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Fresh Thinking 2.0
Medicare Workshop: The Independent Payment Advisory Board

Discussion Summary

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The Patient Protection and Affordable Care Act (PPACA) establishes an Independent Payment Advisory Board (IPAB) with multiple objectives including reduced spending, maintained or improved access to care, better care coordination, and improved quality. IPAB is empowered under certain conditions to make recommendations to constrain Medicare spending that take effect unless overridden by Congressional action. It is also charged with providing advice regarding constraining private sector spending that will be considered by the Secretary and the Congress.

There are several constraints on the IPAB's latitude in making recommendations to constrain Medicare spending. There can be: no changes in eligibility; no restrictions on coverage or rationing; no increases in cost sharing or premiums; and until 2020, no payment rate reductions for hospitals and hospices. While it might be argued that the constraints unduly inhibit IPAB's ability to reduce or control spending, other arguments can be made in support of their appropriateness either as a matter of what types of policies should be delegated to such a non-elected body or as a part of the collective compromise that constituted health reform. The true extent of these constraints remains to be determined. How that will occur is somewhat indeterminate as PPACA places some limits on judicial review of IPAB recommendations.

Starting Point

A first consideration is what is being asked of IPAB relative to its resources. IPAB's proposals must be extremely defensible. IPAB recommendations must achieve reductions in Medicare spending growth beyond those already part of PPACA. The CMS Actuary has already expressed skepticism about the sustainability of the PPACA reductions.[1] Across the board changes are unlikely to be acceptable. It will be important to demonstrate that changes do not impair access and reflect differences in efficiency across providers and areas. Lack of a clear rationale and supporting evidence about impacts would make it more difficult for the Congress to accept proposed changes that may be characterized as threatening access or their constituencies' interests.

[1] CMS Office of the Actuary, "Estimated Financial Effects of the "Patient Protection and Affordable Care Act," as Passed by the Senate on December 24, 2009," Memorandum dated January 8, 2010,

IPAB's proposals also have to be very implementation ready, a challenging task. It appears that there is a 15 month period between the release of an IPAB proposal to MedPAC and MACPAC for comment and its effective date.

Given these requirements for extensive meticulous analysis, not just sound conceptual thinking, there is a concern about how IPAB's resources stack up. The IPAB budget is slightly larger than the current MedPAC budget. That budget level may support around 25 analysts, while the required analyses to develop and support the Board's recommendations likely demand many times that number. There is authority for other staff to be detailed to IPAB by the Secretary. How DHHS supports IPAB will then be a key to its ability to complete the essential tasks. One option is for coordination with the new Center for Medicare and Medicaid Innovation (CMMI). Analyses supporting the Center's efforts could contribute to the development of IPAB proposals as well as demonstrations and pilots the Center wants to test.

Sufficient analytic capacity is a must. In addition, both the IPAB and CMMI would benefit greatly from better and more plentiful data to establish more precisely calibrated payments and design innovations. Existing payment policies are largely based on limited data coming from claims or in certain instances patient assessments. These data are inadequate to explain much of the variation in the receipt of care, its costs, or impact. Fortunately, there is a major opportunity to improve the information base. The ARRA funding of health information technology for physician offices and hospitals provides a means of obtaining richer information about patient conditions and outcomes. Receipt of the ARRA funding by providers is contingent upon engaging in meaningful use of electronic health records. Defining part of meaningful use requirement to include transmission of more information about patient condition and outcomes to payers would increase the ability to design refined and innovative payment policies.

Constraints on IPAB Recommendations

At one level, IPAB is a rate setting commission with strong limitations on its authorities. Before 2020, it is precluded from recommendations reducing payment rates to hospitals and hospices. Depending on how Congress addresses the physician sustainable growth rate conundrum, changing physician payment rates could also be off the table. There is authority to change payments for Medicare Advantage (MA) plans and Part D drug plans. In fact, CBO has suggested reductions in Medicare payments for MA benefits beyond what the traditional program offers would be one important option.[2]

A question is whether IPAB can affect the bulk of traditional fee for service Medicare spending while operating within its constraints regarding hospitals and physicians. In essence, is there the latitude to encourage greater efficiency in service utilization including these providers? PPACA's constraints involve negative prohibitions (e.g.,

[2] CBO, "Patient Protection and Affordable Care Act Incorporating the Manager's Amendment", December 19, 2009.

reducing provider payments or increasing beneficiary cost-sharing). Positive incentives for either providers or beneficiaries that encourage efficiency may be allowed[3].

For example, can IPAB redefine units of services to bundle existing services to encourage more appropriate provision. While PPACA's provisions already include options to move away from traditional fee for service payment, there may be additional opportunities. Could these additional bundles include hospitals or physicians excluded from rate reductions before 2020? Given that these providers account directly or indirectly for such a large share of spending, not being able to do so would handicap this approach. In addition, if hospitals or physicians services are included, are there constraints on rates that might be paid for the bundle before 2020? Defining and implementing bundles is a challenging endeavor even when operating without constraints regarding different providers that may or may not be included. Again the issue of IPAB's capacity it raised. In addition, there is a requirement in PPACA that IPAB consider the administrative resources to implement its proposals. Bundled payments can incent stinting as well as efficiency. Adequate oversight is essential to avoid the former while the thinness of CMS resources for such a task is widely recognized.

On the beneficiary side, could IPAB create incentives for individuals to be more efficient users? Beneficiaries could be rewarded for selecting more efficient providers by having their cost sharing reduced. This would be a major departure for Medicare which has operated with essentially any willing provider rules. This approach would require Medicare to identify efficient or preferred providers, inform beneficiaries, and reward those who used the preferred providers. Preferred provider networks and differential cost sharing are common in the private insurance market. Medicare would face more scrutiny in trying to behave similarly. Given the program's size, inclusion or exclusion from the preferred list would have substantial consequences for providers. There would be very legitimate demands for considerable transparency regarding the criteria for inclusion. The actual task of determining which providers to include would require extensive data analysis raising again questions of IPAB and CMS resources and the robustness of the data available to the program.

Relating to the Private Sector

Medicare has generally been in the fortunate position of being able to ignore the private sector. It is a major purchaser, often the largest single purchaser for a provider. Its payments while less than private payers' have been adequate to assure provider participation and sufficient access. The question is whether Medicare, particularly as it exercises greater restraint, can remain somewhat oblivious to what is transpiring in the private market.

Since the heyday of managed care in the 90s, providers in many markets have taken steps to increase their economic leverage and secure higher prices from private insurers. By

[3] Note the statutory language regarding the excluded provider types states: "the proposal shall not include any recommendation that would reduce payment rates for items and services furnished,….by…". CBO has characterized this provision as prohibiting changes in payment rates and *methodologies* for these providers. (CBO, op.cit.)

2003, more than 90 percent of MSA hospital markets exceeded the DOJ/FTC criterion for high concentration.[4] Less easily documented, consolidation has also occurred among physicians. The formation of large single specialty groups in some market has created the power to demand high fees without fear of exclusion from plans' networks.

There are wide disparities between Medicare payments and private prices across markets. Medicare payments are likely close to private fees in some markets and less than half of private fees in others.[5].

How can/should Medicare respond if access to certain provider types because of the Medicare-private fee gap becomes an issue in selected markets? Raising fees to narrow the gap seems to be a surrender to the monopoly power in those markets. It is not clear Medicare or the IPAB has other tools to deal with this problem. Instead should this be a question of addressing the underlying cause, the excessive concentration among providers which impacts both Medicare and private purchasers. Is the problem more in the bailiwick of the DOJ/FTC? What these agencies can do is also uncertain, particularly with respect to provider consolidations that have been in place for some time. However unless the trends toward market consolidation that have been progressing are reversed and the negative impacts of past consolidation tamed, there may be a need for a new generation of Medicare payment policies that take a very different approach to local market differences. Such policies have received no discussion to date.

IPAB has also been charged with making recommendations to the Secretary and the Congress regarding control spending in the private market? Again it is difficult to identify options that may be effective and politically viable. What IPAB proposes for Medicare may not be an option for private payers. The market leverage of individual insurers may be considerably less than Medicare's and attempts to impose a Medicare inspired solution unsuccessful.

What public sector interventions into the private market might be proposed and accepted are also uncertain. There is experience with both bold policies (certificate of need or all payer rates) and milder ones (patient information). Success and/or acceptance have been elusive. There has been a longstanding premise that costs will reach an unacceptable point as a share of personal incomes and cost containment action will ensue. That the demand for and tolerance of more aggressive cost containing interventions will increase. Are we there? Health reform changes both the stakes and dynamics. There will be an increase in demand as more persons are insured. Insurers and public programs will represent a larger share of customers. Will this translate into greater effectiveness in determining prices for providers? More importantly what will enable better control over the volume of services? What would be the mechanism?

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[4] Vogt, W. and Town, R., "How has hospital consolidation affected the price and quality of hospital care." Robert Wood Johnson Foundation Synthesis Project, Issue 9, February 2006.

[5] Inferences based on US GAO, "Federal Employees Health Benefits Program: Competition and Other Factors Linked to Wide Variation in Health Care Prices," GAO-05-856, August 2005 and MedPAC reports of national Medicare to private fee averages.

Conclusion

IPAB faces multiple challenges in trying to constrain the growth of Medicare spending---ranging from limitations on its authorities and resources to a dearth of readily implementable and effective options that achieve the desired objectives and satisfy the multiple constraints that have been imposed. IPAB is charged with achieving reductions in spending growth in the short term. Whether it has the instruments to do so is a question. In addition, how pursuing a short term savings target affects achievement of larger and/or more sustained long-term savings is not clear. Given the constrained analytic resources, focusing on the short term could preclude investing in proposals requiring more time for development and implementation but that have greater long-term returns.