

Nature of a major payer

- Scope & Content
- Scale
- Rules
- Trust
- Automation

- On issues of
 - Can Medicare pay? → Benefit category
 - Should Medicare pay? → Coverage
 - How is payment made? → Coding
 - How much? → Payment
 - And who gets to provide services?
- Local versus national
- Sometimes not at all...

Evaluating a policy

<i>The Static Model</i>		Quality		
		Less	No change	More
Cost	More	X	X	X
	No change	X	↔	😊
	Less	X	😊	☀️

Who decides?

- Congress and the President
- Political executives
- Career staff
- Local contractors (Fiscal intermediaries, carriers, Medicare Administrative Contractors)
- Providers

What matters in a decision?

- Law and prior policy
- Current direction & emphasis
- Clinical factors
- Cost.....
 - Entitlement/contracts
 - The hose vs. the bucket
- Effect on quality & outcomes
- Administrative factors

- **Fee-for-service:**
 - Pay for each service
 - No separate payments for capital
 - But what's in a payment cell?
 - Rates are prospectively determined
 - 12 payment systems, differ by provider type
 - Annual updates (inflation, policy)
- **Medicare Advantage**
 - Monthly, capitated payment
 - Follows FFS lead, but can do more

Problems, problems...

- Rising aggregate spending
 - Do we restructure the program?
 - Manage better?
- Paying for the “right” care
- Improving the quality of care
- Addressing chronic and high-cost cases
 - Difficult cases, multiple chronic conditions
 - High spenders
 - Can we do a better job delivering care?

- Go from passive payer to active purchaser
- Emphasize “value-based purchasing”
 - Paying for the “right” care
 - Improve accountability
 - Involve the consumer
- Reinvent CMS as public health agency – a primary rather than secondary mission

- Tailoring the payment systems
 - Incent better management choices by expanded bundles (OPPS)
 - Improve payment accuracy by better specifying the bundles (IPPS)
- Competitive bidding (drugs, DME, labs)
- Initiatives aimed at high cost, chronic cases
- Gainsharing

Medicare quality tactics

- Supplement rule-and-survey quality assurance
- Use payment to drive improved quality
 - Improve quality reporting (P4R)
 - Pay for quality performance (P4P)
 - Reduced payment for hospital acquired conditions
- Improve accountability & transparency

- Consumer-driven health care
 - Provide better information on price **and** quality
 - Informed consumer makes better choices
 - Providers improve
 - Transparency and ratings
 - Movement of consumers (can be marginal)
- Personalized medicine

- High-tech, genetic drug therapies and lab tests
- Rapid growth in radiology
- Health information technology
 - Electronic/personal health records
- Telemedicine
- Remote monitoring

- FFS care is frequently fragmented
 - Difficult to effectively integrate technology that involves changes in system of care
- Many innovations that claim to save money cannot document that they do
 - Spend here now, save there later...
 - Absence of direct links
- “One man’s waste is another man’s income”

- Technologies are **embedded effectively in systems of care** for patients
 - Just creating a new tool is not enough
 - Medicare pays for care, not tools
- Something that does a better job of what is already done and Medicare pays for...
- **Evidence of better outcomes** supports use
 - Cost? Prospective savings in another system??
 - Quality?
 - Care outcomes?

Cost versus value

- Payment systems designed to reflect **average resource consumption**
- Direct accounting for **value** propositions not really possible at present
- Reflecting **savings across payment systems is difficult**
 - Look at radiology
- **Capitated** environments may be more hospitable than FFS
 - Is FFS approval a move of convenience or a move of desperation?

View from the top

- Aggregate spending a giant problem
- Emphasis on providing what's needed
- Control of particular spending poor
- New technologies? “Yes, if---”
 - Work well in a system of care
 - Prove their worth