A Stronger MedPAC May Be Part of Health Reform

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Update

On July 17, 2009, Office of Management and Budget (OMB) Director Peter Orszag sent a letter to Speaker of the House Nancy Pelosi requesting consideration of a draft bill that would establish an Independent Medicare Advisory Council (IMAC). Please click the links to read OMB Director Orszag's letter, the draft IMAC Legislation which he enclosed with the letter, and a sectional analysis.

As part of the health care reform debate unfolding in Washington, the Senate Finance Committee, in particular, has made cutting costs in Medicare a priority issue as a means of financing broader health care reform. Finance Committee Chairman, Max Baucus (D-MT), stated recently "[t]o make the system more affordable and provide coverage to all, we need to look at where we spend money on healthcare today. The first place that we should look for savings is within healthcare itself."[1]

As part of this discussion, proposals to change the influence and authority of the Medicare Payment Advisory Commission (MedPAC) have gained traction and attention. Some proposals to reform MedPAC that are currently under consideration would be truly monumental and would give significant new power to MedPAC officials. Under some proposals, MedPAC would be given authority to propose revisions to Medicare payment rates for providers with little Congressional input. Health care providers should be paying close attention to this debate as it plays out in the coming months.

This issue has gotten renewed attention recently because of a letter President Obama sent last week to Senate leaders drafting health care reform legislation. In the June 3 letter, the President wrote to Senate Health, Education, Labor, and Pensions (HELP) Chairman Edward M. Kennedy (D-MA) and Finance Committee Chairman Baucus that he is open to "ideas about giving special consideration to the recommendations of the Medicare Payment Advisory Commission (MedPAC)… [whereby] MedPAC's recommendations on cost reductions would be adopted unless opposed by a joint resolution of the Congress."[2] Nancy-Ann DeParle, Director of the White House Office of Health Reform, is a former MedPAC member herself and has reiterated the President's openness to increasing MedPAC's decision-making authority. In addition to the President's letter, Senator Jay Rockefeller (D-WV), who chairs the Senate Finance Committee's Subcommittee on Health, has introduced legislation (S. 1110) that would specifically give MedPAC greater authority to determine Medicare payment rates.

MedPAC, established through the Balanced Budget Act of 1997 (P.L. 105-33), is currently an independent advisory Congressional Commission which was created to make policy recommendations to the U.S. Congress on issues affecting the Medicare program. The Commission regularly holds meetings, which are open to the public, throughout the year to deliberate upon Medicare payment policy issues and to form recommendations to submit to Congress. The Commission submits two annual reports to Congress — one in March and one in June. Additionally, the Commission advises Congress, as requested, through comments on reports and proposed regulations, Congressional testimony, and staff briefings.

Notably, however, MedPAC's proposals are only policy recommendations. Congress is free to accept, reject, or even fail to consider those recommendations. Although MedPAC is well-respected and its reports and recommendations are considered to be largely free from bias and political considerations, Congress is not now, and has never been, required to address MedPAC's recommendations or to enact them into law.

Proposed Revisions to MedPAC: the Military Base Closure Commission Model

President Obama suggested in his recent letter that an approach where MedPAC could make Medicare payment recommendations, which would be adopted unless expressly rejected by Congress, would be "similar to a process that has been used effectively by a commission charged with closing military bases." The commission that the President was referring to is the Base Realignment and Closure (BRAC) commission, which was established in 1990 "to provide an objective, non-partisan, and independent review and analysis of the list of military installation recommendations issued by the Department of Defense (DoD)."[3] The BRAC process was created as a way to identify military installations for closure or realignment in an unbiased and transparent manner. Five rounds of BRAC closures have taken place to date -- in 1988, 1991, 1993, 1995, and 2005 -- resulting in over 500 recommendations and hundreds of base realignments, closures, and other actions.[4]

It is likely that the President chose the BRAC analogy because the BRAC process is designed to avoid the political—often regional—influences in base closure recommendations. These same influences arise in Medicare payment policy. The BRAC recommendations are intended to save the federal government money on operations and management, but are resisted because of the setback they pose to the local economy. The typical BRAC process involves the development of recommendations for military base closures. The Commission reports its recommendations to the President, who then either forwards the report to Congress with his signed certification of approval or returns it to the Commission for additional evaluation before it is submitted to Congress. Once submitted, Congress has 45 days to enact a joint resolution to reject the report in its entirety; otherwise, it becomes law. The joint resolution of disapproval requires passage by both the Senate and the House. Since the President has agreed with the Commission's recommendations, it is likely that he would veto a resolution of disapproval; for it to become effective, then, two-thirds of the Congress would have to override the veto.

In theory, what President Obama proposed in his letter would be similar to this process. That is to say, MedPAC recommendations could be treated like BRAC recommendations and subject to an up-or-down vote in Congress that cannot be amended or revised once the recommendations are finalized. Under this approach, the political process would, in theory, be marginalized and individual members of Congress would not have an opportunity to alter or revise MedPAC's recommendations. Under this process, rejecting a MedPAC recommendation would, in effect, require a two-thirds vote of Congress. Office of Management and Budget (OMB) Director Peter Orszag, at a Brookings Institution event on June 9, 2009, referred to the proposal to change the process for Medicare payment decision-making as giving MedPAC "fast track authority" so that its recommendations do not just "sit on the shelf".[5]

Senator Rockefeller legislation- S. 1110

Senator Jay Rockefeller (D-WV) has filed legislation, the "Medicare Payment Advisory Commission (MedPAC) Reform Act of 2009" (S. 1110), introduced on May 20, 2009, that would strengthen and change the role of MedPAC. Senator Rockefeller described his bill as taking a "somewhat different approach" from that which the President referred to in his recent letter—S.1110 would make MedPAC an independent executive branch agency, "similar to the Federal Reserve."[6] The bill would revise MedPAC's membership requirements by making membership a full-time position and making the terms of members to one, three, and five years, and would also direct MedPAC to determine payment rates for Medicare items and services and require the Government Accountability Office (GAO) to study and report annually to Congress on Medicare payment policy changes. Most significantly, the legislation would treat MedPAC recommendations as binding without consideration by Congress-- the possibility of overruling such recommendations would not even be considered by the Congress unless three-fifths of the Senate or House agree to consider the measure that could overrule the MedPAC recommendation.

MedPAC Recommendations

Enactment of either the President's proposal or the Rockefeller legislation would carry enormous implications for health care providers. Either proposal would dramatically tilt the balance of power away from elected members of Congress to unelected health care policy experts whose recommendations would effectively require a two-thirds vote of Congress to overturn. In the past, as a general matter, MedPAC's Medicare payment reduction recommendations to Congress have been harsher than those that Congress later agrees to. Recent MedPAC recommendations and reports have focused on a wide range of issues including hospital payment updates, public reporting of physician's financial relationships, payment adequacy and updates in fee-for-service Medicare and outpatient dialysis services, use of high-cost imaging services, the Medicare Advantage program reimbursement methodology, the hospice benefit, and potential payment for follow-on biologics should Congress approve a pathway for them. Below are examples of recommendations or discussion points from MedPAC's March 2009 Report[7]:

- **Medicare Advantage program payment system:** While not making recommendations specifically in its March 2009 report, the Commission devoted a chapter to discussing the MA program, and concluded that: "Paying a plan more than FFS [fee-for-service] spending for delivering the same services is not an efficient use of Medicare funds in the absence of evidence that such payments

result in better quality compared with FFS. We are concerned that the average MA bid for Medicare Part A and Part B services is above average FFS spending, which means that, on average, all enhanced benefits in the plan are funded by the Medicare program and not by plan efficiencies. In addition, a portion of the program payments used to fund enhanced benefits pay for plan administration and profits and not services for beneficiaries."

- **Hospice benefit**: Among its four main recommendations, the Commission recommended that "The Congress should direct the Secretary to change the Medicare payment system for hospice to "have relatively higher payments per day at the beginning of the episode and relatively lower payments per day as the length of the episode increases, include a relatively higher payment for the costs associated with patient death at the end of the episode, and implement the payment system changes in 2013, with a brief transitional period."
- **Home health services**: "The Congress should eliminate the market basket increase for 2010 and advance the planned reductions for coding adjustments in 2011 to 2010, so that payments in 2010 are reduced by 5.5 percent from 2009 levels."
- **Inpatient rehabilitation facility services**: "The update to the payment rates for inpatient rehabilitation facility services should be eliminated for fiscal year 2010."
- **Long-term care hospital services**: "The Secretary should update payment rates for long-term care hospitals for fiscal year 2010 by the projected rate of increase in the rehabilitation, psychiatric, and long-term care hospital market basket index less the Commission's adjustment for productivity growth."
- **High-cost imaging services**: "Congress should direct the Secretary to increase the equipment use standard for expensive imaging machines from 25 hours to 45 hours per week. This change should redistribute relative value units from expensive imaging to other physician services."
- **Physician financial relationship reporting**: Among its five main recommendations on public reporting of financial relationships, the Commission recommended that Congress should "require all manufacturers and distributors of drugs, biologicals, medical devices, and medical supplies (and their subsidiaries) to report to the Secretary their financial relationships with: physicians, physician groups, and other prescribers; pharmacies and pharmacists; health plans, pharmacy benefit managers, and their employees; hospitals and medical schools; organizations that sponsor continuing medical education; patient organizations; and professional organizations."
- **Payment in outpatient dialysis services**: "The Congress should maintain current law and update the composite rate in calendar year 2010 by 1 percent."
- **Follow-on biologics**: While MedPAC has not yet made recommendations on the issue of how follow-on biologics (FOBs) would be paid for by the Medicare program should an FDA-approval pathway be established, the Commission did consider the issue at its March 2009 public meeting. Commissioners heard a presentation from a MedPAC analyst on three possible coding approaches for FOBs and innovator biologics: (1) Make placement in the same billing code contingent on an Food and Drug Administration (FDA) determination of interchangeability; (2) Permit the Secretary to place FOBs and innovator biologics in the same code after input from an advisory committee of scientific experts or a public comment process; and (3) Require FOBs and innovator biologics to be placed in the same billing code, but permit the Secretary to make exceptions if evidence shows that this is not clinically appropriate for particular products.

In the discussion period following the staff presentations on the FOBs issue, the Commissioners had a number of questions and comments about how the above approaches would work, and more fundamentally, whether it was even the right time for MedPAC to be addressing the question of FOBs. There will be a section on follow-on biologics in the Commission's June 2009 Report to Congress, which will be released soon.

Conclusion

President Obama has suggested that he is amenable to a process by which MedPAC could have a new and stronger role similar to BRAC. The President said that this proposal "could be a valuable tool to help achieve health care reform in a fiscally responsible way." [8] Additionally, the President has made his focus on costs clear, stating in his recent letter to Chairmen Kennedy and Baucus, "[h]ealth care reform must not add to our deficits over the next 10 years – it must be at least deficit neutral and put America on a path to reducing its deficit over time." As the Senate HELP and Finance Committees reveal their versions of a comprehensive health care reform bill, followed by House Committee bills, this may be an issue that takes a center position in the discussion on health care cost and reform, and it is one that health care providers should pay close attention to in the coming weeks and months.

[1] Chairman Max Baucus, Press Release, Baucus Holds Roundtable Discussion on Financing Health Care Reform, May 12, 2009

[2] President Barack Obama, Letter to Senators Kennedy and Baucus, June 2, 2009.

[3] See here; BRAC was created by the Defense Base Closure and Realignment Act of 1990 (P.L. 101-510, Title XXIX (Nov. 5, 1990), as amended), as amended. Note, the first round of closures was conducted under the Defense Authorization Amendments and Base Closure and Realignment Act (P.L. 100-526, Title II (Oct. 24, 1988), as amended).

[4] GAO Report, Military Base Closures: Observations of Prior and Current BRAC

Rounds, GAO 05-614, May 3, 2005, available here; and 2005 Final Report to the President

[5] OMB Director Peter Orszag, Keynote Address, "Implementing CER: Priorities, Methods, and Impact," June 9, 2009.

[6] U.S. Senator Jay Rockefeller, Press Release, Rockefeller Commends President Obama for Health Reform Letter, June 3, 2009.

[7] Medicare Payment Advisory Commission, Report to the Congress: Medicare Payment Policy, March 2009

[8] President Barack Obama, Letter to Senators Kennedy and Baucus, June 2, 2009.

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