

Report to the Congress: Medicare and the Health Care Delivery System - June 2013

The Commission's June 2013 Report to the Congress examines a variety of Medicare payment system issues. The report discusses competitively determined plan contributions, reducing payment differences across ambulatory settings, bundling post-acute care services, Medicare's hospital readmissions reduction program, the hospice payment system, and care needs for beneficiaries eligible for both Medicare and Medicaid benefits.

The report also includes three congressionally mandated reports concerning Medicare's add-on payments to ambulance providers, geographic adjustment of payments for work under the physician fee schedule, and Medicare payments for outpatient therapy services. A fact sheet dedicated to these reports is available on the MedPAC website. Finally, an appendix of the report reviews CMS's preliminary estimate of the 2014 update for physician and other health professionals.

COMPETITIVELY DETERMINED PLAN CONTRIBUTIONS (CPC)

- In the report, the Commission continues its discussion of possible ways to redesign the Medicare benefit by focusing on the concept we refer to as competitively determined plan contributions (CPC). CPC has two defining principles:
 - Medicare's payment for a beneficiary's care is set through a competitive process comparing the costs of available options for coverage, including private plans and traditional fee-for-service (FFS).
 - Beneficiaries' individual premiums would vary depending on which coverage option they choose.
- A successful CPC model would depend on strong competition between FFS and private plans offering lower premiums and more attractive benefits, and informed beneficiaries who respond to those offerings.
- Whether a CPC approach can lower overall Medicare spending will depend on the characteristics of each market, the specific design of the program, and how different components of the program interact.
- In this report, the Commission identifies key issues to be addressed if the Congress wishes to pursue a CPC approach. These include how benefits should be standardized for comparability, how to calculate the Medicare contribution, the role of FFS, and the structure of subsidies for low-income beneficiaries.

ADDRESSING MEDICARE PAYMENT DIFFERENCES ACROSS SITES OF CARE

- Medicare's payment rates often vary for the same ambulatory services provided to similar patients in different settings, such as physicians' offices or hospital outpatient departments (OPDs). For example, in 2013 Medicare pays about 140 percent more for a level II echocardiogram in an OPD than it does for the same service in a freestanding physician's office. These differences result in higher program and beneficiary spending.
- As hospital employment of physicians has grown, the provision of many services has been migrating from physicians' offices to the higher paid OPD setting. This shift toward OPDs has resulted in higher program spending and beneficiary cost sharing without significant changes in patient care.

- In general, the Commission maintains that Medicare should base payment rates on the resources needed to safely treat patients in the most efficient setting, adjusting for differences in patient severity.
- In our March 2012 report to the Congress, the Commission recommended that Medicare payment rates for office visits should be the same whether care is provided in an OPD or in a freestanding office.
- With this report, the Commission examines other services that meet its principles for aligning payment rates across settings—both between physicians’ offices and OPDs and ambulatory surgical centers (ASCs) and OPDs. The Commission excluded services typically provided with an emergency department visit or for which patients receiving care in an OPD tend to be sicker than those receiving care in a freestanding office setting.
 - There are 66 groups of services for which the OPD payment rate could be aligned with the physician office rate. These include level II echocardiogram without contrast, minor procedures such as level I debridement and destruction, advanced imaging such as cardiac computed tomographic imaging, and tests such as level IV pathology. Changing OPD payment rates for these services to reduce payment differences between settings would reduce program spending and beneficiary cost sharing by \$900 million in one year.
 - There are 12 groups of services that are commonly performed in ASCs for which the OPD payment rates could be reduced to the ASC level. These include nine eye procedure groups, two nerve injection groups, and one skin repair group. This policy would reduce Medicare program spending and beneficiary cost sharing by about \$600 million per year.
- Considering the impact of these potential payment changes, the Commission discusses a stop-loss policy that would limit the loss of Medicare revenue for hospitals that provide services to a disproportionate share of low-income Medicare patients.

BUNDLING PAYMENTS FOR POST-ACUTE CARE SERVICES

- Under traditional FFS Medicare, the program pays widely varying rates for the care beneficiaries can receive following a hospital stay in the four post-acute care (PAC) settings (skilled nursing facilities, home health care, inpatient rehabilitation facilities, and long-term care hospitals). Nationwide, utilization rates for PAC services vary extensively for reasons not explained by differences in beneficiaries’ health status.
- Depending on the design of a bundled approach, the payment could encourage greater provider accountability for patients’ outcomes and quality of care, coordination of care, and efficient use of resources. Each design aspect involves tradeoffs between increasing the opportunities for care coordination and requiring providers to accept risk for care beyond what they themselves furnish.
- The Commission discusses one possible way to bundle payments for PAC services that would not require providers to build an infrastructure to distribute payments for services delivered by other providers.
 - The illustrative bundle includes the following services that occur within 90 days of a triggering event: the initial hospital stay and any potentially avoidable readmissions, all PAC services, and physician services furnished during the institutional care.
 - CMS would continue to make FFS payments to participating providers, but would withhold a certain amount. CMS would compare actual average spending for a condition to a spending target, return some portion of payments if average spending is below the target and put providers at some risk for spending above the target.
- The Commission has not endorsed a particular bundling design and continues to explore design elements. This analysis may inform CMS’s bundling demonstration programs going forward.

REFINING MEDICARE'S HOSPITAL READMISSIONS REDUCTION PROGRAM

- In 2011, approximately 12 percent of Medicare hospital admissions were followed by a potentially preventable readmission.
- While not all of these readmissions can be prevented, there is an expectation that Medicare readmission rates could be lowered through greater coordination of care.
- At MedPAC's recommendation, Congress enacted a readmission reduction program in 2010 that included a penalty that would reduce Medicare payments beginning in 2013 to hospitals that have had above-average readmission rates.
- Following enactment in 2010, hospitals have increased efforts to reduce readmissions and have shown a small decline in their risk-adjusted readmission rates. The readmission policy may have encouraged hospitals to look beyond their walls and improve care coordination across providers to reduce readmissions.
- The Commission maintains that the policy should continue, but it should eventually be refined through changes in law. Refinements could include:
 - Establishing a fixed, rather than relative, target for readmission rates. Penalties would decline when industry performance improves. Under the current formula, penalties remain constant even if industry-wide readmission rates improve.
 - Using an all-condition readmission measure to increase the number of observations and reduce the random variation seen under current policy.
 - For some conditions (e.g., heart failure) there is a negative correlation between mortality rates and readmission rates; for other conditions there is no significant relationship. Using an all-condition readmission measure would reduce the problem of systematically having higher readmission penalties for hospitals with low mortality rates for certain conditions. Over the longer term, it may be possible to develop a joint readmission/mortality measure.
 - Readmission rates would continue to be reported without an adjustment for patient income. However, for purposes of computing a penalty a hospital's readmission rate could be measured against rates for a group of peer hospitals with a similar share of poor Medicare beneficiaries. In this way, publicly available data would still show any disparities that exist between hospitals treating lower-income and higher-income patients, but the hospitals treating low-income patients would not face a disproportionate share of the penalties.

HOSPICE PAYMENT ISSUES

- In 2009, the Commission recommended reforms to the hospice payment system to better reflect the costs of care over the course of a hospice episode. Using newly available data, the Commission shows how the labor cost of hospice visits changes over the course of a hospice episode. These data demonstrate a U-shaped pattern of labor costs throughout hospice episodes and offer policymakers the evidence needed to begin reforming the payment system away from the current flat per diem payment. To demonstrate this, we present an illustrative example of a revised payment system that could be implemented now using existing data.
- In 2011, Medicare spending on hospice patients with stays that exceeded 6 months was nearly \$8 billion. These long-stay patients comprised about 20 percent of Medicare hospice beneficiaries and represented more than half of all hospice spending. Further, the 10 percent of patients with the longest stays in 2011 had stays of 241 days or more, up from 141 days or more in 2010. This underscores the Commission's prior recommendations to revise the payment system and to conduct medical review of very long stays.
- The Commission presents new analysis on live discharges from hospice, supporting the need to ensure that beneficiaries are appropriate candidates for hospice at their initial admission. Eighteen percent of hospice patients in 2010 were discharged alive from hospices. Among hospices in the top quartile of live discharge

rates, the average rate is 38 percent. Further, for-profit hospices and hospices that exceed the payment cap are significantly more likely to discharge patients alive.

- The Commission examines hospice providers' patient clusters at individual nursing facilities and hospice aide visits patients receive at those facilities. These analyses suggest that a reduction to the hospice payment rate for patients residing in nursing facilities may be warranted. We find that the majority of hospice care in nursing facilities occurs when the hospice provider has multiple patients clustered within individual nursing facilities, suggesting possible efficiencies from treating hospice patients in a centralized location. We also explore the potential for a reduction to the hospice payment rate for patients residing in nursing facilities in light of the overlap in responsibilities between the hospice and the nursing facility.

CARE NEEDS FOR DUAL-ELIGIBLE BENEFICIARIES

- In 2011, about 19 percent of Medicare beneficiaries, about 9 million beneficiaries were dual eligible.
- Programs that coordinate dual-eligible beneficiaries' Medicare and Medicaid benefits (which we refer to as Medicare–Medicaid coordination programs) have the potential to improve dual-eligible beneficiaries' access to services and quality of care.
- The Commission reports on a series of structured interviews with stakeholders (federally qualified health centers (FQHCs), community health centers (CHCs), primary care physicians, health systems, behavioral health providers, aging services organizations, community-based care managers, beneficiary advocates, and health plans) in five states with Medicare–Medicaid coordination programs.
 - In general, the interviewees reported that dual-eligible beneficiaries (both those enrolled in Medicare–Medicaid coordination programs and those not enrolled in those programs) tend to have more complex medical and nonmedical needs than non-dual-eligible Medicare beneficiaries.
 - Dual-eligible beneficiaries were consistently reported to need high-contact, on-the-ground, intensive care management given that their issues are not likely to be resolved in a few physician visits.
 - Dual-eligible beneficiaries' providers tend to operate only in their respective settings and communication with one another across settings regarding a patient's care is not common.
 - Medicare–Medicaid coordination programs focus on getting providers in various settings—hospitals, physicians' offices, and social service agencies, among others—to communicate with one another regarding a beneficiary's care.
 - Medicare–Medicaid coordination programs also seek to leverage community-based resources, including care coordination activities at FQHCs and CHCs.
 - Many FQHCs and CHCs are uniquely positioned to coordinate care for dual-eligible beneficiaries because they provide primary care, behavioral health, and care management services, often at the same clinic site.