MedPAC June 2013 Report to Congress: Medicare and the Health Care Delivery System

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Summaries

Chapter 1: Competitively Determined Plan Contributions

In this chapter, the Commission examined design concepts for a system of competitively determined plan contributions (CPC) in connection with possible benefit redesigns in Medicare. This CPC design approach would include a federal contribution toward the coverage of a Medicare benefit based on a competitive private insurer bidding process and differences in individual premiums dependent on the coverage options beneficiaries choose. The chapter makes clear that competing private plans do not automatically lower overall Medicare costs, which are largely dependent on the characteristics of each market, the model design and the interactions between the models, and that it is possible that the least costly option could include a piecemeal CPC bidding system or require plans to bid on an entire package. Certain design elements are illustrated through examining existing issues in treatment through Medicare Advantage and traditional fee-for-service (FFS) as alternatives.

Moreover, as a major barrier to designing a CPC system model that incorporates dual-eligible beneficiaries, the chapter cites a lack of uniformity in Medicaid benefits and cost-sharing elements among states. In addition, questions still exist about whether this population should be segmented to better accommodate the competitive bidding process.
Chapter 2: Medicare Payment Differences Across Ambulatory Settings

Medicare’s payment rate can often vary drastically for the same or similar ambulatory services depending on the setting, such as a physician’s office or an outpatient department (OPD). The commission maintains that purchasers should not pay more for a service to be performed in a particular setting; instead, Medicare payment rates should be based on the resources needed to treat the patient in the most efficient setting. As many services are migrating from physicians’ offices to usually more expensive OPD settings, it is urgent that payment variations be addressed. The shift toward OPDs is resulting in higher program spending and beneficiary cost, without significant changes in patient care. This is causing concern over the impact of these policies on hospitals that provide ambulatory services to a disproportionate share of low-income patients, who may be more likely to use an OPD as their source of care.

Chapter 3: Approaches to Bundling Payment for Post-acute Care

The administration of care for post-acute incidents can vary substantially due to the type, amount and unexpected nature of treatment service after an acute event. Fee-for-service payments foster overuse of service, as there exists little motivation for a provider to curb the total costs to treat a beneficiary following hospitalization. Under a bundled approach, one payment would cover all post-acute care settings (home health care, inpatient rehabilitation hospitals, long-term care hospitals and skilled nursing facilities). The chapter outlines how a system of well-constructed bundled payments for all settings and providers in a designated time window after a triggering event can entice providers to decrease the costs of care across settings while improving the care quality of services beneficiaries receive. Bundle design tradeoffs, such as the scope and duration of the bundle and the payment incentives, are detailed in the chapter, with Commissioners’ preference largely supportive of inclusive bundles that do not mandate strict infrastructure for making or receiving payments for other providers. Bundling could entail an initial FFS-based approach with a risk-adjusted benchmark and compare a provider’s actual spending with an average episode benchmark spending set forth by the Centers for Medicare and Medicaid Services (CMS). Commissioners convey that bundling could help facilitate continued progress toward larger delivery system reforms and increase provider experience with coordinating care across providers and settings.

Chapter 4: Refining Medicare’s Hospital Readmissions Reduction Program

Following concerns that Medicare readmission rates to hospitals have consistently been too high, Congress enacted a readmission reduction program in 2010. The program includes a penalty that reduces 2013 Medicare payments to hospitals with above-average readmission rates from July 2008 through June 2011. Since enactment there has been a slight decline in readmission rates, but as of 2011, 12.3 percent of Medicare admissions were still followed by potentially preventable readmissions. The Commission has considered four refinements to address the issues with current policy. These include a fixed target for readmission rates; the implementation of an all-condition readmission measure to increase the number of observations while reducing the random variation that single-condition readmission rates face under current policy; the implementation of an all-condition readmission measure to lower the negative correlation between mortality rates and readmission rates that exist for some conditions; and the evaluation of a hospital’s readmission rates against rates for a
group of peer hospitals with similar shares of poor Medicare beneficiaries, in order to adjust readmission penalties for socioeconomic status.

Chapter 5: Medicare Hospice Policy Issues

In March 2009, the Commission made recommendations to improve the hospice payment system, including measures to increase accountability in benefits and to enhance data collection systems. The 2008 enactment of the Affordable Care Act (ACA) gave CMS the authority to revise the payment systems for hospice care beginning in fiscal year 2014. As it stands, no regulatory action has been taken to date on payment reform. This chapter on hospice policy issues detailed recommendations for payment reform, accountability improvement and possible payment structure changes for hospice care in nursing facilities. New data cited within the chapter reveals how the labor costs of hospice visits change over the course of a typical hospice stay, giving policymakers a quintessential illustration of how a possible revised payment model could be implemented. Moreover, the chapter also gave attention to the need for medical review process and improved accountability measures for hospice facilities with high numbers of stays that exceed 180 days. An analysis of rates of live discharges and health outcomes by beneficiary and provider characteristics is provided within the chapter, in order to gain a better understanding of what happens to hospice patients after they are discharged. A specific focus of the chapter is recommendations given to profiling the appropriate candidates for hospice care at initial admission and throughout lengthy stays, in order to decrease costs and better coordinate care. The final section of the chapter addressed approaches to reducing the costs of hospice payments and possible payment restructuring for hospice care nursing facilities based on the overlap in responsibility in patient care in these two arenas.

Chapter 6: Care Needs for Dual-eligible Beneficiaries

Dual-eligible beneficiaries are enrolled in both Medicare and Medicaid benefits and operationally receive medical services through two separate systems. In 2011, approximately 19 percent of the Medicare population was dually eligible for Medicare and Medicaid. For dual-eligible beneficiaries, there exists a higher-than-average diversity of health needs, ranging from fully healthy to cognitive impairments, physical disabilities, developmental disabilities and severe mental illness. Chapter 6 relays interview data was taken from community health centers (CHCs) and federally qualified health centers (FQHCs) in five states in order to gain a better understanding of the on-the-ground, high-contact and intensive care management programs that are most needed among this subgroup. The chapter discloses the lack of care coordination and communication efforts by physicians for Medicare-Medicaid beneficiaries and the lack of knowledge of Medicare-Medicaid Coordination Plan (MMCP) care managers in social services and other resources in beneficiaries’ communities. The chapter touts federally qualified health centers and community health centers as being key resources for better coordinating care for dual-eligible beneficiaries, because they provide assorted resources such as care management services, behavior health services and primary care services, usually at the same clinic site. Suggestions for better coordination included financially aligning Medicare and Medicaid benefits and financially aligning those benefits in the context of a comprehensive primary care system.
Chapter 7: Mandated Report: Medicare Payment for Ambulance Services

Responding to a provision in the Middle Class Tax Relief and Job Creation Act of 2012, the Commission was directed to prepare a number of reports. The first analyzed the impact that add-on payments had on ambulance providers’ Medicare margins. The Commission looked at three temporary add-ons, as well as two permanent add-ons that apply if the patient is transported from a rural area.

The following is a summary of the conclusions arrived at by the Commission through their study: 1) In 2011, the three temporary add-on policies accounted for $192 million of the approximately $5.3 billion in Medicare payments, while the two permanent add-ons were responsible for an additional $220 million. 2) Medicare beneficiaries had little to no difficulty accessing ambulance services, in part due to the increased number of service providers participating in Medicare. 3) Basic life support (BLS) nonemergency services saw quicker growth than more complex transport services. 4) The add-ons currently applied to ground ambulance service are “not well targeted.”

The Commission put forth two recommendations to remedy the issues that were brought to light in their review: to have the temporary add-on payments expire and to have the Secretary take action to address the “clinically inappropriate use of certain BLS nonemergency transports,” which the Commission says is wasting money.

Chapter 8: Mandated Report: Geographic Adjustment of Payments for the Work of Physicians and Other Health Professionals

The second report mandated by the Middle Class Tax Relief and Job Creation Act of 2012 looked at whether Medicare should geographically adjust its fee schedules for physicians in different parts of the country. One form of geographic adjustment that was examined was the geographic practice cost index (GPCI) for “work effort of the physician.” This GPCI is seen by some as beneficial, in that it helps level geographic cost-of-living disparities, but is criticized by those who believe that professionals should receive equal pay for providing equal services, irrespective of location.

The Commission concluded that some sort of adjustment for geography is in fact necessary. However the current method, the GPCI, was deemed to be flawed both conceptually and in terms of implementation. Despite these flaws, the official recommendation of the Commission is for Medicare payments for “work effort of physicians” to be geographically adjusted, but also for the Secretary to begin work on developing a replacement method.

Chapter 9: Mandated Report: Improving Medicare’s Payment System for Outpatient Therapy Services

The Commission was also required to look at Medicare Part B’s coverage of outpatient therapy services (physical therapy, occupational therapy and speech-language pathology), which totaled $5.7 billion in spending for 2011. Currently, there are two spending caps placed on each beneficiary, which are designed to curb excess spending. These caps are fairly ineffective, however, because a “broad exceptions process” provides beneficiaries the ability to go over their cap with relative ease. The Commission’s three main findings are: 1) Medicare lacks clarity in defining what types of services should be applied to which patients, and with what frequency; 2) Medicare suffers from weak
physician oversight requirements; and 3) there exists great disparity between the highest- and lowest-spending areas of the country.

To reduce the frequency with which outpatient therapy services are inappropriately applied, the Commission put forth three recommendations. These recommendations would increase physician oversight and would establish a review process that would help eliminate service abuse. The report notes that their proposals would — compared to a hard spending cap — result in higher Medicare spending. They believe this to be a cost worth bearing, as hard caps could, beyond preventing abuse, limit the therapy services for a patient who medically requires a substantial quantity of services.