Advising the Congress on Medicare issues

Developing payment policy to promote use of services based on clinical evidence

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MEDPAC

Rethinking Medicare's quality strategy

- Focus Medicare's quality strategy on incentives to improve outcomes and reduce potentially inappropriate use
  - Measure rates of use of services with evidence of limited or no comparative clinical effectiveness
  - Design payments to curb fee-for-service (FFS) incentive for overuse, i.e., base payment rates on comparative clinical effectiveness

Today's session

- Commission has repeatedly raised concerns about the value of Medicare spending
- Setting the payment rate of Part B drugs based on comparative clinical evidence
- Setting the payment rate of new services based on comparative clinical evidence
- Two case studies on differences between Medicare's payment policies and other groups' decisions

Setting the payment rate of Part B drugs based on comparative clinical evidence

- Medicare applied the least costly alternative (LCA) policy to Part B drugs between 1995 and 2010
- For a group of drugs that treat the same condition and produce the same outcome, the policy set the payment rate based on the least costly drug
- Improved payment accuracy and resulted in savings for beneficiaries and taxpayers

Application of LCA policies for Part B drugs

- LCA policy affected drugs' payment rate
- Implemented by the contractors' medical directors in the local coverage process
- In one instance, LCA-type policy applied nationally under the hospital outpatient prospective payment system

Lawsuit successfully challenged use of LCA policies

- Policy implemented based on "reasonable and necessary" statutory provision
- A beneficiary challenged use of policy to pay for Part B inhalation drug arguing that the drug should be paid based on its own average sales price plus six percent
- Federal courts agreed with the plaintiff
- In April 2010, LCA policies for Part B drugs were rescinded

LCA policies can be an important tool for beneficiaries and taxpayers

- In 2012, OIG recommended that Medicare seek legislative authority to implement LCA policies for clinically comparable products
- We estimate that beneficiaries and taxpayers would have saved up to $122 million if Medicare had continued to apply policy to one Part B drug class between April 2010 and December 2012

Discussion: Use of LCA policy for Part B drugs

- Medicare would need legislative authority restored to apply LCA policies to Part B drugs
- Development of a transparent process
  - Process considers evidence on the comparative clinical effectiveness of drugs
  - Permits public input and comment from a wide range of stakeholders
  - Includes provider-based exceptions to LCA policies if it is medically necessary
  - Process for revisiting policy as evidence changes

Setting the payment rate of new services based on comparative clinical evidence

- Medicare's payment systems generally do not consider whether a new service results in better outcomes than alternatives
- Instances in which the payment rate for a new service is higher than alternatives even when there is no evidence on whether the new service results in better outcomes

Pearson and Bach (2010) dynamic pricing policy

- New service's payment rate would be linked to evidence on comparative clinical effectiveness
- Policy would assign a new service to one of three categories based on availability of comparative clinical effectiveness evidence

Pearson & Bach (2010) dynamic pricing policy

Clinical evidence	Proposed payment rate
Evidence of improved outcomes compared with alternative	Set according to usual statutory formulas
Evidence of similar outcomes compared with alternative	Equal to alternative treatment
Insufficient evidence to assess comparative effectiveness	Set according to usual statutory formulas for 3 years; at end of period, reevaluate evidence and adjust payment accordingly

Discussion: Setting payment of new services based on comparative clinical evidence

- Medicare would need legislative authority to link payment to comparative clinical evidence
- Development of a transparent process
  - Process considers comparative clinical effectiveness evidence of services
  - Permits public input and comment from beneficiaries and a wide range of stakeholders

Issues: Setting payment of new service based on comparative clinical evidence

- Could also be applied to existing services
- Establishing the time period to generate clinical evidence
- Developing a process for generating and considering clinical evidence
  - Who sponsors research?
  - How should research be designed? Which alternatives should be included?
  - What are criteria for assessing outcomes?

Medicare's payment policies do not always align with other groups' evidence-based decisions

- We present two case studies that describe differences between Medicare's payment policies and:
  - Washington State's and payment policies for medical procedures, tests, and labs
  - The United States Preventive Services Task Force's (USPSTF) recommendations for clinical preventive services

Case 1: Washington State Health Technology Assessment program (WA-HTA)

- Has the ability to make binding coverage determinations for the State's FFS enrollees, workers-compensation claimants, and the State's Departments of Corrections and Veterans' Affairs
- The program evaluates and makes coverage determinations for about 10 health technologies each year
- The WA-HTA contracts for scientific evidence-based reports produced by outside research groups
- An independent clinical committee of eleven practicing health care professionals use these reports to determine which services the State will pay for
- Factors considered include safety, effectiveness, and cost

Washington State policies compared with Medicare

- Payment policies are similar in some cases
  - Robotic assisted surgery
- Instances in which Medicare does not pay for a service Washington State does
  - Vitamin D screening
- Instances in which Washington State does not pay for a service Medicare does
  - Vertebroplasty, electrical neural stimulation, hip resurfacing, certain spinal injections
- We estimate 2012 Medicare spending between $683 million to $2 billion on services not paid for by Washington State

Case 2: Medicare payment and USPSTF recommendations

- Independent advisory panel that assesses scientific evidence about preventive services such as screenings, counseling services, and preventive medications
- Assigns each service a letter grade based on the strength of the evidence and the balance of benefits and harms of a preventive service
- Services receiving a ‘D’ grade by the USPSTF are services for which there is moderate or high certainty that it has no net benefit or that the harms outweigh the benefits
- Some services receiving a ‘D’ grade are paid for by Medicare

Why are Medicare's payment policies not always based on clinical evidence?

- Medicare has limited comparative clinical effectiveness information on which to base its payment policies
  - The Patient Centered Outcomes Research Institute established in 2010 to sponsor comparative clinical effectiveness research
- Many new services fall into existing payment methods or buckets; majority of medical services do not go through Medicare's coverage process
- Medicare's payment systems generally do not consider the comparative clinical effectiveness of a service

Discussion: Better align Medicare payment policy with evidence-based decisions

- In 2012, the Commission recommended that the Congress provide the Secretary with the authority to alter or eliminate cost sharing based on the evidence of the value of services
  - Adjustments and refinements in cost sharing as evidence of the value of services accumulates and evolves
- Development of a transparent process
  - Process considers evidence generated by outside groups
  - Permits public input and comment from beneficiaries and a wide range of stakeholders
  - Includes provider-based exceptions to policies if medically necessary
  - Addresses protections for low-income beneficiaries
  - Addresses supplemental insurance coverage

For Commissioner discussion

- Restore the Secretary's authority to apply LCA policies to Part B drugs
- Pearson and Bach's *dynamic pricing policy*
- Better align Medicare payment policy with evidence-based decisions through cost sharing for low-value services