MEDPAC: Medicare Payment Advisory Commission

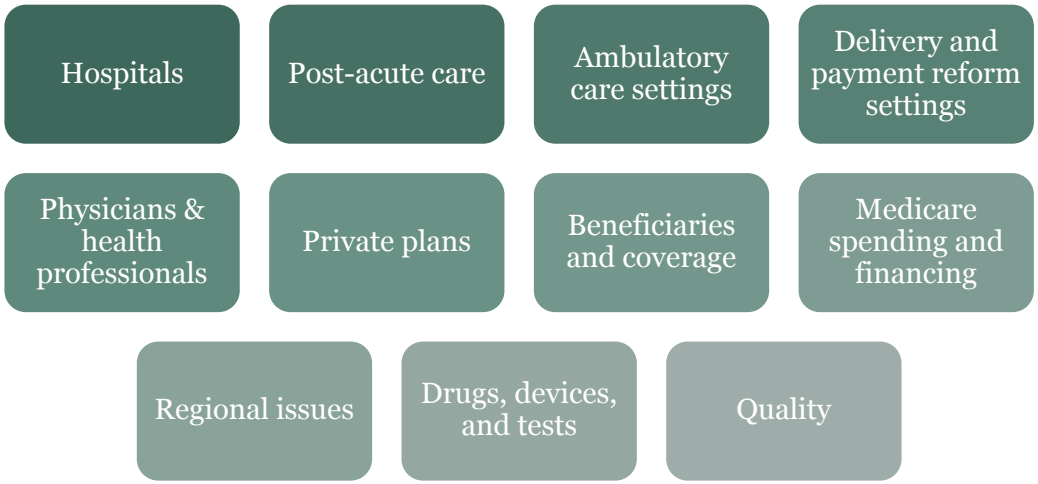
October 5, 2018

MedPAC develops recommendations for Congress on Medicare payments

Overview of MedPAC

- The Medicare Payment Advisory Commission (MedPAC) is an independent congressional agency
- The commission was created by the Balanced Budget Act of 1997, with the goal of advising Congress on the Medicare program
- They have the authority to develop recommendations on payment once a year – as well as a more analytical report to Congress once a year
- MedPAC is also tasked with analyzing access to care, quality of care and other issues affecting Medicare

Research areas of MedPAC:



Examples of MedPAC reports:

- Report to the Congress: Medicare and the Health Care Delivery System, *June 2018*
- Moving Beyond The Merit-based Incentive Payment System, *March 2018*
- Physician And Other Health Professional Services, *March 2017*

Sources: MEDPAC, 2018.

Individuals must meet strict criteria to qualify for Medicare's home health program

Medicare Home Health

Individuals with Original Medicare can use home health benefits if:

1. They are **under the care of a doctor** and are getting services under a plan of care established and reviewed regularly by a doctor
2. A **doctor certifies** that they need one or more of these:
   - Intermittent skilled nursing care
   - Physical therapy
   - Speech-language pathology services
   - Continued occupational therapy
3. The home health agency caring for them is **Medicare certified**
4. A doctor certifies that they are **homebound**
5. A doctor or a professional who works with a doctor (e.g. a nurse practitioner) has documented **meeting with the individual face-to-face** within required timeframes

An individual who requires more than **"intermittent health care"** is not eligible for Medicare home health

- Intermittent is defined by CMS as fewer than 7 days each week and less than 8 hours each day for up to 21 days

Medicare home health care covers the following:

- Skilled nursing care by a registered nurse or a licensed practical nurse
- Physical therapy, occupational therapy and speech-language pathology services
- Part-time or intermittent home health aide services (e.g. personal care)
- Medical social services
- Medical supplies
  - Medicare pays separately for durable medical equipment (DME) such as wheelchairs
  - DME must meet certain criteria and must be ordered by a doctor

Medicare Parts A, B and C require extensive doctor certifications to prove that an individual requires home health services

Sources: "Medicare & Home Health Care," CMS, 2017

Individuals with ALS can face more obstacles when receiving home health care benefits

Home health benefits & individuals with ALS

Patients often **lack understanding of the qualifications required** for coverage and benefits from HHAs

- For example, an individual's condition improving is not a requirement to qualify for coverage

Individuals **sometimes lack knowledge of or an advocate for appeals** and guidance in navigating the health care systems

Some patients who require personal care or behavioral/ social support **may not meet the requirements** for Medicare's home health benefits

- This can have a **huge impact on caregivers**, who may be forced to give more complicated care, such as tracheostomy and feeding tube care

Physicians and other providers **do not always understand & submit the required documentation** to support the initial medical necessity of services required

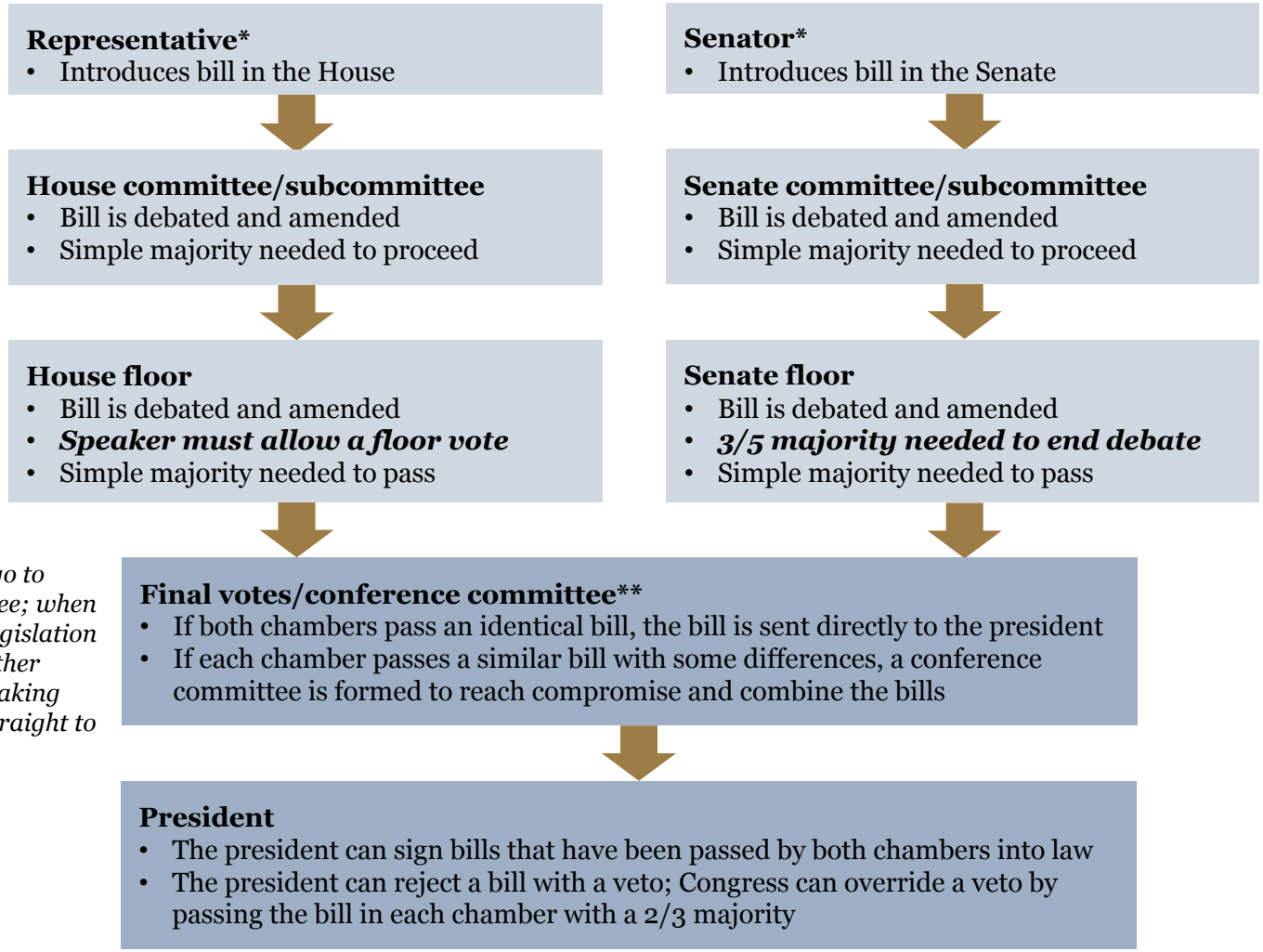
- These can include the homebound or the face-to-face requirement

Out-of-pocket costs to families can result in significant and **overwhelming financial burdens**

Sources: VHA Office of Community Care, U.S. Department of Veterans Affairs; "VA to Pay Non-Contract Providers Using Medicare Payment Models," NAHC, October 29, 2014.

Legislative process: how a bill becomes a law

**Legislation may be introduced in either chamber, except for tax law (must originate in the House)*



***Most major bills go to conference committee; when a chamber passes legislation originating in the other chamber without making changes, bill goes straight to Pres.*

Sources: National Journal research, 2018.

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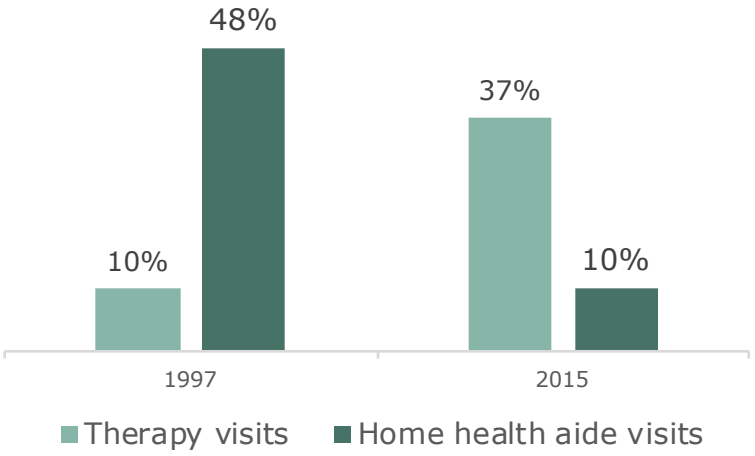
CMS proposes a new payment model for Medicare home health services

- The CMS proposal would change the payment from being based on the number of visits for various forms of therapy to being based on patient characteristics
- CMS projects that under the proposed policies, Medicare spending to home health providers would be reduced by about $80 million
- Opponents of the this proposal say that the new payment model incentivizes home health providers to select patients who need higher-paying services such as joint replacements
- Providers and patient groups think the new payment model will reduce access to services and result in the closure of many home health firms
- Kathy Holt, the associate director of the Center for Medicare Advocacy, argues that many patient groups such as those with ALS and Parkinson's already have a difficult time finding agencies to serve them

MedPAC and CMS are aiming to cut costs to HHAs, which they feel are currently too high

- CMS, in the statement it released in July, said that HHAs may be providing **more therapy services than necessary** because the current payment system makes those services more profitable than nursing
  - This may be supported by the jump in therapy visits from 1997 to 2015
- Holt argues that this incentive on providing therapy has resulted in fewer agencies providing more home-specific care such as help with bathing and getting out of bed



Sources: Qijuan Li, Laura Keohane, Kali Thomas, "Association of Cost Sharing With Use of Home Health Services Among Medicare Advantage Enrollees," The Jama Network, July 2017; "Oppose a 'sick tax' – Block efforts to impose a fee to be paid by patients to access Medicare home health services," NAHC, May 7, 2014

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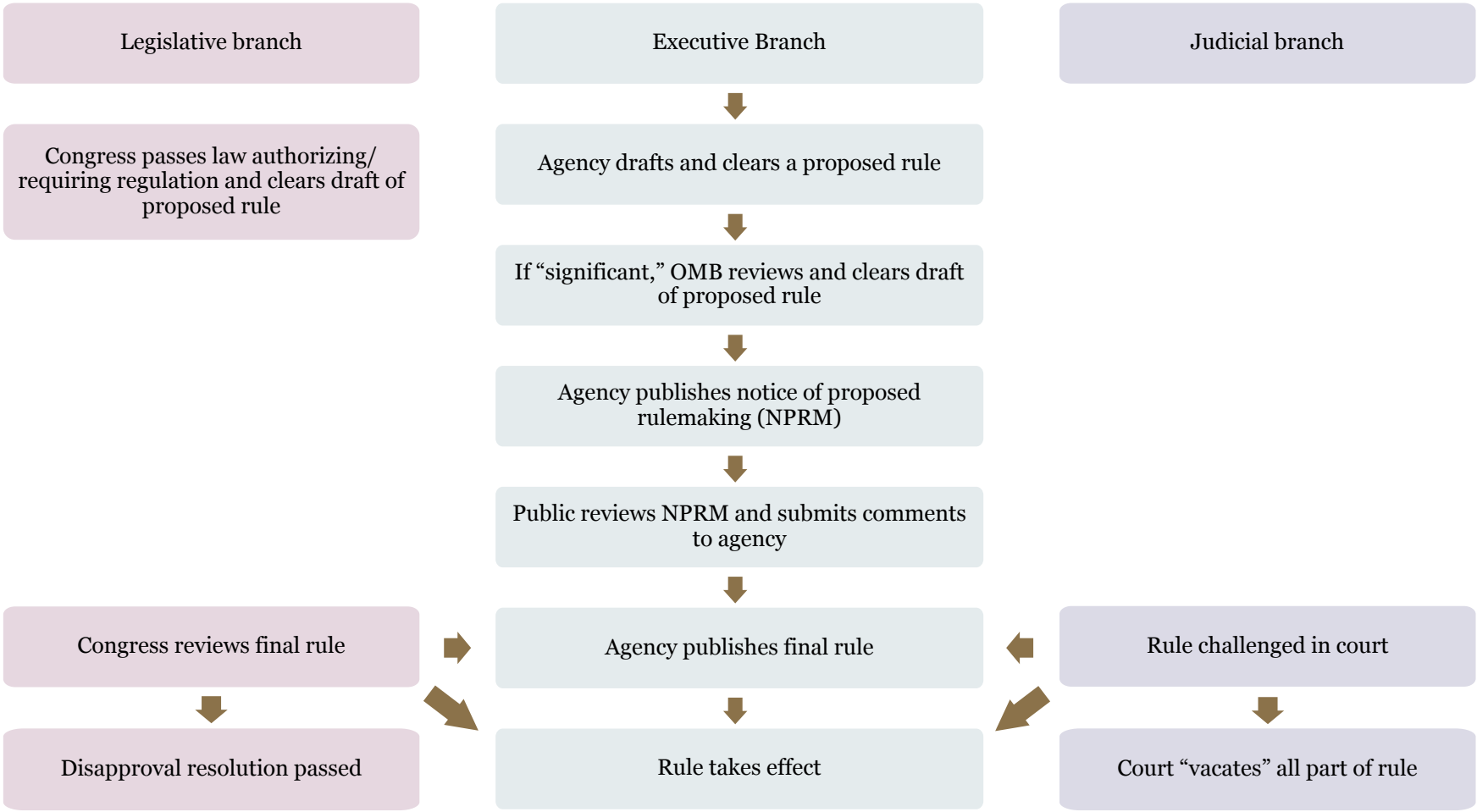
Federal rulemaking process



Source: U.S. Approach to Regulatory Policy, Federal Register, 2018.

AARP report: *Reduce Waste, Fraud, and Abuse in Health Care*

Background:

- The national Health Care Fraud and Abuse Control Program has returned more than $11 billion to the Medicare Trust Fund, while HHS has reported recoveries of $20 billion for 2008 alone
- As the AARP states, broad federal efforts to close loopholes, reduce improper payments and discourage inappropriate conduct saved about $30 billion for Medicare and $9 billion for Medicaid

Examples of fraud in the Medicare & Medicaid system:

A drug manufacturer paid **$328 million** settlement to resolve charges of illegal drug prices and paying kickbacks to doctors/ pharmacies for buying the drug

A Medicaid health maintenance organization was fined **$334 million** for engaging in a scheme to enroll healthy individuals, and refusing to enroll people with pre-existing conditions

A large physician practice paid **$1.7 million** in recoveries for retaining overpayments from Medicare and Medicaid

What can be done?

Increase funding for fraud and abuse control

Spend funds recovered from fraud for further enforcement

Increase transparency to earn trust of patients and public

Establish clinical practice guidelines for overused services

Reduce conflicts of interest for providers

Restrict industry marketing products

Sources: "Reduce waste, fraud, and abuse in health care," Keith Lind, AARP, 2009.