



Integrating Provider-Specific Payment Policies within CMS

The legislative structure of the Medicare program is oriented around specific payment structures for specific sets of providers, and, not surprisingly, the Centers for Medicare and Medicaid Services (CMS) has tended to organize its staff and decision-making processes along similar lines. Hospital payments are governed by certain sections in Title 18 of the Social Security Act, with corresponding staff and rulemaking processes, while physician payments are governed by other parts of Title 18, with their own staff experts and rulemaking processes.

Consistent with its operational responsibilities, this alignment of staff and process with Title 18 is understandable, but stands in contrast to the future direction of payment models, which should favor an integrated approach to considering value, payment structures and levels. At present, the Medicare program faces statutory constraints on its ability to develop and implement new payment models on a widespread basis, a limitation addressed in part by several of the Committee's options, including the Chronic Care Management Innovation Center (CMIC). Expanding CMS' authority to foster such innovation is likely to increase the ability of Medicare to advance payment reform, understanding that with expanded authority would likely come additional oversight and reporting requirements. Such authority may ultimately reside within CMS as envisioned by the CMIC, or, potentially, be vested in another organizational model. Some have suggested that such authority may reside outside of CMS – for example, within a Health Board of some type, or under the auspices of an enhanced MedPAC.

Regardless of the model, flexibility, transparency, and meaningful stakeholder input is essential to assure that changes to payment policies are considered in the context of their impact on patients, providers, and health care purchasers.

The Committee's establishment of the CMIC is a strong first step in this regard. To complement the CMIC, and absent creation of a new or enhanced entity to define and implement broadly applicable payment reform, we suggest that the Committee consider the following:

- CMS should be directed to establish a mechanism to develop and implement a multi-year, multi-sectoral payment policy review and approval process. This mechanism would be charged with developing an integrated approach to updating existing and emerging payment models to assure aligned incentives across providers, and in the context of any state-driven and/or private sector-driven trends and initiatives.
- This new mechanism should solicit input from external stakeholders through both establishing formal multi-stakeholder advisory processes (see below) and using the rulemaking process, with annual opportunities for interested parties to comment on ways to improve the inter-provider consistency of provider-specific payment policies.
- The timing of this public input process should be structured to enable public input and agency decisions to inform the various provider-specific payment updates processes (e.g., the IPPS update, the physician payment rule, etc).
- All provider segments, including post-acute providers, should be encapsulated in this annual notice and comment process.

Incorporating Patient and Third-Party Payer Perspectives Into Medicare Policies

A cursory review of the roster of respondents to CMS's proposed rules governing payment to providers underscores the imbalanced nature of the perspectives received through the notice and comment process: the overwhelming majority of comments derive from affected providers. While patients and their advocates, and third-party payers can and do comment, the highly technical nature of the rules and policies, coupled with the rather limited impact on any single patient or payer has inadvertently resulted in an unlevel playing field. As a result, CMS staff, in reviewing comments, often lack meaningful input from stakeholders outside of the provider community.

While this phenomenon is present in all payment systems, it is most apparent in the area of CMS's annual efforts to update the Physician Fee Schedule, and resource-based relative value scale (RBRVS). The relative values of the services are determined by CMS using its rulemaking authority. In practice, CMS relies heavily on recommendations (provided through the notice and comment rulemaking process) by an outside committee housed by the American Medical Association (AMA): the Relative Value Scale Update Committee or the RUC. The RUC is made up of physicians that represent nearly every specialty. Many of the RUC's recommendations are based on expert panels and qualitative, subjective assessments of the physician work and practice expense components of the RVU value. In response to CMS' request for comments, the RUC offers its recommendations on values for new services, and recommends adjustments to values for existing services on a periodic basis.

Given the cost of analyzing and proposing new or revised RVU values, great weight is given to the RUC's recommendations. (In March 2006, the Medicare Payment Advisory Commission (MedPAC) noted that CMS's five-year review "does not do a good job of identifying services that may be overvalued." They further stated, "CMS has relied too heavily on physician specialty societies to identify services that are mis-valued." Five-year reviews have led to "substantially more increases in RVUs than decreases, even though many services are likely to become overvalued over time."¹) The perspectives of other healthcare stakeholders are notably absent and the broadly dispersed "public good" of assuring valuation for physician services that meets patient-centeredness and affordability goals are not goals that particular constituents will fund or engage in absent funding and facilitation.

The Center for Payment Reform applauds the AMA for committing substantial resources to better inform policy decisions, and respects the substance and process by which the AMA is able to present and reconcile the sometimes-varying views of its many members.

Nonetheless, a means to ensure meaningful input from other stakeholders is urgently needed. As a discrete complement to CMS' regulatory decision-making process, we recommend establishing a federally chartered body that includes patients, third-party payers and provider representatives to inform CMS' annual update processes. This standing, FACA-compliant independent Consumer and Health Care Purchaser and Provider Update Committee (CHUC) would be charged with providing independent input to CMS in its decision-making role with respect to Medicare payment levels, across all provider sectors. The new advisory group should include patients, purchasers, providers and payers – with majority representation by those who receive and pay for care -- and serve as a forum for broader multi-stakeholder input, as well as collection and analysis of relevant information. This new group would be advisory only.

¹ MedPAC, *Medicare Physician Payment*. March 2006.

The Consumer and Health Care Purchaser and Provider Update Committee should be funded with \$5 to \$10 million annually to cover operational costs, conduct independent quantitative studies/surveys on physician and hospital costs and expenses, and facilitate broad input into rate setting from the array of stakeholders.

The Center for Payment Reform (CPR) is a coalition of consumers, purchasers, labor, physicians and other health care providers, payers and policymakers who have come together based on their shared vision that improving quality and affordability in health care requires a transformation in our payment systems.

CPR is supported by foundations and by contributions of employer, consumer, health plan, physician and other provider organizations and is an initiative of the Consumer-Purchaser Disclosure Project. Learn more about the Center for Payment Reform and the Center's Payment Reform Principles at www.centerforpaymentreform.org.