MEDPAC REPORT TO CONGRESS 2015: OOPS, THEY DID IT AGAIN

On March 13, 2015, the Medicare Payment Advisory Commission ("MedPAC") released its annual report to Congress ("Report"). The Report contains MedPAC's recommendation for improvements to Medicare payments to providers as well as recommendations on controls to help combat fraud and waste. As usual, MedPAC has concerns about home health and hospice and makes a number of recommendations as to how Congress could improve the payment for both types of services.

I. MANAGING POST-ACUTE CARE

Before getting into the details of hospice or home health recommendations within the Report, it is important to note MedPAC's discussion of the need to better manage post-acute care. This discussion broadens opportunity for acute care providers and some post-acute providers but also may concern other post-acute providers who are not currently working with an acute care provider. MedPAC's primary concern is the ACO model and other new payment models being explored by CMS, which place acute care providers at financial risk for the cost (and quality) of care provided to Medicare beneficiaries. At the same time, Medicare's rules on beneficiary choice give the acute-care providers little control over the post-acute care their patients receive, because the patient, not the acute-care provider, chooses the post-acute provider. MedPAC first noted this concern last fall. At that time, MedPAC acknowledged that more direct patient steering might be necessary in order to allow the acute care providers to avoid being penalized for failing to meet goals because of the patient's choice of a "low value" post-acute care provider.

In the Report, MedPAC sets out this concern in detail and suggests a number of strategies that might address this issue. MedPAC suggests that beneficiary choice may need to be curtailed in order to allow acute care providers to achieve their objectives. MedPAC notes that soft steering already occurs in acute care, but it recognizes the acute care provider's concerns regarding what they can and cannot say when engaging in soft steering. MedPAC recommends a "refined referral process" in which acute care providers would provide more information about post-acute providers to assist beneficiaries with selecting high quality post-acute providers.

MedPAC also discusses the possibility that CMS would consider policies to more tightly link acute and post-acute providers. For example, MedPAC suggests that CMS consider allowing ACOs to establish formal networks to direct beneficiaries to "high-value" post-acute providers. MedPAC also suggests that CMS consider more formally allowing Hospitals to partner with high-value post-acute providers. MedPAC states in this discussion that "many issues would have to be resolved to ensure hospitals acted responsibly." This implies MedPAC approves of acute-care providers being allowed to actively steer patients to specific post-acute providers, but that it would suggest limitations be placed on when and how such steering could occur. Finally, MedPAC adds that some form of beneficiary cost sharing might also be a tool to encourage beneficiaries to select high-value post-acute providers.

This discussion of beneficiary choice and the need to better direct patients bears good news for hospitals and health systems and their post-acute partners, and potentially problematic news for other homecare and post-acute providers who are not involved in a partnership with acute-care providers. Although this may seem relevantly inconsequential given the effectiveness of current soft steering by acute care providers, if MedPAC and Congress move in this direction, it will be even more important for home care providers to identify and partner with an acute care partner. As health care reform continues, Medicare and MedPAC continue to drive tighter integration along the continuum as a means to improve outcomes, control costs, etc. This trend will make it more and more important for home care providers to identify acute care partners with whom they can work. Providers who wait may find that there are no partners left, which will make it difficult for these providers to survive.

II. HOME HEALTH RECOMMENDATIONS

The Report makes no new recommendations regarding home health but simply adopts MedPAC's recommendations from prior years. Before restating its previous recommendations, MedPAC reviews a number of statistics on the utilization of home health. MedPAC focuses on the growth in home care spending over the long term, with growth of 87 percent from 2002 to 2013. It is unfortunate that MedPAC focuses on this figure because the Report makes it clear that the short-term trend is much different. The Report notes that Medicare home health spending has actually decreased in recent years, declining by 3 percent from 2010 to 2013. Only DME spending declined more in that period. This shows the cuts are working because even as the Medicare beneficiary population grows, home health spending is on the decline.

This makes MedPAC's decision to readopt certain previous recommendations even more concerning.

A. REBASING HOME HEALTH (AGAIN)

MedPAC restates its recommendation that Congress direct Medicare to rebase (or reduce) home health payments. This is somewhat surprising because CMS rebased home health payments several years ago as required by PPACA and implemented an ongoing rebasing reduction at the maximum amount allowed under PPACA. MedPAC believes that the rebasing did not properly align payments to costs. MedPAC has concluded that HHAs run a 10 percent or more profit margin and that, ultimately, rebasing only reduced this by 2 percent. For this reason, MedPAC concludes that further rebasing is needed to properly align home health costs with home health reimbursement.

B. HOME HEALTH COPAYS

MedPAC again recommends a home health co-pay for episodes that are not preceded by a hospitalization or post-acute care use. MedPAC has concluded that the lack of cost sharing by Medicare beneficiaries leads to overutilization of home health, especially in regards to home health episodes that do not follow a hospitalization or post-acute care use. Unfortunately, MedPAC does not consider that imposing a copay on Medicare beneficiaries will lead some patients to avoid seeking services. This re-recommendation is more concerning than usual as it comes in the midst of negotiations on Capitol Hill regarding paying for the SGR replacement. One of the pay-fors that has been rumored to be under discussion are home health copays. At the time of publication, it appears that copays are no longer under consideration as a pay-for to offset the SGR, but MedPAC's continued interest in them means providers should remain vigilant as copays are likely to continue as an item under consideration.

C. INCORPORATING THERAPY INTO THE CASE MIX

MedPAC also reiterates its previous recommendation that Congress revise the home health payment system so that therapy is accounted for not by the number of therapy visits provided but through the case mix. MedPAC has long felt that basing therapy on the number of visits creates the wrong incentives for the industry and leads to overutilization of therapy. MedPAC states that incorporating therapy into the case mix system would eliminate these incentives and lead to proper utilization of therapy. This is a concern because, as CMS has noted, incorporating therapy into the case mix appropriately will be difficult to do in a way that accurately reflects resource utilization. Furthermore, alterations to the case mix system can lead to reductions in reimbursement, even when being described as neutral adjustments. This is a reiteration of a prior recommendation, but the industry will want to continue to watch how this develops, because paying for therapy through case mix could result in further, significant, reductions in home health reimbursement.

III. HOSPICE

MedPAC takes the same approach with hospice as it does home health – largely readopting prior recommendations. MedPAC starts with a discussion of hospice and growth in spending. MedPAC is concerned that the growth in hospice spending appears to correlate to the growth in for-profit providers. This suspicion of for-profit providers is not new, but it serves as a reminder that as hospice spending grows and as the number of for-profit hospice providers grow, hospice scrutiny will also continue to grow. MedPAC is also concerned about the continued growth in non-cancer diagnoses in hospice. MedPAC notes that in 2013, 68 percent of hospice patients were for non-cancer diagnoses. Similarly, MedPAC commented positively on CMS's recent elimination of certain non-cancer diagnoses from hospice. This is a reminder to hospice providers to be aware of the diagnoses of their patient census.

A. UPDATE HOSPICE PAYMENT RATES

The Report contains one new recommendation. MedPAC recommends that Congress eliminate the update to the hospice payment rate for fiscal year 2016. MedPAC projects that hospice will receive a net update of 2.1-2.4 percent on payments in 2016. MedPAC recommends eliminating the update because hospice is already paid sufficiently and eliminating the update will decrease federal program spending between $250,000,000-$750,000,000.

B. PAYMENT REFORM

MedPAC reiterates its recommendation that the hospice payment methodology be reformed. MedPAC encourages Congress to move forward with efforts to move away from the flat per diem that is currently utilized to a methodology that would more closely link the costs at the start of care and end of care to the amounts paid. They feel that this would better correlate to the actual resource utilization in hospice care. CMS is of course studying the issue and is continuing to gather data and has indicated they will be moving forward with some sort of revamp of the payment. It is not clear yet how CMS's retooling hospice reimbursement will look in comparison to what MedPAC and others are proposing.

C. FOCUSED MEDICAL REVIEW

MedPAC also reiterates its recommendation from March 2009 regarding face-to-face and focused medical review. MedPAC acknowledges that most of this recommendation has been implemented but notes that its recommendation regarding focused medical review needed repeating as it has yet to be implemented. The focused medical review MedPAC's recommendation will require, for hospices that have more than 40 percent of their cases remaining on hospice more than 180 days, that all of those stays over 180 days be medically reviewed. MedPAC has concluded that a focused medical review for hospices with unusually high rates of long stay patients provides a greater oversight of the hospice benefit and targets oversight scrutiny against the most questionable providers. MedPAC believes this will provide the most efficient use of resources to oversee the benefit.

CONCLUSION

As in previous years, the Report is mostly bad news for home care providers, although this bad news is mostly in the form of reiterating previous recommendations. However, there are a few new wrinkles that should raise concerns for home health and hospice providers as we move forward.

If you have any questions regarding the Notice, please contact Robert Markette at (317) 977-1454 or rmarkette@hallrender.com, Allison Taylor at (317) 977-1421 or ataylor@hallrender.com or your regular Hall Render attorney.