

M A R C H 2 0 1 5

REPORT TO THE CONGRESS

Medicare Payment Policy



The Medicare Payment Advisory Commission (MedPAC) is an independent congressional agency established by the Balanced Budget Act of 1997 (P.L. 105–33) to advise the U.S. Congress on issues affecting the Medicare program. In addition to advising the Congress on payments to health plans participating in the Medicare Advantage program and providers in Medicare’s traditional fee-for-service program, MedPAC is also tasked with analyzing access to care, quality of care, and other issues affecting Medicare.

The Commission’s 17 members bring diverse expertise in the financing and delivery of health care services. Commissioners are appointed to three-year terms (subject to renewal) by the Comptroller General and serve part time. Appointments are staggered; the terms of five or six Commissioners expire each year. The Commission is supported by an executive director and a staff of analysts, who typically have backgrounds in economics, health policy, and public health.

MedPAC meets publicly to discuss policy issues and formulate its recommendations to the Congress. In the course of these meetings, Commissioners consider the results of staff research, presentations by policy experts, and comments from interested parties. (Meeting transcripts are available at www.medpac.gov.) Commission members and staff also seek input on Medicare issues through frequent meetings with individuals interested in the program, including staff from congressional committees and the Centers for Medicare & Medicaid Services (CMS), health care researchers, health care providers, and beneficiary advocates.

Two reports—issued in March and June each year—are the primary outlets for Commission recommendations. In addition to annual reports and occasional reports on subjects requested by the Congress, MedPAC advises the Congress through other avenues, including comments on reports and proposed regulations issued by the Secretary of the Department of Health and Human Services, testimony, and briefings for congressional staff.

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425 I Street, NW • Suite 701 • Washington, DC 20001
(202) 220-3700 • Fax: (202) 220-3759 • www.medpac.gov



425 I Street, NW • Suite 701
Washington, DC 20001
202-220-3700 • Fax: 202-220-3759
www.medpac.gov

Glenn M. Hackbarth, J.D., Chairman
Jon Christianson, Ph.D., Vice Chairman
Mark E. Miller, Ph.D., Executive Director

March 13, 2015

The Honorable Joseph R. Biden
President of the Senate
U.S. Capitol
Washington, DC 20510

The Honorable John A. Boehner
Speaker of the House
U.S. House of Representatives
U.S. Capitol
Room H-232
Washington, DC 20515

Dear Mr. President and Mr. Speaker:

I am pleased to submit the Medicare Payment Advisory Commission's March 2015 *Report to the Congress: Medicare Payment Policy*. This report fulfills the Commission's legislative mandate to evaluate Medicare payment issues and make recommendations to the Congress.

The report contains 14 chapters:

- a chapter that provides a broader context for the report by documenting Medicare and total health care spending and their impacts on federal spending;
- a chapter that describes the Commission's analytical framework for assessing payment adequacy;
- ten chapters that describe the Commission's recommendations on fee-for-service payment rate updates and related issues;
- a chapter that updates the trends in enrollment, plan offerings, and payments in Medicare Advantage plans; and
- a chapter that updates the trends in enrollment and plan offerings for plans that provide prescription drug coverage.

In this report, we continue to make recommendations aimed at finding ways to provide high-quality care for Medicare beneficiaries at lower costs to the program. It is of note that in light of our payment adequacy analyses, we recommend no payment update in 2016 for five fee-for-service payment systems. In the other sectors (hospital inpatient and outpatient, physician, skilled nursing, and home health), we evaluated current payment adequacy indicators, but we did not take new votes on their recommended payment updates. In each of these sectors in the recent past, the Commission has developed complex multiyear recommendations that address not only their updates but broader problems with the structure of the payment systems. Our assessment of the payment adequacy indicators this year suggests that the trends that led us to make those recommendations continue, and thus we have decided to reiterate our prior recommendations for these sectors.

In addition, we recommend site-neutral payments for certain select conditions between two post-acute care sectors: skilled nursing facilities and inpatient rehabilitation facilities. This recommendation builds on our past recommendations for site-neutral payments between hospital outpatient departments and physicians' offices for certain services, and for consistent payment between acute care hospitals and long-term care hospitals for certain classes of patients. Medicare often pays different amounts for similar services across sectors. Site-neutral payments that base the payment rate on the less costly sector can save money for Medicare, reduce cost sharing for beneficiaries, and reduce the incentive to provide services in the higher paid sector, without compromising beneficiary access to care or health outcomes.

We are also concerned with the issue of future access for Medicare beneficiaries to high-quality primary care. In particular, Medicare's Primary Care Incentive Payment program (PCIP) expires at the end of 2015. The PCIP provides a 10 percent bonus payment on fee schedule payments for primary care services provided by eligible primary care practitioners. Allowing the program to expire without replacement could send a poor signal to those primary care practitioners. While Medicare beneficiaries generally have good access to care now, access in the future could be at risk because of the aging of the population and health care workforce and the increased use of services by the newly insured. The Commission recommends that the additional payments to primary care practitioners continue; however, they should be in the form of a per beneficiary payment as a step away from the fee-for-service payment approach and toward beneficiary-centered payments that encourage care coordination. The per beneficiary payment would be funded in a budget-neutral manner within the fee schedule in a way that would also help rebalance payments among specialists and primary care practitioners.

I hope you find this report useful as the Congress continues to grapple with the difficult task of controlling the growth of Medicare spending while preserving beneficiaries' access to efficiently delivered high-quality care and providing equitable payment for providers.

Sincerely,

A handwritten signature in black ink, appearing to read "Glenn M. Hackbarth". The signature is fluid and cursive, with the first name "Glenn" being the most prominent part.

Glenn M. Hackbarth, J.D.

Enclosure

Acknowledgments

This report was prepared with the assistance of many people. Their support was key as the Commission considered policy issues and worked toward consensus on its recommendations.

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Executive summary

Executive summary

By law, 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 the effects of its spending on the federal budget and its share of national gross domestic product (GDP).
- evaluate payment adequacy and make recommendations concerning Medicare FFS payment policy in 2016 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 prospects 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.
- 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, per statute it focuses on the Commission's recommendations for the annual payment rate updates under Medicare's various FFS payment systems and aligning relative payment rates across those systems so that patients receive efficiently delivered, high-quality care.

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 value of those additional services. To address that problem directly, two approaches must be pursued. First, payment reforms, such as incentives to reduce 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, accountable care organizations, and MA plans—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

Part of the Commission's mandate is to consider the effect of its recommendations on the federal budget and to view Medicare in the context of the broader health care system, which we do in Chapter 1.

Historically, health care spending has risen as a share of GDP, but within the last five years its growth rate has slowed, in both the private sector and for Medicare. The cause of the system-wide slowdown is still a matter of speculation. A variety of factors could have contributed—weak economic conditions, payment and delivery system reforms, a slowdown in the introduction of new medical technologies, and a shift to less generous insurance coverage. The slowdown in Medicare is significant:

Over the past three years, per beneficiary spending grew less than 1 percent per year on average compared with a growth rate over the last four decades of about 8 percent per year on average.

Despite the slowdown in per beneficiary spending, aggregate Medicare spending is projected to increase 5 percent to 7 percent annually over the next decade as the baby-boom generation ages into Medicare. The Medicare population is projected to increase from 54 million beneficiaries today to over 80 million beneficiaries by 2030. New entrants will temporarily reduce the average age of the Medicare population, but among seniors currently entering Medicare, there is a higher prevalence of multiple chronic conditions than in the past, and as this cohort ages, the prevalence of these conditions will increase. These new beneficiaries may also enter Medicare having had types of health insurance coverage that differ from coverage in the past, and those differences may shape their choices and expectations about their Medicare benefit.

Because of the increase in aggregate spending, the imbalance between Medicare's spending and income will continue despite the recent slow growth in per beneficiary spending. The Medicare Part A Trust Fund, which is financed largely through a payroll tax, is currently estimated to become insolvent in 2030. Part B of Medicare is financed largely through general revenues and thus cannot become insolvent. However, Medicare's reliance on general revenues will increase (from 41 percent of program costs today to 45 percent of program costs in about 15 years), and as a result there will be fewer resources available to finance other federal priorities.

The growth in health care spending also affects individuals and families, including Medicare beneficiaries. Increases in private insurance premiums have outpaced the growth of family incomes over the past decade, and cost sharing for Medicare beneficiaries has increased.

Some health care spending is inefficient and wasteful. For Medicare, if such spending can be identified and eliminated, it would improve the program's fiscal sustainability, reduce federal budget pressures, and result in each Medicare dollar that is spent better improving beneficiary health.

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. As discussed in Chapter 2, an update is the amount (usually expressed as a percentage change) by which the base payment for all providers in a payment system is changed relative to the prior year. To determine an update, we first assess the adequacy of Medicare payments for providers in the current year (2015) by considering beneficiaries' access to care, the quality of care, providers' access to capital, and Medicare payments and providers' costs. (Projected Medicare payments for 2015 include the effect of the sequester, which means that if the sequester were not in effect, payments would be about 2 percentage points higher than projected.) Next, we assess how those providers' costs are likely to change in the year the update will take effect (the policy year—2016). As part of the process, we examine payments to support the efficient delivery of services consistent with our statutory mandate. Finally, we make a judgment on what, if any, update is needed. (The Commission also assesses Medicare payment systems for Part C and Part D and makes recommendations as appropriate. But because they are not FFS payment systems, they are not part of the analytic process discussed in Chapter 2.)

This year, we consider 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 services. Each year, the Commission looks at all available indicators of payment adequacy and re-evaluates any prior year assumptions using the most recent data available to make sure its recommendations 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 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 providers' costs for efficiently delivering care not only help create fiscal pressure on all 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 value of those additional services. Broader reforms such as bundled payments and accountable care organizations are meant to

stimulate delivery system reform toward more integrated and value-oriented health care systems.

The Commission also examines payment rates for similar services 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 setting would save money for Medicare, reduce cost sharing for beneficiaries, and reduce the incentive to provide services in the higher paid setting. However, putting the principle of paying the same rate for the same service across settings into practice can be complex because it requires that the definition of the services and the characteristics of the beneficiaries across settings be sufficiently similar. In March 2012, we recommended equalizing rates for evaluation and management office visits provided in hospital outpatient departments (HOPDs) and physicians' offices. Last year, we extended that recommendation to additional services provided in those two settings and recommended consistent payment between acute care hospitals and long-term care hospitals (LTCHs) for certain classes of patients. This year, we are recommending site-neutral payments to inpatient rehabilitation facilities (IRFs) for select conditions treated in both skilled nursing facilities and IRFs. The Commission will continue to analyze opportunities for applying this principle to other services and settings.

Hospital inpatient and outpatient services

The 4,700 hospitals paid under the Medicare prospective payment systems and the critical access hospital payment system received \$167 billion for 10.1 million Medicare inpatient admissions and 196 million outpatient services in 2013. Net payments per beneficiary increased 0.8 percent from 2012 to 2013, reflecting the net effect of a 1 percent decline in inpatient payments per beneficiary and a 5.5 percent increase in outpatient payments per beneficiary.

In Chapter 3, the Commission reiterates the package of changes to the Medicare hospital payment systems it previously recommended. That package consists of aligning payment rates for certain outpatient hospital services with rates paid in physician offices, creating greater equity in rates paid to acute care hospitals and LTCHs, and—in light of those two payment policy changes—increasing inpatient and outpatient payment rates based on our assessment of payment adequacy. These changes were designed to improve financial incentives in these systems while maintaining adequate overall payments.

To move toward paying equivalent rates for the same service across different sites of care, we recommended adjusting the rates paid for a selected set of services when they are provided in HOPDs so they more closely align with the rates paid in freestanding physician offices. Under current policy, Medicare usually pays more for services in outpatient departments even when those services are performed safely in physician offices for comparable patients. This payment difference creates a financial incentive for hospitals to purchase freestanding physicians' offices and convert them to HOPDs. This shift to the higher cost site of care increases program costs and costs for the beneficiary.

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 an LTCH's specialized services. To correct this problem, we recommended a new criterion for patients receiving higher level LTCH payments. Chronically critically ill (CCI) patients (defined as those who spent eight or more days in an intensive care unit during an immediately preceding acute care hospital stay) would still qualify for the relatively high LTCH payment rates. (Current law specifies a three-day threshold.) In contrast, non-CCI patients at LTCHs would receive inpatient prospective payment system (IPPS) standard 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.

Most payment adequacy indicators for acute care hospitals (including access to care, quality of care, and access to capital) are positive. However, average Medicare margins continue to be negative, and under current law they are expected to decline in 2015.

- Access measures include the capacity of providers and the volume of services. Hospitals continue to have excess inpatient capacity in most markets due to several years of declining inpatient volume. (While we have not seen evidence of material increases in Medicare discharges in 2014, some hospitals have reported increased commercial and Medicaid discharges, in part reflecting demand from newly insured individuals. Because the magnitude of the increase is small, most markets will continue to have excess capacity.) Medicare outpatient volume has increased rapidly for several years and continued to grow in 2013.

- Across all hospitals paid under the IPPS, most indicators of quality are improving.
- Access to capital in the bond and equity markets remained strong for most hospitals. Interest rates paid by most hospitals on their bond offerings continue to be low, and the equity markets continue to see hospitals as profitable investments. However, some hospitals struggling with declining volume have faced downgraded credit ratings.
- From 2007 through 2013, overall Medicare payments to IPPS hospitals were 5 percent to 7 percent below allowable Medicare costs, with an industry-wide Medicare margin of –5.4 percent in 2013. We identify a set of relatively efficient hospitals that have historically done well on a set of cost and quality metrics. These relatively efficient hospitals generated a positive overall Medicare margin of about 2 percent in 2013. However, under current law, payments are projected to decline in 2015, which could result in a lower Medicare margin of about –9 percent industry-wide.

Given the consistency between the payment adequacy indicators from last year and the payment adequacy indicators this year, the Commission reiterates its multipart recommendation package. Specifically, we recommend that the Congress direct the Secretary of Health and Human Services to do three things:

- Adjust payment rates for certain services provided in HOPDs so that they more closely align with the rates paid in physician offices for certain select services.
- Set LTCH base payment rates for non-CCI cases equal to IPPS base rates and redistribute the resulting savings to create additional inpatient outlier payments for CCI cases that are treated in IPPS hospitals. The change should be phased in over three years.
- Increase base payment rates for the acute care hospital inpatient and outpatient prospective payment systems in 2016 by 3.25 percent, concurrent with the change to the outpatient payment system discussed above and with initiating the change to the LTCH payment system.

This package of changes will improve incentives in the system to care for patients in the most appropriate setting and ensure that funding in 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 2013, Medicare paid \$68.6 billion for physician and other health professional services. About 876,000 clinicians billed Medicare—573,000 physicians and 303,000 nurse practitioners, physician assistants, therapists, chiropractors, and other practitioners.

Our measures to assess payment adequacy for physicians and other health professionals discussed in Chapter 4 are generally positive.

- Overall, beneficiary access to physician and other health professional services is adequate and largely unchanged from last year. Most beneficiaries report they are able to obtain timely appointments for routine care, illness, or injury, and most beneficiaries are able to find a new doctor without a problem. From 2011 to 2013, the growth in the number of physicians and other health professionals providing services to Medicare beneficiaries kept pace with the growth in the beneficiary population.
- Across all services, volume per beneficiary grew by 0.5 percent in 2013. Among broad categories of service, evaluation and management grew by 1.4 percent, major procedures by 1.2 percent, and other procedures by 0.1 percent, while imaging declined by 1.0 percent and tests by 2.1 percent. The declines in imaging and tests do not raise concerns about access because they follow large increases in the use of these services since 2000. Specific to imaging, the decrease in volume in part reflects a shift in billing for cardiovascular imaging from professionals' offices to hospitals.
- The Commission has been increasingly concerned that Medicare's approach to quality measurement is flawed because it relies on too many clinical process measures. Many current process measures are weakly correlated with outcomes such as mortality and readmissions, and most process measures focus on addressing the underuse of services, while the Commission believes that overuse and inappropriate use are also concerns. Thus, our ability to assess quality for this sector is limited, and the Commission will continue to refine its posture on quality measurement for clinicians.

- Medicare’s payments relative to private insurer payments have remained steady at about 79 percent. In 2012, compensation was lower for primary care physicians than for physicians in specialty groups such as radiology and for nonsurgical, procedural physicians—a disparity large enough to raise significant concerns about fee schedule pricing.

Medicare pays for the services of physicians and other health professionals using a fee schedule, and total payments in a year are limited in principle by the sustainable growth rate (SGR) formula. Due to years of volume growth exceeding the SGR limits and legislative and regulatory overrides of negative updates, an estimated fee reduction of 21.2 percent is scheduled to take effect on April 1, 2015. Except for a 4.8 percent reduction in 2002, however, such reductions—called for in previous years by the SGR formula’s spending limits—have not been implemented.

Because this year’s payment adequacy findings are largely similar to the findings from prior years, the Commission reiterates its long-standing position that the SGR should be repealed. The budgetary cost of repeal remains near historic lows, providing a clear opportunity. Our recommendations for SGR reform are as follows:

- Repeal the SGR and replace it with a 10-year path of legislated updates, with higher updates for primary care services than for other services.
- Collect data to improve the relative valuation of services.
- Identify overpriced services and rebalance payments.
- Encourage accountable care organizations by creating greater opportunities for shared savings.

An additional issue is that Medicare’s Primary Care Incentive Payment program (PCIP) expires at the end of 2015. The PCIP provides a 10 percent bonus payment on fee schedule payments for primary care services provided by eligible primary care practitioners. Allowing the program to expire without replacement could send a poor signal to those primary care practitioners. While Medicare beneficiaries generally have good access to care now, future access could be at risk because of the aging of the population and the health care workforce and because of the increased use of services by the newly insured. The Commission recommends that the additional payments to primary care practitioners should continue; however, they should be in the form of a per beneficiary payment

as a step away from the fee-for-service payment approach and toward beneficiary-centered payments that encourage care coordination. The Commission recommends funding the per beneficiary payment by reducing fees for all services in the fee schedule other than PCIP-defined primary care services (those services could be provided by any practitioner, regardless of specialty designation or whether those services accounted for at least 60 percent of the practitioner’s allowed charges). Beneficiaries would not pay cost sharing, just as beneficiaries do not pay cost sharing to fund the PCIP. This method of funding would be budget neutral and would help rebalance the fee schedule to achieve greater equity of payments between primary care and other services.

Ambulatory surgical center services

Ambulatory surgical centers (ASCs) provide outpatient procedures to patients who do not require an overnight stay after the procedure. In 2013, 5,364 ASCs treated 3.4 million FFS Medicare beneficiaries, and Medicare program and beneficiary spending on ASC services was \$3.7 billion.

Our analysis in Chapter 5 finds that our indicators of payment adequacy for ASC services are positive.

- Beneficiaries’ access to ASC services is adequate. In 2013, the number of Medicare-certified ASCs increased by 1.1 percent (the vast majority of new ASCs were for profit) and the volume of services per beneficiary increased by 0.5 percent. The relatively slow growth may be related to the fact that Medicare payment rates for most ambulatory procedures are higher for HOPDs than for ASCs. This payment difference may help explain why several hospitals have recently expanded their outpatient surgery capacity while growth in the number of ASCs has slowed relative to previous years.
- ASCs began submitting data on quality measures to CMS in October 2012. However, there is not yet sufficient information to assess the quality of ASC care or how it has changed over time.
- Because the number of ASCs has continued to increase, access to capital appears to be adequate.
- Medicare payments per FFS beneficiary increased by 2 percent in 2013. 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 help assess payment adequacy.

On the basis of these indicators, the Commission concludes that ASCs can continue to provide Medicare beneficiaries with access to ASC services with no update to the payment rates for 2016. In addition, we recommend that CMS begin collecting cost data from ASCs without further delay.

Outpatient dialysis services

Outpatient dialysis services are used to treat the majority of individuals with end-stage renal disease (ESRD). In 2013, about 376,000 ESRD beneficiaries on dialysis were covered under FFS Medicare and received dialysis from about 6,000 dialysis facilities; Medicare expenditures for outpatient dialysis services were \$11 billion, a 3 percent increase from 2012.

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

- Dialysis facilities appear to have the capacity to meet demand. Growth in the number of dialysis treatment stations has generally kept pace with growth in the number of dialysis beneficiaries. At the same time, the per treatment use of most dialysis injectable drugs, including erythropoiesis-stimulating agents that are used in anemia management, continued to decline, but at a lower rate than between 2011 and 2012. The new dialysis prospective payment system (PPS) created an incentive for providers to be more judicious about their provision of dialysis drugs.
- Quality is improving for some measures. Between 2010 and 2013, rates of mortality and hospitalization declined. There is also increased use of home dialysis, which is associated with improved patient satisfaction and quality of life.
- 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.
- Between 2012 and 2013, providers' cost per treatment increased by 1.0 percent, while Medicare payment per treatment increased by about 1.5 percent. We estimate that the aggregate Medicare margin was 4.3 percent in 2013, and the projected Medicare margin is 2.4 percent in 2015.

The evidence suggests that payments are adequate; the Commission recommends that the Congress eliminate the update to the outpatient dialysis payment rate for 2016.

Medicare's post-acute care: Trends and ways to rationalize payments

Post-acute care (PAC) providers offer important recuperation and rehabilitation services to Medicare beneficiaries recovering from an acute hospital stay. PAC providers include skilled nursing facilities (SNFs), home health agencies (HHAs), IRFs, and LTCHs. Medicare's payments to the over 29,000 PAC providers totaled \$59 billion in 2013, more than doubling since 2001. Chapter 7 looks at opportunities for reforming the PAC payment systems.

The Commission has frequently observed that Medicare's payments for PAC are too high. The high level of payments results from base rates that are too generous relative to the actual cost of services and from providers exploiting the shortcomings of the payment systems to maximize revenues. Biases in the HHA and SNF PPSs make certain patients, and the services provided to them, more profitable than others. In addition, despite large increases in program spending over a decade, quality of care has not greatly improved—raising questions about the value of the program's purchases. Medicare has a responsibility to improve its payment systems to ensure access for beneficiaries, appropriately reimburse providers for the patients they treat, and control costs.

The Commission's concerns about PAC go beyond the deficiencies of the setting-specific payment systems. The need for PAC is not well defined. Similar patients are treated in different settings at widely varying cost to the Medicare program, and placement decisions often involve a variety of nonclinical factors. Reflecting this ambiguity, Medicare per capita spending on PAC varies across markets more than any other service.

Because of the overlap in patients and services across settings, Medicare ideally would pay for PAC using one payment system based on patient characteristics, not on the site of service. Such fundamental payment reform within FFS Medicare is on the distant horizon. The Commission recommended that CMS collect uniform patient assessment data from the PAC settings to enable more complete comparisons of providers' costs and outcomes. Under the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014, PAC

providers will begin collecting uniform assessment data in 2018. After the Secretary of Health and Human Services has collected two years of data, she is required to submit a report to the Congress recommending a uniform payment system for PAC. Implementing a uniform PAC payment system will be complex; 2023 would be an optimistic target for full implementation. The Act also requires the Commission to develop a prototype prospective payment system spanning the PAC settings and submit a report in 2016.

In the near term, the Commission maintains that Medicare can and should move in the direction of uniform payments by aligning payments across settings for select conditions. The Commission used criteria to identify conditions that may be appropriate for site-neutral payments between IRFs and SNFs. For the select conditions, the majority of cases are treated in SNFs and the risk profiles of patients treated in IRFs and SNFs are similar, yet Medicare's payments made to IRFs are considerably higher than those made to SNFs. To ensure that it proceeded cautiously, the Commission also compared the outcomes for patients treated in both settings and did not find consistent differences.

The Commission recommends that the Congress direct the Secretary to establish site-neutral payments between IRFs and SNFs for select conditions, using criteria such as those described in Chapter 7. For the selected conditions, the Commission recommends that the IRF base rate be set equal to the average SNF payment per discharge for each condition (additional payments that many IRFs receive are not changed by this policy). The policy should be implemented over three years. As part of the policy, IRFs should be relieved from the regulations governing the intensity and mix of services for the site-neutral conditions. This report includes an illustrative policy based on the Commission's criteria; however, CMS should use its rule-making process to first propose criteria to select conditions appropriate for a site-neutral payment policy and then identify the selected conditions. In this way, the Secretary can gather input from key stakeholders.

Skilled nursing facility services

SNFs provide short-term skilled nursing and rehabilitation services to beneficiaries after a stay in an acute care hospital. In 2013, almost 15,000 SNFs furnished 2.4 million Medicare-covered stays to 1.7 million FFS beneficiaries. Medicare FFS spending on SNF services was \$28.8 billion in 2013.

Our measures of payment adequacy discussed in Chapter 8 indicate that Medicare payments to SNFs are adequate. We also find that relatively efficient SNFs—facilities identified under our current definition of providing relatively high-quality care at relatively low costs—had very high Medicare margins (over 20 percent), suggesting that opportunities remain for other SNFs to achieve greater efficiencies.

- Access to SNF services remains adequate for most beneficiaries. The number of SNFs participating in the Medicare program is stable. 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. Days and admissions per FFS beneficiary declined between 2012 and 2013, consistent with declines in inpatient hospital admissions (a three-day inpatient stay is required for Medicare coverage of SNF services).
- Quality measures show mixed performance. Between 2012 and 2013, the community discharge and readmission measures improved, and the functional change measures were essentially unchanged.
- Because most SNFs are part of a larger nursing home, we examine nursing homes' access to capital. Access to capital was adequate in 2013 and is expected to remain so. Medicare is regarded as a preferred payer for SNF services.
- In 2013, the average Medicare margin was 13.1 percent—the 14th year in a row that the average was above 10 percent. Margins continued 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. The projected 2015 Medicare margin is 10.5 percent.
- In 2013, about 500 freestanding facilities provided relatively low-cost and high-quality care over 3 consecutive years and had Medicare margins averaging over 20 percent.

In 2012, the Commission recommended, first, restructuring the SNF payment system to strike a better balance between paying for therapy and nontherapy ancillary (NTA) services (such as drugs), and then rebasing the payment system. During the year of revision, payment rates would be held constant (no update). The Commission recommended three revisions to improve the accuracy of payments: base payments for therapy

services on patient characteristics, establish a separate NTA component specifically to adjust for differences in patients' needs for these services, and add an outlier policy to the PPS. In the year following the PPS revision, CMS would begin a process of rebasing payments, starting with a 4 percent reduction in payments.

The factors examined to assess payment adequacy indicate that the circumstances of the SNF industry have not changed materially during the past year, yet the urgency for change remains. Therefore, the Commission reiterates its two-part recommendation to revise and rebase the SNF payment system. In the first year (2016), there would be no update to the base payment rate while the PPS was revised and, in year two (2017), payments would be lowered by an initial 4 percent. In subsequent years, the Commission would evaluate whether continued reductions were necessary to further align payments with costs.

In its deliberations, the Commission discussed the possibility of recommending an immediate rebasing, followed by the implementation of a revised PPS and subsequent further rebasing. This revised sequence reflects the lack of progress in improving the accuracy of Medicare's payments and lowering the level of the program's payments. An initial reduction could spark interest in revising the PPS so that subsequent reductions are taken from a more equitable distribution of payments across providers. Over the coming year, the Commission will explore this alternative.

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 remained essentially unchanged between 2013 and 2014. In 2013, the average total margin, reflecting all payers and all lines of business, was 1.9 percent. The average non-Medicare margin was -1.9 percent.

Home health care services

Home health agencies provide services to beneficiaries who are homebound and need skilled nursing or therapy. In 2013, about 3.5 million Medicare beneficiaries received care, and the program spent about \$17.9 billion on home health services. The number of agencies participating in Medicare reached 12,613 in 2013.

The indicators of payment adequacy for home health care discussed in Chapter 9 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 2013, the number of agencies continued to increase, with a net gain of 302 agencies. Most new agencies were concentrated in a few states, and for-profit agencies accounted for the majority of new providers. After years of rapid increases (between 2002 and 2013, the total number of episodes increased by 65 percent), the volume of services declined slightly in 2013. This trend is not surprising because Medicare inpatient admissions, an important source of referrals, have declined.
- Performance on quality measures did not change significantly. The share of beneficiaries reporting improvement in walking increased slightly in 2013, and the share of beneficiaries reporting improvement in transferring declined slightly. The share of beneficiaries hospitalized during their home health spell was 27.5 percent, similar to the rate in prior years.
- Access to capital is a less important indicator of Medicare payment adequacy for home health care because the service is less capital intensive than other health care sectors. The significant number of new agencies in 2013 suggests that adequate capital is available for start-ups.
- For more than a decade, payments have consistently and substantially exceeded costs in the home health prospective payment system. Medicare margins for freestanding agencies averaged 12.7 percent in 2013 and averaged 17 percent between 2001 and 2013. The Commission estimates that the Medicare margin for 2015 will be 10.3 percent.

In light of these findings, the Commission reiterates its prior recommendations for home health. First, the Commission recommended that the payment rate be rebased to reflect current use and better align Medicare's payments with the actual costs of providing home health services. The high margins of HHAs since the start of the PPS in 2001 indicate that the payment rates assumed more services than were actually provided. Second, we recommended that the home health PPS not use the number of therapy visits provided as a payment factor.

The trends in use and agency profit margins suggest that the financial incentive for therapy use has encouraged providers to favor therapy-intensive episodes. Third, the Commission recommended that Medicare establish a copay for episodes not preceded by a hospitalization to encourage appropriate use of these services. The volume of episodes of home health for patients residing in the community—episodes not preceded by a prior hospitalization—has more than doubled since 2001. This increase suggests there is significant potential for overuse, particularly since Medicare does not currently require any cost sharing for home health care.

Inpatient rehabilitation facility services

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, and speech–language pathology, as well as prosthetic and orthotic devices. In 2013, Medicare spent \$6.8 billion on IRF care provided in about 1,160 IRFs nationwide. About 338,000 beneficiaries had more than 373,000 IRF stays. On average, Medicare accounts for about 61 percent of IRFs’ discharges.

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

- Our analysis of IRF supply and volume of services provided suggests that capacity remains adequate to meet demand. Between 2012 and 2013, the number of IRFs remained fairly steady at just over 1,160 providers. The average IRF occupancy rate has hovered around 63 percent for the past several years, indicating that capacity is more than adequate to handle current demand for IRF services. Between 2012 and 2013, the number of Medicare cases treated in IRFs was stable at about 373,000 cases.
- All measures of IRF quality that the Commission tracks showed small improvements between 2011 and 2013.
- One major freestanding IRF chain that accounted for almost 40 percent of all freestanding IRFs in 2013 and about a quarter of all IRF discharges have 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 IRFs have maintained reasonable access to capital.

- In 2013, the aggregate Medicare margin remained steady at 11.4 percent. Financial performance continues to vary across IRFs, with margins of freestanding IRFs far exceeding those of hospital-based facilities. We project that IRFs’ aggregate Medicare margin will be 12.6 percent in 2015.

Based on these indicators, the Commission concludes that IRFs can continue to provide Medicare beneficiaries with access to safe and effective care with no update to the payment rates in fiscal year 2016. Our recommendation assumes that site-neutral payments for IRFs and SNFs, which would affect IRF revenues, will not be implemented in fiscal year 2016 (see Chapter 7).

Long-term care hospital services

LTCHs provide 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 its Medicare patients must have an average length of stay greater than 25 days. In 2013, Medicare spent \$5.5 billion on care provided in LTCHs nationwide. About 122,000 beneficiaries had roughly 138,000 LTCH stays. On average, Medicare accounts for about two-thirds of LTCHs’ discharges. Our findings on LTCH payment adequacy are discussed in Chapter 11.

- Trends suggest that access to care has been maintained. We estimate that the number of LTCHs and LTCH beds decreased about 1 percent in 2013. From 2012 to 2013, the number of LTCH cases decreased by 1.9 percent (2.2 percent per capita). This reduction in per capita admissions is consistent with that seen in other inpatient settings.
- LTCHs only recently began submitting quality of care data to CMS. Those data are not yet available for analysis. Using claims data, we found stable or declining unadjusted rates of readmission, death in the LTCH, and death within 30 days of discharge for almost all of the top 25 diagnoses in 2013.
- Access to capital is a limited measure at this time because the current moratorium on new beds and facilities continues to limit future opportunities for growth and reduces the need for capital.
- Since 2007, LTCHs have held cost growth below the rate of increase in the market basket index, a measure of inflation in the prices of goods and services LTCHs buy to provide care. LTCHs had an aggregate 2013

Medicare margin of 6.6 percent compared with 7.4 percent in 2012. We project that LTCHs' aggregate Medicare margin will be 4.6 percent in 2015.

Based on these indicators, the Commission concludes that LTCHs can continue to provide Medicare beneficiaries with access to safe and effective care and accommodate changes in cost with no update to the payment rates for cases in LTCHs in fiscal year 2016.

Hospice services

The Medicare hospice benefit covers palliative and support services for beneficiaries who are terminally ill and who have a life expectancy of six months or less. Beneficiaries may choose to elect the Medicare hospice benefit; in so doing, they agree to forgo Medicare coverage for conventional treatment of their terminal condition. In 2013, more than 1.3 million Medicare beneficiaries (including 47 percent of decedents) received hospice services from over 3,900 providers, and Medicare hospice expenditures totaled about \$15.1 billion.

The indicators of payment adequacy for hospices discussed in Chapter 12 are positive.

- The number of hospice providers increased by more than 5 percent in 2013, almost entirely because of growth in the number of for-profit hospices. Hospice use among Medicare beneficiaries has grown substantially in recent years, suggesting greater awareness of and access to hospice services. The proportion of beneficiaries using hospice services at the end of life continued to grow, and average length of stay changed little in 2013.
- At this time, we do not have data to assess the quality of hospice care provided to Medicare beneficiaries. However, the Patient Protection and Affordable Care Act of 2010 mandated that a hospice quality reporting program begin by fiscal year 2014, and hospices have begun to report data on quality measures to CMS.
- 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 9.6 percent increase in 2013) suggests capital is readily available to for-profit 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 Medicare margin was 10.1 percent in 2012, up from 8.8 percent in 2011. The projected margin for 2015 is 6.6 percent.

Assessing these payment adequacy indicators, the Commission judges that hospices can continue to provide beneficiaries with appropriate access to care with no update to the base payment rate in fiscal year 2016.

The Commission is also reiterating two recommendations made previously because the issues that led to those recommendations persist. First, we recommend that the hospice payment system be reformed to better match the service intensity throughout a hospice episode (higher per diem payments at the beginning of the episode and at the end of the episode near the time of death and lower in the middle). Medicare's hospice payment is not aligned well with the costs of providing care throughout a hospice episode, and as a result, long hospice stays are more profitable than short stays. Second, we recommend focused medical review of hospice providers with many long-stay patients. In our view, implementation of these recommendations would result in substantial improvements to the hospice payment system and accountability for the hospice benefit.

The Medicare Advantage program: Status report

In Chapter 13, the Commission provides a status report on the MA program. In 2014, the program included 3,600 plan options, enrolled more than 15.8 million beneficiaries (30 percent of all beneficiaries), and paid MA plans about \$159 billion to cover Part A and Part B services. The MA program gives Medicare beneficiaries the option of receiving benefits from private plans rather than the traditional FFS Medicare program. The Commission supports the inclusion of private plans in the Medicare program; beneficiaries should be able to choose between the traditional FFS Medicare program and alternative delivery systems that private plans can provide. Because Medicare pays private plans a per person predetermined rate rather than a per service rate, plans have greater incentives to innovate and use care-management techniques.

The Commission has emphasized the importance of imposing fiscal pressure on all providers to improve efficiency and reduce Medicare program costs. For MA, the Commission recommended that benchmarks (Medicare's maximum payment rate in a county for MA plans) be brought down from previous high levels and be set so that the payment system would be neutral and not

favor either MA or the traditional FFS program. Recent legislation has reduced the inequity in Medicare spending between MA and FFS. As a result, over the past few years, plan bids and payments have come down in relation to FFS spending while enrollment in MA continues to grow. The pressure of competitive bidding and lower benchmarks 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.

- Access to MA plans remains high in 2015. Overall, 99 percent of all Medicare beneficiaries have access to an MA plan, and 95 percent have an HMO or local preferred provider organization plan operating in their county of residence.
- Between 2013 and 2014, enrollment in MA plans grew by about 9 percent (or 1.3 million enrollees) to 15.8 million enrollees. About 30 percent of all Medicare beneficiaries were enrolled in MA plans in 2014, up from 28 percent in 2013. Among plan types, HMOs—with 10.4 million enrollees—continue to have the highest share of MA enrollment.
- We estimate that 2015 MA benchmarks (including quality bonuses), bids, and payments will average 107 percent, 94 percent, and 102 percent of FFS spending, respectively. The average net bid did not increase between 2014 and 2015.
- For the first time, we use historical data reported by plans in their MA bids to report on plan margins. The analysis shows that, on average, MA plans in 2012 had a margin of 4.9 percent. Plan sponsors reporting a positive margin accounted for about 91 percent of MA enrollment. There were differences by plan type: employer group plans had higher margins than plans for individual Medicare beneficiaries; for-profit plans had higher margins than nonprofit plans; and special needs plans (SNPs) generally had higher margins than non-SNP plans, except that nonprofit SNP plans reported a slight negative margin.

Medicare payments to plans for an enrollee are based on the plan's payment rate and the enrollee's risk score. The risk scores are based on diagnoses attributed to the beneficiary during the year before the payment year. To receive the maximum payment, plans have an incentive to ensure that providers record all diagnoses. Analyses have shown that MA plan enrollees have higher risk

scores than otherwise similar FFS beneficiaries because of more complete coding. As mandated by the Deficit Reduction Act of 2005, CMS makes an across-the-board adjustment to the scores to make them more consistent with FFS coding practices. We find that CMS would have to increase the coding adjustment (i.e., lower risk scores) by about 3 percent to make the aggregate level of coding in the FFS and MA programs roughly equal.

The Congress instituted a quality bonus program for MA in the Patient Protection and Affordable Care Act of 2010, with bonuses available beginning in 2012. MA plans are able to receive bonus payments if they achieve an overall rating of 4 stars or higher on CMS's 5-star rating system. For plans receiving ratings for both 2014 and 2015, there was virtually no difference between average star ratings for 2014 (3.88) and the ratings for 2015 (3.91). MA quality indicators relative to last year show improvement or no change for many measures, but a decline in mental health measures. We note that only a subset of measures is included in determining the overall star rating, and for that subset, the majority improved. If including measures in the star ratings makes them more likely to improve, it may be reasonable to include the mental health measures that have been declining for several years.

CMS data show that in 2012, about 10 percent of beneficiaries voluntarily changed their MA plan. Of that number, 80 percent chose another MA plan and the remaining 20 percent went to FFS Medicare—meaning that only 2 percent of MA enrollees left MA for FFS. Among the switchers who were faced with changes in plan premiums, the large majority switched to a plan with a lower premium.

Medicare's Plan Finder website helps Medicare beneficiaries choose among plans based on cost and quality. However, the display of premium information for plans offering a reduction in the Part B premium could be improved to make beneficiaries more aware of the existence of such an option and its associated effect on their total out-of-pocket costs.

Status report on Part D

In Chapter 14, the Commission provides a status report on the Medicare prescription drug benefit (Part D). In 2013, Medicare spent almost \$65 billion for the Part D benefit. Monthly premiums averaged about \$29, but individually, the premium beneficiaries paid varied by their plan, level

of income and assets, and whether they were subject to Part D's late enrollment penalty.

In 2014, over 37 million Medicare beneficiaries (about 69 percent) were enrolled in Part D. Of these, more than 11 million received the low-income subsidy (LIS). An additional 5 percent received drug coverage through employer-sponsored plans that receive Medicare's retiree drug subsidy, and about 14 percent received coverage that was at least as generous as Part D from other sources. As of 2012, 12 percent of beneficiaries had no drug coverage or coverage less generous than Part D.

Of those enrolled in Part D, 62 percent were in stand-alone prescription drug plans (PDPs) and the rest in Medicare Advantage–Prescription Drug plans (MA–PDs). In 2015, plan sponsors are offering 1,001 PDPs and 1,608 MA–PDs. The number of PDPs decreased 14 percent from 2014, while the number of MA–PDs remained stable. PDP sponsors appear to be consolidating their plan offerings into a smaller number of more widely differentiated products. Even with these consolidations, beneficiaries have between 24 and 33 PDPs to choose from and many MA–PDs. MA–PDs continue to be more likely than PDPs to offer enhanced benefits, but a smaller share is offering gap coverage compared with previous years. For 2015, 283 premium-free PDPs are available to enrollees who receive the LIS, a 20 percent decline from 2014. Despite this decrease, all regions of the country have at least 4 and as many as 12 PDPs available at no premium to LIS enrollees.

An increasing number of plans use two cost-sharing tiers for generic drugs: a preferred one with lower cost sharing and a nonpreferred one that, in some cases, comes with substantially higher cost sharing. In addition, in 2015 nearly 90 percent of PDPs offer lower cost sharing at preferred pharmacies. Both of these strategies provide financial incentives for enrollees to use lower cost drugs or providers, potentially reducing program costs for basic benefits. However, a risk is that these approaches could increase Medicare's spending for the LIS or affect access to needed medications for some beneficiaries.

Between 2007 and 2013, Part D spending increased from \$46.7 billion to \$64.9 billion (an average annual growth rate of about 6.7 percent). In 2013, LIS payments continued to be the single largest component of Part D spending, while Medicare's reinsurance payments to plans remained the fastest growing component, at an average annual rate of about 16 percent between 2007 and 2013. Program spending for Part D reflects two underlying

trends. First, a large number of patent expirations on widely used brand-name drugs has led to a shift toward use of generics in Part D, with generic drugs accounting for 81 percent of all prescriptions filled in 2012 compared with 61 percent in 2007. Second, the pharmaceutical pipeline is shifting toward greater numbers of biologic products and specialty drugs, many of which have few therapeutic substitutes and high prices. In 2012, the share of enrollees who incurred spending high enough to reach the catastrophic phase of Part D's benefit decreased slightly. However, the share of high-cost enrollees who filled prescriptions for biologic products rose. The use of high-priced drugs by Part D enrollees will likely grow and put significant upward pressure on Medicare spending for individual reinsurance and for the LIS.

Most Part D enrollees appear to have good access to prescription drugs: In 2012, 5 percent reported having trouble obtaining needed medications. Data show that the number of drug claims that are rejected at the pharmacy counter is relatively low (4 percent), and claims that subsequently go through Part D's exceptions and appeals process is lower still. At the same time, CMS has conducted audits that have found some compliance issues with formulary administration, claims adjudication, and appeals. We are unable to determine whether low rates of claims rejections and appeals are cause for concern. In some cases, claims are rejected for valid reasons, such as ensuring patient safety. However, a low appeals rate could reflect a lack of transparency in the appeals process or excessive administrative burden on enrollees and prescribers.

The average quality rating among Part D plans has increased. For 2015, the share of enrollees in high-performing plans (rated 4 or more stars out of the possible 5) is expected to increase to more than 50 percent among PDP enrollees and about 60 percent among MA–PD enrollees. Newly released data on Part D's medication therapy management programs (MTMPs) show that, in 2012, 3.1 million enrollees (about 11 percent of Part D enrollees) participated in an MTMP. Participation rates varied across plans, and only about 10 percent of MTMP enrollees received a comprehensive medication review. ■

CHAPTER

1

Context for Medicare payment policy

Context for Medicare payment policy

Chapter summary

Part of the Commission’s mandate is to consider the effect of its recommendations on the federal budget and to view Medicare in the context of the broader health care system. To help meet its mandate, this chapter examines health care spending growth—for the nation at large and Medicare in particular—and considers its effect on the federal budget as well as individuals and families. This chapter also reviews in detail the profile of the Medicare beneficiary, evidence of wasteful health care spending, and structural features of the Medicare program that contribute to wasteful spending.

Historically, health care spending has risen as a share of gross domestic product (GDP), but within the last five years its growth rate has slowed, in both private sector and Medicare spending. This slowdown, however, came after a significant increase in spending. As a share of GDP, Medicare spending went up by a factor of almost five from 1973 through 2013, increasing from 0.8 percent to 3.5 percent, and has stayed constant as a share of GDP for only the past four years.

The cause of the system-wide slowdown in spending growth is still a matter of speculation. A variety of factors could have contributed—weak economic conditions, payment and delivery system reforms, a slowdown in the introduction of new medical technologies, and a shift to less generous

In this chapter

- National health care spending
- Medicare spending
- Medicare’s financing challenge
- Health care spending consumes growing shares of federal and state budgets and the budgets of individuals and families
- Changes in the Medicare-eligible population
- How quickly will health care spending grow in the coming years?
- Conclusion

insurance coverage. The slowdown in Medicare is significant: Over the past three years, per beneficiary spending grew less than 1 percent per year on average, declining from a growth rate over the last four decades of about 8 percent per year on average.

Despite the slowdown in per beneficiary spending, aggregate Medicare spending is projected to increase 5 percent to 7 percent annually over the next decade as the baby-boom generation ages into Medicare. Over the next few years, both the Medicare Trustees and the Congressional Budget Office project growth in spending per beneficiary to rebound somewhat from the recent very low rates but remain below the high rates of the past several decades.

The persistent imbalance between Medicare's spending and income remains despite the recent slow growth in per beneficiary spending. Part A of Medicare, which is financed largely through a payroll tax, is currently estimated to become insolvent in 2030. Part B of Medicare is financed largely through general revenues and thus cannot become insolvent. However, Medicare's reliance on general revenues will increase (from 41 percent of program costs today to 45 percent of program costs in about 15 years), and as a result there will be fewer resources available to finance other federal priorities and greater pressure to reduce spending or increase taxes. The overall budget picture will continue to shift from other priorities to Medicare, Medicaid, Social Security, and other health spending.

The growth in health care spending also affects individuals and families, including Medicare beneficiaries. Increases in private insurance premiums have outpaced the growth of family incomes over the past decade, and cost sharing for Medicare beneficiaries has also increased.

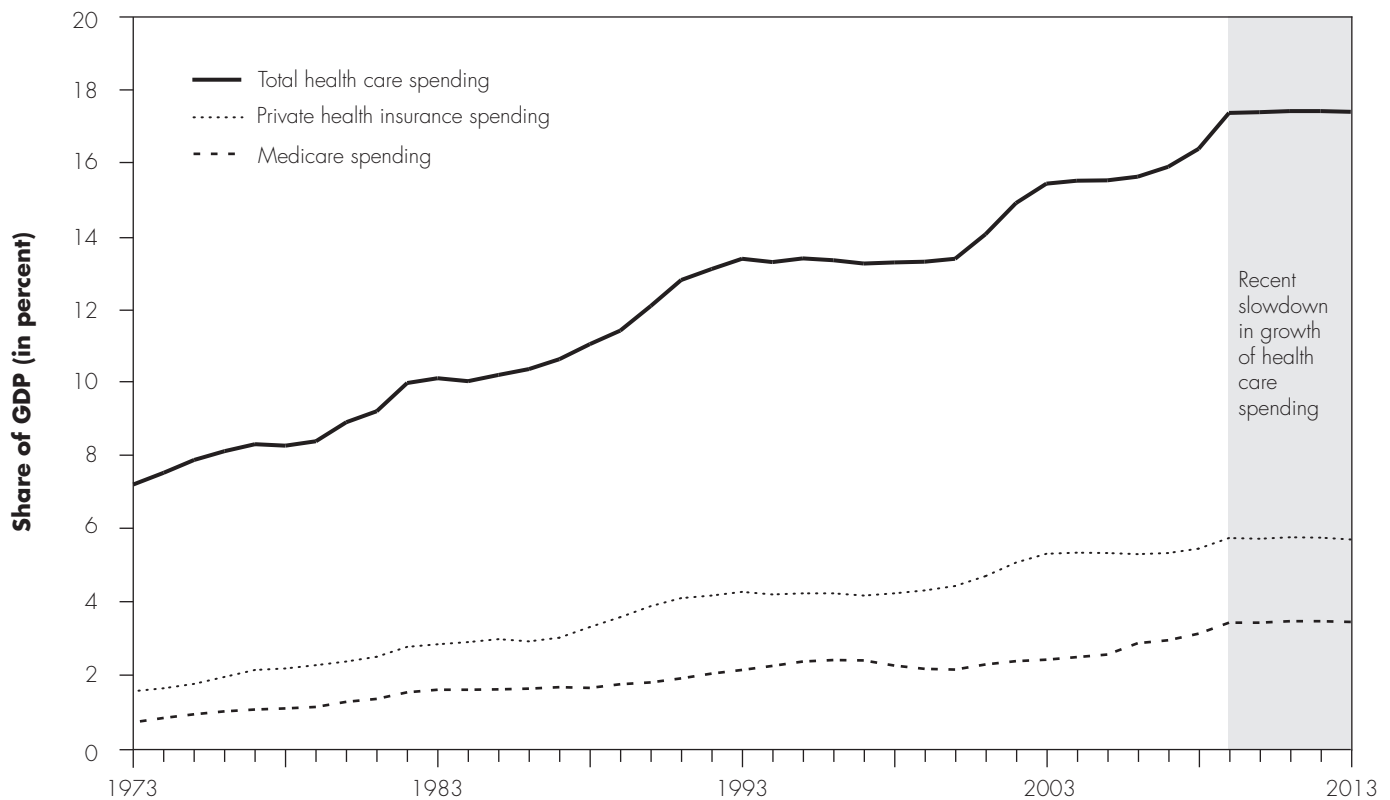
The Medicare population is projected to increase from 54 million beneficiaries today to over 80 million beneficiaries by 2030, significantly changing the population's makeup. Among seniors currently entering Medicare, there is a higher prevalence of multiple chronic conditions than in the past, and as this cohort ages, the prevalence of these conditions will increase. These new beneficiaries may also enter Medicare having had types of health insurance coverage that differ from coverage in the past, and those differences may shape beneficiaries' choices and expectations about their Medicare benefit.

Some health care spending is inefficient and wasteful. For Medicare, if such spending can be identified and eliminated, it would improve the program's fiscal sustainability, reduce federal budget pressures, and result in each Medicare dollar that is spent better improving beneficiary health. Another important consideration

in setting payment policy is evidence of the relationship between the level of spending and increases in health care spending and health care outcomes. Over time, outcomes for the overall population (such as life expectancy) have improved, although questions remain about the value of the marginal health care dollar. Certain structural features of the Medicare program pose challenges for targeting wasteful spending, and the Commission has made recommendations to address those challenges. ■

**FIGURE
1-1**

Historically, health care spending has risen as a share of GDP; recently, its growth has slowed



Note: GDP (gross domestic product). Total health care spending is the sum of all private and public spending. Medicare spending is one component of all public spending.

Source: MedPAC analysis of National Health Expenditures Accounts from CMS 2014.

Introduction

The Medicare program lies at the junction between the national health care system as a whole and the federal government. For this reason, it is important to review the following context in which Medicare operates to understand the payment policies discussed in the rest of this report:

- national health care spending and Medicare spending;
- impact of Medicare spending on the federal budget;
- effects of health care spending growth on individuals and families;
- current and future Medicare beneficiary populations; and
- health care spending drivers and wasteful spending.

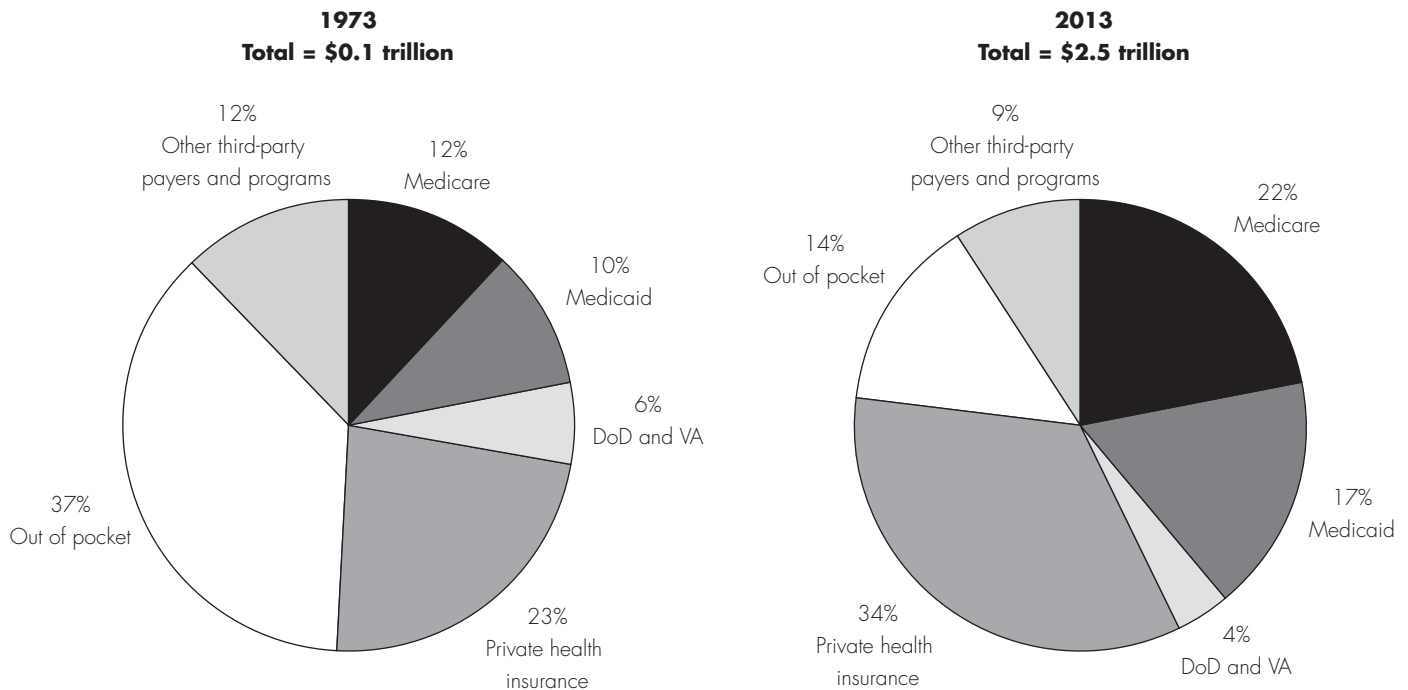
This chapter also reviews the challenges that Medicare in particular faces and the Commission's principles for constructing sound recommendations to address those challenges.

National health care spending

Historically, health care spending has risen every year as a share of gross domestic product (GDP), but recently its growth rate has slowed. That general trend is true for health care spending by private sector payers as well as Medicare (Figure 1-1). As a share of GDP, total health care spending more than doubled from 1973 to 2013, increasing from 7.2 percent to 17.4 percent. As a share of GDP, private health insurance spending more than tripled over that same time period, from 1.6 percent to 5.7 percent. Medicare spending as a share of GDP went

**FIGURE
1-2**

Out-of-pocket spending's share of personal health care spending declined while private and federal health insurance spending's share increased, 1973-2013



Note: DoD (Department of Defense), VA (Department of Veterans Affairs). Private health insurance accounted for a greater share of spending than Medicare (34 percent vs. 22 percent in 2013), but private health insurance is not a single purchaser of health care; it includes many private plans such as traditional managed care, self-insured health plans, and indemnity plans. "Out-of-pocket spending" includes cost sharing for both privately and publicly insured individuals. Premiums are included in the shares of each program (e.g., Medicare, private insurance) rather than in the out-of-pocket share category. Medicaid includes the Children's Health Insurance Program. "Other third-party payers and programs" includes worksite health care, other private revenues, Indian Health Service, workers' compensation, general assistance, maternal and child health, vocational rehabilitation, other federal programs such as the Substance Abuse and Mental Health Services Administration, other state and local programs, and school health.

Source: MedPAC analysis of National Health Expenditures Accounts from CMS 2014.

up by a factor of almost five, increasing from 0.8 percent to 3.5 percent. However, as seen in Figure 1-1, health care spending as a share of GDP has remained relatively constant for the past several years (Centers for Medicare & Medicaid Services 2014).

Health care spending that rises faster than GDP is generally considered unsustainable because it cannot ultimately consume the entire economy and replace the consumption of all other goods and services. However, which factors drove spending to rise faster than GDP is not well understood. The emergence and increasing use of new medical technologies, rising personal income, declining share of health care costs that people paid out of pocket, and market power of providers and insurers appear to have all played a role (Cutler 1995, Newhouse 1992, Smith et al. 2009). The recent slowdown in the

rate of growth in health care spending also has not been fully explained. Contributing factors could include weak economic conditions, payment and delivery system reforms, a slowdown in the introduction of new medical technologies, and increasing use of generic drugs as top-selling brand drugs lose patent protection.

To better understand who is paying for health care, we focus on personal health care spending—all medical goods and services provided for an individual's treatment. Often, spending by several types of payers and programs combine to pay for an individual's health care, including out-of-pocket spending, public and private health insurance, and other third-party payers and programs. Personal health care spending excludes spending on government public health activities (e.g., epidemiological surveillance and disease prevention programs), administration of private

and public health insurance, and investments in medical research, equipment, and structures. In 2013, personal health care spending accounted for 85 percent of total health care spending.

Over the past four decades, total personal health care spending increased from \$0.1 trillion to \$2.5 trillion. On a per person basis, spending increased from \$397 in 1973 to \$7,826 in 2013, an 8 percent increase per year on average. During this period, out-of-pocket spending (e.g., cost sharing, deductibles, and health care services not covered by insurance) as a share of total personal health care spending declined from 37 percent to 14 percent, while the shares accounted for by private health insurance, Medicare, and Medicaid all increased (Figure 1-2). At the same time, Medicare has remained the largest single purchaser of health care in the United States (Centers for Medicare & Medicaid Services 2014).¹

In 2013, Medicare covered 52 million people, Medicaid covered 59 million people, private health insurance covered 189 million people, and about 44 million people were uninsured (Boards of Trustees 2014, Centers for Medicare & Medicaid Services 2014). Some people have coverage from more than one source. In 2013, 11.1 million people were enrolled in both Medicare and Medicaid (Boards of Trustees 2014). Medicaid pays for either a portion or all of the Medicare premium and out-of-pocket health care expenses for those enrollees who qualify for dual enrollment based on limited income and resources. Enrollees in private health insurance may also be enrolled in other third-party health insurance programs. For example, Medicare beneficiaries may also have supplemental insurance sold by private companies.

The decline in the share of health care spending paid directly out of pocket by individuals and the increase in the share of health care spending paid by private and public insurance do not mean that people have experienced similar declines in the share of the health care costs they pay. First, people also pay premiums, which are not included in the out-of-pocket category but, rather, the private health insurance and Medicare categories. Second, people receive lower salaries and reduced benefits in exchange for employer-sponsored health insurance. When an employer contributes to premiums, most economists agree that salary and other benefits are reduced to offset the employer contribution.

In 2013 as well as in 1973, the largest shares of personal health care spending were for hospital care and physician

and clinical services. In 2013, hospital care accounted for 38 percent of spending, or \$937 billion, while physician and clinical services accounted for 24 percent of spending, or \$587 billion (Figure 1-3, p. 10). Smaller shares in 2013 went to spending on prescription drugs (11 percent, or \$271 billion), nursing care facilities (6 percent, or \$156 billion), and home health care services (3 percent, or \$80 billion).

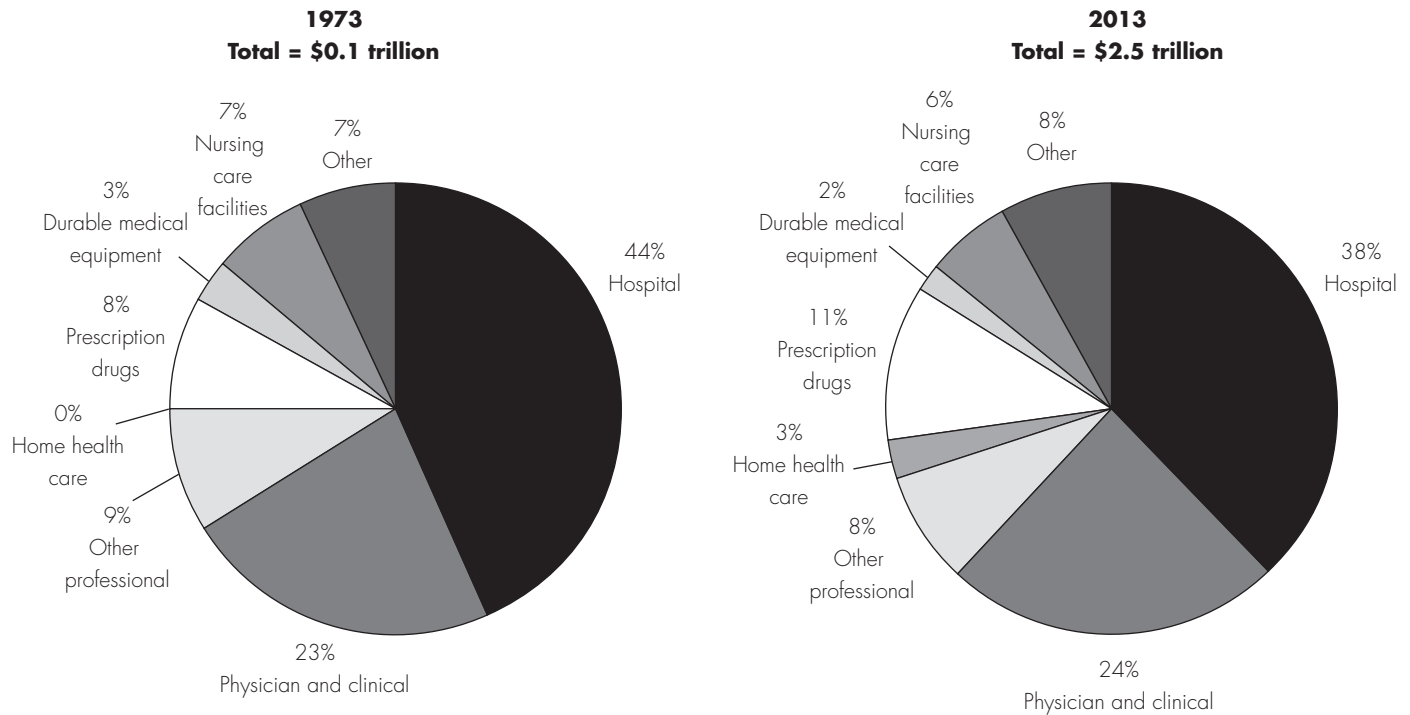
Between 1973 and 2013, the share of spending on hospital care declined from 44 percent to 38 percent, and the share of spending for prescription drugs increased from 8 percent to 11 percent (Centers for Medicare & Medicaid Services 2014). Medicare accounted for 22 percent of spending for all services in 2013, but its share varied by type of service. For example, Medicare spending on home health care services accounted for over 40 percent (Table 1-1, p. 10).

Medicare spending

Like overall health care spending, Medicare spending experienced rapid growth in the past four decades but a slowdown in recent years. Between 1973 and 2013, Medicare spending grew at an average rate of 11 percent annually but has slowed to 4 percent per year since 2010. This slowdown is attributable to a slowdown in the growth of per beneficiary spending—from an average of 8 percent per year between 1973 and 2013 to less than 1 percent per year since 2010 (Boards of Trustees 2014).

Medicare spending can be divided into three program components: the traditional fee-for-service (FFS) program, the Medicare Advantage (MA) program, and the Part D prescription drug program.

- **Medicare's traditional fee-for-service program.** In FFS, Medicare pays health care providers directly for health care goods and services furnished to Medicare FFS beneficiaries at prices set through legislation and regulation.
- **Medicare Advantage program.** As an alternative to FFS, beneficiaries can choose to enroll in MA, which consists of private health plans that receive capitated payments for providing health care coverage to enrollees. MA plans pay health care providers for health care goods and services furnished to their enrollees at prices negotiated between the plans and providers.

**FIGURE
1-3****Hospital care and physician services accounted for the largest shares of personal health care spending in 1973 and 2013**

Note: "Other" includes expenditures on nondurable medical products and other health, residential, and personal care. "Other professional" includes expenditures on dental and other professional services.

Source: MedPAC analysis of National Health Expenditures Accounts from CMS 2014.

**TABLE
1-1****Total health care spending in selected sectors and Medicare's share, 2013**

	Total spending	Medicare spending	Medicare's share of total sector spending
	Dollars in billions		Percentage
Total spending on personal health care	\$2,469	\$551	22%
Hospital	937	243	26
Physician and clinical services	587	130	22
Other professional	191	19	10
Home health care	80	34	43
Prescription drugs	271	75	28
Durable medical equipment	43	8	18
Nursing care facilities	156	35	22
Other	204	8	4

Note: "Other professional" includes expenditures on dental and other professional services. "Other" includes expenditures on nondurable medical products and other health, residential, and personal care.

Source: MedPAC analysis of National Health Expenditures Accounts from CMS 2014.

- **Medicare Part D prescription drug program.**
Through Part D, beneficiaries can obtain subsidized prescription drug coverage by voluntarily purchasing insurance policies from private stand-alone drug plans or MA plans. Medicare heavily subsidizes the premiums established by those plans.

The growth in per beneficiary spending has slowed for all three programs; Figure 1-4 presents average annual growth rates for the last decade (from 2004 to 2013) in three-year periods. Per beneficiary spending growth was particularly low in the last period (from 2010 to 2013). The lower growth rates were generally due to both decreased use of health care services and restrained payment rate increases.

In FFS, per beneficiary growth averaged 1 percent annually from 2010 to 2013 (the last period). In addition to decreased use, the Patient Protection and Affordable Care Act of 2010 (PPACA) reduced annual payment rate updates for many types of providers (other than physicians) beginning in 2012.

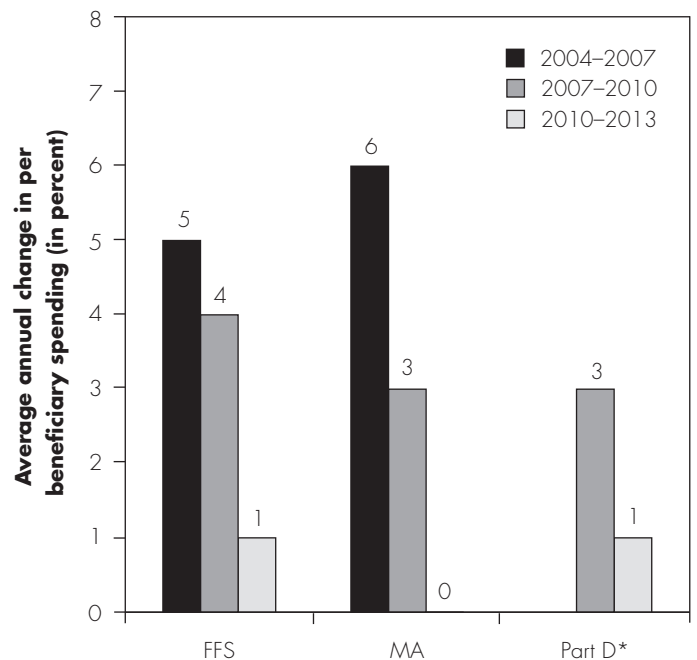
In MA, per beneficiary growth averaged 0 percent annually from 2010 to 2013 (the last period). PPACA reduced payments to MA plans to bring costs more in line with costs in FFS. The growth rate would have been lower, but the PPACA payment reductions were offset somewhat by quality bonus payments and plans' increased coding (when compared with coding for similar FFS beneficiaries), which increases a beneficiary's risk score and thus increases Medicare's payments to MA plans, all other things being equal.

Last, in Part D, per beneficiary growth averaged 1 percent annually from 2010 to 2013. The slowdown in Part D spending was in part due to the increase in low-priced generic drugs on the market and to the efforts of plans to steer beneficiaries to generics and other low-priced drugs.

Figure 1-5 (p. 12) provides a more detailed look at FFS. Generally, we see a slowdown in spending across all settings; however, the impact is not uniform. For example, for inpatient hospital care, the average annual growth in per beneficiary spending fell from 3 percent in the first two periods to –1 percent in the last period. The growth in outpatient hospital care declined but was still growing robustly in the last period at 9 percent annually, in part because of shifts in site of care from both the inpatient hospital setting and physician offices to the outpatient hospital setting.

FIGURE 1-4

Per beneficiary spending growth slowed in FFS, MA, and Part D



Note: FFS (fee-for-service), MA (Medicare Advantage).

*Part D average annual change from 2004–2007 is not shown because the program began in 2006.

Source: 2014 annual report of the Boards of Trustees of the Medicare trust funds.

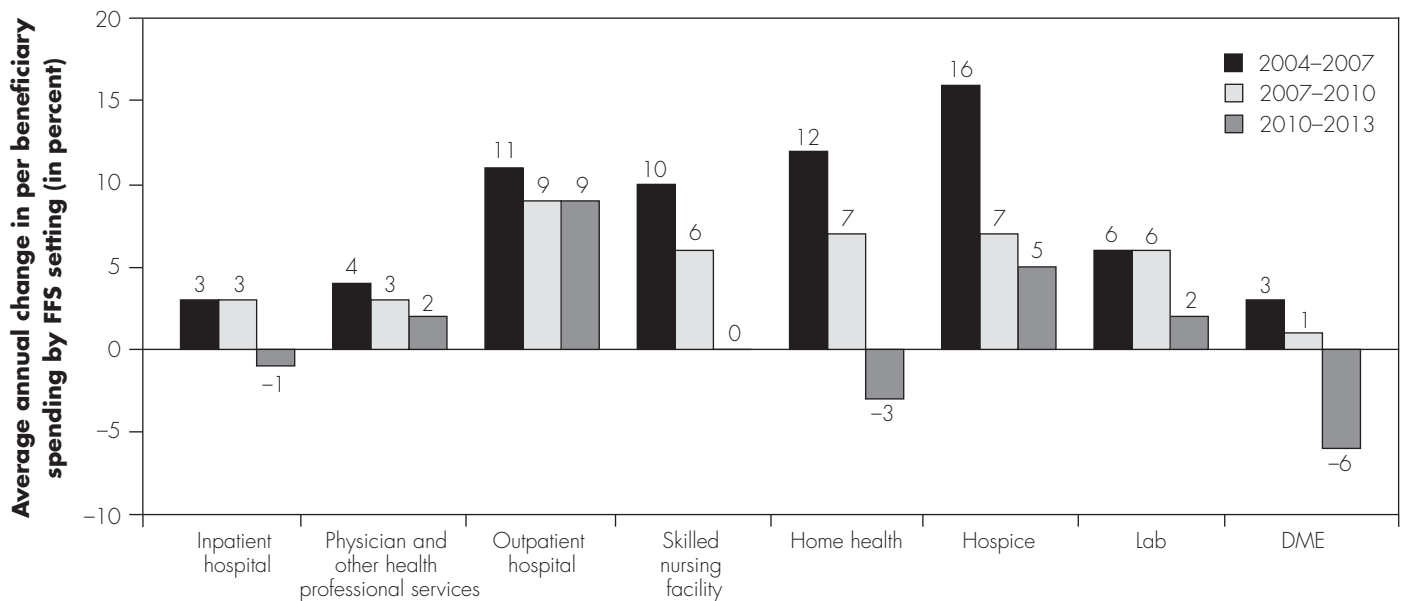
Despite the recent slowing of annual growth rates, cumulative growth in per beneficiary spending over the last decade has increased in almost all settings and quite substantially in some settings (Figure 1-6, p. 12). For example, per beneficiary spending on hospital outpatient services grew 126 percent over the last decade, while per beneficiary spending on inpatient care grew 14 percent.

A comparison of private sector and Medicare spending trends

The growth of per capita spending has also slowed recently in the private sector according to a Health Care Cost Institute analysis of private sector claims data for people younger than 65 covered by employer-sponsored private health insurance (Health Care Cost Institute 2014). Also like Medicare, the private sector experienced a greater slowdown for inpatient hospital care, while outpatient hospital care continued to grow at relatively high rates. However, the slowdown in the private sector

**FIGURE
1-5**

Per beneficiary spending growth in some FFS settings remained strong

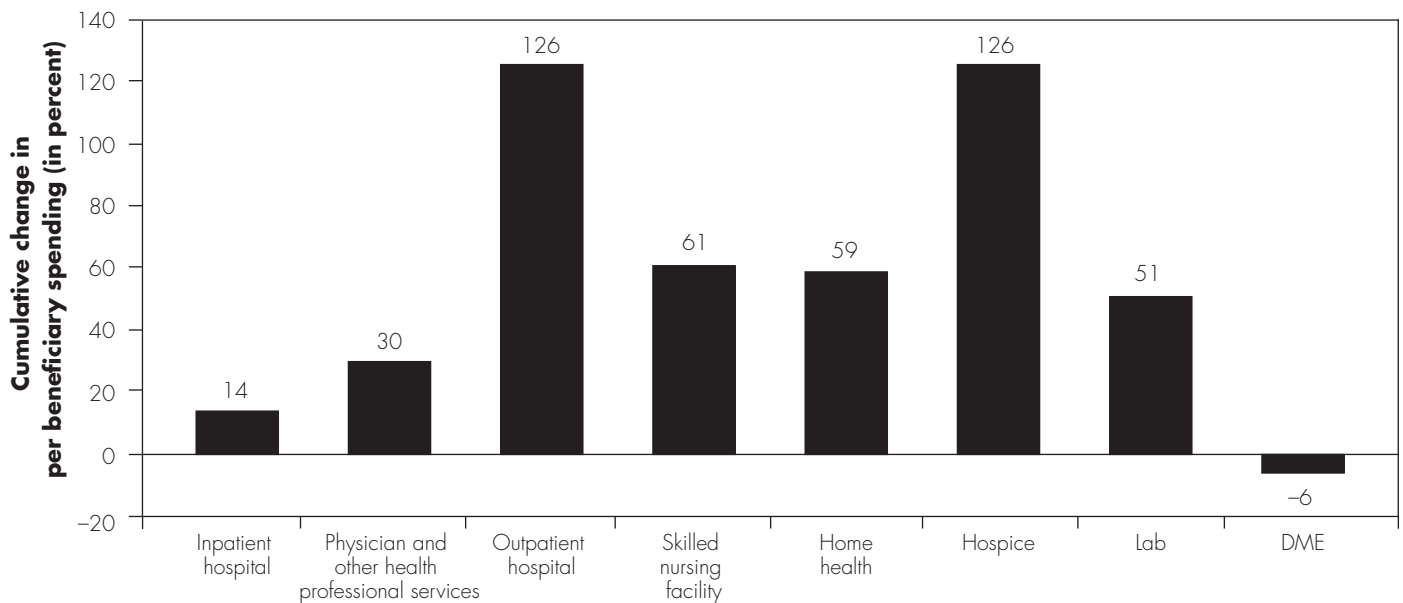


Note: FFS (fee-for-service), DME (durable medical equipment).

Source: 2014 annual report of the Boards of Trustees of the Medicare trust funds.

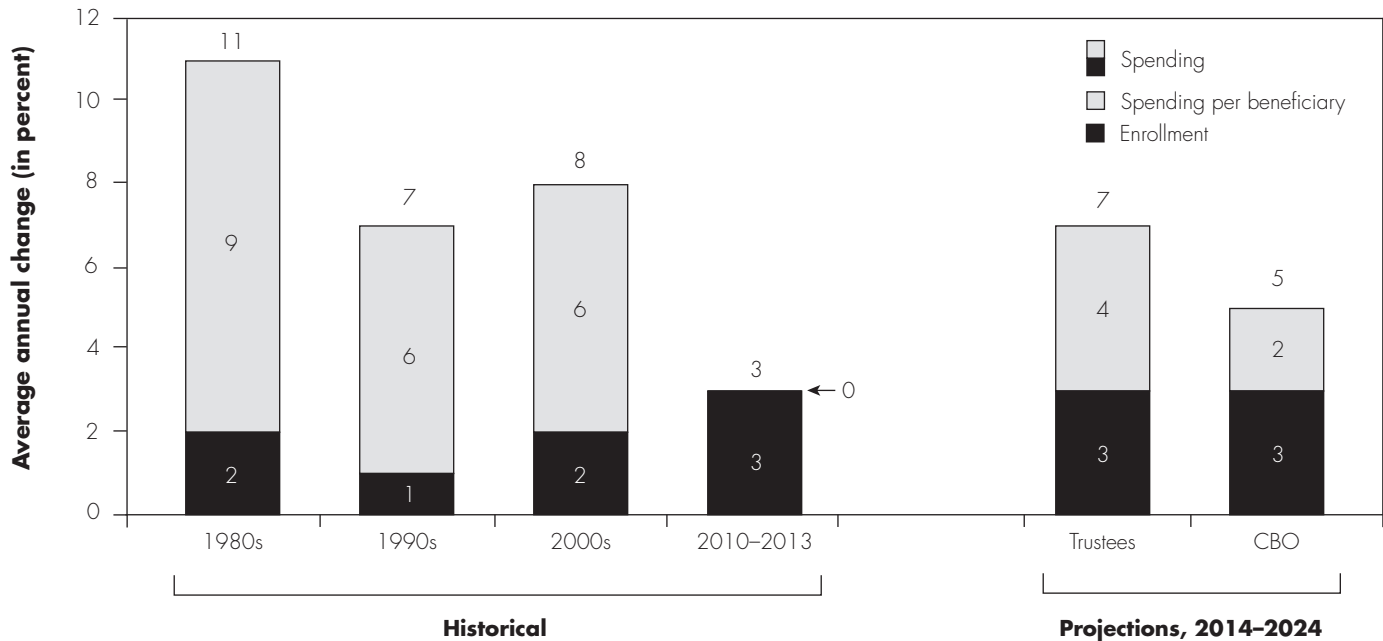
**FIGURE
1-6**

Per beneficiary spending grew over the decade in almost all settings, 2004-2013



Note: DME (durable medical equipment).

Source: 2014 annual report of the Boards of Trustees of the Medicare trust funds.

**FIGURE
1-7****Despite slowdown in per beneficiary spending,
total Medicare spending continues to rise**

Note: CBO (Congressional Budget Office). CBO's 10-year projection is based on current law (as required by its mandate), which includes a scheduled payment rate reduction for services furnished by physicians and other health professionals of about 20 percent in April 2015. The Trustees assume the payment rate update for physicians and other health professionals will equal the recent historical average (0.6 percent per year).

Source: 2014 annual report of the Boards of Trustees of the Medicare trust funds and CBO report *The 2014 Long-Term Budget Outlook*.

was primarily due to a slowdown in the growth rate of health care usage and occurred despite robust price growth.

One key driver of higher prices in the private sector is provider market power (Baker et al. 2014a, Baker et al. 2014b, Gaynor and Town 2012, Robinson and Miller 2014). Hospitals and physician groups are increasingly consolidating, in part to gain market power over insurers with the goal of negotiating higher payment rates. For the private sector, that trend resulted in per capita spending growth of about 4 percent annually from 2009 to 2012.

By comparison, per beneficiary spending for Medicare increased by about 1 percent annually over that period. So while both Medicare and the private sector experienced low growth in the use of health care services, Medicare also experienced restrained increases in payment rates, contributing to its lower growth rate.

Over the long term, trends in the private sector can influence trends in Medicare. If the private sector is unable

to constrain price growth, the profitability of caring for commercially insured patients will increase relative to the profitability of caring for Medicare beneficiaries, potentially impeding access to care for Medicare beneficiaries and exerting pressure on the Medicare program to increase its payment rates (Medicare Payment Advisory Commission 2009, Stensland et al. 2010, White and Wu 2014).

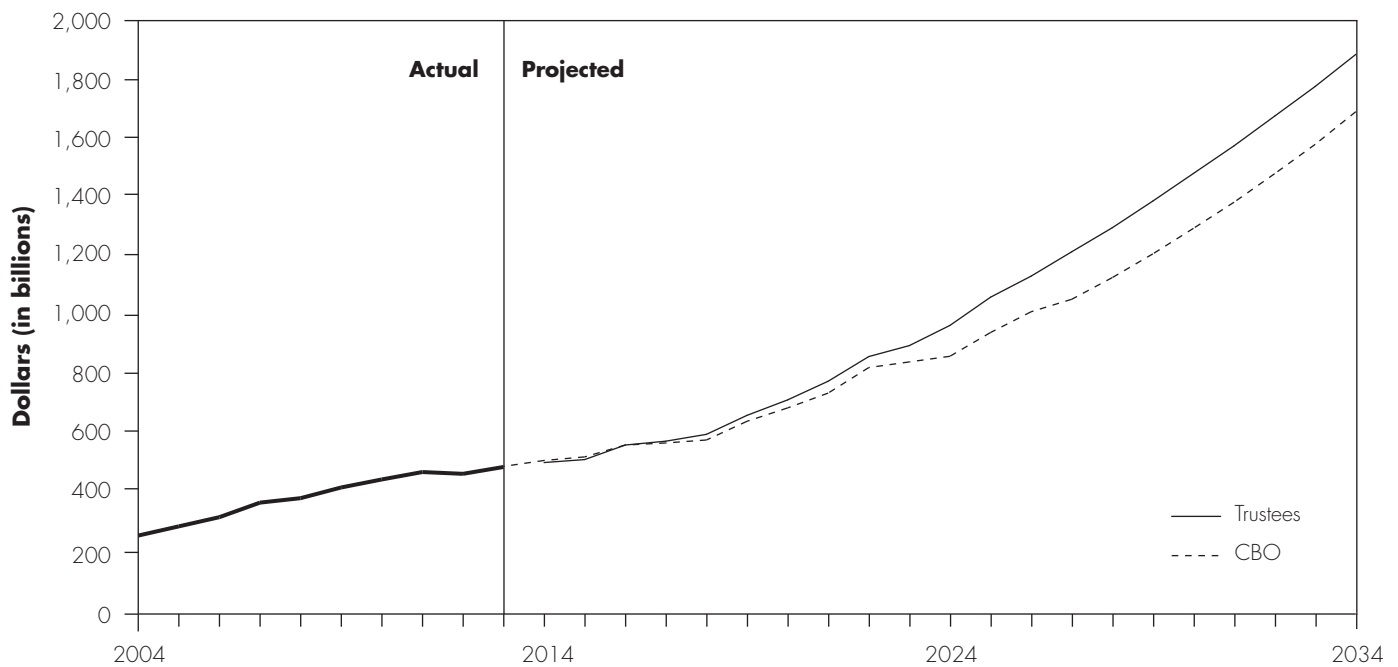
Medicare spending projections

What do these current trends portend for Medicare? The slowdown in per beneficiary spending has received much attention in the news media. The growth in Medicare's per beneficiary spending has fallen from average annual rates of 9 percent in the 1980s and 6 percent in the 1990s and 2000s to 0 percent over the last three years (Figure 1-7).

For the next 10 years, the Trustees and the Congressional Budget Office (CBO) project that growth in per beneficiary spending will be higher than the recent lows but lower than the historic highs, with an average annual

FIGURE
1-8

Trustees and CBO project Medicare spending to reach 1 trillion dollars by 2025 or 2026



Note: CBO (Congressional Budget Office).

Source: 2014 annual report of the Boards of Trustees of the Medicare trust funds and CBO report *The 2014 Long-Term Budget Outlook*.

growth rate of 4 percent according to the Trustees and 2 percent according to CBO (Figure 1-7, p. 13) (Boards of Trustees 2014, Congressional Budget Office 2014a).²

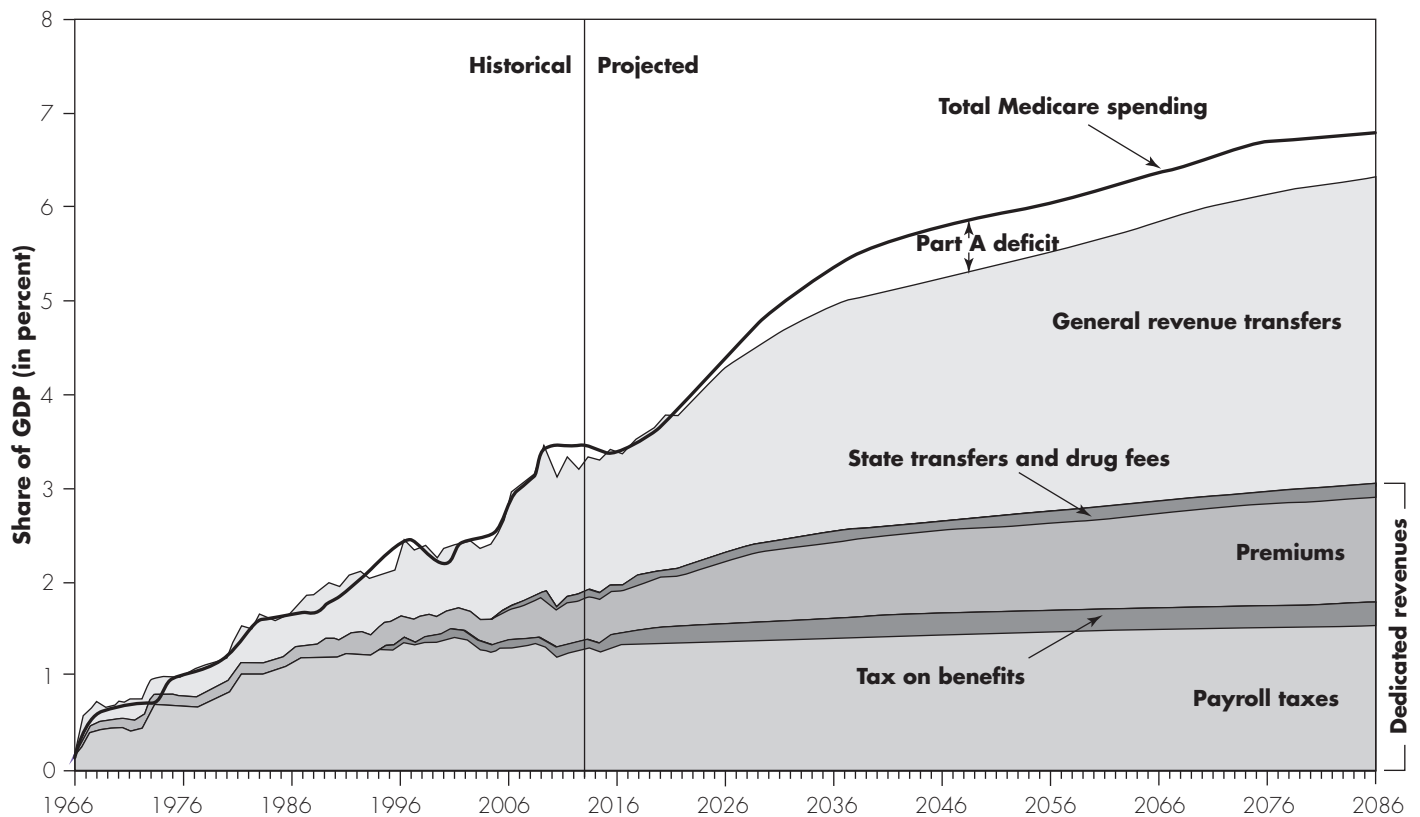
What probably has not received as much media attention is increasing growth in enrollment, from about 2 percent per year historically to 3 percent. That increase occurred over the last few years and is projected to continue throughout the next decade as the baby-boom generation continues to age into the Medicare program. So despite the slowdown in spending per beneficiary, the Trustees project annual growth in total spending to average 7 percent over the next decade, and CBO projects 5 percent. Since GDP is projected to grow at about 4 percent per year over the next decade, Medicare spending is projected to grow 1 percent to 3 percent faster than GDP.

At those rates, total Medicare spending would rise from about \$500 billion today to 1 trillion dollars in the coming decade (by 2025 under the Trustees' projection or by 2026 under CBO's projection) (Figure 1-8) (Boards of Trustees 2014, Congressional Budget Office 2014a).

Medicare's financing challenge

The Medicare Trustees project that Medicare's share of GDP will rise to 5.6 percent in 2040 and to 6.9 percent in 2086 (Figure 1-9). As spending grows, financing from general revenues will grow as a share of total Medicare financing. In this chapter, the term *general revenues* includes both tax revenue not dedicated to a specific purpose and federal borrowing, since federal spending, with few exceptions, has exceeded federal revenues since the Great Depression. As Medicare becomes more dependent on general revenues, fewer resources will be available to finance other priorities such as education and investment in infrastructure and scientific research, resulting in greater pressure to reduce federal spending or increase federal taxes.

Medicare is financed by two trust funds. The Hospital Insurance (HI) Trust Fund covers Part A services, which include inpatient hospital stays and post-acute care like skilled nursing facilities and hospice. The HI Trust Fund

**FIGURE
1-9****General revenue paying for growing share of Medicare spending**

Note: GDP (gross domestic product). "Tax on benefits" refers to the portion of income taxes that higher income individuals pay on Social Security benefits that is designated for Medicare. "State transfers" (often called the Part D "clawback") refers to payments required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 from the states to Medicare for assuming primary responsibility for prescription drug spending. "Drug fees" refers to the fee imposed in the Patient Protection and Affordable Care Act of 2010 on manufacturers and importers of brand-name prescription drugs. These fees are deposited in the Part B account of the Supplementary Medical Insurance trust fund.

Source: 2014 annual report of the Boards of Trustees of the Medicare trust funds.

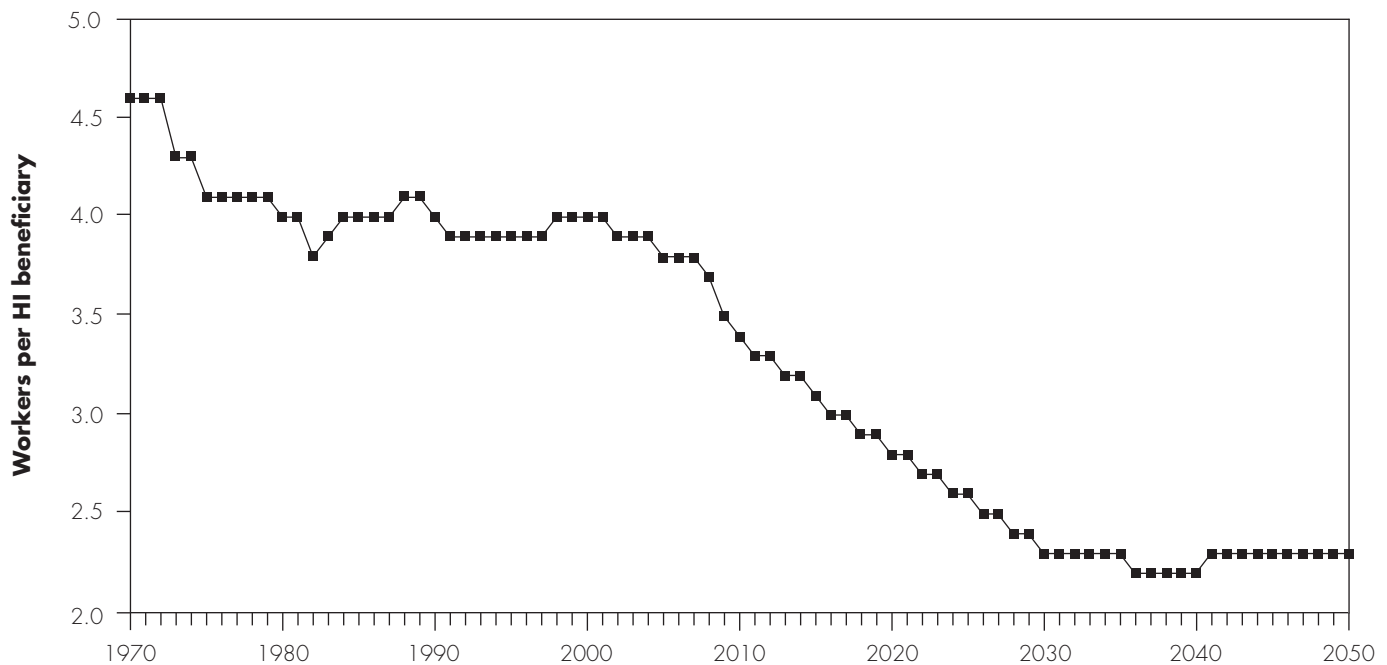
receives financing through a dedicated payroll tax (i.e., a tax on wage earnings). Payroll taxes are projected to grow only slightly faster than GDP because the growth rate is based on earnings growth and because the ratio of workers to retirees is declining with the retirement of the baby-boom generation (Figure 1-10, p. 16).

The number of workers per Medicare beneficiary declined from 4.6 in 1970 to 3.1 today. By 2030, the Trustees project there will be just 2.3 workers for every beneficiary.

Since 2008, the HI Trust Fund (Part A) has run an annual deficit (i.e., paid more in benefits than it collected in

payroll taxes, indicated by the top white layer in Figure 1-9. The Trust Fund still has interest income generated from loaning funds to other parts of the government during times of surplus, but those assets are projected to be exhausted by 2030. The Trustees estimate that the payroll tax would need to be increased from its current rate of 2.9 percent to 3.8 percent to balance the HI Trust Fund over the next 75 years. Otherwise, Part A spending would need to be reduced by 19 percent (Boards of Trustees 2014).

The Supplementary Medical Insurance (SMI) Trust Fund covers services under Part B and Part D. Part B helps pay for physician services and other ambulatory care, such

**FIGURE
1-10****The number of workers per HI beneficiary is projected to decline rapidly**

Note: HI (Hospital Insurance). Hospital Insurance is also known as Medicare Part A.

Source: 2014 annual report of the Boards of Trustees of the Medicare trust funds.

as services received in hospital outpatient departments. Part D helps pay for prescription drug coverage. The SMI Trust Fund is financed by general revenues and premiums. Beneficiaries pay for about 25 percent of Part B and Part D spending through annual premiums. The other 75 percent is paid by taxpayers through general revenues. Because general revenue transfers and premiums are reset each year to match expected Part B and Part D spending, they grow at the same rate as Part B and Part D spending. While that framework technically guarantees that the SMI Trust Fund is balanced, it also increases transfers from the general fund of the Treasury to the Medicare program, thus increasing deficits and the debt.

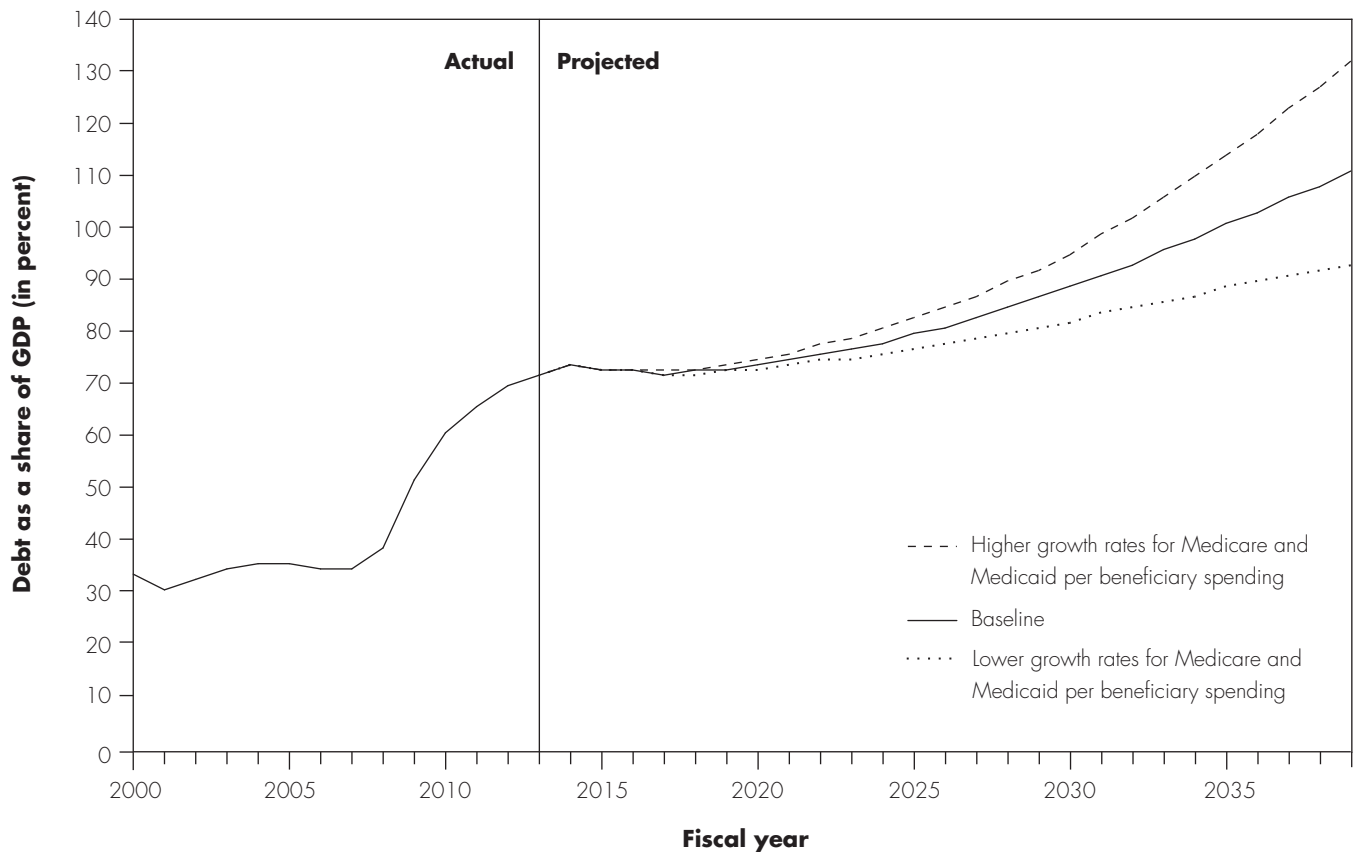
Thus, Medicare's financial challenge includes not only the Part A deficit but also the share of spending financed through general revenue (Figure 1-9, p. 15). Currently, general revenue makes up a little over 40 percent of Medicare income, and the Trustees project that share to continue to grow, adding significantly to federal budget pressures. The projected growth in premiums will also strain household budgets.

Health care spending consumes growing shares of federal and state budgets and the budgets of individuals and families

Because general revenues finance a large share of Medicare and because Medicare is a significant share of the federal budget, Medicare's fiscal sustainability is tightly linked to that of the overall federal budget and vice versa. Similarly, states bear a significant share of Medicaid costs, so rising health care spending also has implications for state budgets. For individuals and families, 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.

Health care spending and the federal budget

Medicare spending is projected to consume 14 percent of the federal budget this year, and Medicare and Medicaid spending combined is projected to consume 23 percent

**FIGURE
1-11****Health care spending growth affects future debt levels**

Note: GDP (gross domestic product). The higher growth rate of per beneficiary spending on Medicare and Medicaid is 0.75 percentage point per year higher than under the baseline assumptions; the lower growth rate is 0.75 percentage point per year lower than under the baseline assumptions.

Source: Congressional Budget Office report *The 2014 Long-Term Budget Outlook*.

(Congressional Budget Office 2014b). With their reliance on general tax dollars and federal deficit spending, those health care programs have a substantial effect on the federal debt.³

Debt equaled 35 percent of GDP at the end of 2007 as the economy entered the last recession (Figure 1-11). In response to the recession, the debt soared, reaching 72 percent of GDP in 2013—a higher percentage than at any point in U.S. history except briefly around World War II. Under baseline assumptions, which reflect current law, CBO projects the debt will reach 100 percent of GDP in about two decades (or by 2035).

However, the CBO baseline assumes that per beneficiary spending for Medicare and Medicaid increases more slowly in the future than it has during the past several

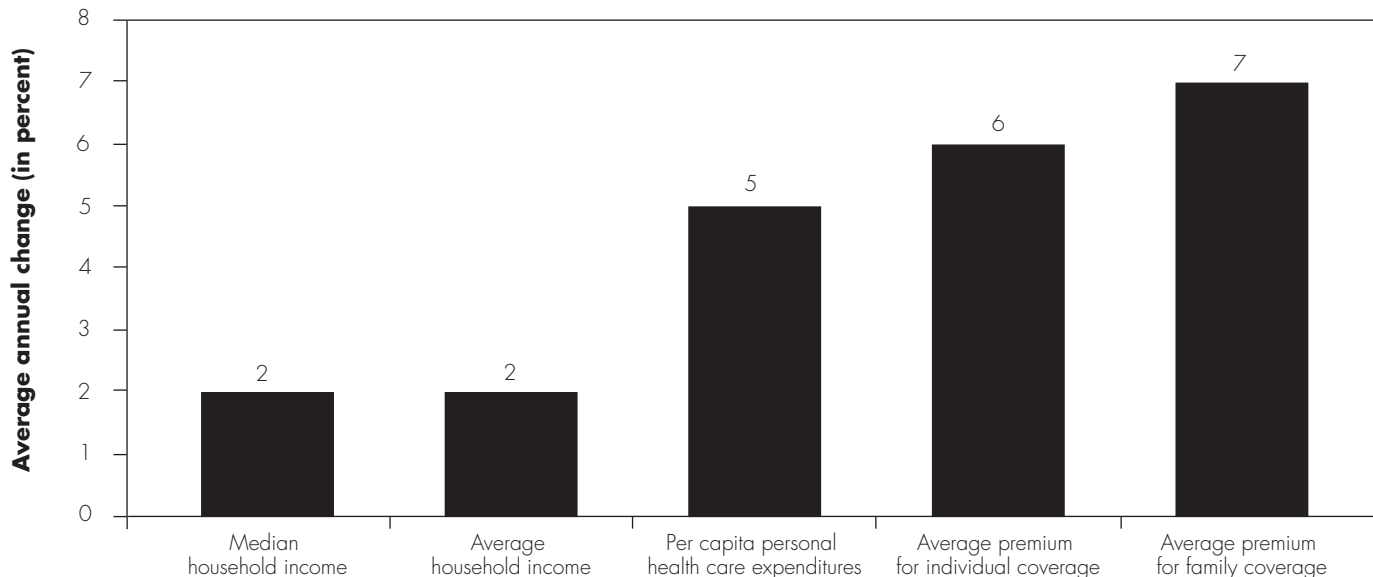
decades (Congressional Budget Office 2014a). If per beneficiary spending growth were three-quarters of a percentage point higher than that of the baseline, then the federal debt would be 114 percent of GDP by 2035. On the other hand, if per beneficiary spending growth were three-quarters of a percentage point lower, then the federal debt would be 89 percent of GDP by 2035. Still, under all three scenarios, the debt projections are at levels not seen since the aftermath of WWII (Figure 1-11).

Health care spending and state budgets

States' liabilities for health care costs include their share of Medicaid spending, which generally covers health care services for low-income children, adults, individuals who are blind or disabled, and some long-term care services for those who are aged and disabled. In 2012, before the

**FIGURE
1-12**

**Growth in health care spending and premiums
outpaced growth in household income, 2002–2012**



Note: Household income, health expenditures, and premiums are all measured in nominal dollars.

Source: Census Bureau, Current Population Survey, Annual Social and Economic Supplements 2013. MedPAC analysis of National Health Expenditures Accounts from CMS 2014, and Kaiser Family Foundation and Health Research & Educational Trust 2014.

coverage expansions made by PPACA, monthly enrollment in Medicaid averaged about 59 million people, and total spending was \$432 billion (Truffer et al. 2013). States and the federal government jointly finance Medicaid; in 2012, before the coverage expansions made by PPACA, the federal share was 58 percent (Truffer et al. 2013).

Under PPACA, states are given the option to expand Medicaid coverage to nonelderly individuals with a family income of less than 138 percent of the federal poverty threshold. States receive full federal financing to cover this expansion population in 2014, phasing down to 90 percent federal financing by 2020.

PPACA also increased the payment amount primary care providers receive for seeing Medicaid patients so that it equaled the Medicare payment in 2013 and 2014. This policy represents a significant increase in payments to providers—the two-year provision increased spending by \$11 billion—with the federal government incurring the cost. The provision expires at the end of 2014. In a recent survey, 15 states indicated that they will continue the higher rates (without federal funding), at least partly, after the provision expires, while 24 states indicated that they

would not continue the rate increase. Some states were undecided at the time of the survey (Smith et al. 2014).

A provision also established under PPACA authority allows state demonstrations for beneficiaries dually eligible for Medicare and Medicaid. In 2011, the Medicare–Medicaid Coordination Office at CMS announced a financial alignment demonstration through which states can develop integrated care programs for full-benefit dual-eligible beneficiaries. States have the option to implement a capitated model, a managed fee-for-service model, or both. Under the capitated model, a health plan receives Medicare and Medicaid capitation payments to cover all Medicare and Medicaid services. As of August 2014, 10 states signed a memorandum of understanding (MOU) with CMS to administer the capitated model, and two states signed MOUs to administer the FFS model (including one state that is also administering the capitated model). Finally, one state is adopting an alternative model.

Health care spending and individual and family budgets

For individuals and families, growth in health care spending means higher health insurance premiums

and higher taxes devoted to health care (Auerbach and Kellerman 2011). For those covered by employer-sponsored health insurance, an increase in premiums also results in lower wage growth because employers offset their increased costs of providing health insurance to their employees (Baicker and Chandra 2006, Gruber 2000, Steuerle 2013). As health care spending increases, an increasing share of income from individuals and families is transferred to hospitals, physicians, and other providers of health care services.

In the last decade, per capita health spending and premiums have grown much more rapidly than median and average household incomes (Figure 1-12). From 2002 to 2012, before the coverage expansions made by PPACA, per capita personal health care spending grew at an average annual rate of 5 percent, while the average annual rates of premiums for individuals and families grew 6 percent and 7 percent, respectively (Centers for Medicare & Medicaid Services 2014, Kaiser Family Foundation and Health Research & Educational Trust 2014). In contrast, during this period, median and average household incomes grew at an average annual rate of just 2 percent (DeNavas-Walt et al. 2013).

Medicare beneficiaries are not exempt from the financial challenges of the program's ever-growing cost-sharing liabilities. In 2012, SMI (Medicare Part B and Part D) premiums and cost sharing consumed 23 percent of the average Social Security benefit (Boards of Trustees 2014). (Those percentages do not include beneficiary spending on premiums for Medicare supplemental insurance.) The Medicare Trustees estimate that those costs will consume 30 percent of the average Social Security benefit by 2031. In 2012, Social Security benefits accounted for about 70 percent of income for seniors, on average. For more than one-fifth of seniors, Social Security benefits account for 100 percent of income (Social Security Administration 2012).

Changes in the Medicare-eligible population

The Medicare population is projected to increase from 54 million beneficiaries at the time of this writing to over 80 million beneficiaries in about 15 years (by 2030) as the baby-boom generation ages into Medicare eligibility. This expansion will bring changes to the Medicare population. First, the average age of the Medicare

population will initially skew younger than in the recent past but then grow rapidly older as the number and share of beneficiaries ages 85 and older increases. Second, more so than previous cohorts of enrollees, members of the baby-boom population will enter Medicare with multiple chronic conditions, a prevalence that is likely to increase in the Medicare population as the baby-boom generation grows older. Those trends will likely exert upward pressure on Medicare spending. Third, beneficiaries entering the program over the next several years will have had very different experiences with employer-sponsored and other forms of health care coverage because of significant changes that have taken place and continue in the private and non-Medicare public health insurance markets.

Age and demographic changes

Enrollment in the Medicare program is projected to grow rapidly over the next two decades as members of the baby-boom generation age into the program (Figure 1-13, p. 20). (Medicare enrollment also includes individuals under age 65 who qualify for Medicare based on disability status. See text box on p. 21.) These individuals began aging into Medicare in 2011 at an average rate of 10,000 people per day. By 2030, Medicare is projected to have over 80 million beneficiaries—up from 54 million beneficiaries today—almost entirely made up of baby boomers (Figure 1-14, p. 20) (Census Bureau 2012).

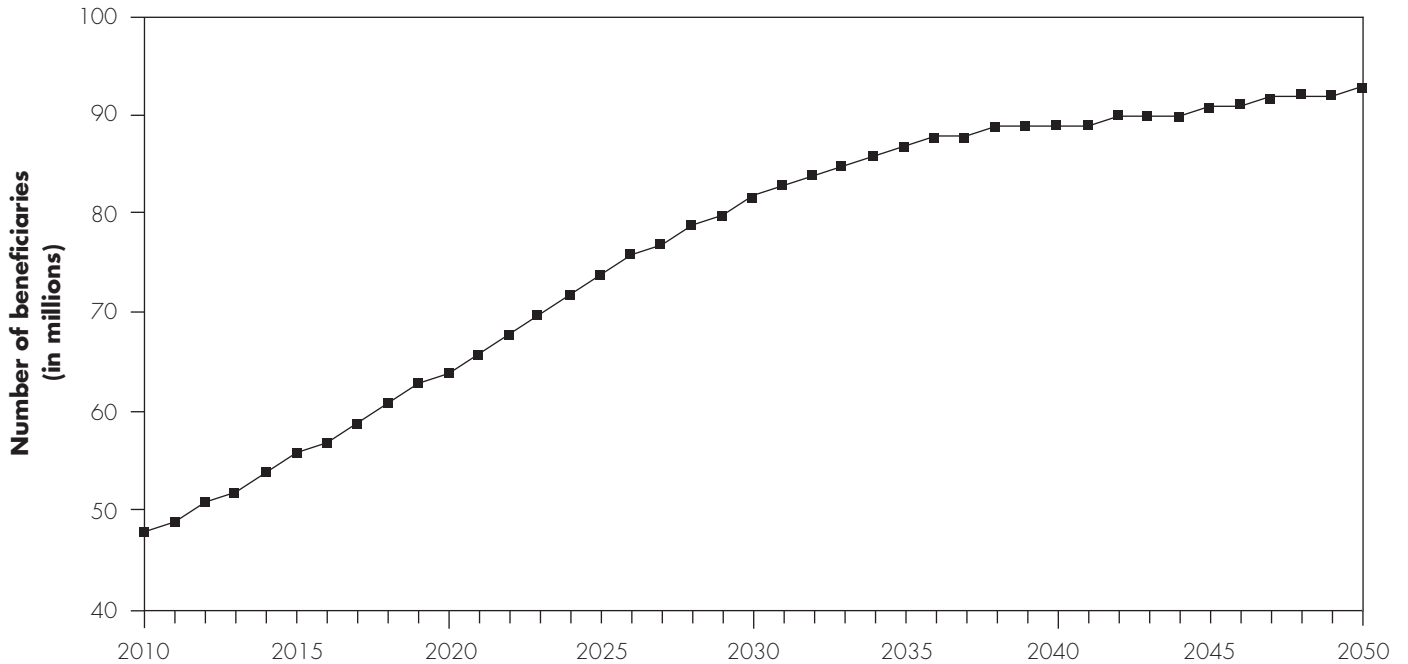
The Medicare population over the next 15 years will be relatively younger as members of the baby-boom generation join its ranks and increase the number of beneficiaries in younger age categories. (Figure 1-15, p. 21). The share of the Medicare population ages 85 years or more is projected to decline slightly through 2025. After 2025, that older share is projected to grow as the baby-boom generation continues to age (Boards of Trustees 2014, Census Bureau 2012).

The older population is, and will be for some time, less diverse racially and ethnically than the total population (Figure 1-16, p. 22). As a proportion of the older population, Whites will remain a majority through 2060 (Figure 1-16, left-side graph). In contrast, as a proportion of the total population, Whites will no longer be a majority by 2043 (Figure 1-16, right-side graph).

There are two main reasons why the racial and ethnic diversity of the older population lags behind the total population. First, when baby boomers were born, almost 90 percent of the total U.S. population was White.

**FIGURE
1-13**

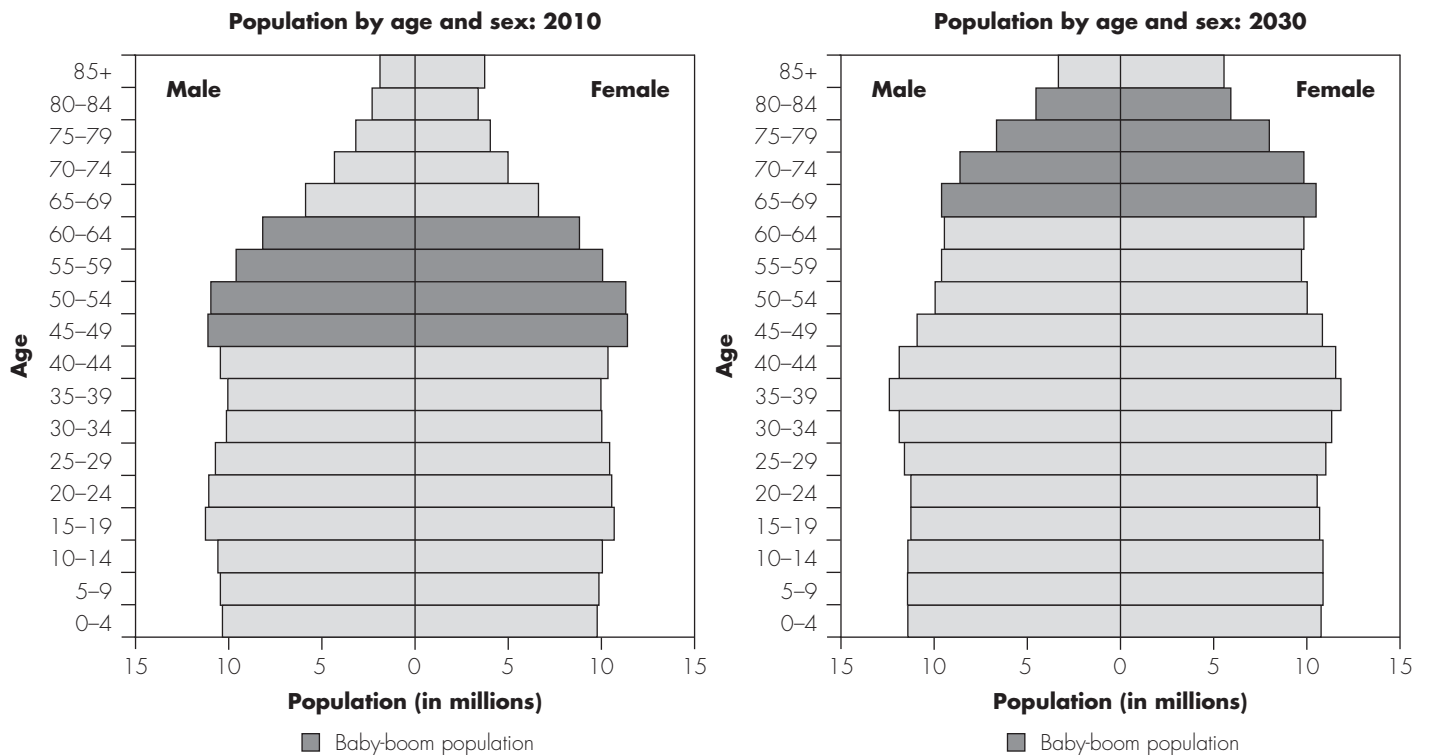
Medicare enrollment projected to grow rapidly as members of the baby-boom generation age into the program



Source: 2014 annual report of the Boards of Trustees of the Medicare trust funds.

**FIGURE
1-14**

By 2030, the entire baby-boom generation will be eligible for Medicare



Source: Census Bureau, 2010 Census and 2012 National Population Projections, middle series.

Disabled Medicare enrollees under the age of 65

Nearly 9 million people under the age of 65 are receiving Medicare because they are entitled to Social Security Disability Insurance (SSDI). They become eligible for Medicare 24 months after their disability begins. Disabled beneficiaries have grown as a share of the Medicare population, reaching 17 percent in 2012. Total Medicare FFS spending in 2012 on the under-65 disabled population was about \$80 billion (or about 17 percent of total FFS spending).

Per beneficiary spending is comparable for the disabled and the aged, although disabled beneficiaries

use lower levels of post-acute care and relatively higher amounts of ambulatory and hospital care. Disabled beneficiaries report more trouble accessing health care services, although this difficulty may be partly because of their relatively low incomes overall (almost half of all disabled beneficiaries are dually entitled to Medicaid). The average age of disabled Medicare beneficiaries is a little over 50; thus they receive Medicare for 15 years before they would have become eligible by turning age 65. ■

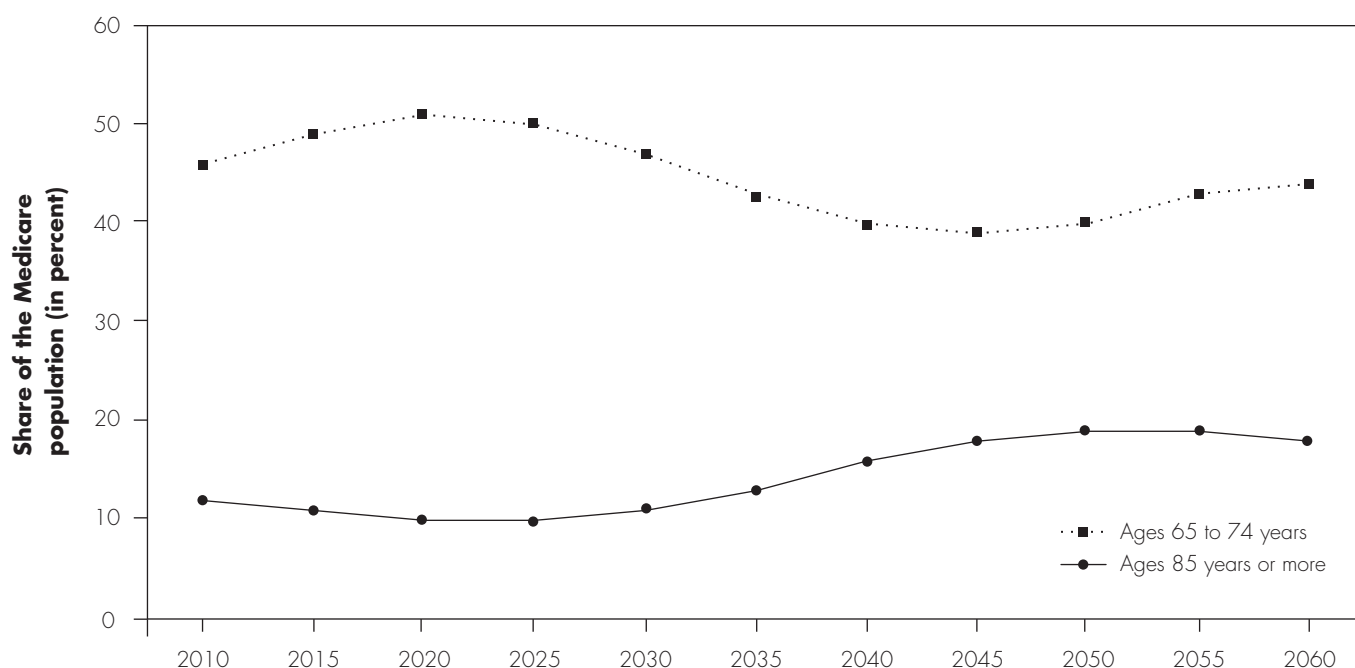
Second, since then, the nation's population has become increasingly diverse through increases in immigration and minority births. However, recent immigration does not have much of an effect on the age structure of the older population because most immigrants are under the age of 40 when they arrive in the United States. (Census Bureau 2012).

Disease burden and prevalence of multiple chronic conditions

Chronic conditions such as high blood pressure, high cholesterol, heart disease, and diabetes are highly prevalent among today's Medicare beneficiaries. In 2010, almost 60 percent had high blood pressure; 45 percent had high cholesterol; and almost one-third had ischemic heart

FIGURE 1-15

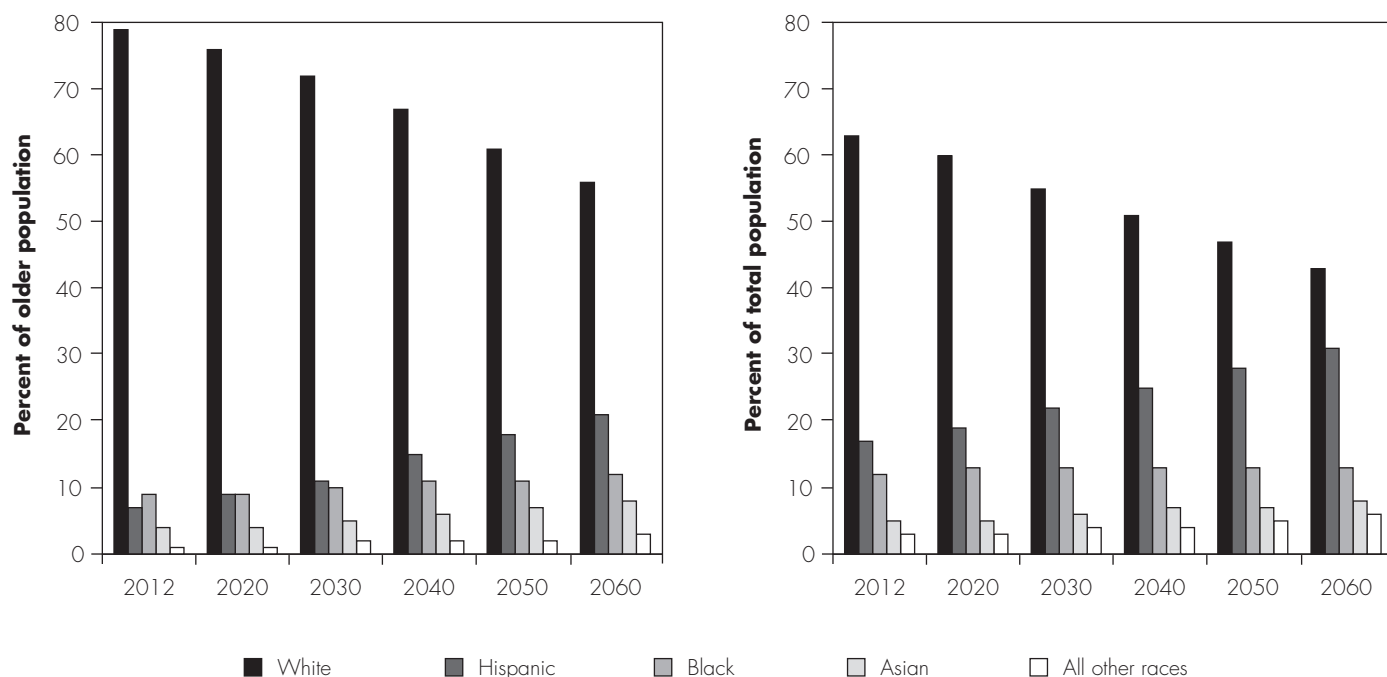
The Medicare population will become younger and then older



Source: 2014 annual report of the Boards of Trustees of the Medicare trust funds and Census Bureau, 2012 National Population Projections.

**FIGURE
1-16**

The older population (ages 65 and older) is less racially and ethnically diverse than the total population



Note: "All other races" includes American Indian and Alaska Native and multiracial.

Source: Census Bureau, 2012 National Population Projections.

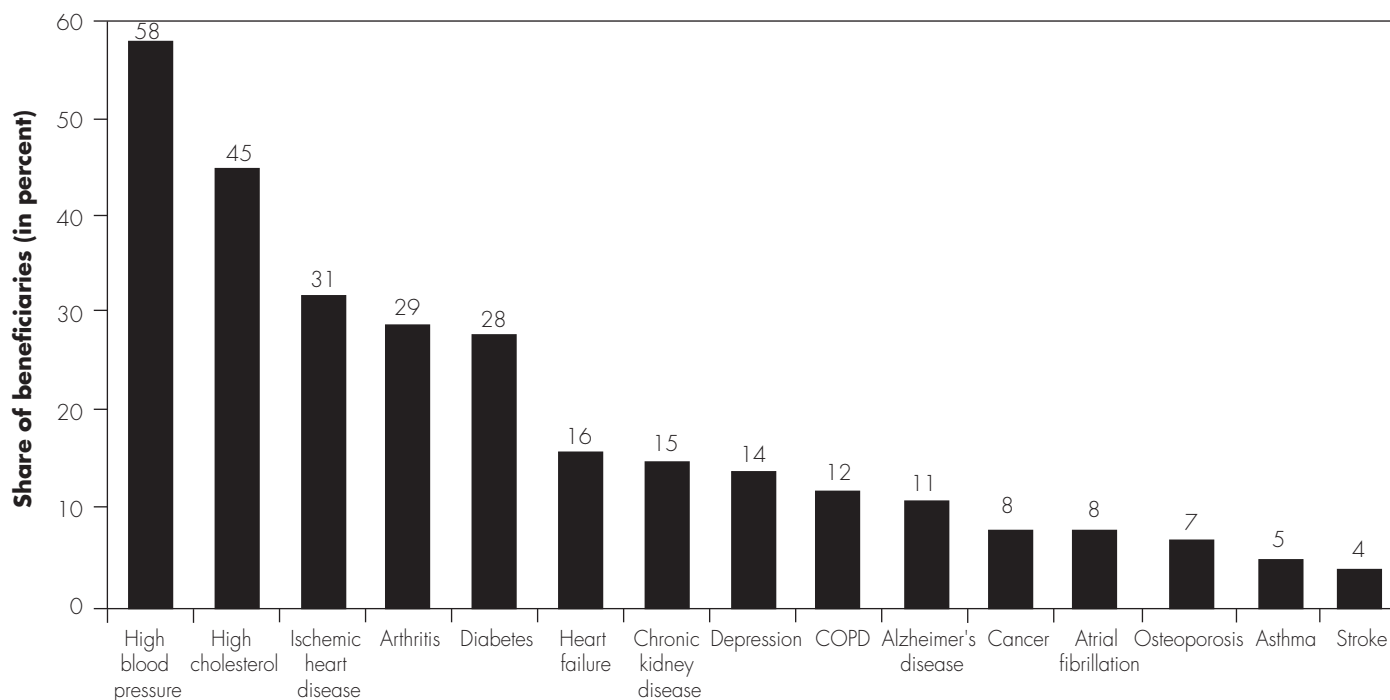
disease, arthritis, or diabetes (Figure 1-17) (Centers for Medicare & Medicaid Services 2012). However, not all chronic conditions have the same effect on per beneficiary spending. While high blood pressure and high cholesterol were the two most prevalent chronic conditions, stroke, chronic kidney disease, asthma, and chronic obstructive pulmonary disease were among the chronic conditions associated with the highest per beneficiary spending.

Today's Medicare beneficiaries are also likely to have multiple (two or more) chronic conditions. In 2010, more than two-thirds of Medicare beneficiaries had multiple chronic conditions, and 14 percent had six or more chronic conditions (Figure 1-18, p. 24). Beneficiaries with six or more chronic conditions accounted for over 40 percent of Medicare spending in 2010, while beneficiaries with one chronic condition or none made up about one-third of the Medicare population, yet accounted for just 7 percent of total Medicare spending. In 2010, Medicare spent an average of \$32,658 per beneficiary with six or more chronic conditions compared with an average of \$9,738

across all FFS Medicare enrollees (Centers for Medicare & Medicaid Services 2012).

Another recent study estimated that in 2010 nearly 15 percent of people older than age 70 (or about 3.8 million people) have dementia—a broad category that includes Alzheimer's disease as one of its forms (Hurd et al. 2013). Medicare beneficiaries with dementia suffer from loss of memory, reasoning, speech, and other cognitive functions, making it difficult for them to make decisions and perform the activities of daily living.

How will the health of the Medicare population change over the next couple of decades as the baby-boom generation ages into the program? An analysis of 2001–2010 National Health Interview Survey data by researchers at the Centers for Disease Control and Prevention (CDC) showed a statistically significant trend from 2007 through 2010 of increasing numbers of adults ages 45 to 64 years with two or three chronic conditions, and a significant increase in the prevalence of four or more

**FIGURE
1-17****Share of Medicare FFS beneficiaries with any of 15 selected chronic conditions, 2010**

Note: FFS (fee-for-service), COPD (chronic obstructive pulmonary disease). The percentages sum to more than 100 percent because beneficiaries may have multiple chronic conditions.

Source: Centers for Medicare & Medicaid Services 2012.

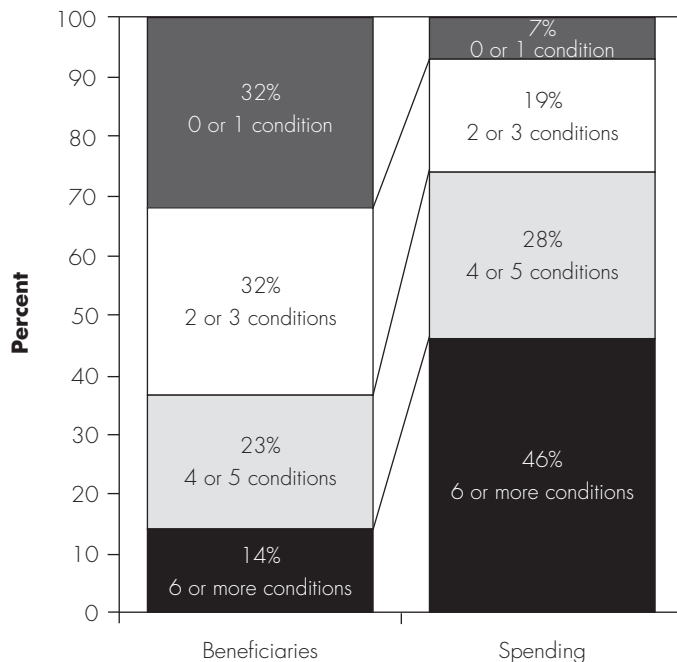
chronic conditions from 2001 through 2010 among the same age cohort (Ward and Schiller 2013). This finding means that a higher share of the baby-boom generation reported having multiple chronic conditions compared with shares of previous generations. The CDC also showed that a higher share of this age cohort reported having had a stroke or having had cancer (which could reflect changes in the use of cancer diagnostic procedures over the period), but a slightly lower share reported having heart disease compared with the shares of previous generations (National Center for Health Statistics 2014).

Because health care service use and costs increase as an individual's number of chronic conditions increases, it is reasonable to expect that these trends mean higher Medicare spending (Anderson 2010, Centers for Medicare & Medicaid Services 2012, Machlin and Soni 2013). In addition, since older beneficiaries are more likely to have multiple chronic conditions (Table 1-2, p. 25), the overall aging of the comparatively larger Medicare population

will almost certainly magnify trends in the prevalence of multiple chronic conditions.

Experience with private health insurance coverage

Changes in the private health insurance market may affect new Medicare beneficiaries' familiarity with different types of coverage and their expectations about out-of-pocket costs. For example, workers covered by private health insurance today are accustomed to receiving health care from a network of participating providers rather than from an unconstrained array of unaffiliated providers. Adults approaching Medicare eligibility who have worked for large employers often have chosen coverage from a range of plans during their working years and, in the future, those purchasing individual health insurance may also gain experience in choosing plans through the new state and federal health insurance exchanges that began in 2014. Those experiences may increase the likelihood that an incoming beneficiary has experience choosing among

**FIGURE
1-18****Medicare spending is concentrated among beneficiaries with multiple chronic conditions, 2010**

Note: Data based on Chronic Condition Warehouse definitions of chronic conditions.

Source: Centers for Medicare & Medicaid Services 2012.

coverage options and increase the willingness of future Medicare beneficiaries to enroll in Medicare Advantage plans or other alternatives to traditional fee-for-service Medicare.

Workers covered by private health insurance today have also experienced rapid growth in premiums and other out-of-pocket costs. Premiums for family coverage increased 80 percent between 2003 and 2013 (Kaiser Family Foundation and Health Research & Educational Trust 2014). Enrollment in high-deductible health plans—plans that have lower premiums than traditional plans but require the enrollee to spend down a large deductible before receiving insurance benefits—has also increased dramatically. In 2013, 20 percent of workers covered by private health insurance were enrolled in a high-deductible health plan that offered some sort of tax-preferred savings account to pay for the deductible compared with just 4 percent in 2006 (Kaiser Family Foundation and Health Research & Educational Trust 2014).

How quickly will health care spending grow in the coming years?

Despite disagreements among researchers about what share of the health care spending slowdown can be attributed to the recession, nearly all agree that the economic contraction starting in 2007 played a role, and many expect that health care spending may reaccelerate as the economy expands (Martin et al. 2014, Ryu et al. 2013, Sisko et al. 2014).

Exploring the factors behind health care spending can help explain why spending growth accelerates or decelerates. But the question of whether health care spending will continue to grow at the rates seen in the last decade or at rates closer to the three previous decades is still unanswerable.

The Commission maintains that past trends will not necessarily carry into the future, regardless of whether they were caused by economic fluctuations or by structural changes. As an example, in the mid-1990s, health care spending slowed dramatically, in part because of a structural change—the rise of managed care plans—but then spending ramped up again as providers and beneficiaries rejected those plans. Similarly, poor economic conditions over the last decade may have exerted pressure on providers to reduce costs, but as the economy recovers and payment pressure diminishes, costs could increase.

Moreover, despite the slowdown, there is still low-value and wasteful care. If wasteful spending can be identified and eliminated, it may be possible to slow the growth in health care spending. Ideally, the elimination of system inefficiencies and waste could result in each Medicare dollar spent better improving beneficiary health, supporting the program's fiscal sustainability and reducing federal budget pressures. Certain aspects of the Medicare program pose challenges to reducing wasteful spending, and the Commission has made recommendations to address some of those challenges.

Factors affecting health care spending

Factors that affect health care spending include technology, health insurance (both having insurance and the nature of that insurance), consolidation of health care providers, and demographics and patient characteristics (particularly income). The factors are also intertwined; for example, one study has posited that the spread of health insurance between 1950 and 1990 increased the demand

**TABLE
1-2**

Older beneficiaries are more likely to have multiple chronic conditions, 2010

Number of chronic conditions	Age (in years)			
	Less than 65	65 to 74	75 to 84	85 and older
0 to 1	47%	37%	23%	17%
2 to 3	28	34	33	29
4 to 5	17	20	27	29
6 and more	9	9	18	25

Note: Number of chronic conditions is based on counts of 15 selected conditions using the Chronic Condition Warehouse definitions. Totals may not sum to 100 percent because of rounding.

Source: Centers for Medicare & Medicaid Services 2012.

for health care, which in turn, induced hospitals and doctors to adopt new medical technologies because more people could afford them. The author estimates that the combined effect accounted for 50 percent of health care spending growth over that time (Finkelstein 2007).

- **Technology** is credited in some studies as having the largest single effect on growth in health care spending (Cutler 1995, Newhouse 1992, Smith et al. 2009). Caution must be taken when interpreting these studies, however. In most studies, analysts have not measured technology's effect on health care spending directly because it is difficult to do so. Instead, analysts have estimated the contributions of other measurable demographic and economic factors and attributed the unexplained portion of spending growth, or residual, to technology. Therefore, depending on the study, the term *technology* can be interpreted broadly to mean any factor that cannot be measured, making it a catch-all term that could include the technology's adoption, diffusion, substitution, and potentially inappropriate application, but also other changes in medical practice. Technology can refer to new procedures and treatments but also to old procedures and treatments applied to a different population or for a purpose different from what was originally intended (Ginsburg 2008). While expensive new technology can improve health and may be of high value, there is also concern that technological advances expand even beyond cases for which they show efficacy, which increases spending without improving patient outcomes (Baicker and Chandra 2011, Garber et al. 2007, Redberg 2011, Welch 2012). Although technological

advances can sometimes decrease spending (for example, an innovation that more effectively treats a condition at a lower cost), in the practice of medicine, such advances and the resulting changes in clinical practice have generally increased total spending.

- **Health insurance coverage**—while increasing access to health care and protecting beneficiaries against the risk of financial hardship when they need expensive care—reduces the incentive for insured individuals to seek the lowest priced effective service. Researchers suggest that population-level changes in insurance coverage may be responsible for up to half of the increase in per capita health care spending since 1950 (Finkelstein 2007, Peden and Freeland 1995). Studies of Oregon's experiment in extending Medicaid coverage by lottery showed that people randomly chosen for Medicaid coverage used services more—an estimated 25 percent more than the uninsured control group (Baicker and Finkelstein 2011, Finkelstein et al. 2012). More recently, shifting health care costs to insurers has slowed because of rising coinsurance, copayments, and deductibles, likely contributing to the recent slowing of the growth in health care spending (Kaiser Family Foundation and Health Research & Educational Trust 2014).
- **Consolidation** of health care providers has been found to increase spending growth, whereas insurer consolidation has been found to have only a modest effect, which can be positive or negative. Market consolidation among providers increases the rates that providers can negotiate from private payers

(Baker et al. 2014a, Baker et al. 2014b, Gaynor and Town 2012, Robinson and Miller 2014). Hospital purchasing of physician practices, in particular, may be occurring in part because of the disparity between higher payment rates for services provided in the hospital outpatient department than the same service provided in a physician office (Medicare Payment Advisory Commission 2014, Medicare Payment Advisory Commission 2013). By contrast, insurer consolidation tends to lower prices paid to providers because providers may be less able to negotiate high prices if there is a dominant insurer (Moriya et al. 2010). However, those lower prices may not be passed on to consumers in the form of lower premiums if there is not enough competition among insurers for consumers. Studies have shown both modest increases and modest decreases in premiums resulting from insurer consolidation (Dafny et al. 2012, Medicare Payment Advisory Commission 2013).

- ***Demographics and patient characteristics*** affect spending growth, but to a lesser extent than might be expected. Among demographic factors, income and wealth are the primary drivers. People who have more expendable income and wealth will use more of it on health care services. Income and wealth also interact with technology; that is, companies may increase their investments in new health care technologies as the market for these services expands. Along these lines, one study posits that the recent slowdown in health care spending is a result not only of the more recent acute recession but also of the relatively sluggish wage growth for many workers during the 2000s. From this viewpoint, while structural changes (such as payment rate cuts in Medicare, growth in beneficiary cost sharing, and state efforts to contain Medicaid costs) also occurred, these factors were in response to the decade-long period of slow economic growth from 2000 to 2011 (Holahan and McMorro 2013). Stagnant wage growth also may explain why health care spending has not rebounded during the economic recovery.

Patient characteristics such as age or disease burden can also affect health care spending, but most studies have assigned a relatively small share of national health care spending growth to changes in the overall health and aging of the population (Congressional Budget Office 2008, Cutler 1995, Gaynor and Town 2012, Newhouse 1992, Smith et al. 2000).

Evidence of wasteful spending suggests that Medicare could spend less without compromising beneficiaries' health care

While analysts debate the causes of slowing health care spending and whether it will be sustained or transient, there is no evidence that the spending slowdown affected only unnecessary care. The Commission believes it is still important to focus on the sizeable share of current health care spending that is inappropriate, unnecessary, or wasteful.

Geographic variation within and outside the United States indicates that some share of spending is not spent effectively

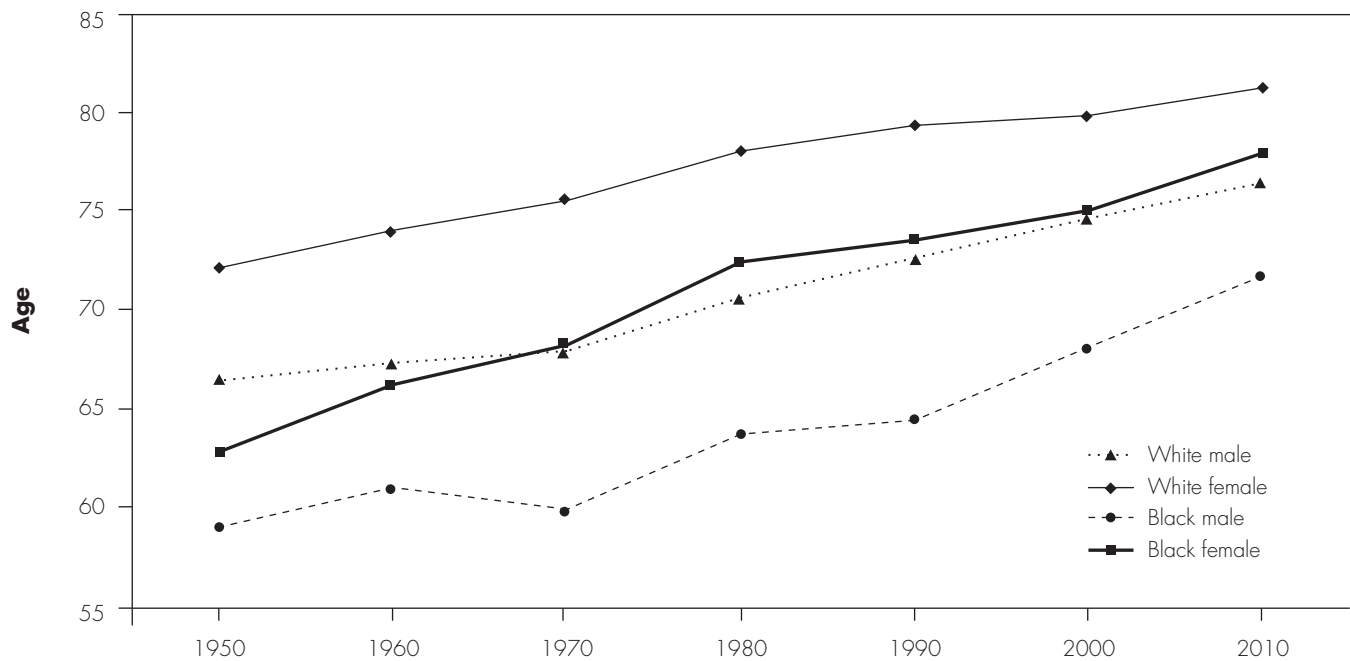
Researchers have documented notable geographic variation (both within the United States and internationally) in health care spending that does not correlate to improved patient outcomes. Certain services that have been widely recognized as low value continue to be performed regularly (Schwartz et al. 2014).

Research on Medicare spending shows that areas with higher spending or more intensive use of services do not have higher quality of care or improved patient outcomes (Fisher et al. 2003a, Fisher et al. 2003b, Institute of Medicine 2013). Even measures of service use, adjusted for health status and standardized prices, show considerable variation (Medicare Payment Advisory Commission 2011b). Even in low-spending areas, some share of health care spending is inappropriate (Leape et al. 1990).

The United States spends more on health care, both per capita and as a share of GDP, than any of the 34 member countries of the Organisation for Economic Co-operation and Development (OECD). However, it is also worth noting that prices are significantly higher for services in the United States as compared with other countries, even when adjusted for purchasing power (Anderson et al. 2003, Laugesen and Glied 2011, Squires 2014, Squires 2012, White 2007). These higher health care spending levels are not accompanied by improved ultimate outcomes; rates of infant mortality and life expectancy are worse in the United States than in most other OECD countries.

Trends in health care quality and outcomes

Other factors for consideration are the trends in health care quality and outcomes and the relationship between these trends and developments in the health care system overall. Life expectancy has improved significantly for

**FIGURE
1-19****Life expectancy at birth, by race and gender**

Source: Centers for Disease Control and Prevention, *Health, United States*, 2013.

the overall population over the past century, although the gains were most striking from 1900 to 1950, during which life expectancy at birth improved by more than 20 years. The gains were also significant in the second part of the 20th century, but to a lesser degree. Over the past decade (from 2000 to 2010), life expectancy at birth improved by an additional two years, to 79 (Xu et al. 2014). However, gains in life expectancy (as well as the starting level) varied by racial and ethnic groups (Figure 1-19). Research also suggests that medical care contributes relatively little to life expectancy gains, on average. When reviewing cross-sectional data on Medicare spending and outcomes, there is little evidence that greater amounts of health care service use or spending result in better quality of care for Medicare beneficiaries.

For some selected diseases, there have been improvements in decreasing mortality for some conditions that are amenable to health care. For example, deaths due to heart disease fell from 590 per 100,000 residents to 180 per 100,000 residents between 1950 and 2010. Similarly, deaths due to cerebrovascular conditions (such as stroke) fell from 180 per 100,000 residents to 39 per 100,000

residents over the same period (National Center for Health Statistics 2014). Rising health care spending may have played a role in these improved outcomes.

Challenges specific to Medicare

The Medicare program is a complex and fragmented system, consisting of multiple paths to entitlement; multiple types of coverage (Part A, Part B, Part C, and Part D); multiple payment systems; and different rules for each setting. The Medicare program must set prices for thousands of discrete services at different levels of aggregation (e.g., inpatient hospital payments are paid based on the stay, while physician payments are based on the service) and in different labor markets across the country. The Medicare program statute and rulemaking include a substantial number of exceptions, adjustments, and modifications to its general policies. Several of Medicare's structural features specifically result in inefficient spending:

- **Fragmented payment system across multiple settings.** The program sets payment rates each year for at least nine different health care settings: inpatient

and outpatient hospitals, physician and other health professional offices, home health agencies, skilled nursing facilities, long-term care facilities, hospices, inpatient rehabilitation facilities, ambulatory surgical centers, and end-stage renal disease facilities. In addition to this yearly rulemaking, administrators oversee other parts of the program that may operate on fee schedules (ambulances, outpatient lab facilities), or on cost-based payment (rural health centers, critical access hospitals). Payment rates for Part C (Medicare Advantage) are set using administrative pricing based on a competitive process, and Part D payments (prescription drugs) are set generally by market rates. But all parts of the Medicare program require significant CMS oversight and administration.

- **Coverage of services delivered by any willing provider.** Under Medicare's statute, the program generally covers all medically necessary services in each benefit category that are delivered by any willing provider (any provider that is willing to meet Medicare's rules). As a result, Medicare does not have the authority to develop provider networks or credential providers, tools that private payers often use to reduce the potential for fraud and abuse. In some cases, the Medicare program even has difficulty removing providers or suppliers whose claims histories clearly demonstrate aberrant patterns.
- **The program's benefit design.** Beneficiaries face differential cost sharing by service (for example, coinsurance for physician services is 20 percent, while home health has no coinsurance); in addition, the cost-sharing amounts, percentages, and deductibles vary by setting, and some services are not covered altogether (for example, Medicare does not generally cover long-term care). Medicare Part A and Part B lack a cap on out-of-pocket costs, a feature that exists in nearly all private insurance policies. In response, many beneficiaries purchase supplemental coverage that includes an out-of-pocket maximum. Most supplemental policies also substantially reduce or eliminate most of the beneficiary liability for coinsurance and deductibles, thereby blunting the impact of cost sharing. As a result, there is little incentive for beneficiaries to be cost-conscious—that is, to select only those services that are necessary and choose providers who use efficient clinical practices (Medicare Payment Advisory Commission 2012).
- **Different prices for the same or similar services.** Given the different settings under which services are delivered, the Medicare program in some cases has different prices for the same or similar services. Under these circumstances, providers have an incentive to shift care to the higher paid setting, which leads to increased program spending and higher beneficiary cost sharing.
- **Undervalued and overvalued services.** In the process of setting prices for thousands of services, certain services are undervalued relative to others. For example, the Commission has raised concerns that the Medicare fee schedule overpays for services provided by clinicians in procedural specialties and underpays for services provided by clinicians in primary care specialties (Medicare Payment Advisory Commission 2011a). The result of this imbalance is significantly higher income for procedural specialties relative to primary care specialties, contributing to a corresponding imbalance in clinician supply.
- **Prompt payment standards.** The Medicare program also follows prompt payment standards, requiring contractors by law to pay claims within 30 days of receipt of a clean claim—one that appears to meet Medicare's rules—or else Medicare will be liable for interest. This emphasis on timely payment means that, in many cases, the claim may be paid and only thereafter identified as potentially fraudulent or erroneous.
- **Vulnerability to patient selection, steering, and overuse.** Another consequence of Medicare's payment structure is its vulnerability to patient selection, steering, and overuse. For example, with some payment systems it is financially advantageous for providers to treat certain kinds of beneficiaries and avoid others, provide certain types of services over others, or treat beneficiaries in a higher paid setting. In addition, in Medicare's fee-for-service system, providers may be able to increase their revenue by increasing the volume of services they provide without commensurate value to the beneficiary. Clinicians also may make referrals to a source of care in which they hold a financial interest or for a service, device, or drug for which they have received payment from the manufacturer.

These features make the program vulnerable to inappropriate care, waste, and fraud. In recent years,

CMS has gained new authorities to exclude potentially fraudulent providers from the program and apply different levels of scrutiny to new providers based on their fraud potential. CMS also has further developed its ability to identify potentially fraudulent billing patterns. However, all of CMS's activities in this area are constrained by resources and subject to statutory requirements that limit its ability to use the same tools to reduce fraud as private insurers (Government Accountability Office 2013).

The Commission's approach to addressing these challenges

Medicare's goal should be to obtain the greatest possible value for the program's expenditures, which means maintaining beneficiaries' access to high-quality services while encouraging their efficient use. However, managing payment rates alone will not address the Medicare FFS system's key challenge—that providers are paid more for doing more services and are not held accountable for the overall outcomes of their patients. Changing this situation will require both payment and delivery system reform.

The Commission's work can be categorized in the following domains: (1) payment accuracy and efficiency, (2) care coordination and quality, (3) information for patients and providers, (4) engaged beneficiaries, and (5) aligned health care workforce. Regardless of the issue, the Commission always considers the interests of three main actors: the beneficiary—access to high-quality, efficient care; the provider—fair and equitable pay; and the taxpayer—the most prudent and valuable use of the public's dollar.

- ***Payment accuracy and encouraging efficiency.*** In Medicare's payment systems, the payment rates for individual products and services may not accurately reflect the cost of furnishing the product or service. Inaccurate payment rates create incentives for higher volume growth for certain services, thereby unduly disadvantaging some providers and unintentionally rewarding others. The Commission pursues payment accuracy in its update recommendations as well as other policy recommendations, with a focus on ensuring that payment is adequate for the efficient provision of care.
- ***Care coordination and quality.*** Providers may provide quality care to uphold professional standards and to have satisfied patients, but until recently Medicare did not have the authority to hold them accountable for or otherwise provide incentives to

improve the quality of care they provide. Similarly, few structures exist in Medicare to hold providers accountable for the full spectrum of care a beneficiary may use, even when they make the referrals that dictate additional resource use. The Commission has supported policies that move Medicare beyond FFS into payment systems that make a provider responsible for the patient's entire episode of care to help address these gaps between settings.

- ***Broadening information available to patients and providers.*** Medicare and its providers lack the information and tools needed to improve quality and use program resources efficiently. For example, Medicare lacks quality data from many settings of care and does not have timely cost or market data to set accurate prices. In addition, beneficiaries now are being called on to make complex choices among delivery systems, drug plans, and providers. Medicare has started to make information available for beneficiaries that could help them choose higher quality providers or lower cost treatments and improve their satisfaction. The Commission has supported policies that promote comparative effectiveness, disclosure of physician financial relationships, and public reporting of quality information.
- ***Engaging beneficiaries.*** While much of the Commission's work focuses on providers and their payment incentives, how beneficiaries view the Medicare program and how they make decisions about their health care are vital to the program's success. Developing policies that engage the beneficiary along with the provider has the potential to improve health, improve the experience of health care provided through Medicare, and control costs for the beneficiary and the taxpayer alike. The Commission has supported reforming the current benefit design and promoted shared decision making.
- ***Aligning the health care workforce.*** Our nation's system of medical education and graduate training is not aligned with the delivery system reforms essential for increasing the value of health care in the United States. The Commission has pursued policies that increase the incentives for residency programs to focus on quality, efficiency, and accountability so that the future clinician workforce can better address the needs of beneficiaries.

Conclusion

The level and growth of health care spending as a share of the economy indicate that an ever-increasing amount of the country's economic activity will be dedicated to purchasing health care. Medicare is the single largest payer in the health care sector and will expand with the aging of the baby-boom generation, greatly increasing program spending. Significant cross-sectional variation in use and spending, which do not correspond to better quality, raise concern that higher health care use and spending are not improving overall health and are putting beneficiaries at risk, both medically and financially.

Because of its size, and because other payers use its payment methods, Medicare has an important influence on the nation's health care delivery system and its evolution. Reciprocally, trends in the private health care insurance

market can influence whether Medicare's payment reforms are ultimately successful. Because of this interaction between public and private payers, the alignment of incentives across payers is an important consideration for delivery system reforms.

Despite the relatively lower rates of spending growth recently experienced by and projected for the Medicare program under current law, the program will continue to absorb increasing amounts of federal revenues. Other public investments such as education and infrastructure will be crowded out by high and growing levels of health care spending. State and federal budgets face continued fiscal pressure, effects intensified by the trends in health care spending. In light of strained federal budgets and the downward trend in personal income, the Medicare program must be vigilant in pursuing reforms that decrease spending and improve quality. ■

Endnotes

- 1 Figure 1-2 shows that the share of spending accounted for by private health insurance (34 percent in 2013) is greater than Medicare's share (22 percent in 2013). However, private health insurance is not a single purchaser of health care; rather, it includes many private plans, including traditional managed care, self-insured health plans, and indemnity plans.
- 2 A small portion of the difference between the Trustees' and CBO's projections is that CBO's 10-year projection is based on current law (as required by its mandate), which includes a scheduled payment rate reduction for services furnished by physicians and other health professionals of about 20 percent in April 2015. Although that reduction is specified under current law, lawmakers have overridden it every year beginning with 2003 and are expected to continue to do so. The Trustees' 10-year projection assumes the payment rate update for physicians and other health professionals will equal the recent historical average (0.6 percent per year).
- 3 As explained in the next section, states and the federal government jointly finance Medicaid, and federal funding comes from general revenues.

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C H A P T E R

2

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

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

Chapter summary

As required by law, the Commission makes payment update recommendations annually for providers paid under fee-for-service (FFS) Medicare. An update is the amount (usually expressed as a percentage change) by which the base payment for all providers in a payment system is changed relative to the prior year. To determine an update, we first assess the adequacy of Medicare payments for providers in the current year (2015) 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—2016). As part of the process, we examine payments to support the efficient delivery of services consistent with our statutory mandate. Finally, we make a judgment about what, if any, update is needed. (The Commission also assesses Medicare payment systems for Part C and Part D and makes recommendations as appropriate. But because they are not FFS payment systems, they are not part of the discussion in this chapter.)

This year, we consider 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 services. Each year, the Commission looks at all available indicators of payment adequacy and re-evaluates any assumptions from prior years using

In this chapter

- Are Medicare payments adequate in 2015?
- What cost changes are expected in 2016?
- How should Medicare payments change in 2016?
- Payment adequacy in context

the most recent data available to make sure its recommendations accurately reflect current conditions. We may also consider changes that redistribute payments within a payment system to correct any biases that may make patients with certain conditions financially undesirable, make particular procedures unusually profitable, or otherwise result in inequity among providers. 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 relatively efficient providers not only help create fiscal pressure on all 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 value of those additional services. Broader reforms such as bundled payments and accountable care organizations are meant to stimulate delivery system reform toward more integrated and value-oriented health care systems. Medicare rates also have broader implications for health care spending. For example, Medicare rates are commonly used to set hospital rates charged to uninsured patients eligible for financial assistance, used by Medicare Advantage plans to set hospital prices, and used by the Department of Veterans Affairs (VA) to pay non-VA providers (Department of Veterans Affairs 2010, Internal Revenue Service 2014, Medicare Payment Advisory Commission 2013a).

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 setting would save money for Medicare, reduce cost sharing for beneficiaries, and reduce the incentive to provide services in the higher paid setting for financial reasons. However, putting into practice the principle of paying the same rate for the same service across settings can be complex because it requires that the definition of the services and the characteristics of the beneficiaries across settings be sufficiently similar. In March 2012, we recommended equalizing rates for evaluation and management office visits provided in hospital outpatient departments and physicians' offices (Medicare Payment Advisory Commission 2012). Last year, we extended that recommendation to additional services provided in those two settings and recommended consistent payment between acute care hospitals and long-term care hospitals for certain classes of patients (Medicare Payment Advisory Commission 2014). This year, we are recommending site-neutral payments to inpatient rehabilitation facilities (IRFs) for select conditions treated in both skilled nursing facilities and IRFs. The Commission will continue to analyze opportunities for applying this principle to other services and settings. ■

Background

The goal of Medicare payment policy should be to obtain 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. Steps toward this goal involve:

- setting the base payment rate (i.e., the payment for services of average complexity) at the right level;
- developing payment adjustments that accurately reflect market, service, and patient cost differences beyond providers' control;
- adjusting payments for quality; and
- considering the need for annual payment updates and other policy changes.

To help determine the appropriate base payment rate for a given payment system in 2016, we first consider whether payments are adequate for relatively efficient providers in 2015. To inform the Commission's judgment, we examine data on beneficiaries' access to care, the quality of care, providers' access to capital, and Medicare payments and providers' costs for 2015. We then consider how providers' costs will change in 2016. Taking these factors into account, we then determine how Medicare payments for the sector in aggregate should change in 2016.

Within a given level of funding for a sector, we may also consider changes in payment policy to improve payment accuracy. Those changes are intended to improve equity among providers or access to care for beneficiaries and may also affect the distribution of payments among providers in a sector. For example, we have recommended removing biases in the skilled nursing facility (SNF) prospective payment system (PPS) that make it more financially desirable to treat patients who need only therapy than to treat medically complex patients.

We also make recommendations to improve program integrity when needed. In some cases, our data analysis reveals problematic variation in service utilization across geographic regions or providers. For example, in reaction to patterns of unusually long stays in a subset of hospices, we recommended medical review focused on hospices that have many long-stay patients.

We compare our recommendations for updates and other policy changes for 2016 with the base payment rates specified in Medicare law to understand the implications for beneficiaries, providers, and the Medicare program. As has been the Commission's policy in the past, we consider our recommendations each year in light of the most current data and, in general, recommend updates for a single year.

Are Medicare payments adequate in 2015?

The first part of the Commission's approach to developing payment updates is to assess the adequacy of current Medicare payments. For each sector, we make a judgment by examining information on the following:

- beneficiaries' access to care
- the quality of care
- providers' access to capital
- Medicare payments and providers' costs for 2015

Some measures focus on beneficiaries (e.g., access to care) and some focus on providers (e.g., the relationship between payments and costs). The direct relevance, availability, and quality of each type of information vary among sectors, and no single measure provides all the information needed for the Commission to judge payment adequacy. Ultimately, the Commission makes its recommendations considering all of these factors.

Beneficiaries' access to care

Access to care is an important indicator of the willingness of providers to serve Medicare beneficiaries and the adequacy of Medicare payments. For example, poor access could indicate that Medicare payments are too low. However, factors unrelated to Medicare's payment policies may also affect access to care. These factors include coverage policy, beneficiaries' preferences, local market conditions, and supplemental insurance.

The measures we use to assess beneficiaries' access to care depend on the availability and relevance of information in each sector. We use results from several surveys to assess physicians' and other health professionals' willingness to serve beneficiaries and beneficiaries' opinions about their access to physician and other health professional services.

For home health services, we examine data on whether communities are served by providers.

Access: Capacity and supply of providers

Rapid growth in the capacity of providers to furnish care may increase beneficiaries' access and indicate that payments are more than adequate to cover providers' costs. Changes in technology and practice patterns may also affect providers' capacity. For example, less-invasive procedures could be performed in outpatient settings and lower priced equipment could be more easily purchased by providers, increasing the capacity to provide certain services.

Substantial increases in the number of providers may suggest that payments are more than adequate and could raise concerns about the value of the services being furnished. For instance, rapid growth in the number of home health agencies suggests that Medicare's payment rates may be more than adequate (confirmed by our analysis of Medicare margins for this sector) and, because the growth has been accompanied by increased cases of fraud, raises concerns about whether current program safeguards are adequate. If Medicare is not the dominant payer for a given provider type, changes in the number of providers may be influenced more by other payers and their demand for services and thus may be difficult to relate to Medicare payments. When facilities close, we try to distinguish between closures that have serious implications for access to care in a community and those that may have resulted from excess capacity.

Access: Volume of services

The volume of services can be an indirect indicator of beneficiary access to services. An increase in volume shows that beneficiaries are receiving more services and suggests sufficient access—although it does not necessarily demonstrate that the services are appropriate. Volume is also an indicator of payment adequacy; an increase in volume beyond that expected for an increase in the number of beneficiaries could suggest that Medicare's payment rates are too high. Very rapid increases in the volume of a service might even raise questions about program integrity or whether the definition of the corresponding benefit is too vague. Reductions in the volume of services can sometimes be a signal that revenues are inadequate for providers to continue operating or to provide the same level of service. Finally, rapid changes in volume between sectors whose services can be substituted for one another may suggest distortions

in payment and raise questions about provider equity. For example, payment rates for evaluation and management (E&M) office visits are much higher in hospital outpatient departments (HOPDs) than in physicians' offices, and HOPDs have recently increased their volume of those services, while physicians' offices have seen a decrease.

However, changes in the volume of services are often difficult to interpret because increases and decreases could be explained by other factors such as population changes, changes in disease prevalence among beneficiaries, technology, practice patterns, deliberate policy interventions, and beneficiaries' preferences. For example, the number of Medicare beneficiaries in the traditional fee-for-service (FFS) program decreased in recent years as more beneficiaries chose plans in the Medicare Advantage program; therefore, we look at the volume of services per FFS beneficiary as well as the total volume of services. Explicit decisions about service coverage can also influence volume. For example, in 2004, CMS began enforcing compliance with a rule mandating that a certain percentage of patients in each inpatient rehabilitation facility (IRF) have 1 of 13 qualifying conditions. As a result, the volume of IRF patients decreased markedly.

Changes in the volume of physician services must be interpreted particularly cautiously. Evidence suggests that for discretionary services, volume may go up when payment rates go down—the so-called volume offset. For other services, such as those requiring significant investment in equipment, volume may eventually shrink. Whether a volume offset phenomenon exists in other sectors depends on how discretionary the services are and on the ability of providers to influence beneficiaries' demand for them.

Quality of care

The relationship between the quality of care and the adequacy of Medicare payment is not direct. Simply increasing payments through an update for all providers in a sector, regardless of their individual quality, is unlikely to solve quality problems because, historically, Medicare payment systems have created little or no incentive for providers to spend additional resources on improving quality. The Medicare program has begun to carry out quality-based payment policies in a number of sectors. However, the Commission has been increasingly concerned that Medicare's approach to quality measurement is flawed because it relies on too many clinical process measures. Many current process

measures are weakly correlated with outcomes of interest such as mortality and readmissions, and most process measures focus on addressing the underuse of services, while the Commission believes that overuse and inappropriate use are also of concern. Therefore, we have begun exploring the use of a small set of population-based outcome measures to assess and compare performance of FFS Medicare, Medicare Advantage (MA), and Medicare accountable care organizations (ACOs) within a local area. We also continue to assess whether provider-level quality measures to make FFS payment adjustments will still be required, even after a population-based quality measurement system is put in place.

Providers' access to capital

Providers must have access to capital to maintain and modernize their facilities and to improve their capability to deliver patient care. Widespread inability to access capital throughout a sector may in part reflect the adequacy of Medicare payments (or, possibly, even the expectation of changes in the adequacy of Medicare payments). Some sectors such as hospitals require large capital investments, and access to capital can be a useful indicator. Other sectors such as home health care do not need large capital investments, so access to capital is a more limited indicator. In some cases, a broader measure such as employment may be a useful indicator of financial health within a sector. Similarly, in sectors where providers derive most of their payments from other payers (such as ambulatory surgical centers) or other lines of business, or when conditions in the credit markets are extreme, access to capital may be a limited indicator of the adequacy of Medicare payments.

Medicare payments and providers' costs for 2015

For most payment sectors, we estimate Medicare payments and providers' costs for 2015 to inform our update recommendations for 2016. To maintain Medicare beneficiaries' access to high-quality care while creating financial pressure on providers to make better use of taxpayers' and beneficiaries' resources, we investigate whether payments are adequate to cover the costs of relatively efficient providers, where available data permit such providers to be defined.

Relatively efficient providers use fewer inputs to produce quality outputs. Efficiency could be increased by using the same inputs to produce a higher quality output or by using fewer inputs to produce the same quality output. We

are exploring ways to define relatively efficient providers. For example, we continue to examine the financial performance of hospitals with consistently low risk-adjusted costs per discharge, mortality, and readmissions (Medicare Payment Advisory Commission 2014, Medicare Payment Advisory Commission 2013b). We also continue to analyze relatively efficient providers in the SNF sector. We have found that some SNFs have considerably lower costs than others and substantially better quality (Medicare Payment Advisory Commission 2011). We have also identified relatively efficient home health agencies (HHAs) (Medicare Payment Advisory Commission 2013b). We plan to explore ways to revise our analyses, recognizing that identifying the efficient provider is a complicated task and is sensitive to the criteria and measures used.

For providers that submit cost reports to CMS—acute care hospitals, SNFs, HHAs, outpatient dialysis facilities, IRFs, long-term care hospitals, and hospices—we estimate total Medicare-allowable costs and assess the relationship between Medicare's payments and those costs. We typically express the relationship between payments and costs as a payment margin, which is calculated as aggregate Medicare payments for a sector, minus costs, divided by payments. By this measure, if costs increase faster than payments, margins will decrease.

In general, to estimate payments, we first apply the annual payment updates specified in law for 2014 and 2015 to our base data (2013 for most sectors). We then model the effects of other policy changes that will affect the level of payments in 2015. To estimate 2015 costs, we consider the rate of input price inflation or historical cost growth, and as appropriate, we adjust for changes in the product (such as fewer visits per episode of home health care) and trends in key indicators (such as historic cost growth and the distribution of cost growth among providers).

Using margins

In most cases, we assess Medicare margins for the services furnished in a single sector and covered by a specific payment system (e.g., SNF or home health services). However, in the case of hospitals, which often provide services that are paid for by multiple Medicare payment systems, our measures of payments and costs for an individual sector could become distorted because of the allocation of overhead costs or the presence of complementary services. For example, having a hospital-based SNF or IRF may allow a hospital to achieve shorter lengths of stay in its acute care units, thereby decreasing

costs and increasing inpatient margins. For hospitals, we assess the adequacy of payments for the whole range of Medicare services they furnish—inpatient and outpatient (which together account for more than 90 percent of Medicare payments to hospitals), SNF, home health, psychiatric, and rehabilitation services—and compute an overall Medicare hospital margin encompassing costs and payments for all the sectors. The hospital update recommendation in Chapter 3 applies to hospital inpatient and outpatient payments; the updates for other distinct units of the hospital, such as SNFs, are covered in separate chapters.

Total margins, which include payments from all payers as well as revenue from nonpatient sources, do not play a direct role in the Commission's update deliberations. The adequacy of Medicare payments is assessed relative to the costs of treating Medicare beneficiaries, and the Commission's recommendations address a sector's Medicare payments, not total payments. We calculate a sector's Medicare margin to determine whether total Medicare payments cover average providers' costs for treating Medicare patients and to inform our judgment about payment adequacy. Margins will always be distributed around the average, and aggregate payment adequacy does not mean that every provider has a positive margin. To assess whether changes are needed in the distribution of payments, we calculate Medicare margins for certain subgroups of providers with unique roles in the health care system. For example, because location and teaching status enter into the payment formula, we calculate Medicare margins based on where hospitals are located (in urban or rural areas) and their teaching status (major teaching, other teaching, or nonteaching).

Multiple factors can contribute to changes in the Medicare margin, including changes in the efficiency of providers, changes in coding that may change case-mix adjustment, and other changes in the product (e.g., reduced lengths of stay at inpatient hospitals). Knowing whether these factors have contributed to margin changes may inform decisions about whether and how much to change payments.

In sectors where the data are available, the Commission makes a judgment when assessing the adequacy of payments relative to costs. No single standard governs this relationship for all sectors, and margins are only one indicator for determining payment adequacy. Moreover, although payments can be known with some accuracy, there may be no “true” value for reported costs, which reflect accounting choices made by providers (such

as allocations of costs to different services) and the relationship of service volume to capacity in a given year. Further, even if costs are accurately reported, as a prudent payer, Medicare may choose not to recognize some of these costs or may exert financial pressure on providers to encourage them to reduce their costs.

Appropriateness of current costs

Our assessment of the relationship between Medicare's payments and providers' costs is complicated by differences in providers' efficiency, responses to changes in payment systems, product changes, and cost reporting accuracy. Measuring the appropriateness of costs is particularly difficult in new payment systems because changes in response to the incentives in the new system are to be expected. For example, the number and types of visits in a home health episode changed significantly after the home health PPS was introduced, although the payments were based on the older, higher level of use and costs. In other systems, coding may change. As an example, the hospital inpatient PPS introduced a patient classification system in 2008 to improve payment accuracy. However, thus far it has resulted in higher payments because provider coding became more detailed, making patient complexity appear higher—although the underlying patient complexity was largely unchanged. Any kind of rapid change in policy, technology, or product can make it difficult to measure costs per unit.

To assess whether reported costs reflect the costs of efficient providers, we examine recent trends in the average cost per unit, variation in standardized costs and cost growth, and evidence of change in the product. One issue Medicare faces is the extent to which private payers exert pressure on providers to constrain costs. If private payers do not exert pressure, providers' costs will increase and, all other things being equal, margins on Medicare patients will decrease. Providers who are under pressure to constrain costs generally have managed to slow their growth in costs more than those who face less pressure (Medicare Payment Advisory Commission 2011, Robinson 2011, White and Wu 2014). Some have suggested that, in the hospital sector, costs are largely outside the control of hospitals and that hospitals shift costs onto private insurers to offset Medicare losses. This belief assumes that costs are immutable and not influenced by whether the hospital is under financial pressure. We find that costs do vary in response to financial pressure and that low margins on Medicare patients can result from a high cost structure that has developed in reaction to high

private-payer rates. In other words, when providers receive high payment rates from insurers, they face no particular need to keep their costs low, and so all other things being equal, their Medicare margins are low because their costs are high. Lack of pressure is more common in markets where a few providers dominate and have negotiating leverage over payers. In some sectors, Medicare itself could exert greater pressure on providers to reduce costs.

Variation in cost growth among a sector's providers can give us insight into the range of performance that facilities can achieve. For example, if some providers in a given sector have more rapid growth in cost than others, we might question whether those increases are appropriate.

Changes in product can significantly affect unit costs. Returning to the example of home health services, one would expect that substantial reductions in the number of visits per 60-day home health episode would reduce costs per episode. If costs per episode instead increased while the number of visits decreased, one would question the appropriateness of the cost growth.

In summary, Medicare payment policy should not be designed simply to accommodate whatever level of cost growth a sector demonstrates. Cost growth can oscillate from year to year depending on factors such as economic conditions and relative market power. Payment policy should accommodate cost growth only after taking into account a broad set of payment adequacy indicators, including the current level of Medicare payments.

What cost changes are expected in 2016?

The second part of the Commission's approach to developing payment update recommendations is to consider anticipated cost changes in the next payment year. This step incorporates not only the uncertainties discussed earlier concerning what cost growth is appropriate but also the uncertainty of any projection into the future. For each sector, we review evidence about the factors that are expected to affect providers' costs. One factor is the change in input prices, as measured by the applicable CMS price index. For facility providers, we start with the forecasted increase in an industry-specific index of national input prices, called a "market basket index." For physician services, we start with a CMS-derived weighted average of price changes for inputs used

to provide physician services. Forecasts of these indexes approximate how much providers' costs would change in the coming year if the quality and mix of inputs they use to furnish care remained constant—that is, if there were no change in efficiency. Other factors may include the trend in actual cost growth, which could be used to inform our estimate if it differs significantly from the projected market basket.

How should Medicare payments change in 2016?

The Commission's judgments about payment adequacy and expected cost changes result in an update recommendation for each payment system. An update is the amount (usually expressed as a percentage change) by which the base payment for all providers in a payment system is changed relative to the prior year. In considering updates, the Commission makes its recommendations for 2016 relative to the 2015 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 2015 base payment. For example, if the statutory base payment for a sector were \$100 in 2015, an update recommendation of 1 percent for a sector means that we are recommending that the base payment in 2016 for that sector should be 1 percent greater, or \$101. If the sequester (which reduces the amount providers receive from Medicare by 2 percent) makes payments in that sector different from our recommended \$101, then the sequester is not consistent with our recommendation.

To be clear, the Commission opposes the sequester as applied to Medicare because it reduces payments across all sectors by 2 percent without regard to payment adequacy. In our thinking, it is not reasonable to treat sectors in the same way if their beneficiaries' access to care, the quality of care, and overall financial performance differ. A more appropriate approach, in our view, is to analyze the circumstances of each sector each year and, where appropriate, recommend changes to the payment rates for each FFS sector. If in the course of this work the Commission would recommend a payment rate below current law, the Commission would bring those savings to the attention of the Congress. This approach would target Medicare savings in areas where spending can be reduced with little effect on beneficiaries

or quality, in contrast to the sequester's uniform reduction across all parts of the program.

It is inaccurate to interpret the Commission's position as recommending that 2 percentage points be added to the Commission's update recommendations to "reverse" the sequester. In fact, because of compounding, doing so would increase program spending much more quickly than overriding the sequester. The sequester in current law decreases payments to providers by 2 percent; it does not change the statutory base payment and it does not compound from year to year as do changes in base payments. In addition, beneficiary cost sharing does not decrease under the sequester; it is computed from the statutory base payment. Increasing base payments would increase beneficiary cost sharing; overriding the sequester would not. The Commission's 2015 margin projections include decreases in Medicare payments in 2015 resulting from the sequester. Projected margins would generally be almost 2 percentage points higher if the sequester were repealed, as we note in each of the payment adequacy chapters.

When our recommendations differ from current law, as they often do, the Congress and the Secretary of Health and Human Services would have to take action and change law or regulation to put them into effect. Each year, we look at all available indicators of payment adequacy and reevaluate prior year assumptions using the most recent data available. The Commission does not start with any presumption that an update is needed or that any increase in costs should be automatically offset by a payment update. Instead, an update (which may be positive, zero, or negative) is warranted only if it is supported by the empirical data, in the judgment of the Commission. The Commission generally takes a year-by-year approach in its deliberations so that the most recent empirical data can be evaluated.

In conjunction with the update recommendations, we may also make recommendations to improve payment accuracy that may affect the distribution of payments among providers. These distributional changes are sometimes, but not always, budget neutral. Our recommendation to shift payment weights from therapy to medically complex SNF cases is one example of a distributional change that would affect providers differentially based on their patients' characteristics.

The Commission, as it makes its update recommendations, may in some cases take into consideration payment

differentials across sectors and make sure the relative update recommendations for the sectors do not exacerbate existing incentives to choose the sector based on payment considerations. The difficulty of harmonizing payments across sectors to remove inappropriate incentives illustrates one weakness of FFS payments specific to each provider type and highlights the importance of moving beyond FFS to more global and patient-centric payment systems. As we continue to move Medicare payment systems toward those approaches, we will also continue to look for opportunities to rationalize payments for specific services across sectors to approximate paying the costs of the most efficient sector and lessen financial incentives to prefer one sector over another.

Paying the same for the same service across settings

A beneficiary can sometimes receive a similar service in different settings. Depending on which setting the beneficiary chooses, Medicare and the beneficiary pay different amounts. For example, when leaving the hospital, patients with joint replacements requiring physical therapy might be discharged with home health care or outpatient therapy, or they might be discharged to a SNF or IRF, and Medicare payments (and beneficiary cost sharing) can differ widely as a result.

A core principle guiding the Commission is that Medicare should pay the same amount for the same service, even when it is provided in different settings. Putting this principle into practice requires that the definition of services in the settings and the characteristics of the patients be sufficiently similar. Where these conditions are not met, offsetting adjustments would have to be made to ensure comparability. Because Medicare's payment systems were developed independently and have had different update trajectories, payments for similar services can vary widely. Such differences create opportunities for Medicare and beneficiary savings if payment is set at the level applicable to the lowest priced setting where the service can be safely performed. For example, under the current payment systems, a beneficiary can receive the same physician visit service in a hospital outpatient clinic or in a physician's office. In fact, the same physician could see the same patient and provide the same service, but depending on whether the service is provided in an outpatient clinic or in a physician's office, Medicare's payment and the beneficiary's coinsurance can differ by 80 percent or more. Nevertheless, it can be difficult to find services in different settings that are defined sufficiently

similarly and to determine whether patients have the same characteristics.

In 2012, the Commission recommended that payments for E&M office visits in the outpatient and physician office sectors be made equal. This service is comparable across the two settings. Our recommendation sets payment rates for E&M office visits in both the outpatient department and physician office sectors equal to those in the physician fee schedule, lowering both program spending and beneficiary liability (Medicare Payment Advisory Commission 2012). Last year, we extended that principle to additional services for which payment rates in the outpatient PPS should be lowered to better match payment rates in the physician office setting (Medicare Payment Advisory Commission 2014). We also recommended consistent payment between acute care hospitals and long-term care hospitals for certain classes of patients (Medicare Payment Advisory Commission 2014). This year, we are recommending site-neutral payments to IRFs for select conditions treated in both SNFs and IRFs (see Chapter 7). The Commission will continue to study other services that are provided in multiple sites of care to find additional services for which the principle of the same payment for the same service can be applied.

Budgetary consequences

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 requires the Commission to consider the budgetary consequences of our recommendations. Therefore, this report documents how spending for each recommendation would compare with expected spending under current law. We also assess the effects of our recommendations on beneficiaries and providers. 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.

Payment adequacy in context

As discussed in Chapter 1, it is essential to look at payment adequacy not only within the context of individual payment systems but also in terms of Medicare as a whole. The Commission is concerned by any increase in Medicare spending per beneficiary without a commensurate increase in value such as higher quality of

care or improved health status. Growth in spending per beneficiary, combined with the aging of the baby boomers, will result in the Medicare program absorbing increasing shares of the gross domestic product and federal spending. Medicare's rising costs are projected to exhaust the Hospital Insurance Trust Fund and significantly burden taxpayers. Ensuring that the recent moderate growth trends in Medicare spending per beneficiary continue will require vigilance. The financial future of Medicare prompts us to look at payment policy and ask what can be done to develop, implement, and refine payment systems to reward quality and efficient use of resources while improving payment equity.

In many past reports, the Commission has stated that Medicare should institute policies that improve the program's value to beneficiaries and taxpayers. CMS is beginning to take such steps, and we discuss them in the sector-specific chapters that follow. Ultimately, increasing Medicare's value to beneficiaries and taxpayers requires knowledge about the costs and health outcomes of services. Until more information about the comparative effectiveness of new and existing health care treatments and technologies is available, patients, providers, and the program will have difficulty determining what constitutes high-quality care and effective use of resources.

As we examine each of the payment systems, we also look for opportunities to develop policies that create incentives for providing high-quality care efficiently across providers and over time. Some of the current payment systems create strong incentives for increasing volume, and very few of these systems encourage providers to work together toward common goals. New programs such as ACOs may start to address these issues, and we are tracking their progress. In the near term, the Commission must continue to closely examine a broad set of indicators, make sure there is consistent pressure on providers to control their costs, and set a demanding standard for determining which sectors qualify for a payment update each year. ■

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C H A P T E R

3

Hospital inpatient and outpatient services

R E C O M M E N D A T I O N

(The Commission reiterates its March 2014 recommendation on hospital payment. See text box, pp. 71–72.)

Hospital inpatient and outpatient services

Chapter summary

The 4,700 hospitals paid under the Medicare prospective payment systems and the critical access hospital payment system received \$167 billion for 10.1 million Medicare inpatient admissions and 196 million outpatient services in 2013. In 2012, the program spent \$165 billion for 10.4 million inpatient admissions and 190 million outpatient services. Net payments per beneficiary increased 0.8 percent from 2012 to 2013, reflecting the net effect of a 1.3 percent decline in inpatient payments per beneficiary and a 5.5 percent increase in outpatient payments per beneficiary.

In this chapter, we reiterate our 2014 recommendation of a package of changes to the Medicare hospital payment systems. This package consists of changing inpatient and outpatient payment rates based on our assessment of payment adequacy, aligning payment rates for certain outpatient hospital services with rates paid to physician offices, and creating greater equity in rates paid to acute care hospitals and long-term care hospitals. These changes are designed to improve financial incentives in these systems while maintaining adequate overall payments.

Assessment of payment adequacy

By law, each year the Commission is required to assess the adequacy of hospital payments and recommend payment updates for hospital inpatient and outpatient services. To evaluate whether aggregate payments are adequate, we

In this chapter

- Are Medicare payments adequate in 2015?
- How should Medicare payment rates change in 2016?

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.

Most payment adequacy indicators (including access to care, quality of care, and access to capital) are positive. However, average Medicare margins continue to be negative, and under current law they are expected to decline in 2015. To judge whether payments are adequate, the Commission makes a collective judgment after discussing the individual payment adequacy indicators listed below.

Beneficiaries' access to care—Access measures include the capacity of providers and the volume of services.

- ***Capacity and supply of providers***—Hospitals continue to have excess inpatient capacity in most markets because of several years of declining inpatient volume.
- ***Volume of services***—Medicare outpatient volume has increased rapidly for several years and continued to grow in 2013. In contrast, Medicare inpatient volume has declined, as has commercial-payer inpatient volume. While we have not seen evidence of material increases in Medicare discharges in 2014, some hospitals have reported increased commercial and Medicaid discharges, in part reflecting demand from newly insured individuals. Because the magnitude of the increase is small, excess capacity will continue in most markets.

Quality of care—Across all hospitals paid under the inpatient prospective payment system (IPPS), most indicators of quality are improving.

Providers' access to capital—Access to capital in the bond and equity markets remained strong for most hospitals. Interest rates paid by most hospitals on their bond offerings continue to be low, and the equity markets continue to see hospitals as profitable investments. However, some hospitals struggling with declining volume have faced downgraded credit ratings.

Medicare payments and providers' costs—From 2007 through 2013, overall Medicare payments to IPPS hospitals were 5 percent to 7 percent below allowable Medicare costs, with an industry-wide Medicare margin of –5.4 percent in 2013. We identify a set of relatively efficient hospitals that have historically done well on a set of cost and quality metrics. These relatively efficient hospitals generated a positive overall Medicare margin of about 2 percent in 2013. However, under current law, payments are projected to decline in 2015 because of changes in Medicare

disproportionate share payments, health information technology payments, and other policy changes. These changes may result in lower margins for all hospitals, including the relatively efficient providers.

Addressing differences in payment rates across sites of care for outpatient care

To move toward paying equivalent rates for the same service across different sites of care, in 2014 we recommended adjusting the rates for certain services when they are provided in hospital outpatient departments (HOPDs) so they more closely align with the rates paid in freestanding physician offices. Under current policy, Medicare usually pays more for services in outpatient departments even when those services are also safely performed in physician offices. For example, Medicare paid more than twice as much for a Level II echocardiogram in an outpatient facility (\$492) as it did in a freestanding physician office (\$228). 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, if a hospital purchased a cardiologist's practice and redesignated that office as part of the hospital, the echocardiograms in that office would be billed as HOPD echocardiograms rather than physician-office echocardiograms, even if there were no change in the physician providing the service, the location of the physician's office, or the equipment being used. In 2013, the volume of echocardiograms billed as HOPD services increased 7 percent, while those billed as physician-office services declined 8 percent. This type of shift to the higher cost site of care increases program costs and costs for the beneficiary. The Commission's 2014 recommendation would reduce Medicare program spending, reduce beneficiary cost sharing, and create an incentive to improve efficiency by caring for patients in the most efficient site for their condition.

Addressing differences in payment rates across sites of care for inpatient care

Payment rates also differ for similar patients in acute care hospitals and long-term care hospitals (LTCHs). As explained in greater detail in the Commission's March 2014 report to the Congress, LTCHs are currently paid much higher rates than traditional acute care hospitals, even for patients who do not require an LTCH's specialized services. To correct this problem, we recommended in 2014 a new criterion for claims to receive the higher level LTCH payments. Chronically critically ill (CCI) patients would still qualify for the relatively high payment rates for LTCH standard diagnosis related groups (DRGs); in contrast, non-CCI cases at LTCHs would receive IPPS standard DRG payment rates. Equalizing non-CCI base rates would reduce LTCHs' average DRG payment for non-CCI cases from about \$40,000 to \$12,000 (the IPPS average for these types of non-CCI cases).

The reduction in LTCH DRG 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 the end, the differences in IPPS and LTCH rates would be reduced. 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.

Recommendation

Given the consistency between the payment adequacy indicators from last year and the payment adequacy indicators from this year, the Commission stands by its multi-part recommendation package from March 2014. Specifically, we recommend that the Congress direct the Secretary of Health and Human Services to take three actions:

- Adjust payment rates for services provided in HOPDs so that they more closely align with the rates paid in physician offices for selected ambulatory payment classifications.
- Set LTCH base payment rates for non-CCI cases equal to acute care hospital base rates and redistribute the resulting savings to create additional inpatient outlier payments for CCI cases that are treated in IPPS hospitals. The change should be phased in over three years.
- Increase base payment rates for the acute care hospital inpatient and outpatient prospective payment systems in 2016 by 3.25 percent, concurrent with the change to the outpatient payment system discussed above and initiating the change to the long-term care hospital payment system.

This package of changes will improve incentives in the system to care for patients in the most appropriate setting and ensure that funding in the acute care hospital systems is adequate to provide high-quality care for Medicare beneficiaries. This can be accomplished by reducing payment rates for services that can safely be provided in lower cost settings and, concurrently, increasing rates for other hospital services by 3.25 percent so that overall Medicare payments are adequate for efficient providers. ■

**TABLE
3-1****Growth in Medicare inpatient and outpatient spending**

Hospital services	2006	2012	2013	Average annual change 2006-2013	Change 2012-2013
Inpatient services					
Total FFS payments (in billions)	\$110	\$119	\$118	1.3%	-0.9%
Payments per FFS beneficiary	3,084	3,232	3,192	0.8	-1.3
Outpatient services					
Total FFS payments (in billions)	29	46	49	7.8	5.9
Payments per FFS beneficiary	884	1,395	1,471	7.9	5.5
Inpatient and outpatient services					
Total FFS payments (in billions)	139	165	167	2.9	1.0
Payments per FFS beneficiary	3,968	4,627	4,663	2.6	0.8

Note: FFS (fee-for-service). Reported hospital spending includes all hospitals covered by Medicare's inpatient prospective payment system along with critical access hospitals. Maryland hospitals are excluded. Fiscal year 2013 payments include partial imputation to account for hospitals that typically do not submit their cost reports to CMS before CMS makes the most recent year available to the public. The combined inpatient and outpatient services per capita are based on a weighted average of Part A and Part B beneficiaries.

Source: MedPAC analysis of CMS Medicare hospital cost reports and Medicare Provider Analysis and Review files.

Background

Medicare spending on hospitals

In 2013, Medicare paid acute care hospitals nearly \$118 billion for fee-for-service (FFS) inpatient care and nearly \$49 billion for FFS outpatient care (Table 3-1). Acute inpatient and outpatient services represented 92 percent of Medicare FFS spending on acute care hospitals. From 2012 to 2013, Medicare inpatient spending per FFS beneficiary decreased by 1.3 percent, and outpatient spending per FFS beneficiary grew by 5.5 percent (Table 3-1).¹ The decline in inpatient payments reflects a 4 percent drop in discharges per capita, which was partly offset by increases in case complexity and Medicare payment rates. The increase in outpatient spending reflects a 4 percent increase in service volume and an increase in Medicare payment rates. On a combined basis, total payments per beneficiary increased by 0.8 percent.

Medicare's payment systems for inpatient and outpatient services

Medicare's inpatient and outpatient prospective payment systems have a similar basic structure. Each has a base rate that is modified for the differences in type of case or service, as well as geographic differences in input prices. However, each prospective payment system (PPS) has

different units of service and a different set of payment adjustments.

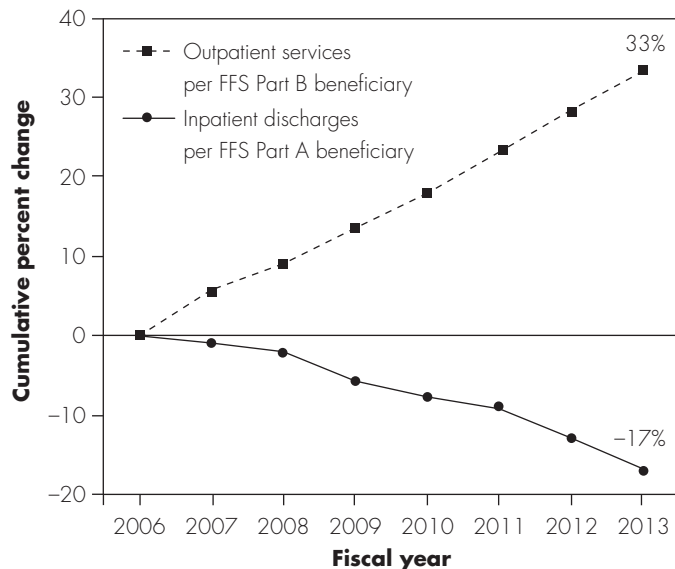
Acute inpatient prospective payment system

Medicare's acute inpatient prospective payment system (IPPS) pays hospitals a predetermined amount for most discharges. The payment rate is the product of a base rate and a relative weight that reflects the expected costliness of cases in a particular clinical category compared with the average of all cases. The labor-related portion of the base payment rate is adjusted by a hospital geographic wage index to account for differences in hospital input prices among market areas. Payment rates are updated annually.

To set inpatient payment rates, CMS uses a clinical categorization system called Medicare severity–diagnosis related groups (MS–DRGs). The MS–DRG system classifies each patient case into 1 of 749 groups, each of which contains cases with similar principal diagnoses, procedures, and severity levels. The severity levels are determined according to whether patients have a complication or comorbidity (CC) associated with the base MS–DRG (the categories are no CC, a nonmajor CC, or a major CC). A more detailed description of the acute IPPS, including payment adjustments, can be found at <http://www.medpac.gov/documents/payment-basics/hospital-acute-inpatient-services-payment-system-14.pdf?sfvrsn=0>.

**FIGURE
3-1**

Medicare inpatient discharges per beneficiary declined as outpatient visits per beneficiary increased



Note: FFS (fee-for-service). Data include general and surgical, critical access, and children's hospitals.

Source: MedPAC analysis of CMS's inpatient and outpatient claims and enrollment data.

Hospital outpatient prospective payment system

The outpatient prospective payment system (OPPS) pays hospitals a predetermined amount per service. CMS assigns each outpatient service to 1 of approximately 800 ambulatory payment classification (APC) groups. Each APC has a cost-based relative weight, and a conversion factor translates these relative weights into payment amounts. In 2015, CMS implemented comprehensive ambulatory payment classifications (C-APCs) in the OPPS and expanded packaging in some APCs.² A more detailed description of the OPPS can be found at <http://www.medpac.gov/documents/payment-basics/outpatient-hospital-services-payment-system.pdf?sfvrsn=0>.

Are Medicare payments adequate in 2015?

To judge whether payments in 2015 are adequate, we examine several indicators of payment adequacy. We

consider beneficiaries' access to care, hospitals' access to capital, changes in the quality of care, and the relationship between Medicare's payments to hospitals' costs for both average and relatively efficient hospitals. Most of our payment adequacy indicators for hospitals are positive, but on average, margins on Medicare patients remain negative for most hospitals and slightly positive for relatively efficient providers.

Beneficiaries' access to care: Access remained good as excess inpatient capacity increased

To evaluate access to care, we examine the availability of hospital services to Medicare beneficiaries by analyzing inpatient and outpatient utilization, hospital openings and closures, hospital occupancy rates, and other measures. Our framework also includes an evaluation of hospitals' access to capital, which provides an outlook on the industry's ability to sustain or expand its existing resources. Collectively, this set of measures provides an overview of hospital service capacity and the availability of hospital services to Medicare beneficiaries.

Medicare beneficiaries' access to hospital services remains good, in part because of excess hospital capacity in most markets. Medicare inpatient discharges declined 4.4 percent per Medicare FFS Part A beneficiary between 2012 and 2013 and fell by a total of about 17 percent from 2006 to 2013 (Figure 3-1). Inpatient volume declined more rapidly in rural hospitals than urban hospitals. Between 2012 and 2013, the total number of rural hospitals' inpatient discharges declined 5.2 percent compared with a 2.3 percent decline in urban hospitals.

From 2012 to 2013, the volume of inpatient services declined approximately 1 percent to 5 percent across all Medicare age groups. Among privately insured individuals under age 65, inpatient discharges per capita declined by 3.5 percent in 2012 and another 2.7 percent in 2013 (Health Care Cost Institute 2014). This trend suggests that inpatient volumes declined for all insured patients through 2013, not just Medicare beneficiaries.

The growth in outpatient services in part reflects incentives to shift patients to higher cost sites of care

From 2012 to 2013, the use of outpatient services increased by 3.8 percent per Medicare FFS Part B beneficiary; over the past seven years, the cumulative increase was 33 percent. Roughly one-third of the growth in outpatient volume in 2013 was due to a 10 percent

increase in the number of evaluation and management (E&M) visits billed as outpatient services. This growth in part reflects hospitals purchasing freestanding physician practices and converting them into hospital outpatient departments (HOPDs). As hospitals do so, market share shifts from freestanding physician offices to HOPDs (Table 3-2). From 2012 to 2013, hospital-based E&M visits per beneficiary grew by 9.4 percent compared with 1.1 percent growth in physician-office-based visits. Other categories of services are also shifting to the higher cost site of care, such as echocardiograms and nuclear cardiology. Hospital-based echocardiograms per capita grew by 7.4 percent compared with an 8.0 percent decline in physician-office echocardiograms. Nuclear cardiology grew by 0.4 percent in HOPDs compared with a 12.1 percent decline in physician offices.

We have documented how the billing for these services has shifted from physician offices to higher cost outpatient sites of care in previous reports (Medicare Payment Advisory Commission 2014b, Medicare Payment Advisory Commission 2013b, Medicare Payment Advisory Commission 2012a). Among other effects, the shift in care setting increases Medicare program spending and beneficiary cost-sharing liability because Medicare payment rates for the same or similar services are generally higher in HOPDs than in freestanding offices.

To address the increased spending that results when services shift from freestanding offices to HOPDs, the Commission recommended adjusting OPPS payment rates so that Medicare payment for E&M office visits is equal in freestanding physician offices and HOPDs (Medicare Payment Advisory Commission 2012b). The Commission also recommended adjusting OPPS payment rates for a set of other services so that payment rates are equal or more closely aligned across these two settings (Medicare Payment Advisory Commission 2014c). We use the increase in E&M office visits provided in HOPDs to illustrate the potential savings to Medicare and beneficiaries from aligning payment rates from the OPPS with the rates in the physician fee schedule.

From 2009 to 2013, the volume of E&M office visits provided to Medicare beneficiaries in HOPDs increased at an average annual rate of 9.2 percent, from 20.3 million visits to 28.9 million visits. As more E&M office visits are provided in HOPDs, the higher payment rates in the OPPS relative to the physician fee schedule result in increasingly higher program spending and beneficiary cost sharing. For example, we estimate that the Medicare program spent \$1

**TABLE
3-2**

E&M office visits and cardiac imaging services are migrating from freestanding offices to HOPDs, where payment rates are higher

	Share of ambulatory services performed in HOPDs, 2012	Per beneficiary volume growth, 2012-2013	
		HOPD	Freestanding office
E&M office visits	10.7%	9.4%	1.1%
Echocardiography	34.6	7.4	-8.0
Nuclear cardiology	39.0	0.4	-12.1

Note: E&M (evaluation and management), HOPD (hospital outpatient department). E&M office visits include Current Procedural Terminology codes 99201-99215. Echocardiography includes services in ambulatory payment classification (APC) 0269, APC 0270, and APC 0697. Nuclear cardiology includes services in APC 0377 and APC 0398.

Source: MedPAC analysis of standard analytic claims files from 2012 and 2013.

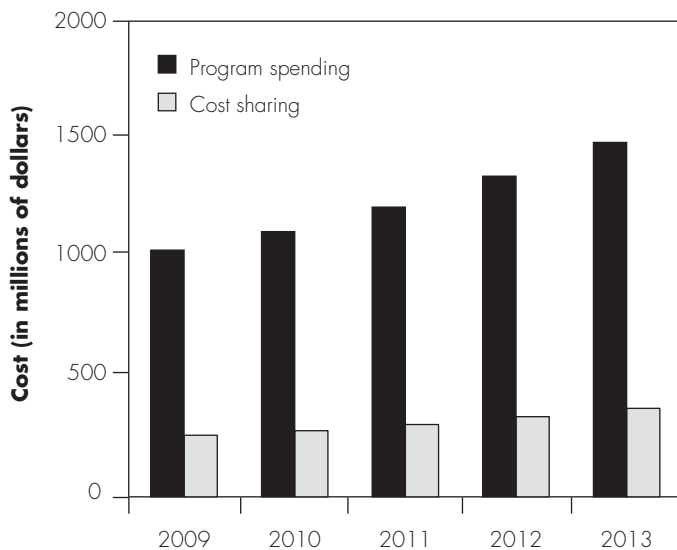
billion more in 2009 and \$1.5 billion more in 2013 than it would have if payment rates for E&M office visits were the same in HOPDs and freestanding offices. Analogously, beneficiaries' cost sharing was \$260 million higher in 2009 and \$370 million higher in 2013 than it would have been because of the higher rates paid in HOPD settings (Figure 3-2, p. 56).³

Part of the decline in discharges and growth in outpatient services is due to increased use of observation services as a substitute for inpatient care

From 2006 to 2013, the number of outpatient observation stays increased by 28 stays per 1,000 beneficiaries (96 percent increase). In contrast, the number of one-day inpatient stays declined by 7 stays per 1,000 beneficiaries (28 percent decline), and the number of inpatient stays with 2 or more days declined by 45 stays per 1,000 beneficiaries (15 percent decline). Because observation stays increased by 28 per 1,000 beneficiaries and inpatient stays declined by a total of 52 per 1,000 beneficiaries, we conclude that about half (28/52) of the 2013 decline in inpatient stays can be explained by the shift of some cases from inpatient to observation.

Excess capacity varies by region

From 2006 to 2013, the national average hospital bed occupancy rate declined from 64 percent to 60 percent,

**FIGURE
3-2****Additional program spending and beneficiary cost sharing due to paying OPPS rates rather than PFS rates for E&M office visits provided in HOPDs**

Note: OPPS (outpatient prospective payment system), PFS ([Medicare] physician fee schedule), E&M (evaluation and management), HOPD (hospital outpatient department). The E&M office visits we analyzed have Current Procedural Terminology codes 99201 through 99215.

Source: MedPAC analysis of outpatient standard analytic claims files for 2009 through 2013 and payment rates for E&M office visits from the 2014 OPPS and 2014 PFS.

despite a concurrent reduction in the number of beds from 2.8 beds to 2.6 beds per 1,000 residents.⁴ The average occupancy rate of all urban hospitals declined by 3.4 percentage points, and the average occupancy rate of all rural hospitals declined by 5.6 percentage points.⁵ The greater decline in rural areas suggests rural individuals increasingly bypass rural hospitals and travel to urban hospitals for inpatient care.

Occupancy rates tend to vary across individual markets and be inversely correlated with the number of beds per capita in a market. The 10 metropolitan areas with the lowest number of beds per capita had an average occupancy rate of 60 percent, and the 10 markets with the highest number of beds per capita had an average occupancy rate of 56 percent. For example, in 2012, the market-wide occupancy rate in Seattle (with fewer than 2 beds per 1,000 people) was 67 percent, while the market-wide occupancy rate in Jackson, MS, (with more than 4 beds per 1,000 people) was 57 percent. There were 345 stays and 2,026 inpatient days per 1,000 beneficiaries in the Jackson hospital referral region (HRR) compared with

222 stays and 1,114 days per 1,000 beneficiaries in the Seattle HRR. After adjusting for input prices, Medicare 2012 inpatient hospital spending per FFS beneficiary (standardized for wages and other factors) was \$2,834 in Jackson compared with \$2,043 in Seattle (Centers for Medicare & Medicaid Services 2014). The difference in inpatient volume and spending per capita reflects a combination of regional differences in beneficiary health status and regional differences in physician practice styles.

Declining occupancy will not significantly affect cost per discharge

The declining volume of discharges at most hospitals raises the question of whether costs per discharge will increase because volume has declined. The prevailing view in the hospital industry is that the majority of hospital costs are fixed. Consequently, if hospitals engage in efforts to control utilization (such as reducing admissions), they will lose the revenue from the discharges and have higher costs per discharge. Therefore, there may be an expectation that hospital payment updates have to increase when inpatient volumes decline. However, in testing the assertion that most costs are fixed, we found that when inpatient volume falls and occupancy rates decline, hospital costs are higher, but the effect is small—suggesting that only a small share of costs (10 percent to 30 percent) are fixed over a one-year period. Therefore, we do not expect there to be a material increase in costs per discharge associated with the observed declines in inpatient volumes (see online Appendix 3-A, available at <http://www.medpac.gov>, for details).

Because the vast majority of large- and medium-sized hospitals' costs are variable, most hospitals could profitably participate in Medicare Advantage or accountable care organization models if they can reduce inpatient utilization in exchange for part of the savings. For smaller hospitals, however, more costs are fixed, making financial success more difficult as volume declines. Therefore, there may be a need for low-volume adjustments or other policies that we have discussed in the past to assist small isolated hospitals (including some critical access hospitals (CAHs)) that lack economies of scale and are facing declining inpatient volume (Medicare Payment Advisory Commission 2011a).

As occupancy fell, hospital closures increased slightly

Overall, 4,760 short-term acute care hospitals submitted a Medicare inpatient claim in 2013, of which approximately

1,329 were CAHs (Flex Monitoring Team 2014). In 2013, 25 acute care hospitals closed and 15 hospitals opened. In addition, our preliminary analysis of hospital closures in 2014 has identified eight closures. Beginning in 2012, hospital closures began to outnumber hospital openings for the first time in over a decade. In light of changes in the practice of medicine, reductions in inpatient discharges, and declining occupancy rates, demand for inpatient services has fallen faster than capacity; therefore, we would expect more closures in the coming years.

Closed hospitals had low occupancy rates and poor margins

The hospitals that closed in 2013 had an average occupancy rate of 34 percent in 2013, lower than the 48 percent average occupancy rate of the hospital nearest to the closing hospital.⁶ For most of the closed facilities, their low occupancy was associated with poor financial performance. The average 2011 and 2012 all-payer profit margins for these hospitals were –8.7 percent and –3.1 percent, respectively. By contrast, the average all-payer margin across all hospitals in 2012 was 6.5 percent. In addition, the closed hospitals were relatively small, with an average of 64 beds. Some of these facilities closed their inpatient service capacity but maintained their outpatient or emergency services.

The group of 15 hospitals that opened in 2013 included a variety of hospital types, ranging from cancer hospitals, emergency care hospitals, neuromedical hospitals, full-service community hospitals, and limited-service hospitals. As a group, these facilities are relatively small, with an average of 40 beds. Most of these facilities offer emergency, imaging, and surgical services. However, many offer a limited set of services that typically include some combination of orthopedic surgery, cardiac surgery, neurological surgery, maternity services, and oncology services.

In aggregate, the 15 hospital openings and 25 closures in 2013 resulted in a net decrease of approximately 1,000 hospital beds. This decrease represents a 0.1 percent reduction in existing bed capacity. American Hospital Association (AHA) survey data reveal that over a longer period, 2006 to 2012, there was a 2.7 percent reduction in national inpatient bed capacity (American Hospital Association 2014), far less than the reduction in discharges over this period. We expect that bed capacity will continue to decline, reflecting a continued decline in inpatient use.

Rural hospital closures

The 11 rural hospital closures were proportionate to the overall share of hospitals that are rural (44 percent). Among the 11 rural hospitals, 2 were 25 miles or more from the nearest hospital, and 9 were between 10 and 25 miles from the nearest hospital. Six of the rural closures were critical access hospitals. These 6 hospitals were an average of 21 miles from the nearest hospital.

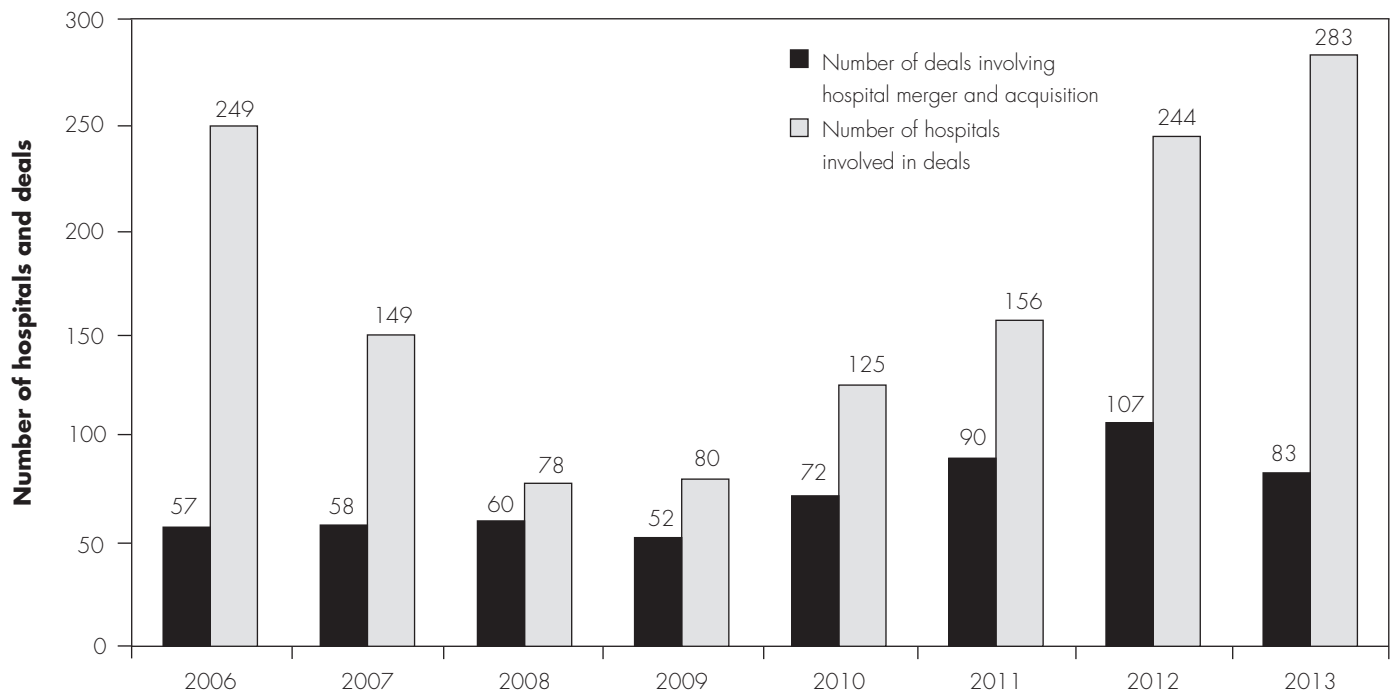
When a CAH closes, the reason is often financial losses due to uncompensated care. Medicare payments are roughly equal to the cost of care at CAHs, and commercially insured patients are generally profitable. But if volumes are low and declining, the profits on commercially insured patients may not be large enough to cover uncompensated care costs. The magnitude of losses on uncompensated care can vary across communities and states. In a September 2014 report about the acute care hospital industry, Deutsche Bank stated that, at the for-profit hospital chains it follows, from July 2013 to July 2014 uninsured discharges declined 50 percent at hospitals in Medicaid-expansion states compared with a 16 percent decline in non-Medicaid-expansion states (Deutsche Bank 2014). Given the declining use of rural hospitals coupled with a desire to maintain access to emergency services in rural areas, it may be time to revisit ways to maintain emergency access in rural areas. Specifically, the special payments made in rural areas could be targeted more at isolated areas with low population density, as discussed in our 2012 report on rural health care (Medicare Payment Advisory Commission 2012a).

Hospital industry consolidation increased

In 2013, 283 individual hospitals were acquired in 83 merger and acquisition transactions (Figure 3-3, p. 58) (Irving Levin Associates Inc. 2014).⁷ These acquisitions represent an increase in the number of hospitals acquired from previous years.

Large acquisitions drove much of the deal-making activity in 2013. Tenet's acquisition of Vanguard Health Systems and Community Health Systems's (CHS) acquisition of Health Management Associates resulted in CHS becoming the second largest chain (\$19 billion in revenues) and Tenet the third largest (\$15 billion in revenues). Hospital Corporation of America remains the largest chain (\$33 billion in revenues) and has also acquired hospitals in recent years.

Vertical integration—hospital systems merging with insurers or with other hospital systems that have an

**FIGURE
3-3****Hospital merger and acquisition activity increased**

Source: MedPAC analysis of 2013 data from Irving Levin Associates Inc.

insurance product—has also continued to increase. For example, in 2014, Baylor Health Care System of northern Texas merged with Scott and White Healthcare of central Texas to form the largest nonprofit health system in Texas, including a health plan originating from Scott and White's side of the deal. In 2013, Pennsylvania's health insurer Highmark Inc. acquired Saint Vincent Health System in Erie; HealthPartners, a nonprofit insurer in Minnesota (with hospitals and clinics of its own), merged with Park Nicollet, a nonprofit physician group practice also with a hospital of its own. Both of these deals vertically integrated regional payers and regional providers to create integrated payer-provider health care systems with a broad geographic base within their markets.

Access to capital and hospital employment remain steady**Bond and equity markets**

Overall, hospitals maintained reasonable access to capital markets in 2013 and 2014. Through the end of 2013, hospital tax-exempt municipal bond offerings amounted to \$18 billion including refinancing, down from \$27 billion in 2012 and \$23 billion in 2011. However, this reduction in

bond offerings could reflect recent reductions in demand for inpatient services. After increasing from 2012 to 2013, the average interest rate for a double-A tax-exempt 30-year nonprofit hospital bond declined from 5.1 percent in November 2013 to 3.6 percent in October 2014. Most of Moody's hospital bond ratings (319) remained unchanged; however, some hospitals have faced downgrades of their credit ratings. Moody's cites the decline in hospitals' volumes as one reason why the number of downgrades (37) exceeded upgrades (27) in 2013 (Moody's Investors Service 2014a).

The share prices of publicly traded hospitals increased substantially in 2014, indicating that the capital markets continue to see hospitals as a profitable investment. For example, the three largest publicly traded hospital companies all had their share prices increase by 17 percent to 53 percent in 2014. Two factors have contributed to the share price growth: strong pricing power, as recently reported by the Healthcare Cost Institute (HCCI), and reduced uncompensated care costs as insurance coverage has expanded (Business Wire 2014b, Business Wire 2014c, Deutsche Bank 2014, Health Care Cost Institute 2014).

Construction spending

The value of hospital construction projects in 2013 remained high, with an increased focus on outpatient facilities. In 2013, the total value of hospital construction was approximately \$26 billion, down from approximately \$28 billion in 2012 (Census Bureau 2014). The decline in construction spending in the last two years may reflect the growth of excess inpatient capacity. The 2014 Construction & Design Survey by Modern Healthcare indicated that the majority of hospital construction has shifted away from inpatient- and toward outpatient-based projects, such as building or renovating medical office buildings, urgent care centers, or emergency departments. Therefore, while inpatient capital spending is declining, outpatient capital spending remains strong. The overall level of capital spending was 1.2 times depreciation in 2013, which suggests capital spending may have been sufficient to replace aging facilities and add some outpatient capacity (Moody's Investors Service 2014b).

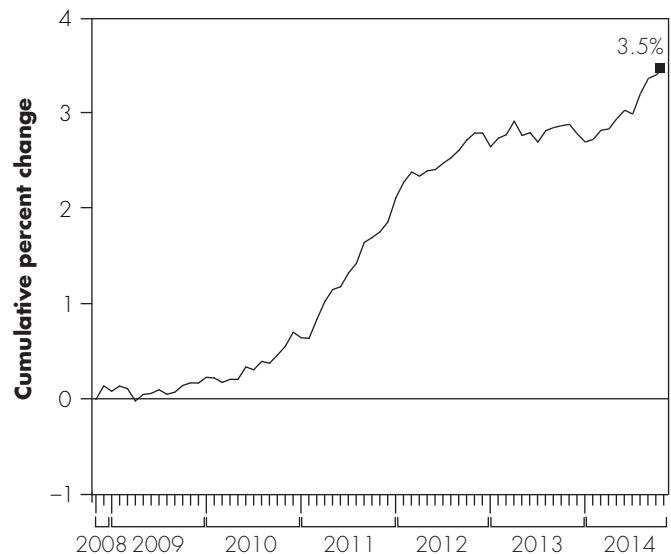
Hospital employment

Over the past six years, hospital employment grew by 3.5 percent, outpacing the 2.5 percent employment growth in the rest of the economy (Figure 3-4). But in the last 12 months, hospital employment growth was relatively flat (0.6 percent) compared with 2 percent private sector employment growth.

We observed, based on data from a separate Bureau of Labor Statistics (BLS) survey that best corresponds to the six-year period described in Figure 3-4, that hospitals hired individuals in computer-related occupations and reduced the number of individuals in lower skilled occupations. Occupations that experienced the largest increase in hospital employment from 2008 to 2013 were computer and science occupations (26 percent), business and financial operations occupations (15 percent), physician assistants (15 percent), pharmacists (15 percent), and clinical health care occupations (6 percent). Occupations that experienced a decline in hospital employment during the same period included licensed practical nurses and licensed vocational nurses (-31 percent), food service staff (-7 percent), and administrative staff (-5 percent). While the number of licensed practical nurses and licensed vocational nurses employed by hospitals declined by 51,000 (-31 percent), the number of registered nurses increased by 94,000 (6 percent) (Bureau of Labor Statistics 2014a).

**FIGURE
3-4**

Hospital employment growth, November 2008 to November 2014



Source: Bureau of Labor Statistics.

In addition, hospitals are increasingly reporting that they employ physicians. Data from the AHA annual survey show a 115 percent increase in physicians employed under a salary model (which excluded physicians who act as contractors for the hospital) from 2007 to 2012.

Access to hospital care is good despite closures and the forthcoming increase in demand for care

Medicare beneficiaries will continue to have access to hospital inpatient and outpatient services despite recent closures and estimated future increases in demand for inpatient services by the newly insured. Although hospital closures have exceeded openings in recent years and hospitals have shed inpatient bed capacity, there is evidence that hospital systems are replacing unneeded inpatient capacity with outpatient capacity. While coverage expansion (resulting from the Patient Protection and Affordable Care Act's state-level health insurance exchanges and Medicaid expansion) will partly offset the general decline in inpatient demand, we still expect excess capacity to grow. We estimate that coverage expansion will result in new admissions equal to roughly 2 percent of current volume.⁸ To date, reports from hospitals suggest growth in inpatient use was modest in 2014. Over the next few years, we expect the effect of the coverage

expansion will be offset by the continued trend toward lower inpatient use, which has reduced occupancy by more than 2 percent in recent years. Therefore, in the near term, inpatient capacity should be sufficient to serve Medicare beneficiaries and the newly insured.

Quality of care: Overall, indicators show improvement

To assess trends in aggregate quality of care across all IPPS hospitals, we use mortality rates and patient safety indicators (PSIs) that are developed and maintained by the Agency for Healthcare Research and Quality (AHRQ). Our analysis of these measures from 2010 through 2013 shows generally positive trends in quality. We observed statistically significant improvements in 7 of 10 mortality rate measures, which include in-hospital and 30-day postdischarge mortality for 5 prevalent clinical conditions.⁹ We also found statistically significant improvements (declines) between 2010 and 2013 in three of the eight AHRQ PSIs that we analyzed.¹⁰ Four other PSI rates also showed declines, but not large enough to reach statistical significance, in part because of the very rare frequency of the adverse patient safety events that the PSI measures are designed to detect.

Readmission rates declining

The Congress enacted a Medicare hospital readmissions reduction program in 2010, and since that time the program has been expanding to cover more conditions. In fiscal year 2015, hospitals will be penalized if they have above-average readmission rates (from a prior three-year period) in one of five clinical conditions (heart failure, acute myocardial infarction, hip or knee replacement, chronic obstructive pulmonary disease, or pneumonia). The penalty is capped at 3 percent of base inpatient payments. Commission analysis has found some small declines in risk-adjusted readmission rates since public reporting began in 2009 and hospitals became aware of the hospital readmission reduction program (Medicare Payment Advisory Commission 2013b). Analysis from CMS also shows a decline in all-cause 30-day readmission rates between 2011 and 2013, from an average of 19 percent to below 18 percent by the start of 2013 (Council of Economic Advisers 2013). The readmission reduction payment policy and other efforts, such as the Partnership for Patients, have encouraged hospitals to look beyond their walls to improve care coordination with providers outside of the hospital and reduce readmissions (Naylor et al. 2012).

Hospital value-based purchasing program payment reduction increases in 2015

The Congress mandated a value-based purchasing (VBP) program for IPPS hospitals beginning in fiscal year 2013. Under the program, CMS reduced all IPPS hospitals' base operating DRG payment amounts by 1.5 percent in 2015 to create a pool of funds from which the performance-based VBP incentive payments will be distributed. This pool of funds will increase to a 2 percent pool by 2016. As required by law, the hospital VBP program is budget neutral; that is, the pool of withheld payments must be redistributed back to hospitals based on their performance on the VBP program's quality measures. The Commission has strongly supported CMS's changes in the program over the past two years to increase the number and weight of outcome measures in the calculation of each hospital's total performance score while reducing the number and weight of clinical process measures.

Hospital-Acquired Condition Reduction Program implemented in 2015

In 2010, the Congress enacted a Hospital-Acquired Condition (HAC) Reduction Program that will take effect in fiscal year 2015: Medicare will reduce IPPS base rates by 1 percent for all hospitals whose performance on a set of HAC measures defined by CMS ranks in the lowest performing quartile nationally. This program is not budget neutral. The 2015 penalty is based on performance data from 2011 to 2013, meaning the hospitals had an incentive to improve HAC performance before 2015. AHRQ reports that hospitals reduced their level of HACs by 17 percent from 2010 to 2013 (Agency for Healthcare Research and Quality 2014).

The Commission has expressed concern that the current statutory design of the HAC Reduction Program penalizes 25 percent of hospitals every year, even if all hospitals significantly reduce HAC rates (Medicare Payment Advisory Commission 2013a). As the Commission discussed when commenting on the current readmission penalty program, it would be more effective to use a fixed performance target for the HAC reduction program. A fixed target would create an incentive for all hospitals to decrease HACs to at least the benchmark rate to avoid the payment penalty.

Medicare payments and providers' costs

In assessing payment adequacy, the Commission also considers the estimated relationship between Medicare payments for, and hospitals' costs of, providing care to

**TABLE
3-3****Cost growth close to input price inflation since 2010**

Cost measure	Annual cost growth				Average annual cost growth 2010-2013
	2010	2011	2012	2013	
Inpatient costs per discharge	1.9%	2.2%	3.2%	3.2%	2.6%
Outpatient costs per service	0.1 *	2.7	3.2	1.2	1.8
Weighted average of services	1.5	2.3	3.1	2.6	2.4
Input price inflation	2.0	2.6	2.1	1.9	2.2

Note: Cost growth numbers are not adjusted for reported changes in case mix. Analysis excludes critical access hospitals and Maryland hospitals. The weighted average is based on services provided to Medicare patients in hospitals, including costs for inpatient, outpatient, skilled nursing facility, inpatient rehabilitation, and home health services.

*Outpatient cost growth was 1.7 percent if we adjusted for complexity of services provided. Input price inflation reflects a weighted average of changes in the hospital operating and capital market basket indexes. The weighted average of services reflects a dollar weighting of cost growth for inpatient and outpatient services.

Source: MedPAC analysis of Medicare cost reports, claims files, and input price estimates from CMS.

Medicare patients. We assess the adequacy of Medicare payments for the hospital as a whole (across all Medicare services), and thus our primary indicator of the relationship between payments and costs is the overall Medicare margin. This margin includes all payments and Medicare-allowable costs attributable to Medicare patients for the six largest covered hospital services plus graduate medical education payments and costs.¹¹

We report the overall Medicare margin across service lines because no hospital service is a purely independent business. For example, we find that operating a skilled nursing facility (SNF) improves the profitability of acute inpatient care services because an in-hospital SNF allows hospitals to safely discharge patients sooner from their acute care beds, thus reducing the cost of the inpatient stay. In addition, the precise allocation of overhead and administrative costs among services presents many challenges. By combining data for all major covered services, we can estimate Medicare margins without the influence of how overhead costs are allocated and how individual service types affect each other's profitability.

To measure the overall pressure that hospitals are under to control costs, we also examine hospital total (all-payer) profit margins and hospital cash flows. When total margins and cash flows are strong, hospitals are under less pressure to control their costs, which in turn affects the Medicare margin.

Medicare payment changes

Growth in Medicare hospital payments per discharge under the IPPS depends primarily on three factors: (1) annual

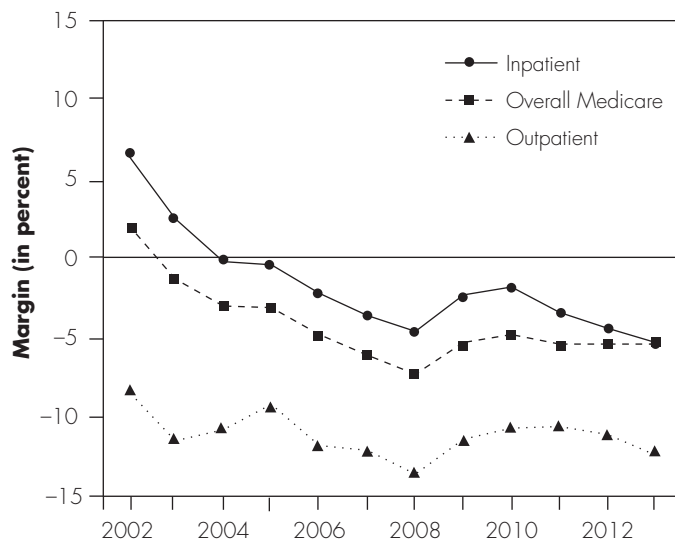
updates to base payment rates, (2) changes in reported case mix, and (3) policy changes that are not implemented in a budget-neutral manner. In 2013, the average payment per case grew by 4.6 percent (before accounting for the sequester). This increase resulted from a 2.7 percent increase in base payment rates through the update and a 2 percent increase in case mix—the largest increase since 2009, after implementation of the MS-DRGs in 2008.¹² Implementation of the sequester adjustment reduced all Medicare claim payment amounts by 2 percent for roughly one-half of the fiscal year starting April 1, 2013.¹³

The additional temporary payments hospitals have received for health information technology (HIT) also significantly increased total Medicare payments. Between 2011 and 2013, Medicare HIT payments rose from \$0.8 billion to \$3 billion, accounting for almost 2 percent of total Medicare FFS revenues in 2013.¹⁴

Rate of cost growth remains close to rate of input price inflation

From 2010 through 2013, hospitals' Medicare inpatient and outpatient costs per case grew an average of 2.4 percent, only about 0.2 percent faster than input price inflation (the hospital market basket index) (Table 3-3). This growth is much slower than experienced through most of the 2000s, when costs increased faster than input price inflation by 1 percentage point or more.

The lower cost growth from 2010 through 2013 was partly due to lower input price inflation facing hospitals, reflecting lower economy-wide inflation for goods and services and slower wage growth. Compensation

**FIGURE
3-5****Hospital Medicare margins:
Inpatient, outpatient, and overall**

Note: A margin is calculated as payments minus costs, divided by payments; margins are based on Medicare-allowable costs. Analysis excludes critical access and Maryland hospitals. Medicare inpatient margins include services covered by the acute inpatient prospective payment systems. "Overall Medicare margin" covers acute inpatient, outpatient, hospital-based skilled nursing facility (including swing beds), home health, and inpatient psychiatric and rehabilitation services, plus graduate medical education and health information technology payments.

Source: MedPAC analysis of Medicare cost reports from CMS.

costs for hospital workers, for example, grew by less than 2 percent in each year from 2010 through 2013, far slower than in prior years. In addition, increases in hospital compensation costs have tended to be less than compensation in the rest of the economy since 2011 (Bureau of Labor Statistics 2014b).

Lower cost growth, however, was not uniform across hospital types. Rural hospitals had much higher cost growth than urban hospitals; from 2009 through 2013, inpatient costs per case increased an average of 3.9 percent in rural hospitals compared with 2.6 percent in urban hospitals. Smaller rural hospitals, those under 50 beds, and sole community hospitals saw even higher average cost increases, 4.6 percent, over the same period. Some of the higher cost growth in rural hospitals could be because of higher revenues associated with the low-volume adjustment, which provided rural hospitals with

higher payments; these payments may have eased the financial pressure on some of these hospitals, resulting in higher cost growth. In addition, total inpatient volume in rural hospitals declined more than urban hospitals, which also may have contributed to higher cost growth because of reduced economies of scale. Urban hospitals with the fewest total discharges also saw much higher cost growth, averaging 4.5 percent from 2009 to 2013, compared with the highest volume urban hospitals, for which cost growth averaged 2.4 percent. Hospitals with lower levels of uncompensated care also had higher average cost growth.

Trend in the overall Medicare margin

We define Medicare margins as Medicare payments minus the allowable costs of treating Medicare patients, divided by Medicare payments. In analyzing hospital margins, we compute margins with and without CAHs, the 1,300 rural hospitals whose payments are based on their incurred costs. We also exclude hospitals in Maryland, which are excluded from the IPPS and paid under a state-wide all-payer prospective payment system. The overall Medicare margin trended downward from 2002 through 2008 (Figure 3-5).¹⁵ However, from 2008 to 2010, the overall Medicare margin went up, from -7.3 percent to -4.8 percent, largely because of increases in reported case mix—the result of documentation and coding changes hospitals made with the introduction of MS-DRGs in 2008—and lower cost growth as a result of the downturn in the economy (Medicare Payment Advisory Commission 2013b). In 2011 and 2012, the Medicare margin declined to -5.4 percent as CMS started to recover past coding-related overpayments. In 2013, the Medicare margin held at -5.4 percent. The overall Medicare margin is dominated by inpatient and outpatient services, which account for 92 percent of hospitals' Medicare revenues. Despite declines in inpatient and outpatient margins in 2013, the overall margin remained relatively steady because of offsetting increases in payments for health information technology.

2013 Medicare margins by hospital type

We further examined overall aggregate Medicare margins by hospital type. In 2013, rural PPS hospitals had a 0.2 percent overall Medicare margin, which was more than 6 percentage points higher than the -5.9 percent margin for urban hospitals (Table 3-4). Smaller rural hospitals saw the greatest improvement in their overall Medicare margins. Between 2010 and 2013, rural hospitals in the bottom quintile of inpatient volume saw their overall margins increase from -2.4 percent to 13.3 percent (not

**TABLE
3-4****Overall Medicare margins by hospital type**

Hospital group	2008	2009	2010	2011	2012	2013
All hospitals (excluding CAHs)	-7.3%	-5.3%	-4.8%	-5.4%	-5.4%	-5.4%
Urban	-7.4	-5.5	-5.1	-5.7	-5.9	-5.9
Rural						
Excluding CAHs	-5.8	-4.2	-2.8	-2.4	-1.4	0.2
Including CAHs	-3.9	-2.7	-1.7	-1.2	0.2	1.2
Nonprofit	-8.5	-6.7	-6.2	-6.8	-7.1	-6.9
For profit	-2.6	0.0	0.2	0.2	1.5	1.2
Government*	N/A	N/A	N/A	N/A	N/A	N/A
Major teaching	-2.3	-1.0	-0.7	-2.0	-2.8	-3.6
Other teaching	-7.5	-5.2	-4.8	-5.1	-5.1	-5.0
Nonteaching	-10.3	-8.2	-7.6	-7.8	-7.4	-6.9

Note: CAH (critical access hospital), N/A (not applicable). Data are for all hospitals covered by the Medicare acute inpatient prospective payment system in 2010 and for CAHs where indicated. A margin is calculated as payments minus costs, divided by payments; margins are based on Medicare-allowable costs. "Overall Medicare margin" covers acute inpatient, outpatient, hospital-based skilled nursing facility (including swing beds), home health, and inpatient psychiatric and rehabilitation services, plus graduate medical education and health information technology payments. The rural margins are shown with and without 1,300 CAHs that are paid 101 percent of costs for inpatient and outpatient services. The margins without CAHs illustrate the profitability of rural inpatient prospective payment system hospitals; the rural margins with CAHs give a fuller picture of rural hospital profitability.

*Government-owned providers operate in a different context from other providers, so their margins are not necessarily comparable.

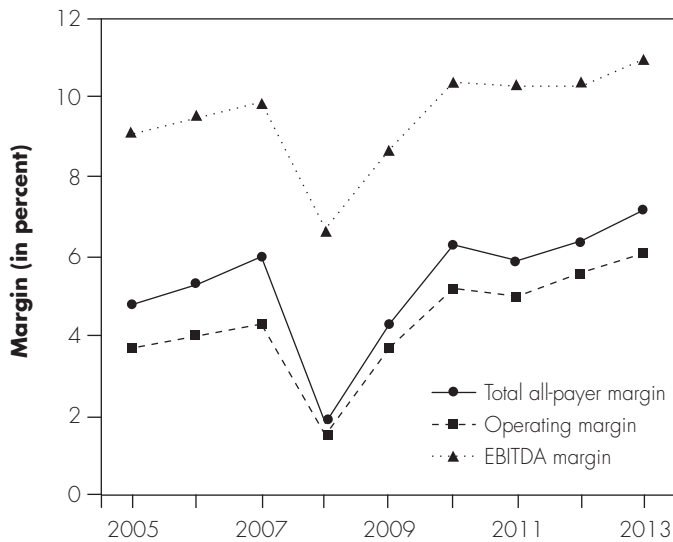
Source: MedPAC analysis of Medicare cost reports, Medicare Provider Analysis and Review files, and impact files from CMS.

shown in Table 3-4). This increase is because many of these hospitals received a combination of low-volume and health information technology payments. Health technology payments will be declining from 2013 to 2016, and the low-volume adjustment is substantially reduced in 2015 unless the Congress extends the temporary low-volume adjustment provisions, which it has done in the past.

In 2013, the overall Medicare margin for major teaching hospitals (e.g., hospitals with a high resident-to-bed ratio) was -3.6 percent. Major teaching hospitals have higher overall Medicare margins than the average IPPS hospital, in large part because of the extra payments they receive through the indirect medical education (IME) and disproportionate share hospital (DSH) adjustments. The difference in the overall Medicare margin between teaching and nonteaching hospitals has narrowed over the past decade. Past Commission analysis has shown that the IME and DSH adjustments have provided payments that substantially exceed the estimated effects that teaching and providing service to low-income patients have on hospitals' average costs per discharge. In June 2010,

the Commission recommended using teaching hospital payments as incentives to train physicians in the skill sets needed by future Medicare beneficiaries (Medicare Payment Advisory Commission 2010a). Nonteaching hospitals, most of which are in urban areas, have lower overall Medicare margins than the average hospital (-6.9 percent in 2013).

In 2013, for-profit hospitals had positive overall Medicare margins (1.2 percent), well above the -6.9 percent overall Medicare margin for nonprofit hospitals. In aggregate, for-profit hospitals had higher inpatient margins (5.5 percentage points higher) and higher outpatient margins (11.2 percentage points higher) than nonprofits. Our analysis of data in recent years shows that most of the differential in margins can be explained by lower inpatient and outpatient costs at for-profit hospitals. A detailed analysis of 2009 outpatient services indicates that for-profit hospitals' outpatient margins also benefit somewhat from a more favorable service mix and from being less likely to incur outpatient teaching costs (Medicare Payment Advisory Commission 2014c).

**FIGURE
3-6****Hospitals' financial performance
has rebounded strongly after
poor performance in 2008**

Note: EBITDA (earnings before interest, taxes, depreciation, and amortization). A margin is calculated as revenues minus costs, divided by payments. Analysis excluded critical access hospitals.

Source: MedPAC analysis of Medicare hospital cost reports.

Total (all-payer) profitability reached a 20-year high in 2013

Hospitals' total (all-payer) profit margins are an indicator of how much financial pressure hospitals are under to control costs. In 2013, total margins for hospitals increased to 7.2 percent, the highest level recorded since the first year of the IPPS more than 20 years ago (Figure 3-6). The growth in these margins was caused by average payment rates rising slightly faster than average cost growth, which was in the 2 percent to 3 percent range during this period. While Medicaid and Medicare payment rate increases have been modest in recent years, all-payer average price increases have exceeded cost growth because of strong increases in private-payer prices. HCCI and BLS report that payment rates from private insurers have grown at an average of 5 percent to 6 percent annually from 2011 through 2013 (Bureau of Labor Statistics 2013, Health Care Cost Institute 2014, Health Care Cost Institute 2012).

While annual cost growth has remained at 3 percent or less in recent years, it may start to increase in response

to hospitals' strong total all-payer margin (Figure 3-6). In addition, cash flow, as measured by earnings before interest, taxes, depreciation, and amortization (EBITDA), increased from 10.3 percent in 2012 to 11.0 percent in 2013, indicating hospitals maintained a relatively strong cash flow. It is unclear whether cost growth will remain at current levels or rebound to levels above input price inflation because of strong all-payer profits. In the past, the Commission has shown that the hospital industry's level of cost growth has been responsive to changes in all-payer profitability (Medicare Payment Advisory Commission 2012b).

Profit margins and financial pressure to constrain costs vary by hospital

In aggregate, profit margins are at record highs. However, profit margins vary widely across hospitals. Some hospitals have strong profits on non-Medicare services and investments and are under relatively little pressure to constrain their costs. Other hospitals, with losses on non-Medicare services, face overall losses (and possibly closure) if they do not constrain costs and generate profits on Medicare patients. To determine the effect of financial pressure on costs, we grouped hospitals into three levels of financial pressure from private payers: high, medium, and low, based on their median non-Medicare profit margins and other factors from 2008 to 2012. For these years, the hospitals under high pressure had non-Medicare profits of less than 1 percent, while the low-pressure hospitals had non-Medicare margins of more than 5 percent. We found that hospitals under high pressure from 2008 to 2012 ended up with lower standardized Medicare costs per discharge in 2013 than hospitals under low levels of financial pressure during the same five-year period. For more details on our analytic methods, see our earlier analysis of payment adequacy (Medicare Payment Advisory Commission 2011b).

Key findings from our analysis of financial pressure on hospitals are:

- **High pressure = low cost.** The 25 percent of hospitals under the most financial pressure had median standardized Medicare costs per case that were roughly 9 percent lower than the national median for all 2,744 IPPS hospitals with available data. Because of their lower Medicare costs, hospitals under pressure generated a median overall Medicare profit margin of 4 percent, which is 9 percentage points above the national median.

- **Low pressure = high cost.** The 59 percent of hospitals that were under a low level of financial pressure had median standardized Medicare costs per case that were 3 percent above the national median. Because of higher costs, they generated a median Medicare profit margin of –9 percent, which is almost 4 percentage points below the national median.
- **For-profit hospitals have different incentives.** For-profit hospitals tended to keep their median standardized Medicare costs per case at the national median even when they were under little financial pressure. This finding suggests that if both types of hospitals receive high payment rates from private payers, the higher revenues tend to result in higher costs in nonprofit hospitals, whereas in for-profit hospitals, a larger share of the revenue is retained as operating profit for shareholders.

A key question is what hospitals under little financial pressure will do with the relatively high profits earned in recent years. One possibility is that we will see a return to the high rates of cost growth seen a decade ago. Another possibility is that nonprofit hospitals may direct their profits toward acquisitions of physician practices, other hospitals, and even insurers. For example, we see continued evidence that physician practices are being acquired by hospitals and that hospitals are using some of their cash flow to purchase other hospitals (Irving Levin Associates Inc. 2014). For-profit systems have returned profits to shareholders in recent years through share buybacks and special dividends.

Relatively efficient hospitals

The goal of our analysis of relatively efficient hospitals is to examine payment adequacy for the group of hospitals that perform relatively well on both cost and quality metrics while serving a broad spectrum of patients. The variables we use to identify relatively efficient hospitals are hospital-level mortality rates (AHRQ Inpatient Quality Indicators), readmission rates (3MTM potentially preventable readmissions), and standardized inpatient Medicare costs per case. Our assessment of efficiency is not in absolute terms but, rather, relative to other IPPS hospitals. For details on the methodology, see our March 2011 report (Medicare Payment Advisory Commission 2011b).

Categorizing hospitals as relatively efficient We assigned hospitals to the relatively efficient group or the control group according to each hospital's performance relative to the national median on a set of risk-adjusted cost and

quality metrics for the period 2010 to 2012.¹⁶ We then examined the performance of the two hospital groups in fiscal year 2013.

Hospitals were identified as relatively efficient if they met four criteria in each year from 2010 to 2012:

- Risk-adjusted mortality rates were in the best two-thirds of all hospitals.
- Risk-adjusted readmission rates were in the best two-thirds of all hospitals.
- Standardized costs per discharge were in the best two-thirds of all hospitals.
- Risk-adjusted mortality or standardized costs per discharge were in the best one-third of all hospitals.

The objective was to identify hospitals that consistently performed at an above-average level on at least one measure (cost or quality) and that always performed reasonably well on all measures. The rationale for this methodology is discussed in detail in our March 2010 report (Medicare Payment Advisory Commission 2010b). In addition to examining claims-based outcomes, we examined each hospital's performance on the Hospital Consumer Assessment of Healthcare Provider and Systems[®] (H-CAHPS[®]) survey. We required that, to be in the set of efficient providers, providers must receive an overall rating of 9 or 10 (on a 10-point scale) from at least 60 percent of the hospital's Medicare beneficiaries.¹⁷

The most recent commissioner discussion regarding the efficient provider analyses raised several questions about the existing methods for defining efficient providers and generated new ideas for consideration. The Commission staff will be undertaking a reexamination of the efficient provider analyses.

Examining performance of relatively efficient and other hospitals from 2010 to 2012 Of the 2,112 hospitals that met our screening criteria, 268 (13 percent) were found to be relatively efficient during the 2010 to 2012 period. This set of relatively efficient providers consisted of a diverse array of hospitals, including large teaching hospitals and smaller rural hospitals. CAHs were excluded from the analysis because they are not paid under the IPPS and have different cost accounting rules.

We examined the performance of relatively efficient hospitals on three measures from 2010 to 2012 by reporting the group's median performance divided by the

**TABLE
3-5****Performance of relatively efficient hospitals**

Relative performance measure	Type of hospital	
	Relatively efficient during 2010-2012	Other hospitals
Number of hospitals	268	1,846
Share of hospitals	13%	87%
Historical performance, 2010-2012 (percent of national median)		
Risk-adjusted:		
Composite 30-day mortality (AHRQ)	82%	102%
Readmission rates (3M TM)	94	101
Standardized Medicare costs per discharge	91	102
Performance metrics, 2013 (percent of national median)		
Risk-adjusted:		
Composite 30-day mortality (AHRQ)	84%	102%
Composite 30-day readmission (CMS)	97	101
Standardized Medicare costs per discharge	90	102
Median:		
Overall Medicare margin, 2013	2%	-6%
Non-Medicare margin, 2013	8	8
Total (all-payer) margin, 2013	6	5

Note: AHRQ (Agency for Healthcare Research and Quality). Relative measures are the median for the group as a percentage of the median of all hospitals. Per case costs are standardized for area wage rates, case-mix severity, prevalence of outlier and transfer cases, interest expense, low-income shares, and teaching intensity. Composite mortality was computed using the AHRQ methodology to compute risk-adjusted mortality for six conditions (acute myocardial infarction, congestive heart failure, pneumonia, gastrointestinal hemorrhage, stroke, and hip fracture). We then weighted the scores for each type of discharge by the share of discharges in that particular hospital. We removed hospitals with low Medicaid patient loads (the bottom 10 percent of hospitals) and hospitals in markets with high service use (top 10 percent of hospitals) because of concerns that socioeconomic conditions and aggressive treatment patterns can influence unit costs and outcomes.

Source: MedPAC analysis of impact file, Medicare Provider Analysis and Review file, Medicare hospital cost reports, and CMS hospital compare data.

median for the set of hospitals in our analysis (Table 3-5). The median relative risk-adjusted 30-day mortality rate among efficient hospitals from 2010 through 2012 was 82 percent of the national median, meaning that the 30-day mortality rate for the efficient group was 18 percent below (that is, better than) the national median. The median readmission rate for the efficient group was 6 percent below the national median. The standardized Medicare cost per discharge for the efficient group was 9 percent lower than the national median. These relatively efficient hospitals are spread across the country and have a diverse set of characteristics, but they are more likely to be larger nonprofit hospitals because those hospitals tend to have better performance on the quality metrics we analyzed. For a more complete description of the methodology and other characteristics of relatively efficient providers, see our March 2011 report (Medicare Payment Advisory Commission 2011b).

Historically strong performers had lower mortality and costs in 2013

The composite mortality rate for the efficient group was 16 percent below the national median in 2013, and the median standardized Medicare cost per discharge in the efficient group was 10 percent lower than the national median. The lower costs allowed the relatively efficient hospitals to generate higher overall Medicare margins. The median hospital in the efficient group had an overall Medicare margin of 2 percent, while the median hospital in the comparison group had an overall Medicare margin of -6 percent. As shown in past years, it is possible to deliver relatively good quality care that patients value at a cost roughly equal to Medicare payment rates.

Explaining the divergence in Medicare and commercial payment rates

Despite Medicare margins of -5 percent to -7 percent in recent years, hospitals' all-payer margins (which include

Medicare) rose to a record high of over 7 percent in 2013. The all-payer margins are at historic highs because of rate increases from private insurers that are well above cost growth, resulting in high margins on patients with commercial insurance (Health Care Cost Institute 2014, Medicare Payment Advisory Commission 2014a). Commercial rates, on average, are about 50 percent higher than hospital costs and more than 50 percent higher than Medicare rates (Health Care Cost Institute 2014, Medicare Payment Advisory Commission 2014a). For example, Aetna and Blue Shield of California pay hospitals rates that are often 200 percent of Medicare's rate for inpatient care and 300 percent of Medicare's rate for outpatient services in California (California Department of Insurance 2014a, California Department of Insurance 2014b).

Some providers and insurers have argued that commercial rates must be high to compensate for losses on Medicare patients; they argue hospitals are forced to “cost shift” onto private payers. However, we argue the reverse: High commercial rates may cause losses on Medicare patients. We contend that most hospitals prefer higher revenues to lower revenues and will raise commercial rates when they have the market power. When hospital revenues are higher, expenditures and costs per discharge are higher (Medicare Payment Advisory Commission 2009, Stensland et al. 2010, White and Wu 2014). Thus, high commercial rates could drive costs up and Medicare margins down. In contrast, the cost-shift theory asserts that losses on Medicare patients cause high private-insurer rates. While hospitals may use their profits on private patients to cover some Medicare patient costs, we do not find that hospital costs are immutable or that hospitals must charge commercial rates that are 200 percent of Medicare. The efficient provider analysis shows that there is room for some hospitals to lower their costs and therefore some room for lower prices. In other words, it is implausible that losses on Medicare patients forced hospitals to raise prices to a level that generated record-high all-payer profits in 2013.

Looking forward, the Medicare program has a limited number of tools to maintain pressure on hospitals to restrain their cost growth. Over the short run, Medicare payment updates could be reduced and hospitals would still be expected to accept Medicare patients because of excess capacity and because Medicare payments exceed marginal costs. Over the long term, significant restraints on payment rate updates without comparable restraint by private insurers on their rates could make it difficult for hospitals that serve primarily Medicare patients to compete

for labor with hospitals primarily serving privately insured patients. The implication is that as long as private payers and employers are unable to constrain commercial rates, hospital profits, costs, or both will rise and the profitability of caring for Medicare patients relative to the profitability of caring for commercially insured patients will continue to diverge.

How would current law changes from 2014 through 2016 affect hospitals' Medicare payments and beneficiaries' access?

Overall Medicare margins were -5.4 percent on average in 2013. The 2 percent sequester was in effect for roughly half of fiscal year 2013 and the full year in 2014, reducing 2014 payments relative to 2013 by almost 1 percentage point. Given the full-year effect of the sequester, we expect overall Medicare margins will decline slightly in 2014.

As we discussed in our March 2014 report to the Congress, a series of policy changes in current law are expected to result in a net reduction in payment rates from 2014 to 2015. Under current law, the base payment rate update is projected to be 2.2 percent. The following payment policy changes are expected to roughly offset the 2015 update:

- Medicare uncompensated care payments will decline because of expansion of the number of insured individuals. That decline will reduce Medicare payments by roughly 1 percent. (However, increases in insured patients will increase non-Medicare revenues).
- Two additional changes will affect hospitals with poor performance on quality metrics:
 - Readmission penalties are expected to increase in 2015 when additional clinical conditions are added to the readmissions policy, which is expected to reduce payments by an additional 0.1 percent in 2015.
 - The 25 percent of hospitals with the lowest performance on HACs will face a 1 percent reduction in their IPPS payments (equal to roughly 0.2 percent of all Medicare hospital payments in 2015).
- Payments for electronic health records (EHRs) are slowly being phased out, causing a decline in EHR payments equivalent to 0.5 percent of overall Medicare payments.

- Mandated recovery of past overpayments because of documentation and coding changes after implementation of MS-DRGs resulted in a 0.8 percent adjustment to inpatient rates, equivalent to 0.5 percent of overall 2015 payments.

We expect cost growth per discharge to be similar to the 3 percent level seen in recent years based on cost growth reported by publicly traded companies and data from the Census Bureau. Because we expect cost growth to be slightly higher than the update in 2015 and because payments will be reduced by about 2.5 percent due to the policy changes listed above, we expect overall Medicare margins to decline by about 3 percent in 2015. A 3 percent reduction would bring margins down from roughly –6 percent in 2014 to approximately –9 percent in 2015. This margin includes the effect of the sequester fully phased in by 2014. If the sequester is removed (consistent with our recommendation), margins would be about 1.8 percent higher, or roughly –7 percent, closer to the levels in recent years.

Marginal profits on Medicare patients

Despite negative margins in 2015, most hospitals will continue to have a financial incentive to increase the volume of Medicare patients they see because their marginal revenue from each additional patient is expected to exceed their marginal cost of caring for an additional Medicare patient. We can estimate the marginal profit on Medicare patients by looking at costs that vary with patient volume (variable costs) and revenues that vary with Medicare volume (variable revenues). Online Appendix 3-A, available at <http://www.medpac.gov>, includes a detailed discussion of costs that are variable over a period of one year.

Marginal costs are expected to be between 70 percent and 90 percent of total costs for hospitals with over 2,000 discharges and closer to 50 percent of total costs for smaller hospitals with under 2,000 discharges (see online Appendix 3-A, available at <http://www.medpac.gov>, for details). For example, if an average-sized hospital's fixed costs were 20 percent of total costs, then the marginal costs would be 80 percent of total costs.

In aggregate, assuming current levels of cost growth, IPPS hospitals' Medicare payments are expected to be equal to 92 percent of total allowable costs in 2015.¹⁸ Medicare uncompensated care payments do not vary with Medicare volume and therefore are not part of variable revenues. They are expected to be equal to roughly 4 percent of total allowable costs in 2015; therefore the marginal revenue

from a service is expected to be close to 88 percent of total allowable costs of that service in 2015.

For a hospital for which variable revenue is equivalent to 88 percent of total costs and variable costs are 80 percent of total costs, the marginal revenue from an additional patient will still exceed the costs. Therefore, the average hospital will still have a direct financial incentive to admit Medicare patients. While marginal profits are a sufficient condition for hospitals to have a financial incentive to see Medicare patients, there are also other reasons for them to do so. Hospitals benefit from indirect incentives such as wanting to keep nonprofit status, wanting to avoid low occupancy rates, and not wanting to alienate physicians by taking only privately insured patients.

Policy changes in 2016 that will affect providers' payments and costs

The 2016 update under current law is projected to be 2.3 percent. However, policy changes will continue to reduce payments, including further reduction in DSH payments, reductions in HIT payments, and an additional adjustment for past overpayments from coding. The net effect of these changes will be an offset of about 2 percentage points of the 2.3 percentage point increase resulting from the update. Depending on cost growth, margins could decline from 2015 to 2016.

Despite potential changes in payments and costs, access is expected to remain strong

Following the enactment of the Patient Protection and Affordable Care Act of 2010, some analysts argued that the slow growth of Medicare payments and continued rapid growth in private payer rates would create a large divergence that, in the long run, could put pressure on Medicare patients' access to care (Foster 2010, Newhouse 2010, Shatto and Clemens 2011). They suggested that either private insurers will have to slow the growth in their payment rates or the Medicare program will have to increase its rates of payment growth to maintain beneficiaries' access to care. In 2011, commercial insurer payment rates were 47 percent above costs, whereas Medicare rates were 6 percent below costs, resulting in a rate gap of 53 percent in 2011. Data from HCCI on private pay increases compared with Medicare rate increases in this chapter suggest that this gap will grow above 53 percent by 2015 (Health Care Cost Institute 2014).

Despite this growing gap, we do not expect to see any near-term material reductions in Medicare beneficiaries' access to care for several reasons:

- Most hospitals have excess capacity; occupancy fell from 64 percent to 60 percent in recent years.
- Medicare payment rates, while less than the total cost of care, are still greater than the marginal cost of care for most hospitals. Therefore, it is still profitable at the margin to see additional Medicare patients.
- Some hospitals currently accept discounts to Medicare rates from Medicare SELECT medigap plans to gain Medicare market share. These hospitals want more Medicare patients even at rates lower than standard Medicare rates.

Because hospitals have a financial incentive and the capacity to serve Medicare patients, we do not believe beneficiaries' access to care is at risk in the near term. However, in the long run, the growing disparity between Medicare rates and commercial rates (which continue to grow at roughly 5 percent per year) will have to be addressed. The gap cannot be closed by increasing Medicare rates by 5 percent or more per year; the Medicare trust fund would not be able to absorb those price increases. Therefore, commercial payment rate growth will have to decline, or eventually the difference between commercial rates and Medicare rates will grow so large that more hospitals would have an incentive to focus primarily on patients with commercial insurance. Thus, in the long term, Medicare beneficiaries' access to care may in part depend on commercial payers restraining rates paid to hospitals.

Addressing differences in payment rates across sites of care for outpatient and inpatient care

As part of our annual March report on payment adequacy, the Commission has traditionally had two objectives. One objective is to recommend an appropriate aggregate level of payments using the update. The second objective is to recommend adjustments in payment policies when necessary to set appropriate relative prices across services and across sites of care. One problem with the current system of relative prices is that differences in prices across care settings are causing distortions in provider incentives. For example, hospital outpatient department rates are not aligned with rates paid for the same services in a physicians' office, giving hospitals an incentive to acquire physician practices and bill for the same services at outpatient rates, increasing costs to the program and to the beneficiary. To remove this incentive, we recommended setting outpatient rates closer to physician office rates for

a set of services that are often performed in both locations. The details are in our June 2013 and March 2014 reports to the Congress (Medicare Payment Advisory Commission 2014c, Medicare Payment Advisory Commission 2013a).

A similar problem exists for hospital inpatient services. Long-term care hospitals (LTCHs) are currently paid much higher rates than traditional acute care hospitals (ACHs), even for patients who do not require the specialized services of an LTCH. To better align payments between the ACH and the LTCH settings, we recommended a new criterion for patients receiving standard LTCH payments. We discussed the details of this recommendation in our March 2014 report to the Congress; in this chapter, we will only highlight the rationale behind the recommendation.

As described in our March 2014 report, Medicare pays LTCHs under a separate PPS, with higher payment rates—for both chronically critically ill (CCI) and non-CCI cases—than payments made for similar patients in other settings (Medicare Payment Advisory Commission 2014c). Historically, there have been few criteria defining LTCHs, the level of care they provide, or the patients they treat. The Commission and others have repeatedly raised concerns that the lack of meaningful criteria for admission to LTCHs means that these providers can admit less-complex patients who could be cared for appropriately in less expensive settings. 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 non-CCI (Medicare Payment Advisory Commission 2013b).

To reduce incentives for LTCHs to admit lower acuity patients—who could be appropriately cared for in other settings at a lower cost to Medicare—the Commission recommended that standard LTCH payment rates be paid only for LTCH patients who meet the CCI profile at the point of transfer from an ACH. LTCH cases that are non-CCI should be paid IPPS rates approximately the same as the MS-DRG payment rates that would have been paid if the patient had been treated in an IPPS hospital in the same local market.¹⁹ The Commission recommended that the Congress use the savings achieved from improving the appropriateness of LTCH payments to improve the accuracy of payments for CCI cases in ACHs paid under the IPPS. Funds that would have been used to make payments under the LTCH payment system instead should be allocated to a new IPPS outlier pool to help alleviate the cost of caring for extraordinarily costly CCI cases in

ACHs. Outlier payments for IPPS CCI cases could be calculated using a lower fixed loss amount, and Medicare could pay 90 percent of hospitals' costs above the CCI outlier threshold. The outlier policy for non-CCI cases in IPPS hospitals would remain unchanged.

In our March 2014 report to the Congress, the Commission recommended that—in the absence of data on the metabolic, endocrine, physiologic, and immunological abnormalities that characterize CCI conditions—Medicare should define LTCH CCI cases as those who spent eight or more days in an intensive care unit (ICU) during an immediately preceding ACH stay. These cases were concentrated in a small number of MS-DRGs that correspond to the “ideal” LTCH patients as typically described by LTCH representatives and critical care clinicians (Dalton et al. 2012). Previous studies have found such severely ill patients more likely to benefit from LTCH care (Kennell and Associates Inc. 2010, Medicare Payment Advisory Commission 2004). At around the same time the Commission made its recommendation, the Congress passed the Pathway for SGR Reform Act of 2013, which contained a number of provisions affecting the LTCH PPS. Among those was a provision that defined patients appropriate for LTCH-level payment as those with a three-day ICU stay (for more detailed information see Chapter 11). The three-day ICU stay threshold scheduled to start in 2016 under current law is less restrictive than the Commission’s recommended eight-day threshold. The Commission also recommended that an exception to the eight-day ICU threshold be made for LTCH cases that received mechanical ventilation for 96 hours or more during an immediately preceding acute care hospital stay.

Similarly, the Commission recommended that the cases in IPPS hospitals that will be eligible for higher outlier payments should be those in which the IPPS stay includes eight or more days in an ICU, with an exception to the eight-day ICU requirement made for patients receiving prolonged mechanical ventilation.

In concert with the payment changes for LTCHs, the Commission suggested that the Congress change the length-of-stay requirement for LTCHs. Currently, to qualify as an LTCH, a facility must maintain an average length of stay of more than 25 days. When non-CCI cases are paid IPPS-based rates, this requirement would apply only for CCI cases and no longer apply for non-CCI cases. This change would remove the financial incentives LTCHs currently have to keep non-CCI patients in the LTCH longer than necessary. Therefore, we would expect the average length of stay and the cost for non-CCI cases at LTCHs to decline. We also expect LTCHs to admit fewer non-CCI cases and to be more selective in choosing which non-CCI cases they do admit.

Without behavioral changes, aggregate payments to LTCHs would decline by about \$2 billion, which would be shifted to IPPS hospitals that care for the most expensive ICU cases. However, because of the expected efficiency gains described above, the net effect on LTCH profits is expected to be far less than \$2 billion. Our March 2014 report to the Congress discusses these effects in detail.

How should Medicare payment rates change in 2016?

Last year, the Commission recommended a package of three changes to Medicare hospital payments: an increase in hospital outlier payments (financed by reduced LTCH payments as discussed above), setting payments for certain services (e.g., echocardiograms) that can be done safely in physician offices at or near the rates paid in physician offices, and a 3.25 percent payment rate update to base payment rates. The increase in outlier payments for IPPS hospitals and the decrease in certain LTCH payments are designed to reduce payment differentials across sites of care. Given that the payment adequacy indicators for 2015 were very similar to the adequacy indicators in 2014, the Commission has decided to stand by its previous multi-part recommendation (see text box). ■

The Commission reiterates its March 2014 recommendation on hospital payment

Recommendation 3, March 2014 report

The Congress should direct the Secretary of Health and Human Services to:

- **reduce or eliminate differences in payment rates between outpatient departments and physician offices for selected ambulatory payment classifications.**
- **set long-term care hospital base payment rates for non-chronically critically ill (CCI) cases equal to those of acute care hospitals and redistribute the savings to create additional inpatient outlier payments for CCI cases in inpatient prospective payment system hospitals. The change should be phased in over a three-year period from [2016 to 2018].**
- **increase payment rates for the acute care hospital inpatient and outpatient prospective payment systems in [2016] by 3.25 percent, concurrent with the change to the outpatient payment system discussed above and with initiating the change to the long-term care hospital payment system.**

Rationale

The Commission balanced several factors in reaching its recommendation. First, incentives to shift care to higher cost sites must be reduced. The recommendation would reduce the incentive to shift patient billing to hospital-owned outpatient facilities when the patient does not need hospital-level care. The recommendation would also reduce the incentive to admit non-CCI patients to long-term care hospitals (LTCHs). The savings from this policy would be used to increase payments for chronically critically ill (CCI) patients in acute care hospitals. This policy of reducing payment rates for non-CCI cases in LTCHs and increasing payments for CCI cases in inpatient prospective payment system hospitals would make the system more equitable and reduce incentives to shift non-CCI cases to the more costly LTCH setting.

The update recommendation is higher than current law because of a balance of several factors. First,

most payment adequacy indicators are positive, but Medicare margins are negative. Second, several current law policy changes are scheduled to reduce payments in 2015 and 2016. Because of these changes and reduced payments, as well as the proposed changes to outpatient payments and outlier payments for CCI cases, an update of 3.25 percent in the base payment is warranted. The Commission maintains that Medicare payment rates should be determined by analysis of payment adequacy rather than an across-the-board sequester reduction. Therefore, the Commission recommends that hospitals receive base payment rates that are 3.25 percent higher than the 2015 base payment rates, and there should be no sequester adjustment. However, if the Congress increases hospital payments by reinstating expiring special payments, the full 3.25 percent update would not be warranted.

We also realize that the proposed changes to the long-term care payment system and the acute care hospital outlier payments for CCI cases would be large. For that reason, we propose that these changes be phased in over a three-year period.

Implications Spending

- As we discussed in the March 2014 recommendation, if the LTCH reform and acute care hospital CCI outlier payments were phased in over three years, roughly \$700 million per year would be transferred from the LTCH payment system to the acute care payment system. Aligning certain outpatient ambulatory payment classifications with physician office rates would reduce payments to hospitals by approximately \$1.4 billion, and increasing the update of base payment rates over current law would increase payments by approximately \$1.7 billion over current law. The net increase in payments to hospitals over current law would be close to \$1 billion.
- The package of three payment changes (the 3.25 percent increase in base payment rates, LTCH reform coupled with acute care hospital CCI

(continued next page)

The Commission reiterates its March 2014 recommendation on hospital payment (cont.)

outlier payments, and aligning certain outpatient ambulatory payment classifications with physician office rates) would increase Medicare program spending by between [\$750 million and \$2 billion in 2016] and between \$5 billion and \$10 billion over five years.

Beneficiaries and providers

- Beneficiaries would see lower cost sharing because the effect of alignment of selected outpatient

payment rates with the physician fee schedule (which lowers cost sharing) is larger than the higher update (which increases cost sharing). The recommendation may also slow or stop the shift of services from freestanding practices to hospital outpatient departments. Payments to LTCHs would decline for the non-CCI cases, and payments to acute care hospitals would increase for CCI cases. In addition, the higher update would increase payments for all cases in acute care hospitals. ■

Endnotes

- 1 Payments per beneficiary include roughly \$7 billion of inpatient and outpatient payments to critical access hospitals, which are paid 1 percent over their costs of inpatient, outpatient, and (in swing beds) post-acute services.
- 2 Before 2015, the OPPS had 39 “device-dependent” APCs, which are populated by services that usually, but not always, require a device to be implanted or used to perform the procedure. For 2015, CMS has transformed 36 of the 39 device-dependent APCs into C-APCs as well as 2 APCs that are not device dependent (0067 Level II stereotactic radiosurgery and 0351 Level VII anterior segment eye procedures). C-APCs combine a primary service and all adjunctive services and supplies reported on a claim (with some exceptions) into a single payment. The exceptions include services such as diagnostic screenings, therapy, and self-administered drugs. CMS also expanded the extent to which items are packaged into larger payment bundles in the OPPS. The specific items included in this expanded packaging include prosthetic supplies and ancillary services that have mean costs of less than \$100 when provided with a procedure, clinic visit, or emergency room visit. These ancillary services are paid separately when provided alone.
- 3 To obtain these results, we used the volume of E&M visits in outpatient PPS hospitals, OPPS payment rates in 2014, and physician fee schedule payment rates in 2014.
- 4 When occupancy is computed, a bed is considered occupied if it is used by an inpatient or an observation patient.
- 5 In 2013, the average hospital bed occupancy rates of urban hospitals and rural hospitals were 63 percent and 41 percent, respectively. Small rural hospitals (100 or fewer beds) had an average occupancy rate of 37 percent in 2013. In contrast, major teaching hospitals had an average occupancy of 75 percent.
- 6 Hospitals that closed were located an average of 15 miles from the nearest competitor. Among the closures, CAHs were an average of 21 miles from their nearest hospital, and IPPS hospitals were an average of 12 miles from the nearest hospital. The CAHs that closed had an average occupancy rate of 35 percent in 2013, and the hospital closest to them had a slightly higher average occupancy rate of 41 percent. The IPPS hospitals that closed had an average occupancy rate of 34 percent, and the closest hospital to them had an average occupancy rate of 49 percent.
- 7 Merger and acquisition (M&A) data from Irving Levin Associates are gathered through media and government (state and federal) reports documenting merger or acquisition agreements reached between the interested parties. Because of the decentralized nature of market activity in this field, these data are likely to underestimate the total volume in M&A deals that occur each year. We also believe that Irving Levin’s data set is somewhat biased toward larger deals.
- 8 There is some evidence that when individuals gain insurance, they increase their inpatient use; in the Oregon Medicaid expansion, newly insured individuals increased their chance of being hospitalized by 2.1 percentage points (Finkelstein et al. 2011). The Congressional Budget Office projects that roughly 30 million people will gain insurance over the next few years; a 2 percentage point increase in admissions of newly insured individuals would yield roughly 600,000 more admissions. Discharge rates reported by the Census and data from for-profit hospitals through the first nine months of 2014 suggest hospitals are seeing a small increase in discharges because of the expansion of insurance coverage and improvement in the economy (Business Wire 2014a, Business Wire 2014b, Business Wire 2014c).
- 9 In-hospital mortality rates for all five conditions that we analyze—acute myocardial infarction, congestive heart failure, hip fracture, stroke, and pneumonia—improved (i.e., went down) by statistically significant percentages from 2010 to 2013. Over the same period, 30-day postdischarge mortality rates demonstrated statistically significant declines (i.e., improved) for stroke and pneumonia but show statistically insignificant changes for the other three conditions.
- 10 The eight AHRQ PSIs that we analyzed are deaths in low-mortality DRGs, deaths among surgical inpatients, iatrogenic pneumothorax, central catheter–related infections, postoperative respiratory failure, postoperative pulmonary embolism/deep-vein thrombosis, postoperative wound dehiscence, and accidental puncture or laceration. Rates of central catheter–related infections and postoperative pulmonary embolisms declined; the other patient safety indicators did not change by a statistically significant amount.
- 11 The six largest services in order of Medicare patient revenues are inpatient acute care, outpatient care, inpatient rehabilitation care, inpatient psychiatric care, home health care, and skilled nursing services.
- 12 It is plausible that the 4 percent reduction in discharges in 2013 was primarily due to a reduction in lower severity cases. Because lower severity cases are treated outside of the hospital or as observation cases, the average case mix remaining within the hospital could increase. In contrast, the case mix changes in 2008 and 2009 were tied to changes in documentation and coding practices. Analyses by both CMS and the Commission have concluded that the increases in

- case mix reported for 2008, 2009, and 2010 (2 percent, 2.6 percent, and 0.5 percent, respectively) resulted from changes in hospitals' documentation and coding rather than from an actual shift toward patients whose care required greater resources (Medicare Payment Advisory Commission 2010b).
- 13 The net effect is that total payments in 2013 were reduced by about 1 percent in fiscal year 2013 because the sequester was in effect for roughly one-half of the fiscal year. The sequester reduces payments from the Medicare program. It does not reduce payments from beneficiaries.
 - 14 The \$3 billion comprises payments to hospitals for FFS patients; it does not include payments for managed care patients or payments received by critical access hospitals under the program.
 - 15 The services included in the overall Medicare margin are Medicare acute inpatient; outpatient; graduate medical education; Medicare SNF (including swing beds); Medicare home health care; Medicare inpatient psychiatric; and Medicare inpatient rehabilitation; as well as special payments for health information technology; temporary extra payments to hospitals located in low-spending counties; and (starting October 1, 2014) uncompensated care payments.
 - 16 We use medians rather than means to limit the influence of outliers on our set of efficient providers.
 - 17 While H-CAHPS and similar patient satisfaction surveys have the limitation of being subjective, we add it as another way to screen out low-value providers because it has the advantage of not being dependent on coding. It is possible that overly aggressive coding by some providers could artificially lower their risk-adjusted cost and risk-adjusted mortality metrics.
 - 18 Hospitals' loss on Medicare patients is expected to be 8 percent of overall Medicare costs in 2015. This same loss is expected to be equal to 9 percent of hospital Medicare revenues.
 - 19 The proposed IPPS rates use the operating and capital base payment rates and MS-DRG relative weights from the IPPS. However, some payment adjustments (e.g., the LTCH geographic wage index) and the LTCH outlier policy differ from the comparable policies in the IPPS. Therefore, LTCH and IPPS payments, while similar, would not be exactly equal in all cases.

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C H A P T E R

4

Physician and other health professional services

R E C O M M E N D A T I O N S

- 4** The Congress should establish a prospective per beneficiary payment to replace the Primary Care Incentive Payment program (PCIP) after it expires at the end of 2015. The per beneficiary payment should equal the average per beneficiary payment under the PCIP and should be exempt from beneficiary cost sharing. Funding for the per beneficiary payment should protect PCIP-defined primary care services regardless of the practitioners furnishing the services and should come from reduced fees for all other services in the fee schedule.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

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(Additionally, the Commission reiterates its 2011 recommendations on moving forward from the sustainable growth rate system. See text box, p. 104.)

Physician and other health professional services

Chapter summary

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 2013, Medicare paid \$68.6 billion for physician and other health professional services, accounting for 16 percent of fee-for-service (FFS) Medicare spending. About 876,000 clinicians billed Medicare—573,000 physicians and 303,000 nurse practitioners, physician assistants, therapists, chiropractors, and other practitioners.

Medicare pays for the services of physicians and other health professionals using a fee schedule, and total payments in a year are limited in principle by the sustainable growth rate (SGR) formula. Because of years of volume growth exceeding the SGR limits and legislative and regulatory overrides of negative updates, an estimated fee reduction of 21.2 percent is scheduled to take effect on April 1, 2015. Except for a 4.8 percent reduction in 2002, such reductions—called for in previous years by the SGR formula’s spending limits—have never been implemented.

Assessment of payment adequacy

We use the following factors to assess payment adequacy for physicians and other health professionals: beneficiary access to care, volume growth, quality, changes in input costs, and differences in compensation across specialties.

In this chapter

- Are Medicare fee schedule payments adequate in 2015?
- How should Medicare payments change in 2016?
- Per beneficiary payment for primary care

Beneficiaries' access to care—Overall, beneficiary access to physician and other health professional services is adequate and largely unchanged from last year. Most beneficiaries report they are able to obtain timely appointments for routine care, illness, or injury, and most beneficiaries are able to find a new doctor without a problem. However, beneficiaries seeking a specialist were more likely to report that they had no problem finding a doctor than beneficiaries seeking a primary care doctor.

- ***Capacity and supply of providers***—The number of physicians and other health professionals providing services to Medicare beneficiaries from 2011 to 2013 grew at rates similar to growth in the beneficiary population.
- ***Volume of services***—Across all services, volume per beneficiary grew by 0.5 percent in 2013. Among broad categories of service, evaluation and management grew by 1.4 percent, major procedures by 1.2 percent, and other procedures by 0.1 percent, while imaging declined by 1.0 percent and tests by 2.1 percent. The decline in imaging and tests do not raise concerns about access because they follow large increases in the use of these services since 2000. Specific to imaging, the decrease in volume includes a shift in billing for cardiovascular imaging from professionals' offices to hospitals.

Quality of care—In prior years' reports, the Commission has assessed quality in ambulatory care settings by reporting trends in a set of ambulatory care process measures. The Commission has been increasingly concerned that Medicare's approach to quality measurement is flawed because it relies on too many clinical process measures. Many current process measures are weakly correlated with outcomes such as mortality and readmissions, and most process measures focus on addressing the underuse of services, while the Commission believes that overuse and inappropriate use are also concerns. Therefore, we are not reporting on the process measures that we have used in the past. We have begun exploring the use of a small set of population-based outcome measures to assess and compare performance of FFS Medicare, Medicare Advantage, and Medicare accountable care organizations in the same locality. We are also assessing whether provider-based quality measures will still be needed to make FFS payment adjustments.

Medicare payments and providers' costs—Medicare's payments relative to private insurer payments have remained relatively steady at around 79 percent. CMS currently projects that the percentage increase in 2016 in the Medicare Economic Index will be 2.2 percent. In 2012, compensation was lower for primary care physicians than for physicians in specialty groups such as radiology and nonsurgical, procedural physicians. The disparity is large enough to raise significant concerns about fee schedule pricing.

Repeal of the SGR

The Commission previously made a multicomponent recommendation to repeal the SGR formula. The Commission's long-standing SGR repeal recommendation is based on these principles: Repeal of the SGR is urgent because it stands in the way of more constructive reforms; beneficiary access must be preserved; payments should be rebalanced between primary care and other specialties; and the Medicare program should encourage movement toward reformed delivery systems.

Because this year's payment adequacy findings are largely similar to the findings in prior years, the Commission continues to reiterate its position on the SGR. The budgetary cost of SGR repeal remains near its historic low, providing clear opportunity for repeal. The Commission urges the Congress to take advantage of this opportunity to repeal the SGR so that policymakers and clinicians can pursue in earnest the kinds of delivery system reforms that can provide improved care for beneficiaries at high value to the Medicare program.

Per beneficiary payment for primary care

Medicare's Primary Care Incentive Payment program (PCIP) expires at the end of 2015. The PCIP provides a 10 percent bonus payment on fee schedule payments for PCIP-defined primary care services furnished by eligible primary care practitioners. The Commission believes that the additional payments to primary care practitioners should continue. Allowing the PCIP to expire without a replacement sends a poor signal to primary care practitioners. While Medicare beneficiaries generally have good access to care now, in the future, the aging of the population and health care workforce and the increased use of services by the newly insured may expose beneficiaries to an increasing risk of impaired access to primary care.

The Commission has become increasingly concerned that the fee schedule—oriented toward discrete services and procedures—is an ill-suited payment mechanism for the ongoing, coordinated care of a panel of patients. Therefore, the Commission recommends that the additional payments to primary care practitioners be in the form of a per beneficiary payment as a step away from the service-oriented FFS payment approach and toward beneficiary-centered payments that encourage care coordination. The Commission recommends funding the per beneficiary payment by reducing fees for all services in the fee schedule other than PCIP-defined primary care services provided by any practitioner, regardless of the practitioner's specialty designation or whether PCIP-defined primary care services accounted for at least 60 percent of the practitioner's allowed charges. Beneficiaries would not pay cost sharing, just as beneficiaries do not pay cost sharing to fund the

PCIP. This method of funding would be budget neutral and would help rebalance the fee schedule to achieve greater equity of payments between primary care and other services. ■

Background

Physicians and other health professionals billing under Medicare's Part B fee schedule deliver a wide range of services—office visits, surgical procedures, and diagnostic and therapeutic services—in a variety of settings.

In 2013, the Medicare program paid \$68.6 billion for physician and other health professional services, or 16 percent of benefit spending in Medicare's traditional fee-for-service (FFS) program. This spending covered 1.1 billion services for 32 million FFS beneficiaries: 98 percent of Part B FFS enrollees had at least one service. Program payments per person served were just over \$3,000 (Centers for Medicare & Medicaid Services 2014c). In 2013, 876,000 professionals billed Medicare through the fee schedule—573,000 physicians and 303,000 nurse practitioners, physician assistants, therapists, chiropractors, and other practitioners.

Medicare uses a fee schedule to pay for physician and other health professional services based on a list of over 7,000 services and their payment rates. In determining payment rates for each service, CMS considers the amount of work required to provide a service, expenses related to maintaining a practice, and professional liability insurance costs. These three factors are then adjusted by variation in the input prices in different markets, and the sum is then multiplied by the fee schedule's conversion factor to produce a total payment amount.¹

The conversion factor, which is \$35.75 for 2015, is updated by a formula known as the sustainable growth rate (SGR). The SGR was established to limit total fee schedule spending by restraining annual updates when spending exceeded certain parameters. Under the SGR formula, fee schedule spending is permitted to increase by growth in input costs, FFS enrollment, and gross domestic product (GDP).²

If volume growth exceeds this target growth rate, the SGR mechanism reduces the yearly update of the conversion factor to a level that would bring spending in line with the target. The SGR was scheduled to produce negative updates beginning in 2002. However, the Congress has not permitted negative updates to go into effect, except for the first year they occurred (2002). There is now a large negative reduction called for under current law, which, absent legislative action, will reduce the payment rate for physician and other health professional services by 21.2 percent on April 1, 2015 (Congressional Budget Office 2014).

In 2011, the Commission laid out its recommendations regarding repeal of the SGR (Medicare Payment Advisory Commission 2011). The recommendation is based on these principles: repeal of the SGR is urgent, beneficiary access must be preserved, payments should be rebalanced between primary care and other specialties, and the Medicare program should encourage movement toward reformed delivery systems.

In addition to the administrative burden that short-term SGR overrides impose on both clinicians and CMS (by sometimes requiring delayed claims processing), the process of short-term overrides (and the search for budgetary offsets) often monopolizes the Medicare policy development process. In other words, constant action on short-term legislative patches means that there is often little time to pursue more meaningful policies to improve the Medicare program and how it pays for physician and other health professional services. At this time, the budgetary cost of SGR repeal remains at historic lows (less than half the cost it was two years ago). Because the measures of payment adequacy are generally similar to last year, the Commission continues to reiterate its recommendations and urges the Congress to repeal the SGR.

Are Medicare fee schedule payments adequate in 2015?

We assess payment adequacy by reviewing beneficiary access to care provided by physicians and other health professionals, volume growth, quality of care, and Medicare's payment rates relative to those in the private sector. Overall, most indicators show no significant change from prior years.

Beneficiaries' access to care

We use a number of measures to assess beneficiary access to timely, appropriate care, including direct reporting from beneficiaries (through, for example, our own beneficiary telephone survey); focus groups with beneficiaries and practitioners; and site visits conducted yearly. Supplementing these primary sources, we also review (1) other surveys of patient access and satisfaction among Medicare beneficiaries and those with private insurance and (2) physician and provider surveys on their willingness to accept Medicare beneficiaries.

Each year, the Commission sponsors a telephone survey of 4,000 Medicare beneficiaries age 65 and over and 4,000

**TABLE
4-1**

**Satisfaction with the overall
quality of health care received in all
settings in the past 12 months, 2014**

	Medicare (age 65 or older)	Private insurance (age 50–64)
Very satisfied	68%	59%
Somewhat satisfied	20	23
Somewhat dissatisfied	3	4
Very dissatisfied	2	1

Note: Table excludes the following responses: "Did not receive health care in past 12 months," "Don't know," and "Refused." It does not include Medicare beneficiaries under the age of 65.

Source: MedPAC-sponsored telephone survey conducted in 2014.

privately insured individuals ages 50 to 64.³ The goal in surveying these two populations is to assess whether access concerns reported by Medicare beneficiaries are unique to the Medicare population or are part of trends in the broader health care delivery system. This year's survey was fielded in the summer and fall of 2014.

The Commission also conducts focus groups in markets around the country to provide a qualitative description of beneficiary and physician experiences with the Medicare program. We conduct these groups in markets where Medicare beneficiaries have reported experiencing relatively less access to routine, specialty, and urgent care through the Consumer Assessment of Healthcare Providers and Systems® (CAHPS®) survey.⁴ In each market, the focus groups consisted of Medicare beneficiaries, non-Medicare-eligible individuals between the ages of 55 and 64, primary care physicians, and nurse practitioners.

Overall, findings from our survey and focus groups and other external sources are very consistent. Medicare beneficiaries have generally stable access to ambulatory care services, and their reported access is either as good as or better than access among privately insured individuals. The share of beneficiaries waiting longer than they wanted for an appointment is largely unchanged from prior years.

Beneficiaries seeking a new primary care doctor are more likely to report difficulty doing so than are beneficiaries seeking a specialist, although the share of beneficiaries experiencing any problem continues to be quite small. Physicians and other types of clinicians appear willing to treat Medicare beneficiaries, although primary care

physicians are less likely than specialty physicians to accept new Medicare patients.

It is worth noting that while overall access to ambulatory care is good, this situation could change in the future. The balance between supply and demand will be affected by aging of the population, aging of the health care workforce, and increased use of services by newly insured people. And in some markets, an imbalance in supply and demand could come more quickly than in others. The Commission is concerned in particular about access to primary care services, given the higher reported difficulty accessing care and the important role primary care will play in delivery system reform.

Medicare beneficiaries' overall satisfaction with care is comparable with privately insured patients

Medicare beneficiaries report high levels of satisfaction with their care and are slightly more likely to report being satisfied than near-beneficiaries with private health insurance. From our telephone survey, higher shares of Medicare beneficiaries report that they are very or somewhat satisfied with their care (88 percent) compared with those who have private insurance (82 percent) (Table 4-1).

Most beneficiaries report that they are able to see a doctor when they need to

From our telephone survey, the share of Medicare beneficiaries reporting that they never had to wait longer than they wanted for routine care (72 percent) or illness or injury care (83 percent) was consistent with prior years and slightly better than the rates reported by the privately insured—69 percent for routine care and 79 percent for illness or injury care (Table 4-2).

Beneficiaries report more difficulty accessing primary care than specialty care Most beneficiaries report they are able to obtain timely appointments for routine care, illness, or injury, and most beneficiaries are able to find a new doctor without a problem. However, beneficiaries seeking a primary care doctor were more likely to report that they had a problem finding a doctor than beneficiaries seeking a specialist (Table 4-2). Overall, 1.2 percent of all Medicare beneficiaries reported that they had a big problem finding a new primary care doctor, and 1.2 percent said they had a big problem finding a new specialist, but among those looking for a new doctor, the share of those reporting a big problem was different for primary care doctors and specialists. For primary care, 8 percent were looking for a new doctor, and of those looking, 15 percent reported a big

**TABLE
4-2**

Most aged Medicare beneficiaries and older privately insured individuals have good access to physician care, 2010–2014

Survey question	Medicare (age 65 or older)					Private insurance (age 50–64)				
	2010	2011	2012	2013	2014	2010	2011	2012	2013	2014
Unwanted delay in getting an appointment: Among those who needed an appointment in the past 12 months, “How often did you have to wait longer than you wanted to get a doctor’s appointment?”										
For routine care										
Never	75%	74%	77% ^b	73%	72% ^a	72%	71%	72%	69%	69% ^a
Sometimes	17 ^b	18	17 ^b	20	20 ^a	21 ^b	21	21 ^b	23	23 ^a
Usually	3	3	3	3	3	4	4	3	4	4
Always	2	2 ^b	2 ^b	3	3	3	3	3	3	3
For illness or injury										
Never	83	82	84	82	83 ^a	80	79	80	77	79 ^a
Sometimes	13	14	12	14	12 ^a	15	17	16	17	16 ^a
Usually	2	2	2	2	2	2	2	2	3	2
Always	1	1	1	1	1 ^a	2	1 ^b	2	2	2 ^a
Not accessing a doctor for medical problems: “During the past 12 months, did you have any health problem or condition about which you think you should have seen a doctor or other medical person, but did not?”										
Percent answering “Yes”	8 ^b	8 ^b	8 ^b	8 ^b	10	12	11	11	11	11
Looking for a new doctor: “In the past 12 months, have you tried to get a new...?” (Percent answering “Yes”)										
Primary care doctor	7 ^b	6 ^b	7 ^b	7	8	7	7	7	8	8
Specialist	13 ^b	14 ^b	13 ^b	14 ^b	17	15	16	18	16	17
Getting a new physician: Among those who tried to get an appointment with a new primary care physician or a specialist in the past 12 months, “How much of a problem was it finding a primary care doctor/specialist who would treat you? Was it...”										
Primary care physician										
No problem	79 ^b	65	72	70	67	69	68	75	67	63
Percent of total insurance group	5.2	3.6	4.7	5.2	5.5	4.8	4.5	5.0	5.2	4.9
Small problem	8 ^b	12	14	11	16	12	16	9	15	16
Percent of total insurance group	0.5	0.7	0.9	0.8	1.3	0.8	1.1	0.6	1.2	1.3
Big problem	12	23 ^b	14	17	15	19	14	15	18	19
Percent of total insurance group	0.8	1.3	0.9	1.3	1.2	1.3	0.9	1.0	1.4	1.5
Specialist										
No problem	87	84	87	86	85	82	86	86 ^b	87	85
Percent of total insurance group	11.0	12.1	11.7	12.4	14.4	12.6	13.9	15.6	13.9	14.5
Small problem	6	8	6	8	7	11	8	7 ^b	6	9
Percent of total insurance group	0.8	1.1	0.7	1.2	1.2	1.8	1.3	1.2	0.9	1.4
Big problem	5	7	7	5	7	6	6	7	7	6
Percent of total insurance group	0.7	1.0	0.9	0.7	1.2	1.0	1.0	1.2	1.1	1.0

Note: Numbers may not sum to 100 percent because missing responses (“Don’t know” or “Refused”) are not included. Sample sizes for each group (Medicare and privately insured) are 4,000. Sample sizes for individual questions varied.

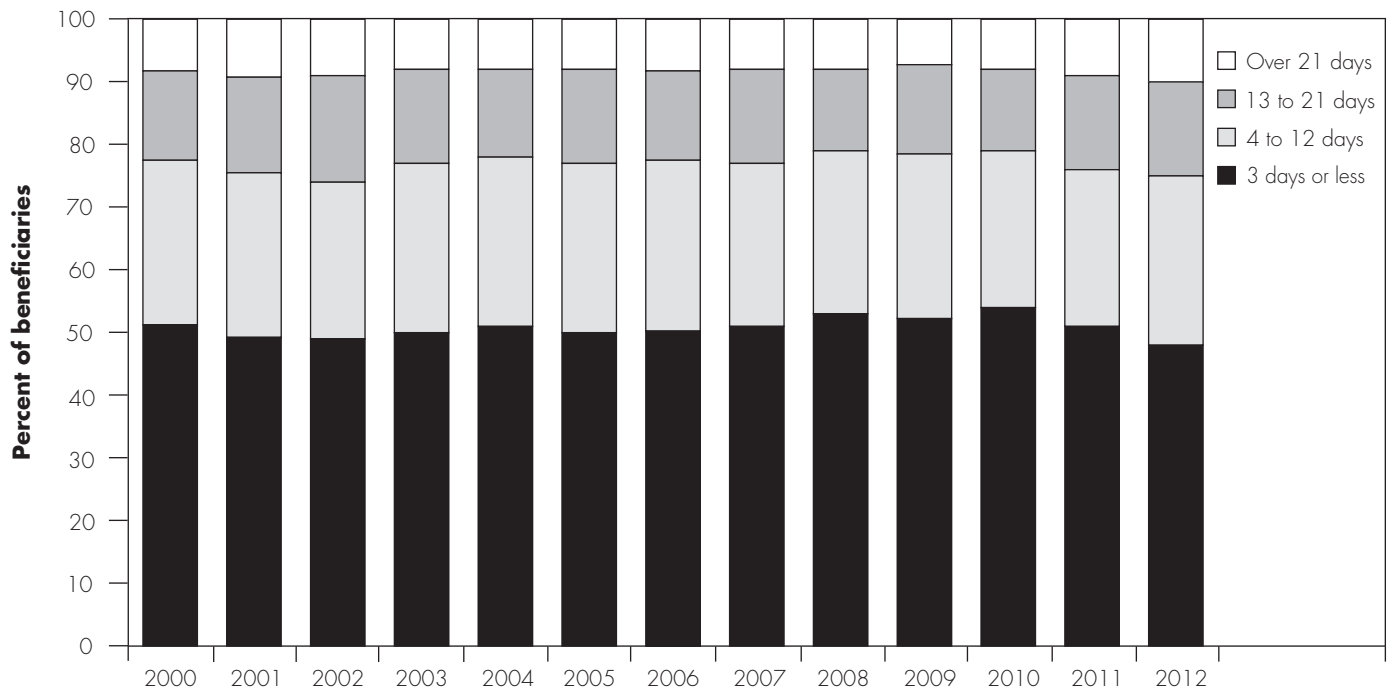
^a Statistically significant difference between the Medicare and privately insured groups in the given year (at a 95 percent confidence level).

^b Statistically significant difference from 2014 within the same insurance coverage category (at a 95 percent confidence level).

Source: MedPAC-sponsored telephone surveys conducted from 2010 to 2014.

**FIGURE
4-1**

Just less than half of beneficiaries can see their doctor within three days, and this share is slightly lower in 2012 than in the past few years



Note: Data include noninstitutionalized beneficiaries only.

Source: Medicare Current Beneficiary Survey, 2000–2012.

problem (8 percent $\times$ 15 percent = 1.2 percent). Among those looking for a new specialist, 17 percent were looking for a new doctor, and of those looking, 7 percent reported a big problem (17 percent $\times$ 7 percent = 1.2 percent).

Medicare beneficiaries overall were slightly less likely than privately insured individuals to report a big problem finding either a new primary care doctor or a new specialist, although the same pattern of greater difficulty finding a primary care doctor than a specialist exists among respondents with private insurance.

Some of the beneficiaries in the focus groups reported difficulty accessing timely appointments with certain types of specialists (specifically, dermatology and neurology). The primary care physicians and nurse practitioners in the focus groups reported difficulty securing referrals to certain types of specialists, in particular dermatology and psychiatry. In one market, some of the primary care physicians said that dermatology is difficult to access because of a shortage of doctors practicing medical dermatology in the area. For psychiatric services, primary care physicians and nurse

practitioners generally attributed the access problems for psychiatric services to a shortage of psychiatrists in the area and to the fact that some psychiatrists do not accept insurance at all (including Medicare).

Some beneficiaries may be seeking a new doctor because they temporarily move to another area (e.g., “snowbirds”). However, these beneficiaries likely have access to physicians and other providers in their resident state who can help them find services in their temporary residence. In addition, snowbirds on average have higher incomes and are in better health than the average beneficiary (Smith and House 2006).

Wait times for appointments The Medicare Current Beneficiary Survey (MCBS), a panel survey of Medicare beneficiaries, includes a question assessing wait times—how long, specifically, respondents waited for their last physician appointment. Over the past decade, about half of beneficiaries reported that they were able to see a doctor within three days. In 2012, these figures declined slightly, to 48 percent (Figure 4-1).

In our focus groups, the reported wait times for routine and urgent care varied, but in general, beneficiaries said they could get an appointment the same day, the next day, or within a week. Some beneficiaries noted that they could get an earlier appointment if they were willing to see another practitioner in their primary care provider's practice. The beneficiaries who had looked for new primary care practitioners recently were generally able to find one who was accepting new patients, although some said the search was time consuming. The near-beneficiaries in our focus groups reported similar experiences with respect to accessing primary care.

Medicare beneficiaries were about as likely to report delaying medical care as privately insured individuals

In our telephone survey, a similar percentage of Medicare beneficiaries (10 percent) and privately insured individuals (11 percent) reported that they had a health problem for which they should have seen, but did not see, a doctor (Table 4-2, p. 85). The rate for Medicare beneficiaries in 2014 (10 percent) is statistically higher than in previous years (8 percent from 2010 to 2013).

The 2012 Medical Expenditure Panel Survey (MEPS) found the rate of Medicare beneficiaries reporting difficulty receiving needed medical care, dental care, or prescription medications at about 9.5 percent, slightly higher than the rate reported for those under age 65 with private insurance (8.4 percent). But the rates of those reporting that they could not obtain needed care because of either cost or insurance-related issues was significantly lower for Medicare beneficiaries than privately insured individuals under age 65 (Agency for Healthcare Research and Quality 2014).

Some groups of beneficiaries report more difficulty obtaining care, although most differences are not large

Among Medicare beneficiaries, a greater share of minority beneficiaries than nonminority beneficiaries reported that they always had to wait longer than they wanted for an illness or injury appointment, but the percentage of both groups was very small (2 percent and 1 percent, respectively). However, minority individuals who had Medicare reported better access than minority individuals with private insurance: 65 percent of Medicare beneficiaries reported they never had to wait for a routine appointment compared with 58 percent for privately insured individuals. Most other differences by race were not significant (Table 4-3, p. 88).

Few reported differences in access between urban and rural beneficiaries

The Commission's telephone survey shows no major differences in access between urban and rural beneficiaries (Table 4-4, p. 89). There was no significant difference between the share of urban and rural beneficiaries experiencing an unwanted delay in getting an appointment, although rural beneficiaries seeking an illness or injury appointment were more likely than urban beneficiaries to report sometimes waiting longer than they wanted. In contrast to earlier years, beneficiaries seeking a specialist were more likely to report a big problem in urban areas (1.4 percent) than in rural areas (0.4 percent), whereas last year the difference was small and not significant.

Differences in access by basis of Medicare eligibility In the MCBS, most beneficiaries did not report significant barriers to care, but they reported access is worse for beneficiaries who are entitled to Medicare on the basis of disability. Of the overall population, 6 percent of beneficiaries reported that they had difficulty obtaining care, and 11 percent of beneficiaries reported that they delayed care because of cost. Among beneficiaries entitled on the basis of disability, the rates were 17 percent and 28 percent, respectively (Centers for Medicare & Medicaid Services 2014a). Beneficiaries entitled on the basis of disability were also about twice as likely as the total Medicare population to report dissatisfaction with overall care, availability of their doctor, and ease of access to their doctor. Some of these differences may be due in part to other differences between disabled and aged beneficiaries: disease burden, type of additional coverage (e.g., Medicaid), and overall resources (e.g., income, social supports).

Difference in access among beneficiaries with different types of coverage

In the MCBS, beneficiaries with supplemental private insurance reported slightly more satisfaction with the ease of access to their doctor and were less likely to report being very unsatisfied (Table 4-5, p. 90). As with other surveys and beneficiary focus groups, the MCBS information on access also shows that beneficiaries who were dually eligible for Medicaid were more likely to report that they were unsatisfied with the ease of access to their doctor than other beneficiaries.

An analysis by the Kaiser Family Foundation of the 2012 CAHPS reported that beneficiaries in FFS Medicare were generally able to get an appointment for routine care as soon as needed at the same rates as beneficiaries in Medicare Advantage (MA)—62 percent (Boccuti et al. 2013).

**TABLE
4-3**

Medicare beneficiaries have better or similar access to physicians compared with privately insured individuals, but minorities in both groups report problems more frequently, 2014

Survey question	Medicare (age 65 or older)			Private insurance (age 50-64)		
	All	White	Minority	All	White	Minority
Unwanted delay in getting an appointment: Among those who needed an appointment in the past 12 months, "How often did you have to wait longer than you wanted to get a doctor's appointment?"						
For routine care						
Never	72% ^a	73% ^a	72% ^a	69% ^a	70% ^a	66% ^a
Sometimes	20 ^a	20 ^a	19 ^a	23 ^a	23 ^a	24 ^a
Usually	3	3	3	4	4	4
Always	3	2	3	3	2 ^b	5 ^b
For illness or injury						
Never	83 ^a	84 ^{ab}	80 ^a	79 ^a	80 ^{ab}	73 ^{ab}
Sometimes	12 ^a	12 ^a	14 ^a	16 ^a	16 ^{ab}	19 ^{ab}
Usually	2	2	2	2	2	3
Always	1 ^a	1	2 ^a	2 ^a	2 ^b	4 ^{ab}
Not accessing a doctor for medical problems: "During the past 12 months, did you have any health problem or condition about which you think you should have seen a doctor or other medical person, but did not?"						
Percent answering "Yes"	10	10	9	11	11	11
Looking for a new doctor: "In the past 12 months, have you tried to get a new...?" (Percent answering "Yes")						
Primary care physician	8	8	8	8	7	9
Specialist	17	18 ^b	14 ^b	17	18 ^b	14 ^b
Getting a new physician: Among those who tried to get an appointment with a new primary care physician or a specialist in the past 12 months, "How much of a problem was it finding a primary care doctor / specialist who would treat you? Was it..."						
Primary care physician						
No problem	67	67	69	63	60	72
Percent of total insurance group, by race	5.5	5.6	5.3	4.9	4.4	6.2
Small problem	16	16	16	16	17	14
Percent of total insurance group, by race	1.3	1.4	1.3	1.3	1.3	1.2
Big problem	15	15	13	19	22	13
Percent of total insurance group, by race	1.2	1.2	1.0	1.5	1.6	1.1
Specialist						
No problem	85	85	83	85	86	84
Percent of total insurance group, by race	14.4	15.2 ^b	11.9 ^b	14.5	15.3 ^b	11.8 ^b
Small problem	7	7	5	9	8	10
Percent of total insurance group, by race	1.2	1.3	0.8	1.4	1.5	1.3
Big problem	7	7	8	6	6	7
Percent of total insurance group, by race	1.2	1.2	1.1	1.0	1.1	0.9

Note: Respondents who did not report race or ethnicity were not included in "White" or "Minority" results but were included in "All" results. Numbers may not sum to 100 percent because missing responses ("Don't know" or "Refused") are not included. Sample sizes for each group (Medicare and privately insured) were 4,000 in 2014. Sample sizes for individual questions varied.

^a Statistically significant difference between the Medicare and privately insured populations in the given year (at a 95 percent confidence level).

^b Statistically significant difference by race within the same insurance category in the given year (at a 95 percent confidence level).

Source: MedPAC-sponsored telephone surveys conducted in 2014.

**TABLE
4-4**

Access to physician care for Medicare beneficiaries is similar to that for privately insured individuals in urban and rural areas, 2014

Survey question	Medicare (age 65 or older)			Private insurance (age 50-64)		
	All	Urban	Rural	All	Urban	Rural
Unwanted delay in getting an appointment: Among those who needed an appointment in the past 12 months, "How often did you have to wait longer than you wanted to get a doctor's appointment?"						
For routine care						
Never	72% ^a	72% ^a	75%	69% ^a	68% ^a	75% ^b
Sometimes	20 ^a	20 ^a	18	23	24 ^{ab}	19 ^b
Usually	3	3	4	4	4	4
Always	3	3	2	3	3	2
For illness or injury						
Never	83 ^a	84 ^a	80	79 ^a	78 ^a	81
Sometimes	12 ^a	11 ^{ab}	16 ^b	16 ^a	17 ^a	16
Usually	2	2	1	2	2	2
Always	1 ^a	1 ^a	2	2 ^a	3 ^a	1
Not accessing a doctor for medical problems: "During the past 12 months, did you have any health problem or condition about which you think you should have seen a doctor or other medical person, but did not?"						
(Percent answering "Yes")	10	10	11	11	11	12
Looking for a new primary care physician: "In the past 12 months, have you tried to get a new...?" (Percent answering "Yes")						
Primary care physician	8	8	10	8	8	7
Specialist	17	18	15	17	18 ^b	14 ^b
Getting a new physician: Among those who tried to get an appointment with a new primary care physician or a specialist in the past 12 months, "How much of a problem was it finding a primary care doctor/specialist who would treat you? Was it..."						
Primary care physician						
No problem	67	68	64	63	61	74
Percent of total insurance group, by area	5.5	5.3	6.3	4.9	4.4	6.2
Small problem	16	14	23	16	17	12
Percent of total insurance group, by area	1.3	1.1 ^b	2.2 ^b	1.3	1.3	1.2
Big problem	15	16	11	19	20	14
Percent of total insurance group, by area	1.2	1.1	2.0	1.4	1.3	1.1
Specialist						
No problem	85	84	90	85	85	85
Percent of total insurance group, by area	14.4	14.8	12.9	14.5	15.0	12.4
Small problem	7	7	6	9	9	8
Percent of total insurance group, by area	1.2	1.3	0.9	1.4	1.5	1.3
Big problem	7	8	3	6	6	7
Percent of total insurance group, by area	1.2	1.4 ^b	0.4 ^b	1.0	1.0	1.1

Note: Numbers may not sum to 100 percent because missing responses ("Don't Know" or "Refused") are not included. Sample sizes for each group (Medicare and privately insured) were 4,000 in 2014. Sample sizes for individual questions varied. MedPAC uses the Census Bureau definitions of urban and rural. The Census Bureau classifies as urban all territory, population, and housing units located within an urbanized area (UA) or an urban cluster (UC). It delineates UA and UC boundaries to encompass densely settled territory, which consists of core census-block groups or blocks that have a population density of at least 1,000 people per square mile and surrounding census blocks that have an overall density of at least 500 people per square mile. In addition, under certain conditions, less densely settled territory may be part of each UA or UC. The Census Bureau's classification of rural consists of all territory, population, and housing units located outside of UAs and UCs.

^a Statistically significant difference between the Medicare and privately insured populations in a given year (at a 95 percent confidence level).

^b Statistically significant difference by area type within the same insurance category in a given year (at a 95 percent confidence level).

Source: MedPAC-sponsored telephone survey conducted in 2014.

**TABLE
4-5****Satisfaction with ease of access to doctor, 2012**

	Medicare and supplemental coverage					
	All Medicare respondents	Medicare HMO	Medicaid	Individually purchased private insurance	Employer-sponsored private insurance	Medicare FFS only
Very satisfied	30%	30%	17%	34%	36%	25%
Very unsatisfied	5	4	10	4	3	7

Note: FFS (fee-for-service).

Source: CMS analysis of the Medicare Current Beneficiary Survey Access to Care file 2012.

Comparisons of access between MA and FFS, however, should be viewed with some caution. Differences in the patient populations in MA and FFS may be responsible for any reported differences in access to care. The Commission has made recommendations that would facilitate comparisons between FFS and MA plans on quality of and access to care (Medicare Payment Advisory Commission 2010).

Beneficiaries receive care from many types of clinicians in a variety of locations

Nearly all beneficiaries in our focus groups reported that they had a regular source of primary care. In the 2012 MCBS, 95 percent of Medicare beneficiaries reported that they had a usual source of medical care (Centers for Medicare & Medicaid Services 2014a).

In our telephone survey in 2014, 11 percent of beneficiaries responded that they saw a nurse practitioner (NP) or physician assistant (PA) for all or most of their primary care, and 26 percent said that they saw an NP or PA for some of their primary care. Rural beneficiaries were more likely than urban beneficiaries to report that they saw an NP or PA for all or most of their care (18 percent for rural beneficiaries vs. 10 percent for urban beneficiaries).

Many beneficiaries and near-beneficiaries in the focus groups said that they were able to access routine or urgent primary care faster, including same-day appointments, by seeing a nurse practitioner in their primary care physician's practice. Nurse practitioners were also described as filling a need for access to care in rural areas, particularly in states with less restrictive scope of practice requirements (see text box). Although many physicians in the focus groups had only positive things to say about

nurse practitioners, some thought their roles should be limited.

More so than in past years, the beneficiaries in this round of focus groups discussed using urgent care centers for routine and urgent primary care. Beneficiaries stated that they generally make this choice when they cannot get appointments with their usual primary care providers right away, or when they think it will be less expensive or more convenient to visit the urgent care center.

Clinician acceptance of Medicare beneficiaries

We also look at the trends regarding providers' willingness to take new Medicare patients. Two analyses of the National Ambulatory Medical Care Survey (NAMCS), a survey of physicians who practice in office settings, find that physician acceptance of new Medicare patients is similar to prior years, with a little less than 90 percent of physicians accepting new patients: 85 percent of primary care physicians (when pediatricians are excluded) and 90 percent of specialist physicians (Boccuti et al. 2013, Shartz et al. 2013).

These measures should be interpreted with some caution, however. Physicians reporting willingness to take new Medicare patients is not the same as Medicare beneficiaries being able to access care. For example, providers are generally much less willing to accept Medicaid than private insurance (about 50 percent of physician offices said they would take Medicaid, as compared with 90 percent for commercial insurance). However, Medicaid and private enrollees were equally likely to report that they have a usual source of care (Frakt 2014, Kenney et al. 2014). The American Medical Association 2013 National Health Insurer Report Card finds that Medicare is comparable with other large payers

Developments regarding scope of practice for advanced practice registered nurses and physician assistants

As noted in previous Commission work, many of the restrictions on the scope of practice for advanced practice registered nurses (APRNs) (for example, nurse practitioners) and physician assistants (PAs) result from state laws that are more restrictive than the Medicare statute. Recent federal activities that affect practice authority for APRNs and PAs include the following:

- recommendations by the Federal Trade Commission to expand scope of practice to increase competition between providers (March 2014);
- proposed changes to the Veterans Administration nursing handbook to treat advanced practice nurses on staff as independent practitioners authorized to treat patients without supervision (2013, not finalized); and
- a Supreme Court case regarding a Board of Dental Examiners' regulation of teeth-whitening services and specifically whether the Board is exempt from antitrust law by acting as a state entity (October

2014). This case may have implications for professional boards in which there is a question of whether the board is unduly restricting behavior for anticompetitive reasons.

Policy changes for APRNs and PAs at the state level include:

- Connecticut and Minnesota's adoption of a Full Practice Authority law;⁵
- enactment in Utah of a bill easing the practice hour requirements before full licensure for psychiatric advanced practice nurses, as well as expanded recognition under Utah's Medicaid program;
- a bill enacted into law in Ohio that would permit limited medication dispensing during a public health emergency; and
- Expansion of authority for APRNs and PAs to conduct prescreening exams for patients requiring involuntary admission (e.g., for psychiatric or safety reasons) in Mississippi. ■

in terms of payment accuracy, timeliness, and transparency (American Medical Association 2013).

The vast majority of primary care physicians and nurse practitioners in our focus groups said that they accept Medicare. Some, however, limit the number of new patients; others limit their panels to patients with certain types of insurance. For example, some of the primary care physicians said they accept Medicare FFS patients but will not accept Medicare Advantage patients because of reimbursement rates and prior authorization requirements.

Supply of physicians and other health professionals billing Medicare has kept pace with enrollment growth, and most services are paid on assignment

Other indicators of access include the supply of providers billing Medicare, whether physicians and other health professionals are participating providers, and whether these providers take assignment (which means that they accept Medicare's payment as payment in full). A small

number of providers opt out of the Medicare program—less than 1 percent.

Supply of physicians and other health professionals billing Medicare has grown at rates similar to enrollment growth

Our analysis of Medicare FFS claims data for 2011 to 2013 shows that the number of physicians and other health professionals furnishing services to Medicare beneficiaries grew at rates similar to growth in the beneficiary population (Table 4-6, p. 92). In 2013, the ratio of physicians in primary care specialties to the number of beneficiaries was 3.7 per 1,000, slightly below the 2011 and 2012 ratios of 3.8 per 1,000. Similarly, in 2013, the ratio of physicians in other specialties fell slightly to 8.2 per 1,000 from the 2011 and 2012 ratios of 8.4 per 1,000. Meanwhile, the number of APRNs and PAs billing Medicare grew each year between 2011 and 2013, from 2.8 per 1,000 to 3.0 per 1,000 to 3.2 per 1,000.

**TABLE
4-6****Physicians and other health professionals billing Medicare, 2011–2013**

Year	Physicians				Advanced practice registered nurses and physician assistants		Other practitioners	
	Primary care specialties		Other specialties					
	Number	Number per 1,000 beneficiaries	Number	Number per 1,000 beneficiaries	Number	Number per 1,000 beneficiaries	Number	Number per 1,000 beneficiaries
2011	169,640	3.8	379,411	8.4	123,959	2.8	140,436	3.1
2012	174,848	3.8	388,237	8.4	138,184	3.0	146,396	3.2
2013	178,404	3.7	394,103	8.2	152,612	3.2	150,466	3.1

Note: Primary care specialties are specialties eligible for the Primary Care Incentive Payment Program: family medicine, internal medicine, pediatric medicine, and geriatric medicine. The number billing Medicare includes those with a caseload of more than 15 different beneficiaries during the year. Beneficiary counts used to calculate numbers per 1,000 include those in fee-for-service and Medicare Advantage on the assumption that professionals are furnishing services to both types. Figures exclude nonperson providers, such as suppliers or lab facilities.

Source: MedPAC analysis of claims data for 100 percent of beneficiaries and the 2014 annual report of the Boards of Trustees of the Medicare trust funds.

Most physicians and other health professionals are part of Medicare's participating provider program, and nearly all claims are taken on assignment

About 96 percent of physicians and other health professionals billing Medicare sign an agreement with Medicare to be part of the participating provider program (Centers for Medicare & Medicaid Services 2012a). Participating providers agree to take assignment for all claims, which means they accept the fee schedule amount as payment in full (most claims are paid on assignment—99.5 percent in 2013). In return, participating providers receive the full fee schedule amount, can receive payments directly from Medicare (rather than billing the beneficiary for the full amount of the service), have their name and address listed on Medicare's website, and can electronically search a beneficiary's supplemental insurance status.

Providers who do not elect to participate receive a 5 percent lower payment amount and can choose whether to take assignment for their claims. If they do not assign a claim, providers may "balance bill" up to 109.25 percent of the fee schedule amount (the limiting charge), with the beneficiary paying the difference between that limiting charge and Medicare's payment.

Balance billing and nonparticipating providers are relatively rare in Medicare, and the total amount of balance billing has been declining over time (Centers for Medicare & Medicaid Services 2012b).

Practitioners who opt out of Medicare are rare, but may be increasing

Physicians and other health professionals opt out of the Medicare program by signing an affidavit with Medicare agreeing that they cannot receive any reimbursement from Medicare, directly or indirectly, for any Medicare patient they see. They must enter into a private contract with Medicare beneficiaries to deliver care to them, and the contract must state that no payment will be made from Medicare either to the beneficiary or to the provider for services delivered by the opt-out physician. Opt-out agreements are in place for two years and can be renewed. Based on data from CMS, as of September 30, 2013, just over 6,600 providers had opted out of the Medicare program, accounting for less than 1 percent of all providers billing under the fee schedule. The largest share of these opt-out providers were psychiatrists and oral surgeons (dentists only), and these two specialties accounted for over half of the opt-out providers.

News reports have highlighted trends in the use of retainer-based medical models, which charge a flat fee for enhanced access to services such as same-day appointments or longer appointments (Gunderman 2014, Wieczner 2013). However, some retainer-based practices also accept insurance, so it is unclear what effect this trend will have on the rate of physicians opting out of Medicare.⁶

Small increase in volume growth

We analyze annual changes in use of services as another indicator of payment adequacy but recommend caution

in interpreting such data because factors unrelated to Medicare's payment adequacy can influence service volume. Our analysis indicates that volume decreases are more likely to be due to factors unrelated to payment, such as general practice pattern changes or concerns about overuse of imaging. For example, the volume of coronary artery bypass grafting has been declining as other interventions substitute for this procedure. Increases in volume may signal overpricing if physicians favor certain services because they are relatively profitable, but other factors—including population changes, disease prevalence, changes in Medicare benefits, shifts in the site of care, technology, and beneficiaries' preferences—can also explain volume increases.

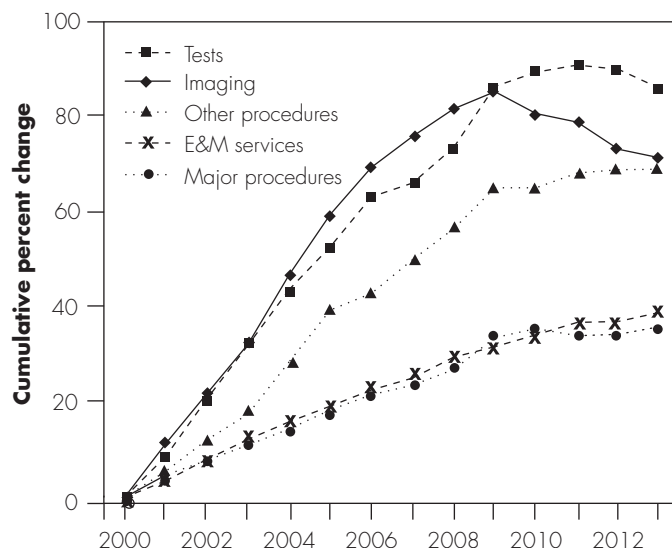
For this year's analysis of volume changes, we used claims data for 2008, 2012, and 2013. We identified the services furnished by physicians and other professionals billing under Medicare's fee schedule and calculated two measures of changes in service use: units of service per beneficiary and volume of services per beneficiary. Volume is measured as units of service multiplied by each service's relative value units (RVUs) from the fee schedule. Our volume growth measure thus accounts for changes in both the number of services and the complexity, or intensity, of those services. For example, growth in the volume of imaging services would account not just for any change in the number of such services but also for any change in intensity as providers substitute computed tomography (CT) scans for X-rays, which are less complex. We used RVUs for 2013 to put service volume for all years on a common scale.

Our volume analysis also accounts for the policy changes that have occurred in payments for office and inpatient consultations. As of 2010, CMS stopped recognizing the billing codes for consultations.⁷ Physicians and other health professionals now use office visit codes and codes for hospital and nursing facility visits instead of consultation codes. If we ignored this change in policy, the volume analysis would show a change in intensity of services—use of lower payment rate visits in place of higher payment rate consultations. To avoid this skewing, we focus the discussion of changes in service use before 2010 on the change in units of service and limit discussion of changes in volume growth to those services not affected by the change in payments for consultations.

In 2013, across all services, volume per beneficiary grew by 0.5 percent (Table 4-7, p. 94). Among broad categories of service, growth rates were 1.4 percent for evaluation

FIGURE 4-2

Growth in the volume of fee schedule services, 2000–2013



Note: E&M (evaluation and management). Volume growth for E&M from 2009 to 2010 is not directly observable because of a change in payment policy for consultations. To compute cumulative volume growth for E&M through 2013, we used a growth rate for 2009 to 2010 of 1.9 percent, which is the average of the 2008 to 2009 growth rate of 1.7 percent and the 2010 to 2011 growth rate of 2.0 percent.

Source: MedPAC analysis of claims data for 100 percent of Medicare beneficiaries.

and management (E&M), –1.0 percent for imaging services, 1.2 percent for major procedures, 0.1 percent for other procedures, and –2.1 percent for tests.

While imaging continues the downward trend we have seen since 2009, use of imaging services remains much higher than it was a decade ago (Figure 4-2). Cumulative growth in the volume of imaging from 2000 to 2009 totaled 85 percent compared with a cumulative decrease in imaging volume since then of about 7 percent. The growth in imaging volume from 2000 to 2009 was exceeded only by the 86 percent growth in the use of tests—such as allergy tests—during those years. Such growth was more than double the cumulative growth rates during the same period for E&M services and major procedures, which were 32 percent and 34 percent, respectively.

The growth in use of imaging and tests has led to concerns about appropriate use of these services. Physicians have warned that diagnostic tests are often ordered without an

**TABLE
4-7****Use of services provided by physicians and other health professionals, per FFS beneficiary**

Type of service	Change in units of service per beneficiary		Change in volume per beneficiary		Percent of 2013 allowed charges
	Average annual 2008-2012	2012-2013	Average annual 2008-2012	2012-2013	
All services	0.6%	-0.2%	N/A	0.5%	100.0%
Evaluation and management	0.2	1.4	N/A	1.4	47.3
Office visit—new and established	0.5	2.8	N/A	2.8	26.8
Inpatient visit—hospital and nursing facility	-0.6	-0.5	N/A	-0.6	15.6
Emergency room visit	2.2	-1.1	3.5%	-0.1	3.1
Hospital visit—critical care	4.7	0.6	4.8	0.5	1.4
Home visit	3.8	1.0	4.3	1.1	0.4
Imaging	-0.5	-0.6	-1.4	-1.0	11.5
Advanced—CT: other	1.8	2.2	0.6	0.9	1.6
Advanced—MRI: other	0.0	1.6	-2.3	0.4	1.1
Echography—other	4.5	4.1	6.7	6.8	1.1
Echography—heart	-0.8	-1.2	-2.1	-7.3	1.0
Standard—nuclear medicine	-6.8	-7.9	-10.1	-10.2	0.9
Standard—musculoskeletal	0.0	0.5	-0.6	0.3	0.9
Standard—breast	1.4	0.9	1.1	0.1	0.7
Imaging/procedure—other	-3.5	-2.0	0.4	5.3	0.7
Advanced—MRI: brain	-1.3	-0.3	-4.4	-1.8	0.5
Advanced—CT: head	1.2	-0.3	-0.6	-0.8	0.4
Standard—chest	-2.1	-3.5	-2.7	-3.6	0.4
Echography—abdomen and pelvis	1.5	0.0	1.8	0.4	0.4
Major procedures	0.3	-1.1	1.2	1.2	7.4
Cardiovascular—other	-1.4	-7.6	0.4	-2.9	1.7
Orthopedic—other	1.6	2.5	3.1	3.6	1.1
Knee replacement	0.9	3.2	1.3	4.4	0.6
Hip replacement	3.2	4.1	3.7	5.2	0.3
Explore, decompress, or excise disc	2.6	0.3	4.7	2.7	0.3
Hip fracture repair	-2.3	0.3	-2.2	0.8	0.3
Coronary angioplasty	-3.3	7.2	-3.2	6.8	0.2
Coronary artery bypass graft	-7.0	-2.8	-7.0	-2.0	0.2
Other procedures	1.9	-0.9	1.9	0.1	22.2
Skin—minor and ambulatory	0.7	1.4	2.3	1.0	4.8
Outpatient rehabilitation	3.9	-2.4	4.7	-1.9	3.3
Radiation therapy	-2.7	-2.5	-1.1	-2.4	1.9
Minor—other	0.6	-1.4	1.2	-0.8	2.0
Cataract removal/lens insertion	-0.4	1.2	-0.2	1.2	1.4
Minor—musculoskeletal	1.8	0.0	2.5	0.6	1.4
Eye—other	10.1	4.8	4.8	2.5	1.1
Colonoscopy	-2.0	0.4	-1.9	0.7	0.9
Upper gastrointestinal endoscopy	0.5	-1.1	1.0	-0.6	0.5
Cystoscopy	0.1	0.1	-0.3	0.2	0.4
Tests	0.8	0.5	2.0	-2.1	4.6
Other tests	1.2	4.9	1.1	0.5	1.7
Laboratory tests—other	3.7	0.7	5.0	0.0	1.6
Electrocardiograms	-0.4	-2.5	-0.2	-3.2	0.5

Note: FFS (fee-for-service), N/A (not available), CT (computed tomography), MRI (magnetic resonance imaging). Volume is measured as units of service multiplied by each service's relative value unit (RVU) from the physician fee schedule. To put service use in each year on a common scale, we used the RVUs for 2013. For billing codes not used in 2013, we imputed RVUs based on the average change in RVUs for each type of service. Some low-volume categories are not shown but are included in the summary calculations. Evaluation and management service volume is not reported for some types of service because a change in payment policy for consultations prevented assignment of RVUs to those services. For 2008, "units of service" for office visits and inpatient visits includes, respectively, office and inpatient consultations. "Laboratory tests" includes tests billable under the fee schedule for physicians and other health professionals and excludes services billable under the laboratory fee schedule.

Source: MedPAC analysis of claims data for 100 percent of Medicare beneficiaries.

understanding of how the results could change patient treatment (Hoffman and Cooper 2012, Redberg et al. 2011). Others have found that some clinicians routinely repeat services, even though standards for doing so are lacking (Welch et al. 2012). One response to such findings is that the American Board of Internal Medicine Foundation has a Choosing Wisely initiative underway to help physicians and patients have conversations about the overuse of imaging and other services (ABIM Foundation 2014, ABIM Foundation 2012).

Volume growth as a measure of change in service use includes shift in billing from professionals' offices to hospitals

As a measure of growth in service use, volume growth has two advantages. First, it accounts for not just changes in the number of services but also any changes in the intensity of services (e.g., substitution of advanced imaging for X-rays). Second, together with changes in fees, volume growth determines growth in spending.

Volume growth, however, is sensitive to shifts in the site of care. The RVUs in the calculation of volume include practice expense RVUs, which are lower for services provided in a facility setting, such as a hospital, compared with services in a nonfacility setting, such as a professional office.⁸ For example, in 2014, the sleep study—a type of neurological test—most frequently used by Medicare beneficiaries had an average nonfacility fee of \$652.⁹ By contrast, when the test is administered in a facility setting, the practice expense RVU is lower, making the average fee \$129.

In recent years, there been a trend toward billing for some services in hospitals instead of professionals' offices. This shift in billing patterns explains at least some of the drop in volume we see for imaging and tests. Indeed, the change in imaging volume would be an increase instead of a decrease if one type of imaging—cardiovascular imaging—were excluded from the calculation.

Decrease in imaging volume includes shift in billing for cardiovascular imaging

The decrease in use of imaging services includes a shift in billing for cardiovascular imaging from professionals' offices to hospitals (Table 4-8). From 2012 to 2013, the number of echocardiograms per beneficiary administered in hospital outpatient departments rose by 7.4 percent, but the number provided in professional offices declined by 8 percent. Similarly, during that period, the number of cardiac nuclear medicine studies per beneficiary

**TABLE
4-8**

Billing for cardiovascular imaging has shifted from professionals' offices to hospitals, 2012–2013

	Share of services performed in HOPDs, 2013	Per beneficiary growth in units of service	
		HOPD	Professional office
Echocardiography	38.0%	7.4%	–8.0%
Nuclear cardiology	42.2	0.4	–12.1

Note: HOPD (hospital outpatient department). Echocardiography includes services in ambulatory payment classification (APC) 0269, APC 0270, and APC 0697. Nuclear cardiology includes services in APC 0377 and APC 0398.

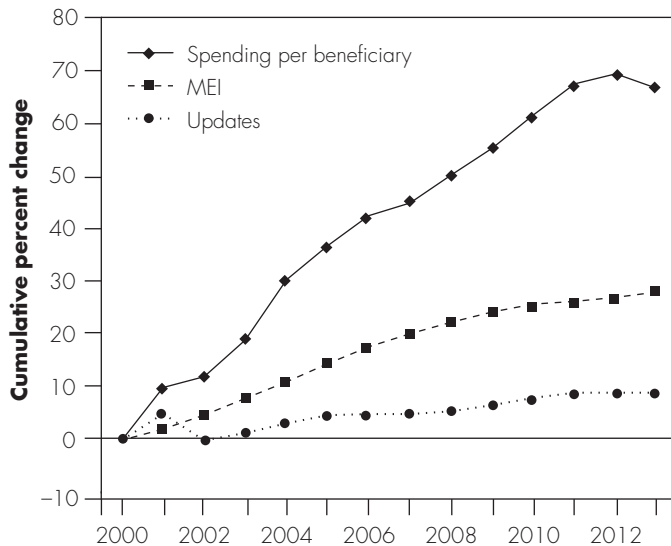
Source: MedPAC analysis of outpatient claims data for 5 percent of Medicare beneficiaries and carrier claims data for 100 percent of Medicare beneficiaries.

administered in hospital outpatient departments increased slightly, by 0.4 percent, but the number in professional offices went down by 12.1 percent. These changes in billing patterns are consistent with reports of an increase in hospital-owned cardiologist practices (American College of Cardiology 2012).

Some of the 1 percent decrease in the volume of imaging services is due to decreases in units of service for nuclear medicine and echocardiography. However, billing for many of these services has simply shifted from the nonfacility setting to the facility setting. If these two services were excluded from the calculations, the volume of all other imaging services from 2012 to 2013 would show a 0.8 percent increase (instead of the 1 percent decrease).

Across all services, volume growth has contributed to an increase in spending

The growth in service volume has contributed to an increase in spending for fee schedule services (Figure 4-3, p. 96). From 2000 to 2013, payment updates for these services increased cumulatively by 9 percent—less than the 28 percent cumulative increase in the Medicare Economic Index. However, spending per beneficiary for the services went up at a cumulative rate of 67 percent. Volume growth, which accounts for most of the difference between the payment updates and spending growth, may include factors other than change in clinical practice, for example, changes in the demographic and health status of beneficiaries.¹⁰ However, most of the volume growth is in the use of more intensive services and more services

**FIGURE
4-3****Volume growth has caused spending to increase faster than input prices and updates, 2000–2013**

Note: MEI (Medicare Economic Index).

Source: 2014 annual report of the Boards of Trustees of the Medicare trust funds and Office of the Actuary 2014.

for an average beneficiary population with little change in clinical and demographic characteristics over time.

From 2012 to 2013, per beneficiary spending for fee schedule services declined by 1.6 percent. With the small increase in volume growth and no change in the fee schedule conversion factor, the sequester—in effect for three-quarters of the year—would account for most of the spending decrease.

The 2013 decrease in spending per beneficiary is small when compared with the increase in spending that occurred from 2000 to 2012, when spending increased at an average annual rate of 4.5 percent. In addition, payment adjustments outside of the update process also affect spending for fee schedule services. Indeed, some of the adjustments—such as those in the \$2.6 billion electronic health records (EHR) program—are not included in the published estimates of fee schedule spending.

Payment adjustments outside of the update process

While volume growth for many categories of services and the conversion factor updates have been low or near zero in recent years, Medicare spending for fee schedule services

is also affected by bonuses, penalties, and other types of payment adjustments. The net effect of these adjustments in recent years has been to increase the effective payment rate to physicians and other health professionals by more than the update of the conversion factor.

The adjustments can be grouped into three categories (Table 4-9). The first category includes payment adjustments made to claims billing for fee schedule services. One example of adjustments in this category is the work geographic practice cost index (GPCI) floor, a legislated policy that raises the work GPCI up to 1 in areas where it otherwise would be below 1. Because the work GPCI is designed to be budget neutral, imposing a floor on the work GPCI increases spending. Another example is the 2 percent reduction in Medicare program payments to all providers imposed by the sequester.

The second category of payment adjustments includes adjustments that were not made to providers' individual claims for services, but were included in Medicare spending totals. These adjustments include the Primary Care Incentive Payment program and health professional shortage area incentive payments. This category also includes three incentive programs: the Physician Quality Reporting System (PQRS) bonus and penalty, the EHR “meaningful use” incentive payments and subsequent penalties for nonusers, and the electronic prescribing (eRx) bonus and penalty.

The third category includes payments to practitioners participating in models run by the Center for Medicare & Medicaid Innovation (CMMI). Currently, three such models make available additional funds for clinicians billing under the fee schedule: two medical home models (the Comprehensive Primary Care Initiative and the Multi-payer Advanced Primary Care Practice demonstration) and the recently announced Transforming Clinical Practices Initiative. The first two models are for practices to test the medical home concept and are available to practices that were approved for the model and comply with model requirements; the third model is in the application review process.

We would note that some of the adjustments are presently positive payment adjustments but will change to negative payment adjustments over the next few years. Specifically, the eRx payment adjustment began to include penalties for nonparticipation between 2012 and 2014, and the EHR Incentive Program and the PQRS payment adjustment will include penalties starting in 2015. In addition, the value

**TABLE
4-9****CMS payment adjustments for eligible physicians and other health professionals billing under the Medicare fee schedule**

Category	Adjustment	Total amount of adjustment in most recent available year (in millions)	Year of estimate and source
Adjustments to fee schedule claims	Work GPCI floor	\$300	2014: CBO estimate of H.R. 4302, one-year extension
	Sequester	-1,200	2013: Estimate from 2014 Medicare trustees report
Adjustments outside fee schedule claims but included in Medicare spending figures	Primary care incentive payment	650	2012: Estimate from claims
	HPSA bonuses, including mental health and surgical bonuses	37	Average of 2011 and 2012: CMS
	EHR Incentive Program	2,563	2013: CMS payment summary
	PQRS	168	2012: CMS experience report
	eRx upward adjustment*	335	2012: CMS experience report
Adjustments outside of Medicare spending figures	CMMI—Comprehensive Primary Care Initiative	172	2014: CMMI Report to Congress
	CMMI—Multi-payer Advanced Primary Care Practice	N/A	CMMI has not released a spending figure for this initiative
	CMMI—Transforming Clinical Practices Initiative	210	\$840 million for the next four years: CMS

Note: GPCI (geographic practice cost index), CBO (Congressional Budget Office), HPSA (health professional shortage area), EHR (electronic health record), PQRS (Physician Quality Reporting System), eRx (electronic prescribing), CMMI (Center for Medicare & Medicaid Innovation), N/A (not available).

*An eRx penalty also applied in 2012 to 59,955 eligible professionals, but CMS did not publish the total reduction in payments.

Sources: CMS/CMMI; CMS, Office of the Actuary; CMS press releases; and CBO.

modifier (not discussed) could result in both upward and downward payment adjustments for clinicians starting in 2015.

Quality of care

In prior years' reports, the Commission has assessed quality in ambulatory care settings by reporting trends in the Medical Ambulatory Care Indicators for the Elderly (MACIEs), a set of claims-based quality measures developed by the Commission. The MACIEs assess under-provision of clinically indicated care. Most MACIEs are process measures—for example, (1) checking whether

certain kinds of routine diagnostic tests were performed for beneficiaries diagnosed with diabetes and heart failure and (2) six potentially avoidable hospitalization measures.

In recent years, the Commission has become concerned that Medicare's predominant approach to quality measurement is flawed. First, it includes too many clinical process measures, which are weakly correlated with such outcomes as mortality and readmissions, outcomes that patients care about most. Second, clinical process measures have focused almost exclusively on the underuse of services, while the Commission believes that overuse

**TABLE
4-10****Trends in selected Prevention Quality Indicators (inpatient admissions of FFS beneficiaries for ambulatory care-sensitive conditions), 2008-2012****Inpatient admissions per 100,000 FFS beneficiaries in age group**

Year	PQI 3: Diabetes long-term complications			PQI 8: Congestive heart failure			PQI 11: Bacterial pneumonia		
	Under 65	65-74	Over 75	Under 65	65-74	Over 75	Under 65	65-74	Over 75
2008	781	257	325	1,056	823	2,474	881	716	1,972
2009	774	243	301	1,047	809	2,408	901	682	1,776
2010	775	238	293	994	767	2,276	822	651	1,730
2011	751	229	275	935	710	2,139	804	631	1,708
2012	728	209	249	892	664	2,033	753	576	1,603

Note: FFS (fee-for-service), PQI (Prevention Quality Indicators). Figures represent the number of hospital admissions for the identified condition for Medicare beneficiaries in each age range per 100,000 beneficiaries. Only FFS beneficiaries enrolled in Part A and Part B are included. Beneficiaries who were enrolled in a Medicare Advantage plan at any point during the year are excluded. Beneficiaries who died during the year are included.

Source: CMS, Data on Geographic Variation. Figures calculated by CMS from the Chronic Conditions Data Warehouse of 100 percent of claims.

and inappropriate use are also significant concerns. Third, it is administratively burdensome for providers to report on clinical process measures that require data extracted from patient medical records (claims-based process measures may avoid these costs, but questions remain about their meaningfulness and possible incentive for overuse). Last, using process measures creates an incentive for providers to focus their resources and attention on the care processes being measured, not on the overall quality of care provided to their patient population.

For these reasons, the Commission supports the use of a small set of population-based outcome measures such as rates of potentially avoidable hospitalizations and readmissions, mortality, and patient experience. One approach, discussed in our June 2014 report to the Congress, is to assess and compare performance of FFS Medicare, Medicare Advantage (MA), and Medicare accountable care organizations (ACOs) within a locality, such as a metropolitan statistical area (MSA) or Dartmouth Atlas Health Service Area (HSA), on the basis of a few key outcome measures (Medicare Payment Advisory

**TABLE
4-11****Variation in Prevention Quality Indicators (inpatient admissions of FFS beneficiaries for ambulatory care-sensitive conditions) among hospital referral regions, 2012****Inpatient admissions per 100,000 FFS beneficiaries in age group**

	PQI 3: Diabetes long-term complications			PQI 8: Congestive heart failure			PQI 11: Bacterial pneumonia		
	Under 65	65-74	Over 75	Under 65	65-74	Over 75	Under 65	65-74	Over 75
Minimum	214	64	68	215	180	820	237	199	723
Median	683	193	223	801	651	2,037	736	563	1,606
Maximum	1,611	679	715	1,900	1,334	3,515	1,459	1,340	3,405

Note: FFS (fee-for-service), PQI (Prevention Quality Indicators). Figures represent the number of hospital admissions for the identified condition for Medicare beneficiaries in each age range per 100,000 beneficiaries. Only Part A and Part B FFS beneficiaries are included. Beneficiaries who were enrolled at any point during the year in a Medicare Advantage plan are excluded. Beneficiaries who died during the year are included.

Source: CMS, Data on Geographic Variation. Figures calculated by CMS from the Chronic Conditions Data Warehouse of 100 percent of claims.

**TABLE
4-12****Variation in potentially preventable admission and potentially preventable emergency department visit rates for FFS Medicare enrollees across metropolitan statistical areas and health service areas, 2011**

Summary statistic	MSAs		HSAs	
	PPA rate	PPV rate	PPA rate	PPV rate
Mean (population weighted)	1.00	1.00	1.00	1.00
10th percentile	0.80	0.82	0.47	0.20
25th percentile	0.91	0.94	0.72	0.42
Median (50th percentile)	1.00	1.06	0.96	0.95
75th percentile	1.10	1.19	1.13	1.19
90th percentile	1.21	1.31	1.29	1.39

Note: FFS (fee-for-service), MSA (metropolitan statistical area), HSA (health service area), PPA (potentially preventable admission), PPV (potentially preventable emergency department visit). Rates were calculated using 3M™ PPA/PPV software. Health service areas with small numbers of enrollees may show extreme (statistically unreliable) high or low values. There are 411 metropolitan statistical areas and 3,340 health service areas.

Source: MedPAC contractor analysis of 2010 and 2011 100 percent Part A and Part B claims data.

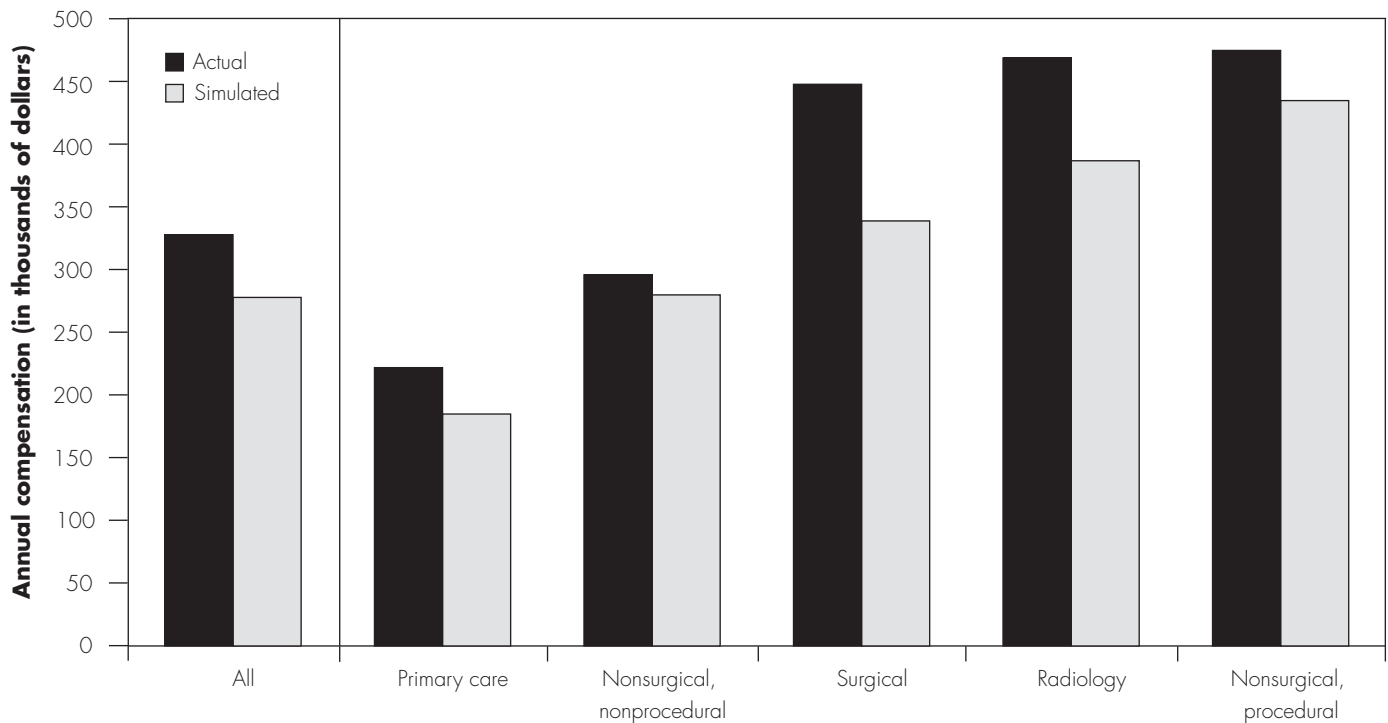
Commission 2014). We acknowledge that this approach may not be appropriate for adjusting FFS Medicare payments to individual providers in an area because, unlike an ACO or MA plan, providers operating in FFS Medicare do not explicitly accept responsibility for the care of a population of beneficiaries. Also, for physicians and other health care professionals, it may be difficult to define clinically meaningful and statistically reliable quality measures for some specialties (for example, certain surgical subspecialties and hospital-based specialties such as radiologists, anesthesiologists, and pathologists).

Population-based outcome measures can gauge the quality of a community's ambulatory care environment. Rates of potentially avoidable hospitalizations are one such measure. For example, some patients with worsening conditions need to be hospitalized, but of these patients, some might have avoided hospitalization had they been treated earlier in an ambulatory setting. CMS publishes data on one set of potentially avoidable hospitalization measures for the Medicare population—the Prevention Quality Indicators (PQIs), developed by the Agency for Healthcare Research and Quality. Table 4-10 presents national results for three prevalent and costly conditions among the Medicare population—diabetes, congestive heart failure, and bacterial pneumonia. The PQIs measure the rate of hospital admissions for the selected condition by age category, expressed as a number per 100,000 beneficiaries.

Most of the rates show improvements over time, but these overall patterns mask wide variation across the United States when these rates are assessed within hospital referral regions. For example, in 2012, avoidable hospitalizations for congestive heart failure varied five-fold on average between the area with the lowest rate and the area with the highest rate (Table 4-11).

The Commission has also explored the feasibility of calculating population-based outcome measures for FFS Medicare in localities across the country using two such measures developed by 3M™ Health Information Systems: potentially preventable admissions (PPAs) and potentially preventable emergency department visits (PPVs). Similar to the PQIs, these measures are designed to assess the effectiveness of ambulatory care delivery within a geographic area. The PPAs and PPVs are based on the premise that, while not every PPA or PPV can be averted, comparatively high rates of these events (when appropriately risk adjusted for variation and severity in the local population's existing clinical conditions) can identify opportunities for improvement in an area's ambulatory care systems.

The Commission's preliminary analyses of PPA and PPV rates using 100 percent Medicare claims data for 2011 revealed two important findings (Table 4-12).¹¹ First, PPA and PPV rates vary significantly across the nation's localities, whether the areas measured are larger, such as

**FIGURE
4-4****Disparities in physician compensation are widest when primary care physicians are compared with radiologists and nonsurgical proceduralists, 2012**

Note: Simulated compensation is compensation as if all services were paid under the Medicare physician fee schedule.

Source: Urban Institute analysis of physician compensation data for MedPAC 2014.

MSAs, or smaller, such as HSAs. For example, MSAs at the 75th percentile of PPA rates had 10 percent more PPAs than the national average, which indicates potential savings for Medicare and its beneficiaries if those areas could be brought down to the average. MSAs at the 25th percentile had PPA rates almost 20 percentage points lower than those at the 75th percentile. The distribution of PPV rates showed similar variation. The second finding is that using smaller areas, such as HSAs instead of MSAs, introduces more variation in the PPA and PPV rates, which could be useful for understanding finer distinctions in outcome differences across localities. For example, the interquartile range (i.e., difference between 25th and 75th percentiles) for PPA rates using HSAs is over 40 percentage points compared with about 20 points for MSAs. In general, larger areas have less variation. The trade-off in using smaller areas is that it may introduce more statistical “noise” (i.e., random variation) in the results, which can be seen in Table 4-12 (p. 99) in the

minimum and maximum PPA and PPV values for HSAs. In practice, this statistical phenomenon could be addressed by imposing a minimum population threshold or other technique to increase the statistical reliability of the results to an acceptable level.

The Commission plans to continue to refine its current position on quality measurement for clinicians, including whether a system that assesses local population-level performance on the basis of a few key outcome measures will still require other, provider-based quality measures to make FFS payment adjustments.

Medicare payments and providers’ costs

Because physicians and other health professionals do not report their costs to the Medicare program, we use other measures to assess the adequacy of Medicare payments relative to clinicians’ costs. The first measure is how Medicare’s payments compare with the fees paid by private

insurers for covered services. The second measure is whether Medicare's fee schedule contributes to differences in physician compensation across specialties—even after accounting for the cost of running a practice. The third measure assesses input prices for physicians and other health professionals—the Medicare Economic Index (MEI).

Ratio of Medicare payments to private insurer payments is steady

Since 1999, Medicare's physician and other health professional fees (including cost sharing) have been about 80 percent of private insurer fees. In 2013, Medicare's payments for physician and other health professional services were 79 percent of commercial rates for preferred provider organizations (PPOs). This analysis uses a data set of paid claims for PPO members of a large national insurer.

Compensation differences between primary and specialty care

The Commission remains concerned that the fee schedule and the nature of FFS payment lead to an undervaluing of primary care and overvaluing of specialty care. First, the Commission has concerns that the resource-based relative value scale, which forms the basis for the fee schedule, includes mispriced services and that these mispriced services cause an income disparity between primary care and specialty physicians. Second, FFS payment allows some specialties to more easily increase the volume of services they provide (and therefore their revenue from Medicare), while other specialties, particularly those that spend most of their time providing E&M services, have limited ability to increase their volume.

For an analysis of the compensation received by physicians—the largest subset of practitioners—the Commission contracted with the Urban Institute, working in collaboration with the Medical Group Management Association (MGMA) (Berenson et al. 2010). The contractor developed a method for analysis of two measures of compensation: “actual compensation,” or actual revenues received by a physician from all payers, and “simulated compensation,” or payments a physician would receive if all the services the physician provided were paid under Medicare's fee schedule.¹² Private payers often use a conversion factor—or multiple conversion factors, depending on the type of service—that differs from Medicare's.

In an update of the initial analysis, the contractor used data from MGMA's Physician Compensation and Production

Survey to analyze physician compensation in 2012. The analysis showed that—averaged across all specialties—actual physician compensation was about \$328,000 per year. Simulated annual compensation for all specialties was about \$277,000—roughly 15 percent lower.¹³

Within these averages, compensation was much higher for some specialties than others. The specialty groups with the highest compensation were the nonsurgical, procedural group and radiology (Figure 4-4).¹⁴ Their actual compensations were on average \$475,000 and \$469,000, respectively. Compensation at these levels was more than double that of the \$222,000 average for primary care specialties.¹⁵ Previous Commission work using MGMA data showed that such disparities also existed when compensation was observed on an hourly basis.¹⁶

Use of simulated annual compensation instead of actual annual compensation resulted in minimal narrowing of the disparities between primary care physicians and specialists. Simulated, radiologists' average annual compensation was about \$387,000, or 2.1 times the \$185,000 compensation for primary care physicians. For nonsurgical, procedural physicians, the average simulated compensation was about \$435,000, or 2.3 times the \$185,000 compensation for primary care physicians.

The fee schedule's RVUs have changed since 2012. The disparities in compensation between primary care physicians and specialists may be affected also by the payments for transitional care management and chronic care management instituted in 2013 and 2015, respectively. Nonetheless, the disparities are large enough to remain a concern. In addition, their persistence—under both actual compensation and simulated compensation—shows that the fee schedule is an important source of the disparities. Validation of the fee schedule's RVUs can help correct the fee schedule's inaccuracies and ensure that physicians at the high end of compensation scale are not overcompensated (see text box, pp. 102–103).

Input costs for physicians and other health professionals are projected to increase from 2015 to 2016

The MEI measures the changes in the market basket of input prices for physician and other health professional services and is adjusted for economy-wide productivity.¹⁷ CMS's current forecast for 2016 is that the change in the MEI will be 2.2 percent (Centers for Medicare & Medicaid Services 2014b).

Validating the fee schedule's relative value units

In 2011, as part of its sustainable growth rate reform package, the Commission recommended that CMS undertake a data collection effort to help identify mispriced services in the fee schedule. CMS now has a statutory mandate and resources to examine and address inaccuracies in the fee schedule. The agency currently has two contracts under way, both of which have taken a “bottom up” approach, meaning they attempt to validate the time estimates for services one by one. This process may require direct observation or time-and-motion studies, or detailed data from electronic health records. This type of study is likely to be burdensome for providers and CMS, biased if the practitioners observed change their behavior because they are observed, and very costly. Because of the burden and cost, it is unlikely that the approach could be repeated regularly to maintain accuracy over the long term.

The Commission is exploring a different approach. Instead of looking at each individual service “bottom-up,” the “top-down” approach looks at the amount of time that a physician worked over the course of a day/week/month and compares it with the time estimates inherent in all the services that the physician billed over that same period. If a physician worked 10

hours, but the fee-schedule assumed that the services provided required 15 hours, the difference might mean that the time estimates in the fee schedule are overstated. Statistical analysis of the data would then provide direction for further investigation by CMS.

A contractor for the Commission explored the feasibility of this approach by collecting data from a small set of physician practices on (1) the services that its practitioners billed (by Current Procedural Terminology code) and (2) the practitioners’ actual hours worked (Zismer et al. 2014). Complete practitioner-level data were available from four practices—cardiology, family medicine, orthopedics, and urology.

Computing averages for each of the practices, the contractor found that, for physicians in all of the practices, the time assumed in the fee schedule exceeded actual hours worked (Figure 4-5). For the physicians in the family medicine practice, the difference was smallest, with fee schedule time averaging 8.8 hours per day, but hours worked per day averaging 7.1 hours, a difference of 24 percent. For the physicians in the orthopedics practice, the difference was the largest among the four practices, with fee

(continued next page)

How should Medicare payments change in 2016?

The Commission’s deliberations on payment adequacy for physicians and other health professionals are informed by beneficiary access to services, volume growth, quality, and input prices for physicians and other health professionals. We find that, on the basis of these indicators, payments are adequate.

On measures of access to the services of physicians and other health professionals, the Commission continues to find—consistent with our findings over many years—that beneficiary access to care is stable. Medicare beneficiaries generally have better overall access than privately insured individuals ages 50 to 64. Other beneficiary access surveys have consistent findings. The number of physicians per beneficiary has remained relatively constant, the number

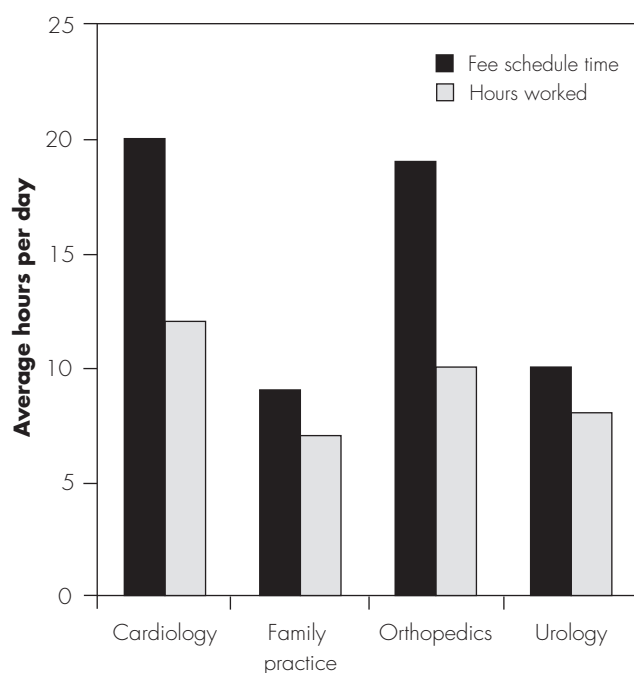
of other health professionals per beneficiary has grown, and the share of providers accepting assignment and enrolled in Medicare’s participating provider program remains high. However, more beneficiaries seeking a primary care doctor report a big problem than beneficiaries seeking a specialist, which continues to be of concern to the Commission.

The volume of physician and other health professional services per beneficiary grew by 0.5 percent in 2013. Growth rates varied across services: 1.4 percent for evaluation and management, –1 percent for imaging services, 1.2 percent for major procedures, 0.1 percent for other procedures, and –2.1 percent for tests. The decline in imaging and tests does not raise concerns about access since they follow large increases in the use of these services since 2000. Specific to imaging, the decrease in volume includes a shift in billing for cardiovascular imaging from professionals’ offices to hospitals.

Validating the fee schedule's relative value units (cont.)

**FIGURE
4-5**

On average, fee schedule time exceeded physician hours worked, 2012 or 2013



Source: Zisner et al. 2014.

schedule time averaging 19.2 hours per day but hours worked averaging 10 hours per day, a difference of 92 percent. This difference suggests that services provided by the orthopedic practice may be based on inflated time estimates and that further investigation of the relative values for these services is needed.

These data represent a small number of practices and physicians and are not definitive. The task of collecting enough data to reliably conduct this analysis has its challenges. However, these preliminary findings are consistent with the Commission's concerns—that primary care services are undervalued in the fee schedule and the time estimates underlying procedural and testing services are overstated. The vast majority of fee schedule time for the physicians in the family medicine practice is time providing office visits. By contrast, the physicians in the other three practices—where the differences between fee schedule time and hours worked are larger—provide more imaging, procedural, and testing services. This approach could be a desirable method for ensuring the accuracy of the fee schedule going forward and is more efficient than trying to validate the relative value units for each individual service. ■

Input prices for physicians and other health professionals are projected to increase by 2.2 percent in 2016 (including a productivity adjustment).

SGR repeal remains the highest priority

The Commission's highest policy priority with respect to Medicare's payments to physicians and other health professionals is repeal of the SGR. Given that this year's payment adequacy findings are largely similar to the findings from prior years, the Commission continues to reiterate its previous recommendations on the SGR as its position with respect to the 2016 fee schedule payment update (see text box, p. 104). The Commission's principles for addressing the SGR are the following:

- **Repeal of the SGR is urgent.** Temporary stop-gap fixes to the SGR have had a destabilizing influence on the Medicare program by creating uncertainty

for clinicians and beneficiaries, and the short-term overrides of the SGR cause administrative burden for providers and CMS.

- **Beneficiary access must be preserved.** Although our review of beneficiary access does not show significant deterioration at the national level, annual crises prompted by pending Medicare payment cuts will only exacerbate any nascent access problems.
- **The fee schedule for services delivered by physicians and other health professionals must be rebalanced to achieve greater equity of payments between primary care and other specialties.** The Commission believes that the imbalance in payment between primary care and specialty care must be corrected to ensure adequate beneficiary access to these services and to support the role of primary care in delivery system reform.

The Commission reiterates its 2011 recommendations on moving forward from the sustainable growth rate system

Recommendation 1

The Congress should repeal the sustainable growth rate (SGR) system and replace it with a 10-year path of statutory fee schedule updates. This path is comprised of a freeze in current payment levels for primary care and, for all other services, annual payment reductions of [5.9 percent]* for three years, followed by a freeze. The Commission is offering a list of options for the Congress to consider if it decides to offset the cost of repealing the SGR system within the Medicare program.

Recommendation 2

The Congress should direct the Secretary to regularly collect data—including service volume and work time—to establish more accurate work and practice expense values. To help assess whether Medicare's fees are adequate for efficient care delivery, the data should be collected from a cohort of efficient practices rather than a sample of all practices. The initial round of data collection should be completed within three years.

Recommendation 3

The Congress should direct the Secretary to identify overpriced fee schedule services and reduce their relative value units (RVUs) accordingly. To fulfill this requirement, the Secretary could use the data collected under the process in Recommendation 2. These reductions should be budget neutral within the fee schedule. Starting in 2015, the Congress should specify that the RVU reductions achieve an annual numeric goal—for each of five consecutive years—of at least 1 percent of fee schedule spending.

Recommendation 4

Under the 10-year update path specified in Recommendation 1, the Congress should direct the Secretary to increase the shared savings opportunity for physicians and health professionals who join or lead two-sided risk accountable care organizations (ACOs). The Secretary should compute spending benchmarks for these ACOs using 2011 fee schedule rates. ■

**Note: Based on more recent Congressional Budget Office estimates of repealing the SGR recommendation, in April 2013 the Commission provided an updated estimate of the reduction for services other than primary care of 3 percentage points or less for each of three years. This estimate assumes that primary care fees are held constant throughout the 10-year period and that one-third of the fiscal burden of repeal is borne by physicians and other health professionals paid under the fee schedule.*

- **Medicare's payment systems must move away from unrestrained FFS and toward new payment models and delivery systems.** New payment models, such as ACOs and bundled payments, offer an opportunity to correct some of the undesirable incentives to increase volume in FFS and have the potential to reward providers who control costs and improve quality.
- **Repeal of the SGR should be done in a fiscally responsible way.** The Commission's recommendations to the Congress are designed to preserve or enhance beneficiary access to quality care while minimizing the financial burden on beneficiaries and taxpayers.

From these principles, the Commission made four distinct recommendations in 2011 and has reiterated these recommendations each year since (see text box).

Repeal the SGR and replace it with a 10-year path of legislated updates, with higher updates for primary care services than for other services Under the Commission's approach, the SGR would be repealed and replaced by a new set of statutory updates over 10 years for services provided by physicians and other health professionals; the update would be different for clinicians who deliver primary care and clinicians who deliver other services. Specifically, fees for non-primary care services would be reduced in each of the first three years, followed by a freeze. Fees for primary care would be frozen for 10 years. Through these reductions and freezes, physicians and

Primary care services and eligible primary care practitioners as defined by the Primary Care Incentive Payment program

Primary care services defined by the Primary Care Incentive Payment program (PCIP) are a subset of evaluation and management services made up primarily of office visits, nursing facility visits, and home visits. Visits to hospital inpatients and emergency department care are not considered PCIP-defined primary care services.

Eligible primary care practitioners include practitioners (1) who have a primary Medicare specialty designation of family practice, internal medicine, pediatrics, geriatrics, nurse practitioner and clinical nurse specialist, or physician assistant and (2) for whom PCIP-defined primary care services account for at least 60 percent of allowed charges under the fee schedule (Centers for Medicare & Medicaid Services 2010). ■

other health professionals would shoulder about one-third of the cost of repealing the SGR.

Collect data to improve the relative valuation of services

The Secretary lacks current, objective data needed to set the fee schedule's RVUs for practitioner work and practice expenses. The Commission recommended that the Secretary regularly collect data from a cohort of efficient practices to establish more accurate work and practice expense values.

Identify overpriced services and rebalance payments The Commission recommended a change in the process for identifying overpriced services in the fee schedule. The Secretary could use the data collected through the prior recommendation to identify overpriced services and adjust the work and practice expense RVUs for these services.

Encourage ACOs by creating greater opportunities for shared savings The Commission recommended that physicians and health professionals who join or lead two-sided risk ACOs should be afforded a greater opportunity for shared savings compared with those in bonus-only ACOs and those who do not join any ACO.

Per beneficiary payment for primary care

The Commission has been concerned about the current state of support for primary care. Primary care is essential for creating the coordinated health care delivery system of the future, but the Medicare fee schedule undervalues it relative to specialty care. Even though the relative payment for primary care services under the fee schedule

has increased over the last decade, compensation for primary care practitioners is still substantially less than that of other specialties (Figure 4-4, p. 100). Disparities in compensation could deter medical students from choosing primary care practice, deter current practitioners from remaining in primary care practice, and leave primary care services at risk of being underprovided. As an indication, the cumulative growth in the volume of E&M services from 2000 to 2013 was less than half the cumulative growth in the volume of imaging, tests, and other procedures (Figure 4-2, p. 93).

In response to its concern, the Commission has made several recommendations over the years to rebalance the fee schedule and bolster support for primary care. The Commission has proposed identifying overpriced services and pricing them appropriately, replacing the SGR with payment updates that are higher for primary care than specialty care, creating a budget-neutral primary care bonus funded from non-primary care services, and establishing a medical home pilot.

PPACA did create a primary care bonus program called the Primary Care Incentive Payment program (PCIP), but it was not budget neutral and thus required additional funding. PCIP provides a 10 percent bonus payment on fee schedule payments for PCIP-defined primary care services provided by eligible primary care practitioners (see text box for definitions). It expires at the end of 2015.

The Commission believes that the additional payments to eligible primary care practitioners should continue. While the amount of the PCIP payment is not large and will probably not drastically change the supply of primary care practitioners, allowing it to expire without a replacement sends a poor signal to primary care practitioners.

New payment for chronic care management services: A comparison with the per beneficiary payment recommendation

Even though fee-for-service (FFS) payment has typically focused on face-to-face activities, CMS has created a new code, which began with the 2015 fee schedule, for non-face-to-face chronic care management (CCM) services (Centers for Medicare & Medicaid Services 2014d). While the Commission supports that effort, the per beneficiary payment model under consideration differs in goals—to replace the expiring primary care bonus payment, to improve support for primary care, and to rebalance the fee schedule—and therefore in design.

Some of the differences are worth emphasizing. First, whereas the CCM code is billable by specialists and

primary care practitioners alike, the per beneficiary payment would be paid to eligible primary care practitioners only. Second, beneficiaries are charged cost sharing for the CCM code, but they would not pay cost sharing under the per beneficiary payment design. Finally, CMS is projecting low use of the CCM code, possibly because of the beneficiary criteria, practice requirements, or beneficiary cost sharing. CMS also could be drawing on experience from the recently introduced billing codes for transitional care management, for which use was much lower than expected. However, the CCM code is new, so actual use could turn out to be much different from projections. ■

However, the Commission has also become increasingly concerned that the fee schedule is an ill-suited payment mechanism for primary care. The fee schedule is oriented toward discrete services and procedures that have a definite beginning and end. In contrast, ideally, primary care services are oriented toward ongoing, non-face-to-face care coordination for a panel of patients. Some patients in the panel will require the coordination of only preventive and maintenance services. Others will have multiple complex chronic conditions and will require extensive care coordination. The fee schedule is not well designed to support these behind-the-scenes activities, and it is precisely these activities that will be crucial in the move to a more coordinated and efficient health care delivery system of the future.

Because of that concern, the Commission recommends continuing the additional payments to primary care practitioners, but in the form of a per beneficiary payment in contrast to the per service payment made under the PCIP. Replacing the PCIP with a per beneficiary payment could be a first step in moving Medicare's payment for primary care from a service-oriented FFS payment approach toward a beneficiary-centered payment approach that encourages care coordination, including the non-face-to-face activities that are a critical component of care coordination.

Although a step in the right direction, the Commission acknowledges that a per beneficiary payment in itself will not guarantee an increase in care coordination activities or even an increase in compensation for eligible primary care

practitioners in all instances. The additional funds, like Medicare payments more generally, are paid to practices and other employers of primary care practitioners. These practices could be solo and small practices, large multispecialty practices, or practices owned by hospital systems. These entities may use the additional funds for purposes other than care coordination. Nonetheless, the Commission believes a per beneficiary payment for primary care is needed until new and better payment and delivery system reforms are established.

In developing its approach, the Commission considered several design issues: payment amount, attribution of beneficiaries to practitioners, requirements that practices must meet to receive payment, and the source of funding (Medicare Payment Advisory Commission 2014). The Commission's specific recommendations on these issues are described below.

Finally, CMS established a new payment for chronic care management that began with the 2015 fee schedule. Its structure and purpose differ from the PCIP and from the per beneficiary payment detailed here. However, the Commission is supportive of the new payment for chronic care management and views the two payments as complementary (see text box).

Payment amount

At least as an initial starting point, the Commission supports funding the per beneficiary payment at the same

level as the PCIP. In 2012, bonus payments totaled about 1 percent of fee schedule spending, or \$664 million. Payments were made to about 169,000 eligible primary care practitioners (accounting for about 20 percent of practitioners who billed Medicare in that year) for providing PCIP-defined primary care services to about 21 million FFS beneficiaries. On average, practitioners received a bonus payment of about \$31 per beneficiary in that year.

At that funding amount, on average, eligible practitioners would receive about \$3,900 in additional Medicare revenue per year, and practitioners who provided primary care services to more FFS Medicare beneficiaries than the average practitioner would earn more. For example, consider a primary care practitioner with a panel of 1,400 patients, of whom 280 (20 percent) are FFS Medicare beneficiaries. A \$31 per beneficiary payment would provide \$8,700 in additional Medicare revenue per year to that practitioner.

That funding amount may not seem like it would provide practitioners with the resources and incentives to undertake significant practice transformation. However, Medicare is not working in isolation. Other payers also are providing per beneficiary payments and other types of support for primary care (Medicare Payment Advisory Commission 2014).

Beneficiary attribution

Unlike the service-based PCIP, a per beneficiary payment necessitates linking a beneficiary to a practitioner to ensure that the right practitioner gets paid and that Medicare does not make duplicate payments to multiple practitioners on behalf of the same beneficiary. The Commission recommends attributing beneficiaries to eligible primary care practitioners prospectively; that is, beneficiaries would be attributed to eligible primary care practitioners at the beginning of the performance year based on the plurality of primary care services provided in the previous year. Eligible primary care practitioners and primary care services are defined as they are in the PCIP (text box, p. 105).

An advantage of this method is the ease with which it could be administered. Like the PCIP, the practitioner would receive payment automatically, without extra paperwork requirements of practitioners or beneficiaries. The practitioner also could be paid throughout the year and thus would be better positioned to make front-end

investments in infrastructure and staffing that facilitate care coordination.

One concern regarding prospective attribution is that practitioners could be paid for beneficiaries no longer under their care if beneficiaries switch practitioners from year to year. However, this possibility is not a large concern for two reasons. First, if some beneficiaries switch practitioners from year to year, as long as practitioners care for about the same number of beneficiaries from year to year, per beneficiary payment under prospective attribution would still be similar. Second, even if the number of beneficiaries seen by a practitioner did change markedly from one year to the next, those changes would be reflected in the attribution for the next performance year and per beneficiary payments in the next performance year would move up or down accordingly.

Practice requirements

The Commission recommends having no practice requirements to receive a per beneficiary payment for two reasons. First, a level of funding approximating the PCIP may not be enough for practices to make substantial investments in care coordination activities and technologies that would significantly transform the delivery of care. Second, regardless of the funding level, evidence concerning the effect of practice requirements on improving quality and reducing health care spending has been mixed. However, the issue of practice requirements could be revisited in the future if the per beneficiary payment amount were to increase and if new evidence were to show that certain practice requirements were effective at increasing quality and lowering costs.

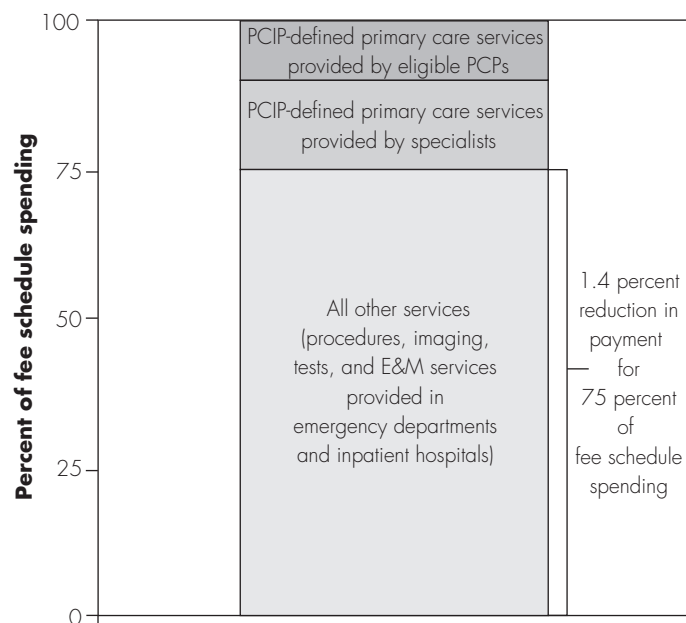
Funding

The Commission recommends funding the per beneficiary payment by reducing fees for all services in the fee schedule other than PCIP-defined primary care services provided by any practitioner, regardless of the practitioner's specialty designation or whether PCIP-defined primary care services accounted for at least 60 percent of the practitioner's allowed charges. Beneficiaries would not pay cost sharing, just as beneficiaries do not pay cost sharing to fund the PCIP. This method of funding would be budget neutral and would help rebalance the fee schedule.

All services in the fee schedule other than PCIP-defined primary care services account for about 75 percent of fee schedule spending. Funding a per beneficiary payment at about the same level of funding as the PCIP, or \$31 per

**FIGURE
4-6**

Funding the per beneficiary payment from services other than PCIP-defined primary care services



Note: PCIP (Primary Care Incentive Payment program), PCPs (primary care practitioners), E&M (evaluation and management). PCIP-defined primary care services are a subset of E&M made up primarily of office visits, nursing facility visits, and home visits. Visits to hospital inpatients and emergency department care are not considered PCIP-defined primary care services. Eligible primary care practitioners include practitioners (1) who have a primary Medicare specialty designation of family practice, internal medicine, pediatrics, geriatrics, nurse practitioner and clinical nurse specialist, or physician assistant and (2) for whom PCIP-defined primary care services account for at least 60 percent of allowed charges under the fee schedule (excluding hospital inpatient care and emergency department visits from the calculation).

Source: MedPAC analysis.

beneficiary per year based on 2012, would require a 1.4 percent reduction in payment for all services in the fee schedule other than PCIP-defined primary care services (Figure 4-6).¹⁸

RECOMMENDATION 4

The Congress should establish a prospective per beneficiary payment to replace the Primary Care Incentive Payment program (PCIP) after it expires at the end of 2015. The per beneficiary payment should equal the average per beneficiary payment under the PCIP and should be exempt from beneficiary cost sharing. Funding for the per beneficiary payment should protect PCIP-defined primary care services regardless of the practitioners furnishing the services and should come from reduced fees for all other services in the fee schedule.

RATIONALE 4

Replacing the PCIP after it expires with a per beneficiary payment for primary care would continue the additional support for primary care and so continue to help overcome the undervaluation of primary care services in the fee schedule. Replacing the PCIP with a per beneficiary payment could also be a first step in moving Medicare's payment for primary care from a service-oriented fee-for-service payment approach and toward a beneficiary-centered payment approach. Funding the per beneficiary payment by reducing fees for all services in the fee schedule other than PCIP-defined primary care services would be budget neutral and would help rebalance the fee schedule.

IMPLICATIONS 4

Spending

- As a budget-neutral policy, the per beneficiary payment for primary care would not affect federal spending relative to current law.

Beneficiary and provider

- For beneficiaries, the per beneficiary payment could improve care delivery, care coordination, and access to primary care services. Beneficiaries would not pay cost sharing just as they do not pay cost sharing to fund the PCIP; therefore, beneficiaries would not incur additional costs relative to current law.
- For providers, a per beneficiary payment for primary care would continue the additional support for eligible primary care practitioners. (Under current law, the additional support expires at the end of 2015.) A per beneficiary payment for primary care would also redistribute payments from procedurally oriented specialists to eligible primary care practitioners. ■

Endnotes

- 1 For further information, see the Commission's *Payment Basics: Physician and Other Health Professional Payment System* at <http://medpac.gov/documents/payment-basics/physician-and-other-health-professionals-payment-system-14.pdf?sfvrsn=0>.
- 2 The SGR target was set at GDP because Medicare Part B (which pays for physician and other health professional services) is funded in part by general tax revenues, which over the long term have grown with GDP.
- 3 The survey is conducted through random digit dialing, supplemented with a custom oversample of certain groups of beneficiaries.
- 4 In 2014, we conducted 18 focus groups in Nashville, TN; Albuquerque, NM; and Harrisburg, PA.
- 5 Full practice authority occurs when APRNs' ability to diagnose, evaluate, order and interpret tests, manage treatments, and prescribe medication is entirely under the state board of nursing.
- 6 Providers may be able to charge a retainer for their Medicare beneficiaries and comply with the law as long as the fee is not for Medicare-covered services. The Office of Inspector General has issued guidance about this topic given the trends in retainer-based practices.
- 7 CMS changed the policy on billing for consultations with the rationale that the relaxation of consultation documentation requirements over time had brought the effort involved in consultations to levels comparable with those of routine E&M visits.
- 8 When a service is billed as furnished in a facility, Medicare makes a separate facility payment to account for the cost of the service in that setting. Beneficiaries also pay cost sharing on this part of the bill.
- 9 The sleep study in this example has a billing code of 95811.
- 10 The effect of the age and gender changes in the overall beneficiary population on spending for physician and other health professional services has generally been small in the recent past, and physician spending is not as variable as total spending by age.
- 11 Details of the PPA and PPV analyses are presented in online Appendix 3-A to the Commission's June 2014 report, available at [http://www.medpac.gov/documents/reports/chapter-3-online-only-appendixes-measuring-quality-of-care-in-medicare-\(june-2014-report\).pdf?sfvrsn=2](http://www.medpac.gov/documents/reports/chapter-3-online-only-appendixes-measuring-quality-of-care-in-medicare-(june-2014-report).pdf?sfvrsn=2).
- 12 In simple terms, simulated compensation was calculated in two steps. Step 1 was annual total RVUs for the services furnished by a physician multiplied by the Medicare conversion factor. Step 2 was the result of Step 1 multiplied by a ratio that was the physician's actual compensation divided by revenues from the physician's professional services and collections from other sources attributable to the physician, such as laboratory services and injectable drugs. Further details are in the contractor's report.
- 13 The 15 percent difference between simulated compensation and actual compensation does not mean that Medicare's payments for physician services are 15 percent lower than private payers' payments for those services. The compensation estimates include compensation attributable to physician services and to services other than physician services, such as laboratory services and injectable drugs. In addition, the comparison is simulated Medicare compensation relative to actual compensation that is attributable to private payers' payments but also some Medicare payments.
- 14 The nonsurgical, procedural specialties in the analysis are cardiology, dermatology, gastroenterology, and pulmonary medicine.
- 15 The primary care specialties in the analysis are family medicine, internal medicine, and general pediatrics.
- 16 To account for differences among specialties in hours worked per week, the contractor's earlier initial analysis for the Commission—with MGMA data for 2007—included comparisons of hourly compensation. The results were similar to those from the analysis of the 2012 data on annual compensation: Hourly compensation for nonsurgical, procedural specialties and radiology was more than double the hourly compensation rate for primary care. Analysis of hourly compensation was not possible with the 2012 data because the newer MGMA survey did not include questions about hours worked.
- 17 The MEI measures the weighted average annual price change for various inputs used by physicians and other health professionals to furnish services.
- 18 These reductions would include reductions in payment for the services other than PCIP-defined primary care services provided by PCPs who otherwise receive the per beneficiary payment.

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C H A P T E R

5

Ambulatory surgical center services

R E C O M M E N D A T I O N

- 5** The Congress should eliminate the update to the payment rates for ambulatory surgical centers for calendar year 2016. The Congress should also require ambulatory surgical centers to submit cost data.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

Ambulatory surgical center services

Chapter summary

Ambulatory surgical centers (ASCs) provide outpatient surgical procedures to patients who do not require an overnight stay after the procedure. In 2013, 5,364 ASCs treated 3.4 million fee-for-service (FFS) Medicare beneficiaries, and Medicare program and beneficiary spending on ASC services was \$3.7 billion.

Assessment of payment adequacy

Our analysis indicates that beneficiaries' access to ASC services is adequate: The available indicators of payment adequacy for ASC services, discussed below, are positive. However, our analysis also indicates slower growth in the number of ASCs and volume of services in 2013 than in previous years.

Beneficiaries' access to care—Our analysis of facility supply and volume of services indicates that beneficiaries' access to ASC services has generally been adequate.

- **Capacity and supply of providers**—From 2008 through 2012, the number of Medicare-certified ASCs grew by an average annual rate of 1.7 percent; in 2013, the number increased by 1.1 percent (the vast majority of new ASCs were for profit). The relatively slow growth may be related to the higher Medicare payment rates for most ambulatory procedures in hospital outpatient departments (HOPDs) than in ASCs; for 2015, the Medicare rates are 82 percent higher in HOPDs than in

In this chapter

- Are Medicare payments adequate in 2015?
.....
- How should Medicare payments change in 2016?
.....

ASCs. This payment difference may help explain why several hospitals have recently expanded their outpatient surgery capacity. In addition, physicians have increasingly been selling their practices to hospitals, and these physicians are more likely to perform procedures at the hospitals that employ them than at freestanding ASCs.

- ***Volume of services***—From 2008 through 2012, the volume of services per FFS beneficiary grew by an average annual rate of 2.1 percent; in 2013, volume increased by 0.5 percent.

Quality of care—ASCs began submitting data on quality measures to CMS in October 2012, and CMS’s contractor released preliminary data for 2013. However, there is not yet sufficient information to assess ASC quality or the change in quality over time.

Providers’ access to capital—Because the number of ASCs has continued to increase, access to capital appears to be adequate.

Medicare payments and providers’ costs—From 2008 through 2012, Medicare payments per FFS beneficiary increased by an average of 3.4 percent per year and by 2.0 percent in 2013. 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.

On the basis of these indicators, the Commission concludes that ASCs can continue to provide Medicare beneficiaries with access to ASC services with no update to the payment rates for 2016. In addition, it is vital that CMS begin collecting cost data from ASCs without further delay. ■

Background

An ambulatory surgical center (ASC) is a distinct entity that primarily provides outpatient procedures to patients who do not require an overnight stay after the procedure. In addition to ASCs, hospital outpatient departments (HOPDs) and, in some cases, physicians' offices perform outpatient surgical procedures.

Since 1982, Medicare has covered and paid for surgical procedures provided in ASCs. Medicare covers about 3,400 procedures under the ASC payment system. Physicians who perform procedures in ASCs or other facilities receive a separate payment for their professional services under the payment system for physicians and other health professionals, also known as the physician fee schedule (PFS). According to surveys, most ASCs have partial or complete physician ownership (Ambulatory Surgery Center Association 2008, Medical Group Management Association 2009b).¹ Physicians who perform surgeries in ASCs they own receive a share of the ASC's facility payment in addition to payment for their professional services. To receive payments from Medicare, ASCs must meet Medicare's conditions of coverage, which specify standards for administration of anesthesia, quality evaluation, operating and recovery rooms, medical staff, and nursing services.

Medicare pays for a bundle of facility services provided by ASCs—such as nursing, recovery care, anesthetics, and supplies—through a system that is primarily linked to the outpatient prospective payment system (OPPS), which Medicare uses to set payment rates for most services provided in HOPDs (a more detailed description of the ASC payment system can be found online at <http://medpac.gov/documents/payment-basics/ambulatory-surgical-center-services-payment-system-14.pdf?sfvrsn=0>). The ASC payment system is also partially linked to the PFS. The ASC system underwent substantial revisions in 2008 (see online Appendix A from Chapter 2C of our March 2010 report to the Congress at http://medpac.gov/documents/reports/Mar10_Ch02C_Appendix.pdf?sfvrsn=9). The most significant changes included a substantial increase in the number of surgical procedures covered, allowing ASCs to bill separately for certain ancillary services, and large changes in payment rates for many procedures.

For most covered procedures, the ASC relative weight, which indicates the relative resource intensity of the

procedure, is based on its relative weight under the OPPS, consistent with a previous Commission recommendation (Medicare Payment Advisory Commission 2004). Although the ASC payment system is linked to the OPPS, payment rates for all services covered under both systems are lower in ASCs for two reasons. First, the relative weights have been lower in the ASC system. CMS makes proportional adjustments to the relative weights from the OPPS to maintain budget neutrality in the ASC system. In 2015, this adjustment reduces the ASC relative weights by 7.8 percent below the relative weights in the OPPS (i.e., the ASC relative weights for these services are 7.8 percent lower than the corresponding OPPS relative weights). Second, for most procedures covered under the ASC system, the payment rate is the product of its relative weight and a conversion factor, set at \$44.07 in 2015, which is lower than the OPPS conversion factor (\$74.14 in 2015).

The ASC conversion factor is lower for two reasons. First, CMS set the initial ASC conversion factor for 2008 so that total ASC payments under the revised payment system would equal what they would have been under the previous payment system.² By comparison, the initial OPPS conversion factor was based on total payments for hospital outpatient services in 2000. Second, CMS updates the ASC conversion factor based on the consumer price index for all urban consumers (CPI-U), whereas it uses the hospital market basket as the basis for updating the OPPS conversion factor. We are concerned that the CPI-U may not reflect ASCs' cost structure (see text box discussing the ASC market basket, pp. 128–129). However, CMS does not collect ASC cost data that could be used to examine whether an alternative input price index would be an appropriate proxy for ASC costs. The ASC industry has opposed the collection of cost information for this purpose (Ambulatory Surgery Center Association 2012). Nevertheless, the Commission has recommended that CMS collect cost data from ASCs to identify an alternative price index (Medicare Payment Advisory Commission 2010b).

CMS uses a method different from the method described above to determine payment rates for procedures that are predominantly performed in physicians' offices and were first covered under the ASC payment system in 2008 or later (under the method described above—the standard ASC method—ASC rates are based on OPPS relative weights). Payment for these “office-based” procedures is the lesser of the amount derived from the standard ASC method or the practice expense portion of the PFS rate that applies when the service is provided in a physician's

office (this amount covers the equipment, supplies, nonphysician staff, and overhead costs of a service). CMS set this limit on the rate for certain office-based procedures to prevent migration of these services from physicians' offices to ASCs for financial reasons.³ The Commission has been investigating payment rate differences across multiple ambulatory settings, including ASCs, HOPDs, and physicians' offices (Medicare Payment Advisory Commission 2014, Medicare Payment Advisory Commission 2013a, Medicare Payment Advisory Commission 2012).

The ASC payment system generally parallels the OPPS in terms of which ancillary services are paid separately and which are packaged into the payment of the associated surgical procedure. In 2015, however, CMS has implemented comprehensive ambulatory payment classifications (C-APCs) for the OPPS but not for the ASC system. C-APCs will largely combine into a single payment all hospital services reported on a claim that are covered under Medicare Part B, with a few exceptions. CMS chose not to implement C-APCs in the ASC system because the ASC claims processing system does not allow for the type of packaging of ancillaries necessary for creating C-APCs.

Starting in 2008, Medicare began making separate payments to ASCs for the following ancillary services:

- radiology services that are integral to a covered surgical procedure if separate payment is made for the radiology service in the OPPS;
- brachytherapy sources implanted during a surgical procedure;
- all pass-through and non-pass-through drugs that are paid for separately under the OPPS when provided as part of a covered surgical procedure; and
- devices with pass-through status under the OPPS.⁴

The Medicare program and beneficiaries pay less for services provided in ASCs than in HOPDs, and evidence suggests that ASCs' internal costs are, on average, lower than HOPDs'. However, we do not have recent ASC cost data that would allow us to quantify cost differences between settings. The Government Accountability Office (GAO) compared ASC cost data from 2004 with HOPD costs and found that provider costs were, on average, lower in ASCs than in HOPDs (Government Accountability Office 2006).⁵ In addition, a study that used data from the

National Survey of Ambulatory Surgery found that the average time for ambulatory surgical visits for Medicare patients was 39 percent lower in ASCs than HOPDs (83 minutes vs. 135 minutes), which could contribute to lower costs in ASCs (Hair et al. 2012).⁶ Average times were also lower in ASCs than HOPDs for specific procedures, such as those involving the digestive system and nervous system. The authors of the study were unable to estimate the extent to which shorter average times in the ASC were due to a healthier mix of patients in ASCs or greater efficiency relative to HOPDs (Hair et al. 2012).

Are Medicare payments adequate in 2015?

To address whether payments for the current year (2015) are adequate to cover the costs of efficient providers and how much payments should change in the coming year (2016), we examine several measures of payment adequacy. We assess beneficiaries' access to care by examining the supply of ASC facilities and changes over time in the volume of services provided, providers' access to capital, and changes in ASC revenue from the Medicare program. ASCs began submitting quality data to CMS in October 2012, and CMS's contractor released preliminary data for 2013. However, there is not yet sufficient information to assess ASC quality or the change in quality over time. Moreover, we cannot examine Medicare payments relative to providers' costs because CMS does not require ASCs to submit cost data.⁷ Finally, we caution that the effect of Medicare payments on the financial health of ASCs is limited because Medicare accounts for a minority of ASC revenue. According to the Medical Group Management Association's most recent national survey of ASCs, Medicare's share of overall ASC revenue was about 17 percent in 2008 (Medical Group Management Association 2009b).⁸ This share may vary regionally; for example, Medicare accounted for 24 percent of revenue for ASCs in Pennsylvania in 2013 (Pennsylvania Health Care Cost Containment Council 2014).

Our available indicators of payment adequacy are positive. Beneficiaries have adequate access to care in ASCs, although some groups of beneficiaries—such as dual eligibles, African Americans, and beneficiaries under age 65—are less likely to receive care in ASCs than in HOPDs (see text box). In addition, ASCs have adequate access to capital, and Medicare payments to ASCs have continued to grow.

Differences in types of patients treated in ambulatory surgical centers and hospital outpatient departments

There is evidence that patients treated in ambulatory surgical centers (ASCs) are different in several ways from those treated in hospital outpatient departments (HOPDs). Our analysis of Medicare claims from 2013 found that the following groups are less likely to receive care in ASCs than in HOPDs: Medicare beneficiaries who also have Medicaid coverage (dual eligibles), African Americans (who are more likely to be dually eligible), beneficiaries who are eligible for Medicare because of disability (under age 65), and beneficiaries who are age 85 or older (Table 5-1).⁹ The smaller share of disabled and older beneficiaries treated in ASCs may reflect the healthier average profile of ASC patients relative to HOPD patients. In addition, the smaller share of African American patients in ASCs relative to HOPDs may be linked to differences in the geographic locations of ASCs and hospitals, the lower rate of supplemental coverage among African Americans, the higher proportion of African Americans who are dual eligibles, and the relatively high percentage of African Americans who use HOPDs or emergency departments (EDs) as their usual source of care (Centers for Medicare & Medicaid Services 2014a).

(continued next page)

TABLE 5-1

Medicare patients treated in ASCs differ from patients treated in HOPDs, 2013

Characteristic	Percent of beneficiaries	
	ASC	HOPD
Medicaid status		
Not Medicaid	86.2%	77.0%
Medicaid	13.8	23.0
Race/ethnicity		
White	87.4	83.6
African American	6.9	10.3
Other	5.7	6.0
Age		
Under 65	14.7	22.2
65 to 84	78.7	67.2
85 or older	6.6	10.6
Sex		
Male	42.5	44.4
Female	57.5	55.6

Note: ASC (ambulatory surgical center), HOPD (hospital outpatient department). All of the differences between ASC and HOPD beneficiaries are statistically significant ($p < 0.05$). The analysis excludes beneficiaries who received services that are not covered in the ASC payment system.

Source: MedPAC analysis of physician/supplier and outpatient standard analytic files, 2013.

Beneficiaries' access to care: Supply of ASCs and volume growth indicate adequate access

Increases in the number of Medicare-certified facilities and volume of services provided to Medicare beneficiaries suggest that beneficiaries have adequate access to care in ASCs. This growth may be beneficial to patients and physicians because ASCs can offer them greater convenience and efficiency compared with HOPDs, the provider type most similar to ASCs. For patients, ASCs can offer more convenient locations, shorter waiting times, and easier scheduling relative to HOPDs; for physicians,

ASCs offer more control over their work environment and specialized staff. In addition, Medicare's payment rates and beneficiaries' cost sharing are generally lower in ASCs than in HOPDs. However, the growth of ASCs may lead to an increase in the overall volume of surgical procedures (see discussion on pp. 124–125).

Capacity and supply of providers: Number of ASCs has increased, but growth has slowed

Between 2008 and 2012, the number of Medicare-certified ASCs increased by an average annual rate of 1.7 percent,

Differences in types of patients treated in ambulatory surgical centers and hospital outpatient departments (cont.)

In a separate analysis, we found that patients treated in HOPDs in 2010 were, on average, more medically complex than patients treated in ASCs, as measured by differences in average patient risk scores (Medicare Payment Advisory Commission 2013b). We used risk scores from the CMS–hierarchical condition categories (CMS–HCC) risk adjustment model used in Medicare Advantage to measure patient severity.¹⁰ CMS–HCC risk scores predict beneficiaries’ relative costliness based on their diagnoses from the prior year and their demographic information (e.g., age and sex). Beneficiaries of average health status have a risk score of about 1.0. The average risk score for HOPD patients across all procedures in 2010 was 1.64 compared with 1.23 for ASC patients; this difference is statistically significant ($p < 0.05$). Beneficiaries who have higher risk scores are likely to be sicker and may require more time and resources to treat. Sicker patients may be referred to HOPDs instead of ASCs because hospitals offer emergency services and access to onsite specialists if complications arise.

We also compared average patient risk scores within each ambulatory payment classification (APC) group, which is a group of similar services. For 46 percent of the APCs in our analysis (representing 30 percent of ASC volume), the average HOPD risk score was significantly higher than the average ASC risk score ($p < 0.05$). However, for the remaining 54 percent of APCs (representing 70 percent of ASC volume), the severity of patients in HOPDs was similar to or less than the severity of patients in ASCs.

There is evidence that ASCs treat fewer Medicaid patients than do HOPDs. According to data from Pennsylvania on Medicare and non-Medicare patients, ASCs are less likely than HOPDs to serve Medicaid patients (Pennsylvania Health Care Cost Containment Council 2014). In Pennsylvania in 2013, Medicaid patients accounted for 5.2 percent of ASCs’ diagnostic and surgical procedures compared with 11.8 percent of HOPDs’ procedures.¹¹ Commercially insured and Medicare patients represented a higher share of ASC procedures than HOPD procedures (87.0 percent vs.

78.2 percent). Although Pennsylvania data may not be nationally representative, national estimates from the National Survey of Ambulatory Surgery (NSAS), conducted by the Centers for Disease Control and Prevention, show that ASCs treated a smaller share of Medicaid patients than hospitals did in 2006. According to the NSAS data, ambulatory surgery visits by Medicaid patients accounted for 3.9 percent of total visits to freestanding ASCs compared with 8.1 percent of total visits to hospital-based surgery centers.¹²

Several factors could explain why ASCs treat a smaller share of Medicaid patients (including dual eligibles) than HOPDs do. A study by Gabel and colleagues suggests that insurance coverage influences a physician’s decision to refer a patient to an ASC or to a hospital (Gabel et al. 2008). This study found that physicians in Pennsylvania were much more likely to refer their commercially insured and Medicare patients than their Medicaid patients to a physician-owned ASC. The location of ASCs may also lead to a smaller share of Medicaid patients; for example, ASC owners may choose to locate in areas with a high proportion of commercially insured patients. In addition, many state Medicaid programs do not pay Medicare’s cost sharing for dual eligibles if the Medicare rate for a service minus the cost sharing is higher than the Medicaid rate for the service (Medicare Payment Advisory Commission 2010a). In states that do not pay the cost sharing for ASC services used by dual eligibles, ASCs could be discouraged from treating these patients. Finally, dual-eligible beneficiaries are more likely to report that their usual source of care is an HOPD or ED than are Medicare beneficiaries who have other types of supplemental coverage (Centers for Medicare & Medicaid Services 2014a). If a patient’s usual source of care is an HOPD or ED, physicians may be more likely to refer the patient to an HOPD for surgery than to another setting. The relatively low rate of ASC use among dual-eligible beneficiaries may partly explain the relatively low rate of ASC use among African Americans (Table 5-1, p. 119). ■

**TABLE
5-2****Number of Medicare-certified ASCs grew by 8 percent, 2008–2013**

	2008	2009	2010	2011	2012	2013
Number of centers	4,955	5,064	5,152	5,228	5,307	5,364
New centers	280	220	193	190	165	108
Closed or merged centers	81	111	105	114	86	51
Net percent growth in number of centers from previous year	4.2%	2.2%	1.7%	1.5%	1.5%	1.1%

Note: ASC (ambulatory surgical center).

Source: MedPAC analysis of Provider of Services file from CMS, 2013.

but the growth rate slowed to 1.1 percent in 2013 (Table 5-2). In 2013, 108 ASCs entered the market while 51 closed or merged with other facilities; 91 percent of the new ASCs were for profit, 5 percent were nonprofit, and 5 percent were government owned.¹³ The slower growth appears to have continued into 2014: The number of ASCs increased by 0.9 percent to 5,414 during the first three quarters of 2014 (an annual growth rate of 1.2 percent).

Several factors might explain the relatively slow growth of ASCs from 2009 through the first three quarters of 2014:

- National health care spending and total Medicare spending have grown very slowly since 2010 (see Chapter 1).
- The ASC payment system underwent a substantial revision in 2008, and investors may have responded cautiously to the large changes in payment rates that occurred under that revision.
- Many hospitals have been expanding their outpatient surgery capacity by acquiring ASCs and integrating them into the hospital or developing new surgery centers that are part of the hospital, which limits the market for new freestanding ASCs (Hirst 2010, Jacobson 2014, Kochman 2014, Livingston 2014, Moody 2014, North Carolina Department of Health and Human Services 2011, Sowa 2014, State of Connecticut 2011). Hospitals' decisions to increase their outpatient surgery capacity may be influenced by the higher rates Medicare pays for ambulatory surgical services provided in HOPDs relative to those in ASCs (in 2015, the Medicare rates are 82 percent higher in HOPDs than in ASCs).

- Physicians are increasingly choosing to be employed by hospitals rather than work in an independent practice (Berenson et al. 2012, Mathews 2012, Medicare Payment Advisory Commission 2013a). These physicians are more likely to provide ambulatory procedures in the hospitals that employ them than in freestanding ASCs.

To provide a more complete picture of capacity in ASCs, we also examined the change in the number of ASC operating rooms. From 2008 through 2013, the total number of ASC operating rooms increased at almost the same rate as the number of ASCs (1.4 percent per year vs. 1.6 percent per year). The mean number of operating rooms per ASC (2.9) and the median number of operating rooms per ASC (2.0) did not change during this period.

ASCs are concentrated geographically. In 2013, Maryland had the most ASCs per Part B fee-for-service (FFS) beneficiary, followed by Georgia and Idaho; each state had at least 30 ASCs per 100,000 Part B FFS beneficiaries. Vermont had the fewest ASCs per FFS beneficiary, followed by West Virginia and the District of Columbia, each of which had fewer than 5 per 100,000 FFS beneficiaries.¹⁴ In addition, in 2013, most Medicare-certified ASCs were for profit and located in urban areas, a pattern that has not changed over time (Table 5-3, p. 122). Urban areas include both cities and suburban areas; it is possible that more ASCs are located in suburban areas than in cities.

Beneficiaries who do not live near an ASC can obtain ambulatory surgical services in HOPDs and, in some cases, physicians' offices. In addition, beneficiaries who live in rural areas may travel to urban areas to receive care in ASCs.

**TABLE
5-3****Most Medicare-certified ASCs
are urban and for profit**

ASC type	2008	2013
Urban	91%	91%
Rural	9	9
For profit	96	96
Nonprofit	4	3

Note: ASC (ambulatory surgical center). In 2013, 1 percent of ASCs were government owned.

Source: MedPAC analysis of Provider of Services file from CMS, 2013.

Continued growth in the number of Medicare-certified ASCs suggests that Medicare's payment rates have been adequate. Other factors have also likely influenced the long-term growth in the number of Medicare-certified ASCs:

- Changes in clinical practice and health care technology have expanded the provision of surgical procedures in ambulatory settings.
- ASCs may offer patients greater convenience than HOPDs (e.g., the ability to schedule surgery more quickly).
- For most procedures covered under the ASC payment system, beneficiaries' coinsurance is lower in ASCs than in HOPDs.¹⁵
- Physicians have greater autonomy in ASCs than in HOPDs, which enables them to design customized surgical environments and hire specialized staff.

- Physicians who invest in ASCs and perform surgery there can increase their revenue by receiving a share of ASC facility payments. The federal anti-self-referral law (also known as the Stark Law) does not apply to services that are part of the ASC bundled payment rate (42 CFR § 411.351).¹⁶
- Because physicians can probably perform more procedures in ASCs than in HOPDs in the same amount of time, they can earn more professional fees.

**Number of beneficiaries treated and volume of
services grew from 2008 to 2013**

We examined growth in the number of FFS beneficiaries treated in ASCs and the volume of ASC surgical services per FFS beneficiary. Because ASC services are covered under Part B, we limited our analysis to FFS beneficiaries who have Part B coverage. From 2008 through 2012, the number of FFS beneficiaries who received ASC services grew by an average of 1.2 percent per year and by 0.7 percent in 2013 (data not shown). From 2008 through 2012, the volume of services per FFS beneficiary increased by an average of 2.1 percent per year and by 0.5 percent in 2013 (Table 5-4).

The services that have historically contributed the most to overall volume continued to constitute a large share of the total in 2013. For example, we evaluated Healthcare Common Procedure Coding System (HCPCS) codes and found that cataract removal with intraocular lens insertion (HCPCS 66984) had the highest volume in both 2008 and 2013, accounting for 18 percent of volume in 2008 and 17 percent in 2013. Also, upper gastrointestinal procedure with biopsy (HCPCS 43239) had the second highest volume in both 2008 and 2013. Moreover, 19 of the 20

**TABLE
5-4****Volume of ASC services per FFS beneficiary has continued to grow**

	2008	2009	2010	2011	2012	2013
Volume of services (in millions)	6.1	6.3	6.5	6.7	6.9	6.9
Volume per 1,000 FFS beneficiaries	192.4	199.3	202.6	206.1	209.2	210.3
Percent change per FFS beneficiary from previous year	5.0%*	3.6%	1.7%	1.7%	1.5%	0.5%

Note: ASC (ambulatory surgical center), FFS (fee-for-service).

*Comparison of volume from 2007 to 2008 is restricted to services covered in 2007 because of the substantial change in the services covered in the ASC payment system in 2008.

Source: MedPAC analysis of physician/supplier standard analytic files, 2007–2013.

**TABLE
5-5****Most frequently provided ASC services in 2013 were similar to those provided in 2008**

Surgical service	2008		2013	
	Percent of volume	Rank	Percent of volume	Rank
Cataract surgery w/ IOL insert, 1 stage	18.2%	1	17.0%	1
Upper GI endoscopy, biopsy	7.9	2	7.8	2
Colonoscopy and biopsy	5.5	3	6.0	3
Diagnostic colonoscopy	5.1	4	2.6	9
After cataract laser surgery	4.6	5	4.0	5
Lesion removal colonoscopy	4.6	6	4.6	4
Injection spine: lumbar, sacral (caudal)	3.7	7	3.2	8
Inject foramen epidural: lumbar, sacral	3.3	8	3.9	6
Injection paravertebral: lumbar, sacral add on*	2.8	9	3.4	7
Injection paravertebral: lumbar, sacral*	1.9	10	2.4	10
Injection foramen epidural add on	1.8	11	2.0	11
Colorectal screen, high-risk individual	1.5	12	1.9	12
Lesion remove colonoscopy	1.5	13	0.8	22
Colorectal screen, not high-risk individual	1.5	14	1.7	13
Upper GI endoscopy, diagnosis	1.4	15	1.1	18
Destruction paravertebral nerve, add on**	1.3	16	1.4	15
Cystoscopy	1.2	17	1.1	17
Cataract surgery, complex	1.1	18	1.4	14
Revision of upper eyelid	1.0	19	0.9	20
Injection spine, cervical or thoracic, add on	0.9	20	1.1	16
Total	70.6		68.3	

Note: ASC (ambulatory surgical center), IOL (intraocular lens), GI (gastrointestinal). The numbers listed in the percent of volume column for 2008 do not sum to the total of 70.6 because of rounding.

*The description of these services changed in 2010 to include imaging guidance.

**The description of this service changed in 2012 to include imaging guidance.

Source: MedPAC analysis of physician/supplier standard analytic files, 2008 and 2013.

most frequently provided HCPCS codes in 2008 were among the 20 most frequently provided in 2013 (Table 5-5). These services comprised about 71 percent of ASC Medicare volume in 2008 and about 68 percent in 2013, and volume per FFS beneficiary increased by an average of 1.1 percent per year from 2008 through 2013.

Services that were outside the 20 most frequently provided HCPCS codes comprised 29 percent of total ASC volume in 2008 and 32 percent in 2013. We organized the HCPCS codes for these services into service categories that are broader than the HCPCS codes listed in Table 5-5 and found that eye procedures, nerve injections (for pain management), arthroscopy, and skin

repair had the highest volume. These four categories comprised 13 percent of total ASC volume in 2008 and 15 percent in 2013.

Outpatient surgical procedures have been growing faster in HOPDs than ASCs

In previous reports, we indicated that growth in outpatient surgical volume was higher in ASCs than in HOPDs, which suggests that surgical services were migrating from HOPDs to ASCs (Medicare Payment Advisory Commission 2012, Medicare Payment Advisory Commission 2011b, Medicare Payment Advisory Commission 2010b, Medicare Payment Advisory Commission 2009). However, in recent years, the growth

in ASC volume appears to have slowed and the growth in HOPD volume appears to have picked up. For example, from 2012 to 2013, volume per FFS beneficiary increased by 0.5 percent in ASCs compared with 3.1 percent in HOPDs.

Some may think that the higher growth rate in HOPDs suggests that services have shifted from ASCs to HOPDs. However, the data do not support that viewpoint. We examined whether a shift in setting occurred among the 31 most frequently provided ASC services, which account for about 75 percent of ASC surgical volume. If a shift had occurred from ASCs to HOPDs, the share of the combined ASC and HOPD volume for these 31 services provided in HOPDs should have increased, but it did not. The share of these services provided in HOPDs stayed fairly constant: 44.9 percent in 2011, 43.3 percent in 2012, and 43.3 percent in 2013.¹⁷ Much of the increase in HOPD surgical volume from 2012 to 2013 occurred among services that are rarely provided in ASCs.

Other evidence also shows that there has not been a shift of surgical services from ASCs to HOPDs. The growth in surgical volume in HOPDs was inconsistent from 2008 through 2013. For example, surgical volume in HOPDs declined by 0.7 percent in 2012 and then increased by 3.1 percent in 2013. In contrast, the growth in ASC volume has been much more consistent over this period (Table 5-4, p. 122). If there had been a shift from ASCs to HOPDs, the rate of growth in ASC volume should have been as inconsistent as that in HOPDs.

The higher growth in HOPDs could be due to factors other than a shift from ASCs to HOPDs, such as a shift of surgical services from freestanding physician offices to HOPDs. A migration of services from freestanding offices to HOPDs would be consistent with evidence of hospitals purchasing physicians' practices and converting them to HOPDs. In prior reports, we have provided evidence of a shift of some nonsurgical services—office visits, echocardiograms, and nuclear cardiology—from freestanding offices to HOPDs, and it is plausible that surgical services also have shifted from freestanding offices to HOPDs (Medicare Payment Advisory Commission 2014, Medicare Payment Advisory Commission 2013a, Medicare Payment Advisory Commission 2012). For example, some of the surgical services that had the largest volume increases in HOPDs in 2013 were wound debridement procedures and a strapping procedure for the lower leg, which are frequently performed in freestanding offices. The growth

of these services in freestanding offices was either negative or much slower than the growth in HOPDs.

Other data also suggest that surgical procedures are no longer migrating from HOPDs to ASCs. In Pennsylvania, ASCs' share of outpatient diagnostic and surgical procedures performed on all patients increased dramatically between 2000 and 2009, from 10.2 percent to 31.3 percent, but remained about the same from 2009 to 2011 and decreased to about 30.5 percent in 2012 and 2013 (Pennsylvania Health Care Cost Containment Council 2014).

We believe it is desirable to maintain beneficiaries' access to ASCs because Medicare and beneficiaries pay less for services provided in ASCs than in HOPDs. Our comparison of the number of cataract surgeries with intraocular lens insertion provided in ASCs with those in HOPDs illustrates this point. We found that, from 2008 through 2013, the proportion of these procedures provided in ASCs increased from 68 percent to 72 percent. Meanwhile, the payment rate for these procedures in 2013 was \$971 in ASCs compared with \$1,730 in HOPDs. Medicare's portion of this payment was \$777 in ASCs and \$1,240 in HOPDs, while the beneficiary's coinsurance was \$194 in ASCs and \$490 in HOPDs.

However, most ASCs have some degree of physician ownership, and this ownership could give physicians an incentive to perform more surgical services than if they provided outpatient surgery only in HOPDs. This additional volume could partly offset the effect of lower rates in ASCs on Medicare spending. Some studies offer limited evidence that physicians with an ownership stake in an ASC perform a higher volume of certain procedures than non-owning physicians (Hollingsworth et al. 2010, Mitchell 2010, Strobe et al. 2009).

Other studies suggest that the presence of an ASC in a market is associated with a higher volume of outpatient surgical procedures (Hollenbeck et al. 2014, Hollingsworth et al. 2011, Koenig and Gu 2013). The most recent study may be the most convincing because it is based on a nationwide sample of Medicare beneficiaries and includes all surgical procedures (Hollenbeck et al. 2014). This study found that introducing ASCs into service areas that previously did not have any resulted in a larger rate of increase in ambulatory surgical procedures than in areas that already had at least one ASC or did not have any ASCs. However,

this study found a smaller effect of ASCs on outpatient surgical volume than did the earlier studies. Although none of these studies assessed whether the additional procedures were inappropriate, they suggest that the presence of ASCs may increase overall surgical volume.

Quality of care: Insufficient data to examine quality of ASCs

Under CMS's Quality Reporting Program for ASCs, ASCs began submitting data in October 2012 on five measures (see text box, pp. 126–127). In early 2014, CMS's contractor (FMQAI) released preliminary national rates for these five measures based on data collected during 2013 (FMQAI 2014). CMS has not yet released final data for 2013 but plans to do so during 2015 (Centers for Medicare & Medicaid Services 2014b). Therefore, we do not yet have sufficient information to assess the quality of ASCs, including changes in quality over time.

CMS's contractor released preliminary data for 2013 on four claims-based patient safety indicators:

- patient fall in the ASC;
- patient burn (such as a chemical, thermal, or electrosurgical burn);
- wrong site, wrong side, wrong patient, wrong procedure, wrong implant; and
- hospital transfer or admission after an ASC procedure when the patient is transferred directly to the hospital from the ASC.

According to the preliminary national data, these events occur very rarely; each type of incident occurred less than once per 1,000 visits to ASCs in 2013 (FMQAI 2014). However, there may be individual ASCs that perform poorly on these measures. CMS has not yet released data for individual facilities but plans to do so during 2015 (Centers for Medicare & Medicaid Services 2014b).

CMS's contractor also released preliminary data from 2013 for a claims-based process measure: timely administration of prophylactic intravenous (IV) antibiotics. This measure assesses the share of ASC patients with a preoperative order for an IV antibiotic to prevent surgical site infection who received the antibiotic on time (within one or two hours before the incision). At the national level, 96 percent of ASC visits met this standard in 2013 (FMQAI 2014).

The Commission has recommended that CMS develop a value-based purchasing program that would use ASC quality data to reward high-performing providers and penalize low-performing providers, but CMS does not have the statutory authority to implement such a program (see text box, pp. 126–127).

Providers' access to capital: Growth in number of ASCs suggests adequate access

Owners of ASCs require capital to establish new facilities and upgrade existing ones. The change in the number of ASCs is the best available indicator of ASCs' ability to obtain capital. The number of ASCs continued to increase in 2013 and the first three quarters of 2014, although at a slower rate than in previous years. However, Medicare accounts for less than 20 percent of ASCs' overall revenue, on average, so other factors may have a larger effect than Medicare payments on access to capital for this sector (Medical Group Management Association 2009a).

In addition, the company that owns and operates the largest number of ASCs in the country—AmSurg—appears to have adequate access to capital. In 2014, it was able to borrow \$1.7 billion from the debt markets to acquire Sheridan Healthcare, a physician outsourcing company (Moody's Investors Service 2014b).¹⁸ AmSurg also continues to have robust earnings growth, which provides it with funds to acquire new ASCs and improve its existing facilities. A market research firm projects that AmSurg's earnings per share of stock will increase by 19 percent in 2014 and 24 percent in 2015 (Deutsche Bank 2014). We caution, however, that AmSurg includes only 5 percent of all Medicare-certified ASCs, so its experience may not represent the entire ASC sector.¹⁹

Medicare payments: Payments have increased steadily

In 2013, ASCs received \$3.7 billion in Medicare payments and beneficiaries' cost sharing (Table 5-6, p. 126). From 2008 through 2012, spending per FFS beneficiary increased by an average of 3.4 percent per year and by 2.0 percent in 2013. The 2.0 percent increase in 2013 reflects a 0.7 percent increase in the ASC conversion factor, a 0.5 percent increase in volume per beneficiary, a 2.1 percent increase in the average relative weight, and a 1.2 percent reduction in spending because of the sequester. The 2.1 percent increase in the average relative weight is fairly large and primarily reflects the growth of cataract surgeries (represented by HCPCS codes 66984 and 66982), which have relative weights well above the average.

Creating a value-based purchasing program for ambulatory surgical centers

To improve the quality of care provided to beneficiaries in ambulatory surgical centers (ASCs), the Commission previously recommended that CMS implement a value-based purchasing (VBP) program to reward high-performing providers and penalize low-performing providers (Medicare Payment Advisory Commission 2012).²⁰ CMS should also publicly report quality measurement results to help researchers and consumers compare quality among facilities. CMS established a Quality Reporting Program for ASCs in 2012; ASCs that do not submit data have their annual update reduced by 2.0

percentage points starting in 2014. However, Medicare payments to ASCs are not adjusted based on how they perform on quality measures, only on whether they successfully reported the measures. CMS currently lacks the statutory authority to implement a VBP program for ASCs.

The Commission supports the ASC Quality Reporting Program but believes that, eventually, high-performing ASCs should be rewarded and low-performing facilities should be penalized through the payment system. In

(continued next page)

How should Medicare payments change in 2016?

Our payment adequacy analysis indicates that the number of Medicare-certified ASCs has increased, beneficiaries' use of ASCs has increased, and access to capital has been adequate. Our information for assessing payment adequacy is limited because, unlike other types of facilities, Medicare does not require ASCs to submit cost data. In addition, there is not yet sufficient information to assess the quality of ASC care or how it has changed over time.

Cost data would enable the Commission to examine the growth of ASCs' costs over time and analyze Medicare payments relative to the costs of efficient providers, which

would help inform decisions about the ASC update. Cost data are also needed to examine whether an alternative input price index would be an appropriate proxy for ASC costs. As discussed in the text box, pp. 128–129, the Commission previously expressed concern that the price index that CMS uses to update ASC payments (the CPI-U) may not reflect ASCs' cost structure (Medicare Payment Advisory Commission 2010b). CMS has also concluded that it needs data on ASC costs to determine whether there is a better alternative than the CPI-U to measure changes in ASCs' input costs (Centers for Medicare & Medicaid Services 2012). To date, however, CMS has not decided to collect cost data.

Although CMS and ASCs have expressed concern that requiring ASCs to submit cost data may impose a burden on

**TABLE
5-6**

Medicare payments to ASCs have grown, 2008–2013

	2008	2009	2010	2011	2012	2013
Medicare payments (in billions of dollars)	\$3.1	\$3.2	\$3.3	\$3.4	\$3.6	\$3.7
Medicare payments per FFS beneficiary	\$97	\$102	\$104	\$106	\$110	\$112
Percent change per FFS beneficiary from previous year	8.1%	5.3%	2.0%	2.0%	4.2%	2.0%

Note: ASC (ambulatory surgical center), FFS (fee-for-service). Medicare payments include program spending and beneficiary cost sharing for ASC facility services. Payments include spending for new technology intraocular lenses.

Source: MedPAC analysis of data from the Office of the Actuary at CMS.

Creating a value-based purchasing program for ambulatory surgical centers (cont.)

our March 2012 report, the Commission made the following recommendation:

The Congress should direct the Secretary to implement a value-based purchasing program for ambulatory surgical center services no later than 2016.

The ASC Quality Reporting Program could lay the foundation for a VBP program. Under the Quality Reporting Program, ASCs began submitting data in 2012 on four patient safety indicators and one process measure. In 2013 and 2014, ASCs began reporting data on two structural measures and a measure of influenza vaccination coverage among health care personnel. In 2015, they began reporting data on two chart-abstracted measures that relate to appropriate follow-up intervals for colonoscopy (Centers for Medicare & Medicaid Services 2013).²¹ CMS recently adopted a new measure of the rate of hospital visits within seven days after an outpatient colonoscopy; CMS will calculate this measure for 2018 using claims data from 2016 (Centers for Medicare & Medicaid Services 2014b). CMS plans to make data collected under the Quality Reporting Program publicly available beginning in 2015 (Centers for Medicare & Medicaid Services 2014b).

Consistent with the Commission's overall position on VBP (also known as pay-for-performance) programs in Medicare, an ASC VBP program should include a relatively small set of measures to minimize the administrative burden on ASCs and CMS. These measures should focus on clinical outcomes because Medicare's central concern should be improving patient outcomes across all ASCs. The program should also minimize the use of measures that require providers to extract data from patients' medical records. Several of the indicators that are reported through the ASC Quality Reporting Program could be used for an ASC VBP program.

An ASC VBP program should reward ASCs for improving their prior year performance and for exceeding quality benchmarks. In addition, funding for the VBP incentive payments should come from existing Medicare spending for ASC services. Initially, funding for the incentive payments should be set at 1 percent to 2 percent of aggregate ASC payments. The size of this

pool should be expanded gradually as more measures are developed and ASCs become more familiar with the program.

CMS should consider incorporating the following patient safety and outcome measures into an ASC VBP program:

- patient fall in the ASC;
- patient burn (such as a chemical, thermal, or electrosurgical burn);
- wrong site, wrong side, wrong patient, wrong procedure, wrong implant;
- hospital transfer or admission after an ASC procedure because of a problem related to the procedure, whether the patient is transferred directly to the hospital from the ASC or admitted to the hospital after returning home from the procedure;²² and
- the rate of surgical site infections (SSIs).

The first three measures listed above are patient safety indicators that ASCs currently report under the ASC Quality Reporting Program. Because these indicators represent errors that are usually preventable, they could be measured against an absolute national benchmark that starts very low and is reduced over time to a rate that approaches zero.

By contrast, the last two indicators listed above (hospital transfer or admission after an ASC procedure and SSI rate) may occasionally occur even in the highest quality facilities. Therefore, an ASC's performance on these indicators should be measured against the performance of other ASCs rather than an absolute national benchmark. Because certain ASCs may report small numbers of cases for the calculation of these measures, the rates reported for these providers could vary substantially from one observation period to the next, due solely to random statistical variation. To address this issue, CMS could consider using composite measures that would aggregate the rates for several measures of rare events into a single rate or using data from multiple years for a single measure. ■

Revisiting the ambulatory surgical center market basket

CMS uses the consumer price index for all urban consumers (CPI-U) as the market basket to update ambulatory surgical center (ASC) payment rates. Because of our concern that the CPI-U may not reflect ASCs' cost structure, in 2010 the Commission examined whether an alternative market basket index would better measure changes in ASCs' input costs (Medicare Payment Advisory Commission 2010b). Using data from a Government Accountability Office (GAO) survey of ASC costs in 2004, we compared the distribution of ASC costs with the distribution of hospital and physician practice costs. We found that ASCs' cost structure is different from that of hospitals and physician offices.

Although CMS has historically used the CPI-U as the basis for Medicare's annual updates to ASC payments, the mix of goods and services in this price index likely does not reflect ASC inputs. The CPI-U is based on a sample of prices for a broad mix of goods and services, including food, housing, apparel, transportation, medical care, recreation, personal care, education, and energy (IHS Global Insight 2009). The weight of each item is based on spending for that item by a sample of urban consumers during the survey period. Although

some of these items are probably used by ASCs, their share of spending on each item is likely very different from the CPI-U weight. For example, housing accounts for 43.4 percent of the entire CPI-U (Bureau of Labor Statistics 2009).

We explored whether one of two existing Medicare indexes would be an appropriate proxy for ASC input costs: the hospital market basket, which is used to update payments for inpatient and outpatient hospital services, or the practice expense component of the Medicare Economic Index (MEI), which measures changes in physicians' practice expenses. It is reasonable to expect that ASCs have many of the same types of costs as hospitals and physician offices, such as medical equipment, medical supplies, building-related expenses, clinical staff, administrative staff, and malpractice insurance.

We used ASC cost data from the GAO survey to compare the distribution of ASC costs with the distribution of hospital costs (derived from the hospital market basket) and physician practice expenses (derived from the practice expense portion of the MEI). Our March 2010 report has more details on the method (Medicare Payment Advisory Commission

(continued next page)

these facilities (Centers for Medicare & Medicaid Services 2011), we believe it is feasible for ASCs to provide a limited amount of cost information. Even though ASCs are generally small facilities that may have limited resources for collecting cost data, such businesses typically keep records of their costs for filing taxes and other purposes. To minimize the burden on CMS and ASCs, CMS should create a streamlined process for ASCs to track and submit a limited amount of cost data. One such mechanism could be annual surveys of a random sample of ASCs, with mandatory response. CMS conducted cost surveys of a sample of ASCs in 1986 and 1994, and the Government Accountability Office conducted a survey of ASC costs in 2004. Another approach would be to require all ASCs to submit streamlined cost reports on an annual basis.

To enable the Commission to determine the relationship between Medicare payments and the costs of efficient ASCs, ASCs would optimally submit the following information:

- total costs for the facility;
- Medicare unallowable costs (e.g., entertainment, promotion, and bad debt);
- the costs of clinical staff who bill Medicare separately, such as anesthesiologists and clinical nurse anesthetists (these costs would be excluded from the facility's costs because these clinicians are paid separately under Medicare);
- total charges across all payers and charges for Medicare patients (CMS could allocate total facility

Revisiting the ambulatory surgical center market basket (cont.)

2010b). Although the GAO data are not sufficient for comparing each category of costs across settings, they suggest that ASCs have a different cost structure from hospitals and physician offices. ASCs appear to have a much higher share of expenses related to medical supplies and drugs than the other two settings, a much smaller share of employee compensation costs than hospitals, and a smaller share of all other costs (such as rent and capital costs) than physician offices.

Since our 2010 analysis, CMS also considered whether the hospital market basket or the practice expense component of the MEI is a better proxy for ASC costs than the CPI-U (Centers for Medicare & Medicaid Services 2012). However, CMS believes that the hospital market basket does not align with the cost structure of ASCs because hospitals provide a much wider range of services than ASCs, such as room and board and emergency care. Therefore, the agency concluded that it needs data on the cost inputs of ASCs to determine whether there is a better alternative than the CPI-U to measure changes in ASCs' input costs.

CMS asked for public comment on the feasibility of collecting cost information from ASCs but did not propose a plan to collect cost data.

The ASC cost data from GAO used in our comparative analysis are 11 years old and do not contain information on several types of costs. Therefore, the Commission has recommended several times that the Congress require ASCs to submit new cost data to CMS (Medicare Payment Advisory Commission 2014, Medicare Payment Advisory Commission 2013b, Medicare Payment Advisory Commission 2012, Medicare Payment Advisory Commission 2011b, Medicare Payment Advisory Commission 2010b). CMS should use this information to examine whether an existing Medicare price index is an appropriate proxy for ASC costs or an ASC-specific market basket should be developed. A new ASC market basket could include the same types of costs that appear in the hospital market basket or MEI but with different cost weights that reflect the unique cost structure of ASCs. ■

costs to Medicare based on Medicare's proportion of total charges); and

- total Medicare payments.

In addition to the information described above, CMS would need to collect data on specific cost categories to determine an appropriate input price index for ASCs. For example, CMS would need data on the share of ASCs' costs related to employee compensation, medical supplies, medical equipment, building expenses, and other professional expenses (e.g., legal, accounting, and billing services). CMS should use this information to examine the cost structure of ASCs and determine whether an existing Medicare price index is an appropriate proxy for ASC costs or an ASC-specific market basket should be developed.

CMS increased the ASC conversion factor by 0.7 percent in 2013, 1.3 percent in 2014, and 1.4 percent in 2015. The update for 2015 was based on a projected 1.9 percent increase in the CPI-U minus a 0.5 percent reduction

for multifactor productivity growth, as mandated by the Patient Protection and Affordable Care Act of 2010 (PPACA).²³

Update recommendation

In recommending an update to ASC payment rates for 2016, the Commission balanced the following objectives:

- maintain beneficiaries' access to ASC services;
- pay providers adequately;
- hold down the burden on the beneficiaries, workers, and firms who finance Medicare;
- maintain the sustainability of the Medicare program by appropriately restraining spending on ASC services;
- keep providers under financial pressure to constrain costs; and
- require ASCs to submit cost data.

In balancing these goals, the Commission concludes that the ASC update for 2016 should be eliminated and that the Congress should require ASCs to submit cost data.

RECOMMENDATION 5

The Congress should eliminate the update to the payment rates for ambulatory surgical centers for calendar year 2016. The Congress should also require ambulatory surgical centers to submit cost data.

RATIONALE 5

On the basis of our payment adequacy indicators and the importance of maintaining financial pressure on providers to constrain costs, we believe that ASC payment rates should not be increased for 2016. That is, the 2016 base payment rate under the ASC payment system should be the same as the base rate in 2015. The indicators of payment adequacy for which we have information are positive: the number of Medicare-certified ASCs and the volume of services have increased, ASCs have adequate access to capital, and Medicare payments to ASCs have continued to grow. Although we do not have cost data or sufficient information to assess quality, the indicators we do have suggest that payments have been adequate.

As we have stated in prior reports, it is vital that CMS begin collecting cost data from ASCs without further delay. Cost data would enable the Commission to examine the growth of ASCs' costs over time and evaluate Medicare payments relative to the costs of efficient providers, which would help inform decisions about

the ASC payment update. Cost data are also needed to evaluate whether an alternative input price index would be an appropriate proxy for ASC costs.

IMPLICATIONS 5

Spending

- The Secretary has the discretionary authority to select an update mechanism for ASC payment rates and has decided to use the CPI-U as the basis for updating payments (Centers for Medicare & Medicaid Services 2007). PPACA requires that the update factor be reduced by a multifactor productivity measure. The currently projected CPI-U increase for 2016 is 1.4 percent, and the forecast of productivity growth for 2016 is 0.5 percent, resulting in a projected update of 0.9 percent to the base payment rates for 2016 (IHS Global Insight, forthcoming). However, we recommend that the update be eliminated. Therefore, relative to current Medicare law, our recommendation would decrease federal spending by less than \$50 million in the first year and by less than \$1 billion over five years.

Beneficiary and provider

- Because of the growth in the number of Medicare-certified ASCs and the volume of ASC services, we do not anticipate that this recommendation will diminish beneficiaries' access to ASC services or providers' willingness or ability to provide those services.
- ASCs would incur some administrative costs to track and submit cost data. ■

Endnotes

- 1 A survey conducted by the ASC Association found that 91 percent of ASCs had at least some physician owners in 2008 (Ambulatory Surgery Center Association 2008). A survey conducted by the Medical Group Management Association found that 74 percent of ASCs were either completely owned by physicians or were physician–hospital joint ventures in 2008 (Medical Group Management Association 2009b).
- 2 The adjustment to the relative weights to maintain budget neutrality could have been done instead through an adjustment to the ASC conversion factor. However, CMS decided to make separate adjustments to the relative weights and the conversion factor. These separate adjustments distinguish the effects of changes to the relative weights from changes to ASCs’ input costs.
- 3 Because CMS updates payment rates in the OPPS and the PFS independently of each other, it is possible for the ASC payment rate for an office-based procedure to be based on the OPPS rate in one year and the PFS rate the next year (or vice versa).
- 4 ASCs and HOPDs receive the same amount for drugs that are paid for separately under the OPPS and for devices that have pass-through status.
- 5 GAO surveyed a random sample of 600 ASCs to obtain cost data from 2004; they received reliable cost data from 290 facilities.
- 6 The average time for a surgical visit includes time spent by the patient in the operating room and postoperative recovery room. This study included only visits in which a single procedure was performed.
- 7 The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 eliminated a prior requirement that the Secretary collect cost data from ASCs every five years.
- 8 Medicare’s share of total ASC revenue varies by type of ASC, ranging from 7 percent for ASCs that specialize in orthopedic procedures to 43 percent for ASCs that specialize in ophthalmology cases (Medical Group Management Association 2009b).
- 9 Because some states have a disproportionately high number of ASCs per beneficiary (e.g., Maryland, Idaho, and Georgia), we weighted beneficiaries so that in each state the percentage of beneficiaries receiving care in ASCs matched the national percentage. This process prevented idiosyncrasies in states that have high concentrations of ASCs from biasing the results. The analysis excluded beneficiaries who received services that Medicare does not cover in ASCs.
- 10 The CMS–HCC model is an abbreviated version of the full HCC model. The full HCC model includes 189 disease categories, while the version of the CMS–HCC we used includes 70. We excluded beneficiaries who had missing risk scores and beneficiaries who were new Medicare enrollees in 2010 because those beneficiaries’ risk scores were not based on diagnosis data. Our analysis included only surgical procedures that were covered in the ASC payment system in 2010.
- 11 These data are based on 272 ASCs and 173 hospitals.
- 12 The sample of freestanding ASCs in the NSAS includes facilities listed in the 2005 Verispan Freestanding Outpatient Surgery Center Database and Medicare-certified ASCs from CMS’s Provider of Services file (Cullen et al. 2009).
- 13 The numbers do not sum to 100 percent due to rounding.
- 14 Whether a state has certificate-of-need (CON) laws for ASCs appears to affect the number of ASCs in the state. Twenty-six states and the District of Columbia (DC) have CON laws for ASCs. Each of the 12 states with the fewest ASCs per FFS beneficiary, as well as DC, has a CON law, while only 3 of the 10 states that have the most ASCs per FFS beneficiary have CON laws. Among these three states, Maryland and Georgia have exceptions in their CON requirements that make it easier to establish new ASCs.
- 15 By statute, coinsurance for a service paid under the OPPS cannot exceed the hospital inpatient deductible (\$1,260 in 2015). The ASC payment system does not have the same limitation on coinsurance, and for a few services the ASC coinsurance exceeds the inpatient deductible. In these instances, the ASC coinsurance exceeds the OPPS coinsurance.
- 16 In addition, the anti-self-referral law does not apply to separately paid ancillary services provided in ASCs, such as radiology services and implantable devices.
- 17 Although there was not much change from 2011 through 2013 in the percentage of these 31 services that were provided in HOPDs, there was some appreciable change in specific services. For 15 of these services, the percentage of the volume that was provided in HOPDs decreased by more than 1 percentage point, and for 6 of these services, the percentage that was provided in HOPDs increased by more than 1 percentage point. Pain management services had an especially large decline in the percentage that was provided in HOPDs.

- 18 With the acquisition of Sheridan, AmSurg was expected to double its annual revenue to over \$2 billion (Moody's Investors Service 2014a).
- 19 AmSurg owns 242 ASCs in partnership with physicians (Moody's Investors Service 2014a). About one-quarter of AmSurg's ASC revenue is from government programs, primarily FFS Medicare and Medicare Advantage (AmSurg Corp. 2014).
- 20 The Commission also described its principles for a VBP program for ASCs in a letter to the Congress commenting on the Secretary's report to the Congress on a VBP program for ASCs (Medicare Payment Advisory Commission 2011a).
- 21 In 2016, ASCs may choose to begin reporting data on a voluntary, chart-abstracted measure of improvement in visual function after cataract surgery. Because this measure is voluntary, ASCs that fail to report this measure will not be subject to a payment reduction.
- 22 The ASC Quality Reporting Program includes a measure of hospital transfer or admission after an ASC procedure when the patient is transferred directly to the hospital from the ASC. We are suggesting that the measure be expanded to include a hospital admission after the patient returns home from the ASC procedure.
- 23 Unlike update factors for other providers, such as the hospital market basket, the CPI-U is an output price index that already accounts for productivity changes (Centers for Medicare & Medicaid Services 2012). Nevertheless, CMS is mandated to subtract multifactor productivity growth from the ASC update factor.

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C H A P T E R

6

Outpatient dialysis services

R E C O M M E N D A T I O N

- 6** The Congress should eliminate the update to the outpatient dialysis payment rate for calendar year 2016.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

Outpatient dialysis services

Chapter summary

Outpatient dialysis services are used to treat the majority of individuals with end-stage renal disease (ESRD). In 2013, about 376,000 beneficiaries with ESRD on dialysis were covered under fee-for-service (FFS) Medicare and received dialysis from about 6,000 dialysis facilities. For most facilities, 2013 was the third year that Medicare paid them using a new prospective payment system (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 2013, Medicare expenditures for outpatient dialysis services in the new payment bundle, including newly bundled items and services, were \$11 billion, a 3 percent increase compared with 2012.

Assessment of payment adequacy

Our payment adequacy indicators for outpatient dialysis services are generally positive.

Beneficiaries' access to care—Measures on the capacity and supply of providers, beneficiaries' ability to obtain care, and changes in the volume of services suggest payments are adequate.

- **Capacity and supply of providers**—Dialysis facilities appear to have the capacity to meet demand. Growth in the number of dialysis treatment

In this chapter

- Are Medicare payments adequate in 2015?
.....
- How should Medicare payments change in 2016?
.....

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

- ***Volume of services***—Between 2012 and 2013, the number of FFS dialysis beneficiaries and dialysis treatments each grew by 2 percent. At the same time, the per treatment use of most dialysis injectable drugs, including erythropoiesis-stimulating agents (ESAs) that are used in anemia management, continued to decline but at a lower rate than between 2011 and 2012. The new dialysis PPS created an incentive for providers to be more judicious about their provision of dialysis drugs.

Quality of care—Using CMS data, we looked at changes in quality indicators between 2010 and 2013. Rates of emergency department use remained relatively constant, while rates of mortality and hospitalization declined. With regard to anemia management, negative cardiovascular outcomes associated with high ESA use have declined. There is increased use (from 8 percent of beneficiaries to 10 percent) of home dialysis, which is associated with improved patient satisfaction and quality of life.

Providers' access to capital—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.

Medicare payments and providers' costs—Our analysis of Medicare payments and costs is based on 2012 and 2013 claims and cost report data submitted to CMS by freestanding dialysis facilities. During this period, cost per treatment increased by 1 percent, while Medicare payment per treatment increased by about 1.5 percent. Taking into account the sequester, we estimate that the aggregate Medicare margin was 4.3 percent in 2013, and the projected Medicare margin is 2.4 percent in 2015.

The evidence suggests that payments are adequate; the Commission judges that outpatient dialysis facilities can continue to provide beneficiaries with appropriate access to care with no update to the base payment rate in 2016. ■

Dialysis treatment choices

Dialysis replaces the filtering function of the kidneys when they fail. The two types of dialysis—hemodialysis and peritoneal dialysis (PD)—remove waste products from the bloodstream differently. Within these two types of dialysis, patients may select various protocols.

Most dialysis patients travel to a treatment facility to undergo hemodialysis three times per week, although patients can also undergo hemodialysis at home. Hemodialysis uses an artificial membrane encased in a dialyzer to filter the patient's blood. Because of recent clinical findings, there is increased interest in more frequent hemodialysis, administered five or more times per week while the patient sleeps, and short (two to three hours per treatment) daily dialysis administered during the day. New research also has increased interest in the use of "every-other-day" hemodialysis; reducing the two-day gap in thrice-weekly hemodialysis may be linked to improved outcomes.

PD, the most common form of home dialysis, uses the lining of the abdomen (peritoneum) as a filter to clear wastes and extra fluid and is usually performed

independently in the patient's home or workplace five to seven days a week. During treatments, a cleansing fluid (dialysate) is infused into the patient's abdomen through a catheter. This infusion process (an exchange) is done either manually (continuous ambulatory peritoneal dialysis) or using a machine (continuous cycler-assisted peritoneal dialysis).

Each dialysis method has advantages and disadvantages—no one method is best for everyone. People choose a particular dialysis method for many reasons, including quality of life, patients' awareness of different treatment methods and personal preferences, and physician training and recommendations. The use of home dialysis has grown modestly since 2009, a trend that has continued under the new PPS. Some patients switch methods when their conditions or needs change. Although most patients still undergo in-center dialysis, home dialysis remains a viable option for most patients because of advantages such as increased patient satisfaction, better health-related quality of life, and fewer transportation challenges compared with in-center dialysis. ■

Background

End-stage renal disease (ESRD) is the last stage of chronic kidney disease and is characterized by permanent irreversible kidney failure. Patients with ESRD include those who are treated with dialysis—a process that removes wastes and fluid from the body—and those who have a functioning kidney transplant. Because of the limited number of kidneys available for transplantation and variation in patients' suitability for transplantation, 70 percent of ESRD patients undergo maintenance dialysis (see the text box). Patients receive additional items and services related to their dialysis treatments, including dialysis drugs to treat conditions such as anemia and bone disease resulting from the loss of kidney function.¹

In 2013, about 376,000 ESRD beneficiaries on dialysis were covered under fee-for-service (FFS) Medicare and received dialysis from about 6,000 dialysis facilities.² Since 2011, Medicare has been paying facilities using

a prospective payment system (PPS) that includes in the payment bundle dialysis drugs, for which facilities previously received separate payments, and services for which other Medicare providers (such as clinical laboratories) previously received separate payments.³ In 2013, Medicare Part B expenditures for outpatient dialysis services included in the payment bundle were \$11 billion. In addition, Part D payments for dialysis drugs—calcimimetics and phosphate binders—that will be included in the PPS payment bundle in 2025 totaled \$1 billion in 2012 (the most recent data available).

Characteristics of fee-for-service dialysis beneficiaries, 2013

Although Medicare generally does not provide disease-specific entitlement, the 1972 amendments to the Social Security Act extended Medicare benefits to people with ESRD, including those under age 65. To qualify for the ESRD program, an individual must be fully or currently insured under the Social Security or Railroad Retirement program, entitled to benefits (i.e., has met the required

**TABLE
6-1****FFS dialysis beneficiaries are disproportionately younger, male, and African American compared with all Medicare FFS beneficiaries, 2013**

	Percent of FFS:	
	Dialysis beneficiaries	All beneficiaries
Age		
Under 45 years	12%	4%
45–64 years	38	14
65–74 years	26	46
75–84 years	18	24
85+ years	7	12
Sex		
Male	55	46
Female	45	54
Race		
White	49	82
African American	36	10
All others	15	8
Residence, by type of county		
Urban	82	78
Rural micropolitan	11	13
Rural, adjacent to urban	5	6
Rural, not adjacent to urban	3	4
Frontier	1	1

Note: FFS (fee-for-service). Urban counties contain a cluster of 50,000 or more people, rural micropolitan counties contain a cluster of 10,000 to 50,000 people, rural adjacent counties are adjacent to urban areas and without a city of at least 10,000 people, and rural nonadjacent counties are not adjacent to an urban area and do not have a city with at least 10,000 people. Frontier counties have six or fewer people per square mile. Totals may not sum to 100 percent due to rounding.

Source: Data compiled by MedPAC from 2013 claims submitted by dialysis facilities to CMS and the 2013 CMS denominator file.

work credits) under the Social Security or Railroad Retirement program, or be the spouse or dependent child of an eligible beneficiary.

Most dialysis beneficiaries have FFS coverage. The statute prohibits enrollment of individuals with ESRD in Medicare Advantage (MA) plans. However, beneficiaries who were enrolled in a managed care plan before an ESRD diagnosis can remain in the plan after they are diagnosed. In 2013, about 14 percent of ESRD beneficiaries were enrolled in MA plans; by comparison, about 28 percent of all Medicare beneficiaries

were enrolled in MA plans. In 2000, the Commission recommended that the Congress lift the prohibition on ESRD beneficiaries enrolling in MA (Medicare Payment Advisory Commission 2000).

In 2013, a majority of FFS dialysis beneficiaries were enrolled in Part D or had other sources of creditable drug coverage: 81 percent of FFS dialysis beneficiaries were enrolled in Medicare's Part D program, and 4 percent received drug coverage through a retiree drug plan or other source of creditable coverage. In 2013, about 70 percent of FFS dialysis beneficiaries with Part D coverage received the low-income subsidy, and about 15 percent of FFS dialysis beneficiaries in 2013 had no Part D coverage or coverage less generous than Part D's standard benefit.

Compared with all Medicare FFS beneficiaries, FFS dialysis beneficiaries are disproportionately young, male, and African American (Table 6-1). In 2013, 76 percent of FFS dialysis beneficiaries were less than 75 years old, 55 percent were male, and 36 percent were African American. By comparison, of all FFS Medicare beneficiaries, 64 percent were less than 75 years old, 46 percent were male, and 10 percent were African American. A greater share of dialysis beneficiaries reside in urban areas compared with all FFS beneficiaries (82 percent vs. 78 percent, respectively). In 2013, FFS dialysis beneficiaries were more likely to be dually eligible for Medicaid and Medicare compared with all Medicare FFS beneficiaries (48 percent vs. 19 percent, respectively, data not shown).

Between 2002 and 2012 (most recent data available), the adjusted rate (or incidence) of new ESRD cases (which includes patients of all types of health coverage who initiate dialysis or receive a kidney transplant) decreased by 0.7 percent per year, from 378 per million people to 353 per million people (United States Renal Data System 2014). Since 2009, the adjusted rate of new ESRD cases has declined by 2 percent per year. This decline is seen across all races and ethnicities (White, African American, Asian Americans, Native American, and Hispanic) and all age groups.⁴ In 2013, we estimate that approximately 82,000 FFS dialysis beneficiaries were new to dialysis, and nearly half (46 percent) were under age 65 and thus entitled to Medicare based on ESRD (with or without disability).⁵

Better primary care management of the risk factors for kidney disease—particularly hypertension and diabetes, which together account for 7 of 10 new cases of ESRD—can help prevent or delay the illness's onset. Although risk-

factor control for hypertension and diabetes has improved for all racial and ethnic groups in Medicare, disparities remain between African Americans and other racial groups. The Commission has long argued that primary care providers are undervalued in Medicare's fee schedule and has made recommendations to support primary care.

Since 2011, CMS has paid most dialysis facilities under the new dialysis PPS

To treat ESRD, dialysis beneficiaries receive care from two principal groups of providers: (1) the clinicians (typically nephrologists) who prescribe and manage the provision of dialysis and establish the beneficiary's plan of care, and (2) facilities that provide dialysis treatments in a dialysis center or that support and supervise the care of beneficiaries on home dialysis. Medicare uses different methods to pay for ESRD clinician and facility services. Clinicians receive a monthly capitated payment established in the Part B physician fee schedule for outpatient dialysis-related management services, which varies based on the number of visits per month, the beneficiary's age, and whether the beneficiary receives dialysis in a facility or at home. While this chapter focuses on Medicare's payments to facilities, it is important to recognize that facilities and clinicians collaborate to care for dialysis beneficiaries. One acknowledgment of the need for collaboration is Medicare's ESRD Comprehensive Care Initiative, which is a shared savings program involving facilities and nephrologists and is expected to begin in 2015.

To improve provider efficiency, in 2011 Medicare began a new PPS for outpatient dialysis services that expanded the payment bundle to include dialysis drugs, laboratory tests, and other ESRD items and services that were previously separately billable.⁶ In addition, beginning in 2012, outpatient dialysis payments are linked to the quality of care that dialysis facilities provide. These changes, mandated by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), were based on the Commission's recommendation to modernize the outpatient dialysis payment system (Medicare Payment Advisory Commission 2001). We contended that Medicare could provide incentives for the efficient delivery of quality care by broadening the payment bundle (to include commonly furnished drugs and services that providers formerly billed separately) and by linking payment to quality. The new PPS is designed to create incentives for facilities to provide services more efficiently by reducing incentives inherent in the former payment method to overuse drugs.

Under the outpatient dialysis PPS, the unit of payment is a single dialysis treatment, and the base payment rate is adjusted for patient-level characteristics—age, body measurement characteristics, onset of dialysis, and six acute and chronic comorbidities—and facility-level factors—low treatment volume and local input prices.⁷ Medicare pays facilities furnishing dialysis treatments in-facility or in a patient's home for up to three treatments per week, unless there is documented medical justification for more than three weekly treatments. In addition, in 2014, the ESRD Quality Incentive Program held facilities responsible for the quality of care they provide, using four clinical measures and three reporting measures. Up to 2 percent of a facility's payment is linked to these quality measures. The Commission's *Payment Basics* provides more information about Medicare's method of paying for outpatient dialysis services (available at <http://medpac.gov/documents/payment-basics/outpatient-dialysis-services-payment-system.pdf?sfvrsn=0>).

Effective 2014, the American Taxpayer Relief Act (ATRA) of 2012 mandated the rebasing (in effect, reducing) of the base payment rate to account for the decline in dialysis drug use under the new PPS. Based on the statutory and regulatory changes summarized in the text box (p. 144), the 2014 base prospective payment rate was \$239.02 per treatment.

Are Medicare payments adequate in 2015?

To address whether payments for 2015 are adequate to cover the costs that efficient providers incur and how much providers' costs should change in the update year (2016), we examine several indicators of payment adequacy. We assess beneficiaries' access to care by examining the treatment capacity of dialysis providers and changes over time in the volume of services provided, quality of care, providers' access to capital, and the relationship between Medicare's payments and providers' costs. Most of our payment adequacy indicators for dialysis services are positive:

- Provider capacity is sufficient.
- Volume growth as measured by the number of dialysis treatments has kept pace with growth in the number of beneficiaries.
- Some quality measures show improvement.

Rebasing the outpatient dialysis payment rate

Effective 2014, the American Taxpayer Relief Act (ATRA) of 2012 mandated that the Secretary rebase the base payment rate to reflect the reduction in the use of dialysis drugs between 2007 and 2012. CMS determined that the base payment rate should be reduced by \$29.93 (in 2014 estimated

prices) to reflect observed changes in drug utilization. The agency announced that it would phase-in the drug utilization adjustment over a three- to four-year period. The first-year (2014) drug utilization adjustment (reduction) was \$8.16 (3.3 percent) per treatment.⁸ ■

- Provider access to capital is sufficient.
- The 2013 Medicare outpatient dialysis margin is estimated at 4.3 percent, and the projected 2015 Medicare margin is 2.4 percent.

Beneficiaries' access to care: Indicators continue to be favorable

Our analysis of access indicators—including the capacity of providers to meet beneficiary demand and changes in the volume of services—shows that beneficiaries' access to care remains favorable.

Capacity has kept pace with patient demand

Growth in the number of dialysis facilities and treatment stations alongside growth in the number of dialysis beneficiaries suggests that between 2008 and 2013, provider capacity kept up with demand for care. During that period, the number of facilities increased annually by 3 percent; facilities' capacity to provide care—as measured by dialysis treatment stations—also grew 3 percent annually (Table 6-2). Capacity at facilities that were freestanding and for profit each grew by 4 percent annually. By contrast, capacity at facilities that were hospital based and nonprofit decreased annually (–4 percent and –2 percent, respectively). Capacity at urban facilities grew at 4 percent per year while capacity at rural facilities grew at 3 percent per year. Trends in supply between 2012 and 2013 were generally similar to those between 2008 and 2013.

Providers of outpatient dialysis services

In 2013, there were roughly 6,000 dialysis facilities in the United States. Since the late 1980s, for-profit, freestanding facilities have provided the majority of dialysis treatments (Rettig and Levinsky 1991). In 2013, freestanding facilities furnished 93 percent of FFS treatments, and for-profit facilities furnished about 89 percent (Table 6-2). In 2013, the capacity of facilities located in urban and rural

areas was generally consistent with where FFS dialysis beneficiaries lived.

Two large dialysis organizations dominate the dialysis industry, which has seen significant consolidation during the past decade.⁹ In 2013, the two largest dialysis organizations (LDOs) accounted for about 70 percent of all facilities and 75 percent of all Medicare treatments. Between 2011 and 2013, both LDOs acquired existing dialysis facilities. Smaller chains have also consolidated. For example, in August 2013, U.S. Renal Care doubled its patient population (to about 14,000) after it completed the acquisition of Ambulatory Services of America, which, in 2007 and 2011, had acquired two dialysis chains (Innovative Dialysis and Renal CarePartners, respectively).

In addition to operating most dialysis facilities, the two large organizations are each vertically integrated. One manufactures and distributes renal-related pharmaceutical products (e.g., phosphate binders), is the leading supplier of dialysis products (such as hemodialysis machines and dialyzers) to other dialysis companies, and operates a company that focuses on the clinical development of new renal therapies. Both organizations operate an ESRD-related laboratory, a pharmacy, and one or more centers that provide vascular access services; they provide ESRD-related disease management services; and they operate dialysis facilities internationally. Both organizations have, in recent years, acquired physician groups. In 2012, DaVita acquired HealthCare Partners, a large operator of medical groups and physician networks; in 2014, Fresenius acquired or purchased majority stakes in multiple health care-related companies.

Type of facilities that closed and their effect on beneficiaries' access to care

Each year, we assess what types of facilities closed and whether certain groups of Medicare dialysis beneficiaries

**TABLE
6-2****Increasing number and capacity of freestanding, for-profit, and large dialysis organizations**

	2013				Average annual percent change			
	Total number of FFS treatments (in millions)	Total number of facilities	Total number of stations	Mean number of stations	Number of facilities		Number of stations	
					2008–2013	2012–2013	2008–2013	2012–2013
All	44.0	6,000	106,500	18	3%	3%	3%	3%
Percent of total								
Freestanding	93%	92%	94%	18	4	4	4	4
Hospital based	7	8	6	14	–4	–4	–4	–5
Urban	84	79	83	19	3	4	4	3
Rural	16	21	17	15	2	2	3	3
For profit	89	86	87	18	4	4	4	4
Nonprofit	11	14	13	17	–3	–1	–2	–1
Two largest dialysis organizations	75	71	71	18	6	4	6	4
All others	25	29	29	17	–3	1	–2	1

Note: FFS (fee-for-service).

Source: Compiled by MedPAC from the 2008, 2012, and 2013 Dialysis Compare database from CMS and 2013 claims submitted by freestanding and hospital-based dialysis facilities to CMS.

are disproportionately affected by facility closures. Using facilities' claims submitted to CMS and CMS's Dialysis Compare database and Provider of Services file, we compare the characteristics of beneficiaries treated by facilities that closed in 2012 with those in facilities that provided dialysis in 2012 and 2013.

On net, between 2012 and 2013, the number of dialysis treatment stations—a measure of providers' capacity—increased by 3 percent. Compared with facilities that treated beneficiaries in both years, facilities that closed in 2012 (about 40 facilities) were more likely to be hospital based and nonprofit, which is consistent with long-term trends in supply of dialysis providers (Table 6-2).

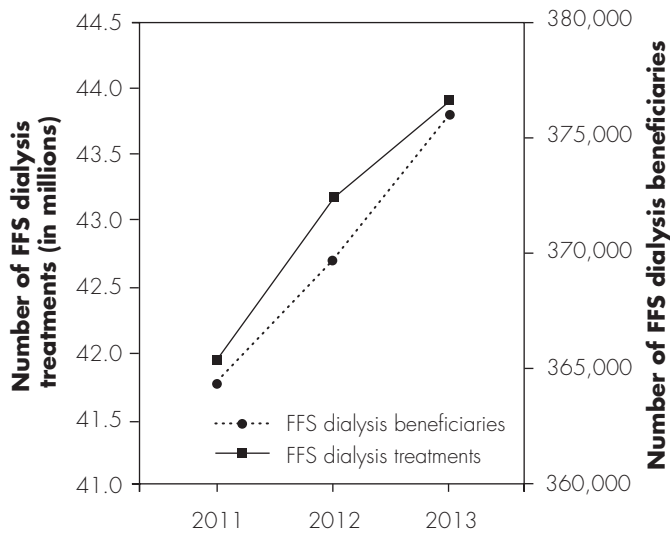
Measured by the number of dialysis treatment stations, closed facilities (which averaged 15 stations) were smaller than facilities open in 2012 and 2013 (which averaged 18 stations). Compared with the distribution of facilities in business both years, a greater proportion of facilities that

closed were in rural areas. However, between 2012 and 2013, the total number of rural facilities increased by 2 percent (Table 6-2).

About 2,600 dialysis beneficiaries were affected by facility closures in 2012. Our analysis found that racial minority groups and poorer patients (as measured by Medicaid eligibility) were not disproportionately affected by these closures. Beneficiary groups who were disproportionately affected included patients who were White and older. Our analysis of 2012 and 2013 claims data suggests that beneficiaries affected by these closures obtained care at other facilities.

Volume of services

To assess changes in the volume of dialysis services, we examined recent trends in the number of dialysis treatments provided to beneficiaries and in the use of injectable drugs administered during dialysis.

FIGURE 6-1**Growth in the number of FFS dialysis treatments and FFS dialysis beneficiaries, 2011–2013**

Note: FFS (fee-for-service).

Source: MedPAC analysis of 2011–2013 claims submitted by dialysis facilities to CMS.

Trends in number of dialysis treatments provided

Between 2012 and 2013, total dialysis treatments grew at an average annual rate that kept pace with the average annual growth in the number of total FFS dialysis beneficiaries—about 2 percent (Figure 6-1). By contrast, between 2011 and 2013, the annual growth in total treatments slightly outpaced the annual growth in the number of FFS dialysis beneficiaries (2.4 percent per year vs. 1.7 percent per year, respectively). The greater treatment growth (compared with beneficiary growth) between 2011 and 2013 is associated with an increase in the number of dialysis treatments per beneficiary during this period (from about 115 dialysis treatments per beneficiary per year to 117 treatments per beneficiary per year, data not shown).

Use of most dialysis drugs has declined under the new outpatient dialysis PPS Because CMS based the per treatment bundled payment rate in the new PPS on 2007 use data, we examined changes between 2007 and 2013 (the most current year for which complete data are available) in the use per treatment for the leading 12 dialysis drugs and aggregated them into 4 therapeutic classes—erythropoiesis-stimulating agents (ESAs), iron agents, vitamin D agents, and antibiotics and all other

drugs.¹⁰ We also examined changes in the use of drugs between 2010, the year before the start of the new PPS, and 2013.

The new PPS increased the incentive for providers to be more judicious in providing dialysis drugs since they are included in the payment bundle. Under the prior payment method, dialysis drugs were paid according to the number of units of the drug administered—in other words, the more units of a drug provided, the higher the Medicare payment.

Between 2007 and 2013, the use of most dialysis drugs declined. During this period, use of eight drugs declined while three increased (ferumoxytol was not marketed in the United States in 2007) (Table 6-3). Per treatment dose of both ESAs declined—erythropoietin by 47 percent and darbepoetin alfa by 63 percent.

However, most of the decline in the use of dialysis drugs has occurred since 2010. For example, between 2010 and 2013, the mean per treatment units of both ESAs declined—erythropoietin by 44 percent and darbepoetin alfa by 55 percent. For ESAs, some of this decline may also have stemmed from clinical evidence showing that higher doses of these drugs led to increased risk of morbidity and mortality, which resulted in the Food and Drug Administration changing the ESA label in 2011.

In addition, usage data suggest that the new PPS increased competition between the two principal vitamin D agents. Under the new PPS (between 2010 and 2013), per treatment use of paricalcitol, the more costly vitamin D drug (according to Medicare average sales price data), declined while per treatment use of doxercalciferol, the less costly vitamin D drug, increased (Table 6-3).

To measure changes in the use by drug class, we took the number of units of a drug provided and multiplied it by the 2014 Medicare price (based on the average of each products' quarterly average sales price).¹¹ On a per treatment basis, dialysis drug use was 45 percent lower in 2013 than in 2007. By drug class, on a per treatment basis between 2007 and 2013, the use of ESAs, injectable iron agents, vitamin D agents, and antibiotics and all other drugs declined by 49 percent, 12 percent, 20 percent, and 79 percent respectively (Figure 6-2, p. 148).

Quality of care: The impact of the new PPS

This year's quality analysis focuses on changes in quality indicators since CMS implemented the new payment method and, except where indicated, uses CMS's monthly

**TABLE
6-3****Use per treatment of dialysis drugs has declined under the new outpatient dialysis PPS**

Dialysis drug	Mean units per treatment*			Aggregate percent change		
	2007	2010	2013	2007-2010	2010-2013	2012-2013
ESAs						
Erythropoietin	5,532	5,214	2,917	-6%	-44%	-6%
Darbepoetin alfa	1.52	1.26	0.56	-17	-55	-15
Iron agents						
Sodium ferric gluconate	0.39	0.15	0.14	-62	-3	-16
Iron sucrose	12.3	16.0	12.6	30	-21	-1
Ferumoxylol**	N/A	0.8	0.024	N/A	-97	10
Vitamin D agents						
Paricalcitol	2.3	2.3	1.4	-2	-40	-5
Doxercalciferol	0.8	0.9	1.2	8	38	-0.2
Calcitriol	0.16	0.13	0.05	-17	-63	-18
Antibiotics						
Daptomycin	0.097	0.217	0.155	123	-29	-10
Vancomycin	0.029	0.024	0.019	-18	-22	-13
Other drugs						
Levocarnitine	0.017	0.010	0.003	-43	-68	-17
Alteplase	0.023	0.020	0.003	-12	-85	-59

Note: PPS (prospective payment system), ESA (erythropoiesis-stimulating agent), N/A (not available). Individual units per treatment are rounded; the aggregate percent change is calculated using unrounded units per treatment.

*Each drug is reported using its own drug units.

**Drug use not available because drug not marketed in the United States in 2007, 2008, and 2009.

Source: MedPAC and Acumen analysis of 2007–2013 claims submitted by dialysis facilities to CMS.

monitoring data (Centers for Medicare & Medicaid Services 2013). From 2010 to 2013, monthly mortality and hospitalization rates modestly declined; emergency department use remained relatively unchanged. Regarding anemia management, negative cardiovascular outcomes associated with high ESA use generally declined. During this period, use of home dialysis, which is associated with improved patient satisfaction and quality of life, modestly increased.

In assessing quality, we also examine the multiple factors that affect access to kidney transplantation. This procedure is widely regarded as a better ESRD treatment option than dialysis in terms of patients' clinical and quality of life outcomes, and demand far outstrips supply. We also discuss CMS's new payment model, which is designed to improve the health outcomes of dialysis beneficiaries while lowering their total Medicare Part A and Part B per capita spending.

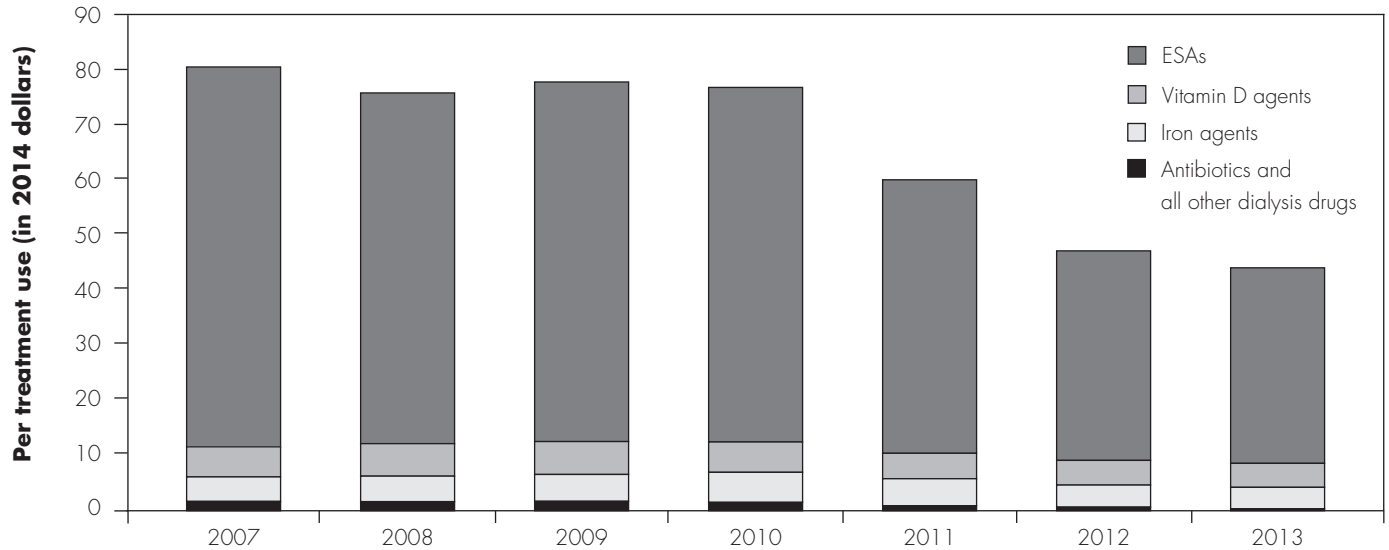
Quality under the new PPS

Figure 6-3 (p. 148) presents changes in key patient outcomes between 2010 and 2013; during this period, the proportion of dialysis beneficiaries who:

- died declined from an average of 1.7 percent per month to 1.5 percent per month.
- used the emergency department remained steady, averaging between 10.5 percent per month and 10.8 percent per month.
- were hospitalized declined each year from an average of 14.3 percent per month to 12.8 percent, respectively. This finding is consistent with the trend of declining inpatient admissions for all Medicare FFS beneficiaries during this period.

**FIGURE
6-2**

Dialysis drug utilization, overall and by drug class, 2007–2013

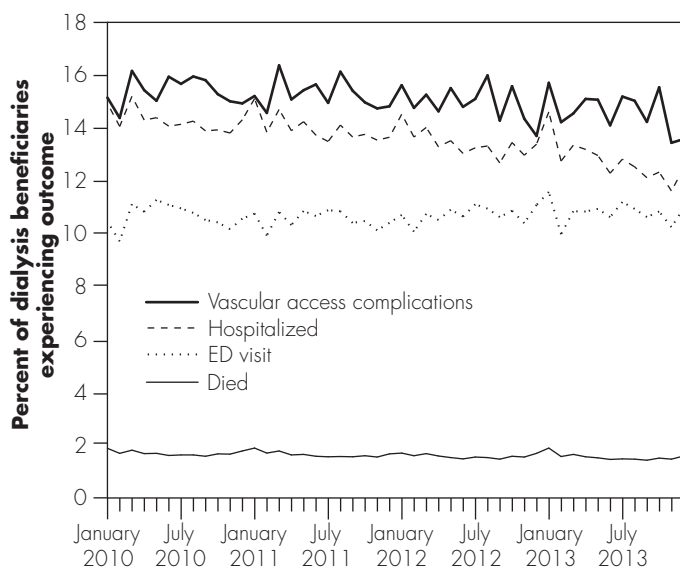


Note: ESA (erythropoiesis-stimulating agent). Per treatment use is estimated for each drug by dividing total units of that drug by total dialysis treatments and multiplying by the average of 2014 quarterly average sales prices. ESAs include erythropoietin and darbepoetin; vitamin D agents include calcitriol, doxercalciferol, and paricalcitol; iron agents include iron sucrose, sodium ferric gluconate, and ferumoxytol; antibiotics and all other drugs include daptomycin, vancomycin, levocarnitine, and alteplase.

Source: MedPAC analysis of 2007–2013 claims submitted by dialysis facilities to CMS and CMS’s 2014 quarterly average sales price files.

**FIGURE
6-3**

**Changes in key outcomes for
dialysis beneficiaries, 2010–2013**



Note: ED (emergency department). Data are compiled on a monthly basis by CMS.

Source: CMS’s end-stage renal disease prospective payment system overview of 2011–2013 claims-based monitoring program.

- experienced a vascular access complication on hemodialysis declined from an average of 15.4 percent per month to 14.7 percent per month.

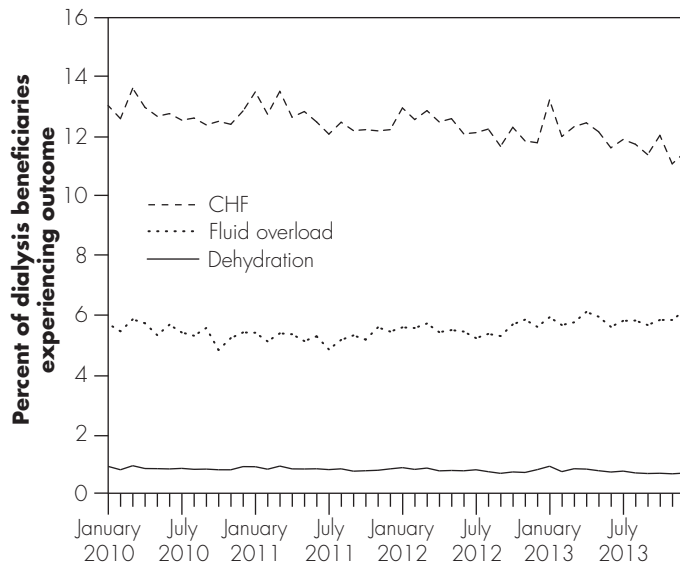
Beneficiaries’ fluid management is related to factors such as the adequacy of the dialysis procedure and dietary management. Figure 6-4 shows that, between 2010 and 2013, the percentage of dialysis beneficiaries diagnosed with congestive heart failure or dehydration declined slightly while the percentage of beneficiaries diagnosed with fluid overload increased slightly.

Process and health outcome measures reflect the change in anemia management under the new PPS. From 2010 to 2013:

- Median monthly hemoglobin levels fell from 11.4 g/dL to 10.6 g/dL in 2012 and 2013.¹² Figure 6-5 shows that the proportion of dialysis beneficiaries with higher hemoglobin levels declined and the proportion with lower hemoglobin levels increased (which is generally associated with lower ESA use).

FIGURE 6-4

Changes in fluid management, 2010–2013



Note: CHF (congestive heart failure). Data are compiled on a monthly basis by CMS.

Source: CMS's end-stage renal disease prospective payment system overview of 2011–2013 claims-based monitoring program.

- The proportion of beneficiaries receiving blood transfusions increased from 2.7 percent to 3.4 percent in 2012 and then leveled off to 3.2 percent in 2013.¹³
- The cumulative share of beneficiaries experiencing negative cardiovascular outcomes—stroke, acute myocardial infarction, and heart failure—associated with higher ESA use generally declined.

As discussed in our June 2014 report, clinical process measures (such as hemoglobin levels) may exacerbate the incentives in FFS to overprovide and overuse services, including ESAs before 2011 (Medicare Payment Advisory Commission 2014). In addition, some clinical process measures may be only weakly correlated with better health outcomes. A given hemoglobin level may reflect adequate anemia management for one patient, whereas the same level may lead to a different response in a different patient. Focusing on clinical outcomes, such as rates of stroke, may be a better indicator of anemia management in the dialysis population. The Commission believes that Medicare should transition over the next decade to a quality-measurement system that uses a small number of population-based outcome measures.

Figure 6-6 (p. 150) shows that between 2010 and 2013, the percentage of dialysis beneficiaries diagnosed with kidney stones, fracture, or peptic ulcers (outcome measures assessing bone and mineral disease management) remained at about the same level.

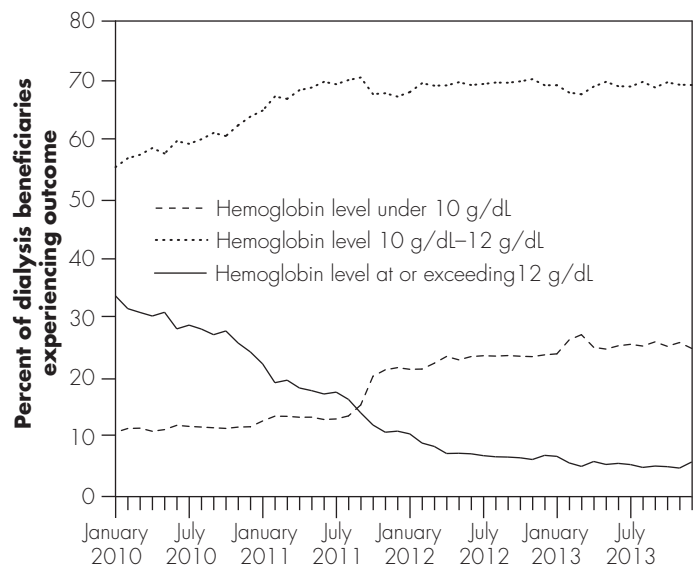
Figure 6-7 (p. 150) shows that from 2010 through 2013, the share of beneficiaries dialyzing at home steadily increased from a monthly average of 8.3 percent to 10.1 percent, respectively. While we are encouraged by this modest increase, we are concerned that differences by race continue; African Americans are consistently less likely to use home methods (data not shown).

Access to kidney transplantation

Kidney transplantation is widely regarded as a better ESRD treatment option than dialysis in terms of patients' clinical and quality of life outcomes. However, demand for kidney transplantation exceeds supply. Factors that affect access to kidney transplantation include the clinical allocation process and donation rates; patients' health literacy, clinical characteristics, and preferences; the availability of patient educational efforts; clinician referral for transplant evaluation at a transplant center; and transplant center policies.

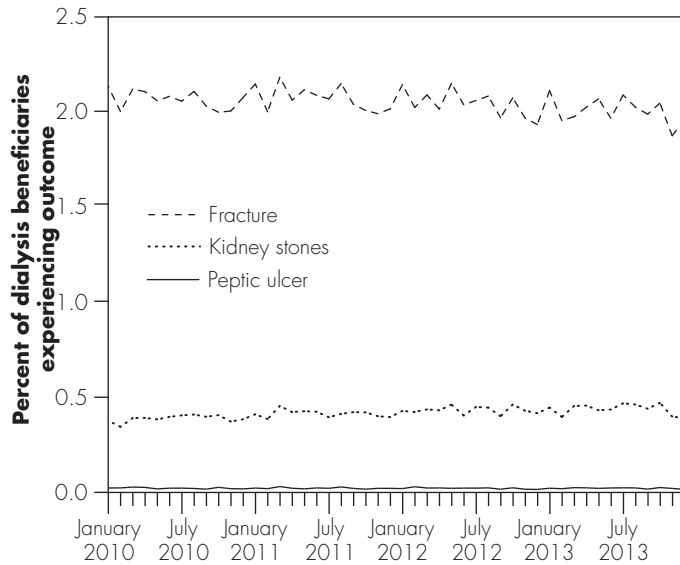
FIGURE 6-5

Changes in hemoglobin levels, 2010–2013



Note: Data are compiled on a monthly basis.

Source: MedPAC analysis of 2010–2013 claims submitted by dialysis facilities.

FIGURE 6-6**Changes in bone and mineral disease management outcomes, 2010–2013**

Note: Data are compiled on a monthly basis by CMS.

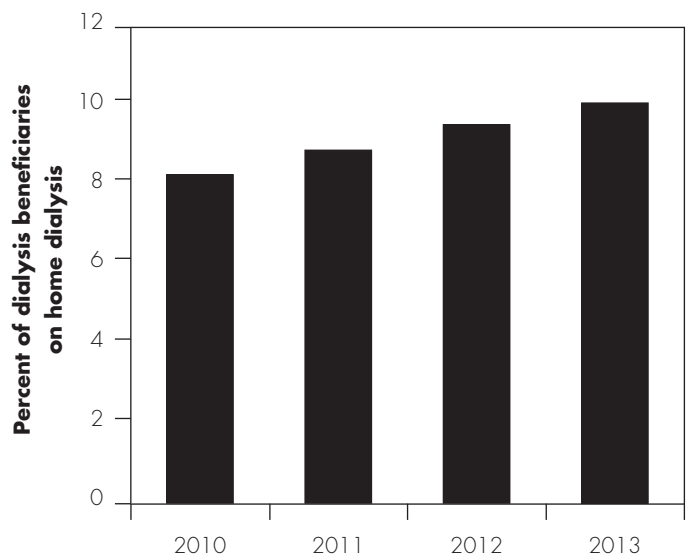
Source: CMS's end-stage renal disease prospective payment system overview of 2011–2013 claims-based monitoring program.

African Americans are less likely than Whites to receive kidney transplants despite their fourfold greater likelihood of developing ESRD. According to Ephraim and colleagues, the lower rates of kidney transplantation for African Americans are associated with multiple factors, including immunological incompatibility with deceased donor kidneys, lower rates of referral for transplantation, lower rates of cadaver kidney donation, and lack of knowledge and suboptimal discussions about kidney transplantation among recipients, their families, and health care providers (Ephraim et al. 2012).

In 2010, to help inform beneficiaries diagnosed with Stage IV chronic kidney disease (CKD) (the disease stage before ESRD) about managing CKD and related comorbidities and their options for care, Medicare began paying for up to six kidney disease education (KDE) sessions per beneficiary. Fewer beneficiaries were provided KDE services in 2013 than in 2011 and 2012—3,600 beneficiaries in 2013 compared with about 4,200 beneficiaries in 2011 and 2012. Medicare KDE spending in 2013 was about \$500,000.¹⁴

The ESRD Comprehensive Care Initiative

The relatively high rates of emergency department visits, hospital admissions, and hospital readmissions among beneficiaries on dialysis suggest that further improvements in quality are needed and that some dialysis beneficiaries might benefit from better care coordination. Developed under the authority of the Center for Medicare and Medicaid Innovation, the ESRD Comprehensive Care Initiative is expected to begin in 2015 and will test whether a new payment model implemented in FFS Medicare can improve the outcomes of dialysis beneficiaries as well as lower Medicare per capita spending for their care. Under this five-year initiative, ESRD Seamless Care Organizations (ESCOs), which will consist of at least one dialysis facility and one nephrologist, will be held accountable for the clinical and financial (Part A and Part B) outcomes of prospectively matched dialysis beneficiaries. ESCOs will be held to either one-sided risk-based payment (if the dialysis facility participating in the ESCO is not operated by an LDO) or two-sided risk-based payment (if the dialysis facility is affiliated with an LDO). The ESRD Comprehensive Care Initiative uses an approach similar to the Medicare Shared Savings Program to calculate the historical expenditure baseline. CMS expects to award

FIGURE 6-7**Increasing use of home dialysis, 2010–2013**

Note: Data represent yearly averages of data compiled by CMS on a monthly basis.

Source: CMS's end-stage renal disease prospective payment system overview of 2011–2013 claims-based monitoring program.

between 10 and 15 ESCOs in 2015. The Commission has said that if structured properly, a shared savings program—in this case, for ESRD providers—could present an opportunity to correct some of the undesirable incentives inherent in FFS payment and reward providers who are doing their part to control costs and improve quality. Online Appendix 6-A, available at <http://www.medpac.gov>, has additional information about the ESRD Comprehensive Care Initiative.

While ESCOs will enroll only dialysis beneficiaries, other accountable care organization models, such as those participating in the Medicare Shared Savings Program, might provide opportunities for beneficiaries with earlier stages of kidney disease to receive better care coordination, particularly in the management of the kidney disease risk factors discussed on p. 142.

Providers' access to capital: Growth trends suggest access is adequate

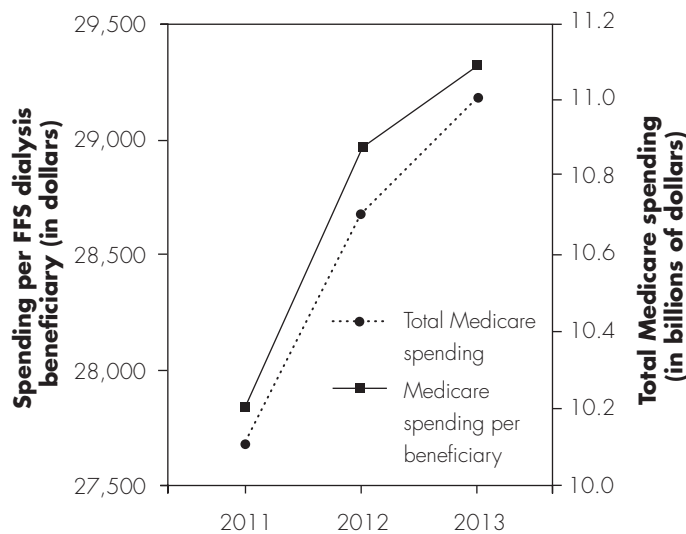
Providers need access to capital to improve their equipment and open new facilities so they can accommodate the growing number of patients requiring dialysis. The two largest dialysis organizations, as well as other renal companies, appeared to have adequate access to capital in 2014. For example, in 2014:

- Fresenius Medical Care announced it would invest up to \$140 million to open a new facility in Tennessee for manufacturing dialysis-related products.
- Fresenius Medical Care acquired or purchased majority stakes in (1) Sound Inpatient Physicians Inc., a hospitalist management organization with 1,000 physicians who provide care in over 100 hospitals and post-acute care centers; (2) MedSpring Urgent Care Centers, which operates 18 centers in Illinois and Texas; (3) National Cardiovascular Partners, which provides endovascular, vascular, and cardiovascular outpatient services and operates 21 outpatient vascular centers in 6 states in partnership with 200 physicians; and (4) Cogent Healthcare, which provides hospitalist and intensivist services by 650 providers in more than 80 hospitals.
- DaVita HealthCare Partners announced a joint venture with Colorado-based Centura Health, which operates 15 hospitals and is jointly owned by Englewood-based Catholic Health Initiatives, a not-for-profit health system, and Adventist Health System, Altamonte Springs, FL.

- Berkshire Hathaway continued its investment in DaVita by purchasing 1.13 million shares in February and an additional 944,000 shares in November. Such an investment suggests the financial attractiveness of the company and the positive economics associated with provision of dialysis services.
- Several private equity and venture capital firms provided growth financing (\$20 million dollars) for Pure Life Renal to launch and acquire dialysis centers. Pure Life Renal is a dialysis management company that furnishes in-center, home-based, and acute dialysis services.
- Dialysis Clinic Inc., the largest nonprofit dialysis chain, acquired the Rubin Dialysis Center and entered into a joint venture agreement with the Billings Clinic.
- NxStage, manufacturer of home hemodialysis equipment, will develop new products for the peritoneal dialysis market. In addition, NxStage, which operates seven dialysis care centers, opened five additional centers.
- Renal Ventures Management, which operates about 30 dialysis centers, opened its first vascular access center in Louisiana.

In public financial filings, the two largest dialysis organizations reported positive financial performance for 2013, including strong treatment (volume) growth, productivity improvements, and cost control initiatives. For example, Fresenius Medical Care announced that it expects to double its revenue between 2013 and 2020 (Zumoff 2014).

Factors unrelated to Medicare's payment policies could affect providers' access to capital. For example, circumstances can occur within a sector that can discourage outside investment because of the actions of certain providers. In 2014, DaVita Healthcare Partners Inc. paid \$350 million to the federal government to resolve claims that it violated the False Claims Act by paying physicians kickbacks to get patient referrals for its clinics and to reduce or eliminate competition from other dialysis centers. Under the settlement, DaVita entered into a Corporate Integrity Agreement with the Department of Health and Human Services Inspector General that includes the appointment of an independent monitor to prospectively review DaVita's arrangements with nephrologists and other health care providers for compliance with the Anti-Kickback Statute. Despite this

**FIGURE
6-8****Medicare FFS spending under
the new PPS, 2011–2013**

Note: FFS (fee-for-service), PPS (prospective payment system).

Source: MedPAC analysis of 2011–2013 claims submitted by dialysis facilities to CMS.

recent settlement, in 2014 assessments, investor analysts concluded that DaVita's core dialysis segment continues to perform very well, and they anticipate solid growth in the dialysis sector.

These current trends in the growth of for-profit providers and consolidation among dialysis providers suggest that the dialysis industry is an attractive business to for-profit providers and that efficiencies and economies of scale are attained in providing dialysis care.

Medicare payments and providers' costs

Each year, we examine the relationship between Medicare's payments and providers' costs as part of our assessment of payment adequacy. To make this assessment, we reviewed Medicare expenditures for outpatient dialysis services in 2013 and examined trends in spending under the new PPS. We also reviewed evidence regarding providers' costs under the new PPS.

Medicare payments for outpatient dialysis services

Between 2012 and 2013, total Medicare spending increased by about 3 percent, from \$10.7 billion to \$11 billion, while per capita spending increased by 1 percent, from about \$28,900 to about \$29,300 (Figure 6-8). The

change in total and per capita spending reflects (1) the 2.3 percent statutory update to the payment rate in 2013, (2) the 2 percent growth in the number of beneficiaries and treatments, and (3) the 2 percent sequester reduction of Medicare's payment to providers that began in April 2013.

Part D spending for dialysis drugs

In 2012 (the most recent year data are available), Part D spending for dialysis drugs that will, on January 1, 2025, be included in the PPS payment bundle, totaled \$1 billion, an increase of 22 percent compared with 2011. Medicare spending for Part D dialysis drugs is not included in the Commission's analysis of Medicare's payments and costs for dialysis facilities. Online Appendix 6-B, available at <http://www.medpac.gov>, provides additional analysis of trends in Part D dialysis drug spending between 2007 and 2012.

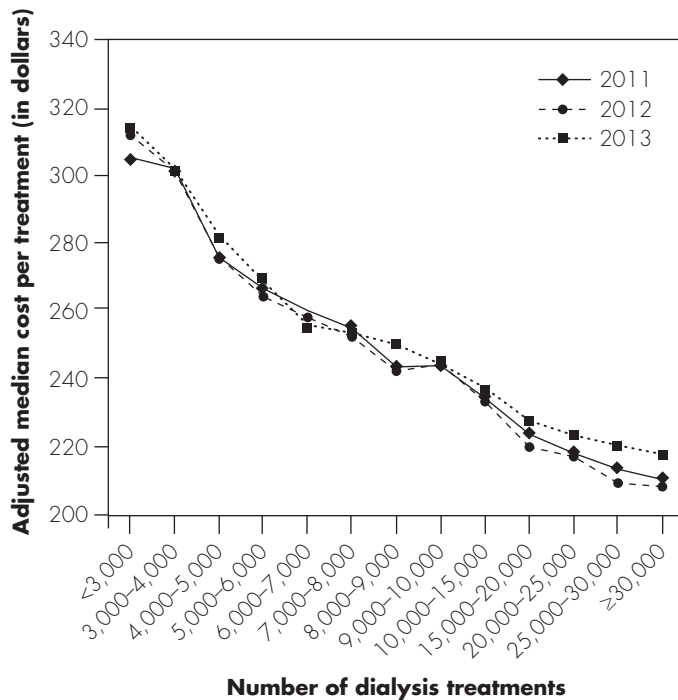
Providers' costs for outpatient dialysis services under the new PPS

To assess the appropriateness of costs for dialysis services paid for under the new PPS, we examine whether aggregate dialysis facility costs reflect costs that efficient providers would incur in furnishing high-quality care. For this analysis, we use 2012 and 2013 cost reports submitted to CMS by freestanding dialysis facilities. For those years, we look at the growth in the cost per treatment and how total treatment volume affects that cost.

Cost growth under the new PPS Between 2012 and 2013, the cost per treatment rose by about 1 percent, from about \$238 per treatment to \$240 per treatment. Variation in cost growth across freestanding dialysis facilities shows that some facilities were able to hold their cost growth well below that of others. For example, between 2012 and 2013, per treatment costs decreased by 4 percent for facilities in the 25th percentile of cost growth and increased by 4 percent for facilities in the 75th percentile.

Cost per treatment is correlated with facility service volume

Cost per treatment is correlated with the total number of treatments a facility provides. For this analysis, we adjusted the cost per treatment to remove differences in the cost of labor across areas and included all treatments regardless of payer. Our analysis showed, in each year from 2011 through 2013, a statistically significant relationship between total treatments and cost per treatment (correlation coefficient equaled -0.5) (Figure 6-9). That is, the greater the facility's service volume, the lower its costs per treatment.

**FIGURE
6-9****Higher volume dialysis
facilities had lower cost per
treatment, 2011-2013**

Note: Cost per treatment is adjusted to remove differences in the cost of labor. Dialysis treatments include those paid for by all sources (not just Medicare-paid treatments).

Source: MedPAC analysis of 2011-2013 cost reports submitted by freestanding dialysis facilities to CMS and the end-stage renal disease wage index files.

Medicare margin for freestanding facilities in 2013

The Commission assesses current payments and costs for dialysis services for freestanding dialysis facilities by comparing Medicare's payments with providers' Medicare-allowable costs. The latest and most complete data available on payments and costs are from 2013. Our analysis includes only facilities that elected to be paid under the new PPS.

For 2013, we estimate that the aggregate Medicare margin was 4.3 percent (Table 6-4). The distribution of margins shows wide variation in performance among freestanding facilities. In 2013, one-quarter of facilities had margins at or below -6.5 percent, and one-quarter of facilities had margins of at least 12.2 percent.

Facility size accounted for the largest variation in freestanding dialysis facilities' margins; facilities with greater total treatment volume had higher margins on average. Urban facilities had higher margins than rural

facilities (4.9 percent and 0.6 percent, respectively); differences in total treatment volume reflect much of the differences observed between urban and rural facilities. Urban dialysis facilities are larger on average than rural facilities with respect to number of treatment stations and Medicare treatments provided. In 2013, urban facilities averaged 19 stations while rural facilities averaged 15 stations; urban facilities averaged 8,300 Medicare treatments while rural facilities averaged 5,700 Medicare treatments.

Projecting the Medicare margin for 2015

On the basis of 2013 payment and cost data, provider cost growth between 2012 and 2013, and policy changes that went into effect between 2013 (the year of our most recent margin estimates) and 2015, we project a 2.4 percent aggregate Medicare margin for dialysis facilities in 2015. The policy changes that are included in this projection include:

- statutory updates of 2.8 percent in 2014 and 0 percent in 2015;
- other policy changes that resulted in increased payments in 2014 and 2015 of 0.6 percent and 0.3 percent, respectively;

**TABLE
6-4****Medicare margin in 2013 varied by
type of freestanding dialysis facility**

Provider type	Medicare margin	Percent of freestanding dialysis facilities
All	4.3%	100%
Urban	4.9	80
Rural	0.6	20
Two largest dialysis organizations	4.1	77
All others	5.2	23
Treatment volume (quintile)		
Lowest	-12.3	20
Second	-3.8	20
Third	2.0	20
Fourth	6.0	20
Highest	9.7	20

Source: Compiled by MedPAC from 2013 cost report and outpatient claims submitted by facilities to CMS and the 2013 Dialysis Compare database.

- a 3.3 percent reduction in payments due to rebasing the payment rate in 2014 to account for the reduction in drug use under the new PPS;
- a reduction in payments due to the ESRD Quality Incentive Program (QIP) in 2014 and 2015 of 0.29 percent and 0.17 percent, respectively; and
- the sequester, which reduces Medicare’s program payments to providers by 2 percent.

How should Medicare payments change in 2016?

The Protecting Access to Medicare Act of 2014 sets the update to the outpatient dialysis payment rate at the market basket, less an adjustment for productivity and 1.25 percentage points. Based on CMS’s latest forecast of the ESRD market basket for calendar year 2016 (2.9 percent), the update to the 2016 payment rate would be 1.15 percent. In addition to this statutory provision, the ESRD QIP is expected to decrease total payments by 0.17 percent in 2016.

Update recommendation

The evidence on payment adequacy suggests that outpatient dialysis payments are adequate. It appears that facilities have become more efficient under the new payment method as measured by declining use of injectable dialysis drugs between 2010 and 2013.

RECOMMENDATION 6

The Congress should eliminate the update to the outpatient dialysis payment rate for calendar year 2016.

RATIONALE 6

Most of our indicators of payment adequacy are positive, including beneficiaries’ access to care, the supply and capacity of providers, volume of services, quality of care, and access to capital. Providers have become more efficient in the use of dialysis drugs under the new payment system. The Medicare margin was 4.3 percent in 2013 and is projected to be 2.4 percent in 2015.

IMPLICATIONS 6

Spending

- In 2016, the statute sets the payment update at the market basket, net of the productivity adjustment, minus 1.25 percentage points. We expect that the Commission’s recommendation would lower federal program spending relative to the statutory update by between \$50 million and \$250 million over one year and by less than \$1 billion over five years.

Beneficiary and provider

- This recommendation may increase the financial pressure on providers but, overall, is expected to have a minimal effect on reasonably efficient providers’ willingness and ability to care for Medicare beneficiaries. We do not anticipate any negative effects on beneficiary access to care. ■

Endnotes

- 1 The term *dialysis drugs* refers to the medications used to treat ESRD.
- 2 In this chapter, the term *beneficiaries* refers to individuals covered by Medicare and *patients* refers to individuals who may or may not be covered by Medicare.
- 3 In this chapter, the term *providers* refers to freestanding and hospital-based dialysis facilities. Technically, under Medicare law, freestanding dialysis facilities are suppliers and hospital-based dialysis facilities are providers.
- 4 Age groups are 19 years or younger, 20 to 44 years, 45 to 64 years, 65 to 74 years, and 75 years or older.
- 5 For individuals entitled to Medicare based on ESRD, Medicare coverage does not begin until the fourth month after the start of dialysis, unless the individual had a kidney transplant or began training for self-care, including those dialyzing at home.
- 6 In 2011, most dialysis facilities (about 93 percent) elected to be paid under the new PPS instead of the four-year transition rate.
- 7 Medicare pays dialysis facilities for uncollected deductibles and coinsurance (bad debt). Medicare paid 100 percent of allowable bad debt in fiscal year (FY) 2012, 88 percent in FY 2013, 76 percent in FY 2014, and will pay 65 percent in FY 2015 and beyond. Before FY 2012, Medicare capped bad debt reimbursement at a facility's unrecovered costs.
- 8 In addition to implementing the 2014 drug utilization adjustment, CMS implemented the statutory update of the base payment rate (by the market basket less the productivity offset) and other positive (regulatory) policy changes. These statutory and regulatory changes resulted in an overall impact of 0 percent compared with total payments in 2013.
- 9 According to CMS's *Provider Reimbursement Manual*, a chain organization consists of a group of two or more health care facilities or at least one health care facility and any other business or entity owned, leased, or, through any other device, controlled by one organization (Centers for Medicare & Medicaid Services 2012).
- 10 These drug classes accounted for nearly all dialysis drug spending (about 97 percent) in 2010, the year before the start of the new payment method.
- 11 Because units vary from drug to drug, we created a standard metric—the product of each drug's unit per treatment and 2014 average sales price—to measure changes in the use across all dialysis drugs.
- 12 Anemia is measured by a blood test to check the level of hemoglobin, the protein that carries oxygen in red blood cells.
- 13 Blood transfusions are of concern to patients because they (1) carry a small risk of transmitting blood-borne infections to the patient, (2) may cause some patients to develop a reaction, and (3) are costly and inconvenient to patients. Blood transfusions are of particular concern for patients seeking kidney transplantation because they increase a patient's alloantigen sensitization, which can require a patient to wait to receive a transplant.
- 14 KDE services were most frequently provided by nephrologists, nurse practitioners, or physician assistants in an office setting. MIPPA does not permit dialysis facilities to bill for KDE services. This analysis used 100 percent of 2011 through 2013 carrier and outpatient claims submitted for KDE services.

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C H A P T E R

7

**Medicare's post-acute care:
Trends and ways to
rationalize payments**

R E C O M M E N D A T I O N

- 7** The Congress should direct the Secretary of Health and Human Services to eliminate the differences in payment rates between inpatient rehabilitation facilities (IRFs) and skilled nursing facilities for selected conditions. The reductions to IRF payments should be phased in over three years. IRFs should receive relief from regulations specifying the intensity and mix of services for site-neutral conditions.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

Medicare's post-acute care: Trends and ways to rationalize payments

Chapter summary

Post-acute care (PAC) providers offer important recuperation and rehabilitation services to Medicare beneficiaries recovering from an acute hospital stay. PAC providers include skilled nursing facilities (SNFs), home health agencies (HHAs), inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCHs). Medicare's payments to the more than 29,000 PAC providers totaled \$59 billion in 2013, more than doubling since 2001.

The Commission has frequently observed that Medicare's payments for PAC are too generous and that its payment systems have shortcomings. The high level of payments results both from base rates that are generous relative to the actual cost of services and from weaknesses in the payment systems that encourage providers to increase payments by strategically conducting patient assessments, increasing the amount of therapy they provide, and selecting certain types of patients over others. There is also significant variation in financial performance within categories of providers (e.g., ownership, freestanding vs. hospital based). Biases in the HHA and SNF prospective payment systems make certain patients, and the services provided to them, more profitable than others. Meanwhile, quality of care, as measured by the Commission, has not considerably improved, raising questions about the value of the program's purchases. In addition, providers' costs per unit of service vary enormously. Medicare has a responsibility to better its payment systems to ensure access for beneficiaries, appropriately reimburse providers for the

In this chapter

- Trends in post-acute care
- Site-neutral payments for select conditions treated in inpatient rehabilitation facilities and skilled nursing facilities
- Private sector ideas for managing post-acute care
- Conclusion

patients they treat, and control costs for the beneficiary and taxpayer alike. It is up to providers to address their cost per unit of care.

But the Commission's concerns about PAC go beyond the shortcomings of the setting-specific payment systems. The need for PAC is not well defined. Similar patients are treated in different settings at widely varying cost to the Medicare program. Placement decisions often reflect local practice patterns, the availability of PAC in a market, patient and family preferences, and financial arrangements between a PAC provider and the referring hospital. Reflecting this ambiguity, Medicare per capita spending on PAC varies more than any other covered service, which is only partly explained by the large differences in the availability of LTCHs and IRFs across markets.

Because PAC can be appropriately provided in a variety of settings, Medicare ideally would pay for PAC using one payment system with payments based on patient characteristics, not on the site of service. Such fundamental payment reforms within fee-for-service (FFS) Medicare are on the distant horizon. The Commission recommended that CMS collect common patient assessment data from the PAC settings to enable more complete comparisons of providers' costs and outcomes. Under the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014, PAC providers will begin collecting uniform assessment data in 2018. After the Secretary of Health and Human Services has collected two years of data, she is required to submit a report to the Congress recommending a uniform payment system for PAC. The IMPACT Act also requires the Commission to develop a prototype prospective payment system spanning the PAC settings, using the uniform assessment data gathered previously during CMS's Post-Acute Care Payment Reform Demonstration (completed in 2011). The Act requires the Commission to submit a report in 2016 presenting an approach for a cross-setting PAC payment system.

In the near term, the Commission maintains that Medicare can and should move in the direction of uniform payments by aligning payments across settings for select conditions. Consistent with the Commission's approach to site-neutral payments in the ambulatory and acute care sectors, the Commission used criteria to identify conditions that may be appropriate for site-neutral payments between IRFs and SNFs. For the select conditions, the majority of cases are treated in SNFs and the risk profiles of patients treated in IRFs and SNFs are similar, yet Medicare's payments made to IRFs are considerably higher than those made to SNFs. To ensure that it proceeded cautiously, the Commission also examined differences in outcomes for patients treated in both settings. Because PAC providers do not collect uniform patient assessment information, it is difficult to compare outcomes. Key

measures (such as changes in patients' function) are not uniformly collected and cannot be adequately risk adjusted. However, neither CMS's PAC demonstration, which gathered comparable data, nor other research has found consistent differences in outcomes between the two settings. Where differences in outcomes have been detected, researchers concede that the comparisons cannot fully control for selection differences between the settings.

The Commission recommends that the Congress direct the Secretary to establish site-neutral payments between IRFs and SNFs for select conditions, using criteria such as those the Commission examined. For the selected conditions, the Commission recommends that the IRF base payment rate be set equal to the average SNF payment per discharge for each condition. The additional payments many IRFs receive for teaching programs and treating low-income patients and high-cost outliers are not changed by this policy. The policy should be implemented over three years to give IRFs time to adjust their cost structures and to give policymakers time to monitor the effects of the change on beneficiaries and providers. As part of the policy, IRFs should be relieved from the regulations governing the intensity and mix of services for the site-neutral conditions. CMS should use its rule-making process to first propose criteria to select conditions appropriate for a site-neutral payment policy and then to identify conditions that would be subject to the site-neutral policy. In this way, the Secretary can gather input from key stakeholders.

The Commission has also considered private sector strategies that FFS Medicare could pursue to direct beneficiaries to higher quality, more cost-effective providers. Although FFS Medicare is more limited in the tools it can use to manage care, certain options could be explored that shift use toward high-value providers while respecting beneficiaries' freedom of choice. ■

Trends in post-acute care

Post-acute care (PAC) providers offer important recuperation and rehabilitation services to Medicare beneficiaries recovering from an acute hospital stay. PAC providers include skilled nursing facilities (SNFs), home health agencies (HHAs), inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCHs). Among beneficiaries enrolled in fee-for-service (FFS) Medicare and discharged from an acute care hospital in 2013, 42 percent went on to post-acute care: 20 percent were discharged to a SNF, 17 percent were discharged to an HHA, 4 percent were discharged to an IRF, and 1 percent were discharged to an LTCH. Medicare is the dominant payer in all but the SNF setting; it is a minority payer in SNFs because most SNFs are predominantly nursing homes providing long-term care, which Medicare does not cover.

Medicare's outlays for PAC are substantial. In 2013, Medicare paid for 9.6 million PAC encounters (IRF and LTCH discharges, home health episodes, and SNF stays) to more than 29,000 PAC providers. Between 2001 and 2012, program payments to PAC providers doubled to \$59 billion. Yet despite this heavy investment, the need for PAC is not well defined, and Medicare gives providers considerable latitude in delineating which patients they admit among the patients referred to them by hospitals. Placement decisions often reflect a variety of nonclinical factors such as local practice patterns, the availability of PAC in a market, patient and family preferences, and financial arrangements between a PAC provider and the referring hospital (Buntin 2007). Reflecting this ambiguity, Medicare per capita spending on PAC varies more than any other covered service, which is only partly explained by the large differences in the availability of LTCHs and IRFs across markets. The Commission and others have noted that similar patients are treated in different settings with widely varying program payments, reflecting the separate systems Medicare uses to establish payments for each setting (Gage et al. 2011, Medicare Payment Advisory Commission 2014a).¹

Complicating the comparison of patients, outcomes, and costs of care across PAC settings is the lack of uniform assessment information about the patients treated in the various PAC settings. In 2014, the Commission recommended that PAC providers gather uniform assessment information from all four settings, which the Congress mandated in the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014. These data

are critical to evaluating providers' selection practices, costs, and outcomes.

The most notable trend in the program's spending across PAC settings is the high and sustained level of Medicare margins (a measure that compares program payments with the costs to treat its beneficiaries) relative to other settings. For example, Medicare margins for HHAs and SNFs have been above 10 percent every year since 2001. Consistently high Medicare margins indicate that program payments are set too high relative to the costs of treating Medicare beneficiaries and are thus a poor use of taxpayer dollars. Another signal that payment rates are too high is the growth in the number of for-profit providers, especially among HHAs. Although the overall number of IRFs and SNFs has not increased, the share of for-profit providers in these industries has climbed.

Another trend in Medicare PAC is the wide variation in Medicare margins. Across all PAC settings, Medicare margins are higher in for-profit facilities compared with nonprofit facilities, and in freestanding providers compared with hospital-based providers. The disparity in margins reflects very different costs per unit of service. In general, larger, freestanding, for-profit facilities have lower unit costs (after controlling for differences in case mix and wages) than smaller, hospital-based, nonprofit facilities. Larger, freestanding providers may be able to achieve more economies of scale. In addition, for-profit entities may be more focused than their nonprofit counterparts on controlling costs so as to maximize returns to investors. In general, Medicare policy should not subsidize providers' inefficiencies except to ensure access (for example, in remote rural locations).

Across all settings, the margin trends are consistent with some providers maximizing revenues by taking advantage of payment system rules and shortcomings. These revenue approaches include strategically assessing patients to take advantage of the case-mix groups, providing additional (potentially unnecessary) therapy to increase revenues (in the case of SNFs and HHAs), and admitting patients who may not need the setting's intensity of care. Further, in HHAs and SNFs, the prospective payment system (PPS) designs result in payments for therapy services that are much higher than these services' costs. As a result, providers benefit financially when they furnish therapy services that may not be medically necessary. The Commission recommended revisions to the SNF and HHA payment systems that would redistribute payments across different types of cases and dampen the

incentives to select certain patients over others and to provide care for financial rather than clinical reasons. The Commission also recommended, and the Congress has partly implemented, revisions to the LTCH PPS to lower payments for patients who are not chronically critically ill.

Despite the large increase in program spending on PAC, quality has not consistently improved among the settings and the measures the Commission tracks. Improvements have generally been nominal or nonexistent. For example, across the measures the Commission tracks, SNF quality did not substantially improve for many years; more recent trends indicate improvements in some measures and no change in others. Similarly, in home health care, there have been improvements in functional change but no improvement in hospitalization rates. IRFs have achieved nominal improvements in quality, while observed LTCH measures have been stable or slightly improved. These lackluster results raise questions about the value of Medicare's purchases of PAC.

The Commission works to improve Medicare's payments for PAC in several ways. First, through its annual review of payment adequacy and its recommendations to revise the Medicare PPSs, the Commission seeks to establish an aggregate level of payments commensurate with the cost to efficiently treat beneficiaries, as well as a more equitable distribution of payments across types of cases, to help ensure access for beneficiaries. Second, to align incentives and improve care across settings, the Commission has recommended penalties to HHAs and SNFs with high readmission rates. These policies would align PAC providers' interests with those of hospitals and support the already growing interest in hospitals and accountable care organizations (ACOs) partnering with high-quality PAC providers. The Congress enacted a SNF readmission policy to begin in 2018.

While these revisions within individual PAC settings will increase the value of Medicare's purchases, the Commission's primary concern is that having separate payment systems for post-acute care does not facilitate rational pricing, encourage coordinated care, or establish a set of consistent incentives across providers. The patient populations in the four PAC settings overlap to some extent, and some PAC services are offered in more than one setting. Yet, because the payment systems differ, Medicare has different prices for similar patients based on the site of service. The Commission believes that Medicare needs a more uniform approach to payment for PAC and continues to make recommendations toward this goal. Uniform

patient assessment data are needed for Medicare to develop a common PAC payment system. The recently enacted IMPACT Act includes new requirements for uniform data collection beginning in 2018. After the Secretary of Health and Human Services has collected data for two years, she is required to submit a report to the Congress recommending a uniform payment system for PAC. The Act also requires the Commission to develop a prototype PPS to span the PAC setting using data CMS gathered during its PAC demonstration and to report to the Congress in July 2016. Given the timing of the data gathering and analysis, the implementation of a uniform payment system could be achieved in 2023 at the earliest. In the near term, carefully crafted site-neutral policies can begin the process of establishing one price for similar patients, regardless of the setting in which the care is provided.

Site-neutral payments for select conditions treated in inpatient rehabilitation facilities and skilled nursing facilities

The Commission's annual review of Medicare payment adequacy for FFS providers has two objectives: (1) to recommend an appropriate aggregate level of payments using the update and (2) to ensure that payments are equitable across providers and patients. As a prudent purchaser, the program should not pay more for care in one setting than in another if the care can be provided safely in a lower cost setting. Rather than base its payments on the setting in which a beneficiary is treated, Medicare should base its payments on the resources needed to treat patients in the most efficient setting, adjusting for patient severity differences that could affect providers' costs. Even as Medicare moves toward integrated payment and delivery systems, the FFS payments underlying these reforms should reflect the most cost-effective site of care.

Price differentials based on site of service create distortions in provider incentives. For example, previous Commission analyses found that when hospital outpatient department payments are not aligned with rates paid for the same services in a physician's office, hospitals have an incentive to acquire physician practices and bill for these services at the higher hospital outpatient rate, increasing program spending and out-of-pocket costs for beneficiaries. Thus, the Commission has recommended a reduction or elimination of price differences for office

visits and selected ambulatory services provided in physicians' offices and hospital outpatient departments. The Commission also has recommended that payments to long-term care hospitals for non-chronically critically ill patients should be equal to those for comparable patients in acute care hospitals (Medicare Payment Advisory Commission 2014b, Medicare Payment Advisory Commission 2012).

In June 2014, the Commission reported on its analysis of payment differences for select services provided by SNFs and IRFs (Medicare Payment Advisory Commission 2014a). While both settings furnish rehabilitation services to beneficiaries after a hospitalization, there are several important differences in the way Medicare pays for SNF and IRF services (see online Appendix 7-A, available at <http://www.medpac.gov>). Medicare pays for patients admitted to SNFs on a per day basis, but pays on a per discharge basis for patients admitted to IRFs.² Many IRFs receive separate payments for teaching, disproportionate share, or outliers, whereas SNFs do not. In addition, IRFs must meet a threshold compliance regarding the facility's mix of cases; SNFs do not have this requirement. In addition, each setting has different services and requirements (see online Appendix 7-A, available at <http://www.medpac.gov>). IRFs are licensed as hospitals and have more extensive requirements regarding the amount of therapy and the frequency and level of medical supervision their patients receive. IRF patients must be able to tolerate and are expected to benefit from an intensive therapy program (often interpreted as requiring three hours of therapy a day). IRF requirements may cut in opposite ways for patient referrals. On the one hand, patients who require additional nursing or physician care may be more likely to go to IRFs; on the other hand, patients must be able to tolerate intensive therapy.

The Commission found that for selected conditions, IRFs and SNFs care for patients with similar risk profiles, despite differences in the mix of services provided and Medicare's facility requirements. Often, SNFs care for more severely ill patients, most likely because of the intensive therapy requirement for IRF patients. Our research and analysis did not consistently find differences in patient outcomes. Yet, Medicare's spending for beneficiaries who used IRFs was more than 60 percent higher than for comparable patients who used SNFs during the initial PAC stay, and IRF patients continued to have higher spending during the 30 days after discharge from facilities. Since SNF and IRF patients are often similar but do not uniformly have different outcomes, it

is not clear what Medicare is purchasing with its higher IRF payments. In some cases, the disparity in Medicare's payments for patients treated in IRFs and SNFs could influence providers' decisions about settings of care and may result in excessive program spending.

Identifying conditions for site-neutral payments

To identify possible conditions and services for site-neutral policies, the Commission used a consistent set of criteria previously described (Medicare Payment Advisory Commission 2014a). We examined conditions for which the majority of patients were treated in SNFs in markets (defined as hospital service areas) with both types of providers.³ In addition, we compared the risk profiles of patients treated in both settings to assess whether SNFs treat the same complexity as patients referred to IRFs. To err on the side of caution, we also examined differences in outcomes. Ideally, we would compare risk-adjusted outcomes, but the Commission recognizes that this information is often not available.

In the Commission's June 2014 Report to the Congress, we examined three high-volume conditions: major joint replacement, hip and femur procedures, and stroke (Medicare Payment Advisory Commission 2014a). The majority of beneficiaries recovering from the orthopedic conditions were treated in SNFs. These patients were similar to orthopedic patients in IRFs in terms of their average risk scores, age, comorbidities, functional status at admission, predicted cost for therapy and nontherapy ancillary services, and eligibility for Medicaid as well as Medicare.

The Commission's analysis of stroke as a potential condition for site-neutral payment was inconclusive. Stroke severity can vary widely, and patients with stroke may suffer from a wide range of comorbidities. We found that, although similar or larger shares of patients treated in SNFs had comorbidities, IRFs treat the majority of stroke patients. Therefore, at this time, the Commission did not include stroke in a site-neutral policy (see online Appendix 7-A, available at <http://www.medpac.gov>, for a discussion of the stroke results), although it is possible that a subset of stroke cases could be considered in the future.

In our consideration of the two orthopedic conditions for a site-neutral policy, we also compared outcomes for patients treated in the two settings. The differences were mixed, in large part because not all the measures were risk adjusted. CMS's PAC demonstration found that

risk-adjusted rates of readmission and changes in patient mobility were comparable, and while IRFs had larger improvements in patients' self-care across all types of cases, their gains were comparable with patients treated in SNFs for musculoskeletal conditions. Spending during the 30 days after discharge from an IRF was higher than the spending after discharge from a SNF. Unadjusted mortality rates were lower for IRFs, but differences would narrow with risk adjustment. The Commission concluded that the two orthopedic conditions (represented by five Medicare severity–diagnosis related groups (MS–DRGs)) would be a good starting point for site-neutral payments.

To identify additional conditions for consideration, we examined conditions frequently treated in IRFs but for which the majority of patients are treated in SNFs (Table 7-A1 in online Appendix 7-A, available at <http://www.medpac.gov>).⁴ Seventeen conditions met the criterion of having the majority of cases treated in SNFs; the MS–DRGs comprised other orthopedic, pulmonary, cardiac, and infection conditions. They make up about 17 percent of IRF cases and spending. When the 17 conditions are combined with the 5 orthopedic conditions we previously reported on in June 2014, the share of spending and cases increases to 30 percent of total IRF spending and cases.

There are large payment differences for the patients treated in IRFs and SNFs for the conditions we examined. On a per stay basis, total Medicare payments in 2012 (including the add-on payments made to many IRFs) averaged 64 percent higher for patients treated in IRFs compared with those treated in SNFs.⁵ Excluding these add-on payments, IRF payments were 49 percent higher than those made to SNFs (Table 7-A2 in online Appendix 7-A, available at <http://www.medpac.gov>).

Similarity of patients treated in IRFs and SNFs

To assess the similarity of risk profiles of patients treated in IRFs and SNFs, we compared their demographics and comorbidities. In markets with both IRFs and SNFs, patients treated in SNFs were older and more likely to be female or dually eligible for Medicare and Medicaid compared with patients treated in IRFs (Table 7-A3 in online Appendix 7-A, available at <http://www.medpac.gov>). In 2012, either the patients treated in IRFs and SNFs had similar Medicare risk scores (the hierarchical condition categories, or HCCs) or the patients treated in SNFs had higher scores (Table 7-A4 in online Appendix 7-A, available at <http://www.medpac.gov>). The most common comorbidities either were more frequent in SNFs or were similar between the two settings (Table 7-A5 in online

Appendix 7-A, available at <http://www.medpac.gov>). Across the conditions, SNFs typically treated the majority of the most severely ill patients, as measured by the severity of illness at discharge from the hospital using all-patient refined–severity of illness levels (Table 7-A6 in online Appendix 7-A, available at <http://www.medpac.gov>). We also compared the severity of illness of patients treated in SNFs in markets with and without IRFs and found them to be similar, suggesting that, for the select conditions, SNFs treat comparable severity mixes of patients, regardless of whether there is an IRF in the market. Finally, CMS's PAC demonstration found considerable overlap in the functional status at admission between patients admitted to SNFs and IRFs (the patients in their analysis spanned all conditions, not just the 17 studied here). We conclude that for the selected conditions, SNFs can treat patients who are discharged to IRFs, and in markets without IRFs, they do.

Outcomes for patients treated in IRFs and SNFs

It is difficult to compare outcomes for patients treated in different settings because of the lack of comparable assessment information about patients' function and cognitive abilities at admission and at the end of treatment. This type of analysis is exactly the reason the Commission recommended the collection of uniform information across PAC settings, which the Congress mandated in 2014. Even with comparable data, there is no way to fully control for the selection of certain types of patients by providers, which is reinforced by program requirements. We fully expect to see differences in outcomes between IRFs and SNFs because IRFs tend to treat healthier patients who must be able to tolerate intensive therapy.

But to proceed cautiously, we compared four outcomes for SNFs and IRFs—hospital readmission rates, changes in functional status, mortality rates, and total Medicare spending during the 30 days after discharge from the qualifying stay—and examined the literature comparing outcomes across the two settings (see text box on outcomes, pp. 168–169). The comparisons yielded mixed results, in part because some of the measures were not risk adjusted. Ideally, all measures would be risk adjusted, but the data needed for risk adjustment were not always available, and even when they were, we could not fully control for differences in patient mix because of selection.

Observed differences in readmission rates for IRF and SNF patients were effectively eliminated with risk adjustment. The PAC demonstration conducted by CMS gathered comparable patient assessment information for beneficiaries treated in participating SNFs and IRFs and enabled careful,

cross-setting study of the patients and their outcomes. The evaluation found that risk-adjusted readmission rates and changes in patients' mobility were comparable between the two settings across all patients and for the four subgroups of patients examined (nervous system, respiratory, circulatory, and musculoskeletal) (Gage et al. 2011). Changes in self-care were larger for patients treated in IRFs compared with patients treated in SNFs, although there was no difference between the settings for the musculoskeletal patients. An IRF-industry sponsored study of 13 groups of conditions found that differences in readmission rates varied by condition group (DaVanzo et al. 2014).

Some researchers have focused on comparing mortality rates of patients treated in both settings. We examined mortality rates without risk adjustment during the SNF and IRF stays and during the 30 days after discharge and found that both were higher for patients treated in SNFs compared with patients treated in IRFs. The difference in rates partly reflects differences in the patient populations: SNF patients were older and often had more comorbidities. It is likely the differences would be much smaller after risk adjustment, but we would expect some differences to remain. Each setting's mortality rates reflect inherent differences in the patient population. Because IRF patients must be able to tolerate and benefit from intensive therapy, we would expect their mortality rates to be very low. Furthermore, because post-acute services are restorative, not curative, it is not the best measure of outcomes for these settings. The IRF industry-sponsored study found that compared with IRFs, SNFs had higher mortality rates during the two years after discharge (DaVanzo et al. 2014). Given the differences between the populations, we would expect patients treated in SNFs to be more likely to die within the next two years compared with patients treated in IRFs.

Finally, we examined Medicare spending during the 30 days after discharge from IRFs and SNFs. We found that program spending was 7 percent higher for beneficiaries discharged from IRFs than for beneficiaries discharged from SNFs. Although IRF patients had considerably lower costs for readmission, they had much higher subsequent PAC spending, perhaps because patients continued to need rehabilitation (see Table 7-A7 in online Appendix 7-A, available at <http://www.medpac.gov>).

Establishing a site-neutral policy for IRFs and SNFs

Ideally, Medicare would pay for PAC using a single payment system that based payments on patient

characteristics, not the site of service. Such fundamental payment reforms within FFS Medicare are on the distant horizon. As required by the IMPACT Act of 2014, the Commission is developing a prototype prospective payment system to span the PAC settings using the uniform assessment data gathered as part of CMS's PAC payment demonstration. The law also requires PAC providers to submit patient assessment data using a uniform assessment tool beginning in 2018 and requires the Secretary of Health and Human Services to recommend a uniform payment system for PAC based on two years of uniform patient assessment data. Thus, a new PAC payment system is unlikely to be in place until 2023 at the earliest.

However, the Commission believes that Medicare should not delay reforms that encourage cost-effective care. Even as Medicare moves toward integrated payment and delivery systems, Medicare can and should move in the direction of uniform payments by establishing a site-neutral policy for IRFs and SNFs to align payments across the two settings for select conditions. For each condition selected, the Commission's site-neutral policy would set the IRF base payment at the average rate paid to SNFs for patients with that condition.⁶ Specifically, CMS would replace the IRF base rate with the average payment per discharge for the same case type for a SNF in the same geographic location. The policy would not change the additional payments many IRFs receive for teaching programs and treating low-income patients and high-cost outliers. At the same time, for patients with conditions paid under the site-neutral policy, IRFs would be relieved of certain regulatory requirements that govern patient care, such as the requirement for intensive therapy, the frequency of physician visits, and the physician-conducted preadmission screening and the postadmission evaluation.⁷ Waiving these requirements would lower IRFs' costs of treating patients with site-neutral conditions. (Regulatory requirements for IRFs would remain the same for conditions not affected by the site-neutral policy.) To identify candidate conditions for a site-neutral policy between IRFs and SNFs, Medicare should establish a set of criteria that considers how frequently the condition is treated in SNFs and the similarity of the risk profile. Outcomes should also be compared to ensure that they do not substantially differ between the two settings.

For conditions not affected by the site-neutral policy, CMS should refine and recalibrate the IRF case-mix groups (CMGs), establish new average standardized costs for the non-site-neutral cases, and recalibrate the weights associated with each CMG. The selection of

Comparing outcomes of rehabilitation care in skilled nursing facilities and inpatient rehabilitation facilities

Researchers and policymakers have frequently sought to compare outcomes for patients treated in different post-acute care settings. Such comparisons are generally compromised by a lack of comparable assessment information about patients' function and cognitive abilities at admission and at the end of treatment. Even with comparable data, there is no way to fully control for the patient selection by providers—selection that is reinforced by program requirements such as the requirement that patients admitted to inpatient rehabilitation facilities (IRFs) be able to tolerate and benefit from intensive therapy.

Studies of costs and outcomes of patients treated in skilled nursing facilities (SNFs) compared with IRFs have largely focused on patients needing rehabilitation following a stroke, hip fracture, or joint replacement. Overall, research studies do not conclusively identify a particular post-acute care setting as having better outcomes for rehabilitation patients. Studies of patients after joint replacement and hip fracture do not have consistent conclusions (Buntin et al. 2010, Dejong et al. 2009a, DeJong et al. 2009b, Deutsch et al. 2006, Deutsch et al. 2005, Herbold et al. 2011, Mallinson et al. 2014, Mallinson et al. 2011, Munin et al. 2005, Walsh and Herbold 2006). Studies of stroke patients found that patients in IRFs had better outcomes than those in SNFs, though selection bias could have contributed to these findings (Buntin et al. 2010, Deutsch et al. 2006).

A 2010 CMS report to the Congress analyzed peer-reviewed research on the effectiveness of IRFs compared with other post-acute care settings and concluded that many studies are limited because they do not adequately control for selection bias (Gage et al. 2010). The report also found inconsistent results across studies comparing outcomes for lower extremity joint replacement patients and hip fracture patients in IRFs and SNFs. The report was unable to conclude definitively whether shifts in discharge destination due to the IRF compliance threshold have affected beneficiaries' access to appropriate rehabilitation services. The ambiguous results of these studies may also suggest that reasonable treatment approaches may differ across beneficiaries. Some patients may be more appropriate for longer stays in less intensive settings while others benefit from shorter, more intensive therapy (Stineman and Chan 2009).

Standardized data from the Continuity Assessment Record and Evaluation (CARE) tool—a uniform post-acute care assessment tool tested through the Medicare Post-Acute Care Payment Reform Demonstration (PAC-PRD)—can help CMS compare outcomes for rehabilitation care across settings. The demonstration used the CARE tool to compare outcomes across sites of care, including readmission to the hospital and improvements on two functional measures, mobility and self-care function. The 2011 report summarizing the findings compared outcomes among IRFs, SNFs, home health agencies, and long-term care hospitals

(continued next page)

the final conditions for a site-neutral policy may remove certain CMGs entirely from the IRF PPS or remove select conditions within a CMG. Because the waiving of certain regulations for treating the site-neutral conditions may lower the costs of the site-neutral cases, the cost of cases remaining under the IRF PPS could increase relative to the average cost, even if actual cost is unchanged. Thus, without recalibration, payments for cases remaining under the IRF PPS could increase simply as a result of the site-neutral policy. Recalculating the relative weights for the cases remaining under the IRF PPS is a way to retain

budget neutrality for these cases; aggregate IRF payments for them would be held to the same aggregate payments these cases receive currently. Such recalibration is typically undertaken by CMS when new case-mix systems are implemented.

A set of relative weights would be estimated using all cases to retain add-on payments at current levels for all cases. IRF PPS add-on payments for teaching program status and share of low-income patients would be calculated by multiplying the applicable IRF teaching and low-income percentages by the wage- and case-

Comparing outcomes of rehabilitation care in skilled nursing facilities and inpatient rehabilitation facilities (cont.)

(Gage et al. 2011). Risk-adjusted readmission rates that controlled for differences in patient acuity did not differ significantly between IRFs and SNFs.

On functional outcomes, the risk-adjusted analysis of data from the PAC-PRD found no significant difference in the average degree of improvement in mobility, but did find a somewhat higher gain in self-care outcomes among patients who received care from IRFs compared with patients treated in SNFs (Gage et al. 2011). But differences in outcomes varied by clinical condition. The demonstration study examined improvement in self-care for the subgroups of patients with musculoskeletal and nervous system conditions, two conditions for which beneficiaries typically receive significant amounts of therapy. For nervous system conditions, the average risk-adjusted gain in self-care improvement was higher in IRFs than in SNFs. In contrast, for musculoskeletal conditions, there was no significant difference in the risk-adjusted degree of improvement between IRF and SNF patients. Where results varied, the difference in improvement among settings was relatively small, less than 5 points on a 100-point scale.

Although the PAC-PRD was able to control for differences in patients to a degree unparalleled by most other research, the study did not randomly assign patients to post-acute care settings, so unobserved factors regarding patient characteristics may have remained and influenced outcomes. For example, the more intensive therapy requirements in IRFs may have resulted in IRFs attracting patients who were more engaged or more motivated to improve. Likewise, factors such as informal

caregiver support that were not included in the model could have influenced both the likelihood of referral to different post-acute care providers and patient outcomes.

There is very little literature comparing outcomes across many conditions. An industry-sponsored study compared several outcomes of patients treated in IRFs and SNFs and found differences across conditions (DaVanzo et al. 2014). To risk adjust the comparisons of the outcomes, the study matched various characteristics of the IRF patients to the patients treated in SNFs, though measures of function were not among the adjusters. Of the various groupings of conditions the study examined, six overlapped with those considered by the Commission. Hospital readmission rates were not consistently better for patients treated in IRFs: They were lower for two condition groups, higher for one, and no different for three condition groups. Four measures—mortality rates, average days alive (a corollary of mortality rate), days residing at home, and program spending—examined outcomes over two years. Given the differences in ages and comorbidities between patients treated in IRFs and SNFs, the study unsurprisingly found that IRFs had lower mortality rates and more days alive, while there were no differences in the number of days patients resided at home between the two settings for patients with hip or knee replacement or other orthopedic condition groups. Emergency room visits per 1,000 patients were no different between the 2 settings for 5 of the 6 conditions, and IRFs had fewer ER visits than SNFs for 1 condition. The spending over two years was higher for patients treated in IRFs for four condition groups and no different for two. ■

mix-adjusted IRF rate. For site-neutral cases with extraordinarily high costs, an outlier payment would be calculated using the IRF PPS fixed loss amount.

Revising the IRF compliance requirements

The implementation of site-neutral payment for IRFs and SNFs would necessitate changes to the IRF compliance rule. The intent of this rule is to distinguish IRFs from acute care hospitals (not from SNFs). Currently, to qualify as an IRF for Medicare payment, facilities must meet a compliance threshold (the “60 percent rule”)

requiring that a certain proportion of all patients have 1 of 13 conditions specified by CMS as typically requiring intensive rehabilitation. An IRF’s compliance rate is calculated by dividing the total number of compliant conditions (the numerator) by the total number of cases (the denominator). Some of the conditions that meet the Commission’s criteria for site-neutral payment—such as hip fracture and amputations—are among CMS’s list of compliant conditions. If patients with these conditions can be treated appropriately in SNFs, they likely do not require the intensity of the IRF setting. Thus, conditions that are

appropriate for site-neutral payment should not count toward the 60 percent rule. Furthermore, the Commission has commented before that more refined criteria are needed to identify patients appropriate for IRFs (Medicare Payment Advisory Commission 2013). The criteria have already narrowed the hip and knee replacement cases and arthritis conditions that count toward the 60 percent rule. Likely there are subsets of other conditions that are appropriate for IRF care and should count toward IRF compliance; conversely, others are not appropriate for IRF care and should not count. The Commission believes that detailed criteria should be developed for all 13 conditions under the 60 percent rule.

The site-neutral policy is not intended to make it more difficult for IRFs to maintain compliance, but this unintended consequence could result if the current threshold policy were not refined. Under a site-neutral policy, the fairer way to calculate the compliance rate would be to remove the site-neutral cases from the numerator and denominator; however, mathematically, this change would lower a facility's compliance rate. Thus, reducing the conditions that count toward the compliance threshold could necessitate a reduction in the threshold itself. For example, nine of the conditions we identified as candidates for a site-neutral policy are among the specified conditions counting toward the 60 percent compliance threshold. If these conditions were selected for site-neutral payment, CMS would calculate each IRF's compliance threshold by subtracting the number of IRF cases with the nine conditions from both the numerator and the denominator. Removing these cases from the calculation would lower the share of cases meeting the compliance threshold; policymakers therefore might consider lowering the compliance threshold correspondingly. Any change to the compliance threshold should be empirically based, with consideration of the set of conditions selected for site-neutral payments and whether those conditions currently count toward threshold compliance. Consistent with current practice, IRFs are likely to continue to treat cases that do not count toward compliance, keeping the share of noncompliant cases below the threshold so they retain their status to be paid as an IRF for conditions unaffected by the site-neutral policy. For facilities treating a large share of site-neutral cases, CMS would need to consider whether they continued to meet the IRF conditions of participation.

Likely effects of a site-neutral policy on program spending

We assessed the impact of a site-neutral policy on payments for the 17 conditions the Commission

considered candidates for the policy in addition to the orthopedic conditions (5 MS-DRGs) previously identified. A site-neutral policy would lower total program spending (including the add-on payments) for the 22 conditions by 7 percent.⁸ The impact on total payments is tempered by two factors. First, the conditions represent a minority of IRF cases. Second, the policy assumes site-neutral payments would not change the add-on payments many IRFs receive for the site-neutral conditions. In 2012, the estimated reductions to aggregate IRF base payments would have totaled \$497 million: \$309 million for the 17 additional conditions and \$188 million for the 5 orthopedic conditions. If a different set of conditions were selected for site-neutral policy, the impact would be different.

Like many major changes to payment policy, the site-neutral policy should be phased in over multiple years. This time frame would give IRFs time to adjust their cost structures and admitting practices and would give policymakers time to evaluate the initial effects of the policy. The Commission considered a period of three years for fully transitioning payments for site-neutral conditions, a time period used in other policies. During the transition, payments for site-neutral conditions could be a blend of IRF and SNF payments, such as a 75 percent IRF/25 percent SNF blend in the first year, a 50/50 blend in the second year, and a 25/75 blend in the third year, with site-neutral payments fully implemented in the fourth year.

The effects on spending assume the current SNF PPS. The Commission has recommended that the SNF PPS be revised so that payments are based on patient characteristics, not the amount of therapy provided. Under the proposed design, payments would be higher for patients whose clinical and functional characteristics increase their need for services. The proposed redesign is assumed to be budget neutral, so that aggregate SNF payments would be the same as under current policy. Our prior work found that the site-neutral effects on IRFs would not be substantially different under a revised SNF PPS (Medicare Payment Advisory Commission 2014a). Differences in effects between current SNF policy and the proposed redesign would depend on the final selection of conditions for the site-neutral policy.

Likely effects of site-neutral payments on IRF patient mix and volume

We cannot estimate how IRF costs, patient mix, and volume would change in response to a site-neutral policy.

With greater regulatory flexibility to adjust their service intensities, IRFs are likely to continue to treat site-neutral conditions, especially given their relatively low occupancy rates (the average is 63 percent) and the high profit margins possible under the SNF PPS. Because some regulations would be waived for site-neutral conditions, IRFs could adjust their cost structures by varying the number of physician face-to-face visits each week and providing fewer hours of therapy each day, as IRF clinicians deem necessary. Such changes would reduce IRF costs for treating site-neutral conditions, thereby leveling the playing field between IRFs and SNFs.

Still, facilities would likely vary in how quickly they could adjust their variable costs. Larger facilities have more options for adjusting those costs (for example, by adjusting the staffing for an entire nursing unit). However, many small IRFs are hospital based, so their affiliation with acute care hospitals affords them opportunities to adjust their cost structures. The Commission's analysis indicates that a large share of acute care hospitals' costs is variable.

Despite lower payments, site-neutral cases could still be profitable for some IRFs or could cover a facility's patient care costs and contribute toward covering a facility's fixed costs (and would be preferable to an empty bed). Hospital-based IRFs could continue to boost total hospital margins (they add about a percentage point to the overall hospital margin). Under the current IRF PPS, hospital-based facilities have break-even Medicare margins, but their contribution margin (a measure of whether Medicare payments cover direct patient care costs) is a healthy 35 percent. Once IRFs have adjusted their cost structures, they—like SNFs—may find that Medicare's SNF payments are highly profitable while achieving comparable outcomes. And because some hospital-based IRFs are low cost (in 2013, 40 percent of the facilities in the lowest cost quartile were hospital based), we believe hospital-based IRFs can manage their costs to remain profitable. Still, as IRFs change the mix of services, therapy intensity, and lengths of stays for cases paid under a site-neutral policy, it will be important to monitor outcomes and the quality of care furnished to these patients.

It is possible that some IRFs would opt to no longer treat patients with site-neutral conditions. After CMS began enforcing the compliance threshold in 2004, IRFs significantly shifted their mix of patients, admitting more cases that counted toward the compliance threshold. It is

possible that some IRFs would again adjust their mix of cases to preferentially admit those paid under the IRF PPS, with site-neutral cases shifting to SNFs. However, industry reaction to site-neutral payment would likely differ across facilities because, with the waiving of requirements, facilities could change their cost structures and service mix to accommodate the change in payment.

An IRF's ability to shift its patient mix toward cases not affected by a site-neutral policy would depend in part on characteristics of the market in which it is located. IRFs located in markets without competitors might find it easier to shift their mix of patients toward those cases that the average SNF is not staffed or equipped to manage, such as patients receiving rehabilitation care for burns or traumatic brain injury. IRFs that compete with other IRFs or specialized SNFs to treat IRF-compliant cases might be limited in the extent to which they can shift their focus toward non-site-neutral cases.

The Commission's analysis indicates that, if some portion of site-neutral cases shifted to SNFs, the SNF industry would have the capacity to treat these cases. In 2012, although the average SNF occupancy rate was high (82 percent), the additional volume associated with movement of site-neutral conditions from IRFs to SNFs would be small relative to total SNF volume. Furthermore, one-quarter of SNFs had occupancy rates at or below 76 percent, indicating capacity to treat additional cases. Average occupancy rates also varied by market (defined as hospital service areas). One-quarter of markets had an average occupancy rate at or below 76 percent and one-quarter had an average occupancy rate at or above 91 percent. In markets with very high SNF occupancy rates, accessing a SNF bed could become more difficult, depending on the extent to which IRFs shifted their case mix.

The method used by the Secretary to identify site-neutral cases could encourage IRFs to change their coding of cases to shift cases out of site-neutral conditions to case-mix categories not affected by the policy, thereby retaining IRF PPS-based payments. For example, if IRF case-mix groups were used, IRFs could shift their coding to avoid those groups. Instead, the use of the hospital MS-DRG system to identify cases would minimize such coding changes. Further, using MS-DRGs as at least part of the method to identify cases for site-neutral payments will allow IRFs and auditors to clearly identify cases as eligible for site-neutral payment before admission. Finally, the MS-DRG system would provide a consistent way to

categorize patients treated in IRFs and SNFs since the SNF and IRF payment systems use different case-mix groups. Critics of this approach posit that MS-DRGs are too broadly defined to identify site-neutral conditions. MS-DRGs could be supplemented with specific diagnoses coded by the hospital or other patient characteristics not subject to manipulation by IRFs, which would mitigate any disadvantages of using MS-DRGs while avoiding the incentives for IRFs to code cases specifically to avoid site-neutral payments.

Hospitals that have affiliations with IRFs may have a greater incentive to code inpatient cases more favorably (avoiding site-neutral conditions), so CMS and the Commission would need to closely monitor their coding practices. For example, certain respiratory conditions lend themselves to alternative coding that could avoid the site-neutral policy. Entities that operate both IRFs and SNFs, including hospitals (185 of the approximately 900 hospitals with IRFs also have SNFs) may have an advantage over other providers to direct cases to one setting or another to maximize total facility revenue.

Likely effects of site-neutral payments on beneficiaries

The effects on beneficiaries would depend on how IRFs responded to the site-neutral policies, but we expect the impact would be small. Clinicians, in consultation with patients and their families, would continue to be the decision makers about where patients received rehabilitation care after discharge from the hospital. The site-neutral policy is not intended to preempt the clinician's prerogative to select the best and most appropriate setting for beneficiaries. Further, the site-neutral policy does not change the program's benefits for beneficiaries. It simply pays providers a different rate for select conditions. Beneficiaries could still be admitted to IRFs, and IRF days would not count toward the 100-day limit of SNF care following a 3-day hospital stay.

Many IRFs are likely to continue to treat these conditions, so the impact on beneficiaries would be minimal. Access to care would remain at current levels. Beneficiary financial liability would not change since most beneficiaries meet the inpatient deductible during their preceding acute hospital stay. The comparability of most outcomes for patients treated in SNFs and IRFs indicate that even if IRFs changed the services they provide, patient outcomes would not necessarily be affected. Moreover, optimal treatments are likely to differ across patients,

with some patients benefiting from longer, less therapy-intensive stays and others benefiting from shorter, more intensive stays.

Under a site-neutral payment policy, the cost-sharing liability of beneficiaries who were shifted to SNFs would remain the same if they stayed less than 21 days. For the conditions considered for site-neutral payment, the vast majority (94 percent) of IRF users had stays of 20 days or less. Patients who were shifted to SNFs and stayed 21 or more days would have higher financial liability than they do currently. However, because most beneficiaries have supplemental coverage and the most common policies cover SNF payments, beneficiary liability for most will not change. Some beneficiaries could opt to go home rather than be admitted to SNFs. For them, cost sharing would depend on whether they opted to receive home health care (with no cost sharing) or outpatient therapy services (with 20 percent copayments).⁹

Given the similarity in readmission rates and functional outcomes between IRFs and SNFs, we expect that patient outcomes would not be affected by the implementation of a site-neutral policy. However, monitoring both access to and quality of care for site-neutral conditions in both settings would be important. This monitoring, which the Commission plans to conduct, will focus on detecting inappropriate provider responses, such as impairing access to care for beneficiaries and furnishing poorer quality of care resulting in worse outcomes. The analysis will consider access to services in markets with high SNF occupancy rates and the potential changes in coding to avoid site-neutral payments.

Recommendation on site-neutral payments for IRFs and SNFs for select conditions

The Commission's recommendation extends site-neutral payment policies to PAC, starting with select conditions treated in IRFs and SNFs. Because the policy would require some changes to the IRF PPS that are set in statute, our recommendation is directed to the Congress. The Secretary should use a set of criteria such as those considered by the Commission to identify appropriate conditions for site-neutral payment. For the selected conditions, the Commission's recommendation would set the IRF base rate at the average payment per discharge made to SNFs. By aligning payments between the two settings, Medicare would move away from paying for services based on the setting in which they are provided and toward a common payment for comparable patients.

RECOMMENDATION 7

The Congress should direct the Secretary of Health and Human Services to eliminate the differences in payment rates between inpatient rehabilitation facilities (IRFs) and skilled nursing facilities for selected conditions. The reductions to IRF payments should be phased in over three years. IRFs should receive relief from regulations specifying the intensity and mix of services for site-neutral conditions.

RATIONALE 7

To identify conditions appropriate for site-neutral payments, the Secretary should establish a set of criteria to identify conditions for the site-neutral policy. For its own criteria, the Commission considered whether the majority of patients were treated in SNFs (thus ensuring that the setting is safe for the treatment of the condition) and whether the patients treated in IRFs and SNFs had similar risk profiles. The Commission also evaluated the research on outcomes for the select conditions to be certain that IRFs did not consistently have higher quality. There is little evidence that IRFs consistently have better outcomes than SNFs. The Secretary should publish the criteria applied and data analyses conducted to identify proposed conditions and should use a notice-and-comment period to gather information in making its final selections. This process will help ensure that the Secretary proceeds cautiously in selecting criteria and conditions for the site-neutral policy. The Commission offers its criteria and analyses of 22 orthopedic, pulmonary, cardiac, and infection conditions to inform the Secretary's process.

For the conditions selected by the Secretary, the base payments to IRFs should be set at the average payment per discharge paid to SNFs for the select set of conditions. The Secretary should replace the IRF base rate with the average payment per discharge for a SNF in the same geographic location for the same case type. The additional payments many IRFs receive for teaching programs and treating low-income patients and high-cost outliers should not change.

As part of a site-neutral policy, the Secretary should relieve IRFs of the regulatory requirements related to the intensity and mix of services furnished to beneficiaries with the select conditions. Requirements for consideration include providing daily intensive therapy, the weekly face-to-face physician visits, and the physician-conducted preadmission and postadmission evaluation. Waiving these

requirements would be expected to lower IRFs' costs. A three-year transition would give IRFs time to adjust their cost structures and provide policymakers time to monitor the initial effects of the policy.

IMPLICATIONS 7

Spending

- The site-neutral policy would lower IRF base rates to the average payment per stay made to SNFs in the same geographic location for the same condition. Add-on payments IRFs receive (for having a teaching program or treating low-income patients or high-cost outlier cases) are not changed by this policy. Over five years, the site-neutral policy would lower program spending relative to current policy by between \$1 billion and \$5 billion. This estimate is consistent with the Commission's estimate of the reductions in payments for a fully implemented policy.

Beneficiary and provider

- The policy lowers payments to IRFs for site-neutral conditions, but the Commission believes many IRFs will continue to treat these cases. IRFs are likely to adjust their cost structures in response to the regulatory relief and continue to admit patients with site-neutral conditions. To the extent that IRFs elect not to treat these patients, some SNFs could experience a commensurate increase in volume.
- We do not anticipate that a site-neutral policy would negatively affect beneficiaries. We expect many IRFs will continue to treat patients with these conditions and, for these beneficiaries, the effects will be minimal. The site-neutral policy will not change the SNF benefit, and the IRF days paid at site-neutral rates will not count toward the 100-day SNF benefit. Some beneficiaries' care may be shifted to SNFs but—because we do not see significant differences between the two settings in terms of readmission rates and mortality—much of their care is expected to be comparable. Cost-sharing liability is not expected to increase for the vast majority of beneficiaries, though it could increase for the small number of beneficiaries who are shifted to SNFs and whose stays exceed 20 days. However, most beneficiaries have supplemental coverage and the most common policies cover the SNF copayments, so the actual cost sharing for most beneficiaries would remain unchanged.

Private sector ideas for managing post-acute care

The Commission examined strategies used by private sector entities to explore additional ways to more effectively manage PAC. A contractor and Commission staff interviewed PAC benefit management vendors, PAC providers participating in CMS's PAC Bundled Payment for Care Improvement Initiative, and officials at health systems with Medicare Advantage (MA) plans or ACOs.

FFS and MA plans differ in the approaches they take

The approaches used by FFS entities (for example, ACOs, providers, and integrated health systems that are paid FFS) and MA plans to manage PAC differ considerably. FFS entities typically guide patient decisions about the choice of PAC setting and provider, whereas MA plans typically establish rules about PAC use. In part, this difference reflects the differences in Medicare rules governing each. MA plans can establish networks of providers in which services are covered and use prior authorization and recertification to direct where enrollees go and how much care they receive, with an appeals process tempering this control somewhat. In contrast, even FFS entities at financial risk (ACOs and entities participating in CMS's bundling initiatives) must allow beneficiaries the freedom to select the provider of their choice and cannot use tiered provider payments, beneficiary copayments, or prior authorization to influence service use. FFS providers must rely on "softer" approaches that guide decisions made by clinicians and patients toward using lower cost, higher quality providers.

Strategies to manage post-acute care under FFS Medicare

Discussions with private sector entities identified two strategies that FFS Medicare could pursue to better manage PAC. First, some ACOs have established partnerships with selected PAC providers. Under this arrangement, ACOs select PAC partners by reviewing the cost and quality metrics for each provider and its geographic coverage. Hospital discharge planning teams then choose from the selected pool of PAC providers when referring patients. Although preferred networks may narrow beneficiary choice, they create a preferred set of higher quality PAC providers that could improve care for beneficiaries without impairing access to care. The process is intended to guide, but not dictate, decision making; beneficiaries retain their choice about where to go. To the

extent that these practices prove successful in referring beneficiaries to appropriate sites of care and lowering readmissions, broader adoption of these practices within FFS has the potential to improve care for beneficiaries and lower costs for the program.

Some FFS provider organizations have concerns about the information on preferred providers they are allowed to present without violating beneficiary freedom of choice rules. In general, "soft steering" is achieved by describing the relative merits of using a preferred provider: higher quality of care, more integrated medical staffs, and better coordinated care. If preferred networks are allowed, CMS should clarify what is and is not allowed in guiding decision making.

Future efforts could permit tighter linkages between ACOs and preferred networks. Because some ACOs are at financial risk for the cost of care, CMS could consider allowing those ACOs to establish formal networks to direct beneficiaries to high-value providers. Likewise, CMS could consider allowing hospitals to partner with high-value PAC providers, though many issues would need to be resolved to ensure hospitals acted responsibly. CMS would need to establish criteria for defining "preferred" status, such as network adequacy, quality and cost measures, and capabilities for managing special care (such as tracheostomy and ventilator care). An idea to explore is whether hospitals would also have to earn this "right" to maintain preferred networks by meeting certain benchmarks, such as achieving low readmission rates or other indicators that suggest they could responsibly manage preferred PAC networks.

A second strategy Medicare could use is to expand beneficiary incentives to use certain settings or providers over others. The PAC cost-sharing structure has not significantly changed since Medicare's inception. Inherent in this structure are financial incentives, unrelated to clinical decisions, that encourage the use of certain settings over others and for certain time periods. For example, the SNF cost-sharing requirement creates an incentive for providers to keep beneficiaries for 20 days, regardless of whether they need this much care. Alternately, cost-sharing incentives could be created to encourage beneficiaries to use preferred providers that offer high-value care. However, changes to beneficiary cost sharing would also have to be sensitive to the amounts beneficiaries already incur. For example, policies could lower the incurred cost sharing when beneficiaries select providers that meet standards for quality and cost of care.

Strategies to manage post-acute care under managed care

Three strategies—prior authorization for the use of high-cost PAC settings, contracting with third-party vendors to manage PAC, and establishing networks that include high-value providers—are used by MA plans. All involve restricting, to varying degrees, beneficiary choice. Prior authorization would require beneficiaries to get approval before the program covered the care, which is not allowed under Medicare rules. Under the traditional FFS program, beneficiaries may be given information about the relative advantages of some providers or settings, but the beneficiary ultimately is free to choose a setting and provider. In addition, to implement prior authorization would require significant administrative resources to identify the settings that would require approval, develop the standards to determine coverage, and establish a process for review and appeals of decisions.

Under a third-party vendor arrangement, a benefit manager receives a monthly fee to manage (and is at financial risk for) the use of PAC. Beneficiaries may appreciate some of the education tools (such as care pathways that detail expected care through the episode) and extra assistance these vendors can provide. However, some beneficiaries may not want their PAC services influenced by an entity that is not their regular source of care. The benefits of guiding beneficiary decision making toward higher value care would need to be evaluated relative to the cost of inserting an additional administrative layer into the placement decision-making process.

A network of preferred providers would identify high-value providers, and beneficiaries who use them would incur lower cost sharing compared with beneficiaries who use out-of-network providers. In this way, freedom of choice is retained, but beneficiaries could face different financial liabilities, depending on their use of in-network or out-of-network providers. MA plans often establish formal networks, delineating where care is covered and generally excluding coverage for out-of-network care. Beneficiary freedom of choice is preserved because beneficiaries choose to enroll in an MA plan.

Conclusion

The complexity and cost of PAC indicates that Medicare needs a range of policies to ensure the appropriate and efficient use of these services. In the near term, the Commission is recommending policies that ensure that program payments under PPS are commensurate with costs, a particularly important policy given the high payments for several PAC settings. In addition, Medicare can begin to move toward site-neutral payments where there is clear overlap in the services provided, such as for certain patients served by SNFs and IRFs. In the longer run, Medicare is beginning efforts to develop a common payment system that will eliminate the adverse incentives and inefficiencies resulting from multiple uncoordinated systems.

The Commission's review of private sector practices suggests that further efforts to improve the management of PAC services in FFS are possible. A refined referral process, one that better supports beneficiary choice by providing beneficiaries with better information about available providers, could encourage the use of higher quality providers. These approaches could be particularly appropriate for ACOs or other models of delivery reform where hospitals and other providers are at risk for the cost of care and quality indicators. However, other approaches may be necessary when no entity is available to assume these risks (for example, holding PAC providers accountable for quality like the Commission has recommended for SNFs and home health agencies). Other changes may include aligning incentives for referring physicians and beneficiaries (for example, through the expanded use of quality information for comparing different PAC providers or by creating incentives through reformed PAC cost sharing). ■

Endnotes

- 1 Each payment system uses its own unit of payment. Skilled nursing facilities are paid on a per day basis, the home health prospective payment system pays for care in 60-day episodes, and the LTCH and IRF systems pay on a per discharge basis.
- 2 Summaries of the SNF and IRF PPSs are available at <http://www.medpac.gov/-documents/-payment-basics>.
- 3 *Majority* refers to the percentage of patients discharged to an IRF or SNF who went to SNFs. It does not consider other discharge destinations.
- 4 To assess whether the majority of cases were treated in SNFs, we examined shares of cases treated in each setting in markets with both types of facilities. Our reasoning is that if the majority of cases elect to go to SNFs even in markets with an IRF, the condition can generally be considered safe in the SNF. Nationwide, the number of SNFs far outnumbers the IRF count. Three-quarters of markets (defined as hospital service areas, or HSAs) do not have IRFs, but the majority of beneficiaries (69 percent) live in markets with at least one IRF. Almost all HSAs with IRFs also have at least one SNF. Because IRFs and SNFs use different case-mix classification systems, we identified comparable conditions using the MS-DRG of the preceding acute care hospital stay.
- 5 For each condition, we summed the daily payments for each SNF stay to compare them with the stay-based payments for IRFs. The average SNF payment excludes the separate payments for outpatient services furnished to SNF patients but excluded from the SNF PPS. Because the services must be infrequent to be excluded from the SNF daily rate, we do not think the average SNF payments would differ substantially from the payments reported here.
- 6 Each condition's average SNF payment reflects the average SNF length of stay and mix of SNF case-mix groups for that condition.
- 7 Having a facility provide two levels of care would not be a unique policy for Medicare. Under current swing bed policies, some rural hospitals provide both acute inpatient hospital and skilled nursing facility services.
- 8 An industry-sponsored study examined the impact of a site-neutral policy for stroke, unilateral joint replacement, and hip and femur procedures, including a broader set of conditions (DaVanzo et al. 2014). This study modeled the President's budget proposals for fiscal years 2014 and 2015 to narrow (but not eliminate) differences in payments between SNFs and IRFs. The proposals allow 25 percent of the difference in overhead costs between SNFs and IRFs and allows 33 percent of the difference in patient care costs. Its findings are similar to the estimates of the three conditions we examined in June 2014.
- 9 For beneficiaries who opt to receive outpatient therapy services, their care could be limited by the annual per beneficiary limits placed on these services.

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CHAPTER

8

Skilled nursing facility services

R E C O M M E N D A T I O N

(The Commission reiterates its March 2012 recommendation on updating Medicare's payments to skilled nursing facilities. See text box, p. 203.)

Skilled nursing facility services

Chapter summary

Skilled nursing facilities (SNFs) provide short-term skilled nursing and rehabilitation services to beneficiaries after a stay in an acute care hospital. In 2013, almost 15,000 SNFs furnished 2.4 million Medicare-covered stays to 1.7 million fee-for-service (FFS) beneficiaries. Medicare FFS spending on SNF services was \$28.8 billion in 2013.

Assessment of payment adequacy

To examine the adequacy of Medicare's payments, we analyze beneficiaries' access to care (including the supply of providers and volume of services), quality of care, provider access to capital, and Medicare payments in relation to providers' costs to treat Medicare beneficiaries. Key measures indicate Medicare payments to SNFs are adequate. We also find that relatively efficient SNFs—facilities identified under our current definition as providing relatively high-quality care at relatively low costs—had very high Medicare margins, suggesting that opportunities remain for other SNFs to achieve greater efficiencies.

Beneficiaries' access to care—Access to SNF services remains adequate for most beneficiaries.

- **Capacity and supply of providers**—The number of SNFs participating in the Medicare program is stable, with a small increase in new providers in 2014. Three-quarters of beneficiaries live in a county with five or more

In this chapter

- Are Medicare payments adequate in 2015?
- How should Medicare payments change in 2016?
- Medicaid trends

SNFs, and less than 1 percent live in a county without one. Available bed days increased slightly. The median occupancy rate was 86 percent, with one-quarter of SNFs having rates at or below 73 percent, indicating some capacity for additional admissions.

- ***Volume of services***—Days and admissions per FFS beneficiary declined between 2012 and 2013, consistent with declines in inpatient hospital admissions (a three-day inpatient stay is required for Medicare coverage of SNF services).

Quality of care—Quality measures show mixed performance. Between 2012 and 2013, the community discharge and readmission measures improved, and the functional change measures were essentially unchanged.

Providers' access to capital—Because most SNFs are part of larger nursing homes, we examine nursing homes' access to capital. Access to capital was adequate and is expected to remain so. Medicare is regarded as a preferred payer of SNF services.

Medicare payments and providers' costs—In 2013, the average Medicare margin was 13.1 percent—the 14th year in a row that the average was above 10 percent. This margin is lower than the 2012 average (14 percent) and reflects reduced revenues due to the implementation of the budget sequester in April 2013. Margins continued 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 (such as share of very old, dual-eligible, and minority beneficiaries). Rather, in part they reflected shortcomings in the SNF prospective payment system (PPS), the resulting favorable selection of rehabilitation patients (over medically complex patients), and providers furnishing high levels of therapy. The disparity in margins between for-profit and nonprofit facilities was considerable and reflected differences in service provision and costs. In 2013, about 500 of the 7,800 freestanding facilities included in the analysis provided relatively low-cost and high-quality care over 3 consecutive years and had Medicare margins averaging more than 20 percent. The projected Medicare margin for 2015 is 10.5 percent.

In 2012, the Commission recommended restructuring and rebasing the SNF payment system. Specifically, the Commission recommended that the Congress direct the Secretary to first revise the SNF PPS to strike a better balance between paying for therapy and nontherapy ancillary (NTA) services (such as drugs). During this year of revision, payment rates would be held constant (no update). The Commission recommended three revisions to improve the accuracy of payments. First, base payments for therapy services on patient characteristics, not

on the amount of rehabilitation therapy provided. Second, remove payments for NTA services from the nursing component and establish a separate component specifically to adjust for differences in patients' needs for these services. Third, add an outlier policy to the PPS. In the year following these three changes, 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 is based on several facts: (1) payments were well above costs, resulting in high and sustained Medicare margins; (2) costs varied widely, but variation was unrelated to case mix or wages; (3) more than 500 SNFs had consistently below-average costs and above-average quality of care, suggesting greater efficiency is possible; (4) the industry continued to maintain high margins despite changing policies; and (5) in many cases, Medicare Advantage payments to SNFs were 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.

The factors examined to assess payment adequacy indicate that the circumstances of the SNF industry have not changed materially during the past year, yet the urgency for change remains. Our work indicates that there is even more need for reform because payments for therapy and NTA services have grown more inaccurate over time. Further, the continued high level of payments essentially requires taxpayers to continue to finance the high margins of this industry.

Therefore, the Commission stands by its two-part recommendation to revise and rebase the SNF payment system. In the first year (2016), there would be no update to the base payment rate while the PPS was revised and, in year two (2017), payments would be lowered by an initial 4 percent. In subsequent years, the Commission would evaluate whether continued reductions were necessary to further align payments with costs.

In its deliberations, the Commission discussed the possibility of recommending an immediate, small rebasing of payments, followed by the implementation of a revised PPS and subsequent further rebasing. Although this sequence would change the Commission's long-standing position to revise the PPS before making payment reductions, it reflects a growing impatience with the lack of progress in improving the accuracy of Medicare's payments and lowering the level of the program's payments. An initial reduction could spark the industry's interest in revising the PPS so that reductions are made from a more equitable distribution of payments across providers. Over the coming year, the Commission will explore this alternative.

Medicaid trends

As required by the Patient Protection and Affordable Care Act of 2010, we report on Medicaid use, spending, and non-Medicare (private payer 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 remained essentially unchanged between 2013 and 2014. In 2013, the average total margin, reflecting all payers and all lines of business, was 1.9 percent. The average non-Medicare margin was –1.9 percent. ■

**TABLE
8-1****Freestanding SNFs and for-profit SNFs account for the majority of facilities, Medicare stays, and Medicare spending**

Type of SNF	Facilities		Medicare-covered stays		Medicare spending	
	2006	2013	2006	2013	2006	2013
Total number	15,178	14,978	2,454,263	2,365,743	\$19.5 billion	\$26.6 billion
Freestanding	92%	95%	89%	94%	94%	97%
Hospital based	8	5	11	6	6	3
Urban	67	72	79	83	81	85
Rural	33	28	21	17	19	15
For profit	68	70	67	71	73	75
Nonprofit	26	25	29	25	24	21
Government	5	5	4	3	3	3

Note: SNF (skilled nursing facility). Totals may not sum to 100 percent due to rounding and missing values.

Source: MedPAC analysis of the Provider of Services and Medicare Provider Analysis and Review files for 2006 and 2013.

Background

Skilled nursing facilities (SNFs) provide short-term skilled nursing care and rehabilitation services, such as physical and occupational therapy and speech–language pathology services. Examples of SNF patients include those recovering from surgical procedures such as hip and knee replacements, or from medical conditions such as stroke and pneumonia. In 2013, almost 1.7 million fee-for-service (FFS) beneficiaries (4.5 percent) used SNF services at least once; program spending on SNF services was \$28.8 billion, or about 8 percent of FFS spending (Centers for Medicare & Medicaid Services 2014b, Office of the Actuary 2014b); 20 percent of hospitalized FFS beneficiaries were discharged to SNFs; Medicare’s average payment per day was \$411; and Medicare’s average payment per stay was \$11,357.¹

Medicare covers up to 100 days of SNF care per spell of illness after a medically necessary inpatient hospital stay of at least 3 days.² For beneficiaries who qualify for a covered stay, Medicare pays 100 percent of the payment for the first 20 days of care. Beginning with day 21, beneficiaries are responsible for copayments. For 2015, the copayment is \$157.50 per day.

The term *skilled nursing facility* refers to a provider that meets Medicare requirements for Part A coverage.³ Most SNFs (more than 90 percent) are dually certified as SNFs and nursing homes (which typically provide less intensive, long-term care services). Thus, a facility that provides skilled care often also provides long-term care services that Medicare does not cover. Medicaid accounts for the majority of nursing facility days (see discussion of Medicaid trends, p. 204).

The mix of facilities where beneficiaries seek skilled nursing care has shifted over time toward freestanding and for-profit facilities (Table 8-1). In 2013, freestanding facilities and for-profit facilities accounted for larger shares of Medicare stays and spending than in 2006. After a steady decline in the number of hospital-based facilities over a decade, that share has been stable since 2011. In 2013, 70 percent of SNFs were for profit; they accounted for a slightly higher share of stays (71 percent) and 75 percent of Medicare payments. Between 2011 and 2013, these shares were fairly stable.

Medicare-covered SNF patients typically comprise a small share of a facility’s total patient population but a disproportionately larger share of the facility’s revenues. In freestanding facilities in 2013, the median Medicare-

covered share of total facility days was 12 percent, but it was 22 percent of facility revenue.

The most frequent hospital conditions of patients referred to SNFs for post-acute care are joint replacement, septicemia, kidney and urinary tract infections, hip and femur procedures except major joint replacement, pneumonia, and heart failure and shock. Compared with other beneficiaries, SNF users are older, frailer, and disproportionately female, disabled, living in an institution, and dually eligible for both Medicare and Medicaid (Medicare Payment Advisory Commission 2013).

SNF prospective payment system and its shortcomings

Medicare uses a prospective payment system (PPS) to pay SNFs for each day of service.⁴ Information gathered from a standardized patient assessment instrument—the Minimum Data Set—is used to classify patients into case-mix categories, called resource utilization groups (RUGs). RUGs differ by the services SNFs provide to a patient (such as the amount and type of rehabilitation therapy and the use of respiratory therapy and specialized feeding), the patient’s clinical condition (such as whether the patient has pneumonia), and the patient’s need for assistance in performing activities of daily living (ADLs). Medicare’s payment system for SNF services is described in the Commission’s *Payment Basics*, available on the Commission’s website (<http://www.medpac.gov/documents/payment-basics/skilled-nursing-facility-services-payment-system-14.pdf?sfvrsn=0>). Though the payment system is referred to as “prospective,” two features undermine how prospective it is: The system makes payments for each day of care (rather than setting a payment for the entire stay), and it bases payments partly on the minutes of rehabilitation therapy furnished to a patient. Both features result in providers having some control over how much Medicare will pay them for their services.

Almost since its inception, the SNF PPS has been criticized for encouraging the provision of unnecessary rehabilitation therapy services and not accurately targeting payments for nontherapy ancillary (NTA) services such as drugs (Government Accountability Office 2002, Government Accountability Office 1999, White et al. 2002). Under current policy, therapy payments are not proportional to costs but, instead, rise faster than providers’ therapy costs increase (Medicare Payment Advisory Commission and The Urban Institute 2014).

Payments for NTA services are included in the nursing component, even though NTA costs vary much more than nursing care costs and are not correlated with them.

In 2008, the Commission recommended revising the PPS to base therapy payments on patient characteristics (not service provision), remove payments for NTA services from the nursing component, establish a separate component within the PPS that adjusts payments for NTA services, and implement an outlier payment policy. An outlier policy would offer some financial protection by partly compensating providers that treat exceptionally costly patients. An outlier case would be defined on a stay basis, not on a day basis, because the financial risk to a facility is determined by its losses over the stay, not a given day.

Since 2008, the Commission has periodically evaluated current policy relative to the alternative design (Carter et al. 2012, Wissoker and Garrett 2010, Wissoker and Zuckerman 2012). Our most recent analysis found that the accuracy of payments has deteriorated over time. Current payments are too high for therapy and are unrelated to the costs of NTA services. As a result, the PPS advantages facilities that predominantly admit patients with rehabilitation care needs and provide intensive therapy, and it discourages facilities from admitting patients who require costly NTA services.

The Commission’s recommended revisions to the PPS would greatly improve the accuracy of payments for therapy and NTA services (Medicare Payment Advisory Commission and The Urban Institute 2014). Assuming no other changes in patient mix or care delivery, aggregate payments would increase for hospital-based facilities (21 percent), nonprofit facilities (4 percent), facilities with relatively high NTA costs (12 percent), facilities with relatively high shares of medically complex days (5 percent for high shares of special care days and 7 percent for high shares of clinically complex days), facilities with relatively low shares of intensive therapy (16 percent), and rural facilities (4 percent). Payments would decrease slightly for for-profit facilities (–1 percent), but the impact would be greater for facilities with relatively high shares of intensive therapy (–7 percent) and low shares of clinically complex days (–3 percent) and special care days (–2 percent). The effects on individual facilities could vary substantially.

Based on its work examining SNFs’ billing practices between 2006 and 2008 and in 2009, the Department of

Health and Human Services (HHS) Office of Inspector General (OIG) recommended that CMS change the way Medicare pays for therapy, consistent with the Commission's recommendation. OIG found that SNFs had increasingly billed for higher payment RUGs, even though the ages and diagnoses of beneficiaries were largely unchanged, and upcoding was responsible for the majority of the billing errors (Office of Inspector General 2012, Office of Inspector General 2011). The Departments of Justice and HHS have increased their investigation of fraud and abuse under the False Claims Act and in 2014 settled three cases involving alleged billing for medically unnecessary therapy services (Department of Justice 2014a, Department of Justice 2014b, Department of Justice 2014c).

CMS's revisions of the SNF PPS

Although CMS has taken steps to enhance payments for medically complex care, it has not revised the basic design of the PPS to pay for NTAs more accurately or to base payments for rehabilitation therapy services on patient care needs. In 2010, CMS changed the definitions of the existing case-mix groups and added 13 case-mix groups for medically complex days.⁵ At the same time, CMS shifted program dollars away from therapy care and toward medically complex care (Centers for Medicare & Medicaid Services 2010). After these changes, the share of days classified into medically complex groups between 2010 and 2012 increased from 5 percent to 7 percent. In 2010 and 2011, CMS also lowered payments for therapy furnished to multiple beneficiaries at the same time rather than in one-on-one sessions, and it required providers to reassess patients when the provision of therapy changed or stopped (which would, in turn, change assignments in case-mix groups).⁶ Despite these changes, we found that Medicare's payments for therapy services continue to exceed the cost of these services, and its payments for NTA services bear no relationship to the cost of these services (Medicare Payment Advisory Commission and The Urban Institute 2014).

CMS's work on alternative designs for the SNF PPS began 13 years ago in response to a legislative requirement (Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000) to conduct research on potential refinements of the SNF PPS (Liu 2007, Maxwell et al. 2003, Urban Institute 2004). Yet, to date, CMS continues to evaluate alternative ways to pay for NTA and therapy services and has not revised the basic PPS design. In 2014, CMS reviewed alternative ways

to pay for therapy and concluded that it would evaluate two approaches over the coming year. One would use patient characteristics to establish payments (such as the alternative design recommended by the Commission); the other would use a combination of resident characteristics and some measure of resource use (Acumen LLC 2014). This fall, CMS announced it was expanding the scope of its research to consider revisions of the entire PPS. We urge CMS to include its plans for revising the well-known shortcomings of the current PPS in its proposed rule for fiscal year 2016.

Are Medicare payments adequate in 2015?

To examine the adequacy of Medicare's payments, we analyze beneficiaries' access to care (including the supply of providers and volume of services), quality of care, providers' access to capital, Medicare payments in relation to costs to treat Medicare beneficiaries, and changes in payments and costs. We also compare the performance of SNFs with relatively high and low Medicare margins and relatively efficient SNFs with other SNFs.

Beneficiaries' access to care: Access is stable for most beneficiaries

We do not have direct measures of access, in part because the need for SNF care, as opposed to other post-acute care (PAC) or no PAC, is not well defined. Instead, we consider the supply and capacity of providers and evaluate changes in service volume. We also examine the mix of SNF days to assess the shortcomings of the PPS that can result in delayed admission for certain types of patients.

Capacity and supply of providers: Supply remains stable

The number of SNFs participating in the Medicare program is stable at just under 15,000. In 2014, there were 98 facilities new to the program, the majority of which were for profit (Centers for Medicare & Medicaid Services 2014a). In 2013, less than 1 percent of beneficiaries lived in a county without a SNF, 5 percent lived in counties with 1 SNF, 17 percent lived in counties with between 2 and 4 SNFs, more than three-quarters of beneficiaries lived in counties with 5 or more SNFs, and 60 percent of beneficiaries lived in counties with 10 or more SNFs. In that year, the median occupancy rate was 86 percent in freestanding facilities, down slightly from 2012 (87

**TABLE
8-2****SNF service use declined between 2012 and 2013**

Volume measure	2006	2008	2010	2012	2013	Percent change 2012-2013
Covered admissions per 1,000 FFS beneficiaries	72	73	72	68	67	-2.2%
Covered days (in thousands)	1,892	1,977	1,938	1,861	1,835	-1.4
Covered days per admission	26.3	27.0	27.1	27.4	27.6	0.7

Note: SNF (skilled nursing facility), FFS (fee-for-service). FFS beneficiaries include users and nonusers of SNF services. Data include 50 states and the District of Columbia.

Source: Calendar year data from CMS, Office of Information Products and Data Analytics 2013.

percent), and 81 percent in hospital-based facilities. Nonprofit, freestanding, and urban facilities had higher occupancy rates compared with other SNFs. Although these averages are high, one-quarter of freestanding facilities had occupancy rates at or below 73 percent, indicating capacity for more admissions.

SNF volume was slightly lower in 2013 than in 2012

In 2013, 4.5 percent of FFS beneficiaries used SNF services, about the same share as in 2012. Between 2012 and 2013, SNF volume per FFS beneficiary declined. We examine service use for FFS beneficiaries because the CMS data on users, days, and admissions do not include service use by beneficiaries enrolled in Medicare Advantage (MA) plans. Admissions per 1,000 FFS beneficiaries declined 2.2 percent, while covered days declined less (-1.4 percent), resulting in a small increase in covered days per admission (Table 8-2). The reductions in per capita SNF admissions were consistent with the decline in per FFS admissions to acute care hospitals. (In general, declines in hospital use will lower SNF admissions because an acute care inpatient hospital stay of at least three days is a prerequisite for Medicare coverage of SNF services.) Declines in hospital admissions (and, to a lesser extent, readmissions) are the key driver of the decline in SNF stays. The increase in observation days, which do not qualify for an inpatient hospital admission, may be a small factor, but because the count of observation stays is low relative to the total number of SNF admissions, they cannot account for the more than 2 percent decline in admissions.

Service mix reflects biases of the PPS

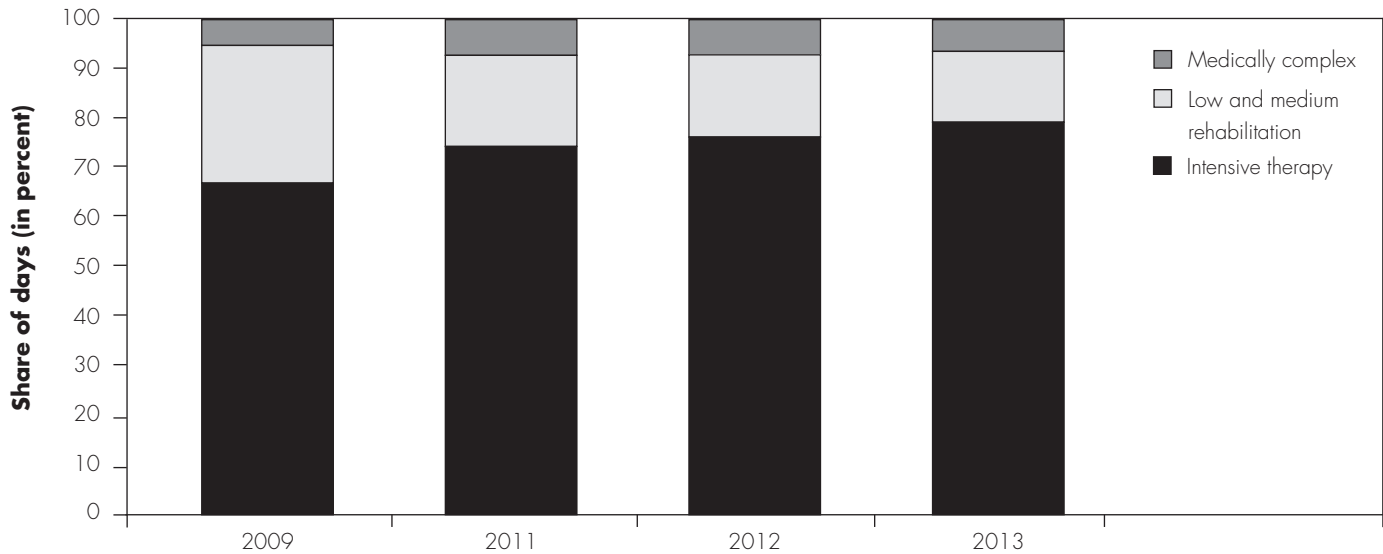
Between 2002 and 2013, the share of days classified into rehabilitation case-mix groups in freestanding facilities

increased from 78 percent to 93 percent.⁷ During the same period, the share of intensive therapy days as a share of total days rose from 29 percent to 79 percent.⁸ The most recent changes indicate the continued intensification of therapy provision (Figure 8-1). Between 2012 and 2013, the share of intensive therapy days increased from 76 percent to 79 percent, and the share of days assigned to the highest rehabilitation case-mix groups (the ultra-high groups) increased from 50 percent to 54 percent. Facilities differed in the amount of intensive therapy they provided. Among freestanding facilities, for-profit facilities and facilities located in urban areas had higher shares of intensive therapy (81 percent for each group) compared with nonprofit facilities (75 percent) and facilities in rural (72 percent) and frontier areas (49 percent). Hospital-based facilities had lower shares of intensive therapy days (54 percent) compared with freestanding facilities. Counties with low counts of inpatient rehabilitation facility (IRF) beds per 1,000 FFS beneficiaries had slightly higher shares of intensive therapy days, though counties with no IRF beds had the lowest share.

Changes in the frailty of beneficiaries at admission to a SNF do not explain the increases in therapy. Compared with the average SNF user in 2011, the average SNF user in 2013 had comparable abilities to perform activities of daily living (as measured by a modified Barthel score) and was the same age. Over the same period, the shares of SNF users requiring the most help with the 10 activities of daily living decreased or were comparable.⁹ Despite these similar characteristics, the share of days assigned to an intensive therapy case-mix group between 2011 and 2013 increased 5 percentage points, from 74 percent to 79 percent. Shorter hospital stays could have shifted some therapy provision from the hospital to the SNF setting. For example, between 2009 and 2013, hospital lengths of stay

**FIGURE
8-1**

The share of intensive therapy days in SNFs continues to increase



Note: SNF (skilled nursing facility). “Medically complex” includes two broad categories of case-mix groups: clinically complex and special care. “Intensive therapy” includes days assigned to ultra-high and very high rehabilitation case-mix groups.

Source: MedPAC analysis of freestanding cost reports 2009–2013.

decreased 7 percent on average for the five highest volume diagnosis related groups discharged to SNFs.

The share of medically complex days (those assigned to the clinically complex or special care case-mix groups) continued to be low (6 percent, down from 15 percent in 2000). Most SNFs admitted these cases: 80 percent of SNFs admitted clinically complex patients and 89 percent admitted special care patients, both up from 2009 when only 54 percent of SNFs admitted clinically complex patients and 64 percent admitted special care patients. Hospital-based units were disproportionately represented in the group of SNFs with the highest shares (defined as the top quartile) of medically complex admissions. Although the payments for medically complex days were increased recently, which encouraged SNFs to admit these patients, rehabilitation days remained highly profitable, and the PPS continued to encourage providers to furnish enough therapy to convert medically complex days to rehabilitation days. The Commission’s recommended design would increase payments for medically complex patients; hospital-based facilities would benefit the most from this policy.

Industry representatives and patient advocates report that patients with high NTA costs (such as those requiring expensive antibiotics) can be hard to place. In addition,

patients who are more likely to require long stays and exhaust their Medicare benefits are also avoided by some facilities because the facility’s daily payments decline if the patient is eligible for Medicaid or the stay results in bad debt.

Quality of care: Improvements in some measures and essentially no change in others

The Commission tracks three broad categories of SNF quality indicators: risk-adjusted rates of readmission, discharge back to the community, and change in functional status during the SNF stay. Between 2012 and 2013, the rates of readmissions and discharge to the community improved, while the two measures of functional change were essentially unchanged.

Rates of rehospitalization and community discharge rates show recent improvements

Between 2000 and 2010, both the rate of rehospitalization for SNF patients with any of five potentially avoidable conditions (congestive heart failure, electrolyte imbalance/dehydration, respiratory infection, septicemia, urinary tract infection/kidney infection) and the rate of discharge to the community remained almost the same (see text box

Measures of skilled nursing facility quality

The community discharge measure includes beneficiaries discharged to a community setting (including assisted living) and excludes those discharged to an inpatient setting (e.g., an acute care hospital or nursing home) within one day of the skilled nursing facility (SNF) discharge. It excludes beneficiaries who die within 1 day of the SNF discharge and beneficiaries who are readmitted to an acute care hospital within 30 days of admission to the SNF. This time frame was revised in 2014 (from excluding readmissions within 100 days) to align it with our readmission measure, which includes beneficiaries readmitted to the hospital within 30 days of discharge from the SNF (Kramer et al. 2015). As a result of the revision, the community discharge numbers for fiscal years 2011 and 2012 have increased from last year's report. Beneficiaries who are discharged to a nursing home are not counted as community discharges, although the risk adjustment method (and the comorbidities) will capture some of the differences in the risks between beneficiaries discharged home and those discharged to a nursing home. In addition, separate models (with their own covariates) are used to estimate expected community discharge rates for different discharge destinations (e.g., discharged home with home health care, discharged home without home health care, and discharged to a nursing home).

The readmission measures count rehospitalized patients whose primary diagnosis for readmission was considered potentially avoidable—that is, the condition should have been managed in the SNF setting. The potentially avoidable conditions include congestive heart failure, electrolyte imbalance/dehydration,

respiratory infection, septicemia, urinary tract or kidney infection, hypoglycemia and diabetic complications, anticoagulant complications, fractures and musculoskeletal injuries, acute delirium, adverse drug reactions, cellulitis/wound infection, pressure ulcers, and blood pressure management. The count excludes readmissions that were likely to have been planned (e.g., inpatient chemotherapy or radiation therapy) and readmissions that signal a premature discharge from the hospital. We separately measure readmissions that occur during the SNF stay and those that occur within 30 days of discharge from the SNF.

The observed rehospitalization and community discharge rates were risk adjusted for medical comorbidity, cognitive comorbidity, mental health comorbidity, function, and clinical conditions (e.g., surgical wounds and shortness of breath). The rates reported are the average risk-adjusted rehospitalization rates for all facilities with 25 or more admissions. Demographics (including race, gender, and age categories except younger than 65 years old) were not important in explaining differences in rehospitalization and community discharge rates after controlling for beneficiaries' comorbidities, mental illness, and functional status (Kramer et al. 2014).¹⁰

Two risk-adjusted measures of functional change gauge the percent of a facility's stays during which patients' conditions improve and the percent of stays during which patients' functioning does not decline, given the prognosis of the facility's patients. Change is measured by comparing the initial and discharge assessments. For stays that go on to use long-term nursing home care, the assessment closest to the end of Medicare coverage is used, as long as it is within 30 days of the

(continued next page)

on measures of SNF quality). More recently, both rates have improved. Between 2011 and 2012, rehospitalization rates declined and community discharge rates increased. These trends repeated between 2012 and 2013, though the improvements were smaller (Table 8-3). Between 2012 and 2013, risk-adjusted community discharge rates increased from 35.6 percent to 37.5 percent, and potentially avoidable rehospitalizations for patients

during their SNF stays declined from 11.5 percent to 11.1 percent.

The rate of readmission for beneficiaries discharged from a SNF and readmitted to a hospital within 30 days reflects how well facilities prepare beneficiaries and their caregivers for safe and appropriate transitions to the next health care setting (or home). Between 2012 and 2013, the

Measures of skilled nursing facility quality (cont.)

end of the SNF stay). Although the initial assessment often occurs toward the end of the first week of the stay, the Minimum Data Set information pertains to the number of times over the past week that assistance was provided, rather than recording functional status at a single point in time. Therefore, any measurement error due to the reliance on an assessment conducted at the end of the first week of the stay is unlikely and would not affect our ability to examine quality trends over time, unless there are changes from year to year in when initial assessments are conducted.

Each stay's initial assessment is used to assign the patient to 1 of 22 case-mix groups using 3 measures of mobility—bed mobility, transfer, and ambulation (Kramer et al. 2014). This classification system acts as

a form of risk adjustment, differentiating patients based on their expected ability to perform the three mobility-related activities of daily living (ADLs). A patient's prognosis is measured using the patient's ability to eat and dress because these two ADLs encompass cognitive functioning and other dimensions of physical functioning that facilitate rehabilitation. The scales of these two measures were revised this year because CMS no longer collects some of the information used.

Risk-adjusted rates compare a facility's observed rates with its expected rates ((actual rate/expected rate) × the national average rates) based on the mix of patients across functional outcome groups. Each facility-level measure combines the functional status information for the three mobility measures. ■

risk-adjusted rehospitalization rate for beneficiaries during the 30 days after discharge from the SNF was essentially unchanged. The rate of rehospitalization during the SNF stay or within 30 days of SNF discharge declined from 15.5 percent to 15.1 percent, indicating opportunities for SNFs to improve the care they provide and the care provided by others after discharge.¹¹

The lower rehospitalization rates reflect increased attention from hospitals to avoid readmission penalties

by partnering with SNFs with low readmission rates (Gerhardt 2014). In addition, many SNFs want to secure volume from MA plans and accountable care organizations by demonstrating improvements in their readmission rates. The American Health Care Association, which supports the SNF rehospitalization program, has a goal for its members to lower readmission rates 15 percent by 2015 and has reported that half of its members met this target (across all patients, not just Medicare) by June 2014 (American Healthcare Association 2015).

**TABLE
8-3**

Improvements in risk-adjusted rates of community discharge and potentially avoidable rehospitalizations

Measure	2011	2012	2013
Discharged to the community	33.2%	35.6%	37.5%
Potentially avoidable rehospitalizations:			
During SNF stay	12.4	11.5	11.1
During 30 days after discharge from SNF	5.8	5.6	5.5
During or 30 days after SNF stay	16.5	15.5	15.1

Note: SNF (skilled nursing facility). Higher rates of discharge to community indicate better quality. Higher rehospitalization rates indicate worse quality. Rates are the average of facility rates and calculated for all facilities with 25 or more stays, except the rate of potentially avoidable rehospitalizations during the 30 days after discharge, which is reported for all facilities with 20 or more stays.

Source: Analysis of fiscal year 2011 through fiscal year 2013 Minimum Data Set data by Kramer et al. 2015.

**TABLE
8-4****Mean risk-adjusted functional outcomes in SNFs
show little change between 2011 and 2013**

Composite measure	2011	2012	2013
Rate of improvement in one or more mobility ADLs	43.6%	43.6%	43.7%
Rate of no decline in mobility	87.2	87.2	87.2

Note: SNF (skilled nursing facility), ADL (activity of daily living). The three mobility activities of daily living include bed mobility, transfer, and ambulation. The rate of mobility improvement is the average rates of improvement in bed mobility, transfer, and ambulation, weighted by the number of stays included in each measure. Stays with improvement in one, two, or three ADLs are counted in the improvement measure. The rate of stays with no decline in mobility is the percent of stays with no decline in any of the three ADLs. Rates are the average of facility rates and calculated for all facilities with 25 or more stays.

Source: Analysis of fiscal year 2011 through fiscal year 2013 Minimum Data Set data by Kramer et al. 2015.

As part of the Protecting Access to Medicare Act of 2014, the Congress enacted a SNF readmission policy, with facilities to begin publicly reporting in October 2017. The law requires the Secretary to develop an all-condition risk-adjusted potentially preventable readmission measure by October 2015. Beginning in October 2018, the Secretary must establish a value-based purchasing program that would adjust a facility's payments based on its readmission rate.

No improvement in managing patients' functional status

Most beneficiaries receive rehabilitation therapy, and the amount of therapy furnished to them has steadily increased over time. Yet patients vary considerably in their expected improvement during the SNF stay. Some patients are likely to improve in several ADLs during their SNF stay, while others with chronic and degenerative diseases may expect, at best, to maintain their function. We measure SNF performance on both aspects of patient function on a risk-adjusted basis (see text box on SNF quality measures, pp. 190–191).

The average risk-adjusted rates were essentially unchanged between 2011 and 2013, indicating that even though the program paid for more therapy during this period, the average functional status of beneficiaries did not improve. In 2013, across all facilities, the mean risk-adjusted facility rate of improvement in one or more mobility ADLs during the SNF stay was 43.7 percent, and the mean percent of facility stays with no decline in any of the three ADLs was 87.2 percent (Table 8-4). These risk-adjusted rates consider the likelihood that a patient will change, given the functional ability at admission.

Large variation in quality measures indicates considerable room for improvement

Considerable variation exists across the industry in five quality measures we track. We found one-quarter of facilities had risk-adjusted community discharge rates lower than 29.2 percent, whereas the best performing quarter of facilities had rates of 46.6 percent or higher (Table 8-5). Similar variation was seen in the rehospitalization rates: The worst performing quartile had rates of potentially avoidable readmissions at or above 13.9 percent, whereas the best quarter had rates at or below 8 percent. Finally, rates of rehospitalization in the 30 days after discharge from the SNF varied most—more than twofold between the 25th percentile and the 75th percentile. The amount of variation across and within the groups suggests considerable room for improvement, all else being equal. There was less variation in the mobility measures.

We controlled for facility and geographic characteristics (with multiple regression models) and found that, compared with freestanding facilities, hospital-based facilities had higher community discharge rates (by 6.6 percentage points) and lower readmission rates (by 2.1 percentage points). Nonprofit facilities had moderately higher community discharge rates (by 0.9 percentage point) and lower readmission rates (also by 0.9 percentage point) than for-profit facilities. Compared with urban facilities, rural SNFs had lower community discharge rates (1.5 percentage points), but not statistically different readmission rates. Differences in the rates between hospital-based and freestanding facilities were not statistically meaningful once we controlled for staffing levels. Another study found nonprofit facilities and

**TABLE
8-5****SNF quality measures varied considerably across SNFs, 2013**

Quality measure	Risk-adjusted rate			
	Mean	25th percentile	75th percentile	Ratio of 25th to 75th percentile
Discharged to the community	37.5%	29.2%	46.6%	1.6
Potentially avoidable rehospitalizations during SNF stay	11.1	8.0	13.9	1.7
Potentially avoidable rehospitalizations within 30 days after discharge from SNF	5.5	3.4	7.2	2.1
Average mobility improvement across the three mobility ADLs	43.6	35.6	52.5	1.5
No decline in mobility during SNF stay	87.2	82.7	92.9	1.1

Note: SNF (skilled nursing facility), ADL (activity of daily living). Higher rates of discharge to community indicate better quality. Higher rehospitalization rates indicate worse quality. Mobility improvement is the average of the rates of improvement in bed mobility, transfer, and ambulation, weighted by the number of stays included in each measure. No decline in mobility is the share of stays with no decline in any of the three mobility ADLs. Rates are the average of facility rates and calculated for all facilities with 25 or more stays, except the rate of potentially avoidable rehospitalizations during the 30 days after discharge, which is reported for all facilities with 20 or more stays.

Source: Analysis of fiscal year 2013 Minimum Data Set data by Kramer et al. 2015.

facilities that did better on their annual survey inspection had lower risk-adjusted readmission rates, but differences by facility type (hospital based versus freestanding) were not significant (Neuman et al. 2014).¹²

There was considerable geographic variation across states in the SNF quality measures. For example, after controlling for differences in the mix of facilities, rates of community discharge varied more than 25 percentage points (the average was 37.5 percent) among the states with the best and worst performing SNFs, and the rates of potentially avoidable rehospitalization (occurring during the SNF stay) varied more than 8 percentage points (the average was 11.1 percent).

Providers' access to capital: Lending in 2014

A vast majority of SNFs operate within nursing homes; therefore, in assessing the SNFs' access to capital, we look at the availability of capital for nursing homes. Though Medicare makes up the minority share of almost all facilities' revenues, many operators see Medicare as the best payer.

Market analysts we spoke with reported that capital is generally available and expected to remain so. Lenders continue to focus on the quality of the potential borrower's management team, its cash flow and amount of debt, operating trends (volume, occupancy, payer mix, and acuity mix), and its ability to carry out strategic plans to shift payer or service mix. For example, if a facility

is planning to increase the number of its short-term rehabilitation patients, shift its payer mix, or improve its quality, lenders want to know the operational changes the facility plans to make to achieve its goals. Lenders continue to focus on facilities with high Medicare and private payer mixes and high "acuity" (i.e., intensive therapy), and the potential to expand both.

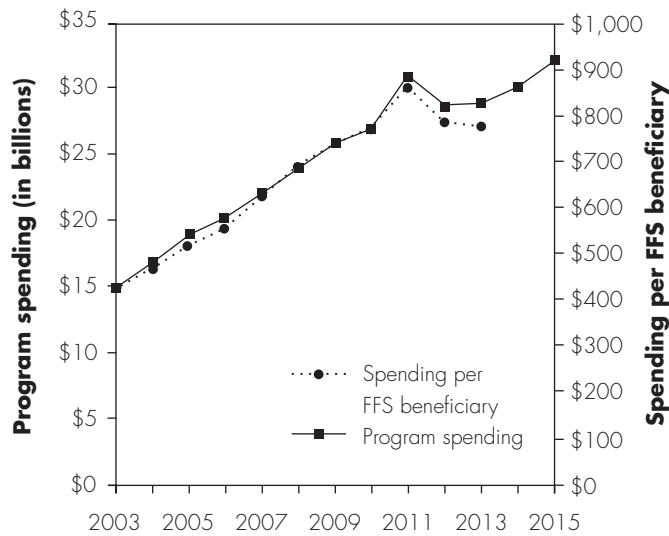
There is increased consolidation this year as health care companies seek more integration across the PAC continuum (Olivia 2014). Strategies include expanding holdings to include multiple PAC service lines (such as home health and hospice) and solidifying presence across the continuum within select markets. Lenders look favorably at a diversified earning stream as a way to spread risk.

The Department of Housing and Urban Development (HUD) continues to be an important lending source. In fiscal year 2014, HUD financed 484 projects, with the insured amount totaling \$4.2 billion. While this number represents a decline from fiscal year 2013, when the count of existing projects that were refinanced is excluded, the number of projects new to HUD increased (including the refinancing of facilities new to HUD, new construction, major renovation, or expansion) (Department of Housing and Urban Development 2014).

Analysts note that in addition to a long-standing wariness about potential budget cuts, lower volume has increased the hesitancy among some lenders. Lenders' reluctance

FIGURE 8-2

After temporary slowdown, SNF spending growth returns to prior pace



Note: SNF (skilled nursing facility), FFS (fee-for-service). Fiscal year spending is shown. Data for 2014 and 2015 are estimates.

Source: CMS, Office of the Actuary 2014.

is not a statement about the adequacy of Medicare's payments to SNFs. Medicare continues to be a preferred payer.

Medicare payments and providers' costs: Medicare margins remained high in 2013

In 2013, the aggregate Medicare margin was 13.1 percent—the 14th consecutive year that Medicare margins were above 10 percent. Margins for individual facilities continue to be highly variable, depending on the facility's share of intensive therapy days, size, and cost per day. The variations in Medicare margins and costs per day were not attributable to differences in patient demographics: High-margin facilities had higher case-mix indexes and higher shares of dual-eligible and minority beneficiaries. Differences by ownership were considerable, with for-profit facilities having much higher Medicare margins than nonprofit facilities. More than 500 freestanding facilities (7 percent of the SNFs included in the analysis of 7,800 facilities) consistently furnished relatively low-cost, higher quality care and had substantial Medicare margins over three consecutive years. Some MA plans' payments were considerably lower than Medicare's FFS payments, and the disparity is unlikely to be explained by differences in

patient mix. These points strongly suggest that SNFs can provide high-quality care at lower payment rates.

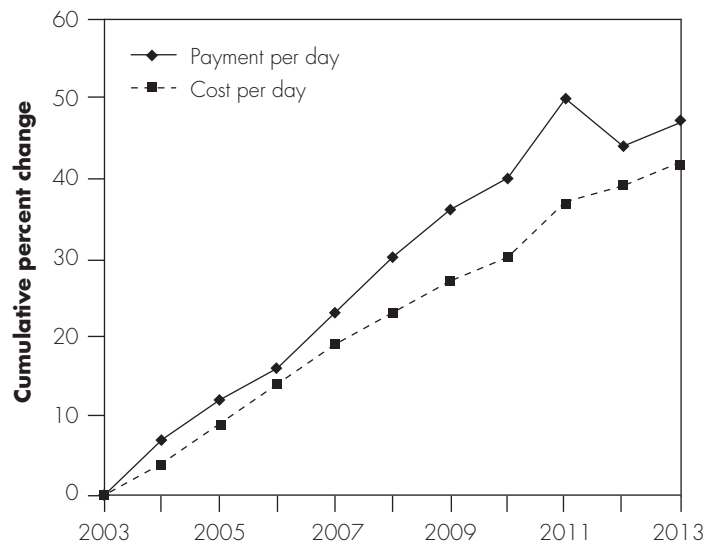
Trends in spending and cost growth

The Office of the Actuary projects program FFS spending for SNF services in fiscal year 2014 to be \$30.2 billion (Figure 8-2). In 2011, payments were unusually high because the rates for the new case-mix classification system included an adjustment that was too large for the mix of therapy modalities assumed in setting the rates. The industry responded to the payment incentive afforded by the new policies and quickly shifted its mix of modalities, and payments increased by 14 percent in 2011. To correct for the excessive payment, CMS revised the adjustment downward in 2012, and total payments were lower in 2012 and 2013. Since then, the growth in spending has risen in line with previous trends, projecting to have increased 4.6 percent in 2014. On a per FFS beneficiary basis, spending in 2013 (\$777) was about the same as in 2012. CMS projects spending in fiscal year 2015 to be \$31.5 billion.

From 2003 to 2013, the cumulative increase in payments per day outpaced the increase in cost per day (Figure 8-3). Costs per day rose 42 percent during this period, while payments grew 47 percent. The large increase in payments

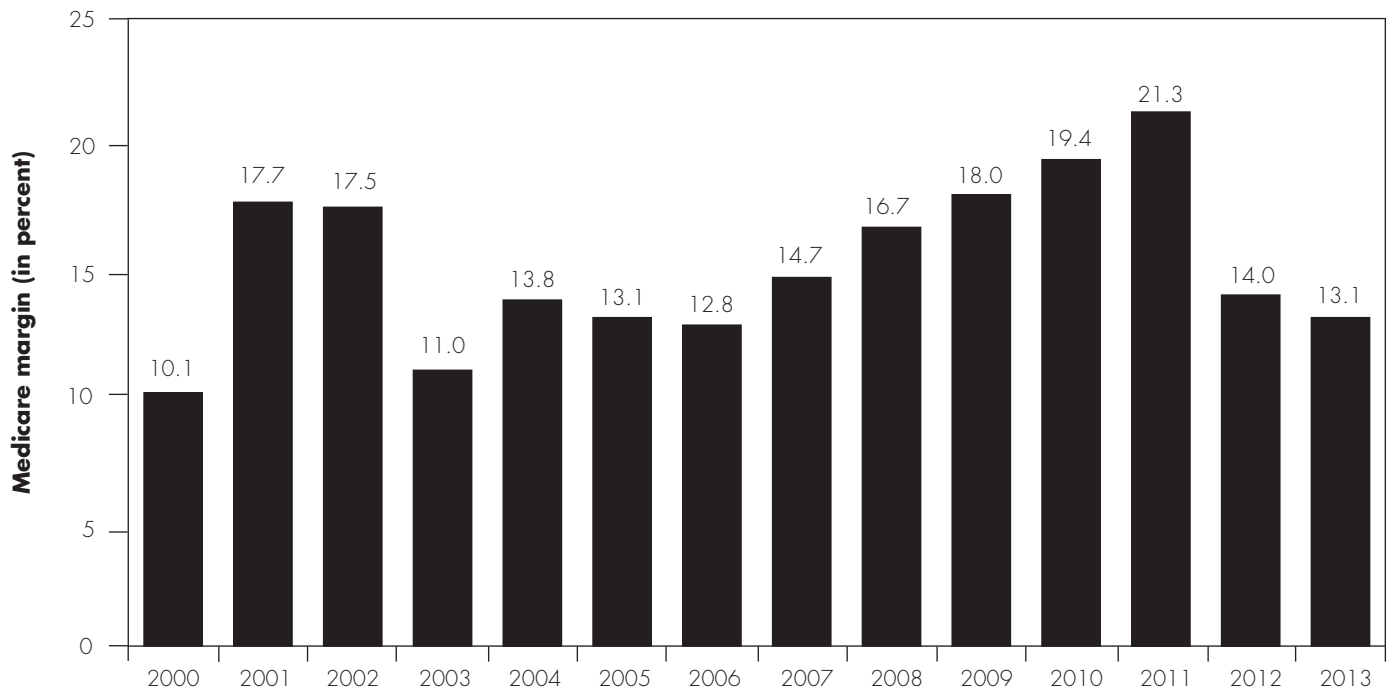
FIGURE 8-3

Cumulative growth in Medicare cost and payments per SNF day, 2003–2013



Note: SNF (skilled nursing facility).

Source: MedPAC analysis of freestanding skilled nursing facility Medicare cost reports from 2003–2013.

**FIGURE
8-4****Freestanding SNF Medicare margins have been above 10 percent since 2000**

Note: SNF (skilled nursing facility).

Source: MedPAC analysis of freestanding SNF cost reports from 2000 to 2013.

reflects the intensification of therapy treatment during this period. Between 2003 and 2011, cost increases were larger than the market basket updates, but because increases in payments exceeded them, SNFs have been highly profitable on average. When Medicare lowered its rates by 11 percent in 2011 to correct for the previous year's overpayments, providers kept their cost growth below the market basket increases. Between 2012 and 2013, cost per day increased at the market basket rate.

By ownership, since 2003, cumulative cost growth for nonprofits has been lower than that of for-profit SNFs. However, since 2011, nonprofits' cost growth has been higher than that of for-profit facilities. In 2013, nonprofit facilities had standardized cost per day (adjusted for differences in wages and case-mix) that was 10 percent higher than the cost per day in for-profit facilities.

SNF Medicare margins remain high

The Medicare margin is a key measure of the adequacy of the program's payments because it compares Medicare's payments with costs to treat beneficiaries. An all-payer

total margin, in contrast, reflects the financial performance of the entire facility across all lines of business (such as ancillary and therapy services, hospice, and home health care) and all payers, and is presented as context for the Commission's update recommendation.

In 2013, the aggregate Medicare margin was 13.1 percent, the 14th consecutive year of Medicare margins above 10 percent (Figure 8-4). The 2013 margin was lower than the 2012 margin for two reasons. First, current law requires market basket increases to be offset by a productivity adjustment. Second, the sequester began lowering payments in April 2013 by 2 percent on an annualized basis.¹³ The combined impact of these policies would have been greater but was offset by the continued increase in the share of cases assigned to the highest payment case-mix groups, the ultra-high therapy groups. In 2011, the Medicare margin was 21.3 percent, reflecting the large increase in payments because of the implementation of the new case-mix groups and an incorrect adjustment factor. Despite reductions to correct SNF payments the following year, Medicare margins remained high in 2012 (14 percent).

**TABLE
8-6****Variation in freestanding SNF Medicare margins reflects the mix of cases and cost per day, 2013**

Subgroup	Medicare margin
All	13.1%
For profit	15.3
Nonprofit	5.0
Rural	12.1
Urban	13.3
Frontier	2.9
25th percentile	3.7
75th percentile	21.7
Intensive therapy: High share of days	15.1
Intensive therapy: Low share of days	8.0
Medically complex: High share of days	11.0
Medically complex: Low share of days	13.9
Small (20–50 beds)	3.7
Large (100–199 beds)	14.4
Standardized cost per day: High	3.2
Standardized cost per day: Low	26.4
Standardized cost per discharge: High	10.6
Standardized cost per discharge: Low	15.1

Note: SNF (skilled nursing facility). “Low” is defined as facilities in the bottom 25th percentile; “high” is defined as facilities in the highest 25th percentile. “Standardized costs per day” are Medicare costs adjusted for differences in area wages and the case mix (using the nursing component’s relative weights) of Medicare beneficiaries.

Source: MedPAC analysis of 2013 freestanding SNF Medicare cost reports.

In 2013, hospital-based facilities (3 percent of program spending on SNFs) continued to have extremely negative Medicare margins (–70 percent), in part because of the higher cost per day reported by hospitals. Previous analysis by the Commission found that routine costs in hospital-based SNFs were higher, reflecting more staffing, higher skilled staffing, and shorter stays (over which to allocate costs) (Medicare Payment Advisory Commission 2007). However, administrators consider their SNF units in the context of the hospital’s overall financial performance. Hospitals with SNFs can lower their inpatient lengths of stay and make inpatient beds available to treat additional inpatient admissions. As a result, hospital-based SNFs can contribute to the bottom-line financial performance

of hospitals: Hospitals with SNFs had lower inpatient costs per case and higher inpatient Medicare margins than hospitals without SNFs.

High and widely varying SNF Medicare margins indicate reforms to the PPS are still needed

The persistently high Medicare margins and the wide variation indicate that the PPS needs to be revised and rebased so that payments more closely match patient characteristics, not the services provided to them. In 2013, one-quarter of freestanding SNFs had Medicare margins of 21.7 percent or higher, while another quarter of freestanding SNFs had margins of 3.7 percent or lower (Table 8-6). The disparity between for-profit and nonprofit facilities is considerable and reflects differences in case mix, service provision, and costs. Facilities with the highest SNF margins had high shares of intensive rehabilitation therapy and low shares of medically complex days. Despite the payment increases for medically complex cases in October 2010, the relative financial performance for facilities with high shares of these cases did not on average improve. Lower cost SNFs and larger SNFs had higher Medicare margins than higher cost SNFs and smaller SNFs. The SNF Medicare margin for facilities with the lowest cost per day (the bottom quartile of cost per day) was 26.4 percent, while the margin for facilities with the highest cost per day (the top quartile) was 3.2 percent.

Differences in costs and revenues between freestanding facilities in the top and bottom quartiles of Medicare margins underscore the need to revise the PPS and more closely align payments with costs. The highest margin SNFs had lower daily costs (their costs were 70 percent of the costs of low-margin SNFs and their revenues were 1.1 times the revenues for low-margin SNFs), driven partly by having higher shares of intensive therapy days (Table 8-7). Treating higher shares of dually eligible or minority beneficiaries did not reduce the financial performance of the highest margin facilities. They had higher shares of these beneficiaries compared with the lowest margin facilities. Facilities with high margins also treated more complex patients (as measured by the relative weights associated with the nursing component of the case-mix groups) but had lower shares of patients classified into medically complex case-mix groups.¹⁴

These differences in financial performance illustrate why the PPS needs to be revised. Even after CMS expanded the number of medically complex case-mix groups and shifted spending away from therapy care, the

**TABLE
8-7****Cost and revenue differences explain variation in Medicare margins for freestanding SNFs in 2013**

Characteristic	SNFs in the top margin quartile	SNFs in the bottom margin quartile	Ratio of SNFs in the top margin quartile to SNFs in the bottom margin quartile
Cost measures			
Standardized cost per day	\$250	\$359	0.7
Standardized cost per discharge	\$11,116	\$13,591	0.8
Standardized ancillary cost per day	\$113	\$154	0.7
Standardized routine cost per day	\$139	\$201	0.7
Average daily census (patients)	88	68	1.3
Average length of stay (days)	46	37	1.3
Revenue measures			
Medicare payment per day	\$474	\$424	1.1
Medicare payment per discharge	\$22,391	\$15,790	1.4
Share of days in intensive therapy	82%	73%	1.1
Share of medically complex days	4%	6%	0.7
Medicare share of facility revenue	26%	16%	1.6
Patient characteristics			
Case-mix index	1.39	1.30	1.1
Dual-eligible share of beneficiaries	40%	27%	1.5
Share minority beneficiaries	13%	4%	3.3
Share very old beneficiaries	30%	35%	0.9
Medicaid share of days	66%	58%	1.1
Facility mix			
Share for profit	90%	60%	N/A
Share urban	76%	68%	N/A

Note: SNF (skilled nursing facility), N/A (not applicable). Values shown are medians for the quartile. Top margin quartile SNFs (n=3,238) were in the top 25 percent of the distribution of Medicare margins. Bottom margin quartile SNFs (n=3,238) were in the bottom 25 percent of the distribution of Medicare margins. "Standardized costs per day" are Medicare costs adjusted for differences in area wages and the case mix (using the nursing component's relative weights) of Medicare beneficiaries. "Intensive therapy" days are days classified into ultra-high and very high rehabilitation case-mix groups. "Very old beneficiaries" are 85 years or older.

Source: MedPAC analysis of freestanding 2013 SNF cost reports.

PPS continues to result in higher Medicare margins for facilities providing intensive therapy. A PPS design based on patient characteristics (such as the one recommended by the Commission) would redistribute Medicare spending to SNFs according to their mix of patients, not the amount of therapy provided.

Ownership of low-margin and high-margin facilities did not mirror the industry mix. Although for-profit facilities made up 70 percent of SNFs overall, they comprised a smaller share (60 percent) of the low-margin facilities and a higher share (90 percent) of the high-margin group.

Variation in costs per day for freestanding SNFs not related to patient demographics or facility characteristics

We also found that most of the variation in costs per day was not related to a SNF's location, case mix, ownership, or beneficiary demographics (a facility's share of very old, dual-eligible, and minority beneficiaries). Across the freestanding facility subgroups, median standardized cost per day varied 13 percent, from \$282 to \$319 per day after differences in wages and case mix were taken into account (Table 8-8, p. 198). However, there was more variation

**TABLE
8-8****Freestanding SNFs' standardized costs per day vary within and across groups, 2013**

Subgroup of SNF	Median	Within-group variation (ratio of high-cost to low-cost SNFs)
All freestanding	\$296	1.23
Location		
Rural	295	1.22
Urban	296	1.24
Ownership		
Nonprofit	319	1.24
For profit	289	1.22
Share of dual-eligible beneficiaries		
Low share	317	1.25
High share	283	1.25
Share of minority beneficiaries		
Low share	302	1.24
High share	282	1.23
Share of very old beneficiaries (over 85 yrs old)		
Low share	288	1.23
High share	311	1.26

Note: SNF (skilled nursing facility). "High-cost SNFs" were in the top 25 percent of the distribution of Medicare cost per day. "Low-cost SNFs" were in the bottom 25 percent of the distribution of Medicare per day. "Standardized costs per day" are Medicare costs adjusted for differences in area wages and the case mix (using the nursing component's relative weights) of Medicare beneficiaries. "Low share" includes facilities in the bottom 25th percentile. "High share" includes facilities in the highest 25th percentile.

Source: MedPAC analysis of freestanding SNF Medicare cost reports 2013 and 2013 Medicare denominator file.

within each group (22 percent to 26 percent). This variation, even after controlling for key reasons why costs might differ, suggests that facilities can lower their costs to match those of other facilities.

High margins achieved by relatively efficient SNFs

The Commission is required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 to consider the costs associated with efficient providers.

We examined the financial performance of freestanding SNFs with consistent cost and quality performance (see text box). To measure costs, we looked at costs per day that were adjusted for differences in area wages and case mix. To assess quality, we examined risk-adjusted rates of community discharge and potentially avoidable rehospitalizations that occurred during the SNF stay. To be included in the relatively efficient group, a SNF had to be in the best third of the distribution of one measure and not in the bottom third on any measure for three consecutive years. According to this definition, 524 SNFs (7 percent of the 7,800 facilities included in the analysis) provided relatively low-cost, high-quality care. Of these, more than half were identified as efficient last year.

Our analyses found that SNFs can have relatively low costs and provide relatively good quality of care while maintaining high margins (Table 8-9, p. 200). Compared with the national average in 2013, relatively efficient SNFs had community discharge rates that were 20 percent higher and rehospitalization rates that were 18 percent lower. Standardized costs per day were 7 percent lower than the average. We did not find significant differences between relatively efficient and other SNFs in terms of occupancy rates or size of facility. Efficient facilities had more complex case mixes (driven in part by higher therapy intensity) but shorter stays. In terms of case-mix days, efficient providers had higher shares of the most intensive therapy days and comparable shares of medically complex days. The higher therapy intensity raised their daily Medicare payments relative to all SNFs, indicating that in addition to controlling their costs, efficient providers pursue revenue strategies to maximize their Medicare payments. The median Medicare margin for efficient SNFs was 20.6 percent, and their total margin (for all payers and all lines of business) was 3.5 percent. Relatively efficient facilities were more likely to be urban and for profit.

We recognize that a SNF may appear to be efficient with respect to the care it provides but may not be when considering a patient's entire episode of care. For example, SNFs that discharge patients to other post-acute care services may keep their own costs low but shift costs to other settings, thus increasing total Medicare program spending. In the future, we may compare providers' costs for the episode of care.

FFS payments for SNF care are considerably higher than MA payments

Another indicator that Medicare's payments under the SNF PPS are too high is the comparison of FFS and MA

Identifying relatively efficient skilled nursing facilities

We defined relatively efficient skilled nursing facilities (SNFs) as those with relatively low costs per day and good quality care for three years in a row, 2010 through 2012. The cost per day was calculated using cost report data and was adjusted for differences in case mix (using the nursing component relative weights) and wages. Quality measures were risk-adjusted rates of community discharge and potentially avoidable rehospitalizations during the SNF stay. Only facilities with at least 25 stays were included in the quality measures.

The method we used to assess performance attempts to limit drawing incorrect conclusions about performance based on poor data. Using three years to categorize SNFs as efficient (rather than just one year) avoids categorizing providers based on random variation or one “bad” year. In addition, by first assigning a SNF to a group and then examining the group’s performance in the next year, we avoided having a facility’s poor data affect both its own categorization and the assessment of the group’s performance. Thus, a SNF’s erroneous data could result in its inaccurate assignment to a group, but

because the group’s performance is assessed with data from later years, these “bad” data would not affect the assessment of the group’s performance.

Fewer facilities this year were both relatively low cost and relatively high quality than last year. Fewer facilities were in the best two-thirds for each measure for three years and therefore could not qualify as being efficient. Among efficient providers, fewer were in the best third for the cost measure and one quality measure, and fewer were in the best third for all three measures. Because nonprofit facilities have a higher cost per day and have had higher recent cost growth, they are underrepresented in the efficient group. Efficient SNFs were located in 39 states, including 1 in a frontier location.

The most recent Commission discussions of the efficient provider analyses raised several questions about the existing methods for defining efficient providers and generated new ideas for consideration. The Commission staff will be undertaking a reexamination of the efficient provider analyses. ■

payments. We compared Medicare FFS and MA payments at five nursing home companies where such information was publicly available. Medicare’s FFS payments averaged 22 percent higher than MA rates (Table 8-10, p. 200).¹⁵ It is possible that smaller MA companies have less leverage and do not negotiate similarly low rates.

We compared the patient characteristics of beneficiaries enrolled in FFS and MA plans in 2013 and found small differences that would not explain the payment differences between the two. Compared with FFS beneficiaries, MA enrollees were the same age, had slightly higher Barthel scores (less than two points, indicating slightly more independence), and had slightly lower (4 percent) risk scores, indicating fewer comorbidities. The considerably lower MA payments indicate some facilities accept much lower payments to treat MA enrollees who are not much different in terms of case-mix from FFS beneficiaries. Some publicly traded firms report seeking managed care patients as a business strategy, indicating that the rates are attractive.

Total margins increased slightly in 2013

The average total margin for freestanding SNFs in 2013 was 1.9 percent, a small increase from 2012 (1.8 percent). A total margin reflects services to all patients (public and private) across all lines of business (for example, their long-term care, hospice, and other services) and revenue sources. Total margins are driven in large part by state policies regarding the level of Medicaid payments and the ease of entry into a market (e.g., whether there is a requirement for a certificate of need).

The publicly traded companies we examined report several trends in revenues. Companies try to grow their high-acuity rehabilitation (including Medicare) days and spread their risk by expanding into other businesses, including home health care, hospice, and outpatient therapy (AdCare 2014, DiversiCare 2014, Ensign Group 2014a, Extendicare 2014a, Kindred Healthcare 2014a, Skilled Healthcare 2014a). In addition, companies try to increase their managed care and private payer business (Extendicare 2014a, Skilled Healthcare 2014a).

**TABLE
8-9****Financial performance of relatively efficient SNFs is a combination of lower cost per day and higher revenues per day****Type of SNF****Performance in 2013****Relatively efficient****All SNFs**

Community discharge rate	48%	40%
Rehospitalization rate	9%	11%
Standardized cost per day	\$272	\$293
Medicare revenue per day	\$487	\$458
Medicare margin	20.6%	14.5%
Total margin	3.5%	2.1%
Facility case-mix index	1.42	1.37
Medicare average length of stay	33 days	37 days
Occupancy rate	88%	87%
Number of beds	120	117
Share intensive therapy days	82%	80%
Share medically complex days	5%	5%
Medicaid share of facility days	58%	61%
Share urban	81%	74%
Share for profit	83%	75%

Note: SNF (skilled nursing facility). The number of freestanding facilities included in the analysis was 7,928. SNFs were identified as “relatively efficient” based on their cost per day and two quality measures (community discharge and rehospitalization rates) between 2010 and 2012. Relatively efficient SNFs were those in the best third of the distribution for one measure and not in the worst third for any measure in each of three years. Costs per day were standardized for differences in case mix (using the nursing component relative weights) and wages. Quality measures were rates of risk-adjusted community discharge and rehospitalization for patients with potentially avoidable conditions within 100 days of hospital discharge. Quality measures were calculated for all facilities with at least 25 stays. “Intensive therapy days” includes days classified into the ultra-high and very high case-mix groups. Table shows the medians for the measure.

Source: MedPAC analysis of quality measures and Medicare cost report data for 2010–2013.

**TABLE
8-10****Comparison of Medicare fee-for-service and Medicare Advantage daily payments in 2014 for five companies****Medicare payment**

Company	FFS	MA	Ratio of FFS to MA payment
Diversicare	\$441	\$380	1.16
Ensign Group	561	412	1.36
Extendicare	474	454	1.04
Kindred	551	436	1.26
Skilled Healthcare	522	410	1.27

Note: FFS (fee-for-service), MA (Medicare Advantage). The rates are reported as “managed care payments,” of which MA would make up the majority. The Kindred rate is specific to MA payments.

Source: Third quarter 10-Q 2014 reports available at each company’s website.

Medicare's skilled nursing facility payments should not subsidize payments from Medicaid or other payers

Industry representatives contend that Medicare payments should continue to subsidize payments from other payers, most notably from Medicaid. However, high Medicare payments could also subsidize payments from private payers. The Commission believes such cross-subsidization is not advisable for several reasons. First, this strategy results in poorly targeted subsidies. Facilities with high shares of Medicare payments would receive the most in subsidies from higher Medicare payments, while facilities with low Medicare shares—presumably the facilities with the greatest need—would receive the smallest subsidies. Shares of Medicare and Medicaid patients vary widely across facilities (Table 8-11). As a result, the impact of the Medicare subsidy would vary considerably across facilities, putting more dollars into facilities with high Medicare use (and low Medicaid use), which are likely to have higher Medicare margins than other facilities.

In addition, Medicare's subsidy does not discriminate among states with relatively high and low Medicaid payments. If Medicare raises or maintains its high payment levels, states could be encouraged to further reduce their Medicaid payments and in turn create pressure to raise Medicare rates. Higher Medicare payments could further encourage providers to select patients based on payer source or to rehospitalize dual-eligible patients to qualify them for a Medicare-covered, higher payment stay. Finally, Medicare's high payments represent a subsidy of Trust Fund dollars (and its taxpayer support) to the low payments made by states and private payers. If the Congress wishes to help certain nursing facilities (such as those with high Medicaid shares), it would be more efficient to do so through a separate targeted policy. ■

**TABLE
8-11**

Medicare and Medicaid shares vary widely across freestanding skilled nursing facilities, 2013

SNF type and payer	Percentile of facility days				
	10th	25th	Median	75th	90th
Medicare share	5%	8%	12%	17%	26%
	Percentile of facility days				
	10th	25th	Median	75th	90th
Medicaid share	0	43	62	74	81

Note: SNF (skilled nursing facility).

Source: MedPAC analysis of SNF Medicare cost reports, 2013.

Even though these shifts may lower their revenues because these payment rates and lengths of stay are typically lower, they are preferred to Medicaid admissions. Furthermore, the average daily payments from Medicaid increased between 2013 and 2014 (DiversiCare 2014, Ensign Group 2014b, Extendicare 2014b, Kindred Healthcare 2014b, Skilled Healthcare 2014b).

Because Medicaid payments are lower than Medicare payments, some in the industry argue that high Medicare payments are needed to subsidize losses on Medicaid residents. This strategy is ill advised for several reasons (see text box). In addition to Medicare's share of facility revenues, other factors that shape a facility's total financial performance are its share of revenues from private payers (generally considered favorable), its other

lines of business (such as ancillary, home health, and hospice services), and nonpatient sources of income (such as investment income).

Payments and costs for 2015

In assessing the payment update for 2016, the Commission considers the estimated relationship between SNF costs and Medicare payments in 2015. To estimate costs for 2014 and 2015, we assumed cost growth of the market basket. To estimate 2014 payments, we began with reported 2013 payments and increased payments by the market basket net of the productivity adjustment (as required by the Patient Protection and Affordable Care Act of 2010) and the forecast error correction in 2014. We also factored in the program's reduced payments for bad debt, as required by the Middle Class Tax Relief and Job Creation Act of 2012, and estimated the impact of the sequester for a full year. For 2015, estimated 2014 payments were increased by the market basket and offset by the productivity adjustment, reduced payments for the bad debts of dual-eligible beneficiaries, and the impact of the sequester. The projected 2015 Medicare margin is 10.5 percent.

How should Medicare payments change in 2016?

In 2012, the Commission recommended to the Congress that it direct the Secretary first to revise the PPS and, in the subsequent year, rebase Medicare payments in stages, with an initial reduction of 4 percent (see text box on recommendation language). The recommendation begins with revising the PPS and not updating payments in the first year (now fiscal year 2016). The revision would be done in a budget-neutral fashion and would redistribute payments away from intensive therapy care that is unrelated to patient care needs and toward medically complex beneficiaries. Payments would increase for the following types of facilities: hospital based, nonprofit, rural, those with high NTA costs, and those treating high shares of medically complex patients. By improving the accuracy of payments, the revised design would narrow the disparities in financial performance that result from the facility's mix of cases treated and its therapy practices (see p. 186). On average, Medicare margins would rise for low-margin facilities and would fall for high-margin facilities. Because payments would be based on a patient's care needs, the design would allow for high payments if a patient required many services but would not (and should

not) address disparities across providers that result from their inefficiencies.

After the proposed revision, the recommendation outlines a strategy to bring payments closer to provider costs over subsequent years, making reductions in stages. This approach acknowledges the need to proceed cautiously but deliberately to help ensure there are no unintended disruptions caused by rebasing. The recommended changes are not expected to impair beneficiary access to care. In fact, they are expected to improve access to services for beneficiaries who might be disadvantaged by the design of the current payment system. Because payments would be reduced after the PPS was redesigned, the effects would be tempered for those facilities whose poor financial performance is based on their mix of cases.

The Commission based its 2012 recommendation on several pieces of evidence pointing to the need to revise and rebase the PPS:

- Aggregate Medicare margins for SNFs have been above 10 percent since 2000. Since the payment system was implemented in 1998, the industry has shifted its mix of days to increase its revenues.
- Variation in Medicare margins is not related to differences in patient characteristics but, rather, to the amount of therapy furnished to patients.
- Large cost differences remain after adjusting for differences in wages, case mix, and beneficiary demographics.
- Relatively efficient SNFs, with relatively low costs and high quality, indicate that payments could be lowered without adversely affecting the quality of care.
- FFS payments to some SNFs were considerably higher than some MA payments, suggesting some facilities are willing to accept much lower rates than FFS payments to treat Medicare beneficiaries.
- The industry has shown it is nimble at responding to the level of Medicare's payments. Even in years when CMS lowered payments, providers tempered the effects with longer stays and the assignment of days into higher payment case-mix groups. In 2010, when payments were recalibrated and lowered to reflect the implementation of new case-mix groups in 2006, program spending still increased. In 2012, when CMS lowered payments to correct its overpayment, facilities

The Commission reiterates its March 2012 update recommendation for skilled nursing facilities

Recommendation 7-1, March 2012 report

The Congress should eliminate the market basket update and direct the Secretary to revise the prospective payment system for skilled nursing facilities (SNFs) for [2016]. Rebased payments should begin in [2017], with an initial reduction of 4 percent and subsequent reductions over an appropriate transition until Medicare's payments are better aligned with providers' costs.

Implications 7-1, March 2012 report

Spending

- When this recommendation was made in March 2012, the spending implications were that it would lower program spending relative to current law by between \$250 million and \$750 million for fiscal year 2013 and between \$5 billion and \$10 billion over five years. Savings occur because current law requires a market basket increase (offset by a productivity adjustment, as required by the Patient Protection and Affordable Care Act of 2010). Updated for implementation three years later, the direction of the savings is identical. The one-year

savings estimate ranges from \$750 million to \$2 billion and the five-year estimated savings is more than \$10 billion.

Beneficiary and provider

- We do not expect an adverse effect on beneficiary access. Most beneficiaries live in counties with multiple providers, so that even if a low-performing SNF were to close, most beneficiaries would continue to have a SNF in the county. Revising the prospective payment system will result in fairer payments across all types of care, making providers more likely to admit and treat beneficiaries with complex care needs. We do not expect the recommendation to affect providers' willingness or ability to care for Medicare beneficiaries. Provider payments will be lower, but the differences in Medicare margins will be smaller. Effects on individual providers will be a function of their mix of patients and current practice patterns. The recommendation would not eliminate all of the differences in Medicare margins across providers because of their large cost differences. ■

kept their cost growth below the SNF market basket for the first year in more than a decade.

The factors examined to assess payment adequacy indicate that the circumstances of the SNF industry have not changed materially during the past year, yet the urgency for change remains. Our work indicates that there is even more need for reform because payments for therapy and NTA services have grown more inaccurate over time. Further, the continued high level of payments essentially requires taxpayers to continue to finance the high Medicare margins of this industry.

Therefore, the Commission stands by a two-part recommendation to revise and rebase the SNF payment system. In the first year (2016), there would be no update to the SNF PPS base rate while the PPS was revised and, in year two (2017), payments would be lowered by an initial 4 percent. In subsequent years, the Commission would evaluate whether continued reductions were necessary to further align payments with costs.

In its deliberations, the Commission discussed the possibility of recommending an immediate small rebasing of payments, followed by the implementation of a revised PPS and subsequent further rebasing. Although this sequence would diverge from the Commission's long-standing position to revise the PPS before payment reductions were made, it reflects a growing impatience with the lack of progress in improving the accuracy of Medicare's payments and lowering the level of the program's payments. The industry has not actively engaged in the Commission's recommended reforms of the SNF PPS. Further, we found that the multiple revisions CMS has made to the PPS have been inadequate to address the fundamental shortcomings and inaccuracies of the current design. An initial reduction could spark the SNF community's interest in revising the PPS so that subsequent reductions are taken from a more equitable distribution of payments across providers. Over the coming year, the Commission will explore this alternative.

**TABLE
8-12****The number of nursing homes treating Medicaid enrollees stayed relatively stable in 2014**

	2004	2006	2008	2010	2012	2013	2014	Percent change 2013-2014
Number of facilities	15,682	15,319	15,201	15,082	15,056	15,035	15,011	-0.2%

Source: Certification and Survey Provider Enhanced Reporting on CMS's Survey and Certification Providing Data Quickly system, 2004-2014.

Medicaid trends

Section 2801 of the Patient Protection and Affordable Care Act of 2010 (PPACA) requires the Commission to examine spending, use, and financial performance trends under the Medicaid program for providers with a significant portion of revenues or services associated with the Medicaid program. We report nursing home spending and use trends for Medicaid and financial performance for non-Medicare payers. Medicaid revenues and costs are not reported in the Medicare cost reports. In a joint publication with the Medicaid and CHIP Payment Access Commission, we report on characteristics, service use, and spending for dual-eligible beneficiaries (Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission 2015).

Medicaid covers nursing home (long-term care) and skilled nursing care provided in nursing facilities. Medicaid pays for long-term care services that Medicare does not cover. For beneficiaries who are dually eligible for Medicaid and Medicare, Medicaid pays the Medicare copayments required of beneficiaries beginning on day 21 of a SNF stay.

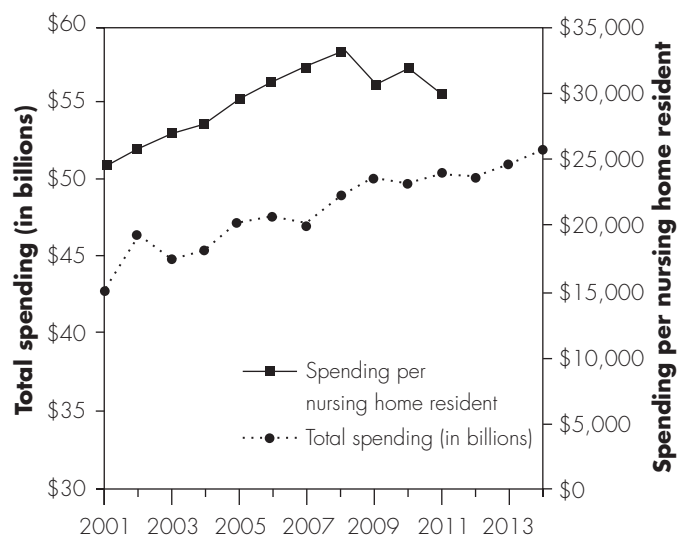
Utilization

There were more than 1.62 million users of Medicaid-financed nursing home services in 2011, the most recent year of available data (Centers for Medicare & Medicaid Services 2013). This use represents a small increase from 2010 but a 4.9 percent decline from 2000. The number of nursing facilities certified as Medicaid providers also declined slightly between 2013 and 2014 (Table 8-12). The decline in facilities may reflect the expansion in some states of home- and community-based services (HCBS), which allow beneficiaries to remain in their homes rather than in an institution. State HCBS waivers and federal initiatives have accelerated the trend toward HCBS.

In fiscal years 2014 and 2015, 42 states and 47 states, respectively, expanded the number of beneficiaries served by HCBS, up from 33 states in fiscal year 2013 (Smith et al. 2014).

Spending

CMS estimates that about \$52 billion (combined state and federal funds) was spent in 2014 on Medicaid-funded nursing home services (Office of the Actuary 2014a) (Figure 8-5). Between 2013 and 2014, Medicaid spending on nursing home services increased by almost 2

**FIGURE
8-5****Total and per user Medicaid
spending on nursing home services**

Note: Resident counts (and therefore per resident spending) are not available for 2012 through 2014.

Source: Total spending data come from CMS, Office of the Actuary. Per user spending data come from Health Care Financing Review 2013 Statistical Supplement available at <https://www.cms.gov/Medicare/MedicaidStatSupp>.

**TABLE
8-13****Non-Medicare margins were negative, but total margins were positive**

Type of margin	2004	2006	2008	2010	2012	2013
Non-Medicare margin	-1.3%	-0.8%	-2.4%	-1.5%	-2.0%	-1.9%
Total margin	1.8	2.2	2.2	3.6	1.8	1.9

Note: "Non-Medicare margins" include the revenues and costs associated with Medicaid and private payers. "Total margins" include the revenues and costs associated with all payers and all lines of business.

Source: MedPAC analysis of freestanding 2004–2014 skilled nursing facility cost reports.

percent. CMS projects spending to grow by 2.3 percent in 2015. Spending increases averaged 1.6 percent annually between 2001 and 2014, for a total of almost 22 percent over the period. Year-to-year changes in spending were variable, increasing in some years and decreasing in others. On a per user basis, spending per nursing home resident averaged \$29,855 in 2011, the most recent year for resident counts. Between 2010 and 2011, spending per resident decreased by about 6.3 percent and represented a 32 percent increase from 2000 (Centers for Medicare & Medicaid Services 2013).

Analysis of Medicaid rate-setting trends found 12 states restricted (froze or lowered) rates paid to nursing homes in 2014, while 38 states and the District of Columbia increased rates (Smith et al. 2014). In 2015, 40 states plan to increase rates and 10 states plan to decrease them. This change represents a steady improvement in the Medicaid revenues for nursing homes. In 2012, 16 states froze rates and another 12 reduced them, while in 2013, 17 states restricted payments for nursing homes. States continue to use provider taxes to raise federal matching funds. In fiscal year 2014, 44 states levied provider taxes on nursing homes, and all of them intended to do so in fiscal year 2015 (Smith et al. 2014).

Medicare's higher payments are often pointed to as evidence that Medicaid rates are too low. However, the acuity of the average Medicare SNF patient is considerably higher than the acuity of the average Medicaid resident. Using data from 2011, we previously estimated that the differences in acuity between the average Medicaid nursing home resident and the average Medicare SNF patient translate to payments that would be 84 percent higher for Medicare patients (White 2012, White et al. 2002). So, while Medicare payments are higher, the vast majority of the difference is explained by differences in the acuity of the enrollees.

Non-Medicare and total margins in nursing homes

In 2013, total margins (reflecting services to all patients across all lines of business and including all revenue sources) were positive (1.9 percent) but lower than total margins in 2010. This decrease reflects the impact of PPACA reductions to Medicare payments since 2010, as well as a growing share of managed care payments that are lower than Medicare's payments. The aggregate non-Medicare margin in 2013 (i.e., for Medicaid and private payers) was -1.9 percent (Table 8-13). ■

Endnotes

- 1 Throughout this chapter, *beneficiary* refers to an individual whose SNF stay coverage (Part A) is paid for by Medicare. Some beneficiaries who no longer qualify for Medicare coverage remain in the facility to receive long-term care services, which are not covered by Medicare. During long-term care stays, beneficiaries may receive services such as physician services, outpatient therapy, and prescription drugs that are paid for separately under the Part B and Part D benefits. Services furnished outside the Part A–covered stay are not paid under the SNF PPS and are not considered in this chapter. Some beneficiaries also qualify for Medicaid and are referred to as dual-eligible beneficiaries.
- 2 A spell of illness begins when a beneficiary has not had hospital care or skilled care in a SNF for 60 consecutive days. Observation days and emergency room stays do not count toward the three-day requirement.
- 3 For services to be covered, the SNF must meet Medicare’s requirements of participation and agree to accept Medicare’s payment rates. Medicare’s requirements relate to many aspects of staffing and care delivery, such as requiring a registered nurse in the facility for 8 consecutive hours per day and licensed nurse coverage 24 hours a day, providing physical and occupational therapy services as delineated in each patient’s plan of care, and providing or arranging for physician services 24 hours a day in case of an emergency.
- 4 The program pays separately for some services, including certain chemotherapy drugs, certain customized prosthetics, certain ambulance services, Part B dialysis, emergency services, and certain outpatient services provided in a hospital (such as computed tomography, MRI, radiation therapy, and cardiac catheterizations).
- 5 There are two broad categories of medically complex case-mix groups: clinically complex and special care. Clinically complex groups are used to classify patients who have burns, surgical wounds, hemiplegia, or pneumonia or who receive chemotherapy, oxygen therapy, intravenous medications, or transfusions while a SNF patient. Special care groups include patients who are comatose; have quadriplegia, chronic obstructive pulmonary disease, septicemia, diabetes requiring daily injections, fever with specific other conditions, cerebral palsy, multiple sclerosis, Parkinson’s disease, respiratory failure, a feeding tube, pressure ulcers of specific sizes, or foot infections; receive radiation therapy or dialysis while a resident; or require parenteral or intravenous feedings or respiratory therapy for seven days.
- 6 In 2010 (for fiscal year 2011), CMS revised how the therapy time for concurrent therapy (two patients engaged in different therapy activities at the same time) was to be allocated between the two patients treated, which effectively lowered the payment for this modality. It also required end-of-therapy assessments to prevent paying for therapy services after they have been discontinued. In 2011 (for fiscal year 2012), CMS revised how the time spent in group therapy (therapy provided in groups with up to four patients engaged in the same therapy activities at the same time) was to be allocated across the four patients in the group, again effectively lowering payments for this modality.
- 7 Medically complex days make up the other 7 percent of days. See endnote 5 for the definition of medically complex.
- 8 Intensive therapy days are those classified in the ultra-high and very high rehabilitation case-mix groups. Rehabilitation groups are based on minutes of rehabilitation provided per week. *Ultra-high rehabilitation* includes patients who received more than 720 minutes per week; *very high rehabilitation* includes patients who received 500–719 minutes per week.
- 9 The 10 activities of daily living include bowel control, bladder control, transfer, walk in the facility corridor, self-feed, toilet, bathe, dress, perform personal hygiene, and bed mobility.
- 10 With inclusion of the other covariates, age categories were not found to be significant in explaining variation in outcomes and were dropped from the models, except for the model explaining differences in rehospitalization during the 30 days postdischarge for community-residing beneficiaries younger than 65.
- 11 The readmission rates of patients during their SNF stay and in the period after discharge cannot simply be added to get a combined rate because, in the combined measure, a stay is counted only once, even if the patient was readmitted during the SNF stay and in the poststay period. In contrast, each relevant stay is counted separately in each measure.
- 12 The study also found differences in staffing were not related to readmission rates, but limitations of the staffing measure (it did not distinguish between staffing type, grouped all staffing hours into ranges rather than using the hours per patient day, and did not adjust for regional variation) may explain this unexpected finding.

- 13 Program payments were lowered by an estimated 1.3 percent, reflecting differences in the cost reporting periods of the freestanding SNFs included in the margin calculation. Almost three-quarters of freestanding SNFs (and the same share of Medicare payments) are on a calendar year cost reporting period; the sequester lowered payments to these SNFs for nine months.
- 14 We use the nursing component (as opposed to the payment weight of the case-mix group) to avoid distorting the measure of patient complexity by the amount of therapy furnished, which could be unrelated to patient care needs. We used the indexes adjusted for CMS's policy decisions to shift payments toward certain case-mix groups and away from others (White 2012). Because the nursing weights for intensive therapy are relatively high, a facility can have both a high case-mix index and a moderate or low share of medically complex patients.
- 15 The differences for Extendicare are smaller than for other companies because many of its contracts with managed care companies are based on the FFS system.

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C H A P T E R

9

Home health care services

R E C O M M E N D A T I O N S

(The Commission reiterates its March 2011 recommendations on improving the home health payment system. See text box, pp. 232–234.)

Home health care services

Chapter summary

Home health agencies provide services to beneficiaries who are homebound and need skilled nursing or therapy. In 2013, about 3.5 million Medicare beneficiaries received home health care, and the program spent about \$17.9 billion on home health services. The number of agencies participating in Medicare reached 12,613 in 2013.

Assessment of payment adequacy

The indicators of payment adequacy for home health care are generally positive.

Beneficiaries' access to care—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.

- **Capacity and supply of providers**—In 2013, the number of agencies continued to increase, with a net gain of 302 agencies. Most new agencies were concentrated in a few states, and for-profit agencies accounted for the majority of new providers.
- **Volume of services**—In 2013, the volume of services declined slightly. The total number of users increased slightly (0.9 percent), while the average number of episodes per home health user declined by 1.9

In this chapter

- Are Medicare payments adequate in 2015?
.....
- How should Medicare payments change in 2016?
.....

percent. This trend is not surprising because spending growth for all health care (including both public and private payers) has slowed in recent years, and Medicare inpatient admissions, an important source of referrals, have declined. These decreases for home health care follow several years of rapid increases: Between 2002 and 2013, the total number of episodes increased by 65 percent, and the number of episodes per home health user increased from 1.6 to 1.9.

Quality of care—Performance on quality measures did not change significantly. The share of beneficiaries reporting improvement in walking increased slightly in 2013, and the share of beneficiaries reporting improvement in transferring declined slightly in 2013. The share of beneficiaries hospitalized during their home health spell was 27.5 percent, similar to the rate in prior years.

Providers' access to capital—Access to capital is a less important indicator of Medicare payment adequacy for home health care because the service is less capital intensive than other health care sectors. 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 acquisition of two large home health companies by other health care companies indicates this market is attractive to investors. The significant number of new agencies in 2013 suggests more than adequate capital necessary for start-ups.

Medicare payments and providers' costs—Medicare spending declined by about 0.5 percent to \$17.9 billion in 2013, but has increased by 87 percent since 2002. For more than a decade, payments have consistently and substantially exceeded costs in the home health prospective payment system. Medicare margins for freestanding agencies averaged 12.7 percent in 2013 and averaged 17 percent between 2001 and 2013. The Commission estimates that the Medicare margin for 2015 will be 10.3 percent. Two factors have contributed to payments exceeding costs: Fewer visits are 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.

The Commission reiterates its prior recommendations for home health

The Commission made several recommendations in 2011 to address some issues with the home health payment system and benefit, and we are reiterating these recommendations for the 2016 payment year (Medicare Payment Advisory Commission 2011a). First, the high margins of home health agencies since the start of the prospective payment system (PPS) in 2001 suggest that the payment rates assumed more services than were actually provided. The Commission recommended that the payment rate be rebased to reflect current utilization and

better align Medicare's payments with the actual costs of providing home health services. Second, the Commission recommended that the home health PPS not use the number of therapy visits provided as a payment factor. Trends in utilization and agency profit margins suggest that the financial incentive for therapy use has encouraged providers to favor therapy-intensive episodes. Third, there has been tremendous growth in the use of home health for patients residing in the community, episodes not preceded by a prior hospitalization. The high rates of volume growth for these types of episodes, which have more than doubled since 2001, suggest there is significant potential for overuse, particularly since Medicare does not currently require any cost sharing for home health care. The Commission recommended that Medicare establish a copay for episodes not preceded by a hospitalization to encourage appropriate use of these services. ■

Background

Medicare home health care consists of skilled nursing, physical therapy, occupational therapy, speech therapy, aide services, and medical social work provided to beneficiaries in their homes. To be eligible for Medicare's home health benefit, beneficiaries must need part-time (fewer than eight hours per day) or intermittent skilled care to treat their illnesses or injuries and must be unable to leave their homes without considerable effort. Medicare requires that a physician certify a patient's eligibility for home health care and that a patient receiving service be under the care of a physician. In contrast to coverage for skilled nursing facility services, Medicare does not require a preceding hospital stay to qualify for home health care. Unlike most services, Medicare does not require copayments or a deductible for home health services. In 2013, about 3.5 million Medicare beneficiaries received home health care, and the program spent \$17.9 billion on home health services. Medicare spending for home health care has doubled since 2001 and currently accounts for about 4 percent of fee-for-service (FFS) spending.

Medicare pays for home health care in 60-day episodes. Payments for an episode are adjusted for patient severity based on patients' clinical and functional characteristics and some of the services they use. If beneficiaries need additional covered home health services at the end of the initial 60-day episode, another episode commences and Medicare pays for an additional episode. Episodes delivered to beneficiaries in rural areas receive a 3 percent payment increase for 2010 through 2015. Coverage for additional episodes generally has the same requirements (e.g., the beneficiary must be homebound and need skilled care) as the initial episode. An overview of the home health prospective payment system (PPS) is available at <http://www.medpac.gov/documents/payment-basics/home-health-care-services-payment-system-14.pdf?sfvrsn=0>.

Use and growth of home health benefit has varied substantially due to changes in coverage and payment policy

The home health benefit has changed substantially since the 1980s. Implementation of the inpatient PPS in 1983 led to increased use of home health services as hospital lengths of stay decreased. Medicare tightened coverage of some services, but the courts overturned these curbs in 1988. After this change, the number of agencies, users, and services expanded rapidly in the early 1990s. Between 1990 and 1995, the number of annual users increased by 75 percent,

and the number of visits more than tripled to about 250 million a year. From 1990 to 1995, spending increased from \$3.7 billion to \$15.4 billion. As the rates of use and lengths of home health service use increased, there was concern that the benefit was serving more as a long-term care benefit (Government Accountability Office 1996). Further, many of the services provided were believed to be inappropriate or improper. For example, in one analysis of 1995–1996 data, the Office of Inspector General found that about 40 percent of the services in a sample of Medicare claims did not meet Medicare requirements for reimbursement, mostly because services did not meet Medicare's standards for a reasonable and necessary service, patients did not meet the homebound coverage requirement, or the medical record did not document that a billed service was provided (Office of Inspector General 1997).

The trends of the early 1990s prompted increased program integrity actions, refinements of coverage standards, temporary spending caps through an interim payment system (IPS), and replacement of the cost-based payment system with a PPS in 2000.¹ Between 1997 and 2000, the number of beneficiaries using home health services fell by about 1 million, and the number of visits fell by 65 percent (Table 9-1, p. 218). The mix of services changed from predominantly aide services in 1997 to mostly nursing visits in 2000, and therapy visits increased between 1997 and 2013 from 10 percent of visits to 36 percent. Between 1997 and 2000, total spending for home health services declined by 52 percent. The reduction in payments had a swift effect on the supply of agencies, and by 2000, the number of agencies had fallen by 31 percent. However, after this period, the PPS was implemented, and service use and agency supply rebounded at a rapid pace. Between 2001 and 2013, the number of home health episodes rose from 3.9 million to 6.7 million (not shown in table). The number of agencies in 2013 was 12,613, almost 1,700 more agencies than the supply at the 1997 spending peak. Almost all the new agencies since implementation of the PPS have been for-profit providers.

The steep declines in services under the IPS did not appear to have adversely affected the quality of care beneficiaries received; one analysis found that patient satisfaction with home health services was mostly unchanged in this period (McCall et al. 2004, McCall et al. 2003). A study by the Commission also concluded that the quality of care did not decline between the IPS and the implementation of the PPS (Medicare Payment Advisory Commission 2004). The similarity in quality of care under the IPS and the PPS suggests that the payment reductions in the Balanced

**TABLE
9-1****Changes in supply and utilization of home health care, 1997-2013**

	1997	2000	2013	Percent change	
				1997-2000	2000-2013
Agencies	10,917	7,528	12,613	-31%	64%
Total spending (in billions)	\$17.7	\$8.5	\$17.9	-52	111
Users (in millions)	3.6	2.5	3.5	-31	39
Number of visits (in millions)	258.2	90.6	114.1	-65	26
Visit type (percent of total)					
Skilled nursing	41%	49%	53%	20	8
Home health aide	48	31	13	-37	-57
Therapy	10	19	36	101	85
Medical social services	1	1	1	1	-22
Number of visits per user	73	37	33	-49	-11
Percent of FFS beneficiaries who used home health services	10.5%	7.4%	9.3%	-30	26

Note: FFS (fee-for-service). Medicare did not pay on a per episode basis before October 2000. Yearly figures presented in the table are rounded, but percent change columns were calculated using unrounded data.

Source: Home health standard analytical file 2013; *Health Care Financing Review*, Medicare and Medicaid Statistical Supplement 2002.

Budget Act of 1997 led agencies to reduce costs and utilization without a measurable difference in the quality of patient care.

A recent court case between the Department of Health and Human Services and the Center for Medicare Advocacy requires the program to clarify the language in its benefit manual to state that the potential for functional or clinical improvement is not necessary in a covered episode of home health care. Coverage will hinge on existing requirements that the beneficiary needs skilled care and meets the homebound requirement. In 2013, CMS released revised guidance implementing the court settlement. It will be difficult to ascertain the impact of this change until experience is gained under the new standards. However, given the rapid growth the benefit has experienced in the past, it remains possible that utilization could increase.

Patient Protection and Affordable Care Act of 2010 changes to payment for home health services

In 2010, the Commission recommended that Medicare lower home health payments to make them more consistent with costs, a process referred to as payment rebasing. The Patient Protection and Affordable Care Act

of 2010 (PPACA) includes several reductions intended to address home health care's high Medicare payments, but these policies may not achieve the Commission's goal of making payments more consistent with actual costs.

PPACA calls for the annual rebasing adjustment to be offset by the payment update for each year in 2014 through 2017. CMS set the rebasing reduction to the maximum amount permitted under the PPACA formula, which was equal to 3.5 percent of the 2010 base rate, or an annual reduction of \$81 per 60-day episode. However, the size of the base rate has increased since 2010, so this reduction will be less than 3.5 percent and will equal 2.8 to 3.0 percent in each year from 2014 through 2017. In addition, over this period, the payment update will raise payments, resulting in a cumulative net payment reduction of 2 percent (Table 9-2). This modest reduction will likely leave substantial margins for home health agencies (HHAs), which have exceeded 10 percent every year since the implementation of PPS.

PPACA's approach to rebasing also affects low utilization payment adjustment (LUPA) episodes, effectively preventing CMS from raising payments for these services to be equal to cost. The LUPA rate is applied in episodes with fewer than five visits and makes a per visit payment instead

**TABLE
9-2****Impact of PPACA rebasing on payments for 60-day episodes**

	2014	2015	2016	2017	Cumulative change, 2014-2017
Rebasing adjustment	-2.8%	-2.8%	-2.9%	-3.0%	-11.6%
Legislated payment update	2.3	2.2	2.5	2.4	9.6
Net annual payment reduction	-0.6	-0.6	-0.4	-0.4	-2.0*

Note: PPACA (Patient Protection and Affordable Care Act of 2010). Payment update estimates are based on the second-quarter 2014 forecast of the home health market basket. Effects of payment changes are multiplicative.

* Total payment decline would be 4 percent in 2017 if the sequester were in effect.

Source: MedPAC analysis based on data from CMS.

of the case-mix-adjusted 60-day episode payment. CMS's cost analysis found that the LUPA rates were too low by 20 percent to 33 percent. The statutory provisions in PPACA limit the degree to which CMS may change payments; as a consequence, the increase allowed by PPACA covers only a portion of this shortfall. LUPAs are a small share of home health volume, comprising about 9 percent of episodes and 1 percent of payments. However, they play an important role in the payment system because they guard against the incentive to provide more than four visits to receive a higher payment. The incentive to exceed the LUPA threshold is already substantial, with the average LUPA payment equaling \$346 compared with \$2,859 for the average full episode in 2013. If LUPA rates remain below cost, agencies have even more incentive to provide more than four visits in an episode to qualify for the full episode payment.

PPACA required the Commission to assess the impact of these payment changes for quality of care and beneficiary access (Medicare Payment Advisory Commission 2014a). Empirical data on the effects of rebasing called for by PPACA are not yet available, so the Commission examined the historical relationship between changes in payment and changes in quality and access for the 2001 through 2012 period. Similar to the results presented in this chapter, the volume of episodes grew substantially in this period, even in years that Medicare reduced home health payments. From 2001 through 2010, episode volume for urban, rural, for-profit, and nonprofit providers grew on a per beneficiary basis. These increases in utilization occurred in years in which the average episode payment decreased as well as in years in which the average payment increased, suggesting that the 2 percent payment reduction will not have a negative effect on access.

The Commission examined three quality measures to assess the relationship between past payment reductions and quality, and the results suggest that payment changes during this period did not have a significant effect. During this period, HHAs' overall rate of unexpected hospitalization during the home health episode—an indicator of poor quality—remained steady at about 28 percent, while average payment per episode increased in most years.² This finding suggests that hospitalization was not sensitive to changes in payments—that is, the higher payments to HHAs did not lead to fewer hospitalizations. Also during this period, performance on two functional measures of quality—the share of patients demonstrating improvement in walking and the share of patients demonstrating improvement in transferring—generally increased. These increases in quality occurred in years in which the average payment per episode decreased as well as years in which the average payment per episode increased, suggesting that changes in payment have little direct relationship to rates of functional improvement.

The Commission will continue to review access to care and quality as data for additional years become available. However, experience suggests that the small PPACA rebasing reductions will not change average episode payments significantly. HHA margins are likely to remain high under the current rebasing policy, and quality of care and beneficiary access to care are unlikely to be negatively affected.

Ensuring appropriate use of home health care is challenging

Policymakers have long struggled to define the role of the home health benefit in Medicare (Benjamin 1993). From the outset, there was a concern that setting a narrow policy could result in beneficiaries using other, more expensive

**TABLE
9-3****Number of participating home health agencies continues to rise**

	2004	2006	2008	2010	2012	2013	Percent change	
							2004-2012	2012-2013
Active agencies	7,651	8,812	9,787	11,453	12,311	12,613	65%	2.5%
Number of agencies per 10,000 FFS beneficiaries	2.1	2.4	2.8	3.2	3.3	3.4	61	2.1

Note: FFS (fee-for-service). "Active agencies" includes all agencies operating during a year, including agencies that closed or opened.

Source: CMS's Provider of Service file and 2014 annual report of the Boards of Trustees of the Medicare trust funds.

services, while a policy that was too broad could lead to wasteful or ineffective use of home health care (Feder and Lambrew 1996). Medicare relies on the skilled care and homebound requirements as primary determinants of home health eligibility, but these broad coverage criteria permit beneficiaries to receive services in the home even though they are capable of leaving home for medical care. Most home health beneficiaries use some form of outpatient services while receiving home health care (Wolff et al. 2008). Medicare does not provide any incentives for beneficiaries or providers to consider alternatives to home health care, such as outpatient services. Beneficiaries who meet program coverage requirements can receive an unlimited number of home health episodes and face no cost sharing. In addition, the program relies on agencies and physicians to follow program requirements for determining beneficiary needs, but there is some evidence that they do not consistently follow Medicare's standards (Cheh et al. 2007, Office of Inspector General 2001).

Even when enforced, the standards permit a broad range of services. For example, the skilled care requirement mandates that a beneficiary needs therapy or nursing care to be eligible for the home health benefit. The intent of the skilled services requirement is that the home health benefit serves a clear medical purpose and is not an unskilled personal care benefit. However, Medicare's coverage standards do not require that skilled visits comprise the majority of the home health services a patient receives. For about 9 percent of episodes in 2010, most services provided were visits from an unskilled home health aide. These episodes raise questions about whether Medicare's broad standards for coverage are adequate to ensure that skilled care remains the focus of the home health benefit.

In 2010, the Commission made a recommendation to curb wasteful and fraudulent home health services

(Medicare Payment Advisory Commission 2010).

This recommendation calls on the Secretary to use her authorities under current law to examine providers with aberrant patterns of utilization for possible fraud and abuse. PPACA permits Medicare to implement temporary moratoriums on the enrollment of new agencies in areas believed to have a high incidence of fraud. Medicare implemented this moratorium authority for home health agencies in July 2013 in the areas of Miami-Dade, FL; Fort Lauderdale, FL; Houston, TX; Dallas, TX; Chicago, IL; and Detroit, MI. There have also been numerous criminal prosecutions for home health fraud, most notably in Miami and Detroit. However, the Commission still observes many areas with aberrant patterns of utilization. For example, even though Miami has been an area of concentrated effort by CMS and law enforcement agencies, this area still has a utilization rate well in excess of other areas. The persistence of aberrant patterns of utilization suggests that continued, or perhaps even expanded, efforts by all of the enforcement agencies are needed to address the scope of fraud in many areas. In addition, the program may want to fully use the authorities already available. For example, Medicare also has the authority to require HHAs to hold surety bonds, but it has not exercised this authority.³

Are Medicare payments adequate in 2015?

The Commission reviews several indicators to determine the level at which payments will be adequate to cover the costs of an efficient provider in 2015. We assess beneficiary access to care by examining the supply of home health providers and annual changes in the volume

**TABLE
9-4****Fee-for-service home health care services have increased rapidly since 2002**

	2002	2006	2010	2012	2013	Percent change		Cumulative change, 2002–2013
						2002–2012	2012–2013	
Home health users (in millions)	2.5	3.0	3.4	3.4	3.5	36.6%	0.9%	37.8%
Share of beneficiaries using home health care	7.2%	8.4%	9.4%	9.2%	9.3%	28.2	0.5	28.9
Episodes (in millions):	4.1	5.5	6.8	6.7	6.7	64.5	–0.5	63.6
Per home health user	1.6	1.8	2.0	2.0	1.9	20.4	–1.4	18.7
Per FFS beneficiary	0.12	0.15	0.19	0.18	0.18	54.4	–0.9	53.0
Payments (in billions)	\$9.6	\$14.0	\$18.4	\$18.0	\$17.9	88.5	–0.6	87.3
Per home health user	\$3,803	\$4,606	\$5,679	\$5,247	\$5,169	38.0	–1.5	35.9
Per FFS beneficiary	\$274	\$387	\$540	\$484	\$479	76.9	–1.0	75.2

Note: FFS (fee-for-service). Percent change is calculated on numbers that have not been rounded.

Source: MedPAC analysis of home health standard analytical file.

of services. The review also examines quality of care, access to capital, and the relationship between Medicare's payments and providers' costs. Overall, the Medicare payment adequacy indicators for HHAs are positive.

Beneficiaries' access to care: Almost all beneficiaries live in an area served by home health care

Supply and volume indicators show that almost all beneficiaries have access to home health services. In 2013, almost all beneficiaries (99.4 percent) lived in a ZIP code served by at least one HHA, 97 percent lived in a ZIP code served by two or more HHAs, and over 84 percent lived in a ZIP code served by five or more agencies. These findings are consistent with our review of access from prior years.⁴

Supply of providers: Home health agency supply surpassed previous peak

In 2013, 12,613 HHAs participated in Medicare, a net increase of 302 agencies from the previous year (Table 9-3). Most new agencies in 2013 were for-profit agencies. The number of agencies is now higher than the previous peak in the 1990s when supply exceeded 10,900 agencies. The high rate of growth is a particular concern because many new agencies appear to be concentrated in states that have had a number of significant fraud reports, including California and Texas. These states, like most, do not have state certificate-of-need laws for home health care, which can otherwise limit the entry of new providers.⁵

From 2004—when 99 percent of beneficiaries lived in a ZIP code served by an HHA—to 2013, the number of agencies per 10,000 FFS beneficiaries rose 61 percent, from 2.1 to 3.4 (Table 9-3). Most of the new agencies were for profit. However, supply varies significantly among states. In 2013, Texas averaged 10.5 agencies per 10,000 beneficiaries, while New Jersey averaged less than 1 agency per 10,000 beneficiaries. Some of this variation was likely due to differences in agency size; for example, in New Jersey, the average agency provided 2,909 episodes compared with 354 episodes per agency for Texas. The extreme variation demonstrates that the number of providers is a limited measure of capacity because agencies can vary in size. Also, because home health care is not provided in a medical facility, agencies can adjust their service areas as local conditions change. Even the number of employees may not be an effective metric because agencies can use contract staff people to meet their patients' needs.

Growth in episode volume slow after many years of rapid growth

In 2013, the volume of services declined slightly, with the number of episodes declining by 0.5 percent (Table 9-4). The total number of users increased slightly (0.9 percent), while the average number of episodes per home health user declined by 1.4 percent. These decreases follow several years of rapid increases. Between 2002 and 2013, the total number of episodes increased by almost 64

**TABLE
9-5****Increase in home health episodes by timing and source of episode**

	Number of episodes (in millions)		Cumulative growth	Percent of episodes	
	2001	2012		2001	2012
Episodes not preceded by a hospitalization or PAC stay:					
First	0.8	1.4	76%	20%	21%
Subsequent	<u>1.3</u>	<u>3.1</u>	141	<u>32</u>	<u>45</u>
Subtotal	2.1	4.5	116	53	66
Episodes preceded by a hospitalization or PAC stay:					
First	1.6	1.8	16%	40	27
Subsequent	<u>0.3</u>	<u>0.5</u>	63	<u>8</u>	<u>7</u>
Subtotal	1.9	2.3	23	47	34
Total	3.9	6.8	72	100	100

Note: PAC (post-acute care). "First" and "subsequent" refer to the timing of an episode relative to other home health episodes. "First" indicates no home health episode in the 60 days preceding the episode. "Subsequent" indicates the episode started within 60 days of the end of a preceding episode. "Episodes preceded by a hospitalization or PAC stay" indicates the episode occurred fewer than 15 days after a stay in a hospital (including long-term care hospitals), skilled nursing facility, or inpatient rehabilitation facility. "Episodes not preceded by a hospitalization or PAC stay" indicates that there was no hospitalization or PAC stay in the 15 days before the episode began. Some data have been rounded, which may affect subtotals and totals.

Source: CMS Datalink file, 2012.

percent and the episodes per home health user increased from 1.6 to 1.9. Between 2002 and 2013, the share of beneficiaries using home health care increased from 7.2 percent to 9.3 percent.

Total home health use has decreased by 2 percent since 2011, and several factors contributed to this recent decline. Nationwide, spending growth for all health care (including both public and private payers) slowed beginning in 2009, with the rate of increase in economy-wide health care spending near or below the growth rate of the U.S. economy. In addition, certain factors unique to Medicare home health care may have led to the decline in the average number of episodes per 100 beneficiaries in those 2 years. In 2010, the Department of Justice and other enforcement agencies started new investigative efforts to scrutinize home health. In 2011, Medicare implemented a PPACA requirement that physicians conduct a face-to-face examination of a beneficiary before authorizing home health care. Finally, Medicare inpatient hospital discharges, which are an important source of home health care patients, have been declining since 2009 and may account for part of the drop in demand for home health care.

The decline in home health utilization has been concentrated in states with the highest utilization rates: Texas, Louisiana, Oklahoma, Mississippi, and Florida. Volume declined by 11 percent in Texas (more than 115,000 episodes) and by 15 percent in Louisiana. However, these areas experienced substantial growth in the previous 12 years. For example, volume of home health services in Texas increased 289 percent between 2001 and 2013. Even after the recent declines, these 5 states had the highest utilization rates on a per beneficiary basis in 2013; as a group, they averaged 33 episodes per 100 beneficiaries, more than twice the average of all other states. Growth continued in other areas, and 34 states had an increase in volume in 2013. California led this group with an increase of over 30,000 episodes.

Since 2002, home health care stays have grown longer and less focused on post-acute care

Between 2002 and 2013, the average number of episodes per user increased by 19 percent, rising from 1.6 to 1.9 episodes per user (Table 9-4, p. 221). The increase indicates that beneficiaries are receiving home health care for longer periods of time and suggests that home health care serves more as a long-term care benefit for some

beneficiaries. This concern is similar to those in the mid-1990s that led to major program integrity activities and payment reductions. The increase in episodes coincides with Medicare's PPS incentives that encourage additional volume: The unit of payment per episode encourages more service (more episodes per beneficiary), and the PPS makes higher payments for the third and later episodes in a consecutive spell of home health episodes.

The rise in the average number of episodes per beneficiary also coincides with a relative shift away from using home health care as a post-acute care (PAC) service. Over the 2001 to 2012 period, the number of episodes not preceded by a hospitalization or PAC stay increased by 116 percent compared with a 23 percent increase in episodes that were preceded by a hospitalization or PAC stay (Table 9-5). During that period, the share of all episodes not preceded by a hospitalization or PAC stay rose from about 53 percent to 66 percent.

The Commission previously examined the characteristics of beneficiaries based on how they most frequently used home health care. Beneficiaries were classified into two categories based on their home health utilization: Beneficiaries for whom the majority of home health episodes in 2010 were preceded by a hospitalization or other post-acute stay were classified as PAC users of home health, while beneficiaries for whom the majority of episodes for 2010 were not preceded by a hospital or PAC stay were classified as community-admitted users.

This cross-sectional analysis suggests that Medicare is serving distinct populations within the home health benefit. In 2010, PAC users averaged 1.4 episodes, while community-admitted users averaged 2.6 episodes. About 42 percent of the episodes provided to community-admitted users were for dual-eligible Medicare and Medicaid beneficiaries; in contrast, the comparable share for PAC users was 24 percent. Community-admitted users also had a larger share of episodes with high numbers of visits from home health aides; for example, aide services were the majority of services provided in 11 percent of the episodes for community-admitted users compared with 4 percent for PAC users. Community-admitted users generally had fewer chronic conditions, tended to be older, and had a higher rate of dementia and Alzheimer's disease. The high share of community-admitted users who were also Medicaid eligible suggests that some of this utilization could have been due to state Medicaid programs inappropriately leveraging the Medicare home health benefit to provide long-term care. Under this practice,

states shift the costs of at least some of their long-term care expenses to the Medicare program.

Volume of therapy services is influenced by incentives in Medicare's payment system

The number of therapy visits a beneficiary receives during a home health care episode is one factor that determines Medicare's payment for a home health episode. Generally, providing more therapy visits raises the episode payment. The Commission has long had a concern that allowing utilization to drive payment creates an incentive for agencies to provide more services regardless of clinical need; changes in episode volume generally reflect these incentives. In 2011, the Commission recommended that Medicare redesign the payment system to rely solely on patient characteristics, not on the number of services provided, for setting payment, but CMS has yet to implement this recommendation (Medicare Payment Advisory Commission 2012b, Medicare Payment Advisory Commission 2011a).

CMS has made numerous changes to the case-mix system intended to ensure the proper use of therapy. For example, CMS has introduced additional supervision requirements and adjusted the case-mix weights to reduce the financial incentives to provide more therapy visits.⁶ However, even with these changes, the share of episodes qualifying for higher therapy payments has continued to increase over time. Episodes that qualify for additional payment due to therapy visits, those with six or more visits, account for over 90 percent of the increase in episode volume since 2008. Episodes consisting of five or fewer therapy visits increased by 1 percent in 2008 through 2013, while those with six or more therapy visits increased by 26 percent (Table 9-6, p. 224). Since 2011, the number of nontherapy episodes has fallen while the therapy episodes have increased, suggesting that the shift toward therapy may be accelerating.

Poorly targeted rural add-on payment does little to improve access to care

An add-on payment of 3 percent for each home health care episode provided to beneficiaries in rural areas expires in 2015. The intent of the add-on was to bolster access, but the high level of utilization in many rural areas results in Medicare's per episode add-on being poorly targeted, with most payments made to areas with higher than average utilization. The use of such a broadly targeted add-on, providing the same payment for all rural areas regardless of access, results in rural areas with the highest utilization

**TABLE
9-6****Growth in therapy services has been significant in recent years**

	2008	2009	2010	2011	2012	2013	Percent change, 2012-2013	Cumulative change, 2008-2013
Episodes with 5 or fewer therapy visits (in millions)	3.9	4.2	4.2	4.1	4.0	3.9	-3.3%	1.0%
Episodes with 6 or more therapy visits (in millions)	2.2	2.4	2.7	2.7	2.7	2.8	3.4	26.0
Total episodes	6.1	6.6	6.8	6.8	6.7	6.7	-0.5	10.2
Share of episodes qualifying for additional payments based on the amount of therapy provided	36.7%	37.0%	39.3%	39.8%	40.4%	42.0%	N/A	N/A

Note: N/A (not applicable). Annual episode values have been rounded to the nearest hundred thousand, but percent change columns were calculated using unrounded data. The sum of column components may not equal the stated total due to rounding.

Source: MedPAC analysis of home health standard analytical file 2013.

drawing a disproportionate share of the add-on payments. For example, 76 percent of the episodes that received the add-on payments in 2013 were in rural counties with utilization higher than the median utilization for all counties. In contrast, the rural counties below the median accounted for 23 percent of the episodes eligible for the add-on payment. Rural counties with the lowest utilization per beneficiary, those in the bottom fifth of utilization, accounted for less than 4 percent of the episodes eligible for the rural add-on payment. Relatively few of the add-on payments were made to areas with low utilization.

In its June 2012 report to the Congress, the Commission noted that Medicare should target rural payment adjustments to those areas that have access challenges (Medicare Payment Advisory Commission 2012a). The large share of payments made to rural areas with above-average utilization does nothing to improve access to care in those areas and raises payments in markets that appear to be more than adequately served by HHAs. Some of the counties with aberrant patterns of utilization suggestive of fraud and abuse are rural; for example, 21 of the 25 top-spending counties in 2013 are rural areas (Table 9-7). Higher payments in areas without access problems can encourage the entry or expanded operations of agencies that seek to exploit Medicare's financial incentives. More targeted approaches that limit rural add-on payments to areas with access problems should be pursued.

The counties listed in Table 9-7 have the highest utilization rates, but high utilization is not confined solely to these areas. Counties in the top quintile have an average utilization of 31 episodes per 100 beneficiaries, 70 percent higher than the national average. These counties include 194 urban counties and 446 rural counties, indicating that high utilization is prevalent in both geographic categories (80 percent of the Medicare beneficiaries residing in the top-quintile counties reside in urban counties). In 2013, a county at the 75th percentile used 17 episodes per 100 beneficiaries, while a county at the 25th percentile used 8 episodes per 100 beneficiaries. In MedPAC's review of geographic variation in Medicare spending, post-acute care services had the greatest variation in spending among areas, and variation in home health services contributed to the wide spread of spending (Medicare Payment Advisory Commission 2011b). This wide distribution suggests that reducing use and spending in many high-spending areas, beyond those listed on Table 9-7, could lower program costs.

Quality of care: Quality measures generally held steady or improved

Medicare reports several quality measures on its Home Health Compare website from which we obtained recent trends for measures associated with function and hospitalization (Table 9-8). In general, the share of beneficiaries showing improvement on the functional

**TABLE
9-7****Most counties with the highest rates of beneficiaries using home health in 2013 were rural**

State	County	Share of FFS beneficiaries using home health services	Episodes per user	Episodes per 100 FFS beneficiaries
TX	Duval*	36.4%	4.4	158.8
TX	Brooks*	34.0	3.9	132.5
FL	Miami-Dade	28.9	2.5	72.2
TX	Jim Hogg*	27.8	4.3	120.7
TX	Willacy*	27.0	3.8	103.9
TX	Jim Wells*	26.3	4.1	106.6
LA	East Carroll*	25.7	3.9	100.9
OK	Choctaw*	25.7	4.0	102.7
TX	Zapata*	25.7	4.1	106.1
TX	Starr*	25.6	3.9	98.9
MS	Claiborne*	23.2	2.8	65.1
TX	Webb	23.0	3.9	89.9
LA	Madison*	22.3	4.3	95.5
TX	Collingsworth*	21.9	4.4	95.6
TN	Hancock*	21.8	2.9	63.5
MS	Holmes*	21.4	3.0	64.8
OK	McCurtain*	21.1	4.1	87.3
TX	Throckmorton*	20.9	4.3	89.0
TX	Hidalgo	20.8	3.5	73.6
OK	Greer*	20.4	3.3	66.8
OK	Latimer*	20.1	4.1	82.9
TX	Robertson	20.1	3.4	67.7
TX	Falls*	20.1	3.5	71.0
MS	Yazoo*	19.9	3.2	63.1
OK	Coal*	19.8	3.2	64.0

Note: FFS (fee-for-service). Counties with fewer than 100 home health users have been excluded.

*Rural county.

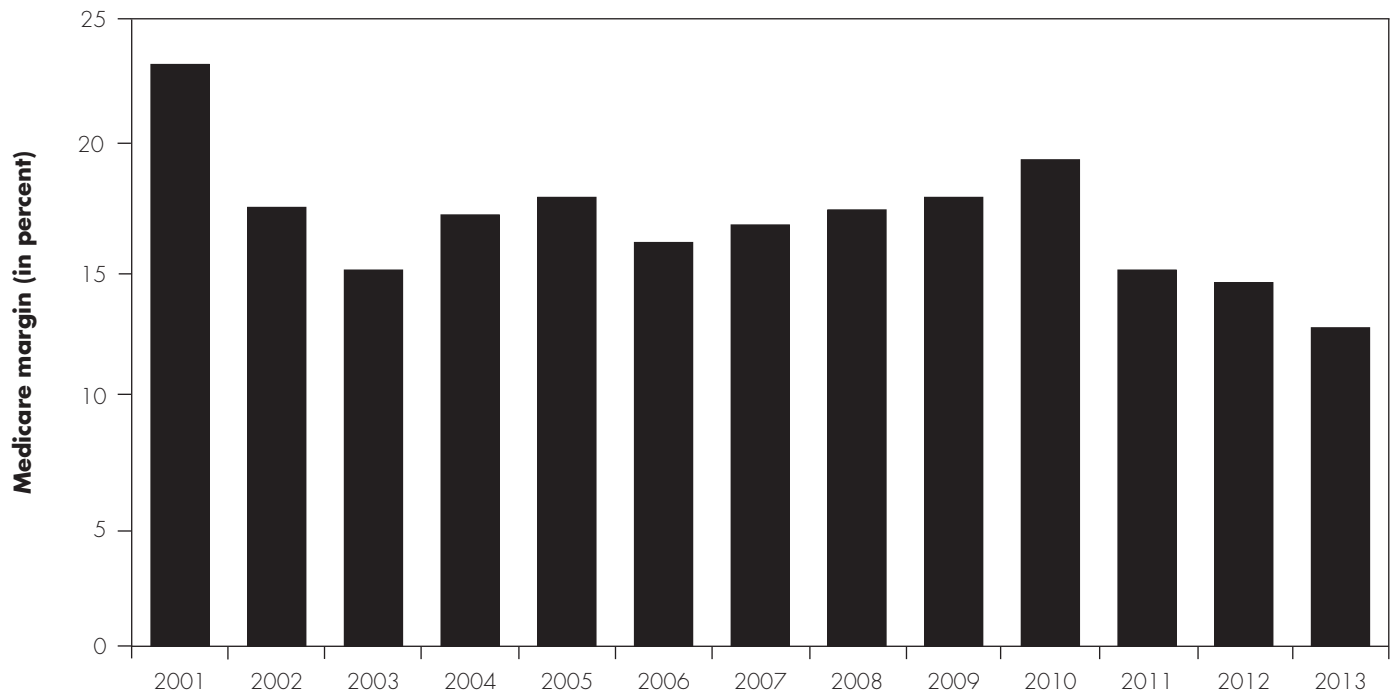
Source: MedPAC analysis of the 2013 home health standard analytical file and the 2013 Medicare denominator file.

**TABLE
9-8****Average home health agency performance on select quality measures**

	2003	2006	2010	2012	2013
Share of an agency's beneficiaries with improvement in:					
Walking	34.8%	41.2%	53.5%	58.3%	58.5%
Transferring	49.1	52.7	52.7	54.6	53.8
Hospitalization	27.5	28.1	28.4	27.5	N/A

Note: N/A (not available). Data are risk adjusted for differences in patient condition among home health patients; includes fee-for-service beneficiaries only. The measures for walking and transferring changed in 2011 and are not comparable to data from prior years.

Source: MedPAC analysis of data provided by the University of Colorado.

**FIGURE
9-1****Medicare margins of freestanding home health agencies since 2001**

Note: An audit of 2011 cost reports indicated that home health agencies overstated their costs that year by 8 percent.

Source: Medicare cost reports 2013.

measures has increased since 2003. The rate of hospitalization has not changed significantly. In 2013, the share of patients with improvement in walking increased slightly, while the share of patients with improvement in transferring declined slightly. These data are collected only for beneficiaries who do not have their home health care stays terminated by a hospitalization, which means that the beneficiaries included in the measure are probably healthier and more likely to have positive outcomes.

As the Commission has noted in the past, there was variation in performance on these quality measures among home health agencies. For example, in 2012, the rate of hospitalization for an agency at the 25th percentile was 20 percent compared with 41 percent for an agency at the 75th percentile. Nonprofit agencies had a lower rate of hospitalization than for-profit agencies, and facility-based agencies generally had a slightly lower rate than freestanding agencies.

The variation in agency performance suggests an opportunity for quality improvement. The Commission

recommended that the Congress direct the Secretary to establish a payment incentive that would reduce payments for agencies with relatively high rates of rehospitalization (Medicare Payment Advisory Commission 2014b). This action would align HHA incentives with those of hospitals under the Hospital Readmissions Reduction Program. Such a policy would also recognize home health care's unique role as a provider that facilitates the transition from inpatient settings to the community. Hospitals may be unable to reduce avoidable readmissions without assistance from home health care, and HHAs would be better partners if they were subject to the same financial incentives.

Providers' access to capital: Access to capital for expansion is adequate

Few HHAs access capital through publicly traded shares or through public debt such as issuing bonds. HHAs are not as capital intensive as other providers because they do not require extensive physical infrastructure, and most are too small to attract interest from capital

markets. Information on publicly traded home health care companies provides some insight into access to capital, but has its limitations. Publicly traded companies may have other lines of business in addition to Medicare home health care, such as hospice, Medicaid, and private-duty nursing. Also, publicly traded companies are a small portion of the total number of agencies in the industry. For these reasons, access to capital is a smaller consideration for home health than for other health care sectors receiving Medicare payment.

Analysis of for-profit companies indicates that they had adequate access to capital in 2013. While the large publicly traded home health firms sold or closed some agencies in 2013, there was also major investment to expand operations. For example, Gentiva purchased Harden Home Health Care, and Almost Family purchased two regional chains to significantly expand its size in 2013. In 2014, two large home health chains were acquired by firms that primarily operate other post-acute services. Kindred Healthcare reached an agreement to purchase Gentiva, one of the two largest publicly traded home health firms, in the fall of 2014. The HealthSouth Corporation, which operates inpatient rehabilitation facilities, recently announced a \$750 million purchase of Encompass, which operates home health agencies in several states. Interest by investors and the continued increase in agency supply suggest that access to capital remains adequate for entities that seek to invest in home health care.

Medicare payments and providers' costs: Payments decreased in 2013 while cost growth remained low

In 2013, average Medicare payments per episode declined by about 0.2 percent, a result of several policies intended to address changes in coding practices unrelated to patient severity and to reduce Medicare's historically high payments for this service. Total spending declined by 0.6 percent to \$17.9 billion. However, this decline is modest compared with the growth the home health benefit has experienced in prior years; since 2002, spending has increased by over 80 percent.

The average cost per episode in 2013 increased by about 0.7 percent relative to the prior year. Low or no cost growth has been typical for home health care, and in some years we have observed a decline in cost per episode (in 2012 the cost per episode declined by 1.3 percent). The ability of HHAs to keep costs low has contributed to their high margins under the Medicare PPS.

Medicare margins have been high since 2001

Home health margins for freestanding HHAs have been very high since the PPS was implemented; Medicare margins averaged 17 percent between 2001 and 2013 (Figure 9-1). These high margins likely have encouraged the entry of new HHAs; the number of new agencies in 2013 was higher than the previous year, and the total number of agencies participating in Medicare has increased by an average of about 509 agencies a year since 2003. The high overpayments have led the Commission to recommend that home health rates be lowered to a level consistent with costs (Medicare Payment Advisory Commission 2011a).

The average margin may be even higher than these amounts for many agencies. The margins that the Commission reports rely on the cost and payment information provided by HHAs on the Medicare cost report. CMS stopped routinely auditing these cost reports when the PPS was implemented in 2001, but it recently conducted an audit of 100 HHA cost reports for 2011. The audit found that costs were overstated by an average of 8 percent in 2011. Because costs were overstated, the profit margin of 15 percent for 2011 was likely understated, and actual margins could have been significantly higher. If reported costs in earlier years were also overstated, then the margins for 2010 and earlier could also be significantly higher. However, audited cost reports are not available for this period, and it is difficult to determine how the degree of misstatement in costs and payments may have changed over this time.

Medicare margins in 2013 declined slightly

In 2013, HHA margins in aggregate were 12.7 percent for freestanding agencies (Table 9-9, p. 228). Financial performance varied from -3.4 percent for an agency at the 25th percentile of the margin distribution to 22 percent for an agency at the 75th percentile (data not shown). For-profit agencies had higher margins than nonprofit agencies, and urban agencies had slightly higher margins than rural agencies. These margin analyses include the effects of the sequester that entered into effect in 2013.

The Commission includes hospital-based HHAs in the analysis of inpatient hospital margins because these agencies function in the financial context of hospital operations. Margins for hospital-based agencies in 2013 were -15.5 percent. The lower margins of hospital-based agencies are chiefly due to their higher costs, some of which may be due to overhead costs allocated to the

**TABLE
9-9****Medicare margins for freestanding home health agencies, 2012 and 2013**

	2012	2013	Percent of agencies, 2013	Percent of episodes, 2013
All	14.5%	12.7%	100%	100%
Geography				
Majority urban	14.9	13.1	84	83
Majority rural	12.8	11.0	16	17
Type of ownership				
For profit	15.3	13.7	89	79
Nonprofit	14.5	10.0	11	21
Government*	N/A	N/A	N/A	N/A
Volume quintile				
First (smallest)	7.1	6.1	20	3
Second	8.1	7.8	20	6
Third	10.1	8.9	20	11
Fourth	13.2	11.2	20	19
Fifth (largest)	16.8	14.8	20	61

Note: N/A (not available). Agencies were classified as majority urban if they provided more than 50 percent of episodes to beneficiaries in urban counties and were classified as majority rural if they provided more than 50 percent of episodes to beneficiaries in rural counties.

*Government-owned providers operate in a different context from other providers, so their margins are not necessarily comparable.

Source: MedPAC analysis of Home Health Cost Report files from CMS.

HHA from its parent hospital. The lower inpatient costs due to shorter hospital stays may more than compensate for any losses from operating an HHA. Urban agencies had slightly higher rates than rural agencies, and larger agencies generally had higher margins than smaller agencies.

Relatively efficient HHAs serve patients with attributes similar to all other HHAs' patients

The Medicare Modernization Act of 2003 requires that the Commission consider the financial performance of an efficient provider in its review of payment adequacy. We examined the quality and cost efficiency of freestanding HHAs to identify a cohort that demonstrates better performance on these metrics relative to its peers (Table 9-10). The measure of cost is risk adjusted per episode, and the measure of quality is a risk-adjusted measure of hospitalization. (The hospitalization measure refers to a hospital stay that occurs during or after a home health episode of care.) Our approach categorizes an HHA as relatively efficient if the agency was in the lowest third on at least one measure (either low cost per episode or a low hospitalization rate) and was not in the highest third of the other measures for three consecutive years (2009

to 2011). About 17 percent of agencies met these criteria in this period. Note that there is one difference in our methodology relative to previous years (we do not exclude high-use areas).

Relatively efficient agencies had margins that were 5.5 percentage points higher with a hospitalization rate that was more than 20 percent lower than other HHAs, and the average cost per visit was about 12 percent lower compared with other HHAs. Relatively efficient HHAs provided services for more episodes, but about 1.2 fewer visits per episode than other HHAs. There was generally no significant difference between the patient attributes of relatively efficient providers and other agencies since they served similar shares of rural and dual-eligible beneficiaries. Compared with other regions, the Middle Atlantic, South Atlantic, and West North Central regions had greater shares of relatively efficient providers.

The most recent Commissioner discussions of the efficient provider analysis raised several questions about the existing methods for defining efficient providers and generated new ideas for consideration. The Commission staff will be undertaking a re-examination of the efficient provider analysis.

**TABLE
9-10****Performance of relatively efficient home health agencies**

Provider characteristics	All	Relatively efficient provider	All other providers
Number of agencies	4,280	711	3,569
Share of for-profit agencies	83%	76%	84%
Medicare margin			
2012	14.5%	19.0%	13.5%
2011	15.2%	21.1%	14.0%
Quality			
Hospitalization rate (2011)	28%	23%	29%
Costs and payments			
Cost per visit, standardized for wages (2012)	\$130	\$126	\$144
Average payment per episode (2012)	\$2,662	\$2,552	\$2,687
Patient severity case-mix index	0.99	1.02	0.99
Visits per episode			
Total visits per episode (2012)	16.7	15.7	16.9
Share of visits by type			
Skilled nursing visits	51%	52%	51%
Aide visits	13%	10%	14%
MSS visits	1%	1%	1%
Therapy visits	35%	37%	34%
Size, 2012 (number of 60-day payment episodes)			
Median	930	1,012	931
Mean	529	622	513
Share of episodes, 2012			
Low-use episode	9%	10%	8%
Outlier episode	2%	2%	2%
Community-admitted episodes	66%	60%	68%
Therapy episodes	37%	37%	36%
Beneficiary demographics, 2012			
Share of episodes provided to dual-eligible			
Medicare/Medicaid beneficiaries	34%	32%	35%
Average age	77	77	77
Share of episodes provided to rural beneficiaries	22%	22%	22%

Note: MSS (medical social services). Sample includes freestanding agencies with complete data for three consecutive years (2009–2011). A home health agency is classified as relatively efficient if it is in the best third of performance for quality or cost and is not in the bottom third of either measure for three consecutive years. Quality is measured using a risk-adjusted measure of hospitalization, and cost is measured using a risk-adjusted cost per episode. Low-use episodes are those with 4 or fewer visits in a 60-day episode. Outlier episodes are those that received a very high number of visits and qualified for outlier payments. Community-admitted episodes are those episodes that were preceded by a hospitalization or prior post-acute care stay. Therapy episodes are those with six or more therapy visits.

Source: Medicare cost reports and standard analytic file.

**TABLE
9-11****Medicare visits per episode before and after implementation of PPS**

Type of visit	Visits per episode			Percent change in:	
	1998	2001	2013	1998-2001	2001-2013
Skilled nursing	14.1	10.5	9.4	-25%	-10%
Therapy (physical, occupational, and speech-language pathology)	3.8	5.2	6.4	39	23
Home health aide	13.4	5.5	2.4	-59	-57
Medical social services	0.3	0.2	0.1	-36	-32
Total	31.6	21.4	18.3	-32	-15
Visits per episode for fully prospective episodes (excludes outlier episodes and episodes with 6 or more therapy visits)	N/A	16.2	11.9	N/A	-27

Note: PPS (prospective payment system), N/A (not applicable). The PPS was implemented in October 2000. Data exclude low-utilization episodes.

Source: Home health standard analytic file.

Medicare margins remain high in 2015

In modeling 2015 payments and costs, we incorporate policy changes that will go into effect between the year of our most recent data, 2013, and the year for which we are making margin predictions, 2015. The major changes are:

- -0.6 percent payment change in 2014, the net impact of a positive payment update (2.3 percent) and the rebasing reduction of \$80.95 per episode;
- -0.6 percent payment change in 2015, the net impact of a positive payment update (2.3 percent) and the \$80.95 per episode rebasing reduction;
- 3 percent add-on in effect for episodes provided in rural areas in 2014 and 2015; and
- assumed episode cost growth of 0.8 percent per year for 2014 and 2015 and annual nominal case-mix growth of 0.5 percent.

On the basis of these policies and assumptions, the Commission projects a margin of 10.3 percent in 2015. This projection assumes that the sequester reduction of 2 percent that went into effect in 2013 remains in effect through 2015. If the sequester does not continue, margins would be about 2 percentage points higher in 2015.

Medicare has always overpaid for home health services under the PPS

Payments for home health care have substantially exceeded costs since Medicare established the PPS. In 2001, the first year of the PPS, average margins equaled 23 percent. The high margins in the first year suggest that the PPS established a base rate well in excess of costs. The base rate assumed that the average number of visits per episode would decline about 15 percent between 1998 and 2001, while the actual decline was about 32 percent (Table 9-11). By providing fewer visits than anticipated, HHAs were able to garner extremely high average payments relative to the services provided.

However, these trends are distorted by the incentives in the payment system and may understate the home health industry's ability to control costs. Recall that the PPS rewards additional therapy visits with higher payments for each visit and has a similar per visit payment increase for outlier episodes. The average number of visits per episode has declined by 27 percent since 2001 for episodes that were paid on a fully prospective basis (that is, ineligible for higher payment based on the number of visits provided), a decline in visits that was almost double the average for all episode types. The decline in visits for episodes paid on a strictly prospective basis may best represent the efficiencies agencies can achieve when the payment system does not reward additional services.

The declining number of visits per episode has contributed to higher agency margins. This mismatch between payment levels and cost growth led to the Commission recommending in March 2010 that Medicare rebase payments to be closer to costs (Medicare Payment Advisory Commission 2010). PPACA mandated reductions beginning in 2014, but these reductions leave HHAs with margins well in excess of costs. Overpaying for home health care has negative financial consequences for the federal budget and the beneficiary; implementing the Commission's prior recommendation for rebasing would better align Medicare's payments with HHAs' actual costs.

How should Medicare payments change in 2016?

A review of the Commission's indicators suggests that access is more than adequate in most areas and that aggregate Medicare payments are well in excess of costs. These indicators are similar to our findings in previous years, and for these reasons, the Commission is reiterating its recommendations from March 2011 (see text box, pp. 232–234) as its position with respect to the 2016 payment update. The Commission has recommended a number of changes to lower payments, address vulnerabilities in the payment system, and establish a new incentive to encourage efficient use of the benefit. ■

The Commission reiterates its March 2011 recommendations on the home health care benefit

In 2011, the Commission noted several problems with the Medicare home health care benefit and made several recommendations to reduce fraud, improve provider and beneficiary incentives, and eliminate the high overpayments under the home health care prospective payment system. We offered four recommendations to address these problems. Those recommendations are included here with updated commentary and rationales.

Recommendation 8-1, March 2011 report

The Secretary, with the Office of Inspector General, should conduct medical review activities in counties that have aberrant home health utilization. The Secretary should implement the new authorities to suspend payment and the enrollment of new providers if they indicate significant fraud.

The Patient Protection and Affordable Care Act of 2010 (PPACA) expanded Medicare's authority to stop payment for fraudulent or suspect services, and last year, the Commission recommended that the Secretary exercise this new authority to curb fraud in home health care. For many years, the Commission has published a list of counties with questionable utilization patterns (Table 9-7, p. 225). As the Commission recommended in the 2011 March report, these counties would be appropriate areas for the Secretary to exercise new PPACA authorities for investigating and interdicting home health fraud. The Department of Health and Human Services began exercising some of these authorities in 2013 when it announced a moratorium on the enrollment of new agencies in several areas of the country.

Medicare and the law enforcement community have made some progress in closing questionable agencies. However, the continued high utilization in many areas, including areas that have experienced significant law enforcement activity, suggests that expanded efforts are warranted. These efforts could include expanded enforcement activity or use of the program's administrative authority. For example, PPACA permits Medicare to suspend payments if CMS, in consultation with the Office of Inspector General (OIG), finds credible evidence of provider fraud, though CMS

has yet to use the authority despite the noted aberrant patterns of home health utilization. Medicare and the other enforcement entities should continue to review home health care spending and pursue providers that appear to engage in behavior that is potentially fraudulent or wasteful.

Implications 8-1

Spending

- The Congressional Budget Office has scored savings from the PPACA provision, so its baseline assumes savings based on the new authority. Implementing this authority would lower home health spending if fraud were discovered. CMS and OIG would incur some administrative expenses.

Beneficiary and provider

- Appropriately targeted reviews would not affect beneficiary access to care or provider willingness to serve beneficiaries.

Recommendation 8-2, March 2011 report

The Congress should direct the Secretary to begin a two-year rebasing of home health rates in 2013 and eliminate the market basket update for 2012.

Medicare has overpaid for home health since establishment of the prospective payment system (PPS) in 2000. The higher payments create financial incentives that can encourage providers to deliver services even when they are unnecessary or of low value. Although PPACA has implemented some payment reductions, they are offset by the annual payment update (Table 9-2, p. 219).

Our recommendation would reduce payments by more than the current law rebasing. First, our policy would not apply the annual payment update as an offset to the rebasing reduction. Second, we would increase the payment reduction to reflect the finding that home health agencies (HHAs) overstated the costs of providing Medicare services on their cost reports. Finally, the payments could further be lowered to account for the lower costs of relatively efficient providers. As noted in Table 9-10 (p. 229), these providers typically have margins that are

(continued next page)

The Commission reiterates its March 2011 recommendations on the home health care benefit (cont.)

about 5 percentage points higher than the overall average. In addition, the Commission believes that its recommendation to eliminate the use of therapy thresholds in the PPS should be implemented along with rebasing. This change would ensure that providers do not attempt to offset rebasing with higher payments by increasing the number of therapy visits they provide.

The Commission expects that rebasing may cause some HHAs to leave the Medicare program, but this effect may be offset by the entry of new providers. The barriers to entry in home health care are lower than for other Medicare providers. Home health care does not require extensive capital expenditures like facility-based providers do, and many states do not require certificate-of-need analysis to establish a new home health agency.

Implications 8-2

Spending

- This recommendation would reduce spending for Medicare services by \$250 to \$750 billion in 2016 and \$5 to \$10 billion over five years.

Beneficiary and provider

- Some reduction in provider supply is likely, particularly in areas that have experienced rapid growth in the number of providers. Access to appropriate care is likely to remain adequate, even if the supply of agencies declines.

Recommendation 8-3, March 2011 report

The Secretary should revise the home health case-mix system to rely on patient characteristics to set payment for therapy and nontherapy services and should no longer use the number of therapy visits as a payment factor.

The Commission is concerned that Medicare's home health PPS encourages providers to base therapy regimens on financial incentives and not patient characteristics. The PPS uses the number of therapy visits provided in an episode as a payment factor: the more visits a provider delivers, the higher the payment. The higher payments obtained by meeting the visit thresholds have led providers to favor patients

who need therapy over patients who do not and have encouraged providers to deliver services that are of marginal value. The Commission's recommendation would use patient characteristics to set payment for therapy, the same approach Medicare currently uses for setting payment for all other services covered in the home health PPS.

Implications 8-3

Spending

- The payment policy changes are designed to be implemented in a budget-neutral manner and should not have an overall impact on spending.

Beneficiary and provider

- Patients who need therapy may see some decline in access, but these services would be available on an outpatient basis after the home health episode ended.

Recommendation 8-4, March 2011 report

The Congress should direct the Secretary to establish a per episode copay for home health episodes that are not preceded by hospitalization or post-acute care use.

The health services literature has generally found that beneficiaries consume more services when cost sharing is limited or nonexistent, and some evidence suggests that the additional services do not always contribute to better health. The lack of cost sharing is a particular concern for home health care because PPS pays for care on a per episode basis that rewards additional volume. The lack of a cost-sharing requirement stands in contrast to most other Medicare services, which generally require the beneficiary to bear some of the costs of Medicare services.

One concern with cost sharing is that it can lead beneficiaries to reduce their use of effective as well as ineffective care. Although some studies have found evidence of adverse effects of reduced care due to cost sharing (Chandra et al. 2010, Rice and Matsuoka 2004), the RAND health insurance experiment concluded that, on average, nonelderly patients who consumed less health care because of cost sharing suffered no net

(continued next page)

The Commission reiterates its March 2011 recommendations on the home health care benefit (cont.)

adverse effects (Newhouse 1993). The Commission's review of the impact of medigap insurance generally found that beneficiaries with this insurance had higher total Medicare spending (Medicare Payment Advisory Commission 2009). The results of the RAND health insurance experiment and the Commission's study suggest that a home health care copay would decrease use of home health care and result in lower overall Medicare spending.

To encourage appropriate use, the Commission recommended that Medicare add an episode copayment for services not preceded by a hospitalization or other post-acute service.⁷ The high rates of volume growth for these types of episodes, which have more than doubled since 2001, suggest there is significant potential for overuse. The addition of a copayment would allow beneficiary cost consciousness to

counterbalance the broad nature of the benefit's use criteria and the volume-rewarding aspects of Medicare's per episode payment policies.

Implications 8-4

Spending

- A copay of \$150 per episode (excluding low-use and posthospital episodes) would reduce spending for Medicare services by \$250 to \$750 billion in 2016 and \$1 to \$5 billion over five years.

Beneficiary and provider

- Some beneficiaries might seek services through outpatient or ambulatory care for which Medicare already has cost-sharing requirements. Some beneficiaries who need relatively few services would have lower cost sharing if they substituted ambulatory care for home health care. ■

Endnotes

- 1 The Balanced Budget Act of 1997 ended coverage of home health care for the purpose of venipuncture services alone.
- 2 The rate excludes hospitalizations that were not planned in advance or part of a normal course of treatment (for instance, organ transplant).
- 3 Surety bond firms review the organizational and financial integrity of an HHA and agree to cover the Medicare obligations, up to a set amount, for those agencies that the surety bond firm believes are low risk. A surety bond would cover liabilities that occur when an agency does not repay funds it owes Medicare (for example, when an agency is found to have improperly billed for services) (Government Accountability Office 1999).
- 4 As of November 2014, our measure of access is based on data collected and maintained as part of CMS's Home Health Compare database. The service areas listed are postal ZIP codes where an agency has provided services in the past 12 months. This definition may overestimate access because agencies need not serve the entire ZIP code to be counted as serving it. At the same time, the definition may understate access if HHAs are willing to serve a ZIP code but did not receive a request in the previous 12 months. The analysis excludes beneficiaries with unknown ZIP codes.
- 5 Certificate-of-need laws vary from state to state, and not all states have them. In general, the laws require that an area have a demonstrated need for additional health care services before a new provider is permitted to enter the market.
- 6 In 2012, CMS reduced payments for episodes with 20 or more therapy visits by 5 percent and reduced payments for episodes with 13 to 19 visits by 2.5 percent. Payments for episodes with five or fewer therapy visits were increased by 3.75 percent. The net effect of the adjustment was budget neutral.
- 7 The recommendation applied only to full episodes—those that included five or more visits.

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CHAPTER

10

Inpatient rehabilitation facility services

R E C O M M E N D A T I O N

- 10** The Congress should eliminate the update to the Medicare payment rates for inpatient rehabilitation facilities in fiscal year 2016.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

Inpatient rehabilitation facility services

Chapter summary

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, and speech–language pathology, as well as prosthetic and orthotic devices. In 2013, Medicare spent \$6.8 billion on fee-for-service IRF care provided in about 1,160 IRFs nationwide. About 338,000 beneficiaries had more than 373,000 IRF stays. On average, Medicare fee-for-service accounts for about 61 percent of IRFs’ discharges.

Assessment of payment adequacy

Our indicators of Medicare payment adequacy for IRFs are generally positive.

Beneficiaries’ access to care—Our analysis of IRF supply and volume of services provided suggests that capacity remains adequate to meet demand.

- **Capacity and supply of providers**—Between 2012 and 2013, the number of IRFs remained fairly steady at just over 1,160 providers. The number of hospital-based and nonprofit IRFs continues to decrease, while the number of freestanding IRFs and for-profit IRFs continues to increase. However, more than half of the new IRFs that opened in 2013 were hospital-based units. The average IRF occupancy rate has hovered around

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.....

63 percent for the past several years, indicating that capacity is more than adequate to handle current demand for IRF services.

- ***Volume of services***—Between 2012 and 2013, the number of Medicare cases treated in IRFs was stable at about 373,000 cases.

Quality of care—The Commission tracks three indicators of IRF quality: risk-adjusted facility discharge to the community, risk-adjusted discharge to skilled nursing facilities (SNFs), and potentially avoidable readmissions to acute care hospitals. All measures showed small improvement between 2011 and 2013. We also report on measures of change in patients' motor function and cognition during their IRF stay. These scores also increased slightly from 2011 to 2013, the period we examined.

Providers' access to capital—One major freestanding IRF chain that accounted for almost 40 percent of all freestanding IRFs in 2013 and about a quarter of all IRF discharges 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 IRFs have maintained reasonable access to capital.

Medicare payments and providers' costs—In 2013, the aggregate Medicare margin remained steady at 11.4 percent, in spite of the sequester. The aggregate margin has risen steadily since 2009. Financial performance continues to vary across IRFs, with margins of freestanding IRFs far exceeding those of hospital-based facilities. Higher margins were largely driven by lower unit costs. The lower costs may stem from greater economies of scale. But freestanding IRFs are also far more likely than hospital-based units to be for profit and therefore may be more focused on controlling costs. There are also notable differences in hospital-based and freestanding IRFs' mix of cases. The difference in the mix of case types across providers raises questions about patient selection and the relative profitability of different case types.

We project that IRFs' aggregate Medicare margin will be 12.6 percent in 2015. This estimate includes the effect of the sequester. If the sequester were not in effect in 2015, our projected margin would be almost 2 percentage points higher.

On the basis of these indicators, the Commission concludes that IRFs can continue to provide Medicare beneficiaries with access to safe and effective care with no update to the payment rates in fiscal year 2016. Our recommendation assumes that site-neutral payments for IRFs and SNFs, which would affect IRF revenues, will not be implemented in fiscal year 2016 (see Chapter 7). ■

Background

After illness, injury, or surgery, some patients need intensive, inpatient rehabilitative care, such as physical, occupational, or speech therapy. Such services are sometimes provided in inpatient rehabilitation facilities (IRFs).¹ To qualify as an IRF, a facility must meet Medicare's conditions of participation for acute care hospitals and must be primarily focused on treating conditions that typically require intensive rehabilitation, among other requirements. IRFs can be freestanding facilities or specialized units within acute care hospitals. To qualify for a covered IRF stay, a beneficiary must be able to tolerate and benefit from intensive therapy and must have a condition that requires frequent and face-to-face supervision by a rehabilitation physician. Other patient admission criteria also apply. In 2013, Medicare spent \$6.8 billion on IRF care provided in about 1,160 IRFs nationwide. About 338,000 beneficiaries had more than 373,000 IRF stays. On average, Medicare accounts for about 61 percent of IRFs' discharges.

Since January 2002, Medicare has paid IRFs under a per discharge prospective payment system (PPS).² Under the IRF PPS, Medicare patients are assigned to case-mix groups (CMGs) based on the patient's primary reason for inpatient rehabilitation, age, and level of functional and cognitive impairment. Within each of these CMGs, patients are further categorized into one of four tiers based on the presence of specific comorbidities that have been found to increase the cost of care. Each CMG tier has a specific weight that reflects the average relative costliness of cases in the group compared with that of the average Medicare IRF case.³ The CMG weight is multiplied by a base payment rate that has been adjusted to reflect geographic differences in the wages IRFs pay. The payment is further adjusted based on the share of low-income patients treated by the IRF. Additional adjustments are made for IRFs that are teaching facilities and for IRFs located in rural areas. The IRF PPS has outlier payments for patients who are extraordinarily costly.⁴

Medicare facility requirements for IRFs

To qualify as an IRF for Medicare payment, facilities must meet the Medicare IRF classification criteria. The first criterion is that providers must meet the Medicare conditions of participation for acute care hospitals. They must also:

- have a preadmission screening process to determine that each prospective patient is likely to benefit significantly from an intensive inpatient rehabilitation program;
- ensure that the patient receives close medical supervision and provide—through qualified personnel—rehabilitation nursing, physical therapy and occupational therapy, and, as needed, speech–language pathology and psychological (including neuropsychological) services, social services, and orthotic and prosthetic devices;
- have a medical director of rehabilitation with training or experience in rehabilitation who provides services in the facility on a full-time basis for freestanding IRFs or at least 20 hours per week for hospital-based IRF units;
- use a coordinated interdisciplinary team approach led by a rehabilitation physician that includes a rehabilitation nurse, a social worker or case manager, and a licensed therapist from each therapy discipline involved in the patient's treatment; and
- meet the compliance threshold (described below).

The compliance threshold requires that no less than 60 percent of all patients admitted to an IRF have as a primary diagnosis or comorbidity at least 1 of 13 conditions specified by CMS.⁵ The intent of the compliance threshold is to distinguish IRFs from acute care hospitals. If an IRF does not meet the compliance threshold, Medicare pays for all its cases on the basis of the inpatient hospital prospective payment system rather than the IRF PPS.

The compliance threshold was originally set at 75 percent of an IRF's cases. But analysis of proprietary data from eRehabData[®] for a sample of IRFs suggests that, before implementation of the IRF PPS, many facilities fell short of that threshold. In 2002, the percentage of IRF cases with 1 of the 13 specified conditions was 42 percent. CMS suspended enforcement of the rule in 2002 because of inconsistent enforcement patterns among Medicare's administrative contractors, but it began consistently enforcing compliance in 2004 and enacted restrictions on some of the qualifying conditions.⁶ The combination of renewed enforcement of the threshold and additional restrictions resulted in a substantial decline in the volume of Medicare patients treated in IRFs. As volume declined, occupancy rates, the number of rehabilitation beds, and the

number of facilities also fell. Average case-mix severity and cost per case increased as IRFs admitted patients with more complex conditions who counted toward the threshold.

The compliance threshold was permanently capped at 60 percent in 2007 by the Medicare, Medicaid, and SCHIP Extension Act of 2007. Since then, the industry has stabilized. According to eRehabData, 60.3 percent of IRFs' cases counted toward the compliance threshold in 2013. Although IRFs' efforts to meet this compliance threshold had a significant effect on IRF volume, the decline was consistent with the underlying reason for tightening enforcement of the compliance threshold—to ensure that providers receiving higher IRF payments are primarily engaged in furnishing intensive rehabilitation to clinically appropriate cases.

Determining compliance can be complex. A case is first evaluated for compliance based on the impairment group code (IGC), which describes the primary reason for inpatient rehabilitation.⁷ (IGCs are also used to assign cases to case-mix groups for payment purposes.) If compliance cannot be determined based on the IGC, the case is evaluated for compliance based on the patient's International Classification of Diseases, Ninth Revision, Clinical Modification (ICD–9–CM) diagnosis codes. Compliance is evaluated either through medical review or through the “presumptive” method, developed by CMS, in which a computer program compares a facility's Inpatient Rehabilitation Facility–Patient Assessment Instrument (IRF–PAI) assessments from the year with a list of eligible codes. The diagnosis codes included on the list are ones that CMS believes demonstrate either that the patient meets criteria for the medical conditions that may be counted toward an IRF's compliance percentage or that the patient has a comorbidity that could cause significant decline in functional ability such that the patient would require intensive rehabilitation (Centers for Medicare & Medicaid Services 2014).

In fiscal year 2016, CMS is removing a large number of ICD–9–CM codes from the list used to qualify for presumptive compliance with the 60 percent rule because the codes alone do not provide sufficient information that the patient would reasonably require intensive inpatient rehabilitation (Centers for Medicare & Medicaid Services 2014). Examples include nonspecific or miscellaneous diagnosis codes and codes for arthritis conditions that would meet the compliance criteria only if severity and prior treatment criteria are met, which could be determined

only through medical review. The Commission supports this effort and encourages CMS to explore further refinements of the 60 percent rule to ensure that higher IRF payments are made to providers that furnish IRF-level services to beneficiaries who need and can tolerate that level of care.

Medicare coverage criteria for beneficiaries

Medicare applies additional criteria that govern whether IRF services are covered for an individual Medicare beneficiary. In 2010, CMS clarified coverage criteria regarding which patients are appropriate to be treated in an IRF, when therapy must begin, and how and when beneficiaries are evaluated. For an IRF claim to be considered reasonable and necessary, there must be a reasonable expectation that the patient meets the following requirements at admission:

- The patient requires active and ongoing therapy in at least two modalities, one of which must be physical or occupational therapy.
- The patient generally requires and can be reasonably expected to actively participate in and benefit from intensive rehabilitation therapy that most typically consists of three hours of therapy a day at least five days a week.
- The patient is sufficiently stable at the time of admission to actively participate in the intensive rehabilitation program.
- The patient requires supervision by a rehabilitation physician. This requirement is satisfied by physician face-to-face visits with a patient at least three days a week.

Are Medicare payments adequate in 2015?

To assess whether payments for fiscal year 2015 are adequate to cover the costs providers incur and how much providers' costs are expected to change in the coming year (2016), we examine several indicators of payment adequacy. Specifically, we assess beneficiaries' access to care by examining the capacity and supply of IRFs and changes over time in the volume of services provided, quality of care, providers' access to capital, and the relationship between Medicare payments and providers' costs.

**TABLE
10-1**

The number of for-profit IRFs and freestanding IRFs continues to grow, while the number of nonprofit IRFs and hospital-based IRFs declines

Type of IRF	Share of Medicare discharges							Average annual change		Annual change
		2004	2006	2008	2010	2012	2013	2004–2006	2006–2012	2012–2013
All IRFs	100%	1,221	1,225	1,202	1,179	1,166	1,161	0.2%	–0.8%	–0.4%
Urban	92	1,024	1,018	1,001	981	973	977	–0.3	–0.8	0.4
Rural	8	197	207	201	198	193	184	2.5	–1.2	–4.7
Freestanding	47	217	217	221	233	239	243	0.0	1.6	1.7
Hospital based	53	1,004	1,008	981	946	927	918	0.2	–1.4	–1.0
Nonprofit	50	768	758	738	729	698	677	–0.7	–1.4	–3.0
For profit	41	292	299	291	294	307	322	1.2	0.4	4.9
Government	9	161	168	173	156	157	155	2.2	–1.1	–1.3

Note: IRF (inpatient rehabilitation facility). Numbers may not sum to totals because of missing data.

Source: MedPAC analysis of Provider of Service files from CMS.

Beneficiaries' access to care: IRF supply and service volume suggest sufficient access

We have no direct indicator of beneficiaries' access to IRF care. There are few clear criteria outlining the need for such care, so we have no way to determine whether IRF care is necessary or beneficial for a given patient or whether another, lower cost post-acute care provider (such as a skilled nursing facility or a home health agency) could provide appropriate care. The absence of IRFs in some areas of the country makes it particularly difficult to assess the need for IRF care since beneficiaries in areas without IRFs presumably receive similar services in other settings. Nevertheless, our analysis of IRF supply and volume of services provided suggests that capacity remains adequate to meet demand.

Capacity and supply of providers: Number of IRFs and occupancy rates suggest adequate capacity

In 2013, there were 1,161 IRFs nationwide, with more than 38,000 beds; each state and the District of Columbia had at least one IRF (Table 10-1). In general, IRFs are concentrated in highly populated states that have large Medicare populations. More than two-thirds of beneficiaries live in a county that has at least one IRF. IRFs are not the sole provider of rehabilitation services in communities; though they do not necessarily provide intensive rehabilitation, skilled nursing facilities (SNFs), home health agencies, comprehensive outpatient

rehabilitation facilities, and independent therapy providers also furnish rehabilitation services. Given the number and distribution of these other rehabilitation therapy providers relative to IRFs, it is unlikely that many areas exist where IRFs are the only provider of rehabilitation therapy services available to Medicare beneficiaries.

In 2013, about 79 percent of IRFs were distinct units located in acute care hospitals; the remaining 21 percent were freestanding facilities. However, because hospital-based units tend to have fewer beds, they accounted for only 53 percent of Medicare discharges from IRFs. Overall, 28 percent of IRFs are for-profit entities. Freestanding IRFs are far more likely to be for profit than hospital-based IRFs (68 percent vs. 17 percent). About 41 percent of Medicare IRF discharges in 2013 were from for-profit facilities. Over time, the number of hospital-based and nonprofit IRFs has declined, while the number of freestanding and for-profit IRFs has increased. Between 2006 and 2013, the number of hospital-based IRFs fell by 9 percent, while the number of freestanding IRFs rose 12 percent.

In 2013, about 35 IRFs closed; about 80 percent of these were hospital-based units. However, almost two-thirds of the new IRFs that opened that year were hospital-based units. Acute care hospitals may find that IRF units help reduce inpatient lengths of stay and free up hospital beds for additional admissions. Previous Commission analyses have

**TABLE
10-2****The number of fee-for-service IRF cases is holding steady**

								Average annual change	Annual change	
	2004	2006	2008	2010	2011	2012	2013	2004– 2008	2008– 2012	2012– 2013
Number of cases	495,349	404,633	356,312	359,307	371,288	373,284	373,118	–7.9 %	1.2%	0.0%
Cases per 10,000 FFS beneficiaries	135.6	111.9	100.4	99.7	101.7	100.1	99.7	–7.2	–0.1	–0.4
Spending (in billions)	\$6.6	\$6.2	\$5.9	\$6.1	\$6.5	\$6.7	\$6.8	–2.6	3.2	1.4
Payment per case	\$13,290	\$15,380	\$16,646	\$17,085	\$17,398	\$17,995	\$18,258	5.8	2.0	1.5
ALOS (in days)	12.7	13.0	13.3	13.1	13.0	12.9	12.9	1.3	–0.8	–0.4
Users	449,362	369,269	323,897	325,506	336,601	339,087	337,704	–7.9	1.2	–0.4

Note: IRF (inpatient rehabilitation facility), FFS (fee-for-service), ALOS (average length of stay).

Source: MedPAC analysis of Medicare Provider Analysis and Review data from CMS.

found that hospitals with IRF units have higher inpatient Medicare margins than hospitals without such units.

The average IRF occupancy rate has hovered around 63 percent for the past several years, indicating that capacity is more than adequate to handle current demand for IRF services. Freestanding IRFs and IRFs located in urban areas had somewhat higher average occupancy rates in 2013 than did their hospital-based and rural counterparts.

Volume of services: Number of IRF cases holding steady

The number of Medicare fee-for-service (FFS) IRF cases grew rapidly throughout the 1990s and the early years of the IRF PPS, reaching a peak of about 495,000 in 2004 (Table 10-2). After CMS renewed its enforcement of the compliance threshold in 2004, IRF volume declined substantially, falling almost 8 percent per year from 2004 to 2008. At that point, volume began to increase slowly. Between 2012 and 2013, volume was stable, remaining at about 373,000 cases.

Since 2008, the number of IRF cases per 10,000 FFS beneficiaries has held steady at about 100. Relatively few Medicare beneficiaries use IRF services because, to

qualify for Medicare coverage, IRF patients must be able both to tolerate and benefit from intensive rehabilitation therapy, which typically consists of at least three hours of therapy a day for at least five days a week. Still, compared with all Medicare beneficiaries, those admitted to IRFs are disproportionately over age 85. Almost a quarter of IRFs' Medicare cases were for beneficiaries aged 85 or older. The use rate of IRFs among Medicare's FFS population continues to be more than twice that of the Medicare Advantage population (see text box, pp. 246–247).

Beginning in 2004, after CMS's renewed enforcement of the compliance threshold and restrictions on some of the qualifying conditions, the total number of IRF cases fell and the mix of cases treated by IRFs shifted markedly. IRFs began to admit a higher share of patients with diagnoses that met the revised compliance threshold, such as stroke, brain injury, and neurological disorders. The growth in cases with neurological disorders—which include multiple sclerosis, Parkinson's disease, and polyneuropathy—has been particularly striking. Between 2004 and 2013, the number of IRF cases with neurological disorders grew 82 percent, even as the total number of Medicare IRF cases declined 24 percent. The number of cases with brain injuries rose 58 percent over

**TABLE
10-3****IRF patient mix is stable after period of rapid change**

Condition	Percent of IRF Medicare FFS cases				Meets compliance threshold	Percentage point change		
	2004	2009	2012	2013		2004–2009	2009–2012	2012–2013
Stroke	16.6%	20.5%	19.4%	19.4%	yes	3.9	–1.1	0.0
Fracture of the lower extremity	13.1	15.1	13.0	12.5	yes	2.0	–2.1	–0.5
Neurological disorders	5.2	9.0	11.6	12.4	yes	3.8	2.6	0.9
Debility	6.2	9.3	10.0	10.2	no	3.1	0.7	0.3
Major joint replacement of the lower extremity	24.1	11.7	10.1	9.0	*	–12.4	–1.6	–1.1
Brain injury	3.9	7.3	7.9	8.2	yes	3.4	0.6	0.2
Other orthopedic conditions	5.2	6.4	7.5	7.7	no	1.3	1.1	0.2
Cardiac conditions	5.3	4.9	5.3	5.4	no	–0.3	0.4	0.1
Spinal cord injury	4.2	4.4	4.6	4.6	yes	0.2	0.2	0.0
All other	16.3	11.3	10.6	10.5	**	–5.0	–0.6	–0.1

Note: IRF (inpatient rehabilitation facility), FFS (fee-for-service). "Fracture of the lower extremity" includes hip, pelvis, and femur fractures. "Neurological disorders" includes multiple sclerosis, Parkinson's disease, and polyneuropathy. Patients with debility have generalized deconditioning not attributable to other conditions. "Other orthopedic conditions" excludes fractures of the hip, pelvis, and femur, and hip and knee replacements. "All other" includes conditions such as amputations, arthritis, and pain syndrome. "Meets compliance threshold" indicates whether the condition counts toward the compliance threshold, which requires that 60 percent of all patients have 1 of 13 specified diagnoses. Numbers may not sum to totals due to rounding.

*Cases admitted for rehabilitation following major joint replacement of the lower extremity count toward the compliance threshold if joint replacement was bilateral, if the patient had a body mass index of 50 or greater, or if the patient was age 85 or older.

**Case types in this category that meet the compliance threshold include congenital deformity, amputation, major multiple trauma, burns, and certain arthritis cases.

Source: MedPAC analysis of Inpatient Rehabilitation Facility–Patient Assessment Instruments from CMS.

the same period. (Notably, we also observe growth in the number of debility cases and cases with other orthopedic conditions, neither of which is among the 13 conditions that count toward the compliance threshold.) As a result, neurological disorders now make up 12.4 percent of all IRF cases compared with 5.2 percent in 2004 (Table 10-3). Beneficiaries with brain injuries now make up 8.2 percent of all IRF cases, up from 3.9 percent in 2004.

In 2013, the most common case type in IRFs was stroke, accounting for 19.4 percent of Medicare cases (Table 10-3). The next most common case types are fracture of the lower extremity (12.5 percent of all Medicare cases) and neurological disorders (12.4 percent). However, the distribution of case types differs by type of IRF. For example, freestanding for-profit IRFs have a lower share of stroke cases (14 percent) and a higher share of cases with neurological disorders (19 percent) (Table 10-4).

**TABLE
10-4****IRF patient mix differs by provider type, 2013**

Condition	All IRFs	Freestanding		Hospital based	
		For profit	Nonprofit	For profit	Nonprofit
Stroke	19%	14%	22%	19%	24%
Fracture of the lower extremity	14	13	12	17	14
Neurological disorders	12	19	7	10	8
Other orthopedic conditions	8	11	7	5	6

Note: IRF (inpatient rehabilitation facility). "Neurological disorders" includes multiple sclerosis, Parkinson's disease, and polyneuropathy. "Fracture of the lower extremity" includes hip, pelvis, and femur fractures. "Other orthopedic conditions" excludes fractures of the hip, pelvis, and femur, and hip and knee replacements.

Source: MedPAC analysis of Inpatient Rehabilitation Facility–Patient Assessment Instruments from CMS.

Comparison of Medicare Advantage and Medicare fee-for-service patients' use of inpatient rehabilitation facility services

Patients who reside in areas with inpatient rehabilitation facilities (IRFs) typically have alternatives for rehabilitation care, including skilled nursing facilities and home health agencies. Alternative post-acute care settings are generally less costly but offer less intensive rehabilitation and medical services. For many patients, any number of settings could provide appropriate care for their conditions. Because Medicare Advantage (MA) plans have incentives to manage care for beneficiaries in a cost-efficient manner, we examined how the population characteristics and use rates of the higher cost IRF services in the MA population compared with use in the fee-for-service (FFS) population.

Medicare requires IRFs to submit patient assessment data for both FFS and MA patients. We examined 2013 data from the IRF–Patient Assessment Instrument and found that the use rate of IRFs among the FFS population in 2013 was more than double the rate of MA patients (Table 10-5). MA enrollees who used IRFs were more likely than FFS beneficiaries to have

(continued next page)

**TABLE
10-5**

FFS beneficiaries have higher IRF use rate, lower severity than MA enrollees, 2013

	FFS patients	MA patients
Cases per 1,000 enrollees	10.1	3.8
Admitted from acute unit of same facility	37.8%	43.0%
Case-mix weight	1.31	1.38
Average LOS (in days)	12.8	13.7
Percent:		
Discharged home	69.9%	72.8%
Discharged home with home health	52.5	53.1
Discharged to SNF	10.9	8.1

Note: FFS (fee-for-service), IRF (inpatient rehabilitation facility), MA (Medicare Advantage), LOS (length of stay), SNF (skilled nursing facility). Discharge destinations do not total 100 percent because patients in the discharged home category also appear in the discharged home with home health category. Some discharge destinations are not shown.

Source: MedPAC analysis of Inpatient Rehabilitation Facility–Patient Assessment Instrument data from CMS.

Quality of care: Small improvements in risk-adjusted measures between 2011 and 2013

This year, to assess the quality of care provided in IRFs, the Commission developed and examined risk-adjusted facility rates of improvement in patients' functional and cognitive abilities, discharge to the community and discharge to SNFs, and potentially avoidable readmissions to acute care hospitals. We use these measures because they reflect the preferences of beneficiaries, the goals of inpatient rehabilitation care, and the objectives of the Medicare program. Beneficiaries who use IRF services are seeking to regain or improve physical and cognitive function after an acute event, surgery, or debilitating medical problem. Community discharge—return to the home—is the goal for many. Rates of discharge to a SNF reflect the extent to which patients continue to need institutional care after the IRF stay. Avoiding costly and harmful hospital readmissions is beneficial for both beneficiaries and the Medicare program.

To accurately compare quality across facilities, measures must be risk adjusted to reflect the relative complexity of cases each facility treats. Without risk adjustment, some facilities may appear to provide higher quality care when in fact they treat a less complex mix of cases, while others may appear to have worse quality when in fact they treat a more complex mix of cases. Risk adjustment allows for fair comparisons across facilities.

Risk-adjusted gains in motor function and cognition

To qualify for coverage of IRF care, beneficiaries must require, be able to participate in, and benefit from intensive rehabilitation therapy. To observe the extent to which IRFs help improve the motor function and cognition of the beneficiaries they treat, we worked with a contractor to develop a risk-adjusted measure of gains in these areas. We wanted measures reflecting the extent to which patients improved their motor skills and cognition during

Comparison of Medicare Advantage and Medicare fee-for-service patients' use of inpatient rehabilitation facility services (cont.)

been admitted to the IRF from an acute-care unit of the same facility (43 percent vs. about 38 percent).

On average, as measured by the IRF case-mix weight, MA IRF patients were more complex than their FFS counterparts, and their average stay was almost a day longer. At the same time, MA IRF patients were more likely to be discharged home and less likely to be discharged to a SNF.

The mix of case types among MA IRF cases was different from that among FFS IRF cases (Table 10-6). A much larger share of MA IRF patients were admitted for rehabilitation after a stroke—34 percent compared with 19 percent for FFS IRF patients. MA IRF cases were also more likely to be admitted because of a brain injury. By contrast, FFS IRF patients were more likely than MA patients to be admitted for rehabilitation for neurological conditions (12 percent vs. 9 percent) and debility (10 percent vs. 6 percent).

This analysis did not control for the availability of IRFs in areas with high MA market penetration. The use rate could also be affected by potential differences in the need for rehabilitation services in the MA population. However, the disparity in use rates suggests that MA plans are more selective in the patients they authorize to receive care in IRFs. ■

**TABLE
10-6**

**Mix of case types among
FFS IRF cases differs from that
of MA IRF cases, 2013**

Type of case	Share of all cases	
	FFS patients	MA patients
Stroke	19%	34%
Fracture of the lower extremity	13	10
Neurological conditions	12	9
Debility	10	6
Major joint replacement of the lower extremity	9	9
Brain injury	8	10
Other orthopedic conditions	8	5
Spinal cord injury	5	6
Cardiac conditions	5	4
Amputation	3	4
All other	8	5

Note: FFS (fee-for-service), IRF (inpatient rehabilitation facility), MA (Medicare Advantage). "Fracture of the lower extremity" includes hip, pelvis, and femur fractures. "Neurological conditions" includes multiple sclerosis, Parkinson's disease, and polyneuropathy. Patients with debility have generalized deconditioning not attributable to other conditions. "Other orthopedic conditions" excludes fractures of the hip, pelvis, and femur, and hip and knee replacements. "All other" includes conditions such as arthritis and pain syndrome. Columns may not sum to 100 percent due to rounding.

Source: MedPAC analysis of Inpatient Rehabilitation Facility–Patient Assessment Instrument data from CMS.

the IRF stay, given their level of function at admission and how much improvement they would be expected to make. Some patients, such as a relatively healthy 68-year-old recovering from an elective hip replacement, are likely to improve across several activities of daily living (ADLs) during their IRF stay. Other patients, such as those who are 85 years old or older and suffering from debility following a prolonged acute care hospital stay, may be expected to make only modest improvement during their IRF stay.

Functional status at admission and discharge is measured using the motor and cognitive admission scores on the IRF–PAI. The IRF–PAI incorporates the 18-item Functional Independence Measure™ (FIM™) to measure

the level of disability in motor and cognitive functioning and the burden of care for a patient's caregivers (Deutsch et al. 2005). Scores for each of the 18 FIM items range from 1 (complete dependence) to 7 (independence).⁸ Scores on the 18 measures can be summed to calculate a motor score (based on 13 FIM items) and a cognitive score (based on 5 FIM items). The motor score at discharge can range from 13 to 91, while the cognitive score can range from 5 to 35, with higher scores indicating more functional independence.

To measure observed improvement in motor function and cognition, we subtracted the respective FIM scores at admission from the FIM scores at discharge to calculate

**TABLE
10-7****Mean risk-adjusted gains in IRF patients' motor and cognitive function rose slightly between 2011 and 2013**

Measure	Risk-adjusted gain in function		
	2011	2012	2013
Motor FIM™ gain	22.3	22.7	23.1
Cognitive FIM™ gain	3.6	3.7	3.8

Note: IRF (inpatient rehabilitation facility), FIM™ (Functional Independence Measure™). The motor FIM measures the level of disability in motor functioning on a 91-point scale. The cognitive FIM measures the level of cognitive impairment on a 35-point scale. FIM gain is calculated as the FIM score at discharge minus the FIM score at admission. Mean FIM gain averages the change of all facilities with 25 or more stays.

Source: Analysis of Inpatient Rehabilitation Facility–Patient Assessment Instruments from CMS (Kramer et al. 2015).

FIM motor and cognitive gains. A larger number indicates more improvement in functional independence and cognition between admission and discharge. Risk-adjusted rates were calculated by comparing a facility's observed rates with its expected rates and multiplying this ratio by the national rate. A facility that admits patients with worse than average prognoses has a lower than average expected rate of achieving these outcomes, which is reflected in the risk-adjusted rate.

In 2013, across all eligible facilities the mean change (gain) in the motor FIM score during the IRF stay was 23.1, while the mean change (gain) in the cognitive FIM score was 3.8 (Table 10-7). Controlling for ownership and location (urban or rural), we found that freestanding IRFs had an average adjusted motor FIM gain that was 2.3 points higher than that of hospital-based IRFs and an average adjusted cognitive FIM gain that was 0.6 points higher. The average risk-adjusted gain in IRF patients'

motor and cognitive FIM scores increased slightly from 2011 to 2013, though we will need to track these measures over time to observe longer term trends.

Changes in motor function and cognition must be interpreted with caution. Because payment is based in part on patients' functional status at admission—with higher payments associated with lower functional status—providers have a financial incentive to code patients in a manner that gives them a low FIM score at admission. As a result, reported gains in motor function and cognition may be overstated.

Risk-adjusted rates of potentially avoidable rehospitalization, discharge to community, and discharge to SNF

Avoidable rehospitalizations of IRF patients expose beneficiaries to hospital-acquired infections and poor care transitions (such as medication errors). At the same

**TABLE
10-8****Small improvements were made in IRFs' risk-adjusted rates of potentially avoidable rehospitalizations, discharge to SNF, and discharge to the community**

Measure	2011	2012	2013
Potentially avoidable rehospitalizations during IRF stay	2.8%	2.6%	2.5%
Discharged to a SNF	6.9	6.6	6.7
Discharged to the community	74.1	75.3	75.9
Potentially avoidable rehospitalizations during 30 days after discharge from IRF	4.9	4.6	4.5

Note: IRF (inpatient rehabilitation facility), SNF (skilled nursing facility). High rates of discharge to the community indicate better quality. High rates of rehospitalization and discharge to SNF indicate worse quality. Rates are the average of facility rates and calculated for all facilities with 25 or more stays.

Source: Analysis of Inpatient Rehabilitation Facility–Patient Assessment Instruments from CMS (Kramer et al. 2015).

**TABLE
10-9****Performance on quality measures varied across IRFs in 2013**

Measure	Risk-adjusted rate		
	Mean	25th percentile	75th percentile
Motor FIM™ gain	23.1	20.7	25.3
Cognitive FIM™ gain	3.8	3.0	4.6
Potentially avoidable rehospitalizations during IRF stay	2.5%	1.5%	3.3%
Discharged to a SNF	6.7	4.3	8.9
Discharged to the community	75.9	72.8	79.1
Potentially avoidable rehospitalizations during 30 days after discharge from IRF	4.5	3.2	5.7

Note: IRF (inpatient rehabilitation facility), FIM™ (Functional Independence Measure™), SNF (skilled nursing facility). High rates of discharge to the community indicate better quality. High rates of rehospitalization and discharge to SNF indicate worse quality. The motor FIM measures the level of disability in motor functioning on a 91-point scale. The cognitive FIM measures the level of cognitive impairment on a 35-point scale. FIM gain is calculated as the FIM score at discharge minus the FIM score at admission. Rates are calculated for all facilities with 25 or more stays.

Source: Analysis of Inpatient Rehabilitation Facility–Patient Assessment Instruments from CMS (Kramer et al. 2015).

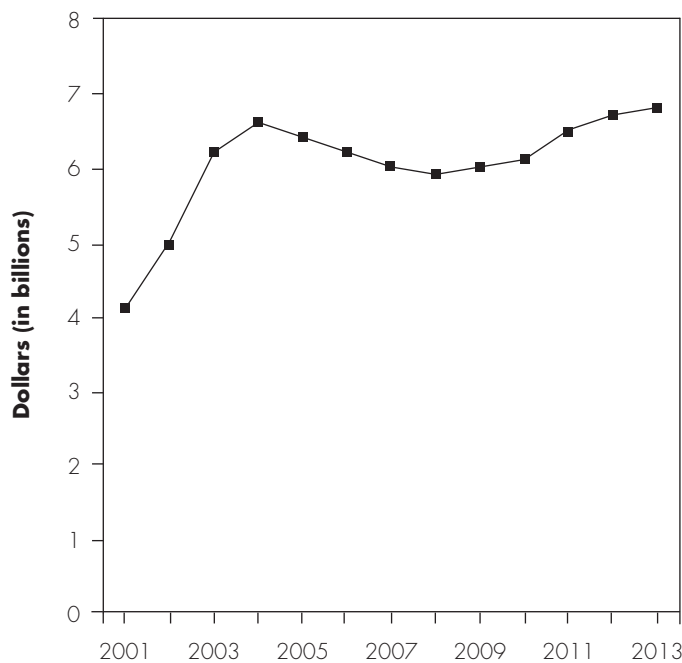
time, they unnecessarily raise spending for the Medicare program. There has been relatively little research on rehospitalization of IRF patients in aggregate, though some studies have focused on one or more rehabilitation impairment categories (Dejong et al. 2009, Galloway et al. 2013, Ottenbacher et al. 2014, Schneider et al. 2013, Schneider et al. 2012). However, research regarding rehospitalization of SNF and nursing home patients has identified several contributing factors that may be within a post-acute care facility's control. These include staffing level, skill mix, and frequency of staff turnover; drug management; and adherence to transitional care protocols, such as discharge counseling, medication reconciliation, patient education regarding self-care, and communication among providers, staff, and patient's family (Grabowski et al. 2008, Kane et al. 2003, Konetzka et al. 2008a, Konetzka et al. 2008b, Lau et al. 2005, Mustard and Mayer 1997).

This year, the Commission worked with a contractor to refine our measures of hospital readmissions during the IRF stay and in the 30 days after discharge from the IRF. Both measures reflect those readmissions that are potentially avoidable with adequate care in the IRF setting.⁹ The measure of readmission in the 30 days after discharge gives information about how well facilities prepare beneficiaries and their caregivers for safe and appropriate transitions to the next health care setting (or home).

Using these refined measures, we found that between 2011 and 2013, the national average rate of risk-adjusted potentially avoidable readmissions directly from the IRF declined slightly, from 2.8 percent to 2.5 percent (Table 10-8). (Lower rates are better.) During that period, the rate of risk-adjusted potentially avoidable readmissions within 30 days after discharge from an IRF also dropped slightly, from 4.9 percent to 4.5 percent.

We also examined rates of discharge to the community and to SNFs. Our refined measure of community discharge does not give IRFs credit for discharging a Medicare beneficiary who is subsequently readmitted to an acute care hospital within 30 days of the IRF discharge. We found that between 2011 and 2013, national average risk-adjusted community discharge rates increased from 74.1 percent to 75.9 percent. (Higher rates are better.) The national average risk-adjusted rate of discharge to SNFs fell from 6.9 percent to 6.7 percent, but controlling for facility-level characteristics, this change was not significant.

The IRF measures we examined varied somewhat across providers (Table 10-9). An IRF at the 25th percentile for risk-adjusted rate of discharge to a SNF had a rate that was half that of an IRF at the 75th percentile. (A lower rate of discharge to a SNF is better.) Controlling for facility-level characteristics, we found that the mean adjusted rate of discharge to a SNF was 1 percentage point higher

**FIGURE
10-1****Program spending for IRF services
has grown steadily since 2009**

Note: IRF (inpatient rehabilitation facility).

Source: MedPAC analysis of Medicare Provider Analysis and Review data from CMS.

for hospital-based IRFs than for freestanding IRFs, but differences between hospital-based and freestanding IRFs' adjusted rates of discharge to the community were not significant. The adjusted rates of potentially avoidable rehospitalizations from IRFs were 0.6 percentage point higher for freestanding IRFs than for their hospital-based counterparts.

Providers' access to capital: IRFs appear to have adequate access to capital

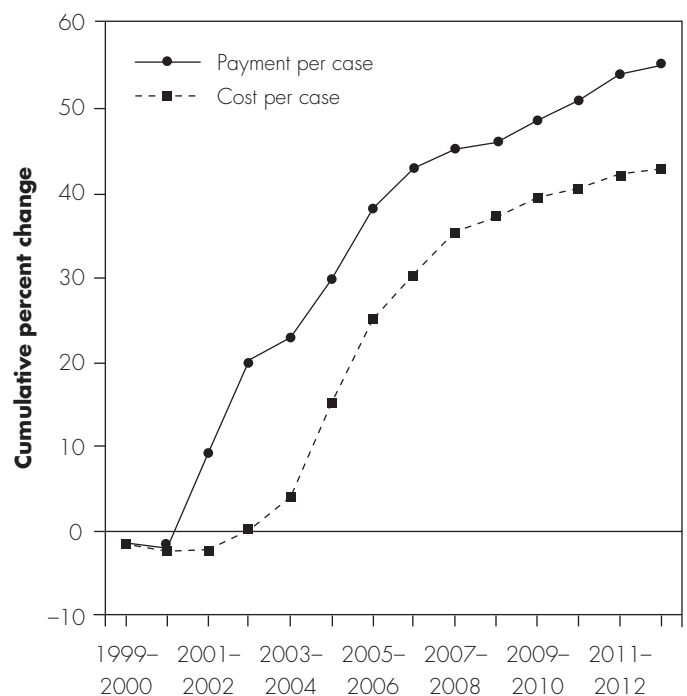
Seventy-nine percent of IRFs are hospital-based units that would access any necessary capital through their parent institutions. Overall, as detailed in Chapter 3 on hospital inpatient and outpatient services, acute care hospitals maintained reasonable access to capital markets in 2013 and 2014. In addition, the share price of publicly traded hospitals increased substantially in 2014, indicating that the capital markets continued to see hospitals as a profitable investment. While respondents to *Modern Healthcare's* 2014 Construction & Design Survey indicated that the majority of hospital construction has now shifted away from inpatient and toward outpatient-

based projects, we note that about 20 new hospital-based IRFs entered the market in 2013 (Moody's Investors Service 2014).

As for freestanding IRFs, market analysts we spoke to continue to rate access to capital for the industry's largest chain, which owned almost 40 percent of all freestanding IRFs in 2013 and accounted for about a quarter of all IRF discharges, as very good. Continued acquisitions of other post-acute care providers and expansion of capacity through construction of new IRFs reflect good access to capital and positive financial health. Most other freestanding IRFs are independent or are local chains with a small number of facilities. The extent to which these providers can access capital is less clear.

Medicare payments and providers' costs: Medicare margins remained high in 2013

In 2013, the Medicare margin remained steady at 11.4 percent, in spite of the sequester. The aggregate margin

**FIGURE
10-2****Under the PPS, IRFs' payments per case have increased cumulatively more than costs, 1999-2013**

Note: PPS (prospective payment system), IRF (inpatient rehabilitation facility). Percent changes are calculated based on consistent two-year cohorts.

Source: MedPAC analysis of Medicare cost report data from CMS.

has risen steadily since 2009. Financial performance continues to vary across IRFs, with margins of freestanding IRFs far exceeding those of hospital-based facilities. Higher unit costs were the primary driver of differences in financial performance between hospital-based and freestanding IRFs. We found that IRFs with the lowest costs tended to be larger and to have higher occupancy rates. Since hospital-based units are usually smaller than freestanding facilities and, on average, have lower occupancy rates, their higher costs may stem from fewer economies of scale. Hospital-based units are also far more likely than freestanding IRFs to be nonprofit facilities and therefore may be less focused on reducing costs to maximize returns to investors. But there are also notable differences in hospital-based and freestanding IRFs' mix of cases, with hospital-based IRFs admitting larger shares of stroke patients and freestanding IRFs admitting larger shares of cases with neurological disorders. The difference in the mix of case types across providers raises questions about patient selection and the relative profitability of different case types.

Trends in spending and cost growth

In the first years of the IRF PPS, Medicare spending for IRF services grew rapidly, climbing an average of 23 percent per year between fiscal year 2001 and fiscal year 2003 (Figure 10-1). (The IRF PPS was implemented in January 2002.) Subsequent legislative and regulatory changes to IRF payment policies slowed and then reduced spending for IRF services. Beginning in 2004, renewed enforcement of the compliance threshold and restrictions of some of the qualifying conditions resulted in a substantial reduction in the number of Medicare patients treated in IRFs. (This reduction was consistent with the underlying reason for the compliance threshold—to direct only the most clinically appropriate cases to this intensive, costly post-acute care setting.) Medicare spending for IRF services also declined from 2004 to 2008, falling 3 percent per year on average.¹⁰ The decline in volume slowed in 2008 and reversed in 2009, after the Congress permanently capped the compliance threshold at 60 percent. Medicare spending for IRF services began to grow again at that point, climbing an average of 3 percent per year between 2008 and 2013. Although IRF volume was almost unchanged between 2012 and 2013, total Medicare payments grew 1.4 percent.

As the IRF patient population shifted to patients with more severe disorders who counted toward the threshold,

**TABLE
10-10**

IRFs with fewer beds have much higher standardized costs per case, 2013

Type of IRF	Mean adjusted cost per discharge
All IRFs	\$16,517
Hospital based	17,627
Freestanding	12,474
Nonprofit	17,233
For profit	14,632
Government	18,740
Urban	15,969
Rural	19,431
Number of beds	
1 to 10	20,173
11 to 21	17,676
22 to 59	15,610
60 or more	12,863

Note: IRF (inpatient rehabilitation facility). Cost per discharge is standardized for differences in wages across geographic areas and differences in case mix across providers. Government-owned facilities operate in a different financial context from other facilities, so their costs are not necessarily comparable.

Source: MedPAC analysis of Medicare cost report and Medicare Provider Analysis and Review data from CMS.

case-mix severity and cost per case increased. However, from 1999 to 2013, the cumulative increase in payments per case outpaced the increases in costs per case (Figure 10-2). Costs per case rose 43 percent during this period, while payments grew 55 percent. Between 2012 and 2013, payments per case increased 1 percent, while costs per case increased 0.6 percent.

Differences in standardized costs suggest economies of scale

Adjusting IRF costs per discharge for differences in wages, case mix, and the number of short-stay cases permits a standardized comparison of costs across different types of IRFs nationwide. The mean adjusted cost per discharge for all IRFs in 2013 was \$16,517 (Table 10-10). IRFs with 10 or fewer beds had an average cost per discharge that was 57 percent higher than that of IRFs with 60 or more beds (\$20,173 vs. \$12,863).

We stratified IRFs into quartiles of standardized costs to compare the characteristics of facilities with the lowest

**TABLE
10-11****Low standardized costs lead to high margins for both hospital-based and freestanding IRFs, 2013**

Characteristic	Quartile	
	Lowest cost	Highest cost
Median cost per discharge		
All	\$11,227	\$21,934
Hospital based	12,127	21,848
Freestanding	10,632	22,514
Median Medicare margin		
All	26.2%	-26.0%
Hospital based	21.6	-26.0
Freestanding	29.5	-23.1
Median		
Number of beds	44	17
Occupancy rate	70%	47%
Case-mix index	1.27	1.22
Share of facilities in quartile that are:		
Hospital based	41%	95%
Freestanding	59	5
Nonprofit	31	63
For profit	65	21
Government	4	16
Urban	93	71
Rural	7	29

Note: IRF (inpatient rehabilitation facility). Cost per discharge is standardized for differences in wages across geographic areas and differences in case mix across providers. Government-owned facilities operate in a different financial context from other facilities, so their costs are not necessarily comparable.

Source: MedPAC analysis of Medicare cost report and Medicare Provider Analysis and Review data from CMS.

and highest costs in 2013 (Table 10-11). IRFs in the lowest cost quartile had a median standardized cost per discharge that was almost half that of the IRFs in the highest cost quartile (\$11,227 vs. \$21,934). The difference in Medicare margins between low-cost and high-cost IRFs was very large. IRFs in the lowest cost quartile had a median Medicare margin of 26.2 percent compared with -26 percent for IRFs in the highest cost quartile.

IRFs with the lowest costs tended to be larger: The median number of beds was 44 compared with 17 in the highest cost quartile. IRFs with the lowest costs also had a higher median occupancy rate (70 percent vs. 47 percent). These results suggest that low-cost IRFs benefit from economies of scale. Low-cost facilities were disproportionately freestanding and for profit. Still, 41 percent of the IRFs in the lowest cost quartile were hospital based, and 31 percent of the IRFs in this group were nonprofit. By contrast, in the highest cost quartile, 95 percent were hospital based, and almost two-thirds were nonprofit.

Margins vary widely by number of beds

Between 2012 and 2013, the aggregate IRF Medicare margin remained almost static, rising from 11.3 percent to 11.4 percent, including the effects of the sequester (Table 10-12). Without the sequester, the aggregate Medicare margin in 2013 would have been 12.3 percent. The aggregate margin has risen steadily since 2009, after a period of declining, though healthy, margins.

Financial performance in 2013 varied across IRFs. Medicare margins in freestanding IRFs far exceeded those of hospital-based facilities. In 2013, the aggregate margin for freestanding IRFs (which accounted for 47 percent of IRF discharges) was 24.1 percent, while hospital-based IRFs (53 percent of IRF discharges) had an aggregate margin of 0.3 percent. However, a quarter of hospital-based IRFs had Medicare margins greater than 10 percent, indicating that many hospitals can manage their IRF units profitably. Further, despite the comparatively low average margin in hospital-based IRFs, evidence suggests that these units make a positive financial contribution to their parent hospitals. Commission analysis found that in 2013, the aggregate Medicare margin for inpatient hospitals with IRF units was a percentage point higher than those of hospitals without IRF units. In addition, hospital-based IRFs' contribution margin (a measure of whether Medicare payments cover direct patient care costs) was a healthy 35 percent.

Margins varied by ownership, with for-profit IRFs tending to have higher margins (not shown in table). Among freestanding IRFs, nonprofit facilities (which accounted for 8 percent of all IRF discharges) had an aggregate margin of 12.8 percent. By comparison, freestanding for-profit IRFs (which accounted for 39 percent of all IRF discharges) had an aggregate margin of 27.3 percent. Likewise, among hospital-based IRFs, the aggregate

**TABLE
10-12****IRF Medicare margins remained steady in 2013**

Type of IRF	Share of Medicare discharges, 2013	Margins									
		2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
All IRFs	100%	16.7%	13.4%	12.3%	11.8%	9.3%	8.4%	8.7%	9.9%	11.3%	11.4%
Urban	92	17.0	13.6	12.6	12.0	9.5	8.7	9.0	10.3	11.7	11.8
Rural	8	13.2	11.1	10.1	9.5	6.9	5.6	4.8	5.3	6.5	6.4
Freestanding	47	24.7	20.7	17.4	18.4	18.1	20.3	21.3	23.2	24.0	24.1
Hospital based	53	12.2	9.3	9.6	8.0	3.8	0.3	-0.4	-0.2	0.8	0.3
Nonprofit	50	12.8	10.3	10.6	9.6	5.2	2.4	2.2	2.7	2.4	1.5
For profit	41	24.4	19.7	16.3	16.7	16.8	18.8	19.6	20.8	23.0	23.4
Government	9	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Number of beds											
Less than 25	25	9.9	6.0	6.3	5.2	0.6	-3.2	-3.9	-3.3	-1.3	-1.3
25 to 49	29	16.2	13.8	12.9	11.9	8.5	6.9	7.4	8.5	7.9	7.7
50 to 99	34	23.7	18.8	16.4	17.0	17.4	19.0	18.8	19.8	21.8	22.4
100 or more	11	18.7	17.7	17.6	15.9	13.5	14.0	14.6	16.4	17.7	16.1

Note: IRF (inpatient rehabilitation facility), N/A (not applicable). Government-owned facilities operate in a different financial context from other facilities, so their margins are not necessarily comparable. Their margins are not presented separately here, although they are included in the margins for other groups (e.g., "all IRFs"), where applicable.

Source: MedPAC analysis of cost report data and Medicare Provider Analysis and Review data from CMS.

margin for nonprofit units (which accounted for 38 percent of all IRF discharges) was -0.9 percent, while that for for-profit units (18 percent of all IRF discharges) was 8 percent. Between 2012 and 2013, total (all-payer) margins across all lines of business for freestanding facilities rose from 9.6 percent to 10.4 percent.¹¹

Higher unit costs were the primary driver of differences in financial performance between hospital-based and freestanding IRFs. Hospital-based IRFs had an average standardized cost per discharge that was 41.3 percent higher than that of freestanding IRFs (Table 10-10, p. 251).¹² Analysis of underlying cost components found that hospital-based IRFs had higher costs across all cost categories, the largest difference being in routine costs. In 2013, routine costs per case (which include the cost of nursing care) were 70 percent higher in hospital-based facilities than in freestanding ones, while ancillary costs per case (such as laboratory and drug costs) were 34 percent higher, and indirect costs per case (which includes

the costs of capital, housekeeping, and administration) were 19 percent higher.

The disparity in costs between hospital-based and freestanding IRFs may be driven by a number of factors. First, hospital-based units are far more likely than freestanding IRFs to be nonprofit and therefore may be less focused on reducing costs so as to maximize returns to investors. In addition, hospital-based IRFs likely achieve fewer economies of scale than their freestanding counterparts. Hospital-based IRFs tend to be smaller and have fewer total cases than freestanding IRFs. In 2013, 67 percent of hospital-based IRFs had fewer than 25 beds compared with 8 percent of freestanding IRFs. Only 7 percent of hospital-based IRFs had 50 or more beds compared with 62 percent of freestanding IRFs. At the same time, occupancy rates were lower in hospital-based IRFs than in their freestanding counterparts (60 percent vs. 67 percent). As a result, hospital-based IRFs had, on average, 480 cases (all-payer) in 2013 compared with almost 1,100 in freestanding IRFs.

In general, hospital-based IRFs tend to have a much larger share of cases with extraordinarily high costs. In 2013, 10 percent of hospital-based IRF cases qualified for high-cost outlier payments compared with just 2 percent of freestanding IRF cases. Indeed, 86 percent of all IRF outlier payments were made to hospital-based facilities. It is not clear whether this disparity stems from differences in efficiency, unmeasured case complexity, or both.

Finally, there are notable differences in hospital-based and freestanding IRFs' mix of cases. A larger share of hospital-based IRFs' patients were admitted with stroke as the primary reason for rehabilitation (23 percent vs. 16 percent in freestanding IRFs), though stroke patients admitted to freestanding IRFs were assessed as having greater motor deficits. Hospital-based IRFs also admitted a larger share of patients needing rehabilitation after fracture of the lower extremity (15 percent vs. 12 percent in freestanding IRFs). Freestanding IRFs admitted larger shares of cases with neurological disorders (17 percent vs. 8 percent in hospital-based IRFs) and other orthopedic conditions (10 percent vs. 6 percent). Notably, the impairment groups of neurological disorders and other orthopedic conditions encompass a broader range of conditions than many of the other groups. That clinical heterogeneity may allow favorable selection of patients within these groups based on their likely cost. Cases with neurological disorders also count toward the compliance threshold, so IRFs with higher shares of these cases may be able to more easily meet the requirements of the 60 percent rule while keeping down costs. The Commission notes that IRF ownership also appears to be correlated with the mix of cases. The differences in the mix of case types across providers may indicate underlying problems in the IRF PPS. The Commission has begun to analyze whether there are systemic biases in Medicare's payments that result in the imbalance in financial performance among provider types.

How should Medicare payments change in 2016?

To estimate 2015 payments, costs, and margins with 2013 data, the Commission considered policy changes effective in 2014 and 2015. Those that affect our estimate of the 2015 Medicare margin include:

- a market basket increase of 2.6 percent for fiscal year 2014, offset by reductions required by the Patient Protection and Affordable Care Act of 2010 (PPACA)

totaling 0.8 percentage point, for a net update of 1.8 percent;

- a market basket increase of 2.9 percent for fiscal year 2015, offset by PPACA-required reductions totaling 0.7 percentage point, for a net update of 2.2 percent;
- changes to the high-cost outlier fixed loss amount in 2014 and 2015, which will increase payments; and
- the application of the sequester, which will decrease payments.

We estimate that IRFs' aggregate Medicare margin will be 12.6 percent in 2015. Based on historical trends, we expect cost growth to be below market basket levels and lower than payment growth. Though the sequester will decrease payments, we do not expect it to be large enough to reverse the trend of increasing margins that has been observed for the past several years. The 12.6 percent margin includes the effect of the sequester. If the sequester were not in effect for 2015, our projected margin would be almost 2 percentage points higher.

On the basis of our review of payment adequacy for IRFs, the Commission recommends that the Congress eliminate the update to the IRF payment rate. Our recommendation assumes that site-neutral payments for selected IRF cases will not be implemented in fiscal year 2016 (see Chapter 7).

RECOMMENDATION 10

The Congress should eliminate the update to the Medicare payment rates for inpatient rehabilitation facilities in fiscal year 2016.

RATIONALE 10

Our indicators of Medicare payment adequacy for IRFs are positive. Stable volume, low occupancy rates, and availability of other rehabilitation alternatives suggest that capacity remains adequate to meet demand. Quality trends are stable or improving. Medicare margins for 2013 were positive. We conclude that IRFs should be able to accommodate cost changes in fiscal year 2016 with the base payment rate held at 2015 levels. Therefore, the 2016 IRF base payment rate should be the same as the 2015 rate.

IMPLICATIONS 10

Spending

- The payment update for IRFs in fiscal year 2016 consists of a forecasted 2.9 percent market basket update for rehabilitation, psychiatric, and long-term

care hospitals; a forecasted –0.5 percent productivity adjustment of the market basket update; and a –0.2 percent market basket reduction per PPACA.¹³ This recommendation would decrease federal program spending relative to the statutory update by between \$50 million and \$250 million in 2016 and by between \$1 billion and \$5 billion over five years.

Beneficiary and provider

- We do not expect this recommendation to have adverse effects on Medicare beneficiaries with respect to access to care or out-of-pocket spending. This recommendation may increase the financial pressure on some providers, but overall we expect a minimal effect on relatively efficient providers' willingness and ability to care for Medicare beneficiaries. ■

Endnotes

- 1 More frequently, Medicare beneficiaries receive inpatient rehabilitation services in skilled nursing facilities (SNFs), in part because nationwide there are many more SNFs than IRFs.
- 2 More information about the prospective payment system for IRFs is available at <http://www.medpac.gov/documents/payment-basics/inpatient-rehabilitation-facilities-payment-system-14.pdf?sfvrsn=0>.
- 3 Patients with a length of stay of fewer than four days are assigned to a single CMG, regardless of diagnosis, age, level of impairment, or presence of comorbidities.
- 4 High-cost outlier cases are identified by comparing the costs of treating the case with a threshold that is equal to the PPS payment for the case plus a fixed loss amount (\$8,848 in 2015, adjusted for the wage index and other facility characteristics). Medicare pays 80 percent of the IRF's costs above the threshold. In fiscal year 2013, about 6 percent of IRF cases received high-cost outlier payments. The prevalence of high-cost outlier cases differed by IRF type. About 10 percent of cases in hospital-based IRFs were high-cost outliers compared with 2 percent of cases in freestanding IRFs.
- 5 The 13 conditions are stroke; spinal cord injury; congenital deformity; amputation; major multiple trauma; hip fracture; brain injury; neurological disorders (e.g., multiple sclerosis and Parkinson's disease); burns; three arthritis conditions for which appropriate, aggressive, and sustained outpatient therapy has failed; and hip or knee replacement when bilateral, the patient's body mass index is greater than or equal to 50, or the patient is age 85 or older.
- 6 CMS's major revisions to the compliance threshold policy in 2004 were (1) increasing the number of conditions that count toward the threshold from 10 to 13 (by redefining the arthritis conditions that counted) and (2) revising the qualifying condition of major joint replacement—a condition that was commonly treated in IRFs—such that only a specific subset of patients with that condition would count toward the compliance threshold.
- 7 An impairment group code is not an ICD–9–CM diagnosis code but part of a separate unique set of codes specifically developed for the IRF PPS for assigning the primary reason for admission to an IRF.
- 8 At admission, a patient may score zero on a FIM item if the activity does not occur.
- 9 These potentially avoidable readmissions are identified by the primary diagnosis for the hospital readmission at the time of hospital discharge. The potentially avoidable readmissions we measure are respiratory-related illness (pneumonia, influenza, bronchitis, chronic obstructive pulmonary disease, asthma); sepsis; congestive heart failure; fractures or fall with a major injury; urinary tract or kidney infection; blood pressure management; electrolyte imbalance; anticoagulant therapy complications; diabetes-related complication; cellulitis or wound infection; pressure ulcer; medication error or adverse drug reaction; and delirium.
- 10 Medicare spending for IRF services was also affected when CMS reduced the IRF standard payment conversion factor by 1.9 percent in 2006 and by 2.6 percent in 2007 to adjust for changes in IRF coding practices that CMS determined did not reflect real changes in IRF patients' acuity.
- 11 Because of the structure of the cost report, all-payer overall margins for hospital-based facilities reflect a margin for the entire hospital rather than for the IRF unit alone. Therefore, we present only all-payer overall margins for freestanding IRFs.
- 12 Facility costs were adjusted for differences in case mix, local market input price levels, and the number of short-stay cases.
- 13 The market basket forecast was made in the third quarter of 2014. When setting the update, CMS will use the most recent forecast available, which may differ from the number we report here.

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CHAPTER

11

Long-term care hospital services

R E C O M M E N D A T I O N

- 11** The Secretary should eliminate the update to the payment rates for long-term care hospitals for fiscal year 2016.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

Long-term care hospital services

Chapter summary

Long-term care hospitals (LTCHs) provide 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 its Medicare patients must have an average length of stay greater than 25 days. In 2013, Medicare spent \$5.5 billion on care provided in LTCHs nationwide. About 122,000 beneficiaries had roughly 138,000 LTCH stays. On average, Medicare accounts for about two-thirds of LTCHs' discharges.

Assessment of payment adequacy

Beneficiaries' access to care—We have no direct measures of beneficiaries' access to needed LTCH services. Instead, we consider the capacity and supply of LTCH providers and changes over time in the volume of services they furnish. Trends suggest that access to care has been maintained.

- **Capacity and supply of providers**—Growth in the number of LTCHs filing Medicare cost reports slowed considerably in recent years because of the moratorium imposed by the Medicare, Medicaid, and SCHIP Extension Act of 2007 and subsequent legislation in effect through December 28, 2012. Even in the absence of the moratorium, we estimate that the number of LTCHs and LTCH beds decreased by about 1 percent in 2013.

In this chapter

- Are Medicare payments adequate in 2015?
- How should Medicare payments change in 2016?
- LTCHs will need to change their cost structures to maintain positive Medicare margins under the revised payment system

- ***Volume of services***—From 2012 to 2013, the number of LTCH cases decreased by 1.9 percent. Controlling for growth in the number of fee-for-service beneficiaries, we found that the number of LTCH cases per beneficiary declined by 2.2 percent between 2012 and 2013. This decrease in per capita admissions is consistent with that seen in other inpatient settings.

Quality of care—LTCHs only recently began submitting quality of care data to CMS. Those data are not yet available for analysis. Using claims data, we found stable or declining non-risk-adjusted rates of readmission, death in the LTCH, and death within 30 days of discharge for almost all of the top 25 diagnoses in 2013.

Providers' access to capital—For the past few years, the availability of capital to LTCHs has not reflected current Medicare payment rates but, rather, uncertainty regarding possible changes to Medicare's regulations and legislation governing LTCHs. The criteria to receive the higher LTCH payment rate specified in the Pathway for SGR Reform Act of 2013, beginning with cost reporting periods starting October 1, 2015, provide more regulatory certainty for the industry compared with recent years. However, payment reductions implemented by CMS and a congressional moratorium on new LTCH beds and facilities through September 2017 continue to limit future opportunities for growth and reduce the industry's need for capital.

Medicare payments and providers' costs—Since 2007, LTCHs have held cost growth below the rate of increase in the market basket index, a measure of inflation in the prices of goods and services LTCHs buy to provide care. Between 2012 and 2013, Medicare payments continued to increase, albeit more slowly than provider costs, resulting in an aggregate 2013 Medicare margin of 6.6 percent compared with 7.4 percent in 2012. Financial performance in 2013 varied across LTCHs, reflecting differences in cost control and responses to payment incentives.

We estimate that LTCHs' aggregate Medicare margin will be 4.6 percent in 2015. This estimate reflects current policy, including sequestration. If sequestration were to be lifted, we would expect the margin to be about 2 percentage points higher.

On the basis of these indicators, the Commission concludes LTCHs can continue to provide Medicare beneficiaries with access to safe and effective care and accommodate changes in their costs with no update to LTCH payment rates in fiscal year 2016.

This update recommendation applies to the Medicare LTCH prospective payment system base payment rate. Thus, this recommendation applies to payments for

discharges that meet the criteria specified in the Pathway for SGR Reform Act of 2013 and to the portion of the blended payment that reflects the LTCH payment rate for discharges that do not meet the specified criteria. If the Congress implements the Commission's recommendation for LTCH payment reform, our recommendation would apply to Medicare's payment rate for chronically critically ill cases in LTCHs. ■

Background

Patients with chronic critical illness—those who exhibit metabolic, endocrine, physiologic, and immunologic abnormalities that result in profound debilitation and often ongoing respiratory failure—frequently need hospital-level care for extended periods. Nationwide, most chronically critically ill (CCI) patients are treated in acute care hospitals (ACHs), but a growing number are treated in long-term care hospitals (LTCHs).¹ These facilities can be freestanding or colocated with other hospitals, as hospitals-within-hospitals (HWHs) or satellites. To qualify as an LTCH for Medicare payment, a facility must meet Medicare’s conditions of participation for ACHs, and its Medicare patients must have an average length of stay greater than 25 days.² By comparison, the average Medicare length of stay in ACHs is about five days. There are no other criteria defining LTCHs, the level of care they provide, or the patients they treat. In 2013, Medicare spent \$5.5 billion on care provided in LTCHs nationwide. About 122,000 beneficiaries had roughly 138,000 LTCH stays. On average, Medicare FFS beneficiaries account for about two-thirds of LTCHs’ discharges.

Since October 2002, Medicare has paid LTCHs prospective per discharge rates based primarily on the patient’s diagnosis and the facility’s wage index.³ Under this prospective payment system (PPS), LTCH payment rates are based on the Medicare severity long-term care diagnosis related group (MS–LTC–DRG) patient classification system, which groups patients primarily according to diagnoses and procedures. MS–LTC–DRGs are the same groups used in the acute care hospital inpatient PPS (IPPS) but have relative weights specific to LTCH patients, reflecting the average relative costliness of cases in the group compared with that of the average LTCH case. The LTCH PPS has outlier payments for patients who are extraordinarily costly.⁴ The LTCH PPS pays differently for short-stay outlier cases (patients with shorter than average lengths of stay), reflecting CMS’s contention that Medicare should adjust payment rates for patients with relatively short stays to reflect the reduced costs of caring for them (see text box discussing short-stay outliers, pp. 266–267). In addition, CMS uses the so-called “25-percent rule”—which prohibits an LTCH from having any more than 25 percent of its patients at any one time admitted from one referring hospital—to discourage LTCHs from admitting too many patients from any one referring hospital (generally an ACH).

Beginning October 1, 2015, Medicare will pay differently for cases that do not meet certain criteria specified in

the Pathway for SGR Reform Act of 2013 (see text box discussing recent legislation, p. 269). Medicare will pay the LTCH rate only for (1) cases that have an ACH stay that includes at least three days in an intensive care unit (ICU) or (2) discharges assigned to the MS–LTC–DRG based on the receipt of mechanical ventilation services for at least 96 hours. The remaining “site-neutral” cases will receive the lesser of either an IPPS-comparable amount or 100 percent of cost for the case.

In contrast, the Commission recommended in March 2014 that LTCHs be paid LTCH rates only for cases that received eight or more days of care in an ICU or received prolonged mechanical ventilation services during the previous ACH stay (see text box discussing Commission recommendations, pp. 270–271). The Commission is concerned that the three-day threshold mandated in the Pathway for SGR Reform Act of 2013 is too low to distinguish the truly chronically critically ill patients treated in LTCHs and that Medicare thus will continue to pay too much for many cases that could be cared for appropriately in other settings at a lower cost to the program.

Are Medicare payments adequate in 2015?

To address whether payments for 2015 are adequate to cover the costs that providers incur in providing services to Medicare beneficiaries and how much providers’ costs are expected to change in the coming year (2016), we examine several indicators of payment adequacy. Specifically, we assess beneficiaries’ access to care (by examining the capacity and supply of LTCH providers and changes over time in the volume of services furnished), quality of care, providers’ access to capital, and the relationship between Medicare payments and providers’ costs.

Beneficiaries’ access to care: Growth over time in supply of providers and volume of services suggests continued access to care

We have no direct measures of beneficiaries’ access to needed LTCH services. There are no clear criteria describing the need for care provided in LTCHs, and the absence of LTCHs in many areas of the country makes it particularly difficult to assess the adequacy of supply (since beneficiaries in areas without LTCHs have access to similar services in other settings). Instead, we consider the overall capacity and supply of LTCH providers and changes over time in the volume of services they furnish.

Payment for short-stay outliers in long-term care hospitals

In the long-term care hospital (LTCH) payment system, Medicare may adjust payments for cases with short stays. CMS defines a short-stay outlier (SSO) case as having a length of stay less than or equal to five-sixths of the geometric average length of stay for the case type. The SSO policy reflects CMS's contention that patients with lengths of stay similar to those in acute care hospitals (ACHs) should be paid at rates comparable with those under the ACH inpatient prospective payment system (IPPS). About 26.3 percent of LTCH discharges received SSO payment adjustments in fiscal year 2013, but this share varied across types of LTCHs. For example, in fiscal year 2013, 25.6 percent of for-profit LTCHs' cases were SSOs compared with 30.5 percent of nonprofit LTCHs' cases.

The amount Medicare pays to LTCHs for an SSO case is the lowest of:

- 100 percent of the cost of the case,
- 120 percent of the per diem amount for the Medicare severity long-term care diagnosis related group (MS–LTC–DRG) multiplied by the patient's length of stay,
- the full MS–LTC–DRG payment, or
- a blend of the IPPS amount for the same type of case and 120 percent of the MS–LTC–DRG per diem amount. The LTCH per diem payment amount makes up more of the total amount as the patient's length of stay increases.

Since December 29, 2012, CMS has applied a different standard to cases with the shortest lengths of stay—those with stays less than or equal to the IPPS average stay for the same type of case plus one standard

deviation. These cases are also paid the lowest of the four payment amounts: the first three listed previously or an amount comparable with the IPPS payment rate, rather than a blended amount. After December 29, 2012, about 13.1 percent of LTCH discharges were very short-stay outliers (VSSOs). In fiscal year 2013, 47 percent of VSSOs received payment equal to 100 percent of costs, and another 43 percent received an amount equal to the IPPS per diem payment. As with SSOs, the share of VSSOs varied across type of LTCH. For example, in fiscal year 2013, 13 percent of for-profit LTCHs' cases were VSSOs compared with 14.6 percent of nonprofit LTCH cases. The Commission estimates that in fiscal year 2015, 45.2 percent of SSO cases—or 12.3 percent of all LTCH cases—will be VSSOs.

Compared with cases that were not SSOs, SSO and VSSO cases were more likely to be of an extreme severity level and to require prolonged mechanical ventilation. Many LTCH SSO and VSSO cases were short because the beneficiary was readmitted to an ACH or died. Twenty-seven percent of VSSO cases were readmitted to an ACH, while 14 percent of SSOs and only 5 percent of longer stay cases were readmitted. Similarly, 42 percent of VSSO cases died in the LTCH compared with 20 percent of SSO cases and 6 percent of longer stays. When VSSO cases were discharged alive, only 26 percent were still living one year after discharge compared with more than half of SSO and non-SSO cases.

Generally, for the same case type, the IPPS payment is substantially less than the payment under the LTCH prospective payment system. As an example, for a case assigned to MS–LTC–DRG 207 (respiratory system diagnosis with prolonged mechanical ventilation), the standard IPPS payment in 2015 is \$31,376, while the

(continued next page)

Capacity and supply of providers: Supply stabilized during the congressionally mandated moratorium

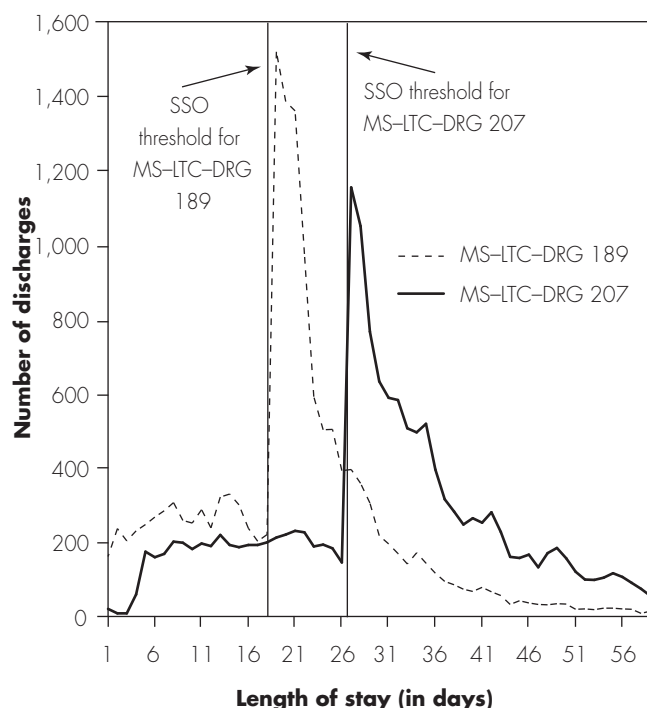
The Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) and subsequent legislation imposed

a limited moratorium on new LTCHs and new beds in existing LTCHs from December 29, 2007, through December 28, 2012. During this time, new LTCHs were able to enter the Medicare program only if they met specific exceptions to the moratorium.⁵ The Pathway

Payment for short-stay outliers in long-term care hospitals (cont.)

FIGURE 11-1

Many LTCH cases in fiscal year 2013 were discharged in the period immediately after the short-stay outlier threshold



Note: LTCH (long-term care hospital), SSO (short-stay outlier), MS-LTC-DRG (Medicare severity long-term care diagnosis related group). Cases in MS-LTC-DRG 207 are those with a respiratory system diagnosis that received prolonged mechanical ventilation. Cases in MS-LTC-DRG 189 are those with pulmonary edema and respiratory failure.

Source: MedPAC analysis of Medicare Provider Analysis and Review data from CMS.

standard LTCH payment is \$79,128. LTCHs therefore have a strong financial incentive to keep patients until their lengths of stay exceed the SSO threshold for the relevant case type, and they appear to respond to that incentive (Figure 11-1). Analysis of lengths of stay by MS-LTC-DRG for 2013 shows that the number of discharges rose sharply immediately after the SSO threshold. This pattern held true across MS-LTC-DRGs and for every category of LTCH. The data strongly suggest that LTCHs' discharge decisions are influenced at least as much by financial incentives as by clinical indicators.

CMS could substantially reduce these financial incentives by lowering the payment penalty for discharging patients before the SSO threshold. For example, short-stay cases could be defined as cases with a covered length of stay that is more than one day shorter than the geometric average length of stay for the MS-LTC-DRG. As with the transfer policy for short-stay cases in the IPPS, payment for the first day of a short-stay LTCH case could be two times the per diem payment rate for the MS-LTC-DRG; payment for each additional day would then be set at the per diem rate, up to the maximum of the full standard per discharge payment (which would be reached one day before the average length of stay for the MS-LTC-DRG). This formula would reduce the substantial cliff in payments that exists under current policy and better match incremental payments for short-stay cases to the provider's incremental costs. ■

for SGR Reform Act of 2013 and subsequent legislation reinstated the moratorium from April 1, 2014, through September 30, 2017.⁶

It is difficult to determine the precise number of LTCHs because of discrepancies in Medicare's data sources on these facilities. The Commission has found inaccuracies in the ownership data in Medicare's Provider of Services file, so we examined Medicare cost report data from 2004 to 2013 to assess the number of LTCH beds and facilities. We consistently found that growth in the number of LTCHs filing Medicare cost reports slowed considerably in the later years of the moratorium (Table 11-1, p. 268).

However, between 2012 and 2013, a larger than usual number of mergers and acquisitions resulted in midyear changes to cost reporting periods for more than 20 facilities. Cost report data therefore indicate 408 LTCHs filed valid cost reports in 2013, 18 fewer than 2012, on net. These data also show that the number of LTCH beds nationwide decreased about 4 percent in 2013. The anomalous cost reporting trends during this period make it impossible to accurately compare changes in the number of LTCH facilities and LTCH beds using cost report data. Using data from Medicare's Provider of Services file, the Commission estimates that between 2012 and 2013, the

**TABLE
11-1****Growth in the number of LTCHs has stabilized over the past several years**

Type of LTCH	Congressionally imposed moratorium							Average annual change		
	2004	2005	2009	2010	2011	2012	2013*	2004–2005	2005–2009	2009–2012
All	315	366	411	416	421	426	408	16.2%	2.9%	1.2%
Urban	299	342	388	389	395	399	380	14.4	3.2	0.9
Rural	16	24	23	27	26	27	28	50.0	–1.1	5.5
Nonprofit	67	78	79	82	77	79	71	16.4	0.3	0.0
For profit	229	265	313	314	326	329	320	15.7	4.2	1.7
Government	19	23	19	20	18	18	17	21.1	–4.7	–1.8

Note: LTCH (long-term care hospital). The Medicare, Medicaid, and SCHIP Extension Act of 2008 and subsequent legislation imposed a moratorium on new LTCHs and new LTCH beds in existing facilities from December 29, 2007 through December 29, 2012.

*2013 data should not be compared with prior years, given an anomalous number of facilities that underwent an acquisition and change in cost reporting period. Using the Provider of Services file, the Commission estimates that the number of facilities decreased from 437 in 2012 to 432 in 2013 (data not shown).

Source: MedPAC analysis of cost report data from CMS.

number of LTCHs and number of beds decreased by about 1 percent.⁷ The Commission found that most of the new LTCHs filing cost reports in 2013 were for-profit facilities. Consistent with historical trends, the Commission estimates that in 2013, more than 75 percent of LTCHs were for profit and 93 percent were located in urban areas.

Volume of services: Number of LTCH users decreased slightly

Beneficiaries' use of LTCH services suggests that access is adequate. Growth in the number of LTCH cases was high in the first years of the LTCH PPS, but it declined from 2005 to 2007 (Table 11-2). Much of this decrease

**TABLE
11-2****The number of Medicare LTCH cases and users decreased between 2012 and 2013**

							Average annual change			
	2004	2005	2007	2011	2012	2013	2004–2005	2005–2007	2007–2012	2012–2013
Cases	121,955	134,003	129,202	139,715	140,463	137,827	9.9%	–1.8%	1.7%	–1.9%
Cases per 10,000										
FFS beneficiaries	33.4	36.4	36.3	38.2	37.7	36.8	9.0	–0.1	0.7	–2.2
Spending (in billions)	\$3.7	\$4.5	\$4.5	\$5.4	\$5.5	\$5.5	21.6	0.0	4.3	–0.4
Spending per FFS beneficiary	\$101.3	\$122.2	\$126.5	\$147.9	\$148.8	\$147.6	20.7	1.7	3.3	–0.8
Payment per case	\$30,059	\$33,658	\$34,769	\$38,664	\$39,493	\$40,070	12.0	1.6	2.6	1.5
Average length of stay (in days)	28.5	28.2	26.9	26.3	26.2	26.5	–1.1	–2.3	–0.5	1.0
Users	108,814	119,282	114,299	122,838	123,652	121,532	9.6	–2.1	1.6	–1.7

Note: LTCH (long-term care hospital), FFS (fee-for-service).

Source: MedPAC analysis of Medicare Provider Analysis and Review data from CMS and the annual report of the Boards of Trustees of the Medicare trust funds.

Recent legislation

The Pathway for SGR Reform Act of 2013 included several provisions related to long-term care hospitals (LTCHs), including changes to payment rates for some cases, changes to the 25-percent rule, and a moratorium on new LTCHs.

“Site-neutral” payments

The Pathway for SGR Reform Act of 2013 established “site-neutral” payments for specified cases in LTCHs, beginning in fiscal year 2016. Under the law, the LTCH payment rate will apply only to LTCH discharges that had an acute care hospital (ACH) stay immediately preceding LTCH admission and for which:

- the ACH stay included at least 3 days in an intensive care unit or
- the discharge is assigned to the Medicare severity long-term care diagnosis related group (MS–LTC–DRG) based on the receipt of mechanical ventilation services for at least 96 hours.

All other LTCH discharges—including any discharges assigned to psychiatric or rehabilitation MS–LTC–DRGs, regardless of intensive care unit use—will be paid an amount based on Medicare’s ACH payment rates under the inpatient prospective payment system or 100 percent of the costs of the case, whichever is lower. These site-neutral payments will be phased in over a two-year period. Beginning with cost reporting periods starting in fiscal years 2016 and 2017, cases that do not meet the specified criteria will receive a blended rate of one-half the standard LTCH payment and one-half the site-neutral payment. These cases receive 100 percent of the site-neutral payment rate beginning with cost reporting periods starting on or after October 1, 2017. Given LTCH’s varying cost reporting periods, the Commission expects fiscal year 2019 to be the first full year in which this policy is completely phased in.

New criteria to receive the LTCH payment rate

Currently, to qualify as an LTCH for Medicare payment, a facility must meet Medicare’s hospital conditions of participation and its Medicare patients must have an average length of stay greater than 25 days. Under the Pathway for SGR Reform Act of 2013, beginning in fiscal year 2016, the LTCH average length of stay will

be calculated only for Medicare fee-for-service cases that are not paid the site-neutral rate. In addition, for cost reporting periods starting on or after October 1, 2019, to continue to receive the LTCH payment rate for eligible cases, an LTCH must have no more than 50 percent of its cases paid at the site-neutral rate.

The “25-percent rule”

The Pathway for SGR Reform Act of 2013 continues to delay the full phase-in of the so-called 25-percent rule for most LTCH hospitals-within-hospitals (HWHs) and LTCH satellites until October 1, 2016. In fiscal year 2005, CMS established the 25-percent rule in an attempt to prevent LTCHs from functioning as units of ACHs; decisions about admission, treatment, and discharge in both ACHs and LTCHs were to be made for clinical rather than financial reasons. The 25-percent rule uses payment adjustments to create disincentives for LTCHs to admit a large share of their patients from a single ACH.

The 25-percent rule initially applied only to LTCH HWHs and LTCH satellites. In July 2007, CMS extended the 25-percent rule to apply also to freestanding LTCHs. The Congress has delayed full implementation of the 25-percent rule so that most HWHs and satellites will be paid standard LTCH rates for eligible patients admitted from their host hospitals as long as the percentage of Medicare admissions from the host hospital does not exceed 50 percent (instead of the more restrictive 25 percent threshold). In addition, the Secretary is prohibited from applying the 25-percent rule to freestanding LTCHs before cost reporting periods that begin on or after July 1, 2016. The law requires the Secretary to submit a report to the Congress on the necessity of a 25-percent rule by October 1, 2015.

Moratorium on new LTCHs

The Protecting Access to Medicare Act of 2014 amended the Pathway for SGR Reform Act of 2013 by imposing a moratorium on new facilities and new beds in existing facilities beginning April 1, 2014. The moratorium allows certain exceptions for new LTCHs but not for increases in the number of certified beds in existing LTCHs or satellite facilities. The moratorium expires on September 30, 2017.⁸ ■

Commission recommendations for long-term care hospitals

The Commission has maintained that long-term care hospitals (LTCHs) should serve only the most medically complex patients—the chronically critically ill (CCI)—and has determined that the best available proxy for intensive resource needs in LTCH patients is intensive care unit (ICU) length of stay during an immediately preceding acute care hospital (ACH) stay. The Commission has also long held that payments to providers should be properly aligned with patients’ resource needs. Further, subject to risk differentials, payment for the same services should be comparable regardless of where the services are provided. In March 2014, the Commission recommended that the LTCH payment system be reformed to better align payments for both CCI and non-CCI cases across LTCH and ACH settings.

The research supporting this recommendation consistently describes CCI patients as having long ACH stays with heavy use of intensive care services (Carson et al. 2008, Donahoe 2012, Macintyre 2012, Nelson et al. 2010, Wiencek and Winkelman 2010, Zilberberg et al. 2012, Zilberberg et al. 2008). Further, in site visits and technical expert panel discussions conducted by Kennell and Associates Inc. and RTI under contract with CMS, LTCH representatives and ACH critical care physicians agreed that medically stable post-ICU patients are appropriate candidates for LTCH care (Centers for Medicare & Medicaid Services 2013, Dalton et al. 2012). In CMS’s Post-Acute Care Payment Reform Demonstration, length of stay in the ICU was significantly associated with post-acute care case complexity, and long ICU stays were a distinguishing characteristic of LTCH patients (Gage et al. 2011).

The Commission maintains that CCI cases are a small share of overall Medicare ACH cases and that the ICU length-of-stay threshold identifying CCI cases should be set accordingly. The Commission therefore recommended that the Congress limit standard LTCH payments to cases that spent eight or more days in an ICU during an immediately preceding ACH stay. The Commission’s analysis of inpatient prospective payment system (IPPS) claims data found that cases with eight or more days in an ICU accounted for

about 6 percent of all Medicare discharges and had a geometric mean cost per discharge that was four times that of other IPPS cases. Further, these cases were concentrated in a small number of Medicare severity–diagnosis related groups that correspond with the “ideal” LTCH patients described by LTCH representatives and critical care clinicians (Dalton et al. 2012). Previous studies have found such severely ill patients more likely to benefit from LTCH care (Kennell and Associates Inc. 2010, Medicare Payment Advisory Commission 2004).

Setting the ICU length of stay threshold for CCI cases at eight days captures a large share of LTCH cases requiring prolonged mechanical ventilation—a service specialty of many LTCHs. However, the Commission is concerned that LTCH care may be appropriate for some patients requiring mechanical ventilation, even if they did not spend eight or more days in an ICU during an immediately preceding ACH stay. The Commission’s analysis of 2012 LTCH claims found that about 22,000 cases (15.8 percent of all LTCH discharges) received prolonged mechanical ventilation services during the LTCH stay. Of these cases, 69.7 percent had an immediately preceding ACH stay that included eight or more days in an ICU, while 15.6 percent had an ACH stay with fewer than eight days in an ICU. (An additional 14.7 percent did not have an ACH stay within three days of admission to the LTCH.)

For LTCH cases that did not spend eight or more days in an ICU during an immediately preceding ACH stay, the Commission recommended that the Secretary of Health and Human Services set the payment rates equal to those of ACHs. The Commission recommended that savings from this policy be used to create additional inpatient outlier payments for CCI cases in IPPS hospitals.

The Commission’s analysis of IPPS claims for patients who were discharged alive from ACHs in 2012 found that about 103,000 cases received prolonged mechanical ventilation services during their ACH stay. Of these cases, 79 percent would have met the CCI criterion because they spent eight or more days

(continued next page)

Commission recommendations for long-term care hospitals (cont.)

in an ACH ICU. The exception to the 8-day ICU threshold for cases that received prolonged mechanical ventilation in the ACH would thus have increased the potential pool of CCI-eligible cases in LTCHs in 2012 by 21,000 nationwide.

The Pathway for SGR Reform Act of 2013 mandated changes to the LTCH PPS, including limiting standard LTCH payments to cases that spent at least three days in an ICU during an immediately preceding ACH stay or to discharges that received an LTCH principal diagnosis indicating prolonged mechanical ventilation. Our analysis of IPPS claims data from 2012 found that

22.8 percent of IPPS discharges spent three or more days in an ICU.

The Commission is concerned that a threshold of fewer than eight days is too low to distinguish the truly CCI patients and thus will allow Medicare to continue to pay too much for many cases that could be cared for appropriately in other settings at a lower cost to the program. The Commission is also concerned that the savings from this policy was not redistributed to ACHs to treat CCI cases, thus perpetuating the wide payment differential for similar CCI cases across hospital settings. ■

is consistent with the decline in beneficiaries' enrollment in FFS Medicare because of their increased enrollment in Medicare Advantage plans. CMS regulations that reduced payments for LTCH services also likely slowed growth in LTCH admissions during that period and beyond. From 2007 to 2012, the number of LTCH cases increased by an annual average rate of 1.7 percent. However, between 2012 and 2013, the number of LTCH cases decreased by 1.9 percent. On a per capita basis (per 10,000 FFS beneficiaries), the decline was 2.2 percent in part because the number of FFS beneficiaries grew at a somewhat faster pace between 2012 and 2013. This decrease in per capita admissions is consistent with the decreases observed in other inpatient settings.

Compared with all Medicare beneficiaries, those admitted to LTCHs are disproportionately disabled (under age 65), over age 85, or diagnosed with end-stage renal disease. They are also more likely to be African American. The higher rate of LTCH use by African American beneficiaries may be due to the concentration of LTCHs in areas of the country with larger African American populations (Dalton et al. 2012, Kahn et al. 2010). Another contributing factor may be a greater incidence of critical illness in this population (Mayr et al. 2010). At the same time, African American beneficiaries may be more likely to opt for LTCH care since they are less likely to choose withdrawal from mechanical ventilation in the ICU, have do-not-resuscitate orders, or elect hospice care (Barnato et al. 2009, Borum et al. 2000, Diringer et al. 2001).

LTCH discharges are concentrated in a relatively small number of diagnosis groups. In fiscal year 2013, the top 25 LTCH diagnoses made up about 64 percent of all LTCH discharges (Table 11-3, p. 272). The most frequently occurring diagnosis was MS-LTC-DRG 207, respiratory system diagnosis with ventilator support for 96 or more hours. Nine of the top 25 diagnoses, representing 36 percent of LTCH cases, were respiratory conditions or involved prolonged mechanical ventilation.

Quality of care: Meaningful measures are not available, but trends for gross indicators are stable

Unlike most of the other types of health care facilities covered by Medicare, LTCHs only recently began reporting to CMS on a limited set of quality measures (see text box discussing quality measures, p. 273); those data are not yet available for analysis. Therefore, the Commission assesses aggregate trends in the quality of LTCH care by examining in-facility mortality rates, mortality within 30 days of discharge, and readmissions from LTCHs to ACHs. We do not risk adjust these outcome measures like we do for other provider types because the available claims data do not provide the level of clinical detail needed to adequately adjust for the comparatively small differences in patient severity and clinical complexity across LTCH patients. LTCH cases are highly concentrated in a few MS-LTC-DRGs, and the vast majority of LTCH patients have multiple diagnoses and comorbidities.

**TABLE
11-3****The top 25 MS-LTC-DRGs made up two-thirds of LTCH discharges in 2013**

MS-LTC-DRG	Description	Discharges	Percentage
207	Respiratory system diagnosis with ventilator support 96+ hours	16,221	11.8%
189	Pulmonary edema and respiratory failure	15,179	11.0
871	Septicemia without ventilator support 96+ hours with MCC	8,458	6.1
177	Respiratory infections and inflammations with MCC	4,324	3.1
592	Skin ulcers with MCC	3,650	2.6
208	Respiratory system diagnosis with ventilator support < 96 hours	3,135	2.3
949	Aftercare with CC/MCC	3,003	2.2
539	Osteomyelitis with MCC	2,877	2.1
190	Chronic obstructive pulmonary disease with MCC	2,439	1.8
682	Renal failure with MCC	2,292	1.7
919	Complications of treatment with MCC	2,235	1.6
559	Aftercare, musculoskeletal system and connective tissue with MCC	2,123	1.5
314	Other circulatory system diagnoses with MCC	2,038	1.5
862	Postoperative and post-traumatic infections with MCC	2,026	1.5
193	Simple pneumonia and pleurisy with MCC	1,979	1.4
4	Tracheostomy with ventilator support 96+ hours or primary diagnosis except face, mouth, and neck without major OR	1,925	1.4
166	Other respiratory system OR procedures with MCC	1,917	1.4
870	Septicemia with ventilator support 96+ hours	1,817	1.3
570	Skin debridement with MCC	1,711	1.2
291	Heart failure and shock with MCC	1,664	1.2
853	Infectious and parasitic diseases with OR procedure with MCC	1,556	1.1
981	Extensive OR procedure unrelated to principal diagnosis with MCC	1,541	1.1
638	Diabetes with CC	1,447	1.0
560	Aftercare, musculoskeletal system and connective tissue with CC	1,414	1.0
602	Cellulitis with MCC	1,398	1.0
Top 25 MS-LTC-DRGs		88,369	64.1
Total		137,846	100.0

Note: MS-LTC-DRG (Medicare severity long-term care diagnosis related group), LTCH (long-term care hospital), CC (complication or comorbidity), MCC (major complication or comorbidity), OR (operating room). MS-LTC-DRGs are the case-mix system for LTCH facilities. The sum of column components may not equal the stated total due to rounding.

Source: MedPAC analysis of Medicare Provider Analysis and Review data from CMS.

For this report, we analyzed readmission and mortality rates for the top LTCH diagnoses from 2008 to 2013. Although rates of readmission and death can vary from year to year, over the 5-year period we found stable or declining rates of readmissions to ACHs and stable or declining mortality rates for these diagnoses, both in facility and 30 days postdischarge.

In 2013, 9 percent of LTCH cases were readmitted to an ACH, 13 percent died in the LTCH, and another 12 percent died within 30 days of discharge from the LTCH. Mortality rates varied markedly by diagnosis group.

Among patients with a principal diagnosis of septicemia with prolonged ventilator support, 37 percent died in the LTCH and 14 percent died within 30 days of discharge. By comparison, among patients with a principal diagnosis of cellulitis without major complications or comorbidities, only 1 percent died in the LTCH and an additional 3 percent died within 30 days of discharge. Among the highest volume MS-LTC-DRGs in 2013, patients with a diagnosis of complications of treatment with major complication or comorbidity (MS-LTC-DRG 919) had the highest readmission rate (17 percent).⁹

Quality measures for long-term care hospitals

The Patient Protection and Affordable Care Act of 2010 (PPACA) required CMS to establish a quality reporting program for long-term care hospitals (LTCHs) by fiscal year 2014 and further stipulated that LTCHs not participating in the program would have their annual payment update reduced by 2 percentage points starting in 2014. Beginning October 1, 2013, LTCHs receive a full payment update only if they successfully report on three quality measures—catheter-associated urinary tract infections (CAUTIs), central line-associated bloodstream infections (CLABSIs), and new or worsened pressure ulcers. Data on incidences of CAUTIs and CLABSIs are collected through the National Healthcare Safety Network (NHSN), an Internet-based surveillance system maintained by the Centers for Disease Control and Prevention (CDC). The data elements needed to calculate the pressure ulcer measure are collected using a data collection instrument called the LTCH Continuity Assessment Record and Evaluation (CARE) Data Set. These data are not yet available for analysis.

In 2014, CMS added two measures to the LTCH quality reporting program: the share of LTCH patients assessed for and appropriately given influenza vaccine and influenza vaccination coverage among facility health care personnel. Using the LTCH CARE Data Set, facilities collect data on the share of patients assessed for and appropriately given influenza vaccine, while the

CDC's NHSN collects data on influenza vaccination coverage among LTCH health care personnel. Payment updates for fiscal year 2016 and after will be affected by LTCHs' reporting on these two measures.

In 2015, LTCHs will be required to begin reporting facility-acquired cases of methicillin-resistant *Staphylococcus aureus* and *Clostridium difficile* through the CDC NHSN. Reductions of LTCH payment updates for reporting on these two measures will begin in fiscal year 2017. Also beginning in 2017, CMS plans to start using claims data to calculate LTCHs' rates of all-cause unplanned readmissions to acute care hospitals. Provider feedback on readmission rates will begin in January 2016, before public reporting.

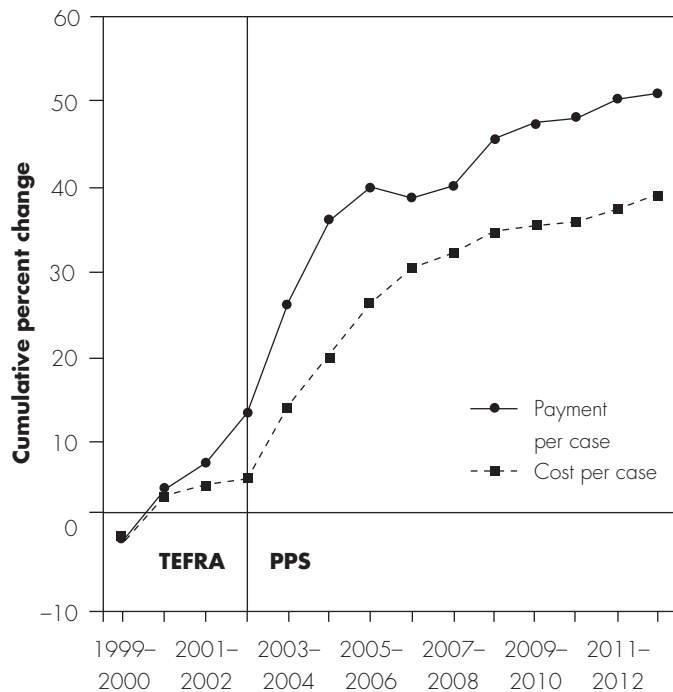
CMS intends to add 4 more measures to the program beginning in fiscal year 2018, which will bring the total number of measures to 12. In January 2016, LTCHs must begin reporting on ventilator-associated events (such as pneumonia, sepsis, and pulmonary embolism) through the CDC NHSN. Starting in April 2016, CMS will begin collecting data on the following three measures using the LTCH CARE Data Set: share of patients experiencing one or more falls resulting in major injury, change in mobility among LTCH patients who require ventilator support, and share of LTCH patients with an admission and discharge assessment and care plan that address patient function. ■

Providers' access to capital: Uncertainty about possible policy changes slows investment

Access to capital allows LTCHs to maintain, modernize, and expand their facilities. If LTCHs were unable to access capital, it might in part reflect problems with the adequacy of Medicare payments since Medicare accounts for about half of LTCH total revenues. However, for the past few years, the availability of capital said more about uncertainty regarding changes to regulations and legislation governing LTCHs than it did about current Medicare payment rates. The criteria to receive the higher LTCH payment rate specified in the Pathway for SGR Reform Act of 2013,

beginning with cost reporting periods starting October 1, 2015, provide more regulatory certainty for the industry compared with recent years. However, payment reductions implemented by CMS and congressional moratoriums on new LTCH beds and facilities from December 2007 through December 2012 and from April 2014 through September 2017 continue to limit future opportunities for growth and reduce the industry's need for capital.

LTCHs and LTCH companies have been positioning themselves for the changing payment environment in which CCI cases will be eligible for the LTCH payment rate and non-CCI cases will be paid a different, lower rate. For example, in this primarily for-profit industry, Kindred

**FIGURE
11-2****LTCHs' per case costs increased at a rate faster than payments in 2013**

Note: LTCH (long-term care hospital), TEFRA (Tax Equity and Fiscal Responsibility Act of 1982), PPS (prospective payment system). Percent changes are calculated based on consistent two-year cohorts of LTCHs.

Source: MedPAC analysis of Medicare cost report data from CMS.

Healthcare, which owns about 20 percent of all LTCHs, has continued to pursue an “integrated care market” strategy. The company operates skilled nursing facilities, inpatient rehabilitation facilities, home health agencies, outpatient rehabilitation providers, and LTCHs within a single market to position itself as an integrated provider of post-acute care (Kindred Healthcare 2013).¹⁰ Kindred hopes this approach will make the company a natural partner for ACHs and accountable care organizations (Barclays 2013). This strategy is also intended to improve the chain’s ability to control its mix of patients and costs and limit the impact of payment policy changes in any one post-acute care sector. As part of this strategy, in the past year the company reached an agreement to acquire Gentiva Health Services, a large provider of home health and hospice care, and Centerre Healthcare Corporation, an inpatient rehabilitation hospital company (Cain Brothers 2014, Kindred Healthcare 2014).

Medicare’s payments and providers’ costs: Cost growth exceeded payment growth for the first time since 2008

Since 2007, LTCHs have held cost growth below the rate of increase in the market basket index, a measure of inflation in the prices of goods and services LTCHs buy to provide care. Between 2012 and 2013, Medicare payments continued to increase, albeit more slowly than provider costs, resulting in an aggregate 2013 Medicare margin of 6.6 percent compared with 7.4 percent in 2012. Financial performance in 2013 varied across LTCHs, reflecting differences in cost control and response to payment incentives.

Reductions in the LTCH base rate slowed spending growth in 2012 and 2013

In the first three years of the LTCH PPS, Medicare spending for LTCH services grew rapidly, climbing an average of 29 percent per year. CMS’s subsequent changes to LTCH payment policies slowed growth in spending between 2005 and 2008 to less than 1 percent per year. MMSEA halted or rolled back the implementation of some CMS regulations designed to address issues of excessive payments to LTCHs. As a result, between 2008 and 2010, spending jumped more than 6 percent per year.¹¹ Although some of the MMSEA provisions continued through fiscal year 2013, spending growth between 2010 and 2013 slowed to 2.1 percent, in part because of mandated reductions in Medicare’s LTCH payment rate beginning in 2011.¹²

LTCHs continued to restrain cost growth, but less so than in recent years

LTCHs appear to be responsive to changes in payment, adjusting their costs per case when payments per case change. In the first years of the PPS, cost per case increased rapidly after a surge in payment per case (Figure 11-2). Between 2005 and 2007, growth in cost per case slowed considerably because regulatory changes to Medicare’s payment policies for LTCHs slowed growth in payment per case to an average of 1.3 percent per year.

Since 2007, LTCHs have held cost growth below the rate of market basket increases, likely because of ongoing concerns about possible changes to Medicare’s payment policies for LTCH services. The slowest growth in average cost per case occurred between 2009 and 2011, when the average cost per case increased less than 1 percent per year. Between 2011 and 2012, average cost per case increased by 1.5 percent. Between 2012 and

**TABLE
11-4****The aggregate average LTCH Medicare margin fell in 2013**

Type of LTCH	Share of discharges	2005	2006	2007	2008	2009	2010	2011	2012	2013
All	100%	11.9%	9.7%	4.7%	3.7%	5.7%	6.8%	6.9%	7.4%	6.6%
Urban	95	12.0	9.9	4.9	3.9	6.0	7.1	7.0	7.5	6.8
Rural	5	10.2	4.7	-0.4	-3.2	-3.0	-0.2	2.9	3.5	2.4
Nonprofit	14	9.1	6.5	1.4	-2.5	-0.7	-0.2	0.4	-0.6	-1.7
For profit	85	13.1	10.9	5.6	5.3	7.4	8.3	8.4	9.0	8.4
Government	1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Note: LTCH (long-term care hospital), N/A (not applicable). Margins for government-owned providers are not shown. They operate in a different context from other providers, so their margins are not necessarily comparable.

Source: MedPAC analysis of Medicare cost report data from CMS.

2013, the average cost per case further increased by 1.8 percent while the annual market basket update, including adjustments required by the Patient Protection and Affordable Care Act of 2010 (PPACA), equaled 2 percent. However, in 2013, CMS began implementing a downward adjustment in response to unexpected changes in coding practices that increased payments to LTCHs relative to CMS's estimates in the first year of the PPS, fiscal year 2003. These adjustments, intended to bring payments to LTCHs more in line with what would have been spent under the previous payment method, decrease the standard federal payment rate by about 3.75 percent over three years. In addition, the reductions from sequestration further reduced growth in payments.

Aggregate LTCH margins decreased

After the LTCH PPS was implemented in 2003, margins rose rapidly for all LTCH provider types, climbing to 11.9 percent in 2005 (Table 11-4). At that point, margins began to fall as growth in payments per case leveled off. From 2009 through 2012, LTCH margins began to climb again as providers consistently held cost growth below that of payment growth. In 2013, the aggregate LTCH margin fell from 7.4 percent to 6.6 percent, primarily because of the first year of a three-year phase-in of the downward adjustment for budget neutrality and the effect of sequestration beginning on April 1, 2013.

Nonprofit LTCHs may be less successful at controlling costs

Financial performance in 2013 varied across LTCHs. At 8.4 percent, margins were highest for for-profit LTCHs,

which account for more than three-quarters of all LTCHs and 85 percent of all LTCH cases. The aggregate margin for nonprofit LTCHs fell from 0.4 percent in 2011 to -0.6 percent in 2012 and then to -1.7 percent in 2013. This decline was due to cost growth that exceeded growth in payments. Between 2012 and 2013, per case costs for nonprofit LTCHs grew almost twice as fast as costs for for-profit LTCHs.

The comparatively poor financial performance of nonprofit LTCHs reflected a number of differences that can affect providers' ability to control their costs. First, though occupancy rates in 2013 for the two groups were fairly similar (65 percent for nonprofit LTCHs vs. 67 percent for for-profit LTCHs), nonprofit LTCHs were smaller and had fewer total cases than for-profit LTCHs (an average of 461 vs. 518). About 70 percent of nonprofit LTCHs had fewer than 50 beds compared with about half of for-profit LTCHs. Nonprofit LTCHs were therefore less likely than for-profit LTCHs to benefit from economies of scale. In addition, nonprofit LTCHs may be less able to control their input costs than for-profit LTCHs that are members of large chains. Those for-profit LTCH chains that own other types of post-acute care providers within a market area likely have a distinct advantage over other LTCHs because they are better able to control their mix of patients and lengths of stay. Nonprofit LTCHs had a larger share of cases with extraordinarily high costs (18.6 percent of nonprofit LTCHs cases qualified for high-cost outlier payments vs. 11.6 percent of for-profit LTCHs' cases), although it is not clear whether this difference stems from differences in efficiency, case complexity, or

**TABLE
11-5****LTCHs in the top quartile of Medicare margins in 2013 had lower costs**

Characteristics	High-margin quartile	Low-margin quartile
Mean margin	20.2%	-12.4%
Mean total discharges (all payers)	522	423
Medicare patient share	69%	64%
Average length of stay (in days)	26	27
Occupancy rate	74%	57%
Mean CMI	1.13	1.09
Mean per discharge:		
Standardized costs	\$28,352	\$39,119
Standard Medicare payment*	37,832	35,401
High-cost outlier payments	1,579	5,461
Share of:		
Cases that are SSOs	25%	29%
Medicare cases from		
primary-referring ACH	35	38
LTCHs that are for profit	93	64

Note: LTCH (long-term care hospital), CMI (case-mix index), SSO (short-stay outlier), ACH (acute care hospital). Includes only established LTCHs—those that filed valid cost reports in both 2012 and 2013. “High-margin quartile” LTCHs were in the top 25 percent of the distribution of Medicare margins. “Low-margin quartile” LTCHs were in the bottom 25 percent of the distribution of Medicare margins. Standardized costs have been adjusted for differences in case mix and area wages. The primary-referring ACH is the acute care hospital from which the LTCH receives a plurality of its Medicare patients. Government providers were excluded.
*Excludes outlier payments.

Source: MedPAC analysis of LTCH cost reports and Medicare Provider Analysis and Review data from CMS.

both. Nonprofit LTCHs also had more short-stay outliers than did for-profit LTCHs (31 percent vs. 26 percent, respectively) and thus received reduced payments for a larger share of their Medicare patients.

Differences between nonprofit and for-profit LTCHs in the mix of cases are difficult to evaluate. By some measures, nonprofit LTCHs appear to care for a somewhat sicker patient population. For example, a higher share of cases in nonprofit LTCHs qualified for high-cost outlier payments. Similarly, nonprofit LTCHs had a higher share of cases that were high-cost outliers during their immediately

preceding ACH stay (16.6 percent compared with 13.3 percent of for-profit LTCHs’ cases). Another indicator suggesting a sicker patient population is length of stay: The average Medicare-covered stay was two days longer in nonprofit LTCHs than in for-profit ones (28 days vs. 26 days). However, longer stays also could result from inefficient care. Other indicators of patient mix suggest fewer differences between the two types of facilities. The average case mix in both nonprofit and for-profit LTCHs was similar. Nonprofit LTCHs also had a similar share of cases that had long ICU stays during an immediately preceding ACH stay (36 percent compared with 35 percent of for-profit LTCHs’ cases).

High-margin LTCHs had lower unit costs

In 2013, higher unit costs were the primary driver of differences in financial performance between LTCHs with the lowest and highest Medicare margins (those in the bottom and top 25th percentiles of Medicare margins) (Table 11-5).¹³ After accounting for differences in case mix and local market input price levels, low-margin LTCHs had standardized costs per discharge that were 38 percent higher than high-margin LTCHs (\$39,119 vs. \$28,352). Low-margin LTCHs likely benefited less from economies of scale. Compared with their high-margin counterparts, low-margin LTCHs had fewer cases overall (an average of 423 compared with 522 for high-margin LTCHs) and lower occupancy rates (57 percent vs. 74 percent). Notably, high-margin LTCHs had a higher average Medicare share of discharges than did low-margin LTCHs (69 percent vs. 64 percent), which suggests that Medicare patients are desirable.

Although the total Medicare payment per discharge was similar for low-margin and high-margin LTCHs, outlier payments made up a larger share of total payments to low-margin LTCHs. High-cost outlier payments per discharge for low-margin LTCHs averaged more than three times the amount paid to high-margin LTCHs (\$5,461 vs. \$1,579). When these outlier payments were removed from total payments, we found that the standard payment per discharge for low-margin LTCHs was 6 percent lower than that for high-margin LTCHs (\$35,401 vs. \$37,832). This difference was in part because the low-margin LTCHs had a lower average case mix (1.09 vs. 1.13 for high-margin LTCHs) and in part because they cared for a disproportionate share of short-stay outlier cases, which often are paid at reduced rates. Such cases made up 29 percent of low-margin LTCHs’ cases compared with 25 percent in high-margin LTCHs.

How should Medicare payments change in 2016?

To estimate 2015 payments, costs, and margins with 2013 data, the Commission considered policy changes effective in 2014 and 2015. Those that affect our estimate of the 2015 Medicare margin include:

- a market basket increase of 2.5 percent for 2014, offset by PPACA-mandated reductions totaling 0.8 percent, for a net update of 1.7 percent;
- a market basket increase of 2.9 percent for 2015, offset by PPACA-mandated reductions totaling 0.7 percent, for a net update of 2.2 percent; and
- budget-neutrality adjustments in 2013, 2014, and 2015 to account for changes in coding practices that resulted in higher than expected LTCH spending in the first year of the PPS. These adjustments, intended to bring spending more in line with what would have been spent under the previous payment method, will decrease payments by about 3.75 percent over three years.

We project that LTCHs' aggregate Medicare margin will be 4.6 percent in 2015. The Secretary has the discretion to update payments for LTCHs; there is no congressionally mandated update. We expect cost growth to be slightly higher than payment growth. The 4.6 percent margin reflects current policy including the effect of sequestration, which currently reduces Medicare program payments to LTCHs by about 2 percentage points. If sequestration were to be lifted, we would expect margins to be about 2 percentage points higher.

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 in 2016. This recommendation applies to payment for discharges that meet the criteria specified in the Pathway for SGR Reform Act of 2013 and the portion of the blended payment that reflects the LTCH payment rate for discharges that do not meet the specified criteria. If the Congress implements the Commission's recommendation for LTCH payment reform, this recommendation would apply to Medicare's payment rate for CCI cases in LTCHs.

Update recommendation

RECOMMENDATION 11

The Secretary should eliminate the update to the payment rates for long-term care hospitals for fiscal year 2016.

RATIONALE 11

The supply of facilities and beds decreased slightly during 2013. The number of LTCH cases decreased both in total and per capita. Notably, on a per FFS beneficiary basis, the decline in the number of LTCH cases was smaller than that seen in the ACH setting and similar to that seen in the skilled nursing facility setting. These trends suggest that access to care in LTCHs has been maintained because a majority of LTCH cases come directly from ACHs. The limited quality trends that we measure appear to be stable. The availability of capital to LTCHs reflects the implementation of a moratorium on new facilities and beds, rather than current payment rates. Medicare margins for 2013 were positive. These trends suggest that LTCHs are able to operate within current payment rates. Therefore, the 2016 LTCH base payment rate should be the same as the 2015 rate.

IMPLICATIONS 11

Spending

- Because CMS typically uses the market basket as a starting point for establishing updates to LTCH payments, this recommendation would decrease federal program spending by between \$50 million and \$250 million in one year and by less than \$1 billion over five years.

Beneficiary and provider

- This recommendation is not expected to affect Medicare beneficiaries' access to care or providers' ability to furnish care.

LTCHs will need to change their cost structures to maintain positive Medicare margins under the revised payment system

The Pathway for SGR Reform Act of 2013 will decrease payments for non-CCI cases to LTCHs beginning in fiscal year 2016 with a two-year phase-in period. Under current law, LTCHs with cost reporting periods beginning on or after October 1, 2015, will be paid the lesser of cost or

an IPPS-comparable rate for non-CCI cases. Without any change in behavior, the Commission would expect a reduction in payment for roughly 40 percent of current LTCH discharges. However, the Commission anticipates substantial changes in behavior that should significantly lower LTCHs' costs for non-CCI cases and therefore reduce the impact on LTCHs' profits. The LTCH industry has repeatedly demonstrated its responsiveness to payment policy changes, and the Commission expects the response to LTCH payment reform to be swift and dramatic.

As shown in the hypothetical example in Table 11-6, in the first year of the transition to the new policy, an LTCH could reduce the length of stay for a non-CCI case by five days and still maintain a positive margin under the IPPS-based payment rate. LTCHs could reduce lengths of stay in a number of ways. They could admit non-CCI cases later in their course of illness, after they have spent a few more days in the acute care hospital. In addition, they could discharge non-CCI cases earlier to lower levels of care. ■

**TABLE
11-6**

**Policy reforms will create incentives
for LTCHs to reduce lengths
of stay for non-CCI cases**

Hypothetical LTCH non-CCI case

	Current policy	First year of transition to new policy
Payment per case	\$40,000	\$30,360
Cost per day	\$1,500	\$1,500
Length of stay (in days)	25	20
Cost per case	\$37,500	\$30,000

Note: LTCH (long-term care hospital), CCI (chronically critically ill). Non-CCI cases are those that did not have an immediately preceding acute care hospital stay that included eight or more days in an intensive care or coronary care unit.

Endnotes

- 1 Over the past decade, both the number and the share of critically ill patients transferred from ACHs to LTCHs have grown markedly. Kahn and colleagues (2010) found that, although the overall number of Medicare admissions to ACH intensive care units fell 14 percent between 1997 and 2006, the number of Medicare patients discharged to LTCHs after ACH intensive care stays almost tripled during the period.
- 2 The Medicare, Medicaid, and SCHIP Extension Act of 2007 also requires LTCHs to have a patient review process that screens patients to ensure appropriateness of admission and continued stay, physician on-site availability on a daily basis, and interdisciplinary treatment teams of health care professionals.
- 3 More information on the prospective payment system for LTCHs is available at <http://www.medpac.gov/documents/payment-basics/long-term-care-hospitals-payment-system-14.pdf>.
- 4 Medicare pays LTCHs outlier payments for patients who are extraordinarily costly. High-cost outlier cases are identified by comparing their costs with a threshold that is the MS–LTC–DRG payment for the case plus a fixed loss amount (\$14,972 in 2015). Medicare pays 80 percent of the LTCH’s costs above the threshold. In fiscal year 2013, about 12.7 percent of LTCH cases received high-cost outlier payments. The prevalence of high-cost outlier cases differed by LTCH ownership. About 11.6 percent of cases in for-profit LTCHs were high-cost outliers compared with 18.6 percent of cases in nonprofit LTCHs. Historically, some case types have been far more likely to be high-cost outliers than others. For example, almost a quarter of cases assigned to MS–LTC–DRG 4 (tracheostomy with prolonged mechanical ventilation) typically receive high-cost outlier payments each year.
- 5 MMSEA and subsequent legislation allowed exceptions to the moratorium for (1) LTCHs that began their qualifying period (demonstrating an average Medicare length of stay greater than 25 days) on or before December 29, 2007; (2) entities that had a binding or written agreement with an unrelated party for the construction, renovation, lease, or demolition of an LTCH, with at least 10 percent of the estimated cost of the project already expended on or before December 29, 2007; (3) entities that had obtained a state certificate of need on or before December 29, 2007; (4) existing LTCHs that had obtained a certificate of need for an increase in beds, issued on or after April 1, 2005, and before December 29, 2007; and (5) LTCHs, located in a state with only one other LTCH, that sought to increase beds after the closure or decrease in the number of beds of the state’s other LTCH.
- 6 The Pathway for SGR Reform Act of 2013 as amended by the Protecting Access to Medicare Act of 2014 allows exceptions to the moratorium for (1) LTCHs that began their qualifying period (demonstrating an average Medicare length of stay greater than 25 days) on or before April 1, 2014; (2) entities that had a binding or written agreement with an unrelated party for the construction, renovation, lease, or demolition of an LTCH, with at least 10 percent of the estimated cost of the project already expended on or before April 1, 2014; and (3) entities that had obtained a state certificate of need on or before April 1, 2014.
- 7 Historically, the Commission has found that Medicare’s Provider of Services (POS) file includes a larger number of facilities than are found in the cost report file. The cost report file provides a more conservative estimate of total capacity because some LTCHs may not yet have filed a cost report for the applicable year when we completed our analysis, while others may be exempt from filing cost reports because of low Medicare volume. However, POS data may overstate the total number of LTCHs because facilities that close may not be immediately removed from the file.
- 8 The Pathway for SGR Reform Act extended the moratorium on the establishment of any new LTCHs or additional beds at existing LTCHs from January 1, 2015, through September 30, 2017. The act provided no exceptions. Subsequently, the Protecting Access to Medicare Act of 2014 changed the moratorium extension start date to April 1, 2014, and allowed exceptions on the establishment and classification of new LTCHs. This law still strictly prohibits increases in the number of Medicare-certified LTCH beds in existing facilities.
- 9 We observed a higher readmission rate (19.7 percent) for cases with respiratory diagnoses with mechanical ventilation lasting less than 96 hours (MS–LTC–DRG 208). However, a higher rate of readmission is expected for this group because it is defined in part by the length of time a service (mechanical ventilation) is received. Any patient with a respiratory principal diagnosis with use of mechanical ventilation who is readmitted to a short-term ACH within 4 days is assigned to MS–LTC–DRG 208, while a similar patient who stays in the LTCH for a longer period likely is assigned to MS–LTC–DRG 207 (respiratory diagnosis with mechanical ventilation lasting more than 96 hours). When we combined cases assigned to MS–LTC–DRGs 207 and 208 and recalculated the rate of readmission, we found that 12.6 percent of these cases were readmitted in 2013.
- 10 In 2013, over 75 percent of LTCHs were for profit; these for-profit facilities accounted for approximately 85 percent of LTCH cases.

- 11 Another factor was growth in the reported patient case-mix index (CMI), which measures the expected costliness of a facility's patients (Centers for Medicare & Medicaid Services 2010, Centers for Medicare & Medicaid Services 2009, Centers for Medicare & Medicaid Services 2008, Centers for Medicare & Medicaid Services 2007, Centers for Medicare & Medicaid Services 2006). Refinements to the LTCH case-mix classification system, implemented in October 2007, likely led to more complete documentation and coding of the diagnoses, procedures, services, comorbidities, and complications that are associated with payment, thus raising the average CMI, even though patients may have been no more resource intensive than they were previously (Centers for Medicare & Medicaid Services 2009, Medicare Payment Advisory Commission 2009, RAND Corporation 1990). Although some part of the increase in LTCHs' CMI between 2008 and 2009 was due to growth in the intensity and complexity of the patients admitted, CMS estimated that the case-mix increase attributable to documentation and coding improvements was 2.5 percent (Centers for Medicare & Medicaid Services 2010, Centers for Medicare & Medicaid Services 2009). Those improvements contributed to growth in payments to providers without corresponding increases in providers' costs. CMS reduced the update to the LTCH base payment rate in fiscal years 2010 and 2011 to partly offset payment increases due to documentation and coding improvements between 2007 and 2009.
- 12 The Patient Protection and Affordable Care Act of 2010 (PPACA) specified that the annual update to the LTCH standard payment rate in 2011 be reduced by half a percentage point. That requirement, combined with a CMS offset to the 2011 update to account for past improvements in documentation and coding, resulted in a negative update to the LTCH payment rate in 2011. PPACA also mandated reductions in the LTCH standard payment rate to be 1.1 percent in 2012, 0.8 percent in 2013, 0.8 percent in 2014, and 0.7 percent in 2015.
- 13 Many new LTCHs operate at a loss for a period after opening. For this analysis of high-margin and low-margin LTCHs, we examined only LTCHs that submitted valid cost reports in both 2012 and 2013. We excluded government-owned LTCHs.

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C H A P T E R

12

Hospice services

R E C O M M E N D A T I O N

12 The Congress should eliminate the update to the hospice payment rates for fiscal year 2016.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

.....
(Additionally, the Commission reiterates its March 2009 recommendations on hospice. See text box, pp. 292–293.)

Hospice services

Chapter summary

The Medicare hospice benefit covers palliative and support services for beneficiaries who are terminally ill and have a life expectancy of six months or less. Beneficiaries may choose to elect the Medicare hospice benefit; in so doing, they agree to forgo Medicare coverage for conventional treatment of their terminal condition. In 2013, more than 1.3 million Medicare beneficiaries (including 47 percent of decedents) received hospice services from over 3,900 providers, and Medicare hospice expenditures totaled about \$15.1 billion.

Assessment of payment adequacy

The indicators of payment adequacy for hospices, discussed below, are positive.

Beneficiaries' access to care—Hospice use among Medicare beneficiaries has grown substantially in recent years, suggesting greater awareness of and access to hospice services. In 2013, hospice use increased across almost all demographic and beneficiary groups examined. However, rates of hospice use remained lower for racial and ethnic minorities than for Whites.

- **Capacity and supply of providers**—The number of hospice providers increased by over 5 percent in 2013, due almost entirely to growth in the number of for-profit hospices. This increase continues a more than decade-long trend of substantial market entry by for-profit providers.

In this chapter

- Are Medicare payments adequate in 2015?
.....
- How should Medicare payments change in 2016?
.....

- ***Volume of services***—In 2013, the proportion of beneficiaries using hospice services at the end of life continued to grow, and average length of stay changed little. Of Medicare beneficiaries who died in 2013, 47.3 percent used hospice, up from 46.7 percent in 2012. Average length of stay among decedents, which increased from about 86 days in 2011 to 88 days in 2012, remained at about 88 days in 2013. The median length of stay for hospice decedents was 17 days in 2013 and has remained stable at approximately 17 or 18 days for more than a decade.

Quality of care—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 were required to report data for specified quality measures or face a 2 percentage point reduction in their annual update for the subsequent fiscal year. Beginning July 2014, CMS replaced the initial two quality measures with seven new quality measures. In 2015, CMS will implement a hospice experience-of-care survey for bereaved family members. Public reporting of quality information is unlikely before 2017, according to CMS.

Providers' access to capital—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 9.6 percent increase in 2013) suggests capital is readily available to for-profit 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.

Medicare payments and providers' costs—The aggregate 2012 Medicare margin, which is an indicator of the adequacy of Medicare payments relative to providers' costs, was 10.1 percent, up from 8.8 percent in 2011. The projected margin for 2015 is 6.6 percent, which includes the effect of the sequester.

Because the payment adequacy indicators for which we have data are positive, the Commission believes that hospices can continue to provide beneficiaries with appropriate access to care with no update to the base payment rate in 2016.

Need for payment reform

Medicare's hospice payment system is not well aligned with the costs of providing care throughout a hospice episode. As a result, long hospice stays are generally more profitable than short stays. In March 2009, the Commission recommended that the hospice payment system be reformed to better match service intensity

throughout a hospice episode of care (higher per diem payments at the beginning of the episode and at the end of the episode near the time of death and lower payments in the middle). The issues that led the Commission to make the payment reform recommendation persist, and we are reiterating the recommendation in this report. We are also reiterating the Commission's March 2009 recommendation for focused medical review of hospice providers with many long-stay patients. In our view, implementation of these recommendations would result in substantial improvements to the hospice payment system and greater accountability for the hospice benefit. ■

Background

Medicare began offering a hospice benefit in 1983, pursuant to the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). The benefit covers palliative and support services for terminally ill beneficiaries who have a life expectancy of six months or less if the terminal illness follows its normal course. A broad set of services is included, such as nursing care; physician services; counseling and social work services; hospice aide (also referred to as home health aide) and homemaker services; short-term hospice inpatient care (including respite care); drugs and biologics for symptom control; supplies; home medical equipment; physical, occupational, and speech therapy; bereavement services for the patient's family; and other services for palliation of the terminal condition. Most commonly, hospice care is provided in patients' homes, but hospice services are also provided in nursing facilities, assisted living facilities, hospice facilities, and hospitals. In 2013, more than 1.3 million Medicare beneficiaries received hospice services, and Medicare expenditures totaled about \$15.1 billion.

Beneficiaries may choose to elect the Medicare hospice benefit; in so doing, they agree to forgo Medicare coverage for conventional treatment of the terminal illness and related conditions. Medicare continues to cover items and services unrelated to the terminal illness. For each person admitted to a hospice program, a written plan of care must be established and maintained by an interdisciplinary group (which must include a hospice physician, registered nurse, social worker, and pastoral or other counselor) in consultation with the patient's attending physician, if any. The plan of care must identify the services to be provided (including management of discomfort and symptom relief) and describe the scope and frequency of services needed to meet the patient's and family's needs.

Beneficiaries elect hospice for defined benefit periods. The first hospice benefit period is 90 days. For a beneficiary to elect hospice initially, two physicians—a hospice physician and the beneficiary's attending physician—are generally required to certify that the beneficiary has a life expectancy of six months or less if the illness runs its normal course.¹ If the patient's terminal illness continues to engender the likelihood of death within 6 months, the hospice physician can recertify the patient for another 90 days and for an unlimited number of 60-day periods after that, as long as he or she remains eligible.² Beneficiaries can disenroll from hospice at any time and can reelect

hospice for a subsequent period as long as the beneficiary meets the eligibility criteria.

Between 2000 and 2012, Medicare spending for hospice care increased dramatically—more than 400 percent, from \$2.9 billion in 2000 to \$15.1 billion in 2012. That spending increase was driven by greater numbers of beneficiaries electing hospice and by growth in length of stay for patients with the longest stays. Occurring simultaneously since 2000 has been a substantial increase in the number of for-profit providers.³

Medicare spending for hospice services in 2013 was \$15.1 billion, about the same as the prior year. The flat spending between 2012 and 2013 partly reflects the effect of the sequester, which reduced Medicare payments to providers by 2 percent beginning April 2013. If the sequester had not been in effect in 2013, Medicare hospice spending would have been about 1.5 percent higher than 2012. Other factors influencing the 2013 spending level include little change in decedent's average length of stay and a slight shift in the mix of hospice patients served, with hospice decedents making up a greater share of hospice providers' caseload in 2013 than 2012.⁴

Medicare payment for hospice services

The Medicare program pays a daily rate to hospice providers. The hospice provider assumes all financial risk for costs and services associated with care for the patient's terminal illness and related conditions. The hospice provider receives payment for every day a patient is enrolled, regardless of whether the hospice staff visited the patient or otherwise provided a service each day. This payment design is intended to encompass not only the cost of visits but also other costs a hospice incurs for palliation and management of the terminal condition and related conditions, such as on-call services, care planning, drugs, medical equipment, supplies, patient transportation between sites of care that are specified in the plan of care, short-term hospice inpatient care, and other less frequently used services.

Payments are made according to a per diem rate for four categories of care: routine home care, continuous home care, inpatient respite care, and general inpatient care (Table 12-1, p. 290). A hospice is paid the routine home care rate (about \$159 per day in 2015) for each day the patient is enrolled in hospice, unless the hospice provides care under one of the other three categories. Overall, routine home care accounts for almost 98 percent of hospice care days. The payment rates for hospice are updated annually by the inpatient hospital market basket

**TABLE
12-1****Medicare hospice payment categories and rates**

Category	Description	Base payment rate, 2015	Percent of hospice days, 2013
Routine home care	Home care provided on a typical day	\$159.34 per day	97.6%
Continuous home care	Home care provided during periods of patient crisis	\$38.75 per hour	0.4
Inpatient respite care	Inpatient care for a short period to provide respite for primary caregiver	\$164.81 per day	0.3
General inpatient care	Inpatient care to treat symptoms that cannot be managed in another setting	\$708.77 per day	1.7

Note: Payment for continuous home care (CHC) is an hourly rate for care delivered during periods of crisis if care is provided in the home for 8 or more hours within a 24-hour period beginning at midnight. A nurse must deliver more than half of the hours of this care to qualify for CHC-level payment. The minimum daily payment rate at the CHC level is \$310 per day (8 hours at \$38.75 per hour); maximum daily payment at the CHC level is about \$930 per day (24 hours at \$38.75 per hour). The above rates apply to hospices that submit the required data on quality. For hospices that do not submit the required data on quality, the rates are reduced through a 2 percentage point reduction in the annual payment update.

Source: Centers for Medicare & Medicaid Services. 2014. *Update to Hospice Payment Rates, Hospice Cap, Hospice Wage Index, Quality Reporting Program, and the Hospice Pricer for FY 2015*. Manual System Pub 100-04 Medicare Claims Processing, Transmittal 3023, August 11.

index. Beginning fiscal year 2013, the market basket index has been reduced by a productivity adjustment, as required by the Patient Protection and Affordable Care Act of 2010 (PPACA). An additional reduction to the market basket update of 0.3 percentage point was required in years 2013–2015 and possibly will be required in years 2016–2019 if certain targets for health insurance coverage among the working-age population are met. Beginning in 2014, hospices that do not report data on quality receive a 2 percentage point reduction in their annual payment update. (To date, the vast majority of hospices have met this reporting requirement.) The payment methodology and the base rates for hospice care have not been recalibrated since initiation of the benefit in 1983.

The hospice daily payment rates are adjusted to account for geographic differences in wage rates. From 1983 to 1997, Medicare adjusted hospice payments with a 1983 wage index. In 1998, CMS began using the most current hospital wage index to adjust hospice payments and applied a budget-neutrality adjustment each year to make aggregate payments equivalent to what they would have been under the 1983 wage index. This budget-neutrality adjustment increased Medicare payments to hospices by about 4 percent. The budget-neutrality adjustment is being phased out over seven years, with a 0.4 percentage point reduction in 2010 and an additional reduction of 0.6 percentage point in each subsequent year through 2016.

Beneficiary cost sharing for hospice services is minimal. Prescription drugs and inpatient respite care are the only

services potentially subject to cost sharing. Hospices may charge coinsurance of 5 percent for each prescription provided outside the inpatient setting (not to exceed \$5) and for inpatient respite care (not to exceed the inpatient hospital deductible). (For a more complete description of the hospice payment system, see <http://www.medpac.gov/documents/payment-basics/hospice-services-payment-system-14.pdf?sfvrsn=0>.)

Commission's prior recommendations

The Commission's analyses of the hospice benefit in the June 2008 and March 2009 reports found that the structure of Medicare's hospice payment system makes longer stays in hospice more profitable for providers than shorter stays. Hospice visits tend to be more frequent at the beginning and end of a hospice episode and less frequent in the intervening period. The Medicare payment rate, which is constant over the course of the episode, does not take into account the different levels of effort that occur during different periods in an episode. This payment structure may be spurring some providers to pursue business models that maximize profit by enrolling patients more likely to have long stays (Medicare Payment Advisory Commission 2009, Medicare Payment Advisory Commission 2008). The mismatch between Medicare payments and hospice service intensity throughout an episode distorts the distribution of payments across providers, making hospices with longer stays more profitable than those with shorter stays. Our analysis also found that the benefit lacked adequate administrative and other controls to check

the incentives for long stays in hospice and that CMS lacked data vital for effective management of the benefit.

In March 2009, the Commission made recommendations to reform the hospice payment system, ensure greater accountability in use of the hospice benefit, and improve data collection and accuracy. The Commission recommended that the hospice payment system be changed from a flat per diem payment to one in which the payment is higher at the beginning and end of the episode (in the last days of life) and lower in the middle. PPACA gave CMS the authority to make budget-neutral revisions to the hospice payment as the Secretary of Health and Human Services determines appropriate, beginning in fiscal year 2014 or later. To date, CMS has conducted research on payment reform and included in the 2014 hospice proposed rule an update on several payment reform models it may consider adopting, including one approach similar to the Commission's recommendation (Centers for Medicare & Medicaid Services 2013). However, CMS has not made a proposal to revise the hospice payment system. Therefore, we are reiterating the Commission's March 2009 recommendation for payment reform in this report (see text box, pp. 292–293). In addition, our June 2013 report quantifies how the labor cost of hospice visits changes over the course of an episode in a u-shaped pattern and provides an illustrative example of a revised payment system that could be implemented now using existing data (Medicare Payment Advisory Commission 2013).

Currently, a substantial amount of Medicare hospice spending is devoted to long-stay patients, who are more profitable than other patients under the current payment system. In 2013, Medicare spent nearly \$9 billion, more than half of all hospice spending that year, on patients with stays exceeding 180 days (Table 12-2). Because the misalignment of the current payment system creates a number of problems (e.g., distorts the distribution of payments across providers, makes the payment system vulnerable to patient selection, and results in program integrity concerns), improvements to the payment system are needed as soon as possible (see text box pp. 292–293.).

In March 2009, the Commission also recommended several steps to increase accountability in the hospice benefit. The Commission recommended requirements for a physician narrative describing the clinical basis for the patient's prognosis in all certifications and recertifications, a face-to-face visit with a physician or nurse practitioner before recertifying patients beyond 180 days of hospice care, and focused medical review of hospice providers

**TABLE
12-2**

More than half of Medicare hospice spending in 2013 was for patients with stays exceeding 180 days

	Medicare hospice spending, 2013 (in billions)
All hospice users in 2013	\$15.1
Beneficiaries with LOS > 180 days	8.8
Days 1–180	2.9
Days 181–365	2.8
Days 366+	3.1
Beneficiaries with LOS ≤ 180 days	6.2

Note: LOS (length of stay). LOS reflects the beneficiary's lifetime LOS as of the end of 2013 (or at the time of discharge in 2013 if the beneficiary was not enrolled in hospice at the end of 2013). All spending presented in the chart occurred only in 2013. Break-out groups do not sum to total because they exclude about \$0.1 billion in payments to hospices for physician visits.

Source: MedPAC analysis of 100 percent hospice claims standard analytic file data and the common Medicare enrollment file from CMS.

with unusually high shares of patients with stays exceeding 180 days. PPACA included provisions similar to all three of these recommended measures. CMS has implemented the first two measures but has not implemented the focused medical review provision. The Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 modified the hospice-focused medical review provision to address concerns related to beneficiary liability for denied services and the formula for identifying providers for focused medical review. Because the focused medical review provision has yet to be implemented, we are reiterating the Commission's recommendation (see text box, pp. 292–293).⁵

Medicare hospice payment limits ("caps")

The Medicare hospice benefit was designed to give beneficiaries a choice in their end-of-life care, allowing them to forgo conventional treatment (often in inpatient settings) and die at home, with family, and according to their personal preferences. The inclusion of the Medicare hospice benefit in TEFRA was based in large part on the premise that the new benefit would be a less costly alternative to conventional end-of-life care (Government Accountability Office 2004, Hoyer 2007). Studies show

The Commission reiterates its March 2009 recommendations on hospice

Payment reform

In March 2009, the Commission recommended that the hospice payment system be reformed to better align payments with the cost of providing care throughout a hospice episode. Currently, Medicare makes a flat payment per day, even though patients generally receive more hospice visits at the beginning and end of an episode, with fewer visits in the middle of an episode. To address the mismatch between payments and hospice service intensity, the Commission recommended that Medicare move away from the flat per diem payment to one that is higher at the episode's beginning and end and lower in the intervening period.

The Congress gave CMS the authority to revise the hospice payment system in a budget-neutral manner as the Secretary determines appropriate, beginning in 2014 or later. To date, the Secretary has not used that authority. Therefore, we are reiterating the Commission's recommendation on payment reform. That recommendation urged payment reform by 2013. While that time frame has already passed, the indicators that led us to make this recommendation have not changed. Therefore, the need for payment reform continues and the recommendation stands.

For a number of reasons, improvements to the hospice payment system are needed as soon as possible. Currently, a substantial amount of Medicare hospice spending is devoted to long-stay patients, who are more profitable than other patients under the current payment system. In 2013, Medicare spent nearly \$9 billion, more than half of all hospice spending that year, on patients with stays exceeding 180 days. Reforming the payment system as the Commission has recommended also addresses concerns about payment rates for very short stays that, because of their high visit intensity, may currently be reimbursed at levels below their cost. Modifying the payment system would help make payments more equitable across providers, decreasing payments to providers who have disproportionately long stays and high margins and increasing payments to providers who have shorter stays and lower margins.

Also, the hospice payment system is vulnerable to patient selection. A hospice that wishes to do so can focus on patient populations likely to have long stays and high profitability (because length of stay varies by observable patient characteristics like diagnosis and location of care). Substantial profit opportunities within the current payment system may have spurred for-profit provider entry into the hospice field and led some

(continued next page)

that beneficiaries who elect hospice incur less Medicare spending in the last two months of life than comparable beneficiaries who do not, but also that Medicare spending for beneficiaries is higher for hospice enrollees in the earlier months before death than it is for nonenrollees. In essence, hospice's net reduction in Medicare spending decreases the longer the patient is enrolled, and beneficiaries with very long hospice stays may incur higher Medicare spending than those who do not elect hospice. (For a fuller discussion of the cost of hospice care relative to conventional care at the end of life, see the Commission's June 2008 report.)

To make cost savings more likely, the Congress included in the hospice benefit two limitations, or "caps," on payments to hospices. The first cap limits the number of days of inpatient care a hospice may provide to 20 percent of its total Medicare patient care days. This cap is rarely

exceeded; any inpatient days provided in excess of the cap are reimbursed at the routine home care payment rate.

The second, more visible cap limits the aggregate Medicare payments that an individual hospice can receive. It was implemented at the outset of the hospice benefit to ensure that Medicare payments did not exceed the cost of conventional care for patients at the end of life. Under the cap, if a hospice's total Medicare payments exceed its total number of Medicare beneficiaries served multiplied by the cap amount (\$26,725.79 in 2014), it must repay the excess to the program.^{6,7,8} This cap is not applied individually to the payments received for each beneficiary but, rather, to the total payments across all Medicare patients served by the hospice in the cap year. The number of hospices exceeding the payment cap historically has been low, but we have found that increases in the number of hospices and increases in very long stays have resulted in more hospices

The Commission reiterates its March 2009 recommendations on hospice (cont.)

providers to pursue revenue-generation strategies such as enrolling patients likely to have long stays who may not meet the hospice eligibility criteria.

Recommendation 6-1, March 2009 report

The Congress should direct the Secretary to change the Medicare payment system for hospice to:

- have relatively higher payments per day at the beginning of the episode and relatively lower payments per day as the length of the episode increases,
- include a relatively higher payment for the costs associated with patient death at the end of the episode, and
- implement the payment system changes in 2013, with a brief transitional period.

These payment system changes should be implemented in a budget-neutral manner in the first year.

Focused medical review

Measures consistent with another Commission recommendation for increased hospice accountability

(shown below) have been implemented, with the exception of focused medical review. Focused medical review of hospices with unusually high rates of long-stay patients would provide greater oversight of the benefit and target scrutiny toward those providers for whom it is most warranted. Therefore, we are reiterating the recommendation that included focused medical review.

Recommendation 6-2A, March 2009 report

The Congress should direct the Secretary to:

- require that a hospice physician or advanced practice nurse visit the patient to determine continued eligibility prior to the 180th-day recertification and each subsequent recertification and attest that such visits took place,
- require that certifications and recertifications include a brief narrative describing the clinical basis for the patient's prognosis, and
- require that all stays in excess of 180 days be medically reviewed for hospices for which stays exceeding 180 days make up 40 percent or more of their total cases. ■

exceeding the cap (with the number peaking in 2009 and beginning to increase again in 2012). With rapid growth in Medicare hospice spending in recent years, the hospice cap is the only significant fiscal constraint on the growth of program expenditures for hospice care (Hoyer 2007).

Are Medicare payments adequate in 2015?

To address whether payments in 2015 are adequate to cover the costs of the efficient delivery of care and how much providers' payments should change in the coming year (2016), we examine several indicators of payment adequacy. Specifically, we assess beneficiaries' access to care by examining the capacity and supply of hospice providers, changes over time in the volume of services

provided, quality of care, providers' access to capital, and the relationship between Medicare's payments and providers' costs. Overall, the Medicare payment adequacy indicators for hospice providers are positive. Unlike our assessments of most other providers, we could not use quality of care as a payment adequacy indicator because information on hospice quality is generally not available.

Beneficiaries' access to care: Use of hospice continues to increase

In 2013, hospice use among Medicare beneficiaries increased, continuing the trend of a growing proportion of beneficiaries using hospice services at the end of life. Of the Medicare beneficiaries who died in 2013, 47.3 percent used hospice, up from 46.7 percent in 2012 and 22.9 percent in 2000 (Table 12-3, p. 295). Hospice use varies by beneficiary characteristics (i.e., enrollment in traditional fee-for-service (FFS) Medicare or Medicare Advantage

(MA); beneficiaries who are and are not dually eligible for Medicare and Medicaid; urban or rural residence; and age, gender, and race), but it increased across almost all beneficiary groups examined in 2013.

Use of hospice is somewhat more prevalent among decedents in MA than in FFS. In 2013, about 46 percent of Medicare FFS decedents and 51 percent of MA decedents used hospice. MA plans do not provide hospice services. Once a beneficiary in an MA plan elects hospice care, the beneficiary receives hospice services through a hospice provider paid by Medicare FFS. In March 2014, the Commission urged that this policy be changed, recommending that hospice be included in the MA benefits package (Medicare Payment Advisory Commission 2014).

Hospice use varies by other beneficiary characteristics. In 2013, a smaller proportion of Medicare decedents who were dually eligible for Medicare and Medicaid used hospice compared with the rest of Medicare decedents (42 percent and 49 percent, respectively). Hospice use is most prevalent among older beneficiaries. In 2013, more than half (55 percent) of Medicare decedents age 85 or older used hospice. Female beneficiaries were also more likely than male beneficiaries to use hospice, which partly reflects the longer average life span for women and greater hospice use among older beneficiaries.

Hospice use also varies by racial and ethnic group (Table 12-3). As of 2013, Medicare hospice use was highest among White decedents, followed by Hispanic, African American, Native American, and Asian American decedents. Hospice use grew among all these groups between 2012 and 2013 and has grown substantially for all groups since 2000. Nevertheless, differences in hospice use across racial and ethnic groups persist but are not fully understood. Researchers examining this issue have cited a number of possible factors, such as cultural or religious beliefs, preferences for end-of-life care, socioeconomic factors, disparities in access to care or information about hospice, and mistrust of the medical system (Barnato et al. 2009, Cohen 2008, Crawley et al. 2000).

Hospice use is more prevalent among urban than rural beneficiaries, although use has grown in all types of areas (Table 12-3). In 2013, the share of decedents residing in urban counties who used hospice was about 49 percent; in micropolitan counties, about 44 percent; in rural counties adjacent to urban counties, about 43 percent; in rural nonadjacent counties, 38 percent; and in frontier counties, about 32 percent. Use rates for beneficiaries in all five of

these areas increased between 0.3 and 0.9 of a percentage point compared with the prior year.

One driver of increased hospice use over the past decade has been growing use by patients with noncancer diagnoses since there has been increased recognition that hospice can care for such patients. In 2013, 68 percent of Medicare decedents who used hospice had a noncancer diagnosis, similar to 2012, and up from 48 percent in 2000. Analysis by CMS has shown that use of nonspecific diagnoses—debility and adult failure to thrive—as a hospice primary diagnosis had grown substantially since 2002. In a hospice proposed rule issued in spring 2013, CMS expressed concern that nonspecific diagnoses do not convey enough information about a hospice patient's condition and announced its intention to no longer allow debility and adult failure to thrive to be reported on claims as the primary hospice diagnosis (effective October 1, 2014). If patients with these diagnoses have a life expectancy of six months or less, they still qualify for hospice, but the hospice must report a more specific primary diagnosis. With this announcement, the diagnosis mix of hospice patients changed: Fewer decedents were reported to have a primary diagnosis of debility and adult failure to thrive in 2013 (9 percent) than in 2012 (16 percent). As of 2013, the most common noncancer primary diagnoses among hospice decedents were heart and circulatory disorders (19 percent) and neurological conditions (18 percent), each increasing 2 percentage points from 2012 (possibly capturing some patients who would have previously been coded with debility or adult failure to thrive).

Capacity and supply of providers: Supply of hospices continues to grow, driven by growth in for-profit providers

In 2013, 3,925 hospices provided care to Medicare beneficiaries, a 5.3 percent increase from the prior year, continuing more than 10 years of growth in the number of hospices providing care to Medicare beneficiaries (Table 12-4, p. 296). For-profit hospices account almost entirely for the growth in the number of hospices. Between 2012 and 2013, the number of for-profit hospices increased by more than 9 percent, while the number of nonprofit hospices was relatively flat and the number of government hospices declined by about 4 percent. As of 2013, about 61 percent of hospices were for profit, 33 percent were nonprofit, and 5 percent were government.

Looking at type of hospice, freestanding hospices account for most of the growth in the number of providers (Table 12-4, p. 296). From 2012 to 2013, the number of

**TABLE
12-3****Use of hospice continues to increase****Percent of Medicare decedents who used hospice**

	2000	2010	2011	2012	2013	Average annual percentage point change 2000–2012	Percentage point change 2012–2013
All beneficiaries	22.9%	44.0%	45.2%	46.7%	47.3%	2.0	0.6
FFS beneficiaries	21.5	43.0	44.2	45.7	46.2	2.0	0.5
MA beneficiaries	30.9	47.8	48.9	50.4	50.6	1.6	0.2
Dual eligibles	17.5	39.2	40.3	41.6	42.1	2.0	0.5
Nondual eligibles	24.5	45.5	46.8	48.4	48.9	2.0	0.5
Age							
<65	17.0	27.2	27.8	29.2	29.2	1.0	0.0
65–74	25.4	38.6	39.3	40.6	40.7	1.3	0.1
75–84	24.2	45.1	46.3	47.8	48.2	2.0	0.4
85+	21.4	50.4	52.0	54.0	55.0	2.7	1.0
Race/ethnicity							
White	23.8	45.8	47.0	48.6	49.2	2.1	0.6
African American	17.0	34.1	35.4	36.8	37.3	1.7	0.5
Hispanic	21.1	37.0	38.3	39.4	40.2	1.5	0.8
Asian American	15.2	28.1	30.0	31.8	32.0	1.4	0.2
Native American	13.0	30.6	32.4	34.0	34.1	1.8	0.1
Sex							
Male	22.4	40.4	41.3	42.8	43.3	1.7	0.5
Female	23.3	47.2	48.6	50.2	50.9	2.2	0.7
Beneficiary location							
Urban	24.3	45.5	46.6	48.0	48.5	2.0	0.5
Micropolitan	18.5	39.8	41.4	43.4	44.3	2.1	0.9
Rural, adjacent to urban	17.6	38.7	40.2	42.2	42.9	2.1	0.7
Rural, nonadjacent to urban	15.8	34.5	35.9	37.7	38.0	1.8	0.3
Frontier	13.2	30.1	30.7	31.9	32.2	1.6	0.3

Note: FFS (fee-for-service), MA (Medicare Advantage). Beneficiary location reflects the beneficiary's county of residence grouped into four categories (urban; micropolitan; rural, adjacent to urban; and rural, nonadjacent to urban) based on an aggregation of the urban influence codes. The frontier category is defined as population density equal to or less than 6 people per square mile.

Source: MedPAC analysis of data from the denominator file and the Medicare Beneficiary Database from CMS.

freestanding providers increased by about 7.6 percent, while the number of hospital-based hospices declined 2.6 percent, and the number of home health–based hospices increased by 2.2 percent.⁹ The number of skilled nursing facility (SNF)–based hospices was small, and increased from 23 to 25. As of 2013, about 72 percent of hospices were freestanding, 14 percent were hospital based, 13 percent were home health based, and less than 1 percent were SNF based.

Overall, the supply of hospices increased substantially between 2000 and 2013 in both urban and rural areas, although the number of hospices located in rural areas has declined modestly since 2007 (Table 12-4, p. 296). Roughly proportionate with the share of Medicare beneficiaries residing in each area, 74 percent of hospices were located in urban areas and 26 percent were located in rural areas as of 2013. The number of hospices located in rural areas is not necessarily reflective of hospice access

**TABLE
12-4****Increase in total number of hospices driven by growth in for-profit providers**

Category	2000	2007	2011	2012	2013	Average annual percent change		Percent change 2012-2013
						2000-2007	2007-2012	
All hospices	2,255	3,250	3,585	3,727	3,925	5.4%	2.8%	5.3%
For profit	672	1,676	2,054	2,199	2,411	13.9	5.6	9.6
Nonprofit	1,324	1,337	1,314	1,318	1,314	0.1	-0.3	-0.3
Government	257	237	217	209	200	-1.2	-2.5	-4.3
Freestanding	1,069	2,103	2,491	2,643	2,844	10.1	4.7	7.6
Hospital based	785	683	587	568	553	-2.0	-3.6	-2.6
Home health based	378	443	486	492	503	2.3	2.1	2.2
SNF based	22	21	21	23	25	-0.7	1.8	8.7
Urban	1,424	2,190	2,536	2,670	2,824	6.3	4.0	5.8
Rural	788	1,012	986	983	978	3.6	-0.6	-0.5

Note: SNF (skilled nursing facility). Numbers may not sum to totals because of missing data on provider characteristics for a small number of providers.

Source: MedPAC analysis of Medicare cost reports, Provider of Services file, and the standard analytic file of hospice claims from CMS.

for rural beneficiaries, as demonstrated by the increase in the share of rural decedents using hospice over this period.¹⁰

Rapid growth in the number of hospices was concentrated in a few states in 2013, while most states experienced modest change in the number of providers. Two states—California and Texas—accounted for 60 percent of the increase in hospice providers. California gained 84 hospice providers and Texas gained 37 hospice providers,

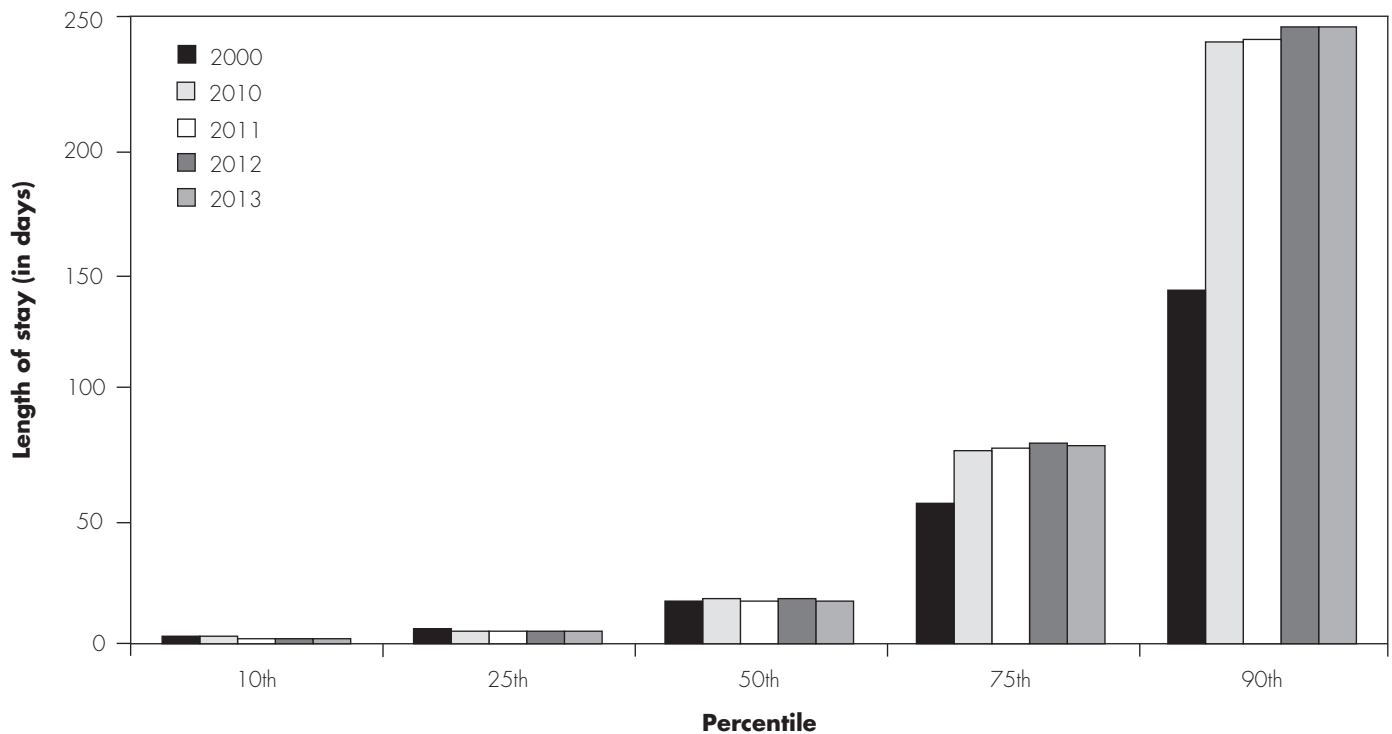
an increase from the prior year of 26 percent and 9 percent, respectively. Arizona and Ohio also saw sizable growth—15 percent and 9 percent, respectively—in provider supply (Arizona gained 12 hospices; Ohio, 11 hospices). As of 2013, California, Texas, and Arizona had an above-average supply of hospice providers (as measured by the number of hospices per 10,000 Medicare decedents per state compared with the national average), while Ohio remained below average.

**TABLE
12-5****Hospice expenditures and average length of stay were virtually unchanged in 2013**

Category	2000	2011	2012	2013	Average annual change, 2000-2011	Percent change, 2011-2012	Percent change, 2012-2013
Number of hospice users (in millions)	0.534	1.219	1.274	1.315	7.8%	4.5%	3.2%
Total spending (in billions)	\$2.9	\$13.8	\$15.1	\$15.1	15.2%	9.3%	-0.1%
Average length of stay among decedents (in days)	53.5	86.3	88.0	87.8	4.4%	2.0%	-0.2%
Median length of stay among decedents (in days)	17	17	18	17	0 days	1 day	-1 day

Note: Average length of stay is calculated for decedents who used hospice at the time of death or before death and reflects the total number of days the decedent was enrolled in the Medicare hospice benefit during his/her lifetime. The number of hospice users, total spending, and average length of stay displayed in the table are rounded; the percent change is calculated using unrounded data.

Source: MedPAC analysis of the denominator file, the Medicare Beneficiary Database, and the 100 percent hospice claims standard analytic file from CMS.

**FIGURE
12-1****Growth in length of stay among hospice patients with the longest stays has slowed**

Note: Length of stay is calculated for decedents who were using hospice at the time of death or before death and reflects the total number of days the decedent was enrolled in the Medicare hospice benefit during his/her lifetime.

Source: MedPAC analysis of the Medicare Beneficiary Database from CMS.

The number of hospice providers is not necessarily an indicator of beneficiary access to hospice because a hospice's service area may extend beyond the boundaries of the county where it is located. The supply of providers—as measured by the number of hospices per 10,000 Medicare decedents—varies substantially across states. As shown in our March 2010 report, there is no relationship between supply of hospices (as measured by number of hospices per 10,000 beneficiaries) and the rate of hospice use (as measured by share of decedents who use hospice before death) across states (Medicare Payment Advisory Commission 2010).

Volume of services: The number of hospice users grew and average length of stay among decedents was virtually unchanged in 2013

The number of Medicare beneficiaries receiving hospice services continued to increase. In 2013, more than 1.31 million beneficiaries used hospice services, up from about 1.27 million in 2012. (Table 12-5). Between 2012

and 2013, the number of hospice users grew 3.2 percent, outpacing growth in the Medicare decedent population (2.5 percent, not shown in table) during this period.

Hospice average length of stay among decedents was 87.8 days in 2013, about the same as the prior year (88 days) (Table 12-5). The flat average length of stay between 2012 and 2013 follows a long period of growth in average length of stay. Between 2000 and 2012, average length of stay grew from about 54 days to 88 days. The increase in average length of stay observed since 2000 in large part reflects an increase in very long hospice stays, while short stays remained virtually unchanged (Figure 12-1). Overall, between 2000 and 2013, hospice length of stay at the 90th percentile grew substantially, increasing from 141 days to 246 days. Growth in very long stays has slowed in recent years. Between 2008 and 2011, the 90th percentile of length of stay grew six days; between 2011 and 2012, it grew five additional days; and in 2013 it was unchanged. Median length, which has held steady at 17 or 18 days

Medicare Care Choices Model demonstration program

CMS has developed a demonstration that will test concurrent palliative and conventional care. Under the Medicare Care Choices Model (MCCM) demonstration, fee-for-service beneficiaries who are hospice eligible but not enrolled in hospice will be permitted to enroll in the demonstration and receive palliative and supportive care from a hospice provider while continuing to receive curative care from other providers. CMS has indicated that one goal of the demonstration is to test whether beneficiaries would be willing to elect supportive palliative care from hospice providers. Another goal is to evaluate the effect of the demonstration on the quality and cost of care and whether beneficiaries choose to enroll in the Medicare hospice benefit later.

Unlike the hospice benefit, under the MCCM, care will be directed by the non-hospice “curative” provider who referred the beneficiary to the demonstration, and the hospice provider will play a supportive role. Hospices providing services under the MCCM “are expected to engage in shared decision making, care coordination and case management of the patient, family, and his/her providers; ensure that the patient’s pain and symptoms are managed; offer appropriate levels of counseling; and address other care needs based on a comprehensive

assessment and plan of care” (Center for Medicare & Medicaid Innovation 2014). In-home nursing, aide services, and respite care are also offered under the MCCM. Hospices will be paid \$400 per month for each enrollee in the MCCM, and beneficiaries will not be liable for cost sharing related to MCCM services.

To be eligible for participation in the demonstration, a beneficiary must have had 2 inpatient hospitalizations in the last 12 months, have certain diagnoses (advanced cancers, chronic obstructive pulmonary disease, congestive heart failure, or HIV/AIDS), live at home (not an assisted living facility or nursing facility), be enrolled in fee-for-service Medicare, and meet the hospice eligibility criteria (a life expectancy of 6 months or less if the disease runs its normal course). The beneficiary must be referred to the demonstration by a provider with whom the beneficiary had at least 3 office visits in the last 12 months for the diagnosis that qualifies the beneficiary for the demonstration. The referring provider must certify that the beneficiary meets the demonstration eligibility criteria. Hospice providers that have exceeded the aggregate cap are not allowed to participate in the demonstration. The demonstration will involve at least 30 hospice providers and 30,000 beneficiaries over a span of 3 years. The start date and hospice providers selected for the demonstration have not yet been announced. ■

since 2000, was 17 days in 2013. In 2013, 25 percent of stays were five days or less, unchanged from the prior year.

The Commission has previously expressed concern about very short hospice stays. More than one-quarter of hospice decedents enroll in hospice only in the last week of life, a length of stay that is commonly thought to be of less benefit to patients than enrolling somewhat earlier. As discussed in our March 2009 report, a Commission-convened panel of hospice industry representatives indicated that very short stays in hospice stem largely from factors unrelated to the Medicare hospice payment system, such as some physicians’ reluctance to have conversations about hospice or a tendency to delay such discussions until death is imminent; difficulty some patients and families may have in accepting a terminal prognosis; and financial

incentives in the FFS system for increased volume of services (Medicare Payment Advisory Commission 2009).

Some point to the requirement that beneficiaries forgo conventional care to enroll in hospice as a factor that contributes to deferring hospice care, resulting in short hospice stays. CMS is in the process of launching a demonstration program to test concurrent palliative care and curative care. Under the demonstration (called the Medicare Care Choices Model), certain FFS beneficiaries who are hospice eligible but not enrolled in the Medicare hospice benefit will be permitted to enroll in the demonstration and receive palliative and supportive care from a hospice provider while continuing to receive curative care from other providers (see text box). With respect to MA, the Commission’s recommendation in March 2014 that hospice be included in the MA benefits

package would give plans greater incentives to develop and test new models aimed at improving end-of-life care and care for beneficiaries with advanced illnesses (e.g., concurrent care or other approaches for providing flexibility in the hospice benefit, palliative care, or shared decision making) (Medicare Payment Advisory Commission 2014).

In addition to concerns about short hospice stays, concerns also exist about the care that patients with advanced illnesses or multiple chronic conditions receive throughout the health care system. Care for these patients is oftentimes fragmented and uncoordinated and does not take into account the individual's overall needs. Also, many patients do not receive adequate information about their condition, prognosis, and treatment options to enable them to make decisions based on their goals and preferences. Some stakeholders have advocated for a variety of policy approaches aimed at improving care for patients with advanced illnesses, such as approaches to pay for or facilitate voluntary advanced care planning or shared decision making, improvements in medical training of health professionals, and advancements in quality measurement (Medicare Payment Advisory Commission 2014).

The Institute of Medicine (IOM) recently issued a report making recommendations on how to improve end-of-life care in the United States (Institute of Medicine 2014). They made a number of recommendations in the area of policies and payment systems, including:

- integrating financing of medical and social services;
- public reporting on quality measures, outcomes, and costs of care near the end of life throughout the health care system for Medicare and other federally funded health care programs;
- creating financial incentives for medical and social services that reduce use of emergency room and acute care services, coordination of care across providers and settings, and improved shared decision making and advanced care planning;
- requiring use of interoperable electronic health care records that contain specific information on advanced care planning; and
- encouraging states to adopt the Physician Orders for Life-Sustaining Treatment paradigm.

The IOM made several other recommendations, such as coverage by government insurers and other payers for comprehensive care for patients with advanced illnesses nearing the end of life; development and adoption of quality measures for clinician-patient conversations and advanced care planning; steps to improve palliative care knowledge and skills among medical professionals; and public education and engagement efforts to provide factual information about care options and to encourage advanced care planning and informed choices based on individual needs and preferences.

Hospice lengths of stay vary by observable patient characteristics, such as patient diagnosis and location, which makes it possible for providers to focus on more profitable patients (Table 12-6, p. 300). For example, Medicare decedents in 2013 with neurological conditions and debility or adult failure to thrive had substantially higher average lengths of stay (147 days and 116 days, respectively) than those with cancer (53 days) and heart or circulatory conditions (81 days). Length of stay is similar for patients with the shortest stays, irrespective of diagnosis, but differs by diagnosis for patients with longer stays. For example, patients with neurological conditions and cancer have similar lengths of stay at the 10th percentile and 25th percentile. However, compared with cancer patients, those with neurological conditions have stays that are about 2 weeks longer at the 50th percentile, about 3 months longer at the 75th percentile, and about 10 months longer at the 90th percentile.

Length of stay also varies by the setting where care is provided. In 2013, average length of stay was higher among Medicare decedents whose main care setting was an assisted living facility (ALF) (152 days) or a nursing facility (111 days) rather than home (89 days) (Table 12-6, p. 300). Length-of-stay differences across settings are most pronounced among patients with longer stays. For example, in 2013, the 75th percentile of length of stay varied by about 100 days across the three settings (86 days at home, 105 days at a nursing facility, and 186 days at an assisted living facility), and the 90th percentile varied by almost 200 days (237 days, 331 days, and 435 days across the three settings, respectively). Even among patients within the same diagnosis group, hospice patients in ALFs had markedly longer stays compared with other settings (data not shown), which warrants further monitoring and investigation in CMS's medical review efforts.

The differences in length of stay by patient characteristics are reflected in differences in length of stay by provider

**TABLE
12-6****Hospice length of stay among decedents by
beneficiary and hospice characteristics, 2013**

Characteristic	Average length of stay (in days)	Percentile of length of stay				
		10th	25th	50th	75th	90th
Beneficiary						
Diagnosis						
Cancer	53	3	6	18	52	129
Neurological conditions	147	3	8	31	167	443
Heart/circulatory	81	2	4	12	66	236
Debility or adult failure to thrive	116	3	8	32	135	336
COPD	113	2	5	22	116	335
Other	42	2	3	6	23	103
Main location of care						
Home	89	4	9	26	86	237
Nursing facility	111	3	6	21	105	331
Assisted living facility	152	5	12	51	186	435
Hospice						
Hospice ownership						
For profit	105	3	6	21	97	306
Nonprofit	68	2	5	14	57	183
Type of hospice						
Freestanding	91	2	5	17	79	257
Home health based	68	2	5	15	61	187
Hospital based	59	2	5	13	51	158

Note: COPD (chronic obstructive pulmonary disease). Length of stay is calculated for Medicare beneficiaries who died in 2013 and used hospice that year and reflects the total number of days the decedent was enrolled in the Medicare hospice benefit during his/her lifetime. "Main location of care" is defined as the location where the beneficiary spent the largest share of his/her days while enrolled in hospice. "Diagnosis" reflects primary diagnosis on the beneficiary's last hospice claim.

Source: MedPAC analysis of 100 percent hospice standard analytical file (claims) data, Medicare Beneficiary Database, Medicare hospice cost reports, and Provider of Services file data from CMS.

type (Table 12-6). In 2013, average length of stay was substantially higher at for-profit hospices than at nonprofit hospices (105 days compared with 68 days). The higher length of stay among for-profit hospices has two components: (1) for-profit hospices have more patients with diagnoses that tend to have longer stays, and (2) for-profit hospice beneficiaries have longer stays for all diagnoses than those of nonprofit hospices. These patterns reinforce the assertion that the payment system favors longer stays and that changes are needed to make it more neutral toward length of stay.

A recent Office of Inspector General (OIG) study of hospice care in ALFs raises similar concerns about the

incentives for hospices to focus on certain types of patients under the current payment system (Office of Inspector General 2015). The OIG study concluded that hospices have financial incentives to serve patients in ALFs because they tend to have diagnoses associated with longer stays (e.g., ill-defined conditions, mental disorders, or Alzheimer's disease) that require less complex care and that result in higher payments per patient for the provider. OIG also found that for-profit hospices receive a greater share of their revenue from ALF patients than do nonprofit hospices and that hospice length of stay for ALF residents was longer among for-profit hospices than nonprofits. OIG also identified 97 hospices in 2012 that relied on ALF

**TABLE
12-7****Hospices that exceeded Medicare's annual payment cap, selected years**

	2002	2009	2010	2011	2012
Percent of hospices exceeding the cap	2.6%	12.5%	10.1%	9.8%	11.0%
Average payments over the cap per hospice exceeding the cap (in thousands)	\$470	\$485	\$426	\$424	\$510
Payments over the cap as percent of overall Medicare hospice spending	0.6%	1.7%	1.1%	1.1%	1.4%
Total Medicare hospice spending (in billions)	\$4.4	\$12.0	\$13.0	\$13.8	\$15.0

Note: The cap year is defined as the period beginning November 1 and ending October 31 of the following year.

Source: MedPAC analysis of 100 percent hospice standard analytical file (claims) data, Medicare hospice cost reports, and Provider of Services file data from CMS. Data on total spending for each fiscal year from the CMS Office of the Actuary.

patients for more than half their revenues and noted that more than 90 percent of these hospices were for profit. OIG made a number of recommendations, including that CMS should reform the payment system to reduce incentives to target beneficiaries with certain diagnoses and those likely to have long stays and that CMS target certain hospices for review (e.g., those providers with a high share of payments from ALFs, patients with stays greater than 180 days, patients with certain diagnoses, and patients who rarely receive visits).¹¹

One pattern of unusual hospice utilization can be found among the 11 percent of hospices in 2012 that exceed the aggregate payment cap.¹² Above-cap hospices have substantially longer lengths of stay than other hospices. About 42 percent of patients receiving care from above-cap hospices in 2012 had stays exceeding 180 days compared with about 20 percent of patients treated by below-cap hospices. As discussed subsequently, above-cap hospices also have substantially higher rates of discharging patients alive than other hospices. These statistics may suggest that above-cap hospices are admitting patients who do not meet the hospice eligibility criteria, which merits further investigation by OIG and CMS.

Between 2011 and 2012, the share of hospices exceeding the cap grew from 9.8 percent to 11 percent, reversing the trend seen since 2009 of a declining share of hospices exceeding the cap (Table 12-7).¹³ Among hospices that exceeded the cap, the average amount over the cap was larger in 2012 than in 2011 (\$510,000 compared with \$424,000). While above-cap hospices are required to return payments that exceed Medicare's cap, the government's ability to obtain repayment from hospices that close is uncertain. At the extreme, at least one hospice

provider in 2012 reportedly closed and reopened as a new hospice to avoid repaying cap overpayments (Waldman 2012). In its 2015 hospice final rule, CMS established a policy that will help facilitate cap overpayment collections in the future. Beginning with cap year 2014, hospices are required to perform their own cap overpayment calculation within three to five months of the close of the cap year and pay Medicare back for the calculated overpayments at that time or their payments will be suspended (Centers for Medicare & Medicaid Services 2014). Before this rule, there was typically a 16- to 24-month lag between the close of the cap year and when hospices had to return any overpayments.¹⁴

Quality of care: Information on hospice quality is limited

We do not have sufficient data to assess the quality of hospice care provided to Medicare beneficiaries because publicly reported information on quality is generally unavailable. PPACA mandated that CMS publish quality measures by 2012. Beginning in fiscal year 2014, hospices that do not report data on quality receive a 2 percentage point reduction in their annual payment update. Public reporting of data on quality from these initiatives is not expected to be available until at least 2017, according to CMS.

For the first year of data reporting, CMS established two quality measures. The first measure tracked pain management, and the second was a process measure designed to help develop future quality measures.¹⁵ These two measures (with small changes) were continued for the second year of the reporting program and affect the payment update for fiscal year 2015. About 10 percent of hospices did not report the required data on quality

and face a 2 percentage point reduction in their update for fiscal year 2015. Nonreporters were generally small providers, and it is possible that some did not report data on quality because they are no longer operating.

Beginning July 2014, CMS replaced the two initial quality measures with seven new quality measures collected using a standardized instrument.¹⁶ The seven quality measures are all process measures (i.e., measures focus on pain screening, pain assessment, dyspnea screening, dyspnea treatment, documentation of treatment preferences, discussion of beliefs and values (if desired by patient), and provision of a bowel regimen for patients treated with an opioid). Hospices are required to report on these seven measures during the second half of calendar year 2014 to receive a full payment update in fiscal year 2016. For the future, CMS has expressed interest in developing outcome measures for symptom management, particularly pain, and patient-reported outcome measures (Centers for Medicare & Medicaid Services 2014).

Beginning in 2015, the hospice quality reporting program will require all hospice providers (except very small providers) to participate in a Consumer Assessment of Healthcare Providers and Systems[®] (CAHPS[®]) hospice survey. Hospices will be required to contract with a CMS-approved vendor to administer the survey. The survey will collect information from the patient's informal caregiver (typically a family member) after the patient's death. The survey collects information on aspects of hospice care that are thought to be important to patients and for which informal caregivers are positioned to provide information. In particular, the survey collects information on how the hospice performed in the following areas: communicating, providing timely care, treating patients with respect, providing emotional support, providing help for symptom management, providing information on medication side effects, and training family or other informal caregivers in the home setting. Participation in the CAHPS hospice survey will affect payment updates beginning in fiscal year 2017.

There may also be opportunities to use claims data to develop additional quality measures or program integrity measures. A technical panel of hospice clinicians, researchers, and quality experts we convened in 2011 suggested that some claims-based indicators of quality could be constructed—such as hospices providing few visits in the last days of life, providing no general inpatient or continuous home care to any patients, or

having unusually high live-discharge rates—as signals of potentially poor quality. In its 2015 hospice final rule, CMS pointed to patterns of care observed in the claims data in these and other areas that raise concerns about quality of care among some providers. Some of these claims-based measures might be useful in quality reporting programs, transparency initiatives, or value-based purchasing efforts, while others may help inform and target oversight and program integrity activities.¹⁷

In the 2015 hospice final rule, CMS discussed analyses by its contractor Abt Associates indicating that 14 percent of hospice decedents who received routine home care did not receive any skilled visits from hospice staff in the last two days of life in 2012 (Centers for Medicare & Medicaid Services 2014).¹⁸ The Abt analysis also found that the share of routine home care patients who did not receive a skilled visit in the last two days of life varied across providers. For example, nearly 5 percent of hospices furnished no skilled visits in the last two days of life for more than 50 percent of their routine home care patients (Centers for Medicare & Medicaid Services 2014).

The Commission is concerned by data on the lack of skilled visits in the last two days of life and the variation in these data across providers. The last days of life tend to be some of the most service-intensive days of a hospice stay. Variation in the provision of skilled visits in the last days of life across providers raises questions about whether some providers are meeting the needs of patients and families during this period. Information on a hospice's provision of visits near the end of life could be valuable to beneficiaries and families as they choose a hospice provider and should be considered for inclusion in CMS's quality reporting or transparency initiatives. We also note that CMS is required to pilot test value-based purchasing for hospice in 2016 and that a measure of hospice visits in the last days of life might be a good candidate for a value-based purchasing payment adjuster. In constructing this type of measure for any of these purposes (quality, transparency, and payment adjusting), several issues would need to be considered. These issues include the type of hospice visits included in the measure; the number of days over which visits are measured; which levels of hospice care are included; whether the measure would focus on the presence/absence of at least one visit or the average number of visits received; and whether data would be combined for all of a provider's patients or broken out separately for patients with

**TABLE
12-8****Some hospices did not provide certain levels of hospice care to any patients in 2013****Percent of hospices that did not provide the following level of care to any patient in 2013**

Category	No general inpatient care	No continuous home care	No inpatient respite care	No general inpatient care or continuous home care	No general inpatient care, continuous home care, or inpatient respite care
All hospices	28%	58%	25%	19%	12%
Hospices by total number of Medicare patients in 2013					
Less than 100	57	71	54	41	28
100–199	25	60	22	17	8
200–299	17	58	11	10	2
300–499	8	50	6	5	2
500 or more	2	39	2	1	0

Source: MedPAC analysis of Medicare claims data from CMS.

different lengths of stay, locations of care, or levels of care. The Commission intends to explore these issues further in future work.

CMS also expressed concern that some providers may not have the capacity to provide all four levels of hospice care, which is required by the Medicare hospice conditions of participation.¹⁹ CMS reported that a sizable share of hospice providers did not furnish general inpatient care (21 percent), continuous home care (57 percent), or inpatient respite care (26 percent) to any hospice patient discharged in 2012 (Centers for Medicare & Medicaid Services 2014). CMS noted that a hospice provider not furnishing a particular level of care to any patients during the year does not necessarily mean it does not have the capacity to provide this care, but these data do raise questions that merit further exploration. Examining this issue using 2013 data, we find results generally similar to those of CMS. A substantial share of hospices did not furnish general inpatient care (28 percent), continuous home care (58 percent), or inpatient respite care (25 percent) to any patient in 2013 (Table 12-8). Some hospices did not furnish several levels of care to any patient in 2013. About 19 percent of providers did not provide general inpatient care or continuous home care to any patient in 2013, with the majority of this group (12 percent of providers) also not providing inpatient respite care to any patient in 2013.

Small hospices were more likely than large hospices not to provide the various levels of care, which may reflect

several factors. Given their relatively small number of patients, some small hospices may not have had any patients who needed these levels of care. It is also possible that some small hospices find it difficult to provide these levels of care, and so they do not offer them. The lack of provision of the four levels of care among larger hospices, although less common, clearly raises questions about whether these providers have the capacity or willingness to furnish these services. CMS has indicated that it intends to monitor utilization patterns of the four levels of care and refer providers with aberrant patterns to Survey and Certification, or other parts of CMS responsible for program integrity, for further investigation. While this concern is an important issue for providers of all sizes, those with large patient populations that do not provide these levels of care merit the most immediate scrutiny. In addition, it might be useful to beneficiaries choosing a hospice provider if there were information in quality reporting or transparency initiatives as to whether a provider has a history of not furnishing these levels of care to any patients.

Hospice providers will have some rate of live discharges because some patients may change their mind about the type of care they wish to receive and disenroll from hospice and because some hospice patients' conditions may improve and they no longer meet the hospice eligibility criteria. However, substantially higher rates of

**TABLE
12-9****Live discharges as a percent
of all discharges, 2012**

Percentile	Type of hospice		
	All	Below cap	Above cap
10th	9%	9%	18%
25th	11	11	27
50th	15	15	38
75th	20	19	49
90th	29	26	67

Note: Hospices that provided care in 2012 but did not provide care in 2013 are excluded from the analysis.

Source: MedPAC analysis of 100 percent hospice standard analytical file (claims) data and the denominator file from CMS.

live discharge than their peers may signal a provider's problems with quality of care or program integrity. A high rate of live discharges could indicate that a hospice provider is not meeting the needs of patients and families, and so they choose to revoke their hospice election. A high rate of live discharges could also signal that the provider is admitting patients who do not meet the eligibility criteria. In 2012, about 17.5 percent of hospice discharges were live discharges. Comparing across providers, live discharges accounted for about 15 percent of the median provider's total discharges (Table 12-9). Ten percent of providers had a live discharge rate of roughly 29 percent or more—at least double the rate of the median provider. Above-cap hospices had particularly high live-discharge rates, ranging from 18 percent at the 10th percentile to 67 percent at the 90th percentile. Live discharges also occurred among below-cap hospices, with the 90th percentile among this group having live discharges account for at least 26 percent of their total discharges. Overall, these data indicate that there are providers—most above-cap hospices and some below-cap hospices—that have high rates of live discharges compared with their peers, which warrants further investigation by CMS or OIG. High live-discharge rates could also be explored as a potential quality indicator.

Providers' access to capital: Access to capital appears to be adequate

Hospices in general are not as capital intensive as other provider types because they do not require extensive

physical infrastructure (although some hospices have built their own inpatient units, which require significant capital). Overall, access to capital for hospices appears strong, given the robust entry of for-profit providers into the Medicare program.

The number of for-profit providers grew more than 9 percent in 2013, indicating that capital is accessible to these providers. In addition, there have been a number of mergers and acquisitions of hospice companies in 2013 and 2014. Some have involved for-profit hospices acquiring smaller providers, and others have involved the sale of hospice companies from one private equity group to another. In addition, hospice companies have been acquired by other types of post-acute care providers. Most recently, two large publicly traded post-acute care providers—Kindred and HealthSouth—each announced deals to add home health and hospice to their service offerings through the acquisition of large home health and hospice chains.

Among nonprofit freestanding providers, less is known about access to capital, which may be more limited. Hospital-based and home health–based nonprofit hospices have access to capital through their parent providers, which currently appear to have adequate access to capital in both sectors.

Medicare payments and providers' costs

As part of the update framework, we assess the relationship between Medicare payments and providers' costs by considering whether current costs approximate what providers are expected to spend on the efficient delivery of high-quality care. Medicare margins illuminate the relationship between Medicare payments and providers' costs. We examined margins through the 2012 cost reporting year, the latest period for which complete cost report and claims data are available. To understand the variation in margins across providers, we also examined the variation in costs per day across providers.

Hospice costs

Hospice costs per day vary substantially by type of provider (Table 12-10), which is one reason for differences in hospice margins across provider types. In 2012, hospice costs per day were about \$146 on average across all hospice providers, an increase in cost per day of about 1.3 percent from the previous year.²⁰ Freestanding hospices had lower costs per day than home health–based hospices and hospital-based hospices. For-profit, above-cap, and

rural hospices also had lower costs per day than their respective counterparts.

The differences in costs per day among freestanding, home health–based, and hospital-based hospices largely reflect differences in average length of stay and indirect costs. Our analysis of Medicare cost report data indicates that, across all hospice types, those with longer average stays have lower costs per day. Freestanding hospices have longer stays than provider-based hospices, which accounts for some, but not all, of the difference in costs per day. Another substantial factor is the higher level of indirect costs among provider-based hospices. Indirect costs include, among others, management and administration, accounting and billing, and capital costs. In 2012, indirect costs made up 31 percent of total costs for freestanding hospices compared with 39 percent of total costs for home health–based hospices and 42 percent for hospital-based hospices.²¹

There are several potential drivers of the higher indirect costs among provider-based hospices. The structure of the cost report for provider-based hospices likely results in some overallocation of overhead costs that are not actually related to the hospices’ operations or management. It is also possible that provider-based hospices truly have higher indirect costs for certain overhead activities. For example, provider-based hospices might have higher indirect costs than freestanding providers if administrative staff wage rates were higher for parent providers (e.g., hospitals or home health agencies) or if provider-based hospices expended more administrative resources coordinating with their parent provider.

Regardless of the source of the higher indirect costs among provider-based hospices, the Commission believes payment policy should focus on the efficient delivery of services to Medicare’s beneficiaries. If freestanding hospices are able to provide high-quality care at a lower cost than provider-based hospices, payment rates should be set accordingly, and the higher indirect costs of provider-based hospices should not be a reason for increasing Medicare payment rates.

Hospice margins

From 2006 to 2012, the aggregate hospice Medicare margin ranged from 5.5 percent to 10.1 percent (Table 12-11, p. 306).²² As of 2012, the aggregate hospice Medicare margin was 10.1 percent, up from 8.8 percent in 2011. Margins varied widely across individual hospice

**TABLE
12-10**

Hospice costs per day vary by type of provider, 2012

	Average	Percentile		
		25th	50th	75th
All hospices	\$146	\$112	\$137	\$171
Freestanding	140	110	132	159
Home health based	156	114	145	181
Hospital based	189	129	170	216
For profit	132	106	127	153
Nonprofit	164	129	155	190
Above cap	123	100	119	142
Below cap	148	114	139	174
Urban	148	114	138	172
Rural	131	108	133	166

Note: Data reflect aggregate costs per day for all types of hospice care combined (routine home care, continuous home care, general inpatient care, and inpatient respite care). Data are not adjusted for differences in case mix or wages across hospices.

Source: MedPAC analysis of Medicare hospice cost reports and Medicare Provider of Services data from CMS.

providers. In 2012, the Medicare margin was –9.6 percent at the 25th percentile, 9.7 percent at the 50th percentile, and 23.6 percent at the 75th percentile of providers. Our estimates of Medicare margins from 2006 to 2012 exclude overpayments to above-cap hospices and are calculated based on Medicare-allowable, reimbursable costs consistent with our approach in other Medicare sectors.^{23,24}

We excluded nonreimbursable bereavement costs from our margin calculations. The statute requires that hospices offer bereavement services to family members of their deceased Medicare patients. However, the statute prohibits Medicare payment for bereavement services (section 1814(i)(1)(A) of the Social Security Act). Hospices report the costs associated with bereavement services on the Medicare cost report in a nonreimbursable cost center. If we included these bereavement costs from the cost report in our margin estimate, it would reduce the 2012 aggregate Medicare margin by at most 1.4 percentage points. This estimate is likely an overestimate of the bereavement costs associated with Medicare hospice patients because we

**TABLE
12-11****Hospice Medicare margins by selected characteristics, 2006–2012**

Category	Percent of hospices 2012	2006	2007	2008	2009	2010	2011	2012
All	100%	6.4%	5.8%	5.5%	7.4%	7.4%	8.8%	10.1%
Freestanding	71	9.7	8.7	8.3	10.2	10.7	11.8	13.3
Home health based	13	3.8	2.3	3.4	5.9	3.2	6.1	5.5
Hospital based	15	-12.7	-10.9	-11.3	-12.2	-16.6	-16.0	-16.8
For profit (all)	59	12.0	10.4	10.3	11.7	12.3	14.8	15.4
Freestanding	51	12.7	11.3	11.5	12.9	13.4	15.9	16.5
Nonprofit (all)	35	1.5	1.6	0.7	3.8	3.0	2.4	3.7
Freestanding	15	5.8	5.6	3.7	6.6	7.6	6.4	7.7
Urban	73	7.1	6.3	5.9	7.9	7.7	9.1	10.3
Rural	27	0.8	1.4	2.1	3.7	5.2	6.0	7.8
Patient volume (quintile)								
Lowest	20	-5.1	-7.9	-8.4	-6.5	-6.5	-4.1	-2.3
Second	20	0.3	1.0	-0.1	2.0	2.0	2.8	5.9
Third	20	2.4	3.0	4.4	4.5	4.5	7.5	9.7
Fourth	20	5.8	5.8	7.2	6.8	6.8	9.9	11.4
Highest	20	8.1	7.0	6.1	9.0	9.0	9.6	10.6
Below cap	89	7.0	6.1	5.9	7.9	7.7	9.1	10.4
Above cap (excluding cap overpayments)	11	0.3	2.5	1.2	1.4	3.2	4.1	5.2
Above cap (including cap overpayments)	11	20.7	20.5	19.0	18.3	17.4	18.4	21.3

Note: Margins for all provider categories exclude overpayments to above-cap hospices, except where specifically indicated. Margins are calculated based on Medicare-allowable, reimbursable costs. The sequester is not included in these margin estimates because the sequester did not begin until April 2013.

Source: MedPAC analysis of Medicare hospice cost reports, 100 percent hospice claims standard analytical file data, and Medicare Provider of Services data from CMS.

are not able to separately identify the bereavement costs related to hospice patients from the costs of community bereavement services provided to the family and friends of decedents not enrolled in hospice. Also, it is important to note that hospices may fund bereavement services, which by statute are not reimbursable by Medicare, through donations. Hospice revenues from donations are not included in our margin calculations.

We also excluded nonreimbursable volunteer costs from our margin calculations. As discussed in our March 2012 report, the statute requires Medicare hospice providers to use some volunteers in the provision of hospice care. Costs associated with recruiting and training volunteers are generally included in our margin calculations because they are reported in reimbursable cost centers. The only

volunteer costs that would be excluded from our margins are those associated with nonreimbursable cost centers. It is unknown what types of costs are included in the volunteer nonreimbursable cost center. If nonreimbursable volunteer costs were included in our margin calculation, it would reduce the aggregate Medicare margin by 0.3 percentage point.

Freestanding hospices have higher margins (13.3 percent) than home health–based and hospital–based hospices (5.5 percent and -16.8 percent, respectively). Provider-based hospices have lower margins than freestanding providers, partly because of their higher indirect costs (e.g., general and administrative expenses, capital costs). If home health–based and hospital–based hospices had indirect cost structures similar to those of freestanding hospices,

we estimate that the aggregate Medicare margin would be about 9 percentage points higher for home health–based hospices and 14 percentage points higher for hospital-based hospices, and the industry-wide aggregate Medicare margin would be about 2 percentage points higher.²⁵

Hospice margins also vary by other provider characteristics, such as type of ownership, patient volume, and urban or rural location. The aggregate Medicare margin was considerably higher for for-profit hospices (15.4 percent) than for nonprofit hospices (3.7 percent). However, freestanding nonprofit hospices, which are not affected by overhead allocation issues, had a higher margin (7.7 percent) than nonprofits overall. Generally, hospices’ margins vary by the provider’s volume; hospices with more patients have higher margins on average. Overall, hospices in urban areas have a higher aggregate Medicare margin (10.3 percent) than those in rural areas (7.8 percent). The difference between rural and urban margins, while not large, may partly reflect differences in volume.

Hospice profitability is closely related to length of stay. Hospices with longer lengths of stay have higher margins. For example, comparing hospice providers based on the percent of their patients’ stays exceeding 180 days, the average margin ranged from –7 percent for hospices in the lowest quintile to 18.3 percent for hospices in the second-highest quintile (Table 12-12). Hospices in the highest length-of-stay quintile had a 13.7 percent average margin after the return of cap overpayments, but without the hospice aggregate cap, these providers’ margins would have averaged 20.3 percent. The Commission’s recommendation to revise the hospice payment system to pay relatively higher rates per day at the beginning and end of the episode (near the time of the patient’s death) and lower rates in the intervening period would better align payments and costs and would likely reduce the variation in profitability across hospices and patients (see text box on this 2009 recommendation, pp. 292–293).

Hospices with a high share of patients in nursing facilities and assisted living facilities also have higher margins than other hospices. For example, in 2012, hospices in the top quartile of share of patients residing in nursing facilities had a 17.1 percent margin compared with a margin of roughly 9 percent in the middle quartiles and a 3 percent margin in the bottom quartile (Table 12-12). Margins also vary by the share of a provider’s patients in assisted living facilities, with a margin ranging from about 2 percent in the lowest quartile to 15.1 percent in

**TABLE
12-12**

**Hospice Medicare margins
by length of stay and
patient residence, 2012**

Hospice characteristic	Medicare margin
Average length of stay	
Lowest quintile	–6.5%
Second quintile	3.6
Third quintile	12.9
Fourth quintile	17.9
Highest quintile	13.4
Percent of stays > 180 days	
Lowest quintile	–7.0
Second quintile	3.3
Third quintile	13.2
Fourth quintile	18.3
Highest quintile	13.7
Percent of patients in nursing facilities	
Lowest quartile	3.0
Second quartile	9.0
Third quartile	9.6
Highest quartile	17.1
Percent of patients in assisted living facilities	
Lowest quartile	2.0
Second quartile	5.3
Third quartile	10.4
Highest quartile	15.1
Note: Margins for all provider categories exclude overpayments to above-cap hospices. Margins are calculated based on Medicare-allowable, reimbursable costs.	
Source: MedPAC analysis of Medicare hospice cost reports, Medicare Beneficiary Database, 100 percent hospice claims standard analytical file, and Medicare Provider of Services data from CMS.	

the highest quartile. Some of the difference in margins among hospices with different concentrations of nursing facility and assisted living facility patients is driven by differences in the diagnosis profile and length of stay of patients in these hospices. However, hospices may find caring for patients in facilities more profitable than caring for patients at home for other reasons in addition to length of stay. As discussed in our June 2013 report, there may be efficiencies in treating hospice patients in a centralized location in terms of mileage costs and staff travel time,

as well as facilities serving as referral sources for new patients. Nursing facilities may also be a more efficient setting for hospices to provide care because of the overlap in responsibilities between the hospice and the nursing facility. Analyses in our June 2013 report suggest that a 3 percent to 5 percent reduction in the hospice routine home care payment rate for patients in nursing facilities may be warranted because of the overlap in responsibilities between the hospice and the nursing facility (Medicare Payment Advisory Commission 2013).

Projecting margins for 2015

To project the aggregate Medicare margin for 2015, we model the policy changes that went into effect between 2012 (the year of our most recent margin estimates) and 2015. The policies include:

- a market basket update of 2.6 percent for fiscal year 2013, 2.5 percent for fiscal year 2014, and 2.9 percent for fiscal year 2015;
- a reduction to the market basket update of 1.0 percentage point in 2013, 0.8 percentage point in 2014, and 0.8 percentage point in 2015 (reflecting a productivity adjustment and an additional adjustment of -0.3 percentage point each year);
- a 2.0 percent reduction in payments because of the sequester that began in April 2013;
- a reduction in payments for years four through six of the seven-year phase-out of the wage index budget-neutrality adjustment factor, which reduced payments to hospices by 0.6 percentage point in each of the three fiscal years from 2013 through 2015; and
- additional wage index changes, which reduced payments in fiscal years 2013 through 2015.²⁶

We also assume a rate of cost growth in 2014 and 2015 that is higher than the historical rate in light of potentially higher administrative costs related to implementing several new administrative requirements (i.e., new claims-data reporting requirements, new quality reporting initiatives, and a revised cost report). Taking these factors into account, we project an aggregate Medicare margin for hospices of 6.6 percent in 2015. The 2015 margin projection includes the effect of the sequester. If the sequester were not in effect in 2015, the margin projection for 2015 would be roughly 2 percentage points higher. This margin projection excludes 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). The margin projection also does not include any adjustment to remove the effect of 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 2 percentage points).

In considering the 2015 margin projection as an indicator of the adequacy of current payment rates for 2016, one policy of note is the continued phase-out of the wage index budget-neutrality adjustment. Our 2015 margin projection reflects the first six years (through 2015) of the seven-year phase-out of the wage index budget-neutrality adjustment. In 2016, the final year of this phase-out will result in an additional 0.6 percentage point reduction in payments.

How should Medicare payments change in 2016?

Update recommendation

RECOMMENDATION 12

The Congress should eliminate the update to the hospice payment rates for fiscal year 2016.

RATIONALE 12

Our payment indicators for hospice are positive. The number of hospices increased more than 5 percent in 2013 because of the entry of for-profit providers. The number of beneficiaries enrolled in hospice increased, and average length of stay held steady. Access to capital appears adequate. The projected 2015 aggregate Medicare margin is 6.6 percent. Based on our assessment of the payment adequacy indicators, hospices should be able to accommodate cost changes in 2016 without an update to the 2015 base payment rate.

IMPLICATIONS 12

Spending

- Under current law, hospices would receive an update in fiscal year 2016 equal to the hospital market basket index (currently estimated at 2.9 percent), less an adjustment for productivity (currently estimated at 0.5 percent). Hospices may also face an additional 0.3 percentage point reduction in the fiscal year 2016 update, depending on whether certain targets

for health insurance coverage among the working-age population are met. As a result, hospices would receive a net update of 2.1 percent or 2.4 percent (based on current estimates). Our recommendation to eliminate the payment update in fiscal year 2016 would decrease federal program spending relative to the statutory update by between \$250 million and \$750 million over one year and between \$1 billion and \$5 billion over five years.

Beneficiary and provider

- We do not expect this recommendation to have adverse effects on beneficiaries' access to care. This recommendation is not expected to affect providers' willingness and ability to care for Medicare beneficiaries. ■

Endnotes

- 1 If a beneficiary does not have an attending physician, the beneficiary can initially elect hospice based on the certification of the hospice physician alone.
- 2 When first established under TEFRA, the Medicare hospice benefit limited coverage to 210 days of hospice care. The Medicare Catastrophic Coverage Repeal Act of 1989 and the Balanced Budget Act of 1997 eased this limit.
- 3 In 2000, 30 percent of hospice providers were for profit, 59 percent were nonprofit, and 11 percent were government. As of 2013, about 61 percent of hospices were for profit, 33 percent were nonprofit, and 5 percent were government.
- 4 Hospice decedents in 2013 (i.e., beneficiaries who received hospice care in 2013 and died in 2013) have substantially fewer days of hospice care than hospice nondecedents (i.e., beneficiaries who received hospice care in 2013 but did not die in 2013).
- 5 The IMPACT Act of 2014 made technical changes to PPACA's statutory language on focused medical review of hospices. The statutory language was revised to ensure that the beneficiary is not held liable for the cost of services denied under focused medical review. Focused medical review applies to hospices whose percentage of stays exceeding 180 days exceeds a threshold specified by the Secretary. The IMPACT Act also revised the formula for calculating a hospice's percentage of stays exceeding 180 days.
- 6 The cap year spans November 1 through October 31 (e.g., cap year 2012 spanned November 1, 2011, to October 31, 2012). Medicare payments for the cap year reflect the sum of payments to a provider for services furnished in the cap year. The calculation of the beneficiary count for the cap year is more complex, involving two alternative methodologies. For a detailed description of the two methodologies and when they are applicable, see our March 2012 report (Medicare Payment Advisory Commission 2012).
- 7 This 2014 cap threshold is equivalent to an average length of stay of 171 days of routine home care for a hospice with a wage index of 1.
- 8 The IMPACT Act of 2014 changed the annual update factor applied to the hospice aggregate cap for accounting years that end after September 30, 2016. Currently, the aggregate cap is updated annually based on the percentage increase in the medical care expenditure category of the consumer price index for all urban consumers. As a result of the IMPACT Act, the aggregate cap will be updated annually by the same factor as the hospice payment rates (market basket net of productivity and other adjustments). This change will keep the amount of hospice days the aggregate cap is equivalent to constant over time.
- 9 Type of hospice reflects the type of cost report filed (i.e., the hospice filed a freestanding hospice cost report or was included in the cost report of a hospital, home health agency, or skilled nursing facility). The type of cost report does not necessarily reflect the location where patients receive care. For example, all types of hospices may serve some nursing facility patients.
- 10 The number of rural hospices is not necessarily reflective of hospice access for rural beneficiaries for several reasons. A count of the number of rural hospices does not capture the size of those hospice providers, their capacity to serve patients, or the size of their service area. Furthermore, a count of hospices located in rural areas does not take into account hospices with offices in urban areas that also provide services in rural areas.
- 11 The OIG report also recommended that claims-based quality measures be developed and adopted, that hospice quality information be made public, and that CMS provide individual hospices with more information on how their utilization patterns compare with their peers.
- 12 Above-cap hospices are more likely to be for-profit, freestanding providers and to have smaller patient counts than below-cap hospices.
- 13 The estimates of hospices over the cap are based on the Commission's analysis. While the estimates are intended to approximate those of the CMS claims processing contractors, differences in available data and methodology have the potential to lead to different estimates. An additional difference between our estimates and those of the CMS contractors relates to the alternate cap methodology that CMS established in the hospice final rule for 2012 (Centers for Medicare & Medicaid Services 2011). Based on that regulation, for cap years before 2012, hospices that challenged the cap methodology in court or made an administrative appeal had their cap payments calculated from the challenged year going forward using a new, alternative methodology. For cap years from 2012 onward, all hospices will have their cap liability calculated using the alternative methodology unless they elected to remain with the original method. For estimation purposes, we have assumed that the alternative methodology was used for cap year 2012. Estimates for cap years 2011 and earlier assumed that the original cap methodology was used.
- 14 This policy—which requires a hospice to estimate its cap liability within three to five months of the close of the cap

- year and remit the calculated overpayments to CMS at that time or face suspension of their payments—should create greater awareness of cap overpayment liabilities by providers and make it more likely that Medicare will collect at least a portion of the overpayments from all above-cap hospices. Because of how the aggregate cap calculation is structured, the amount a hospice owes when the calculation is performed three to five months after the close of the cap will be less than the full amount the hospice owes when the Medicare contractor reconciles the calculation at a later date with more complete claims data. Thus, this policy should ensure that hospices pay a portion of their cap overpayments up front, and then hospices would be liable for the remainder of the overpayments at a later date.
- 15 The initial two quality measures were (1) the share of patients who reported being uncomfortable because of pain at admission whose pain was brought to a comfortable level within 48 hours and (2) whether the hospice tracked at least 3 quality measures focused on patient care and what those measures were.
 - 16 CMS discontinued collection of the pain outcome measure it adopted in the first year of the reporting program because a high rate of patient exclusion made the measure unstable and because the measure was inconsistently administered across providers.
 - 17 The IMPACT Act of 2014 will increase the frequency of hospice recertification surveys, requiring them to occur no less than every 36 months. This requirement of more frequent surveys may be an opportunity for closer scrutiny of providers with aberrant data that raise questions about quality of care or program integrity.
 - 18 Abt defined skilled visits as visits by a nurse, therapist, or social worker. Their measure does not include visits by a hospice aide, physician, spiritual counselor, or volunteer.
 - 19 While routine home care is the most common level of hospice care, other levels—general inpatient care, continuous home care, and inpatient respite care—are available to manage needs in certain situations. General inpatient care is provided in a facility on a short-term basis to manage symptoms that cannot be managed in another setting. Continuous home care is intended to manage a short-term symptom crisis in the home and involves eight or more hours of care per day, mostly nursing. Inpatient respite care is care in a facility for up to five days to provide an informal caregiver a break. Overall in 2013, 87 percent of hospice beneficiaries received routine home care, 22 percent received general inpatient care, 6 percent received continuous home care, and 4 percent received inpatient respite care (with some receiving more than one type of care).
 - 20 The cost per day calculation reflects aggregate costs for all types of hospice care combined (routine home, continuous home, general inpatient, and inpatient respite care). “Days” reflects the total number of days the hospice is responsible for care for its patients, regardless of whether the patient received a visit on a particular day. The cost per day estimates are not adjusted for differences in case mix or wages across hospices and are based on data for all patients, regardless of payer.
 - 21 In general, hospices with a larger volume of patients have lower indirect costs as a share of total costs. While patient volume explains some of the difference in indirect costs across providers, freestanding hospices have lower indirect costs than provider-based hospices, even for providers with similar patient volumes.
 - 22 The aggregate Medicare margin is calculated as follows: $((\text{sum of total payments to all providers}) - (\text{sum of total costs to all providers})) / (\text{sum of total payments to all providers})$. Estimates of total Medicare costs come from providers’ cost reports. Estimates of Medicare payments and cap overpayments are based on Medicare claims data. We present margins for 2012 because it is the most recent period for which we have a complete set of claims data to estimate hospice margins including the effect of the aggregate cap.
 - 23 Hospices that exceed the Medicare aggregate cap are required to repay the excess to Medicare. We do not consider the overpayments to be part of hospice revenues in our margin calculation.
 - 24 Our margin estimates also do not take into account revenues or costs from fundraising and donations.
 - 25 These estimates are adjusted to account for differences in patient volume across freestanding and provider-based hospices.
 - 26 Hospices’ payments increase or decrease slightly from one year to the next because of the annual recalibration of the hospital wage index. The annual wage index recalibration was expected to reduce Medicare payments by 0.1 percentage point in each year from 2013 through 2015, according to estimates in the CMS final rules or notices establishing the hospice payment rates for those years.

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CHAPTER

13

The Medicare Advantage program: Status report

R E C O M M E N D A T I O N S

(The Commission reiterates its March 2014 recommendations on improving the bidding rules in the Medicare Advantage (MA) program and integrating hospice care into the MA benefit package. See text box, pp. 340–341.)

The Medicare Advantage program: Status report

Chapter summary

Each year, the Commission provides a status report on the Medicare Advantage (MA) program. In 2014, the MA program included 3,600 plan options, enrolled more than 15.8 million beneficiaries (30 percent of all beneficiaries), and paid MA plans about \$159 billion to cover Part A and Part B services. To monitor program performance, we examine MA enrollment trends, plan availability for the coming year, and payments for MA plan enrollees relative to spending for fee-for-service (FFS) Medicare beneficiaries. We also provide an update on current quality indicators in MA.

The MA program gives Medicare beneficiaries the option of receiving benefits from private plans rather than the traditional FFS Medicare program. The Commission supports the inclusion of private plans in the Medicare program; beneficiaries should be able to choose between the traditional FFS Medicare program and alternative delivery systems that private plans can provide. Because Medicare pays private plans a per person predetermined rate rather than a per service rate, plans have greater incentives to innovate and use care-management techniques.

The Commission has emphasized the importance of imposing fiscal pressure on all providers of care to improve efficiency and reduce Medicare program costs. For MA, the Commission recommended that benchmarks be brought

In this chapter

- Trends in enrollment, plan availability, payments, and risk coding
- Quality in the Medicare Advantage program

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 in Medicare spending between MA and FFS. As a result, over the past few years, plan bids and payments have come down in relation to FFS spending while enrollment in MA continues to grow. The pressure of competitive bidding and lower benchmarks 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.

Previously, the Commission has recommended that pay-for-performance programs be instituted in Medicare to promote quality, with the expected added benefit of improving efficiency by reducing unnecessary program costs. The Congress instituted a quality bonus program for MA in the Patient Protection and Affordable Care Act of 2010, with bonuses available beginning in 2012. The data on quality indicate that plans are responding to the legislation by paying closer attention to the subset of quality measures that are the basis of bonus payments. More plans have achieved quality ratings that would permit bonuses under the statutory provisions.

Enrollment—Between 2013 and 2014, enrollment in MA plans grew by about 9 percent (or 1.3 million enrollees) to 15.8 million enrollees. About 30 percent of all Medicare beneficiaries were enrolled in MA plans in 2014, up from 28 percent in 2013. Among plan types, HMOs continued to enroll the most beneficiaries (10.4 million), with 19 percent of all Medicare beneficiaries in HMOs in 2014. Between 2013 and 2014, enrollment in local preferred provider organizations (PPOs) increased by about 15 percent and in regional PPOs by about 11 percent. As expected, because of legislation effective in 2010, enrollment in private fee-for-service (PFFS) plans continued to decrease from a high of 2.4 million enrollees in 2009 to about 300,000 enrollees in 2014.

Plan availability—Access to MA plans remains high in 2015, with most Medicare beneficiaries having access to a large number of plans. Almost all beneficiaries have had access to some type of MA plan since 2006, and HMOs and local PPOs have become more widely available in the past few years. Ninety-five percent of Medicare beneficiaries have an HMO or local PPO plan operating in their county of residence, the same as in 2014 and up from 67 percent in 2005. Regional PPOs are available to 70 percent of beneficiaries. Access to PFFS plans decreased as expected between 2014 and 2015, from 53 percent to 47 percent of beneficiaries. Overall, 99 percent of all Medicare beneficiaries have access to an MA plan.

Plan payments—For 2015, the base county benchmarks (in nominal dollars and before any quality bonuses are applied) average approximately 5.5 percent

lower than the benchmarks for 2014. However, as part of the benchmark-setting process, the risk scores used to calculate payments were renormalized, resulting in an approximate increase of 5 percent. The average nominal bid did not increase between 2014 and 2015. We estimate that 2015 MA benchmarks (including quality bonuses), bids, and payments will average 107 percent, 94 percent, and 102 percent of FFS spending, respectively.

Risk adjustment and coding intensity—Medicare payments to plans for an enrollee are based on the plan’s payment rate and the enrollee’s risk score. The risk scores are based on diagnoses attributed to the beneficiary during the year before the payment year. To receive the maximum payment they may rightfully claim, plans have an incentive to ensure that providers serving the beneficiary record all diagnoses completely. Analyses have shown that MA plan enrollees have higher risk scores than otherwise similar FFS beneficiaries because of more complete coding. As mandated by the Deficit Reduction Act of 2005, CMS makes an across-the-board adjustment to the scores to make them more consistent with FFS coding practices. We find that if CMS raised the coding adjustment (i.e., lowered risk scores) by about 3 percent, the aggregate level of coding in the FFS and MA programs would be roughly equal.

Quality measures—A comparison of the most current results for MA quality indicators relative to last year shows that there was improvement in many measures, a decline in mental health measures, and no change in a large proportion of measures. MA plans are able to receive bonus payments if they achieve an overall rating of 4 stars or higher on CMS’s 5-star rating system. Although the distribution of plans at different star levels changed between the 2014 star ratings and the 2015 star ratings, there was little change in average star ratings. For plans receiving ratings for both 2014 and 2015, there was virtually no difference between average star ratings for 2014 (3.88) and the ratings for 2015 (3.91). Only a subset of measures is included in determining the overall star rating. For measures included in the star ratings, the majority improved. If including measures in the star ratings makes them more likely to improve, it may be reasonable to include the mental health measures that have been declining for several years.

Responding to an industry concern that the star rating system has a systematic bias against plans that serve low-income beneficiaries, CMS issued a request for information asking plans for data that can show a causal connection between the low-income status of a plan’s enrollees and the plan’s performance in star ratings. In addition to the association with the low-income status of enrollees, our analysis finds an association between a plan’s star ratings and the share of MA enrollees in a plan who are under age 65.

Plan margins—For this annual status report, we include a new element in our analysis of the MA program. To report on plan margins, we use historical data reported by plans in their MA bids. The analysis shows that, on average, companies participating in MA in 2012 had a margin of 4.9 percent. About 91 percent of enrollment was in companies reporting a positive margin. There were differences by plan type: Employer group plans had higher margins than plans for individual Medicare beneficiaries; for-profit plans had higher margins than nonprofit plans; and special needs plans (SNPs) had higher margins than non-SNP plans, except that nonprofit SNP plans reported a slight negative margin.

Plan switching—CMS data show that in 2012, about 10 percent of beneficiaries voluntarily changed their MA plan. Of that number, 80 percent chose another MA plan and the remaining 20 percent went to FFS Medicare—meaning that only 2 percent of MA enrollees left MA for FFS. Among the switchers who faced changes in plan premiums, the large majority switched to a plan with a lower premium.

Plan options and the Medicare website’s display of beneficiary choices—Medicare’s Plan Finder website helps Medicare beneficiaries choose among plans based on cost and quality. For plans offering a reduction in the Part B premium, the manner of displaying premium information can be improved to make beneficiaries more aware of the existence of such an option and its cost. The display should show a beneficiary’s total premium obligation, including the Part B premium. Because plans have different options for providing extra benefits financed by rebate dollars, there should be an examination of the different incentives plans have in choosing among those options. ■

Background

The Medicare Advantage (MA) program allows Medicare beneficiaries to receive benefits from private plans rather than the traditional fee-for-service (FFS) program. In 2014, the MA program included 3,600 plan options, enrolled more than 15.8 million beneficiaries (30 percent of all beneficiaries), and paid MA plans about \$159 billion to cover Part A and Part B services. The Commission supports including private plans in the Medicare program because they allow beneficiaries to choose between FFS Medicare and alternative delivery systems that private plans can provide. Plans often have flexibility in payment methods, including the ability to negotiate with individual providers; care-management techniques that fill potential gaps in care delivery (e.g., programs focused on preventing avoidable hospital readmissions); and robust information systems that provide more timely feedback to providers. Plans can also reward beneficiaries for seeking care from more efficient providers and give beneficiaries more predictable cost sharing, but plans often restrict the choice of providers.

By contrast, traditional FFS Medicare has lower administrative costs and offers beneficiaries an unconstrained choice of health care providers, but it lacks incentives to coordinate care and is limited in its ability to modify care delivery. Because private plans and traditional FFS Medicare have structural aspects that appeal to different segments of the Medicare population, we favor providing a financially neutral choice between private MA plans and traditional FFS Medicare. Medicare's payment systems should not unduly favor one component of the program over the other.

Efficient MA plans may be able to capitalize on their administrative flexibility to provide better value to beneficiaries who enroll in their plans. However, some of the extra benefits that MA plans provide their enrollees result from payments that would have been lower under FFS Medicare for similar beneficiaries. Thus, those benefits are financed by higher government spending and higher beneficiary Part B premiums (including for those who are in traditional FFS Medicare) at a time when Medicare and its beneficiaries are under increasing financial stress. To encourage efficiency and innovation, MA plans need to face some degree of financial pressure, just as the Commission has recommended for providers in the traditional FFS program. One method of achieving financial neutrality is to link private plans' payments more closely to FFS Medicare

costs within the same market. Alternately, neutrality can be achieved by establishing a government contribution that is equally available for enrollment in either FFS Medicare or an MA plan. The Commission will continue to monitor the effect of the changes mandated by the Patient Protection and Affordable Care Act of 2010 (PPACA) on plan payments and performance and to track progress toward financial neutrality.

Each year, the Commission provides a status report on the MA program. To monitor program performance, 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.

Trends in enrollment, plan availability, payments, and risk coding

In contrast to traditional FFS Medicare, MA enrolls beneficiaries in several types of private health plans. Medicare pays plans a fixed rate per enrollee rather than a fixed rate per service.

Types of MA plans

Our analysis of the MA program uses the most recent data available and reports results by plan type. The plan types are:

- **HMOs and local preferred provider organizations (PPOs)**—These plans have provider networks and can use tools such as selective contracting and utilization management to coordinate and manage care and control service use. They can choose individual counties to serve and can vary their premiums and benefits across counties. These two plan types are classified as coordinated care plans (CCPs).
- **Regional PPOs**—These plans are required to offer a uniform benefit package and premium across designated regions made up of one or more states. Regional PPOs have more flexible network requirements than local PPOs. Regional PPOs are also classified as CCPs.
- **Private FFS (PFFS) plans**—PFFS plans are not classified as CCPs. Before 2011, PFFS plans typically did not have provider networks, making them less able than other plan types to coordinate care. They usually paid providers Medicare's FFS payment rates (instead of negotiated rates) and had fewer quality

**TABLE
13-1****Medicare Advantage plan enrollment continued to grow faster than total Medicare beneficiary growth in 2014**

	MA enrollment (in millions)		Percent change in enrollment	2014 MA enrollment as a share of total Medicare
	November 2013	November 2014		
Total	14.5	15.8	9%	30%
Plan type				
CCP	14.2	15.5	11	29
HMO	9.7	10.4	7	19
Local PPO	3.3	3.8	15	7
Regional PPO	1.1	1.3	11	2
PFFS	0.4	0.3	-21	1
Restricted availability plans included in totals above				
SNPs*	1.9	2.1	12	4
Employer group*	2.7	3.1	16	6
Urban/rural				Share of Medicare population in MA
Urban	12.8	13.9	8	32
Rural	1.7	1.9	11	20

Note: MA (Medicare Advantage), CCP (coordinated care plan), PPO (preferred provider organization), PFFS (private fee-for-service), SNPs (special needs plans). CCP includes HMO, local PPO, and regional PPO plans. The sum of column components may not equal the stated total due to rounding.

* SNPs and employer group plans have restricted availability. Their enrollment is included in the statistics by plan type and location. We present them separately to provide a more complete picture of the MA program.

Source: MedPAC analysis of CMS enrollment files.

reporting requirements. Because PFFS plans generally lacked care coordination, had lower quality measures than CCPs on the measures they reported, paid Medicare FFS rates, and had higher administrative costs than traditional FFS Medicare, they were viewed as providing little value. In response, the Medicare Improvements for Patients and Providers Act of 2008 required that, in areas with two or more network MA plans, PFFS plans can be offered only if they have provider networks. PFFS plans are also now required to participate in quality reporting. Existing PFFS plans had to either locate in areas with fewer than two network plans or develop provider networks themselves, which in effect would change them into PPOs or HMOs, or they would operate as network-based PFFS plans.

Two additional plan classifications cut across plan types. Special needs plans (SNPs) are one of these classifications; they offer benefit packages tailored to specific populations (those beneficiaries who are dually

eligible for Medicare and Medicaid, are institutionalized, or have certain chronic conditions). SNPs must be CCPs. The second classification is employer group plans, which are available only to Medicare beneficiaries who are members of employer or union groups that contract with those plans. Employer group plans are all CCPs. Both SNPs and employer group plans are included in our plan data, with the exception of plan availability figures because these plans are not available to all beneficiaries. (See the Commission's March 2013 report to the Congress for a full chapter on SNPs.)

How Medicare pays MA plans

Plan payment rates are determined by the MA plan bid (the dollar amount the plan estimates will cover the Part A and Part B benefit package for a beneficiary of average health status) and the payment area's benchmark (the maximum amount of Medicare payment set by law for an MA plan to provide Part A and Part B benefits). Plans with higher quality ratings are rewarded with a higher

benchmark. If a plan's bid is above the benchmark, its MA payment rate is equal to the benchmark and enrollees have to pay a premium equal to the difference. If a plan's bid is below the benchmark, its payment rate is its bid plus a percentage (between 50 percent and 70 percent in 2014 and thereafter, depending on a plan's quality ratings) of the difference between the plan's bid and the benchmark; the beneficiary pays no premium to the plan for the Part A and Part B benefits (but continues to be responsible for payment of the Medicare Part B premium and may pay premiums to the plan for additional benefits). The payment amount above the bid is referred to as the rebate. The rebate must be used by the plan to provide additional benefits to the enrollees in the form of lower cost sharing, lower premiums, or supplemental benefits. (A more detailed description of the MA program payment system can be found at <http://medpac.gov/documents/payment-basics/medicare-advantage-program-payment-system-14.pdf?sfvrsn=0>.)

Because benchmarks are often set well above what it costs Medicare to provide benefits to similar beneficiaries in the FFS program, MA payment rates usually exceed FFS spending. In past reports, we examined why benchmarks are above FFS spending and what the ramifications are for the Medicare program. In 2014, Part A and Part B payments to MA plans totaled approximately \$159 billion.

MA plan enrollment growth

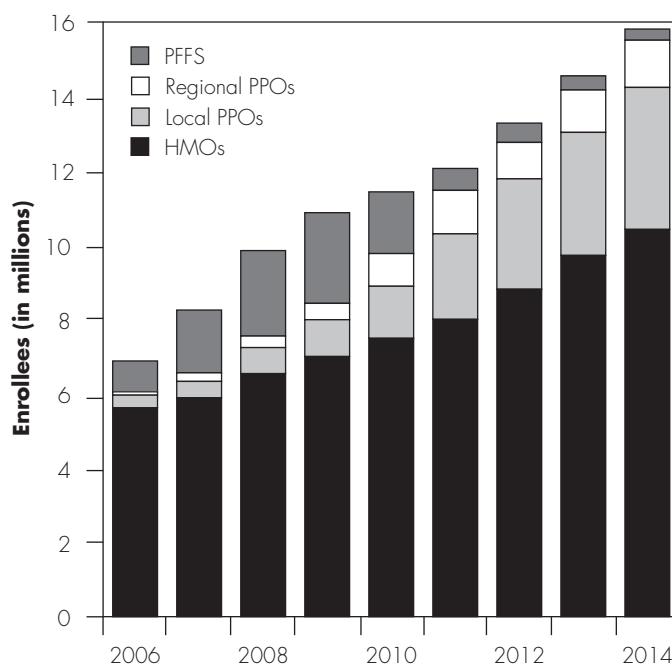
Between November 2013 and November 2014, enrollment in MA plans grew by about 9 percent—or 1.3 million enrollees—to 15.8 million enrollees (compared with growth of about 3 percent in the same period for the total Medicare population). About 30 percent of all Medicare beneficiaries were enrolled in MA plans in 2014, up from 28 percent in 2013 (Table 13-1).

Among plan types, HMOs continued to enroll the most beneficiaries (10.4 million), with 19 percent of all Medicare beneficiaries in HMOs in 2014. Between 2013 and 2014, enrollment in local PPOs continued to grow, by about 15 percent. Regional PPO enrollment increased by about 11 percent. As expected because of legislation effective in 2010, PFFS enrollment continued to decrease from a high of 2.4 million enrollees in 2009 to about 300,000 enrollees in 2014 (Figure 13-1). In 2014, SNP enrollment grew by 12 percent and employer group enrollment grew by 16 percent.

Enrollment patterns differ in urban and rural areas. A larger share of urban beneficiaries are enrolled in MA

FIGURE 13-1

Medicare Advantage enrollment, 2006–2014



Note: PFFS (private fee-for-service), PPO (preferred provider organization).

Source: MedPAC analysis of CMS enrollment files.

(about 32 percent) compared with beneficiaries residing in rural counties (about 20 percent). About one-third of rural MA enrollees were in HMO plans (not shown in Table 13-1) compared with about 70 percent of urban enrollees. By contrast, 7 percent of rural enrollees were in PFFS plans compared with 1 percent of urban enrollees.

The percentage of Medicare beneficiaries enrolled in MA plans in 2014 varied widely by geography. In some metropolitan areas, less than 1 percent of Medicare beneficiaries were enrolled in MA plans (Anchorage, AK), whereas in other areas, enrollment was 60 percent or more (Miami, FL; Pittsburgh, PA; Rochester, NY; and several areas in Puerto Rico).

Growth in MA enrollment in 2014 continued a trend begun in 2003. Since 2003, enrollment has more than tripled. We did not have final 2015 enrollment information as of this report's publication, but plans project overall enrollment growth of 3 percent to 5 percent for 2015. Plan bids for 2014 projected similar growth, but actual growth was 9 percent. Trends vary by plan type. HMOs have grown steadily each year since 2003, but their market

New enrollees in Medicare Advantage and plan switching among Medicare Advantage enrollees

New Medicare beneficiaries do not account for most enrollment growth

Some observers have suggested that half of beneficiaries immediately join Medicare Advantage (MA) plans upon becoming eligible for Medicare. However, our analysis finds that instead, beneficiaries often wait until they are in their late 60s and early 70s, have experienced one or more MA open enrollment periods, and then switch out of fee-for-service (FFS) Medicare. For example, of the 2.5 million beneficiaries new to Medicare in 2012, only 600,000, or 24 percent, enrolled in MA.

The fact that many individuals do not enroll in MA immediately upon their eligibility for Medicare suggests that beneficiaries may not focus on that choice until they have some experience with cost sharing in FFS Medicare or with the widespread marketing that occurs during an MA open enrollment period. These experiences may be important for beneficiaries to understand fully the options between traditional Medicare and MA plans. Medicare may wish to ensure that marketing materials for new entrants to Medicare explain these options more clearly.

Plan switching among Medicare Advantage enrollees

In 2012, CMS data show that 10 percent of beneficiaries in MA voluntarily chose to leave their MA plan to enroll in another MA plan or elected FFS Medicare (excluding those who moved from their plan's service area and beneficiaries enrolled in employer group MA plans). The Commission's analysis of these data shows

that, within that 10 percent, only a small fraction (2 percent of total MA enrollment) moved to traditional FFS Medicare; the rest left one MA plan to join a different MA plan. That is, among the nearly 14 million MA enrollees in 2012, 98 percent remained in MA in their same plan or in another MA plan. Beneficiaries who voluntarily leave MA do not have a right of guaranteed issue of a medigap plan (except in limited circumstances); for beneficiaries who wish to have supplemental coverage, this risk may make FFS less attractive than changing to another MA plan.

We found that when there is plan switching within MA, enrollees generally changed plans to obtain a lower premium or because their current plan increased its premiums. Of the 1.4 million beneficiaries who voluntarily changed their MA status in 2012, 762,000 beneficiaries with no low-income subsidy (LIS) did so during the annual election period (a change effective December 31, 2012). We remove LIS beneficiaries from consideration because the subsidization of the Part D premium in certain plans is a complicating factor. We also remove from the 762,000 number those beneficiaries:

- whose election was a move from MA to FFS,
- who changed their Part D status (e.g., moved from an MA-only plan, with no drug coverage, to a Medicare Advantage–Prescription Drug [plan] (MA–PD)), or
- for whom we do not have premium data in both years.

(continued next page)

share declined between 2006 and 2008, when PFFS plans grew rapidly (Figure 13-1, p. 321). PFFS enrollment plateaued in 2008 and 2009 and then declined as legislated requirements for PFFS plans began to take effect. While enrollment in PFFS declined, enrollment in both local and regional PPOs began to grow.

We have also examined enrollment trends among new beneficiaries and the switching behavior of MA enrollees (see text box).

Plan availability for 2015

Every year, we assess plan availability and projected enrollment for the coming year based on the bid data that plans submit to CMS. We find that access to MA plans remains high in 2015, with most Medicare beneficiaries having access to a large number of plans. While almost all beneficiaries have had access to some type of MA plan since 2006, local CCPs have become more widely available in the past few years (Table 13-3, p. 324). In

New enrollees in Medicare Advantage and plan switching among Medicare Advantage enrollees (cont.)

The remaining number is 436,000 beneficiaries for whom we could determine whether their move from one MA plan to another resulted in a lower premium. Among those 436,000 beneficiaries, 35 percent (151,000) who voluntarily disenrolled from an MA plan in December 2012 moved from a plan that had a zero premium in 2013 to a different plan that also had a zero premium in 2013 (Table 13-2). For each of the remaining categories of beneficiaries, in the majority of cases, the beneficiary's change of plan resulted in a lower premium. For example, the largest category of beneficiaries in the data we examined consisted of

220,000 beneficiaries who were in a plan that raised its premium in 2013. For this group, 90 percent of the beneficiaries who disenrolled from a plan moved to a different plan with a lower premium than they would have paid if they had they remained in their original plan. However, our analysis includes only beneficiaries who decided to make a plan change. The majority of beneficiaries remained in their MA plans, and many of those beneficiaries faced premium increases but decided to remain in their plan even when a lower priced option was available. ■

**TABLE
13-2**

Beneficiaries who switch plans during open enrollment generally do so to have lower premiums

	Beneficiaries (in thousands)	Within group, percent of beneficiaries moving to lower premium plan
Zero-premium and Part B-premium-reduction plans		
Changed from zero-premium plan to new zero-premium plan	151	N/A
Change involved Part B-premium-reduction plans	40	71%
Plans charging a premium		
Original plan premium did not change	14	85
Original plan premium decreased in 2013	11	71
Original plan premium increased in 2013	220	90

Note: N/A (not applicable). A Part B-premium-reduction plan has no Medicare Advantage plan premium and reduces all or part of an enrollee's Part B premium. Changes involving a Part B-premium-reduction plan include a plan's discontinuance of the option, a plan's introduction of the option, and a beneficiary changing to or from a Part B-premium-reduction plan. Data are for a subset of beneficiaries choosing a different option during the annual election period.

Source: MedPAC analysis of CMS voluntary disenrollment data for 2012.

2015, 95 percent of Medicare beneficiaries have an HMO or local PPO plan operating in their county of residence, the same as in 2014 and up from 67 percent in 2005. Regional PPOs are available to 70 percent of beneficiaries. As expected, access to PFFS plans decreased between 2014 and 2015, from 53 percent to 47 percent of beneficiaries. Overall, 99 percent of all Medicare beneficiaries have access to an MA plan, and 98 percent have access to a CCP (not shown in Table 13-3, p. 324).

In 2015, 78 percent of Medicare beneficiaries have access to at least one MA plan that includes Part D drug coverage

and charges no premium (beyond the Medicare Part B premium) compared with 84 percent in 2014. Many beneficiaries have access to plans that offer a reduction in the Part B premium, though they may not be aware of the option (see text box about Part B-premium-reduction plans, pp. 326–327).

We had been using the “zero-premium plan with drugs” measure as an indication of the availability of very generous plans. However, the measure is subject to relatively wide swings based on the yearly pricing strategies of a few plan sponsors. Plan sponsors may

**TABLE
13-3****Access to Medicare Advantage plans remains high****Percent of beneficiaries with access to MA plans by type**

Type of plan	2005	2010	2011	2012	2013	2014	2015
Any MA plan	84%	100%	100%	100%	100%	100%	99%
Local CCP	67	91	92	93	95	95	95
Regional PPO	N/A	86	86	76	71	71	70
PFFS	45	100	63	60	59	53	47
Zero-premium plan with drugs	N/A	85	90	88	86	84	78
Average number of choices	5	21	12	12	12	10	9
Average rebate for nonemployer, non-SNP plans	N/A	\$74	\$83	\$85	\$81	\$75	\$76

Note: MA (Medicare Advantage), CCP (coordinated care plan), PPO (preferred provider organization), N/A (not applicable), PFFS (private fee-for-service), SNP (special needs plan). CCPs include HMO, local PPO, and regional PPO plans. These figures exclude special needs plans and employer-only plans. A zero-premium plan with drugs includes Part D coverage and has no premium beyond the Part B premium. Regional PPOs were created in 2006. Rebates began in 2006. Part D began in 2006.

Source: MedPAC analysis of CMS bid data and population reports.

believe that beneficiaries are more willing to pay a premium to enroll in higher value plans than previously thought. In any event, perhaps the best summary measure of plan generosity is the average rebate, which plans receive to provide additional benefits. The last row of Table 13-3 shows the average rebates for nonemployer, non-SNP plans. For 2015, rebates (which can include allocations to plan administration and profit) for nonemployer, non-SNP plans average \$76 per enrollee per month. The rebates were at roughly the same level as 2014 and 2010 but were lower than the peak years around 2012.

The availability of SNPs has changed slightly and varies by the type of special needs population served (not shown in Table 13-3). In 2015, 82 percent of beneficiaries reside in areas where SNPs serve beneficiaries who are dually eligible for Medicare and Medicaid (the same as in 2014), 47 percent live where SNPs serve institutionalized beneficiaries (also the same as in 2014), and 55 percent live where SNPs serve beneficiaries with chronic conditions (up from 51 percent in 2014). Overall, 86 percent of beneficiaries reside in counties served by at least one type of SNP.

In most counties, a large number of MA plans are available to beneficiaries. For example, beneficiaries in New York City can choose from more than 40 plans in 2015. At the other end of the spectrum, over 200 counties, representing 1 percent of beneficiaries, have no MA plans available; however, many of these beneficiaries have

the option of joining cost plans (another managed care option under Medicare).¹ On average, 9 plans, including 8 CCPs, are offered in each county in 2015, down from 10 plans and 8 CCPs in 2014 (Table 13-3 does not break out CCPs). Plan availability could also be calculated using weights based on the number of beneficiaries living in the county, thus framing the measure as the number of plan choices available to the average beneficiary. According to that calculation, the average beneficiary has 17 plans—including 16 CCPs—available in 2015, down from 18 plans—including 16 CCPs—in 2014. Regardless of the approach to calculating plan availability, the decrease in plan choices from 2010 to 2015 was due to the reduction in PFFS and regional PPO plan choices.

2015 benchmarks, bids, and payments relative to FFS spending

Using plans' bid projections, we compare the Medicare program's projected MA spending with projected FFS spending on a like set of FFS beneficiaries. We calculate and present three sets of percentages: the benchmarks relative to projected FFS spending, the bids relative to projected FFS spending, and the resulting payments to MA plans relative to projected FFS spending. Benchmarks are set each April for the following calendar year. Plans submit their bids in June, incorporating the recently released benchmarks. Benchmarks reflect FFS spending estimates for 2015 made by the CMS actuaries at the time the benchmarks were published in April 2014.

**TABLE
13-4****Projected payments are at or above FFS spending for all plan types in 2015**

Plan type	Percent of FFS spending in 2015		
	Benchmarks*	Bids	Payments
All MA plans	107%	94%	102%
HMO	106	90	101
Local PPO	109	107	107
Regional PPO	102	97	100
PFFS	111	108	111
Restricted availability plans included in totals above			
SNP**	106	93	101
Employer groups**	108	105	106

Note: FFS (fee-for-service), MA (Medicare Advantage), PPO (preferred provider organization), PFFS (private fee-for-service), SNP (special needs plan). Benchmarks are the maximum Medicare program payments for MA plans and incorporate plan quality bonuses. We estimate FFS spending by county using the 2015 MA rate book. We removed spending related to the remaining double payment for indirect medical education payments made to teaching hospitals.

* Benchmarks include quality bonuses.

** SNPs and employer group plans have restricted availability, and their enrollment is included in the statistics by plan type. We have broken them out separately to provide a more complete picture of the MA program.

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

We estimate that 2015 MA benchmarks (including quality bonuses), bids, and payments will average 107 percent, 94 percent, and 102 percent of FFS spending, respectively (Table 13-4). Last year, we estimated that for 2014, these figures would be 112 percent, 98 percent, and 106 percent, respectively. The primary reason for this movement in the ratios is the 5.5 percent decline in the base benchmarks (that is, benchmarks before adding in quality bonuses). These effects, however, are partly (or may be fully) offset by changes in the risk-adjustment calculations and risk-coding intensity.

MA benchmarks

Under PPACA, county benchmarks in 2015 are transitioning to a system in which each county's benchmark in 2017, excluding quality bonuses, will be a certain percentage (ranging from 95 percent to 115 percent) of the average per capita FFS Medicare spending for the county's residents. Counties are ranked by average FFS spending; the highest spending quartile of counties would have benchmarks set at 95 percent of local FFS spending, and the lowest spending quartile would have benchmarks set at 115 percent of local FFS spending. The transition from old benchmarks will be complete by 2017. (See the Commission's March 2011 report for more details on PPACA benchmark changes.) In 2015, more than three-quarters of all counties have base benchmarks

(not including quality payments in the base) that have fully transitioned to the final PPACA levels. These counties include 67 percent of all Medicare beneficiaries and 62 percent of all MA enrollees. Overall, more than three-quarters of the base benchmark transition has occurred:

- In 2011, plan base benchmarks averaged 113 percent of FFS spending.
- In 2015, plan base benchmarks averaged 104 percent of FFS spending.
- In 2017, fully transitioned base benchmarks are expected to average about 101.5 percent of FFS spending.

For 2015, the base county benchmarks (in nominal dollars and before any quality bonuses are applied) average approximately 5.5 percent less than the benchmarks for 2014. However, as part of the benchmark-setting process, the risk-score normalization factor was lowered significantly, resulting in an approximate increase in payment risk scores of 5 percent. (These changes raise the standardized spending for both FFS Medicare and MA. The effect of this restandardization of payments is to raise payments for MA enrollees by 5 percent but leave the ratio with FFS Medicare unchanged.) Also, for 2015, 59 percent of MA enrollees are projected to be in plans that will

Displaying information about Part B–premium-reduction plans in Medicare Advantage

When plans bid below Medicare Advantage (MA) benchmarks and have rebate dollars to provide extra benefits, one of the options a plan has is to reduce the monthly Part B premium for an enrollee. In 2014, Part B premium reductions of \$10 or more per month were available in 162 counties in 12 states, representing 23 percent of the Medicare population (excluding dual-eligible special needs plans (D–SNPs) for beneficiaries dually eligible for Medicare and Medicaid and plans in Puerto Rico, where special circumstances exist). Of the 250,000 beneficiaries enrolled in such plans, 89 percent were enrolled in Florida plans, where half of the Part B–premium-reduction plan enrollees had reductions of \$80 or more per month. In 2015, a Part B–premium-reduction option will be available in 346 counties in 11 states, representing 27 percent of the Medicare population (excluding beneficiaries in Puerto Rico and D–SNPs). In 2015, plan options in which the entire (standard) Part B premium has been reduced to zero are available in 20 counties in the country, all of which are in Florida. For 10 of the 20 counties, only 1 of the 3 to 11 companies operating in the county offers a Part B–premium reduction of more than \$25, and the distribution was similar in the preceding year, suggesting that plans do not feel competitive pressure to offer a significant Part B premium reduction if another plan in the area is doing so.

When considering a Part B–premium-reduction plan, a beneficiary often must make a choice between a fixed amount of monthly savings because of a reduced premium and a variable or uncertain amount in possible out-of-pocket costs. MA organizations offering Part B–premium-reduction plans frequently offer plans in the same service area without a Part B premium reduction but with lower cost sharing for covered services. Beneficiaries can evaluate these choices using Medicare’s Medicare.gov Plan Finder website. The website provides certain tools that help the beneficiary, but the tools provided can be improved.

The default sorting in Plan Finder ranks plans from least costly to most costly, taking into account any Medicare Part B premium reduction, any plan premium, and other expected out-of-pocket costs. A beneficiary can specify his or her health status, which will change the expected out-of-pocket costs. When the initial set of plan options is displayed, it is not immediately evident whether a Part B–premium-reduction plan is available. The display shows the Part B premium for Medicare FFS and premiums for plans—without also showing that the total premium obligation for plans is the plan premium plus the Part B premium. A beneficiary wishing to choose between a lower Part B premium, on the one hand, and lower cost sharing, on the other, would have to take an additional

(continued next page)

receive add-ons to their benchmarks through the PPACA quality bonus provisions. These quality bonus add-ons range from 5 percent to 10 percent. On average, the quality bonuses added 3 percent to the benchmarks in 2015.

Benchmarks for regional plans are based on a weighted average of benchmarks for counties in the region and bids submitted by the regional PPOs. For 2015, regional plans submitted bids in 17 of 26 regions. In 15 of the 17 regions, the average bids were below the region’s average benchmark, so benchmarks for those regions were reduced. As a result, the average regional PPO benchmark (weighted by projected enrollment) was 102 percent of

FFS spending compared with the overall average of 107 percent of FFS spending.

MA bids and payments for different plan types

The modest growth in benchmarks over the past few years may have exerted fiscal pressure on MA plans and encouraged them to better control costs and restrain growth in their bids. The average bid did not increase between 2014 and 2015. The average bid for 2015 is 94 percent of the projected FFS spending for similar beneficiaries. About 62 percent of nonemployer plans bid to provide Part A and Part B benefits for less than what the FFS Medicare program would spend to provide these

Displaying information about Part B–premium-reduction plans in Medicare Advantage (cont.)

step to determine that a reduced Part B premium is one of the factors contributing to the overall expected costs displayed for a given plan. In addition, the beneficiary is not able to search specifically for a Part B–premium-reduction plan. When a beneficiary does arrive at the second level of the display of plan features, the Part B premium for a Part B–premium-reduction plan is shown as an amount less than the standard Part B premium, and the plan premium (if other than zero) is also shown. The plan premium for an MA plan with Part D prescription drug coverage is shown as a total plan premium along with two amounts also shown, the drug component (Part D) and the “health” component (Part C). There are thus three possible pieces of premium information that a beneficiary sees, but not a statement of the total premium obligation (total Part B premium plus any plan premiums). (These issues, and the tendency for plans to add extra benefits rather than reduce the Part B premium, are discussed in a recent article by Stockley and colleagues (Stockley et al. 2014).)

In our interviews with insurance brokers, the brokers noted that Part B–premium-reduction plans were important in some parts of the country and were most attractive to low-income beneficiaries. However, when plans have rebate dollars to provide extra benefits,

the type of benefit that a plan chooses to offer may be affected by whether there is a “load” on the benefit. If plans provide a Part B premium reduction with rebate dollars, there is no load on the benefit—that is, unlike benefits such as reduced cost sharing or added non-Medicare benefits, the plan’s bid for the extra benefit cannot have any administrative costs or margin amount included. The lack of load may help explain why Part B–premium-reduction plans are not more widely available.

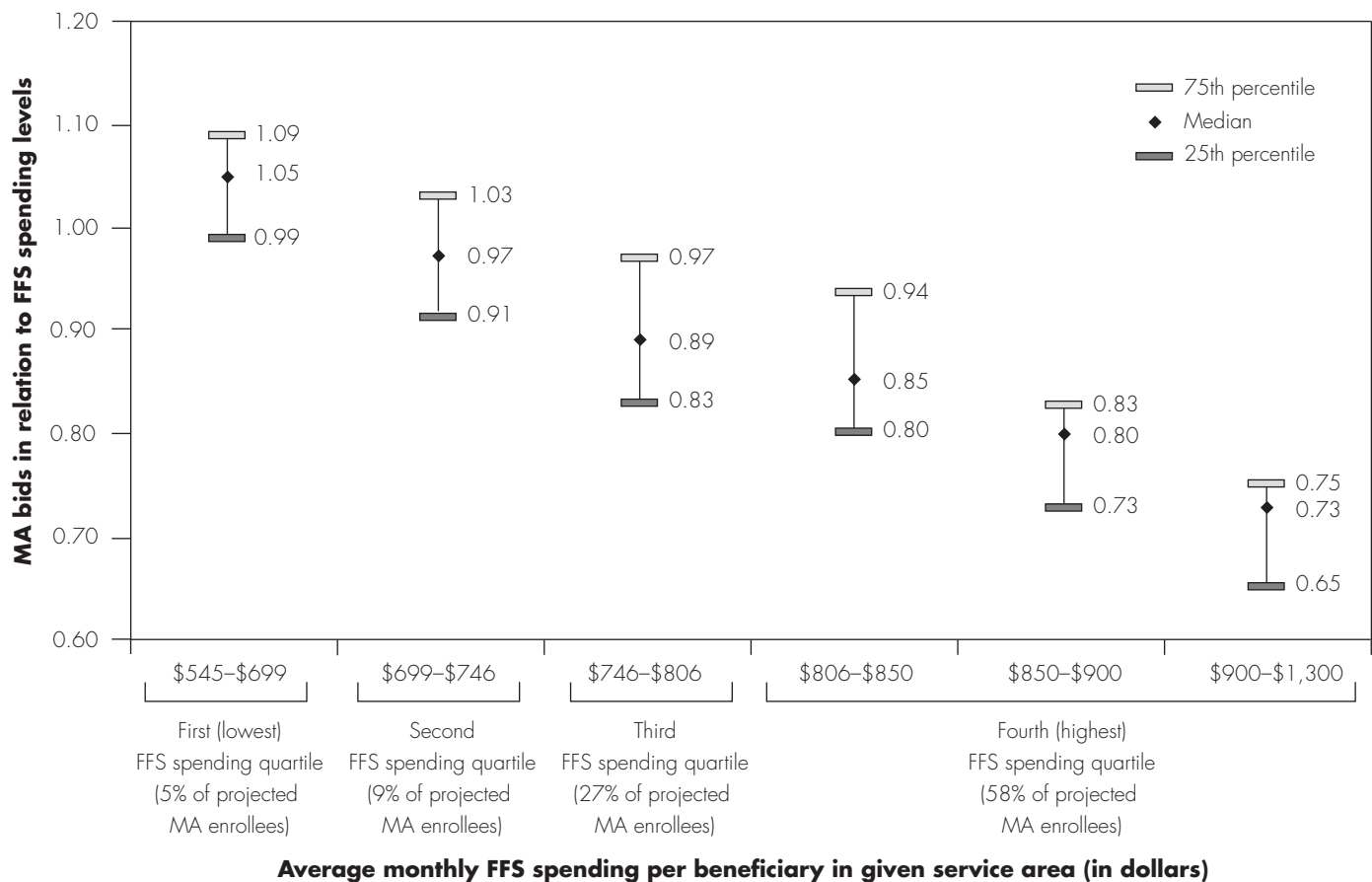
Even where Part B–premium-reduction plans are available, beneficiary enrollment in such plans is limited. In counties with the option available, 7 percent of MA enrollees choose this option. Enrollment might be limited because beneficiaries are able to weigh this option against other options better suited to their needs (such as a plan with lower cost sharing for medical services) or because the presentation of this option lacks transparency. To address the transparency problem, CMS should revise the Medicare.gov display to provide clearer information about total expected cost sharing and the total monthly premium for each MA plan, including the net Part B premium. There should also be an examination of the different incentives that plans have in choosing among the options for providing extra benefits financed by rebate dollars. ■

benefits. These plans are projected to enroll 66 percent of nonemployer MA enrollees in 2015. About 1 million beneficiaries, excluding those enrolled in employer group MA plans, are projected to enroll in plans that bid lower than 75 percent of FFS spending, while a similar number of beneficiaries are projected to enroll in plans that bid at least 110 percent of FFS spending.

Figure 13-2 (p. 328), illustrating over 2,000 plan bids (employer plans, SNPs, and plans in the territories were excluded), shows how plans bid relative to FFS for service areas with different ranges of FFS spending. The first three FFS spending ranges roughly correspond to the FFS ranges in the first three rate quartiles in the PPACA payment rules for 2015. We broke the fourth quartile into three FFS spending ranges because a substantial share of Medicare beneficiaries—about 36 percent—live in

counties in the highest spending quartile. Each FFS range covers the bids of at least 140 plans and 500,000 projected enrollees, with 72 percent of the plans and 76 percent of projected enrollment falling in the three groups between \$746 and \$900 of FFS spending per month.

Plans bid high (relative to FFS) in areas with relatively low FFS spending. When plans bid for service areas that average less than \$699 in monthly FFS spending, they are likely to bid more than FFS (Figure 13-2, p. 328). However, when plan service areas average more than \$699 per month in FFS spending, plans are likely to bid below (sometimes far below) the FFS level. This finding suggests that, geographically, plan costs do not vary as much as FFS spending. Ninety-six percent of beneficiaries live in a county served by at least one plan that bid below the average FFS spending of its service area. However, plans

**FIGURE
13-2****Medicare Advantage bids in relation to FFS spending levels, 2015**

Note: FFS (fee-for-service), MA (Medicare Advantage). Excludes employer group plans, special needs plans, and plans in the territories.

Source: MedPAC analysis of MA bid and FFS expenditure data from CMS.

with large service areas and a geographically dispersed membership are probably not considering exactly how their costs will vary in each county they serve.² While the bidding and payment patterns are reported here as averages, clearly there is much variation within these averages (Table 13-3, p. 324; Figure 13-2).

Although the plan bids average less than FFS spending, payments for enrollees in these plans usually exceed such spending because the benchmarks (including the quality bonuses) are high relative to FFS spending. Overall, plan bids average 94 percent of expected FFS spending for similar beneficiaries in 2015, but because the benchmarks average 107 percent of FFS spending, Medicare pays an average of 102 percent of FFS for beneficiaries enrolled in MA.

The ratio of MA plan payments to FFS spending varies by plan type, but the ratios for all plan types are at or higher

than 100 percent of FFS. For example, HMOs as a group bid an average of 90 percent of FFS spending, yet 2015 payments for HMO enrollees are estimated to average 101 percent of FFS spending because the benchmarks average 106 percent of FFS spending. Local PPOs and PFFS plans have average bids above FFS spending. As a result, payments for local PPO and PFFS enrollees are estimated to be 107 percent and 111 percent, respectively, of FFS spending (Table 13-4, p. 325). Payments for beneficiaries enrolled in regional PPOs averaged 100 percent of FFS because of the relatively low benchmarks for the regional PPOs.

We also analyzed bids and payments to SNPs and employer plans separately because the plans are available only to subpopulations of Medicare beneficiaries and bidding behavior may differ from that of other plan types. In the past, payments to SNPs and their bids tended to

be slightly higher relative to FFS spending than general MA plans. This year, however, SNP bids and payments look much like the average HMO plan (87 percent of SNP enrollees are in HMOs).

Employer group plans consistently bid higher than plans that are open to all Medicare beneficiaries. Employer groups bid an average of 105 percent of FFS compared with 92 percent of FFS for nonemployer plans (not shown in Table 13-4, p. 325). Medicare pays 106 percent of FFS for employer plan enrollees. In the past, the Commission has recommended that CMS evaluate employer plan bids differently. (For more details on employer plans and our recommendation, see the text box (pp. 340–341) and our March 2014 report to the Congress.)

MA risk adjustment and coding-intensity adjustment

Medicare calculates its payment to plans separately for each beneficiary, multiplying the plan's payment rate by the beneficiary's risk score. The risk scores are based on diagnoses that providers coded during the year before the payment year. The diagnoses are reported to Medicare through claims for Medicare FFS beneficiaries or by the plans for MA enrollees. To receive the maximum payment they may rightfully claim, plans have an incentive to ensure that the providers serving the beneficiary record all diagnoses completely.

Recent research has found that risk scores for MA plan members have been growing more rapidly than risk scores for FFS beneficiaries (Kronick and Welch 2014). Thus, as mandated by the Deficit Reduction Act of 2005, CMS has been making an across-the-board adjustment to the scores. Taking into account multiple years of coding differences, CMS reduced risk scores by 3.41 percent from 2010 through 2013. PPACA specifies minimum reductions for 2014 and all future years, although CMS has discretion to make larger reductions. The Government Accountability Office found that CMS should make larger reductions to fully account for the coding differences (Government Accountability Office 2012). The American Taxpayer Relief Act of 2013 increased the minimum reductions that CMS must make in the scores. The mandated reductions will end once CMS begins risk modeling based on MA diagnoses and expenditures rather than on the FFS diagnoses and expenditures supporting the current model. For 2015, CMS has chosen to reduce risk scores by 5.16 percent, the minimum reduction under current law. The law specifies that the minimum reduction rises by 0.25

percentage point each year until 2018, when it would reach 5.9 percent. The minimum reduction would remain 5.9 percent for 2019 and each subsequent year.

The Commission has begun its own analysis of coding differences between beneficiaries in FFS Medicare and those enrolled in MA plans. We used beneficiary risk scores and enrollment data from 2006 through 2013. In one analysis, we built cohorts of beneficiaries whose first full calendar year was spent in FFS and whose second and all subsequent full calendar years (through 2013) were spent entirely in either FFS or MA. For example, one cohort consisted of those beneficiaries whose first full year in Medicare was 2006, who were in FFS for all of 2006, and who either remained exclusively in FFS through 2013 or switched into MA in January 2007 and remained in MA through 2013. We examined the 2006 cohort and all the cohorts whose first full years were in 2007 through 2011. From this approach, analysis shows that all beneficiaries had an initial risk score that reflected their year in the FFS program and that the differences in the growth of their risk scores can be attributed primarily to the program in which they were coded. In this analysis we found:

- Beneficiaries who spent their first calendar year in FFS and then switched to MA had entry risk scores that were 84 percent to 87 percent of those who remained in FFS, for each MA entry year from 2007 to 2012. In other words, beneficiaries enrolling in MA start out with lower risk scores than the average risk scores of beneficiaries remaining in FFS Medicare.
- The ratio of the average MA risk score to the average FFS Medicare risk score grew for every additional year of enrollment.
- The ratio of the average MA risk score to the average FFS Medicare risk score during the first year of enrollment in MA increased from 6 percent for beneficiaries who entered MA in 2007 to 7.5 percent for those who entered MA in 2011. It then jumped to 11 percent for beneficiaries entering MA in 2012, the last year of data we have for this measure.
- After the first year, the ratio of the average MA risk score to the average FFS Medicare risk score tends to increase by about 2 percent for each year the beneficiaries remain in MA.

While this analysis shows compelling evidence that a coding difference exists between beneficiaries in FFS Medicare and MA and that the difference is still growing,

it does not tell us the level of the overall difference, which we would need to evaluate whether the statutory coding adjustment seems adequate. To address this issue, we built cohorts of 2013 MA enrollees based on how long they had been continuously enrolled. We then compared the MA enrollees with FFS Medicare beneficiaries who had spent the same amount of continuous time in FFS. In this analysis we found:

- The cohorts who had remained in MA longer had higher growth in risk scores than their contemporaries who had remained in FFS.
- The MA enrollees who had been enrolled exclusively in MA in 2011, 2012, and 2013 had risk-score growth about 4 percent higher than beneficiaries who exclusively had FFS Medicare coverage for those three years, while the difference for those enrolled continuously during the eight years from 2006 to 2013 was about 13 percent.
- When weighted by the duration of continuous enrollment, the risk scores grew about 8 percent more among the MA population than among the FFS population.

Together these analyses show that because of coding practices, beneficiaries in MA plans will have higher risk scores than they would have had if they had remained in FFS. Further, those differences in coding are larger than the current 5.16 percent coding adjustment mandated by law. If CMS raised the coding adjustment by about 3 percentage points, the aggregate level of coding in the FFS and MA programs would be roughly equal.

CMS could change how it calculates risk scores so that the diagnosis codes used to calculate the scores come from the same sources as those that were used to calibrate the model. For example, beneficiaries in FFS Medicare would rarely, if ever, receive in-home risk assessments. Plans are increasingly submitting diagnoses from these assessments for risk-scoring of their enrollees. In its Advance Notice for MA payment policies for 2015, CMS proposed to discontinue the use of the codes from these assessments in the calculation of risk scores. In the Final Notice, however, CMS withdrew the proposal for 2015. Some might argue home assessments can improve quality. However, the HCC risk model used to adjust payment is based on FFS coding practices, and home assessment scores are not consistent with that model. The National Committee for Quality Assurance (NCQA) has pointed out the same problem in regard to using home assessment diagnosis codes for

risk adjusting quality (readmission) measures (National Committee for Quality Assurance 2012).

Perspective on MA payments

The benchmarks, bids, and payments continue the decline relative to FFS spending begun in 2011. Plan enrollees in 2015 would receive about 102 percent of the funding that Medicare spends on similar FFS Medicare beneficiaries. However, there are issues with coding intensity, and while the Commission has supported paying more for higher quality services, there also may be issues with the star rating system, which is the basis for quality bonuses in MA.

In 2015, the Medicare program is paying about 105 percent (102 percent plus 3 percent because of increased coding) of the expected FFS cost for the Part A and Part B benefits for MA enrollees. In other words, in 2015, the Medicare program is paying about \$8 billion more toward the care for MA enrollees than it would have spent had the beneficiaries remained in FFS Medicare. For that cost, beneficiaries receive an average of \$76 per month (including administrative load and profit) in extra benefits. That \$76 rebate for nonemployer, non-SNP plans is unchanged from 2014. Previous studies found that the extra benefits funded by the rebates were a relatively small portion of the extra Medicare payments and that the extra benefits were funded almost entirely through extra Medicare payments and not by plan efficiencies (Curto et al. 2014, Medicare Payment Advisory Commission 2009, Song et al. 2012).

However, the recent benchmark reductions have put pressure on plans to lower bids and have led to lower Medicare MA payments relative to FFS Medicare. In 2015, MA enrollees will receive an estimated \$11 billion in extra benefits after discounting the administrative costs and profits attached to those benefits. On average nationally, those extra benefits were financed by \$8 billion in Medicare subsidies (payments above FFS costs) and \$3 billion in plan efficiencies. The relative mix of Medicare subsidies and plan efficiencies vary by county. Extra benefits in the lowest spending quartile (the 1.15 quartile) are most likely funded exclusively by Medicare subsidies. In the highest spending quartile (the 0.95 quartile), the extra benefits are funded exclusively by plan efficiencies.

These results, combined with our analysis of margins (see text box), suggest that despite benchmark reductions, plans are doing well on average and continue to be able to offer extra benefits to attract enrollment.

Medicare Advantage plan-reported margins in 2012

One component of Medicare Advantage (MA) bids is the statement of a plan's historical data from the previous year (referred to as the base year) that forms the basis of its bid for the coming year. In the bids submitted for the 2014 contract year, organizations included such data for 2012. We used these plan-reported historical data to determine margin levels in MA in 2012 and analyzed data for plans representing 90 percent of MA enrollment in 2012. In general, our methodology for determining which data to include is similar to that used by the Government Accountability Office (GAO) in its reports on plan margins based on 2013 bid data, which contain 2011 historical information (Government Accountability Office 2013a, Government Accountability Office 2013b). Our results are similar to those of GAO. GAO found, for example, that special needs plans (SNPs) had very high margins and that employer group plans had higher margins than plans for individual Medicare beneficiaries. GAO also found that on average overall, the margins that plans reported as actual results for 2011

were consistent with the projected margins in plan bids submitted in 2010 for the 2011 contract year. However, while that finding was true overall for MA, reported margins differed from projected margins within categories of MA plans (for example, SNP plans and employer group plans had each projected lower 2011 margins in the 2011 bid data than the 2011 margins shown in the historical data included in the 2013 bids).

In 2012, the average margin reported by MA plans, weighted by revenue, was 4.9 percent. Examined at the level of the company or parent organization, more companies had positive margins than negative margins (Table 13-5). As a group, MA plans performed well financially in 2012. Companies accounting for 91 percent of enrollment had positive margins. (This analysis does not include Part D margins for MA prescription drug (MA-PD) plans.) Part D is about 12 percent of revenue for MA-PD plans. Note also that margins for years after 2012 may be lower because of factors such as the program-wide sequester

**TABLE
13-5**

Medicare Advantage company-level margin ranges, weighted by revenue, 2012

Margin categories	Range of margins	Number of companies	Revenue-weighted average margin for group	Percent of total MA revenue in this group	Percent of total enrollment in this group
All companies	-5.6 to 16.1	122	4.9%	100%	100%
Companies with negative margins, totals		43	-3.0	8	9
< -5%	-5.6 to -17.9	17	-8.0	2	2
< -2.5%, ≥ -5%	-2.6 to -4.9	10	-3.5	1	2
< 0, ≥ -2.5%	-0.1 to -2.3	16	-1.2	5	5
Companies with positive margins, totals		79	5.5	92	91
> 0, < 2.5%	0.3 to 2.1	23	1.7	27	25
≥ 2.5%, < 5%	2.6 to 4.9	21	3.4	7	7
≥ 5%, < 7.5%	5.0 to 7.1	8	6.0	25	25
≥ 7.5%, < 10%	7.5 to 9.9	17	7.9	30	30
≥ 10%	10.3 to 16.1	10	13.1	4	5

Note: Enrollment numbers are from the plan-reported member months in the bid historical data. The sum of column components may not equal stated totals due to rounding.

Source: MedPAC analysis of Medicare Advantage bid data.

(continued next page)

Medicare Advantage plan-reported margins in 2012 (cont.)

that reduced Medicare payments, and because of the medical loss ratio requirement introduced in the Patient Protection and Affordable Care Act of 2010 and effective in 2014 for MA plans. However, our analysis of the 2015 bid data indicates that the projected average all-plan margin for the 2015 contract year is similar to the all-plan margin that plans reported for 2012.

One company can have different types of products for which there are individual bids. For example, a company can offer both HMOs and preferred provider organizations, which require separate bids and therefore can have different margins. We also analyzed the bids at the product level and found that margins varied by certain plan characteristics (Table 13-6):

- HMOs had higher margins than other plan types.
- For-profit plans had higher margins than nonprofit plans.
- Looking at a subset of HMOs not offered by employer group plans and the duration of their Medicare contracts, older plans had higher margins than newer plans.
- Employer group plans had higher margins than plans offered to individual Medicare beneficiaries. In the latter category, nonprofit plans reported negative margins.
- In general, SNPs had higher margins than other plans, but nonprofit SNPs had negative margins on average.
- Plans with a majority of enrollment consisting of beneficiaries with full Medicare–Medicaid dual eligibility (that is, full Medicaid coverage) had lower margins than plans with a majority of enrollment consisting of beneficiaries with partial dual eligibility (coverage of the Part B premium only or coverage of cost sharing for some of the partial group).

In the aggregate, the higher margin (2.8 percentage points) for employer plans compared with that for the nongroup plans is close to the difference in administrative costs between the two plan types

**TABLE
13-6**

Medicare Advantage margins vary by certain plan characteristics

Category	2012 margin	Share of enrollment
Plan type		
HMOs	5.4%	68%
Local PPOs	3.1	21
Regional PPOs	4.9	8
PFFS	2.8	3
Profit status		
Nonprofit plans	1.9	30
For-profit plans (before taxes)	6.3	70
Group/nongroup		
Employer group plans	7.2	16
Plans sold to individual Medicare beneficiaries	4.4	84
Plan age		
Older plans	5.1	N/A
Newer plans	3.1	N/A
SNP status		
SNPs	8.6	11
Non-SNPs	4.3	89
SNPs, nonprofit	–0.6	2
SNPs, for profit	11.5	8
Non-SNPs, nonprofit	2.2	28
Non-SNPs, for profit	5.3	61
Type of Medicare–Medicaid dual-eligible enrollment		
Over 50 percent partial dual	12.9	1
Over 50 percent full dual	5.7	6

Note: PPO (preferred provider organization), PFFS (private fee-for-service), N/A (not applicable), SNP (special needs plan). The older and newer plan comparison is for a subset of plans comprised of non-employer group HMOs with 2010 historical data in their 2012 bids, which also appear in the 2014 bid data. Enrollment numbers are from the plan-reported member months in the bid historical data. Figures may not sum due to rounding.

Source: MedPAC analysis of Medicare Advantage bid data.

(6.3 percent and 9.4 percent administrative costs for employer plans and nongroup plans, respectively (data not shown in table)). A major factor is that employer group plans do not incur the high marketing costs

(continued next page)

Medicare Advantage plan-reported margins in 2012 (cont.)

associated with either marketing to individual Medicare beneficiaries or paying commissions to brokers who enroll individual Medicare beneficiaries.

With regard to SNPs, one-third of the enrollment in nonprofit plans was in plans reporting a negative margin when examined at the plan level. Within the group of nonprofit SNP plans, however, 67 percent of the enrollment was in plans with a positive margin (at 5.3 percent), but the overall margin among nonprofit SNPs was pulled down by the high negative margins of plans with 33 percent of the enrollment (data not shown in table).

We also found the following:

- Plans drawing their enrollment from areas with relatively high per capita spending in fee-for-service Medicare had higher margins than other plans.
- Plans with higher average risk scores and plans with greater numbers of enrollees who have multiple conditions had higher average margins. This difference may partly reflect higher coding intensity among certain plans. Kronick and Welch (2014) note that certain plans code more intensively than others. ■

Quality in the Medicare Advantage program

The indicators that we track to evaluate quality in MA come from various sources described more fully in an online appendix to the March 2010 report to the Congress (http://medpac.gov/documents/reports/mar10_ch06_appendix.pdf?sfvrsn=0) and in technical notes from CMS. We generally report results separately by plan type and compare HMOs with local PPOs. In determining whether there has been statistically significant improvement in measures over the last year, and in comparing the two plan types, we include only plans that reported a result for a measure in both reporting years (a “same store” approach). Table 13-7 (p. 334) summarizes HMO and local PPO performance for the most current year compared with the previous year on the major measures we track. For plan types other than HMOs and local PPOs—cost-reimbursed HMOs, regional PPOs, and PFFS—because of the small number of plans involved, we make general statements about their performance.

For HMOs and local PPOs, Table 13-7 (p. 334) shows that performance improved on a number of measures, declined for a small number, and was unchanged for a large proportion of measures.

Healthcare Effectiveness Data and Information Set® (HEDIS®) results

From HEDIS, we tracked 39 measures to compare between 2013 and 2014, as well as 5 SNP-only measures

and results for hospital readmissions. The quality measures derived from HEDIS encompass both clinical process measures and intermediate outcome measures. The most current HEDIS data (reported in June 2014) reflect care provided in 2013.

Among HMOs, about 40 percent of HEDIS measures (19 of 45) showed improvement; PPOs improved on a little more than one-fourth of the measures (13 of 45). For both HMOs and local PPOs, five measures declined—all in the realm of mental health care and substance abuse treatment, for which HEDIS has six measures. NCQA has called attention to the poor performance of plans on these measures, which has been declining over the past three years.

There was no statistically significant difference in performance between HMOs and local PPOs for 25 of the 39 HEDIS measures we track that are comparable between 2013 and 2014. The 25 measures included 6 of HEDIS’s 7 intermediate outcome measures, which is noteworthy in that the intermediate outcome measures are “hybrid” measures involving extraction of data from a sample of medical records. Until 2012, PPOs could use only administrative data, such as claims data, to report results on these measures. The most recent data show that PPOs have caught up with HMOs in their ability to report these measures and in their performance on these measures.

For the hospital readmission measure, all plan types showed improvement in the observed-to-expected ratios, with those ratios declining by an admission-weighted

**TABLE
13-7**

Over the last year a number of MA quality measures improved, a small number declined, and a large proportion were unchanged

Major quality indicators	Total measures tracked	Number improved		Number declined	
		HMO	Local PPO	HMO	Local PPO
HEDIS® measure categories					
Process	32	10	3	5	5
Intermediate outcome	7	3	4	0	0
SNP-only measures	5	5	5	0	0
Readmission rates	1	1	1	0	0
HEDIS subtotals	45	19	13	5	5
CAHPS®-MA					
Patient experience	6	0	0	1	1
HOS					
Health status changes	2	2	2	0	0
Other					
Part D clinical measures	4	4	3	0	0
Total, all	57	25	18	6	6

Note: MA (Medicare Advantage), HEDIS® (Healthcare Effectiveness Data and Information Set®), SNP (special needs plan), CAHPS®-MA (Consumer Assessment of Healthcare Providers and Systems® for MA), HOS (Health Outcomes Survey). Data exclude cost-reimbursed HMO plans and measures that cannot be compared between the two years because of changes in the measure specification.

Source: MedPAC analysis of CMS HEDIS public use files and star ratings data.

average of 0.5 percent for PFFS plans, 6.9 percent for regional PPOs, 3.9 percent for local PPOs, and 5.7 percent for HMOs. Improvements occurred in all five HEDIS measures reported by SNPs only—advance care planning, medication review, functional status assessment, pain assessment, and medication reconciliation postdischarge. Between 2013 and 2014, percentage point increases greater than 10 occurred for medication reconciliation postdischarge (from 27.2 percent to 37.5 percent) and for pain assessment (from 70 percent to 84.6 percent). With respect to other plan types, we found that historical patterns held in 2014. Cost-reimbursed HMOs generally perform better than MA HMOs on HEDIS measures, and regional PPOs and PFFS plans have the lowest rates on HEDIS measures.

The Consumer Assessment of Healthcare Providers and Systems for MA and Health Outcomes Survey results

For patient experience measures, we use the Consumer Assessment of Healthcare Providers and Systems® for MA (CAHPS®-MA) data that CMS reports in its plan

performance indicators for star rating purposes. Between 2013 and 2014, no change occurred in plan performance on six CAHPS-MA measures of beneficiaries' perceptions of their access to care and rating of their health plan and providers, but the measure of beneficiaries' perception of their ability to get care when it was needed declined for both HMOs and local PPOs.

The Health Outcomes Survey (HOS) is the source of some of the survey-based measures that are included in HEDIS measures (such as whether a physician advised a person to undertake physical activity). The HOS is also the source of two outcome measures in the CMS star system that track whether a plan's enrollees report improvement or decline in physical health status or mental health status. Both of these measures showed improvement among MA plans between the most recent reporting period and the prior reporting period. CMS also uses the HOS to determine whether health status changes in a given plan are markedly different from the average across all plans. As in past years, for the most recent two-year period of tracking changes in health status (2011 to 2013), only a

small number of plans (fewer than 6 percent) had changes in their enrollees’ mental or physical health status that differed significantly from the average across all plans (<http://www.hosonline.org/Content/SurveyResults.aspx>).

Part D measures and contract performance measures

CMS gathers data from both MA and Part D to monitor aspects of these programs and administer the star rating system. Part D measures in the overall star rating for Medicare Advantage–Prescription Drug (MA–PD) plans include three medication adherence measures (medications for diabetes, hypertension, and cholesterol). Plans improved their scores on each of these measures, and HMOs improved on the measure of appropriate blood pressure medication prescribed for people with diabetes. Other measures in the star system include contract performance measures focusing on plans’ customer service, appeals processing, and disenrollment, among others. Most of these measures showed improvement over the past year.

The star system and the quality bonus program

Since 2012, the MA program has included a pay-for-performance system that gives bonuses to higher performing plans. The bonuses take the form of an increase in plan benchmarks; higher rated plans are able to use a higher percentage of the difference between bids and benchmarks for rebates, which finance extra benefits. Bonuses are based on a plan’s overall rating, with a maximum of five stars. Part D measures are included for plans that have Part D coverage (most MA plans). Performance on SNP-specific measures is a component of the star rating for sponsors of SNPs. Each element of the star rating is assigned a weight of 1 for process measures, 1.5 for patient experience and access measures, and 3 for outcome measures. An improvement measure that CMS calculates for MA and Part D has a weight of 5, which is an increase from a weight of 3 last year.

Plans that receive 5-star ratings can enroll beneficiaries outside of the annual election period.³ In the 2015 star ratings, 11 MA–PD plans and 2 MA-only contracts received 5-star ratings. Their status as high-rated plans is displayed at Medicare.gov. The lowest rated plans are also flagged, and beneficiaries are cautioned about choosing to enroll in a low-rated plan. This year (contract year 2015) would have been the first year in which CMS could have invoked a provision to terminate the contract of a plan that

TABLE 13–8 Distribution of enrollment by plan star ratings, 2014–2015

Star rating	Percent of total enrollment	
	2014	2015
5.0	10%	10%
4.5	21	19
4.0	22	31
3.5	31	27
3.0	15	11
2.5	1	2

Note: Enrollment is for September 2014. Data exclude cost-reimbursed HMO plans, which are not eligible for bonuses. Figures have been rounded; the unrounded figure for plans at 4.0 stars or above in 2015 is 59 percent.

Source: MedPAC analysis of CMS star ratings and enrollment data.

had three consecutive years of performance at or below the 2.5 star level in either Part C or Part D. However, CMS did not exercise its authority to do so.

Star ratings and changes in the ratings

The 2014 and 2015 star ratings components and methodology are similar in the elements included, but many of the “cut points,” or minimum levels, for a 4-star rating are higher in 2015. Among all plans with any star rating in 2015 (excluding certain plan types not in the quality bonus program), 59 percent of enrollees are in plans with a star rating of 4 or higher based on the 2015 ratings compared with 53 percent for the same set of enrollees if the 2014 star ratings had been used. For plans rated in both 2014 and 2015, even with the improvement in a number of measures included in the star ratings, there was virtually no difference between the 2014 enrollment-weighted average star ratings (3.88) and the 2015 ratings (3.91), which reflects shifts in star ratings and the decline in 4.5-star plan enrollment in particular (Table 13-8). Between 2013 and 2014, the comparable change was a 12 percent increase in the weighted average star ratings (3.41 vs. 3.81, using year 2013 enrollment; data not in table).

Only a subset of HEDIS measures is included in determining a plan’s overall star rating. For HEDIS measures included in the star ratings, the majority improved—10 of 19 for HMOs and 10 of 13 for local PPOs (Table 13-9, p. 336). These data suggest that plans may be giving special attention to measures in the star ratings and that HEDIS mental health measures, which

**TABLE
13-9**

The majority of HEDIS® measures with improved results are measures used in the star rating system

Major measure categories	Total measures tracked	Number used in star ratings	Weighting in star ratings	Across all measures in category, number improved		Of measures improving, number in star ratings		Measures that declined		For measures declining number in star ratings
				HMO	Local PPO	HMO	Local PPO	HMO	Local PPO	
HEDIS measure categories										
Process	32	8	10%	10	3	4	3	5	5	0
Intermediate outcome	7	3	11	3	4	2	3	0	0	0
SNP-only measures	5	3	4	5	5	3	3	0	0	0
Readmission rates	1	1	4	1	1	1	1	0	0	0
HEDIS subtotals	45	15	29	19	13	10	10	5	5	0
CAHPS®-MA										
Patient experience	6	6	13	0	0	0	0	1	1	1
HOS										
Health status changes	2	2	8	2	2	2	2	0	0	0
Other										
Part D clinical measures	4	4	32	4	3	4	3	0	0	0
Health plan improvement	1	1	6	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Drug plan improvement	1	1	6	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Note: HEDIS® (Healthcare Effectiveness Data and Information Set®), PPO (preferred provider organization), SNP (special needs plan), CAHPS®-MA (Consumer Assessment of Healthcare Providers and Systems® for MA), HOS (Health Outcomes Survey), N/A (not applicable). Measures included comprise 94 percent of the weight of measures used in the star rating system. Data exclude cost-reimbursed HMO plans and measures that cannot be compared between the two years because of changes in the measure specification.

Source: MedPAC analysis of CMS HEDIS public use files and star ratings data.

have been declining for several years, should be added to the star rating system as a means of focusing on plan performance on those measures. (However, one issue with the current mental health measures reported in HEDIS is that many plans are unable to report results for some of the measures because of the small number of beneficiaries to whom the measures apply. For example, 30 percent of plans (representing 5 percent of MA enrollment) did not report a result for the measures of follow-up care after hospitalization for a mental illness.)

Moving enrollees to bonus plans

With regard to changes in star ratings, CMS has permitted plans to move enrollees from a contract with a low star rating to a contract with a higher star rating by “cross-walking” members from one contract to another. At the end of 2013, 11 contracts were terminated and their

156,000 enrollees cross-walked to a new contract. Of that number, 122,000 enrollees in 8 contracts (all with the same parent organization) were moved from a contract with a rating below 4 stars to one with 4 or more stars, resulting in additional program expenditures through bonus payments to plans for the 122,000 enrollees who had not been enrolled in bonus-level plans previously. Cross-walking also occurred at the end of 2014, involving 3 companies and 387,000 beneficiaries. In a similar vein, CMS informed plans at risk of termination because of three continuous years of low-star performance that “organizations and sponsors could explore whether it is allowable to consolidate membership currently enrolled in plans offered under low-performing contracts into other plans that will be offered during 2015 in the same service area under a different contract rated at three stars or better” (Centers for Medicare & Medicaid Services 2014b). At the

end of 2014, a total of 84,000 enrollees were moved from plans that were at risk of termination to other plans.

Variation in star ratings by plan type; the performance of dual-eligible SNPs

As noted in CMS's 2015 star ratings fact sheet, plans with the highest star ratings have certain characteristics (Centers for Medicare & Medicaid Services 2014a). Higher rated plans have been in the MA program longer and are more likely to be nonprofit. Our analysis also shows that plans with a high proportion of enrollees who are in an employer-sponsored plan have higher average star ratings. Plan star ratings also vary by plan type, with HMOs (at 3.97 in 2015) having higher enrollment-weighted star ratings than local PPOs (3.88), PFFS plans (3.76), and regional PPOs (3.53).

Contracts whose majority of enrollment is beneficiaries who are Medicare–Medicaid dually eligible beneficiaries have low star ratings. Across all plans, 59 percent of enrollees in plans with a 2015 star rating are in plans that have bonus-level star rating (4 stars or above); however, the corresponding figure among contracts that primarily serve dually eligible beneficiaries is 14 percent (for contracts with 50 percent or more dual-eligible special needs plan (D–SNP) enrollment). Excluding these majority D–SNP contracts, 63 percent of enrollees are in bonus-level plans. Some D–SNPs and their representatives argue that this wide difference between the two categories is due to the special characteristics of the population served by D–SNPs.

To examine whether the design of the star rating system is biased against D–SNPs and plans serving a high proportion of low-income beneficiaries, CMS issued a request for information in September 2014, inviting interested parties to submit data analyses that could illuminate the causes of the difference in star ratings between these and other plans. While acknowledging an association between D–SNP status and low star ratings, CMS asked plans to demonstrate causality or, alternately, to show “that high quality performance in MA or Part D plans can be achieved in plans serving dual eligible beneficiaries and how that performance level is obtained” (Centers for Medicare & Medicaid Services 2014c).

In past work, the Commission has noted that not all D–SNP plans perform poorly in the star rating system. In the 2015 star ratings, as in earlier years, some contracts with 4-star or 4.5-star ratings have enrollment consisting exclusively of dual-eligible beneficiaries. CMS has used a similar

TABLE 13-10 Average overall 2014 star ratings by level of enrollment of beneficiaries under age 65 and D–SNP status in 2012

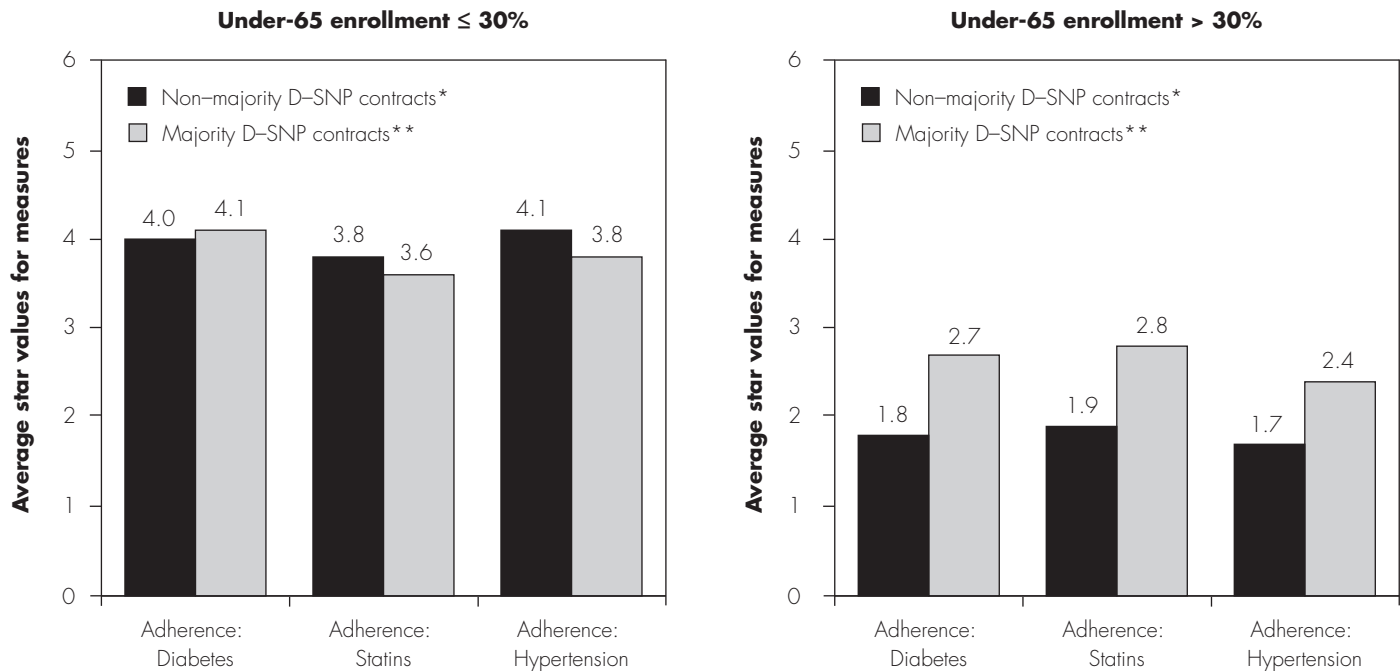
Type of contract	Average overall star rating
Non-majority D–SNPs*	
With under-65 enrollment ≤ 30%	3.74
With under-65 enrollment > 30%	2.94
Majority D–SNPs**	
With under-65 enrollment ≤ 30%	3.52
With under-65 enrollment > 30%	3.16

Note: D–SNP (dual-eligible special needs plan). Data exclude cost-reimbursed HMO plans, which are not eligible for bonuses, and plans in Puerto Rico, which have very low star ratings. Star ratings released in the fall of 2013 are used, reflecting care rendered in 2012. Plan demographic data are as of December 2012. Non-majority D–SNPs with under-65 enrollment ≤ 30% number of contracts $n = 337$; non-majority D–SNPs with under-65 enrollment > 30% $n = 18$; majority D–SNPs with under-65 enrollment ≤ 30% $n = 19$; and majority D–SNPs with under-65 enrollment > 30% $n = 39$.
 * Non-majority D–SNPs have less than 50 percent D–SNP enrollment in contract.
 **Majority D–SNPs have 50 percent or more D–SNP enrollment in contract.

Source: MedPAC analysis of CMS star data, plan reports, and demographic data from the denominator file.

argument—the existence of high-performing D–SNPs—to conclude that the star rating system does not have a systematic bias against D–SNPs. However, in discussions with Commission staff, a plan representative from one of the high-performing D–SNP plans pointed out that part of the reason for the better performance among some D–SNPs is that they serve only beneficiaries age 65 or over (which CMS has permitted in certain circumstances).

Our analysis confirms that in addition to the association between D–SNP status and low star ratings (an association others have documented for a variety of measures, for example, Weiss and Pescatello (2014)), there is also an association between low star ratings and the proportion of enrollment in a plan that consists of beneficiaries under age 65 (beneficiaries entitled to Medicare on the basis of disability or end-stage renal disease). This association is also true for other plan types, with D–SNPs outperforming non-D–SNPs in average star ratings for contracts whose enrollment is at least 30 percent beneficiaries under age 65. Both D–SNPs and non-D–SNPs that serve a large proportion of beneficiaries under 65 have star ratings below the ratings of other plans, but the D–SNPs in the group outperform the non-D–SNPs (Table 13-10).

**FIGURE
13-3****Average 2014 stars for Part D adherence measures, by level of
2012 enrollment of those under age 65 and by majority D-SNP status**

Note: D-SNP (dual-eligible special needs plan). Data exclude cost-reimbursed HMO plans, which are not eligible for bonuses, and Puerto Rico plans, which have very low star ratings. Star ratings released in the fall of 2013 are used, reflecting care rendered in 2012. Plan demographic data are as of December 2012.

* Non-majority D-SNPs have less than 50 percent D-SNP enrollment in contract.

**Majority D-SNPs have 50 percent or more D-SNP enrollment in contract.

Source: MedPAC analysis of CMS star data, plan reports, and demographic data from the denominator file.

In the 2015 star ratings, of the 64 contracts whose enrollment of beneficiaries under age 65 was more than 30 percent as of December 2012, there are no contracts with a star rating higher than 3.5. One contract with a high share of under-65 enrollment that had 4-star status in the 2014 ratings left the MA program at the end of 2014; another has a star rating of 3.5 for 2015. Both the contracts were 100 percent D-SNP plans. The plan whose overall star rating declined registered declines in several measures, including Part D drug adherence measures.

D-SNP plans have difficulty achieving good results on the Part D drug adherence measures (three of the Part D clinical measures, which are heavily weighted in the star system) (Table 13-9, p. 336). Across all plans, under-65 status is a major factor in plan performance on these measures (Figure 13-3).

Compared with the variation in adherence measures, plan types vary less in outcome measures linked to

levels of adherence. In Table 13-11, two adherence measures and their corresponding outcomes illustrate that adherence measures are not highly correlated with intermediate outcome measures, but the adherence measures have a higher correlation with each other as shown by a correlation coefficient closer to 1.0 (the same is true for the statin-adherence and cholesterol-control measures, which are not included in the table). There is also less variation across plans in the stars associated with outcome measures. While the data show parallel results for the four plan-enrollment categories on the two adherence measures, the data show a different pattern of variation in the intermediate outcome measures, with smaller differences in the star ratings across plans and no systematic relationship between adherence and outcomes. These patterns suggest that any bias affecting D-SNPs in the star system could be limited to only certain measures within the star system—such as the adherence measures—and that the measures themselves (and their weighting) should be examined.

**TABLE
13-11****Number of stars for adherence measures and corresponding outcome measures, and their correlation, 2012**

Plan category by enrollment distribution	Control of blood pressure			Control of blood sugar among diabetics			Correlation between the two adherence measures
	Average number of stars			Average number of stars			
	Medication adherence measure	Outcome measure	Correlation coefficient	Medication adherence measure	Outcome measure	Correlation coefficient	
Non-majority D-SNPs*							
With under-65 enrollment ≤ 30%	4.08	3.55	0.44	4.02	3.50	0.36	0.85
With under-65 enrollment > 30%	1.72	3.06	0.19	1.83	2.83	0.30	0.71
Majority D-SNPs**							
With under-65 enrollment ≤ 30%	3.79	3.74	0.26	4.05	3.05	0.08	0.81
With under-65 enrollment > 30%	2.44	3.36	0.14	2.67	2.69	0.17	0.85

Note: D-SNP (dual-eligible special needs plan). Data exclude cost-reimbursed HMO plans, which are not eligible for bonuses, and plans in Puerto Rico, which have very low star ratings. Star ratings released in the fall of 2013 are used, reflecting care rendered in 2012. Plan demographic data are as of December 2012.

*Non-majority D-SNPs have less than 50 percent D-SNP enrollment in contract.

**Majority D-SNPs have 50 percent or more D-SNP enrollment in contract.

Source: MedPAC analysis of CMS star data, plan reports, and demographic data from the denominator file.

Perspective on MA quality

Broadly, over the past year, many MA quality measures have improved, a few have declined, and a large number have remained stable. The subset of measures included in the star rating system have generally improved, though average star ratings have remained virtually unchanged, in part because of changes in the thresholds for achieving a high star rating. It may be advisable to include in the star system those measures that have declined over the last several years—which are the few mental health measures that plans report.

CMS is examining whether there is a systematic bias in the star rating system that disadvantages plans specializing in caring for dual-eligible beneficiaries. While the discussion to date has focused on D-SNPs, we find poorer performance in the star ratings among plans that serve a large share of beneficiaries who are under age 65. For this age group, we find lower star ratings among both D-SNP and non-D-SNP plans, but relatively better performance among D-SNPs.

The text box (pp. 340–341) reiterates the Commission’s two most recent MA recommendations for the MA program. ■

The Commission reiterates its March 2014 recommendations on Medicare Advantage

The Commission reiterates two recommendations it has recently made to improve the bidding rules in the Medicare Advantage (MA) program and to integrate hospice care into the MA benefit package. The effects on spending were estimated at the time the Commission made these recommendations (and we believe the magnitude and the direction of these effects have not substantially changed in the last year).

Recommendation 13-1, March 2014 report

The Congress should direct the Secretary to determine payments for employer group Medicare Advantage plans in a manner more consistent with the determination of payments for comparable nonemployer plans.

The implementation of this recommendation could use the national average bid-to-benchmark ratio for nonemployer plans and apply that ratio to employer group plans. However, alternatives to this approach are also possible.

Implications 13-1 Spending

- We would expect Medicare program spending to decrease. Under the specific option we discussed, spending would decrease between \$250 million and \$750 million over one year and between \$1 billion and \$5 billion over five years.

Plans

- Most employer group plans would be paid less by Medicare because of the lowering of Medicare subsidies. In response, plans could charge

employers more, offer fewer supplemental benefits, make lower profits, or lower their costs.

Beneficiaries

- Some employer group plan enrollees might choose plans in the nonemployer market or move to FFS Medicare if employers dropped plans or increased charges to plan enrollees.

Recommendation 13-2, March 2014 report

The Congress should include the Medicare hospice benefit in the Medicare Advantage benefits package beginning in 2016.

The carve-out of hospice from MA fragments financial responsibility and accountability for care for MA enrollees who elect hospice. Including hospice in the MA benefits package would give plans responsibility for the full continuum of care, which would promote integrated, coordinated care, consistent with the goals of the MA program. With the inclusion of hospice in the MA benefits package, plans would have greater incentive to use the flexibility inherent in the MA program to develop and test innovative programs designed to improve end-of-life care and to improve care for patients with advanced illnesses more broadly. In addition, giving MA plans responsibility for hospice would be a step toward synchronizing accountability for hospice across Medicare platforms (MA, accountable care organizations (ACOs), and fee-for-service (FFS) Medicare). Because the Commission believes it is important to include hospice in the MA benefits package as soon as possible, we have recommended this change be made by 2016. We

(continued next page)

The Commission reiterates its March 2014 recommendations on Medicare Advantage (cont.)

recognize that implementing this change, if it were enacted by the Congress, would require actions by CMS (to recalculate capitation rates and risk scores) and by plans and providers (to negotiate contracts), but we believe this change could be accomplished by 2016 under a tight time line.

Implications 13-2

Spending

- The effect on Medicare program spending is expected to be negligible, with the policy potentially resulting in a small cost or small savings. The estimated one-year and five-year effects on Medicare program spending fall into our smallest budget categories: cost or savings of less than \$50 million over one year and less than \$1 billion over five years.

Beneficiaries and providers

- MA enrollees could benefit from a more integrated, coordinated MA benefits package. Some plans may choose to provide concurrent hospice and conventional care or offer other supplemental benefits designed to improve care for patients with advanced illnesses, which could expand options available to beneficiaries. We would not expect an adverse impact on beneficiaries' access to hospice care. As with other types of Medicare services, beneficiaries might be required to obtain services from a network provider, so they might have fewer hospice providers to choose from than they do under FFS Medicare. MA plans would have the option to charge nominal beneficiary cost sharing for hospice services, whereas under FFS Medicare, there is no cost sharing (with minor exceptions).

If the experience with home health is any guide, MA plans may be unlikely to charge hospice cost sharing. Few MA plans require cost sharing for home health services from network providers.

MA plans would be better positioned to manage and coordinate care for patients with advanced illnesses. If including hospice in MA led some plans to experiment with concurrent care or other approaches that seek to improve care for patients with advanced illnesses, hospice providers could have opportunities to participate in new models of care. Plans and hospices currently engage in private contracting for commercially insured individuals and incur administrative costs associated with that contracting. If hospice were included in MA, the breadth of those contracting activities would increase and plans and hospice providers would incur additional administrative costs associated with them.

Quality

- Including hospice in MA would reduce fragmentation of coverage, which would promote integrated, coordinated care. Furthermore, broadening MA plans' bundle of services to include the full continuum of end-of-life care could incentivize plans to focus more on efforts to improve quality and satisfaction with this care.

Delivery system reform

- Hospice is an area in which Medicare policy differs across delivery systems. Including hospice in MA would be a step toward synchronizing policies across the Medicare system (MA, ACOs, and FFS). ■

Endnotes

- 1 Cost plans are technically not MA plans. They do not submit bids but are paid their reasonable costs under provisions of section 1876 of the Social Security Act.
- 2 If a policy were to force plans to bid their costs for each county separately, then in many instances, bids for distinct counties would be different from those we observe in the data.
- 3 Star ratings are released to coincide with the October–December annual election period. The star ratings released in October 2014 are referred to as the 2015 star ratings (for enrollments effective in 2015). However, the level of any bonus payments and rebate percentages for each year are determined as part of the bidding process. For the 2015 contract year, bids submitted in June of 2014 used 2014 star ratings, released in October 2013, to determine bonus levels for the 2015 benefit packages. Thus, beneficiaries will be using more current (2015) quality ratings to see differences in quality across plans, but the variation in benefit packages that is due to star ratings and their effect on rebate dollars is based on an earlier period’s star ratings (2014 star ratings).

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CHAPTER

14

Status report on Part D

Status report on Part D

Chapter summary

Each year the Commission provides a status report on the Medicare prescription drug benefit (Part D) that describes enrollment levels, plan benefit designs, access to prescription drugs, and the quality of Part D services. The report also analyzes changes in plan bids, premiums, and program costs.

In 2013, Medicare spent almost \$65 billion for the Part D benefit, accounting for more than 12 percent of total Medicare outlays. In 2014, more than 37 million Medicare beneficiaries were enrolled in Part D: About 62 percent were in stand-alone prescription drug plans (PDPs) and the rest were in Medicare Advantage–Prescription Drug plans (MA–PDs). Monthly premiums averaged about \$29 across all plans, but individually, the premium beneficiaries paid varied by their plan, level of income and assets, and whether they were subject to Part D’s late enrollment penalty.

Medicare beneficiaries’ drug coverage in 2014 and benefit offerings for 2015—In 2014, about 69 percent of all Medicare beneficiaries were enrolled in Part D plans, and of those, more than 11 million received the low-income subsidy (LIS). An additional 5 percent received drug coverage through employer-sponsored plans that receive Medicare’s retiree drug subsidy, and about 14 percent received coverage that is at least as generous as Part D from other sources. As of 2012, 12 percent of beneficiaries had no drug coverage or

In this chapter

- Enrollment, plan choices in 2014, and benefit offerings for 2015
- Market structure and strategies of plan sponsors for controlling growth in premiums
- Drug pricing
- Program spending
- Beneficiaries’ access to prescription drugs
- Quality in Part D

coverage less generous than Part D. Our previous analysis showed that beneficiaries with no creditable coverage tended to be healthier, on average.

In 2015, plan sponsors are offering 1,001 PDPs and 1,608 MA-PDs, a 14 percent decrease in the number of PDPs offered compared with 2014, while the number of MA-PDs remained stable. PDP reductions appear to reflect sponsors consolidating their plan offerings into fewer, more widely differentiated products. Even with these consolidations, beneficiaries have between 24 and 33 PDPs to choose from, depending on where they live, as well as many MA-PDs. MA-PDs continue to be more likely than PDPs to offer enhanced benefits, but a smaller share is offering gap coverage (beyond what is required by the Patient Protection and Affordable Care Act of 2010) compared with previous years. For 2015, 283 premium-free PDPs are available to enrollees who receive the LIS, a 20 percent decline from 2014. Despite this decrease, all regions of the country have at least 4 and as many as 12 PDPs available at no premium to LIS enrollees.

An increasing number of plans use two cost-sharing tiers for generic drugs: a preferred one with lower cost sharing and a nonpreferred one that, in some cases, comes with substantially higher cost sharing. In addition, more plans use tiered pharmacy networks that include preferred pharmacies, for which plans have lower cost-sharing requirements. In 2015, nearly 90 percent of PDPs offer lower cost sharing at preferred pharmacies. Both of these strategies provide financial incentives for enrollees to use lower cost drugs or providers, potentially reducing program costs for basic benefits. However, a risk is that these approaches could increase Medicare's spending for the LIS or affect access to needed medications for some beneficiaries.

Part D program spending and bids—Between 2007 and 2013, Part D spending increased from \$46.7 billion to \$64.9 billion (an average annual growth rate of about 6.7 percent). In 2013, LIS payments continued to be the single largest component of Part D spending, while Medicare's reinsurance payments to plans remained the fastest growing component, at an average annual rate of about 16 percent between 2007 and 2013. Program spending for Part D reflects two underlying trends. First, an unusually large number of patent expirations on widely used brand-name drugs has led to a dramatic shift toward use of generics in Part D, with generic drugs accounting for 81 percent of all prescriptions filled in 2012 compared with 77 percent and 61 percent in 2011 and 2007, respectively. This increased use of generics is one reason that average drug spending per enrollee decreased between 2011 and 2012 by 1.5 percent. At the same time, however, the pharmaceutical pipeline is shifting toward greater numbers of biologic products and specialty drugs, many of which have few therapeutic substitutes and high prices.

In 2012, the share of enrollees who incurred spending high enough to reach the catastrophic phase of Part D's benefit decreased slightly. However, the share of high-cost enrollees who filled prescriptions for biologic products rose. The use of high-priced drugs by Part D enrollees will likely grow and put significant upward pressure on Medicare spending for individual reinsurance and for the LIS.

Access to prescription drugs—Most Part D enrollees appear to have good access to prescription drugs: In 2012, 5 percent reported having trouble obtaining needed medications. While a plan's formulary or utilization management tools can provide measures of beneficiaries' access to prescription drugs, a well-functioning exceptions and appeals process is also crucial. Data show that the number of drug claims that are rejected at the pharmacy counter is relatively low (4 percent), and claims that subsequently go through Part D's exceptions and appeals process is lower still. At the same time, CMS has conducted audits that have found some compliance issues with formulary administration, claims adjudication, and appeals. We are unable to determine whether low rates of claims rejections and appeals are cause for concern. In some cases, claims are rejected for valid reasons, such as ensuring patient safety. Yet a low appeals rate could reflect a lack of transparency in the appeals process or excessive administrative burden on enrollees and prescribers. In some cases, beneficiaries may find alternative medications or ways to obtain needed medicines outside of the exceptions and appeals process, such as by using physician samples.

Quality in Part D—The average star rating among Part D plans has increased, particularly among MA-PDs. For 2015, the share of enrollees in high-performing plans (rated 4 stars or more out of the possible 5 stars) is expected to increase to more than 50 percent among PDP enrollees and to about 60 percent among MA-PD enrollees. Newly released data on Part D's medication therapy management programs (MTMPs) show that, in 2012, 3.1 million enrollees (about 11 percent of Part D enrollees) participated in an MTMP. Participation rates varied across plans. Although receiving a comprehensive medication review (CMR) may result in improved quality of care provided under the Part D program, only about 10 percent of MTMP enrollees received a CMR. ■

**TABLE
14-1****Parameters of the defined standard benefit increase over time**

	2006	2014	2015	Average annual percentage change 2006–2015
Deductible	\$250.00	\$310.00	\$320.00	2.8%
Initial coverage limit	2,250.00	2,850.00	2,960.00	3.1
Annual out-of-pocket spending threshold	3,600.00	4,550.00	4,700.00	3.0
Estimated total covered drug spending at annual out-of-pocket threshold	5,100.00	6,690.77*	7,061.76*	3.0
Minimum cost sharing above annual out-of-pocket threshold:				
Copay for generic/preferred multisource drugs	2.00	2.55	2.65	3.2
Copay for other prescription drugs	5.00	6.35	6.60	3.1

Note: *Total covered drug spending at annual out-of-pocket threshold depends on each enrollee's mix of brand and generic drugs filled during the coverage gap. The amounts for 2014 and 2015 are for an individual who is not receiving Part D's low-income subsidy and has no other supplemental coverage.

Source: CMS, Office of the Actuary.

Background

In 2013, Medicare spent almost \$65 billion on the Part D prescription drug program, accounting for more than 12 percent of total Medicare outlays (Boards of Trustees 2014). In 2014, more than 37 million Medicare beneficiaries were enrolled in Part D. Policy goals for the Part D program are to provide enrollees with good access to needed medications and to do so in a way that is financially sustainable into the future. Each year since 2006, the Commission provides a status report on Part D and makes recommendations as necessary. To monitor the degree to which the program is achieving policy goals, we examine several performance indicators: enrollment patterns, plan benefit offerings for 2015, market structure, drug pricing, program costs, beneficiaries' access to prescription drugs, and quality of services.

Part D's approach

Medicare's payment system for Part D is very different from its fee-for-service payment systems for Part A and Part B services. For Part D, Medicare pays competing private plans to deliver prescription drug benefits to enrollees. Instead of setting prices administratively, Medicare's payments to plans are based on bids submitted by plan sponsors. Part D pays for prescription drug benefits whether beneficiaries use traditional Medicare and enroll in stand-alone prescription drug

plans (PDPs) or they enroll in Medicare Advantage plans with drug coverage (Medicare Advantage–Prescription Drug plans (MA–PDs)).

The design of the program is intended to give plan sponsors incentives to offer beneficiaries attractive prescription drug coverage while controlling growth in drug spending. Policymakers envisioned that plans would compete for enrollees based on their premiums, benefit structure (e.g., deductible amount), formularies, quality of services, and networks of pharmacies. The idea was that competition among plans that bear insurance risk would provide strong incentives for plan sponsors to manage drug use and keep spending in check.

The drug benefit

Medicare defines a standard Part D benefit structure with parameters that change at the same rate as the annual change in beneficiaries' average drug expenses (Table 14-1). For 2015, the defined standard benefit includes a \$320 deductible and 25 percent coinsurance until the enrollee reaches \$2,960 in total covered drug spending. Enrollees whose spending exceeds that amount face a coverage gap up to an annual threshold of \$4,700 in out-of-pocket (OOP) spending that excludes cost sharing paid by most sources of supplemental coverage, such as employer-sponsored policies. Above the OOP threshold, enrollees pay the greater of either \$2.65 to \$6.60 per prescription or 5 percent coinsurance.

**TABLE
14-2**

Nearly three-quarters of Medicare enrollees received drug coverage through Part D, 2014

	Beneficiaries	
	In millions	Percent of Medicare enrollment
Medicare enrollment	54.0	100%
Part D enrollment		
Part D plans	37.4	69.3
Plans receiving RDS*	<u>2.6</u>	<u>4.8</u>
Total Part D	40.0	74.2**

Note: RDS (retiree drug subsidy). Part D plan enrollment figures based on enrollment as of March 1, 2014. Totals may not sum due to rounding.
 *Excludes federal government and military retirees covered by either the Federal Employees Health Benefit Program or the TRICARE for Life program.
 **The remaining 25.8 percent of beneficiaries not enrolled in Part D receive drug coverage through other sources (such as the Federal Employees Health Benefits Program, TRICARE for Life, and the Department of Veterans Affairs), had no drug coverage, or had coverage less generous than Part D.

Source: MedPAC based on Table IV.B8 and Table V.B4 of the 2014 annual report of the Boards of Trustees of the Medicare trust funds and monthly Part D enrollment data as of March 1, 2014.

Before 2011, enrollees exceeding the initial coverage limit were responsible for paying the full discounted price of covered drugs (usually without reflecting manufacturers' rebates) up to the annual OOP threshold. Because of changes made by the Patient Protection and Affordable Care Act of 2010 (PPACA), since 2011, non-low-income subsidy beneficiaries face reduced cost sharing for both brand-name and generic drugs filled during the coverage gap (Medicare Payment Advisory Commission 2014b). In 2015, cost sharing for drugs filled during the gap phase is 45 percent for brand-name drugs and 65 percent for generic drugs.¹ An individual with no other source of drug coverage is estimated to reach the \$4,700 limit at \$7,061.76 in total drug expenses.

Plan sponsors can and do offer alternative benefit designs. For example, a plan can offer a deductible lower than \$320, or use tiered copayments rather than coinsurance—provided the alternative benefit meets requirements for actuarial equivalence. Once a plan sponsor offers a plan with basic benefits in a region, it may also offer plans, called enhanced plans, with additional drug coverage that supplements the standard benefit.

Part D includes a low-income subsidy (LIS) that provides assistance with premiums and cost sharing for individuals with low incomes and assets. Individuals who qualify for this subsidy pay zero or nominal cost sharing set by statute. In 2015, most individuals receiving the LIS pay between \$0 and \$2.65 for generic drugs and between \$0 and \$6.60 for brand-name drugs.

Two avenues of competition in Part D

Plan sponsors concentrate much of their attention on premium competition to attract enrollees, since premiums are the most salient feature for consumers (particularly those without the LIS) to compare plan options. Part D plan sponsors submit bids to CMS that represent their revenue requirements (including administrative costs and profit) for delivering the standard benefit to an enrollee of average health. Part D is different from Part C in that Medicare's payments do not involve any comparison with an administratively set benchmark amount. Instead, CMS calculates a nationwide enrollment-weighted average among all the bid submissions.

Plan enrollees must pay a base beneficiary premium (\$33.13 in 2015) plus (or minus) any difference between their plan's bid and the nationwide average bid (Medicare Payment Advisory Commission 2014b). If enrollees choose a plan that is costlier than the average, they pay a higher premium—the full difference between the plan's bid and the nationwide average. If they select a plan that has a lower than average bid, their premium is lower by that difference. If enrollees pick a plan that includes supplemental coverage, they must pay the full price for the additional coverage (i.e., Medicare does not subsidize it). This approach is designed to give plan sponsors the incentive to control their enrollees' drug spending so that they can bid low and keep their premiums attractive. At the same time, sponsors must balance this incentive with beneficiaries' desire to have access to needed medications. A plan with a very limited number of covered drugs might not be attractive to many beneficiaries.

A second avenue of competition involves keeping plan premiums at or below regional benchmarks for the LIS. Part D's bidding process determines the maximum amount that Medicare will pay for premiums on behalf of LIS enrollees. This amount varies across the country's 34 PDP regions. It is based on an average of premiums for plans with basic benefits, weighted by each plan's LIS enrollment in the previous year, and it ensures that at least one stand-alone PDP is available to LIS enrollees at no premium.

This approach to subsidizing LIS enrollees also provides incentives for plan sponsors to control drug spending and bid low. If sponsors do so, they can win or maintain market share without having to incur marketing expenses for LIS enrollees. Each year there is turnover in benchmark plans—those that qualify as premium free. If LIS enrollees are in a plan with a premium above the benchmark and do not choose a plan themselves, Medicare conducts an auto-assignment process: It reassigns these enrollees randomly to a new benchmark plan. Instead of accepting the auto-assignment, LIS enrollees may choose a plan themselves. However, if their selected plan has a premium higher than the benchmark, they must pay the difference between the plan’s premium and the benchmark amount. Once LIS enrollees select a plan themselves, CMS no longer reassigns them to a new plan. Instead, the agency sends letters about premium-free plan options in the enrollee’s region.

Enrollment, plan choices in 2014, and benefit offerings for 2015

In 2014, about three-quarters of Medicare beneficiaries were enrolled in Part D or actuarially equivalent employer drug plans for retirees. Enrollment has shifted somewhat from employers’ retiree drug plans to Part D plans. Less than 2 percent of Part D beneficiaries were in defined standard benefit plans; the rest were in plans that allow for higher copays and deductibles compared with the defined benefit. In 2015, plan sponsors are offering fewer, more widely differentiated PDPs, but beneficiaries continue to have broad choice among Part D plans. The number of MA–PDPs remains stable.

In 2014, about three-quarters of Medicare beneficiaries were in Part D plans or employer plans that got Medicare’s retiree drug subsidy

In 2014, 37 million individuals, about 69 percent of 54 million total Medicare beneficiaries, were enrolled in Part D plans (Table 14-2). An additional 5 percent got drug coverage through employer-sponsored plans that received Medicare’s retiree drug subsidy (RDS) for being the primary provider of coverage.² The remaining 26 percent of Medicare beneficiaries received drug coverage from other sources (such as the Federal Employees Health Benefits Program, TRICARE for Life, and the Department of Veterans Affairs), had no drug coverage,

or had coverage less generous than Part D. An estimate from the 2012 Medicare Current Beneficiary Survey suggests that about 12 percent of beneficiaries had no drug coverage or less generous coverage—a bit higher than the 10 percent reported by CMS during the first few years of Part D. Beneficiaries who do not enroll in Part D tend to be healthier and have lower drug spending (Medicare Payment Advisory Commission 2013).

In recent years, enrollment has shifted noticeably into Part D plans from employer plans that had previously received the RDS (Figure 14-1, p. 354). This shift was probably motivated by changes made by PPACA that increased the generosity of Part D coverage by, over time, eliminating the coverage gap and by altering the tax treatment of drug expenses covered by the RDS. In 2013, about 6 million individuals were in Part D plans operated for employers and their retirees (employer group waiver plans, or EGWPs), with about 2.3 million individuals shifting away from the plans that received the RDS in the previous year.

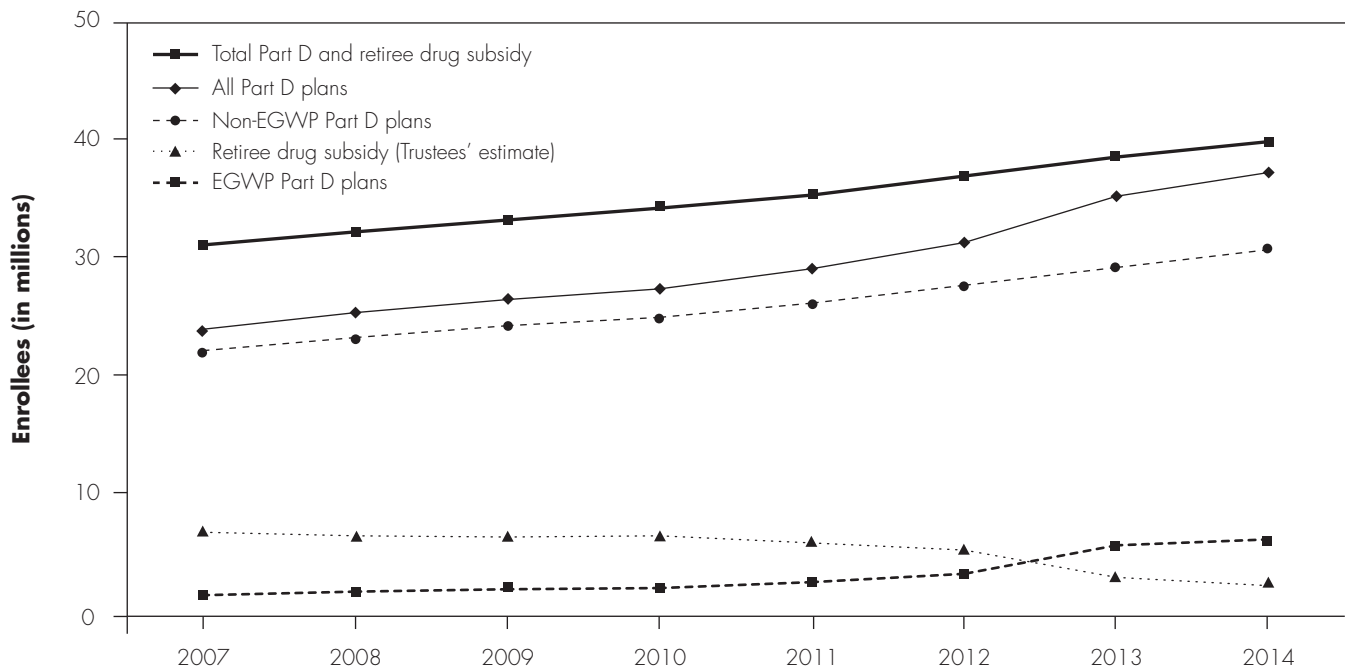
Overall, between 2007 and 2014, the share of Medicare beneficiaries enrolled in Part D plans grew from about 54 percent to 69 percent, or an average of 6 percent annually (Table 14-3, p. 353). Enrollment in MA–PDPs grew more rapidly (10 percent per year, on average) than in PDPs (5 percent annually). In 2014, 38 percent of Part D enrollees were in MA–PDPs compared with 30 percent in 2007.

In 2014, slightly more than 11 million beneficiaries (30 percent of Part D plan enrollees) received the LIS (Table 14-3, p. 355). Of these individuals, about 7 million were dually eligible for Medicare and Medicaid. Another 4 million qualified for the LIS either because they received benefits through the Medicare Savings Programs or the Supplemental Security Income program or because they were eligible after they applied directly to the Social Security Administration. Between 2007 and 2014, the number of Part D enrollees who receive the LIS grew more slowly (3 percent per year) than non-LIS enrollees (8 percent per year). Faster enrollment growth among non-LIS enrollees is partly attributable to the recent growth in EGWPs that shifted beneficiaries into Part D plans from employer plans that had previously received the RDS. Consequently, the share that received the LIS fell from 39 percent to 30 percent; however, spending on behalf of LIS enrollees accounts for about two-thirds of Part D program spending.

More than 70 percent (8.3 million) of LIS enrollees were in PDPs; the rest were in MA–PDPs (data not shown).

**FIGURE
14-1**

Enrollment in Part D plans has increased over time, with fewer employers receiving Medicare's retiree drug subsidy



Note: EGWP (employer group waiver plan).

Source: MedPAC based on monthly Part D enrollment data and Table IV.B8 of the 2014 annual report of the Boards of Trustees of the Medicare trust funds.

Because most LIS enrollees are in traditional Medicare, CMS's process randomly assigns LIS enrollees who have not chosen a plan to benchmark PDPs rather than MA-PDs. However, in recent years, LIS enrollment in MA-PDs has grown because some individuals have selected these plans or joined them through the Medicare-Medicaid financial alignment initiative.

Beneficiaries' enrollment decisions in 2014

Most Part D enrollees are in plans that differ from Part D's defined standard benefit; these plans are actuarially equivalent to the standard benefit or are enhanced in some way. Actuarially equivalent plans have the same average benefit value as defined standard plans but a different benefit structure. For example, a plan may use tiered copayments (e.g., charging \$5 per generic drug and \$50 for a brand-name drug) that can be higher or lower for a given drug compared with the 25 percent coinsurance under the defined standard benefit. Alternatively, instead of having a deductible, a plan may use a cost-sharing rate higher than 25 percent. Once a PDP sponsor offers one plan with basic benefits in a region, it may also offer

up to two plans with enhanced benefits by including, for example, lower cost sharing, coverage for drugs filled during the gap (beyond what is required by PPACA), or an expanded drug formulary that includes non-Part D drugs.

In 2014, 55 percent of PDP enrollees had basic coverage that was actuarially equivalent to the defined standard benefit, most with tiered copayments (Table 14-4). Another 43 percent of PDP enrollees had enhanced benefits—the typical enhancement being a lower deductible rather than benefits in the coverage gap. Just 2 percent of enrollees were in defined standard benefit plans. MA-PD enrollees were predominantly in enhanced plans with no deductible. Enrollees in PDPs were more likely to have a deductible in their plans' benefit design than enrollees in MA-PDs, which reflects the ability of MA-PDs to use a portion of their Part C payments to supplement their Part D drug benefits or to lower Part D premiums.³

Many MA-PDs also use some of their Part C rebate dollars to provide additional Part D benefits in the

**TABLE
14-3****Part D plan enrollment trends, 2007-2014**

	2007	2008	2010	2012	2014	Average annual growth rate 2007-2014
Total Part D enrollment (in millions)	24.2	25.6	27.6	31.5	37.4	6%
Percent of Medicare beneficiaries	54%	56%	58%	60%	69%	
Enrollment by type (in millions)						
PDP	16.9	17.3	17.6	19.8	23.4	5
MA-PD	7.2	8.3	10.0	11.7	14.1	10
Percent in MA-PD	30%	32%	36%	37%	38%	
Enrollment by LIS status (in millions)						
LIS	9.4	9.6	9.9	10.8	11.4	3
Non-LIS	14.8	16.0	17.7	20.7	26.0	8
Percent receiving the LIS	39%	38%	36%	34%	30%	

Note: PDP (prescription drug plan), MA-PD (Medicare Advantage-Prescription Drug [plan]), LIS (low-income subsidy). Figures based on enrollment as of April 1 of each year with the exception of 2007 (enrollment as of July 1, 2007) and 2008 (enrollment as of May 1, 2008). Totals may not sum due to rounding.

Source: MedPAC based on Table IV.B8 and Table V.B4 of the 2014 annual report of the Boards of Trustees of the Medicare trust funds and monthly Part D enrollment data.

coverage gap (Figure 14-2, p. 356). In 2014, only 12 percent of PDP enrollees (about 2.2 million beneficiaries) were in plans that offered benefits in the coverage gap beyond what is required by PPACA. However, 35 percent of PDP enrollees received the LIS, which effectively

eliminates their coverage gap (data not shown). By comparison, 51 percent of MA-PD enrollees (about 5.1 million beneficiaries) were in plans offering some gap coverage.

**TABLE
14-4****MA-PD enrollees more likely to be in enhanced plans with no deductible, 2014**

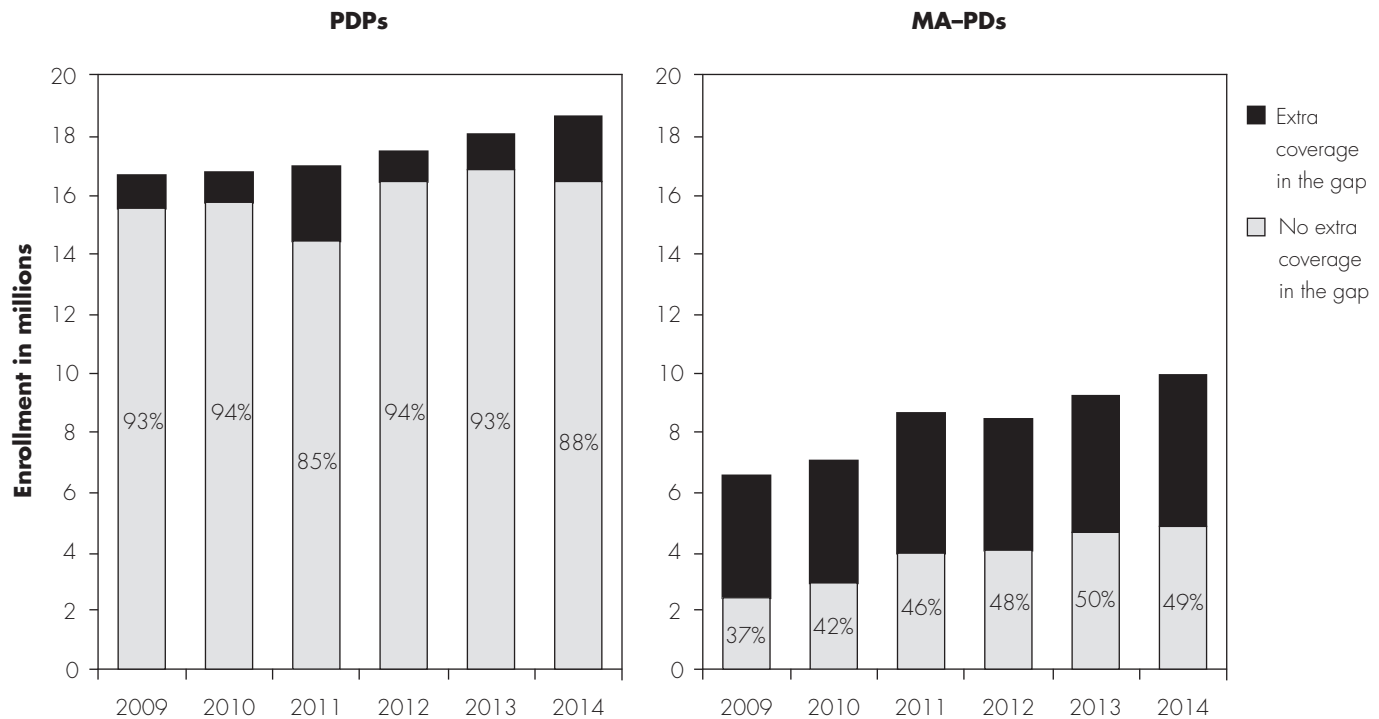
	PDP		MA-PD	
	Number (in millions)	Percent	Number (in millions)	Percent
Total	18.6	100%	9.9	100%
Type of benefit				
Defined standard	0.4	2	0.1	1
Actuarially equivalent*	10.2	55	1.0	10
Enhanced	7.9	43	8.8	89
Type of deductible				
Zero	8.0	43	8.5	86
Reduced	0.7	4	1.1	11
Defined standard**	9.8	53	0.3	3

Note: MA-PD (Medicare Advantage-Prescription Drug [plan]), PDP (prescription drug plan). The MA-PD enrollment described here excludes employer-only plans, plans offered in U.S. territories, 1876 cost plans, special needs plans, demonstrations, and Part B-only plans. Totals may not sum due to rounding.

*Includes actuarially equivalent standard and basic alternative benefits.

**\$310 in 2014.

Source: MedPAC analysis of CMS landscape, plan report, and enrollment data.

**FIGURE
14-2****PDP enrollees are less likely to have extra benefits in the coverage gap**

Note: PDP (prescription drug plan), MA-PD (Medicare Advantage-Prescription Drug [plan]). Figures exclude employer-only plans, plans offered in U.S. territories, 1876 cost plans, special needs plans, demonstrations, and Part B-only plans. Extra coverage in the gap (beyond what is required by the Patient Protection and Affordable Care Act of 2010) is typically restricted to a subset of formulary drugs.

Source: MedPAC analysis of CMS landscape, plan report, and enrollment data.

**TABLE
14-5****Changes in average Part D premiums, 2007-2014**

	Average monthly premium weighted by enrollment (in dollars)						Average annual growth rate 2007-2014
	2007	2010	2011	2012	2013	2014	
All plans (any coverage)	\$23	\$30	\$30	\$30	\$30	\$29	3.3%
PDPs							
Basic coverage	24	34	33	33	32	30	3.0
Enhanced coverage	40	50	63	58	49	49	2.7
Any coverage	27	37	38	38	39	38	4.7
MA-PDs, including SNPs*							
Basic coverage	17	26	27	27	29	25	5.7
Enhanced coverage	9	13	12	12	13	13	6.5
Any coverage	10	14	14	14	15	16	6.1

Note: PDP (prescription drug plan), MA-PD (Medicare Advantage-Prescription Drug [plan]), SNPs (special needs plans). Figures exclude employer-only plans, plans offered in U.S. territories, 1876 cost plans, demonstrations, and Part B-only plans.
 *Reflects the portion of Medicare Advantage plans' total monthly premium attributable to Part D benefits for plans that offer Part D coverage. MA-PD premiums reflect rebate dollars that were used to offset Part D premium costs.

Source: MedPAC analysis of CMS landscape, plan report, and enrollment data.

In 2014, monthly beneficiary premiums averaged about \$29 across all plans (Table 14-5). However, underlying that average is a wide variation, ranging from \$0 for an MA–PD plan to more than \$170 for a PDP offering enhanced coverage (data not shown).⁴ On average, premiums were lower for beneficiaries enrolled in MA–PDs compared with those enrolled in PDPs. Among beneficiaries enrolled in PDPs, individuals in plans that offered enhanced coverage paid, on average, \$19 more per month than those individuals in plans that offered only basic coverage (\$49 vs. \$30). In contrast, beneficiaries enrolled in MA–PDs, on average, paid lower premiums for enhanced coverage than for basic coverage alone (\$13 vs. \$25).

While the average Part D premium (including basic and enhanced coverage) has remained stable over the last few years, average premiums for PDPs and MA–PDs have fluctuated (Table 14-5). For example, average premiums for beneficiaries enrolled in PDPs that offer enhanced coverage experienced large year-to-year fluctuations between 2010 and 2013, ranging from \$49 to \$63.

Two other factors affect the amount of premium paid by a given enrollee. First, higher income beneficiaries pay a larger share of the Part D premium; that is, they have a lower federal subsidy. As with the income-related premium for Part B, the higher Part D premiums apply to individuals with an annual adjusted gross income greater than \$85,000 and to couples with an adjusted gross income greater than \$170,000. A beneficiary whose income exceeds these levels pays an income-related monthly adjustment amount in addition to the Part D premium paid to a plan. In 2014, the adjustment amount ranged from \$12.10 to \$69.30 per month, depending on income. Nearly 1.86 million beneficiaries (about 5 percent of the total Part D enrollment) were subject to the income-related premium in 2014.⁵

Second, individuals enrolling in Part D outside of their initial enrollment period must have proof that they had drug coverage as generous as the standard benefit under Part D (i.e., creditable coverage) to avoid the late enrollment penalty (LEP). The LEP amount depends on the length of time an individual went without creditable prescription drug coverage and is calculated by multiplying 1 percent of the base beneficiary premium by the number of full, uncovered months an individual was eligible but was not enrolled in a prescription drug plan and went without other creditable prescription drug coverage.

Benefit offerings for 2015

Beneficiaries are encouraged to reexamine their plan options from time to time. In addition to changes in plan availability and premiums, most plans make some changes to their benefit offerings—such as deductible amounts and plan formularies—that can directly affect access to and affordability of medications. Here we examine notable changes for the 2015 benefit year.

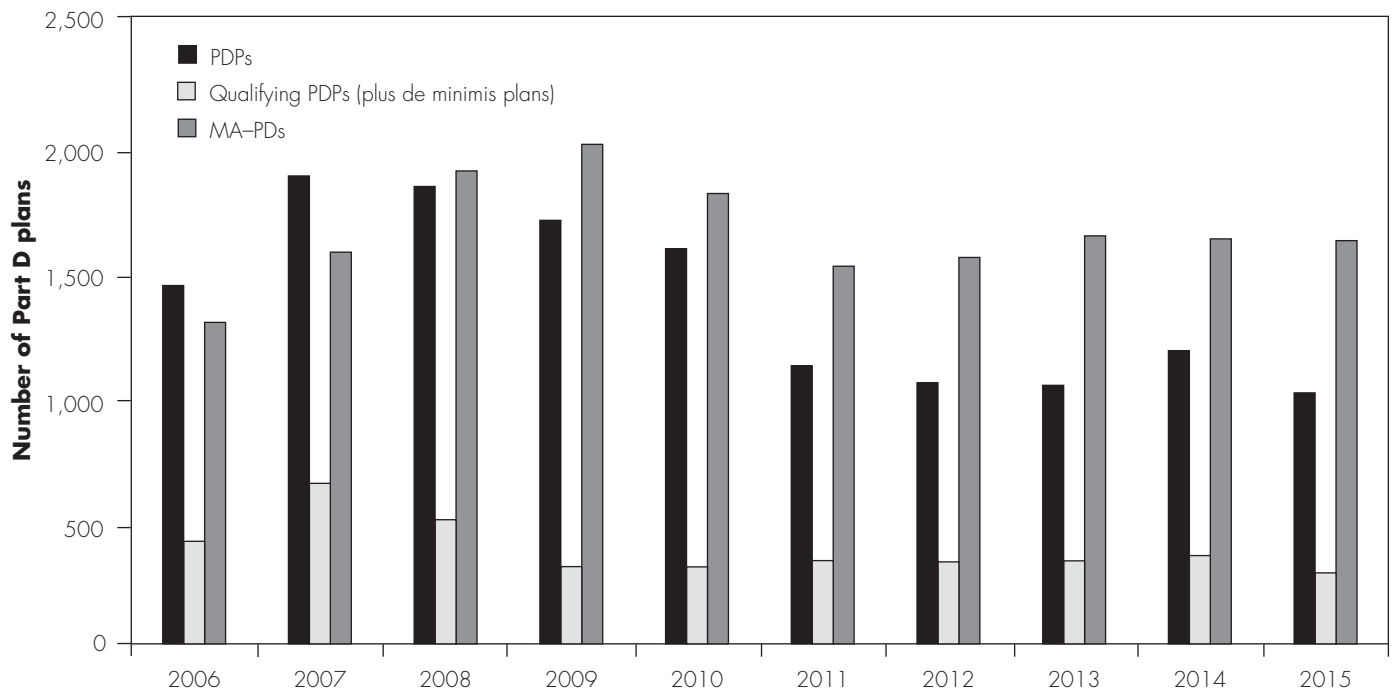
Number of PDPs has declined, but broad choice still available

For 2015, plan sponsors are offering 14 percent fewer PDPs than in 2014, while the number of MA–PDs remains fairly stable (Figure 14-3, p. 358). The decline in PDPs is due largely to consolidation of plans among sponsors that merged with one another or is in response to CMS’s policy intended to differentiate more clearly between basic and enhanced benefit plans and a policy discouraging plans with low enrollment. Most recently, some sponsors may have chosen to reduce their offerings out of concern for rules that were proposed by CMS for 2015—but ultimately were not finalized—that would have limited sponsors to offering no more than two PDPs per region (Centers for Medicare & Medicaid Services 2014f).⁶

Even with fewer PDPs, beneficiaries continue to have a wide variety of choice among plans, ranging from 24 PDP options in Alaska to 33 PDPs in the Illinois region, along with MA–PD options in most areas of the country. The number of MA–PDs available to a beneficiary varies by the county of residence, with a typical county having between 3 and 10 MA–PD plans to choose from. A handful of counties have no MA–PD plans available.

In 2015, the number of qualifying PDPs available to LIS enrollees with no premium declined 20 percent, from 352 in 2014 to 283 (Figure 14-3, p. 358).⁷ Although this decrease is sizable, all regions of the country continue to have a number of premium-free PDPs available, ranging from 4 plans in Florida and Nevada to 12 in Arizona, the Alabama–Tennessee region, and the Idaho–Utah region.

For 2015, about 1.8 million LIS enrollees were affected by the turnover in plans whose premiums no longer fell at or below benchmarks for 2015—potentially subject to reassignment to a benchmark plan by the Medicare program (Hoadley et al. 2014a). However, a sizable share of LIS enrollees (more than 40 percent of total LIS enrollment in recent years) selected a plan that differed from their randomly assigned plan (Hoadley et al. 2014b, Hoadley et al. forthcoming). CMS estimated that for 2015,

**FIGURE
14-3****A wide variety of plans available in 2015, but fewer benchmark PDPs**

Note: PDP (prescription drug plan), MA-PD (Medicare Advantage-Prescription Drug [plan]). "Qualifying PDPs" refers to plans for which low-income subsidy (LIS) enrollees pay no premium because the plans' premiums are at or below a regional premium threshold. "De minimis plans" are plans that CMS permitted to retain their LIS enrollees because the plan premium was within a certain variance of the regional LIS premium threshold. The figures exclude employer-only plans, plans offered in U.S. territories, 1876 cost plans, special needs plans, demonstrations, and Part B-only plans.

Source: CMS landscape and plan report files.

it would need to randomly reassign about 300,000 LIS enrollees to new benchmark plans (e-mail communication from CMS staff, December 10, 2014).

Most MA-PDs offer more generous drug coverage than PDPs, but some MA-PDs have less generous coverage compared with last year

The number of MA-PDs remains fairly stable, and most MA-PD enrollees continue to have more generous coverage than what is typically offered in PDPs—for example, no deductible or some enhanced coverage beyond basic Part D benefits. At the same time, certain MA-PDs are offering less generous coverage than was available in 2014. For example, for 2015, the share of MA-PDs offering enhanced benefits declined to 81 percent compared with 88 percent the year before. From 2014 to 2015, the share of MA-PDs that charge no deductible dropped from 82 percent to 63 percent. Similarly during that time, the share of MA-PDs that

offer no additional coverage in the coverage gap beyond that already called for under PPACA increased from 50 percent of MA-PDs to 56 percent. Note, though, that the increase in the generosity of Part D's basic benefit may be replacing some of the supplemental benefits provided in previous years during the gap phase of the benefit.

The reasons certain MA-PDs are offering less generous coverage are not fully clear. Our analysis of the plan bids suggests that, on average, most MA-PDs continue to allocate about the same amount of Part C rebate dollars for Part D benefits in 2015 as in 2014 (\$26 per enrollee per month, split fairly evenly between basic and enhanced benefits). One possibility is that new plan entrants into the MA-PD market are less generous on average. Another reason may be that the cost of providing Part D benefits rose for MA-PDs, and some plan sponsors chose to scale back the generosity of coverage to a greater extent than they chose to increase their bids. A piece of evidence supporting this hypothesis is that, as a part of their bids,

**TABLE
14-6****Change in premiums for PDPs with the highest 2014 enrollment**

Plan name	Enrollment, 2014 (in millions)	Weighted average monthly premium*		Dollar change	Percentage change
		2014	2015		
AARP MedicareRx Preferred	3.6	\$43.43	\$50.15	\$5.72	15%
SilverScript Choice	2.5	29.47	23.16	-6.33	-21
Humana Preferred	1.7	22.75	26.40	3.65	16
Humana Enhanced	1.3	47.57	52.81	5.24	11
AARP MedicareRx Saver Plus	1.2	23.08	28.00	4.92	21
WellCare Classic	1.1	20.64	31.46	10.82	52
Humana Walmart	0.8	12.60	15.67	3.07	24
CIGNA-HealthSpring Rx Secure	0.8	30.75	31.78	1.03	3
Aetna Medicare Rx Saver	0.5	32.03	24.46	-7.57	-24
First Health Value Plus	0.5	44.50	38.81	-5.69	-13

Note: PDP (prescription drug plan).

*These figures reflect the average of all PDPs offered under the same plan name in each region of the country, weighted by 2014 enrollment.

Source: Hoadley, J., J. Cubanski, E. Hargrave, et al. 2014. *Medicare Part D: A first look at plan offerings in 2015*. Washington, DC: Kaiser Family Foundation. October.

MA-PD plan sponsors projected a large increase in LIS enrollees for 2015—about twice as large as the increase in LIS members projected by PDP sponsors. Even though plan sponsors are supposed to bid on the costs of providing drug benefits to an enrollee of average health, perhaps they anticipated higher costs because of more LIS enrollees.

Greater differentiation among PDP offerings

With the reduction in the number of PDPs, plan sponsors appear to be consolidating offerings into fewer of the more widely differentiated products. Many sponsors appear to be moving closer toward offering one basic plan and one enhanced plan per region. MA-PDs continue to be more likely to include supplemental coverage in their drug benefits. Nevertheless, the share of PDPs with enhanced coverage rose in 2015—55 percent compared with 50 percent in 2014.

For 2015, sponsors continue to use alternatives to Part D's defined standard benefit—the market includes no PDPs with that benefit design, down from 3 percent of PDPs in 2014. In those two years, the share of PDPs that charge the defined standard benefit's deductible amount (\$320 in 2015) also fell, from 49 percent to 44 percent, as did the share of plans that charged no deductible (47 percent compared with 42 percent). Instead, a greater share used a deductible less than \$320.

For 2015, a larger share of PDPs offers additional coverage in the gap—26 percent compared with 21 percent a year earlier. This increase occurred even as the basic Part D benefit became slightly more generous under changes made by PPACA to gradually phase out the coverage gap.⁸

Premiums increased for several PDPs with the highest enrollment

For 2015, monthly premiums for several of the most popular stand-alone PDPs increased, some by substantial percentages. A few popular plans saw premiums decline.

Average premiums for the 10 plans with the highest enrollment ranged from about \$16 per month for Humana Walmart to nearly \$53 per month for Humana Enhanced. Among these 10 PDPs, 3 have premiums that are lower in 2015, ranging from about \$6 to \$8 less per month (Table 14-6). The remaining seven plans saw premiums increase between 2014 and 2015, ranging from about \$1 higher (3 percent) to nearly \$11 higher (52 percent).

Mixed changes in cost-sharing requirements

Cost-sharing requirements in Part D plans have generally been rising over the years. In 2015, changes in cost sharing for the top 10 PDPs across the nation in number

**TABLE
14-7****2015 cost-sharing amounts for stand-alone PDPs with highest 2014 enrollment**

Stand-alone PDPs with the highest 2014 enrollment	Preferred generics		Nonpreferred generics		Preferred brands		Nonpreferred brands		Specialty	
	2014	2015	2014	2015	2014	2015	2014	2015	2014	2015
AARP MedicareRx Preferred	\$3	\$2	\$6	\$5	\$40	\$40	\$85	\$85	33%	33%
SilverScript Choice*	\$2	\$8	N/A	N/A	20%	\$35	35%	45%	25%	33%
Humana Preferred Rx Plan	\$1	\$1	\$2	\$2	20%	20%	35%	35%	25%	25%
Humana Enhanced	\$2	\$3	\$5	\$7	\$42	\$42	\$92	44%	33%	33%
AARP MedicareRx Saver Plus	\$1	\$1	\$2	\$2	\$20	\$20	\$35	\$40	25%	25%
WellCare Classic	\$0	\$0	\$15	\$9	\$40	\$39	\$94	\$89	33%	25%
Humana Walmart	\$1	\$1	\$4	\$4	20%	20%	39%	35%	25%	25%
Cigna-HealthSpring Rx Secure	\$0	\$1	\$3	\$4	\$30	20%	\$65	35%	25%	25%
Aetna Medicare Rx Saver*	\$2	\$0	N/A	\$3	\$43	\$45	\$95	37%	25%	25%
First Health Value Plus	\$3	\$0	\$11	\$3	\$37	\$35	\$88	50%	33%	25%

Note: PDP (prescription drug plan), N/A (not applicable). Enrollment figures are for November 2014 and exclude employer plans and plans offered in U.S. territories. In cases where plans vary cost-sharing amounts across regions, we report unweighted median cost-sharing amounts.

*Indicates just one generic tier in 2014 (Aetna Medicare Rx Saver) or in both 2014 and 2015 (SilverScript Choice).

Source: NORC/Social & Scientific Systems analysis for MedPAC of formularies submitted to CMS.

of enrollees vary from plan to plan. All but one of the 10 PDPs now use a 5-tiered formulary structure, with differential copays between preferred and nonpreferred generic medications (Table 14-7).

Top PDPs offered by UnitedHealth and Humana generally had few changes in cost sharing (Table 14-7). From 2014 to 2015, SilverScript Choice, a basic plan offered by CVS Health that has premiums below regional benchmarks in 32 out of 34 regions, increased generic copays from \$2 to \$8, moved to flat \$35 copays for preferred brand-name drugs, and increased coinsurance rates for nonpreferred brands as well as for therapies on its specialty tier. One of the top plans, WellCare Classic, decreased all cost-sharing requirements for 2015. Other top PDPs had a mixture of cost-sharing increases and decreases.

Several of the top 10 PDPs moved toward using coinsurance for some formulary tiers rather than copayments. For example, Humana Enhanced charges 44 percent coinsurance for nonpreferred brand-name drugs in 2015 rather than a \$92 copayment. Similarly, Cigna-HealthSpring Rx Secure now charges 20 percent and 35 percent coinsurance on preferred and nonpreferred brand-name drugs, respectively, rather than fixed dollar amounts as it did in 2014. First Health Value Plus and Aetna Medicare Rx Saver had similar changes. By charging enrollees a percentage of the cost of their prescriptions

rather than a flat copayment, plan sponsors share some of the risk of price increases for those drugs with beneficiaries.

Market structure and strategies of plan sponsors for controlling growth in premiums

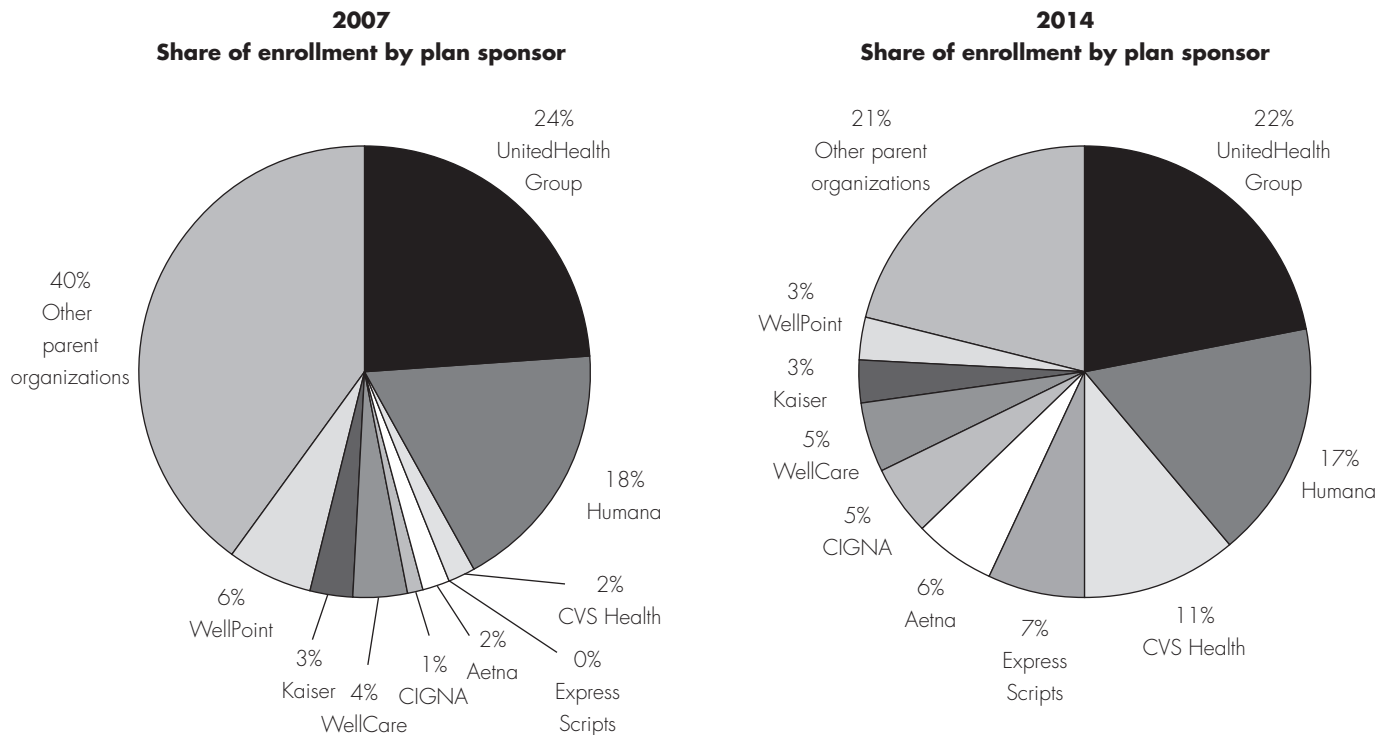
Today, more than 250 organizations participate in Part D as plan sponsors—private entities that act both as insurers and administrators of Medicare prescription drug benefits. The role of plan sponsors is largely the same as in previous years, but the industry's structure has changed substantially since Part D began.

The role of private plan sponsors

Many of the largest plan sponsors, such as UnitedHealth and Humana, offer both MA-PDs and PDPs. Other sponsors offer just one type of product. For example, integrated delivery system Kaiser Permanente offers only MA-PDs, while CVS Health, a leading pharmacy benefit manager (PBM) that also operates one of the largest chains of retail drug stores, participates as a Part D sponsor, but offers only PDPs. All sponsors must hold valid insurance licenses in the states in which they operate, and they must carry out basic functions such as marketing, enrollment,

**FIGURE
14-4**

Plan sponsors have consolidated their enrollment over time



Note: Market shares are based on Part D enrollment, including both stand-alone prescription drug plans and Medicare Advantage prescription drug plans. Employer groups are included.

Source: MedPAC based on enrollment data from CMS.

customer support, claims processing, making coverage determinations, and responding to appeals and grievances.

Sponsors must also carry out the specialized functions of PBMs, using either corporate-owned organizations or a commercial PBM under contract. Those functions include:

- developing and maintaining formularies—lists of drugs the plan covers and the terms under which it covers them;
- negotiating rebates—payments from drug manufacturers for placing their products on a plan's formulary or preferred cost-sharing tier, or for successfully encouraging enrollees to use the manufacturer's drugs; and
- negotiating contracts, including discount agreements, with pharmacies and pharmacy networks on the price the sponsor will pay the pharmacy for prescriptions filled and dispensing fees.

Rebates from pharmaceutical manufacturers and price discounts from pharmacies are key factors affecting the net prices that plan sponsors pay for enrollees' prescriptions. By law, the Medicare program is prohibited from becoming involved in negotiations among plan sponsors, drug manufacturers, and pharmacies.

Concentrated enrollment

A relatively small number of large insurers offer stand-alone PDPs in each of the 34 Part D regions across the country, and many of those same insurers also offer MA-PDs in selected parts of the country. In 2014, the top 9 insurers (those with 1 million or more Part D enrollees each) sponsored plans that accounted for nearly 80 percent of total enrollment (Figure 14-4). By comparison, in 2007, those insurers (some of which were not among the plan sponsors with the highest market shares at the time) had a combined 60 percent of enrollment.

**TABLE
14-8****Distribution of LIS enrollment in Part D plans offered by the largest plan sponsors, 2014**

Plan sponsor	Number of LIS enrollees (in millions)	LIS percent of sponsor's total enrollment (in percent)	Sponsor's share of all LIS enrollment (in percent)
CVS Health	2.3	55%	20%
UnitedHealth Group	2.0	25	18
Humana	1.7	28	15
CIGNA	1.2	72	11
WellCare	0.9	52	8
Aetna	0.7	31	6
Express Scripts	0.4	15	3
WellPoint	0.2	21	2
Kaiser	0.1	11	1
All LIS enrollees	11.4	31	N/A

Note: LIS (low-income subsidy), N/A (not applicable). Enrollment in stand-alone prescription drug plans and in Medicare Advantage–Prescription Drug plans is included. Employer groups are included.

Source: MedPAC based on enrollment data from CMS.

In 2014, just two major companies accounted for nearly 40 percent of the Part D market. UnitedHealth Group offers plans under the AARP name, and in 2014, the insurer had more than 6 million enrollees in its plans (about 1 in 5 Part D enrollees). Humana has also been a large part of this market, with combined enrollment of 17 percent in 2014. After winning a large portion of enrollment at the start of Part D in 2006 through low premiums, Humana lost a significant portion of its market share in 2009 and 2010. However, in 2011, Humana began a cobranding strategy with Walmart to create a network of preferred pharmacies through the retailer that allowed the insurer to offer a low-premium, low-copay plan and regain market share.

Other insurers that initially held smaller shares of the Part D market have had growing influence over time, often through mergers and acquisitions (Hoadley et al. 2014b). The most notable example is CVS Health, which in 2014 had 11 percent of all Part D enrollees in its plans. The company itself is a product of the acquisition of the PBM Caremark by CVS in 2007. CVS Caremark (now CVS Health) dramatically increased its Part D market share through a series of mergers and acquisitions including Long's Drug Stores' RxAmerica plans, Universal American's Community CCRx and Pennsylvania Life product lines, and Health Net Orange PDPs. Similarly, Aetna and CIGNA have increased their market presence

through mergers and acquisitions: CIGNA acquired HealthSpring in 2012 (which had itself previously acquired Bravo's Part D plans), while Aetna acquired Coventry Health Care in 2013.

As the share of enrollment made up by employer groups has grown in Part D, some sponsors have focused on this niche. For example, Express Scripts is perhaps best known as a PBM under contract to commercial health plans and employers. The company participated in Part D as a sponsor in most years of the program, and when it merged with the PBM Medco in 2012, the two companies consolidated their market shares. Since 2010, Express Scripts has significantly ramped up its presence in Part D through offerings of EGWPs.

Competition for LIS enrollees

From a plan sponsor's perspective, LIS enrollees might not be an obvious market niche to pursue. LIS enrollees tend to use more prescription drugs and their cost-sharing requirements are set in law, so plans have less ability to encourage LIS enrollees to use lower cost medicines and pharmacies. Still, there is significant competition among sponsors to bid so that some of their plans have premiums below regional benchmarks. Part D's subsidy payments on behalf of LIS enrollees are risk adjusted to compensate for their higher expected spending. To the extent that LIS

enrollees are more likely to reach Part D's OOP threshold, the program pays for most of their higher benefit spending through individual reinsurance. Also, auto-assignment of LIS enrollees to benchmark plans limits the need for sponsors to spend as much on marketing.

For these reasons, many plan sponsors actively pursue the LIS segment of the Part D market. In 2014, CVS Health had more LIS enrollees than any other sponsor: a total of 2.3 million, or 20 percent of all LIS enrollees (Table 14-8). About 55 percent of enrollees in CVS Health plans receive the LIS. CIGNA and WellCare are other companies among the top nine Part D plan sponsors for which more than half of their enrollees receive the LIS.

Once a sponsor has a sizable number of LIS enrollees, their bid can influence regional benchmarks because the benchmarks are calculated as a regional average premium weighted by LIS enrollment. At the same time, should the sponsor miss a regional benchmark by bidding too high, it would stand to lose potentially sizable numbers of LIS enrollees and market share.

Strategies for controlling growth in plan premiums

Plan sponsors decide how many drugs to list on their formulary and whether to apply utilization management, such as requiring prior authorization to fill prescriptions. Sponsors also set differential copays to encourage enrollees to use preferred medicines or a subset of pharmacies.

When designing formularies, plan sponsors attempt to strike a balance between providing enrollees with access to medications and controlling growth in drug spending. Part D sponsors rely on clinicians (typically, physicians and pharmacists who serve on pharmacy and therapeutics committees) when deciding which drugs to list, subject to CMS regulations. Sponsors also select the cost-sharing tier for each listed drug (if using a tiered formulary structure) and determine whether to apply any utilization management tools such as prior authorization.

Sponsors use formularies to structure competition among drug therapies and to shift utilization toward certain products such as lower cost generics and preferred brand-name drugs. In general, plan sponsors do not receive rebates from manufacturers of generic drugs. However, market competition from generics can, over time, lower prices by 80 percent or more, so promoting the use of generics can play a central part in controlling drug

spending (Kesselheim 2014). Plan sponsors negotiate substantial rebates on certain brand-name drugs, particularly those that face competition from other brands or generics in the same therapeutic class. Across all types of Part D drugs, the Medicare Trustees estimate that in 2014, plan sponsors obtained rebates averaging 13.5 percent of total prescription drug costs, across all types of prescription drugs, whether the plans received rebates for them or not (Boards of Trustees 2014). The CMS Office of the Actuary reports that “many brand-name prescription drugs carry substantial rebates, often as much as 20–30 percent.” Sponsors tend to use rebates to offset plans’ benefit spending (reducing plan premiums) rather than to lower the price of prescriptions at the pharmacy counter.

Most enrollees are in plans that use a five-tier formulary structure

Nearly all plans have used cost-sharing tiers for their formularies since the start of Part D, but over time, plans have moved toward more tiers (Hoadley et al. 2014b). Most plans now use a five-tier formulary—including preferred and nonpreferred generic tiers, preferred and nonpreferred brand-name drug tiers, and a specialty tier. The innovation in this formulary structure involves higher copays for nonpreferred generics relative to preferred, to encourage use of less costly generics. In 2014, 73 percent of PDP enrollees and 72 percent of MA–PD enrollees were in plans with five cost-sharing tiers (Figure 14-5, p. 364).

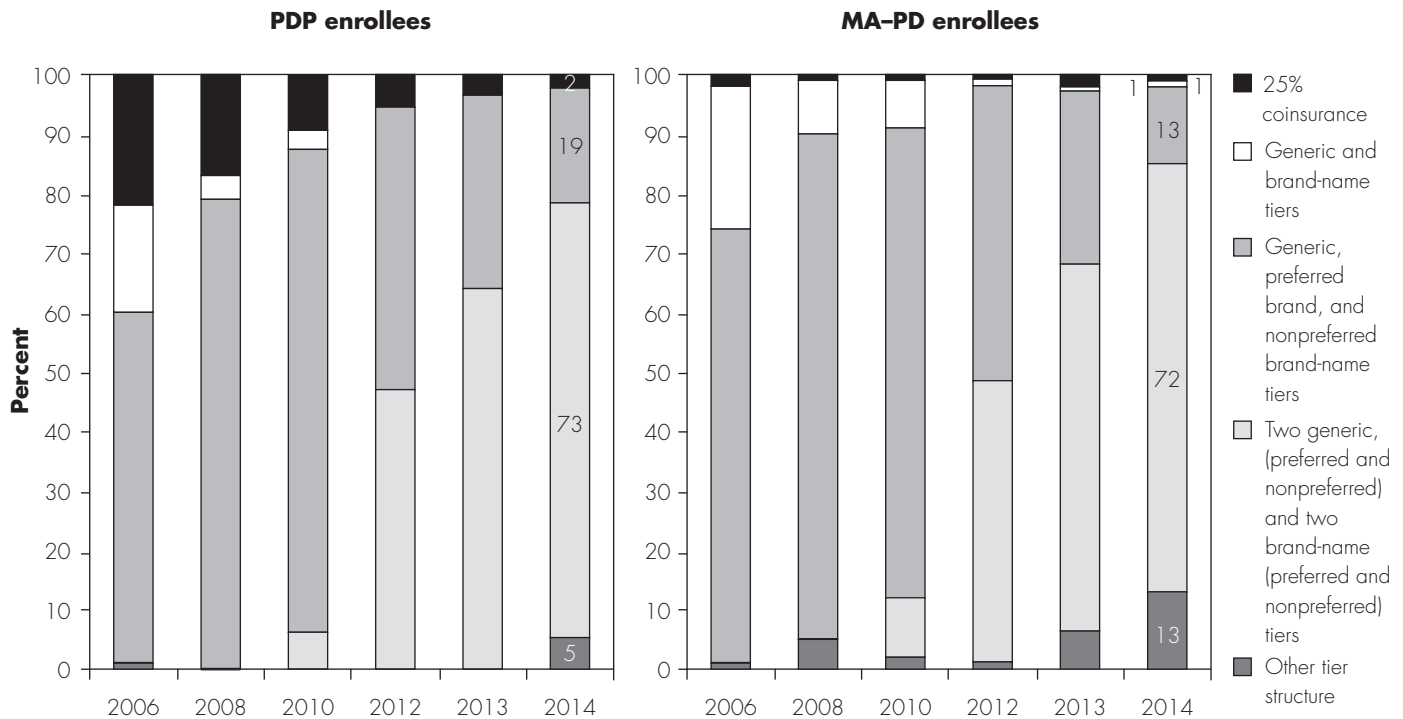
Mixed changes to formularies and continued use of utilization management

Although imperfect, the share of drugs listed on a plan’s formulary and the use of utilization management are measures to gauge the generosity of the plan’s coverage.⁹ Under contract with the Commission, researchers from NORC at the University of Chicago and from Social & Scientific Systems analyzed Part D formulary data for 2015. For this analysis, drugs are defined at the level of chemical entities—a broad grouping that encompasses all of a chemical’s forms, strengths, and package sizes—that combine brand-name and generic versions of specific chemicals (Medicare Payment Advisory Commission 2008).

The use of utilization management tools in Part D—including quantity limits, step therapy, and prior authorization—has grown over the years. Sponsors use such tools for drugs that are expensive, potentially risky, or subject to abuse, misuse, and experimental use. Such

**FIGURE
14-5**

The majority of Part D enrollees are in plans that use a five-tier formulary structure



Note: PDP (prescription drug plan), MA-PD (Medicare Advantage-Prescription Drug [plan]).

Source: NORC/Social & Scientific Systems analysis for MedPAC of formularies submitted to CMS.

**TABLE
14-9**

2015 formularies for stand-alone PDPs with highest 2014 enrollment

Stand-alone PDPs with the highest 2014 enrollment	Percent of drugs on formulary		Percent of formulary drugs with any utilization management*	
	2014	2015	2014	2015
AARP MedicareRx Preferred	92%	89%	23%	36%
SilverScript Choice	N/A	74	N/A	40
Humana Preferred Rx Plan	80	81	48	45
Humana Enhanced	89	89	50	47
AARP MedicareRx Saver Plus	83	83	25	36
WellCare Classic	73	74	38	37
Humana Walmart	82	83	49	45
Cigna-HealthSpring Rx Secure	85	77	38	44
Aetna Medicare Rx Saver	79	73	32	38
First Health Value Plus	78	80	41	38

Note: PDP (prescription drug plan), N/A (not available). Enrollment excludes employer plans and plans in U.S. territories. The number of drugs on the formulary for 2014 is 1,233; for 2015, the number is 1,253.

*Utilization management includes the use of prior authorization, quantity limits, and step therapy requirements.

Source: NORC/Social & Scientific Systems analysis for MedPAC of formularies submitted to CMS.

tools are also often used to encourage the use of lower cost therapies. In 2015, the average enrollee in a PDP faces some form of utilization management for about 38 percent of drugs listed on a plan's formulary; the comparable share for the average MA-PD enrollee is 39 percent.

Some of the 10 largest nationwide PDPs, which accounted for 86 percent of PDP enrollment in 2014, saw their formularies tighten between 2014 and 2015, while others broadened their formularies (Table 14-9).¹⁰ For example, UnitedHealth's AARP Medicare Rx Preferred plan had a modest reduction (3 percentage points) in the number of drugs listed on their formularies. Cigna-HealthSpring Rx Secure and Aetna Medicare Rx Saver tightened their formularies by 6 percentage points to 8 percentage points. Meanwhile the formularies of Humana Preferred Rx Plan, WellCare Classic, Humana Walmart, and First Health Value Plus widened modestly.

The use of utilization management increased for 4 of the 10 largest PDPs and decreased for 5 (Table 14-9). Many plans require some type of utilization management on more than one-third of drugs listed on their formularies. The most common strategy that plan sponsors use to manage enrollees' drug use is to apply a prior authorization requirement. In 2015, about 23 percent of formulary drugs are subject to prior authorization. Among the top 10 PDPs, those operated by Humana have the highest share of drugs with utilization management.

Tiered pharmacy networks

In addition to cost-sharing tiers for specific drugs, many sponsors have moved toward building tiered pharmacy networks that encourage enrollees to fill prescriptions at certain pharmacies by offering preferred (lower) cost sharing.¹¹ In 2014, about 70 percent of PDPs had a preferred network and about 74 percent of PDP enrollees were in a plan that used a tiered pharmacy network (NORC at the University of Chicago 2014).

By law, Part D plan sponsors must do business with all pharmacies that are willing to accept the plan sponsors' terms of its contract, and all such pharmacies are considered to be in the plan's network. However, sponsors may have arrangements with a subset of network pharmacies that offer enrollees preferred cost sharing. Sponsors negotiate additional price concessions, incentive payments, or both with that subset of pharmacies. In some cases, such arrangements are based on pharmacies achieving performance goals for generic dispensing. The use of tiered pharmacy networks has the potential to lower costs to the

Medicare program and to enrollees, but the practice has been controversial (see text box, pp. 366–367).

The Commission has expressed support for plan innovations that can increase efficiency, and we agree with CMS that the competition created by preferred pharmacy networks should result in lower costs for the program and for Part D enrollees. However, we also note that a separate pharmacy access standard may be required to ensure that plan enrollees have reasonable access to preferred cost sharing (Medicare Payment Advisory Commission 2014a). A further concern is that because cost sharing for individuals with the LIS is set statutorily, LIS enrollees do not respond to differential copays, so the approach of using tiered pharmacy networks could increase Medicare's spending for low-income cost sharing.

Drug pricing

The use of differential cost sharing across formulary tiers, combined with the fortuitous timing of an unusually large number of patent expirations on widely used brand-name drugs, has led to a dramatic shift toward the use of generics. Between 2010 and 2013, 30 blockbuster drugs with combined annual sales of about \$100 billion went off patent, and the market for generic drugs expanded rapidly (Galliard Capital Management 2011, Myshko 2012). As a share of total Part D prescriptions, generics rose to 81 percent in 2012 (the latest year of claims data available), up from 77 percent just one year earlier. At the same time, the introduction of new generics is slowing and the drug pipeline contains larger numbers of biologic products and specialty drugs. Plan sponsors have had less success at stemming growth in prices of drugs with few or no substitutes in their therapeutic class.

To track drug prices, the Commission contracted with researchers at Acumen LLC to construct a series of volume-weighted price indexes. The indexes do not reflect retrospective rebates or discounts from manufacturers and pharmacies but, rather, the prices sponsors and beneficiaries pay to pharmacies at the point of sale (including ingredient costs and dispensing fees).

Enrollees' use of generics led to lower Part D drug prices in 2012

Measured by individual national drug codes (NDCs) and excluding manufacturers' rebates, Part D drug prices

Use of tiered pharmacy networks

Between 2010 and 2014, the share of prescription drug plans (PDPs) that used tiered pharmacy networks grew from 11 percent to 70 percent (Table 14-10). In 2014, the 767 PDPs with tiered pharmacy networks accounted for 74 percent of PDP enrollment, an increase from 53 percent in 2013 and 13 percent in 2012.

The share of pharmacies on plans' preferred lists can vary dramatically from one plan to another (Figure 14-6). In 2014, among the largest plans that used tiered pharmacy networks, this share ranged from 10 percent for plans operated by Humana to about 50 percent for some of the Blue plans.¹² The share of pharmacies that are preferred can vary from one region to another within a single plan (or plans that share the same pharmacy networks). For example, in AARP's three plans, 19 percent of pharmacies were preferred in Region 6 (Pennsylvania–West Virginia region), while 74 percent of pharmacies were preferred in Region 27 (Colorado).

Cost sharing for beneficiaries is lower at preferred pharmacies than at nonpreferred pharmacies, with varying degrees of cost-sharing differentials across

plans. Some plans have much stronger incentives than others for their enrollees to use preferred pharmacies. For example, in the 2014 Aetna/CVS Pharmacy Plan, there was a \$3 difference for generics and no difference for brands. By contrast, in the Cigna Medicare Rx Secure plan, cost sharing was \$10 more for preferred generics and brands if an enrollee used a nonpreferred pharmacy, and more than \$20 more for nonpreferred generics and brands (NORC at the University of Chicago 2014).

In January 2014, CMS proposed that cost sharing reductions at preferred pharmacies be permissible only if the reductions did not increase Medicare's payments to plans (Centers for Medicare & Medicaid Services 2014f). CMS's proposal, which was not included in the final rule, was based on research that found higher unit costs among some preferred pharmacies that offered lower cost sharing relative to nonpreferred pharmacies. In September 2014, CMS requested feedback on draft subregulatory guidance that would have required plan sponsors to report all price concessions and incentive payments that could reasonably be approximated at the point of sale (Centers for Medicare & Medicaid Services 2014d). The agency later said that it would

(continued next page)

**TABLE
14-10**

Growth in the number of stand-alone PDPs with tiered pharmacy networks, 2010–2014

	PDPs by use of tiered pharmacy networks									
	2010		2011		2012		2013		2014*	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent
No tiers for pharmacy network	1,396	89%	952	86%	890	86%	557	54%	334	30%
Tiered pharmacy networks	179	11	157	14	151	14	474	46	767	70
Total	1,575	100	1,109	100	1,041	100	1,031	100	1,101	100

Note: PDP (prescription drug plan).

*Excludes the 68 plans sponsored by SmartD Rx because of CMS sanctions in 2014.

Source: NORC/Social & Scientific Systems analysis for MedPAC of formularies submitted to CMS.

Use of tiered pharmacy networks (cont.)

not use this guidance for contract year 2016 based on stakeholder feedback. While pharmacies have generally been supportive of proposals for more transparency in contracts signed by preferred pharmacies and plans, CMS has faced strong opposition from pharmacy benefit managers. They contend that Medicare is interfering in negotiations between pharmacies and plans, which is prohibited by law.

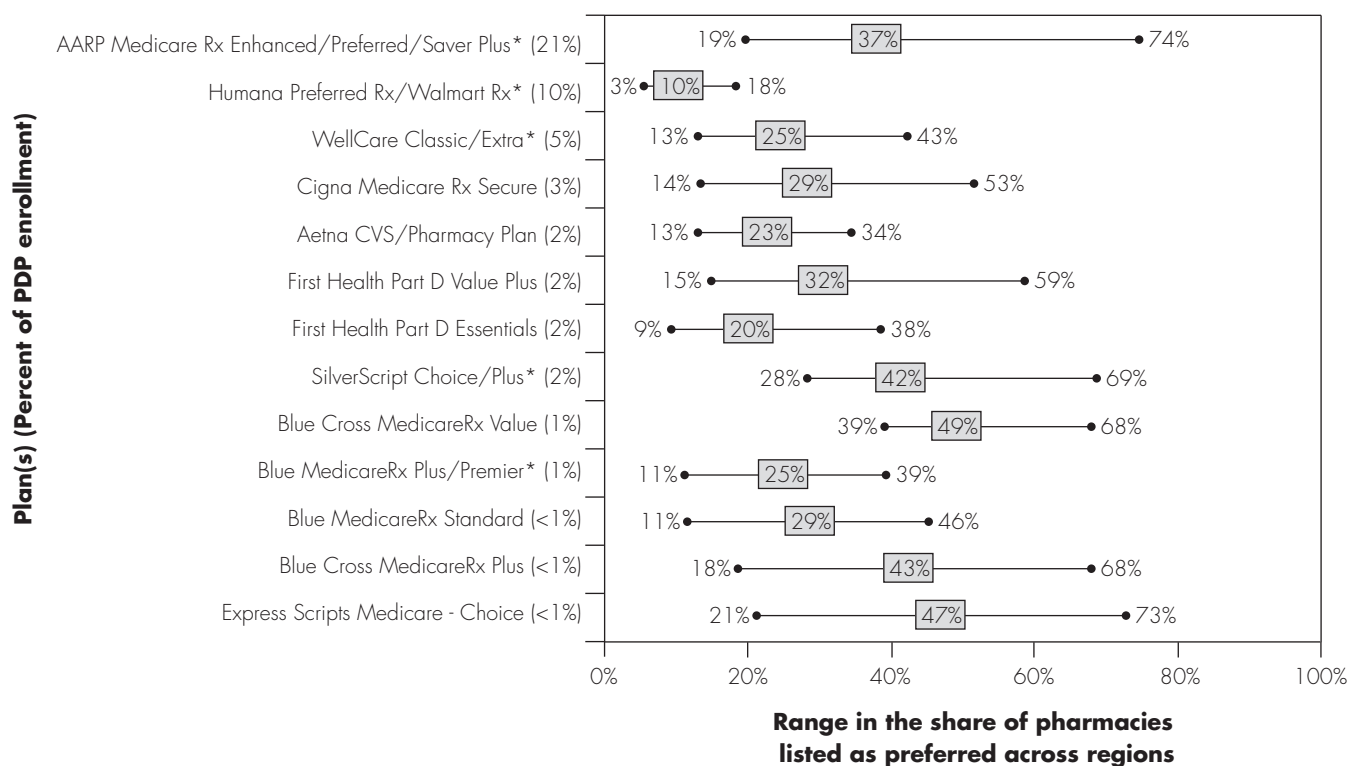
In the same proposed rule, and again in the 2015 Call Letter, CMS also raised concerns about and announced that it would examine beneficiaries' access to preferred pharmacy networks. The study found that, on average, beneficiaries residing in urban areas were less likely

to have convenient access to preferred pharmacies that offered lower cost sharing (Centers for Medicare & Medicaid Services 2014b).¹³

The Commission believes that the use of tiered pharmacy networks can be beneficial for the program and its enrollees if the price concessions that plan sponsors obtain are reflected in prices at the pharmacies or are used to lower premiums. In our comment letter to CMS, we suggested making several programmatic changes to ensure that the use of tiered pharmacy networks does not increase Medicare costs or harm beneficiaries (Medicare Payment Advisory Commission 2014a). ■

FIGURE 14-6

Share of pharmacies listed as preferred for selected plans, 2014



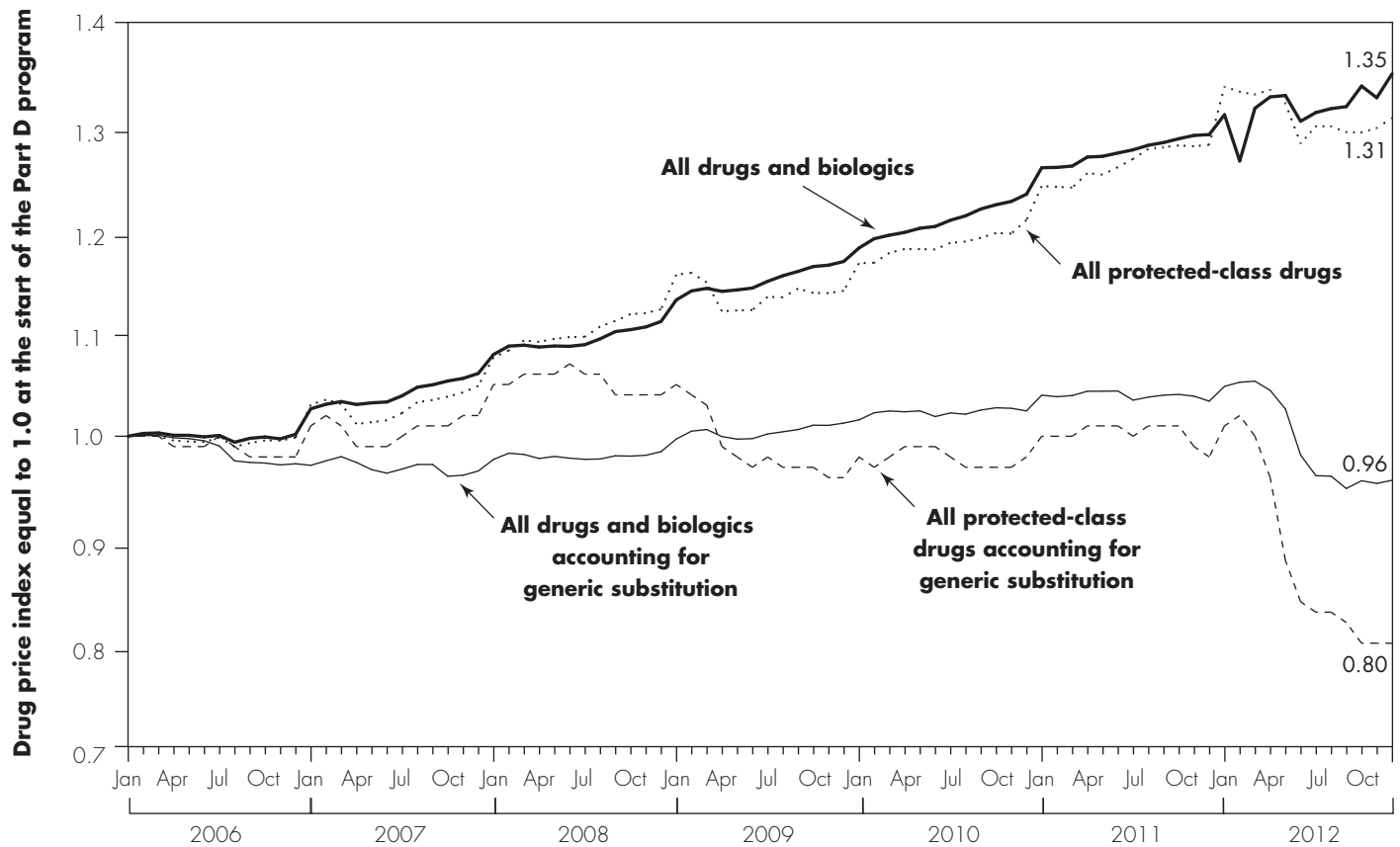
Note: PDP (prescription drug plan). Figures show the minimum and maximum share of pharmacies listed as preferred across regions served by a plan. The average share of pharmacies listed as preferred (shown in the box) is not weighted by enrollment. A plan's share of PDP enrollees is based on enrollment as of February 2014.

*Plans operated by the same sponsor and use the same pharmacy network.

Source: NORC/Social & Scientific Systems analysis for MedPAC of formularies submitted to CMS.

**FIGURE
14-7**

Availability of generics, rather than protected status, is key to slower price growth under Part D



Note: Chain-weighted Fisher price indexes.

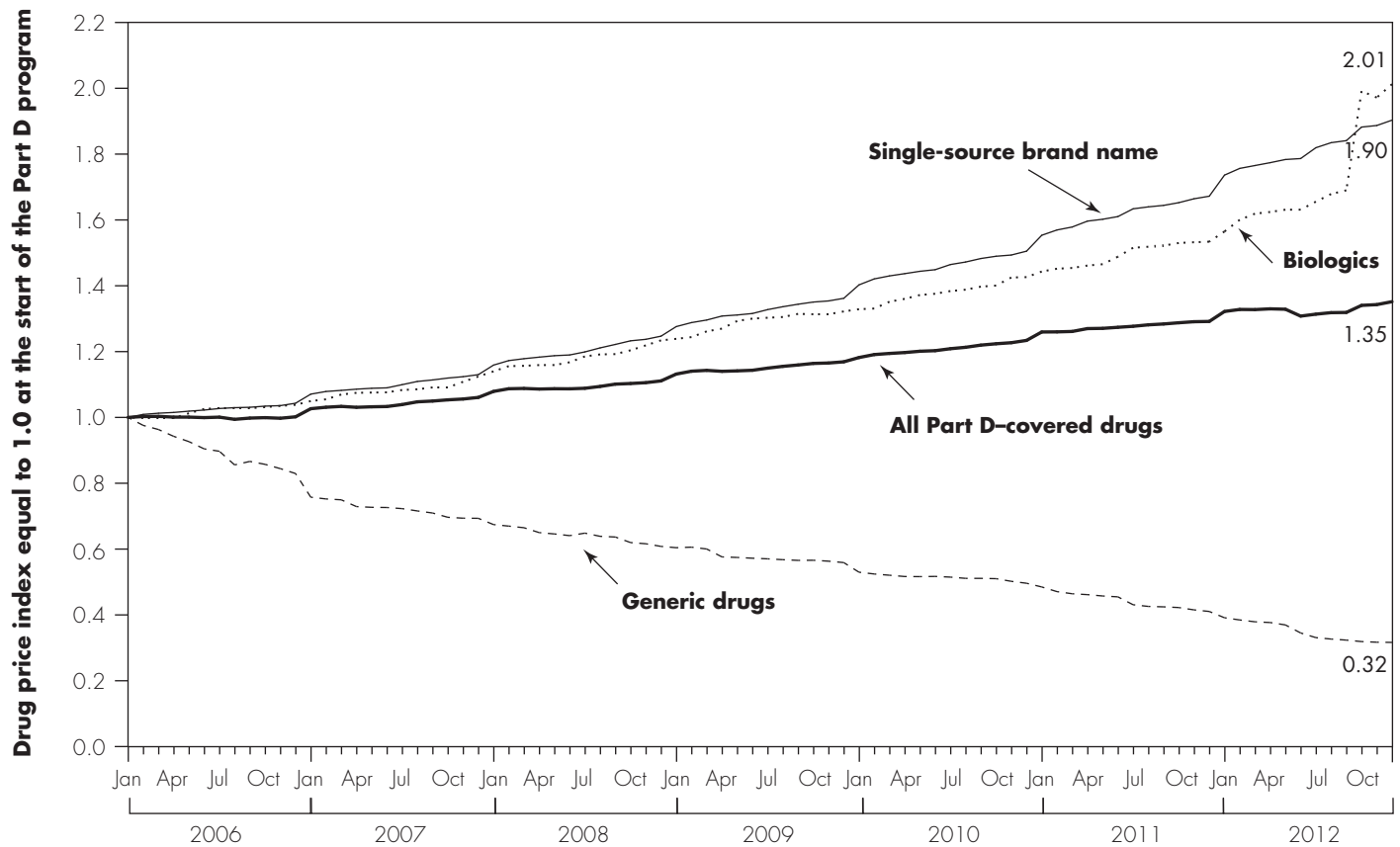
Source: Acumen LLC analysis for MedPAC.

rose between 2006 and 2012 by an average of 35 percent (Figure 14-7).¹⁴ As measured by a price index that takes the substitution of generics for brand-name drugs into account, Part D prices decreased cumulatively by 4 percent.¹⁵

For most drug classes, CMS requires plan formularies to cover at least two drugs in every therapeutic class and key drug type that are not therapeutic substitutes, unless only one drug is approved for that class. This policy is intended to protect beneficiaries who need a drug that is the only one available to treat a certain condition, and it allows competition in classes with multiple products. For six drug classes, CMS requires Part D plans to cover “all or substantially all” drugs in the class. Those classes are antineoplastics, antidepressants, antipsychotics,

antiretrovirals, anticonvulsants, and immunosuppressants used by transplant patients.¹⁶ Plans can charge higher cost sharing for drugs in these classes—for example, by placing them on tiers for nonpreferred brands—but plans may have limited ability to influence utilization of these classes of drugs.

As measured by individual NDCs, prices for drugs in the six protected classes showed a trend between 2006 and 2012 similar to that for all Part D drugs, rising by a cumulative 31 percent (Figure 14-7). This growth was influenced heavily by two classes of drugs: antidepressant and anticonvulsant medications, which accounted for much of the volume of prescriptions in the six classes, and of which there were many generics on the market during this period. Our price indexes for the individual NDCs of antidepressant and anticonvulsant drugs fell by

**FIGURE
14-8****Decline in generic prices and sustained aggressive price growth under Part D for single-source brand-name drugs and biologics**

Note: Chain-weighted Fisher price indexes.

Source: Acumen LLC analysis for MedPAC.

4 percent and 20 percent, respectively, during the seven-year period (data not shown). Growth in the price index for immunosuppressants slowed in recent years due to generic entries in 2009. Other classes are made up almost entirely of brand-name drugs, and the prices of these products grew rapidly, ranging from 40 percent for antiretrovirals to more than 90 percent for antineoplastics.

When protected-class drugs were grouped to take generic substitution into account, their prices fell by a cumulative 20 percent over the seven-year period. Thus, despite the drugs' protected status, plan sponsors appeared to have had success at moving enrollees toward generics for these drugs when generic substitutes were available. However, the drugs' protected status may limit the amount of rebates plan sponsors are able to obtain from manufacturers for

drugs in these classes. We lack rebate information to test this hypothesis.

Prices of brand-name drugs and biologics have grown aggressively

The patterns of price growth across different classes of drugs suggest that prices for drugs with few or no generic substitutes have grown rapidly. When we measured the price growth for drugs with no generic substitutes (single-source brand-name drugs), the growth in prices from 2006 to 2012 was much higher (90 percent) compared with the growth for all Part D-covered drugs (35 percent) (Figure 14-8). Similarly, our price index for biologic products, few (if any) of which have follow-on products available, more than doubled over the same period, while prices of generic

drugs decreased to about 32 percent of the average prices observed at the beginning of 2006.

In the years beyond 2012 (for which Part D claims data are not yet available), several analysts have noted that certain generic medications now have high prices or have experienced sharp price increases (Alpern et al. 2014, Fein 2014, Kesselheim 2014). The high price of some generics may be one motivation for Part D plan sponsors to move toward a five-tier formulary structure, placing higher cost generics on a nonpreferred generic tier.

A number of factors explain price increases for generics, including drug shortages, disruptions in the supply of drugs, and consolidations among manufacturers of generic drugs (Alpern et al. 2014). Factors that are associated with decreased market competition can lead to high and rising prices. Because of growing reliance on generics among Part D enrollees, other populations, and payers, the price increases have drawn the attention of policymakers (Rosenthal 2014).

Similarly, price growth for brand-name and specialty drugs was strong in 2013 (Hartman et al. 2015). By one estimate, retail prices for 227 brand-name drugs that are widely used by older Americans rose by nearly 13 percent in 2013, or about 8 times the rate of general inflation (Schondelmeyer 2014).

Use of higher cost drugs poses a big challenge for the future

Drugs with very high prices pose a future challenge for Part D. As more and more expensive therapies become available, larger numbers of beneficiaries may reach the phase of benefit spending in which Medicare bears most of the insurance risk and pays for 80 percent of benefit spending through individual reinsurance. It is not clear to what degree Part D plan sponsors will be able to negotiate prices with drug manufacturers for these therapies.

Specialty drugs are, by definition, high-cost drugs.¹⁷ Most biologics (large-molecule drugs) are a subset of specialty drugs. Historically, most specialty drugs have been injectables or infusables, but the category now also includes a broader variety of oral and inhaled treatments. One example is the new oral therapy Sovaldi—with an average wholesale price of about \$1,000 per pill or \$84,000 per regimen—and Harvoni, a combination drug that includes Sovaldi, as a treatment for a potentially large population of patients with hepatitis C (Silverman 2014). Because of differences in how they are administered and handled,

spending for specialty therapies spans across both medical and prescription drug benefits.

Among PBMs, growth in price and use of specialty drugs has been driving the overall trend in spending. Across their entire non-Medicare and Medicare books of business, PBMs' spending on specialty drugs has reached around 30 percent and may reach 50 percent of total spending by 2018 (Roberts 2013). Few specialty drugs have generics or biosimilars, and many of the treatments have limited therapeutic substitutes. For this reason, prices for specialty drugs tend to be high, and PBMs and insurers may have less ability to exert downward pressure on price.

The efforts of a few PBMs and Part D plan sponsors to push back on the price of new drugs may be instructive. At the end of 2014, the Food and Drug Administration (FDA) gave its approval to pharmaceutical manufacturer AbbVie to begin marketing Viekira Pak, a treatment for the most common form of hepatitis C, genotype 1. Express Scripts announced in December 2014 that in 2015, it would no longer cover Gilead's products (Sovaldi and Harvoni) or Johnson & Johnson's product (Olysio) for enrollees initiating treatment for hepatitis C, except under limited circumstances (Murphy 2014). Instead, the company will include Viekira Pak as the preferred treatment for hepatitis C patients with genotype 1. AbbVie announced that the list price of a standard course of therapy of Viekira Pak would be \$83,300, but the company reportedly will provide Express Scripts with sizable discounts (described by one investment analyst as on the order of 40 percent) in return for listing the drug on its formulary (Loftus 2014). In January 2015, CVS Health announced that it had reached an agreement with Gilead for discounts on Sovaldi and Harvoni in return for preferred formulary status (Walker 2015).

Because Part D beneficiaries fill so many prescriptions for traditional medicines, enrollees' use of high-cost drugs has thus far made up a limited share of total drug spending. Milliman estimates that in 2011, fewer than 2 percent of non-LIS enrollees and fewer than 5 percent of LIS enrollees filled a specialty-tier prescription (Pyenson et al. 2013). They estimate that in 2012, specialty-tier drugs made up 11 percent of gross per member per month Part D spending for aged, nondual beneficiaries. A previous Commission analysis of enrollees who reached the catastrophic phase of the benefit shows that most of their spending was driven by the volume of traditional prescriptions filled as well as a tendency to use brand-name medications (Medicare Payment Advisory Commission 2013). Many prescriptions

filled by high-cost enrollees were in therapeutic classes that had generic alternatives, rather than products with few therapeutic substitutes. The Commission found that in 2010 and 2011, fewer than 10 percent of enrollees with high drug spending used biologics, and biologics accounted for 6 percent to 7 percent of spending for these beneficiaries.

One likely reason for the limited use of high-cost drugs in Part D so far is that nearly all plans have specialty tiers, which typically carry 25 percent to 33 percent cost sharing. High cost-sharing amounts may discourage some non-LIS enrollees from initiating or completing high-cost treatment. In addition, under Part D rules, enrollees may not appeal cost-sharing amounts for specialty-tier drugs. A similar strategy would not be effective for enrollees whose cost sharing is paid by the LIS. However, some plans may use management tools such as prior authorization to restrain use somewhat. The benefits and costs of broader use of specialty-tier therapies vary substantially from drug to drug.

For the future, the high and increasing cost of specialty drugs poses a big challenge in Part D. Major PBMs and insurers uniformly project that growth in price and use of specialty drugs will continue to drive trends in spending. In the drug pipeline, fewer blockbuster drugs are going generic, and more than half of the FDA's approvals of new drugs in 2013 were for specialty drugs (CatamaranRx 2014). Specialty spending tends to be concentrated in treatments for rheumatoid arthritis and inflammatory diseases, multiple sclerosis, and cancer (Express Scripts 2014)—conditions more prevalent in the Medicare population.

As the use of specialty drugs increases, Part D enrollees and the Medicare program will face increasingly higher costs. Plans will likely continue to require 25 percent to 33 percent coinsurance on high-priced medicines. If larger numbers of beneficiaries begin to use specialty drugs just as the coverage gap is growing smaller, the number who reach Part D's OOP threshold could rise significantly. In turn, Medicare spending for individual reinsurance and low-income cost sharing will also rise.

Program spending

Evidence on program spending gives a mixed picture about the success of Part D plans at containing costs. Predictably, spending for the competitively derived direct-subsidy payments on which sponsors bear the most

insurance risk has grown slowly, while benefit spending on which sponsors bear no insurance risk (low-income cost sharing) or limited risk (the catastrophic portion of the benefit, where Medicare provides 80 percent reinsurance) has grown much faster.

Program subsidies and costs

Medicare pays plan sponsors three major subsidies on behalf of each enrollee in their plans:

- **Direct subsidy**—Medicare pays plans a monthly amount set as a share of the national average bid for Part D basic benefits, adjusted for the risk of the individual enrollee.
- **Reinsurance**—Medicare reimburses plans for 80 percent of drug spending above an enrollee's annual OOP threshold.
- **LIS**—Medicare pays plans to cover expected cost sharing and premiums for enrollees eligible for the subsidy.

Combined, the direct subsidy and reinsurance cover 74.5 percent of basic benefits, on average. Beneficiary premiums cover the remainder.

Between 2007 and 2013, program spending (including the retiree drug subsidy (RDS)) rose from \$46.7 billion to \$64.9 billion (Table 14-11, p. 372). In 2013, direct subsidy payments made up \$20.3 billion, while Medicare paid \$19.5 billion for individual reinsurance, \$23.3 billion for the LIS, and \$1.9 billion in RDSs (Boards of Trustees 2014). Payments to plans for the three subsidies (excluding the RDS) grew by 6.7 percent per year on average.

In 2013, LIS payments continued to be the largest component of Part D spending. Moreover, substantial portions of other categories were spent on behalf of LIS enrollees. Because these individuals tend to use more medications than other Part D enrollees, disproportionate shares of spending for the direct subsidy and individual reinsurance also reflect benefits for LIS enrollees.

Medicare payments for individual reinsurance have grown faster than other components of Part D spending, increasing at an annual average of 16 percent between 2007 and 2013 (Table 14-11, p. 372). This growth has accelerated in recent years, due, in part, to the gradual phase out of the coverage gap that began in 2011. Between 2010 and 2013, payments for individual reinsurance grew

**TABLE
14-11****Medicare's reimbursement amounts for Part D**

	Calendar year						Average annual growth rate 2007-2013
	2007	2009	2010	2011	2012	2013	
Reimbursement amount (in billions):							
Direct subsidy	\$18.1	\$18.9	\$19.7	\$20.1	\$20.8	\$20.3	1.9%
Reinsurance	8.0	10.1	11.2	13.7	15.5	19.5	15.9
Low-income subsidy	16.7	19.6	21.0	22.2	22.5	23.3	5.7
Retiree drug subsidy	<u>3.9</u>	<u>3.9</u>	<u>3.9</u>	<u>3.6</u>	<u>3.2</u>	<u>1.9</u>	-11.4
Total	46.7	52.4	55.8	59.6	62.0	64.9	5.6

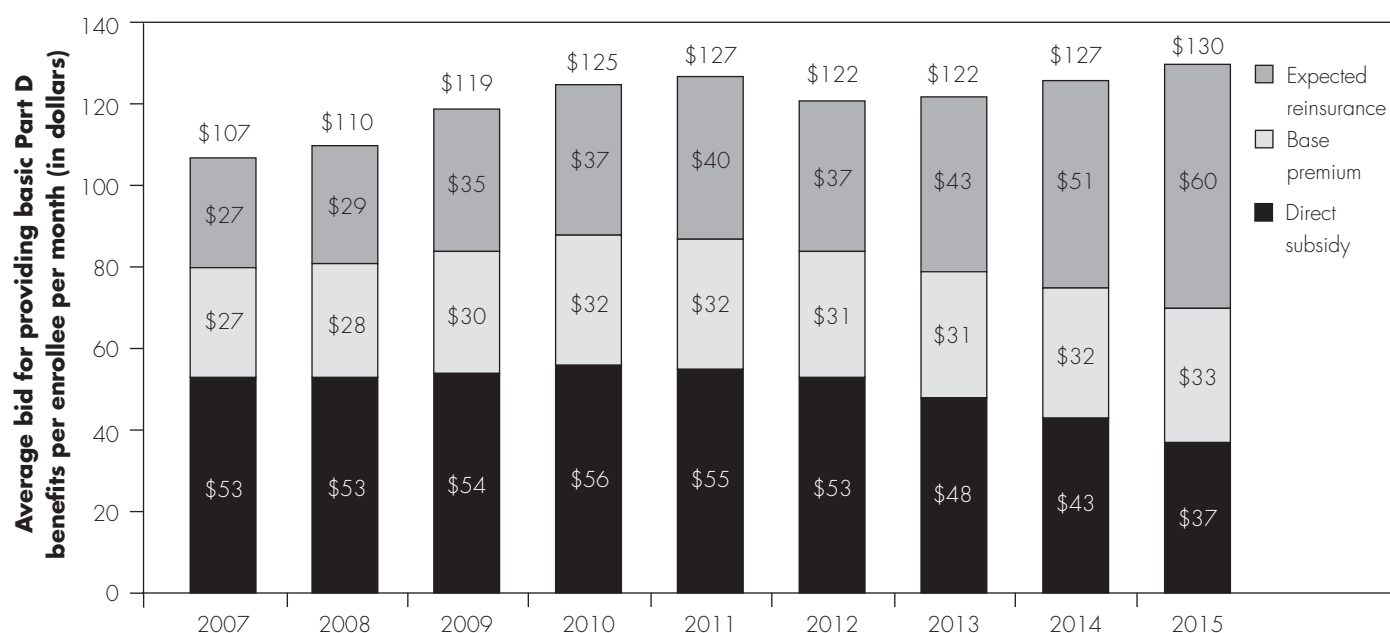
Note: Numbers above reflect reconciliation. Most enrollees paid premiums directly to plans, and those amounts are not included. On a cash basis, the Boards of Trustees estimates that premiums paid by enrollees were \$4.1 billion in 2007, \$5 billion in 2008, \$6.1 billion in 2009, \$6.7 billion in 2010, \$7.3 billion in 2011, \$7.8 billion in 2012, and \$9.3 billion in 2013. Totals may not sum due to rounding.

Source: MedPAC based on Table IV.B9 of the 2014 annual report of the Boards of Trustees of the Medicare trust funds.

by about 20 percent per year compared with 12 percent for 2007 through 2010 (data not shown).

Changes in the national average bid also reflect higher growth in individual reinsurance. Between 2007 and 2015, expected total benefit spending per member per month has grown at a modest rate of 2.4 percent annually, from \$107

to \$130 (Figure 14-9). During that period, the monthly amount that plans expect to receive through the direct subsidy has fallen 4.4 percent annually, from about \$53 to \$37. Over the same period, the amount per member that sponsors expect to receive in reinsurance has grown 10.5 percent annually, from \$27 to about \$60.

**FIGURE
14-9****National average plan bid for basic Part D benefits**

Note: The averages shown are weighted by the previous year's plan enrollment. Amounts do not net out subsequent reconciliation amounts with CMS.

Source: MedPAC based on data from CMS.

**TABLE
14-12****Average per capita spending per month for Part D-covered drugs, 2007-2012**

	Average Part D spending per enrollee per month					
	2007	2008	2009	2010	2011	2012
Average spending						
All Part D	\$212	\$221	\$228	\$231	\$239	\$235
By LIS status						
LIS	301	324	339	348	364	362
Non-LIS	156	159	163	163	167	167
Annual percentage change						
All Part D	4.7%	4.2%	3.0%	1.5%	3.2%	-1.5%
By LIS status						
LIS	8.0	7.7	4.5	2.6	4.6	-0.4
Non-LIS	5.8	2.0	2.3	0.0	2.8	-0.3

Note: LIS (low-income subsidy). For purposes of classifying the Part D prescription drug event (PDE) records by LIS status, monthly LIS eligibility information in Part D's denominator file was used. Estimates are sensitive to the method used to classify PDE records to each plan type and LIS status. Spending includes all payments to pharmacies, including payments by drug plans, Medicare's LIS, and beneficiary out of pocket.

Source: MedPAC analysis of Medicare Part D PDE data and denominator file from CMS.

Enrollment growth among non-LIS enrollees and higher generic use kept per capita spending stable

Between 2011 and 2012, the most recent years for which we have data, average per capita (gross) spending for Part D-covered drugs decreased (-1.5 percent) for the first time since the program began (Table 14-12).¹⁸ Before 2012, per capita spending grew at an annual average of 3 percent. Per capita spending decreased for both LIS and non-LIS enrollees by 0.4 percent and 0.3 percent, respectively, while the number of prescriptions filled continued to grow for both categories of enrollees. Because the number of prescriptions rose, much of the decrease in spending was likely due to increased use of lower cost drugs. Another factor behind the decrease was faster growth in the number of non-LIS enrollees, who tend to have lower drug spending than LIS enrollees.

The use of generic medications has increased over time. Between 2007 and 2012, the overall average generic dispensing rate (GDR) increased from 61 percent to 81 percent (Table 14-13, p. 374). During this period, some of the most popular brand-name drugs lost patent protection, affording more opportunities for generic substitution. GDRs vary across groups of beneficiaries. For example,

MA-PD enrollees are more likely to use generics than PDP enrollees. From 2007 to 2012, average GDRs for MA-PD enrollees consistently exceeded those of PDP enrollees by 4 percentage points to 6 percentage points. LIS enrollees have had a consistently lower GDR than non-LIS enrollees, and that difference grew from 2007 to 2012 from 2 percentage points to 5 percentage points.

LIS enrollees in both PDPs and MA-PDs are less likely to use generic drugs than non-LIS enrollees in their respective plan types. For example, in 2012, the GDR for LIS enrollees was 3 percentage points below that of non-LIS enrollees in PDPs, and 5 percentage points below that of non-LIS enrollees in MA-PDs. For some of the most commonly used classes of drugs, use of generic drugs by LIS enrollees was from 5 percentage points to 13 percentage points below that of non-LIS enrollees for both plan types (data not shown).

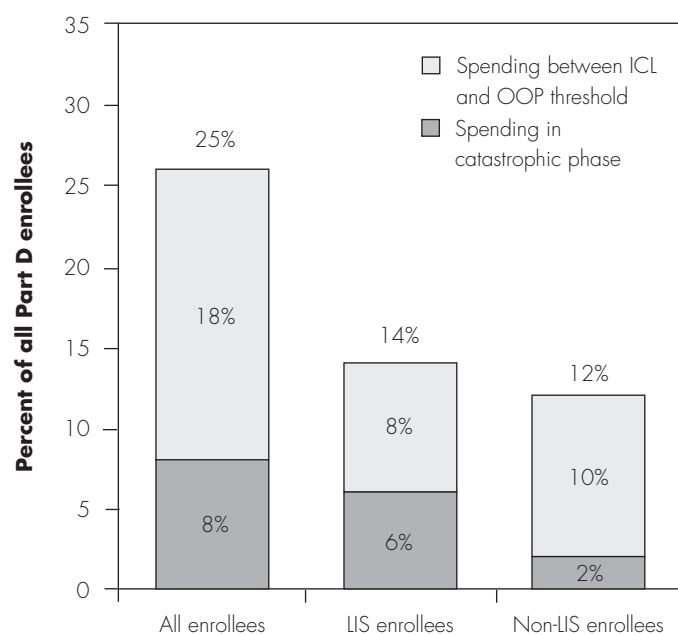
Multiple factors likely contribute to the higher or lower GDRs among groups of beneficiaries. For example, differences in health status may limit the opportunity for clinically appropriate therapeutic substitutions for some beneficiaries. There can also be differences in the prescribing behavior of physicians who are part of a managed care organization and those who are not. Another

**TABLE
14-13****Generic dispensing rate by plan type and LIS status, 2007–2012**

	2007	2008	2009	2010	2011	2012
All Part D	61%	67%	70%	74%	77%	81%
By plan type						
PDP	60	66	69	72	75	80
MA-PD	66	71	74	77	80	84
By LIS status						
LIS	60	65	68	71	74	78
Non-LIS	62	69	72	76	79	83

Note: LIS (low-income subsidy), PDP (prescription drug plan), MA-PD (Medicare Advantage–Prescription Drug [plan]). Shares are calculated as a percent of all prescriptions standardized to a 30-day supply. “Generic dispensing rate” is defined as the proportion of generic prescriptions dispensed. Part D drug event records are classified as PDP or MA-PD records based on the contract identification on each record.

Source: MedPAC analysis of Medicare Part D prescription drug event data and Part D denominator file from CMS.

**FIGURE
14-10****Part D enrollees with spending in the coverage gap and catastrophic phase, 2012**

Note: ICL (initial coverage limit), OOP (out of pocket), LIS (low-income subsidy). LIS enrollees do not face a coverage gap. In 2012, Part D enrollees reached the ICL at \$2,930 in gross drug spending. With no supplemental coverage, an enrollee reached the threshold at \$4,700 of OOP spending or qualifying drug spending made on behalf of the beneficiary, including the 50 percent discount paid for by pharmaceutical manufacturers for brand-name drugs. Some non-LIS enrollees who reached the catastrophic phase of the benefit may have had some gap coverage. Figures may not sum to totals due to rounding.

Source: MedPAC analysis of Part D prescription drug event data and Part D denominator file from CMS.

factor may be the difference in the financial incentives faced by LIS and non-LIS enrollees. Because the LIS limits the cost-sharing liability to the statutorily set copayment amounts, it may limit how well plan sponsors can manage drug spending for their LIS enrollees.

In our March 2012 report, we recommended that the Congress give the Secretary the authority to provide stronger financial incentives to use lower cost generics when they are available (Medicare Payment Advisory Commission 2012). The policy has the potential to reduce the amount Medicare spends on the two largest components of the program’s spending—payments for the LIS and the individual reinsurance. Because about 80 percent of beneficiaries who reach the catastrophic phase of their benefit are those who receive the LIS, encouraging the use of lower cost generics could have a significant effect on reducing the number of individuals who reach the catastrophic phase of the benefit and reducing the amount Medicare pays in individual reinsurance.

Increase in generic use reduced the number of high-cost enrollees

In 2012, a smaller share of Part D enrollees incurred spending high enough to reach the coverage gap (25 percent compared with 28 percent in 2011) (Figure 14-10). LIS enrollees accounted for more than half of those who reached the coverage gap (4.7 million, or about 14 percent of Part D enrollees). Just more than 2.6 million, or 7.7 percent of enrollees, had spending high enough to

**TABLE
14-14****Part D enrollees reaching the benefit's catastrophic cap, 2007–2012**

	2007	2008	2009	2010	2011	2012
In millions						
LIS	1.9	2.0	2.0	2.0	2.1	2.1
Non-LIS	<u>0.4</u>	<u>0.4</u>	<u>0.4</u>	<u>0.4</u>	<u>0.5</u>	<u>0.5</u>
All	2.3	2.4	2.4	2.4	2.6	2.6
Annual percentage change						
LIS		4.6%	–0.5%	–0.1%	9.0%	–3.4%
Non-LIS		4.9	–6.2	–3.9	27.6	6.8
All		4.6	–1.6	–0.8	12.1	–1.4

Note: LIS (low-income subsidy). Growth rates calculated using figures before rounding was applied.

Source: Data from 2007 and 2008 are based on published figures from CMS. Data from 2009 to 2012 are based on MedPAC analysis of Part D prescription drug event data.

reach the OOP phase of the benefit (high-cost enrollees), a reduction from 8.4 percent in 2011. About 2 million of the high-cost enrollees (about 6 percent of Part D enrollees) received the LIS.

Although about 80 percent of high-cost enrollees were individuals who received the LIS, there was a noticeable increase in the number of non-LIS enrollees who reached the OOP phase of the benefit in 2011—from about 400,000 in 2010 to slightly more than 500,000 in 2011, or an increase of more than 27 percent (Table 14-14). Much of this increase is likely a result of changes made by PPACA.¹⁹ Specifically, PPACA called for a 50 percent manufacturer discount on brand-name drugs in the coverage gap, and allowed that discount to count toward the OOP spending threshold.

The number of high-cost enrollees decreased by 1.4 percent between 2011 and 2012, likely reflecting greater use of generic medications in 2012 (Table 14-14). The number of high-cost enrollees who received the LIS decreased by about 73,000 (3.4 percent), while the number of high-cost enrollees who did not receive the LIS increased by 34,000 (6.8 percent). Much of the increase in the number of non-LIS enrollees who incurred high costs likely reflects the higher overall enrollment growth among the non-LIS enrollees (10 percent between 2011 and 2012, data not shown).

Growth in spending and use for high-cost enrollees

Between 2009 and 2012, total drug spending by high-cost enrollees grew by 37 percent cumulatively (Table 14-15, p. 376). About two-thirds of that increase can be explained by the higher drug prices, as measured by the 23 percent increase in the average price paid per prescription during this period. The remainder is attributable to growth in the number of prescriptions filled (11 percent), which is mostly due to the increase in the number of high-cost enrollees (10 percent).

The average price of prescriptions filled by Part D enrollees remained stable from 2009 to 2011, and it decreased by more than 2 percent in 2012. Increases in the use of generic drugs likely offset some of the increases in prices of brand-name drugs during this period. By comparison during this period, average spending per prescription filled among high-cost enrollees grew by 23 percent (about 7 percent annually between 2009 and 2011, and 8 percent between 2011 and 2012).

High-cost enrollees tend to use more brand-name drugs compared with other Part D enrollees. For example, in 2012, the average GDR among high-cost enrollees was slightly less than 68 percent, or about 13 percentage points below the overall Part D average of 81 percent. While the higher growth in prices of drugs taken by high-cost

**TABLE
14-15****Part D spending and utilization by high-cost enrollees, 2009–2012**

	2009–2012					
	2009	2010	2011	2012	Change	Percent change
Enrollees (in millions)	2.4	2.4	2.6	2.6	0.2	10%
Aggregate utilization						
Gross spending (in billions)	\$29.2	\$31.2	\$37.1	\$39.9	\$10.7	37
Prescriptions (in millions)	264.3	264.3	294.0	293.0	28.7	11
Average prescriptions per enrollee	111	112	111	113	1	1
Average spending per prescription	\$110	\$118	\$126	\$136	\$26	23

Note: "Change" and "percent change" columns were calculated using figures before rounding was applied.

Source: MedPAC analysis of Part D prescription drug event data.

enrollees can be explained by their tendency to use more brand-name drugs, for certain classes of drugs, generic substitution is not available. An increasing number of drugs covered under the Part D program falls in the biologics category, for which prices have grown more rapidly compared with other drug products.

Growth in spending for biologics among high-cost enrollees

From 2009 to 2012, the share of high-cost enrollees who filled at least one prescription for a biologic product grew from 8 percent to 11 percent (Table 14-16). High-cost enrollees who did not receive the LIS were more likely to use biologics compared with those who received the LIS, with about 15 percent of non-LIS enrollees filling at least one prescription for biologics in 2012 compared with 10 percent of LIS enrollees (data not shown).

Gross spending on biologics by high-cost enrollees grew from \$1.9 billion to \$3.5 billion, or by more than 90 percent, from 2009 to 2012 (Table 14-16). The faster growth in spending for biologics (32 percent growth in the volume of prescriptions and 45 percent growth in prices) increased biologics' share of total spending on drugs by high-cost enrollees from about 6 percent to about 9 percent (data not shown).

The number of prescriptions for biologic products grew more slowly from 2009 to 2012 (32 percent) than the number of high-cost enrollees using biologics (58 percent)

(Table 14-16). While biologic prescriptions per user declined during this period, average price per prescription for biologics grew by 12 percent to 14 percent per year, resulting in a net increase in spending for biologics per user of more than 20 percent by 2012 compared with 2009.

Beneficiaries' access to prescription drugs

Implementation of the Part D program in 2006 increased the share of beneficiaries with drug coverage from 75 percent to about 90 percent.²⁰ In general, Part D has improved Medicare beneficiaries' access to prescription drugs, with plans available to all individuals.

Most Part D enrollees report good access to prescription drugs

Most Part D enrollees appear to have good access to prescription drugs. Overall, in 2012, about 80 percent were satisfied with the drugs listed on plan formularies, and more than 90 percent reported having good access to pharmacies (Table 14-17). While only 7 percent reported having had prescriptions for medications they did not obtain during the year, that share was somewhat higher among LIS enrollees (9 percent) compared with non-LIS enrollees (6 percent). Among the 7 percent of all enrollees, cost was the main reason for not obtaining

**TABLE
14-16****Growth in spending and utilization for biologics by high-cost enrollees, 2009–2012**

	2009	2010	2011	2012	Percent change 2009–2012
Number of high-cost enrollees using biologics (in thousands)	188.3	183.3	255.4	298.3	58%
As percent of all high-cost enrollees	8%	8%	10%	11%	
Gross spending on biologics (in billions of dollars)	\$1.9	\$2.1	\$2.7	\$3.5	91
Annual percent change	N/A	14%	26%	33%	
Prescriptions for biologics (in millions)	1.11	1.12	1.26	1.47	32
Annual percent change	N/A	1%	12%	16%	
Gross spending per prescription	\$1,672	\$1,885	\$2,120	\$2,419	45
Annual percent change	N/A	13%	12%	14%	

Note: N/A (not available).

Source: MedPAC analysis of Part D prescription drug event data.

medications, accounting for nearly 40 percent, followed by nonformulary status of the medication(s). Combined, cost and the nonformulary status of the medication(s) resulted in about 5 percent of the beneficiaries not obtaining at least one medication during the year. The remaining 2 percent reported that they chose not to obtain medications because they were concerned about reactions to the medications, the medication was not necessary, or they did not think the medication would help.

Exceptions and appeals process

The number of drugs listed on a formulary or the use of utilization management tools—prior authorization, quantity limits, and step therapy requirements—can provide a measure of beneficiaries’ access to prescription drugs. However, for individuals whose prescription medications are not covered by their plans or are covered but have relatively high cost sharing, a well-functioning exceptions and appeals process is crucial to ensuring access to needed medications.

**TABLE
14-17****Part D enrollees’ access to prescription drugs, 2012**

	All Part D	Plan type		LIS status	
		PDP	MA-PD	LIS	Non-LIS
Percent:					
Satisfied with plan list of drugs covered*	80%	78%	83%	81%	80%
Satisfied with the ease of finding pharmacy that accepts drug plan*	92	91	92	90	92
With medication(s) not obtained	7	8	7	9	6
With medication(s) not obtained due to cost or nonformulary status	5	5	4	6	4

Note: PDP (prescription drug plan), MA-PD (Medicare Advantage–Prescription Drug [plan]), LIS (low-income subsidy).

*A small share refused to respond, indicated that they did not know the answer to the question, or had no experience related to the question. For the question about the plan list of drugs, that share was 6 percent. For the question about the ease of finding a pharmacy that accepts the drug plan, the share was about 4 percent.

Source: MedPAC analysis of 2012 Medicare Current Beneficiary Survey Access to Care file.

Part D's exceptions and appeals process is complex, involving multiple levels (Medicare Payment Advisory Commission 2014c). It begins when an enrollee does not receive his or her prescription at a pharmacy because of a plan's utilization management or cost-sharing requirements or because the drug is not listed on the plan's formulary. To initiate a request for an appeal, the enrollee, prescribing physician, or authorized representative must ask the plan for a redetermination.

In 2013, we reported on the effectiveness of the exceptions and appeals process based on data that were available at the time. Although there are multiple levels of appeals, the data we had access to pertained only to the second level of the appeals process, where the plans' adverse coverage determinations were reviewed by an independent review entity. The data were insufficient to make a comprehensive assessment of the plans' administration or effectiveness of the process in ensuring access to needed medications (Medicare Payment Advisory Commission 2014c).

Subsequently, CMS released data on the exceptions and appeals process at the plan level for 2012.²¹ On average, the number of pharmacy claims that were rejected because of formulary restrictions (e.g., the requested drug was not on the plan's formulary, or it required a prior authorization) was small—about 4 percent of claims processed by Part D plans in 2012. When claims were rejected, beneficiaries did not request an appeal in about 94 percent of the cases. For the cases that did reach the first level of appeal (request for a redetermination from the plan), decisions were favorable to beneficiaries in about two-thirds of the cases.

At the same time, CMS audits for benefit years 2012 and 2013 found that plans had difficulties in the areas of Part D coverage determinations, appeals, and grievances (Centers for Medicare & Medicaid Services 2014a, Centers for Medicare & Medicaid Services 2013b). In beneficiary focus groups convened for the Commission during 2014, we continued to find limited awareness and experience with the exceptions and appeals process (Hargrave et al. forthcoming). Among the few who had experience working with their providers to appeal an adverse coverage determination, most found the process to be burdensome. Many reported working with their physicians to find alternative medications instead of appealing plans' coverage decisions.

We are unable to determine whether low rates of claims rejections and appeals are cause for concern. Claims

can be rejected for valid reasons, such as exceeding the quantity limits based on FDA labeling; in the case of certain controlled substances, quantity limits may be applied for patient safety reasons. In other cases, beneficiaries may work with their physicians to find alternative medications or obtain needed medications outside of the exceptions and appeals process, for example, using samples obtained from their physicians. Beneficiaries often avoid this process altogether by switching to a plan—which LIS enrollees can do monthly—whose formulary has their medications. Nevertheless, a low appeals rate could be cause for concern if it reflects a lack of transparency in the appeals process or excessive administrative burden imposed on enrollees and prescribers that discourages them from submitting an appeal.

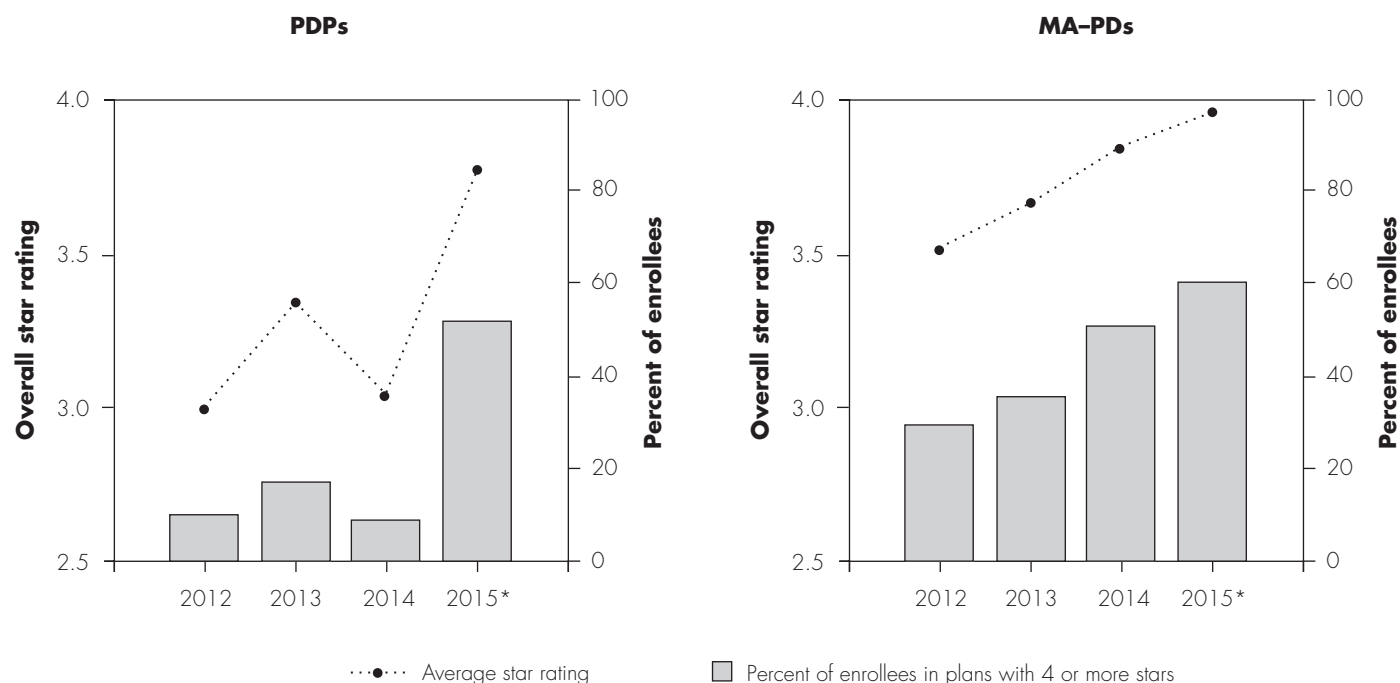
Quality in Part D

CMS collects quality and performance data for Part D plans to monitor sponsors' operations and uses a subset of these data to rate plans on a 5-star system. In 2014, CMS for the first time released plan-level information on medication therapy management programs (MTMPs).

Measuring plan performance

CMS collects quality and performance data for plan sponsors from several sources—the Consumer Assessment of Health Providers and Systems[®] survey, agency monitoring of plans, data furnished by plan sponsors, and claims information (Centers for Medicare & Medicaid Services 2014e). CMS makes selected performance measures available on the Plan Finder at www.medicare.gov to help beneficiaries evaluate their plan options during Part D's annual open enrollment. The lowest rated plans are flagged to caution beneficiaries about choosing those plans. The highest rated plans can enroll beneficiaries outside the annual open enrollment period. In addition, for MA-PDs, Part D performance data affect the Medicare Advantage (MA) program's overall plan ratings used to determine the amount of bonus payment.

For 2015, Part D plan ratings are based on up to 13 metrics that measure plan performance on intermediate outcomes, patient experience, access, and process (Centers for Medicare & Medicaid Services 2014e). Intermediate outcomes measures (5 metrics) receive a weight of 3, while measures related to patient experience and access receive a weight of 1.5.²² In 2015, CMS increased the

**FIGURE
14-11****MA-PDs have more consistent increases in overall star rating and the share of enrollees in high-performing plans**

Note: PDP (prescription drug plan), MA-PD (Medicare Advantage-Prescription Drug [plan]). Figures exclude contracts that are too new to be measured, contracts that do not have enough data available for reporting, and contracts terminating at the end of the calendar year.
*Estimated using 2014 enrollment.

Source: MedPAC based on CMS's fact sheet on 2015 star ratings.

weight assigned to drug plan quality improvement, a measure reflecting changes in drug plans' performance from one year to the next, to 5 (from 3 in 2014 and 1 in 2013). Most MA-PDs are rated on up to 44 measures that assess the quality of medical services provided under Part C (i.e., the MA program), in addition to the 13 measures used to assess the quality of prescription drug (Part D) services provided. CMS aggregates individual scores for each measure (13 for PDPs and 44 for MA-PDs) on the Plan Finder under a 5-star system; 5 stars reflect excellent performance, and 1 star reflects poor performance.

The average star rating (weighted by 2014 enrollment) for 2015 is 3.92 for MA-PDs and 3.75 for PDPs. For 2015, the share of enrollees in plans rated 4 stars or more (high-performing plans) is expected to increase to more than 50 percent among PDP enrollees and to about 60 percent among MA-PD enrollees (assuming no change in the distribution of enrollees across plans in 2015) (Figure 14-11).

Between 2012 and 2014, the share of enrollees in high-performing plans increased steadily for MA-PDs, while a steady increase was not the case with enrollees in PDPs. For example, in 2014, the overall rating among PDPs as well as the share of PDP enrollees in high-performing plans declined. The lower average star rating among PDPs reflected reductions in the ratings for the two contracts (the SmartD Rx PDPs and the SilverScript PDPs) that were placed under CMS enrollment sanctions during the annual open enrollment for the 2014 benefit year. If this enrollment penalty had not been applied, the average rating for PDPs would have been 3.23 for 2014 rather than 3.04 (Centers for Medicare & Medicaid Services 2013a).

In general, changes in the composition of the measures CMS uses to rate plans over the years make it difficult to use star ratings to measure the changes in quality of services provided by plans across years. For example, more emphasis has been placed on intermediate outcome measures in recent years—such as the use of medications

**TABLE
14-18****Use of medication therapy management programs by plan type, 2012**

	All	PDP	MA-PD
Number of medication therapy management enrollees (in millions)	3.1	1.9	1.3
Medication therapy management participation rate			
Overall	11%	10%	11%
Under age 65	11	10	13
Percent of enrollees in long-term care	4%	7%	2%
Percent of enrollees who received medication therapy management service(s)			
Comprehensive medication review	10%	6%	15%
Targeted medication review	97	98	96
Percent of enrollees who had any prescriber intervention(s)			
Received a comprehensive medication review	52%	55%	51%
Did not receive a comprehensive medication review	31	33	28
Received comprehensive medication review and/or targeted medication review	34	34	32
Percent of enrollees who had any therapy change(s)			
Received a comprehensive medication review	33%	29%	35%
Did not receive a comprehensive medication review	13	14	13
Received comprehensive medication review and/or targeted medication review	16	15	17

Note: PDP (prescription drug plan), MA-PD (Medicare Advantage-Prescription Drug [plan]). Figures exclude plans that do not meet the minimum data requirement and plans with invalid data.

Source: MedPAC based on the 2012 public use file for medication therapy management from CMS.

with a high risk of serious side effects and the share of enrollees obtaining medications recommended to treat selected conditions—and less emphasis on process measures such as price accuracy on Medicare’s Plan Finder.

Medication therapy management programs

Part D plans are required to implement MTMPs to improve the quality of the pharmaceutical care for high-risk beneficiaries. These programs are intended to improve medication use and reduce adverse drug events for beneficiaries who have multiple chronic conditions, take multiple medications, and are likely to have annual drug spending that exceeds the annual cost threshold (\$3,138 for 2015). Our earlier review of the MTMPs revealed wide variations in eligibility criteria and the kinds of interventions provided to enrollees (Medicare Payment Advisory Commission 2009).

CMS has been tightening criteria for MTMPs since 2010 and has used guidance from multiple programs to specify MTMP requirements. For example, under CMS MTMP

criteria, plan sponsors cannot require beneficiaries to have more than three chronic conditions or use more than eight medications to be eligible for their MTMP. Plan sponsors are required to offer all MTMP-eligible enrollees a comprehensive medication review (CMR) at least annually and a targeted medication review (TMR) at least quarterly, for ongoing monitoring and follow-up of any medication-related issues.²³

Until recently, little information was available to assess the effectiveness of the MTMPs under Part D. In 2014, CMS released plan-level data on MTMPs for the 2012 benefit year. Data values for some plans were suppressed because of the small number of observations or other data issues identified by CMS. The plans that were included in our analysis represented 29.6 million enrollees, or about 88 percent of Part D enrollees in 2012.

In 2012, 3.1 million, or about 11 percent of Part D enrollees, participated in an MTMP (Table 14-18). Program participation varied widely across plan sponsors. On average, beneficiaries in MA-PDs were slightly

more likely than those in PDPs to enroll in an MTMP (11 percent vs. 10 percent). Participation rates likely varied by beneficiary characteristics, potentially reflecting differences in eligibility criteria and outreach efforts used by plan sponsors. For example, among individuals under age 65 (disabled), those in MA–PDs were more likely to enroll in MTMPs compared with those in PDPs (13 percent vs. 10 percent). Individuals residing in long-term care (LTC) institutions were more likely to participate in an MTMP, with a participation rate of about 21 percent (data not shown).

Although CMR was offered to virtually all MTMP enrollees, only 10 percent of them (about 1 percent of all Part D enrollees) received a CMR in 2012, a rate comparable with that observed in the 2010 benefit year (Table 14-18) (Marrufo et al. 2013). MTMP enrollees in MA–PDs were more than twice as likely as those in PDPs to receive a CMR (15 percent vs. 6 percent). Nearly all enrollees received at least one TMR during the year.

Receiving a CMR can result in more prescriber interventions or therapy changes. For example, in 2012, plan sponsors reached out to prescribers in more than 50 percent of the cases for which a CMR was conducted compared with about 30 percent of the cases for which no CMR was completed (Table 14-18). Changes in therapies were also more likely among cases for which a CMR was completed (33 percent) compared with cases for which no CMR was completed (13 percent), with a higher rate of therapy changes among individuals enrolled in MA–PDs compared with those enrolled in PDPs (35 percent vs. 29 percent).

However, a few caveats are needed in interpreting the findings from the 2012 MTMP data. First, despite the observed association between a CMR completion and MTMP interventions, the data do not allow us to determine whether the higher number of interventions observed among individuals who received a CMR was due to having had a CMR. For example, individuals who accept the offer of a CMR may be more likely to have medication-related issues that need to be addressed. In that case, the observed differences in MTMP interventions would be attributable to the selection of individuals rather than to CMR performance. In other words, a lower rate of MTMP interventions among individuals who did not receive a CMR may or may not indicate a problem.

Although the data showed higher participation in MTMPs by individuals in LTC facilities, less than 1 percent of LIS enrollees received a CMR. Because beneficiaries in LTC facilities are more likely to take multiple medications and may be at a higher risk for polypharmacy, periodic review of their medications is particularly important to their health. In the future, we hope to examine how well Part D's MTMP program is working in LTC settings, particularly given the difference in beneficiary characteristics (e.g., higher prevalence of cognitive issues), potentially different goals (e.g., reducing potentially harmful medications rather than increasing adherence), and the facility environment (e.g., nursing facilities are required by Medicare to conduct a monthly medication review of their residents by a consultant pharmacist). ■

Endnotes

- 1 In 2015, the Part D benefit provides gap coverage of 5 percent for brand-name drugs in addition to a 50 percent discount provided by pharmaceutical manufacturers, reducing the cost sharing during the coverage gap to about 45 percent. The cost-sharing amount for brand-name drugs filled during the coverage gap depends on the amount of the dispensing fee charged, since the 5 percent covered by the Part D benefit applies to both the ingredient cost and the dispensing fee, while the 50 percent manufacturer discount applies only to the ingredient cost.
- 2 If an employer agrees to provide primary drug coverage to retirees with an average benefit value equal to or greater than Part D (called creditable coverage), Medicare provides a tax-free subsidy to the employer for 28 percent of each eligible retiree's drug costs that fall within a specified range of spending. Under PPACA, employers still receive the RDS tax free, but beginning in 2013, they can no longer deduct drug expenses for which they receive the subsidy as a cost of doing business (but they can still deduct prescription drug expenses not covered by the subsidy).
- 3 Under the Part C payment system, which is used to pay MA plans, a portion of the difference between the plan's benchmark payment and its bid for providing Part A and Part B services is referred to as Part C rebate dollars. The rebate dollars can be used to supplement benefits or lower premiums for services provided under Part C or Part D.
- 4 MA-PD premiums reflect Medicare Advantage plans' total monthly premium attributable to Part D benefits for plans that offer Part D coverage and are net of Part C rebate dollars that were used to offset Part D premium costs.
- 5 These figures are based on CMS's estimate as of December 2014.
- 6 CMS allows a sponsor to offer multiple plans in any given service area only if those offerings are substantially different from one another. To be considered "substantially different" for 2015, PDPs must have a difference of at least \$20 per month in a beneficiary's expected monthly OOP costs between basic and enhanced plans. If a sponsor is offering two enhanced PDPs in the same service area, the second enhanced plan must have a higher value than the first, with a difference of at least \$25 in a beneficiary's expected monthly OOP costs between the two enhanced plan offerings.
- 7 Another 20 PDPs (Express Script's SmartD Rx Saver plans and Avalon Insurance Company's SecureRx plans) have premiums below their regional benchmarks, but are subject to CMS marketing and enrollment sanctions. LIS enrollees who were in those 20 plans in 2014 may remain in them for 2015 without paying any of the premium. However, sanctioned PDPs may not receive new LIS enrollees through auto-assignment even when their monthly premium is below the regional benchmark.
- 8 Information on the extent of the coverage provided during the gap is not available for 2015. However, in the past, plans often provided limited coverage in the gap. For example, in 2014, about one-fourth of PDPs with some additional coverage in the gap included fewer than 10 percent of formulary drugs in that coverage (Hoadley et al. 2014a).
- 9 The measure needs to be used with caution because it can be misleading in some circumstances. For example, some plan sponsors list relatively few drugs on their formulary but have an exceptions process that permits good access to other medications. Alternately, other sponsors might list most drugs on their formulary but require prior authorization for relatively larger numbers of drugs.
- 10 The number of drugs in the formulary reference file, which is used as a denominator to calculate the share of all distinct chemical entities listed on plan formularies, increased by about 2 percent between 2014 and 2015.
- 11 CMS has moved away from referring to pharmacies within a plan's network as preferred and nonpreferred pharmacies, depending on the cost sharing amounts that are applicable to medications filled at the pharmacy. Instead, CMS refers to them as pharmacies that offer preferred (lower) or standard cost sharing.
- 12 The average share of pharmacies is not weighted by enrollment.
- 13 *Convenient access* was defined as 90 percent of urban beneficiaries having access to pharmacies within 2 miles of their residence, 90 percent of suburban beneficiaries having access within 5 miles of their residence, and 70 percent of rural beneficiaries having access within 15 miles of their residence.
- 14 An individual NDC uniquely identifies the drug's labeler, drug, dosage form, strength, and package size. Because each drug is often available in different dosages, strengths, and package sizes, the same drug typically has many different NDCs.

- 15 For this index, Acumen grouped NDCs that are pharmaceutically identical, aggregating prices across drug trade names, manufacturers, and package sizes. As a result, brand-name drugs are grouped with their generics if they exist, and the median price more closely reflects the degree to which market share has moved between the two.
- 16 In a proposed rule published January 6, 2014, CMS proposed to remove three classes—antidepressants, antipsychotics, and immunosuppressants for transplant rejection—from the protected status. The Commission was supportive of CMS’s approach in applying objective criteria to determine drug categories or classes of clinical concern while balancing the goals of beneficiary access and welfare with Part D plans’ tools to manage the drug benefit and appropriately constrain costs. We also shared CMS’s concerns about antipsychotics and supported CMS’s move to proceed slowly. However, the agency did not include the measure in its final rule.
- 17 The industry does not have one consistent definition of specialty drugs, but they tend to be characterized as high cost (e.g., the Medicare call letter threshold of \$600 or more per month) and are used to treat a rare condition, require special handling, use a limited distribution network, or require ongoing clinical assessment. See <http://www.ajmc.com/payer-perspectives/0213/The-Growing-Cost-of-Specialty-PharmacyIs-it-Sustainable>.
- 18 The reduction in per capita spending net of rebates is slightly larger than the 1.5 percent reported since the rebates as a share of drug spending increased between 2011 and 2012 (from 11.5 percent to 11.7 percent) (Boards of Trustees 2014).
- 19 PPACA eliminates the coverage gap by (1) requiring pharmaceutical manufacturers to offer a 50 percent discount on brand-name drugs filled during the coverage gap, (2) gradually phasing down cost sharing for generic drugs beginning in 2011, (3) phasing down cost sharing for brand-name drugs beginning in 2013, and (4) reducing the OOP threshold on true out-of-pocket spending over the 2014 to 2019 period.
- 20 The prescription drug coverage that beneficiaries had before 2006 may or may not have been as generous as the Part D benefit. Since implementation of Part D, 90 percent of beneficiaries have drug coverage that is as generous as Part D’s basic benefit.
- 21 After excluding plans with missing or invalid data values, our sample included 769 PDPs and 1,992 MA–PDs, representing nearly 26 million beneficiaries, or about 82 percent of total Part D enrollees, based on enrollment as of April 2012. For the 88 plans that were missing the count of total claims processed in 2012 but had valid records for other data elements used in our analysis, we used Part D claims data for 2012 to assign the total number of claims for each plan.
- 22 CMS assigns a weight of 1 to process measures and measures that are newly introduced in that year.
- 23 CMRs must include an interactive, person-to-person, or telehealth consultation performed by a pharmacist or other qualified provider and a written summary of the review that includes a medication list and action plan, if any, provided to beneficiaries in CMS’s standardized format. A TMR is distinct from a CMR because it is focused on specific actual or potential medication-related problems. A TMR can be person to person or system generated, and interventions may be delivered by mail or faxed to the beneficiary and/or the prescriber, as appropriate (Centers for Medicare & Medicaid Services 2014c).

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A P P E N D I X

A

**Commissioners' voting
on recommendations**



Commissioners' voting on recommendations

In the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, the Congress required MedPAC to call for individual Commissioner votes on each recommendation and to document the voting record in its report. The information below satisfies that mandate.

Chapter 1: Context for Medicare payment policy

No recommendations

Chapter 2: Assessing payment adequacy and updating payments in fee-for-service Medicare

No recommendations

Chapter 3: Hospital inpatient and outpatient services

The Commission reiterates its March 2014 recommendation on hospital payment. See text box, pp. 71–72.

Chapter 4: Physician and other health professional services

The Congress should establish a prospective per beneficiary payment to replace the Primary Care Incentive Payment program (PCIP) after it expires at the end of 2015. The per beneficiary payment should equal the average per beneficiary payment under the PCIP and should be exempt from beneficiary cost sharing. Funding for the per beneficiary payment should protect PCIP-defined primary care services regardless of the practitioners furnishing the services and should come from reduced fees for all other services in the fee schedule.

Yes: Armstrong, Baicker, Buto, Christianson, Coombs, Crosson, Gradison, Hackbarth, Hall, Hoadley, Kuhn, Naylor, Nerenz, Redberg, Samitt, Thomas, Uccello

Additionally, the Commission reiterates its 2011 recommendations on moving forward from the sustainable growth rate system. See text box, p. 104.

Chapter 5: Ambulatory surgical center services

The Congress should eliminate the update to the payment rates for ambulatory surgical centers for calendar year 2016. The Congress should also require ambulatory surgical centers to submit cost data.

Yes: Armstrong, Baicker, Buto, Christianson, Coombs, Crosson, Gradison, Hackbarth, Hall, Hoadley, Kuhn, Naylor, Nerenz, Redberg, Samitt, Thomas, Uccello

Chapter 6: Outpatient dialysis services

The Congress should eliminate the update to the outpatient dialysis payment rate for calendar year 2016.

Yes: Armstrong, Baicker, Buto, Christianson, Coombs, Crosson, Gradison, Hackbarth, Hall, Hoadley, Kuhn, Naylor, Nerenz, Redberg, Samitt, Thomas, Uccello

Chapter 7: Medicare's post-acute care: Trends and ways to rationalize payments

The Congress should direct the Secretary of Health and Human Services to eliminate the differences in payment rates between inpatient rehabilitation facilities (IRFs) and skilled nursing facilities for selected conditions. The reductions to IRF payments should be phased in over three years. IRFs should receive relief from regulations specifying the intensity and mix of services for site-neutral conditions.

Yes: Armstrong, Baicker, Buto, Christianson, Coombs, Crosson, Gradison, Hackbarth, Hall, Hoadley, Kuhn, Naylor, Nerenz, Redberg, Samitt, Thomas, Uccello

Chapter 8: Skilled nursing facility services

The Commission reiterates its March 2012 recommendation on updating Medicare's payments to skilled nursing facilities. See text box, p. 203.

Chapter 9: Home health care services

The Commission reiterates its March 2011 recommendations on improving the home health payment system. See text box, pp. 232–234.

Chapter 10: Inpatient rehabilitation facility services

The Congress should eliminate the update to the Medicare payment rates for inpatient rehabilitation facilities in fiscal year 2016.

Yes: Armstrong, Baicker, Buto, Christianson, Coombs, Crosson, Gradison, Hackbarth, Hall, Hoadley, Kuhn, Naylor, Nerenz, Redberg, Samitt, Thomas, Uccello

Chapter 11: Long-term care hospital services

The Secretary should eliminate the update to the payment rates for long-term care hospitals for fiscal year 2016.

Yes: Armstrong, Baicker, Buto, Christianson, Coombs, Crosson, Gradison, Hackbarth, Hall, Hoadley, Kuhn, Naylor, Nerenz, Redberg, Samitt, Thomas, Uccello

Chapter 12: Hospice services

The Congress should eliminate the update to the hospice payment rates for fiscal year 2016.

Yes: Armstrong, Baicker, Buto, Christianson, Coombs, Crosson, Gradison, Hackbarth, Hall, Hoadley, Kuhn, Naylor, Nerenz, Redberg, Samitt, Thomas, Uccello

Additionally, the Commission reiterates its March 2009 recommendations on hospice. See text box, pp. 292–293.

Chapter 13: The Medicare Advantage program: Status report

The Commission reiterates its March 2014 recommendations on improving the bidding rules in the Medicare Advantage (MA) program and integrating hospice care into the MA benefit package. See text box, pp. 340–341.

Chapter 14: Status report on Part D

No recommendations

Acronyms

Acronyms

ABIM	American Board of Internal Medicine	CKD	chronic kidney disease
ACH	acute care hospital	CLABSI	central line–associated bloodstream infections
ACO	accountable care organization	CMG	case-mix group
ADL	activity of daily living	CMI	case-mix index
AHA	American Hospital Association	CMMI	Center for Medicare & Medicaid Innovation
AHRQ	Agency for Healthcare Research and Quality	CMR	comprehensive medication review
AIDS	acquired immunodeficiency syndrome	CMS	Centers for Medicare & Medicaid Services
ALF	assisted living facility	CMS–HCC	CMS–hierarchical condition category
ALOS	average length of stay	CON	certificate of need
AMA	American Medical Association	COP	condition of participation
AMI	acute myocardial infarction	COPD	chronic obstructive pulmonary disease
APC	ambulatory payment classification	CPI–U	consumer price index for all urban consumers
APN	advanced practice nurse	CPT	Current Procedural Terminology
APR–DRG	all-patient refined–diagnosis related group	CT	computed tomography
APR–SOI	all-patient refined–severity of illness	CY	calendar year
APRN	advanced practice registered nurse	DME	durable medical equipment
ASC	ambulatory surgical center	DoD	Department of Defense
ATRA	American Taxpayer Relief Act of 2012	DRG	diagnosis related group
BLS	Bureau of Labor Statistics	DSH	disproportionate share hospital
BMI	body mass index	D–SNP	dual-eligible special needs plan
CAH	critical access hospital	E&M	evaluation and management
CAHPS®	Consumer Assessment of Healthcare Providers and Systems®	EBITDA	earnings before interest, taxes, depreciation, and amortization
CAHPS®–MA	Consumer Assessment of Healthcare Providers and Systems® for Medicare Advantage	ED	emergency department
C–APC	comprehensive ambulatory payment classification	EGHP	employer group health plan
CARE	Continuity Assessment Record and Evaluation [tool]	EGWP	employer group waiver plans
CAUTI	catheter-associated urinary tract infections	EHR	electronic health record
CBO	Congressional Budget Office	eRx	electronic prescribing
CBSA	core-based statistical area	ESA	erythropoiesis-stimulating agent
CC	complication or comorbidity	ESCO	ESRD Seamless Care Organization
CCI	chronic critical illness/chronically critically ill	ESRD	end-stage renal disease
CCM	chronic care management	FDA	Food and Drug Administration
CCP	coordinated care plan	FFS	fee-for-service
CDC	Centers for Disease Control and Prevention	FIM™	Functional Independence Measure™
CED	Comprehensive End-Stage Renal Disease [care model]	FY	fiscal year
CHS	Community Health Systems	GAO	Government Accountability Office
CHC	continuous home care	GDP	gross domestic product
CHF	congestive heart failure	GDR	generic dispensing rate
CHIP	Children’s Health Insurance Program	GI	gastrointestinal
		GPCI	geographic practice cost index
		HAC	hospital-acquired condition

H-CAHPS®	Hospital Consumer Assessment of Healthcare Providers and Systems®	LTCH	long-term care hospital
HCBS	home- and community-based services	LUPA	low utilization payment adjustment
HCC	hierarchical condition category	M&A	merger and acquisition
HCCI	Health Care Cost Institute	MA	Medicare Advantage
HCFA	Health Care Financing Administration	MACIE	Medicare Ambulatory Care Indicator for the Elderly
HCPCS	Healthcare Common Procedure Coding System	MACPAC	Medicaid and CHIP Payment and Access Commission
HEDIS®	Healthcare Effectiveness Data and Information Set®	MA-PD	Medicare Advantage–Prescription Drug [plan]
HHA	home health agency	MCBS	Medicare Current Beneficiary Survey
HHS	Department of Health and Human Services	MCC	major complication or comorbidity
HI	Hospital Insurance (Medicare Part A)	MCCM	Medicare Care Choices Model
HIT	health information technology	MDS	Minimum Data Set
HIV	human immunodeficiency virus	MedPAC	Medicare Payment Advisory Commission
HMO	health maintenance organization	MEI	Medicare Economic Index
HOPD	hospital outpatient department	MEPS	Medical Expenditure Panel Survey
HOS	Health Outcomes Survey	MGMA	Medical Group Management Association
HPSA	health professional shortage area	MIPPA	Medicare Improvements for Patients and Providers Act of 2008
HRR	hospital referral region	MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003
HSA	health service area	MMSEA	Medicare, Medicaid, and SCHIP Extension Act of 2007
HSA	hospital service area	MOU	memorandum of understanding
HUD	Department of Housing and Urban Development	MRI	magnetic resonance imaging
HWH	hospital-within-hospital	MRSA	methicillin-resistant <i>Staphylococcus aureus</i>
ICD-9-CM	International Classification of Diseases, Ninth Revision, Clinical Modification	MSA	metropolitan statistical area
ICL	initial coverage limit	MS-DRG	Medicare severity–diagnosis related group
ICU	intensive care unit	MS-LTC-DRG	Medicare severity long-term care diagnosis related group
IGC	impairment group code	MTMP	medication therapy management program
IME	indirect medical education	N/A	not applicable
IMPACT	Improving Medicare Post-Acute Care Transformation Act of 2014	N/A	not available
IOL	intraocular lens	NAMCS	National Ambulatory Medical Care Survey
IOM	Institute of Medicine	NCQA	National Committee for Quality Assurance
IPPS	inpatient prospective payment system	NDC	national drug code
IPS	interim payment system	NHSN	National Healthcare Safety Network
IRF	inpatient rehabilitation facility	NIDDK	National Institute of Diabetes and Digestive and Kidney Diseases
IRF-PAI	Inpatient Rehabilitation Facility–Patient Assessment Instrument	NP	nurse practitioner
IV	intravenous	NSAS	National Survey of Ambulatory Surgery
KDE	kidney disease education	NTA	nontherapy ancillary
LDO	large dialysis organization	OECD	Organisation for Economic Co-operation and Development
LEP	late enrollment penalty	OIG	Office of Inspector General
LIS	low-income [drug] subsidy	OOP	out of pocket
LOS	length of stay		
LPN	licensed practical nurse		
LTC	long-term care		

OPPS	outpatient prospective payment system	QIP	quality incentive program
OR	operating room	RDS	retiree drug subsidy
PA	physician assistant	RUG	resource utilization group
PAC	post-acute care	RVU	relative value unit
PAC-PRD	Post-Acute Care Payment Reform Demonstration	RY	rate year
PBM	pharmacy benefit manager	SCHIP	State Children's Health Insurance Program
PCIP	Primary Care Incentive Payment program	SGR	sustainable growth rate
PCP	primary care practitioner	SMI	Supplementary Medical Insurance (Medicare Part B)
PD	peritoneal dialysis	SNF	skilled nursing facility
PDE	prescription drug event	SNP	special needs plan
PDP	prescription drug plan	SSDI	Social Security Disability Insurance
PFFS	private fee-for-service	SSI	Supplemental Security Income
PFS	physician fee schedule	SSI	surgical site infection
POS	Provider of Services	SSO	short-stay outlier
PPA	potentially preventable admission	TEFRA	Tax Equity and Fiscal Responsibility Act of 1982
PPACA	Patient Protection and Affordable Care Act of 2010	TMR	targeted medication review
PPO	preferred provider organization	UA	urbanized area
PPS	prospective payment system	UC	urbanized cluster
PPV	potentially preventable emergency department visit	USRDS	United States Renal Data System
PQI	Prevention Quality Indicator	UTI	urinary tract infection
PQRS	Physician Quality Reporting System	VA	Department of Veterans Affairs
PSI	patient safety indicator	VBP	value-based purchasing [program]
		VSSO	very short-stay outlier

More about MedPAC

Commission members

Glenn M. Hackbarth, J.D., chairman

Bend, OR

Jon B. Christianson, Ph.D., vice chairman

School of Public Health at the University of Minnesota

Minneapolis, MN

Term expires April 2015

Alice Coombs, M.D.

Milton Hospital and South Shore Hospital

Weymouth, MA

Glenn M. Hackbarth, J.D.

Jack Hoadley, Ph.D.

Health Policy Institute, Georgetown

University

Washington, DC

David Nerenz, Ph.D.

Henry Ford Health System

Detroit, MI

Rita Redberg, M.D., M.Sc.

University of California at San Francisco

Medical Center

San Francisco, CA

Craig Samitt, M.D., M.B.A.

Oliver Wyman

Paradise Valley, AZ

Term expires April 2016

Scott Armstrong, M.B.A., F.A.C.H.E.

Group Health Cooperative

Seattle, WA

Katherine Baicker, Ph.D.

Harvard School of Public Health

Boston, MA

Jon B. Christianson, Ph.D.

Herb B. Kuhn

Missouri Hospital Association

Jefferson City, MO

Mary Naylor, Ph.D., F.A.A.N., R.N.

University of Pennsylvania, School of

Nursing

Philadelphia, PA

Cori Uccello, F.S.A., M.A.A.A., M.P.P.

American Academy of Actuaries

Washington, DC

Term expires April 2017

Kathy Buto, M.P.A.

Arlington, VA

Francis “Jay” Crosson, M.D.

Palo Alto, CA

Bill Gradison Jr., M.B.A., D.C.S.

McLean, VA

William J. Hall, M.D., M.A.C.P.

University of Rochester School of Medicine

Rochester, NY

Warner Thomas, M.B.A.

Ochsner Health System

New Orleans, LA

Commissioners' biographies

Scott Armstrong, M.B.A., F.A.C.H.E., is president and chief executive officer (CEO) of Group Health Cooperative, a consumer-governed health system serving 650,000 enrollees through coordinated care plans for groups and individuals and for Medicare, Medicaid, and State Children's Health Insurance Program beneficiaries. He has worked at Group Health since 1986, serving in positions ranging from assistant hospital administrator to chief operating officer; he became president and CEO in 2005. Before joining Group Health, Mr. Armstrong was assistant vice president for hospital operations at Miami Valley Hospital in Dayton, OH. Mr. Armstrong is a member of the board of the Alliance of Community Health Plans and board member of America's Health Insurance Plans and the Seattle Chamber of Commerce. He is also immediate past chair of the Board of the Pacific Science Center and a fellow of the American College of Healthcare Executives. He received his bachelor's degree from Hamilton College in New York and a master's degree in business with a concentration in hospital administration from the University of Wisconsin–Madison.

Katherine Baicker, Ph.D., is C. Boyden Gray Professor of Health Economics and Chair of the Department of Health Policy and Management at the Harvard School of Public Health, where her research focuses on health insurance finance and the effect of reforms on the distribution and quality of care. From 2005 to 2007, Professor Baicker served as a Senate-confirmed member of the President's Council of Economic Advisers. She is a research associate at the National Bureau of Economic Research, is on the Congressional Budget Office's Panel of Health Advisers, is Chair of the Group Insurance Commission of Massachusetts, and is an elected member of the Institute of Medicine. She also served as a commissioner of the Robert Wood Johnson Foundation's Commission to Build a Healthier America, was a member of the Institute of Medicine's Committee on Health Insurance Status and Its Consequences, and served on the faculty of the Economics Department at Dartmouth College. She received her B.A. in economics from Yale University and her Ph.D. in economics from Harvard University.

Kathy Buto, M.P.A., is an expert in U.S. and international health policy. She has recently been involved in a range of volunteer professional engagements, including with the National Academy of Social Insurance, the Robert Wood Johnson Foundation's Healthcare Legacy Forum, and the

National Science Foundation's Study of Women in Policy Making. Her previous positions include vice president of global health policy at Johnson & Johnson, senior health adviser at the Congressional Budget Office, deputy director of the Center for Health Plans and Providers at the Health Care Financing Administration (now Centers for Medicare & Medicaid Services), and deputy executive secretary for health at the Department of Health and Human Services. Ms. Buto received her master's in public administration from Harvard University.

Jon B. Christianson, Ph.D., is the James A. Hamilton Chair in Health Policy and Management in the Division of Health Policy and Management at the School of Public Health at the University of Minnesota. His research has addressed the areas of health finance, payment structures, rural health care, managed care payment, and the quality and design of care systems. Dr. Christianson serves on the Institute of Medicine's Board on Health Care Services and on the editorial board of the *American Journal of Managed Care*. He recently served on the Institute of Medicine's Committee on Geographic Adjustment Factors in Medicare Payment and has chaired AcademyHealth's annual research meeting. Dr. Christianson received his Ph.D. in economics from the University of Wisconsin.

Alice Coombs, M.D., is a critical care specialist and an anesthesiologist at Milton Hospital and South Shore Hospital in Weymouth, MA. She is board certified in internal medicine, anesthesiology, and critical care medicine. Dr. Coombs is past president of the Massachusetts Medical Society (MMS) and a member of MMS's Committee on Ethnic Diversity. She chaired the Committee on Workforce Diversity that is part of the American Medical Association's (AMA's) Commission to Eliminate Health Care Disparities and on the Governing Council for the AMA Minority Affairs Consortium and the AMA Initiative to Transform Medical Education. She helped to establish the New England Medical Association, a state society of the National Medical Association that represents minority physicians and health professionals. Dr. Coombs has served as a member and vice chair of the Massachusetts Board of Registration in Medicine Patient Care Assessment Committee. In addition, she was a member of the Massachusetts Special Commission on the Health Care Payment System.

Francis “Jay” Crosson, M.D., spent 35 years as a physician and physician executive at Kaiser Permanente. In 1997 he founded and then led for 10 years the Permanente Federation LLC, the national umbrella organization for the physician half of Kaiser Permanente. Later he served as senior fellow at the Kaiser Permanente Institute for Health Policy and director of public policy for The Permanente Medical Group. From July 2012 through October 2014, he was group vice president, American Medical Association in Chicago, IL, where he oversaw work related to physician practice satisfaction, efficiency, and sustainability. He currently serves on the National Advisory Council of the Agency for Healthcare Research and Quality. He previously served on MedPAC from 2004 to 2010, including as vice chair from 2009 to 2010. Dr. Crosson received his medical degree from the Georgetown University School of Medicine.

Bill Gradison, Jr., M.B.A., D.C.S., was a scholar in residence in the Health Sector Management Program at Duke’s Fuqua School of Business. He was a member of the U.S. Congress (1975–1993) where he served on the House Budget Committee and the Health Subcommittee of the Committee on Ways and Means. Mr. Gradison was a founding board member of the Public Company Accounting Oversight Board and was vice chairman of the U.S. Bipartisan Commission on Comprehensive Health Care (“Pepper Commission”). Prior positions also include assistant to the Secretary of Health, Education, and Welfare; president of the Health Insurance Association of America; and vice chair of the Commonwealth Fund Task Force on Academic Health Centers. Mr. Gradison received his B.A. from Yale University and an M.B.A. and doctorate from Harvard Business School.

Glenn M. Hackbarth, J.D., M.A., chairman of the Commission, lives in Bend, OR. He was chief executive officer and one of the founders of Harvard Vanguard Medical Associates, a multispecialty group practice in Boston that serves as a major teaching affiliate of Harvard Medical School. Mr. Hackbarth previously served as senior vice president of Harvard Community Health Plan and president of its Health Centers Division, as well as Washington counsel of Intermountain Health Care. He has held various positions at the U.S. Department of Health and Human Services, including deputy administrator of the Health Care Financing Administration (now known as CMS). He is also a past chairman of the board of the Foundation of the American Board of Internal Medicine. Mr. Hackbarth received his B.A. from Pennsylvania State University and his J.D. and M.A. from Duke University.

William J. Hall, M.D., M.A.C.P., is a geriatrician and professor of medicine at the University of Rochester School of Medicine where he directs the Highland Hospital Center for Healthy Aging. He previously served as a member of the board of directors of AARP. His career has focused on systems of health care for older adults. He was instrumental in establishing the Program of All-Inclusive Care for the Elderly and developing many senior prevention and wellness programs. Dr. Hall’s prior service and positions include president of the American College of Physicians and leadership positions in the American Geriatrics Society. He received his bachelor’s degree from the College of the Holy Cross and his medical degree from the University of Michigan Medical School and pursued postdoctoral training at Yale University School of Medicine.

Jack Hoadley, Ph.D., is research professor at the Health Policy Institute of Georgetown University in Washington, DC. Dr. Hoadley previously served as director of the Division of Health Financing Policy for the Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation; as principal policy analyst at MedPAC and its predecessor organization, the Physician Payment Review Commission; and as senior research associate with the National Health Policy Forum. His research expertise includes health financing for Medicare, Medicaid, and the Children’s Health Insurance Program (CHIP); pharmaco-economics and prescription drug benefit programs; and private sector insurance coverage. Dr. Hoadley has published widely on health care financing and pharmaco-economics and has provided testimony to government panels.

Herb B. Kuhn is current president and chief executive officer of the Missouri Hospital Association (MHA), the trade association serving the state’s 176 hospitals and health systems. Before joining MHA, Mr. Kuhn served in multiple roles at the Centers for Medicare & Medicaid Services, including deputy administrator from 2006 to 2009 and director of the Center for Medicare Management from 2004 to 2006. From 2000 to 2004, Mr. Kuhn served as corporate vice president for the Premier Hospital Alliance, serving 1,600 institutional members. From 1987 through 2000, Mr. Kuhn worked in federal relations with the American Hospital Association. Mr. Kuhn received his bachelor of science in business from Emporia State University.

Mary D. Naylor, Ph.D., F.A.A.N., R.N., is the Marian S. Ware Professor in Gerontology and Director of the NewCourtland Center for Transitions and Health at the University of Pennsylvania School of Nursing. For the past two decades, Dr. Naylor has led an interdisciplinary program of research designed to improve the quality of care, decrease unnecessary hospitalizations, and reduce health care costs for vulnerable community-based elders. Dr. Naylor is also the National Program Director for the Robert Wood Johnson Foundation program, Interdisciplinary Nursing Quality Research Initiative, which is aimed at generating, disseminating, and translating research to understand how nurses contribute to quality patient care. She was elected to the National Academy of Sciences, Institute of Medicine in 2005. She also is a member of the RAND Health Board and the National Quality Forum Board of Directors, and was the founding chair of the Board of the Long-Term Quality Alliance.

David Nerenz, Ph.D., is director of the Center for Health Policy and Health Services Research at the Henry Ford Health System in Detroit, MI, as well as director of outcomes research at the Henry Ford Neuroscience Institute and vice chair for research in the Department of Neurosurgery at Henry Ford Hospital. He has served on the National Committee for Quality Assurance's Culturally and Linguistically Appropriate Services Workgroup, the Accountable Care Organization Technical Advisory Committee of the American Medical Group Association, and most recently as co-chair of the National Quality Forum's Expert Panel on Risk Adjustment for Sociodemographic Factors. Dr. Nerenz has served in various roles with the Institute of Medicine, including as chair of the Committee on Leading Health Indicators for Healthy People 2020. He serves on the editorial boards of *Population Health Management* and *Medicare Care Research and Review*.

Rita Redberg, M.D., M.Sc., is professor of clinical medicine at the University of California at San Francisco (UCSF) Medical Center. A cardiologist, Dr. Redberg is also core faculty at the UCSF Philip R. Lee Institute of Health Policy Studies and adjunct associate at Stanford University's Center for Health Policy/Center for Primary Care and Outcomes Research. She is editor of *JAMA Internal Medicine* and chairperson of CMS's Medicare Evidence Development and Coverage Advisory Committee. Dr. Redberg serves in numerous positions on committees of the American Heart Association and the

American College of Cardiology and was a Robert Wood Johnson Health Policy Fellow. She did her undergraduate work at Cornell University and has graduate degrees from the University of Pennsylvania Medical School and the London School of Economics.

Craig Samitt, M.D., M.B.A., is a partner and the Global Provider Practice Leader in Oliver Wyman's Health & Life Sciences Practice. He has led major health systems for 20 years, most recently serving as the president and CEO of HealthCare Partners, a division of DaVita HealthCare Partners. From 2006 through 2013, Dr. Samitt served as president and CEO of Dean Health System in Madison, WI, and previously held senior executive roles at Fallon Clinic, Harvard Pilgrim Health Care, and Harvard Vanguard Medical Associates. He is chair-emeritus of the Group Practice Improvement Network and previously served as an advisory and faculty member of the Centers for Medicare & Medicaid Services' Accountable Care Organization Accelerated Development Learning Sessions. Dr. Samitt received his B.S. in biology from Tufts University; his M.D. from Columbia University, College of Physicians and Surgeons; and his M.B.A. from the Wharton School.

Warner Thomas, M.B.A., is president and CEO of the Ochsner Health System in New Orleans, LA. He oversees a network of 10 hospitals, 45 health centers and clinics, and 2,200 affiliated physicians. The Ochsner system includes the Ochsner Medical Center in New Orleans, the Ochsner Clinic group practice, rurally based and subacute care hospitals, skilled nursing and rehabilitation facilities, and hospice. The Ochsner Medical Center operates one of the largest accredited non-university-based graduate medical education programs in the United States. It is also one of the largest Medicare risk contractors in the region and offers an accountable care organization for Medicare. Mr. Thomas's prior positions include chief operating officer of the Ochsner Clinic, vice president of managed care and network development at the Southern New Hampshire Medical Center, and senior auditor and consultant at Ernst & Young. He received his master's of business administration from Boston University Graduate School of Management.

Cori E. Uccello, F.S.A., M.A.A.A., M.P.P., is senior health fellow of the American Academy of Actuaries, serving as the actuarial profession's chief public policy liaison on health issues. Ms. Uccello focuses on issues related to health insurance financing, coverage and market reforms, and risk-sharing mechanisms. She recently served as a

member of the Technical Review Panel on the Medicare Trustees' report. Before joining the academy in 2001, she was a senior research associate at the Urban Institute where she focused on health insurance and retirement policy issues. She previously held the position of actuarial fellow at the John Hancock Life Insurance Company.

Ms. Uccello is a fellow of the Society of Actuaries and a member of the American Academy of Actuaries. She received an undergraduate degree in math and biology from Boston College and a master's degree in public policy from Georgetown University.

Commission staff

Mark E. Miller, Ph.D.

Executive director

James E. Mathews, Ph.D.

Deputy director

Analytic staff

Catherine Bloniarz, M.S.

Stephanie Cameron, Sc.M.

Carol Carter, Ph.D.

Evan Christman, M.P.Aff.

Zachary Gaumer, M.P.S.

David V. Glass, M.S.

Scott Harrison, Ph.D.

Kevin Hayes, Ph.D.

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Craig K. Lisk, M.S.

Kim Neuman, M.A.

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John Richardson, M.P.P.

Rachel Schmidt, Ph.D.

Julie Somers, Ph.D.

Jeffrey Stensland, Ph.D.

Shinobu Suzuki, M.A.

Ariel Winter, M.P.P.

Daniel Zabinski, Ph.D.

Research assistants

Anna Harty

Katelyn Smalley

Assistant director

Arielle Mir, M.P.A.

Special assistant and scheduler

Emily Johnson

Administrative staff

Reda H. Broadnax, B.S.

*Deputy director of finance
and operations*

Wylene Carlyle

Paula Crowell

Timothy Gulley

Tina Jennings, MTESL

Cynthia Wilson

Staff consultants

Valerie Aschenbach

Julian Pettengill

Joan Sokolovsky, Ph.D.

Carlos Zarabozo, A.B.

