
Executive summary

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By law, the Medicare Payment Advisory Commission reports to the Congress each March on the Medicare fee-for-service (FFS) payment systems, the Medicare Advantage (MA) program, and the Medicare prescription drug program (Part D). In this year's report, we:

- consider the context of the Medicare program in terms of the effects of its spending on the federal budget and its share of national gross domestic product (GDP).
- evaluate payment adequacy and make recommendations concerning Medicare FFS payment policy in 2017 for acute care hospital, physician and other health professional, ambulatory surgical center, outpatient dialysis facility, skilled nursing facility, home health care, inpatient rehabilitation facility, long-term care hospital, and hospice services.
- review the status of the MA plans that beneficiaries can join in lieu of traditional FFS Medicare (Part C).
- review the status of the plans that provide prescription drug coverage (Part D).

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. This report includes recommendations on MA and provides information on Part D, but most of its content focuses on the Commission's recommendations for the annual payment rate updates under Medicare's various FFS payment systems and on aligning relative payment rates across those systems so that patients receive efficiently delivered, high-quality care.

We recognize that managing updates and relative payment rates alone will not solve what have been fundamental problems with Medicare FFS payment systems to date—that providers are paid more when they deliver more services without regard to the value of those additional services and are not routinely rewarded for care coordination. To address these problems directly, two approaches must be pursued. First, payment reforms, such as incentives to reduce excessive hospital readmission rates, need to be implemented more broadly and coordinated across settings. Second, delivery system

reforms that have the potential to encourage high-quality care, better care transitions, and more efficient provision of care—such as medical homes, bundling, accountable care organizations, and MA plans—need to be enhanced and closely monitored, and successful models adopted on a broad scale.

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—their overall level, the relative prices of different services in a sector, and the relative prices of the same service across sectors—an important topic. In addition, constraining unit prices could create pressure on providers to control their own costs and to be more receptive to new payment methods and delivery system reforms.

For each recommendation, we present its rationale, its implications for beneficiaries and providers, and how spending for each recommendation would compare with expected spending under current law. The spending implications are presented as ranges over one-year and five-year periods; unlike official budget estimates, they do not take into account the complete package of policy recommendations or the interactions among them. Although we recognize budgetary consequences, our recommendations are not driven by any single budget target but instead reflect our assessment of the payment rate needed to provide adequate access to appropriate care.

In Appendix A, we list all recommendations and the Commissioners' votes.

Context for Medicare payment policy

Part of the Commission's mandate is to consider the effect of its recommendations on the federal budget and view Medicare in the context of the broader health care system. To help meet that mandate, Chapter 1 examines health care spending growth—for the nation at large and Medicare in particular—and considers its effect on federal and state budgets and on the budgets of individuals and families. The chapter also profiles the next generation of Medicare beneficiaries and reviews evidence of inefficient health care spending, structural features of the Medicare program that contribute to inefficient spending, and the Commission's approach to addressing those challenges.

Health care spending growth may be beginning to accelerate after several years of historic lows. National health care spending and Medicare spending both grew robustly from 1974 to 2009. Then from 2009 to 2013, growth in national health care spending and Medicare spending slowed to average annual rates of 3.6 percent and 4.1 percent, respectively.

The causes of the system-wide slowdown and whether it will be sustained or is transient are still a matter of speculation. A variety of factors could have contributed—weak economic conditions, payment and delivery system reforms, lower Medicare payment rates for most types of providers as mandated by the Patient Protection and Affordable Care Act of 2010 (PPACA), and the increased use of generic drugs as top-selling brand drugs lost patent protection.

However, experience in 2014 suggests that the slowdown may be coming to an end. Government actuaries estimate that spending grew faster that year: National health care spending grew 5.3 percent, and Medicare spending grew 5.5 percent. The increase in national health care spending growth was due largely to coverage expansions for health insurance that commenced that year under PPACA, as well as to a substantial increase in prescription drug spending, especially on new treatments for hepatitis C. The increase in Medicare spending growth was due to a substantial increase in prescription drug spending and spending on outpatient services (services received in hospital outpatient departments, physician services, and other services provided on an outpatient basis).

The aging of the baby-boom generation will have a profound impact both on the Medicare program and the taxpayers who support it. Over the next 15 years, as Medicare enrollment surges, the number of taxpaying workers per beneficiary is projected to decline. By 2030 (the year baby boomers will have all aged into Medicare), the Medicare Trustees project there will be just 2.4 workers for each Medicare beneficiary, down from 4.6 around the time of the program's inception. Those demographics create a financing challenge not only for the Medicare program but also for the entire federal budget. By 2040, under federal tax and spending policies specified in current law, Medicare spending combined with spending on other major health care programs, Social Security, and net interest on the national debt would exceed total federal revenues and would crowd out spending on all other national priorities.

The growth in health care spending also affects state budgets and the budgets of individuals and families. States pay for a significant portion of Medicaid spending (spending funded jointly by states and the federal government for health care services provided to state residents with low incomes). Under PPACA, the Medicaid population is expanding; however, the federal government will pay for most of the costs associated with the expansion. Increases in private insurance premiums have outpaced the growth of individual and family incomes over the past decade, and out-of-pocket costs for Medicare beneficiaries also have increased.

Some health care spending is inefficient. For Medicare, if such spending can be identified and eliminated, it could result in each Medicare dollar being spent more efficiently, improving beneficiary health, supporting the program's fiscal sustainability, and reducing federal budget pressures. Certain structural features of the Medicare program pose challenges for targeting inefficient spending, but the Commission has a framework to address those challenges that focuses on (1) payment accuracy and efficiency, (2) care coordination and quality, (3) information for patients and providers, (4) engaged beneficiaries, and (5) an aligned health care workforce.

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

As required by law, the Commission annually makes payment update recommendations for providers paid under FFS Medicare. As discussed in Chapter 2, an update is the amount (usually expressed as a percentage change) by which the base payment for all providers in a payment system is changed relative to the prior year. To determine an update, we first assess the adequacy of Medicare payments for providers in the current year (2016) by considering trends in beneficiaries' access to care, the quality of care, providers' access to capital, and Medicare payments and providers' costs (including, starting this year, marginal profitability as a measure of a provider's incentive to accept additional Medicare patients). Next, we assess how those providers' costs are likely to change in the year the update will take effect (the policy year—2017). As part of the process, we examine payments to support the efficient delivery of services consistent with our statutory mandate. Finally, we make a judgment about what, if any, update is needed.

This year, we consider recommendations in nine FFS sectors: acute care hospitals, physicians and other health professionals, ambulatory surgical centers, outpatient

dialysis facilities, skilled nursing facilities, home health care agencies, inpatient rehabilitation facilities, long-term care hospitals, and hospices. Each year, the Commission looks at all available indicators of payment adequacy and re-evaluates any assumptions from prior years using the most recent data available to make sure its recommendations accurately reflect current conditions. We may also consider changes that redistribute payments within a payment system to correct any biases that may make patients with certain conditions financially undesirable, make particular procedures unusually profitable, or otherwise result in inequity among providers. Finally, we may also make recommendations to improve program integrity.

These recommendations, if enacted, could significantly change the revenues providers receive from Medicare. Rates set to cover the costs of relatively efficient providers help create fiscal pressure on all providers to control their costs. In addition, the Commission examines payment rates for services that can be provided in multiple settings. Medicare often pays different amounts for similar services across settings. Basing the payment rate on the rate in the most efficient setting would save money for Medicare, reduce cost sharing for beneficiaries, and reduce the incentive to provide services in the higher paid setting for financial reasons. Medicare rates also have broader implications for health care spending. For example, Medicare rates are commonly used to set hospital rates charged to uninsured patients eligible for financial assistance, used by Medicare Advantage plans to set hospital prices, and used by the Department of Veterans Affairs (VA) to pay non-VA providers.

Hospital inpatient and outpatient services

In 2014, the Medicare FFS program paid 4,700 hospitals a total of \$173 billion for 9.7 million Medicare inpatient admissions, 193 million outpatient services, and \$9.4 billion of hospitals' uncompensated care costs. This amount represents a 4 percent increase in hospital spending from 2013. On net, Part A hospital payments increased by \$1 billion and Part B outpatient payments increased by \$5 billion. Part A payments increased because the increase in prices and patient severity more than offset a decline in inpatient volume. In addition, \$9.4 billion of Part A trust fund dollars were reallocated from inpatient disproportionate share (DSH) payments to non-Medicare uncompensated care payments. Outpatient payments rose due to volume increases, price increases, and packaging of some laboratory services that were

covered under the laboratory fee schedule into the outpatient payment rates.

As discussed in Chapter 3, most payment adequacy indicators (including access to care, quality of care, and access to capital) are positive, and Medicare payment rates are still higher than the variable costs associated with Medicare patients. However, Medicare margins are negative on average and about break even for efficient providers, and under current law, margins are expected to decline in 2016. Our findings on payment adequacy are:

- The average hospital occupancy rate was 61 percent in 2014, suggesting hospitals have excess inpatient capacity in most markets.
- Inpatient use per beneficiary declined by 3.6 percent in 2014 and outpatient services increased by 3.7 percent. However, some systems reported increases in both inpatient and outpatient volumes in the first half of 2015.
- Hospital quality metrics remained stable or improved in 2014.
- Access to bond and equity markets remains strong for most hospitals, in part reflecting hospitals' strong all-payer profitability from 2012 through 2014.
- In 2014, hospitals' aggregate Medicare margin was -5.8 percent. However, a set of relatively efficient hospitals were able to break even on Medicare while performing well on quality metrics. In addition, hospitals' marginal profits under Medicare were positive 10 percent; thus, hospitals with excess capacity had a financial incentive to serve more Medicare patients. Under current law, payment rates are projected to decline from 2014 to 2016 due to a \$3 billion decline in uncompensated care payments and other policy changes (by law, uncompensated care payments decline when the share of the population that is insured increases). We project hospitals' aggregate Medicare margin for 2016 will be about -9 percent.

Nonprofit hospitals with high shares of Medicaid and low-income Medicare patients (about one-third of all prospective payment system (PPS) hospitals) qualify for the 340B Drug Pricing Program. These hospitals receive substantial discounts from drug manufacturers for Part B drugs. The Office of Inspector General estimates that the aggregate discount across all 340B providers is 34 percent

of the average sales price (ASP). The hospital outpatient payment system pays for those drugs at 106 percent of each drug's ASP. Because Medicare does not currently adjust outpatient rates for the lower drug acquisition cost at 340B hospitals, Medicare payment rates are much higher than the acquisition costs of Part B drugs at these hospitals. Reducing the price Medicare pays 340B PPS hospitals for separately payable Part B drugs by 10 percent of ASP would accomplish two things. First, it would reduce beneficiary cost sharing. Second, it would reduce program spending for Part B drugs by approximately \$300 million—funds that could be reallocated within the hospital sector to support the Medicare-funded uncompensated care pool, as we discuss below.

The Commission recommends that the Congress direct the Secretary of the Department of Health and Human Services (HHS) to update inpatient and outpatient payments by the amount specified in current law, reduce 340B hospitals' Medicare payment rates for separately payable Part B drugs by 10 percent of ASP, direct the savings from reducing Part B drug payment rates to beneficiaries and to the Medicare-funded uncompensated care pool, and distribute all uncompensated care payments using data from the Medicare cost reports' Worksheet S-10. The use of S-10 uncompensated care data should be phased in over three years to allow for audits and improvement of the data. The Commission's multipart recommendation addresses the issues of updating Medicare hospital payments in view of mixed payment adequacy signals, allows beneficiaries to share in 340B drug discounts, and directs additional payments to hospitals that provide the most uncompensated care.

While the uncompensated care pool would be directly tied to hospitals' uncompensated care costs, the \$3.3 billion in traditional DSH dollars would still be distributed to hospitals based primarily on Medicaid days. Hospitals with high Medicaid shares would be disproportionately helped by the traditional DSH pool, and hospitals with high uncompensated care costs would be disproportionately helped by the uncompensated care pool.

While all hospitals are expected to experience increases in base payment rates due to the update, the effect of the remainder of the recommendation would vary depending on a hospital's characteristics. For example, DSH hospitals with high uncompensated care costs would see increases in payments that are above average, and DSH hospitals with below average uncompensated care costs would see

smaller increases or reductions in Medicare payments. The net effect of reduced payment rates for 340B hospitals' Part B drugs and increases in uncompensated care payments would be a small increase in average payments to 340B hospitals, reflecting the net effect of large increases in payment to 340B hospitals with high levels of uncompensated care (often public hospitals) and relatively smaller payment decreases to the 340B hospitals with lower than average levels of uncompensated care.

Physician and other health professional services

Physicians and other health professionals deliver a wide range of services, including office visits, surgical procedures, and diagnostic and therapeutic services in a variety of settings. In 2014, Medicare paid \$69.2 billion for physician and other health professional services, accounting for 16 percent of FFS Medicare spending. About 892,000 clinicians billed Medicare—576,000 physicians and 315,000 nurse practitioners, physician assistants, therapists, chiropractors, and other practitioners. Medicare pays for the services of physicians and other health professionals using a fee schedule. Current law updates Medicare's conversion factor for the fee schedule by 0.5 percent in 2017.

In Chapter 4, we use the following factors to assess payment adequacy for physicians and other health professionals: beneficiary access to care, volume growth, quality, changes in input costs, and differences in compensation across specialties.

- Overall, beneficiary access to physician and other health professional services is largely unchanged from last year and comparable with access for individuals with private insurance. Most beneficiaries report they are able to obtain timely appointments for routine care, illness, or injury, and most beneficiaries are able to find a new doctor without a problem. A small number of beneficiaries report more difficulty, with a higher share reporting problems obtaining a new primary care doctor than reporting problems obtaining a specialist.
- The number of physicians per beneficiary has remained relatively constant, the number of advanced practice nurses and physician assistants per beneficiary has grown slightly, and the share of providers accepting assignment and enrolled in Medicare's participating provider program remains high.

- In 2014, across all services, volume per beneficiary grew by 0.4 percent. Among broad categories of service, growth rates were 1.4 percent for major procedures, 0.8 percent for other procedures, 0.3 percent for evaluation and management, -0.6 percent for tests, and -1.1 percent for imaging services. While the imaging decrease continues the downward trend we have seen since 2009, use of imaging services remains much higher than it was in 2000. In addition, there has been a continued shift in billing for cardiovascular imaging from freestanding offices to hospitals.
- Currently, the Medicare program relies heavily on process measures to assess clinician quality, and the Commission would prefer the use of a few key outcome measures of importance to Medicare beneficiaries. However, the ability to differentiate performance on outcome measures at the individual clinician level is poor. We report two sets of measures at the national level—avoidable hospitalizations for ambulatory care-sensitive conditions and rates of low-value care in Medicare.
- CMS projects an increase in the Medicare Economic Index of 2.2 percent in 2017.
- In 2014, compensation for primary care physicians continued to be much lower than for physicians in specialty groups, raising concerns about fee schedule mispricing.

The evidence suggests that payments for physicians and other health professionals are adequate. Therefore, the Commission recommends the current law update for 2017.

Ambulatory surgical center services

Ambulatory surgical centers (ASCs) provide outpatient procedures to patients who do not require an overnight stay after the procedure. In 2014, over 5,400 ASCs treated 3.4 million FFS Medicare beneficiaries, and Medicare program spending on ASC services was \$3.1 billion.

Our analyses indicate that beneficiaries' access to ASC services is adequate, and most of the available indicators of payment adequacy for ASC services, discussed in Chapter 5, are positive. However, volume of ASC services declined in 2014.

- Our analysis of facility supply and volume of services indicates that beneficiaries' access to ASC services

has generally been adequate. From 2009 through 2013, the number of Medicare-certified ASCs grew by an average annual rate of 1.5 percent; in 2014, the number increased by 1.9 percent (the vast majority of new ASCs were for profit).

- From 2009 through 2013, the volume of services per beneficiary grew by an average annual rate of 1.3 percent; in 2014, volume decreased by 0.8 percent.
- ASCs began submitting data on quality measures to CMS in October 2012. CMS has made data publicly available for two of these measures and intends to make data on five others publicly available in April 2016. We commend CMS for creating a system for ASCs to submit data on quality measures. However, we are concerned that the data on the two measures that CMS has made publicly available are of limited value in assessing the quality of care in ASCs.
- Because the number of ASCs has continued to increase, access to capital appears to be adequate.
- From 2009 through 2013, Medicare payments per FFS beneficiary increased by an average of 2.6 percent per year and by 3.1 percent in 2014. Although volume per beneficiary decreased by 0.8 percent in 2014, Medicare payments per beneficiary increased because of increases in the ASC conversion factor and the average relative weight of the services provided.
- ASCs do not submit data on the cost of services they provide to Medicare beneficiaries. Therefore, we cannot calculate a Medicare margin as we do for other provider types to assist in assessing payment adequacy.

Considering these indicators, the Commission concludes that ASCs can continue to provide Medicare beneficiaries with access to ASC services with no update to the payment rates for 2017. In addition, we recommend that CMS require the submission of cost data from ASCs.

Outpatient dialysis services

Outpatient dialysis services are used to treat the majority of individuals with end-stage renal disease (ESRD). In 2014, about 383,000 beneficiaries with ESRD on dialysis were covered under FFS Medicare and received dialysis from about 6,300 dialysis facilities. In 2014, Medicare expenditures for outpatient dialysis services were \$11.2 billion, a 1 percent increase from 2013.

Our payment adequacy indicators for outpatient dialysis services, discussed in Chapter 6, are generally positive.

- Dialysis facilities appear to have the capacity to meet demand. Growth in the number of dialysis treatment stations has kept pace with growth in the number of dialysis beneficiaries.
- Between 2013 and 2014, the number of FFS dialysis beneficiaries and dialysis treatments each grew by 2 percent. At the same time, the per treatment use of most dialysis injectable drugs, including erythropoietin that is used in anemia management, continued to decline, but at a slower rate than in 2011 and 2012, the initial years of the PPS. The dialysis PPS created an incentive for providers to be more judicious about their provision of dialysis drugs.
- Using CMS data, we looked at changes in quality indicators since the dialysis PPS was implemented in 2011. Rates of emergency department use modestly increased, while rates of mortality and hospitalization declined. With regard to anemia management, negative cardiovascular outcomes associated with high erythropoiesis-stimulating-agent use have declined. Beneficiaries' use of home dialysis, which is associated with improved patient satisfaction and quality of life, increased from 8 percent to 10 percent of dialysis beneficiaries.
- 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.
- Between 2013 and 2014, cost per treatment increased by 1 percent, while Medicare payment per treatment decreased by about 1 percent. We estimate that the aggregate Medicare margin was 2.1 percent in 2014, and the rate of marginal profit—that is, the rate at which Medicare payments exceed providers' marginal cost—was nearly 18 percent. The 2016 Medicare margin is projected to be 0.8 percent.

The evidence on payment adequacy suggests that payments are adequate; therefore the Commission recommends that the Congress increase the outpatient dialysis base payment rate by the update specified in current law for calendar year 2017.

The Commission continues to have two concerns about the dialysis PPS. First, the low-volume payment adjustment

does not sufficiently target facilities that are both low-volume and isolated. Consequently, some facilities that receive this payment adjustment are in close proximity to other facilities. Second, CMS has not yet examined the appropriateness of the costs that facilities include on their cost reports, which can be done through cost report audits, and has used unaudited data to refine the ESRD market basket and the PPS payment adjustment factors. If facilities' costs are overstated, the Medicare margin—which the Commission uses as an indicator of payment adequacy—will be understated.

To address these concerns, the Commission reiterates its March 2014 recommendation that the Congress should direct the Secretary to redesign the low-volume payment adjustment to consider a facility's distance to the nearest facility and audit dialysis facilities' cost report data.

Skilled nursing facility services

Skilled nursing facilities (SNFs) provide short-term skilled nursing and rehabilitation services to beneficiaries after a stay in an acute care hospital. In 2014, about 15,000 SNFs furnished 2.4 million Medicare-covered stays to 1.7 million FFS beneficiaries. Medicare FFS spending on SNF services was \$28.6 billion in 2014.

To examine the adequacy of Medicare's payments, in Chapter 7, we analyze beneficiaries' access to care (including the supply of providers and volume of services), quality of care, provider access to capital, and Medicare payments in relation to providers' costs to treat Medicare beneficiaries. Key measures indicate Medicare payments to SNFs are more than adequate. We also find that relatively efficient SNFs—facilities identified as providing relatively high-quality care at relatively low costs—had very high Medicare margins, suggesting that opportunities remain for other SNFs to achieve greater efficiencies.

- Access to SNF services remains adequate for most beneficiaries. The number of SNFs participating in the Medicare program is stable. Over 90 percent of beneficiaries live in a county with three or more SNFs, and less than 1 percent live in a county without one. Available bed days increased slightly between 2013 and 2014. In 2014, the median occupancy rate remained at 86 percent, with one-quarter of SNFs having rates at or below 76 percent.
- Days and admissions per FFS beneficiary declined between 2013 and 2014, consistent with declines in

inpatient hospital admissions (a three-day inpatient stay is required for Medicare coverage of SNF services).

- Quality measures show mixed performance. Between 2013 and 2014, the community discharge rate and the rate of hospital readmissions occurring during SNF stays improved slightly. The rate of readmissions that occurred in the 30-day period after discharge from the SNF slightly increased (got worse), and the functional change measures were essentially unchanged.
- Because most SNFs are part of nursing homes, we examine nursing homes' access to capital. Access to capital was adequate and is expected to remain so. Medicare is regarded as a preferred payer of SNF services.
- In 2014, the average Medicare margin was 12.5 percent—the 15th year in a row that the average was above 10 percent. Margins continued to vary greatly across facilities and reflect shortcomings in the SNF PPS that encourage favorable selection of rehabilitation patients (over medically complex patients), differences in costs per day, and the cost control exhibited by some providers. The marginal profit was 20.4 percent. The projected Medicare margin for 2016 is 10.7 percent.

Medicare needs to revise the PPS. Over time, Medicare's payments have grown more inaccurate despite the many changes made to the payment system. The overpayments for therapy services have grown, strengthening the existing incentive to furnish therapy services regardless of clinical value. At the same time, the payments for nontherapy ancillary services are unrelated to these services' costs, making payments even more poorly targeted than they had been.

Given the continued need to revise the SNF PPS and rebase Medicare's level of payments, the Commission recommends that the Congress freeze Medicare's SNF payments for 2017 and 2018 and direct the Secretary to revise the payment system, and that in 2019, the Secretary report to the Congress on whether any additional adjustments are needed to align payment with costs.

As required by PPACA, we report on Medicaid use, spending, and total and non-Medicare margins. Medicaid finances mostly long-term care services provided in nursing homes, but also covers copayments for low-income Medicare beneficiaries (known as dual-eligible

beneficiaries) who stay more than 20 days in a SNF. The number of Medicaid-certified facilities remained essentially unchanged between 2014 and 2015. In 2014, the average total margin, reflecting all payers and all lines of business, was 1.9 percent, the same total margin as in 2013. The average non-Medicare margin (reflecting all payers and all lines of business except Medicare SNF services) was -1.5 percent, a slight improvement from 2013.

Home health care services

Home health agencies provide services to beneficiaries who are homebound and need skilled nursing or therapy. In 2014, about 3.4 million Medicare beneficiaries received care, and the program spent about \$17.7 billion on home health care services. Over 12,400 agencies participated in Medicare in 2014.

The indicators of payment adequacy for home health care, discussed in Chapter 8, are generally positive.

- Access to home health care is generally adequate: Over 99 percent of beneficiaries live in a ZIP code where a Medicare home health agency operates, and 82 percent live in a ZIP code with five or more agencies.
- In 2014, the number of agencies decreased by 1.2 percent after over a decade of continuous growth. From 2004 to 2014, the number of agencies increased by 65 percent. The decline in 2014 was concentrated in areas that experienced sharp increases in supply in prior years.
- In 2014, the volume of services declined slightly. The total number of users decreased by 1.3 percent and the average number of episodes per home health user decreased by 0.8 percent. This trend is not surprising because Medicare inpatient admissions, an important source of referrals, have declined. These decreases for home health care follow several years of rapid increases; between 2002 and 2014, the total number of episodes increased by 60 percent and the episodes per home health user increased from 1.6 to 1.9.
- In 2014, performance on quality measures did not change significantly. The share of beneficiaries reporting improvement in walking and transferring increased slightly; the share of beneficiaries hospitalized during their home health episode was 27.8 percent, similar to the rate in prior years.

- Access to capital is a less important indicator of Medicare payment adequacy for home health care because this sector is less capital intensive than other health care sectors. The major publicly traded for-profit home health companies had sufficient access to capital markets for their credit needs. The acquisition of two large home health companies by other health care companies indicates this sector is attractive to investors.
- In 2014, Medicare spending declined by 1.6 percent to \$17.7 billion. For more than a decade, however, payments have consistently and substantially exceeded costs in the home health prospective payment system. In 2014, Medicare margins for freestanding agencies averaged 10.8 percent. The marginal profit for home health agencies equaled 13.3 percent, indicating that agencies have an incentive to serve additional patients. The Commission projects a margin of 8.8 percent for 2016.

The high margins of home health agencies have led the Commission to recommend eliminating the payment update for 2017 and implementing a two-year rebasing beginning in 2018. These two actions should help to better align payments with actual costs, ensuring better value for beneficiaries and the taxpayer.

We also recommend that, concurrent with the beginning of rebasing in 2018, Medicare eliminate the use of therapy as a payment factor in the home health PPS. This feature of the PPS may create financial incentives that distract agencies from focusing on patient characteristics when setting plans of care. Eliminating this factor would base home health payment solely on patient characteristics, a more patient-focused approach to payment.

Inpatient rehabilitation facility services

Inpatient rehabilitation facilities (IRFs) provide intensive rehabilitation services to patients after an illness, injury, or surgery. Rehabilitation programs at IRFs are supervised by rehabilitation physicians and include services such as physical and occupational therapy, rehabilitation nursing, and speech–language pathology, as well as prosthetic and orthotic devices. In 2014, Medicare spent \$7.0 billion on FFS IRF care provided in about 1,180 IRFs nationwide. About 339,000 beneficiaries had almost 376,000 IRF stays. On average, Medicare accounts for about 60 percent of IRFs’ discharges.

As discussed in Chapter 9, our indicators of Medicare payment adequacy for IRFs are generally positive.

- Between 2013 and 2014, the number of IRFs nationwide grew 1.4 percent, reaching almost 1,180 providers. After declining for several years, the number of hospital-based IRFs and nonprofit IRFs grew slightly during this period, though the rate of growth was outpaced by that of freestanding and for-profit IRFs. The average IRF occupancy rate was 64 percent in 2014. This rate has remained relatively unchanged for several years and suggests that capacity is more than adequate to handle current demand for IRF services.
- Between 2013 and 2014, the number of Medicare FFS cases treated in IRFs grew by less than 1 percent.
- The Commission tracks three broad categories of IRF quality indicators: risk-adjusted change in functional and cognitive status during the IRF stay, discharge to the community and discharge to SNFs, and rates of readmission. Between 2013 and 2014, there were improvements in two measures of functional change and in the rate of discharge to the community. The rates of readmission remained unchanged.
- The parent institutions of hospital-based IRFs continue to have good access to capital. The major freestanding IRF chain, which accounted for 41 percent of all freestanding IRFs in 2014 and about a quarter of IRF discharges, also has very good access to capital. We were not able to determine the ability of other freestanding facilities to raise capital.
- The aggregate Medicare margin has risen steadily since 2009 and increased to 12.5 percent in 2014. Margins of freestanding IRFs continue to exceed those of hospital-based IRFs, largely driven by lower unit costs. The lower costs are due in part to greater economies of scale. But freestanding IRFs are also far more likely than hospital-based units to be for profit and therefore may be more focused on controlling costs. Further, there are notable differences in the mix of cases. To assess whether both types of providers have a financial incentive to expand the number of Medicare beneficiaries they serve, we examined IRFs’ marginal profit. We found that hospital-based IRFs’ marginal profit in 2014 was 19.0 percent, while freestanding IRFs’ marginal profit was 40.6 percent.
- We project that IRFs’ aggregate Medicare margin will be 13.9 percent in 2016.

On the basis of these indicators, the Commission maintains that IRFs can continue to provide Medicare beneficiaries with access to safe and effective care at current payment rates and recommends no update to the payment rates in fiscal year 2017.

Although differences in profitability across IRFs are driven in part by differences in underlying costs, the Commission also finds that the mix of case types is correlated with provider profitability. In addition, we find that high-margin IRFs have patients who are, on average, less severely ill in the preceding acute care hospital stay but who then appear to be more functionally disabled upon admission to the IRF. This discrepancy suggests the possibility that patient selection and assessment and coding practices may contribute to differences in costs—and profitability—across providers. To protect beneficiaries and taxpayers, the Secretary of HHS needs to analyze IRF coding to determine whether it accurately reflects the rehabilitation needs of patients. We recommend this analysis begin with focused medical record reviews of IRFs that have unusual patterns of case mix and coding. Conclusions from that analysis could help identify necessary reforms to the IRF payment system.

Research is also needed to assess variation in costs within the IRF case-mix groups and differences in relative profitability across case-mix groups. In the near term, we recommend that CMS better align IRF payments and costs by redistributing payments within the IRF PPS through an expanded high-cost outlier pool. To maintain budget neutrality, the expanded outlier pool should be funded by reducing the base payment amount for all IRF cases. We recognize that, by increasing payments for the most costly cases, Medicare may increase payments for providers who are less efficient as well as for providers who care for patients whose acuity is not well captured by the case-mix system. While this outcome is not desirable, the Commission's concern about the possible misalignment of Medicare's payments for resource-intensive cases warrants this approach in the near term until the payment system is further reformed. Ultimately, rebasing IRF payments may be necessary to prevent overpayments and protect the long-run sustainability of the Medicare program.

Long-term care hospital services

Long-term care hospitals (LTCHs) provide care to beneficiaries 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 its Medicare patients must have an average length of stay greater than 25 days. In 2014, Medicare spent \$5.4 billion on care provided in LTCHs. About 118,000 FFS beneficiaries had roughly 134,000 LTCH stays. On average, Medicare accounts for about two-thirds of LTCHs' discharges.

We have no direct measures of beneficiaries' access to needed LTCH services. Instead, in Chapter 10, we consider the capacity and supply of LTCH providers and changes over time in the volume of services they furnish. Trends suggest that access to care has been maintained.

- Growth in the number of LTCHs filing Medicare cost reports slowed considerably in recent years because of two moratoriums; the first was in effect through December 28, 2012. The second moratorium has been in effect since April 1, 2014, and extends through September 30, 2017. We estimate that the number of LTCHs and LTCH beds decreased by about 2.3 percent in 2014.
- From 2013 to 2014, the number of LTCH cases decreased by 2.8 percent. Controlling for the change in the number of FFS beneficiaries, the number of LTCH cases per beneficiary declined during this period by 2.6 percent. This decrease in per capita admissions is consistent with that seen in other inpatient settings.
- LTCHs began submitting quality of care data to CMS in 2012. LTCH quality data are not yet available for analysis; however, CMS will begin reporting quality data publicly for four measures beginning in the fall of 2016. Using claims data for 2014, we found stable or declining non-risk-adjusted rates of readmission, death in the LTCH, and death within 30 days of discharge for almost all of the top 25 LTCH diagnoses.
- For the past few years, the availability of capital to LTCHs has not reflected current Medicare payment rates but, rather, uncertainty regarding possible changes to Medicare's regulations and legislation governing LTCHs. The criteria to receive the higher LTCH payment rate specified in the Pathway for SGR Reform Act of 2013, beginning with cost reporting periods starting October 1, 2015, provide more long-term regulatory certainty for the industry compared with recent years. However, payment reductions implemented by CMS and a congressional moratorium on new LTCH beds and facilities through September 2017 continue to limit future opportunities for growth and reduce the industry's need for capital.

- LTCHs had an aggregate Medicare margin of 4.9 percent in 2014 compared with 6.8 percent in 2013. Financial performance in 2014 varied across LTCHs, reflecting differences in cost control and responses to payment incentives. The 2014 LTCH marginal profit, an indicator of whether LTCHs with excess capacity have an incentive to see more Medicare patients, was 20 percent.

Changes in admission patterns and cost structure will occur, resulting from the patient-specific criteria newly implemented in fiscal year 2016. There is a high degree of uncertainty regarding changes in admission patterns and cost per case associated with this new policy this year; therefore, we provide a projected margin range for qualifying cases that meet the specified criteria. We project that LTCHs' aggregate Medicare margin for these qualifying cases will be between 3.3 percent and 5.9 percent in 2016.

Considering these indicators, the Commission concludes LTCHs can continue to provide Medicare beneficiaries with access to safe and effective care and accommodate changes in their costs at current payment rates, and recommends no update to LTCH payment rates in fiscal year 2017. This update recommendation applies to the Medicare LTCH prospective payment system base payment rate, which means it applies to payments for discharges that meet the criteria specified in the Pathway for SGR Reform Act of 2013. Further, it applies to the portion of the blended payment that reflects the LTCH payment rate for discharges that do not meet the specified criteria.

Hospice services

The Medicare hospice benefit covers palliative and support services for beneficiaries who are terminally ill with a life expectancy of six months or less. Beneficiaries may choose to elect the Medicare hospice benefit; in so doing, they agree to forgo Medicare coverage for conventional treatment of their terminal condition. In 2014, more than 1.3 million Medicare beneficiaries (including 47.8 percent of decedents) received hospice services from over 4,000 providers, and Medicare hospice expenditures totaled about \$15.1 billion.

The indicators of payment adequacy for hospices, discussed in Chapter 11, are positive.

- In 2014, the proportion of beneficiaries using hospice services at the end of life continued to grow. Of the total Medicare beneficiary decedents in 2014,

47.8 percent used hospice, up from 47.3 percent in 2013. In 2014, hospice use increased across almost all demographic and beneficiary groups examined. Average length of stay among decedents was about 88 days in 2014, about the same level as the prior two years. The median length of stay for hospice decedents was 17 days in 2014 and has remained stable at approximately 17 or 18 days for more than a decade.

- The number of hospice providers increased by over 4 percent in 2014, due almost entirely to growth in the number of for-profit hospices—continuing a decade-long pattern.
- At this time, we do not have data to assess the quality of hospice care provided to Medicare beneficiaries. PPACA mandated that a hospice quality reporting program begin by fiscal year 2014, but public reporting of hospice quality information is unlikely before 2017.
- Hospices are not as capital intensive as some other provider types because they do not require extensive physical infrastructure. Continued growth in the number of for-profit providers (a 7 percent increase in 2014) suggests capital is readily available to them. Hospital-based and home health–based hospices have access to capital through their parent providers. Less is known about access to capital for nonprofit freestanding providers, for whom capital may be more limited.
- The aggregate 2013 Medicare margin was 8.6 percent, down from 10.0 percent in 2012. The rate of marginal profit—that is, the rate at which Medicare payments exceed providers' marginal cost—was about 12 percent in 2013. The projected aggregate Medicare margin for 2016 is 7.7 percent.

Because the payment adequacy indicators for which we have data are positive, the Commission maintains that hospices can continue to provide beneficiaries with appropriate access to care at current payment levels and recommends no update to the base payment rate in fiscal year 2017.

The Medicare Advantage program: Status report

Each year, the Commission provides a status report on the Medicare Advantage (MA) program. In Chapter 12, we find that in 2015, the MA program included 3,500 plan

options, enrolled more than 16.7 million beneficiaries (30 percent of all beneficiaries), and paid MA plans about \$170 billion to cover Part A and Part B services. To monitor program performance, we examine MA enrollment trends, plan availability for the coming year, and payments for MA plan enrollees relative to spending for FFS Medicare beneficiaries. We also provide updates on risk adjustment, risk coding practices, and current quality indicators in MA. As a result of the analyses, we make recommendations to adjust benchmarks and risk coding.

The MA program gives Medicare beneficiaries the option of receiving benefits from private plans rather than the traditional FFS Medicare program. The Commission strongly supports the inclusion of private plans in the Medicare program; beneficiaries should be able to choose between the traditional FFS Medicare program and alternative delivery systems that private plans can provide. Because Medicare pays private plans a per person predetermined rate rather than per service, plans have greater incentives than FFS providers to innovate and use care-management techniques.

The Commission has emphasized the importance of imposing fiscal pressure on all providers of care to improve efficiency and contain Medicare program costs. For MA, the Commission previously recommended that payments be brought down from previous levels, which were generally higher than FFS, and be set so that the payment system is neutral and does not favor either MA or the traditional FFS program. Legislation has reduced the inequity in Medicare spending between MA and FFS. As a result, over the past few years, plan bids and payments have come down in relation to FFS spending while enrollment in MA continues to grow. The pressure of competitive bidding and lower benchmarks has led to improved efficiencies that enable MA plans to continue to increase MA enrollment by offering benefits that beneficiaries find attractive.

- Between 2014 and 2015, enrollment in MA plans grew by about 6 percent (900,000 enrollees) to 16.7 million enrollees. About 30 percent of all Medicare beneficiaries were enrolled in MA plans in 2015, about the same rate as in 2014, but up from 28 percent in 2013. Among plan types, HMOs continued to enroll the most beneficiaries (11.0 million). Between 2014 and 2015, enrollment increased in local preferred provider organizations (PPOs) by about 9 percent and decreased in regional PPOs by about 1 percent.

- Access to MA plans remains high in 2016: Overall, 99 percent of all Medicare beneficiaries have access to an MA plan. Ninety-six percent of Medicare beneficiaries have an HMO or local PPO plan operating in their county of residence, up from 95 percent in 2015.
- In 2016, 70 percent of MA enrollees are projected to be in plans that will receive add-ons to their benchmarks through the quality bonus provisions of either 5 percent or 10 percent. On average, the quality bonuses in 2016 will add 4 percent to the base benchmarks. We estimate that 2016 MA benchmarks (including the average 4 percent for quality bonuses), bids, and payments will average 107 percent, 94 percent, and 102 percent of FFS spending, respectively.

Removing quality bonuses from the benchmarks, we expect the base benchmarks to average 102 percent of FFS in 2017 and thus approach rough equity with FFS in aggregate. However, there are several distributional issues that remain to be addressed to achieve equity among MA plans. First, CMS's calculation of FFS spending, which is the basis for MA benchmarks, needs refinement to be more representative of FFS spending for the beneficiaries who can enroll in MA plans (i.e., those who have both Part A and Part B). Second, benchmark caps can unduly penalize plans that exceed the cap—often through reduced quality bonuses. Third, double quality bonuses in certain counties inequitably give plans in those counties bonuses twice that of plans with identical quality that are in non-double-bonus counties. Therefore, the Commission recommends eliminating the benchmark caps and double quality bonuses to improve intercounty benchmark equity.

Medicare payments to plans for an enrollee are based on the plan's payment rate and the enrollee's health risk score. Analyses have shown that MA plan enrollees have higher risk scores than similar FFS beneficiaries because of plans' more intensive coding efforts. CMS makes an across-the-board adjustment to the scores to make them more consistent with FFS coding. We find that CMS would need to raise the coding adjustment (i.e., lower enrollees' risk scores) and/or change the way diagnoses are collected for use in the risk adjustment process to ensure the coding levels in aggregate are roughly equal between the FFS and MA programs. Specifically, we recommend an alternative approach to adjusting for coding differences that would (1) remove health risk assessments as a source of diagnoses from risk adjustment calculations, (2) use two years of FFS and MA diagnostic data in the

risk adjustment model, and (3) apply an across-the-board adjustment of appropriate size such that the combined effect eliminates the impact of differences in MA and FFS coding intensity.

The Commission recommended a quality bonus program for MA, and the Congress legislated such a program in PPACA. A comparison of the most current results for MA quality indicators shows that performance improved in several measures, declined for one measure among HMOs, and slightly declined in patient experience measures. In general, quality indicators remained stable, but a number of measures had specification changes that did not allow us to determine year-over-year changes in the measure results.

MA plans are able to receive bonus payments if they achieve an overall rating of 4 stars or higher on CMS's 5-star quality rating system. Across all plans, the share of enrollees in bonus-level plans increased from 59 percent to 70 percent. However, this increase is due in part to contract consolidations whereby an organization combines multiple plans under one surviving plan. For 2016, 16 contracts under 4 stars had their enrollees incorporated into 4-star or 4.5-star contracts.

The Commission and CMS have examined the question of whether the star rating system should take into account population differences when analyses indicate that there are systematic differences in measure results—specifically for low-income beneficiaries and beneficiaries with disabilities. Both the Commission and CMS have found systematic differences among these populations in certain measures, but the effects across plans are relatively small. CMS is considering making adjustments to the star rating system to address the potential bias in star ratings.

Status report on Part D

Each year, the Commission provides a status report on the Medicare prescription drug benefit established under Part D that describes beneficiaries' access to prescription drugs, enrollment levels, plan benefit designs, and the quality of Part D services. The report, in Chapter 13, also analyzes changes in plan bids, premiums, and program costs.

In 2014, Medicare spent \$78 billion for the Part D benefit, accounting for nearly 13 percent of total Medicare outlays. Part D experienced significant growth in 2014 and 2015 program spending, much of which was attributable to new treatments for hepatitis C. In 2015, about 39 million Medicare beneficiaries were enrolled in Part D, either in

stand-alone prescription drug plans (PDPs) or in Medicare Advantage–Prescription Drug plans (MA–PDs).

In 2015, 70 percent of Medicare beneficiaries were enrolled in Part D plans. An additional 4 percent received drug coverage through employer-sponsored plans that receive Medicare's retiree drug subsidy. As of 2013, 12 percent of beneficiaries had no drug coverage or coverage less generous than Part D. Our previous analysis showed that beneficiaries with no creditable coverage tended to be healthier, on average. Among those 39 million individuals enrolled in Part D, 61 percent were in PDPs, and 39 percent were in MA–PDs. Nearly 12 million individuals received the low-income subsidy (LIS), which provides extra help with premiums and cost sharing in Part D.

In 2016, plan sponsors are offering 886 PDPs and 1,682 MA–PDs, an 11 percent decrease from 2015 in the number of PDPs offered and a 5 percent increase in MA–PDs. PDP reductions appear to reflect sponsors consolidating their plan offerings into a smaller number of more widely differentiated products. Even with these consolidations, beneficiaries have between 19 and 29 PDPs to choose from, depending on where they live, as well as typically 9 or more Medicare Advantage options. MA–PDs continue to be more likely than PDPs to offer enhanced benefits, but a smaller share is offering gap coverage (beyond what is required by PPACA) compared with previous years. For 2016, 218 premium-free PDPs are available to enrollees who receive the LIS, a 23 percent decline from 2015. Most regions of the country continue to have at least 3 and as many as 10 PDPs available at no premium to LIS enrollees.

Between 2007 and 2014, Part D spending on an incurred basis increased from \$46 billion to \$73 billion—an average annual growth rate of about 6.8 percent. (The incurred amount of \$73 billion for 2014 differs from the \$78 billion described earlier because the larger amount includes reconciliation payments between Medicare and plan sponsors for benefits delivered in previous years.) In 2014, Part D program payments increased by nearly 15 percent from the year before, much of that increase due to spending for new hepatitis C drugs. Also in 2014, Medicare's reinsurance payments to plans surpassed LIS payments to become the single largest component of Part D spending. Reinsurance also remained the fastest growing component, at an average annual rate of 19 percent between 2007 and 2014. Program spending for Part D reflects two underlying trends. First, an unusually large number of patent expirations on widely used

brand-name drugs has led to a dramatic shift toward use of generics in Part D. Between 2007 and 2013, generic drugs' share of all Part D prescriptions filled rose from 61 percent to 84 percent. However, between 2012 and 2013, the share of enrollees who incurred spending high enough to reach the catastrophic phase of Part D's benefit grew by nearly 10 percent. Spending for these high-cost individuals grew by 8.4 percent per enrollee, driven primarily by increases in the average price per prescription filled. The pharmaceutical pipeline is shifting toward greater numbers of biologic products and specialty drugs, many of which have few therapeutic substitutes and high prices. The use of high-priced drugs by Part D enrollees will likely grow and put significant upward pressure on Medicare spending for individual reinsurance and the LIS.

In general, Medicare beneficiaries have good access to prescription drugs under Part D, with plans available to all individuals. The amounts enrollees pay in cost sharing can also affect access. Generally, between 2007 and 2013, average out-of-pocket costs remained stable or even decreased somewhat, in part because of the phased closure of Part D's coverage gap. For individuals whose

prescription medications either are not covered by their plans or are covered but have relatively high cost sharing, a well-functioning exceptions and appeals process is crucial. Plan-level data show low rates of claim rejections and appeals. At the same time, CMS has conducted audits that have found some compliance issues with formulary administration, claims adjudication, and appeals.

In 2016, the average star rating (an indicator of quality) among Part D plans decreased somewhat for PDPs but increased slightly for MA-PDs. PDP scores changed significantly because of changes to the mix of measures, making it difficult to use star ratings to evaluate changes in quality of services over time. Part D plans are required to implement medication therapy management (MTM) programs to improve quality. Although the Commission supports the goal of improving medication management, we have been concerned with the effectiveness of plans' MTM programs. Beginning in 2017, Medicare will test enhanced MTM programs by providing incentives for stand-alone PDPs to conduct medication reviews and tailor drug benefit designs to encourage adherence to appropriate drug therapies. ■

