MedPAC’s March 2015 Report
Issued to Congress

By law, the Medicare Payment Advisory Commission reports each March on the Medicare fee-for-service payment systems, the Medicare Advantage program, and the Medicare prescription drug program. MedPAC has forwarded its March report to Congress. The 2015 report includes payment policy recommendations for 10 of the health care provider sectors in fee-for-service. MedPAC also reviewed the status of Medicare Advantage plans and Medicare’s Part D. A copy of the 433 page report is available at: http://medpac.gov/documents/reports#.

COMMENT

While the information contained in the MedPAC report is extremely useful and productive, Congress has enacted many Medicare changes without fully adopting MedPAC’s recommendations. No doubt, this year’s recommendations may not be adopted either. None-the-less, a number of key elements in the MedPAC report are contained in the President’s fiscal year 2016 budget proposal. Brief discussions of features in this year’s report follow.

1. HOSPITAL INPATIENT AND OUTPATIENT SERVICES

The 4,700 hospitals paid under the Medicare prospective payment systems and the critical access hospital payment system received $167 billion for 10.1 million Medicare inpatient admissions and 196 million outpatient services in 2013. MedPAC has reiterated its Recommendation 3 contained in the March 2014 report which stated that Congress should direct the Secretary of the U.S. Department of Health & Human Services to do the following.

- Reduce or eliminate differences in payment rates between outpatient departments and physician offices for selected ambulatory payment classifications.
- Set long-term care hospital base payment rates for nonchronically critically ill cases equal to those of acute care hospitals and redistribute the savings to create additional inpatient outlier payments for CCI cases in inpatient PPS hospitals. The change should be phased in over a three-year period from 2016 to 2018.
- Increase payment rates for the acute care hospital inpatient and outpatient prospective payment systems in 2016 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.

MedPAC says that if the LTCH reform and acute care hospital CCI outlier payments were phased in over three years, roughly $700 million per year would be transferred from the LTCH payment system to the acute care payment system. Aligning certain outpatient ambulatory
payment classifications with physician office rates would reduce payments to hospitals by approximately $1.4 billion, and increasing the update of base payment rates over current law would increase payments by approximately $1.7 billion over current law. The net increase in payments to hospitals over current law would be close to $1 billion.

2. PHYSICIAN AND OTHER HEALTH PROFESSIONAL SERVICES

In 2013, Medicare paid $68.6 billion for physician and other health professional services, accounting for 16 percent of Medicare FFS spending. About 876,000 clinicians billed Medicare — 573,000 physicians and 303,000 nurse practitioners, physician assistants, therapists, chiropractors and other practitioners.

MedPAC is making the following four recommendations in this area.

1. Congress should repeal the sustainable growth rate system and replace it with a 10-year path of statutory fee schedule updates. Specifically, fees for nonprimary care services would be reduced in each of the first three years, followed by a freeze. Fees for primary care would be frozen for 10 years. The Commission is offering a list of options for Congress to consider if it decides to offset the cost of repealing the SGR system within the Medicare program.

2. 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.

3. Congress should direct the Secretary to identify overpriced fee schedule services and reduce their relative value units 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, Congress should specify that the RVU reductions achieve an annual numeric goal — for each of five consecutive years — of at least 1 percent of fee schedule spending.

4. Under the 10-year update path specified in Recommendation 1, 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. The Secretary should compute spending benchmarks for these ACOs using 2011 fee schedule rates.

3. AMBULATORY SURGICAL CENTER SERVICES

In 2013, 5,364 ASCs treated 3.4 million FFS Medicare beneficiaries, and spending on ASC services was $3.7 billion.

MedPAC recommends that Congress should eliminate the update to the payment rates for ambulatory surgical centers for calendar year 2016. Congress should also require ambulatory surgical centers to submit cost data.

MedPAC also is saying that Congress should direct the Secretary to implement a value-based purchasing program for ambulatory surgical center services no later than 2016.

4. OUTPATIENT DIALYSIS SERVICES
In 2013, about 376,000 beneficiaries with ESRD on dialysis were covered under Medicare FFS and received dialysis from about 6,000 dialysis facilities. For most facilities, 2013 was the third year that Medicare paid them using a new PPS that includes in the payment bundle certain dialysis drugs and ESRD-related clinical laboratory tests for which facilities and clinical laboratories previously received separate payments. In 2013, Medicare expenditures for outpatient dialysis services in the new payment bundle were $11 billion; a 3 percent increase compared with 2012.

MedPAC recommends that Congress eliminate the update to the outpatient dialysis payment rate for calendar year 2016. MedPAC notes that most of its indicators of payment adequacy are positive, including beneficiaries’ access to care, the supply and capacity of providers, volume of services, quality of care, and access to capital. Providers have become more efficient in the use of dialysis drugs under the new payment system. The Medicare margin was 4.3 percent in 2013 and is projected to be 2.4 percent in 2015.

5. MEDICARE’S POST-ACUTE CARE: TRENDS AND WAYS TO RATIONALIZE PAYMENTS

Post-acute care providers include skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, and long-term care hospitals. Medicare’s payments to the more than 29,000 PAC providers totaled $59 billion in 2013, more than doubling since 2001.

The Commission says it has frequently observed that Medicare’s payments for PAC are too generous and that its payment systems have shortcomings. The high level of payments results both from base rates that are generous relative to the actual cost of services and from weaknesses in the payment systems that encourage providers to increase payments by strategically conducting patient assessments, increasing the amount of therapy they provide and selecting certain types of patients over others.

Among beneficiaries enrolled in Medicare FFS and discharged from an acute care hospital in 2013, MedPAC found 42 percent went on to post-acute care: 20 percent were discharged to a SNF, 17 percent were discharged to an HHA, 4 percent were discharged to an IRF, and 1 percent were discharged to a LTCH. Medicare is the dominant payer in all but the SNF setting; it is a minority payer in SNFs because most SNFs are predominantly nursing homes providing long-term care, which Medicare does not cover.

MedPAC recommends Congress should direct HHS’ Secretary to eliminate the differences in payment rates between inpatient IRFs and SNFs for selected conditions. The reductions to IRF payments should be phased in over three years. IRFs should receive relief from regulations specifying the intensity and mix of services for site-neutral conditions.

The site-neutral policy would lower IRF base rates to the average payment per stay made to SNFs in the same geographic location for the same condition. Add-on payments IRFs receive (for having a teaching program or treating low-income patients or high-cost outlier cases) would not be changed by this policy. Over five years, the site-neutral policy would lower program spending relative to current policy by between $1 billion and $5 billion.

6. SKILLED NURSING FACILITY SERVICES

In 2013, almost 15,000 SNFs furnished 2.4 million Medicare-covered stays to
1.7 million FFS beneficiaries. Medicare FFS spending on SNF services was $28.8 billion in 2013.

MedPAC says that for 2015, estimated 2014 payments were increased by the marketbasket and offset by the productivity adjustment, reduced payments for the bad debts of dual eligible beneficiaries, and the impact of the sequester. The projected 2015 Medicare margin is 10.5 percent.

MedPAC recommends Congress should eliminate the marketbasket update and direct the Secretary to revise the PPS for SNFs for 2016. Rebasing payments should begin in 2017, with an initial reduction of 4 percent and subsequent reductions over an appropriate transition until Medicare’s payments are better aligned with providers’ costs.

7. HOME HEALTH CARE SERVICES

In 2013, about 3.5 million Medicare beneficiaries received home health care, and the program spent about $17.9 billion on such services. The number of agencies participating in Medicare reached 12,613 in 2013.

- MedPAC says Medicare margins averaged 17 percent between 2001 and 2013. These high margins likely have encouraged the entry of new HHAs; the number of new agencies in 2013 was higher than the previous year, and the total number of agencies participating in Medicare has increased by an average of about 509 agencies a year since 2003.

- MedPAC recommends the Secretary, with the Office of the Inspector General, conduct medical review activities in counties that have aberrant home health utilization. The Secretary should implement new authorities to suspend payment and the enrollment of new providers if they indicate significant fraud.

- Congress should direct the Secretary to begin a two-year rebasing of home health rates and eliminate the market-basket update. This recommendation would reduce spending for Medicare services by $250 to $750 billion in 2016 and $5 to $10 billion over five years.

- The Secretary should revise the home health case-mix system to rely on patient characteristics to set payment for therapy and non-therapy services and should no longer use the number of therapy visits as a payment factor.

- 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. A copay of $150 per episode (excluding low-use and post-hospital episodes) would reduce spending for Medicare services by $250 to $750 billion in 2016 and $1 to $5 billion over five years.

8. INPATIENT REHABILITATION FACILITY SERVICES

In 2013, Medicare spent $6.8 billion on FFS IRF care provided in about 1,160 IRFs nationwide. About 338,000 beneficiaries had more than 373,000 IRF stays. On average, Medicare FFS accounts for about 61 percent of IRFs’ discharges.

Financial performance in 2013 varied across IRFs. Medicare margins in freestanding IRFs far exceeded those of hospital-based facilities. In 2013, the aggregate margin for freestanding IRFs (which accounted for 47 percent of IRF discharges) was 24.1 percent, while hospital-based IRFs (53 percent of IRF discharges) had an aggregate margin of 0.3 percent. However, a quarter of hospital-based IRFs had Medicare margins greater than 10 percent.

continued
MedPAC recommends that Congress should eliminate the update to the Medicare payment rates for inpatient rehabilitation facilities in fiscal year 2016.

9. LONG-TERM CARE HOSPITAL SERVICES

In 2013, Medicare spent $5.5 billion on care provided in LTCHs nationwide. About 122,000 beneficiaries had roughly 138,000 LTCH stays. On average, Medicare accounts for about two-thirds of LTCHs’ discharges.

MedPAC recommends the Secretary should eliminate the update to the payment rates for long-term care hospitals for fiscal year 2016.

10. HOSPICE SERVICES

In 2013, more than 1.3 million Medicare beneficiaries (including 47 percent of decedents) received hospice services from over 3,900 providers, and Medicare hospice expenditures totaled about $15.1 billion.

MedPAC recommends the following.

1. 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, and
   • include a relatively higher payment for the costs associated with patient death at the end of the episode.

2. 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 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.

The following two sections are from the MedPAC fact sheet accompanying the report.

Status of the Medicare Advantage Program

• In 2014, MA enrollment increased by 9 percent to 16 million beneficiaries (or 30 percent of all Medicare beneficiaries). Enrollment in HMO plans — the largest plan type — increased 7 percent, to 10.4 million enrollees.

• In 2015, 99 percent of Medicare beneficiaries have access to an MA plan, and 95 percent have access to a network-based coordinated care plan, which includes HMOs and PPOs. Seventy-eight 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 nine MA plan options in 2015.

• Benchmark, bids and payments are all moving down relative to FFS Medicare — 107, 94, and 102 percent respectively in 2015 — and the level of extra benefits have remained stable, at about $75 per month.

• MA enrollees’ risk scores — the factors used to adjust plan payments
based on enrollee health status — grew faster than scores in the FFS population. The Medicare program is required to take a payment reduction of at least 5 percent to account for coding differences between MA and FFS; MedPAC finds that an adjustment of 8 percent in 2015 would more accurately account for current differences.

• Many quality measures included in the star ratings for the MA program improved, but plans’ overall average star rating remained unchanged due to higher thresholds for the 4-star level. Plans saw a decline in performance on mental health measures, which are not included in the star-rating program.

Status of the Part D Program

• In 2014, about 69 percent of Medicare beneficiaries (37 million beneficiaries) were enrolled in Part D plans. An additional 5 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 received the low-income subsidy.

• About 62 percent of Part D enrollees are in stand-alone prescription drug plans; the rest are in Medicare Advantage–Prescription Drug plans.

• The number of plan offerings declined 14 percent from 2014 to 2015, but beneficiaries continue to have many plan choices — between 24 and 33 PDPs to choose from in their region, depending on where they live, along with many MA–PDs.

• There has been consolidation in the number of companies offering Part D. In 2014, the top nine insurers (those with 1 million or more Part D enrollees each) accounted for nearly 80 percent of total enrollment. By comparison, in 2007, those same insurers accounted for 60 percent of enrollment.

• 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 2013, spending on the direct subsidy grew only 1.9 percent annually, while spending on low-income cost sharing and reinsurance grew 5.7 and 15.9 percent annually, respectively.

• More Part D plans are using differential cost sharing to encourage the use of lower cost drugs. In 2015, over 80 percent of PDP formularies have tiers for preferred and nonpreferred brands and generics.

• The increased availability of generic drugs in recent years has driven the generic dispensing rate from 61 percent in 2007 to 81 percent in 2012.

• Prices for single-source brand name drugs and specialty drugs are increasing rapidly, and are expected to drive an increasing share of spending.