The Medicare Payment Perspective

Presentation at:
Pursuit of Value for Medical Devices Strategies for Collaboration Conference

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May 22, 2008

Agenda

- The Evolving Medicare Perspective
- Imaging Services
- Comparative Effectiveness
- Public Disclosure
- Gainsharing
- Bundled Payments and Episodes of Care
- Value-Based Purchasing
- Summary

The Evolving Medicare Perspective

The intersection of business strategy and public policy

Evolving Medicare Perspective Can be Traced Through the Medicare Payment Advisory Committee (MedPAC)

Purpose

- MedPAC is an independent Congressional agency established by the Balanced Budget Act of 1997 (P.L. 105-33) to advise U.S. Congress on issues affecting the Medicare program

Charge

- Although MedPAC's charge is broad, many would consider MedPAC's primary charge to review the "adequacy" of the Medicare payment system for the many types of health care services Medicare funds. The specific criteria used to determine "payment adequacy" vary by service but usually fall within three general categories:
  - » Cost
  - » Quality
  - » Access

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New Focus

Origin

- Increasingly serious concerns about the sustained financial viability of the Medicare system in the past two years

Result

- Future/new MedPAC research will focus on ideas for improving the Medicare program's sustainability through payment and delivery system reform.

Philosophy: From the March Meeting

- *Framework for Evaluating Reform/Determining Value.* Value in the fee-for-service (FFS) Medicare program will be determined by four measures: access to clinically necessary care; quality; efficient use of resources; and equity across providers and beneficiaries. Principles for improving value include: promoting accountability and care coordination; better information; improved incentives for efficiency rather than for increased volume; and setting accurate prices.
- *New Initiatives to Address Present System Shortcomings.* The present Medicare FFS system rewards increased volume and hinders coordinated care. Past MedPAC recommendations suggested tools to promote value and efficiency. Future tools may include accountable care organizations, payment bundling, and a medical home concept.

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Services “Regularly” Reviewed

- Physician services (including those involving use of technology);
- Outpatient dialysis;
- Acute care hospitals – inpatient and outpatient services;
- Skilled nursing facilities;
- Home health care;
- Inpatient rehabilitation facilities;
- Long-term care hospitals;
- Medicare Advantage plans, including special needs plans;
- Medicare Part D – self-administered drug benefit;
- Durable medical equipment;
- Psychiatric hospital services;
- Critical access hospital services; and
- Ambulatory surgery centers.

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New Research Areas

- Fee-for-service benefit redesign;
- Bundled payment around a hospitalization or outpatient procedure;
- Hospital-based value purchasing;
- Mandating public reporting of physicians' financial relationships with drug and device manufacturers, hospitals, and ambulatory surgery centers;
- More effective hospital-physician relationships;
- Comparative effectiveness information production;

Areas discussed today; many common themes

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Imaging: As Seen Through the “Old” But Not Disappearing Lens

Imaging Recommendations (2006-On)

Genesis	Implementation Details	Current Situation
Dramatic growth in volume and intensity of services (62% between 1999 and 2004 – versus 31% for all physician services, with MRI alone increasing 140%)	Select private sector organizations to administer standards	No national/ some limited local Medicare standards applied to physician offices and interpretation; some modalities (such as MRI) not covered by any government standards
Regional variation, calling into question appropriateness of use (3:1 difference at extremes)	Require physicians to meet quality standards as condition of payment	Bill mandating quality standards in Congressional conference committee
Quality variation (uncovered by health plans, professional associations)		

#1 Set standards for all providers who bill Medicare for performing and interpreting diagnostic imaging studies

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Imaging Recommendations

Genesis	Implementation Details	Current Situation
Regional variation in practice patterns, calling into question appropriateness of use (3:1 difference at extremes)	Use Medicare claims to measure physicians' resources and confidentially report results to physicians	No profiling of this type in existence
	Educate physicians about resource use and encourage change in practice patterns	
	Eventually, should be performed as part of larger initiative in which a broad array of services for episodes of care is measured; one method is an episode grouper	

#2 Measure physicians' use of imaging services so that physicians can compare their practice patterns with those of their peers

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Imaging Recommendations

Genesis	Implementation Details	Current Situation	#3 Improve Medicare's coding edits that detect unbundled diagnostic imaging services and reduce technical component payment for multiple imaging services performed on contiguous body parts
Dramatic cost increase accompanying volume and service intensity increase; over 60 percent, from $5.7 billion in 1999 to $9.3 billion in 2003	Design and implement more extensive payment algorithms for like diagnostic imaging procedures that could be bundled for payment purposes and the logic system for electronic claims processing support	CMS* adopted recommendations to reduce payments 25% for multiple imaging services performed on contiguous body parts in the same session	
Private health plan adjustments of recommended type but no Medicare adjustments		Bill recommending 50% reduction in payment for multiple imaging services in Congressional conference committee	

*CMS=Centers for Medicare and Medicaid Services

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Imaging Recommendations

Genesis	Implementation Details	Current Situation
Physician ownership of health care facilities may create a financial incentive to order additional services; GAO* and other studies support hypothesis	Include nuclear medicine and PET procedures as designated health services under the Ethics in Patient Referrals	Nuclear medicine added to list of "designated health services" modalities, effective in 2007
The Ethics in Patient Referrals ("Stark") Act prohibits physicians from referring Medicare or Medicaid patients for "designated health services" (inc. radiology, MRI, CT, and ultrasound) to providers with which the physician has a financial relationship, and such entities from submitting associated claims to Medicare	Expand the definition of physician ownership in the Ethics in Referrals Act to include interests in an entity that derives a substantial proportion of its revenue from a provider of designated health services (e.g., would eliminate physicians' ability to buy a machine, lease it to an imaging center, and be reimbursed a fixed amount per use)	

#4 Strengthen the rules that govern physician investment in imaging centers to which they refer patients

*GAO=Government Accountability Office

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Imaging Recommendations

#5 Improve accuracy of imaging payment rates

Genesis	Implementation Details	Current Situation
Rates based on historical charges	Use new survey data to revise rates downward	No enacted-upon follow-up
Technical component of imaging services payment too high: based on assumption that machine used 50% of time and owners pay 11% interest rate (not supported by surveys)		
Also - observation made that payment levels too much in “high-cost” areas (derivative of prior point) - but no recommendations made		

The New Lenses: Comparative Effectiveness

MedPAC Comparative Effectiveness Recommendation (2007)

Genesis	Implementation Details	Current Situation
Expanding share of US resources spent on health care; value of services furnished to patients unknown	Independent entity with secure, sufficient funding source producing objective information and operating a transparent inquiry process	Entity under consideration; CBO* and others costing implementation; estimates vary significantly
Insufficient credible, empirically-based information for health care providers and patients to make informed decisions about alternative services	Re-examine comparative effectiveness interventions over time and disseminate information to patients, providers, and payers	
Potential to promote care of higher value and quality in both the public and private sectors	Play no role in making or recommending coverage or payment decisions for payers	

Charge an independent entity to sponsor credible research on comparative effectiveness of health care services and disseminate this information to patients, providers, and payers

*CBO=Congressional Budget Office

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Enter: Medical Coverage Advisory Committee (MedCAC)

Purpose

- Established to provide independent guidance and expert advice to CMS on specific clinical topics

Charge

- Explore issues related to specific national coverage decisions (NDCs)
- Explore more general issues not related to NDCs
- Provide insight into complex, sensitive, impactful issues

Composition

- Up to 100 members with expertise in clinical sciences, basic science, administration, patient advocacy, health data, economics, ethics, and other areas

Meeting Process

- Approximately 15 members and guests with expertise in specific area selected for each meeting
- Periodic meetings throughout year - last one in April, 2008

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MedCAC Considering Its Research Priorities - Many of Which Include Comparative Effectiveness

Cardiovascular	Orthopedic	Other Device-Related
Cost effectiveness of CT angiography for cardiovascular imaging (9,7*)	Comparative effectiveness of bone density testing and impact on outcomes (9,8)	Benefits of neuroimaging modalities for headache (4, -)
Best imaging modality for patients with angina (7,9)	Comparative effectiveness of surgical vs. medical management for osteoarthritis (6, -)	Appropriate indications for diagnostic spirometry in lung disease (8,5)
Vascular imaging's impact on clinical practice (7,-**)	Effectiveness of spinal cord stimulation (5,7)	Benefit of hearing aids on cognitive function (9,6)
Screening for atherosclероic disease: impact on outcomes and cost effectiveness assessment (9,7)	Clinical and cost effectiveness of vertebral plasty (8,5)	Use of laryngeal stimulators in reduction of aspiration pneumonia in patients with dysphasia (8,4)

* Indicates scores on scale of 0 to 10 in two rating sessions prior to most recent, with 0 being lowest and 10 highest priority
** Indicates rating not available

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Many Highest-Rated MedCAC Research Priorities are in Cardiovascular and Orthopedic Areas

Cardiovascular	Orthopedic	Other Device-Related
Comparative use of coronary artery angioplasty and stenting versus medical therapy use (8,5*)	Comparative effectiveness of medical versus surgical treatment of spinal stenosis (8,0)	Development of deep brain stimulation for elderly Parkinson's disease patients (6,0)
Comparative effectiveness of treatments for carotid artery disease (6, -**)		Optimal use of vacuum-assisted closures and static and fluidized air mattresses (6, -)
Aerobic fitness interventions and health benefits for patients with ischemic heart disease (10,4)		What are the outcomes associated with minimally invasive procedures for BPH? (5, -)

* Indicates scores on scale of 0 to 10 in two rating sessions prior to most recent, with 0 being lowest and 10 highest priority
** Indicates rating not available

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Public Disclosure

MedPAC's Support for Public Disclosure

Genesis	Implementation Details	Current Situation
Some provider/ manufacturer interactions can lead to technological advances; others may undermine independence and objectivity (2007 settlement between DOJ* and device manufacturers on matter of consulting orthopedic surgeons)	To be worked out	Working version of S. 2029 Physician Payments Sunshine Act of 2008 (in committee), revised from first introduction in 2007 (see next page)
Various private and public organizations have attempted to set standards for relationships; many have shortcomings		"Awareness" of physician-owned implant and other medical device companies (POCs)
MedPAC considering a federal law requiring reporting of relationships		

Unanimous support for the need for public reporting but agreement that details of implementation (agency, amount, *et al*) need to be spelled out before making recommendation (March 2008)

*DOJ=Department of Justice

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Summary of S. 2029 Physician Payments Sunshine Act of 2008, as of May 13, 2008

Reporting

- Beginning 3/31/2011
- Requires drug and device companies to report annually any payment or transfer of value to any physician
- Also requires reporting of physician ownership of any drug or device manufacturer, group purchasing organization, or distributor

Penalties

- $1,000 to $5,000 per failure to report, with an annual cap of $50,000, and $5,000 to $50,000 per knowing failure to report, with an annual cap of $250,000

Website

Preemption of State Reporting Requirements

Definitions

- Covered drug, device, or medical supply: any drug, biological product, device, or medical supply for which payment is available under Title 18, or a state plan under Titles 19 or 21 of the Social Security Act
- Covered recipient: a physician, a physician medical practice, or an entity or individual that receives payment at the request of or designated on behalf of a physician
- Payments or other transfer of value: a transfer of anything of value in the case where the aggregate amount transferred to a covered recipient during a calendar year exceeds $500
- Such term does not include: anything below $25, product samples intended for patients, certain educational materials, certain direct training, equipment loans, a transfer to a physician in a patient capacity, discounts and rebates, anything nominal in value, or in-kind items used for the provision of charity care
- Physician: has the meaning given that term in section 1861(r), and does not include full-time employees of manufacturers

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Direct-to-Consumer (DTC) Advertising - an Emerging Issue

Genesis	Implementation Details	Current Situation
Some suggest that growth in DTC ($791 million in 1996 to $3.2 billion in 2003) is a major contributor to higher drug costs	FDA* process to review and approve materials	Congressional pleas to add to FDA funding for greater ability to fulfill role in this area
As more is spent on prescription drugs technology the value of DTC must come into question	GOA report (2006) that FDA reviews only small proportion of DTC materials and cannot make review a priority	

Stay tuned - issue “gaining traction” - and moving into device and technology arena

*FDA=Food and Drug Administration

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Gainsharing

MedPAC Considerations

Genesis	Current Situation	Implementation Options
Gainsharing is formal hospital-physician agreement entered into for purpose of implementing cost reductions; physicians receive share of hospital's gains attributable to physician effort	Demonstration Series 1 (1991-6): Medicare Participating Heart Bypass Center Demonstration and Medicare Cataract Surgery Alternative Payment Demonstration - largely successful - per CMS	Multiple approaches could be used; newer CMS demonstration projects proposed - none implemented to date
Gainsharing illegal under Sections 1128A(b)(1) and (2) of SSA*; potentially in violation of "anti-kick back" provisions of SSA and "Stark" Law and relief would require statutory authorization; however, OIG** issued advisory opinion (2005) authorizing limited use of gainsharing	Demonstration Series 2 (per MMA***): Medicare Health Quality Demonstration Program - to examine delivery factors that improve quality of care - "non-traditional" gainsharing Demonstration Series 3: (DRA of 2005): Six demonstration projects	Use bundled payment system to effect efficiencies and cooperation (refer to next section)

In 2005 report on specialty hospitals, MedPAC recommended that current prohibition on gainsharing arrangements be repealed, provided safeguards (drawing on OIG work) are implemented to address quality of care concerns

*SSA=Social Security Administration
**OIG=Office of Inspector General
***MMA=Medicare Prescription Drug, Improvement, and Modernization Act of 2003

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Bundled Payments and Episodes of Care

MedPAC Recommendations (March 2008)

Genesis	Implementation Options	Current Situation
Traditional FFS payment does not promote efficiency over an episode of care or create incentives for providers to work cooperatively to manage patient care over time	*Actual bundling:* hospital payment bundled around an episode of inpatient stay plus 30 days post discharge - pilot needed	MedPAC designing system-wide details; particulars being worked out in demonstrations
These shortcoming often work to the disadvantage of patients and lead to resource overutilization	*Virtual bundling:* hospitals receive reward or penalty based on relative spending during the hospitalization	Medicare Acute Care Episode (ACE) Demonstration project - call for participants made May 16, 2008 - hip/knee replacement surgery or CABG surgery in MAC* 4 (TX, OK, NM, CO)
	Readmissions only bundling: penalizes hospitals with high re-admissions rates	Other inpatient pilots to follow; other episodes of care being considered

Confidential CMS report to on provider use around hospitalization

After 2 years, implement virtual bundling system; reduce payments to high and reward low resource users

Create voluntary pilot to explore issues

*MAC=Medicare Administrative Contractor

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Value-Based Purchasing

MedPAC Considerations

Genesis	Current Situation	Implementation Options
The existing Medicare payment system does not necessarily provide rewards for the desired processes and outcomes in inpatient care	The CMS report outlines a system as described to right	Rewards for hospitals based on specific achievements in clinical process of care, outcomes, and patient experience
Accordingly, CMS does not get the “value” that it is seeking in its purchase of this care	Report calls for development of efficiency, care coordinaton, emergency care, patient safety, and outcomes measures but is not specific	Creates an incentive pool to fund the program by withholding portion of the DRG* payments
		System would be phased in over three years, moving from reporting only to full payment on measure achievement

MedPAC endorsed November 2007 CMS report on value-based purchasing (VBP) options for Medicare inpatient hospital services, finding much of the report to be consistent with its own pay-for-performance (P4P) principles

*DRG=Diagnosis Related Groups

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Summary

Summary

- Old lens/approach will not go away
- New lenses will aim to achieve what old did in more comprehensive manner
- Lenses will be focused on devices/technology as they were/are on other products and services
- Orthopedics and cardiovascular technology will be high on the priority list of reforms with specific focus

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