Accelerating Payment Reform in Medicare

The NCHC Fact Sheet Series

Americans face serious health care challenges: rising costs, barriers to access and affordability, and real gaps in care quality, especially for certain chronic diseases. While these challenges affect all of us, they are most acute when we are at our most vulnerable, such as when we confront old age, face disability, weather economic hardship, or reside in communities afflicted by health disparities. Amidst the sometimes heated debates around health care and the federal deficit, ordinary citizens and health care advocates alike need to be informed and engaged. This fact sheet is one of a series examining the policy choices before us.

Background

Health care experts have identified today's approach to paying health care providers, which compensates providers for each service a patient receives, as a major cause of our problems in health care costs and quality.[1] This "fee-for-service" (FFS) system incentivizes the delivery of more tests and procedures at greater cost regardless of whether they improve health or reflect the patient's own preferences. Fixing provider payment across a range of payers is vital if we are to achieve better health outcomes at a lower cost for all.

This fact sheet examines three proposals that may revamp how the largest purchaser of health care in the nation, Medicare, reimburses health care providers.

Replace SGR with Value-based Payment

U.S. Representatives Allyson Schwartz (D-PA) and Joe Heck (R-NV), the U.S. House of Representatives' Committee on Energy and Commerce, the Medicare Payment Advisory Commission (MedPAC), and the Physican Payment Reform Commission have embraced similar strategies for reforming Medicare payment policy.[2,3,4] Each of these approaches begins with permanent repeal of the Sustainable Growth Rate (SGR) formula for physician payment and stabilization of current FFS provider payment for a multi-year period of transition. During this period of transition, Medicare would be charged with aggressively testing new provider payment models and identifying the most successful models. At the conclusion of the period of transition, providers who improved their performance or moved to the new models would see modest improvements to their pay, while those who remained under an unreformed FFS model would see their compensation gradually fall behind that of their colleagues.

Pros

These proposals would accelerate testing of value-based payment models and create strong economic incentives for physicians to adopt those models. Provided that these value-based payments are adjusted based on patients' health status and socio-economic status, this approach could create a powerful incentive to focus on care coordination, disease management, and transitional care for those vulnerable patients with the greatest need and the greatest costs.

Cons

Some argue that FFS, for all its faults, is necessary to assure access to care in sparsely populated rural areas and for certain services like intensive care for poor prognoses.[5] To this line of thinking, incentivizing participation in Accountable Care Organizations (ACOs) and other payment models could reduce the supply of providers in those areas or specialties.

[1]Institute of Medicine (2010). The Healthcare Imperative: Lowering Costs and Improving Outcomes. Washington, DC: The National Academies Press.
[2]Office of Representative Joe Heck (2012). Heck and Schwartz Introduce Legislation to Repeal the SGR and Reform Medicare Physician Payment System. Retrieved from http://heck.house.gov/press-release/heck-and-schwartz-introduce-legislation-repeal-sgr-and-reform-medicare-physician
[3]House Committee on Energy and Commerce (2013). Proposed SGR Legislation. Retrieved from http://docs.house.gov/meetings/IF/IF14/20130722/101205/BILLS-113DiscussionDraftpih-DiscussionDraft.pdf
[4]Medicare Payment Advisory Commission (MedPAC) (2011). Moving forward from the sustainable growth rate (SGR) system. Retrieved from http://www.medpac.gov/documents/10142011_medpac_sgr_letter.pdf
[5]Bindner, Michael G. (2013). Comments for the Record: U.S. House of Representatives, Committee on Ways and Means, Subcommittee on Health. Retrieved from http://fiscalequity.blogspot.com/

Strengthening IPAB

The 2010 Affordable Care Act included a provision that established the Independent Payment Advisory Board (IPAB). The panel's 15 members are tasked with achieving specified levels of savings in Medicare without negatively affecting coverage or quality. If spending on Medicare providers exceeds the rate of overall economic growth plus one percentage point, IPAB must submit to Congress recommendations on how to slow that growth. These recommendations are limited to payment and are prohibited from reducing coverage or benefits. Unless Congress substitutes an equal amount of savings or a three-fifths majority overrides the recommendations without replacement, the Department of Health and Human Services must implement IPAB's proposals.

The Committee for a Responsible Federal Budget has suggested broadening IPAB's mandate by allowing IPAB to reduce the spending growth threshold, eliminating the temporary exemptions for hospitals, and imposing payment reforms on private plans in state exchanges, among several other ideas.[6] President Obama's 2013 budget proposal also recommends tightening the growth threshold and granting IPAB the authority to implement value-based benefit design.[7]

Pros

Supporters argue that IPAB, with its prohibition on benefit cuts, can help reduce the cost of Medicare over time while protecting beneficiaries. They contend that IPAB has the capacity to push forward payment reforms, like further steps toward accountable care and medical homes, which Congress under pressure from provider lobbies could be unable to achieve on its own.

Cons

Opponents across the political spectrum have criticized the concept of the IPAB as excessive delegation of Congressional power to an unelected body. Even if IPAB successfully imposes payment changes, critics argue that the savings would largely come in the form of across-the-board payment cuts, not real improvements in efficiency. As a result, many providers would simply raise prices for consumers with non-Medicare insurance to compensate for those cuts. If this is true, consumers (including vulnerable populations that rely on individual plans, employer-provided coverage, or Medicaid), could see some impact on affordability.

Value-Based Withhold

Drs. Elliott Fisher, James Weinstein, and Jonathan Skinner of the Dartmouth Institute of Health Policy and Clinical Practice have proposed using a "withhold" approach to slow Medicare spending.[7] Under this model, providers in a health care region or network would be given a savings target that is somewhat lower than the projected costs. The target would be risk-adjusted to ensure that providers have strong incentives to seek out patients from vulnerable communities or with multiple health conditions.

Over the course of the year, the providers would bill for their Medicare patients as usual, but Medicare would withhold a percentage of the providers' reimbursements. If the provider group's annual billing is no higher than the savings target and if its performance on measures of care quality is strong, Medicare would return all of those withheld monies to the providers. If the actual costs do not hit the savings target but still come in lower than the costs that their patients are expected to generate, Medicare would return a portion of the withheld amount to the providers. And finally, if costs are at or above the expected level of expenditures, Medicare would not return any of the withheld amount.

The withhold design can most effectively be implemented with ACOs which are explicitly designed to be responsible for population spending and health. Provider services not associated with an ACO or managed care plan would be paid based on the performance of all of the providers in the region.

Pros

The withhold approach creates incentives for providers to move to integrated delivery models (i.e. ACOs). According to supporters of this approach, it could also motivate those providers not involved in integrated care systems to work with other providers in their region to improve access to preventative care, care coordination, and disease management, which vulnerable patients need.[9]

Cons

Critics may argue that this policy unfairly imposes a pay cut on all providers in a region regardless of whether they individually are practicing high-quality medicine or not. Depending on the size of the withhold, a value-based withhold could discourage some providers from participating in Medicare. This could constrict vulnerable beneficiaries' access to the providers of their choice.

[6]Committee for a Responsible Federal Budget (2010). Let's Get Specific: Health Care. Retrieved from: http://crfb.org/sites/default/files/Lets_Get_Specific_Health_Care.pdf
[7]President's Fiscal Year 2013 Budget of the U.S. Government. Retrieved from http://www.whitehouse.gov/sites/default/ files/omb/budget/fy2013/assets/budget.pdf
[8]Skinner JS, Weinstein JN, and Fisher ES (2012). Withholds to Slow Medicare Spending: A Better Deal than Cuts. JAMA, 307(1), 43-44. doi: 10.1001/jama.2011.1946.
[9]Ibid.