MEDPAC Medicare Payment Advisory Commission

FACT SHEET

Report to the Congress: Medicare and the Health Care Delivery System · June 2015

The Commission's June 2015 report examines a variety of Medicare payment system issues. In the eight chapters of this report, we consider: hospital short-stay policy issues, payment policies for Part B drugs, value-based incentives for Part B drugs, polypharmacy and opioid use, risk-sharing in Part D, synchronizing policy across Medicare's payment models, next steps in measuring quality, and the next generation of Medicare beneficiaries.

HOSPITAL SHORT-STAY POLICY ISSUES

- One-day inpatient hospital stays are relatively common in the Medicare program, accounting for over 1 million inpatient admissions (13 percent of the total) in 2012. Medicare generally pays more for short inpatient stays than similar outpatient observation stays, and those inpatient stays are highly profitable.
- The Congress mandated that the Medicare Recovery Audit Contractor (RAC) Program be implemented in 2010 to identify and correct Medicare overpayments and underpayments. RACs have targeted short inpatient stays in their audit efforts, resulting in denials of these claims on the grounds that the patient should have been treated as an outpatient. Hospitals have appealed many claims denied by RACs and have expressed concern about the cost of pursuing appeals, large backlogs in the appeals process, and limited options for rebilling denied inpatient claims as outpatient claims.
- Partly in reaction to the heightened scrutiny of short inpatient stays, hospitals have increased their use of outpatient observation status instead of admitting patients. Greater use of observation stays, in turn, has caused concern about beneficiaries' financial liability. While Medicare cost sharing for outpatient observation services is typically less than the inpatient deductible, for some beneficiaries the greater use of observation status has increased the likelihood that they will not qualify for Medicare coverage of post-acute skilled nursing facility services (which requires a preceding three-day hospital inpatient stay). Beneficiaries in observation status may also be liable for hospital charges related to prescription drugs received in the hospital and not covered under Medicare's outpatient payment system.
- The Commission has developed a set of recommendations that are designed to increase protections for beneficiaries and reduce administrative burden for hospitals while ensuring that Medicare does not overpay for hospital care.

Recommendations:

- The Secretary should:
  - direct recovery audit contractors (RACs) to focus reviews of short inpatient stays on hospitals with the highest rates of this type of stay,
  - modify each RAC's contingency fees to be based, in part, on its claim denial overturn rate,
  - ensure that the RAC look-back period is shorter than the Medicare rebilling period for short inpatient stays, and
  - withdraw the "two-midnight" rule.
- The Secretary should evaluate establishing a penalty for hospitals with excess rates of short inpatient stays to substitute, in whole or in part, for RAC review of short inpatient stays.

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- The Congress should revise the skilled nursing facility three-inpatient-day hospital eligibility requirement to allow for up to two outpatient observation days to count toward meeting the criterion.
- The Congress should require acute-care hospitals to notify beneficiaries placed in outpatient observation status that their observation status may affect their financial liability for skilled nursing facility care. The notice should be provided to patients in observation status for more than 24 hours and who are expected to need skilled nursing services. This notice should allow patients to consult with their physicians and other health care professionals before discharge planning is complete.
- The Congress should package payment for self-administered drugs provided during outpatient observation on a budget-neutral basis within the hospital outpatient prospective payment system.

PAYMENT POLICIES FOR PART B DRUGS

- Medicare Part B covers drugs that are administered by infusion or injection in physician offices and hospital outpatient departments. Medicare pays for most Part B–covered drugs based on the average sales price plus 6 percent (ASP + 6 percent). Medicare pays providers ASP + 6 percent for the drug regardless of the price a provider pays to acquire the drug. Because 6 percent of a higher priced drug generates more revenue for the provider than 6 percent of a lower priced drug, this policy may create incentives for providers to use higher priced drugs when lower priced alternatives are available.
- An alternative policy would convert part or all of the 6 percent add-on to a flat-fee add-on, meaning the add-on would not vary based on the price of the drug. A flat-fee add-on would increase payments for lower priced drugs and reduce payments for higher priced drugs compared with current policy. This might increase the likelihood that providers would choose the least expensive drug in situations where differently priced therapeutic alternatives exist. However, it may also make it difficult for providers to purchase expensive drugs if the flat-fee add-on is not large enough to capture price variation above the ASP.
- The 340B Drug Pricing Program allows some hospitals (and certain other providers) to obtain discounted prices on covered outpatient drugs from drug manufacturers. Medicare pays the same rates (ASP + 6 percent) for Part B drugs to 340B hospitals and non-340B hospitals, even though 340B hospitals purchase outpatient drugs at steep discounts. Beneficiary cost sharing is also the same in both settings.
- Although 340B prices are proprietary, we estimate that the minimum discount that 340B hospitals receive for drugs paid under the outpatient prospective payment system (OPPS) is 22.5 percent of the drugs' ASP, on average. We also estimate that in 2013, 340B hospitals for which we have data received about $3.2 billion in Medicare revenue for drugs paid under the OPPS; by our estimate, those hospitals paid at most $2.4 billion to acquire those drugs.
- Given the high level of Medicare payments relative to 340B hospitals' drug acquisition costs, policymakers might consider whether Medicare should pay less than ASP + 6 percent for Part B drugs purchased by those hospitals. Alternatively, even if Medicare's program payment does not change, beneficiaries' cost sharing for 340B drugs could be reduced.

VALUE-BASED INCENTIVES FOR PART B DRUGS

- In this chapter, we consider three policy ideas for linking Part B drug payments to clinical effectiveness evidence: least costly alternative (LCA) and functional equivalence policies, a consolidated payment code approach, and a bundled approach. The goal of linking payment to clinical effectiveness evidence is to ensure that beneficiaries and the program are purchasing the most effective, least costly drug available to treat a given condition.
- Medicare used LCA and functional equivalence policies from 1995 to 2010. Under this approach, the program pays for a group of drugs with similar health effects at the payment rate of the least costly

product in the group. A consolidated payment code approach, which Medicare used in 2007 and 2008, grouped drugs with similar health effects into a single payment code and set payment based on the volume-weighted average of the ASP for each product.

- For drugs with similar health effects, both of these policies would reduce payments for more expensive drugs and increase payments for less expensive drugs. As a result, more expensive drugs would become less profitable, while less expensive drugs would become more profitable. There are challenges to implementing both approaches. To reinstitute these policies, Medicare would need to define groups of products that treat a given condition with similar health effects and standardize units and frequency of drug administration.
- A bundled payment would cover drugs and their administration costs as well as related services (e.g., inpatient admissions, emergency department visits) across all settings and providers during a defined period under one payment (or a benchmark price across multiple providers). In this chapter, we examine designing oncology bundles because Medicare spending for oncology drugs and biologics accounted for about half of 2013 Part B drug spending in physicians' offices.

RISK-SHARING IN PART D

- Medicare Part D incorporates several risk-sharing mechanisms. Medicare pays drug plans a per member per month amount, called the direct subsidy. The direct subsidy and the beneficiary premium are intended to cover a beneficiary's monthly drug spending. Plans risk losing money if their enrollees' drug spending is higher than the combination of direct subsidy payments and enrollee premiums. CMS risk adjusts direct subsidy payments to counteract plans' incentives to avoid high-cost enrollees.
- Medicare also pays plans individual reinsurance when a beneficiary's spending exceeds the catastrophic threshold. Reinsurance payments equal 80 percent of spending above this threshold. In addition, Part D has symmetric risk corridors that limit each plan's overall losses or profits if actual spending for benefits is much higher or lower than anticipated.
- Competition has kept growth in average Part D premiums fairly low over time. Similarly, Medicare spending for direct subsidy payments, on which plans bear the most insurance risk, has grown slowly—12 percent between 2007 and 2013. However, benefit spending on which plans bear limited risk (the catastrophic portion of the benefit, where Medicare provides individual reinsurance) has grown much faster—143 percent over the same time period—suggesting that plans may be less aggressive about managing drug spending for parts of the benefit for which they bear less risk.
- In each year since Part D began, most plan sponsors have returned a portion of prospective payments back to Medicare after the end of the benefit year through the risk corridor. This pattern raises the question of why, in this competitive market, plan sponsors have consistently bid too high. In this chapter, we examine how Part D's mechanisms for sharing risk with private plans—specifically Medicare's individual reinsurance and risk corridors—may provide incentives to bid in ways that are financially advantageous but not necessarily in the best interests of the Medicare program.
- Individual reinsurance and risk corridors were included in the initial design of Part D to help ensure plan entry and formation of competitive markets. However, the current market for stand-alone drug plans appears robust, and given evidence that these risk sharing mechanisms may create a disincentive for plans to manage drug spending for high-cost enrollees, policymakers may want to consider altering them. The chapter examines several ideas, including requiring plans to cover more spending above the catastrophic cap and changing the current risk corridor structure. The Commission will continue to discuss these policies in future work.

POLYPHARMACY AND OPIOID USE

- Individuals ages 65 and older are at high risk for adverse events such as medication errors associated with polypharmacy (the use of multiple drugs) in part because there are few clinical guidelines for prescribing and managing multiple prescription drugs among this population, who are more likely to suffer from multiple chronic conditions. Medication errors are most likely to occur when a drug regimen is modified (e.g., when a patient transitions from hospital to home), when a patient does not understand drug administration instructions, and when a patient does not follow clinical advice.
- In 2012, over one-third of Part D enrollees filled at least one prescription for an opioid. Enrollees with the highest use of opioids filled an average of 23 opioid prescriptions in that year. Opioids are associated with adverse events, including accidental overdose. Individuals who use opioids also tend to use multiple drugs: In 2012, opioid users filled an average of 52 prescriptions per year, including opioids, from about 10 drug classes. Thus, the risks associated with opioid use are frequently compounded by the aforementioned risks associated with polypharmacy.
- The chapter discusses several policy ideas for addressing polypharmacy and inappropriate opioid prescribing, including some programs that have shown success in the private sector. Ideas include providing stronger incentives for plans to manage polypharmacy and inappropriate opioid prescribing, limiting the number of prescribers per patient or requiring patients to fill their prescriptions at one or two pharmacies, and developing team-based care practices that involve patients and pharmacists in designing and implementing care plans.

SYNCHRONIZING POLICY ACROSS MEDICARE'S PAYMENT MODELS

- The Commission believes that, over the long run, Medicare's payment rules and quality improvement incentives will need to be reconciled across its three payment models: traditional fee-for-service (FFS), Medicare Advantage (MA), and accountable care organizations (ACOs). In its June 2014 report, the Commission began to explore ideas for synchronizing policy across payment models with respect to spending benchmarks, quality measurement, and risk adjustment. It also presented analysis showing that the payment model that is least costly varies among markets.
- In this report, the Commission presents further evidence that no one model is the least costly in all markets. In order to maximize the value of the Medicare program for its beneficiaries and taxpayers, Medicare may need to determine how to set payment rules that reward the most efficient model of care in a market and how to encourage beneficiaries to choose that model. To that end, the chapter focuses on beneficiaries' Part B premiums. We look at three illustrative examples for calculating premiums and consider how beneficiary premiums and program payments might vary by market and model under each example:
    - a nationally set base premium that pays for FFS Medicare in every market;
    - a nationally set base premium that pays for either FFS Medicare or the reference MA plan—whichever costs less—in each market; and
    - a locally set base premium that pays for either FFS Medicare or the reference MA plan—whichever costs less—in each market.
- The first illustrative example is most similar to the current system, in which all beneficiaries pay the same Part B premium for FFS Medicare in all markets. In contrast, under the second example, the national premium would not necessarily purchase FFS in all markets. Instead, in markets where MA is less costly than FFS, the national premium would purchase MA, but beneficiaries would pay extra to enroll in FFS, and vice versa in markets where MA plans are more expensive than FFS. Under the third example, there would not be a single national premium. Rather, premiums would be calculated at the market level, meaning that higher spending markets would have higher premiums than lower spending

markets. Again, the premium would purchase whichever model is least costly in a market, and beneficiaries would pay extra to enroll in the more costly model.

NEXT STEPS IN MEASURING QUALITY

- The Commission is concerned that Medicare's current quality measurement programs, particularly in FFS Medicare, rely primarily on clinical process measures for assessing quality. These are often not well correlated to better health outcomes. Additionally, the Commission believes there are too many measures, which—coupled with the diversity of measures required by private payers—places a heavy reporting burden on providers. In its June 2014 report to Congress, the Commission put forth a concept for an alternative quality measurement system that would rely on a small set of population-based outcome measures that could be measured across Medicare's three payment models.
- In this report, we examine a "healthy days at home" quality measurement concept that may have potential as a population-based outcome measure. The intent of a "healthy days at home" (HDAH) measure is to capture the number of days within a set period that a beneficiary is alive and does not have interactions with the health care system that imply poor health.
- Our initial analysis of HDAH using Medicare claims data suggests that such a concept may be a meaningful and understandable way to compare differences in relative health status across populations. Our preliminary analysis found that the measure's ability to detect differences between populations is magnified when it is focused on beneficiaries who are diagnosed with one or more chronic conditions. However, differences in post-acute care (PAC) use appear to drive HDAH variation across geographic regions, suggesting that the measure may be in part detecting geographic variation in practice patterns rather than differences in beneficiary health status. More research is needed before reaching a conclusion about the utility of this measure.

THE NEXT GENERATION OF MEDICARE BENEFICIARIES

- The Medicare population is projected to increase from 54 million beneficiaries today to over 80 million beneficiaries by 2030 as the baby-boom generation ages into Medicare. The average age of the Medicare population will initially skew younger than in the recent past, but will then rapidly increase. Members of the baby-boom generation have longer life expectancies, smoke at lower rates, and have higher rates of chronic conditions such as obesity and diabetes; however, they are more likely to have certain health conditions under control.
- Baby boomers will also bring a different health insurance experience to the program. Although the oldest boomers may have had plans that paid for any provider, many baby boomers have likely experienced the rise and decline of managed care. Younger boomers may have begun to experience narrow-network plans and high-deductible plans. In addition, it is likely that in the future, fewer Medicare beneficiaries will have generous employer-sponsored supplemental health insurance.
- The recent recession has had an impact on the baby-boom generation. Median family income, median family net worth, and the median value of financial assets have not recovered to their prerecession levels. Some baby boomers may have difficulty recouping their losses before entering retirement. That could leave the next generation of Medicare beneficiaries in a more vulnerable economic state than the current Medicare population.
- The aging of the baby-boom population could also stress the economic well-being of the working-age population. The number of taxpaying workers per Medicare beneficiary has declined from 4.6 in the early years of the program to 3.1 today; by 2030, the Medicare trustees project this number will be 2.3.