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 Medicare program in the context of the federal budget and national gross domestic product (GDP).
- evaluate payment adequacy and make recommendations concerning Medicare FFS payment policy in 2015 for hospital inpatient and outpatient, physician and other health professional, ambulatory surgical center, outpatient dialysis facility, skilled nursing facility, home health care, inpatient rehabilitation facility, long-term care hospital, and hospice services.
- review the need for reform across Medicare's payment systems for post-acute care.
- review the status of the MA plans that beneficiaries can join in lieu of traditional FFS Medicare and make two recommendations: one that reduces excess spending for certain kinds of MA plans and one that improves coordination of end-of-life care.
- review the status of the plans that provide prescription drug coverage (Part D).

The goal of Medicare payment policy is to get good value for the program's expenditures, which means maintaining beneficiaries' access to high-quality services while encouraging efficient use of resources. Anything less does not serve the interests of the taxpayers and beneficiaries who finance Medicare through their taxes and premiums. Although this report addresses many topics to increase value, it focuses on the Commission's recommendations for the annual payment rate updates under Medicare's various FFS payment systems and on aligning relative payment rates across those systems so that patients receive high-quality care in the most efficient setting.

We recognize that managing updates and relative payment rates alone will not solve what has been the fundamental problem with Medicare FFS payment systems to date—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 hospital readmission rates, need to be implemented more broadly and coordinated across settings. Second, delivery system reforms that have the potential to encourage high-quality care, better care transitions, and more efficient provision of care—such as medical homes, bundling, 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 service across sectors—an important topic. In addition, constraining unit prices could create pressure on providers to control their own costs and to be more receptive to new payment methods and delivery system reforms.

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

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

Context for Medicare payment policy

In Chapter 1, we consider Medicare payment policies in the broader context of the nation's health care system—including spending, delivery of care, access to and use of services—and pressure on federal and state budgets. Health care has accounted for a large and growing share of economic activity in the United States, nearly doubling as a share of GDP in the period between 1980 and 2012, from 8.9 percent to 17.2 percent. Growth in spending has slowed somewhat in recent years, dropping below the growth in GDP in 2011 and 2012. Although the causes

of this slowdown are debated, the decade-long period of slow economic growth from 2000 to 2011, decline in real incomes, and shift to less-generous insurance coverage have all likely affected the growth in health care spending.

The level of and growth in health care spending significantly affect federal and state budgets since public spending accounts for nearly half of all health care spending. If this spending continues to consume an increasing share of federal and state budgets, then spending for other public priorities—like education, investment in infrastructure and scientific research—will be crowded out, and the federal government will 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 about 14 percent of GDP in 10 years, whereas total federal revenues have averaged a little over 17 percent of GDP over the past 40 years.

Further, the change in health care spending has a direct and meaningful impact on individuals and families. Evidence shows that the increases in premiums and cost sharing have negated real income growth in the past decade. Likewise, premiums and cost sharing for Medicare beneficiaries are projected to grow faster than Social Security benefits. The lasting effects of the recent economic recession affected the income, insurance status, and assets of many people, including Medicare beneficiaries and adults aging into Medicare eligibility.

Medicare spending per beneficiary over the next 10 years is projected to grow at a slower rate than in the past 10 years (3.3 percent annually compared with 6.1 percent annually). The projected decline is due in part to lower updates for fee-for-service Medicare and lower payments to managed care plans, and in part to the recent slowdown in use of services. In contrast, the number of Medicare beneficiaries will grow notably faster as the baby-boom generation ages into the program (about 3 percent annually compared with about 2 percent annually in the past). Whether or not the slowdown in use is sustained, Medicare spending will continue to increase because of the sustained increase in the number of Medicare beneficiaries. As a result, the program still faces substantial deficits over the long term, and the Hospital Insurance Trust Fund is projected to be exhausted by 2026.

There are indications that some share of health care dollars is not spent effectively or is simply misspent. First, health care spending varies significantly across different regions of the United States, but studies show that populations in the higher spending and higher use regions do not consistently receive better quality care, even after adjusting for observable differences in beneficiaries' health status across regions. Internationally, the United States has much higher per capita spending on health care compared with other developed countries but shorter life expectancies and poorer average health outcomes. Finally, while minority Medicare beneficiaries represent a disproportionate share of high-spending beneficiaries, they tend to experience worse risk-adjusted health outcomes, suggesting that at least a portion of the high spending is not improving the health of minority beneficiaries.

High health care spending levels 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 one-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 control spending and create incentives for beneficiaries to seek and 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 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 (2014) 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—2015). As part of the process, we examine payment adequacy for the "relatively efficient" provider to the extent possible. Finally, we make a judgment on what, if any, update is needed.

This year, we make recommendations in 10 FFS settings: hospital inpatient and outpatient, physician and other health professional, ambulatory surgical center, outpatient dialysis facility, skilled nursing facility, home health care services, inpatient rehabilitation facility, long-term care hospital, and hospice services. Each year, the

Commission looks at all available indicators of payment adequacy and reevaluates any prior year assumptions using the most recent data available to make sure its assessments accurately reflect current conditions. We may 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 services unusually profitable. Finally, we also make recommendations to improve program integrity.

In considering updates, the Commission makes its recommendations this year relative to the 2014 base payment as defined in Medicare's authorizing statute—Title XVIII of the Social Security Act. The Commission's recommendations may call for an increase, a decrease, or no change from the 2014 base payment. For example, if the statutory base payment for a setting was $100 in 2014, an update recommendation of 1 percent for that setting means that we are recommending that the base payment in 2015 for that setting be 1 percent greater, $101. If the current sequester (which reduces the amount providers receive from Medicare by 2 percent) remains in effect in 2015 and makes payments in that setting different than our recommended $101 base payment rate in 2015, that policy would be inconsistent with our recommendation.

The Commission's 2014 margin projections do not include decreases in Medicare payments in 2014 resulting from the sequester because of congressional deliberations signaling a desire to find alternatives to the sequester at the time the Commission made its analytical assessment of payment adequacy. Projected margins would generally be slightly less than 2 percentage points lower than we project if those decreases were included, as we note in each of the payment adequacy chapters.

These update recommendations, if enacted, could significantly change the revenues providers receive from Medicare. Rates set to cover the costs of the relatively efficient provider not only help create fiscal pressure on providers to control their costs but also help create pressure for broader reforms to address what has traditionally been the fundamental problem of FFS payment systems—that providers are paid more when they deliver more services regardless of the quality or value of those additional services. 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 settings. Medicare often pays different amounts for similar services across settings. Basing the payment rate on the rate in the most efficient clinically appropriate setting would save money for Medicare, reduce cost sharing for beneficiaries, and reduce the incentive to provide services in the higher paid setting. In 2012, the Commission recommended that payments for evaluation and management (E&M) office visits in the hospital outpatient and physician office settings be made equal. In this report, we extend that principle to specific services that meet the Commission's criteria for which payment rates in the hospital outpatient prospective payment system (PPS) should be lowered to better match payment rates in the physician office setting. We also recommend consistent payment between acute care hospitals and long-term care hospitals (LTCHs) for certain types of patients. The Commission will continue to study other services that are provided in multiple settings to find additional services for which the principle of the same payment for the same service can be applied.

Hospital inpatient and outpatient services

The 4,700 acute care hospitals paid under the Medicare inpatient PPS, outpatient PPS, and the critical access hospital payment system received $166 billion for 10.4 million Medicare inpatient admissions and 190 million outpatient services in 2012. Net payments per beneficiary were essentially constant from 2011 to 2012 due to roughly equal growth in total payments and the number of FFS beneficiaries with Part A and Part B Medicare coverage.

In Chapter 3, we find that most payment adequacy indicators are positive. However, aggregate Medicare hospital margins continue to be negative, and under current law they would be expected to fall further in 2015.

- We expect Medicare beneficiaries' access to hospital services to remain strong due to excess hospital capacity in most markets. The excess capacity stems from a decline in admissions per capita coupled with few hospital closures. While we eventually expect bed supply to more closely meet demand, there have been only modest reductions in bed supply in recent years. From 2011 to 2012, Medicare inpatient volume declined by 4.5 percent and outpatient service volume grew by 4.3 percent. Combining inpatient and outpatient volumes into a measure of adjusted admissions (which converts outpatient services to

inpatient equivalents) shows overall service use declining by over 2 percent per capita. Because there is excess capacity (occupancy rates averaged 61 percent in 2012), the decline in service volume appears to reflect a decline in demand for services.

- Across all inpatient prospective payment system (IPPS) hospitals, most indicators of quality are improving.
- Most hospitals continue to have adequate access to capital markets. However, in 2013, some hospitals with weak demand for inpatient care have faced downgrades by credit rating agencies.
- We estimate that the aggregate hospital Medicare margin was –5.4 percent in 2012 and project it will be about –6 percent in 2014; margins have been between –5 percent and –7 percent since 2007. However, we identify a set of relatively efficient hospitals that have historically done well on a set of cost and quality metrics that generated a positive overall Medicare margin of about 2 percent in 2011 and 2012. Their margins are expected to remain at 2 percent through 2014. Nonetheless, under current law, payments are projected to decline in 2015; this decline would result in lower margins for all hospitals, including the relatively efficient providers.

In Chapter 3, we recommend a package of changes to Medicare's hospital payment systems for fiscal year 2015 that reduces excessive payment rates for certain outpatient hospital services and aligns them with rates paid in physician offices, creates greater equity between rates paid for similar patients in acute care hospitals and long-term care hospitals, and increases hospital payment rates for fiscal year 2015. This package of recommendations should be considered as a whole because each of these actions affect hospital revenues in different ways and will, together, improve financial incentives in these payment systems while maintaining adequate overall payments.

In an effort to move toward paying the same rate for the same service across different settings, we recommend aligning the payment rates in hospital outpatient departments (HOPDs) for certain services that meet the Commission's criteria with the rates paid in freestanding physician offices. Under current policy, Medicare usually pays more for services in HOPDs—often more than double—even when those services are frequently performed in physicians' offices. This payment difference creates a financial incentive for hospitals to purchase freestanding physicians' offices and convert them to HOPDs without changing their location or patient mix. For example, from 2010 to 2012, we saw a 33 percent increase in echocardiograms in HOPDs and a 10 percent decline in echocardiograms in physicians' offices, with a resulting increase in both beneficiary cost sharing and program spending. To remove this distortion in the payment system, the Commission recommends aligning payment rates between HOPDs and physician offices for specific services that meet the Commission's criteria. This alignment will reduce Medicare program spending, reduce beneficiary cost sharing, and create an incentive to care for patients in the most efficient setting appropriate for their condition.

Payment rates also differ for similar patients in acute care hospitals and LTCHs. LTCHs are currently paid much higher rates than traditional acute care hospitals, even for patients who do not require the specialized services of an LTCH. To correct this problem, we recommend a new chronically critically ill (CCI) criterion for patients receiving higher level LTCH payments. CCI patients would qualify for the LTCH payment rates because they generally need LTCH-level care, while most non-CCI patients would receive IPPS payment rates. The reduction in LTCH rates for non-CCI cases would generate savings that would be transferred to acute care hospitals in the form of higher outlier payments for the most costly CCI cases in acute care hospitals. These changes should be phased in over three years. As a result, the rates paid for services in the two payment systems would be more aligned with patients' needs and less dependent on the payment system under which the provider operates.

The Commission also recommends that the Congress increase payment rates for the acute care hospital inpatient and outpatient prospective payment systems in 2015 by 3.25 percent, concurrent with the change to the outpatient payment system and with initiating the change to the LTCH payment system. These changes will improve incentives in the system to care for patients in the most appropriate setting and ensure that funding within the acute care hospital systems is adequate to provide high-quality care for Medicare beneficiaries.

Physician and other health professional services

Physicians and other health professionals deliver a wide range of services, including office visits, surgical procedures, and diagnostic and therapeutic services in a variety of settings. In 2012, Medicare paid $69.6 billion

for physician and other health professional services. About 850,000 clinicians billed Medicare—550,000 physicians and 300,000 nurse practitioners, physician assistants, therapists, chiropractors, and other practitioners.

Medicare pays for the services of physicians and health professionals under a fee schedule, and total payments are limited in principle by the sustainable growth rate (SGR) formula. However, because of years of volume growth exceeding the SGR limits and legislative and regulatory overrides of negative updates, the SGR each year calls for large negative payment adjustments to fees for physicians and other health professionals.

Informing the Commission's deliberations in Chapter 4 on payment adequacy for physicians and other health professionals are beneficiary access to services, volume growth, quality, and changes in input costs and other measures of payment adequacy.

- Overall, beneficiary access to physician and other health professional services is stable. We generally find similar results to prior years—beneficiaries' access to physician services is similar to (or better than) access among privately insured individuals age 50 to 64. Most beneficiaries report they are able to obtain timely appointments for routine care and illness or injury, and most beneficiaries are able to find a new doctor without a problem (although beneficiaries seeking a primary care doctor are more likely to report that they had a problem than beneficiaries seeking a specialist). The survey does not find statistically significant differences in access between urban and rural beneficiaries, similar to prior years.
- The number of physicians and other health professionals providing services to Medicare beneficiaries from 2010 through 2012 kept pace with growth in the beneficiary population. Across all services, volume per beneficiary remained essentially unchanged, with a growth rate of −0.2 percent in 2012. Among broad categories of service, growth rates were 0.1 percent for E&M, 0.2 percent for major procedures, 0.4 percent for other procedures, −3.2 percent for imaging, and −0.5 percent for tests.
- Most measures of ambulatory care quality between the periods of 2009 to 2010 and 2011 to 2012 improved slightly or did not change, and a few worsened slightly.
- Because physicians and other health professionals do not report their costs to Medicare, we use proxies for Medicare's payments relative to providers' costs. Medicare's payments for fee schedule services relative to private insurer payments have remained constant at about 80 percent.

In light of this information, the Commission reiterates its standing recommendation to repeal the SGR formula, rebalance payments between primary and specialty care, have legislated updates, and increase incentives to move toward coordinated delivery systems such as ACOs. The Commission's recommendation is based on these principles: repeal of the SGR is urgent, beneficiary access to physician services must be preserved, payments should be rebalanced between primary care and other specialties, and the Medicare program should encourage movement toward reformed delivery systems. The Commission sees SGR repeal as urgent because, after a decade of year-end legislative overrides, the policy is causing uncertainty for physician and other clinician practices and has the potential to create instability for beneficiaries. The SGR also bogs down the policy process by focusing efforts on the yearly need to override negative fee schedule updates.

Ambulatory surgical center services

Ambulatory surgical centers (ASCs) provide outpatient procedures to patients who do not require an overnight stay in a facility after the procedure. In 2012, 5,357 ASCs treated 3.4 million FFS Medicare beneficiaries, and Medicare program and beneficiary spending on ASC services was $3.6 billion.

We find in Chapter 5 that the available indicators of payment adequacy for ASC services are positive. However, growth in the number of ASCs and volume of services was slower in 2012 than in previous years.

- Our analysis of facility supply and volume of services indicates that beneficiaries' access to ASC services has generally been adequate. From 2007 through 2011, the number of Medicare-certified ASCs grew by an average annual rate of 2.5 percent, and in 2012 by 1.2 percent. The relatively slow growth may be related to the higher Medicare payment rates for most ambulatory procedures in HOPDs than in ASCs, which may have led some ASC owners to sell their facilities to hospitals. In addition, physicians have increasingly been selling their practices to hospitals and becoming hospital employees. Physicians who are hospital employees may be more inclined to provide surgical services at hospitals than ASCs. From 2007 through 2011, the volume of services per beneficiary

grew by an average annual rate of 4.6 percent; in 2012, volume increased by 1.7 percent.

- ASCs began submitting quality data to CMS in October 2012, but the complete data are not yet publicly available. Consequently, we do not have sufficient information to assess ASCs' quality of care.
- Because the number of ASCs has continued to increase, access to capital appears to be adequate.
- Medicare payments per FFS beneficiary increased by an average of 4.3 percent per year from 2007 through 2012. ASCs do not submit data on the cost of services they provide to Medicare beneficiaries. Therefore, we cannot calculate a Medicare margin as we do for other provider types to assist in assessing payment adequacy.

In light of these findings, the Commission recommends that the Congress eliminate the update to the payment rates for ASCs for 2015 and require ASCs to submit cost data.

Outpatient dialysis services

Outpatient dialysis services are used to treat the majority of individuals with end-stage renal disease (ESRD). In 2012, about 370,000 ESRD beneficiaries on dialysis were covered under FFS Medicare and received dialysis from about 5,800 dialysis facilities. For most facilities, 2012 is the second year that Medicare paid them using a new PPS that includes in the payment bundle certain dialysis drugs and ESRD-related clinical laboratory tests for which facilities and clinical laboratories previously received separate payments. In 2012, Medicare expenditures for outpatient dialysis services in the new payment bundle, including items and services furnished by other providers in prior years, were $10.7 billion, a 6 percent increase compared with 2011.

In Chapter 6, we find that payment adequacy indicators for outpatient dialysis services 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 beneficiaries. Between 2010 and 2012, the number of FFS dialysis beneficiaries and dialysis treatments grew at similar rates (2 percent and 3 percent, respectively). At the same time, the per treatment use of most dialysis injectable drugs, including erythropoietin-stimulating agents (ESAs) that are used in anemia management, substantially declined. The new dialysis PPS created an incentive for providers to be more judicious about their provision of dialysis drugs. In addition, in 2011, the Food and Drug Administration recommended more conservative ESA dosing.
- We looked at changes in quality indicators under the new PPS from 2010 through June 2013. Rates of mortality and emergency department use remained relatively constant while rates of hospitalization declined. With regard to anemia management, average hemoglobin levels declined. Under the new PPS, use of home dialysis, which is associated with improved patient satisfaction and quality of life, increased from 8 percent of beneficiaries to 10 percent.
- Information from investment analysts suggests that access to capital for dialysis providers continues to be adequate. The number of facilities, particularly for-profit facilities, continues to increase.
- Under the new PPS, cost per treatment increased by 2 percent from 2011 to 2012, while Medicare payment per treatment increased by 2.3 percent. We estimate that the aggregate Medicare margin was 3.9 percent in 2012 and project that the aggregate Medicare margin will be 2.9 percent in 2014.

The evidence on payment adequacy suggests that payments are adequate; the Commission recommends that the Congress not increase the outpatient dialysis payment rate for 2015.

In addition, to improve the ESRD payment system, the Commission recommends that the Congress direct the Secretary to include a measure that assesses poor outcomes related to anemia in the ESRD Quality Incentive Program, redesign the low-volume payment adjustment to consider a facility's distance to the nearest facility, and audit dialysis facilities' cost report data. This recommendation addresses concerns that there is a risk under the new PPS that some providers may furnish fewer anemia services (within the bundle) than medically necessary, that the low-volume payment adjustment is not targeting facilities that may be necessary for beneficiary access, and that CMS has not yet examined the appropriateness of the costs that facilities include on their cost reports.

Post-acute care providers: Steps toward broad payment reforms

Post-acute care (PAC) offers important recuperation and rehabilitation services to Medicare beneficiaries recovering after an acute care hospital stay. PAC providers

include skilled nursing facilities (SNFs), home health agencies (HHAs), inpatient rehabilitation facilities (IRFs), and LTCHs. The Commission's goal is to recommend policies for PAC providers that ensure beneficiaries receive medically necessary, high-quality care in the least costly setting appropriate for their condition.

The Commission has noted the shortcomings of Medicare's payment systems for PAC and the clear need for reforms for many years. In Chapter 7, we examine these shortcomings and recommend a key reform concerning patient assessment. We find not only that there are exceptionally high average Medicare margins in most PAC settings but also that the variation across providers in Medicare margins in each setting highlights core problems with the design of the payment systems. The PPSs encourage providers to furnish certain services to boost payments or admit certain kinds of patients based on profitability. Although CMS has adopted setting-specific rules to delineate the types of patients appropriate for IRFs and LTCHs, there is overlap in the types of patients treated in different settings. Because Medicare pays very different rates across settings, treating similar patients in different settings can unnecessarily raise program spending.

Broad reforms of the way Medicare FFS pays for PAC are hampered by the lack of common patient assessment information across the PAC settings. Common patient assessment items would allow policymakers to evaluate differences in the mix of patients treated in different settings, the care providers furnish, and the outcomes patients achieve. Currently, three of the four settings (HHAs, IRFs, and SNFs) are required by CMS to use different assessment instruments. While CMS successfully tested a common assessment tool across PAC settings and in acute hospitals at discharge, CMS has not established a time line to require PAC settings to gather consistent patient assessment information. To help prevent undue delays in the collection of comparable data, the Commission recommends that the Congress direct the Secretary to implement common patient assessment items for use in the four PAC settings beginning in 2016, and we lay out a possible timetable for CMS activities in 2017 and 2018.

Skilled nursing facility services

SNFs furnish short-term skilled nursing and rehabilitation services to beneficiaries after a stay in an acute care hospital. In 2012, almost 15,000 SNFs furnished Medicare-covered care to 1.7 million FFS beneficiaries during 2.4 million stays. Medicare FFS spending on SNF services was $28.7 billion in 2012.

We find in Chapter 8 that indicators of payment adequacy for SNFs are positive. We also found that relatively efficient SNFs—facilities that provided relatively high-quality care at relatively low costs—had high Medicare margins, suggesting that opportunities remain for other SNFs to achieve greater efficiencies.

- Access to SNF services remains stable for most beneficiaries. The number of SNFs participating in the Medicare program was stable between 2011 and 2012. Three-quarters of beneficiaries live in a county with five or more SNFs, and less than 1 percent live in a county without one. Available bed days increased slightly. The median occupancy rate was 87 percent, indicating some excess capacity for admissions. Days and admissions per FFS beneficiary declined between 2011 and 2012, reflecting declines in inpatient hospital admissions (a prerequisite for Medicare coverage).

- The Commission tracks three indicators of SNF quality: risk-adjusted rates of community discharge, readmission to a hospital for potentially avoidable conditions during a beneficiary's SNF stay, and readmission to a hospital within 30 days after discharge from the SNF. All three measures showed small improvement between 2011 and 2012. This year we also report on a measure of change in beneficiaries' functional status during their SNF stay. We found essentially no improvement on this measure between 2011 and 2012.

- Because most SNFs are part of a larger nursing home, we examine nursing homes' access to capital. Capital will continue to be available in 2014, though uncertainties surrounding the federal budget continue to make some lenders wary. This reluctance is not a statement about the adequacy of Medicare's payments to SNFs.

- In 2012, the Medicare margin was 13.8 percent, down from 21.2 percent in 2011, a year of exceptionally high Medicare margins. The 2011 margins were a result of unwarranted overpayments generated by the industry's response to Medicare policy changes. For the 13th consecutive year, Medicare margins were above 10 percent. Margins continue to vary greatly across facilities, depending on the share of intensive therapy days, facility size, and cost per day. The

variations in Medicare margins and costs per day were not attributable to differences in patient demographics; rather they reflect shortcomings in the SNF PPS that favors SNFs treating patients who receive high levels of rehabilitation therapy. The disparity in margins between for-profit and nonprofit facilities is considerable and reflects differences in patient mix, service provision, and costs. We found 11 percent of freestanding facilities furnished relatively low-cost and high-quality care and had substantial Medicare margins over three consecutive years. The projected 2014 margin for freestanding SNFs is 12 percent.

In 2012, the Commission recommended first restructuring the SNF payment system and then rebasing payments. Specifically, the Commission recommended that the Congress direct the Secretary to revise the SNF PPS; during the year of revision, payment rates were to be held 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) should 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 should 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 rebase payments the next year was based on several facts: (1) high and sustained Medicare margins; (2) widely varying costs unrelated to case mix and wages; (3) cost growth well above the change in input prices in most years over the past decade, reflecting little fiscal pressure from the Medicare program; (4) the ability of many SNFs (almost 900) to have consistently relatively low costs and relatively high quality of care; (5) the continued ability of the industry to maintain high margins despite changing policies; and (6) in many cases, Medicare Advantage payments to SNFs 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 these findings. Therefore, the Commission maintains its position with respect to the SNF PPS and urges the Congress to direct the Secretary, as soon as practicable, 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 2012 and 2013. In 2012, the average non-Medicare margin was –2 percent. The average total margin, reflecting all payers and all lines of business, was 1.8 percent.

Home health care services

Home health agencies provide services to beneficiaries who are homebound and need skilled nursing or therapy. In 2012, about 3.4 million Medicare beneficiaries received home care, and the program spent about $18 billion on home health services. The number of agencies participating in Medicare reached 12,311 in 2012.

In Chapter 9, we find that the indicators of payment adequacy for home health care are generally positive:

- Access to home health care is generally adequate: Over 99 percent of beneficiaries live in a ZIP code where a Medicare home health agency operates, and 97 percent live in a ZIP code with two or more agencies. In 2012, the number of agencies continued to increase, with a net gain of 257 agencies. Most new agencies were concentrated in a few states, and for-profit agencies accounted for the majority of new providers. In 2012, the volume of services declined slightly, and total payments declined by about 2 percent, or $400 million. The lower spending comes after several years of increases; total spending between 2002 and 2012 increased by 89 percent. Between 2002 and 2012, the average number of 60-day episodes per home health user increased from 1.6 to 2, indicating that beneficiaries who used home health care stayed in service for longer periods of time.
- Quality measures associated with function and care management were steady or showed a small improvement.
- Access to capital is a less important indicator of Medicare payment adequacy for home health care because it is less capital intensive than most health

care settings. According to capital market analysts, the major publicly traded for-profit home health companies had sufficient access to capital markets for their credit needs, although terms were not as favorable as in prior years. The significant number of new agencies in 2012 suggests that even small 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 for freestanding agencies averaged 14.4 percent in 2012 and 17.5 percent from 2001 through 2011. Two factors have contributed to payments exceeding costs: Fewer visits have been delivered in an episode than is assumed in Medicare's rates, and cost growth has been lower than the annual payment updates for home health care. We project the aggregate Medicare margin for home health agencies in 2014 to be 12.6 percent.

This report reiterates the 2011 recommendations the Commission made to revise and rebase home health payments. Revising the payment system to rely on patient characteristics rather than the number of therapy visits would reduce the incentive to deliver services of marginal value to the beneficiary. Implementing the Commission's prior recommendation for rebasing would reduce payments and better align Medicare's payments with the actual costs of providing home health services. Overpaying for home health services has negative financial consequences for the federal budget and raises the Medicare premiums that beneficiaries pay.

The Commission also makes a new recommendation that Medicare establish a program to incentivize agencies to reduce hospital readmissions from home health care for stays preceded by a hospitalization. About 29 percent of posthospital home health stays result in readmission, and there is tremendous variation among providers. The broad variation suggests the potential for many agencies to lower their readmission rates. Implementing a readmission penalty for home health care could improve care for beneficiaries and lower Medicare spending. Such a policy would also align the incentives of home health agencies with those of hospitals under the Hospital Readmissions Reduction Program and would prepare them to participate in coordinated care models that seek to reduce readmissions, such as accountable care organizations.

Inpatient rehabilitation facility services

IRFs are hospitals that provide intensive rehabilitation services to patients after an injury, illness, or surgery. Rehabilitation programs at IRFs are supervised by rehabilitation physicians and include physical and occupational therapy, rehabilitation nursing, prosthetic and orthotic devices, and speech–language pathology. In 2012, 1,166 IRFs treated over 373,000 Medicare FFS cases. Between 2011 and 2012, Medicare FFS payments for IRFs increased from $6.5 billion to $6.7 billion.

In Chapter 10, we find that our indicators of Medicare payment adequacy for IRFs are positive.

- Our measures of access to care suggest that beneficiaries generally maintained access to IRF services in 2012. The number of cases increased slightly, by about 0.5 percent in 2012. Although the number of unique patients per 10,000 FFS beneficiaries decreased slightly from 2011 to 2012, the number has remained relatively stable over recent years, suggesting relative stability in IRF use. The supply of IRFs nationwide was almost unchanged in 2012, a shift from declines in previous years. The total number of freestanding facilities continued to increase slightly, while the number of hospital-based facilities decreased slightly. Occupancy rates decreased slightly for both facility types to 62.8 percent overall. IRFs are not the sole providers of rehabilitation services in communities; skilled nursing facilities and home health agencies are both potential alternatives for beneficiaries with rehabilitation needs. The overall growth in the number of IRFs, low occupancy rates, and availability of rehabilitation alternatives suggest that capacity remains adequate to meet demand.

- Quality of care measures show improvement in recent years. From 2010 to 2012, Functional Independence Measure™ gain increased by an average of 3 percent each year. Rates of discharge to the community grew by an average of 0.5 percent each year, while rates of discharge to an acute care hospital declined by an average of 2.7 percent each year. These outcomes do not control for changes in case mix over time. Despite a small increase in case-mix severity, quality outcomes improved.

- One major freestanding IRF chain that accounts for about 50 percent of freestanding IRF Medicare revenues and 22 percent of revenues for the entire IRF industry has very good access to capital. We were

not able to determine the ability of other freestanding facilities to raise capital. The parent institutions of hospital-based IRF units have maintained reasonable access to capital.

- Average Medicare payments per case to IRFs increased more than average costs per case from 2011 to 2012; average payments grew 3 percent over 2011, compared with 1.5 percent cost growth. The aggregate Medicare margin for IRFs in 2012 was 11.1 percent. We project a 2014 Medicare IRF margin of 11.8 percent.

On the basis of these indicators, the Commission recommends that the Congress eliminate the update to IRF payment rates in 2015.

Long-term care hospital services

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 (ACHs), and its Medicare patients must have an average length of stay greater than 25 days. In 2012, Medicare spent $5.5 billion on care provided in 420 LTCHs nationwide. About 124,000 beneficiaries had more than 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.

- Trends suggest that access to care has been maintained. Growth in the number of LTCHs slowed considerably during the five-year moratorium imposed by the Medicare, Medicaid, and SCHIP Extension Act of 2007 and subsequent amendments. In the last year of the moratorium (2012), the number of LTCHs rose from 417 to 420, while the number of LTCH beds increased 0.5 percent. From 2011 to 2012, the number of beneficiaries who had LTCH stays increased by 0.7 percent. Controlling for the growth in the number of FFS beneficiaries, we found that the number of LTCH cases declined 1 percent between 2011 and 2012. This reduction in per capita admissions is consistent with (though smaller than) the reduction seen in other settings.

- LTCHs only recently began submitting quality of care data to CMS. Those data are not yet available for analysis. However, using claims data without adjustment for case mix, we found stable or declining rates of readmission, of death in the LTCH, and of death within 30 days of discharge for almost all of the top 25 diagnoses in 2012.

- For the past few years, the availability of capital to LTCHs has reflected uncertainty regarding possible changes to Medicare's regulations and legislation governing LTCHs. The moratorium has reduced opportunities for expansion and the need for capital. With the expiration of the moratorium at the end of 2012, LTCH companies appear to be acting with caution, likely because of the continued scrutiny of Medicare spending on LTCH care.

- Since 2007, LTCHs have held cost growth below the rate of increase in input prices. Between 2011 and 2012, Medicare payments continued to increase faster than provider costs, resulting in an aggregate 2012 Medicare margin of 7.1 percent. We project an aggregate Medicare margin of 6.5 percent in 2014.

The Commission has been concerned for some time about whether Medicare is paying accurately for services provided in LTCHs. LTCHs have positioned themselves as providers of hospital-level care for long-stay CCI patients, but nationwide most such patients are cared for in ACHs, and most LTCH patients are not CCI. Medicare's payments to LTCHs are higher than those made for similar patients in other settings. The Commission's principle is that payment for the same set of services should be the same regardless of where the services are provided. Comparatively attractive payment rates for LTCH care have resulted in an oversupply of LTCHs in some areas and may generate unwarranted use of LTCH services by patients who are not CCI.

Therefore, the Commission recommends that Medicare pay the higher LTCH rates only for LTCH cases that are CCI. Non-CCI cases should be paid at rates based on the IPPS. The Congress should allocate the savings achieved to the IPPS outlier pool to better match payments and costs for extraordinarily costly CCI cases in ACHs. This recommendation should be phased in over three years. The Commission also recommends that the Secretary eliminate the update to the payment rate for LTCHs for fiscal year 2015. Any impact from our first recommendation (should it be implemented) will be small in 2015, and our findings on payment adequacy suggest that LTCHs would continue to serve beneficiaries.

The definition of CCI is crucial to this recommendation. The Commission has determined that length of stay in the intensive care unit (ICU) is the best available proxy measure of case complexity and a good predictor of intensive resource use during post-acute care episodes that begin with an ACH stay. The Commission recommends a threshold of eight days because a lower threshold may fail to adequately distinguish the truly chronically critically ill. In addition, to ensure that patients requiring prolonged mechanical ventilation have appropriate access to the specialty weaning services offered by many LTCHs, the Commission recommends an exception to the eight-day ICU threshold for LTCH cases that receive mechanical ventilation for 96 hours or more during an immediately preceding acute care hospital stay. The Pathway to SGR Reform Act of 2013 mandated changes to the LTCH PPS, including limiting higher LTCH payments to cases that include at least three days in an ICU during an immediately preceding acute care hospital stay beginning in 2016. The Commission is concerned that a three-day threshold is too low to distinguish the truly CCI patient and thus Medicare would continue to pay too much for LTCH care for cases in which the patient could be cared for appropriately in other settings.

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 of their terminal condition. In 2012, more than 1.27 million Medicare beneficiaries received hospice services from over 3,700 providers, and Medicare expenditures totaled about $15.1 billion.

In Chapter 12, we find that our indicators of payment adequacy for hospices are generally positive.

- Hospice use among Medicare beneficiaries has grown substantially in recent years, suggesting greater awareness of and access to hospice services. In 2012, hospice use increased across all demographic and beneficiary groups examined. However, hospice use rates remained lower for racial and ethnic minorities than for Whites. The supply of hospices increased nearly 4 percent in 2012, due almost entirely to growth in the number of for-profit hospices. The increase in 2012 continues a more than decade-long trend of substantial market entry by for-profit providers. The proportion of beneficiaries using hospice services at the end of life continues to grow, and average length of stay increased in 2012. In 2012, 46.7 percent of Medicare beneficiaries who died that year used hospice, up from 45.2 percent in 2011 and 22.9 percent in 2000. Average length of stay among decedents, which increased between 2000 and 2011 from 54 days to 86 days, grew to 88 days in 2012. The median length of stay for hospice decedents was 18 days in 2012 and has remained stable at approximately 17 or 18 days since 2000.

- At this time, we do not have data to assess the quality of hospice care provided to Medicare beneficiaries. The Patient Protection and Affordable Care Act of 2010 mandated that a hospice quality reporting program begin by fiscal year 2014. Beginning in 2013, hospices must report data for specified quality measures or face a 2 percentage point reduction in their annual update for the subsequent fiscal year. Initially, two limited quality measures were adopted. Beginning in July 2014, seven new quality measures will be collected by means of a standardized data collection instrument. In 2015, a hospice experience-of-care survey for bereaved family members will be implemented. CMS has indicated that public reporting of quality information is unlikely before 2017.

- Hospices are not as capital intensive as some other provider types because they do not require extensive physical infrastructure. Continued growth in the number of for-profit providers (a 6.9 percent increase in 2012) suggests that access to capital is adequate for these providers. Less is known about access to capital for nonprofit freestanding providers, for whom capital may be more limited. Hospital-based and home health–based hospices have access to capital through their parent providers.

- The aggregate 2011 Medicare margin was 8.7 percent in 2011, up from 7.4 percent in 2010. The projected margin for 2014 is 7.8 percent. The margin estimates exclude nonreimbursable costs associated with bereavement services and volunteers (which, if included, would reduce margins by at most 1.4 percentage points and 0.3 percentage point, respectively). Margins also do not include any adjustment for the higher indirect costs observed among hospital-based and home health–based hospices (which, if such an adjustment were made,

would increase the overall aggregate Medicare margin by up to 1.5 percentage points).

In light of these findings on payment adequacy, the Commission recommends that no update to payment rates in 2015 is needed for hospices to continue to provide beneficiaries with appropriate access to care.

The Medicare Advantage program: Status report

Each year, the Commission provides a status report on the MA program. In 2013, the MA program included more than 3,600 plan options, enrolled more than 14.5 million beneficiaries (28 percent of all beneficiaries), and paid MA plans about $146 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. We make two recommendations, one on employer group plans and one on including hospice in the MA benefit.

- In 2013, MA enrollment increased by 9 percent to 14.5 million beneficiaries. Enrollment in HMO plans—the largest plan type—increased 10 percent to nearly 10 million enrollees. Local preferred provider organizations (PPOs) grew about 11 percent, to 3.3 million enrollees, and regional PPOs grew about 16 percent, to 1.1 million enrollees. The MA plan bids project an increase in overall enrollment for 2014 of 3 percent to 5 percent, primarily in HMOs and local PPOs.

- In 2014, virtually all Medicare beneficiaries have access to an MA plan (0.4 percent do not), and 99 percent have access to at least one network-based coordinated care plan (CCP), which includes HMOs and PPOs. Eighty-four 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 10 MA plan options, including 8 CCPs.

- We estimate that 2014 MA benchmarks, bids, and payments (including quality bonuses) will average 112 percent, 98 percent, and 106 percent of FFS spending, respectively. Bids and payments relative to FFS remained about the same in 2014 as they were in 2013.

- Comparing last year's quality indicators with the most current results, we see that the majority of measures remained stable, including intermediate outcome measures such as control of blood pressure among patients with hypertension. Also remaining stable or unchanged were patient experience measures from beneficiary surveys in which enrollees rate their health plans and the plans' providers on ease of access to care, customer service, and the perceived level of care coordination. There was improvement in a number of indicators, including process measures such as cancer screenings, hospital readmission rates, and Part D drug adherence measures. As a result, plan star ratings, which are used to determine quality bonuses, improved for many plans.

The MA program gives Medicare beneficiaries the option 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 all providers of care to improve efficiency and reduce Medicare program spending. For MA, the Commission recommended that payments be brought down from previous high levels and be set so that the payment system is neutral and does not favor either MA or the traditional FFS program. Recent legislation has reduced the inequity between MA and FFS. As a result, over the past few years, plan bids have come down in relation to FFS, while enrollment in MA continues to grow. The pressure of competitive bidding has led to either improved efficiency or lower margins that enable MA plans to continue to increase MA enrollment by offering packages that beneficiaries find attractive.

However, employer group plans historically have not demonstrated the same bidding behavior, bidding consistently higher than nonemployer plans because employer group plans lack an incentive to submit competitive bids. Therefore, we recommend that the Congress direct the Secretary to determine payments for employer group MA plans in a manner more consistent with the determination of payments for comparable nonemployer plans. We include an analysis showing how

this determination could be made in a way that would produce more competitive employer group bids and achieve savings for Medicare.

A long-standing issue in MA is that hospice is not included in the MA benefits package. When an MA enrollee elects hospice, the beneficiary typically remains in the MA plan but hospice services are paid for by Medicare FFS. This carve-out of hospice from the MA capitated payment fragments financial responsibility and accountability for care for MA enrollees who elect hospice. We recommend including hospice in the MA benefits package, which would give plans responsibility for the full continuum of care and promote integrated, coordinated care, consistent with the goals of the MA program. Including hospice in the MA benefits package would give plans a greater incentive to use the flexibility inherent in the MA program to develop and test innovative programs aimed at improving end-of-life care and improving care for patients with advanced illnesses more broadly (e.g., concurrent care or other approaches to provide flexibility in the hospice eligibility criteria, palliative care, and shared decision making).

Status report on Part D

Each year, the Commission provides a status report on Part D, the Medicare prescription drug program. In Chapter 14, we provide information on beneficiaries' access to prescription drugs, program costs, and the quality of Part D services. We also analyze changes in plan bids, premiums, benefit designs, and formularies.

- In 2013, about 68 percent of Medicare beneficiaries were enrolled in Part D plans. An additional 6 percent received their drug coverage through employer-sponsored plans that receive Medicare's retiree drug subsidy. Among 35 million Part D plan enrollees, 11.2 million individuals received the low-income subsidy (LIS). In 2011, the most recent year for which data are available, 12 percent of beneficiaries had no drug coverage or coverage less generous than Part D. Our previous analysis showed that beneficiaries with no creditable coverage tended to be healthier, on average. More than half of those without Part D coverage reported they did not take enough medications to need such coverage.
- Although surveys suggest high satisfaction with Part D among enrollees, about 6 percent reported having trouble obtaining needed medications. We examined available data on Part D's exceptions and appeals process but found insufficient data to evaluate its effectiveness. We also found that the process is complex and burdensome for many individuals. Our review suggests a need for additional data on the outcomes of the exceptions and appeals process and a need for a more transparent and streamlined process.
- In 2013, about 64 percent of Part D enrollees were in stand-alone prescription drug plans (PDPs) and the rest in Medicare Advantage–Prescription Drug plans (MA–PDs). Premiums averaged about $30 across all plans.
- The number of plan offerings remained stable between 2013 and 2014, with a modest increase in PDP offerings and slightly fewer MA–PDs. Beneficiaries will continue to have between 28 and 39 PDPs to choose from in their region, depending on where they live, along with many MA–PDs. In 2014, a total of 1,169 PDPs are offered nationwide along with 1,615 MA–PDs. MA–PDs continue to be more likely than PDPs to offer enhanced benefits that include some coverage in the gap—the period between when Part D's initial coverage ends and when the enrollee meets the out-of-pocket threshold to enter the catastrophic phase of the benefit. For 2014, more premium-free PDPs will be available to enrollees who receive the LIS; 352 plans qualified compared with 331 in 2013.
- Between 2007 and 2012, Medicare's Part D spending increased from $46.7 billion to $62.5 billion (about 6 percent annual growth on average). In 2012, LIS payments continued to be the single largest component of Part D spending, while Medicare's reinsurance payments continued to be the fastest growing component, growing at an average annual rate of 14 percent between 2007 and 2012. Aggregate Part D payments to plans continued to grow at a faster rate than the growth in Part D enrollment. The "excess" growth in payments appears to be driven in large part by the growth in the average price of drugs filled, particularly among enrollees receiving the LIS.
- The average costs for basic Part D benefits are expected to grow by 4 percent between 2013 and 2014, but plan sponsors are expecting significant changes in costs for individual components: a decrease of over 10 percent for the direct subsidy and an increase of about 20 percent for the reinsurance component.

An increasing number of plans are adding a nonpreferred generic tier with substantially higher cost-sharing amounts relative to the preferred generic tier. In addition, we are seeing a trend toward the use of tiered network pharmacies that lower cost sharing if one fills medications at a designated preferred pharmacy. In 2014, over 70 percent of all PDPs have tiered pharmacy networks. Both of these strategies provide financial incentives for enrollees to use a lower cost drug (or setting), potentially reducing program costs. However, the use of such financial incentives, while potentially lowering plans' costs of providing the basic benefit, could increase Medicare's spending for the LIS because those beneficiaries do not pay cost sharing and thus have no incentive to use drugs on preferred tiers or preferred pharmacies.

Although we continue to see a large number of plans in Part D, it is not clear whether the competition among plans is providing strong incentives for cost control, particularly once a beneficiary enters the catastrophic phase of the benefit where Medicare pays for 80 percent of the costs through reinsurance. The Commission will continue to explore how the program could be restructured to provide stronger incentives for plans to control drug spending. ■