ONLINE APPENDIXES

1

Context for Medicare payment policy

ONLINE APPENDIX 1-A

Summary of selected Commission recommendations

TABLE 1–A1

Selected MedPAC recommendations made from 2010–2016

MedPAC recommendation	Topic	Date
MedPAC's approach: Payment accuracy and encouraging efficiency		
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
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 eliminate the cap on benchmark amounts and the doubling of the quality increases in specified counties.	Medicare Advantage	March 2016
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
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

TABLE 1–A1 **Selected MedPAC recommendations made from 2010–2016 (cont.)**

MedPAC recommendation	Topic	Date
The Congress should direct the Secretary of Health and Human Services to 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.	Hospital	March 2014
The Congress should direct the Secretary to redesign the low-volume payment adjustment to consider a facility's distance to the nearest facility.	Hospital	March 2014
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
The Congress should permanently reauthorize institutional special needs plans.	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.	Risk adjustment	June 2012
After the changes in the recommendation above 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
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 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 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 Congress should direct the Secretary to identify overpriced fee-schedule services and reduce their relative value units accordingly.	Physician	October 2011
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	October 2011
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

TABLE 1–A1

Selected MedPAC recommendations made from 2010–2016 (cont.)

MedPAC recommendation	Topic	Date
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
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 include the Medicare hospice benefit in the Medicare Advantage benefits package beginning in 2016.	Medicare Advantage	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
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
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

TABLE 1–A1 **Selected MedPAC recommendations made from 2010–2016 (cont.)**

MedPAC recommendation	Topic	Date
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
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. 4), 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
The Congress should establish a per episode copay for home health episodes that are not preceded by hospitalization or post-acute care.	Post-acute care	March 2011
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
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 **Selected MedPAC recommendations made from 2010–2016 (cont.)**

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