

Medicare Payment Systems

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Disclosure and a Caveat

- I am a director of Aetna
- Medicare's reimbursement systems are complex; I will leave out many details and try to focus on the main ideas

The Inpatient Prospective Payment System (IPPS)

- Since 1983 Medicare has used the IPPS to pay most hospitals, \$147 billion (2014)
- It's a take-it-or-leave-it price, no negotiation
- Starts with a per stay (per admission) base payment and makes some adjustments
 - ◆ Physician services are excluded from the IPPS
 - ◆ A detail: There are separate systems for operating and capital expenses, but they function similarly

The IPPS: The Base Payment

- All admissions are classified into one of 751 groups defined by the principal diagnosis, whether there are additional diagnoses and how severe the diagnosis is (“complication or comorbidity” or “major complication or comorbidity”), and whether certain procedures were done
 - ◆ The groups are called MS-DRG’s

The Base Payment, cont.

- Each group has a weight that corresponds to Medicare's estimate of its relative cost
 - ◆ For example, the weight for a bone marrow transplant is 4.37 and for a prostatectomy is 1.0, so, other things equal, the hospital is paid 4.37 times as much for the bone marrow transplant*
- Each year Congress sets a “conversion factor,” which says how many dollars will be paid for a weight of 1.0; future conversion factors were reduced to pay for the ACA

*These are the weights with no complicating conditions. If there are complicating conditions, the weights are higher.

The Wage Adjustment

- Each hospital is classified into a labor market area and hospitals are paid more or less according to how high wages are in that area
 - ◆ Massachusetts has had an exception for the wage index for the past few years, although it will lose that for 2017 through an error
 - Massachusetts hospitals will lose \$160 million*

*Boston Globe, May 2, 2016; CMS denied Massachusetts' appeal to rectify the error on August 2.

Other Adjustments

- The IPPS also has hospital-specific payments: Graduate Medical Education (GME) \$ and Disproportionate Share Hospital (DSH) \$
 - ◆ GME's intent is to reimburse the higher costs of teaching hospitals; it multiplies the base amount by a multiple of the number of residents/bed and also reimburses a percentage of resident salaries
 - ◆ DSH's intent is to help pay for uncompensated care; it pays hospitals with high numbers of Medicaid patients more
 - It is being reduced as the uninsured rate comes down

Other Adjustments, cont.

- Outliers: 5% of base payments go to pay for individuals with very costly stays; these payments are budget neutral
- Technology: Certain expensive new technologies get add-on payments since the base weight does not account for them
- Bad debt: Medicare reimburses for 65% of Medicare bad debt

Other Adjustments, cont.

- Quality/Value-Based Purchasing:
 - ◆ Penalties for excessive readmissions: Imposed on 78% of hospitals nationally in 2016; but only 15% of hospitals lost 1% or more of Medicare revenue and only a few lost the maximum 3%
 - ◆ Around 2% of base payments were redistributed according to quality measures, including infection rates

Incentives of the IPPS

- Per stay payment \Rightarrow incentive for *efficiency*
 - ◆ Major reduction in length of stay
- Within-MS-DRG variation \Rightarrow incentive for *selection*
 - ◆ Early evidence* of modest “dumping” (selecting against high cost cases) to safety net hospitals (generally public hospitals) and also to exempt** hospitals which continued on cost reimbursement up to a limit; those studies have not been repeated

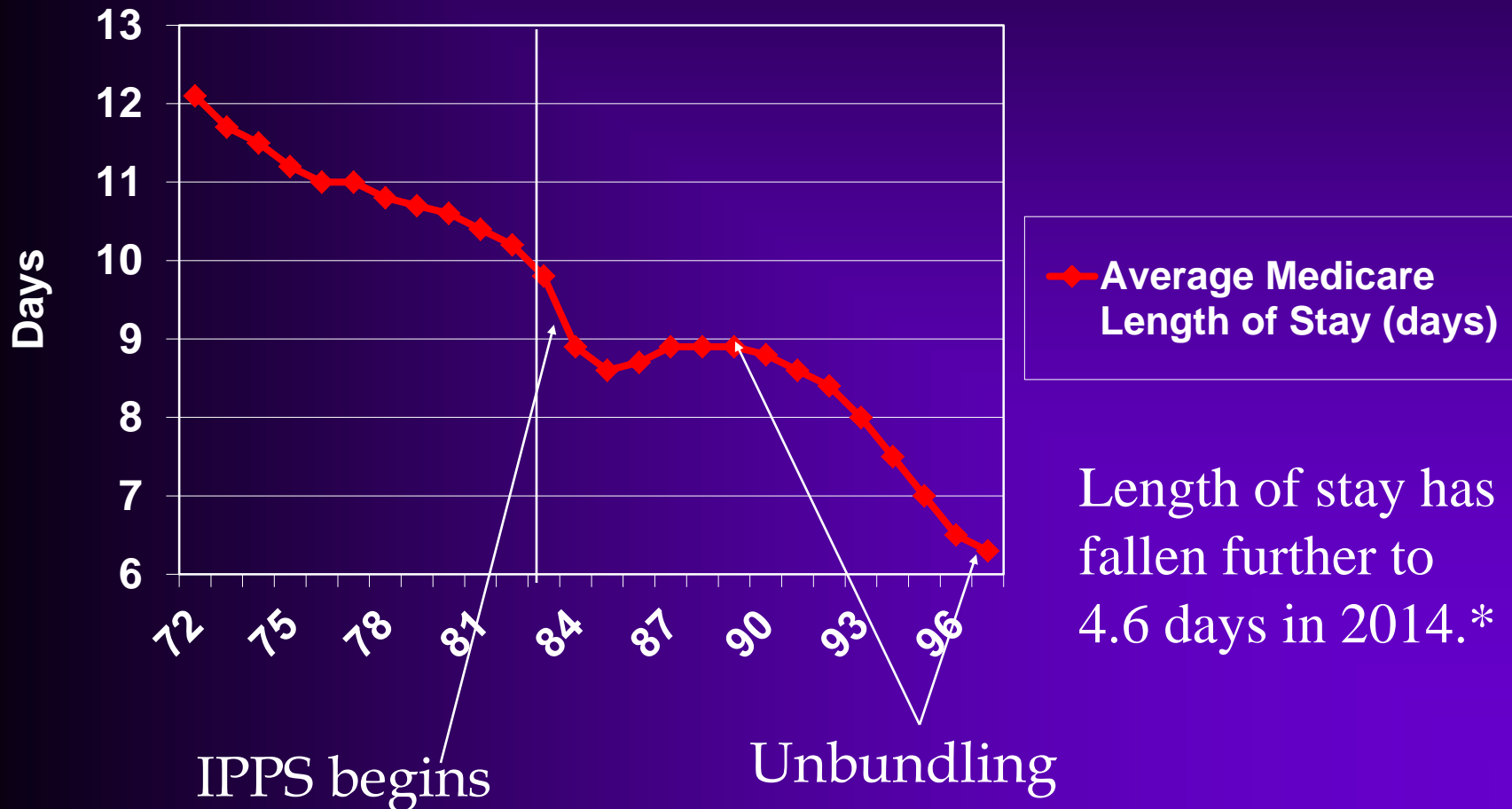
*Dumping to last resort: Newhouse, HCFR, 1989; to exempt hospitals: Newhouse and Byrne, JHE 1988.

**Psychiatric, rehabilitation, and long-term hospitals were initially exempt from the IPPS.

Incentives of the IPPS, cont.

- Marginal Revenue = 0 \Rightarrow incentive to *unbundle* and possibly *stint*
 - ◆ Growth of post-acute and outpatient services since the 1980's from unbundling (shifting last days of stay out of inpatient to post-acute)

Fall in Hospital Length of Stay*



*Sources: HCFA Statistical Supplement, 1999, p. 130 and MedPAC Data Book 2016, Chart 6-9.

The Outpatient Prospective Payment System (OPPS)

- System used for hospital outpatient departments (OPD's) excluding MD's; \$53 billion (2014)
- Introduced in 2000, same principle as IPPS
- Uses Ambulatory Payment Classification (APC's), similar to MS-DRG's, 700 groups
- Adjustments: Wage index, new technology

Physician Payment: The Medicare Fee Schedule (MFS)

- For decades Medicare paid fee-for-service, some change lately; \$69 billion in 2014*
- CMS specifies relative fees for 7,000-8,000 procedures and services; Congress sets a conversion factor
- Also adjusted by an input price index
- Separate components for “work” (take-home), practice expense, malpractice cost

*Includes payments to allied health personnel such as psychologists and chiropractors, but the great bulk is to physicians.

Incentives of the MFS

- To cover fixed cost (e.g., rent) fees must exceed marginal cost, so an MD paid this way can always earn more by doing more
- How to handle “practice costs” for the same service across different sites has been a problem

Site-of-Service Differentials

- Medicare reimbursement for facility costs *for the same procedure* differs by site: OPDs; MD offices; ASCs;* inpatient hospitals
 - ◆ These are “practice expenses” in MD offices; APC amounts include these costs in ASC weights, as do MS-DRG weights in hospitals
 - ◆ Because the three** payment systems differ, payment for same patient getting the same procedure differs by site

*ASC = Ambulatory Surgery Center. Procedures commonly done in ASC's include cataract removal and colonoscopy.

**3 systems: MD office, OPD's and ASC's, inpatient hospital.

A Site-of-Service Differential*

**TABLE
2-1**

Medicare and beneficiaries pay more for a 15-minute E&M office visit provided in an OPD than in a freestanding physician's office, 2013

	Service provided in freestanding physician practice*	Service provided in OPD		
		Physician facility rate*	OPPS rate	Total, OPD rate
Program payment	\$58.00	\$39.76	\$58.94	\$98.70
Beneficiary cost sharing	14.50	9.94	14.74	24.68
Total payment	72.50	49.70	73.68	123.38

Note: E&M (evaluation and management), OPD (hospital outpatient department), OPSS (outpatient prospective payment system). The Current Procedural Terminology code for this visit is 99213.

*Paid under the Medicare physician fee schedule.

Source: MedPAC analysis of payment rates in the 2013 physician fee schedule and OPSS.

Medicare paid 70% more ($=123.38/72.50$) for a 15 minute physician visit in the hospital OPD than for the same 15 minute visit in an office.

*Source: MedPAC, June 2013.

Another Site-of-Service Differential*

Reimbursement was almost double (\$738/\$389) in the OPD

Table 2. Payment rates to physicians and OPDs for laser eye procedures, 2012

	Payment amount	Calculation
Current payment rates		
<i>Service in physician office</i>		
Payment to physician	\$389.01	Work/PLI (\$171.53) + Non-Facility PE (\$217.49)
<i>Service in OPD</i>		
Payment to physician	359.51	Work/PLI (\$171.53) + Facility PE (\$187.98)
Payment to hospital	378.93	Hospital outpatient department rate (\$378.93)
Total payment	\$738.44	
Policy that aligns rates across settings- <i>Service in OPD</i>		
Payment to physician	359.51	Work/PLI (\$171.53) + Facility PE (\$217.49)
Payment to hospital	29.51	Non-Facility PE (\$217.49) - Facility PE (\$187.98)
Total payment	\$389.01	

Note: OPD (hospital outpatient department), PLI (professional liability insurance) PE (practice expense). Payments include both program spending and beneficiary cost sharing.

Source: MedPAC analysis of payment rates in the 2010 physician fee schedule and outpatient prospective payment system.

*Source: MedPAC staff presentation, October 2012.

Why Are Many Cardiologists Becoming Hospital Employees?

- Medicare has, seemingly unwittingly, been driving a major change in the organization of US medical care; MD's historically were self-employed in small scale practices; increasingly they are becoming employees of large practices

Payment for Echocardiograms in the OPD Is 2.5X the Office!

**TABLE
2-3**

Differences in payment rates for level II echocardiogram without contrast provided in physician's office and OPD, 2013

	Payment amount	Calculation
Current payment rates		
<i>Service in physician's office</i>		
Payment to physician	\$188.31	Work (\$) + PLI (\$) + nonfacility PE (\$)
<i>Service in OPD</i>		
Payment to physician	\$62.40	Work (\$) + PLI (\$) + facility PE (\$)
Payment to hospital	\$390.49	OPPS rate (\$)
Total payment	\$452.89	

If the cardiologist is a hospital employee, the hospital can share the difference in reimbursement with the cardiologist.

The Consequences

Table 9. E&M office visits and cardiac imaging services are migrating from freestanding offices to HOPDs, where payment rates are higher

Type of service	Share of ambulatory services performed in HOPDs, 2012	Per beneficiary volume growth, 2010-2012	
		Freestanding office	HOPD
E&M office visits (CPT codes 99201–99215)	10.7%	-2.3%	17.9%
Echocardiograms without contrast (APCs 269, 270, 697)	34.6	-9.9	33.3
Nuclear cardiology (APCs 377, 398)	39.0	-16.8	24.3

Note: E&M (evaluation and management), HOPD (hospital outpatient department), CPT (Current Procedural Terminology), APC (ambulatory payment classification).

Source: MedPAC analysis of Standard Analytic Claims Files from 2010, 2011, and 2012.

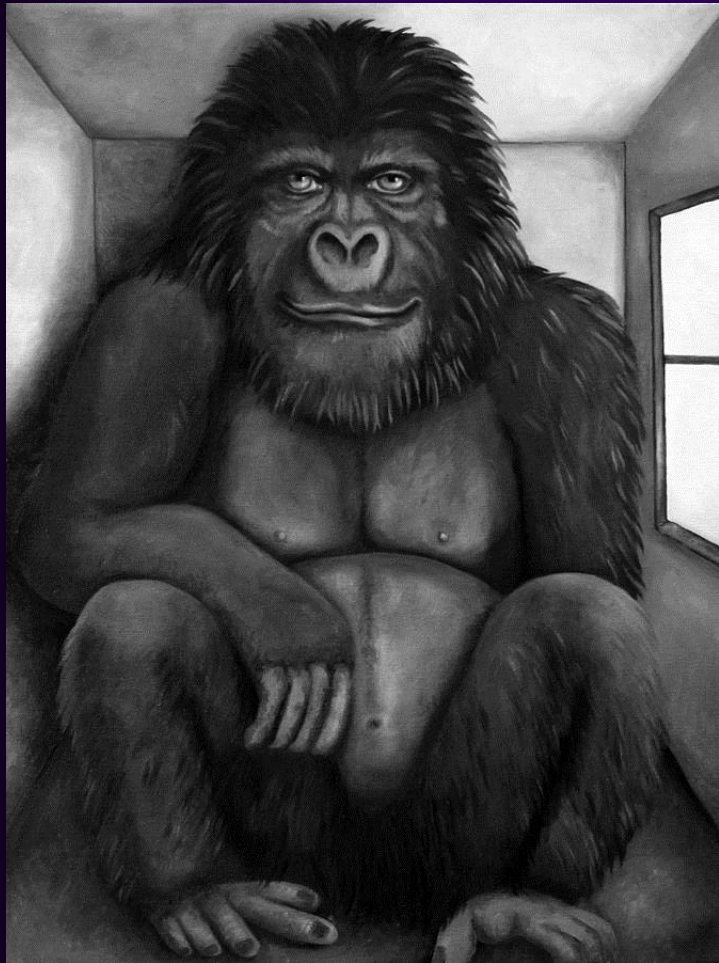
HOPD = Hospital Outpatient Department. See notes to slide for other acronyms.

Source: MedPAC, unpublished. MedPAC has also computed data for 2013-2014 changes for echocardiograms (-5.7% in the office, +7.0% in the HOPD) and nuclear cardiology (-9.6% in the office, +1.1% in the HOPD).

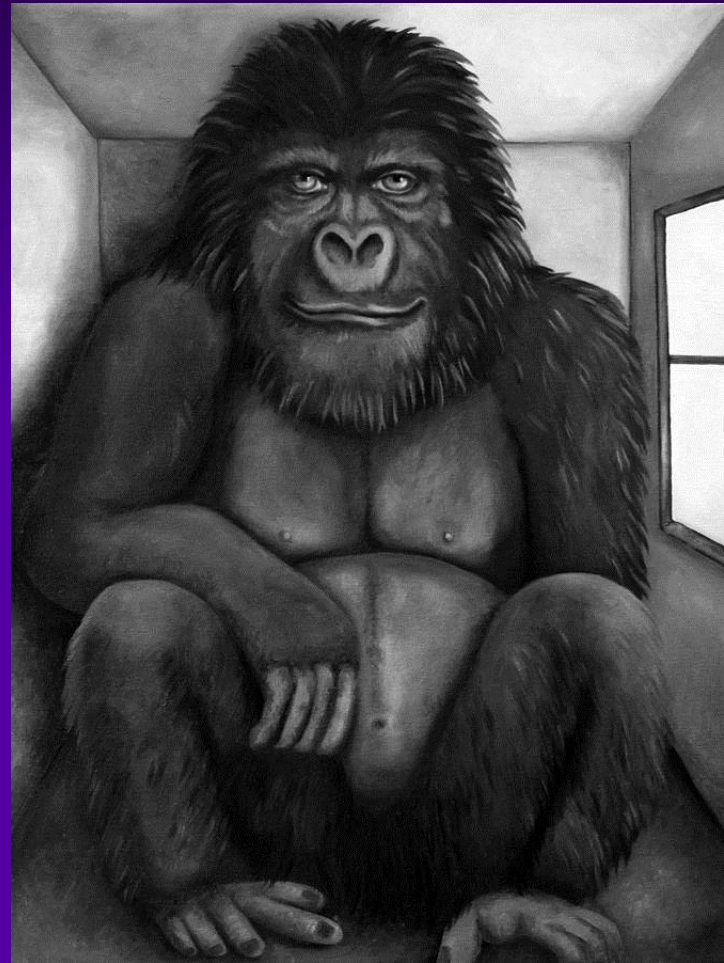
A Bow in the Direction of a Fix

- The Bipartisan Budget Act of 2015 allowed the site-of-service differentials for existing hospitals to remain in place, but restricted new ones
 - ◆ My take: The horse is out of the barn

Health Policy Has Recently Seen Two 800 Pound Gorillas



The ACA



MACRA

MACRA: In 2019 Medicare Physician Payment Changes

- Starting in 2019, almost all MD's will be paid under one of two new payment models, the Merit Based Incentive Payment System (MIPS) or Advanced Alternative Payment Models (APM's); CMS estimates 90% will be paid under the MIPS, and I will focus on the MIPS

The New Payment Methods

- ◆ CMS issued a proposed rule in April 2016 (900+ pages)
- ◆ MIPS: Payments to an individual MD can go up or down 4% in 2019, 5% in 2020, 7% in 2021, and 9% after that based on quality, use of EHR's, clinical practice improvement, and cost*
 - The actual adjustments for any individual MD will depend on the distribution of scores to in order achieve budget neutrality

*Plus there is an extra 10% bonus for "exceptional" performance that is not subject to the budget neutrality adjustment, \$500 million in total.

MIPS, cont.

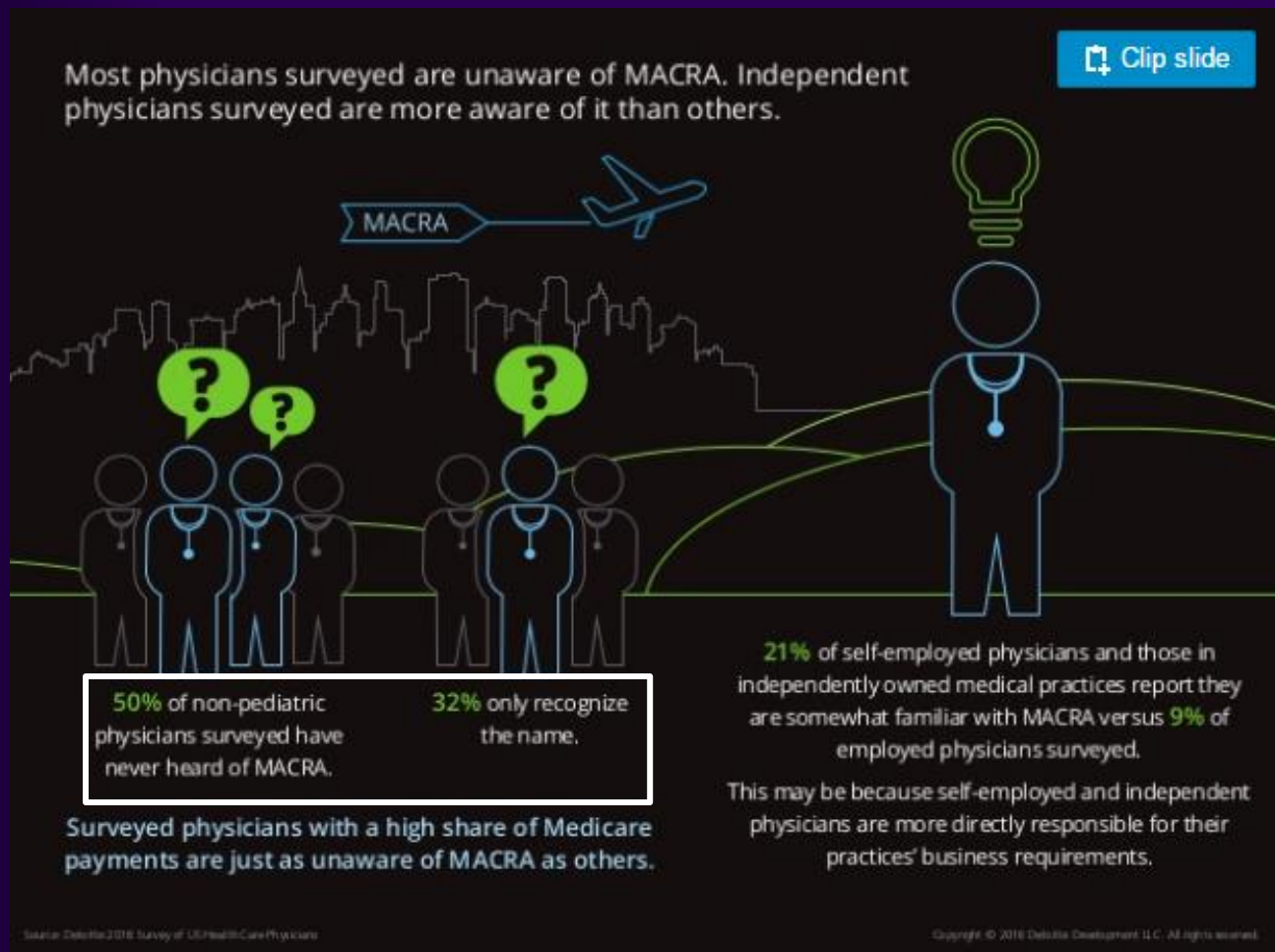
- Although the payment adjustments ($\pm 4\%$ in 2019 for incentive payments, going up to $\pm 9\%$ in 2022) don't start until 2019, **they are based on performance in 2017** and then the adjustment is applied to Traditional Medicare billings in 2019, so from an MD's point of view the new system starts in a few months

The Politics of MACRA

- MACRA was enacted with substantial bipartisan support so although the details may be modified, it is likely to remain policy irrespective of the election results*
 - ◆ The many Republican bills in the House to repeal the ACA exempted its delivery system reforms, which was the heart of the changes in MACRA

*I expect the Final Rule to be issued in November.

Despite MACRA's Importance Most MD's Don't Know of It*



*Source: <http://www.slideshare.net/DeloitteUS/2016-survey-of-us-physicians-physician-awareness-perspectives-and-readiness-for-macra>

And MD's Like FFS Reimbursement or Salary*

Many physicians surveyed will have to adjust their current approach and practice management based upon MACRA's specifications. For example they have low preference for most value-based payment models.

Surveyed physicians reported that they prefer traditional compensation models.



Nearly 8 in 10 physicians surveyed prefer fee-for-service or salary for their compensation.

Performance bonuses currently are less than 10% of current compensation or non-existent for majority of physicians surveyed.

51% of physicians surveyed report receiving performance bonuses that are less than or equal to 10% of their total compensation.

33% of physicians surveyed report that they are not eligible for performance bonuses.

71% of physicians surveyed would participate in value-based payment models if offered financial incentives to do so.

52% of physicians surveyed would opt for shared savings, which is not a qualifying Advanced Alternative Payment Model (APM) under MACRA.



Source: Deloitte 2018 Survey of US Health-Care Physicians

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*Source: Same as prior slide.

And a Month Ago CMS Took Its Foot Off the Gas Pedal

- September 8, 2016: CMS says it will effectively allow a physician to push implementation off a year; all he or she has to do to avoid a negative adjustment is to report some (as yet unspecified) data
- Or the physician can report for part of the year and get a positive adjustment
- Or he or she can participate in the MIPS or the APN as originally specified

My Take on Future Physician Payment

- Moving from the fee-for-service system is going to be a slow process
- Even if an organization like an Accountable Care Organization takes some financial risk, individual physicians may have a large part of their compensation paid under fee-for-service

Conclusions

- Running administered price systems like Medicare's is difficult; prices that are misaligned with cost induce distortions, which may be under- or overprovision of various services or shifts to employed physicians
 - ◆ New products and gains in productivity from experience are hard to account for

Supplemental Slides

The Merit Incentive Payment System (MIPS)

Box. The 4 Components of the Composite Performance Score of the Merit-Based Incentive Payment System

Quality (50% Decreasing to 30% in 2021)

Physicians must report on at least 6 quality measures, including 1 outcome measure if available, from an annually updated inventory (example outcome measures include functional improvement following surgery and depression remission).

Resource Use (10% Increasing to 30% in 2021)

These measures will be calculated by CMS using claims, including 2 general measures that assess the total cost of care for beneficiaries during a year or surrounding a hospitalization, as well as 40 clinical episode measures, as a basis for rewarding efficient physicians.

Advancing Care Information (25%)

This category replaces meaningful use measures on health information technology with fewer and more flexible reporting requirements intended to promote interoperability and data flow relevant to a physician's practice, rather than electronic health record capabilities per se.

Clinical Practice Improvement Activity (15%)

Clinicians must attest to several of a wide range of practice-level activities, such as delivery of telehealth services, participation in registries, and provision of 24/7 access.

Fee-for-service remains; these are adjustments up or down to a physician's payments under TM; more in class 15. CMS estimates ~90% of MD's will be in MIPS in 2019.*

MACRA Pushes MD's Toward Risk-Based Entities*

Provisions Related to Advanced Alternative Payment Models

For clinicians who take a further step towards care transformation, the law creates another path. Clinicians who participate to a sufficient extent in Advanced APMs would qualify for incentive payments.

Importantly, the law does not change how any particular APM rewards value. Instead, it creates extra incentives for participation in Advanced APMs. For years 2019 through 2024, a clinician who meets the law's standards for Advanced APM participation is excluded from MIPS adjustments and receives a 5 percent Medicare Part B incentive payment. For years 2026 and later, a clinician who meets these standards is excluded from MIPS adjustments and receives a higher fee schedule update than those clinicians who do not significantly participate in an Advanced APM.

Standards for Advanced Alternative Payment Models (APMs)

Under the law, Advanced APMs are those in which clinicians accept risk for providing coordinated, high-quality care. As proposed, to be an Advanced APM, models must be a CMS Innovation Center model or a statutorily required demonstration and must generally:

- 1. Require participants to bear a certain amount of financial risk.** Under our proposal, an Advanced APM would meet the financial risk requirement if CMS would withhold payment, reduce rates, or require the entity to make payments to CMS if its actual expenditures exceed expected expenditures.

APM's

- 5% bonus on TM payments for being in an APM; APM's may be Patient Centered Medical Homes or risk-bearing entities like an Accountable Care Organizations, but they have to save money to qualify for a bonus and the amount of financial risk necessary to qualify rises over time*
- Starting in 2026 physicians in APM's are to get 0.75 pct pt updates vs 0.25 for others**

*See slide above; the proposed rule also pushes delivery systems or physician groups toward risk-based contracting in commercial insurance, since commercial contracts count starting in 2021. **This compounds over time.