

Responses to Questions for the Record
Committee on Ways and Means – Health Subcommittee
Hearing on MedPAC June Report
June 19, 2012

Questions from Mr. Brady of Texas

Q. Your report noted that some Medicare Advantage plans do cover the nursing services and supplies associated with home infusion of IVIG for patients with primary immune deficiency disorders. Were you able to determine any cost differential between the various sites of care for those M.A. plans that provided this benefit?

A. No. We were not able to calculate Medicare Advantage costs because data on plans' utilization and costs at the patient level (the so-called "encounter data") are not currently available.

Q. Your report seems to express support for the Center for Medicare and Medicaid Services conducting a demonstration project to understand the costs and benefits associated with coverage of the nursing services and supplies associated with home infusion of IVIG for patients with primary immune deficiency disorders. I have introduced H.R. 1845 that would create such a demonstration project. Would you agree that such a demonstration, specific to IVIG treatment, would be beneficial for patients and the Medicare program?

A. In the report, the Commission discussed the potential for a demonstration program to evaluate whether a home infusion benefit in Medicare improves quality and saves money, compared with the current options beneficiaries face. While the Commission did not rule out the possibility of targeting a demonstration of IVIG for patients with PID, to construct and evaluate a demonstration program focused solely on this population would be challenging. The PID population is small and setting up the demonstration would entail significant administrative costs, making it more difficult to demonstrate savings. Moreover, because the PID population is small, it may be harder to detect statistically significant impacts.

Q. As non-covered services, Medicare beneficiaries who choose to receive IVIG treatment at home for treatment of primary immune deficiency disorders are not able to use MediGap supplemental insurance to pay for nursing services and supplies associated with their treatment. How much money (out of pocket) would patients be able to save if they could use their MediGap insurance to cover the patient share of costs for those services?

A. We cannot estimate the reduced out of pocket (OOP) costs to beneficiaries. For the IVIG population, the reduced OOP costs depend on the number of beneficiaries with Medigap coverage, as well as the private provider rates for supplies and nursing. Also, bear in mind that Medigap premiums would increase for all Medigap holders in order to cover these costs. Finally, it would be unprecedented to require Medigap plans to cover non-Medicare covered services.

Q. Your report specifically noted that out-of-pocket costs for nursing services are a barrier to access for home infusion of IVIG therapy. Why were these costs singled-out as an impediment for this particular treatment? Why is home infusion of IVIG different from other drugs?

A. *Two factors make nursing costs more of an issue for IVIG than some other home infusion drugs like antibiotics. Patients needing IVIG for PID requires a nurse to be present for each administration, which is different from many other home infusion drugs (e.g., antibiotics, parenteral nutrition) where teaching the patient to self-administer is the goal. Also, patients with primary immune disorder (PID) are often not homebound so they do not qualify for the Medicare home health benefit.*

Q. You indicated in your report that MedPAC anticipates minimal woodworking as a result of expanding Medicare coverage of nursing services and supplies of IVIG for patients with primary immune deficiency disorders. Would you please expand on why MedPAC does not believe such woodworking would occur?

A. *Since PID is a rather clinically precise diagnosis, and relatively few individuals receive this diagnosis, it is unlikely that broader Medicare coverage of nursing services and supplies would result in new candidates emerging to access them.*

Question from Ms. Black of Tennessee

Mr. Hackbarth, the duals demonstration project will in many cases remove dual eligibles from their current coverage in Medicaid and Medicare in favor of enrolling them in coordinated plans. However, in the case of Part D, it could remove individuals from the competitive bidding Part D architecture into coverage that is paid exclusively through administered rate setting, which would eschew the discipline that competitive bidding imposes.

Q. Given that some special needs plans under Medicare somehow manage to coordinate Medicare and Medicaid services and still submit competitive Part D bids, is there any reason to suppose that plans in this demonstration could not do the same, if not in the first year, then in years two or three?

A. *The Commission is concerned about this possible feature of the demonstration programs. Specifically, we are concerned that this policy could de-stabilize the Part D prescription drug plan (PDP) market for LIS beneficiaries by affecting the available number of benchmark plans and the amount of the premium subsidy. Dual-eligible beneficiaries are a large portion of the LIS population, and because the proposed scope of the demonstrations is so large and so many dual eligible beneficiaries would be enrolled in plans that did not submit Part D bids, bids would be missing from the LIS benchmark calculation for most or all dual-eligible beneficiaries within a state. Given that some of the plans likely to participate in the demonstrations may already submit Part D bids for other lines of business, CMS should consider whether it is reasonable to expect that they could also submit bids for this program.*

Questions from Mr. Stark of California

Q. Sole Community Hospitals and Mileage Criteria. In order to be eligible for Sole Community Hospital (SCH) status and the special payments that accrue from that status, a hospital must be located at least 35 miles from the nearest like hospital (excluding critical access hospitals). What percentage of SCHs fail to meet that mileage criteria because they are: (1) within 15 miles; (2) between 15 to 25 miles; or (3) between 26 and 35 miles from the nearest like hospital (excluding CAHs)? What percentage are within those mileage limits of either a CAH or a prospective payment hospital?

A. According to Commission analysis, 38 (9%) Sole Communities Hospitals (SCHs) are within 15 miles of another hospital (either PPS or CAH), 120 (29%) are between 15 and 25 miles, and 169 (40%) are between 25 and 35 miles. Focusing only on SCHs' distance from PPS hospitals, 19 (4%) are within 15 miles, 41 (10%) are between 15 and 25 miles, and 103 (24%) are between 25 and 35 miles.

Q. The June report sets forth criteria to structure special payments to rural providers, including the criterion that payments should be targeted to low-volume isolated providers. To the extent your data show that some SCHs are within 35 miles of a PPS hospital or CAH, do those hospitals qualify as meeting the criterion of "isolated provider"?

A. Ultimately, the definition of "isolated" is a matter of judgment and the Congress may choose to consider multiple factors when determining the appropriate criteria, e.g., the type of road or terrain separating two hospitals. The 35 mile threshold was used as a benchmark in the Commission's work since it was originally used to set eligibility for the CAH program.

Q. Critical Access Hospital Swing Beds. In the June 2005 report, MedPAC found that CAHs receive roughly \$1000 in Medicare payments for every post-acute day in a "swing" bed, as compared to payment rates of roughly \$300 per day in a skilled nursing facility. Please provide updated information on the difference, if any, between the Medicare payment for a CAH swing bed day as compared to per diem payments in a SNF. Does this payment difference meet the criteria for special payments to rural providers set forth in the June report?

A. In our June 2012 Report to Congress, we analyzed 2009 payments and cost data and found that CAHs received an average of approximately \$1,315 per day for SNF care. Rural SNFs paid under the SNF PPS received an average of about \$390 per day. This resulted in over \$800 million in additional payments from Medicare in 2009. We expect that amount to grow to \$900 million by 2011. These special payments may not meet the Commission's criteria for special payments, since they may not be targeted to isolated providers. For example, 16% of CAHs are within 15 miles of other hospitals. In addition, cost-based payments maintain lower incentives for cost control than prospective payment.

Q. Benefit Redesign – Combined Parts A and B Deductible. The illustrative benefit redesign contains a \$500 combined deductible, but the Commission did not take a definitive stance on separate or combined deductibles in the recommendations. Why did the Commission decide not to address this issue?

A. *A deductible is a basic component of insurance design; having a deductible enables insurance providers to keep premiums and cost sharing to affordable levels. In the June 2012 Report to Congress, the Commission viewed it as necessary to include a deductible in its revised FFS benefit design and concluded that while the deductible needed to be included, it could be either separate or combined. On the one hand, combining the Parts A and B deductibles would allow Medicare to more closely resemble insurance offerings in the private market. On the other, a combined deductible has the potential to result in higher out of pocket (OOP) expenses early in the benefit year for some beneficiaries, which may be burdensome.*

The Commission recommended the Congress direct the Secretary to develop a benefit design within the guidelines the Commission outlined. This would include the final structure of the deductible(s). The Commission also recommended giving the Secretary authority to modify certain elements of the benefit design, which could over time lead to changes in the beneficiary's OOP spending and reduce the burden of the deductible. This provision does not diminish congressional authority; if the Congress disagreed with the Secretary's proposed actions, it could act to stop the changes.

Questions from Mr. Thompson of California

Q: I have heard concerns from my district on some of the duals demo projects, specifically as they relate to passive enrollment. I have concerns that passive enrollment could limit options for care. In your view, how should CMS evaluate passive enrollment proposal in the dual demo plans from the states? How should they evaluate the interaction between the states' proposals and currently active Medicare Advantage plans? In your testimony, you mention "intelligent assignment" of beneficiaries. Could you explain what intelligent assignment is and how it would work?

A. *CMS proposes to use passive enrollment with an opt-out provision for the capitated model demonstrations. Under this enrollment strategy, beneficiaries will be assigned to a health plan through intelligent assignment unless the beneficiaries opt out of the demonstrations or proactively select a health plan. Intelligent assignment refers to the process of matching a beneficiary to a health plan based on information about a beneficiary's care needs (such as which health plan has most of the beneficiary's providers in-network), rather than through random assignment.*

Since it may not be possible in all cases to perfectly match a beneficiary's needs to a plan's design or provider network, there are several protections the Commission believes should be in place to best ensure that beneficiaries are not harmed in the assignment process. This includes

conducting outreach to beneficiaries' current providers, to make sure they are aware of the upcoming change to their patients' Medicare and Medicaid services.

Plans should be required to contact beneficiaries and assess their care needs shortly after enrollment, so the plans can develop and implement a care plan for each enrollee. In the event that a plan's provider networks do not include a beneficiary's current providers, the Commission believes plans should be required to arrange care with beneficiaries' existing providers during a transition period.

In addition, it is important that beneficiaries be passively enrolled into high-quality plans. Doing so gives the demonstration plans a better chance of improving care for the dual-eligible beneficiaries relative to FFS.

Lastly, even if all precautions and measures are taken, there will still be some beneficiaries that will be passively enrolled into a demonstration plan and will not wish to remain there. The Commission holds that all beneficiaries should be notified in advance of passive enrollment and given the opportunity to opt out at multiple points in the process.