The Quest for Higher Quality at Lower Costs: The Role of Medicare

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Some Initial Observations

Overall delivery system change commonly occurs as a result of basic Medicare payment and other policies:

-- the adoption of the Medicare resource-based relative value scale fee schedule by most payers

-- hospital employment of cardiologists

-- a new, for-profit hospice sector

Initial Observations (cont.)

- Quality reporting and pay-for-performance are about how well providers perform what they set out to do but mostly ignores whether what they do is appropriate for individual patients and produces the right mix of services for the population served
- Value-based purchasing is as much about incentives, organization, and culture as about measuring quality and cost, as in a “value-index”

Initial Observations (cont.)

There may be too much early focus on accountable care organizations as a "game changer" and not enough on many other ACA initiatives. ACOs still need a "proof of concept."

The Center for Medicare and Medicaid Innovation (CMI, CMMI) is crucially important but faces major challenges – it needs some breathing room as well.

Can Medicare Act on Its Own to Reduce Costs and Improve Quality?

- Does the clear need for broad delivery system reform preclude Medicare-only actions?
- Concerns about cost-shifting if Medicare holds its own costs down
- Concerns about second-class care for benes
- Concerns about Medicare overusing its market power
  - But true, value-based purchasing inherently involves balancing access, cost and quality
    - See SGR and why fee cuts to docs don't happen

Public and Private Payers Share Common Interests

(whatever the reality of cost-shifting – the evidence is mixed)

It would be desirable to see more private payer and purchaser engagement in Medicare policy-making, e.g., Medicare fee schedule, evidence-based coverage of new technology

And collaborative purchasing – e.g., the Advanced Primary Care Demonstration being run out of the Innovation Center

Old Fashioned Payment Updates Affect the Delivery System

- Stensland et al. (MedPAC) “Private-Payer Profits Can Induce Negative Medicare Margins” *Health Affairs*, May 2010
- Finds that market power leads hospitals to reap higher revenues from ESI payers, which in turn leads these hospitals to have weaker costs controls > higher costs per unit of service > negative margins on Medicare

Implications for Medicare Payment Policy

- Undisciplined spending by many hospitals produces negative Medicare margins. But efficient hospitals (those without ability to generate high prices) have lower costs, relatively high quality (as measured), and break even or better on Medicare. So payers, including Medicare, need to set rates so that hospitals feel some financial pressure to constrain costs.
- Not so easy for commercial insurers to do this

Provider Consolidation Leads to Increased Negotiating Leverage – and Higher Prices

From work by Center for Studying Health System Change --

Forms of consolidated providers --

- Multi-hospital health care systems
- Hospital mergers within a service area
- Single specialty group mergers
- Multispecialty group practice
- Independent practice associations
- Hospitals employing docs – integrated systems

But There Are Also Leverage Factors Unrelated to Concentration/Consolidation

Environmental factors

-- employer rejection of narrow networks

-- no longer oversupply of beds and docs, with some exceptions (Miami re docs)

Reputation

Geography

Provision of particular clinical services

Regulations (in a couple of places)

“We have clout not because of our size but…who we are. Am I supposed to apologize for that?”

-- executive of an academic health center

Some Policy Implications

- Although providers expect “health reform” to change contracting dynamics, they don’t know when or how, and some are pretty confident that they will continue to get healthy rate increases
- Expect more hospital-physician integration – esp. physician employment by hospitals, whether or not ACOs take off. This has the potential to improve care – and raise prices.
- There seems to be only a limited role for antitrust enforcement

Some Policy Implications (cont.)

- Should we rediscover state-based rate regulation – all-payer rate setting as in Maryland, or, short of that, setting fee maximums on negotiated rates
- Some countries now combine managed competition among sickness funds/insurers with rate setting – the Netherlands, Israel

MedPAC Has Identified Spending Variations for HH, DME, and Hospice

- Spending on these three services represents 14% of total but is 24% of spending in top 10 MSAs with high spending
- Increased relative service use is most noticeable in high use areas (e.g., Odessa, TX MSA 18% above average with these three but average for all other services

MedPAC, Sept 2010

DME Variation in South Florida

(MedPAC BASF file for 2006)

Counties	Beneficiaries	DME $ per capita
Collier	60,000	$220
Monroe	11,000	$260
Broward	141,000	$430
Miami-Dade	184,000	$2200

Home Health Use, Spending, and Episodes Vary Widely

Price adjusted spending per capita in McAllen, Texas is more than 7 times national average

In some counties:

-- over 35% of beneficiaries use home health

-- average over 4 episodes per user, so more home health episodes than beneficiaries

MedPAC Sept, 2010

A CMS contractor found that only 9% of claims were properly coded for Houston beneficiaries with the most severe clinical rating served by potentially fraudulent HHAs.

GAO, Feb, 2009

Hospice Use Patterns Differ Widely

(MedPAC, Sept 2010)

State	decedents in hospice	spending (relative natl. avg.)	Stays > 180 days	Live discharge rate
Miss	35%	1.9	39%	55%
Iowa	48	1.1	16	13
Natl. avg.	39	1.0	18	16

Fraud and Abuse

In FY 2010, CMS estimated that Medicare and Medicaid made a total of > $70 billion in improper payments

Since, 2004, GAO has issued 16 reports containing strategies for “reducing fraud, waste, abuse and improper payments” in Medicare and Medicaid

There Are Numerous ACA "Value-based" Payment Provisions

- PQRI extended through 2014 and penalties for non-reporters in 2015
- Physician Feedback Program – confidential data to docs related to efficiency using episode grouper – 2012
- Value-based payment modifier by 2015 for some and 2017 for all
- Quality Measure Development. AHRQ to identify measure gaps and work to fill them in
- New entity for consensus building, based on convening stakeholder groups – to select measures and set national priorities

Yet, Medicare Mostly Is Precluded From Considering Value in Coverage Policies

- Limited in use of comparative effectiveness research findings and can't mount relevant research
- Can't assure conditions of coverage are being met because lacks resources
- Can't pay a reference price for equivalent Part B drugs or DME because of statutory limitations
- Lacks ability to support "coverage with evidence production"
- And none of this would involve explicit use of cost-effectiveness analysis, which is also prohibited