Medicare Payment Advisory Commission (MedPAC) – January Meeting Summary

The Medicare Payment Advisory Commission (MedPAC) is an independent Congressional agency established by the Balanced Budget Act of 1997 (P.L. 105-33) to advise the U.S. Congress on issues affecting the Medicare program. On Jan. 10-11, 2013, the commission met to finalize recommendations on select policy initiatives to be published in its March 2013 Report to Congress. The meeting was divided into 10 sessions, summarized below.

In brief, MedPAC last week voted on Medicare payment changes:
- Inpatient and outpatient hospital pay — 1 percent increase
- Physicians — SGR repeal (reiterated from 2011 recommendation)
- Long-term care hospitals — no update
- Inpatient rehabilitation — no update
- Home health providers — no update
- Outpatient dialysis — no update
- Ambulatory surgery centers — no update

I. The Medicare Advantage program: Status report; recommendations on special needs plans

Under current law, Medicare Advantage (MA) plans that address the health needs of specific populations are allowed to operate under a unique set of rules, depending on the populations served. These special needs plans (SNPs) exist in three categories: 1) institutionalized beneficiaries (I-SNPs); 2) dual eligibles (D-SNPs); and/or 3) individuals with severe or disabling chronic conditions as specified by CMS (C-SNPs).

The authorization for these SNPs can be found in the Medicare Modernization Act of 2003 (MMA), and subsequent reauthorizations. Most recently, the SNP program was extended for an additional year, until the end of 2013, by the American Taxpayer Relief Act of 2012, at a cost of $300 million.

If Congress chooses not to reauthorize SNPs, as of Jan. 1, 2015, they could operate as regular MA plans, rather than having the authority to serve special beneficiary groups. Reauthorization would increase Medicare costs because spending on beneficiaries in SNPs is generally higher than on those in traditional Medicare. This session focused on SNPs in the context of the expiring statutory authority and the recommendations the Commission has been considering.

MedPAC Recommendations

I-SNPs: Commissioners recommended permanently reauthorizing institutional SNPs (I-SNPs), which enroll beneficiaries who are in nursing homes or in the community at the institutional level of care.
**D-SNPs:** Commissioners approved a recommendation permanently authorizing “integrated” D-SNPs that assure clinical and financial responsibility for Medicare and Medicaid benefits and some Medicaid LTSS and/or behavioral health. Authority for other D-SNPs would be allowed to expire. Commissioners also approved a recommendation permanently authorizing “integrated” D-SNPs that assure clinical and financial responsibility for Medicare and Medicaid benefits and some Medicaid LTSS and/or behavioral health. Authority for other D-SNPs would be allowed to expire.

**C-SNPs:** Commissioners approved a recommendation that would place a moratorium on new C-SNPs as of Jan. 1, 2014, and allow the authority for others to expire, with some exceptions. The recommendation allows an exception for a small number of conditions, including end-stage renal disease, HIV/AIDS and chronic and disabling mental health conditions. Under the C-SNP recommendations, the Department of Health and Human Services would be directed, within three years, to permit MA plans to allow benefits to vary based on individuals’ medical needs. MA plans could then tailor benefit packages for chronic or disabling conditions.

**II. Assessing payment adequacy: hospital inpatient and outpatient services**

By law, each year the Commission is required to assess the adequacy of hospital payments and recommend payment updates for hospital inpatient and outpatient services.

MedPAC’s approach for updating payments consists of two steps: (1) assessing whether current (FY 2013) payments are adequate, based on analysis of beneficiary access to care, changes in quality of care, providers’ access to capital, and Medicare payments and providers’ costs for FY 2013; and (2) making a judgment about how much hospital payments should change in FY 2014.

Based on these assessment criteria, MedPAC voted unanimously in support of a recommendation of a 1 percent payment increase for all inpatient and outpatient hospitals in fiscal year 2014. The final recommendation would increase spending between $750 million to $2 billion over one year, and between $5 billion and $10 billion over five years.

The recommendation will be published in MedPAC’s March report to Congress.

**III. Assessing payment adequacy: physician and other health professional services**

In preparation for their March 2013 Report to Congress, MedPAC examined several factors to determine payment adequacy for Medicare’s fee-schedule payments for physicians and other health professionals. These include beneficiary access to physician and other health professional services, ambulatory care quality, private
insurer rates compared to Medicare rates, and volume growth. Their analysis also examines how costs are likely to change in 2014.

With regard to the adequacy of payments to physicians and other health professionals, MedPAC has noted that, based on responses to its annual survey, Medicare beneficiaries report that they have stable access to physician services, more so than individuals with private insurance. In addition, physicians, MedPAC found, are willing to accept new Medicare patients. While the commission detected a small growth in the overall volume of services of about 1 percent from 2010 to 2011, they found that quality of care remained stable.

The Commissioners were informed by staff of the recent health-related policies enacted as part of the American Taxpayer Relief Act of 2012, namely an extension of current payment rates, which included an override of the scheduled minus 26.5 percent adjustment to physician payments that would otherwise have occurred as required under the sustainable growth rate (SGR) formula. The 10-year budget score for the update provision was $25.2 billion. Such an override is not consistent with the Commission’s position on the SGR. MedPAC’s position is that the SGR should be fully repealed immediately, under condition that such repeal: preserves access, rebalances payments toward primary care and encourages movement toward new payment models and delivery systems; and that the cost of repeal is fully offset.

IV. Assessing payment adequacy: ambulatory surgical center services

This month’s MedPAC meeting found Commissioners finalizing a recommendation that differed from that which the panel seemingly preferred in its December meeting with regard to a payment update for ambulatory surgical centers (ASCs). During their December meeting, most Commissioners indicated support for a draft recommendation of a 0.5 percent increase in ASC payments in 2014. In 2011, ASCs received $3.4 billion, providing care to about 3.4 million beneficiaries in 5,344 ASCs.

However, in their January meeting, Commissioners unanimously voted to recommend Congress not increase payments for ASCs in 2014, at least partly due to data showing that beneficiary access to and supply of ASC services has been adequate. The Commission also recommended ASCs should submit cost data, and it said Congress should require implementation of an ASC value-based purchasing program by 2016. Once ASCs begin submitting cost data, MedPAC may re-evaluate its payment recommendations. The recommendation will be published in the Commission’s March report to Congress.

V. Assessing payment adequacy: outpatient dialysis services
At this session, the Commission examined the current aggregate outpatient dialysis payments and voted on the final recommendation. Specifically, MedPAC asks whether payments for outpatient dialysis services are adequate and how they should be updated in 2014. Commissioners examined data relating to access to care, quality of care, access to capital, and Medicare payments and costs.

Access: There were few facility closures — roughly 90 — in 2010, and few patients were affected by these closures — about 1 percent, or about 3,800 dialysis patients.

Quality: Since implementation of the new PPS, mortality hospitalization and emergency department use, while high, have remained steady.

Capacity: Regarding providers’ capacity, growth in the number of dialysis treatment stations has kept pace with the growth in the number of dialysis patients.

Medicare payments and costs: The Medicare margin for outpatient dialysis services for 2011 is estimated at 2 to 3 percent, and for 2014 is projected at 3 to 4 percent.

Most of the payment adequacy indicators are positive: providers have realized efficiencies under the modernized payment method, particularly in the use of dialysis injectable drugs, and nearly all providers (93 percent) elected to be paid under the new payment method. Thus, the final recommendation is as follows:

Final Recommendation:
Congress should not increase the outpatient dialysis bundled payment rate in 2014.

This recommendation would increase spending relative to current law by between $50 million and $250 million over one year and by less than $1 billion over five years. The Taxpayer Relief Act changed the recommendation’s budgetary implications from December to January, despite the recommendation has not changed. MedPAC does not expect any adverse impacts on beneficiaries’ access to dialysis services or providers.

The Commission unanimously voted in favor of the recommendation. It will appear in the March 2013 report to Congress.

VI. Assessing payment adequacy: home health care services

Each year MedPAC assesses the adequacy of current payments to home health agencies and makes a recommendation regarding payment updates for the next year.

Commissioners examined data on access to care (supply of providers and service utilization), quality of care, providers’ access to capital, and Medicare payments and costs.
In this session, staff reported that Medicare spent about $18 billion on home health services in 2011. The program provided about 6.9 million episodes to 3.4 million beneficiaries. In addition, in 2011, more than 700 providers entered the sector because of the low capital requirements. MedPAC staff stated that the margins for home health providers in 2011 were 14.8 percent and were projected to be 11.8 percent in 2013 due to some regulatory changes such as market basket and case mix cuts.

**Final Recommendation**

The Congress should direct the Secretary to begin a two-year rebasing of home health rates in 2013 and eliminate the market basket increase for 2014.

MedPAC believes this policy would reduce spending by $750 million to $2 billion in 2014 and $5 to $10 billion over five years.

**VII. Assessing payment adequacy: inpatient rehabilitation facility (IRF) services**

In this session, MedPAC sought to determine whether payments to IRFs are adequate and how they should be updated in 2014. To achieve this goal, Commissioners analyzed the most recent available data, specifically considering beneficiaries’ access to care (based on the supply of facilities, occupancy rates and volume of services), as well as quality of care, provider access to capital and provider payments and costs.

Staff reported that indicators of Medicare payment adequacy for IRFs were generally positive. Measures of beneficiary access suggest that capacity remains adequate to meet demand. Margins average 23 percent for freestanding facilities, which tend to have lower costs. Finally, risk-adjusted quality of care remains stable and access to credit appears adequate for both hospital-based and freestanding IRFs. Based on this information, MedPAC recommended no update for inpatient rehabilitation facilities.

**VIII. Assessing payment adequacy: long-term care hospital (LTCH) services**

During this session, MedPAC considered whether payments to long-term care hospitals (LTCHs) are adequate and how they should be updated in 2014, by reviewing information about the adequacy of current aggregate LTCH payments. In assessing the adequacy of the payments, MedPAC considered information related to beneficiaries’ access to care, the supply of LTCHs, changes in the volume of services furnished, quality of care, providers’ access to capital, and Medicare’s payments and costs.

Based on these considerations, MedPAC Commissioners unanimously agreed that providers’ access to capital is adequate and beneficiaries would not be adversely affected if the Centers for Medicare & Medicaid Services eliminated updates to payment rates in the coming fiscal year for both facility types.

If implemented, the recommendation to maintain 2013 levels would decrease spending relative to the statutory update by between $50 million and $250 million over one year and between $1 billion and $5 billion over five years.
IX. Assessing payment adequacy: hospice services

In this session, Commissioners assessed whether payments to hospice are adequate and how they should be updated in 2014. In order to determine their payment recommendation, MedPAC Commissioners specifically considered data related to beneficiary access to care (based on supply of providers and volume of services), quality of care, providers’ access to capital, and Medicare payments and providers’ costs in 2010.

Commission staff reported that less than 1.2 million Medicare beneficiaries used the hospice benefit, with spending totaling $13.8 billion. The percentage of decedent beneficiaries using the hospice benefit increased to 45 percent, up from 23 percent in 2000. The number of hospices has increased, driven specifically by growth in for-profit hospices.

In 2010, aggregate Medicare margins for hospice providers were 7.5 percent. Freestanding agencies had higher margins than provider-based agencies, for-profit providers had higher profits than nonprofits and urban providers had slightly higher margins than rural providers. Margins were higher for providers with longer-stay patients and more patients in nursing and assisted living facilities.

MedPAC staff project that margins in 2013 will be 6.3 percent, which takes into account regulatory changes including market basket adjustments, the phase-out of the wage index budget neutrality adjustment, the implementation of face-to-face visit requirements and new quality reporting requirements.

Based on these data, MedPAC recommended an elimination of the update to the payment rate for hospice for fiscal year 2014. The recommendation to maintain 2013 levels would decrease spending relative to the statutory update by between $50 million and $250 million over one year and between $1 billion and $5 billion over five years.

X. Status report on Part D, with a focus on the role of competition in Part D

Medicare’s outpatient prescription drug benefit is about to enter its eighth year of operation, proving a crucial role to seniors in subsidizing the costs of prescription drugs for Medicare beneficiaries. Enacted as part of the Medicare Modernization Act of 2003 (MMA), Part D plans had about 65 percent of beneficiaries enrolled in 2012, and an additional 9 percent had coverage through employer plans that receive Medicare’s retiree drug subsidy.

The session provided an analysis of the trends of enrollment in stand-alone and Medicare Advantage prescription drug plans participating in Part D for 2013, focusing
on beneficiaries’ access to prescription drugs, the program costs associated with the use of generic drugs and Part D prices, and the importance of Part D’s competitive design. Results of their report and analysis are found below:

**Beneficiary Satisfaction:** In its data collection for 2012, MedPAC found that in general, beneficiaries appear to have good access to prescription drugs. The number of plan offerings remained stable between 2012 and 2013, more gap coverage was being offered, and enrollment rates in both MA-PDP and stand-alone PDPs remained similar to years passed. It was found that of the 10 percent of beneficiaries not enrolled in Part D, factors such as high incomes, good health and younger age seemed to play a large part in their decision not to enroll in coverage. A new trend found and worth mentioning was the increase of PDPs using tiered pharmacy networks (approximately 12.5 percent of PDP); as it stands now, the access and cost implications to this trend have not been fully studied; however, future monitoring and analysis are pending.

**Part D Costs:** The MedPAC Part D study also found that even in 2012, low-income subsidy continues to be the single largest component of Part D spending, with spending for this subsidy growing 36 percent cumulatively between 2007 and 2012. Moreover, reinsurance continues to grow rapidly (up 14 percent in 2013) when compared to other components of the program. It should be noted, however, that the national average bid for 2013 is about the same as it was for 2012, but there are some notable changes in the expected costs of the individual components.

**Drug Prices:** Further, MedPAC points out that an increase in use of generic drugs has kept the Part D prices stable, with the overall generic dispensing rate increasing from 61 percent to 74 percent from 2007 to 2010. In general MedPAC found that with generic substitution, prices remained mostly stable; however, prices of brand-name drugs seem to be growing rapidly.

**Competitive Design:** The final component of the session focused on maintaining the beneficial and necessary components of Part D’s competitive design. Designers of the program believe this component is crucial to offering individual-need attractive coverage while controlling spending. Using CMS data on Part D’s annual open enrollment period to evaluate plan choice changes, MedPAC found that during the first six years of the program, 6 percent of enrollees switched plans each year, similar to switches observed among FEHBP participants. More recent data collected in 2010 and 2011 show that the number of participants voluntarily switching is rising. In general, most switchers were choosing plans of the same type.

Following the presentation of the report, the Commissioners provided comments on the scope and substance on the analysis of data collected by MedPAC. These findings along with the comments will be published in the March 2013 report to Congress.