MEDPAC Medicare Payment Advisory Commission

FACT SHEET

Report to the Congress • March 2013

The Medicare Payment Advisory Commission is required to annually review Medicare payment policies and make recommendations to the Congress. The 2013 report includes payment policy recommendations for 10 of the health care provider sectors in fee-for-service (FFS) Medicare. MedPAC also reviews the status of Medicare Advantage (MA) plans and prescription drug plans (Part D) and makes recommendations for MA special needs plans.

FEE-FOR-SERVICE PAYMENT UPDATE RECOMMENDATIONS

The principal focus of the report is the Commission's recommendations for annual rate adjustments under Medicare's various FFS payment systems, or sector "updates." The Commission bases its update recommendation for each sector on an assessment of payment adequacy, including beneficiary access to care (supply of providers, service use, access surveys); quality of care; providers' access to capital; and provider costs and Medicare payments (where available). The Commission's recommendations for 2014 are listed below.

Inpatient and outpatient hospitals

- The Congress should increase payment rates for the inpatient and outpatient prospective payment systems in 2014 by 1 percent. For inpatient services, the Congress should also require the Secretary of Health and Human Services to use the difference between the statutory update and the recommended 1 percent update to offset increases in payment rates due to documentation and coding changes and to recover past overpayments.

Physicians and other health professionals

- The Congress should repeal the sustainable growth rate (SGR) system and replace it with a 10-year path of statutory fee-schedule updates. This path is comprised of a freeze in current payment levels for primary care and, for all other services, annual payment reductions followed by a freeze. The Commission is offering a list of options for the Congress to consider if it decides to offset the cost of repealing the SGR system within the Medicare program. *(First recommended in October 2011).*
- The Congress should direct the Secretary to regularly collect data—including service volume and work time—to establish more accurate work and practice expense values. To help assess whether Medicare's fees are adequate for efficient care delivery, the data should be collected from a cohort of efficient practices rather than a sample of all practices. The initial round of data collection should be completed within three years. *(First recommended in October 2011).*
- The Congress should direct the Secretary to identify overpriced fee-schedule services and reduce their relative value units (RVUs) accordingly. To fulfill this requirement, the Secretary could use the data collected under the process in recommendation 2 (above). These reductions should be budget neutral within the fee schedule. Starting in 2015, the Congress should specify that the RVU reductions achieve an annual numeric goal—for each of five consecutive years—of at least 1.0 percent of fee-schedule spending. *(First recommended in October 2011).*
- Under the 10-year update path specified in recommendation 1 (above), the Congress should direct the Secretary to increase the shared savings opportunity for physicians and health professionals who join or lead two-sided risk accountable care organizations (ACOs). The Secretary should compute spending benchmarks for these ACOs using 2011 fee-schedule rates. *(First recommended in October 2011).*

Ambulatory surgical centers

- The Congress should eliminate the update to the payment rates for ambulatory surgical centers for calendar year 2014. The Congress should also require ambulatory surgical centers to submit cost data.

425 Eye St, NW • Suite 701 • Washington, DC 20001 • 202-220-3700 • Fax: 202-220-3759 • www.medpac.gov

- The Congress should direct the Secretary to implement a value-based purchasing program for ambulatory surgical center services no later than 2016. *(First recommended in March 2012).*

Outpatient dialysis

- The Congress should not increase the outpatient dialysis bundled payment rate for calendar year 2014.

Skilled nursing facilities

- The Congress should eliminate the market basket update and direct the Secretary to revise the prospective payment system for skilled nursing facilities for 2013. Rebasing payments should begin in 2014, with an initial reduction of 4 percent and subsequent reductions over an appropriate transition until Medicare's payments are better aligned with providers' costs. *(First recommended in March 2012).*

Home health agencies

- The Secretary, with the Office of the Inspector General, should conduct medical review activities in counties that have aberrant home health utilization. The Secretary should implement the new authorities to suspend payment and the enrollment of new providers if they indicate significant fraud. *(First recommended in March 2011).*
- The Congress should direct the Secretary to begin a two-year rebasing of home health rates in 2013 and eliminate the market basket update for 2012. *(First recommended in March 2011).*
- The Secretary should revise the home health case-mix system to rely on patient characteristics to set payment for therapy and nontherapy services and should no longer use the number of therapy visits as a payment factor. *(First recommended in March 2011).*
- The Congress should direct the Secretary to establish a per episode copay for home health episodes that are not preceded by hospitalization or post-acute care use. *(First recommended in March 2011).*

Inpatient rehabilitation facilities

- The Congress should eliminate the update to the Medicare payment rates for inpatient rehabilitation facilities in fiscal year 2014.

Long-term care hospitals

- The Secretary should eliminate the update to the payment rates for long-term care hospitals for fiscal year 2014.

Hospice

- The Congress should eliminate the update to the hospice payment rates for fiscal year 2014.
- The Congress should direct the Secretary to change the Medicare payment system for hospice to:
  - have relatively higher payments per day at the beginning of the episode and relatively lower payments per day as the length of the episode increases,
  - include a relatively higher payment for the costs associated with patient death at the end of the episode, and
  - implement the payment system changes in 2013, with a brief transitional period.

  These payment system changes should be implemented in a budget neutral manner in the first year. *(First recommended in March 2009).*
- The Congress should direct the Secretary to:
  - require that a hospice physician or advanced practice nurse visit the patient to determine continued eligibility prior to the 180th-day recertification and each subsequent recertification and attest that such visits took place,
  - require that certifications and recertifications include a brief narrative describing the clinical basis for the patient's prognosis, and
  - require that all stays in excess of 180 days be medically reviewed for hospices for which stays exceeding 180 days make up 40 percent or more of their total cases. *(First recommended in March 2009).*

STATUS OF THE MEDICARE ADVANTAGE PROGRAM

- In 2012, MA enrollment increased to 13.3 million beneficiaries (27 percent of all Medicare beneficiaries). Enrollment in HMOs, the dominant form of MA plan, grew by 10 percent to nearly 9 million enrollees. Local PPO enrollment increased by about 30 percent, to 3 million enrollees. However, regional PPO enrollment decreased about 16 percent between 2011 and 2012, to 1 million enrollees.
- In 2012, there were more than 3,600 MA plan options. Virtually all Medicare beneficiaries have access to a plan in 2013 (0.4 percent do not), and 99 percent have access to a network-based HMO or PPO. Eighty-six percent of beneficiaries have access to an MA plan that includes Part D drug coverage and has no premium (beyond the Medicare Part B premium). Beneficiaries can choose from an average of 12 MA plan options in 2013.
- In 2013, MA plan bids average 96 percent of FFS spending, and the average HMO plan bid 92 percent of FFS. MA plan bids showed that some managed care plans can offer the standard Medicare benefit for less than FFS costs. However, plans bidding below FFS are not available in some parts of the country.
- Despite lower plan bids and lower county-level benchmarks in 2013, Medicare will still spend 4 percent more for beneficiaries enrolled in MA plans than if those beneficiaries were in traditional Medicare. This is due in part to additional payments to plans under CMS's quality-bonus demonstration.
- In 2012, MA plans showed improvements on some measures of quality, but performance on other measures remained stable. Plans improved on more process and outcomes measures compared to previous years, including colorectal cancer screening rates, assessment of body mass index, and control of blood pressure. Plan performance did not appear to improve or decline for survey-based measures including patient experience measures and two-year outcome results for improved physical or mental health of enrollees.

Medicare Advantage special needs plans

- Special needs plans (SNPs) are a subcategory of MA coordinated care plans. SNPs limit their enrollment to one of the three categories of Medicare beneficiaries with special needs: residents of a nursing home or community residents who are nursing-home certifiable (I–SNPs), beneficiaries with certain chronic or disabling conditions (C–SNPs), and dual-eligible beneficiaries (D–SNPs). Statutory authority for SNPs expires at the end of 2014.

Institutional SNPs

- I–SNPs have lower than expected hospital readmission rates, suggesting that I–SNPs are able to provide an integrated and coordinated delivery system.
- **I-SNP Recommendation:** The Congress should permanently reauthorize institutional special needs plans.

Chronic condition SNPs

- In general, C–SNPs tend to perform no better, and often worse, than other SNPs and MA plans on most quality measures.
- **C-SNP Recommendation:** The Congress should:
    - allow the authority for chronic care special needs plans (C–SNPs) to expire, with the exception of C–SNPs for a small number of conditions, including end-stage renal disease, HIV/AIDS, and chronic and disabling mental health conditions;
    - direct the Secretary, within three years, to permit Medicare Advantage plans to enhance benefit designs so that benefits can vary based on the medical needs of individuals with specific chronic or disabling conditions; and
    - 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.

Dual-eligible SNPs

- The majority of D–SNPs are nonintegrated plans that generally have average to below average performance on quality measures compared with other SNPs and regular MA plans.

- Two D–SNP models incentivize clinical and financial integration of Medicare and Medicaid benefits. First, a single plan—the D–SNP—covers some or all Medicaid long-term care services and supports (LTSS), behavioral health services, or both, through its contract with the state. Under another model, a managed care organization administers the D–SNP and the Medicaid plan that furnishes some or all of the LTSS or behavioral health services. Under this model, integration occurs at the level of the managed care organization across the two plans.
- A number of administrative misalignments act as barriers to integrating Medicare and Medicaid benefits including: misalignment between the Medicare and Medicaid appeals and grievances processes, the inability to jointly market the Medicare and Medicaid benefits that D–SNPs furnish, multiple enrollment cards, and lack of a model contract for states to use as a reference.
- **D-SNP Recommendation 1:** The Congress should permanently reauthorize dual-eligible special needs plans (D–SNPs) that assume clinical and financial responsibility for Medicare and Medicaid benefits and allow the authority for all other D–SNPs to expire.
- **D-SNP Recommendation 2:** For dual-eligible special needs plans (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;
    - direct the Secretary to allow these D–SNPs to market the Medicare and Medicaid benefits they cover as a combined benefit package;
    - direct the Secretary to allow these D–SNPs to use a single enrollment card that covers beneficiaries' Medicare and Medicaid benefits; and
    - direct the Secretary to develop a model D–SNP contract.

STATUS OF THE PART D PROGRAM

- In 2012, over 30 million Medicare beneficiaries (65 percent) were enrolled in Part D plans. An additional 9 percent of beneficiaries received their drug coverage through employer-sponsored plans that receive Medicare's retiree drug subsidy. In 2010, about 17 percent of beneficiaries had other sources of drug coverage, and 10 percent had no drug coverage or coverage less generous than Part D. Beneficiaries without creditable drug coverage tend to be healthier on average.
- Among those in Part D plans, about 11 million (about 34 percent of Part D enrollees) received the low-income subsidy (LIS). About 63 percent of Part D enrollees are in stand-alone prescription drug plans (PDPs); the rest (37 percent) are in Medicare Advantage–Prescription Drug plans (MA–PDs). Most enrollees report high satisfaction with the Part D program and with their plans.
- In 2013, beneficiaries have from 23 to 38 PDP options to choose from, along with many MA plans that also offer prescription drug coverage (MA–PDs).
- Slightly more than half of PDP enrollees have no deductible, while 98 percent of MA–PDs had a reduced deductible or no deductible. In 2012, 6 percent of PDP enrollees were in plans that offered benefits in the coverage gap; however, over 40 percent of PDP enrollees received Part D's LIS (effectively eliminating their coverage gap). By comparison, 52 percent of MA–PD enrollees were in plans offering gap coverage. About half of those enrollees were in plans that covered some generics but not brand-name drugs in the gap.
- For the basic portion of the benefit, CMS estimates an actual average monthly premium of $31.17, about the same as in 2012 ($31.08).