BRYAN CAVE
A Broader Perspective

Alert

Life Sciences and Health Care Client Service Group

To: Our Clients and Friends March 18, 2010

MedPAC Releases its Annual Medicare Payment Policy Report to Congress

On March 15, 2011, the Medicare Payment Advisory Commission (the "Commission") issued its annual Medicare Payment Policy report (the "Report") to Congress. The focus of the Report is the Commission's recommendations for annual rate adjustments under Medicare's fee-for-service ("FFS") payment systems. The report includes payment policy recommendations for ten payment systems: inpatient hospitals, outpatient hospitals, physician and other health professional services, ambulatory surgical centers, outpatient dialysis, skilled nursing facility services, home health services, inpatient rehabilitation facility services, long-term care hospitals, and hospice. The Commission concluded that payment adequacy indicators were positive for ambulatory surgical centers, outpatient dialysis services, inpatient rehabilitation facility services, long term care hospitals, and hospice.

The Report also provides the Commission's status updates with respect to the Medicare Advantage program ("MA") and Part D. Overall, the Commission supports private plans in the Medicare system and favors the ability of beneficiaries to choose between the Medicare program and private plans. In 2010, MA enrollment topped out at 11.4 million beneficiaries, with preferred provider organizations experiencing rapid growth. The Commission predicts that in 2011, Medicare will spend 10 percent more for beneficiaries of MA plans than if those beneficiaries were enrolled in Medicare.

We are providing further summary information respecting hospital services, home health services, physician services, skilled nursing facilities, and the status of Part D.

Hospital Inpatient And Outpatient Services

The Commission reported that between 2005 and 2009 the volume of hospital outpatient services per Medicare FFS beneficiary grew by 4 percent per year, while inpatient admissions per beneficiary declined by 1 percent per year. The Report cited two reasons for improved Medicare margins in 2009. First, Medicare inpatient payments per discharge grew by 5.3 percent, which was the highest growth in payments in over a decade. Second, costs per discharge grew by only 3.0 percent, which was the lowest cost growth since 2000. Quality continues to improve, but patient safety rates and readmission

rates have not improved significantly. In 2009, the Medicare margin for the median efficient hospital was 3.0 percent. As such, the Commission has made the following recommendation:

- Congress should increase payment rates for the acute care hospital inpatient and outpatient prospective payment systems in 2012 by 1 percent.

Home Health Services

The Commission's findings with respect to home health services have led to recommendations that impact many aspects of home health reimbursement. The Commission characterized the indicators of payment adequacy for home health services as generally positive. The report noted that the number of home health agencies continues to increase, with over 650 new agencies in 2010 and a total number that exceeds 11,400. In addition, payments are exceeding costs in home health PPS. For example, Medicare margins for freestanding providers in 2009 were 17.7 percent. The report notes that such margins are related to Medicare's rates assuming more services than are actually being provided and growth in cost per episode is lower than what is assumed in the market basket. These findings, among others, have led to recommendations including:

- 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 should revise the home health case-mix system to rely on patient characteristics to set payment for therapy and non-therapy services.
- Congress should direct the Secretary to establish a per episode co-pay for home health episodes that are not preceded by hospitalization or post-acute care use.
- Congress should direct the Secretary to expeditiously modify the home health payment system to protect beneficiaries from 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.

Physician And Other Health Professional Services

In 2009, Medicare spent about $64 billion on physician and other health professional FFS services. The commission noted, among other findings, that overall service volume, including both service units and intensity, grew 3.3 percent per beneficiary. Also, Medicare's payment for physician fee-schedule services in 2009 averaged 80 percent of private insurer payments for preferred organizations. As such, the Commission concluded that most indicators of Medicare's payment adequacy for fee-schedule services are positive and stable. Therefore the Commission has made the following recommendation:

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

With respect to access to primary care, the Commission noted that access to physician and other health professional services is good nationally, but a small segment of the population continues to report problems finding a new primary care physician. Furthermore, in 2007, the hourly compensation rates for some specialties were more than double the rate for primary care. The Commission further

recommended enhancements to primary care, such as increasing Medicare payments for primary care practitioners.

Skilled Nursing Facility Services

In 2010, Medicare spent $26.4 billion on skilled nursing facility ("SNF") services. The Commission reported, among other findings, that the number of SNFs has gradually increased since 2001. Furthermore, fewer hospital admissions has led to a slight decline in days and admissions on a per FFS beneficiary basis between 2008 and 2009. Overall, the average Medicare margin for freestanding SNFs was 18.1 percent, which indicates that Medicare payments are increasing faster than provider costs. As such, the Commission's recommendations include the following:

- Congress should eliminate the update to payment rates for skilled nursing facility services for fiscal year 2012.
- Congress should require the Secretary to revise the skilled nursing facility (SNF) prospective payment system by adding a non-therapy ancillary (NTA) component, replacing the therapy component with one that established payment based on predicted patient care needs, and adopting an outlier policy.
- Congress should establish a quality incentive payment program for SNFs in Medicare.
- 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.

Status Of Part D

As of 2010, sixty percent of the 46.5 million Medicare beneficiaries were enrolled in Part D plans. Thirty-six percent of those enrolled in Part D received a low-income subsidy ("LIS"). Approximately two-thirds of all Part D enrollees are in stand-alone prescription drug plans ("PDPs"). The remaining one third are enrolled in MA-prescription drug plans ("MA-PDPs"). Most enrollees are highly satisfied with the Part D program and with their plans. For 2011, the Commission noted:

- Beneficiaries on average have from 28 to 38 PDP options to choose from, along with many MA-PDP's.
- The structure of drug benefits for both PDPs and MA-PDPs held fairly steady; the share of plans with no deductible remains at about 40 percent for PDPs and close to 90 percent for MA-PDPs.
- 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.
- Just over 330 premium-free PDPs are available to enrollees who receive the LIS, up from 307 in 2010.

How Do The Recommendations Impact Our Clients

While the Commission's findings and recommendations are not binding upon Congress, the Report will help guide forthcoming adjustments to Medicare payment systems. Such adjustments and shifts in policy will impact many health care providers and their bottom lines.

We would be pleased to discuss the potential impact of these items on your organization. Please feel free to contact any team member of the Bryan Cave Life Sciences and Health Care Client Service Group.