
Executive summary

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

- Consider the context of the Medicare program in terms of its spending and the federal budget and national gross domestic product (GDP).
- Evaluate payment adequacy and make recommendations concerning Medicare FFS payment policy in 2012 for: hospital inpatient, hospital outpatient, physician and other health professional, ambulatory surgical center, outpatient dialysis, skilled nursing, home health, inpatient rehabilitation, long-term care hospital, and hospice.
- Review the status of the MA plans beneficiaries can join in lieu of traditional FFS Medicare.
- Review the status of the plans that provide prescription drug coverage.

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

We recognize that managing updates and relative payment rates alone will not solve the fundamental problem with current Medicare FFS payment systems—that providers are paid more when they deliver more services without regard to the quality or value of those additional services. To address this problem directly two approaches must be pursued. First, payment reforms, such as penalties for excessive readmission rates and linking some percentage of payment to quality outcomes, need to be implemented. Second, delivery system reforms, such as medical homes, bundling, and accountable care organizations, need to be tested and successful models adopted on a broad scale.

In the interim, it is imperative that the current FFS payment systems be managed carefully. Medicare is likely

to continue using its current payment systems for some years into the future. This alone makes Medicare payment rates—their overall level, the relative payment rates of different services in a sector, and the relative payment rates of the same services across sectors—an important topic. In addition, if payment rates were constrained, that could create pressure on providers to control their own costs and to be more receptive to new payment methods and delivery system reforms.

Each chapter presents the payment adequacy information that informs our FFS update recommendations. We present each recommendation; its rationale; and its implications for beneficiaries, providers, and program spending. The spending implications are presented as ranges over one- and five-year periods and, unlike official budget estimates, they do not take into account the complete package of policy recommendations or the interactions among them. In Appendix A, we list all recommendations and the Commissioners' votes.

Context for Medicare payment policy

Between 2009 and 2035, according to projections under current law, Medicare's share of total economic output (GDP) is projected to rise from 3.5 percent to 5.5 percent. As we discuss in Chapter 1, Medicare's cost growth does not occur in a vacuum; it is linked to other forces that drive growth in health care spending at rates well in excess of GDP. Health care spending has risen faster than GDP for over four decades. The reasons for this growth in health care spending are well established: advances in technology, which include changes in the practice of medicine to help providers diagnose or treat illness and the diffusion of treatments to a wider population; changes in insurance; and changes in household income and demographics.

Medicare's spending growth has resulted in Medicare consuming a significant share, 18 percent, of all income tax revenue (in addition to Medicare's dedicated payroll tax revenues, premiums, and cost sharing). Further complicating Medicare's long-term outlook is a large non-Medicare federal fiscal burden. Total debt held by the public is expected to near 70 percent of GDP within the next decade, a level not seen since World War II.

In their 2010 report, the Medicare Board of Trustees project that growth in Medicare spending will be slower for the coming decade than in the previous decade. They

estimate that total Medicare spending will grow by 6.0 percent annually from 2010 through 2019, compared with 9.7 percent from 2000 to 2009. Part of the reason for this slowdown are changes made by the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act of 2010. The Centers for Medicare & Medicaid Services (CMS) Office of the Actuary estimates that the Medicare provisions in PPACA will reduce spending by \$575 billion over 10 years, resulting in Medicare spending that is 9 percent lower by 2019, compared with prior law.

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

The Commission makes payment update recommendations annually for FFS Medicare. An update is the amount (usually expressed as a percentage change) by which the base payment for all providers in a prospective payment system is changed. In Chapter 2, we lay out our general approach for determining an update. We first assess the adequacy of Medicare payments for providers in the current year (2011) by considering beneficiaries' access to care, the supply of providers, service volume, the quality of care, providers' access to capital, and Medicare payments and providers' costs. Next, we assess how those providers' costs are likely to change in the year the update will take effect (the policy year—2012). As part of the process, we examine payment adequacy for the “efficient” provider to the extent possible. Finally, we make a judgment on what, if any, update is needed.

This year, we make update recommendations in 10 FFS sectors: hospital inpatient, hospital outpatient, physician and other health professional, ambulatory surgical center, outpatient dialysis, skilled nursing, home health, inpatient rehabilitation, long-term care hospital, and hospice. These update recommendations can significantly change the level of revenues providers receive from Medicare and help create pressure on providers to contain their cost through efficiencies and to participate in broader reforms to address the fundamental problem in FFS payment systems—that providers are paid more when they deliver more services without regard to the quality or value of those additional services.

We also consider changes that:

- Redistribute payments within a payment system to improve equity among providers or to correct any biases that may make patients with certain conditions financially undesirable or make particular procedures

unusually profitable. For example, we recommend rebalancing skilled nursing facility (SNF) payments between therapy and nontherapy services.

- Improve program integrity—for example, we recommend reviewing aberrant patterns of utilization in home health agencies and hospices.
- Link payment to quality through pay-for-performance initiatives.

Each year the Commission looks at all the indicators of payment adequacy using the most recent data available to make sure its recommendations accurately reflect current conditions.

Hospital inpatient and outpatient services

In 2009, the 3,500 hospitals paid under the hospital inpatient prospective payment system received \$148 billion for roughly 10 million Medicare inpatient admissions and 147 million outpatient services. From 2008 to 2009, Medicare payments per FFS beneficiary for hospital inpatient and outpatient services grew by 6 percent.

In Chapter 3, we present our assessment of payment adequacy for these services. We find:

- Access measures are positive. The supply of hospitals, range of services offered, and the number of hospital employees all continue to grow. The volume of hospital outpatient services per Medicare FFS beneficiary grew by 4 percent per year from 2005 to 2009 as inpatient admissions per beneficiary declined 1 percent per year. Hospital-based outpatient physician office visits grew by 9 percent from 2008 to 2009, representing a quarter of all outpatient volume growth.
- Quality continues to improve on most measures. Hospitals reduced in-hospital and 30-day mortality rates across 5 prevalent clinical conditions. Patient experience measures have shown a slight improvement in recent years. However, patient safety indicators and readmission rates have not improved significantly.
- Access to capital has been volatile over the past three years but appears adequate at this time.
- In 2009, Medicare margins improved. Medicare payment growth outpaced cost growth for two reasons. First, Medicare inpatient payments per discharge grew by 5.3 percent, which was the highest growth in payments in over a decade. The high increase in the average payment rate reflects the update in payment

rates and the effect of hospitals' documentation and coding improvements. Second, costs per discharge grew by 3.0 percent, which was the lowest cost growth since 2000. The lower cost growth reflects the hospital industry's response to the financial crisis that occurred in fall 2008, which increased pressure on hospitals to constrain their cost growth in 2009.

- In 2009, the Medicare margin for the median efficient hospital was 3.0 percent. (We define efficient hospitals as those that consistently perform relatively well on cost, mortality, and readmission measures.) While most of these relatively efficient hospitals generate profits on Medicare patients, about one-third do not.

The Commission recommends an update of 1 percent for both the inpatient and outpatient prospective payment systems for 2012. In its update recommendation, the Commission has struck a balance among several competing factors. On the one hand, average total Medicare margins are negative. On the other hand, our other payment adequacy indicators are positive. Furthermore, the negative Medicare margins reflect in part the lack of private financial pressure for cost containment, and the set of hospitals identified as efficient have a positive median Medicare margin. Based on these circumstances the Commission contemplated an update of 2.5 percent.

However, for inpatient services, changes in documentation and coding following the implementation of Medicare severity–diagnosis related groups in 2008 have created overpayments to hospitals. Current law does not allow full recovery of past overpayments and no action has been taken to stop the ongoing overpayments. The Commission maintains that all overpayments should be recovered and recommends that the Congress require the Secretary of Health and Human Services to make adjustments to payment rates in future years to do so. Stopping the ongoing overpayments is a crucial first step. Therefore, the Commission would reduce the ongoing overpayment by 1.5 percentage points in 2012—that is, the difference between its contemplated update of 2.5 percent and its recommended update of 1 percent. In addition to this 1.5 percent adjustment in 2012, a further 2.4 percent adjustment will be needed in future years to fully prevent further overpayments.

For outpatient hospital services, the Commission is concerned that significant payment disparities among Medicare's ambulatory care settings (hospital outpatient departments, ambulatory surgical centers (ASCs), and physicians' offices) for similar services are fostering

undesirable financial incentives. Physician practices and ASCs are being reorganized as hospital outpatient entities in part to receive higher reimbursements. Medicare should seek to pay similar amounts for similar services, taking into account differences in quality of care and in the relative risks of the patient populations. The Commission is concerned by the incentive to reorganize for higher reimbursement and will examine this issue. However, in the interim, the modest update of 1 percent is warranted in the hospital outpatient setting to limit the growing payment rate disparities among ambulatory care settings.

Physician and other health professional services

Physicians and other health professionals perform a broad range of services, including office visits, surgical procedures, and a variety of diagnostic and therapeutic services furnished in all health care settings. In 2009, FFS Medicare spent about \$64 billion on physician and other health professional services.

In Chapter 4, we find that most indicators of Medicare's payment adequacy for fee-schedule services are positive and stable, suggesting that, at current payment levels, most beneficiaries can obtain care on a timely basis.

- Overall, beneficiary access to physician services is good or better than that reported by privately insured patients age 50 to 64. For example, in 2010, 75 percent of beneficiaries reported that they had no problem scheduling timely routine-care physician appointments.
- Multiple surveys show that most physicians are accepting Medicare patients. For example, the 2008 National Ambulatory Medical Care Survey found that 90 percent of physicians with at least 10 percent of their practice revenue coming from Medicare accepted at least some new Medicare patients.
- Service volume per beneficiary continued to grow in 2009. Overall volume (including both service units and intensity) grew 3.3 percent per beneficiary.
- Most claims-based indicators for ambulatory quality that we examined for the elderly improved slightly or were stable from 2007 to 2009.
- Medicare's payment for physician fee-schedule services in 2009 averaged 80 percent of private insurer payments for preferred provider organizations, a figure unchanged from the preceding year.

In light of these positive indicators and the modest expected growth in physicians' and other health professionals' costs, the Commission recommends an update of 1 percent for physician fee-schedule services in 2012.

We also consider two key issues. The first is beneficiary access to primary care. While our analysis finds that access to physician and other health professional services is good nationally, a small share of the Medicare population continues to report problems finding a new primary care physician—an essential component to a well-functioning delivery system. In addition, a recent study found that in 2007, hourly compensation rates for some specialties were more than double the rate for primary care. The Commission has recommended enhancements to primary care, such as increasing Medicare payments for primary care services provided by primary care practitioners. The Congress's adoption of this policy marks an important step toward ensuring beneficiaries' access to primary care. The Commission will explore other levers to promote primary care including other payment approaches and maximizing the use of health professionals such as advanced nurse practitioners.

The second issue centers on the sustainable growth rate (SGR) system, the budgetary mechanism designed to address growth in Medicare spending for physician and other health professional services. In previous reports, the Commission has discussed the flaws of the SGR system, while recognizing that having an expenditure target can provide some restraint on updates.

A main flaw of the SGR is it neither rewards individual providers who restrain unnecessary volume growth nor penalizes those who contribute most to inappropriate volume increases. Indeed, volume growth has been a major factor in the prescribed SGR payment cuts—cuts expected to be at least 25 percent in 2012.

There is general consensus that fee cuts of that magnitude would be detrimental to beneficiary access to care, and legislative overrides of the SGR have averted payment cuts in recent years. However, these overrides are merely temporary, leading to mounting frustration among physicians, other health professionals, and their patients and to a desire for a longer term remedy. However, the high budgetary cost of eliminating some or all of the scheduled fee cuts in the longer term has prevented such proposals from becoming law. The Commission plans to continue to work on SGR payment policies and consider

various approaches for updating the Medicare physician fee schedule.

Ambulatory surgical centers

ASCs furnish outpatient surgical services to patients not requiring hospitalization and for whom an overnight stay is not expected after surgery. In 2009, Medicare combined program and beneficiary spending on ASC services was \$3.2 billion (\$2.6 billion in program spending), an increase of 5.1 percent per FFS beneficiary over 2008.

In Chapter 5 we find that most of the available indicators of payment adequacy for ASC services are positive:

- Our analysis of facility supply and volume of services indicates that beneficiaries' access to ASC care has generally been adequate. There were 5,260 Medicare-certified ASCs, an increase of 2.1 percent (109 ASCs) over 2008. In 2009, volume increased by 3.4 percent.
- CMS does not require ASCs to submit data on the quality of care they provide. Consequently, we do not have sufficient data to assess ASCs' quality of care.
- ASCs' access to capital appears to be adequate as the number of ASCs has continued to increase.
- Medicare payments per FFS beneficiary increased by 5.1 percent in 2009. ASCs do not submit data on the cost of care they provide to the Medicare program. Therefore, we cannot calculate a margin as we do in other sectors to assist in assessing payment adequacy.

The Commission recommends an increase of 0.5 percent for ASC payments in 2012, concurrent with a requirement that ASCs submit cost and quality data.

Outpatient dialysis services

Outpatient dialysis services are used to treat individuals with end-stage renal disease (ESRD). In 2009, about 340,000 dialysis beneficiaries were covered under FFS Medicare, and Medicare expenditures for outpatient dialysis services, including separately billable drugs administered during dialysis, were \$9.2 billion, an increase of 7 percent from 2008 spending levels.

The payment adequacy indicators for outpatient dialysis services we discuss in Chapter 6 are generally positive:

- Dialysis facilities appear to have the capacity to meet demand. Growth in the number of dialysis treatment

stations has generally kept pace with growth in the number of dialysis patients.

- Between 2008 and 2009, the number of FFS dialysis beneficiaries and dialysis treatments grew by 4 percent. Use of dialysis drugs also increased between 2008 and 2009.
- Dialysis quality has improved over time for some measures, such as use of the recommended type of vascular access—the site on the patient’s body where blood is removed and returned during dialysis. Other measures suggest that improvements in quality are still needed.
- Access to capital for dialysis providers continues to be adequate. The number of facilities, particularly for-profit facilities, continues to increase.
- In 2009, the Medicare margin for composite rate services and dialysis drugs for freestanding facilities was 3.1 percent.

The Commission recommends an update of 1 percent for outpatient dialysis services in 2012. Consistent with the Commission’s long-standing recommendation, a new dialysis prospective payment method began in 2011 that includes dialysis drugs in the payment bundle and requires that CMS implement a quality incentive program beginning in 2012.

Skilled nursing facility services

SNFs furnish short-term skilled nursing and rehabilitation services to beneficiaries after a stay in an acute care hospital. Most SNFs are part of nursing homes that furnish long-term care, which Medicare does not cover. In fiscal year 2010, Medicare spent \$26.4 billion on SNF care.

Most indicators of payment adequacy for SNFs are positive, as we discuss in Chapter 7:

- Access to SNF services remains stable for most beneficiaries, though minorities use SNF services less than other beneficiaries. The number of SNFs has increased gradually since 2001. Available SNF bed days increased 4 percent between 2008 and 2009. However, since 2004, the share of SNFs admitting medically complex patients decreased. As a result, some beneficiaries may have to wait to be placed in a SNF that will take them.

- Days and admissions on a per FFS beneficiary basis decreased slightly between 2008 and 2009. This decline reflects fewer hospital admissions (a prerequisite for Medicare coverage). However, despite these reductions, use rates were higher in 2009 than in 2006.
- SNF quality of care in 2008 was basically unchanged from the prior year.
- Because most SNFs are part of a larger nursing home, we examine nursing homes’ access to capital. Access to capital has improved since 2009 but some investors are wary of the impact of states’ budget difficulties. Any uncertainties in lending do not center on the adequacy of Medicare payments; from all accounts, Medicare remains a sought-after payer.
- Increases in payments between 2008 and 2009 outpaced increases in provider costs, reflecting the continued concentration of days in the highest payment case-mix groups. In 2009, the average Medicare margin for freestanding SNFs was 18.1 percent.

Financial performance continued to differ substantially across the industry—a function of distortions in the prospective payment system (PPS) and cost differences of providers. Compared to SNFs with relatively low margins, SNFs with the highest margins had higher shares of days in intensive rehabilitation case-mix groups and lower shares of days in the medically complex groups. We also examined relatively efficient SNFs and found that it is possible to have costs well below average, above-average quality, and more than adequate Medicare margins.

In light of these findings, the Commission recommends no update for SNFs in 2012. In addition the Commission reiterates its recommendation to:

- revise the SNF PPS to base payments on patient care needs, not on therapy provision,
- establish a quality incentive payment policy for SNFs,
- improve quality measurement for SNFs by adding the risk-adjusted rates of potentially avoidable rehospitalizations and community discharge, and
- report more accurate diagnostic and service-use information.

PPACA requires that we report on Medicaid utilization, spending, and non-Medicare margins for SNFs beginning in 2012. Medicaid finances mostly long-term care services

provided in nursing homes but also covers the copayments for dual-eligible beneficiaries who stay 21 or more days in a SNF. Our initial investigation finds the number of Medicaid-certified facilities decreased between 2000 and 2009 but Medicaid-covered days and spending increased during this period. Non-Medicare margins (for all lines of business) were negative between 2000 and 2009, but total margins (for all payers and all lines of business) were positive.

Home health services

Home health agencies provide services to beneficiaries who are homebound and need skilled care (nursing or therapy). In 2009, about 3.3 million Medicare beneficiaries received home health services from about 11,000 home health agencies. Medicare spent \$19 billion on home health services in 2009.

As we describe in Chapter 8, the indicators of payment adequacy for home health are generally positive:

- Access to home health care is generally adequate. Ninety-nine percent of beneficiaries live in a ZIP code where a Medicare home health agency operates and 98 percent live in a ZIP code with two or more agencies.
 - The number of agencies continues to increase, with over 650 new agencies in 2010. The total number of agencies exceeds 11,400, surpassing the peak of 10,917 agencies in 1997. Most new agencies have been for profit and concentrated in a few states.
 - The volume of services continues to rise. The average number of episodes per user increased by 25 percent from 2002 to 2009 and the share of FFS beneficiaries using home health care increased as well.
 - The Home Health Compare quality measures for 2010 are similar to those for previous years, showing improvement in the functional measures and mostly unchanged rates of adverse events. However, the Commission believes that supplemental measures of quality that focus on specific conditions are needed to assess home health quality and has a project under way to develop new measures.
 - The major publicly traded for-profit home health companies have sufficient access to capital markets for their credit needs. The significant number of new agencies in 2010 suggests that smaller agencies also have access to capital necessary for start-up.
- In prior years, payments have consistently and substantially exceeded costs in the home health PPS. Medicare margins for freestanding providers in 2009 were 17.7 percent. Two factors have contributed to payments exceeding costs: Fewer services are delivered than is assumed in Medicare's rates, and growth in cost per episode has been lower than what is assumed in the market basket.

In consideration of these findings, the Commission recommends that the Congress eliminate the market basket update for 2012 and direct the Secretary to implement a two-year rebasing of home health rates beginning in 2013. In addition, the Commission finds that the home health benefit has significant vulnerabilities that need to be addressed urgently and recommends policies to strengthen program integrity, improve payment accuracy, and establish beneficiary incentives.

- Recent trends in several parts of the nation suggest that fraud has become a significant concern in the home health benefit. The Commission recommends that the Secretary and the Office of Inspector General review areas with aberrant home health utilization and that the Secretary implement suspensions of enrollment and payment in areas with widespread fraud.
- The Commission finds the current home health payment system is flawed and creates incentives for patient selection. Analysis by the Commission and the Urban Institute suggests that the current case-mix system may, in effect, overvalue therapy services and undervalue nontherapy services. The Commission recommends that the Secretary implement a revised payment system that addresses these flaws.
- The lack of cost sharing in Medicare for home health services is unusual, as most services in Medicare's traditional FFS program include some form of beneficiary liability. The Commission recommends adding a cost-sharing requirement, which would make the beneficiary more apt to consider the value of the benefit and share in decision making about when to use home health services.

Inpatient rehabilitation facility services

Inpatient rehabilitation facilities (IRFs) provide intensive rehabilitation services to patients after an injury, illness, or surgery. In 2009, almost 360,000 Medicare FFS

beneficiaries received care in IRFs. Medicare FFS expenditures for IRF services were about \$6 billion in 2009.

Our indicators of Medicare payment adequacy for IRFs, discussed in Chapter 9, are generally positive:

- Our measures of access to care suggest that beneficiaries have sufficient access to IRF services. The supply of IRFs, occupancy rates, and volume were stable in 2009. In addition, the decline in the number of rehabilitation beds since 2005 tapered off in 2009.
- From 2004 to 2010, IRF patients' functional improvement between admission and discharge increased, suggesting improvements in quality. However, changes over time in patient mix make it difficult to draw definitive conclusions about quality trends.
- Hospital-based units, through their parent institutions, have adequate access to capital. The largest chain of freestanding facilities also appears to have adequate access to capital. We are not able to determine the ability of independent freestanding facilities to raise capital.
- The IRF aggregate Medicare margin for 2009 was 8.4 percent.

The Commission recommends a zero update to payments for IRFs in 2012. We conclude that IRFs will be able to absorb cost increases and continue to provide care to clinically appropriate Medicare cases under this update.

Long-term care hospital services

Long-term care hospitals (LTCHs) furnish care to patients with clinically complex problems—such as multiple acute or chronic conditions—who need hospital-level care for relatively extended periods. Medicare is the predominant payer for LTCH services, accounting for about two-thirds of LTCH discharges. In 2009, Medicare spent \$4.9 billion on care furnished by roughly 400 LTCHs nationwide. About 116,000 beneficiaries had almost 131,500 LTCH stays.

Our analysis of payment adequacy indicators in Chapter 10 finds:

- The number of LTCHs increased 6.6 percent between 2008 and 2009, despite a limited moratorium on new LTCHs and new beds in existing LTCHs from July

2007 until December 28, 2012. New LTCHs were able to enter the Medicare program because they met specific exceptions to the moratorium.

- Beneficiaries' use of services suggests that access has not been a problem. Controlling for the number of FFS beneficiaries, we found that the number of LTCH cases rose 0.9 percent between 2008 and 2009, suggesting that access to care was maintained during this period.
- Unlike most other health care facilities, LTCHs do not submit quality data to CMS. Our claims-based analysis found stable or declining rates of readmission, death in the LTCH, and death within 30 days of discharge for most of the top 20 diagnoses in 2009.
- The moratorium on new beds and facilities reduces opportunities in the near future for expansion and need for capital, although the largest LTCH chains continued with construction of new LTCHs that were already in the pipeline and thus exempt from the moratorium. In addition, these chains, which together own slightly more than half of all LTCHs, continued in 2010 to acquire other LTCHs, as well as other post-acute care providers.
- Payments per case increased 6.4 percent between 2008 and 2009. Cost per case rose less than 2 percent. The 2009 Medicare margin for LTCHs was 5.7 percent.

The Commission recommends a zero update for LTCHs in 2012.

PPACA mandates that CMS implement a pay-for-reporting program for LTCHs by 2014. The quality measures LTCHs report should include process, patient safety, and outcome measures. Ideally, those measures should be comparable to measures used in other post-acute settings. Ultimately, policymakers should be able to compare patient safety and outcomes across the post-acute care spectrum to measure value; that is, whether beneficiaries are receiving high-quality care in the least costly setting consistent with their clinical conditions.

Pay for reporting is a first step. The next step should be pay for performance. Linking a portion of LTCH payment to quality will create stronger incentives to improve care delivery. We are exploring measures for LTCHs that will contribute to a strong pay-for-performance program.

Hospice

The Medicare hospice benefit covers palliative and support services for beneficiaries with a life expectancy of six months or less who choose to enroll in the benefit. In 2009, nearly 1.1 million Medicare beneficiaries received hospice services from nearly 3,500 providers, and Medicare expenditures totaled \$12 billion.

The indicators of payment adequacy for hospices are generally positive, as we discuss in Chapter 11:

- Hospice use among Medicare decedents has grown substantially in recent years, suggesting greater awareness of and access to hospice services. In 2009, hospice use increased across almost all demographic and beneficiary characteristics examined.
- The supply of hospices increased 50 percent from 2000 to 2009—growing on average 5 percent per year from 2000 to 2008 and 3 percent from 2008 to 2009. For-profit providers accounted almost entirely for the increase in the number of hospices.
- Use of Medicare hospice services continues to increase, with growth in both the number of hospice users and average length of stay. In 2009, 42 percent of Medicare decedents used hospice, up from 40 percent in 2008 and 23 percent in 2000. Between 2000 and 2009, average stay grew from 54 days to 86 days, reflecting longer stays among patients with the longest stays.
- At this time, we do not have sufficient data to assess the quality of hospice care provided to Medicare beneficiaries, as information on quality of care is very limited. PPACA mandates that CMS publish quality measures in 2012. Beginning in fiscal year 2014, hospices that do not report quality data will receive a 2 percentage point reduction in their annual payment update.
- Hospices are not as capital intensive as some other provider types because they do not require extensive physical infrastructure. The continued influx of new providers suggests access to capital is adequate.
- The aggregate Medicare margin was 5.1 percent in 2008. The margin estimate excludes nonreimbursable costs associated with bereavement services and volunteers (at most 1.5 percent and 0.3 percent of total costs, respectively).

The Commission recommends an update of 1 percent for hospices in 2012. The chapter also reiterates previous Commission recommendations concerning:

- improving the accuracy of the PPS by increasing payments for days at the beginning and end of the episode relative to days in the middle of the episode,
- increasing program integrity by having the Office of Inspector General investigate the prevalence of financial relationships between hospices and long-term care facilities, differences in patterns of nursing home referrals to hospice, enrollment practices at hospices with aberrant utilization patterns, and hospice marketing and admissions practices and their relation to length of stay.

Status report on the Medicare Advantage program

In Chapter 12, we provide a status report on the MA program. The MA program allows Medicare beneficiaries to receive benefits from private plans rather than from the traditional FFS Medicare program. The Commission supports private plans in the Medicare program; beneficiaries should be able to choose between the traditional FFS Medicare program and the alternative delivery systems that private plans can provide. Private plans have greater potential to innovate and to use care management techniques and, if paid appropriately, would have more incentive to do so.

In 2010, MA enrollment increased to 11.4 million beneficiaries (24 percent of all Medicare beneficiaries). Enrollment in HMOs, the dominant form of MA plan, grew by 7 percent. Preferred provider organizations (PPOs) exhibited rapid enrollment growth, with local PPO enrollment growing about 40 percent and enrollment in regional PPOs more than doubling between 2009 and 2010. Enrollment in private FFS (PFFS) plans declined from about 2.4 million to about 1.6 million enrollees as plans reduced their PFFS service areas in anticipation of new network requirements for PFFS beginning in 2011.

In 2011, virtually all Medicare beneficiaries have access to an MA plan and 99 percent have access to a network-based coordinated care plan (CCP). Ninety percent of beneficiaries have access to an MA plan that includes Part D drug coverage and has no premium (beyond the Medicare Part B premium). Beneficiaries can choose from an average of 12 plans, including 8 CCPs.

We estimate that, on average, 2011 MA benchmarks, bids, and payments will be 113 percent, 100 percent, and 110 percent of FFS spending, respectively—similar to the ratios in 2010. That is, on average, Medicare will spend 10 percent more for beneficiaries enrolled in MA plans than if those beneficiaries were in FFS Medicare. MA plan benchmarks were frozen in 2011 and further PPACA changes to the benchmarks will be fully phased in by 2017. This new method of setting MA payment benchmarks may need some technical adjustments to correct intercounty benchmark inequities.

For 2010, quality measures have been stable with some improvement in clinical process measures over the preceding year. At an aggregate level, vaccination rates and measures of patient experience are comparable to the rates in FFS Medicare, although the comparison is limited by differences in population demographics and geographic location. Measures of patient outcomes in MA are stable and not significantly changed from earlier years. There continues to be wide variation in quality indicators across MA plans.

PPACA introduced a pay-for-performance program that, beginning in 2012, would provide bonus payments to higher quality plans under a five-star rating system. The number of stars is based on measures of clinical quality, patients' care experience, and contract performance. Under the PPACA provisions, plans with the highest ratings (four or more stars) would have been the plans receiving quality bonuses. However, from 2012 through 2014, CMS is replacing the PPACA bonus system with a program-wide demonstration that will incur higher program costs. Under the demonstration, plans with as few as three stars will be eligible for bonus payments and administrative measures will have a higher weight in the scoring. Giving bonuses to three-star plans dampens incentives for good performance; heavy reliance on administrative measures may not give sufficient weight to clinical outcomes. The Commission does not favor demonstrations that add program costs without furthering legitimate policy aims.

Status report on Part D

In Chapter 13, the Commission provides a status report on Part D that provides information on beneficiaries' access to prescription drugs—including enrollment figures and benefit design—program costs, and the quality of Part D services.

In early 2010, about 60 percent of the 46.5 million Medicare beneficiaries were enrolled in Part D plans,

slightly over 30 percent had other sources of drug coverage at least as generous as Part D's defined standard benefit, and 10 percent had no drug coverage or coverage less generous than Part D. Among those in Part D plans, about 10 million (about 36 percent of Part D enrollees) received the low-income subsidy (LIS). Roughly two-thirds of Part D enrollees are in stand-alone prescription drug plans (PDPs); the rest are in Medicare Advantage–Prescription Drug plans (MA–PDs). Most enrollees report high satisfaction with the Part D program and with their plans.

For 2011:

- Sponsors are offering fewer stand-alone PDPs and MA–PDs than in 2010. The reduction in plan offerings is primarily the result of CMS guidance to differentiate between basic and enhanced benefit plans as well as to reduce the number of plans with low enrollment and a decline in PFFS plans. These declines should not decrease access, as beneficiaries on average have from 28 to 38 PDP options to choose from, along with many MA–PDs, and more PDPs are available to LIS enrollees at no premium.
- The structure of drug benefits for both PDPs and MA–PDs held fairly steady—the share of plans with no deductible remains at about 40 percent for PDPs and close to 90 percent for MA–PDs. A larger share of PDPs will provide gap coverage—33 percent compared with 20 percent in 2010—while the share of MA–PDs with gap coverage remains at about 50 percent.
- For the basic portion of the benefit, CMS estimates an actual average monthly premium of \$30, which would be an increase by \$1 over the average in 2010.

In 2009, Part D spending totaled \$52.5 billion, and the Medicare Board of Trustees estimated it will have reached \$56 billion in 2010. These expenditures cover the direct monthly subsidy plans receive for their Part D enrollees, reinsurance for very high-cost enrollees, premiums and cost sharing for LIS enrollees, and payments to employers that continue to provide drug coverage to their retirees who are Medicare beneficiaries. In 2009, LIS payments continued to be the largest component of Part D spending.

CMS publishes 19 performance metrics aggregated into a five-star rating system. To date, the metrics focus mostly on customer service and enrollee satisfaction. Although the metrics now include some quality measures, additional measures on patient safety and appropriate medication use could provide further information on quality. ■

