ONLINE APPENDIXES

1

Context for Medicare payment policy

ONLINE APPENDIX 1-A

Summary of Commission recommendations

TABLE 1–A1

MedPAC recommendations made from 2010–2017

MedPAC recommendation	Topic	Date
MedPAC's approach: Payment accuracy and encouraging efficiency		
The Congress should direct the Secretary to: • implement a prospective payment system for post-acute care beginning in 2021 with a three-year transition; • lower aggregate payments by 5 percent, absent prior reductions to the level of payments; • concurrently, begin to align setting-specific regulatory requirements; and • periodically revise and rebase payments, as needed, to keep payments aligned with the cost of care.	Post-acute care	June 2017
The Congress should change Medicare's payment for Part B drugs and biologicals (products) as follows: (1) Modify the average sales price (ASP) system in 2018 to: • require all manufacturers of products paid under Part B to submit ASP data and impose penalties for failure to report. • reduce wholesale acquisition cost (WAC)-based payment to WAC plus 3 percent. • require manufacturers to pay Medicare a rebate when the ASP for their product exceeds an inflation benchmark and tie beneficiary cost sharing and the ASP add-on to the inflation-adjusted ASP. • require the Secretary to use a common billing code to pay for a reference biologic and its biosimilars. (2) No later than 2022, create and phase in a voluntary Drug Value Program (DVP) that must have the following elements: • Medicare contracts with a small number of private vendors to negotiate prices for Part B products. • Providers purchase all DVP products at the price negotiated by their selected DVP vendor. • Medicare pays providers the DVP-negotiated price and pays vendors an administrative fee, with opportunities for shared savings. • Beneficiaries pay lower cost sharing. • Medicare payments under the DVP cannot exceed 100 percent of ASP. • Vendors use tools including a formulary and, for products meeting selected criteria, binding arbitration. (3) Upon implementation of the DVP or no later than 2022, reduce the ASP add-on under the ASP system.	Part B drugs	June 2017
The Secretary should require hospitals to add a modifier on claims for all services provided at off-campus stand-alone emergency department facilities.	Hospital	March 2017
The Congress should eliminate the update to the payment rates for ambulatory surgical centers for calendar year [2018]. The Congress should also require ambulatory surgical centers to submit cost data.	Ambulatory surgical center	March 2017; March 2016; March 2015; March 2014; March 2013
The Secretary should eliminate the update to the payment rates for long-term care hospitals for fiscal year [2017].	Post-acute care	March 2017; March 2016; March 2015; March 2014; March 2013; March 2012; March 2011

TABLE 1–A1

MedPAC recommendations made from 2010–2017

MedPAC recommendation	Topic	Date
The Congress should eliminate the update to the hospice payment rates for fiscal year [2018].	End-of-life care	March 2017; March 2016; March 2015; March 2014; March 2013
The Congress should eliminate the market basket updates for [2018] and [2019] and direct the Secretary to revise the prospective payment system (PPS) for skilled nursing facilities. In [2020], the Secretary should report to the Congress on the impacts of the reformed PPS and make any additional adjustments to payments needed to more closely align payments with costs.	Post-acute care	March 2017; March 2016
The Congress should reduce home health payment rates by 5 percent in 2018 and implement a two-year rebasing of the payment system beginning in 2019. The Congress should direct the Secretary to revise the prospective payment system to eliminate the use of the number of therapy visits as a factor in payment determinations, concurrent with rebasing.	Post-acute care	March 2017
The Congress should reduce the Medicare payment rate for inpatient rehabilitation facilities by 5 percent for fiscal year 2018.	Post-acute care	March 2017
The Secretary should calculate Medicare Advantage benchmarks using fee-for-service spending data only for beneficiaries enrolled in both Part A and Part B.	Medicare Advantage	March 2017
The Secretary should reduce the Medicare Part B dispensing and supplying fee to rates similar to other payers.	Part B drugs	June 2016
The Congress should change Part D to: • transition Medicare's individual reinsurance subsidy from 80 percent to 20 percent while maintaining Medicare's overall 74.5 percent subsidy of basic benefits, • exclude manufacturers' discounts in the coverage gap from enrollees' true out-of-pocket spending, and • eliminate enrollee cost sharing above the out-of-pocket threshold.	Part D	June 2016
The Congress should change Part D's low-income subsidy to: • modify copayments for Medicare beneficiaries with incomes at or below 135 percent of poverty to encourage the use of generic drugs, preferred multisource drugs, or biosimilars when available in selected therapeutic classes; • direct the Secretary to reduce or eliminate cost sharing for generic drugs, preferred multisource drugs, and biosimilars; and • direct the Secretary to determine appropriate therapeutic classifications for the purposes of implementing this policy and review the therapeutic classes at least every three years.	Part D	June 2016
The Secretary should change Part D to: • remove antidepressants and immunosupressants for transplant rejection from the classes of clinical concern, • streamline the process for formulary changes, • require prescribers to provide standardized supporting justifications with more clinical rigor when applying for exceptions, and • permit plan sponsors to use selected tools to manage specialty drug benefits while maintaining appropriate access to needed medications.	Part D	June 2016

TABLE 1–A1

MedPAC recommendations made from 2010–2017

MedPAC recommendation	Topic	Date
The Congress should direct the Secretary of the Department of Health and Human Services to: • update inpatient and outpatient payments by the amount specified in current law; • reduce Medicare payment rates for 340B hospitals' separately payable Part B drugs by 10 percent of the average sales price; • direct the program savings from reducing Part B drug payment rates to the Medicare-funded uncompensated care pool; and • distribute all uncompensated care payments using data from the Medicare cost reports' Worksheet S–10. The use of S–10 uncompensated care data should be phased in over three years.	Hospital	March 2016
The Congress should direct the Secretary to: • develop a risk adjustment model that uses two years of fee-for-service (FFS) and Medicare Advantage (MA) diagnostic data and does not include diagnoses from health risk assessments from either FFS or MA, and • then apply a coding adjustment that fully accounts for the remaining differences in coding between FFS and Medicare Advantage plans.	Medicare Advantage	March 2016
The Congress should direct the Secretary to eliminate the payment update for 2017 and implement a two-year rebasing of the payment system beginning in 2018 for home health care services. The Congress should direct the Secretary to revise the prospective payment system to eliminate the use of therapy visits as a factor in payment determinations, concurrent with rebasing.	Post-acute care	March 2016
The Congress should eliminate the update to the Medicare payment rate for inpatient rehabilitation facilities in fiscal year [2017].	Post-acute care	March 2016; March 2015; March 2014; March 2013; March 2012; March 2011
The Secretary should conduct focused medical record review of inpatient rehabilitation facilities that have unusual patterns of case mix and coding.	Post-acute care	March 2016
The Secretary should expand the inpatient rehabilitation facility outlier pool to redistribute payments more equitably across cases and providers.	Post-acute care	March 2016
The Congress should eliminate the cap on benchmark amounts and the doubling of the quality increases in specified counties.	Medicare Advantage	March 2016
The Congress should eliminate the update to the outpatient dialysis payment rate for calendar year 2016.	Dialysis	March 2015
The Congress should direct the Secretary of Health and Human Services to eliminate the differences in payment rates between inpatient rehabilitation facilities (IRFs) and skilled nursing facilities for selected conditions. The reductions to IRF payments should be phased in over three years. IRFs should receive relief from regulations specifying the intensity and mix of services for site-neutral conditions.	Post-acute care	March 2015
The Congress should direct the Secretary to determine payments for employer group Medicare Advantage plans in a manner more consistent with the determination of payments for comparable nonemployer plans.	Medicare Advantage	March 2014

TABLE 1–A1

MedPAC recommendations made from 2010–2017

MedPAC recommendation	Topic	Date
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 payment classifications.	Hospital, Physician	March 2014
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 payment classifications. • set long-term care hospital base payment rates for non–chronically critically ill cases equal to those of acute care hospitals and redistribute the savings to create additional inpatient outlier payments for chronically critically ill cases in inpatient prospective payment system hospitals. The change should be phased in over a three-year period from 2015 to 2017. • increase payment rates for the acute care hospital inpatient and outpatient prospective payment systems in 2015 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.	Hospital	March 2014
The Congress should direct the Secretary to: • include a measure that assesses poor outcomes related to anemia in the End-Stage Renal Disease Quality Incentive Program. • redesign the low-volume payment adjustment to consider a facility's distance to the nearest facility. • audit dialysis facilities' cost report data.	Dialysis	March 2014
The Congress should: • allow the three temporary ambulance add-on policies to expire; • direct the Secretary to rebalance the relative values for ambulance services by lowering the relative value of basic life support nonemergency services and increasing the relative values of other ground transports. Rebalancing should be budget neutral relative to current law and maintain payments for other ground transports at their level prior to expiration of the temporary ground ambulance add-on; and • direct the Secretary to replace the permanent rural short-mileage add-on for ground ambulance transports with a new budget-neutral adjustment directing increased payments to ground transports originating in geographically isolated, low-volume areas to protect access in those areas.	Ambulance services	June 2013
The Congress should direct the Secretary to: • promulgate national guidelines to more precisely define medical necessity requirements for both emergency and nonemergency (recurring and nonrecurring) ground ambulance transport services; • develop a set of national edits based on those guidelines to be used by all claims processors; and • identify geographic areas and/or ambulance suppliers and providers that display aberrant patterns of use, and use statutory authority to address clinically inappropriate use of basic life support nonemergency ground ambulance transports.	Ambulance services	June 2013
Medicare payments for work under the fee schedule for physicians and other health professionals should be geographically adjusted. The adjustment should reflect geographic differences across labor markets for physicians and other health professionals. The Congress should allow the geographic practice cost index (GPCI) floor to expire per current law and, because of uncertainty in the data, should adjust payments for the work of physicians and other health professionals only by the current one-quarter GPCI and direct the Secretary to develop an adjuster to replace it.	Physician	June 2013

TABLE 1–A1

MedPAC recommendations made from 2010–2017

MedPAC recommendation	Topic	Date
The Congress should direct the Secretary to: • reduce the certification period for the outpatient therapy plan of care from 90 days to 45 days, and • develop national guidelines for therapy services, implement payment edits at the national level based on these guidelines that target implausible amounts of therapy, and use authorities granted by the Patient Protection and Affordable Care Act of 2010 to target high-use geographic areas and aberrant providers.	Post-acute care, hospital, and physician	June 2013
To avoid caps without exceptions, the Congress should: • reduce the therapy cap for physical therapy and speech–language pathology services combined and the separate cap for occupational therapy to $1,270 in 2013. These caps should be updated each year by the Medicare Economic Index. • direct the Secretary to implement a manual review process for requests to exceed cap amounts, and provide the resources to CMS for this purpose. • permanently include services delivered in hospital outpatient departments under therapy caps. • apply a multiple procedure payment reduction of 50 percent to the practice expense portion of outpatient therapy services provided to the same patient on the same day.	Post-acute care, hospital, and physician	June 2013
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.	Hospital	March 2013
The Congress should not increase the outpatient dialysis bundled payment rate for calendar year 2014.	Dialysis	March 2013
The Congress should direct the Secretary to implement a value-based purchasing program for ambulatory surgical center services no later than 2016.	Ambulatory surgical center	March 2012
The Congress should increase payment rates for the inpatient and outpatient prospective payment systems in 2013 by 1.0 percent. For inpatient services, the Congress should also require the Secretary of Health and Human Services beginning in 2013 to use the difference between the increase under current law and the Commission's recommended update to gradually recover past overpayments due to documentation and coding changes.	Hospital	March 2012
The Congress should direct the Secretary of Health and Human Services to reduce payment rates for evaluation and management office visits provided in hospital outpatient departments so that total payment rates for these visits are the same whether the service is provided in an outpatient department or a physician office. These changes should be phased in over three years. During the phase-in, payment reductions to hospitals with a disproportionate share patient percentage at or above the median should be limited to 2 percent of overall Medicare payments.	Site neutral	March 2012
The Secretary of Health and Human Services should conduct a study by January 2015 to examine whether access to ambulatory physician and other health professionals' services for low-income patients would be impaired by setting outpatient evaluation and management payment rates equal to those paid in physician offices. If access will be impaired, the Secretary should recommend actions to protect access.	Site neutral	March 2012

TABLE 1–A1

MedPAC recommendations made from 2010–2017

MedPAC recommendation	Topic	Date
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.	Post-acute care	March 2012
The Congress should direct the Secretary to reduce payments to skilled nursing facilities with relatively high risk-adjusted rates of rehospitalization during Medicare-covered stays and be expanded to include a time period after discharge from the facility.	Post-acute care	March 2012
The Congress should direct the Secretary to identify overpriced fee-schedule services and reduce their relative value units accordingly.	Physician	March 2012*
The Congress should repeal the sustainable growth rate system and replace it with a 10-year path of statutory fee-schedule updates, with higher updates for primary care providers.	Physician	March 2012**
The Congress should direct the Secretary to reduce the physician work component of imaging and other diagnostic tests that are ordered and performed by the same practitioner.	Physician	June 2011
The Secretary should accelerate and expand efforts to package discrete services in the physician fee schedule into larger units for payment.	Physician	June 2011
The Congress should direct the Secretary to apply a multiple procedure payment reduction to the professional component of diagnostic imaging services provided by the same practitioner in the same session.	Physician	June 2011
The Congress should direct the Secretary to establish a prior authorization program for practitioners who order substantially more advanced diagnostic imaging services than their peers.	Physician	June 2011
The Congress should increase payment rates for the acute care hospital inpatient and outpatient prospective payment systems in 2012 by 1 percent. The Congress should also require the Secretary of Health and Human Services to make adjustments to inpatient payment rates in future years to fully recover all overpayments due to documentation and coding improvements.	Hospital	March 2011
The Secretary, with the Office of 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.	Post-acute care	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.	Post-acute care	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.	Post-acute care	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.	Post-acute care	March 2011
The Congress should eliminate the update to payment rates for skilled nursing facility services for fiscal year 2012.	Post-acute care	March 2010; March 2011
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.	Hospital	March 2010

TABLE 1–A1

MedPAC recommendations made from 2010–2017

MedPAC recommendation	Topic	Date
To restore budget neutrality, the Congress should require the Secretary to fully offset increases in inpatient payments due to hospitals' documentation and coding improvements. To accomplish this goal, the Secretary must 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.	Hospital	March 2010
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 should include risk corridors and blended payments that mix prospective payment with elements of cost-based reimbursement.	Post-acute care	March 2010
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, prior authorization, or suspension of prompt payment requirements, in areas that appear to be high risk.	Post-acute care	March 2010
MedPAC's approach: Care coordination and quality		
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.	Physician	March 2015
The Secretary should: • direct recovery audit contractors (RACs) to focus reviews of short inpatient stays on hospitals with the highest rates of this type of stay, • modify each RAC's contingency fees to be based, in part, on its claim denial overturn rate, • ensure that the RAC look-back period is shorter than the Medicare rebilling period for short inpatient stays, and • withdraw the "two-midnight" rule.	Hospital	June 2015
The Secretary should evaluate establishing a penalty for hospitals with excess rates of short inpatient stays to substitute, in whole or in part, for recovery audit contractor review of short inpatient stays.	Hospital	June 2015
The Congress should revise the skilled nursing facility three-inpatient-day hospital eligibility requirement to allow for up to two outpatient observation days to count toward meeting the criterion.	Hospital	June 2015
The Congress should package payment for self-administered drugs provided during outpatient observation on a budget-neutral basis within the hospital outpatient prospective payment system.	Hospital	June 2015
The Congress should direct the Secretary to reduce payments to home health agencies with relatively high risk-adjusted rates of hospital readmission.	Post-acute care	March 2014
The Congress should direct the Secretary to implement common patient assessment items for use in home health agencies, skilled nursing facilities, inpatient rehabilitation facilities, and long-term care hospitals by 2016.	Post-acute care	March 2014

TABLE 1–A1

MedPAC recommendations made from 2010–2017

MedPAC recommendation	Topic	Date
The Congress should direct the Secretary to: • prohibit the use of V codes as the principal diagnosis on outpatient therapy claims, and • collect functional status information on therapy users using a streamlined, standardized, assessment tool that reflects factors such as patients' demographic information, diagnoses, medications, surgery, and functional limitations to classify patients across all therapy types. The Secretary should use the information collected using this tool to measure the impact of therapy services on functional status, and provide the basis for development of an episode-based or global payment system.	Post-acute care, hospital, and physician	June 2013
The Congress should permanently reauthorize institutional special needs plans.	Medicare Advantage	March 2013
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.	Medicare Advantage	March 2013
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.	Medicare Advantage	March 2013
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.	Medicare Advantage	March 2013
The Congress should direct the Secretary to improve the Medicare Advantage (MA) risk-adjustment system to more accurately predict risk across all MA enrollees. Using the revised risk-adjustment system, the Congress should direct the Secretary to pay Program of All-Inclusive Care for the Elderly providers based on the MA payment system for setting benchmarks and quality bonuses. These changes should occur no later than 2015.	Program of All-Inclusive Care for the Elderly	June 2012
The Congress should direct the Secretary to publish select quality measures on Program of All-Inclusive Care for the Elderly (PACE) providers and develop appropriate quality measures to enable PACE providers to participate in the Medicare Advantage quality bonus program by 2015.	Program of All-Inclusive Care for the Elderly	June 2012

TABLE 1–A1

MedPAC recommendations made from 2010–2017

MedPAC recommendation	Topic	Date
After the changes in the recommendation to improve the Medicare Advantage (MA) risk-adjustment system and pay Program of All-Inclusive Care for the Elderly providers based on the MA payment system take effect (see p. 10), the Congress should change the age eligibility criteria for the Program of All-Inclusive Care for the Elderly to allow nursing home–certifiable Medicare beneficiaries under the age of 55 to enroll.	Program of All-Inclusive Care for the Elderly	June 2012
After the changes in the recommendation to improve the Medicare Advantage (MA) risk-adjustment system and pay Program of All-Inclusive Care for the Elderly providers based on the MA payment system take effect, the Secretary should establish an outlier protection policy for new Program of All-Inclusive Care for the Elderly sites to use during the first three years of their programs to help defray the exceptionally high acute care costs for Medicare beneficiaries. The Secretary should establish the outlier payment caps so that the costs of all June 2012 recommendations about care coordination programs for dual-eligible beneficiaries do not exceed the savings achieved by the changes in the recommendation above.	Program of All-Inclusive Care for the Elderly	June 2012
After the changes in the recommendation to improve the Medicare Advantage (MA) risk-adjustment system and pay Program of All-Inclusive Care for the Elderly providers based on the MA payment system take effect (see p. 10), the Secretary should provide prorated capitation payments to Program of All-Inclusive Care for the Elderly providers for partial-month enrollees.	Program of All-Inclusive Care for the Elderly	June 2012
The Secretary should make low-performing providers and community-level initiatives a high priority in allocating resources for technical assistance for quality improvement.	Physician	June 2011
The Secretary should regularly update the conditions of participation so that the requirements incorporate and emphasize evidence-based methods of improving quality of care.	Physician	June 2011
The Congress should require the Secretary to expand interventions that promote systemic remediation of quality problems for persistently low-performing providers.	Physician	June 2011
The Secretary should establish a public recognition program for high-performing providers that participate in collaboratives or learning networks, or otherwise act as mentors, to improve the quality of lower performing providers.	Physician	June 2011
The Secretary should identify categories of patients who are likely to receive the greatest clinical benefit from home health care and develop outcomes measures that evaluate the quality of care for each category of patient.	Home health services	March 2010
The Secretary should collect, calculate, and report quality measurement results in Medicare Advantage at the level of the geographic units the Commission has recommended for Medicare Advantage payments, and calculate fee-for-service quality results for purposes of comparing Medicare Advantage and fee-for-service using the same geographic units.	Medicare Advantage	March 2010
The Secretary should have all health plan types in Medicare Advantage report on the same basis, including reporting measures based on medical record review, and the Congress should remove the statutory exceptions for preferred provider organizations and private fee-for-service plans with respect to such reporting.	Medicare Advantage	March 2010
The Secretary should collect and report the same survey-based data that are collected in Medicare Advantage through the Health Outcomes Survey for the Medicare fee-for-service population, unless the Secretary determines that such data cannot meaningfully differentiate quality among Medicare Advantage plans and between fee-for-service and Medicare Advantage.	Medicare Advantage	March 2010

TABLE 1–A1

MedPAC recommendations made from 2010–2017

MedPAC recommendation	Topic	Date
The Secretary should expeditiously publish specifications for forthcoming Medicare Advantage plan encounter data submissions to obtain the data needed to calculate patient outcome measures.	Medicare Advantage	March 2010
The Secretary should calculate fee-for-service results for Healthcare Effectiveness Data and Information Set administrative-only measures for those measures the Secretary determines can provide a valid comparison of the two sectors.	Medicare Advantage	March 2010
The Secretary should develop and report on additional quality measures for Medicare Advantage plan and Medicare Advantage–to–fee-for-service comparisons that address gaps in current quality measures.	Medicare Advantage	March 2010
MedPAC's approach: Broadening information available to patients and providers		
The Congress should direct the Secretary to: • reduce the certification period for the outpatient therapy plan of care from 90 days to 45 days, and • develop national guidelines for therapy services, implement payment edits at the national level based on these guidelines that target implausible amounts of therapy, and use authorities granted by the Patient Protection and Affordable Care Act of 2010 to target high-use geographic areas and aberrant providers.	Post-acute care	June 2013
The Congress should require acute-care hospitals to notify beneficiaries placed in outpatient observation status that their observation status may affect their financial liability for skilled nursing facility care. The notice should be provided to patients in observation status for more than 24 hours and who are expected to need skilled nursing services. The notice should be timely, allowing patients to consult with their physicians and other health care professionals before discharge planning is complete.	Hospital	June 2015
The Secretary should define electronic health record "meaningful use" criteria such that all qualifying electronic health records can collect and report the data needed to compute a comprehensive set of process and outcome measures consistent with these recommendations. Qualifying electronic health records should have the capacity to include and report patient demographic data such as race, ethnicity, and language preference.	Electronic health record	March 2010
MedPAC's approach: Engaging beneficiaries		
The Congress should direct the Secretary to develop and implement a fee-for-service benefit design that would replace the current design and would include: • an out-of-pocket maximum; • deductible(s) for Part A and Part B services; • replacing coinsurance with copayments that may vary by type of service and provider; • secretarial authority to alter or eliminate cost sharing based on the evidence of the value of services, including cost sharing after the beneficiary has reached the out-of-pocket maximum; • no change in beneficiaries' aggregate cost-sharing liability; and • an additional charge on supplemental insurance.	Benefit redesign	June 2012
The Congress should modify the Part D low-income subsidy copayments for Medicare beneficiaries with incomes at or below 135 percent of poverty to encourage the use of generic drugs when available in selected therapeutic classes. The Congress should direct the Secretary to develop a copay structure, giving special consideration to eliminating the cost sharing for generic drugs. The Congress should also direct the Secretary to determine appropriate therapeutic classifications for the purposes of implementing this policy and review the therapeutic classes at least every three years.	Part D	March 2012

TABLE 1–A1

MedPAC recommendations made from 2010–2017

MedPAC recommendation	Topic	Date
MedPAC's approach: Aligning the health care workforce		
The Congress should authorize the Secretary to change Medicare's funding of graduate medical education (GME) to support the workforce skills needed in a delivery system that reduces cost growth while maintaining or improving quality. • The Secretary should establish the standards for distributing funds after consultation with representatives that include accrediting organizations, training programs, health care organizations, health care purchasers, patients, and consumers. • The standards established by the Secretary should, in particular, specify ambitious goals for practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice, including integration of community-based care with hospital care. • Performance-based GME funding under the new system should be allocated to an institution sponsoring GME programs only if that institution met the new standards established by the Secretary, and the level of funding would be tied to the institution's performance on the standards. The indirect medical education (IME) payments above the empirically justified amount should be removed from the IME adjustment and that sum would be used to fund the new performance-based GME program. To allow time for the development of standards, the new performance-based GME program should begin in three years (October 2013).	Graduate medical education	June 2010
The Secretary should annually publish a report that shows Medicare medical education payments received by each hospital and each hospital's associated costs. This report should be publicly accessible and clearly identify each hospital, the direct and indirect medical education payments received, the number of residents and other health professionals that Medicare supports, and Medicare's share of teaching costs incurred.	Graduate medical education	June 2010
The Secretary should conduct workforce analysis to determine the number of residency positions needed in the United States in total and by specialty. In addition, analysis should examine and consider the optimal level and mix of other health professionals. This work should be based on the workforce requirements of health care delivery systems that provide high-quality, high-value, and affordable care.	Graduate medical education	June 2010
The Secretary should report to the Congress on how residency programs affect the financial performance of sponsoring institutions and whether residency programs in all specialties should be supported equally.	Graduate medical education	June 2010
The Secretary should study strategies for increasing the diversity of our health professional workforce (e.g., increasing the shares from underrepresented rural, lower income, and minority communities) and report on what strategies are most effective to achieve this pipeline goal.	Graduate medical education	June 2010

Note: The list in this table is inclusive of all MedPAC recommendations from 2010 to 2017 except payment updates other than "no update."
*Recommendation first appeared in a MedPAC October 2011 comment letter.
**Recommendation first appeared in a MedPAC October 2011 comment letter.