EVENT RECAP

MEDICARE PAYMENT REFORM:
LESSONS LEARNED AND CONSIDERATIONS FOR THE FUTURE

Overview

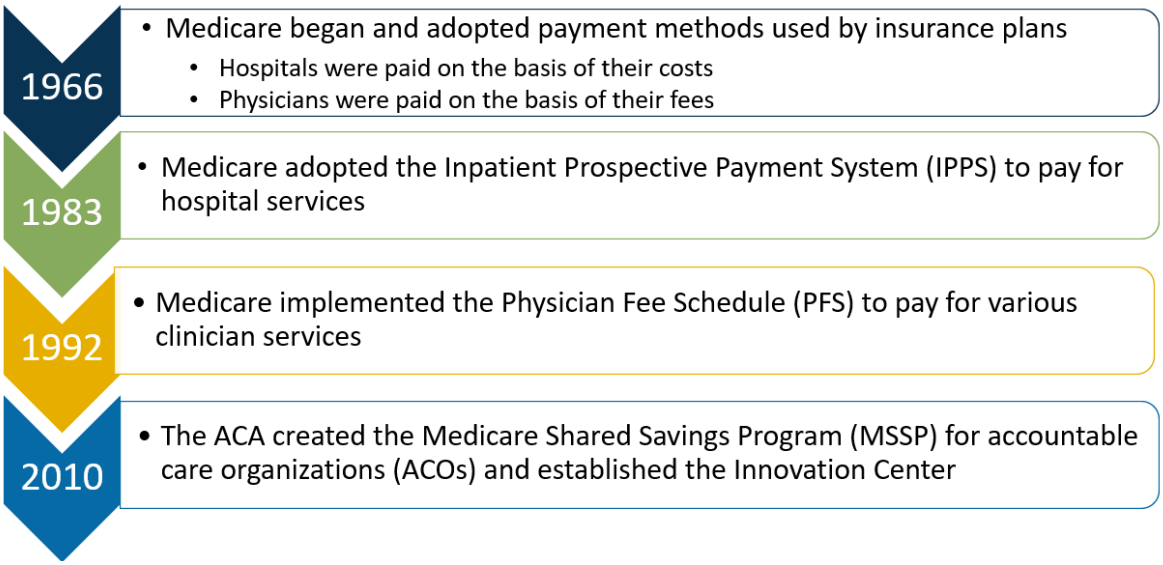
Medicare payment reform aims to increase quality health care for Medicare beneficiaries and improve the program's financial sustainability. On August 31, 2021, the Alliance hosted a briefing that provided background on Medicare payment reform, including new value-based models that have evolved over the past decade. Panelists provided a landscape overview of the most promising federal value-based payment models and the evidence for the models' effectiveness at achieving equity, quality, value, and cost-savings. Attendees learned about the successes and challenges of system-wide population-based payment models and advanced alternative payment models. Speakers will also discuss evidence-informed policy options for accelerating progress on payment reform over the next decade.

For foundational information on coverage or provider rates, see Chapter 2 and Chapter 3 of the Health Policy Handbook, available here. Experts and related resources for this event can be found online.

Key Lessons

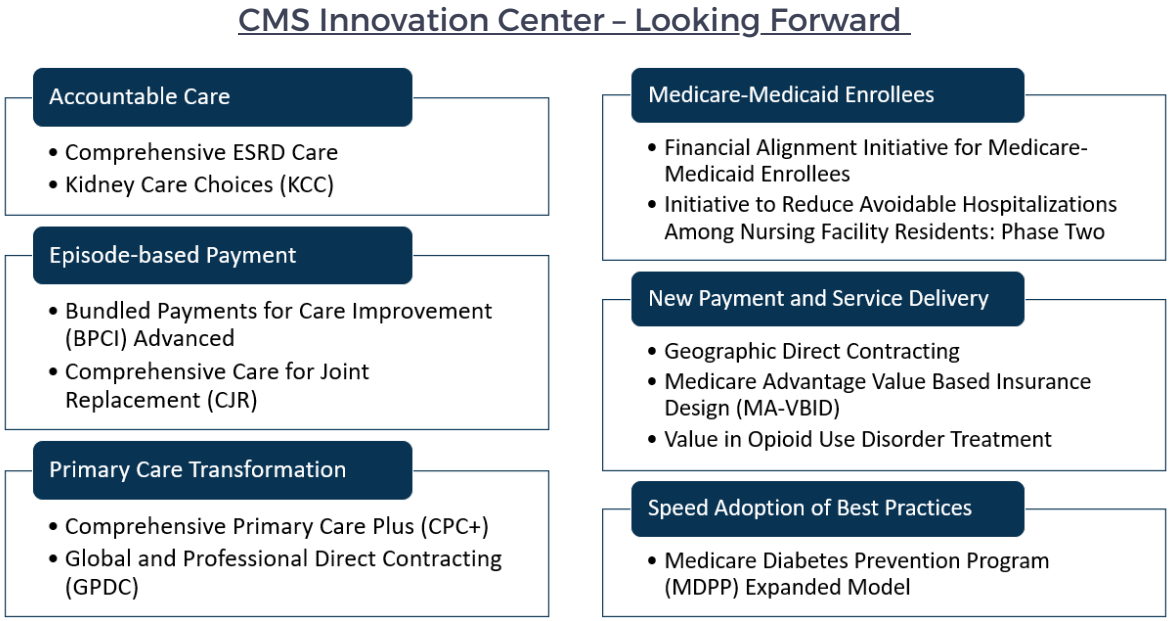
- "**From the beginning, Medicare had addressed spending growth through different ways that have evolved over time**. It [Medicare] was enacted in 1965 and underway the next year. The program opted to adopt payment tools that were largely used by commercial insurance plans at the time. This meant that hospitals were paid on the basis of their cost and physicians were paid on the basis of their fees. As one probably could have predicted, growth ensued." – Jennifer Podulka, MPAff, Principal, Health Management Associates

Medicare Efforts to Address Spending Growth Evolved



Source: Pudolka, Jennifer (2021). Medicare Payment Reform: Lessons Learned [PowerPoint slides]. Health Management Associates. Available here.

- **The Medicare Shared Savings Program is one of the longer-running alternative payment models.** "It's a voluntary opportunity for groups of physicians, hospitals, and other healthcare providers to come together to form Accountable Care Organizations, or ACOs… And part of the reason both for the success in the time it took us to get here is risk. MSSP offers different participation tracks that allow ACOs to assume various levels of risk." – Jennifer Podulka
- "**The Innovation Center [or CMMI was established by the Affordable Care Act in 2010 and] has tested, or is, in, the process of testing 172 models that include Medicare**… Currently there are 28 models underway… arranged into seven categories that are assigned by the Innovation Center." – Jennifer Podulka **The seventh one is not shown in the graphic below because it focuses on Medicaid and CHIP.**



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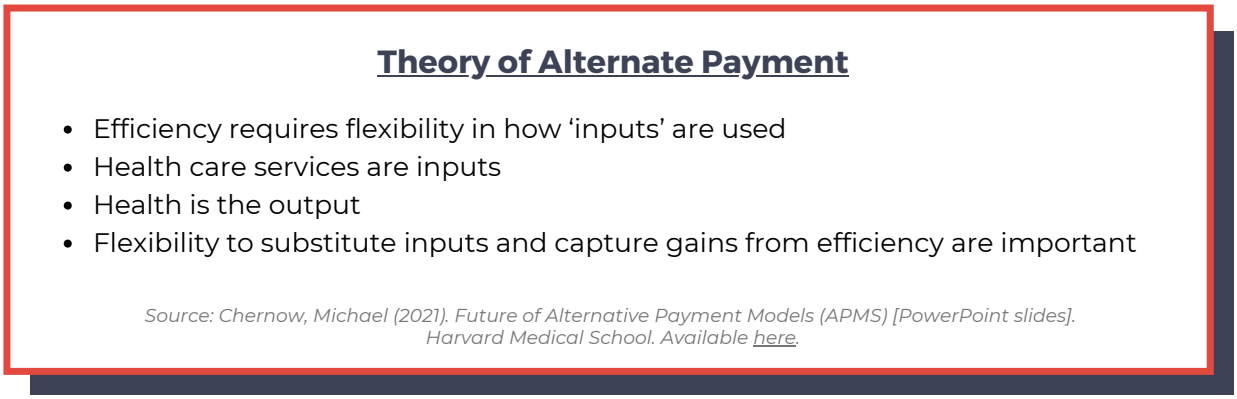

- "There's a lot of inefficiencies in the Medicare program, and we know that from work on geographic variation, we know that from work on low-value care, and overuse. I worry about this a lot going forward…Let's take telehealth for example, it is a very high value, but also has the potential to be overused in a range of ways, and we really struggle with how to manage telehealth in a fee-for-service payment model…We find a lot of problems in use, and I think fee-for-service is sort of part of that reason why we see these inefficiencies. I would certainly say it's not the only reason, but we deal with

them in very clunky ways. So, I'm going to talk about alternative payment models. The basic theory is that efficiency, which is really the only way out of our fiscal conundrum, requires flexibility in how outputs are used…so the core challenge here is, can we set up payment models that encourage the flexibility to substitute the use of these inputs and allow providers to capture the gains from the efficiency." – Michael Chernew, Ph.D., Leonard D. Schaeffer Professor of Health Care Policy, Department of Health Care Policy, Harvard Medical School; Director, Healthcare Markets and Regulation Lab, Harvard Medical School

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

Source: Pham, Hoangmai (Mai) (2021). Blue Sky in Value-Based Payment [PowerPoint slides]. Institute for Exceptional Care. Available here.

- **Medicare payment reform efforts offer opportunities to address health disparities.** "Health care like education, like housing, is physically segregated. In Medicare, something like fewer than 10% of primary care physicians care for over 80% of black Medicare beneficiaries. So, care is quite segregated at baseline. If that's the case, then what we're looking for when we try to address structural sources of disparities are those factors that vary by location and type of provider. When you try to address those, what you want to reach for are no performance metrics, right? Because a hospital could do great on provider performance metrics, but it doesn't solve the issue that they might have much higher fees than other hospitals. When you want to address structural source of disparities you have to turn to what I think of as pricing tools, right? That's things like how you set the spending benchmarks, how you do risk adjustment, or the percent of savings you offer in an ACO or primary care group. The type of factors that affect the dollar per beneficiary that a clinical organization could stand to earn, that acknowledges geography and other types of segregation…It's important to remember that health disparities are driven, really much more so, by non-clinical factors." – Mai Pham, M.D., MPH, President, Institute for Exceptional Care

Questions & Answers

Jennifer, you mentioned our models that successfully reduced spending without reducing quality of care, and improved quality of care without increasing spending — Home Health Value Based Purchasing, Medicare Diabetes Prevention Program, Pioneer ACOs, and RSNAT Prior Authorization — What are some of the core elements of those four models that work?

"I think the finding that mandatory risk, and two-sided risk, or mentored patient risk poses some sort of

advantage to increasing the likelihood of a model being found successful is a somewhat newer finding. Some of the elements included in the four models that have been approved, really don't incorporate the more recent lessons. All four models are really different and they did not all require mandatory and they definitely did not require two sided risk. So that goes to show, CMMI has a lot of characteristics and ideas to work through. Right now, we know some of the things that tend to work better, but we don't have a perfect recipe." – Jennifer Podulka

There was a mention of mandatory participation in models, and this wouldn't be America if we didn't have a conversation about mandatory vs. voluntary. Can you give us of different consideration that policymakers are thinking about when it comes to mandatory vs. voluntary?

"I walk around with a taxonomy of providers in my head, and they fall into four categories, and then there's one crosscutting issue that sits on top. So you've got the true believers, those are the organization that have been doing value based care since before there were ACOs, and they don't know any other way. Then you've got early adopters who are adventuresome, they'll try it but they're extremely empirical. They will try it and do it for as long as it works, and as soon as it stops working for them financially, they'll stop. Then there are the laggards, they are less adventuresome, but if they see their peers doing it and they see that their peers are doing okay, they'll gingerly step in. They're not unwilling, they are just more cautious by nature. Then you've got the never-evers. Those are at least some of the taxonomies, and I think policy makers can't treat providers with a one size fits all approach. For true believers and early adopters, you can afford to offer somewhat more generous financial terms because they are the market leaders. They are the ones that everyone else is watching, if they fail you will lose a lot of momentum." – Mai Pham

How much, if at all, do you think the APM's that are being tested will play a role in extending the solvency of the part A trust fund?

"The trust fund is a challenging issue because it's only one part of Medicare. Let's do a broader question on Medicare and understand that there's a lot of pricing improvement we can do in Medicare. The big picture, Medicare has an efficiency problem, not a pricing problem. Prices are set to rise below inflation, so finding solutions will require finding efficiencies. That's going to be some version of things we are doing in Medicare Advantage, and other changes we make in the Medicare traditional model to get efficiencies. I believe APMs are an important part of that, but we have a ways to go to design the right APMs." – Michael Chernew

We've talked a lot about different goals of value based payment, whether it be increasing affordability, slowing spending, improving quality, or advancing equity. As you have studied the breadth of these models, do you think there are any existing or new ideas to help achieve those goals within the construct?

"When you look at what's happening at the Innovation Center, each of these models is subject to an independent evaluation or an outside group comes in and compares what happens in the CMMI model compared to the control group. There are thousands of pages of tremendous detail, so we're not just saying quality improved, but they are talking about what really improved for the beneficiaries' lives. Did they not have to go back to the hospital a second time? Were they able to stay in their long-term care facility? So, there are lots of elements of quality. Addressing equity and social determinants of health is a newer idea, and incoming leadership has signaled their commitment to it. I would expect to see this start showing up in all sorts of elements for models like provider selection, beneficiary attribution, measures, and eventually it's going to start showing up in evaluation in great detail about all of these models." – Jennifer Podulka