

Medicare Payment Reform: Lessons Learned and Considerations for the Future

August 31, 2021

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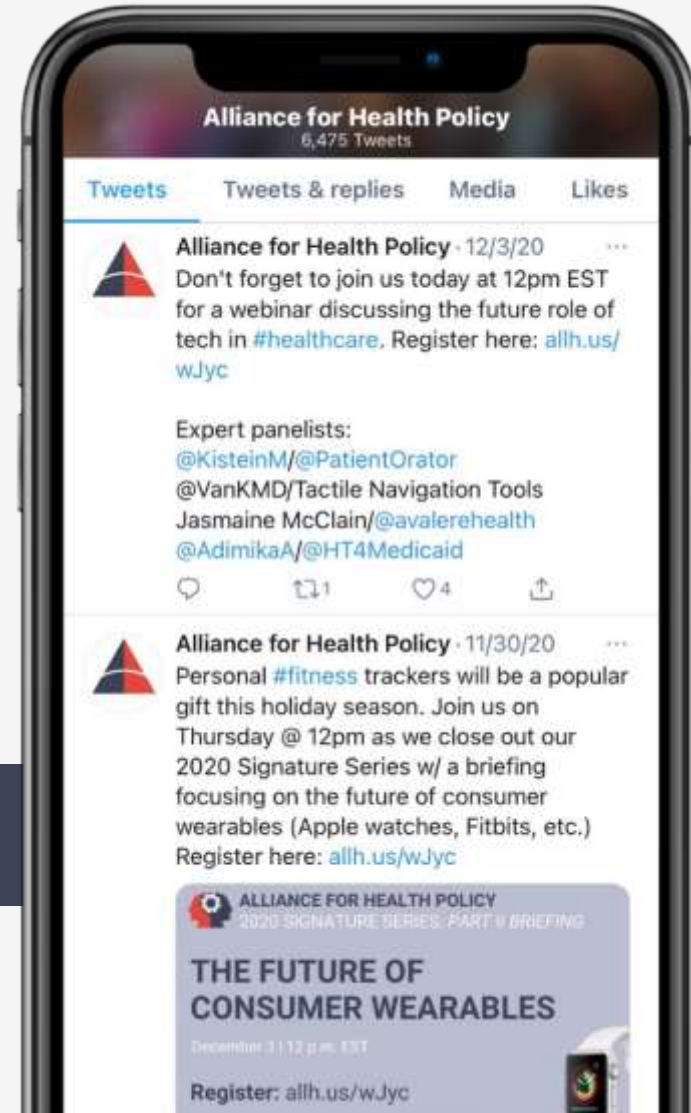


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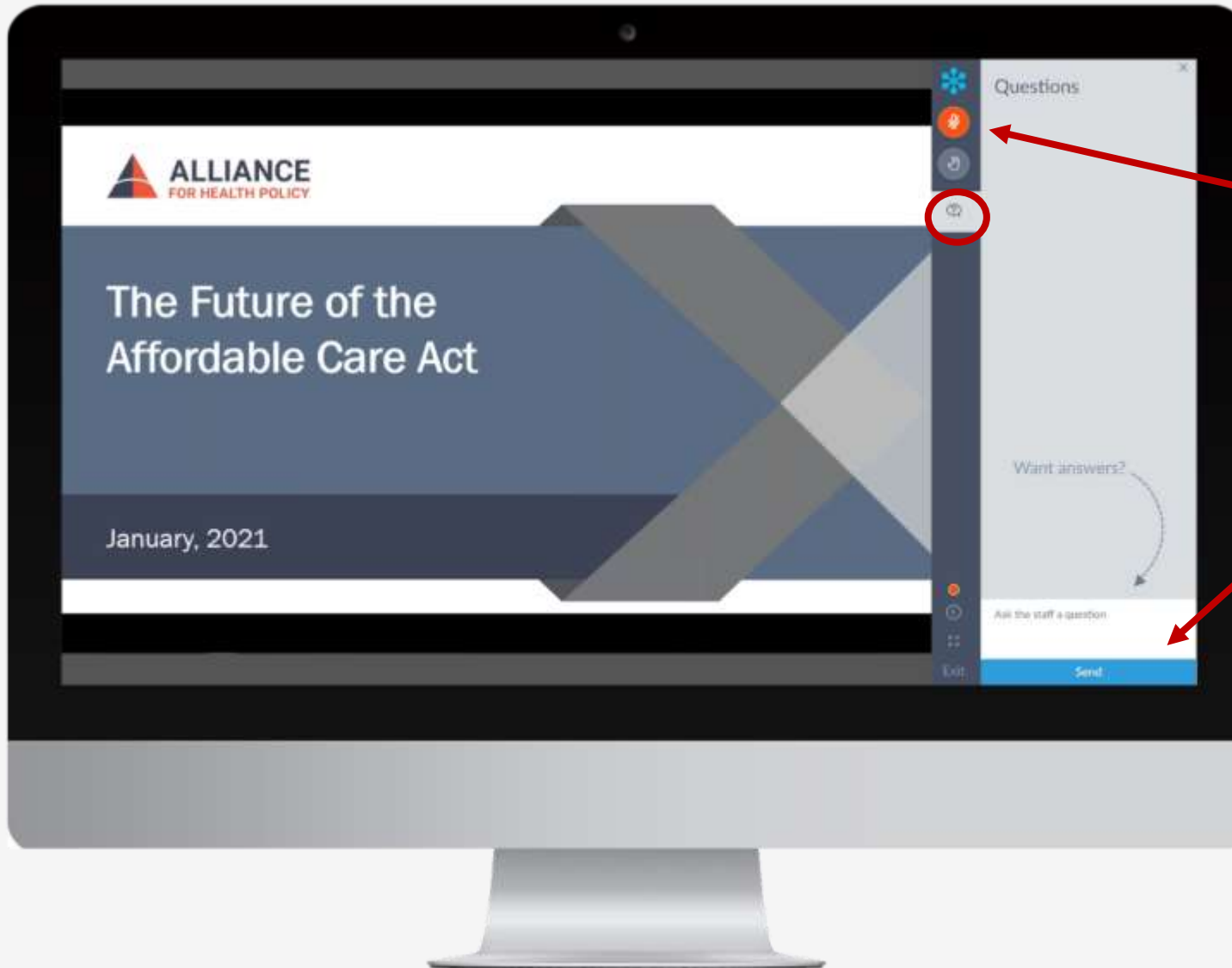


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Panelists



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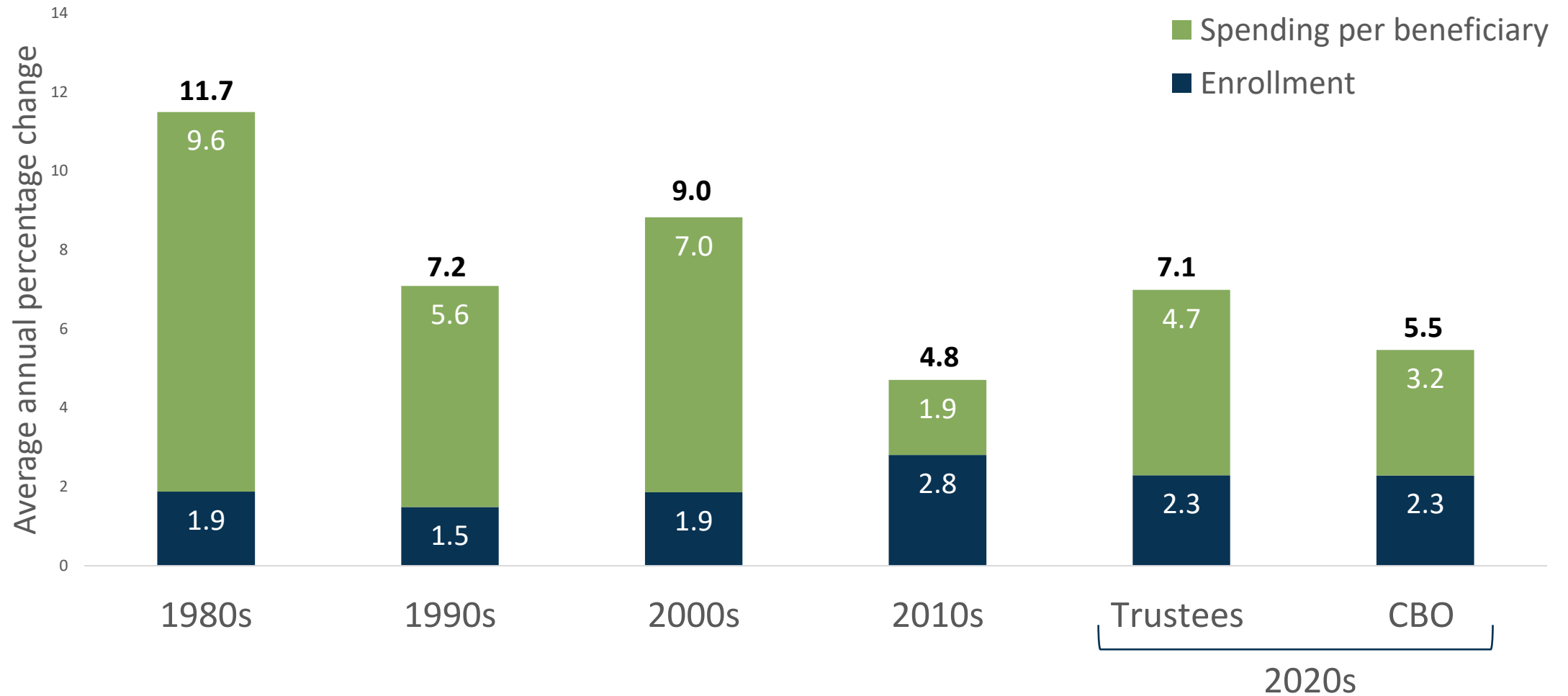
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Medicare Payment Reform: Lessons Learned

Jennifer Podulka, MPAff

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Medicare spending growth varies by decade



Source: HMA Analysis of 2020 Medicare Trustees Report and CBO's Medicare July 2021 Baseline.

Medicare efforts to address spending growth evolved

1966

- Medicare began and adopted payment methods used by insurance plans
 - Hospitals were paid on the basis of their costs
 - Physicians were paid on the basis of their fees

1983

- Medicare adopted the Inpatient Prospective Payment System (IPPS) to pay for hospital services

1992

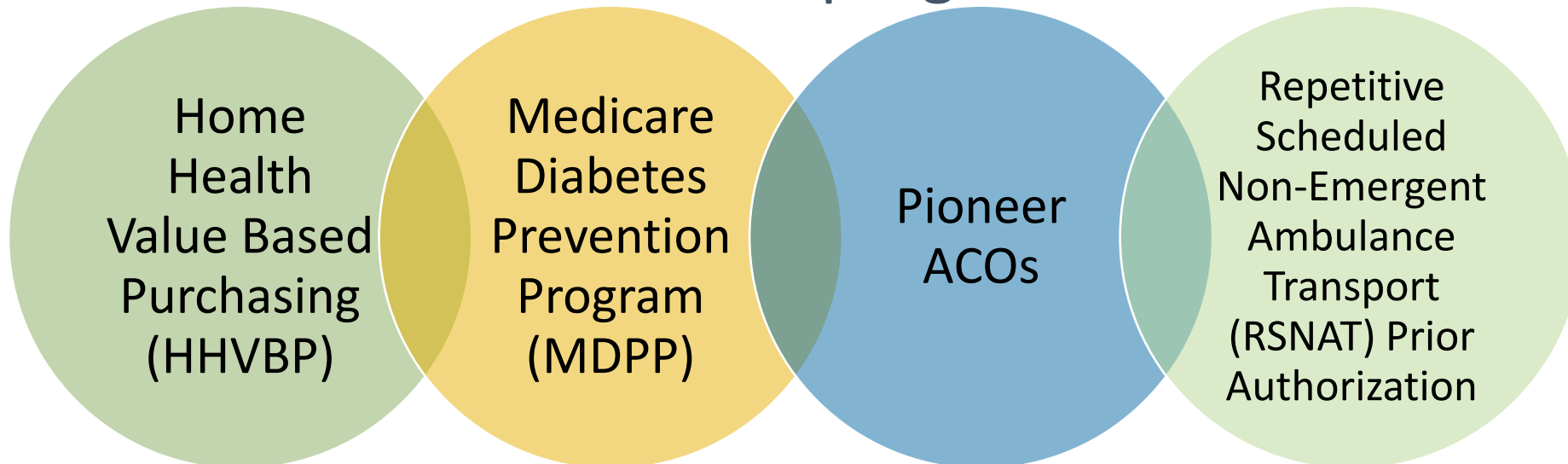
- Medicare implemented the Physician Fee Schedule (PFS) to pay for various clinician services

2010

- The ACA created the Medicare Shared Savings Program (MSSP) for accountable care organizations (ACOs) and established the Innovation Center

CMS Innovation Center – looking back

- Is mandated to test models to determine if they:
 - Reduce spending without reducing quality of care
 - Improve quality of care without increasing spending
- 172 models that include Medicare
- 4 models successfully met the criteria above and **were** introduced into the Medicare program nationwide:



CMS Innovation Center – looking forward

- New CMS leadership published a Health Affairs blog indicating some key takeaways from the past, such as:
 - Mandatory participation and financial incentives help to ensure meaningful provider participation in models
 - Providers find it challenging to accept downside risk if they do not have tools to enable and empower changes in care delivery
- and plans for the future, such as:
 - Make equity a centerpiece of every model
 - Focus on launching fewer models
 - Lower patients' out-of-pocket costs
- The Innovation Center currently has 28 models underway

CMS Innovation Center – looking forward

Accountable Care

- Comprehensive ESRD Care
- Kidney Care Choices (KCC)

Episode-based Payment

- Bundled Payments for Care Improvement (BPCI) Advanced
- Comprehensive Care for Joint Replacement (CJR)

Primary Care Transformation

- Comprehensive Primary Care Plus (CPC+)
- Global and Professional Direct Contracting (GPDC)

Medicare-Medicaid Enrollees

- Financial Alignment Initiative for Medicare-Medicaid Enrollees
- Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents: Phase Two

New Payment and Service Delivery

- Geographic Direct Contracting
- Medicare Advantage Value Based Insurance Design (MA-VBID)
- Value in Opioid Use Disorder Treatment

Speed Adoption of Best Practices

- Medicare Diabetes Prevention Program (MDPP) Expanded Model



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Michael Chernew, Ph.D.

Leonard D. Schaeffer Professor of Health Care Policy and Director of Healthcare Markets and Regulation Lab,
Harvard Medical School



Future of Alternative Payment Models (APMS)

Motivation for APMS

- There are a lot of inefficiencies in Medicare
 - Geographic variation
 - Low value care/ overuse
 - May be worse with new technologies (e.g. telehealth)
 - Inefficient sites of care (e.g. PAC; site neutral)

FFS is an impediment to eliminating these inefficiencies



- We deal with FFS incentive issues with clunky administrative rules (e.g. caps)
- Current policy calls for sub inflation growth in FFS prices

→ Can we develop payment models that encourage efficient care delivery and support the delivery system w/o increasing spending

Alternative Payment Models

Theory of Alternate Payment

- Efficiency requires flexibility in how 'inputs' are used
- Health care services are inputs
- Health is the output
- Flexibility to substitute inputs and capture gains from efficiency are important.

Waste as an Asset: Who Keeps the Savings



MedPAC recommendation (June 2021)

The Secretary should implement a more harmonized portfolio of fewer alternative payment models that are designed to work together to support the strategic objectives of reducing spending and improving quality

How to harmonize CMS's portfolio of models

- Instead of developing models in isolation, CMS should develop a portfolio of models designed to work together
- Models' financial incentives should be complementary, and not become diluted when combined
- Models could have more consistent features (e.g., spending targets, attributing beneficiaries to providers)

One Possible Vision

- Multi-track APM model
 - Low risk for small physician groups, (e.g., CPC+)
 - High risk for large systems (e.g. next gen ACOs, DC Global)
 - Tracks in between (do not impose downside risk for all)
- Add episodes strategically
 - More episode reliance in lower risk tracks
 - Allow episodes to be added ‘under the water line’ by private orgs
- Strong participation incentives, particularly in high-risk tracks
- Remove ratchet from benchmark (e.g., admin pricing)
- Refine: risk adj, attribution and ACO TIN composition rules
- Promote equity in benchmark policy and performance measures

END



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Blue Sky in Value-Based Payment

Hoangmai (Mai) Pham, MD, MPH
President and CEO

August 2021

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Addressing health disparities – Foundational issues

Level set on domains & intersections – race/ethnicity, disability, rural, else?

Performance metrics can shift *within-provider* disparities

Focus on a given provider's behavior

Pricing tools better suited to shift *between-provider* disparities

Favor entities serving more disadvantaged populations via financial benchmarks, risk-adjustment, shared savings %'s, etc.

Acknowledges geographic segregation, disparities in resources due to payer mix

Addressing health disparities – beyond clinical

Social drivers of health

Food security, housing, transportation, social connectedness

Home- and community-based services not just for elderly and disabled

Regulatory flexibility for “in lieu of” services in Medicare

Public/private investment in community infrastructure

Blending/braiding financing streams – HUD, HHS, CDC, VA, DoD

Need for evidence

Perfect role for CMMI but requires a more elastic definition of success

Sustaining Multi-Payer Momentum

Maximize federal government action beyond Medicare & Medicaid
ACA Exchanges, TRICARE, FEHBP, HRSA, ACL

Acknowledge market leverage in private VBP contracting
Commercial VBP deals often held hostage to rate negotiations
Commercial price growth can outstrip savings from lower utilization
HHS goals of high % of private payer spend thru VBP can be counterproductive

Walk the walk on collaboration

Market Leverage Mutes VBP Impact

Status quo is too attractive

- Volume-based inertia even with pandemic shutdowns

- Belief that healthcare prices cannot go down, at least not for powerful providers

- Little divestment from bricks-and-mortar even as digital investment ramps up

Resistance of “must have” providers

- Power from reputation, big employer & network provider, revenues from high prices

- Higher commercial prices exert upward pressure on Medicare prices

- Little incentive to participate in voluntary VBP

- Incumbency dampens competition and slows innovation

Acknowledging market leverage in VBP

Mandatory models

- Rapid ramp-up to downside risk for large, high-price providers

Incentives for use of lower cost care models

- Virtual and in-home services

- Other lower operating cost models of care – e.g., ambulance staff administer urgent care on site rather than transporting to ED

- Favor new market entrants

 - Medicare & Medicaid beneficiary incentives for selecting lower cost models

 - Generous financial benchmarks that still offer discount from current spending

 - Population based payments for bundles of lower cost services

We value your input!

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