

Report to the Congress • March 2010

As required by the Congress, the Medicare Payment Advisory Commission reviews Medicare payment policies and makes recommendations each March. The 2010 report includes payment policy recommendations for ten payment systems: hospital inpatient, hospital outpatient, physician, ambulatory surgical center, outpatient dialysis, hospice, skilled nursing, home health, inpatient rehabilitation facility, and long-term care hospital. It also reviews the status of the Medicare Advantage (MA) plans and prescription drug plans (Part D) and reiterates its payment recommendations for MA plans.

In addition, the report responds to a mandate in the Medicare Improvements for Patients and Providers Act (2008) with recommendations on comparing quality among MA plans and between MA and fee-for-service (FFS).

FEE-FOR-SERVICE PAYMENT UPDATE RECOMMENDATIONS

The principal focus of this report is the Commission's recommendations for annual rate adjustments under Medicare's various FFS payment systems. These annual changes in the rate paid to providers are often referred to as "updates." The Commission bases its update recommendation for each Medicare payment system on an assessment of payment adequacy, including beneficiary access to care (supply of providers, service use, surveys of access), quality of care, providers' access to capital, and provider Medicare margins (where available).

Hospitals

- The Congress should increase payment rates for the acute inpatient and outpatient prospective payment systems in 2011 by the projected rate of increase in the hospital market basket index, concurrent with implementation of a quality incentive payment program.
- To recapture overpayments to hospitals resulting from the conversion to Medicare Severity-Diagnosis Related Groups (MS-DRGs), the Secretary should reduce payment rates in the inpatient prospective payment system by the same percentage (not to exceed 2 percentage points) each year in 2011, 2012, and 2013. The lower rates would remain in place until overpayments are fully recovered.

Physicians

- The Congress should update payments for physician services in 2011 by 1 percent.
- The Congress should establish a budget-neutral payment adjustment for primary care services billed under the physician fee schedule and furnished by primary-care-focused practitioners. The Secretary would use rulemaking to establish criteria for determining a primary-care-focused practitioner based on criteria suggested by MedPAC. (Previously recommended in June 2008, March 2009)

Ambulatory surgical centers

- The Congress should increase payments for ambulatory surgical center (ASC) services in calendar year 2011 by 0.6 percent concurrent with requiring ASCs to submit cost and quality data.

Dialysis

- The Congress should update the composite rate by the projected rate of increase in the ESRD market basket index less the adjustment for productivity growth for calendar year 2011 (a net updated of approximately 0.7%).

Hospice

- The Congress should update the payment rates for hospice for 2011 by the projected rate of increase in the hospital market basket index less the Commission's adjustment for productivity growth (a net update of approximately 1.1%).

The Commission also reiterated its hospice recommendation from March 2009:

- 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.
- 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.
- The Secretary should direct the Office of Inspector General to investigate: the prevalence of financial relationships between hospices and long-term care facilities such as nursing facilities and assisted living facilities that may represent a conflict of interest and influence admissions to hospice, differences in patterns of nursing home referrals to hospice, the appropriateness of enrollment practices for hospices with unusual utilization patterns (e.g., high frequency of very long stays, very short stays, or enrollment of patients discharged from other hospices), and the appropriateness of hospice marketing materials and other admissions practices and potential correlations between length of stay and deficiencies in marketing or admissions practices.
- The Secretary should collect additional data on hospice care and improve the quality of all data collected to facilitate the management of the hospice benefit. Additional data could be collected from claims as a condition of payment and from hospice cost reports.

Skilled Nursing Facility Services

- The Congress should eliminate the update to payment rates for skilled nursing facility services for fiscal year 2011.
- The Congress should require the Secretary to revise the skilled nursing facility (SNF) prospective payment system by: adding a nontherapy ancillary (NTA) component based on patient needs and replacing the therapy component with one based on predicted patient care needs, and adopting an outlier policy. (Previously recommended in June 2008)
- The Congress should establish a budget-neutral quality incentive payment policy for SNFs based on risk-adjusted rates of potentially-avoidable rehospitalizations and community discharge and add these measures to CMS's publicly reported post-acute care quality measures. The Secretary should revise the

pain, pressure ulcer, and delirium measures currently reported on CMS's Nursing Home Compare website; and require SNFs to conduct patient assessments at admission and discharge. (March 2008)

- The Secretary should direct SNFs to report more accurate diagnostic and service-use information by requiring that: claims include detailed diagnosis information and dates of service, services furnished since admission to the SNF be recorded separately in the patient assessment, and SNFs report their nursing costs in the Medicare cost report. (Previously recommended in June 2008)

Home Health

- The Congress should eliminate the market basket update for 2011 and direct the Secretary to rebase rates for home health care services to reflect the average cost of providing care.
- The Congress should direct the Secretary to expeditiously modify the home health payment system to protect beneficiaries from stinting or lower quality of care in response to rebasing. The approaches considered should include risk corridors and blended payments that mix prospective payment with elements of cost-based reimbursement.
- The Secretary should identify categories of patients who are likely to receive the greatest clinical benefit from home health and develop quality outcomes measures for each category of patient.
- The Congress should direct the Secretary to review home health agencies that exhibit unusual patterns of claims for payment. The Congress should provide the authority to the Secretary to implement safeguards, such as a moratorium on new providers, preauthorization, or suspension of prompt payment requirements, in areas that appear to be high risk.

Inpatient Rehabilitation Facilities

- The update to the payment rates for inpatient rehabilitation services should be eliminated for fiscal year 2011.

Long-Term Care Hospitals

- The update to the payment rates for inpatient rehabilitation services should be eliminated for rate year 2011.

STATUS OF MEDICARE ADVANTAGE PROGRAM

In 2009, about 24 percent of Medicare beneficiaries were enrolled in MA plans. In 2010, virtually all beneficiaries have access to an MA plan, with an average of 21 plans available in each county.

In aggregate, the MA program continues to be more costly than the traditional program. In 2010, payments to MA plans continue to exceed what Medicare would spend for similar beneficiaries in FFS. If currently scheduled cuts to physician payment rates take place, MA payments per enrollee are projected to be 113 percent of comparable FFS spending for 2010. If physician fees are not cut, payments will be 109 percent of FFS. Plan bids for the traditional Medicare benefit package are 104 percent of FFS in 2010, compared with 102 percent of FFS in 2009.

MA plans provide enhanced benefits to enrollees, but, these enhanced benefits are largely financed by taxpayers and beneficiaries—and at a high cost. CMS estimates that the Part B premium was \$3.35 per month higher in 2009 than it would have been if spending for MA had been the same as in FFS. In addition, each dollar of enhanced benefits cost the Medicare program on average \$1.08 and as much as \$4.44 in the case of private fee for service plans.

Quality is not uniform among MA plans or plan types. High-quality plans tend to be established HMOs; in contrast, plans that are new in the MA program have lower performance on many measures.

The Commission has not changed its standing policy regarding MA payments, and reiterated its 2005 recommendations in the March 2010 report:

Recommendations on Medicare Advantage Payments

- The Congress should set the benchmarks that CMS uses to evaluate MA plan bids at 100 percent of the fee-for-service (FFS) costs.
- The Congress should also redirect Medicare's share of savings from bids below the benchmarks to a fund that would redistribute the savings back to MA plans based on quality measures. Pay-for-performance should apply in MA to reward plans that provide higher quality care.
- The Secretary should calculate clinical measures for the FFS program that would permit CMS to compare the FFS program with MA plans. (For additional recommendations from MedPAC on measuring quality in MA, see page 5, "Comparing Quality Among MA Plans and Between FFS and MA.")

STATUS OF PART D PROGRAM

As of January 2010, 90 percent of Medicare beneficiaries had some form of drug coverage. Fifty-nine percent of all Medicare beneficiaries enrolled in Part D plans; 32 percent had drug coverage at least as generous as Part D through employer-sponsored plans or other sources. Nearly 10 million Medicare beneficiaries received Part D's extra help with premiums and cost sharing (called the low-income subsidy or LIS).

In 2010, the number of stand-alone prescription drug plan (PDP) options declined by 7 percent, but beneficiaries in each regions still have between 41 and 55 different PDPs to chose among, along with many MA-PDs. On average, Part D enrollees will pay a monthly premium of just over \$30, an increase of about \$2 per month (6%) over 2009 (based on January enrollment). Although premiums increased, in general premium increases were smaller for 2010 than for 2009.

In 2010, 307 premium-free PDPs are available to enrollees who receive the LIS, almost unchanged from 2009. CMS estimated that it needed to reassign just over 1.2 million LIS enrollees to new plans for individuals to avoid paying some of the premium: 1.06 million to a plan offered by a different sponsor and 0.1 million to a plan offered by the same sponsor.

COMPARING QUALITY AMONG MEDICARE ADVANTAGE PLANS AND BETWEEN MEDICARE ADVANTAGE AND FFS

In recent years, the Commission has made a number of recommendations on quality reporting and quality-related payment adjustments in both the MA and FFS programs. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) Section 168 required MedPAC to expand on those recommendations with a report to the Congress about measures for comparing quality and patient experience in the MA and FFS programs, with the goal of collecting and reporting such measures by the year 2011.

This report, which fulfills the MIPPA mandate seeks to accomplish three goals: (1) enable CMS to better manage the Medicare program, (2) provide a basis for differentiating payments based on quality, and (3) provide beneficiaries with better information for making more informed choices among the MA plans and the FFS program.

Medicare currently uses three systems to measure and compare quality across MA plans and track changes over time: Healthcare Effectiveness Data and Information Set (HEDIS®), which measures clinical processes and intermediate clinical outcomes; Consumer Assessment of Healthcare Providers and Systems (CAHPS®), which primarily measures patients' experiences of care delivered through their plans and providers; and Health Outcomes Survey (HOS), which measures changes in beneficiaries' self-reported physical and mental health status over time. However, in their current form, these measures do not enable CMS or beneficiaries to evaluate quality between MA and FFS on comparable terms.

Recommendations on Comparing Quality in MA and between MA and FFS

- The Secretary should define electronic health record (EHR) "meaningful use" criteria such that all qualifying EHRs can collect and report the data needed to compute a comprehensive set of process and outcome measures consistent with these recommendations. Qualifying EHRs should have the capacity to include and report patient demographic data, such as race, ethnicity, and language preference.
- The Secretary should collect, calculate and report quality measurement results in MA at the level of the geographic units the Commission has recommended for MA payments, and calculate FFS quality results for purposes of comparing MA and FFS using the same geographic units.
- The Secretary should have all health plan types in MA report on the same basis, including reporting measures based on medical record review, and the Congress should remove the statutory exceptions for PPOs and private fee-for-service plans with respect to such reporting.
- The Secretary should collect and report the same survey-based data that are collected in MA through the Health Outcomes Survey for the Medicare FFS population, unless the Secretary determines that such data cannot meaningfully differentiate quality among MA plans and between FFS and MA.
- The Secretary should expeditiously publish specifications for forthcoming MA plan encounter data submissions to obtain the data needed to calculate patient outcome measures.
- The Secretary should calculate FFS results for HEDIS administrative-only measures for those measures that the Secretary determines can provide a valid comparison between MA and FFS.
- The Secretary should develop and report on additional quality measures for MA plan and MA-to-FFS comparisons that address gaps in current quality measures.
- The Congress should provide the CMS with sufficient resources to implement the Commission's recommendations in this report.