

Report to the Congress: Medicare Payment Policy

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Statement of
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Before the
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives

Chairman Stark, Ranking Member Camp, distinguished Subcommittee members. I am Glenn Hackbarth, chairman of the Medicare Payment Advisory Commission (MedPAC). I appreciate the opportunity to be here with you this morning to discuss MedPAC's March Report to the Congress and our recommendations on Medicare payment policy.

As required by law, the Medicare Payment Advisory Commission reviews Medicare payment policies and makes recommendations each March. In our March report, we consider Medicare fee-for-service (FFS) payment policy in 2009 for acute care hospitals, physicians, outpatient dialysis, skilled nursing, home health, inpatient rehabilitation facilities, and long-term care hospitals. We also make recommendations to reform payments for the Medicare Advantage (MA) plans beneficiaries can join in lieu of traditional FFS Medicare, recommendations specific to special needs plans (SNPs), and recommendations concerning Medicare programs for low income beneficiaries.

With each passing year, the Commission's concern about Medicare's long-term sustainability grows. To slow the growth in Medicare expenditures, we have concluded that the Congress and CMS will need to make changes across a broad front. Our March report focuses on policy recommendations that would limit provider updates to create incentives for greater efficiency, reward quality, and modify payment rates to private plans and providers to ensure that we neither overpay nor underpay for key services. These recommendations build on previous reports which have discussed tools such as pay for performance, comparative effectiveness, and reporting resource use. Other changes, which we will take up in our June 2008 report, will include ideas for altering Medicare's payment systems to reward better coordination of care and efficiency over time and investing in information about comparative effectiveness. Many changes will be needed to achieve long-term sustainability, but changes in Medicare are complex to develop and implement, and the effects are uncertain and unfold gradually. Time, therefore, is of the essence.

The March report also includes recent findings on enrollment and availability for MA plans and the private plans offering the Medicare prescription drug benefit. We provide information on the benefits and premiums of the plans offering the Medicare prescription drug benefit, both the stand-alone prescription drug plans and the prescription drug plans

affiliated with MA plans. We also provide recommendations to increase participation in the Medicare Savings Programs (MSPs) and the low-income drug subsidy (LIS).

Context for Medicare payment policy

Medicare and other purchasers of health care in our nation face enormous challenges. Health care costs are growing faster than the economy and incomes, and quality frequently falls short of patients' needs. Unexplained variations in the use and quality of care in the current system suggest that opportunities exist for reducing waste and improving quality. The Commission has recommended a number of policies to increase the value of care Medicare purchases, including paying differentially for quality, measuring physician resource use to identify those with more or less intense practice patterns, and analyzing comparative effectiveness. However, the underlying incentives in current payment systems and the structure of the delivery system make significant gains in value difficult to realize.

Medicare fills a critical role in our society—ensuring that the elderly and disabled have access to medically necessary care. Along with other payers in our health care system, the program has also helped to finance important strides in medical technology. However, we should use Medicare's considerable resources more wisely. The program rewards increases in the volume and specialized nature of services but not better health outcomes or higher efficiency. Practice patterns of care vary widely by geographic region, often with a poor relationship between quality and spending. Some stakeholders view the program as one in which all providers are entitled to payment, regardless of the quality, efficiency, or sometimes even the need for their services. Unless these aspects of Medicare change, the financial obligation on beneficiaries and future taxpayers will be unsustainable.

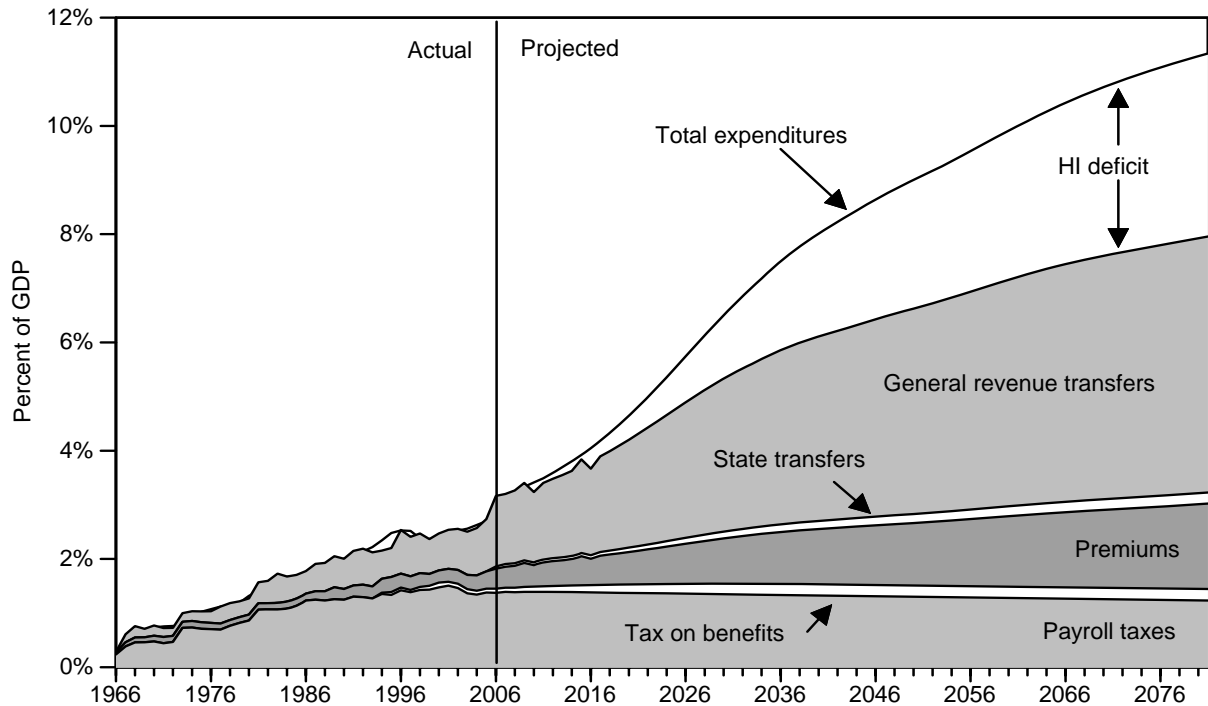
The Medicare trustees and others warn of a serious mismatch between the benefits and payments the program currently provides and the financial resources available for the future. Projected levels of spending could also impose a significant financial liability on Medicare beneficiaries, who must pay premiums and cost sharing. Improving the program's long-term financial prognosis will require some combination of expenditure reductions (e.g., benefit adjustments or payment efficiencies) and new financing.

The program's shaky financial outlook is a strong impetus for change. As is true for other purchasers of health care services in the United States, Medicare's spending is growing much faster than the U.S. economy. In addition, CMS began Medicare's new outpatient prescription drug program, Part D, in 2006. This program adds an important benefit to Medicare but greatly expands the program's need for resources. Finally, the leading edge of the baby boomers will become Medicare beneficiaries after 2010, which will also accelerate Medicare spending. These factors will lead Medicare to require an unprecedented share of our gross domestic product.

If Medicare benefits and payment systems remain as they are today, the Medicare trustees note that over time the program will require major new sources of financing for Part A and will automatically require increasing shares of general tax revenues for Part B and Part D. The trustees project that dedicated payroll taxes will make up a smaller share of Medicare's total revenue and that a large deficit between spending for Part A (HI) and revenue from dedicated payroll taxes will develop (Figure 1).

To finance the projected deficit through 2080, the trustees estimate that Medicare's payroll tax would need to increase immediately from 2.9 percent to 6.44 percent of earned income, or HI spending would need to decrease immediately by 51 percent. Delays in addressing the HI deficit would eventually require even larger increases in the tax rate or even more dramatic cuts in spending. The premiums and general revenues required to finance projected spending for Part B and Part D (SMI) services could impose a significant financial liability on Medicare beneficiaries and on resources for other priorities. If income taxes remain at the historical average share of the economy, the Medicare trustees estimate that the SMI program's share of personal and corporate income tax revenue would rise from 11.4 percent today to 25 percent by 2030. For beneficiaries, even though Part D now covers a portion of their spending on prescription drugs, growth in Medicare premiums and cost sharing for SMI services will require more of their incomes, which could lead to financial hardship for some; in 2004, roughly half of all Medicare beneficiaries had family incomes of less than 200 percent of the federal poverty level.

Figure 1. Medicare faces serious challenges with long-term financing



Note: GDP (gross domestic product), HI (Hospital Insurance). These projections are based on the trustees' intermediate set of assumptions. Tax on benefits refers to a portion of income taxes that higher income individuals pay on Social Security benefits that is designated for Medicare. State transfers (often called the Part D "clawback") refer to payments called for within the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 from the states to Medicare for assuming primary responsibility for prescription drug spending.

Source: 2007 Annual Report of the Boards of Trustees of the Medicare Trust Funds.

Other federal programs such as Social Security and Medicaid will also require greater resources at the same time that Medicare spending expands. Some analysts contend that growth in our nation's economy has historically been large enough to finance expansion of both health and nonhealth spending. Other analysts disagree, saying long-term economic growth alone will not be sufficient to bring the country's fiscal position into balance and financing Medicare by increasing the Federal deficit could reduce economic growth. According to this point of view, expounded by the Congressional Budget Office among others, fiscal stability will require a sizable slowdown in the growth rate of spending on health care and may also require a substantial increase in taxes as a share of our nation's economy.

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

The March report presents the Commission's annual payment update recommendations 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 (2008). Next, we assess how those providers' costs are likely to change in the year the update will take effect (the policy year—2009). Finally, we make a judgment as to what, if any, update is needed. When considering whether payments in the current year (2008) are adequate, we account for policy changes (other than the update) that are scheduled to take effect through the policy year (2009) under current law.

Competitive markets demand continual improvements in productivity from workers and firms. These workers and firms pay the taxes that finance Medicare. As a prudent purchaser, Medicare's payment systems should encourage providers to produce a unit of service as efficiently as possible while maintaining quality. Consequently, the Commission may choose to apply an adjustment to the update to encourage this efficiency. The Commission begins its deliberations with the assumption that all providers can achieve efficiency gains similar to the economy at large (the 10-year average of productivity gains in the general economy, currently 1.5 percent). But the Commission may alter that assumption depending on the circumstances of a given set of providers in a given year. This factor links Medicare's expectations for efficiency to the gains achieved by the firms and workers who pay taxes that fund Medicare.

Hospital inpatient and outpatient services

Most indicators of payment adequacy for hospital services are positive. The number of Medicare-participating hospitals has increased in each of the past four years. Inpatient and outpatient service volume per beneficiary continues to increase. The quality of care hospitals provide to Medicare beneficiaries is mixed; mortality rates have dropped and CMS's quality indicators have improved, but more adverse event rates (e.g., decubitus ulcer, postoperative pulmonary embolism or deep vein thrombosis) have increased than decreased. Spending on hospital construction has risen substantially in recent years—with increases averaging almost

20 percent in the past two years. For the second year in a row, the median values of many financial indicators (such as days cash on hand and measures of debt service coverage) were among the best ever recorded. This ready access to capital indicates that revenue is sufficient to give the capital markets confidence in the credit worthiness of the industry.

One indicator of payment adequacy is negative—we project an overall Medicare margin for hospitals covered by prospective payments of –4.4 percent in 2008. If all hospitals were efficiently providing Medicare services, this low aggregate margin would be a major source of concern. However, hospital costs and Medicare profitability vary widely. Some hospitals are efficient enough to have low costs, positive Medicare margins, and high quality scores. Other hospitals have higher costs and lower Medicare margins.

To understand what may be driving some hospitals to have low costs and others high costs we investigated the relationship between financial pressure and costs. Some hospitals have strong profits on non-Medicare services and investments and are under little pressure to constrain Medicare costs, while others face losses if they do not constrain costs and generate profits on Medicare patients. To test the relationship between financial pressure and hospitals' costs, we divided hospitals into three levels of financial pressure: high, medium, and low. We tested whether hospitals under high levels of financial pressure from 2001 to 2005 ended up with lower standardized inpatient costs per discharge in 2006.

We found that high levels of financial pressure lead to lower standardized costs. Hospitals under high levels of financial pressure have median Medicare standardized costs of \$5,500 per discharge on average (Table 1). In contrast, hospitals with low levels of financial pressure had standardized costs more than 10 percent higher at \$6,200 per discharge and higher cost growth. The shares of rural, urban, and for profit hospitals in each group were very similar (not shown in chart). Medicare should encourage hospitals to be efficient and control their costs, rather than accommodate high cost growth resulting from lack of financial pressure.

Table 1. Financial pressure leads to lower hospital costs

2006 Financial characteristics (medians)	Level of financial pressure 2002 to 2005		
	High pressure	Medium pressure	Low pressure
Standardized cost per discharge	\$5,500	\$5,800	\$6,200
Annual growth in cost per discharge 2003 to 2006	4.6%	5.4%	5.5%
Non-Medicare margin (private, Medicaid, uninsured)	-1.1%	6.3%	13.6%
Overall Medicare margin	3.7	-3.3	-10.8

Note: High pressure: non-Medicare margin less than 1% and annual net worth growth less than 1% absent any Medicare profits. Low pressure: non-Medicare margin greater than 5% and annual net worth growth greater than 1% absent any Medicare profits. Medium pressure: all others. Standardized costs are adjusted for hospital case mix, wage index, outliers, transfer cases, interest expense, and the effect of teaching and low income Medicare patients on hospital costs. The sample includes all hospitals that had complete cost reports on file with CMS by August 31, 2007.

Balancing the indicators of payment adequacy, the Commission recommends an update of market basket (the projected change in hospital input prices) for inpatient and outpatient services, implemented concurrently with a quality incentive payment program. The initial payment withhold for pay for performance should be 1 percent to 2 percent. An individual hospital's quality performance should determine whether its net increase in payments in 2008 is above or below the market basket increase.

We have also found that the current indirect medical education (IME) adjustment (5.5 percent) substantially exceeds the estimated relationship between teaching intensity and costs per case (2.2 percent). Furthermore, teaching hospitals are not accountable for how they use these IME payments. The payments contribute to a wide gap in Medicare margins between teaching and nonteaching hospitals. IME payments are also highly concentrated; fewer than 300 hospitals received three-quarters of the \$5.8 billion payments in 2006. The Commission again recommends that the Congress reduce the IME adjustment by 1 percentage point to 4.5 percent per 10 percent increment in the resident-to-bed ratio. The savings should be used to fund in part a quality incentive payment policy for all hospitals. Last year, we recommended this change in the IME adjustment concurrent with better severity adjustment in the inpatient PPS. The new MS DRGs will better target payments to hospitals that care for the most severely ill patients than IME subsidies do. Therefore, it is time to move forward with IME payment reform. Our update recommendation, this IME recommendation, and pay for

performance should be viewed as a package that would improve the accuracy of Medicare's payments for acute inpatient services while creating a strong incentive for improving the quality of care.

Physician services

Our analysis finds that most indicators of payment adequacy for physicians are stable. Beneficiary access to physicians is generally good at the national level, with no statistically significant changes from last year, but small numbers of beneficiaries continue to report difficulty making timely appointments with their current physician or finding a new primary care physician (finding a new specialist is less of a problem). There may be local areas where access is more limited, but in those areas those limitations might be a function of physician supply and local population trends—and affect access for private-payer patients as well—and not a reflection on Medicare payment rates. We find that the number of physicians providing services to Medicare beneficiaries has more than kept pace with growth in the beneficiary population in recent years, and per beneficiary service volume grew at a rate of 3.6 percent in 2006. Our claims analysis shows small improvements in the quality of ambulatory care. The ratio of Medicare payment rates to private payment rates in 2006 was 81 percent, slightly lower than the rate in 2005 (83 percent). If Medicare rates were rapidly decreasing in relation to private sector rates, access for Medicare beneficiaries could become a concern. But, in fact, the ratio has been around 80 percent for many years and is higher than in the early to mid-1990s, when Medicare payment rates averaged about two-thirds of commercial payment rates for physician services.

However, the current physician payment system has several flaws that need to be addressed. Although the Congress has acted each year since 2003 to avert a scheduled negative update to the physician fee schedule conversion factor, the sustainable growth rate formula continues to call for substantial consecutive negative updates through 2016. The Commission remains concerned that repeated annual reductions in physician payment rates could threaten beneficiaries' access to physician services. Medicare's current FFS payment system does not systematically reward physicians who provide higher quality care or care coordination, and it offers higher revenues to physicians who furnish the most services—whether or not the services add value. The Commission is also concerned that the current distribution of

Medicare physician payments undervalues primary care services and introduces other distorted incentives that encourage overuse of some services and underuse of others. These deficiencies should be corrected for the Medicare program to promote high-quality health care and avert unsustainable growth in spending.

In consideration of expected input costs for physician services and our payment adequacy analysis, the Commission recommends that the Congress update payments in 2009 for physician services by the projected change in input prices less the Commission's adjustment for productivity growth (currently estimated at 1.5 percent). In addition, the Congress should enact legislation requiring CMS to establish a process for measuring and reporting physician resource use on a confidential basis for a period of two years.

The second part of our recommendation, reporting physician resource use, is intended to improve the value of physician services purchased by Medicare. Information on resource use would be immediately useful to physicians who want to understand their own practice patterns. Our eventual goal is for Medicare to base physician payment rates at least in part on physician resource use, but realistically it will take time for CMS to develop the infrastructure and work constructively with stakeholders to implement accurate and actionable resource use measurement and reporting systems. CMS should begin development now to provide confidential reporting and to be prepared to use the information for public reporting and for payment policy, if and when authorized to do so by the Congress.

Adequacy of payments for dialysis services

Most indicators of payment adequacy for outpatient dialysis services are positive. The growth in dialysis facilities, treatment stations, and dialysis treatments has kept pace with the growth in the number of dialysis patients, suggesting continued access to care for most dialysis beneficiaries. Providers have sufficient access to capital, as evidenced by recent expansions. Quality of care is improving for some measures: use of the recommended type of vascular access has improved and more patients receive adequate dialysis and have their anemia under control. However, patients' nutritional status has not improved. We project that Medicare payments will cover the costs of providing outpatient dialysis services to beneficiaries in 2008 with a margin of 2.6 percent.

Therefore, the Commission recommends that the Congress should update the composite rate in calendar year 2009 by the projected rate of increase in the end-stage renal disease market basket index less the Commission's adjustment for productivity growth.

In addition, the Commission reiterates its recommendation that the Congress implement a quality incentive program for physicians and facilities that treat dialysis patients. Credible measures are available that are broadly understood and accepted. Obtaining information to measure quality will not pose an excessive burden and measures can be adjusted for case mix so providers are not discouraged from taking more complex patients. Also, the Commission again states that Medicare should expand the dialysis payment bundle to include dialysis drugs and other commonly furnished services. Together, these steps will better align incentives for providing cost-effective care and reward providers for furnishing high-quality care.

Skilled nursing facility services

Our indicators of the adequacy of Medicare payments to cover the costs of skilled nursing facility (SNF) services to beneficiaries are generally positive. Beneficiaries continue to have good access to services. The supply of SNFs remained essentially constant, and covered days and admissions per beneficiary have both increased. While access was good for most beneficiaries, those needing expensive nontherapy ancillary services may experience delays in being placed in SNFs. Quality is mixed. Rates of discharge to the community increased over the last two years (a positive trend indicating improved quality) but have returned only to the level reached in 2000, and rates of potentially avoidable rehospitalizations continued to increase (indicating worse quality). Access to capital was good. However, in the late summer, trends in the broader lending market—unrelated to the adequacy of Medicare payments—made borrowing more expensive and more restrictive.

For the sixth consecutive year, aggregate Medicare margins for freestanding SNFs were above 10 percent. We project Medicare margins to be 11.4 percent in 2008. Because all access indicators are positive and SNF payments appear to be more than adequate to accommodate the cost growth, the Commission recommends that the Congress eliminate the update for SNFs in 2009.

As in other sectors, the Commission considers the Medicare margin, rather than the total (all payer) facility margin, to guide its update recommendation for SNFs. Trying to increase total facility margins by subsidizing other payers—such as Medicaid—through Medicare SNF payments would not be effective or advisable. First, the subsidy would be poorly targeted. Facilities with high shares of Medicare payments—presumably the facilities that need revenues the least—would receive the most in subsidies and those with high shares from Medicaid or other payers the least. Second, increasing Medicare’s payment rates could encourage states to reduce Medicaid payments further and, in turn, result in pressure to again raise Medicare rates.

The Commission recommends that CMS adopt a quality incentive payment policy for SNFs. Two measures—rates of community discharge and potentially avoidable rehospitalization—capture key goals for SNF patients, are well accepted, have robust risk adjustment, and avoid the problems associated with the current publicly reported measures. We would expect CMS, over time, to add measures to the quality incentive program that reflect other aspects of SNF care. Before adding measures based on changes in patient condition, however, patient assessment information should be gathered at admission and discharge, so that the measures will be unbiased.

We also recommend that CMS improve the public reporting of the post-acute care quality indicators. CMS should:

- add the rates of community discharge and potentially avoidable rehospitalization to their publicly reported indicators;
- revise the pain, delirium, and pressure sore measures that are currently reported so they are more accurate and evaluate only the care furnished during the SNF stay (and not during the preceding hospitalization); and
- gather patient assessment information at admission and discharge so that the quality measures based on patient assessment information reflect the care furnished to all SNF patients, not just the smaller subset who stay long enough to have a second assessment completed for them.

Home health services

Our indicators for home health are positive. Beneficiaries continue to have widespread access to care. Ninety-nine percent of beneficiaries live in an area served by at least one home health agency, and the number of agencies continues to grow faster than the number of Medicare enrollees. The share of FFS beneficiaries using the home health benefit continues to increase, as does the average number of episodes per home health user. Quality trends are mostly unchanged from previous years. The number of beneficiaries who show improvement in walking, bathing, pain management, transferring, and medication management has increased slightly. However, the rate of unplanned emergency department use by home health patients has not improved, and the number of patients hospitalized has increased slightly. The continuing entry of new agencies and the acquisitions of existing agencies by national home health companies suggest that agencies have adequate access to capital. We project that agency margins will equal 11.4 percent in 2008.

The data on access, quality, volume, and financial performance suggest that most agencies should be able to accommodate cost increases without an increase in base payments. Therefore, the Commission recommends that the Congress should eliminate the update for home health agencies in 2009.

Inpatient rehabilitation facility services

Our indicators of payment adequacy for inpatient rehabilitation facilities (IRFs) show stable supply and access, decreases in discharges and spending, increased case mix and payments per case, mixed access to capital, and strong margins. This picture arises in part because of CMS's phase in of the renewed enforcement of the 75 percent rule starting in 2005. (The 75 percent rule requires IRFs to have 75 percent of admissions with one or more of a specified list of conditions. The Congress recently rolled back the 75 percent rule, setting the compliance threshold permanently at 60 percent, in one of several provisions of the Medicare, Medicaid, and SCHIP Extension Act of 2007 related to IRF services.)

Discharges and spending, for example, decreased when CMS started to phase in enforcement of the 75 percent rule in 2005 after increasing rapidly following the introduction of the IRF prospective payment system (PPS) in 2002. Renewed enforcement also caused the average

case mix and payments per case to increase from 2004 to 2006, as the patients who were admitted to IRFs had more complex conditions. Despite the decrease in cases, IRF Medicare margins for 2006 were 12.4 percent. We are projecting IRF Medicare margins for 2008 to be 8.4 percent.

Our recommendation for the IRF payment update balances beneficiary access to care with fiscal constraint. IRFs had begun to adapt to existence under the 75 percent rule, with growth in cost per Medicare case now slightly lower than the growth in Medicare payments for the majority of IRFs. The projected margin should be sufficient to accommodate cost increases in 2009. Therefore, the Commission recommends that the Congress should eliminate the update for inpatient rehabilitation services in 2009. (The Congress eliminated the IRF payment rate update for 2009 in the Medicare, Medicaid, and SCHIP Extension Act of 2007.)

Long-term care hospital services

Assessing current payment adequacy for long-term care hospital (LTCH) services is challenging. On the one hand, the growth in LTCH facilities has slowed substantially and the number of LTCH cases has decreased. On the other hand, spending per FFS beneficiary and payments per case have continued to increase and use per FFS beneficiary has been steady. There was no growth in Medicare spending for LTCH services from 2005 to 2006. The evidence on quality is also mixed. Risk-adjusted mortality rates and readmission to acute care hospitals have fallen. Patients also experienced fewer postoperative pulmonary embolisms and deep vein thromboses. However, patients experienced more decubitus ulcers, infections due to medical care, and postoperative sepsis. LTCHs' access to capital is difficult to judge, with analysts divided in their assessments and expectations for the industry.

In addition, it is difficult to determine when use of LTCH services is appropriate and necessary. Frequently, LTCHs entering the program locate in market areas where LTCHs already exist, raising questions about whether there are sufficient numbers of very sick patients to support the number of LTCHs in the community. Seen in this light, recent slowing in growth of facilities, cases, and Medicare spending may indicate that the industry is approaching equilibrium after a period of explosive growth spurred by overpayment and inappropriate admissions.

The Medicare margin for LTCHs based on 2006 cost reports was 9.4 percent. CMS has since made a number of policy changes that reduce payments for LTCHs. These payment policy changes include recalibrating relative weights in 2007, making adjustments for coding improvements, finding new ways to reimburse LTCHs for patients with the shortest lengths of stay, and reducing aggregate payments for high-cost outliers. Due to these changes, we estimate LTCHs' aggregate Medicare margin will be between -1.4 and -0.4 percent in 2008. This range is based on different assumptions about LTCHs' behavior in response to the 25 percent rule—which limits the percentage of patients an LTCH can receive from a host hospital.

Although the interpretation of payment adequacy indicators is complicated, our estimated Medicare margin for 2008 suggests that LTCHs may not be able to accommodate growth in the cost of caring for Medicare beneficiaries in 2009 without an increase in the base rate. Therefore, the Commission recommends that the Secretary update payment rates for LTCH services by the market basket index, less the Commission's adjustment for productivity growth.

Update on Medicare private plans

The Commission supports private plans in the Medicare program. Medicare beneficiaries should have a choice between the FFS Medicare program and the alternative delivery systems that private plans can provide. Private plans have the flexibility to use care management techniques that are not present in traditional FFS, and—if paid appropriately—they have incentives to innovate and be efficient. The Commission supports financial neutrality between payment rates for the FFS program and the MA program. Financial neutrality means that Medicare should pay the same amount, adjusting for risk, regardless of which option a beneficiary chooses. Neutrality is important to spur efficiency and innovation.

However, MA payments are projected to be 113 percent of expected FFS expenditures in 2008 (Table 2). These added expenditures contribute to the worsening long-range financial sustainability of the Medicare program. In addition, plan bids for the traditional Medicare benefit package are projected at 101 percent of FFS, which means that MA plans, on average,

are less efficient than the traditional Medicare program. The overpayment (117 percent) and inefficiency (108 percent) are even greater for private FFS plans—a plan type in which enrollment has more than doubled in the last year.

Table 2. Payments and bids relative to FFS for 2008 and MA enrollment

	Payments relative to FFS expenditures, 2008	Bids relative to FFS expenditures, 2008	Enrollment as of November 2007 (in millions)	Change in enrollment Nov 06 – Nov 07
All MA plans	113%	101%	8.9	18%
Coordinated care plans	113	99	7.2	8
Private fee-for-service plans	117	108	1.7	101

Note: FFS (fee-for-service), MA (Medicare Advantage). Coordinated care plans include health maintenance organizations and preferred provider organizations.

Source: MedPAC analysis of data from CMS on plan bids, enrollment, and fee-for-service expenditures.

Even though we use the FFS Medicare spending level as a measure of parity for the MA program, the Commission does not think that FFS Medicare is an efficient delivery system in most markets. In fact, much of our work is devoted to identifying inefficiencies in FFS Medicare and suggesting improvements in the program. Well-managed systems that coordinate care and select efficient providers should be at least as efficient as traditional Medicare and in most cases should be more efficient.

Payment policy is a powerful signal of what we value. The original conception (in the 1980s) for private plans in Medicare was that they would be a mechanism for introducing innovation into the program while saving money for Medicare (they were paid 95 percent of FFS). To compete effectively with Medicare, private plans would be compelled to do things that traditional Medicare found difficult or that would be difficult to impose on all beneficiaries and providers—for example, selective contracting with efficient providers and effective management and coordination of care. By increasing payment to levels significantly above traditional Medicare, we have changed the signal we are sending to the market: Instead of efficiency-enhancing innovation, we are getting plans (for example, private FFS plans) that are not well designed to manage care or improve quality and have higher cost.

Some argue that the MA program now has additional goals such as addressing perceived geographic inequity in traditional Medicare and increasing benefits—particularly for low income beneficiaries. These may be legitimate goals, but they could be addressed at a lower cost and in a more targeted way through changes in traditional Medicare. For example, MA enrollment is not limited to low income beneficiaries and any subsidy has to be available to all plan enrollees; high income or low income. MSP and LIS only enroll low income beneficiaries, and thus, improving those programs is a more direct way to target benefits to that population.

Enrollment data show rapid growth in private plans. At the end of 2007, about 20 percent of Medicare beneficiaries were enrolled in MA plans and all beneficiaries have access to an MA plan in 2008, with an average of 35 plans available in each county. However, the growth comes mostly from two types of plans—private FFS plans, which have no requirement to coordinate care or report quality measures, and SNPs, which have not yet been fully evaluated.

In addition, although plans are being paid more, clinical quality measures show disappointing results. Commercial and Medicaid plans improved more in clinical measures over the past year than Medicare private plans. New plans in Medicare—those entering the program in 2004 or later—show poorer performance than older plans on clinical indicators of quality. Moreover, some plan types (e.g. private FFS) are exempt from quality reporting requirements; making it difficult for either the beneficiary or the program to judge their value.

Medicare's strengths are low administrative costs and the ability to set prices. Private plans, on the other hand, have greater latitude to coordinate care and to select providers with efficient practice patterns. Paying private plans at 100 percent of FFS coupled with P4P (as the Commission has recommended) creates the incentive for plans to manage care—that is, reduce costs and improve quality. With the resulting savings, plans can offer additional benefits to beneficiaries and in turn attract enrollment. Paying plans more than 100 percent of FFS adds administrative costs, which Medicare pays for, without any incentive for a

commensurate gain in the management of care or in the quality of care. We are now paying some types of plans much more than traditional FFS, seeing lower efficiency, and seeing new plans with poorer quality performance than old plans. We are not receiving value for the additional money.

We are also concerned with the effectiveness of the special needs plans. SNPs, created by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, were designed to serve Medicare beneficiaries with special needs, such as those in Medicaid or with chronic conditions. These plans are allowed to limit enrollment to those specific categories of beneficiaries. Recent legislation extended SNPs for another year but prohibited new plans from entering and existing plans from extending their service areas. SNPs require further study to determine whether they provide value to the program. As the Congress, CMS, and the Commission continue to evaluate SNPs, we recommend that:

- The Congress should require the Secretary to establish additional, tailored performance measures for SNPs and evaluate their performance on those measures within three years. SNPs now measure and report the same quality measures as other MA plan types, which are not designed to ensure that SNPs provide specialized care for their targeted populations.
- The Secretary should furnish beneficiaries and their counselors with information on SNPs that compares their benefits, other features, and performance with other MA plans and traditional Medicare. A lack of clear information impedes beneficiaries from learning about and making an informed decision about joining a SNP.
- The Congress should direct the Secretary to require chronic condition SNPs to serve only beneficiaries with complex chronic conditions that influence many other aspects of health, have a high risk of hospitalization or other significant adverse health outcomes, and require specialized delivery systems. CMS has not explicitly defined which chronic conditions are appropriate for SNPs to target. Not all chronic condition SNPs are

sufficiently specialized to warrant targeted delivery systems and disease management strategies and the unique ability to limit enrollment to certain beneficiaries.

- The Congress should require dual-eligible SNPs within three years to contract, either directly or indirectly, with states in their service areas to coordinate Medicaid benefits. Without a contract with states to cover Medicaid benefits, it is difficult to coordinate benefits with Medicaid, which should be a goal of the program. Dual-eligible SNPs are not now required to coordinate benefits with Medicaid programs, and many dual-eligible SNPs operate without state contracts.
- The Congress should require SNPs to enroll at least 95 percent of their members from their target population. The law now requires that SNPs enroll people from their target population. However, SNPs can apply for a waiver permitting them to enroll others. The way CMS has applied that provision is to permit SNPs to enroll anyone, picking and choosing who they want, so long as the target population is a higher percentage of the plan's population than it is of the Medicare population nationally.
- The Congress should eliminate dual-eligible and institutionalized beneficiaries' ability to enroll in MA plans, except SNPs with state contracts, outside of open enrollment. They should continue to be able to change plans during special election periods triggered by life events and also continue to be able to disenroll and return to FFS at any time during the year. Currently, dual-eligible and institutionalized Medicare beneficiaries can enroll and disenroll from MA plans monthly. We have heard reports that this provision contributes to plan marketing abuses.
- The Congress should extend the authority for SNPs that meet the conditions specified in the above recommendations for three years. SNPs' authority to limit enrollment will expire December 2009. In light of SNPs' rapid growth in number and enrollment, we call for a rigorous evaluation to inform our decision about recommending them as a permanent MA option.

Part D enrollment, benefit offerings, and plan payments

The report examines Medicare’s prescription drug program as it enters its third year. Our analysis of Part D shows that for 2008 there are more than 1,800 plans and most beneficiaries again have a choice of 50 to 60 stand-alone prescription drug plans (PDPs) in their region. In addition, sponsors are offering more Medicare Advantage–Prescription Drug plans (MA–PDs). Average monthly premiums have increased for 2008 to about \$27 per month, up from the \$23 average for 2007. The average PDP enrollee pays about \$32 per month, while average enrollees in an MA–PD pay about \$13 of their monthly MA premium for Part D benefits. In 2007, around 17 million individuals were enrolled in PDPs and 7 million individuals were in MA–PDs. Enrollees in MA–PD plans are more likely to have enhanced benefits—coverage with an average benefit value higher than basic benefits—than those in PDPs. About 90 percent of Medicare beneficiaries were enrolled in Part D plans or had drug benefits at least as generous as basic Part D coverage from other sources.

Of the 13 million beneficiaries estimated to be eligible for Part D’s “extra help” with premiums and cost sharing, more than 9 million were receiving a low-income subsidy (LIS). Plans that bid less than regional threshold values qualify to enroll LIS beneficiaries without charging them a premium. For 2008, about 2.6 million LIS beneficiaries needed to switch to a different plan if they did not want to pay a premium, considerably more than had to switch in the previous year.

Our look at Part D formularies shows:

- Most plans use a three-tier structure that includes one generic tier and two other tiers that distinguish between preferred and nonpreferred brand-name drugs. For 2007, copays for the median enrollee in either a PDP or an MA–PD with a three-tier formulary were \$5 per 30-day prescription for a generic drug, \$28 or \$29 for preferred brand-name drugs, and \$60 for nonpreferred brands.
- In 2007, more than three-quarters of enrollees were in plans with specialty tiers for expensive products, unique drugs, and biologicals. Cost sharing for specialty-tier drugs is typically 25 percent to 30 percent of the plan’s negotiated price and enrollees may not appeal cost-sharing amounts as they can for drugs on other tiers.

The Commission is concerned that CMS has not made drug claims data available to congressional support agencies and selected executive branch agencies. Because of the lack of data, there are fundamental questions that the Commission and other organizations cannot answer about how Part D is operating, such as:

- which prescription drugs enrollees are using most widely;
- how much, on average, enrollees are paying out of pocket for their medicine; and
- how many beneficiaries are entering Part D's coverage gap.

Without Part D claims data, it is also very difficult to assess efficiency and quality in the overall delivery of health care (Part A, Part B, and Part D). Therefore, the Commission recommends that the Congress should direct the Secretary to make Part D claims data available regularly and in a timely manner to congressional support agencies and selected executive branch agencies for purposes of program evaluation, public health, and safety.

Increasing participation in the Medicare Savings Programs and the low-income drug subsidy

Although the Medicare Savings Programs (MSPs) and the LIS provide significant financial benefits to enrollees with limited incomes, many eligible beneficiaries do not participate. There are many reasons why individuals might choose not to take advantage of these programs, but researchers have found that the main barriers to enrollment are beneficiaries' lack of knowledge of the programs and the complexity of the application processes. Those eligible but not enrolled in MSPs are more likely than those enrolled in MSPs to report that they did not receive needed health care because of cost. Beneficiaries enrolled in MSP programs are deemed eligible for LIS.

We make three recommendations to increase participation in programs designed to aid beneficiaries with limited incomes:

- First, Medicare beneficiaries, particularly those who are hard to reach, prefer to receive information from personal contact. The State Health Insurance Assistance Programs (SHIPs) are the only part of the National Medicare Education program that provides personal counseling to beneficiaries—but their resources are limited. Increased funding

for SHIPs that provide this one-on-one counseling will give more beneficiaries access to programs for which they are eligible. Therefore, the Commission recommends the Secretary should increase SHIP funding for outreach to low-income Medicare beneficiaries.

- Second, federal minimum MSP income and asset levels have not been revised since the programs were established. If MSP criteria were aligned with LIS levels, beneficiaries could apply for both programs at one time. Beneficiaries would find the process simpler and states and the federal government would realize administrative savings. Therefore, the Commission recommends the Congress should raise MSP income and asset criteria to conform to LIS criteria.
- Third, the Social Security Administration (SSA) is responsible for determining LIS eligibility for those individuals who are not automatically deemed eligible for the subsidy. If MSP and LIS eligibility were based on the same criteria, SSA could screen and enroll beneficiaries for both programs simultaneously, providing MSP access to eligible beneficiaries who have not heard of it but have heard of LIS. The Commission recommends the Congress should change program requirements so that the SSA screens LIS applicants for federal MSP eligibility and enrolls them if they qualify.