
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 in some sectors make recommendations concerning Medicare FFS payment policy in 2014 for hospital inpatient and outpatient, physician and other health professional, ambulatory surgical center, outpatient dialysis facility, skilled nursing facility, home health care agency, inpatient rehabilitation facility, long-term care hospital, and hospice.
- review the status of the MA plans beneficiaries can join in lieu of traditional FFS Medicare.
- make recommendations on the MA special needs plans.
- 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 on the annual rate updates for 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 that 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 more broadly. Second, delivery system reforms that encourage high quality, better care transitions, and more

efficient provision of care—such as medical homes, bundling, and accountable care organizations (ACOs)—need to be monitored and successful models adopted on a broad scale.

In the interim, it is imperative that the current FFS payment systems be managed carefully. Medicare is likely to continue using its current payment systems for some years into the future. This fact alone makes unit prices—their overall level, the relative prices of different services in a sector, and the relative prices of the same services across sectors—an important topic. In addition, constraining unit prices could create pressure on providers to control their own costs and to be more receptive to new payment methods and delivery system reforms.

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

In Appendix A, we list all recommendations and the Commissioners' votes. In Appendix B, we reproduce the Commission's October 2011 letter to the Congress in which it recommended repealing the sustainable growth rate (SGR) system (Medicare's formulaic method for updating physician fee-schedule services) and replacing it with specified updates that would no longer be based on an expenditure-control formula. In the initial years, these updates would favor primary care in light of our concerns about beneficiaries' access to those services and the long-standing inequity in rates between primary care services and procedural services. Medicare faces increased urgency to resolve the growing problems created by the SGR system and its destabilizing short-term "fixes."

Context for Medicare payment policy

In Chapter 1, we consider Medicare payment policies in the broader context of the nation's health care system—including spending, delivery of care, and access to and use

of services—and pressure on federal and state budgets. Health care accounts for a large and growing share of economic activity in the United States, nearly doubling as a share of GDP between 1980 and 2011, from 9.2 percent to 17.9 percent. However, growth in spending slowed somewhat in 2010 and 2011. Though the causes of this slowdown are debated, the economic downturn beginning in 2008 has likely had an effect on health care spending since fewer people have insurance and those with insurance may delay care because of cost concerns.

The level of and growth in health care spending significantly affect federal and state budgets since government payers directly sponsor nearly half of all health care spending. If this spending continues to consume an increasing share of federal and state budgets, spending for other public priorities could be crowded out, and the federal government would have less flexibility to support states because of its own debt and deficit burdens. Social Security, Medicare, Medicaid, other health insurance programs, and net interest will account for more than 16 percent of GDP in 10 years, whereas total federal revenues have averaged 18.5 percent of GDP over the past 40 years.

Further, the growth in health care spending has a direct and meaningful impact on individuals and families. Evidence shows that the growth in out-of-pocket spending has negated real income growth in the past decade. In addition, the lasting effects of the economic downturn affected the income, insurance status, and assets (namely, the value of owned homes) of many people, including Medicare beneficiaries and those aging into Medicare eligibility. Likewise, cost sharing and premiums for Medicare beneficiaries are projected to grow faster than Social Security benefits.

The number of Medicare beneficiaries will grow notably faster in the next 10 years than in the past decade as the baby-boom generation ages into the program. In addition, the population aging into the Medicare program will present a new set of challenges since rising obesity levels put this population at a greater risk than previous generations for chronic disease. At the same time, growth in Medicare spending per beneficiary over the next decade is projected to be much smaller than in the past 10 years. Yet even under that assumption of slower growth, the Hospital Insurance trust fund is projected to be exhausted by 2024, and the program faces substantial deficits over the long term.

There are indications that some share of health care dollars is misspent. First, health care spending per capita varies significantly across different regions of the United States, but studies show that populations in the higher spending and higher use regions do not receive better quality care. In addition, despite higher per capita spending by the United States compared with other developed countries, the United States does not perform as well as these countries in the Organisation for Economic Co-operation and Development's internationally accepted health care measures.

Health care spending and growth in spending put pressure on government, family, and individual budgets. For the Medicare program, this pressure is particularly acute given the outlook for the federal budget and the projected increases in Medicare enrollment. Because the Medicare program pays for just over a fifth of all health care in the United States, it has an important influence on the shape of the health care delivery system as a whole. Therefore, it must pursue reforms that decrease the growth in spending and create incentives for beneficiaries to seek and for providers to deliver high-value services.

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

As required by law, the Commission makes payment update recommendations annually for providers paid under 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 (PPS) is changed relative to the prior year. As described in Chapter 2, to determine an update, we first assess the adequacy of Medicare payments for providers in the current year (2013) by considering beneficiaries' access to care, 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—2014). As part of the process, we examine payment adequacy for an "efficient" provider to the extent possible. Finally, we make a judgment on what, if any, update is needed.

In considering updates, the Commission makes its recommendation this year relative to the 2013 base payment. The Commission's recommendations may call for an increase, a decrease, or no change from the 2013 base payment. For example, an update recommendation of 1 percent for a sector means that we are recommending that the base payment in 2014 for that sector should be 1 percent greater than it was in 2013—that is, when all

policy changes related to the base payment are made, the net increase in base payment should be 1 percent.

This year, we make update recommendations in 10 FFS sectors: hospital inpatient and outpatient, physician and other health professional, ambulatory surgical center, outpatient dialysis facility, skilled nursing facility, home health care agency, inpatient rehabilitation facility, long-term care hospital, and hospice. Each year, the Commission looks at all available indicators of payment adequacy and reevaluates prior year assumptions using the most recent data available to make sure its recommendations accurately reflect current conditions. We also consider changes that redistribute payments within a payment system to correct any biases that may result in inequity among providers, make patients with certain conditions financially undesirable, or make particular procedures unusually profitable. Finally, we also make recommendations to improve program integrity.

These update recommendations, if enacted, could significantly change the revenues providers receive from Medicare. Rates set to cover the costs of an efficient provider could create fiscal pressure on all providers to control their costs. They could also help create pressure for broader reforms to address the fundamental problem in FFS payment systems—that providers are paid more when they deliver more services regardless of the quality or value of those additional services. Those broader reforms, such as bundled payments and ACOs, are meant to stimulate delivery system reform—that is, the development of more integrated and value-oriented health care systems.

The Commission also examines payment rates for services that can be provided in multiple sectors. Medicare often pays different amounts for similar services across sectors. Setting the payment rate equal to the rate in the most efficient sector would save money for the Medicare program, reduce cost sharing for beneficiaries, and lessen the incentive to provide services in the higher paid sector. However, putting the principle of paying the same rate for the same service across sectors into practice can be complex because it requires that the definition of the services and the characteristics of the beneficiaries across sectors be sufficiently similar. Last year we made a recommendation to equalize payment rates for office visits provided in hospital outpatient departments and physicians' offices. We will continue to analyze opportunities for applying this principle to other services and sectors, such as sectors that provide post-acute care.

Hospital inpatient and outpatient services

From 2010 to 2011, Medicare payments per FFS beneficiary for inpatient and outpatient services in acute care hospitals grew by 1.6 percent. The 4,800 hospitals paid under the Medicare PPS and critical access hospital payment system received \$158 billion for roughly 10 million Medicare inpatient discharges and 181 million outpatient services. To evaluate whether aggregate payments are adequate, we consider beneficiaries' access to care, changes in the volume of services provided, hospitals' access to capital, quality of care, and the relationship of Medicare's payments to the average cost of caring for Medicare patients. In addition to examining the costs of the average provider, we compare Medicare payments with the costs of relatively efficient hospitals. In Chapter 3 we find:

- Access measures were positive for the period reviewed. The number of hospitals and the range of services offered continue to grow. From 2004 to 2011, outpatient services per beneficiary grew 34 percent and inpatient admissions declined 8 percent due to two factors. First, services continued to shift from inpatient to outpatient settings. Second, hospitals increasingly billed for outpatient services that previously were billed as services provided in physicians' offices.
- Quality continues to improve for most measures. Hospitals reduced 30-day mortality rates across five prevalent clinical conditions, and readmission rates improved slightly from 2008 to 2011. A penalty for above-average readmission rates started in fiscal year 2013. However, it is too soon to know if the penalty will stimulate further reductions in readmissions.
- Access to capital is good due to strong hospital earnings in recent years and low interest rates. Hospitals' level of construction spending remains stable at \$26 billion per year with a slight decline in bond offerings.
- Between 2010 and 2011, the overall Medicare margin declined from -4.5 percent to -5.8 percent. The margin declined primarily because CMS reduced inpatient payment rates in 2011 to recover past overpayments that occurred in 2008 and 2009 due to documentation and coding changes. Looking forward to 2013, we project margins to remain roughly equal (-6 percent) to 2011 levels.
- While Medicare payments are currently less than costs for the average hospital, a key question is whether

current Medicare payments are adequate to cover the costs of efficient hospitals. We find that the median efficient hospital generated a positive 2 percent Medicare margin in 2011.

The inpatient payment update recommendation is based on four factors. First, there is a need to restrain updates to maintain pressure to control costs. Second, most payment adequacy indicators are positive. Third, hospitals changed their documentation and coding in response to the introduction of Medicare severity–diagnosis related groups in 2008, and these documentation and coding changes need to be offset. Fourth, while the average hospital’s margin is projected to remain at roughly –6 percent, the set of relatively efficient hospitals had a median overall Medicare margin of 2 percent. Balancing these factors, the Commission recommends increasing payment rates for the inpatient and outpatient PPSs in 2014 by 1 percent. For inpatient services, CMS should use the difference between the 2014 statutory update and the recommended 1 percent increase to offset the costs to the Medicare program of changes in hospitals’ documentation and coding. In other words, the net increase in base payment rates from 2013 to 2014 should be 1 percent after all adjustments for documentation and coding are made.

We also recommend a 1 percent increase in outpatient rates in 2014. Despite negative overall Medicare margins, a 1 percent increase is appropriate for three reasons: First, there is a need to maintain pressure to constrain costs. Second, there is strong outpatient volume growth of over 4 percent. Third, hospital outpatient payment rates are already substantially higher than payment rates for similar services in other sectors and increasing this difference will encourage even more shifting from lower cost to higher cost settings.

Physician and other health professional services

Physicians and other health professionals deliver a wide range of services, including office visits, surgical procedures, diagnostic services, and therapeutic services in a variety of settings. In 2011, Medicare paid \$68 billion for physician and other health professional services. About 850,000 clinicians bill Medicare—550,000 physicians, with the balance consisting of nurse practitioners and other advanced practice nurses, therapists, chiropractors, and other practitioners.

Informing the Commission’s deliberations on payment adequacy for physicians and other health professionals

are beneficiary access to services, volume growth, quality, changes in input costs, and other measures of payment adequacy. In Chapter 4, we find:

- Overall, beneficiary access to physician and other health professional services is stable and similar to access for privately insured individuals ages 50 to 64. The Commission continues to be concerned about access to primary care physicians, given the Commission’s aim in transforming Medicare from a fee-driven payment model to one that encourages the delivery of efficient, high-quality care.
- Another measure of access is the supply of providers and their willingness to take Medicare patients. The supply of primary care providers and specialists per beneficiary remained constant from 2009 through 2011, and the rates of advanced practice nurses, physician assistants, and other providers grew. A study found that 83 percent of primary care physicians (excluding pediatrics) and 91 percent of specialists accept new Medicare patients.
- The volume of physician and other health professional services grew 1 percent per FFS beneficiary in 2011.
- The majority of measures of ambulatory care quality did not change between the 2008 to 2009 and 2010 to 2011 periods. A few measures improved slightly, and a few worsened slightly.
- Medicare’s payments for fee-schedule services relative to private insurer payments have remained relatively constant at around 80 percent.

The Commission’s deliberations regarding payment updates for physicians and other health professionals are driven by concerns with the SGR, which links annual physician fee updates to volume growth. The SGR has called for negative updates every year since 2002, and every year since 2003 the Congress has provided a short-term override of the negative updates. Because of years of volume growth exceeding the SGR limits and legislative and regulatory overrides of negative updates, fees for physicians and other health professionals would decline by about 25 percent in January 2014 if the SGR went into full effect, according to the Congressional Budget Office (CBO).

The Commission laid out its findings and recommendations for moving forward from the SGR system in its October 2011 letter to the Congress (see Appendix B, pp. 371–392). We found:

- The SGR system, which ties annual updates to cumulative expenditures, has failed to restrain volume growth and may have exacerbated it.
- Temporary, stop-gap fixes to override the SGR undermine the credibility of Medicare because they engender uncertainty and anger among physicians and other health professionals, which may cause anxiety among beneficiaries.
- While our latest access survey does not show significant deterioration at the national level, the Commission is concerned about access—particularly for primary care. The Medicare population is increasing as members of the baby-boom generation become eligible for Medicare, and a large cohort of physicians is nearing retirement age.

The need to repeal the SGR is urgent. Deferring repeal of the SGR will not leave the Congress with a better set of choices as the array of new payment models is unlikely to change and SGR fatigue is increasing. We also note that the budget score for repealing the SGR is volatile. It depends on the relationship between assumptions about changes in the volume of services and growth in the GDP. CBO's most recent budget projections have substantially lowered the budget score for SGR repeal and may present an opportunity for the Congress to act before the score changes again.

In its October 2011 letter, the Commission presented a set of recommendations to eliminate the SGR and replace it with a set of fee-schedule updates, improve the accuracy of physician payments, and encourage movement into ACOs. Our recommendations follow these principles: The link between fee-schedule expenditures and annual updates is unworkable, beneficiary access to care must be protected, and the SGR should be repealed in a fiscally responsible way. We have offered the Congress a set of ideas for offsetting the cost of an SGR repeal within the Medicare program, but it is the prerogative of the Congress to choose among those and other options as it determines how best to finance SGR repeal.

Ambulatory surgical center services

Ambulatory surgical centers (ASCs) furnish outpatient surgical services to patients who do not require an overnight stay after surgery. In 2011, ASCs served 3.4 million FFS Medicare beneficiaries, there were 5,344 Medicare-certified ASCs, and Medicare combined program and beneficiary spending on ASC services

was \$3.4 billion—an increase of 2.2 percent per FFS beneficiary over 2010.

In Chapter 5, we find that most available indicators of payment adequacy for ASC services are positive. However, our findings also indicate slower growth in the number of ASCs and volume of services in 2011 than in previous years:

- Beneficiaries' access to ASC care has generally been adequate. From 2006 through 2010, the number of Medicare-certified ASCs grew by an average annual rate of 3.6 percent. However, growth slowed to 1.8 percent in 2011. The relatively slow growth may reflect the substantial revision of the ASC payment system in 2008 and the much higher Medicare payment rates in hospital outpatient departments than in ASCs for most ambulatory surgical services. From 2006 through 2010, the volume of services per beneficiary grew by an average annual rate of 5.7 percent; in 2011, volume increased by 1.9 percent.
- Although CMS has established a program for ASCs to submit quality data, they did not begin submitting quality data until October 2012. Consequently, we are unable to assess ASCs' quality of care.
- ASCs' access to capital appears to be adequate, as the number of ASCs has continued to increase.
- From 2006 through 2010, Medicare payments per FFS beneficiary increased at an average annual rate of 5.1 percent but slowed to 2.2 percent in 2011. ASCs do not submit data on the cost of services they provide to Medicare beneficiaries. Therefore, we cannot calculate a Medicare margin for them.

On the basis of our payment adequacy indicators, the importance of maintaining financial pressure on providers to constrain costs, and the lack of ASC cost and quality data, the Commission recommends that the Congress eliminate the update to the payment rates for ASCs for calendar year 2014. The Congress should also require ASCs to submit cost data. It is vital that CMS begin collecting cost data from ASCs without further delay. Cost data would enable analysts to examine the growth of ASCs' costs over time and evaluate Medicare payments relative to the costs of an efficient provider, which would help inform decisions about the ASC update. Such data are also needed to analyze whether an alternative input price index would be an appropriate proxy for ASC costs or whether an ASC-specific market basket should be developed.

Outpatient dialysis services

Outpatient dialysis services are used to treat the majority of individuals with end-stage renal disease (ESRD). In 2011, about 365,000 ESRD beneficiaries on dialysis were covered under FFS Medicare and received dialysis from about 5,600 dialysis facilities. For most facilities, 2011 is the first year that Medicare paid them using a modernized PPS that includes in the payment bundle dialysis drugs for which facilities previously received separate payments and services for which other providers (such as clinical laboratories) previously received separate payments. Medicare expenditures for all outpatient dialysis services in the new payment bundle were \$10.1 billion. Excluding items and services that Medicare paid other providers to furnish in prior years, we estimate that in 2011 Medicare expenditures increased about 1 percent compared with 2010 spending levels.

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

- Our measures suggest access is good. 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 2009 and 2011, use of dialysis injectable drugs, including erythropoietin-stimulating agents (ESAs), declined. Some of this decline stems from new clinical evidence that found that higher doses of ESAs—the leading class of dialysis drugs—led to increased risk of morbidity and mortality. In addition, some of this decline stems from providers realizing efficiencies under the modernized payment method.
- 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, such as rates of hospitalization, 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.
- Our analysis of Medicare payments and costs is based on 2011 claims data submitted by freestanding dialysis facilities to CMS and 2010 cost report data from freestanding dialysis facilities (the most current data available). We estimate that the Medicare margin for

outpatient dialysis services was between 2 percent and 3 percent in 2011 and project that the Medicare margin will be between 3 percent and 4 percent in 2013.

Our payment adequacy indicators suggest that payments are adequate. It also should be noted that over 90 percent of the industry opted to be paid fully under the new method rather than go through a transition. It appears that facilities have become more efficient under the new payment method as measured by the declining use of dialysis injectable drugs between 2010 and 2011. In consideration of these findings, the Commission recommends that the Congress not increase the outpatient dialysis bundled payment rate for calendar year 2014.

Current law mandates that rebasing begin in 2014. On the one hand, prompt rebasing of the dialysis PPS may prevent overpayment of these providers, and the fact that nearly all dialysis facilities elected to be paid under the modernized payment method suggests that the base payment rates under the modernized payment method are more generous than in the previous system. On the other hand, it may be too early to determine how much rebasing is needed without 2011 dialysis facility cost reports, which would help to provide a more complete picture of facilities’ response to the modernized payment method. We will reevaluate the adequacy of Medicare’s payments for outpatient dialysis services and the need for and level of rebasing when we have more information.

Post-acute care providers: Shortcomings in Medicare’s fee-for-service highlight need for broad reforms

The Commission’s work on the adequacy of Medicare’s FFS payments focuses on whether payments are sufficient to cover the costs of an efficient provider. At the same time, it is important to consider broader payment reforms aimed at matching patients who need post-acute care (PAC) to the settings that can provide the best outcomes at the lowest cost; we do so in Chapter 7. Several aspects of how Medicare pays for PAC undermine the efficient delivery of care, including the less-than-clear delineations of who needs PAC, the overlap of the services different settings provide, the absence of a common way to compare quality and outcomes across settings, and the lack of incentives to coordinate care among providers and safely transition beneficiaries home.

Recognizing these shortcomings, the Commission has worked on four broad reforms to encourage a more seamless, patient-centered approach to match services

and settings to the needs of each patient. These reforms include bundled payments and ACOs; a common patient assessment instrument; risk-adjusted, outcomes-based quality measures; and the alignment of readmission policies across settings. Under these reforms, payments would reflect the characteristics of the patient, not the services furnished or the setting, and would encourage use of the lowest cost mix of services necessary to achieve the best outcomes.

Skilled nursing facility services

Skilled nursing facilities (SNFs) furnish short-term skilled nursing and rehabilitation services to beneficiaries after a stay in an acute care hospital. In 2011, almost 15,000 SNFs furnished covered care to 1.7 million FFS beneficiaries during 2.4 million stays. Medicare spent \$31 billion on SNF care in 2011.

Indicators of payment adequacy for SNFs were positive. With regard to our assessment of efficient providers, we impute our findings using data from each of the past three years, as cost report data for 2011 were not available at the time of our analysis. We were able to identify facilities that furnished relatively high quality, had relatively low costs compared with other SNFs, and had high Medicare margins, suggesting that opportunities remain for other SNFs to achieve greater efficiencies without losing Medicare revenue. In Chapter 8, we find:

- Access to SNF services remains stable for most beneficiaries. The number of SNFs participating in the Medicare program increased slightly between 2010 and 2011. Bed days available did not change between 2009 and 2010, the most recent years with available data. The median occupancy rate was 88 percent, indicating some excess capacity for admissions. Days and admissions on a per FFS beneficiary basis were essentially unchanged between 2010 and 2011.
- SNF quality of care, as measured by risk-adjusted rates of community discharge and rates of rehospitalization for patients with five potentially avoidable conditions, has changed little over the past decade. This year, the Commission reports a third measure—rehospitalizations within 30 days of discharge from the SNF. The three measures show considerable variation across the industry.
- Because most SNFs are part of a larger nursing home, we examine nursing homes' access to capital. Lending in 2013 is expected to be similar to that in 2012.

Uncertainties surrounding the federal budget continue to make borrowers and lenders wary, but this lending environment reflects the economy in general, not the adequacy of Medicare payments. Medicare remains a preferred payer.

- Increases in payments between 2010 and 2011 outpaced increases in providers' costs, reflecting the continued concentration of days in the highest payment case-mix groups. In addition, payments in 2011 were unusually high because of overpayments resulting from an adjustment made with implementation of the new case-mix groups. Because no 2011 cost report data were available, we estimated a range for the 2011 margins of 22 percent to 24 percent. This year is the 11th year in a row with Medicare margins above 10 percent. We project that the 2013 margin will range from 12 percent to 14 percent.

Last year, the Commission made a recommendation to first restructure the SNF payment system and then to rebase payments in the following year. Specifically, the Commission recommended revising the SNF PPS and, during the year of revision, holding payment rates constant (no update). The Commission discussed three revisions to improve the accuracy of payments. First, payments for therapy services should be based on patient characteristics (not services provided). Second, payments for nontherapy ancillary services (such as drugs) need to be removed from the nursing component and made through a separate component established specifically to adjust for differences in patients' needs for these services. Third, an outlier policy would be added to the PPS. After the PPS is revised, in the following year, CMS would begin a process of rebasing payments, starting with a 4 percent reduction in payments.

This multiyear recommendation to revise the PPS in the first year and then rebase payments in the subsequent year was based on several factors: high and sustained Medicare margins, widely varying costs unrelated to case mix and wages, cost growth well above the market basket that reflects little fiscal pressure from the Medicare program, the ability of many SNFs (more than 900) to have consistently below-average costs and above-average quality of care, the continued ability of the industry to maintain high margins despite changing policies, and in some cases MA payments to SNFs that are considerably lower than the program's FFS payments, suggesting that

some facilities are willing to accept rates much lower than FFS payments to treat beneficiaries.

No policy changes have been made that would materially affect the trajectory of these findings going forward. Therefore, the Commission maintains its position with respect to the SNF PPS and urges the Congress as soon as practicable to direct the Secretary to revise the PPS and begin a process of rebasing payments.

As required by the Patient Protection and Affordable Care Act of 2010, we report on Medicaid utilization, spending, and non-Medicare (private pay and Medicaid) margins. Medicaid finances mostly long-term care services provided in nursing homes but also covers copayments for low-income Medicare beneficiaries (known as dual-eligible beneficiaries) who stay more than 20 days in a SNF. The number of Medicaid-certified facilities decreased slightly between 2011 and 2012. In 2011, estimates of non-Medicare margins and total margins indicate that both improved over 2010. Non-Medicare margins ranged from an estimated –1 percent to –3 percent and total margins ranged from 4 percent to 6 percent for all payers and all lines of business.

Home health care services

Home health agencies provide services to beneficiaries who are homebound and need skilled nursing or therapy. In 2011, about 3.4 million Medicare beneficiaries received home care, and the program spent about \$18.4 billion on home health services. The number of agencies participating in Medicare reached 12,199 in 2011.

We find in Chapter 9 that the indicators of payment adequacy for home health care 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 700 new agencies and 12,199 total agencies in 2011. Most new agencies were concentrated in a few states, and for-profit agencies accounted for the majority of new providers. In 2011, the volume of services was level, and total payments declined by about 5 percent, or \$1 billion. The decline in payments was attributable to a reduction in the Medicare base rate. The lower spending comes after several years of increases, as total spending between 2002 and 2011 increased by 92 percent. Between 2002 and 2010, the average number of 60-day episodes per

home health user increased from 1.6 to 2.0, indicating that beneficiaries who use home health care stayed in service longer.

- Quality was steady or showed a small improvement in measures of beneficiary function.
- Access to capital is a less important indicator of Medicare payment adequacy for home health care because it is less capital intensive than other sectors. The major publicly traded for-profit home health companies had sufficient access to capital markets for their credit needs, and the significant number of new agencies in 2011 suggests that smaller agencies had access to the capital necessary for start-up.
- For over a decade, payments have consistently and substantially exceeded costs in the home health PPS. Medicare margins equaled 14.8 percent in 2011 and averaged 17.7 percent in 2001 through 2010. Medicare margins are estimated to equal 11.8 percent in 2013.

In 2011, the Commission made a multiyear recommendation for home health payments, and this report reiterates that recommendation, including rebasing the home health PPS, changing the case-mix system, implementing a copay for certain home health episodes, and investigating and stopping fraud and abuse in areas with aberrant patterns of use of home health services. Overpaying for home health services has negative financial consequences for the federal government and raises Medicare premiums paid by the beneficiary. Implementing the Commission's prior recommendation for rebasing would reduce payments and better align Medicare's payments with the actual costs of home health agencies.

Inpatient rehabilitation facility services

Inpatient rehabilitation facilities (IRFs) provide intensive rehabilitation services to patients after an injury, illness, or surgery. Rehabilitation programs at IRFs are supervised by rehabilitation physicians and include services such as physical and occupational therapy, rehabilitation nursing, prosthetic and orthotic devices, and speech–language pathology. Between 2010 and 2011, Medicare FFS payments for IRFs increased from \$6.1 billion to \$6.5 billion. In 2011, 1,165 IRFs treated over 371,000 cases of Medicare FFS beneficiaries and the number of beneficiaries who received care at IRFs increased, as did the average payment per case.

Our indicators of Medicare payment adequacy for IRFs, discussed in Chapter 10, are generally positive.

- Our measures of access to care suggest that beneficiaries generally maintained access to IRF services in 2011, with the number of cases and number of unique patients per 10,000 beneficiaries increasing. The volume of cases grew by about 3 percent in 2011. The aggregate supply of IRFs declined slightly in 2011. The number of rehabilitation beds declined moderately and the occupancy rate increased.
- The quality of care remained fairly stable between 2009 and 2010. Outcomes on a functional improvement measure increased slightly and performance on two hospital readmission measures was roughly unchanged. While performance decreased slightly on admission to a SNF within 30 days after discharge to the community, rates of discharge to the community improved moderately.
- Hospital-based IRF units have adequate access to capital through their parent institutions. One major freestanding IRF chain that accounts for about 50 percent of freestanding IRF Medicare revenues and 23 percent of revenues for the entire IRF industry has good access to capital. We were not able to determine the ability of other freestanding facilities to raise capital.
- In 2011, average Medicare payments per case to IRFs grew more than average costs per case. The aggregate Medicare margin for IRFs in 2011 was 9.6 percent. We project a 2013 Medicare IRF margin of 8.5 percent.

On the basis of these indicators, the Commission recommends no update to IRF payment rates in fiscal year 2014. Under this recommendation, IRFs should be able to continue to provide Medicare beneficiaries with access to safe and effective rehabilitation care.

Long-term care hospital services

Although most chronically critically ill patients are treated in acute care hospitals, a growing number are treated in long-term care hospitals (LTCHs). LTCHs furnish care to beneficiaries who need hospital-level care for relatively extended periods. To qualify as an LTCH for Medicare payment, a facility must meet Medicare's conditions of participation for acute care hospitals and have an average length of stay greater than 25 days for its Medicare patients. In 2011, Medicare spent \$5.4 billion on care furnished in 424 LTCHs nationwide. About 123,000

beneficiaries had almost 140,000 LTCH stays. On average, Medicare accounts for about two-thirds of LTCHs' discharges.

In Chapter 11, we find that our indicators of payment adequacy are positive for LTCHs:

- In spite of the moratorium imposed by the Medicare, Medicaid, and SCHIP Extension Act of 2007 and subsequent amendments, the number of LTCHs filing Medicare cost reports increased 9.3 percent between 2008 and 2011. Almost all of this growth took place in 2009, as new LTCHs were able to open because they met specific exceptions to the moratorium. Controlling for growth in the number of FFS beneficiaries, we found that the number of LTCH cases rose 2.8 percent between 2010 and 2011, suggesting that access to care increased during this period.
- LTCHs only recently began submitting quality data to CMS. Those data are not yet available for analysis. Using claims data, we found stable or declining rates of readmission, death in the LTCH, and death within 30 days of discharge for almost all of the top 25 diagnoses in 2011.
- For the past few years, the availability of capital to LTCHs has reflected not current reimbursement rates but rather uncertainty regarding possible changes to Medicare's regulations and legislation governing LTCHs.
- Between 2008 and 2009, growth in payments per case accelerated to 5.5 percent, more than twice as much as the growth in costs. Between 2009 and 2011, payment growth slowed to an average of 1.6 percent per year, while cost growth increased less than 1 percent per year. In 2011, the aggregate LTCH margin rose to 6.9 percent. We project that LTCHs' aggregate Medicare margin will be 5.9 percent in 2013.

These trends suggest that LTCHs are able to operate within current payment rates. On the basis of our review of payment adequacy for LTCHs, the Commission recommends that the Secretary eliminate the update to the LTCH payment rate for fiscal year 2014.

Hospice services

The Medicare hospice benefit covers palliative and support services for beneficiaries with a life expectancy of six months or less. Beneficiaries must "elect" the Medicare hospice benefit; in so doing, they agree to forgo Medicare

coverage for conventional treatment for their terminal condition. In 2011, more than 1.2 million Medicare beneficiaries received hospice services from over 3,500 providers, and Medicare expenditures totaled about \$13.8 billion.

The indicators of payment adequacy for hospices, as we discuss in Chapter 12, are generally positive:

- Hospice use among Medicare beneficiaries has grown substantially in recent years, suggesting greater awareness of and access to hospice services. In 2011, 45.2 percent of Medicare beneficiaries who died used hospice, up from 44.0 percent in 2010 and 22.9 percent in 2000. Average length of stay was steady at 86 days in 2011 after substantial growth since 2000; median length of stay has remained stable at 17 days or 18 days. In 2011, hospice use increased across all demographic and beneficiary groups examined. The supply of hospices has increased substantially since 2000 and continued to grow in 2011, almost entirely due to growth in the number of for-profit providers.
- 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. Statute requires that a hospice quality reporting program begin by fiscal year 2014. As a first step, in 2013 hospices must report data for two quality measures or face a 2 percentage point reduction in their annual update for fiscal year 2014.
- Hospices are not as capital intensive as some other provider types because they do not require extensive physical infrastructure. Continued growth in the number of for-profit providers (a 5 percent increase in 2011) suggests that access to capital is adequate for these providers. Less is known about access to capital for nonprofit freestanding providers, which may be more limited. Hospital-based and home-health-based hospices have access to capital through their parent providers.
- The aggregate Medicare margin was 7.5 percent in 2010, up from 7.4 percent in 2009. The projected 2013 margin is 6.3 percent.

Given that the payment adequacy indicators are positive, the Commission recommends no update to payment rates in 2014. We expect that hospices will be able to continue to provide beneficiaries with appropriate access to care under current payment rates.

The Medicare Advantage program: Status report

Each year the Commission provides a status report on the MA program. In 2012, the MA program included more than 3,600 plan options, enrolled more than 13 million beneficiaries, and paid MA plans about \$136 billion. In Chapter 13, we examine MA enrollment trends, plan availability for the coming year, and payments for MA plan enrollees relative to spending for FFS Medicare beneficiaries. We also provide an update on current quality indicators in MA.

In 2012, MA enrollment increased by 10 percent to 13.3 million beneficiaries (27 percent of all Medicare beneficiaries). Enrollment in HMO plans—the largest plan type—increased 10 percent to nearly 9 million enrollees. Local preferred provider organizations (PPOs) showed rapid growth with enrollment growing about 30 percent, to 3 million enrollees. Regional PPO enrollment decreased about 16 percent, to 1 million enrollees. Enrollment in private FFS plans also declined from about 0.6 million to about 0.5 million enrollees, continuing the expected decline resulting from legislative changes. The MA plan bids submitted to CMS project an increase in overall enrollment for 2013 of 8 percent to 10 percent, primarily in HMOs.

In 2013, virtually all Medicare beneficiaries have access to an MA plan, and 99 percent have access to a network-based coordinated care plan, which includes HMOs and PPOs. Eighty-six percent of beneficiaries have access to an MA plan that includes Part D drug coverage and charges no premium (beyond the Medicare Part B premium). Beneficiaries are able to choose from an average of 12 MA plan options, including 9 coordinated care plans in 2013.

For 2013, the base county benchmarks used to set plans' payment rates are, on average, roughly the same as the benchmarks for 2012. We estimate that 2013 MA benchmarks (including the quality bonuses), bids, and payments will average 110 percent, 96 percent, and 104 percent of FFS spending, respectively. Last year, we estimated that, for 2012, these figures would be 112 percent, 98 percent, and 107 percent, respectively. Benchmark reductions, underestimates of FFS spending levels for 2013, and projected enrollment shifts into HMOs, combined with offsetting quality bonuses, resulted in some movement of projected MA payments toward FFS spending levels.

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, because they are paid a capitated rate rather than on an FFS basis, have greater incentives to innovate and use care management techniques.

The Commission has stressed the concept of imposing fiscal pressure on providers to improve efficiency and reduce Medicare program costs. For MA, the Commission has recommended that payments be brought down from previous high levels and set so that the payment system is neutral and does not favor either MA or the traditional FFS program. Recent legislation has taken the program closer to this point of equity between MA and FFS. As a result, we are seeing evidence of improved efficiency in MA as plan bids have come down in relation to FFS while enrollment in MA continues to grow. The improved efficiency of MA plans enables them to continue to increase MA enrollment by offering benefit packages that beneficiaries find attractive.

The Commission has also recommended that pay-for-performance programs be instituted in Medicare to promote quality. The Congress instituted a quality bonus program for MA with bonuses available beginning in 2012. Recent data on quality suggest that plans are paying closer attention to quality measures, with better medical record validation and other documentation efforts as a contributing factor in improved performance for many plans. More plans have reached the level of quality ratings that would permit bonuses under the statutory provisions.

The Commission supports the concept of the quality bonus program as called for in the statute. Such a pay-for-performance system, combined with continuing fiscal pressure, will help ensure that a strong MA program will do its part in the urgent need to ensure the continued financial viability of the Medicare program. However, CMS has implemented the quality bonus program in a flawed manner at very high program costs not contemplated in the statute, using demonstration authority to pay bonuses to plans with low ratings and increasing bonus amounts for other plans above the level authorized in the statute.

Medicare Advantage special needs plans

In the MA program, special needs plans (SNPs) are a subcategory of coordinated care plans. What primarily distinguishes SNPs from other MA plans is that SNPs limit their enrollment to one of three categories of special needs individuals: dual-eligible beneficiaries, residents of a nursing home or community residents who are nursing home certifiable, and beneficiaries with certain chronic or disabling conditions. In contrast, most regular MA plans must allow all Medicare beneficiaries residing in their service area who meet MA eligibility criteria to enroll in the plan.

In Chapter 14, we discuss the future of SNPs. SNP authority expires at the end of 2014, which means that, in the absence of congressional action, SNPs will have to operate as other MA plans do; all beneficiaries will be eligible to enroll, not just beneficiaries with special needs. Reauthorizing all SNPs would result in increased program spending, because spending on beneficiaries enrolled in MA is generally higher than Medicare FFS spending for similar beneficiaries, and the current law baseline assumes that some beneficiaries enrolled in SNPs will likely return to traditional FFS. We evaluate each type of SNP on how well it performs on quality-of-care measures and whether it encourages a more integrated delivery system than is currently available in traditional FFS Medicare.

Institutional SNPs, known as I-SNPs, are plans for beneficiaries residing in nursing homes or beneficiaries living in the community who require a nursing home level of care. They perform well on a number of quality measures. In particular, hospital readmission rates for I-SNPs are much lower than expected. Reducing hospital readmissions for beneficiaries in nursing homes suggests that I-SNPs provide a more integrated and coordinated delivery system than beneficiaries could receive in traditional FFS. Therefore, the Commission recommends that the Congress permanently reauthorize I-SNPs.

Chronic condition SNPs, known as C-SNPs, are plans for beneficiaries with certain chronic conditions. In general, C-SNPs tend to perform no better, and often worse, than other SNPs and MA plans on most quality measures. The Commission recommended in 2008 that the list of conditions that qualify for a C-SNP be narrowed, and although the list of C-SNP conditions was reduced, we continue to believe that it is too broad. It is our judgment that regular MA plans should be able to manage the majority of chronic conditions and that the C-SNP model

of care for these conditions should be imported into MA plans. This act will move MA plans toward providing services that are better targeted to particular populations and improve the integration of the delivery system in regular MA plans for chronically ill enrollees. There may be a rationale, however, for maintaining C–SNPs for a small number of conditions that dominate an individual’s health. Therefore, the Commission recommends that the Congress:

- allow the authority for C–SNPs to expire, with the exception of C–SNPs for a small number of conditions, including ESRD, HIV/AIDS, and chronic and disabling mental health conditions.
- direct the Secretary, within three years, to permit MA plans to enhance benefit designs so that benefits can vary based on the medical needs of individuals with specific chronic or disabling conditions.
- permit current C–SNPs to continue operating during the transition period as the Secretary develops standards.
- except for the conditions noted above, impose a moratorium on all other C–SNPs as of January 1, 2014.

SNPs for beneficiaries dually eligible for Medicare and Medicaid, known as D–SNPs, generally have average to below-average performance on quality measures compared with other SNPs and regular MA plans, with some exceptions. D–SNPs are required to have contracts with states. However, the contracts, with a few exceptions, generally have not resulted in D–SNPs clinically or financially integrating Medicaid benefits. A number of administrative misalignments act as barriers to integrating Medicare and Medicaid benefits. Therefore, the Commission recommends that the Congress permanently reauthorize D–SNPs that assume clinical and financial responsibility for Medicare and Medicaid benefits and allow the authority for all other D–SNPs to expire. For D–SNPs that assume clinical and financial responsibility for Medicare and Medicaid benefits, the Congress should grant the Secretary authority to align the Medicare and Medicaid appeals and grievances processes and direct the Secretary to remove other barriers to integration of Medicare and Medicaid benefits. These D–SNPs would be able to market all the benefits they cover as a combined benefit package, and it would be easier for them to give enrollees a single enrollment card to access their Medicare and Medicaid benefits. Under this recommendation, the

Secretary would develop an example of a model Medicaid contract with a D–SNP for states to use as a resource.

Status report on Part D

Each year the Commission provides a status report on Part D, the Medicare prescription drug program. In 2011, Medicare spent about \$60 billion for the Part D program and in 2012, nearly 65 percent of Medicare beneficiaries, over 30 million people, were enrolled in Part D. In Chapter 15, we provide information on beneficiaries’ access to prescription drugs—including enrollment figures and benefit and design changes—program costs, and the quality of Part D services. We also analyze changes in plan bids, premiums, benefit designs, and formularies.

Part D is now in its eighth year, and most enrollees report high satisfaction with the Part D program. In 2012, about 63 percent of Part D enrollees were in stand-alone prescription drug plans (PDPs) and the remaining 37 percent were in Medicare Advantage–Prescription Drug plans (MA–PDs). In 2013, a total of 1,033 PDPs are offered nationwide along with 1,627 MA–PDs—about the same as in 2012. Beneficiaries will continue to have between 23 and 38 PDPs to choose from depending on the region, along with many MA–PDs. MA–PDs continue to be more likely than PDPs to offer enhanced benefits that include some coverage in the gap. For 2013, slightly more premium-free PDPs will be available to enrollees who receive the low-income subsidy (LIS). In most regions, LIS enrollees will continue to have many premium-free plans available. In two regions, Florida and Nevada, only two plans qualified as premium free in each region. Among those in Part D plans, 10.8 million low-income individuals (about 34 percent of Part D enrollees) received the LIS.

In 2012, in addition to the nearly 65 percent of Medicare beneficiaries enrolled in Part D plans, another 9 percent received their drug coverage through employer-sponsored plans that receive Medicare’s retiree drug subsidy. CMS reports that, in 2010, about 17 percent received their drug coverage through other sources and 10 percent had no drug coverage or coverage less generous than Part D. Beneficiaries with no creditable coverage tended to be healthier, on average. More than half reported not joining Part D because they did not take enough medications to need such coverage.

Between 2007 and 2011, Part D spending increased from \$46.7 billion to \$60 billion (an average annual growth of about 7 percent), and CMS expects it will

have reached \$62 billion in 2012. These expenditures include the direct monthly subsidy that plans receive for their Part D enrollees, reinsurance paid for very-high-cost enrollees, premiums and cost sharing for LIS enrollees, and payments to employers that continue to provide drug coverage to their Medicare beneficiary retirees. In 2011, LIS payments continued to be the largest single component of Part D spending, while Medicare's reinsurance payments were the fastest growing component. Changes made by the Patient Protection and Affordable Care Act of 2010 to gradually close the coverage gap likely contributed to the higher growth for reinsurance payments between 2010 and 2011.

While average costs for basic Part D benefits are expected to remain stable (growth of less than 1 percent) between

2012 and 2013, plan sponsors are expecting significant changes in costs for individual components: a decrease of over 9 percent for the direct subsidy and an increase of about 14 percent for the reinsurance component. In 2013, the base beneficiary premium is about the same as in 2012 (\$31).

Part D uses a competitive design to give plan sponsors incentives to offer beneficiaries attractive prescription drug coverage while controlling growth in drug spending. Plans that are able to manage drug spending and bid more competitively are supposed to be rewarded with higher enrollment than plans that do not. We find that a higher share of enrollees switched plans voluntarily in recent years than was reported by CMS during the first few years of the program. ■

