

Report to the Congress • March 2011

As required by the Congress, each March the Medicare Payment Advisory Commission reviews Medicare payment policies and makes recommendations. The 2011 report includes payment policy recommendations for ten payment systems: hospital inpatient, hospital outpatient, physician and other health professional, ambulatory surgical center, outpatient dialysis, skilled nursing, home health, inpatient rehabilitation facility, long-term care hospital, and hospice. MedPAC also reviews the status of the Medicare Advantage (MA) plans and prescription drug plans (Part D).

FEE-FOR-SERVICE PAYMENT UPDATE RECOMMENDATIONS

The principal focus of the report is the Commission's recommendations for annual rate adjustments under Medicare's various fee-for-service payment systems. These annual changes in the rates paid to providers are often referred to as "updates." The Commission bases its update recommendation for each Medicare payment system on an assessment of payment adequacy, including beneficiary access to care (supply of providers, service use, surveys of access), quality of care, providers' access to capital, and provider costs and Medicare payments (where available).

Inpatient and outpatient hospitals

- 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.

Physicians and other health professionals

- The Congress should update payments for physician fee schedule services in 2012 by 1 percent.

Ambulatory surgical centers

- The Congress should implement a 0.5 percent increase in payment rates for ambulatory surgical center services in calendar year 2012 concurrent with requiring ambulatory surgical centers to submit cost and quality data.

Dialysis

- The Congress should update the outpatient dialysis payment rate by 1 percent for calendar year 2012.

Skilled nursing facilities

- The Congress should eliminate the update to payment rates for skilled nursing facility services for fiscal year 2012.
- The Congress should require the Secretary to revise the skilled nursing facility (SNF) prospective payment system by: adding a nontherapy ancillary (NTA) component, replacing the therapy component with one that established payment based on predicted patient care needs, and adopting an outlier policy. (*First recommended in June 2008*)
- The Congress should establish a quality incentive payment program for SNFs in Medicare. To improve quality measurement for SNFs, the Secretary should add the risk-adjusted rates of potentially avoidable rehospitalizations and community discharge to its publicly reported post-acute care quality measures. (*First recommended in March 2008*)

- The Secretary should direct SNFs to report more accurate diagnostic and service-use information by requiring that claims include detailed diagnosis information and dates of service. *(First recommended in June 2008)*

Home health

- 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.
- 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.
- 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.
- 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.
- 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. *(First recommended in March 2010)*

Inpatient rehabilitation facilities

- The Congress should eliminate the update to the payment rates for inpatient rehabilitation facilities in fiscal year 2012.

Long-term care hospitals

- The Secretary should eliminate the update to the payment rate for long-term care hospitals for rate year 2012.

Hospice

- The Congress should update the payment rates for hospice for fiscal year 2012 by 1 percent.
- 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)*

- The Secretary should direct the HHS Office of Inspector General to investigate:
 - the prevalence of financial relationships between hospices and long-term care facilities such as nursing facilities and assisted living facilities that may represent a conflict of interest and influence admissions to hospice,
 - differences in patterns of nursing home referrals to hospice,
 - the appropriateness of enrollment practices for hospices with unusual utilization patterns (e.g., high frequency of very long stays, very short stays, or enrollment of patients discharged from other hospices), and
 - the appropriateness of hospice marketing materials and other admissions practices and potential correlations between length of stay and deficiencies in marketing or admissions practices. *(First recommended in March 2009)*

STATUS OF THE MEDICARE ADVANTAGE PROGRAM

- In 2010, MA enrollment increased to 11.4 million beneficiaries (24 percent of all Medicare beneficiaries). Enrollment in HMOs, the dominant form of MA plan, grew by 7 percent. Local PPO enrollment grew by about 40 percent and enrollment in regional PPOs more than doubled between 2009 and 2010 (however, these types of plans represent only 5 percent of enrollment in MA).
- In 2011, virtually all Medicare beneficiaries have access to an MA plan and 99 percent have access to a network-based coordinated care plan (CCP). Ninety percent of beneficiaries have access to an MA plan that includes Part D drug coverage and has no premium (beyond the Medicare Part B premium). Beneficiaries can choose from an average of 12 plans, including 8 CCPs.
- In 2011, on average, Medicare will spend 10 percent more for beneficiaries enrolled in MA plans than if those beneficiaries were in fee-for-service Medicare. MA plan benchmarks were frozen in 2011.
- For 2010, quality measures have been stable with some improvement in clinical process measures over the preceding year. Measures of patient outcomes in MA are stable and not significantly changed from earlier years. There continues to be wide variation in overall quality across MA plans.

STATUS OF THE PART D PROGRAM

- In 2010, about 28 million Medicare beneficiaries (60 percent) were enrolled in Part D plans. Slightly over 30 percent of beneficiaries had other sources of drug coverage at least as generous as Part D's defined standard benefit, and 10 percent had no drug coverage or coverage less generous than Part D.
- Among those in Part D plans, about 10 million (about 36 percent of Part D enrollees) received the low-income subsidy (LIS). Roughly two-thirds of Part D enrollees are in stand-alone prescription drug plans (PDPs); the rest are in Medicare Advantage–Prescription Drug plans (MA–PDs). Most enrollees report high satisfaction with the Part D program and with their plans.
- In 2011, beneficiaries on average have from 28 to 38 PDP options to choose from, along with many MA–PDs.
- The structure of drug benefits for both PDPs and MA–PDs held fairly steady; the share of plans with no deductible remains at about 40 percent for PDPs and close to 90 percent for MA–PDs. A larger share of PDPs will provide gap coverage—33 percent compared with 20 percent in 2010—while the share of MA–PDs with gap coverage remains at about 50 percent.
- For the basic portion of the benefit, CMS estimates an actual average monthly premium of \$30, an increase by \$1 over the average in 2010.
- In 2011, 332 premium-free PDPs are available to enrollees who receive the LIS, up from 307 in 2010. CMS estimates that it will have to reassign 600,000 LIS enrollees to different plans because their previous plan's premium no longer falls below the 2011 LIS threshold, down from about 1 million LIS enrollees reassigned in 2010.