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# Using Medicare to Benchmark Healthcare Prices: Too Much, Too Little or Just Right?

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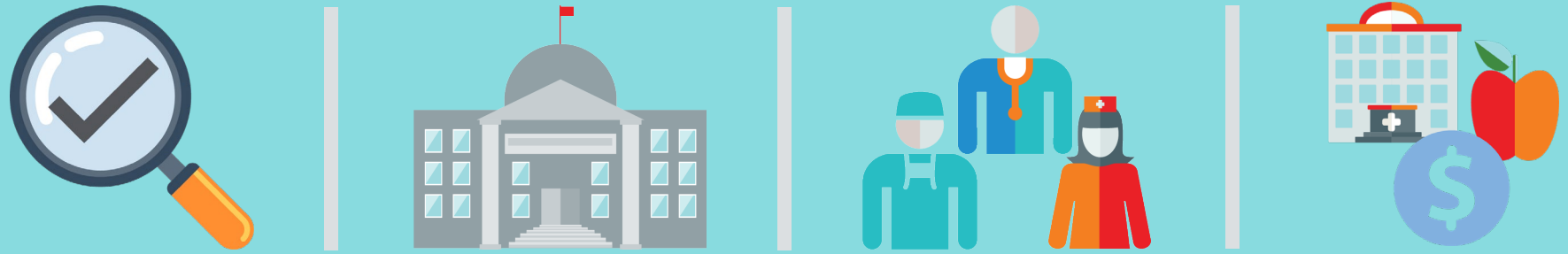

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# Welcome and Introduction

Lynn Quincy
**Healthcare Value Hub**

# Housekeeping

- Thank you for joining us today!
- All lines are muted until Q&A
- Webinar is being recorded
- Technical problems? Call Annaliese Johnson at 202-776-5177

# Agenda

- **Welcome & Introduction**
- Hospital Payment in Medicare
  - **Aditi Sen, PhD, Assistant Professor, John Hopkins University**
- How Does Medicare Pay Physicians?
  - **Steve Martin, Associate Professor, University of Massachusetts Medical School**
- Medicare Prices for Drugs
  - **Sabah Bhatnagar, Policy Analyst, Healthcare Value Hub**
- **Q&A**

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# Aditi Sen, PhD

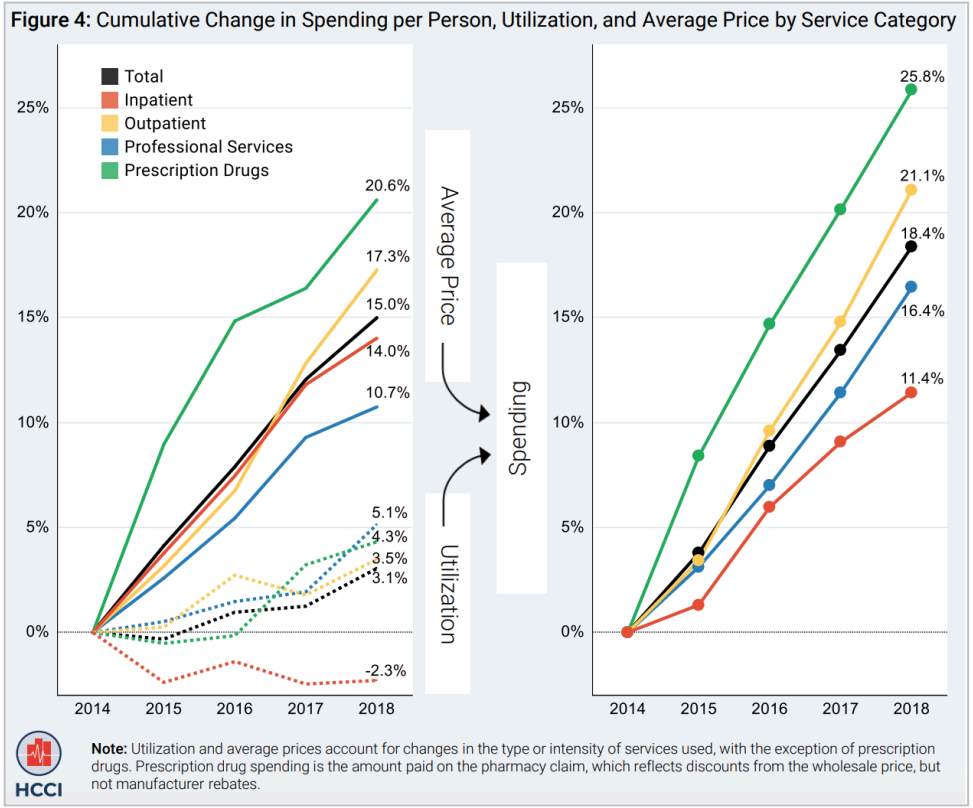
Assistant Professor
**John Hopkins University**
**Bloomberg School of Public Health**

JOHNS HOPKINS
BLOOMBERG SCHOOL
*of* PUBLIC HEALTH

# Hospital Payment in Medicare

**Altarum Healthcare Value Hub**
**Aditi P. Sen**
**Johns Hopkins Bloomberg School of Public Health**
**February 28, 2020**

# Why address health care prices?

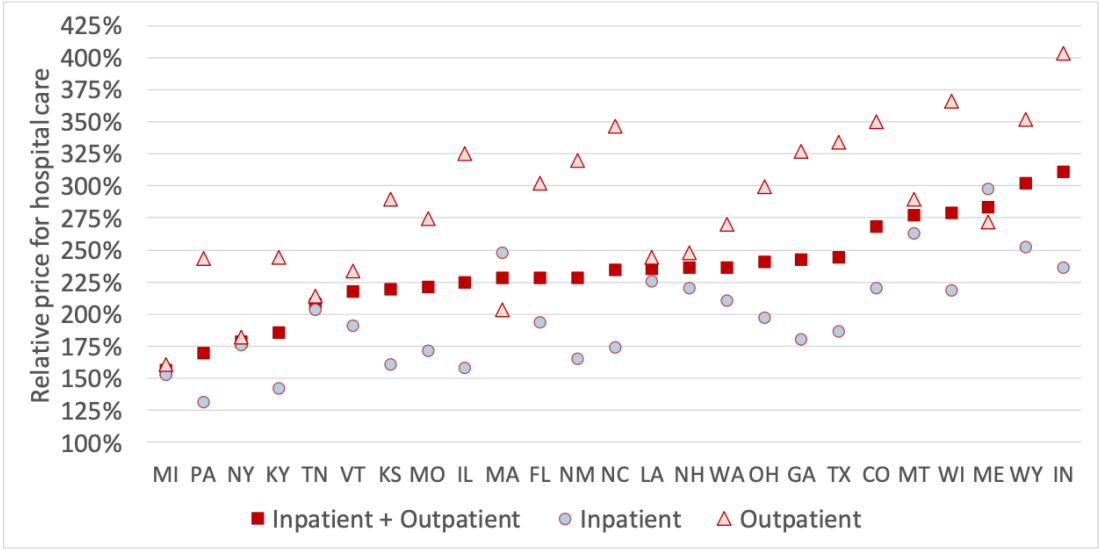


# Why might we consider Medicare as a benchmark?

- Being considered in a range of settings:
  - Public option (WA: 160% Medicare, CO: 155% Medicare)
  - State employee reference pricing (MT: 234% Medicare)
  - Surprise bills regulation
- Takes into account local area characteristics/costs
- Recognizes that certain hospitals have different needs (e.g., critical access)
- Theoretically, rules determining Medicare payments are public and so could be a relatively easily calculated benchmark (reality is more complex, but still likely to be relatively transparent)

# Disparity between private and Medicare hospital payments

**Figure 4.2. Relative Prices, by State, 2017**



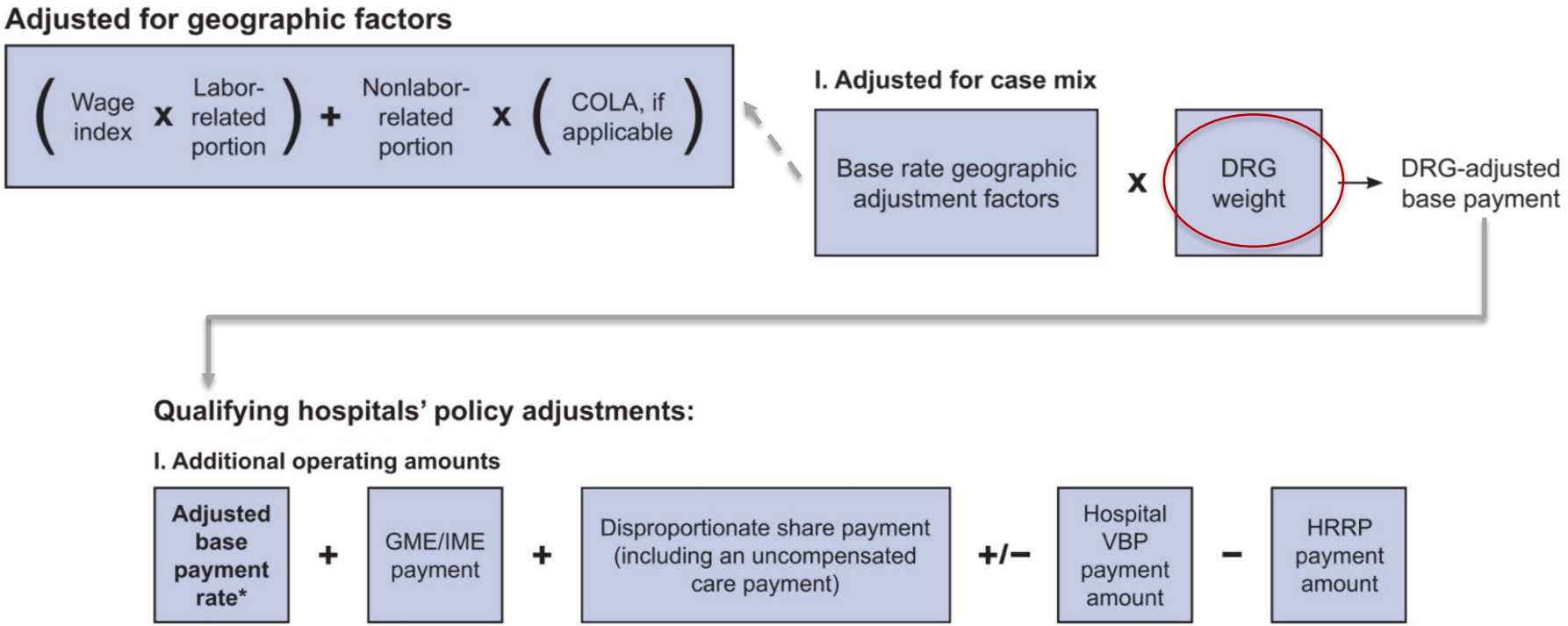

NOTE: Relative prices equal the ratio of the amounts actually paid divided by the amounts that would have been paid—for the same services provided by the same hospitals—using Medicare's price-setting formulas.

White and Whaley. Prices Paid to Hospitals by Private Health Plans Are High Relative to Medicare and Vary Widely Findings from an Employer-Led Transparency Initiative. RAND, 2019.

# Medicare payment to hospitals

- Take a step back: How does Medicare pay hospitals?
  - Inpatient
  - Outpatient
  - Adjustments
- How would it work to use Medicare as a benchmark for private prices?
- How might hospitals respond to lower private sector payments?

# Payment for inpatient services: The IPPS

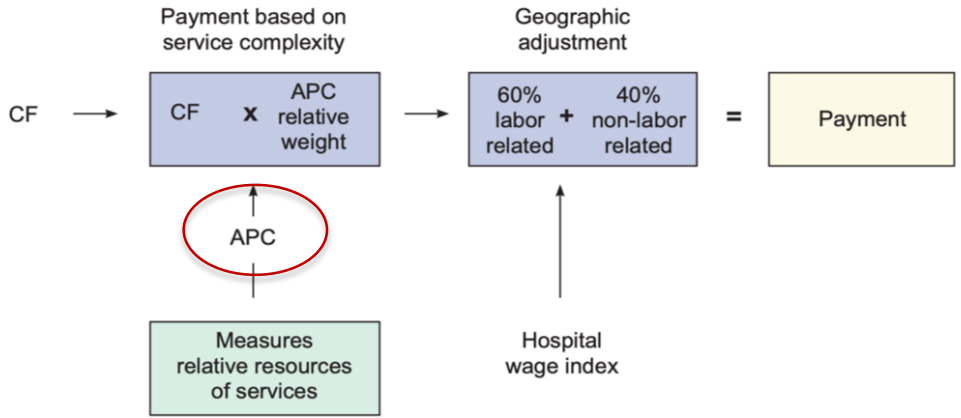


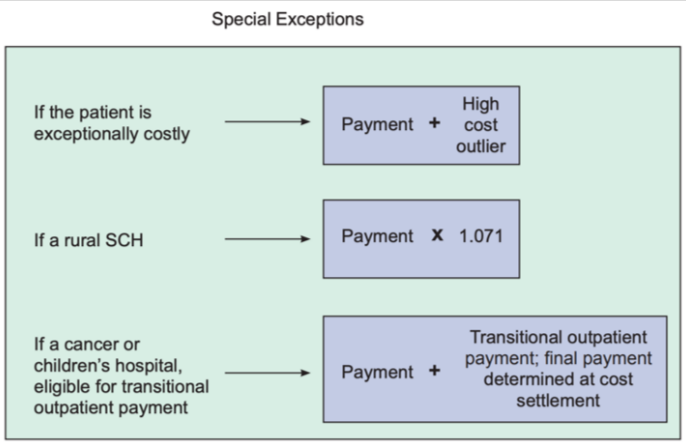

CMS "Acute Care Hospital Inpatient Prospective Payment System," 2019.

# Complexities in inpatient payment: Add-ons

- Disproportionate share hospital (DSH) adjustment
  - Higher payments for hospitals serving a greater proportion of low-income patients
- Direct Graduate Medical Education (GME) adjustment
  - Payments to hospitals for the costs of approved graduate medical education programs
- Indirect medical education (IME) adjustment
  - Additional payment to reflect the higher patient care costs of teaching hospitals relative to non-teaching hospitals
- Outlier payments
  - For cases incurring extraordinarily high costs
- Adjustments for participation in APMs (Hospital VBP, HRRP, HAC)

# Payment for outpatient services: The OPPS




CMS "Hospital Outpatient Prospective Payment System," 2019.

# Complexities in outpatient payment: Non-standard payment

- CMS pays non-standard OPPS rates for many services, including therapy, screenings (in particular, screening and diagnostic mammography), lab tests, some drugs and biologics
- Non-standard OPPS services are largely labs, drugs, physical therapy
- These services are paid under a different fee schedule or bundled with other services for payment (i.e., no separate APC payment)
- Makes OPPS less “off the shelf” user-friendly for repricing than IPPS

# Using Medicare as a benchmark in practice: What goes into the price ratio?

**Calculating the numerator:**

- Source for price:
  - Claims
  - Provider contracts
- Source for utilization:
  - Pre-determined basket of services
  - Actual (historical) utilization based on claims

$$\frac{\text{Private spending for set of services}}{\text{What Medicare would have spent for the same set of services}}$$

# Using Medicare as a benchmark in practice: What goes into the price ratio?

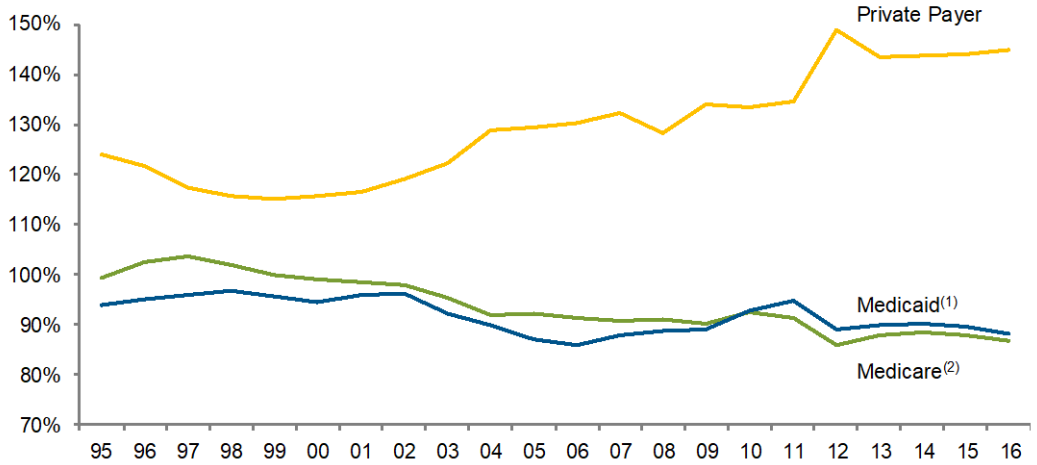
$$\frac{\text{Private spending for set of services}}{\text{What Medicare would have spent for the same set of services}}$$

**Calculating the denominator:**

- Source for price:
  - Rules-based approach (i.e., what Medicare would have paid; simulated)
  - Repricer (i.e., what Medicare would have paid; simulated)
  - Claims allowed amounts (i.e., what Medicare did pay; reflects actual $s)
- Source for utilization:
  - Calculated to reflect the numerator
- Key decision (inpatient): Inclusion of add-ons, e.g., DSH, IME

# Hospital payments and hospital costs

## Chart 4.6: Aggregate Hospital Payment-to-Cost Ratios for Private Payers, Medicare, and Medicaid, 1995 – 2016




Source: Analysis of American Hospital Association Annual Survey data, 2016, for community hospitals.
(1) Includes Medicaid Disproportionate Share Hospital payments.
(2) Includes Medicare Disproportionate Share Hospital payments.

American Hospital Association

# Hospital payments and hospital costs

- Hospitals under financial pressure tend to have lower costs; evidence suggests that increases in payments are associated with increases in cost (and vice versa).

- "Medicare payment policy should not be designed simply to accommodate whatever level of cost growth a sector demonstrates." [MedPAC, 2019]
  - Cost growth can fluctuate dependent on econ conditions, market power, efficiency

- MedPAC bases "payment adequacy" on:
  - Beneficiaries' access to care
  - Quality of care
  - Providers' access to capital
  - Medicare payments and providers' costs

# Take-aways

- Private health care prices are rising
  - Private prices now more than twice Medicare prices
  - Evidence suggests this payment disparity is greater for outpatient vs. inpatient care

- Medicare offers a potentially useful benchmark for prices
  - Starting to be used in a variety of settings, e.g., public option, state-employee reference pricing
  - Transparent, but not simple to implement – decisions re add-ons, lack of transparency in OPPS, whether or not to adjust further…

- Ongoing questions about hospital financial sustainability in the face of lowered private prices; MedPAC and other evidence suggests that hospitals are able to adjust costs

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# Steve Martin

Associate Professor
**University of Massachusetts**
**School of Medicine**

# We Get What We Pay For

## How U.S. Clinicians Are Paid

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Using Medicare to Benchmark Healthcare Prices:
Too Much, Too Little or Just Right?

February 28, 2020

Stephen A. Martin, MD, EdM, FASAM
University of Massachusetts Medical School
Department of Family Medicine and Community Health
Barre Family Health Center

UMassMemorial Health Care | University of Massachusetts Medical School
umassmed.edu

# A Patient's Question for Their Primary Care Center

"Why do you schedule patients every 15 minutes if you know you'll run late all the time?"

# Diamonds and Water

# How Much Should Care Cost?

SPECIAL ARTICLE

# ESTIMATING PHYSICIANS' WORK FOR A RESOURCE-BASED RELATIVE-VALUE SCALE

WILLIAM C. HSIAO, PH.D., PETER BRAUN, M.D., DOUWE YNTEMA, PH.D., AND EDMUND R. BECKER, PH.D.

**Abstract** We have developed a resource-based relative-value scale as an alternative to the system of payment based on charges for physicians' services. Resource inputs by physicians include (1) total work input performed by the physician for each service; (2) practice costs, including malpractice premiums; and (3) the cost of specialty training. These factors were combined to produce a relative-value scale denominated in nonmonetary units.

We describe here the process by which the physician's work was defined and estimated. The study asked two questions: What is the physician's work for each service performed? and Can work be estimated reliably and validly? We concluded that a physician's work has four major dimensions: time, mental effort and judgment, technical skill and physical effort, and psychological stress.

We found that physicians can rate the relative amount of work of the services within their specialty directly, taking into account all the dimensions of work. Moreover, these ratings are highly reproducible, consistent, and therefore probably valid. (N Engl J Med 1988; 319:835-41.)

THERE is a growing consensus that the prevailing method of paying for physicians' services should be fundamentally reformed. Increasingly, physicians, patients, and insurers find the current system based on usual, customary, and reasonable charges to be cumbersome and administratively complex.[1] The current method of payment has also been faulted for "creating patterns of allowed charges that embody inappropriate incentives for the use of medical services, as well as for physicians' decisions on where to locate and what to specialize in."[2] Yet another criticism is that the system "encourages physicians to specialize, to practice in urban and suburban areas, and to perform services in hospital settings — all in the face of stated national policies of encouraging primary care, rural practice, and out-of-hospital services."[3] The current method of payment produces these perverse effects, it

place, charges (prices) are distorted. Policy makers, third-party payers, and many physicians are exploring alternative methods of payment that are not based solely on physicians' charges. One such approach is to base reimbursement on the resource-input cost. That is the approach we have taken.

Three major resource inputs are required to produce medical services or procedures: (1) the total work input by the physician; (2) practice costs, including malpractice premiums; and (3) the opportunity costs of postgraduate training to become a qualified specialist.

These three factors combine to produce the resource-based relative value (RBRV) of a given medical service. One way to merge these factors into a relative value is as follows:

$$\text{RBRV} = (\text{TW})\ (1 + \text{RPC})\ (1 + \text{AST}),$$

**RBRVS**
Resource-Based Relative Value Scale

**RVU**
Relative Value Unit

**RUC**
RVS Update Committee

After establishing a scale (RBRVS) for different services, RVUs are assigned and updated by the RUC.

# What Physicians Are Paid for a Given Service

***Total RVU = (wRVU x wGPCI) + (peRVU x peGPCI) + (mRVU x mGPCI)***

***Payment = (Total RVU) x (CF for the year in question)***

***Work (wRVU)***

Reflects the relative time and intensity associated with providing a service—the "technical skill and effort, mental effort and judgment, and stress."

***Practice Expense (peRVU)***

***Malpractice (mRVU)***

***Geographic Practice Cost Index (GPCI)***

***Conversion Factor (CF) -- $36.09 in 2020***

https://economix.blogs.nytimes.com/2010/12/10/the-little-known-decision-makers-for-medicare-physicians-fees/

https://mdcodepro.com/physician-fee-schedule/

UMassMemorial Health Care | University of Massachusetts Medical School

umassmed.edu

# Smoke-Filled Rooms


- In 1992, the AMA offered to help CMS by updating the initial RVU assignments
- The AMA began from a procedural/surgical standpoint, using their proprietary Current Procedural Terminology (CPT®) code set
- The RUC now has 31 voting members, of whom 4 represent primary care and 1 by Geriatrics
- In shorthand, the members represent "procedural" and "cognitive" specialties
- Office visits, the core service of primary care, were discounted early on

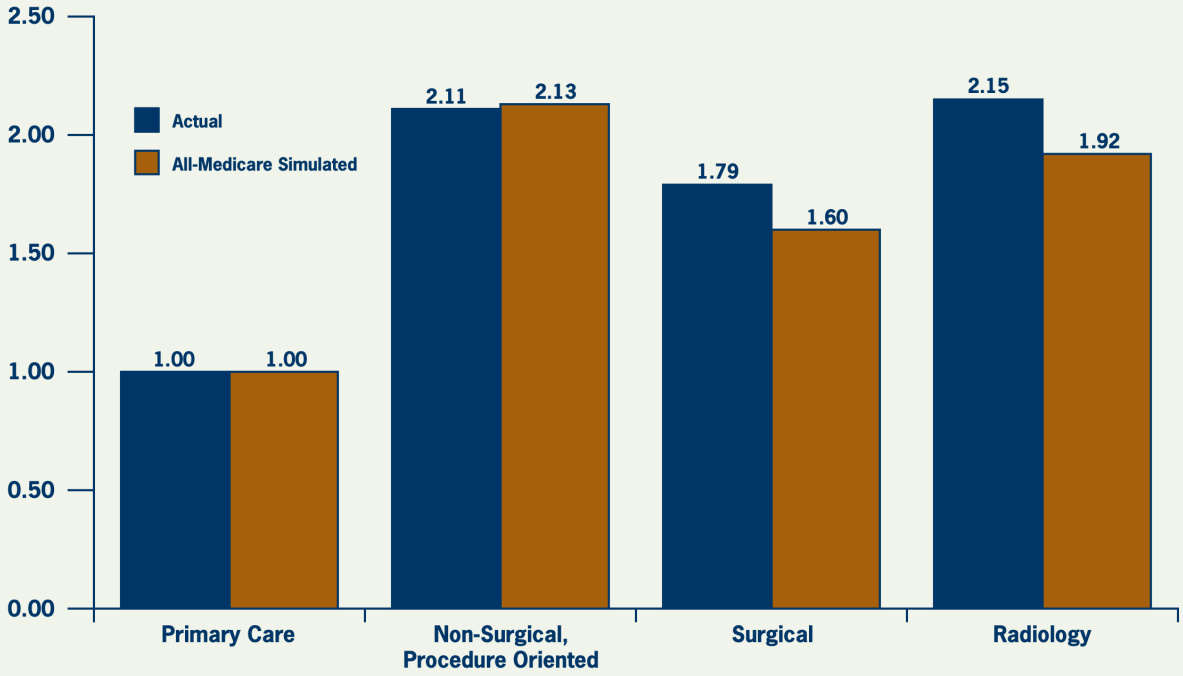
*Fixing Medical Prices*, pp. 93, 95
https://www.ama-assn.org/about/rvs-update-committee-ruc

# Smoke-Filled Rooms



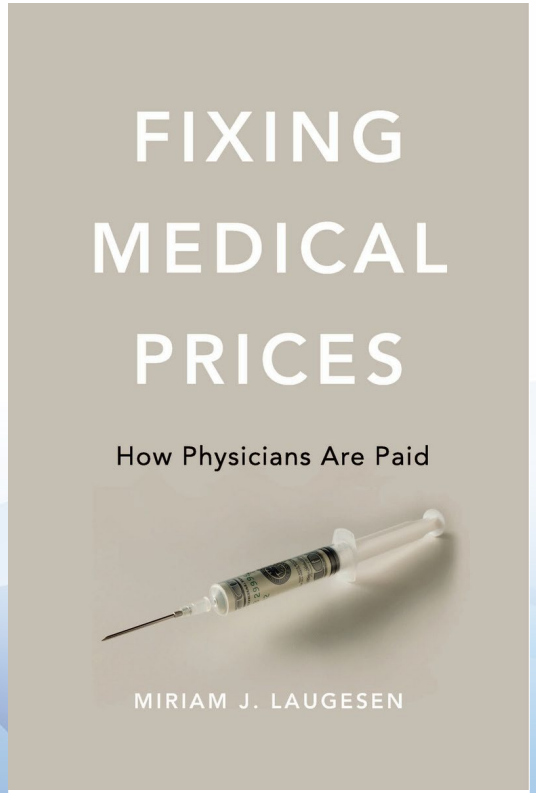
https://nihcm.org/pdf/NIHCM-EV-Berenson_FINAL.pdf
https://washingtonmonthly.com/magazine/julyaugust-2013/special-deal/

## Figure 1. Ratio of Average Hourly Earnings for Specialists Relative to Primary Care

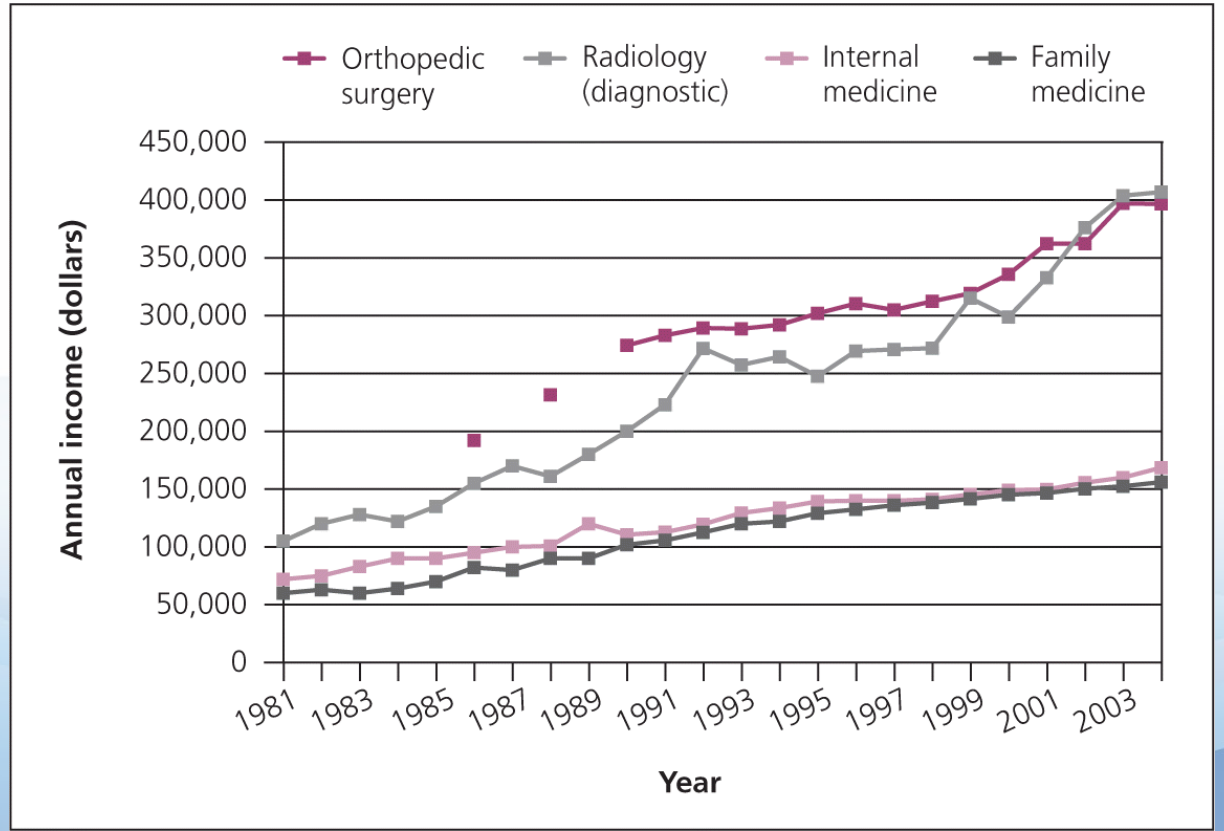



**Source**: Berenson et al. "What if All Physician Services Were Paid under the Medicare Fee Schedule? An Analysis Using Medical Group Management Association Data." Report No. 10-1 to MedPAC, March 2010.

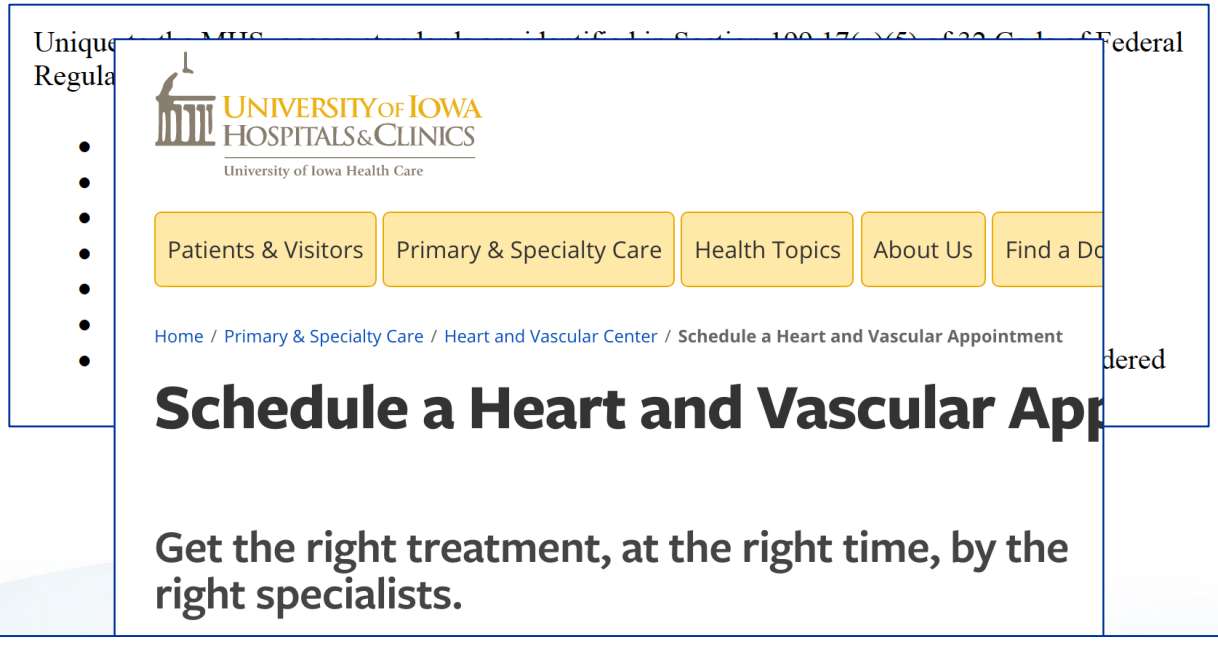
# Smoke-Filled Rooms




https://www.mailman.columbia.edu/public-health-now/news/little-known-physician-committee-helps-decide-how-much-physicians-are-paid




https://www.aafp.org/afp/2010/0915/p601.html




In response to long wait times for child psychiatrists at the hospital, the Community Health Centers of Burlington, a nonprofit health care provider in the city, began a pilot program last year to offer children psychiatric consultations.

At the time, the wait for children seeking psychiatric care at UVMMC was six to nine months, according to the community health provider.

"If my kid was having trouble, that is just not acceptable," said Dr. Peter Gunther, the chief medical officer at the community health centers.

https://health.mil/Reference-Center/Reports/2014/08/29/File-3-MHS-Review-Report-Section-3-Access-to-Care-in-the-MHS
https://uihc.org/schedule-heart-and-vascular-appointment
https://vtdigger.org/2019/06/19/patients-face-frustrating-long-waits-to-see-hospital-specialists/

# Budget Neutrality

- The RUC is mandated to achieve “budget neutrality”
- If a new service is approved – or an existing one is revised upwards – the funding must come from lowering the payment for all other services
- In the case of office visits, because they are by far the most common service, any revision upward in payment would lead to substantial reductions in payments for other services
- Oxen are gored

**“Make surgeries harder and office visits easier.”**

Surgical Department chair to surgeon who received a survey for RVU development
Fixing Medical Prices (p. 62)

**The current set of values “seems to be distorted,” said William Hsiao**, an economist at the Harvard School of Public Health who helped develop the point system. “The AMA fought very hard to take over this updating process. I said this had to be done by an impartial group of people. **This is highly political.**”

https://www.washingtonpost.com/business/economy/how-a-secretive-panel-uses-data-that-distorts-doctors-pay/2013/07/20/ee134e3a-eda8-11e2-9008-61e94a7ea20d_story.html

If I spent five minutes with you and **put in one of these stents, [I’d] probably get paid $1,500.** For me to spend 45 minutes on an established visit with a patient to make sure they are doing their exercise, make sure their diabetes is going okay, and **to try to figure out what their true problem is, probably get paid $15. It’s a completely irrational system.**

Leslie Cho, MD; Director, Cleveland Clinic Women’s Cardiovascular Center
http://transcripts.cnn.com/TRANSCRIPTS/1303/10/se.01.html

**Surely there is something absurd** when a nation pays a primary care physician poorly relative to other specialists and then wrings its hands over a shortage of primary care physicians.

Uwe Reinhardt
https://economix.blogs.nytimes.com/2010/12/10/the-little-known-decision-makers-for-medicare-physicans-fees/

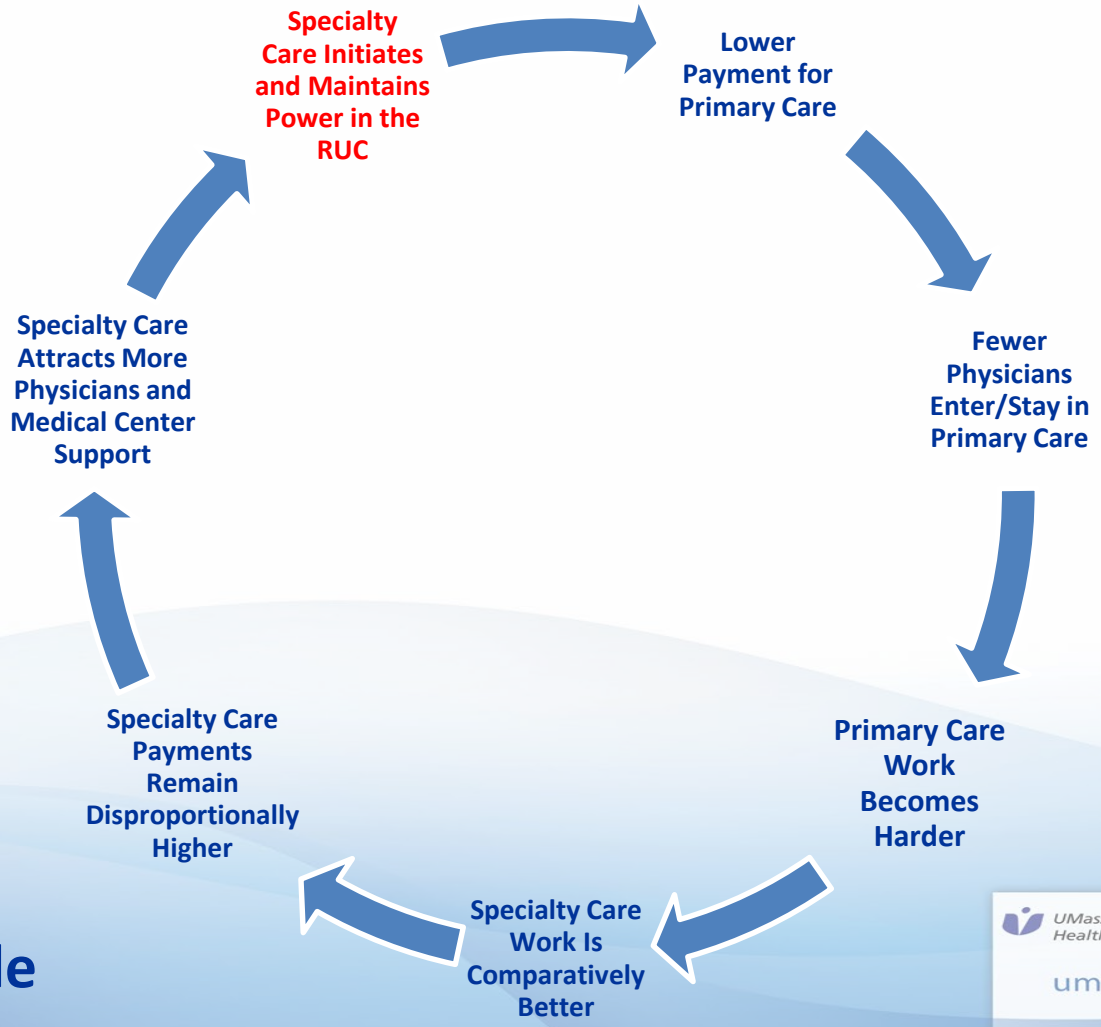
I'm hopeful that … the relatively near future will create the opportunity for people to say, "We made a mistake in 1997. We created a formula that produces irrational and counterintuitive results, and **we're just going to abolish it and start all over again in terms of some kind of cap on Part B payments. It's the only way we're going to get out of this morass.**

Bruce Vladeck, former Medicare Administrator
https://thehealthcareblog.com/blog/2013/02/06/the-untouchables/
https://www.finance.senate.gov/hearings/roundtable-discussion-on-medicare-physician-payments-understanding-the-past-so-we-can-envision-the-future

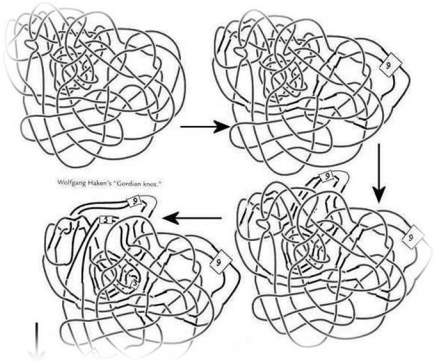
"Both for Medicare beneficiaries and others, the current imbalance between payment for specialty and primary care, driven in significant part by Medicare fee schedules, **greatly undermines consumers' access to essential primary care services."**

Families USA
https://ryortho.com/breaking/anonymous-triggers-new-battle-over-physician-pay/

# The RUC's Vicious Circle



# The Gordian Knot



- RVUs do not (readily) account for non-visit care (e.g., telephone, care coordination, administrative time)
- It is difficult to see how the RUC can be effectively reformed or diminish its inherent conflict of interest
- CMS does not currently have the capability to review and update service codes
- Other developed countries have had a stronger national mandate to place a ceiling on payment; physicians are also generally paid less
- All payment approaches lead to trade-offs
- **Which are we willing to make?**

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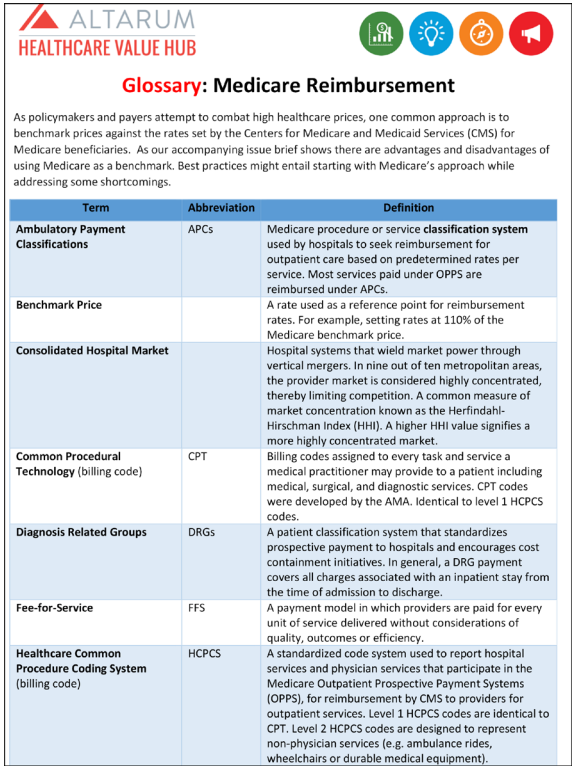
# Sabah Bhatnagar

Health Policy Analyst
**Healthcare Value Hub**

# Resources from the Hub

*Glossary:*



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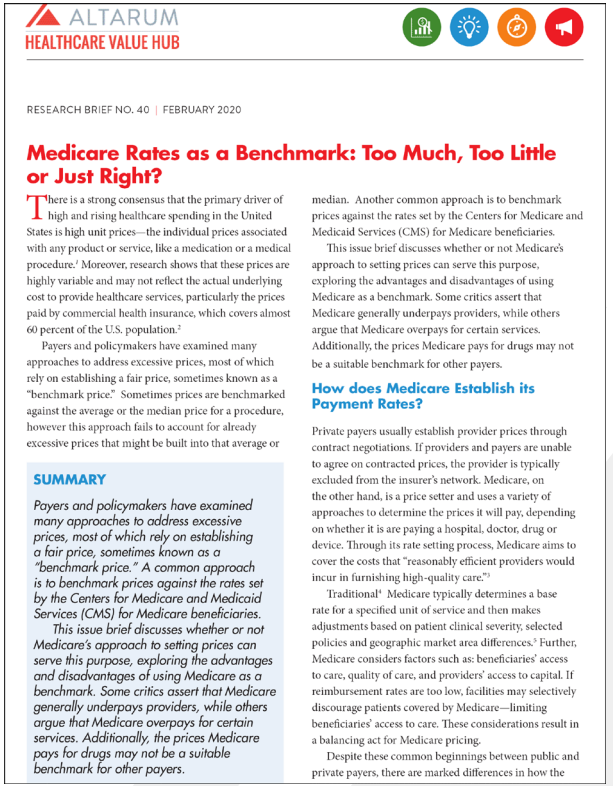
## Glossary: Medicare Reimbursement

As policymakers and payers attempt to combat high healthcare prices, one common approach is to benchmark prices against the rates set by the Centers for Medicare and Medicaid Services (CMS) for Medicare beneficiaries. As our accompanying issue brief shows there are advantages and disadvantages of using Medicare as a benchmark. Best practices might entail starting with Medicare's approach while addressing some shortcomings.

| Term | Abbreviation | Definition |
|---|---|---|
| **Ambulatory Payment Classifications** | APCs | Medicare procedure or service **classification system** used by hospitals to seek reimbursement for outpatient care based on predetermined rates per service. Most services paid under OPPS are reimbursed under APCs. |
| **Benchmark Price** | | A rate used as a reference point for reimbursement rates. For example, setting rates at 110% of the Medicare benchmark price. |
| **Consolidated Hospital Market** | | Hospital systems that wield market power through vertical mergers. In nine out of ten metropolitan areas, the provider market is considered highly concentrated, thereby limiting competition. A common measure of market concentration known as the Herfindahl-Hirschman Index (HHI). A higher HHI value signifies a more highly concentrated market. |
| **Common Procedural Technology** (billing code) | CPT | Billing codes assigned to every task and service a medical practitioner may provide to a patient including medical, surgical, and diagnostic services. CPT codes were developed by the AMA. Identical to level 1 HCPCS codes. |
| **Diagnosis Related Groups** | DRGs | A patient classification system that standardizes prospective payment to hospitals and encourages cost containment initiatives. In general, a DRG payment covers all charges associated with an inpatient stay from the time of admission to discharge. |
| **Fee-for-Service** | FFS | A payment model in which providers are paid for every unit of service delivered without considerations of quality, outcomes or efficiency. |
| **Healthcare Common Procedure Coding System** (billing code) | HCPCS | A standardized code system used to report hospital services and physician services that participate in the Medicare Outpatient Prospective Payment Systems (OPPS), for reimbursement by CMS to providers for outpatient services. Level 1 HCPCS codes are identical to CPT. Level 2 HCPCS codes are designed to represent non-physician services (e.g. ambulance rides, wheelchairs or durable medical equipment). |

*Brief:*



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RESEARCH BRIEF NO. 40 | FEBRUARY 2020

## Medicare Rates as a Benchmark: Too Much, Too Little or Just Right?

There is a strong consensus that the primary driver of high and rising healthcare spending in the United States is high unit prices—the individual prices associated with any product or service, like a medication or a medical procedure.[1] Moreover, research shows that these prices are highly variable and may not reflect the actual underlying cost to provide healthcare services, particularly the prices paid by commercial health insurance, which covers almost 60 percent of the U.S. population.[2]

Payers and policymakers have examined many approaches to address excessive prices, most of which rely on establishing a fair price, sometimes known as a "benchmark price." Sometimes prices are benchmarked against the average or the median price for a procedure, however this approach fails to account for already excessive prices that might be built into that average or median. Another common approach is to benchmark prices against the rates set by the Centers for Medicare and Medicaid Services (CMS) for Medicare beneficiaries.

This issue brief discusses whether or not Medicare's approach to setting prices can serve this purpose, exploring the advantages and disadvantages of using Medicare as a benchmark. Some critics assert that Medicare generally underpays providers, while others argue that Medicare overpays for certain services. Additionally, the prices Medicare pays for drugs may not be a suitable benchmark for other payers.


### SUMMARY

*Payers and policymakers have examined many approaches to address excessive prices, most of which rely on establishing a fair price, sometimes known as a "benchmark price." A common approach is to benchmark prices against the rates set by the Centers for Medicare and Medicaid Services (CMS) for Medicare beneficiaries.*

*This issue brief discusses whether or not Medicare's approach to setting prices can serve this purpose, exploring the advantages and disadvantages of using Medicare as a benchmark. Some critics assert that Medicare generally underpays providers, while others argue that Medicare overpays for certain services. Additionally, the prices Medicare pays for drugs may not be a suitable benchmark for other payers.*

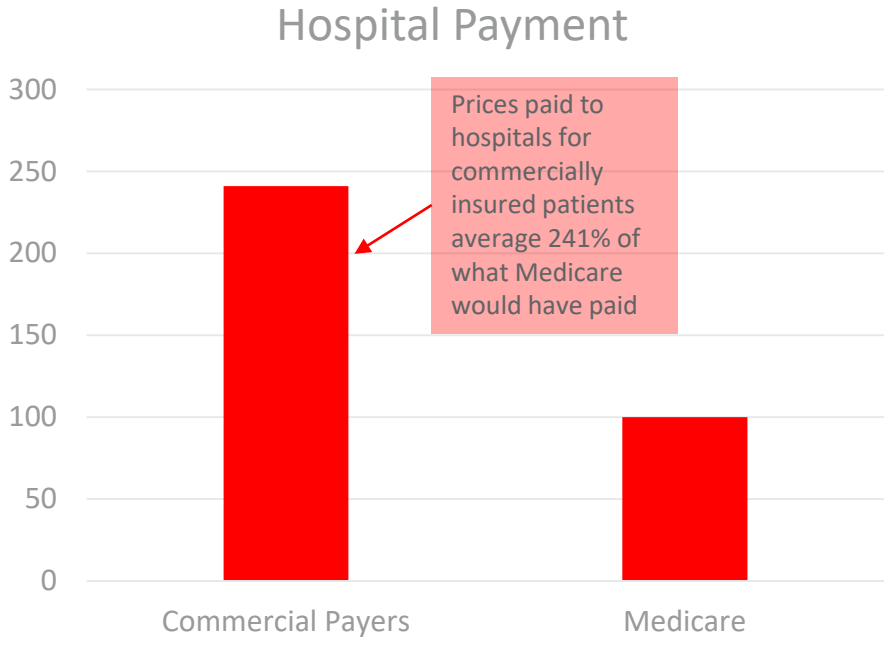

### How does Medicare Establish its Payment Rates?

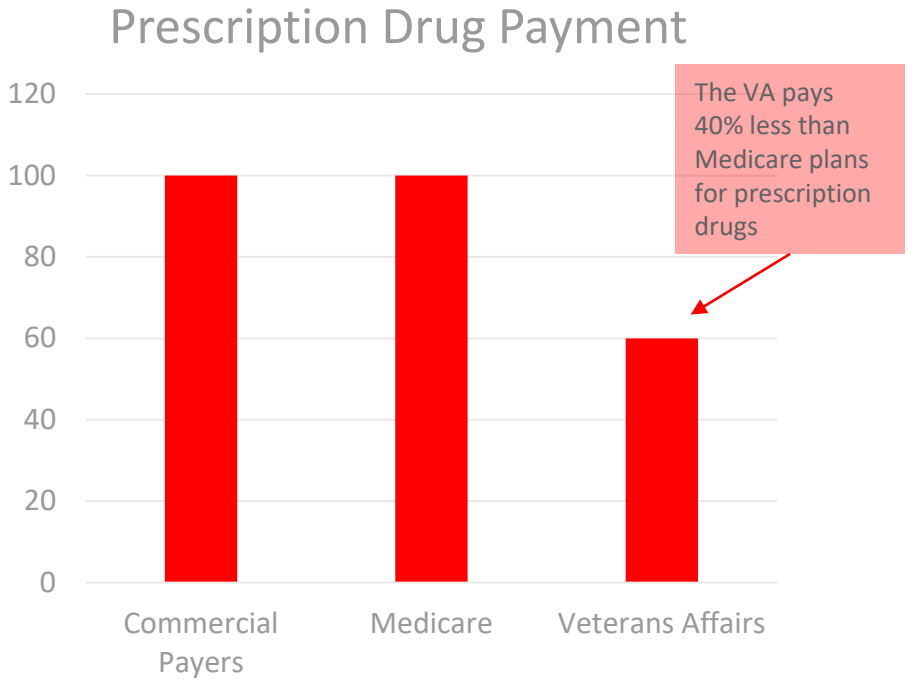
Private payers usually establish provider prices through contract negotiations. If providers and payers are unable to agree on contracted prices, the provider is typically excluded from the insurer's network. Medicare, on the other hand, is a price setter and uses a variety of approaches to determine the prices it will pay, depending on whether it is are paying a hospital, doctor, drug or device. Through its rate setting process, Medicare aims to cover the costs that "reasonably efficient providers would incur in furnishing high-quality care."[3]

Traditional[4] Medicare typically determines a base rate for a specified unit of service and then makes adjustments based on patient clinical severity, selected policies and geographic market area differences.[5] Further, Medicare considers factors such as: beneficiaries' access to care, quality of care, and providers' access to capital. If reimbursement rates are too low, facilities may selectively discourage patients covered by Medicare—limiting beneficiaries' access to care. These considerations result in a balancing act for Medicare pricing.

Despite these common beginnings between public and private payers, there are marked differences in how the

# Medicare Reimbursement for Prescription Drugs



# Questions for our Speakers?

- Use the chat box or to unmute, press *6
- Please do not put us on hold!

# Thank you!

- To Our Speakers, Aditi Sen, Steve Martin and Sabah Bhatnagar!
- The Robert Wood Johnson Foundation

# March webinar:

- **High Healthcare Costs and the Sale of Medical Debt – Is There a Connection?** March 20th, 2020, 2-3pm ET