MODERNIZE MEDICARE PROVIDER PAYMENT

Fifty-five million American—including seniors, disabled citizens and patients facing ALS and end-stage renal disease—depend on Medicare.¹ Medicare payments to providers and plans totaled $620 billion in 2014, accounting for 20% of our $3 trillion in national health expenditures and 14% of the federal budget.¹, ² Improving Medicare payment is a high stakes endeavor for beneficiaries and taxpayers alike. Fortunately, a close look at Medicare spending reveals an opportunity to deliver better care at lower cost. The data show substantial variation among regions and among providers in the volume of services provided, without a clear relationship to care quality or patient health outcomes. Changing Medicare’s reimbursement policies can facilitate the spread of higher-value care. And because Medicare, the largest payer for health care in the United States, has historically served as a catalyst and a template for private sector provider reimbursement changes, improving Medicare payment practices can also promote positive change in the rest of the health care system.

Background

Variation in Medicare spending reveals potential for increasing efficiency.

Medicare per capita spending varies among hospital referral regions, hospital service areas, hospitals and clinics, and even individual providers. Differences persist over time and across different health care services.³ Variation in spending is not fully accounted for by beneficiary age, sex, or health status, other beneficiary demographic factors, insurance plan factors, or types of markets.³

The Institute of Medicine (IOM) concludes the variation in volume of acute and post-acute care accounts for 89% of the variance in total Medicare spending.³ Meanwhile, the IOM found that quality of care is not consistently related to spending or utilization in Medicare.³ In sum, Medicare can realize substantially lower costs without harming quality if incentives encourage better health outcomes instead of higher volume of services.

Bundled payment systems in traditional Medicare have produced savings.

In bundled payment systems, providers are reimbursed based on expected costs for a clinically defined episode of care, instead of receiving separate payments for each individual service. Bundled payments are designed to encourage care coordination and incentivize quality over quantity of services. Two bundled payment demonstrations have been initiated, one of which is ongoing.⁴

1. Acute Care Episode (ACE) Demonstration, 2009-2012: Using bundled payments for acute care related to high-margin cardiac and orthopedic procedures, Medicare achieved combined Part A and B savings of $319 per episode of care, even after accounting for increased post-acute care costs, when the baseline for each episode ranged $1,100–5,142.⁵
2. Bundled Payment for Care Improvement (BPCI) Initiative, 2013-present: This initiative provides bundled payments for both acute and post-acute services associated with any of 48 designated clinical episodes. For participating hospitals and practices, costs decreased by $4,906 or 13.2% during the first year of the initiative. Comparable non-participating providers reported a decrease of only $1,154 or 3.4% during the first year.⁶

Bundled payments served as a catalyst for improved care practices. ACE hospitals identified high-value medical devices, negotiated prices for these devices, coordinated care, and shared quality and spending information with physicians.⁵ Initial evaluations of BPCI providers suggest that they have also taken steps to improve care coordination and focus on higher value practices.⁶
Medicare Accountable Care Organizations have achieved modest savings and substantially better quality.

While the Centers for Medicare & Medicaid Services continue to refine ACO models, ACO programs have slowed cost growth – and increased savings – every year. In 2014, compared to expected expenditure, Medicare saved a total of $585 million through ACOs:

- $120 million across 20 Pioneer ACOs
- $465 million across over 300 Medicare Shared Savings Program (MSSP) ACOs

Simultaneously, ACOs improved quality performance since they began participating in the Pioneer and MSSP ACO models:

- In each year since the initiative began, Pioneer ACOs have improved in quality of care and patient experience scores.
- MSSP ACOs improved on 27 of 33 quality measures and 18 of 22 performance ratings in the first performance year.

Recommendations

Expand and refine successful alternative payment models.

Alternative payment models such as ACOs, bundled payments, and advanced primary care models are already delivering on the promise of better care at lower costs. To realize that promise for more Medicare beneficiaries and ensure the Medicare program receives the maximum benefit from these new models, NCHC recommends that policy makers:

- Expand the use of bundled payments as evidence accumulates about the conditions for which they are effective — while maintaining strong consumer protections.
- Give ACOs flexibility to tailor care to the needs of beneficiaries by waiving those payment and benefit regulations originally designed to restrain volume in the fee-for-service payment environment. Additionally, transition to savings targets based on regional spending instead of individual providers’ past performance, to encourage the most efficient providers to continue to participate.
- Expand advanced primary care and medical home models when proven successful.

To ensure that federal policy supports the development of the next generation of alternative payment models, NCHC strongly supports the preservation of the Centers for Medicare and Medicaid Innovation’s existing authority and funding.

Reform Medicare’s legacy reimbursement systems.

Any serious attempt at reform cannot stop with the promotion of alternative payment models. Over 25 million beneficiaries are neither enrolled in a Medicare Advantage plan nor have their care coordinated through a Medicare ACO or CMMI advanced primary care payment model. In addition, traditional Medicare’s reimbursement policies and rates remain critical components of the payment formulae for the MA plans, ACOs, and alternative payment models now undergoing testing at the Center for Medicare and Medicaid Innovation (CMMI). NCHC supports the following measures:

- Reform existing skilled nursing facility and home health payment systems and implement value-based payment across post-acute settings.
- Ensure effective implementation of the Merit-Based Incentive Payment System (MIPS), enacted as part of the 2015 SGR reform legislation.
- Refine the hospital readmissions reduction program so that hospitals are not punished for providing care to the sickest and poorest patients.

Sources