

# The ACA and Delivery System Reform: A Few Contrarian (or Just Contrary) Views

Robert A. Berenson, M.D.

Institute Fellow, The Urban Institute

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# Some Initial Observations

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Medicare **can** reduce spending without wholesale delivery system reform

Delivery system change commonly occurs from basic Medicare payment and related policies:

- hospital employment of cardiologists
- a new, for-profit hospice sector

Fraud and Abuse **is** a leading driver of spending and can be reduced without major system change



# Initial Observations (cont.)

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Value-based purchasing has been somewhat misapplied by Congress and CMS. 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



# Initial Observations (cont.)

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There has been too much focus on accountable care organizations as a “game changer” and not enough on dozens of 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 time as well.



# Can Medicare Act on Its Own to Reduce Costs?

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Does the clear need for broad delivery system reform preclude Medicare-only actions?

Concerns about cost-shifting

Concerns about second-class care

Concerns about Medicare overusing its market power (but true, value-based purchasing inherently involves balancing access, cost and quality)

– See the SGR and why cuts not implemented



# Public and Private Payers Share Common Interests

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(whatever the reality of cost-shifting)

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

And collaborative purchasing – e.g., the Advanced Primary Care Demonstration



# Old Fashioned Payment Updates Affect the Delivery System

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Stensland et al. “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

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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, and break even 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





# Medicare Physician Fee Schedule

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Berenson, et al. *What if All Physician Services Were Paid Under the Medicare Fee Schedule?* A Contractor Report for MedPAC, 2010

The study simulated MD compensation as if all of their services (in Relative Value Units) were paid at Medicare Fee Schedule Rates



# Simulation Results

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For 2007, actual mean M.D. compensation was \$272,000. Simulated at Medicare rates was \$240,000

Some specialties had simulated compensation 2.5X's that of primary care and were in the mid-\$400,000 range

So the assertions that Medicare pays only “80% of physician costs” ignores the generous income take-out that is part of practice costs

(And some specialties have no plausible option to not take Medicare patients)



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

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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

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Price adjusted spending per capita in McAllen is over 7 times national avg.

In some counties:

- over 35% of beneficiaries use hh
- average over 4 episodes per user, so more hh 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 dischar ge rate
Miss	35%	1.9	39%	55%
Iowa	48	1.1	16	13
Natl. avg.	39	1.0	18	16



# Fraud and Abuse

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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

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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

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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



# ACOs Were Not Ready for Adoption into a Shared Savings Program

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Sec. 3022 modeled after the PGP demo that was not particularly successful even with dedicated, experienced group practices

3 years not long enough commitment for a delivery system to change its business model and medical culture, so they mostly did not try

Shared savings is still FFS

There was (and is) a lack of consensus on many design features – e.g., whether this approach can work with full freedom of choice for beneficiary

CMMI demos might be the better way to proceed



# Sec 3021 Center for Medicare and Medicaid Innovation within CMS

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Broad authority to test lots of new things – e.g. payment models, HIT, patient education, care for cancer patients, post-acute care, chronic care management, tele-health, etc. Greatest emphasis on chronic care approaches

Can adopt more broadly without going back to Congress if achieve certain positive outcomes on quality and/or cost

\$10 billion available over 10 years and has been appropriated



# Policy Makers Face Some Basic Strategic Decisions

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For ACOs, how aggressively to proceed – approve many and try to decisively move the system or test a few dozen as “proof of concept”

Does CMS (CMMI) test a lot of new payment models and see what works or is it more selective based on a vision of where it wants to be in 10 years?

- For example, are bundled episodes an evolutionary path or a *cul-de-sac*?
- What standard payment policies would support move toward new payment models?

Can demos provide answers about provider behavior or mostly focus on operational issues?



# Medicare Research and Demonstrations

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A number of flaws have been identified with current approach – some expressly addressed in the ACA with the CMMI:

- Greater flexibility on budget neutrality
- CMS can implement without going back to Congress (with some discipline)
- \$10 billion over ten years for the CMMI is quantum leaps more than past appropriations.
- Congress has listed 20 priorities for CMMI, but this time did not mandate too many particular pilots and demos



# Demonstration Issues That Need To Be Addressed

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Often, much too long from conception to conclusion or dissemination, e.g., Coordinated Care Demo, 1997-2011. (but not always – Medicare Health Support pilot took only a few years)

Research designs may preclude needed mid-course correction, e.g., Medicare Health Support

How to assess scalability of even successful demonstrations, see PACE.



# Demonstrations Issues (cont.)

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Some potential innovations cannot really be tested in a classic demo because:

- the change is too basic for the provider to undertake with only a short time commitment from one, albeit important, payer, e.g., physician group practice demo
- strategic behavior that may produce misleading findings, e.g., ? Premier P4P demo, competitive bidding for Medicare risk plans (if it had been allowed to proceed)



# Implications for CMMI and Medicare Demonstrations Activity

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Trade offs between need to be firmly evidence-based with imperative to be faster, more flexible, and encourage “local adaptation in response to learning”

Need for a transparent, 10 year strategic plan for the CMMI – choices need to be made

Need for political buffers. Here, a role for a FACA Advisory Committee? MedPAC? IPAB?

CMMI needs be as focused internally – on the range of activities within CMS needing innovation -- as externally focused on new organizational models and payment approaches.

