

Report to the Congress • March 2016

The Medicare Payment Advisory Commission (MedPAC) is required by law to annually review Medicare payment policies and make recommendations to the Congress. The 2016 report includes payment policy recommendations for nine 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

To meet its legislative mandate, the principal focus of the March report is MedPAC's recommendations for annual rate adjustments (or "updates") under Medicare's various FFS payment systems. This year's report includes recommendations in MA as well. MedPAC assesses payment adequacy by examining 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 2017 payment year are listed below.

Hospitals: Inpatient and outpatient services

- The Congress should direct the Secretary of Health and Human Services to:
 - increase inpatient and outpatient payments by the amount specified in current law,
 - reduce Medicare payment rates for 340B hospitals' separately payable 340B drugs by 10 percent of the average sales price (ASP),
 - 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.

Physicians and other health professionals.

- The Congress should increase payment rates for physician and other health professional services by the amount specified in current law for calendar year 2017.

Ambulatory surgical centers

- The Congress should eliminate the update to the payment rates for ambulatory surgical centers for calendar year 2017. The Congress should also require ambulatory surgical centers to submit cost data.

Outpatient dialysis

- The Congress should increase the outpatient dialysis base payment rate by the update specified in current law for calendar year 2017.

Skilled nursing facilities

- The Congress should eliminate the market basket update for 2017 and 2018 and direct the Secretary to revise the prospective payment system (PPS) for skilled nursing facilities.
- In 2019, the Secretary should report to the Congress on the effects of the reformed PPS and make any additional adjustments to payments needed to more closely align payments with costs.

Home health agencies

- 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.
- The Congress should direct the Secretary to revise the PPS to eliminate the use of therapy visits as a factor in payment determinations, concurrent with rebasing.

Inpatient rehabilitation facilities

- The Congress should eliminate the update to the Medicare payment rate for inpatient rehabilitation facilities in fiscal year 2017.
- The Secretary should conduct focused medical record reviews of inpatient rehabilitation facilities that have unusual patterns of case mix and coding.
- The Secretary should expand the inpatient rehabilitation facility outlier pool to redistribute payments more equitably across cases and providers.

Long-term care hospitals

- The Secretary should eliminate the update to the payment rates for long-term care hospitals for fiscal year 2017.

Hospice

- The Congress should eliminate the update to the hospice payment rates for fiscal year 2017.

STATUS OF THE MEDICARE ADVANTAGE PROGRAM

- In 2015, MA enrollment increased by 6 percent to 16.7 million beneficiaries (or 30 percent of all Medicare beneficiaries). Enrollment in HMO plans—the largest plan type—increased to 11 million enrollees.
- In 2016, 99 percent of Medicare beneficiaries have access to an MA plan, and 96 percent have access to a network-based coordinated care plan, which includes HMOs and PPOs. Eighty-one 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. The average beneficiary was able to choose from 15 MA plan options in 2016.
- In 2016, 70 percent of MA enrollees are projected to be in plans that will receive higher payments due to their quality performance. On average, quality bonuses in 2016 will add 4 percent to the base benchmarks.
- In 2016, MA benchmarks (including the quality bonuses), bids, and payments will average 107 percent, 94 percent, and 102 percent of FFS spending, respectively.
- In 2015, 185 parent organizations offered MA plans or participated in the Medicare-Medicaid demonstration project for dually eligible Medicare beneficiaries (in which the plans operate as MA plans). For the 2016 contract year, 9 new organizations are offering MA plans, and 1 organization has discontinued its MA participation, resulting in 193 parent organizations offering plans in 2016.
- In 2015, 54 percent of MA enrollment was in the four largest parent organizations; the top 10 organizations had 69 percent of enrollment. By contrast, in 2007, the four largest organizations had 45 percent of total enrollment and the top ten organizations had 61 percent of total enrollment.
- Many quality measures included in the star ratings for the MA program remained relatively unchanged, with improvement seen in measures of drug adherence and the avoidance of high-risk drugs for the elderly. For the 2016 star rating period, more MA enrollees will be in plans eligible for bonus payments: 70 percent, compared to 59 percent in 2015. However, this increase is due in part to contract consolidations whereby an organization moves enrollees in lower quality plans to a bonus-eligible plan in their contract.
- Current law contains two adjustments to the county benchmarks that create inequity among MA plans. First, certain counties are subject to benchmark caps, which constrain the annual growth rate for benchmarks and

penalize plans that exceed the cap—often through reduced quality bonuses. Second, double quality bonuses in certain counties inequitably give plans in those counties bonuses twice that of plans with identical quality performance that are in non-double-bonus counties. Therefore, the Commission recommends eliminating the benchmark caps and double quality bonuses to improve intercounty benchmark equity.

- Health risk assessments (HRAs) are a preventative care tool used to identify health risks and evaluate patients for disease or disability. The Commission believes HRAs can be a valuable tool for effectively caring for beneficiaries. However, we are concerned about the evidence that a small number of plans are using HRAs to collect diagnosis codes to increase Medicare payment without providing follow-up care. To ensure that HRAs are being used to improve care coordination and quality for the beneficiary, we recommend excluding codes that are present only in HRAs—and not in any subsequent encounter—from the model that determines plan payments. We also recommend basing the CMS–HCC model on two years of diagnostic data. This gives MA plans greater ability to document enrollees’ chronic conditions and reduces variation in Medicare FFS documentation.

RECOMMENDATIONS FOR THE MEDICARE ADVANTAGE PROGRAM

- The Congress should eliminate the cap on benchmark amounts and the doubling of the quality increases in specified counties.
- The Congress should direct the Secretary of Health and Human Services to:
 - develop a risk adjustment model that uses two years of FFS and 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 Medicare and MA plans.

STATUS OF THE PART D PROGRAM

- In 2015, about 70 percent of Medicare beneficiaries (39 million beneficiaries) were enrolled in Part D plans. An additional 4 percent received their drug coverage through employer-sponsored plans that receive Medicare’s retiree drug subsidy. Among Part D plan enrollees, 12 million individuals received the low-income subsidy (LIS).
- About 61 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 11 percent from 2015 to 2016, but beneficiaries continue to have many plan choices—between 19 and 29 PDPs to choose from in their region, depending on where they live, along with many MA–PDs.
- 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 2014, spending on the direct subsidy grew by only 1.5 percent annually, while spending on low-income cost sharing and reinsurance grew by 5.5 and 19.5 percent annually, respectively.
- In 2014, Medicare spent \$78 billion for the Part D benefit. Program expenditures increased by nearly 15 percent from the year before, with much of that increase due to spending for new hepatitis C drugs.
- Between December 2012 and December 2013, the index of Part D prices that accounts for generic substitution grew by 6.6 percent, the highest one-year growth rate observed since the program began. The 2013 increase in the average price index occurred even as the share of generic prescriptions in Part D rose from 81 percent in 2012 to 84 percent in 2013. This suggests that while generics have played an important role in constraining overall price growth, brand price growth began to have a more dominating effect.