MEDPAC Medicare Payment Advisory Commission

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MEDICARE PAYMENT ADVISORY COMMISSION RELEASES REPORT ON MEDICARE PAYMENT POLICY

Washington, DC, February 29, 2008—Today, the Medicare Payment Advisory Commission (MedPAC) releases its March 2008 *Report to the Congress: Medicare Payment Policy.*

MedPAC has concluded that the Congress and CMS will need to make changes across a broad front to increase quality, slow the growth in Medicare expenditures, and address Medicare's long-term sustainability. The report focuses on policy recommendations that create incentives for greater efficiency, reward quality, and modify payment rates to private plans and providers to ensure accuracy and equity.

The report reviews the financial context for Medicare and recommends updates for its fee-for-service (FFS) payment systems. It also reviews recent findings and makes recommendations on Medicare Advantage (MA) plans and recommendations specific to special needs plans (SNPs), reviews findings on the private plans offering the prescription drug benefit (Part D), and makes recommendations on Medicare programs for low income beneficiaries.

MedPAC makes updates and policy recommendations for eight Medicare FFS payment systems for 2009. The update is the amount by which the base payment for all providers in a prospective payment system is changed. For 2009, MedPAC recommends:

- For inpatient and outpatient services, updates equal to the hospital market basket (a measure of input prices), implemented concurrently with a quality incentive payment program. This recommendation balances positive indicators of financial performance (including virtually unprecedented growth in hospital construction), access, and quality—and the finding that some hospitals face little financial pressure to control their costs—against negative Medicare margins. Although separately computed and paid, a hospital's quality performance payment would likely determine whether its net increase in payments in 2009 would be above or below the market basket increase. Part of the funding for a quality incentive payment policy should come from reducing indirect medical education (IME) payments. More than half of the IME add-on payment is unrelated to the additional cost of care that results from the intensity of a hospital's teaching program. The Commission recommends that the Congress reduce the IME adjustment by 1 percentage point to 4.5 percent per 10 percent increment in the resident-to-bed ratio.

- For the physician fee schedule, an update equal to the increase in input prices less MedPAC's adjustment for productivity growth. (The ten year average of productivity gains in the general economy, 1.5 percent for 2009. This factor links Medicare's adjustment for efficiency to the gains achieved by the firms and workers who pay taxes that fund Medicare.) Beneficiary access to physicians is generally good at the national level, but small numbers of beneficiaries continue to report some difficulties—most noticeably in finding a new primary care physician. (The continued availability of primary care physicians and their pay relative to other physicians continue to be of concern to the Commission.) Per beneficiary service volume grew with small improvements in quality. Nonetheless, the sustainable growth rate (SGR) formula continues to call for substantial negative updates through 2016. The Commission is concerned that consecutive annual cuts would threaten beneficiary access to physician services over time. In addition, the Congress should enact legislation requiring CMS to establish a process for measuring and reporting physician resource use on a confidential basis for a period of two years.

- For the outpatient dialysis payment system, an update equal to the projected change in input prices less the Commission's adjustment for productivity growth. Most indicators of payment adequacy are positive including access to care for dialysis beneficiaries. In addition, the Commission reiterates its recommendation that the Congress implement a quality incentive program for physicians and facilities that treat dialysis patients, and also restates that the dialysis payment bundle should be expanded to include dialysis drugs and other commonly furnished services.

- For three of the four post-acute care payment systems—skilled nursing facilities, home health agencies, and inpatient rehabilitation facilities—no increases in the payment rates. These providers continue to have high positive Medicare payment margins and beneficiaries have access to care. These providers can accommodate next year's cost increases without an increase in base payments. In addition, the report recommends a quality incentive program and improved public reporting of quality for skilled nursing facilities. For the fourth, long-term care hospitals, an increase of the market basket index less the Commissions adjustment for productivity, recognizing that because of low projected Medicare margins and rapid regulatory changes, they may not be able to accommodate growth in the cost of caring for Medicare beneficiaries in 2009 without an increase in the base rate.

The Commission supports private plans in the Medicare program. Medicare beneficiaries should have a choice between the FFS Medicare program and the alternative delivery systems that private plans can provide. If paid appropriately, private plans have incentives to innovate and be efficient. Payment rates for the FFS program and the MA program should be financially neutral—Medicare should pay the same amount, adjusting for risk, regardless of which option a beneficiary chooses. Instead, the report finds that MA payments are projected to be 113 percent of FFS in 2008. In addition, plan bids for the traditional Medicare benefit package are projected at 101 percent of FFS, which means that MA plans, on average, are less efficient than the traditional Medicare program. Well-managed systems that coordinate care and select efficient providers should be at least as efficient as traditional Medicare, a highly flawed delivery system, and in most cases should be more efficient. They should also be high quality, yet commercial and Medicaid plans improved more in clinical measures than MA plans, and newer MA plans show poorer performance than older plans. The report also finds that MA plans are available to beneficiaries in every county in 2008 with an average of 35 plans to choose from, and total enrollment in MA plans grew in 2007 to 20 percent, an all-time high. However, most of the enrollment growth was in private FFS plans—whose enrollment more than doubled last year. Yet, private FFS plans have no requirement to coordinate care or report quality measures, and their payments and inefficiency are even greater (117 percent and 108 percent of FFS) than the MA program as a whole.

The Commission is concerned with the effectiveness of MA special needs plans (SNPs), which have also grown rapidly. These plans are allowed to limit enrollment to specific categories of beneficiaries. SNPs require further study to increase their value to the program and the Commission makes recommendations concerning: tailored performance measures, beneficiary information, definition of chronic conditions, coordination of Medicaid benefits, requirements for a targeted population, and enrollment and disenrollment provisions. The report also recommends that the Congress should extend the authority for SNPs for three years. This would provide time for a more a rigorous evaluation and for SNPs to meet the conditions specified in the earlier recommendations.

For 2008 there are more than 1,800 Part D drug plans and most beneficiaries again have a choice of 50 to 60 stand-alone prescription drug plans (PDPs) in their region. Average monthly premiums have increased for 2008 to about $27 per month, up from the $23 average for 2007. Of the 13 million beneficiaries estimated to be eligible for Part D's "extra help" with premiums and cost sharing, more than 9 million were receiving a low-income subsidy (LIS). For 2008, about 2.6 million LIS beneficiaries needed to switch to a different plan if they did not want to pay a premium, considerably more than had to switch in the previous year. The Commission recommends that the Congress should direct the Secretary to make Part D claims data available regularly and in a timely manner to congressional support agencies and selected executive branch agencies for purposes of program evaluation, public health, and safety (for example, post market surveillance). That data is needed to answer fundamental questions about how Part D is operating, and to assess efficiency and quality in the overall delivery of health care.

Although the Medicare Savings Programs (MSPs) and the LIS provide significant financial benefits to enrollees with limited incomes, most eligible beneficiaries do not participate in MSPs. The main barriers to enrollment are beneficiaries' lack of knowledge of the programs and the complexity of the application processes. The report makes three recommendations to increase participation:

- The Secretary should increase State Health Insurance Assistance Programs funding for outreach to low-income Medicare beneficiaries.
- The Congress should raise MSP income and asset criteria to conform to LIS criteria.
- The Congress should change program requirements so that the Social Security Administration screens LIS applicants for federal MSP eligibility and enrolls them if they qualify.

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The Medicare Payment Advisory Commission is an independent Congressional advisory body charged with providing policy analysis and advice concerning the Medicare program and other aspects of the health care system. Its 17 commissioners represent diverse points of view and include health care providers; payers; beneficiary representatives; employers; and individuals with expertise in biomedical, health services, and health economics research.