SAVINGS: MEDICARE PROVIDER PAYMENT MODIFICATIONS

Department of Health and Human Services

The Budget contains several proposals that build on initiatives of the Affordable Care Act to help extend Medicare's solvency while encouraging provider efficiencies and improved patient care. Specifically, the Budget modifies payments to certain hospitals, post-acute care, and other providers, to address payments that exceed patient care costs. It also reduces Medicare's payments to providers for beneficiaries' non-payment of their deductibles and copayments. The Budget also aligns Medicare drug payment policies with Medicaid policies for low-income beneficiaries.

Funding Summary
(In millions of dollars)

.	2013	2014	2015	2016	2017	2013-2017	2013-2022
Medicare Baseline Outlays	528,188	564,132	586,426	639,655	659,719	2,978,120	7,064,937
Proposed changes from current law, Total	-5,026	-13,466	-16,878	-20,103	-23,727	-79,200	-267,473
Reduce Medicare coverage of patients' bad debts	-770	-1,900	-2,950	-3,490	-3,730	-12,840	-35,880
Better align Graduate Medical Education payments with patient care costs	0	-830	-940	-970	-1,010	-3,750	-9,690
Reduce Critical Access Hospital payments from 101% of reasonable costs to 100% of reasonable costs	-70	-120	-120	-130	-130	-570	-1,420
Prohibit Critical Access Hospital designation for facilities that are less than 10 miles from the nearest hospital	0	-40	-60	-60	-60	-220	-590
Adjust payment updates for certain post-acute care providers	-30	-840	-1,920	-3,150	-4,420	-10,360	-56,670
Equalize payments for certain conditions commonly treated in Inpatient Rehabilitation Facilities and Skilled Nursing Facilities	-140	-170	-170	-180	-190	-850	-2,010
Encourage appropriate use of Inpatient Rehabilitation Facilities	-180	-210	-210	-220	-230	-1,050	-2,300
Adjust Skilled Nursing Facility payments to reduce hospital readmissions	0	0	0	-210	-250	-460	-1,950
Align Medicare drug payment policies with Medicaid policies for low-income beneficiaries	-3,796	-9,296	-10,438	-11,613	-13,627	-48,770	-155,553
Dedicate penalties for failure to use Electronic Health Records toward deficit reduction	0	0	0	0	0	0	-590
Update Medicare payments to more appropriately account for utilization of advanced imaging	-40	-60	-70	-80	-80	-330	-820

Note: The savings estimates for these proposals may not include all interactions.

Justification

Reduce Medicare coverage of patients' bad debts. For most eligible provider types, Medicare generally reimburses 70 percent of bad debts resulting from beneficiaries' non-payment of deductibles and copayments after providers have made reasonable efforts to collect the unpaid amounts. This proposal would align Medicare policy more closely with private sector standards by reducing bad debt payments to 25 percent for all eligible providers over three years starting in 2013. The National Commission on Fiscal Responsibility and Reform (Fiscal Commission) recommended a similar proposal.

Better Align Graduate Medical Education payments with patient care costs. Medicare compensates teaching hospitals for the indirect costs stemming from inefficiencies created from residents "learning by doing." MedPAC determined that these Indirect Medical Education (IME) add-on payments are significantly greater than the additional patient care costs that teaching hospitals experience[1]. This proposal would reduce the IME adjustment by 10 percent beginning in 2014. The Fiscal Commission included a similar recommendation.

Reduce Critical Access Hospital (CAH) payments from 101 percent of reasonable costs to 100 percent of reasonable costs. Medicare makes a number of special payments to account for the unique challenges of delivering medical care to beneficiaries in rural areas. These payments continue to be important; however, in specific cases, the adjustments may be greater than necessary to ensure continued access to care. This proposal would improve payment accuracy for CAHs, beginning in 2013.

Prohibit Critical Access Hospital designation for facilities that are less than 10 miles from the nearest hospital. This proposal would ensure this unique payment system is better targeted to hospitals meeting the eligibility criteria, beginning in 2014.

Revision of Skilled Nursing Facility, Home Health, Long-Term Care Hospital, and Inpatient Rehabilitation Facility market basket updates. MedPAC analysis indicates that Medicare payment significantly exceeds the cost of patient care in post-acute care settings, resulting in high Medicare margins. This proposal would gradually realign payments with costs and encourage efficient care delivery through adjustments to payment rate updates for these providers. These adjustments build on recommendations from MedPAC's March 2011 Report to the Congress, in which they recommended that the Congress eliminate payment updates for each of these provider types in 2012.[2]

Equalize payments for certain conditions commonly treated in Inpatient Rehabilitation Facilities (IRFs) and Skilled Nursing Facilities (SNF). The Budget proposes to reduce the differences between IRFs and SNFs in payment for treatment of specified conditions commonly treated in both settings. Care for hip and knee replacements, hip fractures, and certain pulmonary diseases are currently provided in both IRFs and SNFs, but Medicare payments are significantly greater when treated in IRFs. This proposal would reduce IRF payments for selected conditions, beginning in 2013, to better equalize incentives and encourage provision of care in the most clinically appropriate setting.

Encourage appropriate use of inpatient rehabilitation facilities (IRFs). Medicare pays IRFs at a rate that reflects specialized rehabilitation care to patients with the most intensive needs. IRFs must demonstrate this by meeting a compliance threshold which specifies a minimum percentage of patients with designated medical conditions that require intensive rehabilitation services. Starting in 1984, this compliance threshold was set at 75 percent, but it was reduced to 60 percent in 2007. This proposal would return the compliance threshold to its previous 75 percent level beginning in 2013 to better ensure that the higher IRF payments apply to cases requiring this level of care.

Adjust skilled nursing facility (SNF) payments to reduce hospital readmissions. MedPAC analysis shows that nearly 14 percent of Medicare patients that are discharged from a hospital to a SNF are readmitted to the hospital for conditions that could have been avoided.[3] To promote high quality care in SNFs, this proposal reduces SNF payments by up to three percent beginning in 2016 for facilities with high rates of care-sensitive, preventable hospital readmissions.

Align Medicare drug payment policies with Medicaid policies for low-income beneficiaries. Under current law, drug manufacturers are required to pay specified rebates for drugs dispensed to Medicaid beneficiaries. In contrast, Medicare Part D plan sponsors negotiate with manufacturers to obtain plan-specific rebates at unspecified levels. The Department of Health and Human Services Office of Inspector General has found substantial differences in rebate amounts and net prices paid for brand name drugs under the two programs, with Medicare receiving significantly lower rebates and paying higher prices than Medicaid.[4] Moreover, Medicare per capita spending in Part D is growing significantly faster than that in Parts A or B under current law. This proposal would allow Medicare to benefit from the same rebates that Medicaid receives for brand name and generic drugs provided to beneficiaries who receive the Part D Low-Income Subsidy beginning 2013. Manufacturers previously paid Medicaid rebates for drugs provided to the dual eligible population prior to the establishment of Medicare Part D. The Fiscal Commission recommended a similar proposal to apply Medicaid rebates to dual eligibles for outpatient drugs covered under Part D.

Dedicate penalties for failure to use electronic health records (EHRs) toward deficit reduction. Current law offers incentive payments to hospitals and physicians who become meaningful users of electronic health records. Beginning in 2015, Medicare providers that fail to become meaningful users are subject to a penalty, and the penalty is credited to a special account beginning in 2020. This proposal would instead dedicate these penalties to deficit reduction.

Update Medicare payments to more appropriately account for utilization of advanced imaging. Medicare spending for imaging services paid for under the physician fee schedule has grown dramatically over the last decade due to an increase in the number and intensity of these services, though this growth has mediated somewhat in recent years. MedPAC has stated that this volume growth may signal that these

services are mispriced and has supported Medicare payment changes for expensive imaging equipment.[5] Beginning in 2013, this Budget proposes a payment adjustment for advanced imaging equipment to account for higher levels of utilization of certain types of equipment.

Citations

[1] Medicare Payment Advisory Commission, *Aligning Incentives in Medicare*, Report to Congress, June 2010.

[2] Medicare Payment Advisory Commission, *Medicare Payment Policy*, Report to Congress, March 2011.

[3] Medicare Payment Advisory Commission, *Medicare Payment Policy*, Report to Congress, March 2011.

[4] HHS Office of Inspector General, *Higher Rebates for Brand-Name Drugs Result in Lower Costs for Medicaid Compared to Medicare Part D,* August 2011.

[5] Medicare Payment Advisory Commission, *Medicare Payment Policy,* Report to Congress, March 2009.