

Report to the Congress • March 2012

The Medicare Payment Advisory Commission is required to annually review Medicare payment policies and make recommendations to the Congress. The 2012 report includes payment policy recommendations for 10 of the health care provider sectors in fee-for-service Medicare. MedPAC also reviews the status of the Medicare Advantage (MA) plans and prescription drug plans (Part D) and makes recommendations as appropriate.

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 or health care provider sector "updates." The Commission bases its update recommendation for each sector 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). The Commission's recommendations for 2013 are listed below.

Inpatient and outpatient hospitals

- 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 (projected to be 2.9 percent) and the Commission's recommended update (1.0 percent) to gradually recover past overpayments due to documentation and coding changes.
- 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.
- 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.

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 is comprised of a freeze in current payment levels for primary care and, for all other services, annual payment reductions of 5.9 percent for three years, followed by a freeze. The Commission is offering a list of options for the Congress to consider if it decides to offset the cost of repealing the SGR system within the Medicare program. (*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 recommendation 2 (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).*
- 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). The Secretary should compute spending benchmarks for these ACOs using 2011 fee-schedule rates. *(First recommended in October 2011).*

Ambulatory surgical centers

- The Congress should update the payment rates for ambulatory surgical centers by 0.5 percent for calendar year 2013. 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.

Outpatient dialysis

- The Congress should update the outpatient dialysis payment rate by 1 percent for calendar year 2013.

Skilled nursing facilities

- The Congress should eliminate the market basket update for 2013.
- The Congress should direct the Secretary to revise the skilled nursing facility payment system to redistribute payments away from intensive therapy care that is unrelated to patient care needs and toward medically complex care. *(First recommended in June 2008).*
- The Congress should direct the Secretary to begin a rebasing of payments 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.
- 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.

Home health agencies

- 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 2013.

Long-term care hospitals

- The Secretary should eliminate the update to the payment rates for long-term care hospitals for fiscal year 2013.

Hospice

- The Congress should update the payment rates for hospice for fiscal year 2013 by 0.5 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 Congress should direct the Secretary to:
 - require that a hospice physician or advanced practice nurse visit the patient to determine continued eligibility prior to the 180th-day recertification and each subsequent recertification and attest that such visits took place,
 - require that certifications and recertifications include a brief narrative describing the clinical basis for the patient's prognosis, and
 - require that all stays in excess of 180 days be medically reviewed for hospices for which stays exceeding 180 days make up 40 percent or more of their total cases. (*First recommended in March 2009*).

STATUS OF THE MEDICARE ADVANTAGE PROGRAM

- In 2011, MA enrollment increased to 12.1 million beneficiaries (25 percent). Enrollment in HMOs, the dominant form of MA plan, grew by 6 percent. Local PPO enrollment increased by about 65 percent, and enrollment in regional PPOs grew by about 34 percent between 2010 and 2011.
- In 2011, virtually all Medicare beneficiaries had access to an MA plan (0.3 percent did not), and 99 percent had access to a network-based HMO or PPO. Eighty-eight percent of beneficiaries had 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 in 2012.
- In 2012, MA plan bids average 98 percent of fee-for-service (FFS) spending, showing that some managed care plans can offer the standard Medicare benefit for less than FFS costs. However, plans bidding below FFS are not available in many parts of the country.
- Despite lower plan bids and lower county-level benchmarks in 2012, Medicare will still spend 7 percent more for beneficiaries enrolled in MA plans than if those beneficiaries were in traditional Medicare. This is due in part to additional payments to plans under CMS's quality-bonus demonstration.
- In 2011, MA plans showed some improvement on quality. Plans improved on more process and outcomes measures compared to previous years, including colorectal cancer screening rates and control of blood pressure. However, quality of care continues to vary across plans.

STATUS OF THE PART D PROGRAM

- In 2011, about 29 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 11 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 2012, beneficiaries have from 25 to 36 PDP options to choose from, along with many MA plans that also offer prescription drug coverage (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 43 percent for PDPs and 91 percent for MA–PDs. A smaller share of PDPs provide gap coverage—26 percent compared with 33 percent in 2011—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 \$31.08, a slight decrease from \$32.34 in 2011.

Encouraging the use of lower cost medications by LIS beneficiaries

- In 2009, 2.4 million (8 percent) Part D enrollees had spending high enough to reach the catastrophic limit of the Part D benefit. Compared with other Part D enrollees, high-cost beneficiaries filled more prescriptions, filled more expensive prescriptions, and used more brand-name drugs. Of those high-cost enrollees, 83 percent received the LIS.
- Part D plans are limited in their ability to modify drug copayments for LIS enrollees. As a result, brand-name drug co-pays for LIS enrollees do not differ significantly from generic drug copays. As a result, LIS enrollees do not have an incentive to choose the generic drug when one is available. Some Part D plans have successfully used differences in cost sharing to encourage greater use of generic drugs among non-LIS enrollees but have been limited in their ability to do so among LIS enrollees.
- **Part D recommendation:** 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.
- To avoid negatively affecting access to brand-name medications that are in classes with generic substitutes, the Secretary should be granted broad authority and flexibility to appropriately implement the policy for substitutable drugs and to exclude certain classes of drugs where substitutions may not be clinically appropriate. In addition, current exceptions and appeals processes should remain in place to allow beneficiaries to request more preferred cost-sharing status for a drug when clinical reasons prevent them from substituting a lower cost medication.