

## Report to the Congress • March 2015

The Medicare Payment Advisory Commission (MedPAC) is required by law to annually review Medicare payment policies and make recommendations to the Congress. The 2015 report includes payment policy recommendations for ten of the health care provider sectors in fee-for-service (FFS) Medicare. MedPAC also reviews the status of Medicare Advantage (MA) plans and Medicare's prescription drug plans (Part D).

### **FEE-FOR-SERVICE PAYMENT UPDATE RECOMMENDATIONS**

The principal focus of the March report is MedPAC's recommendations for annual rate adjustments under Medicare's various FFS payment systems, or sector "updates." MedPAC 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. MedPAC's recommendations for the 2016 payment year are listed below.

#### **Inpatient and outpatient hospitals**

- The Congress should direct the Secretary of Health and Human Services to:
  - Reduce or eliminate differences in payment rates between outpatient departments and physician offices for selected ambulatory services.
  - Set long-term care hospital (LTCH) base payment rates for non-chronically critically ill (CCI) cases equal to those of acute care hospitals and redistribute the savings from LTCH payments to create additional inpatient outlier payments for CCI cases in inpatient prospective payment system hospitals. The change should be phased in over a three-year period from 2016 to 2018.
  - Increase payment rates for the acute care hospital inpatient and outpatient prospective payment systems in 2016 by 3.25 percent, concurrent with the change to the outpatient payment system discussed above and with initiating the change to the long-term care hospital payment system.

#### **Physicians and other health professionals.**

- The Congress should establish a prospective per beneficiary payment to replace the Primary Care Incentive Payment program (PCIP) after it expires at the end of 2015. The per beneficiary payment should equal the average per beneficiary payment under the PCIP and should be exempt from beneficiary cost sharing. Funding for the per beneficiary payment should protect PCIP-defined primary care services regardless of the practitioners furnishing the services and should come from reduced fees for all other services in the fee schedule.
- 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 should include a payment rate update that is higher for primary care services than for specialty services in order to reduce the disparity between payments to primary care providers and specialists.
- 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 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.

- 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 the recommendation 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.

### **Ambulatory surgical centers**

- The Congress should eliminate the update to the payment rates for ambulatory surgical centers for calendar year 2016. The Congress should also require ambulatory surgical centers to submit cost data.

### **Outpatient dialysis**

- The Congress should eliminate the update to the outpatient dialysis bundled payment rate for calendar year 2016.

### **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 to rely on patient characteristics. Payment rebasing should begin a year after revisions to the prospective payment system are implemented, with an initial reduction of 4 percent and subsequent reductions over an appropriate transition until Medicare’s payments are better aligned with providers’ costs.

### **Home health agencies**

- 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 2016.
- 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.
- 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.
- The Congress should direct the Secretary to reduce payments to home health agencies with relatively high risk-adjusted rates of hospital readmission.
- 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.

### **Inpatient rehabilitation facilities**

- The Congress should eliminate the update to the Medicare payment rates for inpatient rehabilitation facilities in fiscal year 2016.
- The Congress should direct the Secretary of Health and Human Services to eliminate the differences in payment rates between inpatient rehabilitation facilities and skilled nursing facilities for selected conditions. The reductions to inpatient rehabilitation hospital payments should be phased in over 3 years. Inpatient rehabilitation facilities should receive relief from regulations specifying the intensity and mix of services for site-neutral conditions.

### **Long-term care hospitals**

- The Secretary should eliminate the update to the payment rates for long-term care hospitals for fiscal year 2016.

### **Hospice**

- The Congress should eliminate the update to the hospice payment rates for fiscal year 2016.

## **STATUS OF THE MEDICARE ADVANTAGE PROGRAM**

- In 2014, MA enrollment increased by 9 percent to 16 million beneficiaries (or 30 percent of all Medicare beneficiaries). Enrollment in HMO plans—the largest plan type—increased 7 percent, to 10.4 million enrollees.
- In 2015, 99% of Medicare beneficiaries have access to an MA plan, and 95 percent have access to a network-based coordinated care plan, which includes HMOs and PPOs. Seventy-eight percent of beneficiaries have access to an MA plan that includes Part D drug coverage and charges no premium beyond the Medicare Part B premium. In an average county, beneficiaries are able to choose from 9 MA plan options in 2015.
- Benchmark, bids, and payments are all moving down relative to FFS Medicare – 107, 94, and 102 percent respectively in 2015 – and the level of extra benefits have remained stable, at about \$75 per month.
- MA enrollees' risk scores – the factors used to adjust plan payments based on enrollee health status – grew faster than scores in the FFS population. The Medicare program is required to take a payment reduction of at least 5% to account for coding differences between MA and FFS; MedPAC finds that an adjustment of 8% in 2015 would more accurately account for current differences.
- Many quality measures included in the star ratings for the MA program improved, but plans' overall average star rating remained unchanged due to higher thresholds for the 4-star level. Plans saw a decline in performance on mental health measures, which are not included in the star-rating program.

## **STATUS OF THE PART D PROGRAM**

- In 2014, about 69 percent of Medicare beneficiaries (37 million beneficiaries) were enrolled in Part D plans. An additional 5 percent received their drug coverage through employer-sponsored plans that receive Medicare's retiree drug subsidy. Among Part D plan enrollees, 11.2 million individuals received the low-income subsidy (LIS).
- About 62 percent of Part D enrollees are in stand-alone prescription drug plans (PDPs); the rest are in Medicare Advantage–Prescription Drug plans (MA–PDs).
- The number of plan offerings declined 14 percent from 2014 to 2015, but beneficiaries continue to have many plan choices – between 24 and 33 PDPs to choose from in their region, depending on where they live, along with many MA–PDs.
- There has been consolidation in the number of companies offering Part D. In 2014, the top 9 insurers (those with 1 million or more Part D enrollees each) accounted for nearly 80 percent of total enrollment. By comparison, in 2007, those same insurers accounted for 60 percent of enrollment.
- There are three types of payments Medicare makes to plan sponsors: direct subsidy payments (which provide the resources for plans to pay for enrollees' care before they reach the catastrophic limit), low-income cost sharing payments (which subsidize cost sharing for LIS enrollees), and reinsurance payments (which subsidize spending in the catastrophic portion of the benefit). Between 2007 and 2013, spending on the direct subsidy grew only 1.9 percent annually, while spending on low-income cost sharing and reinsurance grew 5.7 and 15.9 percent annually, respectively.
- More Part D plans are using differential cost sharing to encourage the use of lower cost drugs. In 2015, over 80 percent of PDP formularies have tiers for preferred and non-preferred brands and generics.
- The increased availability of generic drugs in recent years has driven the generic dispensing rate from 61 percent in 2007 to 81 percent in 2012.
- Prices for single-source brand name drugs and specialty drugs are increasing rapidly, and are expected to drive an increasing share of spending.