Medicare 101: What You Need to Know – Medicare Payment Approaches

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March 27, 2015

Some Terminology

- Fee-for-service (FFS) – payments made for each individual service provided during an encounter or hospital stay (actually, individual services that are codified and recognized for payment)
- "FFS Medicare" – the commonly used, if incorrect, term for the traditional Medicare (TM) program to distinguish it from Medicare Advantage. In fact, most payments are not FFS in FFS Medicare
- Volume-based payment – payments that increase as a function of the number of units of services performed – most TM payments

Terminology (cont.)

- Value-based payment – payments that include some level of financial rewards or penalties for measured quality and/or incentives for holding down costs
  - Note that value-based payments are usually placed on top of volume-based payments – not either/or
- Population-based payment – payments made prospectively to a provider responsible for a population of individuals, irrespective of the actual services provided

Units of Payment

- Individual services in a fee schedule (>7000 for clinicians under the Medicare Physician Fee Schedule (MPFS))
- Packaged – when various individual services provided at one time are combined into a single payment
- Bundled – 2 meanings – (1) similar to packaging (2) combining the payment streams that go to different providers into a single payment stream
- Episode – a payment for services extending over time
- Case rate – an episode that consists of a hospital stay
- Bundled episode – a payment to one recipient on behalf of multiple providers for services over time; CMMI demonstrations use an accounting of spending against a target, with potential for bonuses, not a combined payment

Units of Payment (cont.)

- Per diem – A packaged payment for services provided for each day of a hospital stay
- Diagnosis-related groups (DRGs) – a case-mix adjusted case rate for a hospital stay regardless of what services are provided or number of days in the hospital
- Capitation – payment by the head, a common form of health status-adjusted, population-based payment made for most or all services, usually made monthly

Bonuses and Penalties

- Pay-for-performance (in Medicare terminology, value-based purchasing) – marginal payments up or down based on performance against specific metrics, usually of quality of care or service use
- Shared savings – placed on volume-based payment approaches in which a provider can gain extra funds by spending less than a target amount. When bonus-only, it is referred to as one-sided risk, when there are also financial penalties for exceeding the target, it is two-sided risk

The Variety of Payment Methods in Traditional Medicare

Fee schedules

- Ambulance transport -- with packaging of services
- Ambulatory surgical centers -- with packaging
- Clinical laboratories
- Durable medical equipment
- Outpatient dialysis – with extensive packaging
- Outpatient hospital – with some packaging
- Physicians and other health professionals – the truest bastion of fee-for-service (although even here there has been episode payments, i.e. “global” periods for major procedures and even some capitation)

The Variety of Payment Methods in Traditional Medicare

Per Diems

- Hospice
- Psychiatric hospitals
- Skilled nursing facilities

Capitation

- Medicare Advantage
- Part D

Episodes

- Home health care – 60 days of care
- Inpatient hospital -- DRGs for a hospital stay
- Inpatient rehabilitation facilities – hospital stay
- Long-term care hospitals – hospital stay

HHS Framework for the Evolution of Payment Models

- Category 1—fee-for-service with no link of payment to quality
- Category 2—fee-for-service with a link of payment to quality
- Category 3—alternative payment models built on fee-for-service architecture
- Category 4—population-based payment

Value-based purchasing includes payments made in categories 2 through 4

HHS Jan 26 Announcement of Goals and Timeline for Value Payments

- 30% of traditional Medicare payments tied to value thru Alternative Payment Models (categories 3,4) by the end of 2016, and 50% by 2018
- 85% tied to value (categories 2-4) by 2016 and 90% by 2018
- CMS says “the majority of Medicare payments now are linked to quality”
  - demonstrating the point that these value payments are placed on top of volume-based payments

Sustainable Growth Rate Repeal & Medicare Provider Payment Modernization Act

(last year's bill title)

Background

- 1997: SGR update formula passed in effort to control volume and “unsustainable” growth in Medicare Part B spending – spending targets for the MPFS tied to increase in GDP
- But since the early 2000s: actual spending has mostly exceeded the targets so clinicians subject to reductions in their fees – which occurred in 2002 (about 4.5% reduction in fees)
- Since 2003: Congress has passed 17 “doc fixes” which postpone but do not eliminate the obligation to reduce the MPFS to make up the accumulated overspending on services.

The Bill Would:

- Repeal the SGR, specifying fee updates for 10, now 5 years, and “improved” payment through a consolidated Merit Based Payment Incentive System (MIPS)
  - as much as 9% more or less would ultimately be applied based on individual and large medical group performance on performance measures of quality and resources used
- Set priorities and funding for quality measure development
- Set up an alternative payment system, with 5% more payments, for physicians actively participating with Alternative Payment Methods, such as accountable care organizations, patient-centered medical homes, bundled payments, if shown effective