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ASSISTANT SECRETARY FOR
PLANNING AND EVALUATION

OFFICE OF
HEALTH POLICY

Medicare: Opportunities for Market-Based Policies

A Report Required by Executive Order 13890

January 14, 2021

U.S. Department of Health & Human Services

Office of the Assistant Secretary for Planning and Evaluation

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Executive Summary

The Medicare program covers more than 60 million beneficiaries. As the population ages and the baby boom generation moves into Medicare, enrollment is projected to continue to grow over the coming years. The program provides access to health care services for the nation's elderly and disabled and has a significant impact on the health care system and the broader economy. In recent years, the program has made progress in moving from unconstrained fee-for-service (FFS) payment to some forms of value-based purchasing. The Center for Medicare and Medicaid Innovation (CMMI) is testing payment and service delivery models that hold participants accountable for the total cost and quality of care; certain models focus on specific episodes of care, while others hold participants accountable for all Medicare inpatient and outpatient services provided to beneficiaries. Nonetheless, there is significant progress that needs to be made in transforming Medicare and the health system in general, to one that is financially sustainable and of high value. In this paper we describe the opportunities for various market-based policies to achieve these objectives.

Market-based payment policies such as competitive bidding, reference pricing, centers of excellence and tiered provider networks have been implemented both in Medicare and across the private sector. While the evidence is not yet sufficient to comprehensively assess how such programs would perform on a national level for Medicare, they do provide lessons learned and suggest opportunities for further success. The Medicare program has had success with competitive bidding to determine payment rates for durable medical equipment and in determining premium subsidies for prescription drug coverage in the Part D program. Among private purchasers, reference pricing has been associated with savings of 5-12% for a limited number of services. Tiered networks for one health plan realized 5% spending reductions in cost per enrollee. Savings have also been found for the use of accountable care organizations (ACOs) in state Medicaid programs. These efforts suggest that carefully selecting the appropriate services, informing patients, protecting patients from unexpected out-of-pocket payments and inconvenience in accessing services, are important factors in program design.

Because Medicare is such a large national program, carefully crafting market-based policies and implementing them in an evidence-based manner will be critical to their overall success. Medicare pays for services furnished to Medicare beneficiaries in a number of ways, including through three major payment approaches: Medicare Advantage, Medicare fee-for-service, and a growing ACO component. There are differences between these sectors in terms of payment mechanisms; distribution of financial risk among the Medicare program, providers, health plans and beneficiaries; distribution of programmatic responsibilities; and choice parameters for beneficiaries. Market-based policies are intended to provide strong financial incentives for making decisions consistent with optimal efficiency and value. One consideration for market-based policies is which decision makers we are targeting with selected policies. For example, are we attempting to influence the decisions of health plans, providers, beneficiaries or all three? If the latter, how do we coordinate the incentives of numerous policies so they are harmonious for achieving our value-based objectives?

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Medicare covers and pays for thousands of health care services and it would be virtually impossible to apply market-based pricing strategies to all of them. Thus, choices may need to be made as these policies are targeted. For example, policies such as reference pricing best apply to a subset of services that are “shoppable.” Competitive bidding may best apply to items or services for which excluding providers or suppliers would not create geographic access problems for beneficiaries. Similarly, choices would need to be made between implementing these policies for individual services and bundles of services, such as for episodes of care. Finally, many markets across the country are highly concentrated and thus, less amenable to market-based policies which require some degree of competition. These policies would best be implemented in more competitive markets alongside parallel policies designed to bring market-based payment rates to less competitive areas.

One potential way to realize the opportunities for market-based policies to achieve objectives for the health care system, while recognizing these challenges, is to proceed in an incremental, evidence-based manner. A first step might be to assess what might be more immediately actionable in transitioning to market-based policies. Current payment systems and CMMI models might be examined for whether modifications could be made to move them toward market-based pricing. For example, CMMI’s current bundled payment models might be examined for whether they could be transitioned to competitive bidding to establish payment rates rather than historical benchmarks. Likewise, an assessment can be made as to whether new services could be added to CMS’s centers of excellence program, which is a form of competitive bidding. Finally, CMS’s current list of “shoppable” services might be scrutinized to determine whether competitive bidding or reference pricing might be applied to them.

A second, longer-term strategy would be to carefully build the data and evidence base, and develop the strategies, needed for a broad based expansion of market-based policies in Medicare. The following actionable steps might be taken:

- Evaluate which individual or bundled services might be amenable to bidding or reference pricing methods
- Evaluate geographic markets for various services to determine their competitiveness
- Evaluate whether data are sufficient to implement policies such as reference pricing and network tiering for some provider groups; and consider the extent to which private sector data might be useful
- Develop strategies to address markets not amenable to market-based policies
- Consider whether policies would be targeted to fee-for-service, MA or both
- Consider which strategies might be best implemented through new legislation and which might be tested and evaluated under Innovation Center authority
- Consider how the portfolio of Innovation Center models and testing market-based policies might be well coordinated as opposed to separate evidence building and policy development streams
- Consider how the current COVID-19 pandemic demonstrates the need for surge capacity and how that might inform the way in which market-based policies are constructed and implemented

The last bullet reflects our current experience with the COVID-19 pandemic and the need to plan for beds, equipment and supplies to meet health emergencies. It means that as we develop our market-based and

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value-based policies, renewed attention should be paid to how we define the “efficiencies” that are the target of these policies. Clearly there would be savings associated with each provider having the incentive to produce care at the lowest cost possible, but such short run efficiency would likely minimize or eliminate excess capacity. In contrast, long run efficiency would account for the need to be able to maintain public health during pandemics, weather events and other emergencies by planning for extra capacity. Bridging this potential tradeoff will be an important consideration for decision makers as market-based policies are developed and implemented.

Introduction

The Medicare program is critical to the nation’s seniors and disabled populations. It has a substantial impact on the U.S. health care system and the economy. Medicare covers more than 60 million beneficiaries. Federal spending for Medicare was \$741 billion in 2018—one-sixth of the federal budget—and is projected to grow faster than inflation for the foreseeable future. Through legislation and regulation, the program can affect both how care is delivered to its beneficiaries and its cost through its pricing, coverage and participation rules. Of equal importance, the decisions made by health plans and providers to comply with Medicare’s rules and incentives can have a significant spillover effect on the entire health care system. Thus, the success of policies to improve the value and sustainability of Medicare spending may indeed have significant consequences for the entire health care system.

To be sure, there has been some progress towards value-based payment in recent years. Medicare’s payment systems have achieved the lowest level of payment rates across payers and the per capita rate of increase is often lower as well. A perhaps more significant trend has been that financing arrangements under Medicare, as well as private insurance, have begun a transformation from largely uncoordinated, fee-for-service arrangements toward more patient centered and value-based care.¹ One goal has been to move towards payment systems that place providers increasingly at financial risk for cost and quality over a larger range of services (e.g. episodes of care or all care). Both through statutory change and the efforts of the CMS Innovation Center, much of Medicare’s payments to providers have transitioned to some form of value or risk based arrangements.

Nonetheless, there are many reasons to believe that greater progress can be made. Spending trajectories and the estimated exhaustion date of the Part A Trust Fund in 2026 are of considerable concern. Many analysts believe that Medicare’s efforts have yet to unlock the value producing innovation in health care delivery that would arise through market driven financial incentives. Questions can be raised concerning whether Medicare’s lower rates and Innovation Center Models have yet to be structured in a way that would induce health plans, providers and consumers to behave as they would in a well-functioning marketplace.

Market based policies might be considered on three basic levels; policies that implement market based pricing into Medicare’s current statutory systems and Innovation Center models; anti-trust policies that would improve the competitiveness of markets; and broad based insurance reform that aimed at enhancing market forces. In this paper, we focus on the first level by examining a number of market based pricing policies that have been considered or implemented across the health care system.

¹ According to CMS’s Learning and Action Network (LAN), less than half (43%) of public and private payments for health care services were determined by fee-for-service arrangements with no quality link. <https://innovation.cms.gov/initiatives/Health-Care-Payment-Learning-and-Action-Network/>

Overview of Report

In this Report, we explore several policy options that decision makers might consider for increasing competition and strengthening market forces in health care financing, delivery and consumer choices.

- In Chapter 1, we first provide background sections that describe Medicare’s spending trends and potential impact of the program on the health care system
- Chapter 2 provides a landscape of Medicare’s current payment systems and Innovation Center activities. Readers familiar with the Medicare program may want to spend less time with this chapter.
- Chapters 3 describes a general framework for considering how market-based policies might be developed and implemented for Medicare
- Chapter 4 summarizes the evidence and lessons from market-based policies that have been implemented in Medicare and in the private sector
- Chapter 5 details the opportunities and challenges in implementing the various market-based policies in Medicare
- Chapter 6 provides potential next steps - actions for moving forward with market-based policies. A final section discusses future health policy considerations in light of the current COVID-19 crisis, which highlights how policies that drive toward short-term efficiency may need to be evaluated as the nation experiences a surge of demand in some hot spot geographic areas.

This report was prepared in response to Executive Order 13890, Protecting and Improving Medicare for Our Nation’s Seniors.² The Executive Order requires that The Secretary shall study and, within 180 days of the date of this order, recommend approaches to transition toward true market-based pricing in the FFS Medicare program.

² <https://www.federalregister.gov/documents/2019/10/08/2019-22073/protecting-and-improving-medicare-for-our-nations-seniors>

Chapter 1. Background: Health Care Spending Trends and Policy Issues

Considerations of new policies for existing programs generally arise for several reasons including: new data which indicates problems with or gaps in current policy; changes in factors such as in demographics or technology which render current policies inadequate, or unanticipated and undesirable consequences of current policies. There are a number of reasons to consider new health care policies in general as well as those specific to Medicare and other public programs. Historically, much of the health care policy debate has centered on containing spending – a key indicator of health system performance. This issue is particularly critical for Medicare because of its potential impact on the federal budget. Moreover, the potential for Medicare’s policies to spillover to the rest of the system places importance on implementing well-constructed policies, monitoring and evaluating their impact and making corrections as required. In this section, we discuss spending trends and projections; as well as the impact of Medicare on the health system.

Spending Trends

Total U.S. health spending has increased substantially over the past several decades. As displayed on Chart 1.1, health spending totaled \$74.6 billion in 1970, reached about \$1.4 trillion in 2000, and more than doubled to \$3.8 trillion in 2019.³ Current health care spending is equal to \$11,621 per person in 2019.⁴ Of particular concern is that U.S. health care spending generally grows faster than the economy (Charts 1.2 and 1.3). Health spending’s share of Gross Domestic Product (GDP) grew from 6.9% in 1970 to 17.8% in 2019.⁵ During the 1970’s and 1980’s, health spending grew faster (11% average) than the GDP (8%), although health spending growth has started to moderate even before the Great Recession of 2008.

³ Total health expenditures represent the amount spent on healthcare and health-related activities (such as administration of insurance, health research, and public health), including expenditures from both public and private funds.

⁴ Princeton University economists Anne Case and Angus Deaton said at an economic conference in San Diego that the US spends \$1 trillion more than Switzerland, the second-most expensive system. It rounds out to an additional \$8,000 a year that American households pay compared to Swiss ones. According to [data from Organization of Economic Cooperation and Development](#), the US spent \$10,209 on healthcare per capita, or per person, in 2017. Life expectancy, though, [is dropping in the US](#).

⁵<https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata>

Chart 1.1

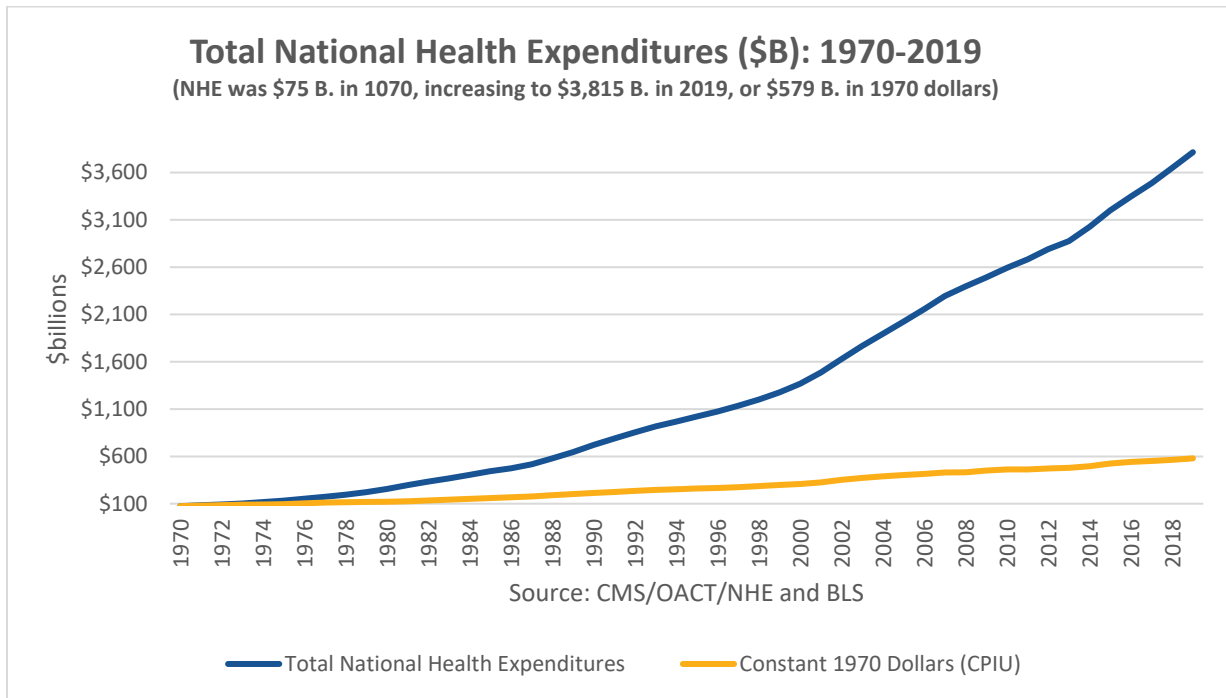


Chart 1.2

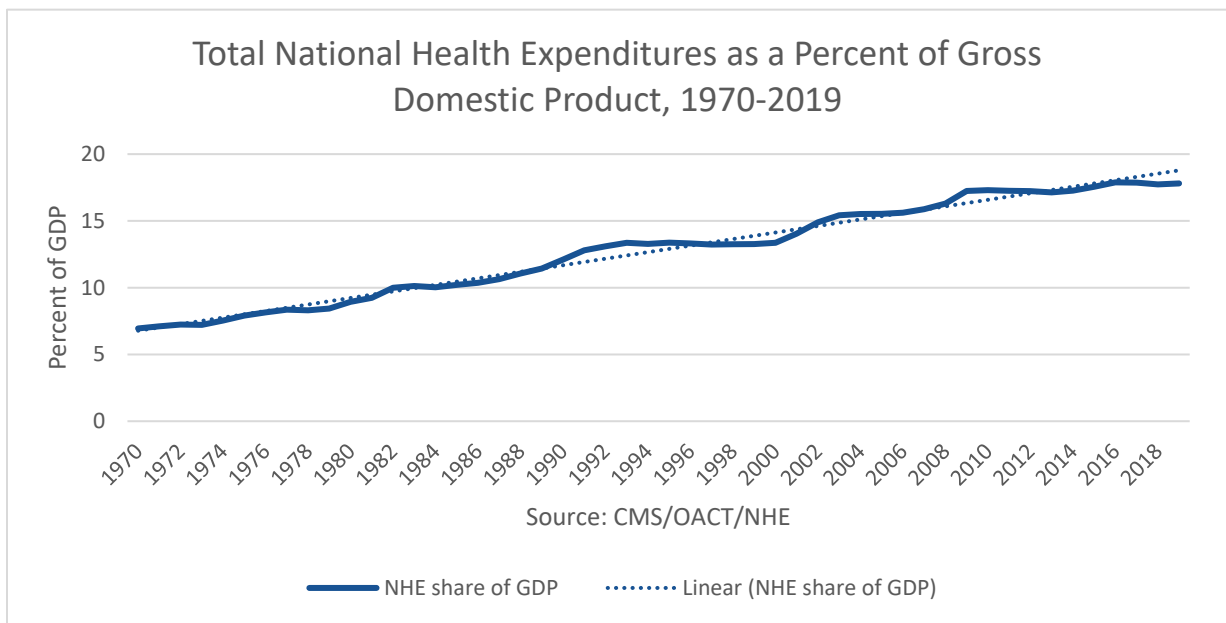
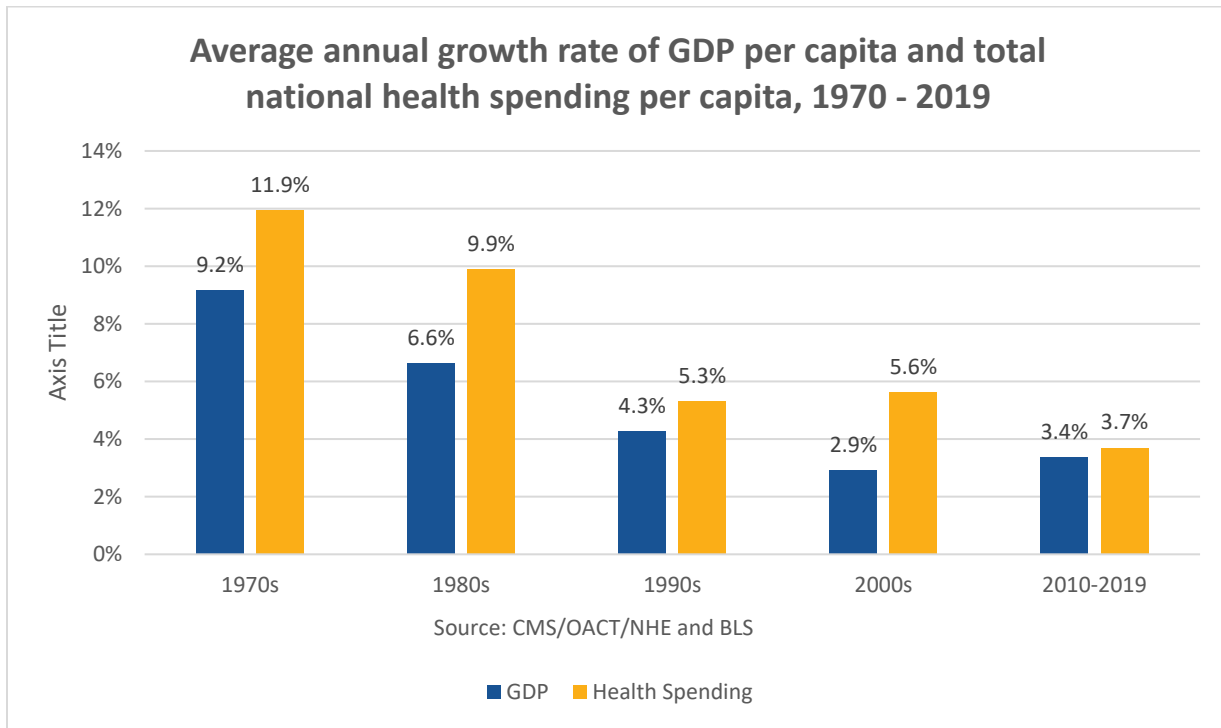


Chart 1.3

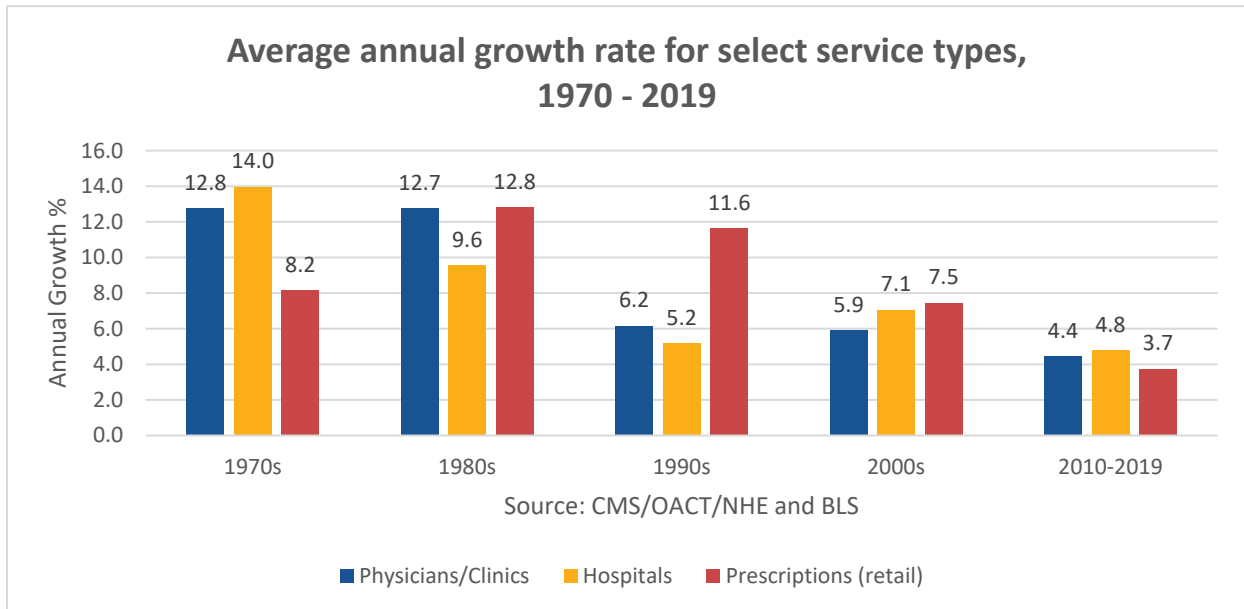


Health Spending by Type of Service or Product

The rate of growth for medical services (e.g. services provided by physicians/clinics or hospitals) varied by service type (Chart 1.4). During the 1970s, hospital expenditures outpaced other services, while during the 1980s and 1990s, physicians/clinics and especially prescriptions experienced faster spending growth. Between 2010 and 2018, average spending growth on physicians/clinics, hospitals, and prescription drugs seemed to converge (4.4%, 4.8%, and 3.7% respectively) (Chart 1.4). In 2018, however, cost increases in hospital and outpatient spending far outpaced spending growth for prescription drugs (Chart 1.5).⁶

⁶ <https://www.cms.gov/files/document/highlights.pdf>

Chart 1.4. Average Annual Growth Rate for Select Service Types, 1970-2018



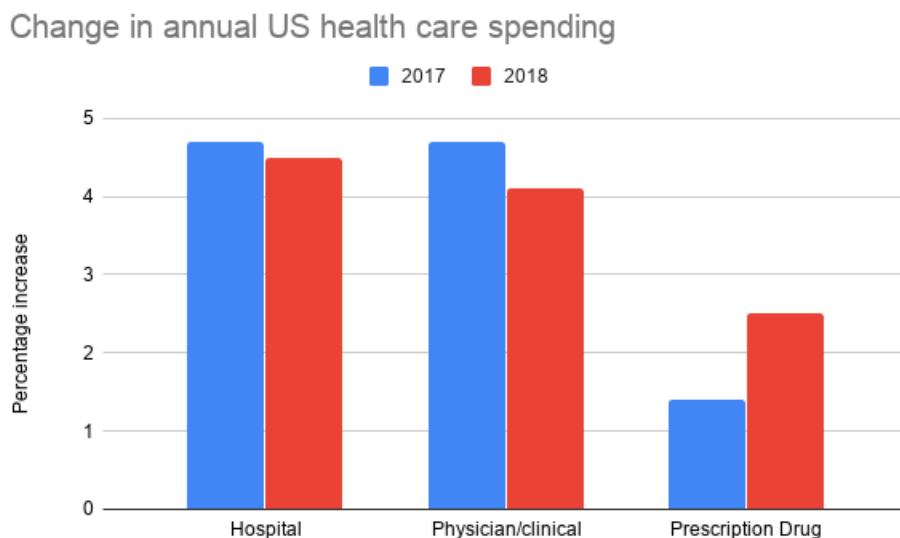
Hospital care accounts for the largest share of spending (33 percent share). Spending for hospital care services increased at about the same rate in 2018 as in 2017 (4.5 percent and 4.7 percent, respectively) and reached \$1.2 trillion in 2018. Faster growth in hospital prices was partly offset by slower growth in non-price factors, such as the use and intensity of services.⁷

Physician and clinical services came in second as the share of health spending (20 percent share). Spending on physician and clinical services increased 4.1 percent to \$725.6 billion in 2018. This was slower than the 4.7 percent growth for physician and clinical services in 2017 and was largely due to a slowdown in non-price factors such as use and intensity services. Although slowing, growth in clinical services continued to outpace the growth in physician services in 2018.

Retail Prescription Drugs accounted for 9 percent share of health spending. Growth in retail prescription drug spending accelerated in 2018, increasing 2.5 percent to \$335.0 billion. The faster growth in 2018 followed 1.4 percent growth in 2017. In 2018, faster growth in non-price factors helped to drive the increase in total retail prescription drug spending growth, while retail prescription drug prices declined by 1.0 percent.

⁷ Data from the Centers for Medicare & Medicaid Services (CMS) show that in terms of per capita health expenditures, less than 14% is spent on drugs. Not unexpectedly, the largest share of costs in our \$3.5 trillion health care system is attributable to hospitals. As Elisabeth Rosenthal has pointed out in a New York Times op-ed, “hospital prices increased a whopping 42% from 2007 to 2014 for inpatient care and 25% for outpatient care, compared to 18% and 6% for physicians.” This growth in hospital spend shows no sign of slowing down.

Chart 1.5. Change in annual U.S. health care spending



Projections, 2020-2028⁸

As displayed on Table 1.1, national health expenditures are projected to grow at an average annual rate of 5.6 percent for 2020–28 and represent 19.7 percent of gross domestic product in 2028.⁹ Among the major payers, average annual spending growth in Medicare (7.7 percent) is expected to exceed that in Medicaid (5.8 percent) and private health insurance (4.8 percent) over the projection period. As displayed on Table 1.2, projected per enrollee rates of growth are more or less comparable among the payers meaning Medicare’s more rapid growth in total spending is mostly as a result of comparatively higher projected enrollment growth.¹⁰ The insured share of the population is expected to remain stable at

⁸ COVID-19 disclaimer in actuarial opinion by the Office of the Actuaries in the Medicare Trustees Report and Medicare spending projections:

The assumptions in this report do not reflect the potential impacts of the COVID-19 pandemic on the Medicare program. Especially in the short range, the pandemic is likely to materially affect the economic, demographic, and healthcare-specific assumptions on which the intermediate projections are based. While it is not possible to adjust the estimates accurately at this time, readers should review the range between the high-cost and low-cost projections as a share of GDP over time to better understand the variability in program costs under different scenarios. Given the potential magnitude of the effects of the pandemic, it is conceivable that actual program experience could be worse than projected in the high-cost scenario, particularly in the near term.

⁹<https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected>

¹⁰ CMS OACT modeled the acceleration in health spending beginning in 2020 in part due to faster growth in personal health care prices as measured by the Personal Health Care Price Index. Also contributing is increasingly higher expected growth in utilization on the part of Medicare beneficiaries and those with private health insurance, the latter influenced by a lagged response to comparatively higher income growth during 2020–22. In addition, in the projection years 2019–28, OACT estimates that Medicare per person will grow faster for a number of reasons, largely because (1) the ACA mandated 0.75 percent payment update reduction to IPPS sunsets in 2019, and (2) both

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around 90 percent throughout the period, as net gains in health coverage from all sources are projected to keep pace with population growth. Because of the relatively higher growth in Medicare spending, the program will increase from 21.4 percent of NHE in 2020 to 25.2 percent in 2028; and from 3.9 percent of GDP to 5.0 percent over the same time period.

Table 1.1

Total National Health Expenditures and Medicare Spending Projections, 2016-28											
	2016	2017	2018	2019	2020	2023	2028	annual growth rate			
								2016-20	2020-28		
Expenditures (\$B)											
NHE	3,347	3,487	3,649	3,815	4,014	4,706	6,193	4.6%	5.6%		
Private health insurance	1,120	1,175	1,243	1,290	1,357	1,555	1,982	4.9%	4.8%		
Medicare	677	705	750	801	859	1,076	1,559	6.1%	7.7%		
Medicaid	565	580	597	621	649	766	1,017	3.5%	5.8%		
NHE as percent of GDP (%)	17.9	17.9	17.7	17.8	18	18.6	19.7	-	-		
Medicare as percent of NHE (%)	20.2	20.2	20.6	21.0	21.4	22.9	25.2	-	-		
Medicare as percent of GDP (%)	3.6	3.6	3.6	3.7	3.9	4.2	5.0	-	-		
Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group & Bureau of Economic Analysis https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2020.00094											

Table 1.2

Per Person National Health Expenditures and Medicare Spending Projections, 2016-28											
	2016	2017	2018	2019	2020	2023	2028	annual growth rate			
								2016-20	2020-28		
Expenditures Per Person / Enrollee (\$)											
NHE	10,379	10,742	11,172	11,597	12,118	13,903	17,611	3.9%	4.8%		
Private health insurance	5,550	5,813	6,199	6,455	6,772	7,682	9,597	5.1%	4.5%		
Medicare	12,137	12,334	12,784	13,328	13,909	16,065	20,751	3.5%	5.1%		
Medicaid	7,948	8,041	8,201	8,382	8,608	9,808	12,486	2.0%	4.8%		
Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group & Bureau of Economic Analysis https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2020.00094											

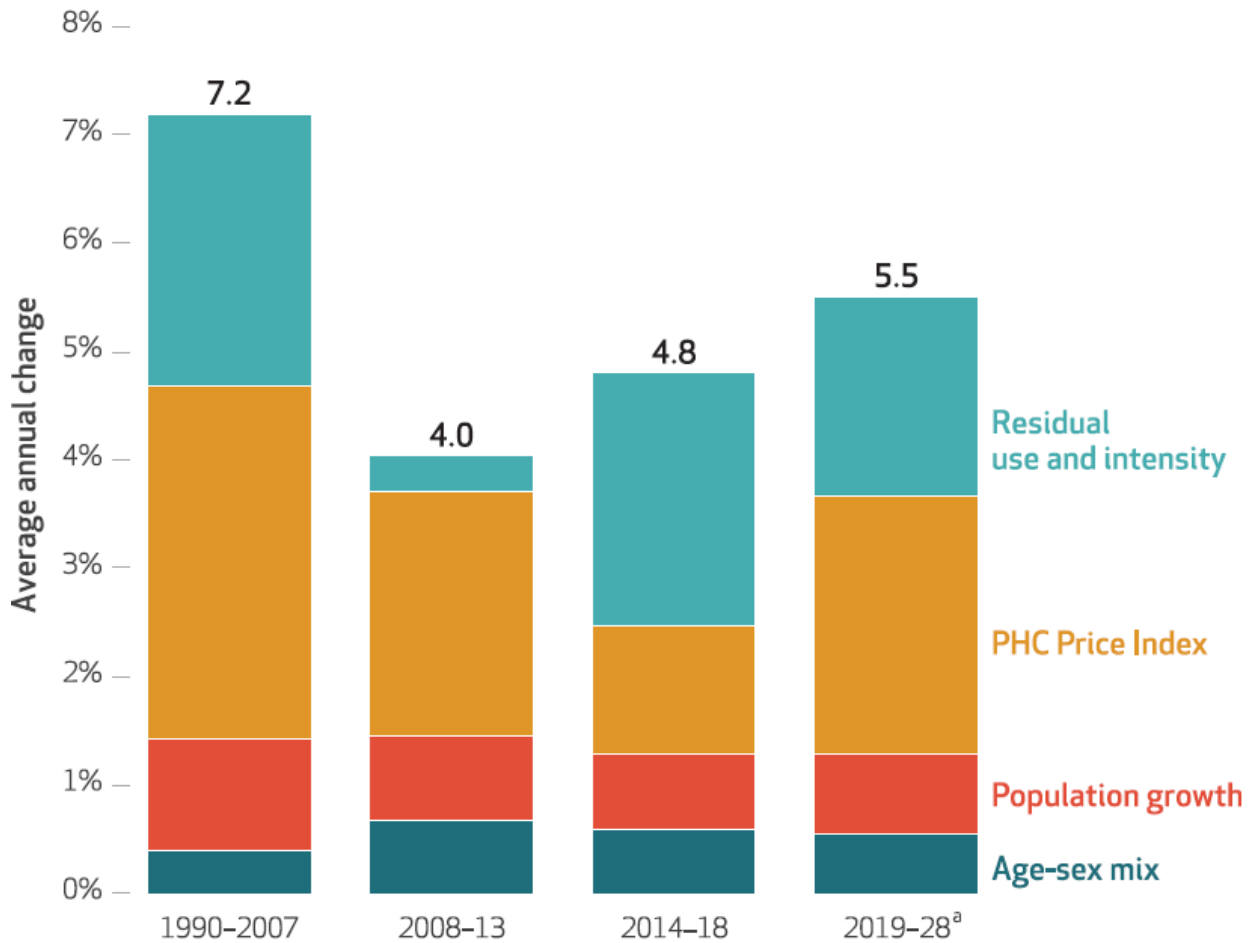
Over the next 10 years, the national health spending growth rate is expected to accelerate for a variety of reasons. Growth in health care prices, reflecting both economy-wide and relative personal health care price inflation, is also expected to rebound somewhat toward rates more consistent with the period before the Great Recession when personal health care price growth exceeds that of economy-wide price inflation. In addition, faster growth in disposable personal income is expected to lead to an increased demand for services. Medicare spending growth is expected to accelerate and be the fastest among the

hospitals' and physicians' use and intensity will increase toward their long-term averages. Netting out the effect of the 0.75% sunset, Medicare per person growth would have been 4.4% (5.1%-0.75%), comparable to the private insurers' per person growth rate of 4.5% predicted for 2020-28.

major payers, reflecting not only the continued enrollment shift of the baby-boom generation into the program but also the growth rate for use and intensity, which is projected to gradually increase toward the rates observed during Medicare’s long-term history.

Chart 1.6

Factors accounting for growth in personal health care (PHC) expenditures, calendar years 1990–2028



SOURCES Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group; and Department of Commerce, Bureau of Economic Analysis and Bureau of the Census.

NOTES Growth in the total PHC Price Index is equal to the sum of economywide and relative PHC inflation and is a chain-weighted index of the price for all personal health care deflators. “Use and intensity” includes the quantity and mix of services. As a residual, this factor also includes any errors in measuring prices or total spending. “Age-sex mix” refers to that mix in the population. ^aProjected.

Health Care Spending: Issues of Concern

Any discussion about the issues that might encourage new policy directions begin with the long-standing concerns over the level and trajectory of health care spending. As described above, health spending is projected to grow faster than GDP in the coming years and account for one-fifth of the entire economy by 2027. Growth in the share of the GDP by one sector such as health care is a particular concern if market forces are not working in a manner consistent with the efficient allocation of goods and services across the economy. That is, there is a concern that because of market imperfections, some amount of the resources used for health care would produce greater value in alternative uses. One indication of this problem is that three separate studies have now estimated that 25% or more of health care spending is wasteful – meaning it does not contribute to outcomes such as quality of care or population health.¹¹ Put another way, it represents spending that could be eliminated without diminishing health outcomes.

The Medicare program and its policies, which as described below have a substantial impact on the overall health care system, have particular concerns about the sustainability of its financing. The ageing of the population will cause acceleration in Medicare spending growth even if there is some moderation in per beneficiary costs. A key indicator of the program's financing adequacy has been at what future date the Part A Trust Fund will be unable to pay all claims. In the most recent Medicare Trustees Report, that date is 2026.¹² Thus, finding ways to reduce spending growth without impairing access, quality and population health is critical.

Medicare and the Health Care System

Throughout its more than fifty-year history, the Medicare program has had a number of positive impacts on the health of Americans and on the health care system. Medicare was enacted to address the problem of Americans most in need of health care – the elderly – being unable to afford and access it to meet their needs. Thus, the program has provided ready access to medical care and a measure of financial security for a vulnerable segment of the population.

The coverage for those who would likely otherwise be without insurance has also benefited health care providers. The assurance of a steady income stream for hospitals and physicians have allowed them to operate in a more financially stable environment, allowing them to make practice, growth and investment decisions with greater certainty about the future. Likewise, Medicare's direct support through the payment system of both hospital capital investments and medical education benefits the entire health care system.

¹¹ The most recent study is William H. Shrank, MD, MSHS1; Teresa L. Rogstad, MPH1; Natasha Parekh, MD, MS2, Waste in the US Health Care System Estimated Costs and Potential for Savings, *JAMA*. 2019;322(15):1501-1509. doi:10.1001/jama.2019.13978. See also, Donald Berwick and Glenn Hackbarth, Eliminating Waste in US Health Care, *JAMA*, April 11, 2012—Vol 307, No. 14; and IOM, *Best Care at Lower Cost: The Path to Continuously Learning Health Care in America*, Sept. 2012

¹² Trustees Report 2020

Finally, Medicare, as does other insurance coverage, has a positive impact on investment and diffusion of new technologies that improve health. The expansion of comprehensive insurance coverage to millions of individuals expands markets for pharmaceuticals, devices and procedures. Previously uninsured individuals have better access to health care services meaning better prevention and treatment regimens, including the access to and affordability of medical technologies. Thus, demand for these items and services increases and investment in research and development (R&D) become potentially more favorable. Recent estimates of the impact of insurance expansions demonstrate the potential effect. These estimates suggest that past coverage expansions through the Medicare and Medicaid programs may have accounted for 25% of the growth in R&D spending over the time period.¹³

The size of Medicare means that it can have a variety of other effects on health and the health care delivery system, with the potential for some of these impacts to be negative. Because Medicare accounts for 20% of health spending and an even larger share of revenues for hospitals and physicians, its policies can spill over to the other purchasers, health plans and patients. Medicare's policies for payment, provider participation and quality efforts cause providers to react in order to accommodate changes in payment or rules by one of their largest sources of income. Those reactions might either have positive or negative consequences for other payers. For example, fundamental changes in provider operations that reduce costs and improve quality are bound to have the same positive effects for all patients.

On the other hand, providers, where able, might react to Medicare policy changes in ways that increase costs for private payers. One method providers might use is called cost shifting – making up for some or all of any Medicare prices decreases or other shortfalls by raising prices to private payers. Evidence on the existence and magnitude of cost shifting in this manner is mixed. Some studies find relationships between Medicare payment declines and private payer price increases although the estimated effects are modest.¹⁴ Other studies cast doubt on whether cost shifting occurs.¹⁵ While still others find an opposite effect whereby price decline in Medicare are matched by decreases in private prices.¹⁶ It is difficult to model these relationships given the dynamics of health care markets and thus, some of the differences in these results are likely due to different statistical methods, data sources and time periods. One market dynamic that may play a substantial role is the degree of market concentration on the provider and insurance sides of each market. Recent studies indicate hospital prices are the highest where the hospital market is very concentrated and the insurer market is competitive.¹⁷ There is concern that Medicare's

¹³ Jeffrey Clemens, "The Effect of U.S. Health Insurance Expansions on Medical Innovation", NBER Working Paper No. 19761, Issued in December 2013

¹⁴ Michael Darden, Ian McCarthy, Eric Barrette, "Who Pays in Pay for Performance? Evidence from Hospital Pricing", NBER Working Paper No. 24304, Issued in February 2018, Revised in August 2019

¹⁵ Frakt, Austin, "Hospitals Don't Shift Costs From Medicare or Medicaid to Private Insurers", JAMA Forum, January 4, 2017,

¹⁶ Chapin White Contrary To Cost-Shift Theory, Lower Medicare Hospital Payment Rates For Inpatient Care Lead To Lower Private Payment Rates, Health Affairs, Vol. 32, No. 5: 935-943

¹⁷ Richard M. Scheffler and Daniel R. Arnold, "Insurer Market Power Lowers Prices In Numerous Concentrated Provider Markets, HEALTH AFFAIRS 36, NO. 9 (2017): 1539–1546

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policy direction of encouraging integrated care and developing models in which providers are responsible for cost and quality over a broad range of services is encouraging provider market consolidation.¹⁸

While the evidence is not quite clear as to the exact mechanisms for providers reacting and markets adjusting to Medicare's policies, it is perhaps a good assumption that Medicare's efforts are highly influential. Medicare policies that encourage inefficiency in health care delivery (or discourage change toward efficiency) will result in lower value for all patients. Conversely, Medicare policies that incentivize real value producing changes are likely to have positive effects across the system. Thus, a forward-looking principle for policy development might be to examine whether *a particular effort might provide incentives for innovations and fundamental restructuring of delivery that would produce high value care for all patients*, or simply provide some Medicare savings that might be offset by higher prices to private payers. Many believe that introducing market-based incentives in Medicare pricing would achieve the former. These approaches are discussed in following sections after a review of Medicare's current payment and value-based policies as a point of departure.

¹⁸ Mark B McClellan et.al., "Payment Reform for Better Value and Medical Innovation" National Academies of Medicine Vital Direction for Health and Health Care series, March 17, 2017

Chapter 2. Current Medicare Payment and Innovation Policy

Overview of Medicare

Medicare is the federal health insurance program for people ages 65 and over, and certain people under age 65 who have a long-term disability. Today, Medicare plays a key role in providing health and financial security to 60 million older people and younger people with disabilities. The program helps to pay for many medical care services, including hospitalizations, physician visits, prescription drugs, preventive services, skilled nursing facility and home health care, and hospice care. In 2018, Medicare spending was \$741 billion and accounted for 15 percent of total federal spending and 20 percent of total national health spending.¹⁹

Most people age 65 or older are eligible for free Medical hospital insurance (Part A) if they have worked and paid Medicare taxes long enough. People under age 65 who receive Social Security Disability Insurance (SSDI) payments generally become eligible for Medicare after a two-year waiting period, while those diagnosed with end-stage renal disease (ESRD) and amyotrophic lateral sclerosis (ALS) become eligible for Medicare with no waiting period.

The Medicare program has 4 parts:

- Part A covers inpatient hospital stays, skilled nursing facility (SNF) stays, home health visits (in conjunction with part B), and hospice care. Hospital inpatient benefits are subject to a deductible (\$1,484 per benefit period in 2021). Part A also requires coinsurance for extended inpatient hospital and SNF stays. Medicare spending for Part A (including spending for enrollees in Part C) was \$308 billion in 2018.
- Part B covers physician visits, outpatient services, preventive services, and home health visits (in conjunction with Part A). Many Part B benefits are subject to a deductible (\$185 in 2019), and, typically, coinsurance of 20 percent. No coinsurance or deductible is charged for most home health services; an annual wellness visit; or for preventive services that are rated 'A' or 'B' by the U.S. Preventive Services Task Force, such as mammography or prostate cancer screenings. Medicare Spending for Part B (including spending for enrollees in Part C) was \$337 billion in 2018.
- Part C refers to the Medicare Advantage program, through which beneficiaries can enroll in a private health plan, such as a health maintenance organization (HMO) or preferred provider organization (PPO), and receive all Medicare-covered Part A and Part B benefits. Medicare Advantage plans generally also have Part D contracts and cover Part D benefits. Enrollment in Medicare Advantage plans has grown over time, with more than 21 million beneficiaries enrolled

¹⁹ Spending in 2018 in the Medicare Trustees Report 2019, Table II.B1: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2019.pdf>

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in Medicare Advantage in 2018, or 35.6 percent of all Medicare beneficiaries.²⁰ Medicare Spending for Part C was \$234 billion in 2018.²¹

- Part D covers outpatient prescription drugs through private plans that contract with Medicare, including stand-alone prescription drug plans (PDPs) and Medicare Advantage plans with prescription drug coverage (MA-PDs). In 2019, beneficiaries have a choice of 27 PDPs and 21 MA-PDs, on average. The Part D benefit helps pay for enrollees' drug costs and provides coverage for very high drug costs. Additional financial assistance is available for beneficiaries with low incomes and modest assets. Enrollees pay monthly premiums and cost sharing for prescriptions, with costs varying by plan. Enrollment in Part D is voluntary; in 2018, 43 million people on Medicare were enrolled in a PDP or MA-PD. Of this total, roughly one in four receive low-income subsidies. Medicare Spending for Part D (including spending for enrollees in Part C) was \$95 billion in 2018.

Basic Approach to Paying for a Service in Traditional Medicare

About two-thirds of Medicare's benefit spending is on services delivered by providers in traditional Medicare (or FFS Medicare).

For most payment systems in traditional Medicare, Medicare:

- determines a base rate for a specified unit of service (average unit cost of an inpatient discharge for inpatient; resource-based relative value of a service/procedure for physicians' services), then makes adjustments based on:
 - patients' clinical severity (diagnosis related group or DRG for inpatient, Ambulatory Payment Category or APC for outpatient); typical intensity/time of the service (RVUs for physicians' services),
 - selected policies (e.g., indirect medical education (IME) or disproportionate share hospital (DSH) for inpatient; multiple procedure payment reduction, health provider shortage area/primary care adjustments for physicians' services),
 - geographic market area cost differences (wage index for institutional; GPCIs for physicians' services),
 - updates payment rates annually to account for inflation adjustments.

Medicare Payment for Hospital Inpatient Services

Medicare beneficiaries enrolled in the traditional fee-for-service (FFS) program receive care in over 3,200 facilities that contract with Medicare to provide acute inpatient care and agree to accept the program's predetermined payment rates as payment in full.

Medicare, administered by the Centers for Medicare & Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS), generally pays hospitals for acute inpatient care using the Inpatient

²⁰ Medicare Trustees Report 2019, Table IV.C1.

²¹ Medicare Trustees Report 2019, Table IV.C2.

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Prospective Payment System (IPPS). Payments made under the IPPS totaled \$118 billion and accounted for about 17 percent of Medicare spending in 2017.²²

The primary objective of the IPPS is to create incentives for hospitals to operate efficiently and minimize unnecessary costs, while at the same time ensuring that payments are sufficient to adequately compensate hospitals for their legitimate costs in delivering necessary care to Medicare beneficiaries. The payment for each discharge is based on a national rate—a standardized payment amount multiplied by a weight, which reflects the relative resources needed to treat an average patient within each clinical category, called the diagnosis related group (DRG). DRGs that are likely to incur more intense levels of care and/or longer lengths of stay are assigned higher payments (there are over 760 Medicare Severity Diagnosis Related Groups).²³

Medicare makes adjustments to the national DRG-based rates to reflect local wage levels for hospital labor and higher costs of living (COLA) in Alaska and Hawaii. In addition, payment adjustments may be made for teaching hospitals (indirect medical education or IME), hospitals that serve a disproportionate share of low income patients (disproportionate share hospital or DSH), or for treating cases with extraordinary costs (outliers) or cases that involve certain approved new technologies. Special provisions apply if a hospital qualifies as a sole community hospital (SCH), Medicare dependent hospital (MDH), or rural referral center (RRC). Over 1,300 rural hospitals qualify as critical access hospitals (CAH) and are paid on a cost basis instead of under the IPPS.

Hospital Outpatient Payment

Medicare began using the outpatient prospective payment system (OPPS) in 2000. OPPS bases its payment on a set of weights that reflect the relative costs of the procedures involved, a conversion factor, and similar to the IPPS, a wage index adjustment and outlier payments. Similar to the physician fee schedule (described below), the OPPS is based on individual procedures identified by the Healthcare Common Procedure Coding System (HCPCS). These individual procedures are grouped into Ambulatory Payment Categories (APCs) based on type of procedure and similarity of cost. OPPS is a fee-for-service payment system in that a separate payment is made for each APC even if multiple APCs are billed for the same visit. Over time, CMS has increased the amount of services (ancillary services) that are packaged with primary services in an APC in order to provide greater cost control incentives. Many of the drugs provided during a visit are paid separately under the OPPS. Some new technologies can be temporarily paid through new technology APCs or pass through payments until sufficient data are available to fully integrate them in the payment system.

²²http://medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_19_hospital_final_v2_sec.pdf?sfvrsn=0

²³ <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/MS-DRG-Classifications-and-Software>

Physician Payment

Medicare pays for physicians' services under Medicare Part B using the Physician Fee Schedule (PFS). CMS considers recommendations of the American Medical Association's (AMA) Relative Value Scale Update Committee (RUC), along with other information and public input, to update and maintain resource-based relative value units (RVUs) for each service under the PFS. CMS applies updates in a budget-neutral manner. CMS first established RVUs under the PFS in 1992 using the Resource-Based Relative Value Scale (RBRVS) initially developed by Harvard University. The PFS is a system that pays physicians based on their effort, rather than outcomes, and it was adopted to reduce inflationary pressure of the previous "reasonable charge" payment basis. The AMA RUC generally submits recommended RVUs to the CMS for consideration; recommendations require support from two-thirds of the RUC, which is mostly comprised of representatives from specialty societies. CMS then adopts RVUs for each service through notice and comment rulemaking. The PFS payment rate is calculated by multiplying the RVUs assigned to a service by geographic practice cost adjustments (GPCIs) and the uniform PFS conversion factor for the year.

Among the 985,000 clinicians who bill Medicare, 61 percent are physicians; the rest are nurse practitioners, physician assistants, and other types of non-physician practitioners. The services of these clinicians are considered to be physicians' services and are paid under Medicare Part B. Payments for these services (about \$69 billion in 2017) account for about 15 percent of Medicare fee-for-service (FFS) spending. Medicare pays for these services based on payment rates established for each service under the Medicare physician fee schedule. The unit of payment is generally the individual service, such as an office visit or a diagnostic procedure. All services—surgical and non-surgical—are classified according to the Healthcare Common Procedure Coding System (HCPCS), which contains codes for over 7,000 distinct services. Payment rates for each service are based on the relative time and intensity of clinician work; practice expenses such as clinical staff, supplies and office overhead; and professional liability insurance (PLI) costs involved in furnishing each service.

Under the PFS, payment rates are based on relative weights, called relative value units (RVUs). Adjustments to Medicare payment rates for physicians' services are required to fit within a budgeted amount, i.e. increased payments for one service would result in decreased payments for another service.

The RVUs and payments are calculated to reflect the relative cost of the inputs used to provide each physicians' service. The distribution of RVUs among the three categories of resource inputs is: clinician work (51%), practice expenses (45%), and professional liability insurance (PLI) (4%). The RVUs for clinician work reflect the relative levels of time and intensity associated with providing each service. The RVUs for practice expenses reflect the cost of office rent, supplies and equipment, clinical and administrative staff, and other direct and indirect overhead costs associated with each service. The PLI RVUs are based on the premiums clinicians pay for professional liability insurance, also known as medical malpractice insurance. Each of the three categories of RVUs is adjusted using separate geographic practice cost indexes. Medicare payment rates under the PFS are subject to other adjustments based on the type of clinician, certain geographic designations, and other factors. Medicare pays the calculated amount, less any applicable beneficiary cost sharing (typically, 20 percent of the PFS rate).

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The PFS payment amount is determined by summing the geographically adjusted RVUs in each of the three categories (work, practice expense and professional liability) and multiplying the total by the fixed dollar conversion factor for the year. The conversion factor is updated each year in accordance with the statute. The CY 2020 PFS conversion factor remains flat at \$36.0896.

Medicare Post-Acute Care

Medicare post-acute care (PAC) providers are defined as skilled nursing facilities (SNFs), home health agencies (HHAs), inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCHs). Medicare PAC services are mainly used for recuperation and rehabilitation. While there is overlap in the types of patients and services provided by Medicare PAC providers, fee-for-service (FFS) payments for PAC services differ across settings. In 2017, total Medicare FFS expenditures for the four PAC settings were about \$60 billion. In addition, PAC users may transfer across a continuum of settings during the course of treatment for an illness or injury. Per the Medicare statute, separate Medicare prospective payment systems (PPSs) were developed for each Medicare PAC setting. The separate statutorily required Medicare PAC PPSs followed the implementation of Medicare inpatient PPS in the 1980s.

Skilled nursing facility (SNF) PPS - In order to be eligible for coverage of care in a SNF, a Medicare FFS patient must have a prior medically necessary inpatient hospital stay of at least 3 consecutive days and the SNF care must be for a condition for which the beneficiary received inpatient hospital services (a hospital-related condition) or a condition that arose in the SNF while a beneficiary was receiving treatment for a hospital-related condition. A beneficiary must need and receive skilled services on a daily basis. SNF covered services include nursing, therapy and ancillary services. The Minimum Data Set (MDS) is a patient assessment used to determine the case mix adjustment of the Medicare SNF PPS payment, and for care planning and quality purposes. Medicare Part A covers up to 100 days of post-hospital SNF care in a benefit period. There are no beneficiary out-of-pocket costs for the first 20 days of SNF care in each benefit period. Beneficiaries pay a coinsurance per day for days 21-100 of SNF care in each benefit period. Patients pay all costs for each day of SNF care after day 100 in a benefit period.

The SNF PPS was originally implemented in 1998. The SNF PPS uses a per-diem unit of payment, which is adjusted for case mix and differences in area wage levels. In FY 2020, CMS implemented SNF PPS case mix methodology changes under the Patient-Driven Payment Model (PDPM). Under the PDPM, patient characteristics are used to classify patients into the components of the SNF PPS per diem rates. Five of the six components of the SNF PPS per diem rates are case-mix adjusted (i.e., the case-mix adjusted components are physical therapy, occupational therapy, speech-language pathology, non-therapy ancillaries, and nursing). In FY 2020, the unadjusted base urban per diem rate (calculated as the sum of the six payment components) was \$420.65. The labor portion of the per diem rate is adjusted by a wage index. The unadjusted SNF PPS per diem rates are annually updated by the SNF market basket index percentage change, which reflects changes over time in the prices of an appropriate mix of goods and services included in covered SNF services. The SNF market basket index percentage change is reduced by a multifactor productivity adjustment and may be further reduced by 2 percent if a SNF fails to report certain quality data to CMS as required by statute. In addition, the adjusted SNF PPS per diem rates are reduced by 2 percent as statutorily mandated under the SNF value-based purchasing program.

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Home Health (HH) PPS - Home health services are provided by health professionals that visit a patient's home. A patient may be certified and recertified by a physician or other allowed practitioner for HH services as long as a patient continues to meet the statutorily required eligibility for the Medicare HH benefit. In order to receive Medicare-covered home health services, a patient must have an intermittent need for skilled nursing services or need therapy, meet the Medicare definition of homebound, be under the plan of care of a physician or allowed practitioner, and receive services under a plan of care established and reviewed by a physician or allowed practitioner. A face-to-face encounter with a physician or an allowed non-physician practitioner is required within specified timeframes. Medicare covered HH services include services such as part-time or intermittent skilled nursing services, physical therapy, speech-language pathology, occupational therapy, part-time or intermittent home health aide services, medical social work services, and medical supplies. The Outcome Assessment and Information Set (OASIS) is a patient assessment data set used for case-mix adjustment of payment, care planning, and quality.

The HH PPS was originally implemented in 2000 and uses a per-episode unit of payment, which changed from a 60-day to a 30-day period in CY 2020 per the Bipartisan Budget Act of 2018 (BBA 2018). In CY 2020, the national standardized 30-day period payment was \$1,864.03. The base episode payment rate is adjusted for patient case-mix and the labor portion of the rate is adjusted by a wage index. In CY 2020, CMS implemented home health PPS case mix methodology changes under the patient-driven groupings model (PDGM) which uses the 30-day period. Each home health patient is categorized into a home health resource groups (HHRGs) under the PDGM. The structure of the PDGM includes admission source (institutional or community entrant) and timing of the episode (early or late), clinical grouping from diagnosis, functional impairment level collected from the OASIS, and comorbidities. The HH PPS rates are annually updated for inflation, include a productivity adjustment, and adjusted for quality reporting to CMS. In addition, there are adjustments for high cost outlier cases and low-utilization payment adjustments.

Inpatient Rehabilitation Facility (IRF) PPS - IRFs are a category of inpatient rehabilitation hospitals and inpatient rehabilitation units within hospitals, which may be excluded from the acute inpatient PPS if certain criteria are met. In order to receive payment as an IRF under the IRF PPS, a facility must meet the 60% compliance threshold which requires no less than 60% of the IRF's inpatient population require intensive rehabilitation services for treatment of at least one of the 13 qualifying medical conditions. Among other coverage criteria, IRF patients are expected to actively participate in and benefit from an intensive rehabilitation program which generally consists of 3 hours of therapy per day at least 5 days per week. The IRF patient assessment instrument (PAI), which is used to assess each Medicare Part A FFS or Medicare Part C (Medicare Advantage) patient admitted or discharged from an IRF, is used for case mix adjustment of payment, care planning, and quality measures.

IRF PPS was launched in 2002. The IRF PPS uses a per-discharge unit of payment. In FY 2020, the base IRF PPS per-discharge payment was \$16,489. Patients are classified into a rehabilitation impairment category (RIC). Within each RIC, patients are further classified into a case mix group (CMG) based on their motor score, cognitive function, and age at admission. Patients are also assigned to a co-morbidity tier. The labor portion of the IRF per-discharge rate is updated by a wage index. The IRF PPS rates are annually

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updated for inflation, include a productivity adjustment, and are adjusted for quality reporting to CMS. In addition, there are adjustments for high cost outlier cases and short-stay CMGs. Additional adjustments for qualifying IRFs include rural area, share of low-income patients, and teaching facility adjustments.

Medicare Long-Term Care Hospital (LTCH) PPS - LTCHs are hospitals excluded from the acute inpatient PPS. LTCHs are required to have an average Medicare inpatient length of stay of more than 25 days. These hospitals generally serve complex and seriously ill patients (e.g., ventilator patients, burn patients). The LTCH continuity assessment record and evaluation (CARE) data set is currently used for care planning and quality. The LTCH PPS was established in 2002.

Standard Payment Rate: Generally, to qualify for this higher standard LTCH PPS payment rate, an LTCH discharge must meet the following requirements: the admission to the LTCH was immediately preceded by an acute-care hospital stay, either with a prior intensive care unit (ICU) stay of at least 3 days OR receipt of at least 96 hours of ventilator services in the LTCH; and the LTCH discharge does not have a principal diagnosis relating to a psychiatric or rehabilitation condition.

Site-Neutral Rate: LTCH discharges that do not meet the standard LTCH PPS rate criteria are paid at a site-neutral payment rate. In FY 2020, the base LTCH standard PPS per discharge rate was \$42,677.64. The labor portion of the base LTCH rate is adjusted by a wage index. The LTCH per discharge rate is adjusted for using a Medicare severity long-term care diagnosis related group (MS-LTC-DRG). The LTCH PPS rates are annually updated for inflation, include a productivity adjustment, and are adjusted for quality reporting to CMS. There are payment adjustments for interrupted stays. In addition, there are adjustments for high cost outlier cases and short-stay outliers.

Payments to Medicare Advantage Plans

Medicare Advantage (MA) plans are health plan options that are approved by Medicare and are run by private companies. They are part of the Medicare program and are sometimes called Part C. Beneficiaries can choose among local HMOs, PPOs or private FFS plans as well as regional PPO plans. Medicare beneficiaries can choose these plans as an alternative to receiving their Part A and B benefits through the traditional Medicare program. In MA plans, beneficiaries receive through that plan all Part A and B Medicare covered services, subject to specific exceptions (e.g., hospice services, acquisition costs for kidneys for transplant, certain new or changes in benefits that raise a significant cost). Many plans also include Medicare prescription drug coverage (Part D). An important feature of MA is that plans can offer additional benefits (known as “supplemental benefits”) not available in the traditional Medicare program. These plans can also require beneficiaries to use certain health care providers.

Each year, plans that have contracted with Medicare to participate in MA must submit a bid which must represent the plans’ revenue needs for providing Part A and Part B benefits to the average beneficiary in the each service area of the plan. Thus, the bid must include the costs of paying providers for expected use of health care items and services, administrative costs and any financial margin required. The claims cost component is based on the prices the plan has agreed upon with providers and expected utilization patterns. A recent report estimated that on average, claims (medical) costs accounted for 86.3 percent

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of MA plans' revenues, administrative expenses were 9.1% and profits 4.5%.²⁴ Medicare reviews these bids based on the reasonableness of the assumptions used for estimating revenue needs. The plan's bid is also reviewed based on the other contracting requirements described above (e.g. network adequacy, cost sharing limits). The bids can be rejected if all standards are not met or if CMS determines that the bid proposes significant increases in cost sharing or decreases in benefits offered under the plan.

MA capitation payments to plans are based on these bids and a benchmark set by Medicare. The benchmark is a bidding target established for each county based on a statutory methodology, which starts with an approximation of what would be paid for care under the traditional program and involves several adjustments. It represents the maximum payment (subject to risk adjustment) that the Medicare program will make to an MA plan on behalf of a beneficiary.

One of the adjustments is to multiply the estimated per capita cost under the traditional Medicare program by an applicable percentage. Each county is ranked according to its per capita fee-for-service program costs in a recent year to determine an applicable percentage. The percentage is then multiplied by the county's estimated per capita FFS costs for the payment year in order to determine the benchmark. Table 2.1 displays the applicable percentages by quartile of FFS costs.

Table 2.1. Applicable Percentages by Quartile

Quartile	Applicable Percentage
4 th (highest)	95%
3 rd	100%
2 nd	107.5%
1 st (lowest)	115%

Source: Advance Notice of Methodological Changes for Calendar Year (CY) 2017 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2017 Call Letter, February 2016

The ACA also amended the Social Security Act to require Medicare to make quality bonus payments to MA plans that meet certain standards under a five star quality rating system. For quality evaluation purposes, plans are evaluated at the contract level, which represent a group of plans from a single issuer. Contracts' quality is judged on a comprehensive set of quality measures representing multiple quality domains: staying healthy, managing chronic conditions, member experience, member complaints and changes in performance, and customer service. For those MA contracts that also provide Part D, or prescription drug benefits, performance is also evaluated on a similar set of Part D quality metrics. Performance across Part C and Part D metrics is combined to produce an overall Star Rating for plans that cover both Part C and Part D.

²⁴ Government Accountability Office, MEDICARE ADVANTAGE: 2011 Profits Similar to Projections for Most Plans, but Higher for Plans with Specific Eligibility Requirements, December 2013, <https://www.gao.gov/products/GAO-14-148>

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The resulting stars, which range from values of 1-5, are used for several purposes. They are publicly reported to facilitate beneficiary choice; they are reported to the health plans to facilitate ongoing improvement; and they are used to provide financial bonuses to high-performing contracts. MA contracts achieving 4 or more stars are eligible for a Quality Bonus Payment (QBP) of a 5 percentage point increase in the applicable percentage. Beneficiaries can also switch to 5-star contracts at any point in the year using a regulatory special enrollment period for that purpose – not only during open enrollment; in the same vein of encouraging enrollment in 5-star contracts, consistently low-performing plans are ineligible for online enrollment. The QBP is implemented as a percentage point increase to the applicable percentage displayed on Table 2.1. That is, the QBP increases the benchmark for plans with 4 or more stars. For example, a five star plan located in a county ranked in the upper quartile of FFS costs would receive 100% of the FFS rate rather than 95%.

Payments to plans are determined by comparing the bids submitted by plans to these established benchmarks. If the bid is greater than the benchmark described above, the plan is paid the risk adjusted benchmark rate by Medicare and then must charge an additional Part C premium to beneficiaries who choose the plan in order to cover the additional costs reflected in the bid. If the bid is less than the benchmark, the plan receives their risk adjusted bid plus a beneficiary rebate, which is a percentage of the difference between the risk adjusted bid and the risk adjusted benchmark. The percentage difference (between 50% and 70%) is based on the plan's star ratings. The rebate must be returned to beneficiaries in the form of supplemental benefits (additional items and services, or reductions in cost sharing for Part A and B benefits) and/or reductions in Part B or Part D premiums. Thus, the higher the star rating, the more revenue a plan has to increase benefits or reduce cost sharing. The part of the difference not returned to plans in rebates is retained by the Medicare program.

The risk adjustment methodology used in the MA program can also result in plans' ability to generate additional revenues by changing their diagnostic coding practices. CMS uses claims data from FFS to estimate the risk adjustment model and applies this model to diagnostic data submitted by plans. This method can result in higher payments for the same levels of risk when the plans submit diagnoses more comprehensively than is done in FFS. While the motivation behind the higher level of reported diagnoses can vary, the effect on the risk adjustment model is the same. That is, higher levels of diagnostic documentation generally lead to higher payments than would be the case if plans coded like FFS providers.²⁵ It should be noted that Congress has mandated a minimum coding intensity adjustment each year to address this issue.

Payment for Prescription Drugs in Medicare Part D

The Medicare Modernization Act of 2003 (MMA) authorized Medicare Part D as a voluntary drug benefit for Medicare beneficiaries, and the Part D program was implemented in January 2006. Private plans compete for enrollees by providing and managing the drug benefit.²⁶ Each enrollee in either Part A or Part

²⁵

²⁶ The Medicare Part D drug benefit is administered through private prescription drug plans, which each separately design and manage benefits and pay claims. Private prescription drug plans use purchasing arrangements and

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B is also entitled to enroll in a Part D prescription drug plan. In addition, some Medicare Advantage plans also cover the Part D benefit. These plans are known as MA-PDs. Similar to Part B, enrollment in Part D is voluntary and the enrollee pays a monthly premium.²⁷ In 2018, total enrollment in Medicare was 59.9 million, of which enrollment in Part D was 45.8 million.²⁸ Enrollees in Part D pay a monthly premium, in addition to cost sharing, which typically includes costs up to a deductible, for their drugs. Low-income beneficiaries (LIS) pay lower or no premiums, cost sharing, or deductibles. The majority of beneficiaries now have drug coverage, plan choices remain plentiful, and premium growth has been moderate.²⁹

Under Part D, private plan sponsors submit annual premium bids for providing the benefit. Medicare subsidizes 74.5 percent of the national average standard coverage for all types of beneficiaries. That average subsidy takes two forms:

- Direct subsidy—a capitated payment to plans calculated as a share of the adjusted national average of plan bids.
- Individual reinsurance—Medicare subsidizes 80 percent of drug spending above the out-of-pocket threshold. Reinsurance acts as a form of risk adjustment by providing greater federal subsidies for the highest cost enrollees.

In addition, Medicare establishes symmetric risk corridors separately for each plan to limit a plan's overall losses or profits. Under risk corridors, Medicare limits a plan's potential losses (or gains) by financing some of the higher-than-expected costs (or recouping excessive profits). Also, Medicare pays plans that enroll low-income beneficiaries most of those enrollees' cost sharing and premiums.

CMS pays plans a monthly prospective payment for each enrollee based on plan bids (the direct subsidy) after making two adjustments. First, the plan bid is adjusted by the enrollee's case mix and other subsidy factors, such as low-income status and long-term institutionalized status. Second, CMS subtracts enrollee's premium from the plan's approved bid.

CMS reconciles actual levels of enrollment, risk factors, levels of incurred allowable drug costs (after rebates and other discounts), reinsurance amounts, and low-income subsidies after the end of each year.³⁰

utilization management, including negotiation of prices with manufacturers and pharmacies, formularies, step therapy, quantity limitations, and prior authorization. All formularies must include all (with specified exceptions) drugs in the immunosuppressant, antidepressant, antipsychotic, anticonvulsant, antiretroviral, and antineoplastic classes to ensure patient access to these protected classes of drugs. The current exceptions include that the formulary does not have to include all therapeutic equivalents (i.e., generics) and can use safety edits to limit quantities (see 42 CFR 423.120(b)(2)(vi)).

²⁷ Starting in 2011, higher income enrollees pay higher premiums, as in Part B.

²⁸ Medicare Trustees Report 2019 Table II.B.1, Medicare Trustees Report (2019). Retrieved from: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2019.pdf>

²⁹ <https://www.kff.org/medicare/fact-sheet/an-overview-of-the-medicare-part-d-prescription-drug-benefit/>

³⁰ http://medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_19_partd_final_sec.pdf?sfvrsn=0

Payment for Laboratory Services

Prior to 2018, Medicare paid for clinical laboratory services at rates that were based on historical charges. The Protecting Access to Medicare Act (PAMA) of 2014 generally required that Medicare payment be based on the rates paid by subset of private payors to certain laboratories. These new rates were phased-in starting in 2018. This implementation not only lowered aggregate Medicare spending but also updated the relative rates by HCPCS code. To calculate these rates, PAMA generally requires applicable laboratories to submit to CMS certain applicable information regarding private payor rate and associated volume of tests, for each HCPCS code. For most tests, the Medicare payment rate is equal to the weighted median of private payor rates reported. Clinical laboratory services are performed by three laboratory types—independent laboratories, physician office laboratories, and hospital laboratories. Only laboratories receiving a majority of their Medicare revenues under the Clinical Laboratory Fee Schedule or the Physician Fee Schedule are required to report applicable information to CMS for use in establishing Medicare rates. This requirement largely excludes hospital laboratories, which tend to have higher private payor rates for laboratory tests by virtue of greater market power.

Payment for Durable Medical Equipment, Orthotics and Prosthetics (DMEPOS)

In the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP), suppliers bid for contracts to furnish items and services, identified by Healthcare Common Procedure Coding System (HCPCS) codes, under several different product categories. Each supplier submits a bid amount for the lead item in the product category. The Social Security Act mandates that CMS establish a single payment amount (SPA) for each competitively bid item based on winning bids from multiple suppliers.

CMS establishes a pivotal bid for each product category in each Competitive Bidding Area (CBA). A pivotal bid is the lowest composite bid based on bids submitted by suppliers for a product category that includes a sufficient number of suppliers to meet beneficiary demand for items in that category. A composite bid is the bid submitted by the supplier for the lead item in the product category. The suppliers whose composite bids are less than or equal to the pivotal bid for the product category and that meet the supplier eligibility requirements are selected by CMS as winning suppliers.

The Social Security Act requires CMS to use information on the payment determined under the CBP to adjust the DME fee schedule amounts for items furnished in areas that are not subject to competitive bidding. Over the past four years, CMS has adjusted the fee schedule amounts for DME items furnished outside of competitive bidding areas in a number of ways. For example, the fee schedule amounts have been adjusted based on a blend of 50 percent of the adjusted fee schedule amount for the area and 50 percent of the unadjusted fee schedule amount, adjusted based on a blend of 75 percent of the adjusted fee schedule amount and 25 percent of the unadjusted fee schedule amount, and fully adjusted (based on 100 percent of the adjusted fee schedule amount), depending on when and where the items were furnished.

Value-Based Purchasing Programs

In order to shift providers' payment incentives under the above payment systems from volume to value, Medicare has implemented value-based purchasing (VBP) programs across provider settings. These programs introduce competition between providers for incentives (or not to receive penalties) based on their performance on quality and/or costs. The programs, however, are designed in different ways, and may encourage competition in different ways, i.e. penalties vs. incentives or achievement vs. improvement. One study found substantial variation in the degree to which Medicare VBP programs incorporated best practices known to change provider incentives in pay-for-performance programs. In addition to VBP programs that build on the FFS payment architecture, new VBP payment and delivery models have emerged that seek to fundamentally change how providers are paid, such as Accountable Care Organizations' shared savings models. In the following sections, evidence from evaluation of these models are presented.

Inpatient Hospitals

Currently, there are three hospital VBP programs that use financial penalties and rewards to incentivize changes in the quality, outcomes, and costs of health care: the Hospital Readmissions Reduction Program (HRRP) and the Hospital Value-Based Purchasing Program (HVBP), for which payment adjustments began fiscal year (FY) 2013; and the Hospital-Acquired Conditions Reduction Program (HACRP), for which payment adjustments began in FY 2015. These programs are collectively intended to encourage hospitals to improve overall quality of care, improve patient safety, and reduce costs and hospital readmissions. Hospitals also receive confidential Hospital-Specific Reports (HSRs) with data on their performance to help inform areas for improvement.

HRRP - Under the HRRP, hospitals face payment penalties if they have higher-than-expected readmission rates for a key set of conditions common in the Medicare population. The program initially focused on acute myocardial infarction (acute MI), heart failure (HF), and pneumonia, but has now expanded to include chronic obstructive pulmonary disease (COPD), total knee or hip arthroplasty (TKA/THA), and coronary artery bypass grafting (CABG). Program penalties are applied to Medicare base-operating diagnosis-related group (DRG) payments, across hospitals' total Medicare book of business. The HRRP follows a specific methodology to calculate risk-standardized readmission rates for each hospital in the program based on a three-year performance period. The measure compares a particular hospital's performance on the readmission measure to the average performance of a hospital with the same case mix. The HRRP penalty is based on payments for these higher-than-expected readmissions as a proportion of total payments for all admissions. Thus, the proportion of all payments for the five conditions currently included in the excess readmission calculation is a significant driver of the size of penalties.

In response to concerns that safety-net hospitals are unfairly penalized because of the more vulnerable patient population they serve, Congress required in the 21st Century Cures Act of 2016 that CMS implement a peer-grouping methodology to determine program penalties. Under the regulatory peer-grouping methodology adopted by CMS, hospitals are divided into five peer groups based on the proportion of their population who are dually-eligible for Medicare and full-benefit Medicaid, and

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penalties are distributed within peer groups. As expected and designed, the new methodology, first applied in FY2019, results in fewer safety-net hospitals penalized and a decrease in readmissions penalties, but also slightly fewer hospitals penalized overall.

HACRP - The HACRP is focused on reducing the incidence of infections and other adverse safety events in U.S. hospitals. The program was created in Section 3008 of the 2010 Patient Protection and Affordable Care Act (ACA), and its first payment year was FY 2015.

Hospitals with a total score greater than the 75th percentile of all Total HAC scores (i.e., the worst-performing quartile) are subject to a flat 1% penalty on their total inpatient Medicare revenues, which includes base diagnosis-related group (DRG) payments as well as add-ons like disproportionate share hospital (DSH) payments and payments for medical education.

For FY 2020, the total HAC score is based on data for six quality measures, including CMS' Recalibrated Patient Safety Indicator (PSI) 90, a claims-based composite measure, and five health care associated infection measures based on data reported to Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN).

HVBP - The HVBP program is authorized under section 1886(o) of the Social Security Act, and payment adjustments under that program began in FY 2013. The HVBP program assesses hospitals' performance in four domains: clinical outcomes; person and community engagement; safety; and efficiency and cost. The budget-neutral program works by withholding a percentage of hospitals' Medicare payments for inpatient services each year and redistributing the total amount of such withhold as incentive payments to hospitals based on their performance on measures in each of the domains. Withholding started at 1% of a hospital's base-operating DRG payments in FY 2013 and is now capped at 2% for FY 2017 and beyond.

The program assesses hospitals' performance across the four domains, equally weighted. Unlike the other two hospital VBP programs, hospitals are generally scored on both achievement and improvement for each measure in the HVBP program. Achievement is scored on a scale of 1 to 10 based on performance thresholds calculated using national data (median performance rate) and benchmarks (the top decile of national performance). Improvement is also scored on a scale of 1 to 10, based on improvement between the baseline period and the performance period. Hospitals earn the higher of their achievement or improvement points for each measure.

Physicians – MIPS

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) repealed the Sustainable Growth Rate formula and established two payment paths for clinicians to receive incentives and future annual payment updates. Unless clinicians participate in an advanced alternative payment model, they are subject to a VBP program called the Merit-Based Incentive Payment (MIPS) program, unless otherwise excluded. MIPS assesses performance in four categories: quality (45% in 2020), promoting interoperability (25%), improvement activities (15%), and cost (15%). Beginning in 2019, all MIPS eligible clinicians receive positive, neutral, or negative payment adjustments (up to 9% increase or decrease in 2020). The program

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is budget neutral—the negative payment adjustments for some clinicians fund the positive payment adjustments for others.

Post-Acute Care (PAC)

SNF VBP - The Skilled Nursing Facility Value-based Purchasing (SNF VBP) adjusts Medicare payments to SNFs based on their performance on a SNF all-cause, all-condition hospital readmission measure. The SNF VBP is authorized under section 1888(h) of the Social Security Act, and payment adjustments under that program began in FY 2019. CMS withholds 2% of SNF Medicare payments to fund the program each year. CMS redistributes approximately 60% of the withhold to SNFs as incentive payments.

HHVBP Model - The Home Health Value-based Purchasing (HHVBP) Model is a mandatory model implemented by the Centers for Medicare & Medicaid Innovation in nine states. Since 2018, the HHVBP Model has adjusted payments based on performance on process, outcome, and patient experience measures. The maximum payment adjustment increases from 3 percent in 2018 to 8 percent in 2022; in 2020, the maximum payment adjustment is 6 percent either upwards or downwards.

Dialysis Facilities – ESRD QIP - Beginning with renal dialysis services furnished in 2012, the End-Stage Renal Disease Quality Incentive Program (ESRD QIP) penalizes ESRD facilities that do not achieve a minimum total performance score with respect to their performance on safety, patient and family engagement/care coordination, and clinical care measures. A facility that does not achieve the minimum total performance score that applies for the program year will receive a payment reduction to its Medicare payments of up to 2 percent based on how far below the minimum total performance score the facility performs.

Alternative Payment Models

Accountable Care Organizations

The Medicare Shared Savings Program (Shared Savings Program) was established in the Affordable Care Act (ACA) and is a voluntary program available to accountable care organizations (ACOs). The Shared Savings Program uses financial incentives tied to quality metrics and savings with the goal of increasing coordination of care and reducing the rate of growth in expenditures for Medicare beneficiaries. ACOs are groups of providers and suppliers that have agreed to be accountable for the care of a defined population of Medicare fee-for-service (FFS) beneficiaries and have at least 5,000 assigned Medicare beneficiaries for each benchmark and performance year. Savings or losses are determined by comparing actual expenditures for performance year assigned beneficiaries to benchmark expenditures. The ACO framework is a means of grouping providers and suppliers together into one organization with a collective incentive to reduce the rate of growth in Medicare expenditures, including by reducing the use of excessive services, while maintaining a fee-for-service payment system. It maintains the fee-for-service payment system for providers and suppliers and beneficiaries' freedom to choose their healthcare providers.

The first ACOs started in the Shared Savings Program in 2012. Initially, the program allowed for ACOs to take a gradual path to assuming financial risk for their performance. The Shared Savings Program has

undergone changes since it launched, however. The most recent change, adopted in the December 2018 Pathways to Success final rule, offers two participation tracks: BASIC and ENHANCED. The BASIC track is designed to have a “glide path” for eligible ACOs that allows two years of one-sided risk before three years of two-sided risk with increasing amounts of potential shared losses. It is designed for ACOs that are inexperienced with risk to gradually phase into higher levels of performance-based risk without facing significant downside from the start. The ENHANCED track, by contrast, is for experienced ACOs and only offers greater risk sharing.

CMS Innovation Center Models

The CMS Innovation Center was established by section 1115A of the Social Security Act (as added by section 3021 of the Affordable Care Act). Congress created the CMS Innovation Center for the purpose of testing “innovative payment and service delivery models to reduce program expenditures ... while preserving or enhancing the quality of care” for those individuals who receive Medicare, Medicaid, or Children’s Health Insurance Program (CHIP) benefits. The statute provided the Secretary of the Department of Health and Human Services (HHS) with the authority under section 1115A(c) to expand through rulemaking the duration and scope of a model being tested or a demonstration project under section 1866C, including implementation on a nationwide basis, subject to certain requirements. In order for the Secretary to exercise this authority, the Secretary must determine that the expansion is expected to either reduce program spending without reducing quality of care or improve quality of care without increasing spending. CMS’ Chief Actuary must certify that expansion of the model would reduce (or not increase) net program spending, and the Secretary must determine that the expansion would not deny or limit the coverage or provision of benefits under Medicare, Medicaid, or CHIP. The Secretary’s expansion determinations are made based on evaluations performed by CMS under section 1115A(b)(4).

The law also requires that the Secretary terminate or modify models tested under section 1115A, at any time after testing has begun and before completion, unless the Secretary determines that the model is expected to improve the quality of care without increasing spending, reduce spending without reducing quality of care, or improve quality of care and reduce spending. For these purposes, the CMS Chief Actuary must make a certification in support of the Secretary’s determinations with respect to program spending.

Thus, CMMI is organized to support the design and testing of new payment and service delivery models, as well as to support demonstrations and other projects. The Innovation Center comes with a simple mission: lower costs and improve or maintain quality by driving delivery system transformation. If the Innovation Center develops a successful idea, Medicare and Medicaid may work to quickly replicate it nationwide. If an idea is not successful, the Innovation Center goes back to the drawing board and develop something different taking into account lessons learned.

To date, the Innovation Center has designed, tested, and evaluated numerous alternative payment models including shared savings, primary care medical home, bundled payment, and disease-specific models (see Figure 2.1). The Innovation Center tested the Pioneer ACO Model and is testing the Next Generation ACO model. Two notable recent models are Primary Care First and Direct Contracting Model Professional and Global Options. The Primary Care First Model is designed to offer greater flexibility,

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increased transparency, and performance-based payments to practices that specialize in patients with complex chronic conditions and high need, seriously ill populations. The goals of the model are to reduce Medicare spending by preventing avoidable inpatient hospital admissions and to improve quality of care and access to care for all beneficiaries, particularly those with complex chronic conditions and serious illness. Under Direct Contracting, there are two participation options: Professional and Global. Professional offers lower risk sharing (50% shared savings/losses) and shifts slightly away from FFS by providing primary care capitation. The Global option has higher risk sharing (100% shared savings/losses) and allows the participant to choose either primary care capitation or total care capitation.

A similarly named, but distinct, model is the Geographic Direct Contracting Model (“Geo”). The Geo Model will allow Direct Contracting entities (DCEs) to take responsibility for the total cost of care for Medicare fee-for-service beneficiaries in a geographic region. With this model, CMMI is testing allowing entities some of the flexibilities and risk bearing of Medicare Advantage and commercial health risk-sharing arrangements within the fee-for-service Medicare system. CMMI is currently accepting Letters of Interest from potential DCE applicants. CMS expects to issue a Request for Applications in January 2021. The Geo model will be tested over six years with two three-year performance periods, the first of which starts on January 1, 2022 and the second of which starts on January 1, 2025.

Figure 2.1. Summary of Selected Innovation Center Models, Initiatives, and Demonstrations

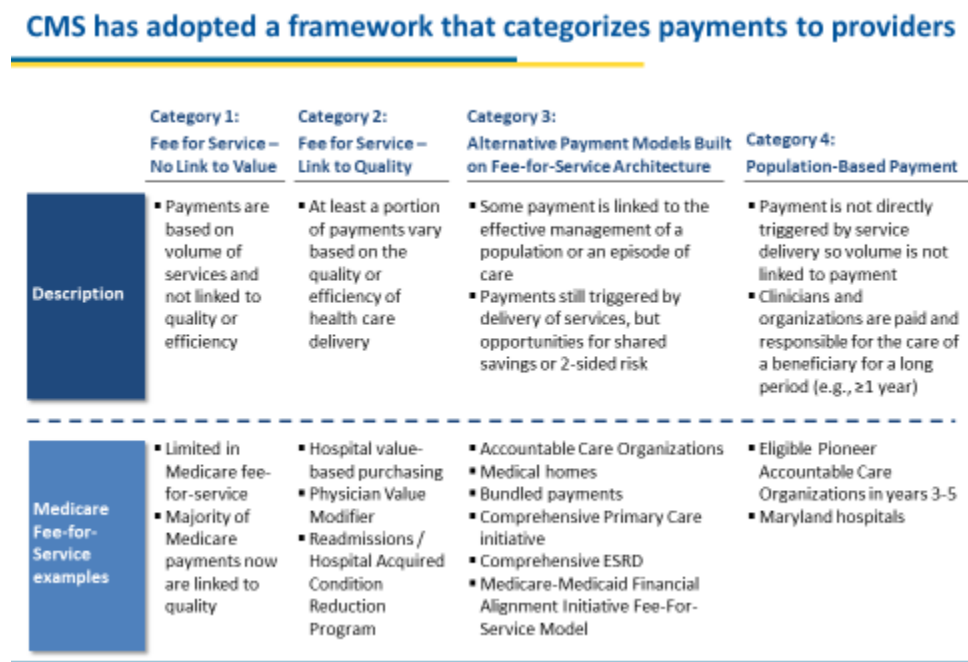
Pay Providers	<p>Test alternative payment models</p> <ul style="list-style-type: none"> ▪ Accountable Care <ul style="list-style-type: none"> – ACO Investment Model – Pioneer ACO Model – Medicare Shared Savings Program (run by the Center for Medicare) – Comprehensive ESRD Care Initiative – Next Generation ACO ▪ Primary Care Transformation <ul style="list-style-type: none"> – Comprehensive Primary Care Initiative (CPC) & CPC+ – Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration – Independence at Home Demonstration – Graduate Nurse Education Demonstration – Home Health Value Based Purchasing – Medicare Care Choices – Frontier Community Health Integration Project – Medicare Diabetes Prevention Program Expanded Model 	<ul style="list-style-type: none"> ▪ Bundled payment models <ul style="list-style-type: none"> – Bundled Payment for Care Improvement Models 1-4 – Oncology Care Model – Comprehensive Care for Joint Replacement ▪ Initiatives Focused on the Medicaid <ul style="list-style-type: none"> – Medicaid Incentives for Prevention of Chronic Diseases – Strong Start Initiative – Medicaid Innovation Accelerator Program ▪ Dual Eligible (Medicare-Medicaid Enrollees) <ul style="list-style-type: none"> – Financial Alignment Initiative – Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents – Medicare-Medicaid ACO Model ▪ Medicare Advantage (Part C) and Part D <ul style="list-style-type: none"> – Medicare Advantage Value-Based Insurance Design Model – Part D Enhanced Medication Therapy Management
Deliver Care	<p>Support providers and states to improve the delivery of care</p> <ul style="list-style-type: none"> ▪ Learning and Diffusion <ul style="list-style-type: none"> – Partnership for Patients – Transforming Clinical Practice ▪ Health Care Innovation Awards ▪ Accountable Health Communities 	<ul style="list-style-type: none"> ▪ State Innovation Models Initiative <ul style="list-style-type: none"> – SIM Round 1 & SIM Round 2 – Maryland All-Payer Model – Pennsylvania Rural Health Model – Vermont All-Payer ACO Model ▪ Million Hearts Cardiovascular Risk Reduction Model
Distribute Information	<p>Increase information available for effective informed decision-making by consumers and providers</p> <ul style="list-style-type: none"> ▪ Information to providers in Innovation Center models 	<ul style="list-style-type: none"> ▪ Shared decision-making required by many models

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As described above, the Medicare program develops and maintains a diverse array of payment systems for health care providers and health plans, as well as testing and implementing new models of payment and delivery. The program has undergone a significant transition from unrestricted fee-for-service payment towards performance-based systems. Figure 3.1 summarizes the types of payment mechanisms available.³¹ Although all of these main payment mechanisms are currently used to some extent, the transition over the past ten years has moved much of the payment flow from left to right on the Figure. One major objective of these programs is to begin paying for outcomes rather than volume. That is, to move from unrestricted fee-for-service payment to payment which holds plans and providers accountable for both cost and quality. Of equal importance, a key objective is to change the delivery of care to be more coordinated and patient centered.

Figure 3.1. Medicare’s Payment Risk Continuum



Source: Rajkumar R, Conway PH, Tavenner M. CMS – engaging multiple payers in payment reform. JAMA 2014;311(19):1967-8.

In terms of policy, it is important to assess how successful these programs have been and what further possible policies might be pursued to enhance our ability to achieve these key objectives. There are two

³¹ We note that this Figure refers to payments under the traditional program. Currently, 40% of beneficiaries are enrolled in Medicare Advantage plans that receive a capitated payment from the program.

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ways the current transition might be evaluated. First, how successful has the program been in moving away from unrestricted FFS payment. In that regard, progress has been made as most payment to plans and providers is in some way based on performance rather than solely on volume.³² A second, more difficult question is whether achieving the lower prices relative to the private sector and conditioning them on performance have resulted in the type of innovation and substantial changes in health care delivery that would be consistent with a high value system – that is, systems that can deliver improvements in population health at lower costs.

As detailed in the following section of this report, the financial incentives of a well-functioning competitive market assure that high quality goods and services are produced at the lowest possible cost. A reasonable evaluation question therefore is whether Medicare's policies have indeed resulted in the innovation and efficiency that would occur in such a marketplace. To be sure, within each of the columns on Figure 3.1 there are payments that include financial risks for plans and providers and incentives for reducing costs. For example, bundled payment such as for inpatient stays encourages hospitals to provide only necessary services during an admission. MA, ACO models and bundling models all contain various degrees of financial risk based on costs and quality.

Clearly, the projections of Medicare and overall health spending and the estimates of wasteful spending suggest there is still progress that needs to be made. One concern is that Medicare's payment mechanisms and innovative model testing have not yet been constructed in a way that provides the same strength of financial incentives or discipline as would a competitive market. That is, Medicare's prices may still be higher than would occur in a competitive market and the models being tested by the Innovation Center may yet to have achieved the financial risk and rewards that would occur in such a market.

As described above, there are general components to Medicare's pricing systems: what services are included under a particular payment rate; what method and data are used to establish the rate; and what adjustments are made to account for differences among plans and providers (e.g. adjustments for local labor costs or teaching status for hospital payments). For Innovation Center models, similar factors must be considered along with establishing parameters for upside and downside risk. Administered pricing is complex, and any of these payment components might be constructed in a manner that provides financial cushion or opportunities for revenue enhancement for providers, either of which could significantly reduce the financial incentives for real cost and quality improvements.

There are several examples of this issue. Most payment systems, such as those for inpatient and outpatient services, base their rates on some measure of historical costs relevant to the plans or providers that fall under the system.³³ Because these costs can reflect the inefficiencies that the payment methods sought to address, they may be higher than would occur in a competitive market, reducing incentives for improvement. Under both the hospital inpatient system and the current MA program, coding practices

³² The LAN estimates only 10% of Medicare FFS payments are not related to performance. <http://hcp-lan.org/workproducts/apm-discussion-2018.pdf>

³³ Costs are sometimes determined as charges adjusted by a cost to charge ratio. Charges on a service by service basis may differ from the prices that would occur in a well-functioning market.

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provide opportunities for revenue enhancement that may further reduce incentives.³⁴ The separate payment systems for post-acute care services provide a number of influences, other than patient needs, that may affect care decisions such as choosing a site of care.³⁵ Finally, current ACO initiatives may have only achieved modest savings because their financial risk initially have been too small to make investing in real changes in care delivery attractive. Recent trends toward greater savings are occurring as the degree of downside risk has grown.³⁶

While the value-based programs have focused attention on provider accountability for quality, it is not clear they have incentivized major changes in the delivery of care. HRRP has been associated with a short-term reduction in readmissions but the positive effect seemed to bottom out fairly quickly.³⁷ Results for the HVBP program have been mixed. For example, one study found that incorporating cost measures in the program may have resulted in low-cost, low-quality hospitals being more likely to receive bonuses compared to when the program only evaluated performance on quality.³⁸ Another study of the program did not find evidence the program resulted in improved performance compared with critical access hospitals not participating in the program.³⁹ At minimum, these results suggest that the incentives in these policies have not been strong enough to induce major changes in care delivery.

Another issue with current Medicare policy is that the beneficiaries do not have strong incentives to choose high value providers. Since cost sharing is mainly determined by service type, out-of-pocket payments can be the same regardless of provider choice. Thus low value providers are not punished to the same extent, and high value providers rewarded, as they would be in a competitive market.⁴⁰ Similarly, Medicare has generally been very inclusive with regard to providers with little statutory or political support for favoring high performers and excluding poor performers.⁴¹

Finally, while Medicare is large, it is only one source of payment for providers. Thus, as discussed previously, there are opportunities for enhancing revenues rather than looking to reduce costs in response

³⁴ Paul D Jacobs and Richard Kronick, “Beneficiary Health Risk?”, Health Services Research, [Volume 53, Issue 6](#), 4097-5015.

³⁵ Institute of Medicine (2013). Variation in Health Care Spending: Target Decision Making, Not Geography. Retrieved from <http://www.nationalacademies.org/hmd/Reports/2013/Variation-in-Health-Care-Spending-Target-Decision-Making-Not-Geography.aspx>; Fowler, A. et al. Corporate Investors Increased Common Ownership and Hospitals and The Postacute Care and Hospice Sectors. Health Aff. 2017;36(9):1547-1555

³⁶ Jonathan Gonzalez-Smith, William K. Bleser, David Muhlestein, Robert Richards, Mark B. McClellan, Robert S. Saunders, “Medicare ACO Results for 2018: More Downside Risk Adoption, More Savings, and All ACO Types Now Averaging Savings”, Health Affairs Blog, October 25, 2019

³⁷ Zuckerman, Rachael, Sheingold, Steven, Orav, John, Ruhter, Joel, and Epstein, Arnold. “Readmissions, Observation, and the Hospital Readmissions Reduction Program”, April 21, 2016, N Engl J Med 2016; 374:1543-1551

³⁸ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4910877/#idm139754015638272title>

³⁹ <https://www.nejm.org/doi/full/10.1056/NEJMsa1613412>

⁴⁰ Leemore S Dafny and Thomas H Lee, “Health Care Needs Real Competition”, from Harvard Business Review, December 2016, <https://hbr.org/2016/12/health-care-needs-real-competition>

⁴¹ James Capretta, “The role of Medicare FFS in Inefficient Health Care Delivery”, American Enterprise Institute and Robert Wood Johnson Foundation, April 2013

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to Medicare policies. For example, hospitals have integrated both horizontally and vertically which increases their market power to raise prices for private payers.

Thus, there is at least the potential for Medicare to pursue policies that would incentivize more fundamental, value producing changes in health care delivery. In particular, new policies or modifications to existing ones that increased competition or provided stronger market-based incentives could force market participants to engage in the same type of value-enhancing innovation that might occur in well-functioning markets. That is, providers and health plans would need to look for real cost savings as opposed to revenue enhancements. Such fundamental change would likely affect all patients and therefore have positive spillovers to the private insurers.

Promoting competition and market-based incentives in health care will likely require careful and informed policymaking. In the following section, we describe some of the issues for crafting these policies for Medicare and the entire health system.

Markets, Market-Based Policies, and Medicare

It is probably not controversial to state that there is general agreement among policymakers that improving the performance of both Medicare and the health care system is critical both to the health of the population and the economy. Given the discussion above, it is likely that new policies will be needed to achieve a fully patient-centered, high value health care system. As solutions to the cost and quality problems have been sought, the role of competition and market forces in health care markets has been frequently discussed and analyzed. Although economists might not agree on the same set of policies, most would agree that improving competition and market-based incentives would be preferable where possible.

Before discussing specific market-based policies for Medicare, it is worthwhile returning to a more detailed discussion of health care markets as a prelude. In well-functioning markets, competition provides strong financial incentives for efficiency. Informed consumers shop for the best value in products and sellers compete on price and quality of those products. The financial incentives in this environment assure that sellers continually innovate to reduce costs and improve their products by adopting new technologies and/or new business models. The consequences of not being innovative are that less efficient producers are driven from the market by more aggressive and creative competitors.

In theory, markets that function well to assure efficiency and quality have several characteristics. In general, competition requires that there be a sufficient number of buyers and sellers, and that there are relatively low costs for market entry and exit. In these markets, the buyers and sellers interact directly with each other. That is, the consumer pays directly to the seller for the good or service being purchased. A key assumption is that consumers have good information on the price and attributes of the product, such as quality, and are good judges of value for money. Under these conditions, buyers and sellers make independent decisions based on market price. Finally, consumers pay the full price for the good or service and fully derive its benefit – that is, there are no positive or negative externalities or public goods aspects to the market transaction.

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Health care markets are subject to a number of well-known deviations from these ideal conditions. First, rather than being a transaction only between the patient and provider, most health care is paid through a third party: health insurers. This means that consumers are shielded from the immediate cost of their services and may not shop as carefully, or tend to overconsume, relative to what their decision making would be in a well-functioning market. In addition, consumers may not have or be able to process the complex information about their health conditions or the services that might be used for diagnosis and treatment. That is, there is asymmetric information between patient and provider; the latter playing a dual role as the seller and patient agent. Thus, decisions of buyers and sellers are interdependent rather than independent.

These deviations from the ideal conditions of well-functioning markets are the basis of public policy intervention in health care. There is general agreement that health care markets alone will not achieve optimal levels of efficiency and quality; but far less agreement on the intensity and content of public policy interventions. One side of the debate sees market failures as necessitating very active government involvement in health care markets.⁴² In general, this approach would mean a heavier regulatory approach to health care markets. Others believe markets are the best answer and point to circumstances where market forces are already at work. For example, competition seems to work well in markets for services such as laser eye and cosmetic surgery—markets in which there are competing providers, easily assessed outcomes, and little insurance coverage.⁴³ Other reports suggest that where there are competitors, hospitals that provide better quality of care to gain market position.⁴⁴ This report will focus on policies that would be designed to enhance competition and market forces in order to incentivize innovation that would reduce cost growth and improve health outcomes.

Health care markets are dynamic, as are the interactions and decisions of the participants including insurers, providers and patients. A one-size-fits-all market-based policy approach may not be successful. Different types of market-based incentives may be needed depending on which participants we envision making different decisions about payment, quality and the organization of care. For example, consumers may have more ability to be informed, value-based shoppers for some types of services than others. Consumers shopping for elective or primary care services may have more information, incentives and ability to carefully choose providers based on cost and quality than patients with chronic diseases shopping for complex and coordinated services. The former are sometimes called “shoppable” services. The latter may be better able to shop for health plans or provider organizations to manage their care. Likewise, provider-based competition may be more effective for some services or geographic markets than in others. For example, competitive bidding strategies would likely not be an optimal approach in

⁴² Kenneth J Arrow, “The Uncertainty and Welfare Economics of Medical Care”, *American Economic Review*, Volume 53, Issue 5, December 1963, pp. 941-973; Thomas Rice and Lynn Unruh, *The Economics of Health Care Reconsidered*, Fourth Edition, Health Administration Press, 2015

⁴³Herrick DM. The Market for Medical Care Should Work Like Cosmetic Surgery. National Center for Policy Analysis Policy report No. 349. Dallas, TX. May 2013.
<https://www.healthworkscollective.com/wpcontent/uploads/2013/06/st349.pdf>. Accessed September 28, 2018

⁴⁴ Amitabh Chandra, Amy Finkelstein, Adam Sacarny and Chad Syverson, “Research: Perhaps Market Forces Do Work in Health Care After All”, *Harvard Business Review*, December 05, 2016

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highly concentrated provider or insurance markets. Moreover, as described below, different types of policies may be targeted to different levels of decision making to reflect these interrelated issues. Policies can be crafted more artfully to the extent these factors are well understood. It is important therefore to describe some definitional issues that come into play, and discuss a framework that can help to harmonize the variety of market-based policies that might be considered.

A quick review of the relevant literature on health care policies might lead to a conclusion that there are some very simple choices: regulation vs. competition; consumer driven competition vs. health plan competition vs. provider competition; and demand side policies vs. supply side policies. Experience, however, suggests an array of policy choices that is far more complex may be needed. Regulation is often thought of as extensive intervention in the market such as for pricing of services, establishing quality and participation standards and involvement with the process of care. In contrast, a competition approach would rely on market-based incentives to establish prices and assure the provision of high quality, efficiently produced care. In practice, some mix of the approaches that have been used with varying degrees of success in the past might be looked to as a building block for more effective policies in the near future. For example, as described in previous sections, Medicare has had some success with its Part D drug benefit and DMEPOS competitive bidding programs which have relied on competitive market forces. These programs are a balance between regulation and competition. A regulatory framework establishes basic rules for the competition and assures beneficiary protections; market-based financial incentives induce suppliers and plan sponsors to offer quality products at a lower price. Likewise, Innovation Center models such as those for ACOs provide financial incentives for reducing cost and improving quality without regulating how care is provided.

Very prescriptive regulation is only one way to approach public policy intervention into health care markets. Regulation may instead be the table setter for effective competition – policies developed to overcome obstacles to competition rather than replacing market driven forces to achieve desired outcomes. Improving on Medicare’s current pricing, value-based purchasing and Innovation Center models will require well-crafted policies that carefully consider how to unlock, rather than impede, market forces that will drive health care value. These policies will need to be carefully crafted to influence multiple layers of decision making in health care markets and assure that these various incentives work in concert rather than conflict with each other.

In developing and implementing market-based policies it will be important to consider three closely related factors; how the delivery system is organized, the structure of financial incentives inherent in its payment systems and what is the desired locus of decision making under a new set of policies intended to transform this system. Currently, most Medicare beneficiaries can choose to receive their care through fully capitated MA plans, or through the traditional program by providers paid under fee-for-service arrangements that are increasingly quality based. Some beneficiaries in the traditional program are attributed to alternative payment models such as ACOs, which are paid on a fee-for-service basis but with financial risk for cost and quality. The current incentives for health plans and providers to improve quality and reduce costs vary under these arrangements; as do those for beneficiaries in choosing among coverage options, providers and services.

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A closely related policy issue revolves around the desired locus of decision making in the system. That is, what is the mix of decision making among purchasers, health plans, providers and patients that is to be influenced by various market-based policies? To what extent does the system rely on:

- rules, requirements and information issued by purchasers such as Medicare to assure quality and to assist patients choices among health plans;
- decisions made by the competing health plans regarding care management, provider networks, payment and quality programs;
- provider behavior driven by competition,
- or by competitive forces driven from the patient level (e.g. patient choices concerning individual providers and services)?

Can policies to improve competition within these four levels of decision making coexist and how can they best be integrated and coordinated?

The MA program, accounting for one-third of Medicare beneficiaries, provides an example of coexisting decision making at all levels. The government establishes Medicare's methods for determining capitated payments, requirements for benefit packages, quality standards, conditions for participation, plan bids and provides information to beneficiaries to assist them in their choices. MA plans are responsible for establishing provider networks and payment arrangements, implementing quality programs and along with the providers, assuring the full range of services is available for beneficiaries. Beneficiaries first choose between MA and traditional Medicare; and if the former, they will then choose among MA plans based on premiums, their health needs and preferences. If they maintain traditional Medicare, beneficiaries also make choices of providers with few restrictions. Whether they receive services in an APM (such as ACOs), however, is not generally their choice. Instead, assignment to an APM is generally based on the physician practices they choose.

Some guiding principles policies involved might be summarized along three general dimensions:

1. The first being a **continuum of payment arrangements** with unrestricted fee-for-service at one end and full capitation at the other (Figure 2). Between the extremes would be payment arrangements incorporating different degrees of financial risk and quality adjustment including ACO arrangements, bundled payment, and value-based payment programs. As in current policy, the payment rates within any of these categories could either be set by Medicare based on historical data or through a competitive bidding process.
2. The second dimension might classify policies based on **the locus of decision making** along a continuum from regulatory to market competitive, depending on by whom rules are made, for whom and to what extent patient choice and financial incentives replace very prescriptive regulations. Put another way, a useful way to classify the range of possibilities for desired health care system and related policies is by the distribution of key decisions among the Medicare program, health plans, providers and beneficiaries.

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3. Finally, the third dimension of these potential payment/delivery combinations **distribute financial risk** differently among these participants.

Figure 3.2 summarizes these three dimensions and Figure 3.3 summarizes them by existing and potential payment/delivery mechanisms for Medicare.

Figure 3.2. Dimensions for Considering Alternative Visions for the Delivery System

Dimension	Range of Options & Considerations
1. Continuum of Payment Arrangements	Unrestricted FFS, to partial FFS risk-bearing based on performance, to APMs such as ACOs or to full capitation (population based payment)
2. Locus of Decision-making	<p>Regulatory – most pricing, provider participation, quality and coverage rules made by Medicare and other large purchasers</p> <p>Competitive – decisions driven by market forces – provider and consumer driven</p> <ul style="list-style-type: none"> • Consumer-based – consumers with financial incentives and appropriate information drive decisions through their choices • Provider based – strong financial incentives for market driven performance <p>Managed competitive – purchasers make rules for health plan competition, informed consumers choose among health plans who create networks of providers, decide on benefits, negotiate provider prices</p> <p>Hybrid/Integrated decision making – financing/delivery system finds a balance of decision making by purchasers, plans, providers and patients who may shop for select elective services</p>
3. Financial Risk	<p>Under unrestricted FFS ,the Medicare program bears most of the risk</p> <p>Various value-based pricing programs, bundled payment or APMs place some risk on providers</p> <p>Capitation places most risk on the health plans</p> <p>A consumer choice model places more of the risk on beneficiaries in terms of the potential for higher out of pocket costs</p>

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Figure 3.3. Distribution of Decision-Making and Financial Risk Under Medicare Programs: Illustrative Examples

Medicare Program		Health Plans	Providers	Beneficiaries
Traditional FFS	<p>Detailed payment/coverage/quality/consumer information/decisions made by the government</p> <p>Financial risk largely at program level</p>	Part D plans bear some competitive risk if their bid is above the national average since they must charge an additional premium	Minor financial risk for bundled or packaged payment	Some financial consequences if higher cost services chosen over lower cost, equally effective services
FFS with Market Driven influences (e.g. tiered networks, reference pricing)	<p>Detailed payment/coverage/quality/consumer information/decisions made by the government</p> <p>Competitive processes (e.g. bidding) can be used to establish payment rates</p> <p>Some financial risk shifted to providers based on cost and quality and beneficiaries based on choices</p>		Under some market-based payment plans, providers bear financial risk if too costly or poor quality	Beneficiaries can bear financial risk for choosing more costly providers or services
Global Accountability APMs (e.g. shared savings initiatives)	<p>As with FFS, detailed payment/coverage/quality/consumer information/decisions made by the government. Initiative responsible for ACO rules</p> <p>Some financial risk shifted to delivery organization</p>		Delivery organization bears at least some financial risk based on cost and quality	Currently beneficiaries are assigned or aligned either using claims or by the beneficiary choosing a provider/suppliers as his or her main source of care – risk similar to FFS
Medicare Advantage	Government establishes rules for plan participation and competition/benefit requirements/payment benchmarks/plan level quality	MA plans are responsible for provider payment,	Providers can bear risk for cost and quality based on	Beneficiaries choose the MA plan and may face higher out-of-pocket costs

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Medicare Program		Health Plans	Providers	Beneficiaries
	measurement/provides beneficiary information Substantial financial risk shifted to MA plans	provider networks, quality programs, copay structures MA plans bear full financial risk for the Part benefits covered under capitation	arrangements they may have with the MA plan	if they choose less efficient organizations; MA plans generally must cover Part A and Part B services such that the aggregate cost sharing across the plan is at least actuarially equivalent to FFS Medicare cost sharing.

As Figure 3.3 indicates, the three dimensions are interrelated. For traditional FFS, CMS is responsible for most of the administrative decision-making and financial risk. It is important to note that as financial risk is shifted to plan and provider organizations so is the responsibility for the aspects of administrative decision making. Under capitation or other forms of population based payment, Medicare payments to plans are predetermined – they are not affected by the plans actual costs for the year. Thus, participating plans or providers bear the financial risk if their actual costs exceed the payments. These organizations undertake much of the decision-making the Medicare Program must do in traditional Medicare such as provider participation and payment arrangements. In addition, other responsibilities related to cost control such as program integrity considerations are also shifted to the plan or provider organization. ACO participants currently receive FFS payments so the Medicare Program bears most of the administrative decision-making. But as downside risk increases under these models, the ACOs will also need to take on more cost related administrative issues, including functions similar to what CMS now undertakes to assure program integrity.

Chapter 4. Market-Based Policies across the Health Care System

The above analysis suggests that market-based policies for Medicare might take several forms. They could work within Medicare Advantage and the traditional Medicare programs or induce more competition between them. They might specifically address the incentives faced by beneficiaries and those that affect providers. Finally, they might consider how to provide greater financial incentives within the new payment and delivery models being tested by the Innovation Center.

In general, these policies either attempt to induce more competition in the market or, where traditional competition may be limited, to structure financial incentives for plans, providers and beneficiaries that might cause them to behave as if they were in a competitive market. In this report, we focus on market-based policies that can be achieved through Medicare's pricing and benefit policies. Thus, we do not address approaches such as anti-trust enforcement and changing Medicare's insurance structure, which are addressed in a previous Report.⁴⁵

One specific set of policies would replace administered pricing with those generated through a **competitive process such as bidding**. Such policies could affect the full range of covered services (Medicare Advantage) or be applied to specific services (e.g. DME) or bundles of services (e.g. DRGs).⁴⁶ Participants whose cost structures result in bids above the price generated by the process would participate at a financial disadvantage.

- In some cases, those providers might be excluded from providing services to Medicare beneficiaries for some period of time (e.g. **exclusive contracting** with a Center of Excellence).
- Similarly, **reference pricing** could be used when a reasonable benchmark is available – e.g. from a price distribution in the market, a price from an equally effective lower cost service, or some other external measure. Again, those participants with prices above the reference would be at a competitive disadvantage.
- Finally, there are policies to provide **beneficiaries with incentives** to choose high value services and providers by a combination of making relevant information accessible and structuring cost sharing to be favorable to desired choices. These incentives are generally combined with tiering services or providers based on cost and quality.

These policy alternatives are summarized on Table 4.1.

⁴⁵ U.S. Department Of Health And Human Services, U.S. Department Of The Treasury, U.S. Department Of Labor “Reforming America’s Healthcare System Through Choice and Competition”, December 2018, <https://www.hhs.gov/about/news/2018/12/03/reforming-americas-healthcare-system-through-choice-and-competition.html>

⁴⁶ Currently, MA plans do bid against a known benchmark. Alternative approaches are discussed below.

Table 4.1. Summary of Market-Based Approaches

Policy	Mechanism	Services Covered	Competitive Effects
Competitive Bidding	<p>Plans and providers submit bids based on their cost of providing services</p> <p>Medicare payment calculated from the bids (e.g. mean, median bid)</p>	Bidding could be for all Part A and B services (MA plans), bundles of services (e.g. episode based) or individual services (DRGs, physician fee schedule services)	<p>Plans with bids above the chosen benchmark are either excluded from the market or participate at a cost disadvantage</p> <p>The competitive effect is enhanced if beneficiaries face higher cost sharing for choosing higher cost providers or plans</p>
Centers of Excellence	Similar to competitive bidding except “bid” is combination of cost, outcomes, volume and experience	Usually for specific services for which experience, specialists and special facilities are required –e.g. transplants	Strong incentives to deliver high quality, efficient service delivery or be excluded
Reference Pricing	Reference price is calculated based on a distribution of prices or costs available in the market; an external price; or the price of a lower cost alternative of equal effectiveness	Typically for services that are “shoppable” – patients can more easily compare prices and quality ratings such as laser eye surgery	<p>Similar to competitive bidding</p> <p>Those above the reference price either will lose volume or find ways to reduce their price</p>
Tiered provider networks	<p>Providers are grouped into tiers based on their cost and quality</p> <p>Patients are given information to choose among the higher and lower tier providers</p> <p>Often cost sharing incentives are included for choosing the high value tiers</p> <p>Could also be implemented as</p>	Covers all services by provider type	<p>Providers in lower value tiers are at a disadvantage as informed consumers choose; often with cost sharing incentives.</p> <p>These providers either lose patient volume or work to improve their value to achieve a higher tier</p>

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	exclusive networks – lower tier providers excluded from coverage		
Enhance Market-based Incentives for Alternative Payment Models	Shift more risk to delivery organizations; Increase risk sharing parameters Change benchmarks to reflect competitive costs	All	ACOs and other organizations (Geographic Direct Contracting Entities) would need to innovate and reduce costs to a greater extent than under current policy to avoid financial losses

Impact of Market-Based Approaches: Evidence from Current Initiatives

Medicare

DMEPOS Competitive Bidding Program (CBP)

The CBP described in Chapter 2 has reduced the prices Medicare pays for these items and produced considerable savings for the program.⁴⁷ Because of concern that price reductions might be associated with adverse effects on beneficiaries – for example in access or quality of items – the Department has conducted an ongoing evaluation of the CBP. The evaluation studied key items over several years in bidding and non-bidding areas and found no evidence of either access problems or adverse health consequences.⁴⁸

There are several lessons for implementing other market-based policies in Medicare. First that a careful, evidence-based implementation of the policy is important. The competitive bidding program was preceded by a carefully controlled demonstration project that provided strong evidence that the program could be successful. The program was then fully implemented in the geographic areas tested, followed in two years by expansion to one hundred additional areas. Second, careful monitoring and evaluation is important. Prior to the formal evaluation described above, CMS maintained careful monitoring of data as well as a mechanism for beneficiary complaints. In addition, modifying the program as needed as time goes on can also be important. In response to continued concerns about the bidding/price setting method, CMS paused the DMEPOS competitive bidding program from 2018-2020 and developed new rules for Round 2021 of the program.

⁴⁷Newman D, Barrette E, McGraves-Lloyd K. Medicare Competitive Bidding Program Realized Price Savings For Durable Medical Equipment Purchases. *Health Affairs (Project Hope)*. 2017;36(8):1367-1375.

⁴⁸Tarazi W, Zuckerman R, Sheingold S. Impact of Medicare’s Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program on Utilization, Spending, and Adverse Health Outcomes (Internal Document), Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services.

Medicare Part D

Part D is often pointed to as a success and a model for competitive approaches for Medicare policy. The potential penalty of having a premium that is high relative to the federal subsidy provides strong incentive for plan sponsors to provide a quality benefit at the lowest possible cost. The program has expanded drug coverage to most seniors while premium subsidies have been flat or even declining in recent years. Growth in spending has fluctuated with the introduction of new pharmaceuticals and the expiration of market exclusivity for certain products, but according to the Medicare Trustees on average per beneficiary spending has grown roughly at the rate of inflation and even declined in recent years.⁴⁹ The market remains competitive, providing adequate plan choices for beneficiaries. Moreover, the vast majority of beneficiaries surveyed are satisfied with the benefit.⁵⁰

There are lessons to be learned for market-based policies from both Part D and CBP. Markets for both tend to be contestable – that is, have low exit and entry costs and so assuring competition and choice is possible in most geographic areas. Second, both are markets for products that can be accessed easily by beneficiaries locally or in the home. Thus, there is little concern that market exclusions or withdrawals would cause supply imbalances within markets. Finally, there is a potential tradeoff between the strength of financial incentives and the desire to protect beneficiaries.⁵¹ For example, certain formulary restrictions imposed by Medicare may limit plans' ability to negotiate best prices, but assure access of particular drugs to beneficiaries.

Innovation Center Models

Savings from the Shared Savings Program are calculated as the difference between benchmark spending relative to actual spending net of any shared savings payments made under the program. These savings have increased over time (Figure 2.1). The program achieved net savings for the first time in 2017 at about \$35 per beneficiary.⁵² Programmatic savings more than doubled in 2018 to \$73 per beneficiary.⁵³ In addition, ACOs that accepted downside risk achieved greater savings.⁵⁴ Researchers have typically found that ACOs maintain or improve the quality of care. In the first four years of the Shared Savings Program,

⁴⁹ 2020 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, <https://www.cms.gov/files/document/2020-medicare-trustees-report.pdf>

⁵⁰ Medicare Today, "New National Survey: Nearly 9 in 10 Seniors Satisfied with Medicare Part D", <http://medicaretoday.org/2017/07/new-national-survey-nearly-9-in-10-seniors-satisfied-with-medicare-part-d-2/>

⁵¹ Michael Adelberg and Marissa Schlaifer, "The Other Side Of Managed Competition: The Tension Between Protection And Innovation In Medicare Advantage And Part D Benefits", Health Affairs Blog, December 8, 2017

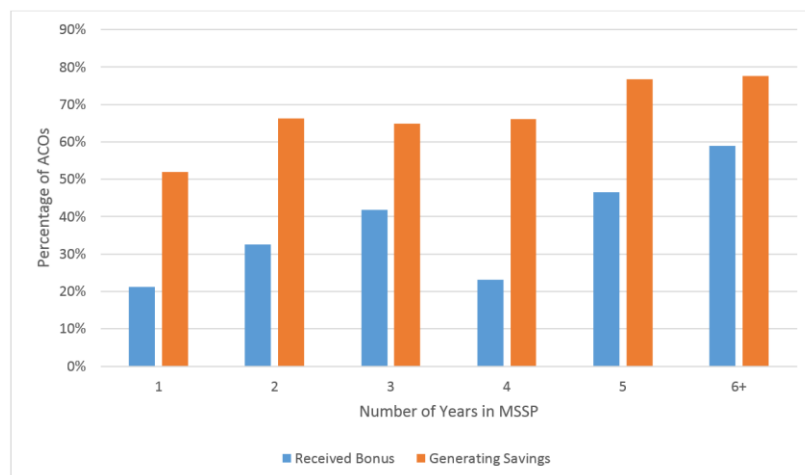
⁵² William K. Bleser, David Muhlestein, Robert S. Saunders, Mark B. McClellan, "Half A Decade In, Medicare Accountable Care Organizations Are Generating Net Savings: Part 2" Health Affairs Blog, September 21, 2018

⁵³ Jonathan Gonzalez-Smith, William K. Bleser, David Muhlestein, Robert Richards, Mark B. McClellan, Robert S. Saunders, "Medicare ACO Results for 2018: More Downside Risk Adoption, More Savings, and All ACO Types Now Averaging Savings", Health Affairs Blog, October 25, 2019

⁵⁴ Ibid.

ACOs saw quality measure improvements that exceeded those of fee-for-service providers.⁵⁵ Quality has remained high for ACOs with a composite score of 93% in 2016 and 91% in 2017.⁵⁶

Chart 4.1. Change in MSSP Program Savings Over Time



Source: Jonathan Gonzalez-Smith, William K. Bleser, David Muhlestein, Robert Richards, Mark B. McClellan, Robert S. Saunders, "Medicare ACO Results for 2018: More Downside Risk Adoption, More Savings, and All ACO Types Now Averaging Savings", Health Affairs Blog, October 25, 2019

While in aggregate ACOs have been found to achieve savings and maintain or improve quality of care, there is variation in the size of the savings associated with the type of ACO. Physician groups that form ACOs theoretically have more incentive to reduce expensive hospital admissions than ACOs organized around a hospital because those lost admissions do not affect their overall revenue. This expectation is borne out in the data. One study found that intented physician-led MSSP ACOs reduced spending per beneficiary by 3.1 percent relative to control group while hospital ACOs reduced spending per beneficiary by 0.38 percent.⁵⁷ In order to encourage increased participation of physician-led ACOs, CMS' most recent changes to the Shared Savings Program as part of the December 2018 Pathways to Success final rule, grant physician-led ACOs more time to participate under one-sided risk to give them more time.

The ACO assessments have an interesting consideration for thinking about evaluating potential market-based policies. The savings described above were calculated according to a programmatic formula used to assess spending effects and calculate shared savings. These savings are calculated relative to a benchmark developed for the Shared Savings Program. An alternative for calculating savings that is more typical for a formal program evaluation is to compare actual spending with a counterfactual which is established using a comparison group of like providers who are not in ACOs. The counterfactual represents what spending for the ACO providers and suppliers would have been had they not joined the

⁵⁵ Bleser WK, Saunders RS, Muhlestein DB, Morrison SQ, Pham HH, McClellan MB. ACO quality over time: the MSSP experience and opportunities for system-wide improvement. *Am J Accountable Care*. 2018;6(1):e1–15.

⁵⁶ Ibid.

⁵⁷ McWilliams JM, Hatfield LA, Landon BE, Hamed P, Chernew ME. Medicare spending after 3 years of the Medicare Shared Savings Program. *N Engl J Med*. 2018;379(12):1139–49

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ACO. Relative to this baseline, savings would be much greater than the programmatic savings.⁵⁸ In other words, spending for the ACO providers and suppliers would have increased at a rate faster than the benchmark rate had they not joined an ACO.

Episode-based Payment Initiatives – The Innovation Center has tested a number of Episode-based Payment Initiatives, including Bundled Payments for Care Improvement (BPCI), the Comprehensive Care for Joint Replacement (CJR) Model, the Oncology Care Model (OCM), and the BPCI Advanced Model. In these models, participating providers and suppliers receive standard Medicare fee-for-service rates for their care. The cost of this care is then retrospectively compared to target prices set by CMS for an episode’s bundle of services. While some of the models have resulted in decreased utilization and lower expenditures, evaluations of these models have not found net savings to Medicare. There was no impact on the quality of care based on the claims-based quality measures used for these models.⁵⁹

The most successful episode payment model bundled payments used simple attribution methods and focused on easily identifiable beneficiaries with predictable care needs. Across the episode payment models, common lessons have emerged around themes including target price setting, beneficiary attribution, and overlap. In terms of lessons most relevant to market-based policies, the pricing mechanisms and setting the right levels of financial risk and reward are critical.

Primary Care Transformation – The Innovation Center has tested many initiatives and models aimed at improving primary care while reducing costs, such as the Comprehensive Primary Care initiative and the Health Care Innovation Awards (HCIA) Primary Care Redesign Programs. A systematic review of six of these CMMI initiatives found multi-payer initiatives to be better suited to giving practices financial resources and supporting practice transformation, compared to initiatives conducted through one payer, because multi-payer initiatives increase financial contributions and expand policy decisions to apply to greater shares of patients.⁶⁰ The same report identified several initiative-level features that may support how practices transform into advanced primary care practices.⁶¹ Financial support was key; different practices need different support based on their current stage of transformation. Initiatives with shared savings introduced challenges for practices, due to their timing, uncertainty, and payment methodologies, but combining shared savings with per beneficiary per month payments mitigated some of these issues. Tailored technical assistance (TA) through a learning system was valuable as primary care practices adapted their electronic health records, changed workflows, and hired new staff to become advanced primary care practices. Overall, there was no consistent pattern for the four main outcomes of the models; expenditures, ED visits, admissions and readmissions.

⁵⁸ Blesser, Op.Cit.

⁵⁹ CMMI.CMS Innovation Center Episode Payment Models. January 2020. <https://innovation.cms.gov/files/reports/episode-payment-models-wp.pdf>

⁶⁰ <https://innovation.cms.gov/files/reports/primarycare-finalevalrpt.pdf> 2018. Systematic Review of CMMI Primary Care Initiatives Final Report.

⁶¹ <https://innovation.cms.gov/files/reports/primarycare-finalevalrpt.pdf> 2018. Systematic Review of CMMI Primary Care Initiatives Final Report.

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State-Based Initiatives – The Innovation Center has tested initiatives with varying levels of state involvement, from having strong state roles in State Innovation Models (SIMs), a Medicaid-focused state involvement such as with the Medicaid Emergency Psychiatric Demonstration, to other programs with other state roles, such as HCIA-funded programs. CMMI contracted a systematic review of lessons learned of 12 different state-based programs selected by CMMI, which found that states can succeed as conveners, though states vary in readiness and resources.⁶² Longer model timelines fostered innovation by allowing strategies to be adjusted as needed, and tailored technical assistance improved program effectiveness. Leveraging existing partnerships and communicating with all stakeholders (providers, payers, and patients) was crucial. Flexibility in payment approaches, eligibility and enrollment as well as transparent and predictable methodologies that incentivize a consistent set of activities were associated with low burden and higher provider acceptance. Changing model design and features during the model test periods was sometimes associated with significantly better results, although sometimes mid-course changes had unintended consequences. Additionally, states are well-positioned to support HIT adoption, such as by funding implementation activities and using their authority to require participation.

Discussion – Models developed by CMMI seek to move beyond fee-for-service payment for Medicare providers and suppliers. Instead, they generally seek to broaden the scope of compensation for care and put the participant at risk for costs that exceed what would typically be expected under traditional fee-for-service payment. Typically models have involved a comparison to a benchmark price for either a bundle of services (e.g. Episode-based Payment Initiatives) or the total costs for an attributed patient for a period of time (e.g. Accountable Care). In general, these benchmark prices are set based on the FFS spending for the same or equivalent beneficiaries. To the extent that model participants are more efficient than the benchmark, they are able to share that savings with the Medicare program. But, this savings is based on what the costs might hypothetically be under fee-for-service, not based on competing with another entity on price.

In 2017, CMS set a new direction for the Innovation Center. Based on feedback from a RFI and other stakeholder input, CMS enumerated principals under which models will be considered. Among these principals was “Enhancing Choice and Competition in the Market: promoting competition based on quality, outcomes, and costs.” This explicitly emphasizes increasing choice and competition in the market for health care as a goal of Innovation Center models. Several recent models developed by the Innovation Center demonstrate this emphasis on increasing competition in health care markets, including:

- Medicare Advantage Value-Based Insurance Design – This model allows Medicare Advantage plans to use different out-of-pocket costs for certain services to better reflect their value to the patient. This allows plans to further target their benefit design and better compete on their ability to provide cost-effective care to their enrollees.
- Kidney Care Choices - Creates a financial incentive for health care providers to manage Medicare beneficiaries with chronic kidney disease in a cost effective way. Previously, in-center

⁶² L&M Policy Research. Innovation Center State-Based Initiatives: A Systematic Review of Lessons Learned. August 2018. <https://innovation.cms.gov/files/reports/statebasedinitiatives-lessonslearned.pdf>

hemodialysis was essentially the default treatment for patients beginning dialysis despite its high cost.

- **Geographic Direct Contracting Model** - In this model, Direct Contracting Entities (DCEs) will be at risk for the costs of care for Medicare fee-for-service beneficiaries in a region. Beneficiaries will retain their choice of provider and supplier, but the DCE will be responsible for beneficiary total cost of care. CMS will select participants, in part, based on the size of their proposed discount to be applied to the model's benchmark for purposes of calculating shared savings.

Private Purchasers

In addition to Medicare's Innovation Center models and competitive programs such as bidding for DME and the Part D benefit, Medicaid, state employee plans, employers and private insurers have actively pursued innovative and market-based policies. This section reviews these efforts.

Reference Pricing

Reference pricing is a system in which a purchaser or insurer selects a price it is willing to pay for a health care service. Patients who obtain care from a provider with a price at or below the reference price pay only the normally required cost sharing (e.g., deductibles, coinsurance). Consumers selecting providers that charge more than the reference prices would have to pay the difference between the provider's charge and the reference price, along with any cost-sharing for the reference price. Many countries use reference pricing to pay for drugs.⁶³ Reference pricing for drugs has received less attention in the U.S. It is important to note, however, that most commercial and Part D plans use some form of tiered copayments. These policies have similar financial incentives to reference pricing for consumers, but do not address price variation within therapeutic classes as well as reference pricing.⁶⁴

Reference pricing typically been set on "shoppable" services which are non-emergency tests or procedures with a large price variation across providers and quality of care remains fairly equal.⁶⁵ Reference pricing can be set at a dollar amount or at a relative price (e.g., 60th percentile, 150 - 200 percent of Medicare) for a service or bundled package of services.

With consumers having the incentive to switch to lower-priced providers, the price competition could lead to providers strategically lowering their prices to increase their market share. Reference pricing could lead to more efficient hospital specialized lines of service and offer patients incentives to go along with

⁶³ Kang, S., DiStefano, Michael J., Socal, M., Anderson, G.F., 2019. Using External Reference Pricing in Medicare Part D to Reduce Drug Price Differentials with other Countries. *Health Affairs*. 2019;38(5):804-811.

⁶⁴ James C. Robinson, Pharmaceutical Reference Pricing: Does It Have a Future in the U.S.? Commonwealth Fund, September 10, 2018, <https://www.commonwealthfund.org/publications/issue-briefs/2018/sep/pharmaceutical-reference-pricing-future#:~:text=Under%20reference%20pricing%2C%20at%20least,set%20as%20the%20reference%20product.&text=In%20reference%20pricing%2C%20one%20or,or%20deductibles%20for%20all%20drugs.>

⁶⁵ Insana, P., How does Reference-base Pricing Work. BrittonGallagher Blog posting. Accessed at: <http://info.brittongallagher.com/blog/how-does-reference-base-pricing-work-pros-and-cons-for-group-benefits>

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ACO incentives to refer patients to lower-cost specialists and facilities. Reference pricing has three main objectives:

1. Encourage patients to receive care from providers with higher value (high quality at low cost) by reducing cost sharing for these patients.
2. In competitive markets, reference pricing provides additional leverage to providers with higher prices than the reference price to reduce prices and protect patient volumes.
3. Preserve consumers' choices by giving them the opportunity to weigh the trade-off between cost sharing and provider's value.

Some large employers in the U.S. are using reference pricing for at least some health care services. The 2016 Aon survey of U.S. based employers with at least 500 employees showed that 5 percent of the employers had adopted reference-based pricing and 60 percent said they may add it in the next 3 to 5 years.⁶⁶ The 2013 Mercer survey showed that 10 percent of large employers with 500 or more employees used reference pricing and 22 percent were considering it. About 15 percent of the largest employers with 10,000 or more employees used reference pricing and 30 percent more were considering it. Safeway's reference pricing for laboratory tests, CT scans and MRI procedures had increased usage of low-price facilities ranging from 9.0 to 18.6 percent and reductions in price paid from 10.5 to 32.0 percent.⁶⁷

There are also a number of state level initiatives in reference pricing:

1. The Montana state employees plan set their reference price at more than 220 to 245 percent of Medicare in 2016 for hospitals.⁶⁸ Six of the 11 largest hospitals would not agree to the new contracts a month before the deadline but eventually only one hospital did not sign. The last hospital signed on after hundreds of union leaders and employees called the hospital. Savings were almost \$1 million a month in the second half of 2016 and all of 2017.
2. The North Carolina state benefits plan planned in 2018 for a new contract starting in January 2020 to pay most of hospitals that agreed to reference pricing of 160 percent of the Medicare rate for inpatient services and 230 percent for outpatient services.⁶⁹ Rural hospitals would be paid 218

⁶⁶ Aon. 2016 Aon Health Care Survey. Accessed at <https://healthresources.aon.com/reports-2/2016-aon-health-care-survey>. 2017 survey not available as of December 2019.

⁶⁷ Robinson, *ibid.*

⁶⁸ Hansard, S., August 22, 2019. Insurance Payments Tied to Medicare Intrigue States, Employers. [Bloomberglaw.com](https://news.bloomberglaw.com/health-law-and-business/backers-of-medicare-based-payments-undaunted-by-tar-heel-setback-1). Accessed at <https://news.bloomberglaw.com/health-law-and-business/backers-of-medicare-based-payments-undaunted-by-tar-heel-setback-1>

⁶⁹ Darkdaily, December 18, 2019. North Carolina Providers Slow State Effort to Impose Reference Pricing They Claim Could Remove Hundreds of Doctors and Medical Service Providers from the State's Healthcare Network. Darkdaily (serving Clinical Labs & Pathology Groups). Accessed at: <https://www.darkdaily.com/north-carolina-providers-slow-state-effort-to-impose-reference-pricing-they-claim-could-remove-hundreds-of-doctors-and-medical-service-providers-from-the-states-healthcare-network/>.

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percent of Medicare.⁷⁰ Medical lab and pathology services would be paid at 160 percent of Medicare.⁷¹ However, only five hospitals agreed to the new contract, even at a higher reference pricing of 186 to 196 percent of Medicare.⁷² Providers are permitted to revert to the Blue Options PPO Network rates instead of being paid the reference pricing.

3. The Oregon state employee health plan has a fixed price for bariatric surgery, major joint replacement surgery and oral appliances starting in 2014.⁷³ More than \$3 million annual savings have been achieved. The legislature set Oregon state employee plan's in-network reimbursement for hospitals at 200 percent of Medicare and 185 percent for hospitals out-of-network and hospitals can't bill state workers for the difference between these rates and hospital charges.⁷⁴
4. California Public Employees Retirement System (CalPERS which offers health coverage to state, school, and public agency employees and retirees) implemented reference pricing for several specific procedures (cataract surgery, colonoscopy, and arthroscopy) with increased usage of low-price facilities ranging from 8.6 to 14.2 percent and reductions in price paid ranging from 17.0 to 19.8 percent.⁷⁵ One measure of care quality (the rate of surgical complications) did not change as patients moved from hospitals to ambulatory sites of care.

Studies have estimated potential savings for reference pricing of 5 percent⁷⁶, 8 percent⁷⁷, or up to 12 percent⁷⁸ on "shoppable" services for all privately insured.

Limiting factors on reference pricing include: application focused on a few procedures, usually applies to the facility fee and not the professional fee, balance billing potential for consumers, arbitrary pricing that

⁷⁰ Appleby, J., March 22, 2019. More states Turning to Medicare-based contracting for employee health care. Benefits Pro. Accessed at: <https://www.benefitspro.com/2019/03/22/more-states-turning-to-medicare-based-contracting-for-employee-health-care/>.

⁷¹ Darkdaily, op. cit.

⁷² Pifer, R., August 9, 2019. North Carolina Folds to Provider Pressure with Insurance Plan Shifting away from Set Rates. Healthcare Dive. Accessed at: <https://www.healthcaredive.com/news/north-carolina-folds-to-provider-pressure-with-insurance-plan-shifting-away/560649/>.

⁷³ Vendehey, J., December 3, 2018. Opportunities to Contain Costs and Improve Value in Oregon Health Care Markets. Oregon Health Authority. Accessed at: <http://oregonbusinessplan.org/wp-content/uploads/2018/12/PEBB.OEBB-FINAL-FULL-2.pdf>.

⁷⁴ Appleby, J., March 22, 2019. More states Turning to Medicare-based contracting for employee healthcare. Benefits Pro. Accessed at: <https://www.benefitspro.com/2019/03/22/more-states-turning-to-medicare-based-contracting-for-employee-health-care/>.

⁷⁵ Robinson, J.C., Brown, T.T., and Whaley, C., March 2017. Reference Pricing Changes the 'Choice Architecture' of Health Care for Consumers. Health Affairs 36(3): 524-530.

⁷⁶ White, C. and Eguchi, M., October 2014. Reference Pricing. National Institute for HealthCare Reform. Accessed at http://nihcr.org/wp-content/uploads/2016/07/Research_Brief_No._18.pdf.

⁷⁷ Robinson, op. cit.

⁷⁸ American Academy of Actuaries, November 2018. Estimating the Potential Health Care Savings of Reference Pricing. Accessed at: https://www.actuary.org/sites/default/files/files/publications/ReferencePricing_11.2018.pdf.

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hospitals and other providers may not accept, and administrative challenges to reprice services based on Medicare rates.⁷⁹

Interviews with a convenience sample of 13 individuals across 12 organizations (self-insured employers, consulting firms and purchasing coalitions) found that few employers have implemented reference pricing although they knew about its potential.⁸⁰ There were concerns about complexity, risk of catastrophic out-of-pocket costs for employees, making employees dissatisfied, and need for educating and assisting employees. The savings were not significant compared to total health care costs (limited to a few specific procedures) and adoption of reference pricing could hurt hiring and retaining employees.

Most providers accept Medicare rates for Medicare patients but it can be difficult to set prices based on a percentage of Medicare rates that satisfy both payer and providers and assures adequate supply of providers for private patients.

Lessons:

1. Reference pricing needs to be high enough to ensure that consumers have access to providers with high value with no additional cost-sharing.
2. More communication with plan enrollees about which providers have prices at or below the reference price and which providers have prices above the reference price, their prices and the effects on cost-sharing.
3. Need for laws that encourage competition and support transparency of quality and cost.

Centers of Excellence

Insurers and self-insured employers can contract with a limited number of Centers of Excellence (CoE) for specific procedures. The providers offer high-quality care at a discounted price for a higher volume of patients.⁸¹ The CoE may be the only covered provider for specific procedures such as transplants or may be a supplement with lower cost sharing than in the broader provider networks to encourage CoE use. Even with the health plan covering travel and lodging, costs may be lower at the CoE.

Larger firms are more likely to offer Centers of Excellence. About 16 percent of all firms with 50 or more workers had their largest health plan encouraging care at designated Centers of Excellence in 2019. Larger firms were more likely to offer Centers of Excellence (34 percent of firms with 1000-4999 workers and 52 percent of firms with 5000 or more workers) in their largest plan. Of all firms with Centers of Excellence offered in their largest plan, 19 percent covered travel and lodging in those centers. In the

⁷⁹ Boland, P., Gibson, D., 2014. The Promise and the Pitfalls of Reference Pricing. *ManagedCare Magazine*. Accessed at <https://www.managedcaremag.com/archives/2014/5/promise-and-pitfalls-reference-pricing>.

⁸⁰ Sinaiko, A.D., Alidina, S., and Mehrotra, A., 2019. Why Aren't More Employers Implementing Reference-Based Pricing Benefit Design? *American Journal of Managed Care*. 2019;25(2):85-88.

⁸¹ Robinson, J.C., and MacPherson, K., 2012. Payers Test Reference Pricing and Centers of Excellence to Steer Patients to Low-Price and High-Quality Providers. *Health Affairs* 2012: 31(9) 2028-2036.

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largest firms with 5000 or more workers, 46 percent of the firms with Centers of Excellence in their largest plan covered travel and lodging.

The home improvement company Lowe's began a CoE program for nonemergency cardiac procedures in April 2010 only at the Cleveland Clinic with no cost sharing and reimbursement for travel costs for the patient and companion.⁸² Blue Shield offered CalPERS 16 CoEs in nine markets in California that passed the clinical criteria for "Blue Distinction" for orthopedic surgery and were the only covered providers.⁸³ Walmart started their CoE program in 2012 for heart, spine and transplant surgeries at six sites with no cost-sharing and reimbursed travel expenses for the patient and a companion.⁸⁴ In 2019, Walmart had 15 medical care partners, including Johns Hopkins, the Mayo Clinic, the Cleveland Clinic, and Emory Healthcare for transplants, spine, heart, knee, and hip surgeries. The company introduced a new policy to only cover spine surgery at one of eight CoEs.

There are lessons to consider for this approach. Insurers and employers have their own criteria for CoEs, which may change or the CoEs may not meet the criteria in the future. Even with the health plan covering travel and lodging, costs may be lower at the CoE. However, consumers need to be educated on the CoE option or requirement. Some patients may be unhappy and inconvenienced by traveling to a CoE even with travel reimbursement and there may be coordination issues with follow-up care back home. Strategies include:

1. Health plans can offer multiple CoEs or offer CoE(s) as supplements to provider networks to give consumers more choice.
2. More communication with plan enrollees about CoEs and the effects on cost-sharing.
3. Need for laws that encourage competition and support transparency of quality and cost.
4. Need more studies on evaluating quality and cost at CoEs.

Tiered Provider Networks

Tiered provider networks result when health plans sort providers who treat comparable patients into tiers based on value (quality and cost). Health plans give better ranking to providers with higher quality and lower cost. Health plans provide this information to patients in order to help them understand the provider's value relative to other providers and to give financial incentives (lower cost sharing) to patients when they choose providers with higher value (preferred providers).⁸⁵

Tiered provider networks function differently in different provider markets.² In competitive markets, providers who are placed in lower tiers will risk losing patient volumes and therefore will negotiate prices

⁸² Robinson, *ibid.*

⁸³ Robinson, *ibid.*

⁸⁴ HITconsultant.net. Why Walmart Centers of Excellence Model Could Redefine How Employers Deliver Quality Care. Accessed at: <https://hitconsultant.net/2019/03/06/walmart-centers-of-excellence-model-quality-care/#.Xh9s12CP6Uk>.

⁸⁵ Sinaiko AD, Landrum MB, Chernew ME. Enrollment In A Health Plan With A Tiered Provider Network Decreased Medical Spending By 5 Percent. *Health affairs (Project Hope)*. 2017;36(5):870-875.

in order to be placed in higher tiers. On the other hand, dominant providers, who usually have the highest patient volumes in concentrated markets, need to protect these volumes. Therefore, dominant providers will try to stop efforts to create tiered networks or demand that they are placed in high tiers regardless of their value.

Objectives: There are three objectives for tiered provider networks²⁸⁶:

1. Encourage patients to receive care from providers with higher value (high quality at low cost) by reducing cost sharing for these patients.
2. In competitive markets, tiered provider networks provide additional leverage to providers in lower tiers to negotiate prices and protect patient volumes.
3. Preserve consumers' choices by giving them the opportunity to weigh the trade-off between cost sharing and provider's value.

Prevalence: Larger firms are more likely to have tiered provider network:

Almost one-third of firms with 5,000 or more workers included a high-performance or tiered provider network in their largest health plan in 2019 compared to 13-14 percent of firms with 50 to 999 workers and 13 percent of firms overall with 50 or more workers, similar to figures in the 2015 survey.⁸⁷

Examples:

1. Massachusetts Group Insurance Commission (GIC) covers 460,000 state employees, retirees, dependents and some municipalities. GIC has offered tiered networks since 2007. Currently, each one of the 11 GIC health plans includes at least two tiers for specialists and may include two or three tiers for primary care physicians, specialists, and hospitals.⁸⁸ The providers in the tiers are determined by the health plan based on cost efficiency and quality of care standards or based on the provider group's relationship to a type of hospital (community, teaching, specialty, or academic medical center) or simply by whether the provider is part of academic medical centers.
2. The Minnesota State Employee Group Insurance Program (SEGIP) has covered state employees and their dependents since 2002. The primary care clinics in SEGIP are categorized into four cost-sharing tiers based on the clinic's past total cost of care.⁸⁹

⁸⁶ Delbanco SM, R.; Berenson, R.; Upadhyay D. Payment Methods and Benefit Designs: How They Work and How They Work Together to Improve Health Care: Tiered Networks. 2016; http://www.urban.org/sites/default/files/03_tiered_networks.pdf. Accessed December, 27, 2019.

⁸⁷ 2019 Survey of Employer-Health Benefits Survey. Kaiser Family Foundation. 2019; <http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2019>. 2015 Survey of Employer-Health Benefits Survey. Kaiser Family Foundation and Health Research & Education Trust. 2019; <http://files.kff.org/attachment/report-2015-employer-health-benefits-survey>.

⁸⁸ Massachusetts Group Insurance Commission website. <https://www.mass.gov/info-details/gic-non-medicare-health-insurance-products>.

⁸⁹ Sinaiko AD, Landrum MB, Chernew ME. Enrollment In A Health Plan With A Tiered Provider Network Decreased Medical Spending By 5 Percent. *Health affairs (Project Hope)*. 2017;36(5):870-875.

Delbanco SM, R.; Berenson, R.; Upadhyay D. Payment Methods and Benefit Designs: How They Work and How They Work Together to Improve Health Care: Tiered Networks. 2016; Massachusetts Group Insurance Commission

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3. Blue Cross Blue Shield of Massachusetts started offering tiered network health plans in 2008. These networks included hospitals, imaging centers, clinical and diagnostic labs, and primary care providers, and categorized into three tiers based on performance and cost: enhanced (the highest performing), standard (moderate performers), and basic (the lowest performing providers).¹

Impact:

Compared to plans without a tiered network, the Blue Cross Blue Shield of Massachusetts tiered network plans were associated with 5 percent (\$43.36) lower total adjusted medical spending per member per quarter (\$830.07 vs. \$873.43).⁹⁰ **Weaknesses of tiered networks:** Although the objectives mentioned above provide strengths to tiered provider networks, there are still weaknesses for these networks. For example, tiered networks may not be feasible in concentrated markets, providers may not be accountable for the care they provide, small markets may have few providers and hence non-functional networks, and small differential cost sharing may not change consumers' behavior⁹¹

Choices to mitigate weaknesses of tiered networks²:

1. Tiered networks need to be large enough to ensure that consumers have access to providers with high value.
2. Transparency of the tiers designation process informs consumers and helps them make decisions.
3. Tiered networks must be based on both quality and cost, not just on cost as some networks do.
4. Large differential cost sharing between different tiers will affect consumers' behavior to seek care from high-value providers.
5. Need for laws that encourage competition and support transparency of quality and cost.
6. Value-based insurance design (V-BID) could be used with tiered networks. For example, the Blue Groove model of the Blue Shield of California provided enrollees with V-BID subsidies for receiving care from higher tier providers.

ACOs and State Medicaid Programs

An accountable care organization (ACO) is at risk for the total cost of care and quality of care for a specific population. Savings are usually shared between Medicaid and the ACO if costs are less than the benchmark. At least part of the losses may also be shared if costs are more than the benchmark.

website. <https://www.mass.gov/info-details/gic-non-medicare-health-insurance-products>; The State Health Access Data Assistance Center. Tiered Provider Cost-Sharing: Improving Efficiency through Consumer Choice and Provider Incentives. 2017; <https://www.shadac.org/news/tiered-provider-cost-sharing-improving-efficiency-through-consumer-choice-and-provider>. Accessed December, 23, 2019.

⁹⁰ Sinaiko op. cit.

⁹¹ Delbanco op. cit.

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Fourteen states had Medicaid ACOs in State Fiscal Year 2019-2020.⁹² There were an estimated 3.7 million Medicaid enrollees in 86 Medicaid ACOs in 2018.⁹³ Medicaid ACOs had more lives per contract than Medicare ACOs (average of 43,500 compared to 17,500 for Medicare contracts and 24,300 for commercial contracts). Most Medicaid ACOs have only one contract.

States have used various federal authorities to establish Medicaid ACO programs, including Section 1115 demonstrations, state plan amendments and managed care authority.⁹⁴ States have used federally supported Delivery System Reform Incentive Payment (DSRIP) programs and State Innovation Models (SIM) grants to design, test, implement or expand Medicaid ACO programs. There are three general models of Medicaid ACOs that have been implemented by states to date, driven by: (1) a provider, (2) an MCO, and (3) a regional/community partnership. Minnesota and Maine have provider-led Medicaid ACOs. Oregon's Coordinated Care Organizations (CCOs) are similar to MCOs but providers and community members are more involved. Colorado and New Jersey have regional/community-based ACOs.

Colorado Medicaid saved \$77 million in 2011-2013 and lowered ED visits, high-cost imaging and hospital readmissions. Maine Medicaid saved \$4.6 million in 2013 and \$8.1 million in 2014. Minnesota saved \$212 million in 2012-2015 and exceeded quality targets. Oregon CCOs have limited annual cost growth to 3.4 percent and had a 23 percent decrease in ED visits and a 68 percent decrease in inpatient admissions related to asthma and COPD. Vermont had \$17 million in savings in 2014-2015 and exceeded quality benchmarks.

⁹² Kaiser Family Foundation. States that Reported ACOs in Place. Accessed at: <https://www.kff.org/medicaid/state-indicator/states-that-reported-accountable-care-organizations-in-place/>

⁹³ Leavitt Partners, May 1, 2019. The Medicaid ACO Landscape. Accessed at: <https://leavittpartners.com/press/leavitt-partners-releases-the-medicaid-aco-landscape-white-paper/>.

⁹⁴ Matulis, R and Lloyd, J., February 2018. The History, Evolution, and Future of Medicaid ACOs. Accessed at: <https://www.chcs.org/resource/history-evolution-future-medicaid-accountable-care-organizations/>.

Chapter 5. Potential Market-Based Policy Directions for Medicare

This report has detailed a number of reasons that new directions for Medicare’s transition to value-based policies might be considered. In particular, these new directions would focus on ways to enhance competition and market-based incentives for key participants in health care. Medicare’s own experience with market-based policies as well as the experiences of states, purchasers and employee plans show promise and can provide some guidance for new Medicare policies. While these potential policies would focus on Medicare, their success would likely spillover to other payers and patients in a positive way. Positive spillovers and moving toward a value-based system would be enhanced to the extent there was collaboration between Medicare’s and other payers.

The principal objective of these policies would be improve health system value through 1) enhancing competition among plans and providers; or 2) in structurally noncompetitive markets by incentivizing plans and providers to behave in a manner similar to what would occur in a competitive market. In general, these policies would replace administered pricing with prices that reflect as closely as possible those that would be generated by a well-functioning market and encourage beneficiaries to shop for high value plans, providers and services. Examples of tested alternatives for implementing these policies are competitive bidding, reference pricing, centers of excellence and tiered provider networks; potentially paired with changes in beneficiary cost sharing requirements.

General Considerations for Market-Based Policies

The analysis presented in this report also suggests that policies might be considered along a number of dimensions. First, they might be considered within the Medicare Advantage program, specific to APMs in the traditional program, and for fee-for-service providers not associated with APMs. Such policies would be intended to enhance competition within these sectors. Policies that would synchronize incentives for these sectors in a way that would enhance competition between them might also be considered. Similarly, policies might be crafted based on whether their incentives are intended for plans, providers or beneficiaries; or some combination of the participants.

It will also be important to recognize important characteristics of particular services and markets that affect the feasibility and desirability of specific market-based policies. For example, due to complexity of information required to make choices, some services may be more “shoppable” than others. The structural characteristics of markets also have to be considered in tailoring policies. Many of the policies discussed – for example, tiered networks, competitive bidding – require that a certain number of potential competitors are in the market. Many markets have few competitors and some have one dominant provider. Thus, alternative policies would likely be needed for these markets. Indeed, one report notes

that there may be a relationship to consider between “shoppable” services and market structure.⁹⁵ That is, the most “shoppable” services are more amenable to being delivered by multiple providers while more complex services might be more efficiently delivered by fewer providers.

Another consideration is that competitive bidding can be a policy unto itself for a particular market or a means of implementing another competitive policy. Market-based policies might be implemented in one of two ways: competition for the market or competition within the market. In the former, a winning bidder or bidders are selected to participate in the market for a defined period of time while losing bidders are excluded. In the latter, all bidders may participate but those whose bids are higher than a chosen “price” participate at a competitive disadvantage. An example of competition for the market in which one winner is chosen is Louisiana’s subscription model for an expensive Hepatitis C drug. They selected one of three possible manufacturers and granted them exclusive rights to their Medicaid and prison markets. In some cases, multiple providers that meet specific criteria might be selected. In Medicare’s DMEPOS competitive bidding program, CMS selects several suppliers whose bids are below the chosen price while excluding those above. Thus, as in the example, competitive bidding can be the basis of selecting providers such as Centers of Excellence for specific services or the basis of other policies such as reference pricing. The MA and Part D programs include bidding but those plans that bid above the benchmarks that determine Medicare’s payment are at a disadvantage as they compete.

Particularly for programs that employ the competition within the market approach, beneficiary incentives would likely be important. Those participants’ whose costs are above the chosen price would only have strong incentive to become more efficient if they would be punished by beneficiaries switching to lower cost providers. For MA and Part D, plans above the established benchmarks have to charge a higher premium to beneficiaries than those at or below the benchmark providing incentive for the choice of lower cost plans. On the other hand, under the FFS program cost sharing for covered services is determined as a percent of the Medicare payment and participating physicians cannot balance bill for costs above that payment. These factors, along with some beneficiaries having Medigap coverage, reduce beneficiaries’ incentives to shop for lower cost providers and services. Therefore, market-based policies might consider different cost sharing policies to complement the pricing strategies.

It also may be important to consider timing and phasing in of policies. The objective of enhancing market-based incentives is to drive value-based innovation and fundamental change in how care is delivered. These changes could require significant modification in care algorithms, staffing, reconfiguration of professional teams and facilities. Moreover, new training for health system managers as well as clinical and nonclinical staff may be required to design and implement these new business models. In order to minimize potentially unintended and adverse consequences, new policies might recognize that fundamental changes may take some time to take hold by phasing toward the stronger incentives over a predetermined period.

⁹⁵Penelope Dash and David Meredith, “When and How Provider Competition Can Improve Health Care Delivery”, , McKinsey, November 2010, <https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/when-and-how-provider-competition-can-improve-health-care-delivery>

Finally, policymakers might consider the administrative costs and responsibilities of various market-based policies. As discussed in a previous section, policies might be targeted to the decision making of different participants as well as to different services or groups of services. However, it is not likely to be feasible for Medicare to administer market-based policies such as competitive bidding and reference pricing for thousands of services across multiple providers. These policies are perhaps better implemented for services for which they are likely to be most effective and least likely to cause disruptions in access for beneficiaries. Moreover, applying these policies for individual services might solve the issue of calculating a more market oriented price, it would not solve other fee-for-service issues such as incentivizing care coordination.⁹⁶ This issue might better be addressed by applying market-based pricing (e.g. competitive bidding) to bundled services such as for episodes of care or for all care. These pricing arrangements hold providers or plans accountable for the costs and quality of a wider range of services and thus encourage coordination to reduce costs.

Enhancing Competition in Medicare Advantage

Medicare Advantage is a growing and popular program now accounting for more than one third of all beneficiaries. Relative to the traditional program, MA plans provide one stop shopping for beneficiaries for their A, B and D benefits, include a limit on out-of-pocket spending for Part A and B benefits and can include supplemental benefits. They may also provide more limited provider networks than the traditional program.

The basic policy premise of MA and similar predecessor programs was that the plan's ability to manage and coordinate care would enable them to provide higher quality and more benefits at a lower cost than fee-for-service Medicare. Until recent years, however, CMS's costs for the MA program were higher than the traditional fee-for-service program in large part because the methods for establishing benchmarks. Currently, the MA payment benchmarks are based on historical and projected fee-for-service costs at the local level adjusted for a number of policy changes. Changes in their calculation authorized by ACA have reduced the benchmarks on average to 107% of fee-for-service costs in 2019; while plan bids of 89% of fee-for-service have resulted in payments to MA plans being about equal to fee-for-service.⁹⁷

A remaining concern is that even the current lower benchmarks do not provide the same incentives for innovation and producing value as would those determined by a fully competitive bidding process. That is, plans bidding under the conditions of a benchmark that would be determined by the distribution of their bids, rather than a pre-determined and known benchmark, would have greater incentives to find ways to provide high quality care at the lowest cost possible. Competitive bidding by MA plans has the potential to move toward efficient pricing as well as to yield budget savings. One concern about this approach would be whether the potentially lower benchmarks would reduce plan participation or make MA less attractive than FFS Medicare. In the below sections we discuss synchronizing competitive policies between MA, FFS and ACO type models.

⁹⁶ Robert A. Berenson and Paul B. Ginsburg, "Improving The Medicare Physician Fee Schedule: Make It Part Of Value-Based Payment", *Health Affairs*, Vol. 38, No. 2

⁹⁷ MedPAC March 2019 Report to Congress

Options for competitive bidding to establish MA benchmarks

There are a number of ways that a competitive bidding proposal might be implemented. For one, Medicare could calculate the benchmark for each area (county) as the mean (or some other statistic from the distribution of bids). As in the current program, beneficiaries choosing plans above the benchmark would need to pay the difference out of pocket. It is likely that many more plans would be at a competitive disadvantage under this option than under current policy. Other payment policies such as rebate percentages and quality payment bonuses for star ratings could be retained or modified for the new policy.

One challenge to this approach in its simplest form relates from the fact that MA is a well-established program. A phase-in from current law to a system based on competitive bidding may need to be used to avoid significant disruption. For example, some plans may have to reduce the very popular supplemental benefits they provide. One approach would be to blend the new and existing benchmarks over some time period. For example, a series of phase-in percentages might be selected such as 15% in the first year, 10% in the second, 5% in the third, and 0% going forward. In the first year, the benchmark would be set at the competitive bid plus 15% of the current law benchmark, capped at the current law benchmark. Most counties would be unaffected at this level, and most of the affected counties would previously have had high rebates. As the percentage of the old benchmark used in the methodology fell over time, more counties would be impacted. In the fourth year, all counties would be impacted.

Another way of minimizing any disruptive impact is to return to “known” benchmark for a pre-determined period of time. That is, the competitively determined benchmark in the initial year would remain in effect for some period (e.g. 3-5 years) is updated by a chosen inflation factor in each of these years. In this way, it would not be necessary to have a high percentage of plans above the benchmark in each year. Plans have an opportunity to reorganize their care and contractual arrangement to get below the anticipated/new benchmark in subsequent years. A rebid could take place at regular intervals to assure market-based incentives remained strong.

Market-Based Incentives for the Traditional Medicare Program

Medicare has already implemented policies to enhance market forces and consumer choice. CMS is finalizing to collect hospitals’ median payer-specific negotiated charges for Medicare Advantage organizations on the Medicare cost report for cost reporting periods ending on or after January 1, 2021. In addition, beginning in FY 2024, the agency is adopting the use of this data in a new market-based methodology to set the MS-DRG relative weights that are used in determining Medicare payment rates for inpatient hospital stays.⁹⁸ In addition, CMS completed a price transparency initiative increase market competition by better informing consumers about their choices. Finally, while not specifically detailed below, proposals for site neutral pricing policies for some ambulatory and post- acute services might be

⁹⁸ <https://www.cms.gov/newsroom/fact-sheets/fiscal-year-fy-2021-medicare-hospital-inpatient-prospective-payment-system-ipps-and-long-term-acute-0>

considered as market based by providing incentives for consumer to be in charge of selecting high value providers.⁹⁹

Competitive Bidding for Select Services

Most Medicare payment rates, whether for individual or bundles of services, are set administratively according to statute and regulation. The payment rates often reflect historical costs and charges for providers, and are not sensitive to supply and demand conditions as would be prices in a well-functioning market.¹⁰⁰ One alternative would be to use competitive bidding to set payment rates that more closely aligned with market prices. As described in Chapter 2, Medicare already has experience with this type of pricing for DMEPOS. The program has reduced spending without apparent adverse consequences for beneficiaries.

Running such a program for the thousands of prices Medicare administers across all the provider types would be an impossible undertaking. There may be select services or bundles that could be chosen for such a program, however. For example, specific DRGs, physician fee schedule services or bundles of services based on defined episodes of care that are high volume and delivered by multiple providers within geographic areas might be selected. Whichever is chosen, providers could be asked to submit bids for their best price of delivering the services or bundle of services. Medicare could then choose one of several methods of setting a market price and choosing participants. Like the DMEPOS program, they could select a price that assures sufficient supply and access for beneficiaries. All providers whose bids were at or below that price would be able to participate in the market while bidders above the market price would be excluded.¹⁰¹ All bidders could participate but those above the established price would be at a competitive disadvantage if they could not reduce their costs. To reduce both administrative costs for Medicare and burden on providers, the bid price could be established for a set period of time and updated annually as opposed to bidding being required every year.

Under this approach, providers would have strong incentive to efficiently produce the service or service bundle in order to construct a bid based on the lowest possible cost. Over time, the providers would need to innovate to improve efficiency or face the risk of market exclusion. There are limitations to this approach, however. As with any competitive approach, having a sufficient number of market participants is optimal. For some services and markets there may be only one provider, or one dominant provider, so losing market share due to competition or even the threat of market exclusion through the bidding process is not a powerful incentive. In addition, the selection of winning bidders would need to assure convenient access for beneficiaries across the market area. Bidding programs for items such as DMEPOS and self-administered drugs do not generally cause access problems because they can be delivered to the

⁹⁹ As well as reducing or eliminating price differentials between sites of service, these policies might also include fewer restrictions on where services can be performed in order to increase competition.

¹⁰⁰ Roger Feldman, Bryan Dowd and Robert Coulam, "Medicare's Role in Determining Prices Throughout the Health Care System" Mercatus Working Paper, October 2015

¹⁰¹ Or, as discussed below, they could use the bidding determined price as a reference price.

home or through medical offices. Access problems for some beneficiaries might arise for services that must be delivered in a hospital or other facility, if the selected providers are not located conveniently.

One approach to these issues might be to build on current models, such as the episode-based models currently being tested by the Innovation Center, by converting them to bidding. Both the BPCI Advanced and CJR models are in the field and have specific definitions for the included episodes of care and the providers and supplier types that may initiate them.¹⁰² Payments are currently either retrospective or prospective, depending on the model, but based on historical costs. For future models, CMS could design the model such that participants would be required to bid based on their anticipated costs and a price set from the bids. The evaluations could then look at savings, quality changes and any unanticipated consequences such as access problems.

As with other competitive policies, bidding will require a minimum number of potential participants to be effective. Bidding would not yield desired results in geographic areas that have virtual monopolies of particular providers such as hospitals, one option for these areas is to exclude them from bidding, but import Medicare prices from areas that have successful bidding programs. Payment for DMEPOS items furnished in non-bidding areas is based on the prices obtained from the bidding areas.

Bidding and Centers of Excellence

Centers of excellence are a version of bidding with competition for the market. That is, a limited number of centers will be chosen to provide a particular service or set of services. As described earlier, large employers have used this approach with some success. This approach might best be used for complex services that might best be delivered by fewer providers than many in order to achieve the best outcomes. Thus, one difference between this approach and general bidding is that the criteria for selecting bidders include more than cost. Centers of excellence generally imply that the chosen facilities will not only be efficient in terms of cost, but through their volume, experience and skills can deliver high quality care and superior outcomes. Thus the “bid” may contain a combination of all of these factors including historical experience with patient outcomes.

Medicare currently uses this approach for organ transplants, lung volume reduction surgery (LVRS), specific PET scans, ventricular assist devices as destination therapy and carotid stenting.¹⁰³ For all of these services, CMS determined that some combination of special skills, facilities, experience or ability to provide an array of support services were required. Facilities were selected based on these requirements rather than on cost. Nonetheless, strong financial incentives (the risk of being excluded) can be associated with this approach.

Medicare could consider expanding the center of excellence programs and potentially include costs as part of the selection criteria. Since payment rates are uniform for the services, costs could be based on an

¹⁰² <https://innovation.cms.gov/files/reports/episode-payment-models-wp.pdf>

¹⁰³ <https://www.cms.gov/Medicare/Medicare-General-Information/MedicareApprovedFacilities>

episode of care including hospital and physician services, associated support and preparation services and post-acute care.

Reference Pricing

Reference pricing is a system in which an insurer or purchaser selects a price it is willing to pay for a health care service. As discussed below, there are a number of methods that might be used to derive the reference price, but it is generally calculated from a distribution of prices (e.g. a mean or median). Thus, at least initially the prices of some providers will be below the reference price and some above. It is typically implemented as a competition within the market strategy so all providers can participate, but those with prices above the reference price are at a disadvantage to the extent their higher prices reflect less efficient operations.

Most reference pricing policies are accompanied by strong consumer incentives for choosing lower cost providers. Enrollees who obtain care from a provider with a price at or below the reference price pay only the normally required cost sharing (e.g., deductibles, coinsurance). Enrollees obtaining care from a higher-priced provider pay not only the normally required cost sharing but also an additional cost, typically the difference between the reference price and the allowed charge. To the extent consumers react to these financial incentives, higher price providers would face pressure to reduce their prices; and become more efficient in order to do so.

The limited experience in private programs reviewed above suggest that reference pricing could potentially yield savings to the Medicare program and incentivize innovative, value seeking changes on the part of providers. There are likely to be many ambulatory services and some inpatient services that are amenable to this approach. There would be three operational and policy challenges for the program; selecting appropriate services for reference pricing, setting the reference price and, making changes to current law and policy which weaken beneficiary incentives to choose lower cost providers.

One challenge for Medicare is that it tends to pay uniform prices for services and thus, a distribution from which to calculate the reference price does not exist. One alternative therefore is to move away from the administered price of the selected services and use a bidding approach to establish the reference price. A second alternative would be to use prices from private payers as was done for the laboratory fee schedule. A third alternative is to apply reference pricing to bundles of services. Medicare's data would allow for calculating episode costs which even at uniform prices would vary based on differences in utilization and intensity of services. Thus, a distribution would be available from which to choose or calculate a reference price. Still another alternative for select services is to take advantage of variation that exists in administered pricing when the same service is offered in a variety of facilities that are paid under separate fee schedules. One good example is for many ambulatory services that can be provided in physicians' offices, hospital outpatient departments and ambulatory surgical centers (ASCs). A site neutral payment (e.g. the lowest price paid) could be used as a reference price and adjusted as need to reflect legitimate cost difference among the facilities.

Any of these approaches would reduce program spending and likely encourage some effort to increase efficiency and/or improve the quality and patient convenience of the service. But as with other

approaches, beneficiary incentives to shop for the lowest price would be limited by Medicare’s current cost sharing structure and Medigap protection. Thus, reference pricing could be coupled with some forms of balance billing or cost sharing tiers that would reward beneficiaries that choose the lower cost providers and impose additional costs on those choosing providers with higher prices; along with limitations on Medigap coverage.

Tiered Provider Networks

Tiered networks are created by designating groups of network providers into levels, or tiers, based on the value—cost and quality—of the care they provide. The providers that deliver care that is high value—low cost and high quality—are in the highest tier, while those that provide care that is low value are in the lowest tier. Accordingly, tiered networks are also called high-performing networks.¹⁰⁴ Again, this approach is likely to be more effective if there are cost-sharing consequences for beneficiary choices. For example, if patients who seek care from high-value, or preferred, providers have lower out-of-pocket costs. Differential cost sharing by tier allows the consumer to make tradeoffs between the choice of provider and the cost of care.

Most private plans already have benefit plans that use tiered networks.¹⁰⁵ Tiered networks for Medicare could contribute to instilling market-based incentives for providers and beneficiaries. Hospitals and physicians in lower tiers would risk the loss of patient volume and revenues unless they improved their performance. Of course, as with the other market-based policies described above, complementing the tiered networks with beneficiary cost sharing changes would result in more powerful incentives for value-based behavior on the part of providers. While this approach would be new to beneficiaries in the traditional program, those in MA have become accustomed to narrower network choices.

There would be many challenges to implementing a tiered network approach in Medicare. First, program would need to have the appropriate data and methods to rank providers by value – that is some combination of cost and quality. Again, since Medicare’s prices are uniform, costs would have to be developed for episodes of care and appropriately risk adjusted. In addition, while hospital quality measures are well developed, measures for physicians, particularly those in small and rural practices, is more difficult.

In Traditional Medicare, clinicians are currently evaluated on quality and costs in the Merit-based Incentive Payment System (MIPS). However there may be various feasibility concerns in using current MIPS quality and cost data to determine tiered provider networks, such as limited availability of common quality and cost measures, measure sample size issues, and limited coverage of specialists in episode-based cost measures. These issues most affect small, specialist-only practices, who make up the majority

¹⁰⁴ Delbanco SM, R.; Berenson, R.; Upadhyay D. Payment Methods and Benefit Designs: How They Work and How They Work Together to Improve Health Care: Tiered Networks. 2016; http://www.urban.org/sites/default/files/03_tiered_networks.pdf. Accessed December, 27, 2019. Urban Institute.

¹⁰⁵ Sinaiko AD, Landrum MB, Chernew ME. Enrollment In A Health Plan With A Tiered Provider Network Decreased Medical Spending By 5 Percent. *Health affairs (Project Hope)*. 2017;36(5):870-875.

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of practices in the US. There does not yet exist a common set of quality measures to evaluate all clinicians in MIPS, except for a claims-based measure of hospital readmission rates. However, this measure is not sufficiently reliable to assess the quality of clinicians in small practices with 10 or less clinicians. Using MIPS quality data to determine preferred networks may be premature, and could undermine the financial viability of small, independent primary care practices, who tend to have lower rates of readmissions and spending compared to practices owned by large health systems.¹⁰⁶

Secondly, for costs, physicians are evaluated in MIPS on broad, claims-based measure of total costs of care attributed to the primary care physician and hospital episode costs attributed to the outpatient physician after hospital discharge. However ASPE has estimated that less than a third of small practices, most of whom are specialists, have enough Medicare cases to report these broad cost measures. For specialists, there are some new MIPS condition or procedure-specific episode cost measures but these measures do not yet cover all specialists.¹⁰⁷

In summary, the lack of quality and cost measure comparability and availability for all clinicians could undermine the validity and acceptability of the proposed tiered network enterprise among clinicians. Using quality and cost information to create tiered provider networks may be something to work towards in the future, when more robust and clinically meaningful data is available. Recognizing the burden of reporting in MIPS, CMS has recently announced it plans to revamp the MIPS program to introduce MIPS Value Pathways that will create meaningful sets of quality and cost measures more relevant to a clinician's scope of practice. In this framework, CMS envisions a set of administrative claims-based quality measures that focus on population health/public health priorities to reduce reporting burden, as well as specialty/condition specific measures reported by clinicians. This framework is planned to be implemented starting in performance year 2021, but may take many years for pathways to be implemented across all relevant conditions and specialties, developed in collaboration with medical specialty societies. Identifying preferred providers by specialty or condition based on the clinically relevant MIPS pathways would increase acceptability to providers and patients.

Another important issue is that tiered networks will be most effective in markets where there are a sufficient number of providers to compete. In this approach, providers are incentivized to reduce costs and improve quality to avoid losing their patients to better performing competitors. Where there are few hospitals or particular types of specialists or dominant providers, these incentives will not be as strong.

Some of these issues might be minimized by initially limiting or testing tiered networks in particular geographic areas and/or specific provider specialties. For example, the policy might first be implemented in urban areas that have sufficient numbers of key provider types and meaningful differences in

¹⁰⁶ Casalino LP, Pesko MF, Ryan AM, Mendelsohn JL, Copeland KR, Ramsay PP, Sun X, Rittenhouse DR, Shortell SM. Small primary care physician practices have low rates of preventable hospital admissions. *Health Aff (Millwood)*. 2014 Sep;33(9):1680-8.; Pesko MF, Ryan AM, Shortell SM, Copeland KR, Ramsay PP, Sun X, Mendelsohn JL, Rittenhouse DR, Casalino LP. Spending per Medicare Beneficiary Is Higher in Hospital-Owned Small- and Medium-Sized Physician Practices. *Health Serv Res*. 2018 Aug;53(4):2133-2146.

¹⁰⁷ Chen, L.M., Samson, L.W., Zuckerman, R.B. et al. Challenges of Measuring Costs of Care for US Practices. *J GEN INTERN MED* (2020).

performance for assigning tiers. Initially, the policy could be applied to select specialties for whom cost and quality measures are validated and more accepted by the profession. Still another option is to begin by assigning ACO and other selected APM model participants in an area to a favored tier and build out from there. This approach might reduce administrative burden for the program and incentive for providers and patients to choose ACOs.

Continue Moving Toward Market-Based Incentives for ACOs

ACO initiatives represent an alternative payment model built on a fee-for-service platform but with financial incentives to reduce cost and coordinate care. ACOs in the various models have had different degrees of upside and downside financial risk. The evidence to date suggests that savings are growing over time and that ACOs that face greater financial risk have better outcomes. Moreover, better performing ACOs have been found to be most innovative in terms of patient care.¹⁰⁸ CMS is already moving the direction that would be suggested by evidence and for increasing market-based incentives. In both the Shared Savings Program and Innovation Center models, ACOs are being moved more rapidly to greater risk sharing and potentially capitated payment.

CMS might consider some additional methods of enhancing these incentives. One alternative would be to consider competitive bidding or another market-based method of establishing ACO benchmarks. In addition, payment waivers that CMS issues to allow ACOs to offer certain benefit enhancements might be refined to assure that current policies do not become an obstacle to innovation. In addition, CMS might consider doing more detailed studies that focus on factors that have been associated with the best performing ACOs and those associated with those that have not performed as well. The information produced by these studies could help more ACOs improve performance as they face greater financial risk.

Synchronizing Incentives among Payment Sectors

Along with the proposals for setting MA benchmarks through competitive bidding is a long-standing debate concerning whether traditional Medicare should compete directly with MA.¹⁰⁹ In particular, whether the Program's subsidies should be equal across the two sectors. The argument made is that competitive bidding within MA would replace administered benchmarks with market-based benchmarks; providing strong incentives for plans to innovate and produce high quality care at the lowest cost possible. A more comprehensive Program reform might include the fee-for-service sector as a "bidder." In that approach, the average FFS cost in an area might serve as the bid. If it was higher than the MA competitive benchmark, beneficiaries would have to pay a higher premium for choosing FFS. Likewise, if it were lower beneficiaries could have their Part B premium reduced. In any case, this approach might be considered a more level playing field approach for providing choices to beneficiaries.

¹⁰⁸ Clare Pierce-Wrobel and Jeff Micklos, "How The Most Successful ACOs Act As Factories Of Innovation" Health Affairs Blog, January 29, 2019

¹⁰⁹ Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, "Payment for Medicare Advantage Plans: Policy Issues and Options", June 30, 2009, <https://aspe.hhs.gov/basic-report/payment-medicare-advantage-plans-policy-issues-and-options>

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Many questions have been raised about the exact method of implementing this approach. The policy development is somewhat more complicated now because the growing ACO enrollment might be treated as a third payment sector to potentially compete with MA and traditional FFS. MedPAC has termed the process of thinking about how to construct benchmarks to be financially neutral among the three sectors as synchronization of payment. Financially neutral means beneficiaries would receive the same subsidization of their costs regardless of the choice they make among the three sectors to best meet their needs and preferences.¹¹⁰

While beginning the research and policy development for synchronization would be strategic so that it would remain a policy option for the future, implementing market-based policies within sectors first may be more prudent at this time. As discussed in this section, developing and implementing market-based policies would require considerable amount of informed decision-making, potential testing and evaluation, and policy modification. ACOs themselves are still evolving as care models. Therefore, it might be best to make competitive progress within the three sectors as a first step, and consider synchronization in the future.

¹¹⁰ MedPAC March 2015 Report

Chapter 6. Conclusion and Recommendations for Moving Forward

Policy Recommendations for Moving Forward

One of the messages in this report is that carefully crafting market-based policies will be critical to their success. As discussed, not all markets are structurally amendable to competition; some services might be considered more “shoppable” than others might and there may be data issues that limit implementation of specific policies. Thus, developing information to support an evidence-based approach to new policies may be advisable. It should be remembered that the DME competitive bidding program was implemented after a controlled demonstration was conducted and evaluated. The change in the laboratory fee schedule occurred after research on the impact on using private pricing data and then a data collection effort.

The potential tools for market-based policies includes competitive bidding, centers of excellence, reference pricing and tiered provider networks. An important question therefore is how to target these policies initially – e.g. to which payment models in Medicare (FFS, MA etc.), which services and which participants (beneficiaries, providers, both). The first steps that might be taken would be developing the information base and strategies for moving forward with market-based policies. These include:

- Evaluate which individual or bundled services might be amenable to bidding or reference pricing methods
- Evaluate geographic markets for various services to determine their competitiveness
- Evaluate whether data are sufficient to implement policies such as reference pricing and network tiering for some provider groups; and consider the extent to which private sector data might be useful
- Develop strategies to address markets not amenable to market-based policies
- Consider whether policies would be targeted to fee-for-service, MA or both
- Consider which strategies might be best implemented through new legislation and which might be tested and evaluated under Innovation Center authority
- Consider how the current COVID-19 pandemic demonstrates the need for surge capacity and how that might frame the way market-based policies are constructed and implemented

Developing the information base for considering new policies will be important. A good first step would be to begin with CMS’s current list of hospital “shoppable” services and identify other services that might be targets for bidding or reference pricing.¹¹¹ These services would have many providers in a market, be non-emergent, be easily identified by patients for price shopping and only minor expected variations in quality. In addition, services for which cost and outcomes would not vary substantially based on the health status of the patient would be preferable to reduce the need for risk adjustment. Once a catalog

¹¹¹ <https://www.cms.gov/files/document/2019-12-03-hospital-presentation.pdf>

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of these services containing all of the necessary data on them by market was compiled, informed decisions could be made on which market-based policies might be most effective for different geographic areas.

Similarly, research can be conducted to identify bundled services that might be productive targets for bidding or reference pricing. The bundles might be for particular treatment episodes as are current Innovation Center efforts. They might also be extended to include physician services as well as the facility services. Current efforts rely on costs calculated using Medicare's current prices. The new research would analyze ways of establishing the market-based price and analyze other important issues. For example, as pricing is moved from individual services to service bundles issues of quality measurement and risk adjustment become more important.

Simultaneously, research should be conducted to characterize various markets by their degree of competitiveness or concentration. These measures might be developed for hospitals, physician practices and characterize the degree of vertical integration in a market. Improving Medicare's databases on ownership of facilities would enhance the latter task. These data would allow for informed choices over markets that might be more amenable to market-based policy vs. those in which other price or cost control strategies might need to be developed.

Data and methods assessments will also be important. As noted above, policies that bundle services require more information and complex decisions regarding what services are included, what time periods apply and how they should be risk adjusted. Policies that would classify providers, such as tiering, require these decisions as well as quality data to determine value. It will be useful therefore to evaluate our value-based purchasing programs to determine whether current measures are adequate for large portions of the provider community or whether improvements are needed for market-based purposes.

It will be important to consider what policies might be implemented in highly concentrated markets. Many of the market-based policies described in this report would not be successful in markets with dominant providers. One option would be to import prices from more competitive markets in which successful market-based policies were implemented. These prices could then be adjusted for any geographic factors deemed necessary.

Finally, many of the policies discussed in this report would need to be authorized and implemented in one of two ways: through legislation providing new statutory authority, or through the Innovation Center's current authority. Since Medicare has little experience with many of the policies that might be considered, the Innovation Center could test them, conduct the evaluations and then scale or modify as appropriate. Experience tells us that each model requires the Innovation Center to make a number of choices such as; appropriate scale of the model, choice of geographic areas, and whether it is implemented as a voluntary or mandatory model. These choices can be both technically and politically challenging and therefore, additional statutory authority might be helpful in some cases.

Health Policy, Pricing and Efficiency in the Post COVID-19 World

Improving the efficiency and value of our health care system will remain a critical objective for future health policy. Assuring that health systems remain affordable and sustainable while maximizing public health will be critical. Nonetheless, how we view efficiency moving forward needs to reflect the current experience with the COVID-19 pandemic.

As the number of infected persons multiplies, the U.S., as well as other nations, has struggled to assure health system capacity and supplies to meet peak patient demand. There are shortages of beds, professionals, equipment and supplies in some geographic areas. This experience is a useful reminder that defining efficiency, and associated pricing, in the health care sector, may need to account for certain factors in a different manner than in other markets. Specifically, consideration should be given to what might be termed static vs. dynamic efficiency, or short run vs. long run efficiency. That is, while short run efficiency suggests producing output at the lowest cost possible; this condition might not be viewed as prudent from a more dynamic efficiency perspective.

Indeed, these considerations are the basis of our policies regarding pharmaceutical markets. Clearly, if competition were allowed so that the price of brand drugs were reduced to reflect their immediate cost of production, health care costs would be significantly lower. Pricing that reflects current production costs would not financially compensate producers for the often substantial research and development costs for bringing a drug to market, however. Therefore, there would be little incentive for innovation of new drugs and potential future improvements in public health would be foregone. Thus, market exclusivity is granted to newly approved drugs that allows for some number of years in which price can exceed current production costs.

It is possible that policies related to efficiency, incentives and pricing for at least some health care providers will have to include these long run considerations. Simply stated, the most efficient short run operations in terms of human capital (staffing) and physical capital (beds and equipment) may not be in the best interest of our public health in the long run. The system must maintain the capacity to quickly ramp up to meet public health emergencies. This suggests that capacity may need to be larger than short-term efficiency would otherwise suggest so that it can be scaled when peak capacities are needed.

These considerations make it no less important that we find the right mix of policies and incentives to move our health care system towards greater value. It does mean that as we craft our policies, we balance the desire to reduce the immediate costs of care with our expectations of how the system will respond to future health emergencies. Finding that balance will present significant challenge for policymakers.

Conclusion

Medicare has made significant progress in moving away from unrestricted fee-for-service payment toward paying for quality and outcomes. The Shared Savings Program and the Innovation Center models have increased their rate of savings for the Program and have moved steadily toward adding greater financial risk for participants. Nonetheless, there is more progress to be made. Based on projected spending growth, for Medicare and health care in general, it will continue to grow as a share of the overall economy. The exhaustion date for the Medicare Part A Trust Fund is within the near term.

This report has described the potential for market-based policies to reduce spending growth and improve quality for the Medicare Program and its beneficiaries. These policies would be intended to incentivize the financially motivated choices and care innovations that would occur in a well-functioning, competitive market. If effective, these policies would not only benefit Medicare but could have positive spillovers for all purchasers and patients.

Private purchasers and health plans have already implemented a number of market-based strategies with some success. These strategies include competitive bidding, reference pricing, centers of excellence and tiered provider networks. Medicare, which has had success with DMEPOS competitive bidding and Part D plan competition, could adopt some of these strategies to enhance its movement towards value-based purchasing.

For a program as large as Medicare, it will be important to structure these policies carefully. Medicare now has three primary payment approaches: MA, ACOs and traditional fee-for-service. (This is not including bundled payments, primary care medical home, or other such models). Thus, there is potentially a mix of market-based policies that affect plan competition, provider competition and beneficiaries' choices. The various policies have different implications for the distribution of decision-making and financial risk among these participants and the Medicare Program. Local market structure can be important to the potential success of these policies and should be considered. Finally, different types of services may be more or less amenable to shopping and therefore the potential success of consumer driven policies.

With those considerations, the fiscal situation of Medicare and the health care system places some urgency on finding a policy mix that can result in both bending the spending trajectory and improving health outcomes. Both economic theory and the experience of state level programs, employers and private insurers suggest that market-based policies can work and provide lessons on how they might be implemented to avoid adverse or unintended effects. Whether authorized through new legislation or through current Innovation Center authority, these policies might be implemented through model designs that can be evaluated and modified as needed before potentially scaling to the national level.

Medicare does have the opportunity to successfully make competitive improvements within the MA, ACO, and fee-for-service payment approaches. Some consideration might also be given to synchronization among these payment models in a way that may provide further gains from competition among them. Specifically, policies might be examined that incentive beneficiaries to make the choice between these

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three sectors based on their preferences and health needs, but with the program's subsidy to them being financially neutral.

Finally, we have emphasized in this Report that with the opportunities market-based policies present for improving Medicare comes the challenges of providing the right information to policymakers for crafting these programs. Developing a framework for policy development that specifies the preferred means and ends, as well as constructing the appropriate evidence base, are critical. The current COVID-19 pandemic adds a layer complexity to these tasks in necessitating considerations of how the goals of improved efficiency and reduced cost incorporate the need to maintain capacity to meet future health emergencies.

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SUGGESTED CITATION

Steven H Sheingold, Nguyen Xuan Nguyen, Rose Chu, Medicare: Opportunities for Market-Based Policies, Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. January, 2021.

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