AAO-HNS Summary of December 2014 Medpac

1) ASSESSING PAYMENT ADEQUACY AND UPDATING PAYMENTS: PHYSICIAN AND OTHER HEALTH PROFESSIONAL SERVICES

The Commission listened to a presentation including several statistics that reflect payment adequacy across different demographics and settings. For instance, based on the commission's yearly telephone survey and yearly focus groups of beneficiaries and providers along with site visits, the commission found that roughly 80% of patients were somewhat satisfied or more with Medicare and Private Insurance Company plans and that most patients did not have trouble finding a new primary care doctor or specialist. Further, the Commission found that provider participation in Medicare was stable and opt-out rates were low and that the ratio of Medicare payment rates to PPO rates was roughly 79%. There were small volume decreases for imaging and tests but the commission indicated these were largely accounted for by decreases in cardiac imaging and appropriateness campaigns such as Choosing Wisely.

There were a few trends that were of concern to the commission. These included shifts towards billing some services in hospitals instead of offices which is increasing program spending and beneficiary out of pocket costs and shifts in cardiac imaging billing from office environment to the outpatient setting.

The Commission noted that volume increases have raised spending more than increases in input prices or the updates (e.g. spending has increased normally at the rate of population growth). Payment adjustments such as fee schedule updates, incentive payments and penalties, and other types (e.g. CMMI demos) have effectively increased payments by more than updates to the conversion factors.

The overall assessment for payment adequacy reflects that it has not changed. Despite that fact, the presentation recommended a few factors to address such as disparities in compensation and repeal of the sustainable growth rate (SGR) formula. If a repeal of SGR is not possible in the near future, the Commission recommended further investigation into potential changes to the SGR formula.

An assessment of the per beneficiary payments for primary care physicians reflects that primary care doctors are undervalued in the fee schedule. One recommendation the presenter made to offset this difference is to enhance per beneficiary payment to replace the expiring (2015) primary care bonus. This payment would not be contingent on practice requirements and would be payable for beneficiaries prospectively attributed to practitioners.

As a conclusion, the presenter summarized that payments were adequate but recommended repeal of the SGR and supported a per beneficiary payment for primary care providers.

Chairman's Draft Recommendation

Congress should direct the Secretary of HHS to:

1. **Establish a prospective per beneficiary payment to replace Primary Care Incentive Payment program (PCIP) after it expires at the end of 2015. Funding should come from reduced fees for all services in the fee schedule other than eligible primary care services.**

Rationale: Need to increase payment of primary care providers and eliminate inaccuracy in fee schedule
Implications: As a budget neutral policy, the per beneficiary payment would not affect federal spending relative to current law. The payment would continue additional financial support for primary care practitioners by redistributing fee schedule payments from specialty care to primary care. Providers could use the payment to improve care delivery, care coordination, and access to primary care services.
Presentation: Found Here

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2) MEDICARE ADVANTAGE PROGRAM: STATUS REPORT

The Commission additionally discussed the current status of the Medicare Advantage Program, assessing enrollment, availability, benchmarks, bids, payment and risk coding intensity. Further they reviewed plan quality performance.

Overall Medicare Advantage enrollment has steadily increased since 2006 with growing percentages in most categories of enrollees including HMOs, Local PPOs and Regional PPOs. Enrollment only decreased in the category private fee for service plans (PFFS).

According to MedPAC analysis of coding risk, the commission found that MA' enrollees had higher coding risk and that coding had a higher intensity than fee for service (FFS) payments. The commission also indicated there were uncorrected coding differences in MA and resultantly MA payments are 105% of FFS in 2015. MedPAC reviewed Medicare Advantage's star system that rates different plans available. The commission recommended that the system was an accurate rater of plans that should continue to emphasize outcomes but that discerning improvement was difficult due to several shifts in thresholds and enrollment among plans. MA organizations have been moving plan enrollees from plans that are not eligible for bonus payments to those that are eligible for bonus payments under the star rating system. In 2015, MA insurers will move nearly 400,000 beneficiaries from ineligible plans to plans eligible for bonus payments.

The commission briefly assessed the Medicare.gov plan finder and recommended that the website should provide clearer information about plan premiums. Currently, the site does not state a beneficiary's total premium obligation when a plan includes a reduction in the part B premium as an extra benefit. Beneficiaries must be able to consider premiums as well as other out of pocket costs when assessing different types of plans. As such, the Commission's recommendation was to improve Medicare Plan Finder to provide clearer information about total expected cost sharing and total monthly premium.

The presentation can be found here.