Medicare Policy Issues Affecting Primary Care Physicians

Robert A. Berenson, M.D.
Institute Fellow, The Urban Institute
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The Presentation Will

- Review the state of play in the Medicare Fee Schedule
- Provide a catalogue of important ACA provisions (with some commentary)
- Talk about the priorities and initiatives of the Center for Medicare and Medicaid Innovation
- Comment on whether the Patient-centered Medical Home, as defined, promotes the established elements of primary care or not

The Medicare Fee Schedule – Mend It or End It?

- Broad consensus on the need to move from volume- to value-based payment (although there are different views of what the latter means – but that is another discussion)
- There is only so much time and political capital to go around and the RBRVS-based fee schedule has been pretty refractory to change. So some would ignore it altogether and get on with testing major payment alternatives

Reasons for Mending It

- The new approaches are not ready – and some are difficult technically. FFS inevitably will be with us for longer than many would like.
- If there is successful political opposition to reducing prices for manifestly overvalued services, wouldn't there be more to a fundamental overhaul of FFS? (However, arguably a major reform may be easier to pull off than incremental changes battling on the current turf of FFS?)

Mending (cont.)

- The building blocks for some of the new approaches, e.g. bundled episodes, are Fee Schedule and DRG payments – bundles would include existing price distortions
- Current income disparities interfere with the environment to permit needed collaboration between specialists and primary care docs in MSGPs,IPAs and ACOs (whatever they are)
- Various provider groups use work RVUs to assess physician productivity, regardless of how they compensate their physicians

Current Medicare Fee Schedule Issues in Play

How CMS, relying a lot on the RUC, determines RVUs

- MedPAC has focused on this issue, especially as related to flawed time estimates in the RUC process
- AAFP threats of dropping out of the process
- Physician suit brought against HHS for violating APA, FACA, etc. in reliance on RUC
- McDermott bill to require an alternative approach
- In this round (2012 physician payment rule), CMS accepted fewer RUC recommendations and has asked for review of core, high dollar services that have not been looked at for a while
- A problem is lack of CMS funding to decrease reliance on free labor the RUC process provides

Growing Consensus About Need to Revise or Supplement OV Codes

To better capture the work involved with chronic care management

- RUC has a chronic care committee
- Fast track AAFP workgroup looking at issue
- ASPE (in HHS) has contracted with the Urban Institute to examine a number of fee schedule issues, incl. OV definitions

So CMS withdrew request to RUC to go through another round of E&M battles, pending ASPE and other recommendations on OV definitions, along with concurrent work on medical homes and ACOs

ACA Sections of Direct Relevance (with some commentary)

Sec 3001 Hospital Value-based Purchasing starts in 10/12 (there is a growing view that the process measures used in Hospital Compare, etc. are not very useful)

3007 Physician Fee Schedule Value-based Payment Modifier by 2015 (good luck with this one)

3021 Center for Medicare and Medicaid Innovation

3022 Medicare Shared Savings Program (CMS in the final reg accomplished a strategic retreat to get some participation by providers)

3023 Bundled Payment Pilot (CMMI moving on 4 models around a hospitalization – I think the approach has problems, especially dealing with appropriateness of the episode)

ACA sections (cont.)

3024 Independence at Home (geriatric home care for frail elderly – to use "shared savings")

3025 Hospital Readmissions Reduction in FY 2012 (is the payment penalty enough to change behavior in hospitals where most needed?)

3026 Community-based Care Transitions – already in place to assist hospitals in reducing readmissions

3027 Gainsharing Demonstration extension (think about it – doesn't gainsharing accomplish the objectives of bundled payments, without the technical and physician-hospital relations difficulties? The OIG limits use of gainsharing on quality grounds, but we proceed with bundling major quality concerns?)

ACA sections (cont.)

3502 Community Health Teams to support PCMH

3506 Shared Decision Making – sets up SHM Resource Centers

3126 Community Health Integrated Model Demo – for tests of rural integration models

3140 Medicare Hospice Concurrent Care Demo

2703 Medicaid Health Home targeted to individuals with chronic conditions

2704 Medicaid Bundled Payment demo in up to 8 states

2705 Medicaid Global Payment System demo for safety net hospitals to move from FFS to global payment in up to 5 states

2706 Medicaid Pediatric ACO demo

ACA Sections Related to Reporting

- 3002 Physician Quality Reporting to provide feedback to physicians on performance – related to meaningful use
- 3003 Physician Feedback Reports – on resource use
- 10331 Public Reporting of Physician Performance Information – creates a Physician Compare website by 1/1/13 (very ambitious)
- 3015 Collection of Quality and Resource Use Measures

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Innovation Center: Basic Facts

- $10 billion per decade (2011-2020) already appropriated so change of Congress not enough to undo this – although some conservatives want to
- Formed primarily to test new payment and delivery models
- Must improve quality with no increased spending or reduce spending with no decrease in quality
- ACA listed 18 priorities, but advisory only. The Center determines priorities, strategic direction
- Protected from previous level of OMB scrutiny. The CMS actuary now must certify that criteria re spending and impact on quality are being met

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Perceived Problems With Previous CMS Activities to Explore Innovations

- There have been notable successes – inpatient prospective payment (DRGs), RBRVS?, PACE, hospice benefit, competitive bidding for DME, risk-based contracting to private health plans, various other prospective payment systems
- Sometimes even a negative result can be useful, as with the first real trial of vendor-based, telephonic disease management -- but participants point to problems related to inability to do "rapid cycle" modifications to approach, target population, etc.
- There are positive findings even in a "negative" demo, as with various tests of chronic care management like patient self-management and transitional care

Problems (cont.)

- Political opposition and non-evidence based decision-making -- see Participating Heart Bypass Center Demo and attempt to expand; it effectively was boycotted. Also see declaration of success of PGP demo despite negative findings in the RTI evaluation
- Often a very lengthy process – PGP demo took 11 years and conclusions were drawn before the final years leading to perhaps premature establishment of the Shared Savings Program for ACOs

Innovation Center Approaches

Bringing in experienced experts on specific aspects of care delivery to complement career CMS demo staff

- A number of clinicians and other issue experts have taken pay cuts to work at CMMI as GS 15s
- Broad use of IPAs to have people come for a year and sometimes stay on

Commitment to "rapid learning" and "rapid cycle evaluation," the latter headed by Will Shrank (from Harvard/Brigham)

- Attempt to marry evaluation rigor with real-time modifications of demo specifications based on rapid learning

Approaches (cont.)

Promulgation of Portfolio Criteria for projects having "the greatest potential impact on Medicare, Medicaid, and CHIP beneficiaries, and the ability to improve how care is delivered nationally."

Reliance on RFPs – with competitive applications, rather than ad hoc one-on-one funding

Apparent commitment to multi-payer collaboration on demonstrations (although can't fund non-public ones)

Not all innovation to be tested in demos – also attempting to increase the system's capacity for spreading innovation in other ways – here some site-specific opportunities

Announced Initiatives

Primary Care Redesign

Multi-payer Advanced Primary Care Demo (MAPCaP) – multi-payer collaborative funding to 8 states based on assorted medical home definitions

Comprehensive Primary Care Initiative – similar but targets private payers rather than states as applicants and seems to have a more basic set of expectations tied to primary care, rather than medical home (I will explain)

FQHC Advanced Primary Care Practice Demo to test PCMH in FQHCs –but need at least 200 Medicare beneficiaries so a Medicare hook as well

Initiatives (cont.)

Accountable Care Organizations (companion to Shared Savings Program)

PGP Transition Demonstration continues PGP for the 10 programs that have participated

Pioneer ACO Model for groups with a track record of risk-taking and able to take financial risk

Advanced Payment ACO Model to provide some start-up funding for some Shared Savings Program organizations to become ACOs as advanced payment off of expected savings

Initiatives (cont.)

Dual-eligibles – initial focus on state-based initiatives (which is somewhat controversial – colleagues at UI argue that dual programs should be organized by Medicare, not the states)

State Demonstrations to Integrate Care for Dual Eligible Individuals – up to $1 million for 15 states to develop care coordination models

Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees will test both capitation and FFS models

Reducing Preventable Hospitalizations in Nursing Home Residents is related to the incentives nursing homes have to shift patients to higher paying Medicare SNF payment rather than Medicaid support for nursing home residential costs.

Other Initiatives

Innovation Advisors Program to establish a network of experts to help the Center as well as local provider orgs

The Health Care Innovation Challenge will award up to $1 billion in grants (each about $1 million) to engage a broad set of partners to originate in the field. A focus will be on new models of workforce development and rapid deployment care improvement models

Partnership for Patients will award up to $500 million to reduce hospital-acquired infections and 30 day readmissions.

Now For Something Provocative

I suggest that the PCMH may represent the failure of primary care (based on the reality of what physicians are now willing to do) rather than its enhancement, by the lack of attention in PCMH assessment instruments and payer expectations to assuring the 4 pillars of primary care – access, longitudinal continuity, comprehensiveness, and care coordination. The first 3 of these are given short shrift in the instruments; payers are now to going to pay for desirable enhancements to primary care without necessarily getting the basics.

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