

Report to the Congress • March 2014

The Medicare Payment Advisory Commission (MedPAC) is required by law to annually review Medicare payment policies and make recommendations to the Congress. The 2014 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 makes recommendations regarding the Medicare Advantage program (Part C), as well as reviewing the status of 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 2015 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 payment classifications.
 - 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 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.

Physicians and other health professionals.

- 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. *(First recommended in October 2011).*
- 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). *(First recommended in October 2011).*
- 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. *(First recommended in October 2011).*
- 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. (*First recommended in October 2011*).

Ambulatory surgical centers

- The Congress should eliminate the update to the payment rates for ambulatory surgical centers for calendar year 2015. The Congress should also require ambulatory surgical centers to submit cost data.
- The Congress should direct the Secretary to implement a value-based purchasing program for ambulatory surgical center services no later than 2016. (*First recommended in March 2012*).

Outpatient dialysis

- The Congress should not increase the outpatient dialysis bundled payment rate for calendar year 2015
- The Congress should instruct the Secretary to:
 - Include a measure that assesses poor outcomes related to anemia in the End-Stage Renal Disease Quality Incentive Program.
 - Re-design the low-volume adjustment to consider a low-volume facility's distance to the nearest facility; and
 - Audit dialysis facilities' cost reports.

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. 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. (*First recommended in 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 at least one period after discharge from the facility. (*First recommended in March 2012*).

Home health agencies

- The Congress should direct the Secretary to reduce payments to home health agencies with relatively high risk-adjusted rates of hospital readmission.
- 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. (*First recommended in 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. (*First recommended in 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. (*First recommended in 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. (*First recommended in March 2011*).

Inpatient rehabilitation facilities

- The Congress should eliminate the update to the Medicare payment rates for inpatient rehabilitation facilities in fiscal year 2015.

Long-term care hospitals

- The Secretary should eliminate the update to the payment rates for long-term care hospitals for fiscal year 2015.

Hospice

- The Congress should eliminate the update to the hospice payment rates for fiscal year 2015.
- 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. (*First recommended in March 2009*).

STATUS OF THE MEDICARE ADVANTAGE PROGRAM

Findings

- In 2013, MA enrollment increased by 9 percent to 14.5 million beneficiaries (or 28 percent of all Medicare beneficiaries). Enrollment in HMO plans—the largest plan type—increased 10 percent, to nearly 10 million enrollees. Local preferred provider organizations (PPOs) showed continued growth in enrollment between 2012 and 2013, with enrollment growing about 11 percent, to 3.3 million enrollees.
- In 2014, virtually all Medicare beneficiaries have access to an MA plan, and 99 percent have access to a network-based coordinated care plan, which includes HMOs and PPOs. Eighty-four 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 10 MA plan options in 2014.
- We estimate that 2014 MA benchmarks, bids, and payments (including the quality bonuses) will average 112 percent, 98 percent, and 106 percent of FFS spending, respectively.
- The star ratings the MA program uses to determine quality bonuses improved for many plans. These results reflect improvement on several types of measures, including Part D outcome measures, readmission rates, clinical process measures, and contract performance measures. However, many measures remain unchanged over the last year, such as control of blood pressure among patients with hypertension and patients' reported experiences with access to care, customer service, and care coordination.
- Among MA plans, employer group plans do not demonstrate the same bidding behavior as other MA plan types, bidding consistently higher than nonemployer plans. We believe that this difference results from the fact that employer group plans do not have to attract individual enrollees, and therefore lack incentive to submit competitive bids. In this report, the Commission makes a recommendation to change these plans' bids (and resulting payments) to be consistent with competitively set bids.
- Under current law, hospice is not included in the MA benefits package. When an MA enrollee elects hospice, the beneficiary typically remains in the MA plan, but hospice services are paid for by FFS Medicare. This carve-out of hospice from MA fragments financial responsibility and accountability for care for MA enrollees who elect hospice. In this report, the Commission makes a recommendation to include hospice in the MA benefits package.

Recommendations

- 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 non-employer group plans.
- The Congress should include the Medicare hospice benefit in the Medicare Advantage benefits package beginning 2016.

STATUS OF THE PART D PROGRAM

- In 2013, about 68 percent of Medicare beneficiaries (over 35 million beneficiaries) were enrolled in Part D plans. An additional 6 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 (about 32 percent) received the low-income subsidy (LIS).
- About 64 percent of Part D enrollees are in stand-alone prescription drug plans (PDPs); the rest are in Medicare Advantage–Prescription Drug plans (MA–PDs).
- 2014 premiums average about \$30 across all plans. The actual premium paid by individual beneficiaries depends on their selected plan and income level, as well as whether they are subject to Part D's late enrollment penalty.
- The number of plan offerings remained stable between 2013 and 2014, with a modest increase in PDP offerings and slightly fewer MA–PDs. Beneficiaries will continue to have between 28 and 39 PDPs to choose from in their region, depending on where they live, along with many MA–PDs.
- In 2013, slightly less than half of PDP enrollees were in plans with reduced or no deductible, while 98 percent of MA–PD enrollees had reduced or no deductibles. Only 7 percent of PDP enrollees (about 1.2 million beneficiaries) were in plans that offered benefits in the coverage gap beyond the 50% discount on brand name drugs and 2.5% plan responsibility required by PPACA; however, about 37 percent of PDP enrollees received Part D's LIS, effectively eliminating their coverage gap. By comparison, 50 percent of MA–PD enrollees (about 4.6 million beneficiaries) were in plans offering more extensive gap coverage.
- When a beneficiary's plan does not cover a prescribed drug or places it on a higher cost sharing tier, a beneficiary may use the plan's exceptions and appeals process to attempt to obtain the drug. While there is limited data on the effectiveness of the exceptions and appeals process in Part D, interviews with beneficiaries and counselors suggests the process is complex and burdensome for many individuals.