

Report to the Congress: Medicare Payment Policy

March 17, 2009

Statement of
Glenn M. Hackbarth, J.D.

Chairman
Medicare Payment Advisory Commission

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

Chairman Stark, Ranking Member Herger, 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 the Congress, each March the Medicare Payment Advisory Commission reviews and makes recommendations for Medicare fee-for-service (FFS) payment systems and the Medicare Advantage (MA) program. In our March report, we:

- Consider the context of the Medicare program in terms of its spending and the federal budget and national GDP.
- Consider Medicare FFS payment policy in 2010 for: inpatient and outpatient hospitals, physicians, ambulatory surgical centers, outpatient dialysis facilities, skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, and long-term care hospitals.
- Review the status of the MA plans beneficiaries can join as an alternative to traditional FFS Medicare and our MA recommendations.
- Review the status of the plans that provide prescription drug coverage.
- Make recommendations on public reporting of financial relationships among pharmaceutical and device manufacturers, physicians, and health care organizations.
- Make recommendations on reforming Medicare's hospice payment system.

MedPAC's report offers a set of recommendations for Medicare payments that balance the need to assure beneficiaries' access to care with the need to spend the dollars wisely. These recommendations are driven in part by the Commission's and other researchers' conclusions that providers' costs are not immutable, but instead are influenced by how providers are paid. The recommendations contained in the report exert fiscal pressure—in the form of limited Medicare updates—to help constrain costs both in the short and long run. The recommended actions are one part of a broader array of recommendations aimed at more fundamentally reforming Medicare's delivery system, most recently discussed in our June 2008 report, including ideas for example to reward better coordination of care and efficiency over time and invest in information about comparative effectiveness.

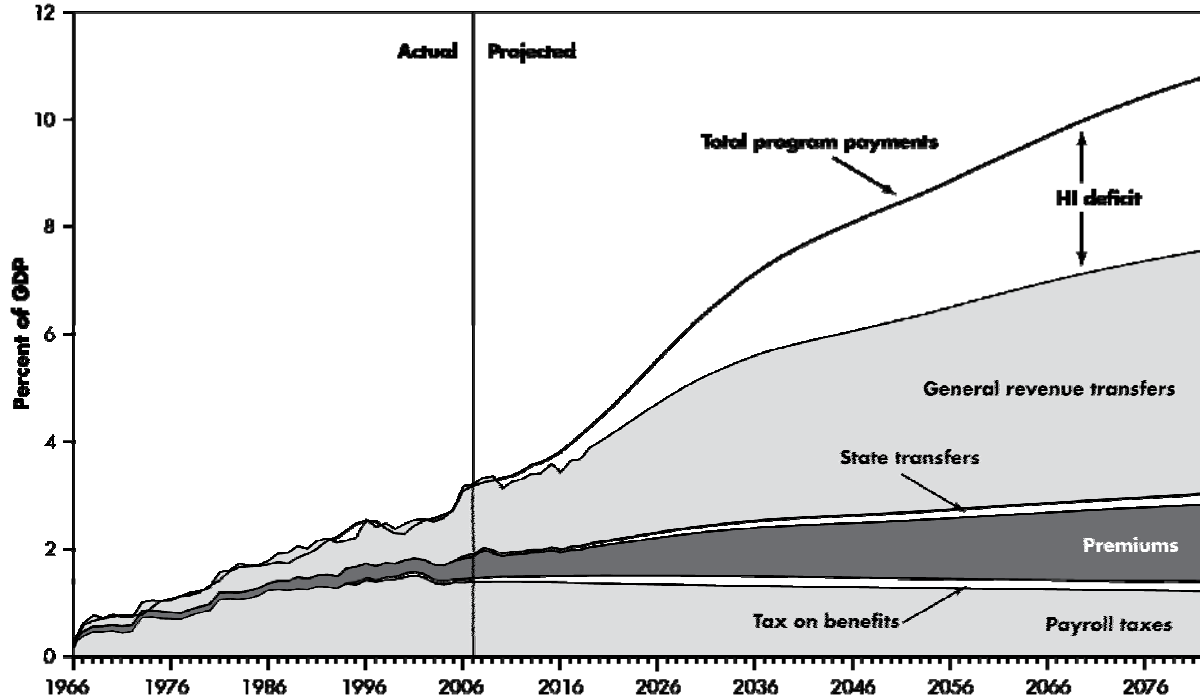
Context for Medicare payment policy

Medicare and other purchasers of health care in our nation face enormous challenges. Health care costs are increasing for individuals and private and public payers, while quality frequently falls short of patients' needs. The Commission has recommended a number of measures to increase the accountability of providers and the value of care, such as pay for performance, measuring resource use, penalizing high readmission rates, and research comparing the effectiveness of medical treatments. The marked variation in both service use and quality of care across the nation, suggest that opportunities exist for reducing spending while improving quality for beneficiaries.

Health care spending—including Medicare spending—has been growing much faster than the economy. The growth in national income, the availability of newer medical technologies, and the cost-increasing effects of health insurance are thought to account for much of this long-term growth, and some of those forces will likely push future spending even higher. Medicare will have the additional challenge of higher enrollment associated with retiring baby boomers. Technological and demographic factors notwithstanding, the current structure and functioning of our health care system that encourages service volume rather than quality and coordination also contributes to the significant expenditure levels. Medicare payment policy is an important tool for encouraging greater efficiency and effectiveness in the delivery of care.

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. 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).

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: 2008 annual report of the Boards of Trustees of the Medicare Trust Funds.

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 11.1 percent today to 24 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

individuals. In 2004, roughly half of all Medicare beneficiaries had family incomes of less than 200 percent of the federal poverty level.

Analysts across the political spectrum have raised concerns that the Medicare program—in its current form—may become too heavy a fiscal burden and squeeze the funding for other federal priorities. The Congressional Budget Office (CBO) finds that any feasible set of policy solutions will require a 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.

Changes in Medicare payment systems are complex to develop and implement. Delaying action constrains the options for addressing Medicare's problems. In the short run, while changes are being formulated, MedPAC recommends payment updates designed to exert fiscal pressure to encourage providers to improve their efficiency.

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

Each year, in accordance with our mandate, the Commission makes payment update recommendations annually for fee-for-service (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. For each sector, we first assess the adequacy of Medicare payments for providers in the current year (2009), taking into account factors affecting the efficient provision of services and policy changes (other than the update) that are scheduled to take effect in the policy year (2010) under current law. Next, we assess how those providers' costs are likely to change in 2010, the year the update will take effect. In addition to these provider-specific factors, the Commission also considers the payment update from the perspective of the economy-wide gains achieved by the firms and workers who pay taxes that fund Medicare. Competitive markets demand continual improvements in processes and quality from those workers and firms. Medicare's payment systems should exert the same pressure on providers of health care services.

Hospital inpatient and outpatient services

Most indicators of payment adequacy for hospital services are positive. Access to hospital services continues to be good with more hospitals opening than closing. In fact, the overall level of hospital construction was at a record high in 2007 and many hospitals are expanding the services they offer their communities. MedPAC and others have expressed concern about the degree to which these capital investments add value to clinical care. For example, the Center for Studying Health Systems Change has raised the possibility of a return to the “medical arms race,” as hospitals compete on amenities and new technology (Berenson, 2006). Despite increasing competition from independent diagnostic testing facilities and ambulatory surgery centers, the volume of hospital outpatient services furnished to Medicare beneficiaries has grown, indicating that access is strong. Quality of care measures are generally improving.

Access to capital has been erratic in 2008. Bond offerings and construction started off at a record pace in January but froze in September 2008 due to an economy-wide freeze of the credit markets. The difficulties in accessing capital resulted from a sudden economy-wide breakdown of the credit markets rather than any change in the level of Medicare hospital payments. Recently, hospitals with robust fundamentals have been able to issue debt, but even financially sound hospitals face higher interest rates.

While most payment adequacy indicators are positive, hospitals’ Medicare margins remain negative. Average Medicare margins, which were -5.9 percent in 2007, are projected to be -6.9 percent in 2009 (after accounting for the effects of payment policy changes scheduled for 2010 under current law).

Factors influencing cost growth and financial performance

Several observations inform our assessment of payment adequacy in light of these negative Medicare margins. First, hospitals’ costs are not immutable. MedPAC research shows that hospitals under financial pressure are able to constrain their costs. The hypothesis is that hospitals with high margins on non-Medicare patients face less pressure to constrain costs, as a result their costs increase and their Medicare margins tend to be low. Consistent with the

hypothesis, hospitals facing lower financial pressure (i.e. high non-Medicare margins and growing net worth) in recent years (2002 through 2006) tended to have higher costs and hence lower Medicare margins in 2007 than hospitals under greater financial pressure (Table 1). In 2007, hospitals under low financial pressure in the prior years had higher standardized costs per discharge (\$6,400) than hospitals under high financial pressure (\$5,800).

Table 1. High financial pressure leads hospitals to constrain costs

| 2007 Financial characteristics (medians) | Level of financial pressure 2002 to 2006 | |
|--|--|--------------|
| | High pressure | Low pressure |
| Standardized cost per discharge | | |
| All hospitals | \$5,800 | \$6,400 |
| Non-profit hospitals | 5,700 | 6,500 |
| For-profit hospitals | 5,900 | 6,000 |
| Annual growth in cost per discharge 2004 to 2007 | 4.8% | 5.0% |
| Non-Medicare margin (private, Medicaid, uninsured) | -2.4% | 13.5% |
| Overall Medicare margin | 4.2 | -11.7 |

Note: High pressure hospitals had median non-Medicare profit margins of 1 percent or less from 2002 to 2006 and net worth would have grown by less than 1 percent per year from 2002 to 2006 if the hospital's Medicare profits had been zero. Low pressure hospitals had median non-Medicare margins were greater than 5 percent from 2002 to 2006 and a net worth that would have grown by more than 1 percent per year if its Medicare profits were zero. Standardized costs are adjusted for case mix, wage index, outliers, transfer cases, interest expense, and the effect of teaching and low-income Medicare patients on costs per discharge.

Source: MedPAC analysis of Medicare Cost Report and claims files from CMS available as of August, 2008.

Over time, aggregate hospital cost growth has moved in parallel with margins on private-payer patients. Due to managed care restraining private-payer payment rates in the 1990s, hospitals' rate of cost growth in that period was below input price inflation. However, from 2001 through 2007, after profits from private payers increased, hospitals' rate of cost growth was higher than the rate of increase in the market basket of input prices (MedPAC, 2009). This has resulted in lower Medicare margins. Hospitals with the highest private payments and most robust non-Medicare sources of revenues have lower Medicare margins (-11.7 percent) than hospitals under greater fiscal pressure (4.2 percent).

While Medicare margins for hospitals may be negative in aggregate, Medicare payments are still adequate to cover the costs of efficient hospitals. As shown in Table 2, MedPAC analysis has identified a set of low-cost hospitals that consistently out-perform other hospitals on a series of quality measures, including mortality and readmissions. Among this set of hospitals, we found that Medicare payments on average roughly equaled the hospitals' costs.

Table 2. Characteristics of traditionally high performing hospitals

| | Relatively efficient during 2004-2006 | Other hospitals |
|---|---------------------------------------|-----------------|
| Number of hospitals | 338 (12%) | 2535 (88%) |
| Historical performance 2004-2006 | | |
| Relative risk-adjusted composite 30-day mortality (AHRQ) | 87% | 106% |
| Relative standardized cost per discharge 2004-2006 | 90 | 102 |
| Relative risk-adjusted readmission rates (2005) | 97 | 101 |
| Quality metrics in 2007 | | |
| Relative risk-adjusted composite 30-day mortality (AHRQ) | 86% | 103% |
| Relative risk-adjusted 30-day AMI mortality (CMS) | 98 | 100 |
| Relative risk-adjusted 30-day CHF mortality (CMS) | 97 | 101 |
| Relative risk-adjusted 30-day pneumonia mortality (CMS) | 94 | 101 |
| Relative risk-adjusted all-condition in-hospital mortality (3M) | 83 | 102 |
| Relative percent of patients highly satisfied (H-CAHPS) | 100 | 100 |
| Relative standardized costs | 89 | 102 |
| Median Medicare margin in 2007 | 0.5% | -7.4% |

Note: AHRQ (Agency for Healthcare Research and Quality); H-CAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems); AMI (Acute myocardial infarction); CHF (Congestive heart failure). Relatives are the median for the group as a percentage of the median of all hospitals. Per case costs are standardized for area wage rates, case-mix, severity, prevalence of outlier and transfer cases, interest expense, low-income shares, and teaching intensity. Composite mortality was computed using AHRQ methodology to compute risk-adjusted mortality for eight conditions (AMI, CHF, Pneumonia, gastrointestinal hemorrhage, stroke, craniotomy, coronary artery bypass graft, and abdominal aortic aneurysm repair). We then weighted the scores for each type of discharge by the share of discharges in that particular hospital.

Hospital update

The Commission recommends an update equal to the projected increase in the market basket for inpatient and outpatient services (projected to be 2.7% in 2010), with this update implemented concurrently with a quality improvement program. Given the mixed payment adequacy indicators, the Commission believes a hospital's quality performance should determine whether its payments increase more or less than the market basket – a recommendation we have made in previous years. We find that the combination of fiscal pressure and rewards for quality can result in the provision of more efficient and better

patient care. A quality improvement, or pay-for-performance, payment pool would be funded by setting aside 1 to 2 percent of overall payments. Put differently, although the sector as a whole would get a full market basket increase, the Commission is not saying that each hospital deserves a full update. The net effect of our update policy and a 1 to 2 percent set-aside for pay-for-performance is that only hospitals with poor quality rankings will get less than a full market basket update. To be explicit, dollars would be redistributed from lower performing hospitals to high performing hospitals.

Medicare as a public payer funds medical education programs through both direct and indirect payments. In 2007, Medicare's indirect medication education (IME) payments to teaching hospitals totaled \$6 billion. As we have in prior years, we recommend a reduction in the IME adjustment equivalent to 1 percentage point to 4.5 percent per 10 percent increment in the resident-to-bed ratio. These dollars would be used to help fund in part the quality improvement program recommended above. There are two reasons for this recommendation. First, we find that these payments are set at a level more than twice the costs associated with teaching residents (MedPAC, 2007, 2009). Second, the new MS-DRG severity adjustment increases payments to teaching hospitals to the extent they treat more severe cases.

Physician services and ambulatory surgical centers

We assess overall payment adequacy for physician services in fee-for-service (FFS) Medicare, examine payments for expensive imaging services, and assess payment adequacy for ambulatory surgical centers (ASCs)—facilities that are typically owned wholly or in part by physicians.

Physician update and primary care

Our analysis of physician services provided in fee-for-service (FFS) Medicare finds that, overall, most indicators of payment adequacy are positive and stable, suggesting that most beneficiaries can obtain physician care when they need it.

- Our 2008 survey of beneficiaries indicates that beneficiary access to physicians is generally good, and by most measures, better than that reported by privately insured patients age 50 to 64. Among the small share of beneficiaries (6 percent) who reported

that they looked for a new primary care physician, we did see some access problems, with 28 percent reporting problems finding one.

- Our survey shows that Medicare beneficiaries are less likely than privately insured individuals to report problems getting timely illness or injury appointments. Among those who scheduled an illness or injury appointment, 84 percent of Medicare beneficiaries and 79 percent of privately insured individuals said they “never” experienced a delay, while 12 percent of Medicare beneficiaries reported “sometimes” having to wait longer than they wanted, compared with 16 percent for privately insured individuals.
- Physicians continue to accept and treat Medicare patients: 92 percent of office-based physicians who receive 10 percent or more of their practice revenue from Medicare were accepting new Medicare patients in 2007, and the share of physicians who have participation agreements with Medicare was 95 percent in 2008.
- MedPAC’s 2008 beneficiary survey also examined differences in access to physician services between white and minority beneficiaries. In general, minorities were more likely than whites to experience access problems. This does not appear to be unique to Medicare; privately insured minorities were also more likely than privately insured whites to have access problems.
- Medicare payment rates continue to be about 80 percent of private insurance payment rates as they have for the past decade.
- In 2007, the volume of physician services provided per beneficiary grew almost 3 percent.

In light of these findings, the Commission recommends that for 2010, the Congress update payments for physician services by 1.1 percent.

The Commission remains concerned that primary care services are undervalued and at a significant risk of being underprovided, despite some recent increases in payments for primary care services. To underscore the urgency of this issue, the Commission voted to reiterate its previous recommendation that Congress increase payments for primary care services when provided by practitioners who focus on primary care (MedPAC 2008a). This adjustment would be budget neutral within the fee schedule.

Changing payments for expensive imaging services

The Commission recognizes that there has been rapid technological progress in diagnostic imaging over the past several years, which has enabled physicians to diagnose and treat illness with greater speed and precision. However, the rapid volume growth of costly imaging services may be driven, at least in part, by prices that are too high. Further, high payment rates for imaging services means that payment rates for primary care and other services are lower.

CMS's method for setting practice expense relative value units (a key factor that determines payment rates) for advanced imaging services assumes that imaging machines are operated 25 hours per week, or 50 percent of the time that practices are open for business. This assumption has led to higher payments for these services. Higher payments encourage providers with low expected volumes to purchase expensive imaging machines. Once providers purchase machines, they have an incentive to use them as frequently as possible. Indeed, there is evidence that MRI and computed tomography (CT) machines are used much more frequently than Medicare assumes.

The Commission recommends that Medicare adopt a normative standard in which providers are assumed to use costly imaging machines at close to full capacity (45 hours per week, or 90 percent of the time that providers are assumed to be open). Such a normative standard would discourage providers from purchasing expensive imaging equipment unless they had sufficient volume to justify the purchase. The Secretary should start by adopting a standard of 45 hours per week for all diagnostic imaging machines that cost at least \$1 million and should explore applying this standard to imaging equipment that costs less. This change would reduce payment rates for costly imaging services and increase rates for other physician services like evaluation and management and major procedures.

Payment adequacy in ambulatory surgical centers

Physicians furnish outpatient surgical services in their offices, hospital outpatient departments, and increasingly, ambulatory surgical centers (ASCs). ASCs are a source of revenue for many physicians, as over 90 percent of ASCs have at least one physician owner.

ASCs offer several advantages to physicians and patients over hospital outpatient departments. Physicians have greater control and may be able to perform more surgeries per day in ASCs because they often have customized surgical environments and specialized staffing. Patients may be able to schedule surgery more quickly, experience shorter waiting times, and find ASCs that are more conveniently located. Whether ASCs provide less costly or higher quality care than other settings is hard to say, because ASCs do not submit data to the Medicare program on their costs or the quality of the care they provide.

Indicators suggest that ASC Medicare payment rates are adequate. From 2002 to 2007, the number of ASCs grew by an average of 6.7 percent per year, volume per beneficiary grew by 9.8 percent per year, and the number of Medicare beneficiaries served in ASCs increased by 7.5 percent per year.

CMS made substantial changes to the ASC payment system in 2008. The most significant changes include a different method for setting payment rates, allowing separate payment for certain ancillary services, and a 32 percent increase in the number of procedures covered under the ASC payment system. Under the revised payment system, 86 percent of all procedures have a higher payment rate than under the old system. However, the highest-volume procedures have lower payment rates. If ASCs diversify the procedures they provide to Medicare beneficiaries over the four-year transition period to the new payment system, they should be able to maintain or increase their Medicare revenue.

Weighing our findings on payment adequacy and the revised payment system, the Commission recommends that ASCs receive a payment update of 0.6 percent in calendar year 2010. The Commission also recommends that ASCs be required to submit cost and quality data to the Secretary. Current law requires that ASC payment rates be increased by the full amount of the consumer price index for all urban consumers (CPI-U) in 2010. However, the Commission plans to examine how well the CPI-U measures input price changes for ASCs and explores alternative price indexes.

Dialysis services

Most of our indicators of payment adequacy for outpatient dialysis services are positive. The growth in the number of dialysis facilities and treatment stations has kept pace with the growth in the number of dialysis patients, suggesting continued access to care for most dialysis beneficiaries. MedPAC specifically considered whether African-American beneficiaries and beneficiaries eligible for Medicare and Medicaid had more difficulty than other beneficiaries accessing dialysis services and found that in 2006, facilities that closed did not treat a higher proportion of these patients compared with those that remained in business.

The growth in the number of dialysis treatments has kept pace with patient growth between 2006 and 2007. The total volume of most dialysis drugs administered grew between 2004 and 2007 but more slowly than in the past because of statutory and regulatory changes that lowered the payment rate for most dialysis drugs. In addition, the decline in the use of erythropoietin, the leading dialysis drug, may also be linked to a warning by the Food and Drug Administration and recent studies reporting side effects with the use of this drug class.

Some measures of quality of care are improving. Use of the recommended type of vascular access—the site on the patient’s body where blood is removed and returned during hemodialysis—has improved since 2000. More patients receive adequate dialysis and have their anemia under control. However, improvements in quality are still needed.

Recent evidence about trends in the increase in the number of dialysis facilities suggests that providers have sufficient access to capital. Both the large dialysis organizations and smaller chains have obtained private capital to fund acquisitions.

The Medicare margin for composite rate services and dialysis drugs for freestanding dialysis facilities was 4.8 percent in 2007. The two largest dialysis chains (which may benefit from economies of scale) realized a higher Medicare margin than other providers (6.9 percent versus 0.2 percent). We project the overall Medicare margin for freestanding dialysis facilities will be 1.2 percent in 2009.

The sum of these indicators suggests that a moderate update of the composite rate is in order. Therefore, the Commission recommends that the Congress maintain current law and update the composite rate by 1 percent for calendar year 2010.

Skilled nursing facility services

Our indicators of the adequacy of Medicare payments for skilled nursing facility (SNF) services are generally positive. These indicators include a stable supply of providers, a slight increase in service volume, and growth in Medicare margins. Quality indicators were mixed. Access to capital is tight, reflecting general uncertainty in the financial markets, not the adequacy of Medicare payments. Most beneficiaries continue to have good access to services, especially rehabilitation services. However, patients seeking medically complex care may experience delays in placement. Since 2002, admissions for medically complex patients have been increasingly concentrated in fewer facilities. The growing concentration of medically complex cases in fewer SNFs, the continued growth and intensity of rehabilitation days, and the wide variation in Medicare margins underscore the inequities and poor incentives of the current PPS design. Previously recommended revisions to the PPS—which we reiterate in this report—would more accurately reflect providers’ costs to treat different types of cases, thereby reducing the incentive to admit certain patients over others and producing a more equitable distribution of Medicare margins across facilities. The commission also recommends the adoption of a pay-for-performance program to improve quality (March 2008).

Between 2006 and 2007, Medicare costs for freestanding SNFs grew faster than in the two previous years. However, Medicare payments continued to outpace SNF costs, in part because of the increase in the days classified into the highest-payment case-mix groups. As a result, the aggregate Medicare margin for freestanding SNFs was 14.5 percent in 2007, making this the seventh consecutive year that the aggregate Medicare margin was above 10 percent. The aggregate margin for 2009 is projected to be 12.6 percent. Because indicators are generally positive and SNF payments are more than adequate to accommodate anticipated cost growth, the Commission recommends a zero update for SNFs in 2010.

Home health services

Indicators of payment adequacy for home health services are positive. Access, volume, and the supply of agencies remained stable or increased, suggesting that Medicare beneficiaries have adequate access to care. Quality continued to improve, and the turmoil in the financial markets does not appear to have significantly impaired access to capital for this industry.

Home health agencies continued to be paid significantly more than cost, with average margins of 16.6 percent in 2007. The home health industry has maintained average Medicare margins of about 16.5 percent a year since 2002. At the same time, the mix of visit types has changed and the average number of visits per episode has dropped 30 percent from 1998 to 2007.

In 2007, volume and average payment per episode continued to rise, with total payments growing 12 percent to \$16 billion. The number of home health users also rose, even as the number of traditional fee-for-service enrollees declined due to greater enrollment in Medicare Advantage plans. The type of episodes provided continued to shift to higher-paying services. At the same time, home health agency costs have remained low. We estimate home health margins to be 12.2 percent for 2009. The 2009 margin is expected to decline because administrative adjustments to take back coding increases offset the market basket increase.

Because of the consistently high margins and other positive indicators, the Commission has concluded that home health payments should be significantly reduced in 2010 and 2011 to ensure that Medicare does not continue to overpay home health providers. Therefore, the Commission recommends that the Congress should eliminate the market basket increase for 2010 and advance the planned reductions for coding adjustments in 2011 to 2010, so that payments in 2010 are reduced by 5.5 percent from 2009 levels.

The reduction in 2010 will begin the process of reducing payments to appropriate levels, but further reductions might be necessary. The package of service delivered under the home health benefit has changed substantially since the PPS was established, and the current rates are well in excess of the efficient provider's cost. The Commission recommends the Congress direct the Secretary to re-base rates for home health care services in 2011 to reflect

the average cost of providing care.

However, the Commission is concerned that quality of care be maintained when the rebasing is implemented. Thus, the Commission also recommends that the Congress should direct the Secretary to develop payment measures that ensure adequate beneficiary care. Two types of safeguards need to be developed: financial safeguards that can be proposed concurrently with the rebasing recommended for 2011 (e.g., risk sharing, blending prospective payment with a per-visit payment), and quality of care safeguards linking payment to avoidance of adverse events, which can be implemented as soon as practicable.

Inpatient rehabilitation facility services

Our assessment of payment adequacy for inpatient rehabilitation facilities (IRFs), which provide intensive rehabilitation services in an inpatient setting, reflects recent changes in Medicare policy that significantly affect the volume of IRF services. In 2004, CMS renewed enforcement of the 75 percent rule, which required IRFs to have a certain percentage of admissions with one or more of a specified list of conditions. The compliance threshold was to be phased in from 50 percent to 75 percent over several years. Before the phase-in to 75 percent was complete, the Congress set the compliance threshold permanently at 60 percent from July 2007 going forward, in one of several provisions of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) related to IRF services. The overall policy goal of the rule is to direct the most clinically appropriate cases to this intensive, costly setting. The renewed implementation of this rule was expected to result in a decline in IRF volume for certain types of cases and an increase in IRF average patient complexity.

Our indicators of Medicare payment adequacy are on net positive. From 2004 to 2007, Medicare IRF discharges declined as was expected, but the number of IRF beds did not decline as much—suggesting that capacity remains adequate to meet demand. With the decline in IRF volume, there has been a corresponding increase in the volume of patients in home health and SNFs, suggesting that beneficiaries who would have received care in an IRF are receiving care in other settings. Access to capital has tightened in 2008 due to the economy-wide credit crisis. However, the changes in the credit markets are not related to

Medicare payment changes. Measures of quality (functional gain between admission and discharge) continue to show improvement. However, changes over time in the mix of IRF patients make it difficult to draw definitive conclusions about quality trends.

The actual 2007 margin for IRFs is 11.7 percent and our projected 2009 Medicare margin is 4.5 percent. The projected decrease in the margin is the result of a MMSEA provision that eliminated the IRF payment update for the second half of 2008 and all of 2009. The margin projection for 2009 does not assume increased cost control efforts by IRFs in response to the MMSEA's elimination of the IRF update or the decline in discharges in recent years. To the extent that IRFs restrain their cost growth in response to these changes, the projected 2009 margin would be higher than we have estimated. Based on our analysis of payment adequacy, the Commission recommends eliminating the update to payment rates for inpatient rehabilitation services for fiscal year 2010.

Long-term care hospital services

Long-term care hospitals (LTCHs) furnish care to patients with clinically complex problems who need hospital-level care for relatively extended periods (average length of stay for Medicare patients must be greater than 25 days). Medicare is the dominant payer for LTCH services, accounting for about 70 percent of LTCH discharges. This sector has been marked by rapid growth and geographic concentration. Concerns about this growth and the appropriateness and necessity of some admissions prompted CMS to impose the 25 percent rule, under which Medicare generally pays less if more than a specified percentage of a hospitals-within-hospitals (HWHs) or satellite LTCH's patients is referred from its host hospital. The MMSEA delayed the full implementation of this rule and its extension to freestanding LTCHs.

Growth in the number of LTCHs has remained relatively flat between 2005 and 2007 and the number of HWHs has fallen an average of 2 percent per year as the 25% rule takes effect. Beneficiaries' use of services suggests that access has not been a problem. We found that LTCH use per FFS beneficiary increased slightly between 2005 and 2007. The evidence on quality is mostly positive. Readmission rates for the top 15 LTCH diagnoses have been stable or declining. Rates of death in the LTCH and death within 30 days of discharge also have

been declining for most diagnoses. LTCH patients appear to have experienced fewer infections due to medical care and fewer cases of postoperative sepsis. However, patients appear to have experienced more decubitus ulcers and more cases of postoperative pulmonary embolisms and deep vein thrombosis.

As with other sectors, LTCHs' access to capital in the current economy-wide credit crisis does not reflect Medicare payment adequacy. LTCH's need for major capital will be mitigated in the short term by the three-year moratorium on new beds and facilities imposed by the MMSEA.

LTCHs' Medicare margin for 2007 is 4.7 percent. Although implementation of the MMSEA somewhat improved the financial outlook for LTCHs, growth in facilities' costs is still likely to outweigh payment increases over the next few years. As a result, we estimate LTCHs' aggregate Medicare margin will be 0.5 percent in 2009.

On balance, our indicators of payment adequacy are positive and the Commission recommends that the Secretary update payment rates for LTCH services by the market basket index less an adjustment of 1.3 percent, with this adjustment designed to provide an incentive to control costs while maintaining quality. Under the current forecast of the rehabilitation, psychiatric, and LTCH market basket, the Commission's recommendation would update the LTCH payment rates by about 1.6 percent in 2010.

The Medicare Advantage program

The Medicare Advantage (MA) program provides Medicare beneficiaries with an alternative to the fee-for-service (FFS) Medicare program. It enables them to choose a private plan to provide their health care. Those private plans can use alternative delivery systems and care management techniques, and they have the flexibility to innovate. The Commission supports private plans in the Medicare program, but has consistently expressed concerns about the current MA payment system.

In our analyses of data on enrollment, availability, payments, benefits, and quality we find:

- About 22 percent of Medicare beneficiaries were enrolled in MA plans in 2008 and all beneficiaries have access to an MA plan in 2009.
- Plans provide enhanced benefits to enrollees and overwhelmingly these benefits are not financed out of plan efficiency, but rather by the Medicare program and other beneficiaries, and at a high cost. For example, each dollar's worth of enhanced benefits in private FFS (PFFS) plans costs the Medicare program over three dollars.
- Quality is not uniform among MA plans or plan types. High quality plans tend to be established HMOs; more recent plans have lower rankings on many measures.

As shown in Table 2, in 2009, payments to MA plans continue to exceed what Medicare would spend for similar beneficiaries in FFS. MA payments per enrollee are projected to be 114 percent of comparable FFS spending for 2009. In the aggregate, the MA program continues to be more costly than the traditional program. Plan bids for the traditional Medicare benefit package are 102 percent of FFS in 2009, an increase from 101 percent in 2008, which means that plans in aggregate continue to be less efficient than FFS Medicare. As an exception, HMOs continue to bid below FFS, bidding 98 percent of FFS.

Table 3. Payments exceed FFS spending for all plan types in 2009

| Plan type | Enrollment as of November 2008 (in millions) | Benchmarks (percent of FFS spending in 2009) | Bids | Payments |
|---------------------|---|---|-------------|-------------|
| All MA plans | 9.9 | 118% | 102% | 114% |
| HMO | 6.6 | 118 | 98 | 113 |
| Local PPO | 0.7 | 121 | 108 | 118 |
| Regional PPO | 0.3 | 114 | 106 | 112 |
| PFFS | 2.3 | 120 | 113 | 118 |

Note: FFS (fee-for-service), MA (Medicare Advantage), PPO (preferred provider organization), PFFS (private fee-for-service), SNP (special needs plan). Benchmarks are the maximum Medicare program payments for MA plans. We estimate FFS spending by county using the 2009 MA rate book. We removed spending related to the double payment for indirect medical education payments made to teaching hospitals. Totals may not add due to rounding.

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

To be clear, even though we use the FFS Medicare spending level as a measure of parity for the MA program, this should not be taken as a conclusion that the Commission believes that FFS Medicare is an efficient delivery system in most markets.

High MA payments provide a signal to plans that the Medicare program is willing to pay more for the same services in MA than it does in FFS. Similarly, these higher payments signal to beneficiaries that they should join MA plans because they offer richer, benefits, albeit financed by taxpayer dollars. This is inconsistent with MedPAC's position supporting financial neutrality between FFS and MA. To encourage efficiency across the Medicare program, Medicare needs to exert comparable and consistent financial pressure on both the FFS and MA programs, coupled with meaningful quality measurement and pay-for-performance (P4P) programs, to maximize the value it receives for the dollars it spends. The Commission has made recommendations in previous years to further these aims in the MA program, and those recommendations are reiterated in this report.

Part D Prescription Drug Benefit

Part D uses competing private plans to deliver outpatient prescription drug benefits. Each year, sponsors submit plan bids for providing Part D benefits. Part D sponsors may change plans' benefit designs, formularies, and cost-sharing requirements. Policymakers need to stay informed about changes to ensure that Part D meets the broader goal of giving beneficiaries access to appropriate drug therapies. Year-to-year changes in bids and enrollee premiums give policymakers information about how well sponsors are managing drug benefit costs for beneficiaries and for taxpayers.

In the report, we describe Part D enrollment in 2008 and plan offerings for 2009. We also report on one aspect of Part D intended to promote quality: medication therapy management programs. We find:

- Ninety percent of Medicare beneficiaries received some form of drug coverage in 2008. Fifty-eight percent of all Medicare beneficiaries enrolled in Part D plans; 32 percent had drug coverage at least as generous as Part D through employer-sponsored plans or other sources. Twenty-one percent of Medicare beneficiaries had lower premiums and cost sharing via the low-income subsidy (LIS). CMS estimates that 2.6 million were eligible for the LIS but were not enrolled.
- In 2009, the number of stand-alone prescription drug plan (PDP) options declined by

7 percent, but a typical beneficiary still has about 49 PDPs among which to choose. Sponsors are offering 6 percent more Medicare Advantage–Prescription Drug plans (MA–PDs) than in 2008.

- For 2009, Part D premiums are higher than in 2008. If enrollees stayed in the same plan, they saw premiums rise by an average of \$6 above 2008 levels to nearly \$31 per month (an increase of 24 percent).
- For 2009, we estimate that more than 80 percent of enrollees are in plans that use one generic tier and separate tiers for preferred and nonpreferred brand-name drugs in their formulary. (The formulary includes the list of drugs a plan may cover, cost-sharing tiers, and information on whether a drug is subject to tools such as prior authorization.)
- Cost sharing tended to rise among PDPs for 2009. Copays for the typical enrollee in a PDP rose to \$7 per 30-day supply of a generic drug, \$38 for a preferred brand-name drug, and \$75 for a nonpreferred brand. MA–PD cost sharing was more likely to remain at 2008 levels, with the exception of increased coinsurance for specialty-tier drugs.
- For 2009, fewer premium-free PDPs are available to enrollees who receive the LIS: 308 plans qualified, compared with 495 in 2008. CMS estimated that it needed to reassign about 1.6 million LIS enrollees to new plans for individuals to avoid paying some of the premium.
- A small percentage of beneficiaries are enrolled in Medication Therapy Management Programs (MTMPs). While all plans are required by Medicare to offer MTMPs to beneficiaries enrolled in their drug plans, MTMPs differ in the number and type of chronic conditions and prescriptions a beneficiary must have to be eligible, the kinds of interventions provided to enrollees, and the outcomes sponsors measure. More standardized collection and reporting of outcome measures could be used to determine whether programs are meeting their goals of improving the quality of pharmaceutical care, what patient populations benefit from these programs, and what interventions are most successful.

Public reporting of physicians' financial relationships

Drug and device manufacturers have extensive financial relationships with physicians, academic medical centers, and other health care entities. These financial ties have led to many advances in medical research, technology, and patient care. However, they may also create conflicts between the commercial interests of manufacturers and physicians' obligation to do what is best for their patients. The line between appropriate and inappropriate interactions may not always be clear, but there is no doubt that the interactions should be transparent. Transparency does not imply that all—or even most—of these financial ties undermine physician–patient relationships.

Requiring manufacturers to publicly report their financial relationships with physicians and other health care entities should have several important benefits. For example, it could discourage physicians from accepting gifts or payments that violate professional guidelines. It would also help CMS and other payers determine whether physicians' practice patterns are influenced by their interactions with industry. The Commission recommends that the Congress require manufacturers to report their financial relationships with physicians and other health care entities and that the Secretary post this information on a public, searchable website.

In 2005, pharmaceutical manufacturers provided free samples with a retail value of more than \$18 billion to physicians and other providers. While free samples may benefit patients, there are concerns that they may influence physicians' prescribing decisions and lead physicians and patients to rely on more expensive drugs when less expensive medications might be equally effective. More information about the distribution of samples would enable researchers to study their impact on prescribing patterns and overall drug costs and could help payers and health plans target education to providers about alternative drug options. The Commission recommends that the Congress require pharmaceutical manufacturers to report information about drug samples and their recipients. The Secretary would make this information available for research and legitimate business purposes through data use agreements.

In addition to financial relationships with drug and device manufacturers, physicians may also have financial ties to health care facilities. There has been rapid growth in physician investment in hospitals and ambulatory surgical centers, for example. Although physician ownership of facilities may improve access and convenience for patients, evidence suggests that physician-owned hospitals are associated with a higher volume of services within a market. The Commission recommends that the Secretary collect information on physician investment in hospitals and other health care providers and make it available in a public database, which would facilitate research on how physician ownership might influence patient referrals, quality of care, volume, and overall spending.

Physicians have a wide variety of financial relationships with hospitals besides investment interests, yet we know very little about their prevalence. If information on these relationships were publicly available, payers and researchers could use it to examine their impact on referral patterns, volume, quality, and cost. Through the Disclosure of Financial Relationships Report, CMS plans to collect detailed data from a sample of hospitals on their ownership, investment, and compensation arrangements with physicians. We recommend that the Secretary use data from this survey to report to the Congress on the prevalence of various arrangements. This report could help guide future decisions on what types of physician-hospital relationships—in addition to ownership—should be publicly reported.

Reforming Medicare's hospice benefit

The Medicare hospice benefit was established in 1983 to allow beneficiaries to choose palliative care and other benefits consistent with their personal preferences for end-of-life care as an alternative to conventional medical interventions. The creation of the Medicare hospice benefit was more than just a change to the Medicare benefits package; it was a statement recognizing and respecting social values and patient preferences at the end of life. Since Medicare began covering hospice care, the share of beneficiaries electing hospice has grown, as there has been increased recognition that hospice can appropriately care for patients with non-cancer diagnoses.

Along with this expansion, hospice stays have grown longer, with especially rapid growth occurring since 2000. Medicare hospice spending also rose rapidly, more than tripling between 2000 and 2007, when it reached \$10 billion. Over this time, the number of Medicare-participating hospices increased by more than 1,000 providers, nearly all of which were for-profit entities. The Commission's analysis of the hospice benefit in our June 2008 report shows that Medicare's hospice payment system contains incentives that make very long stays in hospice profitable for the provider, which may have led to inappropriate utilization of the benefit among some hospices. We also find that the benefit lacks adequate administrative and other controls to check the incentives for long stays in hospice, and that CMS lacks data vital to the effective management of the benefit.

To address these problems, we make recommendations to reform the payment system, to ensure greater accountability within the hospice benefit, and to improve data collection and accuracy. In making these recommendations, the Commission recognizes the importance of the hospice benefit and its substantial contribution to end-of-life care for beneficiaries. The goal of these recommendations is to strengthen the hospice payment system and deter program abuse. It is not to discourage enrollment in hospice. Thus, the Commission's recommendations are intended to encourage hospices to admit patients at a point in their terminal disease that provides the most benefit for the patient. The Commission recommends:

- A revised hospice payment system under which per-diem payments begin at a relatively higher rate, decline as length of stay increases, and provide an additional payment at the end of the episode. This model would better reflect hospices' level of effort in providing care throughout the course of a hospice episode and promote stays of a length consistent with hospice as an end-of-life benefit. Without a change in the payment system, there is a risk that hospice in Medicare will become a de facto long-term care benefit, inconsistent with the statutory intent of the program. At the same time, it should be noted that the new payment system would affect the length of stay by ensuring decisions regarding admissions to the benefit would be made at the appropriate time in the patient's disease progression. Changes would be made in a budget neutral manner in the first year.

- More oversight of hospices' compliance with Medicare eligibility criteria and greater physician engagement in the process of certifying and recertifying patients' eligibility for the Medicare hospice benefit. One contributor to increasing length of stay may be insufficient attention to the patient's clinical indicators on the part of the physician certifying the patient's continued eligibility for hospice. Requiring additional documentation, coupled with focused medical case reviews of hospices with a greater share of very long stays would help ensure that hospice is used to provide the most appropriate care for eligible patients. We envision the Medicare case reviews to be targeted to the hospices with high average lengths of stay, not all hospices. In addition, potential conflicts of interest among hospices and other providers caring for hospice patients should be addressed and we have recommended that the HHS Inspector General investigate nursing home and hospice referrals.
- Additional data be collected on hospice claims and cost reports. Hospice claims should contain information on the kind and duration of visits provided to a patient to better understand care provided and to differentiate patterns of care among different types of patients and hospices. Hospice cost reports should include additional information on revenues and be subject to additional reviews to ensure they serve as accurate fiscal documents.

References

Berenson RA, Bodenheimer T, Pham HH. 2006. Specialty-service lines: salvos in the new medical arms race. *Health Affairs* 25, no. 5: w337-w343.

Centers for Medicare and Medicaid Services, Department of Health and Human Services. 2008. Medicare program: Home health prospective payment system rate update for calendar year 2009; 73; final rule 65351. *Federal Register* 73, no. 213 (November 3): 65351-65384.

Medicare Payment Advisory Commission. 2007. *Medicare payment policy*. Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2009. *Medicare payment policy*. Washington, DC: MedPAC.