A Strategic Purchasing Model for Medicare

Robert Berenson, M.D.

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Data Acquisition, Analysis, and Problem Identification

- Routine analysis of administrative data, e.g., as done with Dartmouth Atlas
- Focused site visits to high cost geographic regions, using Center for Studying Health System Change model, supported by clinical/medical record review
- ? How much to use insights of contractor medical directors, QIOs

Categories of Potential Purchasing Interventions or Tools

- Provider Eligibility Requirements
  - Conditions of participation
- Benefit Design
  - Reduced cost-sharing for screening services
- Coverage Policy
  - Designated organ transplant centers
- Payment Policy
  - Resource-based relative value scale
- Technical Assistance to Providers
  - Quality Improvement Organizations

Categories of Potential Purchasing Interventions or Tools (cont.)

- Consumer Information and Education
  - National Beneficiary Education Program
- Paying for Performance
  - Risk adjustment-based bonuses for CHF performance
- Collaboration Among Purchasers
  - National Quality Forum
- Intervene in Delivery System
  - Disease management demonstrations

Provider Eligibility Requirements

- In general, can be used to “protect the floor,” not “raise the ceiling”
- Lots of good ideas re structural requirements desired of providers: shared EMR, shared decision-making, CPOE, CLAS, etc. but important barriers to selective contracting
- Opportunity to have “preferred providers,” e.g., in Centers of Excellence and competitive bidding demonstrations

Benefit Design

- Doubt that program could have different benefits based on place of residence (although certainly that is the effect of the M+C payment method)
- But could have national benefits that only some qualify for, essentially as is done in coverage policy, e.g., care management payments to providers for patients with multiple chronic conditions

Coverage Policy

- Hx. of failure to implement a rule that implements “reasonable and necessary” language in statute – see Foote, JHPPL
- Potential to limit use of approved technology through improved execution of managed care approaches of prior authorization, second opinions, etc.
- Example – implantable cardioverter defibrillator

Payment Policy

- Distortions of current payments partly drive cost-increasing behavior – surgical DRGs vs. medical DRGs
- Consider paying closer to marginal costs, at the margin, in high volume situations (don’t have to determine appropriateness)
- Regional expenditure targets – could set up a local dynamic not available nationally

Payment Policy (cont.)

- Competitive bidding for inanimate objects, e.g., DME, clinical lab
- Negotiation over payments would seem difficult, but might be allowed for dealing with providers in high cost areas
- Note that the DME competitive bidding model includes elements of selective contracting and negotiation

Technical Assistance to Providers

- The basic function of the evolving QIO program (which may limit its ability to serve oversight purposes)
- Mixed experience with results of informing and educating professionals – ESRD networks positive; SUPPORT not positive
- Surely, a necessary element in dealing with care in the last months of life, where regulatory approaches would be resisted

Consumer Information and Education

- Most activity, based in commercial plans, has been focused on clinical outcomes, patient satisfaction and basic information about plans and providers
- Opportunity to inform and educate about provider commitments to structural and process elements of care delivery based in Quality Chasm-type recommendations

Paying for Performance

- Private purchaser initiatives are plagued by lack of requisite market share
- Medicare is better positioned as dominant payer, but fair process and other concerns
- Concern about tiering among providers that could be further exacerbated
- Tricky design issues – pay based on national or regional benchmarks or provider-specific improvement?

Collaboration With Other Purchasers

- Medicare’s payment and related policies affect costs for private purchasers, and not just by threat of cost-shifting
- An important cause of development of specialty hospitals
- Missed opportunity for private purchasers to participate in Medicare rule-making
- Other potential synergies, e.g., P4P

Intervene in the Delivery System

- Should be both national and targeted to high cost based on results of site-specific findings
- Preserve choice and private sector providers but provide beneficiaries options that they might want to take advantage of
- Modeled after more recent managed care activities, e.g., hospitalists, “coaches”