrain the program integrity risks posed by physician-owned distributors (PODs) of devices and prosthetics.
- CMS began to phase in the DMEPOS Competitive Bidding Program (CBP) in 2011 to use market competition to set payment rates and limit fraud and abuse, while ensuring beneficiaries retained access to needed DMEPOS products. The CBP began with some of the highest cost and highest volume DMEPOS products in nine large urban areas and has been expanded into more areas of the country over time. CBP has been successful in driving down the cost of DMEPOS products for the Medicare program and beneficiaries; Medicare's payment rates for some of the highest expenditure DMEPOS products have fallen by an average of 50 percent. By contrast, Medicare spending for products excluded from CBP have continued to grow. To address overpayments for these products, more could be moved into CBP.
- PODs derive revenue from selling devices to their physician-owners to use in procedures the physician-owners perform on their own patients. PODs can distort the supply chain for medical devices, potentially resulting in an increase in the volume of services performed on beneficiaries, higher costs for hospitals and the Medicare program, and inappropriate care. The Commission suggests several ways policymakers could constrain these risks, including two options to revise the Stark law, which is intended to prohibit physicians from referring Medicare beneficiaries to certain health care facilities in which they have a financial interest. The Commission supports increasing the transparency of POD–physician relationships by requiring all PODs to report under the Open Payments program—a program designed to shed light on financial ties between physicians and certain industries.

APPLYING THE COMMISSION'S PRINCIPLES FOR MEASURING QUALITY TO POPULATION-BASED MEASURES AND HOSPITAL QUALITY INCENTIVES

- The Commission has recommended that Medicare link payment to the quality of care to reward accountable entities and providers for offering high-quality care to beneficiaries. In this report, the Commission formalizes a set of principles for measuring quality in the Medicare program. Overall, quality measurement should be patient oriented, encourage coordination, and promote delivery system change. Medicare quality incentive programs should use a small set of population-based measures (e.g., outcomes, patient experience, value) to assess quality of care in Medicare Advantage (MA) plans, ACOs, and FFS in defined market areas, as well as for beneficiaries cared for by specified hospitals, groups of clinicians, and other providers. Medicare quality incentive programs should score population-based measure results against absolute performance thresholds and use peer grouping to account for social risk factors.
- We apply the Commission's principles to two population-based outcome measures that may be used to evaluate quality of care for different populations. Potentially preventable admissions (PPAs) constitute an important quality measure, and we find enough variation of performance in this measure to make it useful in assessing quality. We also tested a home and community days (HCDs) measure to assess how well health care markets keep people alive and out of health care institutions, but found limited variation in performance and have concluded that this measure's utility may be limited.
- We also explore replacing the four existing payment incentive programs Medicare uses to assess hospital performance with a single quality payment program. The Commission is concerned that the current, overlapping hospital quality payment and reporting programs (the Hospital Inpatient Quality Reporting Program, Hospital Readmissions Reduction Program, Hospital-Acquired Condition Reduction Program, and Hospital Value-based Purchasing) create unneeded complexity in the Medicare program. The Congress could create a single hospital value incentive program (HVIP) that is patient oriented, encourages coordination across providers and time, and promotes change in the delivery system. The HVIP would

account for social risk factors by adjusting payment through peer grouping. Over the next year, the Commission plans to continue work on the HVIP.

RECENT PERFORMANCE OF AND LONG-TERM ISSUES CONFRONTING MEDICARE ACCOUNTABLE CARE ORGANIZATIONS

- Medicare accountable care organizations (ACOs) were created to reduce growth in Medicare spending and improve the quality of care for beneficiaries by giving providers greater responsibility for costs and quality of care. We review the current Medicare ACO models and their performance. The Commission finds that two-sided ACOs have been more successful at producing savings than one-sided ACOs, and we consider six issues that are important to sustaining two-sided ACOs in Medicare: the role of hospitals as participants in ACOs; the trade-offs of asymmetric models; setting appropriate benchmarks; an alternative for distributing the 5 percent bonus for clinicians in advanced alternative payment models; the role of specialists in ACOs; and the long-term viability of two-sided ACOs in the Medicare program.

MANAGED CARE PLANS FOR DUAL-ELIGIBLE BENEFICIARIES

- Dual-eligible beneficiaries (individuals who receive both Medicare and Medicaid) often have complex health needs but are at risk of receiving fragmented or low-quality care because of the challenges in obtaining services from two distinct programs. Many argue that the two programs could be better integrated by developing managed care plans that provide both Medicare and Medicaid services. Integrated plans could improve quality and reduce federal and state spending because they would have stronger incentives to coordinate care. However, these plans have been difficult to develop, and only 8 percent of full-benefit dual-eligible beneficiaries are now enrolled in a plan with a high level of Medicare and Medicaid integration. We examine the use of integrated plans and consider three potential policies that would encourage the development of highly integrated plans.
- There are four types of plans that serve dual-eligible beneficiaries: The Medicare–Medicaid Plans (MMPs) under the financial alignment demonstration, MA dual-eligible special needs plans (D–SNPs), fully-integrated dual-eligible SNPs (FIDE SNPs), and the Program of All-Inclusive Care for the Elderly. There are significant differences among these plans in several key areas, including their level of integration with Medicaid, ability to use passive enrollment, and payment methodology.
- Three potential policies to encourage the development of integrated plans are: limiting how often dual-eligible beneficiaries can change their coverage, limiting enrollment in D–SNPs to dual eligibles who receive full Medicaid benefits, and expanding the use of passive (automatic) enrollment.

MEDICARE COVERAGE POLICY AND USE OF LOW-VALUE CARE

- We review the coverage processes used in FFS Medicare and by Medicare Advantage (MA) plans and Part D sponsors and examine the use of low-value care in Medicare. Medicare covers many items and services without an explicit coverage policy. When an explicit coverage policy *is* required, policies are often based on little evidence and usually do not include a consideration of a service's value relative to existing treatment options. Many MA plans are permitted to use tools that are not widely used in FFS Medicare (e.g., requiring prior authorization, using variable levels of cost sharing).
- Some researchers contend that there is substantial use in the Medicare program of low-value care—care that has little or no clinical benefit, or care in which the risk of harm from the service outweighs its potential benefit. Our review of the literature reveals that such care is prevalent across FFS Medicare, Medicaid, and commercial insurance plans. In 2014, annual Medicare spending for certain types of low-value care ranged from $2.4 billion to $6.5 billion. These spending estimates are conservative because they do not reflect the downstream costs of low-value services. We also present three case studies on potentially low-value services in FFS Medicare: starting dialysis earlier in the course of chronic kidney disease, proton beam therapy, and H.P. Acthar Gel (a drug covered under Part D).

- We identify six tools that Medicare could consider using to address the use of low-value care in the program: prior authorization, clinical decision support and provider education, increasing beneficiary cost sharing for low-value services, delivery system reform and new payment models that hold providers accountable for the cost and quality of care, revisiting coverage determinations on an ongoing basis, and linking FFS coverage decisions and payment policies to information about the comparative clinical effectiveness and cost-effectiveness of health care services.