Executive summary

Executive summary

As required by the Congress, each March the Medicare Payment Advisory Commission reviews and makes recommendations for Medicare fee-for-service (FFS) payment systems and the Medicare Advantage (MA) program. In this report, we:

- Consider the context of the Medicare program in terms of its spending and the federal budget and national gross domestic product.
- Consider Medicare FFS payment policy in 2011 for: hospital inpatient, hospital outpatient, physician, ambulatory surgical center, outpatient dialysis, hospice, skilled nursing, home health, inpatient rehabilitation, and long-term care hospital.
- Discuss the status of the MA plans beneficiaries can join in lieu of traditional FFS Medicare and reiterate prior year payment recommendations.
- Review the status of the plans that provide prescription drug coverage.
- Respond to a congressional mandate to examine how to compare quality among MA plans and between those plans and traditional Medicare.

The goal of Medicare payment policy is to get good value for the program's expenditures, which means maintaining beneficiaries' access to high-quality services while encouraging efficient use of resources. Anything less does not serve the interests of the taxpayers and beneficiaries who finance Medicare through their taxes and premiums. Although this report addresses many topics to increase value, its principal focus is the Commission's recommendations for annual rate increases (updates) under Medicare's various FFS payment systems.

We recognize that managing updates and relative payment rates will not solve the fundamental problem with current Medicare FFS payment systems—that providers are paid more when they deliver more services without regard to the quality or value of those additional services. To address this problem directly, payment and delivery system reforms the Commission has discussed in the past such as medical homes, bundling, and accountable care organizations will have to be investigated and successful models adopted on a broad scale. That is unlikely to happen in the near term, however, because implementing comprehensive reform is complicated and may require reorganization of the delivery of care—a complex and time-consuming activity in its own right.

In the interim, it is imperative that the current FFS payment systems be managed carefully. Medicare is likely to continue using its current payment systems for some years into the future. This fact alone makes unit prices—both their overall level and the relative prices of different services—an important topic. In addition, unit prices could affect the prospects for payment reform by eliminating unnecessary expenditures, providing an impetus for providers to volunteer for experiments with new payment methods, and shaping the delivery system by changing relative values.

Changing Medicare's payment methods is essential to improving efficiency and value in health care delivery. But such payment reform is unlikely to happen—or at least will not happen as quickly—without steady pressure on the level of prices paid by Medicare as well as attention to the relative values assigned to different services.

At the beginning of each chapter, we list the recommendations it contains. Within the chapters, we present each recommendation; its rationale; and its implications for beneficiaries, providers, and program spending. The spending implications are presented as ranges over one- and five-year periods and, unlike official budget estimates, do not take into account the complete package of policy recommendations or the interactions among them. In Appendix A, we list all recommendations and the Commissioners' votes.

Context for Medicare payment policy

The Medicare program and other United States health care payers are on an unsustainable financial path, as we discuss in Chapter 1. For most of the post-World War II period, health care costs have risen faster than the economy. CMS reports that health care's total share of the economy rose from 7 percent in 1970 to an estimated 17 percent in 2009. This high rate of growth is projected to continue, absent meaningful financing and delivery reforms.

A number of factors are responsible for the sustained high rates of growth in health care costs for public and private programs. The Congressional Budget Office cites advances in medical technology, national wealth, and the consumption-increasing effects of insurance as major

contributors to historic and projected growth. Other factors include changes in demographics and disease burden, rising personal incomes, and increases in prices charged by providers.

Rising spending places an increased burden on those who fund it. Higher premiums for health care benefits have resulted in increased employee benefit costs eclipsing wage increases; in effect, workers are receiving smaller increases in cash salaries in exchange for increases in insurance benefits. For Medicare beneficiaries, rising spending means that a growing share of their income must be used to pay Medicare premiums and cost sharing. Finally, for taxpayers the rising cost of Medicare and other federal health programs will require higher taxes and reduce the resources available for other federal priorities.

Studies show that much of the increase in health care spending is not explained by improvements in health status, clinical outcomes, or quality of life and that recommended clinical services are not always provided. These findings, combined with the projected increases in health spending, represent the core challenges for policymakers: how to increase quality, improve the efficiency of the delivery system, and find the resources to finance care.

Many of the barriers that prevent Medicare from improving quality and controlling costs stem from the incentives in Medicare's payment systems, which are primarily FFS and provide incentives that reward more services instead of better quality. Furthermore, Medicare's payment rates for individual products and services are not always accurate, leading to overpayments that do not encourage efficiency and may cause providers to prefer delivering overpriced services relative to others. Payments are based on the type and volume of services provided, and providers are not accountable for the quality of care they provide. Also, within the piecemeal FFS payment system there is no incentive for providers to coordinate care. Finally, Medicare providers and beneficiaries do not have the information they need to improve quality and use resources efficiently.

To begin to address these problems, the Commission has recommended a number of changes, such as rewarding providers for improving quality and holding providers accountable for the quality of care beneficiaries receive and the resources expended to provide it. The Commission is assessing approaches that revise the single-setting "silos" that are the unit of payment for most FFS payment systems. These changes, with other changes to the delivery system that the Commission has recommended, aim to improve the quality of care and health outcomes by creating incentives for providers to work together.

Assessing payment adequacy and updating payments in fee-for-service Medicare

The Commission makes payment update recommendations annually for FFS Medicare. An update is the amount (usually expressed as a percentage change) by which the base payment for all providers in a prospective payment system is changed. To determine an update, we first assess the adequacy of Medicare payments for efficient providers in the current year (2010). Next, we assess how those providers' costs are likely to change in the year the update will take effect (the policy year—2011). Finally, we make a judgment on what, if any, update is needed. When considering whether payments in the current year are adequate, we generally account for policy changes (other than the update) that are scheduled to take effect in the policy year under current law. This year, we make update recommendations in 10 FFS sectors: hospital inpatient, hospital outpatient, physician, ambulatory surgical center, outpatient dialysis, hospice, skilled nursing facility, home health, inpatient rehabilitation facility, and long-term care hospital. We discuss the analyses of payment adequacy for the first six sectors in Chapter 2 and for the four post-acute care sectors in Chapter 3.

Each year we look at all the indicators of payment adequacy and reevaluate any prior year assumptions using the most recent data available. The Commission's judgments about payment adequacy and expected cost changes result in an update recommendation for each payment system. In addition, in some cases the update may incorporate an allowance for productivity. Competitive markets demand continual improvements in productivity from workers and firms. These workers and firms pay the taxes used to finance Medicare. Medicare's payment systems should exert the same pressure on providers of health services. The Commission begins its deliberations with the expectation that Medicare should benefit from productivity gains in the economy at large (the 10-year average of productivity gains in the general economy, currently 1.3 percent). This factor links Medicare's expectations for efficiency to the gains achieved by the firms and workers who pay the taxes that fund Medicare. But the Commission may alter that expectation depending on the circumstances of a given set of providers in a given year.

Hospital inpatient and outpatient services

Medicare inpatient and outpatient FFS payments per beneficiary grew by 3.7 percent from 2007 to 2008, resulting in hospitals receiving approximately $139 billion for inpatient and outpatient services. In aggregate, most indicators of payment adequacy are positive, but profit margins on Medicare patients remain negative for most of the 3,500 hospitals participating in the inpatient prospective payment system in 2008.

- Beneficiaries are gaining access to a broader array of services from a growing number of providers. Capacity continues to grow with more hospitals opening than closing for seven straight years. Hospitals report growth in the range of services they offer and in the number of health care workers they employ. Service volume continues to grow in the outpatient setting. Despite increasing competition from independent diagnostic testing facilities and ambulatory surgical centers, the volume of hospital outpatient services per Medicare FFS beneficiary has grown by more than 4 percent per year from 2003 to 2008. Part of the growth is due to a shift of services from the inpatient to the outpatient setting. Despite that shift, inpatient services per FFS beneficiary declined by an average of only 0.1 percent annually over the same five-year period.

- Quality continues to improve on most measures. Hospitals reduced 30-day mortality across all six conditions we monitor, process of care measures are improving, and patient satisfaction has improved. However, readmission rates remain unchanged, and indicators of patient safety show mixed results.

- Capital markets have been volatile over the past year. Credit markets froze in late 2008, but by late 2009 interest rates paid by hospitals had fallen and the monthly volume of bond offerings during 2009 has been roughly similar to the level in 2007.

- Medicare inpatient payments per discharge rose by 4.5 percent in 2008 while hospitals' costs grew 5.5 percent. Hospitals' profit margins on overall Medicare services (including inpatient, outpatient, skilled nursing, inpatient rehabilitation, and home health) declined from –6 percent in 2007 to –7.2 percent in 2008. Cost growth appears to have slowed in 2009 due to financial pressure from the recession but may return to trend in 2010.

A key question is whether Medicare payments are adequate to cover the costs of efficient providers. We find that Medicare payments on average do cover the costs of relatively efficient hospitals; however, we also find that most of these hospitals do not generate significant profits from serving Medicare beneficiaries.

The Commission recommends an update equal to the projected increase in the hospital market basket index (currently projected to be 2.4 percent) for inpatient and outpatient services, with this update implemented concurrently with a quality improvement program that would increase or decrease payments based on the quality of care provided. A hospital's quality performance would determine whether its payments increase more or less than the market basket increase.

To ensure that the aggregate level of hospital payments is correct, the update recommendation is coupled with a recommendation to correct for the effect of improved documentation and coding on Medicare payments. As expected, implementation of Medicare severity–diagnosis related groups (MS–DRGs) in 2008 gave hospitals a financial incentive to improve medical record documentation and diagnosis coding to more fully account for each patient's severity of illness. Documentation and coding improvements strengthen measurement of patient severity, but they also increase reported case mix under MS–DRGs without a real increase in patient severity or the resources hospitals must use to furnish inpatient care. To ensure that the transition to MS–DRGs is budget neutral, an offsetting adjustment must be applied to the Medicare base payment amounts to recover past overpayments and prevent future overpayments. We recommend spreading this budget-neutrality adjustment over several years.

Physician services

Physician services include office visits, surgical procedures, and a broad range of other diagnostic and therapeutic services furnished in all settings, not just physician offices. In 2008, the traditional FFS Medicare program spent about $61 billion on physician services, accounting for 13 percent of total Medicare spending.

Most indicators of payment adequacy for physician services are positive and stable, suggesting that most beneficiaries can obtain physician care on a timely basis.

- Overall, beneficiary access to physician services is generally good and in several measures better than that reported by privately insured patients age 50 to 64.

Most beneficiaries are able to get timely appointments. Among the small share of beneficiaries looking for a new physician, most could find one; however, finding a primary care physician was more difficult than finding a specialist. Racial and ethnic minorities were more likely to experience access problems whether covered by Medicare or private insurance.

- A 2008 survey conducted by the Center for Studying Health System Change found that most physicians (74 percent) accepted all or most new Medicare patients in their practice. In our analysis of Medicare claims, we find 95 percent of physicians and other health professionals registered to bill Medicare had participation agreements with Medicare requiring them to accept Medicare's fee schedule amount for all Medicare patients.

- Service volume per beneficiary grew at a faster rate in 2008 than in 2007. Overall volume (reflecting both service units and intensity) grew 3.6 percent per beneficiary. Most of the claims-based ambulatory quality indicators that we examined for the elderly improved slightly or were stable from 2006 to 2008. Medicare's payment for physician services in 2008 was about 80 percent of private insurer payments, about the same levels it has been over the last decade.

In consideration of these factors, the Commission recommends that Medicare's payment for physician services be increased by 1.0 percent in 2011. However, the Commission is still concerned about the mispricing of services in the physician fee schedule and the inequity of a payment system that allows some physicians—often those in procedural specialties—to generate volume and revenue more readily than others. The Commission reiterates its earlier recommendations to increase payments for selected primary care services and plans future work on these issues.

Ambulatory surgical centers

Ambulatory surgical centers (ASCs) furnish outpatient surgical services to patients not requiring hospitalization and for which an overnight stay is not expected after surgery. In 2008, Medicare combined program and beneficiary spending on ASC services was $3.1 billion, an increase of 9.7 percent per FFS beneficiary over 2007.

- Access to ASC care has generally been adequate. The number of Medicare-certified ASCs was about 5,200, an increase of 3.7 percent over 2007, while volume increased 10.5 percent.

- ASCs' access to capital appears to be adequate as the number of ASCs has continued to increase.

- We do not have sufficient data to assess ASCs' quality of care because ASCs are not required to submit quality data in any form.

Considering these indicators, the Commission recommends a 0.6 percent increase to the payment rates for ASC services in calendar year 2011 concurrent with requiring ASCs to submit cost and quality data.

The projected change in providers' input prices is an important part of the Commission's annual update process. Due to concerns that the market basket index CMS uses to update ASC payments (the consumer price index for all urban consumers) may not reflect ASCs' input prices, we examined whether an alternative Medicare price index would better measure changes in ASC costs. Our analysis of ASC cost data from a 2004 survey indicates that ASCs appear to have a much higher share of expenses related to medical supplies and drugs than hospitals and physician offices, a much lower share of labor costs than hospitals, and a smaller share of all other costs than physician offices. Given these marked differences, the Congress should require ASCs to submit cost data to CMS, which should decide whether to use an existing Medicare price index as a proxy for ASC costs or to develop an ASC-specific market basket.

Outpatient dialysis services

Outpatient dialysis services are used to treat individuals with end-stage renal disease (ESRD). In 2008, about 330,000 beneficiaries were covered by Medicare and received dialysis from nearly 5,000 ESRD facilities. In that year, Medicare expenditures for outpatient dialysis services, including separately billable drugs administered during dialysis, were $8.6 billion.

Our payment adequacy indicators for outpatient dialysis services are generally positive.

- Dialysis facilities appear to have the capacity to meet beneficiaries' demand. The growth in the number of dialysis treatment stations has generally kept pace with the growth in the number of dialysis beneficiaries, and the number of ESRD facilities

continues to increase. The few facility closures do not appear to disproportionately affect African Americans or beneficiaries dually eligible for Medicare and Medicaid.

- Since 1996, the number of dialysis treatments has kept pace with the growth in the number of beneficiaries. Statutory and regulatory changes that CMS implemented beginning in 2005 reversed spending trends for dialysis drugs. Although dialysis drug spending has decreased since 2004, our analysis suggests that the volume of drugs increased but at a slower rate than in previous years.
- Dialysis quality has improved over time for some measures, such as the use of the recommended type of vascular access—the site on the patient's body where blood is removed and returned during dialysis. Other measures suggest that improvements in quality are still needed. In particular, the proportion of all dialysis patients registered on the kidney transplant waiting list remains low and rates of hospitalization and mortality remain high.
- Information from investment analysts suggests that access to capital for dialysis providers continues to be adequate. The number of facilities, particularly for-profit facilities, continues to increase.

In 2008, the Medicare margin for composite rate services and dialysis drugs for freestanding facilities was 3.2 percent. We project the Medicare margin for freestanding dialysis facilities will be 2.5 percent in 2010. This projection does not take into account the 2 percent reduction in total spending that the Medicare Improvements for Patients and Providers Act of 2008 mandated to begin in 2011 under the new dialysis payment method because: (1) the regulatory provisions to implement the new payment method are not finalized and (2) providers' response to the new payment method is unknown. Including drugs and services that Medicare now separately pays for may lead to improvements in the efficiency of care.

Our analysis suggests that a moderate update of the composite rate is in order. Therefore, the Commission recommends updating the composite rate for calendar year 2011 by the projected rate of increase in the ESRD market basket less the Commission's adjustment for productivity growth.

Hospice

The Medicare hospice benefit covers palliative and support services for beneficiaries with a life expectancy of six months or less who choose to enroll in the benefit. In 2008, more than 1 million Medicare beneficiaries received hospice services from more than 3,300 providers and Medicare expenditures exceeded $11 billion.

Overall, the indicators of payment adequacy for hospices are generally positive:

- Hospice use among Medicare decedents has grown substantially in recent years, suggesting greater awareness of and access to hospice services. Hospice use increased across all demographic and beneficiary characteristics examined. Despite this growth, use remained lower among racial and ethnic minorities. The supply of hospices grew substantially (47 percent) from 2000 to 2008—almost all new hospices were for-profit providers. Medicare spending on hospice services nearly quadrupled between 2000 and 2008, reflecting more beneficiaries enrolling in hospice and longer lengths of stay.
- We do not have sufficient evidence to assess quality, as information on quality of care is very limited. Efforts to provide a pathway for further development of quality measures are ongoing.
- Hospices are not as capital intensive as most other provider types because they do not require extensive physical infrastructure. Evidence suggests that access to capital is favorable for large publicly traded hospice companies, for-profit freestanding hospices, and hospital-based and home-health-based hospices. Access to capital for nonprofit freestanding hospices is difficult to discern.
- The aggregate Medicare margin was 5.9 percent in 2007. We project that the aggregate margin will be 4.6 percent in 2010. These margin estimates exclude the costs of bereavement services (about 1.5 percent of total costs), which are not reimbursable by Medicare.

The Commission concludes that hospice providers can operate within the current payment system with a moderate update. We therefore recommend that the Congress update payment rates for hospice services by the hospital market basket index, less the Commission's adjustment for productivity growth.

Post-acute care providers: An overview of issues

In Chapter 3 we discuss the Commission's assessment of the adequacy of Medicare's payments in each post-acute care sector (skilled nursing facility, home health, inpatient rehabilitation facility, long-term care hospital). We first note four common themes across the sectors:

- Payments are not accurately calibrated to costs in each sector.
- Services overlap among settings.
- The post-acute care product is not well defined.
- Assessment instruments differ among settings.

Refining the prospective payment systems (PPSs) and their case-mix systems will not resolve issues of whether patients go to the lowest cost, appropriate post-acute setting or whether they need post-acute care at all. Some patients might recover and recuperate at home using outpatient services or might do better by staying a few more days in the acute care hospital. Medicare would also want to make sure that beneficiaries receive the most clinically appropriate and effective care, regardless of the setting.

To this end, the Commission is looking beyond payment adequacy to think more broadly about how to match patients who use post-acute care with the set of services that can provide the best outcomes at the lowest cost. Building on past Commission work, in Chapter 3 we discuss two possible next steps. First, CMS could implement readmission policies for all post-acute care settings so that providers' incentives are aligned and they share the responsibility for avoiding unnecessary rehospitalizations. Second, CMS could establish a pilot to test the concept of bundling payments around a hospitalization for select conditions and include post-acute care in those bundles. Bundling payments represents a bigger step toward aligning financial incentives and provider responsibility for patient outcomes across settings.

Skilled nursing facility services

Skilled nursing facilities (SNFs) furnish short-term skilled nursing and rehabilitation services to beneficiaries after a stay in an acute care hospital. Most SNFs are part of nursing homes that furnish long-term care, which Medicare does not cover. In 2008, about 15,000 SNFs furnished covered care to 1.6 million beneficiaries. In 2009, Medicare spending on SNF care was $25.5 billion.

Most indicators of payment adequacy for SNFs are positive.

- Access to SNF services remains good for most beneficiaries but certain subgroups of beneficiaries—those with medically complex care needs and members of racial minorities—warrant further analysis. Days and admissions on a per FFS beneficiary basis increased slightly between 2007 and 2008, suggesting that access was maintained, but, since 2003, the share of SNFs admitting medically complex patients decreased.
- SNF quality of care shows mixed results since 2000. Between 2006 and 2007, the risk-adjusted rates of community discharge increased to reach the highest level since 2000, while potentially avoidable rehospitalizations have steadily risen, although the most recent increase was minimal.
- Because most SNFs are part of a larger nursing home, we examine nursing homes' access to capital. Access to capital improved over the last year but the lending terms are stricter and owners and operators are more carefully screened than in the past. Uncertainties in lending do not center on the adequacy of Medicare payments: From all accounts, Medicare remains a sought-after payer.
- Increases in payments between 2007 and 2008 outpaced increases in provider costs, reflecting the continued concentration of days in the highest payment case-mix groups. In 2008, the average Medicare margin for freestanding SNFs was 16.5 percent. We project a Medicare margin for 2010 of 10.3 percent. Financial performance continued to differ substantially across the industry—a function of distortions in the PPS and cost differences of providers. Compared with SNFs with relatively low margins, SNFs with the highest margins had higher shares of days in intensive rehabilitation case-mix groups and lower shares of days in the medically complex groups. Our previously recommended changes to the PPS design would, if implemented, narrow the differences in financial performance across the industry.

In light of these findings, the Commission recommends a zero update for 2011 and reiterates its prior recommendations on SNF PPS design and pay for performance.

Home health services

Home health agencies provide services to beneficiaries who are homebound and need skilled care (nursing or therapy). In 2008, about 3.2 million beneficiaries received home health services from about 10,000 home health agencies under the Medicare benefit. Medicare spent $16 billion on home health services in 2008.

The indicators of payment adequacy for home health are mostly positive:

- Access to home health is widespread, with 99 percent of beneficiaries living in a ZIP code where a Medicare home health agency operates. The number of agencies continues to increase, with about 500 new agencies in 2009. Most new agencies since 2002 are in Texas, Florida, and Michigan. There are concerns that growth in certain areas, including Miami–Dade County, Florida, is related to increased fraud and abuse activity by some providers. The volume of services continues to rise. More beneficiaries are receiving home care, and the number of episodes per beneficiary continues to rise.
- The Home Health Compare measures for 2009 are similar to those for previous years, showing improvement in the functional measures and mostly unchanged rates of adverse events. However, the Commission has concerns about the current measures and believes further study is needed before it can draw definitive conclusions about quality.
- Home health agencies are smaller and do not have the capital-intensive needs found in most other health care sectors. According to capital market analysts, the major publicly traded for-profit home health companies have access to capital markets for their credit needs. For smaller agencies, the significant number of new agencies in 2009 suggests that they have access to capital necessary for start-up.
- Payments have consistently and substantially exceeded costs in the home health PPS. Medicare margins in 2008 were 17.4 percent. For 2010, the Commission projects margins of 13.7 percent.

Taking into consideration the generally positive indicators of payment adequacy, the Commission has concluded that home health payments need to be significantly reduced. To start with, the Commission recommends a zero update for 2011 and that the Congress direct the Secretary to rebase rates for home health care services to reflect the average cost of providing care.

In addition, efforts need to be made to strengthen quality measurement and program integrity. The Commission recommends that the Congress should direct the Secretary to expeditiously modify the home health payment system to protect beneficiaries from stinting or lower quality care in response to rebasing. The approaches should include risk corridors and blended payments that mix prospective payment with elements of cost-based reimbursement. The Secretary should also identify categories of patients who are likely to receive the greatest clinical benefit from home health and develop outcomes measures that evaluate the quality of care for each category of patient. Finally, the Congress should direct the Secretary to review home health agencies that exhibit unusual patterns of claims for payment and provide the Secretary with the authority to implement safeguards—such as a moratorium on new providers, prior authorization, or suspension of prompt payment requirements—in areas that appear to be high risk.

Inpatient rehabilitation facility services

More than 330,000 Medicare FFS beneficiaries received care in inpatient rehabilitation facilities (IRFs) in 2008. Between 2007 and 2008, Medicare FFS expenditures for IRF services declined from $5.95 billion to $5.84 billion, largely due to declines in FFS enrollment and a small decline in IRF utilization. FFS spending on IRF services is projected to decrease slightly in 2009 and increase from 2010 onward as Medicare FFS enrollment growth accelerates.

Our indicators of Medicare payment adequacy for IRFs are generally positive.

- Our measures of beneficiary access to care suggest that beneficiaries have sufficient access to IRF services. After declining slightly in 2006 and 2007, the supply of IRFs was unchanged in 2008. The IRF occupancy rate was 62 percent in 2008. The stability in provider supply and low occupancy rate suggest that capacity remains adequate to meet demand. In 2008, the proportion of Medicare FFS beneficiaries admitted to IRFs decreased slightly by 0.6 percent. Our assessment of hospital discharge patterns to post-acute care suggests that beneficiaries who were not admitted to IRFs as a result of the 2004 CMS compliance threshold were able to obtain

rehabilitation care in other settings, such as SNFs and home health.

- From 2004 to 2009, IRF patients' functional improvement between admission and discharge has increased, suggesting improvements in quality. However, changes over time in patient mix make it difficult to draw definitive conclusions about quality trends.
- Credit markets have begun to ease relative to the credit crisis of 2008 and are operating in a more normal manner. Both hospital-based units, through their parent institutions, and chains of freestanding facilities exhibit continued access to capital. We are not able to determine the ability of independent freestanding facilities to raise capital.
- Growth in cost per case has slowed since 2007 but continues to grow faster than payments. Nevertheless, the IRF aggregate Medicare margin for 2008 was 9.5 percent. We project that this figure will fall to 5.0 percent in 2010. To the extent that IRFs restrain their cost growth in response to fiscal pressure, the projected 2010 margin could be higher than we have estimated.

On the basis of our analyses, the Commission concludes that IRFs will be able to accommodate cost changes in fiscal year 2011 at current payment levels and recommends a zero update. We will closely monitor payment update indicators to reassess our update recommendation for the next fiscal year.

Long-term care hospital services

Long-term care hospitals (LTCHs) furnish care to patients with clinically complex problems—such as multiple acute or chronic conditions—who need hospital-level care for relatively extended periods. To qualify as an LTCH for Medicare payment, a facility must meet Medicare's conditions of participation for acute care hospitals and have an average length of stay greater than 25 days for its Medicare patients. Medicare is the predominant payer for LTCH services, accounting for about two-thirds of LTCH discharges. In 2008, Medicare spent $4.6 billion on care furnished in the just under 400 LTCHs nationwide. About 115,000 beneficiaries had almost 131,000 LTCH stays.

Our payment adequacy indicators for LTCHs suggest that they are able to operate within the current payment system.

- The Medicare, Medicaid, and SCHIP Extension Act imposed a three-year limited moratorium on new LTCHs and new beds in existing LTCHs. Controlling for change in the number of FFS beneficiaries, we found that the number of LTCH cases rose 3.6 percent between 2007 and 2008, suggesting that access to care was maintained during that period.
- LTCHs do not submit quality data to CMS. Existing measures of quality are not reliable for LTCHs, and new ones need to be developed. Analyzing unadjusted aggregate trends in in-facility mortality, mortality within 30 days of discharge, and readmission to acute care, we find that, across all diagnoses, rates of death and readmission have remained stable and readmission rates have been stable or declining for the most frequently occurring LTCH diagnoses. The Commission is planning to explore the feasibility of developing meaningful quality measures for LTCHs and the data needed for measurement.
- Relatively little equity has been raised by LTCH chains in recent months. This situation is likely due, at least in part, to the moratorium on new LTCHs, which has reduced opportunities for expansion and therefore reduced the need for capital.
- Between 2007 and 2008, spending per FFS beneficiary climbed 4.7 percent. Over the same period, costs per case grew 2.1 percent. The 2008 Medicare margin for LTCHs was 3.4 percent. We estimate LTCHs' aggregate Medicare margin will be 5.8 percent in 2010.

Taking into account these findings, the Commission recommends a zero update to payment rates for LTCH services for rate year 2011.

The Medicare Advantage program

The Medicare Advantage (MA) program allows Medicare beneficiaries to receive benefits from private plans rather than from the traditional FFS program. The Commission supports private plans in the Medicare program; beneficiaries should be able to choose between the traditional FFS Medicare program and the alternative delivery systems that private plans can provide. Private plans have greater potential to innovate and to use care management techniques and, if paid appropriately, would have more incentive to do so.

The Commission also supports financial neutrality between FFS and the MA program. Financial neutrality means that the Medicare program should not pay MA plans more than it would have paid for the same set of services under FFS. Currently, Medicare spends more under the MA program than under FFS for similar beneficiaries. This higher spending results in increased government outlays and higher beneficiary Part B premiums (including higher premiums for beneficiaries in FFS) at a time when both the Medicare program and its beneficiaries are under increasing financial stress.

In Chapter 4 we report that most indicators of program performance—enrollment, plan availability, and quality of care—are generally positive or stable, but another measure—costliness—precludes MA from achieving its goal to be efficient relative to FFS. MA enrollment continued to grow through 2009. Compared with 2008, when 22 percent of beneficiaries were enrolled in MA plans, as of November 2009, 24 percent of Medicare beneficiaries—10.9 million—were enrolled in nearly 4,890 MA plans. Payments to MA plans increased from $93 billion in 2008 to $110 billion in 2009. This amount represents 26 percent of all Medicare expenditures in 2009. In 2009, Medicare spent roughly $14 billion dollars more for the beneficiaries enrolled in MA plans than it would have spent if they had stayed in FFS Medicare. To support the extra spending, Part B premiums were higher for all Medicare beneficiaries (including those in FFS). CMS estimated that the Part B premium was $3.35 per month higher in 2009 than it would have been if spending for MA enrollees had been the same as in FFS.

In 2010, an MA plan of some type is available to all Medicare beneficiaries and a coordinated care plan is available to almost all. Eighty-five percent of beneficiaries have access to an MA plan that includes Part D drug coverage and has no premium (beyond the Medicare Part B premium), and access to MA special needs plans is greater than in 2009. On average, beneficiaries can choose from 21 different plans in their county of residence. MA payments will continue to exceed Medicare FFS spending for similar beneficiaries in 2010, although by less than in 2009. MA plans will continue to provide enhanced benefits but at a high cost to the Medicare program.

Status report on Part D

Part D of Medicare provides an outpatient prescription drug benefit through the use of competing private plans. In Chapter 5 we examine several indicators of beneficiary access and program spending.

In early 2009, about 90 percent of the 45 million Medicare beneficiaries had Part D drug coverage or its equivalent—about 59 percent were enrolled in Part D plans and 31 percent had other sources of creditable coverage. About 10 percent had no drug coverage or coverage less generous than Part D. Among those in Part D plans, nearly 10 million low-income individuals (21 percent of all Medicare beneficiaries) received extra help with premiums and cost sharing through the low-income subsidy (LIS). Roughly two-thirds of Part D enrollees are in stand-alone prescription drug plans (PDPs); the rest are in MA–Prescription Drug plans (MA–PDs).

- Sponsors are offering about 7 percent fewer PDPs in 2010 than in 2009, but beneficiaries will continue to have from 41 to 55 PDP options to choose among, along with many MA–PDs. For 2010, sponsors are tightening benefit designs for PDPs with respect to deductibles and gap coverage while keeping largely the same structure for MA–PDs.
- Part D enrollees in 2010 are paying, on average, $30.52 per month, up less than $2.00 (6 percent) from 2009. In 2010, the average PDP enrollee pays $37.67 per month, and the average MA enrollee pays $13.99 per month.

CMS sets a maximum amount in each region that Medicare will pay for extra help with premiums through the LIS. If a plan's premium is below that threshold, LIS enrollees pay no premium. In 2010, about the same number of such PDPs met this criterion as in 2009 (307), and each region has at least four such PDPs. CMS needed to reassign an estimated 1.06 million LIS enrollees to plans offered by a different sponsor because their previous plan's premium did not fall below the 2010 threshold.

The Medicare trustees estimate Part D spending was $53 billion in 2009, $4 billion more than in 2008. Part D's LIS became the largest component of Part D spending in 2008 and continues to be in 2009. The fastest growing component of Part D is Medicare's reinsurance payments for the highest spending enrollees, due in part to the difficulty of negotiating rebates for high-cost drugs and biologics that have few competing therapies.

CMS publishes 19 performance metrics aggregated into a 5-star rating system through the Medicare Prescription Drug Plan Finder at www.medicare.gov. Currently, two

metrics address patient safety, while the rest focus on customer service and enrollee satisfaction. For 2010, CMS has set more requirements addressing how sponsors operate, monitor, and report on their plans' medication therapy management programs.

Report on comparing quality among Medicare Advantage plans and between Medicare Advantage and fee-for-service Medicare

In recent years, the Commission has made a number of recommendations on quality reporting and quality-related payment adjustments in both the MA and traditional Medicare FFS programs. In response to a congressional mandate, in Chapter 6 we make additional recommendations on quality measurement and reporting in Medicare. Specifically, Section 168 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) requires the Commission to submit a report to the Congress by March 31, 2010, about measures for comparing quality and patient experience in the MA and FFS programs, with the goal of collecting and reporting such measures by the year 2011. MIPPA requires that the report:

- address methods for comparing quality among MA plans as well as between the MA and FFS programs,
- address issues in public reporting and benchmarking, and
- include recommendations for legislative or administrative changes as the Commission finds appropriate.

Any changes the Commission recommends in March 2010 would have to be implemented immediately for collection and reporting of measures in 2011. CMS, health plans, and other entities need as much lead time as possible to implement changes and to be prepared for data collection and reporting in that one-year time frame. Thus, we have taken an incremental approach, building on current measurement systems and data sources to improve quality comparisons in the short term—by 2011. For the longer term—that is, by 2013 and beyond—we recommend ways to expand current reporting to encompass Medicare FFS and to fill in gaps in the current measurement sets, including the use of outcome measures to compare MA and FFS in local geographic areas. We also recommend leveraging the capabilities and increased use of health information technology, which will be supported by Medicare payment incentives beginning in 2011, to facilitate improvements in quality measurement.

On the basis of our findings, the Commission makes recommendations that address the use of electronic health records, the geographic unit of analysis for quality comparisons, uniformity in quality data reporting requirements, comprehensiveness of quality measures, and the issue of whether there are sufficient dedicated resources for CMS. Although the resources required to implement these recommendations are likely to be substantial, we believe it is important to beneficiaries, providers, and policymakers that comparisons on quality be as accurate and reliable as possible. The unintended consequences of incomplete or flawed comparisons would be detrimental to the goal of improving quality across Medicare. ■