TO: NPA Member Contacts, Board of Directors, Public Policy Committee and PACE State Association Executive Directors

FROM: Shawn M. Bloom

DATE: June 18, 2012

RE: MedPAC’s June, 2012 Report to the Congress

On Friday, the Medicare Payment Advisory Commission (MedPAC) issued its June, 2012 report to Congress, “Medicare and the Health Delivery System.” The report includes a chapter on care coordination programs for dual-eligible beneficiaries addressing PACE. Throughout the development of the commission’s initial draft recommendations, NPA engaged MedPAC staff including commenting at hearings, submitting extensive written comments, and participating in multiple meetings with MedPAC staff. Although the final report does not carry the force of law, Congress often follows MedPAC’s recommendations when considering policy changes to the Medicare program. Later this year, Congress will have to pass legislation to prevent a cut to physician payments and will likely look to this report for guidance with regard to other Medicare payment issues. NPA will work with members of Congress as they consider policy changes based on the MedPAC report to address any implications these changes would have for PACE.

Of significant concern to NPA is MedPAC’s recommendation to align PACE county payment rates with Medicare Advantage benchmarks based on an analysis concluding that PACE payments are, on average, 17% greater than fee-for-service costs. This analysis does not compare PACE costs to Medicare fee-for-service expenditures for a nursing home level of care population and does not address inadequacies in the current risk adjustment methodology. MedPAC acknowledges these risk adjustment inadequacies in its report, noting that severity of illness and interaction of multiple illnesses are not currently accounted for in Medicare’s risk adjustment model.

Though NPA does not agree that the analysis of PACE and fee-for-service costs summarized in MedPAC’s report provides a sound rationale for a change in PACE’s
county payment rates, we are pleased to note that this change would not occur without improvements in Medicare’s risk adjustment methodology for PACE. Specifically, MedPAC recommends that the change in benchmarks is implemented simultaneous with revisions to Medicare’s risk adjustment methodology with the objective of more accurately predicting costs for Medicare beneficiaries with multiple diseases and greater disease severity who are disproportionately enrolled in PACE.

NPA is also pleased that MedPAC included in its recommendations:

- development of quality bonus payments for PACE
- expansion of PACE eligibility to include nursing home eligible individuals who are under the age of 55
- outlier payments for new PACE programs
- development of quality performance measures for PACE

Please see Attachment 1 for additional information regarding the MedPAC recommendations included in the June report.

In reviewing MedPAC’s recommendations, NPA is concerned that an adequate risk adjustment methodology and appropriate quality bonus payment system will be difficult for the Centers for Medicare and Medicaid Services (CMS) to develop for PACE. Our concerns reflect our own and MedPAC’s prior analyses indicating that the current HCC risk adjustment and frailty adjustment models underestimate the costs of a PACE population relative to Medicare fee-for-service costs, and as a result underestimate appropriate payment to PACE organizations.

Moving from the county benchmarks currently used as the basis for payments to PACE organizations to the county benchmarks used in the MA program (as MedPAC is recommending) would result in lower benchmarks for PACE. If achieved, improvements in the risk adjustment methodology would at least partially offset these reductions in the county benchmarks. New quality bonus payments would also partially offset the decrease in the county benchmarks. It will be critical for improved risk adjustment and quality bonus payments to offset the recommended benchmark reductions in order to sustain adequate payment for PACE organizations.

It is important to note that in making its recommendations, MedPAC’s aim is to place all Medicare managed care options on a consistent payment platform through use of the same county benchmarks and appropriate risk adjustment. MedPAC’s report expresses its admiration for PACE and notes that PACE serves as an example of the kind of integration that the commission's members would like to see for all high-need Medicare beneficiaries.

On Tuesday, June 19, MedPAC’s recommendations will be presented at a Congressional hearing. Additionally, MedPAC will brief the staff of Congressional committees with jurisdiction over Medicare and CMS staff. NPA will continue to assess MedPAC’s recommendations and their potential impact, and work with CMS and federal legislators
to assure that MedPAC’s recommendations do not result in further financial strain on PACE organizations.

If you have any questions regarding the MedPAC recommendations and NPA’s ongoing response, please contact Peter Fitzgerald at 703/535-1519 or peterf@npaonline.org.
Attachment 1

MedPAC Recommendations Regarding PACE

1. **PACE Payment**: Congress should direct the Secretary to improve the Medicare Advantage (MA) risk adjustment system to more accurately predict risk across all Medicare Advantage and PACE enrollees, including improvements to better predict the costs of care for high-need beneficiaries. Medicare also should specify quality measures that will allow for PACE to be included in the quality bonus payment system currently limited to MA plans. Upon implementation of these improvements, CMS shall use MA benchmarks as the basis for PACE payment. (Currently, PACE payments are based on PACE-specific county-level rates in place before passage of the Affordable Care Act.) CMS should not implement new benchmarks for PACE until risk adjustment improvements and quality bonus payments have been established, no later than 2015.

2. **PACE Performance Measurement**: Congress should direct the Secretary to publish select quality measures on PACE providers and develop appropriate quality measures to enable PACE providers to participate in the MA quality bonus program by 2015. The report notes that measures could be based on current measures for the MA program or could be based on a set of measures developed to reflect the PACE population. The commission recognizes the challenges in accurately reporting measures given the small numbers of enrollees at some PACE sites and instructs CMS to take steps to address this challenge.

3. **PACE Eligible Population**: Congress should change the age eligibility criteria for PACE to allow nursing home-certifiable Medicare beneficiaries under the age of 55 to enroll. This change should not be implemented until a revised risk adjustment methodology and quality bonus payments are implemented, and MA county benchmarks are used as the basis for PACE payment.

4. **PACE Outlier Protection**: The Secretary should establish an outlier protection policy for new PACE programs to use during their first three years of operation to help defray the costs of exceptionally high acute care utilization for individual Medicare beneficiaries. This change should not be implemented until a revised risk adjustment methodology and quality bonus payments are implemented, and MA county benchmarks are used as the basis for PACE payment.

5. **PACE Enrollment**: Medicare should allow for mid-month enrollments and establish a partial month capitation methodology. This change should not be implemented until a revised risk adjustment methodology and quality bonus payments are implemented, and MA county benchmarks are used as the basis for PACE payment.