

# **Report to the Congress: Medicare Payment Policy**

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Statement of

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Chairman Brady, Ranking Member McDermott, distinguished Committee members. I am Glenn Hackbarth, chairman of the Medicare Payment Advisory Commission (MedPAC). I appreciate the opportunity to be here with you this morning to discuss MedPAC's annual report on Medicare payment policy.

The Medicare Payment Advisory Commission is a congressional support agency that provides independent, nonpartisan policy and technical advice to the Congress on issues affecting the Medicare program. The Commission's goal is to achieve a Medicare program that ensures beneficiary access to high-quality care, pays health care providers and plans fairly by rewarding efficiency and quality, and spends tax dollars responsibly.

## **Introduction**

The Medicare Payment Advisory Commission reports to the Congress each March on the Medicare fee-for-service (FFS) payment systems, the Medicare Advantage (MA) program, and the Medicare prescription drug program (Part D). In this report we:

- consider the context of the Medicare program in terms of its spending and the federal budget and national gross domestic product (GDP).
- evaluate payment adequacy and in some sectors make recommendations concerning Medicare FFS payment policy in 2014 for: hospital inpatient and outpatient, physician and other health professional, ambulatory surgical center, outpatient dialysis facility, skilled nursing facility, home health care agency, inpatient rehabilitation facility, long-term care hospital, and hospice.
- review our position on repealing the sustainable growth rate (SGR) system.
- review the status of the MA plans beneficiaries can join in lieu of traditional FFS Medicare.
- make recommendations on the MA special needs plans.
- review the status of the plans that provide prescription drug coverage.

Health care accounts for a large and growing share of economic activity in the United States, nearly doubling as a share of GDP between 1980 and 2011, from 9.2 percent to 17.9 percent. Growth in spending slowed somewhat in 2010 and 2011, although the causes of this slowdown are debated and may not be long-lasting. Pressure on the federal budget will continue as Social Security, Medicare, Medicaid, other health insurance programs, and net interest are projected to account for more than 16 percent of GDP in 10 years, whereas total federal revenues have averaged 18.5 percent of GDP over the past 40 years.

The number of Medicare beneficiaries will grow notably faster in the next 10 years than in the past decade as the baby-boom generation ages into the program. In addition, the population aging into the Medicare program will present a new set of challenges since rising obesity levels put this population at a greater risk than previous generations for chronic disease. At the same time, growth in Medicare spending per beneficiary over the next decade is projected to be much smaller than in the past 10 years. Yet even under that assumption of slower growth, the Hospital Insurance trust fund is projected to be exhausted by 2024, and the program faces substantial deficits over the long term.

In this year's report, we continue to make recommendations to increase the efficiency of Medicare—that is, to find ways to provide high-quality care for Medicare beneficiaries at lower costs to the program. It is of note that, in light of our payment adequacy analyses, in this report we recommend no update for 2014 for five fee-for-service payment systems and a 1 percent update for the hospital inpatient and outpatient payment systems. For two sectors, skilled nursing facilities (SNFs) and home health agencies (HHAs), we have reiterated previous recommendations calling for an array of reforms including rebasing (lowering the base rate). For the physician and other health professional payment system we have called for repeal of the SGR, which governs physician fee schedule payments. We discuss each of these in more detail below.

## **The Commission's mandate**

The goal of Medicare payment policy is to get good value for the program's expenditures, which means maintaining beneficiaries' access to high-quality services while encouraging efficient use

of resources. Anything less does not serve the interests of the taxpayers and beneficiaries who finance Medicare through their taxes and premiums. Although this report addresses many topics to increase value, its principal focus—in accordance with our Congressional mandate—is the Commission’s recommendations for the annual rate updates under Medicare’s various FFS payment systems.

We recognize that managing updates and relative payment rates alone will not solve the fundamental problem with current Medicare FFS payment systems—that providers are paid more when they deliver more services without regard to the quality or value of those additional services. To address that problem directly, two approaches must be pursued. First, payment reforms that encourage quality and coordination in the traditional FFS system, such as penalties for excessive readmission rates and linking some percentage of payment to quality outcomes, need to be implemented more broadly. Second, delivery system reforms that move away from FFS and encourage high quality, better care transitions, and more efficient provision of care—such as medical homes, bundling, and accountable care organizations (ACOs)—need to be monitored and successful models adopted on a broad scale.

In the interim, it is imperative that the current FFS payment systems be managed carefully. Medicare is likely to continue using its current payment systems for some years into the future. This fact alone makes unit prices—their overall level, the relative prices of different services in a sector, and the relative prices of the same services across sectors—an important topic. In addition, constraining unit prices in FFS creates pressure on providers to control their own costs and to be more receptive to new payment methods and delivery system reforms.

In all of our work we look at five principles to achieve value in the Medicare program:

- increase fiscal pressure—restrain payment rates so that providers strive for efficiency,
- ensure equity—make sure the payment system does not systematically favor some providers or patients with certain conditions over others,
- ensure program integrity—monitor patterns of use and reduce opportunities for fraud and abuse,
- improve care coordination—encourage providers to coordinate care across sectors, and

- move payment and care delivery from FFS to coordinated care models with more global payments.

Several examples may elucidate these principles:

- We have recommended rebasing the home health prospective payment system (PPS) to increase fiscal pressure. This sector has been enjoying double-digit margins on Medicare business for over a decade. The payment system has to be rebased to recognize how home health agencies have changed the service since the original PPS was defined so that they will be under fiscal pressure to improve efficiency. Additionally, the Commission has recommended changes to the underlying payment system to increase equity and several program integrity actions to control abuse.
- The Commission has recommended improving equity between primary care and specialist services paid for under the physician fee schedule. The current bias of higher pay for procedural services could influence physicians to avoid primary care careers, the service for which beneficiary access is most threatened and which arguably has the greatest chance of leading to more efficient use of health care.
- Some recommendations, such as our recommendation for a hospital readmission penalty, would both encourage care coordination and increase fiscal pressure. Ideally, a hospital readmission penalty would encourage a hospital to work more closely with the post-acute and ambulatory care systems to minimize readmissions through improved care transitions and coordination. At the same time, it would create fiscal pressure on hospitals to improve efficiency and minimize readmissions. Coupled with our recommendations for readmission penalties on other responsible providers such as SNFs, this policy would create even broader pressure to coordinate care to avoid readmissions.
- As another example improving program integrity, we have recommended increased attention to the extremely long lengths of stay (LOS) in some hospices. While very short LOS followed by death may mean a beneficiary entered hospice too late in the course of a terminal illness, excessively long LOS followed by discharge from a hospice may indicate inappropriate use. Where there is a pattern of such stays, it raises questions about the integrity of the hospice benefit.

## **Update recommendations**

As required by law, the Commission makes payment update recommendations annually for providers paid under FFS Medicare. An update is the amount (usually expressed as a percentage change) by which the base payment for all providers in a PPS is changed relative to the prior year. To determine an update, we first assess the adequacy of Medicare payments for providers in the current year (2013) by considering beneficiaries' access to care, the quality of care, providers' access to capital, and Medicare payments and providers' costs. Next, we assess how those providers' costs are likely to change in the year the update will take effect (the policy year—2014). As required by statute, we examine payment adequacy for an “efficient” provider to the extent possible. Finally, we make a judgment on what, if any, update is needed.

In considering updates, the Commission makes its recommendation for 2014 payments relative to the 2013 base payment. The Commission's recommendations may call for an increase, a decrease, or no change from the 2013 base payment. For example, an update recommendation of 1 percent for a sector means that we are recommending that the base payment in 2014 for that sector should be 1 percent greater than it was in 2013—that is, when all policy changes related to the base payment are made (e.g. adjustments for coding changes, sequester), the net increase in base payment should be 1 percent.

This year, we make update recommendations in 10 FFS sectors: hospital inpatient and outpatient, physician and other health professional, ambulatory surgical center, outpatient dialysis facility, skilled nursing facility, home health care agency, inpatient rehabilitation facility, long-term care hospital, and hospice. Each year, the Commission looks at all available indicators of payment adequacy and reevaluates prior year assumptions using the most recent data available to make sure its recommendations accurately reflect current conditions. We also consider changes that redistribute payments within a payment system to correct any biases that may result in inequity among providers, make patients with certain conditions financially undesirable, or make particular procedures unusually profitable.

For each recommendation, we present its rationale, its implications for beneficiaries and providers, and how spending for each recommendation would compare with expected spending under current law. The spending implications are presented as ranges over one-year and five-year

periods; unlike official budget estimates, they do not take into account the complete package of policy recommendations or the interactions among them. Although we recognize budgetary consequences, our recommendations are not driven by a budget target but instead reflect our assessment of the level of payment needed to provide adequate access to appropriate care.

Given that our payment adequacy indicators are positive, the Commission recommends no update to payment rates in 2014 for five sectors (ambulatory surgical center (ASC), outpatient dialysis facility, inpatient rehabilitation facility, long-term care hospital, and hospice). We expect that providers in those sectors will be able to continue to provide beneficiaries with appropriate access to care under current payment rates. In the case of ASCs we also recommend that the Congress require ASCs to submit cost data to enable analysts to examine the growth of ASCs' costs over time and evaluate Medicare payments relative to the costs of an efficient provider. We also note that dialysis facilities appear to have become more efficient under the new payment method put in place in 2011; the Commission will return to examine rebasing that payment system as more complete information becomes available.

For two sectors, inpatient and outpatient hospital, we recommend a 1 percent update for 2014. The inpatient payment update recommendation is based on four factors. First, there is a need to restrain updates to maintain pressure to control costs. Second, most payment adequacy indicators are positive. Third, hospitals changed their documentation and coding in response to the introduction of Medicare severity–diagnosis related groups in 2008, and those documentation and coding changes need to be fully offset. (The American Taxpayer Relief Act of 2012 recovers past overpayments—at a more rapid pace than we recommended—but did not adjust for coding changes that started in 2010.) Fourth, while the average hospital's margin is projected to remain negative, the set of relatively efficient hospitals had a median overall Medicare margin that was positive. For inpatient services, we recommend that CMS should use the difference between the 2014 statutory update and the recommended 1 percent increase to offset the costs to the Medicare program of changes in hospitals' documentation and coding. In other words, the net increase in base payment rates from 2013 to 2014 should be 1 percent after all adjustments for documentation and coding are made.

We also recommend a 1 percent increase in outpatient rates in 2014. Despite negative overall Medicare margins, a 1 percent increase is appropriate for three reasons: First, there is a need to maintain pressure to constrain costs. Second, there is strong outpatient volume growth: 4.4 percent per Part B beneficiary in 2011, over 33 percent from 2004 to 2011. Third, hospital payment rates in outpatient departments (OPDs) are already substantially higher than payment rates for similar services in other sectors (e.g., rates for evaluation and management visits are 80 percent higher in OPDs than in physicians' offices) and increasing that difference would encourage further shifting of services from lower to higher cost settings. For example, from 2010 to 2011 the volume of echocardiograms in OPDs grew by 18 percent while it decreased by 7 percent in physicians' offices. Shifting to higher cost sectors results in higher costs for both the Medicare program and beneficiaries.

In the skilled nursing and home health sectors, we reiterated our recent multiyear recommendations that address not only the updates for those two sectors but also broader problems with the structure of the payment systems; our assessment of the payment adequacy indicators this year suggests that the trends that led us to make those recommendations continue.

For the skilled nursing sector we reiterate our recommendation from last year to first restructure the SNF payment system and then to rebase payments in the following year. Specifically, the Commission recommended revising the SNF PPS and, during the year of revision, holding payment rates constant (no update). The Commission discussed three revisions to improve the accuracy of payments. First, payments for therapy services should be based on patient characteristics (not services provided). Second, payments for nontherapy ancillary services (such as drugs) need to be removed from the nursing component and made through a separate component established specifically to adjust for differences in patients' needs for these services. Third, an outlier policy would be added to the PPS. After the PPS is revised, in the following year CMS would begin a process of rebasing payments, starting with a 4 percent reduction in payments.

For the home health sector, we reiterate our recommendations from 2011. That multipart recommendation included: rebasing the home health PPS, changing the case-mix system, implementing a copay for certain home health episodes, and investigating and stopping fraud and



abuse in areas with aberrant patterns of use of home health services. Overpaying for home health services has negative financial consequences for the federal government and raises Medicare premiums paid by the beneficiary. Implementing the Commission’s prior recommendation for rebasing would reduce payments and better align Medicare’s payments with the actual costs of home health agencies.

For the physician and other health professional fee schedule we have restated our previous recommendations because the dominant concern is the SGR system and its issues, which are described in the next section.

Table 1 summarizes the recommendations in this report.

**Table 1. March 2013 report recommendations**

<b>Sector</b>	<b>Recommendation</b>
Hospital inpatient and outpatient	1 percent update
Physician and other health professional	Multipart SGR repeal from 2011
Ambulatory surgical center	Zero update, require cost data
Outpatient dialysis facility	Zero update, evaluate rebasing as data become available
Skilled nursing facility	Multipart recommendation from 2012
Home health agency	Multipart recommendation from 2011
Inpatient rehabilitation facility	Zero update
Long-term care hospital	Zero update
Hospice	Zero update
Special needs plans	Reauthorize some, not others

### **Sustainable growth rate (SGR) system**

The Commission's deliberations regarding payment updates for physicians and other health professionals are driven by concerns with the SGR, which links annual physician fee updates to several factors including volume growth. The SGR has called for negative updates every year since 2002, and every year since 2003 the Congress has provided a short-term override of the negative updates. Because of years of volume growth exceeding the SGR limits and legislative and regulatory overrides of negative updates, fees for physicians and other health professionals

would decline by about 25 percent in 2014 if the SGR went into full effect, according to the Congressional Budget Office (CBO).

The Commission laid out its findings and recommendations for moving forward from the SGR system in its October 2011 letter to the Congress

[http://medpac.gov/documents/10142011\\_MedPAC\\_SGR\\_letter.pdf](http://medpac.gov/documents/10142011_MedPAC_SGR_letter.pdf). We found:

- The SGR system, which ties annual updates to cumulative expenditures, has failed to restrain volume growth and may have exacerbated it.
- Temporary, stop-gap fixes to override the SGR undermine the credibility of Medicare because they engender uncertainty and anger among physicians and other health professionals, which may cause anxiety among beneficiaries.
- While our latest access survey does not show significant deterioration at the national level, the Commission is concerned about access—particularly for primary care. The Medicare population is increasing as members of the baby-boom generation become eligible for Medicare; at the same time, physicians in that generation are reaching retirement age.

The need to repeal the SGR is urgent. Deferring repeal of the SGR will not leave the Congress with a better set of choices as the array of new payment models is unlikely to change and SGR fatigue is increasing. We also note that the budget score for repealing the SGR is volatile. It depends on the relationship between growth in the volume of services and growth in the GDP. In each of the last three decades we have seen periods of rapid volume growth and periods of slower growth. CBO's most recent budget projections have substantially lowered the budget score for SGR repeal, and may present an opportunity for the Congress to act before the score changes again.

In Appendix B of the March report, we reproduced the Commission's October 2011 letter to the Congress. In that letter, the Commission presented a set of recommendations to eliminate the SGR and replace it with a set of fee-schedule updates, improve the accuracy of physician payments, and encourage movement into ACOs. The Commission recommended:

- the SGR should be repealed, severing the link between future payment updates and cumulative expenditures for services provided by physicians and other health professionals. In place of the SGR, the Commission outlined a 10-year path of legislated updates, including updates for primary care services that are different from those for other services.
- CMS should collect data to improve payment accuracy, identify overpriced services within the fee schedule, and be required by the Congress to achieve an annual numeric goal for their reduction.
- the Medicare program should encourage movement from FFS into risk-bearing ACOs by creating greater opportunities for shared savings.

Our recommendations follow these principles: The link between fee-schedule expenditures and annual updates is unworkable, beneficiary access to care must be protected, and the SGR should be repealed in a fiscally responsible way. We have offered the Congress a set of ideas for offsetting the cost of an SGR repeal within the Medicare program, but it is the prerogative of the Congress to choose among those and other options as it determines how best to finance SGR repeal.

## **Medicare Advantage, SNPs, and Part D**

Thus far we have considered updates in Medicare’s traditional FFS program, also known as Medicare Part A and Part B. In addition, we review the status of Medicare Part C (the Medicare Advantage program) and Medicare Part D (the Medicare prescription drug program).

### **Medicare Advantage (MA)**

Each year the Commission provides a status report on the MA program, which is becoming an increasingly important part of Medicare. In 2012, MA enrollment increased by 10 percent to 13.3 million beneficiaries (27 percent of all Medicare beneficiaries). Virtually all Medicare beneficiaries now have access to an MA plan, and 99 percent have access to a network-based coordinated care plan, which includes HMOs and preferred provider organizations. We estimate that 2013 MA benchmarks (including the quality bonuses), bids, and payments will average 110 percent, 96 percent, and 104 percent of FFS spending, respectively—all of which are closer to FFS spending this year than last year. This is important because the Commission has stressed

the concept of imposing fiscal pressure on providers to improve efficiency and reduce Medicare program costs. For MA, the Commission has recommended that payments for MA plans relative to FFS be brought down from previous high levels and set so that the payment system is neutral and does not favor either MA or the traditional FFS program. We are seeing evidence of improved efficiency in MA as plan bids have come down in relation to FFS while enrollment in MA continues to grow. The improved efficiency of MA plans enables them to continue to increase MA enrollment by offering benefit packages that beneficiaries find attractive.

The Commission has also recommended that pay-for-performance programs be instituted in Medicare to promote quality. The Congress instituted a quality bonus program for MA with bonuses available beginning in 2012. The Commission supports the concept of the quality bonus program as called for in the statute. Such a pay-for-performance system, combined with continuing fiscal pressure, will help ensure that a strong MA program will do its part in the urgent need to ensure the continued financial viability of the Medicare program. However, CMS has implemented the quality bonus program in a flawed manner at very high program costs not contemplated in the statute, using demonstration authority to pay bonuses to plans with low ratings and increasing bonus amounts for other plans above the level authorized in the statute.

### **MA special needs plans (SNPs)**

Special needs plans (SNPs) are MA plans that can limit their enrollment to one of three categories of special needs individuals. SNP authority expires at the end of 2014. Reauthorizing all SNPs would result in increased program spending because spending on beneficiaries enrolled in MA is generally higher than Medicare FFS spending for similar beneficiaries, and some beneficiaries would likely return to FFS. In response to several inquiries from the Congress, we evaluated each type of SNP on how well they perform on quality-of-care measures and whether they encourage a more integrated delivery system than is currently available in traditional FFS Medicare.

- The Commission recommends that the Congress should permanently reauthorize institutional SNPs (I-SNPs), which are plans for beneficiaries residing in nursing homes or beneficiaries living in the community that require a nursing home level of care. They perform well on a number of quality measures. In particular, hospital readmission rates for I-SNPs are much lower than expected. Reducing hospital readmissions for

beneficiaries in nursing homes suggests that I-SNPs provide a more integrated and coordinated delivery system than beneficiaries could receive in traditional FFS.

- Chronic condition SNPs (C-SNPs) are plans for beneficiaries with certain chronic conditions. In general, C-SNPs tend to perform no better, and often worse, than other SNPs and MA plans on most quality measures (but there are exceptions). The Commission recommends that the Congress should:
  - allow the authority for C-SNPs to expire, with the exception of C-SNPs for a small number of conditions, including ESRD, HIV/AIDS, and chronic and disabling mental health conditions.
  - direct the Secretary, within three years, to permit MA plans to enhance benefit designs so that benefits can vary based on the medical needs of individuals with specific chronic or disabling conditions. (In other words, incorporate the C-SNP model into standard MA plans.)
  - permit current C-SNPs to continue operating during the transition period as the Secretary develops standards.
  - except for the conditions noted above, impose a moratorium for all other C-SNPs as of January 1, 2014.
  
- The Commission recommends that the Congress should permanently reauthorize SNPs for beneficiaries dually eligible for Medicare and Medicaid (D-SNPs) that assume clinical and financial responsibility for Medicare and Medicaid benefits and allow the authority for all other D-SNPs to expire. For D-SNPs that assume clinical and financial responsibility for Medicare and Medicaid benefits, the Congress should grant the Secretary authority to align the Medicare and Medicaid appeals and grievances processes and direct the Secretary to remove other barriers to integration of Medicare and Medicaid benefits. For example, these D-SNPs would be able to market all the benefits they cover as a combined benefit package and it would be easier for them to give enrollees a single enrollment card to access their Medicare and Medicaid benefits. Under this recommendation, the Secretary would develop an example of a model Medicaid contract with a D-SNP for states to use as a resource.

## **Part D, the Medicare prescription drug program**

Each year the Commission provides a status report on Part D, the Medicare prescription drug program. In 2012, nearly 65 percent of Medicare beneficiaries, over 30 million people, were enrolled in Part D. Most enrollees report high satisfaction with the Part D program. In 2013, the number of plans offered is about the same as in 2012. Beneficiaries will continue to have between 23 and 38 stand-alone prescription drug plans (PDPs) to choose from depending on the region, along with many Medicare Advantage–Prescription Drug plans. For 2013, slightly more premium-free PDPs will be available to enrollees who receive the low-income subsidy (LIS).

Between 2007 and 2011, Part D spending increased from about \$47 billion to \$60 billion (an average annual growth of about 7 percent), and CMS expects it will have reached \$62 billion in 2012. These expenditures include the direct monthly subsidy plans receive for their Part D enrollees, reinsurance paid for very-high-cost enrollees, premiums and cost sharing for LIS enrollees, and payments to employers that continue to provide drug coverage to their Medicare beneficiary retirees. In 2011, LIS payments continued to be the largest single component of Part D spending, while Medicare’s reinsurance payments were the fastest growing component. While average costs for basic Part D benefits are expected to remain stable (growth of less than 1 percent) between 2012 and 2013, plan sponsors are expecting significant changes in costs for individual components: a decrease of over 9 percent for the direct subsidy and an increase of about 14 percent for the reinsurance component. In 2013, the base beneficiary premium is about the same as in 2012 (\$31).